

Community Health Needs Assessment

2019



Tioga Service Area, North Dakota

*Melana Howe, RN, BA, MSA
Howe Enterprises, LLC.*



Center for Rural Health

University of North Dakota
School of Medicine & Health Sciences

Table of Contents

Executive Summary 3

Overview and Community Resources 4

Assessment Process 8

Demographic Information 12

Survey Results 18

Findings of Key Informant Interviews and Community Meeting..... 41

Priority of Health Needs 44

Next Steps – Strategic Implementation Plan..... 47

Appendix A – Survey Instrument..... 49

Appendix B – County Health Rankings Model..... 57

Appendix C – Prioritization of Community’s Health Needs 68

Appendix D – Survey “Other” Responses 69

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

Executive Summary

To help inform future decisions and strategic planning, Tioga Medical Center (TMC) and the Upper Missouri District Health Unit (UMDHU) conducted a community health needs assessment (CHNA) in 2018/2019, the previous CHNA was conducted in 2016. The Center for Rural Health (CRH) at the University of North Dakota School of Medicine & Health Sciences (UNDSMHS) facilitated the assessment process, which solicited input from area community members and healthcare professionals as well as analysis of community health-related data.



To gather feedback from the community, residents of the area were given the opportunity to participate in a survey. There were 84 surveys submitted (65 electronic and 19 paper) by TMC service area residents. The area residents completed the surveys between September 24 and November 18, 2018. Additional information was collected through 12 key informant interviews and community members. The input from the residents, who primarily reside in Williams 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.

Williams County population from 2010 to 2017 increased 48.9% compared to the state average of 12.3%. The average number of residents under the age of 18 (27.9%) for Williams County is higher than the state average (23.3%). The percentage of residents ages 65 and older is 5.2% lower for Williams County (9.8%) than the North Dakota average (15.0%), and the rates of education are slightly higher for Williams County (92.3%) than the North Dakota average (92.0%) for high school graduates, and significantly lower for bachelor's degree or higher (22.5%) compared to 28.2% for North Dakota. Williams County has less individuals below the poverty line (6.8%) compared to the state average (10.7%), however has a significantly higher level of individuals without health insurance under age 65 years (7.6% compared to 8.1% respectively).

Data compiled by County Health Rankings show Williams County is doing better than North Dakota in four health outcomes and tied or better than the national levels in four factors. Williams County is ranked 11th of 49 counties in North Dakota in health outcomes overall.

Williams County, according to County Health Rankings data, is performing poorly relative to the rest of the state in 17 factors and is not meeting the United States Top 10% performers in 20 factors.

Of the potential community and health needs set forth in the survey, the 84 Williams County service area residents who completed the survey indicated the following 10 needs as the most important:

- Having enough child daycare services
- Not having enough affordable housing
- Availability of mental health services
- Extra hours for appointments such as evenings and weekends
- Depression/anxiety among adults
- Alcohol use and abuse by adults
- Drug use and abuse by youth including prescription drugs
- Alcohol use and abuse by youth
- Availability of resources to help the elderly stay in their homes
- Cost of long-term nursing home care

The survey responses revealed the biggest barriers to receiving healthcare locally (as perceived by community members), included the need for extra hours for appointments, such as evenings and weekends (22%) and no insurance or limited insurance (22%). The third highest rating was not able to get appointments/limited hours (20%) followed by not enough specialists (17%).

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

- People are friendly, helpful, and supportive
- People who live here are involved in their community
- Family-friendly
- Local events and festivals
- Safe place to live
- Quality school system
- Healthcare
- Recreational and sports activities

Input from community leaders, provided through key informant interviews, and the community focus group, echoed many of the concerns raised by survey respondents.

Concerns emerging from these sessions were:

- Depression because of family situations - moved away from support system, working parents, social dynamics/split families
- Obesity - crosses all age groups and is also a community item (walking paths)
- Mental health for everyone, including providers trying to solve the issue.
- Youth - scares me - for the kids - parents forget to pick them up (parental involvement and parties (drinking at bar, darts). What about the next generation?
- Drug issue and get ahead of it.
- Wellness/exercise facility - consider re-directing healthcare sales tax
- Cancer - I know many with cancer - young people, 19-50 years of age.
- There is not a huge understanding of what goes on - more education on various healthcare needs. People travel 10 hours to go to therapy session.
- Depression.
- Availability of mental health and utilization of what is available.
- Concerns about health services - in general mental healthcare is lacking for all ages.
- Depression/anxiety, this is a concern for all age groups and can lead to many other issues.

Overview and Community Resources

With assistance from the CRH and the UMDHU, the Tioga Medical Center completed a CHNA of the service area. Many community members and stakeholders worked together on the assessment.

Tioga Community

Tioga Medical Center is located in northwestern North Dakota, approximately 45 miles east of Williston and 90 miles west of Minot. Along with the hospital, agricultural, and oil and gas operations, provide the economic base for the town of Tioga and Williams County. According to the 2010 U.S. census, Williams County had a population of 22,398, while Tioga had a population of 1230. Between 2010 and 2017, according to the Census Bureau estimates, Williams County was the fastest-growing county in the United States, trailing only to neighboring McKenzie County, to its south. The estimated population of Tioga is 3,000 and Williston, the county seat of Williams County, is estimated at 33,349 (2017).



Tioga and Williams County have a number of community physical assets and resources that can address population health improvement including, a bike path, swimming pool, city parks, tennis courts, golf course, skating rink, and movie theatre. Lake Sakakawea, just south of Tioga, offers boating, hiking, ATV riding, and fishing.

The Tioga community has a strong faith community of one Catholic and four Protestant churches. There is a strong assortment of service and social organizations including clubs, guilds and industry groups.

Each major town in Williams County has other valued community assets including public transportation and good grocery stores. The Tioga school system offers a comprehensive program for students kindergarten through grade 12.

Other healthcare providers in the community in addition to the TMC and UMDHU are fire and ambulance services, dental services, counseling services, and mental health services.

Upper Missouri District Health Unit

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

Specific services provided by UMDHU are:

- Blood pressure checks
- Breastfeeding resources
- Car seat program
- Emergency response & preparedness services
- Environmental health services (water, sewer, health hazard abatement)
- Family planning (STD and HIV testing)
- Flu shots
- Foot care
- Foreign travel immunizations
- Immunizations
- Member of Child Protection Team
- Newborn home visits/clinic
- Nutrition education
- School health (education/resources in the schools)
- Tobacco prevention and control
- Tuberculosis testing and management
- WIC (women, infants & children) program
- Tribal services

Tioga Medical Center

TMC's stated mission is to address the healthcare needs of the community by providing quality care and promoting education and wellness. Founded for the primary purpose of administering healthcare in its most complete form, including care in the form of mercy and love, TMC offers professional healthcare to all persons regardless of race, color, creed, age, or disability. Efforts for a healthcare facility in Tioga started with discussions in the early 1950s and culminated with construction of a hospital in 1961. Development has continued with a 30-bed nursing home completed in 1977 and an independent living facility with 22 apartments that opened its doors in 1998.

Together with the Tioga Clinic that is open weekdays, the nursing home, independent living facility and the 25-bed critical access hospital make up the TMC. In addition, TMC also operates two satellite rural clinics in Williams County which are located in the communities of Ray and Powers Lake.



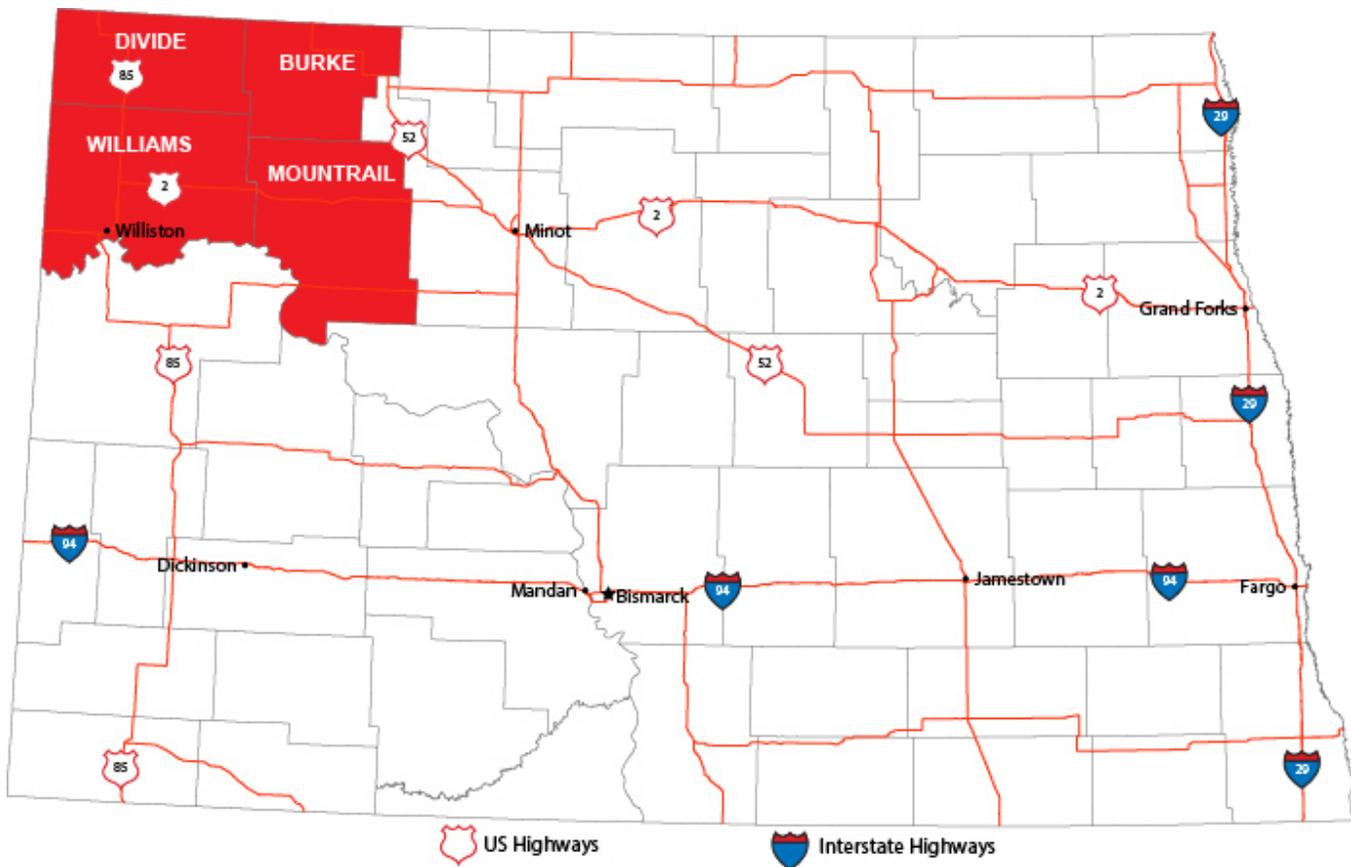
The mission of TMC is to address the healthcare needs of the community through providing quality healthcare and promoting education and wellness.

The TMC vision was founded for the primary purpose of administering healthcare in its most complete form. This means care in the form of mercy and love, as well as providing a professional service.

All persons regardless of race, color, creed, age, or disability are entitled to the best care medical science has to offer. Restorative, physical, mental, social, and spiritual facilities are available to each individual admitted, to aid in recovery and enrich their life. These individuals are in a transitional and stressful part of their life. They now require professional care, guidance, and support to provide for their needs to obtain their highest level of functioning. Our philosophy is to protect and promote the rights of each individual and to illicit active participation in their plan of care. The provision of in-service educational programs for employees is essential to maintain a standard of quality for the services our facility provides to the residents and patients served by the TMC.

Figure 1 illustrates the location of the counties.

Figure 1: Williams, Mountrail, Divide and Burke Counties, North Dakota



Services that Tioga Medical Center offers locally include:

General and Acute Services

- Hospital (acute care)
- Emergency room
- Swing bed
- Long term care
- Independent senior housing
- Mammogram
- MRI
- Ultrasound
- Outpatient surgery
- Counseling services
- Immunizations
- GI procedures (colonoscopy or EDGs)

Physical and occupational therapy Services

- General orthopedics
- Pre-and post-surgical rehabilitation
- Pain management
- Wound/burn care
- Athletic injuries/sports medicine
- Women's health
- Vestibular rehabilitation
- Neurological rehabilitation
- Back education and rehabilitation
- Geriatric issues (balance/falls)
- Myofascial release
- Hand therapy
- Splinting/bracing
- ADL equipment needs and training
- Home safety assessments
- Wheelchair assessments
- Speech therapy

Laboratory and Radiology Services

- Drug screening
- Breath and alcohol testing
- Outpatient lab services
- CT-scan
- DEXA scan

Clinical Services

- Wellness through patient education and screenings
- Chronic disease management
- Geriatric care
- Health maintenance exams
- Preoperative exams
- Individualized care to all ages
- Child/newborn wellness exams
- DOT exams and other health screenings
- Health and wellness counseling for all ages
- Adolescent health
- Breast health
- Minor procedures
- Chronic disease management
- Women's health (annual exams, basic OB care, contraceptive implants)
- Health maintenance exams
- Diabetic education and foot care

Assessment Process

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

A CHNA benefits the community by:

- 1) Collecting timely input from the local community members, providers, and staff;
- 2) Providing an analysis of secondary data related to health-related behaviors, conditions, risks, and outcomes;
- 3) Compiling and organizing information to guide decision making, education, and marketing efforts, and to facilitate the development of a strategic plan;
- 4) Engaging community members about the future of healthcare; and
- 5) Allowing the community hospital to meet the federal regulatory requirements of the Affordable Care Act, which requires not-for-profit hospitals to complete a CHNA at least every three years, as well as helping the local public health unit meet accreditation requirements.

This assessment examines health needs and concerns in Williams County.

The CRH, in partnership with the TMC, facilitated the CHNA process. Community representatives met regularly in-person, by telephone conference, and email. A CHNA liaison was selected locally, who served as the main point of contact between the CRH and the Tioga area communities. A small steering committee (see Figure 2) was formed that was responsible for planning and implementing the process locally. Representatives from the CRH met and corresponded regularly by teleconference and/or via the eToolkit with the CHNA liaison. The community group (described in more detail below) provided in-depth information and informed the assessment process in terms of community perceptions, community resources, community needs, and ideas for improving the health of the population and healthcare services. Twelve people, representing a cross section demographically, were interviewed one-on-one or attended the focus group meeting. The meeting was highly interactive with good participation. Some of the medical facility staff and board members attended as well, but largely played a role of listening and learning.

Figure 2: Steering Committee

| | |
|------------------|--|
| Shelby Dean | Tioga Clinic, Manager |
| Ryan Mickelson | Tioga Medical Center, VP/COO/CFO |
| Jenna Hove | Tioga Medical Center, Director of Social Service |
| Juliet Artman RN | Prevention Team Program Manager |

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

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

- A survey solicited feedback from area residents;
- Community leaders representing the broad interests of the community took part in one-on-one key informant interviews;

- The Community Group, comprised of community leaders and area residents, convened to discuss area health needs and inform the assessment process; and
- A wide range of secondary sources of data were examined, providing information on a multitude of measures, including demographics, health conditions, indicators, outcomes, rates of preventive measures; rates of disease; and at-risk behavior.
- The CRH is one of the nation’s most experienced organizations committed to providing leadership in rural health. Its mission is to connect resources and knowledge to strengthen the health of people in rural communities. The CRH is the designated State Office of Rural Health and administers the Medicare Rural Hospital Flexibility (Flex) program, funded by the Federal Office of Rural Health Policy, Health Resources Services Administration, and Department of Health and Human Services. The CRH connects the UNDSMHS and other necessary resources, to rural communities and their healthcare organizations in order to maintain access to quality care for rural residents. In this capacity, the CRH works at a national, state, and community level.

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

Community Group

A Community Group consisting of five community key members met on October 1, 2018. During this first Community Group meeting, group members were introduced to the needs assessment process, reviewed basic demographic information about the community, and served as a focus group. Focus group topics included community assets and challenges, the general health needs of the community, community concerns, and suggestions for improving the community’s health.

The Community Group met again on January 23, 2019 with 12 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 Williams 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 TMC and UMDHU. 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 seven key informants were conducted in person in Tioga on October 1, 2018. A representative from the CRH conducted the interviews. Interviews were held with selected members of the community who could provide insights into the community’s health needs. The informant interviews included public health professionals with several years of direct experience in the community, including working with medically underserved, low income, and minority populations, as well as with populations with chronic diseases.

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

Survey

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

copy of the survey instrument is included in Appendix A.

The community member survey was distributed to various residents of its service area, which is defined as Williams County.

The survey tool was designed to:

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

Specifically, the survey covered the following topics:

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

To promote awareness of the assessment process, press releases were published in local newspapers in Williams County. Additionally, information was posted on the TMC's Facebook page with several updates. Approximately 200 community member surveys were available for distribution in Williams County. The paper surveys were available at the clinics and the medical center.

To help ensure anonymity, included with each survey was a postage-paid return envelope to the CRH. In addition, to help make the survey as widely available as possible, residents could also request a survey by calling TMC. The survey period ran from September 24, 2018 to November 18, 2018. A total of 84 surveys were completed, 65 of them electronic and 19 of them paper. This response rate is on par for this type of unsolicited survey methodology and indicates an engaged community.

Secondary Data

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

Social Determinants of Health

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

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

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

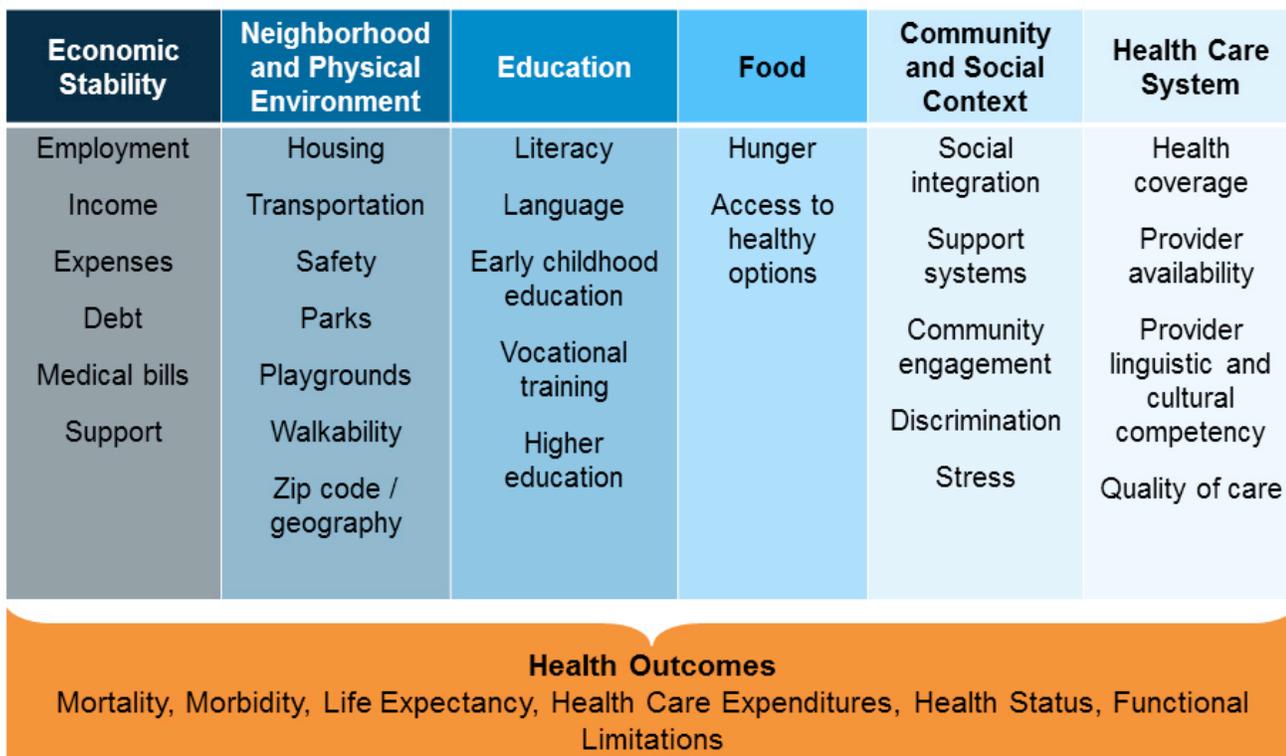
Figure 3: Social Determinants of Health



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

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

Figure 4: Social Determinants of Health



Demographic Information

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

(From 2010 Census/2017 American Community Survey; more recent estimates used where available)

| | Williams | North Dakota |
|---|----------|--------------|
| Population (2017) | 33,349 | 755,393 |
| Population change (2010-2017) | 48.9 | 12.3% |
| People per square mile (2010) | 10.8 | 9.7 |
| Persons 65 years or older (2016) | 9.8% | 15.0% |
| Persons under 18 years (2016) | 27.9% | 23.3% |
| Median age (2016 est.) | 32.0 | 35.2 |
| White persons (2016) | 86.9% | 87.5% |
| Non-English speaking (2016) | 5.3% | 5.6% |
| High school graduates (2016) | 92.3% | 92.0% |
| Bachelor’s degree or higher (2016) | 22.5% | 28.2% |
| Live below poverty line (2016) | 6.8% | 10.7% |
| Persons without health insurance, under age 65 years (2016) | 7.6% | 8.1% |

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

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, Mountrail County is compared to North Dakota rates and national benchmarks on various topics ranging from individual health behaviors to the quality of healthcare.

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

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

| Health Outcomes | Health Factors (continued) |
|---|---|
| <ul style="list-style-type: none">• Length of life• Quality of life | <ul style="list-style-type: none">• Clinical care<ul style="list-style-type: none">- Access to care- Quality of care• Social and Economic Factors<ul style="list-style-type: none">- Education- Employment- Income- Family and social support- Community safety• Physical Environment<ul style="list-style-type: none">- Air and water quality- Housing and transit |
| Health Factors | |
| <ul style="list-style-type: none">• Health behavior<ul style="list-style-type: none">- Smoking- Diet and exercise- Alcohol and drug use- Sexual activity | |

Table 2 summarizes the pertinent information gathered by County Health Rankings as it relates to Williams County. 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 TMC or UMDHU or of any particular medical facility.

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.

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

Williams County rankings within the state are included in the summary following. For example, Williams County ranks 11th out of 49 ranked counties in North Dakota on health outcomes and 45th on health factors. The measures marked with a bullet point (•) are those where a county is not measuring up to the state rate/percentage; an asterisk (*) indicates that the county is faring better than the North Dakota average but is not meeting the U.S. Top 10% rate on that measure. Measures that are not marked with a bullet or asterisk but are marked with a plus sign (+) indicate that the county is doing better than the U.S. Top 10%.

The data from County Health Rankings shows that Williams County is doing equal to or better than other counties in North Dakota on all but two of the outcomes, (premature deaths and the percentage of diabetics) landing at or above rates for other North Dakota counties.

Williams County rates equal to or better than the national top 10% health outcomes in:

- Reporting poor or fair health
- Reporting less poor physical health days
- Reporting less poor mental health days
- Reporting less low birth weights

Williams County rates equal to or better than the national top 10% in the following health factors:

- High food environment index
- Children in poverty
- Children in single households
- Lower unemployment
- No drinking water violations

Data compiled by County Health Rankings show Williams County is doing better than North Dakota in health factors in the following areas:

- Food environment index
- Children in poverty
- Children in single-parent households
- Severe housing problems

Of the identified health factors, the behavioral factors in which Williams County is performing poorly relative to the rest of the state include:

- Adult obesity
- Physical inactivity
- Excessive drinking
- Alcohol-impaired driving deaths
- Sexually transmitted diseases
- Teen birth rate
- Less primary care physicians
- Less dentists
- Less mental health providers
- Higher preventable hospital stays
- Less diabetic monitoring
- Less mammography screening
- Higher unemployment
- Higher violent crimes
- Higher injury deaths



Williams County (27%) ranks higher than the state (26%) in excessive drinking rates, which are compared to the national average (13%).

Table 2: Selected Measures from County Health Rankings 2018 - Williams County

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

* Not meeting U.S. top 10% performers

• Not meeting North Dakota average

| | Williams County | U.S. Top 10% | North Dakota |
|---|------------------------|--------------|----------------|
| Ranking: Outcomes | 11th | | (of 49) |
| Premature death | 7,600 •* | 5,300 | 6,600 |
| Poor or fair health | 12% + | 12% | 14% |
| Poor physical health days (in past 30 days) | 2.7 + | 3.0 | 3.0 |
| Poor mental health days (in past 30 days) | 2.6 + | 3.1 | 3.1 |
| Low birth weight | 5% + | 6% | 6% |
| % Diabetic | 9% •* | 8% | 8% |
| Ranking: Factors | 45th | | (of 49) |
| <i>Health Behaviors</i> | | | |
| Adult smoking | 20% * | 14% | 20% |
| Adult obesity | 36% •* | 26% | 32% |
| Food environment index (10=best) | 9.3 + | 8.6 | 9.1 |
| Physical inactivity | 26% •* | 20% | 24% |
| Access to exercise opportunities | 82% * | 91% | 75% |
| Excessive drinking | 27% •* | 13% | 26% |
| Alcohol-impaired driving deaths | 57% •* | 13% | 48% |
| Sexually transmitted infections | 554.0 •* | 145.1 | 427.2 |
| Teen birth rate | 45 •* | 15 | 25 |
| <i>Clinical Care</i> | | | |
| Uninsured | 9% * | 6% | 9% |
| Primary care physicians | 1,960:1 •* | 1,030:1 | 1,330:1 |
| Dentists | 1,560:1 •* | 1,280:1 | 1,550:1 |
| Mental health providers | 860:1 •* | 330:1 | 610:1 |
| Preventable hospital stays | 58 •* | 35 | 49 |
| Diabetic monitoring (% of diabetic Medicare enrollees ages 65-75 that receive HbA1c monitoring) | 82% •* | 91% | 87% |
| Mammography screening (% of Medicare enrollees ages 67-69 receiving screening) | 59% •* | 71% | 69% |
| <i>Social and Economic Factors</i> | | | |
| Unemployment | 4.4% •* | 3.2% | 3.2% |
| Children in poverty | 8% + | 12% | 12% |
| Income inequality | 4.3 * | 3.7 | 4.3 |
| Children in single-parent households | 20% + | 20% | 28% |
| Violent crime | 469 •* | 62 | 26 |
| Injury deaths | 94 •* | 55 | 68 |
| <i>Physical Environment</i> | | | |
| Air pollution – particulate matter | 7.2 * | 6.7 | 7.5 |
| Drinking water violations | No + | No | |
| Severe housing problems | 9% + | 9% | 11% |

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

Children's Health

The National Survey of Children's Health touches on multiple intersecting aspects of children's lives. Data are not available at the county level; listed below is information about children's health in North Dakota. The full survey includes physical and mental health status, access to quality healthcare, and information on the child's family, neighborhood, and social context. Data is from 2011-12. 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% |

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

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

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

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

The data shows Williams County is performing more poorly than the North Dakota average on four factors:

- Uninsured children at 5.1% higher than state average
- Medicaid recipient population is 4.8% higher than state average
- Licensed child care capacity is only 17% compared to the North Dakota state average of 41.9%. A difference of almost 25%.
- The 4-year high school cohort graduation rate in 2017 was 5.9% less than the state average.

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

| | Williams County | North Dakota |
|--|------------------------|---------------------|
| Uninsured children (% of population age 0-18), 2016 | 7.5% | 9.0% |
| Uninsured children below 200% of poverty (% of population), 2016 | 27.2% | 41.9% |
| Medicaid recipient (% of population age 0-20), 2017 | 23.9% | 28.3% |
| Children enrolled in Healthy Steps (% of population age 0-18), 2013 | 1.4% | 2.5% |
| Supplemental Nutrition Assistance Program (SNAP) recipients (% of population age 0-18), 2017 | 13.5% | 20.1% |
| Licensed childcare capacity (% of population age 0-13), 2018 | 30.5% | 41.9% |
| 4-Year High School Cohort Graduation Rate, 2017 | 83.4% | 87.0% |

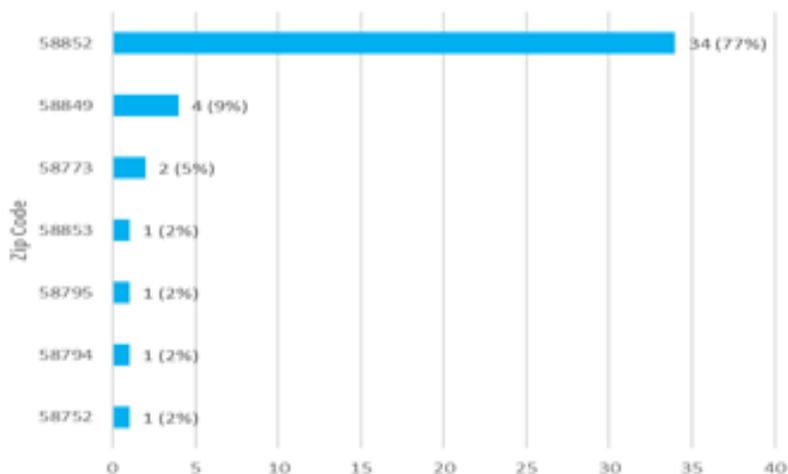
Source: <https://datacenter.kidscount.org/data#ND/5/0/char/0>

Survey Results

As noted previously, 84 community members completed the survey in communities throughout the counties in the TMC service area. The survey requested that respondents list their home zip code. While not all respondents provided a zip code, 44 did, revealing that the largest majority of respondents (77%, N=34) live in Tioga. These results are shown in Figure 5.

Figure 5: Survey Respondents' Home Zip Code

Total respondents= 44



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

Survey Demographics

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

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

- 27% (N=14) were age 55 or older
- The majority (92%, N=49) were female.
- Respondents (34%, N=17) had bachelor's degrees or higher.
- The number of those working full time (61%, N=31)
- Only 4% of those who reported their ethnicity / race were non-white /Caucasian.
- 20% of the population (N=10) had household incomes of less than \$50,000. 34% reported incomes over \$100,000 (N=17)

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

Figure 6: Age Demographics of Survey Respondents

Total respondents = 84

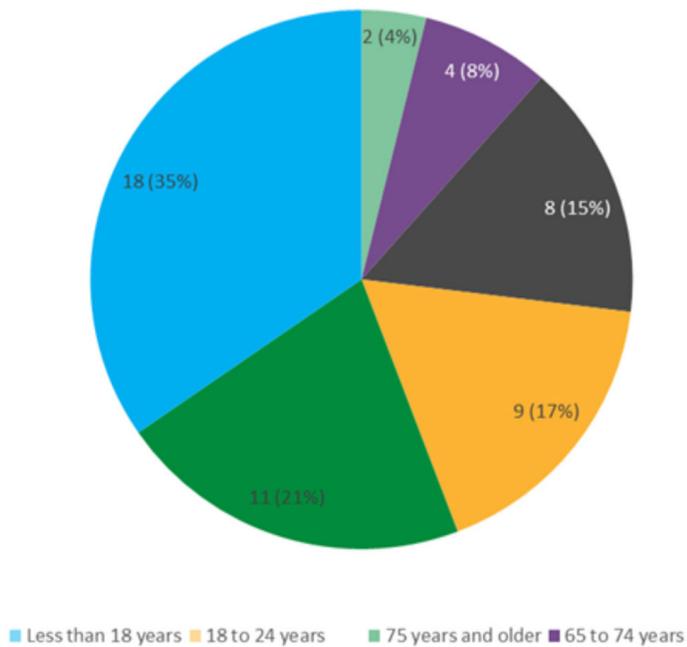


Figure 7: Gender Demographics of Survey Respondents

Total respondents = 49

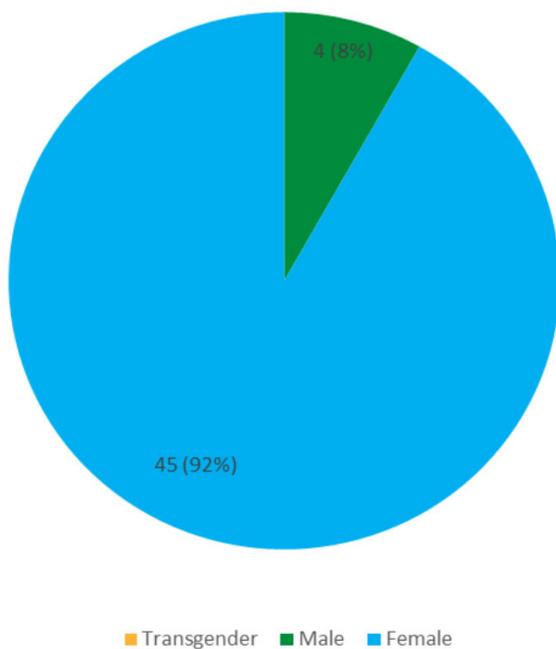


Figure 8: Educational Level Demographics of Survey Respondents

Total respondents = 51

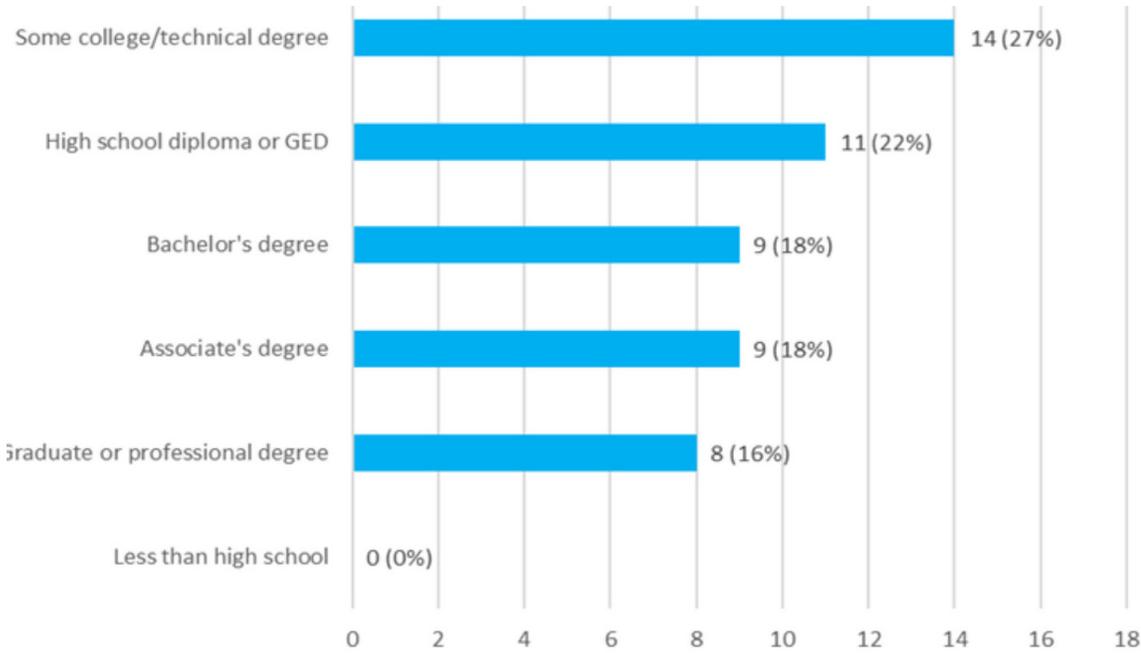
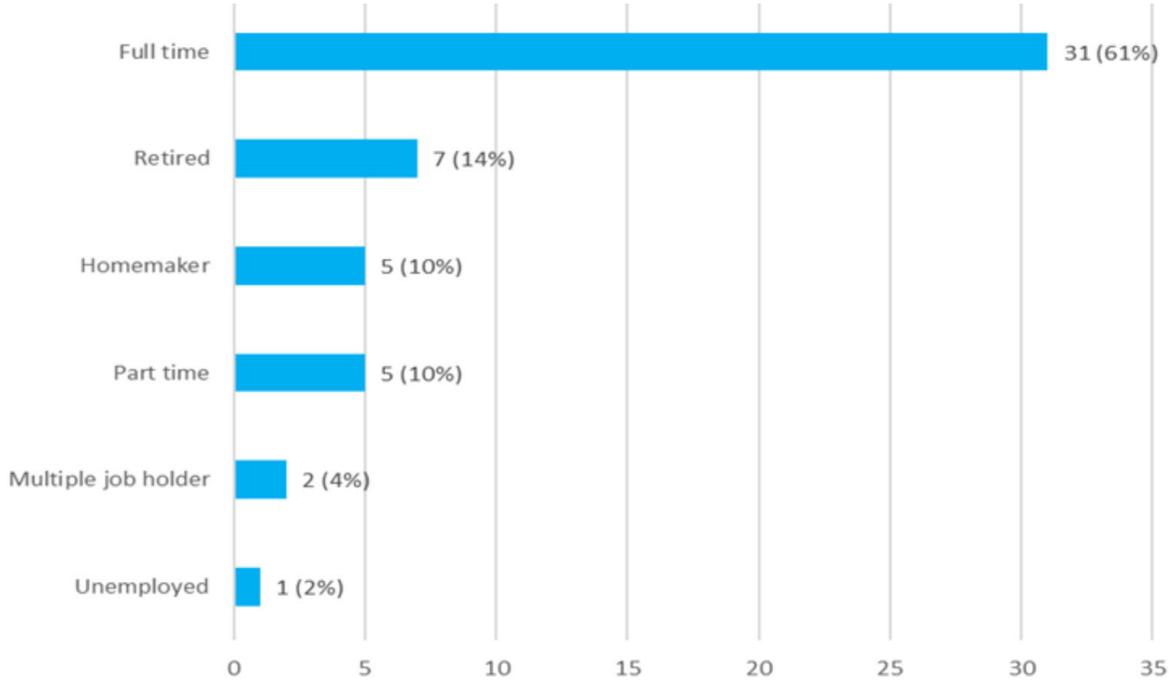


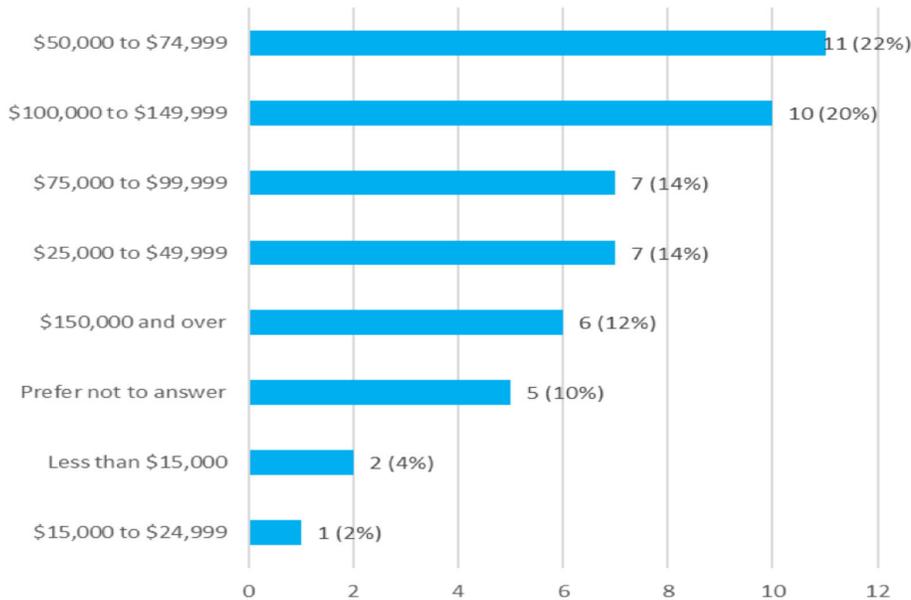
Figure 9: Employment Status Demographics of Survey Respondents

Total respondents = 51



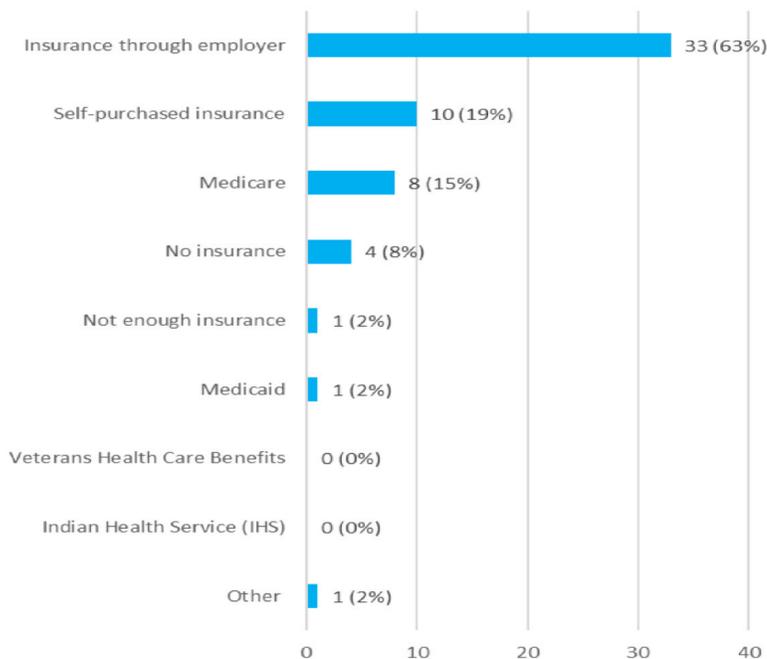
Of those who provided a household income, 20% (N=10) community members reported a household income of less than \$25,000, 34% (N=17) indicated a household income of \$100,000 or more. This information is shown in Figure 10.

Figure 10: Household Income Demographics of Survey Respondents
Total respondents = 49



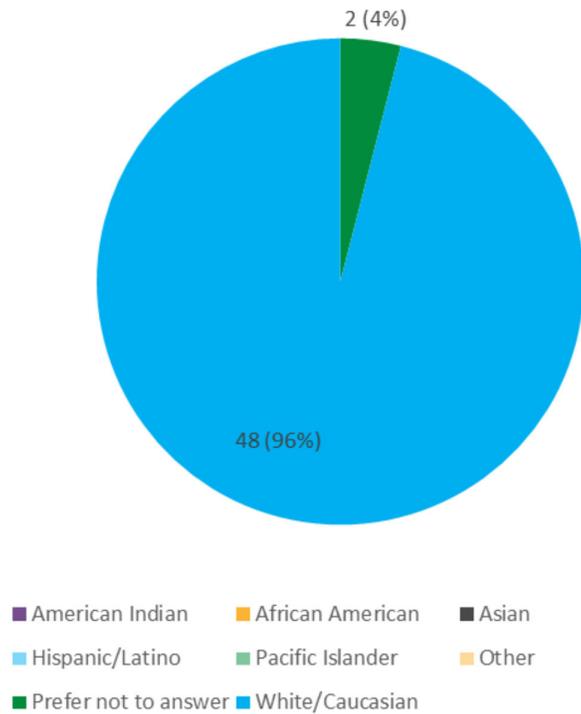
Community members were asked about their health insurance status, which is often associated with whether people have access to healthcare. Of those responding to the question, 10% (N=5) of the respondents reported having no health insurance or being under-insured. The survey results are higher than the state data for the county uninsured rate of those under the age of 65 (8.1%) and Williams county (7.6%). This could be a result of a small sample size. The most common insurance types were insurance reported by the respondents was through one's employer (N=33 or 63%), followed by self-purchased (N=10 or 19%) and Medicare (N=8 or 15%).

Figure 11: Health Insurance Coverage Status of Survey Respondents
Total respondents = 58



As shown in Figure 12, nearly all of the respondents were white/Caucasian (96%) (N=50). This response is significantly higher than the Williams County data (2016) of 63.3% white/Caucasian.

Figure 12: Race/Ethnicity Demographics of Survey Respondents
N=50

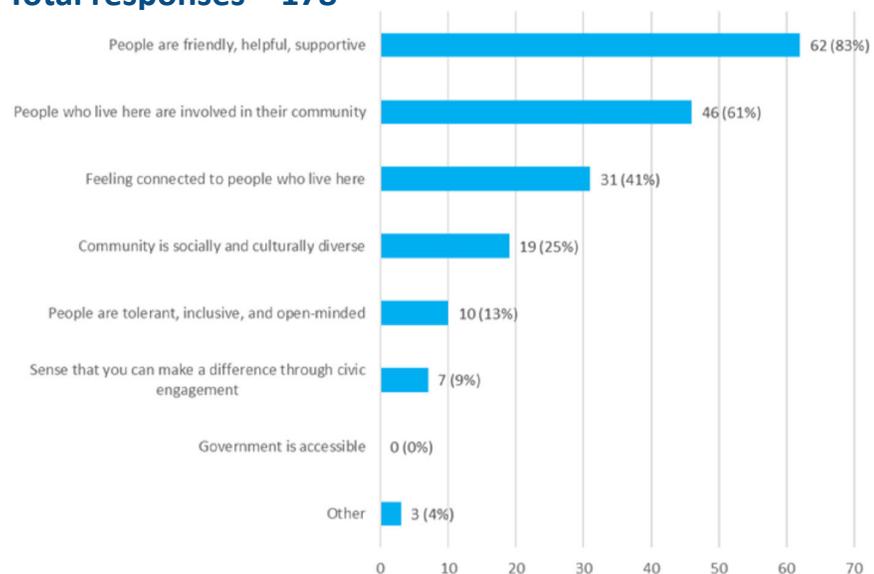


Community Assets and Challenges

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.

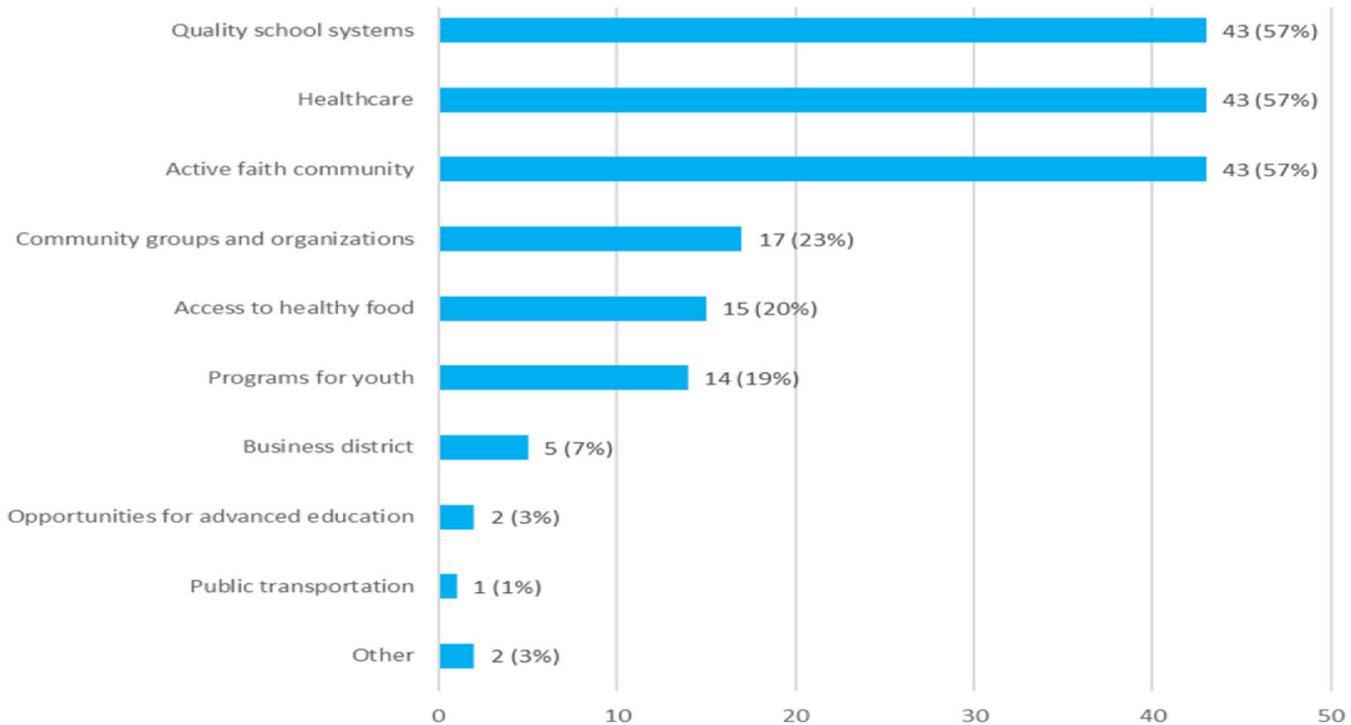
Figures 13 to 16 illustrate the results of these questions.

Figure 13: Best Things about the PEOPLE in Your Community
Total responses = 178



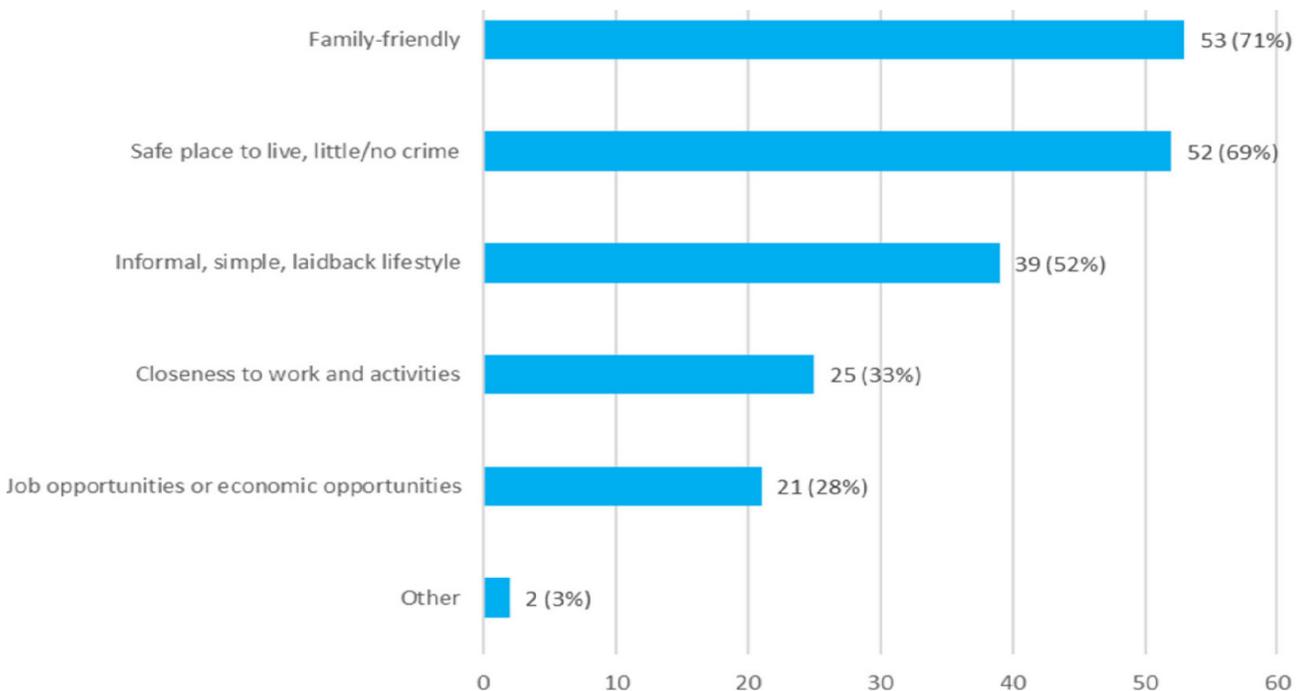
Over 83% (N=62) individuals stated the community was friendly, helpful, and supportive. However, one of the comments under “other” stated that if you are not from this area you are treated as an outcast.

Figure 14: Best Things about the SERVICES AND RESOURCES in Your Community
Total responses = 442



The only “other comment” made was by one individual who felt there is a lack of businesses, lack of career and educational advancement and the lack of healthcare.

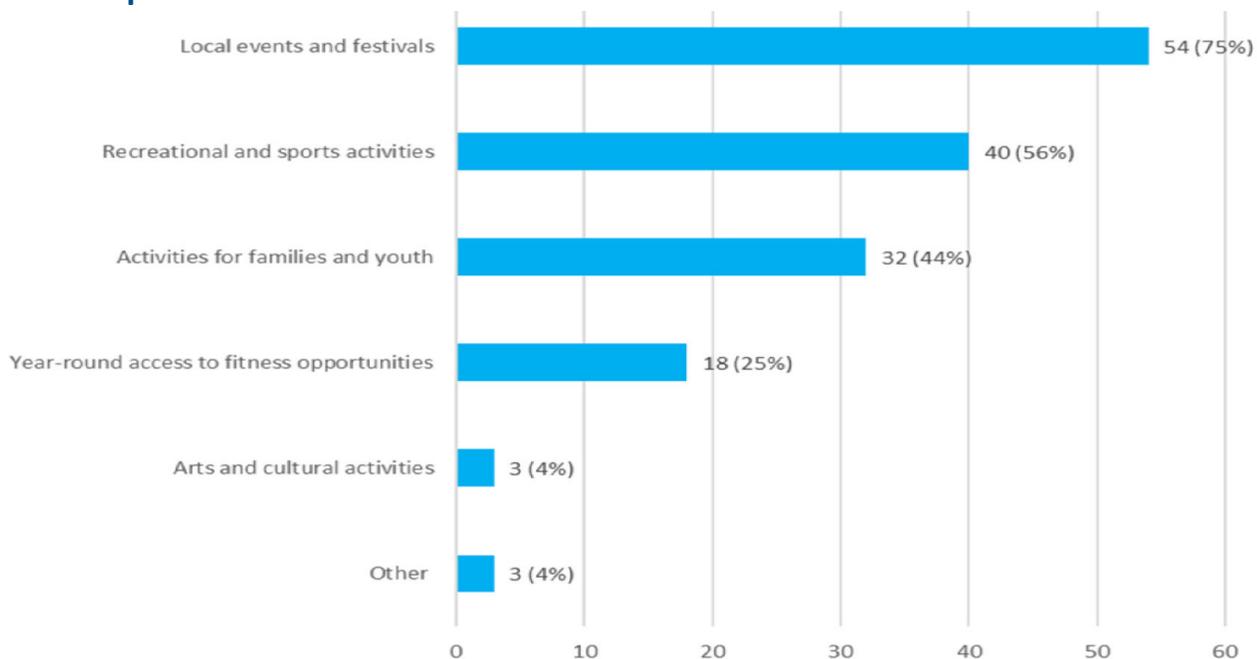
Figure 15: Best Things about the QUALITY OF LIFE in Your Community
Total responses = 192



Only one comment written in as “other” stated “friendly if you are from here and if not, people are not friendly. There is also a lack of job opportunity.

Figure 16: Best Thing about the ACTIVITIES in Your Community

Total responses = 150



One individual who selected “Other” specified that the best things about the activities in the community is hunting. A second person stated there are no activities.

Community Concerns

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

- Community and environmental health
- Availability/Delivery of health services
- Adult population concerns
- Youth population concerns
- Senior population concerns

With regard to responses about community challenges, the most highly voiced concern in each category were:

- Having enough child daycare services
- Availability of mental health services
- Drug use and abuse with youth
- Depression and anxiety with adults
- Cost of long-term/nursing home care
- Lack of affordable housing
- Impact of oil development on their community

Figures 17 through 22 illustrate these results.

Figure 17: Community/Environmental Health Concerns

Total responses = 175

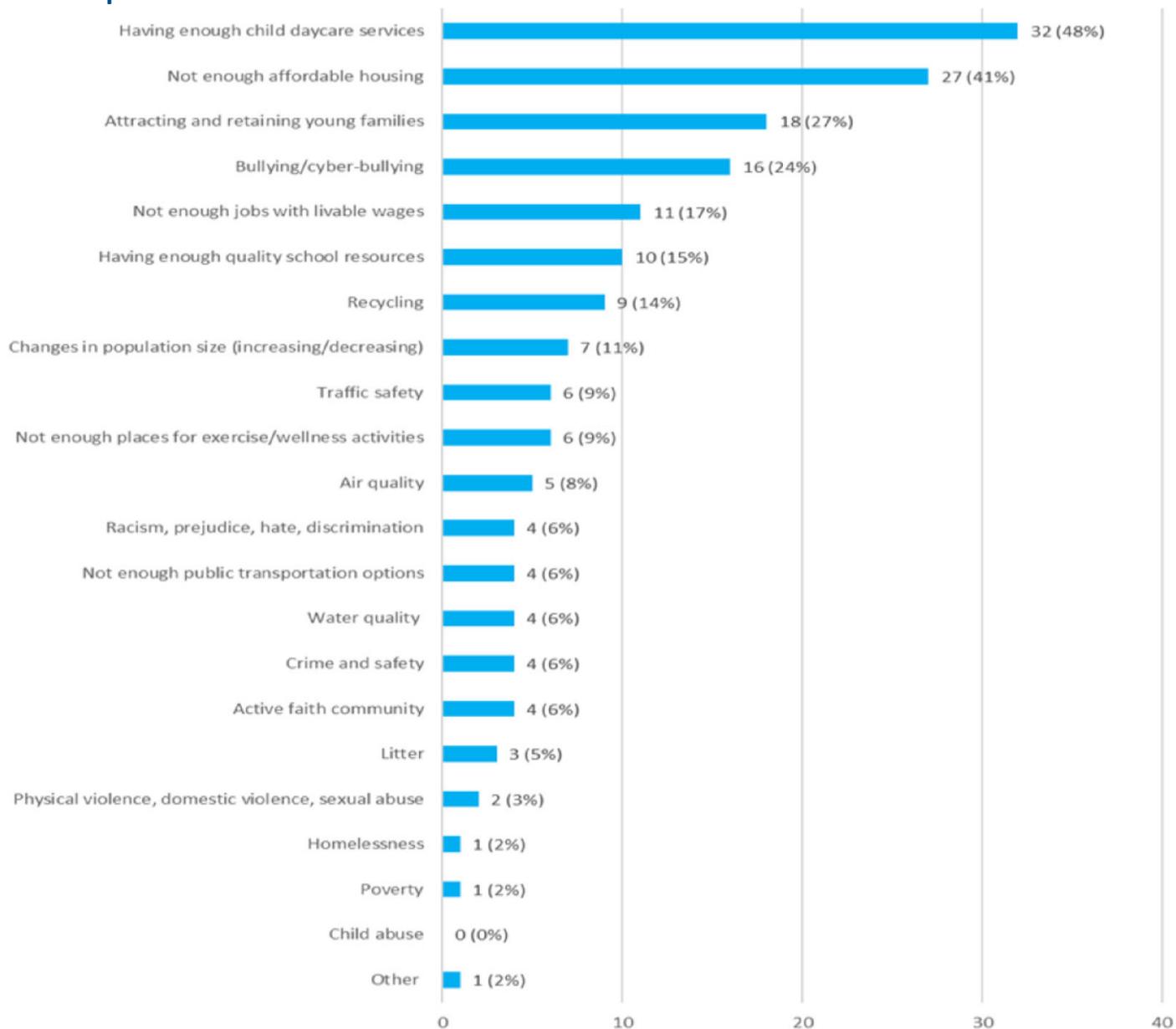
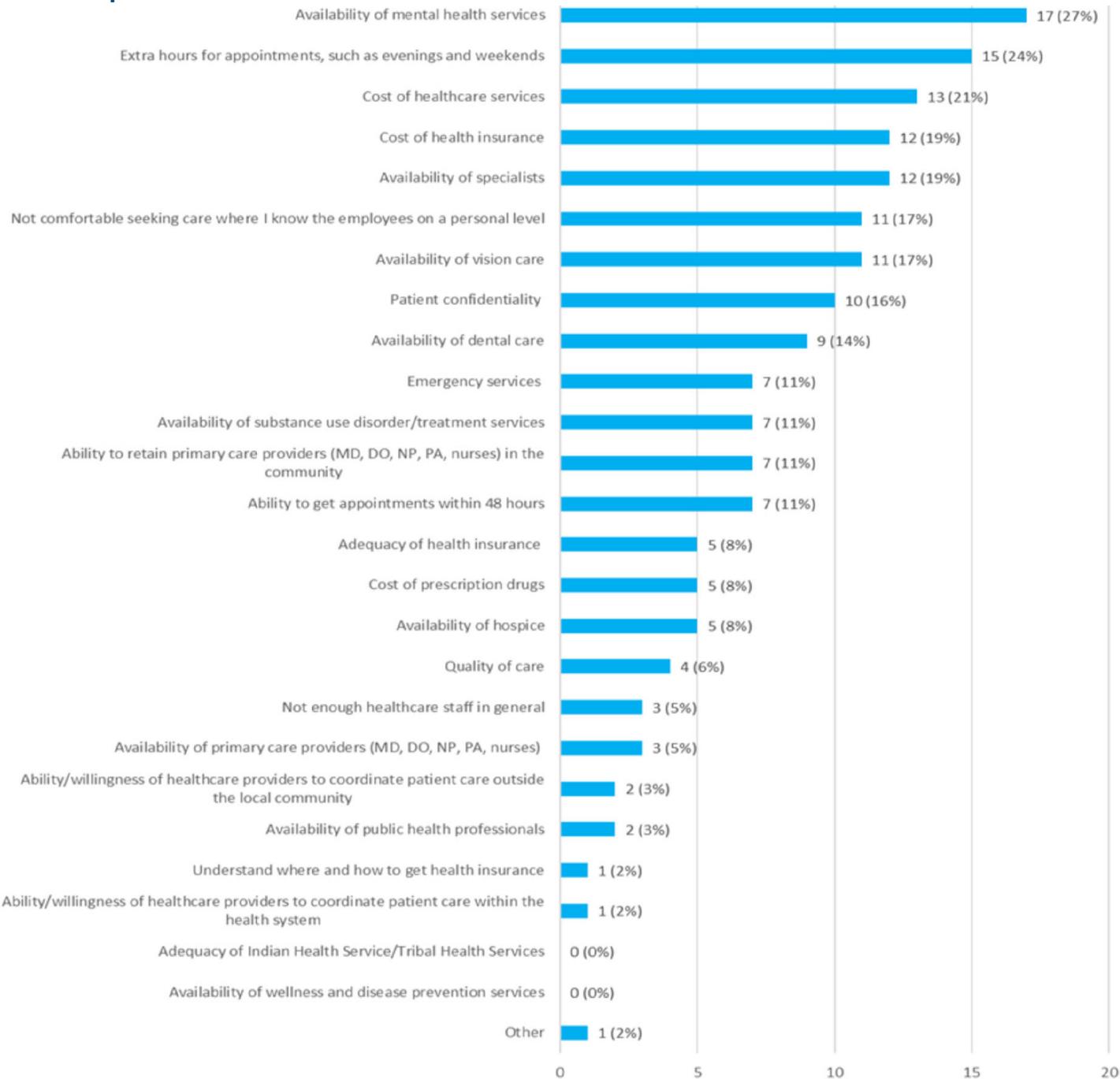


Figure 18: Availability/Delivery of Health Services Concerns

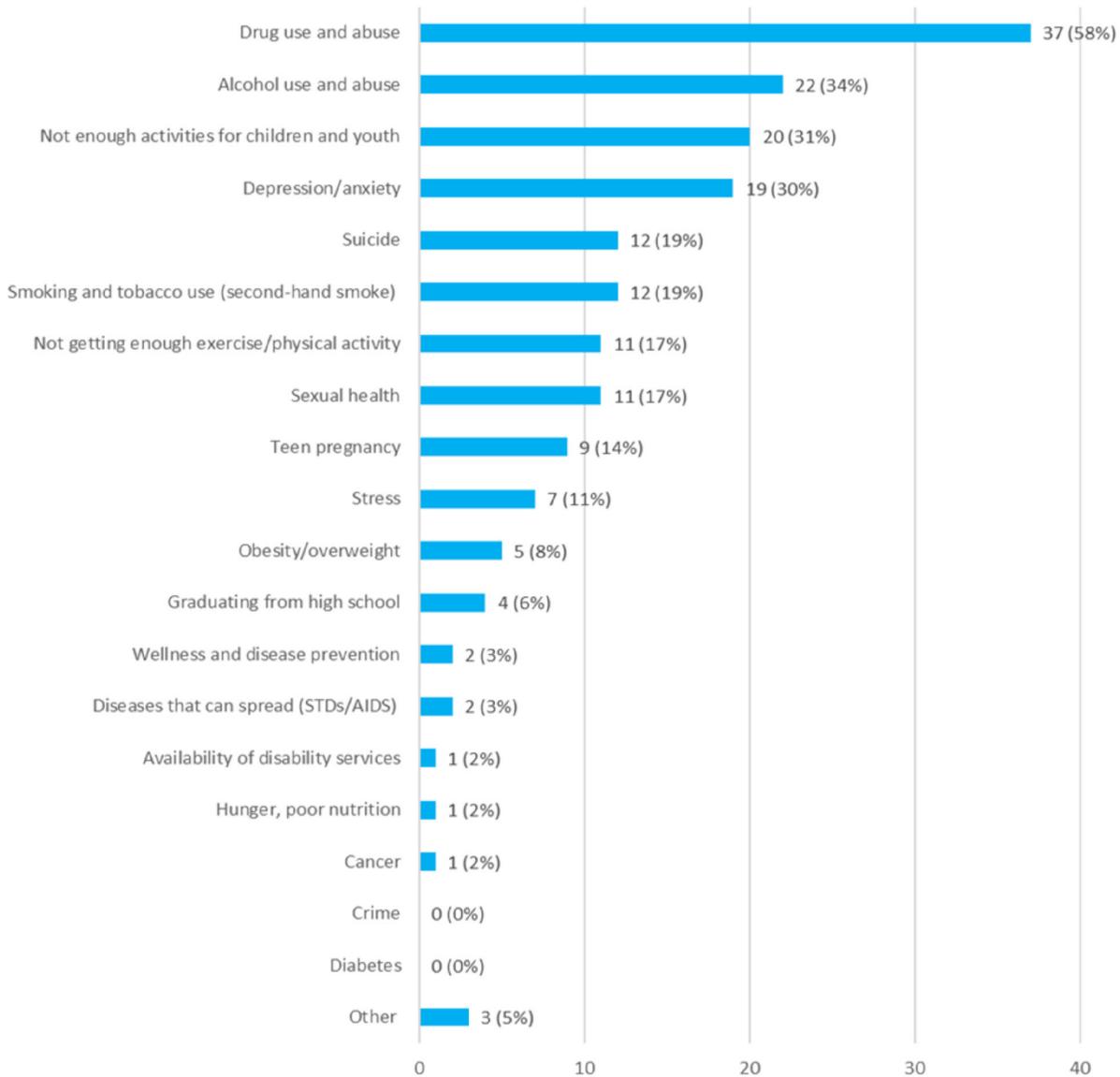
Total responses = 170



Respondents who selected “Other” identified concern was a comment wishing there were more physicians. They like most of the physician assistants, but it’s nice to have more doctors.

Figure 19: Youth Population Health Concerns

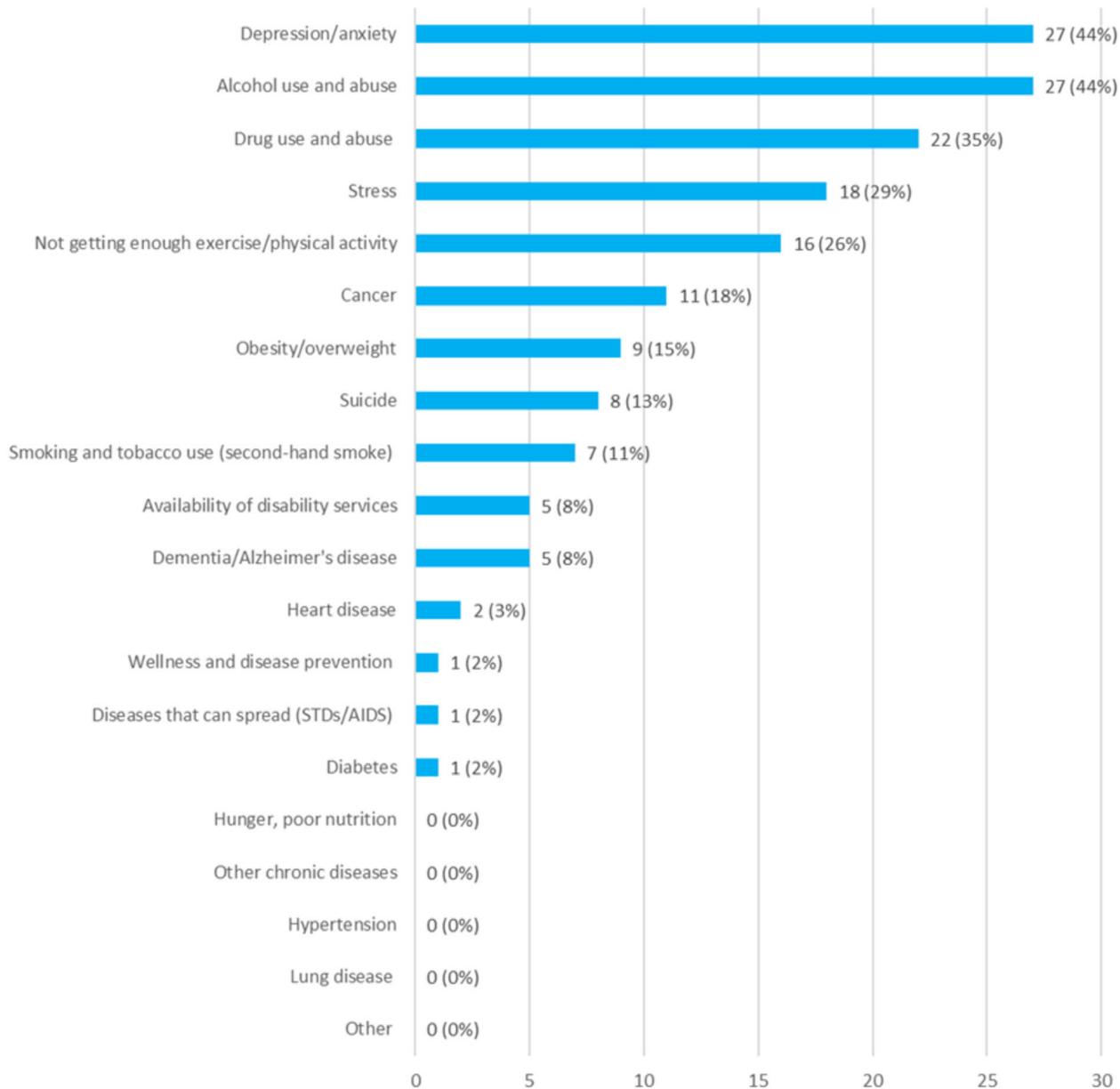
Total responses = 179



Listed in the “Other” category for youth population concerns was more parents need to encourage their children to be in sports. There was also a comment of concern about vaping concerns, sexting, and cyberbullying.

Figure 20: Adult Population Concerns

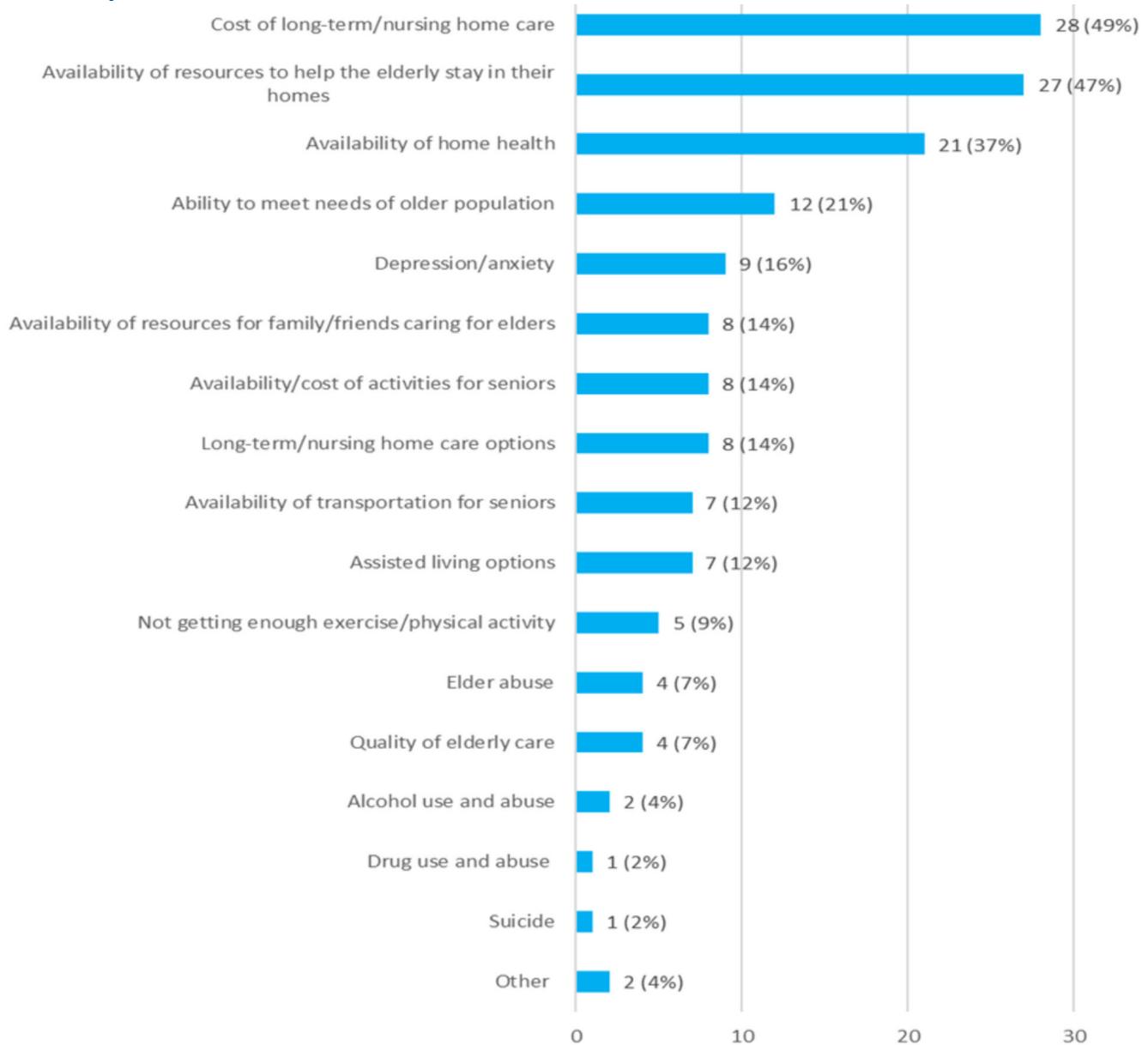
Total responses = 160



Listed in the “Other” category for adult population concerns was the isolation of elderly people and mental health support.

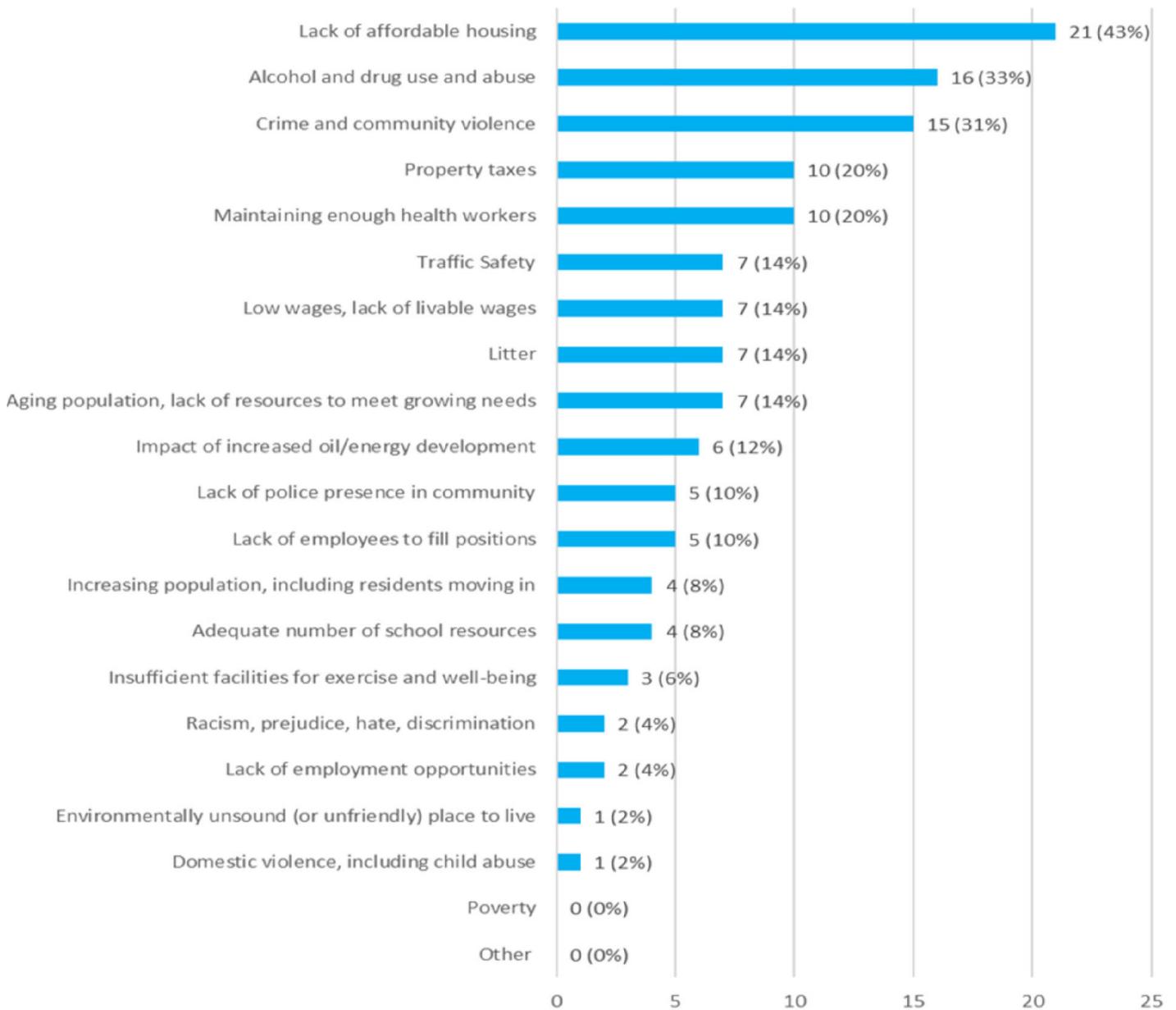
Figure 21: Senior Population Concerns

Total responses = 154



In the “Other” category, concerns listed were the distance elders have to travel to buy groceries and a need for resources for legal help.

**Figure 22: Survey-What are the Impacts from the Oil Development in the Community
N=133**



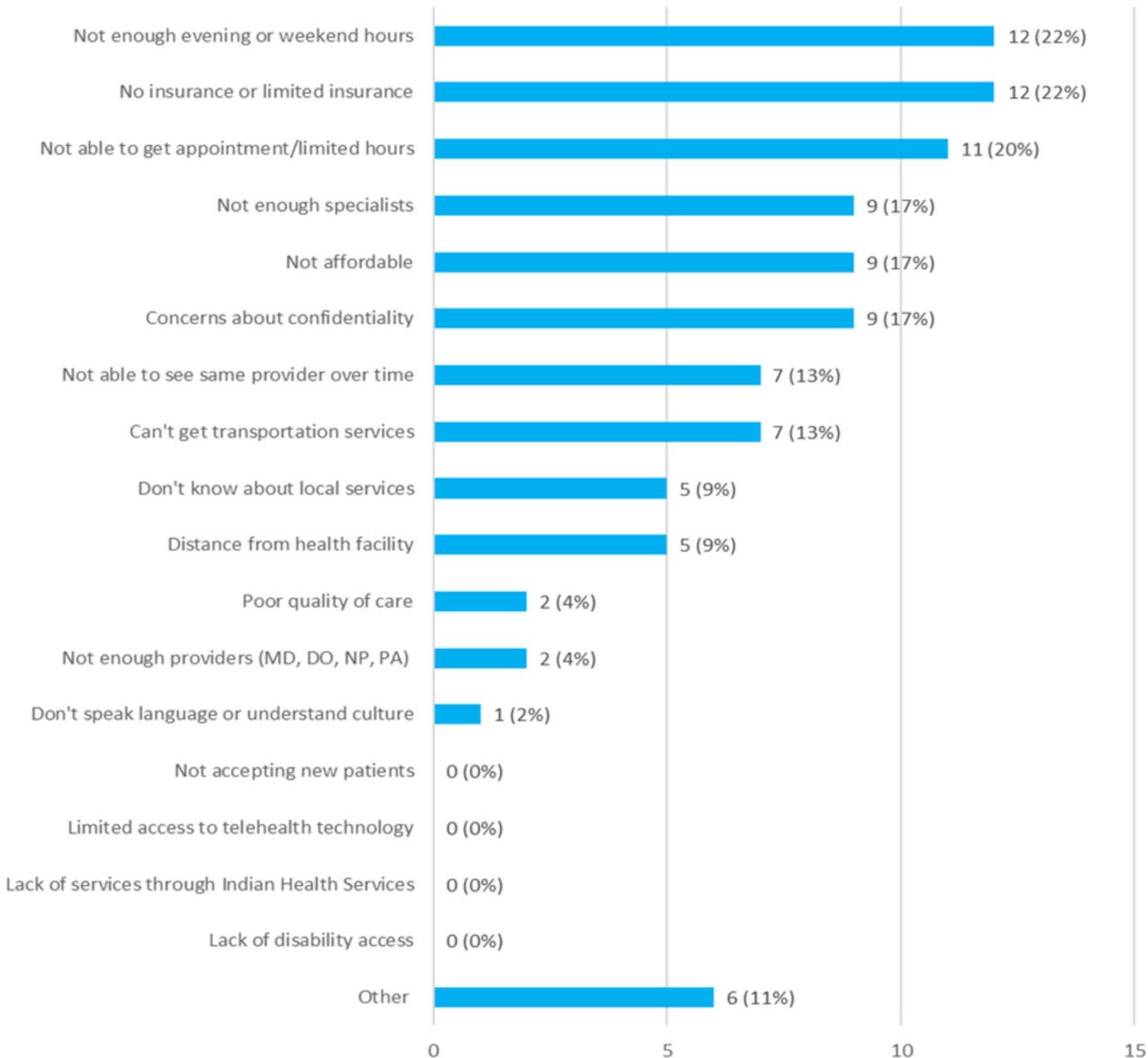
Delivery of Healthcare

The survey asked residents what they see as barriers that prevent them, or other community residents, from receiving healthcare. Tied for the most prevalent barrier perceived by residents was; not enough weekend and evening hours and no insurance or limited insurance (N=12). The third most common barrier is not being able to get appointments/limited hours (N=11). The next three barriers tied with nine respondents each; not enough specialists, not affordable, and concerns about confidentiality.

The majority of concerns indicated in the “Other” category were in regard to billing issues.

Figure 23: Perceptions about barriers to care-what prevents individuals from receiving healthcare

Total responses = 97



Comments under “other” were there are not enough dentists and there are not enough licensed doctors. One individual stated the turnover rate in nurses is due to low wages. Another comment was the medical system is not in their network for insurance coverage.

Considering a variety of healthcare services offered by TMC, respondents were asked to indicate if they were aware that the healthcare service is offered and to also indicate what, if any, services they or a family member have used at TMC, at another public health unit, or both. See figures 24-29.

Figure 24: General and Acute Services
N=191

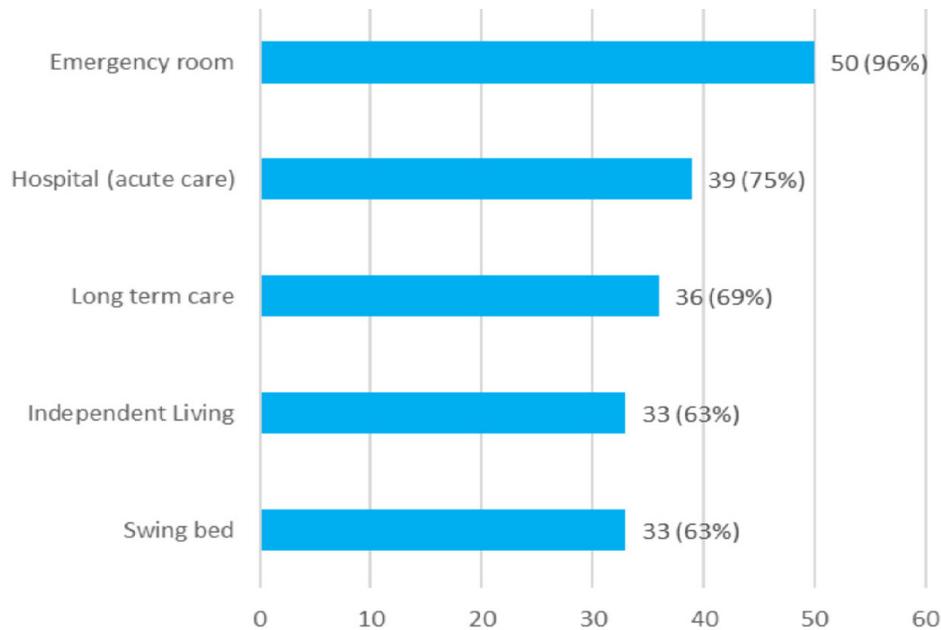


Figure 25: Physical therapy and Occupational Therapy Services
N=217

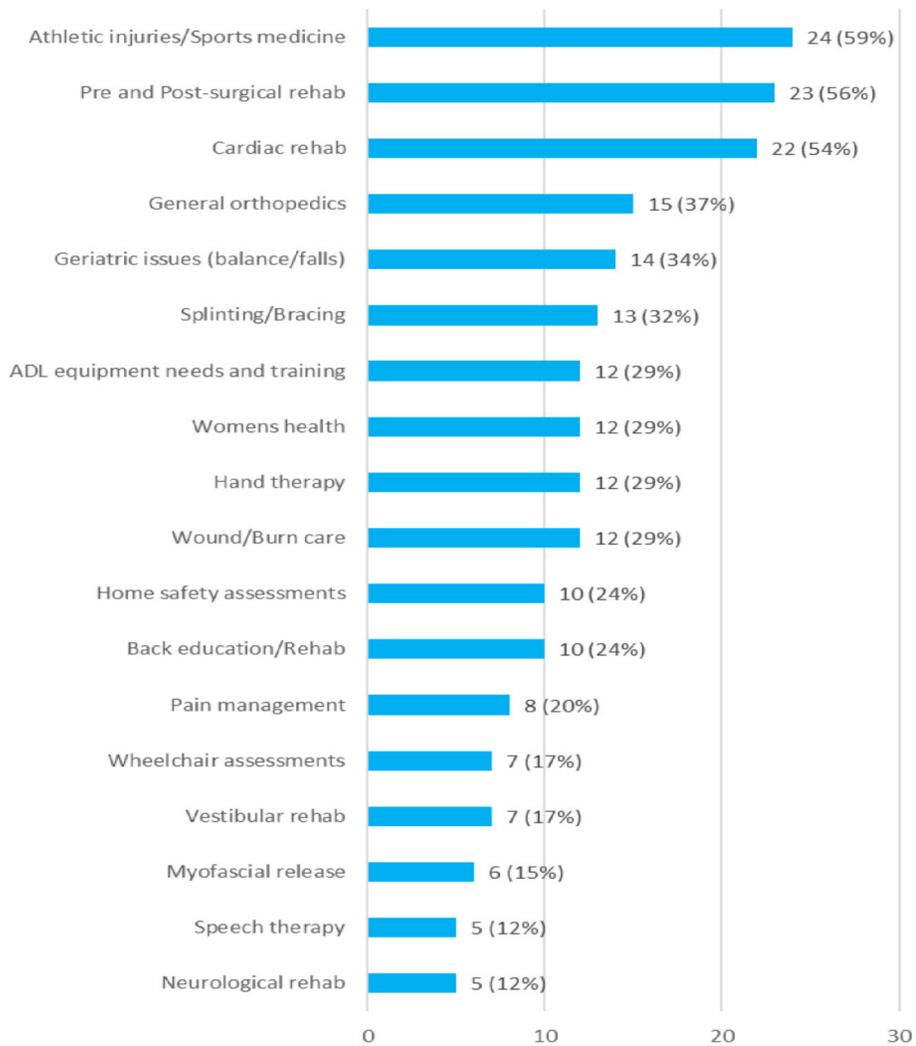


Figure 26: Laboratory Services N=97

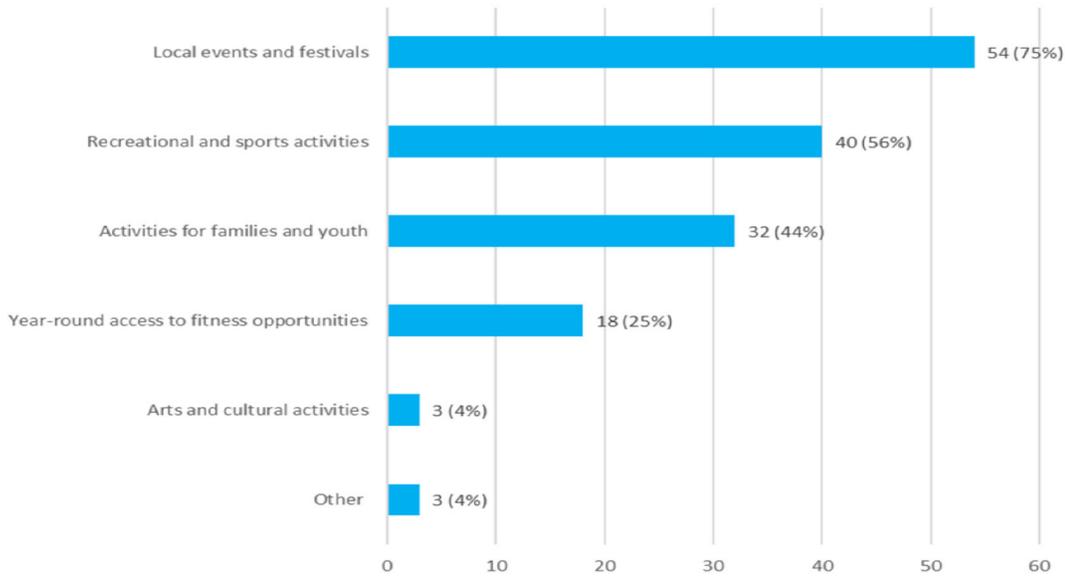


Figure 27: Radiology Services N=57

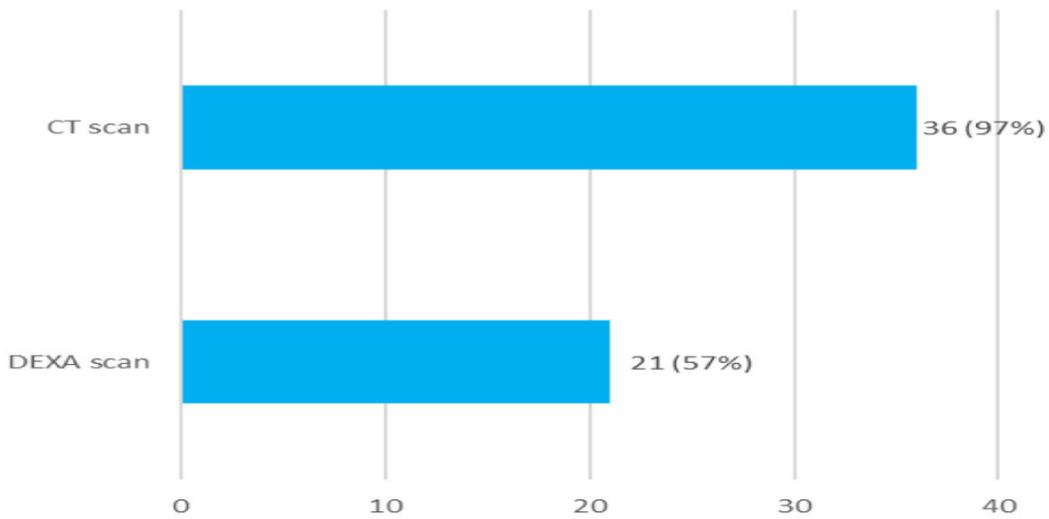


Figure 28: Clinical services

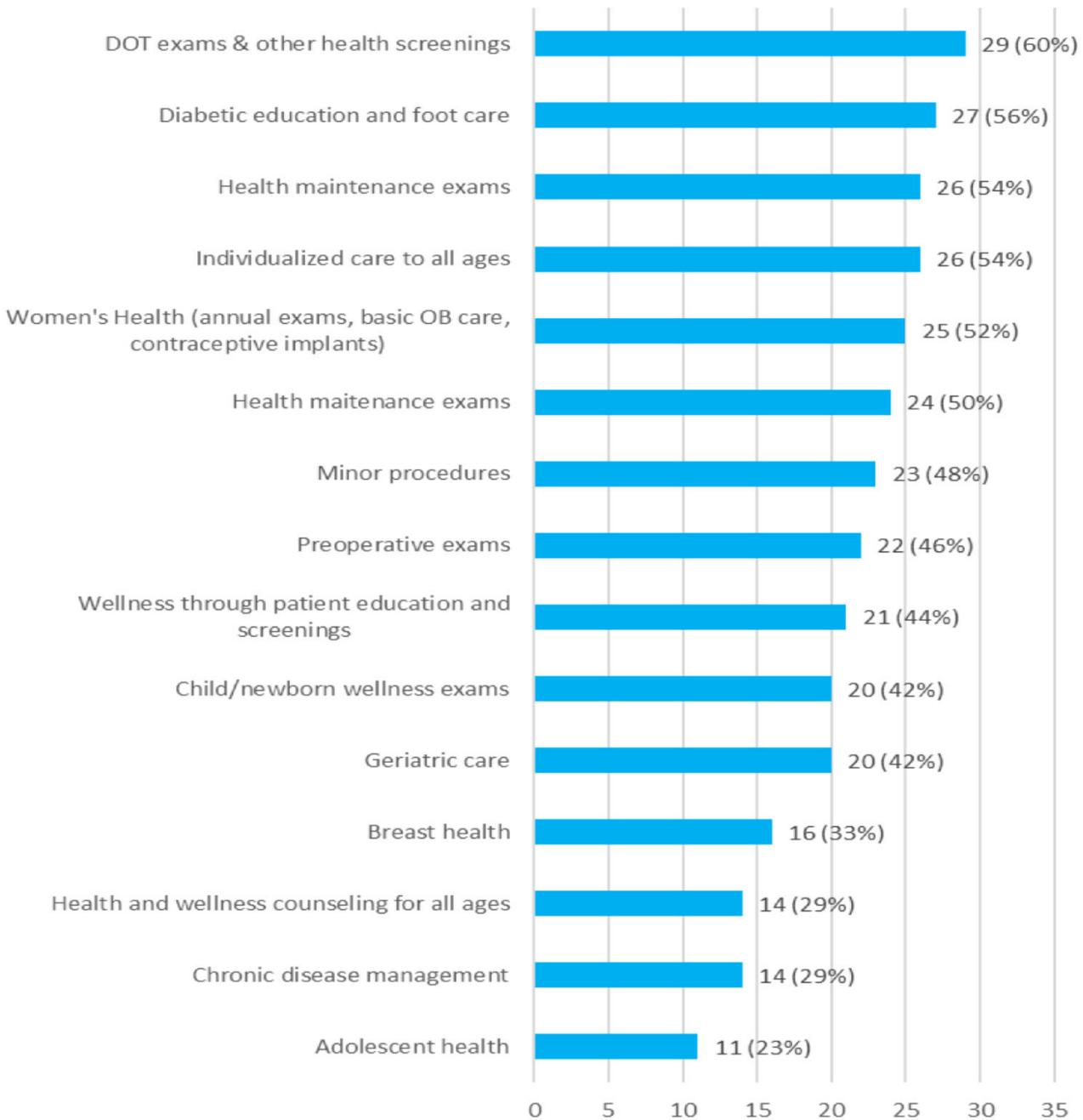


Figure 29: Awareness and Utilization of Public Health Services N=81

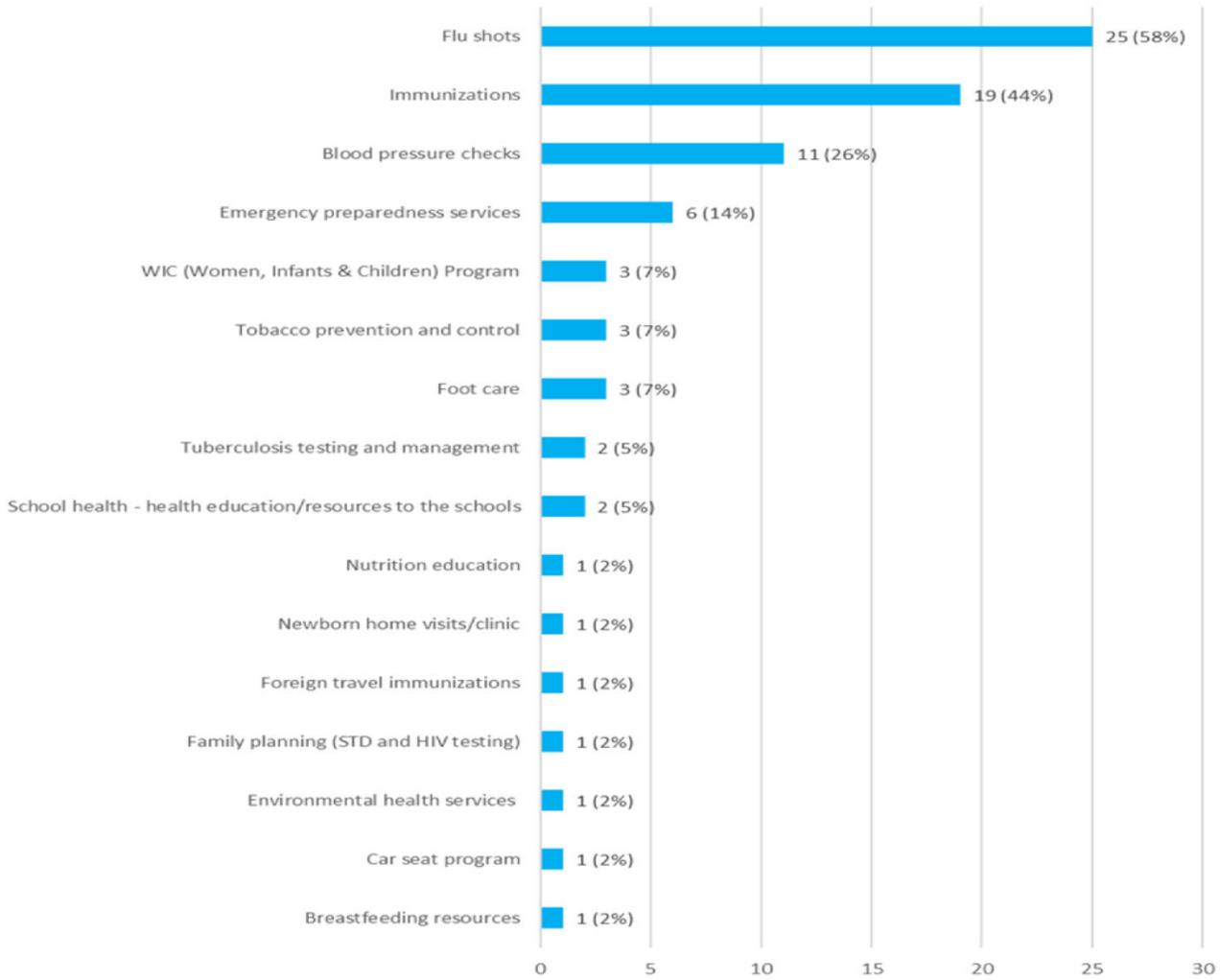
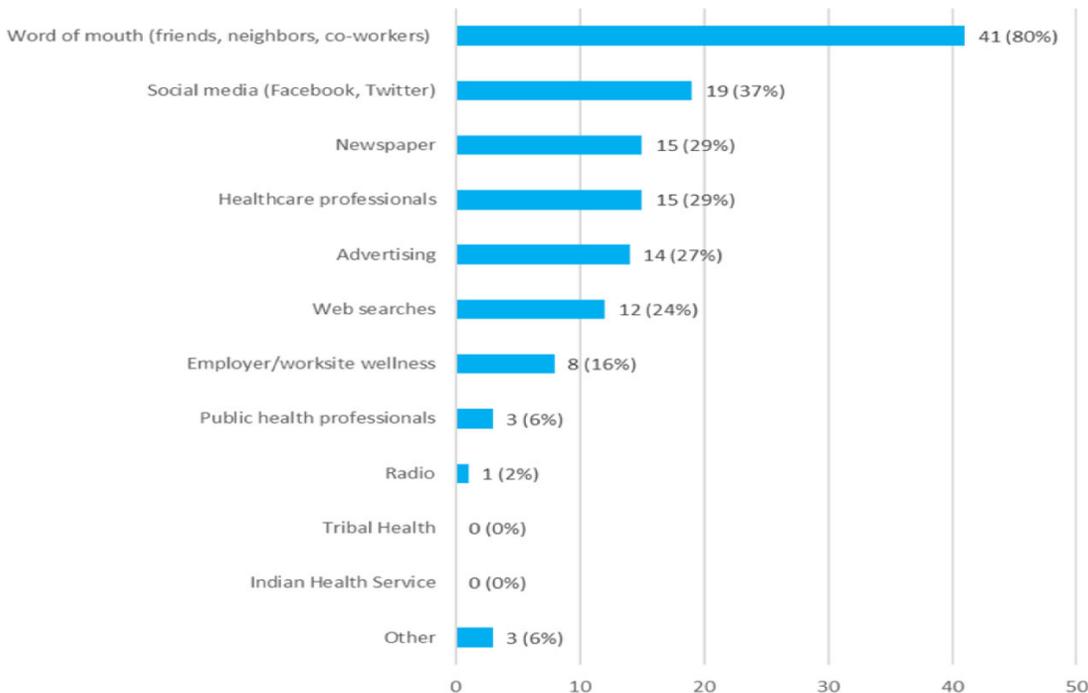


Figure 30: Where Do You Find Out About Local Health Services in Your Area? N = 131



Other comments were: Pastors, TV ads, City Hall, school.

Figure 31: Do You Work for the Hospital, Clinic or Public Health Unit?

N= 52

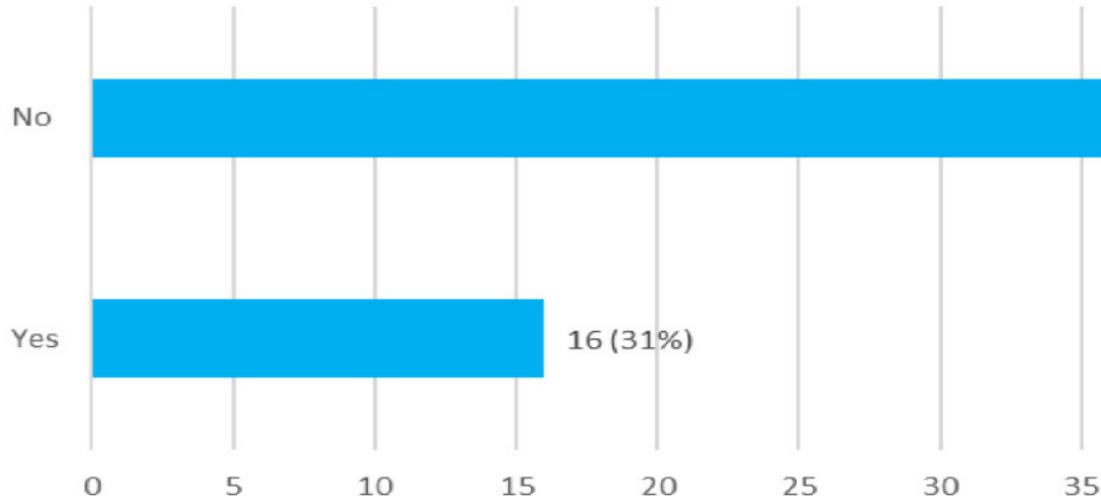


Figure 32. When asked of the monthly services at Tioga Medical Center, if they were aware of or have used which services in the past year? N=149

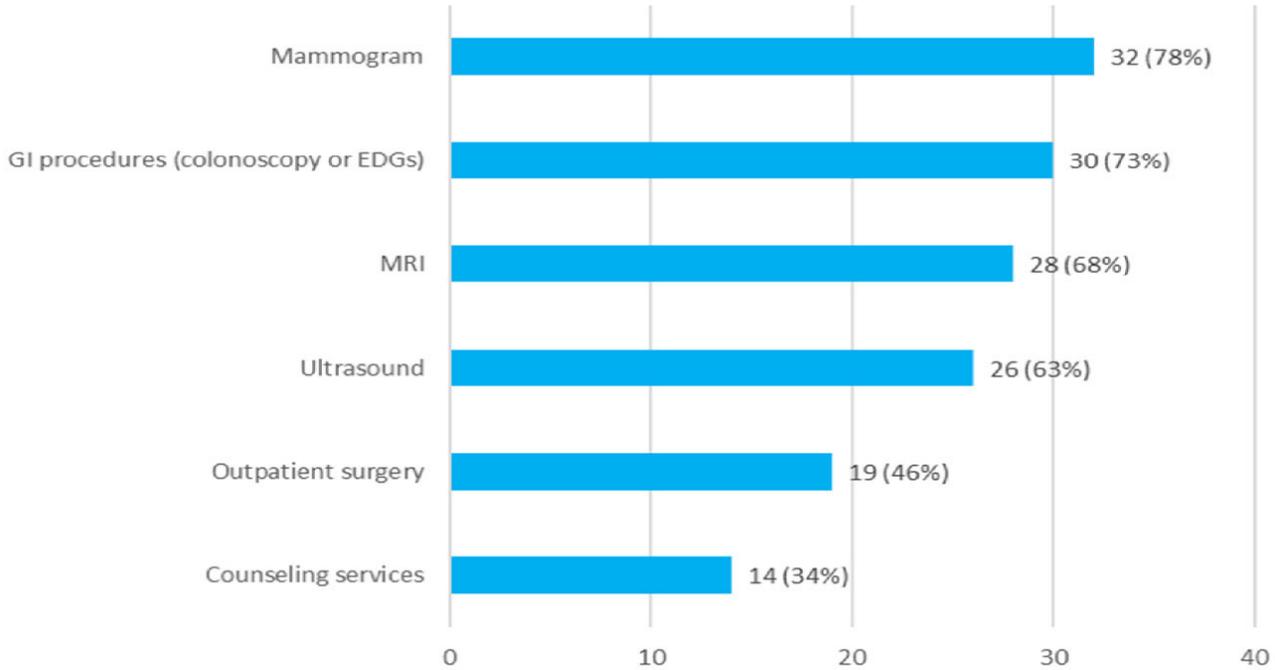


Figure 33. When asked if the respondent was aware of or used in the past year these services offered locally by other providers/organizations at Tioga Medical Center N= 87

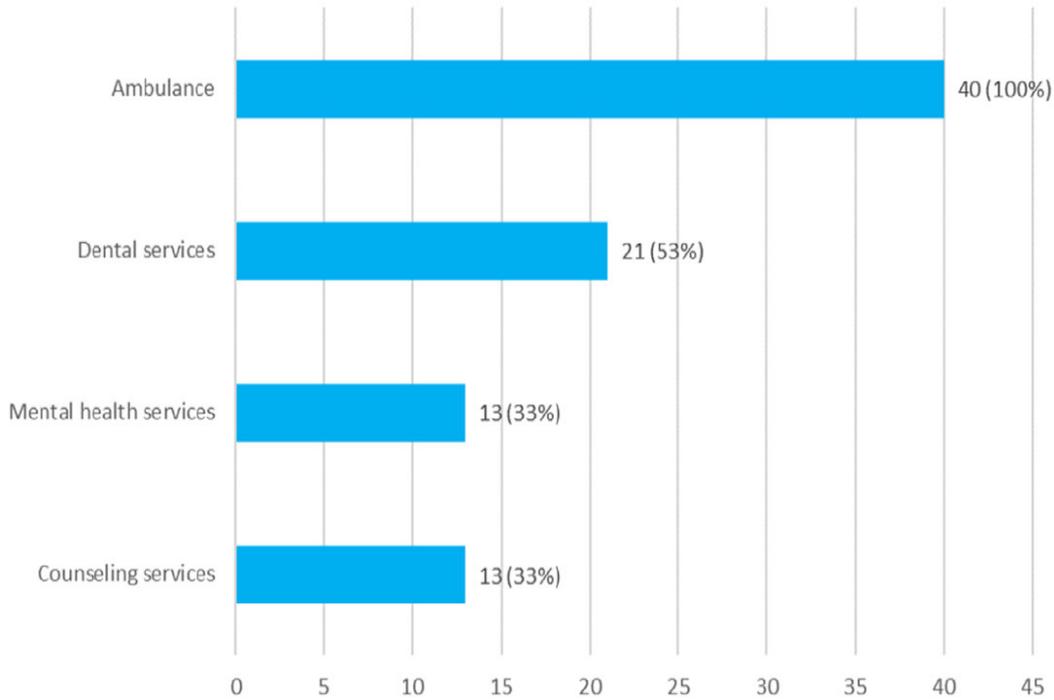


Figure 34: Survey-Awareness of Tioga Medical Center’s well-child services in collaboration with the UMDHU N=53

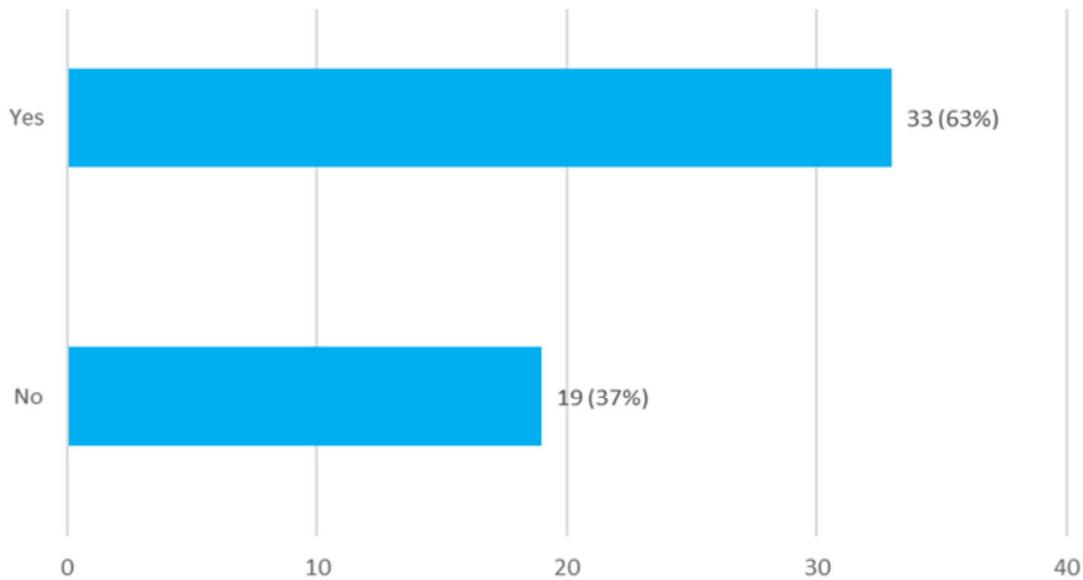


Figure 35. Do you feel you have access to accurate information regarding immunization records? N=52

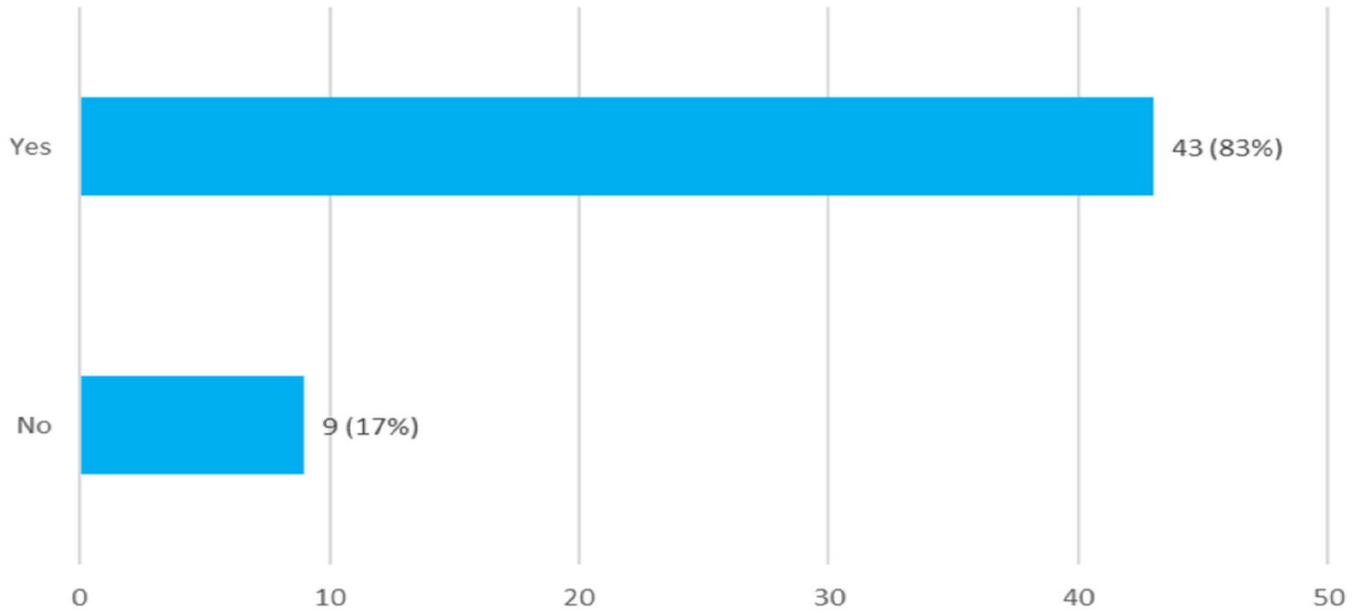
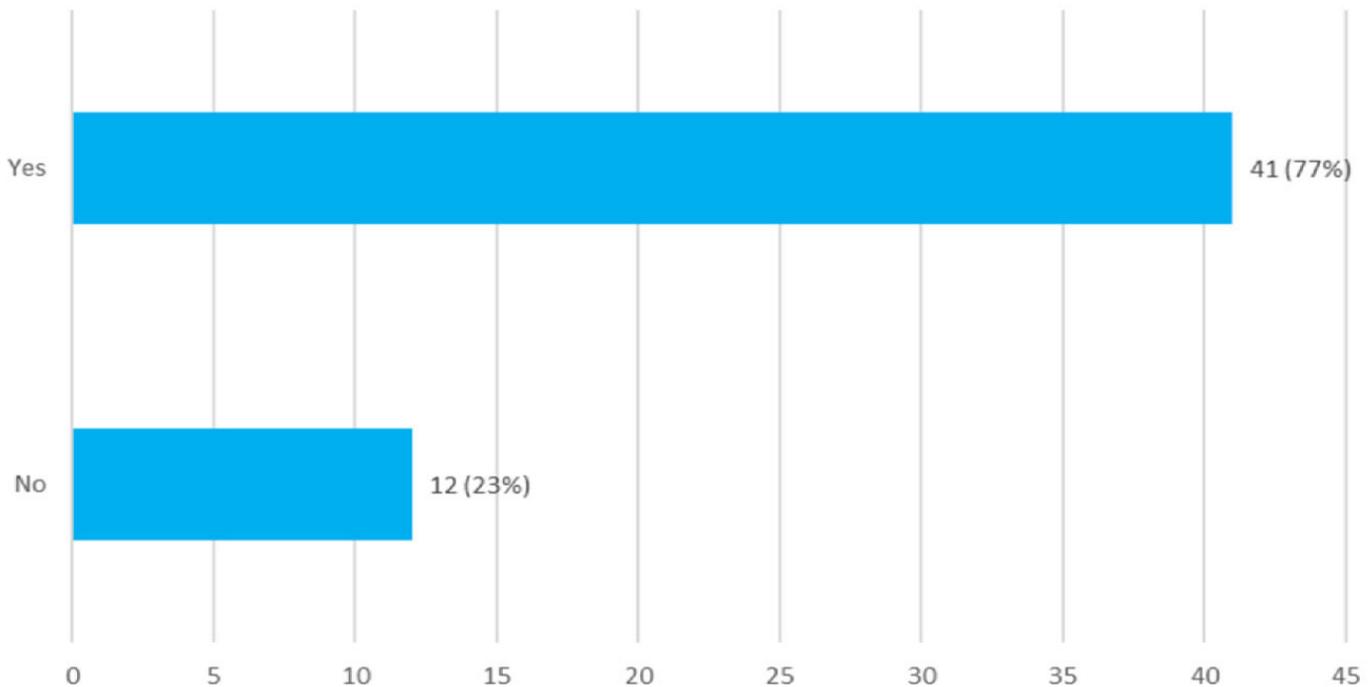


Figure 36: When the respondents were asked if they were aware the UMHD provides immunization information, the responses were: N=53

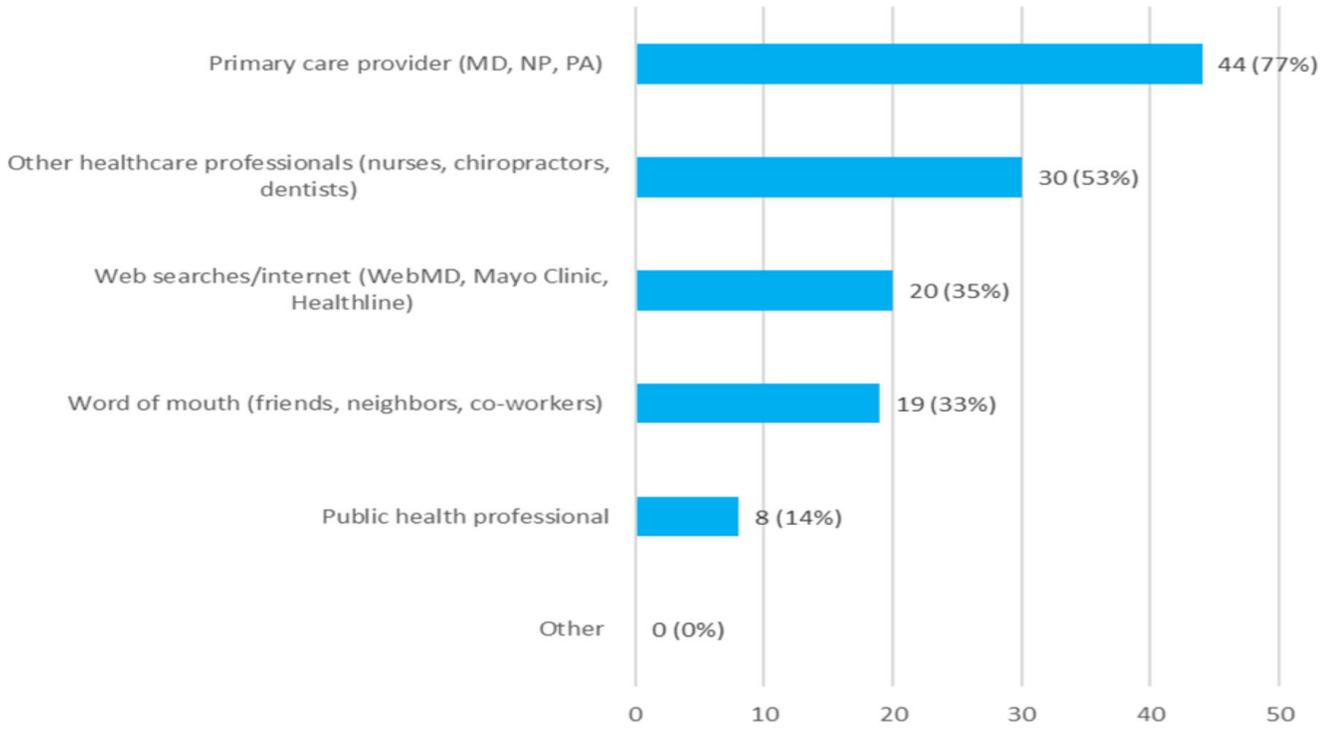


Respondents were asked where they go to for trusted health information. Primary care providers (N=44) received the highest response rate, followed by other healthcare professionals (N=30), and then web searches/internet (N=20).

Results are shown in Figure 37.

Figure 37: Sources of Trusted Health Information

Total responses = 121



Findings from Key Informant Interviews & the Community Meeting

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

The key informant identified the following items as the highest concerns:

Community/Environmental Health Concerns

- Having enough child daycare services
 - Physical violence, domestic violence, sexual abuse
 - Bullying/cyber-bullying
- (The following four tied for votes)
- Not enough affordable housing
 - Changes in population size
 - Not enough places for exercise and wellness activities
 - Traffic safety (speeding, road safety, seatbelt use, drunk/distracted driving)

Availability/Delivery of Health Services Concerns

- Availability of mental health services
- Cost of health insurance
- Availability of substance use disorder/treatment services

Adult Population Health Concerns

- Depression/anxiety
- Drug use and abuse (including prescription drug abuse)
- Suicide
- Alcohol use and abuse

Youth Population Health Concerns

- Drug use and abuse (including prescription drug abuse)
- Depression/anxiety
- Suicide
- Alcohol use and abuse

Senior Population Health Concerns

- Cost of long-term/nursing home care
- Depression/anxiety
- Availability of resources to help the elderly stay in their homes
- Availability/cost of activities for seniors

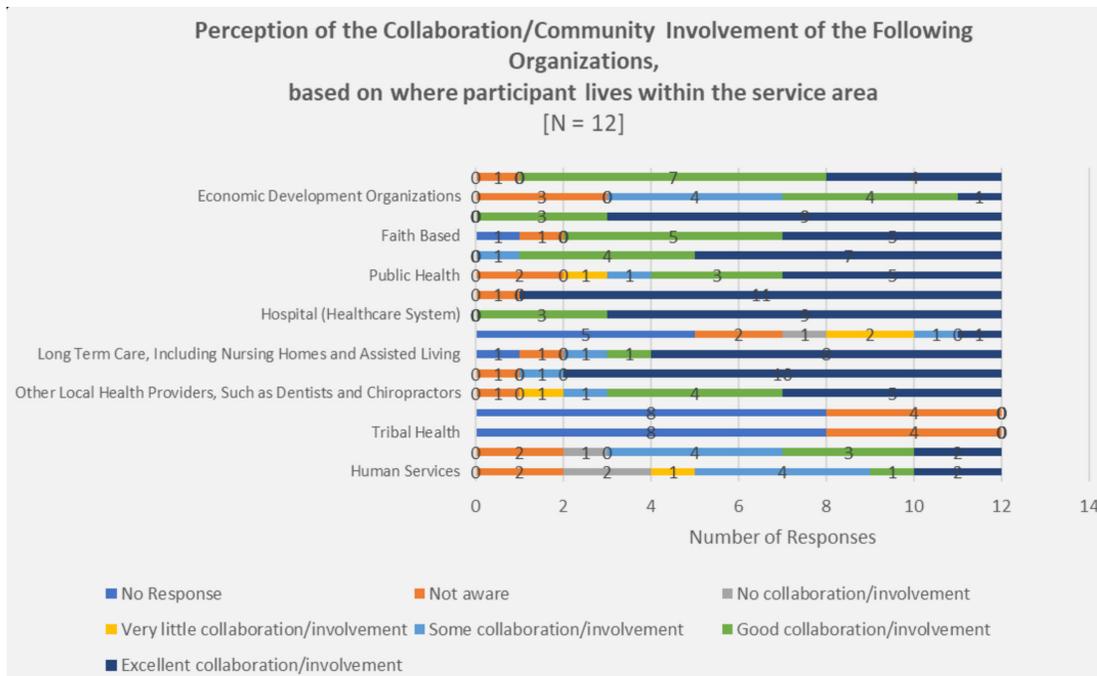
Generally, overarching issues that developed during the interviews and community meeting can be grouped into five categories (not listed in any particular order and to provide context for the identified needs, the following are some additional comments made by those interviewed:

- Affordable care for elderly
- Care for elderly in their homes
- Entertainment and activities
- Affordable housing
- Bullying
- Attracting and keeping tradespeople
- Cost of healthcare insurance
- Litter is in the ditches and fields-need recycling
- No walking paths
- Wider variety of activities indoors for exercise
- The faith community has many programs, but attendance is poor
- More teachers are needed
- Large Hispanic group and kids are participating and treated well. White transient kids don't participate in school activities, so issues are there.
- School zones aren't followed
- Expensive child care
- Resources for people new to the community
- Healthcare staff retention
- Retaining young families
- Lack of access to healthy food
- Lack of community unity
- Transportation for seniors living at home
- Williston has been on a diversion for inpatients for the last month in North Dakota due to overload in their facility.

Community Engagement and Collaboration

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

Figure 39. Perception Collaboration/Community Involvement Scale of 1-5 (5 excellent)



The emergency services, including ambulance and fire scored the highest (excellent or good collaboration combined) followed closely by the hospital, and the area pharmacies, the school and healthcare.

- Comments regarding collaboration were:
- Massage therapist-none, optometrist-none, chiropractor-limited
- Social Services-No idea of what is offered and there is very limited access.
- Social Services-It is not utilized. Many barriers including communication.
- Social Services-Williston-based and is slow to respond.
- Human Services-Getting better
- Human Services-No idea of what is offered and very limited access.
- Human Services-Need more mental health access-beds are rare (go to Bismarck, Grand Forks, or Fargo)
- Human Services- Not utilized. Many barriers including communication.
- Human Services-New counseling, not sure who with
- Human Services-Pulled staff- so not present at all

Priority of Health Needs

A Community Group met on January 23, 2019. There were 12 community members who attended the meeting. Representatives from the CRH presented the group with a summary of this report’s findings, including background and explanation about the secondary data, highlights from the survey results, including perceived community assets and concerns, and barriers to care, and findings from the key informant interviews.

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

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

- Attracting and retaining young families (7 votes)
- Cost of healthcare services (5 votes)
- Extra hours for appointments, i.e. evenings and weekends(4 votes)
- Depression/ anxiety for adults(4 votes)
- Not enough activities for youth (4 votes)
- Depression/ anxiety for youth (4 votes)

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

1. Attracting and retaining young families (6 votes)
2. Depression/ anxiety among youth (3 votes)
3. Having enough child daycare services (1 vote)
4. Not enough affordable housing (1 votes)

*One participant could not decide.

Following the prioritization process during the second meeting of the Community Group and key informants, the number one identified need was attracting and retaining young families. A summary of this prioritization is found in Appendix C.

Comparison of Needs Identified Previously

| Top Needs Identified 2016 CHNA Process | Top Needs Identified 2019 CHNA Process |
|---|---|
| Youth drug use and abuse | Attracting and retaining young families |
| Youth alcohol use and abuse | Depression/anxiety among the youth |
| Cost of health insurance | Having enough child daycare services |
| Availability of resources to help the elderly stay in their homes | Not enough affordable housing |
| Teen pregnancy | |

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

Implementation Plan for Needs Identified 2016-2018 Community Health Needs Assessment

Tioga Medical Center

Covered Facilities: All health facilities that are involved in this plan (hospitals, public health, ambulances, etc.)

Community Health Needs Assessment: A Community Health Needs Assessment (CHNA) was performed in the Winter of 2015-2016 in collaboration with public health to determine the most pressing needs of the Tioga area.

Implementation Plan Goals: The Board of TMC has determined that the following health needs identified in the CHNA should be addressed through the implementation strategy noted for each such need:

1. Youth Drug use and Abuse

- a. Contact with students in grades 5-12 in Tioga/Ray/Powers Lake communities regarding dangers of drug use and abuse.
- b. Increase youth understanding of the dangers of drug use

Key Objectives:

- a. Decrease drug use and abuse in ages 19 and under

Implementation Strategy:

- a. Initial anonymous survey to determine current use
- b. Law enforcement present to schools on the dangers of drugs
- c. Presentation by medical staff the effects drugs have on the body
- d. Poster to schools regarding dangers of drug use
- e. Ongoing follow up with anonymous survey

Update for 2017- North Dakota Bureau of Criminal Investigation presented a program to address drug use on January 25, 2017 to students in grades 8 to 12.

Update for 2018- None

2. Youth alcohol use and abuse

- a. Contact with students in grades 5-12 in Tioga/Ray/Powers Lake communities regarding dangers of alcohol use and abuse.
- b. Increase youth understanding of the dangers of drug use

Key Objectives:

- a. Determine the use and abuse of alcohol in ages 19 and under through an anonymous survey

Implementation Strategy:

- b. Initial anonymous survey to determine current use
- c. Law enforcement present to schools the dangers of alcohol
- d. Presentation by medical staff on the effects alcohol has on the body

- e. Poster to schools regarding dangers of alcohol use
- f. Ongoing follow up with anonymous survey

Update for 2017- North Dakota Bureau of Criminal Investigation presented a program to address alcohol on January 25, 2017 to students in grades 8-12.

Update for 2018- None

3. Teen Pregnancy

- a. Decrease incidence of teen pregnancy (ages 17 and under or still in high school)
- b. Increase awareness of sexually transmitted diseases
- c. Educate on health consequences of teen pregnancy

Key Objectives:

- a. Create a support group for teen mothers
- b. Create awareness of counseling services
- c. Create prenatal care and well-baby checks

Implementation Strategy:

- a. Upper Missouri or Lutheran Social Services to present on teen pregnancy
- b. Nancy Carlson, FNP, present to students in grades 5 and 6 on the anatomy of pregnancy, risks/dangers, prenatal care, counseling services

Update for 2017- Tioga schools declined participation in Family Planning/STD presentations given by the Upper Missouri District Health Unit.

Update for 2018

Education provided to the students:

Amber Nelson, DON

March 28th, 2018

Puberty education for girls in grades 4 and 5 2 hours

March 29th, 2018

Puberty education for girls in grade 6, combined education 2 hours

Jeff, PAC

March 29th, 2018

Puberty education for boys in grades 4 and 5 2 hours

March 29th, 2018

Puberty education for boys in grade 6, combined education 2 hours

4. Availability of Resources to help the elderly stay in their homes.

- a. Educate the public on resources and services to assist elderly to remain in their homes

Implementation strategy:

- a. Have Wildrose Transportation present on their services to senior centers in Tioga/Ray/Powers Lake
- b. Have Mercy Home Health present to TMC providers on services available
- c. Have Mercy Home Health present to Senior Centers in Tioga/Ray/Powers Lake

Update for 2017-

The TMC collaborated with Giving Hearts LLC of Stanley for home care services referrals.

Update for 2018-

The TMC collaborated with Giving Hearts LLC of Stanley for home care services referrals.

Other Needs Identified but not addressed:

Cost of health insurance: TMC is a participating provider in Medicaid Expansion and a Hospital Presumptive Eligibility (HPE) provider. In addition, TMC has an uncompensated plan in place that accepts applications up to 200% of poverty level.

Next Steps – Strategic Implementation Plan

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

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

Community Benefit Report

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

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

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

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

What Are Community Benefits?

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

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

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

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

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

Appendix A – CHNA Survey Instrument



Williams County Health Survey

Tioga Medical Center and the Upper Missouri District Health Unit are interested in hearing from you about community health concerns.

The focus of this effort is to:

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



Scan here to take the survey online!

If you prefer, you may take the survey online at <http://tinyurl.com/Tioga18> 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 22, 2018. Your opinion matters – thank you in advance!

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

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

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

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

- | | |
|---|---|
| <input type="checkbox"/> Access to healthy food | <input type="checkbox"/> Opportunities for advanced education |
| <input type="checkbox"/> Active faith community | <input type="checkbox"/> Public transportation |
| <input type="checkbox"/> Business district (restaurants, availability of goods) | <input type="checkbox"/> Programs for youth |
| <input type="checkbox"/> Community groups and organizations | <input type="checkbox"/> Quality school systems |
| <input type="checkbox"/> Healthcare | <input type="checkbox"/> Other (please specify) _____ |

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

- | | |
|--|--|
| <input type="checkbox"/> Closeness to work and activities | <input type="checkbox"/> Job opportunities or economic opportunities |
| <input type="checkbox"/> Family-friendly; good place to raise kids | <input type="checkbox"/> Safe place to live, little/no crime |
| <input type="checkbox"/> Informal, simple, laidback lifestyle | <input type="checkbox"/> Other (please specify) _____ |

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

- | | |
|--|---|
| <input type="checkbox"/> Activities for families and youth | <input type="checkbox"/> Recreational and sports activities |
| <input type="checkbox"/> Arts and cultural activities | <input type="checkbox"/> Year-round access to fitness opportunities |
| <input type="checkbox"/> Local events and festivals | <input type="checkbox"/> Other (please specify) _____ |

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

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

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

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

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

- Adequacy of Indian Health Service or Tribal Health Services
- Other (please specify) _____

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

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

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

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

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

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

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

Delivery of Healthcare

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

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

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

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

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

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

- | | |
|--|---|
| <input type="checkbox"/> Hospital (Acute Care) | <input type="checkbox"/> Long Term Care |
| <input type="checkbox"/> Emergency Room | <input type="checkbox"/> Independent Living |
| <input type="checkbox"/> Swing Bed | |

15. Considering **PHYSICAL AND OCCUPATIONAL THERAPY SERVICES** at Tioga Medical Center, which services are you aware of (or have you used in the past year)? (Choose ALL that apply)

- | | |
|--|--|
| <input type="checkbox"/> General Orthopedics | <input type="checkbox"/> Pain Management |
| <input type="checkbox"/> Pre-and Post-surgical rehab | <input type="checkbox"/> Wound/Burn Care |

- Athletic Injuries/Sports Medicine
- Women's Health
- Vestibular Rehab
- Neurological Rehab
- Back Education/Rehab
- Geriatric Issues (Balance/Falls)
- Myofascial Release
- Hand Therapy
- Splinting/Bracing
- ADL Equipment Needs and Training
- Home Safety Assessments
- Wheelchair Assessments
- Speech Therapy
- Cardiac Rehab

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

- Drug Screening
- Breath and Alcohol Testing
- Outpatient Lab Services

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

- CT-Scan
- DEXA Scan

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

- Wellness through Patient Education and Screenings
- Chronic Disease Management
- Geriatric Care
- Health Maintenance Exams
- Preoperative Exams
- Individualized care to all ages
- Child/Newborn Wellness Exams
- DOT Exams & Other Health Screenings
- Health and wellness counseling for all ages
- Adolescent health
- Breast health
- Minor Procedures
- Chronic Disease Management
- Women's Health
 - Annual Exams
 - Basic OB care
 - Contraceptive Implants
- Health Maintenance Exams
- Diabetic Education and Foot Care

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

- Mammogram
- MRI
- Ultrasound
- GI Procedures (colonoscopy or EDGs)
- Outpatient Surgery
- Counseling Services
- Immunizations

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

- | | |
|--|--|
| <input type="checkbox"/> Ambulance | <input type="checkbox"/> Counseling Services |
| <input type="checkbox"/> Dental Services | <input type="checkbox"/> Mental Health Service |

21. Are you aware of Tioga's Medical Center well-child services in collaboration with the Upper Missouri District Health Unit?

- Yes No

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

- | | | |
|--|---|---|
| <input type="checkbox"/> Advertising | <input type="checkbox"/> Public health professionals | <input type="checkbox"/> Word of mouth, from others (friends, neighbors, co-workers, etc.) |
| <input type="checkbox"/> Employer/worksites wellness | <input type="checkbox"/> Radio | <input type="checkbox"/> Other: (please specify) |
| <input type="checkbox"/> Healthcare professionals | <input type="checkbox"/> Social media (Facebook, Twitter, etc.) | _____ |
| <input type="checkbox"/> Indian Health Service | <input type="checkbox"/> Tribal Health | |
| <input type="checkbox"/> Newspaper | <input type="checkbox"/> Web searches | |

Public Health Services

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

- | | |
|--|--|
| <input type="checkbox"/> Blood Pressure checks | <input type="checkbox"/> Foot Care |
| <input type="checkbox"/> Breastfeeding resources | <input type="checkbox"/> Foreign Travel Immunizations |
| <input type="checkbox"/> Car seat program | <input type="checkbox"/> Immunizations |
| <input type="checkbox"/> Emergency Preparedness services-work with community partners and part of the emergency response team | <input type="checkbox"/> Newborn Home Visits/Clinic |
| <input type="checkbox"/> Environmental Health Services (mold inspection, sewer, health hazard abatement, school and daycare inspections) | <input type="checkbox"/> Nutrition Education |
| <input type="checkbox"/> Family Planning (STD and HIV testing) | <input type="checkbox"/> School Health-health education and resources to the schools |
| <input type="checkbox"/> Flu Shots | <input type="checkbox"/> Tobacco Prevention and Control |
| | <input type="checkbox"/> Tuberculosis testing and management |
| | <input type="checkbox"/> WIC (Women, Infants & Children) Program |

24. Do you feel you have access to accurate information regarding immunization records?

- Yes No

25. Are you aware the Upper Missouri Health District provides immunization information?

- Yes No

26. Where do you obtain immunization information? _____

Oil Impacted Community Concerns

27. Regarding impacts from **OIL DEVELOPMENT** in your community, concerns are (choose up to **THREE**):

- | | |
|--|--|
| <input type="checkbox"/> Adequate number of school resources | <input type="checkbox"/> Lack of employment opportunities |
| <input type="checkbox"/> Aging population, lack of resources to meet growing needs | <input type="checkbox"/> Lack of police presence in community |
| <input type="checkbox"/> Alcohol and drug use and abuse | <input type="checkbox"/> Litter |
| <input type="checkbox"/> Crime and community violence | <input type="checkbox"/> Low wages, lack of livable wages |
| <input type="checkbox"/> Domestic violence, including child abuse | <input type="checkbox"/> Maintaining enough health workers (e.g., medical, dental, wellness) |
| <input type="checkbox"/> Environmentally unsound (or unfriendly) place to live | <input type="checkbox"/> Poverty |
| <input type="checkbox"/> Impact of increased oil/energy development | <input type="checkbox"/> Property taxes |
| <input type="checkbox"/> Increasing population, including residents moving in | <input type="checkbox"/> Racism, prejudice, hate, discrimination |
| <input type="checkbox"/> Insufficient facilities for exercise and well-being | <input type="checkbox"/> Traffic safety, including speeding, road safety and drunk driving |
| <input type="checkbox"/> Lack of affordable housing | <input type="checkbox"/> Other: (please specify) _____ |
| <input type="checkbox"/> Lack of employees to fill positions | |

Demographic Information: Please tell us about yourself.

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

Yes

No

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

- | | | |
|--|---------------------------------------|--|
| <input type="checkbox"/> Indian Health Service (IHS) | <input type="checkbox"/> Medicaid | <input type="checkbox"/> Veteran's Healthcare Benefits |
| <input type="checkbox"/> Insurance through employer | <input type="checkbox"/> Medicare | <input type="checkbox"/> Other (please specify) |
| <input type="checkbox"/> Self-purchased insurance | <input type="checkbox"/> No insurance | _____ |

30. Age:

- | | | |
|---|---|---|
| <input type="checkbox"/> Less than 18 years | <input type="checkbox"/> 35 to 44 years | <input type="checkbox"/> 65 to 74 years |
| <input type="checkbox"/> 18 to 24 years | <input type="checkbox"/> 45 to 54 years | <input type="checkbox"/> 75 years and older |
| <input type="checkbox"/> 25 to 34 years | <input type="checkbox"/> 55 to 64 years | |

31. Highest level of education:

- | | | |
|---|--|--|
| <input type="checkbox"/> Less than high school | <input type="checkbox"/> Some college/technical degree | <input type="checkbox"/> Bachelor's degree |
| <input type="checkbox"/> High school diploma or GED | <input type="checkbox"/> Associate degree | <input type="checkbox"/> Graduate or professional degree |

32. Gender:

- | | | |
|---------------------------------|-------------------------------|--------------------------------------|
| <input type="checkbox"/> Female | <input type="checkbox"/> Male | <input type="checkbox"/> Transgender |
|---------------------------------|-------------------------------|--------------------------------------|

33. Employment status:

- | | | |
|------------------------------------|--|-------------------------------------|
| <input type="checkbox"/> Full time | <input type="checkbox"/> Homemaker | <input type="checkbox"/> Unemployed |
| <input type="checkbox"/> Part time | <input type="checkbox"/> Multiple job holder | <input type="checkbox"/> Retired |

34. Your zip code: _____

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

- | | | |
|---|---|---|
| <input type="checkbox"/> American Indian | <input type="checkbox"/> Hispanic/Latino | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> African American | <input type="checkbox"/> Pacific Islander | <input type="checkbox"/> Prefer not to answer |
| <input type="checkbox"/> Asian | <input type="checkbox"/> White/Caucasian | |

36. Annual household income before taxes:

- | | | |
|---|---|---|
| <input type="checkbox"/> Less than \$15,000 | <input type="checkbox"/> \$50,000 to \$74,999 | <input type="checkbox"/> \$150,000 and over |
| <input type="checkbox"/> \$15,000 to \$24,999 | <input type="checkbox"/> \$75,000 to \$99,999 | <input type="checkbox"/> Prefer not to answer |
| <input type="checkbox"/> \$25,000 to \$49,999 | <input type="checkbox"/> \$100,000 to \$149,999 | |

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

Thank you for assisting us with this important survey!

Appendix B – County Health Rankings Explained

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

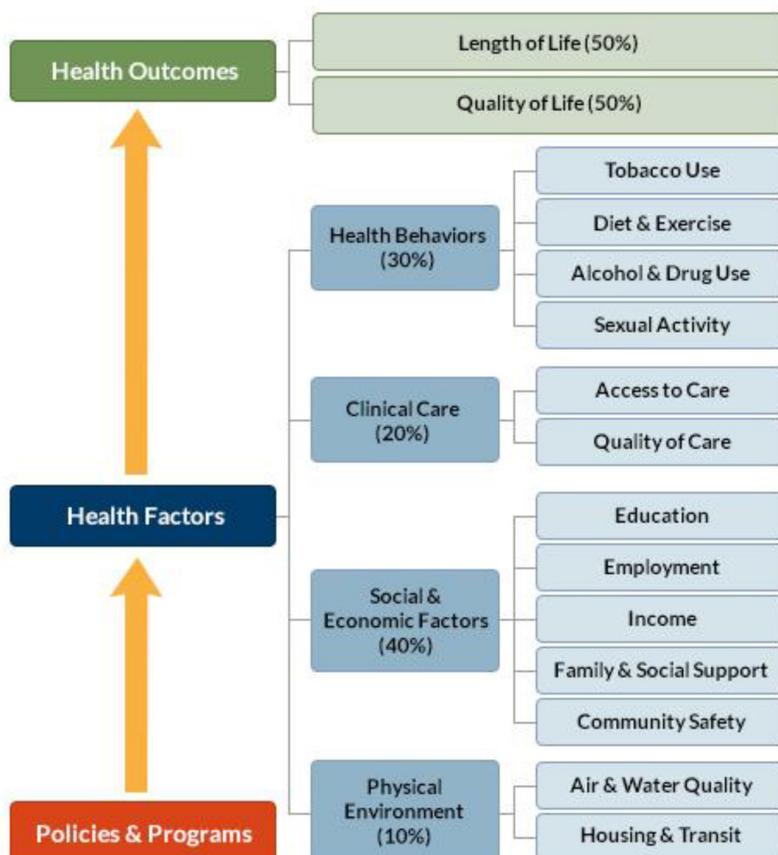
Methods

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

What is Ranked

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

Ranking System



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

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

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

Data Sources and Measures

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

Data Quality

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

Calculating Scores and Ranks

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

Health Outcomes and Factors

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

Health Outcomes

Premature Death (YPLL)

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

Reason for Ranking

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

Poor or Fair Health

Self-reported health status is a general measure of health-related quality of life (HRQoL) in a population. This measure is based on survey responses to the question: "In general, would you say that your health is excellent, very good, good, fair, or poor?" The value reported in the County Health Rankings is the percentage of adult respondents who rate their health "fair" or "poor." The measure is modeled and age-adjusted to the 2000 U.S. population. Please note that the methods for calculating this measure changed in the 2016 Rankings.

Reason for Ranking

Measuring HRQoL helps characterize the burden of disabilities and chronic diseases in a population. Self-reported health status is a widely used measure of people's health-related quality of life. In addition to measuring how long people live, it is important to also include measures that consider how healthy people are while alive.

Poor Physical Health Days

Poor physical health days is based on survey responses to the question: "Thinking about your physical health, which includes physical illness and injury, for how many days during the past 30 days was your physical health not good?" The value reported in the County Health Rankings is the average number of days a county's adult respondents report that their physical health was not good. The measure is age-adjusted to the 2000 U.S. population. Please note that the methods for calculating this measure changed in the 2016 Rankings.

Reason for Ranking

Measuring health-related quality of life (HRQoL) helps characterize the burden of disabilities and chronic diseases in a population. In addition to measuring how long people live, it is also important to include measures of how healthy people are while alive – and people's reports of days when their physical health was not good are a reliable estimate of their recent health.

Poor Mental Health Days

Poor mental health days is based on survey responses to the question: "Thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental health not good?" The value reported in the County Health Rankings is the average number of days a county's adult respondents report that their mental health was not good. The measure is age-adjusted to the 2000 U.S. population. Please note that the methods for calculating this measure changed in the 2016 Rankings.

Reason for Ranking

Overall health depends on both physical and mental well-being. Measuring the number of days when people report that their mental health was not good, i.e., poor mental health days, represents an important facet of health-related quality of life.

Low Birth Weight

Birth outcomes are a category of measures that describe health at birth. These outcomes, such as low birthweight (LBW), represent a child's current and future morbidity — or whether a child has a “healthy start” — and serve as a health outcome related to maternal health risk.

Reason for Ranking

LBW is unique as a health outcome because it represents multiple factors: infant current and future morbidity, as well as premature mortality risk, and maternal exposure to health risks. The health associations and impacts of LBW are numerous.

In terms of the infant's health outcomes, LBW serves as a predictor of premature mortality and/or morbidity over the life course.[1] LBW children have greater developmental and growth problems, are at higher risk of cardiovascular disease later in life, and have a greater rate of respiratory conditions.[2-4]

From the perspective of maternal health outcomes, LBW indicates maternal exposure to health risks in all categories of health factors, including her health behaviors, access to healthcare, the social and economic environment the mother inhabits, and environmental risks to which she is exposed. Authors have found that modifiable maternal health behaviors, including nutrition and weight gain, smoking, and alcohol and substance use or abuse can result in LBW.[5]

LBW has also been associated with cognitive development problems. Several studies show that LBW children have higher rates of sensorineural impairments, such as cerebral palsy, and visual, auditory, and intellectual impairments.[2,3,6] As a consequence, LBW can “impose a substantial burden on special education and social services, on families and caretakers of the infants, and on society generally.”[7]

Health Factors

Adult Smoking

Adult smoking is the percentage of the adult population that currently smokes every day or most days and has smoked at least 100 cigarettes in their lifetime. Please note that the methods for calculating this measure changed in the 2016 Rankings.

Reason for Ranking

Each year approximately 443,000 premature deaths can be attributed to smoking. Cigarette smoking is identified as a cause of various cancers, cardiovascular disease, and respiratory conditions, as well as low birthweight and other adverse health outcomes. Measuring the prevalence of tobacco use in the population can alert communities to potential adverse health outcomes and can be valuable for assessing the need for cessation programs or the effectiveness of existing programs.

Adult Obesity

Adult obesity is the percentage of the adult population (age 20 and older) that reports a body mass index (BMI) greater than or equal to 30 kg/m².

Reason for Ranking

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

Food Environment Index

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

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

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

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

Reason for Ranking

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

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

Physical Inactivity

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

Reason for Ranking

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

Access to Exercise Opportunities

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

Individuals who:

- reside in a census block within a half mile of a park or
- in urban census blocks: reside within one mile of a recreational facility or

- in rural census blocks: reside within three miles of a recreational facility
- are considered to have adequate access for opportunities for physical activity.

Reason for Ranking

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

Excessive Drinking

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

Reason for Ranking

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

Alcohol-Impaired Driving Deaths

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

Reason for Ranking

Approximately 17,000 Americans are killed annually in alcohol-related motor vehicle crashes. Binge/heavy drinkers account for most episodes of alcohol-impaired driving.[1,2]

Sexually Transmitted Infection Rate

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

Reason for Ranking

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

Teen Births

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

Reason for Ranking

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

more likely to be overweight/obese in adulthood, and more likely to experience depression and psychological distress [5-7].

Uninsured

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

Reason for Ranking

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

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

Primary Care Physicians

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

Reason for Ranking

Access to care requires not only financial coverage, but also access to providers. While high rates of specialist physicians have been shown to be associated with higher (and perhaps unnecessary) utilization, sufficient availability of primary care physicians is essential for preventive and primary care, and, when needed, referrals to appropriate specialty care.[1,2]

Dentists

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

Reason for Ranking

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

Mental Health Providers

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

Reason for Ranking

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

Preventable Hospital Stays

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

Reason for Ranking

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

Diabetes Monitoring

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

Reason for Ranking

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

Mammography Screening

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

Reason for Ranking

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

Unemployment

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

Reason for Ranking

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

Children in Poverty

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

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

Reason for Ranking

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

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

Income Inequality

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

Reason for Ranking

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

Children in Single-Parent Households

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

Reason for Ranking

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

Violent Crime Rate

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

Reason for Ranking

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

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

Injury Deaths

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

Reason for Ranking

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

Air Pollution-Particulate matter

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

Reason for Ranking

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

Drinking Water Violations

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

Reason for Ranking

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

Severe Housing Problems

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

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

- household is severely cost burdened.

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

Reason for Ranking

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

Appendix C – Prioritization of Community’s Health Needs

Community Health Needs Assessment

Tioga, North Dakota

Ranking of Concerns

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

| | Priorities | Most Important |
|---|------------|----------------|
| Community/Environmental Health Concerns | | |
| Having enough child daycare services | 4 | 1 |
| Not enough affordable housing | 3 | 1 |
| Attracting and retaining young families | 7 | 6 |
| | 1 | |
| Availability/Delivery of Health Services Concerns | | |
| Availability of mental health services | 3 | |
| Extra hours for appointments i.e. evenings and weekends | 4 | |
| Cost of healthcare services | 5 | |
| | | |
| Adult Population Health Concerns | | |
| Depression/anxiety | 4 | |
| Alcohol use and abuse | 1 | |
| Drug use and abuse (including prescriptions) | 1 | |
| Stress | 1 | |
| | | |
| Youth Population Health Concerns | | |
| Drug use and abuse (including prescriptions) | 3 | |
| Alcohol use and abuse | | |
| Not enough activities for children and youth | 4 | |
| Depression/anxiety | 4 | 3 |
| | | |
| Senior Population Health Concerns | | |
| Cost of long-term/nursing home care | | |
| Availability of resources to help elderly stay in their homes | 1 | |
| Availability of home health | 1 | |
| Ability to meet the needs of the older population | 2 | |
| | | |

Appendix D – Survey “Other” Responses

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

1. When asked what prevents people (including other community residents) from receiving healthcare “other” responses were:

- Scared of doctors, hospitals. Expense.
- No insurance. Viral assumption. Bad past experience in past. Don’t believe in - use herbal.
- Cost. Don’t want to be confronted about personal behavior. Personal choices - buy a boat or smoke, etc.
- Cost - no or high deductible. Can cure ourselves tough.
- Ignorance. Lack of insurance.
- Cost. No insurance.
- Money
- Stigma in small town. Culture - don’t seek care.
- Lack of insurance or money for services.

2. When the key informants were given a list of services provided by the District Health Unit to review and comment on whether they think the community is aware of these locally available services.

a. Are there any services that are on the list that you were not aware of?

- Foreign travel immunizations
- Newborn house visits
- HIV/STD testing

b. Are there any services that are not on the list that you would like to see added?

- Mental health
- Mental health in schools

c. Are there any specific services that you feel should have increased marketing?

- All (3)
- Environmental services
- Foot care for the general population
- Family planning in high schools
- Car seat program

3. When asked what are the reasons that community members use the Medical Center rather than other providers for healthcare needs, the responses were:

- Good triage and assessments.
- Easy to work with - students and family. Support school programs - shots programs and illness
- Convenience. Like the providers. Level of trust (know us and our families)
- Quality of care and they take care of you like family. Clinics in Ray and Powers Lake.
- Convenience. Location.
- Because it’s here - great staff. Offer everything you need day to day.
- Get what can here - access. Want to keep hospital and clinic here.
- Convenience - like the providers. Refer to therapy - collaboration vice.
- They receive good care and are being heard by us “they listen to me.” They know we have good follow through. Very good availability. Our staff knows the patients.

4. When asked the reasons community members use other healthcare providers rather than the Tioga Medical Center, the responses were:

- Referrals. Specialists and skip primary care.
- Surgeries. Referrals to specialists.
- Perception - folks don't want people to know their business. We are less educated or proficient.
- Looking for a specific provider. Not a positive result with past provider. Turnover of initial provider and rebuilding a new relationship.
- Personal choice - past issues with staff, more comfortable seeing someone out of town.
- Rural town - don't want neighbors to know. Previous bad experience.
- Referrals - surgery.
- Privacy. Specialists. Distrust smaller town docs.
- Don't manage pain - other pain management. Specialty care such as cardiology. Don't know that we can manage a lot of primary care concerns.

5. When asked "what single issue do you feel is the biggest challenge facing your community?" the responses were:

- Affordable care for the elderly.
- Affordable housing for those of us not in the oilfield industry.
- Alcohol abuse / depression
- Attracting and keeping tradespeople (plumbers, electricians, carpenters, etc.)
- Bullying.
- Cost of health insurance
- Drug abuse / addiction
- Drug use
- Elderly in their homes needing assistance with activities of daily living- bathing, shopping, meal prep
- Entertainment and activities for people
- Everyone wants activities or projects to start around town, but no one wants to help do the work.
- Expensive childcare and housing
- Extreme lack of all the elder care services.

Lack of small-town local government knowledge to help small businesses families & community. Lack of leadership development within all government agencies.

- Healthy food at restaurants and adult rec sports/activities
- Lack of unity
- Mental health/suicide/drug abuse
- Narrow mindedness, race prejudice
- Need better medical personnel, someone who doesn't use web md, and misdiagnosis is a big thing. Costing extra \$ when people have to come back or go elsewhere because the patient knows the we're told wrongly simply based on symptoms.
- Needing more Doctors and nurses that will stay here longer
- Not enough facilities
- Resources for people new to the community
- Retaining young families
- Suicide in all ages
- Teens using prescription drugs
- The high-cost of living with such low incomes.
- There needs to be more community activities for adults and teens
- Transportation for seniors living at home to go shop, post office
- Depression as a result of family situations - moved away from support system, working parents, social

dynamics/split families!

- Obesity - crosses all age groups and is also a community item (walking paths)
- Mental health for everyone, including providers trying to solve the issue.
- Youth - scares me - for the kids - parents forget to pick them up (parental involvement and parties (drinking at bar, darts). What about the next Generation?)
- Drug issue and get ahead of it.
- Wellness/Exercise facility - consider re-directing healthcare sales tax
- Cancer - I know many with cancer - young people. 19-50 years of age.
- There is not a huge understanding of what goes on - more education on various healthcare needs. People travel 10 hours to go to therapy session.
- Depression.
- Availability of mental health and utilization of what is available.
- Concerns about health services - in general mental healthcare is lacking for all ages.
- Depression/anxiety. This is a concern for all age groups and can lead to many other issues.

6. Other concerns not already listed in the survey, but were added by participants were:

- School attendance is poor - K to 12. Family trips, eye appts, mental health. Tardiness (parent issue)
- People are getting lazier - no one to work, want disability or refuse to work. Don't want to better themselves or community. Too much cell phone. All this causing obesity.
- All things social media. Addiction. False information.
- There aren't any grief services.
- Law enforcement do a good at their job. Good to see them out - highway patrol and sheriff's deputies.
- It cost to travel, food, health services. Social injustice due to lack of public interest or knowledge of the issues. The state needs to invest in the facility and staff with more providers. So much to be done. Social services changing to regional services will make it worse. Human Services is a joke. Appalling due to lack of services.
- Nutrition specialists for better choices. Better cooperation with faith based and mental health to coordinate approaches to all addictions.

7. When asked "What specific healthcare services, if any, do you think should be added locally?" responses were:

- Dentist
- Every ER should be equipped to treat a rape victim. They should NOT have to be referred to larger facility. It's hard enough to go in once
- Extended clinic hours/walk-in clinic hours
- Help elders stay in their home
- Home health
- Home healthcare aides
- Mammography, Dementia/ Alzheimer's Unit
- Mental Healthcare (3)
- MRI
- Obstetrics/gynecology
- Oral surgeons and prosthodontists
- Trinity
- VISION SPECIALIST
- Women's health
- Parkinson's program

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

- I think for being in a small community, Tioga Medical Center offers a wide variety of services that fit the needs of Tioga residents and the surrounding areas.
- I would like to see more information on what a person can make appointments for other than having an injury or illness. What types of lab tests can I get done to check my overall health when I don't feel sick? What are my physical therapy options for soreness/ aches without having an accident or sports-injury?
- Need more mental health, drug/ alcohol counseling
- Not enough holistic healthcare or engagement to look at what is causing discomfort
- Not enough mental health needs
- Not enough leadership development within the communities
- Pay competitive salaries to keep nurses and doctors in the community as the cost of living increased with oil activity
- Phone answering, long time to get appt, accuracy of updating personal medical records and keeping them updated (where does this info go when nothing changed from visit to visit?)
- Speech services for stroke patients
- Survey way too long
- Waste of \$, could definitely get better personnel who actually know how to treat individuals as that, and not treat patient is the same based on past patients.
- We need extended clinic hours, particularly for oil workers who tend to use ER services for non-emergency care due to scheduling problems (No clinic hours in the evenings or on weekends). We also need amenities like good restaurants.
- Market all the hospital programs at the Powers Lake Clinic.

9. When asked "where do you obtain immunization information", responses were:

- Clinic (4)
- County health nurse
- Did not do immunizations on my 5 girls
- Don't know for sure
- Dr. Office
- Healthcare provider (2)
- I haven't for myself
- Medical records (2)
- Not sure. Online?
- Tioga Medical Center (2)
- UMHD (3)