2016 Community Health Needs Assessment

Ashley Area
North Dakota

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Executive Summary

Introduction and Overview

To help inform future decisions and strategic planning, Ashley Medical Center-AMC (a Critical Access Hospital – CAH – located in Ashley, ND) and McIntosh District Health Unit-MDHU (a county public health agency) conducted a community health needs assessment in McIntosh County. All non-profit hospitals are required under the Affordable Care Act to conduct an environmental health assessment and to develop an implementation plan based on the data every three years. To assure a broad representation of health concerns the non-profit hospitals must engage local public health in the process. Acute care hospitals and public health typically address different facets of heath; having both involved in a community health engagement process can facilitate a more comprehensive process, one that ultimately benefits the community. The Center for Rural Health (CRH) at the University of North Dakota School of Medicine and Health Sciences facilitated the assessment, which included the solicitation of input from area community members and health care professionals as well as analysis of community health-related data. CRH assembled a local team or the Community Group to lead the process. It had representation from the hospital, public health, and community members. All worked together on this Community Health Needs Assessment (CHNA) process and will continue to collaborate on a Community Health Implementation Plan (CHIP).

To gather feedback from the community, residents of the counties were given the chance to participate in a survey. One hundred seventy-four McIntosh County residents completed the survey. Additional information was collected through seven key informant interviews with community leaders along with a focus group (about 25 community members). The input from all of these residents represented the broad interests of the communities of McIntosh County. Together with secondary data gathered from a wide range of sources, the information gathered presents a snapshot of health needs and concerns in the community.

It will help the reader to understand that a community health needs assessment process looks at a wide range of issues, interests, and subjects. It may not be apparent, at first glance, why some community elements are part of the process. For example, the report will address what is called "community assets." This includes attitudes and perspectives about life in the community: best attributes of people in the community, available services and resources, quality of life, and local activities. This may not seem relevant in

a health assessment; however, health is a broader concept than simply our physical health status. It is inclusive of the environment and how that environment impacts our daily life, contributes to stress, provides physical and emotional outlets, and impacts our overall outlook and attitude. Thus, our relationship with our broader community is an important part of our health. In a similar vein, health experts frequently reference the concept called "social determinants of health." According to the World Health Organization reported at the Rural Health Information Hub (https://www.ruralhealthinfo.org/topics/social-determinants-of-health) the definition of social determinants of health is as follows: "*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 a wider set of forces: economics, social policies, and politics.*" This is the CRH operating framework for the community health assessment process. Social determinants of health are the ingredients that go into making our health status. They influence our health outcomes. They impact the overall population health of the area. As one resource stated: "*social determinants of health refer to the set of factors that contribute to the social patterning of health, disease, and illness.*"

Social determinants of health contribute to what is called "population health." According to Kindig in What is Population Health, population health refers to the "*Health outcomes of a group of individuals, including the distribution of such outcomes within the group.*" A group, as defined by Kindig, can be geographically based (such as all the people in a county), or it can be based on race, gender, economic strata, or a myriad of categories. From a health policy perspective, a population health approach focuses on the root cause of problems and the entailing solutions. Population health is also a primary focus of the Affordable Care Act and much of what we do to change our health system is being done in an effort to improve population health. Non-profit hospitals and public health are seen as central players in doing so. Much of our health system is moving from a focus on volume (and paying providers based on the numbers seen) to a renewed focus on value (which is more outcome based where providers are paid more on the result and quality of medical and health care treatment than on the numbers seen). The CHNA and CHIP process are community focused efforts that are intended to assist not only the health provider/professional, but also an active and committed community in their own population health approach. Another concept to be aware of is that the CHNA and CHIP are tools that help a non-profit hospital to meet its "community benefit" obligation. In order to maintain their legal status as a non-profit hospital, it must be shown that the hospital is providing a community benefit and the CHNA is explicitly required as a means to assist in that process. Charity care has been the stipulated obligation prior to the enactment of the Affordable Care Act; however, under

the current law non-profit hospitals must show proof of a community benefit and showing how the hospital addresses access to care and promotes population health improvement are accepted ways.

There are four broad categories of social and physical determinants that influence population health. Our *physical environment* contributes about 10 percent of our health status. This includes the built environment such as buildings and transportation; environmental quality such as air and water quality; physical barriers such as obstacles for people with disabilities; and, the natural environment such as plants, weather, or climate change. *Health care* is a second factor of population health. This generally refers to the health care system and its many facets. For many people, when they think of health or what contributes to their health, they think primarily of the health system (doctors, nurses, hospitals, etc.) and are surprised to learn that our health care system contributes about 20 percent to our health status. This includes access to health care such as having health insurance, health care costs, language and health literacy, and the availability of health providers and services; the quality of health care and patient safety including health promotion and disease prevention, and adequate hospitalization stays; viability of health systems and other economic factors associated with provider reimbursement and changing revenue streams; and much of public health policy which develops laws and regulations governing the health system. *Health behaviors* is a third population health factor. This refers to our individual decision making as it relates to health: Do we smoke? Do we exercise? Do we drink alcohol or use drugs? Research shows that health behaviors contribute 30 percent of our health. Health behaviors, while they may be associated with individual choice and decisions, are more and more becoming a focus of the health care system, public policy, employers, and health insurance payers. Our health decisions have an impact on health status (e.g., morbidity and mortality), and they also have an impact on the cost of health services (e.g., societal costs of smoking, obesity, chemical dependency to the employer, government, and insurance payers). *Socio-economic* factors are the fourth and final contributor to population health. Socio-economic variables account for roughly 40 percent of health. This is largest area and maybe the most surprising. However, education, employment status, income, community conditions, social norms and attitudes, crime and violence, and food and nutrition all contribute to our health status. Research over the years has shown that people have better health relative to others as it is associated with more education, higher incomes, job stability, community safety, or functional family dynamics.

It should be pointed out, that this outline of health determinants is only one model. Others have five determinants as they include genetics or family history which can

account for about 20 percent. This is very legitimate as our genetic code is certainly a contributor to our health status.

Key Findings

In terms of demographics, McIntosh County reflects state averages in some ways, but contrasts in other ways. It is similar to the state in terms of the level of poverty (13.8% - McIntosh County, 11.9% - North Dakota) and the percentage of veterans (9.2% McIntosh County, 10% North Dakota). However, there are greater differences between McIntosh County and the state on a number of measures. For example, McIntosh County residents are significantly below the state average in terms of median household income ($40,258- McIntosh County, $60,200- ND) and are actually closer to the lower end of the state range ($34,000 - $86,400). The high school graduation level is below the state level (75% - McIntosh County, 91%, ND). People in McIntosh County tend to be older in comparison to the state aggregate. In McIntosh County 19.0% of people are 18 years of age and younger in comparison to 22.7% for the state. At the other end of the age continuum, 31.3% of McIntosh County residents are 65 years of age or older whereas for North Dakota, as a whole, this stands at 14.2%. Another way to assess population age is to look at median age (median being the middle point where 50% are above and 50% are below the number). This shows that McIntosh County has one of the oldest median ages in the state at 52.1 years of age. This contrasts with 35.1 for the state and over 37.8 for the U.S. It should be pointed out that over the last 10 years the median age for North Dakota has dropped, most likely due to the influx of people associated with the oil expansion in the west. There were only eight states that have seen their states become younger from 2005-2014, and North Dakota led the nation with the largest decline of four years from a median of 39.1 in 2005 to 35.1 in 2014. The next closest states noting a decline in the median age were Alaska and Montana, with each experiencing a lowering or ages by 0.6 years. With a median age of 35.1, North Dakota has the fifth youngest population in the nation. McIntosh County also contrasts more markedly from the state in terms of people who have a bachelor degree. In McIntosh County, 18.6% have a bachelor degree or higher in comparison to 27.3% for the state.

Data compiled by County Health Rankings (a national data base for all U.S. counties) looks at both *health outcomes* as well as *health factors* that contribute to those outcomes (e.g., whether someone smokes, state of physical activity, number of children in poverty, as well as others are health factors). This data set is one of the primary set of community measures used by the CRH in conducting your CHNA. The data show that with respect to *health outcomes,* McIntosh County is, overall, worse than North Dakota

as a whole. Only on poor mental health days (in past 30 days) and poor physical health days (in past 30 days) did McIntosh County outperform the state and the national data (poor physical health days: 2.8 days McIntosh County, 2.9 days North Dakota and 2.9 days national) (poor mental health days: 2.7 days, McIntosh County, 2.8 days North Dakota and 2.9 days national). For low birth weight and percent diabetic McIntosh County exceeded the national measure (negative comparison). In reviewing poor or fair health, the county did better than the state but worse than the top 10% performing counties for the nation. Finally, premature death data was not reported in the County Health Rankings data file for McIntosh County. There also is room for improvement on individual *health factors* that influence population health, such as health behaviors, clinical care, social and economic factors, and the physical environment. McIntosh County compared unfavorably to the state and the nation on 12 of 25 health factors which are presented below:

- Adult obesity
- Physical inactivity
- Access to exercise opportunities
- Uninsured
- Primary care physicians
- Dentists
- Preventable hospital stays
- Diabetic screening
- Mammography screening
- Children in poverty
- Income inequality
- Injury deaths

McIntosh County outperformed the state but scored below national statistics on the following six *health factors*:
- Adult smoking
- Excessive drinking
- Sexually transmitted diseases
- Children in single parent households
- Violent crime
- Air pollution – particulate matter

McIntosh County compared unfavorably to North Dakota but better than the national average on the following *health factor*:

- Unemployment

McIntosh County compared unfavorably to the national average but better than North Dakota on the following *health factor*:

- Severe housing problems

McIntosh County scored better than either the state or national data on two of the 25 *health factors*, which are as follows:

- Food environment index
- Alcohol impaired driving deaths

Data was not reported for McIntosh County on teen birth rate and mental health providers so comparisons cannot be made. For drinking water violations the data is recorded as a yes or no in terms of having violations and in this case McIntosh County it was categorized as no for violations.

In addition to the County Health Rankings, another CHNA tool was a community survey that was employed. Of 107 potential community and health needs set forth in the survey or presented by survey respondents, McIntosh County residents who took the survey, indicated these eight needs as the most important:

1. Ability to recruit and retain primary care (n=119)
2. Cancer (118)
3. Attracting and retaining young families (103)
4. Change in population size (81)
5. Availability of resources to help the elderly (80)
6. Availability of dental care (80)
7. Diabetes (78)
8. Jobs with livable wages (76)

The survey also revealed that the biggest barriers to receiving health care as perceived by community members were as follows:

- Not enough doctors (n= 64)
- Not enough specialists (58)
- Concerns about confidentiality (26)
- Distance from health facility (20)

When asked about the quality of life for the community, respondents indicated that the top community assets were:

- Safe place to live, little/no crime   (n=153)
- Family friendly; good place to raise kids   (139)
- Closeness to work and activities   (87)
- Informal, simple, laidback lifestyle   (75)

The survey also asked the respondent to rate a series of resources and services available in the community. The top ones are presented below:

- Active faith community   (n=114)
- Health care   (n=105)
- Quality of the school systems   (n=96)
- Business district (restaurants, availability of goods)   (n=35)
- Community groups and organizations   (n=34)
- Access to healthy foods   (n=32)

Input from community leaders provided via key informant interviews (phone interviews) and one focus group (on site) echoed many of the concerns raised by survey respondents. Thematic concerns emerging from these sessions (in descending order) were:

- Not enough jobs with livable wages, not enough to live on
- Availability of resources to help the elderly stay in their homes
- Attracting and retaining young families
- Change in population size (decreasing)
- Availability of resources for family and friends caring for elders
- Dementia/Alzheimer's disease
- Being able to meet the needs of an older population
- Assisted living options

Following careful consideration of the results and findings of this assessment, Community Group members in a second meeting determined the top issues. Each issue was ranked with participants being able to select three. After this each participant could select one issue that they viewed as the most significant issues. Following this methodology the top community health issues facing Ashley are presented below with the number of first place votes in parenthesis:

- Attracting and retaining young families (9 votes)
- Assisted living options (5)

- Jobs with livable wages (2)
- Availability of resources to help the elderly stay in their home (1)

The group has begun the next step of strategic planning to identify ways to address significant community needs.

Overview and Community Resources

The purpose of conducting a community health assessment is to describe the health of local people, identify areas for health improvement, identify use of local health care services, determine factors that contribute to health issues, identify and prioritize community needs, and help health care leaders identify potential action to address the community's health needs. A health needs assessment benefits the community by: 1) collecting timely input from the local community; 2) providing an analysis of secondary data related to health-related behaviors, conditions, risks, and outcomes; 3) compiling and organizing information to guide decision making, education, and marketing efforts, and to facilitate the development of a strategic plan; and 4) engaging community members about the future of health care. Completion of a health assessment also is a requirement for public health departments seeking accreditation.

With assistance from the Center for Rural Health at the University of North Dakota School of Medicine and Health Sciences, Ashley Medical Center (AMC) and McIntosh District Health Unit completed a community health assessment of McIntosh County. Many community members and stakeholders worked together on the assessment.

Community Description

As illustrated in Figure 1, McIntosh County is located in south-central North Dakota and borders South Dakota. It is primarily an agricultural economy with a number of small businesses, typically family owned and operated. The county is unique in that it is one of only four rural counties where there are two hospitals operating, in Ashley and Wishek. Thus, health care is an important part of the local economy. The county seat is Ashley, which lies in the south-central are of the county, approximately seven miles from the South Dakota border. The state capital, Bismarck, is located two hours to the north and west of Ashley. Ashley has the second largest community endowment fund in the state

and has targeted these local monies towards a variety of economic development projects. Along with the hospital, the courthouse, school, and agriculture provide the economic base for the town of Ashley and McIntosh County. The 2014 estimated population of McIntosh County was 2,801. Ashley's estimated population in 2014 was 749. Rural McIntosh County has several incorporated cities, including Wishek (992 people), Zeeland (85), Lehr (80), and Venturia (10). It is classified as a frontier county (6 or less people per square miles) as it has 2.9 people per square miles (ND has 9.7 people per square miles).

Ashley has a number of community assets and resources that can be mobilized to address population health improvement. In terms of physical assets and features, the community includes a fitness trail, swimming pool, City Park, tennis courts, golf course and fitness center. Lake Hoskins Park and Dry Lake offers recreation, fishing, and camping opportunities. McIntosh County offers prime hunting opportunities. Ashley offers cultural attractions with the Heritage Center which pays tribute to the early history of the area.

Each major town in McIntosh County has a fitness center. Public transportation provided by South Central Services. Progressive downtown Ashley Businesses provide necessary services and retail goods and are valued assets of the community. The Ashley Public School system offers a comprehensive program for students Pre-K to 12.

Other health care facilities and services in the area include AMC Clinic in Zeeland and Ashley, pharmacy, optometrist, dentist, chiropractor, massage therapy, Women Infants & Children (WIC Program is based at AMC). Wishek Hospital Clinic Association also provides healthcare services to our county with a 24 bed critical access hospital and clinic located in Wishek. The Wishek Living Center has a 60 bed nursing home and operates the Prairie Hills Assisted Living with 19 assisted living units, serving residents of McIntosh County.

Ashley has a volunteer ambulance service that provides advanced life support services with paramedics that are also employed by AMC. The Ashley Ambulance Service provides emergency services throughout the county, and also are the primary

responders and emergency responder educators for the Acciona Wind Farm 24 miles southeast of Ashley.

Figure 1: McIntosh County, North Dakota
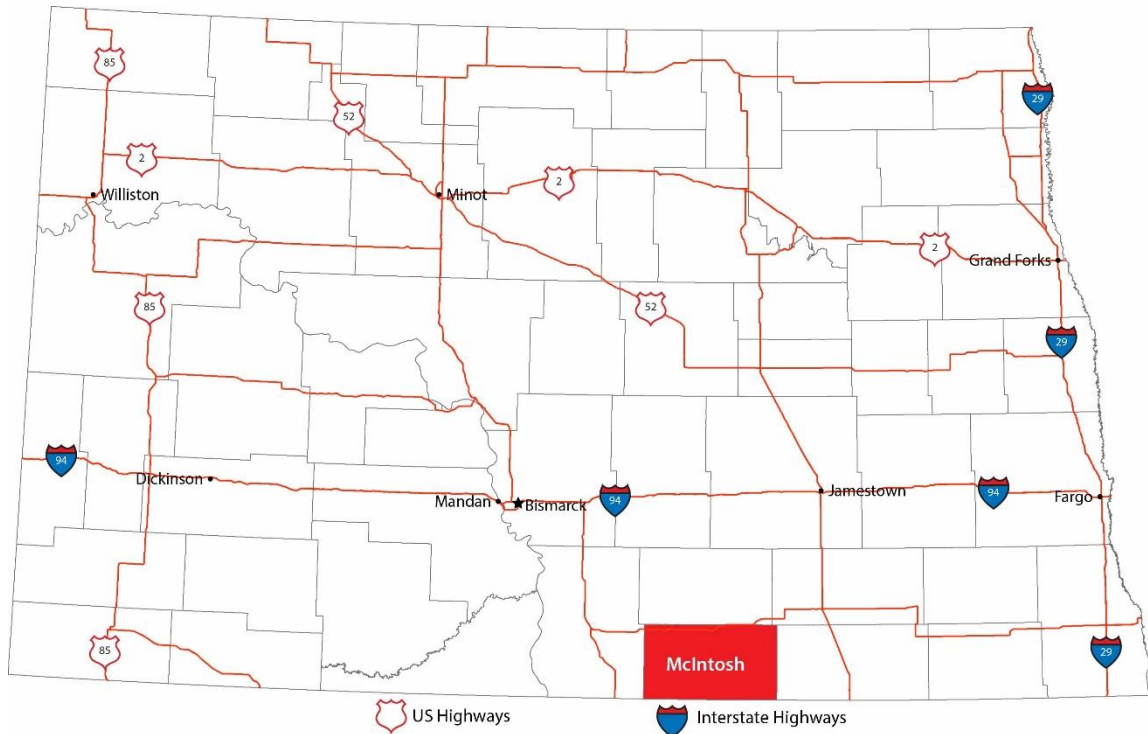
Ashley Medical Center

The Ashley Medical Center (AMC) opened its door in 1952. Today, AMC has grown into a fully integrated healthcare system with a 20 bed critical access hospital (CAH) along with swing beds and a level 5 trauma emergency room. The skilled nursing home has 40 beds. AMC operates two rural health clinics. Low income housing is provided with a 25 unit Harmony Home Apartment Complex, and an 8 unit apartment area within the main facility.

AMC provides acute care services, including inpatient, outpatient, swing bed, and 24/7 emergency room care. AMC staffs AMC Ashley Clinic and AMC Zeeland Clinic. A 40 bed attached skilled nursing home is also part of AMC and serviced by the provider staff. The hospital manages a professional building where a chiropractor, an optometrist, and an ophthalmologist practice. The ophthalmologist performs cataract surgery at the Ashley Medical Center on a monthly basis.

Services that AMC offers locally include:

General and Acute Services

1. Acne Treatment
2. Allergy, flu, & Pneumonia Shots
3. Blood Pressure Checks
4. Cardiac Rehab
5. Clinic
6. Emergency Room
7. Hospital (Acute care)
8. Independent Senior Housing
9. Mole, wart,& skin lesion removal
10. Ophthalmology Evaluation and Surgical Services (visiting physician)
11. Pharmacy
12. Podiatry – evaluation (visiting physician)
13. Prenatal care up to 32 weeks
14. Physicals – Annual, DOT, sports & insurance
15. Sports Medicine
16. Surgical Services – biopsies
17. Surgical Services – outpatient
18. Swing Bed Services

Screening/Therapy Services

1. Chronic Disease Management
2. Holter Monitoring
3. Laboratory Services
4. Lower Extremity Circulatory Assessment
5. Occupational Physicals
6. Pediatric Services
7. Physical Therapy
8. Sleep Studies (mobile unit)
9. Social Services

Radiology Services

1. CT Scans
2. Digital Mammography
3. Echocardiograms (mobile unit)
4. EKG
5. General X-ray
6. Nuclear Medicine (mobile unit)
7. MRI (mobile unit)
8. Ultrasound (mobile unit)
9. DEXA Scan (bone density, mobile unit)

Laboratory Services

1. Hematology
2. Blood Types
3. Clot Times
4. Chemistry
5. Urine Testing
6. Blood Bank (only one in region)

7. Arterial Blood Gases   8. Rapid Cardiac Diagnostics

Services Offered by Other providers/organizations
1. Ambulance
2. Chiropractic Services
3. Massage Therapy
4. Optometric/Vision Services (visiting physician)

AMC Recent Recognition and Awards

In July of 2014, AMC was recognized for its exemplary commitment to their employee safety and health under the OSHA Safety and Health Achievement Recognition Program (SHARP). The hospital was nominated for this award through the North Dakota Consultation Program at Bismarck State College. Through the fire and safety committee the hospital demonstrated its commitment to employee safety and health by establishing an effective safety and health management system.

IVantage also gave AMC recognition in April of 2015 when the hospital was named a 2015 Top 100 Critical Access Hospital, achieving top performance among its peers and earning national recognition. The news release for this award stated the Ashley Medical Center scored in the top 100 of critical access hospitals on the IVantage Hospital Strength INDEX. The INDEX is the industry's most comprehensive rating of US acute care hospitals, and the only one to include the country's 1300 CAHs. The results recognize that the top 100 CAHs provide a safety net to communities across rural America – measuring them across 62 different performance metrics, including quality, outcomes, patient perspective, affordability, population risk and efficiency.

In May of 2015, AMC was designated by the National Rural Health Association as a Top 20 Best Practice in Patient Satisfaction among all critical access hospitals in the U.S. Representatives from the hospital received the award in person at the National Rural Health Association Conference in Kansas City, Missouri on October 2, 2015.

Ashley Medical Center is a healthcare organization with a mission to provide preventative, curative, supportive, and educational healthcare that meets the physical, emotional, and spiritual needs of the people we serve. AMC serves as a "hub" for community based health services, integrating different levels of care and services through one organizational structure. It is essential to its patients not only for acute and emergency care services, but also the link for primary care, nursing home services, elder care services, and living structures. AMC extends beyond the standard definition of a hospital.

The long term goal of AMC is to provide patients with the best quality of care regardless of geographic barriers. Having the motivation to overcome the challenges of rural health care and provide its patients with care that is equal to or better than they would receive in an urban facility.

McIntosh District Health Unit

McIntosh District Health Unit provides public health services that include environmental health, nursing services, health screenings, and education services. The health unit works primarily with ages 0-18 and those 55 and over. Each of these programs provides a wide variety of services in order to accomplish the mission of public health, which is to assure that North Dakota is a healthy place to live and each person has an equal opportunity to enjoy good health.

Specific services McIntosh District Health Unit provide are:

1. Childhood immunizations from birth through "college" shots
2. Flu shots for all ages
3. In school education on hygiene, handwashing, puberty, and bullying
4. Host in school immunization and flu clinics
5. Offer car seats along with installation and education

6. Hearing screens
7. Coordination of eye checks by the Lions organization
8. Health Tracks for eligible families
9. Foot care for ages 60 and over or special needs patients (provided in home, at the office, or at senior centers)
10. Blood Pressure checks
11. Medication setups
12. Stepping On program for ages 55 and over
13. Sewer Permits

There is regional collaboration with Jamestown and other public health units for the following:
1. Tobacco
2. Emergency Preparedness
3. Environmental Health
4. Maternal & Child Health
5. Chronic Disease and Cancer Awareness

Assessment Process

The Center for Rural Health (CRH) provided substantial support to Ashley Medial Center (AMC) and McIntosh District Health Unit (MDHU) in conducting this needs assessment. The CRH involvement was funded partially through its Medicare Rural Hospital Flexibility (Flex) Program. The Flex program is federally funded by the federal Office of Rural Health Policy (ORHP), an agency within the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services. The CRH is one of the nation's most experienced organizations committed to providing leadership in rural health. Created in 1980 by the UND School of Medicine and Health Sciences its mission is to connect resources and knowledge to strengthen the health of people in rural communities. As the federally designated State Office of Rural Health (SORH) for North Dakota– which is also funded by ORHP and HRSA - and the home to the North Dakota Medicare Rural Hospital Flexibility (Flex) program, the CRH connects the School of Medicine and Health Sciences and the university to rural communities and their health institutions to facilitate developing and maintaining rural health delivery systems, access to care, availability of care, and community development and engagement. In this capacity the Center works both at a national level and at state and community levels.

The assessment process was collaborative. Professionals from the hospital and the public health unit were heavily involved in planning and implementing the process. They met regularly by telephone conference and via email with representatives from the CRH. The Community Group (described in more detail below) provided in-depth information and informed the assessment in terms of community perceptions, community resources, community needs, and ideas for improving the health of the population and health care services. Representatives from the hospital and public health were heavily involved in planning the Community Group meetings. The Community Group was comprised of many residents from outside the hospital and health department, including representatives from local government, businesses, and social services.

As part of the assessment's overall collaborative process, the CRH facilitated efforts to collect data for the assessment in a variety of ways involving both primary data (original) and secondary data (data that already exists): (1) a community survey solicited feedback from area residents; (2) community leaders representing the broad interests of the community took part in one-on-one key informant interviews; (3) community members participated in a focus group, and (4) a wide range of secondary sources of data was

examined, providing information on a multitude of measures including demographics; health conditions, indicators, and outcomes; rates of preventive measures; rates of disease; and at-risk behaviors.

The survey instrument was developed out of a collaborative effort that took into account input from health organizations around the state. The North Dakota Department of Health's public health liaison organized a series of meetings that garnered input from the state's health officer, local public health unit professionals from around North Dakota, representatives of the CRH, and representatives from North Dakota State University.

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

Community Group

A community group consisting of twenty-five community members was convened and first met on March 16, 2016. During the first community group meeting, group members were introduced to the needs assessment process, reviewed basic demographic information about McIntosh County, and served as a focus group. Focus group topics included community assets and challenges, the general health needs of the community, community concerns, and suggestions for improving the community's health.

The community group met again on April 25, 2016 with eighteen 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 McIntosh 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 Ashley Medical Center and McIntosh District Health Unit. They included representatives of the health community, business community, economic development, political bodies, law enforcement, education, faith community, EMS, agriculture, elderly, and young families. Not all members of the group were present at both meetings.

Interviews

One-on-one interviews with seven key informants were conducted. These were face-to-face interviews conducted during March 2016. Representatives from the CRH conducted the interviews. Participating in interviews were key informants (e.g., members of the community group and others) who could provide insights into the community's health needs. Included among the informants were public health professionals (with special knowledge in public health acquired through several years of direct experience in the community including working with medically underserved, low income, and minority populations, as well as with populations with chronic diseases); child care providers; business representatives; education professionals; ministers; and emergency services.

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

In addition, a *focus group* comprised of the community group was held with about 25 individuals in March 2016. The same type of topics that were addressed in the key informant interviews were discussed in the focus group.

The CRH prefers a mixed methods approach to community assessments, one that incorporates secondary data (e.g., County Health Rankings) with primary data (e.g., community surveys, key informant interviews, and focus groups). Key informant interviews are different from focus groups in that the key informant is a solo interview and the focus group is a multiple number of people. Each is legitimate but one is not superior to the other. The dynamics are different (individual vs. group dynamics) and this tends to produce better input and results.

Survey

A survey was distributed to gather feedback from the community. The survey was not intended to be a scientific or a statistically valid sampling of the population. Rather, it was what is called a "convenience sample" which is one of the main types of non-probability sampling methods. It is not a random sample but is based on the ease in gaining input from a population, hence it is convenient. A convenience sample is a legitimate methodology and has been employed by the Center for Rural Health in working with rural communities where it has become increasingly difficult to gain the required validity in a random sample (i.e., the response rates have lowered significantly). A convenience sample is designed to be an additional tool for collecting quantitative data from the community at large – specifically, information related to

community-perceived health needs. A copy of the survey tool is contained in Appendix A.

The survey was distributed to various residents of McIntosh 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 and challenges, levels of collaboration within the community, broad areas of community and health concerns, need for health services, barriers to using local health care, preferences for using local health care versus traveling to other facilities, travel time to their clinic and hospital, use of preventive care, use of public health services, suggestions to improve community health, and basic demographic information.

Approximately 350 community member surveys were available for distribution in McIntosh County. To promote awareness of the assessment process, informative ad was placed in the Ashley Tribune. Additionally, information was published in the AMC/SNF newsletter. The community also utilized AMC Facebook Page and the website. A radio spot was developed and ran on KSJB along with an ad on the local access channel. Participation in community functions to promote the survey and process included fund raisers, a meeting at the Senior Citizens, and staff meetings at the AMC. The surveys were distributed in several locations in the community including café, banks, grocery store, city office, public health, clinics, AMC lobby, C-store. Decorative drop boxes were placed with an informative overview of the survey, and a business card with the online survey link were available at the business sites.

The key focus was to disseminate the surveys in an easy manner to get them in the hands of as many people as possible. The CRH has placed greater emphasis on community engagement in this version of CHNA process so working with the community groups (and having one primary contact in the community to work with on the process) was an important strategy. The community group used their natural outreach methods in a positive way for community members to be involved in not only assisting the hospital and public health, but in building local awareness and support for a discussion of community health issues.

To help ensure anonymity, included with each survey was a postage-paid return envelope to the CRH. The survey period ran from March 1, 2016 to April 1, 2016. Area residents also were given the option of completing an online version of the survey, which was publicized in the same manner as the paper survey. The final number of completed surveys was 174. There were 117 paper, and 57 on-line. The response rate was 50% (49.7%). 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 were collected from a variety of sources including the U.S. Census Bureau, the North Dakota Department of Health, the Robert Wood Johnson Foundation's County Health Rankings (which pulls data from 20 primary data sources), the National Survey of Children's Health Data Resource Center, the Centers for Disease Control and Prevention, the North Dakota Behavioral Risk Factor Surveillance System, and the National Center for Health Statistics.

Social Determinants of Health

Social determinants of health are, according to the World Health Organization,

"the circumstances in which people are born, grow up, live, work, and age and the systems put in place to deal with illness. These circumstances are in turn shaped by wider set of forces: economics, social policies and politics. "
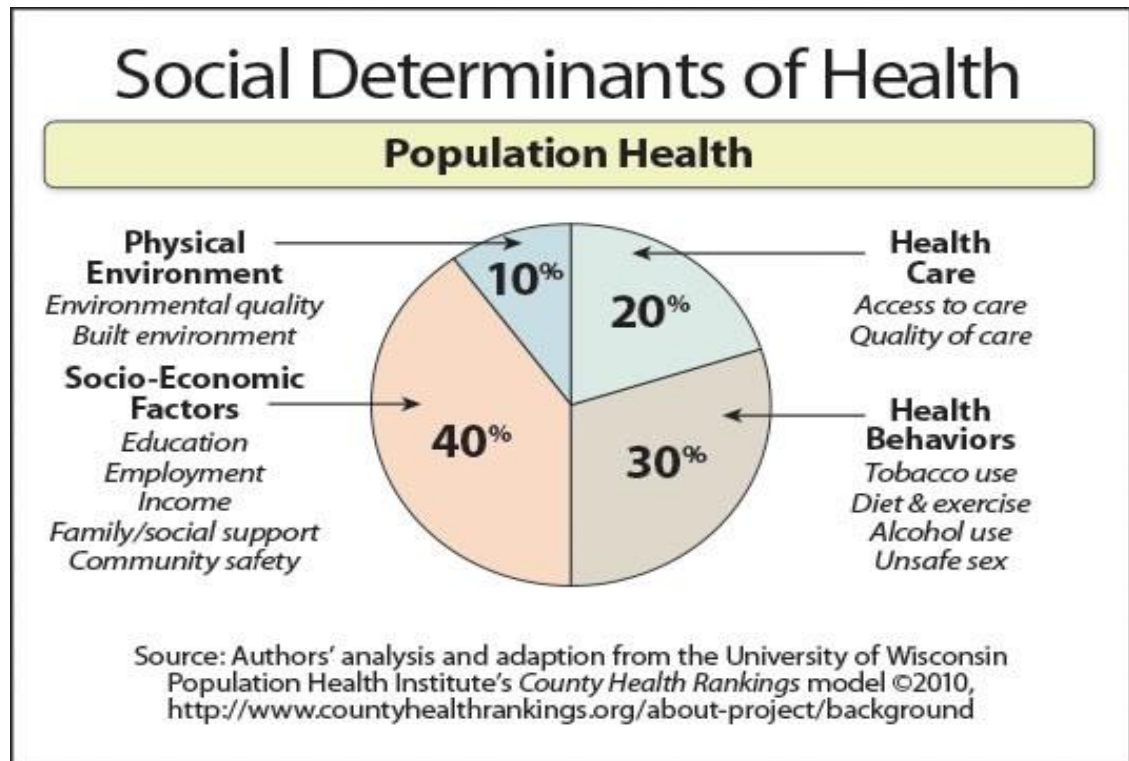
Income-level, educational attainment, race/ethnicity, and health literacy all impact the ability of people to access health services. Basic needs, such as clean air and water and safe and affordable housing are all essential to staying healthy, And also impacted by social factors listed above. The impact of these challenges can be compounded by the barriers already present in rural areas, such as limited public transportation options and fewer choices to acquire healthy food.

Figure 2 illustrates the small percent (20%) that health care quality and services, while vitally important, play in the overall health of individuals and ultimately of a community. Physical environment, socio-economic factors, and health behaviors play a much larger part (70%) in impacting health outcomes. Therefore, as needs or concerns were raised through this community health needs assessment process, it was imperative to keep in

mind how they impact the health of the community and what solutions can be implemented.

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

Figure 2: Social Determinants of Health

Social Determinants of Health

Population Health

Physical Environment
Environmental quality
Built environment

Socio-Economic Factors
Education
Employment
Income
Family/social support
Community safety

10%

20%

40%

30%

Health Care
Access to care
Quality of care

Health Behaviors
Tobacco use
Diet & exercise
Alcohol use
Unsafe sex

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

Demographic Information

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

TABLE 1: MCINTOSH COUNTY: INFORMATION AND DEMOGRAPHICS (From 2010 Census/2014 American Community Survey; more recent estimates used where available)		
	McIntosh County	**North Dakota**
Population, 2015 est.	**2,759**	**756,927**
Population change, 2010-2015	**-1.8%**	**12.5%**
Land area, square miles 2010	**975**	**69,001**
People per square mile, 2010	**2.9**	**9.7**
White persons (not incl. Hispanic/Latino), 2014 est.	**97.7%**	**89.1%**
Persons under 18 years, 2014 est.	**19.0%**	**22.8%**
Persons 65 years or older, 2014 est.	**31.3%**	**14.2%**
Non-English spoken at home, 2014 est.	**17.1%**	**5.3%**
High school graduates, 2014 est.	**76.4%**	**91.3%**
Bachelor's degree or higher, 2014 est.	**18.1%**	**27.3%**
Live below poverty line, 2013 est.	**13.0%**	**11.5%**

While the population of North Dakota has grown significantly from 2010 (over 12%), there has been a slight decline in McIntosh County of almost 2% (1.8%). McIntosh County is also a frontier county following the federal definition of having six or less people per mile (2.9 in McIntosh). McIntosh is slightly more white than the state, has a smaller percentage of people 18 years of age and younger and a much higher percentage being 65 and older than the state (at a rate more than double than found in the state), and has a lower percentage who are high school graduates. The poverty rate is slightly higher than the state rate.

Health Conditions, Behaviors, and Outcomes

As noted above, several sources of secondary data were reviewed to inform this assessment. The data are presented below in three categories: (1) County Health Rankings, (2) the public health community profile, and (3) children's health.

County Health Rankings

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

The data used in the 2015 County Health Rankings are pulled from more than 20 data sources and then are compiled to create county rankings. Counties in each of the 50 states are ranked according to summaries of a variety of health measures. Those having high ranks, such as 1 or 2, are considered to be the "healthiest." Counties are ranked on both health outcomes and health factors. Below is a breakdown of the variables that influence a county's rank. A model of the 2015 County Health Rankings – a flow chart of how a county's rank is determined – may be found in Appendix B. For further information, visit the County Health Rankings website at www.countyhealthrankings.org.

Health Outcomes	**Health Factors** (continued)
• Length of life	• Social and Economic Factors
• Quality of life	○ Education
	○ Employment
Health Factors	○ Income
• Health Behavior	○ Family and social support
○ Smoking	○ Community safety
○ Diet and exercise	• Physical Environment
○ Alcohol and drug use	○ Air and water quality
○ Sexual activity	○ Housing and transit
• Clinical Care	
○ Access to care	
○ Quality of care	

Table 2 summarizes the pertinent information gathered by County Health Rankings as it relates to McIntosh County. It is important to note that these statistics describe the population of a county, regardless of where county residents choose to receive their medical care. In other words, all of the

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following statistics are based on the health behaviors and conditions of the county's residents, not necessarily the patients and clients of Ashley Medical Center and McIntosh District Health Unit or of particular medical facilities.

For most of the measures included in the rankings, the County Health Rankings' authors have calculated the "Top U.S. Performers" for 2015. The Top Performer number marks the point at which only 10% of counties in the nation do better, i.e., the 90th percentile or 10th percentile, depending on whether the measure is framed positively (such as high school graduation) or negatively (such as adult smoking).

McIntosh County's rankings within the state are also included in the summary below. For example, McIntosh County ranks 40th out of 47 ranked counties in North Dakota on health outcomes and 24th on health factors. The measures marked with a red checkmark (✔) are those where McIntosh County is not measuring up to the state rate/percentage; a blue checkmark (✔) indicates that the county is faring better than the North Dakota average, but not meeting the U.S. Top 10% rate on that measure. Measures that are not marked with a colored checkmark, but are marked with a smiling icon (☺) indicate that the county is doing better than the U.S. Top 10%.

The data from County Health Rankings show that McIntosh County is doing better than compared to the rest of North Dakota on three measures of *health outcomes*, (poor physical health days (in past 30 days) and poor mental health days (past 30 days). In comparison, for poor physical health days it was 2.8 days for McIntosh County vs. 2.9 days for North Dakota and 2.9 days for the top U.S performers. For poor mental health days it was similar with 2.7 days for McIntosh compared to 2.8 days for North Dakota and 2.9 days for the U.S. On the other hand, it is worse than the U.S. and North Dakota aggregates for low birth weight and percentage of people who are diabetic, and worse than the U.S. but ahead of North Dakota on poor or fair health. On *health factors*, McIntosh County is doing better than the aggregate U.S. rates and North Dakota counties on the following measures: food environment index and alcohol impaired driving deaths. McIntosh County compared unfavorably to the state and the nation on 12 of 25 health factors which are presented below:

- Adult obesity
- Physical inactivity
- Access to exercise opportunities

- Uninsured
- Primary care physicians
- Dentists
- Preventable hospital stays
- Diabetic screening
- Mammography screening
- Children in poverty
- Income inequality
- Injury deaths

McIntosh County compared unfavorably to North Dakota but better than the national average on the following *health factor*:
- Unemployment

McIntosh County compared unfavorably to the national average but better than North Dakota on the following *health factor*:
- Severe housing problems

Data was not reported for McIntosh County on teen birth rate and mental health providers so comparisons cannot be made. For drinking water violations the data is recorded as a yes or no in terms of having violations and in this case McIntosh County it was categorized as no for violations.

	McIntosh County	U.S. Top 10%	North Dakota
TABLE 2: SELECTED MEASURES FROM *COUNTY HEALTH RANKINGS* – MCINTOSH COUNTY			
Ranking: Outcomes	**40th**		**(of 49)**
Premature death	-	5,200	6,600
Poor or fair health	13% ✓	12%	14%
Poor physical health days (in past 30 days)	2.8 ☺	2.9	2.9
Poor mental health days (in past 30 days)	2.7 ☺	2.8	2.9
Low birth weight	7% ✓✓	6%	6%
% Diabetic	11% ✓✓	9%	8%
Ranking: Factors	**24th**		**(of 49)**
Health Behaviors			
Adult smoking	15% ✓	14%	20%
Adult obesity	32% ✓✓	25%	30%
Food environment index (10=best)	8.8 ☺	8.4	8.5
Physical inactivity	32% ✓✓	20%	25%
Access to exercise opportunities	39% ✓✓	91%	66%
Excessive drinking	18% ✓	12%	25%
Alcohol-impaired driving deaths	0% ☺	14%	47%
Sexually transmitted infections	145.4 ✓	134.1	419.1
Teen birth rate	-	19	28
Clinical Care			
Uninsured	18% ✓✓	11%	12%
Primary care physicians	2,750:1 ✓✓	1,040:1	1,260:1
Dentists	2,800:1 ✓✓	1,340:1	1,690:1
Mental health providers	-	370:1	610:1
Preventable hospital stays	56 ✓✓	38	51
Diabetic screening	83% ✓✓	90%	86%
Mammography screening	59% ✓✓	71%	68%
Social and Economic Factors			
Unemployment	3.2% ✓	3.5%	2.8%
Children in poverty	18% ✓✓	13%	14%
Income inequality	4.9 ✓✓	3.7	4.4
Children in single-parent households	25% ✓	21%	27%
Violent crime	80 ✓	59	240
Injury deaths	129 ✓✓	51	63
Physical Environment			
Air pollution – particulate matter	9.6 ✓	9.5	10.0
Drinking water violations	No	No	-

Severe housing problems	10% ✓	9%	11%

Children's Health

The National Survey of Children's Health touches on multiple intersecting aspects of children's lives. Data are not available at the county level; listed below is information about children's health in North Dakota. The full survey includes physical and mental health status, access to quality health care, and information on the child's family, neighborhood, and social context. Data are from 2011-12. 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%
Health Care		
Children currently insured	**93.5%**	94.5%
Children who had preventive medical visit in past year	**78.6%**	84.4%
Children who had preventive dental visit in past year	**74.6%**	77.2%
Young children (10 mos.-5 yrs.) receiving standardized screening for developmental or behavioral problems	**20.7%**	30.8%
Children aged 2-17 with problems requiring counseling who received needed mental health care	86.3%	61.0%
Family Life		
Children whose families eat meals together 4 or more times per week	83.0%	78.4%
Children who live in households where someone smokes	**29.8%**	24.1%
Neighborhood		
Children who live in neighborhood with a park, sidewalks, a library, and a community center	58.9%	54.1%
Children living in neighborhoods with poorly kept or rundown housing	12.7%	16.2%
Children living in neighborhood that's usually or always safe	94.0%	86.6%

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

- Obese or overweight children
- Children with health insurance
- Preventive primary care and dentist visits
- Developmental/behavioral screening
- Children in smoking households

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

The data show that McIntosh County is performing better than the North Dakota average on 1) children enrolled in Healthy Steps (the state's version of the Children's Health Insurance Program), 2) the Supplemental Nutrition Assistance Program, SNAP or "food stamps," and 3) high school drop-out rate. For the latter, it was significantly better than the state rate. McIntosh County performed worse than the state average for the following:

- Uninsured children (roughly twice the state rate)
- Uninsured children below the 200% of federal poverty rate
- Children served by Medicaid
- Licensed child care capacity

TABLE 4: SELECTED COUNTY-LEVEL MEASURES REGARDING CHILDREN'S HEALTH		
	McIntosh County	**North Dakota**
Uninsured children (% of population age 0-18), 2013	**16.2%**	8.7%
Uninsured children below 200% of poverty (% of population), 2013	**58.4%**	47.8%
Medicaid recipient (% of population age 0-20), 2015	**30.7%**	27.9%
Children enrolled in Healthy Steps (% of population age 0-18), 2013	**5.6%**	2.5%

Supplemental Nutrition Assistance Program (SNAP) recipients (% of population age 0-18), 2015	**14.1%**	20.7%
Licensed child care capacity (% of population age 0-13), 2015	**33.1%**	43.1%
High school dropouts (% of grade 9-12 enrollment), 2014	**0.8%**	2.8%

Survey Results

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

Survey Demographics

To better understand the perspectives being offered by survey respondents, survey-takers were asked a few demographic questions. Throughout this report, numbers (N) instead of percentages (%) are reported because percentages can be misleading with smaller numbers. Survey respondents were not required to answer all survey questions; they were free to skip any questions they wished. As a basis for comparison, the reader is reminded that 174 respondents answered the survey.
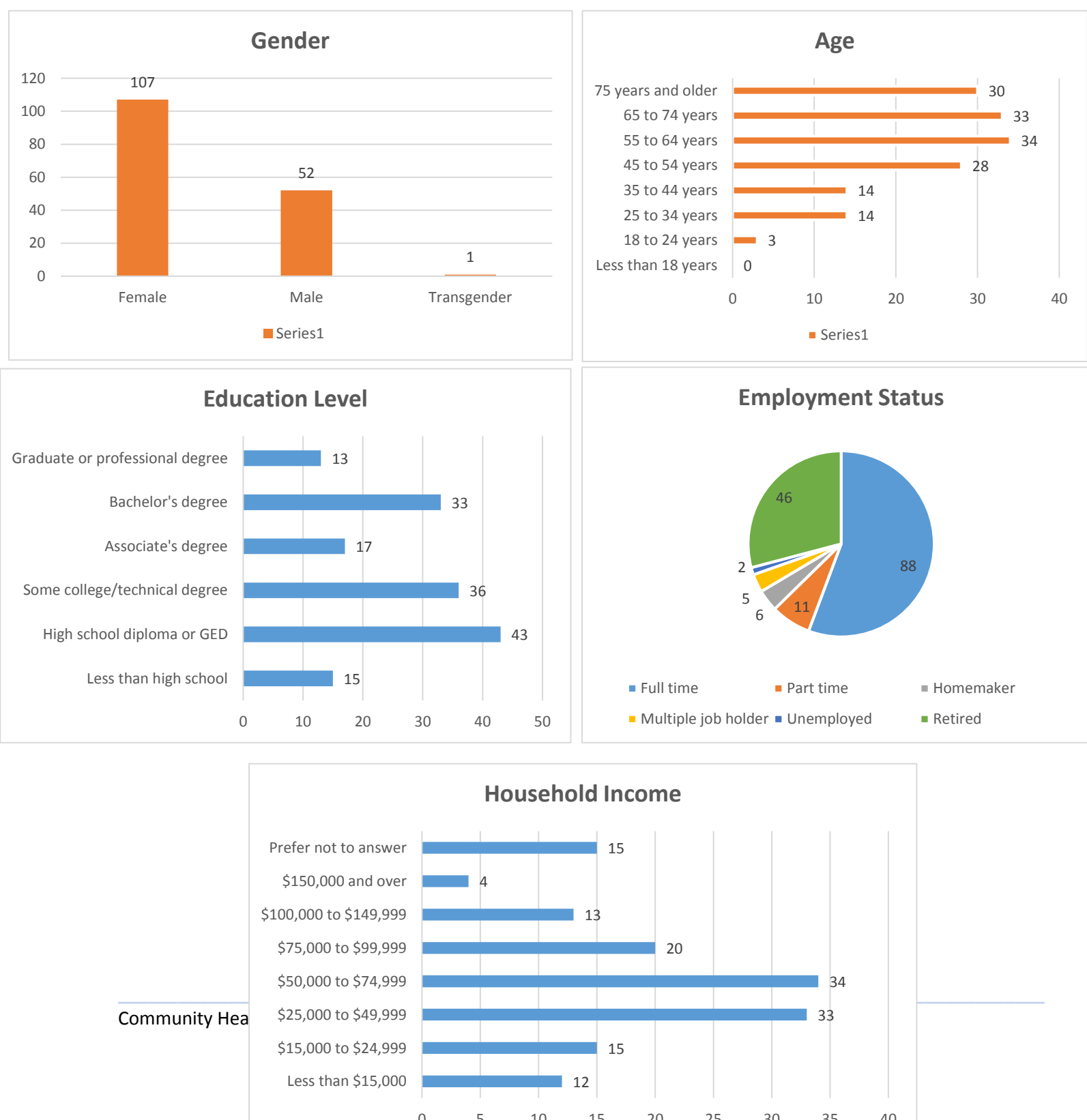
With respect to demographics of those who chose to take the survey:
- The most common age range were people 55 and over (97 respondents) with the most common age group being those 55-64 (34 respondents). The smallest age group were those 18-24 years of age (3)
- A large majority were female (107 out of 174 respondents).
- Respondents tended to be more educated with a strong majority (99) having at least some college or a technical degree.
- A slight majority (88) worked full time, followed by retired (46).
- In terms of income, the most common income category was $50,000-$74,999 (34) which was closely followed by $25,000-$49,999 (33). If we use $75,000 as the comparison point, then 52 respondents made $75,000 or more and 94 earned less than $75,000. Seventeen respondents earned $100,000 or more while 12 earned less than $15,000.

Figure 2 shows these demographic characteristics (age, gender, employment status, education level, and annual household income). It illustrates the wide range of community members' household characteristics and indicates how this assessment took

into account input from parties who represent the varied interests of the community served, including wide age ranges, those in diverse work situations, and lower and higher-income community members.

Figure 3: Demographics of Survey Respondents

Gender

Female	107
Male	52
Transgender	1

Series1

Age

75 years and older	30
65 to 74 years	33
55 to 64 years	34
45 to 54 years	28
35 to 44 years	14
25 to 34 years	14
18 to 24 years	3
Less than 18 years	0

Series1

Education Level

Graduate or professional degree	13
Bachelor's degree	33
Associate's degree	17
Some college/technical degree	36
High school diploma or GED	43
Less than high school	15

Employment Status

Full time	88
Retired	46
Part time	11
Homemaker	6
Multiple job holder	5
Unemployed	2

Household Income

Prefer not to answer	15
$150,000 and over	4
$100,000 to $149,999	13
$75,000 to $99,999	20
$50,000 to $74,999	34
$25,000 to $49,999	33
$15,000 to $24,999	15
Less than $15,000	12

Community Hea

Health Care Access

Community members were asked about their health insurance status (Figure 4). Health insurance status often is associated with whether people have access to health care. Nationally, rural Americans have a lower level of health insurance coverage than found in urban areas. Out of 208 responses (the number of responses exceeds the number of respondents because people could make multiple selections, such as having insurance through their employer but also saying they did not have enough insurance) the most common insurance type was having insurance through the employer or being self-insured (117 responses). Medicare (federal program for people 65 and older or disabled) was selected by 70 people and Medicaid (federal and state for people who meet income criteria) was chosen by 6 respondents. No respondents indicated they had no insurance.

Figure 4: Insurance Status
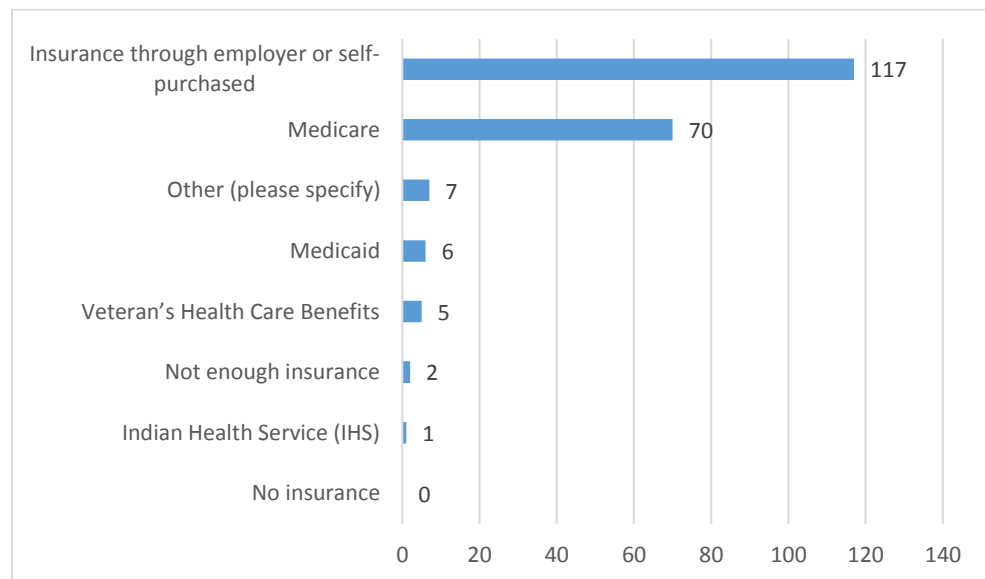
Another way of measuring access is looking at the availability of health services (Figure 5). If care is not available that impedes actual access to services. Survey respondents

were provided a number of services to assess. The largest category was 86 responses identifying availability of primary care providers as a concern. This was followed by availability of dental care (80 responses), availability of specialists (63), ability to get appointments (45), availability of vision care (39), and availability of mental health services (38).

Figure 5: Availability of Health Services
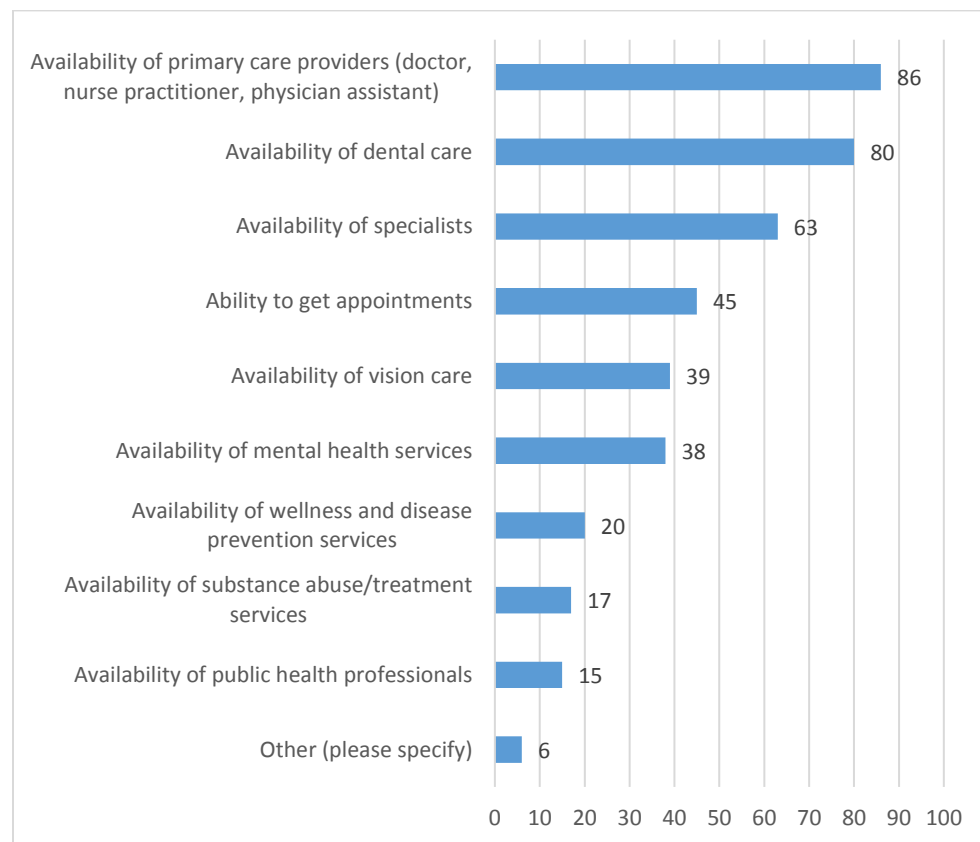
Concerns about the delivery of health services (Figure 6) constitutes a third way to measure access. This looks at constraints within the system of care. While not the highest rated concern, much of the unease was associated with costs as the 2nd, 3rd, and 4th highest rated concerns dealt with costs. The number one concern was the ability to recruit and retain primary care providers with 119 responses. Following this were these systemic elements: cost of health insurance (69), cost of prescription drugs (59), cost of health care services (37), and patient confidentiality (30). The latter, while not a dominant concern, is one to discuss as it can generate additional problems.

Figure 6: Delivery of Health Services

Category	Value
Ability to recruit and retain primary...	119
Cost of health insurance	69
Cost of prescription drugs	59
Cost of health care services	37
Patient confidentiality	30
Quality of care	26
Extra hours for appointments, such as...	19
Sharing of personal health information...	14
Providers using electronic health records	6
Other (please specify)	3
Adequacy of Indian Health or Tribal...	0
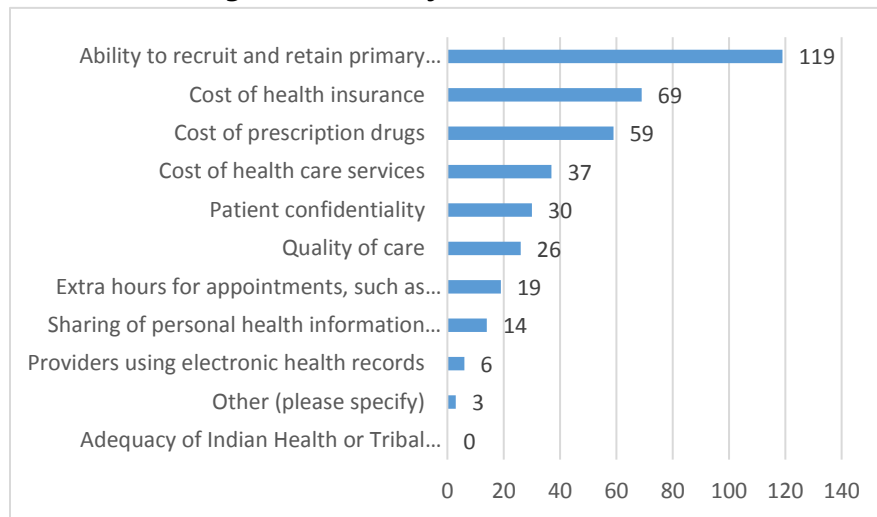
Community Assets, Challenges, and Collaboration

In the Executive Summary, we introduced the concepts of population health and the social and physical determinants of health. Those ideas come into play when looking at community assets, challenges, and even the element of community collaboration. The community context (i.e., how we see our community from an economic, social, and cultural construct) is more than a livability function as it also influences individual health and overall population health. Survey-takers were asked what they perceived as the best things about their community in four categories: people, services and resources, quality of life, and activities. In each category, respondents were given a list of choices and asked to pick the three best things. Respondents occasionally chose less than three or more than three choices within each category. If more than three choices were selected, their responses were not included. The results indicate that community assets include the following:

- Safe place to live, little/no crime — 153 responses
- Family friendly, good place to raise kids — 139
- People are friendly, helpful, supportive — 134
- Year round access to fitness opportunities — 119
- Active faith community — 114
- Local events and festivals — 107
- People who live here are involved in their community — 106
- Health care — 105
- Recreational and sports activities — 103

Figures 7 to 10 illustrate the results of these questions.

Respondents were asked, what were the best things about the people in their community (Figure 7)? Overall, there was a strong opinion that it was the nature or quality of the people. The top three findings related to the people being friendly, helpful, and supportive (134); believing the people who live in Ashley are involved in their community (106); and feeling connected to the people who live in Ashley (102). This indicates respondents identify with their community and possibly believe it is the people and how they interact with each other that is the core of what makes this community the way it is; they see it as a good place to live.

Figure 7: Best Things about the PEOPLE in Your Community
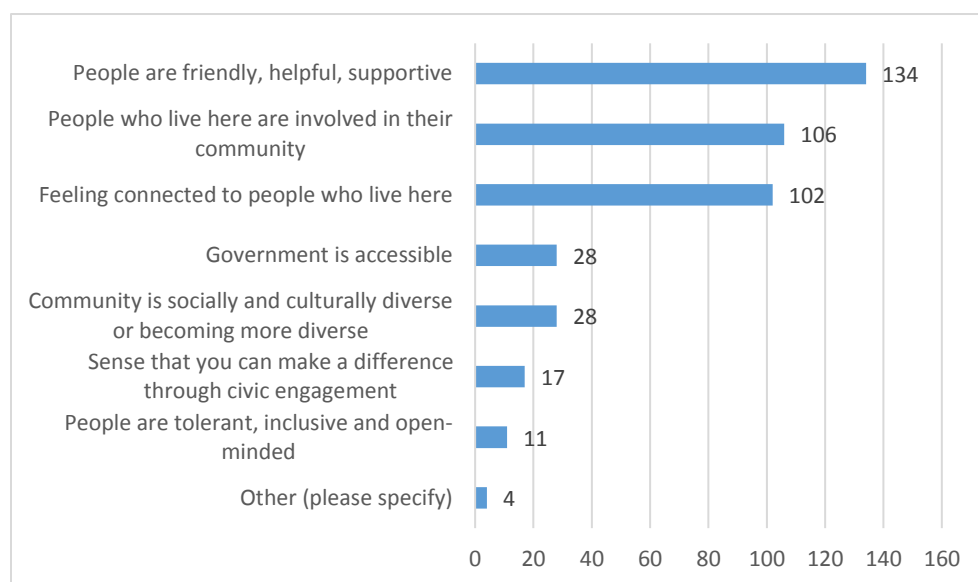
Another measure of community assets is to ask about the services and resources found in the community (Figure 8). In addition to the nature and quality of the people, a community is comprised of many facets including organizations, community sectors, and available services. In the case of Ashley, the top rated service or resource was the active faith community (114), closely followed by health care (105), and then the quality school system (96). There was a significant drop-off to the next items with the business district (35) and community groups and organizations (34) rounding out the top five.

**Figure 8: Best Things about the SERVICES AND RESOURCES in Your Community**
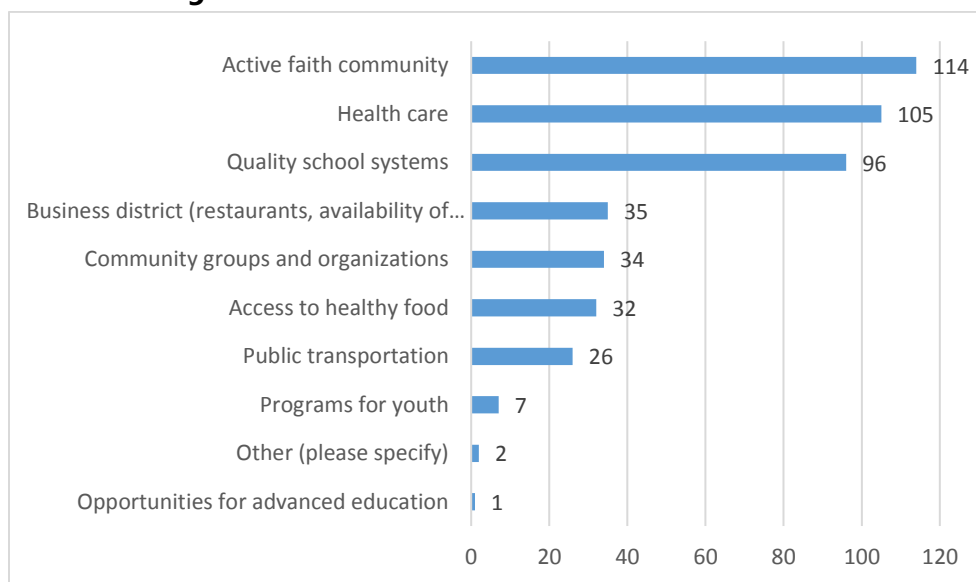
A third measure of community assets are indicators of quality of life (Figure 9). Quality of life typically refers to some standard of health, comfort, or happiness. What are the essential elements that contribute to this feeling in Ashley? The study found the number one indicator to be a sense of a safe place to live with little or no crime (139). This condition was the highest rated factor associated with community assets. This was followed by a family friendly good place to raise kids (156); a closeness to work and activities (87); and an informal, simple, laidback lifestyle (75). It is interesting to note that the lowest rated quality of life condition was job opportunities or economic opportunities (2).

Figure 9: Best Things about the QUALITY OF LIFE in Your Community
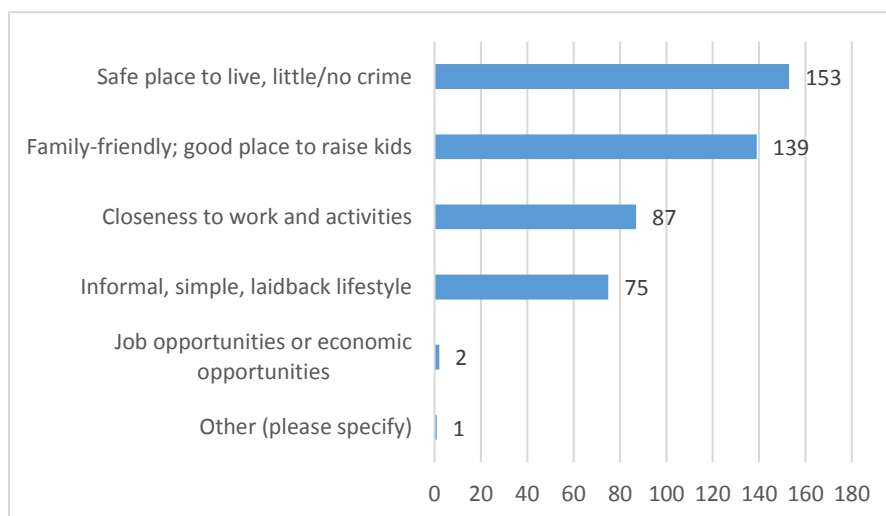
Activities found in a community represent the final measure of community assets (Figure 10). Activities are those added features of a community that make living there extra special. We need essential services, community sectors and organizations, a way to make a living, and a sense of belonging to be a member of a community; however, activities are also essential in fleshing out the experience. Sometimes they are the factors that make a person or family select one community as home over another. In the case of Ashley and McIntosh County the most highly rated activity was year round access to fitness opportunities (119 responses). This was followed by local events and festivals (107). Recreational and sports activities (103) and activities for families and youth (64) round out the top four. Arts and cultural activities (7) was the lowest rated activity.

Figure 10: Best Thing about the ACTIVITIES in Your Community
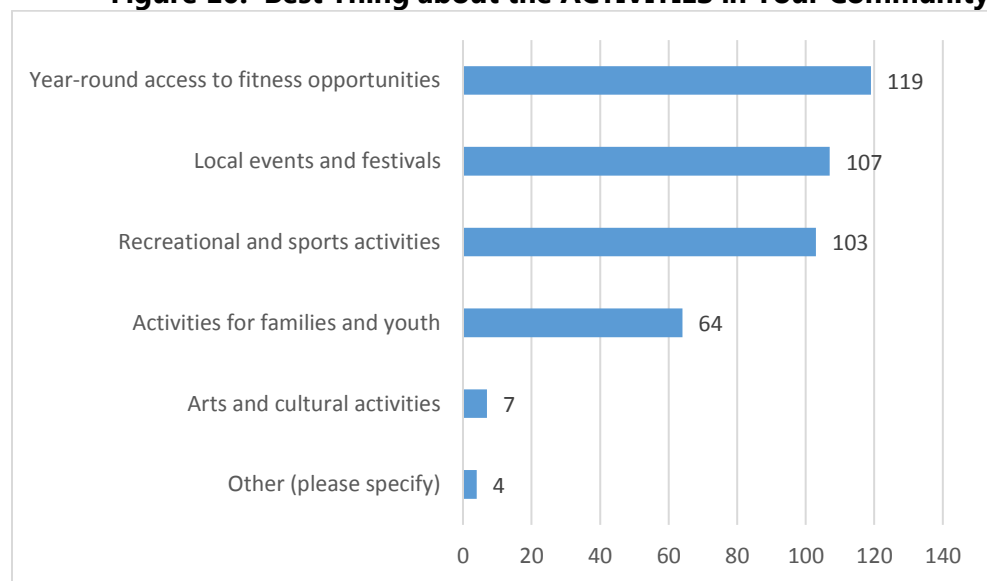
In addition to what are called closed-ended questions (i.e., questions where the respondent is provided a choice of selections), the survey also asked open ended questions whereby the respondent could simply write out an answer in their own words. Respondents were asked, "*What are the major challenges facing your community?"* There were 161 separate responses coded to this question. Answers were analyzed, coded, and assigned to a theme that represented a category of response. The most commonly cited themes that represent challenges and sub-themes include the following (e.g., population is a theme and declining is a sub-theme):

- Population – declining, aging, impact of either a declining or aging population on the town, lack of diversity (30 comments on declining population alone, 15 specific to aging, and 6 more general for a total of 51)

- Economic conditions – availability of jobs, livable wages, low wages, economic opportunity, viability to attract young families, limited economic development, rising costs of services/products, limited tax base, quality of workforce (31)
- Attracting and retaining physicians – recruit a physician, just have PA or NP, overly reliant on NP/PA without physician, retain physicians, difficulty in recruiting (20)
- Attracting and retaining young people and families – willingness to live here, things to do/attractions/activities, jobs/good jobs to support family, opportunities for business (19)
- Aging related issues/services (including assisted living) – ability to keep in their home, lack of assisted living, lack of home care, nursing home not full, keeping up with the needs of elderly, fear losing senior meals and bus service, lack of elder activities. (13)
- Poverty – welfare mentality, attracting poor people, younger people not working (6)

Specific comments from the survey respondents provide some insights into the reasoning behind these issues being identified as community challenges:

- Population:
    - Declining/decreasing population (stated this way 16 times).
    - Aging in place.
    - Retaining populations with lack of good paying jobs.
    - This is an elderly community.
    - It is a small town that is dying. There are no jobs to attract young people.
    - An aging population with limited business and resources to attract and retain young people.
    - Small town that does not want to grow.
    - A declining population with few job opportunities or activities for youth.
    - No acceptance of some of the out-of-towners brought in who are trying to be productive and involved.
    - Declining population, attracting good people to stay, get people to get active because much of the time they could be doing things.
- Economic conditions:
    - Maintaining main street businesses.
    - Finding businesses who can employ and recruit new workers with a living wage.
    - Keeping quality businesses in town to provide jobs.

- o   There are no jobs to attract young people.
- o   Low wages (3 comments).
- o   Lack of jobs (7 comments).
- o   Jobs for young families.
- o   Can't get decent reliable people to work/poor work ethic (3 comments).
- o   No tax base.
- o   Lack of people wanting to be business owners.
- o   Increased cost of services and goods.
- o   Need new/more businesses – meat shop, additional grocery store, car wash, good restaurant.
- • Attracting and retaining physicians:
  - o   Being able to recruit a doctor for the hospital.
  - o   Retaining a doctor to our hospital.
  - o   Inability to get a physician.
  - o   Ability to recruit a doctor.
  - o   Not having a doctor.
  - o   Recruit and retain a good doctor.
  - o   Getting a doctor for our hospital and nursing home.
  - o   A doctor coming to stay in our town.
  - o   It would be nice to have a MD on board instead of 3 NP's.
  - o   No doctor just PA.
  - o   We NEED a doctor we have enough nurse practitioners.
- • Attracting and retaining young people families:
  - o   Bring back younger couples and families and staying here.
  - o   We need to get younger people to stay here.
  - o   Need good jobs to bring young people to town.
  - o   Keeping the younger generation home.
  - o   Hardly any younger people, large number of people over 80.
  - o   Not many young people.
  - o   Too many young people that ae able to work are living off the county.
  - o   Difficulty in recruiting and retaining families.
  - o   Attracting and maintaining younger families.
  - o   An aging population with limited business and resources to attract and retain young people.
  - o   Youth staying in our community.
  - o   Aging community and keeping young families.
  - o   An aging population and inability to attract young families and providing jobs for young families.

- o Keeping our youth and younger couples here in Ashley!
- o Need young people not on welfare.
- o No young people.
- o Not enough young people getting involved.
- Aging related issues/services (including assisted living):
  - o Resources to help elderly stay in their homes.
  - o An aging community. A lack of assisted living and home care for seniors.
  - o Not retaining the elderly for our nursing home.
  - o Elderly care and changes in federal health care regulations; keeping up with the needs of the elderly and healthcare system due to changing dynamics.
  - o Nursing home has open beds and not many patients in the hospital.
  - o This is an elderly community. There needs to be more assisted living options and more help for the older generation.
  - o We have some great services available, like the senior meals and the bus service, the fear is keeping it here because of a declining usage due to the decline in the population.
  - o [Services] for older people, need to try to keep [them] in their home as long as possible. No programs.
  - o Keeping the elderly happy in their homes.
  - o A lack of housing and assisted living.
  - o Caring for our elderly.
  - o An aging population who are unable to qualify for the nursing home care but need help staying in their own homes.
  - o Lack of activities for the elderly.
  - o Assisted living.
- Poverty:
  - o The community has many social services and welfare families.
  - o The increase in transient persons coming to our community in search of [and] taking advantage of low public housing costs, higher welfare payouts, and health care. This stresses community resources for others.
  - o The number of recipients receiving assistance for social services and not working but expecting the town to take care of their needs then spend lots of time in the bars; using public transit to go to larger towns to shoplift.
  - o Too many young people that are able to work are living off the county.

There is a great deal of overlapping themes. The analysis attempts to break comments into identifiable themes; however, when we speak our thoughts follow a natural order with one thought leading to another. In an analysis such as this some of that is lost. With that in mind, there are connections that should be shared with the reader. Under population there was the identification of population decline and an aging population. In the comments these were frequently connected by the respondent. They would identify population erosion along with the issue of a population that was described as elderly. They are connected by many respondents. Sometimes, population decline was also connected with an aging population and the difficulty in recruiting and/or retaining young people and families. In addition, while economic conditions was a stand-alone theme, this too was connected to the population decline. Some respondents expressed a "big picture" and complex way of stating community challenges. For some population decline, loss of young people, an aging in place population, and the lack of jobs (particularly good paying jobs) all coalesced into a larger community dynamic that expressed the issue or challenge. This is all very reasonable for community residents. While most of us would prefer to not have to "deal" with challenges it is best when they exist to be aware of them and some of the thinking or attitudes that surround the issue. This creates the impetus for solutions. It is also important to realize that Ashley community members are concerned about and care deeply for their community. That is a good foundation.

The other identified themes, while they may have been smaller in number are still important. These themes included the following: alcohol and drug use and the ability to address these concerns; the ability of people to work together to address community issues; and the small town culture of resisting change and new people.

Finally, the open ended question allowed for greater clarity and nuance in understanding community conditions. Verbatim responses "flesh-out" some of the more static numbers giving them more meaning. Some of the economic and population findings (e.g., good paying jobs, loss of working age people, services for the elderly) substantiate social determinants of health factors. These issues can and do impact the overall population health.

Community Concerns

A focus of the community health assessment was exploring community and health concerns, which are relevant to a renewed focus on population health. The survey offered seven categories of concerns and asked respondents to pick their top three concerns. The seven categories were as follows:

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

The community and health concerns were assessed by the respondents with each respondent identifying their top three. The concerns with more than 100 votes were as follows:

- Ability to recruit and retain primary care   (119)
- Cancer   (118)
- Attracting and retaining young families   (103)

The issues that had at least 80 votes included these:

- Availability of primary care providers   (86)
- Change in population size   (81)
- Availability of resources to help the elderly   (80)
- Availability of dental care   (80)

The issues that had at least 70 votes are included below:
- Diabetes   (78)
- Jobs with livable wages   (76)
- Assisted living options   (75)

The top three originate from three separate concern categories: delivery of health services to your community (ability to recruit and retain primary care – 119); physical health concerns (cancer – 118); and community health concerns (attracting and retaining young families – 103). The three are good examples of social determinants and population health. To improve the health of the population, a community needs health care providers and professionals. To be a vital community, one that is growing and offering both a sustainable patient base and an employable workforce it needs younger people and families and a dynamic population base. Conditions like cancer and diabetes are amenable to community health efforts such as physical inactivity, obesity, and healthy living.

There were other concerns that while they did not make an arbitrary cut-off of 70 are still important, and need to be considered by the community. This would include the following: cost of health insurance (69), obesity/overweight (68), youth alcohol use and abuse (63), and depression (60) rounded out the top half.
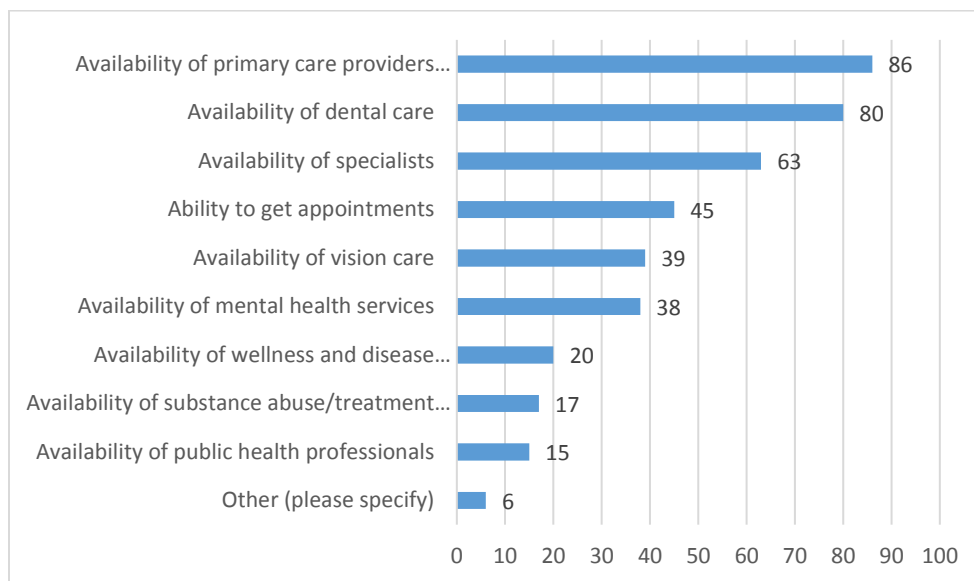
Figures 11 through 17 illustrate these results.

Community health concerns (Figure 11) is the first subject area. Essentially, this looks at overall community related factors or community sectors and/or services. Similar to the open ended question regarding challenges facing the community primary issues found included attracting and retaining young families (103 responses), change in population size (81), and jobs with livable wages (76). While noted in the open ended comments, from a numerical perspective poverty was relatively low (7 responses).

Figure 11: Community Health Concerns
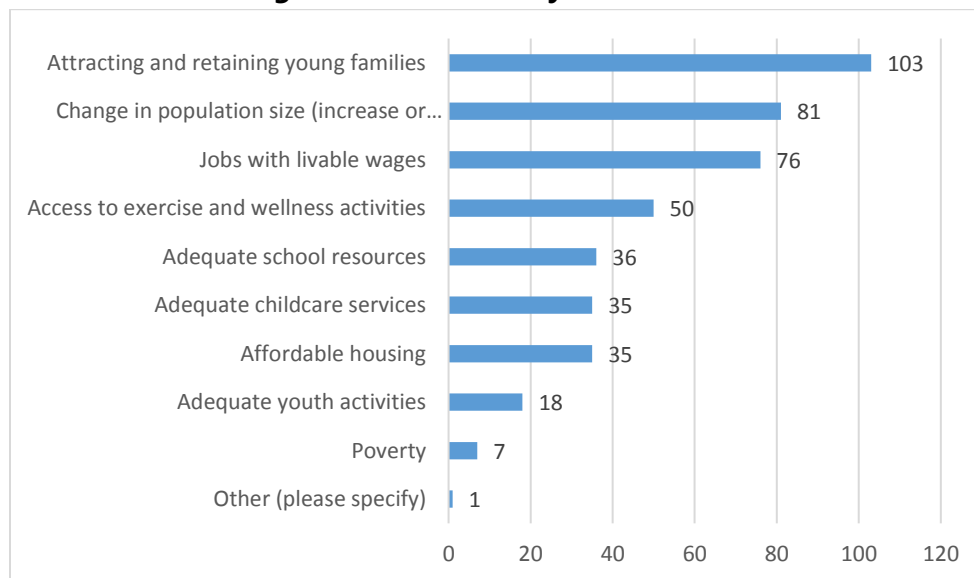
Concerns regarding the availability of health services (Figure 12) found as primary issues the following: availability of primary care providers (86 responses), availability of dental care (80), availability of specialists (63), ability to get appointments (45), availability of vision care (39), and availability of mental health services (38). Each of these is a unique facet of health and the health delivery system. The availability of and access to health professionals is a significant factor in considering overall population health. They also represent implications for a community in terms of the ability to grow and sustain basic community operations.

Figure 12: Availability of Health Services Concerns

Category	Value
Availability of primary care providers…	86
Availability of dental care	80
Availability of specialists	63
Ability to get appointments	45
Availability of vision care	39
Availability of mental health services	38
Availability of wellness and disease…	20
Availability of substance abuse/treatment…	17
Availability of public health professionals	15
Other (please specify)	6

Safety/environmental health concerns (Figure 13) address a comprehensive set of conditions. This covers a gamut ranging from ambulance to discrimination/prejudice to air quality. Nevertheless, they all constitute safety and environmental concerns. The primary concerns were as follows: water quality (well water, lakes, rivers) (47), emergency services (ambulance and 911) (47), traffic safety (speeding, road safety) (46), public transportation (options and cost) (46), crime and safety (27), and prejudice/discrimination (23). At the other end of the continuum, low graduation rates garnered 7 responses.

Figure 13: Safety/Environmental Health Concerns

Category	Value
Water quality (well water, lakes, rivers)	47
Emergency services (ambulance & 911)…	47
Traffic safety (i.e. speeding, road safety,…	46
Public transportation (options and cost)	46
Crime and safety	27
Prejudice, discrimination	23
Air quality	19
Physical violence, domestic violence…	14
Land quality (litter, illegal dumping)	9
Low graduation rates	7
Other (please specify)	3
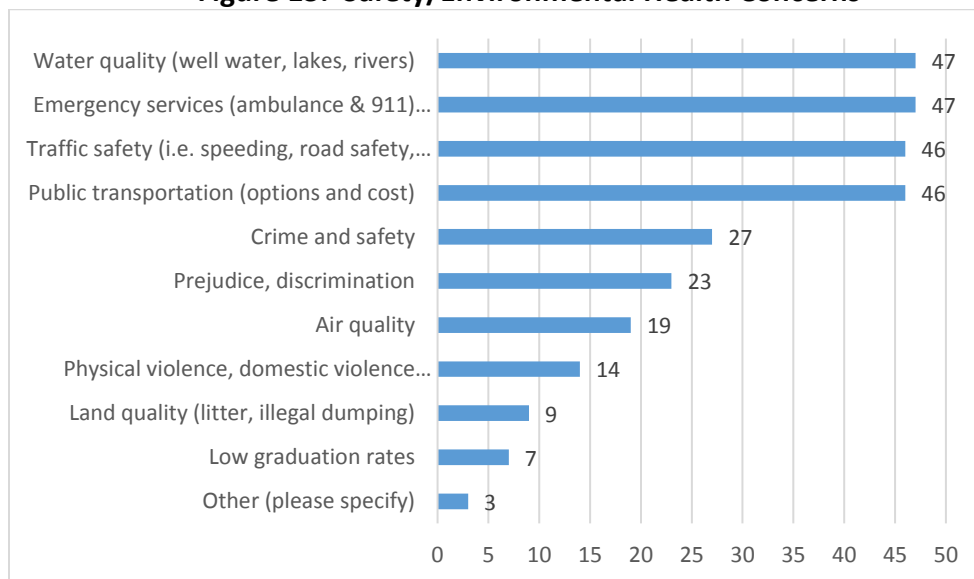
Delivery of health services (Figure 14) addresses a number of access issues. The primary issues were as follows: ability to recruit and retain primary care providers (119), cost of health insurance (69), cost of prescription drugs (59), cost of health care services (37), and patient confidentiality (30). Ability to recruit and retain primary care providers was not only the highest ranked delivery issue, it was also the highest ranked community concern from the seven categories of concerns. There is a precipitous drop-off between the primary care concern (119 responses) and the second highest delivery of health services concern, cost of health insurance (69). This certainly does not mean that insurance costs are not a problem; however, there is a heavy concentration of concern with regard to the issue of having an adequate supply of medical providers. This gives support to the previous finding from the open ended question regarding community concerns that found a number of people voicing concerns regarding the physician supply.

Figure 14: Delivery of Health Services Concerns
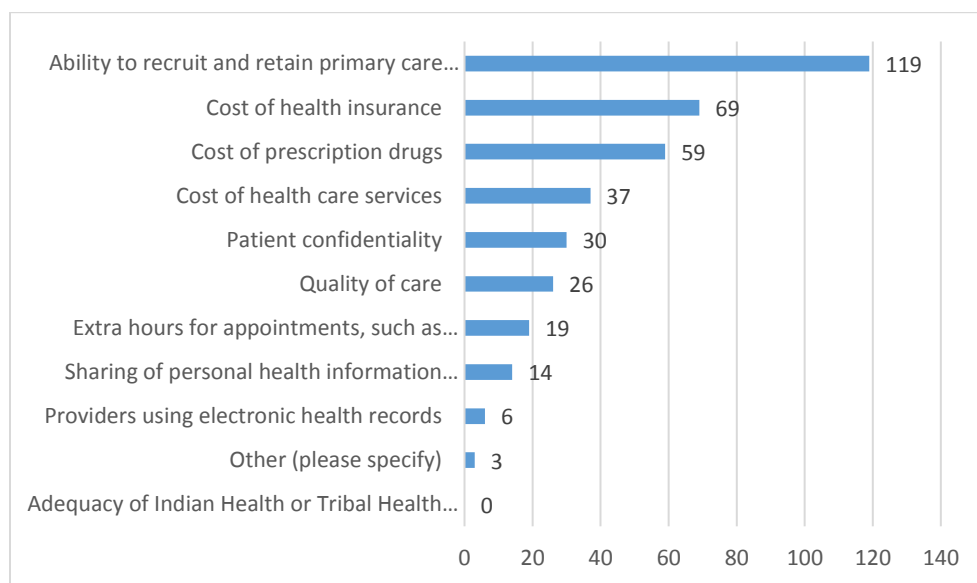
Physical health concerns (Figure 15) are often the most visible of the various dimensions of health. It is what may be the most apparent to us. Physical health has many components including physical activity, nutrition and diet, wellness, and sexual health. The McIntosh County respondents found that cancer was the greatest concern (118 responses) followed by diabetes (78), obesity/overweight (68), and heart disease (62). The lowest rated physical health concern was youth sexual health (9 responses). With 118 responses, cancer was not only the highest rated physical health concern, it was the second highest ranked community concern from the seven categories of concerns.

Figure 15: Physical Health Concerns

Concern	Value
Cancer	118
Diabetes	78
Obesity/overweight	68
Heart disease	62
Poor nutrition, poor eating habits	29
Wellness and disease prevention, including…	17
Youth obesity	11
Teen pregnancy	10
Youth sexual health (including sexually…	9
Lung disease (i.e. Emphysema, COPD,…	5
Other (please specify)	3
Youth hunger and poor nutrition	2
Sexual health (including sexually…	1
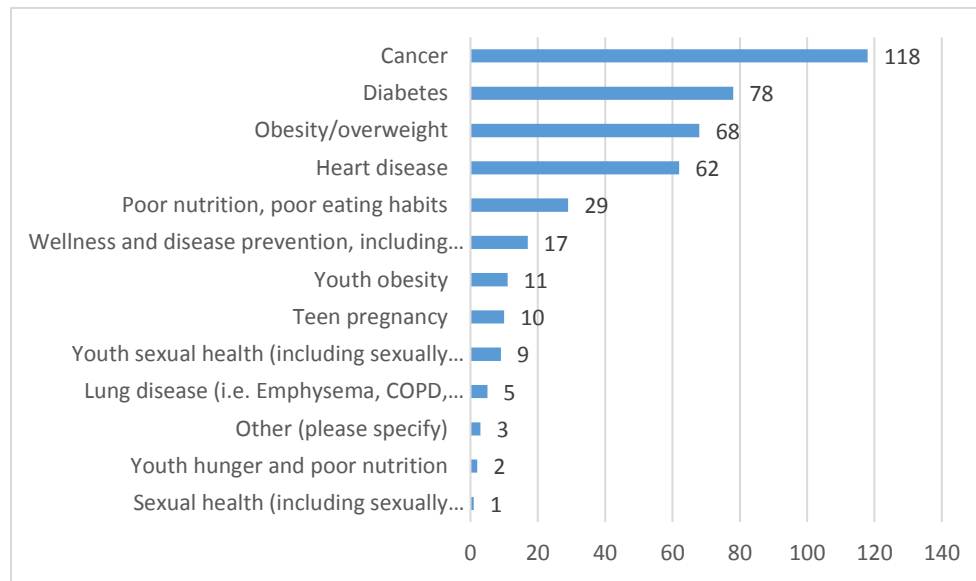
Another dimension of health is mental health and substance abuse (Figure 16). The top concerns are as follows: youth alcohol use and abuse (63 responses), depression (60), adult alcohol use and abuse (54), stress (47) and adult tobacco use (47). The lowest ranked concerns wore adult suicide (11) and youth suicide (6). In North Dakota, behavioral and mental health has received significant attention from citizens, providers, and policy makers. In 2014, there was an independent report commissioned by the legislature that found numerous issues with regard to access to behavioral and mental health services, the delivery system, workforce supply, and payment. The 2015 legislature took up many of these issues but there is an ongoing need for system change and reform.

Figure 16: Mental Health and Substance Abuse Concerns

Concern	Value
Youth alcohol use and abuse (including…	63
	60
Adult alcohol use and abuse (including…	54
	47
Adult tobacco use (exposure to second-…	36
	27
Adult drug use and abuse (including…	27
	25
Youth tobacco use (exposure to second-…	18
	14
Adult suicide	11
	6
Other (please specify)	2
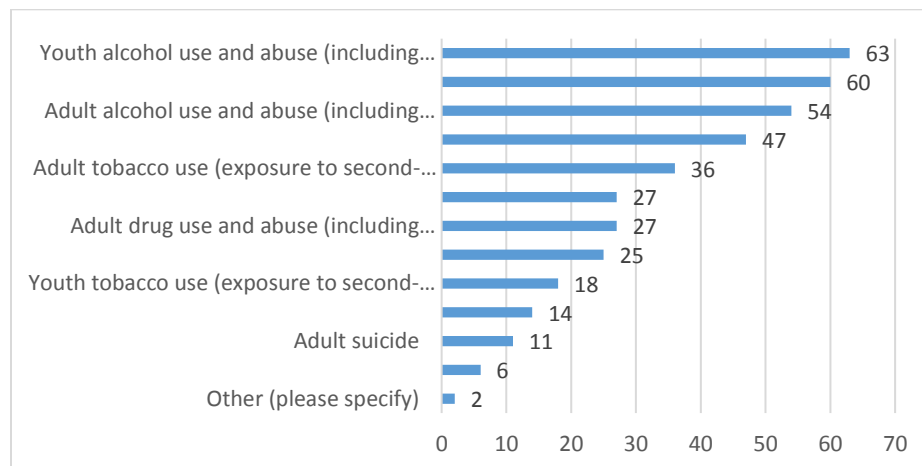
Senior population concerns (Figure 17) represents the final set of overarching community concerns. This section primarily addresses services and resources, but is also inclusive of Alzheimer's and Dementia. The top ranked concern was the availability of resources to help the elderly stay in their homes (80 responses). This was followed by assisted living options (75), Dementia/Alzheimer's disease (62), ability to meet the needs of the older population (54), and availability of resources for family (46). The lowest ranked senior issue was cost of activities for seniors (4).

Figure 17: Senior Population Concerns

Concern	Responses
Availability of resources to help the elderly…	80
Assisted living options	75
Dementia/Alzheimer's disease	62
Ability to meet needs of older population	54
Availability of resources for family and…	46
Long-term/nursing home care options	35
Availability of activities for seniors	29
Cost of activities for seniors	4
Other (please specify)	3
Elder abuse	2
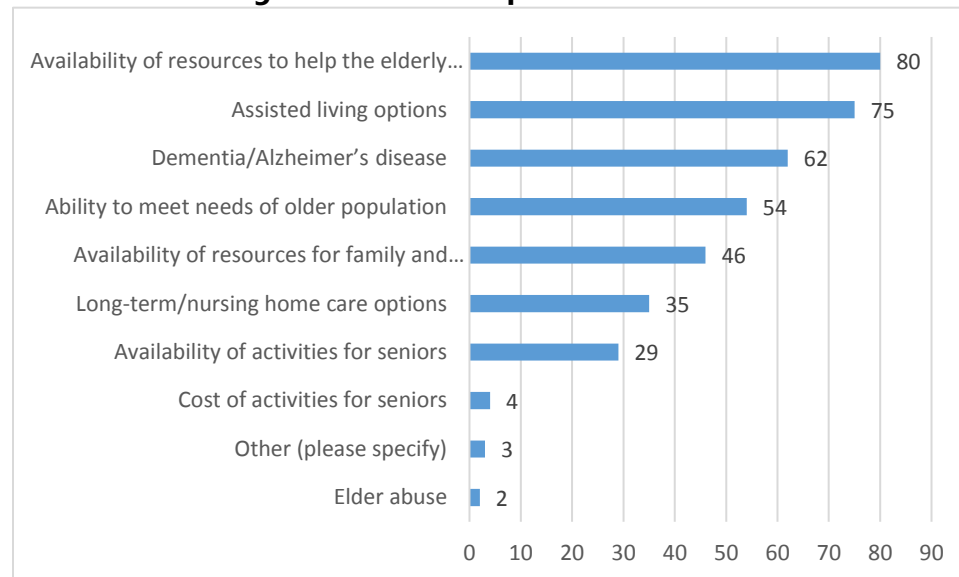
Delivery of Health Care

The final section of the survey addressed the delivery of health care. This looked at perceived barriers to care, and also asked respondents to assess hospital and public health services based on their awareness or use. This latter is particularly useful for the local institutions of health as it provides insight on how the public (clients, patients, customers) view the facility and the services. It presents opportunities for marketing of services that may need greater exposure.

The survey asked residents what they see as barriers that prevent them or others from receiving health care. The results show access to care factors to be predominant. The most prevalent barrier perceived by residents was not enough doctors (64) which has support from the open ended comments that were provided in the survey. The second highest barrier was related, not enough specialists (58). At this point there is a drop off to the third rated barrier, concerns about confidentiality (26). Sometimes access to care concerns present perceptions that the facility leadership may seek to address through

public education. Presenting how the facility is addressing the perceived barrier and/or how it plans to address it. Regardless, one of the benefits of the community health needs assessment is it provides the decision makers with evidence of perceptions that can be addressed.

Figure 18: Perceptions about Barriers to Care
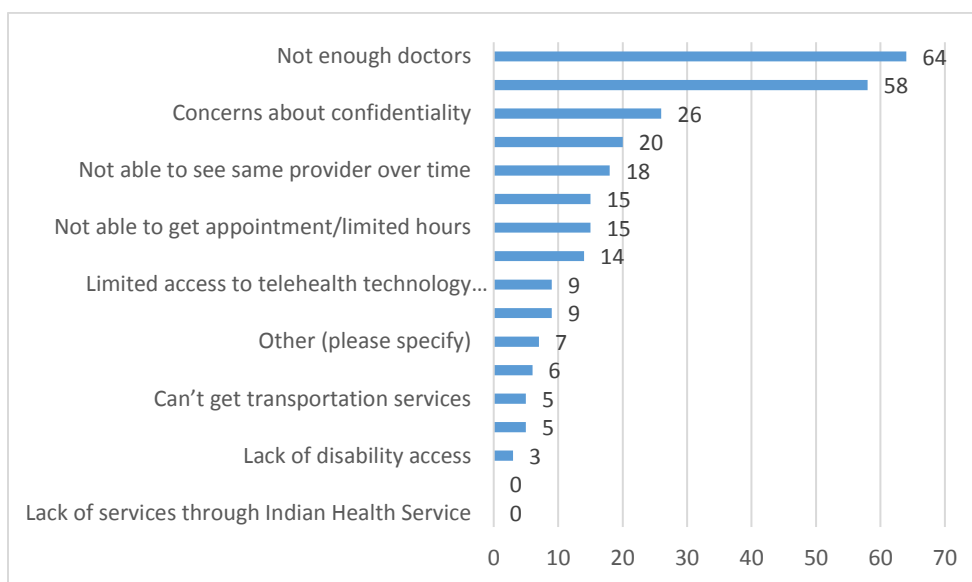
Measuring the public's awareness of Ashley health services was also important. As was previously stated, such information assist the health facility in determining advertising and marketing. For this section we only focus on those services or resources that were most problematic for the respondents. In other words, the services that they were least aware of or use the least. For the hospital, three questions were asked. One question addressed general and acute care services; another question dealt with screening therapy services; the third question focused on radiology. The services with the lowest level of recognition/use are listed below for the three categories:

Acute and general services:

- Mental health services   10
  responses
- Laparoscopic surgery   17
- Telemedicine for mental health   28
- Podiatry (foot/ankle) visiting specialist   33
- Home health care   33
- Telemedicine via eEmergency   40
- Surgery   42

- *(As a point of comparison the most recognized or used services were the clinic (150), emergency room (108), and hospital (80).*

Screening/therapy services:

- Speech therapy   8 responses
- Telemedicine   28
- Diet instruction   59
- *(As a point of comparison the most recognized or used screening/therapy services were laboratory services (134), physical therapy (112), and health screenings (93).*

Radiology services:

- Telemedicine   21 responses
- Echocardiogram   51
- Ultrasound mobile unit   61
- MRI mobile unit   83
- CT scan   87
- *(As a point of comparison the most recognized or used radiology services were general x-ray (123), mammography (107), and EKG-Electrocardiography (90).*

Respondents were also asked about *other area/local health providers.* Chiropractic services led the field being either recognized or used by respondents with 115 responses. This was followed by the ambulance (112), optometric/vision services (82), fitness/wellness program (81), massage therapy (75), and telemedicine (17).

Finally, respondents were asked which services and facility improvements would they *financially support through donations or fundraisers*. The answers are as follows:

- Assisted living   68
- Install an elevator near apartments for nursing home access
  to second floor dining/activity area   60
- Breezeway between clinic and hospital   53
- Emergency room renovations   46
- Energy efficient improvements (i.e., new windows)   39
- Hospice   39
- Update floor plan at Ashley Medical Center   38
- Updates/improvements to Ashley Medical Center   22
- House calls   18
- Visiting specialist   11

A final area of inquiry for the delivery of health care assessed *sources of health information.* Again, this section is particularly interested in barriers found in accessing care and services and also the public's awareness of services. Thus, how do people learn about health and health care services is instructive. In terms of where do people turn to for trusted health information, the survey revealed that, by a large margin, for trusted health information residents turned to a primary care provider (doctor, nurse practitioner, physician assistant) with about 130 responses. Other common sources of trusted health information are other health care professionals (nurses, chiropractors, dentists, etc.) 78 responses, web searches (50), word of mouth (49), and public health professional (22).

Figure 19: Sources of Trusted Health Information
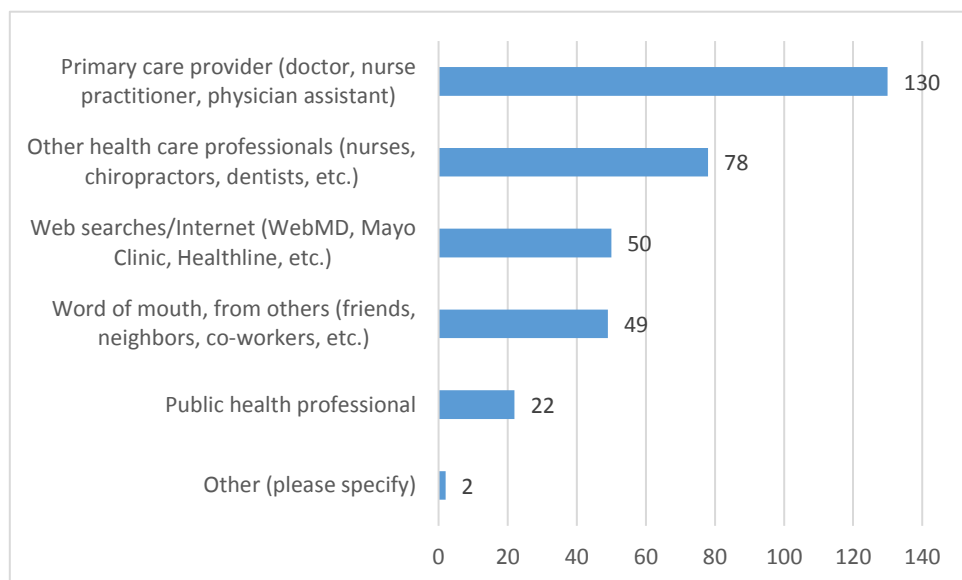
A slightly different question asked respondents to identify how they find out about local health services. The number one source was word of mouth from others (113 responses), followed by the newspaper (67), health care professionals (66), and advertising (42). While social media had only 17 responses it is still a practical idea to find more ways to use it. Many people under 35 do not rely on traditional sources such as the newspaper and favor social media. For today's marketing it is best to employ a multi-source strategy that mixes traditional communication with emergent communication.

Findings from Key Informant Interviews and Focus Group

In addition to the community survey, which has been the source of primary data to this point (along with the secondary data from the County Health Rankings report), the

community health needs assessment process employed two additional primary research methodologies. 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 an on-site focus group with over one dozen community members.

First, the key informant interview respondents were asked to comment on 1) the best things about Ashley and 2) the major challenges facing Ashley. Below are the themes that emerged from the content analysis, with some corroborating verbatim statements from key informants.

Best things about Ashley:
- Caring
    - Everyone cares about one another.
    - If you are sick someone is going to bring you soup.
- Familiarity
    - People know each other, what to expect, who needs help.
    - We watch out for each other.
    - Negative is we know too much.
    - Who do you belong too (reference to what family line does the person come from).
- Small town
    - All the good things of a small town.
    - People want to meet you.
    - Easy to get to know people.
    - People can trust and rely on each other.
- Family
    - Good place to raise kids.
    - Safe.
    - Good place to go to school.
- Pride
    - Pride in the community.
    - Who we are.
    - What this town means.
    - Lot of community spirit.
    - Strive to be progressive.
- Institutions

- o Good hospital people are proud of it
- o Hospital is a major thing.
- o Strong school.
- o Businesses are good.
- o EMS takes care of us.
- o Lots of churches.
- o City council is good.
- o Good leadership.
- In it together
  - o People pull together.
  - o Think of the town not just yourself.
  - o Some have come back to live.
  - o Old and young get along side by side.

Major challenges facing Ashley:

- Retention of youth
  - o Try to keep the community viable.
  - o Need to keep school or the town dies.
  - o Nervous that the younger people are not going to come back.
  - o Bringing youth back to the community.
- Jobs/employment
  - o Not enough good paying jobs.
  - o Can't attract younger people without the jobs that support a family.
  - o Being competitive but some don't want competition.
  - o Jobs, this is always a concern.
  - o If you're not in farming or the medical field, not a lot of opportunity.
  - o Families experiencing financial pressures.
  - o No options for a second income.
- Aging community and county
  - o Not enough younger to care for the older ones.
  - o Get older all the time.
  - o Age of the population is huge.
- Declining population
  - o Hard on school, hospital, churches, and business.
  - o Increase in number of funerals over the last few years.
  - o Population count is our biggest barrier.
  - o Community will continue to shrink.

- o Attracting new people.
- o Don't have enough younger women to make families.
- Transportation and distance
  - o Have bus but long trips for the elderly (all day).
  - o Elders out in the country hard for them.
- Retention of primary care
  - o Have to keep the docs or hospital will close.
  - o Growing number of elderly contributes to services needed at the hospital.
- Health of the community
  - o Growing problems with mental health, cancer, and depression.

Both key informants and the focus group participants were provided with a list of community and health concerns that were categorized as five themes. Each theme had 6-24 separate issues/concerns. The respondents were asked to select up to three *significant concerns* per thematic category. The findings are presented below:

- Community and environmental concerns
  - o 20 respondents -- Not enough jobs with livable wages, not enough to live
  - o 19 Attracting and retaining young families
  - o 19 Change in population size
- Health services concerns
  - o 16 respondents -- Ability to retain doctors and nurses in the community
  - o 10 Availability of mental health
  - o 10 Availability of dental care
  - o 10 Cost of health insurance
- Physical, mental health, and substance abuse concerns
  - o 17 Dementia/Alzheimer's disease
  - o 10 Cancer
  - o 10 Depression
  - o 10 Stress
- Youth and children concerns
  - o 16 Youth mental health
  - o 15 Not enough activities for children and youth
  - o 15 Youth alcohol use and abuse

- Aging population concerns
  - o 20 Availability of resources to help the elderly live in their homes

- o 18   Availability of resource for family and friends caring for elders
- o 17   Being able to meet needs of older population
- o 17   Assisted living options

Many of the issues raised through the interview process be it in one-on-one interviews or the group focus group support what was identified through the survey. Specifically, issues related to the need to attract and retain younger people and families, providing good paying jobs, an aging population, and the need to attract and maintain the local health system particularly through an adequate provider base found support in the survey and in the interviews. These are strong community issues.

Community Engagement and Collaboration

Key informants also were asked to weigh in on community engagement and collaboration of various organizations and stakeholders in the community. Specifically, participants were asked, "On a scale of 1 to 5, with 1 being no collaboration/community engagement and 5 being excellent collaboration/community engagement, how would you rate the collaboration/engagement in the community among these various organizations?" They were then presented with a list of 13 organizations or community segments to rank. According to these participants, the hospital, pharmacies, public health, and other local health providers are the most engaged in the community. The averages of these rankings (with 5 being "excellent" engagement or collaboration) were:

Community Engagement/Collaboration
Scale of 1-5 (5 excellent)

Ashley Medical Center (4.46)

Schools (4.40)

Business and industry (4.38)

Emergency services, including ambulance and fire (4.35)

Faith Based Organizations (4.31)

Long term care, including nursing homes and assisted living (4.17)

Economic development organizations (4.13)

Public Health (4.07)

Law enforcement (4.00)

Other local health providers, (i.e. dentists and chiropractors) (3.93)

Pharmacies (3.90)

Human services agencies (3.00)

Social Services (2.56)

Priority of Health Needs

A community roup met on April 26, 2016. A representative 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 and focus group.

Following the presentation of the assessment findings, and after consideration of and discussion about the findings, all members of the group were asked to identify what they perceived as the top four community health needs. All of the potential needs were listed on large poster boards, and each member was given four stickers so they could place a sticker next to each of the four needs they considered the most significant. For the final stage, meeting participants were provided with a single sticker which they could apply to what they perceived to be the most significant issue facing the community.

The community group members determined the significant health needs for Ashley and McIntosh County to be as follows:

- Attracting and retaining young families   (9 votes)
- Assisted living options   (5)
- Jobs with livable wages   (2)
- Availability of resources to help the elderly stay in their home   (1)

A summary of this prioritization may be found in Appendix C.

The community group then began the second portion of the meeting: strategic planning to identify ways to address the prioritized significant needs. Because of time constraints, the group did not cover all of the planning necessary to create a comprehensive improvement plan. There was some preliminary discussions surrounding the community health issues of attracting and retaining young families and support for assisted living. The local economic development commission has plans to work with community development experts from North Dakota State University on attracting and retaining young families. The hospital will likely be part of that process. At the April meeting hospital representatives focused on the assisted living issue. The group will reconvene, review their work, make the determination for their focus, and develop goals and action items then. The CRH could be available to assist them at a later date.

A steering committee or other group will meet to continue the work that was started by the community group and culminate with a community health improvement plan that can be executed.

Comparison of Needs Identified Previously

Top Needs Identified 2013 CHNA Process	Top Needs Identified 2016 CHNA Process
Access to needed equipment/facility update	Attracting and retaining young families
Aging population services	Assisted living options
Financial viability of the hospital	Jobs with livable wages
Health care workforce shortage	Availability of resources to help the elderly stay in their homes

Next Steps – Strategic Implementation Plan

Although a community health needs assessment and strategic implementation plan are required by hospitals and local public health units considering accreditation, it is important to keep in mind the needs identified, at this point, will be broad community-wide needs along with health care system specific. This process is simply a first step to identify needs 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 to begin working on. The strategic planning process will begin with identifying current initiatives/programs and resources in place, to address the need(s), what is needed and feasible; and what role and responsibility will the hospital, clinic, and various community organizations play in developing strategies and implementing specific activities to address the community health need selected. Community engagement is essential for successfully developing a plan and executing the action steps for addressing one or more of the needs identified.

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

Community Benefit Report

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

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

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

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

What Are Community Benefits?

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

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

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

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

- Provided for marketing purposes.
- Restricted to hospital employees and physicians.

- Required for all health care providers by rules or standards.
- Questionable as to whether it should be reported.
- Unrelated to health or the mission of the organization.

Appendix A – Paper Survey Instrument

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

ASHLEY MEDICAL CENTER
Working for a Healthier You

Ashley Area Health Survey

Ashley Medical Center is interested in hearing from you about community health concerns. The focus of this effort is to:

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

Scan to take the survey online!

If you prefer, you may take the survey online at http://tinyurl.com/AshleyMedCenter.

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 Brad Gibbens at 701.777.2569.

Surveys will be accepted through March 25, 2016. Your opinion matters – thank you in advance!

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

Q1. Considering the **PEOPLE** in your community, the best things are (choose up to <u>THREE</u>):

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

Q2. Considering the **SERVICES AND RESOURCES** in your community, the best things are (choose up to <u>THREE</u>):

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

Q3. Considering the **QUALITY OF LIFE** in your community, the best things are (choose up to <u>THREE</u>):

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

Q4. Considering the **ACTIVITIES** in your community, the best things are (choose up to <u>THREE</u>):

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

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

Q5. Considering the **COMMUNITY HEALTH** in your community, concerns are (choose up to THREE):

- ☐ Access to exercise and wellness activities
- ☐ Adequate childcare services
- ☐ Adequate school resources
- ☐ Adequate youth activities
- ☐ Affordable housing

- ☐ Attracting and retaining young families
- ☐ Change in population size (increase or decrease)
- ☐ Jobs with livable wages
- ☐ Poverty
- ☐ Other (please specify) _____

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

- ☐ Ability to get appointments
- ☐ Availability of primary care providers (doctor, nurse practitioner, physician assistant)
- ☐ Availability of dental care
- ☐ Availability of mental health services
- ☐ Availability of public health professionals

- ☐ Availability of specialists
- ☐ Availability of substance abuse/treatment services
- ☐ Availability of vision care
- ☐ Availability of wellness/disease prevention services
- ☐ Other (please specify) _____

Q7. Considering the **SAFETY/ENVIRONMENTAL HEALTH** in your community, concerns are (choose up to THREE):

- ☐ Air quality
- ☐ Crime and safety
- ☐ Emergency services (ambulance & 911) available 24/7
- ☐ Land quality (litter, illegal dumping)
- ☐ Low graduation rates
- ☐ Physical violence, domestic violence (spouse/partner/family)

- ☐ Prejudice, discrimination
- ☐ Public transportation (options and cost)
- ☐ Traffic safety (i.e. speeding, road safety, drunk/distracted driving, and seatbelt use)
- ☐ Water quality (well water, lakes, rivers)
- ☐ Other (please specify) _____

Q8. Considering the **DELIVERY OF HEALTH SERVICES** in your community, concerns are (choose up to THREE):

- ☐ Ability to recruit and retain primary care providers (doctor, nurse practitioner, physician assistant)
- ☐ Adequacy of Indian Health or Tribal Health services
- ☐ Cost of health care services
- ☐ Cost of health insurance
- ☐ Cost of prescription drugs
- ☐ Extra hours for appointments, such as evenings and weekends

- ☐ Patient confidentiality
- ☐ Providers using electronic health records
- ☐ Quality of care
- ☐ Sharing of personal health information between healthcare providers
- ☐ Other (please specify) _____

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

- ☐ Cancer
- ☐ Diabetes
- ☐ Lung disease (i.e. Emphysema, COPD, Asthma)
- ☐ Heart disease
- ☐ Obesity/overweight
- ☐ Poor nutrition, poor eating habits
- ☐ Sexual health (including sexually transmitted diseases/AIDS)

- ☐ Teen pregnancy
- ☐ Youth hunger and poor nutrition
- ☐ Youth obesity
- ☐ Youth sexual health (including sexually transmitted infections)
- ☐ Wellness and disease prevention, including vaccine-preventable diseases
- ☐ Other (please specify) _____

Q10. Considering the **MENTAL HEALTH AND SUBSTANCE ABUSE** in your community, concerns are (choose up to THREE):

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

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

Q11. Considering the **SENIOR POPULATION** in your community, concerns are (choose up to THREE):

- ☐ Ability to meet needs of older population
- ☐ Assisted living options
- ☐ Availability of activities for seniors
- ☐ Availability of resources for family and friends caring for elders
- ☐ Availability of resources to help the elderly stay in their homes

- ☐ Cost of activities for seniors
- ☐ Dementia/Alzheimer's disease
- ☐ Elder abuse
- ☐ Long-term/nursing home care options
- ☐ Other (please specify) _____

Q12. What are the major challenges facing your community?

_____

_____

Delivery of Health Care

Q13. What specific health care services, if any, do you think should be added locally?

_____

_____

Q14. What **PREVENTS** you or other community residents from receiving health care locally? (Choose ALL that apply)

- ☐ Can't get transportation services
- ☐ Concerns about confidentiality
- ☐ Distance from health facility
- ☐ Don't know about local services
- ☐ Don't speak language or understand culture
- ☐ Lack of disability access
- ☐ Lack of services through Indian Health Services
- ☐ Limited access to telehealth technology (patients seen by providers at another facility through a monitor/TV screen)

- ☐ No insurance or limited insurance
- ☐ Not able to get appointment/limited hours
- ☐ Not able to see same provider over time
- ☐ Not accepting new patients
- ☐ Not affordable
- ☐ Not enough doctors
- ☐ Not enough evening or weekend hours
- ☐ Not enough specialists
- ☐ Poor quality of care
- ☐ Other (please specify) _____

Q15. Are you aware that you can have laboratory work and general x-rays completed at Ashley Medical Center, even if you're seeing an out-of-town specialist?

☐ Yes   ☐ No

Q16. Primary care services are provided at Ashley Medical Center by Nurse Practitioners. Do you go to another medical facility in order to see a physician for your primary care services?

☐ Yes   ☐ No

Q17. Where do you turn for trusted health information? (Choose ALL that apply)
- ☐ Other health care professionals (nurses, chiropractors, dentists, etc.)
- ☐ Primary care provider (doctor, nurse practitioner, physician assistant)
- ☐ Public health professionals
- ☐ Web searches/Internet (WebMD, Mayo Clinic, Healthline, etc.)
- ☐ Word of mouth, from others (friends, neighbors, co-workers, etc.)
- ☐ Other (please specify) _____

Q18. Where do you find out about **LOCAL HEALTH SERVICES** available in your area? (Choose ALL that apply)
- ☐ Advertising
- ☐ Employer/worksite wellness
- ☐ Health care professionals
- ☐ Newspaper
- ☐ Public health professionals
- ☐ Radio
- ☐ Social media (Facebook, Twitter, etc.)
- ☐ Web searches
- ☐ Word of mouth, from others (friends, neighbors, co-workers, etc.)
- ☐ Other (please specify)_____

Q19. Considering **GENERAL and ACUTE SERVICES** at Ashley Medical Center, which services are you aware of (or have you used in the past year)? (Choose ALL that apply)
- ☐ Anesthesia services
- ☐ Clinic
- ☐ Emergency room
- ☐ Home health care
- ☐ Hospital (acute care)
- ☐ Laparoscopic surgery
- ☐ Mental health services
- ☐ Ophthalmology (eye/vision) (visiting specialist)
- ☐ Podiatry (foot/ankle) (visiting specialist)
- ☐ Surgical services
- ☐ Swing bed and respite care services
- ☐ Telemedicine via eEmergency
- ☐ Telemedicine for mental health

Q20. Considering **SCREENING/THERAPY SERVICES** at Ashley Medical Center, which services are you aware of (or have you used in the past year? (Choose ALL that apply)
- ☐ Diet instruction
- ☐ Health screenings
- ☐ Laboratory services
- ☐ Physical therapy
- ☐ Telemedicine for _____
- ☐ Speech therapy

Q21. Considering **RADIOLOGY SERVICES** at Ashley Medical Center, which services are you aware of (or have you used in the past year)? (Choose ALL that apply)
- ☐ EKG—Electrocardiography
- ☐ CT scan
- ☐ Echocardiogram
- ☐ General x-ray
- ☐ Mammography
- ☐ MRI mobile unit
- ☐ Telemedicine for _____
- ☐ Ultrasound mobile unit

Q22. Considering services offered locally by **OTHER PROVIDERS/ORGANIZATIONS**, which services are you aware of (or have you used in the past year)? (Choose ALL that apply)
- ☐ Ambulance
- ☐ Chiropractic services
- ☐ Massage therapy
- ☐ Optometric/vision services
- ☐ Fitness/wellness programs
- ☐ Telemedicine for _____

Q23. Of the following services and facility improvements, which would you financially support through donations or fundraisers? (Choose ALL that apply)
- ☐ Assisted living
- ☐ Breezeway between clinic and hospital
- ☐ Install an elevator near apartments for nursing home access to second floor dining/activity area
- ☐ Emergency room renovations
- ☐ Energy efficient improvements (i.e. new windows)
- ☐ Update flooring at Ashley Medical Center
- ☐ Hospice
- ☐ House calls
- ☐ Updates/improvements to Ashley Medical Center (please specify) _____
- ☐ Visiting specialist (please specify) _____
- ☐ Other (please specify) _____

Demographic Information: Please tell us about yourself.

Q24. Do you work for the hospital, clinic, or public health unit?
- ☐ Yes
- ☐ No

Q25. Health insurance or health coverage status (choose ALL that apply):
- ☐ Indian Health Service (IHS)
- ☐ Insurance through employer or self-purchased
- ☐ Medicaid
- ☐ Medicare
- ☐ No insurance
- ☐ Not enough insurance
- ☐ Veteran's Health Care Benefits
- ☐ Other (please specify) _____

Q26. Age:
- ☐ Less than 18 years
- ☐ 18 to 24 years
- ☐ 25 to 34 years
- ☐ 35 to 44 years
- ☐ 45 to 54 years
- ☐ 55 to 64 years
- ☐ 65 to 74 years
- ☐ 75 years and older

Q27. Highest level of education:
- ☐ Less than high school
- ☐ High school diploma or GED
- ☐ Some college/technical degree
- ☐ Associate's degree
- ☐ Bachelor's degree
- ☐ Graduate or professional degree

Q28. Gender:
- ☐ Female
- ☐ Male
- ☐ Transgender

Q29. Employment status:
- ☐ Full time
- ☐ Part time
- ☐ Homemaker
- ☐ Multiple job holder
- ☐ Unemployed
- ☐ Retired

Q30. Your zip code: _____

Q31. Race/Ethnicity (choose ALL that apply):
- ☐ American Indian
- ☐ African American
- ☐ Asian
- ☐ Hispanic/Latino
- ☐ Pacific Islander
- ☐ White/Caucasian
- ☐ Other: _____
- ☐ Prefer not to answer

Q32. Annual household income before taxes:
- ☐ Less than $15,000
- ☐ $15,000 to $24,999
- ☐ $25,000 to $49,999
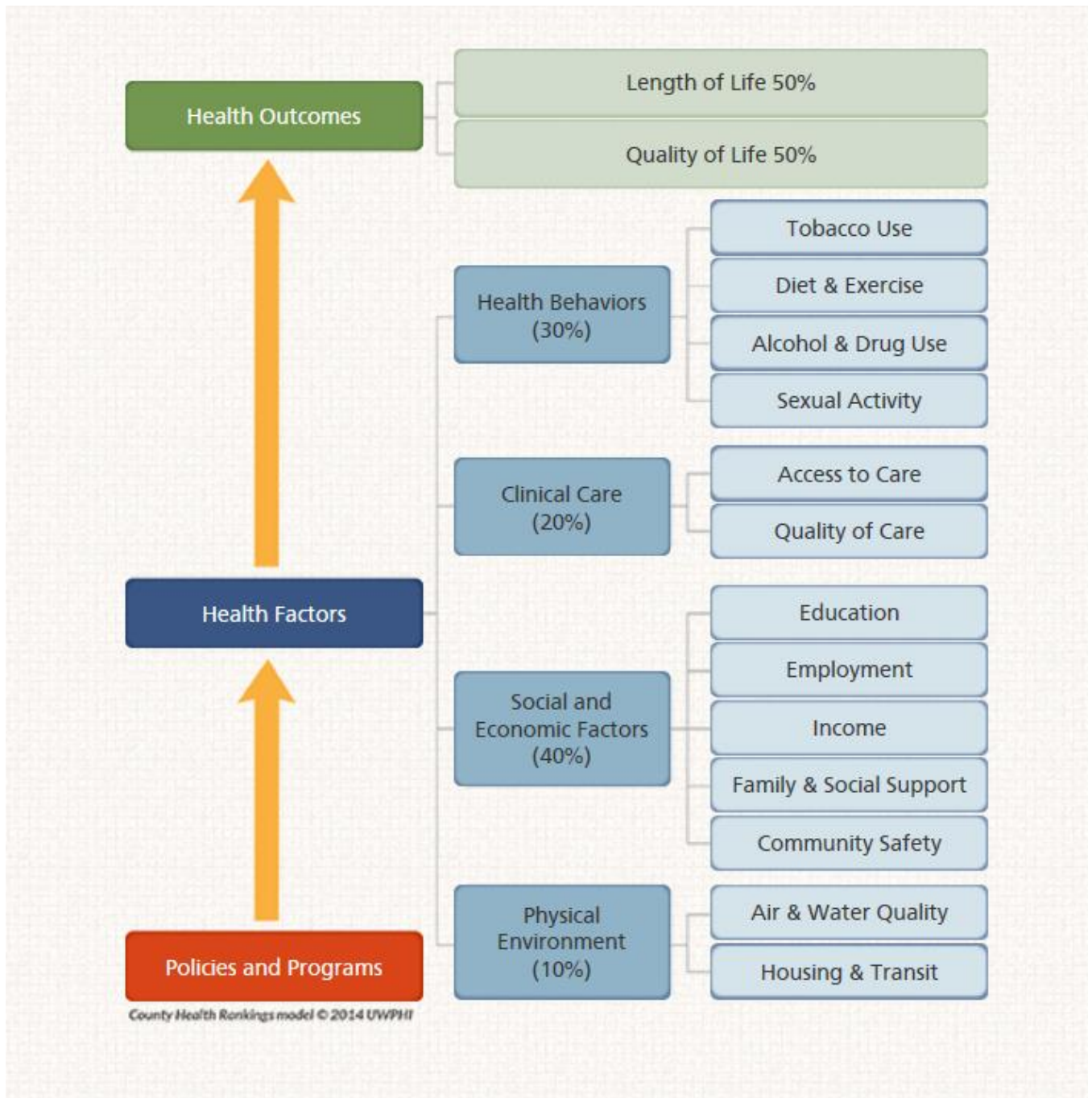- ☐ $50,000 to $74,999
- ☐ $75,000 to $99,999
- ☐ $100,000 to $149,999
- ☐ $150,000 and over
- ☐ Prefer not to answer

Q33. Overall, please share concerns and suggestions to improve the delivery of local health care.

_____

_____

_____

Thank you for assisting us with
this important survey!

Appendix B – County Health Rankings Model

County Health Rankings model © 2014 UWPHI

Appendix C – Prioritization of Community's Health Needs

Community Health Needs Assessment
Ashley, North Dakota

Ranking of Concerns

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

	Priorities	Most Important
DELIVERY OF HEALTH SERVICES		
Ability to recruit and retain primary care providers (MD's, NP's, and PA's)	5	
Cost of health insurance	1	
Cost of prescription drugs	0	
Cost of health care services	0	
AVAILABILITY OF HEALTH SERVICES		
Availability of primary care providers	0	
Availability of dental care	4	
Availability of specialists	0	
Ability to get appointments	0	
MENTAL HEALTH AND SUBSTANCES ABUSE		
Youth alcohol use and abuse	0	
Depression	4	
Adult alcohol use and abuse	0	
Stress	0	
SAFETY/ENVIRONMENTAL HEALTH		
Water quality (well water, rivers)	0	
Emergency services (ambulance and 911)	0	
Traffic safety (speeding, road safety)	0	
Public transportation (options and cost)	1	
AGING POPULATION		
Availability of resources to help the elderly stay in their homes	6	1
Assisted living options	6	5
Dementia/Alzheimer's Disease	1	
Ability to meet the needs of the older population	3	
COMMUNITY HEALTH		
Attracting and retaining young families	15	9
Change in population size	6	
Jobs with livable wages	10	2
Access to exercise and wellness activities	0	
PHYSICAL HEALTH		
Cancer	3	
Diabetes	0	
Obesity/overweight	3	
Heart disease	0	