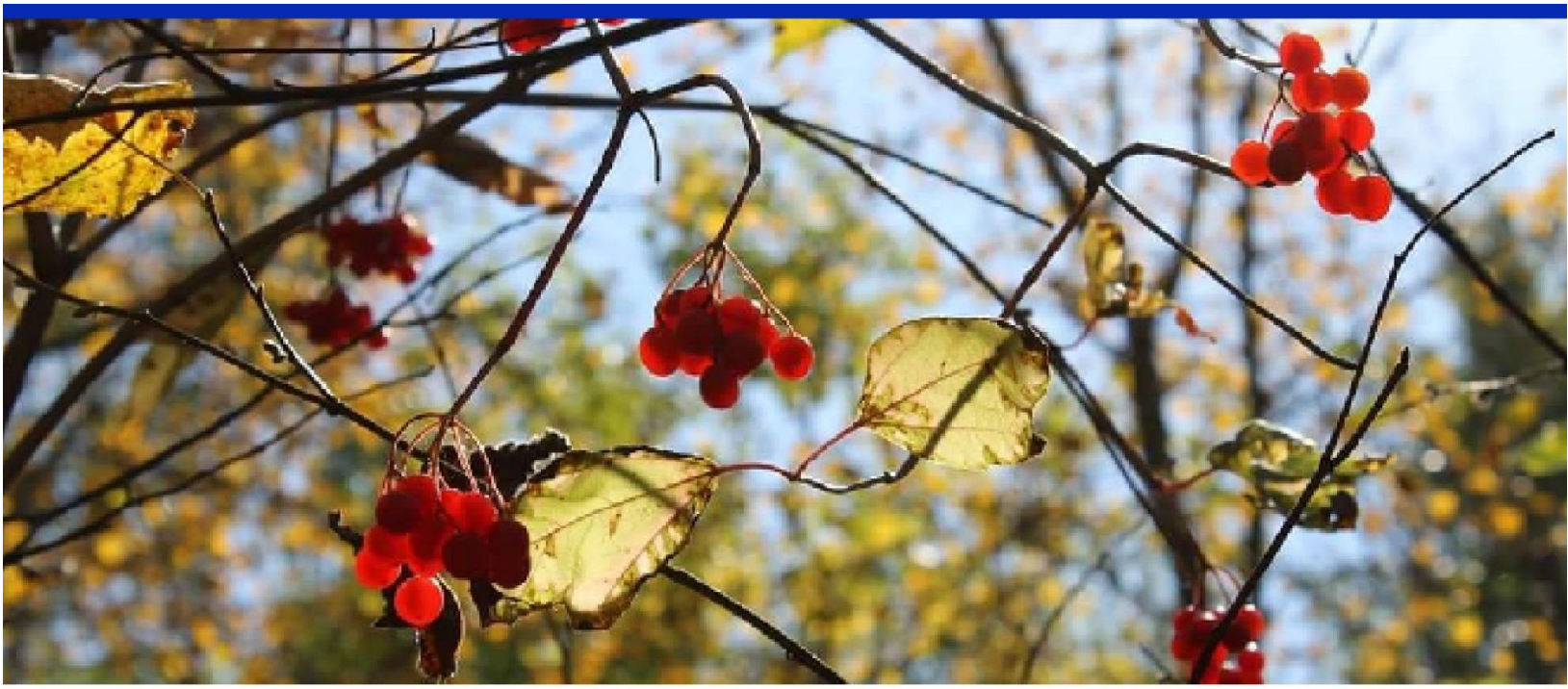

2017 Community Health Assessment

Hettinger Service Area

North Dakota

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WEST RIVER HEALTH SERVICES
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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, West River Health Services (WRHS) conducted a community health needs assessment (CHNA). The Center for Rural Health (CRH) at the University of North Dakota School of Medicine and Health Sciences facilitated the assessment process, which solicited input from area community members and healthcare professionals as well as analysis of community health-related data.

To gather feedback from the community, residents of the area were given the opportunity to participate in a survey. Two hundred ninety-eight WRHS service area residents completed the survey. Additional information was collected through six key informant interviews with community leaders. The input from the residents, who primarily reside in Adams 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, Adams County's population from 2010 to 2016 decreased 1.6%. The average of residents younger than 18 (19.3%) is four percentage points lower than the North Dakota average (22.3%). The percentage of residents ages 65 and older is considerably higher (25.0%) than the North Dakota average (14.5%). The median household income in Adams County ($52,118) is lower than the state average for North Dakota ($60,557).

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

- Poor or fair health;
- Poor physical health days;
- Poor mental health days;
- Adult smoking;
- Food environment index;
- Alcohol-impaired driving deaths;
- Uninsured;
- Primary care physicians;
- Children in poverty;
- Children in single-parent households;
- Violent crime;
- Air-pollution – particulate matter; and
- Drinking water violations.

Factors in which Adams County was performing poorly relative to the rest of the state include:

- Percentage with diabetes;
- Adult obesity;
- Physical inactivity;
- Teen birth rate;
- Number of preventable hospital stays;
- Diabetes screening;
- Number of dentists;
- Mammography screening;
- Unemployment;
- Number of mental health providers; and
- Access to exercise opportunities.

Of 82 potential community and health needs included in the survey, the 298 WRHS service area residents who completed the survey indicated the following eight needs as the most important:

- Attracting and retaining young families;
- Cancer;
- Cost of health insurance;
- Obesity/overweight;
- Jobs with livable wages;
- Cost of healthcare services;
- Adult alcohol use and abuse (including binge drinking); and
- Ability to recruit and retain primary care providers (doctor, nurse practitioner, physician assistant).

The survey also revealed the biggest barriers to receiving healthcare (as perceived by community members). They included concerns about confidentiality (N=79), not enough evening or weekend hours (N=72), and no insurance or limited insurance (N=71).

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

- Safe place to live, little/no crime;
- Healthcare;
- People are friendly, helpful, and supportive; and
- Family-friendly; good place to raise kids.

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:

- Changes in population size (increasing and decreasing);
- Youth hunger and poor nutrition;
- Attracting and retaining young families;
- Long-term care/nursing home/assisted living options;
- Availability of resources for family and friends caring for elders;
- Alcohol use and abuse (adult and youth); and
- Youth mental health.

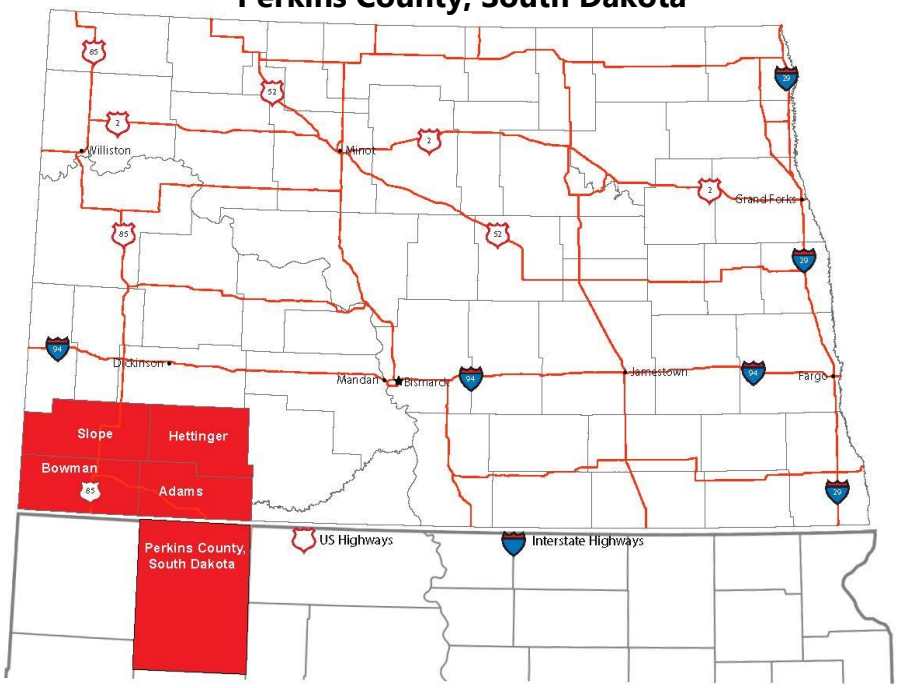
Overview and Community Resources

With assistance from the CRH at the University of North Dakota School of Medicine and Health Sciences, WRHS completed a CHNA of the WRHS service area. The hospital identifies its service area as the towns of Bowman, Bucyrus, Dickinson, Haynes, Hettinger, Mott, New England, and Reeder in North Dakota and Lemmon, South Dakota.

Hettinger is located along Highway 12 in southwest North Dakota, four miles from the South Dakota border and 60 miles from Montana. The city is located in Adams County in the heart of agriculture and ranch country. This area promotes a strong, family-oriented lifestyle with friendly, honest people who take great pride in their community and where many merchants call you by your first name and treat you like part of the family.

WRHS, through its hospital and clinic in Hettinger and clinics in Bowman, Dickinson, Mott, New England, and Scranton, North Dakota, and Lemmon, South Dakota, serves a large area in southwestern North Dakota and northwestern South Dakota. Figure 1 illustrates the location of the counties.

Figure 1: Adams, Bowman, Hettinger, Slope Counties, North Dakota, and Perkins County, South Dakota



West River Health Services

WRHS is located in Hettinger, North Dakota. It has become a nationally recognized model of the rural healthcare delivery system. It is a 17-physician and 10-advanced practice practitioner, multi-specialty group practice. It includes a Critical Access Hospital (CAH), five rural health clinics, a non-rural health clinic, an eye center, a wellness center, and an ambulance service providing professional services in a very rural/frontier region of the United States.

The corporate structure of the organization is comprised of three 501C3 (not-for-profit) corporations. WRHSF is the foundation/fundraising and parent corporation. WRHS is the healthcare services (hospital, six clinics, and other ambulatory healthcare services) corporation. Western Horizons Living Centers is the care center's (skilled and assisted living) corporation. Each corporation has board members from across the geographic area served

by the organization. It serves a geographic area of roughly 20,000 square miles and roughly the same number of people.
The hospital element of WRHS, West River Regional Medical Center (WRRMC) is a 25-bed, CAH with a Level IV Trauma Center designation. Through the years, WRRMC has received recognition for quality and innovation in service. In 2014, 2015, and 2017, the National Rural Health Association recognized WRRMC as one of the top 20 CAHs out of the 1,300 CAHs in the nation. The medical center has a fully integrated surgical center, birthing wing, and intensive care unit.

Every day, all nurses, doctors, and staff provide comprehensive health and wellness services to the residents and visitors of the region. WRHS and its partners in healthcare are dedicated to excellence in practice, innovation in service, compassion for the people they serve, and respect for one another. Providing access to quality medicine in a rural environment has been the vision and goal of this medical system since its inception.

The total financial impact of WRHS is $14.25 million. The primary financial impact of WRHS is $9.50 million with a secondary financial impact of $4.75 million.

Services offered locally by WRHS include:

Hospital

- Birthing wing/obstetrics unit
- General accute
- Intensive care unit (ICU)
- Medical surgical unit
- Newborn nursery
- Palliative care room
- Pediatric patient services
- Surgery center
- Swing bed unit
- Twenty-five bed CAH

Twenty-Four Hour Emergency Care

- Acute stroke ready hospital
- Ambulance services – land and/or air flight
- Certified staff in trauma care, cardiac life support, and pediatric life support
- Level IV trauma center
- Nurses - certified in advanced cardiac life support and trauma nursing

Medical Providers

- Family medicine
- Family medicine and obstetrics
- General surgery
- Geriatric medicine
- Internal medicine
- Optometric medicine
- Pediatric medicine
- Podiatric medicine
- Radiology/diagnostic medicine

Surgical Services

- Cesarean section
- Colonoscopy and endoscopy
- Gastroscopy
- General surgery – inpatient and outpatient
- Laparoscopic surgery
- Ophthalmology surgery
- Orthopedic surgery
- Pain management
- Podiatric surgery
- Outpatient infusion therapy

Radiology Services

- Bone density (DEXA)
- Computed tomography (CT)
- Digital x-ray imaging
- Fluoroscopy procedures
- Full field digital mammography
- Injection therapy
- Magnetic resonance imaging (MRI)
- Nuclear medicine imaging
- Ultrasound, including Echo and obstetric

Laboratory Services

- Automated chemistry
- Blood banking
- Clinical microscopy
- Coagulation
- Hematology
- Microbiology
- Special chemistry
- Pathology

Rehabilitation Services

- Athletic Training
- Balance and dizziness treatments
- Certified lymphedema therapists (lower and upper extremities)
- Occupational therapy
- Physical therapy

Other Services

- Behavioral health – counseling/therapy
- Cardiac rehab services
- Cardiac stress testing
- Ambulatory cardiac monitoring
- Diabetes education
- DOT physicals
- Health and wellness services
- Home medical services
- Infusion therapy
- Medical nutrition therapy
- Respiratory care
- Sleep studies
- Specialized care
- Visiting nurses

Visiting Specialists

- Clinical audiologist
- Interventional cardiologist
- Ophthalmologist
- Orthopedic surgeon
- Psychiatrist

Services Offered by Other Providers/Organizations

- ABLE – group home for developmentally disabled
- Chiropractic services
- Counseling
- Dance
- Dakota Prairie Helping Hands
- Dental services
- Fitness training
- Massage therapy
- Meals on Wheels
- Parks and recreation – swimming lessons, summer recreation, golf course
- Pharmacy
- Public health nurse
- Second 40 club
- Senior citizen center
- Specialized care/senior care
- Social services
- WIC is a program for pregnant and breastfeeding women, infants, and children

Southwest District Health Unit

North Dakota's public health system is decentralized, with 28 independent local public health units working in partnership with the North Dakota Department of Health. The 28 local public health units are organized into single or multi-county health districts, city/county health departments, or city/county health districts. Seventy-five percent of the local health units serve single county, city, or combined city/county jurisdictions, while the other 25 percent serve multi-county jurisdictions. The majority of the multi-county jurisdictions are in the western part of the state. In this decentralized approach, the units are required to meet state standards and follow state laws and regulations, but they can exercise their own powers and have administrative authority to make decisions to meet their local needs.

The local public health infrastructure has the capacity and expertise necessary to carry out services and programs needed in their jurisdictions. Therefore, the health units function differently from one another, and each offers its own unique array of services. Southwestern District Health Unit is based out of Dickinson, North Dakota.

Services Provided by Southwestern District Health Unit

- Alcohol prevention
- Behavioral health
- Blood pressure checks
- Breastfeeding resources
- Dental health
- Diabetes screening
- Emergency preparedness services - work with community partners as part of local emergency response team
- Environmental health services (water, sewer, health hazard abatement, inspections)
- Flu shots
- Health maintenance
- Health tracks (child health screening)
- Immunizations
- Medication setup - home visits
- Member of child protection team and county interagency team
- Newborn home visits
- Nutrition education
- Preschool education programs and screening
- School health - vision, health education and resource to the schools, school nursing support
- Tobacco prevention and control
- Tuberculosis testing and management
- West Nile program - surveillance and education
- WIC (Women, Infants, and Children) Program
- Worksite wellness

Assessment Process

The purpose of conducting a 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 facilitating 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 primarily in Adams County but includes the additional service-area counties of Hettinger, Slope, and Bowman counties in North Dakota and Perkins County in South Dakota. Located in these counties are the North Dakota communities of Hettinger, Dickinson, Reeder, Bucyrus, Haynes, Bowman, New England, and Mott as well as Lemmon in South Dakota.

The CRH, in partnership with WRHS, facilitated the CHNA process. Selected locally, a CHNA liaison served as the main point of contact between the CRH and WRHS. Administrators and other professionals from WRHS were involved in planning and implementing the process. Along with representatives from the CRH, they met regularly by telephone conference and via email. The community group, described in more detail below, provided in-depth information and informed the assessment in terms of community perceptions, community resources, community needs, and ideas for improving the health of the population and healthcare services. Representatives from WRHS were involved in planning the community group meetings. The community group was comprised of residents from outside the hospital, including representatives from local government, businesses, and social services.

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 and participated in a series of meetings that gathered input from the state's health officer, local public health unit professionals from around North Dakota, representatives of the CRH, 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 School of Medicine and Health Sciences, 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 14 community members was convened September 20, 2017. During the first meeting, group members were introduced to the needs assessment process, reviewed basic demographic information about the WRHS service area, and served as a focus group. Focus group topics included community assets and challenges, the general health needs of the community, concerns, and suggestions for improving the community's health.

The community group met again on November 29, 2017, with 15 participants in attendance. At the second meeting, the community group 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 Adams County was presented. The group was tasked with identifying and prioritizing the community's health needs. Not all members of the group were present at both meetings.

Interviews

Representatives from the CRH conducted one-on-one, in-person interviews with four key informants, as well as two phone interviews on September 20, 2017. Interviews were held with selected members, including individuals from a non-WRHS provider, area businesses, the school system, and agriculture.

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

Survey

A survey was distributed to solicit feedback from the community and was not intended to be a scientific or statistically valid sampling of the population. It was designed to be an additional tool for collecting qualitative data from the community at large – specifically,

information related to community-perceived health needs. A copy of the survey instrument is included in Appendix A.

The community member survey was distributed, electronically and paper copy, to a variety of residents of the WRHS service area, described in detail below.

The survey tool was designed to:

- Learn of the best 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 raise awareness of the assessment process and promote the importance of the process, press releases were distributed in the local newspaper. Notifications about the survey and the CHNA process were posted on the WRHS website and Facebook and were also included in local radio ads. The school sent surveys home with all of the students for their parents to complete, and surveys were distributed at the community health day.

One thousand paper surveys were available for distribution in the service area, at area businesses, in WRHS, at the public health units, and at the local churches. To ensure anonymity, a postage-paid return envelope to the CRH was provided with each survey. Online surveys were submitted directly to the CRH. The survey was available from September 15 through October 15, 2017.

The online version of the survey was publicized with the link or URL disseminated in all press releases. A total of 162 online surveys were completed. In total, paper and online, 298 community member surveys were completed. This equates to a response rate of 13% of Adams County, which is in line with the average for this type of survey methodology.

Secondary Data

Secondary data was collected and analyzed to provide descriptions of (1) population demographics, (2) general health issues (including any population groups with particular health issues), and (3) contributing causes of community health issues. Data was collected from a variety of sources, including the United States Census Bureau; Robert Wood Johnson Foundation's County Health Rankings, which pulls data from 20 primary data sources (www.countyhealthrankings.org); the National Survey of Children's Health, which touches on multiple intersecting aspects of children's lives (www.childhealthdata.org/learn/NSCH); 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

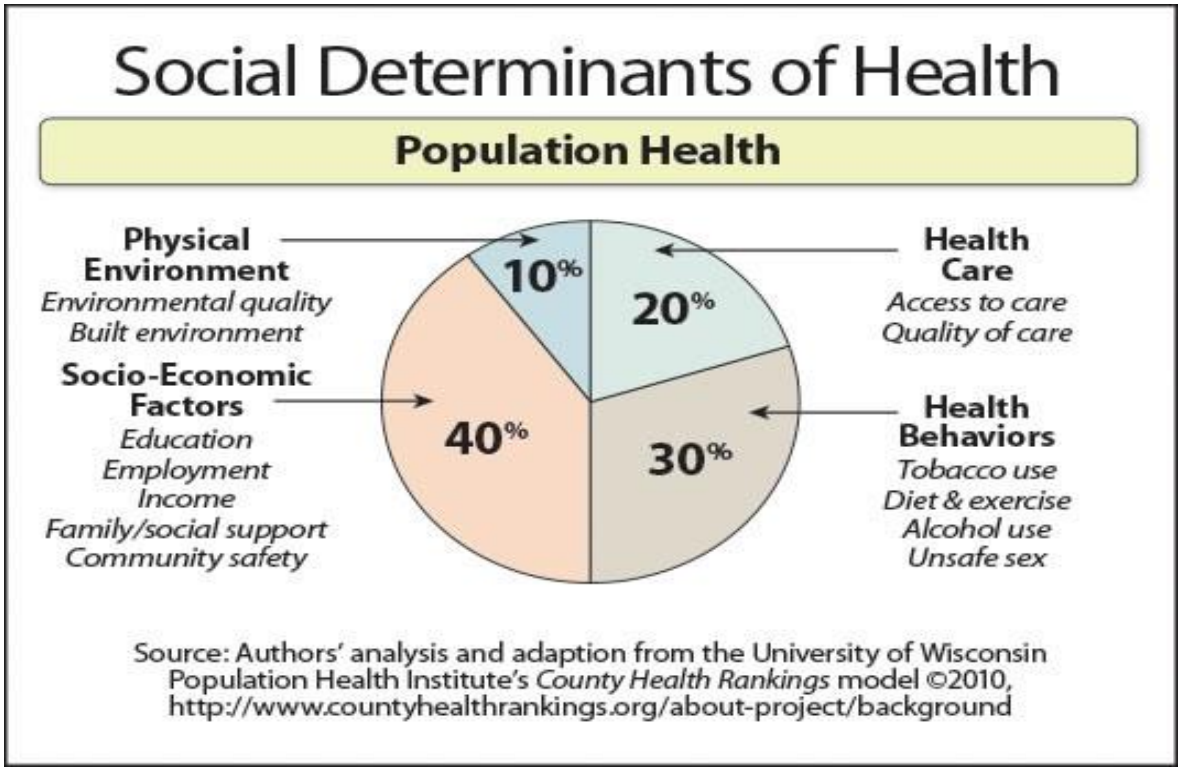
Social determinants of health are, according to the World Health Organization, *"the circumstances in which people are born, grow up, live, work, and age and the systems put in place to deal with illness. These circumstances are in turn shaped by wider set of forces: economics, social policies and politics."*

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

Figure 2 illustrates the small percentage (20%) that healthcare quality and services, while vitally important, play in the overall health of individuals and ultimately of a community. Physical environment, socio-economic factors, and health behaviors play a much larger part (70%) 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.

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 2: Social Determinants of Health



Demographic Information

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

TABLE 1: ADAMS COUNTY: INFORMATION AND DEMOGRAPHICS (From 2010 Census/2016 American Community Survey; more recent estimates used where available)		
	Adams County	**North Dakota**
Population, 2016 est.	**2,305**	**757,952**
Population change, 2010-2016	**-1.6%**	**12.7%**
Land area, square miles, 2010	**988**	**69,001**
People per square mile, 2010	**2.4**	**9.7**
White persons (not incl. Hispanic/Latino), 2016 est.	**93.2%**	**85.0%**
Persons under 18 years, 2016 est.	**19.3%**	**23.3%**
Persons 65 years or older, 2016 est.	**25.0%**	**14.5%**
Non-English spoken at home, 2015 est.	**4.3%**	**5.6%**
High school graduates, 2015 est.	**95.9%**	**91.7%**
Bachelor's degree or higher, 2015 est.	**24.8%**	**27.7%**
Live below poverty line, 2015 est.	**9.6%**	**10.7%**

While the population of North Dakota has grown in recent years, Adams County has seen a decrease in population since 2010. The U.S. Census Bureau estimates show that the county's population decreased from 2,343 (2010) to 2,305 (2016).

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, Adams 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 2015 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 2015 County Health Rankings – a flowchart 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 Adams 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 Southwestern Public Health Unit and WRHS or of particular medical facilities.

For most of the measures included in the rankings, the County Health Rankings' authors have calculated the "Top U.S. Performers" for 2015. 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).

Adams County rankings within the state are included in the summary following. For example, Adams County ranks 24th out of 49 ranked counties in North Dakota on health outcomes and 12th on health factors. The measures marked with a red checkmark (✓) are those where Adams County is not measuring up to the state rate/percentage; a blue checkmark (✓) indicates that the county is faring better than the North Dakota average but is not meeting the U.S. top 10% rate on that measure. Measures that are not marked with a colored checkmark but are marked with a smiling icon (☺) indicate that the county is doing better than the U.S. top 10%.

The data from County Health Rankings shows that Adams County is doing better than many counties compared to the rest of the state on all but one of the *outcomes*, landing at or above rates for other North Dakota counties. However, Adams County, like many North Dakota counties, is doing poorly in many areas when it comes to the U.S. top 10% ratings. One particular outcome where Adams County does not meet the U.S. top 10% ratings is the percentage of the population diagnosed with diabetes. On health *factors*, Adams County performs below the North Dakota average for counties in some areas as well.

Adams County lags the state average on the following reported measures:

- Adult obesity
- Physical inactivity
- Access to exercise opportunities
- Teen birth rate
- Number of dentists
- Number of mental health providers
- Number of preventable hospital stays
- Diabetes screening percentage
- Mammography screening
- Percentage of unemployment

TABLE 2: SELECTED MEASURES FROM *COUNTY HEALTH RANKINGS* 2016 – ADAMS COUNTY

	Adams County	U.S. Top 10%	North Dakota
Ranking: Outcomes	**24th**		**(of 49)**
Premature death	-	5,200	6,600
Poor or fair health	11% ☺	12%	14%
Poor physical health days (in past 30 days)	2.7 ☺	2.9	2.9
Poor mental health days (in past 30 days)	2.8 ☺	2.8	2.9
Low birth weight	-	6%	6%
% Diabetic	11% ✓✓	9%	8%
Ranking: Factors	**12th**		**(of 49)**
Health Behaviors			
Adult smoking	14% ☺	14%	20%
Adult obesity	32%✓✓	25%	30%
Food environment index (10=best)	8.4 ☺	8.3	8.4
Physical inactivity	28% ✓✓	20%	25%
Access to exercise opportunities	2% ✓✓	91%	66%
Excessive drinking	19% ✓	12%	25%
Alcohol-impaired driving deaths	0%☺	14%	47%
Sexually transmitted infections	-	134.1	419.1
Teen birth rate	29✓✓	19	28
Clinical Care			
Uninsured	11% ☺	11%	12%
Primary care physicians	204:1 ☺	1,040:1	1,280:1
Dentists	2,360:1 ✓✓	1,320:1	1,630:1
Mental health providers	2,360:1 ✓✓	360:1	640:1
Preventable hospital stays	65✓✓	38	51
Diabetic screening	77%✓✓	91%	87%
Mammography screening	59% ✓✓	71%	69%
Social and Economic Factors			
Unemployment	2.9% ✓	3.5%	2.7%
Children in poverty	12% ☺	13%	14%
Income inequality	3.9✓	3.7	4.4
Children in single-parent households	18% ☺	21%	27%
Violent crime	42 ☺	59	240
Injury deaths	-	51	63
Physical Environment			
Air pollution – particulate matter	6.3 ☺	9.5	10.0
Drinking water violations	No ☺	No	
Severe housing problems	11% ✓	9%	11%

✓ = Not meeting North Dakota average

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

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

Children's Health

The National Survey of Children's Health touches on multiple intersecting aspects of children's lives. Data are not available at the county level; listed below is information about children's health in North Dakota. The full survey includes physical and mental health status, access to quality healthcare, and information on the child's family, neighborhood, and social context. Data are from 2016. 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%	11.6%
Children 10-17 overweight or obese	**35.8%**	31.3%
Children 0-5 who were ever breastfed	79.4%	79.2%
Children 6-17 who missed 11 or more days of school	4.6%	6.2%
Healthcare		
Children currently insured	**93.5%**	94.5%
Children who had preventive medical visit in past year	**78.6%**	84.4%
Children who had preventive dental visit in past year	**74.6%**	77.2%
Young children (10 mos.-5 yrs.) receiving standardized screening for developmental or behavioral problems	**20.7%**	30.8%
Children aged 2-17 with problems requiring counseling who received needed mental healthcare	**86.3%**	61.0%
Family Life		
Children whose families eat meals together 4 or more times per week	83.0%	78.4%
Children who live in households where someone smokes	**29.8%**	24.1%
Neighborhood		
Children who live in neighborhood with a park, sidewalks, a library, and a community center	58.9%	54.1%
Children living in neighborhoods with poorly kept or rundown housing	12.7%	16.2%
Children living in neighborhood that's usually or always safe	94.0%	86.6%

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

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

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

The data show that Adams County is performing more poorly than the North Dakota average on uninsured children and uninsured children below 200% of poverty. The most marked difference was on the measure of uninsured children below 200% of poverty (more than 11% higher rate in Adams County).

TABLE 4: SELECTED COUNTY-LEVEL MEASURES REGARDING CHILDREN'S HEALTH

	Adams	North Dakota
Uninsured children (% of population age 0-18), 2015	**12.4%**	7.9%
Uninsured children below 200% of poverty (% of population), 2014	**56.9%**	45.2%
Medicaid recipient (% of population age 0-20), 2015	**27.1%**	28.1%
Children enrolled in Healthy Steps (% of population age 0-18), 2013	**4.9%**	2.5%
Supplemental Nutrition Assistance Program (SNAP) recipients (% of population age 0-18), 2015	**13.4%**	20.5%
Licensed child care capacity (% of population age 0-13), 2017	**46.7%**	41.5%
High school dropouts (% of grade 9-12 enrollment), 2013	**0.0%**	2.8%

Survey Results

As noted previously, 298 community members completed the survey in communities throughout the counties in the WRHS service area. Survey results are reported in seven categories: demographics; healthcare access; community assets, challenges; community concerns; delivery of healthcare; and other concerns or suggestions to improve health.

Survey Demographics

To better understand the perspectives being offered by survey respondents, those taking the survey 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 the demographics of those who chose to complete the survey:

- 27% (N=64) were ages 55 or older, and 33% (N=80) were younger than 35 years of age.
- The majority (82%, N=202) were female.
- A little less than half of the respondents (49%, N=121) had bachelor's degrees or higher.
- The number of those working full time (63%, N=157) was more than four times higher than those who were retired (14%, N=36).
- Thirty-five percent of the population (N=68) had household incomes of less than $50,000.

Figures 3 through 7 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. Of those who provided a household income, 8% (N=15) of the community members reported a household income of less than $25,000, and 24% (N=47) indicated a household income of $100,000 or more.

Figure 3: Age Demographics of Survey Respondents

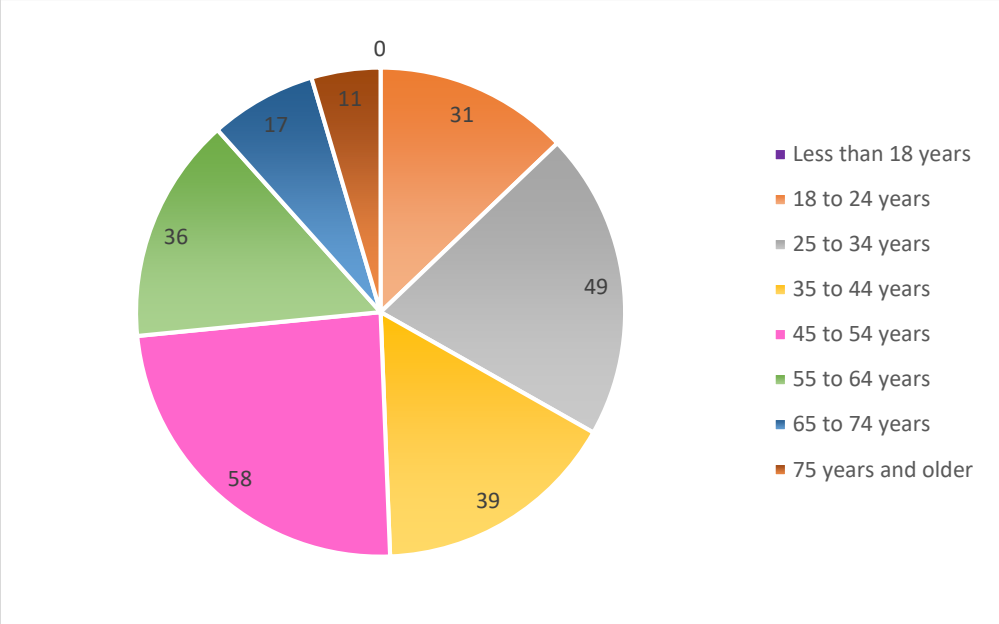


Figure 4: Gender Demographics of Survey Respondents

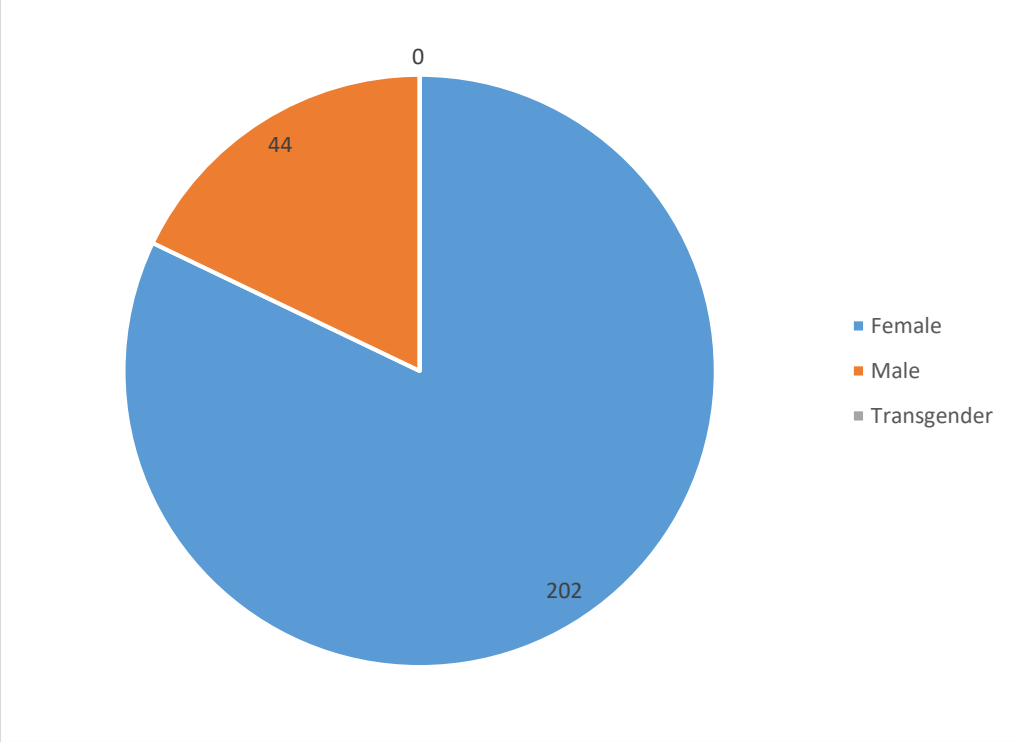


Figure 5: Educational Level Demographics of Survey Respondents

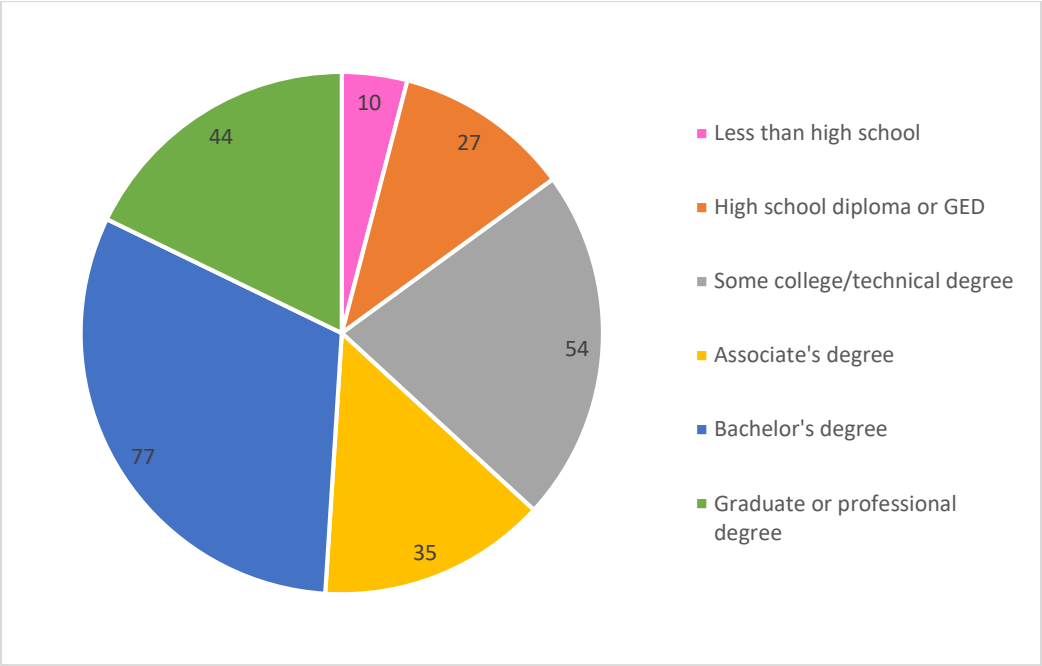


Figure 6: Employment Status Demographics of Survey Respondents

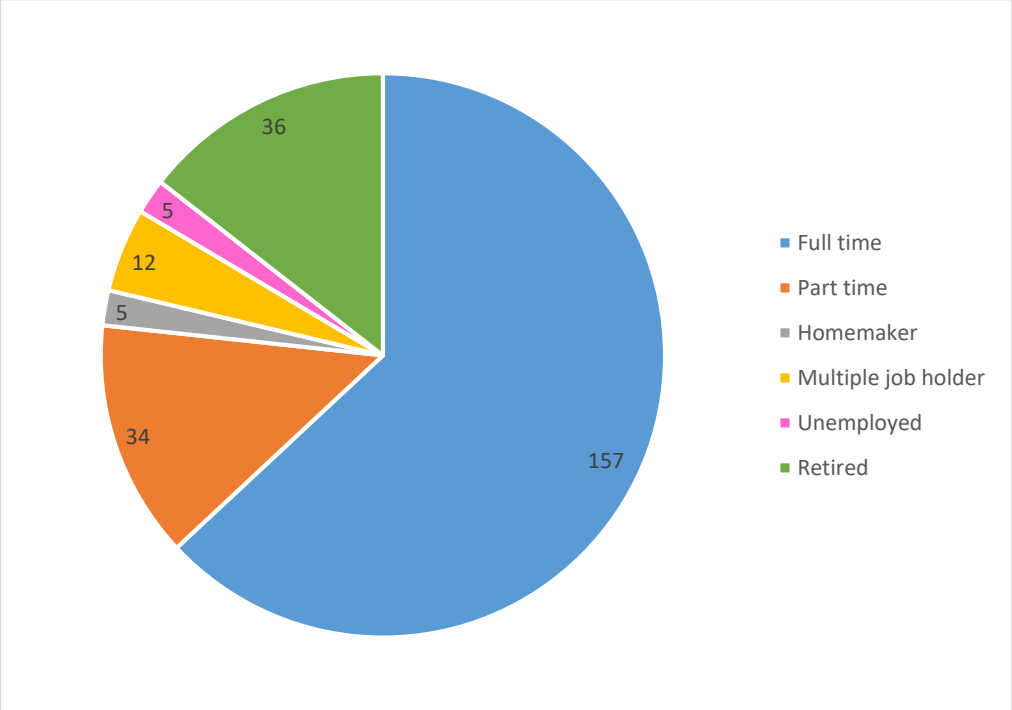
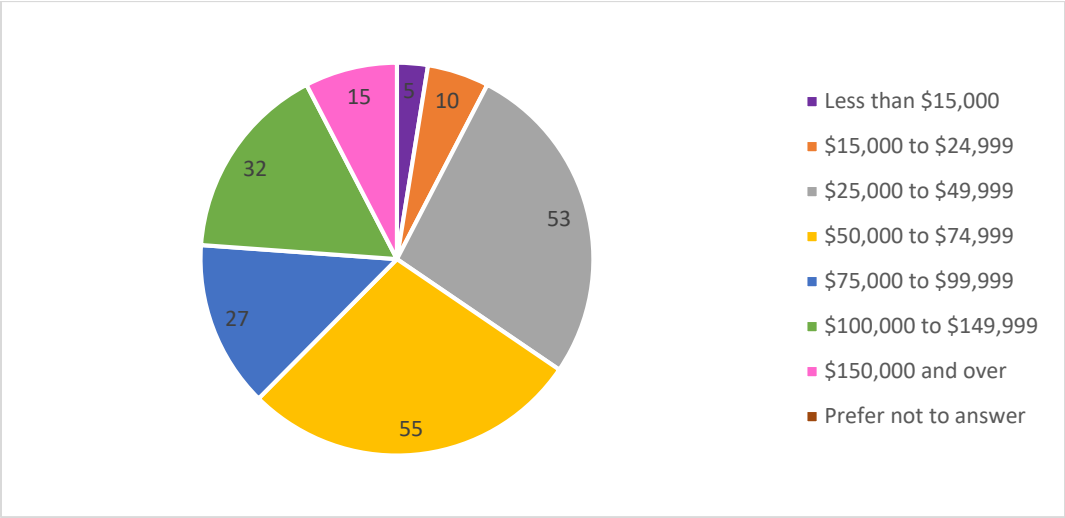
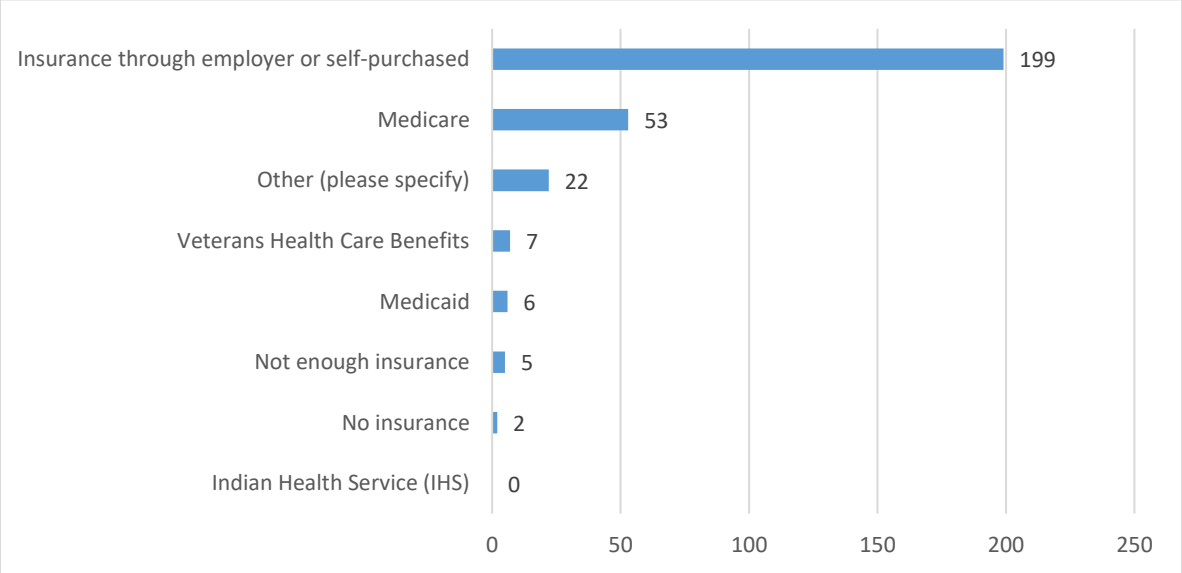


Figure 7: Household Income Demographics of Survey Respondents



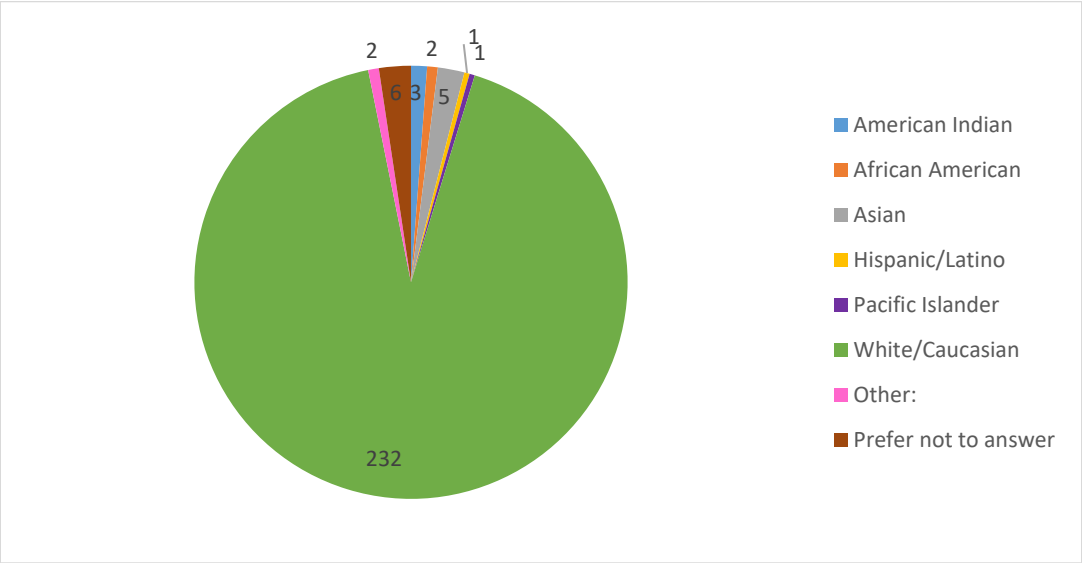
Community members were asked about their health insurance status, which is often associated with whether people have access to healthcare. Two percent (N=7) of the respondents reported having no health insurance or being underinsured. Figure 8 shows that the most common insurance types were insurance through one's employer or self-purchased (N=199) or Medicare (N=53).

Figure 8: Health Insurance/Coverage Status



As shown in Figure 9, the large majority of the respondents were white/caucasian (92%). This was in line with the race/ethnicity of the overall population of Adams County.

Figure 9: Race/Ethnicity Demographics of Survey Respondents



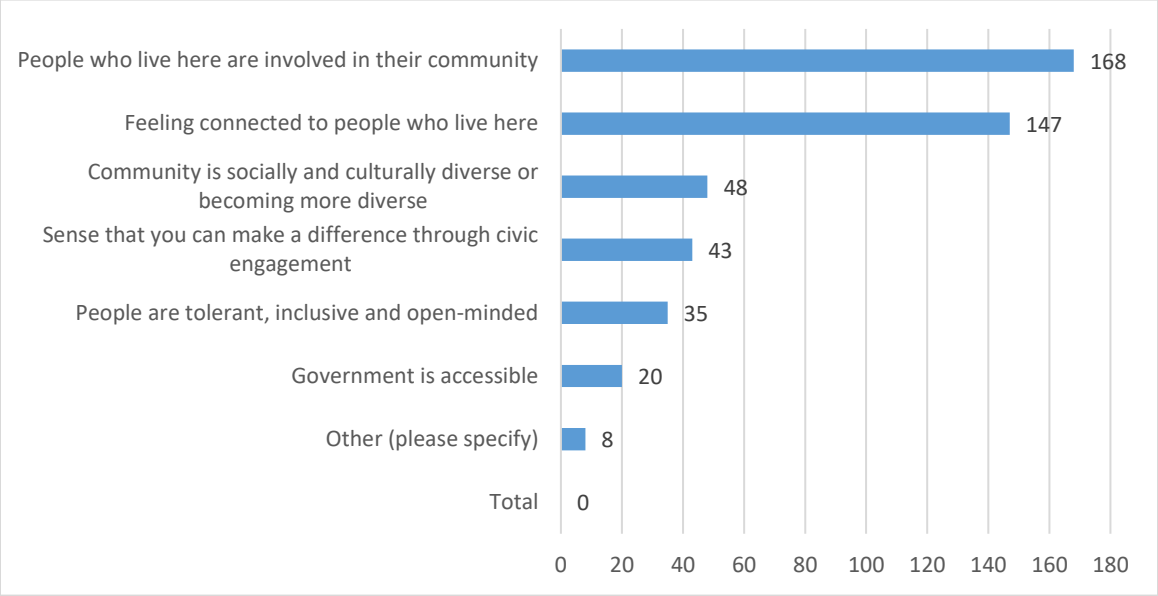
Community Assets and Challenges

Survey respondents were asked what they perceived as the best things about their community in four categories: people, services and resources, quality of life, and activities. In each category, respondents were given a list of choices and asked to pick the three best things. Respondents occasionally chose less than three or more than three choices within each category. If more than three choices were selected, their responses were not included. The results indicate there is consensus (with more than 200 respondents agreeing) that community assets include:

- Safe place to live, little/no crime (N=237);
- Healthcare (N=223);
- People are friendly, helpful, supportive (N=218); and
- Family-friendly, good place to raise kids (N=208).

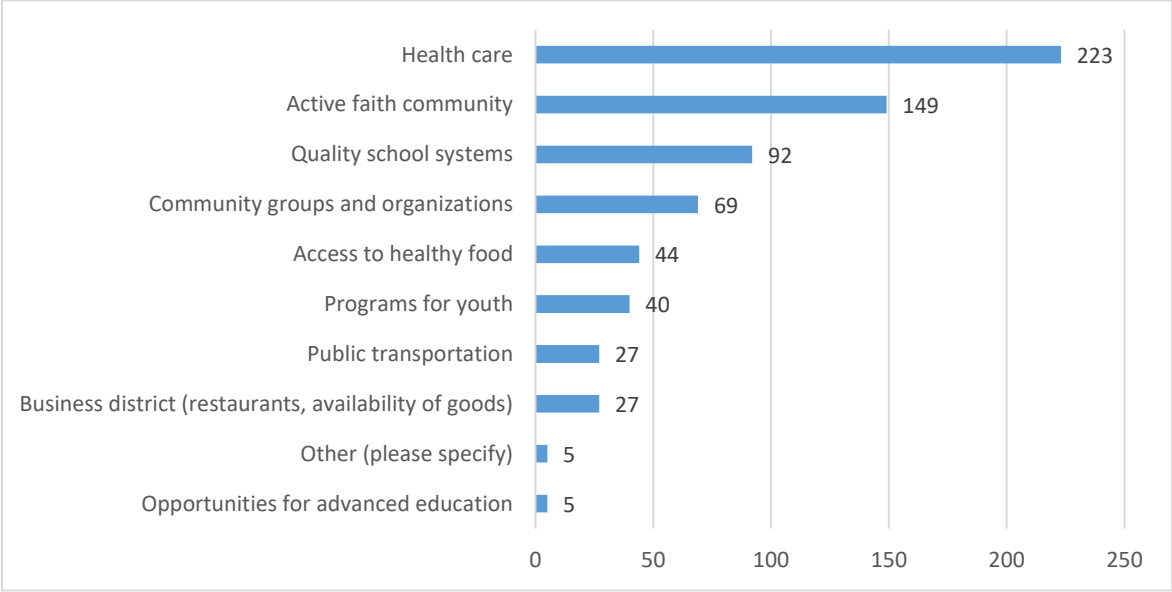
Figures 10 to 13 illustrate the results of these questions.

Figure 10: Best Things about the PEOPLE in Your Community



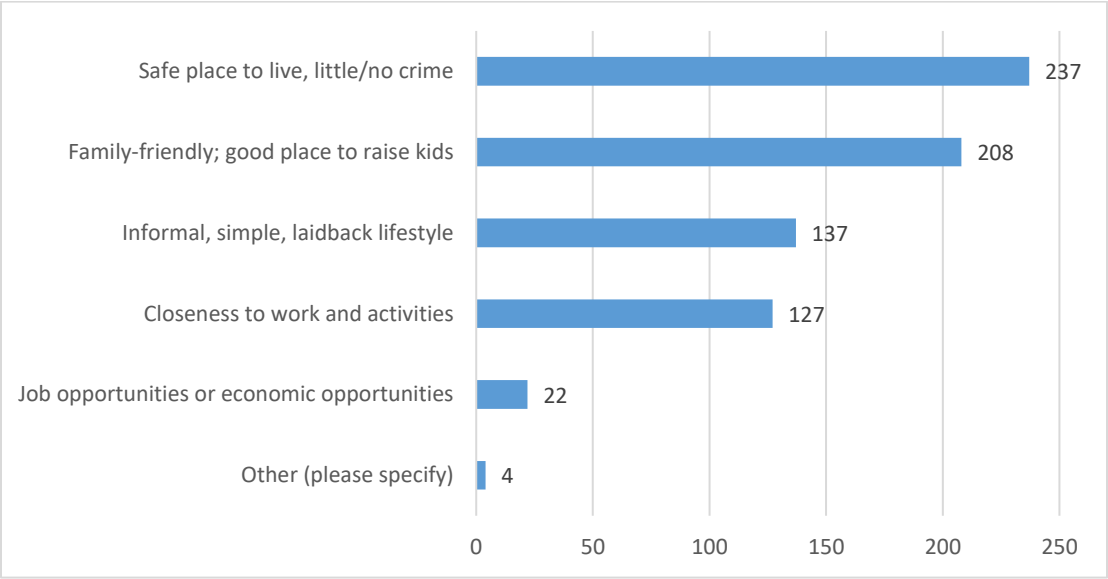
Respondents who selected "Other" specified that the best things about the people included generosity, quiet streets, and volunteerism.

Figure 11: Best Things about the SERVICES AND RESOURCES in Your Community



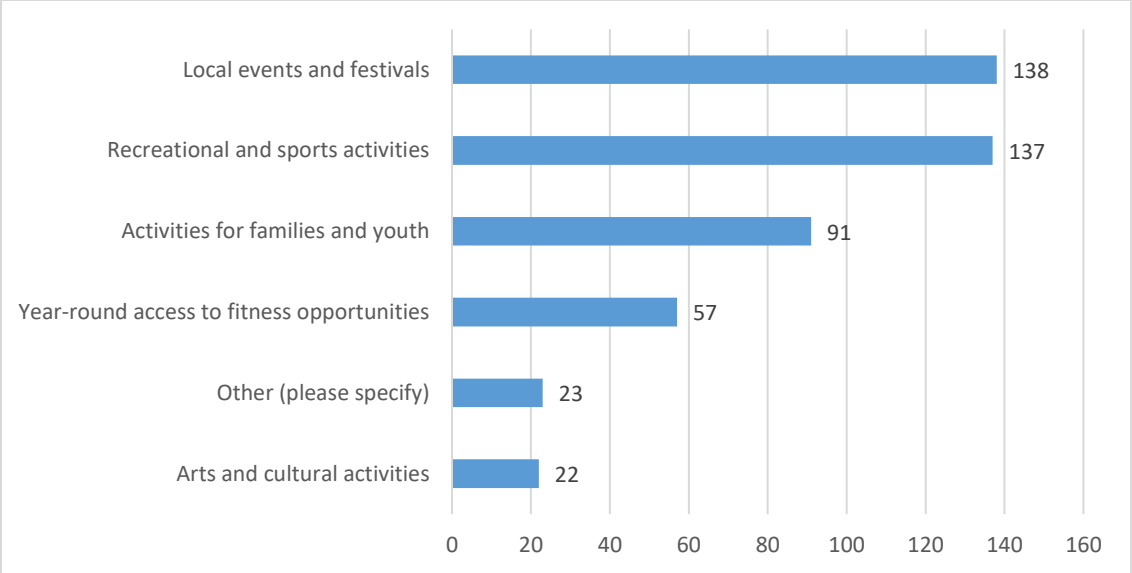
Respondents who selected "Other" specified that the best things about services and resources included good highway system for out-of-town travel and open spaces.

Figure 12: Best Things about the QUALITY OF LIFE in Your Community



Having a community that was not crowded was noted in the "Other" category.

Figure 13: Best Thing about the ACTIVITIES in Your Community



Numerous items were listed in the "Other" category, including family time, movie theater, outdoor activities, public library, school sporting events, and being close to the Black Hills.

In another open-ended question, residents were asked, "What are the major challenges facing your community?" The most commonly cited challenges include the aging and declining population, difficulty in keeping businesses/retail open, declining economy, lack of qualified staff for jobs, lack of employment opportunities, difficulty in attracting and retaining the younger population, and high rates of alcohol consumption.

Community Concerns

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

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

Echoing focus group responses in the survey about community challenges, the most highly voiced concerns were:

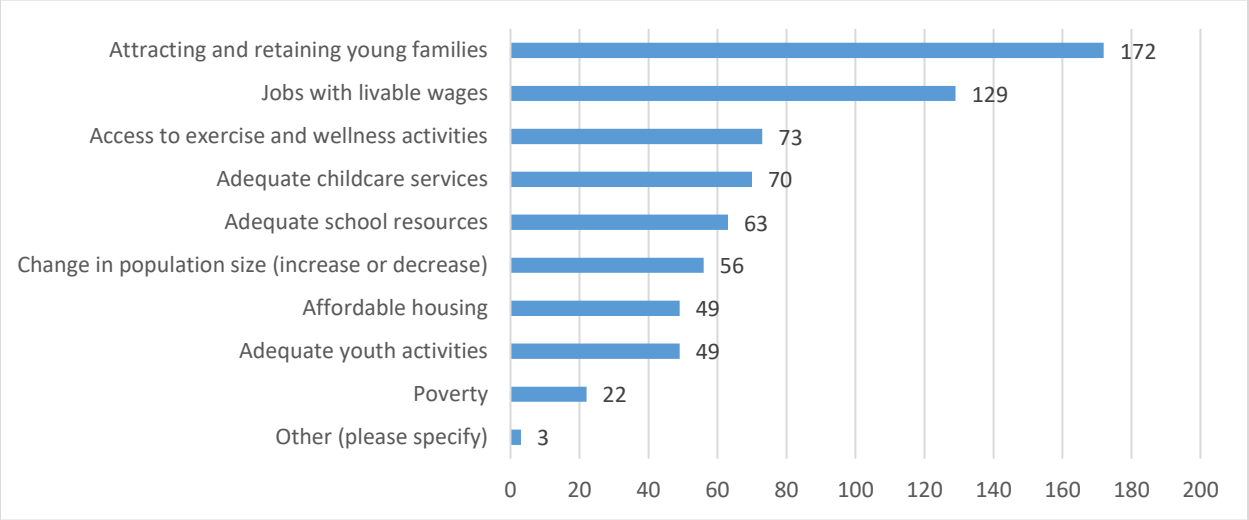
- Attracting and retaining young families (N=172);
- Cancer (N=165);
- Cost of health insurance (N=142);
- Obesity/overweight (N=132);
- Jobs with livable wages (N=129);
- Cost of healthcare services (N=126);
- Adult alcohol use and abuse (including binge drinking) (N=122); and
- Ability to recruit and retain primary care providers (doctor, nurse practitioner, physician assistant) (N= 118).

The other issues that had at least 90 votes included:

- Availability of resources to help the elderly stay in their homes (N=115);
- Long-term/nursing home care options (N=102);
- Availability of specialists (N=100);
- Youth alcohol use and abuse (including binge drinking) (N=97);
- Availability of substance abuse/treatment services (N=91); and
- Assisted living options (N=91).

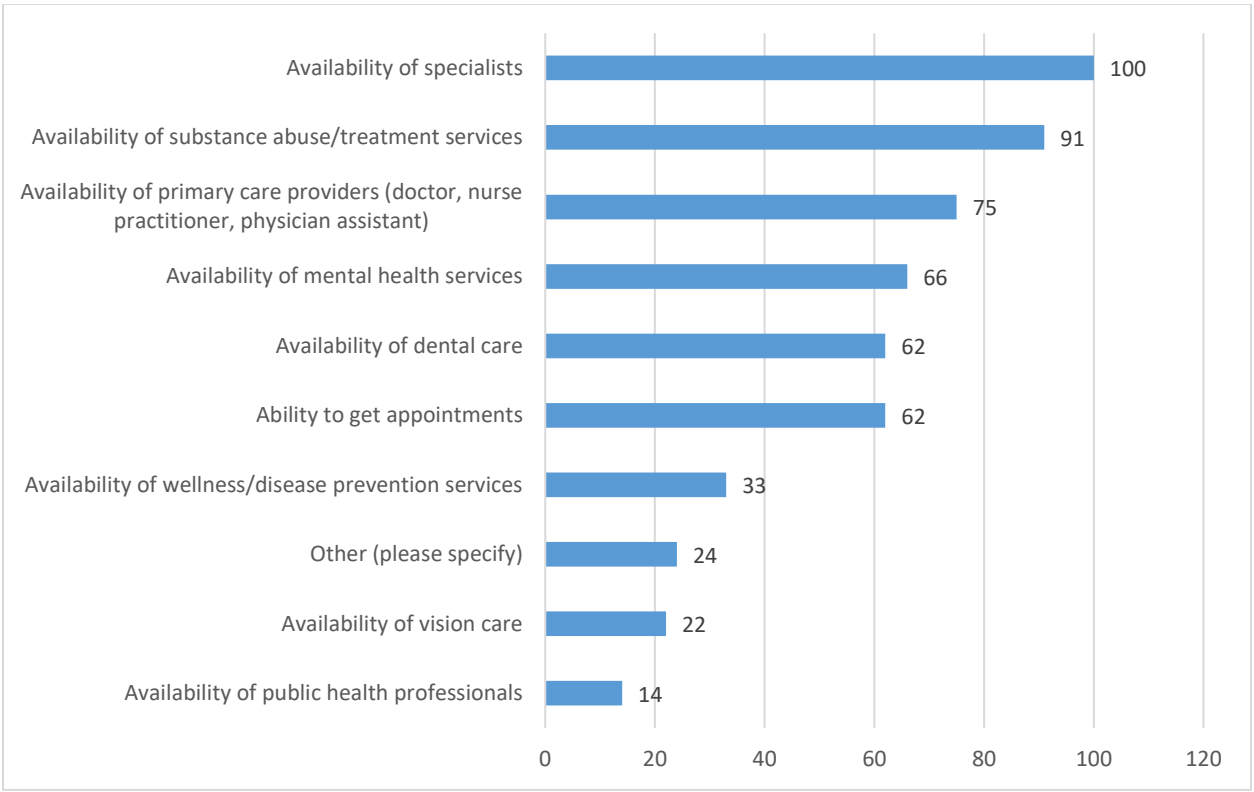
Figures 14 through 20 illustrate these results.

Figure 14: Community Health Concerns



The "Other" category for community health concerns indicated that there was a need for more volunteers to keep the ambulance service in the community, and one response indicated that that vagrants were an issue.

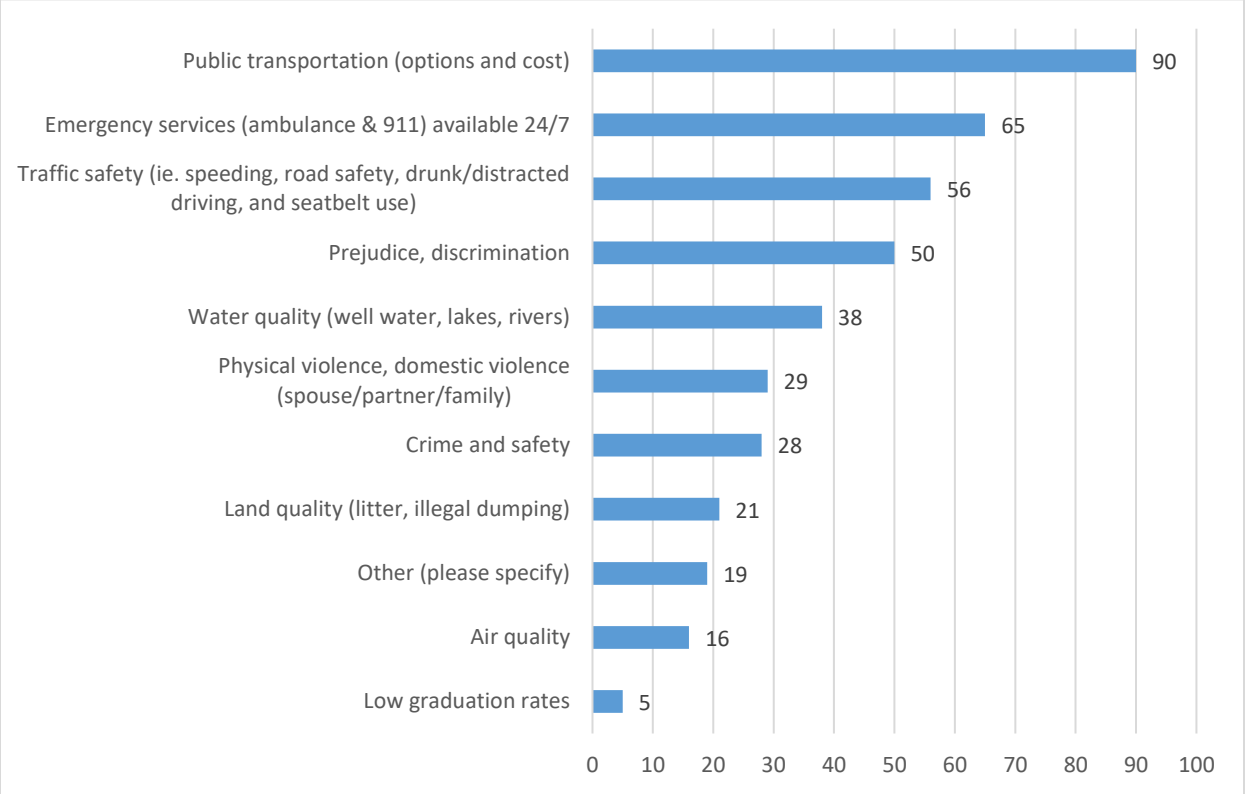
Figure 15: Availability of Health Services Concerns



Respondents who selected "Other" specified availability of health services concerns as:

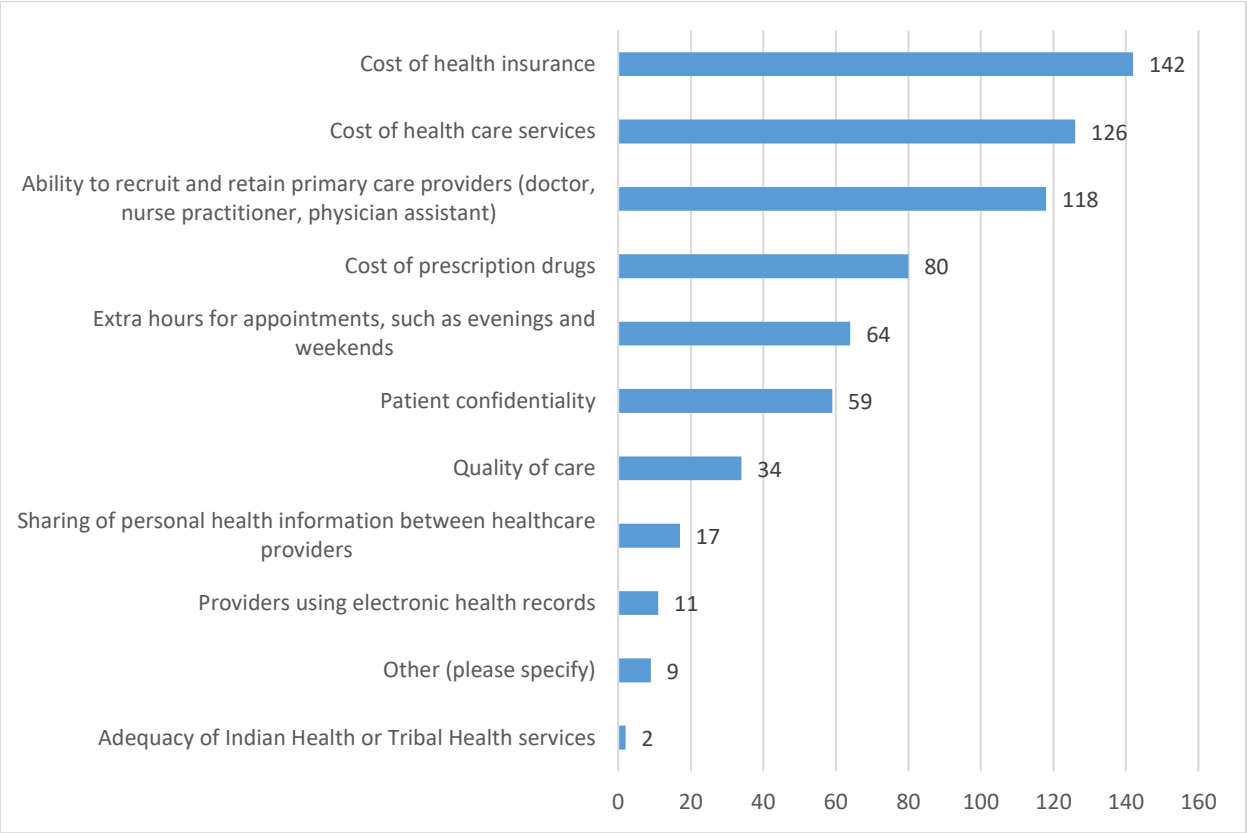
- Affordable healthcare;
- Affordable housing for independent seniors 65 and older;
- Availability of doctors and nurses in the future;
- Communications;
- Difficulty in getting appointments the same day as illnesses;
- Frequent appointment cancellations;
- Inability to see the same provider or specialist over time;
- Lack of somewhere inside to work out/walk/run in the winter;
- Lack of mental health providers/services;
- Lack of hospice;
- Lack of nurses;
- Long-term viability of the hospital;
- Need for a speech therapist;
- No longer have a night clinic; and
- Wait times too long.

Figure 16: Safety/Environmental Health Concerns



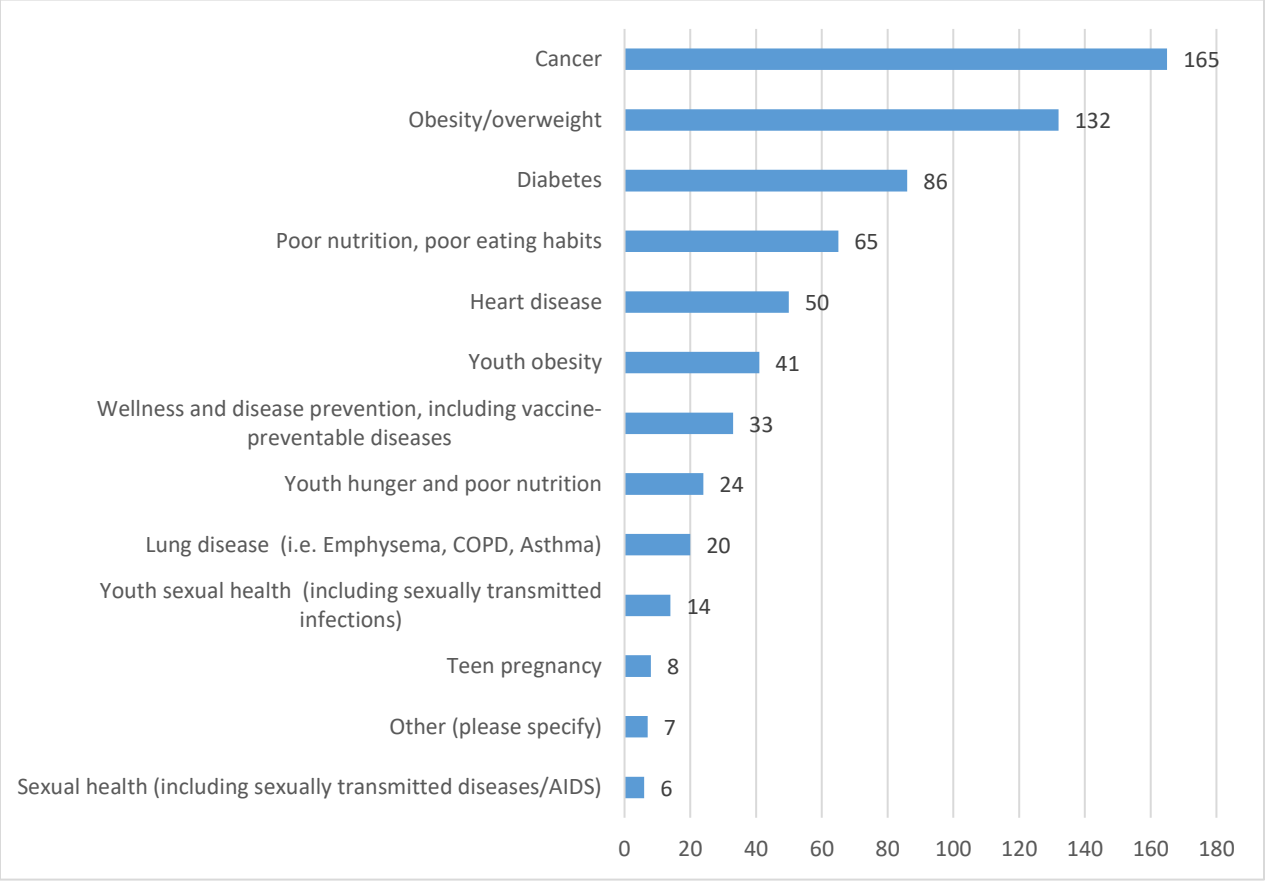
Listed in the "Other" category for safety and environmental health concerns were annual citywide cleanup, drought, wildfire, drugs, no recycling services, overworked/underpaid law enforcement, and the clearing of snow from rural roads.

Figure 17: Delivery of Health Services Concerns



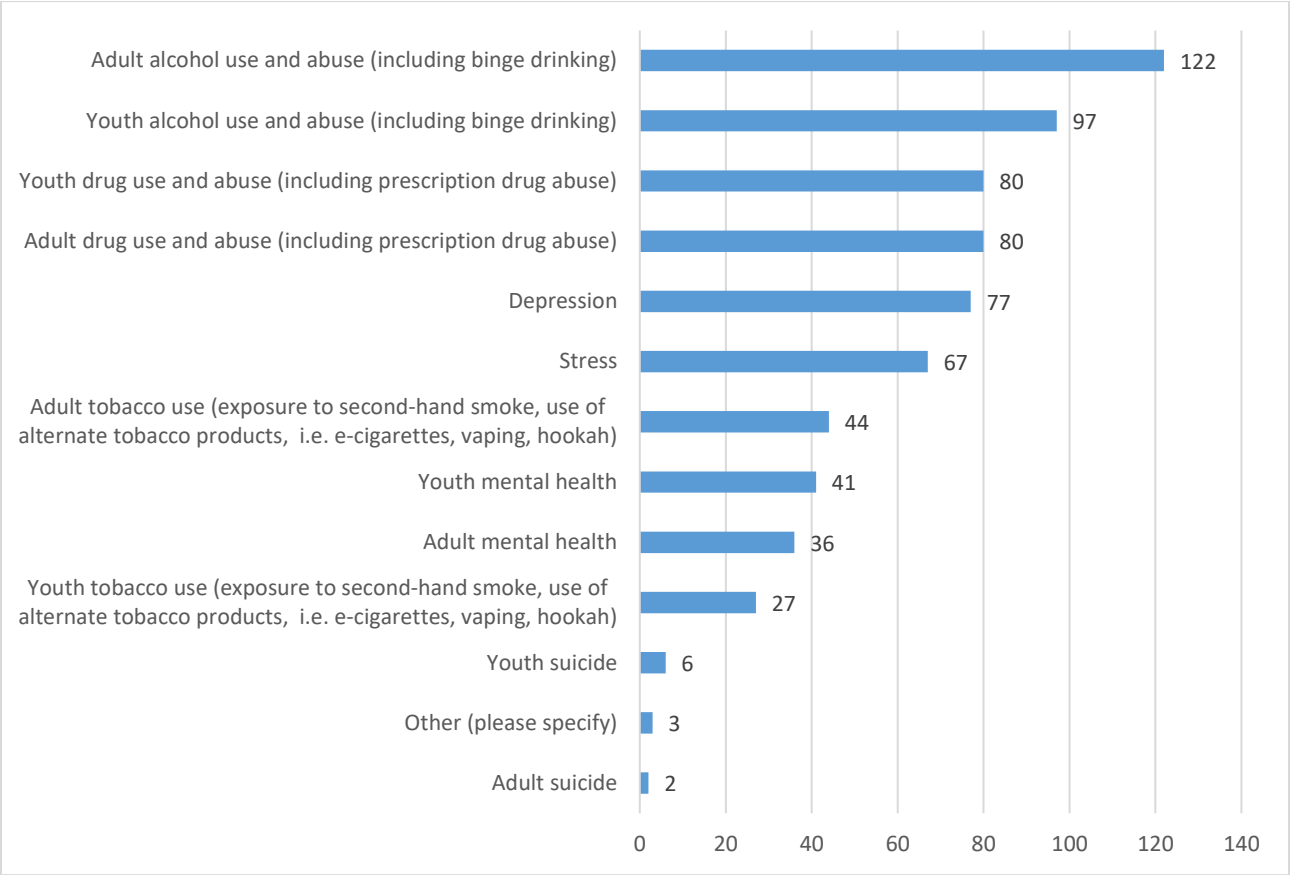
Other concerns related to the delivery of health services included the ability to recruit and retain qualified health professionals to the area (including nurses, technicians, housekeepers, billing staff, etc.), errors in patient records, billing issues, cutting clinic hours, reduced autonomy of providers due to government regulations, and the Mott pharmacy not taking Medicaid as payment.

Figure 18: Physical Health Concerns



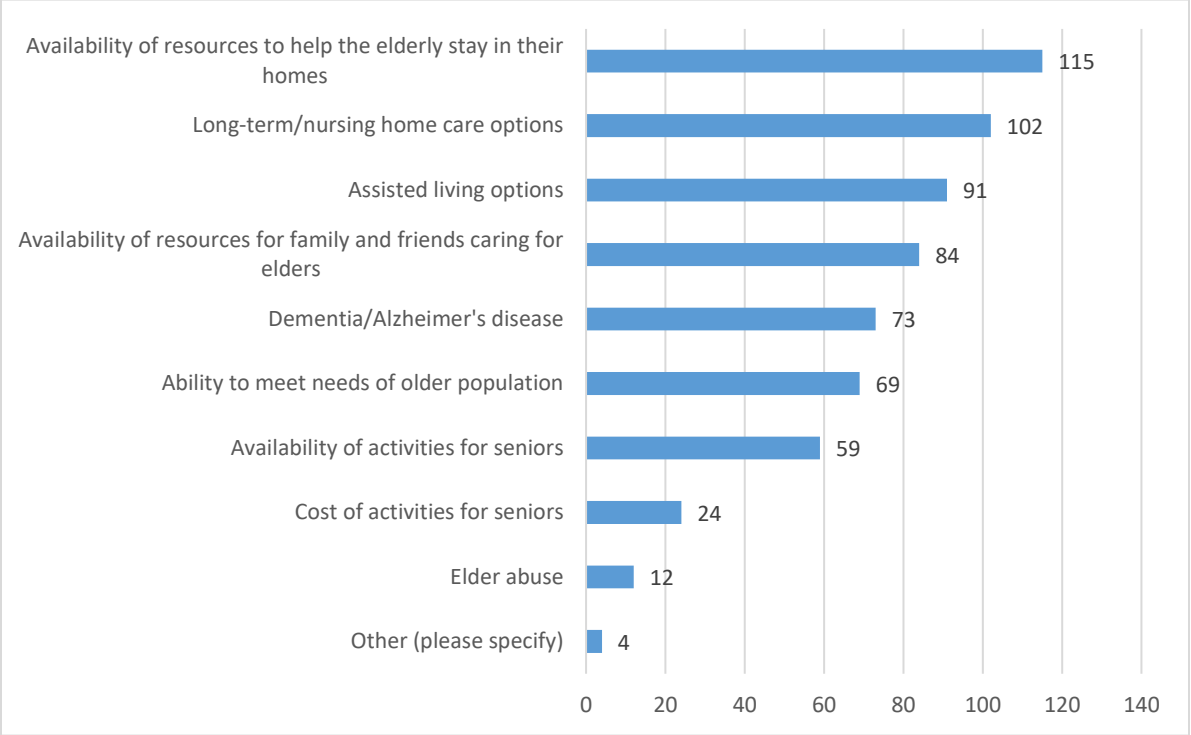
In the "Other" category, the concerns listed were alcohol abuse, drug abuse, physical abuse/neglect, and it is too expensive to go to a provider for healthcare issues.

Figure 19: Mental Health and Substance Abuse Concerns



One respondent mentioned in the "Other" category that all tobacco use is a concern.

Figure 20: Senior Population Concerns



The four responses in the "Other" category were the cost of assisted living; the quality of care received in assisted living; cost too much to be in the nursing home; and the visiting nurse is not covering the remote areas of the service area.

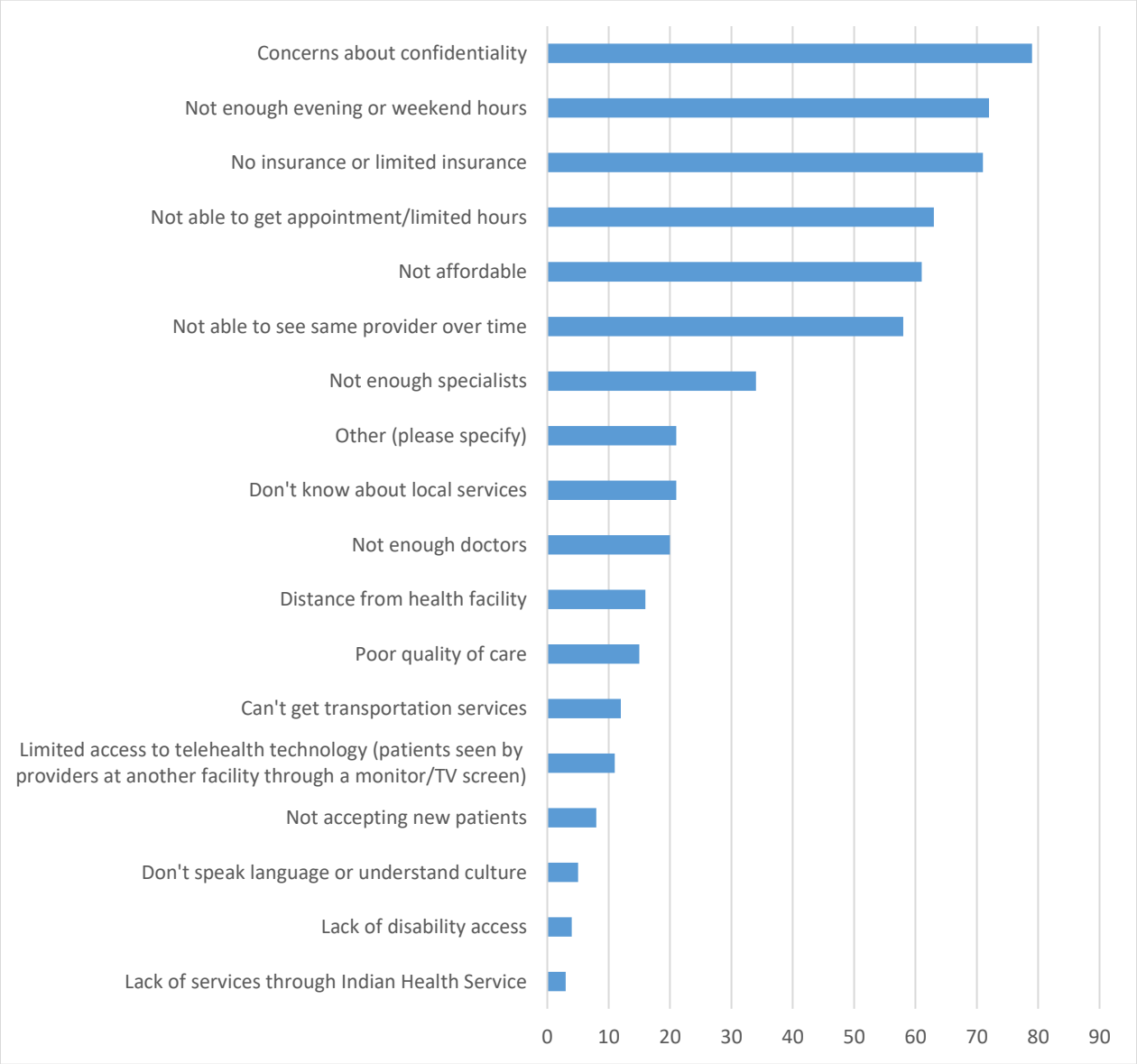
Delivery of Healthcare

The survey asked residents what they see as barriers that prevent them, or others, from receiving healthcare. The most prevalent barrier perceived by residents was concerns about confidentiality (N=79). Confidentiality is commonly indicated in this particular question. It can imply the comfort level of survey respondents for seeking care locally because they know the providers and other staff or the actual sharing of personal health information. This, and all survey results, will need further dissecting. The next highest barrier was not enough evening or weekend hours (N=72). After these, the next most commonly identified barriers were no insurance or limited insurance (N=71), not able to get an appointment/limited hours (N=63), and not affordable (N=61). Other issues listed included errors in billing, government regulations, distance to main clinic, limited mental health appointments/availability, local physical therapy, lack of natural health providers, unable to

get appointments with the same provider due to his/her location availability, services are not locally available, and poor customer service.

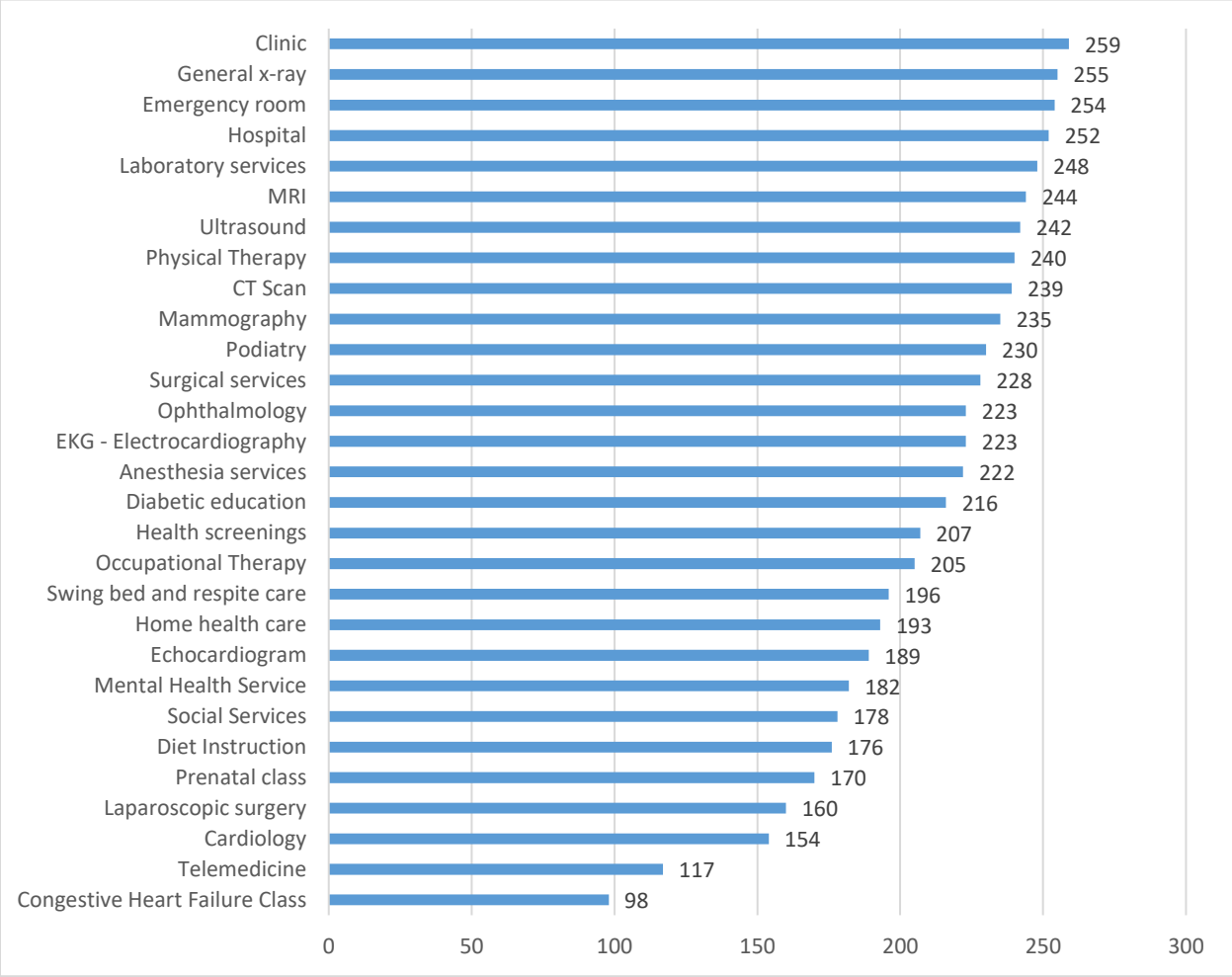
Figure 21 illustrates these results.

Figure 21: Perceptions about Barriers to Care



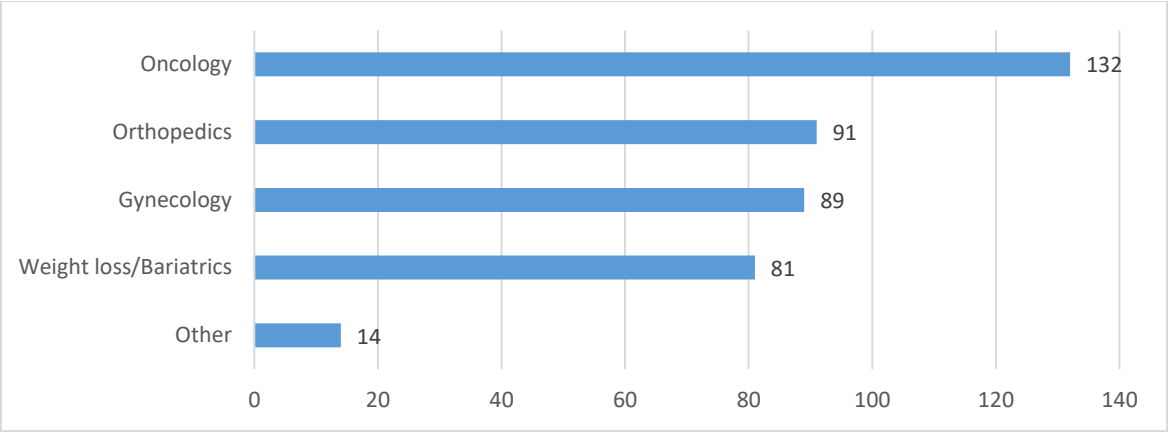
Considering a variety of health services, respondents were asked what services they were aware of that WRHS offered (Figure 22).

Figure 22: WRHS Services that Respondents Are Aware of Being Offered



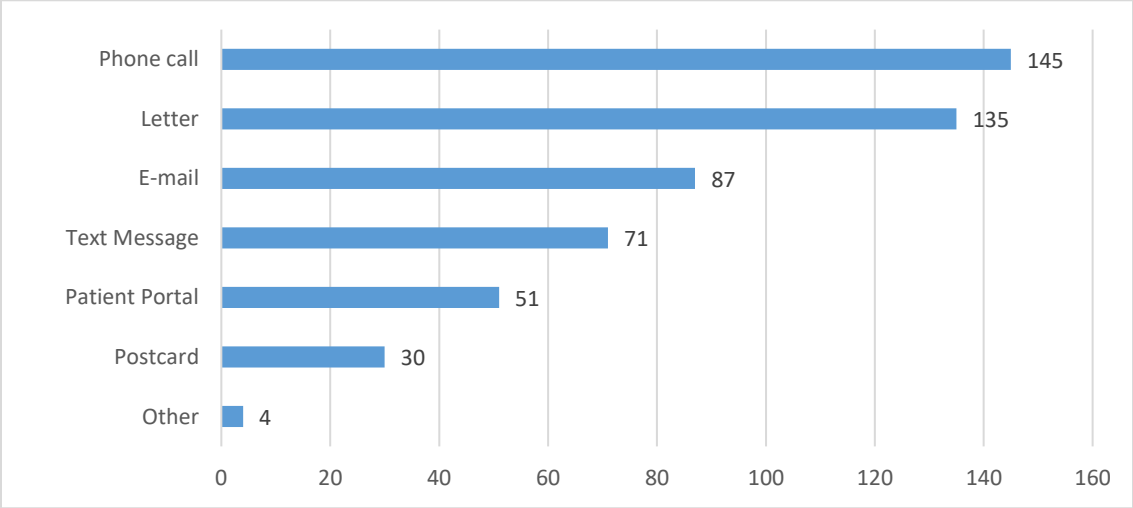
In an effort to gauge community members' interest in services not currently provided by WRHS, a question was asked that provided options for respondents to select and recommend services not listed. Additional services recommended included addiction services, chiropractic care, defibrillator/pacemaker check, dental services, EEG tests, geriatrics, group therapy, pain management, parent education, rheumatology, respiratory therapy, and speech therapy.

Figure 23: Additional Services Needed at WRHS



WRHS service area respondents were asked to indicate their preferred method of communication regarding healthcare needs. The top two methods included phone call (N=145) and letter (N=135). See Figure 24.

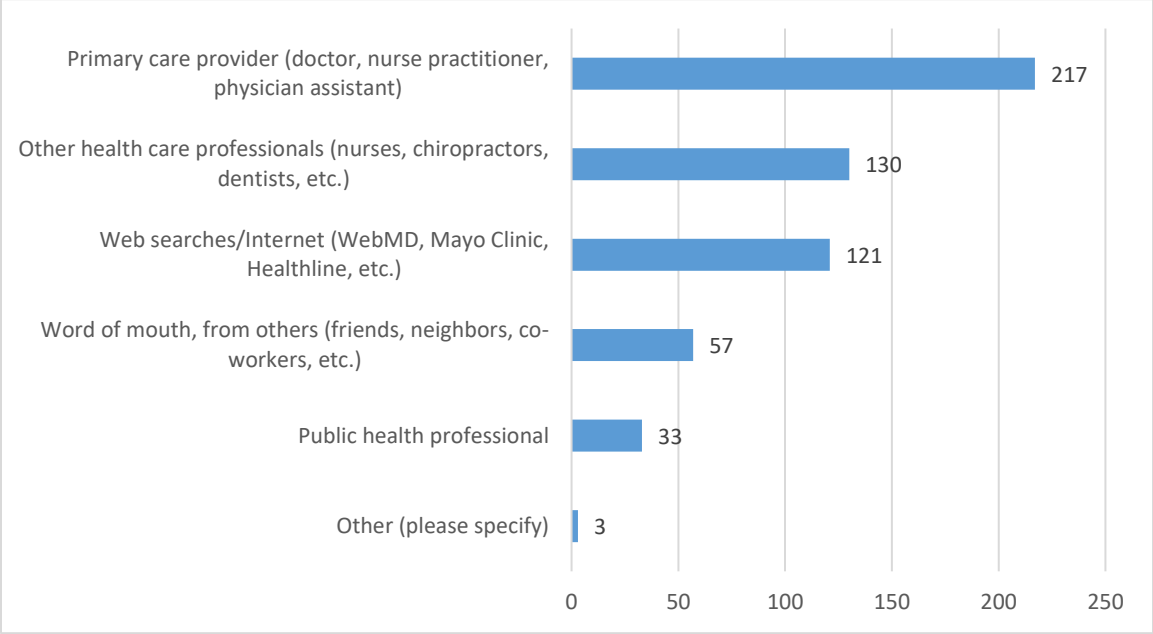
Figure 24: Preferred Method of Contact Regarding Healthcare Needs



Respondents were asked where they go to for trusted health information. Primary care providers (N=217) received the highest response rate, followed by other healthcare professionals (N=130), and then web/internet searches (N=121). Other items listed included books, television, and insurance accordant care line.

Results are shown in Figure 25.

Figure 25: Sources of Trusted Health Information



Findings from Key Informant Interviews and the Community Meeting

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

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

- Mental health issues;
- Overweight/obesity; and
- Youth hunger and poor nutrition.

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

Mental health issues

- Mental health issues. People do not want to talk about it so it gets swept under the rug.
- Healthcare access – the distance for some people to travel for mental health or substance abuse treatment services is way too far.
- We need additional mental health services – some that specialize in youth.

Obesity/overweight

- Other than the community center in Lemmon, there isn't any place to do any outdoor walking. It would be great to have an established walking trail.
- Change your lifestyle
- Eat less, move more!
- We are in need of a community center – there is not one nearby and the cost to use the community center in Lemmon is outrageous.

Youth hunger and poor nutrition

- Youth living in poverty – parents may have money but they don't spend it on their kids and the kids suffer.
- We have kids that go all weekend without a real meal when they aren't in school.
- Poor nutrition, hunger, abuse, and neglect of youth is my top concern for the community.

Community Engagement and Collaboration

Key informants and focus group participants also 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 score or rank services provided. They were then presented with a list of 13 organizations or community sectors 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:

- Economic development organizations (4.5);
- Emergency services, including ambulance and fire (4.5);
- Faith-based (4.5);
- Hospital (healthcare system) (4.5);
- Law enforcement (4);
- Long-term care, including nursing homes and assisted living (4);
- Pharmacies (4);
- Schools (4);
- Social Services (4);
- Business and industry (3.5);
- Other local health providers, such as dentists and chiropractors (3);
- Public Health (2.5); and
- Human services agency (1).

Priority of Health Needs

A community group met on November 29, 2017. Eleven participants 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 consideration of and discussion about the findings, all participants 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 so he/she could place a sticker next to each of the four needs he/she considered the most significant.

The results were totaled, and the concerns with the most votes were:

- Availability of substance abuse/treatment services (6 votes);
- Attracting and retaining young families (5 votes);

- Adult alcohol use and abuse (including binge drinking) (5 votes);
- Cancer (4 votes); and
- Obesity/overweight (4 votes).

Then, from those top five priorities, each person put one sticker on the item he/she felt was the most important. The rankings were:

1. Obesity/overweight (4 votes);
2. Availability of substance abuse/treatment services (2 votes);
2. Cancer (2 votes);
4. Attracting and retaining young families (1 vote); and
4. Adult alcohol use and abuse (including binge drinking) (1 vote).

Following the prioritization process during the second meeting of the community group and key informants, the number one identified need was obesity/overweight. A summary of this prioritization may be found in Appendix C.

Comparison of Needs Identified Previously

Top Needs Identified 2015 CHNA Process	Top Needs Identified 2017 CHNA Process
Mental health services	Obesity/overweight
Healthy lifestyle for the community	Availability of substance abuse/treatment services
Access to healthcare providers	Cancer
	Attracting and retaining young families
	Adult alcohol use and abuse (including binge drinking)

The current process did not identify any identical common needs from 2014. However, mental health services are very closely tied to availability of substance abuse/treatment services. For the 2017 CHNA process, adult alcohol use and abuse closely relates with the availability of substance abuse/treatment services. Another close relationship, though not identical, that emerged between the 2014 and 2017 needs assessment process is healthy lifestyle for the community and obesity/overweight.

Hospital and Community Projects and Programs Implemented to Address Needs Identified in 2015

In response to the needs identified in the 2015 CHNA process, the following actions were taken.

Mental health services: Since the last CHNA process, WRHS implemented a behavioral health team consisting of a group of professionals with mental health backgrounds trained to treat the needs of those in the service area. The behavioral health team consists of a family practice physician, pediatric physician, medication management therapist, psychiatric mental health nurse practitioner, professional clinical counselor, pastoral counselor/therapist, social worker and visiting specialist in psychiatry through telehealth.

John P. Joyce, MD, Family Medicine
Carrie Ann K. Ranum, MD, Pediatric Medicine
Rose B. Bergquist, PA-C, CNS-PMH, Medication Management/Therapist
Jacquelyn A. Hedstrom, DNP, APRN, PMHNP-BC, Psychiatric Mental Health
Tara L. Jorgenson, LPCC, QMHP, Program Coordinator/Licensed Professional Clinical Counselor
Roger E. Dieterle, M.Div., MS, Pastoral Counselor/Therapist
Cheryl M. Nasset, LICSW, Licensed Independent Clinical Social Worker
Visiting Specialist - Gabriela Balf, MD, Psychiatrist and Internist

Healthy lifestyles for the community: The community was concerned with cancer, heart disease, diabetes, and wellness. In the past few years, WRHS has increased emphasis on these areas through wellness education, diabetic awareness, and increased attention to preventative care and services. Specifically wellness education has been presented at the yearly WRHS Community Health Day. Screenings related to diabetes, cancer and heart disease have been provided/coordinated at those events. WRHS invited the Bismarck Cancer Center to the Community Health Day the past two years and also participated in and helped disseminate cancer awareness and screening information during their cancer awareness campaign in the community. Along with Southwestern District Health Unit, WHRS hosted healthy food demos at the local grocery store and helped coordinate nutrition events in the community involving NDSU Extension and the ND Beef Commission. WRHS also promoted the WRHS fitness center in an effort to encourage physical activity and held its yearly Fourth of July Fun Run/Walk. Staff presented talks at the second Forty Club regarding a variety of health topics to help educate our senior population. Wellness Education was provided to the youth of the Community at a 4H Activity Day event. Through combined efforts with the ND Cancer Coalition Sun, education was provided to youth by our Community Health Coordinator

at Shelly's Safety Day. Sunscreen Sticks and Cards from the ND Cancer Coalition were shared with youth at local baseball practice.

Access to healthcare providers: The community also expressed concern during the last CHNA process about the number of providers available and the turnover of providers due to retirement. WRHS and the University of North Dakota School of Medicine collaborated in training physicians to practice in rural medicine in the first Rural Residency Program in the state. The first year of residency is done in Bismarck, North Dakota, which provides a great intern year program to get the resident ready to practice and treat patients when they arrive in Hettinger. The program in Hettinger is set up similar to others with a monthly Accreditation Council for the Graduate Medical Education-required rotation. In addition, the resident is on call, one night a week, in the emergency room. This provides a great opportunity to initially see patients and follow through with their care, whether this be discharging and following up in the clinic or admitting to the hospital. It truly does embody the role of a family medicine physician. WRHS is continually recruiting and in 2016 hired general surgeon Matthew T. Hefty, MD, who is board certified in general surgery.

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, are 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 agreed upon prioritized needs on which to begin working. The strategic planning process will begin with identifying 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 process, as well as the Implementation Plan.

Community benefit 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 Affordable Care Act'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 the 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
The University of North Dakota School of Medicine & Health Sciences

WEST RIVER HEALTH SERVICES

Public Health
Prevent. Promote. Protect.

Hettinger Area Health Survey

West River Health Services and Southwestern District Health Unit is interested in hearing from you about community health concerns.

The focus of this effort is to:

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

If you prefer, you may take the survey online at http://tinyurl.com/WRHS2017 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 October 15, 2017. 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.

Q1. 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) _____

Q2. 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
- ☐ Health care
- ☐ Opportunities for advanced education
- ☐ Public transportation
- ☐ Programs for youth
- ☐ Quality school systems
- ☐ Other (please specify) _____

Q3. 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) _____

Q4. 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) _____

Working Draft ©2016, University of North Dakota – Center for Rural Health

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

Q5. What are the major challenges facing your community?

_____

_____

Q6. Considering the **COMMUNITY HEALTH** in your community, concerns are (choose up to THREE):

- ☐ Access to exercise and wellness activities
- ☐ Adequate childcare services
- ☐ Adequate school resources
- ☐ Adequate youth activities
- ☐ Affordable housing
- ☐ Attracting and retaining young families
- ☐ Change in population size (increase or decrease)
- ☐ Jobs with livable wages
- ☐ Poverty
- ☐ Other (please specify) _____

Q7. Considering the **AVAILABILITY OF HEALTH SERVICES** in your community, concerns are (choose up to THREE):

- ☐ Ability to get appointments
- ☐ Availability of doctors and nurses
- ☐ Availability of dental care
- ☐ Availability of mental health services
- ☐ Availability of public health professionals
- ☐ Availability of specialists
- ☐ Availability of substance abuse/treatment services
- ☐ Availability of vision care
- ☐ Availability of wellness/disease prevention services
- ☐ Other (please specify) _____

Q8. Considering the **SAFETY/ENVIRONMENTAL HEALTH** in your community, concerns are (choose up to THREE):

- ☐ Air quality
- ☐ Crime and safety
- ☐ Emergency services (ambulance & 911) available 24/7
- ☐ Land quality (litter, illegal dumping)
- ☐ Low graduation rates
- ☐ Physical violence, domestic violence (spouse/partner/family)
- ☐ Prejudice, discrimination
- ☐ Public transportation (options and cost)
- ☐ Traffic safety (i.e. speeding, road safety, drunk/distracted driving, and seatbelt use)
- ☐ Water quality (well water, lakes, rivers)
- ☐ Other (please specify) _____

Q9. Considering the **DELIVERY OF HEALTH SERVICES** in your community, concerns are (choose up to THREE):

- ☐ Ability to retain doctors and nurses in the area
- ☐ Adequacy of Indian Health or Tribal Health services
- ☐ Cost of health care services
- ☐ Cost of health insurance
- ☐ Cost of prescription drugs
- ☐ Extra hours for appointments, such as evenings and weekends
- ☐ Patient confidentiality
- ☐ Providers using electronic health records
- ☐ Quality of care
- ☐ Sharing of information between healthcare providers
- ☐ Other (please specify) _____

Q10. Considering the **PHYSICAL HEALTH** in your community, concerns are (choose up to THREE):

- ☐ Cancer
- ☐ Diabetes
- ☐ Lung disease (i.e. Emphysema, COPD, Asthma)
- ☐ Heart disease
- ☐ Obesity/overweight
- ☐ Poor nutrition, poor eating habits
- ☐ Sexual health (including sexually transmitted diseases/AIDS)
- ☐ Teen pregnancy
- ☐ Youth hunger and poor nutrition
- ☐ Youth obesity
- ☐ Youth sexual health (including sexually transmitted infections)
- ☐ Wellness and disease prevention, including vaccine-preventable diseases
- ☐ Other (please specify) _____

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Q11. Considering the **MENTAL HEALTH AND SUBSTANCE ABUSE** in your community, concerns are (choose up to THREE):

- ☐ Adult alcohol use and abuse (including binge drinking)
- ☐ Adult drug use and abuse (including prescription drug abuse)
- ☐ Adult tobacco use (exposure to second-hand smoke, use of alternate tobacco products (i.e. e-cigarettes, vaping, hookah)
- ☐ Adult mental health
- ☐ Adult suicide
- ☐ Depression
- ☐ Stress
- ☐ Youth alcohol use and abuse (including binge drinking)
- ☐ Youth drug use and abuse (including prescription drug abuse)
- ☐ Youth mental health
- ☐ Youth suicide
- ☐ Youth tobacco use (exposure to second-hand smoke, use of alternate tobacco products i.e. e-cigarettes, vaping, hookah)
- ☐ Other (please specify) _____

Q12. Considering the **SENIOR POPULATION** in your community, concerns are (choose up to THREE):

- ☐ Ability to meet needs of older population
- ☐ Assisted living options
- ☐ Availability of activities for seniors
- ☐ Availability of resources for family and friends caring for elders
- ☐ Availability of resources to help the elderly stay in their homes
- ☐ Cost of activities for seniors
- ☐ Dementia/Alzheimer's disease
- ☐ Elder abuse
- ☐ Long-term/nursing home care options
- ☐ Other (please specify) _____

Delivery of Health Care

Q13. Considering the services at WRHS, which services are you aware of? (Choose ALL that apply)

- ☐ Anesthesia services
- ☐ Cardiology
- ☐ Clinic
- ☐ Congestive Heart Failure Class
- ☐ CT scan
- ☐ Diabetic Education
- ☐ Diet instruction
- ☐ Echocardiogram
- ☐ EKG
- ☐ Emergency Room
- ☐ General x-ray
- ☐ Health screenings
- ☐ Home health care
- ☐ Hospital
- ☐ Laboratory services
- ☐ Laparoscopic surgery
- ☐ Mammography
- ☐ Mental health services
- ☐ MRI
- ☐ Occupational therapy
- ☐ Ophthalmology (eye/vision)
- ☐ Physical therapy
- ☐ Podiatry (foot/ankle)
- ☐ Prenatal Class (Stork Screen)
- ☐ Social services
- ☐ Surgical services
- ☐ Swing bed and respite care
- ☐ Telemedicine
- ☐ Ultrasound

Q14. Considering services not currently provided at WRHS, which do you see a need for in addition to those offered. (Choose your top two)

- ☐ Gynecology
- ☐ Oncology
- ☐ Orthopedics
- ☐ Weight loss/Bariatrics
- ☐ Other:_____

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Q15. What **PREVENTS** you or other community residents from receiving health care? (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 doctors
- ☐ Not enough evening or weekend hours
- ☐ Not enough specialists
- ☐ Poor quality of care
- ☐ Other (please specify) _____

Q16. Where do you turn for trusted health information? (Choose ALL that apply)

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

Q17. How do you prefer to be contacted about health care needs? (Choose ALL that apply)

- ☐ E-mail
- ☐ Letter
- ☐ Patient Portal
- ☐ Phone call
- ☐ Postcard
- ☐ Text message
- ☐ Other: _____

Q18. What specific health care services, if any, do you think should be added locally?

_____

_____

Demographic Information: Please tell us about yourself.

Q19. Do you work for the hospital, clinic, or public health unit?

☐ Yes ☐ No

Q20. Health insurance or health coverage status (choose ALL that apply):

- ☐ Indian Health Service (IHS)
- ☐ Insurance through employer or self-purchased
- ☐ Medicaid
- ☐ Medicare
- ☐ No insurance
- ☐ Not enough insurance
- ☐ Veteran's Health Care Benefits
- ☐ Other (please specify) _____

Q21. 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

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Q22. 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

Q23. Gender:

☐ Female
☐ Male
☐ Transgender

Q24. Employment status:

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

Q25. Your zip code: _____

Q26. Race/Ethnicity (choose ALL that apply):

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

Q27. 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

Q28. Overall, please share concerns and suggestions to improve the delivery of local health care.

_____

_____

Thank you for assisting us with this important survey!

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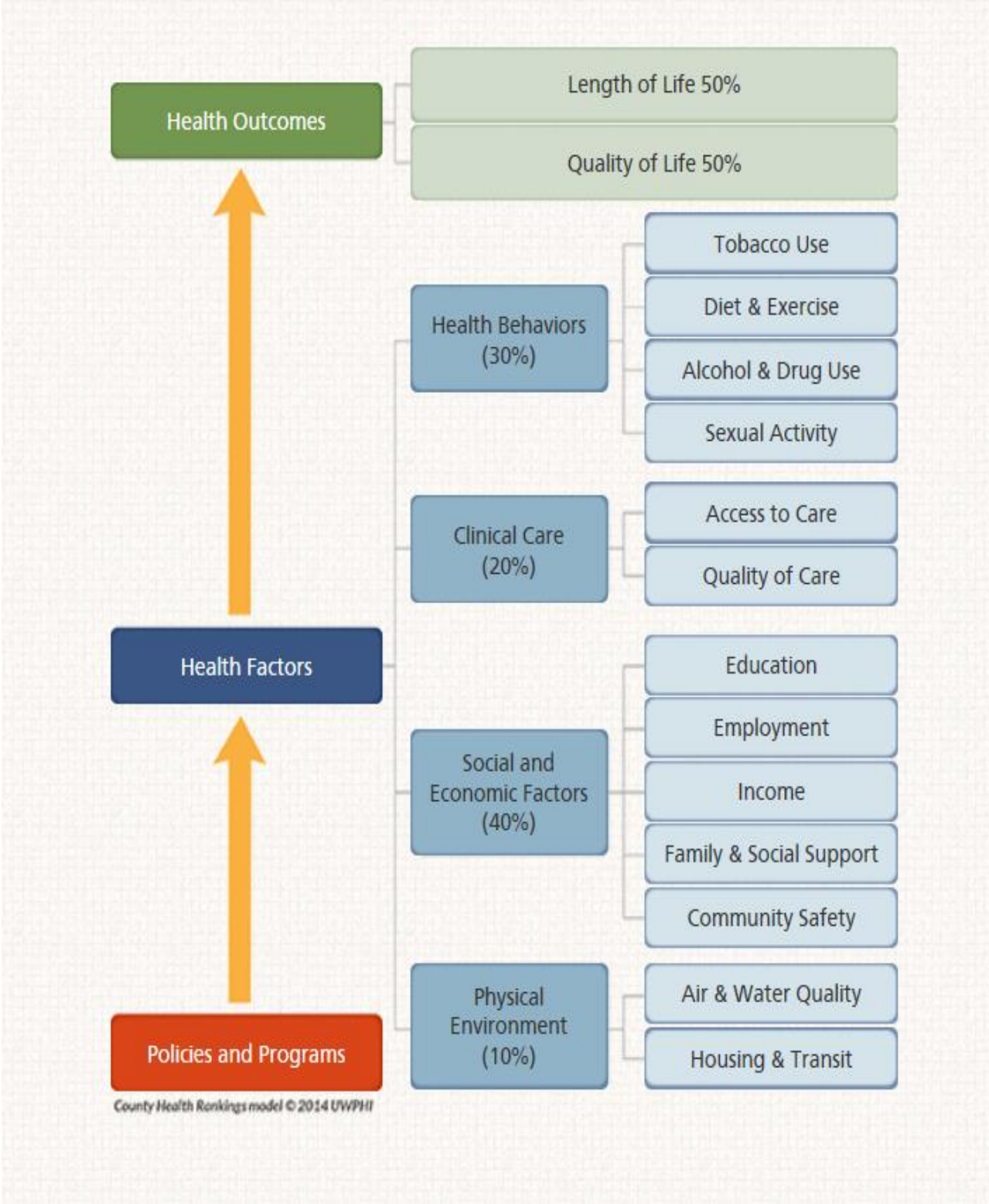
Appendix B – County Health Rankings Model



Appendix C – Prioritization of Community's Health Needs

Community Health Needs Assessment
Hettinger, 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
CONCERNS ABOUT COMMUNITY HEALTH		
Attracting & retaining young families	5	**1**
Jobs with livable wages	0	
Access to exercise and wellness activities	3	
Adequate childcare services	0	
AVAILABILITY OF HEALTH SERVICES		
Availability of specialists	1	
Availability of substance abuse/treatment services	6	**2**
Availability of primary care providers	1	
Availability of mental health services	0	
DELIVERY OF HEALTH SERVICES		
Cost of health insurance	0	
Cost of health care services	2	
Ability to recruit and retain primary care providers	2	
Cost of prescription drugs	0	
SAFETY/ENVIRONMENTAL HEALTH		
Public transportation (options & cost)	0	
Emergency services (ambulance & 911) available 24/7	1	
Traffic safety (ie. Speeding, road safety, drunk/distracted driving, and seatbelt use)	0	
Prejudice, discrimination	0	
PHYSICAL HEALTH		
Cancer	4	**2**
Obesity/overweight	4	**4**
Diabetes	0	
Poor nutrition/poor eating habits	0	
MENTAL HEALTH/SUBSTANCE ABUSE		
Youth alcohol use & abuse (including binge drinking)	2	
Adult alcohol use & abuse (including binge drinking)	5	**1**
Youth drug use & abuse (including prescription drug abuse)	1	
Adult drug use & abuse (including prescription drug abuse)	0	
SENIOR POPULATION		
Availability of resources to help the elderly stay in their homes	1	
Long-tem/nursing care options	0	
Assisted living options	0	
Availability of resources for family & friends caring for elders	2	

Community Health Needs Assessment Established Priorities for 2018-2021
Assessment Performed by the University of North Dakota Center or Rural Health
Plan Developed by the West River Health Services, West River Health Services Foundation, and Western Horizons Living Centers Boards of Directors in January 2018

Each of these items below were discussed at the community interviews coordinated by the CRH and the results of those discussions were communicated to both the Boards of Directors and the members of the West River Health Services Medical Staff who were present at the Board Retreat:

1. Obesity/Overweight Population
2. Availability of Substance Abuse/Treatment Services
3. Cancer: Treatment, Services, and Support
4. Attracting and Retaining Young Families
5. Adult Alcohol Use and Abuse (Binge Drinking)

These items will be migrated into the Short-Term (0-12 months), and Long-Term (12-36 months) strategic Plans. The short-term plan will be reviewed by the WRHS Board of Directors on a monthly basis, and the long-term plan will be updated on a quarterly basis to the same group. Yearly at the Annual Board retreat the plans are reviewed for appropriateness and adjustments are made when needed.

The West River Health Services Board of Directors approved the short-term Strategic Plan and the Final CHNA report at the March 2018 Board of Directors meeting.

Administration and the Medical Staff at West River Health Services strives to meet the needs of our communities and looks forward to the outcomes of this report and corresponding strategic work.

Matt Shahan, CEO
WRHSF, WRHS, WHLC

2018 Community Health Needs Assessment Implementation Plan
West River Health Services

Priority	Identified Health Need	Strategy	Intended Impact	Commitment of Resources	Collaboration
1	Obesity	1. Expand wellness education services to services area. 2. Utilize Diabetic Educators, Nutrition Education, and Ideal Protein services to assist community in obtaining a healthy weight.	Healthier community that is more active	1. Commitment made to the City of Hettinger to donate fitness equipment located in the WRHS Rehab Center to the community of Hettinger so that it can be utilized in the Hettinger Armory when ready. 2. Social Media marketing of healthy eating options, partnered with the Ideal Protein service line. Joint events to be held with the NDSU Extension Center on health eating and cooking.	City of Hettinger, Hettinger Armory, NDSU Extension Center
2	Availability of substance abuse/treatment services	Recruit additional specialists to expand access to care	Decrease abuse of substances through the prevention and treatment of substance abuse.	Utilization of current medical staff and the addition of medical staff to properly support the needs of our community members. Outreach to local churches and support groups so that patients unwilling to seek out medical care have options outside the clinical realm.	Local church groups, AA, and other community based support group
3	Cancer	Identify partners in the region who are willing to provide tele oncology services to WRHS.	Provide oncology services close to home so that our community members can seek such treatment in the comfort of their own community.	Clinical space, marketing, and continuing education of our providers and nursing staff on caring for this vulnerable population.	Outreach Oncology, Bismarck Cancer Center, Sanford, etc.
4	Attracting and retaining young families	Promoting WRHS staff to be more involved with the communities we serve, so that young families see an organization that fits their own values.	Younger families are needed to replace our aging workforce, not just at WRHS, but in our surrounding communities.	Marketing time and materials, family friendly events. Staff utilization of Community Benefit Time to be leaders in the community.	Local volunteer groups, family based clubs, Burgers and Brats in the park.
5	Adult alcohol use and abuse (including binge drinking)	Provide fun, alcohol free, events that are family based. Continued training of our Behavioral and Mental health team on how to assist our patients better.	Healthier community with other avenues of dealing with the stresses of rural living.	Commitment inside and outside of business hours of WRHS participation in service area activities. Providers may go on the radio, newspaper, or online to provide education and resources to our service area.	Local likeminded volunteer groups and family based clubs.