Community Health Needs Assessment

2019

Rolette County, North Dakota

Brad Gibbens, MPA
Deputy Director and Assistant Professor

Shawn Larson, BA
Project Coordinator

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

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Executive Summary

To help inform future decisions and strategic planning, Presentation Medical Center (PMC) conducted a community health needs assessment (CHNA) in 2019, the previous CHNA having been conducted in 2016. The Center for Rural Health (CRH) at the University of North Dakota School of Medicine and 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. Three hundred fifteen PMC service area residents completed the survey. Additional information was collected through eight key informant interviews with community members. The input from the residents, who primarily reside in Rolette County, represented the broad interests of the communities in the service area. Together with secondary data gathered from a wide range of sources, the survey presents a snapshot of the health needs and concerns in the community.

With regard to demographics, Rolette County's population from 2010 to 2018 increased 2.6%. The average of residents under age 18 (33.6%) for Rolette County is higher than the North Dakota average (23.3%). The percentage of residents ages 65 and older is 3.8% lower for Rolette County (11.2%) than the North Dakota average (15.0%), and the rates of education are slightly lower for Rolette County (85.7%) than the state average (92.0%). The median household income in Rolette County ($36,170) is significantly lower than the state average for North Dakota ($61,285).

Data compiled by County Health Rankings show Rolette County is doing better than North Dakota in health outcomes/factors for four categories. The county is performing poorly relative to the rest of the state in 26 outcome/factor categories.

Of the 82 potential community and health needs set forth in the survey, the 315 PMC service area residents who completed the survey indicated the following ten needs as the most important:

- Ability to retain primary care providers and nurses
- Alcohol use and abuse – youth and adult
- Availability of resources to help the elderly stay in their homes
- Cost of long-term/nursing home care
- Crime and safety, adequate law enforcement personnel
- Drug use and abuse – youth and adult
- Long-term/nursing home care options
- Not enough activities for children/youth
- Not enough jobs with livable wages
- Poverty

The survey also revealed the biggest barriers to receiving healthcare (as perceived by community members). They included not being able to see the same provider over time (N=93), not enough providers (MD, DO, NP, PA) (N=76), no or limited insurance (N=66), and not able to get appointments/limited hours (N=66).

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

- Informal, simple, laid back lifestyle
- Closeness to work and activities
- People are helpful, friendly and supportive
- Family-friendly; good place to raise kids
- Recreational sports and activities

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:

- Ability to retain primary care providers and nurses
- Alcohol use and abuse – adults and youth
- Availability of transportation for seniors
- Crime and safety, adequate law enforcement personnel
- Drug use and abuse – adults and youth

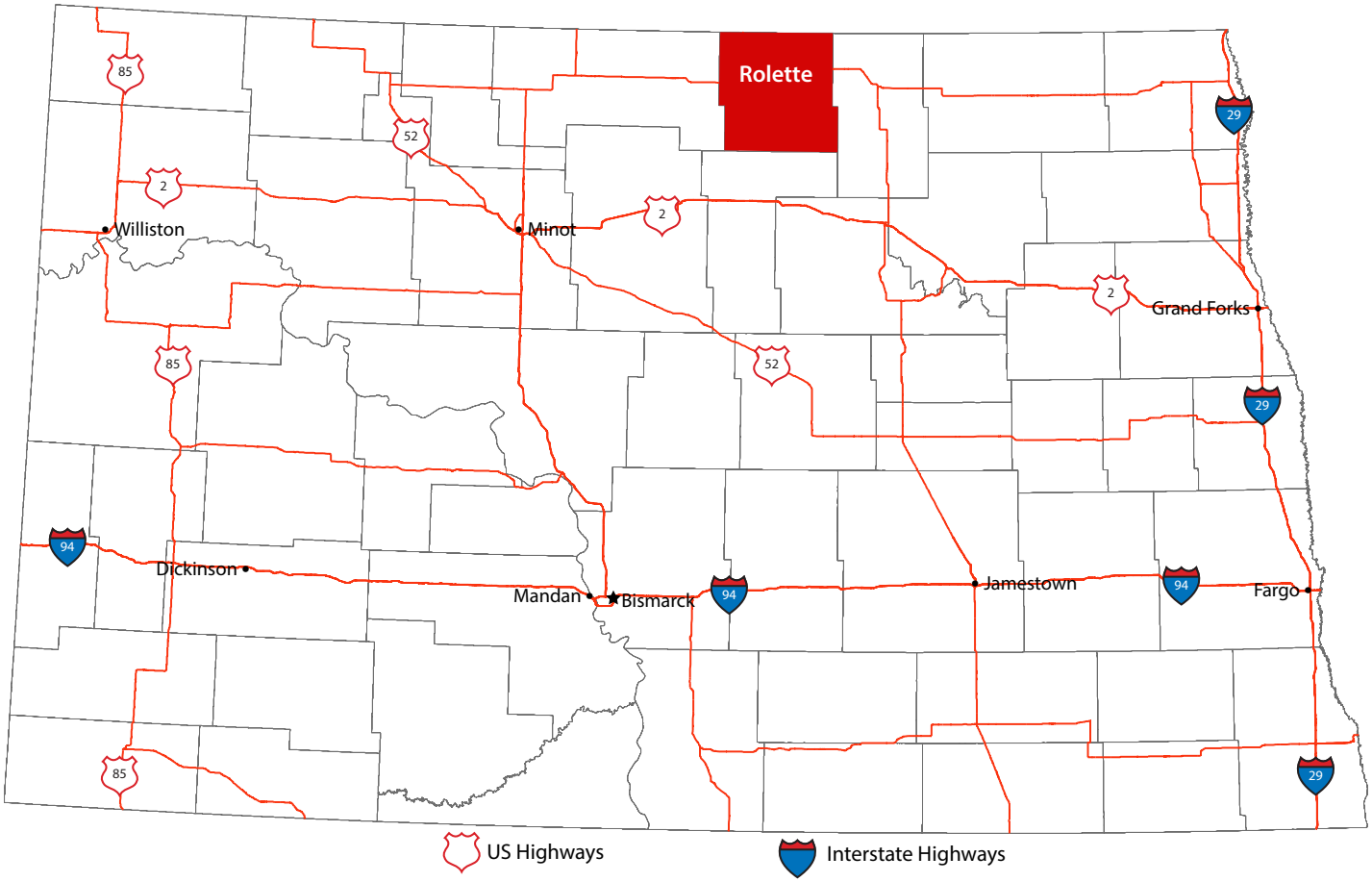
Overview and Community Resources

With assistance from the CRH at the UNDSMHS, PMC completed a CHNA of the PMC service area. The hospital identifies its service area as Rolette County. Many community members and stakeholders worked together on the assessment.

PMC is located in northcentral North Dakota, approximately 120 miles northeast of Minot and 10 miles from the Canadian border. The hospital, agriculture, multiple school districts, Rolette County and Turtle Mountain Band of Chippewa Indians tribal governments, and multiple small businesses provide the economic base for Rolette County. Rolette County is one of the state's poorest counties. According to the U.S. Census Bureau 2018 estimates, Rolette County has a population of 14,301 with a median household income of $36,170 (www.census.gov)

Rolette County has a number of community physical assets, features, and resources that can be mobilized to address population health improvement including; a bike path, swimming pool, city park, two golf courses, skating rink, two fitness centers, and a movie theatre. There are also multiple lakes and multi-use trails for biking, hiking, and ATV riding. Rolette County Lion's Park offers recreation and camping opportunities. Rolette County offers several cultural attractions such as multiple pow wows, horse racing at Chippewa Downs, and numerous musical and artistic events throughout the year. Each major town in Rolette County has a public school and good grocery stores that are also valued community assets.

Figure 1: Rolette County



Presentation Medical Center

Presentation Medical Center (PMC) is one of the most important assets in the community and the largest charitable organization in Rolette County. PMC includes a 25-bed critical access hospital located in Rolla, along with a co-located clinic. As a hospital and designated level IV trauma center, the facility provides comprehensive care for a wide range of medical and emergency situations. PMC clinic provides a wide range of clinical services to residents of Rolette County. PMC is part of the local healthcare system, which also includes Turner Dental in Rolla, the Rolette Community Nursing Home in Rolette, the Dunseith Community Nursing Home in Dunseith, Indian Health Services hospital and clinic in Belcourt, and Northland Clinic in Rolla and Rolette. PMC provides comprehensive medical care with physician and advanced practice medical providers and consulting/visiting medical providers. With 105 employees, PMC is one of the largest employers in the region. It has two full-time physicians, one part-time physician, one physician assistant, and three nurse practitioners for a combined total of seven healthcare providers.

The mission of PMC is: Presentation Medical Center, in union with the Sisters of Mary of the Presentation, is a Catholic healthcare organization. Through the power and example of Jesus Christ and his gospel values, we are committed to joyfully provide holistic care and healing with integrity, compassion and respect to all we serve.

Services offered locally by PMC include:

General and Acute Services

- Allergy, flu & pneumonia
- Blood pressure checks
- Cardiac rehab
- Clinic
- Emergency room
- Gynecology (visiting physician)
- Hospital (acute care)
- Mole/wart/skin lesion removal
- Nutrition counseling
- Obstetrics (visiting physician)
- Pharmacy
- Podiatry – evaluation and surgery
- Prenatal care up to 32 weeks
- Physicals: annuals, D.O.T., sports & insurance
- Surgical services – biopsies
- Surgical services – outpatient
- Swing bed services

Screening/Therapy Services

- Chronic disease management
- Holter monitoring
- Laboratory services
- Lower extremity circulatory assessment
- Massage therapy
- Occupational physicals
- Pediatric services
- Physical therapy
- Respiratory care
- Sleep studies
- Social services

Radiology Services

- CT scan
- Digital mammography 3D
- Echocardiograms
- EKG
- General x-ray
- Nuclear medicine (mobile unit)
- MRI (mobile unit)
- Ultrasound (onsite)

Laboratory Services

- Hematology
- Blood types
- Clot times
- Chemistry
- Urine testing

Services Offered by Other Providers/Organizations

- Ambulance
- Chiropractic
- Dental services
- Massage therapy

Rolette County Public Health District

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

Specific services that RCPHD provides are:

- Blood pressure checks
- Breastfeeding support and breastfeeding peer counseling program
- Breast pump rental
- Car seat program
- Cardiopulmonary resuscitation (CPR) education
- Child health (well-baby checks)
- Diabetes screening
- Disease control and prevention surveillance
- Emergency preparedness services-work with community partners as part of local emergency response team
- Environmental health services (water, sewer, health hazard abatement)
- First aid classes
- Flu shots
- Fluoride varnish program
- Health tracks (child health screening)
- Heart health
- Hepatitis C and HIV testing and counseling
- Immunizations (adult and child)
- Injury prevention
- Maternal child health education
- Member of child protection team and county interagency team
- Opioid prevention
- Preschool education programs and screening
- Rolette County Wellness Coalition
- School health—vision, hearing, screenings in schools
- School health education and resource to the schools
- Sexually transmitted infection testing and treatment
- Tobacco prevention and control
- Tuberculosis testing and management
- Underage alcohol prevention program
- West Nile program—surveillance and education
- WIC (women, infants and children) program
- Women's Way
- Worksite wellness

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 action to address the community's health needs.

A CHNA benefits the community by:

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

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

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

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

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

This assessment examines health needs and concerns in Rolette County. In addition to Rolla, located in the county are the communities of Rolette, Dunseith, Belcourt, and St. John.

The CRH, in partnership with PMC and RCPHD, 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 Rolla. 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. Sixteen people, representing a cross section demographically, attended the focus group meeting. The meeting was highly interactive with good participation. PMC staff and board members were in attendance as well but largely played a role of listening and learning.

Figure 2: Steering Committee

Chris Albertson	CEO, Presentation Medical Center
Shelley Counts	Auditor, City of Dunseith
Barb Frydenlund	Director, Rolette County Public Health District
Herb Hall	Community member
Brad Nash	Superintendent, Mount Pleasant School District
Michael Stewart	Disaster Coordinator, Rolette County
Nikki Wilkes	Care Coordinator, Presentation Medical Center

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 garnered input from the state's health officer, local North Dakota public health unit professionals, and representatives from North Dakota State University.

As part of the assessment's overall collaborative process, 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, was convened to discuss area health needs and inform the assessment process; and
- A wide range of secondary sources of data were examined, providing information on a multitude of measures, including demographics, health conditions, indicators, outcomes, rates of preventive measures; rates of disease; and at-risk behavior.

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 was convened and first met on April 11, 2019. 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 May 29, 2019 with 11 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 Rolette 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 PMC and RCPHD. They included representatives of the health community, business community, political bodies, law enforcement and education. Not all members of the group were present at both meetings.

Interviews

One-on-one interviews with seven key informants were conducted in person in Rolla on April 11, 2019. One additional key informant interview was conducted over the phone on April 26, 2019. 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. Included among the informants were public health professionals with special knowledge in public health acquired through several years of direct experience in the community, including working with medically underserved, low income, and minority populations, as well as with populations with chronic diseases.

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

Survey

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

The community member survey was distributed to various residents of Rolette County, which is included in the PMC 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, articles were published in both local newspapers in Rolette County. Additionally, information was published on PMC's and RCPHD's social media sites.

Approximately 315 community member surveys were completed in Rolette County. The surveys were distributed by community group members and at PMC, RCPHD, and online via social media.

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 could request a hard copy of the survey by calling PMC or RCPHD. The survey period ran from April 1, 2019 to April 29, 2019. Thirty-four completed paper surveys were returned.

Area residents also were given the option of completing an online version of the survey, which was publicized in two community newspapers and on the social media sites of both PMC and RCPHD. Two hundred eighty-one online surveys were completed. One of those online respondents used the QR code to complete the survey. In total, counting both paper and online surveys, 315 community member surveys were completed, equating to a 36.3% response rate. This response rate is above average 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 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.

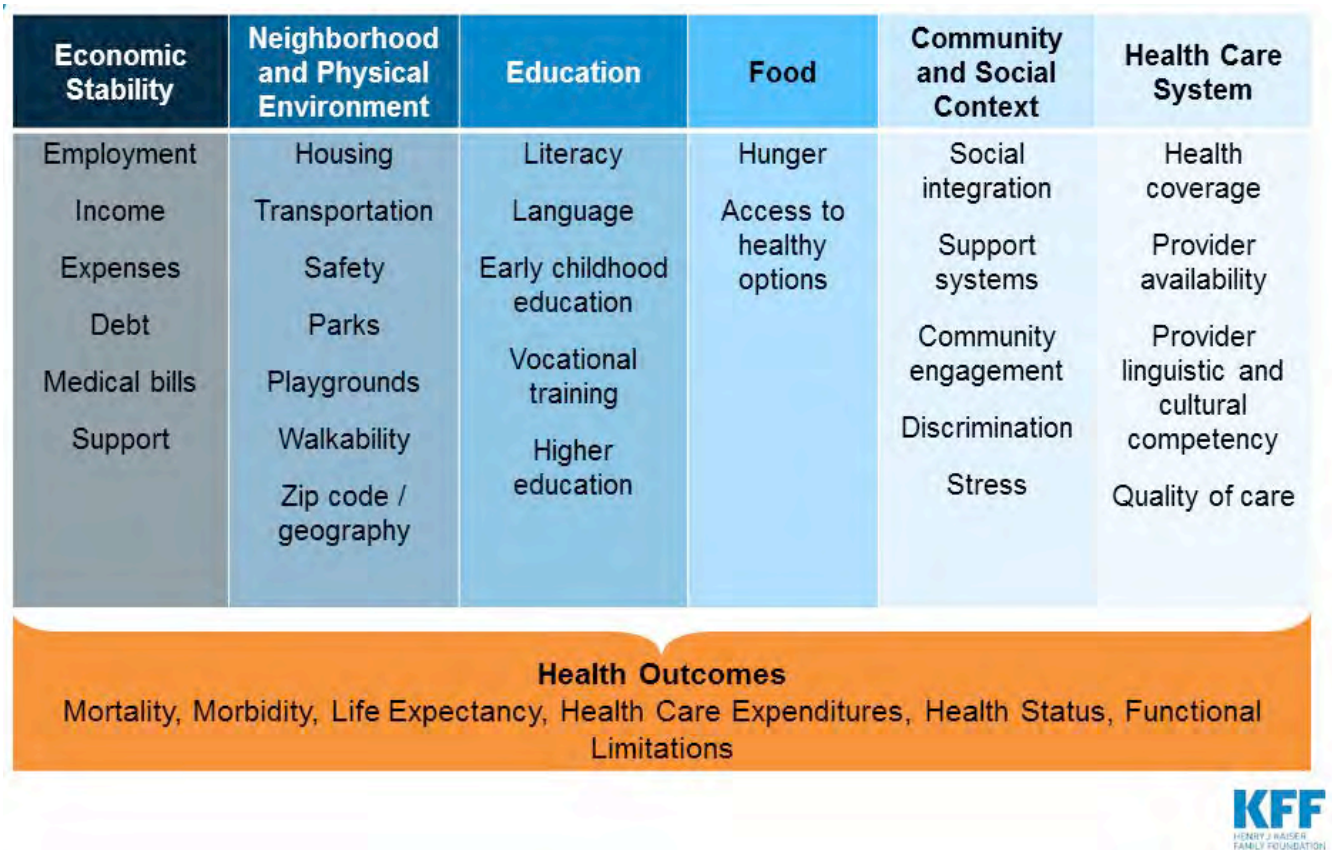
Healthy People 2020, (https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health) illustrates that health and healthcare, while vitally important, play only one small role (approximately 20%) in the overall health of individuals, and ultimately of a community. Social and 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 community health needs assessment process, it was imperative to keep in mind how they impact the health of the community and what solutions can be implemented. See Figure 3.

Figure 3: Social Determinants of Health

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

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

Figure 4: Social Determinants of Health



Demographic Information

TABLE 1: Rolette County: INFORMATION AND DEMOGRAPHICS

	Rolette County	North Dakota
Population (2018)	14,301	755,393
Population change (2010-2018)	2.6%	12.3%
People per square mile (2010)	15.4	9.7
Persons 65 years or older (2017)	11.2%	15.0%
Persons under 18 years (2017)	33.6%	23.3%
Median age (2017 est.)	30.6	35.2
White persons (2017)	18.6%	87.5%
Non-English speaking (2017)	1.2%	5.6%
High school graduates (2017)	85.7%	92.0%
Bachelor's degree or higher (2017)	20.7%	28.2%
Live below poverty line (2017)	27.1%	10.7%
Persons without health insurance, under age 65 years (2017)	18.2%	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#

Along with the population of North Dakota, Rolette County has grown in recent years. The U.S. Census Bureau estimates show that Rolette County's population has increased from 13,937 (2010) to 14,301 (2018).

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, Rolette 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 2019 County Health Rankings are pulled from more than 20 data sources and then are compiled to create county rankings. Counties in each of the 50 states are ranked according to summaries of a variety of health measures. Those 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 2019 County Health Rankings – a flow chart of how a county's rank is determined – may be found in Appendix B. For further information, visit the County Health Rankings website at www.countyhealthrankings.org.

Health Outcomes

- Length of life
- Quality of life

Health Factors

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

Health Factors (continued)

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

Table 2 summarizes the pertinent information gathered by County Health Rankings as it relates to Rolette County. It is important to note that these statistics describe the population of a county, regardless of where county residents choose to receive their medical care. In other words, all of the following statistics are based on the health behaviors and conditions of the county's residents, not necessarily the patients and clients of Rolette County Public Health and Presentation Medical Center or of any particular medical facility.

For most of the measures included in the rankings, the County Health Rankings' authors have calculated the "Top U.S. Performers" for 2019. 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).

Rolette County rankings within the state are included in the following summary. For example, the county ranks 48th out of 49 ranked counties in North Dakota on health outcomes and 49th on health factors. The measures marked with a with a bullet point (•) are those where a county is not measuring up to the state rate/percentage; a square (■) indicates that the county is not meeting the U.S. Top 10% rate on that measure. Measures that are not marked with a colored checkmark 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 Rolette County is doing poorer than many counties compared to the rest of the state on all of the outcomes, landing below rates for other North Dakota counties. Like many North Dakota counties, Rolette County is also doing poor in many areas when it comes to the U.S. Top 10% ratings.

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

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

- Excessive drinking
- Dentists
- Violent crime

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

- Premature death
- Poor or fair health
- Poor physical health days
- Poor mental health days
- Low birth weight
- Adult smoking
- Adult obesity
- Food environment index
- Physical activity
- Access to exercise opportunities
- Alcohol-impaired driving deaths
- Sexually transmitted infections
- Teen birth rate
- Uninsured
- Primary care physicians
- Mental health providers
- Preventable hospital stays
- Mammography screenings
- Flu vaccinations
- Unemployment
- Children in poverty
- Income inequality
- Children in single-parent households
- Social associations
- Violent crime
- Injury deaths
- Air pollution – particulate matter
- Severe housing problems

TABLE 2: SELECTED MEASURES FROM COUNTY HEALTH RANKINGS 2019 –Rolette County

● = Not meeting North Dakota average

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

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

Blank values reflect unreliable or missing data

TABLE 2: SELECTED MEASURES FROM *COUNTY HEALTH RANKINGS* 2019 – ROLETTE COUNTY			
	Rolette County	**U.S. Top 10%**	**North Dakota**
Ranking: Outcomes	**48th**		**(of 49)**
Premature death	13,600 ●■	5,400	6,700
Poor or fair health	27% ●■	12%	14%
Poor physical health days (in past 30 days)	5.1 ●■	3.0	3.0
Poor mental health days (in past 30 days)	4.6 ●■	3.1	3.1
Low birth weight	9% ●■	6%	6%
Ranking: Factors	**49th**		**(of 49)**
Health Behaviors			
Adult smoking	32% ●■	14%	20%
Adult obesity	39% ●■	26%	32%
Food environment index (10=best)	7.3 ●■	8.7	9.1
Physical inactivity	29% ●■	19%	22%
Access to exercise opportunities	64% ●■	91%	74%
Excessive drinking	19% ■	13%	26%
Alcohol-impaired driving deaths	48% ●■	13%	46%
Sexually transmitted infections	1,058.1 ●■	152.8	456.5
Teen birth rate	70 ●■	14	23
Clinical Care			
Uninsured	17% ●■	6%	8%
Primary care physicians	2,440:1 ●■	1,050:1	1,320:1
Dentists	1,320:1 ■	1,260:1	1,530:1
Mental health providers	970:1 ●■	310:1	570:1
Preventable hospital stays	6,434 ●■	2,765	4,452
Mammography screening (% of Medicare enrollees ages 67-69 receiving screening)	33% +	49%	50%
Flu vaccinations (% of fee-for-service Medicare enrollees receiving vaccination)	36% ●■	52%	47%
Social and Economic Factors			
Unemployment	10.2% ●■	2.9%	2.6%
Children in poverty	32% ●■	11%	11%
Income inequality	7.6 ●■	3.7	4.4
Children in single-parent households	62% ●■	20%	27%
Violent crime	41 +	63	258
Injury deaths	107 ●■	57	69
Physical Environment			
Air pollution – particulate matter	5.8 +●	6.1	5.4
Drinking water violations	No	NA	NA
Severe housing problems	17% +	9%	11%

Source: http://www.countyhealthrankings.org/app/north-dakota/2019/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 may be found at www.childhealthdata.org/learn/NSCH.

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

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

Health Status	North Dakota	National
Children born premature (3 or more weeks early)	10.8%	11.5%
Children 10-17 overweight or obese	30.0%	31.0%
Children 0-5 who were ever breastfed	82.4%	79.2%
Children 6-17 who missed 11 or more days of school	3.0%	3.7%
Healthcare		
Children currently insured	95.5%	93.9%
Children who had preventive medical visit in past year	77.8%	82.2%
Children who had preventive dental visit in past year	76.4%	79.5
Young children (10 mos.-5 yrs.) receiving standardized screening for developmental or behavioral problems	11.7%	9.8%
Children aged 2-17 with problems requiring counseling who received needed mental healthcare	1.1%	2.4%
Young children (9-35 mos.).) receiving standardized screening for developmental problems	31.5%	31.1%
Family Life		
Children whose families eat meals together 4 or more times per week	**75.5%**	73.0%
Children who live in households where someone smokes	16.1%	15.5%
Neighborhood		
Children who live in neighborhood with a parks, recreation centers, sidewalks and a library	37.0%	39.2%
Children living in neighborhoods with poorly kept or rundown housing	9.9%	12.8%
Children living in neighborhood that's usually or always safe	98.3%	94.5%

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 ages 2-17 years 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 show that Rolette County is performing more poorly than the North Dakota average on all of the examined measures except the percentage of the population who are enrolled in Healthy Steps. The most marked difference was on the measure of Medicaid recipients (just over 38% higher rate in Rolette County).

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

	Rolette County	North Dakota
Uninsured children (% of population age 0-18), 2016	13.1%	9.0%
Uninsured children below 200% of poverty (% of population), 2016	44.2%	41.9%
Medicaid recipient (% of population age 0-20), 2017	66.4%	28.3%
Children enrolled in Healthy Steps (% of population age 0-18), 2013	2.2%	2.5%
Supplemental Nutrition Assistance Program (SNAP) recipients (% of population age 0-18), 2017	58.0%	20.1%
Licensed childcare capacity (% of population age 0-13), 2019	22.7%	44.3%
4-Year High School Cohort Graduation Rate, 2018	85.9%	88.0%

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

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

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

Table 5 depicts some of the YRBS data that has been collected in 2013, 2015, and 2017. At this time, the North Dakota-specific data for 2017 is not available, so data for 2013 and 2015 are shown for North Dakota. They are further broken down by rural and urban percentages. The trend column shows a "=" for statistically insignificant change (no change), "↑" for an increased trend in the data changes from 2013 to 2015, and "↓" for a decreased trend in the data changes from 2013 to 2015. The final column shows the 2017 national average percentage. For a more complete listing of the YRBS data, see Appendix C.

TABLE 5: Youth Behavioral Risk Survey Results

North Dakota High School Survey

Sources: https://www.nd.gov/dpi/uploads/1298/2015NDHStatewideYRBSReport20151110FINAL2NoCover.pdf; https://www.nd.gov/dpi/uploads/1298/2015NDHTrendReportUpdated42016.pdf; https://www.cdc.gov/healthyyouth/data/yrbs/results.htm

	ND 2013	ND 2015*	ND Trend ↑, ↓, =	Rural ND Town Average	Urban ND Town Average	National Average 2017
Injury and Violence						
% of students who rarely or never wore a seat belt.	11.6	8.5	↓	10.5	7.5	5.9
% of students who rode in a vehicle with a driver who had been drinking alcohol (one or more times during the 30 prior to the survey)	21.9	17.7	↓	21.1	15.2	16.5
% of students who talked on a cell phone while driving (on at least 1 day during the 30 days before the survey)	67.9	61.4	↓	60.7	58.8	NA
% of students who texted or e-mailed while driving a car or other vehicle (on at least 1 day during the 30 days before the survey)	59.3	57.6	=	56.7	54.4	39.2
% of students who were in a physical fight on school property (one or more times during the 12 months before the survey)	8.8	5.4	↓	6.9	6.1	8.5
% of students who were ever physically forced to have sexual intercourse (when they did not want to)	7.7	6.3	=	6.5	7.4	7.4
% of students who were bullied on school property (during the 12 months before the survey)	25.4	24.0	=	27.5	22.4	19.0
% of students who were electronically bullied (includes e-mail, chat rooms, instant messaging, websites, or texting during the 12 months before the survey)	17.1	15.9	=	17.7	15.8	14.9
% of students who made a plan about how they would attempt suicide (during the 12 months before the survey)	13.5	13.5	=	12.8	13.7	13.6
Tobacco, Alcohol, and Other Drug Use						
% of students who currently use an electronic vapor product (e-cigarettes, vape e-cigars, e-pipes, vape pipes, vaping pens, e-hookahs, and hookah pens at least 1 day during the 30 days before the survey)	NA	22.3	↑	19.7	22.8	13.2
% of students who currently used cigarettes, cigars, or smokeless tobacco (on at least 1 day during the 30 days before the survey)	27.5	20.9	↓	22.9	19.8	14.0
% of students who drank five or more drinks of alcohol in a row (within a couple of hours on at least 1 day during the 30 days before the survey)	21.9	17.6	↓	19.8	17.0	13.5
% of students who currently used marijuana (one or more times during the 30 days before the survey)	15.9	15.2	=	13.2	17.1	19.8
% of students who ever took prescription drugs without a doctor's prescription (such as OxyContin, Percocet, Vicodin, codeine, Adderall, Ritalin, or Xanax, one or more times during their life)	17.6	14.5	↓	13.2	16.0	14.0
Weight Management, Dietary Behaviors, and Physical Activity						
% of students who were overweight (>= 85th percentile but <95th percentile for body mass index)	15.1	14.7	=	15.4	14.6	15.6
% of students who were obese (>= 95th percentile for body mass index)	13.5	14.0	=	16.3	12.9	14.8

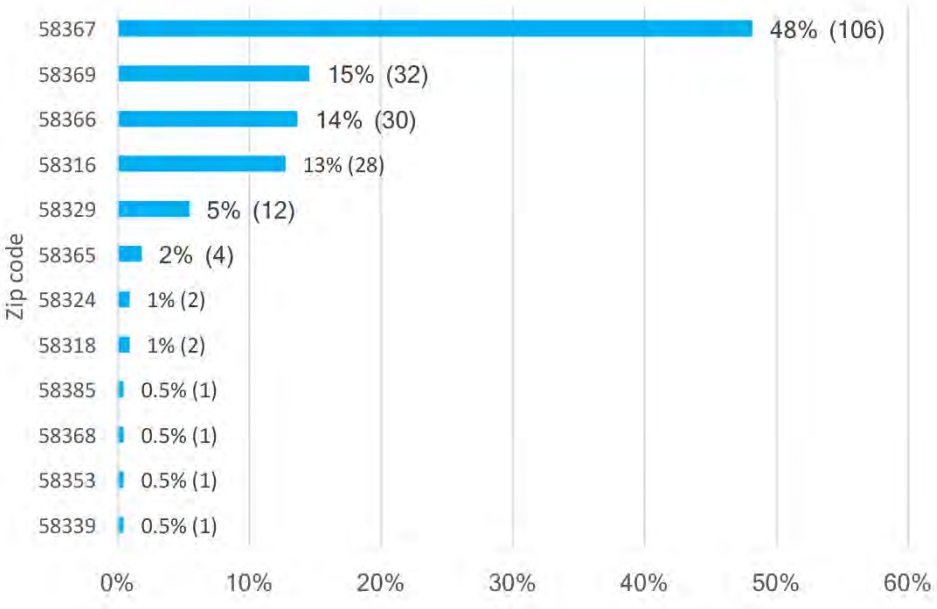
% of students who did not eat fruit or drink 100% fruit juices (during the 7 days before the survey)	3.4	3.9	=	4.3	4.1	5.6
% of students who did not eat vegetables (green salad, potatoes [excluding French fries, fried potatoes, or potato chips], carrots, or other vegetables, during the 7 days before the survey)	6.0	4.7	=	4.5	5.2	7.2
% of students who drank a can, bottle, or glass of soda or pop one or more times per day (not including diet soda or diet pop, during the 7 days before the survey)	23.4	18.7	=	21.4	18.0	18.7
% of students who did not drink milk (during the 7 days before the survey)	11.1	13.9	↑	11.6	13.7	26.7
% of students who did not eat breakfast (during the 7 days before the survey)	10.5	11.9	=	10.7	11.8	14.1
% of students who most of the time or always went hungry because there was not enough food in their home (during the 30 days before the survey)	3.1	2.2	=	2.4	2.8	NA
% of students who were physically active at least 60 minutes per day on 5 or more days (doing any kind of physical activity that increased their heart rate and made them breathe hard some of the time during the 7 days before the survey)	50.6	51.3	=	51.7	50.1	46.5
% of students who watched television 3 or more hours per day (on an average school day)	21.0	18.9	=	20.7	18.2	20.7
% of students who played video or computer games or used a computer 3 or more hours per day (for something that was not school work on an average school day)	34.4	38.6	↑	39.4	38.0	43.0
Other						
% of students who ever had sexual intercourse	44.9	38.9	↓	39.3	39.1	39.5
% of students who had 8 or more hours of sleep (on an average school night)	30.0	29.5	=	34.5	28.7	25.4
% of students who brushed their teeth on seven days (during the 7 days before the survey)	71.5	71.0	=	67.8	70.1	NA

Sources: https://www.nd.gov/dpi/uploads/1298/2015NDHStatewideYRBSReport20151110FINAL2NoCover.pdf; https://www.nd.gov/dpi/uploads/1298/2015NDHTrendReportUpdated42016.pdf; https://www.cdc.gov/healthyyouth/data/yrbs/results.htm

Survey Results

As noted previously, 315 community members completed the survey in communities throughout the PMC service area. The survey requested that respondents list their home zip code. While not all respondents provided a zip code, 220 did, revealing that the majority of respondents (48%, N=106) lived in Rolla. These results are shown in Figure 5. For all questions that contained an "Other" response, all of those direct responses is found in Appendix D. In some cases, a summary of those comments is additionally included in the report narrative.

Figure 5: Survey Respondents' Home Zip Code
Total respondents: 220



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

Survey Demographics

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

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

- 36% (N=61) were age 55 or older
- The majority (77%, N=184) were female
- More than half of the respondents (56%, N=137) had bachelor's degrees or higher
- The number of those working full time (81%, N=194) was just over 11 times higher than those who were retired (7%, N=18)
- 72% (N=172) of those who reported their ethnicity/race were white/Caucasian
- 25% of the population (N=59) had household incomes of less than $50,000

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

Figure 6: Age Demographics of Survey Respondents
Total respondents = 242

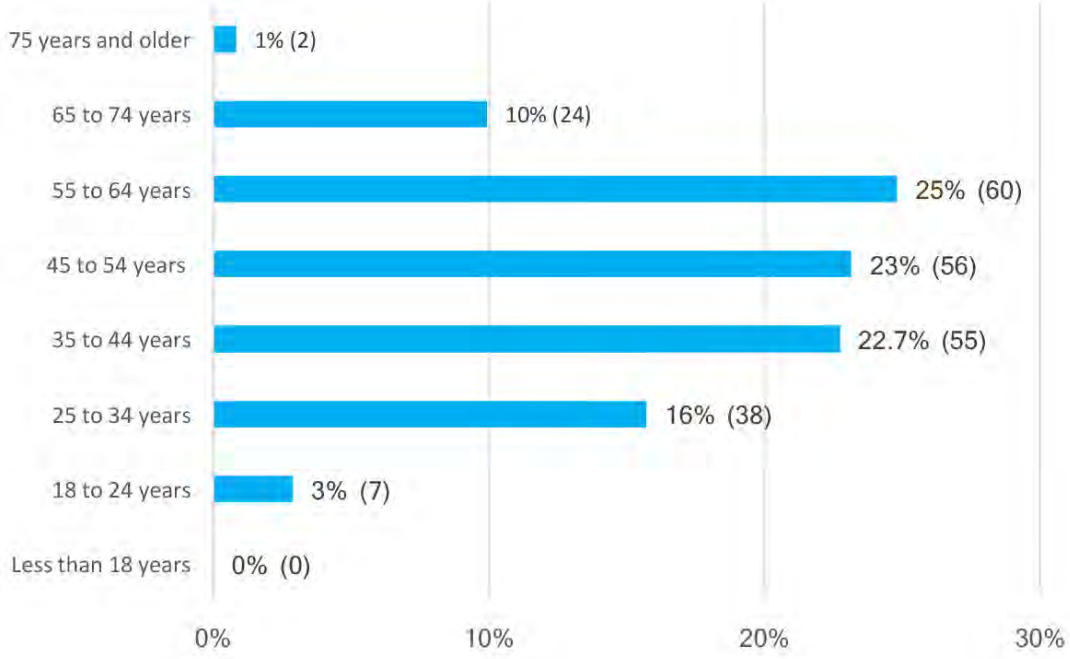


Figure 7: Gender Demographics of Survey Respondents
Total respondents = 240

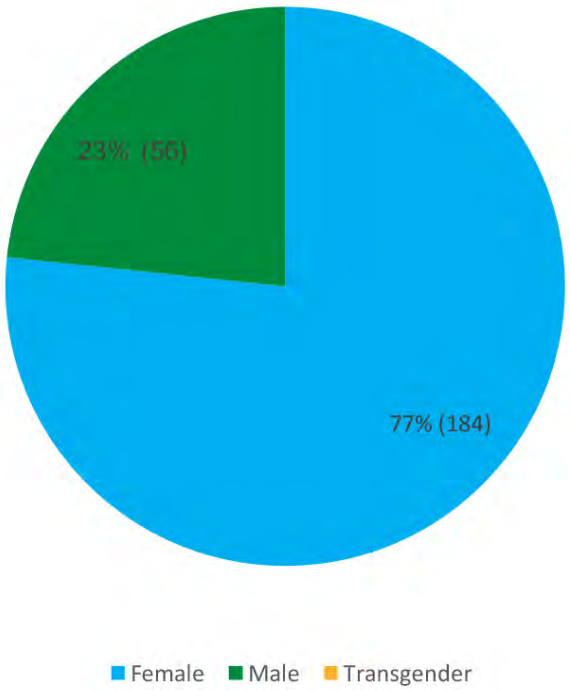


Figure 8: Educational Level Demographics of Survey Respondents
Total respondents = 242

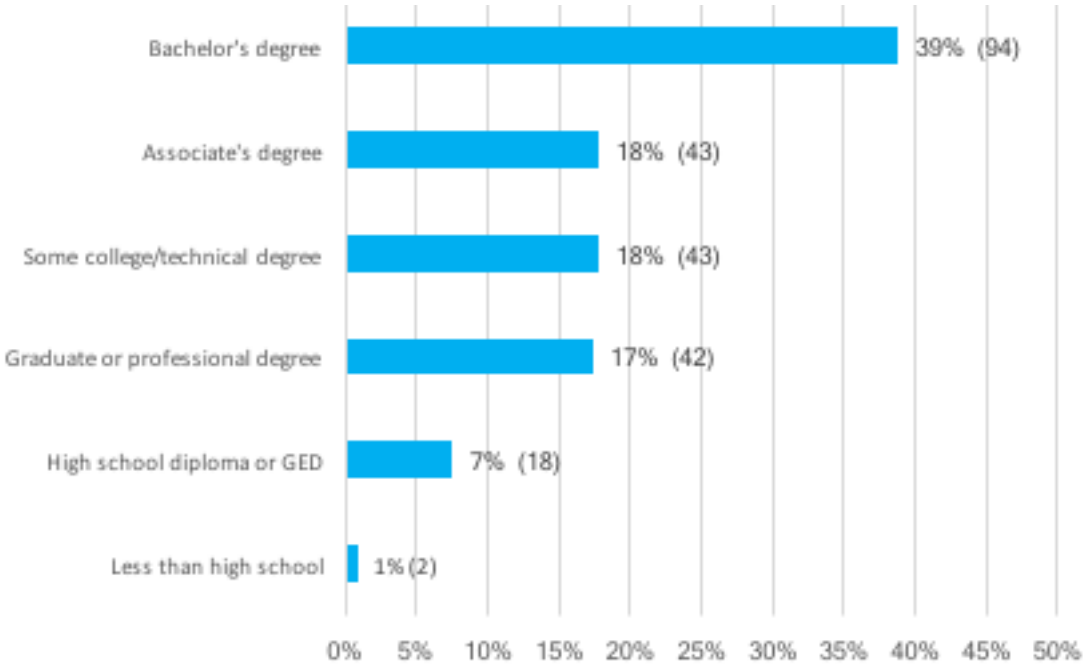
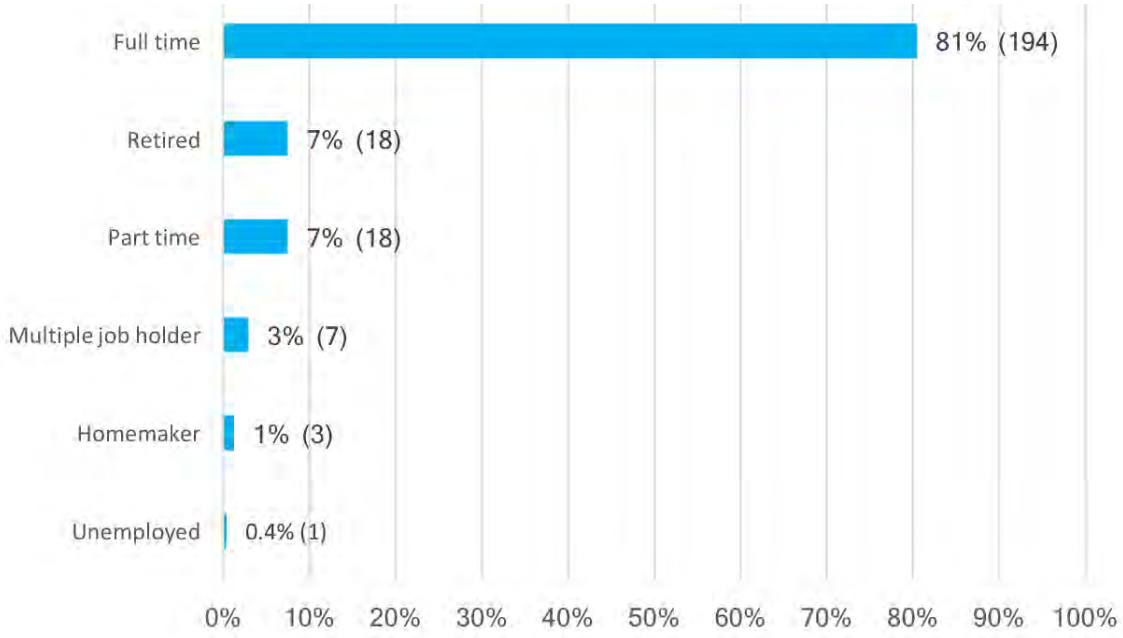
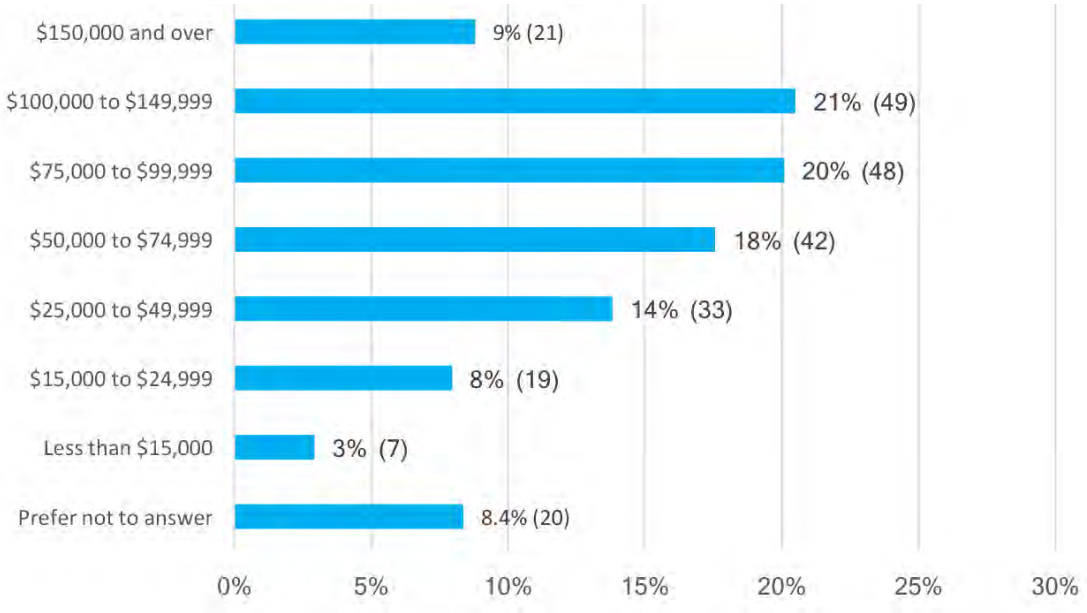


Figure 9: Employment Status Demographics of Survey Respondents
Total respondents = 241



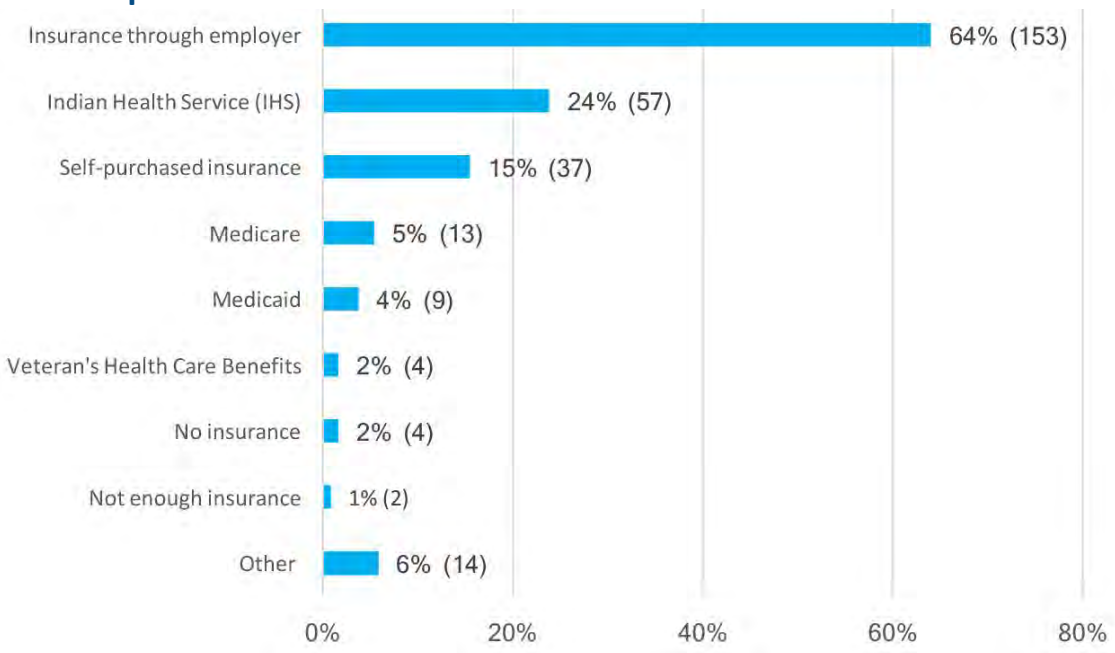
Of those who provided a household income, 11% (N=26) community members reported a household income of less than $25,000. Thirty percent (N=70) indicated a household income of $100,000 or more. This information is show in Figure 10.

Figure 10: Household Income Demographics of Survey Respondents
Total respondents = 239



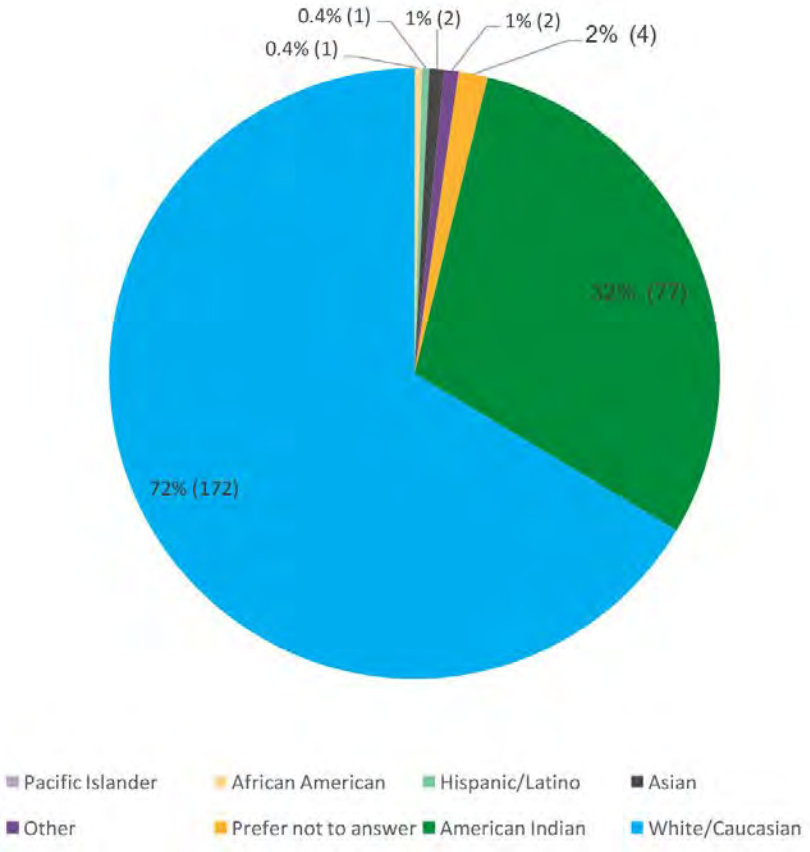
Community members were asked about their health insurance status, which is often associated with whether people have access to healthcare. Three percent (N=16) of the respondents reported having no health insurance or being under-insured. The most common insurance types were insurance through one's employer (N=153), followed by Indian Health Service (N=57) and self-purchased insurance (N=37).

Figure 11: Health Insurance Coverage Status of Survey Respondents
Total respondents = 293



As shown in Figure 12, most of the respondents were white/Caucasian (72%). This was markedly disproportionate with the race/ethnicity of the overall population of Rolette County; the U.S. Census indicates that 18.6% of the population is white in Rolette County, with 78.0% being American Indian.

Figure 12: Race/Ethnicity Demographics of Survey Respondents
Total respondents = 259



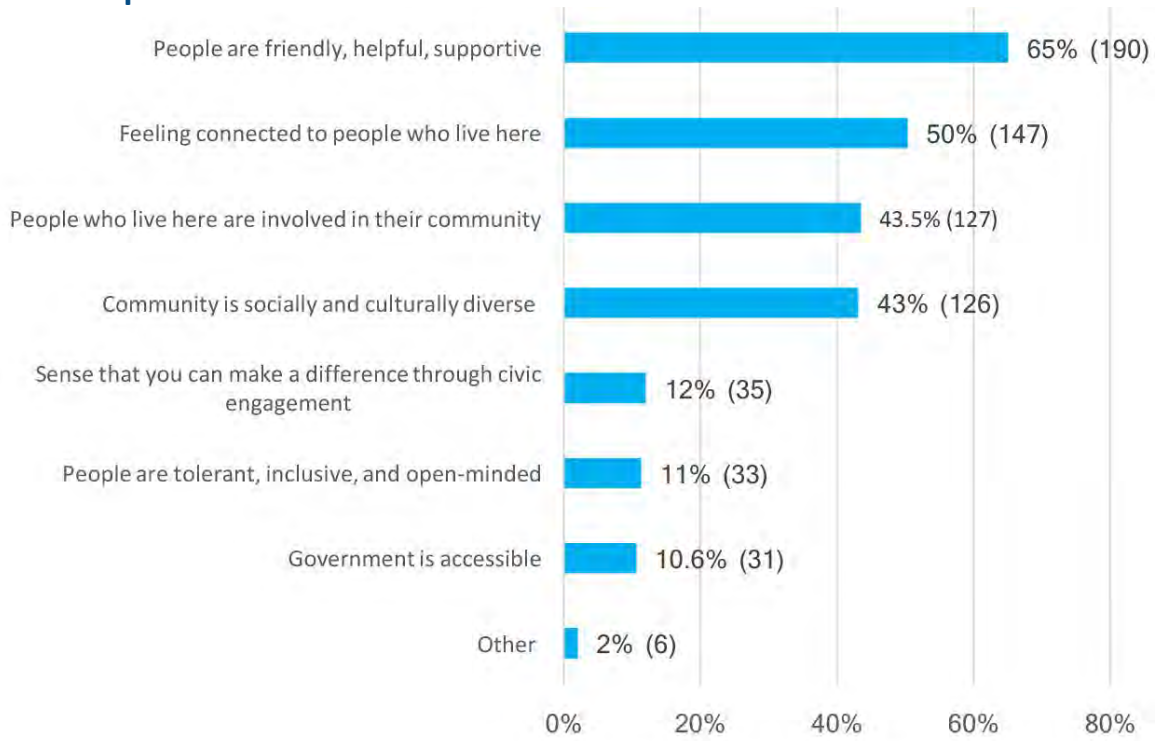
Community Assets and Challenges

Survey-respondents were asked what they perceived as the best things about their community in five categories: people, services and resources, quality of life, activities, and geographic setting. 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 150 respondents agreeing) that community assets include:

- Informal, simple, laid-back lifestyle (N=198)
- Closeness to work and activities (N=193)
- People are friendly, helpful and supportive (N=190)
- Family-friendly; good place to raise kids (N=184)
- Relatively small size and scale of community I live in (N=175
- Quality school systems (N=157)
- Recreational sports and activities (N=152)
- Natural setting: outdoors and nature (N=151)

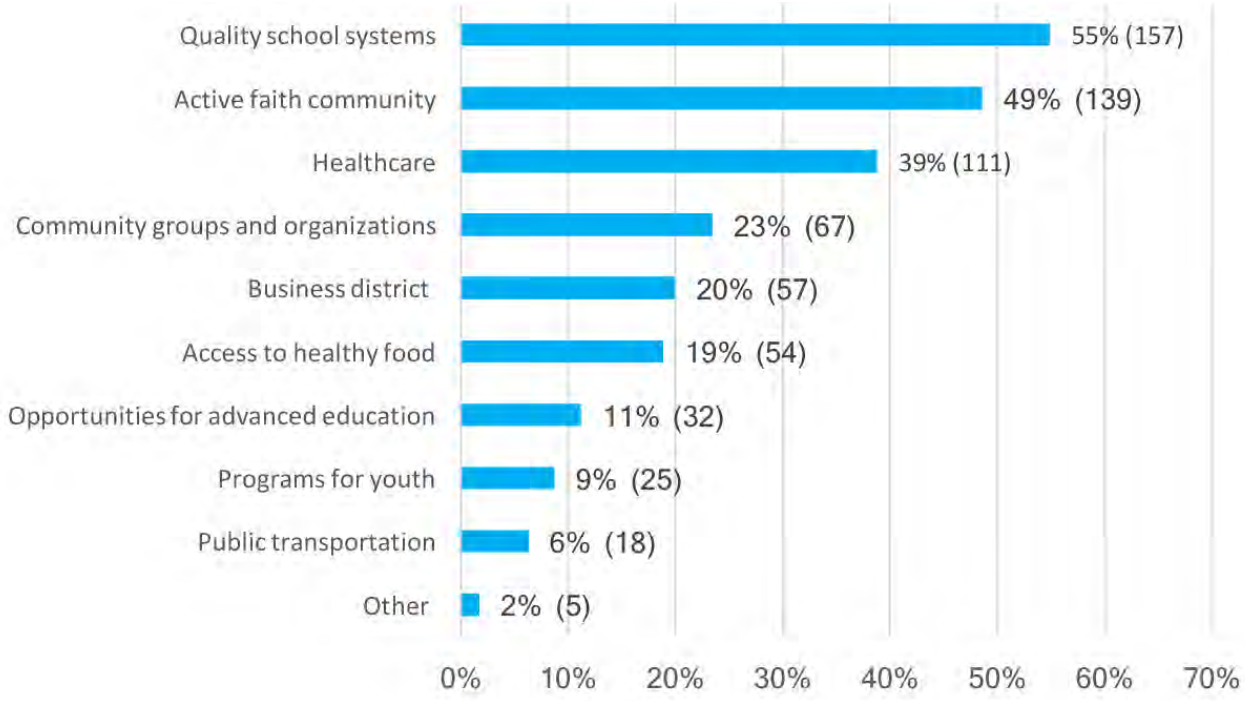
Figures 13 to 17 illustrate the results of these questions.

Figure 13: Best Things about the PEOPLE in Your Community
Total responses = 695



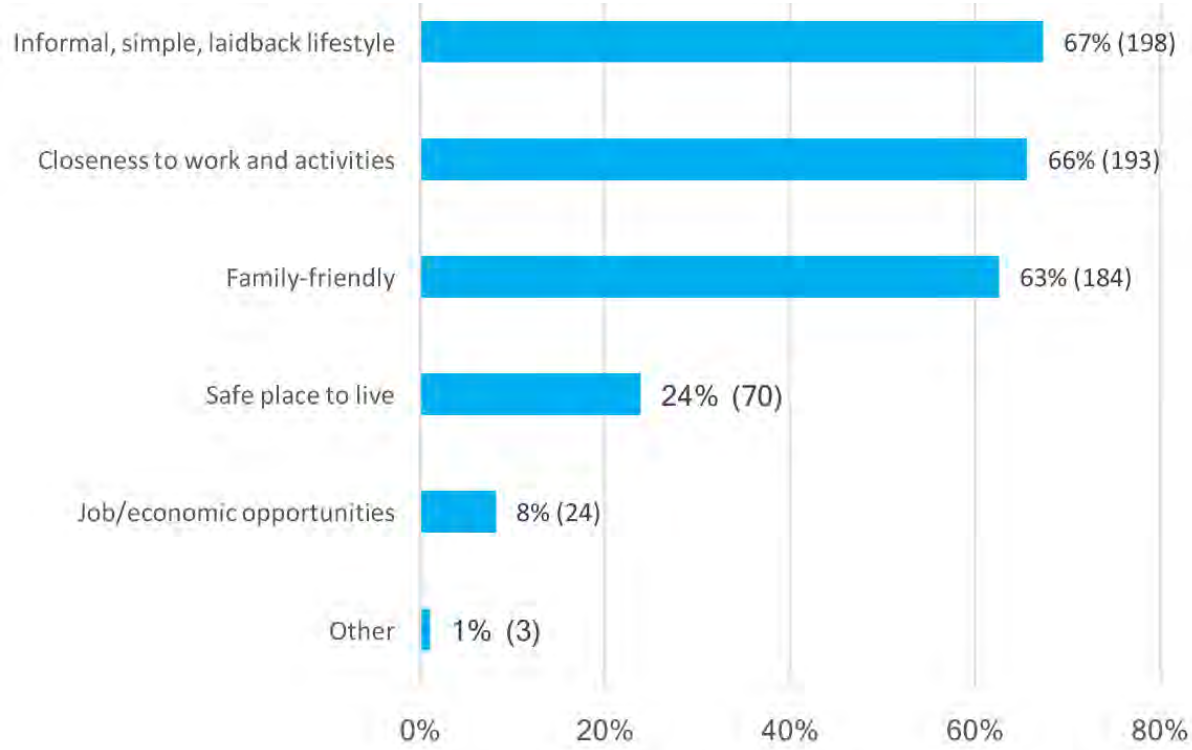
Included in the "Other" category of the best things about the people was that there is diversity and a decently sized population.

Figure 14: Best Things about the SERVICES AND RESOURCES in Your Community
Total responses = 665



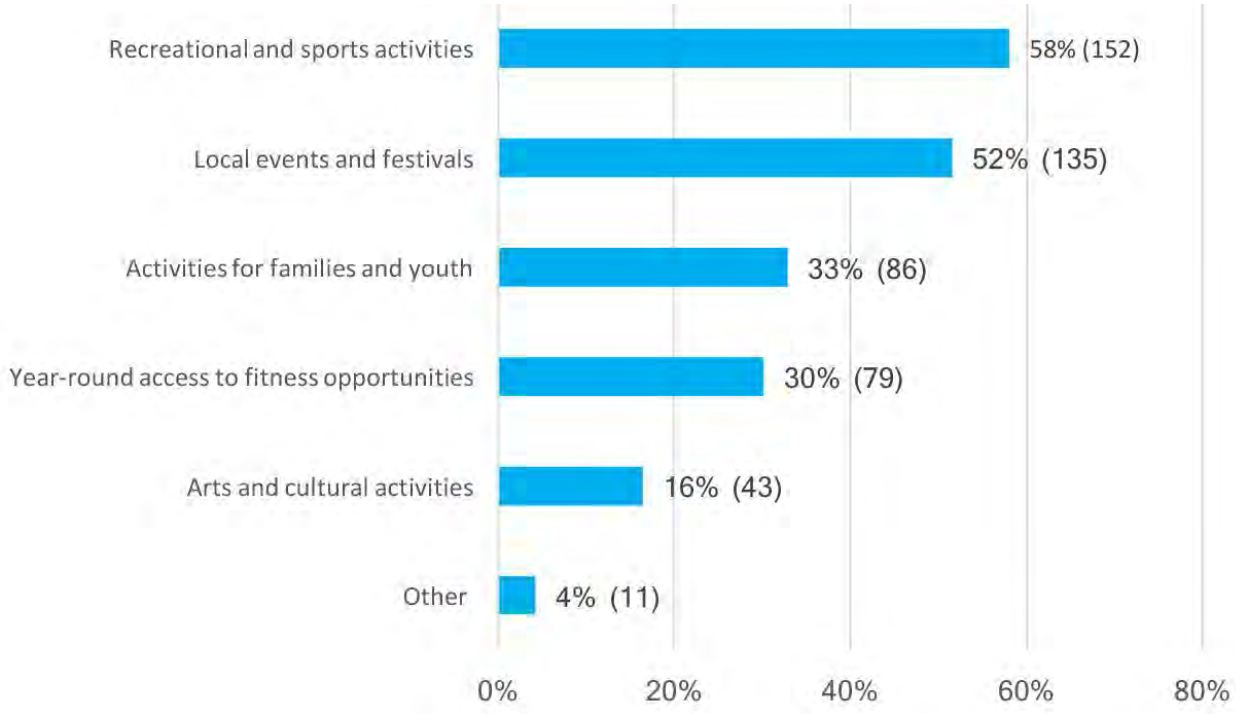
Respondents who selected "Other" specified that the best things about services and resources included EMS and a car dealership.

Figure 15: Best Things about the QUALITY OF LIFE in Your Community
Total responses = 672



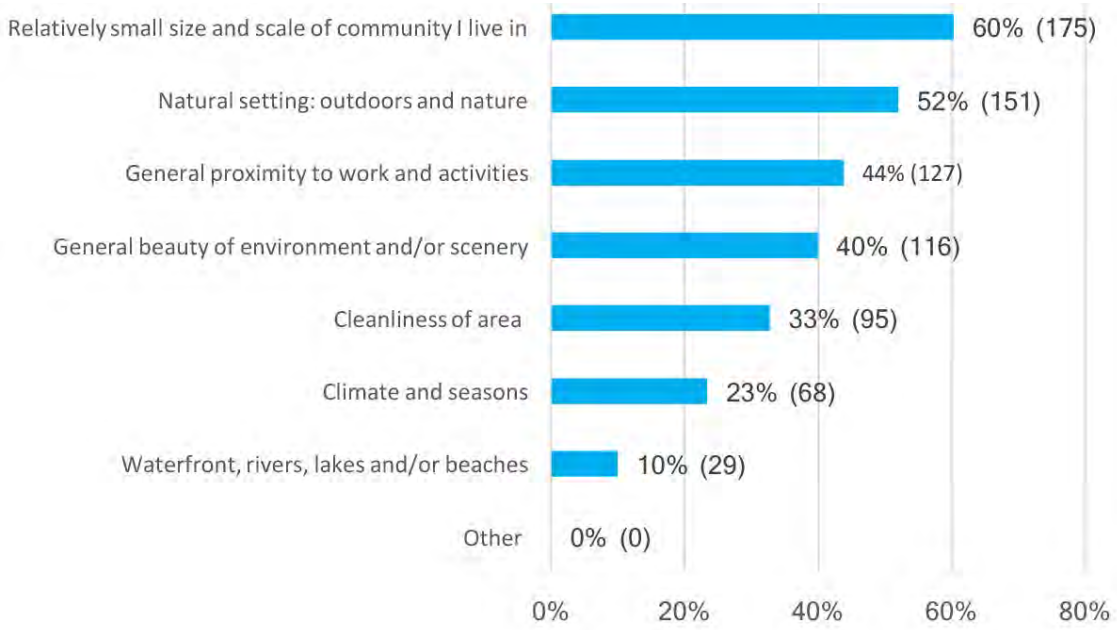
The two "Other" responses regarding the best things about the quality of life in the community were closeness to family and country living.

Figure 16: Best Thing about the ACTIVITIES in Your Community
Total responses = 506



Respondents who selected "Other" specified that the best things about the activities in the community included having a movie theater and outdoor opportunities.

Figure 17: Best Thing about the GEOGRAPHIC SETTING of Your Community
Total responses = 761



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 five categories and pick their top three concerns. The five categories of potential concerns were:

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

With regard to responses about community challenges, the most highly voiced concerns (those having at least 100 respondents) were:

- Drug use and abuse - adults (N=163)
- Drug use and abuse – youth (N=154)
- Alcohol use and abuse (N=142)
- Alcohol use and abuse – youth (N=120)
- Not enough jobs with livable wages (N=120)
- Poverty (N=111)
- Ability to retain primary care providers and nurses (N=102)

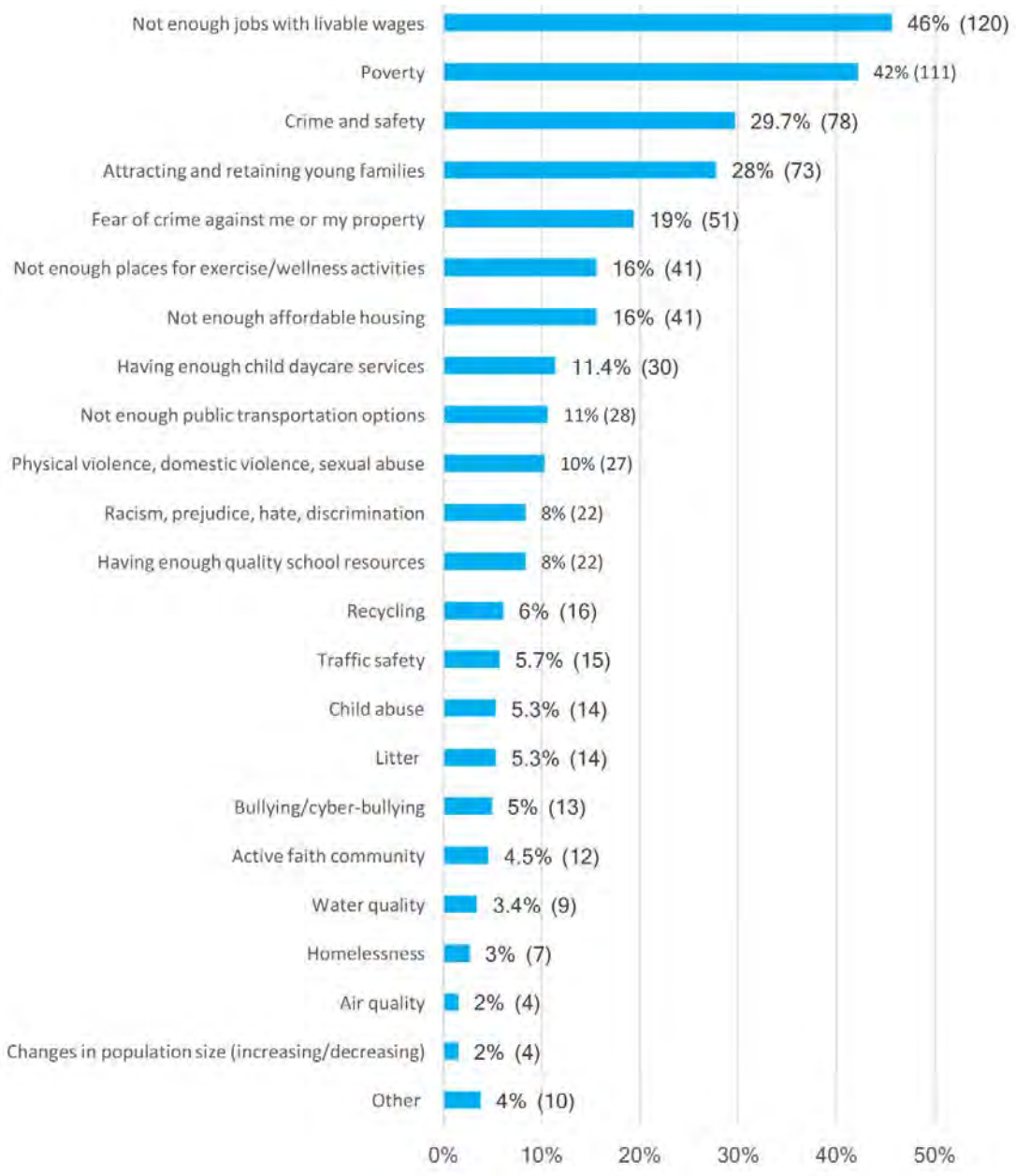
The other issues that had at least 50 votes included:

- Cost of long-term/nursing home care (N=97)
- Availability of resources to help the elderly stay in their homes (N=91)
- Not enough activities for children and youth (N=84)
- Long-term/nursing home care options (N=78)
- Smoking and tobacco use, second-hand smoke or vaping/juuling – youth (N=75)

- Depression/anxiety – adults (N=69)
- Obesity/overweight – adults (N=68)
- Ability to meet the needs of the older population (N=67)
- Diabetes – adults (N=61)
- Availability of vision care (N=61)
- Not getting enough exercise/physical activity – adults (N=57)
- Smoking and tobacco use, second-hand smoke or vaping/juuling – adults (N=53)

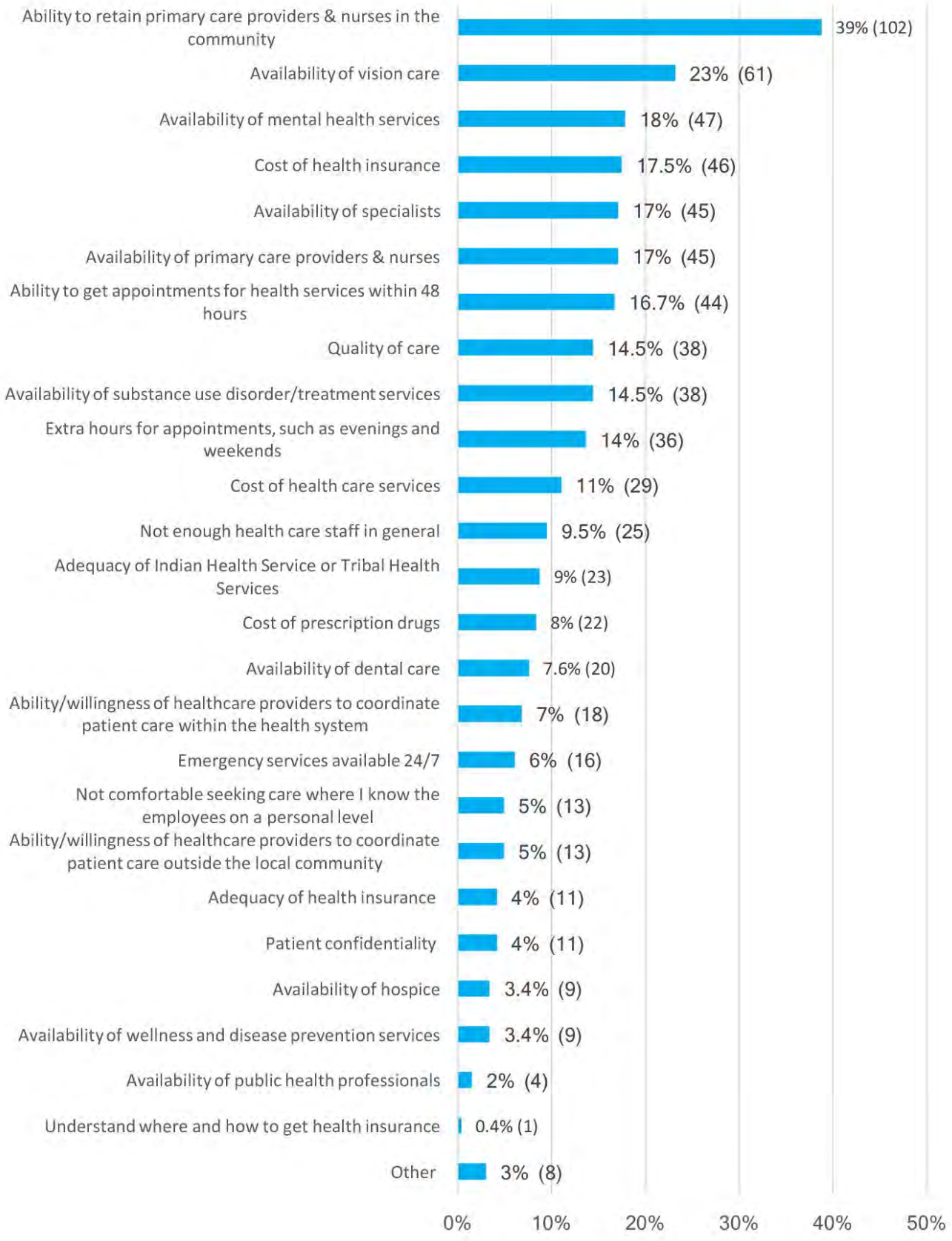
Figures 18 through 22 illustrate these results.

Figure 18: Community/Environmental Health Concerns
Total responses = 762



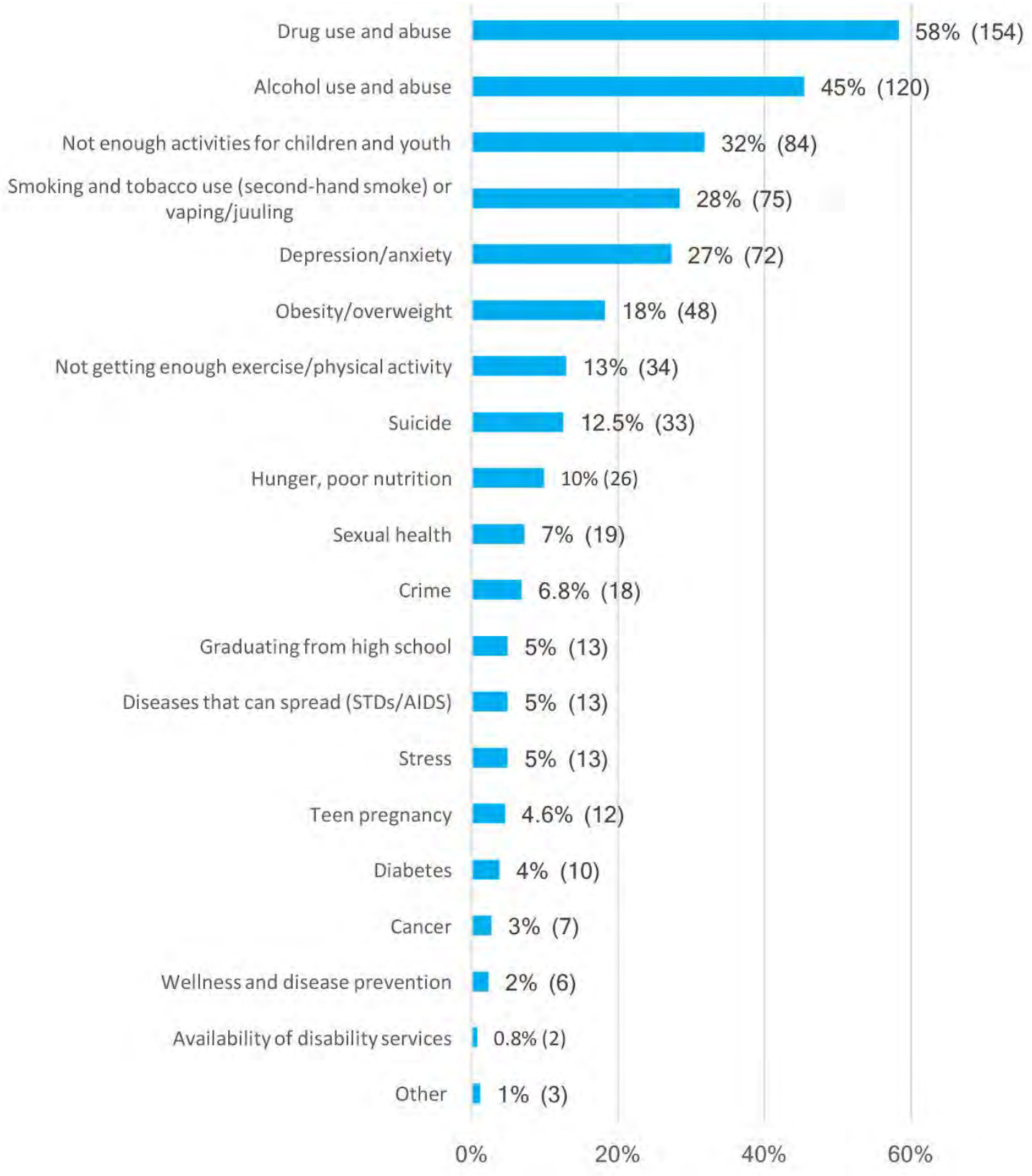
In the "Other" category for community and environmental health concerns, the following were listed: affordable healthy food, drug abuse, lack of youth activities, and a lack of access to the fitness center during the cold temperatures.

Figure 19: Availability/Delivery of Health Services Concerns
Total responses = 734



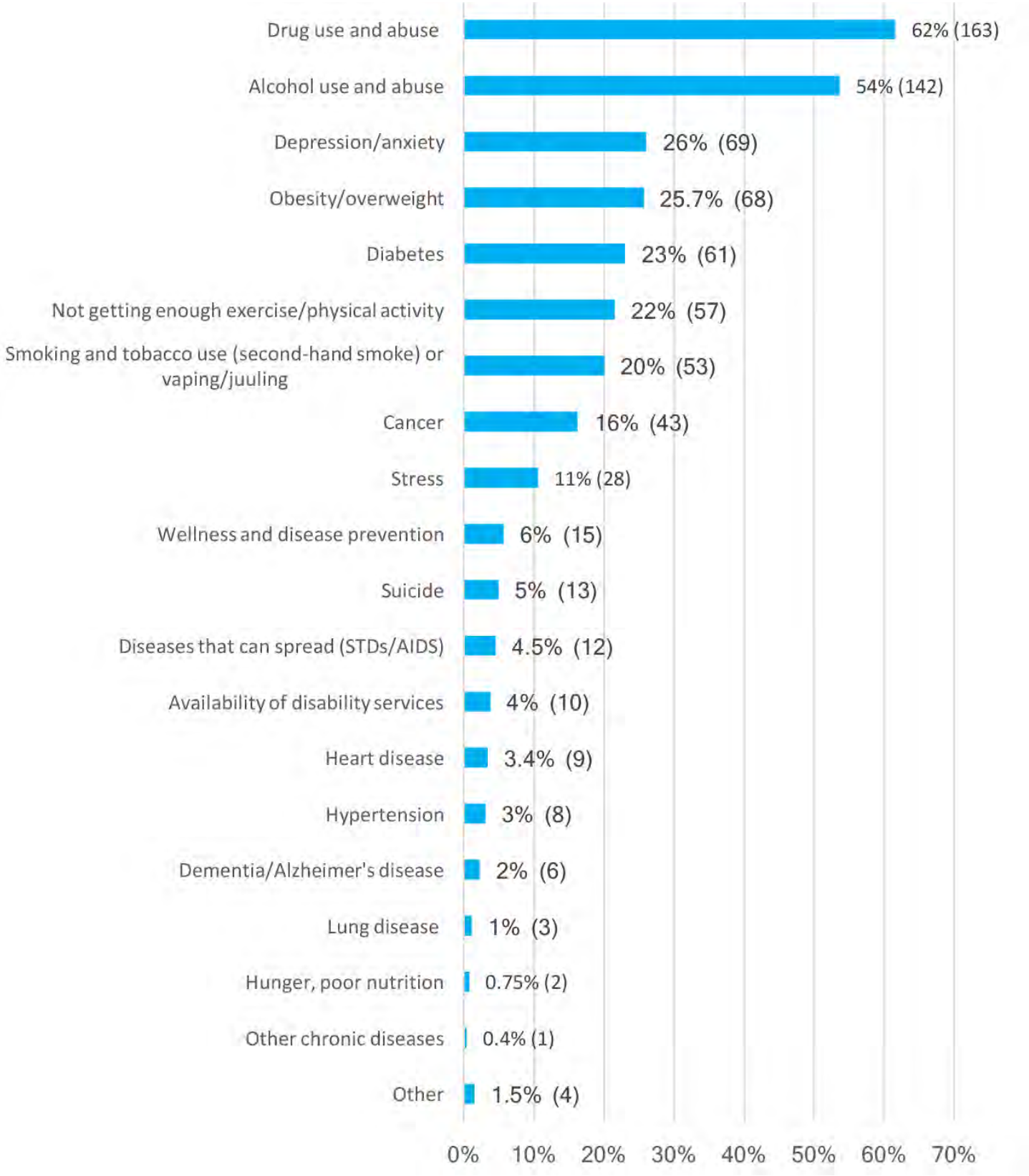
Respondents who selected "Other" identified concerns in the availability / delivery of health services as a lack of an optometrist and lack of collaboration with other healthcare providers in the area.

Figure 20: Youth Population Health Concerns
Total responses = 762



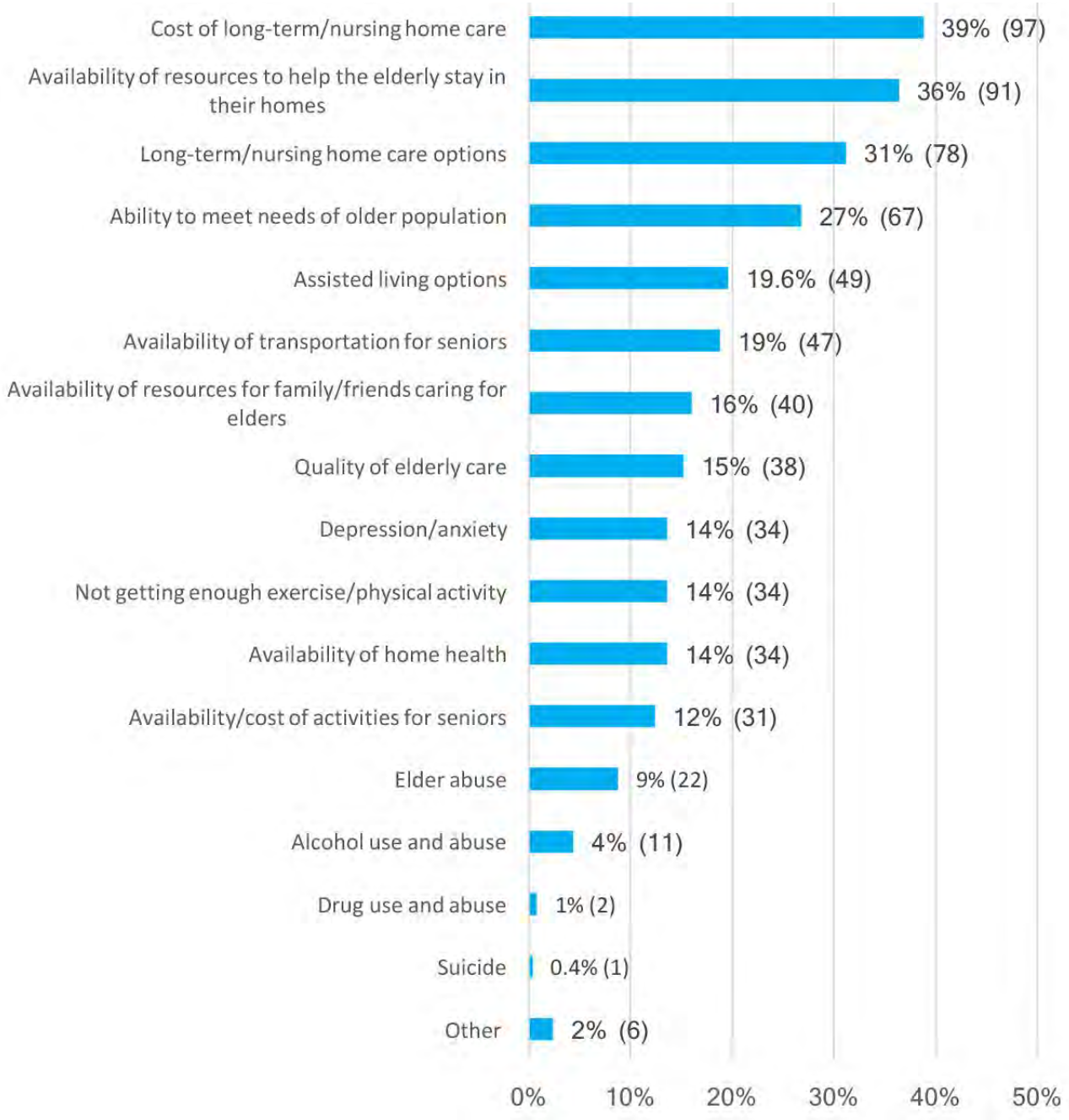
Listed in the "Other" category for youth population concerns were bullying and not being prepared for college.

Figure 21: Adult Population Concerns
Total responses = 767



Crime and lack of a middle class were indicated in the "Other" category for adult population concerns.

Figure 22: Senior Population Concerns
Total responses = 682



In the "Other" category, concerns included lack of hospice, lack of public funding for providing services to seniors, and elders raising grandchildren.

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

1. Drug use
2. Crime

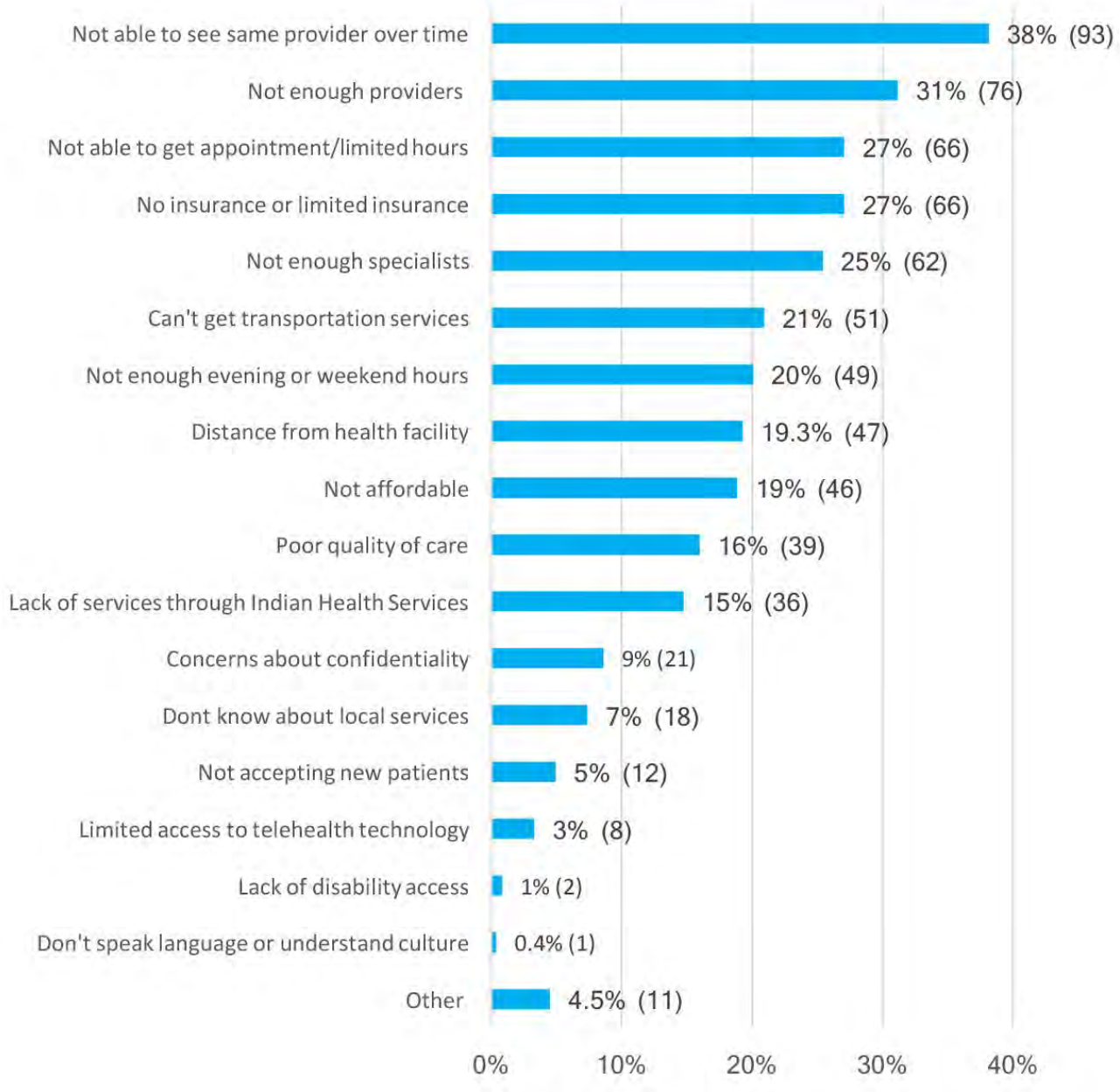
Other biggest challenges that were identified were poverty, healthcare leadership, alcohol abuse, availability of activities for all ages, retention of young families, retention of healthcare providers, and mental health services.

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 being able to see the same provider over time (N=93), with the next highest being not enough providers (MD, DO, NP, PA) (N=76). After these, the next most commonly identified barriers were no insurance or limited insurance (N=66), not able to get appointment/limited hours (N=66), and not enough specialists (N=62). Several concerns indicated in the "Other" category were in regards to the cost of insurance, followed by comments noting the lack of physicians, eye doctors, and radiology services.

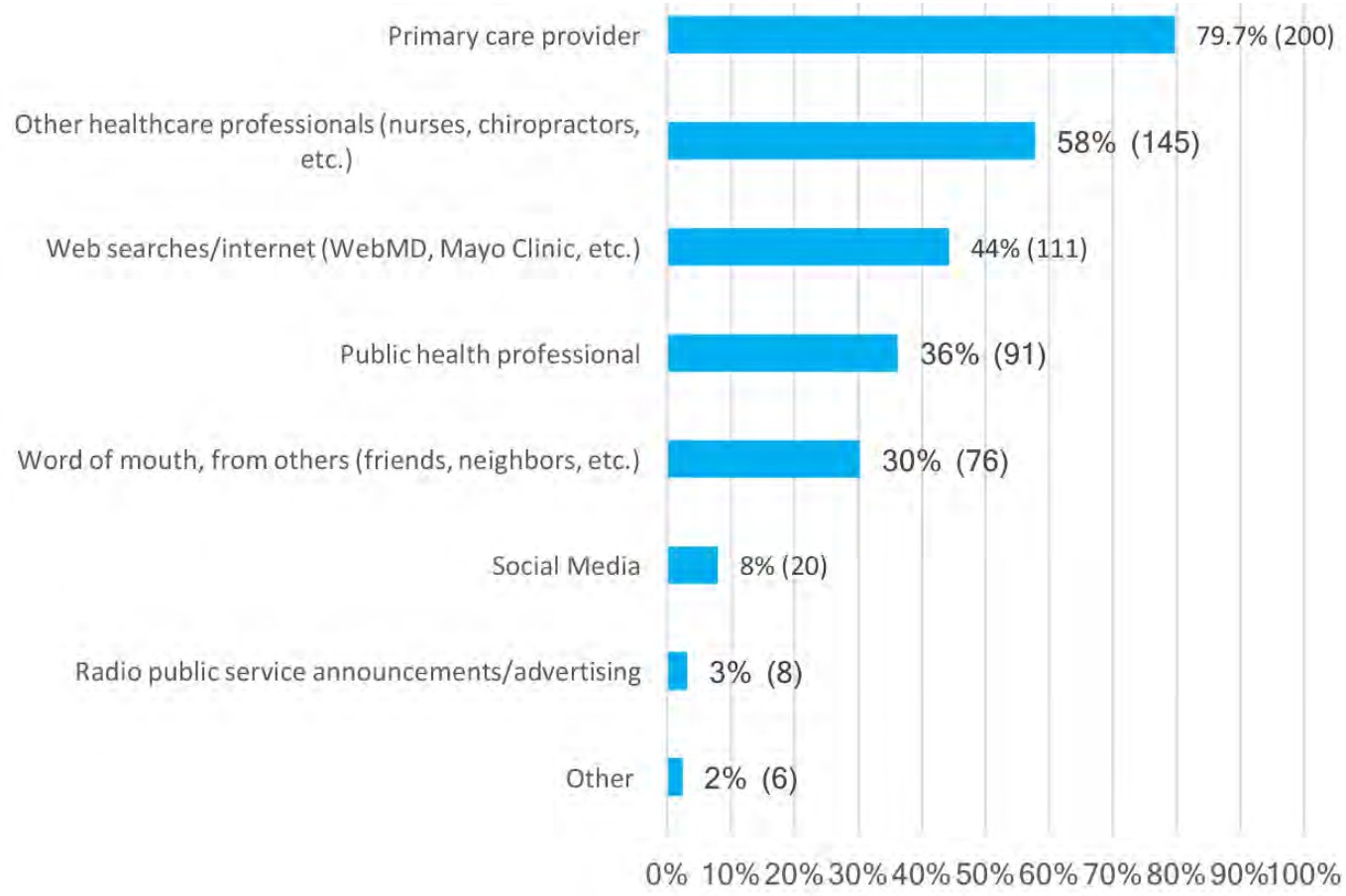
Figure 23 illustrates these results.

Figure 23: Perceptions about Barriers to Care
Total responses = 704



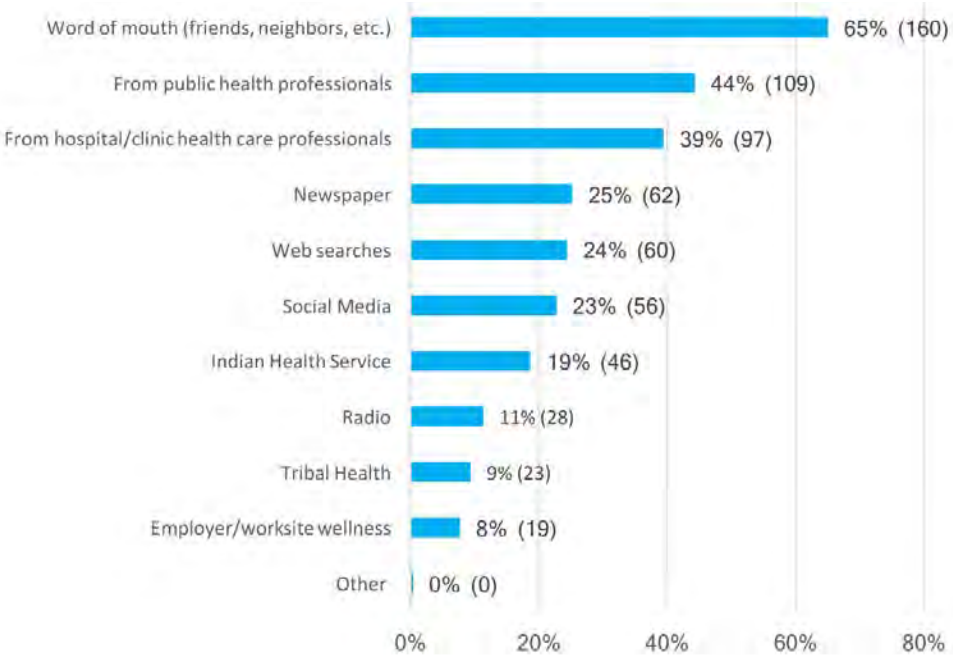
Community members were asked where they go for trusted health information and where they find out about health services available in the area, seen in Figures 24 and 25.

Figure 24: Sources of Trusted Health Information
Total responses = 657



Some responses in the "Other" category include journals, the newspaper, and out-of-area providers.

Figure 25: Sources for Availability of Health Services
Total responses = 660



The one "Other" response stated sandwich boards.
Figures 26 and 27 show data from questions on how long it takes members to reach their preferred clinic and hospital.

Figure 26: Travel Time to Preferred Clinic
Total responses = 248

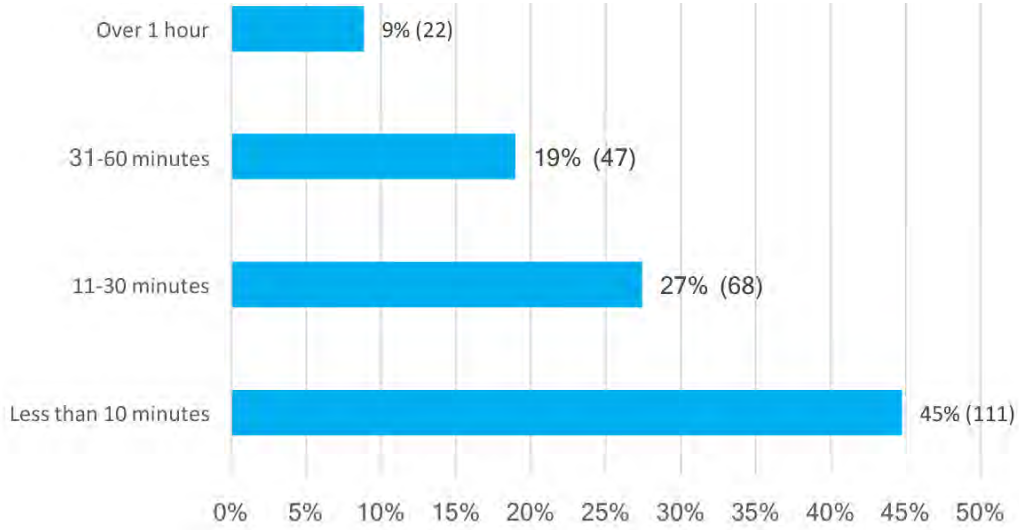
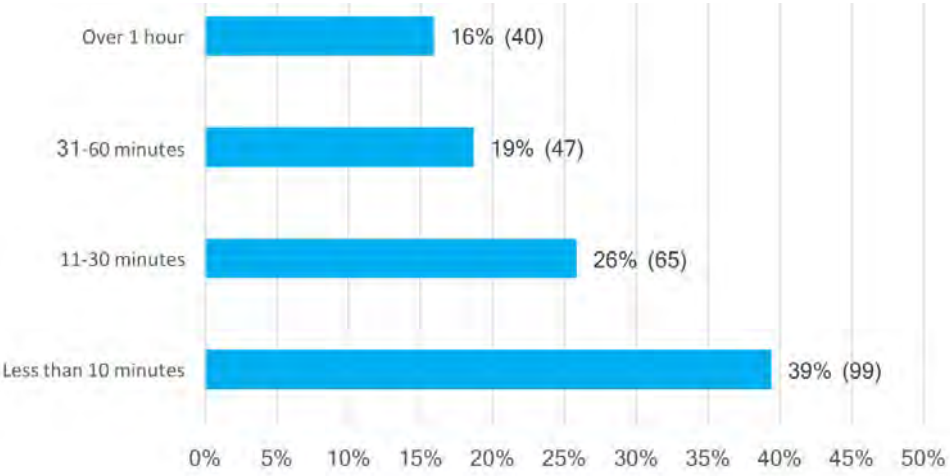
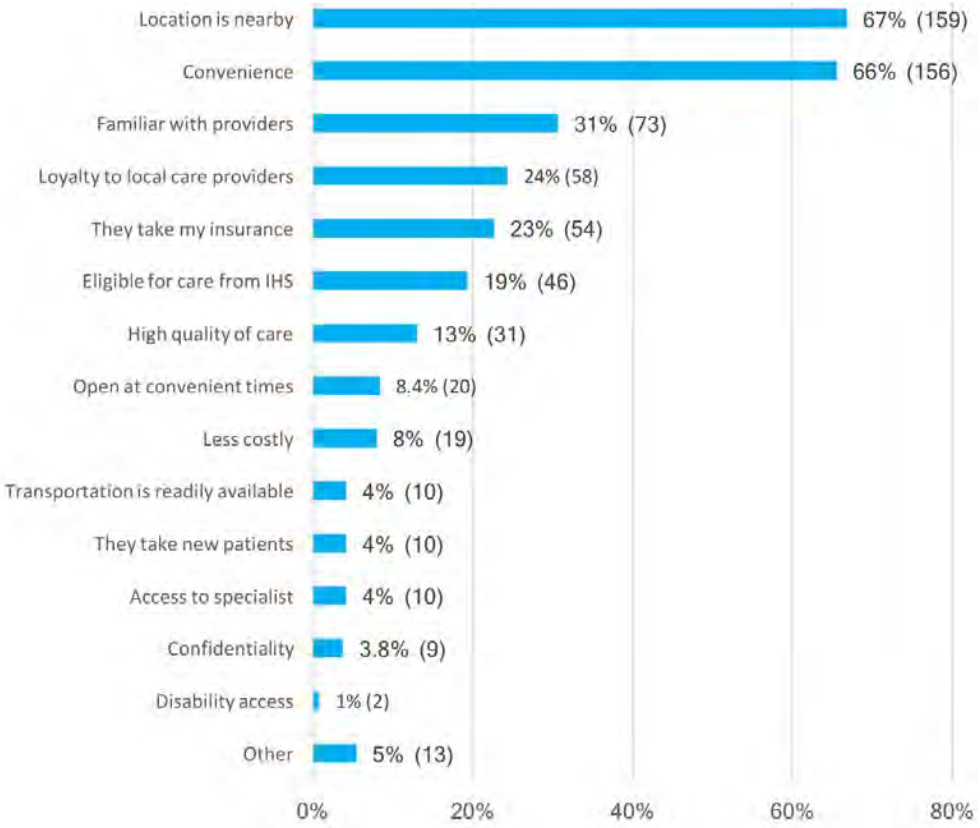


Figure 27: Travel Time to Preferred Hospital
Total Responses = 251



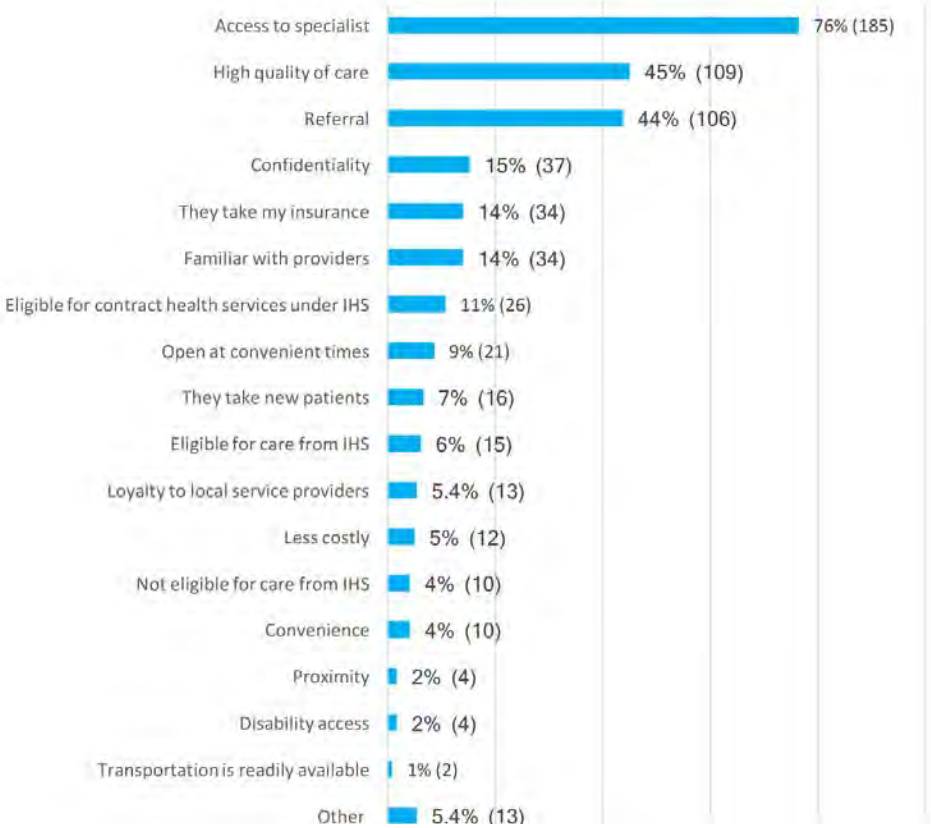
Respondents were asked why they choose to seek healthcare services close to home and why they go out of the area for these services (Figures 28 and 29)

Figure 28: Reasons for Receiving Local Healthcare
Total Responses = 670



Responses in the "Other" category mentioned emergency needs and that their specialist travels to them.

Figure 29: Reasons for Receiving Healthcare Outside of the Area
Total responses = 651



Cancer treatment, providing services not available locally, past experiences with PMC, don't want have to have a medical relationship with people that they see outside of the facility were some of the responses in the "Other" category.

Respondents were asked if they would support a tobacco tax increase in North Dakota. The funds would be used to address preventative health programs, such as tobacco prevention, opioid abuse preventions, and alcohol abuse prevention (Figure 30). Participants were also asked if they supported the legal tobacco purchase age from 18 to 21 years (Figure 31) and maintaining the North Dakota Smoke Free Law (Figure 32).

Figure 30: North Dakota Tobacco Tax Increase Support
Total responses = 247

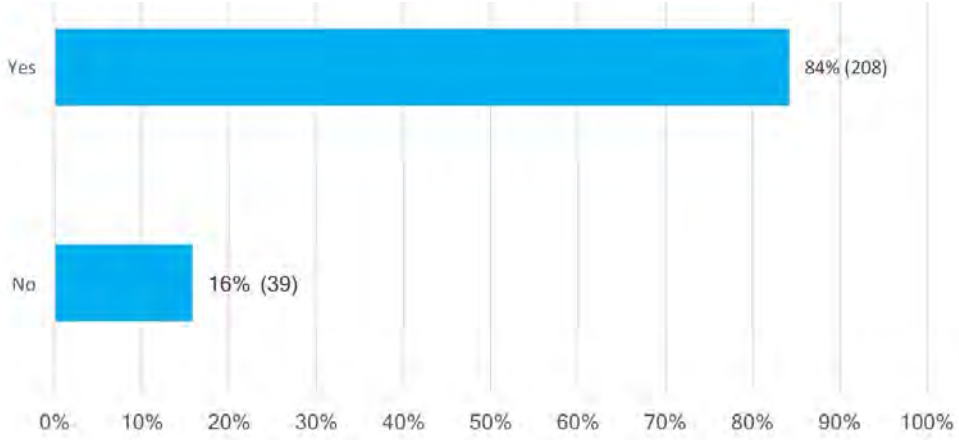


Figure 31: Support for Increasing Tobacco Purchase Age
Total responses = 247

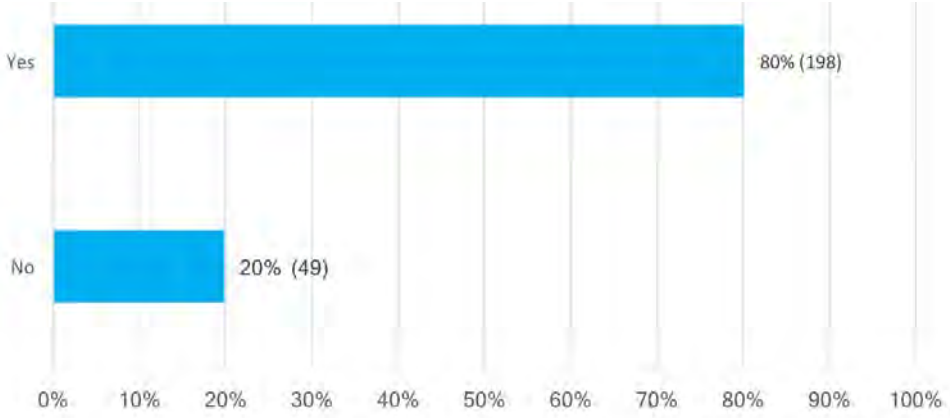


Figure 32: Support to Maintain North Dakota Smoke Free Law
Total responses = 248

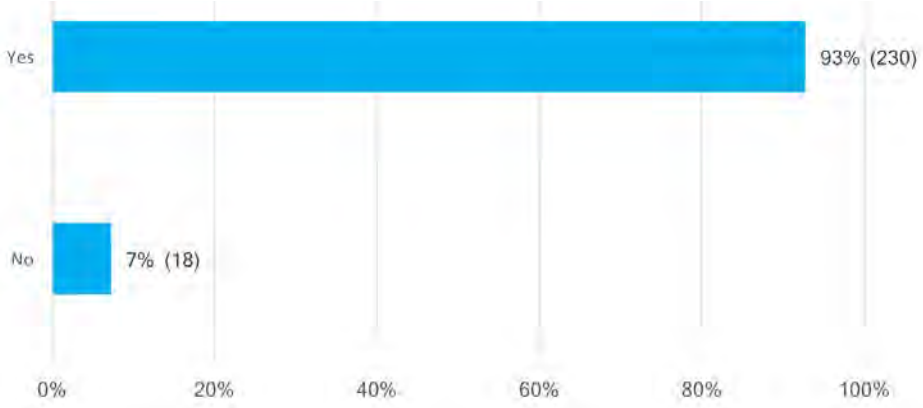


Figure 33: Awareness of Medicaid Expansion
Total responses = 246

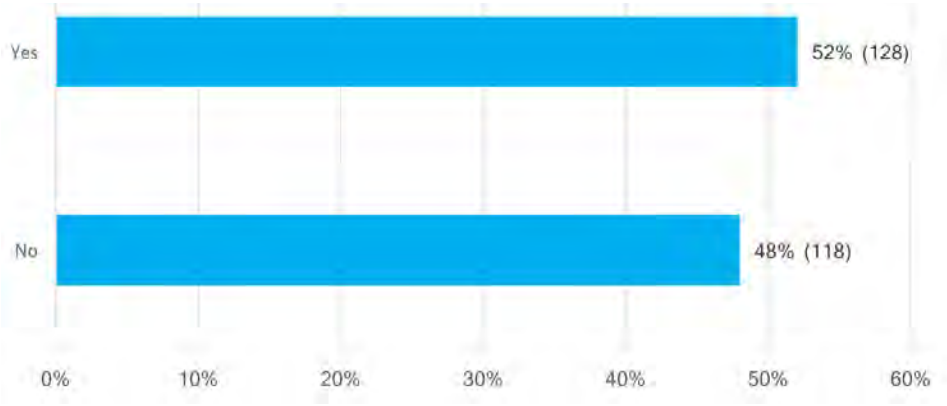
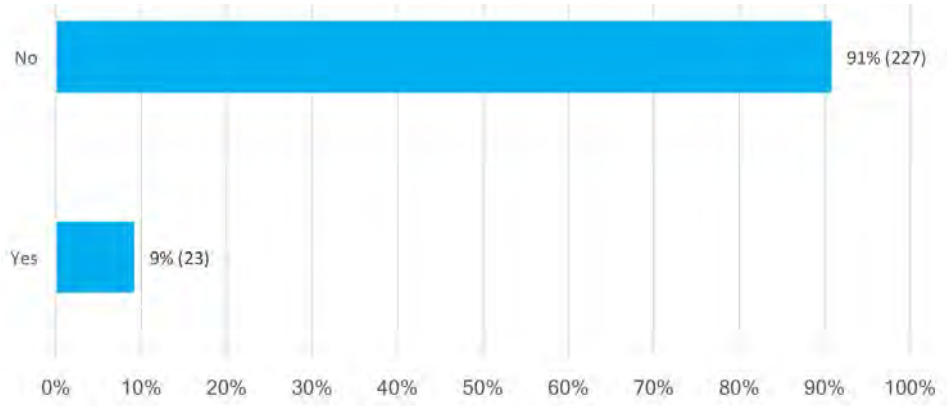


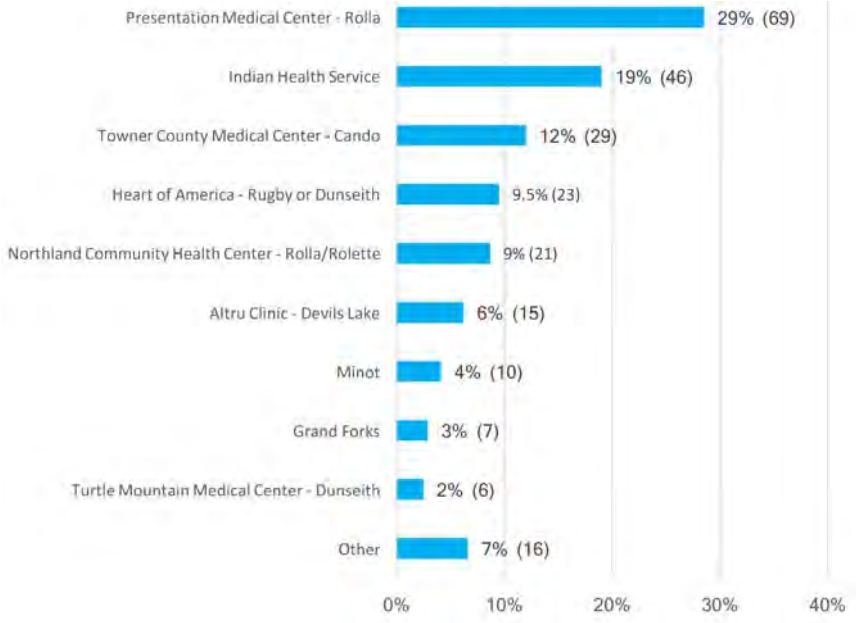
Figure 34 shows the responses from asking if community members have ever experienced food insecurity: not knowing where your next meal is coming from or involuntarily eating less than you need on a regular basis.

Figure 34: Experience with Food Insecurity
Total responses = 250



Respondents were asked where they receive the majority of their medical care for Figure 35.

Figure 35: Preferred Location for Medical Care
Total responses = 242



Included in the "Other" category were Bismarck, CHI Devils Lake, Fargo, and Turtle Mountain Family Medicine.

Participants were asked if they or a family member had any interaction with PMC or Rolette County Public Health District and, if so, to rate their experience with care and treatment, a score of 1 being less than adequate and 5 being excellent.(See Figure 36).

Figure 36: Experience with PMC and RCPHD

Please rate your perception and quality of care your received at:	**1** - Less than adequate	**2**	**3**	**4**	**5** - Excellent
Presentation Medical Center					
The care I received was:	5% (9)	6% (10)	22% (36)	37% (61)	30% (49)
I was treated with compassion and respect by staff:	7% (11)	4% (6)	13% (22)	36% (60)	40% (67)
Rolette County Public Health District					
The care I received was:	0% (0)	0% (0)	8% (12)	29% (46)	64% (102)
I was treated with compassion and respect by staff:	0% (0)	1% (2)	6% (9)	26% (41)	67% (105)

Figures 37-40 illustrate respondents being asked of their awareness and utilization of the various services offered by PMC and other local providers/organizations.

Figure 37: Awareness and Utilization of GENERAL and ACUTE SERVICES
Total responses = 755

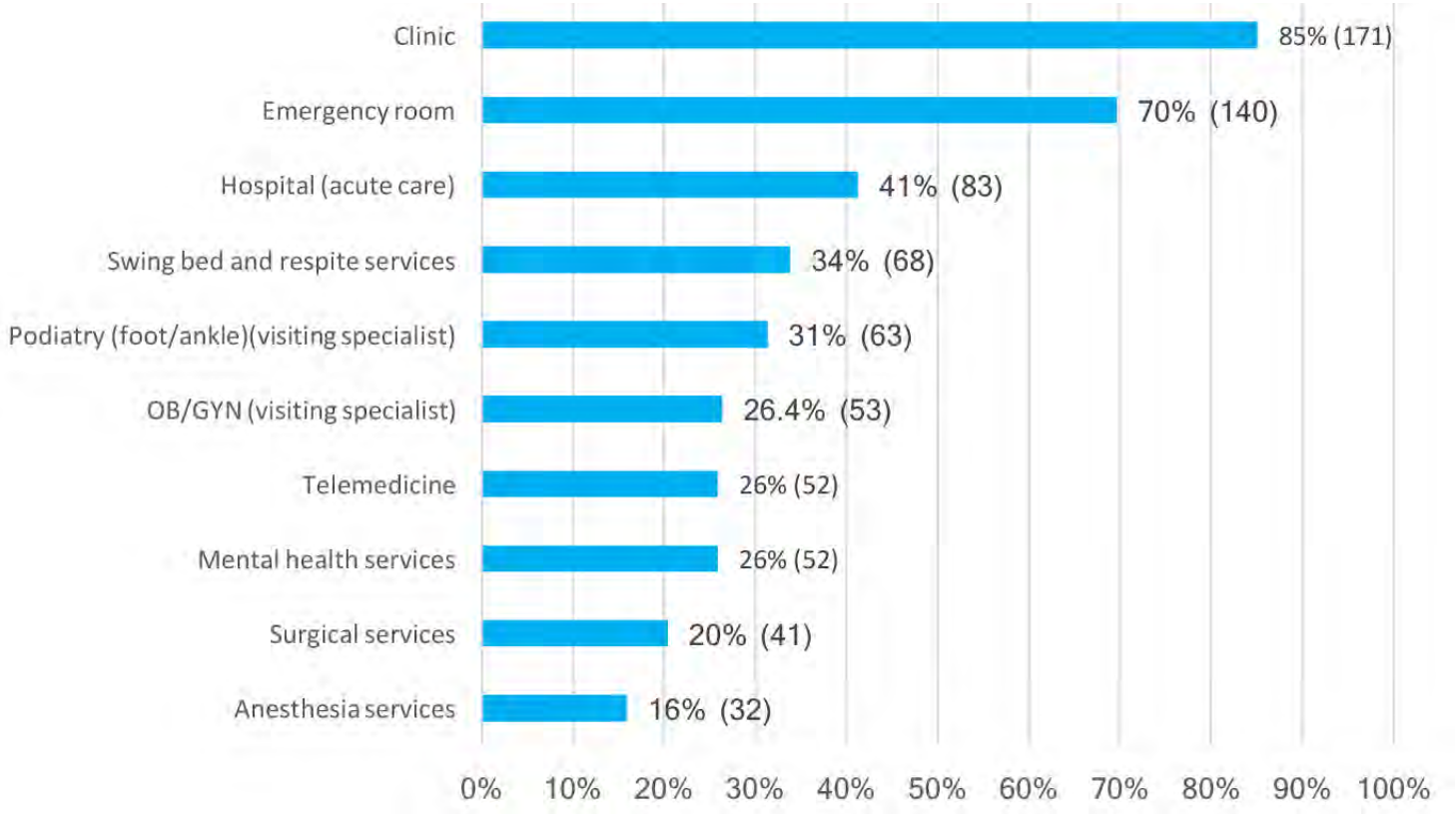


Figure 38: Awareness and Utilization of SCREENING/THERAPY SERVICES
Total responses = 534

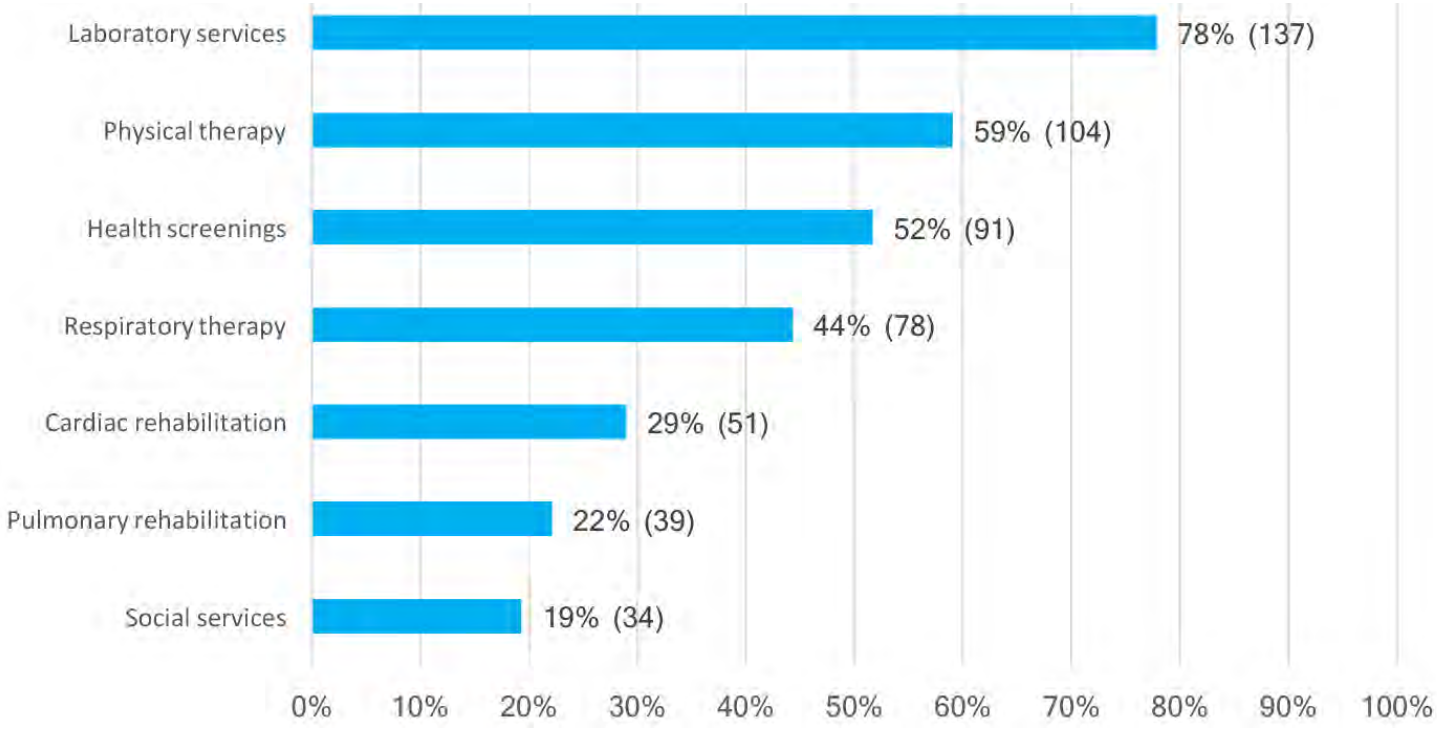


Figure 39: Awareness and Utilization of RADIOLOGY SERVICES
Total responses = 582

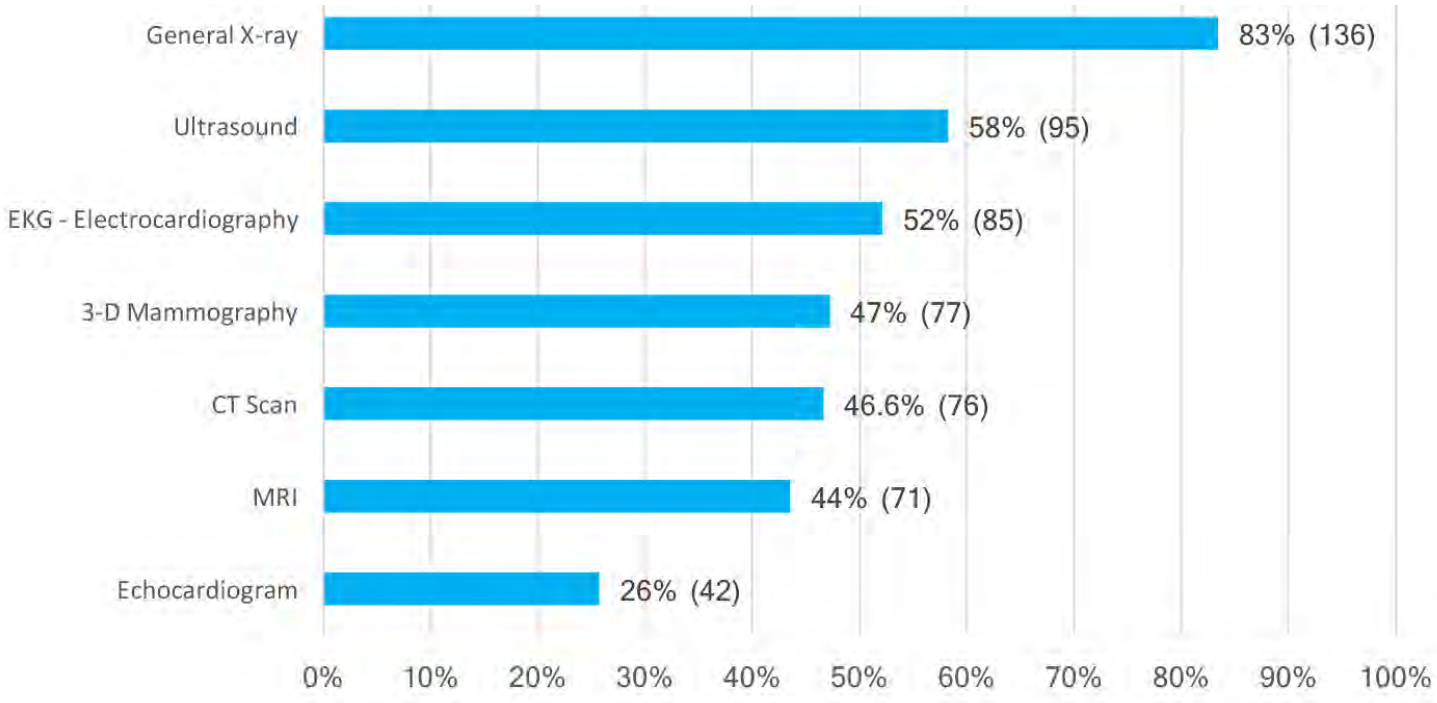


Figure 40: Awareness and Utilization of TELEMEDICINE SERVICES
Total responses = 160

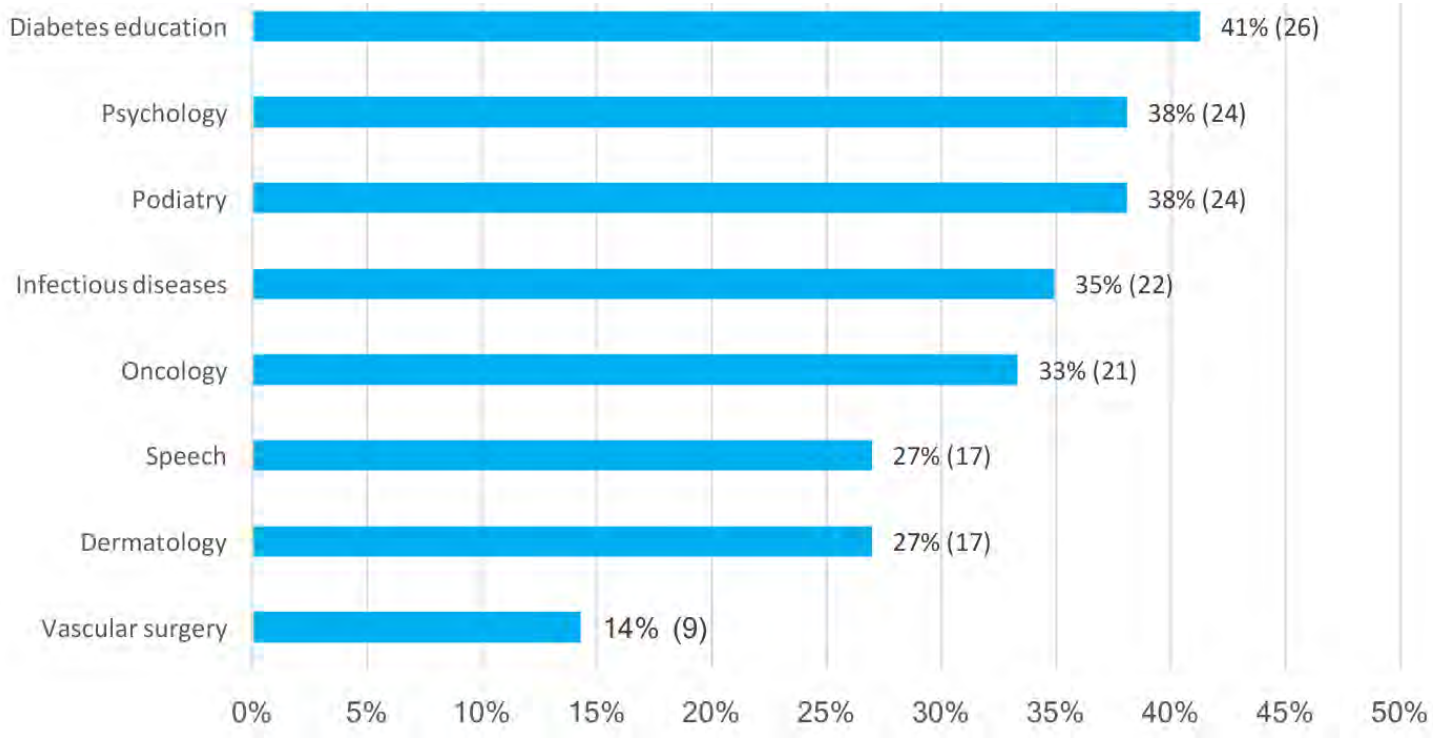


Figure 41: Awareness and Utilization of OTHER PROVIDERS/ORAGNIZATIONS
Total responses = 428

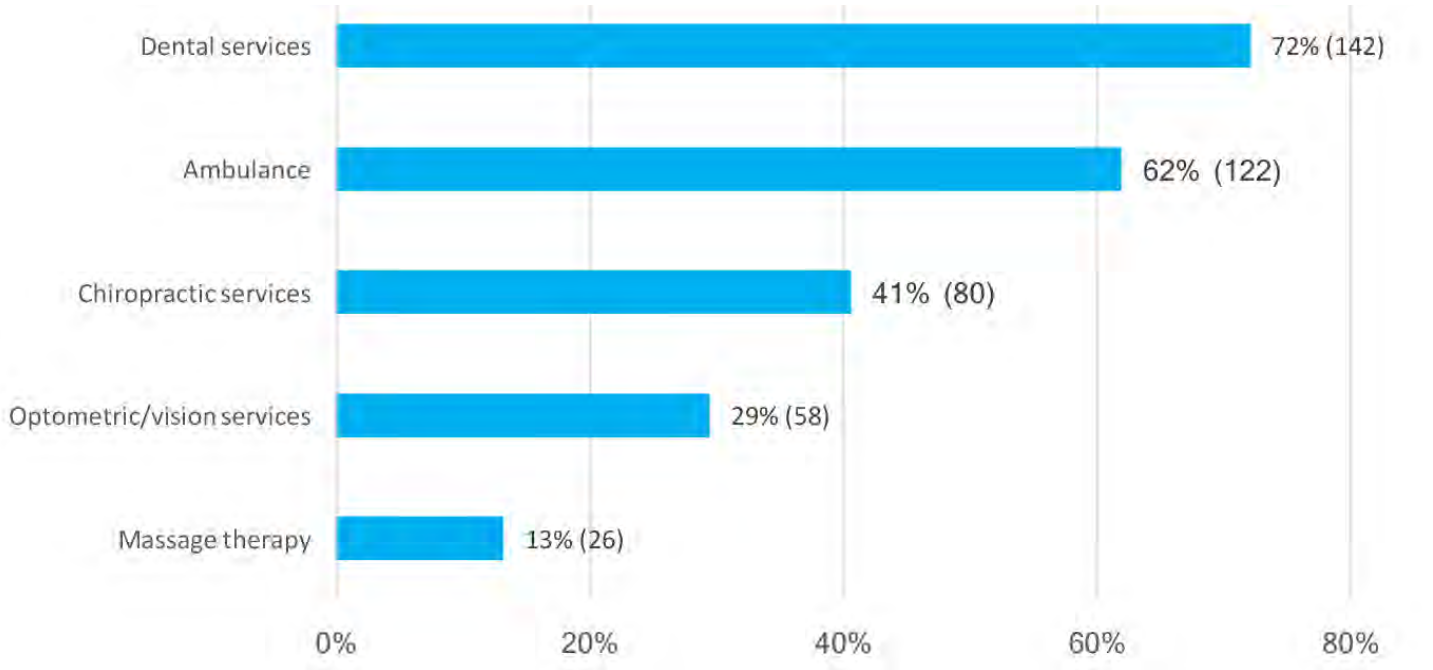
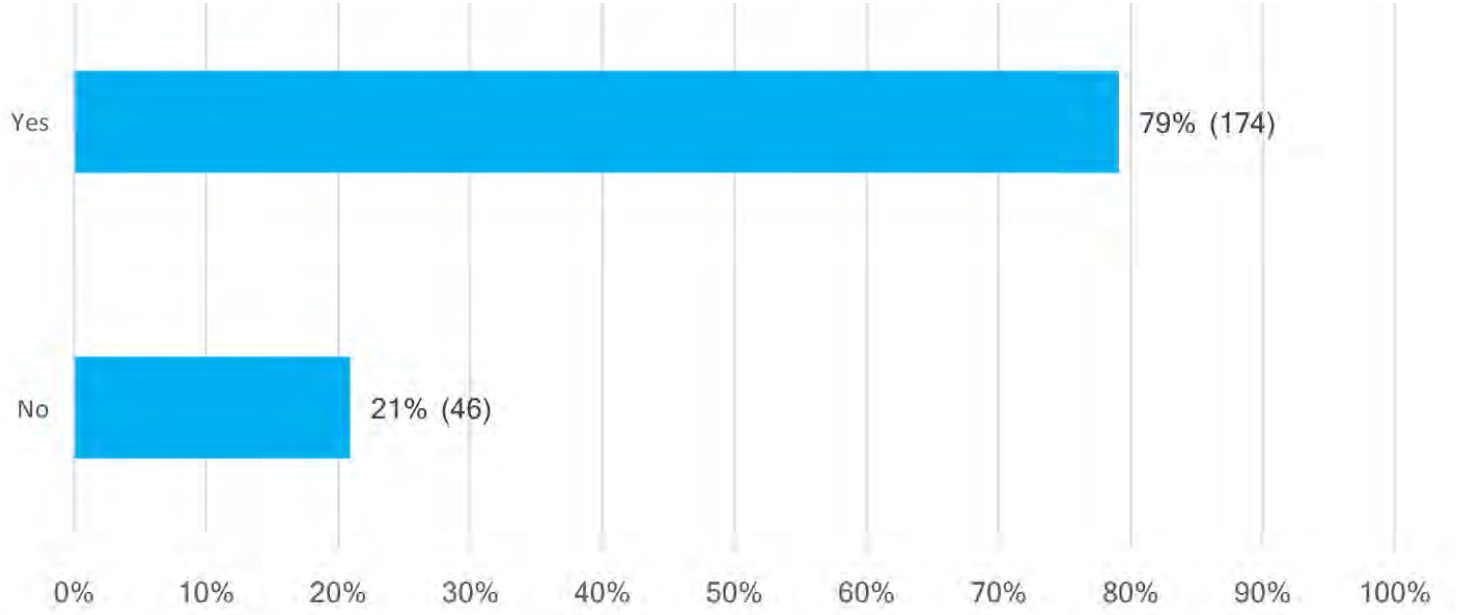


Figure 41 shows the results from asking if respondents would recommend services offered by PMC to family and friends. Over three quarters said that they would recommend PMC services.

Figure 42: Recommendation of PMC Services
Total responses = 220



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

- Cardiology
- Chemotherapy
- Chiropractic services
- Dental services
- Dermatology
- Diabetes education
- Drug/alcohol addiction services
- ENT
- Mental health
- OB/GYN services
- Occupational therapy
- Orthodontist
- Orthopedics
- Pain management
- Pediatrics
- Transportation services

While not a service, many respondents indicated that they would like physicians and specialists added. Some comments mentioned expanding the hospital or adding a clinic, and others requested more collaboration between local healthcare facilities.

The final question on the survey asked respondents to share concerns and suggestions to improve the delivery of local healthcare. A common theme among these comments emerged regarding concerns over a shortage of medical doctors. Community members noted that the quality providers they have had in the past are not employed with PMC long enough to build a strong rapport with their patients, and they feel uncomfortable with what they perceive as a lack of consistency. Rivaling the mentions for additional doctors were the requests for specialists. Although optometry services was most frequently cited, responses calling for additional specialty fields in general were common. Currently, due to the distance to access some specialists, transportation is also an issue that was brought up.

Due to the aforementioned inconsistency in providers, respondents stated concerns over being able to keep the hospital running in the community, with worries over losing the emergency room being specifically mentioned. There were also comments voicing frustration with PMC's management, which some members think is out of touch with the community, linking it with quality concerns—which was also mentioned several times—and worries over keeping the hospital operating. There is a feeling that this is also a reason for providers leaving the area.

Collaboration with other healthcare facilities in the area was also a top priority in the suggestions. Respondents pointed out that they would benefit from being able to utilize lab and x-ray services if ordered from providers outside of PMC, but feel that the relationship between the entities is not strong enough to allow for such shared services. Respondents would like to see these facilities work together better for the welfare of the patients.

Several comments expressed their satisfaction with PMC and the services offered, particularly for the size of the community.

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
- Alcohol use and abuse – adults and youth
- Crime and safety, adequate law enforcement personnel
- Drug use and abuse – adults and youth
- Poverty

To provide context for the identified needs, 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

- There is a lack of quality doctors, especially when you want to build a relationship to feel comfortable.
- We have had a large rate of turnover with our providers, which makes it difficult to want to receive care.

Alcohol use and abuse

- There are a lot of kids drinking at a young age and adults who take it way too far.
- I think too many people are turning to alcohol to solve their problems, which causes a lot of issues within their families and the community.

Crime and safety, adequate law enforcement personnel

- Crime has increased significantly, people have been talking about it a lot. Usually related to the opioid and drug use.
- Crime, specifically theft, has left a lot of destruction in the area, and it is usually linked to drugs.

Drug use and abuse

- Meth and heroin is being brought in from other states and affecting our community.
- Drug use is a problem, with people trying to get ahold of them.

Poverty

- We live in a location with a lot of individual dependencies on government funding.
- There aren't a lot of jobs with decent pay, so there are a lot of lower-income families in the area.

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:

- Public Health (4.5)
- Emergency services, including ambulance and fire (4.25)
- Hospital (healthcare system) (4.0)
- Schools (4.0)
- Business and industry (3.5)
- Pharmacy (3.5)
- Faith-based (3.5)
- Long-term care, including nursing homes and assisted living (3.5)
- Law enforcement (3.5)
- Economic development organizations (3.25)
- Other local health providers, such as dentists and chiropractors (3.25)
- Social Services (3.25)
- Human services agencies (3.25)
- Indian Health Services (3.0)
- Tribal Health (3.0)
- Clinics not affiliated with the main health system (2.5)

Priority of Health Needs

A community group met on May 29, 2019, with 11 community members attended the meeting. Representatives from the CRH presented the group with a summary of this report's findings, including background and explanation about the secondary data, highlights from the survey results (including perceived community assets and concerns, and barriers to care), and findings from the key informant interviews.

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

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

- Ability to retain primary care providers (MD, DO, NO, PA) (7 votes)
- Drug use and abuse – youth (6 votes)
- Obesity – adults (6 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 retain primary care providers (MD, DO, NP, PA) (4 votes)
2. Drug use and abuse (including prescription drugs) – youth (4 votes)
3. Obesity – adults (3 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 is found in Appendix D.

Comparison of Needs Identified Previously

Top Needs Identified 2016 CHNA Process	Top Needs Identified 2019 CHNA Process
• Availability of resources for family, friends caring for elderly • Help elderly stay in their homes • Not enough jobs with livable wages • Ability to retain doctors and nurses in the community • Youth drug use and abuse (including prescription drugs) • Diabetes	• Ability to retain primary care providers (MD, DO, NP, PA) • Youth drug use and abuse (including prescription drugs) • Adult obesity

The current process found two needs that coincide with the 2016 results: youth drug use and abuse and the ability to retain providers. However, obesity is often associated with type 2 diabetes, showing a link with that need as well.

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

In response to the needs identified in the 2016 CHNA process, the following actions were taken:

*Need 1:*The ability to recruit and retain doctors and nurses in the community – One of the main concerns from the community needs assessment was the limited number of primary healthcare providers in Rolette County. While this is a concern of most of the rural counties in North Dakota, Presentation Medical Center (PMC) is keenly aware of the importance of continual recruitment and the value of retaining medical staff. In September of 2016, the medical staff consisted of two physicians and three family nurse practitioners. PMC also hired a new graduate physician assistant, who joined the staff on January, 2017. Recruiting for medical staff is a high priority at the facility, along with continuing the discovery to find solutions and options for the retention of staff. The most important aspect to hiring any new healthcare providers is to have them live and become part of the Rolla community. In 2017, PMC developed a formal healthcare provider retention plan to focus on the importance of retaining qualified providers. In addition to adding another physician, a medical provider recruitment/retention plan has been developed and implemented. The plan has been successful in helping PMC recruit new providers, and has identified changes in certain operations, which provide greater satisfaction and healthcare delivery to the Rolette population.

Need 2: High Rates of Diabetes – The high rate of diabetes is a medical issue that the 2016 Community Health Needs Assessment revealed. The same issue was also identified as high priority in 2013. PMC has committed to providing a nurse educator to host weekly diabetes education for the general public of the area. PMC works closely with Rolette County Public Health District (RCPHD) on public education information that has a focus on diabetes prevention and obesity, as well as support group activities. A diabetes control section has been implemented to PMC's quality dashboards to monitor diabetic patients and improve control of the disease process, and reports quarterly to the Central Quality Improvement/Peer Review Committee. In November 2016, a grant was written to facilitate and receive funding to implement a population health strategy that would screen 500 additional Rolette County residents for hypertension, refer individuals for further medical evaluation, and provide health education regarding disease processes and modifiable risk factors. PMC will continue to offer an Outreach Specialty Podiatrist for foot care and will continue to provide additional information to patients. This task will be ongoing with collaboration from Rolette County Public Health.

Need 3: Alcohol/Drug Use and Abuse – Alcohol/drug use and abuse were listed high on the PMC health concerns, as well as on the 2015 Rolette County Public Health Needs Assessment. The survey indictates that attention must be focused at this continued health issue in our area. In 2016, RCPHD started an education and awareness program that PMC actively participates and collaborates in awareness events and presentations to the community. In 2017, PMC increased screening and education through clinic and mental health providers. PMC, with assistance from RCPHD, also provides education materials, when appropriate, at community events and the yearly community health fair. In 2018, PMC, in collaboration with Rolette County Public Health and the Rural Mental Health Consortium, sponsored two community forums entitled "the Opioid Epidemic," whereby community members were shown a video on the opioid epidemic and allowed to participate in a discussion with a panel of North Dakota experts on opioid abuse and addiction. PMC continues to work with RCPHD to jointly and strategically address alcohol/drug abuse in the community. As such, the CEO of PMC is a member of the Rolette County Public Health Coalition.

The above implementation plan for PMC is posted on their website at https://pmc-rolla.com/forms-documents.html.

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

Presentation Medical Center
SMP Health System

Public Health
Rolette County Public Health District

Rolette County Health Survey

Presentation Medical Center and Rolette County Public Health District are interested in hearing from you about community health concerns.

The focus of this effort is to:

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

If you prefer, you may take the survey online at https://tinyurl.com/RollaND19 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 April 22, 2019. 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) _____

5. Considering the **GEOGRAPHIC SETTING** of your community, the best things are (choose up to THREE):

- ☐ Cleanliness of area (e.g., fresh air, lack of pollution and litter)
- ☐ Climate and seasons
- ☐ General beauty of environment and/or scenery
- ☐ General proximity to work and activities (e.g., short commute, convenient access)
- ☐ Natural setting: outdoors and nature
- ☐ Relatively small size and scale of community I live in
- ☐ Waterfront, rivers, lakes and/or beaches
- ☐ Other (please specify)_____

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

6. 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
- ☐ Fear of crime against me or my property
- ☐ 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) _____

7. 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) _____

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

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

10. 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) _____

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

_____

_____

Delivery of Healthcare

12. 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) _____

13. 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, etc.)
- ☐ Social Media
- ☐ Radio Public Service Announcements/Advertising
- ☐ Word of mouth, from others (friends, neighbors, co-workers, etc.)
- ☐ Other (please specify) _____

14. Where do you find out what health services are available in your area? (Choose ALL that apply)

- ☐ From public health professionals
- ☐ Indian Health Service
- ☐ Newspaper
- ☐ Radio
- ☐ Word of mouth (friends, neighbors, co-workers)
- ☐ From hospital/clinic health care professionals
- ☐ Social media
- ☐ Tribal Health
- ☐ Web searches
- ☐ Employer/worksite wellness
- ☐ Other (please specify)_____

15. How long does it take you to reach the **clinic** you usually go to?

- ☐ Less than 10 minutes
- ☐ 11-30 minutes
- ☐ 31-60 minutes
- ☐ Over 1 hour

16. How long does it take you to reach the **hospital** you usually go to?

- ☐ Less than 10 minutes
- ☐ 11-30 minutes
- ☐ 31-60 minutes
- ☐ Over 1 hour

17. Please tell us why you seek health care services **close to home.** (Choose ALL that apply)

- ☐ Access to specialist
- ☐ Confidentiality
- ☐ Convenience
- ☐ Disability access
- ☐ Eligible for care from IHS
- ☐ Familiar with providers
- ☐ High quality of care
- ☐ Less costly
- ☐ Location is nearby
- ☐ Loyalty to local care providers
- ☐ Open at convenient times
- ☐ They take my insurance
- ☐ They take new patients
- ☐ Transportation is readily available
- ☐ Other (please specify)_____

18. Please tell us why you go **out of the area** for health care needs. (Choose ALL that apply)

- ☐ Access to specialist
- ☐ Confidentiality
- ☐ Convenience
- ☐ Disability access
- ☐ Familiar with providers
- ☐ High quality of care
- ☐ Less costly
- ☐ Eligible for contract health services under IHS
- ☐ Eligible for care from IHS
- ☐ Loyalty to local service providers
- ☐ Not eligible for care from IHS
- ☐ Open at convenient times
- ☐ Proximity
- ☐ Referral
- ☐ They take my insurance
- ☐ They take new patients
- ☐ Transportation is readily available
- ☐ Other (please specify)_____

19. Do you support an increase tax on tobacco products sold in North Dakota to be used to address prevention health programs such as tobacco prevention, opioid abuse prevention, and alcohol abuse prevention?

☐ Yes ☐ No

20. Do you support increasing the legal age to purchase tobacco products in North Dakota from 18 years of age to 21 years of age?

☐ Yes ☐ No

21. Do you support maintaining the North Dakota Smoke Free Law?

☐ Yes ☐ No

22. Are you aware of Medicaid Expansion? Health insurance available to persons who have an income 138% above the federal poverty line.

☐ Yes ☐ No

23. Have you or your family experienced food insecurity; that is, not knowing where your next meal is coming from or involuntarily eaten less than you need on a regular basis for a period of time?

☐ Yes ☐ No

24. Where do you receive the majority of your medical care?

- ☐ Presentation Medical Center
- ☐ Towner County Medical Center
- ☐ Turtle Mountain Medical Center-Dunseith
- ☐ Altru Clinic-Devils Lake
- ☐ Minot
- ☐ Indian Health Service
- ☐ Heart of America Rugby or Dunseith
- ☐ Northland Community Health Center-Rolla/Rolette
- ☐ Grand Forks
- ☐ Other_____

25. In the past year, have you or a family member had any interaction with Presentation Medical Center or Presentation Clinic?

☐ Yes ☐ No

If you answered "Yes" to the above question: Please rate your perception and quality of care you received at Presentation Medical Center or Presentation Clinic.

1 being Less than Adequate up to 5 being Excellent.

	Less than adequate				Excellent
	1	2	3	4	5
The care that was received at Presentation Medical Center/Presentation Clinic was:					
I was treated with compassion and respect by Presentation Medical Center/Presentation Clinic staff.					

26. In the past year, have you or a family member had any interaction with Rolette County Public Health District?

☐ Yes ☐ No

If you answered "Yes" to the above question: Please rate your perception and quality of care you received at Rolette Public Health District.

1 being Less than Adequate up to 5 being Excellent.

	Less than adequate				Excellent
	1	2	3	4	5
The care that was received at Rolette County Public Health District was:					
I was treated with compassion and respect by Rolette County Public Health staff.					

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

☐ Anesthesia services
☐ Mental health services
☐ Surgical services
☐ Clinic
☐ OB/GYN (visiting specialist)
☐ Swing bed and respite services
☐ Emergency room
☐ Hospital (acute care)
☐ Telemedicine
☐ Podiatry (foot/ankle)(visiting specialist)

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

☐ Health screenings
☐ Social services
☐ Pulmonary rehabilitation
☐ Laboratory services
☐ Respiratory therapy
☐ Physical therapy
☐ Cardiac rehabilitation

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

☐ EKG-Electrocardiography
☐ General X-ray
☐ Ultrasound
☐ CT scan
☐ 3-D Mammography
☐ Echocardiogram
☐ MRI

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

☐ Dermatology
☐ Oncology
☐ Vascular surgery
☐ Podiatry
☐ Psychology
☐ Diabetes education
☐ Infectious diseases
☐ Speech

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

☐ Ambulance
☐ Dental services
☐ Optometric/vision services
☐ Chiropractic services
☐ Massage therapy

32. Would you recommend the services offered at **Presentation Medical Center** to your family and friends?

☐ Yes ☐ No

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

_____

_____

Demographic Information: Please tell us about yourself.

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

☐ Yes ☐ No

35. 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) _____

36. 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

37. Highest level of education:

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

38. Gender:

☐ Female ☐ Male ☐ Transgender

39. Employment status:

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

40. Your zip code: _____

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

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

42. 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

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

_____

_____

Thank you for assisting us with this important survey!

Appendix B – County Health Rankings Explained

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

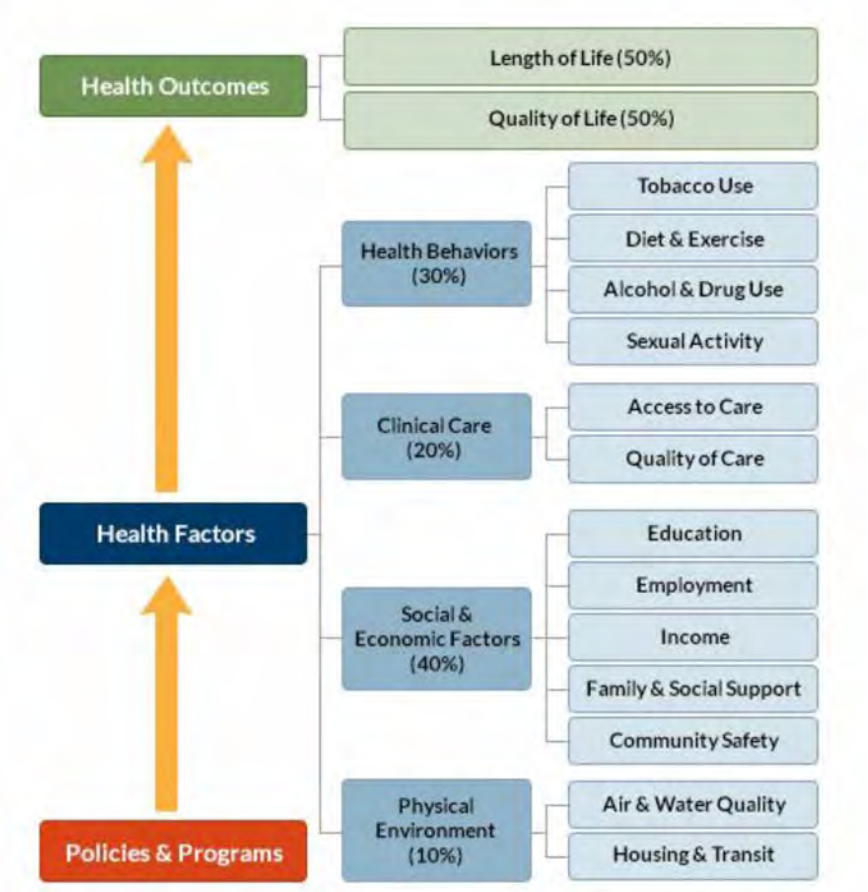
Methods

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

What is Ranked

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

Ranking System



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

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

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

Data Sources and Measures

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

Data Quality

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

Calculating Scores and Ranks

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

Health Outcomes and Factors

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

Health Outcomes

Premature Death (YPLL)

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

Reason for Ranking

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

Poor or Fair Health

Self-reported health status is a general measure of health-related quality of life (HRQoL) in a population. This measure is based on survey responses to the question: "In general, would you say that your health is excellent, very good, good, fair, or poor?" The value reported in the County Health Rankings is the percentage of adult respondents who rate their health "fair" or "poor." The measure is modeled and age-adjusted to the 2000 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 – Youth Behavioral Risk Survey Results

North Dakota High School Survey

*2017 YRBS North Dakota Data is not yet available, so the 2015 data was used.

Rate Increase ↑, rate decrease↓, or no statistical change = in rate.

	ND 2013	ND 2015*	ND Trend ↑, ↓, =	Rural ND Town Average	Urban ND Town Average	National Average 2017
Injury and Violence						
Percentage of students who rarely or never wore a seat belt.	11.6	8.5	↓	10.5	7.5	5.9
Percentage of students who rode in a vehicle with a driver who had been drinking alcohol (one or more times during the 30 prior to the survey)	21.9	17.7	↓	21.1	15.2	16.5
Percentage of students who talked on a cell phone while driving (on at least 1 day during the 30 days before the survey, among students who drove a car or other vehicle)	67.9	61.4	↓	60.7	58.8	NA
Percentage of students who texted or e-mailed while driving a car or other vehicle (on at least 1 day during the 30 days before the survey, among students who had driven a car or other vehicle during the 30 days before the survey)	59.3	57.6	=	56.7	54.4	39.2
Percentage of students who never or rarely wore a helmet (during the 12 months before the survey, among students who rode a motorcycle)	29.8	28.7	=	32.8	24.7	NA
Percentage of students who carried a weapon on school property (such as a gun, knife, or club on at least 1 day during the 30 days before the survey)	6.4	5.2	=	6.6	4.5	3.8
Percentage of students who were in a physical fight on school property (one or more times during the 12 months before the survey)	8.8	5.4	↓	6.9	6.1	8.5
Percentage of students who were ever physically forced to have sexual intercourse (when they did not want to)	7.7	6.3	=	6.5	7.4	7.4
Percentage of students who experienced physical dating violence (one or more times during the 12 months before the survey, including being hit, slammed into something, or injured with an object or weapon on purpose by someone they were dating or going out with among students who dated or went out with someone during the 12 months before the survey)	9.7	7.6	=	6.9	8.0	8.0
Percentage of students who have been the victim of teasing or name calling because someone thought they were gay, lesbian, or bisexual (during the 12 months before the survey)	9.6	9.7	=	10.4	9.7	NA
Percentage of students who were bullied on school property (during the 12 months before the survey)	25.4	24.0	=	27.5	22.4	19.0
Percentage of students who were electronically bullied (including being bullied through e-mail, chat rooms, instant messaging, websites, or texting during the 12 months before the survey)	17.1	15.9	=	17.7	15.8	14.9
Percentage of students who felt sad or hopeless (almost every day for 2 or more weeks in a row so that they stopped doing some usual activities during the 12 months before the survey)	25.4	27.2	=	24.9	28.9	31.5
Percentage of students who seriously considered attempting suicide (during the 12 months before the survey)	16.1	16.2	=	15.8	16.7	17.2
Percentage of students who made a plan about how they would attempt suicide (during the 12 months before the survey)	13.5	13.5	=	12.8	13.7	13.6
Percentage of students who attempted suicide (one or more times during the 12 months before the survey)	11.5	9.4	↓	10.3	11.3	7.4

	ND 2013	ND 2015*	ND Trend ↑, ↓, =	Rural ND Town Average	Urban ND Town Average	National Average 2017
Tobacco Use						
Percentage of students who ever tried cigarette smoking (even one or two puffs)	41.4	35.1	↓	37.3	32.5	28.9
Percentage of students who smoked a whole cigarette before age 13 years (for the first time)	7.9	7.2	=	7.3	6.7	9.5
Percentage of students who currently smoked cigarettes (on at least 1 day during the 30 days before the survey)	19.0	11.7	↓	13.2	11.8	8.8
Percentage of students who currently frequently smoked cigarettes (on 20 or more days during the 30 days before the survey)	6.6	4.3	↓	4.3	4.7	2.6
Percentage of students who currently smoked cigarettes daily (on all 30 days during the 30 days before the survey)	3.9	3.2	=	3.2	3.2	2.0
Percentage of students who usually obtained their own cigarettes by buying them in a store or gas station (during the 30 days before the survey among students who currently smoked cigarettes and who were aged <18 years)	7.8	16.9	↑	0.2	1.0	NA
Percentage of students who tried to quit smoking cigarettes (among students who currently smoked cigarettes during the 12 months before the survey)	55.5	47.4	=	49.1	52.7	NA
Percentage of students who currently use an electronic vapor product (e-cigarettes, vape e-cigars, e-pipes, vape pipes, vaping pens, e-hookahs, and hookah pens at least 1 day during the 30 days before the survey)	NA	22.3	↑	19.7	22.8	13.2
Percentage of students who currently used smokeless tobacco (chewing tobacco, snuff, or dip on at least 1 day during the 30 days before the survey)	13.8	10.6	↓	12.6	9.5	5.5
Percentage of students who currently smoked cigars (cigars, cigarillos, or little cigars on at least 1 day during the 30 days before the survey)	11.7	9.2	↓	9.7	9.7	8.0
Percentage of students who currently used cigarettes, cigars, or smokeless tobacco (on at least 1 day during the 30 days before the survey)	27.5	20.9	↓	22.9	19.8	14.0
Alcohol and Other Drug Use						
Percentage of students who ever drank alcohol (at least one drink of alcohol on at least 1 day during their life)	65.8	62.1	=	64.5	59.9	60.4
Percentage of students who drank alcohol before age 13 years (for the first time other than a few sips)	15.2	12.4	=	15.3	12.9	15.5
Percentage of students who currently drank alcohol (at least one drink of alcohol on at least 1 day during the 30 days before the survey)	35.3	30.8	↓	32.8	29.3	29.8
Percentage of students who drank five or more drinks of alcohol in a row (within a couple of hours on at least 1 day during the 30 days before the survey)	21.9	17.6	↓	19.8	17.0	13.5
Percentage of students who usually obtained the alcohol they drank by someone giving it to them (among students who currently drank alcohol)	37.0	41.3	=	41.1	40.4	43.5
Percentage of students who tried marijuana before age 13 years (for the first time)	5.6	6.3	=	5.8	5.8	6.8
Percentage of students who currently used marijuana (one or more times during the 30 days before the survey)	15.9	15.2	=	13.2	17.1	19.8
Percentage of students who ever took prescription drugs without a doctor's prescription (such as OxyContin, Percocet, Vicodin, codeine, Adderall, Ritalin, or Xanax, one or more times during their life)	17.6	14.5	↓	13.2	16.0	14.0
Percentage of students who were offered, sold, or given an illegal drug on school property (during the 12 months before the survey)	14.1	18.2	↑	15.9	19.9	19.8

	ND 2013	ND 2015*	ND Trend ↑, ↓, =	Rural ND Town Average	Urban ND Town Average	National Average 2017
Percentage of students who attended school under the influence of alcohol or other drugs (on at least one day during the 30 days before the survey)	9.9	8.6	=	7.9	9.0	NA
Sexual Behaviors						
Percentage of students who ever had sexual intercourse	44.9	38.9	↓	39.3	39.1	39.5
Percentage of students who had sexual intercourse before age 13 years (for the first time)	3.8	2.6	=	3.3	3.3	3.4
Weight Management and Dietary Behaviors						
Percentage of students who were overweight (>= 85th percentile but <95th percentile for body mass index, based on sex and age-specific reference data from the 2000 CDC growth chart)	15.1	14.7	=	15.4	14.6	15.6
Percentage of students who were obese (>= 95th percentile for body mass index, based on sex- and age-specific reference data from the 2000 CDC growth chart)	13.5	14.0	=	16.3	12.9	14.8
Percentage of students who described themselves as slightly or very overweight	32.0	32.2	=	34.2	31.5	31.5
Percentage of students who were trying to lose weight	45.4	44.7	=	45.0	43.0	47.1
Percentage of students who did not eat fruit or drink 100% fruit juices (during the 7 days before the survey)	3.4	3.9	=	4.3	4.1	5.6
Percentage of students who ate fruit or drank 100% fruit juices one or more times per day (during the 7 days before the survey)	64.7	62.5	=	8.5	8.8	60.8
Percentage of students who did not eat vegetables (green salad, potatoes [excluding French fries, fried potatoes, or potato chips], carrots, or other vegetables, during the 7 days before the survey)	6.0	4.7	=	4.5	5.2	7.2
Percentage of students who ate vegetables one or more times per day (green salad, potatoes [excluding French fries, fried potatoes, or potato chips], carrots, or other vegetables, during the 7 days before the survey)	62.8	58.5	↓	61.2	60.0	59.4
Percentage of students who did not drink a can, bottle, or glass of soda or pop (not including diet soda or diet pop, during the 7 days before the survey)	25.3	25.6	=	23.5	21.7	27.8
Percentage of students who drank a can, bottle, or glass of soda or pop one or more times per day (not including diet soda or diet pop, during the 7 days before the survey)	23.4	18.7	=	21.4	18.0	18.7
Percentage of students who did not drink milk (during the 7 days before the survey)	11.1	13.9	↑	11.6	13.7	26.7
Percentage of students who drank two or more glasses per day of milk (during the 7 days before the survey)	42.4	35.8	↓	36.6	35.3	17.5
Percentage of students who did not eat breakfast (during the 7 days before the survey)	10.5	11.9	=	10.7	11.8	14.1
Percentage of students who most of the time or always went hungry because there was not enough food in their home (during the 30 days before the survey)	3.1	2.2	=	2.4	2.8	NA
Physical Activity						
Percentage of students who were physically active at least 60 minutes per day on 5 or more days (doing any kind of physical activity that increased their heart rate and made them breathe hard some of the time during the 7 days before the survey)	50.6	51.3	=	51.7	50.1	46.5
Percentage of students who watched television 3 or more hours per day (on an average school day)	21.0	18.9	=	20.7	18.2	20.7
Percentage of students who played video or computer games or used a computer 3 or more hours per day (for something that was not school work on an average school day)	34.4	38.6	↑	39.4	38.0	43.0

	ND 2013	ND 2015*	ND Trend ↑, ↓, =	Rural ND Town Average	Urban ND Town Average	National Average 2017
Other						
Percentage of students who had 8 or more hours of sleep (on an average school night)	30.0	29.5	=	34.5	28.7	25.4
Percentage of students who brushed their teeth on seven days (during the 7 days before the survey)	71.5	71.0	=	67.8	70.1	NA
Percentage of students who most of the time or always wear sunscreen (with an SPF of 15 or higher when they are outside for more than one hour on a sunny day)	11.2	12.5	=	10.3	12.8	NA
Percentage of students who used an indoor tanning device (such as a sunlamp, sunbed, or tanning booth [not including getting a spray-on tan] one or more times during the 12 months before the survey)	19.6	12.2	↓	13.3	12.8	NA

Appendix D – Prioritization of Community's Health Needs

Community Health Needs Assessment

Rolla, North Dakota

Ranking of Concerns

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

	Priorities	Most Important
COMMUNITY/ENVIRONMENTAL HEALTH CONCERNS		
Attracting & retaining young families	2	
Crime and safety	3	
Not enough jobs w/ livable wages	0	
Poverty	1	
AVAILABILITY/DELIVERY OF HEALTH SERVICES CONCERNS		
Ability to retain primary care providers (MD, DO, NP, PA)	7	4
Availability of mental health services	3	
Availability of vision services	3	
Cost of health insurance	0	
YOUTH POPULATION HEALTH CONCERNS		
Alcohol use and abuse	1	
Drug use and abuse (including prescription drugs)	6	4
Not enough activities for children and youth	0	
Smoking and tobacco use, second-hand smoke or vaping/juuling	3	
ADULT POPULATION HEALTH CONCERNS		
Alcohol use and abuse	2	
Depression/anxiety	0	
Drug use and abuse (including prescription drugs)	2	
Obesity	6	3
SENIOR POPULATION HEALTH CONCERNS		
Ability to meet the needs of the older population	0	
Availability of resources to help the elderly stay in their homes	2	
Cost of long-term/nursing home care	0	
Long-term/nursing home options	0	

Appendix E – Survey "Other" Responses

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

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

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

- Divided into race
- It's quiet
- None, people in our community need to get off their high horse and stop thinking they are so much better than everyone else in the community; there is a lot of immaturity in this community
- There is diversity; however, for Caucasians the reverse discrimination is extremely present; family connection is big as far as employment—being related counts, money matter; quiet for the most part and used to the area
- We still have reasonable numbers

2. Considering the SERVICES AND RESOURCES in your community, the best things are: "Other" responses:

- A car dealership
- EMS
- I think we lack in all of these areas
- We still have a few people

3. Considering the QUALITY OF LIFE in your community, the best things are: "Other" responses:

- Close to family
- Country living
- None of these

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

- Again we lack in all these areas
- Movie theater
- Nature
- Not many activities
- Outdoor opportunities
- Outdoor sportsman activities
- Outdoors
- Pool/golf course
- Rural area
- This is a potential growth area in this community
- Wish there were more outdoor activities

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

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

- Affordable healthy food
- Drug abuse
- Drug and alcohol abuse
- Have fitness facility, but it's too cold to access ½ of the year
- No hospital leadership
- Nothing for the youth to do
- PMC refusing to work with Northland

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

- Ability/willingness of healthcare providers to work together to coordinate patient care with alternative medicine provide
- Availability of quality providers
- Lack of optometrist
- No health leadership
- Nuns=nepotism
- PMC not working with Northland
- You'll never have quality care from a catholic hospital, they are failures because they refuse to hire qualified administrators
- Zero hospital leadership

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

- All of these options
- Bullying
- Not prepared for college

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

- All of these options
- Crime
- Only rich and poor

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

- Education for families who are caring for elderly to know what resources we have in our community to help them
- Elders raising grandchildren
- Lack of hospice
- Lack of public funding for senior providers to give service
- Wellness and self-care for the elderly

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

- Adequate law enforcement and healthcare
- A strong economic plan to maintain businesses and add jobs
- Addiction
- Alcohol and drug usage that relates to the increased crime and safety concerns

- Alcohol abuse
- Alcohol and drug abuse leads to an increase in crime and the neglect and abuse of children in the families
- Alcohol use and abuse among all ages
- Ambulance service has to come from a distance
- Availability of activities for youth and seniors to do
- Chronic disease and sever poverty
- Chronic disease in general, severe poverty and lack of progress in improvement of County Health Rankings
- Continuity of programs regardless of mental health, bariatric or anything – the funding isn't enough to do anything long term and the funding goes to whatever the "illness of the moment" is
- Coordination of health services between all agencies in our area to include outreach and networking together more with the community to accomplish missions
- Cost of living for senior population
- Costs of needed services and the limited tax base to pay for them; too many young persons on welfare not working
- Crime
- Crime and safety
- Crime – so much theft and property destruction. My assumption is most of the crime is linked to drugs. Hard to promote this community when you have to lock/alarm everything. And hard to send kids out to play when you don't know who might show up in your yard. Also hard for the community to want to create new businesses/recreation locations when you know you have to worry about recouping the cost of vandalism/robbery
- Crime/drugs
- Criminal activity without consequences
- Declining rural populations lead to shortages in many different area. There are simply not enough people left to meet the service needs of those who remain
- Drug abuse
- Drug abuse which I believe contributes to the high theft/crime rates
- Drug epidemic
- Education for our families to keep our elderly in respectful, independent as possible settings while maintaining our nursing homes to the highest standards for awesome care for our elderly
- Elderly abuse by family
- Family caregiver availability to assist to keep elders in their home
- Healthcare
- Healthcare leadership
- Hospital needs to work with surrounding clinics
- I feel that there are not enough financial services to help when our elders need to be placed in assisted living or nursing homes
- I feel the biggest challenge for our community and surrounding communities is the drug problem. The drug abuse is only getting worse whether it is prescribed or street drugs
- I feel the biggest challenge is seeing the younger generation going down the wrong path, not going to college, partying, drugs, alcohol, etc.
- If I receive my care at Northland I am not able to have my labs and x-rays or other tests performed at PMC. I am forced to drive 30+ miles for these things
- Illicit drug use
- Inadequate mental health and substance abuse counseling and rehabilitation, not enough resources to cover the extensive problem
- Increase in crime to include theft and illegal drug use
- Indifference
- Keeping good providers so healthcare is consistent

- Keeping our young people here
- Lack of activities for our younger children
- Lack of activity options (fitness, recreational activities) year round that could promote healthy lifestyles and offer options for the youth to avoid engaging in criminal or illicit behaviors
- Lack of healthcare leadership and leadership in general, nepotism, old boys network
- Lack of health leadership, we need a big hospital to set up a clinic here
- Lack of law enforcement due to financial state of the county and the city
- Lack of true faith which is reflected I immoral choices like infidelity, poor parenting, broken families, defensiveness rather than acceptance of one's faults/mistakes
- Long-term/nursing home care options
- Mental health/exercise and physical activity
- Money – both personal income and community support from county and state funding shortfalls
- No good clinics available
- No good educated people returning
- Not enough activities for anyone of any age
- Obtaining and retaining quality (not quantity) healthcare providers, especially MDs, NPs, PAs, and nurses
- Our senior citizens need more services than they receive. We have our retirement home, but our elders need to receive better care for their meals, transportation to and from the clinic for appointments, have a senior companion person go into the elderly's home to clean and wipe down their homes
- PMC and Northland not working together
- Police and law enforcement fire protection funding
- Political bullying
- Poor safety for people walking and speed of traffic in entire city. Who wants to walk or even ride bike with this fast traffic?
- Poverty
- Prejudice
- Probably the lack of health education related to drugs, alcohol, and tobacco for people of all ages
- Qualified caregivers
- Quality medical care
- Retention of adequate healthcare providers
- Retention of young families
- Single parent households and a lack of respect for authority
- The abuse of alcohol and drugs
- The high level of drug abuse and drug addicts that live in our community. The increased rate of crime caused by drug addicts who may be looking for money to buy more drugs. The fear this population causes other citizens.
- The lack of facilities that allow for physical activity and positive entertainment for all ages especially during the winter months
- The town is slowly getting smaller, less places to eat, less things to do, less jobs, more businesses closing
- Theft
- Too many drugs
- What is life all about – a person's world view is critical – theistic, non-theistic, pantheistic
- Youth
- Zero healthcare leadership, you can't run a hospital playing guitar, golfing and on Facebook six hours a day

Delivery of Healthcare

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

- Clinic hours and lack of providers, high turnover with providers
- Fragmented care, lack of primary care
- High deductible insurance
- Insurance is expensive
- More MDs needed
- Need all radiology services local
- No alternatives to the establishment
- No local eye doctor

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

- Doctor from previous location
- Journals
- Newspaper
- Out-of-area providers
- Out-of-town doctors
- Towner County Medical

14. Where do you find out what health services are available in your area? "Other" responses:

- Sandwich board

17. Please tell us why you seek healthcare services close to home. "Other" responses:

- Copays are paid and then go elsewhere
- Don't
- Emergency needs
- I don't go to healthcare services close to home, one-hour drive
- I don't go to Rolla
- I don't waste my time in Rolla
- I use Altru for my healthcare needs
- My specialist comes closer to me, stationed in Grand Forks, one comes to Devils Lake and one comes to Cando
- Only for basic care needs
- There are no healthcare service options close to home; I am not able to seek healthcare services close to home
- We do not seek healthcare in this area
- We don't doctor around here
- We go out of town, unless it is an emergency

18. Please tell us why you go out of the area for healthcare needs. "Other" responses:

- Cancer treatment
- History with patient
- I trust them

- I'd rather not have medical relationships w/ people I interact with outside of that setting – I like the separation
- No providers locally, when we get a new doctor they leave for some reason. I really hope we can continue with our excellent emergency room doctors and nurses
- OB/GYN
- Provide services not available here
- There are not any healthcare options within my area; the only available options are out of the area
- They don't have the same administration
- They know what they're doing
- Trust providers

24. Where do you receive the majority of your medical care? "Other" responses:

- Avoid healthcare especially PMC
- Bismarck
- CHI Devils Lake
- Fargo
- Minneapolis
- Turtle Mountain Family Medicine
- VA

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

- A fitness and wellness center
- A major clinic, such as Sanford, Altru, etc.
- A new clinic but only if operated by a large hospital so you get things done right
- A real clinic with physicians. Try not running good providers out of town to better working environments
- A Sanford clinic
- Additional mental health counseling services
- An eye clinic other than just IHS
- Anything dealing with the heart
- Better dental, possibly dialysis
- Birthing children in Rolla
- Birthing doctors
- Cancer treatment services and telemed services with cancer specialists
- Cardiologist, pulmonologist, and endocrinology
- Chemo services locally, OB/GYN services
- Chiropractic services
- Dental
- Dermatologist
- Diabetes education, substance abuse peer support, MAT, increased access to mental health services
- Drug and alcohol rehab, mental health, pain clinic, access to medical marijuana, diabetic clinic
- Drug/alcohol addiction – detox unit
- ENT/family medicine
- Eye and hearing services
- Eye care
- Eye doctor

- Get an administrator that doesn't spend all his time at the golf course or on Facebook
- Get rid of PMC, replace with a real hospital
- I would like Presentation to be able to communicate with other facilities online through "My Chart"
- In-house chiropractic and massage
- It would be nice to have a full-time dermatologist
- Massage therapy
- Mental health
- More doctors instead of Pas or NPs
- More elder care
- More mental health services are needed
- More specialists are needed n the area
- Not compatible with my insurance
- Occupational therapy
- Options to get all radiology procedures at PMC from all healthcare facilities
- Optometrist
- Optometry
- Orthodontist, vision, neurologist, more dental and more psych/counseling services from out of the community
- Pain management, mental health for adolescents (behavior therapy)
- Pediatrics
- Primary care—it is hard to have a primary care doctor when they change so frequently
- Rolla is not too far from me, but neither is it "local." The services mentioned in the preceding few questions seem like a good starting point
- Sanford
- Specialty clinics
- Transportation to go see specialists
- Treatment for alcohol and other drug use
- Vision and ENT specialists
- We need a big hospital to set up a clinic

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

- Access to cancer treatment and survivor services locally
- After hour care instead of emergency would be nice. Having clinics stay open until later in the evenings/weekends
- Availability of local options is my primary concern
- Better billing, itemized. Don't charge more for people with insurance as it deters those from seeking care, more transportation to specialists
- Bring in a wider variety of specialists more often
- Bring Sanford Health here, even a smaller, remote office would help
- Coding/billing access to devices like nebulizer machines to rent/buy from ER
- Collaboration among entities
- Consistent medical providers, collaboration for lab/x-ray services with other medical facilities within Rolla and Rolette specifically
- Difficulties I face as a practicing provider is follow up with patients – either they do not have a reliable phone or address or don't have reliable transportation services to get to appointments either in or out of town
- Education regarding in-utero/sperm contamination while using drugs. We have a drug-baby epidemic! Also education on nutrition is vital, as that can steer people's attitudes, personalities, mental health and motivation to be productive

- Extended clinic hours
- Facility working with one another
- For a small community the area health units offer a lot of services; an optometrist in town would be nice
- Give nurses better pay
- Healthcare services need to work together, there needs to be communication, coordination and planning between all entities
- I believe that PMC provides excellent healthcare. That administration is doing a fantastic job. Furthermore, they appear to have an exceptional grasp on what the community needs and conforming PMC to meet those new needs as they arise
- I believe there needs to be more qualified medical staff. Doctors who can build a report within the people in our community so we are comfortable receiving care from these providers.
- I don't know which services I would be eligible for through Medicaid at Presentation. I go to IHS because I know it's covered as far as cost, but it is very difficult to get in to see the doctor there.
- I think Northland and PMC need to work more closely together. I feel that I and others would benefit from being able to utilize lab and x-ray services at PMC if ordered by my doctor and Northland. Furthermore, why does PMC not want that added revenue from us outside patients? Do they turn away orders from Bottineau, Rugby or Cando as well? I feel like this would be setting up the hospital for financial hardship. Rolette Public Health is top notch and absolutely fantastic to work with for getting my kids immunized and I appreciate their reminders by text!
- I wasn't able to un-check my recommendation regarding Presentation medical Center. I don't have an opinion either way as we doctor at HOA in Rugby
- I worry that we will lose our hospital for lack of consistent providers. There are problems somewhere in the system and I think it starts in the Fargo office and trickles down to the local level. The Presentation sisters do not have a clue what is going on. They are so out of touch with the real business world. I really hope another hospital would purchase PMC and put it back on the map as a functional hospital. We have the population to support it. I really worry that we will lose our emergency room if circumstances don't change.
- It would be nice and a little more convenient to have an eye clinic in Rolla that accepted Medicaid. Also would be nice if we did have a pediatrician in the clinic for the children. But other than all of that I think we have a very awesome hospital and some of the best care around!
- It would be nice to see more providers and accessibility to specialists. The area is in need of an optometrist.
- Lack of MDs
- Local healthcare would benefit from more specialties, even if done via telemedicine
- More access to specialists and providers
- More MDs needed to guide inexperienced FNP – I see too many exams that are not needed or ordered improperly
- More providers – specialty fields
- Need for real leadership, not a semi-pro golfer
- New administration, we don't need a social media golfer running our healthcare
- Obtain & retain qualified healthcare providers MDs and NPs
- PMC is a terribly managed facility, and the nuns have no use for the community, we need Sanford to come in and start a decent clinic
- PMC management has taken advantage of our community for far too long
- Presentation Medical center is ridiculously expensive for a clinic service and visit
- Real management not this good old boy crap, we need and deserve more than golf, guitars and Facebook
- Rolla hospital should work more with insurance
- Sanford
- The billing department at Presentation Medical Center needs customer service training. People dealing with medical bills should not be degraded or belittled no matter what the situation. The woman who works there was very rude until I called her mistreatment to her attention. She then apologized but how many people will do what I did? We are the customer and deserve to be treated respectfully

- The last survey for this I did came back and there was no comments so I assumed PMC got to view the data before publishing if it happens again these are a joke!
- This area is in need of additional mental health counseling services. Also, drug addiction counseling. Perhaps both could be offered at a reduced fee because oftentimes people seeding these services have limited funds
- Transportation to and from appointments
- Turnover in primary care providers
- We had good doctors at tone time in this area for many years but the general feeling from the community is that the providers at PMC now are less than adequate
- We have to travel too far to see specialists. If we could have more specialists come to our area or get more telemed service with cancer treatment doctors, it would save a lot of travel and work time lost. I don't understand why I can't get blood results with a face-to-face phone call or telemed call instead of driving four hours for these results
- We need to look at some type of fitness center and program for our community. The more physically active the better chances for better choices in many other health areas, mental, physical, diabetes, healthier choices concerning smoking etc. It also would help with recruitment of providers. Also, losing our eye doctor has forced people to go elsewhere for those services, if our dentist decides to retire that would leave another large "hole." Retaining doctors, Pas, etc. is essential so that community members feel they can support the hospital because they have the same provider they did the previous year. There are those who also believe that massage and chiropractic options are helpful with health, and many times PT services conflict with this belief, but the truth is people are going to use these options and the hospital is missing out. Also more options to Grand Forks specialists vs Minot. People know that Trinity is a terrible hospital and do not trust them, even if the specialists are qualified Trinity is just not a quality facility.