Community Health Needs Assessment

CHI St. Alexius Health Dickinson (Stark County) Service Area

Dickinson, North Dakota

2022

Nicole Threadgold, MBA, Project Coordinator
Holly Long, BS, Project Coordinator
Kylie Nissen, BBA, CHA, Program Director

The board of directors for CHI St. Alexius Health Dickinson approved this Community Health Needs Assessment in March 2022.

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

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Executive Summary

To help inform future decisions and strategic planning, CHI St. Alexius Health Dickinson Medical Center 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. Two hundred twenty-seven residents in the service area completed the survey. Additional information was collected through six key informant interviews with community members. The input from the residents, who primarily reside in Stark 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, Stark County's population from 2010 to 2019 increased by 30.1%. The average number of residents under age 18 (27.1%) for Stark County comes in 3.6 percentage points higher than the North Dakota average (23.5%). The percentage of residents, ages 65 and older, is 1.4% lower for Stark County (13.9%) than the North Dakota average (15.3%), and the rate of education is slightly lower for Stark County (90.5%) than the North Dakota average (92.5%). The median household income in Stark County ($72,045) is higher than the state average for North Dakota ($63,473).

Data, compiled by County Health Rankings, shows Stark County is doing worse than North Dakota in health outcomes/factors for four categories; and Stark County is doing better than North Dakota in health outcomes/factors for seven categories.

Of 106 potential community and health needs set forth in the survey, the 227 CHI St. Alexius Health Dickinson Medical Center service area residents who completed the survey indicated the following ten needs as the most important:

- Availability of mental health services
- Alcohol use and abuse – Adult
- Availability of specialists
- Availability of resources to help the elderly stay in their homes
- Drug use and abuse - Youth
- Cost of long-term/nursing home care
- Depression/anxiety – Youth and Adult
- Having enough child daycare services
- Not enough affordable housing
- Bullying/cyberbullying

The survey also revealed the biggest barriers to receiving healthcare (as perceived by community members). They included not enough specialists (N=74), not able to get appointment/limited hours (N=52), and not enough providers (N=41).

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

- Safe place to live
- Family friendly
- People are friendly, helpful, and supportive
- Year-round access to fitness opportunities
- Recreational and sports activities
- Active faith community

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:

- Alcohol use and abuse
- Availability of mental health services
- Having enough child daycare services
- Not enough affordable housing
- Not enough jobs with livable wages, not enough to live on

Overview and Community Resources

With assistance from CRH at the UNDSMHS, CHI St. Alexius Health Dickinson Medical Center completed a CHNA of their service area. The hospital identifies its service area as Stark, Golden Valley, Dunn, Billings, Morton, Slope, Hettinger, Bowman, and Adams Counties in North Dakota as well as the eastern edge of Montana and northwestern edge of South Dakota. Many community members and stakeholders worked together on the assessment, including Southwestern District Health Unit (SWDHU). The Dickinson area has a number of community assets and resources that are potentially available to address significant health needs.

Dickinson is located in the southwest quadrant of North Dakota, approximately 65 miles from both the Montana and South Dakota borders. It is less than an hour drive from Lake Sakakawea, the largest of the mainstream reservoirs on the Missouri River, which provides fishing, camping, and other recreation. Dickinson's economy is based primarily on the oil and gas industry, agriculture, manufacturing, professional and other services, and retail. Dickinson is home to Dickinson State University, a four-year public university with an in-person enrollment of nearly 1,000 students and more than 800 additional online students.

The city's public education system includes the following: a high school, junior high, and five elementary schools; private schools serving the community are Hope Christian Academy and Dickinson Catholic Schools, consisting of two elementary schools and a high school.

Dickinson's five largest employers are Dickinson Public Schools; Steffes Corporation; Dickinson State University; Killdeer Mountain Manufacturing; and CHI St. Alexius Heath Dickinson Medical Center.

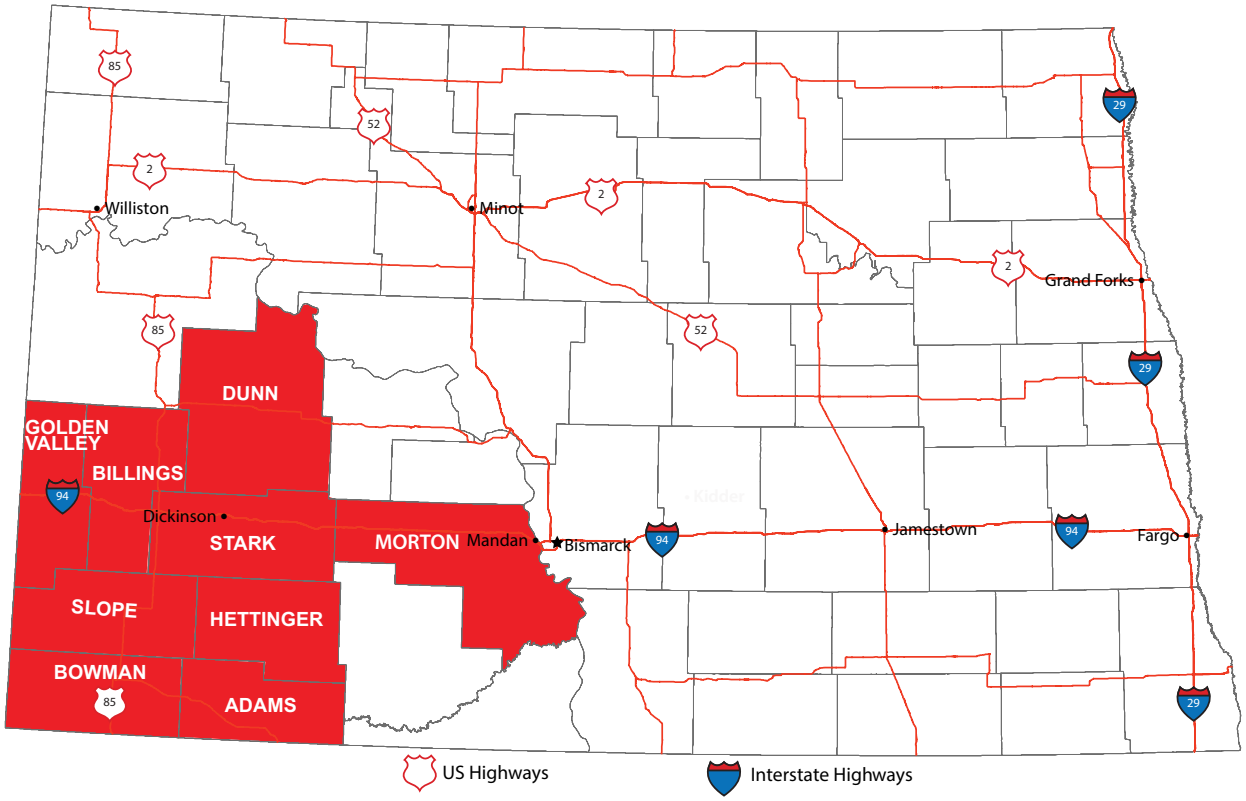
To address the area's need for quality, skilled workers, a Southwest Career and Technical Education Academy is actively being developed. Dickinson Public Schools, Dickinson State University, Trinity Catholic Schools, and the Roughrider Area Career and Technical Center have teamed up to create a task force and initiate the program. High school and college students will have the opportunity to enroll, starting in August 2022.

Dickinson Park District offers 31 developed parks, nine future park areas, and pedestrian trails. Also available are an 18-hole golf course, two disc-golf courses, Patterson Lake Recreation Area, and nearby hunting, fishing, and camping. Coming to Dickinson in 2022 is Friendship Park, an inclusive playground, designed with

consideration for children with special needs, such as wheeled mobility, sensory issues, hearing and vision impairment, and compromised immune systems. The West River Community Center is a 135,000-square-foot fitness facility that features an indoor pool, golf room, climbing wall, indoor tennis courts and track, basketball courts, racquetball courts, strength and cardiovascular equipment, and free weights. For children, it offers an indoor playground, childcare services, water slides, and other aquatic play areas.

As illustrated in Figure 1, CHI St. Alexius Health Dickinson Medical Center and SWDHU are located in southwestern North Dakota. The medical center and SWDH unit are both located in the city of Dickinson, Stark County. Both serve the nine counties in the southwest corner of North Dakota. Zip codes in the service area include: 58541, 58580, 58601, 58621, 58622, 58624, 58623, 58625, 58626, 58630, 58631, 58632, 58634, 58636, 58638, 58639, 58640, 58641, 58642, 58643, 58645, 58646, 58647, 58649, 58650, 58651, 58652, 58653, 58654, 58656, 58757, 58562, 58835, 58847, 58854, and 59270.

Figure 1: Stark, Dunn, Golden Valley, Billings, Morton, Slope, Hettinger, Bowman and Adams Counties



CHI St. Alexius Health Dickinson Medical Center

CHI St. Alexius Health Dickinson Medical Center, located in Dickinson, North Dakota, is a 25-bed, Critical Access Hospital (CAH) with a Level IV Trauma Center, accredited by the American College of Surgeons and The Joint Commission (TJC). CHI St. Alexius Health constructed a new, state-of-the-art replacement hospital facility, which opened in 2014. The hospital and adjacent medical clinic are located in the same facility at 2500 Fairway Street in Dickinson. It also administers clinic services at the rural family clinic in Beach, North Dakota. CHI St. Alexius Health Dickinson Medical Center, in 2021, earned a 5-star overall quality rating from CMS (Centers for Medicare & Medicaid Services). The CAH profile for CHI St. Alexius Health Dickinson Medical Center, which includes a summary of hospital-specific information, is available in Appendix A.

CHI St. Alexius Health Dickinson Medical Center is part of CommonSpirit Health, a nonprofit, Catholic health system, created in February 2019 by Catholic Health Initiatives and Dignity Health.

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. With a team of approximately 125,000 employees and 25,000 physicians and advanced practice clinicians, CommonSpirit Health operates 137 hospitals and more than 1000 care sites across 21 states. In FY 2020, Catholic Health Initiatives and Dignity Health had combined revenues of nearly $29.6 billion and provided $4.6 billion in charity care, community benefit, and unreimbursed government programs.

Mission
As CommonSpirit Health, 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.

Values
Our values at CommonSpirit Health are the core principles that enable and inspire us to deliver humankindness: Compassion, Inclusion, Integrity, Excellence and Collaboration.

Vision
A healthier future for all – inspired by faith, driven by innovation, and powered by our humanity.

Dickinson is the only hospital in a 100-mile radius, offering Level IV trauma services, including care for stroke, cardiac, and burns as well as serving as the tertiary center for hospital services in southwestern North Dakota. Dickinson has increased its population by about 40% over the past three years with the median age steadily decreasing as the population becomes younger. CHI St. Alexius Health Dickinson Medical Center provides outreach to its communities through programs, such as the Wibaux County Blood Draw in Wibaux, Montana, and Mammos and Mochas, a special Saturday event at which patients can schedule an annual mammogram.

CHI St. Alexius Health Dickinson Foundation supports the hospital and clinics by advancing its healthcare-related programs and supporting technology important to improved care for patients. Recently, the Foundation's purchase of the Mako SmartRobotics System (robotic-arm assisted technology for orthopaedic surgeries) has made a positive impact on precision and quality outcomes for patients undergoing joint replacement surgeries here.

Services offered locally by CHI St. Alexius Health Dickinson Medical Center include:

General and Acute Services

- 24/7 emergency care
  - Level IV trauma center
  - Medical helicopter
- Acute care services
  - Medical/surgical/pediatric unit
  - Intensive care unit
- Cardiac and pulmonary
- Clinical dietitian
  - Diabetic education
- Kidney dialysis
- Laboratory services
- Obstetrics
  - Labor & delivery
  - Breastfeeding classes and breastfeeding clinic
  - Childbirth classes
  - Level II nursery
- Rehab services
  - Physical therapy
  - Occupational therapy
  - Industrial medicine
  - Speech therapy
  - Wound care
  - Aquatic therapy
- Rehabilitation and gym
  - Silver Sneakers location
- Respiratory care
- Sleep diagnostics program
- Spiritual care services

- Surgical services
  - Endoscopy
  - Laparoscopy
  - OB/GYN
  - Orthopaedic
  - Cataract & eye procedures

14. Additional services
  - Lefty's Café
  - Gift shop
  - Chapel
  - Coffee shop

Clinic Services

- Allergy shots
- Clinical dietitian
  - Diabetic education
- Cosmetic services
- Family medicine
- Genetic screening
- Internal medicine
- Orthopaedic
- Pediatrics
- Radiology services
- Surgical care
- Tobacco cessation program
- Visiting specialists
  - Mental health via telehealth
  - Nephrology
  - Cardiology
  - Pediatric neurology
  - Orthotics
  - Employee Assistance Program
  - Pelvic bladder care
  - Pediatric asthma clinic via telehealth
- Women's health
  - OB/GYN
  - Centering Pregnancy Prenatal Program
  - InterSTIM procedures
  - Botox cosmetic
  - Laser hair removal and skin rejuvenation
  - Juvederm dermal fillers

Screening/Therapy Services

- Chiropractic services
- Chronic disease management
- Holter monitoring
- Laboratory services
- Lower extremity circulatory assessment
- Occupational physicals
- Occupational therapy
- Pediatric services
- Physical therapy
- Respiratory care
- Sleep studies
- Social services

Radiology Services

- Bone density
- Breast MRI
- Cardiac stress tests
- Contrast enhanced mammography
- Echocardiograms
- EKG
- MRI
- Routine diagnostics (x-rays)
- Stereotactic breast biopsies
- Nuclear medicine
- Ultrasound
- Wide angle 3D mammography
- 128-slice CT scanner
- 3D prenatal ultrasound

Laboratory Services

- Blood types
- Chemistry
- Clot times
- Drug screening
- Hematology
- Urine testing

Services offered by OTHER providers/organizations

- Ambulance
- Chiropractic services
- Cryotherapy
- Dental services
- Dermatology
- Massage therapy
- Nutritional guidance
- Optometric/vision services
- Physical therapy
- Podiatry

Southwestern District Health Unit

Southwestern District Health Unit (SWDHU) is located in Dickinson and provides a variety of services and programs that maintain or improve the health status of the general population and their environment.

SWDHU's role in the community became highly visible at the onset of the COVID-19 pandemic, when SWDHU leadership and staff became frontline staff in testing, educating, and vaccinating the public.

Specific services that SWDHU provides are:

- Alcohol prevention
- Bicycle helmet safety
- Blood pressure checks
- Breastfeeding resources
- Car seat program
- Child health (well baby checks)
- Correction facility health
- Diabetes screening
- Emergency preparedness and response services-work with community partners as part of local emergency response team; training and exercise
- Environmental health services (water, sewer, health hazard abatement)
- Flu shots
- Health maintenance (services for those 60 years and older)
- Health Tracks (child health screening)
- Home health
- Immunizations, including travel international vaccines
- Medication setup-home visits
- Member of child protection team
- Newborn home visits
- Nutrition education
- Office visits and consults
- Preschool education programs & screening
- Ryan White/AIDS
- School health-- vision, hearing, in school nursing, health education and resource to the schools
- Suicide screening
- Telemedicine for psychiatric services
- Tobacco prevention and control
- Tuberculosis testing and management
- Vector control
- West Nile program-surveillance and education
- WIC (Women, Infants, and Children) program
- Women's Way
- Worksite Wellness-Community Partners
- Youth education

Assessment Process

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

A CHNA benefits the community by:

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

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

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

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

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

This assessment examines health needs and concerns in the nine-county service area of CHI St. Alexis Health Dickinson Medical Center and SWDHU. Those counties are Adams, Billings, Bowman, Dunn, Golden Valley, Hettinger, Morton, Slope, and Stark. Parts of McKenzie County are also served. Towns and cities located in the services area include Dickinson, Beach, Killdeer, Watford City, New England, Bowman, Hettinger, and New England.

CRH, in partnership with CHI St. Alexius Health Dickinson Medical Center and SWDHU, 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 CHI St. Alexius Health Dickinson Medical Center. A small steering committee (see Figure 2) was formed and was responsible for planning and implementing the process locally. Representatives from CRH met and corresponded regularly by teleconference and/or via the eToolkit with the CHNA liaison. The community group (described in more detail below) provided in-depth information and informed the assessment process in terms of community perceptions, community resources, community needs, and ideas for improving the health of the population and healthcare services. Twenty people, representing a cross section demographically, attended the focus group meeting. The meeting was highly interactive with good participation. CHI St. Alexius Health Dickinson Medical Center staff and board members were in attendance as well but largely played a role of listening and learning.

Figure 2: Steering Committee

Sherry Adams	Executive Director, Southwest District Health Unit
DeeAnna Opstedahl	Interim President, CHI St. Alexius Health Dickinson Medical Center
Kayla Kleinjan	Interim CNO, CHI St. Alexius Health Dickinson Medical Center
John Odermann	Manager of Mission and Ancillary Services, CHI St. Alexius Health Dickinson Medical Center

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.

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. 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 their 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.

Members of the community group and the key informants represented the broad interests of the community, served by CHI St. Alexius Health Dickinson Medical Center and SWDHU. They included representatives of the health community, business community, agriculture, economic development, 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.

Community Group

A community group, consisting of 20 community members, was convened and first met on July 27, 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.

The community group met again on September 23, 2021, with 15 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 Stark County. The group was then tasked with identifying and prioritizing the community's health needs.

Interviews

One-on-one interviews with six key informants were conducted in person in Dickinson on July 27, 2021. A representative from CRH conducted the interviews. Interviews were held with selected members of the

community who could provide insights into the community's health needs. Included among the informants were public health professionals with special knowledge in public health, acquired through several years of direct experience in the community, including working with medically underserved, low income, and minority populations as well as with populations with chronic diseases.

Topics, covered during the interviews, included the general health needs of the community, the general health of the community, community concerns, delivery of 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 Stark County, CHI St. Alexius Health Dickinson Medical Center's main service area. The survey tool was designed to:

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

Specifically, the survey covered the following topics:

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

To promote awareness of the assessment process, press releases led to published articles in the Dickinson Press newspaper. Additionally, information was published on CHI St. Alexius Health Dickinson Medical Center's website and Facebook page.

Approximately 50 paper surveys were available for distribution in Stark County. To help ensure anonymity, included with each survey was a postage-paid return envelope to CRH. The survey period ran from July 12, 2021 to July 30, 2021. Zero completed paper surveys were returned.

Area residents were also given the option of completing an online version of the survey, which was publicized in the Dickinson Press, featured in a story on KFYR-TV, emailed to at least 21 community groups, and on the websites and Facebook pages of both CHI St. Alexius Health Dickinson Medical Center and SWDHU. **Two hundred forty online surveys were completed with 227 being analyzed. Eleven of those online respondents used the QR code to complete the survey. This equates to a 10% response rate, which is slightly below the average response rate of 13% for this type of unsolicited survey methodology.**

Secondary Data

Secondary data was collected and analyzed to provide descriptions of: (1) population demographics, (2) general health issues (including any population groups with particular health issues), and (3) contributing causes of community health issues. Data was collected from a variety of sources, including the United States 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); 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); and Youth Risk Behavior Surveillance System (YRBSS) data, which is published by the Centers for Disease Control and Prevention (https://www.cdc.gov/healthyyouth/data/yrbs/index.htm).

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 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.

There are numerous models that depict the 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

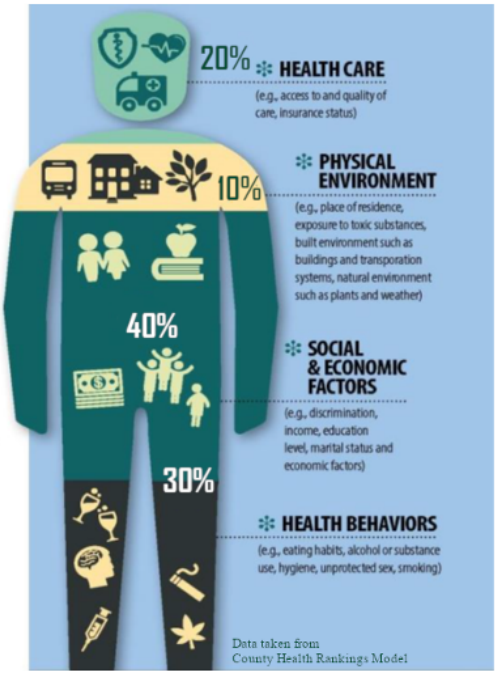


Figure 4 (Henry J. Kaiser Family Foundation, https://www.kff.org/disparities-policy/issue-brief/beyond-health-care-the-role-of-social-determinants-in-promoting-health-and-health-equity/), provides examples of factors that are included in each of the social determinants of health categories that lead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

Figure 4: Social Determinants of Health

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

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

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Health Equity and COVID-19 Assessments for Southwestern District Health Unit, which includes Stark County

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 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 June 22, June 24, June 25, and July 6, 2021, Southwestern District Health Unity conducted meetings to determine the COVID-19 perceptions and immunization needs of Stark, Adams, Billings, Bowman, Golden Valley, Hettinger, Slope, and Dunn Counties.

COVID-19 in Stark County

When COVID-19 vaccine became available at the end of December 2020, the partners worked diligently together to get the vaccine out to the priority groups. SWDHU helped coordinate with providers to make sure the limited vaccine doses were available throughout the region.

The groups had similar findings with just a few variances. The group members were very calm, informed, and engaged in the discussion. Below are the findings to the questions:

Concerns that were heard, regarding COVID-19 vaccine

- Want to have children---worried causes infertility
- It was made too fast/not enough safety measures
- Worried will have long-term side effects from the vaccine
- It causes myocarditis
- New way of making the vaccine not done before
- Bad side effects
- Tribal thinking-"remember smallpox"

Misinformation about COVID-19 vaccine

- You can get COVID from the vaccine
- It changes your DNA
- Implanting a chip to track you
- I had COVID I don't need the shot
- Don't need it-government ploy
- A+ blood type---can't get COVID
- Too many heavy metals in vaccine-magnets can stick to your arm
- No one really died from COVID-just from underlying conditions

Why did people want to get vaccinated?

- Tired of isolation and tired of masks
- Loved one died from COVID or seriously ill from it
- Want life to be "normal"
- Want to travel
- Know "long-haulers"
- Want to see family
- Get away from lockdown
- Be a good example to my community

Why are people against the COVID-19 vaccine?

- Politics trumped science
- "You are vaccinated, so I don't need to"
- It was made too fast and not studied enough
- Better to have natural immunity
- Young can fight it off---no need to vaccinate
- Against all vaccines
- Too bad of side effects
- Want children
- Don't want to be ostracized by community or family-politically
- COVID has a 99.98% survival rate---doesn't make you that sick

Current Strategies

To Date: 13,364 doses of the COVID-19 vaccine have been given throughout the eight-county region.

	Adolescents 12-17 years of age as of July 12, 2021				
COUNTY	Adolescents 12-17 with >=1 dose of COVID vaccine	12-17 Population (NDIIS)	12-17 Population (2019 Census)	% Adolescents 12-17 with >=1 dose (NDIIS denominator)	% Adolescents 12-17 with >=1 dose (2019 Census denominator)
ADAMS	8	140	145	5.7%	5.5%
BILLINGS	2	32	52	6.3%	3.8%
BOWMAN	8	239	247	3.3%	3.2%
DUNN	5	226	331	2.2%	1.5%
GOLDEN VALLEY	8	167	157	4.8%	5.1%
HETTINGER	7	189	182	3.7%	3.8%
SLOPE		21	48	0.0%	0.0%
STARK	180	2,652	2,505	6.8%	7.2%
TOTALS	218	3,666	55,355	5.9%	0.4%

***2019 Census denominator is calculated for age as of 7/1/2019. NDIIS denominator is calculated for age as of today's date.*

COUNTY	Adults 18-64 years of age as of July 12, 2021				
	Adults 18-64 with >=1 dose of COVID vaccine	18-64 Population (NDIIS)	18-64 Population (2019 Census)	% Adults 18-64 with >=1 dose (NDIIS denominator)	% Adults 18-64 with >=1 dose (2019 Census denominator)
ADAMS	438	1,190	1,157	36.8%	37.9%
BILLINGS	99	252	524	39.3%	18.9%
BOWMAN	448	1,616	1,615	27.7%	27.7%
DUNN	436	2,068	2,600	21.1%	16.8%
GOLDEN VALLEY	197	919	928	21.4%	21.2%
HETTINGER	386	1,536	1,320	25.1%	29.2%
SLOPE	28	133	420	21.1%	6.7%
STARK	5,672	20,330	18,569	27.9%	30.5%
TOTALS	7,704	28,044	27,133	27.5%	28.4%

COUNTY	Adults 65-74 years of age as of July 12, 2021				
	Adults 65-74 with >=1 dose of COVID vaccine	65-74 Population (NDIIS)	65-74 Population (2019 Census)	% Adults 65-74 with >=1 dose (NDIIS denominator)	% Adults 65-74 with >=1 dose (2019 Census denominator)
ADAMS	234	329	318	71.1%	73.6%
BILLINGS	34	68	111	50.0%	30.6%
BOWMAN	274	453	346	60.5%	79.2%
DUNN	202	378	400	53.4%	50.5%
GOLDEN VALLEY	135	252	249	53.6%	54.2%
HETTINGER	242	357	272	67.8%	89.0%
SLOPE	25	45	107	55.6%	23.4%
STARK	1,765	2,958	2,271	59.7%	77.7%
TOTALS	2,911	4,840	4,074	60.1%	71.5%

COUNTY	Adults 75 and older as of July 12, 2021				
	Adults 75 plus with >=1 dose of COVID vaccine	75 plus Population (NDIIS)	75 plus Population (2019 Census)	% Adults 75 plus with >=1 dose (NDIIS denominator)	% Adults 75 plus with >=1 dose (2019 Census denominator)
ADAMS	244	337	314	72.4%	77.7%
BILLINGS	20	38	100	52.6%	20.0%
BOWMAN	258	395	325	65.3%	79.4%
DUNN	184	278	314	66.2%	58.6%
GOLDEN VALLEY	107	211	202	50.7%	53.0%
HETTINGER	202	308	279	65.6%	72.4%
SLOPE	19	36	71	52.8%	26.8%
STARK	1,497	2,264	2,101	66.1%	71.3%
TOTALS	2,531	3,867	3,706	65.5%	68.3%

Current strategies that have been implemented to have worked well to date:

- The SW region has worked well together throughout the process-initially referring clients to each other to make sure all doses were used. Later as vaccine became available, the providers worked together to stagger clinic days, so more days were available. Providers also made sure to refer to clinics that had certain vaccine available. They also worked together to make sure various locations were available and covered, such as the university or Wal-Mart.
- SWDHU worked very closely with County Emergency Managers and leaders to set up rotating clinics throughout the eight counties. Emergency Managers helped get various locations and supported the various clinics. The providers took the guidance and lead from what their communities wished and made vaccine available.
- SWDHU worked with Public Transit to provide free rides to any vaccine clinics. Providers also worked together to offer vaccinations to any home-bound person wanting a dose.
- Utilizing all avenues of media to get the word out about the various clinics was also a tool used. It was found, though, the large COVID 19 listserv group was a good source of getting information out as well as advertising on the radio stations every week.
- Some of the minority populations were reached through their employers or through word of mouth. SWDHU was a great avenue for many of the minority groups, as no insurance was needed. Having handouts in Spanish and a translator system in place did help tremendously.
- Having consistent clinics that communities knew to expect also did help, as people knew of dates and times. Allowing for a variety of times also was beneficial.
- Working with each school in the region in May to see if they wanted a vaccine clinic in their school, in their specific town, or using current clinics, but being the messenger also worked well, as it gave them the power to decide.
- Staff called businesses multiple times, offering SWDHU to vaccinate at their business or informing them of clinics. Many agencies were receptive, if they were not pressured.
- SWDHU worked with all LTC agencies that didn't have a provider and was able to get all the residents/ staff vaccinated, returning several times.
- Setting up a Walk-in/ no appointment system helped increase the number of vaccinations, especially with those who didn't have computer access.
- Having the National Guard and many staff trained on the PreMod system helped when there were many people waiting for vaccine. It helped speed up registration.
- Medical providers continue to educate and encourage vaccinations with visits.

Barriers

Even though vaccine has been made available throughout the region, there continues to be vaccine hesitancy among many and in many areas of the southwest. Some identified barriers are as follows:

- Social perception: being seen going to "get a COVID" vaccine is seen as giving in to the system
- With everything opening up and lower cases---perception is that the Pandemic is over
- Especially summer in ND, last thing on people's minds is getting a COVID shot.
- Our biggest barrier is that people in the region are against anything related to COVID, so whether it is testing, masking, or vaccinating, they do not want to hear about it. Politics has overridden Science.

Next Steps

Discussion suggested that it may unfortunately just take time for people to trust taking the vaccine, such as full FDA approval. Others suggest that some may never sway for getting vaccinated, due to strong political/family or religious beliefs. With that population, just continuing to promote the clinics via the various media outlets and continuing to educate, may be the only thing that can be continued.

Health Equity Strategic Plan

Southwestern District Health Unit started its Health Equity Strategic Planning in April 2021 to determine goals for 2021/2023. In the months that followed, the following goals were established, based on information from SWDHU staff, partners, stakeholders, and strategic development consultant and changes affected SWDHU due to:

- Enhance the access to health care for SWDHU citizens
- Enhance presence and capabilities to meet current and future SWDHU community needs
- Enhance vaccine availability and awareness
- Employee ability to more effectively identify early signs and symptoms of public health issues, behavioral health in particular

Inherent ongoing goals were identified and include:

- Focus public health practice to address the determinants of health
- Enhance ability to identify and respond to emerging health issues

SWDHU continues to review and update goals in the objectives to better serve our clients. The goals identified in this strategic health equity plan have been chosen, specifically, to sustain and create growth in SWDHU's operations as well as significantly compliment the menu of services SWDHU offers the fullest extent possible.

Priority 1: Improve Access to HealthCare

- Goal 1: Increase capacity and capabilities to meet public health needs in SW North Dakota.

  o Objective 1: Do a Feasibility Study to acquire a larger facility to increase capacity, staffing, and additional programs for better outreach to SW ND.

    - Whiting Building would increase capacity from 12,500 sq feet to 54,000 square feet.

Priority 2: Increase Vaccine Awareness, Availability, and Rates Throughout SW ND

- Goal 1: Solidify public trust and vaccine hesitancy by providing consistent education and messaging.

  o Objective 1: Solidify public trust on vaccines by using consistent CDC and NDDoH messaging and education through various meetings and media sources.

- Goal 2: Increase COVID, influenza, and other vaccination rates throughout eight county regions in SW ND.

  o Objective 1: Provide access and availability of COVID, flu, and other vaccines to increase rates throughout SW ND.

Priority 3: Build Capacity and Infrastructure to Improve Health Equity

- Goal 1: Increase awareness of behavioral health signs, symptoms, and needs in clients, served by SWDHU.

  o Objective 1: Train staff on various behavioral issues in order to identify needs and refer to appropriate programs.

- Goal 2: Increase staff awareness to health equities.

- o Objective 1: Train employees to address health equities in communities
- Goal 3: Meet with various stakeholders and coalitions to identify gaps in health equity
  - o Objective 1: Increase awareness and ways to address gaps of health equity throughout SW ND.
- Goal 4: Address disparities in SWDHU Emergency Response Plan
  - o Objective 1: Identify known and unknown gaps in Emergency Response Plan by May 1, 2022.

Demographic Information

Table 1: STARK COUNTY: INFORMATION AND DEMOGRAPHICS

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

	Stark County	North Dakota
Population (2019)	31,489	762,062
Population change (2010-2019)	30.1%	13.3%
People per square mile (2010)	18.1	9.7
Persons 65 years or older (2019)	13.9%	15.7%
Persons under 18 years (2019)	27.1%	23.6%
Median age (2019 est.)	34.2	35.1
White persons (2019)	91.7%	86.9%
High school graduates (2019)	90.5%	92.6%
Bachelor's degree or higher (2019)	22.4%	30.0%
Live below poverty line (2019)	8.5%	10.6%
Persons without health insurance, under age 65 years (2019)	6.5%	8.1%
Households with a broadband Internet subscription (2019)	80.2%	80.7%

Source: https://www.census.gov/quickfacts/fact/table/ND,US/INC910216#viewtop and https://data.census.gov/cedsci/profile?g=0400000US38&q=North%20Dakota

As the population of North Dakota has grown in recent years, Stark County has also seen an increase in population since 2010. The U.S. Census Bureau estimates show that Stark County's population increased from 24,199 (2010) to 31,489 (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, Stark County is 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. The 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 Stark County. It is important to note that these statistics describe the population of a county, regardless of where county residents choose to receive their medical care. In other words, all of the following statistics are based on the health behaviors and conditions of the county's residents, not necessarily the patients and clients of CHI St. Alexius Health Dickinson Medical Center and Southwestern District Health Unit 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).

Stark County rankings within the state are included in the summary following. For example, Stark County ranks 10th out of 46 ranked counties in North Dakota on health outcomes and 18th 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 shape 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 show that Stark County is doing equal to or better than many North Dakota counties on all but one of the outcomes (low birth weight). Stark County is meeting or exceeding three of the five outcomes areas when compared to the U.S. Top 10% ratings. Stark County does not meet the U.S. Top 10% ratings for the outcomes of premature death and low birth weight.

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

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

- Premature death
- Poor physical health days
- Poor mental health days
- Food environment index
- Preventable hospital stays
- Unemployment
- Children in poverty
- Income inequality
- Children in single-parent households
- Violent crime
- Injury deaths
- Air pollution – particulate matter

Outcomes and factors in which Stark County is performing poorly, relative to the rest of the state, include:

- Low birth weight
- Adult obesity
- Sexually transmitted infections
- Teen birth weight
- Primary care physician ratio
- Dentist ratio
- Mental health provider ratio
- Social associations

TABLE 2: SELECTED MEASURES FROM COUNTY HEALTH RANKINGS 2021 – STARK 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

	Stark County	U.S. Top 10%	North Dakota
Ranking: Outcomes	**10th**		**(of 46)**
Premature death	6,500 ■	5,400	6,600
Poor or fair health	14% +	14%	14%
Poor physical health days (in past 30 days)	3.1 +	3.4	3.2
Poor mental health days (in past 30 days)	3.5 +	3.8	3.8
Low birth weight	7% ■ ●	6%	6%
Ranking: Factors	**18th**		**(of 45)**
Health Behaviors			
Adult smoking	20% ■	16%	20%
Adult obesity	36% ■ ●	26%	34%
Food environment index (10=best)	9.4 +	8.7	8.9
Physical inactivity	21% ■	19%	23%
Access to exercise opportunities	76% ■	91%	74%
Excessive drinking	24% ■	15%	24%
Alcohol-impaired driving deaths	40% ■	11%	42%
Sexually transmitted infections	493.2 ■ ●	161.2	466.6
Teen birth rate	27 ■ ●	12	20
Clinical Care			
Uninsured	8% ■	6%	8%
Primary care physicians	1,550:1 ● ■	1,030:1	1,300:1
Dentists	2,420:1 ● ■	1,210:1	1,510:1
Mental health providers	610:1 ● ■	270:1	510:1
Preventable hospital stays	3,279 ■	2,565	4,037
Mammography screening (% of Medicare enrollees ages 65-74 receiving screening)	53% ■	51%	53%
Flu vaccinations (% of fee-for-service Medicare enrollees receiving vaccination)	50% ■	55%	50%
Social and Economic Factors			
Unemployment	2% +	2.6%	2.4%
Children in poverty	9% +	10%	11%
Income inequality	4.3 ■	3.7	4.4
Children in single-parent households	12% +	14%	20%
Social associations	10 ● ■	18.2	16.0
Violent crime	151 ■	63	258
Injury deaths	65 ■	59	71
Physical Environment			
Air pollution – particulate matter	4 +	5.2	4.7
Drinking water violations	No		
Severe housing problems	12% ■	9%	12%

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	93.4%	93.4%
Children who spent less than 10 minutes with the provider at a preventive medical visit	18.4%	19.0%
Children (1-17 years) who had preventive a dental visit in the past year	75.4%	79.6%
Children (3-17 years) received mental health care	12.0%	10.4%
Children (3-17 years) with problems requiring treatment did not receive mental health care	1.2%	2.3%
Young children (9-35 mos.) receiving standardized screening for developmental problems	32.6%	36.4 %
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 neighborhoods with parks or playgrounds	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 focus on the main components of children's well-being; more information about KIDS COUNT is available at www.ndkidscount.org. The measures, highlighted in blue in the table, are those in which the counties are doing worse than the state average. The year of the most recent data is noted.

The data show Stark County is performing more poorly than the North Dakota average on only one factor: 4-year high school cohort graduation rate.

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

	Stark County	North Dakota
Child food insecurity, 2019	6.6%	9.6%
Medicaid recipient (% of population age 0-20), 2020	25.6%	26.6%
Children enrolled in Healthy Steps (CHIP) (% of population age 0-18), 2020	1.5%	1.6%
Supplemental Nutrition Assistance Program (SNAP) recipients (% of population age 0-18), 2020	13.6%	16.9%
Licensed childcare capacity (# of children), 2020	1,054	36,701
4-year high school cohort graduation rate, 2019/2020	87.6%	89.0%
Victims of child abuse and neglect requiring services (rate per 1,000 children ages 0-17), 2019	9.01	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 United States. The YRBS was designed to monitor trends, compare state health risk behaviors to national health risk behaviors and intended for use to plan and evaluate as well as 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. They are further broken down by rural and urban percentages. The trend column shows a "=" for statistically insignificant change (no change), "↑" for an increased trend in the data changes from 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.

TABLE 5: Youth Risk Behavior 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
% 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	16.7
% 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
% 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 3 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 who are 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 to which categories these needs belong 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

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

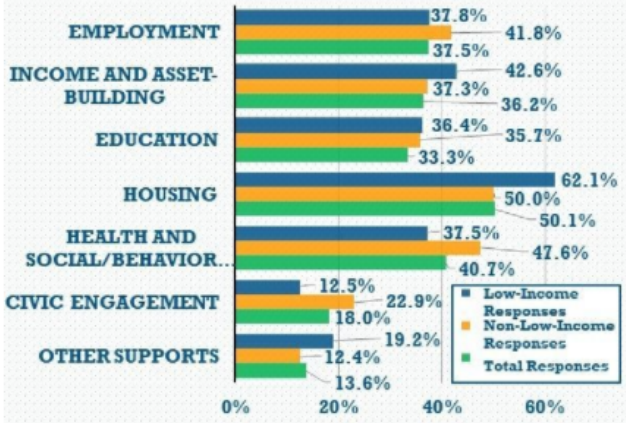
3,458 Total Survey Responses

- **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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info@capnd.org 701-232-2452
https://www.capnd.org/

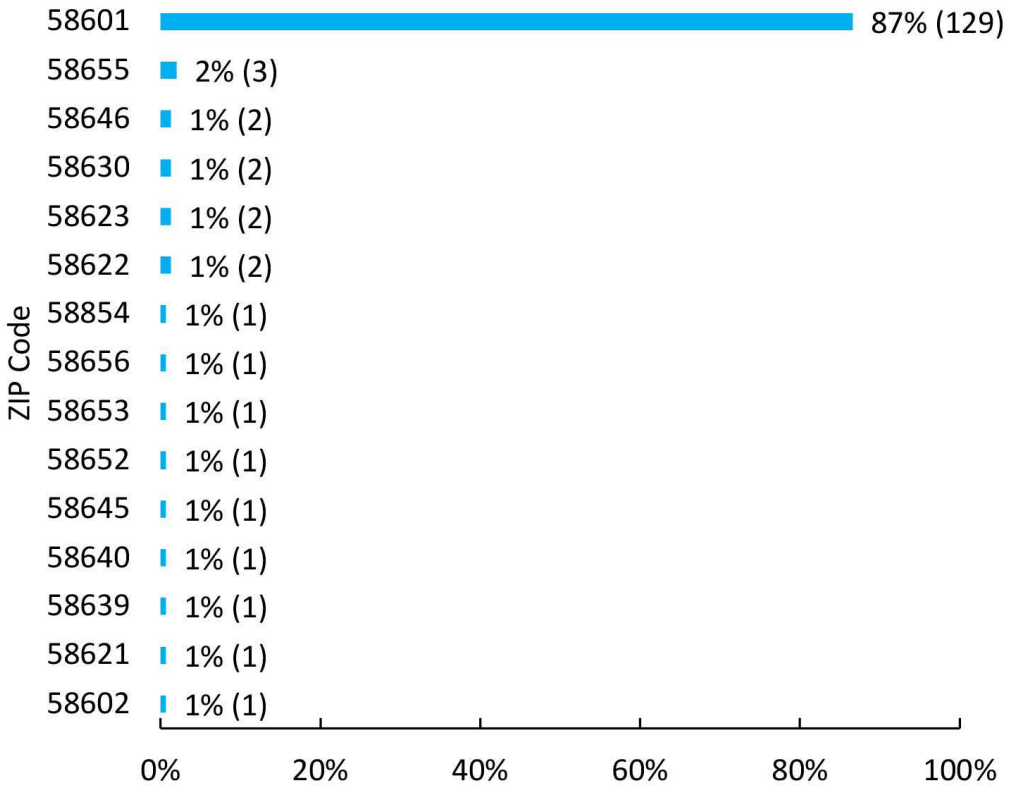
Survey Results

Two hundred forty community members completed the survey in communities throughout the counties in the CHI St. Alexius Health Dickinson Medical Center service area. Two hundred twenty seven of the 240 survey responses were deemed useable and analyzed. 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, 149 did, revealing that a large majority of respondents (87%, N=129) lived in Dickinson. These results are shown in Figure 5.

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.

Figure 5: Survey Respondents' Home Zip Code
Total respondents: 149



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.

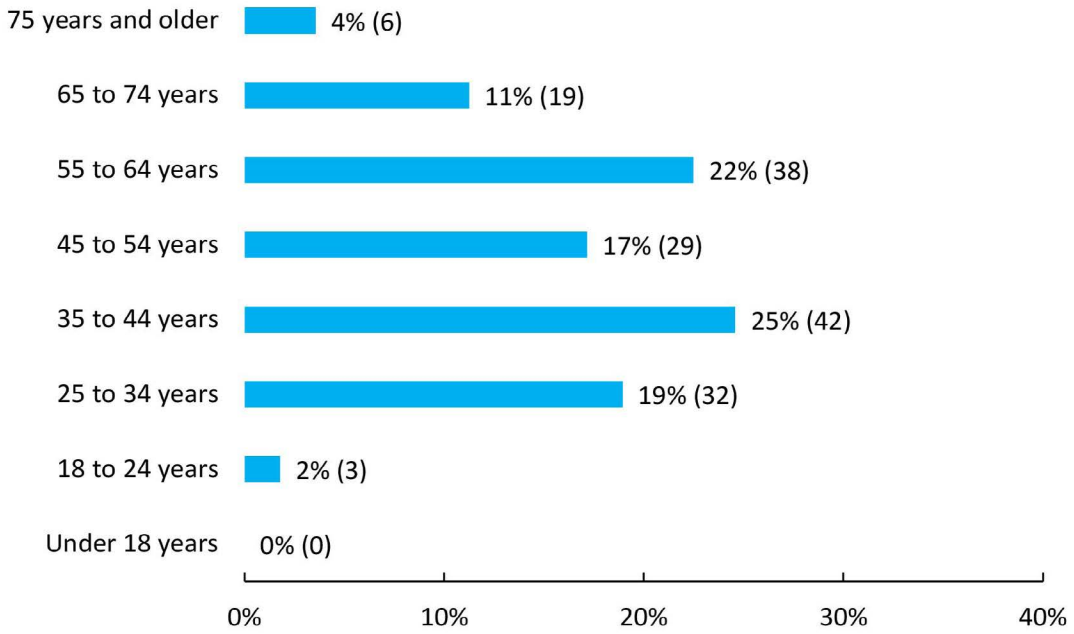
With respect to demographics of those who chose to complete the survey:

- 37% (N=63) were age 55 or older
- The majority (75%, N=125) were female
- More than half of the respondents (68%, N=116) had bachelor's degrees or higher

- The number of those working full time (74%, N=126) was more than seven times higher than those who were retired (10%, N=17)
- 96% (N=163) of those who reported their ethnicity/race were White/Caucasian
- 15% of the population (N=24) had household incomes of less than $50,000

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 of Survey Respondents
Total respondents = 163



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

Figure 7: Gender Demographics of Survey Respondents
Total respondents = 166

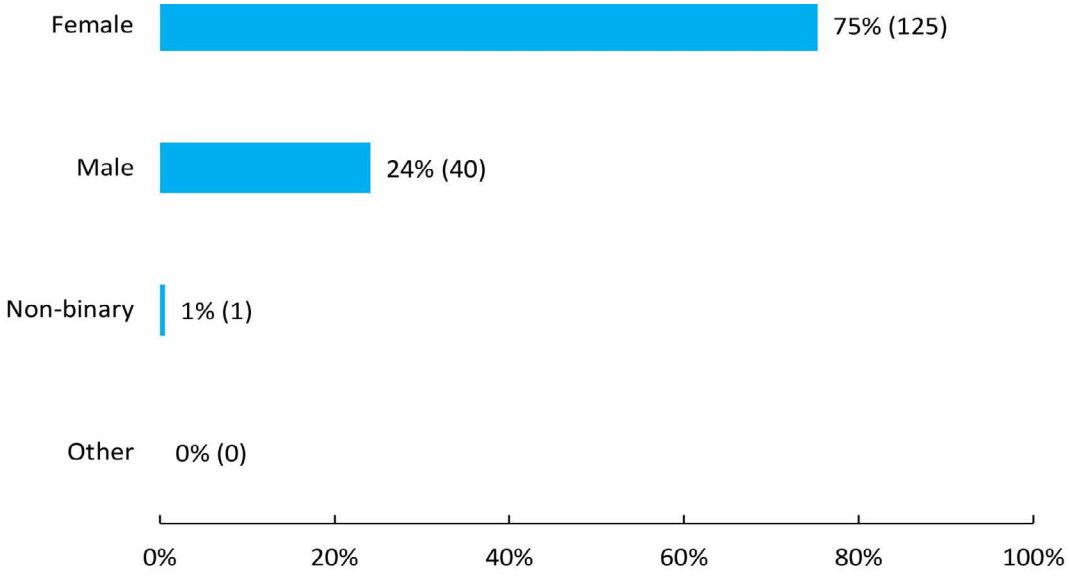


Figure 8: Educational Level Demographics of Survey Respondents
Total respondents = 169

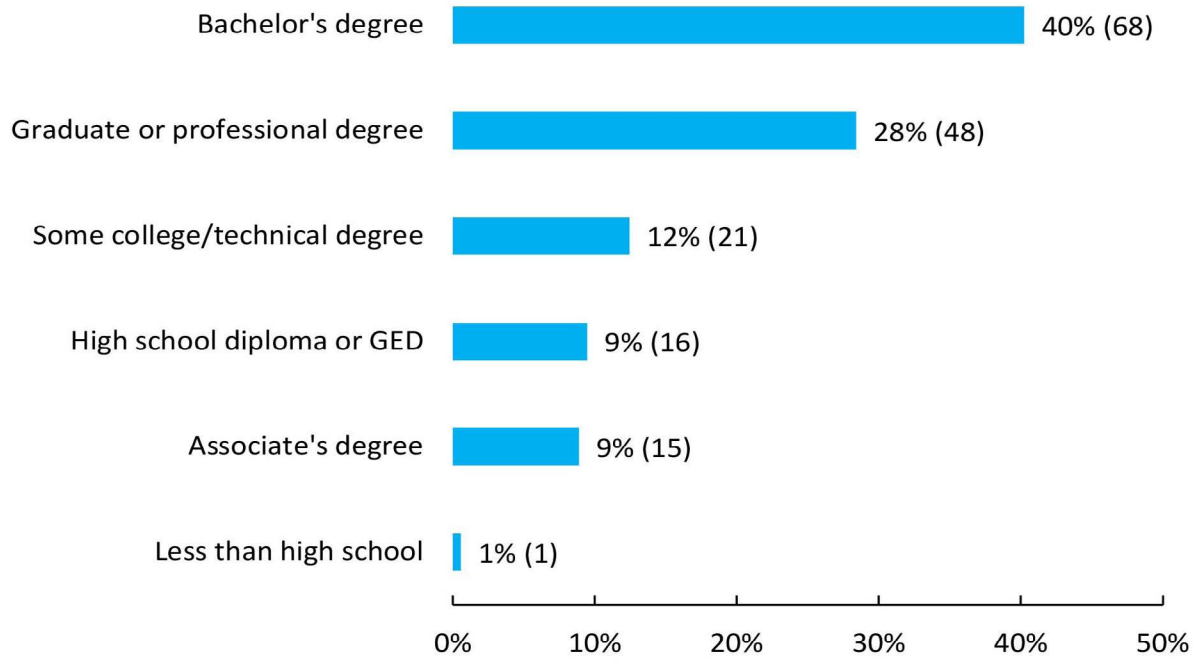
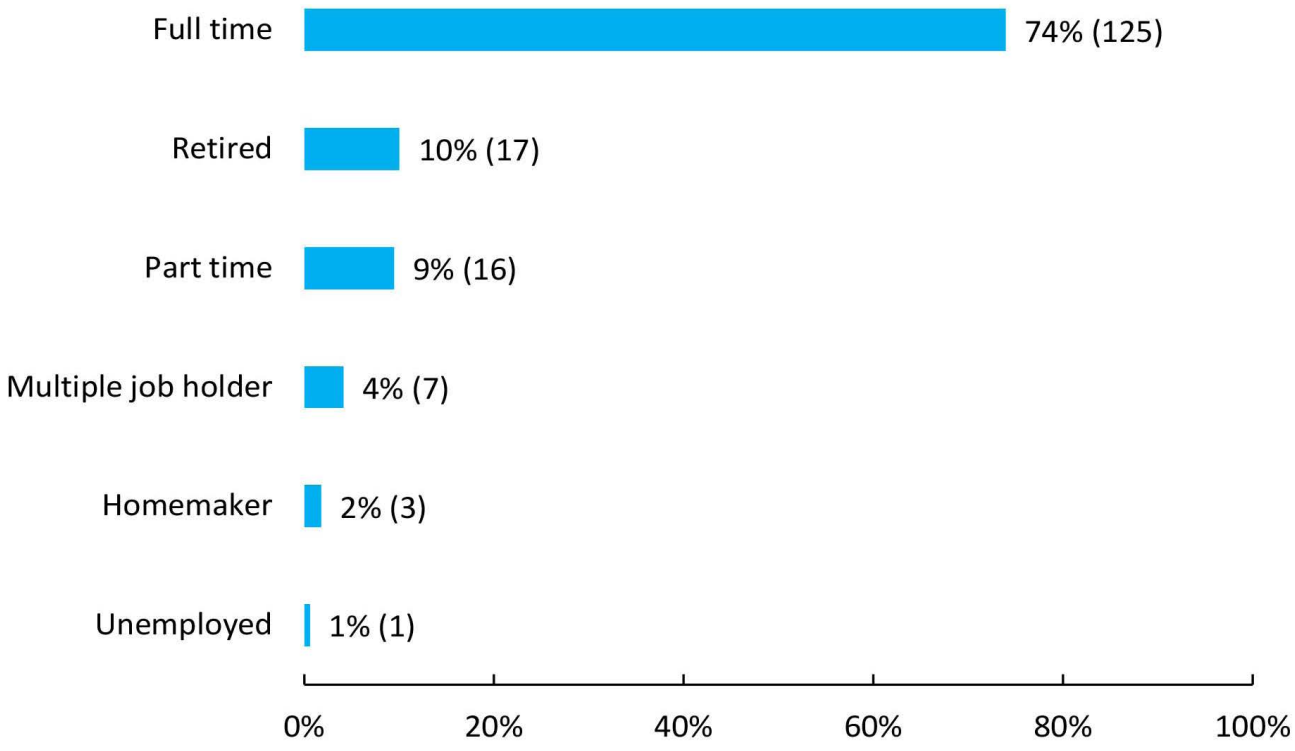
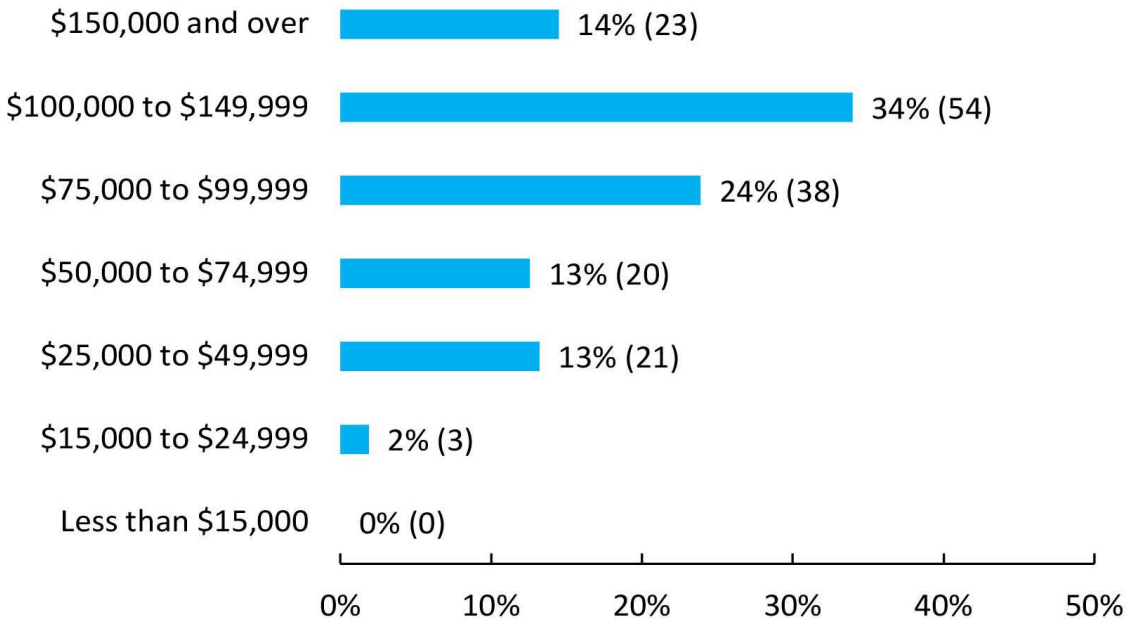


Figure 9: Employment Status Demographics of Survey Respondents
Total respondents = 169



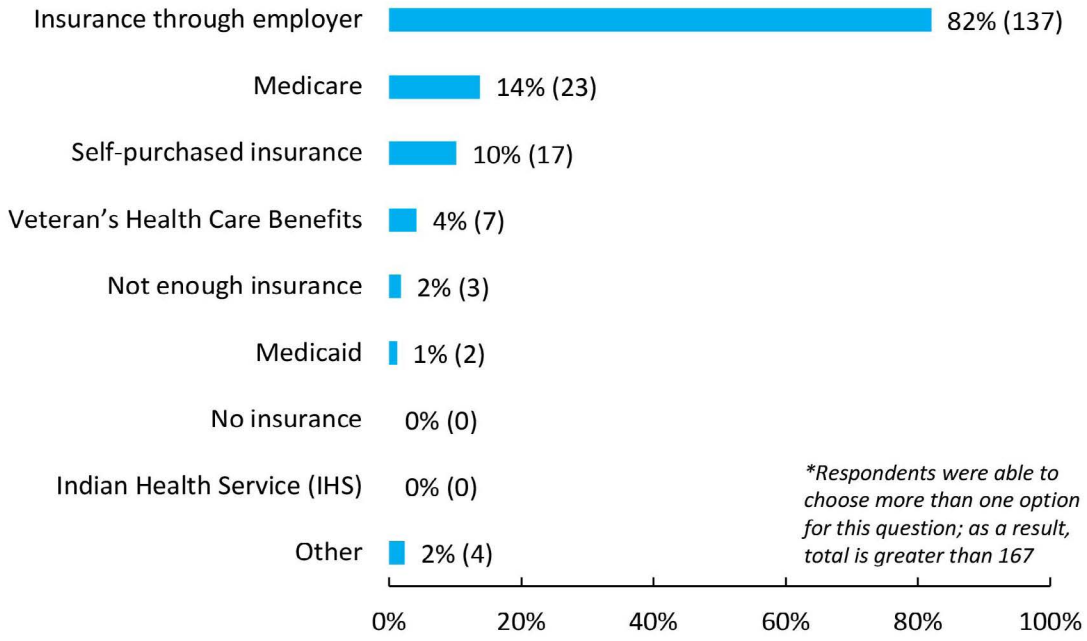
Of those who provided a household income, 2% (N=3) community members reported a household income of less than $25,000. Forty-eight percent (N=77) indicated a household income of $100,000 or more. This information is shown in Figure 10.

Figure 10: Household Income Demographics of Survey Respondents
Total respondents = 159



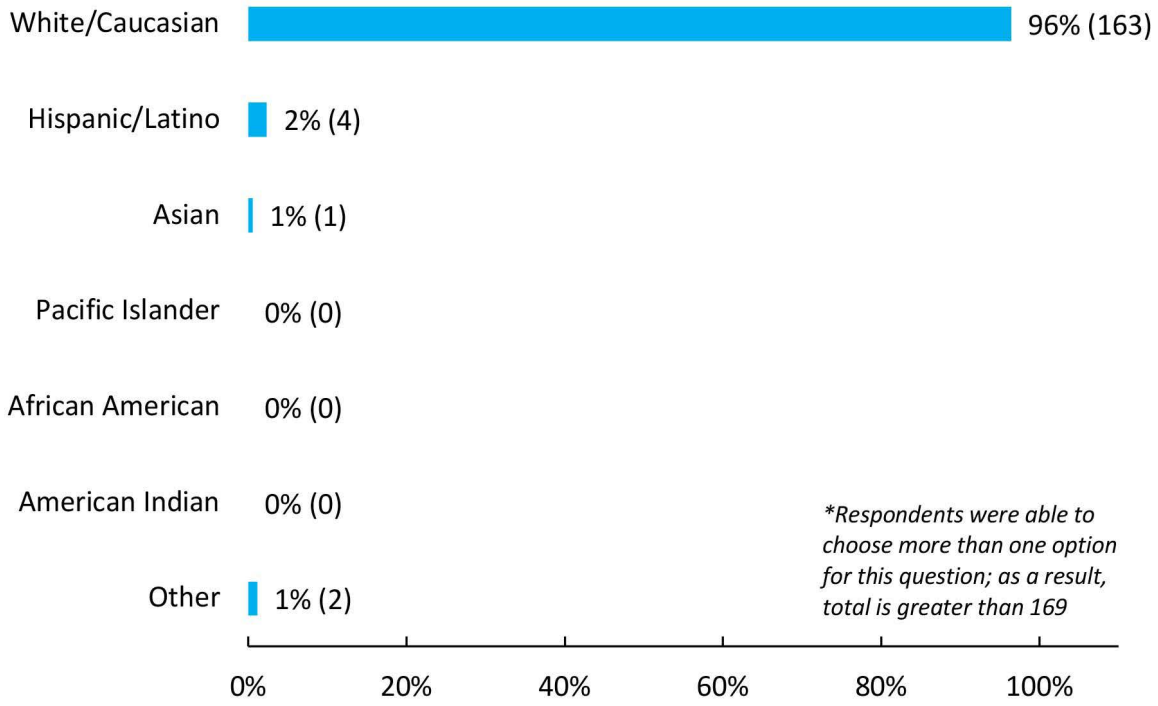
Community members were asked about their health insurance status, which is often associated with whether people have access to healthcare. Two percent (N=3) of the respondents reported being under-insured. The most common insurance types were insurance through one's employer (N=137), followed by Medicare (N=23), and self-purchased (N=17).

Figure 11: Health Insurance Coverage Status of Survey Respondents
Total respondents = 167



As shown in Figure 12, nearly all of the respondents were White/Caucasian (96%). This percent was slightly higher than the race/ethnicity of the overall population of Stark County; the US Census indicates that 91.7% of the population is White/Caucasian in Stark County.

Figure 12: Race/Ethnicity Demographics of Survey Respondents
Total respondents = 169*



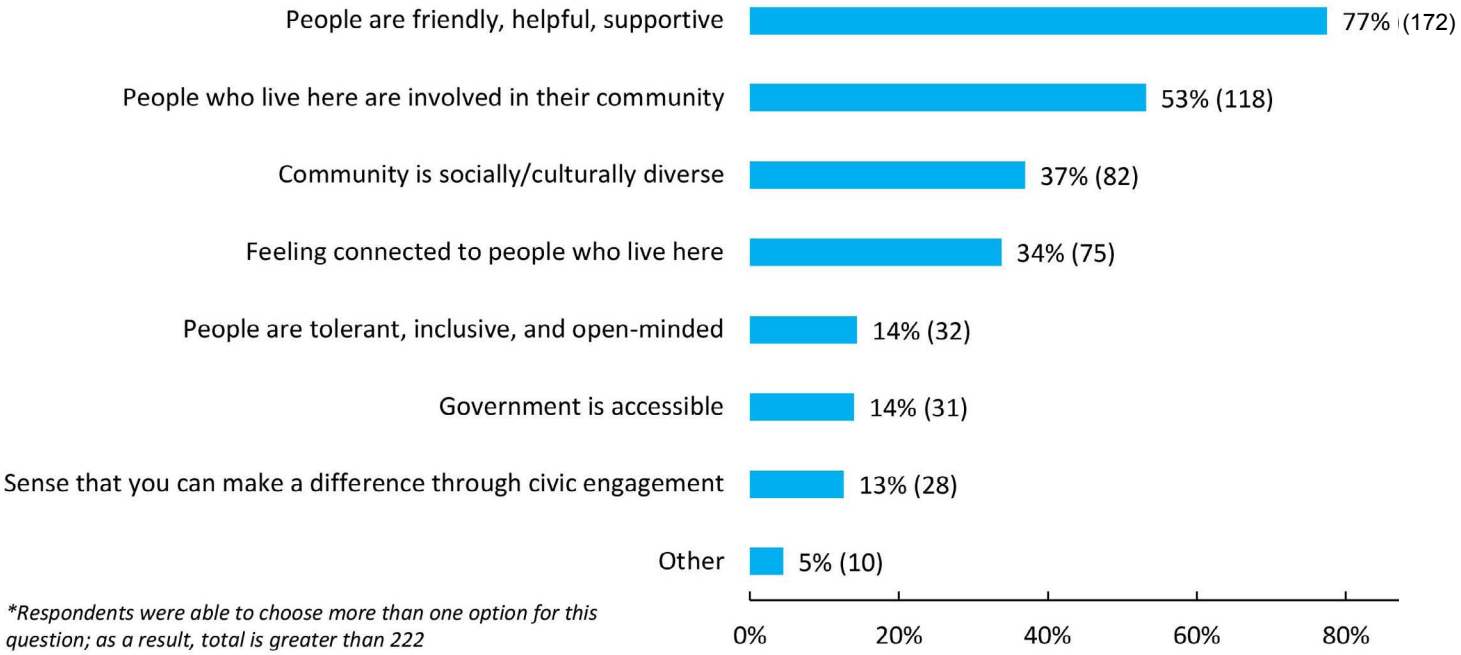
Community Assets and Challenges

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 119 respondents agreeing) that community assets include:

- People are friendly, helpful, supportive (N=172)
- Family-friendly (N=161)
- Year-round access to fitness opportunities (N=145)
- Recreational and sports activities (N=139)
- Safe place to live (N=130)
- Closeness to work & activities (N=125)
- Active faith community (N=119)

Figures 13 to 16 illustrate the results of these questions.

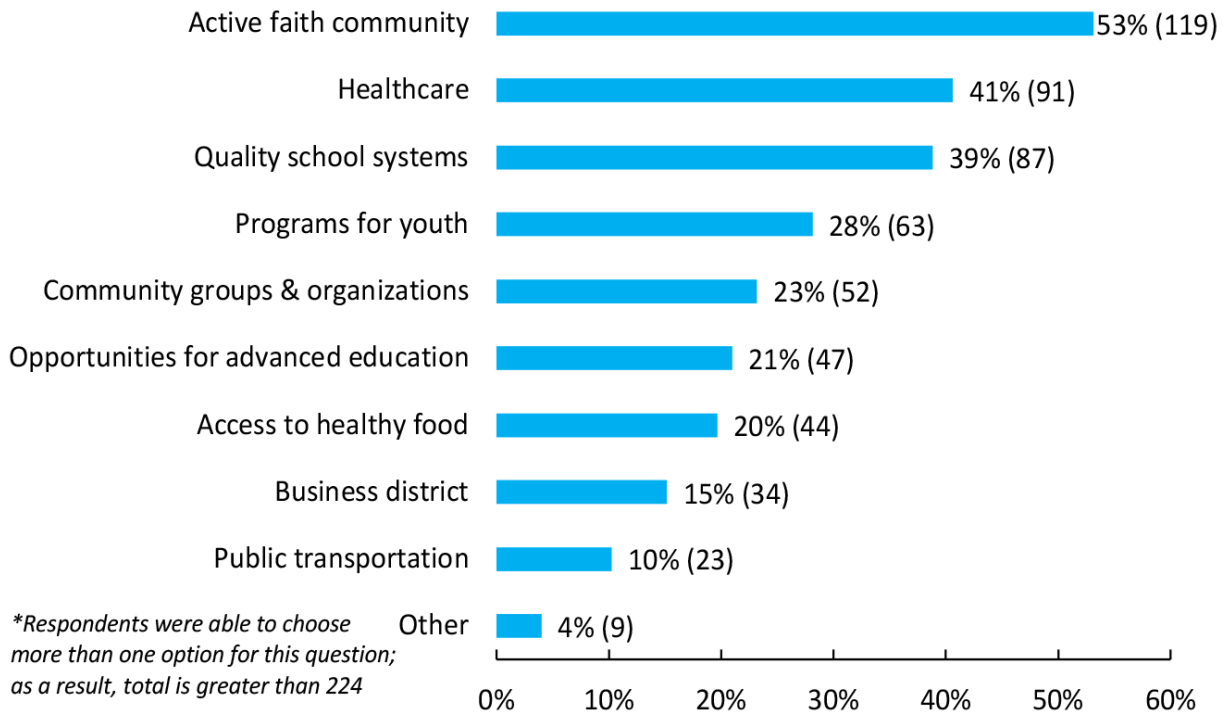
Figure 13: Best Things About the PEOPLE in Your Community
Total responses = 548



**Respondents were able to choose more than one option for this question; as a result, total is greater than 222*

Included in the "Other" category of the best things about the people was the feeling of safety.

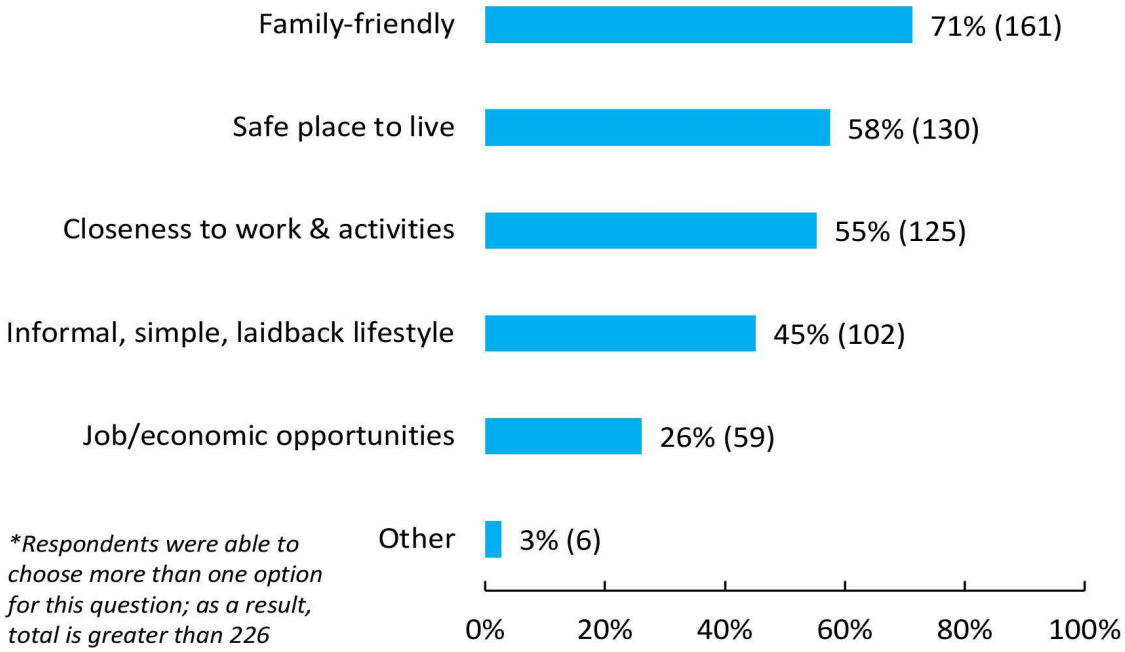
Figure 14: Best Things About the SERVICES AND RESOURCES in Your Community
Total responses = 224*



**Respondents were able to choose more than one option for this question; as a result, total is greater than 224*

Respondents who selected "Other" specified the best things about services and resources included fitness and recreation.

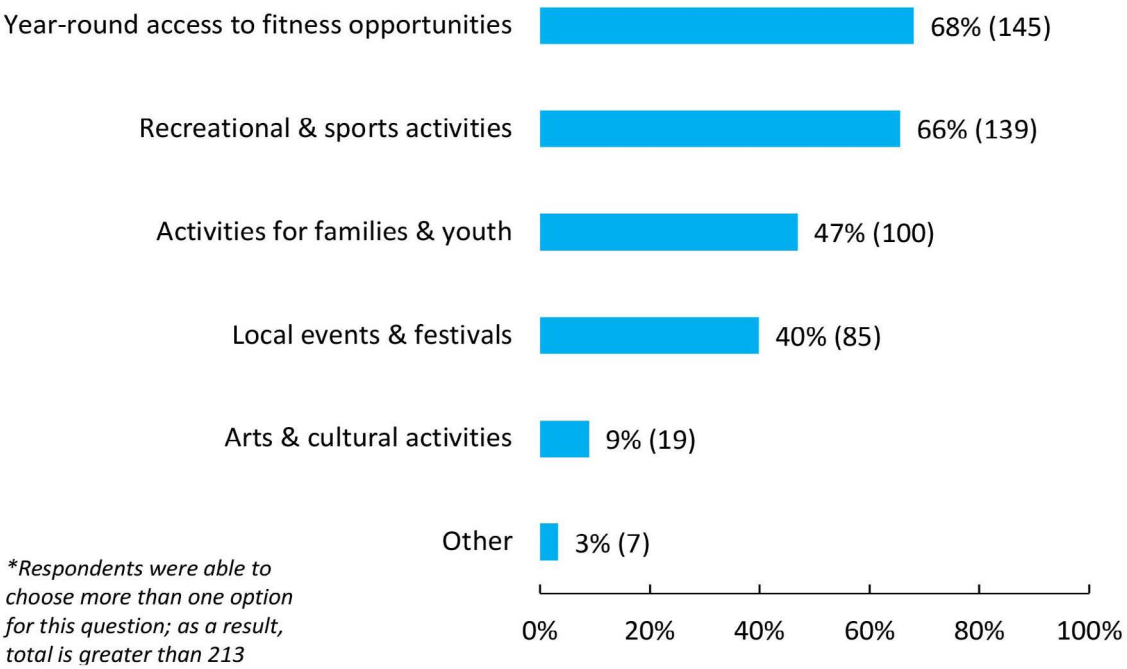
Figure 15: Best Things About the QUALITY OF LIFE in Your Community
Total responses = 226*



**Respondents were able to choose more than one option for this question; as a result, total is greater than 226*

The "Other" responses, regarding the best things about the quality of life in the community, included no traffic/congestion, recreational opportunities, and providing for the learning challenged.

Figure 16: Best Thing About the ACTIVITIES in Your Community
Total responses = 213*



**Respondents were able to choose more than one option for this question; as a result, total is greater than 213*

Respondents who selected "Other" specified that the best things about the activities in the community included affordability of WRCC and community programs and bowling.

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
- Violence

With regard to responses about community challenges, the most highly voiced concerns (those having at least 72 respondents) were:

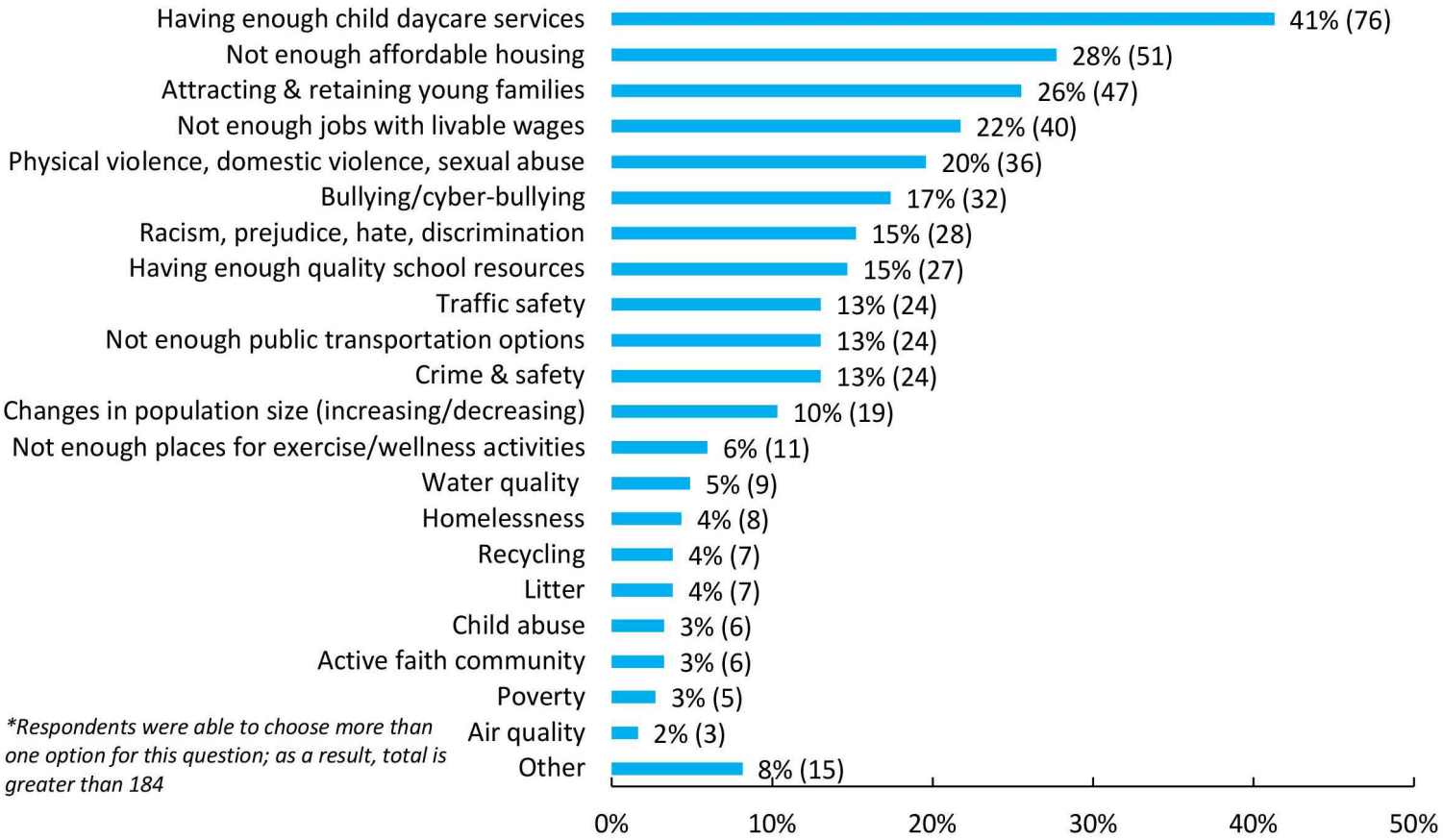
- Depression/anxiety – Youth (N=99)
- Alcohol use & abuse – Adult (N=97)
- Bullying/cyber-bullying (N=96)
- Depression and anxiety – Adult (N=91)
- Child abuse/neglect (N=88)
- Drug use and abuse – Youth (N=86)
- Alcohol use and abuse – Youth (N=85)
- Availability of mental health services (N=85)
- Availability of specialists (N=78)
- Having enough child daycare services (N=76)
- Drug use and abuse – Adult (N=72)
- Cost of long-term/nursing home care (N=72)

The other issues that had at least 50 votes included:

- Smoking & tobacco use (second-hand smoke, vaping) (N=62)
- Not enough affordable housing (N=51)
- Availability of resources to help the elderly stay in their homes (N=68)
- Domestic/intimate partner violence (N=68)
- Emotional abuse (N= 59)

Figures 17 through 23 illustrate these results.

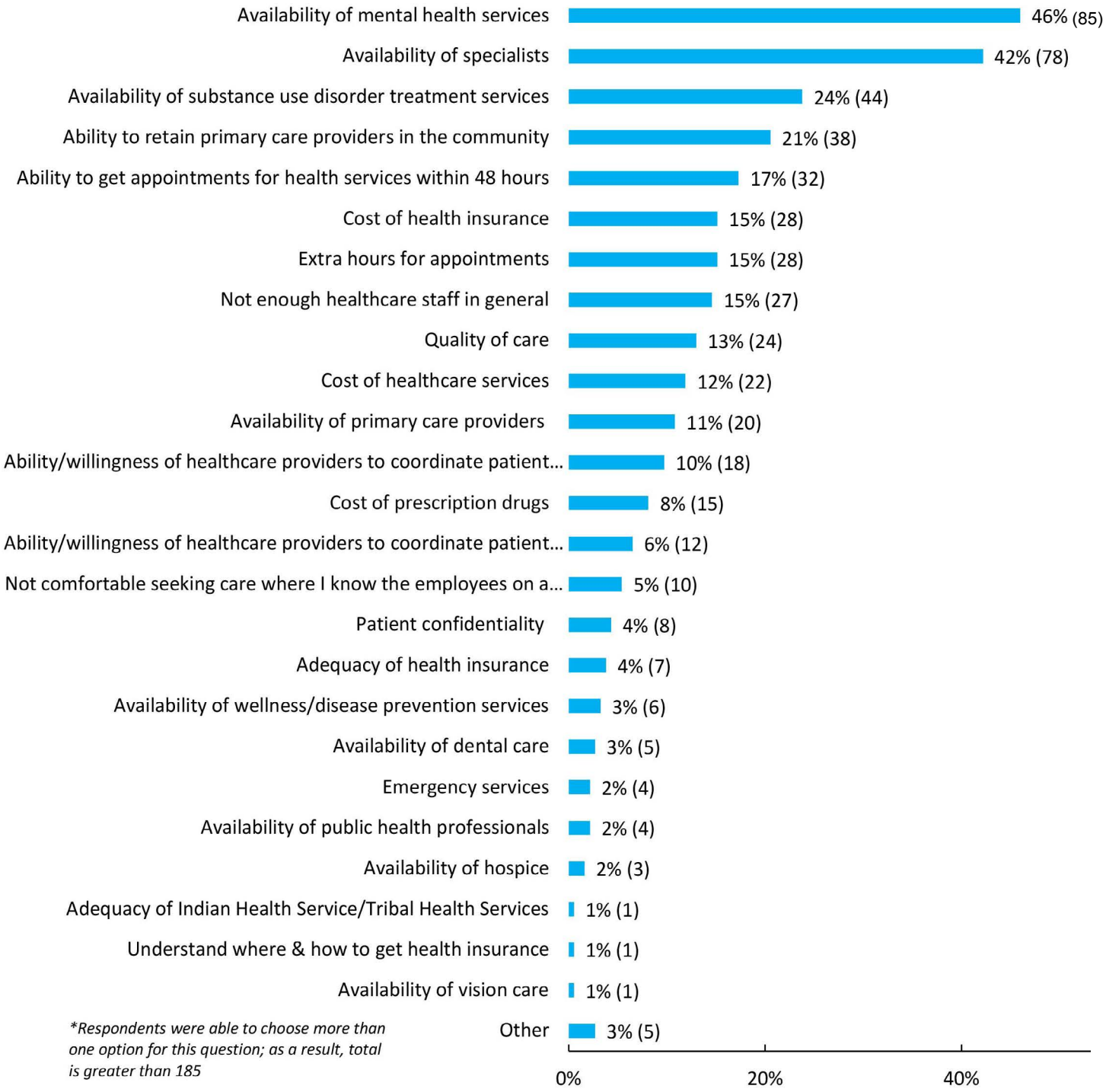
Figure 17: Community/Environmental Health Concerns
Total responses = 184*



**Respondents were able to choose more than one option for this question; as a result, total is greater than 184*

In the "Other" category for community and environmental health concerns, the following were listed: Not enough mental/behavioral health and substance abuse resources, not enough affordable activities for families, not enough businesses, retail shopping, restaurants, quality emergency room services, toxic social media, youth depression/anxiety, and those with disabilities unable to find employment.

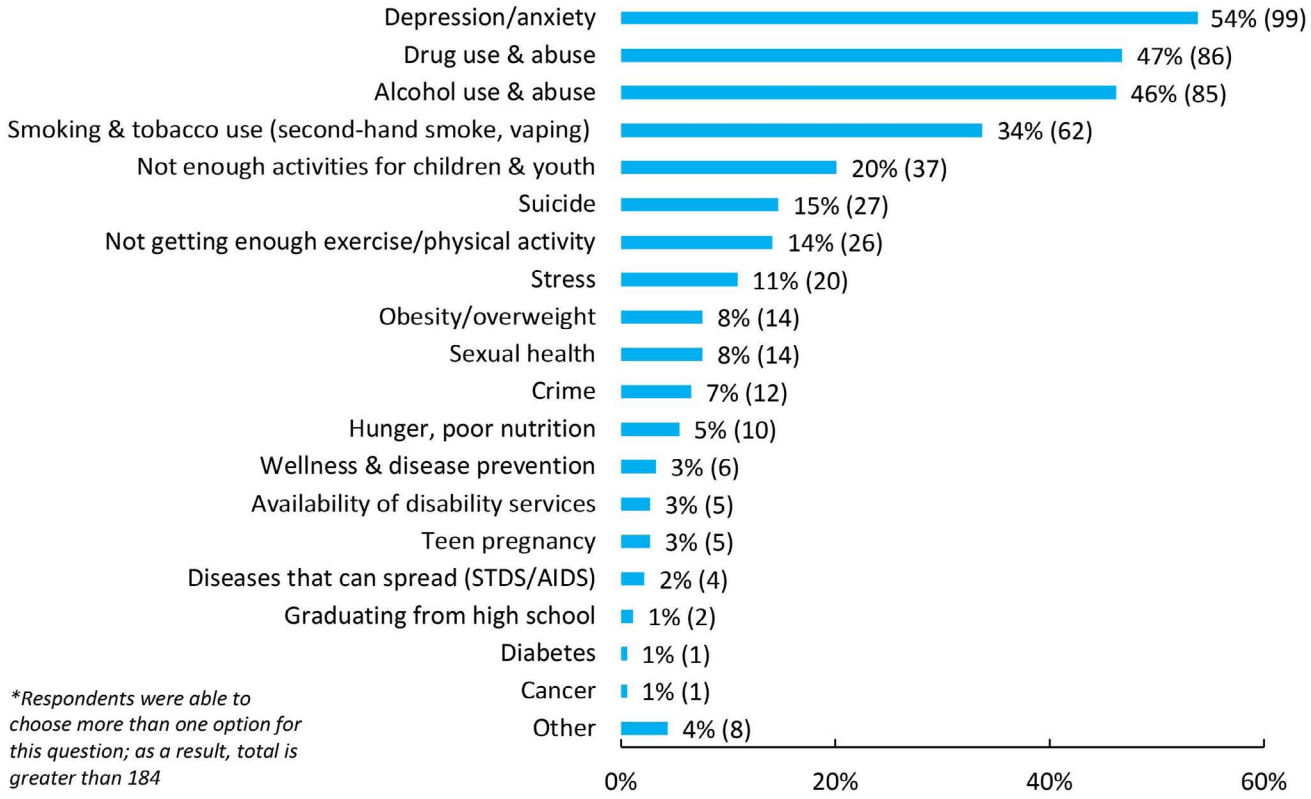
Figure 18: Availability/Delivery of Health Services Concerns
Total responses = 185*



**Respondents were able to choose more than one option for this question; as a result, total is greater than 185*

Respondents who selected "Other" identified concerns as follows: complete cancer facility, dermatologist, getting healthcare results in a timely manner, values that support efforts to avoid/prevent COVID-19, and, lack of trust in local health services.

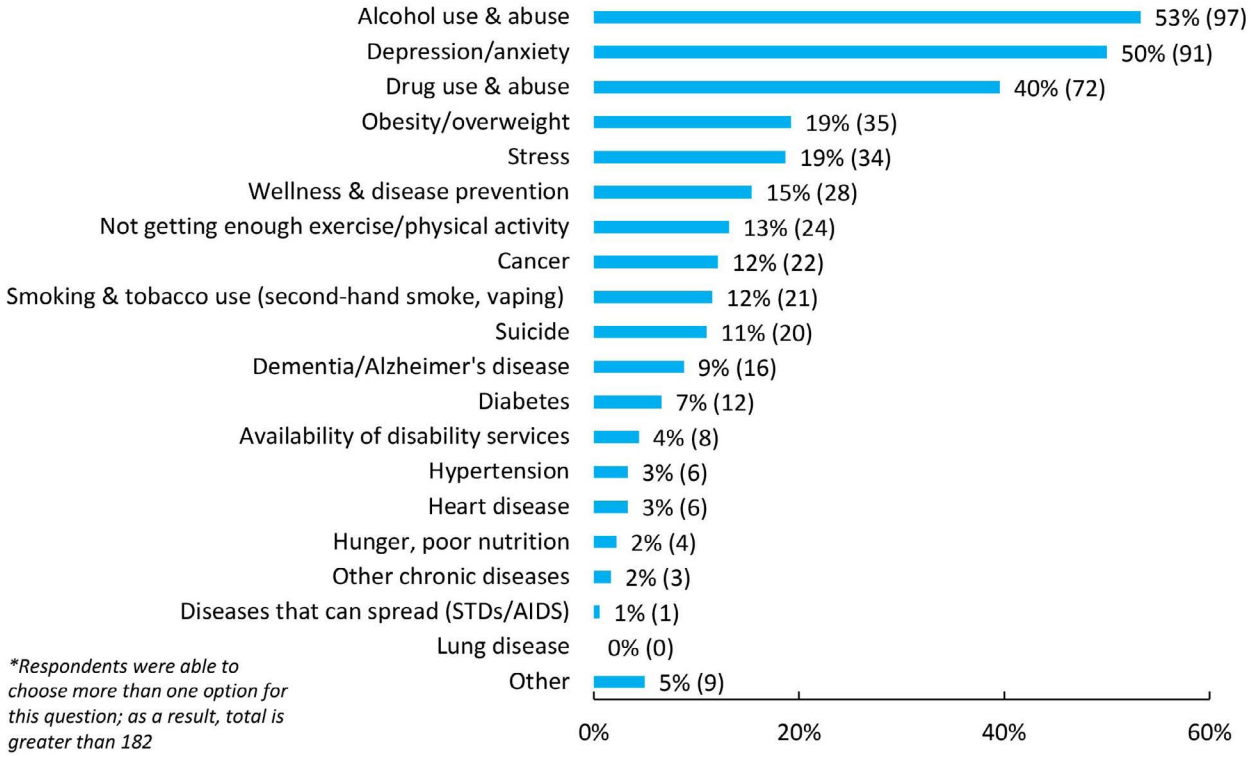
Figure 19: Youth Population Health Concerns
Total responses = 184*



Respondents were able to choose more than one option for this question; as a result, total is greater than 184

Listed in the "Other" category for youth population concerns were: ADHD services are lacking in schools, behavioral health needs overall, cyberbullying, not enough activities for children over the age of five, parents not engaged with their own children, respect for authority, too many broken and disconnected family settings for children, and, toxic social media.

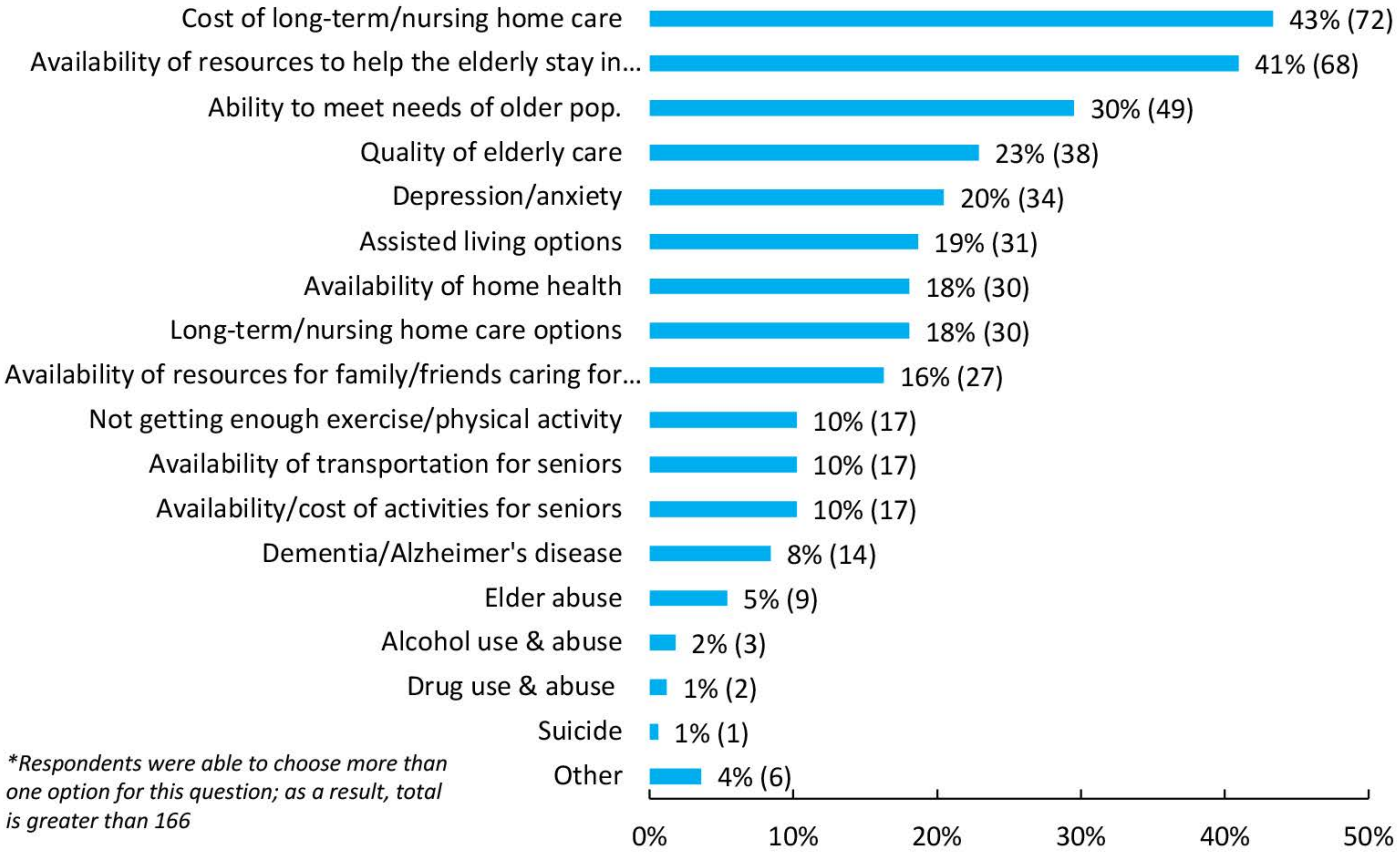
Figure 20: Adult Population Concerns
Total responses = 182*



Respondents were able to choose more than one option for this question; as a result, total is greater than 182

Those items indicated in the "Other" category for adult population concerns included: all of the above, behavioral health needs, dermatologist or pain management, government-forced medical decisions, loneliness/isolation of elders, mental health resources, parents not making their children their priority, racism, hate speech, hard to be around such hateful people, toxic social media, other chronic diseases, and serious mental illness.

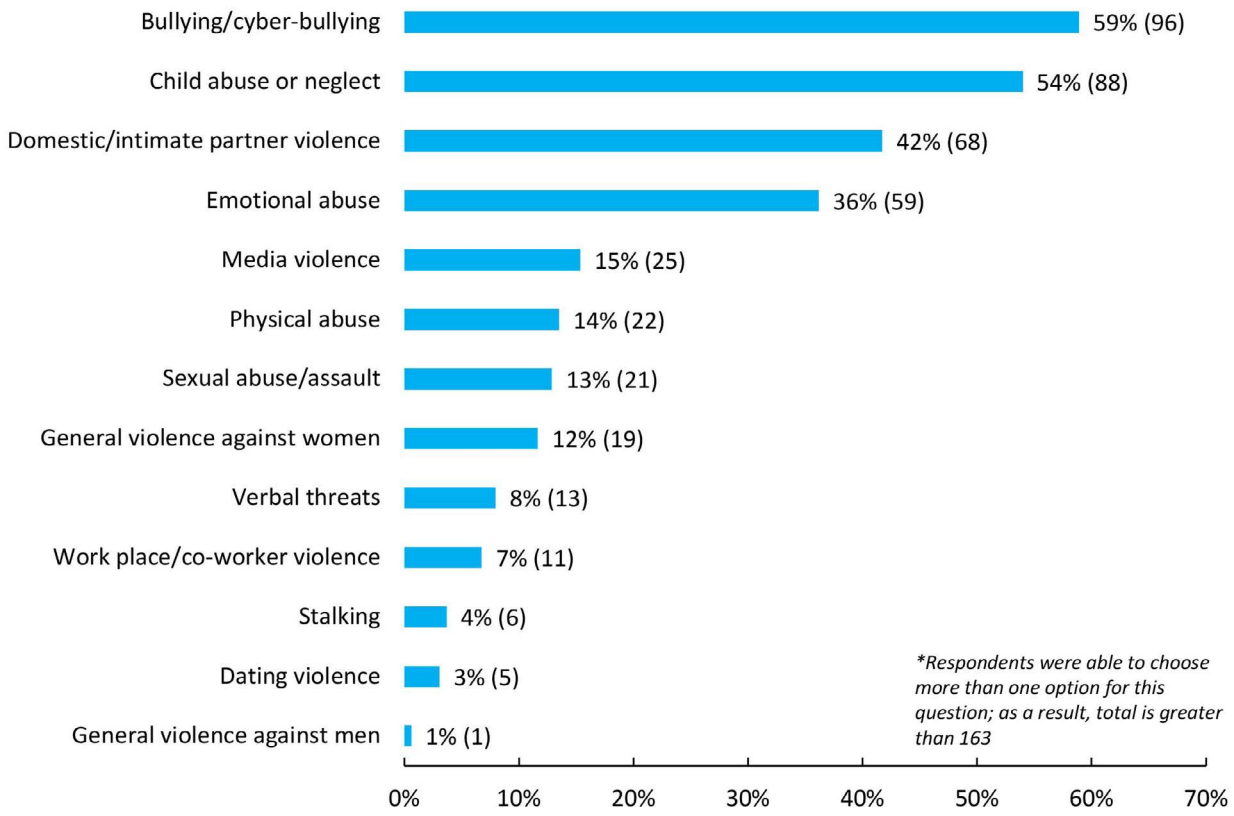
Figure 21: Senior Population Concerns
Total responses = 166*



**Respondents were able to choose more than one option for this question; as a result, total is greater than 166*

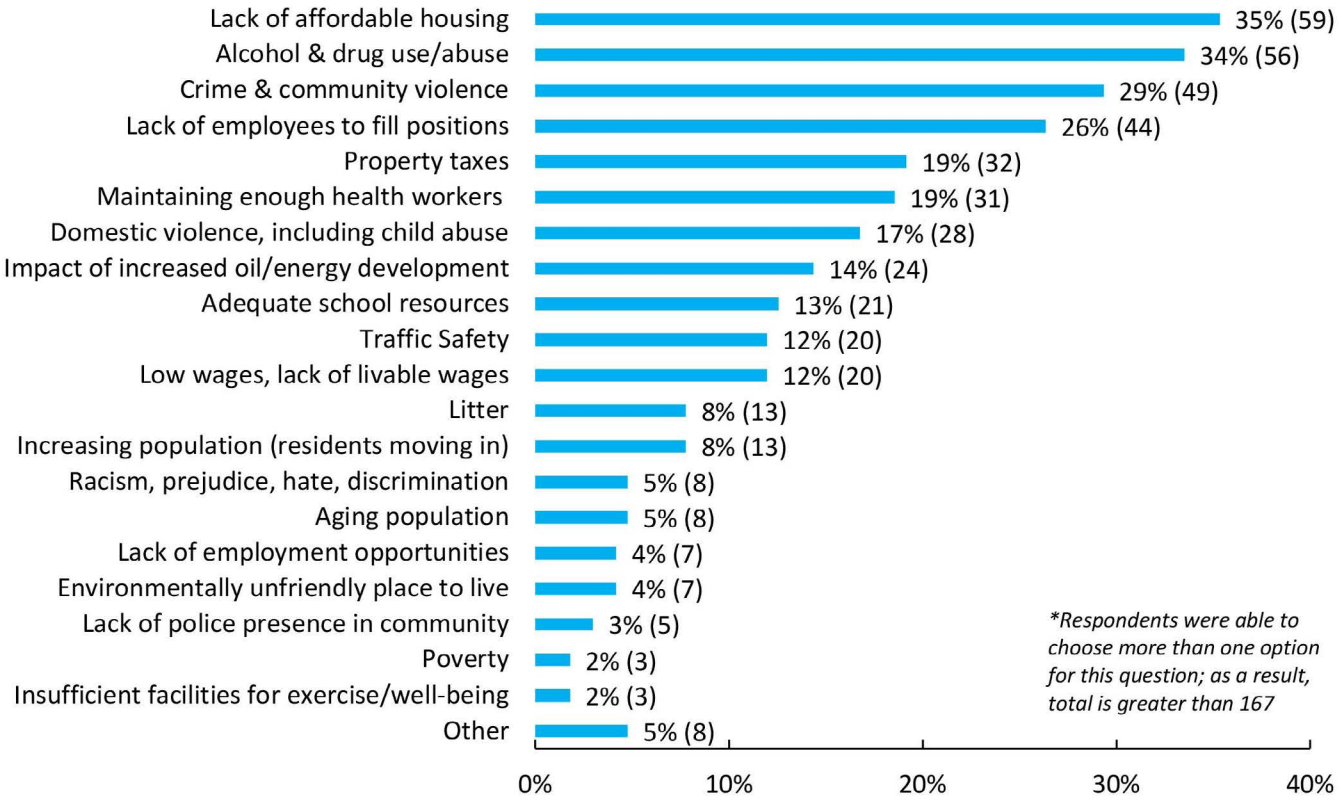
Those items listed in the "Other" category include: all of the above, behavioral health overall, cost of prescription medications and cost of food on fixed income, loneliness, mental illness, and transportation cost.

Figure 22: Violence Concerns
Total responses = 163*



CHI St. Alexius Health Dickinson Medical Center elected to include a question, specific to Oil Development concerns. Here are the respondents' selections.

Figure 23: Oil Development Concerns
Total responses = 167*



Responses in the "Other" category included behavioral health services, lack of employment opportunities for women, lack of high paying jobs outside of oil development, limited shopping, no stores to shop, rental prices, and retaining new families.

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:

Availability of mental health services

Alcohol use and abuse (adults)

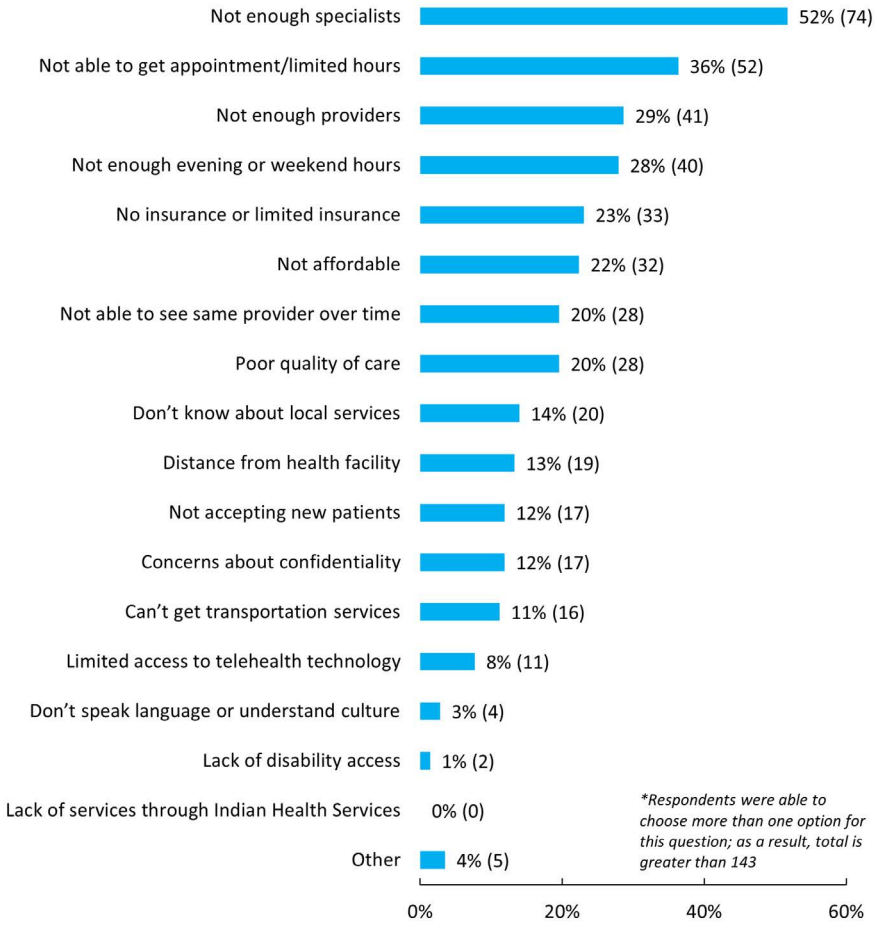
Other biggest challenges that were identified were the following: not enough affordable housing, ability to retain primary care providers, availability of specialists, not enough jobs with livable wages, not enough to live on, racism, prejudice, hate, discrimination, having enough child daycare services, and lack of retail options.

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=74) with the next highest being not able to get appointment/limited hours (N=52). After these items, the next most commonly identified barriers were not enough providers (N=41), not enough evening and weekend hours (N=40), and no insurance or limited insurance (N=33). The majority of concerns indicated in the "Other" category were regarding not being able to get into a regular provider for a week and going to a walk-in only to be told they should go to a regular provider, lack of specialists, stigma against behavioral health, not enough local providers for behavioral health, unable to see a doctor, and unwillingness to get vaccinations.

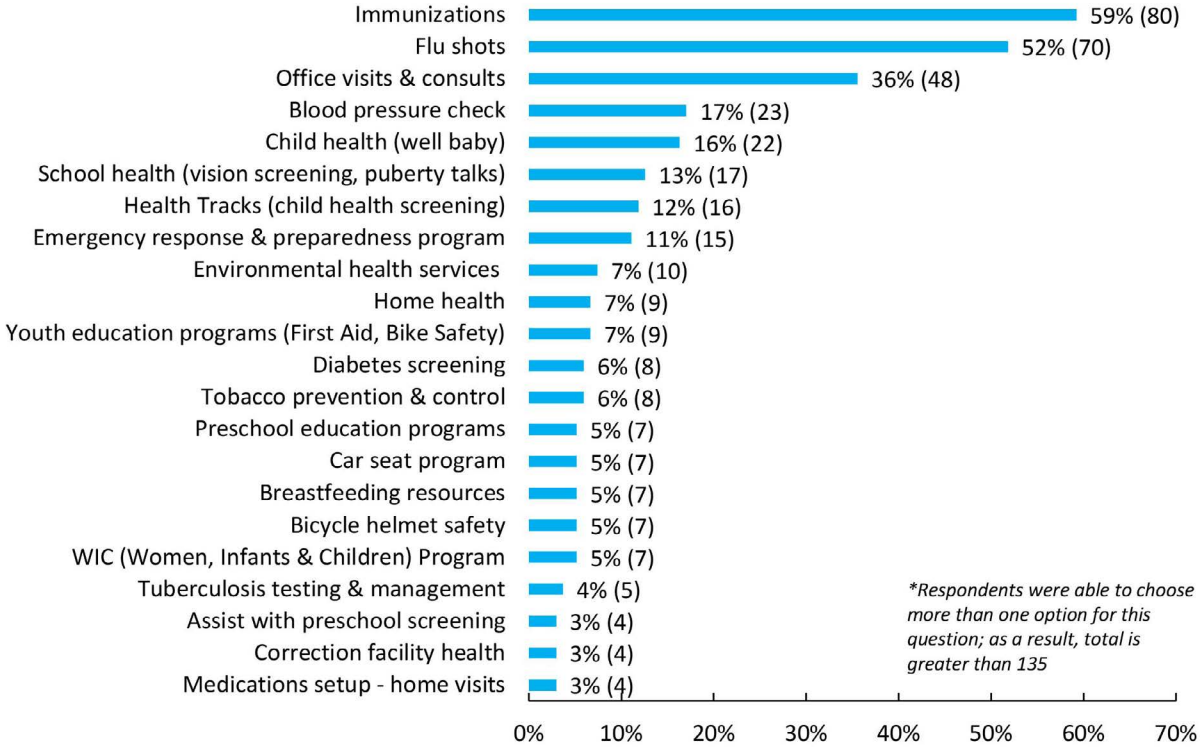
Figure 24 illustrates these results.

Figure 24: Prevents Residents from Receiving Care Locally
Total responses = 143*



Considering use of healthcare services, offered by Southwestern District Health Unit, respondents were asked to indicate what, if any, services they or a family member have used in the past year at Southwestern District Health Unit, at another public health unit, or both (See Figure 25).

Figure 25: Use of Public Health Services in the Past Year
Total responses = 135*



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 addiction and mental health services. Other requested services included:

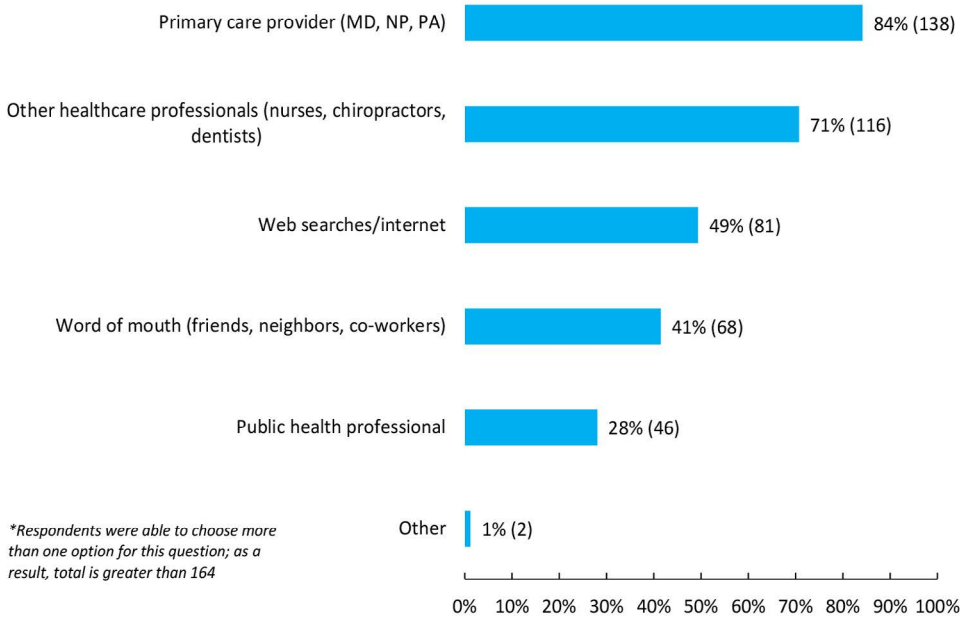
- Cardiology
- Dermatology
- More providers
- Urgent care/walk-In
- Cancer center
- ENT
- Naturopathy
- Nephrology
- Neurologist
- Orthopedics
- Pain management
- Pulmonologist
- Specialists
- Urology
- Pediatric dentistry
- Pediatrics

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. Services, where they felt the hospital should increase marketing efforts, included education on healthcare items that can be done in Dickinson and sent to specialists, cardiology, preventative maintenance, and obstetrics/birth. For public health, increased marketing efforts beyond COVID were suggested. Well-rounded marketing was suggested to reach all audiences, as different audience segments may use only one type of media.

Respondents were asked where they go to for trusted health information. Primary care providers (N=138) received the highest response rate, followed by other healthcare professionals (N=116), and then web/Internet searches (N=81).

Results are shown in Figure 26.

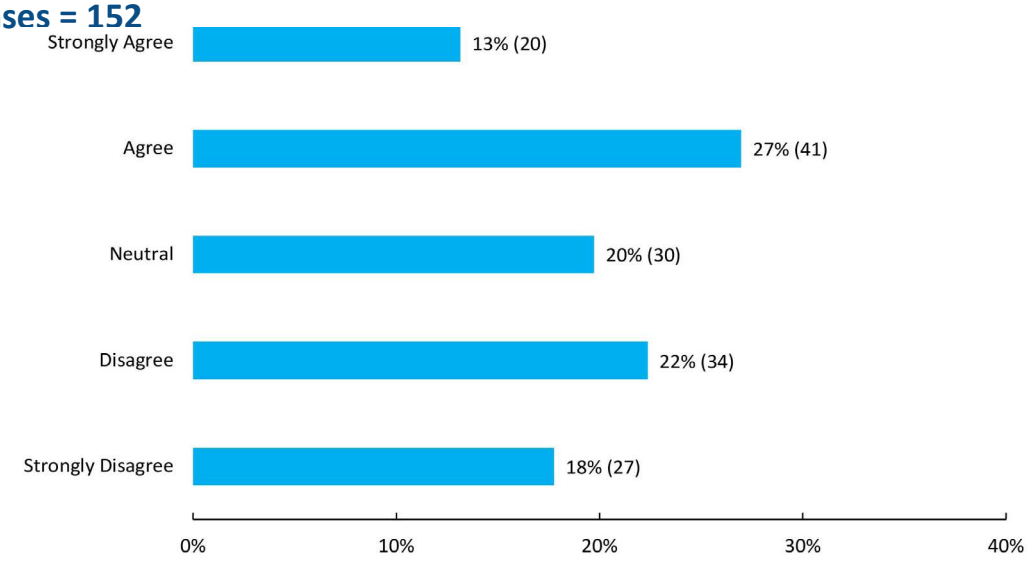
Figure 26: Sources of Trusted Health Information
Total responses = 164*



In the "Other" category, respondents listed national patient support groups and newspaper articles.

Respondents were asked if they agreed that individuals in the community would favor a sales tax (e.g. a 1-cent sales tax) to support an identified need in the community. Responses were distributed somewhat evenly (see Figure 27).

Figure 27: Community Support for a Sales Tax
Total responses = 152



The final question on the survey asked respondents to share concerns and suggestions to improve the delivery of local healthcare. The majority of responses focused on concern with better quality services. Emergency Room services were mentioned for both quality and staff coverage. Providers' ability to truly listen, while being open-minded, is important along with patient confidentiality. It is felt providers work in silos, and improved collaboration is needed. The lack of providers and specialists, serving the Dickinson area, is a worry.

Behavioral health and substance use disorder also rank high amongst concerns. It is difficult to place patients in need of these services and often results in the patient needing to be transported many miles across the state for an open bed, if one is found. This transport requires extra resources, which leaves the local community short-handed during the transport. A mental health facility and sober living facility in the area would help alleviate these concerns.

One respondent pointed out that educating patients to advocate for themselves is important.

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
- Availability of mental health services
- Having enough child daycare services
- Not enough affordable housing
- Not enough jobs with livable wages, not enough to live on

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

Alcohol use and abuse

- This is prevalent and culturally ingrained
- It's everywhere here
- Binge drinking – I used to teach. There is underage drinking among all students. It runs deep in the community
- The Youth Risk Behavior Survey – used to be done but stopped. They are trying to get it back going.
- State wide- binge drinking is an issue

Availability of mental health services

- Acknowledged problem in community. Sometimes patients seem to hop around to the providers like a revolving door.
- Need to find a way to help people with mental health. People with mental health issues end up being a hot potato between services.
- Human services history- would provide all services for people. Became overwhelming, people didn't get quality care. More focus on people who need the most.
- Really lack on the western side of the state.
- Western ND needs mental health services. People are sent out because no services available. Kick the can down the road, "it's not my job".

- All goes back to depression, anxiety, suicide not being treated.
- Insurance barriers exist (only certain insurance or cash only) where referrals may not be taken due to these barriers. Seems private services can pick and choose who they want to serve. Crisis unit is dual service as a residential facility, but need to discharge because can't be all in one, need to base on severity of patient.
- Residential step-down treatment doesn't really exist. Acute hospitalization needs are not available here – no psych unit in the region at all. Have to go across the state for services – frustration for local providers, sheriffs etc., who have to do local transports to out of town facilities for patients. Need place to stabilize people closer to home.

Having enough child daycare services

- There's a correlation with the workforce piece. If we can provide high quality daycare, we can attract parents to the workforce.
- People are not able to go back to work. Daycares have closed permanently.
- There are too many open jobs and not enough high-quality daycare.
- If a provider shuts down, everyone scrambles to find a new place.
- Need quality daycare options. The state as a whole is underfunded especially the western side of the state.
- This is underfunded by the state – look for oil tax or other state assistance to encourage daycares to set up. Plus require licensing to assure quality.
- Trying to set up a daycare center had too big of barriers for one interested person, so they walked away from trying.
- Needs to be addressed at state level instead of each community trying to figure it out.
- Economics are tied to daycare.
- To have meaningful work is essential to mental health. To not have work that provides for your family is very tough. The economic engines are not easily turned on, and some of those things that shut down in the pandemic will take years to rebuild.
- There are economic issues. Backgrounds checks, staffing with livable wages, there is turnover in workers constantly.

Not enough affordable housing

- People cannot get into housing due to having a felony. Those people do not have any options. They end up being on a waiting list for 6-12 months. It's easier to re-offend and re-enter jail for housing and food.
- Zoning and Planning could be possibly taken over at the state level – would take out of the community's hands the ability to determine affordable housing.
- When oil was up, rent went way up. After the oil boom, the rent prices didn't change.
- Low income housing and rental assistance are the only way to make it possible.
- This has been ongoing for many years.

Not enough jobs with livable wages, not enough to live on

- During pandemic, people got a taste of what it is like.
- Dealing with issues from the pandemic and it will continue.
- This is a struggle for some.
- We need to attract families, and we need jobs with livable wages to do that.

Community Engagement and Collaboration

Key informants and focus group participants were asked to weigh in on community engagement and collaboration of various organizations and stakeholders in the community. Specifically, participants were asked, "On a scale of 1 to 5, with 1 being no collaboration/community engagement and 5 being excellent collaboration/community engagement, how would you rate the collaboration/engagement in the community among these various organizations?" This was not intended to rank services provided. They were presented with a list of 13 organizations or community segments to rank. According to these participants, emergency services, law enforcement, and business and industry are the most engaged in the community. The averages of these rankings (with 5 being "excellent" engagement or collaboration) were:

- Emergency services, including ambulance and fire (4.2)
- Law enforcement (4.2)
- Business and industry (4.0)
- Public health (3.9)
- Hospital (healthcare system) (3.8)
- Faith-based (3.8)
- Schools (3.8)
- Economic development organizations (3.7)
- Human/social services (3.4)
- Other local health providers, such as dentists and chiropractors (3.3)
- Clinics not affiliated with the main health system (3.2)
- Pharmacies (3.2)
- Long-term care, including nursing homes and assisted living (2.9)

Priority of Health Needs

A community group met on September 23, 2021. Fifteen community members attended the meeting, which was held via Zoom to accommodate a surge in COVID-19 cases. Representatives from 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 in an online survey, where each member was asked to select the four needs that they considered the most significant.

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

- Alcohol use and abuse for all ages (7 votes)

- Availability of mental health services (7 votes)
- Depression/anxiety (6 votes)
- Not enough affordable housing (3 votes)

From those top four priorities, each person then voted in a second online survey on the item they felt was the most important. The rankings were:

1. Availability of mental health services (12 votes)
2. Alcohol use and abuse for all ages (2 votes)
3. Not enough affordable housing (1 vote)
4. Depression/anxiety (0 votes)

Following the prioritization process, during the second meeting of the community group and key informants, the number one identified need was the availability of mental health services. 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
Availability of mental health services	Availability of mental health services
Depression and anxiety among the youth population	Alcohol use and abuse for all ages
	Not enough affordable housing
	Depression/anxiety

The current process identified the common need of availability of mental health services from 2019. Additionally, depression/anxiety were listed in general for 2021 compared to depression and anxiety among the youth population in 2019.

CHI St. Alexius Health Dickinson Medical Center 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 Dickinson Medical Center Board vote, a notation will be documented in the board minutes reflecting the approval and then the report will be widely available to the public on the hospital's website and a paper copy will be available for inspection upon request at the hospital. Written comments on this report can be submitted to CHI St. Alexius Dickinson Medical Center Mission Director at 2500 Fairway Street, Dickinson, North Dakota 58601.

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: Availability of mental health services – In relation to the Key finding of "Availability of Mental Health Services" and "Availability of substance use disorder/treatment services," CHI St. Alexius Health has further

identified three major areas or "gaps" in the community that could be addressed: 1.) An Inpatient Behavioral Health Unit, 2.) An inpatient substance abuse and behavioral health counseling center, located in the service area, and 3.) A transitionary or supportive housing site with a "housing first" approach.

- Work on #1 has been conducted in earnest in cooperation with the North Dakota Department of Human Services and Badlands Human Service Center. Conversations and planning surrounding the construction and management of a possible inpatient unit at CHI St. Alexius Health Dickinson Medical Center is ongoing.
- Staff from CHI St. Alexius Health Dickinson Medical Center serve on the SW Homeless Coalition board, which is building a business plan to open a transitionary/supportive housing unit to help bridge the gap between a stay in acute care or incarceration and help this population by providing them with one of their primary human needs. Effective working to create a site that resources could "wrap around."

Need 2: Depression and anxiety among the youth population – The city of Dickinson, following a survey conducted by Dickinson Public Schools students and with the urging of staff at CHI St. Alexius Health Dickinson Medical Center, SWDHU, and other community partners, have started a youth commission that will work to address the concerns of youth in the community. This step is a small one in the direction of working to address these concerns, but it is a step and one that youth have embraced excitedly.

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

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

Community Benefit Report

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

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

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

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

What Are Community Benefits?

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

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

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

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

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

Appendix A – Critical Access Hospital Profile

Critical Access Hospital Profile
Spotlight on: Dickinson, North Dakota
CHI St. Alexius Health Dickinson

Quick Facts

Administrator/CEO:
DeeAnna Opstedahl - interim

City Population:
22,882 (2019 Estimate)[1]

County Population:
31,489 (2019 Estimate)[1]

County Median Household Income:
65,712 (2019 Estimate)[1]

County Median Age:
38.5 (2019 Estimate)[1]

Owned by: Nonprofit, Community

Hospital Beds: 25

Trauma Level: IV

Critical Access Hospital Designation: 2009

Economic Impact on the County

Employment Impact:
Direct – 257
Secondary – 175
Total – 432

Financial Impact:
Direct – $25.5 million
Secondary – $7.3 million
Total – $32.84 million

Mission

As CommonSpirit Health, 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: Stark
Address: 2500 Fairway Street
Dickinson, ND 58601
Phone: 701.456.4000
Fax: 701.456.4800
Web: CHIStAlexiusHealth.org/Dickinson

CHI St. Alexius Health, located in Dickinson, North Dakota, is a 25-bed Critical Access Hospital with a Level IV Trauma Center accredited by the American College of Surgeons and The Joint Commission (TJC). We carry the vision of our founding Sisters by building healthier communities through a healing ministry. Along with our hospital located at 2500 Fairway Street in Dickinson, we administer a wide range of clinic services at the same location, along with our rural clinic in Beach, North Dakota. CHI St. Alexius Health is part of CommonSpirit Health, a nonprofit, Catholic health system created in February 2019 through the alignment of Catholic Health Initiatives and Dignity Health. With its national office in Chicago and a team of approximately 150,000 employees and 25,000 physicians and advanced practice clinicians, CommonSpirit operates 139 hospitals and more than 1000 care sites across 21 states.

CHI St. Alexius Health Credentials & Recognitions:

- Currently holds The Joint Commission's National Quality Approval award.
- 5 Star Overall Hospital Quality Rating by CMS
- 2013 Top Performer on Key Quality Measures® Recognition from The Joint Commission for Pneumonia and Surgical Care
- Radiology department is accredited by ACR in Nuclear Medicine, MRI, Mammography, and CT Scan
- Cardiac rehabilitation program certified by the American Association of Cardiovascular and Pulmonary Rehabilitation (AACVPR)
- Named a HealthStrong™ Top 100 Critical Access Hospital in 2013
- UND Center for Rural Health Outstanding Rural Health Program – CenteringPregnancy
- North Dakota Department of Health - Designated ND Acute Stroke Ready Hospital & Acute Stroke Ready Hospital Quality Excellence Award

Vision

A healthier future for all – inspired by faith, driven by innovation, and powered by our humanity.

Core Values

COMPASSION • INCLUSION • INTEGRITY • EXCELLENCE • COLLABORATION

Staff

Physicians: 12
Nurse Practitioners 8
PAs: 8
RNs: 124
Total Employees: 338

Sources

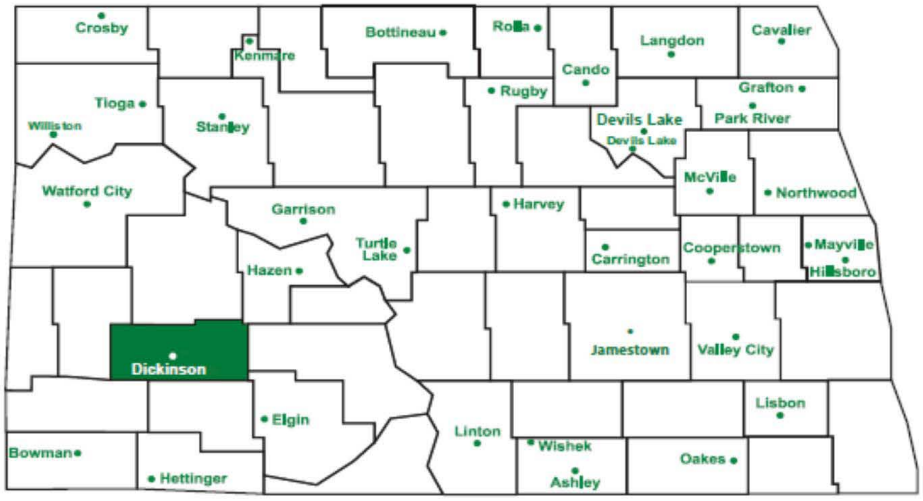
[1] US Census Bureau; American Factfinder; Community Facts

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

Services

- Emergency Care - Level IV Trauma Center
- Acute Care Services: Medical/Surgical-Pediatric Unit & Intensive Care Unit
- Obstetrics – Level II Nursery
- Surgical Services
- Radiology & X-Ray services including 3D Mammography & Breast MRI
- Laboratory Services
- Respiratory Care
- Sleep Diagnostics Program
- Home Health & Hospice Services
- Kidney Dialysis
- Multi-disciplinary clinic
- Orthopaedics withRobotic-Assisted Technology
- Rehab Services
  - Physical Therapy
  - Occupational Therapy
  - Industrial Medicine
  - Speech Therapy
  - Wound Care
  - Cardiac & Pulmonary Rehabilitation
  - Aquatic Therapy
- Regional medical helicopter availability base located on site (Valley Med Flight)
- Visiting specialists in such fields as cardiology, pulmonology, nephrology and mental health services

North Dakota Critical Access Hospitals



Recreation

Dickinson is a progressive community of over 27,000 people that serves as a regional center for over 101,000. Strong incremental growth over the past decade has been fueled be a diverse economy fed by new wealth from energy, agriculture, and manufacturing.

Dickinson is the destination community for entertainment, shopping, and business services. Roughrider Days Fair & Expo, the North Dakota Ukrainian Festival, Homecoming at Dickinson State University Campus, Rodeos, Specialty Vehicle Shows, Art in the Park, and our Concert Series are just some of the activities available here.

For the outdoors lovers, world-class bird and big-game hunting compliment hiking, biking and equestrian trails. The West River Community Center is the envy of all North Dakota indoor recreation centers with two pools, tennis courts, climbing wall, fitness center, racquetball and more.

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 of 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

Appendix B – Economic Impact Analysis

December 2020

CHI St. Alexius Health Dickinson

CHI St. Alexius Health

Dickinson Medical Center

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

Economic Impact

CHI St. Alexius Health Dickinson is composed of a Critical Access Hospital (CAH), a clinic, and home health in Dickinson, North Dakota.

CHI St. Alexius Health Dickinson **directly** employs **257 FTE employees** with an annual payroll of over **$25.5 million** (including benefits).

- After application of the employment multiplier of 1.68, these employees created an additional **175** jobs.
- The same methodology is applied to derive the income impact. The income multiplier of 1.29 is applied to create nearly **$7.3 million** in income as they interact with other sectors of the local economy.
- **Total impacts = 432 jobs and more than $32.84 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.

Fact Sheet Author: Kylie Nissen, BBA

For additional information, please contact:
Kylie Nissen, Program Director, Center for Rural Health
kylie.nissen@und.edu • (701) 777-5380

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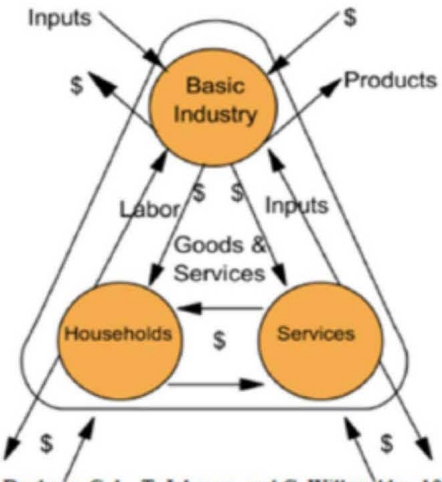
University of North Dakota
School of Medicine & Health Sciences

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

This project is/was supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) through the Medicare Rural Hospital Flexibility Grant Program and the State Office of Rural Health Grant.

Appendix C – CHNA Survey Instrument

Dickinson Area Health Survey

CHI St. Alexius Health Dickinson and Southwestern District Health Unit are interested in hearing from you about community health concerns.

The focus of this effort is to:

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

If you prefer, you may take the survey online at
https://tinyurl.com/Dickinson2021CHNA
or by scanning on the QR Code at the right.

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 Nicole Threadgold at 701.330.3264.

Surveys will be accepted through July 26, 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
- ☐ Local events and festivals
- ☐ Recreational and sports activities
- ☐ Year-round access to fitness opportunities
- ☐ Other (please specify): _____

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

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

- ☐ Active faith community
- ☐ Attracting and retaining young families
- ☐ Not enough jobs with livable wages, not enough to live on
- ☐ Not enough affordable housing
- ☐ Poverty
- ☐ Changes in population size (increasing or decreasing)
- ☐ Crime and safety, adequate law enforcement personnel
- ☐ Water quality (well water, lakes, streams, rivers)
- ☐ Air quality
- ☐ Litter (amount of litter, adequate garbage collection)
- ☐ Having enough child daycare services
- ☐ Having enough quality school resources
- ☐ Not enough places for exercise and wellness activities
- ☐ Not enough public transportation options, cost of public transportation
- ☐ Racism, prejudice, hate, discrimination
- ☐ Traffic safety, including speeding, road safety, seatbelt use, and drunk/distracted driving
- ☐ Physical violence, domestic violence, sexual abuse
- ☐ Child abuse
- ☐ Bullying/cyber-bullying
- ☐ Recycling
- ☐ Homelessness
- ☐ Other (please specify): _____

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

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

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

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

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

- ☐ Alcohol use and abuse
- ☐ Drug use and abuse (including prescription drug abuse)
- ☐ Smoking and tobacco use, exposure to second-hand smoke 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): _____

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 violence
- ☐ Physical abuse
- ☐ Stalking
- ☐ Sexual abuse/assault
- ☐ Verbal threats
- ☐ Work place/co-worker violence

11. Regarding impacts from **OIL DEVELOPMENT** in your community, concerns are (choose up to THREE):

- ☐ Adequate number of school resources
- ☐ Aging population, lack of resources to meet growing needs
- ☐ Alcohol and drug use and abuse
- ☐ Crime and community violence
- ☐ Domestic violence, including child abuse
- ☐ Environmentally unsound (or unfriendly) place to live
- ☐ Impact of increased oil/energy development
- ☐ Increasing population, including residents moving in
- ☐ Insufficient facilities for exercise and well-being
- ☐ Lack of affordable housing
- ☐ Lack of employees to fill positions
- ☐ Lack of employment opportunities
- ☐ Lack of police presence in community
- ☐ Litter
- ☐ Low wages, lack of livable wages
- ☐ Maintaining enough health workers (e.g., medical, dental, wellness)
- ☐ Poverty
- ☐ Property taxes
- ☐ Racism, prejudice, hate, discrimination
- ☐ Traffic safety, including speeding, road safety and drunk driving

Other (please specify): _____

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

_____

_____

Delivery of Healthcare

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)

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

14. What **PREVENTS** you or other 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): _____

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

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

16. 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): _____

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

_____

_____

18. Do you agree that individuals in the community would favor a sales tax (e.g., a 1-cent sales tax) to support an identified need in the community?

- ☐ Strongly Agree
- ☐ Agree
- ☐ Neutral
- ☐ Disagree
- ☐ Strongly Disagree
- ☐ Don't Know

Demographic Information: Please tell us about yourself.

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

- ☐ Yes
- ☐ No

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

- ☐ Hospital or public health website
- ☐ Hospital or public health social media
- ☐ Hospital or public health employee
- ☐ Hospital or public health facility
- ☐ At a healthcare facility (not the hospital or public health)
- ☐ 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
- ☐ Poster around town
- ☐ Flyer in the mail
- ☐ Word of Mouth
- ☐ Direct email (if so, from what organization):_____
- ☐ Other (please specify): _____

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

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

22. 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

23. Highest level of education:

- ☐ Less than high school
- ☐ High school diploma or GED
- ☐ Some college/technical degree
- ☐ Associate's degree
- ☐ Bachelor's degree
- ☐ Graduate or professional degree

24. Sex:

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

25. Employment status:

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

26. Your zip code: _____

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

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

28. Annual household income before taxes:

- ☐ Less than $15,000
- ☐ $15,000 to $24,999
- ☐ $25,000 to $49,999
- ☐ $50,000 to $74,999
- ☐ $75,000 to $99,999
- ☐ $100,000 to $149,999
- ☐ $150,000 and over

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

_____

_____

Appendix D – County Health Rankings Explained

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

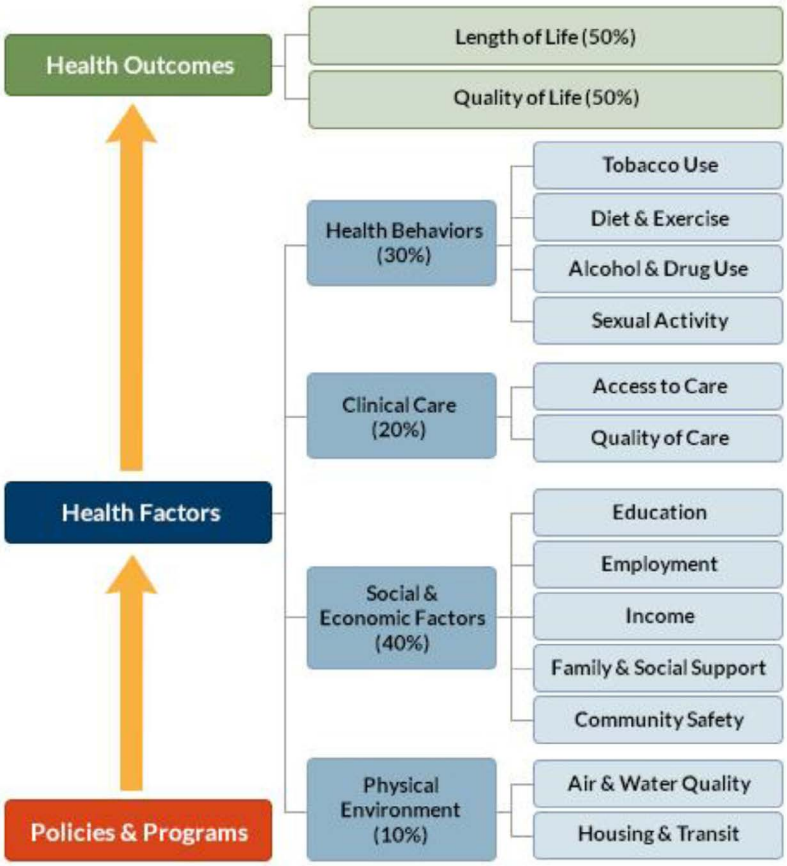
Methods

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



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

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

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

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

Data Sources and Measures

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

Data Quality

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

Calculating Scores and Ranks

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

Health Outcomes and Factors

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

Health Outcomes

Premature Death (YPLL)

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

Reason for Ranking

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

Poor or Fair Health

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

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

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

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

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

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

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

Health Factors

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

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

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

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

Food Environment Index

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

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

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

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

Reason for Ranking

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

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

Physical Inactivity

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

Reason for Ranking

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

Access to Exercise Opportunities

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

Individuals who:

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

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

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

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

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

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

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

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

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

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

Uninsured

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

Reason for Ranking

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

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

Primary Care Physicians

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

Reason for Ranking

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

Dentists

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

Reason for Ranking

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

Mental Health Providers

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

Reason for Ranking

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

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

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

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.

Flu Vaccinations

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

Reason for Ranking
Influenza is a potentially serious disease that can lead to hospitalization and even death. Every year there are millions of influenza infections, hundreds of thousands of flu-related hospitalizations, and thousands of flu-related deaths. An annual flu vaccine is the best way to help protect against influenza and may reduce the risk of flu illness, flu-related hospitalizations, and even flu-related death. It is recommended that everyone 6 months and older get a seasonal flu vaccine each year, and those over 65 are especially encouraged because they are at higher risk of developing serious complications from the flu.

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

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

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

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

Reason for Ranking

Poverty can result in an increased risk of mortality, morbidity, depression, and poor health behaviors. A 2011 study found that poverty and other social factors contribute a number of deaths comparable to leading causes of death in the 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

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

Injury Deaths

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

Reason for Ranking

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

Air Pollution-Particulate matter

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

Reason for Ranking

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

Drinking Water Violations

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

Reason for Ranking

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

Severe Housing Problems

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

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

- household is severely cost burdened.

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

Reason for Ranking

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

Appendix E – Youth Risk Behavior Survey Results

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

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

	ND 2015	ND 2017	ND 2019	ND Trend ↑, ↓, =	Rural ND Town Average	Urban ND Town Average	National Average 2019
Percentage of students who made a plan about how they would attempt suicide (during the 12 months before the survey)	13.5	14.5	15.3	=	16.3	16.0	15.7
Percentage of students who attempted suicide (one or more times during the 12 months before the survey)	9.4	13.5	13.0	=	12.5	11.7	8.9
Tobacco Use							
Percentage of students who ever tried cigarette smoking (even one or two puffs)	35.1	30.5	29.3	=	32.4	23.8	24.1
Percentage of students who smoked a whole cigarette before age 13 years (even one or two puffs)	NA	11.2	NA	**NA**	NA	NA	NA
Percentage of students who currently smoked cigarettes (on at least one day during the 30 days before the survey)	11.7	12.6	8.3	↓	10.9	7.3	6.0
Percentage of students who currently frequently smoked cigarettes (on 20 or more days during the 30 days before the survey)	4.3	3.8	2.1	↓	2.3	1.7	1.3
Percentage of students who currently smoked cigarettes daily (on all 30 days during the 30 days before the survey)	3.2	3.0	1.4	↓	1.6	1.2	1.1
Percentage of students who usually obtained their own cigarettes by buying them in a store or gas station (during the 30 days before the survey among students who currently smoked cigarettes and who were aged <18 years)	NA	7.5	13.2	=	9.4	10.1	8.1
Percentage of students who tried to quit smoking cigarettes (among students who currently smoked cigarettes during the 12 months before the survey)	NA	50.3	54.0	=	52.8	51.4	NA
Percentage of students who currently use an electronic vapor product (e-cigarettes, vape e-cigars, e-pipes, vape pipes, vaping pens, e-hookahs, and hookah pens at least one day during the 30 days before the survey)	22.3	20.6	33.1	↑	32.2	31.9	32.7
Percentage of students who currently used smokeless tobacco (chewing tobacco, snuff, or dip on at least one day during the 30 days before the survey)	NA	8.0	4.5	↓	5.7	3.8	3.8
Percentage of students who currently smoked cigars (cigars, cigarillos, or little cigars on at least one day during the 30 days before the survey)	9.2	8.2	5.2	↓	6.3	4.3	5.7
Percentage of students who currently used cigarettes, cigars, or smokeless tobacco (on at least 1 day during the 30 days before the survey)	NA	18.1	12.2	NA	15.1	10.9	10.5
Alcohol and Other Drug Use							
Percentage of students who ever drank alcohol (at least one drink of alcohol on at least one day during their life)	62.1	59.2	56.6	=	60.6	54.0	NA
Percentage of students who drank alcohol before age 13 years (for the first time other than a few sips)	12.4	14.5	12.9	=	16.4	13.2	15.0
Percentage of students who currently drank alcohol (at least one drink of alcohol on at least one day during the 30 days before the survey)	30.8	29.1	27.6	=	29.4	25.4	29.2
Percentage of students who currently were binge drinking (four or more drinks of alcohol in a row for female students, five or more for 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
Percentage of students who tried marijuana before age 13 years (for the first time)	5.3	5.6	5.0	=	5.5	5.1	5.6
Percentage of students who currently used marijuana (one or more times during the 30 days before the survey)	15.2	15.5	12.5	=	11.4	14.1	21.7

	ND 2013	ND 2017	ND 2019	ND Trend ↑, ↓, =	Rural ND Town Average	Urban ND Town Average	National Average 2019
Percentage of students who ever took prescription pain medicine without a doctor's prescription or differently than how a doctor told them to use it (counting drugs such as codeine, Vicodin, OxyContin, Hydrocodone, and Percocet, one or more times during their life)	NA	14.4	14.5	=	12.8	13.3	14.3
Percentage of students who were offered, sold, or given an illegal drug on school property (during the 12 months before the survey)	18.2	12.1	NA	NA	NA	NA	21.8
Percentage of students who attended school under the influence of alcohol or other drugs (on at least one day during the 30 days before the survey)	NA	NA	NA	NA	NA	NA	NA
Sexual Behaviors							
Percentage of students who ever had sexual intercourse	38.9	36.6	38.3	=	35.4	36.1	38.4
Percentage of students who had sexual intercourse before age 13 years (for the first time)	2.6	2.8	NA	NA	NA	NA	3.0
Weight Management and Dietary Behaviors							
Percentage of students who were overweight (>= 85th percentile but <95th percentile for body mass index, based on sex and age-specific reference data from the 2000 CDC growth chart)	14.7	16.1	16.5	=	16.6	15.6	16.1
Percentage of students who had obesity (>= 95th percentile for body mass index, based on sex- and age-specific reference data from the 2000 CDC growth chart)	13.9	14.9	14.0	=	17.4	14.0	15.5
Percentage of students who described themselves as slightly or very overweight	32.2	31.4	32.6	=	35.7	33.0	32.4
Percentage of students who were trying to lose weight	NA	44.5	44.7	=	46.8	45.5	NA
Percentage of students who did not eat fruit or drink 100% fruit juices (during the seven days before the survey)	3.9	4.9	6.1	=	5.8	5.3	6.3
Percentage of students who ate fruit or drank 100% fruit juices one or more times per day (during the seven days before the survey)	NA	61.2	54.1	↓	54.1	57.2	NA
Percentage of students who did not eat vegetables (green salad, potatoes [excluding French fries, fried potatoes, or potato chips], carrots, or other vegetables, during the seven days before the survey)	4.7	5.1	6.6	=	5.3	6.6	7.9
Percentage of students who ate vegetables one or more times per day (green salad, potatoes [excluding French fries, fried potatoes, or potato chips], carrots, or other vegetables, during the seven days before the survey)	NA	60.9	57.1	↓	58.2	59.1	NA
Percentage of students who did not drink a can, bottle, or glass of soda or pop (such as Coke, Pepsi, or Sprite, not including diet soda or diet pop, during the seven days before the survey)	NA	28.8	28.1	=	26.4	30.5	NA
Percentage of students who drank a can, bottle, or glass of soda or pop one or more times per day (not including diet soda or diet pop, during the seven days before the survey)	18.7	16.3	15.9	=	17.4	15.1	15.1
Percentage of students who did not drink milk (during the seven days before the survey)	13.9	14.9	20.5	↑	14.8	20.3	30.6
Percentage of students who drank two or more glasses per day of milk (during the seven days before the survey)	NA	33.9	NA	NA	NA	NA	NA
Percentage of students who did not eat breakfast (during the 7 days before the survey)	11.9	13.5	14.4	=	13.3	14.1	16.7
Percentage of students who most of the time or always went hungry because there was not enough food in their home (during the 30 days before the survey)	NA	2.7	2.8	=	2.1	2.9	NA
Physical Activity							
Percentage of students who were physically active at least 60 minutes per day on 5 or more days (doing any kind of physical activity that increased their heart rate and made them breathe hard some of the time during the 7 days before the survey)	NA	51.5	49.0	=	55.0	22.6	55.9

	ND 2015	ND 2017	ND 2019	ND Trend ↑, ↓, =	Rural ND Town Average	Urban ND Town Average	National Average 2019
Percentage of students who watched television three or more hours per day (on an average school day)	18.9	18.8	18.8	=	18.3	18.2	19.8
Percentage of students who played video or computer games or used a computer three or more hours per day (counting time spent on things such as Xbox, PlayStation, an iPad or other tablet, a smartphone, texting, YouTube, Instagram, Facebook, or other social media, for something that was not school work on an average school day)	38.6	43.9	45.3	=	48.3	45.9	46.1
Other							
Percentage of students who had eight or more hours of sleep (on an average school night)	NA	31.8	29.5	=	31.8	33.1	NA
Percentage of students who brushed their teeth on seven days (during the 7 days before the survey)	NA	69.1	66.8	=	63.0	68.2	NA
Percentage of students who most of the time or always wear sunscreen (with an SPF of 15 or higher when they are outside for more than one hour on a sunny day)	NA	12.8	NA	NA	NA	NA	NA
Percentage of students who used an indoor tanning device (such as a sunlamp, sunbed, or tanning booth [not including getting a spray-on tan] one or more times during the 12 months before the survey)	NA	8.3	7.0	=	6.0	5.9	4.5

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

Appendix F – Prioritization of Community's Health Needs

Community Health Needs Assessment
Dickinson, North Dakota
Ranking of Concerns

The top concerns for each of the six topic areas, based on the community survey results, were listed in an online survey for meeting participants to rank. The numbers below indicate the total number of votes by the people in attendance at the second community meeting. The "Priorities" column lists the number of votes for the concerns indicating which areas are felt to be priorities. Each person was given four votes. During this online prioritization, Alcohol Use and Abuse was listed only once with "all ages" denoted. It is shown here as identified concerns from the survey, key informant interviews and community meeting in both the Youth and Adult populations. The "Most Important" column lists the number of votes placed after the first round of voting was complete and the top four priorities were selected based on the highest number of votes. Each person was then asked to vote for the item they felt was the most important priority of the top four ranked priorities.

	Priorities	Most Important
COMMUNITY/ENVIRONMENTAL HEALTH CONCERNS		
Attracting & retaining young families	0	
Having enough child daycare services	2	
Not enough affordable housing	3	1
Not enough jobs with livable wages	0	
AVAILABILITY/DELIVERY OF HEALTH SERVICES CONCERNS		
Ability to retain primary care providers (MD, DO, NP, PA, nurses) in the community	2	
Availability of specialists	0	
Availability of substance use disorder treatment services	6	
Availability of mental health services	12	12
YOUTH POPULATION HEALTH CONCERNS		
Alcohol use and abuse (all ages, Youth and Adult)	7*	2*
Depression/anxiety (all ages, Youth and Adult)	8**	0**
Drug use and abuse (all ages, Youth and Adult)	4	
Smoking and tobacco use (second-hand smoke, vaping)	0	
ADULT POPULATION HEALTH CONCERNS		
Alcohol use and abuse (all ages, Adult and Youth)	7*	2*
Depression/anxiety (all ages, Adult and Youth)	8**	0**
Drug use and abuse (all ages, Youth and Adult)	4	
Obesity/overweight	1	
Stress	1	
SENIOR POPULATION HEALTH CONCERNS		
Ability to meet needs of older population	0	
Availability of resources to help elderly stay in their homes	2	
Cost of long-term/nursing home care	1	
Quality of elderly care	0	
VIOLENCE CONCERNS		
Bullying/cyber-bullying	2	
Child abuse/neglect	2	
Domestic/intimate partner violence	2	
Emotional abuse (Ex. Intimidation, isolation, verbal threats, withholding of funds)	0	
*This concern was presented as one encompassing concern for all ages in the online ranking and received 7 total votes for the Priorities column and 2 total votes for the Most Important column. **This concern was presented as one encompassing concern for all ages in the online ranking and received 8 total votes for the Priorities column and 0 total votes for the Most Important column.		

Appendix G – Survey "Other" Responses

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

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

1. Considering the PEOPLE in your community, the best things are: "Other" responses:
    - (2) None of the above
    - Feels safer then a bigger city
    - I may be an outlyer, but I am unable to state a "best thing" about Dickinson
    - Negative Nellies
    - Not radicalized one ay or the other
    - Safe neighborhoods, compared to other places I've lived
    - There are medical facilities here
    - Value education
    - We back the blue!
2. Considering the SERVICES AND RESOURCES in your community, the best things are: "Other" responses:
    - Again, none apply
    - City refuse dept does an awesome job
    - Events in summer
    - Fitness and wellness centers
    - Grocery Store
    - None of the above
    - Recreation facility
    - Sad to say most all of the options are not good services or resources
    - We have more resources than immediate surrounding areas
3. Considering the QUALITY OF LIFE in your community, the best things are: "Other" responses:
    - All of the above.
    - No traffic, congested neighborhoods, etc
    - None
    - Provide for the learning challenged
    - Recreational opportunities
4. Considering the ACTIVITIES in your community, the best things are: "Other" responses:
    - Affordability of WRCC and community programs
    - Bowling
    - None we don't have anything that if you go there are to many people abd drnking and smoking. Nothing for the kids unless you can pay the high prices for the community center. Why is Dickinson spending all this money on new lighting,stupid sidewalks outside Dickinson that no one uses, no place to shop no good resturants I really don't understand why anyone would want to ove here. We have all theseold houses with holes in the roofs or the house is ready to colapes.
    - None of the above
    - Not to happy with the local events
    - Out of town lacks these

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:

- Behavioral health resources
- Drug Use
- Junk & too many dogs in the city.
- No activities/ facilities for kids in the winter months besides the rec
- No inpatient services for mental health and substance abuse
- No shopping, few restaurants with variety
- Not enough businesses
- Not enough cheap or free activities for family year round
- Not enough restaurants, shopping
- Not enough retail shopping
- Not having adequate mental health like inpatient psychiatric services
- Quality emergency room services
- The only way a person with a disability can get a job here is someone they knows hires them. The Voc Rehab office here does not help people with disabilities they can work jobs no one else will work. It's a disgrace especially when you have the qualifications and they won't help. Back stabling employers around here tell other employers who to hire and if they ask they tell then no work ethics or sick a lot when your supervisor bullies you and then not sending the paperwork for FMLA to help family. It's not fair to the patients or coworkers. Unreal no employer will help you even if you really really wants a job.
- Toxic Social Media
- Youth depression anxiety

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

- Complete cancer facility
- Dermatologist
- Getting healthcare results in a timely manner
- Values that espouse active efforts to avoid prevent Covid vaccines, masks, social distancing, etc
- We don't have a health service hear that anyone can trust. You go into ER in the morning they run a few tests then release then. They get home and collapse so back up to the hospital again with a different doctor who tells you your family member only has about 4 to 6 weeks to live because they have cancer everywhere. If you an older adult and you are having so much pain and they said to bad we don't give out drugs on the weekend. It is so easy to get a staph infection then you go to Bismarck but not soon enough so amputation.

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

- ADHD services lacking in schools
- Behavioral health needs overall
- Cyber Bullying
- Not enough activities for children over the age of 5
- Parents not engaged with their own kids
- Respect for authority
- Too many broken and disconnected family settings for children
- Toxic Social Media

9. Considering the ADULT POPULATION in your community, concerns are: "Other" responses:
    - All of the above
    - Behavioral health needs
    - Dermatologist or pain mngmt
    - Government forced medical decisions
    - Loneliness/isolation of elders
    - Mental health resources
    - Parents not making their children their priority
    - Racism, hate speech, hard to be around such hateful people
    - Toxic Social Media

Other chronic diseases:

- Mental Illness
- Serious mental illness

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

    - All of the above
    - Behavioral health overall
    - Cost of prescription medications and cost of food on fixed income
    - Loneliness
    - Mental illness
    - Transportation cost

12. Regarding impacts from OIL DEVELOPMENT in your community, concerns are: "Other" responses:

    - Behavioral health services
    - Lack of employment opportunities for women
    - Lack of high paying jobs outside of oil development
    - Limited shopping
    - No stores to shop.
    - Rental Prices
    - Retaining new families

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

    - Access to behavioral health services and lack of collaboration between the mental health community providers.
    - Access to mental health services.
    - Adequate salary for many people working in service industry
    - Affordable housing
    - Affordable housing/living places for seniors without owning and maintaining a home
    - Affordable, modern housing
    - Alcohol and drug misuse
    - Break down of family units and disconnect/ lack of effective communication. Too much alcohol and drug use
    - Care and Treatment for all stages of mental health
    - Commitment
    - Complexity to get services now with new government restructure
    - Depression/anxiety
    - Diversity
    - Drug and alcohol use in teens.

- Drugs & violence
- Economic conditions (lack of rain, heat, price of fuel, rising costs of most everything)
- Empathy for the needy/disabled.
- Favoritism based on old money
- Fluctuating population
- Getting and keeping healthcare professionals. We need quality health care with more specialists. We need doctors that care and not just push drugs. find out what is really the problem. We the people are not numbers. we are human beings.
- Having enough resources for the elderly. Also services for the people with drug and alcohol issues.
- Having the appropriate amount of law enforcement staff to deal with growing number of challenges that law enforcement faces every day.
- Health specialist
- Help wanted at nearly every establishment in town, unable to fill positions
- HOUSING COSTS
- I don't know why anyone would move here. no shopping, not good medical facility, the elderly and disabled are not being helped. Right now if I could move I would but I'm stuck here. Those Assistant Living places don't care about their residence, the food is terrible, and they are charged for any other little thing they need to do, and those places charge too much. How can a person survive on disablility unless you give everything up to Social Services that you have worked so hard for. Ive had agencys to just let my daughter live on the street! Really this is how poor and disabled people are treated. They might find you a cheap place to live either a druggy place or a dirt hole. A person can always have suicide thoughts mostly everyday and no one to help you.
- INCREASE IN CRIME AND DRUG/ALCOHOL USE
- Infrastructure
- Judges who do not follow through with recommended sentencing guidelines for repeat drug offenders. ND State Hospital and other providers who do not follow court recommendations for commitment of clients with high risk mental health issues or seek out recommendations from other providers who have knowledge of the situation. New state protocols that have been implemented who have social service offices dropping clients who then fall through the cracks without anywhere else to turn for help, case management and other assistance. Who's brilliant idea was that?
- Lack of behavioral health services. Lack of counseling services. Lack of services for adolescence. The lack of transparency and services provided by the state, the human service center. Being referred to the human service center is a joke. They are rude, give you the run around and then ship you out the door without offering any real help. Not able to talk to anyone in charge.
- Lack of daycare resources. No support from the city.
- Lack of employee's to fill positions
- Lack of facilities to address mental health and substance abuse. We are running out of places to send people to that need help.
- Lack of local behavioral/mental health resources
- Lack of mental health services from ages youth to senior adults, not having enough high intense services like residential treatment, not having inpatient services
- Lack of people willing to work at lower paying jobs such as fast food, retail stores, and restaurants. Younger people not having the same work ethic.
- Lack of Providers, and inpatient mental health, and inpatient addiction treatment facilities for all populations.
- Lack of resources- daycare, hospice, providers
- LACK OF RETAIL SHOPPING RESULTING IN LOSS OF TAX REVENUE. ONLINE AND OUT OF TOWN SHOPPING.
- Lack of transparency among agencies whether it be government (stark/dickinson commissions) , public schools- they all want more from their citizens both monetarily and physically in efforts- but they are not inclusive and/or degrading when the public does not support their views
- Local and state government that don't listen to what the people need, they do what the federal government tells them.
- Low wages, lack of livable wages

- Mental health care
- Mental health issues. We have some major problems with mental health issues within Dickinson and NOT NEARLY enough people to combat this issue, which is getting worse.
- Mental health options. Badlands is really the only facility that can take dual diagnosis individuals. There is no place for people with mental health and substance abuse to stay at and to get the appropriate resources for sobriety. RCC is a place where people can go for a short time but there is no consistency with them and it is a revolving door for mental health and addiction. There needs to be more long term solutions for these individuals with addiction. They are dropped off at the ER and the staff in the ER is expected to treat and cure them. The facilities in Bismarck and Fargo are always full and to get transportation is absolutely horrible because it requires the sheriff's dept. and they are short staffed and busy as well. These individuals deserve better. This is not the first time somebody in the community has brought this up. There needs to be more emphasis and thought put into these issues.
- Mental health related services
- Mental healthcare
- My community lost Herberger's, Penny's, and many other retail stores. Older citizens have no decent clothing or shoe stores to utilize.
- N/A
- Not able to attract families including good doctors so people would not say, "I'd rather take a chance at dying going to Bismarck than to be assured of death in Dickinson." I have heard this often by many different people.
- Not enough restaurants in Dickinson
- Not enough things to do for teens and younger children, for teens they tend to go more towards the drugs and alcohol for something to do and younger children i think they should have more activities/places to play at.
- Not having enough healthcare professionals to sustain the growing community.
- Not having enough support for natural health care approaches.
- Our ER department in Dickinson needs a overhaul of new professionals. People are risking their health to drive to Bismarck to avoid the ER here.
- Parents not engaged with kids and not wanting to parent. This leads to generations of bad behavior
- Proliferation of ignorance and arrogance driving's decisions/behaviors
- Property taxes are way too high!
- Racism and absence of understanding the impact of it in our community
- Racism, prejudice, hate speech. Especially adults passing the rhetoric to their kids as seen from my middle school and high school aged children
- Racism, prejudice, hate, discrimination
- Retail shopping
- The community lacks a self-identity.
- The decline of the faith-based nuclear family as a stable support system for youth.
- The difference between our economy and the wages of being able to live here are skewed due to the oil impact.
- The exclusionary attitude of those in the area. If you weren't born here, from here originally, then you are considered an "outsider". It is sad.
- The fact there are no cheap or free activities for familys year round . For a family with more than 2 kids it gets extremely expensive going to the few places we have for children because admissions are usually $8+ per child, so if you're like me and have 4 kids that's $32 for 1 time .
- The ridiculously high cost of housing (rent and also houses for sale), along with the high cost of utilities and property taxes
- There is a general lack of accessible behavioral health services for both youth and adults and a lack of overall social determinants of health (i.e. employment coaching, access to quality healthcare for individuals experiencing behavioral health and community based services, homeless shelter, transitional housing, and affordable/low income housing, and transportation. There are people who could work but may not have the skills to complete the work that is in demand, especially in trades. Private providers often don't take insurance and if they do, may only take private insurance. Self pay services don't serve those who need them most.

- There is a vast space between the have and the have nots. A huge number of people live in poverty due to lack of job skills, lack of initiative, lack of education, poor health, or poor daily living skills. Many of these, living almost hidden from sight, are kids who do not have someone to guide and encourage them. Those kids are an after thought, if they are thought of at all.
- There isn't enough resources for mental health care. It's not affordable in most places here. We have zero in patient care for the mentally disabled. People struggle to find a support system here with out being judged or talked about since it's a small community. We need an entire building for mental health care, and drug and alcohol services for those struggles.
- There's nothing in Dickinson to draw people from other areas. We need a big mall, mini golf, zip lining, bumper cars, skeet shooting, horse back riding, floating down green river in tubes...
- Tolerance and acceptance. There are so many racists here.
- Toxic Social Media
- Winter activity
- Wrap-around services for mental and behavioral health. We have a number of committed and dedicated organizations in the community, but the lack of three major things prevents success: 1.) In-Patient Psych Beds for stabilization of patients, 2.) In-Patient counseling/substance abuse treatment center, 3.) Long-term transitional or supportive housing

Delivery of Healthcare

15. What PREVENTS you or other community residents from receiving healthcare: "Other" responses:

- Cant get in to regular provider for weeks, go to walk in where they tell you that you should be going to your regular provider. Shaming. Medical providers dislike of "old people" (seems like that is getting younger, like 60"
- Lack of specialists
- Stigma against behavioral health; not enough local providers for behavioral health
- Unable to see the DOCTOR
- Unwillingness to get vaccinations

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

- Community Agencies
- Online research
- Publication on what is available each year

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

- National Patient Support Groups
- Newspaper article

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

- A cancer center and more dermatologist!!
- A Walk in clinic at the hospital
- Addiction and Mental Health
- Anything for mental health and substance abuse
- Better emergency room capability. Seems like most calls are transferring elsewhere.
- Birthing center, other (more natural) options
- Cancer doctor, cardiologists
- Cancer specialists...cardiologists..
- Cancer treatment, heart doctors, diabetic specialists, endocrinologist
- Cardiologists, pulmonologists, and psychiatrists
- Childbirth/preparing for labor classes. Rehabilitation for drugs and alcohol.

- Competing hospital???
- Counseling and addiction services
- Dermatalogy
- (2) Dermatologist
- (5) Dermatology
- Dermatology, Oncology, ENT, neurology
- Dermatology, Oncology, Psychiatry
- Dermatology, Psychiatry, Nephrology, Cardiology, Neurology
- Dermotology
- Drug treatment centers/rehabs!!
- Ear nose and throat, Pulmonologist and other sepicalties
- ENT, Cardiology
- Free/ affordable behavioral health options; better care management for disabled
- Full laboratory testing, not waiting for results to come days later from Bismarck
- Heart and lung
- Heart specialist
- Heart, dermatology for all ages
- I think what we have is pretty good--we should "beef up"/strengthen what we have
- (5) mental health
- Mental health and substance abuse services
- MENTAL HEALTH CARE HOSPITAL
- Mental Health especially in Pediatric
- Mental Health Services
- Mental health, more visiting specialties
- Mental Health, specifically childrens. I have to drive my kiddo to Bismarck to receive quality counseling services. When we were in Dickinson he had to go through the RCC area to get into the elevator to see a practitioner which I think is inappropriate and made us both feel unsafe
- Mental health, substance abuse counseling
- More mental health care
- More mental health services, it takes way too long to get in to mental health professionals.
- More Orthopedics and cardiac specialists
- More specialist, there no 1 specialist in particular just specialist in general. I know myself and others get very annoyed with having to travel over an hour 1 way just to see a specialist if needed
- More specialists
- More substance abuse and mental health services
- More vision care, speciality care, inpatient mental health and substance abuse treatment
- More walk-in, more providers to choose from
- N/A
- Natural Health providers.
- Pain management and dermatology. cancer services
- Pediatric mental health, dermatology
- Pediatrics
- Services for cancer patients needing treatment
- (2) Specialists
- Specialists in pediatric dentistry, pain management, neurology, pediatric specialists like diabetes and cardiology
- Specialists, more available practices

- Specialty care
- Specialty doctors
- Transportation assistance to specialists, if needed
- Urgent care
- (2) Urology
- We are in dire need of a homeless shelter + a homeless shelter for women/children only so the DV center can serve those who are DV and not everyone who needs shelter. We need transitional housing and affordable housing. We need public transportation that is more accessible and far more affordable.
- We have nothing here and what we do have is the worst. Ive gone into rooms that supposable were cleaned with bloody gauze on the floor. Don't get to see your regular doctor who knows you the best. We have no good specialists but if you want to get an infection besure to go to Sanford Clinic by the time the doctor is done with you you are missing parts of your body because you have an incompetive doctor.
- We need mental health facility for adults and youth
- We need more doctors. Period. Especially pediatricians.

22. Health insurance or health coverage status: "Other" responses:

- MEDICA
- Supplement through retirement program
- TriCare
- Tricare For Life

28. Race/Ethnicity: "Other" responses:

- Human

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

- A more comprehensive/collaborative approach with the various stakeholder groups is essential to making this happen. Ignoring naysayers who are barrier focused is also a key to success that has regretfully gotten in the way of us moving forward in the past.
- Access to specialists at the local level during non typical business hours. I will not travel out of town to see specialists and/ or take excessive time off from work. There is frequently long wait times to see a specialist or in getting labs, or xrays. This results in an added expense in loss of wages or additiinal childcare. My time is as valuable as a doctor.
- ADHD youth camps for different ages. More services for children and young adults on the spectrum. Social discussion groups.
- Attract and retain quality Doctors, Nurses and all healthcare employees. Warm bodies fill space, but cannot provide quality service.
- Better people in healthcare, reduced overhead in the area of administration and other ways to reduce the cost of quality healthcare services without reducing providers compensation.
- Confidential and patient care have caused our family to travel to Bismarck.
- CONFIDENTIALITY WITH PATIENTS.
- Consistency in providers is an issue - they come/they go and we are left starting over with someone new. The biggest health issue is behavioral health.
- Educating patients on self reliance and taking control of their health
- Gov't (local, state) should make solid fact based decisions
- Healthcare professionals need to have training on how to work with those with mental illness and SUD to better treat individuals holistically. Would recommend that the CHI hospital and clinics do survey with patients about how they are treated , how can they improve. How can patients be treated in a way that is compassionate, supportive and make sure all healthcare staff are trained to work with those with mental illness, substance use.
- Hospital needs to have a walk in clinic, more visiting specialists, improve hospital billing system.
- I believe our local Public Health has done everything to help Dickinson citizens get the proper care or are told where to go to get the care.
- I feel that healthcare is fragmented and is not aligned in the community. Providers are siloed and there

is a lot of stigma and/or lack of understanding of behavioral health conditions, especially substance use disorder as a chronic and persistent brain disease. I would love to see the community work together with a growth mindset and all providers and partners acknowledge a role in making the community healthier.

- I feel there is a major need for the lower income people in the community for healthcare especially for younger girls.
- I would love to see more providers brought to Dickinson or have all providers under one roof. It would be nice if Sanford and CHI could combine and work together. It is hard to see patients being sent from one facility to the other because certain services are not provided by each facility. Our area needs a mental health facility and some type of sober living house for the community. Alcohol and drug abuse is an issue in this community and it has always been, I think that is why it is passed over because people have grown "used" to it or numb to it. Hand-in-hand with that comes the mental health aspect also (which COVID has not helped). We need to address our community as a whole and that includes our mental health and well-being, if we cannot do that then we are failing our community as so-called health providers.
- Improve the rating of the hospital by having better emergency room care.
- Increase service providers. Putting the patient first.
- It is hard to get to talk with your provider unless you keep scheduling appointments which can be hard if can't get to the clinic. You present with concerns and you are referred to a "specialist" who is not helpful.
- It would be great to have more specialty services locally or via telehealth. There are some available, but it takes weeks or months to get an appointment. More providers would help. Having a better licensing/credentialing process for the providers would help too. Recruitment of professional staff to work rurally.
- It would be nice to have a cancer center like Bismarck and more cancer doctors so we don't have to travel to Bismarck. We also need more dermatologists! There are none here in Dickinson
- Less harrassment from health professionals about getting vaccinated. Respect a person's individual right to choice.
- More open-minded professionals in the ER who do not gossip when the patient and family can clearly hear what's going on in the hall. Better compassion, less judgemental behaviors, better confidentiality
- More specialists and better er coverage ability for all of sw nd.
- My husband and I actually have found doctors in Bismarck ND because they are very good with Health care down there..
- N/A
- Need more options for providers, better quality of providers. I go to bismarck for my health care needs because i do not trust the providers here. my insurance only covers CHI and there are no CHI walk-in or urgent care facilities here
- Need more physicians and specialists and definitely need Sanford physicians to have admitting privileges to our hospital. Need more sharing with CHI and Sandford.
- None
- Our tax money is already going to programs in this community. They are overall poorly run services and lack quality employees. We need higher standards for the publicly funded services in this area.
- Quality of care is sorely lacking with general medicine and especially emergency department. Baby unit is the only A+ part of our healthcare system.
- Rural health is a disaster. Preventative/education resources are beneficial, but any emergent, crisis, or long term care is unmet here.
- Sometimes when there is an overabundance of patients, short staffing is a problem
- Telehealth visits for out-of-town specialists should be implemented for visits not requiring specialized physical assessments. Physical assessments could be done by the primary doctor beforehand.
- The western and of the state makes SO much money for ND. Yet places like Fargo, Bismarck have all the resources.
- Transportation
- Understanding the complexity of getting and retaining specialists in this area, I would still like to see us have more weekly options to them at the very least. The population needs this service, it is a stress and concern to get to these appointments when needed, especially the older people who may have limited

transportation options

- We have a huge need for mental health resources in the community, especially inpatient. It is very hard to find beds in this state for inpatient mental health and if we can find a bed, it is difficult to secure transport to these facilities, as they typically require two sheriff's deputies.
- We need additional access to behavioral health services. The local governmental agency (BLHSC) needs to collaborate and share information on their programming. The agencies need to work together to ensure transition between services for clients is effective. There are not enough providers at the local human service center but they DO NOT share information with the community. Clients are not provided with options or assistance in accessing services. There is no collaboration if a patient is seen in a community provider and is identified as a person who has serious mental illness to access services at BLHSC as they do not collaborate with community providers. There also needs to be more SUD services.
- We need better mental health services with in community. What we have works but it's not nearly enough for the problems this community has.
- We need more doctors and medical professionals that truly care and listen to their patients instead of passing you on to another doctor that doesn't know why you were sent to him. Maybe a mental health doctor could be on staff for the other doctors that need a little help that day. Maybe with a clearer head, they could give better treatment.
- We need to increase the quality of ER care that currently exists in our local facility.
- We very much need a cardiology dept, more docs, and doctors to work together to transfer a patient out of Dickinson if they cannot help that person rather than insisting they stay here.