Community Health Needs Assessment

2019

Lake Region Area, North Dakota

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Executive Summary

To help inform future decisions and strategic planning, CHI St. Alexius Health Devils Lake, along with Lake Region District Health Unit conducted a community health needs assessment (CHNA) in 2019, the previous CHNA having been conducted in 2016. The Center for Rural Health (CRH) at the University of North Dakota School of Medicine and Health Sciences (UNDSMHS) facilitated the assessment process, which solicited input from area community members and healthcare professionals as well as analysis of community health-related data.

To gather feedback from the community, residents of the area were given the opportunity to participate in a survey, three hundred thirty-nine (339) CHI St. Alexius Health and Lake Region District Health Unit service area residents completed the survey. Additional information was collected through eight key informant interviews with community members throughout the service area. The input from the residents, who primarily reside in Ramsey County, with others residing in Benson, Eddy, and Pierce counties, represented the broad interests of the communities in the service area. Together with secondary data gathered from a wide range of sources, the survey presents a snapshot of the health needs and concerns in the community.

With regard to demographics, Ramsey and Benson County populations from 2010 to 2017 increased 0.6% and 4.1% respectively. Whereas, Eddy and Pierce County populations declined by 2.9% and 5.9% during that time. The average of residents under age 18 (23.5%) for Ramsey County is slightly higher than the state average, (23.3%), Benson is significantly higher (34.5%), Eddy is the same as the North Dakota average, and Pierce is slightly less (22.0%). The percentage of residents ages 65 and older is higher than the North Dakota average (15.0%), for Ramsey (19.3%), Eddy (22.0%), and Pierce (23.1%) Counties and lower for Benson County (13.7%). The rates of education, for all four counties, are somewhat less than the North Dakota average (92.0%) – Ramsey (91.3%), Benson (84.7%), Eddy (88.5%), and Pierce (90.4%). The median household income in Ramsey County ($55,927), Benson County ($44,500), and Eddy County ($55,294), and Pierce County ($55,304) are all lower than the state average for North Dakota ($61,285).

Data compiled by County Health Rankings show Ramsey and Eddy Counties are doing better than North Dakota in health outcomes/factors for 15 categories, Benson County is doing better than North Dakota in 6 categories, and Pierce County is doing better than North Dakota in 14 categories.

Ramsey County, according to County Health Rankings data, is performing poorly relative to the rest of the state in 16 outcome/factor categories; Benson County is performing poorly relative to the rest of North Dakota in 24 categories, Eddy County is performing poorly relative to the rest of the state in 11 outcome/factor categories, and Pierce County is performing poorly relative to the rest of the state in 15 outcome/factor categories.

Of the 82 potential community and health needs set forth in the survey, the 339 CHI St. Alexius Health service area residents who completed the survey indicated the following 10 needs as the most important:

- Having enough child daycare services
- Not enough jobs with livable wages, not enough to live on
- Extra hours for appointments, such as evenings or weekends
- Availability of specialists
- Alcohol use and abuse – Youth
- Drug use and abuse (including prescription drugs)– Youth
- Drug use and abuse (including prescription drugs)– Adult
- Alcohol use and abuse – Adult
- Cost of long-term/nursing home care
- Availability of resources to help the elderly stay in their homes

The survey also revealed the biggest barriers to receiving healthcare (as perceived by community members). They included not enough evening or weekend hours, (N=109), no insurance or limited insurance (N=108), not affordable (N=82), and not able to get appointment/limited hours (N=75).

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

- People are friendly, helpful and supportive
- People who live here are involved in their community
- Active faith community
- Quality school systems
- Family friendly; good place to raise kids
- Safe place to live, little/no crime
- Quality school systems
- Recreational and sports activities
- Year-round access to fitness opportunities

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:

- Having enough child daycare services
- Availability of mental health services
- Availability of resources to help the elderly stay in their homes
- Availability of resources for family and friends caring for elders
- Depression/anxiety – Adults
- Drug use and abuse - Adults
- Drug use and abuse – Youth
- Smoking and tobacco use, exposure to second-hand smoke – Youth
- Not enough jobs with livable wages, not enough to live on
- Having enough child daycare services

Overview and Community Resources

With assistance from the CRH at the UNDSMHS, CHI St. Alexius Devils Lake along with Lake Region District Health Unit completed a CHNA of the service area. The hospital identifies its service area as a 50-mile radius around Devils Lake. Lake Region District Health Unit identifies its service area as Ramsey County, Benson County, Eddy County, and Pierce County. Many community members and stakeholders from all service areas worked together on the assessment.

Devils Lake, in Ramsey County, is a progressive community of over 7,300 located in the northeast quadrant of the state. The Devils Lake area has a lot of opportunities for people and has a thriving economy due to a diverse economy of agriculture, energy, national and international manufacturing, and tourism. Devils Lake has been known for a long time for fishing and other watersports. It has been named the perch capital of the world. There are a number of boat ramps and other facilities around the lake to facilitate recreational activities on the lake. Recreation in the form of open water and ice fishing is estimated to have generated more than $20 million annually. Sully's Hill National Game Preserve is located on the lake's southern shore. Grahams Island State Park is located on an island in the lake and is the base for the National Walleye Tournament Circuit and Devils Lake Chamber of Commerce Fishing Tournament. Another big fishing tournament is the Devils Lake Volunteer Fire Department Ice Fishing Tournament.

In addition to services provided by CHI St. Alexius Health Devils Lake, the following are available:

- Pharmacies
- Altru Clinic – Lake Region
- Dentists (multiple)
- Veterans services
- Chiropractors (multiple)
- Vision services (multiple)
- Lake Region District Health Unit (office location)

New Rockford, in Eddy County, has a number of community assets and resources that can be mobilized to address population health improvement, including the following:

- New Rockford Family Clinic (part of CHI St. Alexius Health Carrington Medical Center)
- Pharmacy
- James River Dentistry
- Nicolai Chiropractic Center
- Peak Performance Physical Therapy and Sports
- Lutheran Home of the Good Shepherd
- Lake Region District Health Unit (office location)

Rugby, in Pierce County, has a number of community assets and resources, including the following:

- Pharmacies
- Heart of America Medical Center (Critical Access Hospital, rural health clinic)
- Chiropractic services
- Dental clinics
- Dakota Eye Institute
- Backstrom Physical Therapy
- Lake Region District Health Unit (office location)

Benson County, which includes the towns of Minnewaukan, Maddock, and Fort Totten, includes the following community assets and resources:

- Pharmacies
- Social services
- Veterans services
- Heart of America Johnson Clinic
- Public health
- Tribal health
- Lake Region District Health Unit (office location in Minnewaukan)

The Spirit Lake Indian Reservation is situated within Benson County, and offers a great deal of services to its members, including: WIC, public health nursing, EMS, diabetes education and information, transportation to appointments, and more.

In the summer of 2015, Cankdeska Cikana Community College (CCCC) conducted the Spirit Lake Comprehensive Community Assessment (CCA) to identify health and wellness needs and to provide support for health, educational, employment, and other program development and implementation. The following information is from the CCA Executive Summary www.littlehoop.edu/pdf/CAA_Final_Full_Report_3_30_16.pdf.

The CCA sample included 285 people representing their household. Their average age was 40, ranging from 16 to 89; 70% were female. Ninety-two percent were enrolled members of Spirit Lake Tribe; 80% had lived in the community for 18 or more years. Forty-six percent were never-married, 34% married or an unmarried couple living together. Fifty-one percent had a high school degree; 28% had less than a high school degree; and 22% had an associate's degree, bachelor's degree, or graduate or professional degree. Thirty-eight percent of the participants reported an individual income of under $5,000.00; 73% under $20,000.00. The most common number of adults in a household was 2 (range 1 to 10 adults per household; the average number of people per family was 4.86 (range 0-19 people in a family).

People completing the survey were asked whether they had any of 11 chronic diseases. The two most common were arthritis and diabetes; 82 people said they had some form of arthritis. Sixty-four percent reported some joint pain. Sixty people had diabetes or were prediabetic. People with mental health issues included:

- 7% were currently taking medicine or receiving treatment from a doctor or other health professional for any type of mental health condition or emotional problem.
- 16% said that a doctor had told them they had an anxiety disorder.
- 12% had been diagnosed with depression in the past.
- 49% screened positive for further testing for depression on the PHQ2.
- 3% scored above 55 on the PHQ8, an indication that they had a major depressive disorder.
- During the past 12 months, 11 people said they had considered suicide and 7 had a plan about how they would attempt suicide

People completing the survey rated their life satisfaction highly (M=1.71, scale range from 1=Very Satisfied to 4=Very Dissatisfied); 94% said they were satisfied or very satisfied.

Factors influencing wellness and life satisfaction include education and child care; economic issues; housing; childhood safety; individual behaviors; access to healthcare; transportation; and communications.

Lack of childcare prevented or interfered with the ability to work outside the home; 25% said they needed childcare and 32% said that relatives provided childcare. Respondents indicated the childcare at times other than 8:00 am to 5:00 pm, when childcare is closed for holidays, and weekends is the most needed.

Individual and family incomes were low. The most common sources of income were Food Stamps and employment. Only 20% of respondents owned their own home; a small number said they changed their living situation often. Four were currently homeless and 41% had been homeless at some time.

To identify early childhood adverse events that might influence health outcomes in adulthood, participants were asked whether they had experienced any of 10 adverse events prior to the age of 18. The most common childhood adverse event was having parents who were never married, separated, or divorced. The next most common childhood adverse event was living with someone who was a problem drinker or alcoholic. Almost everyone had experienced at least 1 adverse event; 82% had five or more adverse events.

Individual factors.

Individual behaviors that may influence health outcomes include obesity, smoking, substance use. The average BMI was 29.87 (minimum=2.65, maximum=70.41). Forty-one percent of the respondents were obese. Eighty percent of the respondents had smoked more than 100 cigarettes at some point in their life; 55% were currently smoking. When asked "how many days in the past 30 days did you have at least one drink of any alcoholic beverage such as beer, wine, a malt beverage or liquor," 162 (57%) said they had had no drinks in the past 30

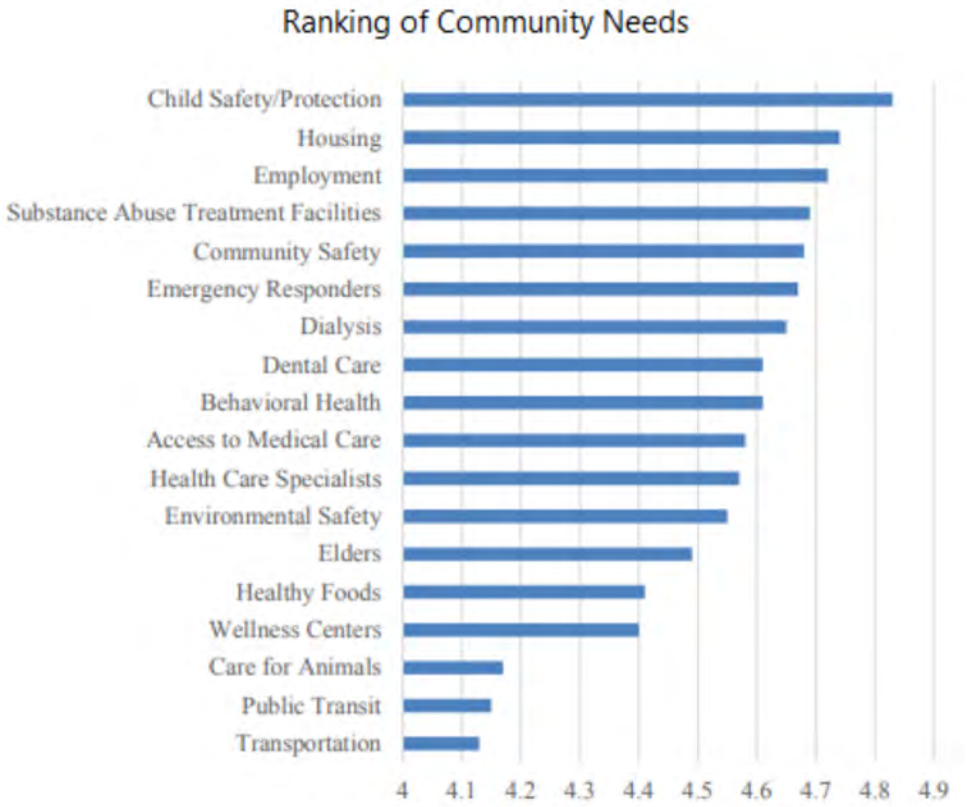
days. When asked "how many times during the past 30 days did you have 5 or more drinks if you are male, 4 or more drinks if you are female on an occasion," 188 participants said they had not engaged in binge drinking in the past 30 days; 97 (34%) had engaged in binge drinking at least one time. Thirty-one of the 36 people who made a comment about drinking said they were sober. Eighty-one percent nearly always or always wear a seat beat.

Access to healthcare, transportation, and communications.

All but six participants reported having some sort of healthcare coverage; the most common types of healthcare were Medicaid (58%) and Indian Health Service (56%). Fifty-six percent of the participants had a personal doctor or healthcare provider. The most common mode of transportation was one's own car (54%). The next most common mode of transportation was riding with relatives (37%). Seventy-four percent (211 people) had access to a working phone. People completing the survey were more likely to access the internet at home or through their phone (36% and 34% respectively).

When people completing the survey were asked to rate needs in the community using 18 items, on a scale of "1= Not at All Important" to "5=Very Important", all of the items were rated above 4. The highest rated item was Child Safety and Protection, closely followed by two items, Housing and Employment. The next five most highly-rated items were health needs (see Figure 1).

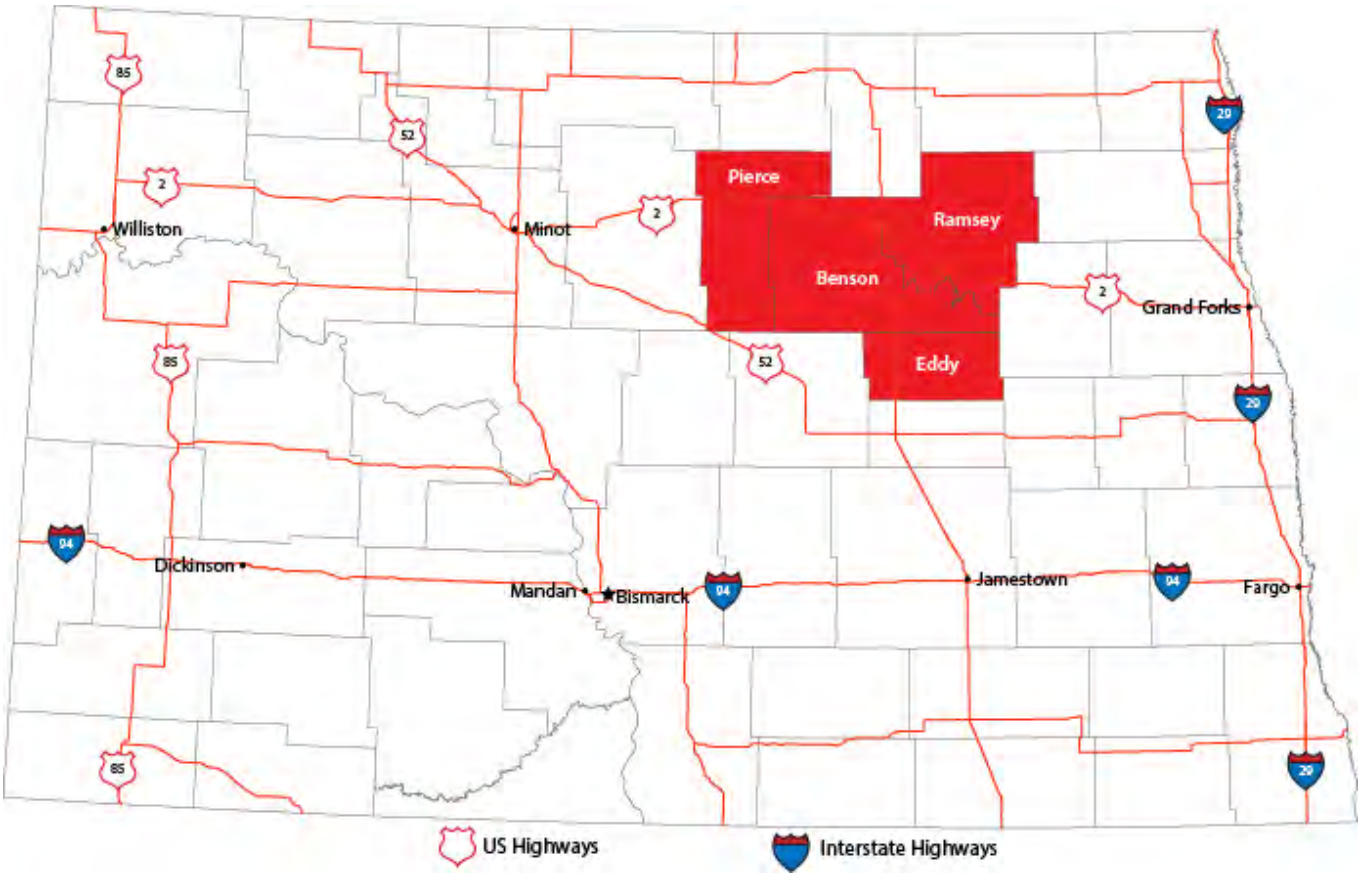
Figure 1: Spirit Lake Nation Comprehensive Community Assessment 2015



When asked what they thought the most important health needs at Spirit Lake Nation were, people completing the survey said that behavioral health issues were most critical; 166 comments were about substance use and 15 were about mental health issues. Chronic diseases (N=119), especially diabetes (N=73) and cancer (21), were also identified as critical health issues. Participants identified healthcare access and quality as the most important factors influencing health outcomes. Fifteen people thought that more community activities, especially for children, were needed to reduce risk factors such as drug and alcohol use. When asked the final question, what the most important community needs were, people reiterated the need for community activities (N=32), especially for children (N=24). Behavioral health issues were the second most frequently mentioned needs.

Figure 2 illustrates the location of the counties.

Figure 2: Ramsey, Benson, Eddy, and Pierce Counties



CHI St. Alexius Devils Lake

CHI St. Alexius Devil Lake Hospital is a 25-bed Critical Access Hospital accredited by The Joint Commission, licensed by the North Dakota State Department of Health, and certified by the Department of Health and Human Services for participation in the Medicare Program. Our hospital has been committed to providing patients quality medical treatment in the Lake Region area and surrounding communities since 1902. Our patients have access to a state-of-the-art health care facility, including 24-7 emergency care, a swing bed program, extensive therapy services, a critical care unit, obstetrical care, and advanced radiology. Our professional and caring staff is dedicated to ensuring patients have compassionate and excellent care. CHI St. Alexius Health Devils Lake Hospital was designated as a "Top 100 Critical Access Hospital" in 2016 and 2018.

If a patient needs a higher level of care than CHI St. Alexius Health Devils Lake Hospital can provide, their network of referral relationships allows them to transfer patients, quickly and efficiently, as needed. Their physicians are able to consult with specialists near and far using TeleHealth, a videoconferencing service.

The mission of Catholic Health Initiatives is to nurture the healing ministry of the Church, supported by education and research. Fidelity to the Gospel urges us to emphasize human dignity and social justice as we create healthier communities. The mission of Catholic Health Initiatives is to live our core values of Reverence, Integrity, Compassion and Excellence by improving the health of the people and communities we serve and pioneering models and systems of care to enhance care delivery.

Services offered locally by CHI St. Alexius Health, Devils Lake include:

- Cardiac rehabilitation
- Critical care unit
- Emergency services
- Laboratory services
- Medical/Surgical unit
- Obstetrics unit
- Occupational therapy
- Physical therapy
- Radiology services
  - o Cardiac imaging
  - o Magnetic Resonance Imaging (MRI)
  - o Computed Tomography Imaging (CAT)
  - o Ultrasound imaging
  - o Vascular imaging
- Respiratory therapy
- Speech therapy
- Surgical services
  - o Ophthalmology
  - o Obstetrics
  - o Podiatry
  - o Endoscopy
  - o General surgery
- Swingbed unit

Lake Region District Health Unit

Lake Region District Health Unit (LRDHU) is a four-county, district health unit providing services to the people of Benson, Eddy, Pierce, and Ramsey counties. It provides public health services that include environmental health, nursing services, and the WIC (women, infants, and children) program. Each of these programs provides a wide variety of services in order to accomplish the mission of public health, which is to assure that North Dakota is a healthy place to live and each person has an equal opportunity to enjoy good health. To accomplish this mission, Lake Region District Health Unit (LRDHU) is committed to the promotion of healthy lifestyles, protection and enhancement of the environment, and provision of quality healthcare services for the people of North Dakota. LRDHU has been serving the Lake Region area since 1950.

Specific services that LRDHU provides are:

- Bicycle helmet safety education resources
- Blood pressure checks
- Breastfeeding resources
- Child passenger Safety Seat Distribution Program
- Child health

- Correction facility health
- Diabetes screening
- Emergency response and preparedness program
- Environmental health services
- Health Tracks (child health screening)
- Immunizations
- Medication setup
- Member of child Protection Team and County Interagency Team
- Home visits
- Nutrition education
- Office visits and consults
- Preschool education programs
- Radon testing kits
- School health (vision, hearing, scoliosis screenings in schools, health education)
- Preschool education programs and screening
- Substance abuse prevention program
- Referral services
- Tobacco Prevention and Control
- Tuberculosis testing and management
- West Nile program—surveillance and education
- WIC (Women, Infants & Children) Program
- Worksite Wellness
- Youth education programs (first aid, bike safety)

Assessment Process

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

A CHNA benefits the community by:

1) Collecting timely input from the local community members, providers, and staff;

2) Providing an analysis of secondary data related to health-related behaviors, conditions, risks, and outcomes;

3) Compiling and organizing information to guide decision making, education, and marketing efforts, and to facilitate the development of a strategic plan;

4) Engaging community members about the future of healthcare; and

5) Allowing the community hospital to meet the federal regulatory requirements of the Affordable Care Act, which requires not-for-profit hospitals to complete a CHNA at least every three years, as well as helping the local public health unit meet accreditation requirements.

The CRH, in partnership with CHI St. Alexius Health and LRDHU, facilitated the CHNA process. Community representatives met regularly in-person, by telephone conference, and email. A CHNA liaison was selected locally, who served as the main point of contact between the CRH and Devils Lake. A small steering committee (see Figure 2) was formed that was responsible for planning and implementing the process locally. Representatives from the CRH met and corresponded regularly by teleconference and/or via the eToolkit with the CHNA liaison. The community group (described in more detail below) provided in-depth information and informed the assessment process in terms of community perceptions, community resources, community needs, and ideas for improving the health of the population and healthcare services. Twenty-two people, representing a cross section demographically from all four counties, attended five group meetings. The meetings were highly interactive with good participation. CHI St. Alexius staff and board members, along with LRDHU staff were in attendance as well.

Figure 2: Steering Committee

Michelle Belt	CEO	Spirit Lake Health Center
Kenny Baker	Health Board Chairman	Spirit Lake Tribal Health
Annette Groves	Director of Nursing	Lake Region District Health Unit
Allen McKay	Administrator	Lake Region District Health Unit
Amber Stokke	Clinic Manager	Altru Clinic-Lake Region
Andrew Lankowicz	FACHE, President	CHI St. Alexius Health Devils Lake Hospital
Shannon Lauinger	Executive Assistant/ CHNA Liason	CHI St. Alexius Health Devils Lake Hospital
Rhonda Allery	Director	Lakes Social Service District

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

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

- A survey solicited feedback from area residents;
- Community leaders representing the broad interests of the community took part in one-on-one key informant interviews;
- The community group, comprised of community leaders and area residents, was convened to discuss area health needs and inform the assessment process; and
- A wide range of secondary sources of data were examined, providing information on a multitude of measures, including demographics, health conditions, indicators, outcomes, rates of preventive measures; rates of disease; and at-risk behavior.

The CRH is one of the nation's most experienced organizations committed to providing leadership in rural health. Its mission is to connect resources and knowledge to strengthen the health of people in rural communities. The CRH is the designated State Office of Rural Health and administers the Medicare Rural Hospital Flexibility (Flex) program and is funded by the Federal Office of Rural Health Policy, Health Resources Services Administration, and Department of Health and Human Services. The CRH connects the UNDSMHS and other necessary resources, to rural communities and their healthcare organizations in order to maintain access to quality care for rural residents. In this capacity, the CRH works at a national, state, and community level.

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

Community Group

Five community group meetings were scheduled. Altogether, 27 community members convened. The first of the five community meeting was held in Devils Lake on January 17, 2019 with nine people in attendance. The second and third meetings were held February 1, 2019 in Rugby and Maddock. There were two people at the Rugby meeting and six in attendance for the Maddock meeting. The final two meetings were held February 12, 2019 in Fort Totten and New Rockford. Seven people attended the Fort Totten session and New Rockford had three people in attendance. During the first community group meeting in each location, group members were

introduced to the needs assessment process, reviewed basic demographic information about the community, and served as a focus group. Focus group topics included community assets and challenges, the general health needs of the community, community concerns, and suggestions for improving the community's health.

The community group met as a whole again on April 9, 2019 with 21 community members in attendance. Everyone who was invited to the first community meetings in each location and all of the key informants were invited to attend the second community meeting. At the second meeting, the community group was presented with survey results, findings from key informant interviews and the focus group, and a wide range of secondary data relating to the general health of the population in Ramsey, Benson, Eddy, and Pierce counties. The group was then tasked with identifying and prioritizing the community's health needs.

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

Interviews

One-on-one interviews with seven key informants were conducted in person on January 17, 2019 in Devils Lake, on February 1, 2019 in Rugby and Maddock, and on February 12, 2019 in New Rockford and Fort Totten. Representatives from the CRH conducted the interviews. Interviews were held with selected members of the community who could provide insights into the community's health needs. 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 healthcare by local providers, awareness of health services offered locally, barriers to receiving health services, and suggestions for improving collaboration within the community.

Survey

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

The community member survey was distributed to various residents of Ramsey, Benson, Eddy and Pierce counties, which are included in the CHI St. Alexius and LRDHU service area. The survey tool was designed to:

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

Specifically, the survey covered the following topics:

- Residents' perceptions about community assets;
- Broad areas of community and health concerns;
- Awareness of local health services;
- Barriers to using local healthcare;

- Basic demographic information;
- Suggestions to improve the delivery of local healthcare; and
- Suggestions for capital improvements.

To promote awareness of the assessment process, the survey was advertised in flyers that were put up throughout the community for one month, by public service announcements and advertisements on local radio stations, through social media reminders on Facebook, advertisements in the local newspaper, and on the radio show Coffee Time on KZZY FM radio station.

Approximately 300 paper copies of the community member survey were available for distribution throughout Ramsey, Benson, Eddy, and Pierce counties. The surveys were distributed by community group members and at CHI St. Alexius, LRDHU, and businesses throughout all four counties.

To help ensure anonymity, included with each paper survey was a postage-paid return envelope to the CRH. In addition, to help make the survey as widely available as possible, residents also could request a survey by calling CHI St. Alexius or LRDHU. The survey period ran from January 7, 2019 to February 28, 2019. There were 77 completed paper surveys returned.

Area residents also were given the option of completing an online version of the survey. There were 255 online surveys completed. Of those, 19 online respondents used the QR code to complete the survey. In total, counting both paper and online surveys, 332 community member surveys were completed, equating to a 6.0% response rate. This response rate is below average (13.0%) for this type of unsolicited survey methodology.

Secondary Data

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

Social Determinants of Health

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

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

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

Figure 3: Social Determinants of Health

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

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

Figure 4: Social Determinants of Health

Economic Stability	Neighborhood and Physical Environment	Education	Food	Community and Social Context	Health Care System
Employment	Housing	Literacy	Hunger	Social integration	Health coverage
Income	Transportation	Language	Access to healthy options	Support systems	Provider availability
Expenses	Safety	Early childhood education		Community engagement	Provider linguistic and cultural competency
Debt	Parks	Vocational training		Discrimination	
Medical bills	Playgrounds	Higher education		Stress	Quality of care
Support	Walkability				
	Zip code / geography				

Health Outcomes
Mortality, Morbidity, Life Expectancy, Health Care Expenditures, Health Status, Functional Limitations

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Demographic Information

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

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

	Ramsey County	Benson County	Eddy County	Pierce County	North Dakota
Population (2017)	11,519	6,936	2,316	4,099	760,077
Population change (2010-2017)	0.6%	4.1%	-2.9%	-5.9%	12.3%
People per square mile (2010)	9.6	4.8	3.8	4.3	9.7
Persons 65 years or older (2016)	19.3%	13.7%	22.0%	23.1%	15.0%
Persons under 18 years (2016)	23.5%	34.5%	23.3%	22.0%	23.3%
Median age (2016 est.)	85.4%	42%	93.1%	93.4%	87.5%
White persons (2016)	3.5%	4.1%	2.6%	1.5%	5.6%
Non-English speaking (2016)	91.3%	84.7%	88.5%	90.4%	92.3%
High school graduates (2016)	24.7%	15.4%	23.3%	15.8%	28.9%
Bachelor's degree or higher (2016)	12.3%	28.4%	10.6%	11.8%	10.3%
Live below poverty line (2016)	8.4%	14.5%	9.8%	9.8%	8.8%
Persons without health insurance, under age 65 years (2016)		12.4%	6.3%	6.8%	8.1%

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

The population of North Dakota has grown in recent years, and Ramsey and Benson Counties have been no exception, seeing an increase in population since 2010. The U.S. Census Bureau estimates show that Ramsey County's population increased from 11,451 (2010) to 11,519 (2017), and Benson County's population increased from 6,660 (2010) to 6,936 (2017). However, both Eddy and Pierce counties have shown a decrease in population since 2010. Eddy County's population decreased from 2,385 (2010) to 2,316 (2017), and Pierce County's population fell from 4,357 (2010) to 4,099 (2017)..

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, Dunn, Mercer, and Oliver Counties are compared to North Dakota rates and national benchmarks on various topics ranging from individual health behaviors to the quality of healthcare.

The data used in the 2019 County Health Rankings are pulled from more than 20 data sources and then are compiled to create county rankings. Counties in each of the 50 states are ranked according to summaries of a variety of health measures. Those having high ranks, such as 1 or 2, are considered to be the "healthiest." Counties are ranked on both health outcomes and health factors. Following is a breakdown of the variables that influence a county's rank.

A model of the 2019 County Health Rankings – a flow chart of how a county's rank is determined – is found in Appendix B. For further information, visit the County Health Rankings website at www.countyhealthrankings.org.

Table 2: County Health Rankings

Health Outcomes
- Length of life
- Quality of life

Health Factors
- Health behavior
  - Smoking
  - Diet and exercise
  - Alcohol and drug use
  - Sexual activity

Health Factors (continued)
- Clinical care
  - Access to care
  - Quality of care
- Social and Economic Factors
  - Education
  - Employment
  - Income
  - Family and social support
  - Community safety
- Physical Environment
  - Air and water quality
  - Housing and transit

Tables 2 and 3 summarize the pertinent information gathered by County Health Rankings as it relates to Ramsey, Benson, Eddy, and Pierce Counties. It is important to note that these statistics describe the population of a county, regardless of where county residents choose to receive their medical care. In other words, all of the following statistics are based on the health behaviors and conditions of the county's residents, not necessarily the patients and clients of LRDHU and CHI St. Alexius or of any particular medical facility.

For most of the measures included in the rankings, the County Health Rankings' authors have calculated the "Top U.S. Performers" for 2019. 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).

Ramsey, Benson, Eddy, and Pierce Counties rankings within the state are included in the summary following. For example, Ramsey County ranks 44th out of 49 ranked counties in North Dakota on health outcomes and 27th on health factors. The measures marked with a red bullet point (•) are those where a county is not measuring up to the state rate/percentage; a blue square (■) indicates that the county is faring better than the North Dakota average but is not meeting the U.S. Top 10% rate on that measure. Measures that are not marked with a colored checkmark but are marked with a plus (+) indicate that the county is doing better than the U.S. Top 10%.

The data from County Health Rankings shows that Ramsey County is doing better than many counties compared to the rest of the state on all but three of the outcomes, landing at or above rates for other North Dakota counties. However, the county, like many North Dakota counties, is doing poor in many areas when it comes to the U.S. Top 10% ratings. One particular outcome where Ramsey County does not meet the U.S. Top 10% ratings is the percentage of the population with poor or fair health.

On health factors, Ramsey County performs below the North Dakota average for counties in several areas as well.

Data compiled by County Health Rankings show Ramsey County is doing better than North Dakota in health outcomes and factors for the following indicators:

- Adult smoking
- Drinking water violations
- Excessive drinking

- Flu vaccinations
- Mammography screening (% of Medicare enrollees ages 67-69 receiving screening)
- Number of dentists
- Number of mental health providers
- Number of primary care physicians
- Number of uninsured
- Poor mental health days
- Poor or fair health
- Poor physical health days
- Severe housing problems
- Social associations
- Violent crime

Data compiled by County Health Rankings show Ramsey County is doing better than North Dakota in health outcomes and factors for the following indicators:

- Adult smoking
- Drinking water violations
- Excessive drinking
- Flu vaccinations
- Mammography screening (% of Medicare enrollees ages 67-69 receiving screening)
- Number of dentists
- Number of mental health providers
- Number of primary care physicians
- Number of uninsured
- Poor mental health days
- Poor or fair health
- Poor physical health days
- Severe housing problems
- Social associations
- Violent crime

Outcomes and factors in which Ramsey County was performing poorly relative to the rest of the state include:

- Access to exercise opportunities
- Adult obesity
- Air pollution – particulate matter
- Alcohol impaired driving deaths
- Children in poverty
- Children in single-parent households
- Food environment index
- Income inequality
- Injury deaths
- Low birth weight
- Physical inactivity
- Premature death
- Preventable hospital stays
- Sexually transmitted infections
- Teen birth rate
- Unemployment

County Health Rankings shows that Benson County is not doing as well as other counties compared to the rest of the state, landing at or above rates for other North Dakota counties in only one measure. The county, like many North Dakota counties, is doing poor in many areas when it comes to the U.S. Top 10% ratings as well. One particular outcome where Benson County does not meet the U.S. Top 10% ratings is the percentage of the

population with poor or fair health.

On health factors, Benson County performs below the North Dakota average for counties in several areas as well.

Data compiled by County Health Rankings show Benson County is doing better than North Dakota in health outcomes and factors for the following indicators:

- Adult obesity
- Drinking water violations
- Excessive drinking
- Flu vaccinations
- Low birth weight
- Violent crime

Outcomes and factors in which Benson County was performing poorly relative to the rest of the state include:

- Access to exercise opportunities
- Adult smoking
- Air pollution – particulate matter
- Alcohol-impaired driving deaths
- Children in poverty
- Children in single-parent households
- Food environment index
- Income inequality
- Injury deaths
- Mammography screening (screening (% of Medicare enrollees ages 67-69 receiving screening)
- Number of dentists
- Number of mental health providers
- Number of uninsured
- Physical inactivity
- Poor mental health days
- Poor or fair health
- Poor physical health days
- Premature death
- Preventable hospital stays
- Severe housing problems
- Sexually transmitted infections
- Social associations
- Teen birth rate
- Unemployment

The data from County Health Rankings shows that Eddy County is doing better than many counties compared to the rest of the state on all but one of the outcomes, landing at or above rates for other North Dakota counties. However, the county, like many North Dakota counties, are doing poor in many areas when it comes to the U.S. Top 10% ratings. One particular outcome where Eddy County does not meet the U.S. Top 10% ratings is the percentage of the population with poor or fair health.

On health factors, Eddy County performs below the North Dakota average for counties in several areas as well.

Data compiled by County Health Rankings show Eddy County is doing better than North Dakota in health outcomes and factors for the following indicators:

- Adult smoking
- Air pollution – particulate matter
- Children in single parent households
- Drinking water violations
- Excessive drinking
- Low birth weight
- Mammography screening (% of Medicare enrollees ages 65-74 receiving screening)
- Number of dentists
- Poor mental health days
- Poor or fair health
- Poor physical health days
- Preventable hospital stays
- Severe housing problems
- Social associations
- Violent crime

Outcomes and factors in which Eddy County was performing poorly relative to the rest of the state include:

- Access to exercise opportunities
- Adult obesity
- Alcohol impaired driving deaths
- Children in poverty
- Flu vaccinations
- Food environment index
- Income inequality
- Injury deaths
- Number of uninsured
- Physical inactivity
- Unemployment

The data from County Health Rankings shows that Pierce County is doing better than many counties compared to the rest of the state on one of the outcomes, landing at or above rates for other North Dakota counties. However, the county, like many North Dakota counties, are doing poor in many areas when it comes to the U.S. Top 10% ratings. One particular outcome where Pierce County does not meet the U.S. Top 10% ratings is the rates of low birth weight.

On health factors, Pierce County performs below the North Dakota average for counties in several areas as well.

Data compiled by County Health Rankings show Pierce County is doing better than North Dakota in health outcomes and factors for the following indicators:

- Access to exercise opportunities
- Adult smoking
- Air pollution – particulate matter
- Alcohol-impaired driving deaths
- Drinking water violations
- Excessive drinking
- Mammography screening (% of Medicare enrollees ages 65-74 receiving screening)
- Number of dentists
- Poor mental health days
- Poor or fair health
- Sexually transmitted infections
- Social associations
- Teen birth rate
- Violent crime

Outcomes and factors in which Pierce County was performing poorly relative to the rest of the state include:

- Adult obesity
- Children in poverty
- Children in single parent households
- Flu vaccinations
- Food environment index
- Income inequality
- Injury deaths
- Low birth weight
- Number of primary care physicians
- Number of uninsured
- Physical inactivity
- Poor physical health days
- Preventable hospital stays
- Severe housing problems
- Unemployment

● = Not meeting North Dakota average

■ = Not meeting U.S. Top 10% Performers

+ = Meeting or exceeding U.S. Top 10% Performers

Blank values reflect unreliable or missing data

TABLE 2: SELECTED MEASURES FROM *COUNTY HEALTH RANKINGS* 2019 – PIERCE AND EDDY COUNTY

	Pierce County	Eddy County	U.S. Top 10%	North Dakota
Ranking: Outcomes	**46th**	**29th**		**(of 49)**
Premature death			5,400	6,700
Poor or fair health	14% ■	14% ■	12%	14%
Poor physical health days (in past 30 days)	3.1 ●■	3.0 +	3.0	3.0
Poor mental health days (in past 30 days)	3.0 +	2.9 +	3.1	3.1
Low birth weight	11% ●■	5% +	6%	6%
Ranking: Factors	**38th**	**42nd**		**(of 49)**
Health Behaviors				
Adult smoking	18% ■	16% ■	14%	20%
Adult obesity	33% ●■	34% ●■	26%	32%
Food environment index (10=best)	8.4 ●■	8.4 ●■	8.7	9.1
Physical inactivity	25% ●■	30% ●■	19%	22%
Access to exercise opportunities	71% ■	70% ●■	91%	74%
Excessive drinking	21% ■	19% ■	13%	26%
Alcohol-impaired driving deaths	38% ■	100% ●■	13%	46%
Sexually transmitted infections	139.1 +		152.8	456.5
Teen birth rate	15 ■		14	23
Clinical Care				
Uninsured	10% ●■	10% ●■	6%	8%
Primary care physicians	1,420:1 ●■		1,050:1	1,320:1
Dentists	1,020:1 +	770:1 +	1,260:1	1,530:1
Mental health providers			310:1	570:1
Preventable hospital stays	4,738 ●■	3,929 ■	2,765	4,452
Mammography screening (% of Medicare enrollees ages 65-74 receiving screening)	52% +	52% +	49%	50%
Flu vaccinations (% of fee-for-service Medicare enrollees that had an annual flu vaccination)	25% ●■	42% ●■	52%	47%
Social and Economic Factors				
Unemployment	3.2% ●■	4.6% ●■	2.9%	2.6%
Children in poverty	15% ●■	13% ●■	11%	11%
Income inequality	5.4 ●■	4.8 ●■	3.7	4.4
Children in single-parent households	30% ●■	27% ■	20%	27%
Social associations	25.8 +	25.4 +	21.9	16.0
Violent crime	138 ■	169 ■	63	258
Injury deaths	88 ●■	127 ●■	57	69
Physical Environment				
Air pollution – particulate matter	5.4 +	5.3 +	6.1	5.4
Drinking water violations	No +	No +		
Severe housing problems	17% ●■	9% +	9%	11%

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

● = Not meeting North Dakota average

■ = Not meeting U.S. Top 10% Performers

+ = Meeting or exceeding U.S. Top 10% Performers

Blank values reflect unreliable or missing data

TABLE 2: SELECTED MEASURES FROM *COUNTY HEALTH RANKINGS* 2019 – RAMSEY AND BENSON COUNTY

	Ramsey County	Benson County	U.S. Top 10%	North Dakota
Ranking: Outcomes	**44th**	**47th**		**(of 49)**
Premature death	8,100 ●■	16,800 ●■	5,400	6,700
Poor or fair health	13% ■	25% ●■	12%	14%
Poor physical health days (in past 30 days)	3.0 +	4.7 ●■	3.0	3.0
Poor mental health days (in past 30 days)	2.8 +	4.1 ●■	3.1	3.1
Low birth weight	9% ●■	6% +	6%	6%
Ranking: Factors	**27th**	**47th**		**(of 49)**
Health Behaviors				
Adult smoking	19% ■	30% ●■	14%	20%
Adult obesity	33% ●■	32% ■	26%	32%
Food environment index (10=best)	9.0 ●	6.6 ●■	8.7	9.1
Physical inactivity	26% ●■	27% ●■	19%	22%
Access to exercise opportunities	73% ●■	63% ●■	91%	74%
Excessive drinking	22% ■	19% ■	13%	26%
Alcohol-impaired driving deaths	56% ●■	50% ●■	13%	46%
Sexually transmitted infections	877.0 ●■	1,895.5 ●■	152.8	456.5
Teen birth rate	38 ●■	94 ●■	14	23
Clinical Care				
Uninsured	8% ■	14% ●■	6%	8%
Primary care physicians	1,050:1 +		1,050:1	1,320:1
Dentists	1,150:1+	6,940:1 ●■	1,260:1	1,530:1
Mental health providers	230:1 +	1,730:1 ●■	310:1	570:1
Preventable hospital stays	4,812 ●■	6,565 ●■	2,765	4,452
Mammography screening (% of Medicare enrollees ages 65-74 receiving screening)	57% +	47% ●■	49%	50%
Flu vaccinations (% of fee-for-service Medicare enrollees that had an annual flu vaccination)	53% +	32% ■	52%	47%
Social and Economic Factors				
Unemployment	2.7% ●	3.5% ●■	2.9%	2.6%
Children in poverty	16% ●■	40% ●■	11%	11%
Income inequality	4.9 ●■	5.5 ●■	3.7	4.4
Children in single-parent households	34% ●■	59% ●■	20%	27%
Social associations	19.1 ■	7.4 ●■	21.9	16.0
Violent crime	143 ■	29 +	63	258
Injury deaths	73 ●■	158 ●■	57	69
Physical Environment				
Air pollution – particulate matter	5.6 ●	5.6 ●	6.1	5.4
Drinking water violations	No +	No +		
Severe housing problems	10% ■	16% ●■	9%	11%

Source: http://www.countyhealthrankings.org/app/north-dakota/2019/rankings/outcomes/overall

Children's Health

The National Survey of Children's Health touches on multiple intersecting aspects of children's lives. Data are not available at the county level; listed below is information about children's health in North Dakota. The full survey includes physical and mental health status, access to quality healthcare, and information on the child's family, neighborhood, and social context. Data is from 2016-17. More information about the survey is found at www.childhealthdata.org/learn/NSCH.

Key measures of the statewide data are summarized below. The rates highlighted in red signify that the state is faring worse on that measure than the national average.

Table 3: Selected Measures Regarding Children's Health (For children aged 0-17 unless noted otherwise)

TABLE 3: SELECTED MEASURES REGARDING CHILDREN'S HEALTH (For children aged 0-17 unless noted otherwise)		
Health Status	**North Dakota**	**National**
Children born premature (3 or more weeks early)	10.8%	11.6%
Children 10-17 overweight or obese	**35.8%**	31.3%
Children 0-5 who were ever breastfed	79.4%	79.2%
Children 6-17 who missed 11 or more days of school	4.6%	6.2%
Healthcare		
Children currently insured	**93.5%**	94.5%
Children who had preventive medical visit in past year	**78.6%**	84.4%
Children who had preventive dental visit in past year	**74.6%**	77.2%
Young children (10 mos.-5 yrs.) receiving standardized screening for developmental or behavioral problems	**20.7%**	30.8%
Children aged 2-17 with problems requiring counseling who received needed mental healthcare	**86.3%**	61.0%
Family Life		
Children whose families eat meals together 4 or more times per week	83.0%	78.4%
Children who live in households where someone smokes	**29.8%**	24.1%
Neighborhood		
Children who live in neighborhood with a park, sidewalks, a library, and a community center	58.9%	54.1%
Children living in neighborhoods with poorly kept or rundown housing	12.7%	16.2%
Children living in neighborhood that's usually or always safe	94.0%	86.6%

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

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

- Obese or overweight children ages 10-17;
- Children with health insurance;
- Preventive primary care and dentist visits;
- Developmental/behavioral screening for children 10 months to 5 years of age;
- Children ages 2-17 years who have received needed mental healthcare; and
- Children living in smoking households.

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

The data show that Ramsey County is performing more poorly than the North Dakota average on three of the examined measures. The most marked difference was on the measure of Supplemental Nutrition Assistance Program (SNAP) Recipients (7% higher rate in Ramsey County).

The data show that Benson County is performing more poorly than the North Dakota average on all of the examined measures. The most marked difference was on the measure of Medicaid recipients (54.1% higher rate in Benson County).

The data show that Eddy County is performing more poorly than the North Dakota average on all but two of the examined measures, Supplemental Nutrition Assistance Program (SNAP) recipients and the 4-Year High School Cohort Graduation Rate. The most marked difference was on the measure of licensed childcare capacity (22.3% lower rate in Eddy County).

The data show that Pierce County is performing more poorly than the North Dakota average on all but three of the examined measures. The most marked difference was on the measure of licensed childcare capacity (22.3% lower rate in Pierce County).

Table 4: Selected County-Level Measures Regarding Children's Health

	Ramsey County	Benson County	Pierce County	Eddy County	North Dakota
Uninsured children (% of population age 0-18), 2016	8.1%	11.0%	10.1%	11.0%	9.0%
Uninsured children below 200% of poverty (% of population), 2016	40.7%	53.3%	40.4%	44.8%	41.9%
Medicaid recipient (% of population age 0-20), 2017	39.9%	82.4%	31.1%	37.4%	28.3%
Children enrolled in Healthy Steps (% of population age 0-18), 2013	3.6%	3.6%	5.6%	4.8%	2.5%
Supplemental Nutrition Assistance Program (SNAP) recipients (% of population age 0-18), 2017	27.1%	64.6%	16.0%	19.4%	20.1%
Licensed childcare capacity (% of population age 0-13), 2018	60.7%	17.6%	22.0%	22.0%	41.9%
4-Year High School Cohort Graduation Rate, 2017	89.7%	80.6%	100%	100%	87.0%

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

Another means for obtaining data on the youth population is through the Youth Risk Behavior Survey (YRBS). The YRBS was developed in 1990 by the Centers for Disease Control and Prevention (CDC) to monitor priority health risk behaviors that contribute markedly to the leading causes of death, disability and social problems among youth and adults in the United States. The YRBS was designed to monitor trends, compare state health risk behaviors to national health risk behaviors and intended for use to plan, evaluate and improve school and community programs. North Dakota began participating in the YRBS survey in 1995. Students in grades, 7-8 & 9-12 are surveyed in the spring of odd years. The survey is voluntary and completely anonymous.

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 5 depicts some of the YRBS data that has been collected in 2013, 2015, and 2017. At this time, the North Dakota-specific data for 2017 is not available, so data for 2013 and 2015 are shown for North Dakota. 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 2013 to 2015, and "↓" for a decreased trend in the data changes from 2013 to 2015. The final column shows the 2017 national average percentage. For a more complete listing of the YRBS data, see Appendix C.

TABLE 5: Youth Behavioral Risk Survey Results - North Dakota High School Survey

Source: https://www.nd.gov/dpi/uploads/1298/2015NDHStatewideYRBSReport20151110FINAL2NoCover.pdf; https://www.nd.gov/dpi/uploads/1298/2015NDHTrendReportUpdated42016.pdf; https://www.cdc.gov/healthyyouth/data/yrbs/results.htm

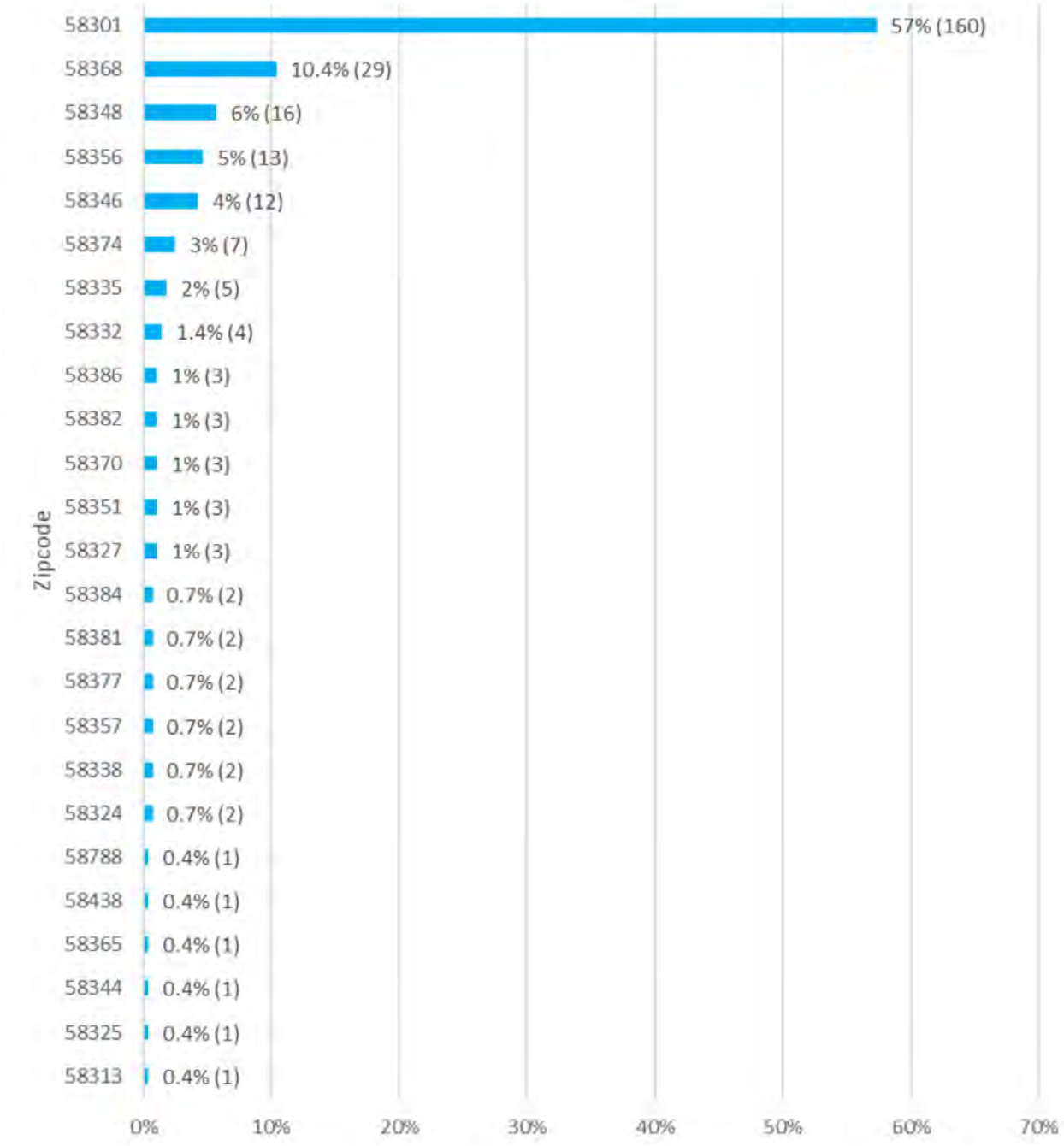
	ND 2013	ND 2015*	ND Trend ↑, ↓, =	Rural ND Town Average	Urban ND Town Average	National Average 2017
Injury and Violence						
% of students who rarely or never wore a seat belt.	11.6	8.5	↓	10.5	7.5	5.9
% of students who rode in a vehicle with a driver who had been drinking alcohol (one or more times during the 30 prior to the survey)	21.9	17.7	↓	21.1	15.2	16.5
% of students who talked on a cell phone while driving (on at least 1 day during the 30 days before the survey)	67.9	61.4	↓	60.7	58.8	NA
% of students who texted or e-mailed while driving a car or other vehicle (on at least 1 day during the 30 days before the survey)	59.3	57.6	=	56.7	54.4	39.2
% of students who were in a physical fight on school property (one or more times during the 12 months before the survey)	8.8	5.4	↓	6.9	6.1	8.5
% of students who were ever physically forced to have sexual intercourse (when they did not want to)	7.7	6.3	=	6.5	7.4	7.4
% of students who were bullied on school property (during the 12 months before the survey)	25.4	24.0	=	27.5	22.4	19.0
% of students who were electronically bullied (includes e-mail, chat rooms, instant messaging, websites, or texting during the 12 months before the survey)	17.1	15.9	=	17.7	15.8	14.9
% of students who made a plan about how they would attempt suicide (during the 12 months before the survey)	13.5	13.5	=	12.8	13.7	13.6

Tobacco, Alcohol, and Other Drug Use						
% 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 1 day during the 30 days before the survey)	NA	22.3	↑	19.7	22.8	13.2
% of students who currently used cigarettes, cigars, or smokeless tobacco (on at least 1 day during the 30 days before the survey)	27.5	20.9	↓	22.9	19.8	14.0
% of students who drank five or more drinks of alcohol in a row (within a couple of hours on at least 1 day during the 30 days before the survey)	21.9	17.6	↓	19.8	17.0	13.5
% of students who currently used marijuana (one or more times during the 30 days before the survey)	15.9	15.2	=	13.2	17.1	19.8
% of students who ever took prescription drugs without a doctor's prescription (such as OxyContin, Percocet, Vicodin, codeine, Adderall, Ritalin, or Xanax, one or more times during their life)	17.6	14.5	↓	13.2	16.0	14.0
Weight Management, Dietary Behaviors, and Physical Activity						
% of students who were overweight (>= 85th percentile but <95th percentile for body mass index)	15.1	14.7	=	15.4	14.6	15.6
% of students who were obese (>= 95th percentile for body mass index)	13.5	14.0	=	16.3	12.9	14.8
% of students who did not eat fruit or drink 100% fruit juices (during the 7 days before the survey)	3.4	3.9	=	4.3	4.1	5.6
% of students who did not eat vegetables (green salad, potatoes [excluding French fries, fried potatoes, or potato chips], carrots, or other vegetables, during the 7 days before the survey)	6.0	4.7	=	4.5	5.2	7.2
% 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 7 days before the survey)	23.4	18.7	=	21.4	18.0	18.7
% of students who did not drink milk (during the 7 days before the survey)	11.1	13.9	↑	11.6	13.7	26.7
% of students who did not eat breakfast (during the 7 days before the survey)	10.5	11.9	=	10.7	11.8	14.1
% 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)	3.1	2.2	=	2.4	2.8	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 7 days before the survey)	50.6	51.3	=	51.7	50.1	46.5
% of students who watched television 3 or more hours per day (on an average school day)	21.0	18.9	=	20.7	18.2	20.7
% of students who played video or computer games or used a computer 3 or more hours per day (for something that was not school work on an average school day)	34.4	38.6	↑	39.4	38.0	43.0
Other						
% of students who ever had sexual intercourse	44.9	38.9	↓	39.3	39.1	39.5
% of students who had 8 or more hours of sleep (on an average school night)	30.0	29.5	=	34.5	28.7	25.4
% of students who brushed their teeth on seven days (during the 7 days before the survey)	71.5	71.0	=	67.8	70.1	NA

Survey Results

As noted previously, 339 community members completed the survey in communities throughout the counties in the CHI St. Alexius Health Devils Lake and LRDHU service area. The survey requested that respondents list their home zip code. While not all respondents provided a zip code, 279 did, revealing that the large majority of respondents (57%, N=160) lived in Devils Lake. These results are shown in Figure 5.

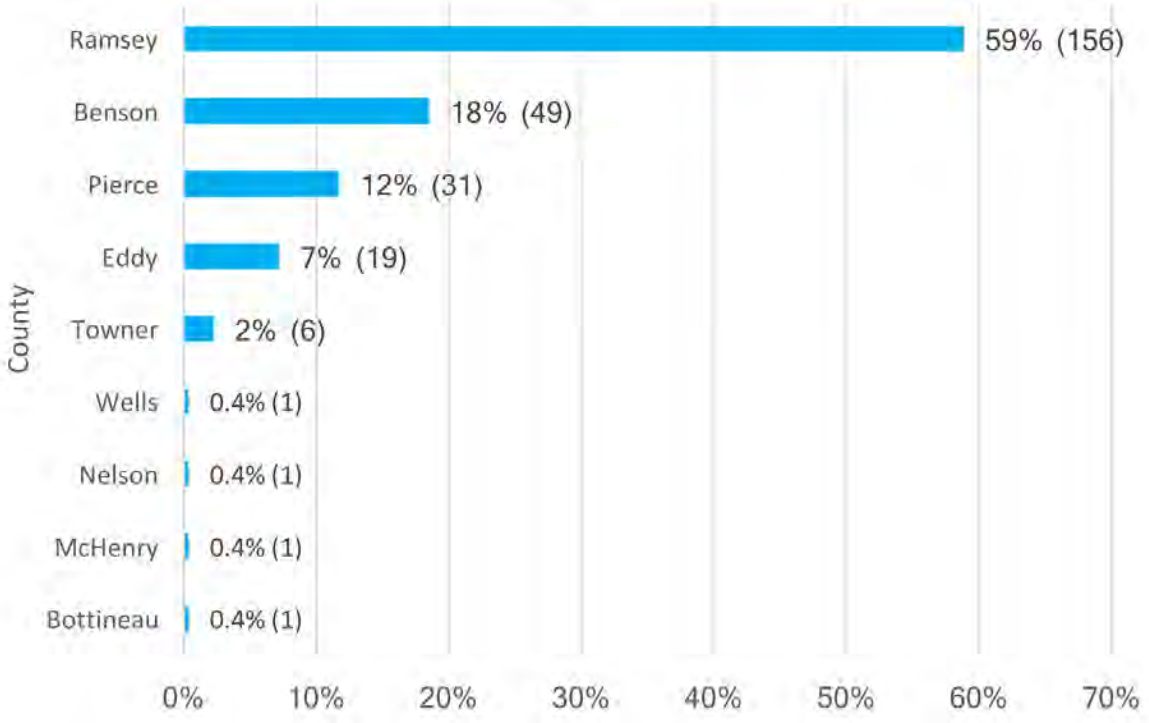
Figure 5: Survey Respondents' Home Zip Code
Total respondents: 279



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

Respondents were also asked to indicate their county of residence. The majority of repondents reside in Ramsey County, followed by Benson, Pierce, then Eddy. There were a small number of respondents from counties outside of those four (Figure 6).

Figure 6: County of Residence of Survey Respondents



Survey Demographics

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

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

- 36% (N=107) were age 55 or older.
- The majority (78%, N=228) were female.
- About half of the respondents (49%, N=144) had bachelor's degrees or higher.
- The number of those working full time (78%, N=229) was just greater than ten times higher than those who were retired (7%, N=22).
- 92% (N=270) of those who reported their ethnicity/race were white/Caucasian.
- 24% of the population (N=67) had household incomes of less than $50,000.

Figures 7 through 13 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 7: Age Demographics of Survey Respondents
Total respondents = 295

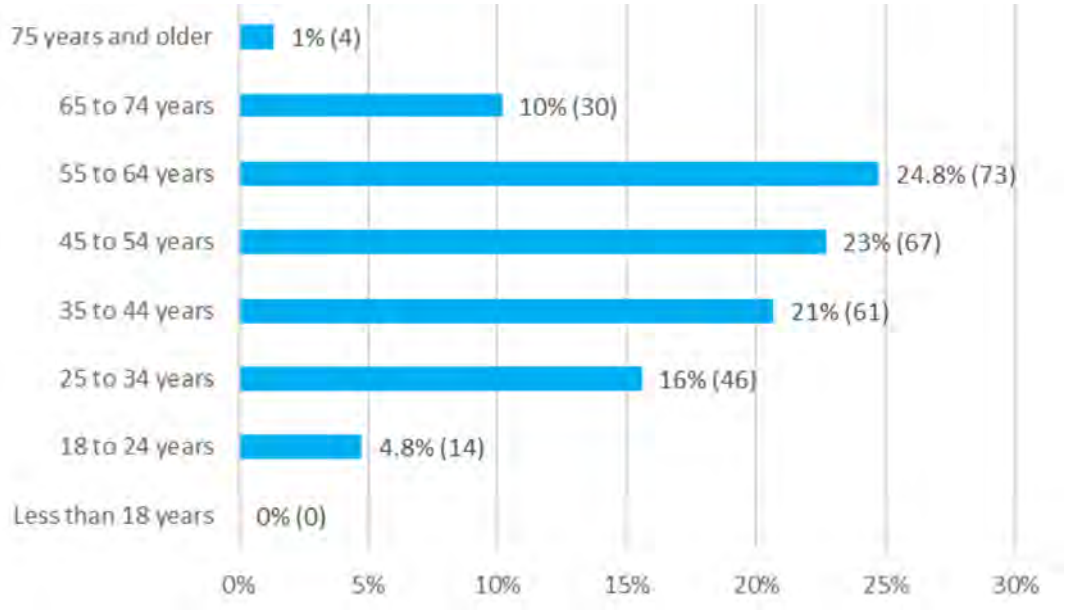


Figure 8: Gender Demographics of Survey Respondents
Total respondents = 291

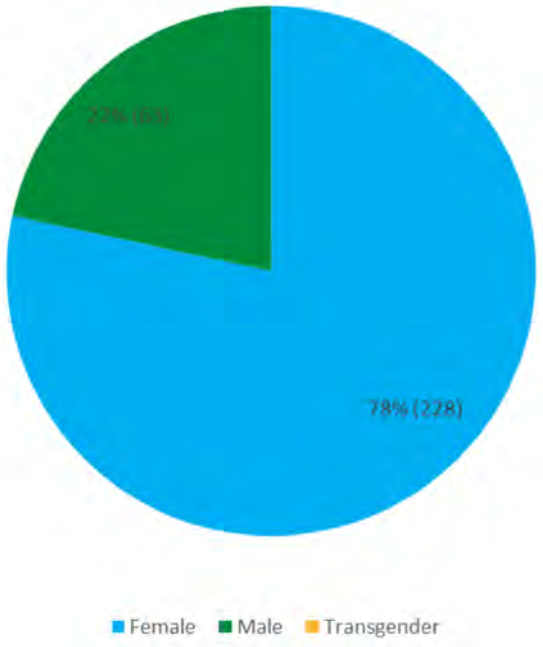


Figure 9: Educational Level Demographics of Survey Respondents
Total respondents = 293

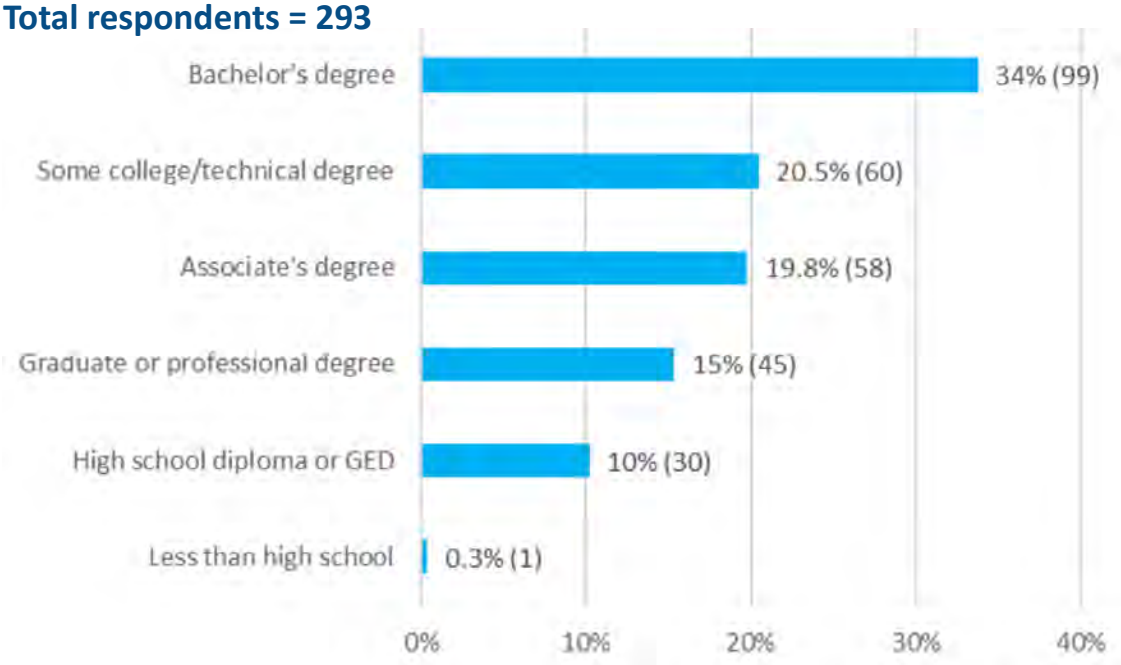
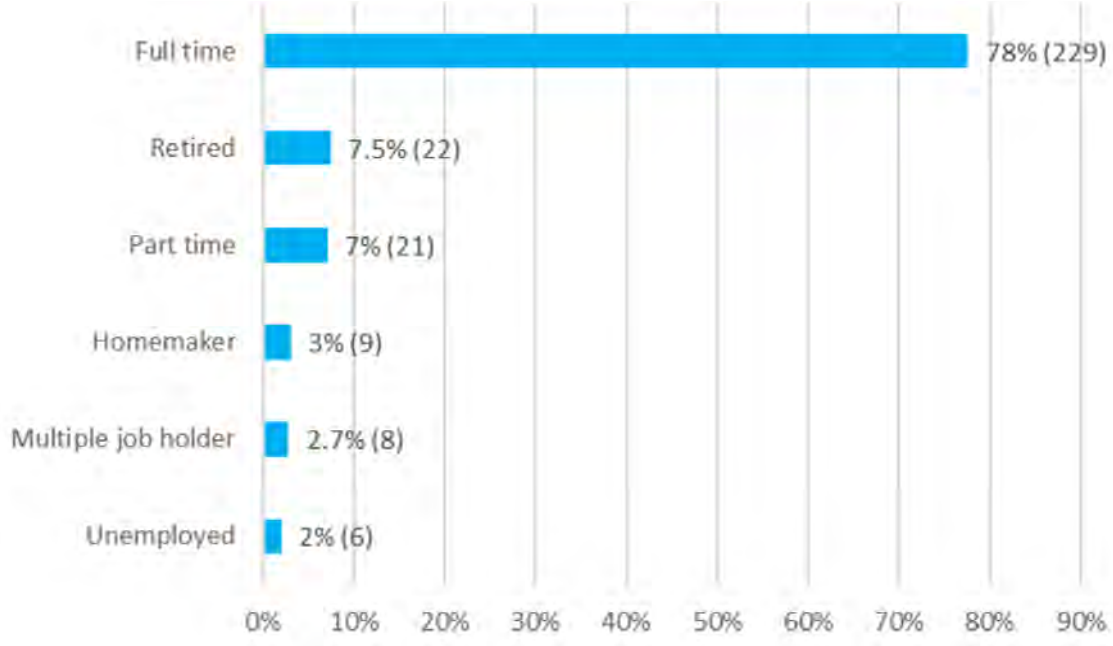
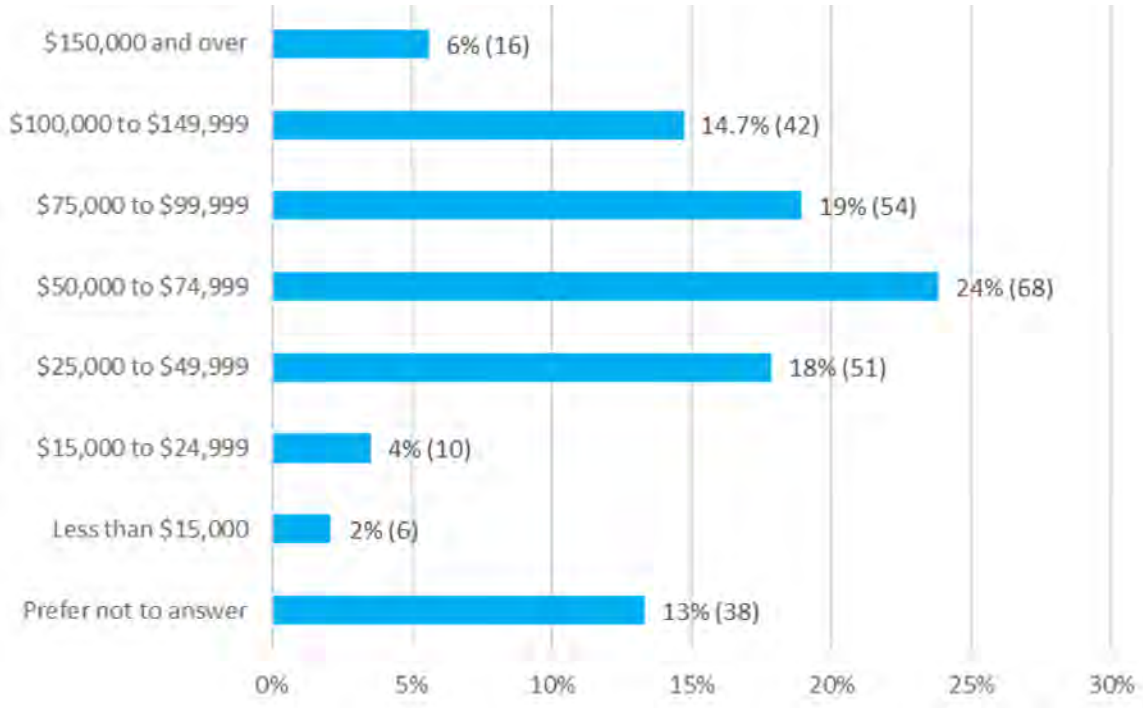


Figure 10: Employment Status Demographics of Survey Respondents
Total respondents = 295



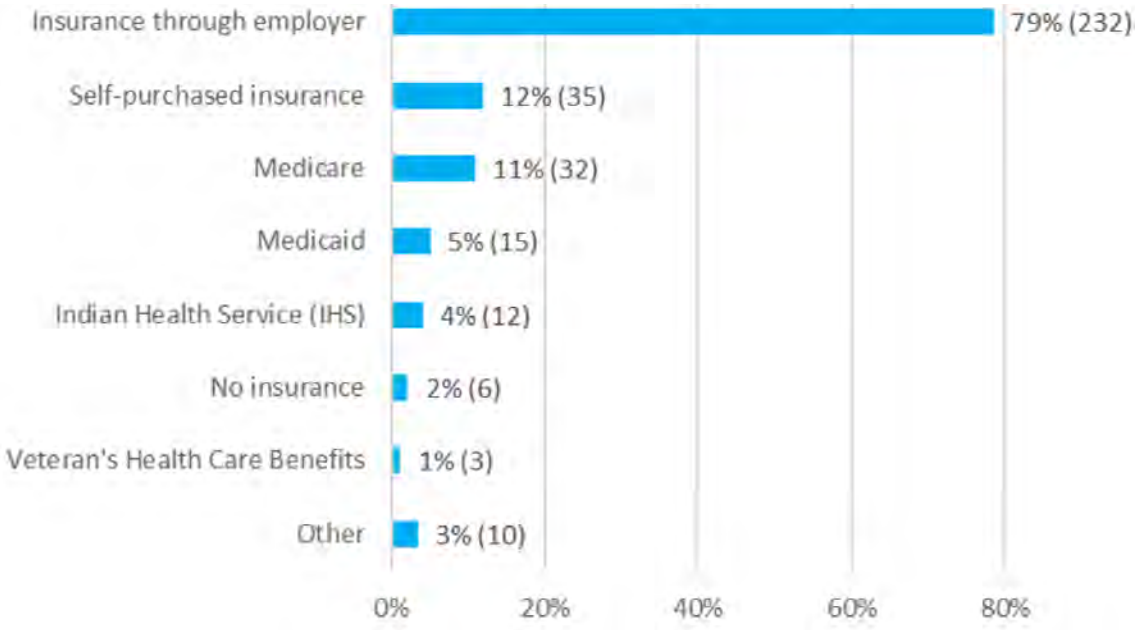
Of those who provided a household income, 6% (N=16) of the community members reported a household income of less than $25,000. Twenty-one percent (N=58) indicated a household income of $100,000 or more. This information is show in Figure 10.

Figure 11: Household Income Demographics of Survey Respondents
Total respondents = 285



Community members were asked about their health insurance status, which is often associated with whether people have access to healthcare. Two percent (N=6) of the respondents reported having no health insurance. The most common insurance types were insurance through one's employer (N=232), followed by self-purchased (N=35) and Medicare (N=32).

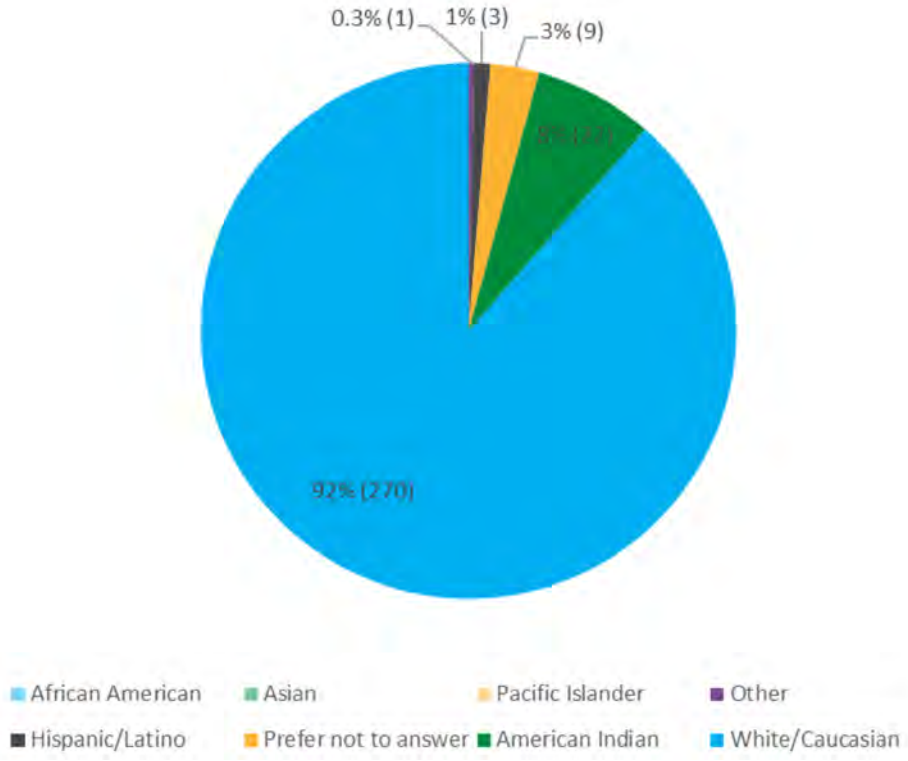
Figure 12: Health Insurance Coverage Status of Survey Respondents
Total respondents = 295



As shown in Figure 12, nearly all of the respondents were white/Caucasian (92%). This was in-line with the race/ethnicity of the overall population of Ramsey, Eddy, and Pierce Counties; the US Census indicates that 85.4% of the population is white in Ramsey County, 93.4% white in Pierce County, and 93.1% white in Eddy County. The US Census indicates that 42% of the population is white in Benson County.

Other responses include: AARP, Flex options, health track, and utilizing parent's insurance.

Figure 13: Race/Ethnicity Demographics of Survey Respondents
Total respondents = 293



Community Assets and Challenges

Survey-respondents were asked what they perceived as the best things about their community in four categories: people, services and resources, quality of life, and activities. In each category, respondents were given a list of choices and asked to pick the three best things. Respondents occasionally chose less than three or more than three choices within each category. If more than three choices were selected, their responses were not included. The results indicate there is consensus (with at least 173 respondents agreeing) that community assets include:

- People are friendly, helpful, supportive (N=237);
- Family-friendly; good place to raise kids (N=232);
- Recreational and sports activities (N=207);
- Safe place to live, little/no crime (N=206);
- Active faith community (N=192);
- Closeness to work and activities (N=179); and
- People who live here are involved in their community (N=173).

Figures 14 to 17 illustrate the results of these questions.

Figure 14: Best Things about the PEOPLE in Your Community
Total responses = 324

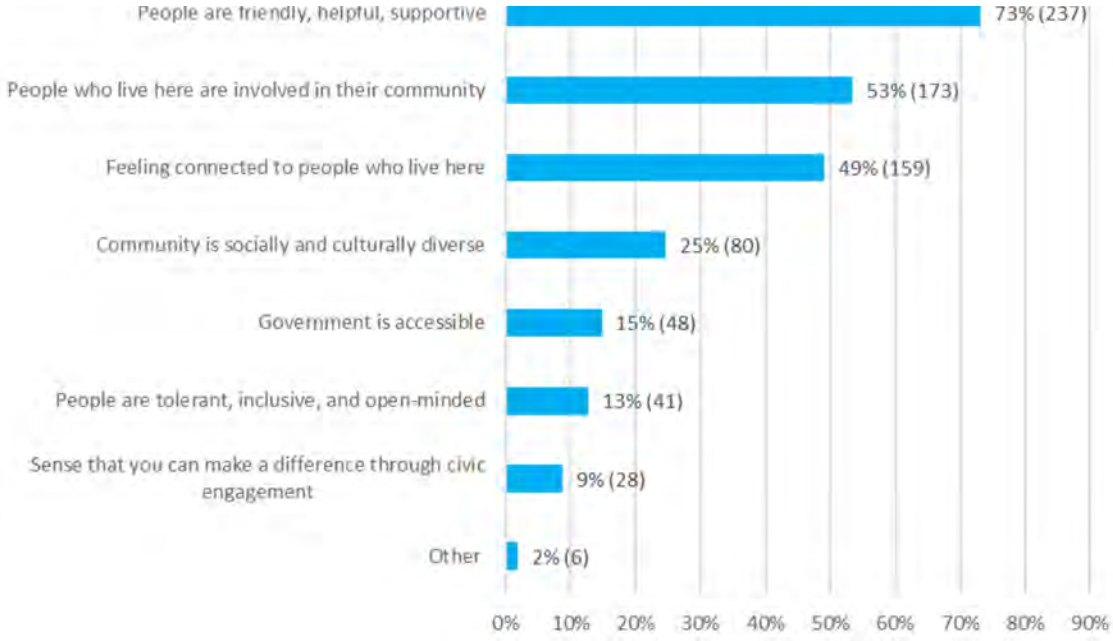
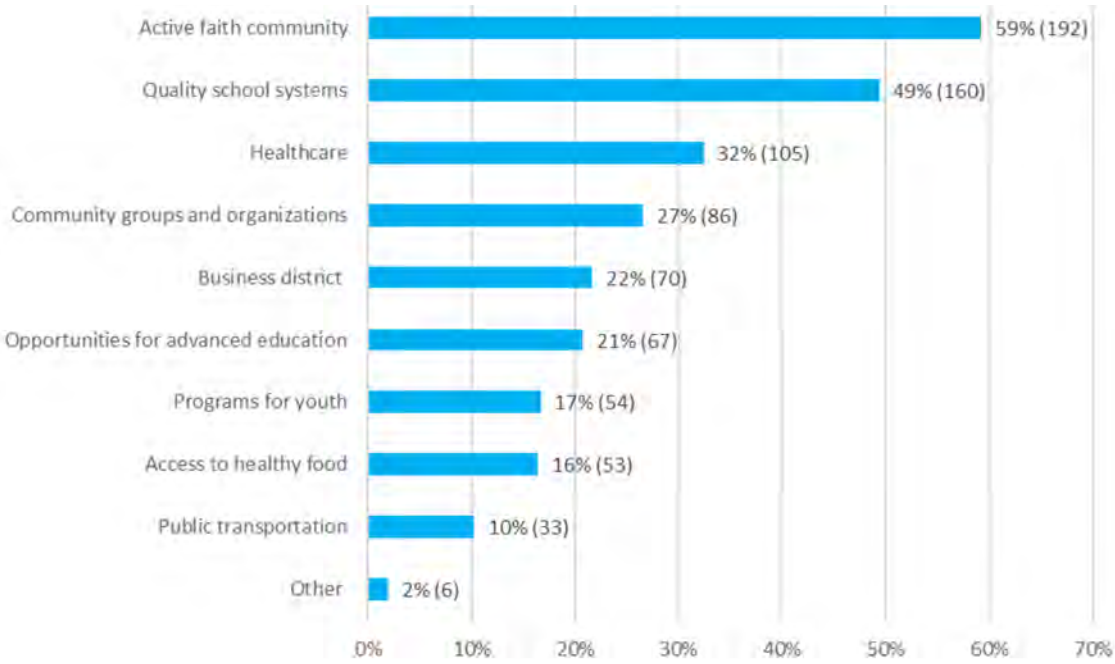
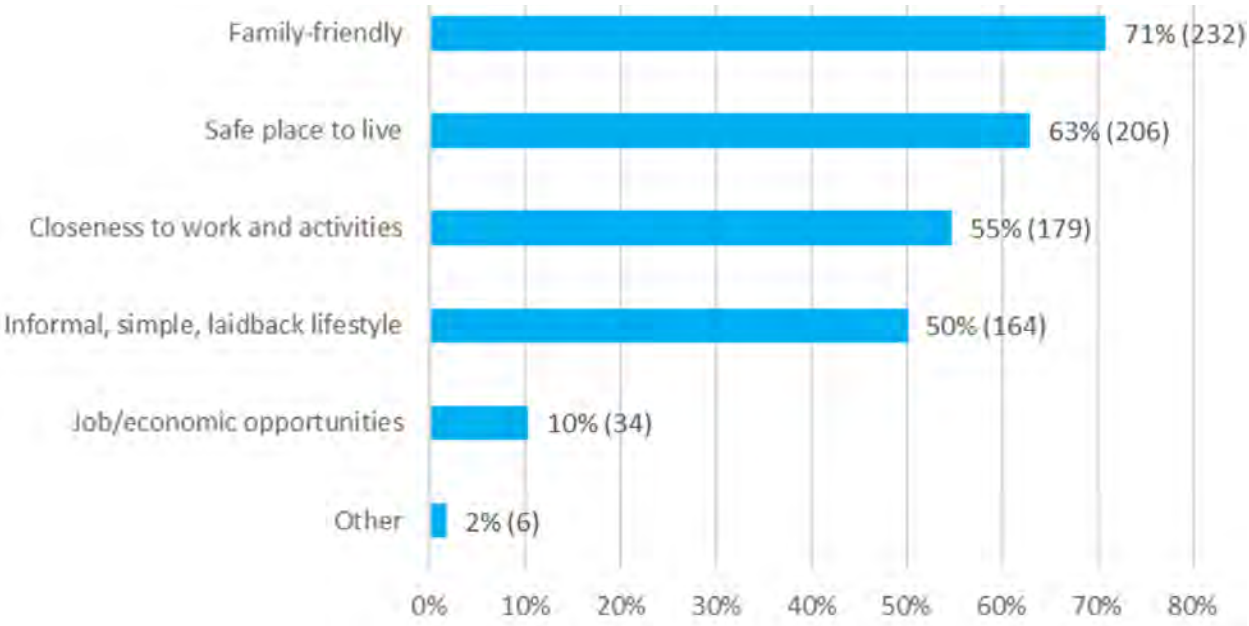


Figure 15: Best Things about the SERVICES AND RESOURCES in Your Community
Total responses = 324



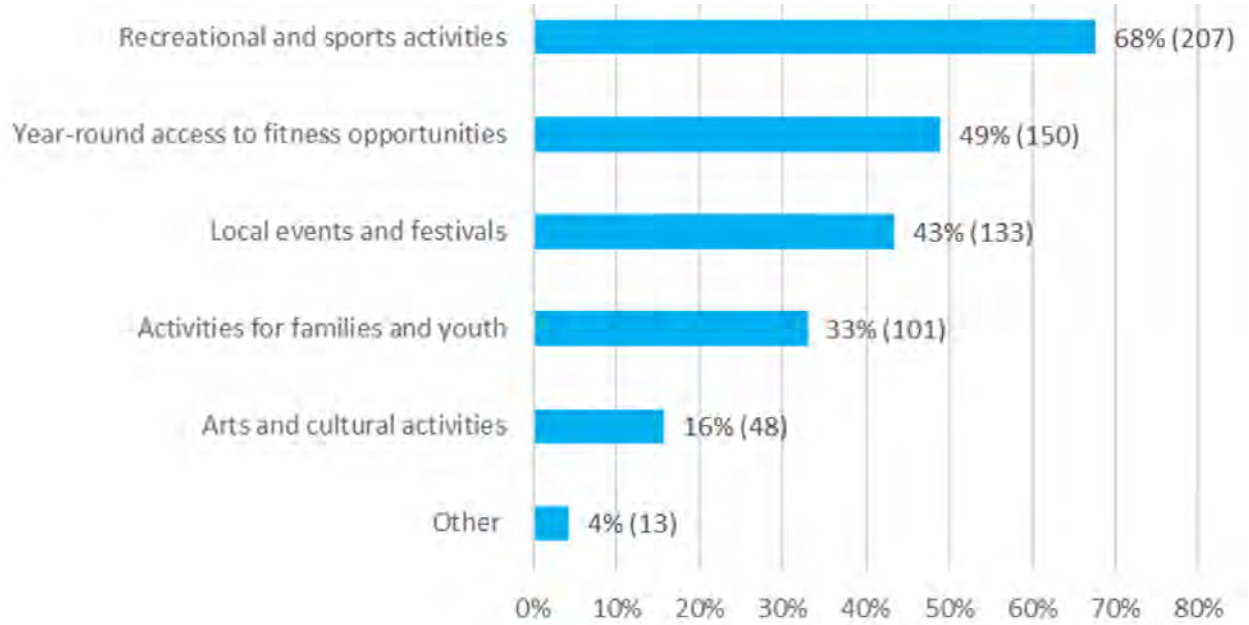
Respondents who selected "other" specified that the community has dedicated first responders and that there is accessibility to sports and activities that promote health for people of all ages.

Figure 16: Best Things about the QUALITY OF LIFE in Your Community
Total responses = 327



"Other" responses mentioned good hunting and fishing opportunities, good air and water quality, and that everyone knows everyone and is supportive when needed.

Figure 17: Best Thing about the ACTIVITIES in Your Community
Total responses = 306



Respondents who chose "other" mentioned the area's 4H programs, access to hunting and fishing, the restoration of the opera house, café and library in Maddock, and the ease of access to sports and fitness opportunities.

Community Concerns

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

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

With regard to responses about community challenges, the most highly voiced concerns (those having at least 127 respondents) were:

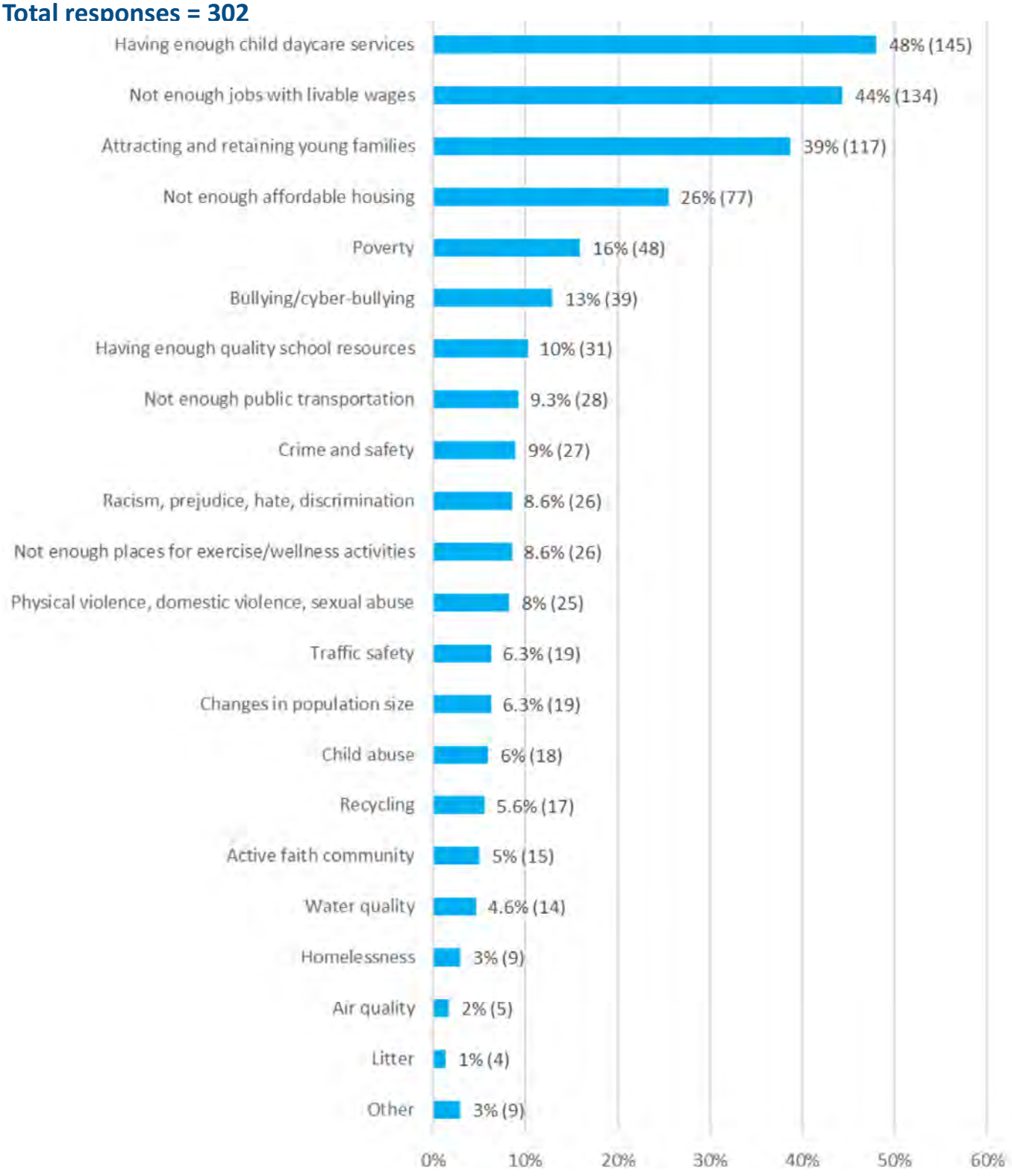
- Bullying/cyber-bullying (N=204);
- Child abuse or neglect (N=180);
- Alcohol use and abuse – Adults (N=160);
- Drug use and abuse – Youth (N=158);
- Cost of long-term/nursing home care (N=154);
- Having enough child daycare services (N= 145);
- Drug use and abuse – Adult (N=143);
- Not enough jobs with livable wages, not enough to live on (N=134); and
- Alcohol use and abuse – Youth (N=127).

The other issues that had at least 77 votes included:

- Attracting and retaining young families (N=117);
- Availability of resources to help the elderly stay in their homes (N=114);
- Extra hours for appointments, such as evenings and weekends (N=102);
- Depression/anxiety – Youth (N=95);
- Smoking and tobacco use, exposure to second-hand smoke - Youth (N=94);
- Not enough activities for children and youth (N=90);
- Depression/anxiety – Adult (N=89);
- Suicide (N=83);
- Availability of specialists (N=78); and
- Not enough affordable housing (N=77).

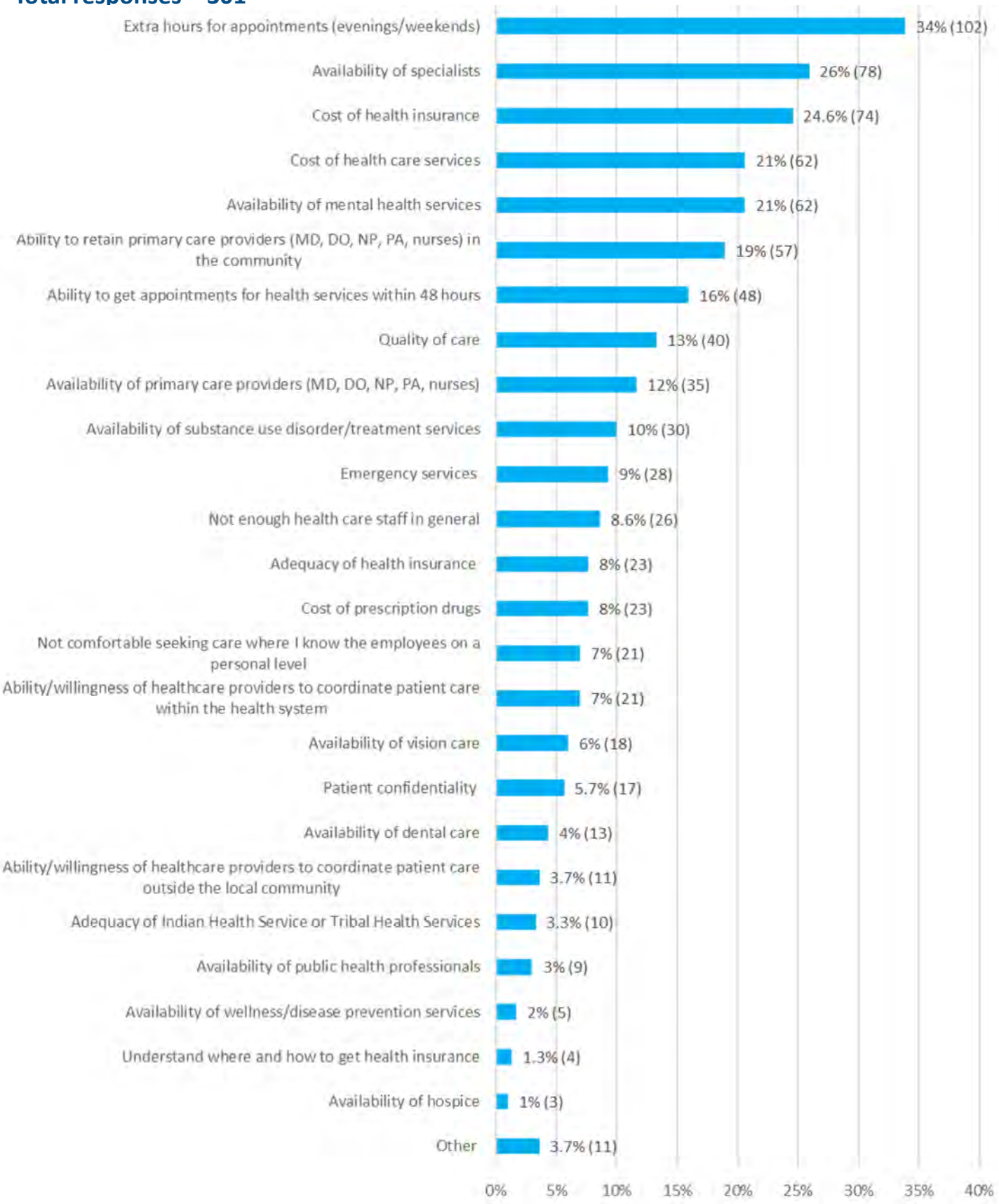
Figures 18 through 23 illustrate these results.

Figure 18: Community/Environmental Health Concerns
Total responses = 302



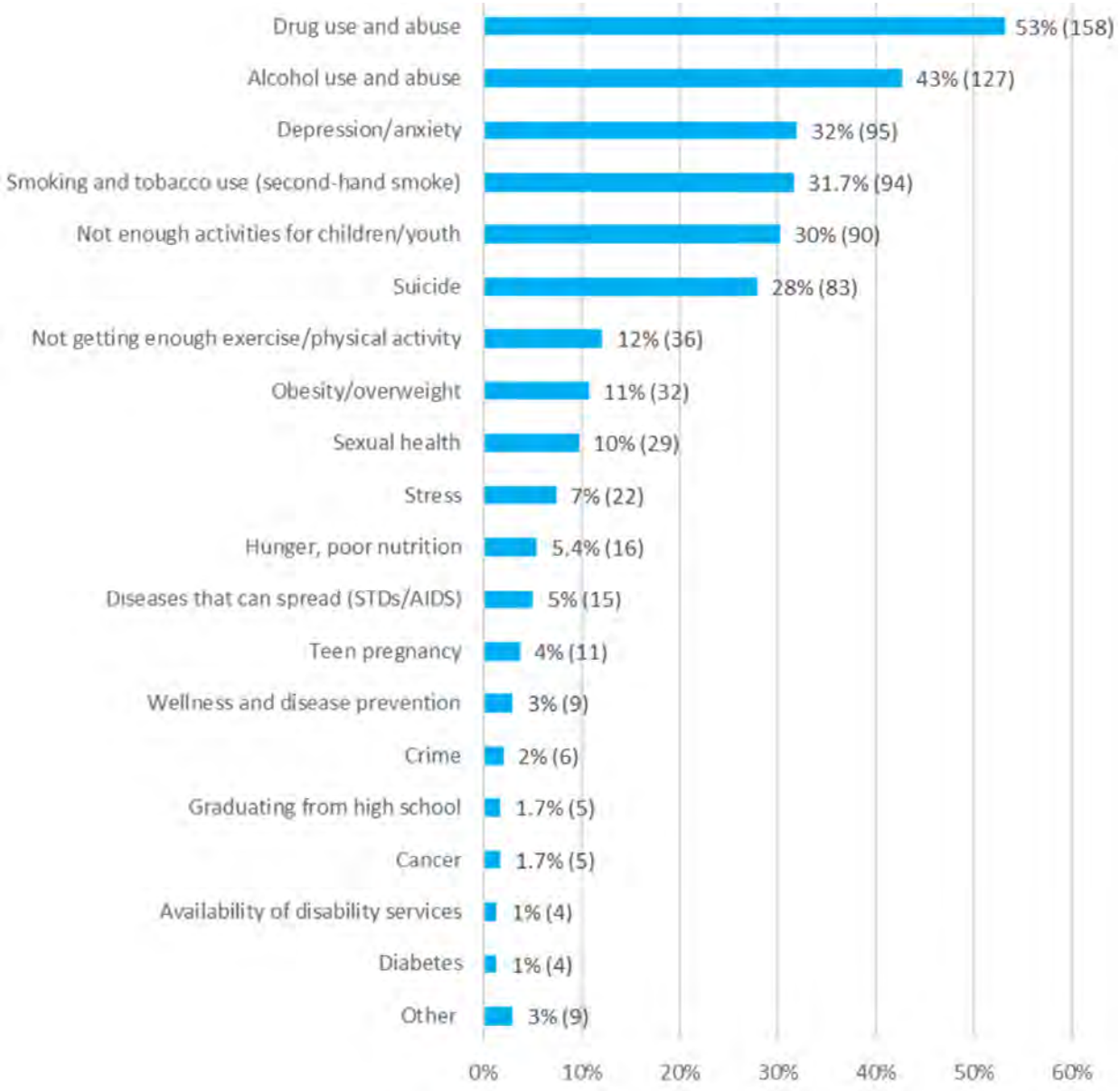
Included in the "Other" category were responses that mentioned child abuse, drug abuse, lack of activities for children, lack of child daycare services, lack of a visual arts center or related events, a desire for more youth activities that aren't sports related, and the lack of a grocery store.

Figure 19: Availability/Delivery of Health Services Concerns
Total responses = 301



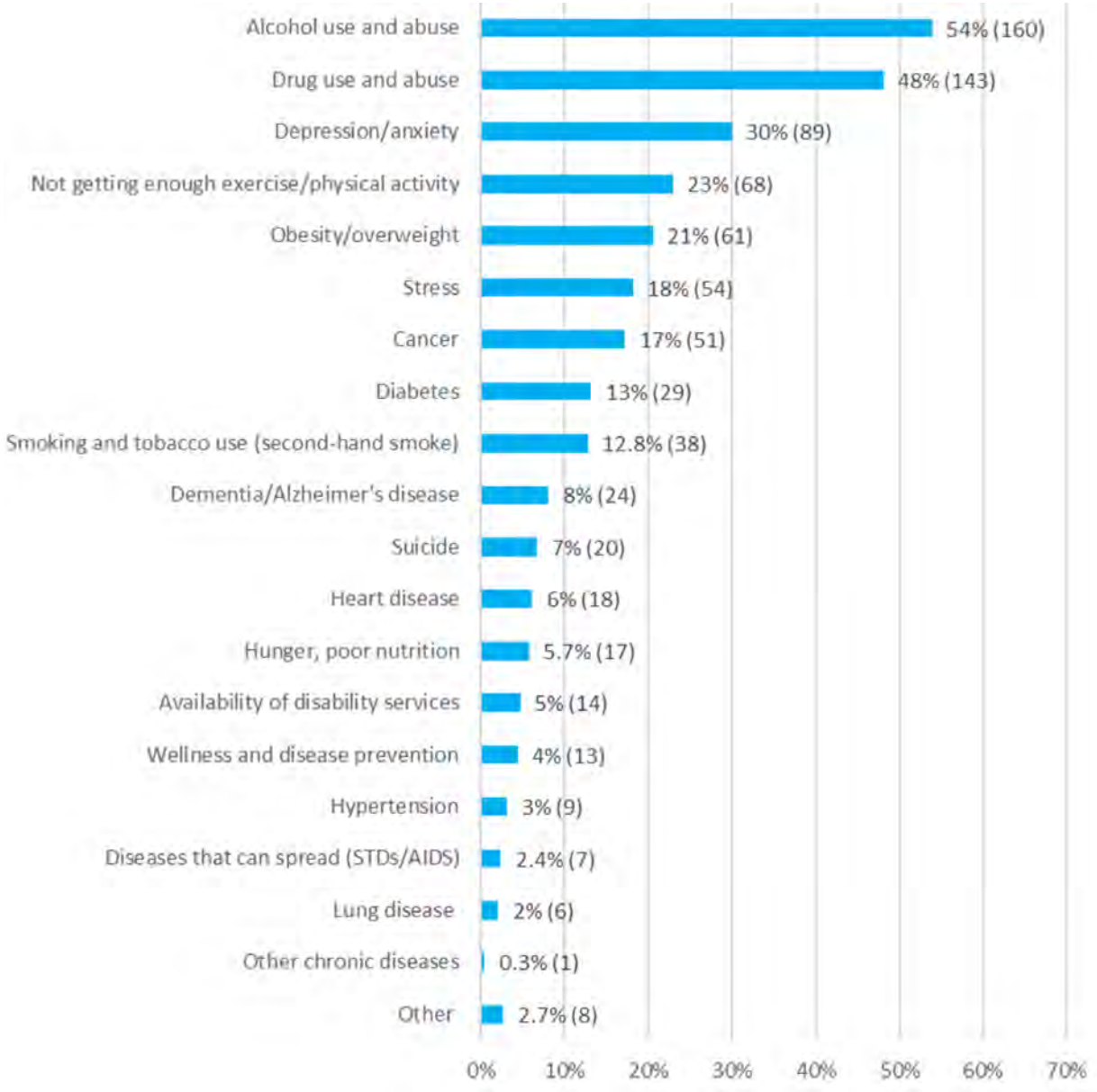
Respondents who selected "Other" had concerns about the lack of urgent care or other options besides the ER, the quality of service provided in the ER, having to see a different doctor with each visit, lack of specialists, the need for orthodontic care in the community, and the desire to see telemedicine services expanded.

Figure 20: Youth Population Health Concerns
Total responses = 297



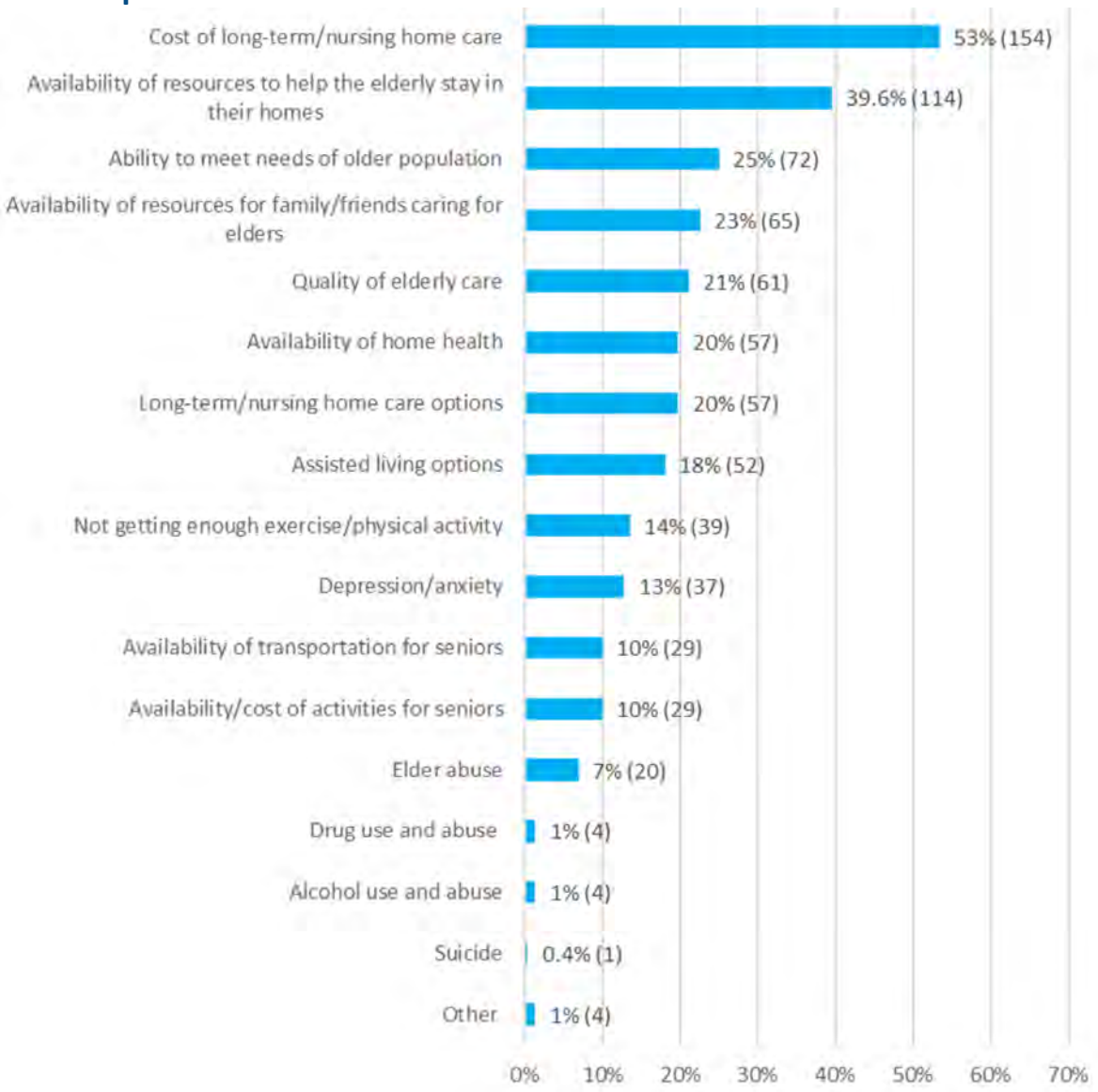
"Other" responses reflected concerns about bullying, addressing mental health needs, the overuse of electronics, and child poverty.

Figure 21: Adult Population Concerns
Total responses = 297



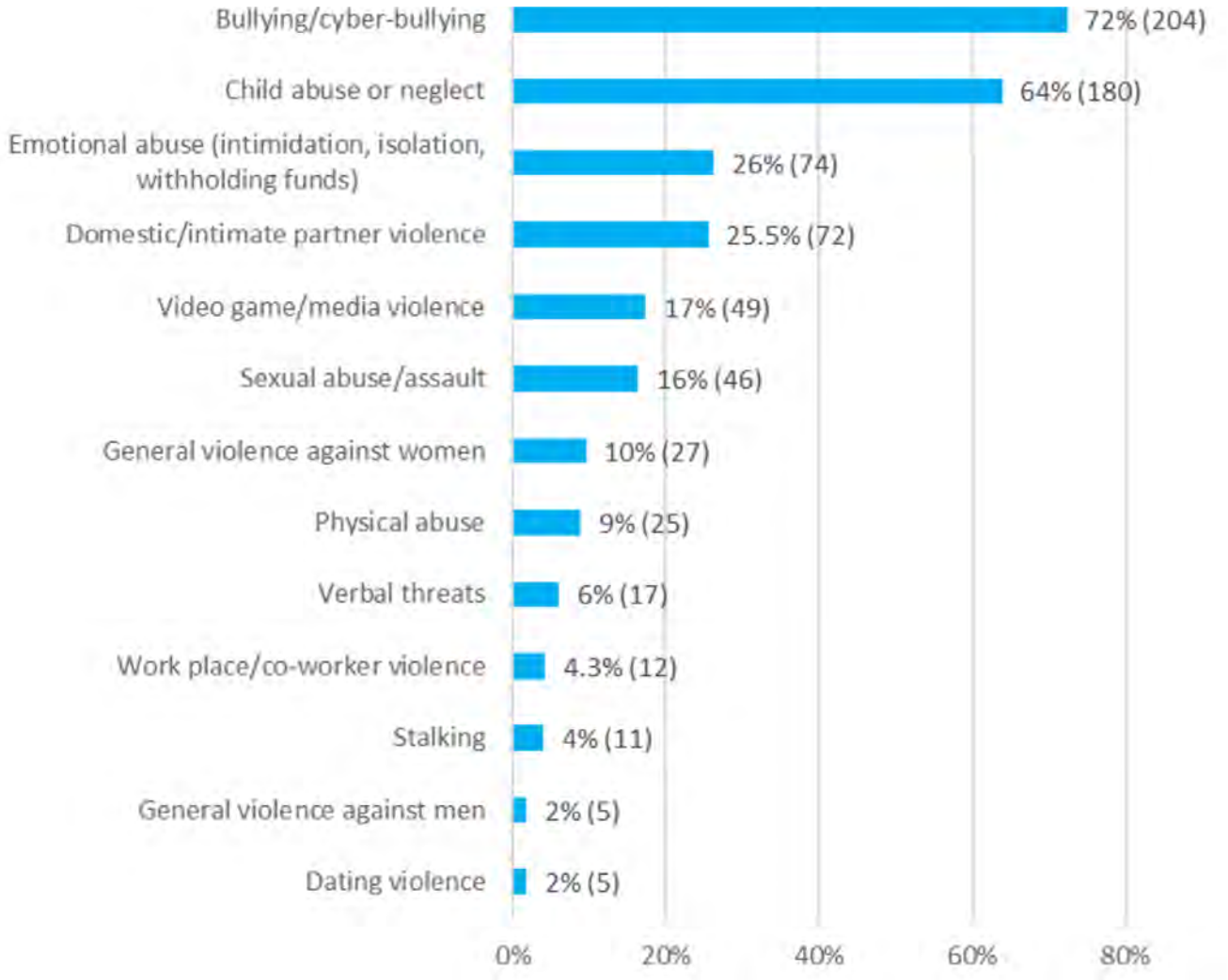
Respondents who selected "Other" cited concerns about the lack of home health services, addressing mental health concerns, not enough access to wellness activities, and the desire to see more community activities for adults.

Figure 22: Senior Population Concerns
Total responses = 288



Respondents who selected "Other" had concerns regarding the cost of housing/rent, lack of grocery store in town, the dwindling numbers in basic care nursing home in their community, and that the local senior center isn't getting utilized by the senior population.

Figure 23: Violence Concerns
Total responses = 282



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. Alcohol and drug abuse
2. Poverty

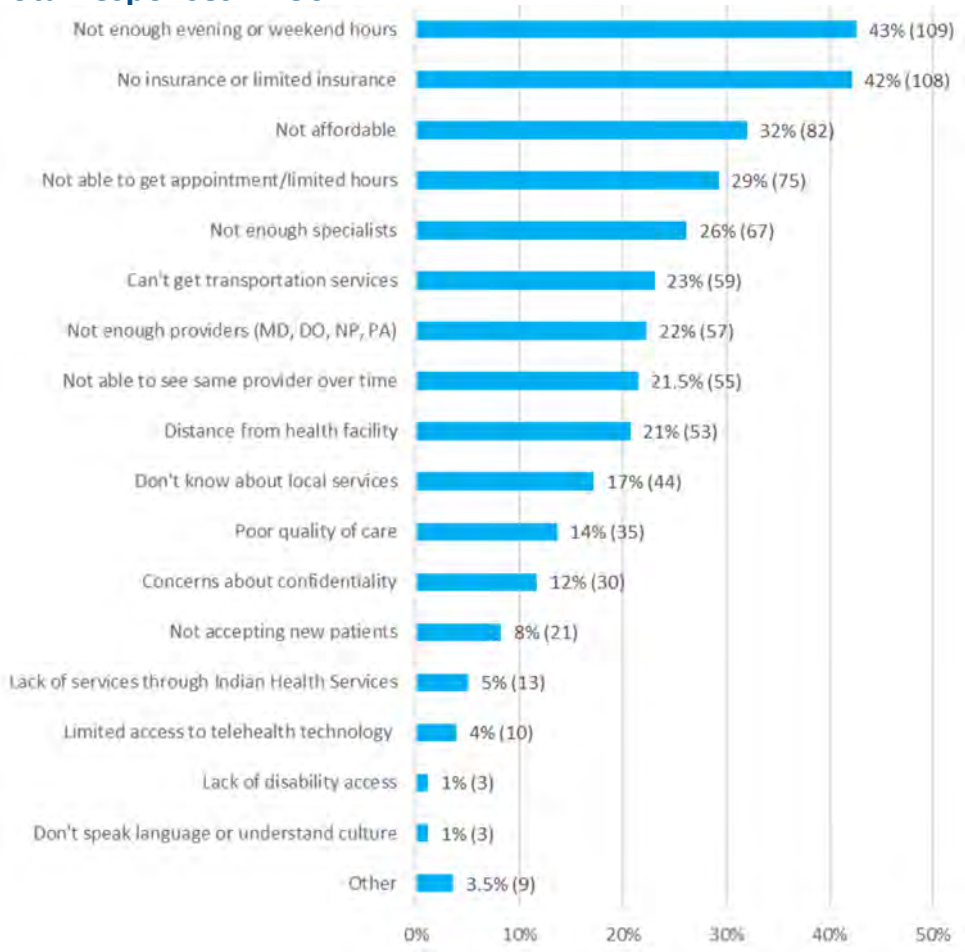
Other biggest challenges that were identified were affordable healthcare and insurance, bullying, child abuse and neglect, housing for low-income, lack of mental health services, loss of jobs, no grocery store, racism, lack of retail stores, lack of activities and things to do, and availability of jobs with good wages.

Delivery of Healthcare

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 not enough evening or weekend hours (N=109), with the next highest being no insurance or limited insurance (N=108). After these, the next most commonly identified barriers were not affordable (N=82), not enough specialists (N=67), and not enough providers (MD, DO, NP, PA) (N=57). The majority of concerns indicated in the "Other" category was in regards to loss or lack of physicians, followed by a couple comments noting the lack of natural/holistic medicine options, and a poor billing system.

Figure 24 illustrates these results.

Figure 24: Perceptions about Barriers to Care
Total responses = 256



"Other" responses about barriers to care included having to drive long distances for quality care, the lack of female doctors for female patients, and the lack of a walk in clinic or urgent care. Others stated that they felt the quality of care is excellent.

In an open-ended question, respondents were asked what specific healthcare services, if any, they think should be added locally. The number one desired service to add locally was urgent care or a clinic that offered evening and weekend hours.

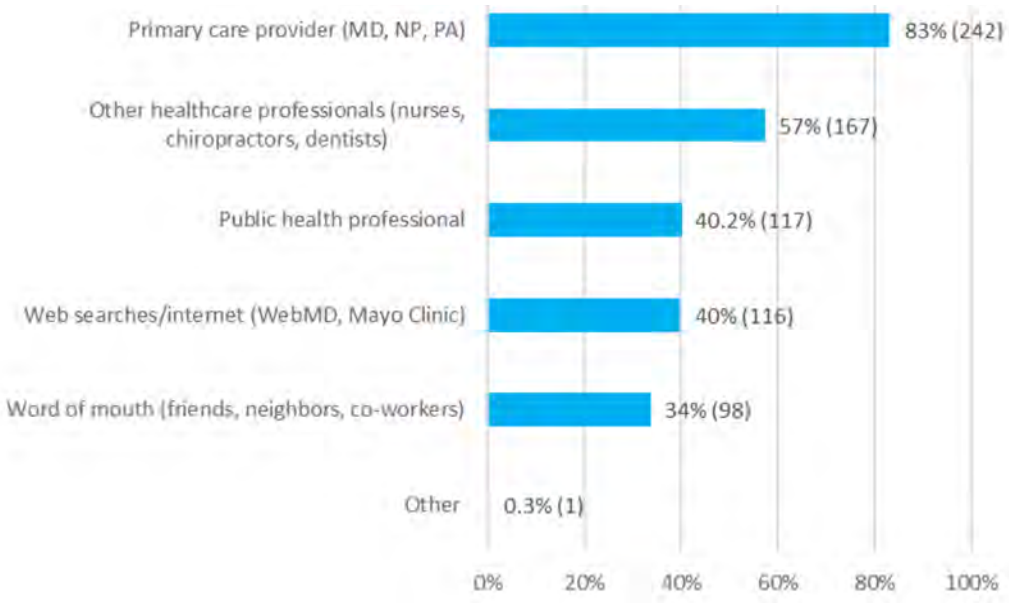
- Addiction counseling
- Cancer specialists
- Cardiology
- Dentist
- Dermatology
- Family planning
- Full-time surgeon
- Kidney dialysis
- Mental health expansion to schools, jails
- Orthodontics
- Pediatrician
- Physical therapy
- Sexual health
- Telemedicine services
- Urgent care
- Walk-in clinic open evenings/weekends
- Vision services
- Walk-in clinic with weekend hours
- Weight management
- Wellness/exercise classes for elderly

The key informant and focus group members felt that the community members were aware of some of the health system and public health services. There were a number of services where they felt the hospital should increase marketing efforts, these included OB services, emergency services, and EMT course trainings in schools for kids. It was also noted that the hospital does not have the best reputation, which leads patients to go out of town for services, even if they are aware of the services offered locally.

Respondents were asked where they go to for trusted health information. Primary care providers (N=242) received the highest response rate, followed by other healthcare professionals (N=167), and then public health professionals (N=117).

Results are shown in Figure 25.

Figure 25: Sources of Trusted Health Information
Total responses = 291



Respondents were asked how they find out about local services. Results are shown in Figure 26.

Figure 26: Sources Used to Find Out About Local Services
Total responses = 290

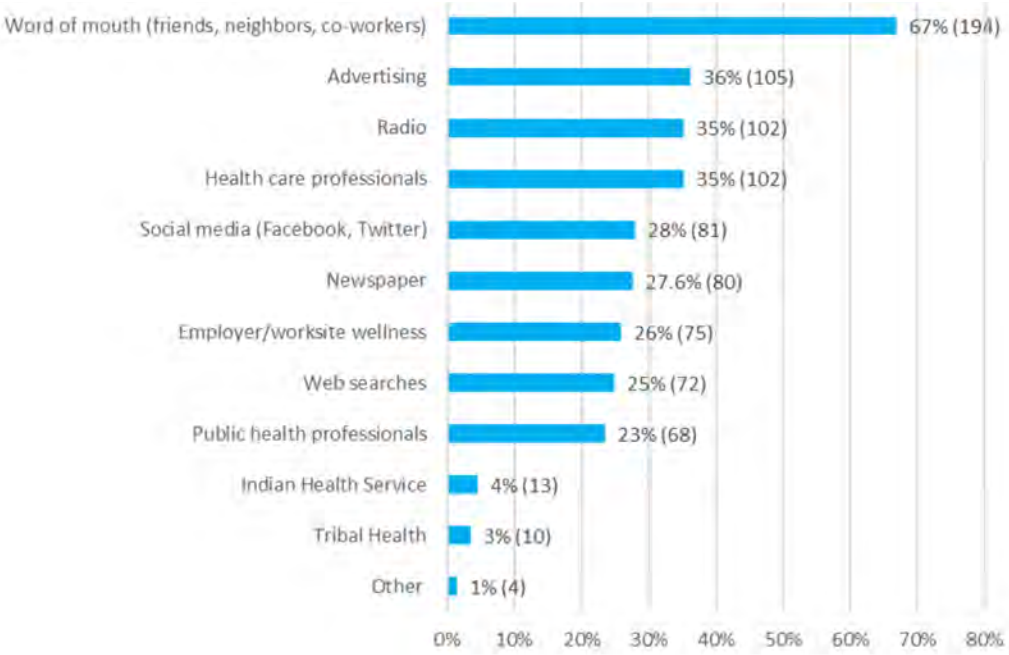
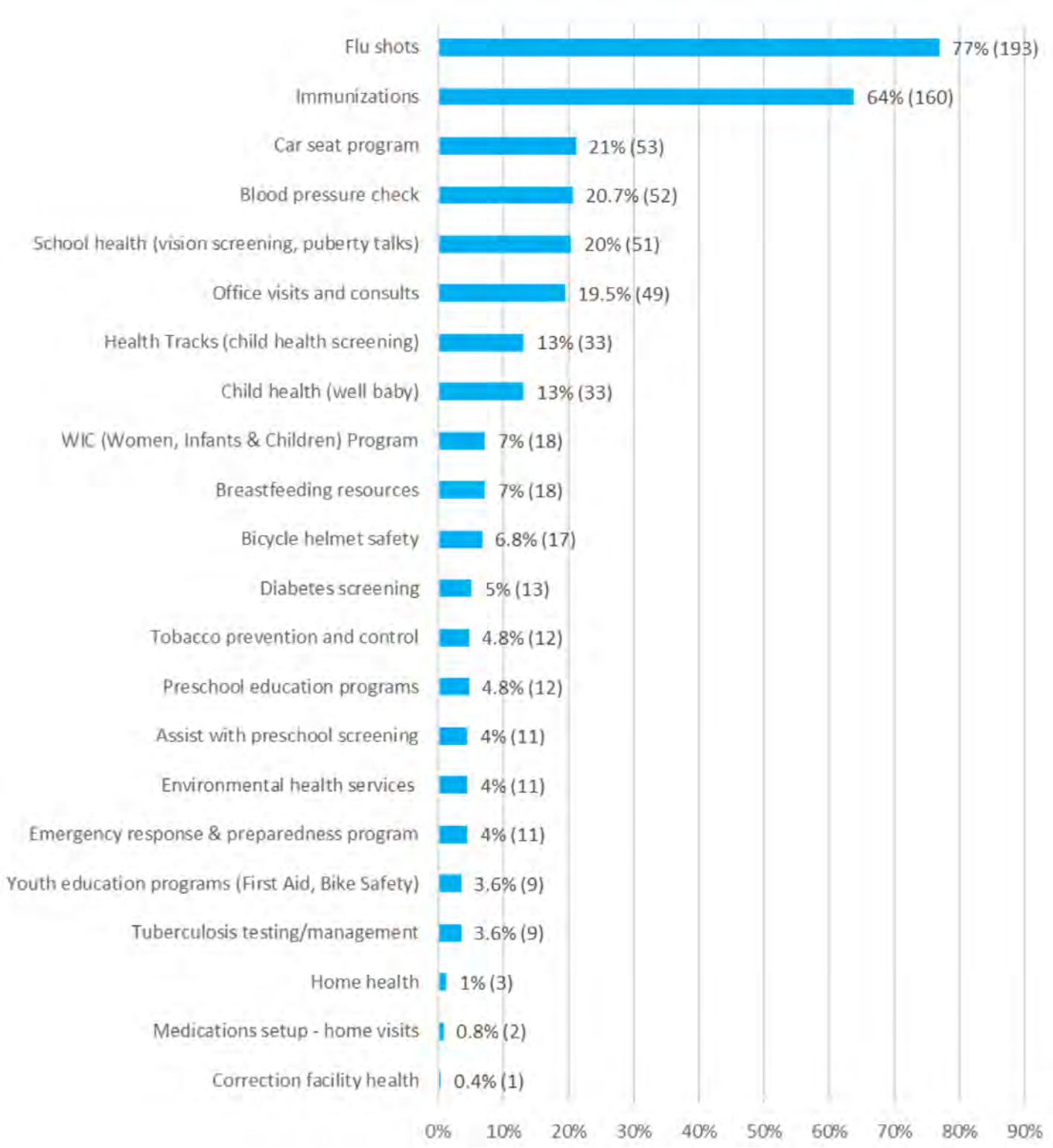


Figure 27: Utilization of Public Health Services
Total responses = 290



The final question on the survey asked respondents to share concerns and suggestions to improve the delivery of local healthcare. The majority of responses focused on concern with the lack of an urgent care option, or offering extended hours during evenings or weekends. Several respondents suggested adding extended evening and weekend hours or having a walk-in clinic/urgent care available to cut down on the use of unnecessary visits to the emergency room.

There were also many suggestions and concerns relating to being able to be seen for a medical appointment as well as being able to see the same provider over time. There was an expressed need for more primary care providers, internal medicine doctors, and other specialists that are willing stay in the area. Some indicated they have concerns with the time it takes to be seen locally. Being referred to a specialist out of town and having to wait weeks for an appointment is far from desirable. Respondents would also like to see the local healthcare facilities in the community work together to provide better care for their patients.

A lack of trust in the healthcare facility was also reflected in the comments. Instances of discrimination and lack of confidentiality were mentioned. Respondents stated providers and staff need to be more compassionate and respectful of their patients regardless of religion or race.

There is also a call for additional services or improvement on existing services. Respondents would like to see expanded access to mental health treatment services including: substance use disorder/chemical dependence treatment, suicide, bullying, and violence counseling services. There was also an expressed need for an improved dialysis unit, expanded access to telemedicine, a syringe exchange program, availability of an X-ray and MRI machine (instead of having to drive two hours round trip), and the addition of a cancer facility. One respondent mentioned the need for more daycare providers in the community.

Cost of healthcare and health insurance was another area of concern among respondents. Several participants stated the cost incurred was a concern, even to those who are fully insured. Some stated they had to go out of town to seek more affordable healthcare and others would like to see a reduced rate for those who have no healthcare plan, or the implementation of a payment system for those who can't afford to pay directly out of pocket. Respondents also indicated that the cost of preventive health procedures (colonoscopy) that aren't covered by insurance are too high to pay out of pocket.

Lack of transportation to and from appointments was another voiced concern. Respondents would like to see more free public transportation being offered at extended hours. Other issues such as homelessness and the desire for the community to offer more activity options for families.

Findings from Key Informant Interviews & the Community Meeting

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

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

- Alcohol/drug use and abuse
- Availability of mental health services
- Availability of resources to help the elderly stay in their homes
- Availability of transportation
- Having enough child daycare services

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

Alcohol/drug use and abuse

- Marijuana is a very commonly used drug among high school aged kids.
- 90% of children in social services care are due to meth use by their parents.
- Rampant drug abuse in all age categories – finding needles in parks and out in the community.

Availability of mental health services

- The school, social services, and jail went together to hire a therapist and she's at full capacity.
- A lot of our younger clients have to go to Minot for services.

Availability of resources to help the elderly stay in their homes

- We need to offer more in home services like laundry, cooking and cleaning, picking up medications, grocery shopping, etc.

Availability of transportation

- Medicaid transportation is a huge issue.
- I've had patients not get care they need due to lack of transportation.
- If we had medical transportation assistance, it would take care of a lot of our clients to they could make their appointments.
- I have patients that could come to me for services but don't have the money for transportation and there is a lack of that service in outlying areas.
- Medicaid does not pay for transportation in Eddy County.

Having enough child daycare services

- We need more licensed daycare, there isn't enough room in the home daycares.
- When someone gets a job they don't have daycare for their children – nursing home has daycare but they only offer to those working at the home.
- Daycare is a constant ongoing need in our community.
- We don't have enough child daycare services in Fort Totten and in Devils Lake.
- The community is in crisis mode trying to figure this issue out.

Priority of Health Needs

A Community group met on April 9, 2019. There were 21 community members who attended the meeting. Representatives from the CRH presented the group with a summary of this report's findings, including background and explanation about the secondary data, highlights from the survey results (including perceived community assets and concerns, and barriers to care), and findings from the key informant interviews.

Following the presentation of the assessment findings, and after considering and discussing the findings, all members of the group were asked to identify what they perceived as the top four community health needs. All of the potential needs were listed on large poster boards and each member was given four stickers to place next to each of the four needs they considered the most significant. It was decided, prior to the initial voting that alcohol use and abuse, drug use and abuse (including prescription drugs), and depression/anxiety, which were concerns listed in both the youth concerns and the adult concerns, would be combined to all ages, instead of being individually listed in each age group.

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

- Extra hours for appointments, such as evening and weekends (12 votes)
- Having enough child daycare services (9 votes)
- Drug use and abuse (including prescription drugs) – all ages (8 votes)
- Alcohol use and abuse – all ages (8 votes)
- Availability of mental health services (7 votes)

The community group made the decision to combine drug use and abuse (including prescription drugs) – all ages and alcohol use and abuse – all ages into one category: substance use and abuse – all ages. From those 4 top priorities, each person put one sticker on the item they felt was the most important. The rankings were:

1. Substance use and abuse – all ages (16 votes)
2. Extra hours for appointments, such as evening and weekends (9 votes)
3. Availability of mental health services (3 votes)
4. Having enough child day care services (0 votes)

One person put their top choice as not enough affordable housing, but this was not one of the top categories to be voted on.

Following the prioritization process during the second meeting of the Community Group and key informants, the number one identified need was the substance use and abuse for all ages. A summary of this prioritization may be found in Appendix C.

Comparison of Needs Identified Previously

Top Needs Identified 2016 CHNA Process	Top Needs Identified 2019 CHNA Process
Drug use and abuse, including prescription drugs in adults and youth	Substance use and abuse – all ages
Alcohol use and abuse, including binge drinking in adults and youth	Extra hours for appointments, such as evenings and weekends
Unemployment/underemployment	Availability of mental health services
	Having enough child daycare services

The current process identified a few common needs from 2016. Previously, drug use and abuse, including prescription drugs in adults and youth and alcohol use and abuse, including binge drinking in adults and youth were identified. These needs were identified again in 2019, but were combined into one overall category of substance use and abuse – all ages.

Hospital and Community Projects and Programs Implemented to Address Needs Identified in 2016

In response to the needs identified in the 2016 CHNA process, the following actions were taken:

Need 1: Drug use and abuse, including prescription drugs in adults and youth – The significant health need identified in our 2016 Community Health Needs Assessment (CHNA) is to reduce non-medical use of prescription drugs, in particular opioids.

There were six activities identified in the CHNA process that were identified to help achieve three projected outputs or goals. These activities included:

- Creating a prescription drug abuse campaign plan
- Establishing a community based multi-disciplinary drug abuse care team that included the following partners: CHI St. Alexius Health, Spirit Lake Nation Clinic, Altru Lake Region Clinic, Premier Clinic, Lake Region Health District Unit and Lake Region Social Services
- Conducting a minimum of six educations sessions per calendar year for providers, patients, and community partners on dangers associated with unused, unneeded, or expired prescription drugs in the home and to educate about safe and effective drug return and disposal
- Expanding yellow container drug take back program to all Lake Region pharmacies and clinics
- Reducing drug seeking and doctor shopping behavior in the hospital emergency room
- Applying for Office of National Drug Control Policy Drug Free Communities Grant

While there was limited success in coordinating with community agencies due to staff and funding limitations, there has still been continued education sessions encouraging safe an effective disposal of expired prescription drugs.

- The first goal is to remove 2,000 pounds of unused, unneeded or expired prescription drugs in the two county service area by December 31, 2019. This process is currently in progress and on track to meet this goal. The North Dakota Board of Pharmacy reports that there has been 340.5 pounds of pharmaceuticals returned by four pharmacies in the Devils Lake area as of January 2019.

- The second goal is to eliminate therapeutic drug monitoring from the top 20 emergency department diagnosis list by leveraging the North Dakota Prescription Drug Monitoring Program (PDMP) to assist in detecting drug diversion. This goal has been met and there is on-going monitoring for potential drug seeking and doctor shopping behaviors in order to ensure that therapeutic drug monitor remains off the top 20 emergency department diagnosis list.
- Goal three is obtaining and using grant funds to hire a part time Drug-Free Communities Grant coordinator. There have not yet been efforts to address this goal.

Need 2: Alcohol use and abuse, including binge drinking in adults and youth – The board decided not to focus on this area at this time.

Need 3: Unemployment/underemployment – The board decided not to focus on this area at this time.

The above implementation plan for CHI St. Alexius Health Devils Lake is posted on their website at https://www.chistalexiushealth.org/sites/default/files/assets/Devils%20Lake/communityassessment/2016CHNA-CHIP_DL.pdf.

Next Steps – Strategic Implementation Plan

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

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

Community Benefit Report

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

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

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

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

What Are Community Benefits?

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

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

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

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

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

Appendix A – CHNA Survey Instrument

Lake Region Area Health Survey

CHI St. Alexius Health-Devils Lake Hospital and Lake Region District Health Unit are interested in hearing from you about community health concerns.

The focus of this effort is to:

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

If you prefer, you may take the survey online at http://tinyurl.com/DevilsLake18 or by scanning on the QR Code at the right.

Scan here to take the survey!

Surveys will be tabulated by the Center for Rural Health at the University of North Dakota School of Medicine and Health Sciences. Your responses are anonymous, and you may skip any question you do not want to answer. Your answers will be combined with other responses and reported only in total. If you have questions about the survey, you may contact Kylie Nissen at 701.777.5380.

Surveys will be accepted through February 18, 2019. Your opinion matters – thank you in advance!

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

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

- ☐ 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
- ☐ Opportunities for advanced education
- ☐ Public transportation
- ☐ Programs for youth
- ☐ Quality school systems
- ☐ Other (please specify) _____

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
- ☐ Job opportunities or economic opportunities
- ☐ Safe place to live, little/no crime
- ☐ Other (please specify) _____

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
- ☐ Recreational and sports activities
- ☐ Year-round access to fitness opportunities
- ☐ Other (please specify) _____

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

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
- ☐ 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
- ☐ Other (please specify) _____

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

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

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

10. Regarding various forms of **VIOLENCE** in your community, concerns are (choose up to THREE):

- ☐ Bullying/cyber-bullying
- ☐ Child abuse or neglect
- ☐ Dating violence
- ☐ Domestic/intimate partner violence
- ☐ Emotional abuse (ex. intimidation, isolation, verbal threats, withholding of funds)
- ☐ General violence against women
- ☐ General violence against men
- ☐ Physical abuse
- ☐ Stalking
- ☐ Sexual abuse/assault
- ☐ Verbal threats
- ☐ Video game/media violence
- ☐ Work place/co-worker violence

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

_____

_____

Delivery of Healthcare

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

- ☐ Bicycle helmet safety
- ☐ Blood pressure check
- ☐ Breastfeeding resources
- ☐ Car seat program
- ☐ Child health (well baby)
- ☐ Correction facility health
- ☐ Diabetes screening
- ☐ Emergency response & preparedness program
- ☐ Flu shots
- ☐ Environmental health services (water, sewer, health hazard abatement)
- ☐ Health Tracks (child health screening)
- ☐ Home health
- ☐ Immunizations
- ☐ Medications setup—home visits
- ☐ Office visits and consults
- ☐ School health (vision screening, puberty talks, school immunizations)
- ☐ Preschool education programs
- ☐ Assist with preschool screening
- ☐ Tobacco prevention and control
- ☐ Tuberculosis testing and management
- ☐ WIC (Women, Infants & Children) Program
- ☐ Youth education programs (First Aid, Bike Safety)

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

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

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

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

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

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

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

_____

_____

Demographic Information: Please tell us about yourself.

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

☐ Yes ☐ No

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

- ☐ Indian Health Service (IHS)
- ☐ Insurance through employer
- ☐ Self-purchased insurance
- ☐ Medicaid
- ☐ Medicare
- ☐ No insurance
- ☐ Veteran's Healthcare Benefits
- ☐ Other (please specify) _____

19. Age:

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

20. 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

21. Gender:

- ☐ Female
- ☐ Male
- ☐ Transgender

22. Employment status:

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

23. Your zip code: _____

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

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

26. Annual household income before taxes:

- ☐ Less than $15,000
- ☐ $15,000 to $24,999
- ☐ $25,000 to $49,999
- ☐ $50,000 to $74,999
- ☐ $75,000 to $99,999
- ☐ $100,000 to $149,999
- ☐ $150,000 and over
- ☐ Prefer not to answer

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

_____

_____

Thank you for assisting us with this important survey!

Appendix B – County Health Rankings Explained

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

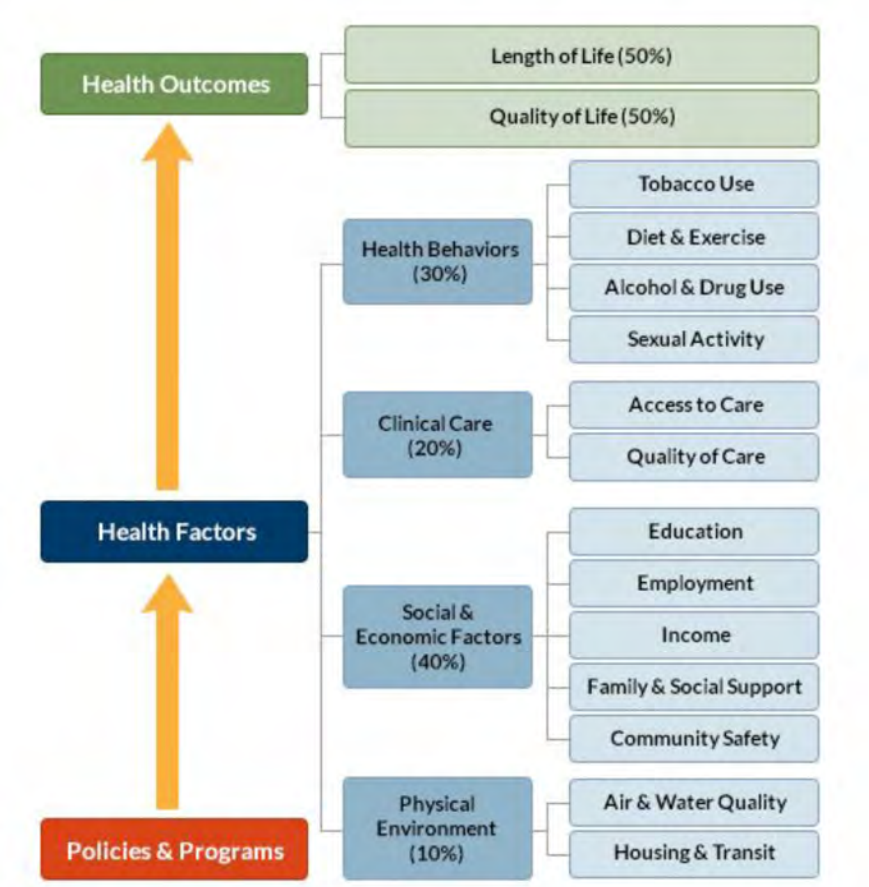
Methods

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

What is Ranked

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

Ranking System



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

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

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

Data Sources and Measures

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

Data Quality

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

Calculating Scores and Ranks

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

Health Outcomes and Factors

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

Health Outcomes

Premature Death (YPLL)

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

Reason for Ranking

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

Poor or Fair Health

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

Reason for Ranking

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

Poor Physical Health Days

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

Reason for Ranking

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

Poor Mental Health Days

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

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

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

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

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

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

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

Health Factors

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

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

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

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

Food Environment Index

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

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

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

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

Reason for Ranking

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

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

Physical Inactivity

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

Reason for Ranking

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

Access to Exercise Opportunities

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

Individuals who:

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

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

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

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

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

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

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

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

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

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

Reason for Ranking
Evidence suggests teen pregnancy significantly increases the risk of repeat pregnancy and of contracting a 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 [1]. Pregnant teens are more likely than older women to receive late or no prenatal care, have eclampsia, puerperal endometritis, systemic infections, low birthweight, preterm delivery, and severe neonatal conditions [2, 3]. Pre-term delivery and low birthweight babies have increased risk of child developmental delay, illness, and mortality [4]. Additionally, there are strong ties between teen birth and poor socioeconomic, behavioral, and mental outcomes. Teenage women who bear a child are much less likely to achieve an education level at or

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

Uninsured

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

Reason for Ranking

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

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

Primary Care Physicians

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

Reason for Ranking

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

Dentists

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

Reason for Ranking

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

Mental Health Providers

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

Reason for Ranking

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Injury Deaths

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

Reason for Ranking

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

Air Pollution-Particulate matter

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

Reason for Ranking

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

Drinking Water Violations

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

Reason for Ranking

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

Severe Housing Problems

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

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

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

Reason for Ranking

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

Appendix C – Youth Behavioral Risk Survey Results

Appendix C – Youth Behavioral Risk Survey Results

North Dakota High School Survey

*2017 YRBS North Dakota Data is not yet available, so the 2015 data was used.

Rate Increase ↑, rate decrease ↓, or no statistical change = in rate.

	ND 2013	ND 2015*	ND Trend ↑, ↓, =	Rural ND Town Average	Urban ND Town Average	National Average 2017
Injury and Violence						
Percentage of students who rarely or never wore a seat belt.	11.6	8.5	↓	10.5	7.5	5.9
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)	21.9	17.7	↓	21.1	15.2	16.5
Percentage of students who talked on a cell phone while driving (on at least 1 day during the 30 days before the survey, among students who drove a car or other vehicle)	67.9	61.4	↓	60.7	58.8	NA
Percentage of students who texted or e-mailed while driving a car or other vehicle (on at least 1 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)	59.3	57.6	=	56.7	54.4	39.2
Percentage of students who never or rarely wore a helmet (during the 12 months before the survey, among students who rode a motorcycle)	29.8	28.7	=	32.8	24.7	NA
Percentage 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)	6.4	5.2	=	6.6	4.5	3.8
Percentage of students who were in a physical fight on school property (one or more times during the 12 months before the survey)	8.8	5.4	↓	6.9	6.1	8.5
Percentage of students who were ever physically forced to have sexual intercourse (when they did not want to)	7.7	6.3	=	6.5	7.4	7.4
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)	9.7	7.6	=	6.9	8.0	8.0
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)	9.6	9.7	=	10.4	9.7	NA
Percentage of students who were bullied on school property (during the 12 months before the survey)	25.4	24.0	=	27.5	22.4	19.0
Percentage of students who were electronically bullied (including being bullied through e-mail, chat rooms, instant messaging, websites, or texting during the 12 months before the survey)	17.1	15.9	=	17.7	15.8	14.9
Percentage of students who felt sad or hopeless (almost every day for 2 or more weeks in a row so that they stopped doing some usual activities during the 12 months before the survey)	25.4	27.2	=	24.9	28.9	31.5
Percentage of students who seriously considered attempting suicide (during the 12 months before the survey)	16.1	16.2	=	15.8	16.7	17.2
Percentage of students who made a plan about how they would attempt suicide (during the 12 months before the survey)	13.5	13.5	=	12.8	13.7	13.6
Percentage of students who attempted suicide (one or more times during the 12 months before the survey)	11.5	9.4	↓	10.3	11.3	7.4

	ND 2013	ND 2015*	ND Trend ↑, ↓, =	Rural ND Town Average	Urban ND Town Average	National Average 2017
Tobacco Use						
Percentage of students who ever tried cigarette smoking (even one or two puffs)	41.4	35.1	↓	37.3	32.5	28.9
Percentage of students who smoked a whole cigarette before age 13 years (for the first time)	7.9	7.2	=	7.3	6.7	9.5
Percentage of students who currently smoked cigarettes (on at least 1 day during the 30 days before the survey)	19.0	11.7	↓	13.2	11.8	8.8
Percentage of students who currently frequently smoked cigarettes (on 20 or more days during the 30 days before the survey)	6.6	4.3	↓	4.3	4.7	2.6
Percentage of students who currently smoked cigarettes daily (on all 30 days during the 30 days before the survey)	3.9	3.2	=	3.2	3.2	2.0
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)	7.8	16.9	↑	0.2	1.0	NA
Percentage of students who tried to quit smoking cigarettes (among students who currently smoked cigarettes during the 12 months before the survey)	55.5	47.4	=	49.1	52.7	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 1 day during the 30 days before the survey)	NA	22.3	↑	19.7	22.8	13.2
Percentage of students who currently used smokeless tobacco (chewing tobacco, snuff, or dip on at least 1 day during the 30 days before the survey)	13.8	10.6	↓	12.6	9.5	5.5
Percentage of students who currently smoked cigars (cigars, cigarillos, or little cigars on at least 1 day during the 30 days before the survey)	11.7	9.2	↓	9.7	9.7	8.0
Percentage of students who currently used cigarettes, cigars, or smokeless tobacco (on at least 1 day during the 30 days before the survey)	27.5	20.9	↓	22.9	19.8	14.0
Alcohol and Other Drug Use						
Percentage of students who ever drank alcohol (at least one drink of alcohol on at least 1 day during their life)	65.8	62.1	=	64.5	59.9	60.4
Percentage of students who drank alcohol before age 13 years (for the first time other than a few sips)	15.2	12.4	=	15.3	12.9	15.5
Percentage of students who currently drank alcohol (at least one drink of alcohol on at least 1 day during the 30 days before the survey)	35.3	30.8	↓	32.8	29.3	29.8
Percentage of students who drank five or more drinks of alcohol in a row (within a couple of hours on at least 1 day during the 30 days before the survey)	21.9	17.6	↓	19.8	17.0	13.5
Percentage of students who usually obtained the alcohol they drank by someone giving it to them (among students who currently drank alcohol)	37.0	41.3	=	41.1	40.4	43.5
Percentage of students who tried marijuana before age 13 years (for the first time)	5.6	6.3	=	5.8	5.8	6.8
Percentage of students who currently used marijuana (one or more times during the 30 days before the survey)	15.9	15.2	=	13.2	17.1	19.8
Percentage of students who ever took prescription drugs without a doctor's prescription (such as OxyContin, Percocet, Vicodin, codeine, Adderall, Ritalin, or Xanax, one or more times during their life)	17.6	14.5	↓	13.2	16.0	14.0
Percentage of students who were offered, sold, or given an illegal drug on school property (during the 12 months before the survey)	14.1	18.2	↑	15.9	19.9	19.8

	ND 2013	ND 2015*	ND Trend ↑, ↓, =	Rural ND Town Average	Urban ND Town Average	National Average 2017
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)	9.9	8.6	=	7.9	9.0	NA
Sexual Behaviors						
Percentage of students who ever had sexual intercourse	44.9	38.9	↓	39.3	39.1	39.5
Percentage of students who had sexual intercourse before age 13 years (for the first time)	3.8	2.6	=	3.3	3.3	3.4
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)	15.1	14.7	=	15.4	14.6	15.6
Percentage of students who were obese (>= 95th percentile for body mass index, based on sex- and age-specific reference data from the 2000 CDC growth chart)	13.5	14.0	=	16.3	12.9	14.8
Percentage of students who described themselves as slightly or very overweight	32.0	32.2	=	34.2	31.5	31.5
Percentage of students who were trying to lose weight	45.4	44.7	=	45.0	43.0	47.1
Percentage of students who did not eat fruit or drink 100% fruit juices (during the 7 days before the survey)	3.4	3.9	=	4.3	4.1	5.6
Percentage of students who ate fruit or drank 100% fruit juices one or more times per day (during the 7 days before the survey)	64.7	62.5	=	8.5	8.8	60.8
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 7 days before the survey)	6.0	4.7	=	4.5	5.2	7.2
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 7 days before the survey)	62.8	58.5	↓	61.2	60.0	59.4
Percentage of students who did not drink a can, bottle, or glass of soda or pop (not including diet soda or diet pop, during the 7 days before the survey)	25.3	25.6	=	23.5	21.7	27.8
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 7 days before the survey)	23.4	18.7	=	21.4	18.0	18.7
Percentage of students who did not drink milk (during the 7 days before the survey)	11.1	13.9	↑	11.6	13.7	26.7
Percentage of students who drank two or more glasses per day of milk (during the 7 days before the survey)	42.4	35.8	↓	36.6	35.3	17.5
Percentage of students who did not eat breakfast (during the 7 days before the survey)	10.5	11.9	=	10.7	11.8	14.1
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)	3.1	2.2	=	2.4	2.8	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)	50.6	51.3	=	51.7	50.1	46.5
Percentage of students who watched television 3 or more hours per day (on an average school day)	21.0	18.9	=	20.7	18.2	20.7
Percentage of students who played video or computer games or used a computer 3 or more hours per day (for something that was not school work on an average school day)	34.4	38.6	↑	39.4	38.0	43.0

	ND 2013	ND 2015*	ND Trend ↑, ↓, =	Rural ND Town Average	Urban ND Town Average	National Average 2017
Other						
Percentage of students who had 8 or more hours of sleep (on an average school night)	30.0	29.5	=	34.5	28.7	25.4
Percentage of students who brushed their teeth on seven days (during the 7 days before the survey)	71.5	71.0	=	67.8	70.1	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)	11.2	12.5	=	10.3	12.8	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)	19.6	12.2	↓	13.3	12.8	NA

Appendix D – Prioritization of Community's Health Needs

Community Health Needs Assessment
Devils Lake, North Dakota
Ranking of Concerns

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

	Priorities	Most Important
COMMUNITY/ENVIRONMENTAL HEALTH CONCERNS		
Attracting & retaining young families	0	
Having enough child daycare services	9	0
Not enough affordable housing	4	
Not enough jobs with livable wages	1	
AVAILABILITY/DELIVERY OF HEALTH SERVICES CONCERNS		
Availability of mental health services	7	3
Extra hours for appointments, such as evenings and weekends	12	9
Cost of healthcare services	0	
Availability of substance use disorder treatment services	0	
Availability of specialists	5	
Cost of health insurance	2	
YOUTH POPULATION HEALTH CONCERNS		
~~Alcohol use and abuse~~	-	
~~Drug use and abuse (including prescription drugs)~~	-	
Suicide	2	
~~Depression/anxiety~~	-	
Smoking and tobacco use, exposure to second-hand smoke, juuling/vaping	1	
Not enough activities for children	3	
ADULT POPULATION HEALTH CONCERNS		
Alcohol use and abuse (all ages)	8	
Drug use and abuse (including prescription drugs) (all ages)	8 > 16	
Substance use and abuse (all ages)		16
Cancer	0	
Depression/anxiety (all ages)	3	
Not getting enough exercise/physical activity	1	
SENIOR POPULATION HEALTH CONCERNS		
Cost of long-term/nursing home care	1	
Availability of resources to help elderly stay in their homes	6	
Ability to meet needs of older population	2	
Availability of resources for family and friends caring for elders	0	
Assisted living options	0	
Availability of home health	0	
VIOLENCE CONCERNS		
Domestic/intimate partner violence	1	
Bullying/cyber-bullying	4	
Child abuse/neglect	0	
Emotional abuse (isolation, verbal threats, withholding of funds)	0	

Appendix E – Survey "Other" Responses

The number in parenthesis () indicates the number of people who indicated that EXACT same answer. All comments below are directly taken from the survey results and have not been summarized.

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: "Other" responses:
    - At MiSU college
    - Diversity is not necessarily a strength.
    - I am white and worked out on the reservation for two years…There is a huge disconnect between Devils Lake and there... we should work together and not apart
    - Lacks all of the above
    - None
    - Our community needs to work on tolerance of diversity
2. Considering the SERVICES AND RESOURCES in your community, the best things are: "Other" responses:
    - Dedicated 1st Responders
    - Faith community is not diverse
    - None of these
    - Nothing enticing
    - Sports
    - There are activities for all ages and accessibility to common interest activities for all ages stressing community health
3. Considering the QUALITY OF LIFE in your community, the best things are: "Other" responses:
    - Devils Lake area needs to address the drug and crime culture that so many people are concerned have become the face of the region.
    - Everyone knows everyone and is supportive when needed
    - Good air/water quality; no pig farms nearby
    - (2) Hunting/fishing opportunities
    - Nothing enticing
4. Considering the ACTIVITIES in your community, the best things are: "Other" responses:
    - 4-H Programs
    - A group of individuals joined commitments to restore a 1905 opera house adding local arts restorations to our community as well as local restaurant gathering place and enhanced library center. Outside educators, authors and other educational programs run through the librarian.
    - Anything in sports or fitness
    - Fishing
    - (2) Hunting and fishing
    - Lacks in all of the above
    - Location
    - None
    - That's it
    - There isn't enough of all the above
    - There needs to be more community programs that work together

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: "Other" responses:

- Abandoned houses that should be torn down, no grocery store
- Child neglect
- (2) Drug abuse
- No visual arts center or events
- Not enough for young people to do
- Swimming lessons and more youth activities minus sports
- There aren't enough things for kids to do - we need a community center or something indoor during the winter time
- There is not enough child daycare services. I wish I could select that option more than once

6. Considering the AVAILABILITY/DELIVERY OF HEALTH SERVICES in your community, concerns are: "Other" responses:

- Adding competition of clinic surgery has not lowered costs or increased quality of care
- After hours urgent care. Other options than ER
- ER help is a disaster. Will travel to Grand Forks for ER services
- Lack of adequately trained ER staff
- No access to urgent care
- On this list I would need to pick a lot more than 3
- Orthodontic care. Too many travel out of town. Would be great if we could get an orthodontist here a few times each month!
- Rural areas lack all of the above
- Seeing a different doctor every time you have a spur of the moment visit.
- Surgeon's not here
- Telemedicine is the one area that we wanted to add to our tech center in the late 90s but we were unable to achieve. Small rural communities all suffer lack of immediate access to specialized health evaluations and direction

8. Considering the YOUTH POPULATION in your community, concerns are: "Other" responses:

- (2) Bullying
- Bullying is greater in rural areas
- Bullying/coping
- Definitely more than 3 in this category
- I'm certain there are youth involved in experimentation w/health risks as in all communities. Our school, parents, clergy and extended family members seem to work well together in communicating and loving our youth. These areas are not given closed eyes or ears. The welfare of our youth is our future.
- Mental health
- Overuse of electronics
- Poverty - children cannot access activities

9. Considering the ADULT POPULATION in your community, concerns are: "Other" responses:

- Activities for mid adults
- Child neglect
- Grocery store

- Lack of home health services
- Mental health needs not meet
- Mental illness
- Not enough access to wellness programs
- We have a small basic care nursing home which continues and encourages community involvement and interaction from youth through seniors. Everyone knows everyone and it continues connectedness for our basic care citizens entwined with other seniors. My observations would be that there is awareness and concern for all senior citizens. People seem to carry concerns for each other overall while I'm sure there are those suffering some of the above

10. Considering the SENIOR POPULATION in your community, concerns are: "Other" responses:

- Housing cost - apartment rental
- No grocery store in town
- Not enough utilize senior center
- Small basic care nursing home growing small

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

- "We don't have a problem" mentality
- Access to emergency healthcare - long waits - not enough resources to meet the patients' needs
- Affordable healthcare
- Affordable health insurance
- Affordable healthcare without needing to be transferred or referred out of town
- Aging!
- At this time the biggest issue facing our community are all the youth that are committing suicide or making attempts at suicide. A lot of them are bullied at school and Devils Lake is very clique oriented. Youth through adults.
- Availability of child daycare
- Availability of in-town transport
- Availability of jobs that can sustain a house hold.
- Availability of quality activities for all people (summer and winter)
- Available and affordable child care
- Bullying
- Bullying in schools
- Bullying in the middle school aged children. We are not acknowledging enough the issue that lies within that age group and that school system. Too much is being swept under the rug.
- Child abuse and bullying
- Child abuse and neglect.
- Child abuse on the reservation
- Child neglect
- Cost of quality healthcare
- Cyber bullying among adults.
- Daycare
- Decreasing population
- (2) Depression
- Diversity and acceptance
- Domestic violence
- (2) Drug abuse
- Drug addiction including pills.
- (4) Drug and alcohol abuse

- Drug and alcohol addiction - the fallout is violence, crime, and abuse/neglect of children.
- Drug and alcohol use in Devils Lake are out of control. Youth as well as adults. Alcohol is a bigger problem than smoking when it comes to healthcare costs it's just that no one talks about that. If you're a smoker and you cost the general public money it's a crime, but if you are addicted to alcohol and cost the community money... it's no big deal. No, I'm not a smoker, never have been. Just trying to make a point.
- Drug and alcohol use in our youth population
- Drug issues, meth and marijuana
- Drug use within the community
- Drugs
- Drugs (meth and heroin)
- Drugs and alcohol abuse both teens and adults
- Drugs and alcohol. Read the ND.courts.gov and look at all the drug charges.
- Drugs, alcohol, bullying, neglect, too many liquor establishments in the area.
- Employment. If we lose the hospital, we lose most of the good jobs in the community.
- Failure of the North Dakota Department of Corrections to hold sentenced criminals for the entire term of their court ordered term of incarceration.
- Family structure
- Feeling safe downtown after hours.
- Getting medical attention in the time needed. Stroke patients that live in rural areas for example may have adverse effects due to diagnosis time lag and/or the time it takes to get to a healthcare facility.
- Getting people to work vs using welfare.
- Gossip!!
- Growth and affordability with the tax base in place
- Having enough daycare providers!
- Healthcare costs
- Healthcare and costs
- Helping the older population
- Housing for elderly
- Housing shortage (low income)
- I believe the greatest issue is the lack of community events available for entertainment
- I feel that the biggest challenge that our community currently has is substance abuse. A lot of teens and also adults drink, smoke, do drugs in our community I believe this is because of bullying and lack of activities do for families and for teens do besides bars/partying.
- I think if there was some place safe and fun for kids to do, especially in the winter/weekends, there would maybe be less opportunity for young kids to get involved in drugs/alcohol. There aren't many options for families to do fun things together - we end up driving to Grand Forks for the day so our kids can jump on some trampolines.....which in turn leads to spending money out of town on food, in other stores, etc.
- Inability to attract young families
- Inability to grow
- Increasing crime in the community.
- It's more of a hand in hand issue. The rate of bullying and suicide in this community with its youth is staggering.
- Jobs
- Keeping resources close: food, healthcare, school etc. Instead of it moving further and further into the hub cities
- Keeping young families in our community
- Keeping young from bullying and violence
- Lack of child care - quality child care!

- Lack of disability services.
- Lack of high-paying jobs
- Lack of home health for seniors.
- Lack of mental health and chemical dependency/abuse treatment options, especially for teens
- Lack of mental health and treatment facilities.
- Lack of opportunities to bring families in and keep people here. There aren't very many jobs available and very few drawing cards for the community of Maddock.
- Lack of quality mental health programing
- Lack of quality public health services for all community members. Segregation of mistreatment towards native families within Ramsey County PH unit!
- Lack of shopping
- Losing population
- Loss of jobs and how to cope with it. In addition, availability for other opportunities of employment.
- Low population, no place to purchase even basic products.
- Mental health service expansion
- Mental health/drug abuse - prescription and illegal
- Methamphetamine related issues
- Need an urgent care/ walk in clinic
- Neglect
- No full time surgeon
- (3) No grocery store
- No one has to take responsibility for their choices/actions. It is a problem for someone else to shoulder/fix. Unfortunately this is not a local problem but a trend of society in general
- Not be able to attract new people to the community because not enough jobs.
- Not enough healthy activities for children and families
- Not enough job opportunities which pay enough that people can support a family on decently, without relying on credit cards.
- Not enough jobs and the pay rate of some jobs isn't high enough to meet the cost of living. I am a single mom and I know I need two fulltime jobs to pay for my apartment and that cuts into my time with my children.
- Not enough mental health services here.
- Not enough options available for youth in the community to do outside of schools activities. EX: Bowling alley, place for youth to hang out and feel safe- but not a "babysitting place" so to speak.
- Not having a full scale multi use recreation center with options for indoor recreation for all ages. Most communities our size and larger have a rec center. Not having a facility is detrimental when trying to retain and attract families.
- Nothing for teens and children to do when not in sports.
- Nothing to draw or keep good quality families here.
- Opioid epidemic
- Overall general community education regarding all of the above
- People on social services with so many jobs open
- Poor economy
- Population decline especially in youth which effects the school.
- Poverty - it impacts everything from access to community news, utilizing resources, education, quality of child care and opportunity
- Poverty and the circumstances (domestic issues, drug/alcohol/tobacco use and abuse, child hunger, etc.) that surround people and families in poverty
- Poverty. Less than livable wages effects all realms including health and home issues.
- (2) Provide living wage jobs so the community can grow and thrive

- (2) Racism
- Racism and bullying
- Reasonable housing and healthcare for elderly living on a fixed budget.
- Relationship choices.
- Reliable daycare
- Retail stores - need to go out of Devils Lake for most shopping (very inconvenient)
- Retaining population
- Safety and clean water
- Spread of drug use in all ages - I feel that Devils Lake is being invaded with drug traffic and the violence that comes with it.
- Suicide
- Teen pregnancy and drug abuse
- The availability of after-hours healthcare- primarily care on Saturday's and availability of pharmacy services over the weekend. The ER is the only place in Devils Lake available for healthcare on the weekends currently.
- The availability of jobs that provide good wages. Too many people have 2 jobs.
- The community not working together as a whole - meaning they should put personal feelings aside
- The drug and alcohol use of teenagers.
- The fact that there is not many options for things to do in this town besides drinking. There's 15-20 places to buy or drink alcohol. The only thing here for kids to do is going swimming to the public pool and that's only open 3 months out of the year.
- The lack of understanding of and resources for mental healthcare for all ages of people.
- The local commitment to invest in these above problems always looking to the federal government for help. The working poor and problems associated with this practice among businesses is systemic.
- The need for change is apparent, but with the younger generation that gets out of poverty they move away as Devils Lake does not have much to offer for the younger generations.
- There are too few jobs that pay a living wage and housing and daycare costs are too high. Devils Lake is just not a family friendly town anymore.
- Things for youth
- Too much alcohol and drugs (marijuana) use by teenagers and young adults.
- Wages
- Water quality
- We need a cohesive healthcare system in town, i.e. communications between all entities for the patient. I also want to have a primary physician who stays in the community more than two years. I don't like driving to Grand Forks to see my OB/GYN and other specialists, yet away we drive.
- Would be nice to have more options for family activities that won't cost a fortune

Delivery of Healthcare

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

- Clinic for non-emergency problems open on the weekend and evening
- A free clinic would benefit the many people living at minimum wage in the community
- A REAL emergency room
- A walk in clinic with extended hours, the Emergency Room is very expensive and the wait takes hours
- A walk in clinic or outpatient clinic
- Addiction counseling, we went several months without even one addiction counselor in town.
- Additional dialysis services for the increasing number of chronic kidney disease patients.
- Additional medical providers
- After hours care, not ER

- After hours urgent care for weekends especially. Local people are having to pay high emergency room visits for things such as an infection that would be good for an urgent care visit.
- After hours walk-in clinic. The only choice we have now is the ER.
- Birth control, STD/STI testing, pregnancy counseling - but that's mostly our county commissioners fighting it, stopping public health from providing those services.
- Cancer facility
- Cancer specialists, OBGYN, any specialists
- Clinic night and weekend coverage
- Dental
- Dentist
- Dentist or eye doctor that accept BCBS insurance (Now VSP)
- Dermatology
- Diabetic specialty
- Dialysis and chemo therapy
- Expanded hours for walk in clinic
- Extended hours emergency needs - dental options on Fridays/evenings
- Extended hours for people who work during the day and can't take the time off.
- Eyes - ears - mouth
- Family planning, sexual health issues, eldercare, more QSPs
- Full time staff cardiologist
- Full time surgeon
- Gastric bypass
- Gastric bypass surgery centers
- General surgeon full time.
- Infant toddler mental health, individuals who specialize in preschool and school age mental health
- In-hospital psychiatric help
- It would be nice to see an urgent care/walk in clinic, especially on weekends. I hate having to pay ER prices when my child gets sick over a weekend.
- Keep local clinic open longer hours
- Kidney dialysis, cancer chemo
- Mental health expansion to schools, jail
- More access/providers for mental health and limited number visits
- More affordable mental health services
- More evening and weekend hours
- More home visiting capabilities. Ability to do INR testing in the home for elderly.
- More psych - ability to see a variety of insurances and prescribe medications/give treatment
- More specializations
- More surgical services
- N/A
- Need to feel as though emergencies can be handled efficiently on a consistent basis
- Night clinic to free up the emergency room for true emergencies.
- Occupational health; more psychiatric services
- Orthopedics, geriatric
- Orthodontic care
- Orthodontics, eye clinics need to take state eye insurance
- Orthodontist, dermatologist, surgeon
- Pediatric dentistry for Medicaid children

- (2) Pediatrician
- Possibly a psychologist or maybe a counselor
- Services available for the population that doesn't work/get active during the "9 - 5" hours.
- Spa, manicures/pedicures
- Specialists: i.e. ENT, MD
- Tele-med counseling service as in this small community people would rather receive counseling from someone they don't run into in the grocery store.
- Telemedicine services for consultations and aftercare for our rural citizens when needed. We are basically 120-150 miles from our specialists
- Treatment programs for chemical abuse/dependency, both out-patient and in-patient
- Urgent care clinic
- Urgent care – evenings and weekends
- Urgent care for after-hours needs that aren't necessarily an "emergency"
- Urgent care for nights and weekends
- Urgent care or expanded hours at clinic. Community HMO. Fire the current hospital administration.
- Urgent care would be a benefit to the community
- (3) Walk in clinic
- Walk in clinic and/or extended hours
- Walk in clinic, another provider--like Sanford
- Weekend and after hours urgent care. Not only ER
- Weekend coverage
- Weekend walk in clinics
- X-ray, physical therapy

16. What PREVENTS community residents from receiving healthcare? "Other" responses:

- Cost transparency for all
- Have to drive to Grand Forks for adequate ER care as hospital keeps using substandard providers.
- I don't know that this is a problem
- N/A
- Not enough female docs to care for women past childbearing age.
- Our local hospital can't even put in a stich. All cases that are more than the common cold transfer to Grand Forks
- Overall excellent health. Have annual checkups and access to my PA when needed (very rarely). Utilize county nurse for shot maintenance schedule and completion
- Walk in clinics would be nice
- We need an urgent care clinic

17. Where do you find out about LOCAL HEALTH SERVICES available in your area? "Other" responses:

- Common knowledge, small community
- Do not know
- Lived here for years
- N/A

18. Where do you turn for trusted health information? "Other" responses:

- Have chosen to take several healthcare needs/services to larger North Dakota cities

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

- Advanced eye care that accepts PERS Insurance. Other than Wal-Mart

- A walk-in clinic would be nice, or more evening and weekend availability
- Add more evening hours so the use of the emergency room can be limited. Many times I have tried to wait or waited till Monday to make an appointment, to avoid ER costs.
- Add more help
- Affordable flight insurance if needed in an emergency. Affordable flight provider.
- After hours clinic
- Aging, rural population requires more proactive outreach for primary care and addressing the needs of the community
- All medical emergencies get transported to Grand Forks! Devils Lake is just a band aid station!
- Cancer facility and bigger dialysis unit
- Community healthcare facilities should be able to work together better. There is enough business for everyone. I will say that I recently had to use the ER on the weekend and I was very impressed that I was in and out in about 3 hours. I think they have worked on that area in past few years and have made improvements
- Confidentiality is a huge deal, no one feels comfortable at our local establishments
- Continued education on healthcare for community members with no insurance/lack of income
- Cost and availability are huge concerns for my family, even with health insurance. Also, it's often very difficult to get seen same day or to see my primary care provider. Also, it would be greatly appreciated it the provider I am seeing took more than 30 seconds. There are times I have waited 45 minutes or longer to get seen and the doctor is in and out of the office in less than 5 minutes, which is not quality care. Doctors and nurses also need to put their religion aside when caring for patients and should not be allowed to turn someone away due to religious reasons, not everyone is Catholic, but everyone does deserve to be treated with respect and provided quality care. Lastly, all patients should be treated well and with respect. Several doctors and nurses treat Native Americans poorly or will tell them to go to IHS for care, this is wrong!
- Costs are out of hand for both care and insurance.
- Current provider only puts Band-Aids on problems to keep you coming back, instead of actually fixing the issue.
- Doctor retention over time, don't have to change. Share medical history and information between clinics and hospitals
- Emergency room providers should be more compassionate/understanding always seem crabby
- Evening healthcare hours and weekend hours.
- Expand access to tele-med: dermatology, counseling services,
- Expand hours of service. Increase emergency services and staff. Update facilities.
- Fire current CEO and Head Nurse, elevate the CFO to CEO and start to provide quality care with an increased moral at the hospital. Current head nurse has caused 3 paramedics to quit in the last few months. Coverage is diminishing which will hurt the bottom line in the community. Hospital is #1 employer in community. Without it everything else will start to fail.
- Having to go out of town to receive affordable dental care that will take payments. Going out of town for prenatal appointments and other appointments for my child because they don't have enough or adequate staff here.
- Healthcare services are too quick to send people on their way in attempt to keep up with demand.
- High cost! Distance to specialists
- Homeless concerns
- Honestly, we need better professionals and positions than can be filled in a professional manner. We also need people who are flexible and can work in the event of unexpected circumstances. If this has already been brought up and met previously, then this maybe (perhaps) gratuitous.
- I am very concerned about the use of the emergency room by low-income families for issues that can be handled in at the clinic but they either do not have work hours that allow going to the clinic, to long of a wait or unable to see their primary physician. Devils Lake needs urgent care or some after hour services!! I have lived in Devils Lake for 20 years and have seen the medical services drastically improve. Keep up the good work.
- I really think that an Urgent Care would be a benefit. ER visits can be costly to people especially those without insurance and when there is a need to see a provider after clinic hours/weekends but not quite

ER material, an Urgent Care would be a great asset.

- I think it is a shame that the healthcare facilities (Mercy Hospital and Altru Health System) can't work together. They seem to be competing with each other. They are more concerned about the money they make than about the professional care they provide to their patients.
- I think providing free transportation would be nice
- Increased daycare providers, weekend walk in clinics or extended hours to prevent emergency room visits for clinic health issues.
- It need to be more affordable
- Keep rural clinics available
- Keep the small clinics open in smaller areas
- Mainly that anything other than the common cold are transferred to Grand Forks. The specialist doctors do come here if you can wait 2 to 3 months to get into them. In most cases your issue is more pressing than that.
- Mental health expansion should include substance abuse, suicide, bullying, and violence. These services should affect all community settings with ease of access improved.
- More doctors, more hours, syringe exchange program
- More family activities? Indoor playground, events sponsored by local groups etc.
- More flyers in mail regarding available resources - more radio ads regarding available resources
- More of positions available evening and weekend hours without having to visit the emergency room
- More physicians in the clinic and longer clinic hours
- More primary care givers
- more provider clinic hours
- More transportation services for patients. Fort Totten to Devils Lake. Devils Lake to Grand Forks. Devils Lake to Fargo. Better dialysis unit, bigger, brighter.
- N/A
- Need easy access for affordable, quality healthcare and easy local access to at least one specialist... Pulling my kid out of school for a 15-minute appointment because I have to take her to Grand Forks. Or they should be open weekends
- Need more government funding so local facilities can stay competitive and up to date
- Need more public transportation available at a wider variety of hours.
- Need to have growth in the community. Need events or things to do for the youth, also for couples
- Needs to be more diverse and offer services that people will use.
- None.
- Offer more late clinic hours for families that work late. Offer a reduced rate for people whom have no healthcare plan.
- Open urgent care facility
- Out of pocket costs for preventative health (colonoscopy, vision exams, etc) can be costly, even for 'fully insured' persons and specialty providers are difficult to see in a timely manner.
- Regular MDs and specialists (full time staff), such as cardiologist. Must travel outside of Devils Lake or else wait for a long time for an appointment when someone comes from Grand Forks (usually monthly or longer).
- Retain enough staff to keep the hospitals functioning properly.
- Sell the hospital to Altru so we have consistent care delivered in a confidential manner if you need to use hospital services. Our family refuses to even stop there anymore if we need ER care and just drive to Grand Forks. Inpatient doctors are great but nursing staff is poorly trained and rude. Have heard the OB nurses are great but haven't needed their services.
- Shortage of county nurses
- The area needs more physicians who are willing to stay longer. I believe we have many great ones in the Lake Region. It just seems once you find one you like, they leave. We've had four primaries in the last 10 years. I finally switched to going to Grand Forks for my OB/GYN needs because I was tired of the runaround.

- The biggest concern is gaining the communities trust. There are many out there who feel discriminated at the healthcare facilities in this community, so they bad mouth them to others. They need to get out and mix among the community, get more hands on, and maybe the trust will become established.
- The most basic problem with healthcare is the cost, no simple solution for that one. I do, however, think most people do not know what all services the public health nurse offers at a much lower cost - perhaps advertising these services more often would provide people with another, lower cost, option they never knew was available to them.
- There is not enough "mental health" facilities available, especially after hours and weekends.
- There needs to be a local YMCA or some kind of fitness center that is for ALL ages and is affordable, or where insurance will help cover. Also there needs to be a pool with staff who teach swimming lessons all day along with a daycare in the facility so that parents are able to work out as well. Minot has an amazing facility and I wish all towns had one like it!
- Urgent care – evenings and weekends. More stability with good doctors/nurse practitioners.
- Very good job done for healthcare. Surrounding communities (Rugby) for healthcare issues.
- We lose our capability of allowing our seniors needing care beyond basic care. I believe most of these folks pass away of a broken heart as they are faced with leaving their home, friends and support groups, not to mention daily visits from family
- We need a couple more internal medicine doctors and we need to be able to have a clinic in the evenings to free up the emergency room.
- We need a lot more doctors, especially family practice doctors. It's hard to get into your own doctor with any pressing health issues so you have to pick another doctor and the wait time to be seen is usually 4 -5 times longer than Grand Forks or Fargo
- We need more MD's here. Also if your doctor isn't sure what is going on, get a second opinion. Work in teams instead of for themselves. Don't wait so long to refer patients on and when the patient asks for a referral don't put them off, because as a patient we know our bodies better than anyone and we want answers not to be told we will see how your next appointment goes and then have to wait 3 - 4 months to get into a specialist, but yet you are concerned about their issue and want to see them, but oops sorry we don't have an opening until 4 months later. This is not good service to patients.
- We need more provider and providers that want to stay in the community
- We need more public transportation and available ambulances
- We really need an urgent care option to eliminate unnecessary ER visits.
- We really need somewhere to go for after-hours/weekend care other than the hospital ER.
- With our central location there should be able to be more services and specialists
- Worry local clinic will close causing local drug store to close. 40 miles to nearest hospital. Need for more seatbelt, helmet and car seat education and enforcement.
- Would like to see help with getting a colonoscopy. It should be considered preventive maintenance, but is not covered by insurance. The cost of getting one is outrageous.
- Would love to see some kind of chemical dependency treatment available in Rugby.
- X-ray and MRI machines would be cool to have access to rather than driving nearly two hours round trip.