McKenzie Health

2025 Community Health Needs Assessment

Watford City, North Dakota

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McKenzie Health Community Health Needs Assessment

Executive Summary

A community health needs assessment (CHNA) is a crucial tool for understanding and improving the health and well-being of a community by identifying key health issues, informing strategic planning, and fostering collaborative efforts among various stakeholders. The McKenzie Health CHNA focused on identifying and addressing the health needs of McKenzie County by gathering data and input from the community to identify the most pressing health issues, including chronic diseases, mental health, access to healthcare services, and social determinants of health.

McKenzie Health executed a CHNA process that included collecting primary and secondary data. The CHNA steering committee composed of the chief executive officer (CEO), chief medical officer (CMO), and Chief of Strategy, Communications, and Innovation at McKenzie Health as well as the CEO and a registered nurse (RN) from Upper Missouri District Health Unit oversaw the CHNA along with the project consultant, Cibolo Health. Organizations and community stakeholders within the primary service area were engaged in identifying the needs of the community. Community organizations, government agencies, educational systems, health and human services entities, as well as others, were engaged throughout the CHNA. The comprehensive primary data collection phase resulted in contributions from a multitude of regional community stakeholders and representatives from organizations.

Input from the community was sought through a community survey, key informant interviews, and focus groups (community meetings). Community input was aligned with secondary data collections and presented to the CHNA Steering Committee, focus group participants, and key informant interviewees as a framework for assessing current community needs, identifying new/emerging health issues, and advancing health improvement efforts to address identified needs.

Specifically, the primary data collection consisted of several project components. In total, 123 surveys were collected, 6 key informant interviews were conducted, and 9 community members participated in the data collection focus group. All collection modes involved individuals who represented a) broad interests of the community, b) populations of need, or c) persons with specialized knowledge in public health.

A second community meeting composed of the key informant interviewees and those that were invited to the first focus group/community meeting met on March 11, 2025 where the data analysis was presented and attendees voted on the top priorities for 2025 based on primary and secondary data results. There were 12 people in attendance. McKenzie Health recognized its needs from the previous assessment and will build upon those issues, but most importantly, McKenzie Health identified additional areas of concern that require attention. Based on collective information from the previous implementation strategy plan along with the needs identified in the current cycle McKenzie Health will reinforce and create new strategies to bridge the gap and address the needs of those in their service area.

With regard to demographics, McKenzie County's population in 2022 grew 116.9% from the 6,412 people who lived there in 2010. For comparison, the population in the US grew 7.7% and the population in North Dakota grew 15.5% during that period (https://usafacts.org/). McKenzie County’s population from 2010 to 2020 increased by 116.9%. The average number of residents under age 18 (32.3%) for McKenzie County comes in 8.8 percentage points higher than the North Dakota average (23.5%). The percentage of residents ages 65 and older, is 6.5% lower for McKenzie County (10.2%) than the North Dakota average (16.7%). The median household income in McKenzie County ($33,813) is much higher than the state average for North Dakota ($71,970).

Data compiled by County Health Rankings show McKenzie County is doing better than the North Dakota average in health outcomes/factors for 13 categories. It is scoring poorer than the North Dakota average in health outcomes/factors for 25 categories.

Of 106 potential community and health needs set forth in the survey, the 123 McKenzie Health service area residents who completed the survey indicated the following ten needs as the most important:

Not enough affordable housing
Depression/anxiety - youth
Alcohol use and abuse – all ages
Smoking and tobacco use, exposure to second hand smoke, vaping
Stress
Drug use and abuse (including prescription drugs) – all ages
Availability of resources to help the elderly stay in their homes
Cost of long-term/nursing home care
Long-term/nursing home care options
Suicide

The survey also revealed the biggest barriers to receiving healthcare (as perceived by community members). They included no insurance or limited insurance (N=52, not affordable (N=47), and not able to get appointment/limited hours (N=47).

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

People are friendly, helpful, supportive
Family-friendly; good place to raise kids
People who live here are involved in their community
Job or economic opportunities
Recreational and sports activities
Local events and festivals
Safe place to live, little/no crime
Feeling connected to people here

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

Depression/anxiety – All ages
Not enough affordable housing
Alcohol use and abuse – all ages
Availability of mental health services
Drug use and abuse – all ages
Cost of long term/nursing home care

Through community input, the top identified community concerns were:
1. Availability of mental health services
2. Not enough affordable housing
3. Drug use and abuse (including prescription drug abuse)

At McKenzie Health, the commitment is to the patients and their families, whatever their needs might be. The goal is to achieve the highest degree of healthcare for these patients and their families. They are rural America where they provide hometown values committed to quality services, continuity of care, assurance of qualified staff and family involvement for individual patients and clients. McKenzie Health has 12 locations, 54 departments, and over 320 health experts to achieve this goal.

McKenzie Health, along with Upper Missouri District Health Unit, and community partners, will work to put together an Implementation Plan. The Implementation Plan will layout how the community plans to address the concerns brought forward through the CHNA process.

Introduction

A community health needs assessment (CHNA) is a crucial tool for understanding and improving the health and well-being of a community by identifying key health issues, informing strategic planning, and fostering collaborative efforts among various stakeholders. The McKenzie Health CHNA focused on identifying and addressing the health needs of McKenzie County by gathering data and input from the community to identify the most pressing health issues, including chronic diseases, mental health, access to healthcare services, and social determinants of health.

A CHNA involves community members, healthcare providers, and other stakeholders in the assessment process, fostering collaboration and ensuring that the community's voice is heard in identifying health priorities.

The legal and regulatory context of a Community Health Needs Assessment (CHNA) is primarily shaped by the requirements established under the Affordable Care Act (ACA) in the United States. The ACA requires all non-profit hospitals to conduct a CHNA every three years, and all accredited public health units to conduct a CHNA every five years. This provision is aimed at ensuring that hospitals remain accountable to the communities they serve by addressing local health needs that are systematically identified.

The hospitals must produce a written report documenting the CHNA. This report should include a description of the community served, the process and methods used to conduct the assessment, and a prioritized list of identified health needs. Alongside the CHNA, hospitals must develop an implementation strategy that outlines how they plan to address the identified health needs. This strategy must be approved by the hospital's governing body and included in the hospital's annual IRS Form 990 Schedule H submission. The CHNA report and implementation strategy must be made widely available to the public.

The CHNA encompasses a range of benefits aimed at improving public health and fostering a more informed, engaged, and healthier community. A comprehensive profile of the health of the community as well as an identification of the most pressing health issues and priorities from the community member's perspective will result from the CHNA. By including community involvement in the assessment, residents/stakeholders will have a greater awareness of the health issues and challenges facing the community. Engagement by this population during the assessment will also increase the likelihood that they will be willing to assist in the implementation of interventions designed to improve the findings that were a top concern. The implementation plan will layout the roadmap to addressing the top concerns found in the CHNA.

Ultimately, the outcome most anticipated is that implementation of targeted health interventions and programs designed to address specific health concerns will improve overall community health. The plan should also lead to decreased health disparities among different population groups, leading to more equitable health outcomes.

Another outcome of a CHNA is strengthened partnerships and collaborations among healthcare providers, public health agencies, community organizations, and other stakeholders. The result is an enhanced collective impact through coordinated efforts to address community health issues.

Methodology

To ensure community engagement in the data collection, information was collected in a variety of ways:

- A survey solicited feedback from residents within the hospital's service area;
- Key informant interviews of community leaders representing the broad interests of the community;
- Focus groups, comprised of community leaders and area residents, convened to discuss area health needs and inform the assessment process in a community meeting.

Community engagement is essential to a successful CHNA. Community involvement ensures that the assessment accurately reflects the health needs and priorities of the population it serves. The hospital, along with the local public health unit, works to identify and involve a diverse group of stakeholders, including healthcare providers, public health officials, community organizations, educators, business leaders, and residents to participate in the key informant interviews and the focus groups/community meetings. These participants provided in-depth information and informed the assessment process in terms of community perceptions, community resources, community needs, and ideas for improving the health of the population and healthcare services.

As previously described, a wide range of secondary sources of data were examined, providing information on a multitude of measures, including demographics; health conditions, indicators, outcomes; rates of preventive measures; rates of disease; and at-risk behaviors.

A common approach to survey research is online survey. However, this approach is not without limitations. There is always the concern of non-response as it may affect the representativeness of the sample as well as having to eliminate any surveys completed by those outside of the service area being assessed. Thus, a mixture of different data collection methodologies is recommended.

Conducting key informant interviews in addition to the random sample survey allows for a more robust sample, and ultimately, these efforts help to increase the community response rate. Partnering with local community organizations such as public health, schools, churches, and senior centers, just to name a few, assists in reaching segments of the population that might not otherwise respond to a survey.

While key informant data can offer invaluable insight into the perception of a community or group of individuals, qualitative data can be difficult to analyze. For this reason, key informant data are grouped into common themes.

Given the low population in the service area, key informant interview participants may still be hesitant to express their opinions freely even though the reporting of any comments is de-identified.

Another barrier in relation to the low population density of rural communities often requires regional reporting of many major health indices, including chronic disease burden and behavior health indices. The North Dakota BRFSS, through a cooperative agreement with the CDC, is used to identify regional trends in health-related behaviors. The fact that many health indices for rural and frontier counties are reported regionally makes it impossible to set the target population aside from the most developed North Dakota counties.

Process

A CHNA characteristically involves four key steps to ensure a comprehensive understanding of the community's health needs and priorities: 1) planning and preparation, 2) data collection, 3) data analysis, and 4) identify and prioritize health needs.

Planning and Preparation

In March 2024, McKenzie Health selected Cibolo Health to facilitate the 2025 CHNA process. Cibolo Health helps independent rural hospitals create networks with their peers to overcome the obstacles rural healthcare providers face. At that time, a CHNA liaison was selected locally, who served as the main point of contact with Cibolo Health for the CHNA process. A steering committee composed of a diverse group of stakeholders, including representatives from healthcare and public health (see Figure 1), was formed that was responsible for planning and implementing the process locally.

Figure 1: Steering Committee

Name	Title	Organization
Lynn Welker	Chief of Strategy, Communications and Innovation	McKenzie Health
Pete Edis	CEO	McKenzie Health
Dr. Gary Ramage	CMO	McKenzie Health
Javayne Oyloe	CEO	Upper Missouri District Health Unit
Ashley Saylor	RN	Upper Missouri District Health Unit

Data Collection

Once the framework for the process was in place, data collection began. There are two types of data that were collected, primary data that is gathered first-hand, and secondary data that is collected from existing data sources such as County Health Rankings and the US Census. This can include data on demographics, health status, healthcare access, and social determinants of health.

Primary Data Collection

Primary data was collected directly from the community through surveys, key informant interviews, and focus groups/community meetings. This helps to gather first-hand information on community perceptions and experiences. This was done in three ways: key informant interviews, community meetings/focus groups, and a survey.

Key Informant Interviews

On December 11, 2024, a representative from Cibolo Health conducted three key informant interviews via Zoom. Two additional key informant interviews were conducted via Zoom the following week. Interviews were held with invited members of the community who could provide insights into the community's health needs. Included among the informants were public health professionals with special knowledge in public health acquired through several years of direct experience in the community, including working with medically underserved, low income, and minority populations, as well as with populations with chronic diseases.

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

Focus Groups/Community Meetings

A community group consisting of nine community members convened and first met on December 11, 2024. During this first focus group/community meeting, attendees were introduced to the needs assessment process, reviewed basic demographic information about the community, and served as a focus group. Focus group topics were very similar to those included in the key informant interviews, including community assets and challenges, the general health needs of the community, community concerns, and suggestions for improving the community's health. This first data gathering focus group represented a cross section demographically. McKenzie Health staff were in attendance as well but largely played a role of listening and learning.

The community group met again on March 11, 2025 with twelve community members in attendance. At this second community meeting the attendees, which consisted of those that attended the first community meeting as well as the key informants, were presented with survey results, findings from key informant interviews and the first

community meeting, and a wide range of secondary data relating to the general health of the population in the service area. The group was then tasked with identifying and prioritizing the community's health needs.

Members of the second community meeting represented the broad interests of the service area of McKenzie Health and UMDHU. They included representatives of the healthcare community, public health, social services, business community, political bodies, law enforcement, education, agriculture, and faith community. Not all members of the group were present at both meetings.

Survey

A survey was distributed throughout the hospital service area, which included residents of McKenzie County. It was designed to be an additional tool for collecting qualitative data from the community at large – specifically, information related to community-perceived health needs. A copy of the survey instrument is included in Appendix A and a full listing of direct responses provided for the questions that included "Other" as an option are included in Appendix B.

The original survey tool was developed and used by the Center for Rural Health (CRH). In order to revise the original survey tool to ensure the data gathered met the needs of hospitals and public health, the CRH worked with the North Dakota Department of Health's public health liaison. CRH representatives also participated in a series of meetings that garnered input from the state's health officer, local North Dakota public health unit professionals, and representatives from North Dakota State University. The survey has since been edited by Cibolo to reflect changes in health practices and the data needs of the communities.

Similar to the questions asked in the key informant interviews and first community meeting, the survey was designed to:

- Learn of the community's assets and concerns;
- Gather perceptions and attitudes about the health of the community as well as collect suggestions for improvement; and
- Learn how local health services are used by residents.

Specifically, the survey covered the following topics:

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

To promote awareness of the assessment process, print ads were run in the McKenzie County Farmer. The survey was available via survey social media platforms, digital ads, and organizational forwards by non-healthcare groups like the Williston Wire, to encourage people to participate. The survey link was also promoted in church bulletins.

The survey was open from September 4, 2024 to January 3, 2025. While the primary survey collection tool was an online survey utilizing Survey Monkey, paper surveys were also available upon request. Forty-seven completed paper surveys were returned. The survey link and paper copies were distributed by community group members and at McKenzie Health and UMDHU. Survey participation was promoted by McKenzie Health on social media platforms as well as through print ads in the McKenzie County Farmer. Resources did not allow for the survey to be provided in Spanish, and McKenzie County has a large number of Spanish speaking individuals, which likely resulted in reduced survey submissions. Seventy-six online surveys were completed. In total, counting both paper

and online surveys, 123 community member surveys were completed, equating to a 3% response rate. This response rate is low for this type of unsolicited survey methodology.

Secondary Data Collection

In a CHNA, secondary data sources are crucial for providing a comprehensive overview of the health status and needs of the community. Secondary data was collected and analyzed to provide descriptions of: (1) population demographics, (2) general health issues of the population, and (3) contributing causes of community health issues. The data was collected from a variety of sources, such as census, public health, and socio-economic data, as well as Behavioral Risk Factor Surveillance System and the Youth Risk Behavior Surveillance System. Specific sources include:

The U.S. Census Bureau, which provides demographic data including age, gender, race, income, and education levels, which are essential for understanding the population's structure and socio-economic status (https://data.census.gov/).

County Health Rankings & Roadmaps, a program of the University of Wisconsin Population Health Institute, draws attention to why there are differences in health within and across communities (www.countyhealthrankings.org). Annually since 2010, the University of Wisconsin Population Health Institute and the Robert Wood Johnson Foundation have produced the County Health Rankings—a "population health checkup" for the nation's over 3,000 counties. They base the Rankings on a conceptual model of population health that includes both health outcomes (mortality and morbidity) and health factors (health behaviors, clinical care, social and economic factors, and the physical environment). Data for over 30 measures available at the county level are assembled from a number of national sources. Composite scores are then ordered and counties are ranked from best to worst health within each state.

The Centers for Disease Control and Prevention (CDC) provides data on disease prevalence, vaccination rates, and health behaviors in a publication called the Youth Risk Behavior Surveillance System (YRBSS). The YRBSS is a set of surveys that track behaviors that can lead to poor health in students grades 9 through 12 (https://www.cdc.gov/healthyyouth/data/yrbs/index.htm).

The National Survey of Children's Health (NSCH) provides rich data on multiple, intersecting aspects of children's lives—including physical and mental health, access to and quality of health care, and the child's family, neighborhood, school, and social context. The National Survey of Children's Health is funded and directed by the Health Resources and Services Administration Maternal and Child Health Bureau (www.childhealthdata.org/learn/NSCH).

North Dakota KIDS COUNT, which is a national and state-by-state effort to track the status of children, sponsored by the Annie E. Casey Foundation (www.ndkidscount.org), compiles and shares current, comprehensive data on child and family well-being in each of North Dakota's 53 counties. The data addresses six domains: demographics, health, education, family and community, economic well-being, and safety.

It is important that sufficient secondary source data on youth is collected for the community's CHNA because the surveys conducted as part of the primary data collection are not collected for people under the age of 18.

By utilizing these diverse sources of secondary data, a CHNA can develop a detailed and accurate picture of the community's health needs and resources, which is essential for planning effective health interventions and policies.

Data Analysis

Data collected during the CHNA process was utilized through both quantitative and qualitative analysis. Through quantitative analysis, numerical data was used to identify trends, disparities, and key health indicators. This involved statistical analysis and comparisons to state or national benchmarks. Qualitative data from community groups and key informant interviews, as well as open ended survey questions was used to identify common themes and insights into the community's health needs and priorities.

Identifying and Prioritizing Health Needs

Key health issues were identified based on the data analysis by identifying the most pressing health issues affecting the community. During the second community meeting, the attendees from the first community meeting and the key informants gather at a second meeting to prioritize the health concerns based on the CHNA findings that were presented to them. The meeting attendees consider numerous factors, such as the severity of the issue, the number of people affected, and the ability to make an impact. The top concerns that the community members feel should be addressed in the next three years were identified.

Community Profile

McKenzie Health identifies its primary service area as McKenzie County and Western North Dakota. McKenzie Health is located in Watford City, North Dakota, the county seat of McKenzie County, and serves as a 24-bed critical access hospital. Additionally, McKenzie Health operates a rural health clinic, specialty clinics, walk-in clinic, surgery center, long term care, assisted living, and a wellness center. Sanford Health offers clinic services in our building as well, with two FNP providers and visiting specialists. McKenzie Health's hospital is 1 hour from Williston, 1.5 hours from Dickinson, 2.5 hours from Minot, and 3 hours from Bismarck.

McKenzie County was the fastest growing county in the nation and saw a 131.2% increase in population in just 10 years, from 6,360 to 14,252. Located in Western North Dakota, McKenzie County is unique in its economy, landscape, and "can-do" attitude. Once known as the "Island Empire", the county is bordered by the Yellowstone River, Lake Sakakawea and the Missouri River and Little Missouri River. The natural resource-based economy is dependent on farming, ranching, and energy development with landscapes ranging from rich farmland to rugged badlands. The county is home to over 500,000 acres of Little Missouri National Grasslands, an area rich in oil reserves and grassland resources. (https://www.mckenziecounty.net/About/McKenzie-County-Communities).

According to the U.S. Census Bureau QuickFacts: McKenzie County, North Dakota, the estimated census for 2023 in McKenzie County was 14,252, and McKenzie County makes up the majority of services rendered by McKenzie Health. The racial makeup of the county was 74% white, 8.3% American Indian, 13% Hispanic or Latino, 2.2% Black and 1.2% Asian. The number of housing units increased from 3,090 in 2010 to 7,661 in 2020 to 7,841 in 2023.

Other healthcare facilities and services in McKenzie County include: Legendary Smiles Dental office, one Optometry Clinic, two Chiropractor Clinics with one offering massage therapy, and Garden of Healing and Elevated Therapeutic Massage, massage therapy clinics. McKenzie Health also offers Home and Community Based Services for Medicaid and private pay clients as a Quality Service Provider Agency for McKenzie County's Department of Human Services (social services). Personal care and assistance with Activities of Daily Living (ADLs), housekeeping, non-medical transportation, companionship and homemaker services are offered through this program.

Watford City 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 bike path; a fitness center with a therapy pool, weights and exercise machines and a track available for winter walking; Anytime Fitness, and the Rough Rider Center. Parks and recreation include an indoor and outdoor swimming pool/ water park, eleven city parks, tennis courts, golf course, movie theatre, Theodore Roosevelt Park, Tobacco Gardens Resort and Marina, and the Maah Daah Hey Trail. McKenzie County offers several cultural attractions such as the Heritage Park Museum, which pays tribute to the early history of the city and region.

Watford City offers public transportation through the Northwest Transit, where seniors can ride free and the Veterans Administration supplies transportation for local vets. The community also has a four grocery stores; one locally owned grocery store offers delivery services on Wednesdays and the two pharmacies offer medication delivery as well. The McKenzie County Public School System offers a comprehensive program for students K-12 and has four separate buildings, Fox Hills Elementary and Badlands Elementary hosting grades K-5, the Middle School hosting grades 6-8, and the High School grades 9-12. The Wolf Pup Preschool offers privately funded preschool, with the Head Start Program offering publicly funded preschool for low-income students. Some licensed as well as unlicensed daycares are available in the area.

Figure 1. McKenzie County

Snapshot of McKenzie County

Demographics

Table 1. McKenzie County Demographics
Source: https://www.countyhealthrankings.org/ (2024)

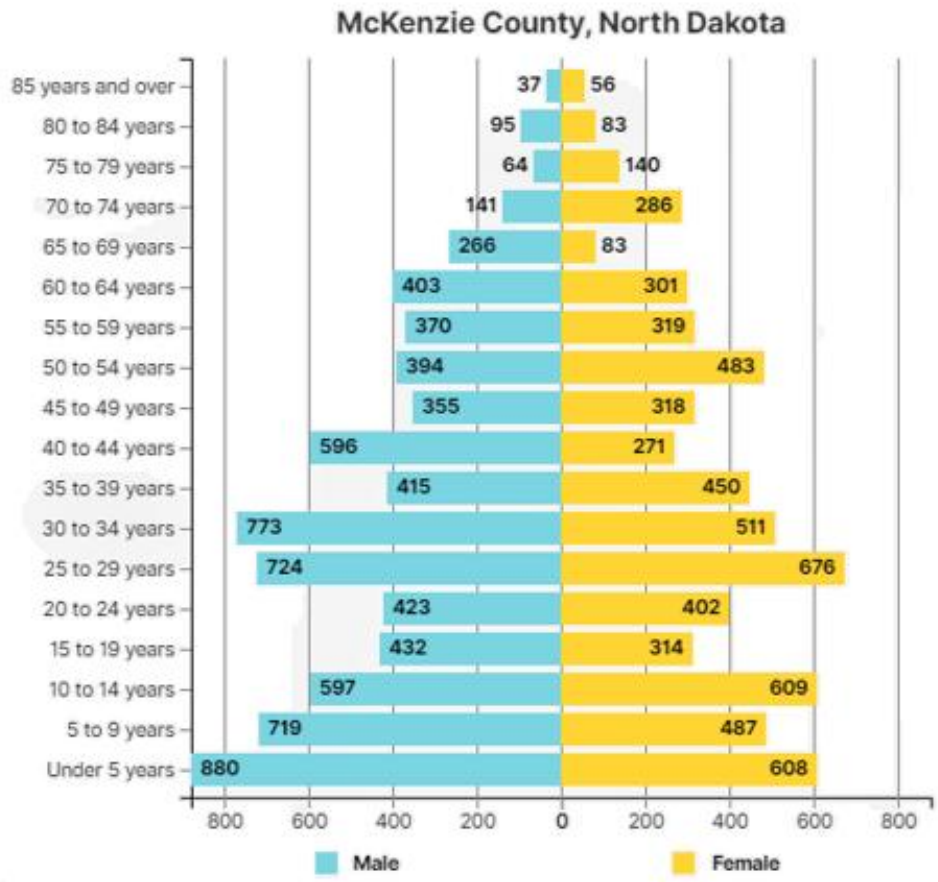
	McKenzie County	North Dakota
Population (2022)	13,908	779,261
% Below 18 Years of Age	32.30%	23.50%
% 65 and Older	10.20%	16.70%
% Non-Hispanic Black	1.70%	3.40%
% American Indian or Alaska Native	9.00%	5.30%
% Asian	1.20%	1.70%
% Native Hawaiian or Other Pacific Islander	0.10%	0.10%
% Hispanic	11.90%	4.60%
% Non-Hispanic White	74.30%	83.00%
% Not Proficient in English	1%	1%
% Female	46.90%	48.60%
% Rural	54.50%	39.00%

Age

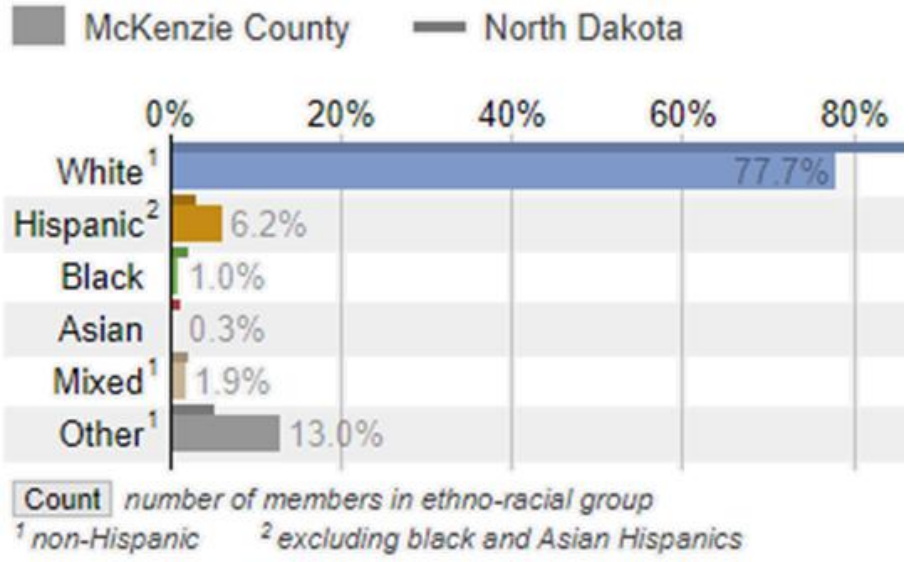
30.5 ± 0.6
Median Age in McKenzie County

36.2 ± 0.3
Median Age in North Dakota

Population Pyramid: Population by Age and Sex



Race & Ethnicity



Source: https://statisticalatlas.com/county/North-Dakota/McKenzie-County/Race-and-Ethnicity

Types of Language Spoken at Home

Measure	Value
English only	89.1%
Spanish	7.7%
Other Indo-European languages	0.9%
Asian and Pacific Islander languages	0.5%
Other languages	1.9%

Income and Earnings

$83,813 ± $3,433
Median Household Income in McKenzie County

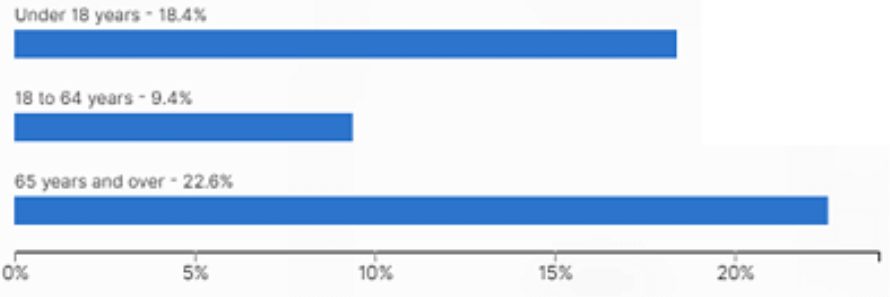
$71,970 ± $2,072
Median Household Income in North Dakota

Poverty

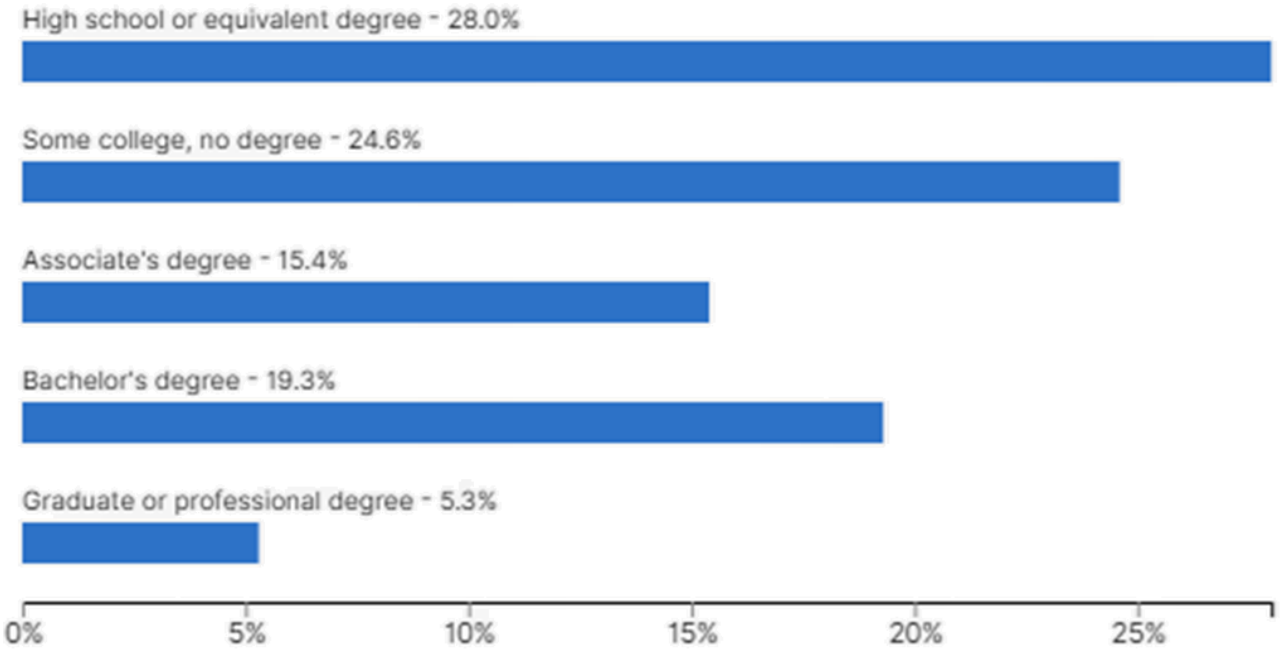
13.4% ± 2.8%
Poverty, All people in McKenzie County

11.5% ± 0.9%
Poverty, All people in North Dakota

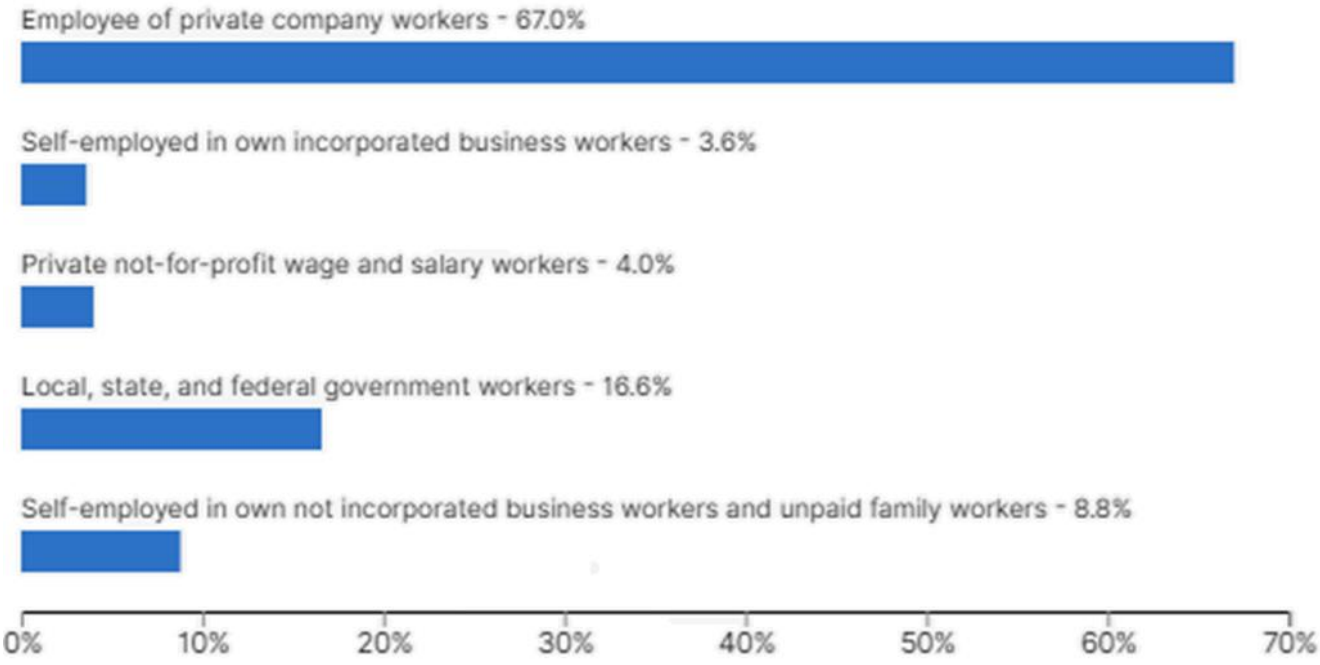
Poverty by Age
in McKenzie County, North Dakota



Education Attainment (Population 25 Years and Older)



Class of Worker



Employment and Labor Force Status

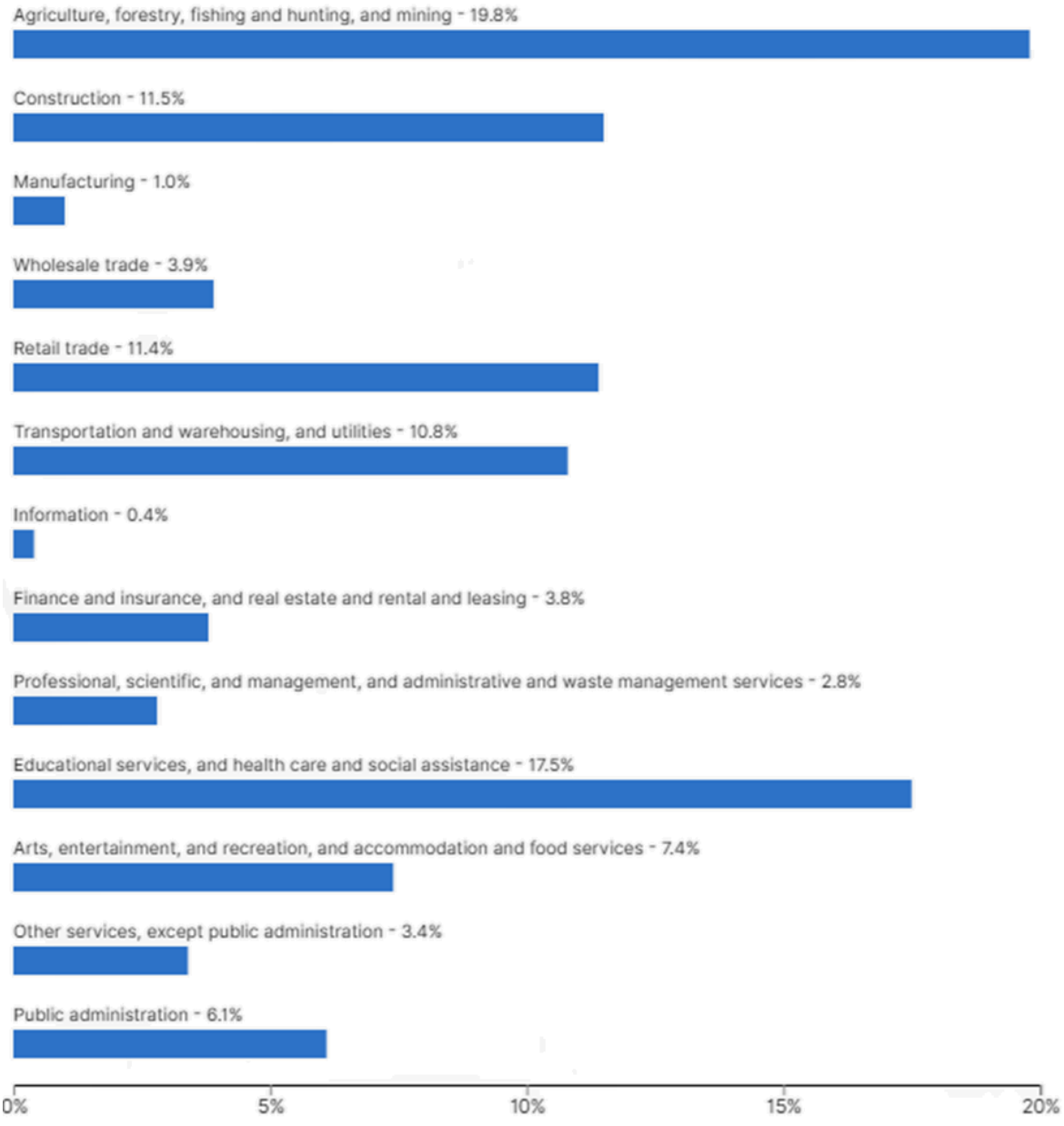
67.8% ± 3.5%
Employment Rate in McKenzie County, North Dakota

66.1% ± 0.9%
Employment Rate in North Dakota

Means of Transportation to Work (Workers 16 Years and Over)

Measure	Value
Drove alone	81.2%
Carpool	7.7%
Public transportation	0.2%
Walked	3.3%
Bicycle	1.6%
Taxicab, motorcycle, or other means	0.6%
Worked from home	5.3%

Industry for the Civilian Employed Population 16 Years and Over

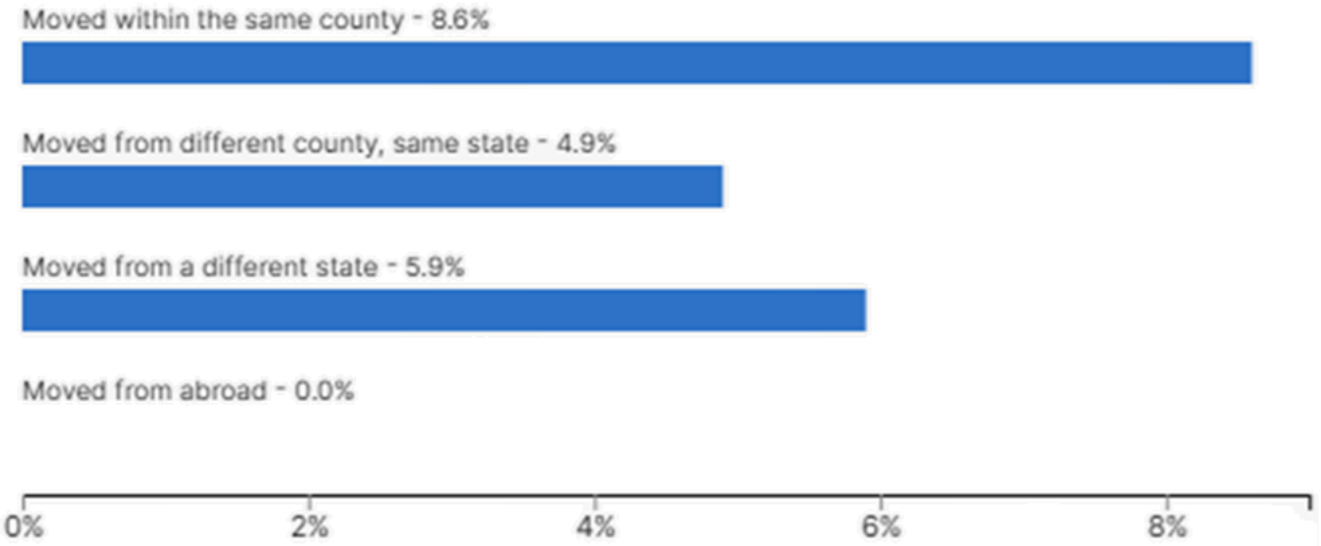


5.9% ± 1.8%
Moved From a Different State in the Last Year in McKenzie County, North Dakota

4.5% ± 0.6%
Moved From a Different State in the Last Year in North Dakota

Residential Mobility

Residential Mobility in the Last Year



Financial Characteristics of Home Rental

$1,192 ± $83
Median Gross Rent in McKenzie County

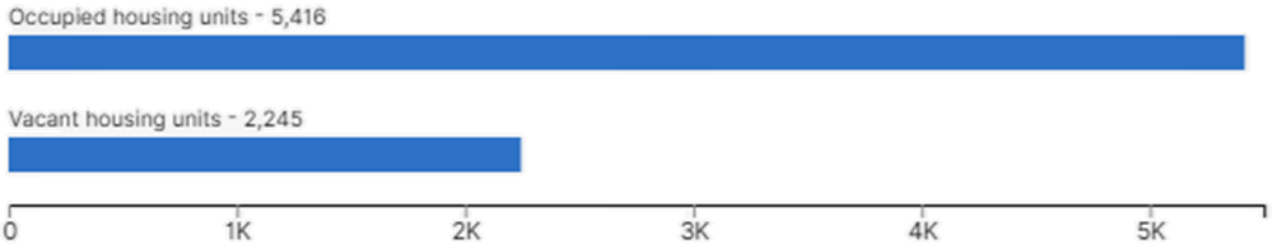
$863 ± $21
Median Gross Rent in North Dakota

Homeownership Rate

56.5% ± 3.9%
Homeownership Rate in McKenzie County

65.1% ± 1.2%
Homeownership Rate in North Dakota

Housing Occupancy



H1 | *2020 Decennial Census*

Health Insurance

15.7% ± 3.3%
Without Health Care Coverage in McKenzie County, North Dakota

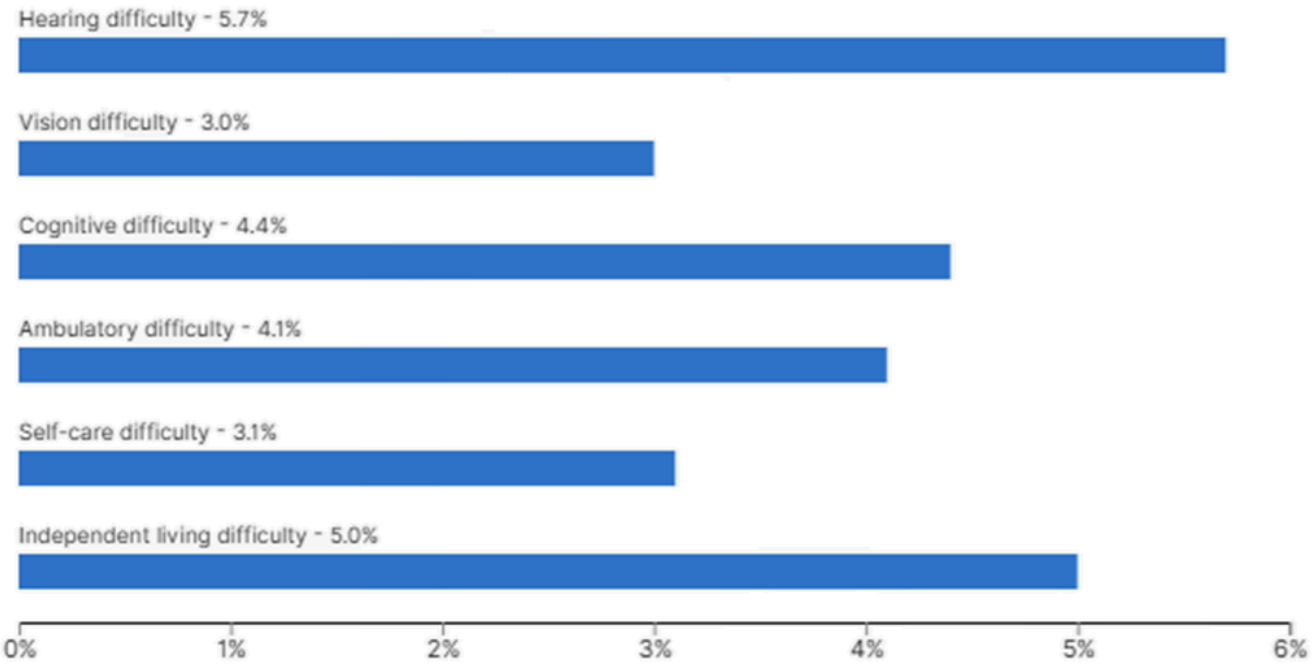
6.4% ± 0.7%
Without Health Care Coverage in North Dakota

Disability

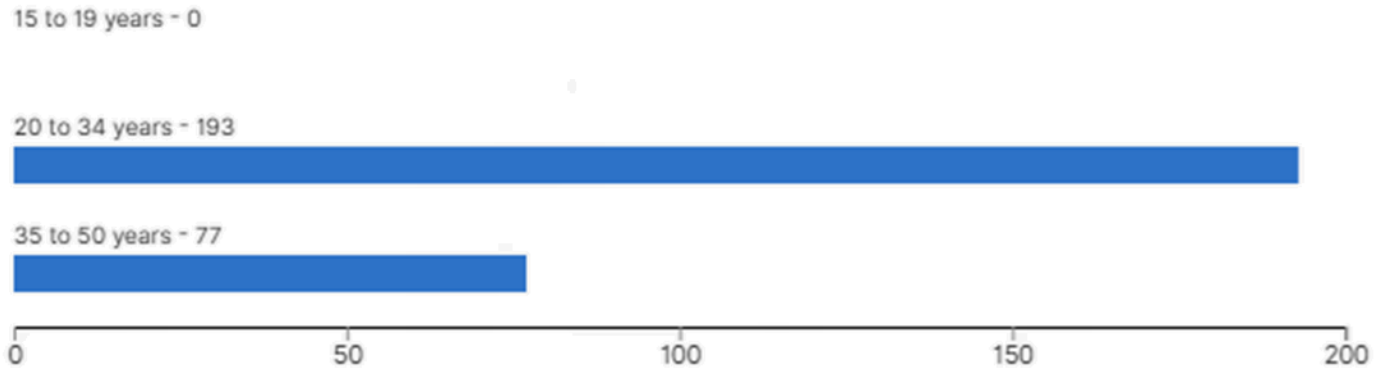
9.8% ± 2.1%
Disabled Population in McKenzie County, North Dakota

12.2% ± 0.7%
Disabled Population in North Dakota

Types of Disabilities
in McKenzie County, North Dakota



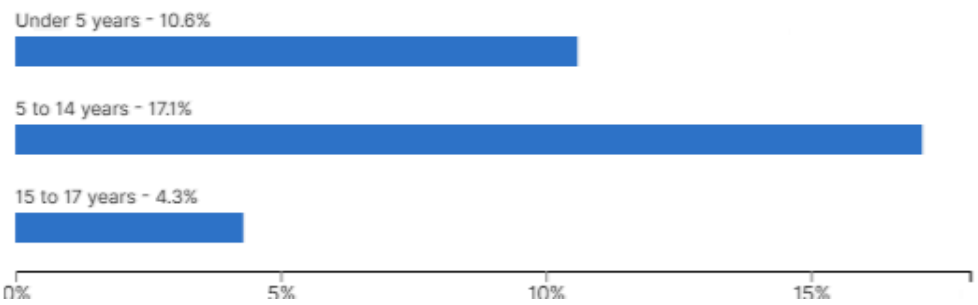
Women with Births in the Past 12 Months



Children

32.0% ± 0.6%
Under 18 years old in McKenzie County

23.2% ± 0.1%
Under 18 years old in North Dakota



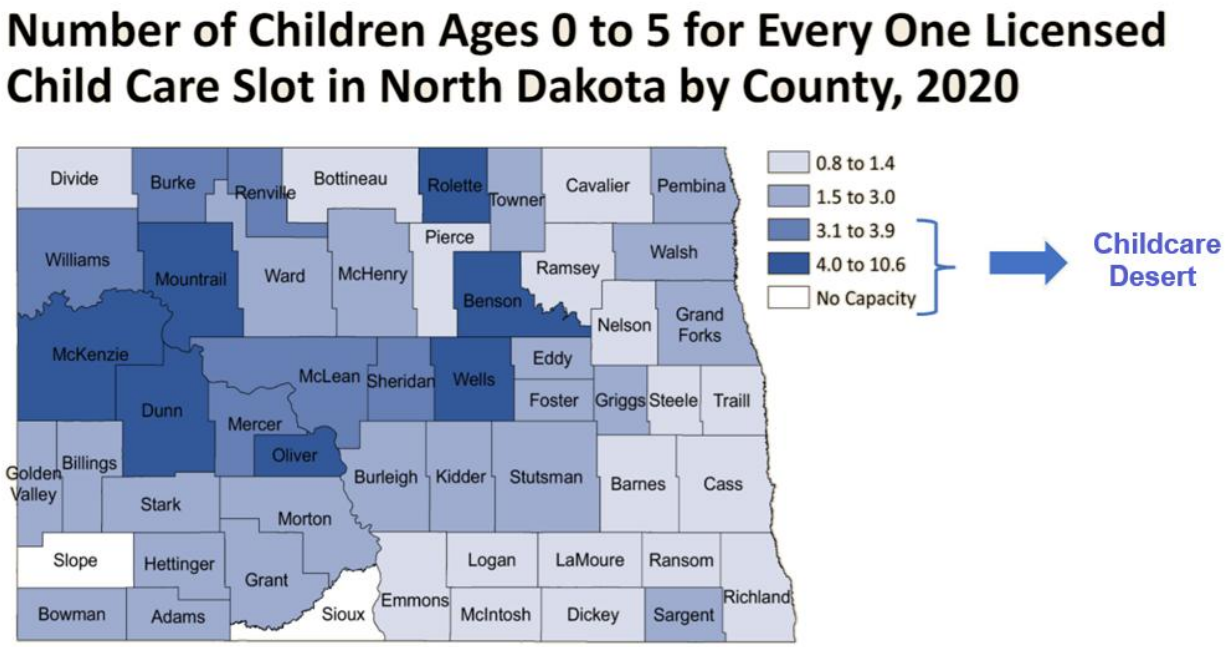
Families and Houshold Characteristics

3.33 ± 0.24
Average Family Size in McKenzie County, North Dakota

2.93 ± 0.05
Average Family Size in North Dakota

Daycare

Daycare plays a role in many communities, including those in McKenzie Health's service area. As shown below, McKenzie County is considered a childcare desert.



Children: U.S. Census Bureau, 2016-2020 American Community Survey 5-Year Estimates
Licensed Child Care Slots: Child Care Aware of North Dakota

McKenzie Health

McKenzie County Healthcare Systems (dba McKenzie Health) began its mission in 1952 as McKenzie County Memorial Hospital. On July 1, 2004, with the merger of the Good Shepherd Home Corporation and the McKenzie County Memorial Hospital Corporation, McKenzie County Healthcare Systems, Inc. was born. This resulted in the consolidation of all healthcare services in McKenzie County. McKenzie Health consists of the hospital, rural health clinic, specialty clinics, Good Shepherd Home (long term care), Horizon Assisted Living, the Connie Wold Wellness Center, and satellite offices. Our goal is to provide our rural communities with access to quality healthcare.

McKenzie Health is here today because of the hard work and vision of community minded individuals. These people epitomize the spirit of work and caring that made McKenzie County the place it is today. They spoke of the "founders of our community" and how they "spent the vigor of their youth building up the way of life we enjoy today." They felt a responsibility to provide quality healthcare to those pioneers. With that same attitude, we continue to work to provide healthcare services to those who choose to live and work in a rural area.

McKenzie Health is a faith-based organization, supported by the Christian churches in our community. We are committed to excellence and service in a person-centered environment that respects the human life of all, regardless of race, creed, color, national origin, disability, pregnancy, sex and/or marital status.

The grand opening of McKenzie Health's new medical facility took place on June 22, 2018. This $76.3M, state-of-the-art facility features a brand new hospital, clinics, as well as updates to the connected Good Shepherd Home (nursing home) and nearby Horizon Assisted Living.

Some additional highlights of the new medical facility include:

- 24 inpatient rooms
- 9 emergency bays
- Helipad
- 44 private resident rooms (Good Shepherd Home)
- 3 couples resident rooms (Good Shepherd Home)
- 4 outdoor courtyards
- Greenhouse
- Imaging center
- 2 operating rooms
- Several procedure rooms

McKenzie Health provides many different services to meet the nees of the community. They include:

Rural Health Clinic: Primary Care, Medication Management, Chronic Condition Management, Annual Physicals, Women's Health, Diabetes Monitoring, Well-Child Checks, and Sports Physicals.

340B Pharmacy Program.

Visiting Nurse Service: Wound Care, Blood Draw, Dressing Change, Teaching and Assessment for Chronic Disease (e.g., Diabetes, Heart Failure, or COPD), Teaching New Procedures, and IV Medications.

Home and Community Based Services: Home-based Personal Care, Non-medical Transportation, Companionship, and Nurse Education and Medication Management is provided by qualified staff to medicaid and private pay individuals, within a 25 mile radius of Watford City.

McKenzie Health Specialty Clinics: Oncology, Orthopedic, General Surgery, ENT, Urology, Cardiology, and Pulmonology Services.

Hospital: Emergency, Laboratory, Cardiac Rehabilitation, Nutrition, Physical Therapy, Occupational Therapy, Speech Therapy, Mammography, MRI, CT-Scan, Echo, Sleep Studies, Pulmonary Rehabilitation, Palliative Care, Nursing, Diabetes Education, Chronic Disease Management, and Telemedicine Services.

Walk-in Clinic: Foot Care, Coughs/Colds, Medication Refills, Sports Physicals, Flight Physicals, Medication Assistance Program, Diabetes Monitoring.

Assisted Living/Long Term Care: The Good Shepherd Home and Horizon Assisted Living use their Longterm Decision Tree Tool to help decide which best fits the patient's needs.

The Good Shepherd Home- services include:
- 47-bed skilled nursing home,
- 9-bed basic care, 24-hour nursing care 7 days a week, for those caring for loved ones in their own home,
- Day Care and Respite Care,
- Dementia Support Group and information,
- Resident Council,
- Family Council,
- Pastoral Care with Chapel Services 7 days/week.

The Horizon Assisted Living - services include:
- 9 one bedrooms,
- 2 one bedrooms with a den,
- 4 two bedrooms,
- 24 hour call system,
- Onsite staff 8am-6 pm,
- Laundry and Mail services,
- Weekly vitals & monthly nursing assessments,
- Wheelchair accessible,
- Security controlled,
- Furnished with a stove, refrigerator, air conditioner and blinds.

Connie Wold Wellness Center: Boot Camp, Cardio Sculpt, Cardio Lift, Senior Strength, Spin, Cross Cycle, Yoga, and Pilates.

Additional Services: Chiropractic, massage therapy, dental, and optometric/vision services. Community Ambulance, First Responders and Enhanced 911 Emergency Service

Upper Missouri District Health Unit

The Upper Missouri District Health Unit (UMDHU) was founded and began offering sanitation and nursing services in Divide, McKenzie and Williams Counties in 1947. It was the third public health unit formed in the state. Mountrail County joined the health unit in 1949. The central office is located in Williston; satellite offices are maintained in Crosby, Stanley and Watford City (all are county seats).

Upper Missouri District Health Unit (UMDHU) provides public health services that encompass all residents aged birth to end of life in Divide, McKenzie, Mountrail, and Williams Counties. Services include environmental health, emergency preparedness, nursing services, WIC (women, infants, and children) Program, and ATOD prevention and education services. Each of these programs provides a wide variety of services in order to accomplish the mission of public health, which is to assure that our community is a healthy place to live and each person has an equal opportunity for optimal health.

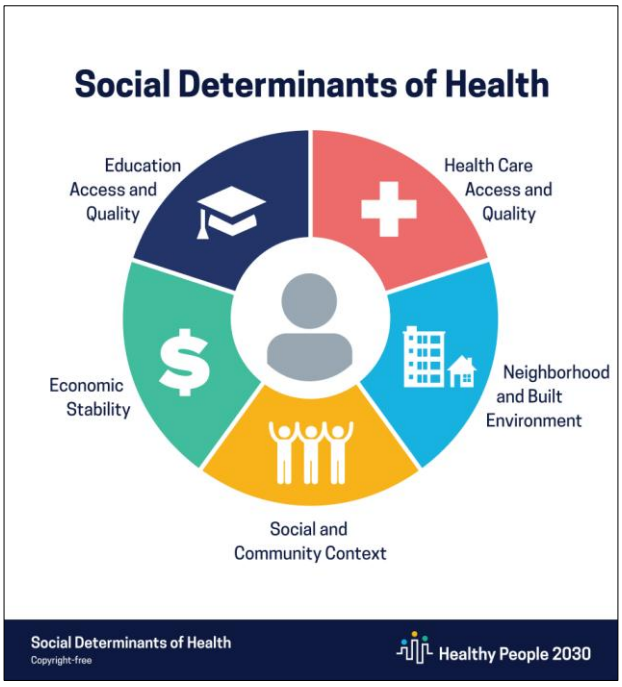
Funding for public health services comes from a variety of funding sources. Programs and services are covered by county mill dollars, state funding, federal funding, donations and fees for services. UMDHU applies for other funding opportunities that support the mission. Services are available to all eligible UMDHU residents including all age groups and economic status. UMDHU uses a sliding fee scale for some services, based on financial income.

Mission
UMDHU, serving Northwestern North Dakota, promotes healthy lifestyles through health education, prevention and control of disease and the protection and enhancement of the environment.

UMDHU works to prevent illness and injury, promote healthy communities and offer protection of the environment keeping it clean, healthy and safe. Quality of life is improved and money is saved when illness and injury are prevented. Health Promotion goals are to develop public policy and programs to support healthy lifestyles and to encourage the public to practice healthy lifestyles. A clean and safe environment doesn't just happen. Assisting people to identify and prevent public health risks in their community is an important public health responsibility.

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



Social determinants of health (SDOH) are the conditions in which people are born, grow, live, work, and age that affect a wide range of health, functioning, and quality-of-life outcomes (economic stability, education access and quality, social and community context, health care access and quality, neighborhood and built environment). SDOH are fundamental factors that influence health outcomes and disparities. Addressing these determinants is necessary for creating healthier communities, achieving health equity, and ensuring that all individuals have the opportunity to lead healthy lives. By focusing on SDOH, we can develop more effective and comprehensive public health strategies that go beyond medical care to address the broader factors affecting health. County Health Rankings help depict where each county sits in regards to the SDOH of their population.

The data used in the 2024 County Health Rankings are pulled from more than 30 data sources and then are compiled to create county rankings. Counties in each of the 50 states are ranked according to summaries of a

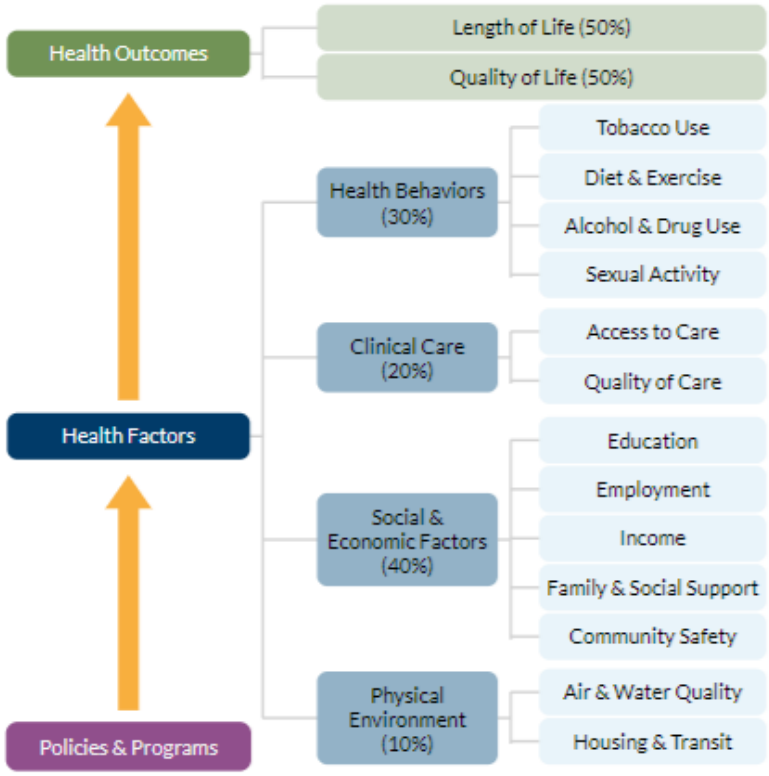
variety of health measures. Those having high ranks, such as 1 or 2, are considered to be the "healthiest." Counties are ranked on both health outcomes and health factors. The data reflected is from 2022 – there is a two-year lag in the data.

A model of the 2024 County Health Rankings – a flow chart of how a county's rank is determined – may be found in Appendix F. For further information, visit the County Health Rankings website at www.countyhealthrankings.org.

Health Outcomes tell us how long people live on average within a community, and how much physical and mental health people experience in a community while they are alive. They are influenced by many factors, such as clean water, affordable housing, the quality of medical care and the availability of good jobs. Programs and policies at the local, state and federal levels influence these factors. Many things influence how well and how long we live. Health Factors represent those things we can improve to live longer and healthier lives. They are indicators of the future health of our communities. Figure 1 shows the County Health Rankings Model.

Figure 1. County Health Rankings Model

Source: https://www.countyhealthrankings.org/what-impacts-health/county-health-rankings-model



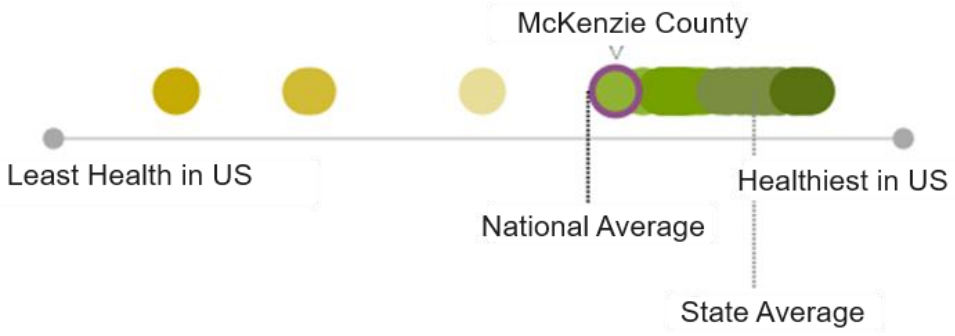
McKenzie County is faring worse than the average county in North Dakota for Health Outcomes and Health Factors, and better than the average county in the nation. Figure 2 depicts where McKenzie County falls in regards to health outcomes and health factors compared to the least healthy in the US, the healthiest in the U.S., the state average, and the national average.

Figure 2. McKenzie County Health Outcomes and Factors

Source: www.countyhealthrankings.org

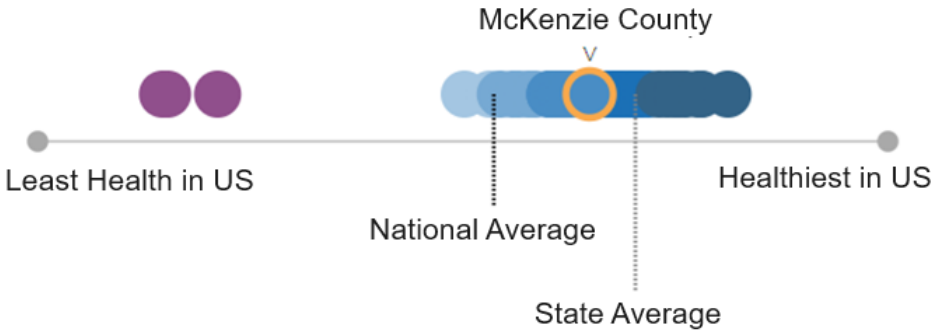
Health Outcomes:

- Length of life
- Quality of life



Health Factors:

- Health behavior
- Clinical care
- Social & Economic Factors
- Physical Environment



The following is a chart showing the County Health Rankings of McKenzie County relative to the North Dakota average and the U.S. top 10% performers. For most of the measures included in the rankings, the County Health Rankings' authors have calculated the "Top U.S. Performers" for 2024. 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).

The measures marked with a bullet point (●) are those where a county is not measuring up to the state rate/percentage; a square (■) indicates that the county is not meeting the U.S. Top 10% rate on that measure. Measures that are not marked with a colored shape but are marked with a plus sign (+) indicate that the county is doing better than the U.S. Top 10%.

TABLE 2: SELECTED MEASURES FROM *COUNTY HEALTH RANKINGS* 2024
MCKENZIE COUNTY

● = Not meeting North Dakota average
■ = Not meeting U.S. Top 10% Performers
\+ = Meeting or exceeding U.S. Top 10% Performers
Note: Blank values reflect unreliable or missing data

	McKenzie County	North Dakota	United States
HEALTH OUTCOMES			
Length of Life			
Premature Death	12,500 ● ■	7,600	8,000
Life Expectancy	76.0 ● ■	78.1	77.6
Quality of Life			
Poor or Fair Health	15% ● ■	13%	14%
Poor Physical Health Days	3.2 ●	3.1	3.3
Poor Mental Health Days	3.9 +	4.0	4.8
Low Birthweight	7% +	7%	8%
Diabetes Prevalence	10% ●	9%	10%
HEALTH FACTORS			
Health Behaviors			
Adult Smoking	18% ● ■	16%	15%
Adult Obesity	37% ● ■	36%	34%
Food Environment Index	7.7 ●	9.1	7.7
Physical Inactivity	27% ● ■	25%	23%
Access to Exercise Opportunities	39% ● ■	76%	84%
Excessive Drinking	23% +	23%	18%
Alcohol-limpaired Driving Deaths	32% ■	39%	26%
Sexually Transmitted Infections	332.9 +	511.5	495.5
Teen Births	23 ● ■	15	17
Clinical Care			
Uninsured	13% ● ■	9%	10%
Uninsured Adults	13% ● ■	10%	12%
Uninsured Children	13% ● ■	8%	5%
Primary Care Physicians	6,910:1 ● ■	1,290:1	1,330:1
Dentists	3,480:1 ● ■	1,420:	1,360:1
Mental Health Providers	3,480:1 ● ■	450.0:1	320.0:1
Other Primary Care Providers	1,740:1 ● ■	540.0:1	760.0:1
Preventable Hospital Stays	489 +	2,945	2,681
Mammography Screening	43% ●	53%	43%
Flu Vaccinations	29% ● ■	49%	46%

TABLE 2: SELECTED MEASURES FROM *COUNTY HEALTH RANKINGS* 2024
MCKENZIE COUNTY

● = Not meeting North Dakota average
■ = Not meeting U.S. Top 10% Performers
\+ = Meeting or exceeding U.S. Top 10% Performers
Note: Blank values reflect unreliable or missing data

	McKenzie County	North Dakota	United States
Social & Economic Factors			
High School Completion	93% +	93%	89%
Unemployment	1.9% +	2.1%	3.7%
Children in Poverty	9% +	12%	16%
Income Inequality	4.0 +	4.4	4.9
Social Associations	11.6 +	15.5	9.1
Injury Deaths	115 ●■	75	80
School Funding Adequacy	$6,535 +	$3,128	$634
Gender Pay Gap	0.57 +	0.79	0.81
Median Household Income	$84,200 +	$73,200	$74,800
Living Wage	$51.57	$43.37	
Child Care Centers	1 ●■	7	7
Homicides		3	6
Suicides	28 ●■	19	14
Physical Environment			
Air Pollution - Particulate Matter	3.6 +	5	7.4
Drinking Water Violations	No		
Homeownership	56% ●■	63%	65%
Severe Housing Problems	15% +	12%	17%
Severe Housing Cost Burden	8% +	10%	14%
>30 minute Drive to Work	26% ●	15%	36%
Traffic Volume	13 +	83	108
Broadband Access	89% +	86%	88%

Children's Health

The National Survey of Children's Health (NSCH) provides rich data on multiple, intersecting aspects of children's lives—including physical and mental health, access to and quality of health care, and the child's family, neighborhood, school, and social context. The NSCH is funded and directed by the Health Resources and Services Administration (HRSA) Maternal and Child Health Bureau. A revised version of the survey was conducted as a mail and web-based survey by the Census Bureau in 2016, 2017, 2018, 2019, 2020, 2021 and 2022. Data reported in Table 3 is from 2021-2022. Items noted in red show where North Dakota is fairing more poorly than the national average.

Table 3. Data Resource Center for Child & Adolescent Health
2021-2022 National Survey of Children's Health
Source: https://www.childhealthdata.org/

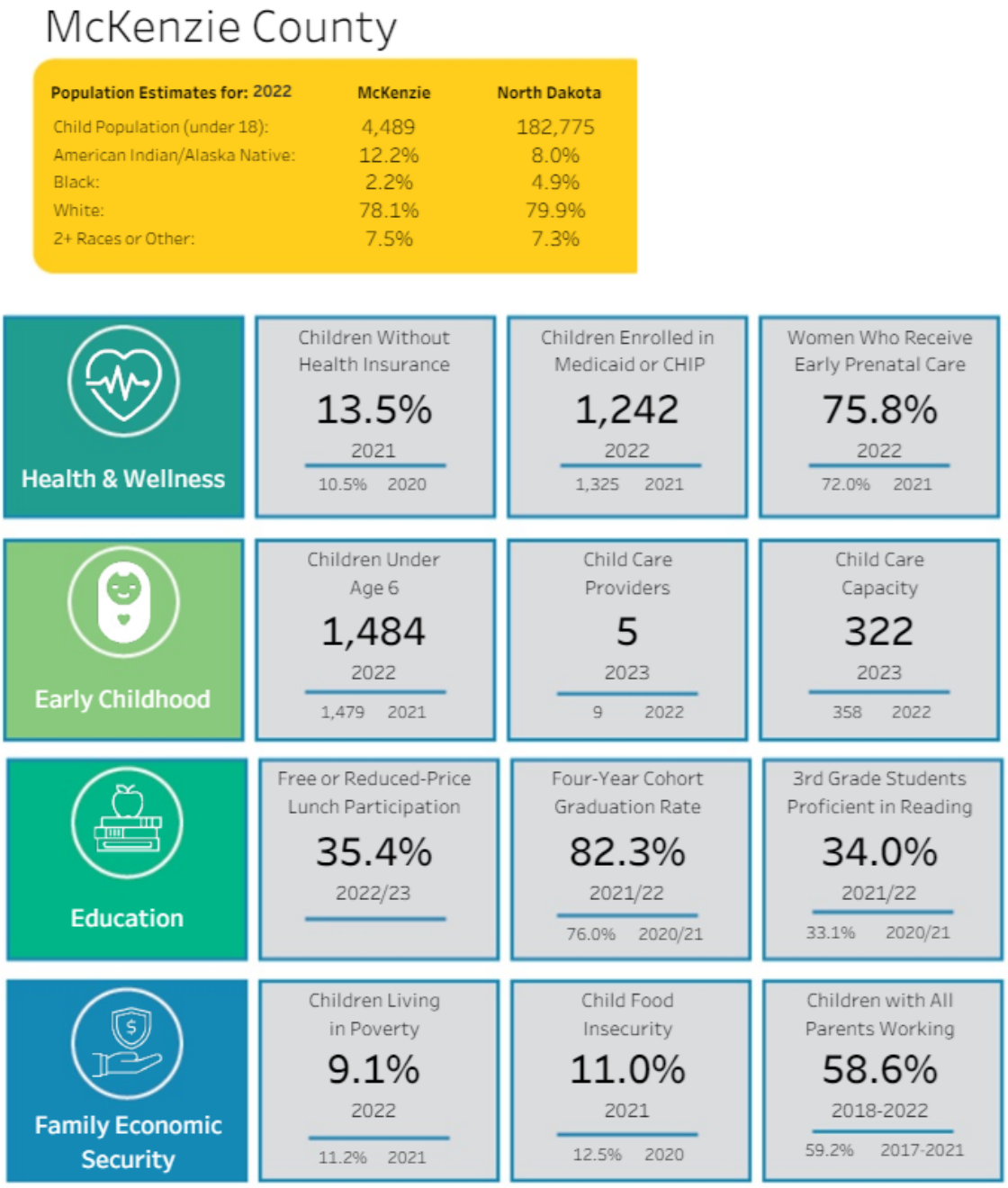
Health Status	North Dakota	National
Children born premature (3 or more weeks early)	11.0%	11.4%
Children 10-17 overweight or obese	28.0%	33.7%
Children 0-5 who were ever breastfed	77.6%	81.5%
Community and School Activities		
Children 6-17 who missed 11 or more days of school	**5.9%**	5.7%
Children 12-17 who work for pay	53.4%	35.6%
Health Care		
Children currently insured	94.3%	93.1%
Children that had one or more preventative visits in the past year	**73.6%**	76.8%
Children who spent less than 10 minutes with the provider at a preventive medical visit	16.1%	18.8%
Children (1-17 years) who had a preventive dental visit in the past year	77.7%	77.0%
Children (0-17 years) who have seen an eye doctor in the past 2 years	51.7%	39.4%
Children (3-17 years) received mental health care	13.4%	11.6%
Children (3-17 years) who had difficulties getting the mental health treatment/counseling needed and did not obtain care	5.0%	5.5%
Young children (9-35 mos.) receiving standardized screening for developmental problems in the past year	46.1%	33.7%
Children who have received coordinated, ongoing, comprehensive care within a medical home	52.3%	46.1%
Family Life		
On most weekdays, children who usually spend 4 or more hours in front of a TV, computer, cellphone or other electronic device watching programs, playing games, accessing the internet or using social media, not including schoolwork	18.4%	22.9%
Children who live in households where someone smokes	**17.1%**	12.7%
Children who have, during the past year, not afford to eat	3.1%	4.5%
Neighborhood		
Children who live in neighborhoods with parks, recreation centers, sidewalks, and a library	**33.6%**	36.1%
Children living in neighborhoods with poorly kept or rundown housing	19.5%	24.7%
Children living in a safe neighborhood	76.3%	66.2%

North Dakota KIDS COUNT is dedicated to providing current, relevant, and reliable data to shape the issues affecting North Dakota children and families. North Dakota KIDS COUNT also regularly updates the KIDS COUNT Data Center to include the most recent statistics for children and families. The KIDS COUNT Data Center is a project of the Annie E. Casey Foundation, and KIDS COUNT is a comprehensive source for data on child and family well-being in the United States (https://ndkidscount.org/county-data). See Appendix B. In addition to the

population demographics of children in McKenzie County and North Dakota, Figure 3 shows the 2021-2022 results versus the 2020-2021 results when available.

Figure 3. McKenzie County KIDS COUNT Data Report

Source: https://ndkidscount.org/county-data



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

Table 4 depicts some of the YRBS data that has been collected in 2017, 2019, and 2021(most recent published data). They are further broken down by rural and urban percentages. The trend column shows a "=" for statistically insignificant change (no change), "↑" for an increased trend in the data changes from 2019 to 2021, and "↓" for a decreased trend in the data changes from 2019 to 2021. The final column shows the 2021 national average percentage. For a more complete listing of the YRBS data, see Appendix C.

Table 4. Youth Behavioral Risk Survey Results

North Dakota High School Survey

Rate Increase ↑, rate decrease ↓, or no statistical change **=** in rate from 2019-2021.

	ND 2019	ND 2021	ND Trend ↑, ↓, =	Rural ND Town Average	Urban ND Town Average	National Average 2021
% of students who rarely or never wore a seat belt (when riding in a car driven by someone else)	5.9	49.6	↑	9.2	5.5	39.9
% of students who rode in a vehicle with a driver who had been drinking alcohol (one or more times during the 30 prior to the survey)	14.2	13.1	=	18.2	13.7	14.1
% of students who talked on a cell phone while driving (on at least one day during the 30 days before the survey)	59.6	5.0	↓	64.9	64.2	NA
% of students who texted or e-mailed while driving a car or other vehicle (on at least one day during the 30 days before the survey)	53.0	55.4	=	59.9	55.9	36.1
% of students who were in a physical fight on school property (one or more times during the 12 months before the survey)~2017/2019~ *in 2021 replaced by* % of students who carried a weapon on school property (such as a gun, knife, or club, on at least 1 day during the 30 days before the survey)	7.1	5.0	↓	6.2	4.4	3.0
% of students who experienced sexual violence (being forced by anyone to do sexual things [counting such things as kissing, touching, or being physically forced to have sexual intercourse] that they did not want to, one or more times during the 12 months before the survey)	9.2	9.4	=	9.7	11.6	11
% of students who were bullied on school property (during the 12 months before the survey)	19.9	15.8	↓	19.8	15.0	15.0
% of students who were electronically bullied (includes texting, Instagram, Facebook, or other social media ever during the 12 months before the survey)	14.7	13.6	↓	16.2	14.5	15.9
% of students who made a plan about how they would attempt suicide (during the 12 months before the survey)	15.3	14.8	=	15.1	17.2	17.6
% of students who currently use an electronic vapor product (e-cigarettes, vape e-cigars, e-pipes, vape pipes, vaping pens, e-hookahs, and hookah pens at least one day during the 30 days before the survey)	33.1	21.2	↓	24.2	23.6	18.0
% of students who currently used cigarettes, cigars, or smokeless tobacco (on at least one day during the 30 days before the survey)	12.2	5.9	↓	8.0	6.1	3.8
% of students who currently were binge drinking (four or more drinks for female students, five or more for male students within a couple of hours on at least one day during the 30 days before the survey)	15.6	14.0	=	17.8	14.6	10.5
% of students who currently used marijuana (one or more times during the 30 days before the survey)	12.5	10.7	=	10.2	12.9	15.8

% of students who ever took prescription pain medicine without a doctor's prescription or differently than how a doctor told them to use it (counting drugs such as codeine, Vicodin, OxyContin, Hydrocodone, and Percocet, one or more times during their life)	14.5	10.2	↓	9.7	11.0	12.2
% of students who were overweight (>= 85th percentile but <95th percentile for body mass index)	16.5	15.6	=	15.5	14.2	16.0
% of students who had obesity (>= 95th percentile for body mass index)	14.0	16.3	=	17.4	15.0	16.3
% of students who did not eat fruit or drink 100% fruit juices (during the seven days before the survey)	6.1	5.0	=	5.7	4.6	7.7
% of students who did not eat vegetables (green salad, potatoes [excluding French fries, fried potatoes, or potato chips], carrots, or other vegetables, during the seven days before the survey)	6.6	5.9	=	5.3	6.2	9.3
% of students who drank a can, bottle, or glass of soda or pop one or more times per day (not including diet soda or diet pop, during the seven days before the survey)	15.9	16.6	=	17.5	13.8	14.7
% of students who did not drink milk (during the seven days before the survey)	20.5	26.2	↑	21.2	29.4	35.7
% of students who did not eat breakfast (during the seven days before the survey)	14.4	15.1	=	14.5	17.3	22.0
% of students who most of the time or always went hungry because there was not enough food in their home (during the 30 days before the survey)	2.8	2.1	=	2.2	2.1	NA
% of students who were physically active at least 60 minutes per day on 5 or more days (doing any kind of physical activity that increased their heart rate and made them breathe hard some of the time during the seven days before the survey)	49.0	56.5	↑	58.0	55.3	NA
% of students who watched television 3 or more hours per day (on an average school day) *In 2021 replaced by*Percentage of students who spent 3 or more hours per day on screen time (in front of a TV, computer, smart phone, or other electronic device watching shows or videos, playing games, accessing the Internet, or using social media, not counting time spent doing schoolwork, on an average school day)	18.8	75.7	↑	75.8	78.6	75.7
% of students who played video or computer games or used a computer 3 or more hours per day (for something that was not schoolwork on an average school day) *In 2021, % of students who played video or computer games was combined with % of students who watch television 3 or more hours per day.	45.3	NA	NA	NA	NA	NA
% of students who ever had sexual intercourse	38.3	36.6	=	36.5	37.0	30
% of students who had eight or more hours of sleep (on an average school night)	29.5	24.5	↓	28.3	23.2	22.7
% of students who brushed their teeth on seven days (during the seven days before the survey)	66.8	67.9	=	64.5	69.9	NA

Sources: https://www.cdc.gov/healthyyouth/data/yrbs/results.htm; https://www.nd.gov/dpi/districtsschools/safety-health/youth-risk-behavior-survey

Low Income

The 2023 Needs Assessment Study of Low-Income North Dakota Individuals and Families, was a collaborative effort between the Community Action Agencies (CAAs) and North Dakota State University (NDSU). It was carried out through the utilization of surveys and focus groups, followed by statistical analysis. Specifically, the

assessment involved a variety of survey methods, including both online and paper surveys, chosen based on their appropriateness for different respondent groups, targeting low-income individuals and families across the state of North Dakota.

Findings from the study found that "Rental Assistance" remained the top priority need among people experiencing poverty throughout the state under the category of "Housing". Inconsistencies between the responses from low-income or non-low-income respondents were found, which reflect distinct needs within these two groups. For example, the top priority need for the non-low-income respondents is "Mental Health Service", while "Rental Assistance" stands as the top need for the low-income people, as well as the broader community, including both low-income and non-low-income people. Individuals and families with higher incomes tend to prioritize Civic Engagement and Community Involvement, including aspects like "Recreational Activities" and "Safe Neighborhoods, Sidewalks, Parks". Conversely, those with lower incomes are more inclined to place greater emphasis on fundamental necessities such as "Rental Assistance", "Food", and "Dental Insurance/Affordable Dental". This divergence in priorities reflects varying needs and concerns across income levels.

Increased living costs and inflation have emerged as significant contributing factors to the causes of poverty across the state, and they could also be the key drivers behind the top priority need for "Rental Assistance". The frequently mentioned causes of poverty, derived from analysis of the qualitative data collected across the state, are listed below in order of frequency (with the most frequently mentioned causes listed first).

1. Increasing living costs/Inflation
2. Disability, Mental Illness, Severe Anxiety/Depression, etc.
3. Childcare Issue for Working Parents
4. Family Instability
5. Less/No Skills for Jobs (with better pay and benefits)
6. Lack of Affordable Transportation (to and from work)
7. Generational Poverty
8. Lack of Education
9. Bad Record/Background

Survey Results

A total of 123 community members completed the survey in communities throughout McKenzie Health's service area. For all questions that contained an "Other" response, all of those direct responses may be found in Appendix B. In some cases, a summary of those comments is additionally included in the report narrative. The "Total respondents" number under each heading indicates the number of people who responded to that particular question and the "Total responses" number under the heading depicts the number of responses selected for that question (some questions allow for selection of more than one response). An asterisk (*) indicates that survey respondents were able to select more than one answer response.

The survey requested that respondents list their home zip code. While not all respondents provided a zip code, 108 did, revealing that a large majority of respondents (67%, N=72) lived in the Watford City area (58854). The next highest area was Williston (58801) with 12% (N=13) and Arnegard (6%, N=6). There were two respondents from Sidney, Montana area and the remainder were from surrounding ND zip codes.

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

Survey Demographics

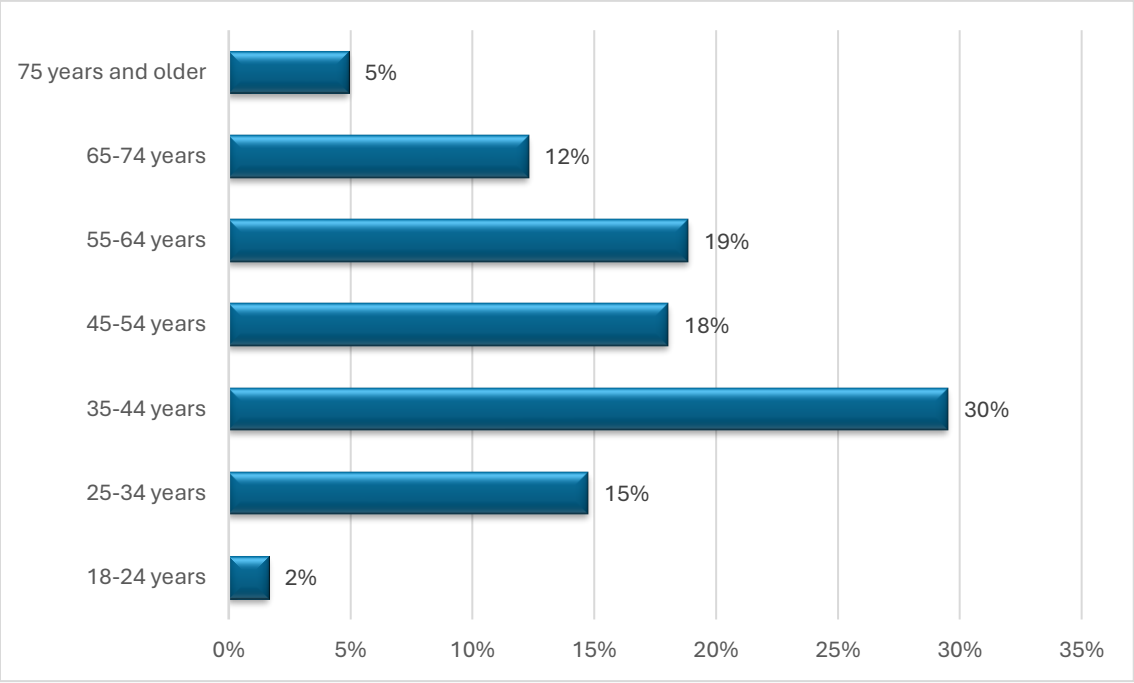
To better understand the perspectives being offered by survey respondents, survey-takers were asked a few demographic questions. Throughout this report, numbers (N) instead of just percentages (%) are reported because percentages can be misleading with smaller numbers. Survey respondents were not required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

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

- 30% (N=36) were age 55 or older.
- The majority (77%, N=94) were female.
- Just over half of the respondents (42%, N=51) had bachelor's degrees or higher.
- The number of those working full time (74%, N=89) was more than three times higher than those who were retired (12%, N=14).
- 91% (N=110) of those who reported their ethnicity/race were white/Caucasian.
- 22% of the population (N=24) had household incomes of less than $50,000.
- 79% (N=95) had insurance through their employer.

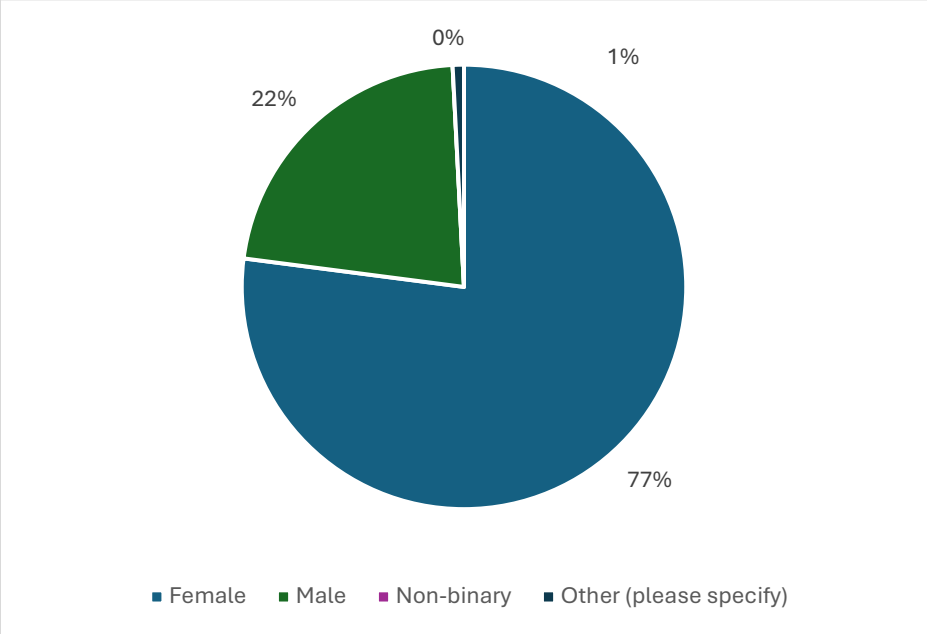
Figures 8 through 14 show these demographic characteristics. It illustrates the range of community members' household incomes and indicates how this assessment took into account input from parties who represent the varied interests of the community served, including a balance of age ranges, those in diverse work situations, and community members with lower incomes.

Figure 8: Age Demographics of Survey Respondents
Total respondents = 122



People under age 18 are not targeted using this survey method. Youth data is gathered from secondary sources.

Figure 9: Gender Demographics of Survey Respondents
Total respondents = 122



As shown in Figure 10, the large majority of respondents were white/Caucasian (91%). This is six percent higher than the race/ethnicity of the overall population of McKenzie County; the US Census indicates that 85% of the population is white in McKenzie County. Some of the discrepancy in survey completion is likely due to not being able to offer the survey in Spanish as well as English.

Figure 10: Race/Ethnicity Demographics of Survey Respondents
Total respondents = 121

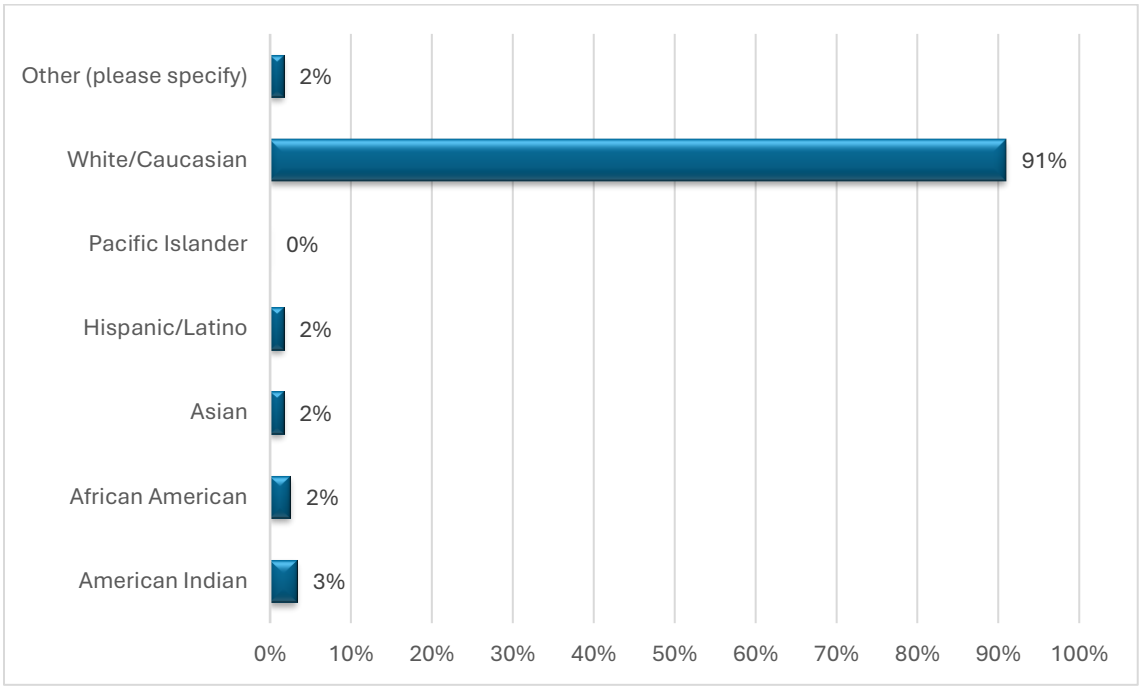


Figure 11: Educational Level Demographics of Survey Respondents

Total respondents = 121

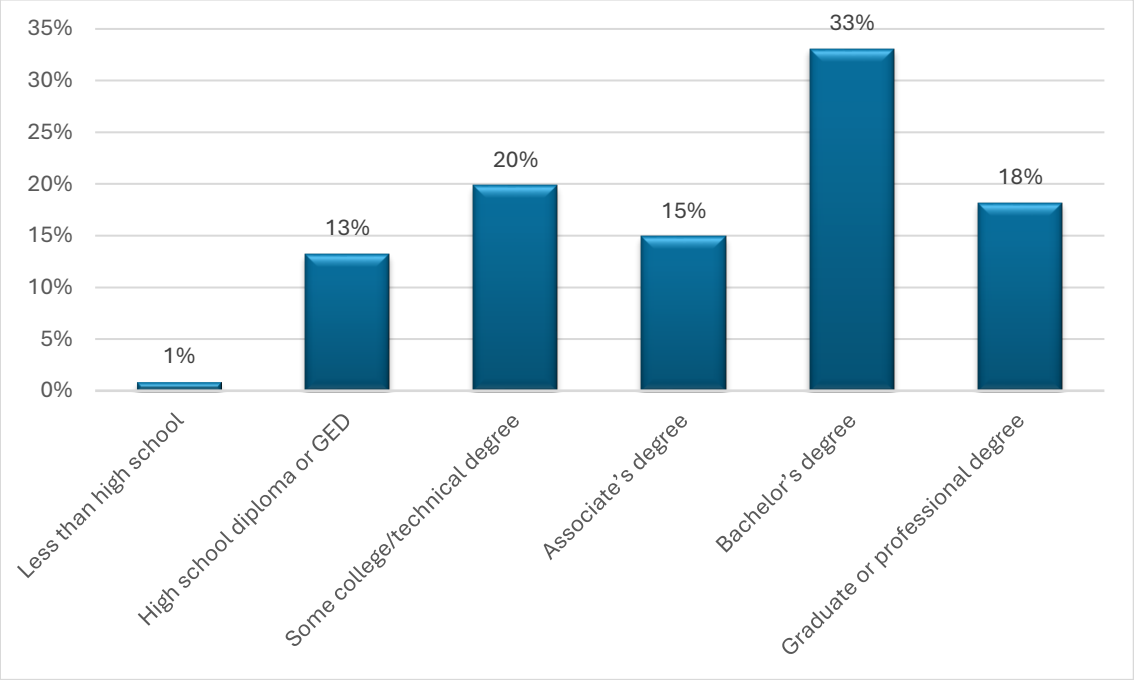
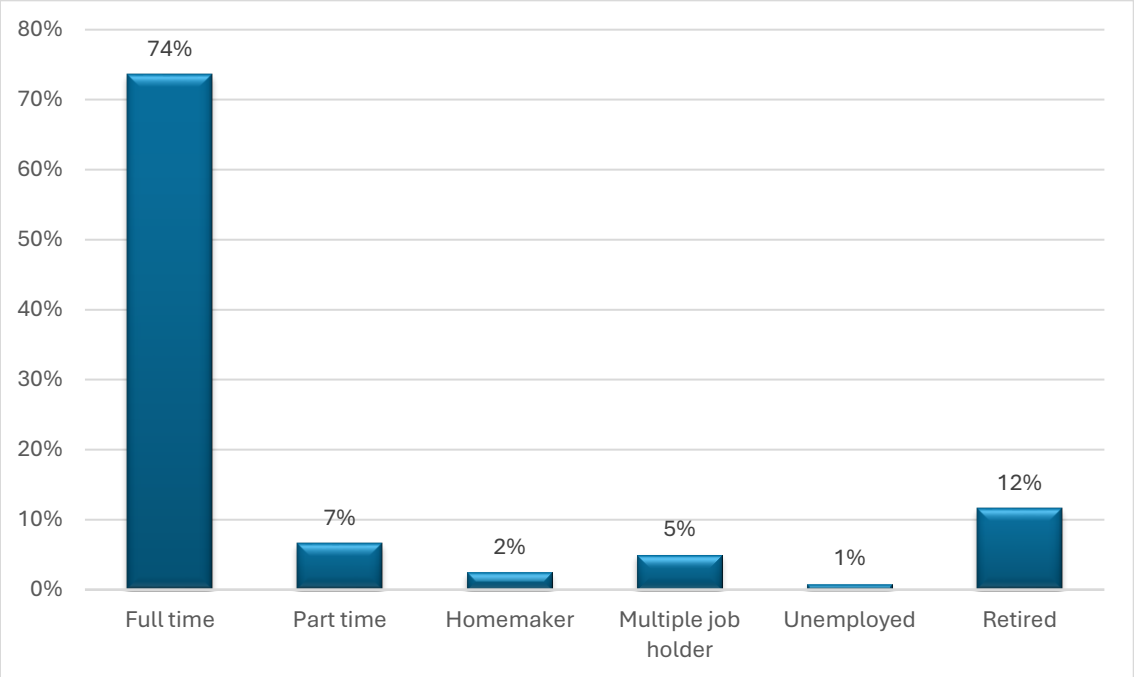


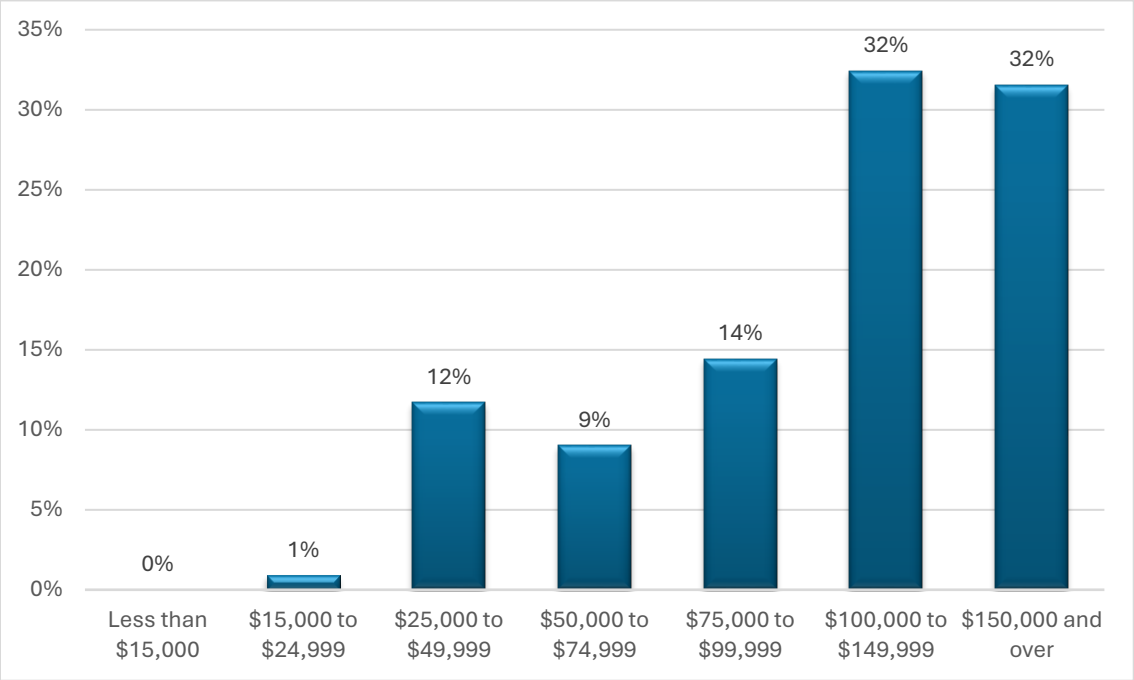
Figure 12: Employment Status Demographics of Survey Respondents

Total respondents = 121



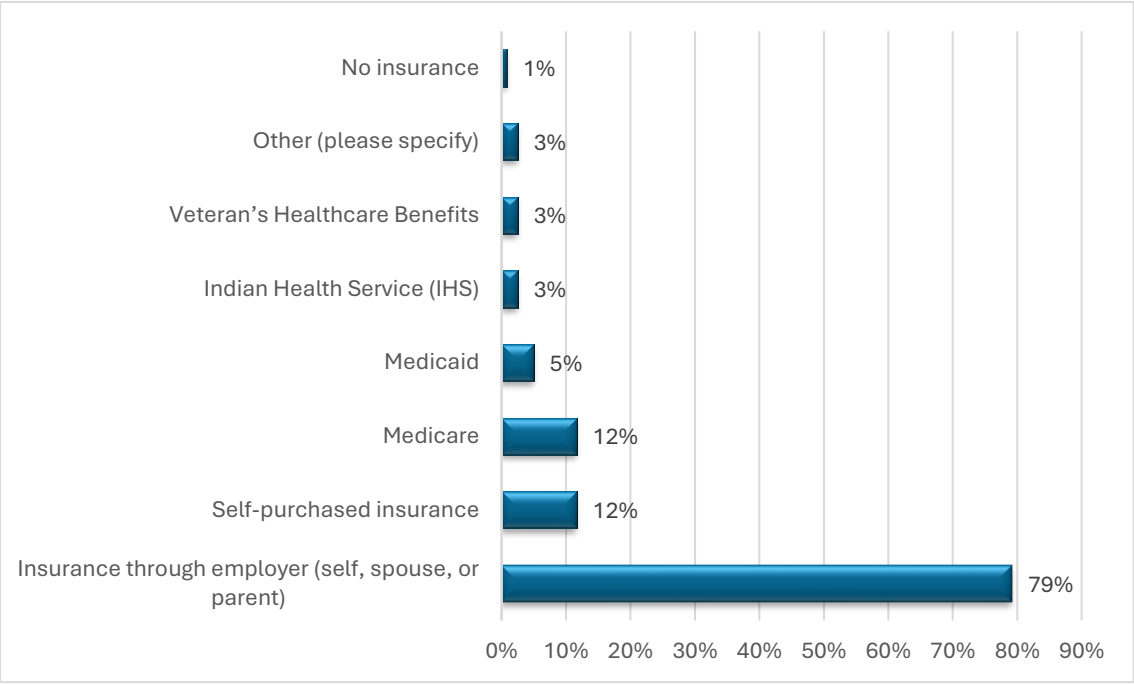
Of those who provided a household income, 13% (N=14) community members reported a household income of less than $50,000. Almost two-thirds, 64% (N=71) indicated a household income of $100,000 or more. This information is shown in Figure 13.

Figure 13: Household Income Demographics of Survey Respondents
Total respondents = 111



Community members were asked about their health insurance status, which is often associated with whether people have access to healthcare. Only one respondent reported having no health insurance. The most common insurance types were insurance through one's employer (N=95), followed by self-purchased (N=14) and Medicare (N=14). The "Other" responses were supplemental plans and COBRA.

Figure 14: Health Insurance Coverage Status of Survey Respondents
Total respondents = 120



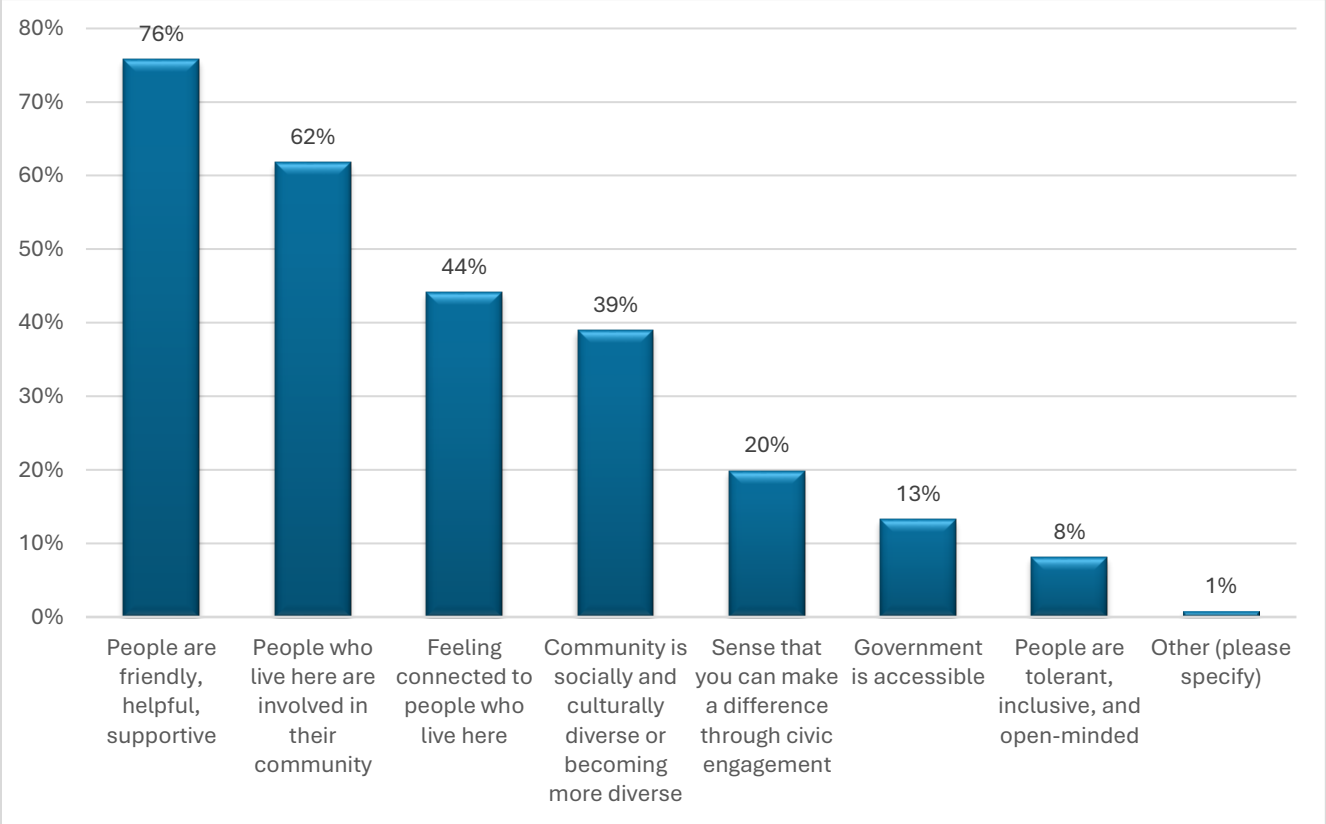
Community Assets and Challenges

Survey-respondents were asked what they perceived as the best things about their community in four categories: people, services and resources, quality of life, and activities. In each category, respondents were given a list of choices and asked to pick the three best things. Respondents occasionally selected less than three or more than three choices within each category. The results indicate there is consensus (with at least 80 respondents agreeing) that community assets include:

- People are friendly, helpful, supportive (N=103);
- Family-friendly; good place to raise kids (N=89);
- People who live here are involved in their community (N=84); and
- Job opportunities or economic opportunities (N=83);

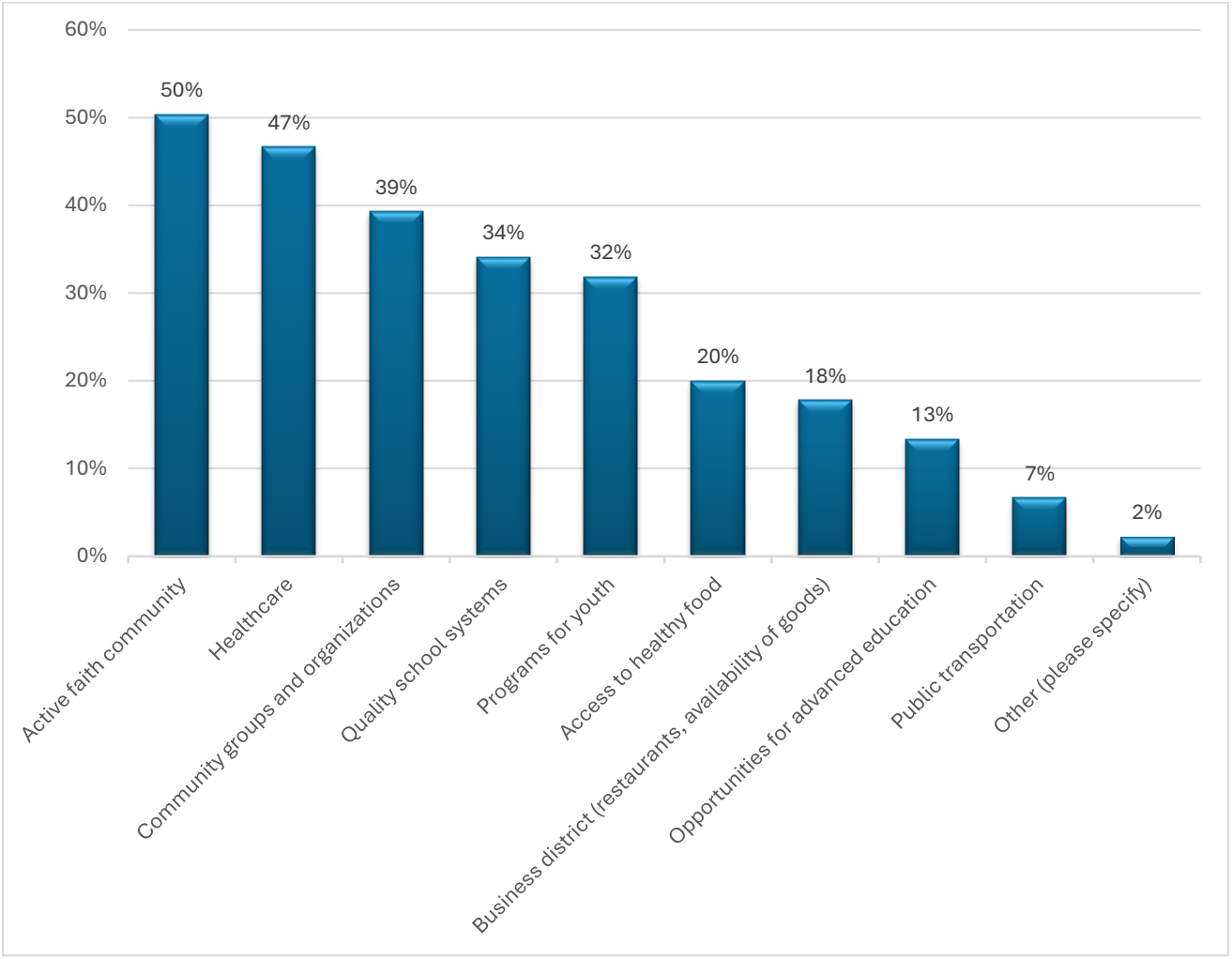
Figures 15 to 17 illustrate the results of these questions.

Figure 15: Best Things about the PEOPLE in Your Community
Total responses = 136



Included in the "Other" category of the best things about the people was that they are hard working.

Figure 16: Best Things about the SERVICES AND RESOURCES in Your Community
Total responses = 135



Economic opportunity and low population density were other items listed in the best things about services and resources.

Figure 17: Best Things about the QUALITY OF LIFE in Your Community
Total responses = 135

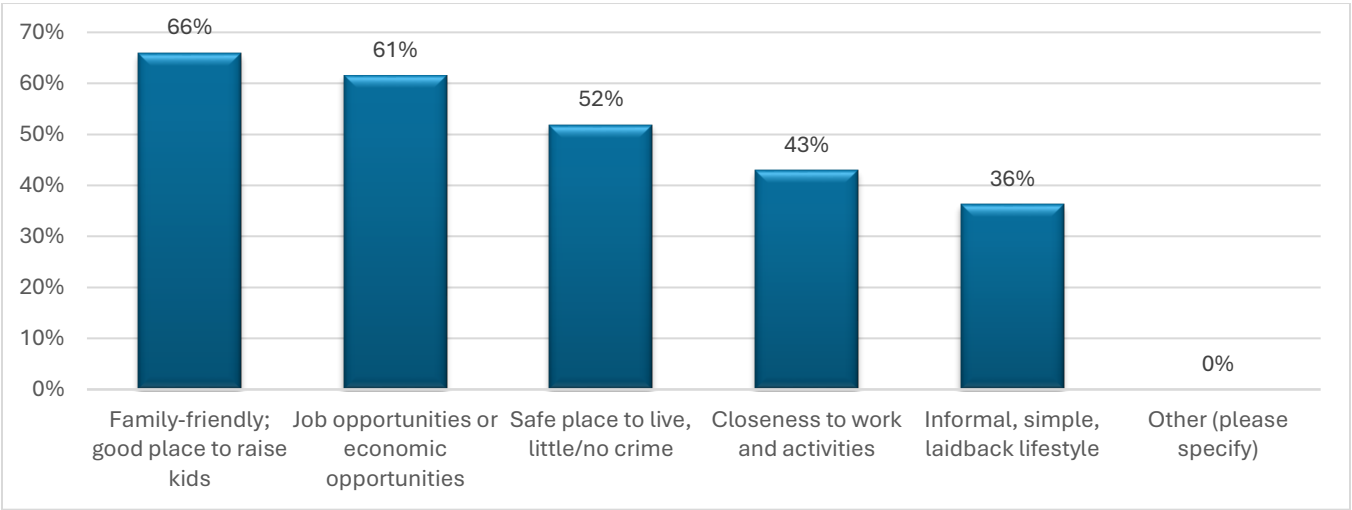
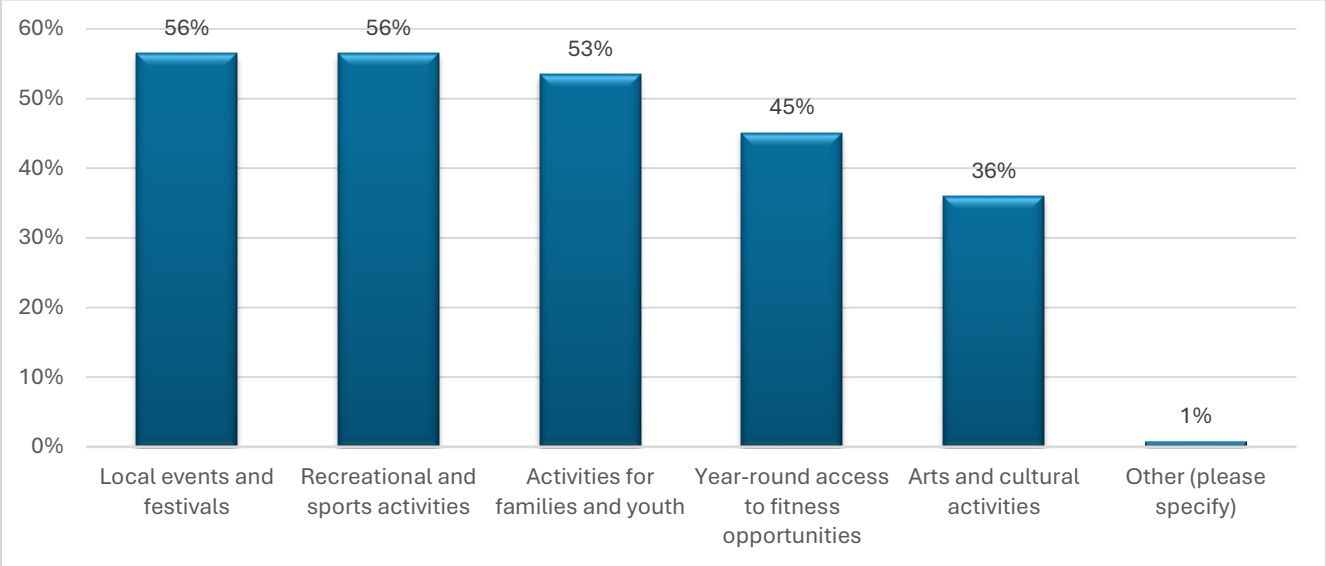


Figure 18: Best Thing about the ACTIVITIES in Your Community
Total responses = 122



Community Concerns

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

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

With regard to responses about community challenges, the most highly voiced concerns (those having at least 50 respondents) were:

- Not enough affordable housing (N=86);
- Depression/anxiety – Youth (N=60);
- Alcohol use and abuse – Adults (N=56);
- Smoking and tobacco use, exposure to second-hand smoke, or vaping - Youth (N= 54);
- Stress – Adult (N=54)
- Drug use and abuse (including prescription drugs) – Youth (N=53);
- Availability of resources to help the elderly stay in their homes (N=53);
- Cost of long-term/nursing home care (N=53); and
- Drug use and abuse (including prescription drugs) – Adults (N=51);

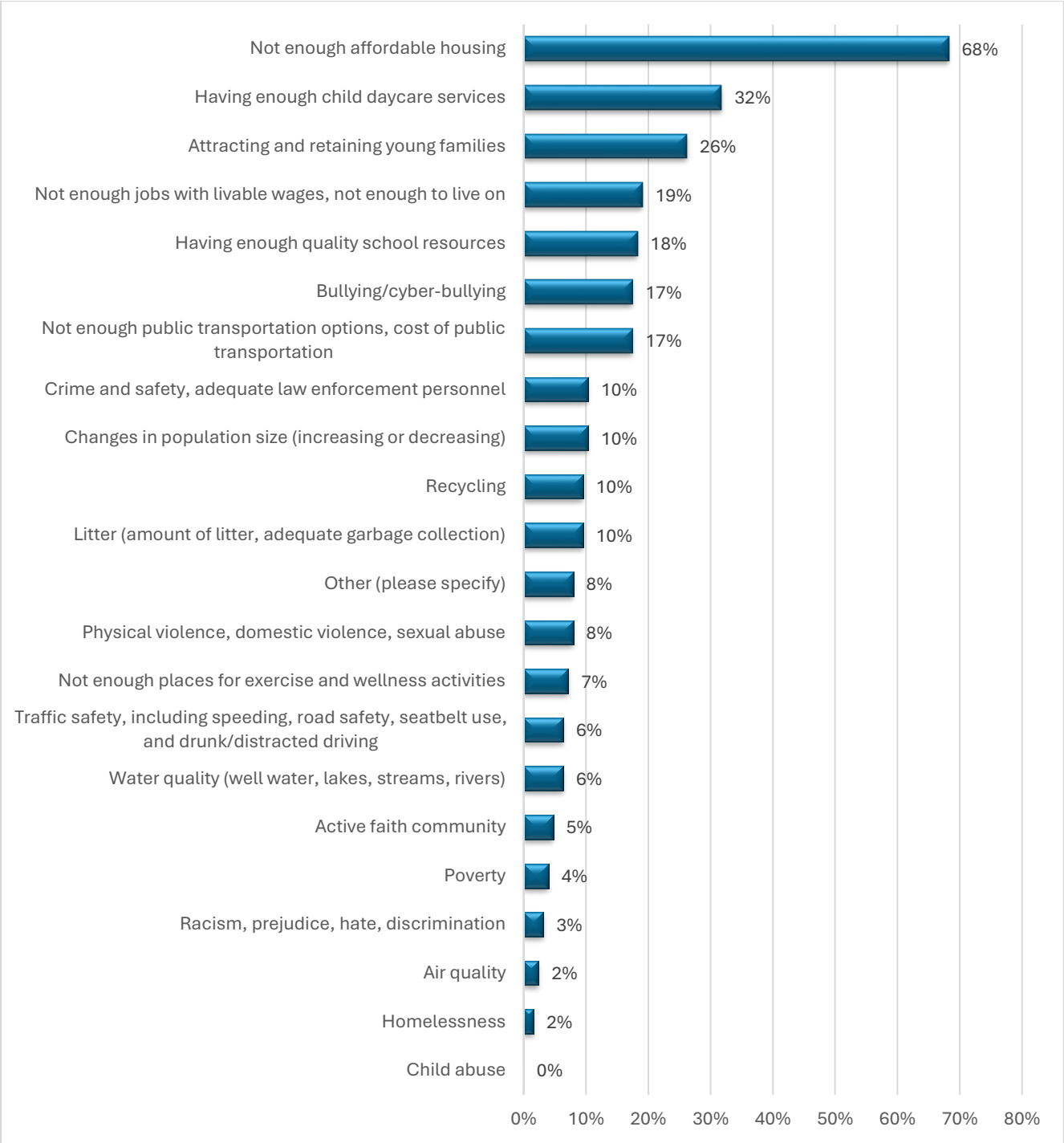
The other issues that had at least 40 votes included:

- Long-term/nursing home care options (N=47);
- Alcohol us and abuse – Youth (N=46);
- Suicide (N=44);
- Availability of mental health services (N=43); and
- Having enough child daycare services (N=40).

For questions that had long responses that are truncated in the charts, the full text is in italics below each chart.

Figures 19 through 24 illustrate these results.

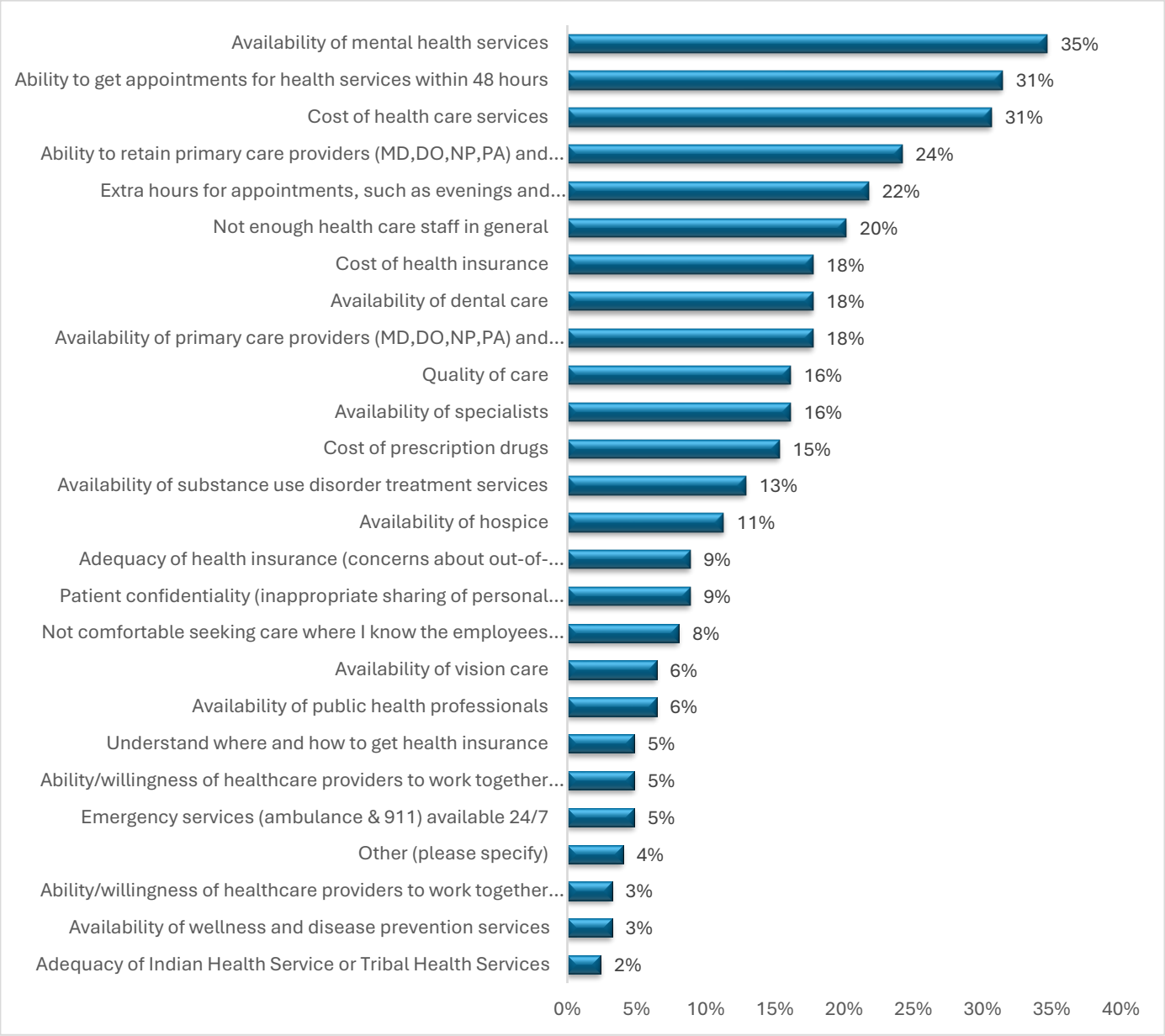
Figure 19: Community/Environmental Health Concerns
Total responses = 126



In the "Other" category for community and environmental health concerns, the following were listed: mail services, schools - ESL, mental health challenges, access to affordable healthy food, not enough things for young people to do, not enough healthcare, affordable counseling for children, lack of specialists.

Figure 20: Availability/Delivery of Health Services Concerns

Total responses = 124

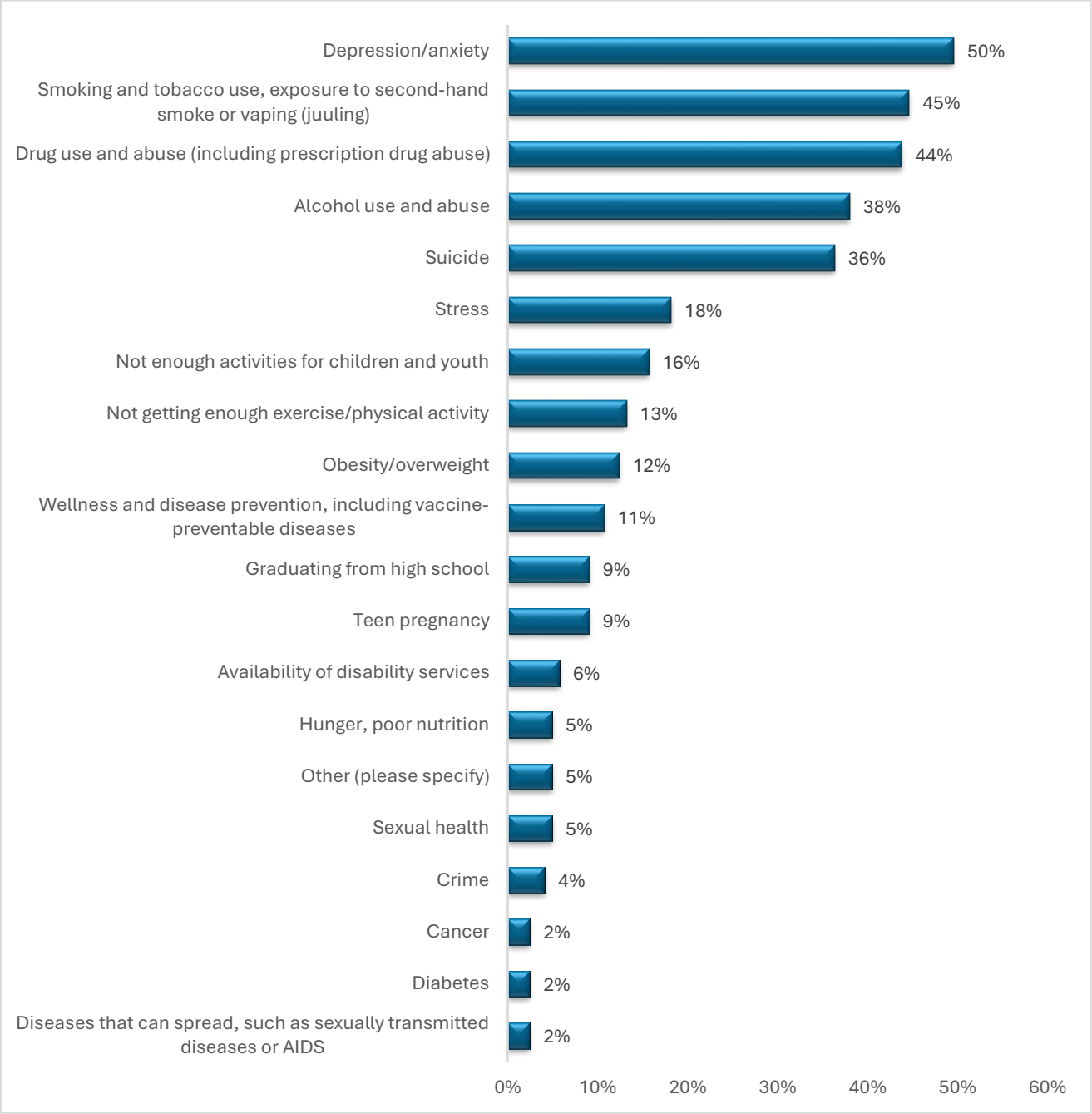


Cut-off chart text:

- *Ability to retain primary care providers (MD,DO,NP,PA) and nurses in the community*
- *Extra hours for appointments, such as evenings and weekends*
- *Availability of primary care providers (MD,DO,NP,PA) and nurses*
- *Adequacy of health insurance (concerns about out-of-pocket costs)*
- *Not comfortable seeking care where I know the employees at the facility on a personal level*
- *Ability/willingness of healthcare providers to work together to coordinate patient care outside the health system*
- *Ability/willingness of healthcare providers to work together to coordinate patient care within the health system*

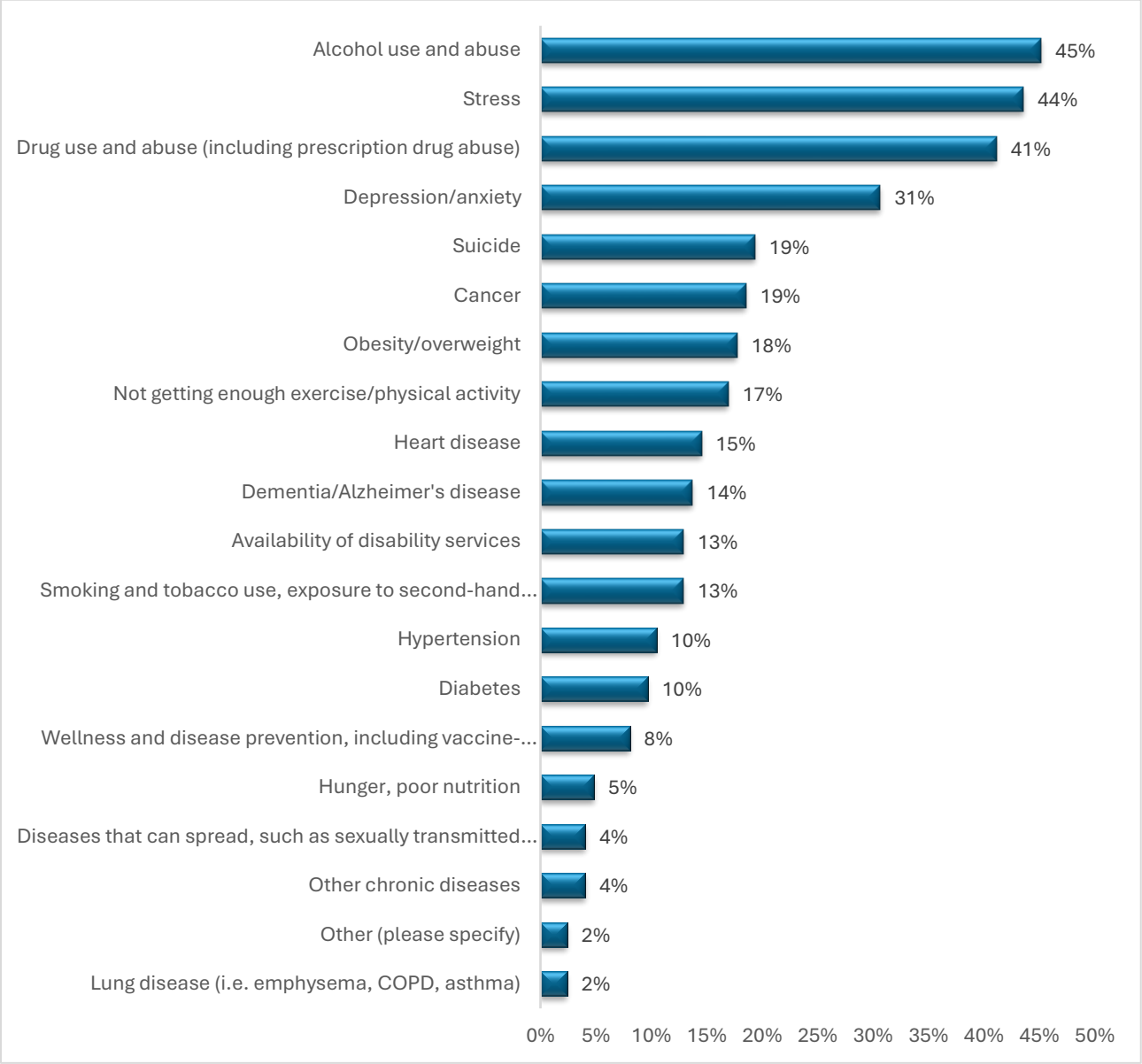
In the "Other" category for Availability/Delivery of Health Services Concerns were more space needed in the nursing home/needing to keep nursing home residence local, low blood supply, lack of providers.

Figure 21: Youth Population Health Concerns
Total responses = 121



Comments included in the "Other" category for the Youth Population included lack of self-harm resources in the school, importance of blood donation, social media, bullying, and quality of education.

Figure 22: Adult Population Concerns
Total responses = 124

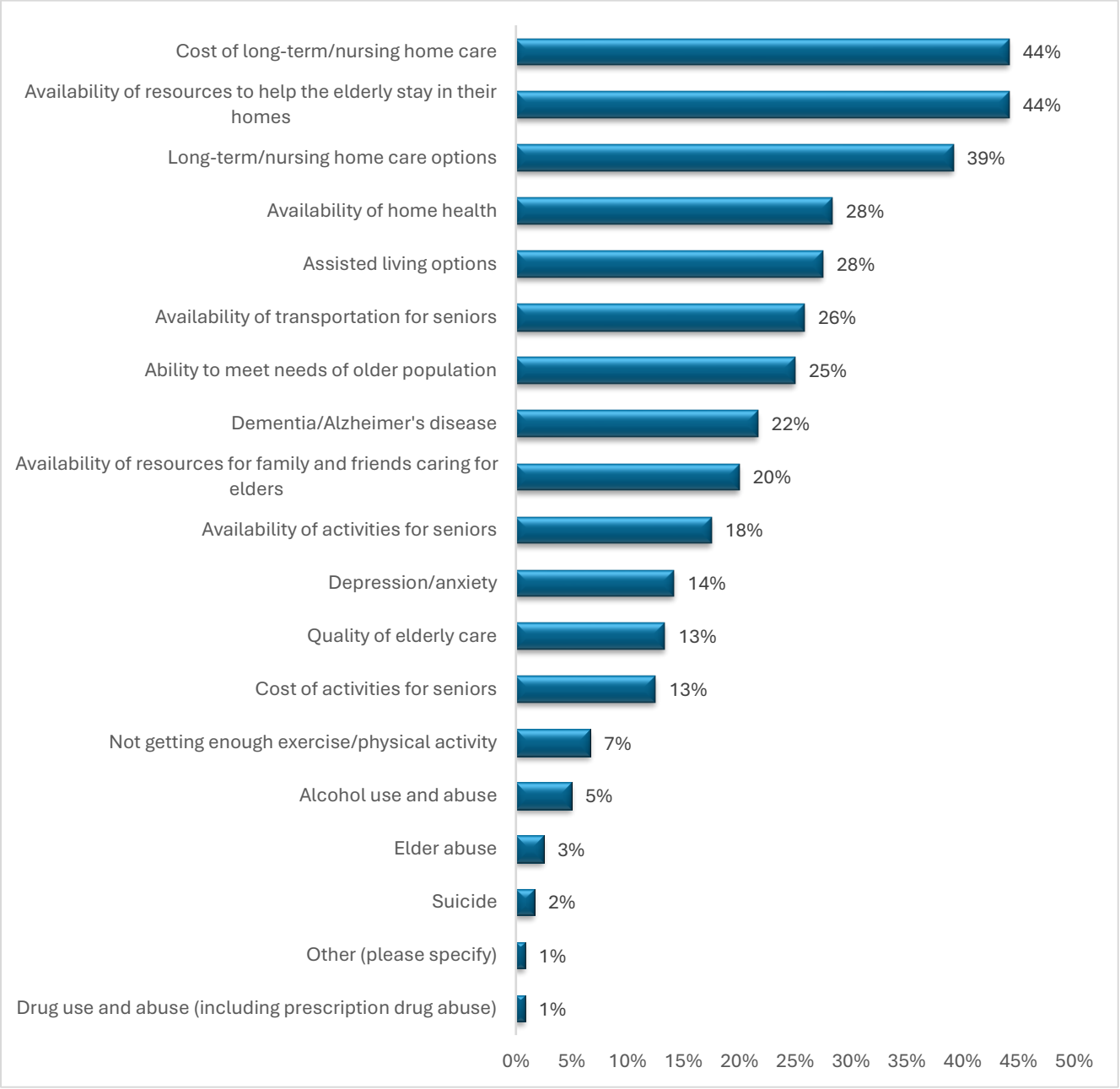


Cut-off chart text:

- *Smoking and tobacco use, exposure to second-hand smoke or vaping (juuling)*
- *Wellness and disease prevention, including vaccine-preventable diseases*
- *Diseases that can spread, such as sexually transmitted diseases or AIDS*

Comments included in the "Other" category for the Adult Population Concerns included cost of food and overall health.

Figure 23: Senior Population Concerns
Total responses = 120



In the "Other" category, the one concern was hunger and poor nutrition.

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

1. Housing
2. Elderly care

Other biggest challenges that were identified were housing and care for the elderly. Housing was by far the biggest concern listed. Elderly care had a significant number of mentions, and other challenges not identified as often were mental health, drugs, healthcare, things to do for youth, stress, events to meet people, and costs of healthcare and long-term/nursing home care.

Delivery of Healthcare

The survey asked about the health and health care of the survey respondents. They were asked to rate their overall health from poor to excellent. In another question they were asked to indicate any chronic conditions that applied to them. Finally, they were asked if they had a primary care physician. A primary care provider manages chronic diseases, promotes comfort and transparency of medical history, lower overall healthcare costs, ensures routine screenings for early detection before minor issues become big concerns, and refers to specialty care when necessary.

Figure 24-26 illustrates the results of each.

Figure 24: How would you rate your overall health?
Total responses = 123

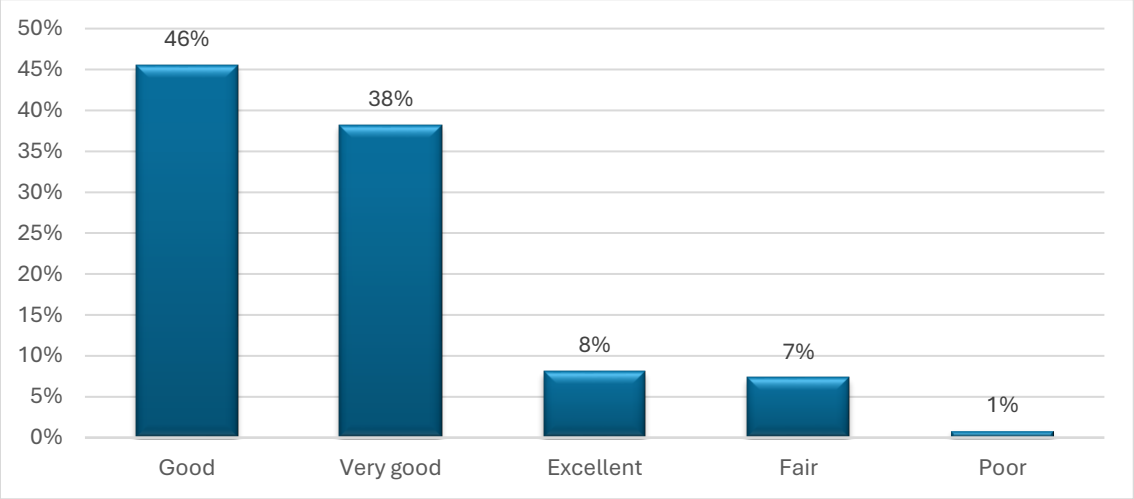
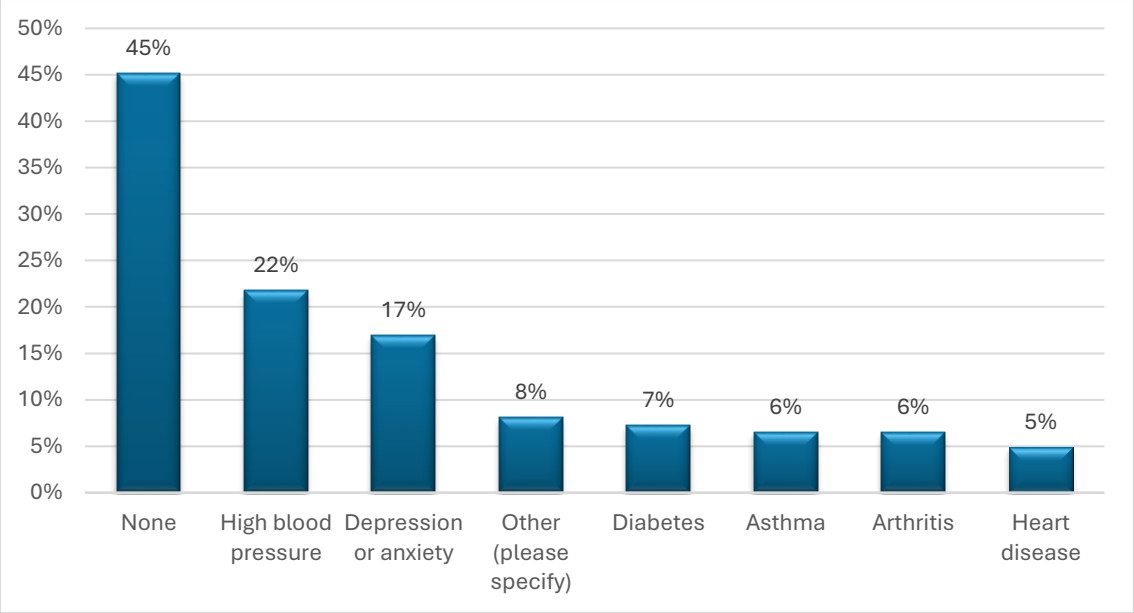
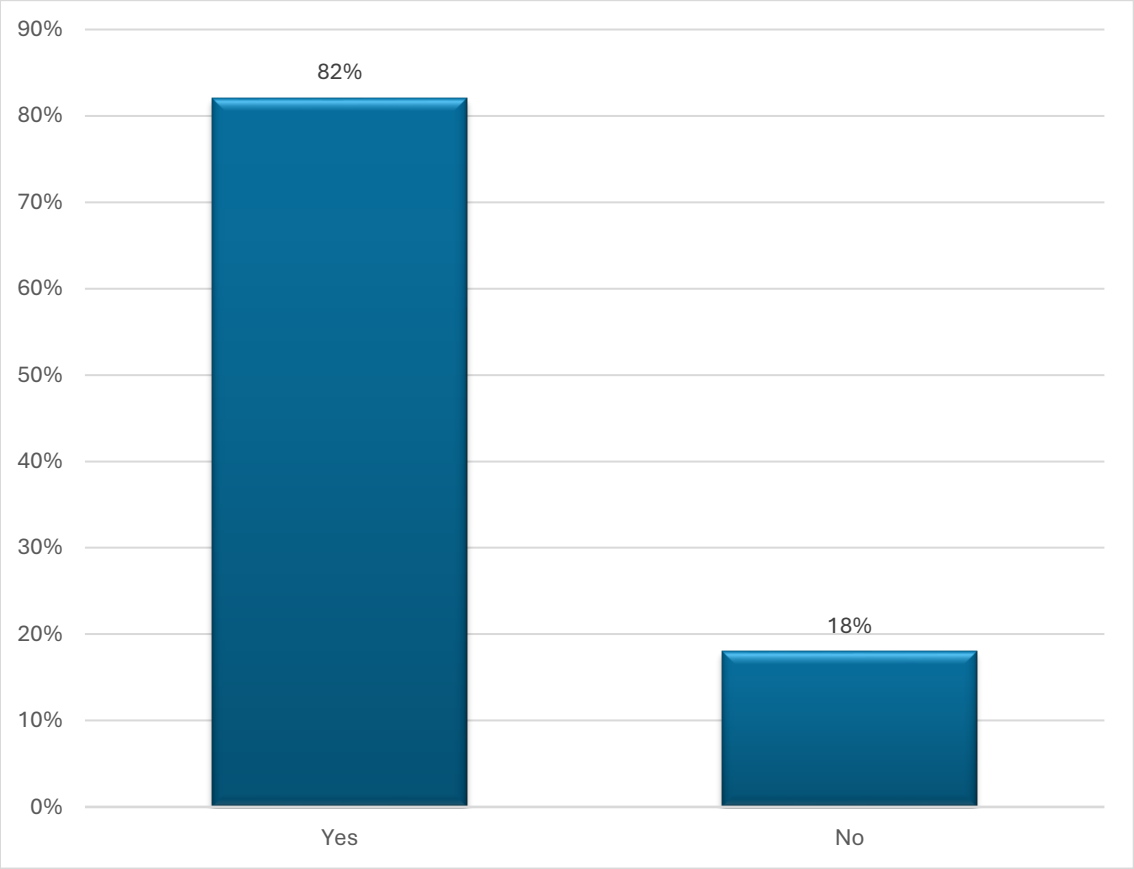


Figure 25: Do you have any chronic conditions (check all that apply)
Total responses = 124



Other responses included, but weren't limited to: gout, still trying to figure out what is wrong, osteoporosis, irritable bowel syndrome, low blood pressure, and hormone replacement therapy.

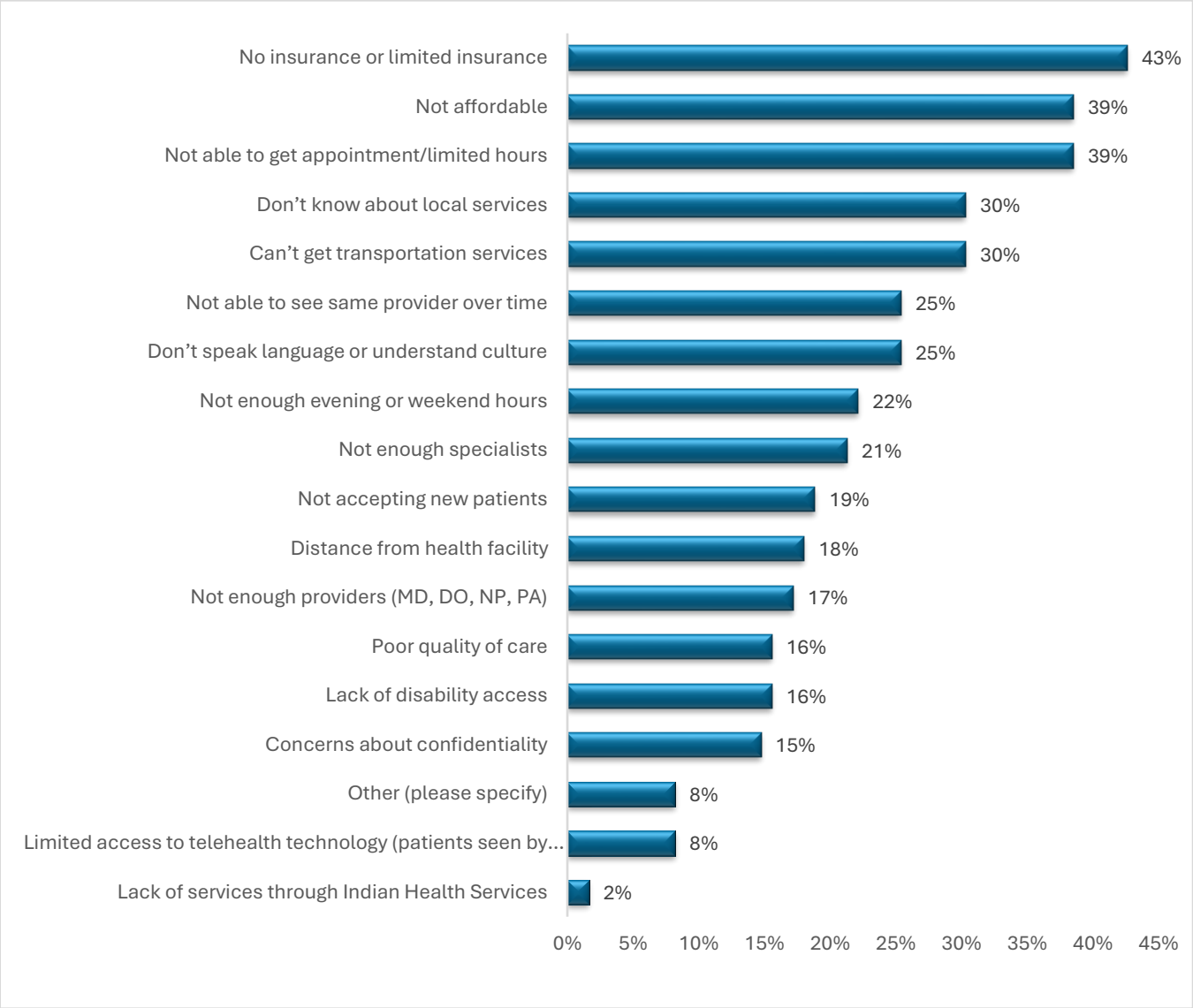
Figure 26: Do you have a primary care physician?
Total responses = 117



The survey asked residents what they see as barriers that prevent them, or other community residents, from receiving healthcare. The most prevalent barrier perceived by residents was no insurance or limited insurance (N=52), not affordable (N=47), and not able to get appointment/limited hours (N=47). After these, the next most commonly identified barriers were that they didn't know about the local services (N=37) and can't get transportation services (N=37). The concern in the "Other" category were primarily costs, 24-hour pharmacy availability, timing of specialists being onsite, hours of urgent care, and general reluctance to seek care.

Figure 27 illustrates these results.

Figure 27: Perceptions about Barriers to Care
Total responses = 122

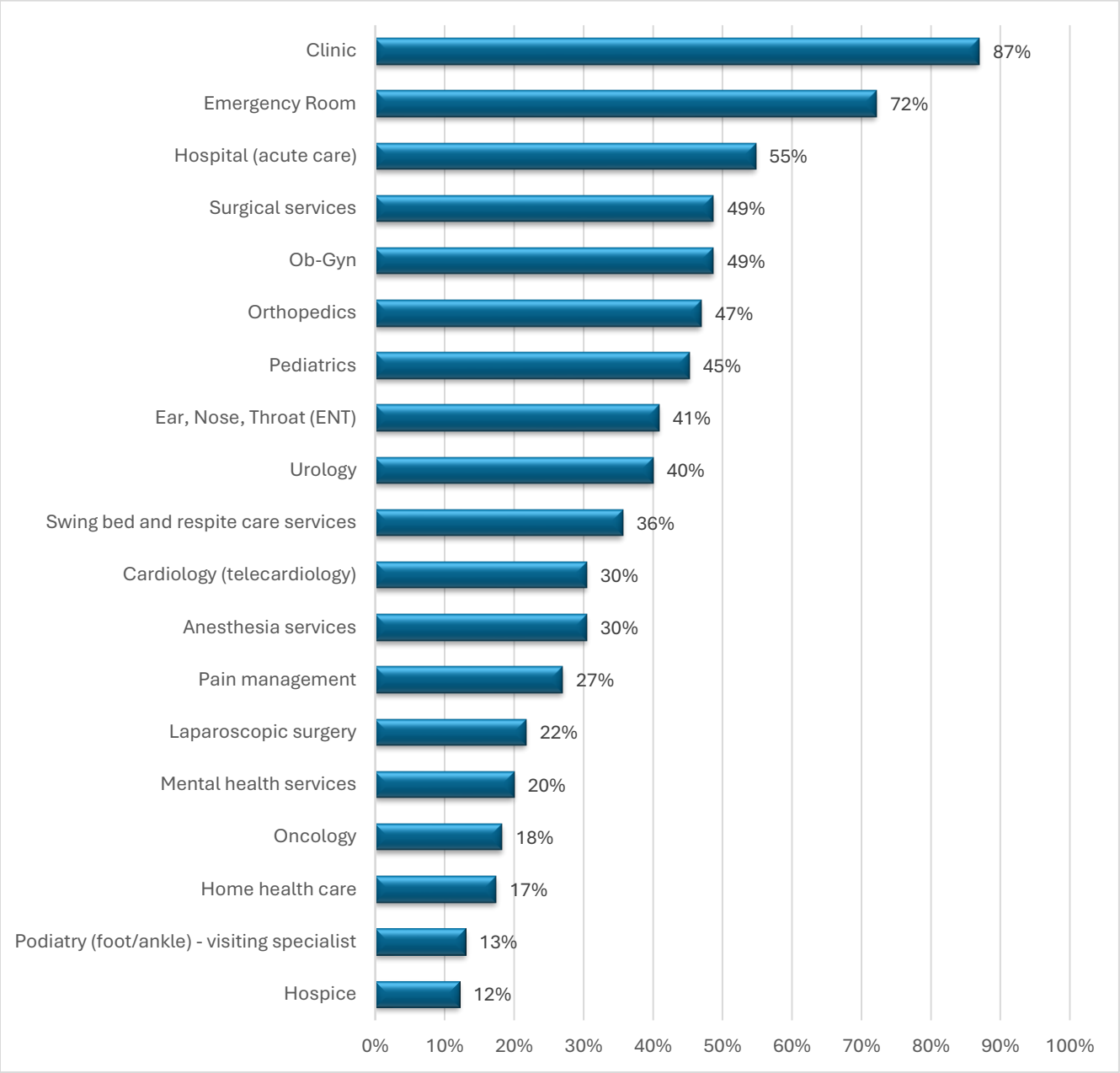


Cut-off chart text:

- *Limited access to telehealth technology (patients seen by providers at another facility through a monitor/TV screen)*

Survey takers were asked to consider services offered at McKenzie Health and then indicate which services they are aware of or have used in the past year. Assisted living and swing bed were the most recognized services. See Figure 28 for the full list.

Figure 28: Services Utilized/Aware of at McKenzie Health
Total responses = 115



In an open-ended question, respondents were asked what specific healthcare services, if any, they think should be added locally. The most desired service to add locally was more specialists (dermatology, podiatry, cardiology, oncologist, rheumatology, neurology, etc.). Other requested services included:

- Mental health services
- More primary care physicians
- Substance abuse treatment services
- Telehealth
- Weekend and evening services
- Therapists/Counselors (marriage, family, child, weight loss)

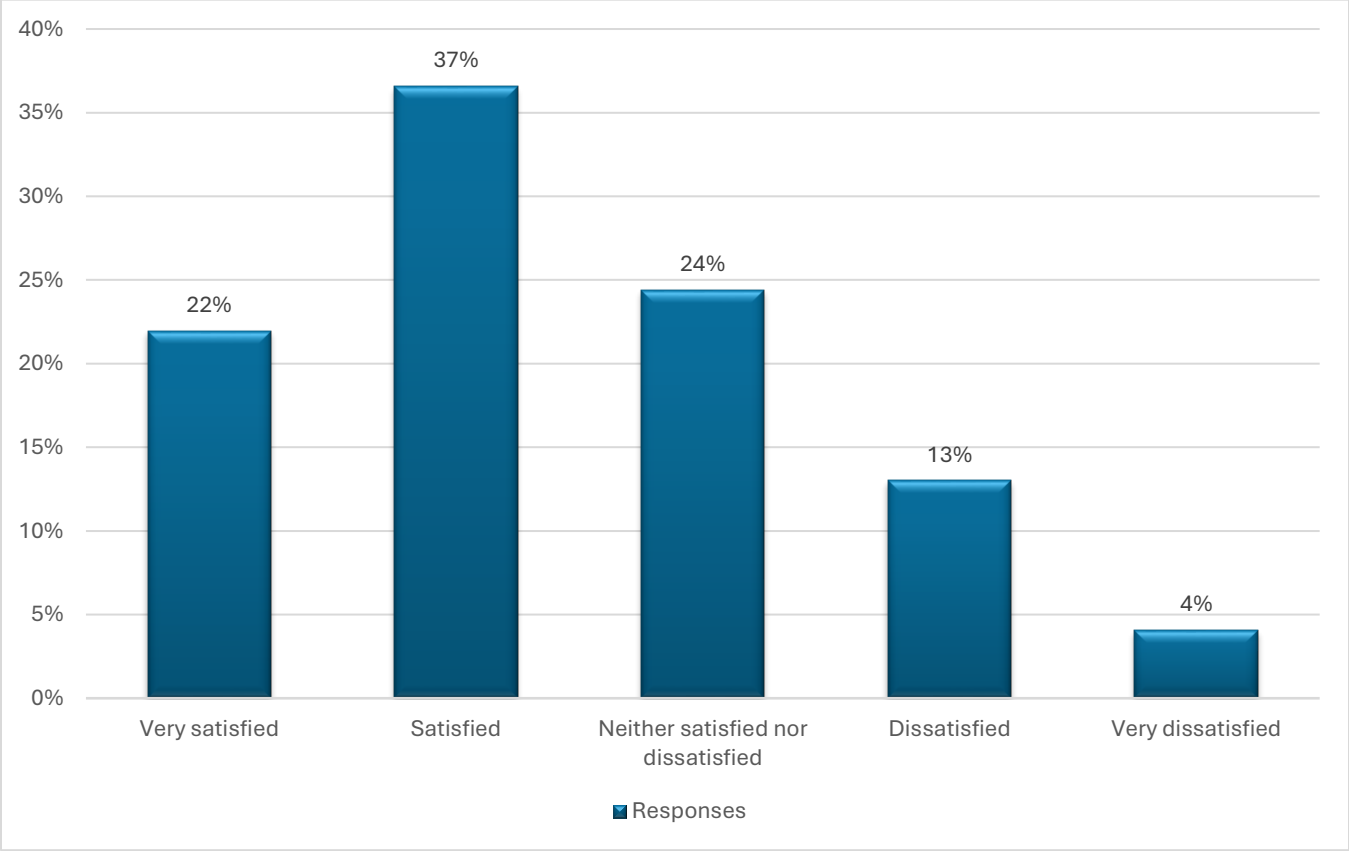
A full list of survey responses is provided in Appendix B.

The key informant and community group members felt it would be beneficial to add in-house translation services, such as interpreters. However, they recognize that this would be difficult to recruit.

The key informant and focus group members didn't feel that the community members were aware of all the services that the health system offers. Because of the high transient population, it is difficult to reach all the people that are routinely rotating in and out of the community. The population, relative to most of North Dakota, is also quite diverse with a large number not speaking English as their first language. This makes it more difficult to make the community as a whole aware of what services are available and how to access them. The participants also felt that few knew all that the local public health unit has to offer regarding services for the community.

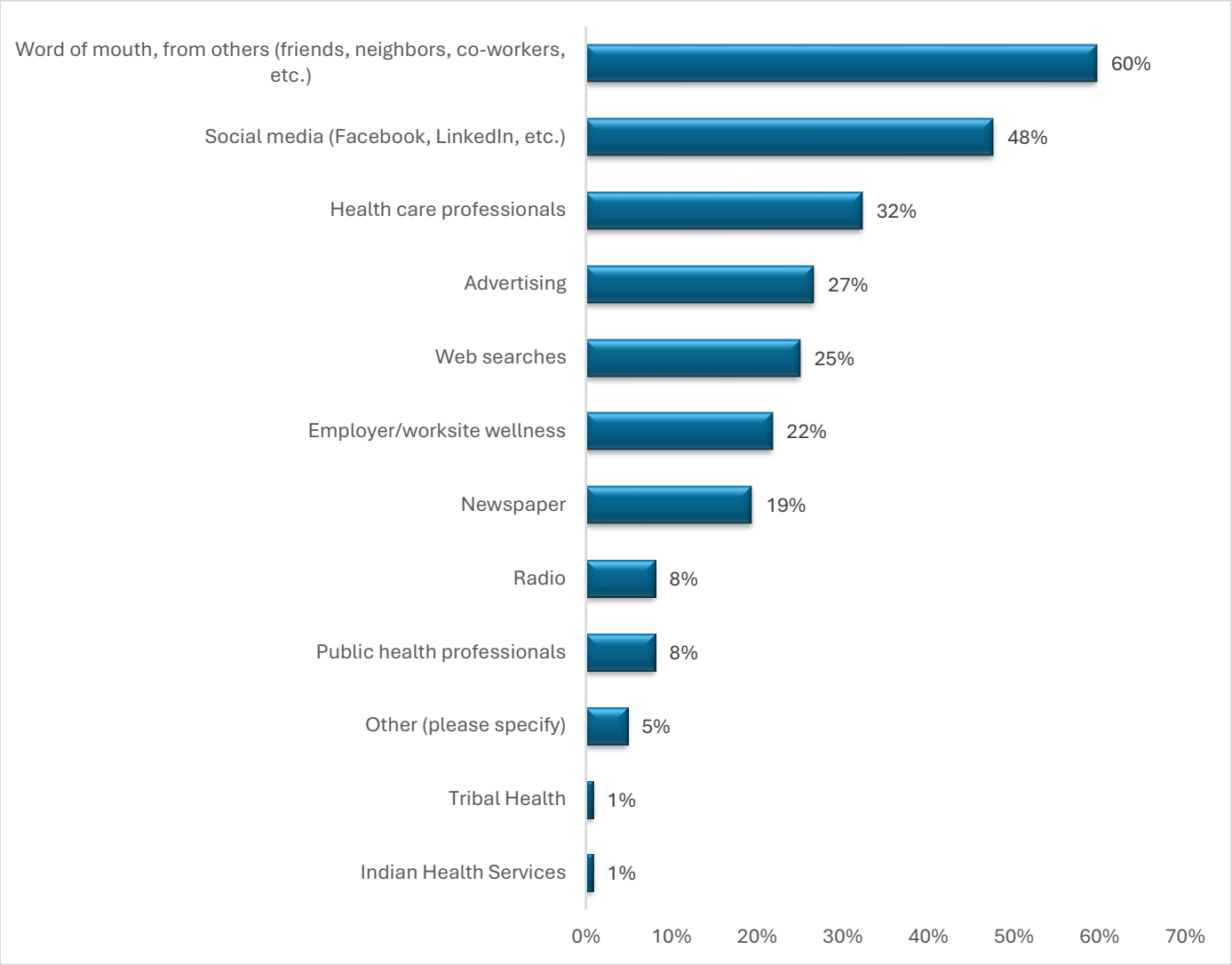
Survey respondents rated how satisfied they are with the healthcare services in their community from very satisfied to very dissatisfied. The majority of respondents were satisfied.

Figure 29: Satisfaction with the Community's Healthcare Services
Total responses = 123



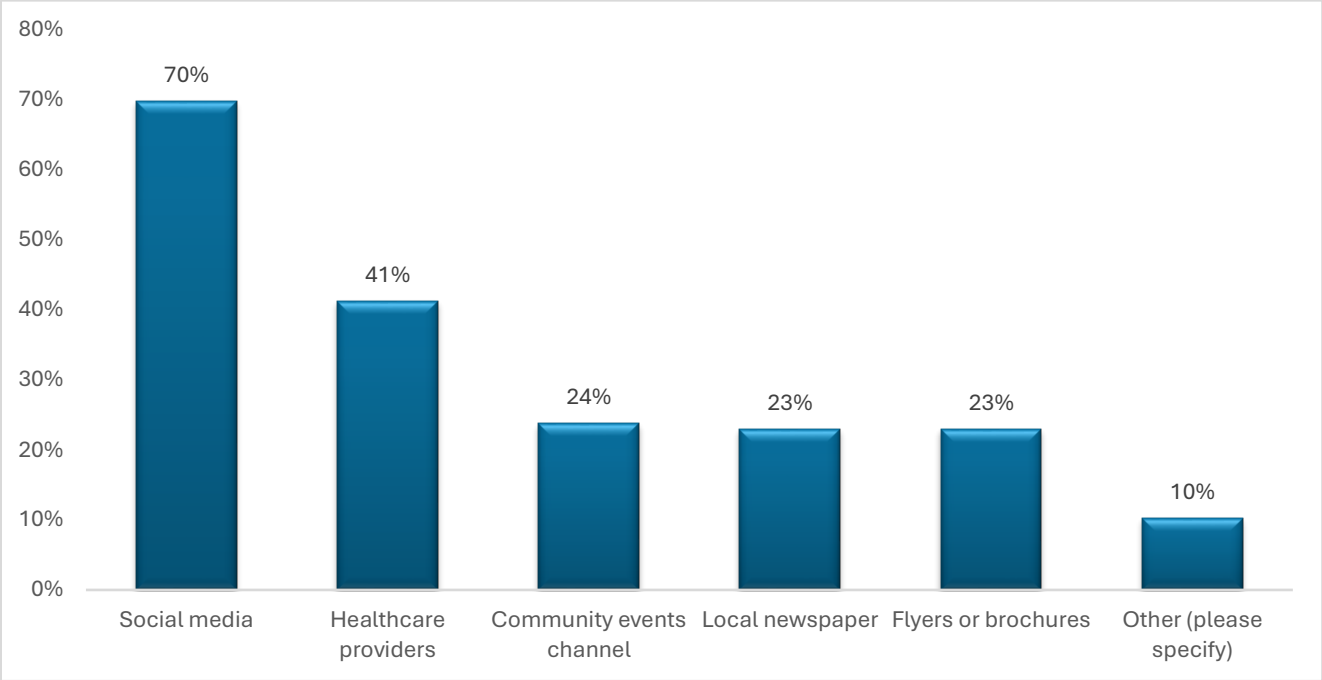
To get a better understanding of how community members receive information about what health services are available locally and what their preference in mode of receiving is, a couple questions were asked (Figure 30 and 31). Word of mouth was the top way that people find out about local services, followed by social media.

Figure 30: Where You Find Out About Local Health Services
Total responses = 124



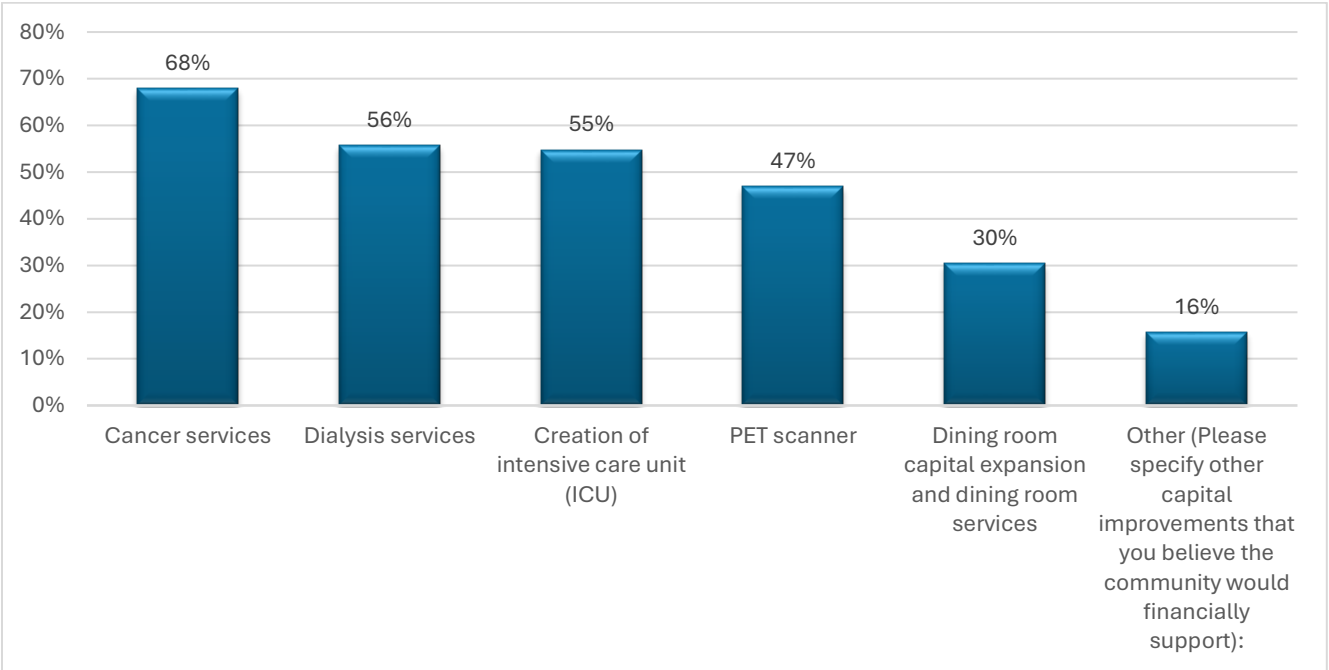
When asked what the best way for you to receive information about health services and resources, respondents indicated social media followed by healthcare providers as the top sources. Figure 31 illustrates these results. Other responses included website, email, Facebook, economic development authority, job development authority, Rotary, online advertisements, and web searches.

Figure 31: Best Way to Receive Information about Health Services and Resources
Total responses = 126



In an effort to gauge how individuals in the community would financially support capital improvements by McKenzie Health, a question was asked that provided options for people to choose ways that they believed the community would be financially supportive (see Figure 32).

Figure 32: Financial Support for Capital Improvements by McKenzie Health
Total responses = 115



Other types of capital improvements that were recommended included movie theater at Food Shepherd Home – this received many mentions. Others were 7 days a week urgent care clinic or pediatric clinic, bariatric counseling

and services, expanding Fit For Life program, improved or new clinic facilities, hiring more professionals locally, and inpatient mental health/mental health services.

The final question of the survey asked respondents to share concerns and suggestions to improve the delivery of local healthcare. Thirty-three responses were received.

Recommendations for changes include more advertisements about available services and costs, availability of the walk-in clinic and urgent care, and more education about how to use the emergency room. A suggestion was made that when businesses have a new hire it would be nice to take them on a tour of the hospital and have them shake the hands of the admission staff, clinic staff, doctors and nurses while highlighting the hospital's success.

Additional things people would like to see added include evening and weekend appointments so people don't have to go to the emergency room if something comes up and counselors that can take new patients.

Relating to care providers, higher quality of care from providers and hiring additional staff as the hospital grows to prevent burnout from the current staff were indicated as suggestions. Geography and retention for the area is tough, is there a way to work with recruiters like 3RNet to help bring in healthcare professionals that can handle a city that is medium-sized but still has a very 'small town feel' and lack of some amenities that some other slightly larger cities have? Having more quality healthcare professionals in town helps both the provider and patient (preventing burnout, keeping providers from seeing too many patients a day, and the patient feels more connected to the provider and healthcare system, more prone to go in and get preventative care instead of waiting in the ER).

When it comes to specialists, a recommendation was made to hire specialists that live in the area for more availability rather than only coming twice a month. Others say that it is frustrating when they're only available a certain number of days per month.

Improvement of leadership. Someone local who understands and cares. Someone who has lived through the growth and will be here when it’s done.

It was mentioned a couple of times that improving on the current services instead of expanding would be preferable. Also, there is a need to be concerned with consistent quality providers before adding new services and facilities. If a person does not even want to go to the clinic because of the poor service, they are not going to go to a specialty clinic or provider though MCHS. However, also to note, the options for healthcare services and the addition of new doctors has been a huge improvement according to one respondent.

Findings from Key Informant Interviews & the Focus Group

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

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

- Alcohol use and abuse – youth and adult
- Availability of mental health services
- Cost of long-term/nursing home care
- Depression/anxiety – all ages
- Not enough affordable housing

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

Alcohol use and abuse

- Alcohol abuse is a concern for those in this community.
- Alcohol use and abuse – with every crime there is alcohol involved even if it isn't at the bar, it's at home.

Availability of mental health services

- Care for those struggling with substance use disorders - alcohol and drugs. Working together within the community to provide inclusive and respectful healthcare treatment while waiting or receiving substance use disorder treatment in the community.
- Mental health is a big concern.
- Mental health services – when people have resources to help them through things that can change everything for them – can make or break a person.

Depression/anxiety

- The stress that youth are faced with leads to depression and anxiety and ultimately can lead to suicide if they don't get help.
- This is a top concern for our community.

Not enough affordable housing

- While it isn't like it was during the boom, this continues to be a problem.
- Hard to get people to move here when there aren't decent houses that people can afford.
- Affordable housing – not enough available.
- Impacts every aspect of everyday life – cost of housing and lack of housing.
- This includes having affordable long-term care/nursing home care for our seniors.

Community Engagement and Collaboration

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

- Emergency services, including ambulance and fire (4.42)
- Law enforcement (4.27)
- Economic development organizations (4.17)
- Hospital (healthcare system) (4.08)
- Business and industry (3.83)

- Long-term care, including nursing homes and assisted living (3.83)
- Schools (3.67)
- Pharmacy (3.36)
- Faith-based (3.25)
- Public health (3.25)
- Clinics not associated with McKenzie Health (3.0)
- Other local health providers, such as dentists and chiropractors (3.0)
- Human/Social Services (2.92)

Limitations

The Community Survey results are meant to represent the opinions and needs of the general population in McKenzie Health's service area. This survey used a convenience sampling method as it was distributed and made broadly available throughout the service area. The survey was only available in English, so there may have been some people unable to complete the survey due to a language barrier. It should be noted that when looking at survey demographics, most respondents were white females. Half had at least a bachelor's degree or higher. Most respondents were also fully employed and nearly two-thirds reported income exceeding $100,000. As a convenience sampling method was employed, data findings may not necessarily represent the entire community.

Prioritization of Health Needs

A community group composed of those that attended the first community meeting as well as the key informants met on March 11, 2025. Twelve community members attended the meeting. A facilitator from Cibolo Health presented the group with a summary of this report's findings, including background and explanation about the secondary data, highlights from the survey results (including perceived community assets and concerns, and barriers to care), and findings from the key informant interviews.

Following the presentation of the assessment findings, and after considering and discussing the findings, all members of the group were asked to identify what they perceived as the top four community health needs. All of the potential needs were listed and attendees noted their three items of biggest concern.

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

- Availability of mental health services (6 votes)
- Not enough affordable housing (5 votes)
- Drug use and abuse (including prescription drug abuse) (5 votes)

From those top three priorities, each attendee voted on the one item they felt was the most important to address in the next three years. The rankings were:

1. Availability of mental health services (11 votes)
2. Not enough affordable housing (2 votes)
3. Drug use and abuse (including prescription drug abuse) (1 vote)

Upon completion of the prioritization process, the number one identified need, as voted on by those attending the second community meeting, was the availability of mental health services. A summary of this prioritization may be found in Appendix I.

Comparison of Needs Identified Previously

Top Needs Identified 2022 CHNA Process	Top Needs Identified 2025 CHNA Process
Not enough affordable housing	Availability of mental health services
Availability of resources to help the elderly stay in their homes	Not enough affordable housing
Having enough child daycare services	Drug use and abuse (including prescription drug abuse)
Availability of mental health services	

The current process did identify one identical common need from the previous cycle, the availability of mental health services was identified in the 2022 CHNA process.

McKenzie Health invited written comments on the 2022 CHNA report and implementation strategy both in the documents and on the website where they are widely available to the public. No written comments have been received.

Upon adoption of this CHNA Report by the McKenzie Health Board vote, a notation will be documented in the board minutes reflecting the approval and then the report will be widely available to the public on the hospital's website, and a paper copy will be available for inspection upon request at the hospital. Written comments on this report can be submitted to McKenzie Health.

Hospital and Community Projects and Programs Implemented to Address Needs Identified in 2022

In response to the needs identified in the 2022 CHNA process, the following actions were taken:

Need 1: Not enough affordable housing – Since the last CHNA process, McKenzie Health has purchased several homes in the community to utilize as resources for providers and staff who are in Watford City providing services. Additionally, with many offers of employment, housing is an added benefit where either housing is provided or a stipend issued. Housing continues to be a challenge in Watford City and, as such, some legislative action has been suggested as well to address the need.

Need 2: Availability of resources to help the elderly stay in their homes – McKenzie Health's Chronic Care Management Team deploys to see individuals in their homes to address needs. They provide blood pressure monitoring, bring flu and COVID vaccinations, assist patients with getting access to assistive devices like walkers, and help with follow-up care.

Need 3: Having enough child daycare services – McKenzie Health worked to address daycare services and the expense associated with it by reserving several slots with the local daycare specifically for our staff members. A flexible work schedule is offered as well to help accommodate staff with children.

Need 4: Availability of mental health resources – McKenzie Health now has a listing in FirstLink, a 501(c)3 nonprofit, which is responsible for answering the 2-1-1 Helpline statewide for North Dakota and the National Suicide Prevention Lifeline for the entire state of North Dakota and parts of Minnesota. Anyone can call this number 24 hours/day and be connected to a live person who can provide information about local resources and a listening ear. A "Preventing Suicide – What to Know and Expect with Suicidal

Thoughts, Plans, or Threats in Pediatric Patients" trifold was developed for utilization in the Emergency Department for parents and guardians. Philomena Cunningham, Psychiatric Mental Health Nurse Practitioner (PMHNP), was hired to see patients for psychiatric assessments, diagnoses, and medication management. Her services are offered via telemedicine on Tuesdays, Wednesdays, and Fridays. She is bilingual (English/Spanish) and will see patients from age 6 to adult.

The above implementation plan for McKenzie Health is posted on the McKenzie Health website at Community Health Needs Assessment | McKenzie Health.

Recommendations and Action Plan

Within five months and 15 days, an implementation plan mapping out how the community will address the findings of the CHNA has to be approved by the McKenzie Health board of directors. Although a CHNA and strategic implementation plan are required by hospitals and accredited local public health units, it is important to keep in mind the needs identified, at this point, will be broad community-wide needs along with healthcare system-specific needs. This process is simply a first step to identify needs and determine areas of priority.

The next step is to convene the steering committee, or other community group that includes those that will be valuable in enacting changes, to outline the path that will be taken to implement change to improve the health of the community. A strategic planning process will begin with identifying current initiatives, programs, and resources already in place to address the identified community need(s). Additional steps include identifying what is needed and feasible to address (taking community resources into consideration) and what role and responsibility the hospital, clinic, and various community organizations play in developing strategies and implementing specific activities to address the community health need selected. Community engagement is essential for successfully developing a plan and executing the action steps for addressing one or more of the needs identified.

All activities proposed in the implementation plan will need to be monitored and evaluated to see if the plan is working or if modifications need to be made. The implementation plan is a starting place, it will need to be refined as you travel through the three years of application.

Appendix A – Community Survey Instrument

McKenzie Health CIBOLO

McKenzie Health Service Area Health Survey

Community Health Needs Assessment

McKenzie Health and Upper Missouri District Health Unit are interested in hearing from you regarding the community health needs in your area. A Community Health Needs Assessment (CHNA) survey is designed to gather information about the health needs and priorities of a community. It is important that we have the thoughts of those within the community providing their opinions. These questions help identify the health needs of the community, the barriers to accessing healthcare, and the resources that are most needed. The survey results are then used to inform community health improvement plans and strategies.

Surveys will be tabulated by Cibolo Health (https://cibolohealth.com/). Your responses are completely 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 aggregate. If you have questions about the survey or the process, please contact Kylie Nissen at kylie.nissen@cibolohealth.com or 701.330.0464.

Surveys will be accepted through December 15, 2024.

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

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

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

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

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

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

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

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

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

McKenzie Health CIBOLO

McKenzie Health Service Area Health Survey

Community Concerns

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

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

- [ ] Active faith community
- [ ] Attracting and retaining young families
- [ ] Not enough jobs with livable wages, not enough to live on
- [ ] Not enough affordable housing
- [ ] Poverty
- [ ] Changes in population size (increasing or decreasing)
- [ ] Crime and safety, adequate law enforcement personnel
- [ ] Water quality (well water, lakes, streams, rivers)
- [ ] Air quality
- [ ] Litter (amount of litter, adequate garbage collection)
- [ ] Having enough child daycare services
- [ ] Other (please specify)

- [ ] Having enough quality school resources
- [ ] Not enough places for exercise and wellness activities
- [ ] Not enough public transportation options, cost of public transportation
- [ ] Racism, prejudice, hate, discrimination
- [ ] Traffic safety, including speeding, road safety, seatbelt use, and drunk/distracted driving
- [ ] Physical violence, domestic violence, sexual abuse
- [ ] Child abuse
- [ ] Bullying/cyber-bullying
- [ ] Recycling
- [ ] Homelessness

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

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

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

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

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

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

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

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

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

McKenzie Health CIBOLO

McKenzie Health Service Area Health Survey

Health Status and Behaviors

11. How would you rate your overall health?

- ◯ Excellent
- ◯ Very good
- ◯ Good
- ◯ Fair
- ◯ Poor

12. Do you have any chronic conditions (check all that apply)

- [ ] Diabetes
- [ ] High blood pressure
- [ ] Heart disease
- [ ] Depression or anxiety
- [ ] Asthma
- [ ] None
- [ ] Arthritis
- [ ] Other (please specify)

13. Do you have a primary care physician?

- ◯ Yes
- ◯ No

McKenzie Health CIBOLO

McKenzie Health Service Area Health Survey

Delivery of Healthcare

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

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

15. Considering GENERAL and ACUTE SERVICES at McKenzie Health, which services are you aware of (or have you used in the past year)? (Choose ALL that apply)

- [ ] Anesthesia services
- [ ] Cardiology (telecardiology)
- [ ] Clinic
- [ ] Emergency Room
- [ ] Ear, Nose, Throat (ENT)
- [ ] Home health care
- [ ] Hospice
- [ ] Hospital (acute care)
- [ ] Laparoscopic surgery
- [ ] Mental health services
- [ ] Ob-Gyn
- [ ] Oncology
- [ ] Orthopedics
- [ ] Pain management
- [ ] Pediatrics
- [ ] Podiatry (foot/ankle) - visiting specialist
- [ ] Urology
- [ ] Surgical services
- [ ] Swing bed and respite care services

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

17. How satisfied are you with the healthcare services in your community?

- ◯ Very satisfied
- ◯ Satisfied
- ◯ Neither satisfied nor dissatisfied
- ◯ Dissatisfied
- ◯ Very dissatisfied

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

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

19. What is the best way for you to receive information about health services and resources? (check all that apply)

- [ ] Local newspaper
- [ ] Social media
- [ ] Community events channel
- [ ] Other (please specify)
- [ ] Healthcare providers
- [ ] Flyers or brochures

20. Do you believe individuals in the community would financially support any of the following capital improvements by McKenzie Health? (Choose ALL that apply)

- [ ] Cancer services
- [ ] Dialysis services
- [ ] Dining room capital expansion and dining room services
- [ ] Other (Please specify other capital improvements that you believe the community would financially support):
- [ ] Creation of intensive care unit (ICU)
- [ ] PET scanner

McKenzie Health CIBOLO

McKenzie Health Service Area Health Survey

Demographic Information:

Please tell us about yourself.

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

- [ ] Indian Health Service (IHS)
- [ ] Insurance through employer (self, spouse, or parent)
- [ ] Self-purchased insurance
- [ ] Medicaid
- [ ] Other (please specify)
- [ ] Medicare
- [ ] No insurance
- [ ] Veteran's Healthcare Benefits

22. Age:

- ◯ Less than 18 years
- ◯ 18-24 years
- ◯ 25-34 years
- ◯ 35-44 years
- ◯ 45-54 years
- ◯ 55-64 years
- ◯ 65-74 years
- ◯ 75 years and older

23. 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

24. Gender:

- ◯ Female
- ◯ Male
- ◯ Non-binary
- ◯ Other (please specify)

25. Employment status:

- ◯ Full time
- ◯ Part time
- ◯ Homemaker
- ◯ Multiple job holder
- ◯ Unemployed
- ◯ Retired

26. Your zip code:

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

- [ ] American Indian
- [ ] African American
- [ ] Asian
- [ ] Other (please specify)
- [ ] Hispanic/Latino
- [ ] Pacific Islander
- [ ] White/Caucasian

28. 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

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

Thank you for assisting us with this important survey!

Appendix B – Open-Ended Question Survey Responses

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

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

    - Hard Working

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

    - I dont believe that there is best services or resources within this community. Access to healthy foods? There is only one grocery store and they do not have the best selection of produce and are over priced. As far as the business district there is not a lot of choices or they do not meet all needs of different people. Healthcare, yes the healthcare is growing but, there is room for improvement regarding the patients care.
    - economic opportunity
    - Low population density

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

    - no opportunites for youth to have fun outside of school sports or on the weekends

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

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

    - v.s. mail services
    - Schools - ESL
    - Mental health challenges
    - Access to affordable healthy food
    - not enough things for young people to do, ie. bowling alley, arcade, etc. so they stay away from drinking and drugs
    - need more things to do for youth bowling alleys, arcades, laser tag
    - Not enough healthcare
    - AFFORDABLE COUNSELING FOR CHILDREN OF ALL AGES
    - Lack of healthcare specialists (there's good general prac Doctors and nurses, but anything you need more specialized opinions on or in a specialty emergency, people are always seemingly shipped to Minot or Bismarck-and that concerns me).
    - I

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

    - more space in nursing home

- Being able to keep nursing home residents local
- blood supply
- ability/willingness of healthcare providers to work
- complete lack of providers, everywhere you call it's three weeks to get in for an emerging condition. Only option is ER or walk-in.

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

- self harm resources withing community/school system
- importance of blood donation
- social media
- Social media should be an option!
- Bullying
- Quality of education is not up to par with other schools in ND

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

- cost of food services
- CKD
- Overall health (food, sleep, movement, stress...)

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

- Hunger and poor nutrition

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

- Adult stress
- (2) Affordable housing
- Affordable housing for families and places for youth to go and have fun and hang out, especially during the winter. They need a place to stay out of trouble.
- Affordable housing. Prices of goods vs record corporate profits
- Aging population and corresponding services/activities
- An aging community that has growing healthcare needs
- Availability of quality housing.
- Children not having access to resources to ask for help and feel safe to talk to someone. There are many children that slip through the cracks in our community and it might be that we have such a large turn around in the school system that goes along with the oilfield ups and downs. After school program that isn't just for sports.
- Climate change policies that eliminate carbon based energy rather than innovation
- Cliqueness of well known born and raised people from Watford. Gymnastics program and hockey program create a divide. Feels like if your wallet isn't deep enough your opinion doesn't matter is welcomed.
- Community needs growth! Allow needed businesses and resources to develop within our community to give the needed diverse options. Almost everyone I know within this community travel outside of the county to get needed resources and services.
- Cost of health care

- cost of housing
- Cost of living for any one person not working in oilfield and cost of groceries
- Cost of long-term/nursing home care
- costs
- Don't have any
- Drugs
- drugs and abundance of abuse
- Education
- elder care
- elderly care
- Finding workers who are competent and resilient
- Getting new entertainment stuff here for our youth.
- Good health care
- Growing population and the challenges
- (2) Healthcare
- Healthcare, weekends and evenings primarily.
- heart disease
- (8) Housing
- Housing and daycare an health care specialist
- housing availability
- Housing-affordable for moderate incomes.
- It's multi-faceted, but immediate needs are more healthcare professionals living/working in the community to service the population and so the existing professionals aren't overwhelmed or face sever burn out. Education is improving, but more school facilities are needed (new elementary school is being built, but the bond vote was difficult and STARTED in 2017) in order to provide a proper teacher-student ratio and adequate classrooms to students (again, so teachers aren't burnt out and students don't feel left behind). A lesser third issue is attracting and retaining more basic businesses (this town NEEDS another grocery store, anytime you go to the 3.5 in town, it's always over-crowded, no matter what time of day) and more bigger box stores to supply needs so you don't have to online order. The small business community in town is great, but can be very niche, not carry some basic things, or just simply don't have the help or hours to be effective.
- Keeping locals local
- Lack of housing
- Lack of knowledge of resources. A single source of trusted information for all things health and wellness.
- Leadership
- Limited resources for elderly
- Meeting like people in the community through events/fairs
- mental health
- Mental health treatment options; we need a psych facility so we don't have to transfer so many patients to Minot, Fargo, and Bismarck.
- Multi-cultural resources
- N/A
- Not enough activities to do outside of bars.
- Not enough adult activities.
- Not enough compensation to live here. Which means no workers
- Not enough medical staff

- Not enough resources especially for our elderly, e.g. transportation
- Not good Teen this - need more Save Fun Choices
- nothing for youth to do
- Nursing home costs
- Overwhelm/stress and poor general health decisions
- People only come here to make money and then leave, not to provide services for those that are here to stay. Lack of services in all areas- health, senior living, activities and the biggest is shopping!! The city seems to not want businesses to come in and take away from the small businesses, which in turn, makes people leave. They want the shopping options/variety. All of the small businesses sell the same things; it's not helpful. Health care is getting a little better, but still very much lacking in availability.
- Places to eat
- Quality healthcare
- Regarding health care, lack of providers for the huge increase in population.
- Resources available for home health for the sick and aging
- Respite for caregivers
- retaining quality people for needed jobs
- Safety and security, 2. alcohol and drug abuse. 3. public transportation
- (2) Stress
- (2) Suicide
- Supply of affordable housing.
- taking care of elderly-not enough nursing home/assisted living options in 200 mile range
- Teen suicide
- That I have to drive 3 hours to Minot or Bismarck to get any type of specialist healthcare. The last healthcare survey done by the City showed over 70% of residents had to travel long hours to another city to get any decent healthcare
- The "importance" community's support of local businesses, community involvement in organizations needs to encourage/embraced by new comers to our community. Also the importance of sharing the community's history because shares where we have been and the importance to our future.
- the churches does not accepts different nationalities in there churches. that is a problem not very welcome at all
- There are not enough doctors here! I shouldn't have to go 3 hours to get QUAILITY health care. My grandfather almost died when there was blood in his urine bag and doctors didn't listen.
- There isn't any activities or places for children or families to go. Example.. Fun zone, bowling, trampoline park.
- We need a good hospital
- we need something in place in the community to where when our elder people who cant get out to go Grocey shopping / Doctor's appointment we need a group of people who can do these tasks for our Elder's in Watford City

Delivery of Healthcare

12. Do you have any chronic conditions?
    - Gout
    - (5) didn't specify
    - alcohol abuse

- Still trying to find out what is going on after seeing # primary physicians, multiple specialist, and personal research.
- Osteoporosis, IBS, HRT
- Low Blood Pressure

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

- illegal aliens - out of US - no soc sec # and state won't pay
- cost of out of pocket expenses
- 24-hour pharmacy availability
- $
- High cost of health care and long wait for dental/vision with high cost
- Having access to specialties in rural healthcare is great, however it's sometimes more inconvenient to only have them available X amount of days/ months vs having a couple of specialties/ providers available all the time.
- bariatric patients in wheel chairs - their chairs DO NOT fit through the doorways of the patient rooms, therefore, how can they be seen?
- Urgent care needs to be open later in the evening; patients need to be able to go without having to pay up front vs going to the ED
- General reluctance
- Na

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

- .
- (2) Allergy
- Another eye doctor
- Behavioral health
- CANCER CARE
- Cardiologist
- (2) Cardiology
- dental, dental and dental
- (3) Dermatology
- (2) Dialysis
- Extend urgent care hours
- Full time Specialists
- Gynecology
- home health and nursing home care
- Home healthcare options for elderly. Substance abuse and more mental inpatient options.
- Hospice
- I don't know
- ICU services
- Immunology/allergist - experienced; therapist - marriage, family, and child
- in home PT,OT
- it's difficult to drive the distance to specialists that know what they are doing and to get a surgery needed.
- Less specialties, more availability of providers most days of the month.
- Level 2 NSY

- Mental health care for ALL ages. Any services that allow patients to get care here with out having to travel.
- mental health services with an emphasis on military and youth (teens) and very young elementary students including parenting classes
- Mental health; groups for kids to help with anxiety, stress and depression; there's too many young kids who are taking medications
- More mental health counselling
- More mental health options
- More mental health services more treatment for drugs
- More primary physicians
- (2) N/A
- need more women's health centers
- Neurology
- (3) Oncology
- Pediatric Infusions
- Pediatric mental health
- (2) Podiatrist
- Podiatry, Hospice
- Primary care and more specialty physicians.
- Providers in town not traveling or contract providers. Want providers to stay and be continuent with patient care.
- Respite services
- Rheumatology, Cardiology, Podiatry
- safety and security
- special doctors
- specialty physicians
- Telehealth and more specialist
- To be frank, more quality healthcare professionals of every level would be welcome (again, to prevent provider burnout and to ensure that patients are getting proper care and attention).
- Unsure at this time
- Weekend and Evening services
- Weight loss counseling and services. I see alot more young adults that are not healthy. Better food program
- X
- you should have more then one nursing home

18. Where do you find out about LOCAL HEALTH SERVICES available in your area? (Choose ALL that apply)
    - at work
    - employee meetings
    - employed there
    - Billboards
    - EDC, JDA
    - Billboards

19. What is the best way for you to receive information about health services and resources? (check all that apply)

- Fb
- email
- Website
- (4) Word of mouth
- Within the hospital, staff emails
- EDC, JDA , Rotary
- personal research online
- Email, web search
- Not sure
- online adverts

20. Do you believe individuals in the community would financially support any of the following capital improvements by McKenzie Health? (Choose ALL that apply)
    - 7 day a week urgent care clinic or a pediatric clinic
    - Bariatric counseling and services
    - Expanding Fit For Life program
    - Gistl Marie Theatre
    - Good Shepherd Home Movie Theater
    - I think we need to focus on what we have first and then expand. However I feel the cancer services would be used the most. Unfortunately there is a lot of cancer in our community
    - improved or new clinic facilities, hiring of more professionals locally.
    - in order to have these services, staff needs to be able to afford to live in the community
    - inpatient mental health
    - Literally any mental health improvements.
    - mental health services
    - (2) movie theater @ GSH
    - Not sure
    - Nursing home movie theater
    - Please do expansion in Williston
    - Theater for nursing home
    - Too much money has been given without getting quality available services back in return.

21. Health insurance or health coverage status (choose ALL that apply)
    - supplement policy
    - supplement
    - COBRA

29. Overall, please share concerns and suggestions to improve the delivery of local healthcare.
    - better advertisement about available services
    - Better quality - experienced regular Drs everyday - pediatrics too
    - Communication of services, availability, and costs
    - Dont have any

- Evening and weekend appointments so people don't have to go to the emergency room if something comes up. Specialists that live in the area for more availability rather than only coming twice a month.
- Evening and weekend services other than the ER
- Geography and retention for the Williston area is tough, I understand that. Is there a way to work with NPO/recruiters like 3RNet to help bring in healthcare professionals that are able to handle a city that is medium-sized but still has a very 'small town feel' and lack of some amenities that cities like even a Minot have? Again, just having MORE quality healthcare professionals in town helps both the provider and patient (preventing burnout, keeping providers from seeing too many patients a day, and the patient feels more connected to the provider and healthcare system, more prone to go in and get preventative care instead of waiting until they keel over in the ER). I also think that WSC healthcare program and new building will help bolster some basic nursing and assistants into the system, but may take a larger investment to get those higher level (NPs, MDs, other specialists) into the system (again, the education and amenities/businesses piece would play into attracting and retaining professionals).
- I feel the hospital is growing very fast. There will be some growing pains. Need to hire more staff and make sure morale is good. Pay is good so we can keep staff local instead of hiring travelers.
- I have no concerns.
- Improvement of leadership. Someone local who understands and cares. Someone who has lived through the growth and will be here when it’s done.
- Improving the delivery of local healthcare doesn't always mean expanding. I believe it is great that we have specialties available, but is frustrating when they're only available a certain number of days per month. Most times it seems more convenient to be able to have providers available all the time versus having them locally. I feel improving the services we DO have available should be more of a priority than expanding them.
- Knowledgeable staff/employees that have the right answers - don’t like when one dr says one thing and another says something else. Hard to know what or who to believe.
- Lack of housing options reduces the opportunity for more people to come to Watford City to work at the hospital
- More "caring" medical doctors that actually take the time to listen to ones concerns, answering questions instead of looking at one reading and stating "oh well this is normal so there is nothing wrong.
- more cardiology - drive to Bismarck is difficult for elderly in weather and time
- More education about the walk in clinic and urgent care. More education about how to use the ER (education/advertisements)
- more MDs needed
- (2) N/A
- no concerns
- None
- NOT DEPENDABLE
- Options for healthcare services and the addition of new doctors has been a huge improvement
- Overall physician retention and specialty care is far from close. Pediatric and orthopedics main concern
- Providers with continuity of care not traveling providers switching on and off staff weekly and bi-weekly.
- Specialist care and an increase of hospital room use.
- Specialist locally
- specialists

- There are not enough counselors here that are confidential or are open to new patients. My son needed severe help a few years back and had to be taken to another hospital because ours couldn't handle the situation.
- treat everyone equal
- We need the ability to attract & keep quality doctors
- We need to be concerned with consistent quality providers before adding new services and facilities. If a person does not even want to go to the clinic because of the poor service, they are not going to go a specialty clinic or provider though MCHS.
- When businesses have a new hire it would be nice to take them on a tour of the hospital and yes have them shake the hand of the admission staff, clinic staff, doctors and nurses while highlighting the hospital's success.

Appendix C – NDDHHS 2024 Child Care Profile

NORTH Dakota | Health & Human Services
Be Legendary.

Child Care Profile
2024
MCKENZIE County

Children Potentially Needing Child Care

	0-2 yrs	3 yrs	4-5 yrs	6-12 yrs	Total
Children in County by Age[1]	828	302	597	1944	3369
% of Children Ages 0 to 5 with All Parents in the Labor Force[1]					58.4%
% of Children Ages 6 to 13 with All Parents in the Labor Force[1]					61.2%
Children Ages 0 to 5 potentially needing child care due to parents in workforce					1727
Children Ages 6 to 12 potentially needing child care due to parents in workforce					1175
Capacity of state-licensed child care programs (family, group, center, school-age[3])					430
Current Child Care Assistance Program Recipients Age 0-13					
Percent to which supply meets potential demand					15%

State-Licensed Early Childhood Program Type and Capacity[2] (2024)

	Family	Group in a home	Group in a facility	Center	Total
Number of Programs	1	1	6	2	10
Licensed Capacity	9	14	122	285	430
Reported Vacancies[4]	0	0	0	30	30
Programs open before 7:00 a.m.	1	0	0	0	1
Programs open after 6:00 p.m.	0	0	0	0	0
Programs open on Weekends	0	0	0	0	0
Reported Size of Workforce	1	1	27	89	118
State-licensed school-age programs[3]	0	with a licensed capacity of			0

Annual Cost of State-Licensed Child Care[2] (Due to the limited number of programs, rates reflect a regional average)

	Home-based Programs		Centers and Group Facilities	
Age of Child	**Average**	**Highest Rate**	**Average**	**Highest Rate**
Ages 0 to 17 months	$9,100	$10,400	$11,336	$14,820
18 to 35 months	$11,267	$15,600	$10,677	$13,520
Ages 3 to 5	$11,267	$15,600	$10,140	$13,000
Ages 6 to 12 (Annual costs for school-age children vary greatly based on hours needed.)				

1. 2022 ND Kids Count Fact Book
2. ChildCare Aware® of North Dakota WorkLife Systems Database
3. School-age care numbers reflect programs licensed exclusively as before and after school programs under Early Childhood Services rules. Not all school-age programs are required to be licensed. In addition, many school-age children are enrolled in family/group programs and child carecenters.
4. Vacancies change daily and may not match the location or program characteristics desired by families needing care. A 10% vacancy rate allows families some choice among programs.

Appendix D – McKenzie Health CAH Profile

Critical Access Hospital Profile
Spotlight on: Watford City, North Dakota

McKenzie Health

Administrator/CEO: Peter Edis

Chief of Medical Staff:
Dr. Gary Ramage

Board Chair:
Gary Brown

City Population:
5,885 (2020 Decennial Census)[1]

County Population:
14,252 (2020 Decennial Census)[1]

County Median Household Income:
$83,813 (American Community Survey 5-Year Estimates)[1]

County Median Age:
31.5 (2020 American Community Survey 5-year Estimates)[1]

Service Area Population:
25,000

Owned by: Nonprofit

Hospital Beds: 24

Skilled Nursing Facility Beds: 36

Trauma Level: V

Critical Access Hospital Designation: 1999

Economic Impact on the Community[2]

Employment Impact:
Direct – 310
Secondary – 62
Total – 372

Financial Impact:
Primary – $17.5 million
Secondary – $3.57 million
Total – $21 million

Mission:

Our commitment is to the patients and their families, whatever their needs may be. Our goal is to achieve the highest level of healthcare for these patients and their families. We are rural USA, therefore, we provide hometown values committed to quality services, continuity of care, assurance of qualified staff, and family involvement for individual
patients and clients.

County: McKenzie
Address: 709 4th Ave NE, Watford City, ND 58854
Phone: (701) 842-3000
Fax: (701) 842-6248
Web: www.mckenziehealth.com

McKenzie Health, supported by the Christian churches in our community, is a 24-bed Medicare certified hospital, offering swing bed program services. Dedicated to a healing ministry, we are committed to excellence and service in a person-centered environment that respects the human life of all, regardless of race, creed, color, national origin, disability, pregnancy, sex, and/or marital status.

McKenzie Health supports a team approach to effectively and efficiently meeting the needs of our patients and their families. Evidence-based nursing practice is an important element of quality care at McKenzie Health. The nursing staff incorporates evidence-based decision making to optimize outcomes for patients, improve clinical practice, achieve cost-effective nursing care, and ensure accountability in decision making.

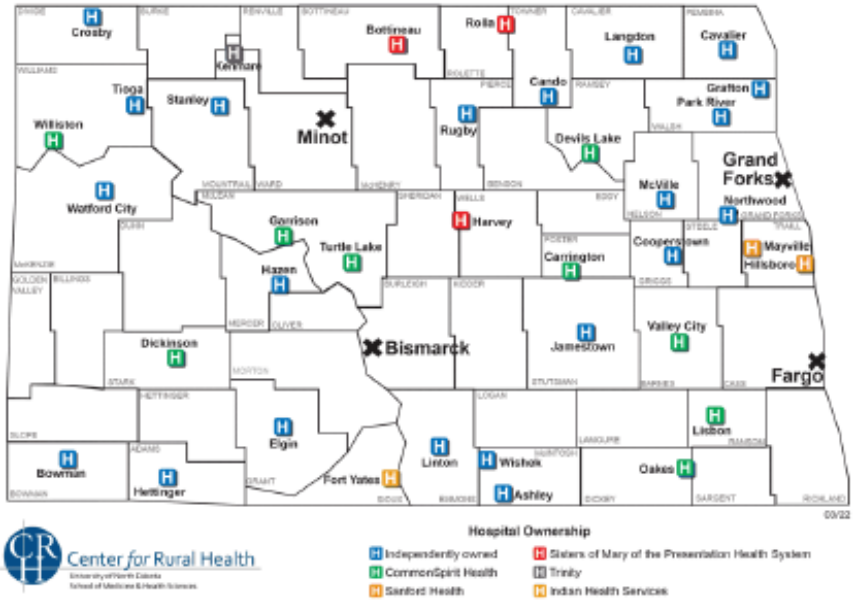
Services: McKenzie Health provides the following services directly:

- **Assisted living**
- **Pediatrics**
- **Cardiac rehab**
- **Physical therapy**
- **Echocardiography**
- **Pulmonary rehab**
- **Emergency services**
- **Gynecology**
- **Radiology (MRI, CT, X-ray, US, Dexa)**
- **General surgery**
- **Hospitalist services**
- **Respiratory therapy**
- **Inpatient pharmacy**
- **Respite care**
- **Laboratory services**
- **Rural Health Clinic**
- **Nursing**
- **Nursing home**
- **Specialty clinics: orthopedics, general surgery, urology, otolaryngology, sports medicine**
- **Nutrition services**
- **Surgery department**
- **Obstetrics**
- **Occupational therapy**
- **Swing bed program**
- **Speech therapy**
- **Orthopedic surgery**
- **Pain management**
- **Pelvic floor physical therapy**
- **Prostate fusion biopsies**
- **Wellness center**

McKenzie County Healthcare Systems provides the following services through contract or agreement:

- **Telecardiology**
- **Telepsych**

North Dakota Critical Access Hospitals



Center for Rural Health

History

McKenzie County Healthcare Systems, Inc. was born on July 1, 2004, with the merger of the Good Shepherd Home Corporation and the McKenzie County Memorial Hospital Corporation. This resulted in the consolidation of all healthcare services in McKenzie County. McKenzie County Healthcare Systems (MCHS) consists of a 24-bed CAH, emergency department, Rural Health Clinic, specialty clinics, urgent care, physical therapy, occupational therapy, and speech therapy. Connie Wold Wellness Center, Good Shepherd Home Nursing Home, and Horizon Assisted Living.

McKenzie County Memorial Hospital officially opened its doors on March 10, 1952. Dr. A.H. Lamal was the first physician, with Mrs. Royce Gravert, R.N. as the administrator. New building additions were added in 1963 and 1977. In 1986, the McKenzie County Clinic opened across the street from the hospital, under the experienced eye of Dr. G.D. Ebel. The Healthy Hearts Wellness Center was opened in 1992 to provide the community with a workout center.

The Good Shepherd Home was opened on January 8, 1964. The Lutheran churches of McKenzie County, in conjunction with the Arnegard Old Folks Home, had a vision of providing Christian care to the aging residents of their community. The first board of directors included Lee Stenehjem, Murphy Ecklund, Ivan Omlid, Sidney Swenson, and Paul Berge. In 1994, the Basic Care Addition was added. In 1986, the Heritage Senior Apartments were added, and in 2002 the Horizon Assisted Living Facility opened their doors. In late 2017, the nursing home the nursing home moved, and in July 2018, MCHS moved into their newly constructed building.

Recreation

Watford City is in west central North Dakota, just 40 miles from the Montana border. The economic base of the area relies primarily on farming, ranching, and oil and gas related industries. Two elementary schools and a high school provide educational services to the community. Within 50 to 125 miles of the city, post-secondary opportunities are available from four state-affiliated universities. The city park system includes several parks, a swimming pool, hockey rink, tennis courts and softball complex. An 18-hole golf course is only two miles east of town. Lake Sakakawea, the world's 3rd largest man-made lake, is 25 miles north, with outstanding opportunities for fishing, sailing, and other water sports. The North Dakota Badlands and Theodore Roosevelt National Park's North Unit are 15 miles south, offering spectacular scenery, hiking, camping, and canoeing on the Little Missouri River.

Staff

Physicians: 29
PAs: 3
DNP: 21
Nurse Practitioners: 9
RNs: 76
LPNs: 10
Total Employees: 372

Sources

[1] **-US Census Bureau; American Factfinder, Community Facts**

[2] **-Economic Impact 2020 Center for Rural Health Oklahoma State University and Center for Rural Health University of North Dakota**

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

This project is supported by the Medicare Rural Hospital Flexibility Grant Program at the Center for Rural Health, University of North Dakota School of Medicine & Health Sciences located in Grand Forks, North Dakota.

ruralhealth.und.edu

Updated 08/2024

Appendix E – McKenzie Health Economic Effects

In a report titled, "The Economic Contribution of McKenzie County Healthcare Systems" that was prepared for McKenzie County Health Systems in March 2023 by the North Dakota State University, the following was reported in the Center for Social Research Report 110:

Total Economic Effects

Total economic effects (direct, indirect and induced) for operations and capital expenditures for 2022 was $58.3 million and projected to be $67.8 million in 2023 (Table 8). The combined labor income from operations and capital expenditures was $29.4 million in 2022 and is projected to remain stable in 2023 at $33.6 million. Total value-added to gross state product from operations and capital expenditures was $43.3 million in 2022 and is projected to increase to $51.8 million in 2023.

Table 8. Total (Direct, Indirect and Induced) Economic Effects, Capital Expenditures, Key Economic Measures, McKenzie County Healthcare Systems, 2021, 2022 and 2023 (projected)

	Type of Economic Metric		
Expenditure Type	**Economic Output**	**Labor Income**	**Value-Added (GCP)**
	----------000s $----------		
	2022		
Operations Expenditures	$58,200.9	$29,382.9	$43,215.6
Capital Expenditures	$76.6	$33.0	$47.9
Total Operations and Capital Expenditures	$58,277.5	$29,415.9	$43,263.5
	2023 (Projected)		
Operations Expenditures	$67,705.4	$33,497.5	$51,688.4
Capital Expenditures	$110.1	$52.8	$73.7
Total Operations and Capital Expenditures	$67,815.5	$33,550.3	$51,762.1

Appendix F - County Health Rankings Explained

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

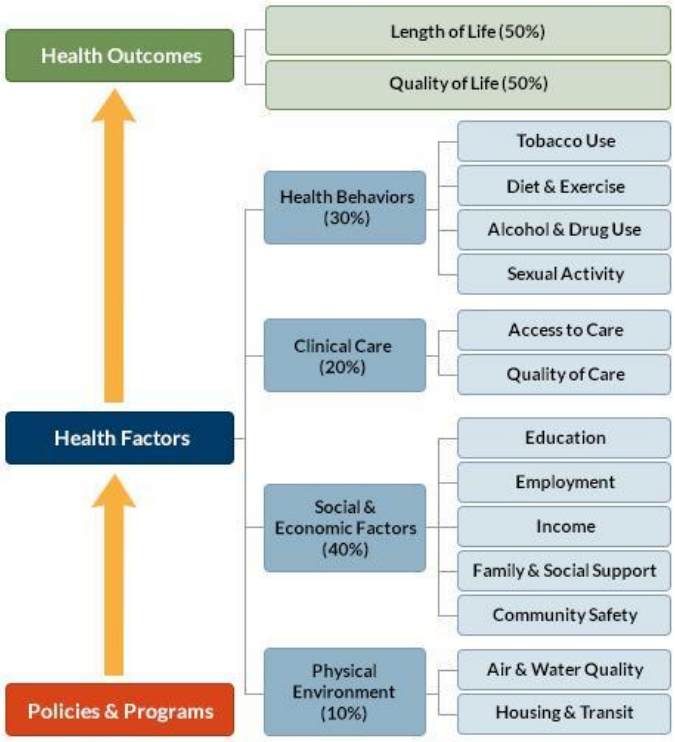
Methods

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

What is Ranked

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

Ranking System



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

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

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

Data Sources and Measures

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

Data Quality

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

Calculating Scores and Ranks

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

Health Outcomes and Factors

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

Health Outcomes

Premature Death (YPLL)

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

Reason for Ranking

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

Poor or Fair Health

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

Reason for Ranking

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

Poor Physical Health Days

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

Reason for Ranking

Measuring health-related quality of life (HRQoL) helps characterize the burden of disabilities and chronic diseases in a population. In addition to measuring how long people live, it is also important to include

measures of how healthy people are while alive – and people's reports of days when their physical health was not good are a reliable estimate of their recent health.

Poor Mental Health Days

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

Reason for Ranking

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

Low Birth Weight

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

Reason for Ranking

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

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

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

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

Health Factors

Adult Smoking

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

Reason for Ranking

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

Adult Obesity

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

Reason for Ranking

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

Food Environment Index

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

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

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

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

Reason for Ranking

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

Additionally, access in regard to a constant source of healthy food due to low income can be another barrier to healthy food access. Food insecurity, the other food environment measure included in the

index, attempts to capture the access issue by understanding the barrier of cost. Lacking constant access to food is related to negative health outcomes, such as weight gain and premature mortality. In addition to asking about having a constant food supply in the past year, the module also addresses the ability of individuals and families to provide balanced meals, further addressing barriers to healthy eating. It is important to have adequate access to a constant food supply, but it may be equally important to have nutritious food available.

Physical Inactivity

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

Reason for Ranking

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

Access to Exercise Opportunities

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

Individuals who reside in a census block within a half mile of a park; in urban census blocks: reside within one mile of a recreational facility; and in rural census blocks: reside within three miles of a recreational facility are considered to have adequate access for opportunities for physical activity.

Reason for Ranking

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

Excessive Drinking

Excessive drinking is the percentage of adults that report either binge drinking, defined as consuming more than four (women) or five (men) alcoholic beverages on a single occasion in the past 30 days, or heavy drinking, defined as drinking more than one (women) or two (men) drinks per day on

average. Please note that the methods for calculating this measure changed in the 2011 rankings and again in the 2016 rankings.

Reason for Ranking

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

Alcohol-Impaired Driving Deaths

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

Reason for Ranking

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

Sexually Transmitted Infection Rate

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

Reason for Ranking

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

Teen Births

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

Reason for Ranking

Evidence suggests teen pregnancy significantly increases the risk of repeat pregnancy and of contracting a sexually transmitted infection (STI), both of which can result in adverse health outcomes for mothers, children, families, and communities. A systematic review of the sexual risk among pregnant and mothering teens concludes that pregnancy is a marker for current and future sexual risk behavior and adverse outcomes. Pregnant teens are more likely than older women to receive late or no prenatal care, have eclampsia, puerperal endometritis, systemic infections, low birthweight, preterm delivery, and severe neonatal conditions. Preterm delivery and low birthweight babies have increased risk of child developmental delay, illness, and mortality. Additionally, there are strong ties between teen birth and poor socioeconomic, behavioral, and mental outcomes. A teenage woman who bears a child is much less

likely to achieve an education level at or beyond high school, much more likely to be overweight/obese in adulthood, and more likely to experience depression and psychological distress.

Uninsured

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

Reason for Ranking

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

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

Primary Care Physicians

Primary care physicians is the ratio of the population to total primary care physicians. Primary care physicians include nonfederal, practicing physicians (MDs and DOs) younger than age 75 specializing in general practice medicine, family medicine, internal medicine, and pediatrics. Note this measure was modified in the 2011 rankings and again in the 2013 rankings.

Reason for Ranking

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

Dentists

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

Reason for Ranking

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

Mental Health Providers

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

Reason for Ranking

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

Preventable Hospital Stays

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

Reason for Ranking

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

Mammography Screening

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

Reason for Ranking

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

Flu Vaccinations

Flu vaccinations are Percentage of fee-for-service (FFS) Medicare enrollees that had an annual flu vaccination.

Reason for Ranking

Influenza is a potentially serious disease that can lead to hospitalization and even death. Every year there are millions of influenza infections, hundreds of thousands of flu-related hospitalizations, and thousands

of flu-related deaths. An annual flu vaccine is the best way to help protect against influenza and may reduce the risk of flu illness, flu-related hospitalizations, and even flu-related death. It is recommended that everyone 6 months and older get a seasonal flu vaccine each year, and those over 65 are especially encouraged because they are at higher risk of developing serious complications from the flu.

Unemployment

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

Reason for Ranking

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

Children in Poverty

Children in poverty is the percentage of children younger than age 18 living in poverty. Poverty status is defined by family; either everyone in the family is in poverty or no one in the family is in poverty. The characteristics of the family used to determine the poverty threshold are number of people, number of related children younger than age 18, and whether the primary householder is older than age 65. Family income is then compared to the poverty threshold; if that family's income is below that threshold, the family is in poverty. For more information, please see Poverty Definition and/or Poverty.

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

Reason for Ranking

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

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

Income Inequality

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

Reason for Ranking

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

Children in Single-Parent Households

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

Reason for Ranking

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

Violent Crime Rate

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

Reason for Ranking

High levels of violent crime compromise physical safety and psychological well-being. High crime rates can also deter residents from pursuing healthy behaviors, such as exercising outdoors. Additionally, exposure to crime and violence has been shown to increase stress, which may exacerbate hypertension and other stress-related disorders and may contribute to obesity prevalence. Exposure to chronic stress also contributes to the increased prevalence of certain illnesses, such as upper respiratory illness and asthma in neighborhoods with high levels of violence.

Injury Deaths

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

Reason for Ranking

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

Air Pollution-Particulate Matter

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

Reason for Ranking

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

Drinking Water Violations

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

Reason for Ranking

Recent studies estimate that contaminants in drinking water sicken 1.1 million people each year. Ensuring the safety of drinking water is important to prevent illness, birth defects, and death for those with compromised immune systems. A number of other health problems have been associated with

contaminated water, including nausea, lung and skin irritation, cancer, and kidney, liver, and nervous system damage.

Severe Housing Problems

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

- Housing unit lacks complete kitchen facilities;
- Housing unit lacks complete plumbing facilities;
- Household is severely overcrowded; or
- Household is severely cost burdened.

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

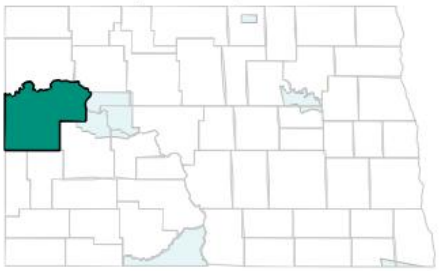
Reason for Ranking

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

Appendix G – North Dakota KIDS COUNT

View State Profile

Select a county on the map below:



Light blue shading shows the five American Indian reservations within North Dakota.

North Dakota County Profiles

McKenzie County

Population Estimates for: 2022	McKenzie	North Dakota
Child Population (under 18):	4,489	182,775
American Indian/Alaska Native:	12.2%	8.0%
Black:	2.2%	4.9%
White:	78.1%	79.9%
2+ Races or Other:	7.5%	7.3%

Health & Wellness

Children Without Health Insurance	Children Enrolled in Medicaid or CHIP	Women Who Receive Early Prenatal Care
13.5%	1,242	75.8%
2021	2022	2022
10.5% 2020	1,325 2021	72.0% 2021

Early Childhood

Children Under Age 6	Child Care Providers	Child Care Capacity
1,484	5	322
2022	2023	2023
1,479 2021	9 2022	358 2022

Education

Free or Reduced-Price Lunch Participation	Four-Year Cohort Graduation Rate	3rd Grade Students Proficient in Reading
35.4%	82.3%	34.0%
2022/23	2021/22	2021/22
	76.0% 2020/21	33.1% 2020/21

Family Economic Security

Children Living in Poverty	Child Food Insecurity	Children with All Parents Working
9.1%	11.0%	58.6%
2022	2021	2018-2022
11.2% 2021	12.5% 2020	59.2% 2017-2021

KIDS COUNT NORTH DAKOTA

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For more information on this data or North Dakota KIDS COUNT, contact ndkidscount@gmail.com or visit ndkidscount.org

Appendix H – Youth Behavioral Risk Survey Results

Youth Behavioral Risk Survey Results

North Dakota High School Survey

Rate Increase ↑, rate decrease ↓, or no statistical change = in rate from 2017-2019

	ND 2015	ND 2017	ND 2019	ND Trend ↑, ↓, =	Rural ND Town Average	Urban ND Town Average	National Average 2019
Injury and Violence							
Percentage of students who rarely or never wore a seat belt (when riding in a car driven by someone else)	8.5	8.1	5.9	=	8.8	5.4	6.5
Percentage of students who rode in a vehicle with a driver who had been drinking alcohol (one or more times during the 30 prior to the survey)	17.7	16.5	14.2	=	17.7	12.7	16.7
Percentage of students who talked on a cell phone while driving (on at least one day during the 30 days before the survey, among students who drove a car or other vehicle)	NA	56.2	59.6	=	60.7	60.7	NA
Percentage of students who texted or e-mailed while driving a car or other vehicle (on at least one day during the 30 days before the survey, among students who had driven a car or other vehicle during the 30 days before the survey)	57.6	52.6	53.0	=	56.5	51.8	39.0
Percentage of students who never or rarely wore a helmet (during the 12 months before the survey, among students who rode a motorcycle)	NA	20.6	NA	**NA**	NA	NA	NA
Percentage of students who carried a weapon on school property (such as a gun, knife, or club on at least one day during the 30 days before the survey)	5.2	5.9	4.9	=	6.2	4.2	2.8
Percentage of students who were in a physical fight on school property (one or more times during the 12 months before the survey)	5.4	7.2	7.1	=	7.4	6.4	8.0
Percentage of students who experienced sexual violence (being forced by anyone to do sexual things [counting such things as kissing, touching, or being physically forced to have sexual intercourse] that they did not want to, one or more times during the 12 months before the survey)	NA	8.7	9.2	=	7.1	8.0	10.8
Percentage of students who experienced physical dating violence (one or more times during the 12 months before the survey, including being hit, slammed into something, or injured with an object or weapon on purpose by someone they were dating or going out with among students who dated or went out with someone during the 12 months before the survey)	7.6	NA	NA	**NA**	NA	NA	8.2
Percentage of students who have been the victim of teasing or name calling because someone thought they were gay, lesbian, or bisexual (during the 12 months before the survey)	NA	11.4	11.6	=	12.6	11.4	NA
Percentage of students who were bullied on school property (during the 12 months before the survey)	24.0	24.3	19.9	↓	24.6	19.1	19.5
Percentage of students who were electronically bullied (including being bullied through texting, Instagram, Facebook, or other social media during the 12 months before the survey)	15.9	18.8	14.7	↓	16.0	15.3	15.7

Percentage of students who felt sad or hopeless (almost every day for two or more weeks in a row so that they stopped doing some usual activities during the 12 months before the survey)	27.2	28.9	30.5	=	31.8	33.1	36.7
Percentage of students who seriously considered attempting suicide (during the 12 months before the survey)	16.2	16.7	18.8	=	18.6	19.7	18.8
	ND 2015	ND 2017	ND 2019	ND Trend ↑, ↓, =	Rural ND Town Average	Urban ND Town Average	National Average 2019
Percentage of students who made a plan about how they would attempt suicide (during the 12 months before the survey)	13.5	14.5	15.3	=	16.3	16.0	15.7
Percentage of students who attempted suicide (one or more times during the 12 months before the survey)	9.4	13.5	13.0	=	12.5	11.7	8.9
Tobacco Use							
Percentage of students who ever tried cigarette smoking (even one or two puffs)	35.1	30.5	29.3	=	32.4	23.8	24.1
Percentage of students who smoked a whole cigarette before age 13 years (even one or two puffs)	NA	11.2	NA	**NA**	NA	NA	NA
Percentage of students who currently smoked cigarettes (on at least one day during the 30 days before the survey)	11.7	12.6	8.3	↓	10.9	7.3	6.0
Percentage of students who currently frequently smoked cigarettes (on 20 or more days during the 30 days before the survey)	4.3	3.8	2.1	↓	2.3	1.7	1.3
Percentage of students who currently smoked cigarettes daily (on all 30 days during the 30 days before the survey)	3.2	3.0	1.4	↓	1.6	1.2	1.1
Percentage of students who usually obtained their own cigarettes by buying them in a store or gas station (during the 30 days before the survey among students who currently smoked cigarettes and who were aged <18 years)	NA	7.5	13.2	=	9.4	10.1	8.1
Percentage of students who tried to quit smoking cigarettes (among students who currently smoked cigarettes during the 12 months before the survey)	NA	50.3	54.0	=	52.8	51.4	NA
Percentage of students who currently use an electronic vapor product (e-cigarettes, vape e-cigars, e-pipes, vape pipes, vaping pens, e-hookahs, and hookah pens at least one day during the 30 days before the survey)	22.3	20.6	33.1	↑	32.2	31.9	32.7
Percentage of students who currently used smokeless tobacco (chewing tobacco, snuff, or dip on at least one day during the 30 days before the survey)	NA	8.0	4.5	↓	5.7	3.8	3.8
Percentage of students who currently smoked cigars (cigars, cigarillos, or little cigars on at least one day during the 30 days before the survey)	9.2	8.2	5.2	↓	6.3	4.3	5.7
Percentage of students who currently used cigarettes, cigars, or smokeless tobacco (on at least 1 day during the 30 days before the survey)	NA	18.1	12.2	NA	15.1	10.9	10.5
Alcohol and Other Drug Use							
Percentage of students who ever drank alcohol (at least one drink of alcohol on at least one day during their life)	62.1	59.2	56.6	=	60.6	54.0	NA
Percentage of students who drank alcohol before age 13 years (for the first time other than a few sips)	12.4	14.5	12.9	=	16.4	13.2	15.0
Percentage of students who currently drank alcohol (at least one drink of alcohol on at least one day during the 30 days before the survey)	30.8	29.1	27.6	=	29.4	25.4	29.2
Percentage of students who currently were binge drinking (four or more drinks of alcohol in a row for female students, five or more for	NA	16.4	15.6	=	17.2	14.0	13.7

male students within a couple of hours on at least one day during the 30 days before the survey)							
Percentage of students who usually obtained the alcohol they drank by someone giving it to them (among students who currently drank alcohol)	41.3	37.7	NA	**NA**	NA	NA	40.5
Percentage of students who tried marijuana before age 13 years (for the first time)	5.3	5.6	5.0	=	5.5	5.1	5.6
Percentage of students who currently used marijuana (one or more times during the 30 days before the survey)	15.2	15.5	12.5	=	11.4	14.1	21.7
	ND 2013	ND 2017	ND 2019	ND Trend ↑, ↓, =	Rural ND Town Average	Urban ND Town Average	National Average 2019
Percentage of students who ever took prescription pain medicine without a doctor's prescription or differently than how a doctor told them to use it (counting drugs such as codeine, Vicodin, OxyContin, Hydrocodone, and Percocet, one or more times during their life)	NA	14.4	14.5	=	12.8	13.3	14.3
Percentage of students who were offered, sold, or given an illegal drug on school property (during the 12 months before the survey)	18.2	12.1	NA	NA	NA	NA	21.8
Percentage of students who attended school under the influence of alcohol or other drugs (on at least one day during the 30 days before the survey)	NA	NA	NA	NA	NA	NA	NA
Sexual Behaviors							
Percentage of students who ever had sexual intercourse	38.9	36.6	38.3	=	35.4	36.1	38.4
Percentage of students who had sexual intercourse before age 13 years (for the first time)	2.6	2.8	NA	NA	NA	NA	3.0
Weight Management and Dietary Behaviors							
Percentage of students who were overweight (>= 85th percentile but <95th percentile for body mass index, based on sex and age-specific reference data from the 2000 CDC growth chart)	14.7	16.1	16.5	=	16.6	15.6	16.1
Percentage of students who had obesity (>= 95th percentile for body mass index, based on sex- and age-specific reference data from the 2000 CDC growth chart)	13.9	14.9	14.0	=	17.4	14.0	15.5
Percentage of students who described themselves as slightly or very overweight	32.2	31.4	32.6	=	35.7	33.0	32.4
Percentage of students who were trying to lose weight	NA	44.5	44.7	=	46.8	45.5	NA
Percentage of students who did not eat fruit or drink 100% fruit juices (during the seven days before the survey)	3.9	4.9	6.1	=	5.8	5.3	6.3
Percentage of students who ate fruit or drank 100% fruit juices one or more times per day (during the seven days before the survey)	NA	61.2	54.1	↓	54.1	57.2	NA
Percentage of students who did not eat vegetables (green salad, potatoes [excluding French fries, fried potatoes, or potato chips], carrots, or other vegetables, during the seven days before the survey)	4.7	5.1	6.6	=	5.3	6.6	7.9
Percentage of students who ate vegetables one or more times per day (green salad, potatoes [excluding French fries, fried potatoes, or potato chips], carrots, or other vegetables, during the seven days before the survey)	NA	60.9	57.1	↓	58.2	59.1	NA
Percentage of students who did not drink a can, bottle, or glass of soda or pop (such as Coke, Pepsi, or Sprite, not including diet soda or diet pop, during the seven days before the survey)	NA	28.8	28.1	=	26.4	30.5	NA
Percentage of students who drank a can, bottle, or glass of soda or pop one or more times per day (not including diet soda or diet pop, during the seven days before the survey)	18.7	16.3	15.9	=	17.4	15.1	15.1

Percentage of students who did not drink milk (during the seven days before the survey)	13.9	14.9	20.5	↑	14.8	20.3	30.6
Percentage of students who drank two or more glasses per day of milk (during the seven days before the survey)	NA	33.9	NA	NA	NA	NA	NA
Percentage of students who did not eat breakfast (during the 7 days before the survey)	11.9	13.5	14.4	=	13.3	14.1	16.7
Percentage of students who most of the time or always went hungry because there was not enough food in their home (during the 30 days before the survey)	NA	2.7	2.8	=	2.1	2.9	NA
Physical Activity							
Percentage of students who were physically active at least 60 minutes per day on 5 or more days (doing any kind of physical activity that increased their heart rate and made them breathe hard some of the time during the 7 days before the survey)	NA	51.5	49.0	=	55.0	22.6	55.9
	ND 2015	ND 2017	ND 2019	ND Trend ↑, ↓, =	Rural ND Town Average	Urban ND Town Average	National Average 2019
Percentage of students who watched television three or more hours per day (on an average school day)	18.9	18.8	18.8	=	18.3	18.2	19.8
Percentage of students who played video or computer games or used a computer three or more hours per day (counting time spent on things such as Xbox, PlayStation, an iPad or other tablet, a smartphone, texting, YouTube, Instagram, Facebook, or other social media, for something that was not school work on an average school day)	38.6	43.9	45.3	=	48.3	45.9	46.1
Other							
Percentage of students who had eight or more hours of sleep (on an average school night)	NA	31.8	29.5	=	31.8	33.1	NA
Percentage of students who brushed their teeth on seven days (during the 7 days before the survey)	NA	69.1	66.8	=	63.0	68.2	NA
Percentage of students who most of the time or always wear sunscreen (with an SPF of 15 or higher when they are outside for more than one hour on a sunny day)	NA	12.8	NA	NA	NA	NA	NA
Percentage of students who used an indoor tanning device (such as a sunlamp, sunbed, or tanning booth [not including getting a spray-on tan] one or more times during the 12 months before the survey)	NA	8.3	7.0	=	6.0	5.9	4.5

Sources: https://www.cdc.gov/healthyyouth/data/yrbs/results.htm; https://www.nd.gov/dpi/districtsschools/safety-health/youth-risk-behavior-survey

Appendix I – McKenzie Health Prioritization

Community Health Needs Assessment
Watford City, North Dakota
Ranking of Concerns

The top concerns for each of the five topic areas, based on the community survey results, were listed on flipcharts. 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 blue dots placed on the concerns indicating which areas are felt to be priorities. Each person was given four dots to place on the items they felt were priorities. The "Most Important" column lists the number of red dots placed on the flipcharts. After the first round of voting, the top five priorities were selected based on the highest number of votes. Each person was given one dot to place on the item they felt was the most important priority of the top five highest ranked priorities.

	Priorities	Most Important
COMMUNITY/ENVIRONMENTAL HEALTH CONCERNS		
Not enough affordable housing	5	2
Bullying/cyber-bullying	2	
Physical violence, domestic violence, sexual abuse	3	
Having enough child daycare services	4	
Attracting and retaining young families	1	
Not enough jobs with livable wages, not enough to live on	0	
AVAILABILITY/DELIVERY OF HEALTH SERVICES CONCERNS		
Availability of mental health services	6	11
Ability to retain primary care providers (MD, DO, NP, PA) and nurses	0	
Ability to get appointments for health services within 48 hours	1	
Cost of health care services	0	
YOUTH POPULATION HEALTH CONCERNS		
Smoking and tobacco use, exposure to second-hand smoke, vaping	2	
Suicide	4	
Not getting enough physical activity	0	
ADULT POPULATION HEALTH CONCERNS		
Stress	0	
SENIOR POPULATION HEALTH CONCERNS		
Cost of long-term/nursing home care	2	
Availability of resources to help elderly stay in their homes	0	
Being able to meet the needs of the older population	2	
Assisted living options	1	
Long-term/nursing home care options	0	
Availability of home health	3	
ALL AGES		
Depression/anxiety	0	
Alcohol use and abuse	1	
Drug use and abuse (including prescription drug abuse)	5	1