Community Health Needs Assessment

Sakakawea Medical Center, Coal Country Community Health Center, Western Plains Public Health, Hill Top Home of Comfort, and Knife River Care Center – Service Area

Hazen, North Dakota

2025

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Executive Summary

To help inform future decisions and strategic planning, Sakakawea Medical Center (SMC), Coal Country Community Health Center (CCCHC), Western Plains Public Health (WPPH), Hill Top Home of Comfort (HTHC), and Knife River Care Center (KRCC) (collectively "Local Health Providers") 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 (UND) School of Medicine & Health Sciences (SMHS) 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. Three hundred thirty-one local health provider service area residents completed the survey. Additional information was collected through seven key informant interviews with community members. The input from the residents, who primarily reside in Dunn, Mercer, and Oliver Counties, represented the broad interests of the communities in the service area. Together with secondary data gathered from a wide range of sources, the survey presents a snapshot of the health needs and concerns in the community.

With regard to demographics, Dunn County's population from 2020 to 2023 decreased by 1.8 percent; Mercer County's population also decreased 0.5 percent, and Oliver County had a population increase of 0.2 percent. The average number of residents younger than age 18 (26%) for Dunn County comes in 2.4 percentage points higher than the North Dakota average (23.6%); Mercer County's population younger than age 18 (23.5%) is 0.1 percentage points lower than the state average, and Oliver County (23.7%) comes in 0.1 percentage points higher than the state average for population younger than 18. Residents ages 65 and older is 3.9 percent higher for Dunn County (19.6%) than the North Dakota average (15.7%), 7.6 percent higher for Mercer County, and 10.5 percent higher for Oliver County. The rate of education is slightly lower for Dunn County (90.6%), Mercer County (89.5%), and slightly higher for Oliver County (94.6%) than the North Dakota average (93.5%). The median household income in all three counties is higher than the state average for North Dakota ($75,949), with Dunn County at $94,688; Mercer County at $79,405; and Oliver County at $76,953.

Data compiled by County Health Rankings show Dunn, Mercer, and Oliver Counties are doing better collectively than North Dakota in health outcomes/factors for seven categories; Dunn County is doing better than North Dakota in health outcomes/factors for 13 categories; Mercer County is doing better than North Dakota in health outcomes/factors for 11 categories; and Oliver County is doing better than North Dakota in health outcomes/factors for 12 categories.

Dunn, Mercer, and Oliver Counties, according to County Health Rankings data, are collectively performing poorly, relative to the rest of the state, in four outcome/factor categories; Dunn County is performing worse than the state average in 14 categories; Mercer County is performing worse than the state average in 10 categories; and Oliver County is performing worse than the state average in 12 categories.

Of 106 potential community and health needs set forth in the survey, the 331 local health provider service area residents who completed the survey indicated the following nine needs as the most important:

- Attracting and retaining young families
- Availability of specialists
- 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
- Not getting enough exercise/physical activity
- Smoking and tobacco use

The survey also revealed the biggest barriers to receiving healthcare (as perceived by community members). They included not enough specialists (N=56), no insurance or limited insurance (N=54), and not enough evening or weekend hours (N=50).

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

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

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

- Alcohol use and abuse – adult
- Drug use and abuse – youth and adult
- Availability of resources to help the elderly stay in their homes
- Depression/anxiety – youth and adult
- Attracting and retaining young families
- Not enough affordable housing

Overview and Community Resources

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

Mercer and Dunn counties border the southern shore of Lake Sakakawea, and Oliver County borders the Missouri River. While tourism is a major industry during the summer season, agriculture and the energy industry are the backbone of the area. Also known as "The Energy Trail," the area contains the United States' only coal-to-synthetic natural gas plant and the nation's largest lignite mine. The tri-county area is also home to several electric generating stations, wind farms, and coal-generated power plants. In addition, the area hosts the expansion and exploration of the oil drilling operations that have expanded since the tapping of the Bakken Shale deposit.

Major communities located in the tri-county area are as follows:

Hazen, located in west central North Dakota, is considered the "heart" of Mercer County. The area is primarily focused on agriculture. The school district provides K-12 educational services. Nearby, Lake Sakakawea and the Missouri River provide many recreational activities. The community has a swimming pool, an indoor ice arena, tennis courts, ball diamonds, walk/bike paths, a movie theater, a golf course, a dog park, gyms, and city parks.

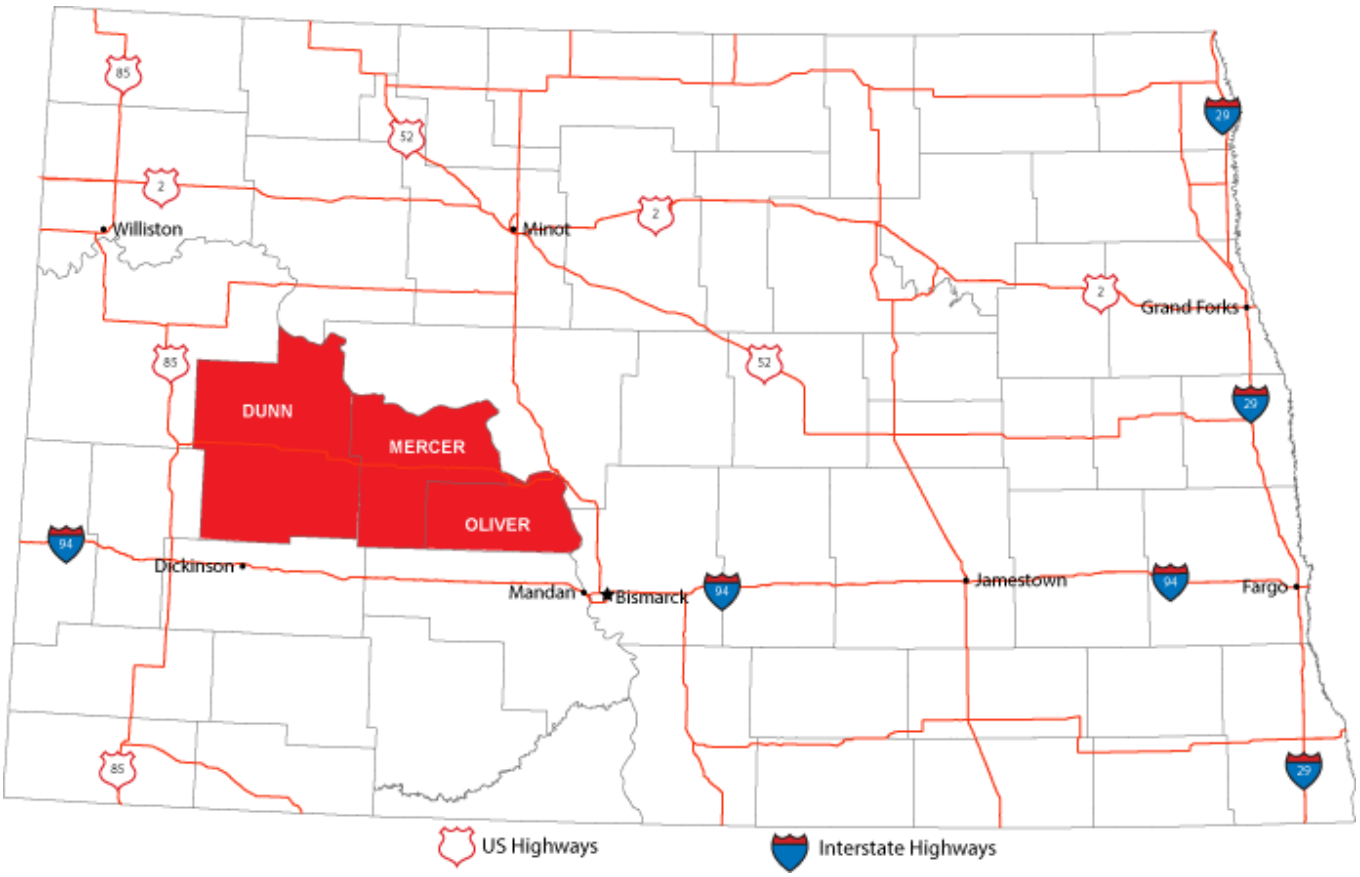
Beulah, located 10 miles from Hazen, is sometimes called the "Energy Capital of North Dakota," with the three largest employers being part of the energy industry. Beulah has a K-12 school system and an active parks and recreation organization. Beulah also offers a full-service wellness/fitness center, golf course, swimming pool, dog park, walk/bike path, skateboard park, outdoor sports complex, and a myriad of recreational activities at Lake Sakakawea, including fishing, camping, boating, and water sports.

Center is the only incorporated city in Oliver County and has a K-12 school system. It offers an indoor junior Olympic size pool that is open year-round, a golf course, and several parks with available camping, including Cross Ranch State Park and the Cross Ranch Preserve, which are only a short drive from the city. There are many fishing opportunities in the area, including nearby Nelson Lake, which is the only lake in the state that does not freeze in the winter due to the water being warmed by the nearby power plant.

Killdeer, centrally located in Dunn County, is the largest city in the county and is known as the "hub" of cowboy country. Highway 22 and Highway 200 intersect on the south edge of the city, and Interstate 94 is only 34 miles south. Killdeer is home to many area ranchers, and the oil industry is an integral part of the economy with the Little Knife Field located only 15 miles west of the city. Killdeer has a K-12 school system, golf course, and is the gateway to the beautiful Killdeer Mountains, which features the Little Missouri State Park, the Badlands Trail Rides, Eastview Campgrounds, and the Lewis & Clark Trail.

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

Figure 1: Dunn, Mercer, and Oliver Counties



Sakakawea Medical Center (SMC)

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

SMC's mission is to:

- Provide high quality care that is measured and continuously improved.
- Provide individualized care that exceeds expectations of those we serve.
- Strengthen partnerships with providers to enhance coordination of care and improve system performance.
- Be a steward of resources.
- Commit to service excellence.
- Be a vital contributor to our area communities.
- Recognize the value of each employee and provide opportunities for personal growth and development that complement the needs of the organization.

SMC dates back to 1941. The original hospital consisted of about a dozen beds on the second floor of one of the original main street buildings. The hospital was a private undertaking by a Beulah woman who ran the facility for several years until Hazen's plans for a new, modern hospital facility were well underway. Community effort continued to keep the hospital open for a time, but the hospital closed in 1946 due to difficulty finding competent personnel. Pursuant to an agreement with Lutheran Hospital and Homes Society for operation of a hospital, construction began on a new facility in 1946. The hospital with 23 beds opened in 1948. By the late 1960s, it was apparent that either major remodeling or a new facility was needed. With local donations and Hill-Burton federal funds, a 39-bed, 8-bassinet hospital was built at the east edge of Hazen, opening in 1970. The Hazen Memorial Hospital Association took over the hospital from Lutheran Hospitals Homes Society in 1969.

In 1982, the hospital embarked on a $1.2 million expansion and renovation. The hospital changed its name to SMC in 1988. Senior Suites at Sakakawea (licensed basic care facility) was added to the hospital campus in 1997.

In the fall of 2015, directly south of the hospital, the Board of Directors broke ground to begin the construction of a replacement facility. The retiring facility was closed, and a new $30.5 million replacement facility opened on April 5, 2017.

The new medical center houses a federally qualified health clinic within the hospital, an expanded emergency room and surgical area, handicapped-accessible patient rooms, a centralized registration area and nurse's station, and a myriad of other needed changes and technology updates. The new facility was designed to increase staff efficiency and accommodate changes underway in the delivery of healthcare as well as assisting healthcare providers to meet growing demands within the service area.

Services offered locally by Sakakawea Medical Center (SMC) include:
General and Acute Services

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

- Infection prevention
- Pharmacy
- Surgical services – CRNA
- Surgical services – endoscopies
- Surgical services – general
- Surgical services – women's health
- Trauma care
- Treatment room/infusions
- Urgent care

Surgical Services

- Appendectomy (removal of the appendix)
- Biopsies
- Colonoscopies
- Cholecystectomy (removal of gall bladder)
- Carpel tunnel release
- Colon (bowel resection)
- Cyst removals
- EGD (Esophagogastroduodenoscopy)
- Hernia repair
- Hysterectomies
- Ovary and tube removals
- Paracentesis
- Pilonidal cyst
- Thyroidectomy
- Thoracentesis

Screening/Therapy Services

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

- Stress testing
- Women's pelvic health

Radiology Services

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

Laboratory Services

- Blood Banking-Transfusion Service
- Chemistry
- Coagulation studies
- Hematology
- Phlebotomy
- SAT/BAT 3rd Party Collections
- Serology
- Urine testing

Treatment Room/Infusion Services

- Blood and Blood Product Transfusions
- Re-hydration Therapy
- Electrolyte Replacement Therapy
- Antibiotic Therapy
- Iron Infusions
- Specialty Medications
- Rabies Prophylaxis
- CADD Pump Removal
- PICC/Port Care
- Wound Care & Suture Removal

Other/Additional Services

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

Contracted Services

- Avera eEmergency
- Bismarck Radiology Associates
- Bismarck State College - Registered Nurse Program, Practical Nurse Program
- Altru Virtual ePharmacy
- Great Plains Rehab Services
- LifeSource - (organ, tissue and eye procurement organization)
- North Dakota Public Health Laboratories

- North Dakota VFC Immunization Program
- Northern Plains Lab
- Nutrition Counseling
- Pathology Consultants
- Speech Therapy
- Translation services
- Transportation services
- United Blood Services
- Virtual Radiology

Services offered by OTHER providers/organizations

- Ambulance
- Audiology
- Cardiology
- Chiropractic services
- Dental services
- Employee assistance
- Massage therapy
- Mental Health
- Nursing Home
- OB/GYN Clinic
- Optometric/vision services
- Orthopedics (visiting physician)
- Podiatry

Coal Country Community Health Center (CCCHC)

Coal Country Community Health Center (CCCHC) is a local, non-profit healthcare provider with clinics in Beulah, Hazen, Center, and Killdeer. As a federally qualified health center (FQHC), Coal Country improves access to care by serving all residents, including low-income and medically underserved people. Generally, CCCHC's costs of care rank among the lowest, and their focus on prevention reduces the need for more expensive in-patient and specialty care, which, on a national basis, saves billions of dollars for taxpayers. Coal Country is governed by a board of directors from the communities it serves.

The team of providers delivers primary care for the entire community. Funded by a federal grant, the Center's sliding fee scale allows patients to pay according to their individual ability. This and other efforts help ensure that no one in the community goes without proper healthcare services.

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

Services provided by Coal County Community Health Center (CCCHC):
General Medical and Integrated Care Services

- Infant, child, adolescent, and adult exams
- Mole/wart/skin lesion removal
- Diabetes self-management education, continuous blood glucose monitoring, and insulin pump management
- Consultant pharmacy

- Physicals; D.O.T., sports, pre-employment and insurance
- Sports medicine and concussion management
- Substance Use Disorder Services – drug and alcohol evaluations, intensive outpatient program, aftercare
- DUI seminars, MIP/MIC seminars
- Eligibility assistance – sliding fee scale – health discount program
- Employee Assistance Program
- Family planning, including implanted and oral contraception
- Geriatrics
- Home visits
- Infusion therapy
- Joint Injections
- Medication assisted therapy – suboxone
- Mental/behavioral health services including school integration services
- Occupational health medicine
- Outreach and enrollment services including certified Senior Health Insurance Counselors
- Pediatrics, including early childhood development specialists
- Prenatal and post-partum care
- Psychiatry via telehealth
- Tobacco/nicotine cessation services including youth program "Catch My Breath"
- Translation services
- Transportation services
- Virtual visits
- Visiting nurse services
- Welcome to Medicare and Medicare annual wellness visits
- Women's health including Women's Way program
- 340B Drug Discount Program

Comprehensive Care Coordination Services

- Chronic disease management
- Remote patient monitoring
- Social determinants of health (SDOH) screening and referral services
- Great Plains Food Bank Food Box program
- Community Care Coordination, including in- home safety evaluations and home visits
- Behavioral health case management

Screening and Preventive Care Services

- Chronic disease management
- Electrocardiograms
- Infant, child, adolescent, and adult preventive exams and immunizations
- Moderate complexity laboratory and basic radiology services, including visiting diagnostic ultrasound
- Health and wellness screenings
- NIOSH Coal Workers' Health Surveillance Program (CWHSP) including black lung screenings
- Pulmonary function tests
- Preventive dental

Contracted Services

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

- Pathology Consultants
- Dental
- Pediatric psychiatry

Visiting Specialists

- Audiology
- Cardiology
- Early intervention program
- Hearing consultant
- Home medical products and services
- OB/GYN
- Orthopedist
- Podiatry
- Psychology

Services offered by Other Providers/Organizations

- Pediatric therapy services
- In-home private pay senior care
- Dental services – visiting orthodontic care
- Chiropractic services

Western Plains Public Health (WPPH)

Founded in 1950, Western Plains Public Health is a five-county multidistrict health unit, providing health services to the people of Mercer, Oliver, Grant, Morton, and Sioux Counties. Public health services provided are environmental health, nursing services, tobacco/substance abuse prevention, and WIC (Women, Infants, and Children) program. Each of these programs provides a wide variety of services to accomplish the mission of public health, which is to assure that North Dakota is a healthy place to live, and each person should have an equal opportunity to enjoy good health. To accomplish this mission, Western Plains Public Health is committed to the promotion of healthy lifestyles, protection and enhancement of the environment, and provision of quality healthcare services for the people of North Dakota.

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

Specific services that Western Plains Public Health provides are:

- Beyond birth education
- Bicycle helmet safety education
- Blood pressure checks
- Breastfeeding resources
- Car seat program
- CPR and first aid
- Emergency preparedness services-work with community partners as part of local emergency response team
- Harm Reduction – Good Neighbor Program
- Environmental health services (water, sewer, health hazard abatement, food/beverage, public swimming pools, body art)
- Home Visiting – health maintenance
- Immunizations
- Infection control (HIV/AIDS, Hep C, STIs, TB testing and management)

- Nurse-Family Partnership
- School health – vision, hearing, health education, and resources to the schools
- Substance abuse prevention
- Tobacco prevention and control
- WIC (Women, Infants, and Children) Program
- Women's Way

Knife River Care Center (KRCC)

Originally called the Beulah Community Nursing Home, Knife River Care Center (KRCC) was incorporated in 1962. Over the years, it has grown to 86 skilled nursing care beds. After various remodeling and expansion projects, KRCC broke ground for a replacement facility in 2006 and moved in on January 26, 2008.

KRCC is a long-term care facility in Beulah and has the following as its mission statement: "Knife River Care Center is dedicated to the preservation of dignity and respect to those we serve and employ. With great compassion, we strive to make excellence our standard."

Services provided by Knife River Care Center:

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

Hill Top Home of Comfort (HTHC)

Hill Top Home of Comfort, a non-profit public organization located in Killdeer, is a 58-bed skilled nursing care facility with a 20-unit assisted living facility attached.

The establishment of Hill Top Home of Comfort made it possible for people in the community and surrounding areas to remain 'at home' while receiving nursing care. Hill Top offers post acute care, assisted living, and long term care at the facility.

The mission of Hill Top Home of Comfort is to "provide an atmosphere of warmth and caring to the people that call it home." It has been said that home is where the heart is, and they are proud that Hill Top has earned the reputation of being known as "the Home with Heart."

In addition, to caring for the individual, recognizing that to age is a natural part of the life process, Hill Top Home of Comfort has set up continuing goals as follows:

- To provide care that extends and enhances the quality of life for residents
- To contribute in every way to the fullest possible development of his/her potential by preventative, corrective, or supportive care
- Above all, respect the dignity of the individual

Services provided by Hill Top Home of Comfort:

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

Assessment Process

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

A CHNA benefits the community by:

1. Collecting timely input from the local community members, providers, and staff.
2. Providing an analysis of secondary data, related to health-related behaviors, conditions, risks, and outcomes.
3. Compiling and organizing information to guide decision making, education, and marketing efforts, and to facilitate the development of a strategic plan.
4. Engaging community members about the future of healthcare.
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, as well as helping the local public health unit and federally qualified health center meet accreditation and assessment requirements.

This assessment examines health needs and concerns in Dunn, Mercer, and Oliver Counties, which are all included in the local health providers' service area. In addition to Hazen, located in this service area are the communities of Beulah, Center, Dodge, Dunn Center, Golden Valley, Halliday, Killdeer, Pick City, Stanton, and Zap.

The Center for Rural Health (CRH), in partnership with local health providers, facilitated the CHNA process. Community representatives met regularly in-person, by telephone conference, and email. A CHNA liaison was selected locally, who served as the main point of contact between CRH and Hazen. A steering committee (see Figure 2) was formed that was responsible for planning and implementing the process locally. Representatives from CRH met and corresponded regularly by the eToolkit with the CHNA liaison. The community group (described in more detail below) provided in-depth information and informed the assessment process in terms of community perceptions, community resources, community needs, and ideas for improving the health of the population and healthcare services. There were 17 people, representing a cross section demographically, who attended the community group meeting. The meeting was highly interactive with good participation.

Figure 2: Steering Committee

Chastity Dolbec	Director of Patient Care and Innovation, CCCHC
Tiffany Carroll	Executive Assistant, SMC & CCCHC
Blake Kragnes	Administrator, KRCC
Gerry Leadbetter	Administrator, HTHC
Heidi Moore	Public Health Nurse, WPPH
Kara Pulver	Marketing Director, SMC & CCCHC
Rachel Sem	Director of Nursing, SMC
Erin Ourada	Administrator, WPPH
Kurt Waldbillig	Chief Executive Officer, SMC & CCCHC

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

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

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

CRH is one of the nation's most experienced organizations committed to providing leadership in rural health. Its mission is to connect resources and knowledge to strengthen the health of people in rural communities. CRH is the designated State Office of Rural Health and is 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 national, state, and community levels.

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 17 community members, was convened and first met on October 21, 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 January 6, 2025, with 15 community members in attendance. At this second meeting, the community group was presented with survey results, findings from key informant interviews and the focus group, and a wide range of secondary data relating to the general health of the population in Dunn, Mercer, and Oliver Counties. The group was then tasked with identifying and prioritizing the community's health needs.

Members of the community group represented the broad interests of the community served by SMC, WPPH, KRCC, HTHC, and CCCHC. They included representatives of the health community, business community, and education leaders. Not all members of the group were present at both meetings.

Interviews

One-on-one interviews with six key informants were conducted in person in Hazen on October 21, 2024. Any key informants who were unavailable completed their interview via Zoom or phone call. Interviews were held with selected members of the Community Group as well as other key informants who could provide insights into the community's health needs.

Topics covered during the interviews included general health needs of the community, the general health of the community, community concerns, delivery of health care 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 Dunn, Mercer, and Oliver Counties, which are all included in the health care provider service area. The survey tool was designed to:

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

Specifically, the survey covered the following topics:

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

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

To help ensure anonymity, included with each survey was a postage-paid return envelope to CRH. The survey period ran from October 7, 2024 to October 21, 2024. There were three completed paper surveys returned.

Area residents also were given the option of completing an online version of the survey. To promote awareness of the assessment process and the survey, advertisements were printed in four newspapers in the communities of Beulah, Center, Hazen, and Killdeer. Additionally, information was published and distributed by local area chambers of commerce to their membership via email. Local Health Providers also published information on their social media pages and websites. Three hundred twenty-eight online surveys were completed. Forty-four of those online respondents used the QR code to complete the survey. In total, 331 community member surveys were completed, equating to a 19% response rate. This response rate is much higher than usual for this type of unsolicited survey methodology and indicates a somewhat engaged community, which is about 13%.

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

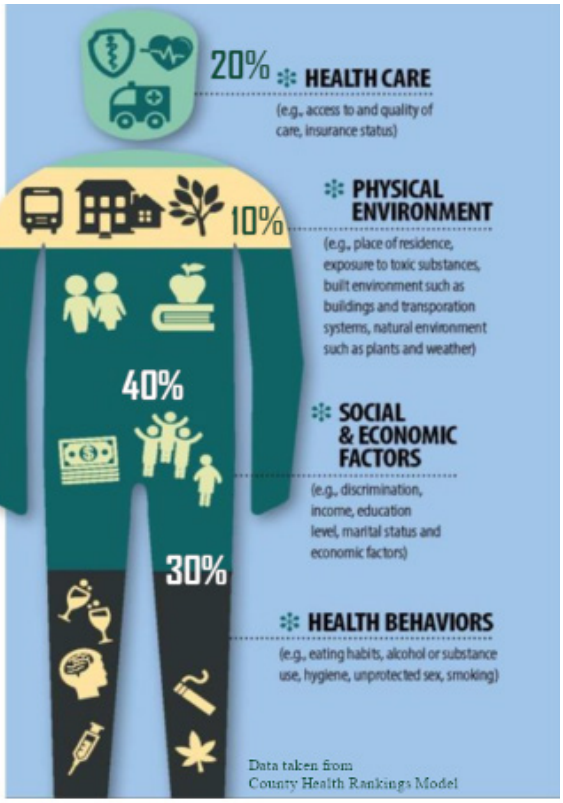
Social determinants of health are, according to the World Health Organization, "The circumstances in which people are born, grow up, live, work, and age and the systems put in place to deal with illness. These circumstances are in turn shaped by wider set of forces: economics, social policies, and politics."

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.

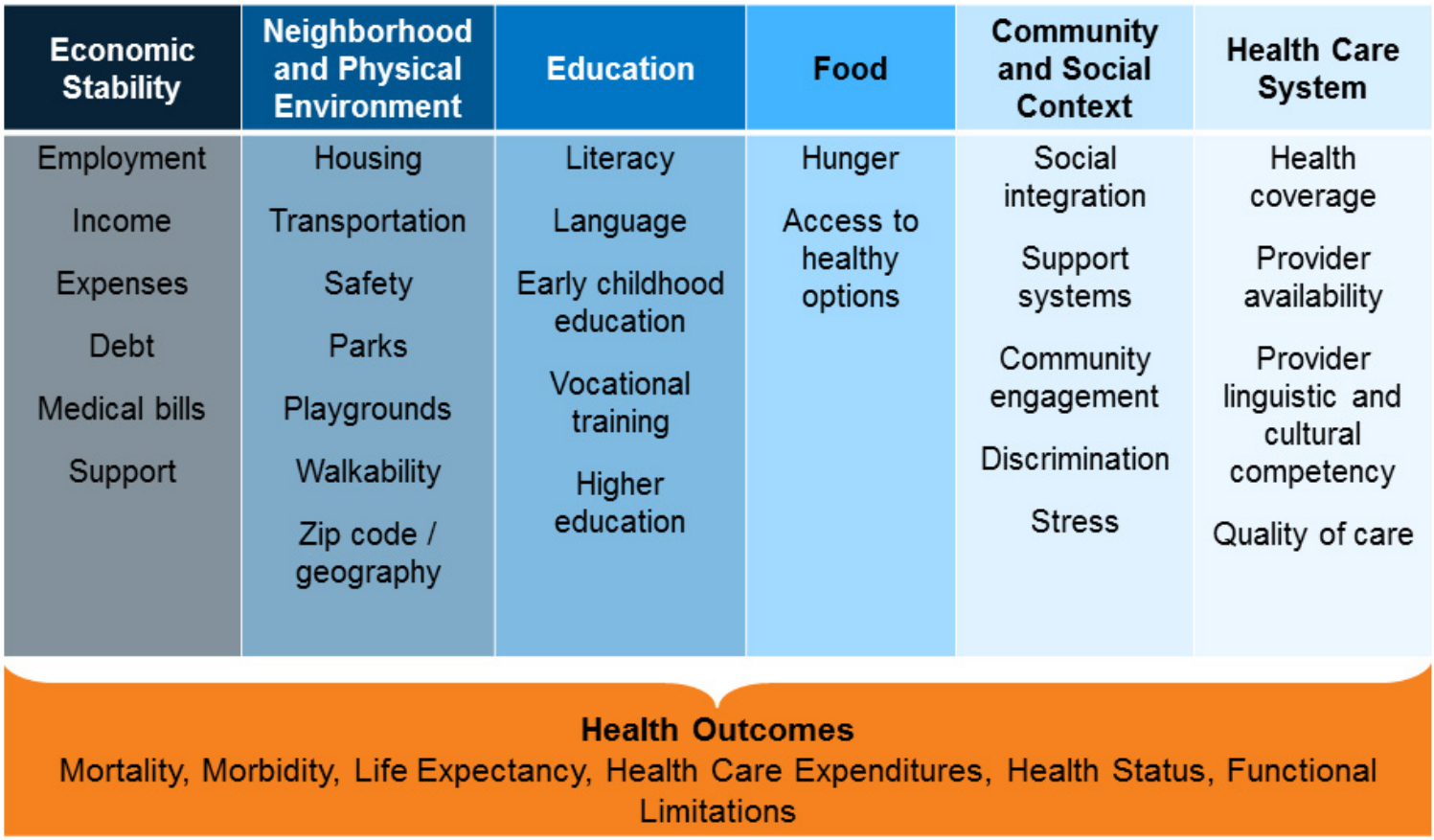
For Figure 3, data have been derived from the County Health Rankings model, (https://www.countyhealthrankings.org/resources/county-health-rankings-model), and it illustrates that healthcare, while vitally important, plays only one small role (approximately 20%) in the overall health of individuals and, 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



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



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Demographic Information

TABLE 1: Summarizes general demographic and geographic data about Dunn, Mercer, and Oliver Counties.
From 2020 Census/2023 American Community Survey; more recent estimates used where available.

	Dunn County	Mercer County	Oliver County	North Dakota
Population (2023)	4,019	8,309	1,879	783,926
Population change (2020-2023)	-1.8%	-0.5%	0.2%	0.6%
People per square mile (2020)	2.0	8.0	2.6	11.3
Persons 65 years or older (2023)	19.6%	23.3%	26.2%	15.7%
Persons under 18 years (2023)	26.0%	23.3%	23.7%	23.6%
Median age (2022)	39.0	44.0	47.0	35.5
White persons (2023)	83.5%	93.4%	94.8%	86.4%
High school graduates (2018-2022)	90.6%	89.5%	94.6%	93.5%
Bachelor's degree or higher (2018-2022)	19.0%	19.9%	21.6%	31.4%
Live below poverty line (2022)	11.4%	7.2%	9.7%	9.8%
Persons without health insurance, under age 65 years (2022)	10.1%	6.6%	5.6%	5.3%
Households with a broadband Internet subscription (2022)	83.9%	86.2%	81.1%	85.8%

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

While the population of North Dakota has grown in recent years, the U.S. Census Bureau estimates show Dunn County has seen a decrease of 1.8%, from 4,095 (2020) to 4,019 (2023); Mercer County has seen a slight decrease from 8,350 (2020) to 8,309 (2023), and Oliver County has seen a small increase from 1,877 (2020) to 1,879 (2023).

County Health Rankings

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

The data, used in the 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 that 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.

Health Outcomes

- Length of life
- Quality of life

Health Factors

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

Health Factors (continued)

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

Table 2 summarizes the pertinent information gathered by County Health Rankings as it relates to Dunn, Mercer, and Oliver Counties. It is important to note that these statistics describe the population of a county, regardless of where county residents choose to receive their medical care. In other words, all of the following statistics are based on the health behaviors and conditions of the county's residents, not necessarily the patients and clients of Coal Country Community Health Center, Western Plains Public Health, Sakakawea Medical Center 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 2024. 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).

The measures marked with a bullet point (•) are those where a county is not measuring up to the state rate/percentage; a square (■) indicates that the county is not meeting the U.S. Top 10% rate on that measure. Measures that are not marked with a colored shape but are marked with a plus sign (+) indicate that the county is doing better than the U.S. Top 10%.

The data from County Health Rankings show that Dunn, Mercer, and Oliver Counties, like many North Dakota counties, are doing poorly in many areas, when it comes to the U.S. Top 10% rankings and the rest of the state. One particular outcome where Dunn, Mercer, and Oliver Counties do not meet the U.S. Top 10% ratings is excessive drinking.

On health factors, Dunn, Mercer, and Oliver Counties perform below the North Dakota average for counties in several areas as well.

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

- Low rates of poor mental health days
- Low rates of low birth weight
- Excessive drinking
- Alcohol-related driving deaths
- Low rates of sexually transmitted infections
- Low number of preventable hospital stays
- Low unemployment rates
- Income inequality
- High rates of social associations
- Low number of injury deaths
- Air pollution – particulate matter
- No drinking water violations
- Low rates of severe housing problems

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

- Premature deaths
- Poor mental health days (in past 30 days)
- Low birth weight
- Food environment index
- Physical inactivity
- Access to exercise opportunities
- Excessive drinking
- Low rates of sexually transmitted infections
- Low rates of teen birth rate
- Uninsured rate
- Primary care provider to patient ratio
- Dentist to patient ratio
- Preventable hospital stays
- Children in poverty
- Income inequality
- Children in single-parent households
- Social associations
- No drinking water violations
- Air pollution, particulate matter
- Low rates of severe housing problems

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

- Low rates of poor or fair health
- Low rates of poor mental health days
- Physical inactivity
- Excessive drinking
- Uninsured
- Mammography screening
- Income inequality
- Children in single-parent households
- High rates of social associations
- Air pollution, particulate matter
- No drinking water violations
- Severe housing problems

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

- Premature death
- Poor or fair health
- Poor physical health days
- Adult obesity
- Adult smoking
- Food environment index
- Physical inactivity
- Access to exercise opportunities
- Teen birth rate
- Number of uninsured
- Mammography screening in Medicare enrollees
- Flu vaccinations in Medicare enrollees
- Children in poverty
- Children in single-parent households
- Injury deaths

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

- Poor or fair health
- Poor physical health days
- Adult smoking
- Adult obesity
- Alcohol-impaired driving deaths
- Number of uninsured
- Number of mental health providers
- Rate of mammography screening in Medicare enrollees
- Rate of Flu vaccinations in Medicare enrollees
- Unemployment rate
- Injury deaths

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

- Poor physical health days
- Adult obesity
- Adult smoking
- Food environment index
- Access to exercise opportunities
- Alcohol-impaired driving deaths
- Number of primary care providers
- Number of dentists
- Number of preventable hospital stays
- Flu vaccinations in Medicare enrollees
- High unemployment rate
- Children in poverty

Table 2: Selected Measures from County Health Rankings 2024-DUNN, OLIVER, AND MERCER COUNTY • = Not meeting North Dakota Average, ■ = Not meeting U.S. Top 10 % Performers + = Meeting or exceeding U.S. Top 10% performers.

	Dunn County	Mercer County	Oliver County	U.S. Top 10%	ND
Ranking: Outcomes					
Premature death	8,200 •■	5,500 +		8,000	7,600
Poor or fair health	14% •+	14% •+	13% +	14%	13%
Poor physical health days (in past 30 days)	3.2 •+	3.2 •+	3.2 •+	3.3	3.1
Poor mental health days (in past 30 days)	3.5 +	3.9 +	3.9+	4.8	4.0
Low birth weight	5% +	6% +		8%	7%
Ranking: Factors					
Health Behaviors					
Adult smoking	17% •■	18% •■	17% •■	15%	16%
Adult obesity	40% •■	40% •■	37% •■	34%	36%
Food environment index (10=best)	8.6 •+	9.4 +	7.8 •+	7.7	9.1
Physical inactivity	28% •■	25% ■	25% ■	23%	25%
Access to exercise opportunities	35% •■	78% ■	45% •■	84%	76%
Excessive drinking	22% ■	22% ■	20% ■	18%	23%
Alcohol-impaired driving deaths	27% ■	80% •■	75% •■	26%	39%
Sexually transmitted infections	247.8 +	120.1 +		495.5	511.5
Teen birth rate	20 •■	10 +		17	15
Clinical Care					
Uninsured	13% •■	8% +	8% +	10%	9%
Primary care physicians		1,190:1+	1,870:1 •■	1,330:1	1,290:1
Dentists		1,190:1 +	1,860:1 •■	1,360:1	1,420:1
Mental health providers		1,190:1 •■		320:1	450:1
Preventable hospital stays	1,224 +	2,446 +	3,863 •■	2,681	2,945
Mammography screening (% of Medicare enrollees aged 65-74 receiving screening)	47% •+	50% •+	60% +	43%	53%
Flu vaccinations (% of fee-for-service Medicare enrollees receiving vaccination)	33% •■	20% •■	31% •■	46%	49%
Social and Economic Factors					
Unemployment	1.3% +	3.3% •+	3.3% •+	3.7%	2.1%
Children in poverty	16% •+	8% +	15% •+	16%	12%
Income inequality	4.0 +	4.3 +	3.8 +	4.9	4.4
Children in single-parent households	22% •+	17% +	16% +	25%	18%
Social associations	17.3 +	24.0 +	16.0 +	15.5	9.1
Injury deaths	65 +	85 •■		80	75
Physical Environment					
Air pollution – particulate matter	4.1 +	6.1 •+	4.6 +	7.4	5.0
Drinking water violations	No	No	No		
Severe housing problems	10% +	9% +	11% +	17%	12%

Source: Source: http://www.countyhealthrankings.org/app/north-dakota/2022/rankings/outcomes/overall

Children's Health

The National Survey of Children's Health touches on multiple intersecting aspects of children's lives. Data are not available at the county level; listed below is information about children's health in North Dakota. The full survey includes physical and mental health status, access to quality healthcare, and information on the child's family, neighborhood, and social context. Data are from 2021-22. More information about the survey may be found at www.childhealthdata.org/learn/NSCH.

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

Table 2: 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%	11.4%
Children aged 6-17 who were overweight or obese	28%	33.8%
Children aged 0-5 who were ever breastfed	77.6%	81.5%
Children aged 6-17 who missed 11 or more days of school	5.9%	5.7%
Healthcare		
Children currently insured	94.3%	93.1%
Children who spent less than 10 minutes with the provider at a preventive medical visit	16.1%	18.8%
Children (1-17 years) who had preventive a dental visit in the past year	77.7%	77.0%
Children (3-17 years) received mental healthcare	13.4%	11.6%
Children (3-17 years) with problems requiring treatment did not receive mental healthcare	2.6%	2.8%
Young children (9-35 mos.) receiving standardized screening for developmental problems	46.1%	33.7%
Family Life		
Children whose families eat meals together four or more times per week	54.8%	53.5%
Children who live in households where someone smokes	17.1%	12.7%
Neighborhood		
Children who live in neighborhoods with parks, recreation centers, sidewalks, and a library	33.6%	36.1%
Children living in neighborhoods with poorly kept or rundown housing	2.1%	3.6%
Children living in neighborhood that's usually or always safe	76.3%	66.2%

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 (0-5 years) who were ever breastfed
- Children (6-17 years) who missed 11 or more days of school
- Children living in smoking households
- Children who live in neighborhoods with parks, recreation centers, sidewalks, and a library

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. The measures highlighted in blue in the table are those in which the counties are doing worse than the state average. The year of the most recent data is noted.

The data show Dunn and Oliver County are performing more poorly than the North Dakota average for four-year high school graduation rate; Mercer County is performing better than North Dakota in this category. Dunn, Mercer, and Oliver Counties are doing better in all other categories than North Dakota.

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

	Dunn County	Oliver County	Mercer County	North Dakota
Child food insecurity, 2022	12.4%	12.5%	12.4%	13.5%
Medicaid recipient (% of population age 0-20), 2023	27.1%	20.8%	24.2%	29.4%
Children enrolled in Healthy Steps (CHIP) (% of population age 0-18), 2023	1.1%	0.9%	2.2%	2.4%
Supplemental Nutrition Assistance Program (SNAP) recipients (% of population age 0-18), 2023	11.5%	7.5%	9.3%	15.6%
Licensed childcare capacity (# of children), 2024	108	44	289	35,367
Four-year high school cohort graduation rate, 2022/2023	78.4%	>=80%	>=95%	82.7%
Victims of child abuse and neglect requiring services (rate per 1,000 children ages 0-17), 2023	NA	NA	NA	4.89

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, to compare state health risk behaviors to national health risk behaviors, and intended to be used 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
Injury and Violence							
% 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
Tobacco, Alcohol, and Other Drug Use							
% of students who currently use an electronic vapor product (e-cigarettes, vape e-cigars, e-pipes, vape pipes, vaping pens, e-hookahs, and hookah pens at least one day during the 30 days before the survey)	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
Weight Management, Dietary Behaviors, and Physical Activity							
% 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
Other							
% 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/healthyyouth/data/yrbs/results.htm; https://www.nd.gov/dpi/districtsschools/safety-health/youth-risk-behavior-survey

Low Income Needs

The North Dakota Community Action Agencies (CAAs), as nonprofit organizations, were originally established under the Economic Opportunity Act of 1964 to fight America's war on poverty. CAAs are required to conduct statewide needs assessments of people experiencing poverty. The most recent statewide needs assessment study of low-income people in North Dakota, sponsored by the CAAs, was performed in 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 statistically 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 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.

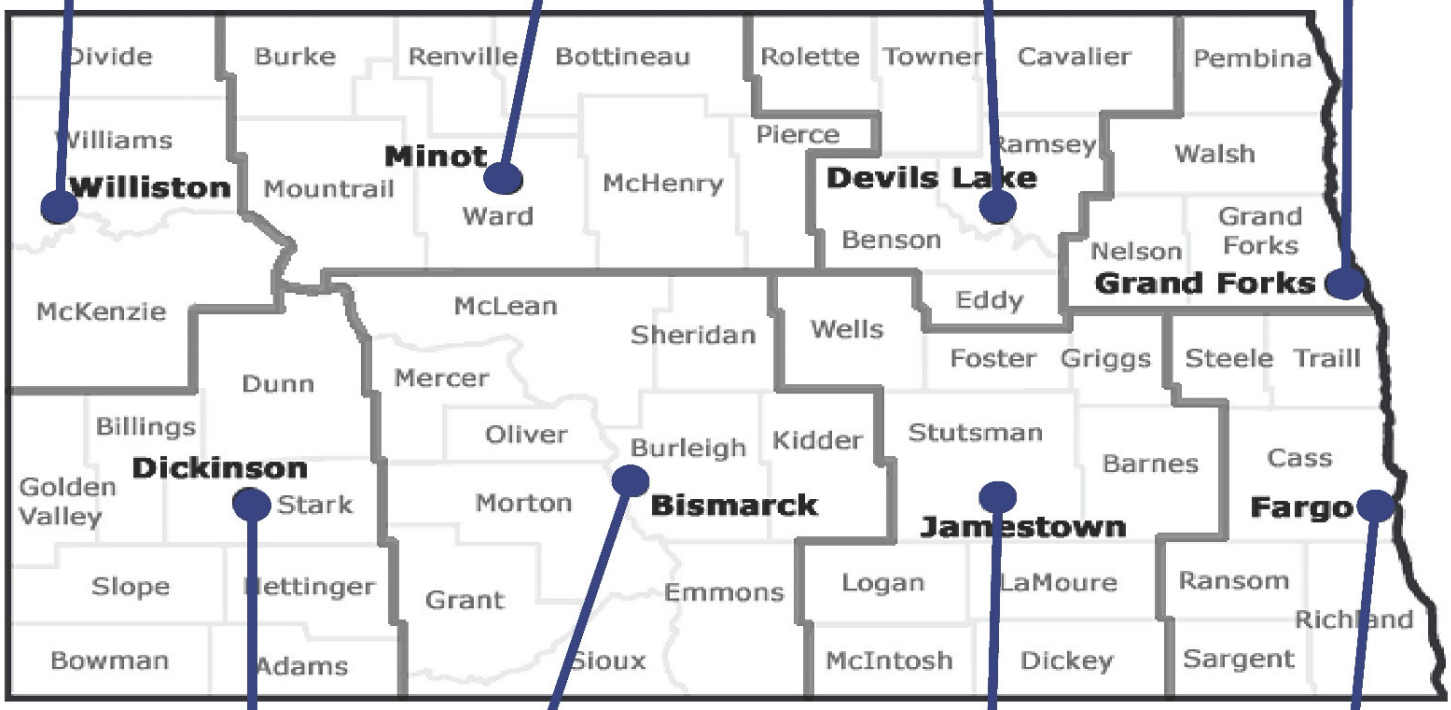
Top Regional Needs for Households Experiencing Poverty

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

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

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

Region 4
1. Housing
2. Health and Social/Behavior Development
3. Other Supports



Region 8
1. Housing
2. Health and Social/Behavior Development
3. Income and Asset-Building

Region 7
1. Housing
2. Employment
3. Income and Asset-Building

Region 6
1. Housing
2. Income and Asset-Building
3. Employment

Region 5
1. Housing
2. Income and Asset-Building
3. Health and Social/Behavior Development

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.

Community Action Partnership of North Dakota
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Helping People. Changing Lives. Community Action Partnership of North Dakota — North Dakota's Poverty Fighting Network

NDSU North Dakota State University

North Dakota Be Legendary. | Community Services — Commerce

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.

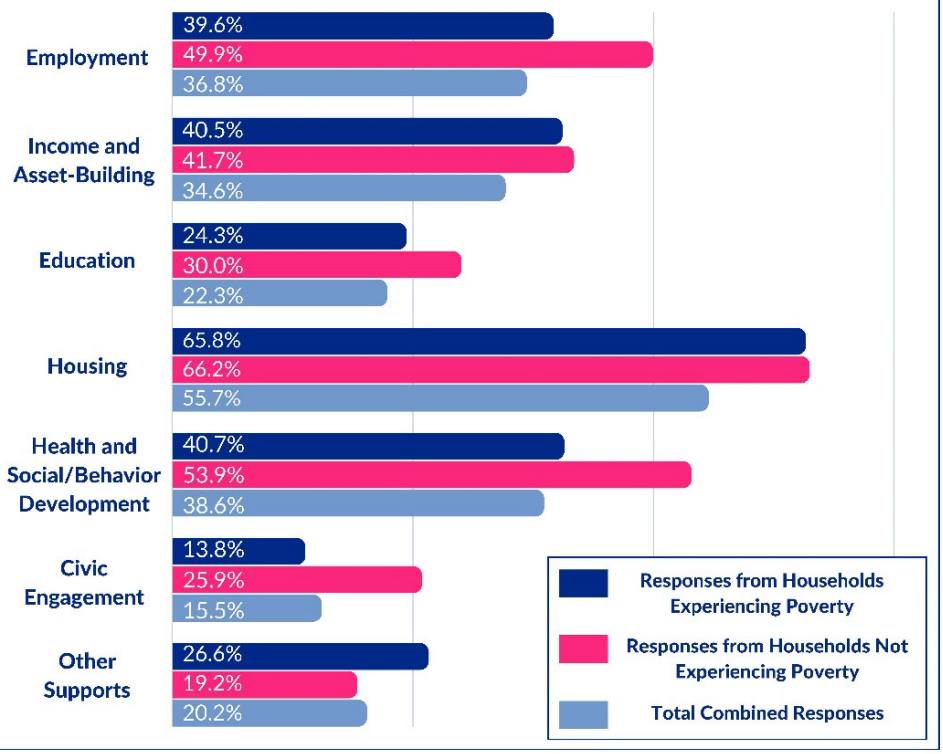
Statewide Specific Needs By Population Type

Households Experiencing Poverty	Households Not Experiencing Poverty	Overall Combined Community Needs
1. Rental Assistance	1. Mental Health Services	1. Rental Assistance
2. Food	2. Recreational Activities	2. Food
3. Dental Insurance/Affordable Dental Care	3. Safe Neighborhoods, Sidewalks, Parks	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.

Community Action Partnership of North Dakota
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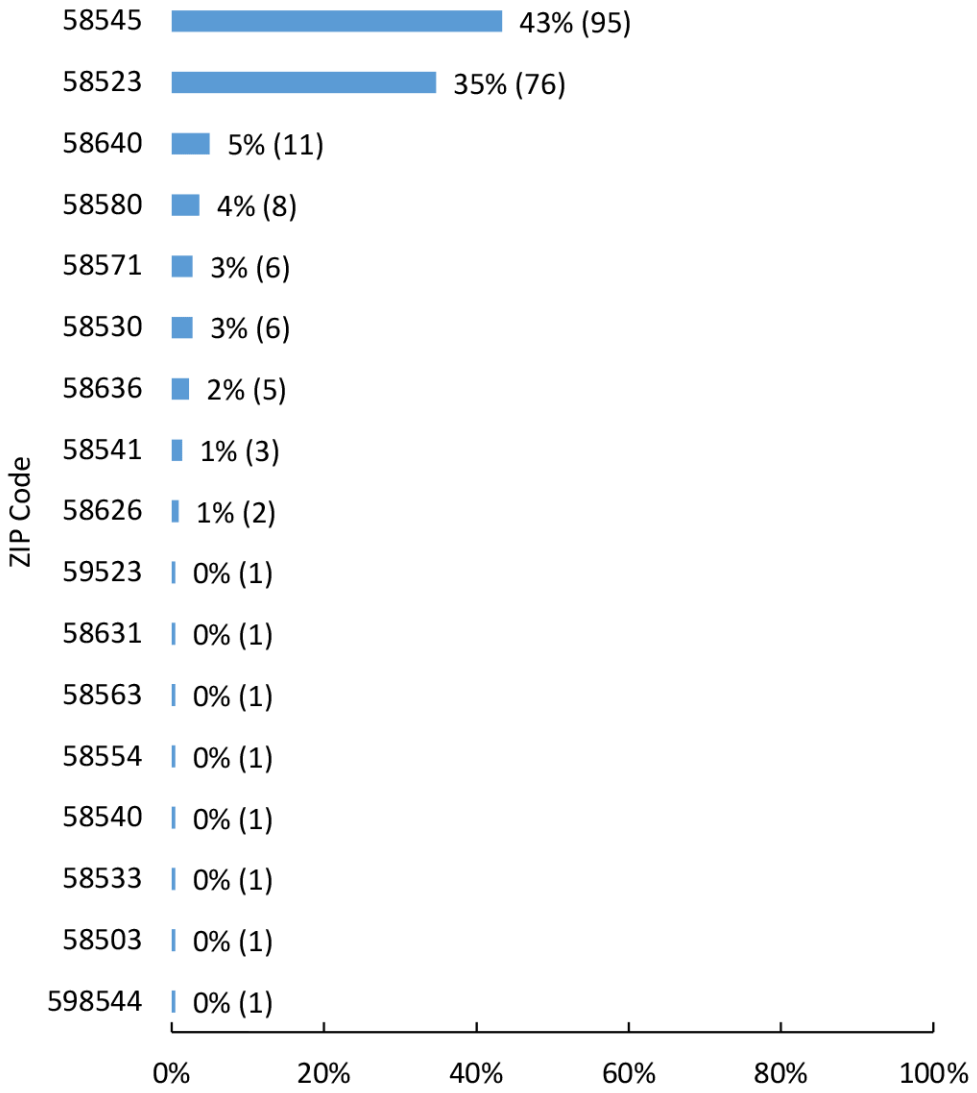
Survey Results

As noted previously, 331 community members completed the survey in communities throughout the counties in the local health providers service area. For all questions that contained an "Other" response, all of those direct responses may be found in Appendix F. 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, 219 did, revealing that a large majority of respondents lived in Hazen (43%, N=95) and Beulah (35%, N=76). These results are shown in Figure 5.

Figure 5: ZIP Code of Respondents
Total respondents: 219



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

Survey Demographics

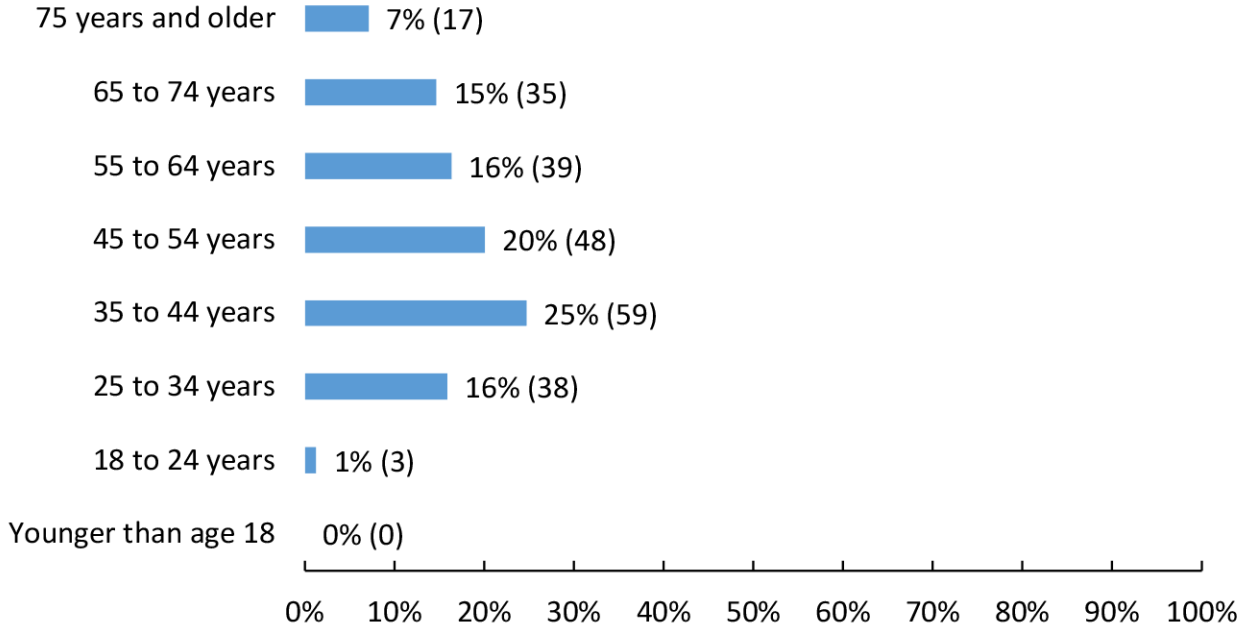
To better understand the perspectives being offered by survey respondents, survey-takers were asked a few demographic questions. Survey respondents were not required to answer all questions.

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

- 25% (N=59) were aged 35 to 44 years.
- The majority (82%, N=194) were female.
- 51% (N=121) had bachelor's degrees or higher.
- The number of those working full time (58%, N=137) was about two times higher than those who were retired (27%, N=65).
- 99% (N=235) of those who reported their ethnicity/race were White/Caucasian.
- 14% of the population (N=31) had household incomes of less than $50,000.

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

Figure 6: Age Demographics of Survey Respondents
Total respondents = 239



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

Figure 7: Gender Demographics of Survey Respondents
Total respondents = 237

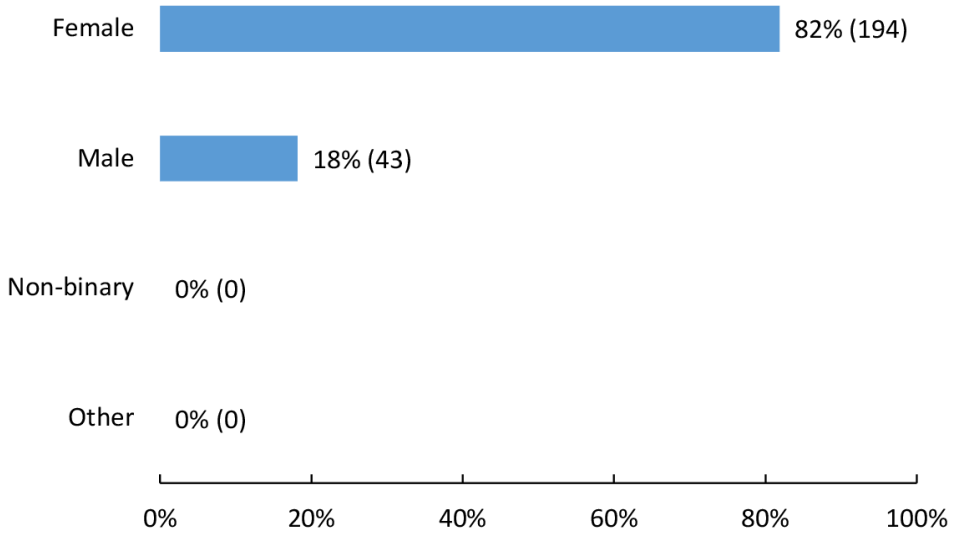


Figure 8: Educational Level Demographics of Survey Respondents
Total respondents = 238

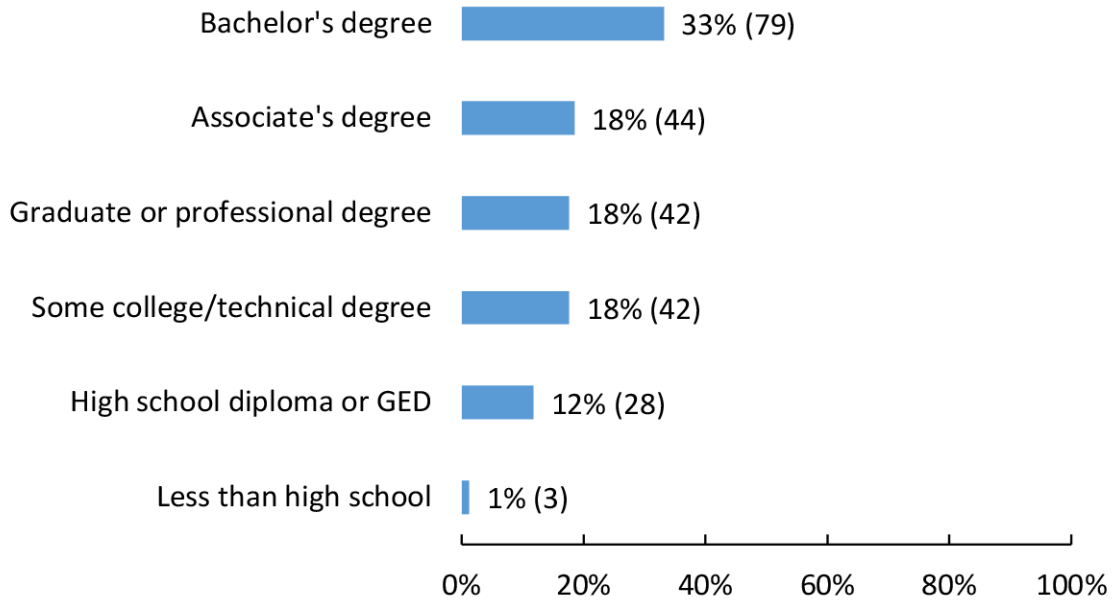
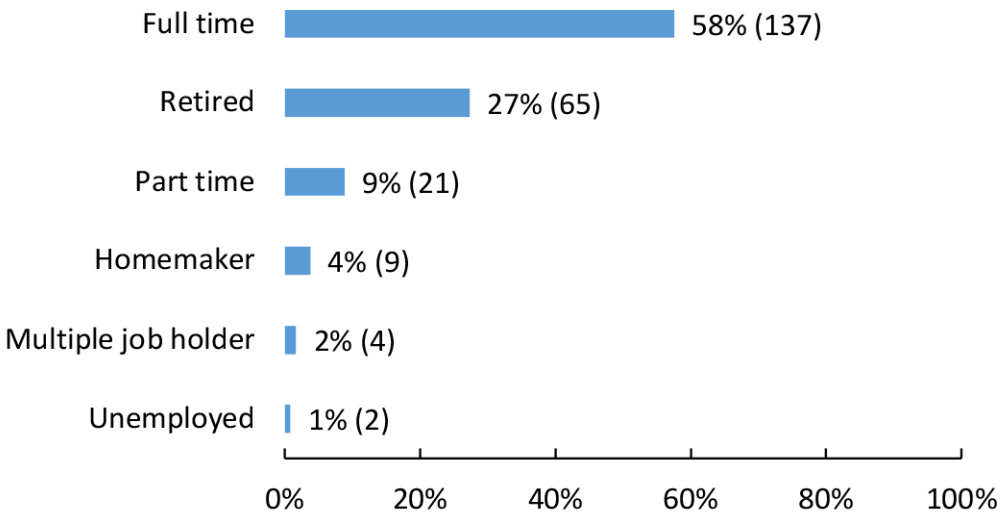
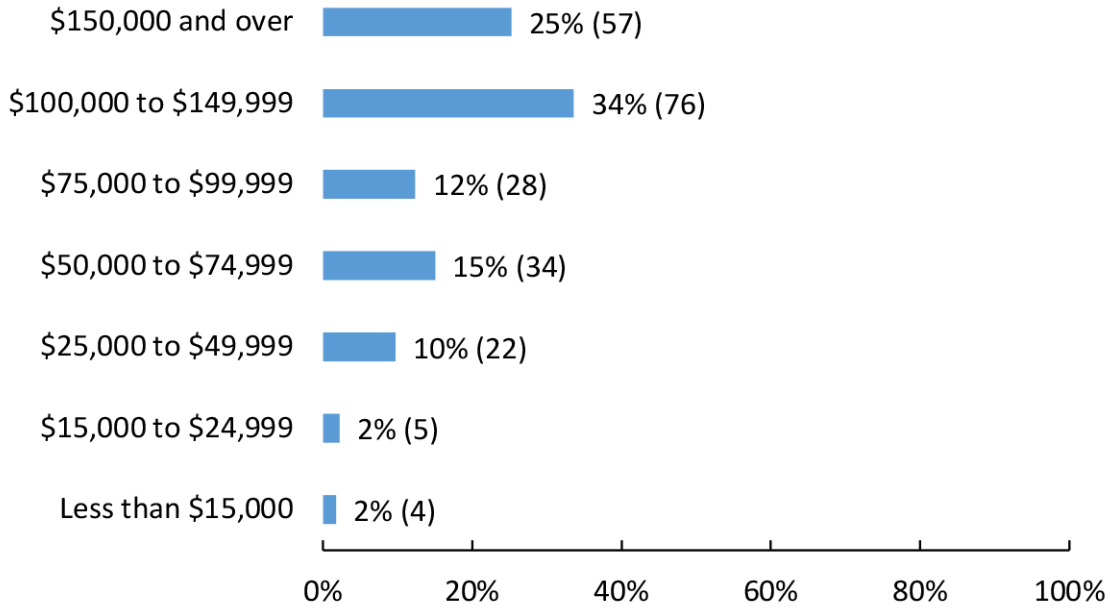


Figure 9: Employment Status Demographics of Survey Respondents
Total respondents = 238



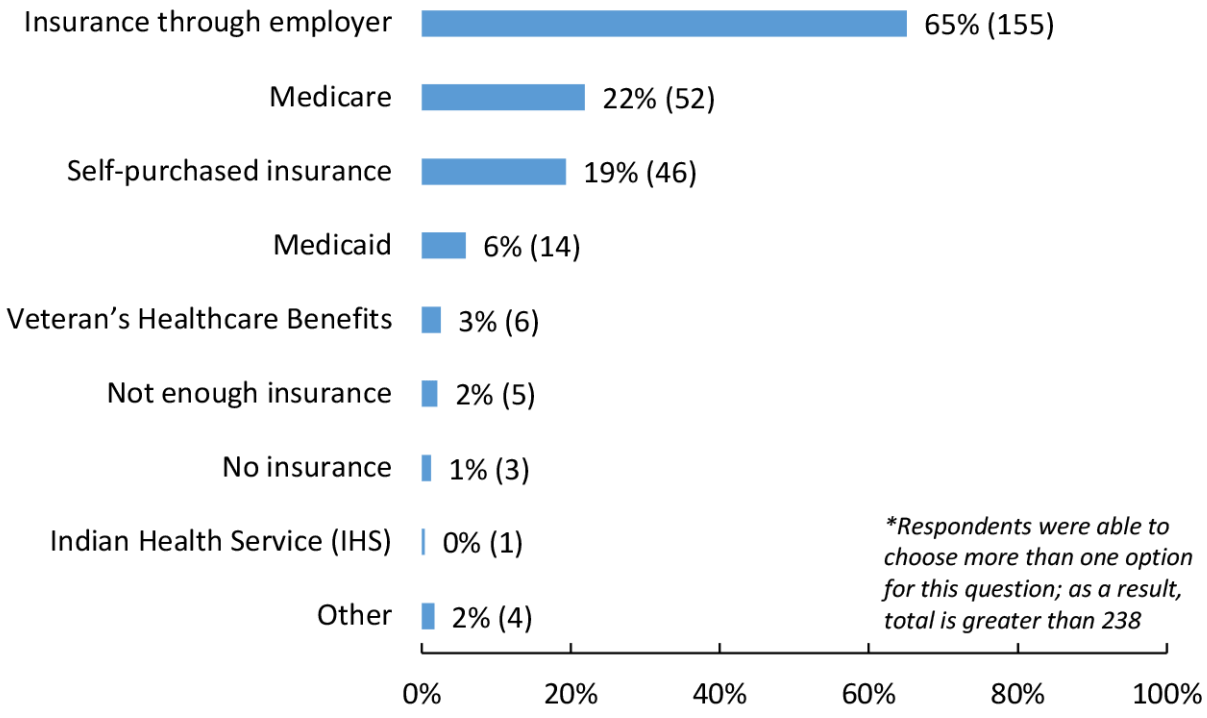
Of those who provided a household income, four percent (N=9) community members reported a household income of less than $25,000. Fifty-nine percent (N=133) indicated a household income of $100,000 or more. This information is shown in Figure 10.

Figure 10: Household Income Demographics of Survey Respondents
Total respondents = 226



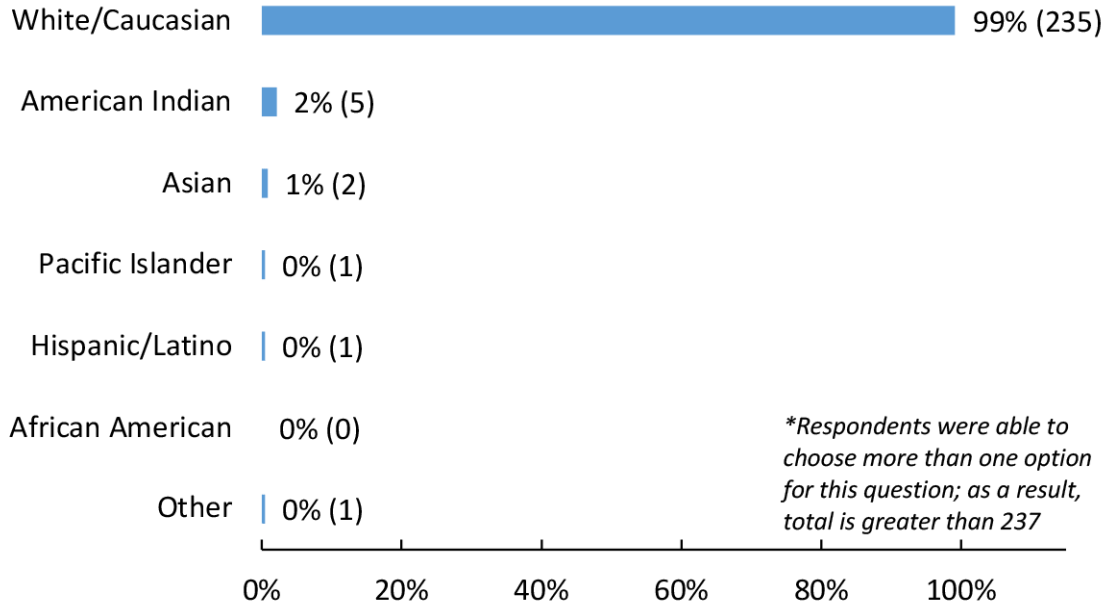
Community members were asked about their health insurance status, which is often associated with whether people have access to healthcare. Three percent (N=8) of the respondents reported having no health insurance or being under-insured. The most common insurance types were insurance through one's employer (N=155), followed by Medicare (N=52), and self-purchased (N=46).

Figure 11: Health Insurance Coverage Status of Survey Respondents
Total respondents = 238*



As shown in Figure 12, nearly all of the respondents were White/Caucasian (99%). This was a higher rate of White/Caucasian for race/ethnicity of the overall population of Dunn, Mercer, and Oliver Counties; the U.S. Census indicates that 83.5% of the population is White in Dunn County, 93.4% in Mercer County, and 94.8% in Oliver County.

Figure 12: Race/Ethnicity Demographics of Survey Respondents
Total respondents = 237*



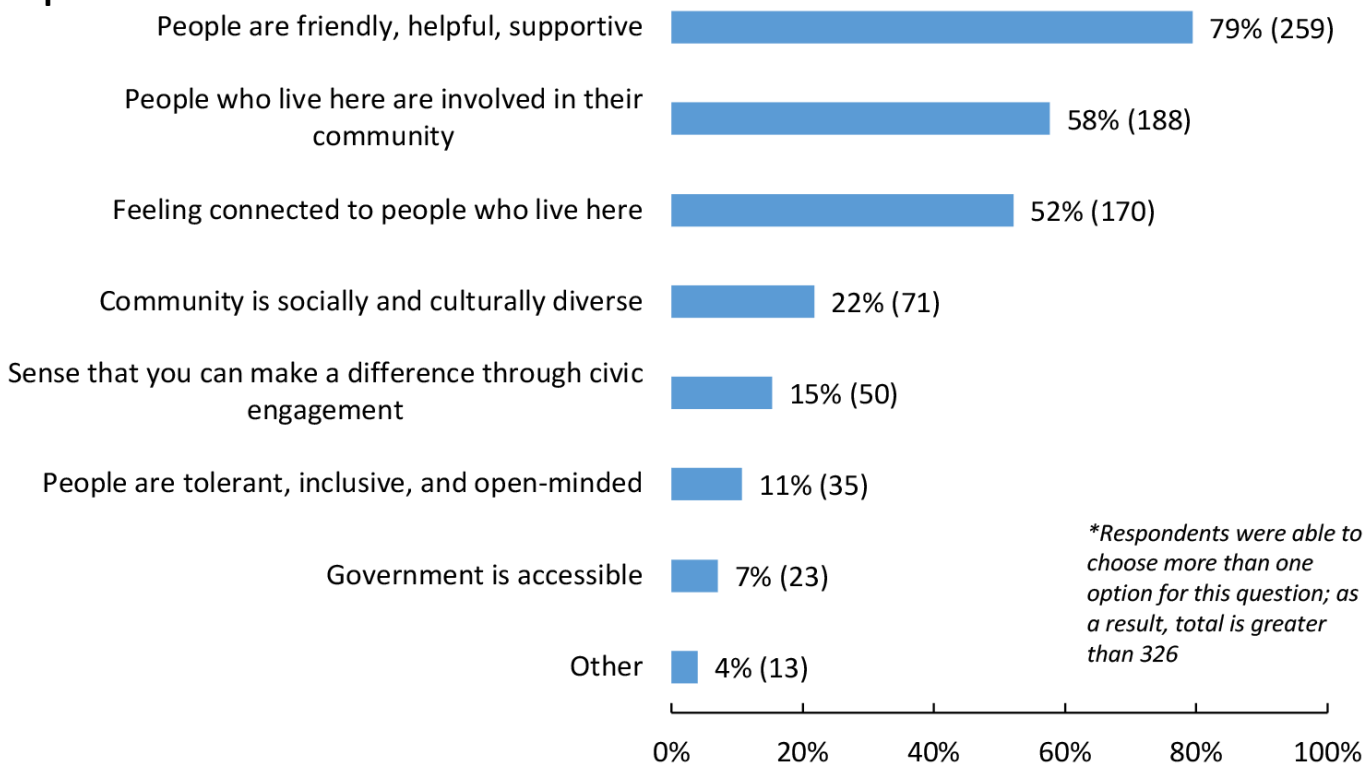
Community Assets and Challenges

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 200 respondents agreeing) that community assets include:

- Family-friendly (N=261)
- People are friendly, helpful, supportive (N=259)
- Safe place to live (N=250)
- Healthcare (N=240)
- Recreational and sports activities (N=202)

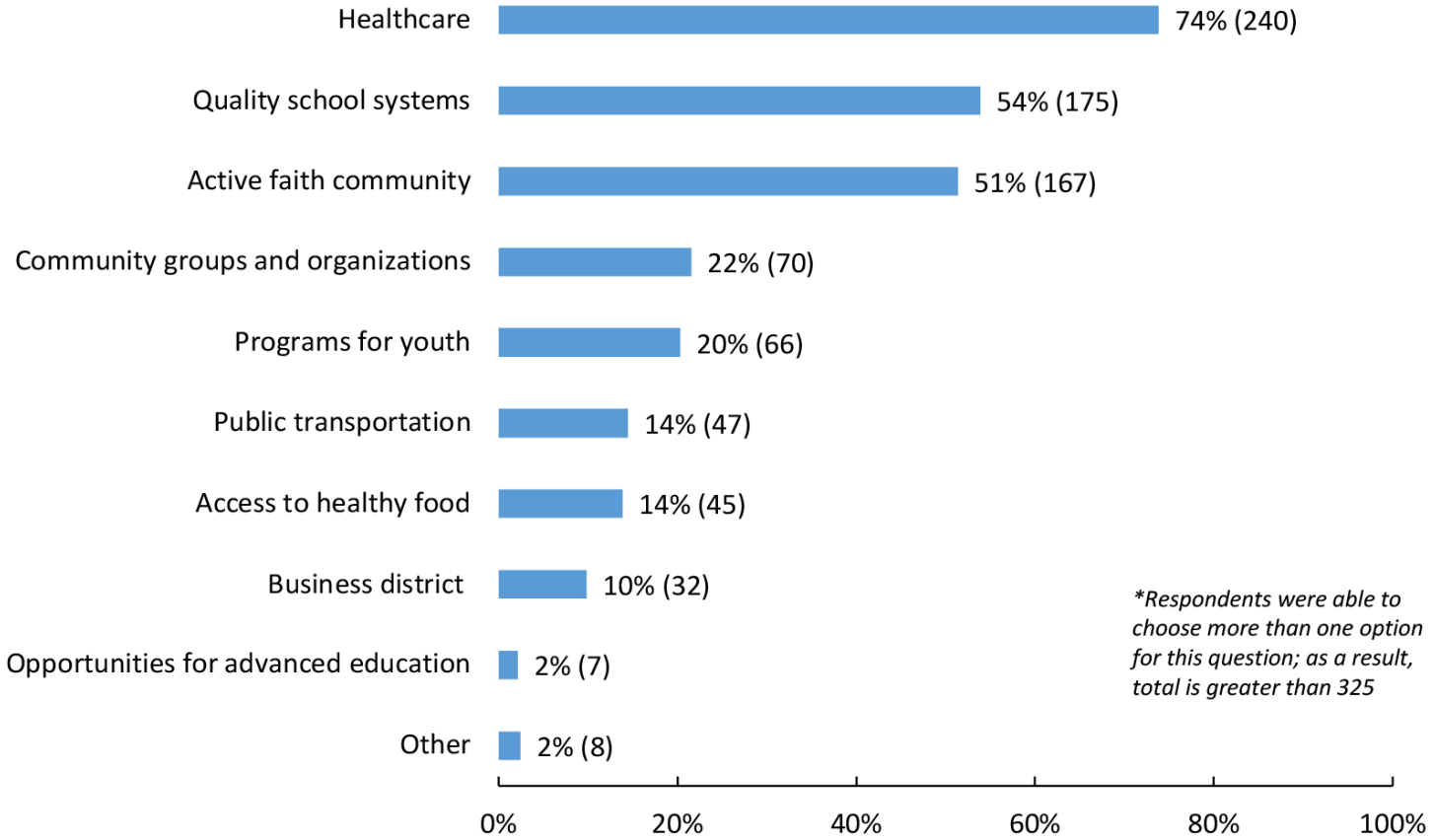
Figures 13 to 16 illustrate the results of these questions.

Figure 13: Best Things About the PEOPLE in Your Community
Total responses = 70*



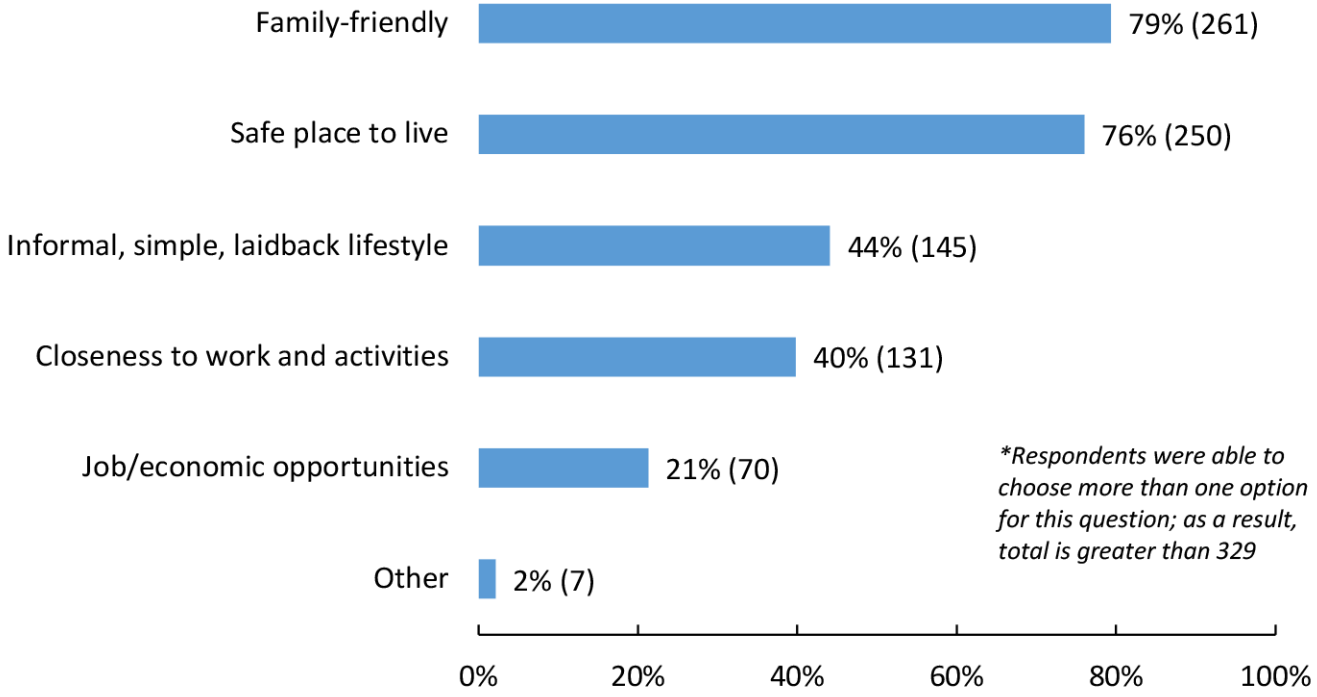
The "Other" category of the best things about the people are that residents are involved in the community, and Hazen has a great local government.

Figure 14: Best Things About the SERVICES AND RESOURCES in Your Community
Total responses = 325*



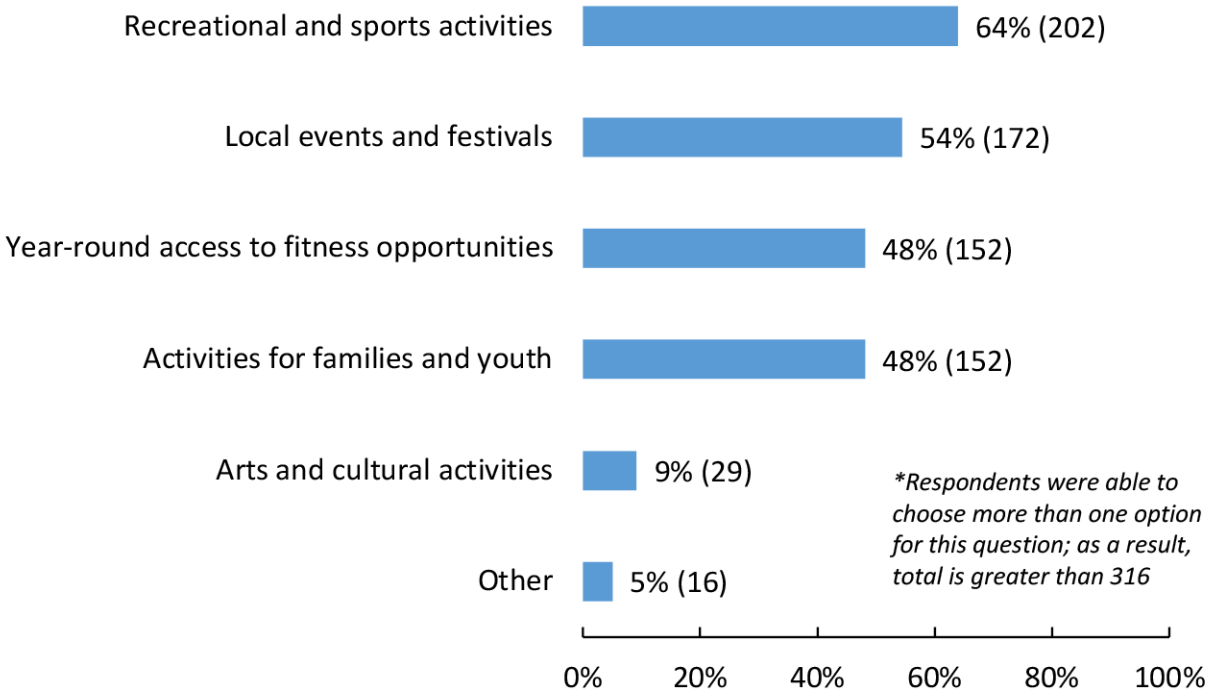
The "Other" category of the best things about the services and resources includes local parks and the opportunity of higher paying jobs.

Figure 15: Best Things About the QUALITY OF LIFE in Your Community
Total responses = 329*



Respondents who selected "Other" specified that the best things about the quality of life include closeness to work, good healthcare, and there is always something to do.

Figure 16: Best Thing About the ACTIVITIES in Your Community
Total responses = 316*



Respondents who selected "Other" specified that the best things about the activities in the community included access to nature, hunting, fishing, outdoors, church activities, and lakes and rivers.

Community Concerns

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

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

With regard to responses about community challenges, the most highly voiced concerns (those having at least 25 respondents) were:

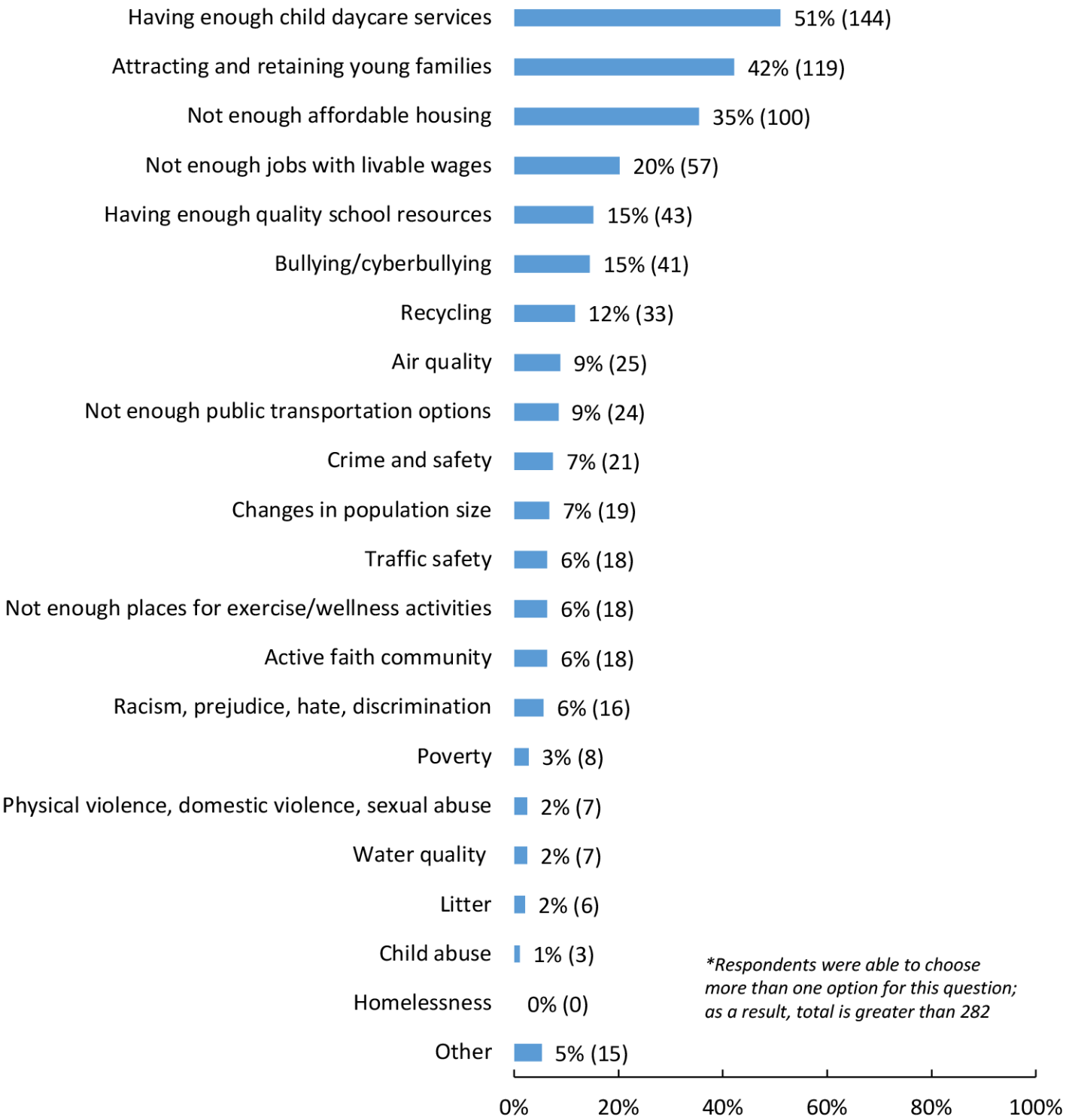
- Depression/anxiety – youth (N=37)
- Having enough child daycare services (N=37)
- Attracting and retaining young families (N=33)
- Depression/anxiety – adults (N=32)
- Long-term/nursing home care options (N=30)
- Availability of vision care (N=28)
- Alcohol use and abuse – youth (N=27)
- Not enough affordable housing (N=27)
- Not enough jobs with livable wages (N=26)

The other issues that had at least 18 votes included:

- Availability of mental health services (N=22)
- Alcohol use and abuse – adults (N=21)
- Ability to meet needs of an older population (N=21)
- Smoking and tobacco use (N=21)
- Availability of resources to help the elderly stay in their homes (N=20)
- Extra hours for appointments (N=19)
- Cost of long-term/nursing home care (N=18)

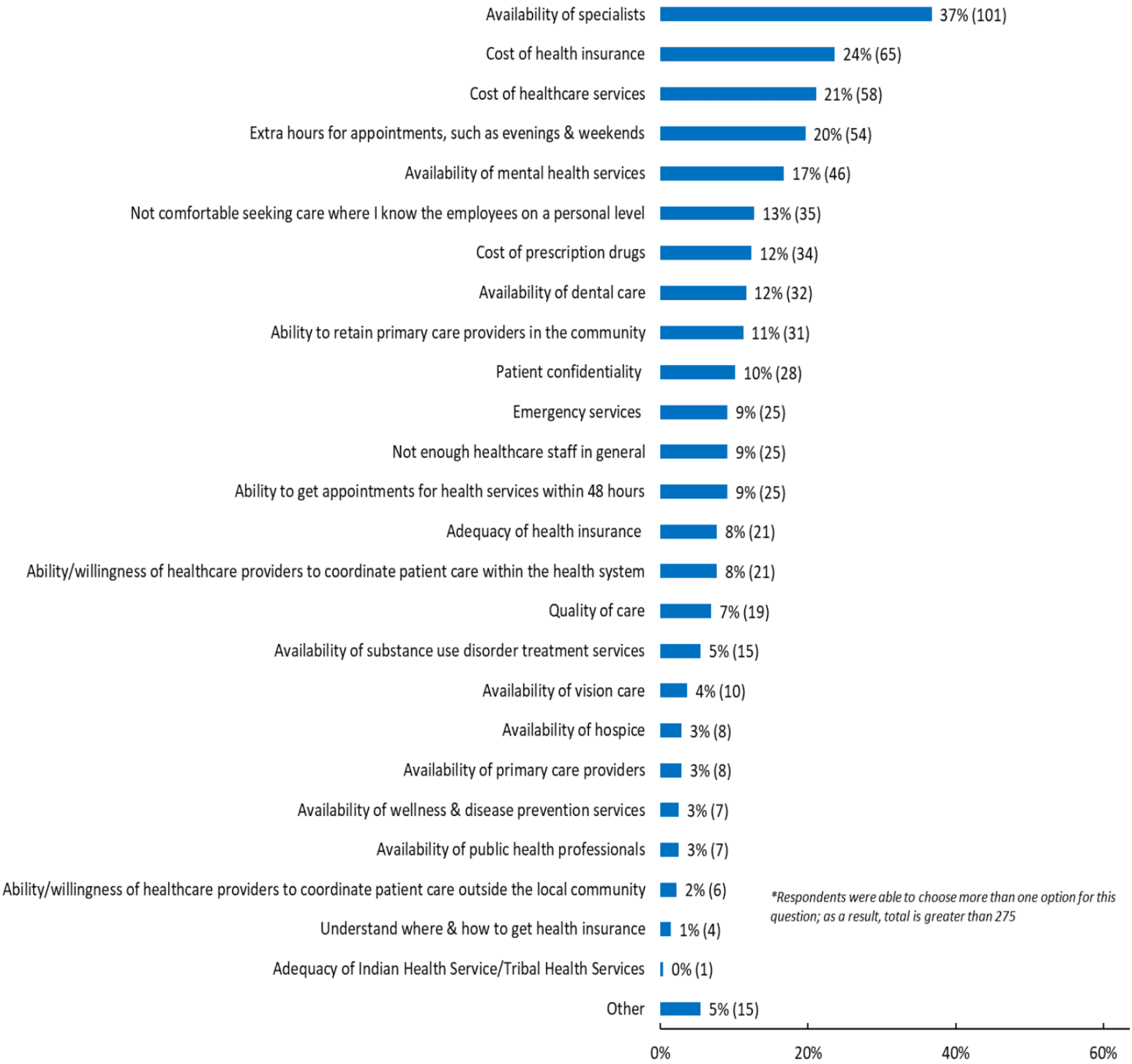
Figures 17 through 21 illustrate these results.

Figure 17: Community/Environmental Health Concerns
Total respondents = 282*



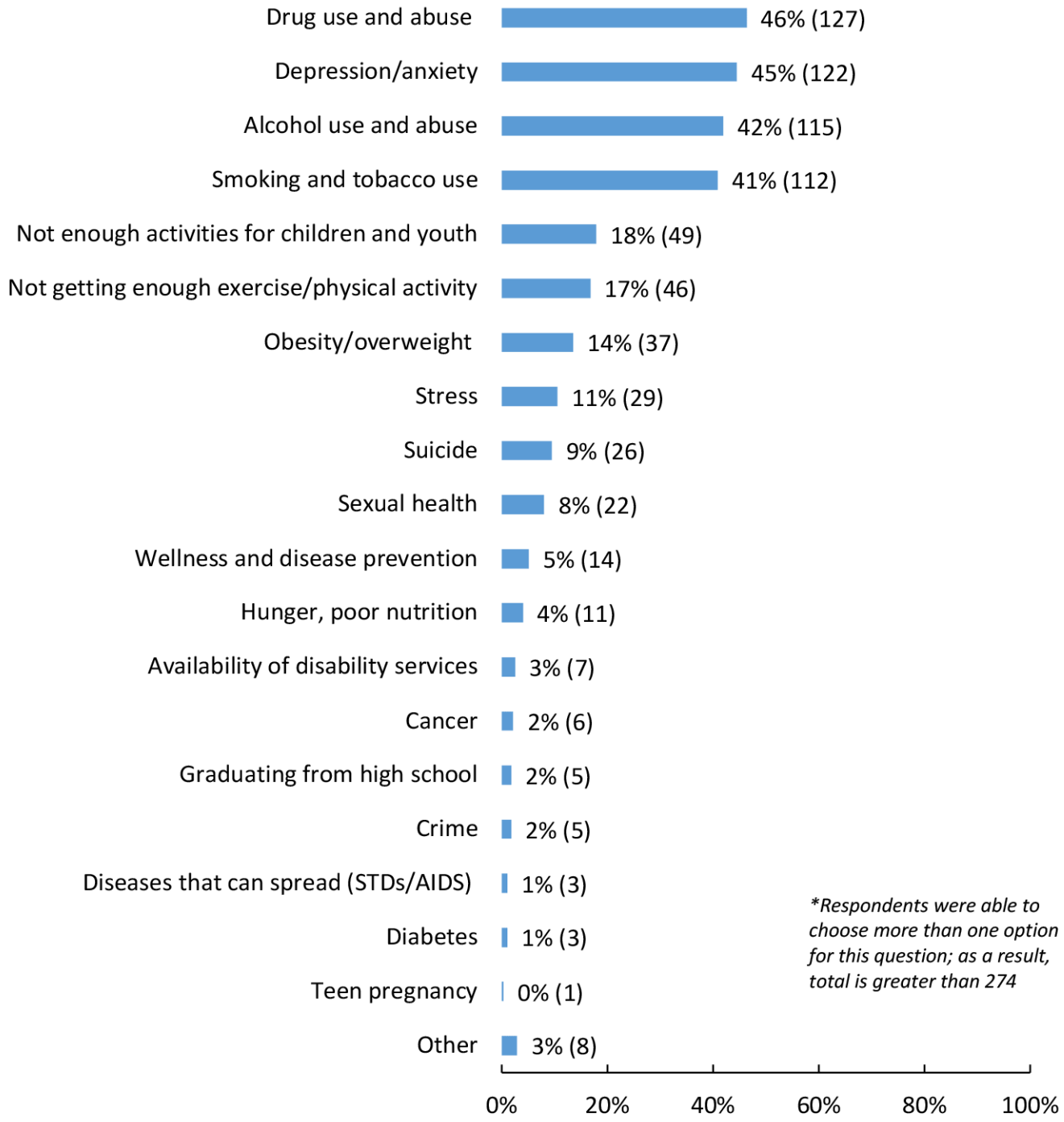
In the "Other" category for community and environmental health concerns, the following were listed: local government, no grocery store or supplies in town, affordable food that is healthy, lack of arts, domestic and child abuse, not enough child daycare services, limited school resources, need more walking and bike paths, drugs, clean water, more surgeons, rising taxes, and affordable housing for young families to move to the area.

Figure 18: Availability/Delivery of Health Services Concerns
Total respondents = 275*



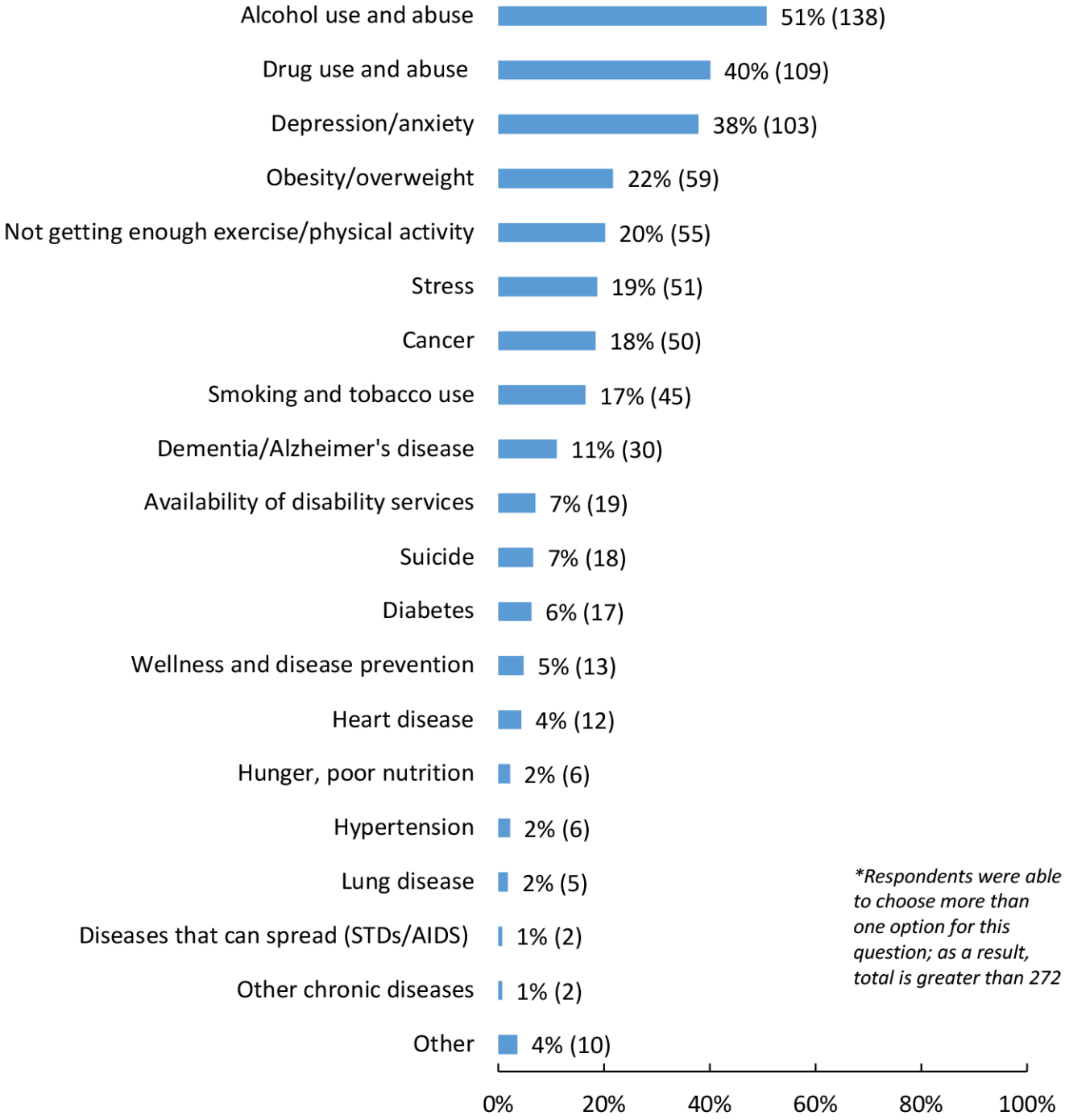
Respondents who selected "Other" identified concerns in cost of medical care, health insurance denials and needing prior authorization for medicine, tests, and referrals, having a blend of eastern and western medicine, more holistic medicine, confidence in the providers, need more walk-in availability, and need more providers, specialists, and surgeons.

Figure 19: Youth Population Health Concerns
Total respondents = 274*



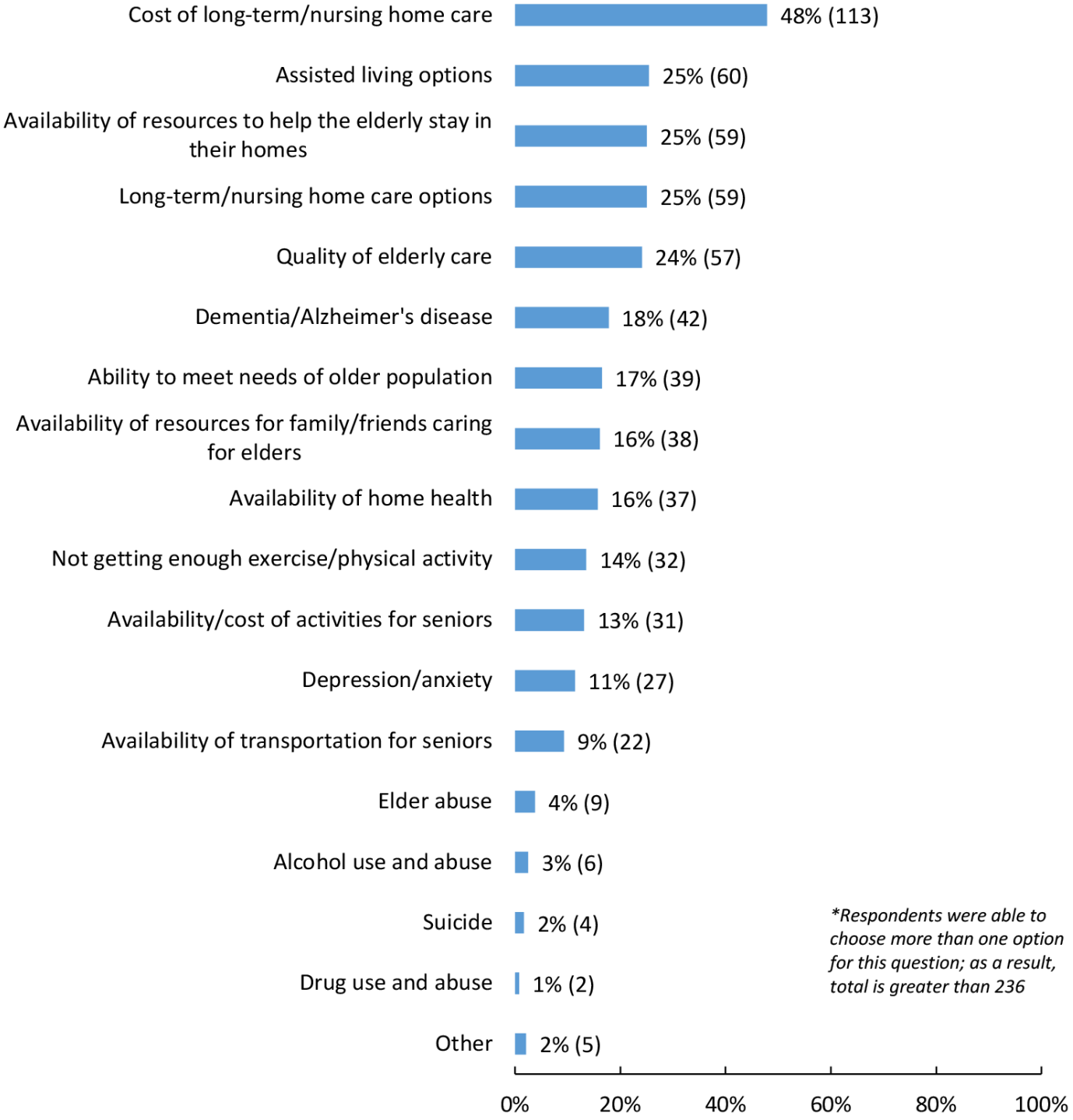
Listed in the "Other" category for youth population concerns were not having enough for youth to do may lead to/ causes many of the other issues, learning to become responsible, caring adults, not entitled, self-absorbed adults, bullying, have no young, and have a safe place to gather that is not a school activity.

Figure 20: Adult Population Concerns
Total respondents = 272*



Activities that are not related to drinking, drugs, no daycare at the gym, mental health, dementia education for families, swimming pool for back patients, exercise program for Parkinson's and other similar diseases, and elder services were indicated in the "Other" category for adult population concerns.

Figure 21: Senior Population Concerns
Total respondents = 236*



In the "Other" category, concerns listed were affordable taxes that allow the elderly to stay in their homes, no for exercising, and cancer.

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. Substance use and abuse
2. Political divide, limiting entrepreneurship, and expanding businesses

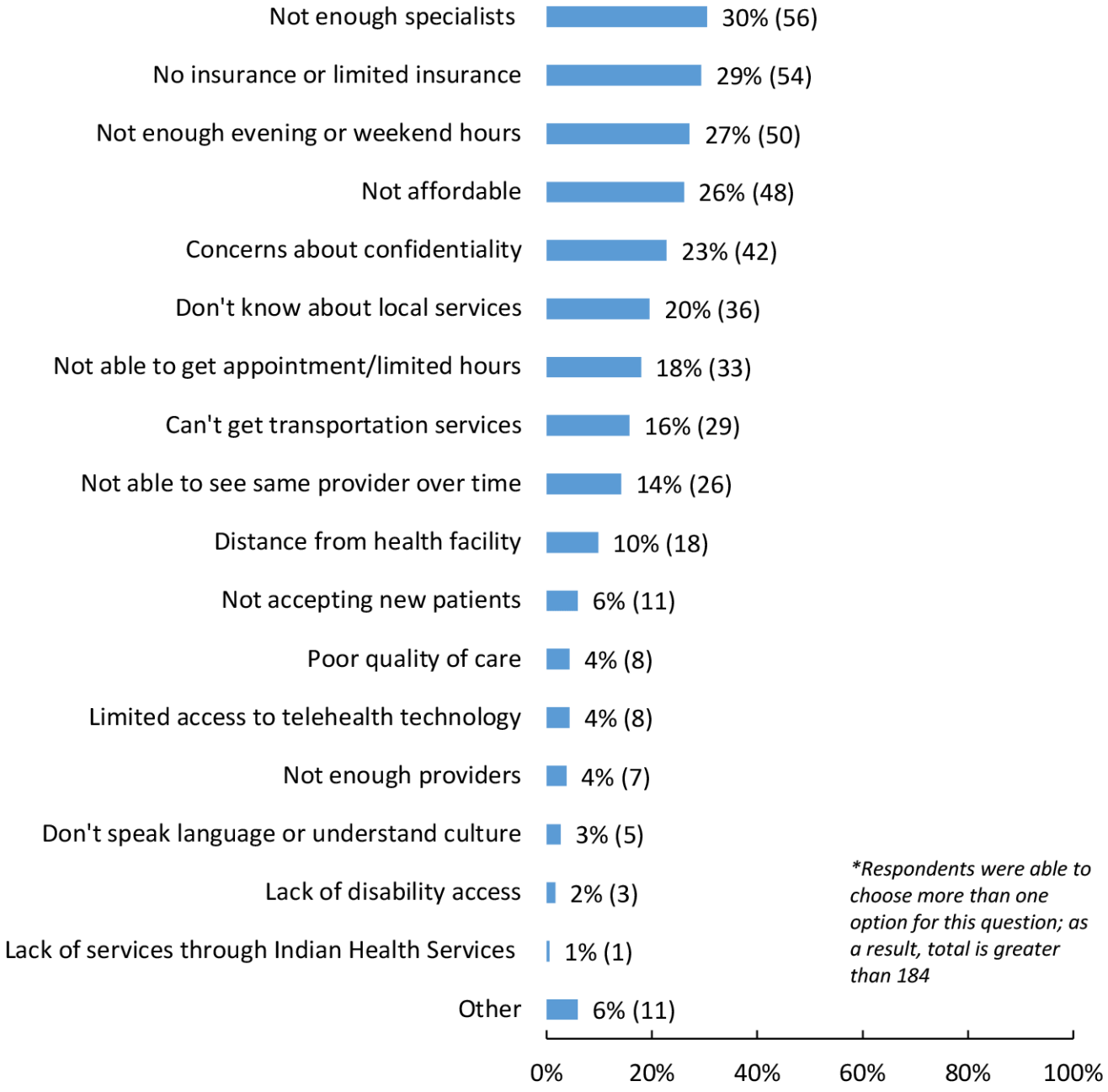
Other biggest challenges that were identified were access to good healthcare, depression/anxiety, cost of living, concerns about quality care at long-term care facility, lack of daycare services, more resources for people with disabilities, better collaboration and coordination between healthcare facilities, inability to attract families to live in the community, excessive taxes, need more healthcare staff, lack of activities for the family, and lack of affordable housing.

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 specialists (N=56), with the next highest being no insurance or limited insurance (N=54). After these, the next most commonly identified barriers were not enough evening or weekend hours (N=68), and not affordable (N=48). The majority of concerns indicated in the "Other" category were don't trust doctors, lack of confidentiality, don't offer natural health services, and privacy.

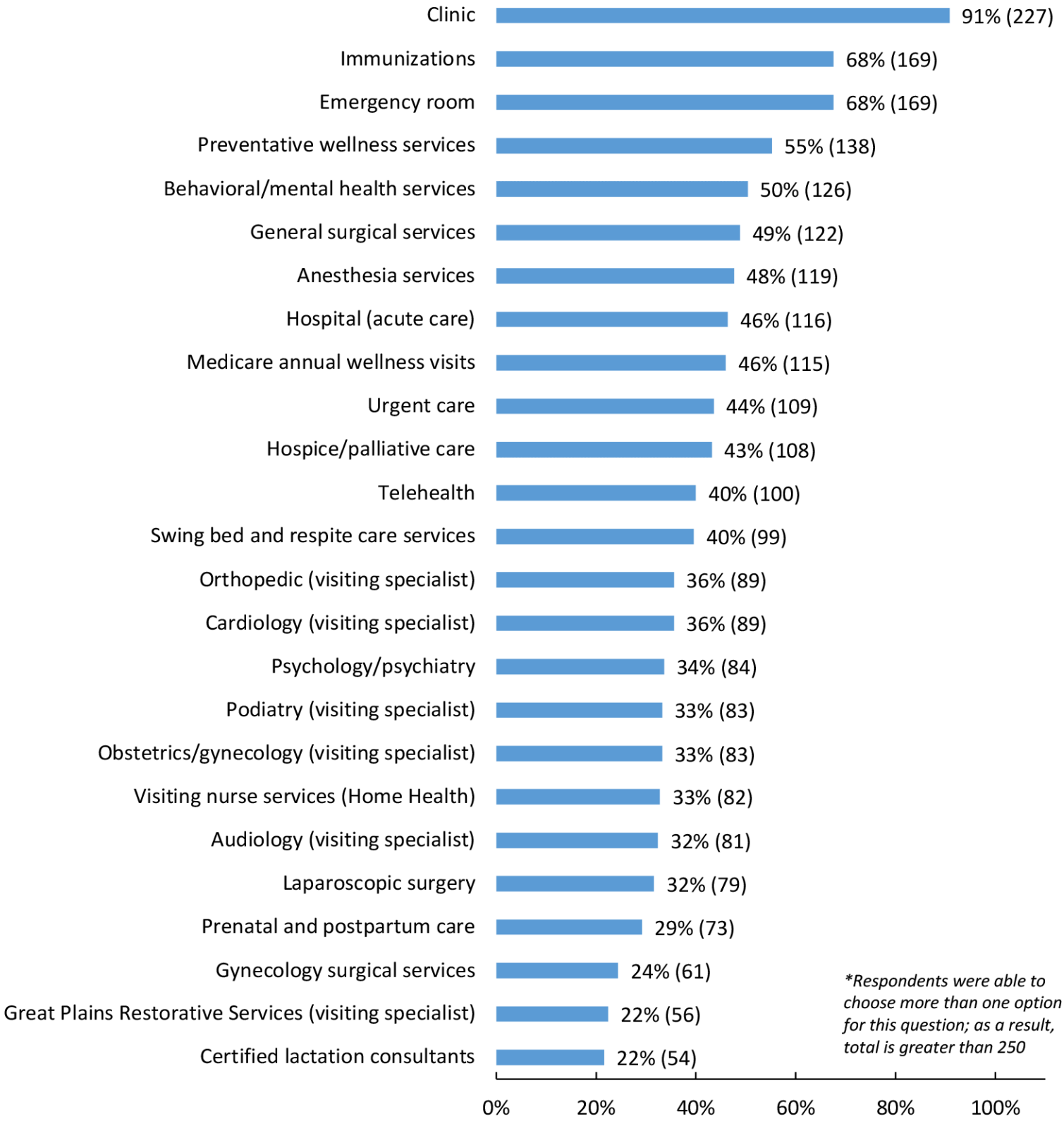
Figure 22 illustrates these results.

Figure 22: Perceptions about Barriers to Care
Total respondents = 184*



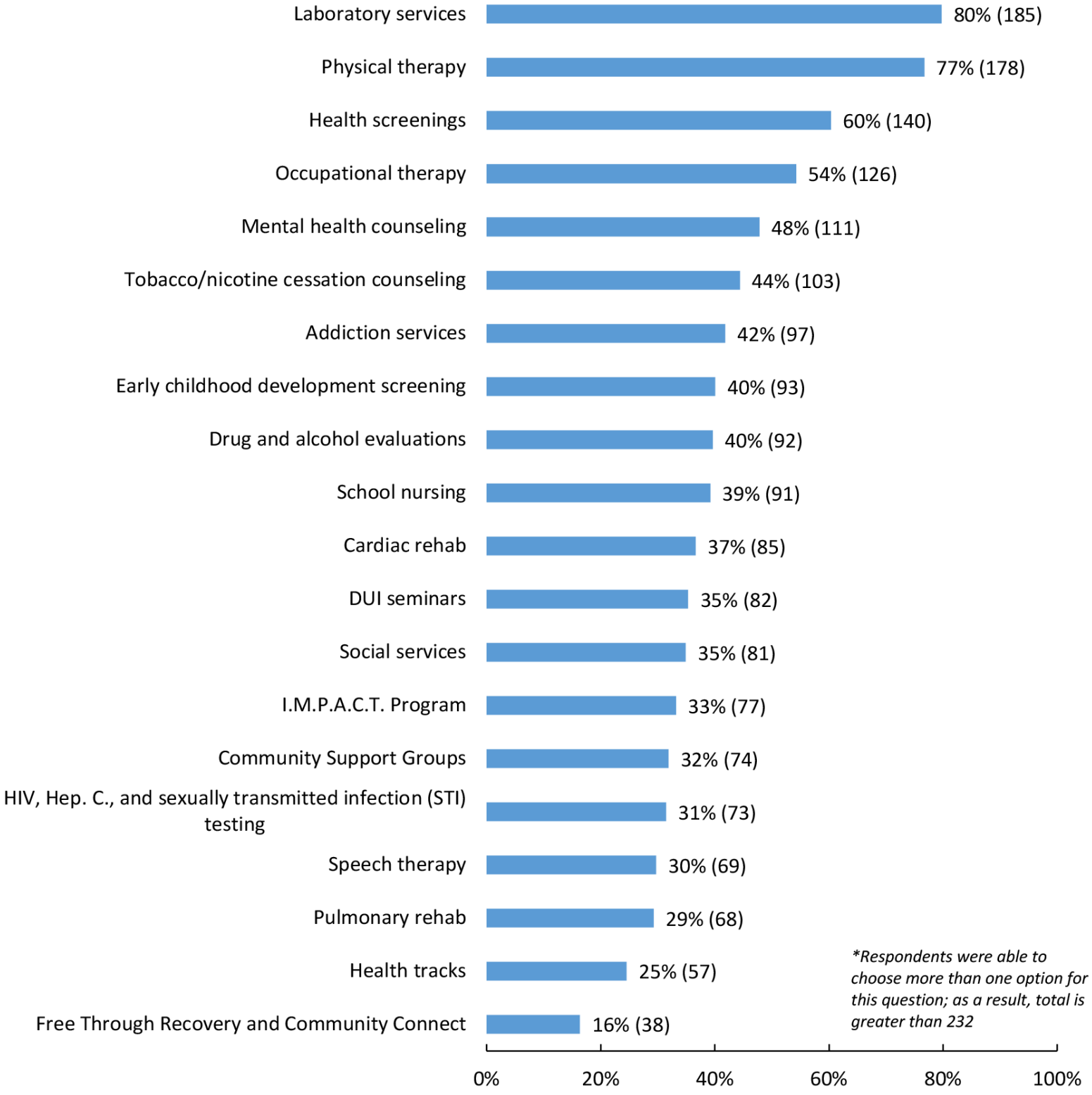
Considering a variety of healthcare services offered by Sakakawea Medical Center (SMC) and Coal Country Community Health Center (CCCHC), respondents were asked to indicate if they were aware of or have utilized that healthcare service through SMC and CCCHC (See Figure 23).

Figure 23: Use and Awareness of General and Acute Services
Total respondents = 250*



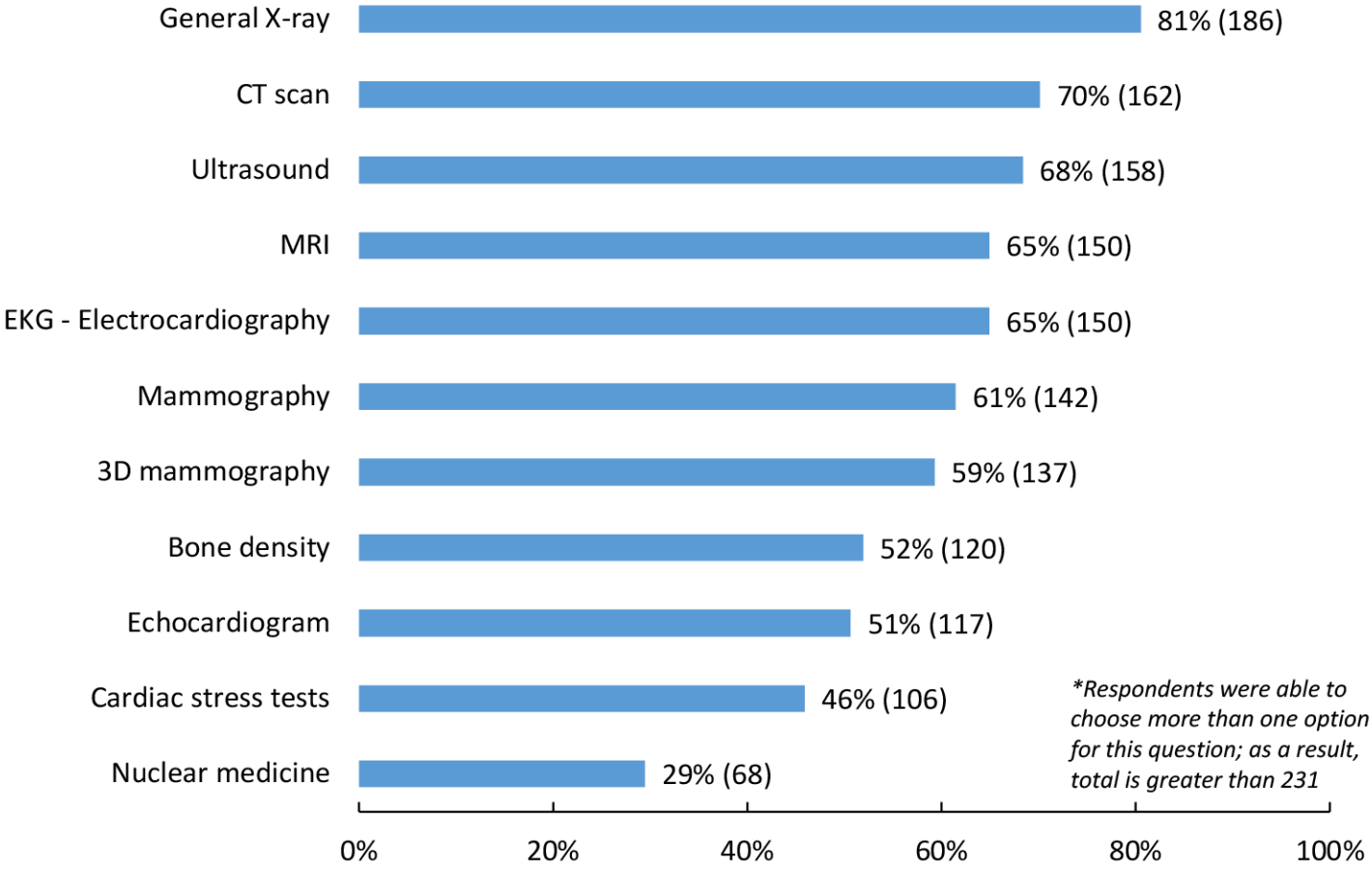
Considering the screening and therapy services offered by SMC and CCCHC, respondents were asked to indicate if they were aware of or have utilized that healthcare service through SMC and CCCHC (See Figure 24).

Figure 24: Use and Awareness of Screening and Therapy Services
Total respondents = 232*



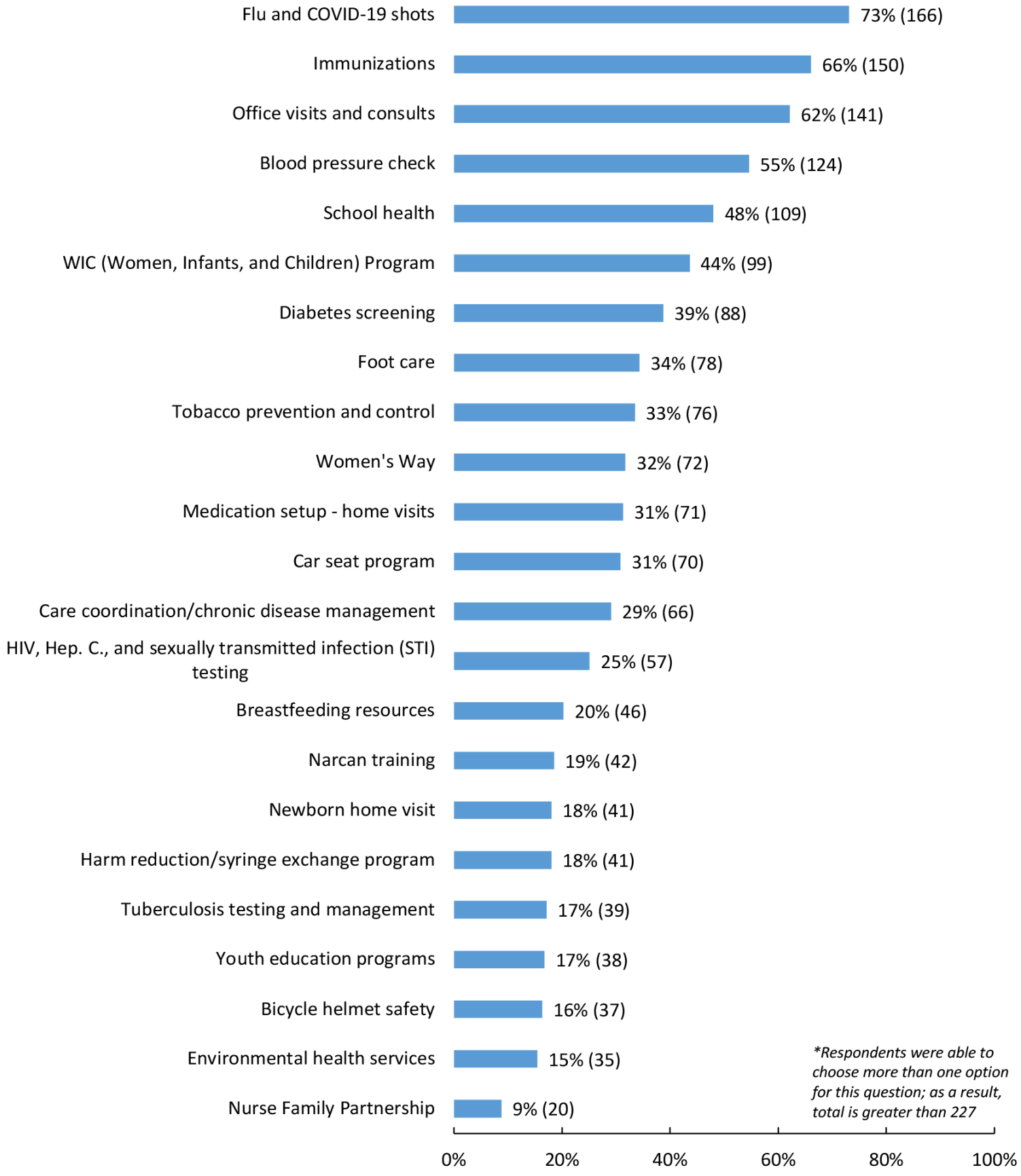
Considering the radiology services offered by SMC and CCCHC, respondents were asked to indicate if they were aware of or have utilized that healthcare service through SMC and CCCHC (See Figure 25).

Figure 25: Use and Awareness of Radiology Services
Total respondents = 231*



Considering a variety of healthcare services offered by Western Plains Public Health, respondents were asked to indicate if they were aware of or have utilized that healthcare service through Western Plains Public Health (See Figure 26).

Figure 26: Awareness and Utilization of Community and Public Health Services
Total respondents = 227*

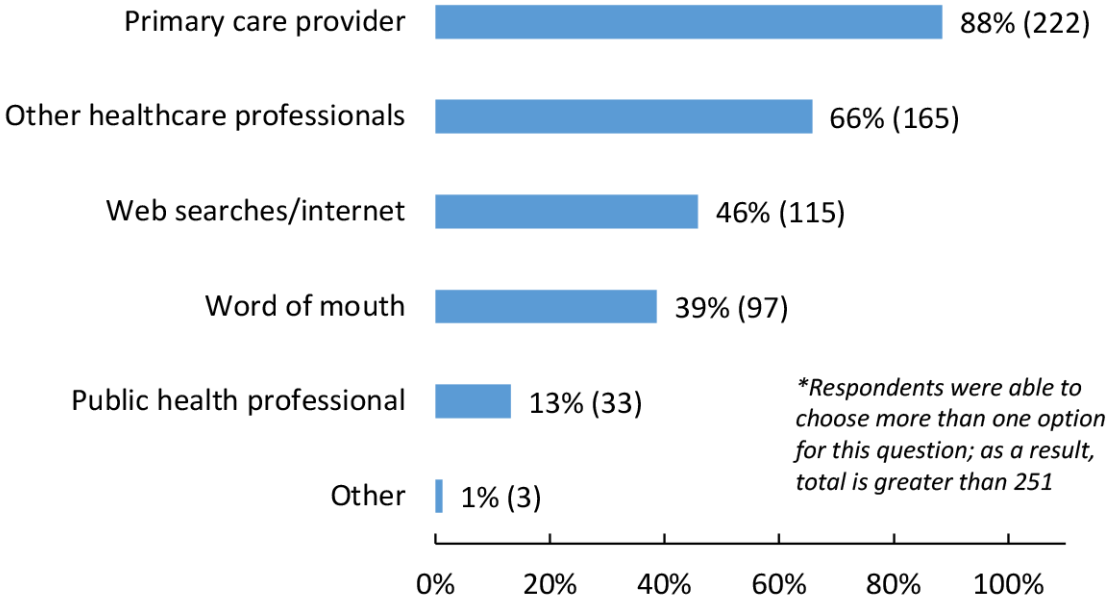


In an open-ended question, respondents were asked what specific healthcare services, if any, they think should be added locally. The number one desired service to add locally was more availability of specialty services. Other requested services included:

- More availability of specialty providers
- Dermatology
- Dialysis
- Detox/treatment options
- Nephrology
- Cancer treatments available locally
- Cardiology
- Immunizations
- Dental and vision care
- Free or reduced dental cost for elderly
- Holistic health options
- Ultrasound available 24/7
- More community-based services
- Community food share coop
- Educational classes for various topics, such as parenting, fall prevention, and nutrition
- Parkinson's and other support groups
- Yoga and strength training classes
- Elderly prescription services
- Access to mental health providers

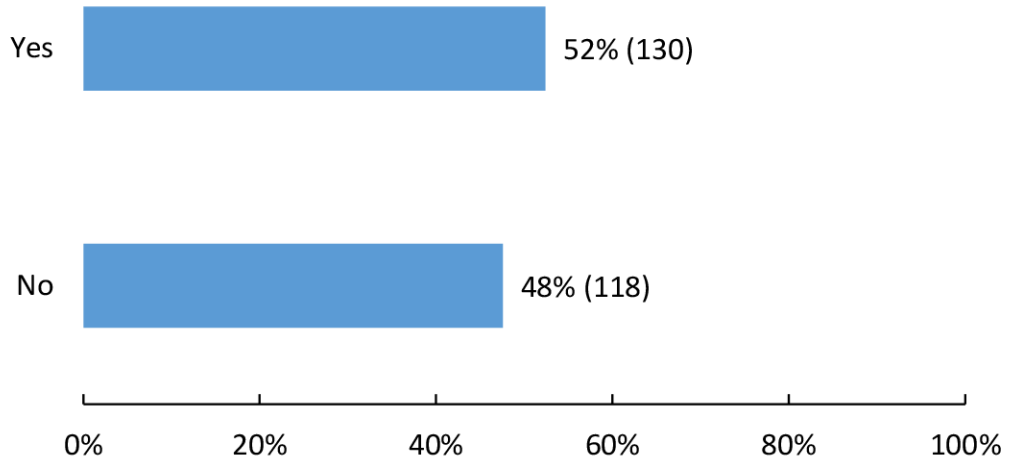
The key informant and focus group members felt that the community members were aware of the majority of the health system and public health services. There were a number of services where they felt the public health services should increase marketing efforts; these items included nurse family partnership, car seat program, and helmet safety. When asked what should be added as a service, respondents stated public health should add family wellness education from nutrition to proactive wellness and keep doing home visits.

Figure 27: Sources of Trusted Health Information
Total respondents = 251*



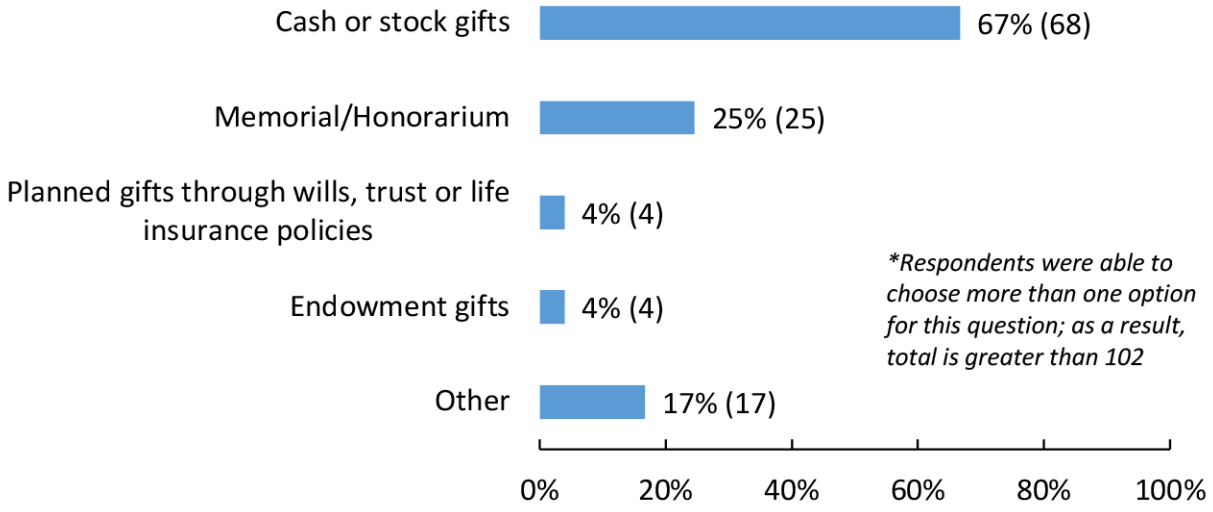
In the "Other" category, homeopath, local health food store, and National Comprehensive Cancer Network guidelines were mentioned.

Figure 28: Awareness of Local Healthcare Foundations
Total respondents = 248



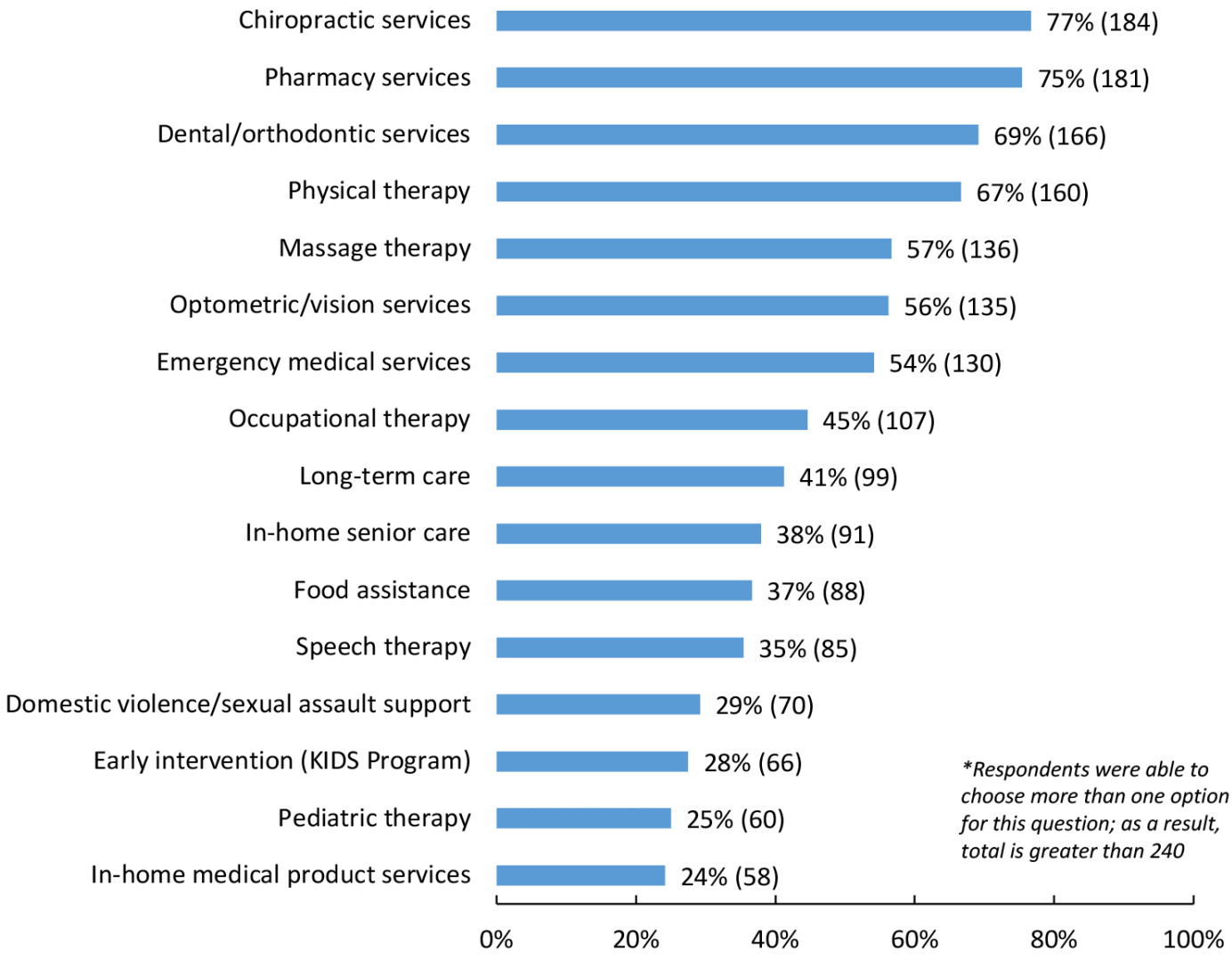
In an effort to gauge ways that community members would financially support facility improvements/ new equipment, a question was included asking them to select ways they are most likely to support facility improvements/new equipment at SMC (see Figure 29). In the "Other" category were ways community members supported the foundation or hospital. Answers included attended benefits, volunteered time, served on the board, and other fundraisers in the community.

Figure 29: Forms of Support for Local Healthcare Foundations
Total respondents = 102*



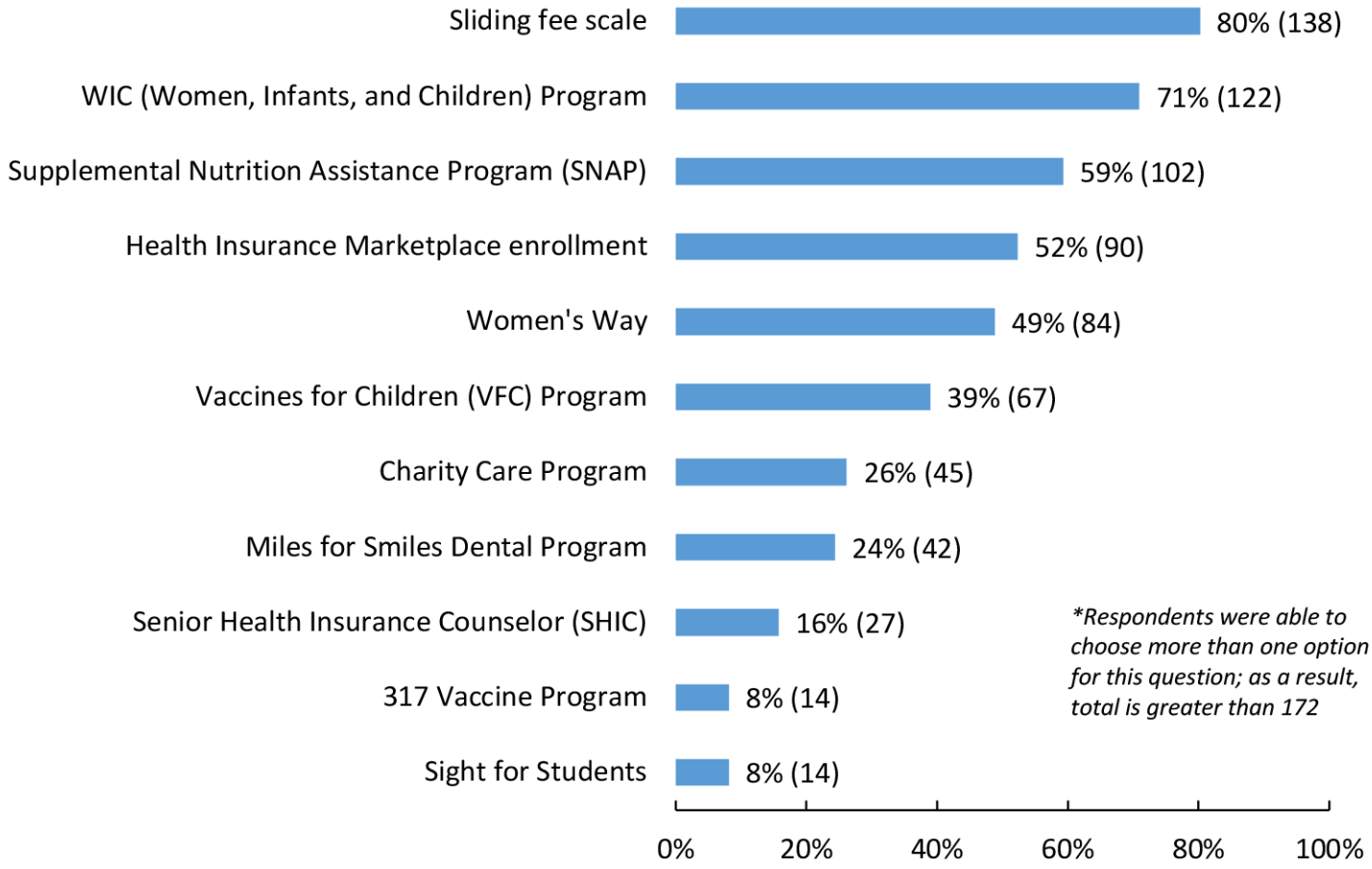
Respondents were asked if they used or were aware of other services in the community. The majority of respondents said they used or are aware of chiropractic services and pharmacy services (See Figure 30).

Figure 30: Use/Awareness of Other Services in the Community
Total respondents = 240*



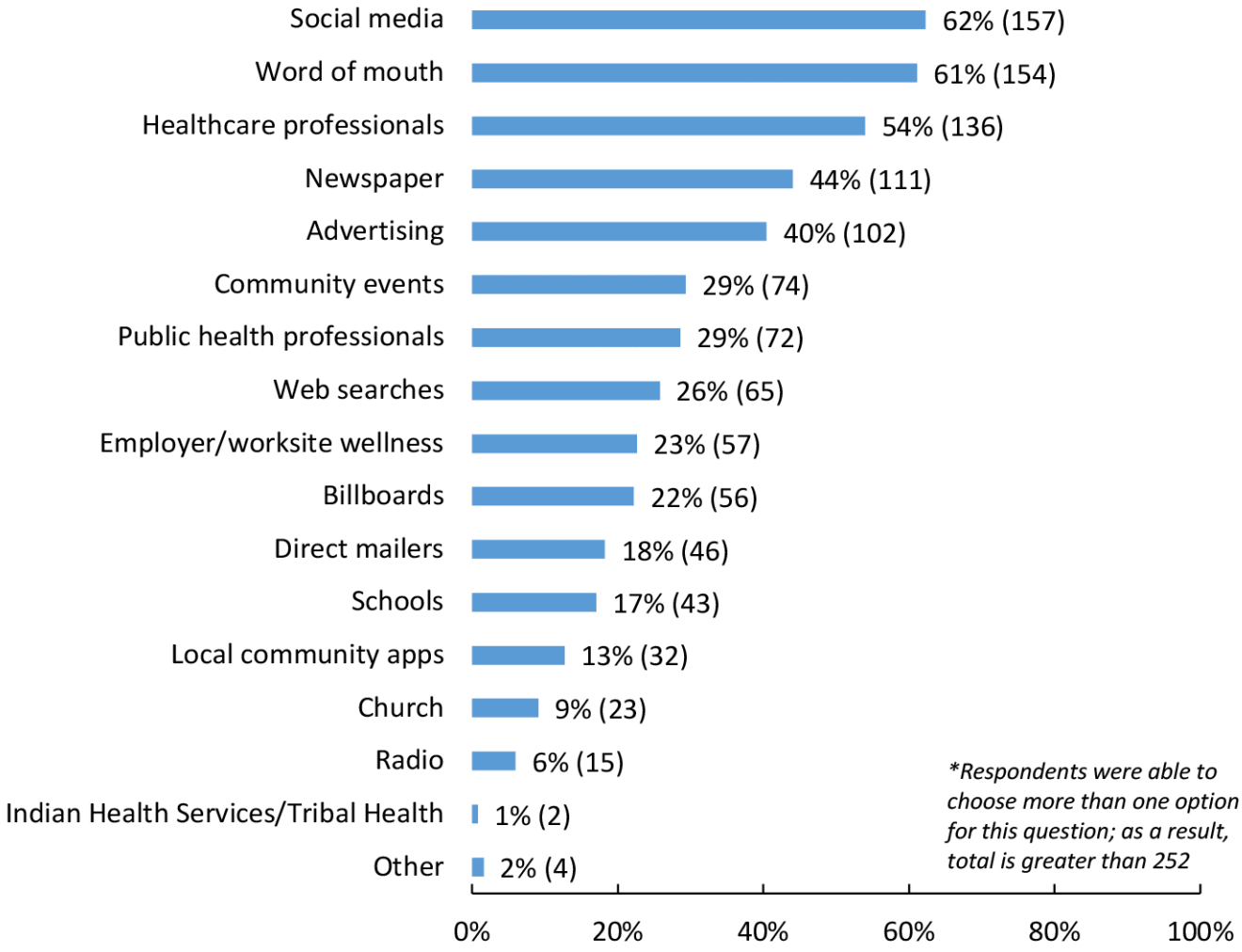
When asked about use or awareness of the eligibility resources in the community, respondents chose sliding fee scale and Women, Infants, and Children (WIC) Program as most used or are aware of their services. (See Figure 31)

Figure 31: Use/Awareness of Eligibility Resources in the Community
Total respondents = 172*



Respondents were asked where they go to for sources of information about local health services. Social media (N=157) received the highest response rate, followed by word of mouth (N=154), and then healthcare professionals (N=136). Results are shown in Figure 32.

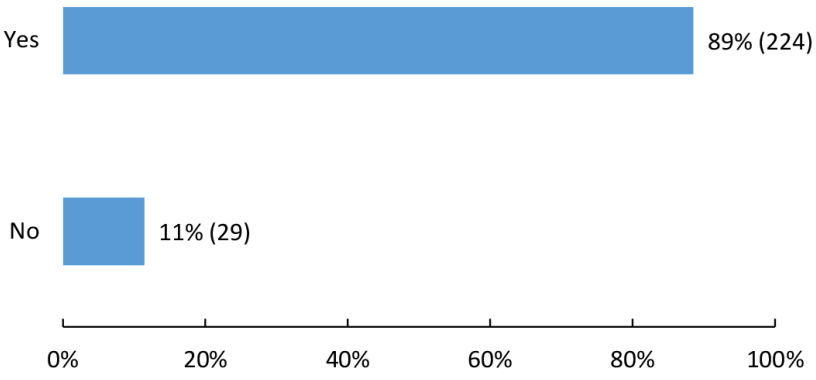
Figure 32: Sources of Information about Local Health Services
Total respondents = 252*



In the "Other" category, people who work for the clinic was listed as a source of trusted information.

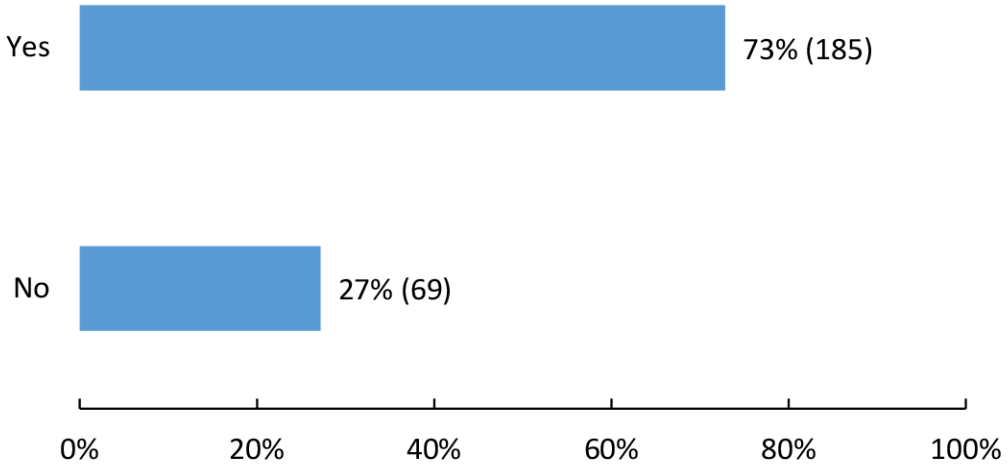
Respondents were asked if they had an established Primary Care Provider (PCP) in the community. A majority of the respondents selected Yes (N=224), and 11% selected No (N= 29). Respondents were asked "Why not" if they selected No. Their responses included: new to the area, not needed yet, have established care elsewhere, no availability, and privacy concerns. Results are shown in Figure 33.

Figure 33: Respondents with an Established PCP in the Community
Total respondents = 253



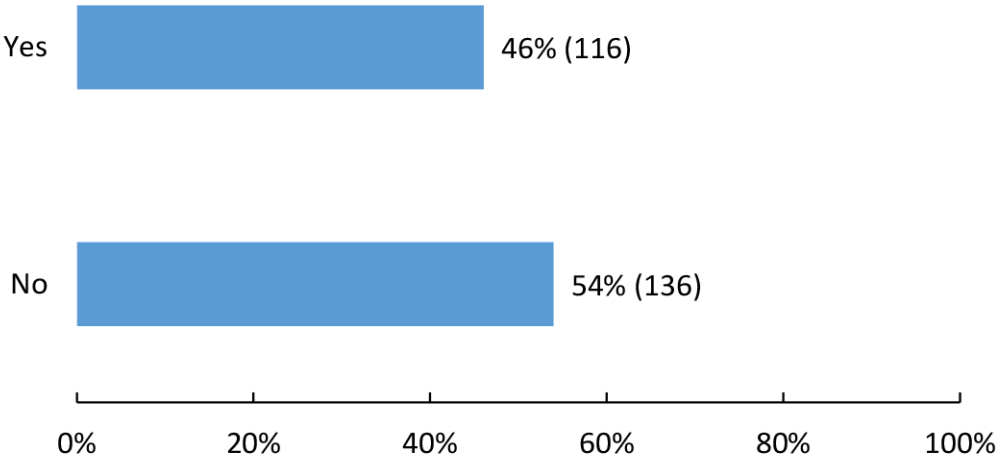
Respondents were asked if they have used the SMC Emergency Department. A majority of the respondents selected Yes (N=185), and 27% selected No (N= 69). Respondents were asked "Why not" if selected No. Their responses included: have not needed to use it, new to area, too far, and too expensive. Results are shown in Figure 35.

Figure 35: Utilization of Sakakawea Medical Center Emergency Department
Total respondents = 254



Respondents were asked if they have used SMC's Surgical Care Services. A majority of respondents selected No (N=136), and 46% selected Yes (N=116). Respondents were asked "Why not" if they selected No. Their responses included: no need so far, lack of trust in surgeon, unaware of service, and out of network. Results in Figure 36.

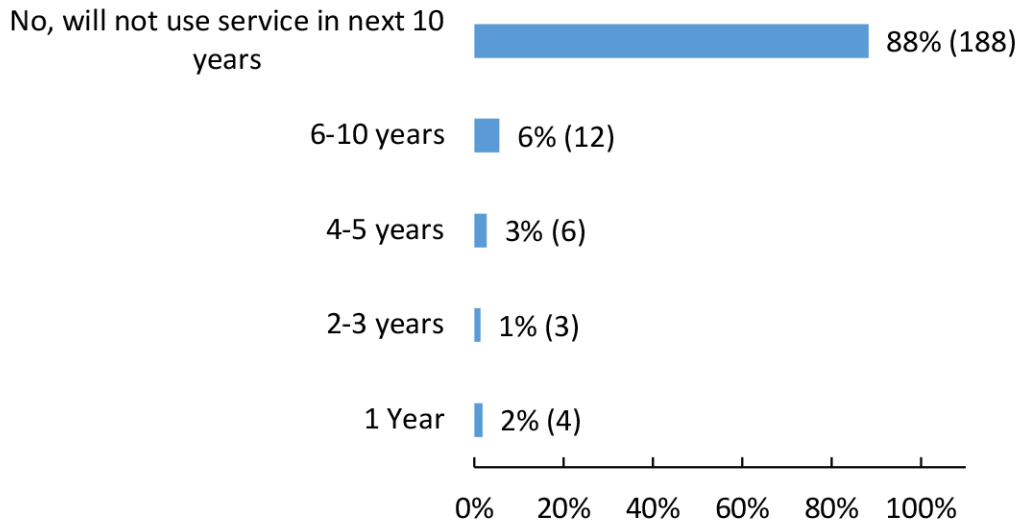
Figure 36: Utilization of Sakakawea Medical Center Surgical Care Services
Total respondents = 252



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

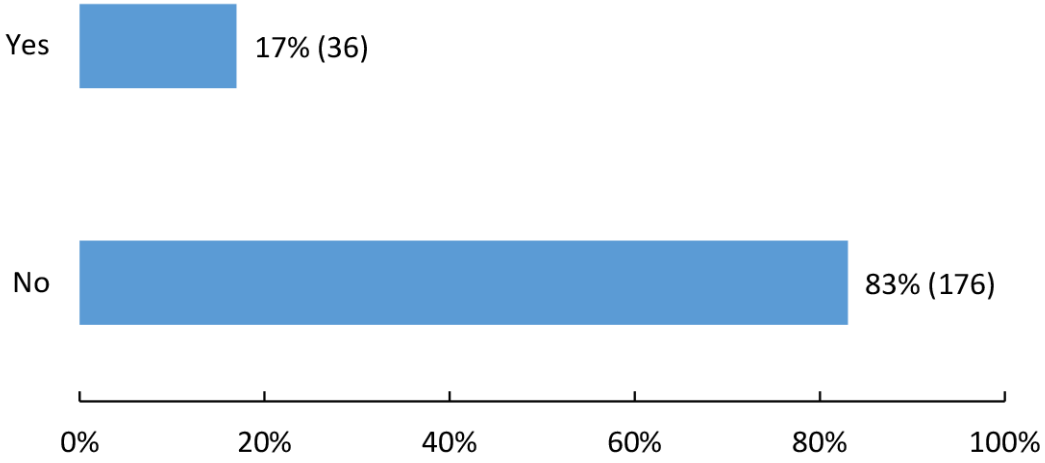
Respondents were asked when Hill Top Home of Comfort services will be needed. The majority of the respondents selected not in the next 10 years (N=188), followed by 6-10 years (N= 12). Results are shown in Figure 37.

Figure 37: When Hill Top Home of Comfort Services will be Needed
Total respondents = 213



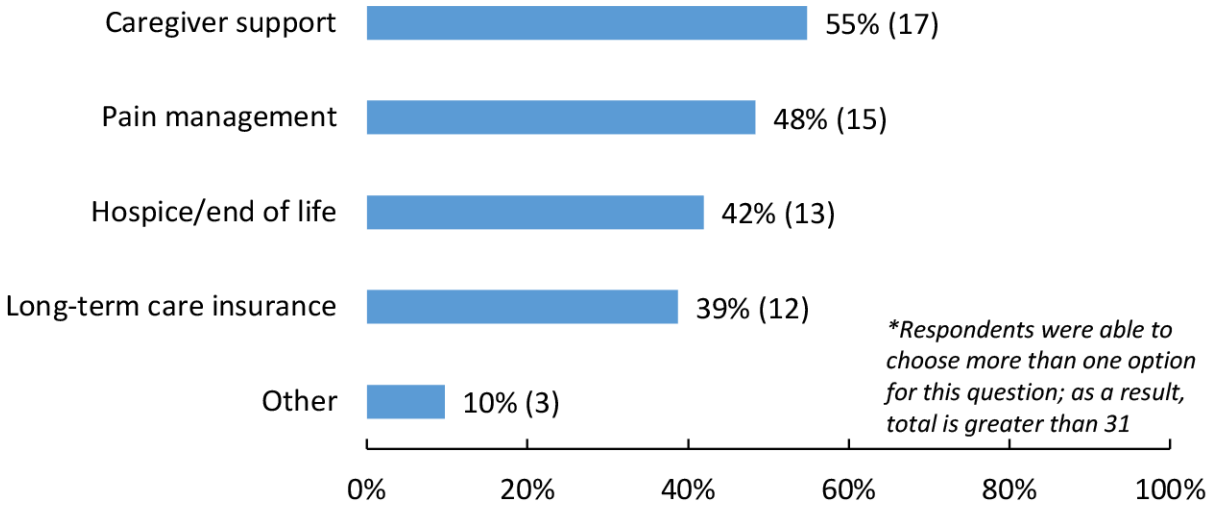
When asked about anticipated use of Hill Top Home of Comfort community health education, 83% of respondents selected No (N=176). Results are shown in Figure 38.

Figure 38: Anticipated Use of Hill Top Home of Comfort Community Health Education
Total respondents = 212



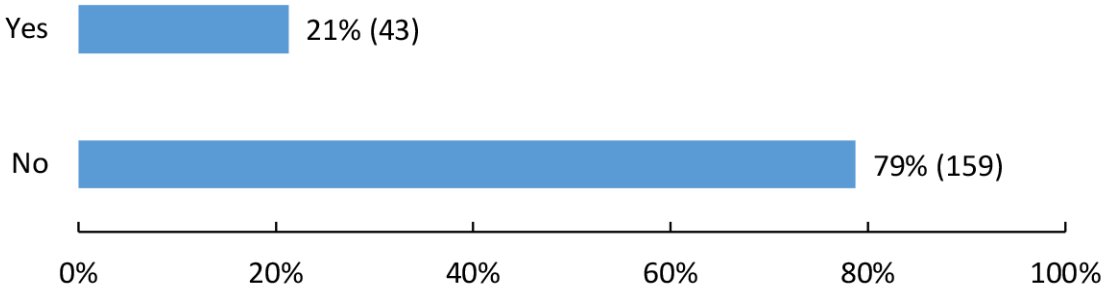
When asked about beneficial types of health education from Hill Top Home of Comfort, caregiver support was the top choice. "Other" responses included health oversight, diet and exercise for aged people, and dementia. Results are shown in Figure 39.

Figure 39: Beneficial Types of Health Education from Hill Top Home of Comfort
Total respondents = 31*



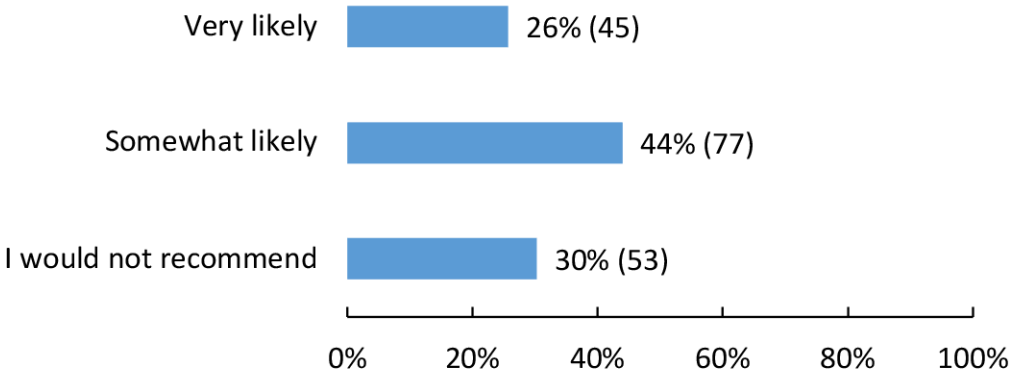
Respondents were asked about the awareness of outpatient services from Therapy Solutions at Hill Top Home of Comfort. Seventy-nine percent of respondents were not aware, while 21% were aware of these services. Results are shown in Figure 40.

Figure 40: Awareness of Outpatient Services from Therapy Solutions at Hill Top Home of Comfort
Total respondents = 202



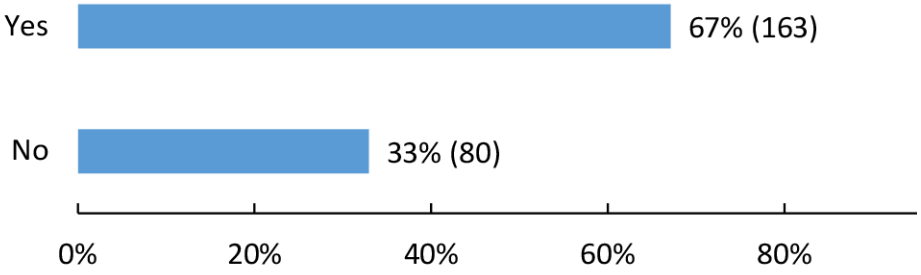
When respondents were asked how likely they would recommend therapy services at Hill Top Home of Comfort community, 70% of the respondents (N= 122) were at least somewhat likely to recommend it. Results are shown in Figure 41.

Figure 41: Likelihood of Recommending Therapy Services at Hill Top Home of Comfort
Total respondents = 175



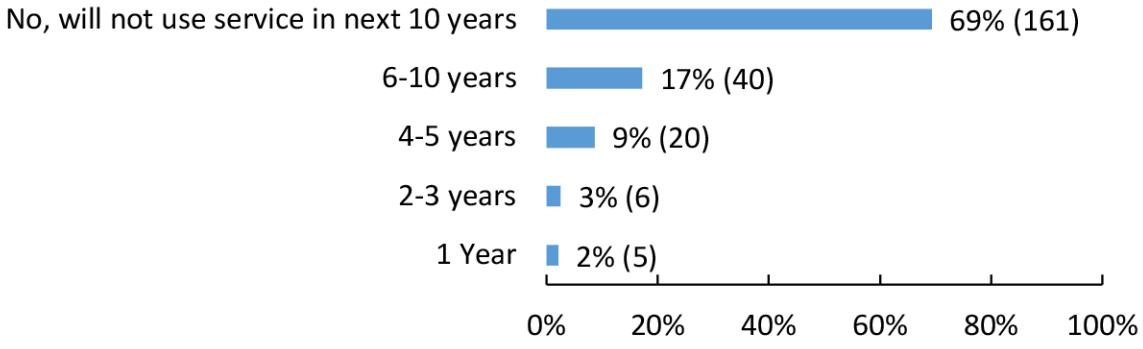
Respondents were asked about the awareness of therapy services at Knife River Care Center. Sixty-seven percent of respondents were aware (N= 163), while 33% were not aware of these services (N= 80). Results are shown in Figure 42.

Figure 42: Awareness of Therapy Services at Knife River Care Center
Total respondents = 243



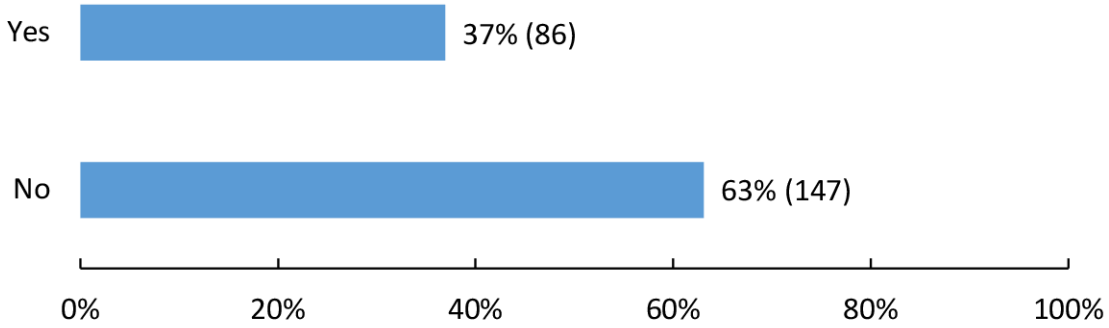
Respondents were asked when Knife River Care Center services will be needed. The majority of the respondents selected not in the next 10 years (N=161), followed by 6-10 years (N= 40). Results are shown in Figure 43.

Figure 43: When Knife River Care Center Services will be Needed
Total respondents = 232



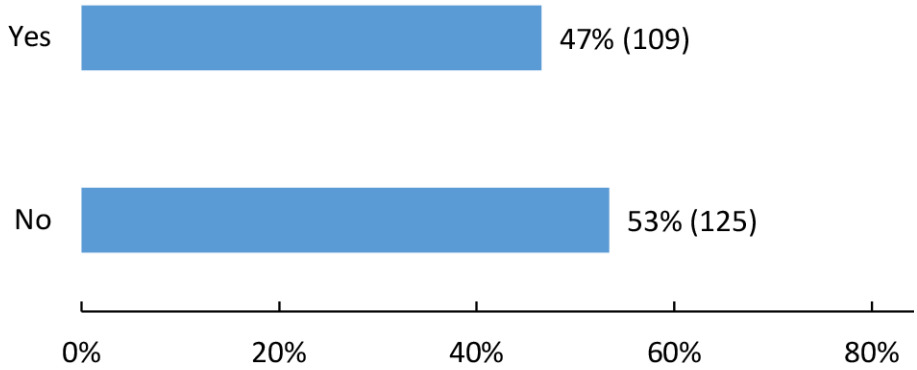
When asked about anticipated use of fall prevention and management classes at Knife River Care Center, 37% of respondents do anticipate using the classes (N= 86), while 63% do not plan on using the classes (N= 147). Results are shown in Figure 44.

Figure 44: Anticipated Use of Fall Prevention and Management Classes at Knife River Care Center
Total respondents = 233



When asked about anticipated use of Alzheimer's Disease classes at Knife River Care Center, 47% of respondents do anticipate using the classes (N= 109), while 53% do not plan on using the classes (N= 125). Results are shown in Figure 45.

Figure 45: Potential Utilization of Alzheimer's Disease Classes Offered by Knife River Care Center
Total respondents = 234



The final question on the survey asked respondents to share concerns and suggestions to improve the delivery of local healthcare. A number of community residents are frustrated with the limited clinic hours for walk-in, evening, and weekend hours. They want more access to visiting specialists. One respondent stated that it is hard for people who work factory hours or farm all day to take time off to schedule an appointment. Rather than taking the time off, they chose to ignore their pain and put off important, and sometimes lifesaving tests. Others decide to leave town to go to a larger facility that has longer operating hours for patients. Other respondents stated they had concerns regarding the pharmacy and patients being able to access vital medication, especially on weekends.

There were a few respondents who stated they had concerns about gossiping amongst staff. They feel there's a lack of confidentiality, and some of the staff have poor attitudes. One respondent stated the doctors need to be nicer and not make patients feel they are beneath them. It is unclear as to whether these experiences are from years past or more recent; however, it is clear there should be efforts made to all staff to ensure patients feel heard, and their experience at SMC and CCCHC are a satisfying one.

Child daycare services have been an issue for a number of years for the Hazen/Beulah area. It is not a unique issue, as many towns across North Dakota have the same problem. One resident stated that the reason there is a staffing shortage in nearly every industry is due to young families not being able to find quality child daycare services. Many families have to take opposite shifts so one parent can stay home with the children, or they rely on retired family members to help with childcare services. Many families depend on help through the Child Care Assistance Program through the North Dakota Health and Human Services. This assistance helps, but if the jobs that are available only pay minimum wage, it will cost parents more money to work and pay the copayment than it will to stay home. These barriers and challenges cause young parents to leave to find a better situation for their family.

Some of the respondents mentioned wanting more educational classes for residents. They believe it would be beneficial for all ages to cover different topics at each class. They would also like more help with mental health and how to handle stressful situations. With bullying happening to young people on and offline, this idea could help prevent something from happening. One person asked for these educational classes to be held by someone who is qualified to handle such material.

Others believe that local health providers do a great job of identifying and delivering healthcare within its means and offers a wide variety of healthcare services.

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 meetings can be grouped into five categories (listed in alphabetical order):

- Attracting and retaining young families
- Availability of vision care
- Depression/anxiety
- Having enough child daycare services
- Not enough affordable housing

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

Attracting and retaining young families

- It is getting harder to find qualified nursing staff
- There is a staff shortage overall across the country

Cost of long-term/nursing home care

- Cost of care and out of pocket expenses can deter people from receiving care
- Many people do not have access to affordable insurance
- No more hospice care, elderly have to leave town

Depression/anxiety

- Affects all ages and seeing increasing numbers
- Kids being pulled from school for social anxiety
- Leads people to self-medicating

Having enough child daycare services

- Families are having issues trying to find childcare
- Young parents have to depend on family members to watch their children
- There are no quality daycares with openings for children

Not enough affordable housing

- We cannot attract families to live here if there is nowhere for them to stay

Community Engagement and Collaboration

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

- Hospital (healthcare system) (4.75)
- Emergency services, including ambulance and fire (4.5)
- Law enforcement (4.5)
- Schools (4.5)
- Faith-based (4.25)
- Long-term care, including nursing homes and assisted living (4.25)
- Business and industry (4.0)
- Pharmacy (3.75)
- Public health (3.75)
- Clinics not affiliated with the main health system (3.5)
- Other local health providers, such as dentists and chiropractors (3.5)
- Economic development organizations (3.25)
- Human/Social services agencies (2.5)
- Tribal Health/Indian Health Services (2.25)

Priority of Health Needs

A community group met on January 6, 2025. Fifteen 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 four needs they considered the most significant.

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

- Depression/anxiety - all ages (8 votes)
- Availability of specialists (7 votes)
- Having enough child daycare services (7 votes)
- Not enough affordable housing (6 votes)

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

1. Availability of specialists (5 votes)
2. Depression/anxiety (4 votes)
3. Not enough affordable housing (3 votes)
4. Not enough child daycare services (3 votes)

Following the prioritization process during the second meeting of the community group and key informants, the number one identified need was depression and anxiety for all ages. A discussion was held during the meeting, and participants decided to combine all ages for depression and anxiety. 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
Depression/anxiety (all ages)	Depression/anxiety (all ages)
Attracting and retaining young families	Availability of specialists
Availability of mental health services	Having enough child daycare services
Having enough child daycare services	Not enough affordable housing

The current process identified similar common needs from 2022. Depression/anxiety and having enough child daycare services were identified as a need during the last community health needs assessment. Availability of specialists and not enough affordable housing are new top needs that were identified during the current process.

Upon adoption of this CHNA report by the Sakakawea Medical Center Board vote and Coal Country Community Health Center 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 Sakakawea Medical Center.

Sakakawea Medical Center and Coal Country Community Health Center 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.

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:

Substance Use (Alcohol and Drug Use/Misuse) All Ages:

- Clinics and hospital perform alcohol and substance use screening on all patients 12 years of age and older with referrals as identified
- Local school district Youth Risk Behavior Survey (YRBS) completion and data analysis
- Long-term care screenings
- TAAP (Training Academy for Addiction Professionals) hosted site for LAC students.
- WECONNECT app – Contingency Management app
- Local SUD programming to include:
  - » SUD Assessments
  - » DUI Seminar
  - » MIP/MIC Seminar
  - » Tobacco/Nicotine Cessation Counseling by Trained Tobacco Specialists at all clinics and hospital
  - » Youth and adolescent curriculum (Catch My Breath, NOT, InDepth)

- » Syringe exchange program
- » Harm reduction model - WPPH
- » In-patient SUD Consultation at SMC
- » Individual counseling
- » Aftercare
- » Contemplation groups
- » Intensive Outpatient Program (IOP)
- » Medication Assisted Therapy (MAT) Suboxone for OUD
- » Medication Assisted Therapy (Vivitrol) for AUD
- » Referral to Mutual Support Meetings (NA, AA)

Depression and Anxiety – All Ages

- Universal screening SMC, CCCHC, Custer Health (renamed WPPH), and Knife River Care Center
- YRBS completion and data analysis
- EAP – employee assistance program
- Trauma Informed Care
- Comprehensive behavioral health department at CCCHC with behavioral health care coordination and case management services
- Visiting psychologist and tele-psychiatry
- IMPACT Program
- WARC (Women's Action Resource Center)
- AveL eCare Intake Assessment
- Community Support Group – Wellness Matters
- Mercer County Youth Bureau
- Crisis management
- ND Pediatric Mental Health Care Access program
- BIMAS2 screenings in schools

Availability of Resources to Help the Elderly Stay in Their Homes

- Stepping On Program / Silver Sneakers
- CCCHC transportation services
- West River Transit, Hazen Busing, VA van
- Local wellness centers
- ADRL
- Home and community-based services (VNS, Palliative, CCM, PT/OT In-home Safety Evals)
- Tytocare virtual care platform
- Home visits
- AWVs/TCM/CCM

- Senior Citizen Centers

Attracting and Retaining Young Families

- Annual salary surveys for market adjustments at local healthcare organizations
- Community collaboration and partnerships for the delivery of community events
- Dakota Nursing Program available locally for LPN and RN programs
- Beulah Chamber welcome packets for new residents
- JDA personnel in Killdeer for Dunn County
- Vision West committee
- Career advancement opportunities within the healthcare system
- CCCHC/SMC hosted sites for advanced practice providers and licensed healthcare professionals
- Marketing opportunities at career fairs
- Collaborative CHNA, CHIP, and Population Health Committee focused on improving health outcomes for the community (i.e., Jumpstart to Wellness, Healthy Halloween Bash, etc.)
- Killdeer school district provides on-site daycare

The above implementation plan for SMC and Coal Country Community Health Center is posted on the SMC's and CCCHC's website at https://www.smcnd.org/collaboration.

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: Hazen, North Dakota

Sakakawea Medical Center

Administrator:
Kurt Waldbillig

Chief of Medical Staff:
Jacinta Klindworth, MD

Board Chair:
Fred Stern

City Population:
3,044 (2022 estimate)[1]

County Population:
8,333 (2022 estimate)[1]

County Median Household Income:
$82,155 (2022)[1]

County Median Age:
44 (2022 estimate)[1]

Owned by: Nonprofit

Hospital Beds: 13

Trauma Level: V

Critical Access Hospital Designation: 2001

County: Mercer
Address: 510 8th Avenue NE
Hazen, ND 58545-4637
Phone: (701) 748-2225
Fax: (701) 639-4343
Web: smcnd.org

Present

Caring for our community is a long-standing tradition at Sakakawea Medical Center (SMC). Since our founding more than 77 years ago, we have strived to care for all who need us and to bring health, healing, and a better quality of life to our neighbors. SMC consists of a Critical Access Hospital (licensed for 13 beds) and 34-bed licensed basic care facility. The medical center is a community-owned, not-for-profit organization with a charitable purpose, governed by a volunteer board of directors. Any money remaining after expenses have been paid, is reinvested back into healthcare and stays in the community to purchase needed medical equipment and support health education and other community needs.

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

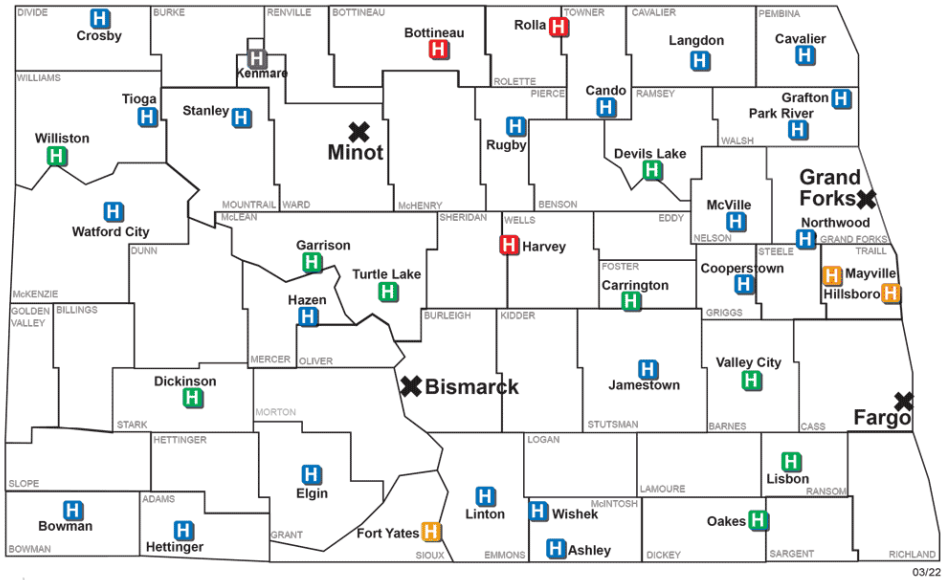
Vision

We strive to be a complete healthcare system dedicated to providing the best comprehensive care possible to the area we serve. Our vision is to enhance the lives of our patients, families, and area communities through high quality healthcare and services."

Sakakawea Medical Center provides the following services through the hospital:

- Acute care
- Anesthesia
- Cardio-pulmonary services
- Cardiac stress testing
- Emergency services (Level V Trauma)
- Hospice care
- Laboratory
- Observation care
- Pharmacy
- Physician services
- Rehabilitation services (physical, occupational and speech therapy)
- Radiology services: CT, ultrasound, 3D mammography, bone densitometry, general X-ray, MRI
- Senior Suites (basic care facility)
- General surgery
- Swing bed program
- Social services
- Urgent care clinic
- Volunteer services
- Respiratory therapy
- Peripheral Arterial Disease (PAD)
- Worksite wellness screenings and educational programs

North Dakota Critical Access Hospitals



Hospital Ownership

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

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

History

SMC dates back to 1941. The original hospital consisted of about a dozen beds on the second floor of one of the original main street buildings. The hospital was a private undertaking by a Beulah woman who ran the facility for several years until Hazen's plans for a new, modern hospital facility were well underway. Community effort continued to keep the hospital open for a time, but the hospital closed in 1946 due to difficulty finding competent personnel. Pursuant to an agreement with Lutheran Hospital and Homes Society for operation of a hospital, construction began on a new facility in 1946. The hospital, with 23 beds, opened in 1948. By the late 1960s, it was apparent that either major remodeling or a new facility was needed. With local donations and Hill-Burton federal funds, a 39-bed, 8-bassinet hospital was built at the east edge of Hazen, opening in 1970. The Hazen Memorial Hospital Association took over the hospital from Lutheran Hospitals and Homes Society in 1969. In 1982, the hospital embarked on a $1.2 million expansion and renovation. The hospital changed its name to Sakakawea Medical Center in 1988. Senior Suites at Sakakawea (licensed basic care facility) was added to the hospital campus in 1997.

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

The top priority of services identified during this process included:

- Additional providers
- Additional mental health services
- More accessible clinic(s), more locations, longer hours
- Increased access to specialists
- Additional equipment/technology

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

In the fall of 2015, directly south of the old hospital, the board of directors broke ground to begin the construction of a replacement facility. The retiring facility was closed, and a new $30.5 million replacement facility opened in April 2017. The new medical center houses a health clinic attached within the hospital, an expanded emergency room and surgical area, handicapped-accessible patient rooms, a centralized registration area and centralized nurse's station; and a myriad of other needed changes and technology updates. The new facility was designed to increase staff efficiency and accommodate changes underway in the delivery of healthcare as well as assisting healthcare providers to meet growing demands within the service area.

Staff

Physicians: 8
Nurse Practitioners: 4
PAs: 2
CRNAs: 1
RNs: 38
CNAs: 18
Total Employees: 142

Local Sponsors and Grant Funding Sources

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

Sources

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

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

ruralhealth.und.edu

Updated 2/2025

Appendix B – CHNA Survey Instrument

Mercer, Oliver, and Dunn County Area Health Survey

Healthcare providers in Dunn, Mercer, and Oliver Counties are interested in hearing from you about community health concerns.

The focus of this effort is to:

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

If you prefer, you may take the survey online at https://tinyurl.com/CHNAHAZEN2024 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 October 21, 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):

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

_____

_____

Delivery of Healthcare

11. Considering the **GENERAL** and **ACUTE SERVICES** at Sakakawea Medical Center and Coal Country Community Health Center, which services are you aware of (or have you used in the past year)? (Choose ALL that apply.)

- ☐ Anesthesia services
- ☐ Audiology (visiting specialist)
- ☐ Behavioral/mental health services
- ☐ Cardiology (visiting specialist)
- ☐ Clinic
- ☐ Emergency room
- ☐ Hospice/palliative care
- ☐ Hospital (acute care)
- ☐ Laparoscopic surgery
- ☐ Medicare annual wellness visits
- ☐ Obstetrics/gynecology (visiting specialist)
- ☐ Orthopedic (visiting specialist)
- ☐ Telehealth (medical and behavioral health)
- ☐ Prenatal and postpartum care
- ☐ Podiatry (foot/ankle – visiting specialist)
- ☐ Preventative wellness services
- ☐ Psychology/psychiatry
- ☐ General surgical services
- ☐ Gynecology surgical services
- ☐ Swing bed and respite care services
- ☐ Urgent care
- ☐ Great Plains Restorative Services (visiting services)
- ☐ Visiting nurse services (Home Health)
- ☐ Certified lactation consultants
- ☐ Food assistance (Great Plains Food Bank)
- ☐ Immunizations

12. Considering **SCREENING/THERAPY SERVICES** at Sakakawea Medical Center and Coal Country Community Health Center, which services are you aware of (or have you used in the past year)? (Choose ALL that apply.)

- ☐ Addiction services (Aftercare and intensive outpatient program)
- ☐ Drug & Alcohol Evaluations
- ☐ DUI Seminars
- ☐ Free Through Recovery and Community Connect
- ☐ Mental Health Counseling
- ☐ Early Childhood Development Screening
- ☐ Health screenings
- ☐ HIV, Hep. C. & Sexually transmitted infection (STI) testing
- ☐ I.M.P.A.C.T program (Integrating Mental Health, Physical Health and Continuity of Care Together)
- ☐ Laboratory services
- ☐ Occupational therapy
- ☐ Physical therapy
- ☐ Social services
- ☐ Speech therapy
- ☐ Cardiac Rehab
- ☐ Pulmonary Rehab
- ☐ Tobacco/nicotine cessation counseling
- ☐ School Nursing
- ☐ Community Support Groups (Fall Prevention, Caregivers, Wellness Matters)
- ☐ Health Tracks

13. Considering **RADIOLOGY SERVICES** at Sakakawea Medical Center and Coal Country Community Health Center, which services are you aware of (or have you used in the past year)? (Choose ALL that apply.)

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

14. Considering available **COMMUNITY AND PUBLIC HEALTH SERVICES**, which services are you aware of (or have you used in the past year)? (Choose ALL that apply.)

- ☐ Bicycle helmet safety
- ☐ Blood pressure check
- ☐ Breastfeeding resources
- ☐ Car seat program
- ☐ Care coordination/chronic disease management
- ☐ Newborn Home Visit
- ☐ Nurse Family Partnership
- ☐ Diabetes screening

- ☐ Emergency response & preparedness program
- ☐ Foot care
- ☐ Flu & COVID-19 shots
- ☐ Environmental health services (water, sewer, health hazard abatement)
- ☐ Harm reduction/syringe exchange program
- ☐ Narcan Training
- ☐ HIV, Hep. C. & Sexually transmitted infection (STI) testing
- ☐ Immunizations
- ☐ Medications setup-home visits
- ☐ Office visits and consults
- ☐ School health (vision screening, growth and development talks, school immunizations)
- ☐ Tobacco prevention and control
- ☐ Tuberculosis testing and management
- ☐ WIC (Women, Infants & Children) Program
- ☐ Women's Way
- ☐ Youth education programs (First Aid)

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

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

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

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

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

_____

_____

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

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

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

- ☐ Can't get transportation services
- ☐ Concerns about confidentiality

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

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

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

21. Considering the availability of physicians and mid-level providers (nurse practitioners, physician assistants) in your community, have you established a Primary Care Provider (PCP)?

- ☐ Yes
- ☐ No, if no, why not? _____

22. Have you established with a Primary Care Provider (PCP) locally at Coal Country Community Health Center?

- ☐ Yes
- ☐ No, if no, why not:
  - ☐ Availability/Access
  - ☐ Cost
  - ☐ Privacy/Trust
  - ☐ Quality of Care
  - ☐ Services Offered

23. Have you used the Sakakawea Medical Center Emergency Department?

- ☐ Yes
- ☐ No, if no, why not?
  - ☐ Availability/Access
  - ☐ Cost
  - ☐ Privacy/Trust
  - ☐ Quality of Care
  - ☐ Services Offered

24. Have you used the Surgical Care Services at Sakakawea Medical Center?

- ☐ Yes
- ☐ No, if no, why not?
  - ☐ Availability/Access
  - ☐ Cost
  - ☐ Privacy/Trust
  - ☐ Quality of Care
  - ☐ Services Offered

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

☐ Yes ☐ No

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

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

27. In Dunn County, Hill Top Home of Comfort offers Assisted Living and skilled nursing services. Do you expect that you or anyone within your immediate family (parents, grandparents, etc.) will use these services, and if so, when?
Within the next:

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

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

☐ Yes ☐ No

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

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

30. In Dunn County, are you aware that Therapy Solutions from Dickinson provides outpatient therapy services (physical therapy, occupational therapy, speech therapy) at Hill Top Home of Comfort?

☐ Yes ☐ No

31. If you needed therapy or know someone who does, how likely would you be to recommend the services offered at Hill Top Home of Comfort?

☐ Very likely ☐ Somewhat likely ☐ I would not recommend

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

☐ Yes ☐ No

33. In Mercer County, Knife River Care Center offers skilled nursing and therapy services for short stay and long stay residents. Do you expect that you or anyone within your immediate family (parents, grandparents, etc.) will use these services, and if so, when?
Within the next:

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

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

☐ Yes ☐ No

35. If Knife River Care Center offered classes related to educational sessions on Alzheimer's Disease for community members would you or one of your immediate family members (parents, grandparents, etc.) utilize these services?

☐ Yes ☐ No

Demographic Information: Please tell us about yourself.

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

☐ Yes ☐ No

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

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

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

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

39. Age:

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

40. Highest level of education:

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

41. Gender:

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

42. Employment status:

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

43. Your zip code: _____

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

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

45. Annual household income before taxes:

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

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

_____

_____

Thank you for assisting us with this important survey!

Appendix C – County Health Rankings Explained

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

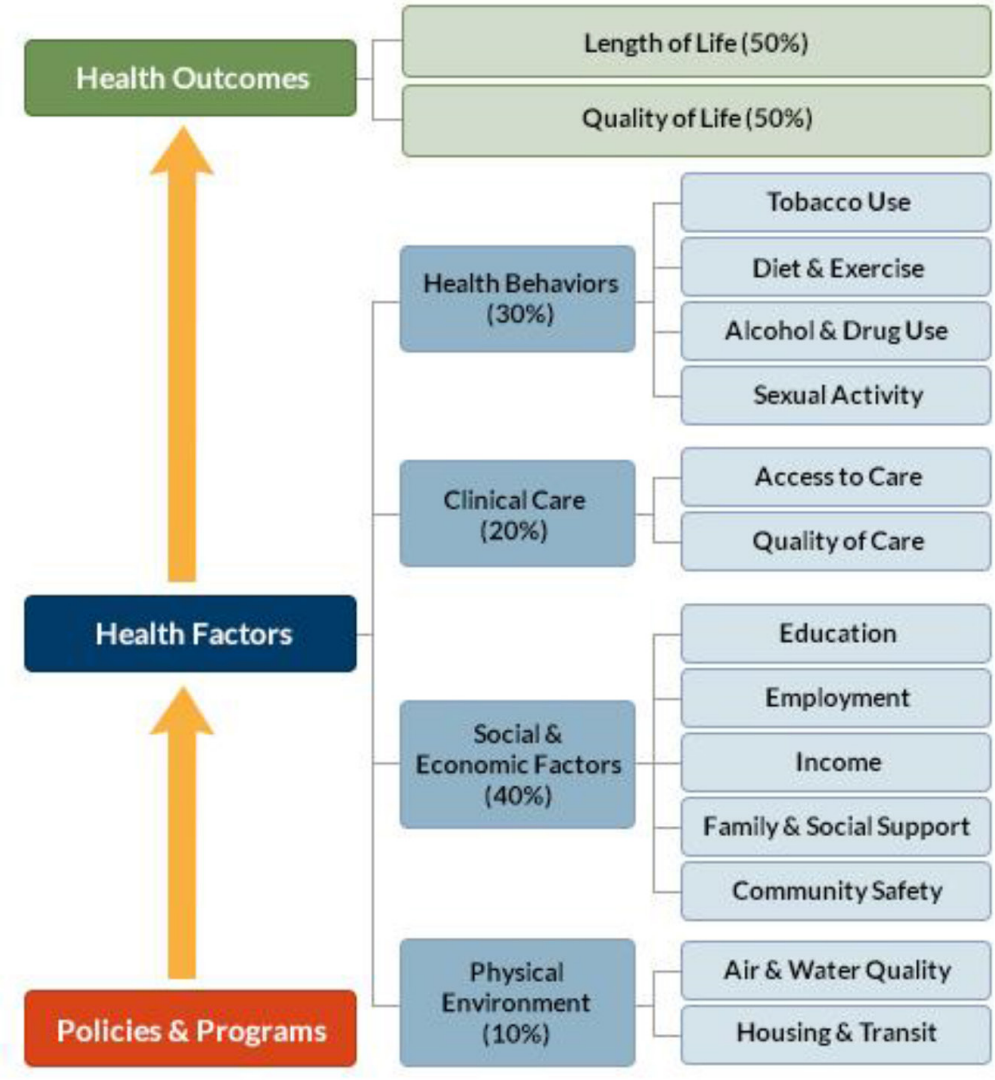
Methods

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/m2.

Reason for Ranking

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

Food Environment Index

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

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

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

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

Reason for Ranking

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

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

may be equally important to have nutritious food available.

Physical Inactivity

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

Reason for Ranking

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

Access to Exercise Opportunities

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

Individuals who:

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

Reason for Ranking

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

Excessive Drinking

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

Reason for Ranking

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

Alcohol-Impaired Driving Deaths

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

Reason for Ranking

Approximately 17,000 Americans are killed annually in alcohol-related motor vehicle crashes. Binge/heavy drinkers

account for most episodes of alcohol-impaired driving.[1,2]

Sexually Transmitted Infection Rate

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

Reason for Ranking

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

Teen Births

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

Reason for Ranking

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

Uninsured

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

Reason for Ranking

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

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

Primary Care Physicians

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

Reason for Ranking

Access to care requires not only financial coverage, but also access to providers. While high rates of specialist

physicians have been shown to be associated with higher (and perhaps unnecessary) utilization, sufficient availability of primary care physicians is essential for preventive and primary care, and, when needed, referrals to appropriate specialty care.[1,2]

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Reason for Ranking
Adults and children in single-parent households are at risk for adverse health outcomes, including mental illness (e.g. substance abuse, depression, suicide) and unhealthy behaviors (e.g. smoking, excessive alcohol use).[1-4] Self-reported

health has been shown to be worse among lone parents (male and female) than for parents living as couples, even when controlling for socioeconomic characteristics. Mortality risk is also higher among lone parents.[4,5] Children in single-parent households are at greater risk of severe morbidity and all-cause mortality than their peers in two-parent households.[2,6]

Violent Crime Rate

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

Reason for Ranking

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

Injury Deaths

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

Reason for Ranking

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

Air Pollution-Particulate matter

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

Reason for Ranking

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

Drinking Water Violations

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

Reason for Ranking

Recent studies estimate that contaminants in drinking water sicken 1.1 million people each year. Ensuring the safety of drinking water is important to prevent illness, birth defects, and death for those with compromised immune systems.

A number of other health problems have been associated with contaminated water, including nausea, lung and skin irritation, cancer, kidney, liver, and nervous system damage.

Severe Housing Problems

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

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

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

Reason for Ranking

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

Appendix 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 2015	ND 2017	ND 2019	ND Trend ↑, ↓, =	Rural ND Town Average	Urban ND Town Average	National Average 2019
Injury and Violence							
Percentage of students who rarely or never wore a seat belt (when riding in a car driven by someone else)	8.5	8.1	5.9	=	8.8	5.4	6.5
Percentage of students who rode in a vehicle with a driver who had been drinking alcohol (one or more times during the 30 prior to the survey)	17.7	16.5	14.2	=	17.7	12.7	16.7
Percentage of students who talked on a cell phone while driving (on at least one day during the 30 days before the survey, among students who drove a car or other vehicle)	NA	56.2	59.6	=	60.7	60.7	NA
Percentage of students who texted or e-mailed while driving a car or other vehicle (on at least one day during the 30 days before the survey, among students who had driven a car or other vehicle during the 30 days before the survey)	57.6	52.6	53.0	=	56.5	51.8	39.0
Percentage of students who never or rarely wore a helmet (during the 12 months before the survey, among students who rode a motorcycle)	NA	20.6	NA	**NA**	NA	NA	NA
Percentage of students who carried a weapon on school property (such as a gun, knife, or club on at least one day during the 30 days before the survey)	5.2	5.9	4.9	=	6.2	4.2	2.8
Percentage of students who were in a physical fight on school property (one or more times during the 12 months before the survey)	5.4	7.2	7.1	=	7.4	6.4	8.0
Percentage of students who experienced sexual violence (being forced by anyone to do sexual things [counting such things as kissing, touching, or being physically forced to have sexual intercourse] that they did not want to, one or more times during the 12 months before the survey)	NA	8.7	9.2	=	7.1	8.0	10.8
Percentage of students who experienced physical dating violence (one or more times during the 12 months before the survey, including being hit, slammed into something, or injured with an object or weapon on purpose by someone they were dating or going out with among students who dated or went out with someone during the 12 months before the survey)	7.6	NA	NA	**NA**	NA	NA	8.2
Percentage of students who have been the victim of teasing or name calling because someone thought they were gay, lesbian, or bisexual (during the 12 months before the survey)	NA	11.4	11.6	=	12.6	11.4	NA
Percentage of students who were bullied on school property (during the 12 months before the survey)	24.0	24.3	19.9	↓	24.6	19.1	19.5
Percentage of students who were electronically bullied (including being bullied through texting, Instagram, Facebook, or other social media during the 12 months before the survey)	15.9	18.8	14.7	↓	16.0	15.3	15.7
Percentage of students who felt sad or hopeless (almost every day for two or more weeks in a row so that they stopped doing some usual activities during the 12 months before the survey)	27.2	28.9	30.5	=	31.8	33.1	36.7
	ND 2015	ND 2017	ND 2019	ND Trend ↑, ↓, =	Rural ND Town Average	Urban ND Town Average	National Average 2019
Percentage of students who seriously considered attempting suicide (during the 12 months before the survey)	16.2	16.7	18.8	=	18.6	19.7	18.8
Percentage of students who made a plan about how they would attempt suicide (during the 12 months before the survey)	13.5	14.5	15.3	=	16.3	16.0	15.7
Percentage of students who attempted suicide (one or more times during the 12 months before the survey)							
Tobacco Use							
Percentage of students who ever tried cigarette smoking (even one or two puffs)	35.1	30.5	29.3	=	32.4	23.8	24.1

Percentage of students who smoked a whole cigarette before age 13 years (even one or two puffs)	NA	11.2	NA	**NA**	NA	NA	NA
Percentage of students who currently smoked cigarettes (on at least one day during the 30 days before the survey)	11.7	12.6	8.3	↓	10.9	7.3	6.0
Percentage of students who currently frequently smoked cigarettes (on 20 or more days during the 30 days before the survey)	4.3	3.8	2.1	↓	2.3	1.7	1.3
Percentage of students who currently smoked cigarettes daily (on all 30 days during the 30 days before the survey)	3.2	3.0	1.4	↓	1.6	1.2	1.1
Percentage of students who usually obtained their own cigarettes by buying them in a store or gas station (during the 30 days before the survey among students who currently smoked cigarettes and who were aged <18 years)	NA	7.5	13.2	=	9.4	10.1	8.1
Percentage of students who tried to quit smoking cigarettes (among students who currently smoked cigarettes during the 12 months before the survey)	NA	50.3	54.0	=	52.8	51.4	NA
Percentage of students who currently use an electronic vapor product (e-cigarettes, vape e-cigars, e-pipes, vape pipes, vaping pens, e-hookahs, and hookah pens at least one day during the 30 days before the survey)	22.3	20.6	33.1	↑	32.2	31.9	32.7
Percentage of students who currently used smokeless tobacco (chewing tobacco, snuff, or dip on at least one day during the 30 days before the survey)	NA	8.0	4.5	↓	5.7	3.8	3.8
Percentage of students who currently smoked cigars (cigars, cigarillos, or little cigars on at least one day during the 30 days before the survey)	9.2	8.2	5.2	↓	6.3	4.3	5.7
Percentage of students who currently used cigarettes, cigars, or smokeless tobacco (on at least one day during the 30 days before the survey)							
Alcohol and Other Drug Use							
Percentage of students who ever drank alcohol (at least one drink of alcohol on at least one day during their life)	62.1	59.2	56.6	=	60.6	54.0	NA
Percentage of students who drank alcohol before age 13 years (for the first time other than a few sips)	12.4	14.5	12.9	=	16.4	13.2	15.0
Percentage of students who currently drank alcohol (at least one drink of alcohol on at least one day during the 30 days before the survey)	30.8	29.1	27.6	=	29.4	25.4	29.2
Percentage of students who currently were binge drinking (four or more drinks of alcohol in a row for female students, five or more for male students within a couple of hours on at least one day during the 30 days before the survey)	NA	16.4	15.6	=	17.2	14.0	13.7
Percentage of students who usually obtained the alcohol they drank by someone giving it to them (among students who currently drank alcohol)	41.3	37.7	NA	**NA**	NA	NA	40.5
	ND 2013	ND 2017	ND 2019	ND Trend ↑, ↓, =	Rural ND Town Average	Urban ND Town Average	National Average 2019
Percentage of students who tried marijuana before age 13 years (for the first time)	5.3	5.6	5.0	=	5.5	5.1	5.6
Percentage of students who currently used marijuana (one or more times during the 30 days before the survey)	15.2	15.5	12.5	=	11.4	14.1	21.7
Percentage of students who ever took prescription pain medicine without a doctor's prescription or differently than how a doctor told them to use it (counting drugs such as codeine, Vicodin, OxyContin, Hydrocodone, and Percocet, one or more times during their life)	NA	14.4	14.5	=	12.8	13.3	14.3
Percentage of students who were offered, sold, or given an illegal drug on school property (during the 12 months before the survey)							
Percentage of students who attended school under the influence of alcohol or other drugs (on at least one day during the 30 days before the survey)	NA	NA	NA	NA	NA	NA	NA
Sexual Behaviors							
Percentage of students who ever had sexual intercourse							

Percentage of students who had sexual intercourse before age 13 years (for the first time)	2.6	2.8	NA	NA	NA	NA	3.0
Weight Management and Dietary Behaviors							
Percentage of students who were overweight (>= 85th percentile but <95th percentile for body mass index, based on sex and age-specific reference data from the 2000 CDC growth chart)	14.7	16.1	16.5	=	16.6	15.6	16.1
Percentage of students who had obesity (>= 95th percentile for body mass index, based on sex- and age-specific reference data from the 2000 CDC growth chart)	13.9	14.9	14.0	=	17.4	14.0	15.5
Percentage of students who described themselves as slightly or very overweight	32.2	31.4	32.6	=	35.7	33.0	32.4
Percentage of students who were trying to lose weight	NA	44.5	44.7	=	46.8	45.5	NA
Percentage of students who did not eat fruit or drink 100% fruit juices (during the seven days before the survey)	3.9	4.9	6.1	=	5.8	5.3	6.3
Percentage of students who ate fruit or drank 100% fruit juices one or more times per day (during the seven days before the survey)	NA	61.2	54.1	↓	54.1	57.2	NA
Percentage of students who did not eat vegetables (green salad, potatoes [excluding French fries, fried potatoes, or potato chips], carrots, or other vegetables, during the seven days before the survey)	4.7	5.1	6.6	=	5.3	6.6	7.9
Percentage of students who ate vegetables one or more times per day (green salad, potatoes [excluding French fries, fried potatoes, or potato chips], carrots, or other vegetables, during the seven days before the survey)	NA	60.9	57.1	↓	58.2	59.1	NA
Percentage of students who did not drink a can, bottle, or glass of soda or pop (such as Coke, Pepsi, or Sprite, not including diet soda or diet pop, during the seven days before the survey)	NA	28.8	28.1	=	26.4	30.5	NA
Percentage of students who drank a can, bottle, or glass of soda or pop one or more times per day (not including diet soda or diet pop, during the seven days before the survey)	18.7	16.3	15.9	=	17.4	15.1	15.1
Percentage of students who did not drink milk (during the seven days before the survey)	13.9	14.9	20.5	↑	14.8	20.3	30.6
Percentage of students who drank two or more glasses per day of milk (during the seven days before the survey)	NA	33.9	NA	NA	NA	NA	NA
Percentage of students who did not eat breakfast (during the seven days before the survey)							
Percentage of students who most of the time or always went hungry because there was not enough food in their home (during the 30 days before the survey)	NA	2.7	2.8	=	2.1	2.9	NA
	ND 2015	ND 2017	ND 2019	ND Trend ↑, ↓, =	Rural ND Town Average	Urban ND Town Average	National Average 2019
Physical Activity							
Percentage of students who were physically active at least 60 minutes per day on 5 or more days (doing any kind of physical activity that increased their heart rate and made them breathe hard some of the time during the seven days before the survey)							
Percentage of students who watched television three or more hours per day (on an average school day)	18.9	18.8	18.8	=	18.3	18.2	19.8
Percentage of students who played video or computer games or used a computer three or more hours per day (counting time spent on things such as Xbox, PlayStation, an iPad or other tablet, a smartphone, texting, YouTube, Instagram, Facebook, or other social media, for something that was not school work on an average school day)	38.6	43.9	45.3	=	48.3	45.9	46.1
Other							
Percentage of students who had eight or more hours of sleep (on an average school night)	NA	31.8	29.5	=	31.8	33.1	NA

Appendix E – Prioritization of Community's Health Needs

Community Health Needs Assessment

Hazen, 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
COMMUNITY/ENVIRONMENTAL HEALTH CONCERNS		
Attracting & retaining young families	3	
Having enough child daycare services	7	3
Not enough affordable housing	6	3
Not enough jobs with livable wages		
AVAILABILITY/DELIVERY OF HEALTH SERVICES CONCERNS		
Cost of healthcare services	3	
Cost of health insurance		
Availability of specialists	7	5
Extra hours for appointments	2	
YOUTH POPULATION HEALTH CONCERNS		
Alcohol use and abuse	3	
Drug use and abuse (including prescription drugs)	1	
Depression/anxiety	8	4
Smoking & tobacco use or vaping/juuling	5	
ADULT POPULATION HEALTH CONCERNS		
Alcohol use and abuse	2	
Drug use and abuse (including prescription drugs)		
Depression/anxiety	5	
Obesity/overweight	2	
Not getting enough exercise/physical activity		
SENIOR POPULATION HEALTH CONCERNS		
Availability of resources for family and friends caring for elders	3	
Availability of resources to help elderly stay in their homes		
Cost of long-term/nursing home care		
Depression/anxiety	2	
Long-term/nursing home care options	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 or edited for spelling/grammar. The question numbers below correspond to the survey question that allowed for an "Other" response. Not all questions allowed for an "Other" response; those numbers are skipped in this Appendix.

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:
    - n/a
    - Anonymity
    - People are involved in their community up to a point
    - Ring new to the community I feel they are very unwelcoming
    - People are from everywhere & generally get along
    - Hazen's great in their govt and community support
    - don't agree with any of these
    - There is a division between long- and short-time residents
    - Don't talk to many people
    - People are generally friendly or supportive, unless an individual is covered in body art or if they dress different.
    - toxic community
    - I don't know
    - not sure
2. Considering the SERVICES AND RESOURCES in your community, the best things are: "Other" responses:
    - We need to support kids and youth by having daycare at the gym
    - none, lacking in all areas
    - Local parks
    - don't agree with any of these
    - Neighbors hardly talk to each other. Good teachers don't stay. We need a Doctor here.
    - Opportunity for high paying jobs
    - None of these truly apply, at least that I've been exposed to. There is no variety or priority with healthy food, we have many churches but some struggle to truly engage in the community, there are few restaurants, not sure what's out there for community groups, Hazen hospital seems to have limited resources with mildly complex issues in my experience, education is Hopefully improving but wasn't much when I was enrolled. I think public transportation is only for school busses or nursing homes. Maybe it has changed in the last few years, but there were very minimal youth programs that I can remember. I guess I can't speak from experience about the schools today, but they weren't very advanced a few years ago.
    - There really isn't anything
3. Considering the QUALITY OF LIFE in your community, the best things are: "Other" responses:
    - Closeness to work (sans activities)
    - No daycare at the gym is difficult
    - It is hard to feel accepted amongst a community you aren't from and move to.
    - Very good healthcare
    - Always something to do in Hazen. Also, the access to quality healthcare is amazing for such a rural area.
    - Crime, drugs and no employment opportunities
    - not a happy environment

4. Considering the ACTIVITIES in your community, the best things are: "Other" responses:

- access to nature
- hunting/fishing/outdoors
- n/a
- Beyond lacking in this area
- Church activities
- No daycare at the gym makes it difficult
- Lack of the above
- don't agree with any of these
- Nothing really to do
- Close to lake
- Nice community
- Lakes & rivers
- nothing
- Cost of living

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:

- Local Government
- no grocery store, having to go out of town for supplies
- Affordable healthy food/groceries
- Lack of the Arts
- Domestic violence and child abuse, not having enough daycare services & needing to con't to increase the school resources
- We need more sidewalks, walking and bike paths
- The outside of people's homes are looking very trashy
- Access to healthy food
- Drugs!
- Healthy affordable food
- Hazen water is pretty gross.
- More surgeons
- Taxes are high/raising.
- This town needs a motel with a pool. Why are we letting Beulah take people out of Hazen.
- No place for young families to gather our young children to play during fall/winter months

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

- Availability of wholistic healthcare
- Having a blend of eastern and western medicine
- Cost of medical care
- Health Insurance denials and insistence on prior authorizations for so many different things, i.e., meds, imaging, etc. Insurance seems to think they have more knowledge and skill than physicians and primary care providers.
- Confidence of healthcare providers following through with care They say they will do something and then they don't.
- No complaints
- quality of care at KRCC

- Cost of dental and vision care especially glasses, etc.
- We are as a rural so extremely fortunate to have the healthcare available that we do. ZERO complaints!
- Need no appointment walk in clinics without having to make an appointment
- Availability of outside specialists to accept SMC services
- No care available at all except FNP / PA.
- More surgeons
- A small walk in clinic when the clinic is closed. Saturday and Sunday.

7. Considering the YOUNG POPULATION in your community, concerns are: "Other" responses:

- Not having enough for youth to do may lead to/ causes many of the other issues I would've chosen
- Learning to become responsible, caring adults, not entitled, self-absorbed adults
- Bullying
- Have no young
- I worry about our youth and their future.
- Safe place to gather that is not a school activity
- involvement in sports

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

- Again not having enough to do other than drink in our community leads or may lead to many of the above that I would've chosen as well
- Overall help for the elderly.
- DRUGS
- No daycare available at the gym
- Mental health
- Dementia education to families
- No complaints
- No Swimming pool for back patients to get exercise
- Exercise for Parkinson's and others in need of a support group
- not sure

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

- None of the above
- No concerns
- Affordable taxes and specials that require elderly to give up their homes
- No pool for exercises
- Cancer

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

- Quality Long Term Care Facility in the area. KRCC is not a quality facility that I would want a loved one in.
- Lack of availability of safe, reliable daycare makes attracting and retaining young families/employees difficult.
- Cost of living
- Mental health needs/Suicide
- Information for support groups for various things should be better known or marketed to the community.
- Alcohol use/abuse
- Availability of resources for family and friends caring for elders
- Little activity for children families
- Having enough services to treat anxiety and depression across all age groups.
- Jobs
- High quality of care in our nursing home

- Getting young people here to work and help take care of the aging/retired population.
- Assistant living options
- Marijuana and access to self-harming substances along with low income limitations to self-care in households
- attracting and keeping young families in the area
- Cost of long-term care.
- The ability of people to work together for the good of everyone.
- There is very little to do in our community for all ages. Many of our regular annual events have been the same as well. We need to get younger people engaged in our commissions and boards in order to bring change and progression to the community.
- The prevalence of neglectful parents
- Specialist availability
- Housing
- CCCHC needing to initiate collaboration with all entities in Mercer, Oliver, and Dunn County to promote wellness for our community members.
- At the current time, getting help for mentally ill +/or drug/alcohol dependent individuals is lacking. Unless someone is deemed to be a danger to themselves or others, their needs can be overlooked easily. They may not have the ability to ask for help for themselves. I live near a person who is obviously mentally ill + possibly substance abusing, but even with calls to law enforcement, this person is still frequently acting out, yelling obscenities, mowing the street, and acting bizarrely in many other ways. I feel scared living near this person, and this person really needs help.
- Not enough housing.
- Attracting families. This includes adequate housing options and adequate retail
- X
- Politics
- No safe place for kids and youth- they are not allowed to use the gym and there aren't enough sidewalks or bike paths throughout the town.
- Drug use
- Alcoholism
- Quality affordable housing for young families considering moving to our community.
- People are being misinformed due to social media.
- Severe anxiety, no one likes me. Not involved in the community, not wanted.
- Drugs and inadequate police force
- "Re: health care- confidentiality. I would rather drive to Bismarck or Dickinson to see doctors than see doctors in Hazen-Beulah.
- Re: having a growth mindset. Our communities are against progress. "
- Only one senior center very limited hours but great lunches available
- Assisted living options
- When I ride bike around town, I almost feel depressed looking at how terrible some properties look. The yards and junk that is laying around is terrible. It leaves a sense of Hazen being a trashy town-
- Not enough daycare facilities.
- Not truly feeling welcomed into the community if not originally from here. Especially if in mid 20s, finding a well-paying job with benefits while having a 4-year bachelor's degree but bot being originally from here being a problem, mental health, and events in the community that don't involve clichés of people who are uninviting.
- More options for childcare to promote retention of young families in smaller towns
- Equal opportunity to jobs and also discrimination issues
- Access to healthy food
- Not enough people
- Daycare options
- "Dishonest Government persons. People on commissions with their own agendas"
- Shifting long-standing cultural norms about diet and exercise to stay healthier longer. This would put less stress on all the healthcare resources. It is generally accepted here that as people age they simply stop moving and

have pain when moving, gain weight, deal with blood sugar, cholesterol and blood pressure issues.

- No one wants to make changes for the better
- Not having access to the proper help for disabled persons
- Keeping young people in it
- Inadequate care for our elderly community members at KRCC
- Cancer
- Money needed to run the city.
- We need more businesses like a hotel and attract entrepreneurs.
- DRUGS! It broke my heart to hear a cashier who comes from another state far away state "nice place but your drugs here are terrible". Meaning the drug use is high and access is very easy.
- Licensed contractors
- Activities for single adults 25-35 or so other than bars.
- Health care workers
- Availability of safe and affordable housing for community members of all ages.
- Care of the elderly. Cost and quality.
- We have a BIG BOYS club (commissioners board) who rack up millions in bills and the people have to pay. People had to pay over $3000. Extra that's PLUS taxes on their homes. MANY ELDERLIES SELLING THEIR HOMES BECAUSE OF IT!
- Drug/substance abuse-specifically alcoholism and methamphetamine dependence.
- Availability of options for community growth and enrichment. I feel if there were more opportunities then the community would grow and thrive.
- Hazen has no way to expand. I want to buy land to put 2 homes and storage units. Nothing available as we are landlocked. Beulah is (sorry for lack of better words) a shit show. HIGH assessments, increase in property taxes, no access to govt officials, and if you are a resident the word is shut up, pay and we will make the decisions. Businesses and individuals are living to Hazen for a better/fair community.
- The unchecked, over-militarized police force, both local and county. They basically seem to do whatever they want. Knowing the actual law is optional for them.
- Political divide on social media and city officials
- Education in all health matters is lacking. There needs to be more local education on what programs are even offered locally. I have no idea what my local medical facilities even offer nor do I know where to look! Costs should also be more transparent for all medical procedures instead of all of this tricky medical coding that is really just a way for a health agency to take advantage of those who can't afford it.
- "Costs"
- Drug use/abuse and lack of accountability.
- Resources
- Lack of Main Street Businesses
- Retaining families! There are not enough stores, activities, etc. in town to keep people from moving away. If we were able to have more things to do, shop, etc., more families may want to live here vs Bismarck/Mandan.
- the poor quality of the nursing home
- Our government makes decisions without the appropriate public input. Our recent street project is an example where our city government pushed a multimillion-dollar project down our throats without considering the financial impact to property owners with anticipation of additional projects being undertaken in the near future.
- Getting people involved. No one wants to step up and help, but they want it all, and expect everyone else to do it.
- activities for young families/young children under the school age.
- Lack of activities outside of bar events or bar sports.
- Drugs and alcohol abuse
- Retaining health care staff
- Affordable groceries, more surgeons
- Lack of affordable housing
- Low wages

- Alcohol/drug abuse
- Lack of services for disabled community
- Gossip
- Scheduling appointments with specialists that are not 2+months out.
- "Keeping the community vital with jobs and opportunities that retain the younger people and
- Maintaining a diverse retail segment"
- Divisiveness within and caused by local politics.
- Shrinking community
- Jobs and environment for families to move and stay in Hazen.
- Loss of hospice because the hospital CEO is not understanding how important it is to the town
- Economy loss of jobs due to green energy
- There is a severe lack of family engagement in the community. Very few events for young families that may be new to the community
- Cost of living
- The turmoil and issues within the city of Beulah's government has led us to want to leave that community and move to a different city in this area. It has made Beulah not an attractive place to live.
- I hope I don't have to be put into a place where I have to make decisions on LTC for family members. I don't hear good things about our facility.
- Drug use
- Cost of things
- Alcoholism and an unwillingness to change

Delivery of Healthcare

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

- Ultrasound availability 24/7 at SMC. More availability for after-hours/weekend urgent care
- Parenting classes
- Wellness checks for individuals on medical marijuana or hx of neurodivergence
- Expansion of physical therapy scopes
- Cardiologist, oncology
- Oncology services, assisted living and long-term care that are comparable to Bismarck in amenities when you pay the same price with no amenities, people will always go out of our counties for that
- Cancer treatment, all have to go too far for chemo.
- More specialists
- Year-round group exercise and fall prevention
- Dermatologist and orthodontics
- Covid vaccinations
- Na
- Natural medicine-homeopathy
- Longer weekend hours.
- Elderly prescription services
- Dental services in Center
- Dermatology
- Preventative wellness awareness sessions: diet, exercise, stretching
- Cancer, kidney dialysis
- Pediatric ot
- Chemo treatments
- Dental care for seniors for free or reduced fees

- Dental and vision care.
- Maybe a small satellite hospital where procedures can be administered locally.
- None. I would like to see more therapists as utilizing local ones can be uncomfortable.
- community food share coop
- Detox
- More surgeons
- Nephrology
- Parkinson's and other support groups
- Dialysis

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

- I work at the clinic
- social media
- Husband
- I don't know and that's the problem

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

- Only used when needed
- None of the above
- I don't see a prevention
- I don't know of anything that prevents one from getting health care.
- Unwilling to seek care.

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

- Homeopath
- Our local health food store NEW WAY HEALTH
- NCCN Guidelines/UpToDate

21. Considering the availability of physicians and mid-level providers (nurse practitioners, physician assistants) in your community, have you established a Primary Care Provider (PCP)? "Why not" responses:

- new to the area
- Not needed yet
- Mine is in Bismarck
- do not wish to disclose
- Don't want to be seen in a town where nurses employees will talk about my health insurance
- No, I'm comfortable with any of the physicians on CCCHC and SMC
- We don't go to the dr that frequently
- Just haven't got around to it and worried about confidentiality
- No time
- not needed
- Go to Bismarck
- Have not made the time to schedule a wellness visit.
- Not sure how to do or feel like I have a choice
- lack of availability due to schedule
- Doctor in Bismarck (2)
- Do not doctor
- Don't feel the need to.
- Had one and was not satisfied

22. Have you established with a Primary Care Provider (PCP) locally at Coal Country Community Health Center? "Why not" responses:

- new to area
- Don't feel like its necessary at this time
- Mine is in Bismarck
- My PCP is in Bismarck due to wanting to keep my medical information private in a small town/work environment.
- do not wish to disclose
- Wanted a more specialized provider, not a general practice and close to work
- established care long ago at Sanford
- already established elsewhere
- Don't want to see somewhere my health will be talked about
- Sort of… I don't have a PCP at Coal Country but when I do go I see the same provider every time
- Lost two who moved to new place or position
- Not needed
- Go to Dickinson
- No dr available in center nd
- Out of network
- Same as above answer
- Haven't had the time to make it to an appointment
- Primary doctor is located at Dakota Gasification Company
- I go to Dickinson
- not needed
- Go to Bismarck
- Not available when I want
- Didn't take my past insurance.
- Doctor available through work
- Have not made the time to schedule a wellness visit.
- Not sure how to do or feel like I have a choice
- Doctor in Bismarck (2)
- Do not doctor
- Lack of confidentiality
- Don't feel the need to.
- prefer care at a facility that does not know me personally
- Because I got treated poorly and made me feel like a total loser

23. Have you used the Sakakawea Medical Center Emergency Department? "Why not" responses:

- No need.
- haven't needed the service
- I've never needed emergency services
- new to area
- No need
- Never needed
- Haven't needed to (4)
- haven't needed it (3)
- not needed (5)
- I should instead of Dickinson
- Never had the need.

- Has not been needed yet
- Haven't had an emergency
- Knew that head injury after fall might need attention not available in Hazen on a weekend.
- out of area
- Distance from house.
- Haven't needed
- I haven't needed if.
- I just go to the closets hospital that I know about
- Not necessary
- N/a
- Too far away
- Haven't needed
- Have not needed it
- Unneeded
- No need this year
- No emergency transpired requiring service
- to far
- No need to (2)
- No Emergencies
- Didn't need it
- Have not needed services.
- Have not needed to yet thankfully.
- Not needed it
- have not needed ER services
- Have not needed to
- Have not needed emergent services
- The primary ER person is unprofessional.
- To expensive
- Have not had a need to
- Been Lucky
- No need yet
- No need
- Have not needed to

24. Have you used the Surgical Care Services at Sakakawea Medical Center? "Why not" responses:

- No need (13)
- Haven't needed to at this time
- I haven't needed surgical care
- No need so far
- Have not needed surgical services
- new to area
- Don't trust surgeon
- Haven't needed it
- n/a (4)
- Unaware of this
- not needed (12)
- Have not had surgery

- Haven't heard good things about it
- Haven't needed to (2)
- Haven't scheduled yet
- no current need
- No medical need
- Haven't had a surgery
- Out of network
- Haven't needed
- PCP at sanford
- Have not needed it
- Unneeded
- No surgeries needed at the gind
- Not needed as of yet
- No need for surgical care
- Have not had the need at this tome
- to far
- Was referred to sanford
- None needed
- Not necessary (3)
- No Surgeries
- Not specialized enough
- Cardiologist in Bismarck
- No need to
- Have not needed services.
- My insurance always choose the most cost effective option which for now has been CHI St. Alexis.
- So far no need.
- Never needed
- haven't needed too, prefer Bismarck
- Not needed it
- have not needed surgical services
- have not needed to
- not comfortable (2)
- have not needed surgery
- Fortunately haven't needed the service, but will use if needed
- Would prefer Bismarck
- Haven't needed to use them yet.
- Haven't had to
- have not needed surgical services
- No surgery yet
- Not needed yet
- Haven't needed it
- Didn't need
- Was more comfortable with having my gallbladder out by a different male surgeon than the one I work closely with
- Have not needed to
- haven't needed to
- No need at this time.

- No need has occurred

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

- attending fundraisers
- attended fundraisers
- employee supported
- serve on board
- SMC Donor
- SMC Foundation
- Cash donations
- Benefits
- Volunteer
- Donations for fundraising efforts through personal and business.
- Fundraisers (2)
- Volunteered time
- Annual fundraisers.
- Jeans fund

29. If yes, what education would you or your family find beneficial? "Other" responses:

- Health oversight
- Diet & exercise for aged people
- dementia

37. How did you acquire the survey (or survey link) that you are completing? "Other" responses:

- CCCHC employee
- In My Chart
- Beulah App
- My Chart (6)
- Family member
- Work at Hill top. Logged into my account and was in my account
- our local clinic
- Work
- MyChart App
- At clinic
- Facebook
- Marketing Director
- I am a Bof D member

38. Health insurance or health coverage status? "Other" responses:

- Pers
- Medicare advantage plan for retirees through union
- Marketplace
- ChampVA

44. Race/Ethnicity? "Other" responses:

- American

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

- The ability to advertise more effectively for the services offered at each clinic location.
- Vaccine-neutral providers who won't turn patients away because of vaccine status are needed.

- "Several questions asked function on predication that the surveyed individual has family in the community to refer to the services, which is not applicable in my case. ""Not applicable"" is a valid answer not being accounted for.
- Demographic information is specific enough to identify the individual filling in the survey, which may color the choice of answers away from what the person filling in may have otherwise answered honestly."
- Lots of education! Provide different topics and bring in specialists to talk about these topics.
- We have a wonderful local healthcare system. We are lucky to have such great providers who go out of the way to help their patients
- Poor care T knife river retirement center
- Physical therapy maintenance program for pain management.
- SMC should have an urgent care more than just Saturdays from 9-1 PM. It would be helpful to have services available for plant workers and shift workers after the clinic has closed between the hours of 6-8 PM that isn't the ER. After school childcare is a HUGE issue as there isn't one and older kids don't want to work these days. It is impossible for working parents who have (8-5 or shift 6-6) jobs get kids from school at 255 or 315 Monday through Friday especially if they don't have family in the small town. It would be nice if CCCHC/SMC/KRCC could offer an afterschool program for its employees in Beulah AND Hazen for this purpose. We have a very young healthcare worker population who need this in order to keep the clinic open from 3-5 PM as many of our nurses and providers have young kids who will be in school in the next year to 3 years. Confidentiality is an issue in both the clinic and hospital. Staff choose to seek care in Bismarck for this purpose. If the confidentiality hasn't happened to them, they know someone it has happened to which burns a bridge. The walls are NOT soundproof in the clinics or hospital, meaning you can hear everything a provider or staff are saying whether good or bad about their day or the patient. Local transportation specifically for doctor appointments in Bismarck that can't be offered locally would be helpful to families with financial strains.
- I have concerns about retaining and hiring enough excellent health care workers, CNA's to providers, in our small community. Health care professionals have a stressful job; they absolutely need to valued and given what resources, human or otherwise, in order to provide excellent services to our patients.
- They need services to provide chemo for locals. Too much travel for specialists.
- Healing your body through natural methods should be the way-not pharmaceuticals that cause more problems. Healthy eating, natural medicines should be what drs talk about.
- I think the healthcare in this area is outstanding and I have complete trust in the staff at all facilities.
- I love the work the SMC and CCCHC staff do. Great providers and great staff. The availability of Specialists in North Dakota is concerning, for both inpatient and outpatient care. The lack of specialist available in Bismarck, Fargo, Minot, Grand Forks, etc. is something that the state should work on collaboratively. SMC and CCCHC can't fix this issue, but it impacts the residents of Mercer, Oliver and Dunn counties.
- Our critical access hospitals and clinics are vital to small communities but their services are limited.
- MD at Center clinic instead of NP only. Or more provider options.
- Healthcare MUST listen to patients 100% of the time. When walking into an exam room, nowhere or nothing else exists - NOTHING but what is in that room and in that file- past and recent.
- Providers must be informed about the available programs and resources that support recovery, aging safely at home, respite for family caregivers, and services for veterans. Greater collaboration in education and community support is essential to bridging the gaps in care plans. Also, many elderly people should not be left alone or driving, and more could be done to make our community a safer and better place for all.
- Overall, I think we have exceptional healthcare services in Mercer County. Both the facilities and professionals are wonderful. I feel the Knife River Care Center is struggling with adequate, consistent and quality care in many areas from CNA level to adequate time with medical doctors and more staff is a critical need in most areas.
- None
- The quality of care at KRCC is far from satisfactory. If there is no improvement in care, I will do my absolute best to prevent all of my loved ones from living there.
- You don't seem to do much for Oliver County so we go to Bismarck. ER in Hazen sends you to Bismarck anyhow so pointless to go there.
- I feel so fortunate to have the level of healthcare and high-quality providers that we have in Mercer county.
- Over regulation. Federal and state support to keep rural healthcare available and affordable.
- Seek greater diversity among local providers.

- I've talked to MANY physical therapists, doctors, friends who are saddened by NOT HAVING A year-round pool for physical therapy and exercises. Closest one is 80 miles away. Older people can't get out and drive that far nor can they afford to do it especially in the winter.
- Everything is great and we are so fortunate. Other than mental health. We need more providers here or visiting providers. PLEASE!!!
- education, education, education....the hardest part is for those working to stay on top of anything health related and knowing the services offered and where to look is a big deal for this community in my opinion.
- Still short on availability of Day Care. Currently, I believe we are often short of nurses. Currently, we have an adequate number of doctors. Big challenge is to retain doctors and be able to hire more nurses.
- Lack of confidentiality, poor attitude of professionals, gossip among staff, lack of services even though advertised as having them,
- I would like to see more services for the ER at SMC. There is a beautiful facility, and it seems like people get referred to Bismarck instead of having treatment there.
- Having to go to Bismarck is not an option. Need more surgeons and professionals in Hazen at the hospital
- I think we have great health care in Beulah!
- The doctors need to simply be nice and not sarcastic and make a person feel like they are beneath them.
- Small walk in clinic so you don't have to go to pay emergency price on off hours.
- Really unhappy that hospice has been closed because of lack of wanting to help dying people and their families!
- My biggest concern is access to the pharmacy for patients to get medications, especially on weekends. I see the issue more when I am working at SMC, Saturday's patients need to rush out of urgent care to get to the pharmacy to pick up the Rx, or needing to be mindful when discharging patients from the ED on Saturday that they need Rx medications to get them through Monday and not just the next day.