2016 Community Health Needs Assessment

Garrison Area
North Dakota

Lynette Dickson, MS
Kylie Nissen, BBA
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Executive Summary

To help inform future decisions and strategic planning, CHI St. Alexius Health Garrison conducted a community health needs assessment in McLean County. The Center for Rural Health, University of North Dakota, School of Medicine and Health Sciences facilitated the assessment process, which included input from area community members and health care professionals; as well as analysis of community health-related primary and secondary data.

To gather feedback from the community, residents of the counties were given the chance to participate in a survey. Approximately 177 McLean County took the survey. Additional information was collected through ten key informant interviews with community leaders. Input from residents represented broad interests of the communities of McLean County. Secondary data, gathered from a range of sources; and primary data from the survey, key-informant interviews, and community meeting present a snapshot of health needs and concerns in the community.

In terms of demographics, McLean County tends to reflect state averages. The percentages of residents under age 18 is close to the state average, and of those aged 65 and older are a few percentage points higher than the North Dakota averages. Rates of education are very close to North Dakota averages. The median household income in McLean County ($53,778) is slightly lower than the state average of North Dakota ($55,579).

Data compiled by County Health Rankings show that with respect to health outcomes, McLean County ranks 42nd out of 47 counties in health outcomes and 24th out of 47 counties in health factors. There also is room for improvement on individual factors that influence health, such as health behaviors, clinical care, social and economic factors, and the physical environment. Factors on which McLean County was performing poorly, relative to the rest of the state, included:

- premature death
- poor or fair health
- poor mental health days (in last 30 days)
- % of people with diabetes
- adult smoking
- physical inactivity
- access to exercise opportunities
- uninsured
- sufficient numbers of dentists
- preventable hospital stays
- unemployment
- children in poverty
- injury deaths
- drinking water violations
Of 71 potential community and health needs set forth in the survey, McLean County residents who took the survey, indicated the seven needs as the most important:

1. Attracting and retaining young families
2. Availability and ability to recruit and retain primary care providers (doctor, nurse practitioner, physician assistant)
3. Crime and Safety
4. Cancer
5. Youth drug use and abuse (including prescription drug abuse)
6. Availability of resources to help the elderly stay in their homes

The survey also revealed the biggest barriers preventing people from receiving health care locally, perceived by community members responding, was: not able to get appointments/limited hours (42); not able to see the same provider (35) over time; and not enough evening or weekend hours (35); and not enough specialists (34).

When asked what the best aspects of living in the county were, respondents indicated the following:

- Friendly, helpful, and supportive people; good place to raise kids
- People are involved in their community
- Healthcare
- Local events and festivals

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

- Availability of wellness and disease prevention services
- Attracting young people and families
- Need for additional services for the elderly
- Recruiting and retaining medical staff
- Mental health needs – adult and youth, to include substance abuse (alcohol and drugs)

Following careful consideration of the results and findings of this assessment, Community Group members determined that, in their estimation, the most significant health needs or issues in the community are:
• Ability to recruit and retain primary care providers (MD, PA, NP) (12)
• Youth drug use and abuse (11)
• Adult drug use and abuse (7)
• Cost of health insurance (6)
• Availability of resources to help elderly stay in their homes (5)
• Obesity/overweight (5)

Following the prioritization process, the second meeting of the Community Group, youth drug use and abuse was the number one identified need, followed closely by the ability to recruit and retain primary care providers.
Overview and Community Resources

The purpose of conducting a community health assessment is to describe the health of local people, identify areas for health improvement, identify use of local health care services, determine factors that contribute to health issues, identify and prioritize community needs, and help health care leaders identify potential action to address the community’s health needs. A health needs assessment benefits the community by: 1) collecting timely input from the local community; 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; and 4) engaging community members about the future of health care. Completion of a health assessment also is a requirement for public health departments seeking accreditation.

With assistance from the Center for Rural Health at the University of North Dakota School of Medicine and Health Sciences, CHI St. Alexius Health Garrison completed a community health assessment of McLean County, a single county served by CHI St. Alexius Health Garrison. Many community members and stakeholders worked together on the assessment.

CHI St. Alexius Health Garrison is located in West Central North Dakota 45 miles south of Minot, ND and 75 miles north of Bismarck, ND. CHI St. Alexius Health Garrison serves a four county region. Garrison’s service area consists mainly of northern McLean County with some patients coming from eastern McHenry and southern Ward County and the eastern edge of Mountrail County. The main community is Garrison with patients coming from Max, Ryder, Makoti, Parshall, White Shield, Coleharbor, and Riverdale. Along with the hospital, agriculture, tourism, and energy production provide the economic base for the town of Garrison and McLean County. According to the 2010 U.S. Census, Garrison had a population of 1,435, with a 2013 estimated population of 1,552. Within a 40-mile radius trade area of Garrison there is a population of 5,977.
Garrison has a number of community assets and resources that can be mobilized to address population health improvement. In terms of physical assets and features, the community includes a swimming pool, numerous city parks, a state park, tennis courts, golf course, skating rink, and movie theatre. Ft. Stevenson State Park offers multi-use trails for biking, recreation and camping opportunities as well as hosting numerous summer events. Lake Sakakawea is located three miles south of Garrison and offers numerous opportunities for outdoor recreation such as camping, hunting, and fishing. Garrison offers several cultural attractions such as the ND Fire Fighters Museum and ND Fallen Firefighter Memorial, Garrison Heritage Park, and ND Fishing Hall of Fame. Garrison is also home to the ND Governors Walleye Cup Fishing tournament and the annual Dickens Christmas Festival, which runs three weekends after Thanksgiving.

Garrison has a fitness center and public transportation, a recently expanded grocery store, and many restaurants and eating establishments. The Garrison Public school system offers a comprehensive program for students K-12.

Other health care facilities and services in the area include the Trinity Health Clinic in Garrison, a pharmacy, an optometrist, a dentist and a chiropractor.
Figure 1: McLean County, North Dakota

CHI St. Alexius Health Garrison

Opened in 1952, CHI St. Alexius Health Garrison is one of the most important assets in the community and the largest charitable organization in the Garrison area. CHI St. Alexius Health Garrison includes a 22-bed, critical access hospital, 4 bed Emergency Department, 28 bed Skilled Nursing Facility, and a Rural Health Clinic. As a hospital and designated level V trauma center, the hospital provides comprehensive care for a wide range of medical and emergency situations. Garrison is part of Catholic Health Initiatives and part of the CHI St. Alexius Health system, the largest health system and Western in Central North Dakota. CHI St. Alexius Health has seven hospitals and numerous clinics in Western and Central North Dakota with CHI St. Alexius Health in Bismarck as the systems hospital. CHI St. Alexius Health Garrison provides comprehensive medical care with physician and mid-level medical providers on staff and monthly consulting/visiting medical providers. With nearly 155 employees, CHI St. Alexius Health Garrison is the largest employer in the region. It has one full
time physician, one part-time physician, and three Family Nurse Practitioners and Physician Assistants. A 2010 economic impact study estimated that CHI St. Alexius Health Garrison had a total economic impact on McLean County of slightly over $5.6 million.

The mission of CHI St. Alexius Health Garrison is:

“The Mission of Catholic Health Initiatives is to nurture the healing ministry of the Church, supported by education and research. Fidelity to the Gospel urges us to emphasize human dignity and social justice as we create healthier communities.”

Specific services provided by CHI St. Alexius Health Garrison:

**General and Acute Services**

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

**Screening/Therapy Services**

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

13. Pediatric services

### Radiology Services
1. CT scan  
2. DEXA (Bone Density) Scans  
3. Digital mammography  
4. EKG  
5. General X-Ray  
6. Nuclear medicine (mobile unit)  
7. MRI (mobile unit)  
8. Ultrasound (mobile unit)

### Laboratory Services
1. Hematology  
2. Rapid testing kits  
3. Chemistry  
4. Coagulation  
5. Urinalysis

### Services offered by OTHER providers
1. Ambulance  
2. Chiropractic services  
3. Dental Services  
4. Massage therapy  
5. Optometric/vision services  
6. Retail pharmacy

### Telemedicine Services
1. eEmergency  
2. eHospitalists  
3. TelePharmacy  
4. TelePsychiatry

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**Assessment Process**

The purpose of conducting a community health needs assessment is to describe the health of local people, identify areas for health improvement, identify use of local health care services, determine factors that contribute to health issues, identify and prioritize community needs, and help health care leaders identify potential action to address the community’s health needs. A health needs assessment benefits the community by:

1) Collecting timely input from the local community, 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 health care; and

5) Allowing the community hospital to meet federal regulatory requirements of the Affordable Care Act, which requires not-for-profit hospitals to complete a community health needs assessment 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 Garrison and surrounding market area. In addition to Garrison we included Max, White Shield, Ryder, Coleharbor, and Riverdale in the assessment process.

The assessment process was highly collaborative. Administrators and other professionals from CHI St. Alexius Health Garrison and First District Health Unit were actively engaged in planning and implementing the assessment process. A CHNA Liaison was selected locally, who served as the main point of contact, between the Center for Rural Health and Garrison. A small Steering Committee was formed that was responsible for planning and implementing the process locally. Representatives from the Center for Rural Health, met and corresponded regularly by teleconference and/or via email 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 health care services. Steering Committee members selected and invited a number of residents, from outside the hospital and local health department, in their respective communities, including representatives from local government, businesses, schools and social services to participate in the key-information interviews and community group meetings.

The base survey instrument, used in the process, was also developed collaboratively and took into account input from health organizations around the state. The original survey tool was developed and previously utilized by the Center for Rural Health. In order to assure the survey tool met the needs of hospitals and public health the Center for Rural Health, worked with the North Dakota Department of Health’s public health liaison and participated in a series of meetings that garnered input from the state’s health officer,
local public health unit professionals from around North Dakota, representatives of the Center for Rural Health, and representatives from North Dakota State University.

As part of the assessment’s overall collaborative process, the Center for Rural Health 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 range of secondary sources of data were examined, providing information on a multitude of measures including demographics; health conditions, indicators, and outcomes; rates of preventive measures; rates of disease; and at-risk behavior.

The Center for Rural Health (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 (SORH) and administers the Medicare Rural Hospital Flexibility (Flex) program, funded by the Federal Office of Rural Health Policy, Health Resources Services Administration (HRSA), Department of Health and Human Services. The Center connects the School of Medicine and Health Sciences, and other necessary resources, to rural communities and their health care organizations in order to maintain access to quality care for rural residents. In this capacity the Center 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 and first met on March 24, 2016. During this first Community Group meeting, group members were introduced to the needs assessment process, reviewed basic demographic information about McLean County, 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 25, 2016 with 16 community members in attendance. At this second meeting the Community Group was presented with survey results, findings from key informant interviews and the focus group, and a wide range of secondary data relating to the general health of the population in McLean County. The group was then tasked with identifying and prioritizing the community’s health needs.

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

Interviews

One-on-one interviews, with six key informants, were conducted in person in Garrison on March 24, 2016. A representative from the Center for Rural Health conducted the interviews. Interviews were held with selected members of the Community Group as well as other key informants who could provide insights into the community’s health needs. 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 health care by local providers, awareness of health services offered locally, barriers to receiving health services, and suggestions for improving collaboration within the community.
Survey
A survey was distributed to gather feedback from the community. The survey was not intended to be a scientific or statistically valid sampling of the population. Rather, 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.

Community Member Survey
The community member survey was distributed to a variety of residents of Garrison and surrounding 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, levels of collaboration within the community, broad areas of community and health concerns, need for health services, concerns about the delivery of health care in the community, barriers to using local health care, preferences for using local health care versus traveling to other facilities, travel time to a clinic and hospital, use of preventive care, use of public health services, suggestions to improve community health, and basic demographic information.

To promote awareness of the assessment process, press releases led to published articles in the newspaper for Garrison, the McLean County Independent.

Approximately 500 community member surveys were available for distribution. The surveys were distributed by Community Group members, at churches, the public health office, community events, and area businesses.

To help ensure anonymity, included with each survey was a postage-paid return envelope to the Center for Rural Health. In order to make the survey available as widely as possible residents could also request a survey by calling CHI St. Alexius Health, Garrison. The survey period ran from March 11 – April 1, 2016, 42 completed paper surveys were returned.
Area residents were also given the option of completing an online version of the survey, which was publicized in the newspaper, at local businesses, emailed to the Garrison Chamber of commerce business listing, and printed on business cards to pass out to community members. There were 135 online surveys completed. In total (paper and online) 177 surveys were completed, equating to a response rate of 11%. This response rate is on par for this type of survey methodology and indicates a fairly 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 were collected from a variety of sources including the U.S. Census Bureau; the North Dakota Department of Health; the Robert Wood Johnson Foundation’s County Health Rankings (which pulls data from 20 primary data sources); the National Survey of Children’s Health Data Resource Center; the Centers for Disease Control and Prevention; the North Dakota Behavioral Risk Factor Surveillance System; and the National Center for Health Statistics.

**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 and to meet their basic needs, such as clean air and water; safe and affordable housing, are all essential to staying healthy. 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 percent (20%) that health care 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 are raised through this community health needs assessment process, it is 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**

![Social Determinants of Health Diagram]

Source: Authors’ analysis and adaption from the University of Wisconsin Population Health Institute’s County Health Rankings model ©2010, http://www.countyhealthrankings.org/about-project/background
Demographic Information

Table 1 summarizes general demographic and geographic data about McLean County; and also Mountrail, Ward, and McHenry Counties.

<table>
<thead>
<tr>
<th></th>
<th>McLean County</th>
<th>Mountrail County</th>
<th>Ward County</th>
<th>McHenry County</th>
<th>North Dakota</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Population, 2014 est.</strong></td>
<td>9,578</td>
<td>9,782</td>
<td>69,384</td>
<td>5,988</td>
<td>739,482</td>
</tr>
<tr>
<td><strong>Population change, 2010-2014</strong></td>
<td>6.9%</td>
<td>27.5%</td>
<td>27.5%</td>
<td>11%</td>
<td>9.9%</td>
</tr>
<tr>
<td><strong>Land area, square miles</strong></td>
<td>2,328</td>
<td>1,942</td>
<td>2,056</td>
<td>1,912</td>
<td>69,001</td>
</tr>
<tr>
<td><strong>People per square mile, 2010</strong></td>
<td>4.2</td>
<td>4.2</td>
<td>30.6</td>
<td>2.9</td>
<td>9.7</td>
</tr>
<tr>
<td><strong>White persons (not incl. Hispanic/Latino), 2014 est.</strong></td>
<td>90.6%</td>
<td>68.7%</td>
<td>89.4%</td>
<td>97.2%</td>
<td>89.1%</td>
</tr>
<tr>
<td><strong>Persons under 18 years, 2014 est.</strong></td>
<td>22%</td>
<td>25%</td>
<td>23.2%</td>
<td>23.2%</td>
<td>22.8%</td>
</tr>
<tr>
<td><strong>Persons 65 years or older, 2013 est.</strong></td>
<td>21.5%</td>
<td>10.8%</td>
<td>11.5%</td>
<td>19.0%</td>
<td>14.2%</td>
</tr>
<tr>
<td><strong>Non-English spoken at home, 2013 est.</strong></td>
<td>4.2%</td>
<td>5.9%</td>
<td>4.8%</td>
<td>4.0%</td>
<td>5.3%</td>
</tr>
<tr>
<td><strong>High school graduates, 2013 est.</strong></td>
<td>90.5%</td>
<td>90.2%</td>
<td>92.9%</td>
<td>88.4%</td>
<td>90.9%</td>
</tr>
<tr>
<td><strong>Bachelor’s degree or higher, 2013 est.</strong></td>
<td>17.5%</td>
<td>18.3%</td>
<td>25.9%</td>
<td>16.3%</td>
<td>27.2%</td>
</tr>
<tr>
<td><strong>Live below poverty line, 2013 est.</strong></td>
<td>10.9%</td>
<td>12.3%</td>
<td>12.1%</td>
<td>19.5%</td>
<td>11.9%</td>
</tr>
</tbody>
</table>

The population of North Dakota has grown in recent years, McLean County has seen a slight increase in population since 2010, as the U.S. Census Bureau estimates show that the county’s population increased from 2010 (8,962) to 2014 (9,578).
Health Conditions, Behaviors, and Outcomes

As noted above, several sources of secondary data were reviewed to inform this assessment. The data are presented below in three categories: (1) County Health Rankings, and (2) children’s health.

**County Health Rankings**

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

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. Below is a breakdown of the variables that influence a county’s rank. A model of the 2015 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](http://www.countyhealthrankings.org).

<table>
<thead>
<tr>
<th>Health Outcomes</th>
<th>Health Factors (continued)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Length of life</td>
<td>• Social and Economic Factors</td>
</tr>
<tr>
<td>• Quality of life</td>
<td>○ Education</td>
</tr>
<tr>
<td>Health Factors</td>
<td>○ Employment</td>
</tr>
<tr>
<td>• Health Behavior</td>
<td>○ Income</td>
</tr>
<tr>
<td>○ Smoking</td>
<td>○ Family and social support</td>
</tr>
<tr>
<td>○ Diet and exercise</td>
<td>○ Community safety</td>
</tr>
<tr>
<td>○ Alcohol and drug use</td>
<td>• Physical Environment</td>
</tr>
<tr>
<td>○ Sexual activity</td>
<td>○ Air and water quality</td>
</tr>
<tr>
<td>• Clinical Care</td>
<td>○ Housing and transit</td>
</tr>
<tr>
<td>○ Access to care</td>
<td></td>
</tr>
<tr>
<td>○ Quality of care</td>
<td></td>
</tr>
</tbody>
</table>
Table 2 summarizes the pertinent information gathered by County Health Rankings as it relates to McLean 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 CHI St. Alexius Health Garrison 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).

McLean County's rankings within the state also is included in the summary below. For example, McLean County ranks 42nd out of 47 ranked counties in North Dakota on health outcomes and 24th on health factors. The measures marked with a red checkmark (✓) are those where McLean, and the other counties are not measuring up to the state rate/percentage; a blue checkmark (✓) indicates that the county is faring better than the North Dakota average, but 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 show that McLean County is behind a majority of North Dakota on health outcomes measures, preforming lower than most other North Dakota counties, and not meeting the marks for many of the U.S. Top 10% ratings, except for low birth weight. One particular outcome is premature death. This is the years of potential life lost before age 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. This measure allows communities to target resources to high-risk areas and further investigate causes of premature death.

On health factors, McLean County is performing in the middle of the rest of North Dakota counties.
McLean County lags the state on the following reported measures:

- premature death
- poor or fair health
- poor mental health days (in last 30 days)
- % of people with diabetes
- adult smoking
- physical inactivity
- access to exercise opportunities
- uninsured
- sufficient numbers of dentists
- preventable hospital stays
- unemployment
- children in poverty
- injury deaths
- drinking water violations

<p>| TABLE 2: SELECTED MEASURES FROM COUNTY HEALTH RANKINGS – MCLEAN COUNTY |
|-------------------------------------------------|----------------|--------|----------------|---------|--------|----------|</p>
<table>
<thead>
<tr>
<th>Ranking: Outcomes</th>
<th>McLean County</th>
<th>Mountrail County</th>
<th>Ward County</th>
<th>McHenry County</th>
<th>U.S. Top 10%</th>
<th>North Dakota</th>
</tr>
</thead>
<tbody>
<tr>
<td>Premature death</td>
<td>10,960 ✓ ✓</td>
<td>9,600 ✓ ✓</td>
<td>6,400 ✓ ✓</td>
<td>10,000 ✓ ✓</td>
<td>5,200</td>
<td>6,388</td>
</tr>
<tr>
<td>Poor or fair health</td>
<td>13% ✓ ✓</td>
<td>16% ✓ ✓</td>
<td>12% ✓</td>
<td>13% ✓ ✓</td>
<td>10%</td>
<td>12%</td>
</tr>
<tr>
<td>Poor physical health days (in past 30 days)</td>
<td>2.7 ✓ ✓</td>
<td>3.1 ✓ ✓</td>
<td>2.6 ✓</td>
<td>2.8 ✓ ✓</td>
<td>2.5</td>
<td>2.7</td>
</tr>
<tr>
<td>Poor mental health days (in past 30 days)</td>
<td>2.7 ✓ ✓</td>
<td>2.8 ✓ ✓</td>
<td>2.7 ✓ ✓</td>
<td>2.6 ✓ ✓</td>
<td>2.3</td>
<td>2.4</td>
</tr>
<tr>
<td>Low birth weight</td>
<td>5.8% 😊</td>
<td>7% ✓ ✓</td>
<td>6% ✓</td>
<td>6% ✓</td>
<td>5.9%</td>
<td>6.5%</td>
</tr>
<tr>
<td>% Diabetic</td>
<td>11% ✓</td>
<td>10% ✓</td>
<td>7% 😊</td>
<td>9% ✓</td>
<td>-</td>
<td>8%</td>
</tr>
<tr>
<td>Ranking: Factors</td>
<td>24th</td>
<td>45th</td>
<td>14th</td>
<td>43rd</td>
<td>(of 47)</td>
<td></td>
</tr>
</tbody>
</table>

Health Behaviors

<table>
<thead>
<tr>
<th></th>
<th>McLean County</th>
<th>Mountrail County</th>
<th>Ward County</th>
<th>McHenry County</th>
<th>U.S. Top 10%</th>
<th>North Dakota</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult smoking</td>
<td>19% ✓ ✓</td>
<td>22% ✓ ✓</td>
<td>21% ✓ ✓</td>
<td>20% ✓ ✓</td>
<td>14%</td>
<td>18%</td>
</tr>
<tr>
<td>Adult obesity</td>
<td>30% ✓</td>
<td>34% ✓ ✓</td>
<td>30% ✓</td>
<td>29% ✓</td>
<td>25%</td>
<td>30%</td>
</tr>
<tr>
<td>Food environment index (10=best)</td>
<td>8.2 ✓ ✓</td>
<td>9.5 😊</td>
<td>8.1 ✓ ✓</td>
<td>5.7 ✓ ✓</td>
<td>8.4</td>
<td>8.5</td>
</tr>
<tr>
<td>Physical inactivity</td>
<td>28% ✓ ✓</td>
<td>34% ✓ ✓</td>
<td>27% ✓ ✓</td>
<td>29% ✓ ✓</td>
<td>20%</td>
<td>25%</td>
</tr>
<tr>
<td>Access to exercise opportunities</td>
<td>48% ✓ ✓</td>
<td>58% ✓ ✓</td>
<td>72% ✓</td>
<td>0% ✓ ✓</td>
<td>92%</td>
<td>68%</td>
</tr>
<tr>
<td>Excessive drinking</td>
<td>19% ✓</td>
<td>27% ✓ ✓</td>
<td>25% ✓ ✓</td>
<td>23% ✓ ✓</td>
<td>10%</td>
<td>22%</td>
</tr>
<tr>
<td></td>
<td>27% ✓</td>
<td>40% ✓</td>
<td>46% ✓</td>
<td>27% ✓</td>
<td>14%</td>
<td>46%</td>
</tr>
<tr>
<td>--------------------------------</td>
<td>-------</td>
<td>-------</td>
<td>-------</td>
<td>-------</td>
<td>-----</td>
<td>-----</td>
</tr>
<tr>
<td>Alcohol-impaired driving deaths</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sexually transmitted infections</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Teen birth rate</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Clinical Care**

<table>
<thead>
<tr>
<th></th>
<th>Uninsured</th>
<th>Primary care physicians</th>
<th>Dentists</th>
<th>Mental health providers</th>
<th>Preventable hospital stays</th>
<th>Diabetic screening</th>
<th>Mammography screening</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>13% ✓</td>
<td>-</td>
<td></td>
<td></td>
<td>58 ✓</td>
<td>88% ✓</td>
<td>72.2% ☹</td>
</tr>
<tr>
<td></td>
<td>17%</td>
<td>3,130:1 ✓</td>
<td>9,517:1 ✓</td>
<td>1,960:1 ✓</td>
<td>54 ✓</td>
<td>81% ✓</td>
<td>60% ✓</td>
</tr>
<tr>
<td></td>
<td>12%</td>
<td>1,740:1 ✓</td>
<td>1,390:1 ✓</td>
<td>530:1 ✓</td>
<td>46 ✓</td>
<td>85% ✓</td>
<td>69% ✓</td>
</tr>
<tr>
<td></td>
<td>17% ✓</td>
<td>-</td>
<td></td>
<td></td>
<td>62 ✓</td>
<td>85% ✓</td>
<td>70% ✓</td>
</tr>
<tr>
<td></td>
<td>11%</td>
<td>1,045:1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>12%</td>
<td>1,279:1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Social and Economic Factors**

<table>
<thead>
<tr>
<th></th>
<th>Unemployment</th>
<th>Children in poverty</th>
<th>Income inequality</th>
<th>Children in single-parent households</th>
<th>Violent crime</th>
<th>Injury deaths</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>4.0% ✓</td>
<td>13% ✓</td>
<td>4.4 ✓</td>
<td>19% ☹</td>
<td>66 ✓</td>
<td>95 ✓</td>
</tr>
<tr>
<td></td>
<td>1.3% ☹</td>
<td>14% ✓</td>
<td>4.8 ✓</td>
<td>34% ✓</td>
<td>111 ✓</td>
<td>104 ✓</td>
</tr>
<tr>
<td></td>
<td>2.7% ☹</td>
<td>11% ☹</td>
<td>3.8 ✓</td>
<td>23% ✓</td>
<td>212 ✓</td>
<td>59 ✓</td>
</tr>
<tr>
<td></td>
<td>4.5% ✓</td>
<td>16% ✓</td>
<td>4.3 ✓</td>
<td>28% ✓</td>
<td>48 ☹</td>
<td>79 ✓</td>
</tr>
<tr>
<td></td>
<td>4.0%</td>
<td>13%</td>
<td>3.7</td>
<td>20%</td>
<td>59</td>
<td>50 ✓</td>
</tr>
<tr>
<td></td>
<td>2.9%</td>
<td>12%</td>
<td>4.4</td>
<td>26%</td>
<td></td>
<td>64 ✓</td>
</tr>
</tbody>
</table>

**Physical Environment**

<table>
<thead>
<tr>
<th></th>
<th>Air pollution – particulate matter</th>
<th>Drinking water violations</th>
<th>Severe housing problems</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>9.8 ✓</td>
<td>8% ✓</td>
<td>8% ☹</td>
</tr>
<tr>
<td></td>
<td>9.8 ✓</td>
<td>-</td>
<td>10% ✓</td>
</tr>
<tr>
<td></td>
<td>9.8 ✓</td>
<td>-</td>
<td>10% ✓</td>
</tr>
<tr>
<td></td>
<td>9.6 ✓</td>
<td>Yes</td>
<td>9%</td>
</tr>
<tr>
<td></td>
<td>9.5</td>
<td>0%</td>
<td>9%</td>
</tr>
<tr>
<td></td>
<td>10.0</td>
<td>3%</td>
<td>11%</td>
</tr>
</tbody>
</table>

Community Health Needs Assessment - 2016
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 health care, and information on the child’s family, neighborhood, and social context. Data are from 2011-12. Additional 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% |
| Health Care | | |
| 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 health care | 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 (age 10-17)
- Children currently insured
- Children who had preventive medical and dentist visits
- Children receiving developmental/behavioral screening
- Children in households where someone smokes

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

The data show that McLean County is performing better than the North Dakota average on all of the examined measures except the number of uninsured children (and below 200% poverty), and licensed child care capacity. The most marked difference was on the measure of availability of licensed child daycare.

<table>
<thead>
<tr>
<th>TABLE 4: SELECTED COUNTY-LEVEL MEASURES REGARDING CHILDREN’S HEALTH</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>McLean County</strong></td>
</tr>
<tr>
<td>Uninsured children (% of population age 0-18), 2013</td>
</tr>
<tr>
<td>Uninsured children below 200% of poverty (% of population), 2013</td>
</tr>
<tr>
<td>Medicaid recipient (% of population age 0-20), 2014</td>
</tr>
<tr>
<td>Children enrolled in Healthy Steps (% of population age 0-18), 2013</td>
</tr>
<tr>
<td>Supplemental Nutrition Assistance Program (SNAP) recipients (% of population age 0-18), 2012</td>
</tr>
</tbody>
</table>
Survey Results

As noted above, 177 community members completed the survey in communities throughout the county. Survey results are reported in six categories: demographics; health care access; community assets, challenges, and collaboration; community concerns; delivery of health care; 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 percentages (%) are reported because percentages can be misleading with smaller numbers. Survey respondents were not required to answer all survey questions.

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

- Greatest number of respondents (41) were aged 55-64 or older, although there was a fairly even distribution of ages.

- The majority of respondents (N=118) were female; and 119 total had some college/technical, associate degree (N=60), bachelor’s (40) or graduate/professional degree (N=19);

- Majority (N=84) worked full-time, or next group were (N=38) retired.

Figures 3 through 8 show these demographic characteristics. It illustrates the range of community members’ household income and indicates how the assessment took into account input from those who represent varied interests of the community served, including a range of ages, those in diverse work situations, and some lower-income community members. Of those who provided a household income, only 11 survey

<table>
<thead>
<tr>
<th>Licensed child care capacity (% of population age 0-13), 2014</th>
<th>33.3%</th>
<th>14.7%</th>
<th>59.3%</th>
<th>27.4%</th>
<th>43.1%</th>
</tr>
</thead>
<tbody>
<tr>
<td>High school dropouts (% of grade 9-12 enrollment), 2013</td>
<td>2.6%</td>
<td>6.0%</td>
<td>1.4%</td>
<td>1.4%</td>
<td>2.8%</td>
</tr>
</tbody>
</table>
respondents reported a household income of less than $25,000, with 76 of those indicating a household income between $25,000-$99,999.

**Figure 3: Zip Code Demographics of Survey Respondents**
Figure 4: Age Demographics of Survey Respondents

- 18 to 24 years: 41
- 25 to 34 years: 28
- 35 to 44 years: 18
- 45 to 54 years: 17
- 55 to 64 years: 16
- 65 to 74 years: 30
- 75 years and older: 0
- Less than 18 years: 0

Figure 5: Gender Demographics of Survey Respondents

- Female: 118
- Male: 31
- Transgender: 0
Figure 6: Educational Level Demographics of Survey Respondents

- Less than high school: 17
- High school diploma or GED: 19
- Some college/technical degree: 29
- Associate's degree: 40
- Bachelor's degree: 43

Figure 7: Household Income Demographics of Survey Respondents

- Less than $15,000: 28
- $15,000 to $24,999: 10
- $25,000 to $49,999: 20
- $50,000 to $74,999: 26
- $75,000 to $99,999: 15
- $100,000 to $149,999: 12
- $150,000 and over: 1
- Prefer not to answer: 1

Community Health Needs Assessment - 2016
Figure 8: Employment Status Demographics of Survey Respondents

[Diagram showing employment status demographics with categories: Full time, Part time, Homemaker, Multiple job holder, Unemployed, Retired.

- Full time: 84
- Part time: 38
- Homemaker: 7
- Multiple job holder: 20
- Unemployed: 1
- Retired: 0]
Health Care Access

Community members were asked what their health insurance status is. Health insurance status is often associated with whether people have access to health care. No respondents reported having no health insurance or being under-insured. The most common insurance types were insurance through one’s employer or self-purchased (N=127), Medicare (N=43) and Medicaid (N=1).

Figure 9: Insurance Status

<table>
<thead>
<tr>
<th>Insurance Type</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Insurance through employer or self-purchased</td>
<td>127</td>
</tr>
<tr>
<td>Medicare</td>
<td>43</td>
</tr>
<tr>
<td>Other, Please specify:</td>
<td>12</td>
</tr>
<tr>
<td>Veteran’s Health Care Benefits</td>
<td>4</td>
</tr>
<tr>
<td>Indian Health Service (IHS)</td>
<td>2</td>
</tr>
<tr>
<td>Not enough insurance</td>
<td>2</td>
</tr>
<tr>
<td>Medicaid</td>
<td>1</td>
</tr>
<tr>
<td>No insurance</td>
<td>0</td>
</tr>
</tbody>
</table>

Community Assets, Challenges, and Collaboration

Survey-respondents were asked what they perceived as the best things about their community in five 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 the top three community assets include:

- Friendly, helpful, and supportive people; good place to raise kids
- People are involved in their community
- Healthcare
- Local events and festivals
Figures 10 through 13 illustrate the results of these questions.

**Figure 10: Best Things about the PEOPLE in Your Community**

- People are friendly, helpful, supportive: 141
- People are involved in their community: 138
- Feeling connected to people who live here: 78
- Community is socially and culturally diverse: 41
- Making a difference through civic engagement: 37
- People are tolerant, inclusive and open-minded: 12
- Government is accessible: 8
- Other (please specify): 2

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

- Health care: 137
- Business district (restaurants, availability of goods): 84
- Active faith community: 80
- Community groups and organizations: 66
- Quality school systems: 63
- Access to healthy food: 34
- Programs for youth: 10
- Public transportation: 6
- Other (please specify): 3
- Opportunities for advanced education: 1
**Figure 12: Best Things about the QUALITY OF LIFE in Your Community**

- Family-friendly; good place to raise kids: 138
- Safe place to live, little/no crime: 108
- Closeness to work and activities: 96
- Informal, simple, laidback lifestyle: 84
- Job opportunities or economic opportunities: 15
- Other (please specify): 3

**Figure 13: Best Thing about the ACTIVITIES in Your Community**

- Local events and festivals: 144
- Recreational and sports activities: 122
- Activities for families and youth: 97
- Year-round access to fitness opportunities: 34
- Arts and cultural activities: 25
- Other (please specify): 3
Community Concerns

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

- Community health
- Availability of health services
- Safety/environmental health
- Delivery of health services
- Physical health
- Mental health and substance abuse
- Senior population

Echoing the weight of respondents’ comments in the survey question about community challenges, the three most highly indicated concerns:

- Availability and ability to recruit and retain primary care providers (doctor, nurse practitioner, physician assistant) (93)
- Cancer (83)
- Youth drug use and abuse (including prescription drug abuse) (82)

The other issues that had at least 75 votes included:

- Obesity/overweight (N=77)
- Attracting and retaining young families (N=76)

Figures 14 through 20 illustrate these results.
Figure 14: Community Health Concerns

- Attracting and retaining young families: 76
- Jobs with livable wages: 70
- Affordable housing: 59
- Adequate childcare services: 57
- Access to exercise and wellness activities: 37
- Adequate school resources: 33
- Adequate youth activities: 25
- Change in population size (increase or decrease): 15
- Poverty: 9
- Other (please specify): 5

Figure 15: Availability of Health Services Concerns

- Availability of primary care providers (doctor, nurse practitioner, physician assistant): 71
- Availability of specialists: 65
- Ability to get appointments: 61
- Availability of mental health services: 41
- Availability of substance abuse/treatment services: 35
- Availability of dental care: 21
- Availability of wellness and disease prevention services: 20
- Availability of vision care: 15
- Availability of public health professionals: 12
- Other (please specify): 11
Figure 16: Safety/Environmental Health Concerns

- Crime and safety: 63
- Traffic safety: 48
- Emergency services (ambulance & 911) available 24/7: 42
- Physical violence, domestic violence: 29
- Public transportation (options and cost): 27
- Water quality (well water, lakes, rivers): 26
- Lack of police presence in community: 21
- Prejudice, discrimination: 19
- Land quality (litter, illegal dumping): 18
- Air quality: 13
- Low graduation rates: 5
- Other (please specify): 5
Figure 17: Delivery of Health Services Concern

- Ability to recruit and retain primary care providers (doctor, nurse practitioner, physician assistant): 93%
- Cost of health insurance: 66%
- Cost of prescription drugs: 59%
- Cost of health care services: 56%
- Extra hours for appointments, such as evenings and weekends: 37%
- Quality of care: 19%
- Patient confidentiality: 18%
- Providers using electronic health records: 11%
- Adequacy of Indian Health or Tribal Health services: 11%
- Sharing of information between healthcare providers: 10%
- Other (please specify): 3%
**Figure 18: Physical Health Concerns**

- Cancer: 93
- Obesity/overweight: 77
- Diabetes: 59
- Heart disease: 33
- Poor nutrition, poor eating habits: 30
- Youth obesity: 24
- Wellness and disease prevention: 17
- Youth sexual health (including STI's): 15
- Lung disease (i.e. Emphysema, COPD, Asthma): 14
- Youth hunger and poor nutrition: 10
- Teen pregnancy: 7
- Sexual health (including STD's & AIDS): 2
- Other (please specify): 2
Figure 19: Mental Health and Substance Abuse Concerns

- Youth drug use and abuse (including prescription drug abuse): 82
- Adult drug use and abuse (including prescription drug abuse): 64
- Adult alcohol use and abuse (including binge drinking): 60
- Youth alcohol use and abuse (including binge drinking): 53
- Depression: 28
- Stress: 28
- Youth tobacco use (exposure to second-hand smoke, use of alternate tobacco products i.e. e-cigarettes, vaping, hookah): 20
- Adult tobacco use (exposure to second-hand smoke, use of alternate tobacco products i.e. e-cigarettes, vaping, hookah): 19
- Adult mental health: 15
- Youth mental health: 10
- Youth suicide: 4
- Other (please specify): 3
- Adult suicide: 2
In another open-ended question, residents were asked, “What are the major challenges facing your community?” Most of the commonly cited challenges mirrored those identified above: for example, much concern about keeping the hospital and clinic open so health care services are available locally; need for mental health services, and considerable concern related to drug abuse and crimes of theft; need for good jobs and affordable housing for recruiting younger adults and families; perceived lack of support for the local school system; volunteer base, to support the community, is growing older and becoming burnt out and there is a limited number of younger people who are willing to get involved.
**Delivery of Health Care**

The survey asked residents what they see as barriers that prevent them, or others, from receiving health care locally. The most prevalent barrier perceived by residents was not being able to get an appointment/limited hours (42); not able to see same provider over time (35); not enough weekend hours (35); followed by not enough specialists (N=34); and not enough doctors, PAs or NPs (33). Figure 21 illustrates these results.

**Figure 21: Barriers to Seeking Health Care Locally**

- Not able to get appointment/limited hours: 42
- Not able to see same provider over time: 35
- Not enough evening or weekend hours: 35
- Not enough specialists: 34
- Not enough Doctors, Physician Assistants (PA), or Family Nurse Practitioners (FNP): 33
- Not accepting new patients: 23
- Concerns about confidentiality: 17
- Don’t know about local services: 14
- No insurance or limited insurance: 13
- Not affordable: 11
- Other (please specify): 11
- Distance from health facility: 6
- Poor quality of care: 6
- Can’t get transportation services: 6
- Limited access to telehealth technology (patients seen by providers at another facility through a monitor/TV screen): 4
- Lack of services through Indian Health Service: 2
- Lack of disability access: 0
- Don’t speak language or understand culture: 0
Respondents were provided a list of 27 health care services, offered by CHI St. Alexius, Garrison, and asked which they were aware of or had used in the past year. The top three were clinic services (133); laboratory services (124); and emergency services (121). The remaining services are displayed in Figure 22.

**Figure 22: Which services, are you aware of (or have you used in the past year).**
The survey also solicited input about what health care services should be added locally, and 35 responses provided suggestions. Many of the suggestions were similar to those mentioned previously such as mental health, to include addiction treatment/recovery; many comments expressing the need for another doctor; and frustration of not being able to get an appointment in a timely manner and suggested a desire to have walk-in and/or extended clinic hours (i.e. weekend evenings). Other suggestions were: cancer related treatment, podiatry/foot care; dermatology, urologist, diabetes specialists, respiratory specialist, cardiac care; and elder care, adult day care for elderly parents. Lastly, some comments were included with regard to the lack of customer service when calling in about their bill.

Respondents reported they found out about local health services by word of mouth, from others; and health care professionals (Figure 23).

**Figure 23: Source for learning about local health services.**
The survey revealed that, by a large margin, for trusted health information residents turned to a primary care provider (doctor, nurse practitioner, physician assistant) and other health care professionals; and next source is through web searches/internet (WebMD, Mayo Clinic, Healthline, etc.).

**Figure 24: Sources of Trusted Health Information**

- **Primary care provider (doctor, nurse practitioner, physician assistant)**: 134
- **Other health care professionals (nurses, chiropractors, dentists, etc.)**: 85
- **Web searches/Internet (WebMD, Mayo Clinic, Healthline, etc.)**: 73
- **Word of mouth, from others (friends, neighbors, co-workers, etc.)**: 45
- **Public health professional**: 21
- **Other (please specify)**: 4
Findings from Key Informant Interviews & Community Meeting (Focus Group)

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. The themes that emerged from these sources were wide-ranging, with some directly associated with health care and others more rooted in broader community matters.

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

- Availability of wellness and disease prevention services
- Attracting young people and families
- Need for additional services for the elderly
- Recruiting and retaining medical staff
- Mental health needs – adult and youth, to include substance abuse (alcohol and drugs)

To provide context for these expressed needs, below are a few comments that interviewees and community members made about these issues:

**Availability of wellness and disease prevention services**
- Few winter activities - not much to do in the winter.
- Good eating and exercise habits for children. Start them young

**Attracting and retaining young families**
- Not enough jobs with livable wages
- Childcare services are needed.
**Additional Services for the Elderly**

- Some people struggle having to take time off of work to assist the elderly they care for.
- Not necessarily home health, but some resources to help elderly stay in their homes – med set-up, wound care. There isn’t anything here.

**Recruiting and Retaining Medical Staff**

- It’s getting the staff we need to provide the needed services. If you don’t have the staff, you can’t provide the services.
- New providers, are looking for a more flexible practice model than current/previous providers. Need to be creative when recruiting.
- Being able to recruit and retain staff is a community responsibility.
- Providers are need to increase availability of appointments – walk-in-clinics, extended hours.

**Mental Health, to include Substance Abuse (Alcohol and Drugs)**

- Public health receive a number of calls related to suicide.
- Drug use. Meth and pot. Sherriff’s department are #2 for drug arrests. 2 overdoses seen/week on average in the hospital.
- Need to work together to address drug problem. Garrison hospital calls the sheriff’s department when they think that someone is in there as a drug seeker. Lack of drug rehab and system is not setup to discourage drug use.
- Have a program that a person doesn’t lose job if tested positive, instead have them participate in a treatment program.
- Services limited, or people aren’t aware of what is available; no place to refer people with addiction problems.
Community Engagement and Collaboration

Key informants 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?” They were then presented with a list of 13 organizations or community segments to rank. According to these participants, the hospital, pharmacies, public health, and other local health providers are the most engaged in the community. The averages of these rankings (with 5 being “excellent” engagement or collaboration) were:

- Pharmacies (5)
- Law enforcement (4.5)
- Economic development organizations (4.5)
- Emergency services, including ambulance and fire (4.5)
- Hospital (4.5)
- Long term care, including nursing homes and assisted living (4)
- Business and industry (4)
- Faith Based Organizations (4)
- Schools (3.5)
- Public Health (3.5)
- Other local health providers, (i.e. dentists and chiropractors) (3)
- Social Services (3)
- Clinics (3)
- Tribal health (2)
- Human services agencies (1.5)
Priority of Health Needs

A Community Group met on May 25, 2016. Sixteen community members of the group attended the meeting. A representative from the Center for Rural Health 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 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 so they could place a sticker 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 recruit and retain primary care providers (MD, PA, NP) (12)
- Youth drug use and abuse (11)
- Adult drug use and abuse (7)
- Cost of health insurance (6)
- Availability of resources to help elderly stay in their homes (5)
- Obesity/overweight (5)

Following the prioritization process, the second meeting of the Community Group, youth drug use and abuse was the number one identified need, followed closely by the ability to recruit and retain primary care providers.

A summary of this prioritization may be found in Appendix C.
Comparison of Needs Identified Previously

<table>
<thead>
<tr>
<th>Top Needs Identified 2013 CHNA Process</th>
<th>Top Needs Identified 2016 CHNA Process</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aging population services</td>
<td>Ability to recruit and retain primary care providers (MD, PA, NP)</td>
</tr>
<tr>
<td>Chronic disease management</td>
<td>Youth drug use and abuse</td>
</tr>
<tr>
<td>Health care workforce shortages</td>
<td>Adult drug use and abuse</td>
</tr>
<tr>
<td>Marketing &amp; promotion of hospital services</td>
<td>Cost of health insurance</td>
</tr>
</tbody>
</table>

Projects/Programs Implemented to Address Needs Identified in 2013

The following are projects/programs – actions taken, in response to the needs identified through the 2013 community health needs assessment process.

Service/Program development for specific population groups. Such as health promotion and chronic disease management.

1. Held health fairs, which offered a wide spectrum of health screenings and promoted educational sessions on chronic diseases and also offered flu shots.
2. Ran public service ads in our local paper high lighting a specific chronic disease to educate the public on living a healthy lifestyle.
3. A Community Resource Coordinator was on a county committee that identified county health and safety issues. This committee worked on improving the health of county residents.
4. Offered a couple of vascular health screenings, at no cost, on a Saturday in the clinic.

Health care workforce shortages:

1. Developed a comprehensive recruitment strategy.
2. Developed recruitment folders to distribute to potential professional candidates. Folders included information on hospital, services, and community.
3. Developed recruitment banners to take to college job fairs. Also purchased other items for our recruitment booth such as table coverings. Attended 6 to 8 college job fairs.

Marketing & promotion of hospital services:

1. Developed a comprehensive marketing plan developed
2. Bi-weekly ads in paper placed in paper for one year highlighting a different service, every two weeks, provided.
3. Developed new hospital brochures, highlighting services offered; and distributed throughout the service area.
4. Promoted services at health fairs and agriculture shows.

Access and availability to services:

a. Conducted a complete review of service offerings and reviewed what the public wanted for specialty medical services.

b. Hospital services added were Nuclear Medicine and bone densitometry, and arranged for the mobile MRI truck to double its yearly visits to our facility.

c. Also increased the use tele-medicine by adding eEmergency, eHospitalist, and tele-psychiatry services to our hospital.

We, unfortunately, were unable to offer more additional specialty physician services. Due to shortages of specialty physicians and specialty doctors were busy, in their large urban clinics, and felt traveling to rural hospitals was unproductive.

**Next Steps–Strategic Implementation Plan**

Although a community health needs assessment 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 health care system specific. This process is simply a first step to identify needs, 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 to begin working on. The strategic planning process will begin with identifying current initiatives/programs and resources in place, to address the need(s), what is needed and feasible; and what role and responsibility will 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**

We strongly encourage you to review your Community Benefit Report to determine how/if it
aligns with the needs identified, through your CHNA, as well as your Implementation Plan.

The community benefit requirement is a long-standing requirement of non-profit 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
health care organizations demonstrate their commitment to community service through
organized and sustainable community benefit programs providing:

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

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](https://www.irs.gov/pub/irs-pdf/r69545.pdf), 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 health care 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 health care 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 health care 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

Garrison Area Health Survey

CHI St. Alexius Health-Garrison Hospital is interested in hearing from you about community health concerns. The focus of this effort is to:

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

If you prefer, you may take the survey online at http://tinyurl.com/CHIGarrison or by scanning 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 1, 2016. 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) ________________________
**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?

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

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

| □ | |
| □ Ability to get appointments | □ Availability of specialists |
| □ Availability of primary care providers (doctor, nurse practitioner, physician assistant) | □ Availability of substance abuse/treatment services |
| □ Availability of dental care | □ Availability of vision care |
| □ Availability of mental health services | □ Availability of wellness/disease prevention services |
| □ Availability of public health professionals | □ Other (please specify) ____________ |

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

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

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

| □ Ability to recruit and retain primary care providers (doctor, nurse practitioner, physician assistant) | □ Extra hours for appointments, such as evenings and weekends |
| □ Adequacy of Indian Health or Tribal Health services | □ Patient confidentiality |
| □ Cost of health care services | □ Providers using electronic health records |
| □ Cost of health insurance | □ Quality of care |
| □ Cost of prescription drugs | □ Sharing of information between healthcare providers |
| □ Other (please specify) ____________ | |

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

| □ Cancer | □ Teen pregnancy |
| □ Diabetes | □ Youth hunger and poor nutrition |
| □ Lung disease (i.e. Emphysema, COPD, Asthma) | □ Youth obesity |
| □ Heart disease | □ Youth sexual health (including sexually transmitted infections) |
| □ Obesity/overweight | □ Wellness and disease prevention, including vaccine-preventable diseases |
| □ Poor nutrition, poor eating habits | □ Other (please specify) ____________ |
| □ Sexual health (including sexually transmitted diseases/AIDS) | |
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 SERVICES at CHI St. Alexius Health-Garrison Hospital, which services are you aware of (or have you used in the past year)? (Choose ALL that apply)
- Adult day care
- Cardiac rehab
- Cardiology (visiting specialist)
- Clinic
- CT scan
- Diet instruction
- EKG—Electrocardiography
- Emergency room
- General x-ray
- Ultrasound
- Health screenings
- Home health care
- Hospice
- Hospital (acute care)
- Laboratory services
- Mammography
- Mental health services
- MRI
- Occupational therapy
- Orthopedic (visiting specialist)
- Physical therapy
- Skilled Nursing Facility
- Social services
- Swing bed and respite care services
- Telemedicine via eEmergency

Q14. What PREVENTS you or other community residents from receiving health care locally? (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, Physician Assistants (PA), or Family Nurse Practitioners (FNP)
- Not enough evening or weekend hours
- Not enough specialists
- Poor quality of care
- Other (please specify) ________________
Q15. What specific health care services, if any, do you think should be added locally?


Preventive Care and Public Health Service

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

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

Demographic Information: Please tell us about yourself.

Q18. Do you work for the hospital, clinic, or public health unit?

☐ Yes
☐ No

Q19. 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) ______________

Q20. 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

Q21. 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

Q22. Gender:

☐ Female
☐ Male
☐ Transgender

Q23. Employment status:

☐ Full time
☐ Part time
☐ Homemaker
☐ Multiple job holder
☐ Unemployed
☐ Retired
Q24. Your zip code: ________________

Q25. Race/Ethnicity (choose ALL that apply):

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

Q26. Annual household income before taxes:

☐ Less than $15,000 ☐ $60,000 to $74,999 ☐ $150,000 and over
☐ $15,000 to $24,999 ☐ $75,000 to $99,999 ☐ Prefer not to answer
☐ $25,000 to $49,999 ☐ $100,000 to $149,999

Q27. Overall, please share concerns and suggestions to improve the delivery of local health care.

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

Thank you for assisting us with this important survey!
Appendix B – County Health Rankings Model
## Appendix C – Prioritization of Community’s Health Needs

The top four or five concerns for each of the seven topic area, 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 or six priorities** were selected based on the highest number of votes. Each person was given one red dot to place on the item they felt was the most important priority of the top five highest ranked priorities.

<table>
<thead>
<tr>
<th>Topic Area</th>
<th>Priorities</th>
<th>Most Important</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>DELIVERY OF HEALTH SERVICES</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ability to recruit and retain primary care providers (MD, NP, PA)</td>
<td>12</td>
<td>7</td>
</tr>
<tr>
<td>Cost of health insurance</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>Cost of health care services</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Cost of prescriptions</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td><strong>AVAILABILITY OF HEALTH SERVICES</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Availability of primary care providers (MD, NP, PA)</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Availability of specialists</td>
<td>0</td>
<td></td>
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<tr>
<td>Ability to get appointments</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Availability of mental health services</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td><strong>MENTAL HEALTH AND SUBSTANCES ABUSE</strong></td>
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<td></td>
</tr>
<tr>
<td>Youth drug use and abuse</td>
<td>11</td>
<td>8</td>
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<tr>
<td>Adult drug use and abuse</td>
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<td>1</td>
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<tr>
<td>Adult alcohol use and abuse</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Youth alcohol use and abuse</td>
<td>2</td>
<td></td>
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<tr>
<td><strong>SAFETY/ENVIRONMENTAL HEALTH</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Crime and Safety</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Traffic safety</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Emergency Services (ambulance and 911 24/7)</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Physical/domestic violence</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Public transportation (options/costs)</td>
<td>2</td>
<td></td>
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<tr>
<td><strong>AGING POPULATION</strong></td>
<td></td>
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<tr>
<td>Ability to meet the needs of the older</td>
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<tr>
<td>Availability of resources to help the elderly stay in their homes</td>
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<tr>
<td>Availability of resources for family and friends caring for elders</td>
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<td></td>
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<tr>
<td>Dementia/Alzheimer’s</td>
<td>1</td>
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<tr>
<td>Assisted living options</td>
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<td><strong>COMMUNITY HEALTH</strong></td>
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<td>Attracting and retaining young families</td>
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<tr>
<td>Jobs with livable wages</td>
<td>0</td>
<td></td>
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<tr>
<td>Affordable housing</td>
<td>0</td>
<td></td>
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<tr>
<td>Adequate childcare services</td>
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<td><strong>PHYSICAL HEALTH</strong></td>
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<tr>
<td>Cancer</td>
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<td>Obesity/overweight</td>
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<tr>
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<tr>
<td>Heart Disease</td>
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<td>Poor Nutrition</td>
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