Community Health Needs Assessment

CHI St. Alexius Health Carrington Medical Center Service Area

Carrington, North Dakota

2022

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The board of directors for CHI St. Alexius Health Carrington Medical Center approved this Community Health Needs Assessment in January 2022.

Center *for* Rural Health
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Executive Summary

To help inform future decisions and strategic planning, CHI St. Alexius Health Carrington Medical Center (CMC) and Foster County Public Health conducted a Community Health Needs Assessment (CHNA) in 2021, the previous CHNA having been conducted in 2019. 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. One hundred seventy-one CMC service area residents completed the survey. Additional information was collected through five key informant interviews with community members. The input from the residents, who primarily reside in Eddy County and Foster County, represented the broad interests of the communities in the service area. Together with secondary data gathered from a wide range of sources, the survey presents a snapshot of the health needs and concerns in the community.

With regard to demographics, Foster County's population from 2010 to 2019 decreased by 3.8%, and Eddy County's population decreased 4.1%. The average number of residents under age 18 (21.5%) for Foster County comes in 2.1 percentage points lower than the North Dakota average (23.6%), and Eddy County comes in .2% lower than the state average. The percentage of residents, ages 65 and older, is almost 7% higher for Foster County (22.6%) and 8% higher for Eddy County than the North Dakota average (15.7%), and the rate of education is almost 2.5% lower for Foster County (90.3%) and about 4% lower for Eddy County (89.4%) than the North Dakota average (92.6%). The median household income in Eddy County ($54,868) is much lower than the state average for North Dakota ($64,894), whereas Foster County ($61,425) is just slightly lower.

Data compiled by County Health Rankings show Eddy County and Foster County are doing better than North Dakota in health outcomes/factors for 15 categories; Eddy County is doing better than North Dakota in health outcomes/factors for seven categories; and Foster County is doing better than North Dakota in health outcomes/factors for 15 categories.

Eddy County and Foster County, according to County Health Rankings data, are performing poorly relative to the rest of the state in 13 outcome/factor categories; Eddy County is performing worse than the state average in nine categories; and Foster County is performing worse than the state average in seven categories.

Of 106 potential community and health needs set forth in the survey, the 171 CMC service area residents who completed the survey indicated the following ten needs as the most important:

- Alcohol use and abuse – Youth and Adult
- Attracting and retaining young families
- Availability of resources to help the elderly stay in their homes
- Having enough child daycare services
- Cost of long-term/nursing home care
- Depression/anxiety – Youth and Adult
- Drug use and abuse – Youth and Adult
- Suicide - Youth
- Recycling
- Not enough jobs with livable wages

The survey also revealed the biggest barriers to receiving healthcare (as perceived by community members). They included not enough specialists (N=26), not enough evening or weekend hours (N=24), and concerns about confidentiality (N=22).

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

- People are friendly, helpful, and supportive
- Feeling connected to people who live here
- Community is socially and culturally diverse
- Government is accessible
- Sense that you can make a difference through civic engagement
- People are tolerant, inclusive and open-minded

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

- Depression/anxiety – Youth and Adult
- Having enough child daycare services
- Extra hours for appointments, such as evenings and weekends
- Cost of long-term/nursing home care
- Alcohol use and abuse

Overview and Community Resources

With assistance from the CRH at the UNDSMHS, CHI St. Alexius Health Carrington Medical Center (CMC) and Foster County Public Health completed a CHNA of the Carrington service area. The hospital identifies its service area as Foster County and Eddy County in their entirety plus portions of Stutsman, Wells and Griggs Counties; the last three have a medical center in their county. Many community members and stakeholders worked together on the assessment. ZIP Codes within CHI St. Alexius Health Carrington's service area include: Eddy: 58356, 58374; Foster: 58421, 58443, 58445, 58464; Griggs: 58416, 58425, 58448, 58452, 58484; and Wells: 58341, 58418, 58422, 58423, 58438, 58451, 58486.

CHI St. Alexius Health CMC is located in a frontier area and is licensed as a Critical Access Hospital with two provider-based rural health clinics. One clinic is attached to the Carrington hospital, and the other is located 16 miles to the north in New Rockford, North Dakota. Carrington is located in east central North Dakota, just two hours from four major cities in North Dakota: Fargo, Minot, Grand Forks, and Bismarck.

Along with the hospital, the economy is based on agri-business, service industries and retail trade. Foster County is 635 square miles of land, located in the center of North Dakota. It is one of the smallest of the state's 53 counties, 18 miles by 36 miles in dimension. It is bordered by Eddy, Griggs, Stutsman and Wells counties. Foster is divided into 18 townships with the seat of county government located in Carrington. Population of Foster County is 3,210.

According to the U.S. Census Bureau estimated census for 2019, the three major counties that utilize CHI St. Alexius Health CMC services of Foster, Eddy, and Wells have a total area of 2,536 square miles and approximately 9,331 people. The racial makeup of the counties was 94.9% White.

Other health care facilities and services in the Carrington area include dental services, chiropractors, massage therapists, optometry services, mental health services, and long-term healthcare centers with various additional levels of care and services, including Sanford Health Clinic and Jamestown Regional Health Clinic. Social Services also offer bathing, housekeeping, and meal preparation services through Quality Service Providers.

Carrington has a number of community assets and resources that are potentially available to address significant health needs. In terms of physical assets and features, the community includes a bike path, fitness center, facility available for winter walking, swimming pool, bowling alley, city park, tennis courts, golf course,

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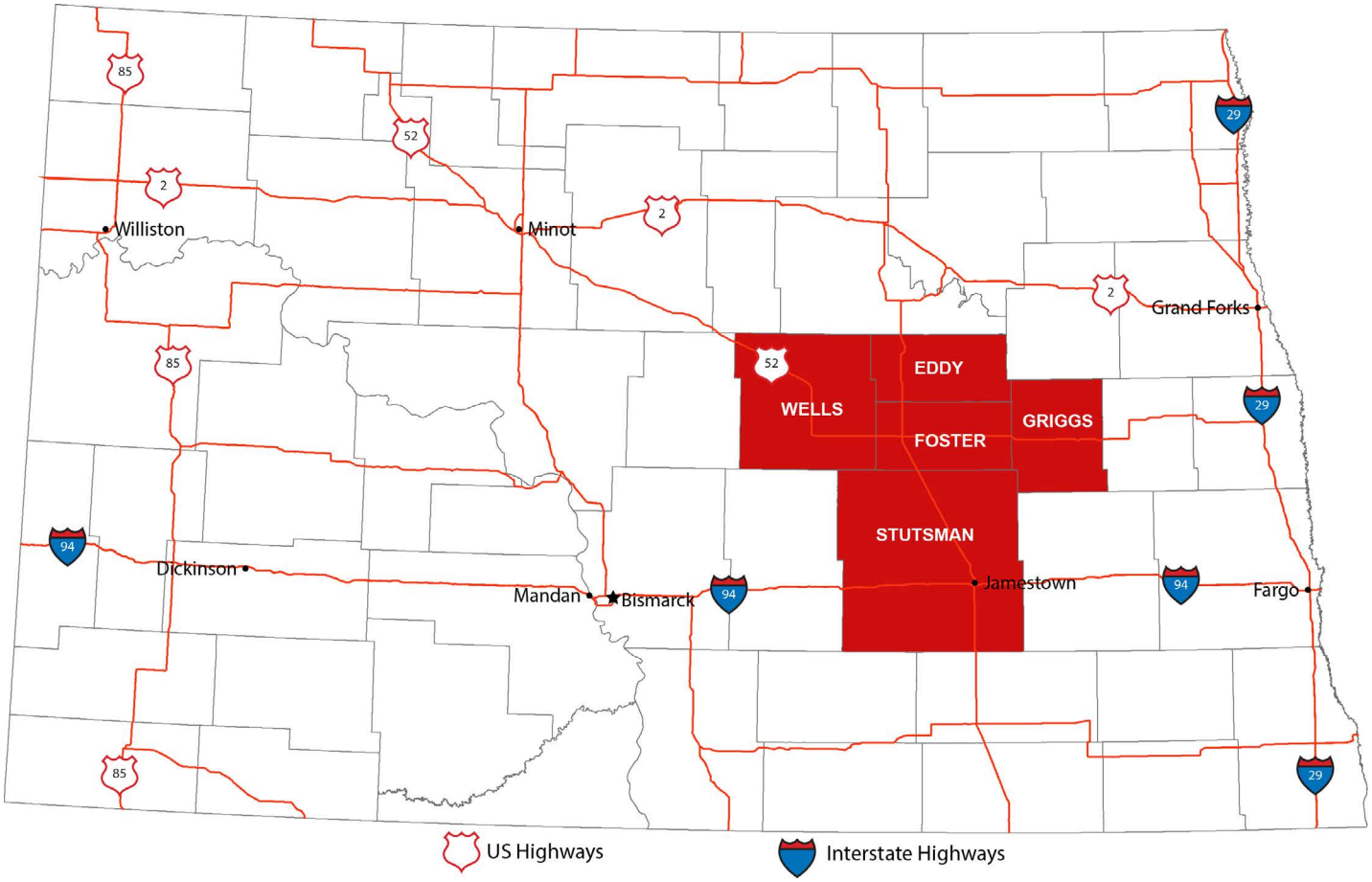
movie theatre, local winery and garden, and birding drives. Foster County offers several cultural attractions, such as the Foster County Museum, which pays tribute to the early history of the city and region.

Carrington offers public transportation through South Central Transit and through Faith In Action – an entity of CMC. The community also has a grocery store and two pharmacies with delivery services. The Carrington school system offers a comprehensive program for students K-12. The Carrington Public School system also offers preschool to a small population, and a privately funded preschool is also available in the community. Some licensed as well as unlicensed daycares are available in the area.

Figure 1: Eddy, Foster, Wells, Griggs, and Stutsman Counties



CHI St. Alexius Health Carrington Medical Center

In 1941, the hospital was leased to the Presentation Sisters of the Fargo Diocese. The Presentation Sisters joined the Catholic Health Corporation of Omaha in 1980 and later became part of Catholic Health Initiatives. In 2019, Catholic Health Initiatives along with Dignity Health formed CommonSpirit Health. In recent years, CHI St. Alexius Health CMC has often been recognized as one of the top Critical Access Hospitals in the United States. This recognition extended to 2020 where it received the status as a United States Top 20 Critical Access Hospital.

CommonSpirit Health is a nonprofit, Catholic health system dedicated to advancing health for all people. It was created in February 2019 through the alignment of Catholic Health Initiatives and Dignity Health. CommonSpirit Health is committed to creating healthier communities, delivering exceptional patient care, and ensuring every person has access to quality healthcare. With its national office in Chicago and a team of approximately 150,000 employees, 25,000 physicians, and advanced practice clinicians, CommonSpirit Health operates 137 hospitals and more than 1,000 care sites across 21 states. In FY 2018, Catholic Health Initiatives and Dignity Health had combined revenues of $29.2 billion and provided $4.2 billion in charity care, community benefit and unreimbursed government programs.

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CMC has a significant economic impact on the region. They directly employ 88 full-time employees with an annual payroll of over $5.42 million (including benefits). These employees create an additional 43 jobs and more than $1.74 million in income as they interact with other sectors of the local economy. This employment results in a total impact of 131 jobs and more than $7.2 million in income. Additional information is provided in Appendix B.

Mission - The mission of CommonSpirit Health is making the healing presence of God known in our world by improving the health of the people we serve, especially those who are vulnerable, while we advance social justice for all.

Vision - Our vision is to provide a healthier future for all – inspired by faith, driven by innovation, and powered by our humanity.

Values - Our Values are what brings our Mission to life and allows for our Vision to become reality:
• Compassion • Inclusion • Integrity • Excellence • Collaboration

CHI St. Alexius Health CMC is one of the most important assets in the community and one of the largest charitable organizations in the Carrington area, giving $475,746 back to the community in fiscal year 2020. CHI St. Alexius Health includes a 25-bed, critical access hospital with various outpatient therapies and services located in Carrington and a rural health clinic with locations in Carrington and New Rockford. As a hospital, clinic, and designated level 5 trauma center, the medical center provides comprehensive care through a physician, physician assistants, nurse practitioners, and consulting/visiting medical providers for a wide range of medical and emergency situations. With approximately 130 staff members, CHI St. Alexius Health along with contracted healthcare agencies housed within the facility is one of the largest employers in the region.

Services offered locally by CHI St. Alexius Health CMC include:

General and Acute Services

1. Acne treatment
2. Allergy, flu, pneumonia, COVID-19 shots
3. Blood pressure checks
4. Cardiology (visiting physician)
5. Clinic all ages
6. Emergency room
7. Hospital (acute care)
8. Mole/wart/skin lesion removal
9. Nutrition counseling
10. Pharmacy
11. Prenatal care up to 32 weeks
12. Physicals: annuals, D.O.T., sports, and insurance
13. Medicare wellness visits
14. Sports medicine
15. Surgical services—outpatient (gallbladder, hernia repair, vein ablation, endoscopy, etc.)

Screening/Therapy Services

1. Behavioral health (mental health)
2. Chronic disease management
3. Stress testing: exercise and nuclear
4. Lower extremity circulatory assessment
5. Pastoral care
6. Pediatric services
7. Physical therapy (full service contracted)
8. Respiratory care
9. Sleep studies
10. Social services
11. Suboxone clinic

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Radiology Services

1. CT scan
2. Dexa
3. Digital mammography
4. EKG
5. General x-ray
6. Holter and event (heart) monitoring
7. Nuclear medicine (mobile unit)
8. MRI (mobile unit)
9. Ultrasound (echocardiograms, vein, OB, organs)

Laboratory Services

1. Hematology
2. Blood types
3. Clot times
4. Chemistry
5. Urine testing
6. Microbiology

Foster County Public Health

Foster County Public Health (FCPH) provides public health services that encompass all residents, aged birth to death. Services include environmental health, nursing services, immunizations, WIC (women, infants, and children) program, health screenings and education services. Each of these programs provides a wide variety of services in order to accomplish the mission of public health, which is to assure that Foster County is a healthy place to live, and each person has an equal opportunity for optimal health. To accomplish this mission, FCPH is committed to the prevention of disease and injury, promotion of healthy lifestyles, protection and enhancement of the environment, and provision of quality health care services for the people of Foster County.

Public Health services in Foster County date back to 1920. During the 1920-1921 years, Sarah Zimmerman first provided nursing services to Foster County. A public health nurse provided services to the county sporadically over the subsequent years. In 1981, Foster County Public Health became its own public health department when it dissolved from being a part of Lake Region District Health. Since 1981, Foster County Public Health has provided continued public health nursing services to the county.

The office is overseen by a medical health officer, a board of health comprised of community health workers, as well as the board of county commissioners. Currently, the public health office employs five staff members. Services are available Monday through Friday from 8:00 am to 12:00 pm and 1:00 pm to 4:00 pm.

Funding for public health services comes from a variety of funding sources. Programs and services are covered by county mill dollars, state funding, federal funding, and fees for services. FCPH actively applies for competitive funding dollars as well.

Services are available to all Foster County residents, including all age groups and all economic statuses. FCPH uses a sliding fee scale for services, based on financial income. Immunizations are available to all ages eligible for vaccinations, including those who do not have medical insurance.

Mission

The Mission of Foster County Public Health is to "Prevent, Promote and Protect for optimal community health". To fulfill this mission, Foster County Public Health uses its Core Values:

- Collaboration – Working with other facilities/services in the community to promote optimal health
- Communication – Promoting trust through mutual, honest and open dialogue
- Prevention – Using knowledge to prevent disease/injury and make smart decisions to maintain optimal health

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- Respect – Appreciating the dignity, knowledge, and contributions of all persons
- Teamwork – Working together to share purpose and a common goal

Vision

Our vision at Foster County Public Health is "Building a Healthy Community…Together." In order to fulfill this vision, FCPH uses a set of guidelines known as the ten essential public health services.

Specific services that FCPH provides are:

- Angel Tree Project at Christmas
- Blood pressure checks
- Car seat program
- Child health- weight checks, ear checks, etc.
- Emergency response and preparedness program
- Environmental health services
- Family planning services- pregnancy testing and contraceptive options for both females and males
- Flu shots- ages 6 months and older
- Health tracks- child health screening
- Home visits- chronic disease maintenance, medication set-ups
- Immunizations
- Injections- Depo Estradiol, Depo Provera, Depo Testosterone, Vitamin B12
- Lab testing- blood sugar, hemoglobin, COVID-19, lipid panel
- Lice checks
- Office visits and consults
- Preschool screening assistance
- School health
- Sewer permit applications for county residents
- Substance use prevention and education for youth and adults
- Tobacco cessation program with distribution of free cessation products
- Tuberculosis testing and management
- Water testing kits
- Wellness clinics
- West Nile Program
- Women, Infants & Children (WIC) Program
- 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;

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

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

This assessment examines health needs and concerns in Foster County and Eddy County as well as Griggs, Stutsman and Wells Counties, which are all included in the CHI St. Alexius Health CMC service area. In addition to Carrington, located in the service area are the communities of Bowdon, Fessenden, Glenfield, Grace City, Kensal, New Rockford, Pingree, and Woodworth.

CRH, in partnership with CMC and Foster County Public Health, 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 CRH and CMC. 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 videoconference 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. Fifteen people, representing a cross section demographically, attended the focus group meeting. The meeting was highly interactive with good participation. CMC staff and board members were in attendance as well but largely played a role of listening and learning.

Figure 2: Steering Committee

Jodi Hovdenes	Chief Nursing Officer, CHI St. Alexius Health Carrington Medical Center
Carol Risovi	Human Resources, CHI St. Alexius Health Carrington Medical Center
Margaret Johnson	Clinic Manger, CHI St. Alexius Health Carrington Medical Center
Anthony Dukart	Mission Director, CHI St. Alexius Health Carrington Medical Center
Lisa Hilbert	Administrator, Foster County Public Health
Amber Kruse	RN, Foster County Public Health
Jennifer Whitman	Prevention Coordinator, Foster County Public Health

The original survey tool was developed and used by CRH. In order to revise the original survey tool to ensure the data gathered met the needs of hospitals and public health, 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, 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.

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

Community Group

A community group, consisting of fifteen community members, was convened and first met on July 28, 2021. During this first community group meeting, group members were introduced to the needs assessment process, reviewed basic demographic information about the community, and served as a focus group. Focus group topics included community assets and challenges, the general health needs of the community, community concerns, and suggestions for improving the community's health.

Members of the community group and key informants represented the broad interests of the community served by CMC and FCPH. They included representatives of the health community, business community, political bodies, law enforcement, education, faith community, and social service agencies. Not all members of the group were present at both meetings.

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.

The community group met again on September 13, 2021 with sixteen community members in attendance. At this second meeting, the community group was presented with survey results, findings from key informant interviews and the focus group, and a wide range of secondary data, relating to the general health of the population in Eddy and Foster Counties. The group was then tasked with identifying and prioritizing the community's health needs.

Interviews

One-on-one interviews with three key informants were conducted in person in Carrington on July 28, 2021. Two additional key informant interviews were conducted over the phone in July of 2021. A representative from the CRH conducted the interviews. Interviews were held with selected members of the community who could provide insights into the community's health needs.

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

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 C, and a full listing of direct responses provided for the questions that included "Other" as an option are included in Appendix G.

The community member survey was distributed to various residents of Foster County as well as Eddy, Griggs, Stutsman and Wells Counties, which are all included in the CMC 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.

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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; and
- Suggestions to improve the delivery of local healthcare.

To promote awareness of the assessment process, CHI St. Alexius Health CMC and FCPH shared links of the survey on their websites and social media pages. A QR code was offered to patients who visited the two CHI St. Alexius Health clinics in Carrington and New Rockford as well as the FCPH building and the hospital. Emails of the survey link were sent to various community groups, and it was promoted via radio as well. Promotion was also done at the local Community market. The surveys were distributed by community group members and at CHI St. Alexius Health CMC and FCPH.

To help ensure anonymity, included with each survey was a postage-paid return envelope to CRH. In addition, to help make the survey as widely available as possible, residents also could request a survey by calling CMC or FCPH. The survey period ran from July 1, 2021 to July 31, 2021. Three completed paper surveys were returned.

Area residents were also given the option of completing an online version of the survey. One hundred sixty-eight online surveys were completed. Fifteen of those online respondents used the QR code to complete the survey. In total, counting both paper and online surveys, 171 community member surveys were completed, equating to a 7% response rate. This response rate is low for this type of unsolicited survey methodology but is on par for this year. Lower response rates, responses at about half of what we typically see, are occurring throughout the state for surveys being conducted this year. We feel this response is largely due to the current pandemic and not being out interacting with the community as much as in a typical year, thus resulting in less surveys being disseminated and less knowledge of the survey availability.

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.

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There are numerous models that depict social determinants of health. While the models may vary slightly in the exact percentages that they attribute to various areas, the discrepancies are often because some models have combined factors when other models have kept them as separate factors.

For Figure 3, data has been derived from the County Health Rankings model (https://www.countyhealthrankings.org/resources/county-health-rankings-model) and it illustrates that healthcare, while vitally important, plays only one small role (approximately 20%) in the overall health of individuals and ultimately of a community. Physical environment, social and economic factors, and health behaviors play a much larger part (80%) in impacting health outcomes. Therefore, as needs or concerns were raised through this Community Health Needs Assessment process, it was imperative to keep in mind how they impact the health of the community and what solutions can be implemented.

Figure 3: Social Determinants of Health

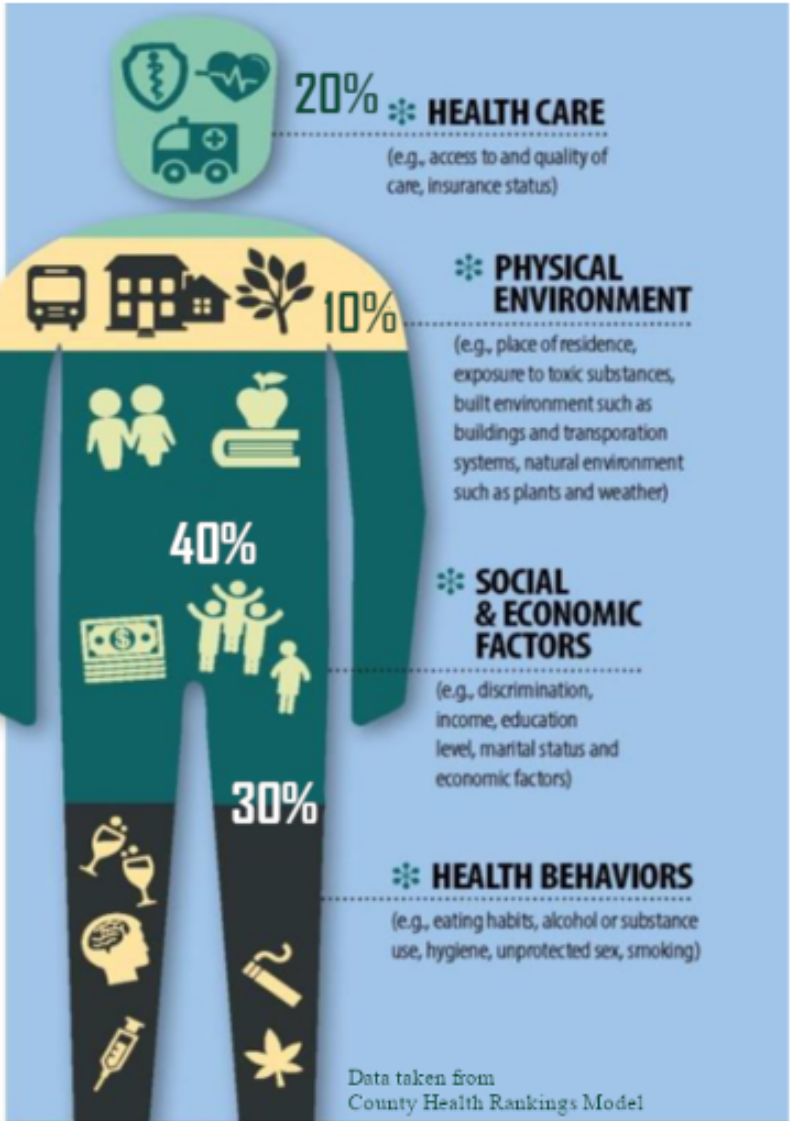

Figure 4 (Henry J. Kaiser Family Foundation, https://www.kff.org/disparities-policy/issue-brief/beyond-health-care-the-role-of-social-determinants-in-promoting-health-and-health-equity/), provides examples of factors that are included in each of the social determinants of health categories that lead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

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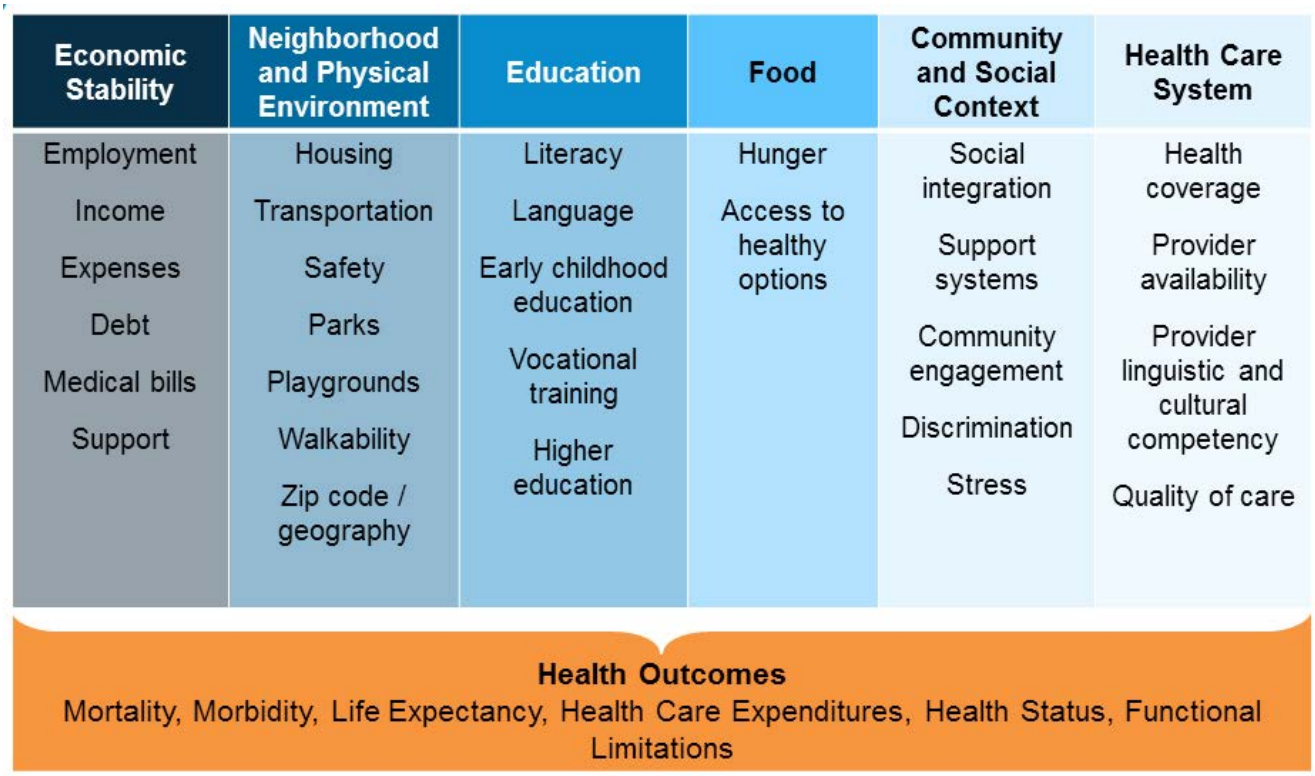
Figure 4: Social Determinants of Health



Health Equity and COVID-19 Assessments for Foster and Eddy Counties

The COVID-19 pandemic has brought social and racial injustice and inequity to the forefront of public health. It has highlighted that health equity is still not a reality as COVID-19 has unequally affected many minority groups, putting them more at risk of getting sick and dying from COVID-19. Many factors, such as poverty and healthcare access, are intertwined and have a significant influence on the people's health and quality-of-life. "Essential workers" are those who conduct a range of operations and services in industries that are essential to ensure the continuity of critical functions in the United States, from keeping us safe, to ensuring food is available at markets, and to taking care of the sick. A majority of these workers belong to and live within communities disproportionately affected by COVID-19. Essential workers are inherently at higher risk of being exposed to COVID-19 due to the nature of their work, and they are disproportionately representative of racial and ethnic minority groups.

On July 28, 2021, a focus group was held in Carrington, North Dakota to assess the COVID-19 perceptions and immunization needs of Foster County. This meeting was held in conjunction with their local Community Health Needs Assessment. The focus group was organized by Foster County Public Health in partnership with CHI St. Alexius Carrington and facilitated by the Center for Rural Health (CRH) at the University of North Dakota (UND) School of Medicine & Health Sciences (SMHS). This report contains the findings from the focus group as well as secondary data, related to demographics, COVID-19, and immunization rates.

COVID-19 in Foster County

The COVID-19 vaccine data dashboard is administered by the North Dakota Department of Health and provides daily vaccine doses administered and weekly vaccine coverage rates for North Dakota. Dashboard data is based on COVID-19 vaccine doses reported to the North Dakota Immunization Information System (NDIIS). North Dakota immunization providers who are not receiving COVID-19 vaccine allocations through the North Dakota Department of Health Division of Immunizations, including Indian Health Services, Veteran's Affairs, and Department of Defense facilities, may not be entering COVID-19 vaccine information into the NDIIS, and their doses administered will not be accounted for in this data.

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County-level doses administered, and coverage rate data are based on the vaccine recipient's county of residence, not the location of the administering provider site.

As of August 4, 2021, in North Dakota, 650,066 doses of the COVID-19 vaccine have been administered. In Foster County alone, 2,919 COVID-19 vaccine doses have been administered. Statewide, the one dose coverage rate for 12 and over is 49.7%, 52.5% for 18 and older, and 76.3% for 65 and older. See Figure 2 for the Foster County breakdown by age of one dose coverage and fully vaccinated (up-to-date coverage). Foster County has 58.0% for 12 and older, 58.0% for 18 and older, and 85.9% for 65 and older Up-to-Date Coverage Rate as of August 4, 2021.

Figure 2: 1 Dose Coverage Rate | Up-to-Date Coverage Rate[2]

There are five COVID-19 vaccine enrolled provider sites in Foster County and 420, total, in North Dakota. Currently, only three providers are actively administering COVID-19 vaccine due to low demand.

There have been a total of 9,402 tests (1,847 unique individuals) completed in Foster County, resulting in 600 positive PCR Cases; 581 have recovered, and 19 have died as of August 9, 2021.[4]

Immunization Rates for Foster County

The following chart (Figure 3) depicts immunization rates for Foster County during the 2021 first quarter, for children, 19-35 months of age, by the last day of the quarter who are up-to-date with the selected vaccine by the end of the quarter.

Figure 3. Percent of Foster County Children 19-35 Months of Age for 2021 Q1[3]

Vaccine	Rate (%)	Rate (%) North Dakota
4:3:1:3:3:1:4 Series	82.09	60.99
DTap	85.07	66.84
Hepatitis A	73.13	59.54
Hepatitis B	92.54	82.24
Hib UTD	83.58	67.86
MMR	94.03	79.13

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PCV	92.54	71.99
Polio	91.04	80.79
Varicella	94.03	79.09
Td/Tdap	93.67	95.07
Varicella	91.56	93.73

The following chart (Figure 4) depicts immunization rates for Foster County during the 2021 first quarter, for Foster County teens, ages 13-17 years, by the last day of the quarter who received the specified number of doses of the selected vaccine by the end of the quarter.

Figure 4. Percent of Foster County Teens 13-17 Years of Age for 2021 Q13[3]

Vaccine	Rate (%)	Rate (%) North Dakota
HPV Female Start	85.04	74.56
HPV Female UTD	77.95	62.29
HPV Male Start	81.13	72.63
HPV Male UTD	73.58	58.09
MCV4 dose 1	93.64	88.60
MCV4 dose 2	81.40	60.65
Men B dose 1	75.58	46.29
Men B UTD	43.02	19.65
Td/Tdap	94.92	88.77
Varicella	93.64	89.61

The following chart (Figure 5) depicts immunization rates for Foster County during the 2021 first quarter, for Foster County adults, 19 years of age and older, who received the specified number of doses of the selected vaccine by the end of the quarter.

Figure 5. Percent of Foster County Adults 19 Years of Age and Oder for 2021 Q1[3]

Vaccine	Rate (%)	Rate (%) North Dakota
PCV13 after 65 years	57.61	59.91
PPSV23 after 65 years	49.38	52.95
Shingrix® dose 1 after 50 years	25.83	29.38
Shingrix® UTD after 50 years	22.08	22.77
Tdap after 19 years	70.72	70.76
Zostavax after 60 years	37.17	34.41
Men B dose 1	75.58	46.29
Men B UTD	43.02	19.65
Td/Tdap	94.92	88.77
Varicella	93.64	89.61

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Focus Group Discussion
On July 28, 2021, a focus group was held in Carrington, North Dakota to assess the COVID-19 perceptions and immunization needs of Foster County. Foster County Public Health Department invited members of the community with varying backgrounds and opinions to join in the focus group that was facilitated by CRH at UND SMHS, in conjunction with a community meeting for the Community Health Needs Assessment. That same day and the week following, key informant interviews were conducted, one-on-one, with seven additional members of the community.

Those persons who participated in the focus group and key informant interviews include representatives of business, healthcare, news media, agriculture, government, and education.

Effects of COVID-19 and the Introduction of the COVID-19 Vaccine on the Community
At the beginning of the pandemic, people didn't think it was real. It was a struggle to get buy in and to make the community safe. When the state started implementing restrictions, then people started buying in. Community members felt that the majority of people weren't really affected by COVID-19, except the service industry. The Paycheck Protection Program (PPP) loan was very helpful for those businesses. Restaurants and retail areas suffered, and many didn't qualify for assistance, so many community members started ordering items online. Agriculture was the least affected, as they were able to continue with their work and didn't have to be involved with the public very much. Medical facilities were overworked, and public health was blamed by those who thought they were being authoritative, regarding the restrictions put in place. The COVID-19 pandemic brought a new level of frustration to the community from federal government to county-level government with the one-size fits all mandates that didn't always make sense for the community. Some felt local leadership started to do the same thing to the point where it wasn't about safety but about compliance/liability issues. The community had a mask mandate a little prior to the state's mask mandate, but everything was already in place; a domino effect was taking place. The community had a task force that would talk about what they knew at the time, but things could always change by the next day. It was difficult for a lay person to keep up with the ever-changing COVID-19 information.

The COVID-19 vaccine changed attitudes in the community. There seemed to be a big demand for the vaccine in the community; some got it right away, but there were others worried about side effects. The older generation saw how sick people got from COVID-19 and were willing to get vaccinated; the younger generation seems to think they are invincible. People in the community who had never gotten a flu shot previously were changing their minds and getting the COVID-19 vaccine. Community members noted that the current surge of COVID-19 nationwide is happening because people are unvaccinated. There was some bullying for those who didn't want to get vaccinated.

Reasons People in the Community Want to be Vaccinated
People in the community wanted to get vaccinated for their own safety and to help slow the spread of COVID-19. They wanted it to be done and over with and saw vaccination as the best way to do that. People wanted to get vaccinated if they were afraid of the virus or its effects or were part of a high-risk group. When the vaccine was first available, there weren't enough vaccines for those who wanted it; when everyone got what they needed, it became difficult to get them to take the vaccine.

Reasons People in the Community Do Not Want to be Vaccinated
People in the community do not want to be vaccinated because many younger people were getting their information online, and it was not valid information. Some people believed they would be sterilized from the COVID-19 vaccine. Younger people felt they wouldn't get very sick from COVID-19, so there was no reason to get vaccinated against it. Some people don't want to be vaccinated because of its emergency approval only at this time. There is so much information being provided, and people do not know what is true and what is false. Some people are cautious about getting a vaccine due to where it is offered (e.g. gas stations, interstate rest stops). Local employees are leery about getting vaccinated due to sterility concerns; while farmers are mostly self-isolated, they don't think they need to be vaccinated. Some people haven't had a personal experience with COVID-19, so they don't think they need to be vaccinated.

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Sources of COVID-19 Information
People in the community get COVID-19 information from public health, newspapers, television, and social media. Healthcare workers did everything possible to make people aware it was available and went out of their way to accommodate people to the best of their ability. Public health was on the radio station weekly as well. Social media seemed to be a source of questionable information, as most of it was opinion-based. The CDC and North Dakota Department of Health were listed as reliable sources of information, but some noted that some people don't trust any information from any source.

Barriers to Receiving the COVID-19 Vaccination
At the beginning of vaccine distribution, there were barriers in availability of COVID-19 vaccines due to supply and demand but nothing now. Initially, there were lots of people wanting to be vaccinated, but the state was only getting a limited number of doses. Public health has done everything they could to make people aware of where to get vaccinated. People who do not want to get vaccinated are not willing to listen to public health. When public health went into the schools, some children did not get vaccinated there due to fear of bullying; more children were, and continue to be, vaccinated outside of school.

Ways to Increase Confidence and Vaccination Rates
Community members felt that talking more with those that do not want to be vaccinated against COVID-19 would increase vaccine confidence as well as getting parents involved and asking them to get vaccinated to protect themselves and others. There is concern that healthcare staff won't be able to handle another round of COVID-19 infections if it happens; they are short-staffed as it is. Statewide, there is a lack of nursing staff. Stressing this lack may help increase vaccination rates. Addressing concerns one-on-one was brought up as a way to handle questions. If the Delta variant comes to the community, there would need to be more information from the North Dakota Department of Health on the virus and numbers in the state. The community needs to be kept up-to-date if another wave of COVID-19 comes through the community; the constantly changing information destroyed the public's trust in the CDC.

COVID-19 in Eddy County
On June 29, 2021, a focus group was held in Devils Lake, North Dakota to assess the COVID-19 perceptions and immunization needs of Ramsey, Benson, Eddy, and Pierce counties. The focus group was organized by Lake Region District Health Unit and facilitated by CRH at the UND SMHS. This report contains the findings from the focus group as well as secondary data, related to demographics, COVID-19, and immunization rates.

The COVID-19 vaccine data dashboard is administered by the North Dakota Department of Health and provides daily vaccine doses administered and weekly vaccine coverage rates for North Dakota. Dashboard data are based on COVID-19 vaccine doses reported to the North Dakota Immunization Information System (NDIIS). North Dakota immunization providers who are not receiving COVID-19 vaccine allocations through the North Dakota Department of Health Division of Immunizations, including Indian Health Services, Veteran's Affairs, and Department of Defense facilities, may not be entering COVID-19 vaccine information into the NDIIS, and their doses administered will not be accounted for in this data.

County-level doses administered, and coverage rate data are based on the vaccine recipient's county of residence, not the location of the administering provider site.

As of June 29, 2021, in North Dakota, the 623,118 doses of the COVID-19 vaccine have been administered. In the Lake Region District Health Unit service area (2,868 Pierce County; 1,883 Eddy County; 4,305 Benson County; 9,642 Ramsey County), there have been 18,698 COVID-19 vaccine doses administered. Statewide, the one dose coverage rate is 50.7% and 48.0% are fully immunized. See Figure 2 for the Eddy County breakdown by age of one dose coverage and Figure 3 for fully vaccinated (up-to-date coverage). Eddy County has a 54.9% Up-to-Date Coverage Rate as of June 29, 2021

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Figure 2: 1 Dose Coverage Rate by County[2]

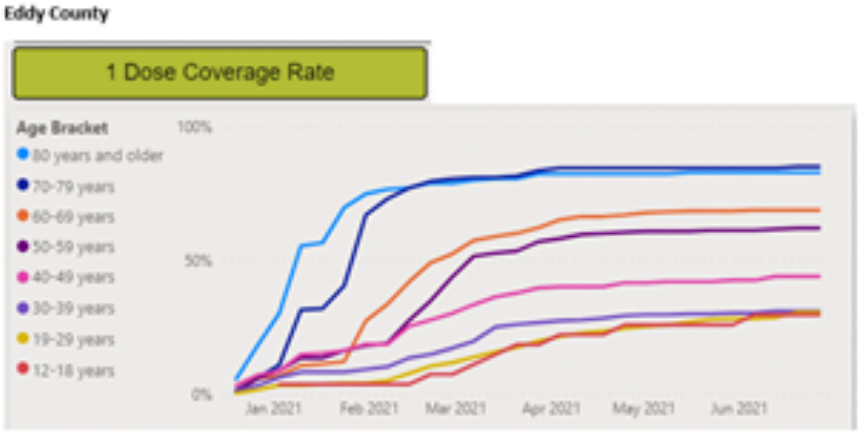
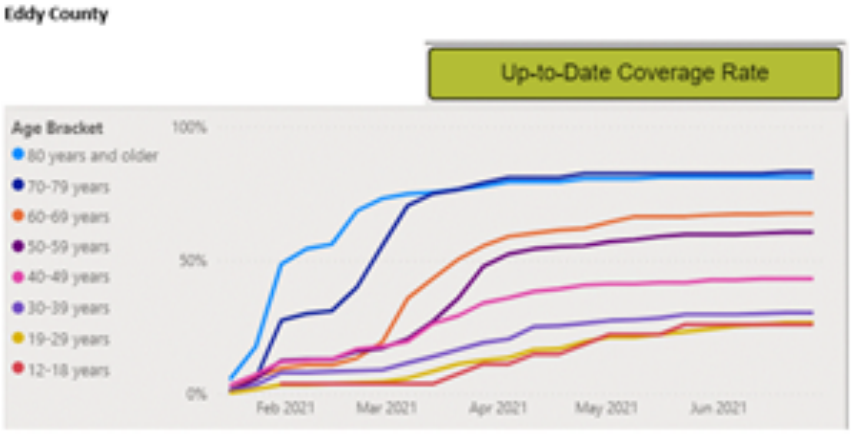


Figure 3: Up-to-Date Coverage Rate by County[2]



There is one COVID-19 vaccine enrolled provider site in Eddy County.

Immunization Rates for Eddy County

The following chart (Figure 4) depicts immunization rates for Eddy County during the 2021 first quarter, for children, 19-35 months of age, by the last day of the quarter who are up-to-date with the selected vaccine by the end of the quarter.

Figure 4. Percent of Eddy County Children 19-35 Months of Age for 2021 Q1[3]

	Eddy County
Vaccine	Rate (%)
4:3:1:3:3:1:4 Series	77.27
DTap	84.09
Hepatitis A	84.09
Hepatitis B	90.91
Hib UTD	84.09
MMR	88.64
PCV	88.64
Polio	88.64
Varicella	88.64

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The following chart (Figure 5) depicts immunization rates for Eddy County during the 2021 first quarter, for teens, ages 14-17 years, by the last day of the quarter who received the specified number of doses of the selected vaccine by the end of the quarter.

Figure 5. Percent of Eddy County Teens 14-17 Years of Age for 2021 Q1[3]

	Eddy County
Vaccine	Rate (%)
HPV Female Start	85.71
HPV Female UTD	84.71
HPOV Male Start	84.71
HPV Male UTD	78.82
MCV4 dose 1	94.44
MCV4 dose 2	73.02
Men B dose 1	63.49
Men B UTD	47.62
Td/Tdap	95.14
Varicella	95.83

The following chart (Figure 6) depicts immunization rates for Eddy County during the 2021 first quarter, for adults, 19 years of age and older, who received the specified number of doses of the selected vaccine by the end of the quarter.

Figure 6. Percent of Eddy County Adults 19 Years of Age and Older for 2021 Q1[3]

	Eddy County
Vaccine	Rate (%)
PCV13 after 65 years	65.78
PPSV23 after 65 years	59.57
Shingrix® dose 1 after 50 years	29.33
Shingrix® UTD after 50 years	24.15
Tdap after 19 years	72.07
Zostavax after 60 years	43.24

Focus Group Discussion

On June 29, 2021, a focus group was held in Devils Lake, North Dakota to assess the COVID-19 perceptions and immunization needs of the Lake Region District Health Unit's services area that includes Pierce County, Benson County, Eddy County, and Ramsey County. North Dakota assessed the COVID-19 perceptions and immunization needs of the Lake invited members of the communities with varying backgrounds and opinions to join in the focus group that was facilitated by CRH at the UND SMHS.

Present at the meeting and providing input were representatives from education, social services, emergency management/fire, public health, long-term care, hospital, clinics, county commission, and community members. There were representatives from Ramsey, Pierce, Benson, and Eddy County present in the meeting room, on Zoom, or who had emailed in responses.

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Effects of COVID-19 and the Introduction of the COVID-19 Vaccine on the Community
At the beginning of the pandemic, Devils Lake largely shutdown, and many businesses had to close for a while. Restaurants stayed open by making delivery an option. The places that could deliver made it through the best. Innovation helped businesses survive the pandemic.

Leaders in the community felt they were proactive when deciding policies regarding COVID. The leaders decided to do a mask mandate 3 weeks before the North Dakota Governor enacted the state mandate.

People who cared for others with disabilities stated that it was very hard on them because they didn't understand the pandemic or the mask mandate. For many with disabilities, wearing a mask was difficult because it was something they had not had to do before the pandemic, and they didn't understand why they had to wear one now. They said that when the vaccine became available, the families wanted it right away for their loved ones so that they would be safe and be able to live more normally without so many new rules that they didn't understand.

When the pandemic began, domestic violence reporting was quiet for a while. When restrictions began to be lifted and places started opening up, the domestic violence incidents dramatically increased. Drugs overdoses and suicide attempts rates also increased.

When the vaccine first came out, there was an attitude toward the vaccine in the healthcare-related settings of excitement and skepticism, with similar responses from people in the community. The older population was very excited and lined up outside of the vaccination site, in the cold (negative 30 degrees at times), to receive it. However, there was initially not enough vaccine for everyone, so some had to go home and come back another day. They were upset about not being able to get it right away, but they did come back to get it when there was more available. There were also people who came from out-of-state, prior to North Dakota putting restrictions on recipients needing to be residents, to get vaccinated. There was a busload of people that drove from Wisconsin to receive it. Businesses have asked public health to come to their business and offer the vaccine to employees, and public health has offered this service for many.

On the opposite end of the spectrum, there were some who felt that the information disseminated by what they deemed the "State-run media people" was made to terrify people of COVID-19 to the point that they didn't get essential healthcare. This person said that they personally witnessed older members of the community who died because they were told by a doctor that their dental work was not an essential need during lockdown. They also reported knowing of people who died in nursing homes because they were without their loved ones around them. They felt that some ignoramuses, arrogant doctors were the ones telling people that there was a need to lockdown all of society. Statements heard by those persons who were against the vaccine endangered the lives of everyone who took it, and it also endangered the health and/or lives of those who are around the vaccinated.

COVID-19 has affected how many had to do their job and still, with the pandemic not being over, continue to do their job. Emergency workers dress in full PPE, and there have been changes, regarding care along with much more cleaning. They were able to access PPE right away, but the cleaning supplies were more difficult. Amazon for medical businesses helped tremendously. They were able to order cleaning supplies and PPE through Amazon that were only available to healthcare workers. Nearly all emergency responders are vaccinated. Due to COVID, paramedics are going in to clear sites for police; previously, it was police clearing sites for the paramedics to ensure safety. Today, emergency response is pretty much back to normal, but they continue to wear PPE.

Law enforcement had to change the way they approached and were approached by others. Officers had to learn new techniques when engaging with people to protect themselves and others from the virus. Today, things are pretty much back to normal when interacting with others.

Reasons People in the Community Want to be Vaccinated
Some people stated the only reason they got vaccinated was because they wanted to gather with their family and friends safely. Others wanted to be able to cross the border in Canada to go hunting and fishing. People are looking for things to go back to normal. They want to hold graduations, gather with family, and celebrate. Student athletes wanted to enjoy their sport without having to wear masks or socially distance from others. They also didn't want to have to quarantine if they were a close contact because that would result in missing practices and games.

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Reasons People in the Community Do Not Want to be Vaccinated
Some of the reasons people heard that community members don't want to be vaccinated ranged from being mild concerns to conspiracy theories.

There are thoughts that the COVID-19 vaccine is, at best, an experiment foisted on the American people. At worst, it is the deliberate engaging in of population control by euthanasia of the unborn, the elderly, or those in between. This thought is all brought to people by the likes and ilk of the corrupt and evil Anthony Fauci, for the afore-mentioned nefarious purposes, and others yet to be revealed. They feel that they have heard a lot of misinformation about how "safe" and "approved by the FDA" and "lifesaving" and "is better than nature" and etc., etc., etc., from sources that I don't trust; namely, the main-stream media, the medical industry, and the likes of Anthony Fauci. The info I've heard from trusted sources primarily comes from people who are willing to acknowledge that they really don't know what will happen with this vaccine because it's not been properly tested or approved. What the vaccine companies try to tell us about the mRNA "treatment" goes against everything that I ever studied in biology. And yet if you raise a question about it, you're just a racist conspiracy nut, who doesn't believe in "Science".

There are claims that the vaccine has endangered the lives of everyone who took it, and it also endangered the health and/or lives of those who are around the vaccinated. The medical industry, as a whole, will publicly deny the effects of "shedding," but this person claims to have read way too many articles, written by doctors, speaking to the dangers of what this vaccine purports to do. They have seen first-hand some of the effects of "shedding," and they know others who have experienced first-hand the effects as well.

People feared experiencing the possible side effects that come from the vaccine along with being worried about any long-term effects, such as reproduction issues. Some feel that children don't need to get the shot since they aren't as affected as older people. Some who have had it don't feel they need it; they believe they're immune to it. Others have stated religious reasons to not getting the vaccine.

It was repeated several times that there are those who don't believe they need it because it isn't that bad, or they won't get it. Also, frequently heard was that they don't trust the long-term effects.

There was a healthcare provider in the area who told her patients that she will not get vaccinated, and her family won't be either. That opinion pushed people to not get vaccinated because they felt it may not be safe.

The media, Dr. Fauci, and government agencies, such as the CDC and other political people have lost the trust of many people. Because of the rapidly changing recommendations, the trust in what is reported is not there.

Refusal to get vaccinations, in general, by non-vaxxers has been a hinderance. In addition to those already against vaccinations of any kind, there are additional people who just don't trust the COVID vaccine. There are more non-vaxxers today than previously known. Public health has struggled with non-vaxxers for over 25 years. They get their information from social media, and often it isn't accurate, such as saying that vaccines cause autism.

Sources of COVID-19 Information
A huge number of people receive their information from Facebook. People will believe anything they read on Facebook and don't research the information they see on social media. Healthcare workers will suggest looking on the CDC website for valid information to co-workers, patients, and others. Also suggested sources that public health and healthcare facilities in the area are recommending are NDresponse.gov and health.nd.gov.

Lake Region Public Health stated that radio has been their main source to communicate with the community. They also use posters that were hung up throughout the counties. They found that newspapers were not as effective for their areas as they are in larger towns because things changed too frequently, and the local newspapers in their counties only publish once a week. In the smaller towns they used newsletters to communicate with their community, and that method worked for them. Facebook was another source for officials to communicate. Since things changed frequently, they were able to give updates to the community immediately through social media.

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Barriers to Receiving the COVID-19 Vaccination
Participants stated it was very easy to get vaccinated if a person wanted it. Multiple agencies have been working together to do home visits and going directly to those who have health issues and can't go to the clinic. Public health also going to youth group homes to give shots.

There was a response from one person who felt that there was way too good of an ability to access the vaccine. They drove from Minot to Leeds in June, and at a rest area just east of Minot, there was a sign saying that Canadian truckers and anyone else can come to the rest area and get a free COVID shot. They feel that there are people stupid enough to drive into a rest area, roll up their sleeve, and allow someone who claims to be qualified, inject them with a supposed vaccine that all along has been promoted by the "scientists" as needing to be kept at an outrageously cold temperature that only very sophisticated facilities could manage.

Ways to Increase Confidence and Vaccination Rates
When required masking and other restrictions were lifted, some people felt things were back to normal, so they didn't feel the need to get vaccinated. There was hope amongst those present at the meeting that with variants coming into North Dakota, people may change their minds and get the vaccine if they haven't already.

There may be a way for employers to do more. There are employees who don't see any perks to getting the vaccine; even if they got vaccinated, they still must wear a mask. Some employers have considered changing rules for staff who have been vaccinated, such as allowing them to not have to wear a mask. Healthcare facilities haven't had any restrictions lifted even though other businesses have.

In the college, 60% of staff are vaccinated. The remaining 40% stated they were not going to get it, stating political or religious reasons. Public health came, held vaccination clinics, and will be on site during orientation this fall. This summer, the two college cohorts are the police academy and nursing students. They were told in the spring that if there was a 75% vaccination rate amongst their class, they wouldn't have to follow the mitigation protocols, but they did not reach that mark and are having to mask and distance during the summer semester.

College athletes wanted life to become normal again and came running to be vaccinated. They wanted the real college experience, with no mask mandate or other COVID-19 policies, such as social distancing. Leaders wanted to give incentives for staff and students to get vaccinated; however, it was rejected by many. Since then, the school has adopted a "Don't ask, don't tell" stance, regarding the vaccine. They cannot advocate either position. It became a personal choice. They are struggling with fall semester and what that will look like. They are a two-year college, so every year, half of their population is new. With the new students coming in, they don't know how many students will be vaccinated. Staff are not looking forward to going back to having restrictions. If they go back to mandates, they feel it will get ugly with pushback from both students and some staff.

During the last school year, there were pop-up vaccine sites at the college. Nurses were at the Student Union and stated the atmosphere toward them had changed from when the vaccine first came out to the end of the semester. They were told by others, "we came here to eat not get vaccines shoved down our throats." They realized they had to neutralize the way they approached people, regarding the vaccine.

Businesses have asked public health to come to their business as a way to make it convenient for employees to get vaccinated. This effort should continue to be done. Another thing that has been occurring and will continue is that the county/city officials back the public health, enabling them to work together to provide a consistent message.

There is a hill to climb to reach those that have not already been vaccinated. A strong opinion by one person who said they hope there is not a way to increase the number who get vaccinated and that they try to tell anyone who will listen the dangers of this whole vaccination program.

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General Thoughts
There must continue to be the county/city officials backing public health and communicating a consistent message.

In long-term care facilities, 90% of residents are vaccinated. Staff is at a 60% vaccination rate, and the other 40% refuse. The skilled nursing facilities must follow CDC guidelines, which includes masking and testing weekly. The staff have seen the toll COVID-19 took on the residents they cared for yet still refuse to get vaccinated. One staff said they already had it and won't need to get the vaccine since they are immune. A healthcare worker present at the meeting said they don't understand that thought process when unvaccinated staff could pass the virus onto residents in long-term facilities. The safety of others should be enough reason to get it, but they will not buy into it.

The community wants a smooth transition into the school year. When school starts, if they don't impose guidelines on children that are unvaccinated, there will be soaring rates of COVID-19 positives. However, it is unknown if there is enough courage or stamina by the schools to impose restrictions. These concerns over requirements when school starts are strong, and they need to plan on how school will look in the fall. Most of the students won't be vaccinated. In addition to those under 12, the timing of when children, ages 12-17, were able to get the vaccine hindered distribution. It was the end of the school year, and it was hard for public health to get the vaccine to some areas. Some school officials stated that too many students may not graduate and were told no because they didn't want them to deal with side effects and risk the students not coming to school because they didn't feel well. There were some schools in areas outside of Devils Lake that let public health come in to vaccinate students.

Demographic Information

Table 1 summarizes general demographic and geographic data about Eddy and Foster Counties.

	Eddy County	Foster County	North Dakota
Population (2019)	2,287	3,210	762,062
Population change (2010-2019)	-4.1%	-3.8%	13.3%
People per square mile (2010)	3.8	5.3	9.7
Persons 65 years or older (2019)	23.7%	22.6%	15.7%
Persons under 18 years (2019)	23.4%	21.5%	23.6%
Median age (2019 est.)	45.8	44.8	35.1
White persons (2019)	92.6%	96.6%	86.9%
High school graduates (2019)	89.4%	90.3%	92.6%
Bachelor's degree or higher (2019)	26.2%	26.7%	30%
Live below poverty line (2019)	10%	8.8%	10.6%
Persons without health insurance, under age 65 years (2019)	9.4%	7.9%	8.1%
Households with a broadband Internet subscription (2019)	72.3%	79.0%	80.7%

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

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While the population of North Dakota has grown in recent years, Eddy and Foster Counties have seen a decrease in population since 2010. The U.S. Census Bureau estimates show that Eddy County's population decreased from 2,385 (2010) to 2,287 (2019), and Foster County's population decreased from 3,338 (2010) to 3,210 (2019).

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, Eddy County and Foster County 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 2021 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 counties 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 2021 County Health Rankings – a flow chart of how a county's rank is determined – may be found in Appendix D. For further information, visit the County Health Rankings website at www.countyhealthrankings.org.

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

Table 2 summarizes the pertinent information gathered by County Health Rankings as it relates to Eddy and Foster 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 Foster County Public Health and CHI St. Alexius Health Carrington Medical Center 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 2021. 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).

Eddy County and Foster County rankings within the state are included in the summary following. For example, Eddy County ranks 38th out of 46 ranked counties in North Dakota on health outcomes and 39th on health factors. Foster County ranks 17th out of 46 ranked counties in North Dakota on health outcomes and

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5th on health factors. The measures marked with a bullet point (•) are those where a county is not measuring up to the state rate/percentage; a square (■) indicates that the county is not meeting the U.S. Top 10% rate on that measure. Measures that are not marked with a colored checkmark but are marked with a plus sign (+) indicate that the county is doing better than the U.S. Top 10%.

The data from County Health Rankings shows that Foster County is meeting or exceeding the U.S. Top 10% in all outcomes whereas Eddy County is doing better than many counties compared to the rest of the state on all except for two of the outcomes, landing at or above rates for other North Dakota counties. However, both counties, like many North Dakota counties, are doing poor in many areas when it comes to the U.S. Top 10% ratings. The two particular outcomes where Eddy County does not meet the U.S. Top 10% ratings is poor of fair health and poor physical health days.

On health factors, Eddy and Foster Counties perform below the North Dakota average for counties in several areas as well.

Data compiled by County Health Rankings show Eddy County and Foster County are doing better than or equal to North Dakota in health outcomes and factors for the following indicators:

- poor mental health days
- low birth weight
- dentists
- mammography screening (% of Medicare enrollees ages 67-69 receiving screening)
- air pollution
- drinking water violations
- severe housing problems

Data compiled by County Health Rankings show Foster County is additionally doing better than or equal to North Dakota in health outcomes and factors for the following indicators:

- poor or fair health
- poor physical health days
- food environment index
- unemployment
- children in poverty
- income inequality
- children in single-parent households
- social associations
- violent crime

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

- physical inactivity
- access to exercise opportunities
- injury deaths
- social associations
- injury deaths

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

- poor physical health days
- food environment index
- alcohol-impaired driving deaths
- uninsured
- unemployment
- children in poverty
- social associations

Additional outcomes and factors in which Foster County was performing poorly relative to the rest of the state include:

- adult obesity
- mental health providers
- preventable hospital stays
- flu vaccinations

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TABLE 2: SELECTED MEASURES FROM COUNTY HEALTH RANKINGS 2021 – EDDY COUNTY and FOSTER COUNTY

● = 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* 2021 – EDDY COUNTY and FOSTER COUNTY				
	Foster County	**Eddy County**	**U.S. Top 10%**	**North Dakota**
Ranking: Outcomes	**17th**	**38th**		**(of 46)**
Premature death			5,500	6,600
Poor or fair health	14% +	16% ■	14%	14%
Poor physical health days (in past 30 days)	3.1 +	3.5 ■●	3.4	3.2
Poor mental health days (in past 30 days)	3.5 +	3.7 +	3.8	3.8
Low birth weight	5%+	6% +	6%	6%
Ranking: Factors	**5th**	**39th**		**(of 45)**
Health Behaviors				
Adult smoking	18% ■	21% ■	16%	20%
Adult obesity	41% ■●	34% ■	26%	34%
Food environment index (10=best)	9.5 +	8.0 ■●	8.7	8.9
Physical inactivity	31% ■●	33% ■●	19%	23%
Access to exercise opportunities	69% ■●	70% ■●	91%	74%
Excessive drinking	23% ■	24% ■	15%	24%
Alcohol-impaired driving deaths		100% ■●	11%	42%
Sexually transmitted infections		215.9 ■	161.2	466.6
Teen birth rate	14 ■	20 ■	12	20
Clinical Care				
Uninsured	8% ■	9% ■●	6%	8%
Primary care physicians	1,610:1 ■		1,030:1	1,300:1
Dentists	800:1 +	760:1 +	1,210:1	1,510:1
Mental health providers	1,610:1 ■●		270:1	510:1
Preventable hospital stays	2983 ■●	4,017 ■	2,565	4,037
Mammography screening (% of Medicare enrollees ages 65-74 receiving screening)	56% +	60% +	51%	53%
Flu vaccinations (% of fee-for-service Medicare enrollees receiving vaccination)	45% ■●	31% ■	55%	50%
Social and Economic Factors				
Unemployment	2.7% +	4.5% ■●	2.6%	2.4%
Children in poverty	11% +	14% ■●	10%	11%
Income inequality	3.7 +	4.4 ■	3.7	4.4
Children in single-parent households	5% +	14% ■	14%	20%
Social associations	24.9 +	13% ■●	18.2	16
Violent crime	19 +	169 ■	63	258
Injury deaths	110 ■●	112 ■●	59	71
Physical Environment				
Air pollution – particulate matter	4.8 +	4.8 +	5.2	4.7
Drinking water violations	No	No		
Severe housing problems	6% +	11% +	9%	12%

Source: http://www.countyhealthrankings.org/app/north-dakota/2021/rankings/outcomes/overall

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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 2018-19. More information about the survey may be found at www.childhealthdata.org/learn/NSCH.

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

TABLE 3: SELECTED MEASURES REGARDING CHILDREN'S HEALTH (For children ages 0-17 unless noted otherwise), 2019

Health Status	North Dakota	National
Children born premature (3 or more weeks early)	9.6%	11.2%
Children 10-17 overweight or obese	24.8%	31.4%
Children 0-5 who were ever breastfed	84.6%	80.6%
Children 6-17 who missed 11 or more days of school	3.9%	4.5%
Healthcare		
Children currently insured	18.4%	93.4%
Children who had preventive medical visit in past year	75.4%	19.0%
Children who had preventive dental visit in past year	12.0%	79.6%
Young children (10 mos.-5 yrs.) receiving standardized screening for developmental or behavioral problems	1.2%	10.4%
Children aged 2-17 with problems requiring counseling who received needed mental healthcare	32.6%	2.3%
Family Life		
Children whose families eat meals together 4 or more times per week	75.5%	73.6%
Children who live in households where someone smokes	15.3%	14.4%
Neighborhood		
Children who live in neighborhood with a park, sidewalks, a library, and a community center	81.1%	75.4%
Children living in neighborhoods with poorly kept or rundown housing	9.1%	13.3%
Children living in neighborhood that's usually or always safe	97.4%	95.0%

Source: https://www.childhealthdata.org/browse/survey

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:

- Children (1-17 years) who had a preventative dental visit in the past year
- Young children (9-35 mos.) receiving standardized screening for developmental problems
- Children who live in households where someone smokes

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-

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being; more information about KIDS COUNT is available at www.ndkidscount.org. The measures highlighted in blue in the table are those in which the counties are doing worse than the state average. The year of the most recent data is noted.

The data shows Eddy County is performing more poorly than the North Dakota average on all of the examined measures except the percentage of the population who are Medicaid recipients, licensed childcare capacity and percentage of the 4-year high school graduation rate. The most marked difference was on the measure of child food insecurity (over 4% higher rate in Eddy County).

Foster County is meeting or exceeding the North Dakota average in all measures.

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

	Foster County	Eddy County	North Dakota
Child food insecurity, 2019	7.9%	**13.7%**	9.6%
Medicaid recipient (% of population age 0-20), 2019	21.0%	**25.1%**	26.6%
Children enrolled in Healthy Steps (CHIP) (% of population age 0-18), 2020	0.8%	**3.7%**	1.6%
Supplemental Nutrition Assistance Program (SNAP) recipients (% of population age 0-18), 2020	12.5%	**18.4%**	16.9%
Licensed childcare capacity (# of children), 2020	139	75	36,701
4-year high school cohort graduation rate, 2019/2020	≥90%	≥90%	89.0%
Victims of child abuse and neglect requiring services (rate per 1,000 children ages 0-17), 2019	9.75 (2015)	**16.67 (2018)**	9.98

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 U.S. The YRBS was designed to monitor trends and 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 and 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 2015, 2017, and 2019. It is 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 2017 to 2019, and "↓" for a decreased trend in the data changes from 2017 to 2019. The final column shows the 2019 national average percentage. For a more complete listing of the YRBS data, see Appendix E.

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TABLE 5: Youth Behavioral Risk Survey Results

North Dakota High School Survey
Rate Increase ↑, rate decrease ↓, or no statistical change = in rate from 2017-2019.

	ND 2015	ND 2017	ND 2019	ND Trend ↑, ↓, =	Rural ND Town Average	Urban ND Town Average	National Average 2019
Injury and Violence							
% of students who rarely or never wore a seat belt (when riding in a car driven by someone else)	8.5	8.1	5.9	=	8.8	5.4	6.5
% of students who rode in a vehicle with a driver who had been drinking alcohol (one or more times during the 30 prior to the survey)	17.7	16.5	14.2	=	17.7	12.7	16.7
% of students who talked on a cell phone while driving (on at least one day during the 30 days before the survey)	NA	56.2	59.6	=	60.7	60.7	NA
% of students who texted or e-mailed while driving a car or other vehicle (on at least one day during the 30 days before the survey)	57.6	52.6	53.0	=	56.5	51.8	39.0
% of students who were in a physical fight on school property (one or more times during the 12 months before the survey)	5.4	7.2	7.1	=	7.4	6.4	8.0
% of students who experienced sexual violence (being forced by anyone to do sexual things [counting such things as kissing, touching, or being physically forced to have sexual intercourse] that they did not want to, one or more times during the 12 months before the survey)	NA	8.7	9.2	=	7.1	8.0	10.8
% of students who were bullied on school property (during the 12 months before the survey)	24.0	24.3	19.9	↓	24.6	19.1	19.5
% of students who were electronically bullied (includes texting, Instagram, Facebook, or other social media ever during the 12 months before the survey)	15.9	18.8	14.7	↓	16.0	15.3	15.7
% of students who made a plan about how they would attempt suicide (during the 12 months before the survey)	13.5	14.5	15.3	=	16.3	16.0	15.7
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 one day during the 30 days before the survey)	22.3	20.6	33.1	↑	32.2	31.9	32.7
% of students who currently used cigarettes, cigars, or smokeless tobacco (on at least one day during the 30 days before the survey)	NA	18.1	12.2	**NA**	15.1	10.9	10.5
% of students who currently were binge drinking (four or more drinks for female students, five or more for male students within a couple of hours on at least one day during the 30 days before the survey)	NA	16.4	15.6	=	17.2	14.0	13.7
% of students who currently used marijuana (one or more times during the 30 days before the survey)	15.2	15.5	12.5	=	11.4	14.1	21.7
% of students who ever took prescription pain medicine without a doctor's prescription or differently than how a doctor told them to use it (counting drugs such as codeine, Vicodin, OxyContin, Hydrocodone, and Percocet, one or more times during their life)	NA	14.4	14.5	=	12.8	13.3	14.3
Weight Management, Dietary Behaviors, and Physical Activity							
% of students who were overweight (>= 85th percentile but <95th percentile for body mass index)	14.7	16.1	16.5	=	16.6	15.6	16.1
% of students who had obesity (>= 95th percentile for body mass index)	13.9	14.9	14.0	=	17.4	14.0	15.5
% of students who did not eat fruit or drink 100% fruit juices (during the seven days before the survey)	3.9	4.9	6.1	=	5.8	5.3	6.3
% of students who did not eat vegetables (green salad, potatoes [excluding French fries, fried potatoes, or potato chips], carrots, or other vegetables, during the seven days before the survey)	4.7	5.1	6.6	=	5.3	6.6	7.9

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% of students who drank a can, bottle, or glass of soda or pop one or more times per day (not including diet soda or diet pop, during the seven days before the survey)	18.7	16.3	15.9	=	17.4	15.1	15.1
% of students who did not drink milk (during the seven days before the survey)	13.9	14.9	20.5	↑	14.8	20.3	30.6
% of students who did not eat breakfast (during the seven days before the survey)	11.9	13.5	14.4	=	13.3	14.1	16.seven
% of students who most of the time or always went hungry because there was not enough food in their home (during the 30 days before the survey)	NA	2.seven	2.8	=	2.1	2.9	NA
% of students who were physically active at least 60 minutes per day on 5 or more days (doing any kind of physical activity that increased their heart rate and made them breathe hard some of the time during the seven days before the survey)	NA	51.5	49.0	=	55.0	22.6	55.9
% of students who watched television 3 or more hours per day (on an average school day)	18.9	18.8	18.8	=	18.3	18.2	19.8
% of students who played video or computer games or used a computer three or more hours per day (for something that was not schoolwork on an average school day)	38.6	43.9	45.3	=	48.3	45.9	46.1
Other							
% of students who ever had sexual intercourse	38.9	36.6	38.3	=	35.4	36.1	38.4
% of students who had eight or more hours of sleep (on an average school night)	NA	31.8	29.5	=	31.8	33.1	NA
% of students who brushed their teeth on seven days (during the seven days before the survey)	NA	69.1	66.8	=	63.0	68.2	NA

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

Low Income Needs

The North Dakota Community Action Agencies (CAAs), as nonprofit organizations, were originally established under the Economic Opportunity Act of 1964 to fight America's war on poverty. CAAs are required to conduct statewide needs assessments of people experiencing poverty. The more recent statewide needs assessment study of low-income people in North Dakota sponsored by the CAAs was performed in 2020. The needs assessment study was accomplished through the collaboration of the CAAs and North Dakota State University (NDSU) by means of several kinds of surveys (such as online or paper surveys, etc., depending on the suitability of these survey methods to different respondent groups) to low-income individuals and families across the state of North Dakota. In the study, the survey data were organized and analyzed in a statistical way to find out the priority needs of these people. The survey responses from low-income respondents were separated from the responses from non-low-income participants, which allows the research team to compare them and then identify the similarity, difference, and uniqueness of them in order to ensure the validity and accuracy of the survey study and avoid bias. Additionally, two comparison methods were used in the study, including cross-sectional and longitudinal comparisons. These methods allow the research team not only to identify the top specific needs under the seven need categories, including Employment, Income and Asset-Building, Education, Housing, Health and Social/Behavior Development, Civic Engagement, and Other Supports, through the cross-sectional comparison, but also to be able to find out the top specific needs regardless of which categories these needs belong to through the longitudinal comparison.

Top Needs Identified by People Experiencing Poverty Across North Dakota

Category	Need
Housing	Rental Assistance
Income	Financial Issues
Employment	Finding a job
Health	Dental Insurance/Affordable Dental Care
Education	Cost

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2020 North Dakota LOW INCOME COMMUNITY NEEDS

Helping People. Changing Lives. community Action PARTNERSHIP
AMERICA'S POVERTY FIGHTING NETWORK

NDSU NORTH DAKOTA STATE UNIVERSITY

Assessed by CAPND and NDSU, November 2020

KEY FINDINGS

1st Priority Need

Rental Assistance

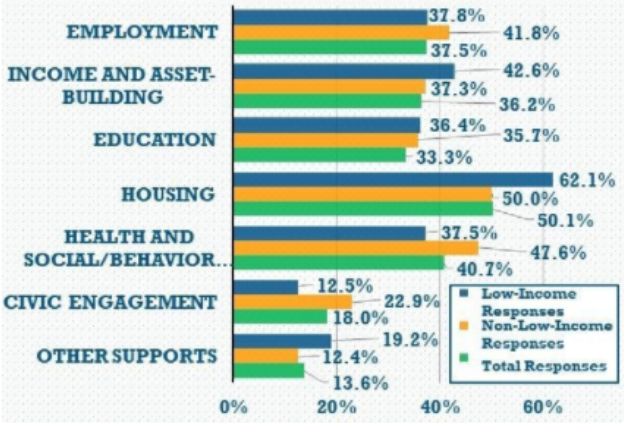
3,458 Total Survey Responses

- **1,086** Low-Incomes
- **2,084** Non- Low-Incomes
- **288** Others (roles cannot be identified)

"***Rental Assistance***" becomes the 1st priority need of people experiencing poverty across the state under the category of "***Housing***". This need, however, would represent their immediate (short-term) need, which could be partially or significantly affected by the pandemic of COVID-19.

- The 1st priority need for the non-low-income respondents is "***Mental Health Service***".
- For the community (including both low-income and non-low-income people), the 1st priority need is "***Dental Issuance/Affordable Dental***".

STATEWIDE OVERALL NEEDS



TOP STATEWIDE SPECIFIC NEEDS

Low-Incomes
- **Housing** - Rental Assistance
- **Health and Social/Behavior Development** - Dental Insurance/Affordable Dental
- **Other Needs** - Food

Non-Low-Incomes
- **Health and Social/Behavior Development** - Mental Health Service
- **Health and Social/Behavior Development** - Health Insurance/Affordable Health Care
- **Income and Asset-Building** - Budget/Credit/Debit Counseling

Community (Low-Income & Non-Low-Income)
- **Health and Social/Behavior Development** - Dental Insurance/Affordable Dental
- **Health and Social/Behavior Development** - Health Insurance/Affordable Health Care
- **Health and Social/Behavior Development** - Mental Health Service

TOP REGIONAL OVERALL NEEDS FOR LOW-INCOMES

1. Housing
2. Health and Social/Behavior Development
3. Income and Asset - Building

1. Housing
2. Income and Asset - Building
3. Employment

1. Housing
2. Employment
3. Health and Social/Behavior Development

1. Health and Social/Behavior Development
2. Income and Asset - Building
3. Housing

1. Housing
2. Income and Asset - Building
3. Education

1. Housing
2. Education
3. Income and Asset - Building

1. Housing
2. Health and Social/Behavior Development
3. Income and Asset - Building

1. Housing
2. Employment
3. Income and Asset - Building

ACKNOWLEDGMENTS

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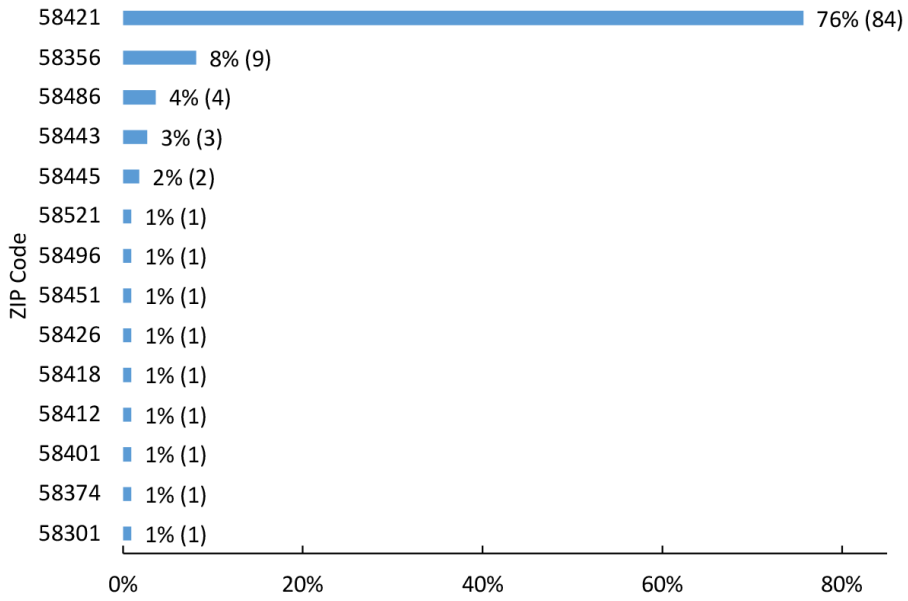
Survey Results

As noted previously, 171 community members completed the survey in communities throughout the counties in the CMC service area. For all questions that contained an "Other" response, all of those direct responses may be found in Appendix G. In some cases, a summary of those comments is additionally included in the report narrative. The "Total respondents" number under each heading indicates the number of people who responded to that particular question and the "Total responses" number under the heading depicts the number of responses selected for that question (some questions allow for selection of more than one response).

The survey requested that respondents list their home zip code. While not all respondents provided a zip code, participants, numbering 111, did, revealing that a large majority of respondents (76%, N=84) lived in Carrington. These results are shown in Figure 5.

Figure 5: Survey Respondents' Home ZIP Code
Total respondents: 25



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

Survey Demographics

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

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

- 40% (N=52) were age 55 or older.
- The majority (80%, N=103) were female.
- Slightly more than half of the respondents (56%, N=72) had bachelor's degrees or higher.
- The number of those working full time (59%, N=76) was just over four times higher than those who were retired (14%, N=18).
- 98% (N=121) of those who reported their ethnicity/race were White/Caucasian.
- 23% of the population (N=27) had household incomes of less than $50,000.

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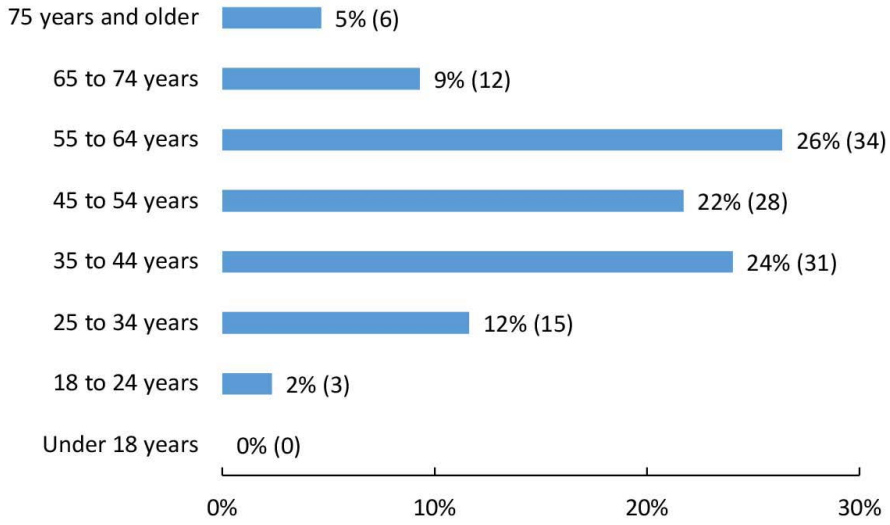
Figures 6 through 12 show these demographic characteristics. It illustrates the range of community members' household incomes and indicates how this assessment took into account input from parties who represent the varied interests of the community served, including a balance of age ranges, those in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

Figure 6: Age Demographics of Survey Respondents
Total respondents = 129



For the CHNA, people younger than age 18 are not questioned, using this survey method.

Figure 7: Gender Demographics of Survey Respondents
Total respondents = 128

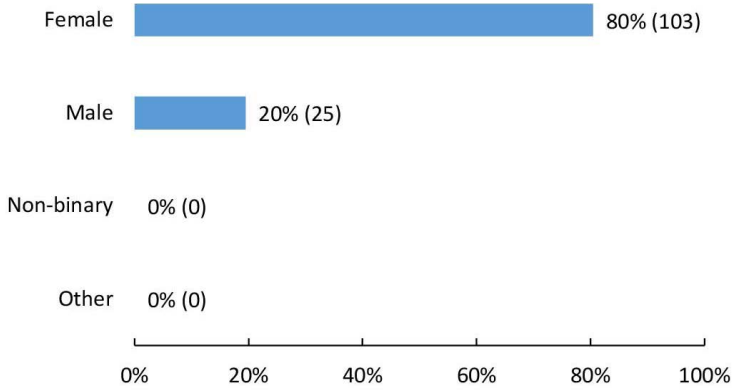


Figure 8: Educational Level Demographics of Survey Respondents
Total respondents = 129

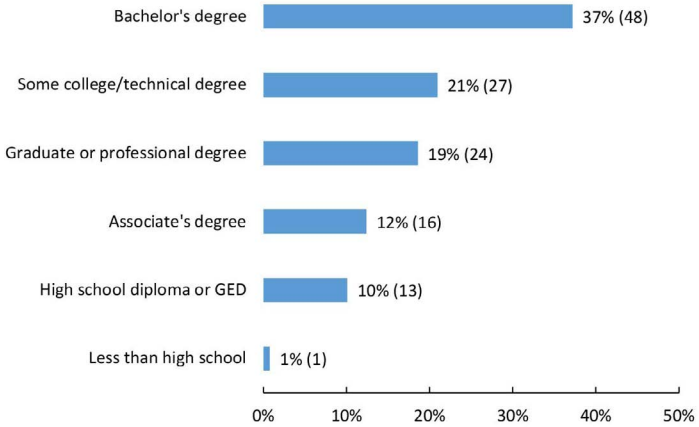


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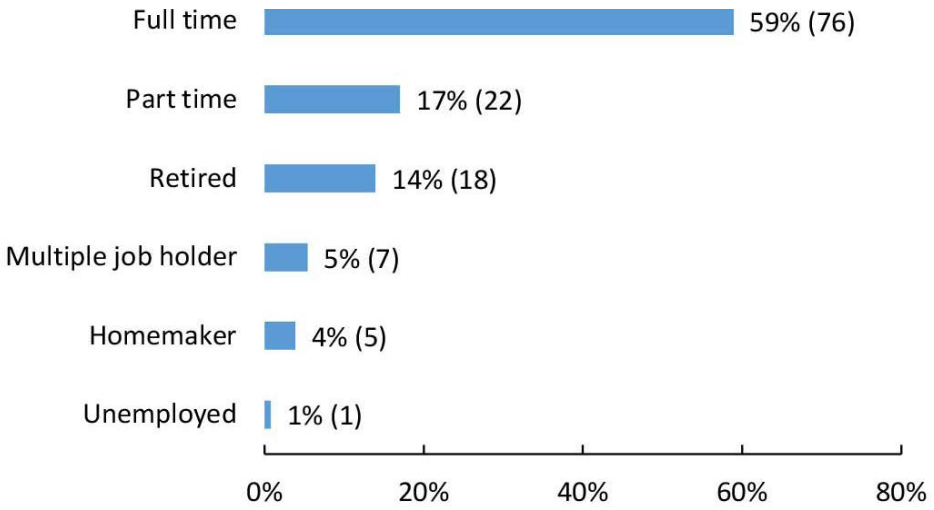
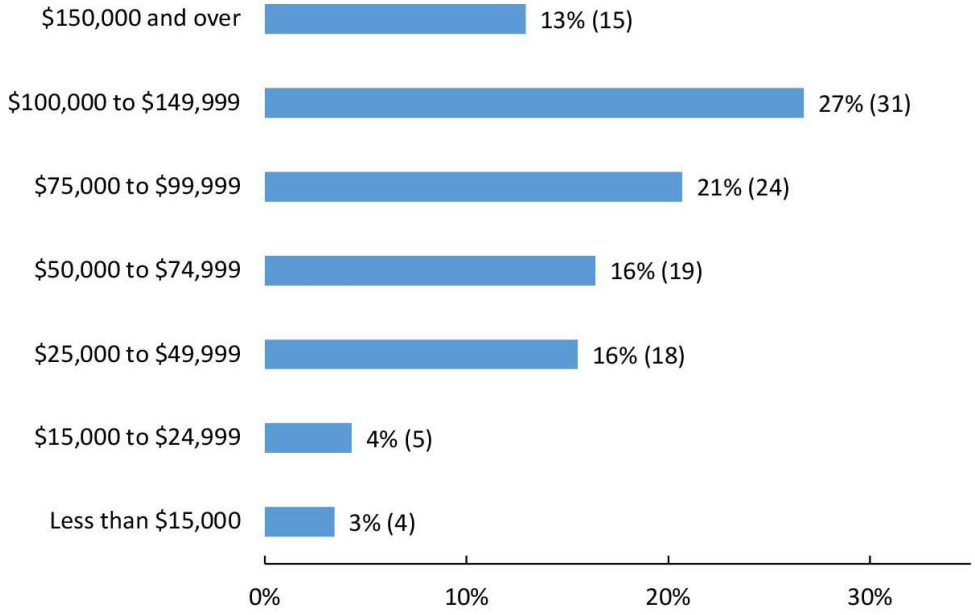
Figure 9: Employment Status Demographics of Survey Respondents
Total respondents = 129



Of those who provided a household income, 7% (N=9) community members reported a household income of less than $25,000. Forty percent (N=46) indicated a household income of $100,000 or more. This information is shown in Figure 10.

Figure 10: Household Income Demographics of Survey Respondents
Total respondents = 116



Community members were asked about their health insurance status, which is often associated with whether people have access to healthcare. Four percent (N=5) of the respondents reported having no health insurance or being under-insured. The most common insurance types were insurance through one's employer (N=87), followed by self-purchased (N=23), and Medicare (N=17).

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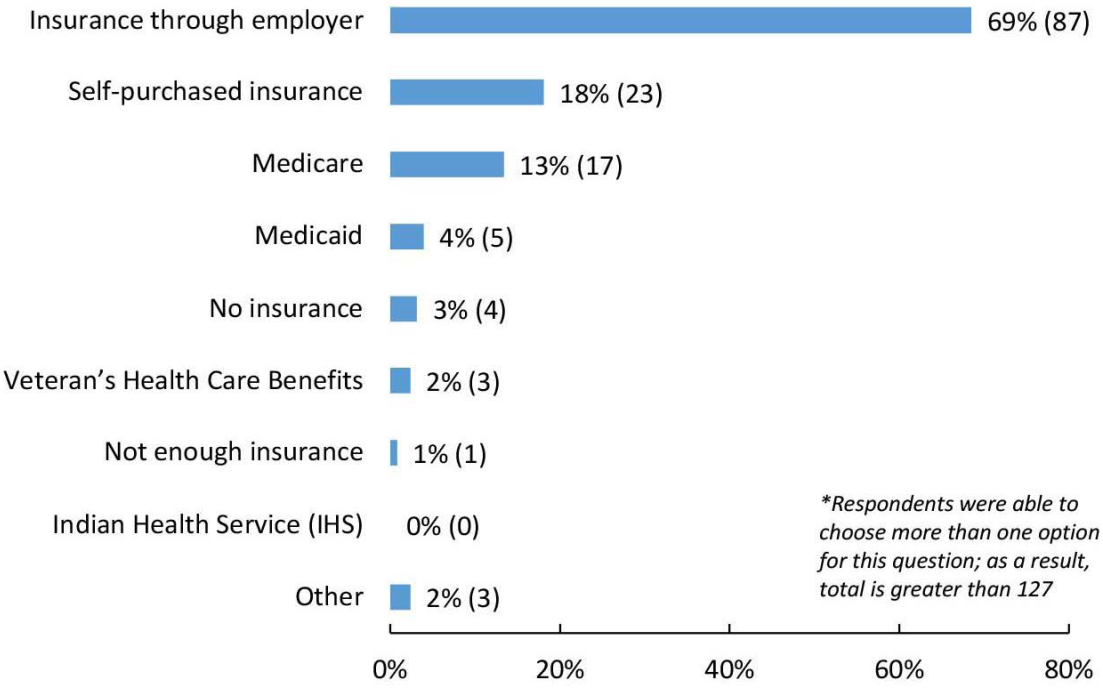
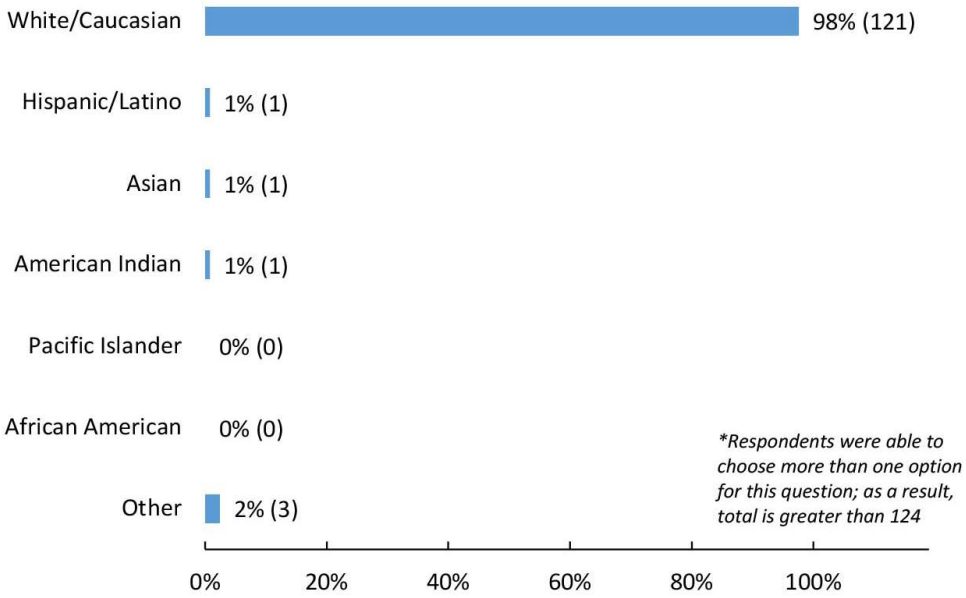
Figure 11: Health Insurance Coverage Status of Survey Respondents
Total respondents = 127



As shown in Figure 12, nearly all of the respondents were White/Caucasian (98%). This result was in-line with the race/ethnicity of the overall population of Eddy and Foster Counties; the US Census indicates that 96.9% of the population is White in Foster County and 92.6% in Eddy County.

Figure 12: Race/Ethnicity Demographics of Survey Respondents
Total respondents = 124



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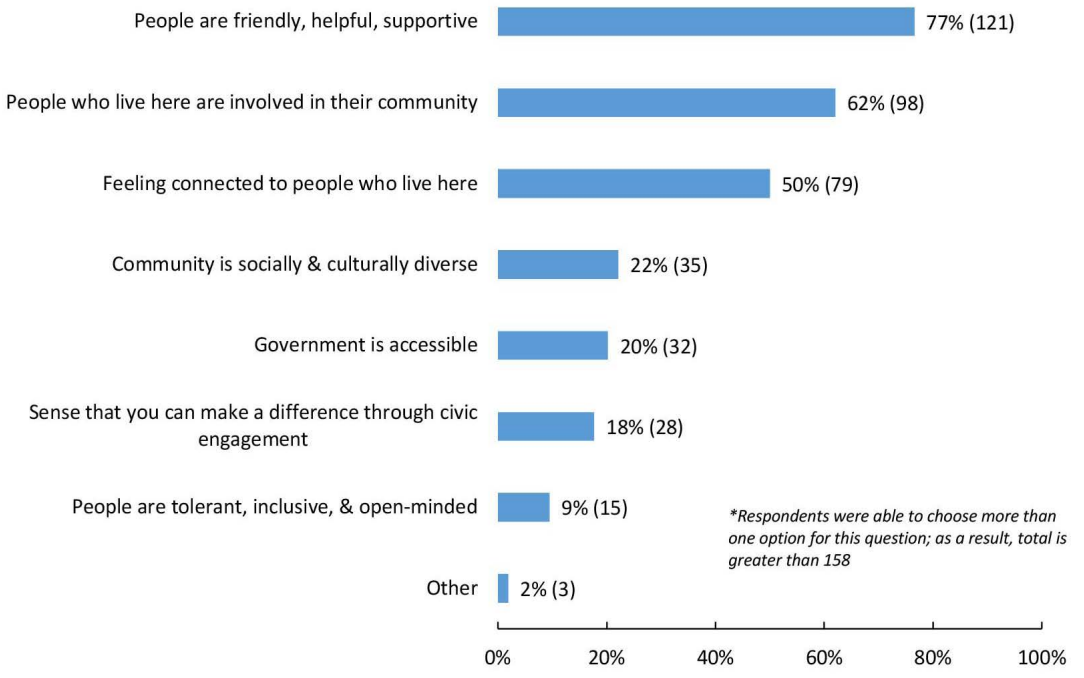
Community Assets and Challenges

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 159 respondents agreeing) that community assets include:

- Safe place to live, little/no crime (N=141);
- Family friendly (N=129);
- People are friendly, helpful, supportive (N=121); and
- Quality school systems (N=110).

Figures 13 to 16 illustrate the results of these questions.

Figure 13: Best Things about the PEOPLE in Your Community
Total responses = 411



Included in the "Other" category of the best things about the people was that they were too new to answer and none of the above.

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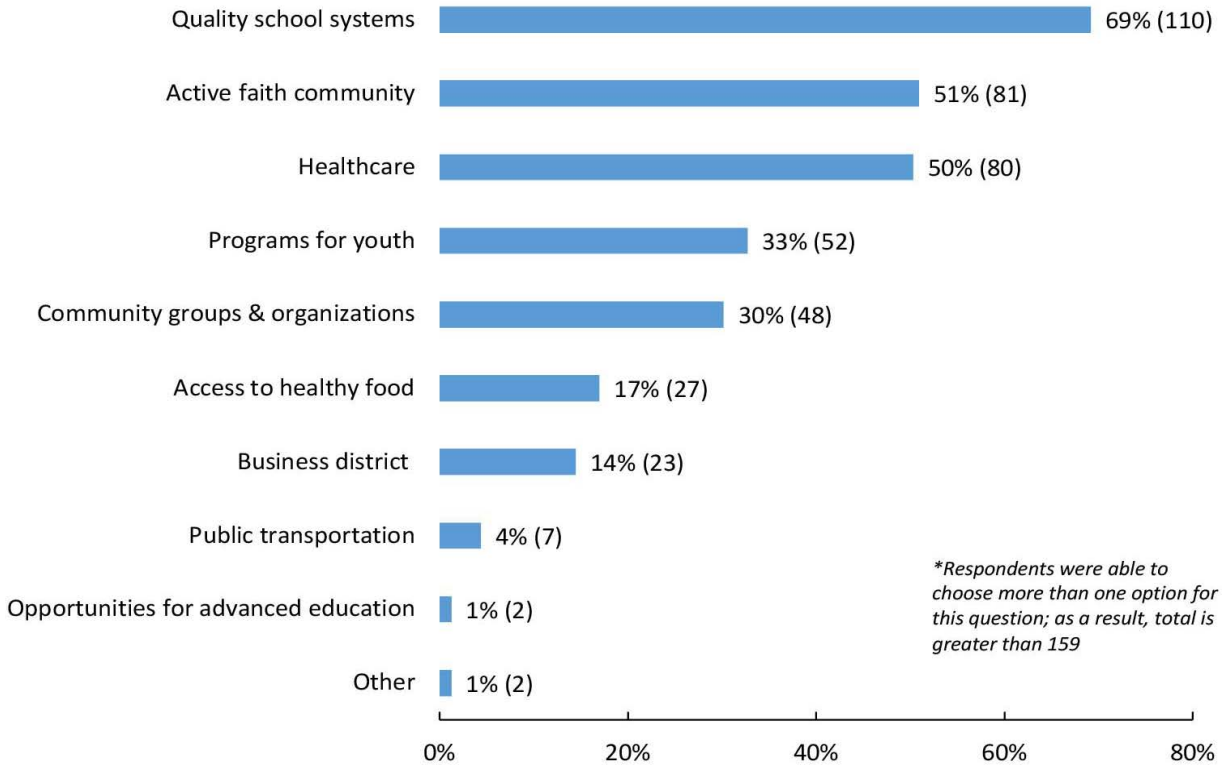
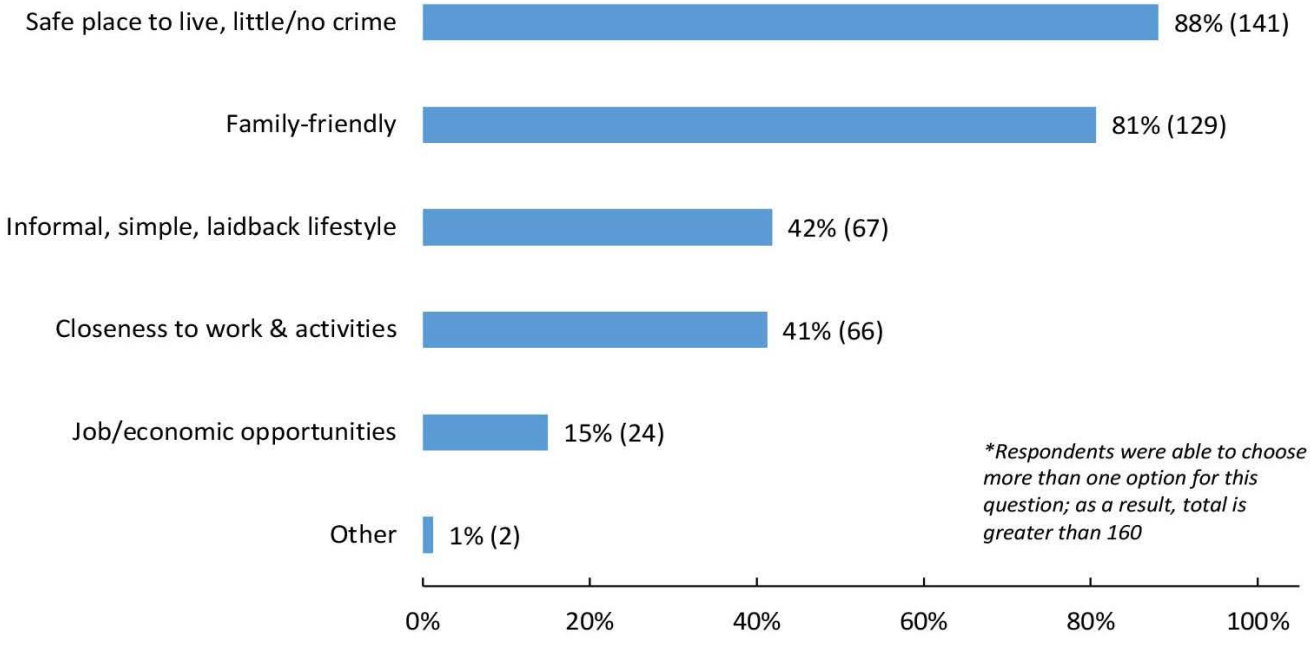
Figure 14: Best Things about the SERVICES AND RESOURCES in Your Community
Total responses = 432



Included in the "Other" category of the best things about the people was that they were too new to answer and none of the above.

Figure 15: Best Things about the QUALITY OF LIFE in Your Community
Total responses = 429



The two "Other" responses regarding the best things about the quality of life in the community was healthcare access.

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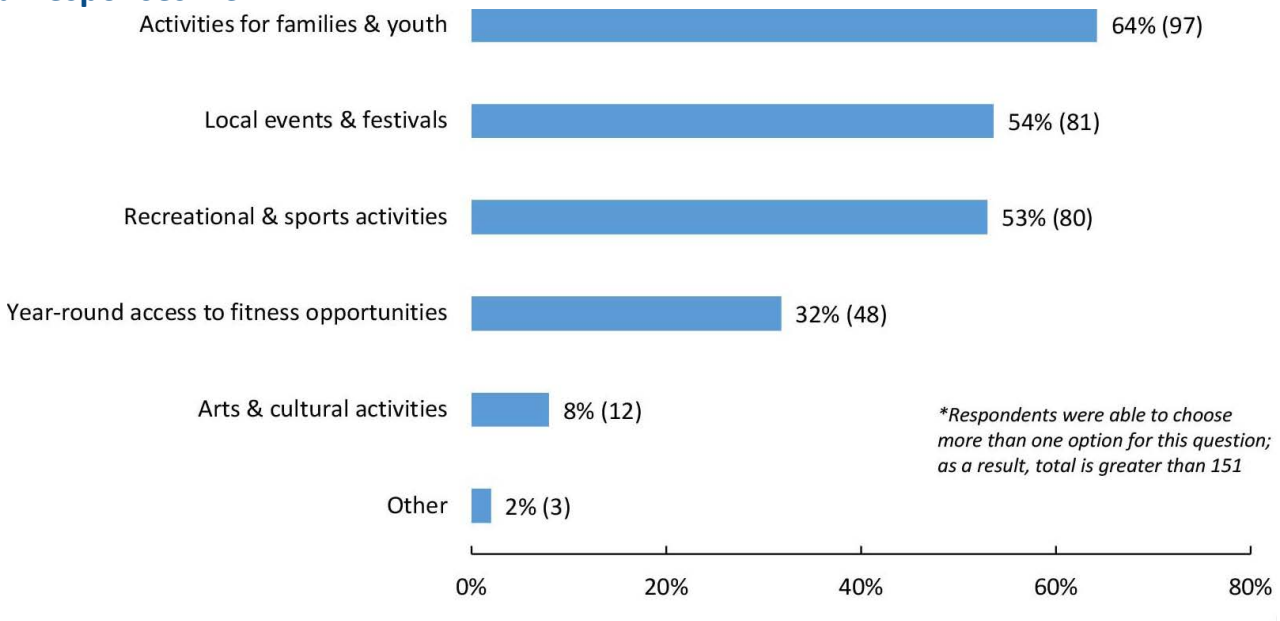
Figure 16: Best Thing about the ACTIVITIES in Your Community
Total responses = 321



Respondents who selected "Other" specified that the best things about the activities in the community included the library and opportunities to volunteer.

Community Concerns

At the heart of this CHNA was a section on the survey asking survey respondents to review a wide array of potential community and health concerns in 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 55 respondents) were:

- Bullying/cyber-bulling (N=94)
- Alcohol use & abuse (Adult) (N=78)
- Alcohol use & abuse (Youth) (N=71)
- Having enough child daycare services (N=68)
- Cost of long-term/nursing home care (Seniors) (N=63)
- Attracting & retaining young families (N=59)
- Depression/Anxiety (Youth) (N=58)
- Drug use & abuse (Youth) (N=56)
- Depression/Anxiety (Adult) (N=56)

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The other issues that had at least 40 votes included:

- Availability of resources to help the elderly stay in their homes (Seniors) (N=54)
- Suicide (Youth) (N=53)
- Smoking & tobacco use (Youth) (N=47)
- Recycling (N=46)
- Child abuse or neglect (N=45)
- Ability to retain primary care providers in the community (N=43)
- Not enough jobs with livable wages (N=42)
- Availability of specialists (N=40)
- Drug use & abuse (Adult) (N=40)

Figures 17 through 22 illustrate these results.

Figure 17: Community/Environmental Health Concerns
Total responses = 385

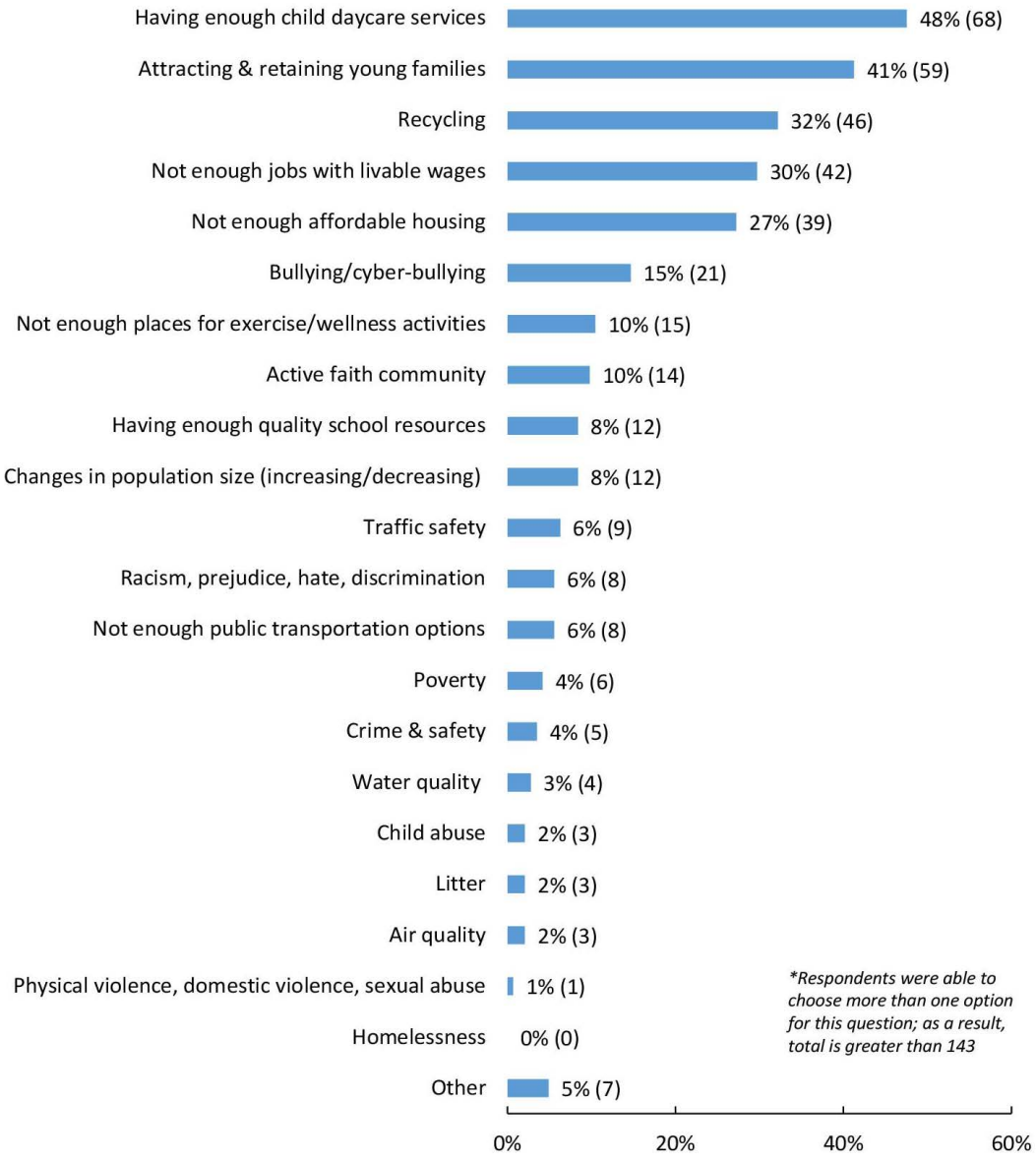

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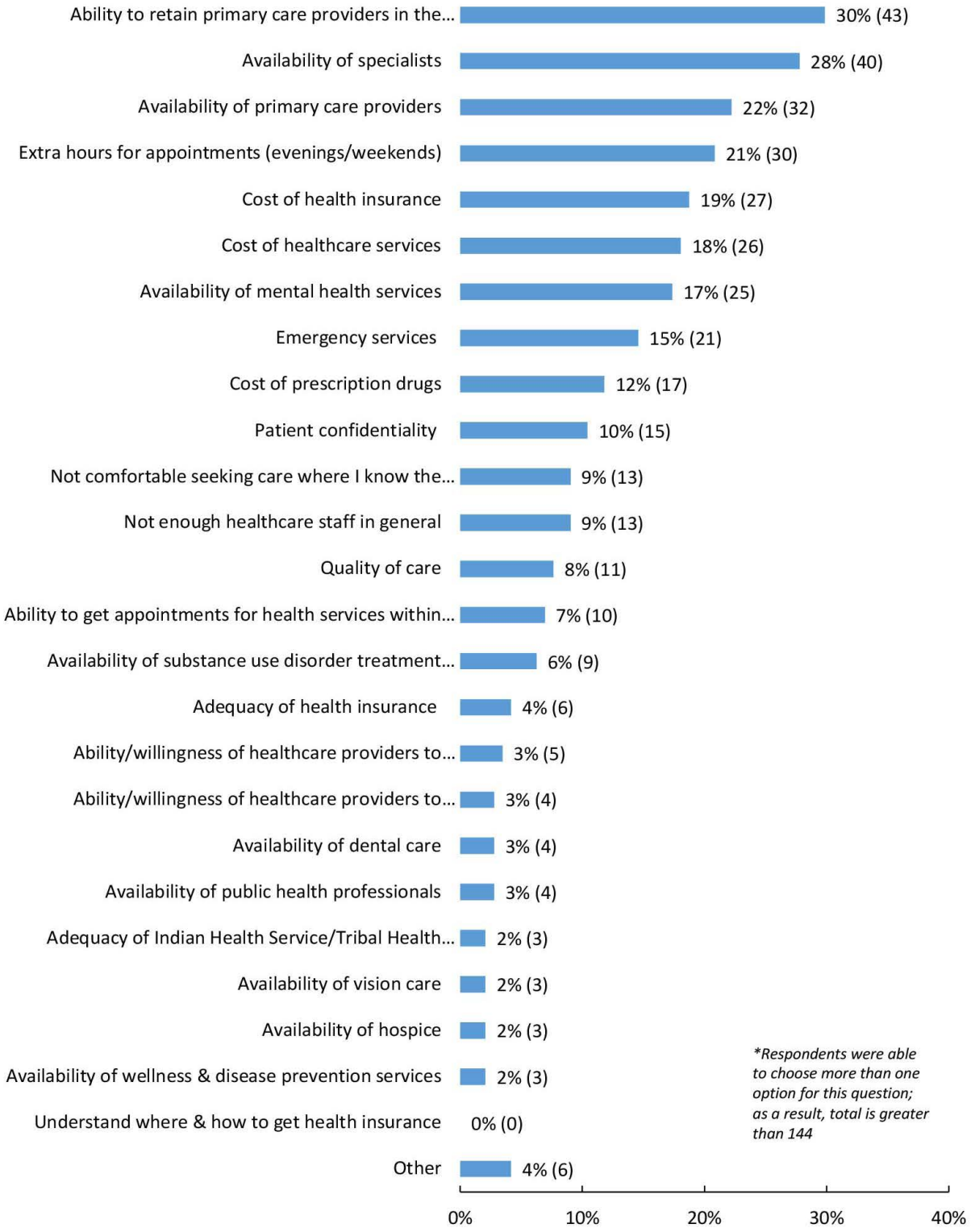
Figure 18: Availability/Delivery of Health Services Concerns
Total responses = 373



Respondents who selected "Other" identified concerns in the availability of naturopathic services, overreach of county health authority, respectful care, and the healthcare workers do not seem happy.

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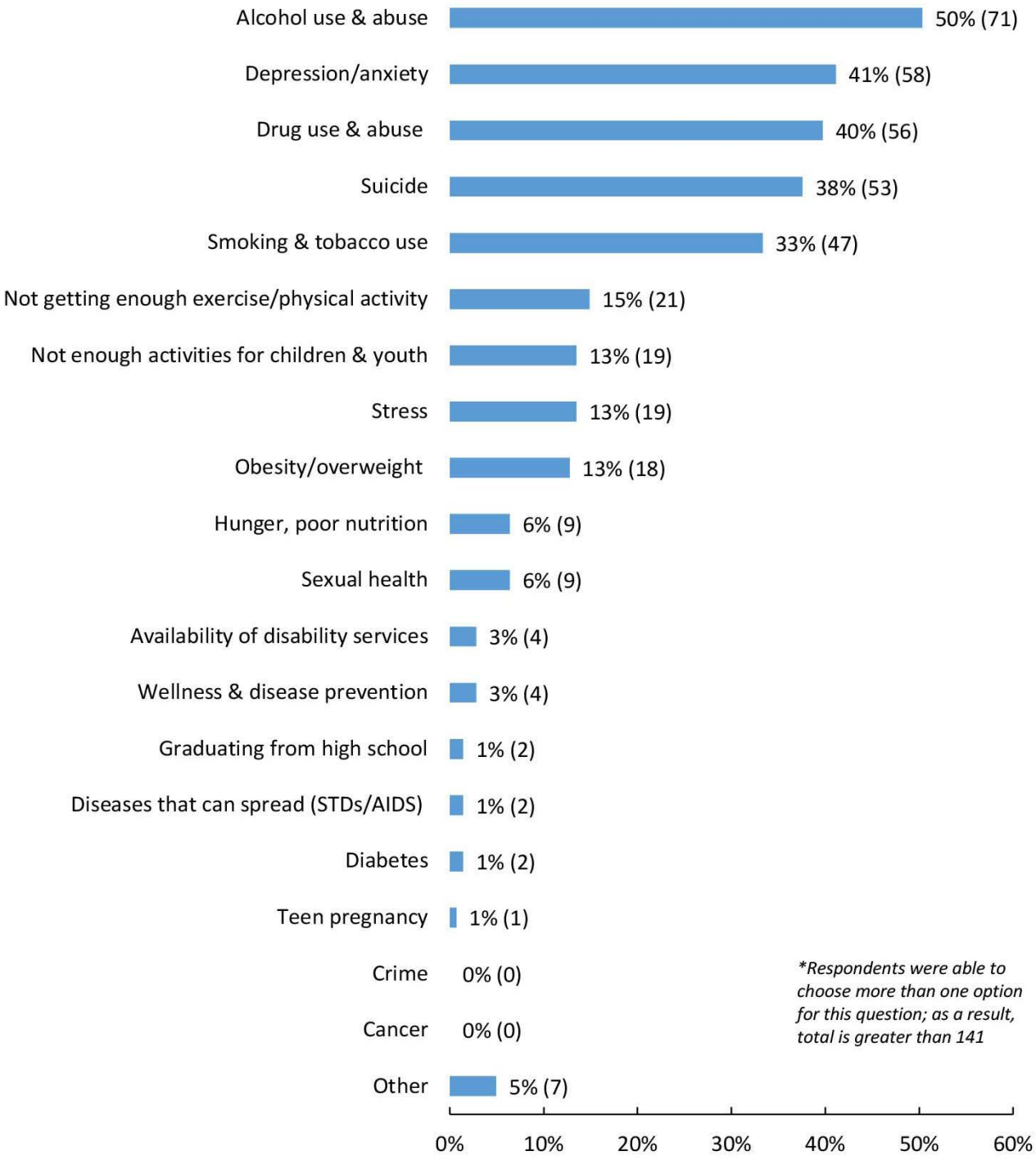
Figure 19: Youth Population Health Concerns
Total responses = 402



Listed in the "Other" category for youth population concerns bullying, lack a culture of excellence and respect in the school, parents who are not good role models for their children, online safety (specifically social media), and children being lazy.

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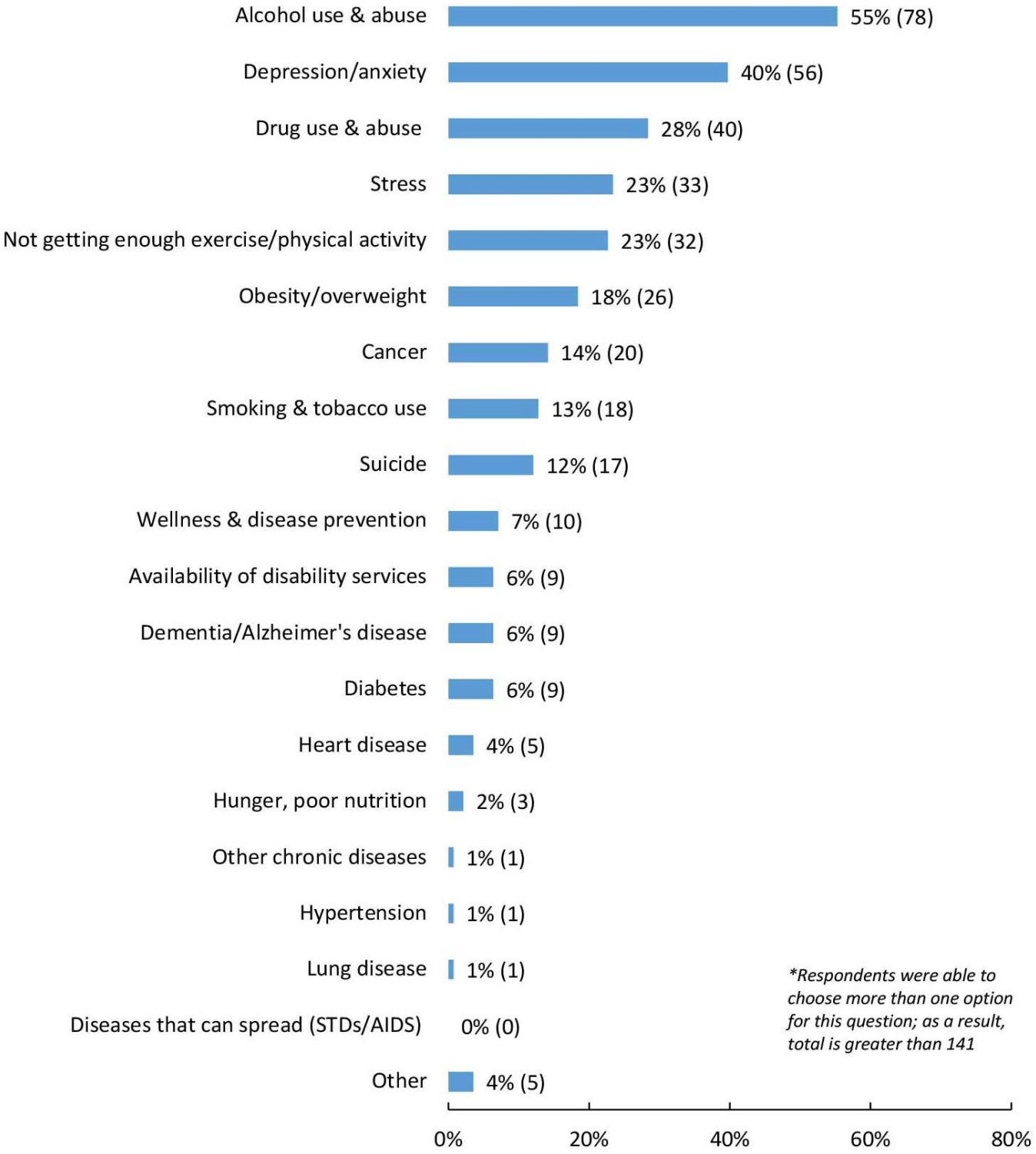
Figure 20: Adult Population Concerns
Total responses = 373



Having to "keep up with the Jones'," among certain groups of people found it hard to make friends, adults who don't work, and adults who put too much emphasis on sports were indicated in the "Other" category for adult population concerns.

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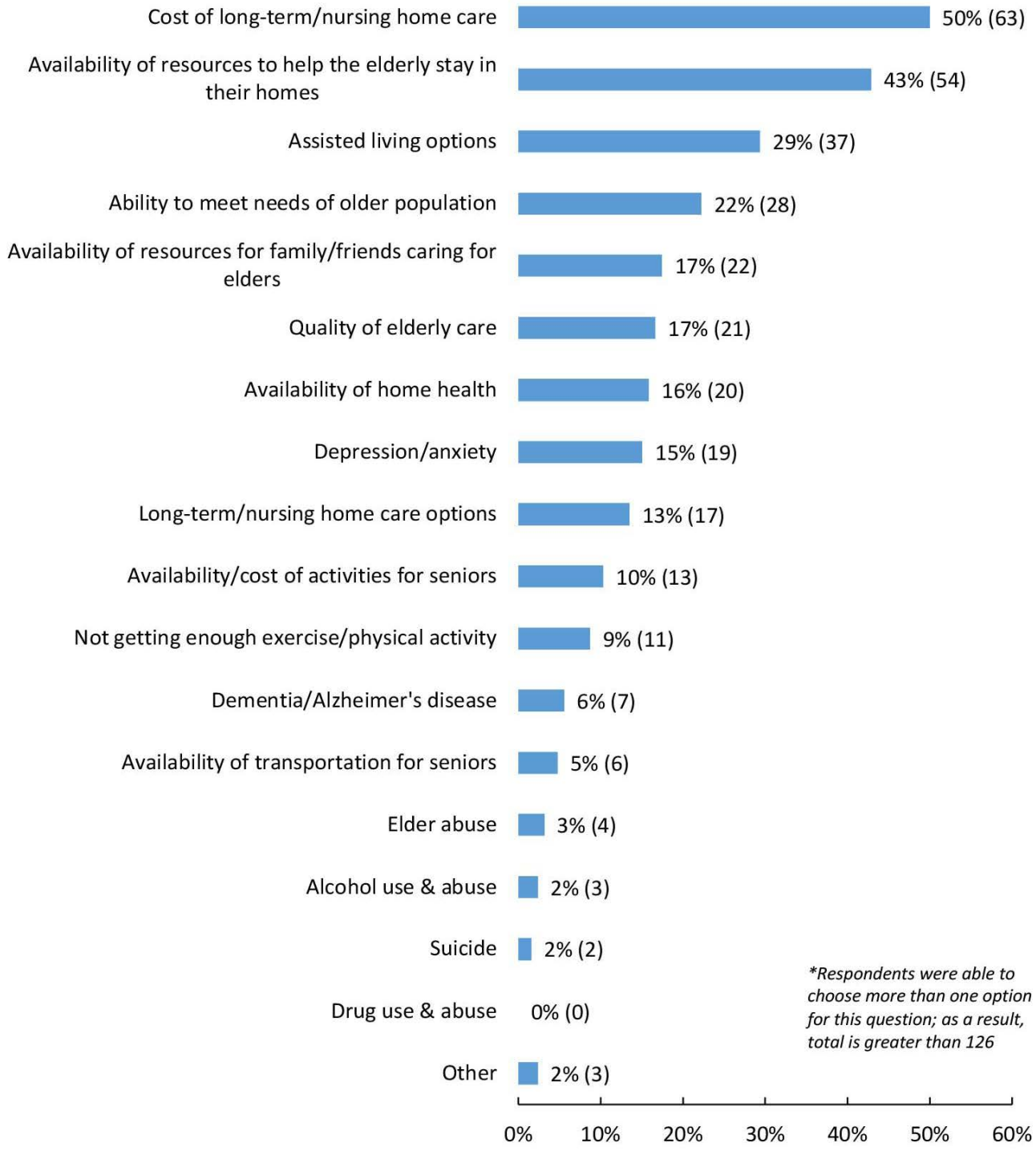
Figure 21: Senior Population Concerns
Total responses = 330



In the "Other" category, lack of caregivers in long-term care, a need for an updated senior center with more activities and keeping residents confined to the nursing home or assisted living were the concerns noted for seniors.

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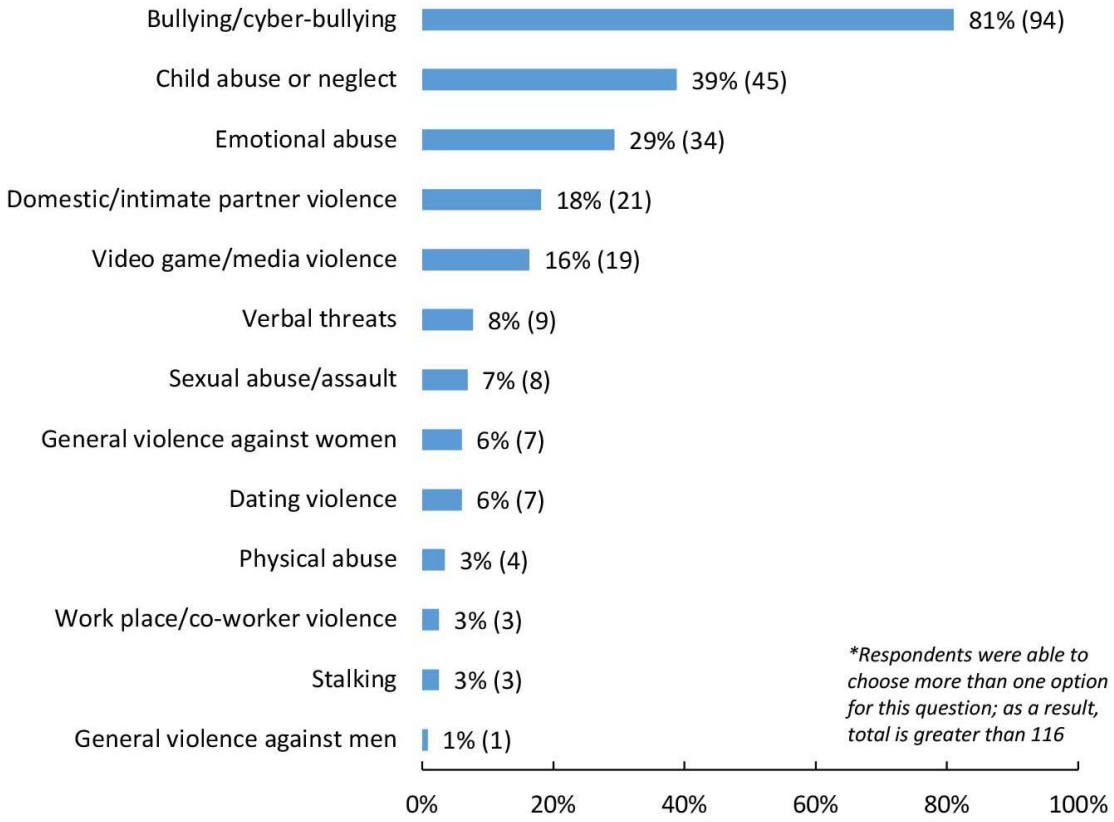
Figure 22: Violence Concerns
Total responses = 255



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/drug abuse
2. Mental health (includes depression/anxiety and suicide)

Other biggest challenges identified were attracting and retaining young families, affordable housing, the availability of substance abuse treatments, obesity, poor nutrition and lack of exercise, lack of childcare and the lack of/retaining physicians.

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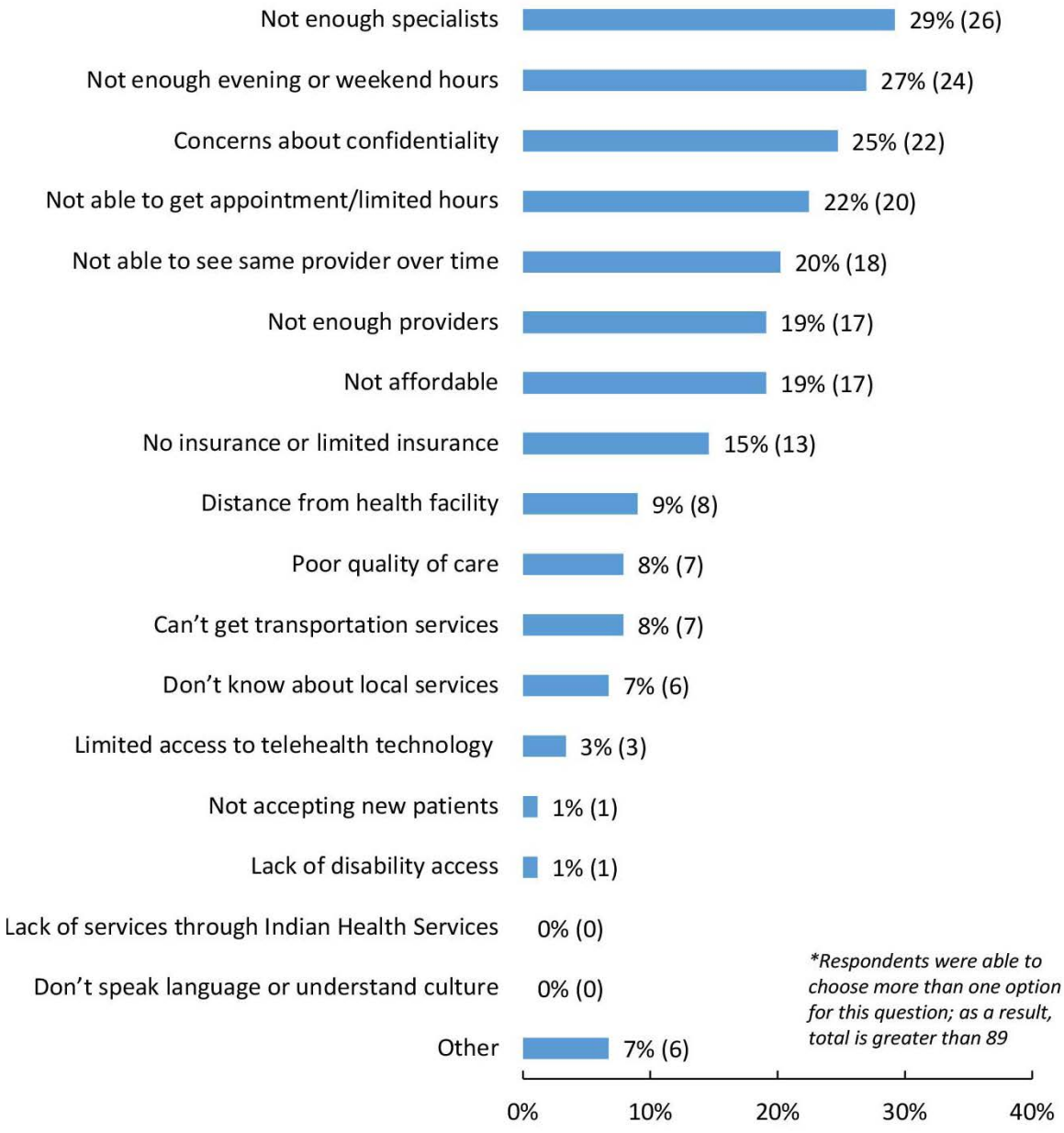
Delivery of Healthcare

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 specialists (N=26) with the next highest being not enough evening or weekend hours (N=24). After these obstacles, the next most commonly identified barriers were concerns about confidentiality (N=22), not able to get appointment/limited hours (N=20), and not able to see same provider over time (N=18). The majority of concerns indicated in the "Other" category were that they are a patient at another facility, and they do not trust the current providers.

Figure 23 illustrates these results.

Figure 23: Perceptions about Barriers to Care
Total responses = 196



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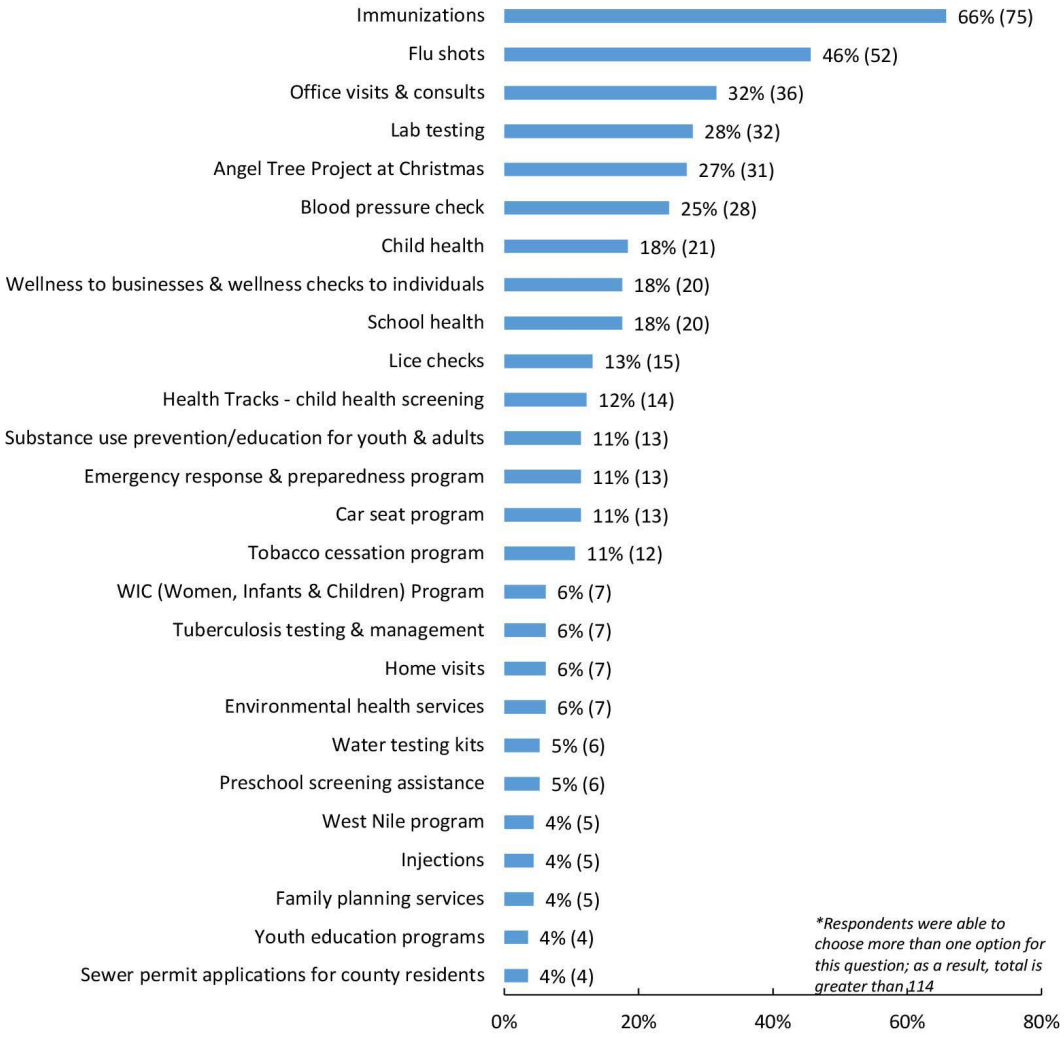
Considering a variety of healthcare services offered by Foster County Public Health (FCPH), respondents were asked to indicate if they were aware that the healthcare service is offered though FCPH and to also indicate what, if any, services they or a family member have used at FCPH, at another public health unit, or both (See Figure 24).

Figure 24: Awareness and Utilization of Public Health Services



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 mental health services. Other requested services included:

- Health and wellness coaches
- Dietician
- Phone for health-related questions
- Mental health counseling
- Dermatology
- More MD level providers
- Maternity/baby delivery
- Cardiac Rehab
- Non-Emergent Weekend Care
- More Specialists
- More telemedicine providers
- Immunizations in the clinic for well-child visits
- Naturopath Doctor
- Psychologist
- Physical Therapist
- Occupational Therapy
- Speech Therapist
- Home healthcare

While not a service, many respondents indicated that they would like specialists added, such as dermatology, obstetrics, telehealth, and a psychologist. Many respondents expressed the need for more mental health resources, including counseling.

The key informant and focus group members felt that the community members were aware of the majority of the health system and public health services. They also felt that the marketing of the services had been good but would like to see an increase marketing effort on more general awareness of all the services available and how to take advantage of those services. The group also discussed the need to bring back the Saturday morning Urgent Care Clinic.

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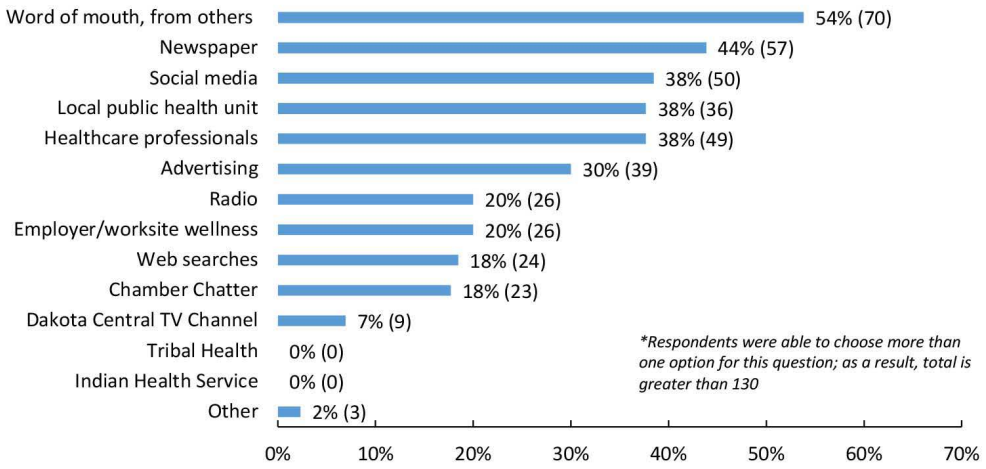
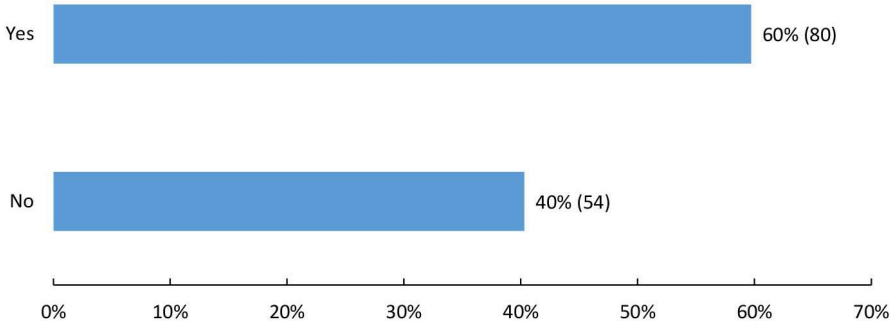
Figure 25: Where do you find out about local health services?
Total responses = 412



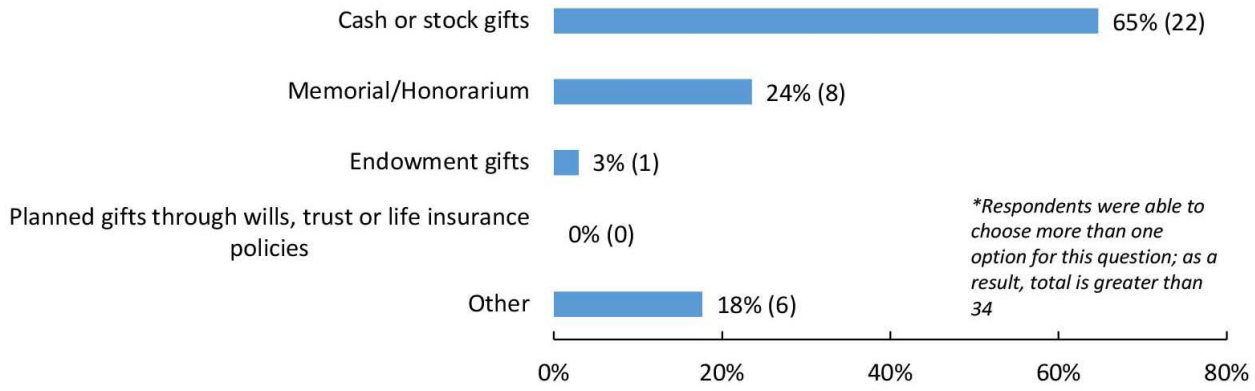
In the "Other" category, respondents listed transportation, or they call and ask.

Figure 26: Awareness of CHI St. Alexius Health Carrington Medical Center's Foundation
Total responses = 134



In an effort to gauge ways that community members have financially supported the CHI St. Alexius Health Carrington Foundation, a question was included, asking them to select ways they have supported the CHI St. Alexius Health Carrington Foundation (see Figure 27). Recommendations in the "Other" category included fundraisers and donated items for an auction.

Figure 27: Have you supported the CHI St. Alexius Health Carrington Foundation in any of the following ways?
Total responses = 34



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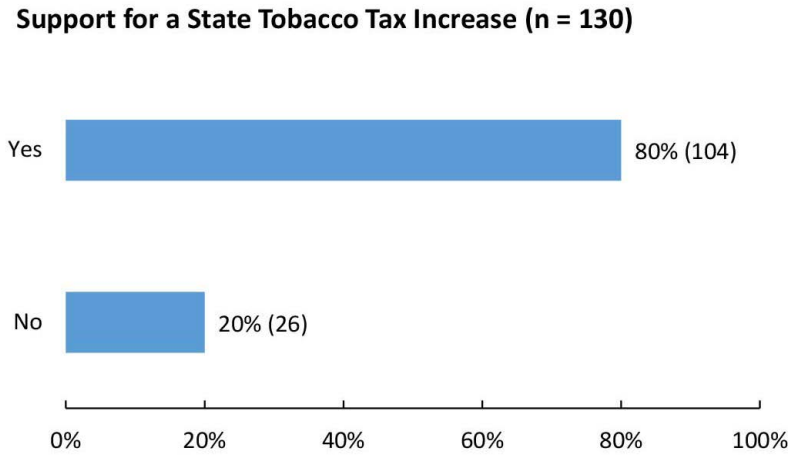
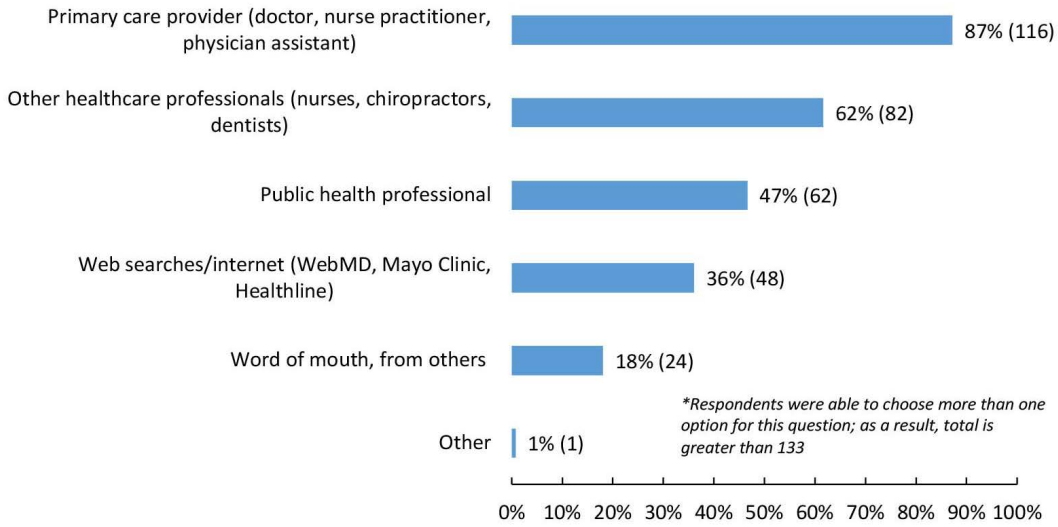
Respondents were asked if they would support a Tobacco Tax increase in North Dakota. The funds would be used to address preventative health in all substance use areas, such as opioids, alcohol, tobacco, and others (Figure 28).

Figure 28: North Dakota Tobacco Tax Increase Support
Total responses = 130



Respondents were asked where they go to for trusted health information. Primary care providers (N=116) received the highest response rate, followed by other healthcare professionals (N=82), and public health professional (N=62).

Figure 29: Sources of Trusted Health Information
Total responses = 333



In the "Other" category, Veteran Affairs was listed as a source of trusted information.

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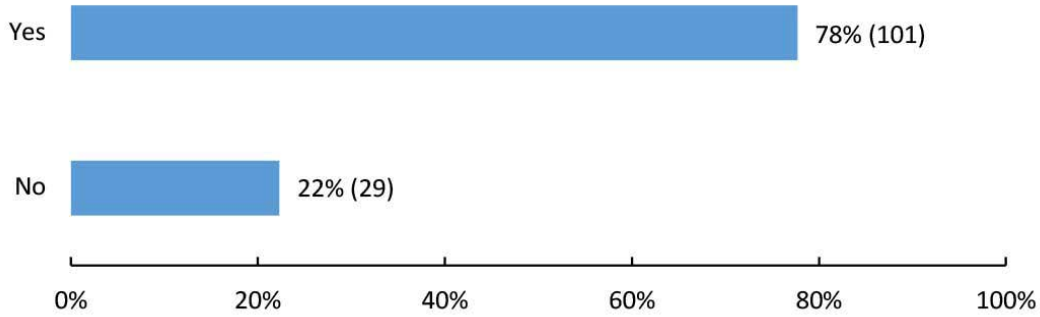
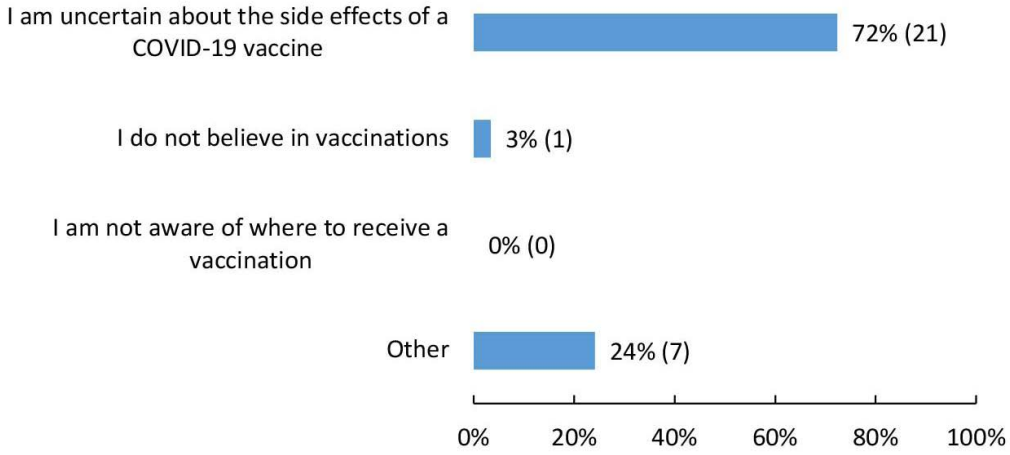
Respondents were asked additional questions, regarding whether or not they have received a COVID-19 vaccine and if they have not, what was the reason. The majority of respondents indicated they have received the vaccine (N=101) with 22% (N=29) indicating they have not (Figure 30).

Figure 30: Received a COVID-19 Vaccine
Total responses = 130



The main answer respondents chose as to why they have not received the vaccine was that they are uncertain of the side effects (N=21), followed next by "Other".

Figure 31: Reasons for not receiving the COVID-19 vaccine
Total responses = 33



In the "Other" category, the reasons for not getting the vaccine include being pregnant, advised to wait due to medical reasons, long term testing has not been done, they do not want to get it, and it isn't necessary.

Additional questions were asked, regarding the Carrington and New Rockford Clinics and options for more clinic hours.

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Figure 32: Use of CHI St. Alexius Health Carrington Clinic Services
Total responses = 124

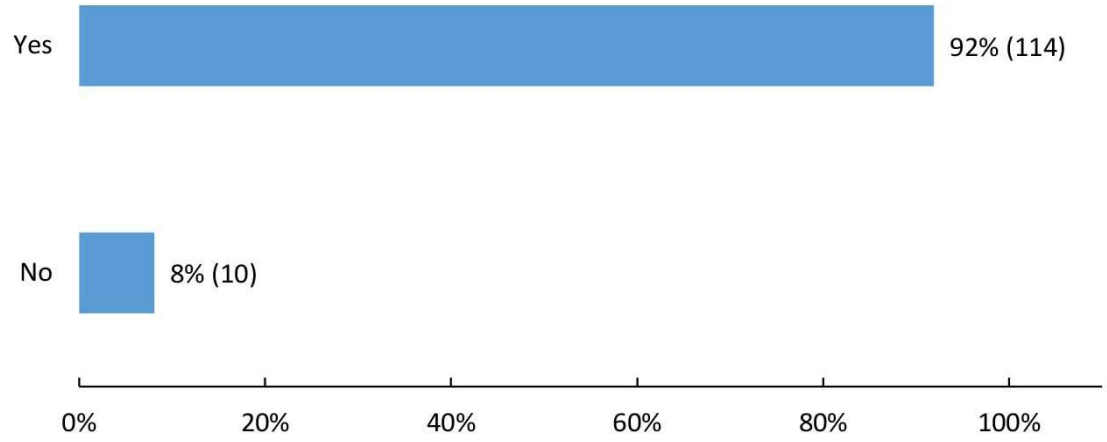
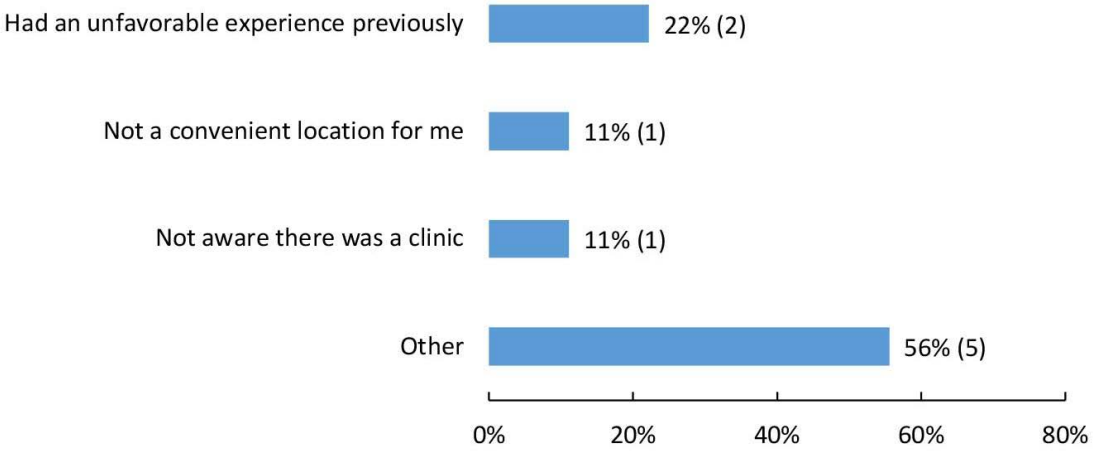


Figure 33: Why CHI St. Alexius Health Carrington Clinic was not used
Total responses = 9



The "Other" responses included they haven't needed it in the past year; they travel to Fargo for better care; their primary is no longer there, and they don't want people in the community talking about reasons why they went in.

Figure 34: Options for more clinic hours
Total responses = 106

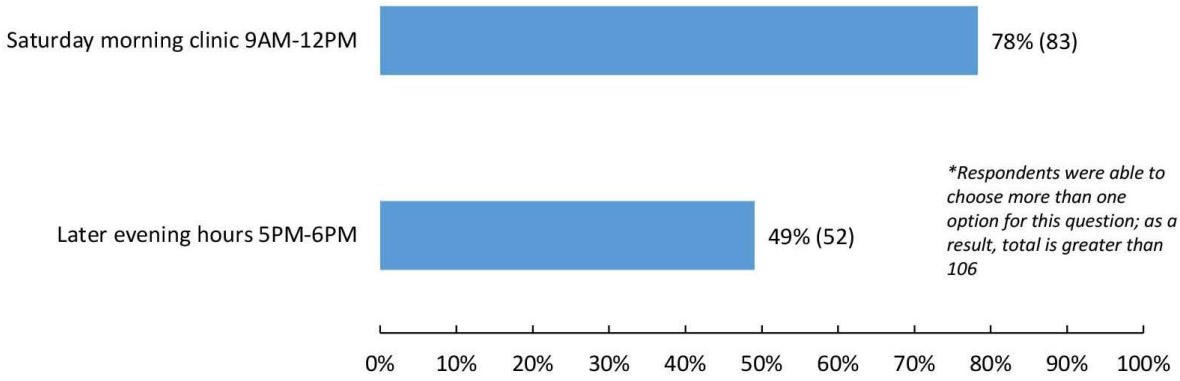


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Figure 35: Use of CHI St. Alexius Health Clinic in New Rockford
Total responses = 133

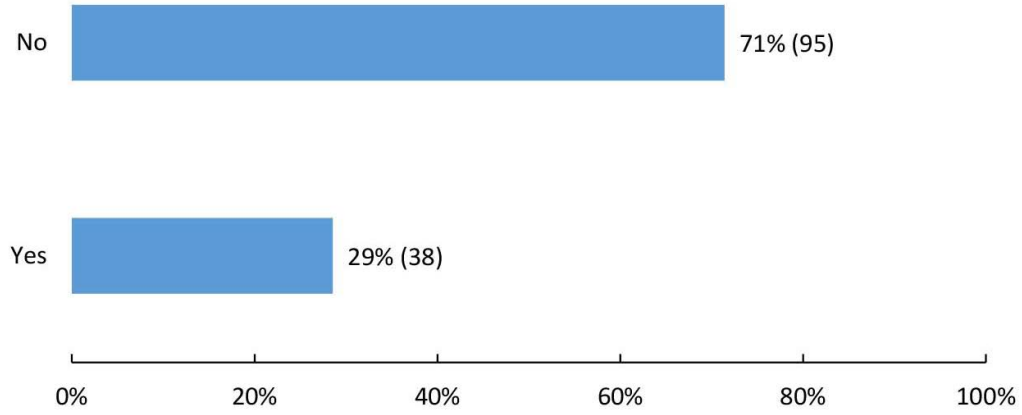
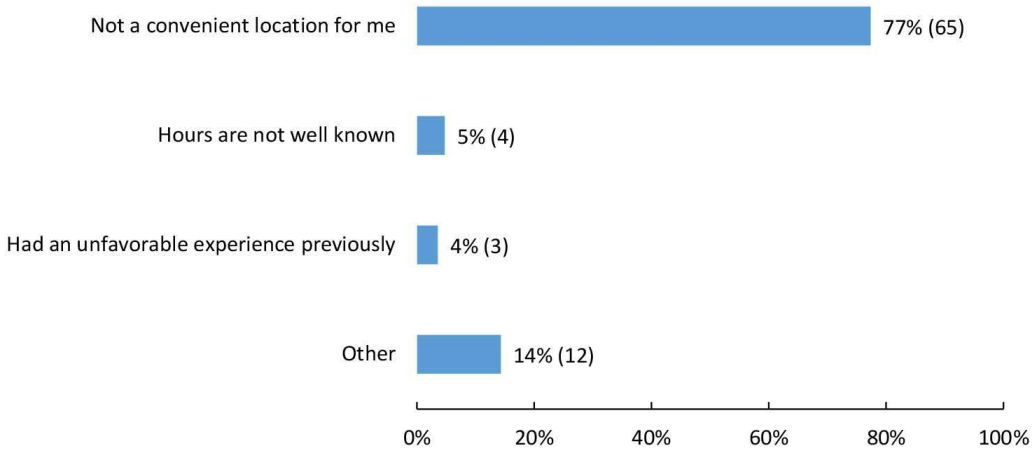
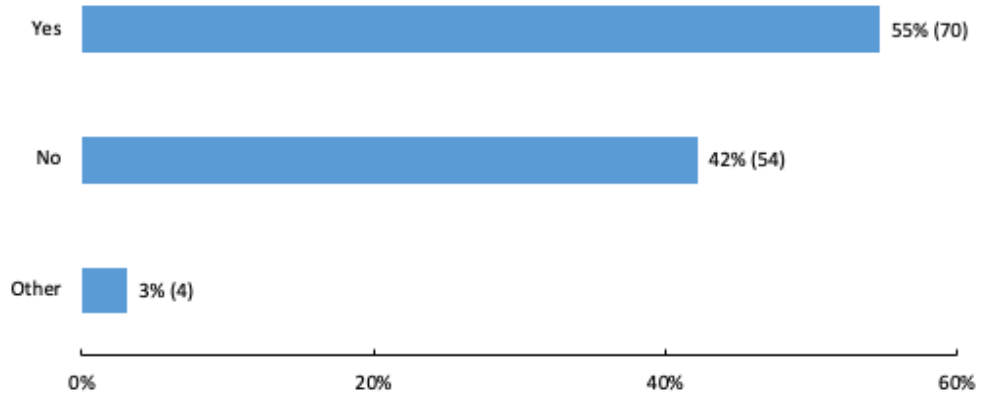


Figure 36: Why CHI St. Alexius Health Clinic in New Rockford was not used
Total responses = 84



The half of the "Other" responses were that they did not need it (N=6). Other responses included they go to Carrington, drive to Fargo and wasn't aware there was a provider there.

Figure 37: Would extra clinic hours be used for vaccinations and flu shots
Total responses = 128



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One last 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 physicians and confidentiality.

Requests were made to have more quality physicians (MDs, DOs), not just more NPs and PAs. A need was specified for more physicians to reduce the burnout and be able to retain them. General concerns about management and employee retention were indicated.

Another point made was to have transportation available to get to the larger cities for healthcare appointments for those that aren't able to drive or have trouble driving.

Concerns about patient confidentiality were expressed. There have been conversations in the hallway that have been overheard, regarding why someone is there. Someone stated that they had had multiple instances where the reason why they were being seen in the clinic has been shared with people before they were ready to share that information.

People would like to see more options for appointments that allow people to get in to be seen sooner and better accommodate the schedules of those that work full-time. When working with the VA, it was felt that there needs to be a better way to handle the billing.

One respondent expressed that they felt that CMC wasn't involved in the community and does not contribute to other groups in the community; they didn't see CMC representatives sit on boards or participate in other organizations. The organization uses purchasing contracts, so they do not shop locally. They sensed that the hospital didn't uphold the mission of compassion and caring because they required COVID-19 patients to pay for a clinic visit when patients did not need a clinic visit and only needed a test.

Others are completely satisfied with the present delivery of health services in the community and believe that CMC does an excellent job taking care of the community and that there are fantastic providers and healthcare workers.

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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 use and abuse
- Attracting and retaining young families
- Availability of mental health and substance use disorder treatments services
- Depression/anxiety
- Extra hours for appointments, such as evenings and weekends

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

Alcohol use and abuse

- Top concern is addressing alcohol abuse in both adults and youth
- Concern with having so many bars in the community
- Big problem with opioids

Attracting and retaining young families

- A good job has been done bringing back the younger generations
- Long term issues in rural areas

Availability of mental health and substance use disorder treatment services

- With proper treatment, this solution could improve health with other issues in the community, more than just substance abuse and stress

Depression/anxiety

- Depression and anxiety lead to stress and suicide
- Mainly with agriculture and businesses right now with difficult decisions due to COVID-19 restrictions
- This issue also leads to stress and suicide in youth as many students have a fear of not making good decisions; many expectations are on them
- The school has contracted with a licensed counselor once a week at no cost to the family

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

- Public health (4.3)
- Emergency services, including ambulance and fire (4.2)
- Economic development organizations (4.2)
- Schools (4.1)
- Hospital (healthcare system) (4.0)
- Law enforcement (3.9)
- Faith-based (3.8)
- Business and industry (3.8)
- Other local health providers, such as dentists and chiropractors (3.8)
- Pharmacy (3.7)
- Clinic not affiliated with the main health system (3.6)
- Long-term care, including nursing homes and assisted living (3.5)
- Human services agencies (3.25)
- Social services (3.0)

Priority of Health Needs

A community group met on September 13, 2021. Sixteen community members attended the meeting. Representatives from the CRH presented the group with a summary of this report's findings, including background and explanation about the secondary data, highlights from the survey results (including perceived community assets and concerns, and barriers to care), and findings from the key informant interviews.

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

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

- Mental health (includes depression/anxiety/suicide/stress (all ages) (16 votes)

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- Ability to retain primary care providers & nurses (13 votes)
- Enough child daycare services (8 votes)
- Alcohol use & abuse (all ages) (5 votes)

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

- Mental health (includes depression/anxiety/suicide/stress (all ages) (7 votes)
- Ability to retain primary care providers & nurses (5 votes)
- Enough child daycare services (4 votes)
- Alcohol use & abuse (all ages) (0 votes)

Following the prioritization process during the second meeting of the community group and key informants, the number one identified need was mental health (including depression/anxiety/suicide/stress) for all ages. A summary of this prioritization may be found in Appendix F.

Comparison of Needs Identified Previously

Top Needs Identified 2019 CHNA Process	Top Needs Identified 2021 CHNA Process
Ability to retain primary care providers (MD, DO, NP, PA) and nurses	Mental health for all ages (includes depression/anxiety/suicide/stress)
Attracting and retaining young families	Ability to retain primary care providers and nurses
Not enough affordable housing	Enough child daycare services
Availability of resources to help elderly stay in their homes	Alcohol use & abuse (all ages)

The current process identified one identical common need from 2019, which was the ability to retain primary care providers. CHI St. Alexius Health, Carrington invited written comments on the most recent CHNA report and Implementation Strategy both in the documents and on the website where they are widely available to the public. No written comments have been received.

Upon adoption of this CHNA Report by the CHI St. Alexius Health Carrington Board vote, a nomination will be documented in the board minutes reflecting the approval and then the report will be widely available to the public on the hospital's website, and a paper copy will be available for inspection upon request at the hospital. Written comments on this report can be submitted to CHI St. Alexius Health Carrington Mission Director at 800 4th St. N, Carrington, North Dakota 58421.

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Hospital and Community Projects and Programs Implemented to Address Needs Identified in 2019

In response to the needs identified in the 2019 CHNA process, the following actions were taken:

Need 1: Ability to Retain Primary Care Providers (MD, DO, NP, PA) – CHI St Alexius Health Carrington Medical Center held quarterly meetings with a committee of five community resource people who were invited to each meeting to offer suggestions. Only two of the five community members attended regularly. Suggestions were implemented from the community group to add to CMC already existing plan for onsite recruitment. The committee invited area healthcare providers to a meet and greet off site of CMC, which was held at a local venue, which had very poor attendance by area healthcare providers. Invitations were sent out via email and phone calls and postcard reminders were sent one week prior to the meeting. In March 2020, when the COVID-19 pandemic started, the committee stopped onsite recruitment and community involvement. Three candidates were brought forward. Two offers were made and turned down. One candidate was not considered a good fit and, therefore, no offer was extended. In the fall of 2020, a modified recruitment was arranged for one candidate for an onsite visit. No offer was extended.

Need 2: Attracting and Retaining Young Families – CHI St. Alexius Health Carrington Medical Center and community members created a committee to address this need. The committee applied for and received a grant to promote the need. The grant allowed for the committee to have young families interviewed for television commercials. The main focus of the interviews was asking why the young family chose Carrington in which to live and work. The commercials were aired locally until 2021.

Need 3: Not Enough Affordable Housing – CHI St. Alexius Health Carrington Medical Center started a committee with local community members to address this need. The meetings were not successful, and nothing much happened with the committee. However, a local private company began to build affordable housing in 2021 outside the purview of the committee. The committee attempted to interview the private company multiple times, but each time the company declined the interview.

Need 4: Availability of Resources to Help Elderly Stay in Their Homes – Since the last CHNA process, Foster County Public Health conducted a round table meeting with county partners to discuss access to services for elderly to remain in their homes. Due to the COVID-19 pandemic, the group struggled to meet due to community disease levels as well as COVID-19 response activities.

However, Foster County Public Health was able to address a substantial gap in the community and work with community partners to create an Adult and Aging Services Resource Guide. The guide assists county residents with identification of resources as well as how to access them and aid the elderly, their families, and healthcare professionals to retain the elderly in their homes and in our community. The resource guide will be distributed in the fall of 2021 the community through the Carrington Senior Citizen Center, Meals on Wheels, FCPH, CHI St. Alexius Health Carrington, Carrington's Daily Bread, Golden Acres Manor and Estates, and CHI Health at Home, among others. The guide will also be available online. The booklets will be used as a resource in discharge planning for the hospital, nursing home, and home health. Family members will be able to find services to keep elderly relatives in their homes longer. Elderly community members will also find more comfort and safety in their own homes.

Foster County Public Health worked with its own staff as well as collaborated with Carrington City Library and Carrington Senior Center to assist elderly in accessing registration for COVID-19 vaccines as well as participating in survey responses for census data collections.

Foster County Public Health worked with South Central Transportation to create free rides for all citizens who needed transport to/from COVID-19 vaccine clinics.

Need 5: Adult and Youth Alcohol Use and Abuse – The community was concerned during the last CHNA process about the amount of adult and youth alcohol use and abuse in the service area.

In order to continue to reduce alcohol use among youth in Foster County and to address the community norm

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of the belief by adults that underage drinking is acceptable at a certain age below 21 and is a rite of passage, FCPH implemented the Project Northland Curriculum in the Carrington and Midkota Public Schools. The Project Northland curriculum has a strong family component. By working with students and parents, FCPH is aiming to set protective factors in place early and to challenge and change the community norms. In the Carrington Middle School, the Project Northland curriculum was taught to the 6th and 7th graders. The 8th grade class will be added in the upcoming year. In the Midkota Middle School, the Project Northland curriculum was taught to the 7th and 8th graders. The Midkota Middle School does not have 6th grade in their school or in their county.

Project Northland is an evidence-based series for middle school and high school students. Project Northland interventions target all students, putting it in the category of universal prevention efforts or primary prevention. The needs of most students for information and skills are met at this level. This alcohol-use prevention program is backed by more than eighteen years of research and more than forty-five scientific publications. The goals of Project Northland are to delay the age when young people begin drinking, reduce alcohol use among young people who have already tried drinking, and limit the number of alcohol-related problems of young people. Research has shown that, in addition to effectively achieving its alcohol prevention goals, Project Northland can significantly reduce teens' marijuana and tobacco use. Project Northland is a nationally recognized alcohol-use prevention program. The four Project Northland curricula were developed at the University of Minnesota from research funded by the National Institute on Alcohol Abuse and Alcoholism.

The Project Northland curricula invite participation and experiential learning at home, in the classroom and in the local community. A vital aspect of Project Northland is this multifaceted approach. Prevention research shows that addressing alcohol use at multiple levels strengthens outcomes. Incorporating best practices for effective prevention, the curriculum engages students as individuals and addresses influences in the family, with peers, at school, and in the local community and broader society. Project Northland addresses these domains more comprehensively than any other prevention program. Project Northland utilizes peer-led, experiential, activity driven learning strategies to actively educate students. Families are enlisted to support a "no use" message, while communities mobilize to reduce youth access to alcohol and to promote alcohol-free norms for youth. The curricula are user friendly for teachers, fun for students, inviting to families, and effective in preventing alcohol use.

Also, to reduce youth and adult alcohol use and to challenge and change the community norms, a media campaign was implemented with Facebook posts and videos, local billboards, radio spots, a Parents Lead campaign, and other mediums. FCPH has also hosted alternative activities for youth during the summers at the fair and at the community pool.

The above implementation plan for CHI St. Alexius Health Carrington Medical Center is posted on the CHI St. Alexius Health's website at https://www.chistalexiushealth.org/about-us/community-health-assessments.

Next Steps – Strategic Implementation Plan

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

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"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.

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Appendix A – Critical Access Hospital Profile

Spotlight on: Carrington, North Dakota

CHI St. Alexius Health

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Carrington Medical Center

Quick Facts

President:
Mariann Doeling

Chief of Medical Staff:
Dr. Michael Page

Board Chair: Mike Lefor

City Population:
1,980 (2019 estimate)[1]

County Population:
3,210 (2019 estimate)[1]

County Median Household Income:
$54,839 (2019 estimate)[1]

County Median Age:
44.8 years (2019 estimate)[1]

Service Area Population:
5,497 (2019 estimate)[1]

Owned by: CommonSpirit Health

Trauma Level: V

Critical Access Hospital Designation: 2001

Economic Impact on the Community[2]

Employment Impact:
Direct - 88
Secondary – 43
Total Impact– 131

Financial Impact:
Direct - $5.42 million
Secondary – $1.74 million
Total – $7.2 million

Mission:

As a member CommonSpirit Health, the nation's largest not for profit healthcare system and largest faith based healthcare system, we make the healing presence of God known in our world by improving the health of the people we serve, especially those who are vulnerable, while we advance social justice for all.

County: Foster
Address: 800 4th Street North
Carrington, ND 58421
Phone: (701) 652-3141 or (800) 532-8623
Fax: (701) 652-2884
Web: www.chistalexiushealth.org

Carrington Health Center is a modern Critical Access Hospital with all private rooms that has offered healthcare in the community for over 100 years with continued Catholic Health Care sponsorship. The health care is all encompassing and Carrington Health Center offers it with quality and person-centered care. Nursing staff is cross trained to all areas of healthcare in the facility. Excellent radiology and lab departments offer a wide variety of services including in-house CAT Scan, Ultrasound, and mammography in addition to basic radiographs. The physical therapy department complements our many other services. Carrington Health Center offers a wide variety of services including, a hospital-owned ambulance with Advance Life Support capabilities, as well as two rural health clinics. Several regional specialists rotate their services at Carrington Health Center at the clinic and in the hospital setting, offering total patient care. arrington Health Center has a very active hospital auxiliary that fundraises for many items needed at the Health Center.

Carrington Health Center provides the following services directly:

- Hospital and Clinic Services
- Ambulance Service
- Physical Therapy
- Antibiotic Therapy
- Diabetic Services
- Emergency Room
- Endoscopes
- General Lab Services
- Dexa Scans
- Radiology
- Respiratory Therapy
- Social Services

Carrington Health Center provides the following services through contract or agreement:

- Anesthesia Services
- MRI Services
- Nuclear Medicine
- Sleep Apnea Studies
- Hospice
- Home Health

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Staffing

Physicians: 3
PAs: 3
RNs: 29
LPNs: 10
Total Employees: 184

Local Sponsors and Grant Funding Sources

- Blue Cross Blue Sheild
- Center for Rural Health
  - SHIP Grant (Small Hospital Improvement Program)
  - Flex Grant (Medicare Rural Hospital Flexibility Grant Program)
- Health Resources and Services Administration Loan Repayment

Sources

1 - US census Bureau; 2010 State and County QuickFacts; Foster County, ND

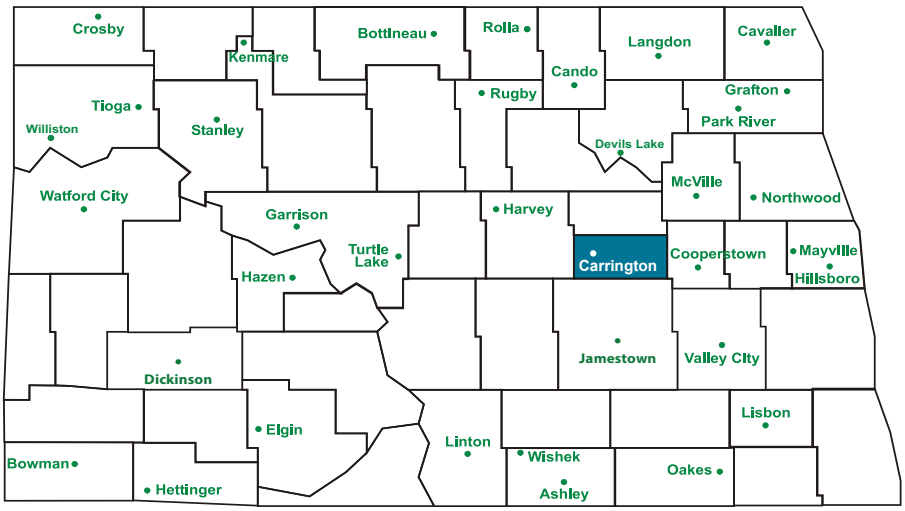
2 - Economic Impact 2020 Center for Rural Health Oklahoma State University and Center for Rural Health University of North Dakota

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

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

ruralhealth.und.edu

North Dakota Critical Access Hospitals



History:

The Carrington Hospital Association was chartered in 1915 and the Stockowners' Association built the original hospital the following year.

In 1941, the hospital was leased to the Presentation Sisters of the Diocese of Fargo. A larger, more modern facility was soon needed, and in 1956 a newly constructed building was dedicated. Ownership of this building was transferred to the Presentation Sisters in the mid 1970's.

The original hospital was then used as a nursing home care unit. In 1964, the Presentation Sisters built a skilled and intermediate nursing facility called Holy Family Guest Home which is currently..

The present hospital was constructed and occupied in 1986 and was known to be one of the most modern and up-to-date facilities in the state of North Dakota. In June of 1993, the Foster County Medical Center was merged with the Health Center and redesignated as a Rural Health Clinic.

In 1980, the Sisters joined with Catholic Health Corporation of Omaha. In 1996 the Presentation Sisters, along with two other Catholic Health Systems, formed a corporation known as Catholic Health Initiatives. This organization represents ten religious congregations and has a presence in 74 communities and 21 states, which includes 83 hospitals and 50 long term care facilities. In February 2019, Catholic Health Initiatives formed a new healthcare organization with Dignity Health called CommonSpirit Health.

Recreation:

Carrington is in east central North Dakota, just two hours from four major cities in North Dakota including Fargo, Minot, Grand Forks, and Bismarck, North Dakota's capital and second largest city. Its strong economy is based on agri-business, service industries and retail trade. Carrington Public School System provides an excellent curriculum for students K-12 that includes a wide variety of sports and music-theatre; adult education programs are also offered. The park board maintains four city parks, ball diamonds and picnic tables, a swimming pool, a shooting range and tennis courts. In 2003 Cross Roads Golf Course opened, which is a beautiful well-kept eighteen-hole golf course. There is a youth recreation center that includes an in-house movie theatre. An eight lane bowling alley opened in August 2008 and includes a meeting room, a space for entertaining guests for special occasions as well as a sandwich bar. Several recreation areas are available within a 30-minute drive of the city. This community offers excellent hunting and fi shing opportunities.

Updated 12/21

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Appendix B – Economic Impact Analysis

CHI St. Alexius Health

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Carrington Medical Center

Healthcare, especially a hospital, plays a vital role in local economies.

Economic Impact

CHI St. Alexius Health Carrington Medical Center is composed of a Critical Access Hospital (CAH), two rural health clinics (located in Carrington and New Rockford), and an emergency medical services unit.

CHI St. Alexius Health Carrington Medical Center **directly** employs **88 FTE employees** with an annual payroll of over **$5.42 million** (including benefits).

- After application of the employment multiplier of 1.49, these employees created an additional **43** jobs.
- The same methodology is applied to derive the income impact. The income multiplier of 1.32 is applied to create more than **$1.74 million** in income as they interact with other sectors of the local economy.
- **Total impacts = 131 jobs and nearly $7.2 million in income**.

Healthcare and Your Local Economy

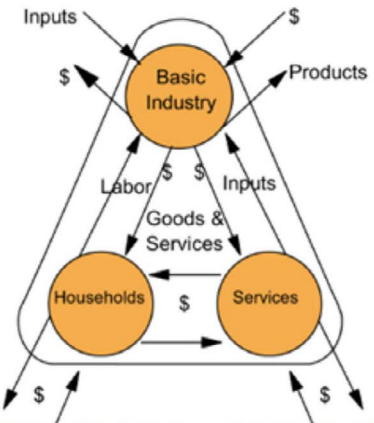
The health sector in a rural community, anchored by a CAH, is responsible for a number of full- and part-time jobs and the resulting wages, salaries, and benefits. Research findings from the National Center for Rural Health Works indicate that rural hospitals typically are one of the top employers in the rural community. The employment and the resulting wages, salaries, and benefits from a CAH are critical to the rural community economy. Figure 1 depicts the interaction between an industry like a healthcare institution and the community, containing other industries and households.

Key contributions of the health system include

- Attracts retirees and families
- Appeals to businesses looking to establish and/or relocate
- High quality healthcare services and infrastructure foster community development
- Positive impact on retail sales of local economy
- Provides higher-skilled and higher-wage employment
- Increases the local tax base used by local government

Data analysis was completed by the Center for Rural Health at the Oklahoma State University Center for Health Sciences utilizing IMPLAN data.

Figure 1. *An overview of the community economic system.*



Source: Doeksen, G.A., T. Johnson, and C. Willoughby. 1997. Measuring the Economic Importance of the Health Sector on a Local Economy: A Brief Literature Review and Procedures to Measure Local Impacts

Fact Sheet Author: Kylie Nissen, BBA

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Appendix C – CHNA Survey Instrument

CHI St. Alexius Health Carrington Area Health Survey

CHI St. Alexius Health Carrington and Foster County Public Health 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/Carrington21.

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 Amy Breigenzer at 701.777.8002.

Surveys will be accepted through July 31, 2021. 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
- ☐ Recreational and sports activities
- ☐ Year-round access to fitness opportunities

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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): _____

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

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

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

- ☐ Alcohol use and abuse
- ☐ Drug use and abuse (including prescription drug abuse)
- ☐ Smoking and tobacco use, exposure to second-hand smoke or vaping (juuling)
- ☐ Cancer
- ☐ Lung disease (i.e. emphysema, COPD, asthma)
- ☐ Diabetes
- ☐ Heart disease
- ☐ Hypertension
- ☐ Dementia/Alzheimer's disease
- ☐ Other chronic diseases: _____
- ☐ 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
- ☐ Cost of activities for seniors
- ☐ Availability of activities for seniors
- ☐ Availability of resources for family and friends caring for elders
- ☐ Quality of elderly care
- ☐ Cost of long-term/nursing home care
- ☐ 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): _____

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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
- ☐ Media/video game violence
- ☐ Physical abuse
- ☐ Stalking
- ☐ Sexual abuse/assault
- ☐ Verbal threats
- ☐ Workplace/co-worker violence

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

_____

_____

Delivery of Healthcare

12. Considering **SCREENING/THERAPY SERVICES** at CHI St. Alexius Health Carrington hospital, which services are you aware of (or have you used in the past year? (Choose ALL that apply)

- ☐ Diabetes instruction
- ☐ Radiology/imaging
- ☐ Laboratory services
- ☐ Nutritional/dietary instruction
- ☐ Physical therapy
- ☐ Cardiac monitoring (Stress tests)

13. 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)

- ☐ Angel Tree Project at Christmas
- ☐ Blood pressure checks
- ☐ Car seat program
- ☐ Child health – weight checks, ear checks, etc.
- ☐ Emergency response and preparedness program
- ☐ Environmental health services
- ☐ Family planning services –pregnancy testing and contraceptive options for both females and males
- ☐ Flu shots – ages 6 months and older
- ☐ Health Tracks – child health screening
- ☐ Home visits – chronic disease maintenance, medication set-ups
- ☐ Immunizations – all ages
- ☐ Injections – Depo Estradiol, Depo Provera, Depo Testosterone, Vitamin B12
- ☐ Lab testing – blood sugar, hemoglobin, COVID-19, lipid panel
- ☐ Lice checks – school, daycare, or office setting
- ☐ Office visits and consults
- ☐ Preschool screening assistance
- ☐ School health – Safe Dates, puberty talks, school immunizations
- ☐ Sewer permit applications for county residents
- ☐ Substance use prevention & education for youth and adults – alcohol, tobacco, and other drugs
- ☐ Tobacco cessation program
- ☐ Tuberculosis testing and management
- ☐ Water testing kits
- ☐ Wellness to businesses & wellness checks to individuals - flu shots, Tetanus and other immunizations, education, and health screenings
- ☐ West Nile program — mosquito collection and education
- ☐ WIC (Women, Infants & Children) program
- ☐ Youth education programs - bike safety, etc.

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14. Have you used the clinic services owned by CHI St. Alexius Health Carrington?

☐ Yes ☐ No

15. If you answered "No" to question 14, why not?

☐ Not aware there was a clinic
☐ Not a convenient location for me
☐ Had an unfavorable experience previously
☐ Other: _____

16. The clinic in Carrington reduced hours during 2020 due to COVID-19. Would you use services if offered:

☐ Saturday morning clinic 9AM-12PM ☐ Later evening hours 5PM – 6PM

17. Have you used the New Rockford, ND Clinic: CHI St. Alexius Health Family Clinic?

☐ Yes ☐ No

18. If you answered "No" to question 17, why not?

☐ Not a convenient location for me
☐ Hours are not well known
☐ Had an unfavorable experience previously
☐ Other: _____

19. Would you use an afterhours/evening clinic for you or your child to receive scheduled vaccinations or annual flu shots?

☐ Yes
☐ No
☐ Other: _____

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

_____

_____

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

☐ Advertising
☐ Employer/worksite wellness
☐ Healthcare professionals
☐ Indian Health Service
☐ Newspaper
☐ Local Public Health Unit
☐ Radio
☐ Social media (Facebook, Twitter, etc.)
☐ Tribal Health
☐ Web searches
☐ Word of mouth, from others (friends, neighbors, co-workers, etc.)
☐ Chamber Chatter
☐ Dakota Central TV Channel
☐ Other: (please specify): _____

22. 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): _____

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23. 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): _____

24. Are you aware of CHI St. Alexius Health Carrington's Foundation, which exists to financially support services for the community?

☐ Yes ☐ No

25. Have you supported the CHI St. Alexius Health Carrington Foundation in any of the following ways? (Choose ALL that apply)

- ☐ Cash or stock gift
- ☐ Endowment gifts
- ☐ Memorial/Honorarium
- ☐ Planned gifts through wills, trusts, or life insurance policies
- ☐ Other (please specify): _____

26. Did you receive a COVID-19 Vaccine?

☐ Yes ☐ No

27. If you responded "No" to question 26, why did you choose not to receive a vaccine?

- ☐ I do not believe in vaccinations
- ☐ I am uncertain about the side effects of a COVID-19 vaccine
- ☐ I am not aware of where to receive a vaccination
- ☐ Other: _____

28. Do you support a tobacco tax increase in North Dakota, to be used to address preventative health in ALL substance use areas (opioids, alcohol, tobacco, etc.)?

☐ Yes ☐ No

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Demographic Information: Please tell us about yourself.

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

☐ Yes ☐ No

30. How did you acquire the survey (or survey link) that you are completing?

☐ Hospital or public health website
☐ Hospital or public health social media page
☐ Hospital or public health employee
☐ Hospital or public health facility
☐ Economic development website or social media
☐ Other website or social media page (please specify): _____
☐ Newspaper advertisement
☐ Newsletter (if so, what one):_____
☐ Church bulletin
☐ Flyer sent home from school
☐ Flyer at local business
☐ Flyer in the mail
☐ Word of mouth
☐ Direct email (if so, from what organization):_____
☐ Other (please specify): _____

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

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

32. 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

33. 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

34. Sex:

☐ Female
☐ Male
☐ Non-binary
☐ Other (please specify): _____

35. Employment status:

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

36. Your zip code: _____

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

☐ American Indian
☐ African American
☐ Asian
☐ Hispanic/Latino
☐ Pacific Islander
☐ White/Caucasian
☐ Other: _____

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38. 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

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

_____

_____

Thank you for assisting us with this important survey!

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Appendix D – County Health Rankings Explained

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

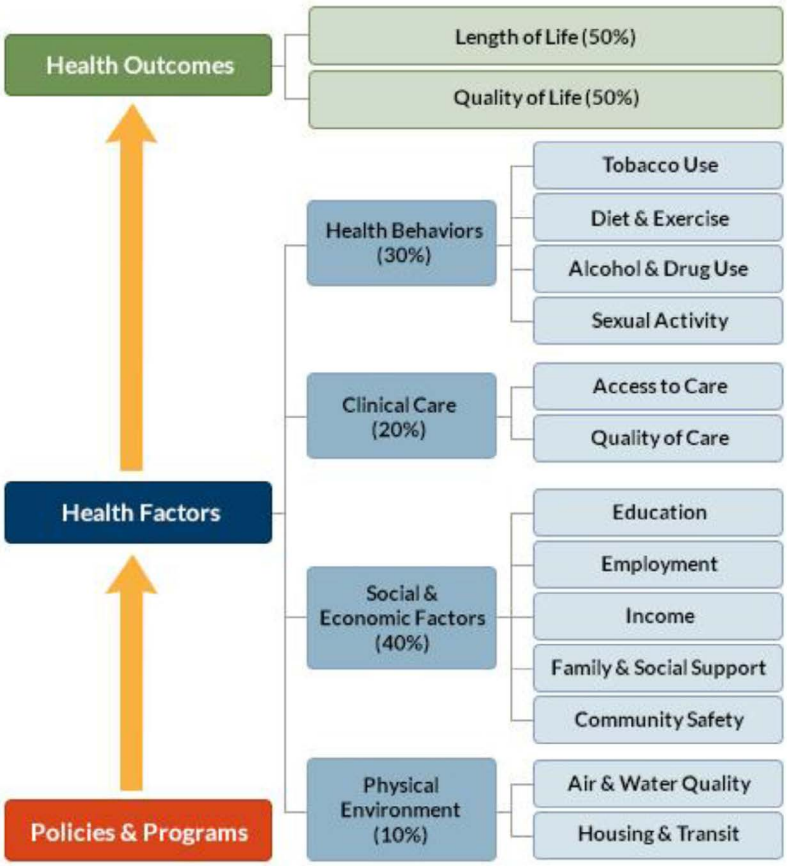
Methods

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



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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.

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Health Outcomes and Factors

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

Health Outcomes

Premature Death (YPLL)

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

Reason for Ranking

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

Poor or Fair Health

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

Reason for Ranking

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

Poor Physical Health Days

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

Reason for Ranking

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

Poor Mental Health Days

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

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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]

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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

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

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

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

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

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

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

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

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

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

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

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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.

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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.

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Reason for Ranking

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

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

Income Inequality

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

Reason for Ranking

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

Children in Single-Parent Households

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

Reason for Ranking

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

Violent Crime Rate

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

Reason for Ranking

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

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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

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- 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.

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Appendix E – Youth Behavioral Risk Survey Results

Youth Behavioral Risk Survey Results
North Dakota High School Survey
Rate Increase "↑" rate decrease "↓", or no statistical change = in rate from 2017-2019

	ND 2015	ND 2017	ND 2019	ND Trend ↑, ↓, =	Rural ND Town Average	Urban ND Town Average	National Average 2019
Injury and Violence							
Percentage of students who rarely or never wore a seat belt (when riding in a car driven by someone else)	8.5	8.1	5.9	=	8.8	5.4	6.5
Percentage of students who rode in a vehicle with a driver who had been drinking alcohol (one or more times during the 30 prior to the survey)	17.7	16.5	14.2	=	17.7	12.7	16.7
Percentage of students who talked on a cell phone while driving (on at least one day during the 30 days before the survey, among students who drove a car or other vehicle)	NA	56.2	59.6	=	60.7	60.7	NA
Percentage of students who texted or e-mailed while driving a car or other vehicle (on at least one day during the 30 days before the survey, among students who had driven a car or other vehicle during the 30 days before the survey)	57.6	52.6	53.0	=	56.5	51.8	39.0
Percentage of students who never or rarely wore a helmet (during the 12 months before the survey, among students who rode a motorcycle)	NA	20.6	NA	**NA**	NA	NA	NA
Percentage of students who carried a weapon on school property (such as a gun, knife, or club on at least one day during the 30 days before the survey)	5.2	5.9	4.9	=	6.2	4.2	2.8
Percentage of students who were in a physical fight on school property (one or more times during the 12 months before the survey)	5.4	7.2	7.1	=	7.4	6.4	8.0
Percentage of students who experienced sexual violence (being forced by anyone to do sexual things [counting such things as kissing, touching, or being physically forced to have sexual intercourse] that they did not want to, one or more times during the 12 months before the survey)	NA	8.7	9.2	=	7.1	8.0	10.8
Percentage of students who experienced physical dating violence (one or more times during the 12 months before the survey, including being hit, slammed into something, or injured with an object or weapon on purpose by someone they were dating or going out with among students who dated or went out with someone during the 12 months before the survey)	7.6	NA	NA	**NA**	NA	NA	8.2
Percentage of students who have been the victim of teasing or name calling because someone thought they were gay, lesbian, or bisexual (during the 12 months before the survey)	NA	11.4	11.6	=	12.6	11.4	NA
Percentage of students who were bullied on school property (during the 12 months before the survey)	24.0	24.3	19.9	↓	24.6	19.1	19.5
Percentage of students who were electronically bullied (including being bullied through texting, Instagram, Facebook, or other social media during the 12 months before the survey)	15.9	18.8	14.7	↓	16.0	15.3	15.7
Percentage of students who felt sad or hopeless (almost every day for two or more weeks in a row so that they stopped doing some usual activities during the 12 months before the survey)	27.2	28.9	30.5	=	31.8	33.1	36.7
	ND 2015	ND 2017	ND 2019	ND Trend ↑, ↓, =	Rural ND Town Average	Urban ND Town Average	National Average 2019
Percentage of students who seriously considered attempting suicide (during the 12 months before the survey)	16.2	16.7	18.8	=	18.6	19.7	18.8
Percentage of students who made a plan about how they would attempt suicide (during the 12 months before the survey)	13.5	14.5	15.3	=	16.3	16.0	15.7
Percentage of students who attempted suicide (one or more times during the 12 months before the survey)							
Tobacco Use							
Percentage of students who ever tried cigarette smoking (even one or two puffs)	35.1	30.5	29.3	=	32.4	23.8	24.1

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Percentage of students who smoked a whole cigarette before age 13 years (even one or two puffs)	NA	11.2	NA	**NA**	NA	NA	NA
Percentage of students who currently smoked cigarettes (on at least one day during the 30 days before the survey)	11.7	12.6	8.3	↓	10.9	7.3	6.0
Percentage of students who currently frequently smoked cigarettes (on 20 or more days during the 30 days before the survey)	4.3	3.8	2.1	↓	2.3	1.7	1.3
Percentage of students who currently smoked cigarettes daily (on all 30 days during the 30 days before the survey)	3.2	3.0	1.4	↓	1.6	1.2	1.1
Percentage of students who usually obtained their own cigarettes by buying them in a store or gas station (during the 30 days before the survey among students who currently smoked cigarettes and who were aged <18 years)	NA	7.5	13.2	=	9.4	10.1	8.1
Percentage of students who tried to quit smoking cigarettes (among students who currently smoked cigarettes during the 12 months before the survey)	NA	50.3	54.0	=	52.8	51.4	NA
Percentage of students who currently use an electronic vapor product (e-cigarettes, vape e-cigars, e-pipes, vape pipes, vaping pens, e-hookahs, and hookah pens at least one day during the 30 days before the survey)	22.3	20.6	33.1	↑	32.2	31.9	32.7
Percentage of students who currently used smokeless tobacco (chewing tobacco, snuff, or dip on at least one day during the 30 days before the survey)	NA	8.0	4.5	↓	5.7	3.8	3.8
Percentage of students who currently smoked cigars (cigars, cigarillos, or little cigars on at least one day during the 30 days before the survey)	9.2	8.2	5.2	↓	6.3	4.3	5.7
Percentage of students who currently used cigarettes, cigars, or smokeless tobacco (on at least one day during the 30 days before the survey)							
Alcohol and Other Drug Use							
Percentage of students who ever drank alcohol (at least one drink of alcohol on at least one day during their life)	62.1	59.2	56.6	=	60.6	54.0	NA
Percentage of students who drank alcohol before age 13 years (for the first time other than a few sips)	12.4	14.5	12.9	=	16.4	13.2	15.0
Percentage of students who currently drank alcohol (at least one drink of alcohol on at least one day during the 30 days before the survey)	30.8	29.1	27.6	=	29.4	25.4	29.2
Percentage of students who currently were binge drinking (four or more drinks of alcohol in a row for female students, five or more for male students within a couple of hours on at least one day during the 30 days before the survey)	NA	16.4	15.6	=	17.2	14.0	13.7
Percentage of students who usually obtained the alcohol they drank by someone giving it to them (among students who currently drank alcohol)	41.3	37.7	NA	**NA**	NA	NA	40.5
	ND 2013	ND 2017	ND 2019	ND Trend ↑, ↓, =	Rural ND Town Average	Urban ND Town Average	National Average 2019
Percentage of students who tried marijuana before age 13 years (for the first time)	5.3	5.6	5.0	=	5.5	5.1	5.6
Percentage of students who currently used marijuana (one or more times during the 30 days before the survey)	15.2	15.5	12.5	=	11.4	14.1	21.7
Percentage of students who ever took prescription pain medicine without a doctor's prescription or differently than how a doctor told them to use it (counting drugs such as codeine, Vicodin, OxyContin, Hydrocodone, and Percocet, one or more times during their life)	NA	14.4	14.5	=	12.8	13.3	14.3
Percentage of students who were offered, sold, or given an illegal drug on school property (during the 12 months before the survey)							
Percentage of students who attended school under the influence of alcohol or other drugs (on at least one day during the 30 days before the survey)	NA	NA	NA	NA	NA	NA	NA
Sexual Behaviors							
Percentage of students who ever had sexual intercourse							

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Percentage of students who had sexual intercourse before age 13 years (for the first time)	2.6	2.8	NA	NA	NA	NA	3.0
Weight Management and Dietary Behaviors							
Percentage of students who were overweight (>= 85th percentile but <95th percentile for body mass index, based on sex and age-specific reference data from the 2000 CDC growth chart)	14.7	16.1	16.5	=	16.6	15.6	16.1
Percentage of students who had obesity (>= 95th percentile for body mass index, based on sex- and age-specific reference data from the 2000 CDC growth chart)	13.9	14.9	14.0	=	17.4	14.0	15.5
Percentage of students who described themselves as slightly or very overweight	32.2	31.4	32.6	=	35.7	33.0	32.4
Percentage of students who were trying to lose weight	NA	44.5	44.7	=	46.8	45.5	NA
Percentage of students who did not eat fruit or drink 100% fruit juices (during the seven days before the survey)	3.9	4.9	6.1	=	5.8	5.3	6.3
Percentage of students who ate fruit or drank 100% fruit juices one or more times per day (during the seven days before the survey)	NA	61.2	54.1	↓	54.1	57.2	NA
Percentage of students who did not eat vegetables (green salad, potatoes [excluding French fries, fried potatoes, or potato chips], carrots, or other vegetables, during the seven days before the survey)	4.7	5.1	6.6	=	5.3	6.6	7.9
Percentage of students who ate vegetables one or more times per day (green salad, potatoes [excluding French fries, fried potatoes, or potato chips], carrots, or other vegetables, during the seven days before the survey)	NA	60.9	57.1	↓	58.2	59.1	NA
Percentage of students who did not drink a can, bottle, or glass of soda or pop (such as Coke, Pepsi, or Sprite, not including diet soda or diet pop, during the seven days before the survey)	NA	28.8	28.1	=	26.4	30.5	NA
Percentage of students who drank a can, bottle, or glass of soda or pop one or more times per day (not including diet soda or diet pop, during the seven days before the survey)	18.7	16.3	15.9	=	17.4	15.1	15.1
Percentage of students who did not drink milk (during the seven days before the survey)	13.9	14.9	20.5	↑	14.8	20.3	30.6
Percentage of students who drank two or more glasses per day of milk (during the seven days before the survey)	NA	33.9	NA	NA	NA	NA	NA
Percentage of students who did not eat breakfast (during the seven days before the survey)							
Percentage of students who most of the time or always went hungry because there was not enough food in their home (during the 30 days before the survey)	NA	2.7	2.8	=	2.1	2.9	NA
	ND 2015	ND 2017	ND 2019	ND Trend ↑, ↓, =	Rural ND Town Average	Urban ND Town Average	National Average 2019
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 seven days before the survey)							
Percentage of students who watched television three or more hours per day (on an average school day)	18.9	18.8	18.8	=	18.3	18.2	19.8
Percentage of students who played video or computer games or used a computer three or more hours per day (counting time spent on things such as Xbox, PlayStation, an iPad or other tablet, a smartphone, texting, YouTube, Instagram, Facebook, or other social media, for something that was not school work on an average school day)	38.6	43.9	45.3	=	48.3	45.9	46.1
Other							
Percentage of students who had eight or more hours of sleep (on an average school night)	NA	31.8	29.5	=	31.8	33.1	NA

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Appendix F – Prioritization of Community's Health Needs

Community Health Needs Assessment
Carrington, North Dakota
Ranking of Concerns

The top concerns for each of the six topic areas, based on the community survey results, were listed on flipcharts. The numbers below indicate the total number of votes (dots) by the people in attendance at the second community meeting. The "Priorities" column lists the number of 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		
Enough child daycare services	8	4
Attract & retain young families	4	
Not enough affordable housing	3	
Recycling	1	
AVAILABILITY/DELIVERY OF HEALTH SERVICES CONCERNS		
Ability to retain primary care providers & nurses	13	5
Availability of primary care providers & nurses	1	
Extra hours for appointments (ex. Evenings/weekends)	3	
Availability of specialists	2	
YOUTH POPULATION HEALTH CONCERNS		
Alcohol use & abuse (all ages)		
Drug use & abuse (include prescription drugs) (all ages)		
Depression & anxiety (included in mental health) (all ages)		
Suicide (included in mental health) (all ages)		
Smoking & tobacco use, exposure to second hand smoke, vaping	0	
ADULT POPULATION HEALTH CONCERNS		
Alcohol use & abuse (all ages)	5	0
Drug use & abuse (includes prescription drugs) (all ages)	0	
Mental Health (includes depression/anxiety/suicide/stress (all ages)	16	7
Stress (included in mental health) (all ages)		
SENIOR POPULATION HEALTH CONCERNS		
Being able to meet the needs of older population	1	
Cost of long-term/nursing home options	0	
Assisted living options	0	
Availability of resources to help elderly stay in their homes	4	
Depression/Anxiety (all ages)		
VIOLENCE CONCERNS		
Bulling/Cyber-bulling	2	
Child abuse/neglect	1	
Emotional abuse (isolation, verbal threats, withholding $)	0	
Domestic/intimate partner violence	0	

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Appendix G – Survey "Other" Responses

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

1. Considering the PEOPLE in your community, the best things are: "Other" responses:
    - I am too new to the community to make a decision
    - None of the above
    - Unfortunately, you can't make a difference in this community*. They are not willing to put in ANY work to make changes to help better this community. There is ONLY one who is willing to listen*. The rest are part of the good old boys club.
2. Considering the SERVICES AND RESOURCES in your community, the best things are: "Other" responses:
    - I live in a small-town population around 200 our town has a post office bar\restaurant. we go 13 miles to get everything and most everyone works there also.
    - Thankfully some of the businesses are open extended hours
3. Considering the QUALITY OF LIFE in your community, the best things are: "Other" responses:
    - Crime would be even less if the police wouldn't let them off so easy
    - health care access
4. Considering the ACTIVITIES in your community, the best things are: "Other" responses:
    - Library
    - Lots of things to do if you are willing help or volunteer
    - We have something's during the year but mostly we drive to Carrington for things.

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:
    - Anti vaxers
    - Decreasing number of community-involved people
    - Healthcare, more physicians
    - Mental health resources
    - Need quality rentals for families
    - Not enough activities for adults
    - Underage drinking and vaping
6. Considering the AVAILABILITY/DELIVERY OF HEALTH SERVICES in your community, concerns are: "Other" responses:
    - Availability of Naturopath services
    - I am using Carrington because that's where I go for services
    - Overreach of county health authority
    - Respect care is needed
    - The workers at the health center all seem miserable and unhappy

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

- Bullying
- Culture of excellence and respect in schools
- Lots of kids with parents who are lousy role models. Not working, always in trouble with law, etc...
- Mental health help, anxiety, stress, etc
- Not enough activities outside of sports and church
- Online safety (specifically regarding social media)
- Plan lazy the kids are

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

- Having to keep up with the Jones'
- Loneliness/ very clicky groups, it's hard to make friends
- Not health related but ones that don't work and then have too many kids
- Rides to out of town health care.
- Too much emphasis on sports.

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

- Lack of caregivers for LTC
- The overreach and control of locking up people in nursing homes & assisted living
- Updated senior center with more activities

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

- (7) Alcohol abuse
- Alcohol abuse. Also mental health issues - asking for help, getting help, etc.
- (7) Drug use
- The bars are open to late and people driving drunk and nothing being done to stop it. Cops are nowhere to be found when bars closed. The youth learn from the behavior of their parents. Parents allowing underage children to drink in the homes and host parties.
- Educating our teens on vaping and alcohol and teaching them that you don't do things because someone wants you to. I think they should know when you leave and go to college etc you leave find new friends so don't let someone else influence who you are and what you do. A real friend won't pressure you to do anything you don't want to do. I think we need to be more real and truthful about life and people.
- The long-term effects that result from substance use (child abuse and neglect, poor brain development, poor academic achievement, legal trouble, etc.).
- Not enough medical staff who do their job
- Attracting and retaining health care providers.
- Getting a MD to come here and stay because of the administration of our hospital/clinic services. Not able to keep them on staff. I personally know of a few doctors that would want to come to the Carrington/Foster County area that will not because of this.
- Health care. There is only one doctor at the clinic I go to. That's just nuts! I have not a clue how he manages his own physical/mental self. In fact, I have noticed he seems to be wearing out.
- Also, for some of us, it's near impossible to find rides for appointments far away. Most health issues require out of town doctor appointments."
- Retaining physicians
- We need Drs
- Affordable Housing
- Getting our businesses back to normal after shut downs that should NEVER have happened!!

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- Close minded city councilmen.
- Good paying jobs
- Out migration of people to larger cities. Lack of economic development to attract or keep residents
- Taxes preventing businesses from coming or expanding. They would bring better paying jobs.
- (3) People not willing to work causing staffing issues.
- People who don't work or who just use the system and then bring others as well. People not from here and don't invest in community but just come "hide out" it seems.
- (4) Lack of childcare
- City Government future challenge will be finding the resources to replace our aging storm water and sanitary sewer systems.
- How about the sewers backing up when it rains really hard
- Lack of vision that is what is lacking in this State, No new tech. transportation, or any other advancement. A high-speed rail system for one would open up a cornucopia for the people of this state from jobs to housing. Just think of getting from one side of the state to the other in less than an hour, shipping emergency supplies, or just a part for a machine that would take a day to otherwise get know you can have it in half that time. Housing could be expanded in small community if you could have a safe and speedy commute to and from work and home. To have safe and cost-efficient mass transit system that we could all us opens up off shoot business like lift services, electric car rentals and other like services. As far as I'm concern until we can get around the state a lot faster we'll keep two steps behind other developed countries.
- Having enough to do for kids in the winter.
- Not being inclusive of all, discrimination
- Racism and discrimination
- Not enough younger adult leaders who are willing to get involves/ be involved /lead and or volunteer in civic organizations
- Small, cliquey town that doesn't welcome those that aren't from here
- (2) Out migration of people to larger cities. Lack of economic development to attract or keep residents
- Getting people involved in community. People want more to do, but few are willing to do the work to make it happen
- People are prejudiced.
- (5) Ability to retain young families.
- Quality rental units, that are safe and well-maintained
- Access to adequate mental health options.
- Mental health
- (3) Suicide
- Depression & anxiety in our youth.
- bullying involving children and adults
- emotional abuse
- How can you have a park board that no one holds them accountable?!?!? Why is there not a push for a pool for our youth and aging adults?!?! Who really is in charge of checks and balance with this board? Why is there not term limits? Nothing but adult bullies!!
- People are overly busy. No time for families to be together at home

Delivery of Healthcare

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

- I call and ask.
- I work there.
- Transportation

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

- Health and wellness coaches; personal diet program and exercise
- Phone line to call and ask health related questions. Just simple things such as nutrition questions
- Mental Health
- Mental health counseling
- more mental health resources
- Psychologist, Physical Therapist, and Dietician
- Youth mental health programs
- Dermatology, more options for therapists
- At least one more doctor.
- More MD level providers
- More MD's, people who care about the health and we'll bring of their patients
- Maternity / baby delivery
- Cardiac rehab
- Cardiac Rehab should be available, along with more access to specialists
- Dermatology, more options for therapists
- Access to Specialists; non-emergent weekend care
- More availability of specialists (dermatology, pediatric ortho)
- More telemedicine, driving to Bismarck for a consultation is ridiculous.
- Occupational therapy, speech therapist
- Saturday clinic
- Weekend hours
- Immunizations in the clinic for well child checks
- Naturopath doctor
- No comment - perhaps home healthcare
- None
- None, get great care now.

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

- I am a patient at another facility.
- (3) Nothing prevents me getting great health care at CHI
- Plain and simple I don't trust the current providers and seek other clinics to take my family to
- Unsure

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

- VA

18. Have you supported the CHI St. Alexius Health Carrington Foundation in any of the following ways?

- Attending the gala
- (2) Fundraisers
- Gala attended
- I have only been here 3 weeks
- Items for auction

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19. Why was CHI St. Alexius Health Carrington Clinic not used?

- Haven't needed in this past year
- I drive to Fargo for health services. They are far better.
- My primary is no longer here.
- Really don't want people in community knowing/talking about what I was there for.
- They let my doctor go so followed him to Harvey

20. Why was CHI St. Alexius Health New Rockford Clinic not used?

- (6) Did not need
- Get in to Carrington clinic if needed
- Have clinic in Carrington to use.
- I drive to Fargo. Services are better.
- Not aware of provider
- Rather support my own community

21. Would you use an afterhours/evening clinic for you or your child to receive scheduled vaccinations or annual flu shots?

- I don't have children
- Maybe
- Na
- Not at county health. Won't go there anymore due to their overreach of power during the "pandemic "

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

- CONFIDENTIALLY! When you're in the hallway and hear remarks they are making about why a person is there. I would rather drive the hour to Jamestown because they treat you with kindness and don't judge you. People only seek care if they feel they need to and when you are treated poorly makes it hard to come back here. They get paid for their service so why make the patient feel horrible that they came in.
- We've had multiple instances where why we're being seen in the clinic has been shared with people before we are interested in sharing. We've also had a few times where we have been seen by a dr and been told our child who has a fever is just teething, and the same day we go to a dr in another town and we are told they have double ear infections, sinus infections etc. it's frustrating confidentiality is not taken seriously, and that drs a quick to assume teething because they are at the appropriate age.
- Terrible management at CHI. I feel employees are leaving because of it.
- The lab is awful. They don't read instructions and orders correctly. I've had to take my daughter in 3 times and every time have had to take her back because they messed up her draw. The providers don't care or listen to me as a mom. I had my daughter in twice for a yeast infection and they said everything was fine. Took her to another Dr and it was so bad, it was all over her body and had to be put on very strong antibiotics. The quality and care is sub-par at best and I will do everything I can to not have to go there.
- The professionalism and access to health care are reasons we retired in Carrington. Very happy with my PA and all staff. Had a bad experience with one lab person during a blood draw, they hit a nerve in my arm and didn't seem to care. Otherwise, five stars for CHI.
- It would be nice to have a list of all available services offered by all healthcare facilities within our community. Easy access/easy to find resources would decrease the chances of putting off an appointment or exam until "later".
- Not aimed at Carrington but all Healthcare entities .....make appointments easier to get. It shouldn't take so long to get appt and then if an additional test or person is needed to be seen it sometimes takes another week or 2. Offer evening and weekend appts so we do t have to take so much time off. Streamline systems so can see more than 1 person in a day.

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- CHI St. Alexius in Carrington needs to work better with the VA about their programs and how to bill, where to send the bill. Community care, emergency care.
- Elderly need more especially for our veterans. In most cases they get taken advantage of or they do not get the help they need. The community needs to look out for drugs/alcohol.
- I think having some options after working hours for people who work full time to get into the doctor and get their kids into the doctor.
- Need at least one doctor at CHI Carrington. It's shameful that there is only one doctor to cover such as large area. I also wish there was some sort of transportation to get to large cities for health care. I am 77 and don't do very well at driving long distances. Example, I have 2 appointments in 3 days in Fargo the end of this month and dread the trips.
- Although I am satisfied with care I've received here, my husband has many chronic conditions that we feel need oversight by a physician and there is only one in Carrington.
- For a small community, we have a good healthcare facility. Additional doctors would be good. When I came here, we had 3. Now only have 1.
- Get more doctors
- I don't want to pay to see an NP or PA, I go to the doctor to see a doctor
- (3) More MD's not PA or NP but Medical Doctors.
- Not overly concerned except for the shrinking staff. We need our clinic and local doctors.
- We need to attract and retain doctors! If we burn out the one MD we have, what is the backup plan?
- I think our local healthcare workers and facility are doing an excellent job taking care of our area and community
- I'm completely satisfied with the present delivery of all the health services in our community.
- Why is this written in the negative? We have fantastic providers and the community is lucky to have them and the hospital in Carrington. Public Health does a good job too.
- Carrington Health Center is no longer involved in the community and does not contribute to other groups in the community. They do not send representatives to sit on boards or participate in other organizations. They expect the community to donate and support the hospital and clinic, however, they do not support in the community in the same way. For example, the President does not shop locally and use the pharmacies, car dealership, grocery store, etc. The organization uses purchasing contracts so they do not shop locally either. The hospital also does not uphold the mission of compassion and caring. They discriminated against COVID-19 patients during their time of need when tests were available. They also required COVID-19 patients to pay for a clinic visit when patients did not need a clinic visit and only needed a test. They are more concerned with money then doing what is best for the community during the pandemic.
- Stop holding diabetic medication hostage! On account someone doesn't come in every 3 months!

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