Community Health Needs Assessment

2019

Garrison Area, North Dakota Service Area

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

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This project was supported, in part, by the Federal Office of Rural Health, Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS), Medicare Rural Flexibility Hospital Grant program. This information or content and conclusions are those of the author and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS, or the U.S. Government.

Executive Summary

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

To gather feedback from the community, residents of the area were given the opportunity to participate in a survey. There were 104 (electronic-79, paper-25) Garrison service area residents who completed the survey. Additional information was collected through six key informant interviews with community members. The input from the residents, who primarily reside in northern McLean County, portions of southern Ward County and portions of southern Mountrail County, represented the broad interests of the communities in the service area. Together with secondary data gathered from a wide range of sources, the survey presents a snapshot of the health needs and concerns in the community.

City of Garrison Population 2016: 1,505
McLean County Population 2016: 9,576
County Median Household Income: $59,976
County Median Age: 46.6
Estimated population of the service area for
CHI St. Alexius Garrison is 5,500 individuals.
Source: U.S. Census Bureau

McLean County's population from 2010 to 2017 increased 8.1%. The average number of residents under age 18 (21.3%) for McLean County is lower than the state average (23.3%). The percentage of residents ages 65 and older is about 7.8% higher for McLean County (22.8%) than the North Dakota average (15.0%), and the rates of education are slightly lower for McLean County (91.5%) than the North Dakota average (92.0%). The median household income in McLean County ($59,976/2016) slightly below the state average for North Dakota ($60,656/2016). Compared to the median United States household income, North Dakota median household income is $3,039 higher.

Data compiled by County Health Rankings show McLean County is doing better than North Dakota in 6 health outcomes, better than the national levels in 4 factors, and tied with the national levels in two factors.

McLean County, according to County Health Rankings data, is performing poorly relative to the rest of the state in 12 factors and is not meeting the United Stated Top 10% performers in 25 factors.

Of the 82 potential community and health needs set forth in the survey, the 104 Garrison service area residents who completed the survey indicated the following 10 needs as the most important:

- Attracting and retaining young families
- Not having jobs with livable wages
- Availability and ability to retain primary care providers (MD, DO, NP, PAs) and nurses
- Drug use and abuse (including prescription drugs for both adult and youth populations
- Alcohol use and abuse by both adult and youth populations
- Availability of resources to help the elderly stay in their homes
- Assisted living options
- Cost of long-term care options

The survey also revealed the biggest barriers to receiving healthcare (as perceived by community members). Those barriers included the ability to retain primary care providers (MD,DO, NP, PA) and nurses (N=47), availability of primary care providers (MD, DO, NP, PA and nurses) (N=29), and cost of health insurance (N=20).

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

- Active faith community
- Healthcare
- Quality school systems
- Access to healthy food
- Community groups and organizations
- Business district

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:

- Attracting and retaining young families
- Bullying/cyberbullying
- Ability to retain primary care providers (MD, DO, NP, PA) and nurses
- Not enough healthcare staff in general and cost of healthcare
- Drug use and abuse among adults and youth
- Alcohol use and abuse among adults and youth
- The cost of long-term/nursing home care

Overview and Community Resources

With assistance from the CRH at the UNDSMHS, the CHI St. Alexius Health Garrison completed a CHNA of the Garrison service area. The hospital identifies its service area as northern Mclean County, portions of southern Ward County and portions of southern Mountrail County. Many community members and stakeholders worked together on the assessment.

The Garrison Community

Whether you're returning to Garrison, North Dakota for a summer visit, considering a chance to come fish or hunt, or thinking about finding a new home, this is a community that comes together to meet your expectations. The community's retail, service, and professional businesses offer personal care by experienced and friendly personnel. Garrison schools, churches, and organizations remain strong threads in the basic of community life. Year-round recreation opportunities keep area sportsmen enjoying the current season and looking forward to the next. Special events reward enthusiasts with great memories and growing friendships.

Garrison offers all the amenities to make it home: a picturesque location, unbelievable recreation right out your back door, and the comforts of a full-service business district & medical services nearby.

Garrison, North Dakota sprung up in 1905 and organized as a village in 1907. The Taylor Brothers, Cecil and Theodore founded the original town, in 1903. The post office was established June 17, 1903. Later, when the Soo Line ran its tracks farther north, the town moved to its present location. Garrison is seated just six miles off Highway 83 between Minot and Bismarck and sits just a few miles north of beautiful Lake Sakakawea.

Business flourished in the early years. The early leaders saw Garrison as a town "bustin' at the seams" with gun totin' rascals. Fortunately for decades to come, the West was tamed, and homes and businesses grew into a solid community. Currently, Garrison boasts many businesses, offering residents and guests the best a small town can offer, right here at home.

Garrison was long considered the Agricultural Gateway City because it was situated in the heart of rich farmland, available at low prices. In 1914-1915 it was considered the largest primary wheat shipping point and was incorporated as a city in 1916.

After 100 years, Garrison remains a great place to be! Whether you're returning for a summer visit, considering a chance to come fish or hunt, or thinking about finding a new home, this is a community that comes together to meet your expectations.

CHI St. Alexius Health-Garrison

CHI St. Alexius Health

The CHI St. Alexius Health regional healthcare system was formed in April 2016, when several Catholic Health Initiative healthcare facilities joined together to form the largest healthcare delivery system in central and western North Dakota. The system is comprised of a tertiary hospital in Bismarck, and critical access hospitals (CAHs) in Carrington, Dickinson, Devils Lake, Garrison, Turtle Lake, and Williston as well as numerous clinics and outpatient services. CHI St. Alexius Health also manages four CAHs in North Dakota that are located in the communities of Ashley, Elgin, Linton, and Wishek, as well as Mobridge Regional Hospital & Clinics in Mobridge, South Dakota.

Catholic Health Initiatives

CHI St. Alexius Health is part of Catholic Health Initiatives (CHI), a national nonprofit health system based in Englewood, Colorado. The faith-based system operates in 18 states and includes 103 hospitals. Additional services offered within the system are: long-term care, assisted and residential living communities, community health services organizations, home health agencies, and numerous outpatient facilities.

CHI St. Alexius Health Garrison includes the services of a 22-bed CAH, a 28-bed skilled nursing facility, an attached rural health clinic, and a newly remodeled emergency department that is available 24 hours a day. They offer many outpatient services, including physical therapy, radiology services, laboratory services, cardiac rehabilitation, and IV treatments.

Since opening in 1952, CHI St. Alexius Health Garrison has been dedicated to serving the residents of Garrison and the surrounding rural communities. CHI St. Alexius Health includes the Garrison Hospital and the Garrison Family Clinic.

Mission

The Mission of Catholic Health Initiatives is to nurture the healing ministry of the Church, supported by education and research. Fidelity to the Gospel emphasizes human dignity and social justice to create healthier communities.

To fulfill this mission, Catholic Health Initiatives, as a values-driven organization, will:

- Assure the integrity of the healing ministry in both current and developing organizations and activities;
- Develop creative responses to emerging healthcare challenges;
- Promote mission integration and leadership formation throughout the entire organization;

- Create a national Catholic voice that advocates for systemic change and influences health policy with specific concern for persons who are poor, alienated and underserved; and
- Steward resources by general oversight of the entire organization.

Vision

Our Vision is to live up to our name as One CHI:

- Catholic: Living our Mission and Core Values.
- Health: Improving the health of the people and communities we serve.
- Initiatives: Pioneering models and systems of care to enhance care delivery.

The Garrison Foundation is managed by the CHI St. Alexius Health Foundation office in Bismarck. All funds donated to Garrison Foundation advances patient care in Garrison through the purchase of new equipment, technology, and helping with patient programs. Below are the programs the Garrison Foundation funds support.

Vital Capital Medical Needs Fund – Garrison

- By donating to the Vital Capital Medical Needs Fund – Garrison, your gift helps purchase the newest medical devices, equipment, and health technology essential to meeting Garrison's community's healthcare needs.

Hospice – Garrison

CHI Health at Home, located in Bismarck, North Dakota, is the largest regional provider of home care and hospice. CHI Health at Home provides hospice services to Garrison. All donations are used to support the hospice program through its memorial events, bereavement services, group services, volunteer recruitment and education, patient safety and communication pieces, hospice patient flower deliveries, and so much more. Your contribution helps loved ones and their families go through the end-of-life journey in the most dignified way.

Services offered locally by CHI St. Alexius Health Garrison include:

General and Acute Services

1. Acne treatment
2. Adult day care
3. Allergy, flu & pneumonia shots
4. Blood pressure checks
5. Cardiology (visiting physician)
6. Cardiac rehab
7. Clinic
8. Emergency room
9. General surgeon-consulting (visiting physician)
10. Gynecology
11. Hearing services (visiting specialist)
12. Hospital (acute care)
13. Immunizations
14. Mental health services (visiting physician)
15. Mole/wart/skin lesion removal & biopsies
16. Nutrition counseling
17. Orthopedics (visiting physician)
18. Pharmacy (inpatient/outpatient)
19. Physicals: annuals, DOT, sports & insurance
20. Prenatal care up to 32 weeks
21. Respite care
22. Skilled nursing facility
23. Sports medicine
24. Swing bed services

Screening/Therapy Services

1. Chronic disease management
2. Holter monitoring
3. IV therapies
4. Laboratory services
5. Lower extremity circulatory assessment
6. Occupational physicals
7. Occupational therapy
8. Pediatric services
9. Physical therapy
10. Respiratory care
11. Restorative care
12. Social services
13. Sports injury screening

Radiology Services

1. Bone densitometry (DexaScan)
2. CT scan
3. Digital mammography
4. Echocardiograms
5. EKG
6. General x-ray
7. Nuclear medicine (mobile unit)
8. MRI (mobile unit)
9. Ultrasound (mobile unit)

Laboratory Services

1. Chemistry
2. Coagulation
3. Hematology
4. Rapid testing kits
5. Urine testing

Services offered by OTHER providers/organizations

1. Ambulance
2. Chiropractic services
3. Dental services
4. Massage therapy
5. Optometric/vision services
6. Retail pharmacy

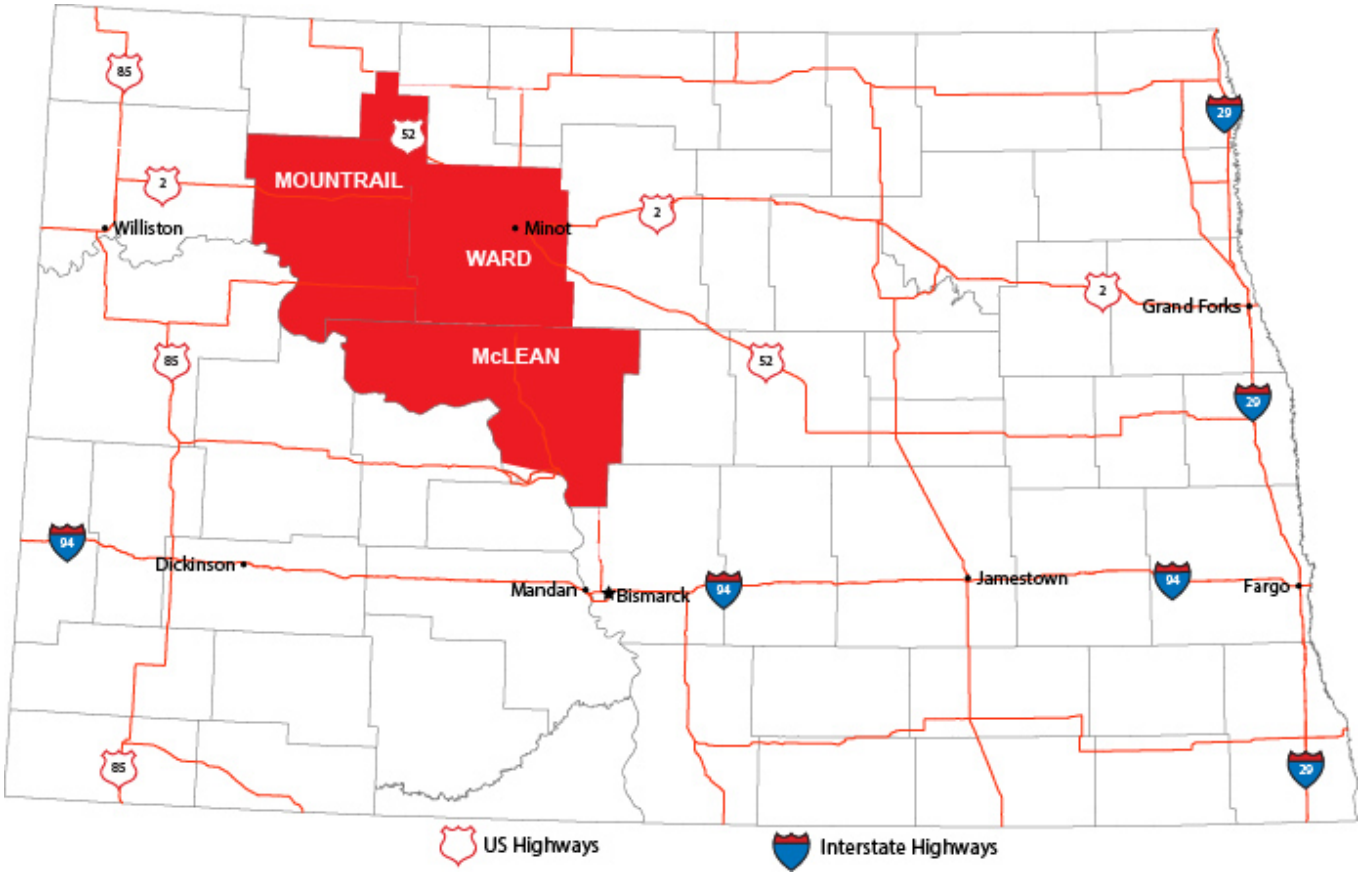
Telemedicine Services

1. eEmergency
2. eHospitalists
3. TelePharmacy
4. TelePsychiatry

Education Services

1. CPR (offered free to public)
2. Satellite site for Dakota Nursing Program through Bismarck State College

Figure 1: McLean, Ward and Mountrail Counties



Assessment Process

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

A CHNA benefits the community by:

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

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

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

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

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

This assessment examines health needs and concerns in the service area of CHI St. Alexius Health Garrison and McLean County, specifically.

The CRH, in partnership with CHI St. Alexius Health Garrison, facilitated the CHNA process. Community representatives met regularly in-person, by telephone conference, and email. A CHNA liaison was selected locally, who served as the main point of contact between the CRH and CHI St. Alexius Health Garrison. A

small steering committee (see Figure 2) was formed that was responsible for planning and implementing the process locally. Representatives from the CRH met and corresponded regularly by teleconference and/or via the eToolkit with the CHNA liaison. The community group (described in more detail below) provided in-depth information and informed the assessment process in terms of community perceptions, community resources, community needs, and ideas for improving the health of the population and healthcare services. There were 16 people, representing a cross section demographically, who attended the focus group meeting. The meeting was highly interactive with good participation. Some of the medical facility staff and board members attended as well, but largely played a role of listening and learning.

Figure 2: Steering Committee

Amy Heer	McLean County Public Health Nurse
Gary Larson	Business Owner/S&J Hardware
Lindsay Bofenkamp	GAIA Director
Nick Klemisch	Superintendent, Garrison Public Schools
Tod Graeber	Administrator, CHI St. Alexius Health Garrison
Mandi Wilcox	Administrative Assistant, CHI St. Alexius Health Garrison
Beth Hetletved	VP Nursing, CHI St. Alexius Health Garrison

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

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

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

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

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

Community Group

A Community Group consisting of 16 community members met on August 21, 2018. During this first Community Group meeting, group members were introduced to the needs assessment process, reviewed basic demographic information about the community, and served as a focus group. Focus group topics included community assets and challenges, the general health needs of the community, community concerns, and suggestions for improving the community's health.

The Community Group met again on November 5, 2018 with ten 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 McLean County. The group was then tasked with identifying and prioritizing the community's health needs.

Members of the Community Group represented the broad interests of the community served by CHI St. Alexius Health Garrison. They included representatives of the health community, business community, political bodies, law enforcement, education, faith community, and social service agencies. Not all members of the group were present at both meetings.

Interviews

One-on-one interviews with six key informants were conducted in person in Garrison on August 21, 2018. A representative from the CRH conducted the interviews. Interviews were held with selected members of the community who could provide insights into the community's health needs. The informant interviews included public health professionals with several years of direct experience in the community, including working with medically underserved, low income, and minority populations, as well as with populations with chronic diseases.

Topics covered during the interviews included the general health needs of the community, the general health of the community, community concerns, delivery of healthcare by local providers, awareness of health services offered locally, barriers to receiving health services, and suggestions for improving collaboration within the community.

Survey

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

The community member survey was distributed to various residents of its service area which is defined as northern Mclean County, portions of southern Ward County, and portions of southern Mountrail Counties which are all included in the CHI St. Alexius Health Garrison service area.

The survey tool was designed to:

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

Specifically, the survey covered the following topics:

- Residents' perceptions about community assets;
- Broad areas of community and health concerns;

- Awareness of local health services;
- Barriers to using local healthcare;
- Basic demographic information;
- Suggestions to improve the delivery of local healthcare; and
- Suggestions for capital improvements.

To promote awareness of the assessment process, press releases were published in the local newspapers, weekly posts were placed on the medical facility Facebook website and single page flyers with a QR code for the online survey were placed around town.

Approximately 250 community member surveys were available for distribution in McLean County as well as Ward and Mountrail Counties. Community Group members, other medical facilities, public health, and local churches distributed the surveys.

To help ensure anonymity, included with each survey was a postage-paid return envelope to the CRH. In addition, to help make the survey as widely available as possible, residents also could request a survey by calling CHI St. Alexius Health Garrison. The survey period ran from August 21, 2018 to September 30, 2018. A total of 104 surveys were completed, 79 of them electronic and 25 of them paper. This response rate is on par for this type of unsolicited survey methodology and indicates an engaged community.

Secondary Data

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

Social Determinants of Health

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

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

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

Figure 3: Social Determinants of Health

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

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

Figure 4: Social Determinants of Health

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

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

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Demographic Information

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

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

	McLean County	North Dakota
Population (2017)	9,685	755,393
Population change (2010-2017)	8.1%	12.3%
People per square mile (2010)	4.2	9.7
Persons 65 years or older (2016)	22.8%	15.0%
Persons under 18 years (2016)	21.3%	23.3%
Median age (2016 est.)	46.6	35.2
White persons (2016)	90.4%	87.5%
Non-English speaking (2016)	2.7%	5.6%
High school graduates (2016)	91.5%	92.0%
Bachelor's degree or higher (2016)	18.3%	28.2%
Live below poverty line (2016)	9.2%	10.7%
Persons without health insurance, under age 65 years (2016)	9.2%	8.1%

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

While the population of North Dakota has grown in recent years, there was less of a population change in McLean County (8.1%) compared to the state average (12.3%). It can also be noted the number of persons 65 or older in 2017 (22.8%) is significantly higher than the North Dakota average which is only 15%.

County Health Rankings

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

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

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

Health Outcomes

- Length of life
- Quality of life

Health Factors

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

Health Factors (continued)

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

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

McLean County rankings within the state are included in the summary following. For example, McLean County ranks 16th out of 49 ranked counties in North Dakota on health outcomes and 35th on health factors. The measures marked with a bullet point (•) are those where a county is not measuring up to the state rate/percentage; a asterisk (*) indicates that the county is faring better than the North Dakota average but is not meeting the U.S. Top 10% rate on that measure. Measures that are not marked with a bullet or asterisk but are marked with a plus sign (+) indicate that the county is doing better than the U.S. Top 10%.

The data from County Health Rankings shows that McLean County is doing better than many counties compared to the rest of the state on all but two of the outcomes, (low birth weight and the percentage of diabetics) landing at or above rates for other North Dakota counties. However, McLean County, like many North Dakota counties, is doing poor in many areas when it comes to the U.S. Top 10% ratings. McLean County rates higher than the national 10% in premature deaths, individuals stating poor or fair health in the past 30 days, low birth weight, and percentage of people with diabetes.

On *health factors*, McLean County performs below the North Dakota average for counties in several areas as well:

- Adult obesity
- Food environment index
- Physical inactivity
- Access to exercise opportunities
- Uninsured
- Primary care physicians
- Dentists
- Mental health providers
- Unemployment
- Injury deaths

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

- Poor physical health days
- Poor mental health days

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

- Children in poverty
- Children in single-parent households
- Diabetic monitoring
- Severe housing problems

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

- Premature deaths
- Poor or fair health
- Poor physical health days
- Poor mental health days
- Alcohol impaired deaths
- Sexually transmitted infections

Factors in which McLean County is performing health behaviors poorly relative to the rest of the state include:

- Adult smoking
- Food environment
- Access to exercise
- Excessive drinking
- Alcohol-impaired driving deaths
- Sexually transmitted diseases
- Teen birth rate

Factors in which McLean County is performing poorly relative to the rest of the state include:

- Higher uninsured
- Less primary care physicians
- Less dentists
- Less mental health providers
- Less diabetic monitoring
- Higher unemployment
- Higher injury deaths

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

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

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

• Not meeting North Dakota average

	McLean County	U.S. Top 10%	North Dakota
Ranking: Outcomes	**16th**		**(of 49)**
Premature death	5,900 *	5,300	6,600
Poor or fair health	13% *	12%	14%
Poor physical health days (in past 30 days)	2.8 +	3.0	3.0
Poor mental health days (in past 30 days)	2.7 +	3.1	3.1
Low birth weight	7% •*	6%	6%
% Diabetic	11% •*	8%	8%
Ranking: Factors	**35th**		**(of 49)**
Health Behaviors			
Adult smoking	18% *	14%	20%
Adult obesity	36% •*	26%	32%
Food environment index (10=best)	8.2 •*	8.6	9.1
Physical inactivity	26% •*	20%	24%
Access to exercise opportunities	46% •*	91%	75%
Excessive drinking	22% *	13%	26%
Alcohol-impaired driving deaths	37% *	13%	48%
Sexually transmitted infections	208.8 *	145.1	427.2
Teen birth rate	24 *	15	25
Clinical Care			
Uninsured	10% •*	6%	9%
Primary care physicians	4,870:1•*	1,030:1	1,330:1
Dentists	4,870:1•*	1,280:1	1,550:1
Mental health providers	9,730:1 •*	330:1	610:1
Preventable hospital stays	46 *	35	49
Diabetic monitoring (% of diabetic Medicare enrollees ages 65-75 that receive HbA1c monitoring)	92%+	91%	87%
Mammography screening (% of Medicare enrollees ages 67-69 receiving screening)	69% *	71%	69%
Social and Economic Factors			
Unemployment	3.6% •*	3.2%	3.2%
Children in poverty	11% +	12%	12%
Income inequality	4.0 *	3.7	4.3
Children in single-parent households	20% +	20%	28%
Violent crime	98 *	62	260
Injury deaths	73 •*	55	68
Physical Environment			
Air pollution – particulate matter	7.5 *	6.7	7.5
Drinking water violations	Yes *	No	
Severe housing problems	9% +	9%	11%

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

Children's Health

The National Survey of Children's Health touches on multiple intersecting aspects of children's lives. Data are not available at the county level; listed below is information about children's health in North Dakota. The full survey includes physical and mental health status, access to quality healthcare, and information on the child's family, neighborhood, and social context. Data is from 2016-17. More information about the survey is found at www.childhealthdata.org/learn/NSCH.

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

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

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

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

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

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

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

The data shows that Eddy County is performing more poorly than the North Dakota average on all of the examined measures except the percentage of the population who are Supplemental Nutrition Assistance Program (SNAP) recipients and the 4-year high school graduation rate. The most marked difference was on the measure of licensed childcare capacity (almost 20% lower rate in Eddy County).

Foster County is performing more poorly than the North Dakota average on only two factors: uninsured children below 200% and licensed childcare capacity (almost 16% lower rate in Foster County).

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

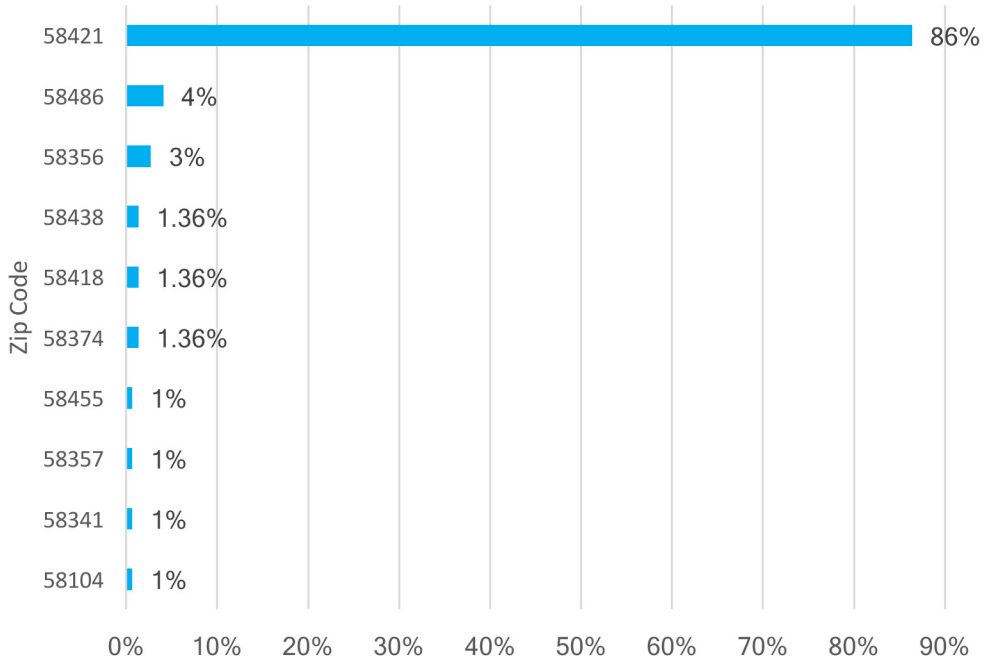
	McLean County	North Dakota
Uninsured children (% of population age 0-18), 2016	11.0%	9.0%
Uninsured children below 200% of poverty (% of population), 2016	40.1%	41.9%
Medicaid recipient (% of population age 0-20), 2017	27.5%	28.3%
Children enrolled in Healthy Steps (% of population age 0-18), 2013	2.7%	2.5%
Supplemental Nutrition Assistance Program (SNAP) recipients (% of population age 0-18), 2017	14.9%	20.1%
Licensed childcare capacity (% of population age 0-13), 2018	25.1%	41.9%
4-Year High School Cohort Graduation Rate, 2017	93.1%	87.0%

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

Survey Results

As noted previously, 104 community members completed the survey in communities throughout the counties in the CHI St. Alexius Health Garrison service area. The survey requested that respondents list their home zip code. While not all respondents provided a zip code, 79 did, revealing that the large majority of respondents (76%, N=79) lived in Garrison. These results are shown in Figure 5.

Figure 5: Survey Respondents' Home Zip Code
Total respondents: 79



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

Survey Demographics

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

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

- 56% (N=48) were age 55 or older
- The majority (73%, N=62) were female.
- Respondents (24%, N=21) had bachelor's degrees or higher.
- The number of those working full time (62%, N=53) was just less than three times higher than those who were retired (19%, N=16).
- Only 1 of 85 of those who reported their ethnicity/race were non-white/Caucasian.
- 20.7% of the population (N=17) 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 = 86

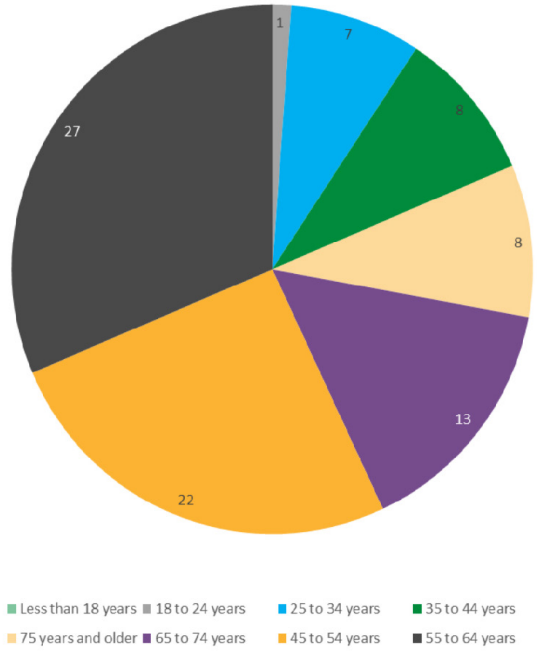


Figure 7: Gender Demographics of Survey Respondents
Total respondents = 85

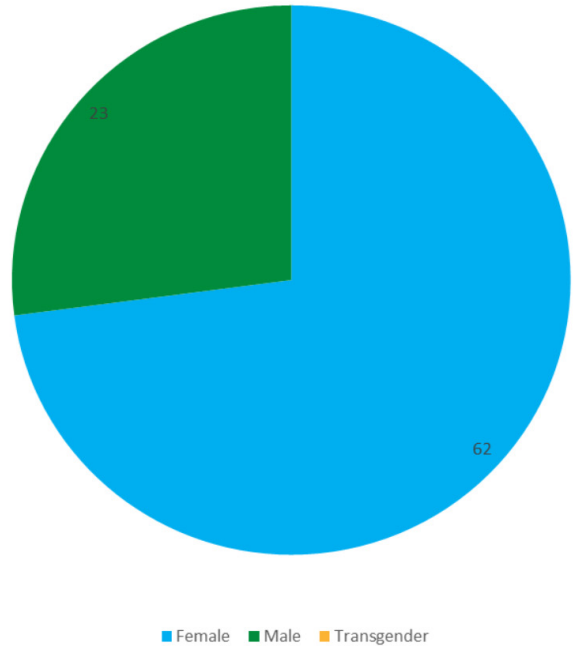


Figure 8: Educational Level Demographics of Survey Respondents
Total respondents = 85

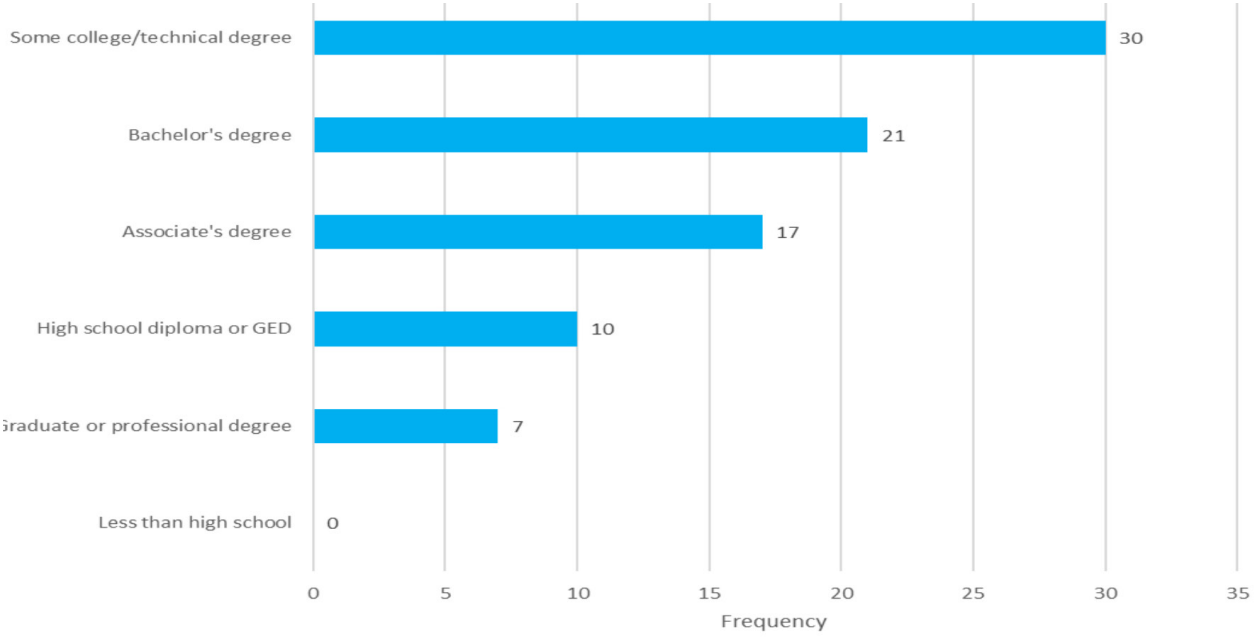
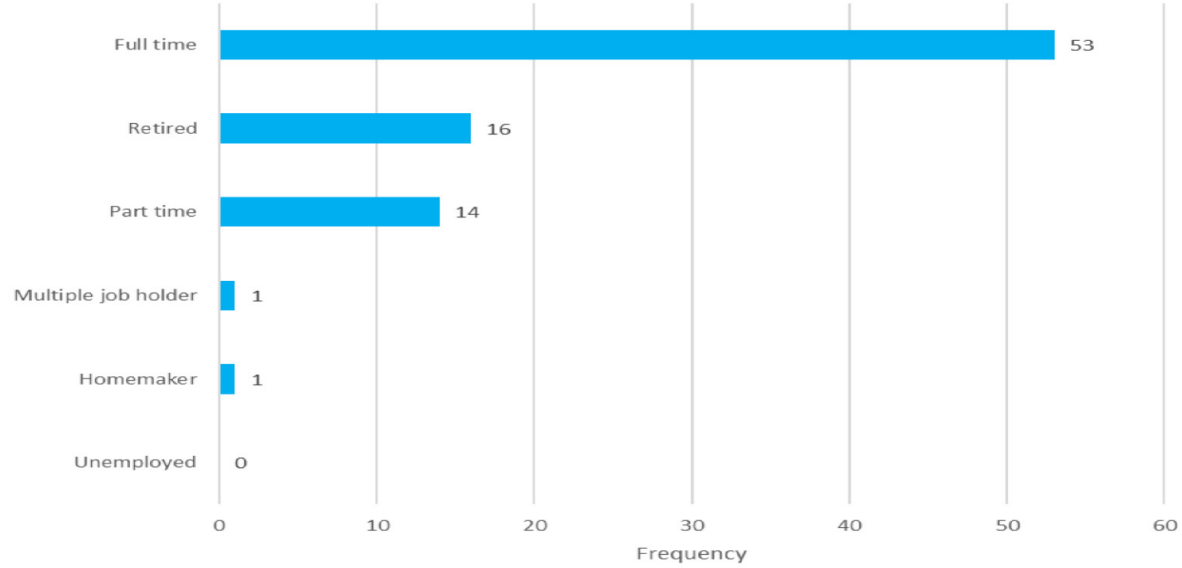
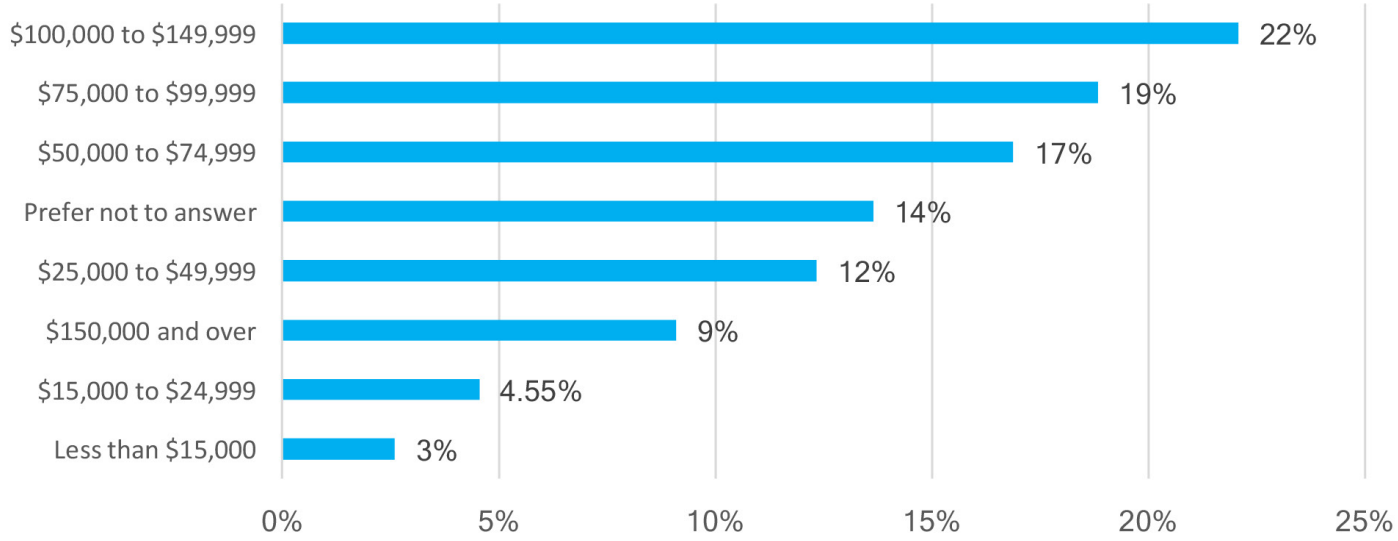


Figure 9: Employment Status Demographics of Survey Respondents
Total respondents = 85



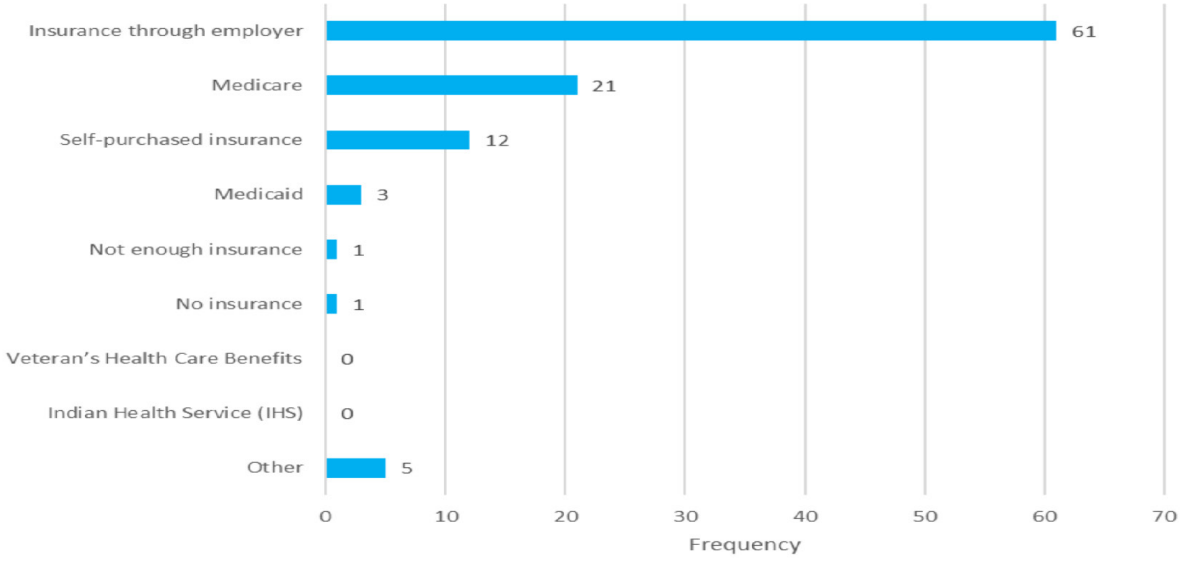
Of those who provided a household income, 9.4% (N=6) community members reported a household income of less than $25,000, 13% (N=11) indicated a household income of $100,000 or more. This information is show in Figure 10.

Figure 10: Household Income Demographics of Survey Respondents
Total respondents = 85



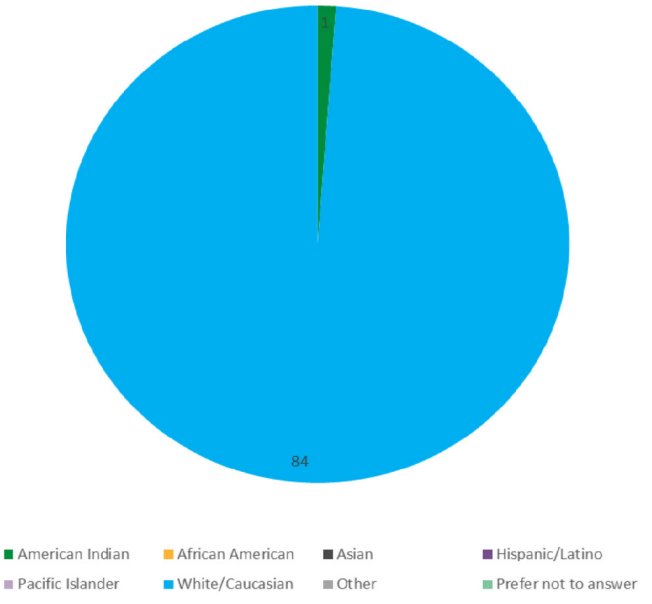
Community members were asked about their health insurance status, which is often associated with whether people have access to healthcare. Less than 2% (N=2) of the respondents reported having no health insurance or being under-insured. The most common insurance types were insurance through one's employer (N=61), followed by Medicare (N=21) and self-purchased (N=12).

Figure 11: Health Insurance Coverage Status of Survey Respondents
Total respondents = 104



As shown in Figure 12, nearly all of the respondents were white/Caucasian (1.78%). This response is slightly lower than the McLean County data (2016) of 90.4% white/Caucasian.

Figure 12: Race/Ethnicity Demographics of Survey Respondents
Total respondents = 85



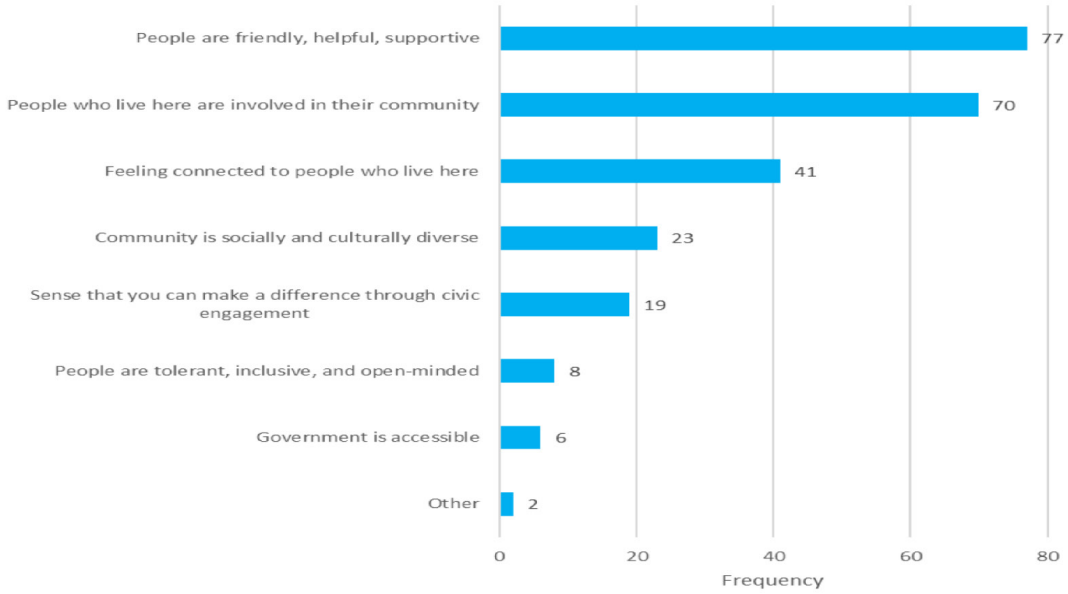
Community Assets and Challenges

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 104 respondents agreeing) that community assets include:

- Local events and festivals (N=85)
- Family-friendly (N=78)
- People are friendly, helpful, supportive (N=77)
- People who live here are involved in their community (N=70).
- Safe place to live, little or no crime (N=69)
- Healthcare (N=67)

Figures 13 to 16 illustrate the results of these questions.

Figure 13: Best Things about the PEOPLE in Your Community
Total responses = 246



Over 117 individuals stated the community was friendly, helpful, supportive and had feelings of being connected to the people living in the community, and the community was inclusive however, included in the "Other" category of the best things about the people was this comment; "This is the first community I've felt all these areas are of great concern and lacking. It is very challenging to break into social groups and find people who are not just surface friendly. The community is very "clicky."

Figure 14: Best Things about the SERVICES AND RESOURCES in Your Community
Total responses = 262

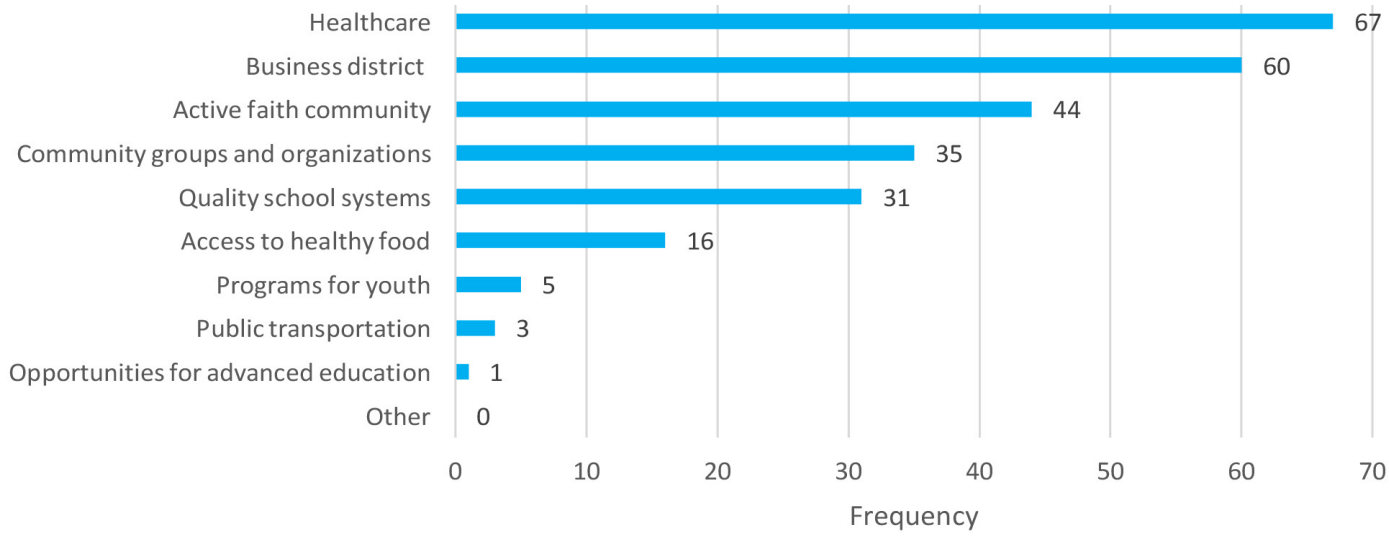


Figure 15: Best Things about the QUALITY OF LIFE in Your Community
Total responses = 253

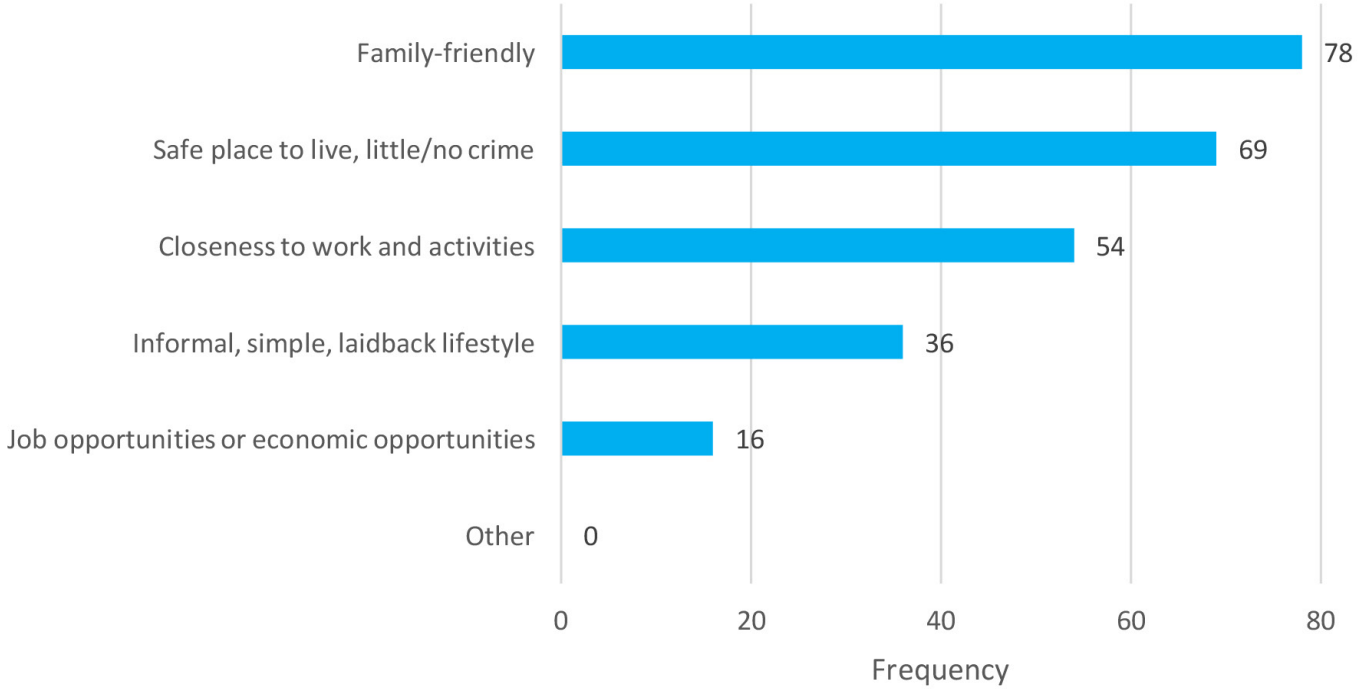
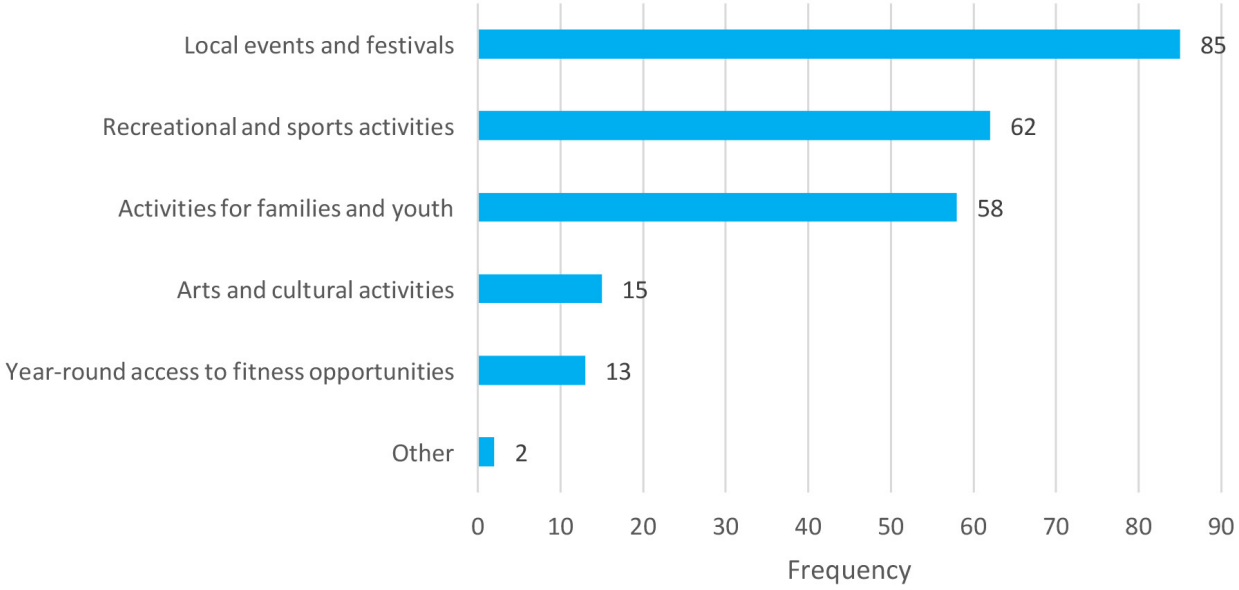


Figure 16: Best Thing about the ACTIVITIES in Your Community
Total responses = 235



Respondents who selected "Other" specified that the best things about the activities in the community included Lake Sakakawea and its park as well as the lake life and hunting. There are activities for family and youth, festivals and events, recreational and sports activities, fitness opportunities year-round.

Community Concerns

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

- Delivery of health services;
- Availability of health services;
- Mental health and substances abuse;
- Safety/environmental health;
- Aging population;
- Community health; and
- Physical health.

With regard to responses about community challenges, the most highly voiced concerns (those having at least 45 respondents) were:

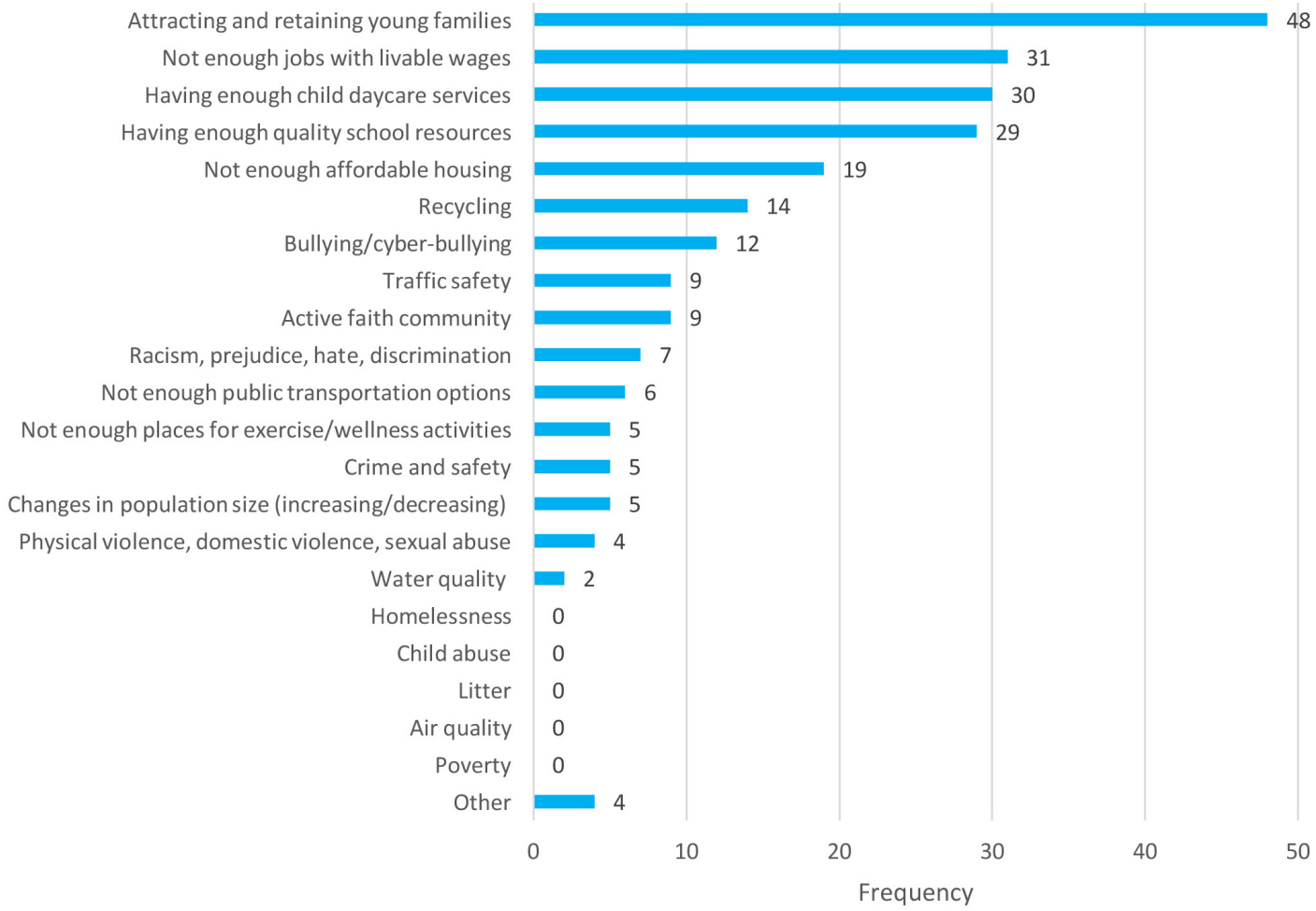
- Drug use and abuse – Youth (N=58);
- Alcohol use and abuse – Youth (N=53);
- Bullying/cyber-bullying – Youth (N=53);
- Attracting and retaining young families (N=48);
- Availability of resources for elderly to stay in their homes (N=47) and
- Ability to retain primary care providers (MD,DO, PA, NP)(N=46)

The other issues that had at least 45 votes included:

- Alcohol use and abuse – Adults (N=43);
- Cost of long-term/nursing home care (N=43);
- Drug use and abuse -Adults (N=33);
- Child abuse/neglect (N=31) and
- Not enough jobs with livable wages (N=31);

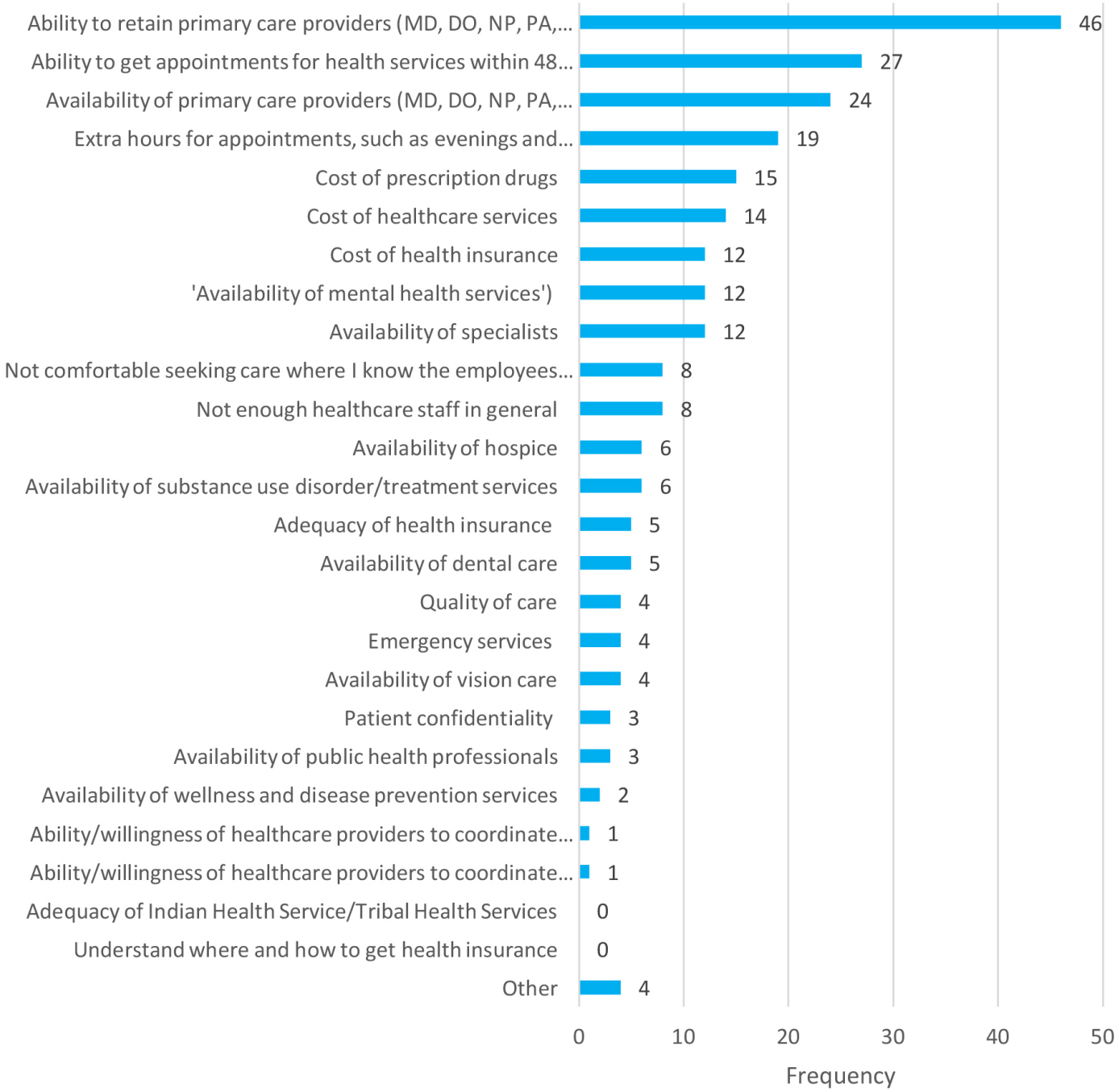
Figures 17 through 22 illustrate these results.

Figure 17: Community/Environmental Health Concerns
Total responses = 235



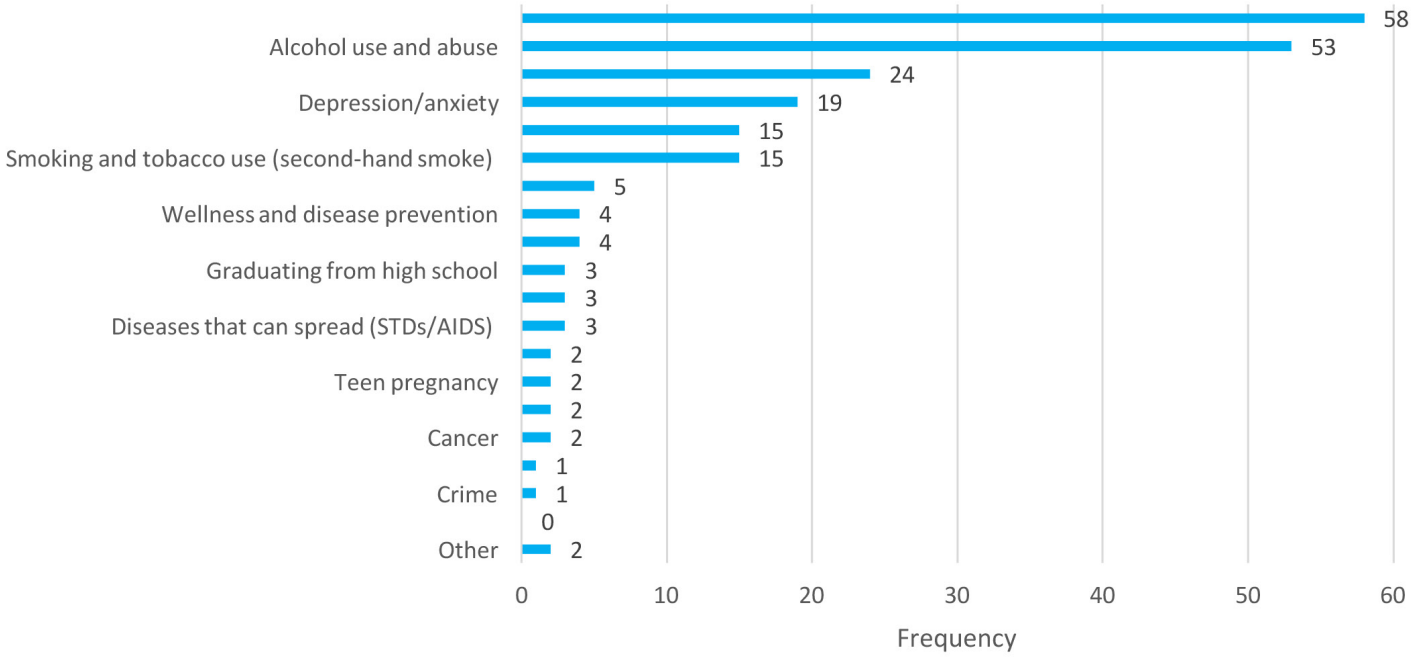
In the "Other" category for community and environmental health concerns, the following were listed: free beaches, lack of healthcare accessibility, not enough people for wait-staff at cafes/restaurants.

Figure 18: Availability/Delivery of Health Services Concerns
Total responses = 245



Respondents who selected "Other" identified concerns were having a physical therapist trained for lymph edema, affordable dental and vision care, staffing at the hospital seems inadequate and too many local people abuse the ER and instead should be seen at the clinic.

Figure 19: Youth Population Health Concerns
Total responses = 218



Listed in the "Other" category for youth population concerns were bullying and parents are bad role models.

Figure 20: Adult Population Concerns
Total responses = 231

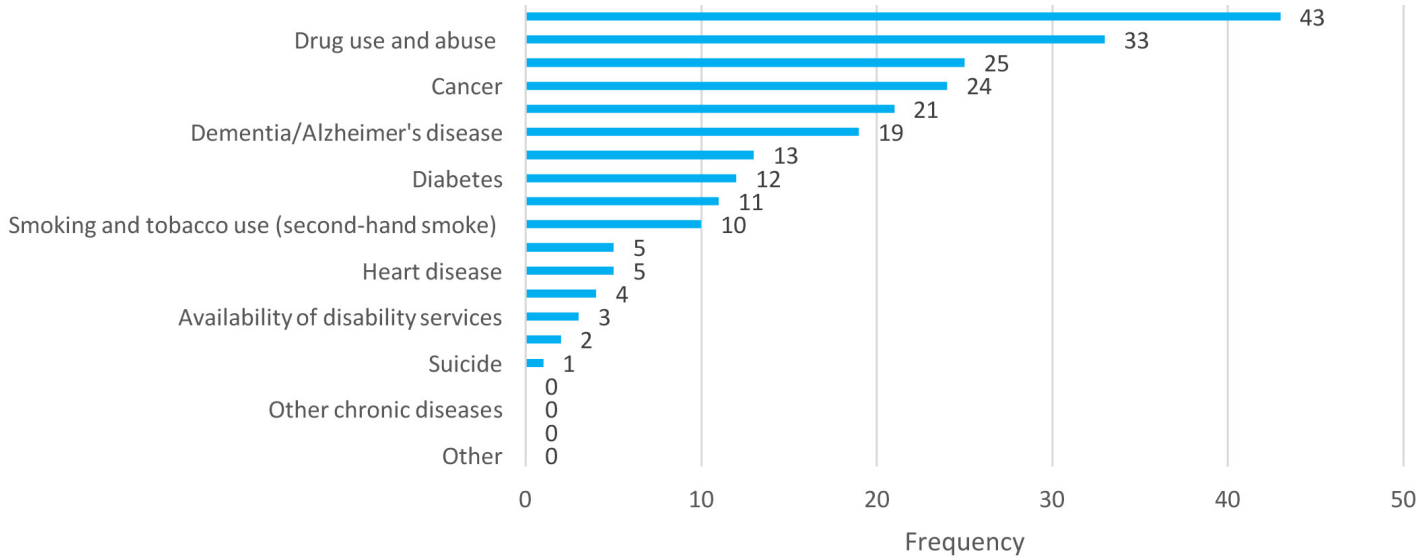
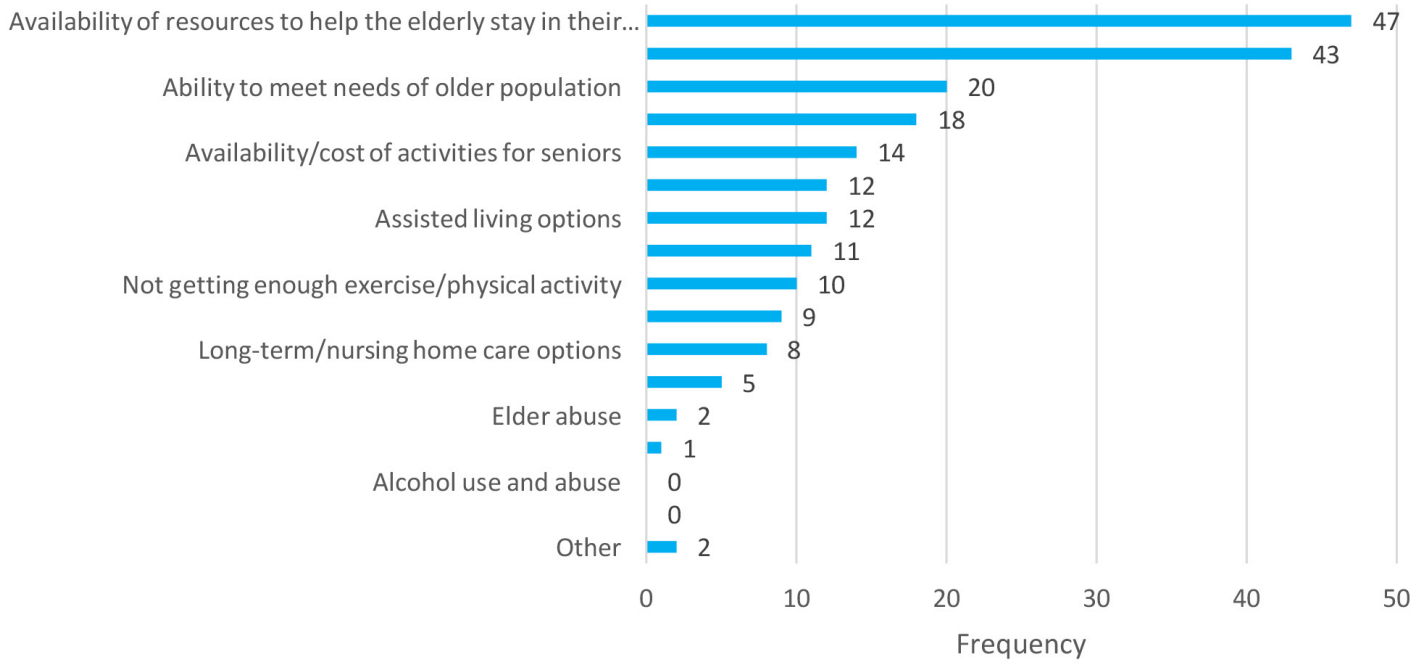
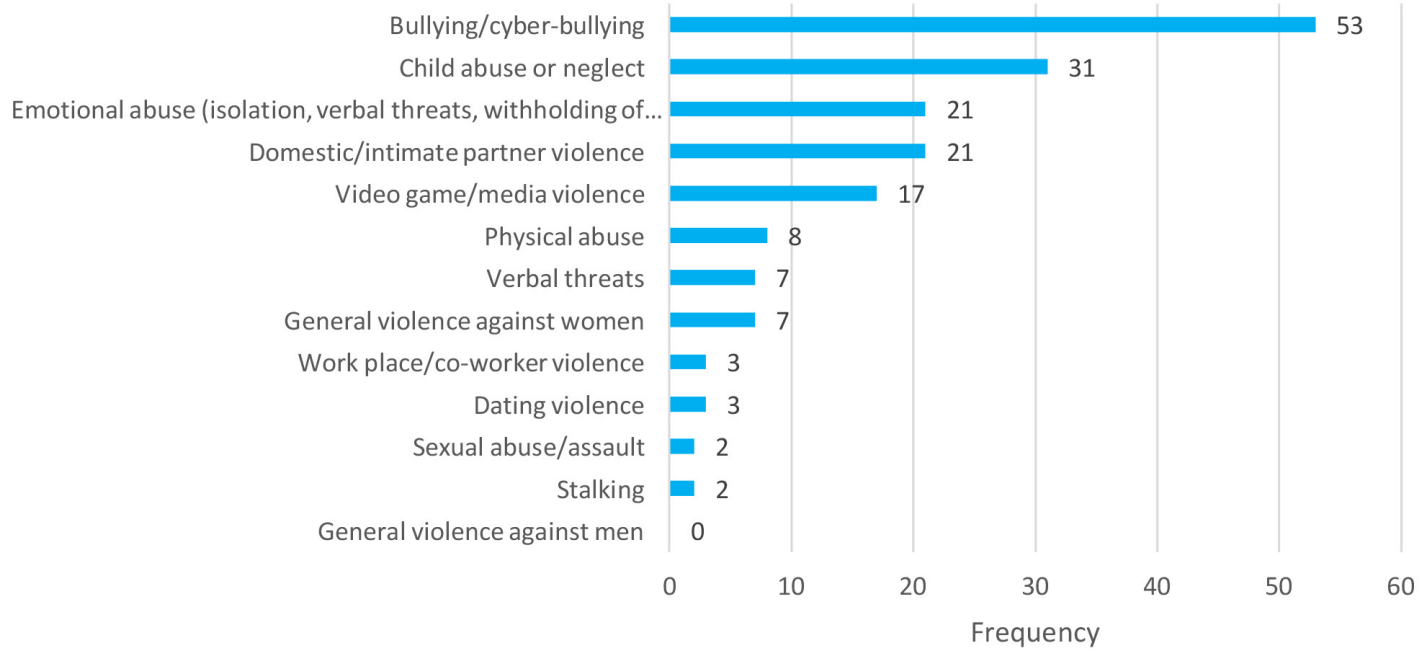


Figure 21: Senior Population Concerns
Total responses = 214



In the "Other" category, the concerns listed were the cost of prescriptions and local pharmacy not taking their insurance and the lack of hospice availability.

Figure 22: Violence Concerns
Total responses = 175



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

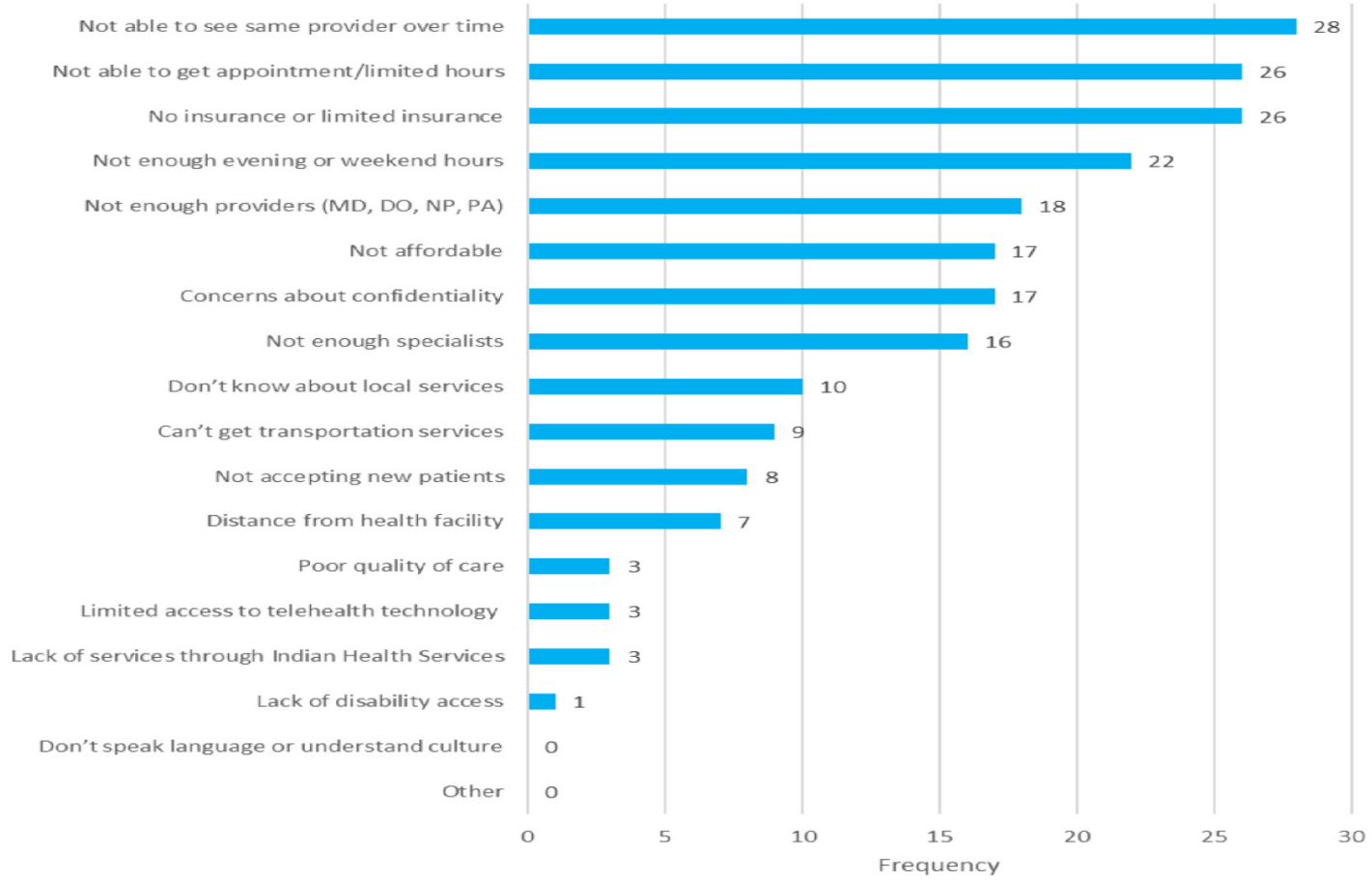
There were several comments about the community's ability to hold a stable population in order to maintain essential services such as education, healthcare, keeping businesses and filling local jobs. Statements included; the local community is aging, and it is difficult to bring in younger families due to the high cost of living based on a recreational economy.

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 providers (MD, DO, NP, PA) (N=46), with the next highest being not affordable (N=40). After these, the next most commonly identified barriers were not being able to see the same provider over time (N=38), no insurance or limited insurance (N=32), and not enough specialists (N=31). The majority of concerns indicated in the "Other" category were in regard to loss or lack of physicians, followed by a couple comments noting the lack of natural/holistic medicine options, and a poor billing system.

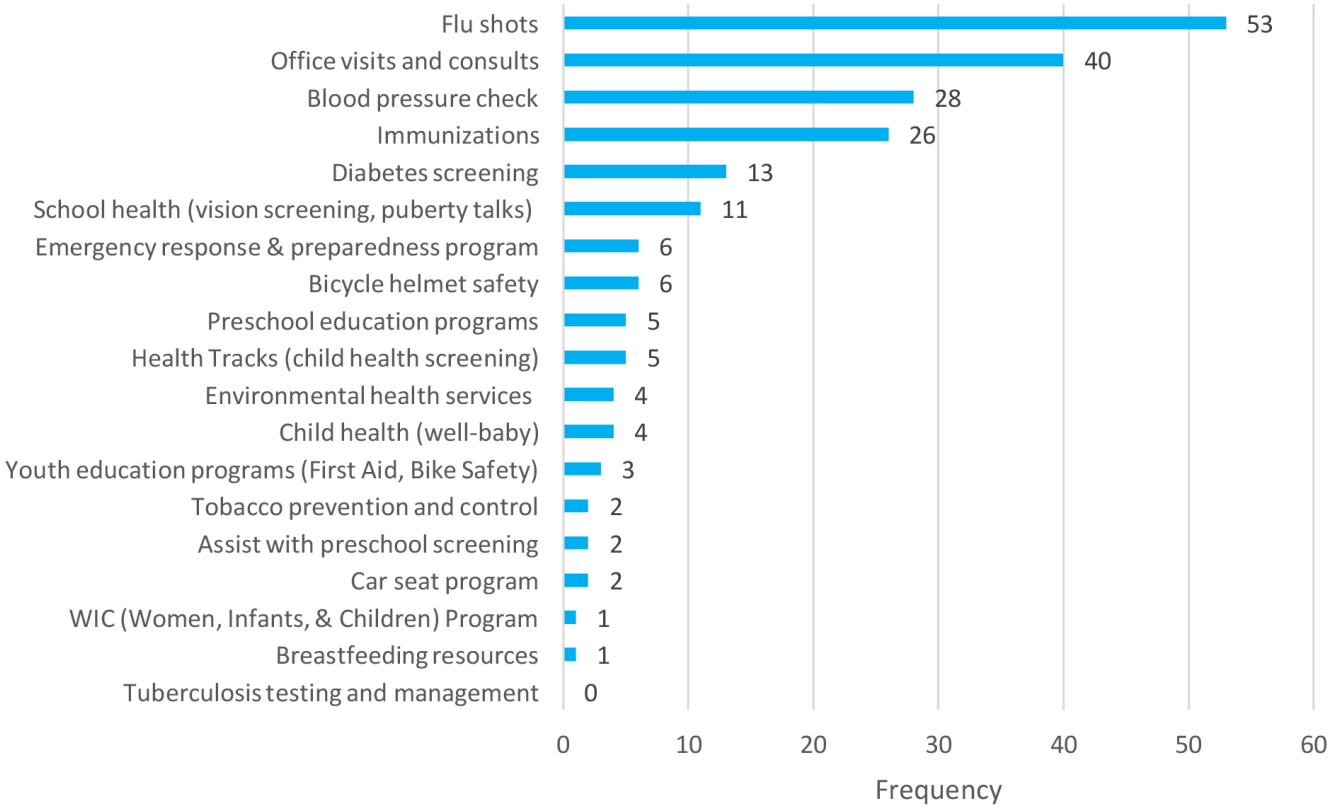
Figure 23 illustrates these results.

Figure 23: Perceptions about Barriers to Care
Total responses = 214



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

Figure 24: Awareness and Utilization of Public Health Services

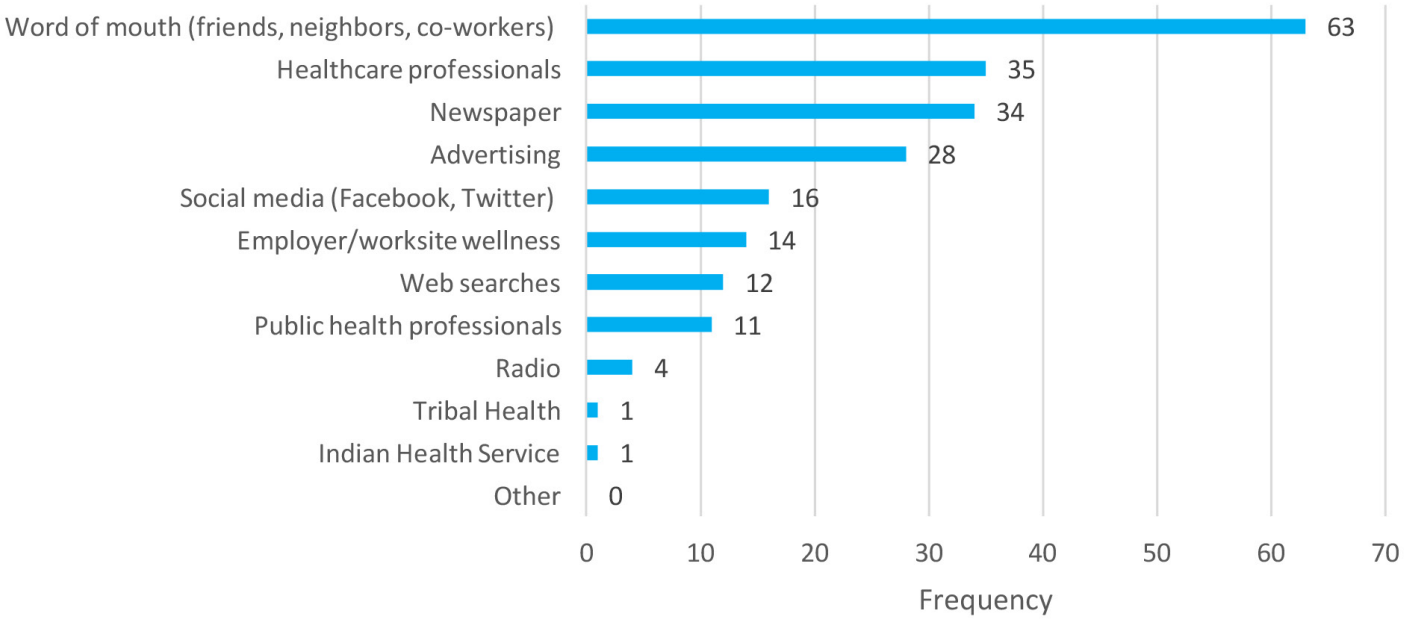


When the respondents were asked what specific healthcare services, if any should be added locally, the following items were listed;

- A convenience care/walk in clinic would be nice for the minor things you need to see a doctor for.
- A strengthened mental health and substance abuse program.
- Accessibility of appointments. I have had them tell me that the whole week is booked...when you have a sick child a week won't work and not everyone can afford ER visits even with insurance.
- Add more general doctors as the one we have is spread too thin.
- Another MD, not a NP or PA
- Bone & Joint
- Clinic maybe part-time on Saturdays being able to get an appointment when calling now when I am sick not 2-3 weeks from now.
- Dermatology
- Generally, availability of screening for diabetes and dementia/Alzheimer's in addition to high blood pressure.
- It would be nice if we had a dentist in the area.
- Mental healthcare services

- More doctors. Keep current doctors
- More physicians
- NA
- Nothing that I can think of
- OBGYN
- Walk in clinic
- Weekend and evening hours for people who work but can't get away during the day
- Allowing teens to get birth control help
- Arthritic related
- Evening and weekend appointments
- Extended clinic hours and maybe have a walk-in clinic to limit abuse of the emergency room
- Mental health availability
- Mental healthcare
- Mental healthcare
- More mental health
- No more FNPs and NPs and only doctors as the rest aren't knowledgeable enough and misdiagnose all the time.
- Vision
- Walk-in/convenient care clinic

Figure 25: Where Do You Find Out About Local Health Services in Your Area? Total responses = 219



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

Figure 26: Do You Work for the Hospital, Clinic or Public Health Unit?
Total responses = 85

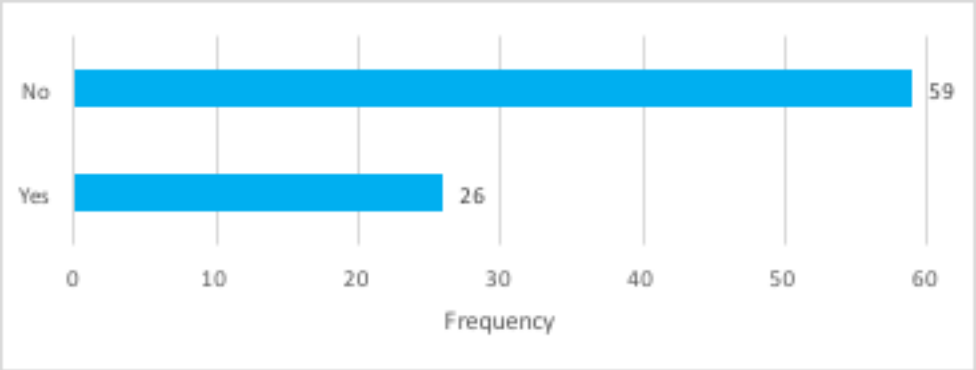
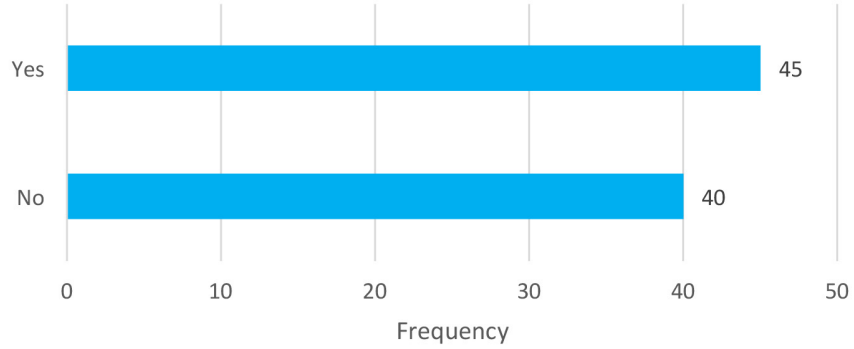


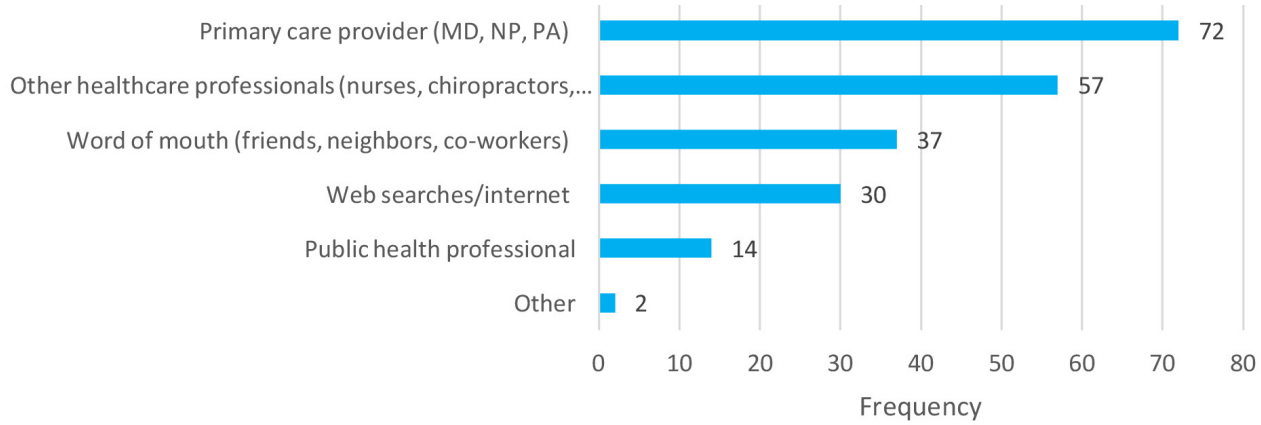
Figure 27: Awareness of Garrison Hospital's Foundation, Which Exists to Financially Support CHI St. Alexius Health Garrison
Total responses = 95



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

Results are shown in Figure 29.

Figure 29: Sources of Trusted Health Information
Total responses = 212



In the "Other" category, pharmacist was listed as a source of trusted information.

Findings from Key Informant Interviews & the Community Meeting

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

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

- Ability to retain primary care providers (MD, DO, NP, PA) and nurses in the community
- Availability of mental health and substance use and disorder treatment services
- Availability of resources for the elderly to assist family and friends and to help them stay in their homes.
- Concerns about air and water quality.
- Drug use and abuse among both adults and youth.

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

Ability to retain primary care providers (MD, DO, NP, PA) and nurses in the community

- We are very fortunate to have our emergency room.
- We have a great physician assistant, but being without a doctor...well, it's not the same.
- The CHI culture makes it hard to hang on to local staff. We are continuously losing them.
- We have such a lack of public health presence. We need a strong push to retain healthcare providers and young families.
- We need a stronger public health presence.
- Garrison has a retaining health services turnover issue.

Availability of mental health and substance use disorder treatment services

- Mental health needs to be offered locally as transportation is such an issue. People travel multiple times a week for treatment to Bismarck or further. It's financially impossible to do. We need a full-time person in mental health.
- We need more mental health support in the school system. We need drug/alcohol support staff to help our youth. "Screen time" is also having an impact on their health.

Availability of resources for the elderly

- There is a sense of serving elderly-rewarding, taking care of those from here for years. They are so vulnerable.
- We need home health services. There is a great need and public health gets lots of calls.
- We need a food pantry in this town. Other small towns have it around us.

- Sometimes they (elderly) don't understand and need help making sense of healthcare.
- We need resources to help people in their own homes. I experience several people per week who I worry about how they manage to live in their own homes with little outside supervision or help.

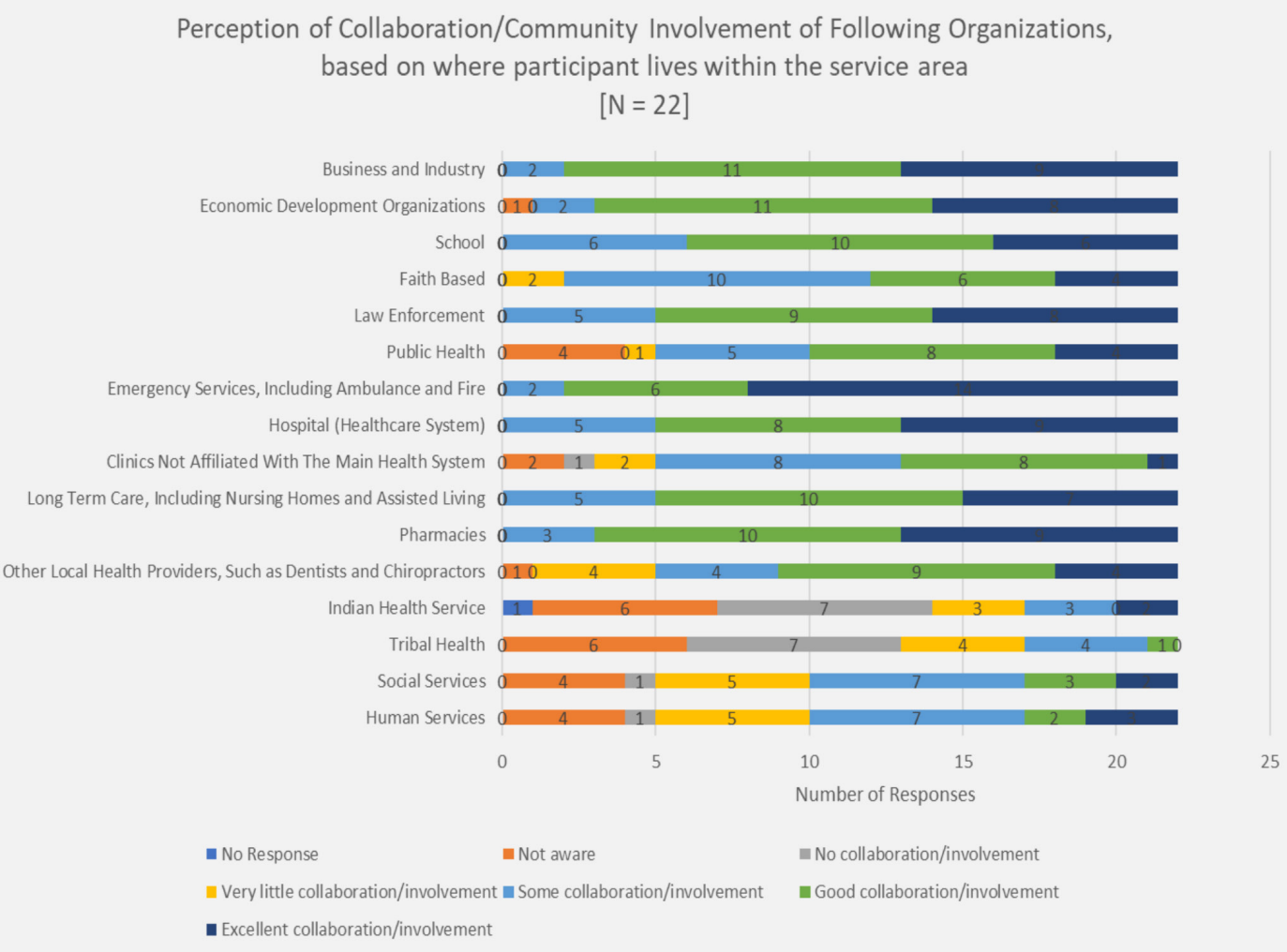
Drug use and abuse among both youth and adults.

- There is significant drug use, abuse and trafficking in this town.
- Mental health is huge. There are issues with drug and alcohol with a bad home life, making it worse. Folks get transferred with mental health issues to Fargo because there are not enough inpatient beds in North Dakota. We need to get ahead of the game to decrease needs of inpatient services.

Community Engagement and Collaboration

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

Figure 30. Perception Collaboration/Community Involvement



Priority of Health Needs

A Community Group met on November 5, 2018. There were 10 community members who attended the meeting. Representatives from the CRH presented the group with a summary of this report's findings, including background and explanation about the secondary data, highlights from the survey results, including perceived community assets and concerns, and barriers to care, and findings from the key informant interviews.

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

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

- Ability to retain primary care providers (MD, DO, NP, PAs) and nurses (7 votes)
- Youth drug use and abuse (6 votes)
- Adult obesity and overweight (5 votes)
- Having enough child day care services (4 votes)

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

1. Ability to recruit and retain primary care providers (4 votes)
2. Youth drug use and abuse (4 votes)
3. Adult obesity/overweight (4 votes)
4. Having enough child day care services (0 votes)

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

Comparison of Needs Identified Previously

Top Needs Identified 2016 CHNA Process	Top Needs Identified 2019 CHNA Process
• Ability to recruit and retain primary care providers (MD, DO, PA, NP)	• Ability to recruit and retain primary care providers (MD, DO, PA, NP)
• Adult drug use and abuse	• Youth drug use and abuse
• Youth drug use and abuse	• Adult drug use and abuse
• Cost of health insurance	• Having enough child day care services

The current process identified the top need to be the same as the from 2014. However, the issue of youth drug use and abuse has moved into second place from third place. The third-place need is adult obesity and being overweight, not concerns about their drug use and abuse. New to the list is a concern about child care services.

Hospital and Community Projects and Programs Implemented to Address Community Health Needs Assessment:

A Community Health Needs Assessment (CHNA) was performed in Winter 2015/2016 in collaboration with public health to determine the most pressing health needs of western McLean County.

Implementation Plan Goals: The Board of CHI St. Alexius Health Garrison has determined the following health needs identified in the CHNA should be addressed through the implementation strategy noted for each such need:

Specific Needs Identified in CHNA:

1. Goal: Ability to recruit and retain primary care providers (MD, PA, NP)

- To fully staff our clinic, hospital, and ER with a full complement of providers to meet the needs of our growing community.

Key Objectives:

- Retain current practicing primary care providers.
- Actively recruit primary care providers with a passion to work in rural health.

Implementation Strategies:

- Maintain CHI St. Alexius Health Garrison hospital and clinic designations as a National Health Service Corps site. This allows our primary care providers access to loan repayment on student loans along with a commitment of service.
- Update our recruitment folders to distribute to potential professional candidates.
- Continue to promote Health Career Scholarships to students in our community.
- Engage the community and community leaders in the recruitment and retention of providers.
- Develop new and more flexible practice models within the hospital and clinic setting.
- Offer continuing education opportunities to current staff.
- Continue as a rural rotation site for UND Center for Family Medicine. Offer opportunities for Advanced Practice Clinicians (APC) and APC students to follow our providers in hopes of gaining interest in working in a rural facility.

Accomplishments & Outcomes:

- Retained Dr. Dornacker, family practice physician and Dr. Harchenko as medical director for Garrison and Turtle Lake.
- Recruited two new physician assistants and two new family nurse practitioners.
- Recruited three international registered nurses and several local nurses to fill our nursing rolls at the hospital and clinic.
- Recertified the hospital as a National Health Service Corps site for three more years.
- Met with Chamber of Commerce, Better Living for Garrison, and Garrison Area Improvement

Association on provider needs in the community. Garrison Area Improvement Association gave $10,000 for the community match for a State and Federal Loan Repayment Program for one family nurse practitioner.

- Redesigned ER/hospital coverage and clinic scheduling to meet the needs of the community and make for a better work life balance for our providers.
- Continue to host UND physician interns as they complete a rural rotation in our hospital and clinic.
- Hosted several PA's and FNP's for rural rotations in our hospital and clinic.
- Started an onsite Nursing Program in collaboration with Bismarck State College and the Dakota Nursing Program. We currently have six nursing students enrolled in the program.

2. GOAL: Youth drug use and abuse –

- To educate the youth of our community of the dangers of drug use and abuse.

Key Objectives:

- Help in organizing events to keep the youth in a safe environment.
- Increase the awareness of the dangers of drug use and abuse in our community.

Implementation Strategies:

- Partner with the public school district on implementing a drug awareness day or lyceum.
- Partner with the McLean County Sheriff's department and Public Health office on education for students, parents, and community members.
- Develop a list of mental health drug and alcohol addiction counselors for referral of patients and community members in need of assistance.
- Provide education at public health fairs.

Accomplishments & Outcomes:

- Partnered with the Garrison Public School system to bring in a speaker to talk to the 7th through the 12th grade students about the hazards of driving under the influence.
- Provided education at several of our health fairs about alcohol, drugs, and nicotine use and abuse. Partnered with McLean County Sheriff's department, NDABATE, and First District Health Unit on educational events to the youth of our area.

3. GOAL: Adult drug use and abuse –

- To educate our community of the dangers of drug use and abuse.

Key Objectives

- To inform the adults of the effects of their actions and keep them from getting the youth involved in drug use.
- Provide education on risks of abuse of prescription medications.

Implementation Strategies

- Partner with the McLean County Sheriff's department to offer public awareness presentations on current drug issues that our community faces.
- Partner with the McLean County Sheriff's department and Public Health office on education for students, parents, and community members.

- Develop a list of mental health drug and alcohol addiction counselors for referral of patients and community members in need of assistance.
- Provide education at public health fairs.
- Provide education to our providers on the CDC's suggested guidelines for prescribing opioids for chronic pain.
- Provide public education on narcotics/opioids and Schedule II drugs.

Accomplishments and Outcomes:

- Partnered with the McLean County Sheriff's department on an educational event at a couple of our annual Health Fairs to educate the public on drug use and abuse.
- McLean County Sheriff's department held a public meeting to show drugs and drug paraphernalia that was confiscated in McLean County over several months.
- Did a lot of work on public education on opioids for our patients.
- A family nurse practitioner student partnered with our clinic to study opioid prescribing habits and alternatives to opioid prescribing.

Next Steps – Strategic Implementation Plan

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

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

Community Benefit Report

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

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

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

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

What Are Community Benefits?

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

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

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

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

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

Appendix A – CHNA Survey Instrument

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

CHI St. Alexius Health
Imagine better health.℠
Garrison Hospital

Garrison Community Health Needs Survey

CHI St. Alexius Health Garrison Hospital is 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

Scan to take the survey online!

If you prefer, you may take the survey online at http://tinyurl.com/Garrison18 or by scanning on the QR Code at the right.

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

Surveys will be accepted through September 30th, 2018. Your opinion matters – thank you in advance!

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

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

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

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

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

_____

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

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

_____

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

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

_____

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

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

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

_____

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

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

  _____

7. 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
- ☐ 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
- ☐ 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
- ☐ Depression/anxiety
- ☐ Suicide
- ☐ Alcohol use and abuse
- ☐ Drug use and abuse (including prescription drug abuse)
- ☐ Availability of activities for seniors
- ☐ Elder abuse
- ☐ Other (please specify) _____

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

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

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

Delivery of Healthcare

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

- ☐ Bicycle helmet safety
- ☐ Blood pressure check
- ☐ Breastfeeding resources
- ☐ Car seat program
- ☐ Child health (well-baby)
- ☐ Diabetes screening
- ☐ Emergency response & preparedness program
- ☐ Flu shots
- ☐ Environmental health services (water, sewer, health hazard abatement)
- ☐ Health Tracks (child health screening
- ☐ Immunizations
- ☐ Office visits and consults
- ☐ School health (vision screening, puberty talks, school immunizations)
- ☐ Preschool education programs
- ☐ Assist with preschool screening
- ☐ Tobacco prevention and control
- ☐ Tuberculosis testing and management
- ☐ WIC (Women, Infants & Children) Program
- ☐ Youth education programs (First Aid, Bike Safety)

13. 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) _____

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

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

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

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

16. Are you aware of Garrison Hospital Foundation, which exists to financially support CHI St. Alexius Health Garrison?

☐ Yes ☐ N

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

_____

_____

Demographic Information: Please tell us about yourself.

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

☐ Yes ☐ No

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

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

20. 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

21. Highest level of education:

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

22. Gender:

- ☐ Female
- ☐ Male
- ☐ Transgender

23. Employment status:

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

24. Your zip code: _____

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

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

26. Annual household income before taxes:

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

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

_____

_____

_____

_____

Thank you for assisting us with this important survey!

Elective Survey Questions

Appendix B – County Health Rankings Explained

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

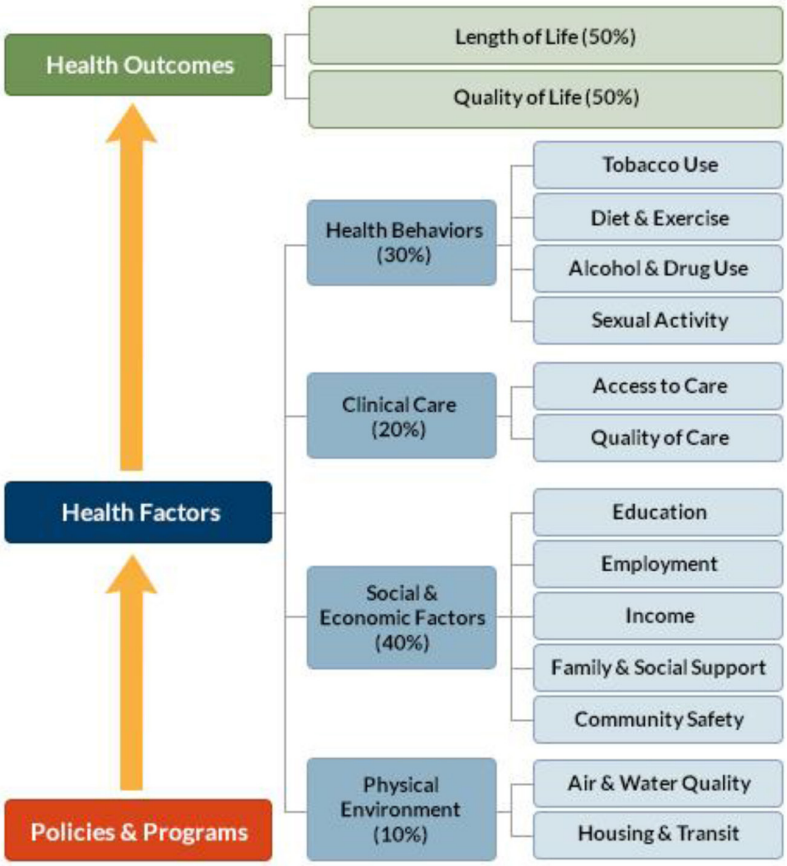
Methods

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

What is Ranked

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

Ranking System



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

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

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

Data Sources and Measures

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

Data Quality

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

Calculating Scores and Ranks

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

Health Outcomes and Factors

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

Health Outcomes

Premature Death (YPLL)

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

Reason for Ranking

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

Poor or Fair Health

Self-reported health status is a general measure of health-related quality of life (HRQoL) in a population. This measure is based on survey responses to the question: "In general, would you say that your health is excellent, very good, good, fair, or poor?" The value reported in the County Health Rankings is the percentage of adult respondents who rate their health "fair" or "poor." The measure is modeled and age-adjusted to the 2000 US 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 US 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 US 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 US, 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 sexually transmitted infection (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 US 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 US communities can have broad health impacts, including increased risk of mortality, poor health, and increased cardiovascular disease risks. Inequalities in a community can accentuate differences in social class and status and serve as a social stressor. Communities with greater income inequality can experience a loss of social connectedness, as well as decreases in trust, social support, and a sense of community for all residents.

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

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

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

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

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

Injury Deaths

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

Reason for Ranking

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

Air Pollution-Particulate matter

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

Reason for Ranking

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

Drinking Water Violations

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

Reason for Ranking

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

Severe Housing Problems

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

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

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

Reason for Ranking

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

Appendix C – Prioritization of Community's Health Needs

Community Health Needs Assessment

Garrison, North Dakota

Ranking of Concerns

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

	Priorities	Most Important
Community/Environmental Health Concerns		
Attracting and retaining young families	2	
Not having jobs with livable wages	1	
Having enough child care services	4	
Not having enough quality school resources		
Availability/Delivery of Health Services Concerns		
Ability to retain primary care providers (MD.DO. NP. PAs) and nurses	7	4
Ability to get appointments for health services within 48 hours	1	
Availability of primary care providers (MD, DO, NP, PAs) and nurses	1	
Extra hours of appointments such as evenings and weekends		
Adult Population Health Concerns		
Alcohol use and abuse		
Drug use and abuse	3	
Obesity/overweight	5	2
Cancer		
Youth Population Health Concerns		
Drug use and abuse	6	4
Alcohol use and abuse		
Not getting enough exercise/physical activity	3	
Depression/anxiety		
Senior Population Health Concerns		
Availability of resources to help elderly stay in their homes	2	
Cost of long-term care/nursing home care		
The ability to meet the needs of the older population	3	
Availability of home health	2	
Violence Concerns		
Bullying/Cyber-bullying		
Child abuse/neglect		
Emotional abuse (Isolation, verbal threats ,with-holding of funds)		
Domestic/Intimate partner violence		

Appendix D – Survey "Other" Responses

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

1. Considering the PEOPLE in your community, the best things are: "Other" responses:

- Clicky
- This is the first community I've felt all these areas are of great concern and lacking. It is very challenging to break into social groups and find people who are not just surface friendly. The community is very clicky.

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

- Lake Sakakawea and its park.
- Lake life and hunting. Activities for family and youth, festivals and events, recreational and sports activities, fitness opportunities year-round

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:

- Free public beaches
- No real concerns
- Lack of healthcare accessibility
- Not enough people for wait-staff at cafes/restaurants

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

- Affordable dental and vision care
- Staffing at hospital seems inadequate
- Too many local people abuse the ER and instead should be seen at clinic

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

- Bullying
- Parents are bad role models

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

- Cost of prescriptions and local pharmacy not taking their insurance
- Hospice availability

11.Regarding various forms of violence in your community, concerns are "Other" responses:

- None

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

- Availability of low-income housing – rental properties – due to lower paid jobs in smaller communities
- Ability to get along even with different viewpoints.
- Affordable housing, daycare
- Affordable housing. Everything is based around the lake, driving up prices.
- Aging population
- Alcohol Use and abuse.
- Attracting new families
- Bullying/cyber-bullying
- Competent providers at the clinic. I took my daughter in for a UTI infection and the PA had no idea what to give a little girl with an allergy to amoxicillin. He wanted to give her something that could give her tendonitis, he then went to check with a nurse
- Drugs
- Enough jobs for young couples that have good, livable wages
- Finding people who are genuine and faithful as friends and who aren't just out to gossip and slander others.
- Getting and keeping good physicians and providing good healthcare services
- Good paying jobs.
- Growth infrastructure needs
- Having enough trained healthcare personnel to care for the local senior population in the future.
- I'm not sure maybe domestic violence.
- Keeping on retaining healthcare providers and young families
- Keeping healthcare and schools funded
- Keeping our young people in the community with jobs that pay enough to support a family. 1/3 of our community work outside of the city because of these costs.
- Keeping school update and good teachers
- Keeping younger people in the community
- Lack of enough MD's. Over working the ones, we have.
- Law Enforcement in city limits is virtually non-existent
- Loss of population
- Need for a new school in an attempt to retain young families and providers
- Not enough activities for our youth year -round.
- We need a new school, but tax payers are afraid of increased tax to pay it.
- Wellness, lack of year-round exercise
- Cost of healthcare, whether this factor will shut down small town clinics and hospitals
- Drug and alcohol addiction and use
- Finding new residents to fill local jobs
- Keeping a medical doctor or two on staff at the clinic/hospital
- Need for med marijuana
- Not enough stores
- Pay is very poor and should get cost of living raise every year as prices keep going up and wages don't, and they continue to take our benefits away at the hospital

Delivery of Healthcare

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

- Lived here all my life.
- From work.

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

- A convenience care/walk in clinic would be nice for the minor things you need to see a dr. for
- A strengthened mental health and substance abuse program
- Accessibility of appointments. I had them tell me that the whole week is booked when you have a sick child a week won't work and not everyone can afford ER visits even with insurance.
- Add more general doctors as the one we have is spread too thin.
- Another MD- not a NP or PA
- Bone & Joint
- Clinic maybe part-time on Saturdays being able to get an appointment when calling now when I am sick not 2-3 weeks from now.
- Dermatology
- Generally, availability of screening for diabetes and dementia/Alzheimer's in addition to high blood pressure.
- It would be nice if we had a dentist in the area.
- Mental Healthcare services
- More doctors. Keep current doctors
- More physicians
- NA
- Nothing that i can think of
- OBGYN
- Walk in clinic
- Weekend and evening hours for people who work but can't get away during the day.
- Allowing teens to get birth control help
- Arthritic related
- Evening and weekend appointments
- Extended clinic hours and maybe have a walk- in clinic to limit abuse of the emergency room
- Mental health availability
- (2) Mental healthcare
- More mental health
- No more FNP and NPs and only doctors as the rest aren't knowledgeable enough and misdiagnose all the time.
- Vision
- Walk-in/convenient care clinic

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

- Worry about losing our doctor.

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

- Nothing is confidential, and everyone knows who and why people are in the hospital as it is discussed daily at the bars.

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

- Expensive even with insurance, and it takes so long to get a bill and bill does not give enough description

as to what it is for

- Availability of getting into clinic and not having to utilize the ER for small things.
- Ability to retain quality MDs
- Appointments.
- Excellent services considering size of community
- Hopefully the ER can get back to a full- time on site doctor. Instead of on call.
- I would like to see some evening and weekend appointments. I prefer to see a doctor rather than a PA or FNP.
- Length of time to get an appointment. Doctors leaving
- More competent management (parent management comp.); less stress for employees of local clinic and hospital.
- My biggest concern right now is losing the only MD on staff.
- My wife and me, live in this community May-Oct. last year, I believe delivery of healthcare is good.
- Open up more clinic visit slots.

Retaining healthcare professionals. CHI to support local businesses would go a long way toward local people supporting CHI.

- Some of the local nurses like to gossip and they have slandered me personally because of my own interactions with them in the community they didn't approve of. My opinion of them is incredibly low and I do not consider them professionals in any sense.
- Undo the CHI purchase and get the St Alexius system back to the high-quality care it used to be
- Would like to see some type of payment for taking care of someone in your family.
- Get more medical doctors to not overload the one MD we do have
- To keep and retain a good MD
- Walk in clinic, after hours clinic, convenient care, staffing at local hospital and ER