



## The Community Health Needs Assessment Process in North Dakota: The Importance of Community in Community Health

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- Established in 1980, at The University of North Dakota (UND) School of Medicine and Health Sciences in Grand Forks, ND
- One of the country's most experienced state rural health offices
- UND Center of Excellence in Research, Scholarship, and Creative Activity
- Home to seven national programs
- Recipient of the UND Award for Departmental Excellence in Research

**Focus on**

- Educating and Informing
- Policy
- Research and Evaluation
- Working with Communities
- American Indians
- Health Workforce
- Hospitals and Facilities

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## Big Picture of Health Reform

- Why reform? – access, quality, and cost
- Focus of reform – better care, better health, and lower the growth in costs
- Financial access and system reform
- System reform
  - Emphasis on population health and implications of social determinants on health
  - Volume to value
  - Quality, performance, and outcome
  - New payment methods
- Financial access
  - Individual mandate
  - Medicaid expansion
  - Marketplace (the Exchange)
  - Protection against pre-existing condition exclusion, yearly/lifetime caps
  - Young adults stay on parents plan
  - Donut Hole protection

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## Regulatory Requirement for CHNA

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## Affordable Care Act

Mandates Community Health Needs Assessment (CHNA) be conducted every 3 years by all non-profit hospitals.

Enforced by: IRS

Penalties:

- \$50,000 excise tax per year of non-compliance.
- Puts tax exempt status in jeopardy.

Need: (1) CHNA Report  
(2) Implementation Strategy

Two sets of regulations issued: 2011 and 2013 (clarifications 2014, 2015, 2016).



## CHNA Goals



### Purpose:

1. Describe community health.
2. Present snapshot of health gaps, needs and concerns.

### Goals:

1. Identification and prioritization of health needs.
2. Develop strategic implementation.

## Affordable Care Act – 2011 Regulation

IRS Notice 2011-52 (July 7, 2011):



Guidance on assessment/report requirements. Some detail on what must be documented.

Primary focus:

- Take into account **broad interests of community**, including:
  - Public health
  - Medically underserved, low-income, minority populations, and populations with chronic diseases
  - Federal, tribal, regional, state, or local health depts. or agencies

Also set forth requirements of Implementation Strategy.

## Affordable Care Act – 2013 Regulation



IRS REG-106499 (April 5, 2013):

- IRS relaxes stance on penalties: No penalty if failures to meet requirements were **minor, inadvertent, and due to reasonable cause.**
- Errors/omissions not **willful** or **egregious** will be excused if corrected and disclosed.

## Affordable Care Act – CHNA

- Must take into account input from persons who represent the **broad interests of the community**, including those with special knowledge of, or expertise in, **public health.**
- At a minimum, must take into account input from:
  - (1) at least one state, local, tribal, or regional governmental public health department;
  - (2) members of community's medically underserved, low-income, and minority populations, or individuals/organizations representing interests of such populations; and
  - (3) written comments received on hospital's most recent CHNA and implementation strategy.

## Affordable Care Act – CHNA

- Must make CHNA report widely available to public.
  - Conspicuously post report on hospital's website (or link to other website with report).
  - Report must remain on the website until two subsequent reports have been posted.
  - Must make a paper copy available for public inspection at hospital without charge.
  - May post **draft** of report without starting 3-year cycle.

## Affordable Care Act - CHNA

### Implementation Strategy – Basics

#### For each significant health need, must:

1. Describe how hospital plans to address need
  - a) Describe actions and anticipated impact.
  - b) Identify programs and resources to commit.
  - c) Describe collaboration with other facilities/organizations.
2. Or: Identify need as one hospital does not intend to address and explain why.
  - Brief explanation is sufficient.

Hospital must adopt implementation strategy in same taxable year CHNA is conducted.



## **Focus on Social Determinants of Health And Community Benefit Requirement**

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## **Population Health**

**“Health outcomes of a group of individuals, including the distribution of such outcomes within the group.”** (Kindig, *What is Population Health?*)

- Groups can be based on geography, race, ethnicity, age, language, or other arrangements of people
- Focus – Health Outcomes (what is changed, what are the impacts, what results?)
- What determines the outcomes (determinants of health)?
- What are the public policies and the interventions that can improve the outcomes?

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## Social Determinants

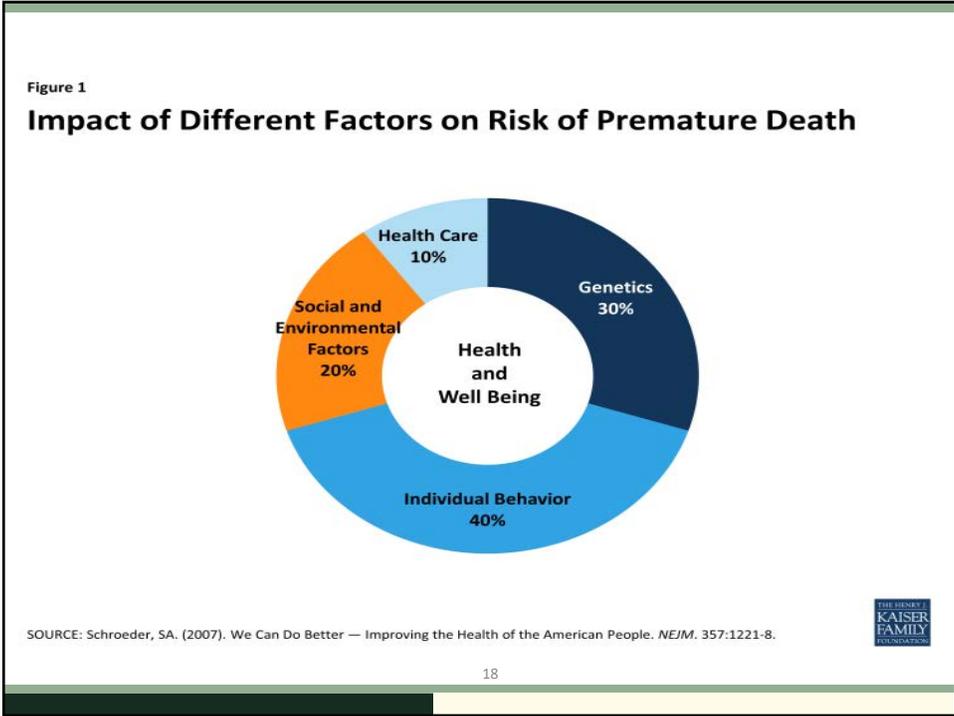
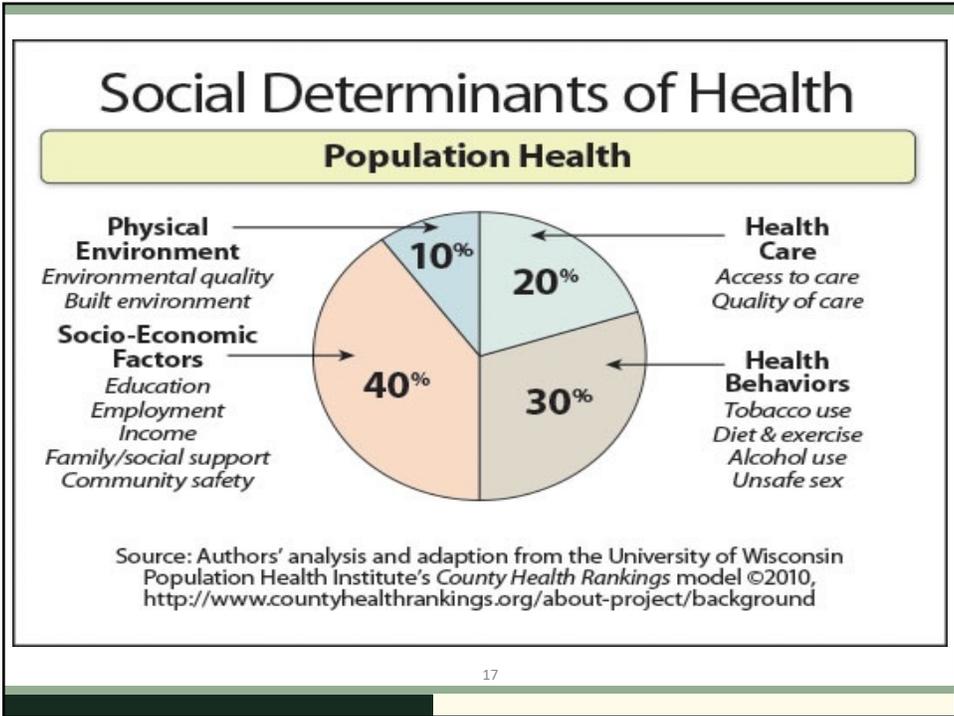
### World Health Organization definition:

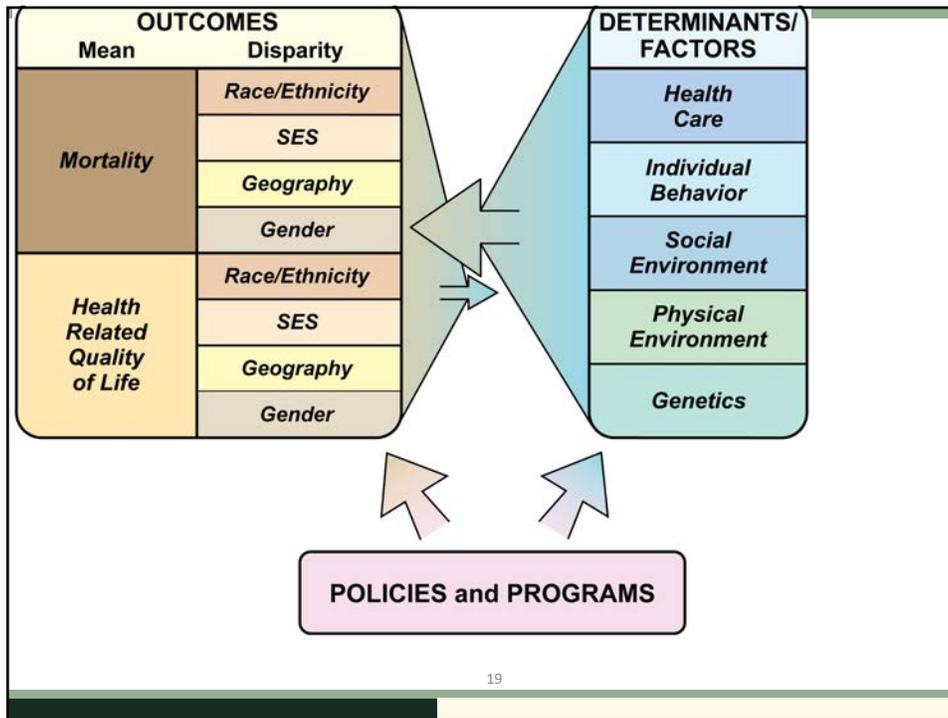
"the circumstances in which people are born, grow up, live, work and age, and the systems put in place to deal with illness. These circumstances are in turn shaped by a wider set of forces: economics, social policies, and politics."

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## Social Determinants of Rural Health

Rural residents tend to be poorer than urban residents

- Average median household income is \$42,628 for rural counties (\$52,204 for urban counties) (2013)
- The average percentage of children living (ages 0-17) in poverty is 26% in rural counties (21% urban) (2013)

Rural residents' educational attainment (2009-2013) - Averaged across counties

- 16.5% have < high school education (14.7% urban)
- 36.3% have only a high school diploma (31.9% urban)
- 17.4% have a Bachelor's degree or higher (24% urban)

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## Social Determinants of Health

- 1) Economic stability
  - Poverty, employment, food security, housing stability
- 2) Education
  - High school graduation, enrollment in higher education, language and literacy, early childhood education and development
- 3) Social and community context
  - Social cohesion, civic participation, perceptions of discrimination and equity, incarceration/institutionalization
- 4) Health and health care
  - Access to health care, access to primary care, health literacy
- 5) Neighborhood and built environment
  - Access to healthy foods, quality of housing, crime and violence, environmental conditions

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## Social Determinants Impact on Access to Health Care

- Poverty, income, and employment status contribute to:
  - Health insurance coverage
  - The ability to pay out-of-pocket costs such as co-pays and prescription drug costs
  - Time off work to go to an appointment
  - A means of transportation to visit a healthcare provider
- The skills to effectively communicate with healthcare providers
- An expectation that they will receive quality care, whatever their race/ethnicity or income level.

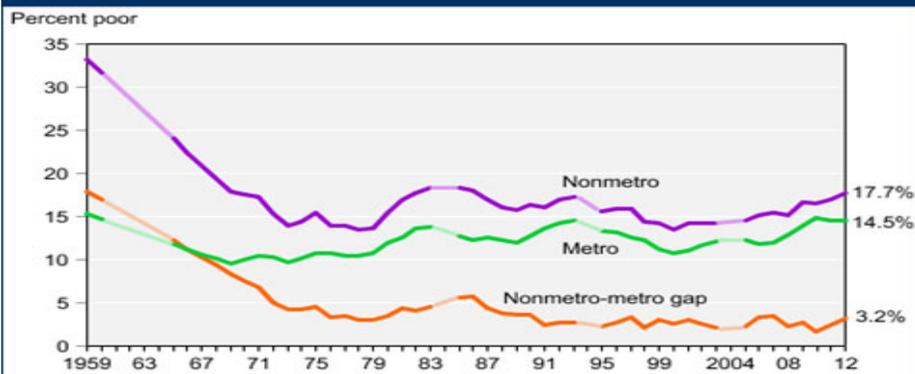
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Stutsman County



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Poverty rates by metro/nonmetro residence, 1959-2012

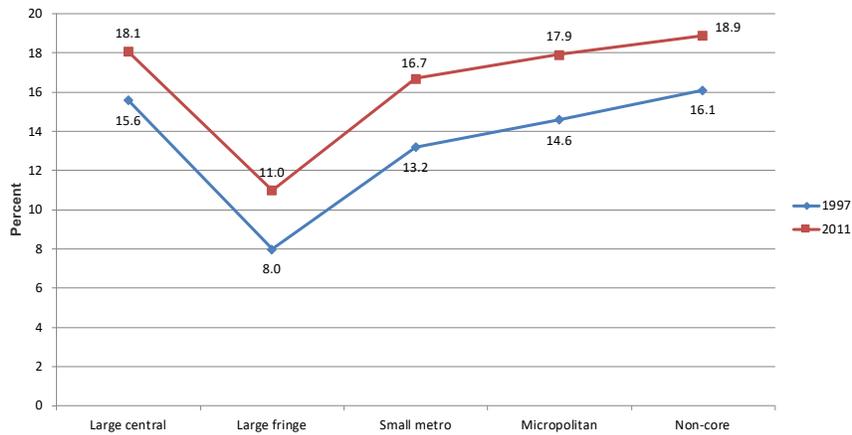


Note: Metro status of some counties changed in 1984, 1994, and 2004. Metro and nonmetro rates are imputed for 1960-66, 1984, 1994, and 2004.  
Source: USDA, Economic Research Service using data from U.S. Census Bureau and U.S. Department of Labor, Bureau of Labor Statistics, Current Population Survey (March Supplements and 2013 Annual Social and Economic Supplements).

Source: [Poverty Overview](#), USDA Economic Research Service

## Population: Poverty

Population in poverty by rurality



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### Community Benefit

• **Language conversion** (conceptualization changes) – moving population health, outcomes, and determinants of health into the language of the Affordable Care Act and making it more relevant to the hospital or other segments in the health care delivery system

• Program or activities that provide treatment and/or promote health in **response to an identified community need**. Key criteria:

- Generates a low or negative margin (financial performance measurement)
- Responds to needs of special populations (e.g., uninsured)
- Supplies a service/program that would likely be discontinued if it were based on financial criteria
- Responds to public health needs but you first need to identify them
- Involves education or research that improves overall community health

## Community Benefit- Program and Activities

### •Community Benefit Services Categories

- **Community health improvement services**
  - **Community health education, community based clinical services** (screenings, health fairs, free clinics) **health care support services** (enrollment in public programs, trans.)
- **Health professional education**
  - **Physicians/medical students/residents, nurses/nursing students, other health professionals** (internships and residency training, job shadowing and mentoring, scholarships/loan repayment, and in-service programming)
- **Subsidized health services**
  - **Services provided to the community that are not expected to be self sustaining** (hospital outpatient services, emergency and trauma, women's and children's services, behavioral health, outpatient palliative care, subsidized continuing care, and renal dialysis services)

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## Community Benefit- Program and Activities

- **Research**
  - **Involved in clinical research** (unreimbursed/unfunded costs of studies on therapeutic protocol) and community health research (studies on health issues for vulnerable populations and research studies on innovative health care delivery models)
- **Financial and in-kind contributions**
  - **Cash donations, grants, in-kind donations, and cost of fund-raising for community programs** (contributions and/or matching funds to not-for-profit organizations, event sponsorship, meeting space for non-profit organizations and groups, and services of hospital grant writer to assist local health agencies)

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## Community Benefit- Program and Activities

- **Community building activities (community health improvement services) – IRS says do not generate inpatient or outpatient bills)**
  - **Physical environment** –interventions to improve community health (community vegetable gardens or walking trails); Support system and workforce enhancement (recruitment of providers for medically underserved areas); Leadership development for community members (advocacy training for community members); Coalition building(disaster preparedness committees); and community health improvement advocacy
  
- **Community benefit operations**
  - **Community health needs assessments** – also community benefit planning and administration – activities associated with fundraising or grant writing for community programs

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## North Dakota CAHs and Community Benefit

### • Obesity and physical activity

- Community farmer's market
- Pilot wellness programs with hospital staff
- Monthly cooking classes
- 12 week weight management program
- Community run and/or walk
- Community access to school fitness center
- CDM monitor program
- Target fitness and exercise to elderly (stretching and movement)
- Step competitions (pedometers)



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## North Dakota CAHs and Community Benefit

### • Healthcare workforce

- Increase use of social media
- Create community marketing group – hospital, economic development, chamber of commerce
- Support local students, financial support for nursing and medicine, and other health professions
- Create local R & R committee with representatives from community – school, bank, business, realtor, church, younger people
- Create a promotional video
- Work with CRH workforce specialist



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## North Dakota CAHs and Community Benefit

- **Mental health**

- Develop mental health screenings in schools
- Support groups
- Work with UND MSW, counseling, and psychology programs for student interns
- Tele-mental health



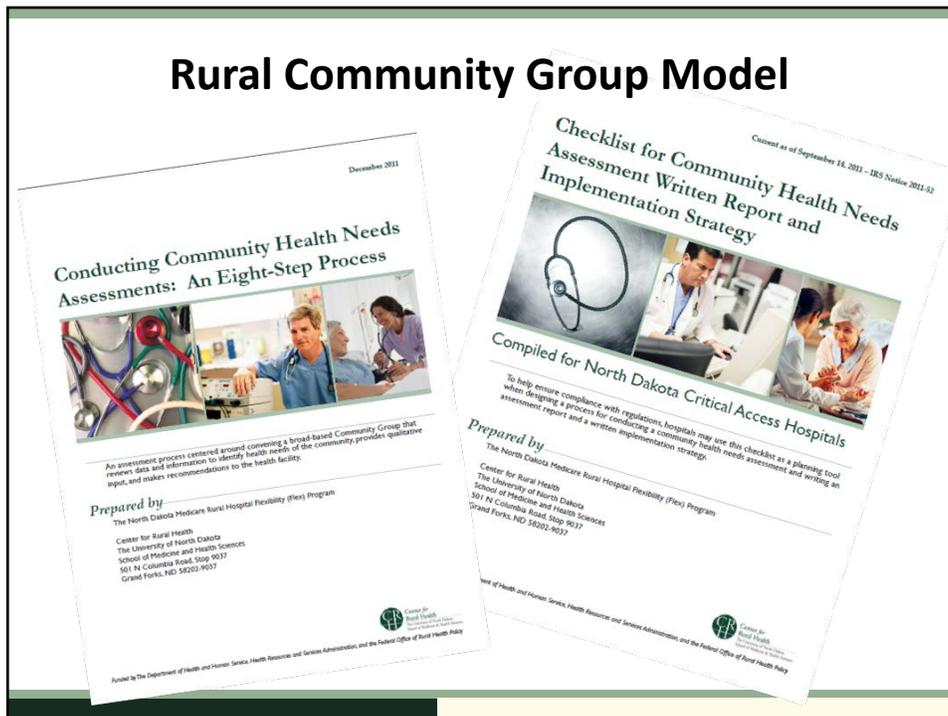
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## Community Engagement Model for CHNA: Rural Community Group Model (RCGM)

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## Rural Community Group Model



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#### Rural Community and Rural Health

- **Communities are comprised of key sectors that have economic, social, and cultural components – together they comprise the town**
  - **Health (with human services)**
  - **Business (can have one or two dominant business types – ag, oil – economic impact of health and health care)**
  - **Education (school consolidation and sport coop changing some of the community identity)**
  - **Government – city, county, special districts – role of park board with health care)**
  - **Faith (social and cultural connections – access to health)**
- **Viable health systems need viable communities – strong education, business, faith, government and business, like those sectors need a strong health system (e.g. health access for employees, general health improvement, health care is large employer adding to business and schools)**

## Why is Community Engagement Important to Rural Health

- Health care providers and organizations cannot operate in isolation.
- Even more important as we implement health reform – new payment models – movement from volume payments to value based payments as more and more providers are assessed and reimbursed on outcomes and patient satisfaction.
- Community members input on needs, issues, and solutions more critical than ever – community involvement in finding solutions (CHNA) that reflect their needs – community ownership not just the health providers – hospitals must address “community benefit”
- Building local leadership and local capacity – think of the next generation of community leadership.
- Communication – listening to the community – educating the community.
- Simple answer: You need to be engaged because you need to survive.

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## Rural Community Group Model (RCGM) Methodology

- Adapted from National Center for Rural Health Works and CRH Community Engagement process
- Mixed methods
  1. Primary data
    - a) Community Group – Focus Group
    - b) Key Informant Interviews
    - c) Surveys
  2. Secondary data

## RCGM and Rural Communities

### At the Community Level:

- Rely on word-of-mouth dissemination – build awareness
- Recognize social capital within rural towns – informal nature
- Utilize CEO or administrator to gain entrée to the community
- Utilize community leaders to build community awareness, community buy-in, and distribution of surveys
- Beware of group think and social stigma
- Build local capacity – skills, leadership, role of health providers in addressing community needs

## RCGM Planning

### Timeline: Two community site visits

- 3-6 months to complete report
- \$15-60,000 using outside consultants
- CRH now charges \$4,500 for a CHNA

### Resources needed:

- Survey software
- 300-1,000 paper surveys per assessment
- Data entry
- Researcher/Facilitator – generally 2 CRH faculty/staff for each CHNA
- Laptop & projector
- Ability to synthesize data, analyze qualitative data, statistical analysis of quantitative data
- *Biggest community resource is commitment and time*

## Rural Community Group Model

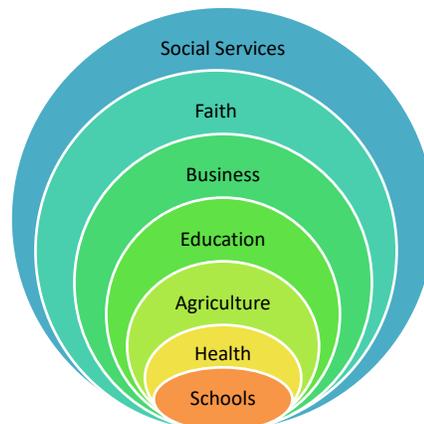
### Convene broad-based Community Group:

1. Meets at least twice.
2. Serves as focus group (1<sup>st</sup> Meeting).
3. Reviews data and information to identify health needs (2<sup>nd</sup> Meeting).
4. Prioritizes needs (2<sup>nd</sup> Meeting).
5. Prioritized needs become the focus for Community Benefit (Implementation Plan).

## Rural Community Group Model

### Community Group composition

1. Represent broad interests of community
2. 12-20 individuals
3. Selected by CEO



## Advantage of RCGM

- Used same assessment method in about 2/3<sup>rd</sup> of critical access hospitals in North Dakota (CRH worked with these)
- Useful to share findings among communities (learn from others, partnerships) – web page
- Valuable to capture health needs at particular time and measure change
- Beneficial to enact change at local and state levels
- Community awareness and active involvement is critical – population health requires the community

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## Secondary Data: County Health Rankings

- Robert Wood Johnson Foundation, collaborating with the University of Wisconsin Population Health Institute
- Illustrate community health needs and provide guidance for actions to improve health.
- Counties compared to state rates and Top 10% nationally in various topics ranging from individual health behaviors to the quality of health care (use 20+ sources of data).
- <http://www.countyhealthrankings.org/app/north-dakota/2016/overview>

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### Summary of Secondary Data: Strengths

<http://www.countyhealthrankings.org/app/north-dakota/2016/overview>

#### **Nelson County in Top 10% Nationally 😊 :**

- Low rates of poor or fair health
- Low rates of poor physical health days
- Low rates of poor mental health days
- High rates of diabetic screening
- High rates of mammography screening
- No drinking water violations
- Low rates of severe housing problems

## Summary of Secondary Data: Potential Needs

<http://www.countyhealthrankings.org/app/north-dakota/2016/overview>

### **Nelson County not meeting state average:**

- Low birth weight
- % Diabetic
- Food environment index
- Physical inactivity
- Access to exercise opportunities
- Alcohol-impaired driving deaths
- Uninsured
- Primary care physicians
- Dentists
- Preventable hospital stays
- Unemployment
- Children in poverty
- Income Inequality
- Children in single-parent households
- Injury deaths

### **Nelson County not meeting Top 10% nationally:**

- Premature death
- Low birth weight
- % Diabetic
- Adult smoking
- Adult obesity
- Food environment index
- Physical inactivity
- Access to exercise opportunities
- Excessive drinking
- Alcohol-impaired driving deaths
- Sexually transmitted infections
- Uninsured
- Primary care physicians
- Dentists
- Preventable hospital stays
- Unemployment
- Children in poverty
- Income inequality
- Children in single-parent households
- Violent crime
- Injury deaths
- Air pollution – particulate matter

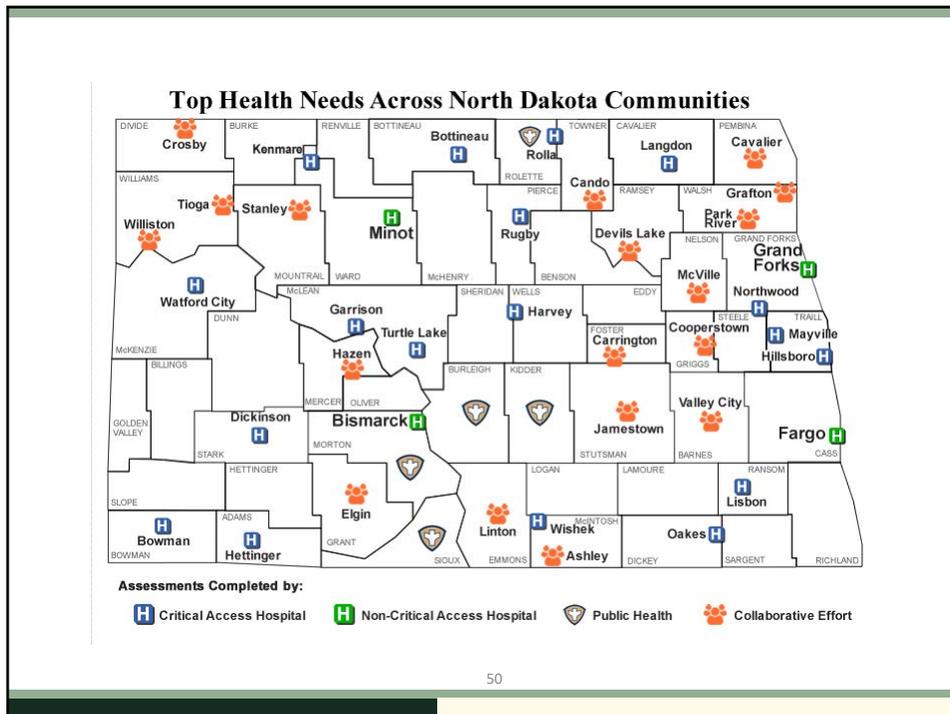
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## Key Informant Interviews & Focus Group

- One-on-one interviews held with key informants (6-10) who can provide insights into community's health needs.
- Selected by hospital CEO or administrator.
- Must interview public health professional.
- IRB consent; limits of confidentiality.
- Topics include:
  - general health needs of the community;
  - awareness/use of health services offered locally;
  - suggestions for improving collaboration within the community,
  - barriers to local care; and
  - reasons community members use local health care providers, and reasons community members use other facilities for health care.

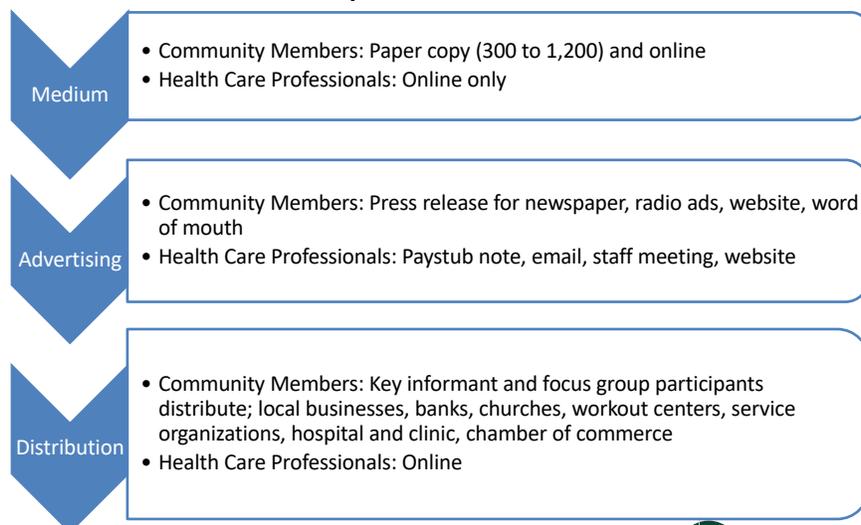




### Survey of the Community

- **Community survey looked at the following:**
  - community assets,
  - awareness and utilization of local health services,
  - barriers to using local services,
  - suggestions for improving collaboration within the community,
  - local health care delivery concerns,
  - reasons consumers use local health care providers and reasons they seek care elsewhere,
  - travel time to the nearest local provider clinic and to the nearest clinic not operated by a local provider, demographics (gender, age, marital status, employment status, income, and insurance status), and
  - any health conditions or diseases respondents currently have.

### Survey Dissemination





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## **Community Group - 2<sup>nd</sup> Meeting**

- **Group members** are presented with:
  - Survey results
  - Findings from key informants and focus group
  - Secondary data relating to general health of service area
- Tasked with identifying and prioritizing community's health needs
- Community Benefit



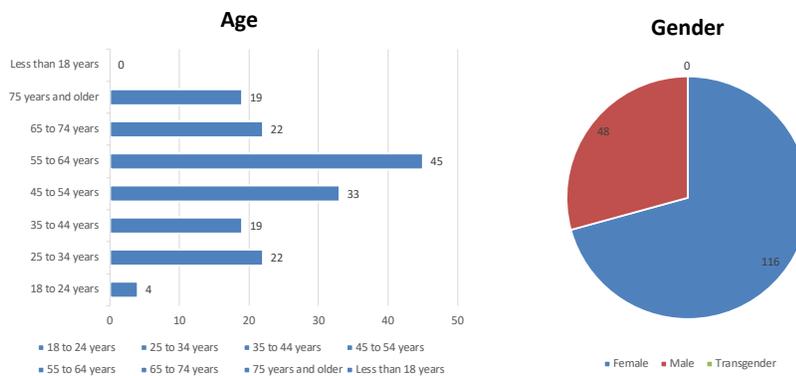
## Community is Critical

- **Community health needs tend to be:**
  - Population health – chronic disease management, prevention, health promotion
  - Hospital focused but critical to addressing and improving community health – workforce and hospital viability
- **Collaboration**
  - Hospital and public health
  - Hospital, public health, primary care
  - Other health organizations
  - Other important partners – school, business, economic development, human services, faith community, local government
  - Can we create a vision on a multi-community level? – networks across organizations and communities

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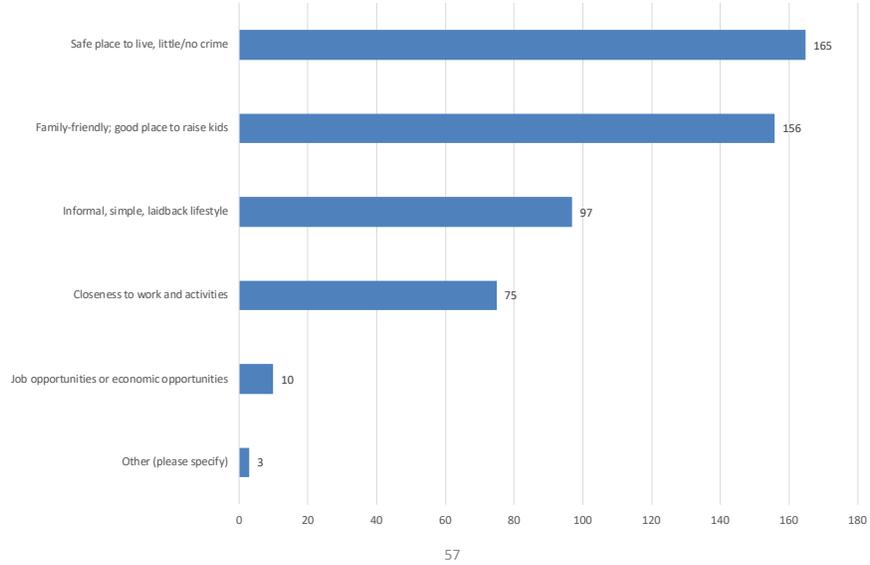
## Survey Results Demographics

Responses from **189** community members  
(**79** paper, **110** online)

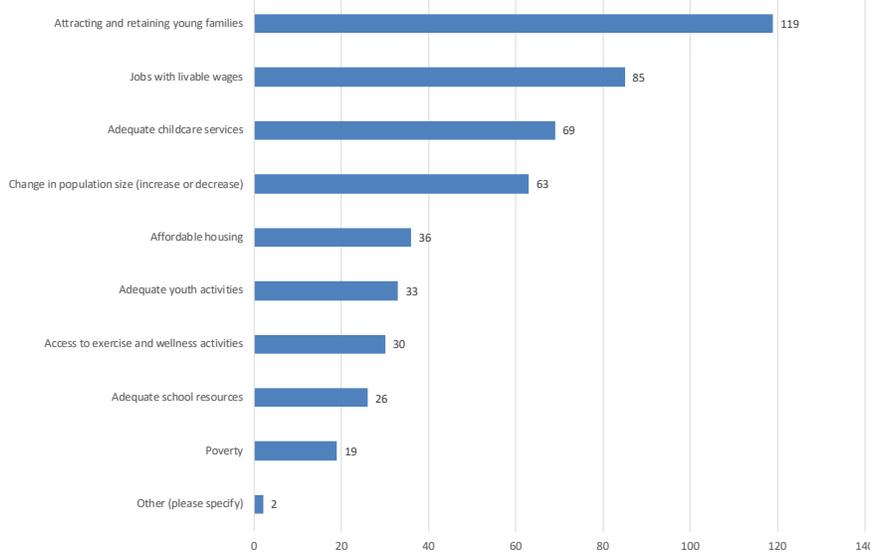


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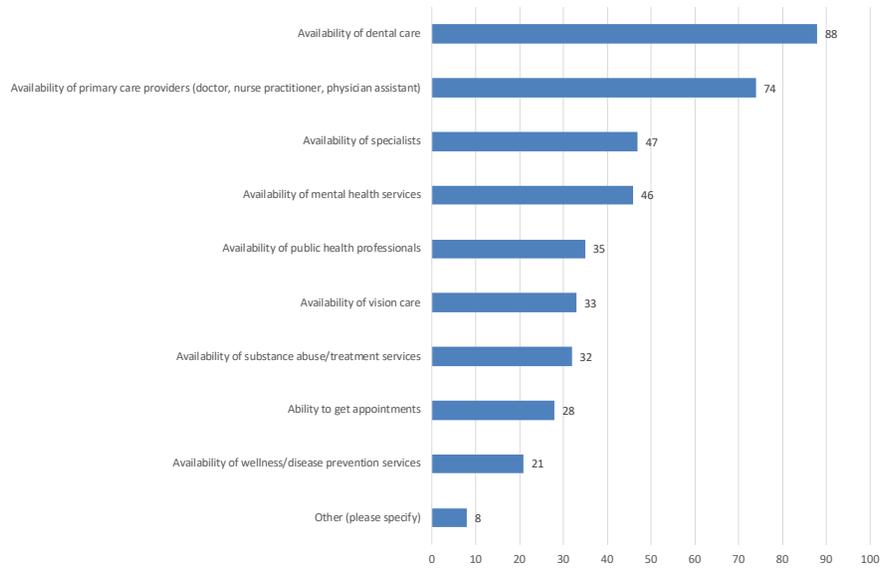
## Three Best Things: Quality of Life



## Survey – Concerns about Community Health

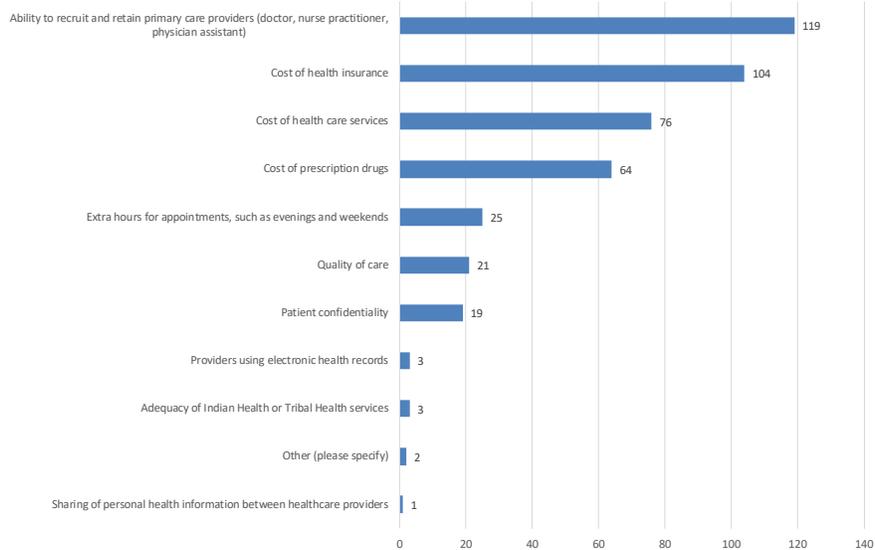


## Survey – Concerns about Availability of Health Services



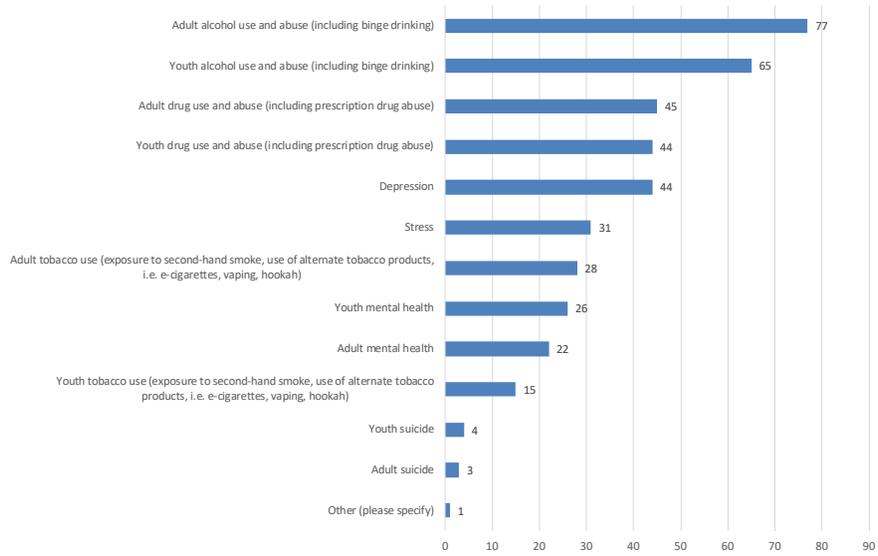
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## Survey – Concerns with Delivery of Health Services



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## Survey – Mental Health/Substance Abuse Concerns



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## Findings - Key Informant Interviews

### Best things about the McVile Area (open ended)

- **Caring** – “everyone is willing to help anyone at any time,” “we take care of each other with fundraisers and support,” “not from here but the community would do the same for me,” “if there is a benefit we are coming out to support,” “they’re always there to help you if you need it,” “the people-everyone knows everyone, everyone is concerned about everyone else”
- **Size and location**– “right size, “it is a good place to live,” “a small tidy town,” “ruralness of the area helps to keep the riff-raff out,” “it’s a little more isolated which is a good thing but the bad thing is we think we [are protected] from issues,” “we feel safe on the streets”
- **Services** – “we have all the basic services,” “having a hospital,” “the businesses we have”
- **Equity/Equality** – “I feel comfortable here-everyone is treated the same,” “it is safe for everyone,” “what we think in rural America, it is the picture,” “welcoming place,” “a sense of volunteerism that isn’t always prevalent in the urban areas”

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## Findings - Key Informant Interviews

### Major Challenges Facing the McVile Area (open ended)

- **Population** – “very small county population wise that is a major problem and decreasing population,” “decreasing population, (said twice)” “no families moving in to sustain the economy”
- **Age** – “aging population, (said twice)” “people 75 and older moving to Grand Forks and Valley 4000 and can’t fault them as it is medically related,” “high elderly population,” “we don’t see as many young people moving to the area as they do in the urban areas,”
- **Services** – “buy things but maybe not local,” “all the services are elsewhere so we have a trend of that happening,”
- **Providers** – “keeping a doctor on hand,” “keep providers, don’t let them burn out,” “not a lot of providers – go to Grand Forks and Devils Lake,” “have providers but people don’t go to them because it is a very small town (leave for other services so seek medical care out of town too),” “basic EMS not ALS”
- **Substance Abuse** – “drug problems,” “high alcohol usage rate,”
- **Culture** – “stubborn independent mindset, they wait for the last minutes for medical care”
- **Housing** – “fixing up homes that are dilapidated”

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## CHNA Report – Regulatory Requirements

### CHNA Documentation Requirements (cont'd)

#### 2. Description of process/methods

- a) Describe data and how collected
- b) Identify collaborators/contractors

#### Assessment Methodology

Pine Valley Medical Center serves an area in northwestern North Dakota and northeastern Montana. The majority of patients come from an area within a 60-mile

#### Community Group

A Community Group consisting of 19 community members met on October 30, 2012. During this first Community Group

#### Interviews

One-on-one interviews with key informants were conducted on October 30 and 31, 2012. A representative of the Center

#### Survey

A survey was distributed to gather feedback from community members. The survey was intended to be a scientific or statistically valid sample

#### Secondary Research

Secondary data was collected and analyzed to provide a snapshot of health conditions, behaviors, and outcomes. Information was collected from

### Secondary Sources Used

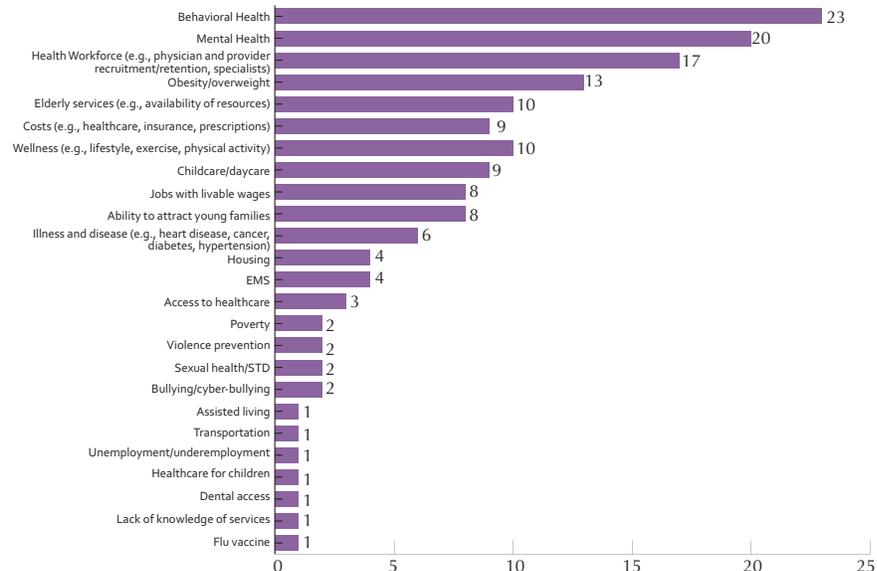
- U.S. Census Bureau
- North Dakota Department of Health
- Robert Wood Johnson Foundation's County Health Rankings (which pulls data from 14 primary data sources)
- North Dakota Health Care Review, Inc. (NDHCRI)
- North Dakota KIDS COUNT
- National Survey of Children's Health Data Resource Center
- Centers for Disease Control and Prevention
- North Dakota Behavioral Risk Factor Surveillance System
- National Center for Health Statistics

## Emergent Health Trends in North Dakota

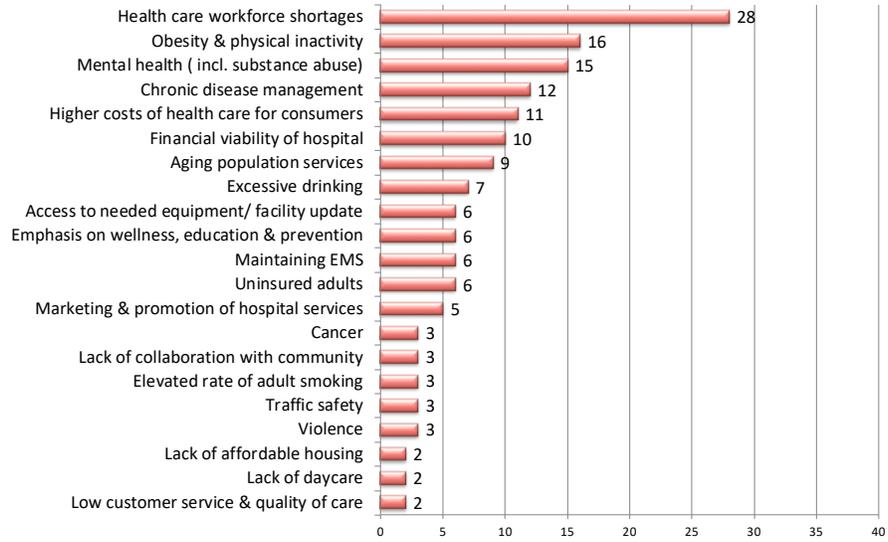
- **45 CHNA (N=41 that we had data) for 2014-2016**
  - 41 included 37 hospital based CHNA and 4 Public Health (accreditation)
- **Aggregated individual CHNA data.**
- **Thematic analysis of prioritized list of needs**
  - Behavioral Health = (23 or 56% of CHNA)
    - Adult and/or adolescent drug and/or alcohol use, availability of providers
  - Mental Health = (20 or 49% of CHNA)
    - Service availability, availability of providers, depression
  - Health Workforce = (17 or 41% of CHNA)
    - Physician and provider recruitment/retention, specialty care access
  - Obesity/overweight = (13 or 32% of CHNA)
    - Access to health clubs, exercise, healthy eating, children
  - Jobs with livable wages = (8 CHNA)
  - Attract and retain young families = (8 CHNA)



### Identified Community Health Needs



## Significant Needs Across North Dakota (2011-2013)



**Action to Improve Your Community's Health**  
<http://www.countyhealthrankings.org/roadmaps/action-center>



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### **Resources to Assist CAHs in Addressing Community Needs**

- Flex grants
- Rural Health Outreach, Network Development, and/or Network Planning
- (new) public health funding
- Contact Rural Assistance Center (<http://www.raonline.org/>)
- CHNA web site <http://ruralhealth.und.edu/projects/community-health-needs-assessment>

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**Resources to Address Community Health Needs**

- **Flex Grants – 2013-2014**
  - **Hazen** – archistruction (i.e., organizational and physical integration) consultant fees for feasibility analysis
  - **Lisbon** – community awareness and education-obesity prevention, healthy eating, wellness screens
  - **Watford City** – physician recruitment candidate site visit related costs
  - **Langdon** – community ed./awareness obesity prevention, healthy eating, phys. ed., cancer screening
  - **Harvey** – professional production of physician recruitment and hospital service awareness DVDs
  - **Oakes**-health coach program reduce unnecessary hospital readmission rates, inappropriate use ED
  - **Carrington**-wellness and disease management program
  - **Turtle Lake**- marketing of hospital services and workforce recruitment
  - **Crosby**-e-emergency
  - **Garrison**-marketing of hospital services and workforce recruitment
  - **Rugby**-telehealth connectivity with Altru
  - **Northwood**-weight management and physical activity program
  
- **Focus is broad to reflect the needs that emerged from the CHNA process but 1<sup>st</sup> year of Flex funding CAHs to address community needs had these themes:** health promotion/disease prevention, disease management (and reduce unnecessary hospitalizations), health workforce, marketing of hospital

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## What are Rural Health Outreach Grants?

- Federal rural health outreach grants support the direct delivery of health care and related services, to expand existing services, and to enhance health service delivery through education, promotion, and prevention programs
- Emphasis is on the actual delivery of specific services rather than the development of organizational capacity
- In this way they contrast with ORHP Rural Health Network Development grants where more of the emphasis is place on “building the network.”
- Both grant programs do require a network of three separate legal entities

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Center for Rural Health



## What are the Limitations on Funds?

- Grantee cannot use the funds for the purchase, construction, renovation, or improvement of real property.
  - Funds, can, however, be used for the purchase/rental of equipment and vehicles up to 40% of the total annual federal share.
- Grantee cannot use funds for the delivery of direct patient care.
- Grantee cannot use funds to reduce or supplant existing levels of institutional and/or other non-federal financial support.
- Network members are expected to use grant funds in a collaborative manner and not to pursue individual projects that benefit only one member organization.

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**Resources to Address Community Health Needs**

- **Rural Health Outreach Grants – federal grants from HRSA**
  - 3 year grants
  - \$200,000 a year starting for 2014 round (had been \$150,000; \$125,000; and \$100,000 prior –significant increase in funding)
  - Requires a network of 3 separate legal organizations
  - Applicant must be rural and non-profit
  - Can have partner that is urban and/or for-profit
  - Common partnerships have been hospitals, public health, education
  - Program started 1991- one of oldest from Office of Rural Health Policy
  - 23 Outreach grants have been funded in ND since 1991 (ND one of leading states)
  - At least 17 rural hospitals involved as applicant or partner
  - 18 grants had a rural hospital
  - Dickinson in 4 Outreach grants; Wishek in 2

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**Resources to Address Community Health Needs**

- **Rural Health Outreach Grants – federal grants from HRSA**
  - *ND Outreach Grants have Addressed the Following:*
  - Community wellness, education, exercise (network from Park River to 8 smaller towns)
  - Health screenings, community health education – CAH, public health, community action agency -covered 8 counties (Dickinson)
  - Three-share program to increase insurance coverage – multiple hospitals
  - Mental health consortium – 4 CAHs (Bottineau, Harvey, Kenmare, and Rolla)
  - Behavioral health, telemedicine – CAH and tertiary hospital (Hazen and Bismarck)
  - Suicide prevention – CAH, public health, primary care clinic (Valley City)
  - Community wellness, education, exercise, chronic disease – CAH, public health, and Job/Economic Development (Langdon)
  - Chronic disease management – CAH, public health, multi-county service area
  - Prevention, screenings, chronic disease – CAH, public health, pharmacy, tertiary hospital (Wishek)
  - Alzheimer’s care, education, training – 2 CAHs and tertiary hospital
  - EMS – first responder training, pager system – CAH, tribal health, ambulance units, group home



Home > What We Do > Projects > Community Health Needs Assessment

## Communities that Share the Same Need

A resource for communities interested in networking with others who are addressing similar issues, based on findings from their Community Health Needs Assessments.

Unless otherwise noted, all communities listed picked the related issue as a top need for the 2011-2013 period.

**Access to Needed Equipment/Facility Update**

- Bowman

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**Aging Population Services**

- Ashley
- Bottineau
- Cando
- Cavaler
- Devils Lake
- Fargo-Sanford
- Grafton
- Hillsboro
- Kidder County
- Minot
- Park River
- Rolla
- Rugby
- Tioga
- Turtle Lake

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**Attracting and Retaining Young Families**

New category in 2014-2016

- Ashley
- Bottineau
- Cando
- Crosby
- Elgin
- McVie
- Northwood

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**Cancer**

- Hillsboro

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**Chronic Disease Management**

Cardiovascular, Diabetes, Respiratory

- Bismarck-St. Alexius
- Kenmare
- Langdon
- Minot
- Rolla

**Bottineau (Bottineau County)**

**St. Andrew's Health Center**

Phone: 701-228-9300  
 Fax: 701-228-9384  
 Type: Hospital - Critical Access Hospital

- View Hospital Profile
- Economic Impact
- Community Needs Health Assessment
  - Report





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**Bowman (Bowman County)**

**Southwest Healthcare Services - Bowman**

Phone: 701-523-3214  
 Fax: 701-523-4139  
 Type: Hospital - Critical Access Hospital

- View Hospital Profile
- Economic Impact
- Community Needs Health Assessment
  - Report
  - Implementation Strategy




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**Cando (Towner County)**

**Towner County Medical Center**

Phone: 701-968-2550  
 Fax: 701-968-2574  
 Type: Hospital - Critical Access Hospital

- View Hospital Profile
- Economic Impact
- Community Needs Health Assessment
  - Report
  - Implementation Strategy




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**Carrington (Foster County)**

**CHI St. Alexius Health Carrington**

Phone: 701-652-3141  
 Fax: 701-652-2884  
 Type: Hospital - Critical Access Hospital

- View Hospital Profile
- Community Needs Health Assessment
  - Report
  - Implementation Strategy



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Sciences

## Nexus for Residents and Students with CHNA

### Targeted Rural Health Education Project (TRHE)

- CRH, ND Rural Health Association, UNDSMHS DFCM
- Non-mandatory learning experience about community health issues – CHNA as resource
- Population health and social determinants
- Medical residents and health professional
- Use CHNA to understand a community health issue, work with local provider and community leaders, write article (with guidance from Dr. Kay Miller-Temple of CRH)
- Enhance leadership skills
- Currently 6 student and 1 resident
- Dr. Dave Schmitz, Chair, DFCM brought idea here – NRHA visibility



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## Final Thoughts

- Health reform, the ACA, embodies an emphasis on population health and importance of social determinants of health
- CHNA are required and have a positive impact on the community – awareness, engagement, and community members leading – opportunity for better and stronger relationships
- TRHE is an opportunity for students – help you to be a better provider



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Contact us for more information!

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The University of North Dakota  
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