CHI St. Alexius Health

2019 Community Health Implementation Strategy

Adopted October 2019

Catholic Health Initiatives

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At-a-Glance Summary

Community Served

The residents of the cities of Bismarck and Mandan and their surrounding areas are the primary sources of those patients served by CHI St. Alexius Health. Bismarck is the capital of the state of North Dakota and the county seat of Burleigh County. The U.S. Census population estimate for Bismarck in 2017 was 72,865 people and 95,030 for Burleigh County. Bismarck is the second most populous city in the state of North Dakota. The City of Mandan is directly across the Missouri River from Bismarck. Bismarck and Mandan make up the core of the Bismarck-Mandan Metropolitan Statistical Area.

As a hub of retail and health care, Bismarck is the economic center of south central North Dakota and north central South Dakota. Bismarck has received national recognition and stands out as an emerging community by being listed on the following: Forbes Best Small Places for Business and Careers, Milken Institute's Best Small Cities, and CNN Money's list of top 100 places to live in the nation. Bismarck-Burleigh county serves as home to higher education facilities such as the University of Mary, Bismarck State College and United Tribes Technical College, in addition to several of the state's top businesses.

Significant Community Health Needs Being Addressed

The significant community health needs the hospital is helping to address and that form the basis of this document were identified in the hospital's most recent Community Health Needs Assessment (CHNA). Needs being addressed by strategies and programs are:

- Opioid Abuse
- Food Insecurity
- Domestic Violence

Strategies and Programs to Address Needs

The hospital intends to take actions and dedicate resources to address these needs, including:

1. Opioid Abuse
   a. Review current takeback policy
   b. Assess prescription usage
   c. Review literature on other programs
   d. Plan provider education programs
   e. Educate patients
2. Food Insecurity
   a. Assess food hunger among dialysis patients
   b. Educate nurses and physicians on assessment of food insecurity
   c. Work with dietary, food pantries and families to simplify the process of obtaining appropriate foods
3. Explore opportunities to educate health professionals about domestic violence
   a. Assess for domestic violence
   b. Appreciate selected interventional skills in domestic violence situations

Anticipated Impact 	The thrust of these three strategies will impact the general health of the community served by CHI St. Alexius Health. They deal primarily with those living in the community rather than hospitalized patients, seeking ways to keep them healthy and out of acute care.
Planned Collaboration 	Opioid Abuse: CHI St. Alexius Health and Dignity Health will use a grant to: 1) work together to impact the abuse of opioids; 2) learn from one another and share in a broader impact of a joint program; and 3) participate in a grant designed to reduce the usage of opioids. Food Insecurity: The kidney dialysis patients, nurses and families will work with the dietary department to assess need; with the social work department to identify means of meeting the need; and with mission enhancement to ensure the need is met to the best of our ability. Domestic Violence: Education programs exploring safety behaviors, assessment programs and intervention strategies will be offered throughout the medical center and clinics.

This document is publically available online at https://www.chistalexiushealth.org/about-us/community-health-assessments

Written comments on this report can be submitted to the CHI St. Alexius Health Administration Office, 900 East Broadway, Bismarck ND 58506.

Our Hospital and the Community Served

About CHI St. Alexius Health

CHI St. Alexius Health is a member of Catholic Health Initiatives, which is a part of CommonSpirit Health.

CHI St. Alexius Health, founded in 1885 to care for the health needs of the people of the region, supports the Catholic health ministry's commitment to improve the health of our communities and provide quality and compassionate health care. CHI St. Alexius Health Bismarck is an acute care medical center offering a full line of inpatient and outpatient medical services, including primary and specialty physician clinics, home health and hospice services, durable medical equipment services, and a fitness and human performance center. Besides the main campus located in Bismarck, North Dakota, CHI St. Alexius Health owns and operates hospitals and clinics in Garrison and Turtle Lake, North Dakota. CHI St. Alexius Health also manages the hospital and clinics owned by Mobridge Regional Hospital in Mobridge, South Dakota. CHI St. Alexius Health also owns and operates family care clinics in Bismarck, Mandan, Minot and Washburn. Since our founding, CHI St. Alexius Health Bismarck has been dedicated to serving the residents of central and western North Dakota, northern South Dakota and eastern Montana.

CHI St. Alexius Health is a Roman Catholic organization whose sponsors are the Benedictine Sisters of Annunciation Monastery, Bismarck, North Dakota. As a Catholic Institution within the Diocese of Bismarck, we abide by the Ethical and Religious Directives of Catholic Health Care Services as promulgated by the United States Conference of Catholic Bishops.

CHI St. Alexius Health is committed to building on its strengths in providing faith-based care to better serve communities in the region through enhanced services and improved coordination of care. Our partnerships ensure a viable, innovative, high quality care for everyone who enters under our arch.

Believing that everyone should have access to high quality, affordable health care, we work toward creating the highest value health care delivery models. We are dedicated to serving all patients who need our care. Approximately half of our medical services are for Medicare patients and patients in other government programs.

	2016	2017	2018	Grand Total
Garrison Memorial Hospital	**$ 11,459.33**	**$ 2,011,772.09**	**$ 1,354,413.63**	**$ 3,377,645.05**
FINANCIAL ASSISTANCE WRITE OFF	$ 11,459.33	$ 629,475.27	$ 77,623.47	$ 718,558.07
PRESUMPTIVE CHARITY		$ 81,456.56	$ 1,118,608.68	$ 1,200,065.24
PRESUMPTIVE SCORED CHARITY		$ 1,300,840.26	$ 158,181.48	$ 1,459,021.74
St. Alexius Medical Center	**$ 6,029,311.28**	**$125,310,578.19**	**$58,599,899.68**	**$189,939,789.15**
FINANCIAL ASSISTANCE WRITE OFF	$ 6,029,311.28	$ 61,087,233.37	$22,031,233.75	$ 89,147,778.40
PRESUMPTIVE CHARITY		$ 2,635,050.51	$20,744,763.57	$ 23,379,814.08
PRESUMPTIVE SCORED CHARITY		$ 61,588,294.31	$15,823,902.36	$ 77,412,196.67
Turtle Lake Community Memorial Hos	**$ 1,478.60**	**$ 611,085.35**	**$ 741,381.12**	**$ 1,353,945.07**
FINANCIAL ASSISTANCE WRITE OFF	$ 1,478.60	$ 165,755.46	$ 22,996.63	$ 190,230.69
PRESUMPTIVE CHARITY		$ 4,414.32	$ 672,327.38	$ 676,741.70
PRESUMPTIVE SCORED CHARITY		$ 440,915.57	$ 46,057.11	$ 486,972.68
Grand Total	**$ 6,042,249.21**	**$127,933,435.63**	**$60,695,694.43**	**$194,671,379.27**

CHI St. Alexius Health follows the Internal Revenue guidelines and the recommendations of the Catholic Health Association for Community Benefit reporting. It is the policy of Catholic Health Initiatives and its tax-exempt Direct Affiliates and tax-exempt Subsidiaries that are health care providers to collaborate with community partners to identify community needs and assets, and to plan, coordinate and implement responses to such needs. In addition, because it is important to ensure that the communities served by CHI Entities benefit from CHI programs and services, it is the policy of CHI to document and report on CHI Entity community benefit activities in a consistent and comprehensive manner.

In February of 2019, CHI St. Alexius Health, as part of Catholic Health Initiates (CHI), merged with Dignity Health to form CommonSpirit Health. Together, we seek to be stronger in our delivery of health care to:

- Build healthier communities wherever we are
- Transform health care access and delivery
- Personalize care for those with acute and chronic conditions
- Create an inspired culture of excellence for our employees and physicians
- Advance our sacred calling to serve all

CHI St. Alexius Health Bismarck is proud of its stellar reputation as a caring, high quality medical center and of its many awards for clinical excellence, customer satisfaction and community service, but we are even more proud of our dedication to our mission.

Throughout its history, the medical center has proudly served central and western North Dakota. Our ever-expanding lists of medical programs, services and providers play an important role in the overall health and wellbeing of our communities.

Our Mission

The mission of Catholic Health Initiatives is to nurture the healing ministry of the Church, supported by education and research. Fidelity to the Gospel urges us to emphasize human dignity and social justice as we create healthier communities.

Financial Assistance for Medically Necessary Care

CHI St. Alexius Health delivers compassionate, high quality, affordable health care and advocates for members of our community who are poor and disenfranchised. In furtherance of this mission, the hospital provides financial assistance to eligible patients who do not have the capacity to pay for medically necessary health care services, and who otherwise may not be able to receive these services. The financial assistance policy and a plain language summary of the policy are on the hospital's website.

Description of the Community Served

CHI St. Alexius Health serves residents of the cities of Bismarck, Mandan, and Lincoln along with the neighboring counties.
Bismarck is the capital of the state of North Dakota and the county seat of Burleigh County; Mandan is the county seat of Morton County. The U.S. Census population estimate for Bismarck in 2017 was 72,865 people and 95,030 for Burleigh County. Bismarck is the second most populous city in the state of North Dakota. Bismarck is on the east bank of the Missouri River, directly across the river from the city of Mandan. The two cities make up the core of the Bismarck-Mandan Metropolitan.

Statistical Area

As a hub of retail and health care, the Bismarck/Mandan area is the economic center of south central North Dakota and north central South Dakota. Bismarck has received national recognition and stands out as an emerging community by being listed on the following: Forbes

Best Small Places for Business and Careers, Milken Institute's Best Small Cities, and CNN Money's list of top 100 places to live in the nation. Bismarck-Burleigh County serves as home to higher education facilities such as Bismarck State College, the University of Mary, United Tribes Technical College in addition to several of the state's top businesses.

2018 Community Health Needs Assessment

In 2018, CHI St. Alexius Health participated in a Community Health Needs Assessment in collaboration with both local hospitals, Bismarck-Burleigh County Health and Sanford Health. This section of the report contains information regarding the purpose of the assessment and a description of the surveys and information gathered throughout the survey process. Priorities have been identified and key concerns will be addressed through implementation strategies in the next three years.

Purpose

The purpose of the survey of residents in the greater Bismarck-Mandan area (i.e., Burleigh and Morton counties in North Dakota) was to learn about the perceptions of area residents regarding their personal health, the prevalence of disease, and other health issues in the community.

This Community Health Needs Assessment is a collaborative project of CHI St. Alexius Health, Bismarck-Burleigh Public Health and Sanford Health, whose efforts ultimately lead to the implementation of comprehensive strategies for community health improvement in our local area.

Study Design & Methodology
Primary Research
Key Stakeholder Survey

An online survey was conducted with identified community key stakeholders. The study concentrated on the stakeholders' concerns for the community specific to economic wellbeing, transportation, children and youth, the aging population, safety, health care and wellness, mental health and substance abuse. The study was conducted through a partnership with Center for Social Research (CSR) at North Dakota State University. The CSR developed and maintained links to the online survey tool. Bismarck-Burleigh Public Health distributed the survey link via email to stakeholders and key leaders located within the Bismarck/Mandan community and Burleigh and Morton counties. Data collection occurred during December 2017. A total of 68 community stakeholders participated in the survey.

Resident Survey

The resident survey tool included questions about the respondent's personal health. An online survey was developed in partnership with public health experts. The Minnesota Health

Department reviewed the survey and advised to include key questions used in the State Health Improvement Program (SHIP) surveys and those questions were included in this survey. The North Dakota Public Health Association developed an Addendum to the survey with questions specific to the American Indian population. The survey was sent to a representative sample of the Burleigh county and Morton county populations secured through Qualtrics, a qualified vendor. A total of 645 community residents participated in the resident survey.

Community Asset Mapping

Asset mapping was conducted to find the community resources available to address the assessed needs. Each unmet need was researched to determine what resources were available to address the needs.

Community Stakeholders Meeting

Community stakeholders were invited to attend a presentation of the findings of the CHNA research. On Thursday, April 5, 2018, the Community Health Collaborative Core Group hosted a Community Health Stakeholders meeting at the Bismarck Event Center Prairie Rose Rooms 102 & 103. Community profile information for Burleigh and Morton counties were presented to attendees in addition to survey findings from NDSU Center for Social Research. A total of 61 stakeholders were present for the Community Health Stakeholders meeting representing the following agencies:

- AARP, Bismarck City Commission
- Bismarck Parks & Recreation
- Bismarck Police Department
- Bismarck-Burleigh Public Health
- Bismarck-Mandan Chamber of Commerce
- Bridging the Dental Gap
- Burleigh County Commission
- Burleigh County Housing Authority
- Charles Hall Youth Services
- CHI St. Alexius Health
- City of Bismarck Administration
- Community Healthcare Association of the Dakotas
- Community Options
- Go! Bismarck Mandan
- Heartview Foundation
- Lutheran Social Services
- Mandan Police Department
- Mental Health America of ND
- Missouri Valley Homeless Coalition
- ND Department of Health
- Ruth Meiers Hospitality House
- Sanford Health
- State Legislators

- UND Center for Family Medicine
- United Tribes Technical College
- United Way
- University of Mary
- Vulnerable Adult Protective Services
- West Central Human Service Center
- YMCA

Following the presentations, facilitated round table discussions took place where attendees provided feedback on the survey results and shared ideas on how their organizations could assist with the needs identified. Facilitators captured the discussions and feedback from attendees.

Prioritization Process

The primary and secondary research data was analyzed to develop the top unmet needs. The analyzed list of needs was developed into a worksheet. A multi-voting methodology from the American Society for Quality was implemented to determine what top priorities would be further developed into implementation strategies. Community stakeholders utilized the worksheet for voting and prioritization was completed and ranked as follows:

Health Indicator/Concern CHNA Survey Results	Stakeholder Group Consensus Ranking
Economic Well-Being A. Homelessness 4.44 B. Housing accepting chemical dependency, mental health, criminal history, domestic violence 4.33 C. Availability of affordable housing 3.87 D. Hunger 3.64 (No food no $ to buy more)	1. Homelessness 2. Affordable Housing 3. Hunger
Children and Youth A. Cost of quality child care 3.97 B. Substance abuse by youth 3.97 C. Childhood obesity 3.94 D. Teen suicide 3.86 E. Cost of services for at-risk youth 3.79 F. Bullying 3.78 G. Availability of quality child care 3.69 H. Availability of services for at-risk youth 3.69 I. Teen tobacco use 3.54	1. Available services for at-risk youth 2. Childhood Obesity 3. Substance Abuse by Youth
Aging Population A. Cost of long-term care 4.07 B. Cost of memory care 4.03 C. Cost of in-home services 3.69	1. Cost of long-term care 2. Cost of in-home services 3. Cost of memory care
Safety A. Abuse of prescription drugs 4.27 B. Culture of excessive and binge drinking 3.74 C. Domestic violence 3.74 D. Presence of street drugs 3.71 E. Child abuse and neglect 3.64 F. Sex trafficking 3.63 G. Criminal activity 3.50	1. Abuse of prescription drugs 2. Culture of excessive & binge drinking 3. Child abuse & neglect
Healthcare Access A. Availability of mental health providers 4.27 B. Availability of behavioral health providers 4.23 C. Access to affordable prescription drugs 3.67 D. Access to affordable healthcare 3.66 E. Access to affordable health insurance 3.65 F. Care coordination between providers/services3.64 G. Availability of non-traditional hours 3.56	1. Availability of mental health providers 2. Availability of behavioral health providers 3. Access to affordable healthcare
Wellness A. Obesity (30% self-report overweight/38% obese) B. High cholesterol (26% self-reported high) C. Hypertension (22% self-reported high BP) D. Asthma (19% self-reported asthma) E. Arthritis (17% self-reported arthritis) F. Diabetes (11% self-reported diabetes)	1. Obesity 2. Diabetes 3. High cholesterol
Mental Health and Substance Abuse A. Drug use and abuse 4.53 B. Alcohol use/abuse 4.19 (42% self-report binge drinking) C. Depression 3.90 D. Suicide 3.89 E. Dementia and Alzheimer's Disease 3.63 F. Anxiety and stress (49% report anxiety/stress)	1. Drug use and abuse 2. Depression 3. Alcohol use & abuse

Community Assessment and Significant Needs

Statements	Mean**	Percent of respondents*						
		Level of attention needed						
		1 None	2 Little	3 Moderate	4 Serious	5 Critical	NA	Total
Coordination of care between providers and services (N=64)	3.64	3.1	15.6	25.0	26.6	29.7	0.0	100.0
Timely access to medical care providers (N=64)	3.17	4.7	25.0	35.9	17.2	17.2	0.0	100.0
Timely access to dental care providers (N=64)	3.09	4.7	32.8	26.6	20.3	15.6	0.0	100.0
Timely access to vision care providers (N=63)	2.52	12.7	41.3	33.3	6.3	6.3	0.0	99.9
Use of emergency room services for primary health care (N=62)	3.47	1.6	17.7	35.5	22.6	22.6	0.0	100.0
MENTAL HEALTH AND SUBSTANCE ABUSE								
Alcohol use and abuse (N=64)	4.19	0.0	3.1	20.3	31.3	45.3	0.0	100.0
Dementia and Alzheimer's disease (N=63)	3.63	0.0	11.1	33.3	34.9	19.0	1.6	99.9
Depression (N=63)	3.90	0.0	4.8	25.4	44.4	25.4	0.0	100.0
Drug use and abuse (e.g., prescription drugs, synthetic opioids, marijuana, heroin, cocaine) (N=64)	4.53	0.0	0.0	6.3	34.4	59.4	0.0	100.1
Exposure to secondhand smoke (N=64)	2.80	6.3	42.2	25.0	18.8	7.8	0.0	100.1
Smoking and tobacco use (N=64)	3.08	4.7	29.7	32.8	18.8	14.1	0.0	100.1
Stress (N=63)	3.41	3.2	15.9	36.5	25.4	19.0	0.0	100.0
Suicide (N=64)	3.89	0.0	4.7	32.8	31.3	31.3	0.0	100.1

*Percentages may not total 100.0 due to rounding.

**NA (not applicable) responses were excluded when calculating the Means. As a result, the number of responses (N) in Appendix Table 1, which reflects total responses, may differ from the Ns in Figures 1 through 7, which exclude NA.

Statements	Mean**	Percent of respondents*						
		Level of attention needed						
		1 None	2 Little	3 Moderate	4 Serious	5 Critical	NA	Total
Coordination of care between providers and services (N=64)	3.64	3.1	15.6	25.0	26.6	29.7	0.0	100.0
Timely access to medical care providers (N=64)	3.17	4.7	25.0	35.9	17.2	17.2	0.0	100.0
Timely access to dental care providers (N=64)	3.09	4.7	32.8	26.6	20.3	15.6	0.0	100.0
Timely access to vision care providers (N=63)	2.52	12.7	41.3	33.3	6.3	6.3	0.0	99.9
Use of emergency room services for primary health care (N=62)	3.47	1.6	17.7	35.5	22.6	22.6	0.0	100.0
MENTAL HEALTH AND SUBSTANCE ABUSE								
Alcohol use and abuse (N=64)	4.19	0.0	3.1	20.3	31.3	45.3	0.0	100.0
Dementia and Alzheimer's disease (N=63)	3.63	0.0	11.1	33.3	34.9	19.0	1.6	99.9
Depression (N=63)	3.90	0.0	4.8	25.4	44.4	25.4	0.0	100.0
Drug use and abuse (e.g., prescription drugs, synthetic opioids, marijuana, heroin, cocaine) (N=64)	4.53	0.0	0.0	6.3	34.4	59.4	0.0	100.1
Exposure to secondhand smoke (N=64)	2.80	6.3	42.2	25.0	18.8	7.8	0.0	100.1
Smoking and tobacco use (N=64)	3.08	4.7	29.7	32.8	18.8	14.1	0.0	100.1
Stress (N=63)	3.41	3.2	15.9	36.5	25.4	19.0	0.0	100.0
Suicide (N=64)	3.89	0.0	4.7	32.8	31.3	31.3	0.0	100.1

*Percentages may not total 100.0 due to rounding.

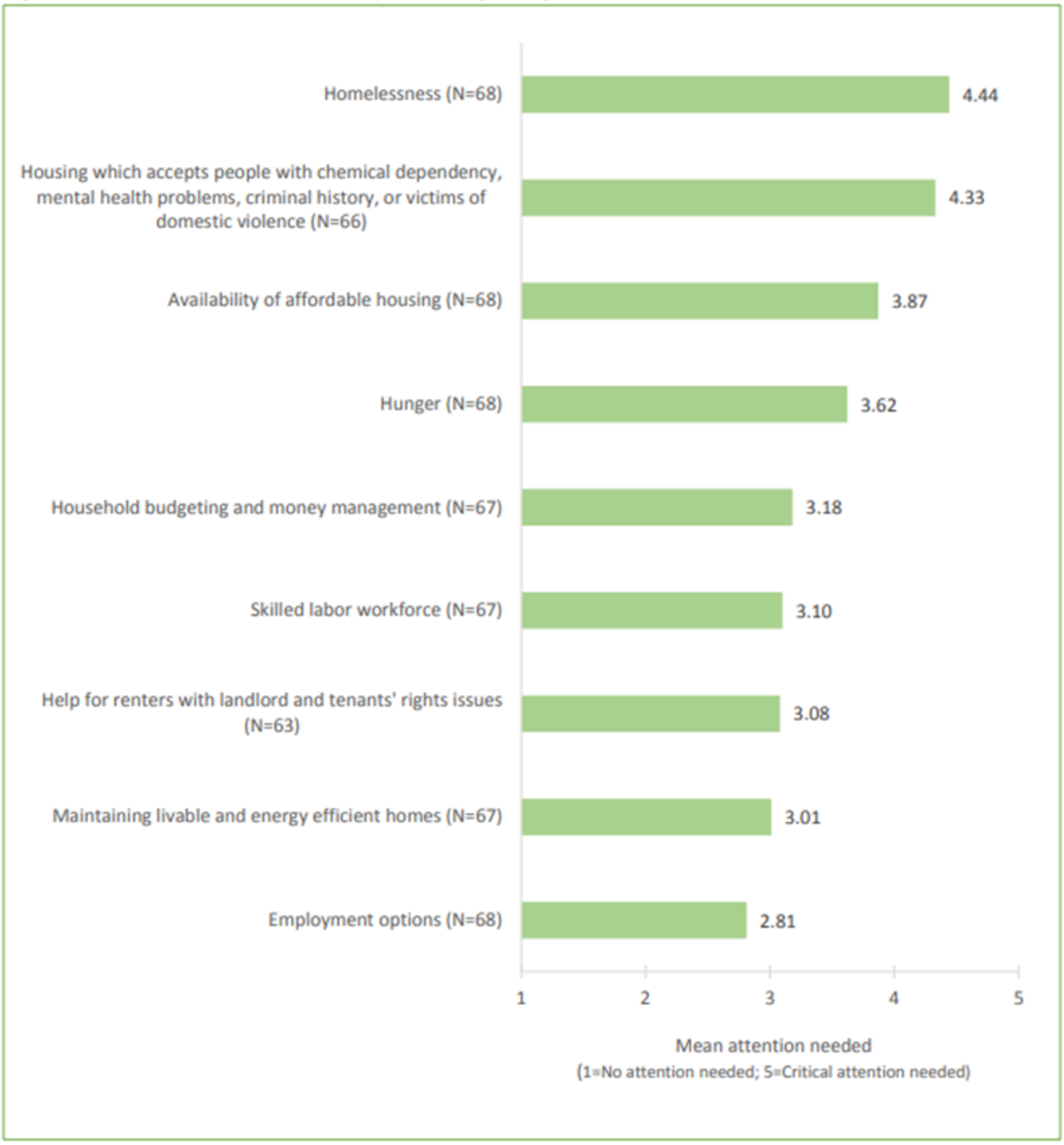
**NA (not applicable) responses were excluded when calculating the Means. As a result, the number of responses (N) in Appendix Table 1, which reflects total responses, may differ from the Ns in Figures 1 through 7, which exclude NA.

SURVEY RESULTS

Current State of Health and Wellness Issues Within the Community

Using a 1 to 5 scale, with 1 being "no attention needed"; 2 being "little attention needed"; 3 being "moderate attention needed"; 4 being "serious attention needed"; and 5 being "critical attention needed," respondents were asked to, based on their knowledge, select the option that best describes their understanding of the current state of each issue regarding ECONOMIC WELL-BEING, TRANSPORTATION, CHILDREN AND YOUTH, the AGING POPULATION, SAFETY, HEALTHCARE AND WELLNESS, and MENTAL HEALTH AND SUBSTANCE ABUSE.

Figure 1. Current state of community issues regarding ECONOMIC WELL-BEING



The hospital engages in multiple activities to conduct its community health improvement planning process. These include, but are not limited to, conducting a Community Health Needs Assessment with community input at least every three years, identifying collaborating community stakeholder organizations, describing anticipated impacts of program activities and measuring program indicators.

Figure 2. Current state of community issues regarding TRANSPORTATION

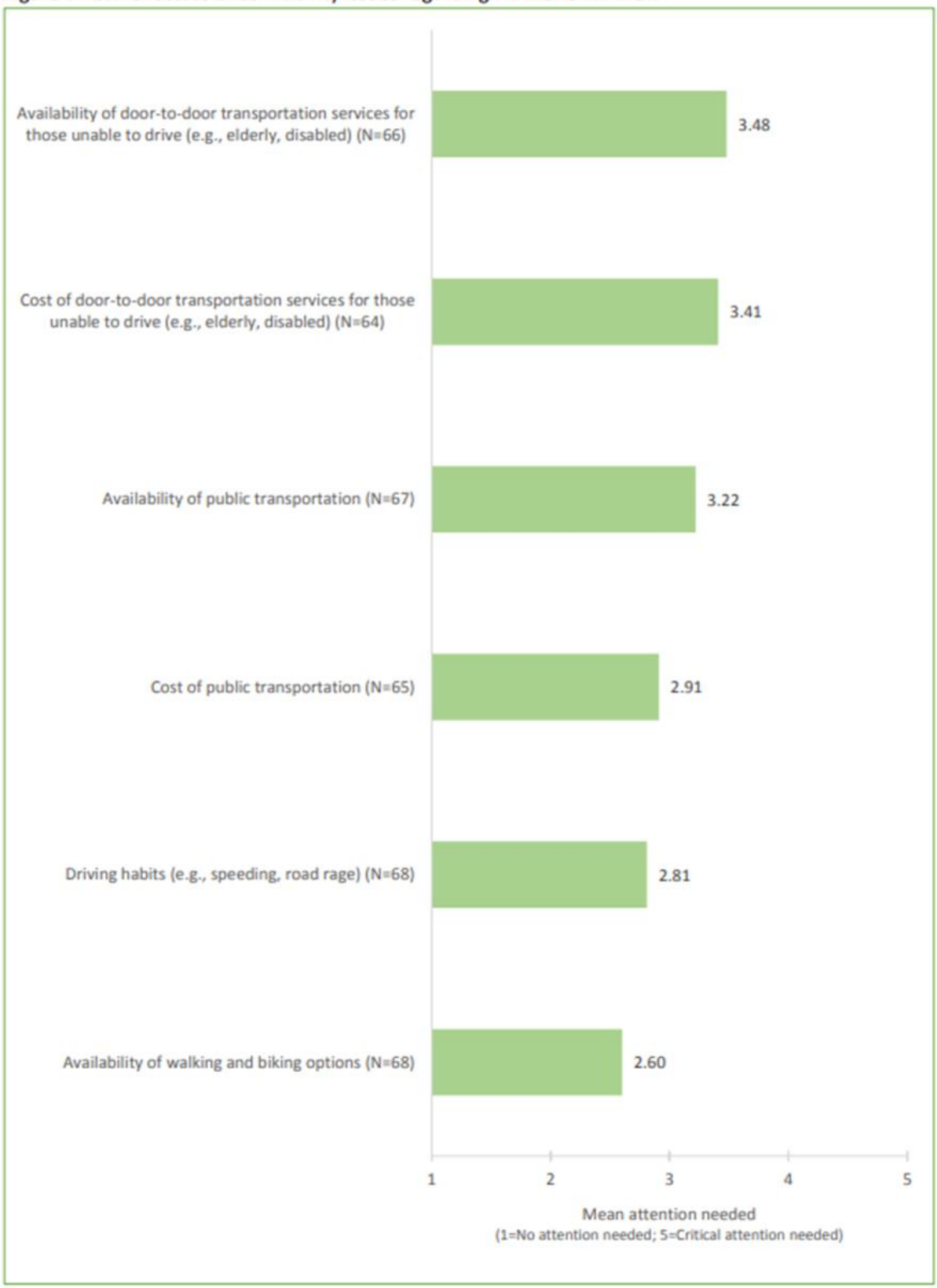


Figure 3. Current state of community issues regarding CHILDREN AND YOUTH

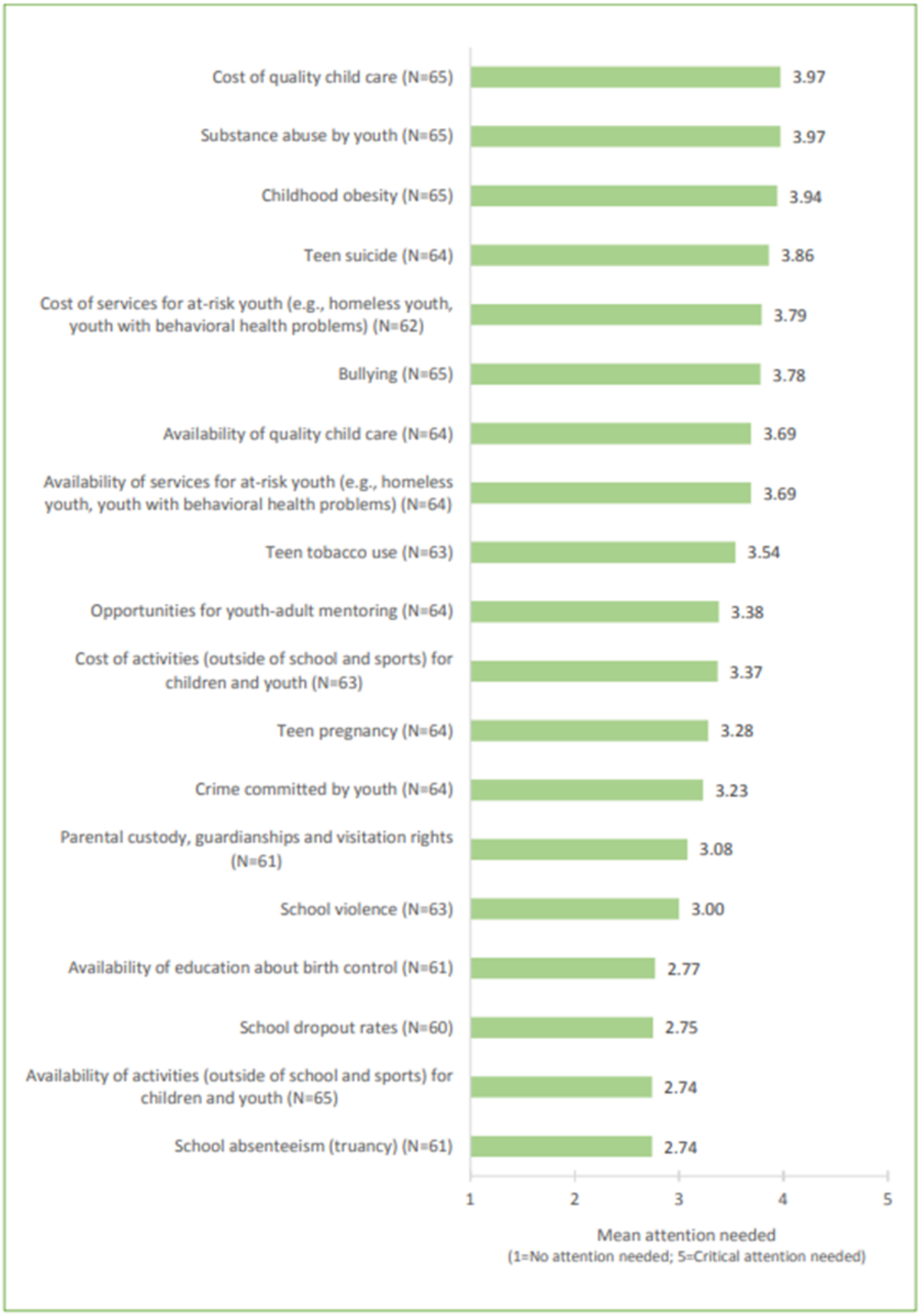


Figure 4. Current state of community issues regarding the AGING POPULATION

Figure 5. Current state of community issues regarding SAFETY

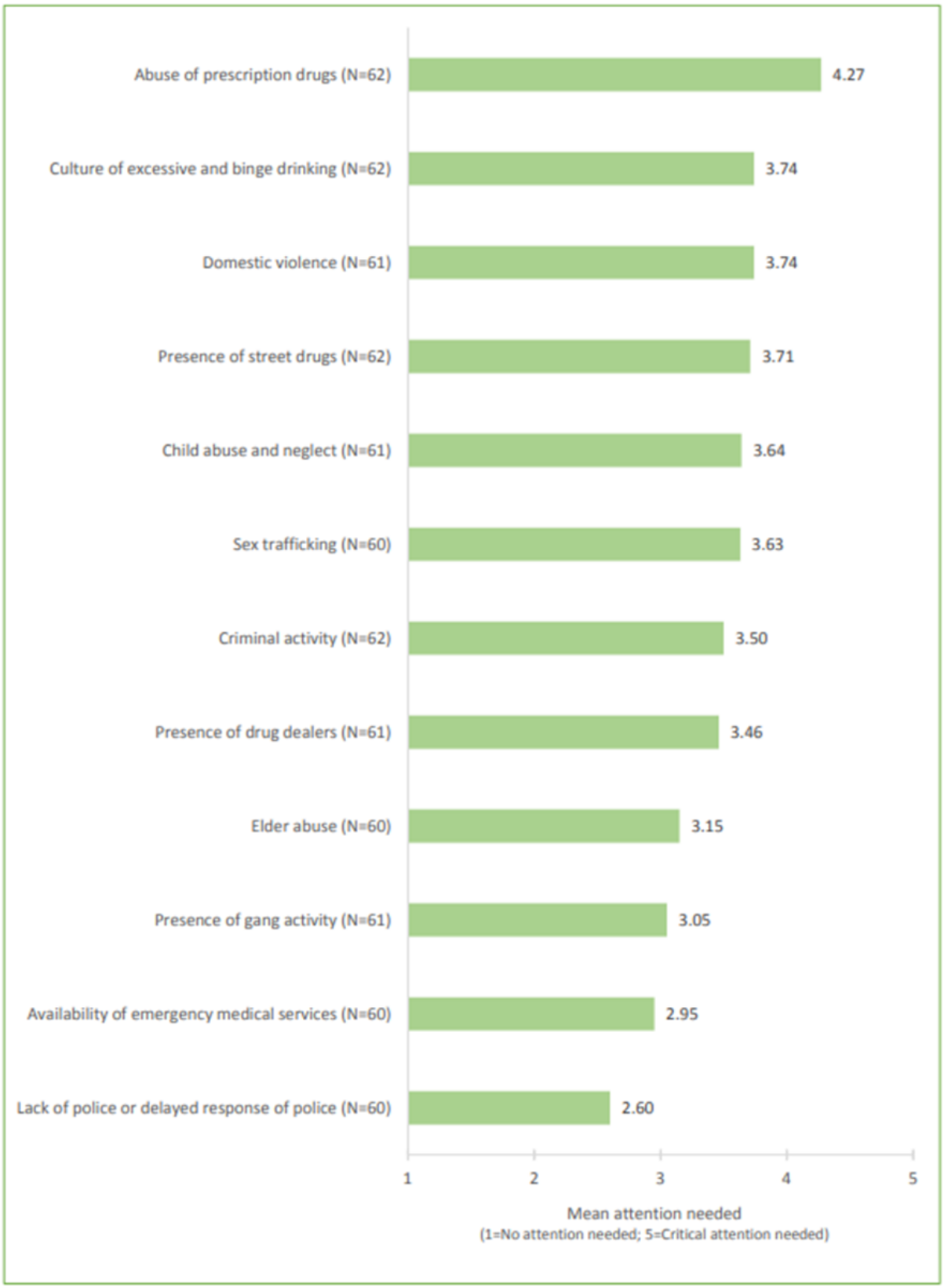
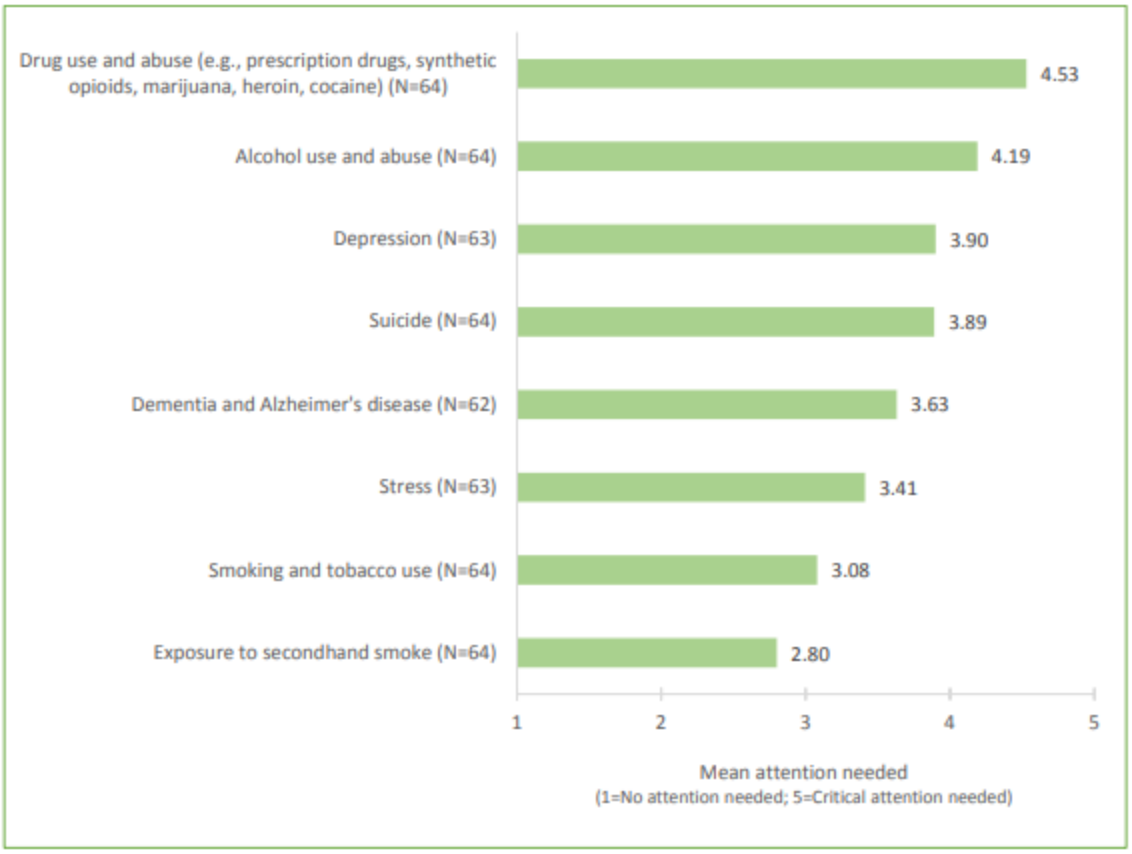


Figure 6. Current state of community issues regarding HEALTH CARE AND WELLNESS

Figure 6. Current state of community issues regarding HEALTH CARE AND WELLNESS

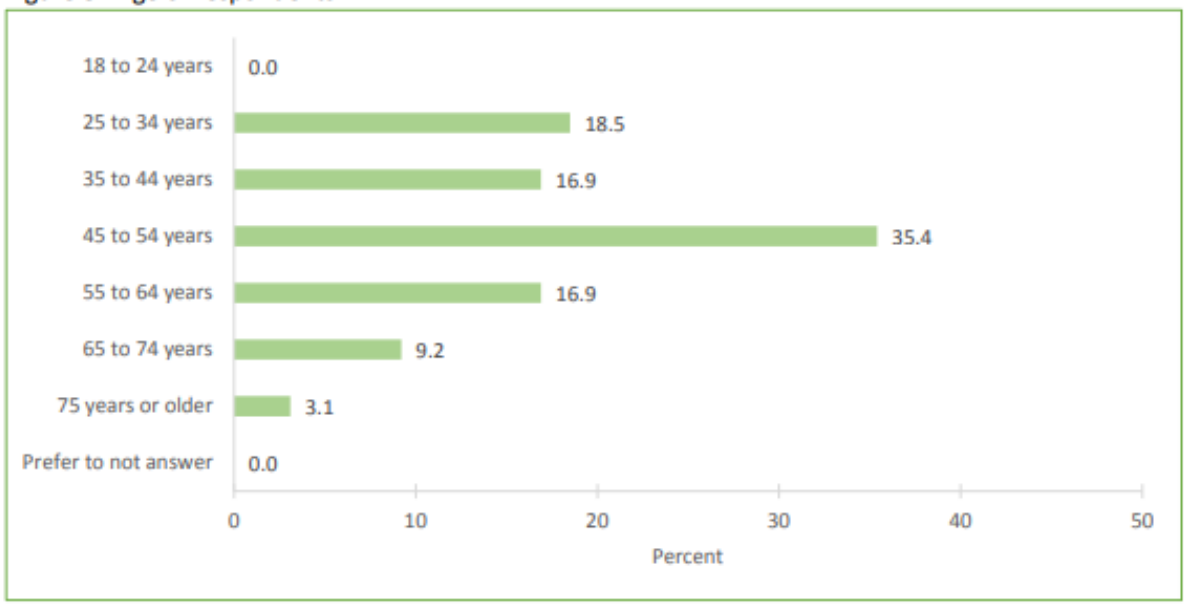
Figure 6. Current state of community issues regarding HEALTH CARE AND WELLNESS

Figure 7. Current state of community issues regarding MENTAL HEALTH AND SUBSTANCE ABUSE



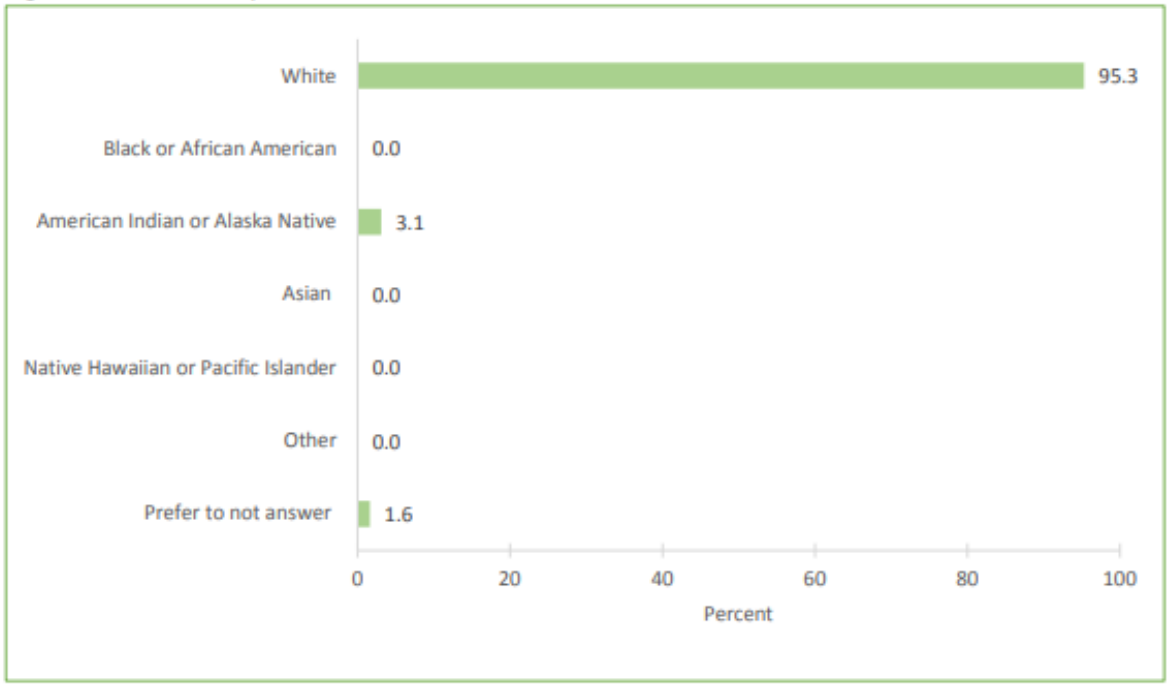
Demographic Information

Figure 8. Age of respondents



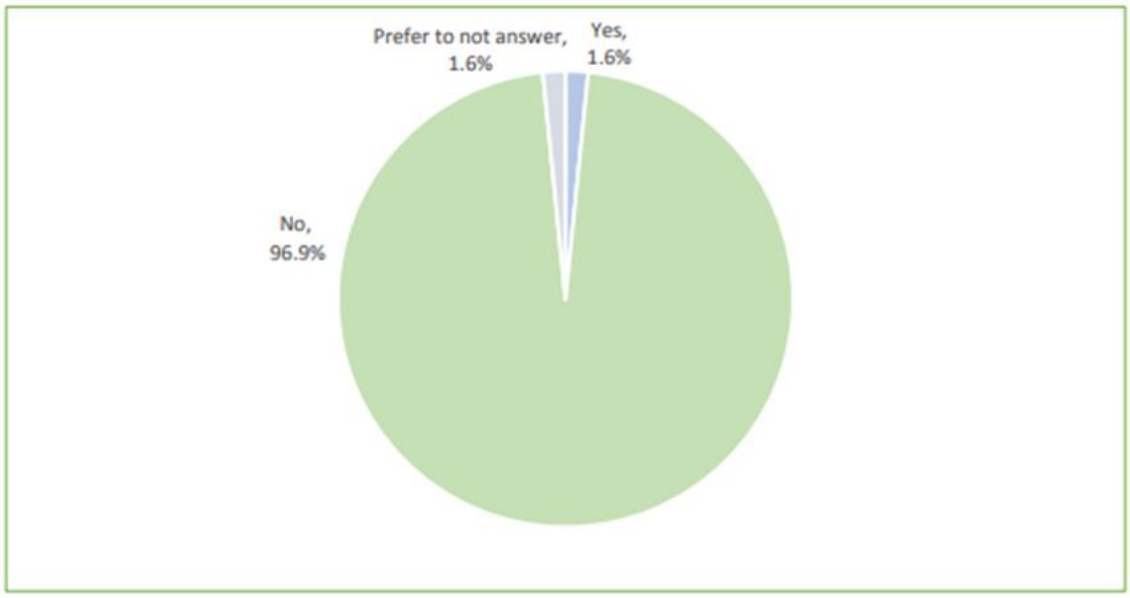
N=65

Figure 10. Race of respondents



N=64

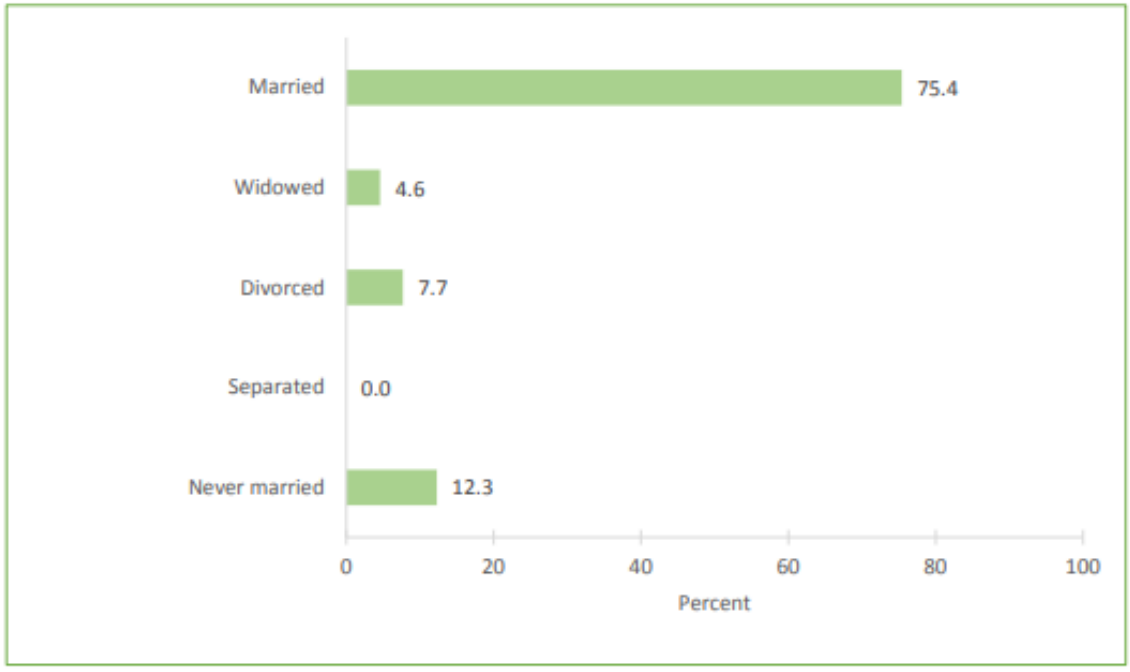
Figure 11. Whether respondents are of Hispanic or Latino origin



N=64

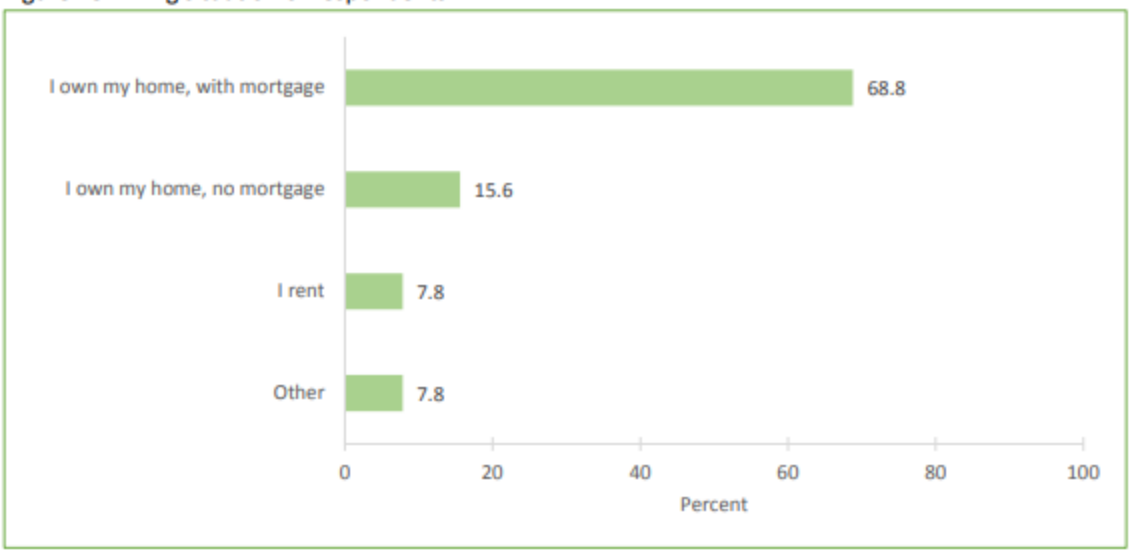
*Percentages do not total 100.0 due to rounding.

Figure 12. Marital status of respondents



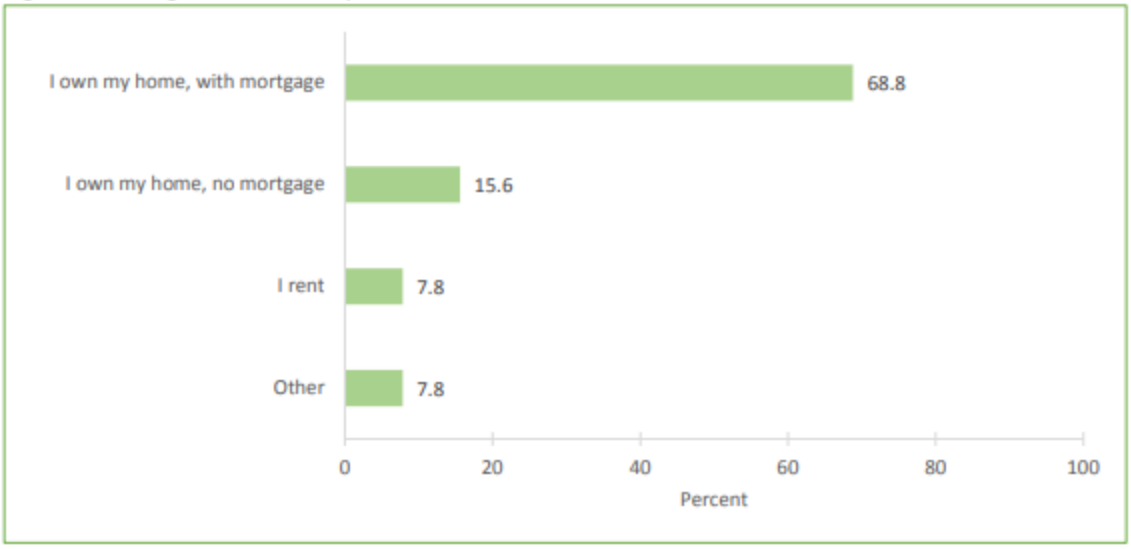
N=65

Figure 13. Living situation of respondents



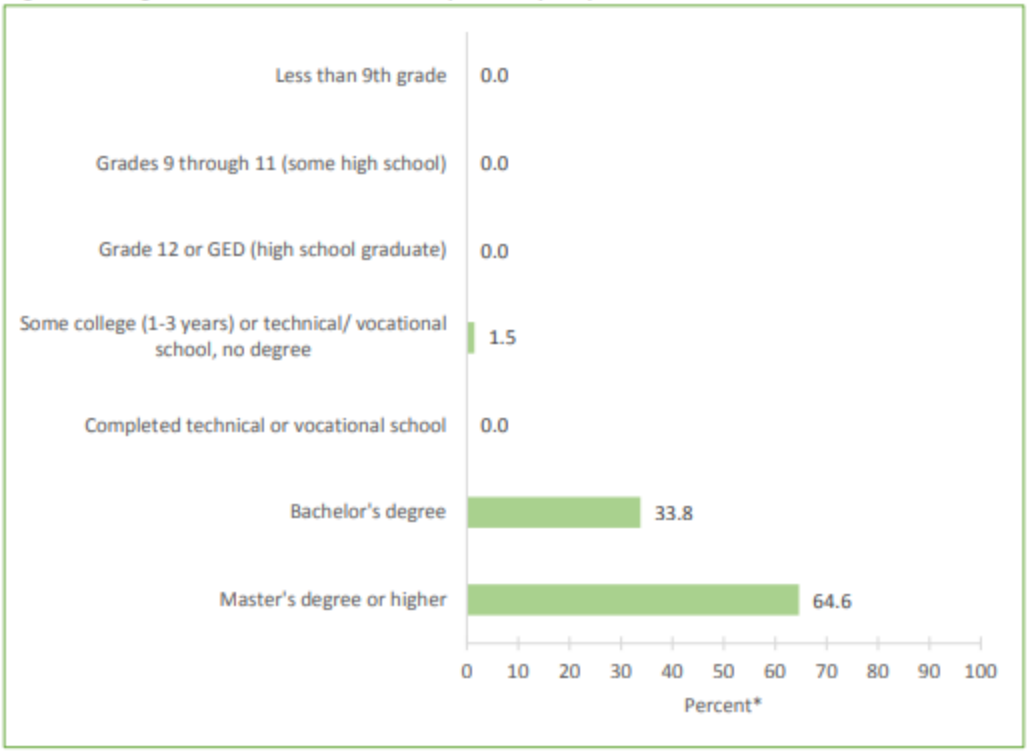
N=64

Figure 13. Living situation of respondents



N=64

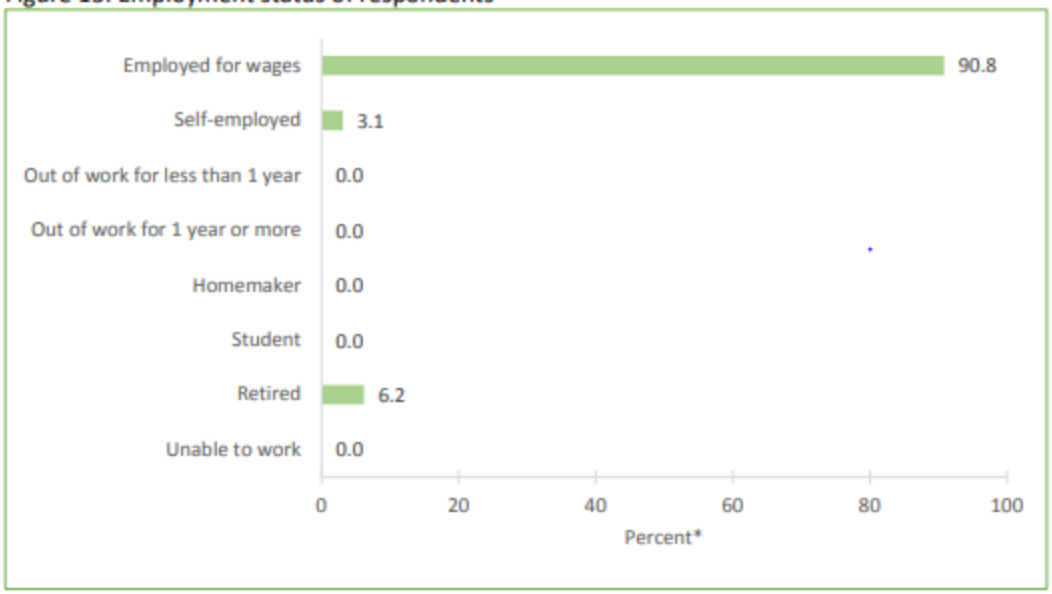
Figure 14. Highest level of education completed by respondents



N=65

*Percentages do not total 100.0 due to rounding.

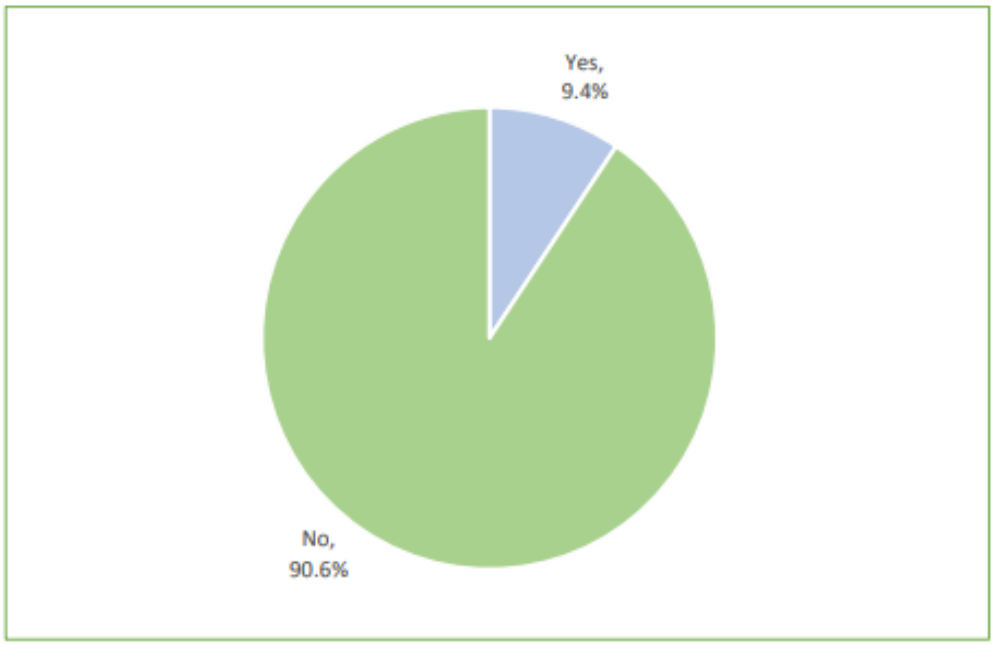
Figure 15. Employment status of respondents



N=65

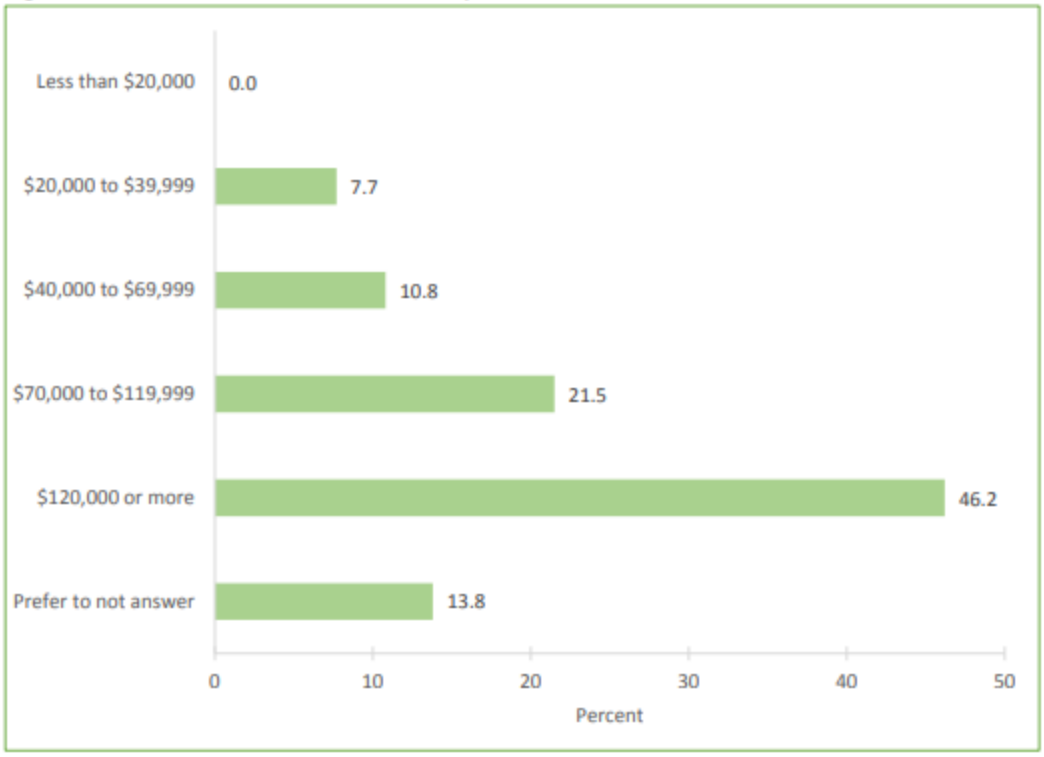
*Percentages do not total 100.0 due to rounding.

Figure 16. Whether respondents are military veterans



N=64

Figure 17. Annual household income of respondents, from all sources, before taxes



N=65

Table 1. Zip code of respondents

Zip code	Number of respondents
58501	20
58503	17
58504	13
58554	10
57504	1
58502	1
58530	1

N=63

Table 2. Comments from respondents

Comments
Need to address the need for homeless shelter & support services and intoxication management facility & services as soon as possible.
North Dakota needs better tenant rights. As it stands currently, tenants can be evicted for little to no reason. Most cases I see they are evicted for trying to improve the living space they are occupying because the landlord will not put any money into the property. It is unfair. The condition of some of the places I inspect are deplorable especially when I find out how much they cost. This issue only adds to the poverty issues most people are facing right now.
Survey did not include Brain Injury services or lack of. We need awareness and continuum of care for individuals with Mild, Moderate and Traumatic Brain Injuries.
Teen drug and alcohol substance abuse problems are very prevalent in our community.
Thanks for doing the survey.
There are questions that would be answered differently for Mandan vs. Bismarck (i.e. law enforcement availability).
There is a lack of jobs in leadership roles and at the mid to higher income range.
There should be a category that says "Don't Know".
This is perception data, influenced by community messaging. As I filled out the survey, I realized I was responding in some areas that I know little about. Ex: bullying is down but since bullying isn't defined, respondents may think bullying is conflict. They are very different terms.

APPENDIX TABLE

Appendix Table 1. Current state of health and wellness issues within the community

Statements	Mean**	Percent of respondents*						
		Level of attention needed						Total
		1 None	2 Little	3 Moderate	4 Serious	5 Critical	NA	
ECONOMIC WELL-BEING ISSUES								
Availability of affordable housing (N=68)	3.87	1.5	2.9	30.9	36.8	27.9	0.0	100.0
Employment options (N=68)	2.81	7.4	36.8	27.9	23.5	4.4	0.0	100.0
Help for renters with landlord and tenants' rights issues (N=67)	3.08	4.5	26.9	32.8	16.4	13.4	6.0	100.0
Homelessness (N=68)	4.44	0.0	1.5	14.7	22.1	61.8	0.0	100.1
Housing which accepts people with chemical dependency, mental health problems, criminal history, or victims of domestic violence (N=68)	4.33	1.5	1.5	17.6	19.1	57.4	2.9	100.0
Household budgeting and money management (N=68)	3.18	4.4	11.8	51.5	23.5	7.4	1.5	100.1
Hunger (N=68)	3.62	0.0	10.3	38.2	30.9	20.6	0.0	100.0
Maintaining livable and energy efficient homes (N=68)	3.01	8.8	17.6	42.6	22.1	7.4	1.5	100.0
Skilled labor workforce (N=68)	3.10	2.9	25.0	33.8	32.4	4.4	1.5	100.0
TRANSPORTATION ISSUES								
Availability of door-to-door transportation services for those unable to drive (e.g., elderly, disabled) (N=68)	3.48	0.0	20.6	29.4	26.5	20.6	2.9	100.0
Availability of public transportation (N=68)	3.22	1.5	29.4	25.0	30.9	11.8	1.5	100.1
Availability of walking and biking options (N=68)	2.60	14.7	35.3	27.9	19.1	2.9	0.0	99.9
Cost of door-to-door transportation services for those unable to drive (e.g., elderly, disabled) (N=68)	3.41	1.5	20.6	30.9	20.6	20.6	5.9	100.1
Cost of public transportation (N=68)	2.91	2.9	36.8	32.4	13.2	10.3	4.4	100.0
Driving habits (e.g., speeding, road rage) (N=68)	2.81	5.9	36.8	38.2	8.8	10.3	0.0	100.0
CHILDREN AND YOUTH								
Availability of activities (outside of school and sports) for children and youth (N=65)	2.74	10.8	32.3	33.8	18.5	4.6	0.0	100.0
Availability of education about birth control (N=64)	2.77	7.8	28.1	42.2	12.5	4.7	4.7	100.0
Availability of quality child care (N=65)	3.69	0.0	16.9	21.5	35.4	24.6	1.5	99.9
Availability of services for at-risk youth (e.g., homeless youth, youth	3.69	0.0	9.2	33.8	33.8	21.5	1.5	99.8

Statements	Mean**	Percent of respondents*						
		Level of attention needed						
		1 None	2 Little	3 Moderate	4 Serious	5 Critical	NA	Total
with behavioral health problems) (N=65)								
Bullying (N=65)	3.78	0.0	7.7	30.8	36.9	24.6	0.0	100.0
Childhood obesity (N=65)	3.94	0.0	4.6	26.2	40.0	29.2	0.0	100.0
Cost of activities (outside of school and sports) for children and youth (N=65)	3.37	0.0	13.8	50.8	15.4	16.9	3.1	100.0
Cost of quality child care (N=65)	3.97	1.5	6.2	21.5	35.4	35.4	0.0	100.0
Cost of services for at-risk youth (e.g., homeless youth, youth with behavioral health problems) (N=64)	3.79	0.0	6.3	35.9	26.6	28.1	3.1	100.0
Crime committed by youth (N=65)	3.23	1.5	20.0	40.0	27.7	9.2	1.5	99.9
Opportunities for youth-adult mentoring (N=65)	3.38	1.5	13.8	43.1	26.2	13.8	1.5	99.9
Parental custody, guardianships and visitation rights (N=64)	3.08	0.0	29.7	34.4	25.0	6.3	4.7	100.1
School absenteeism (truancy) (N=63)	2.74	3.2	41.3	34.9	12.7	4.8	3.2	100.1
School dropout rates (N=62)	2.75	1.6	45.2	30.6	14.5	4.8	3.2	99.9
School violence (N=65)	3.00	1.5	32.3	35.4	20.0	7.7	3.1	100.0
Substance abuse by youth (N=65)	3.97	0.0	7.7	23.1	33.8	35.4	0.0	100.0
Teen pregnancy (N=65)	3.28	0.0	26.2	36.9	16.9	18.5	1.5	100.0
Teen suicide (N=65)	3.86	0.0	10.8	26.2	27.7	33.8	1.5	100.0
Teen tobacco use (N=65)	3.54	3.1	13.8	30.8	26.2	23.1	3.1	100.1
THE AGING POPULATION								
Availability of activities for seniors (e.g., recreational, social, cultural) (N=64)	2.98	3.1	25.0	43.8	17.2	6.3	4.7	100.1
Availability of long-term care (N=64)	3.24	1.6	28.1	26.6	26.6	14.1	3.1	100.1
Availability of memory care (N=64)	3.37	1.6	23.4	28.1	25.0	18.8	3.1	100.0
Availability of resources for family and friends caring for and helping to make decisions for elders (e.g., home care, home health) (N=64)	3.44	0.0	15.6	37.5	29.7	14.1	3.1	100.0
Availability of resources for grandparents caring for grandchildren (N=63)	3.25	0.0	25.4	31.7	27.0	11.1	4.8	100.0
Availability of resources to help the elderly stay safe in their homes (N=64)	3.49	1.6	14.1	31.3	32.8	15.6	4.7	100.1
Cost of activities for seniors (e.g., recreational, social, cultural) (N=64)	3.05	3.1	26.6	42.2	9.4	14.1	4.7	100.1
Cost of in-home services (N=63)	3.69	1.6	9.5	28.6	34.9	22.2	3.2	100.0
Cost of long-term care (N=63)	4.07	1.6	3.2	22.2	30.2	39.7	3.2	100.1
Cost of memory care (N=62)	4.03	1.6	3.2	25.8	27.4	40.3	1.6	99.9
Help making out a will or health care directive (N=63)	2.97	3.2	30.2	38.1	17.5	7.9	3.2	100.1

Statements	Mean**	Percent of respondents*						
		Level of attention needed						
		1 None	2 Little	3 Moderate	4 Serious	5 Critical	NA	Total
SAFETY								
Abuse of prescription drugs (N=62)	4.27	0.0	3.2	14.5	33.9	48.4	0.0	100.0
Availability of emergency medical services (N=60)	2.95	5.0	40.0	23.3	18.3	13.3	0.0	99.9
Child abuse and neglect (N=62)	3.64	0.0	9.7	37.1	30.6	21.0	1.6	100.0
Criminal activity (N=62)	3.50	0.0	16.1	33.9	33.9	16.1	0.0	100.0
Culture of excessive and binge drinking (N=62)	3.74	1.6	6.5	35.5	29.0	27.4	0.0	100.0
Domestic violence (N=62)	3.74	0.0	8.1	30.6	38.7	21.0	1.6	100.0
Elder abuse (N=62)	3.15	0.0	25.8	40.3	21.0	9.7	3.2	100.0
Lack of police or delayed response of police (N=62)	2.60	12.9	37.1	27.4	14.5	4.8	3.2	99.9
Presence of drug dealers (N=62)	3.46	1.6	19.4	30.6	25.8	21.0	1.6	100.0
Presence of gang activity (N=62)	3.05	3.2	33.9	32.3	12.9	16.1	1.6	100.0
Presence of street drugs (N=62)	3.71	0.0	9.7	35.5	29.0	25.8	0.0	100.0
Sex trafficking (N=61)	3.63	0.0	18.0	27.9	24.6	27.9	1.6	100.0
HEALTH CARE AND WELLNESS								
Access to affordable dental insurance coverage (N=64)	3.36	1.6	15.6	46.9	17.2	18.8	0.0	100.1
Access to affordable health insurance coverage (N=63)	3.65	1.6	6.3	36.5	36.5	19.0	0.0	99.9
Access to affordable health care (N=64)	3.66	1.6	6.3	37.5	34.4	20.3	0.0	100.1
Access to affordable prescription drugs (N=64)	3.67	1.6	4.7	35.9	40.6	17.2	0.0	100.0
Access to affordable vision insurance coverage (N=64)	3.27	1.6	21.9	40.6	20.3	15.6	0.0	100.0
Access to technology for health records and health education (N=64)	2.78	10.9	31.3	32.8	15.6	7.8	1.6	100.0
Availability of behavioral health (e.g., substance abuse) providers (N=64)	4.23	0.0	1.6	20.3	31.3	46.9	0.0	100.1
Availability of doctors, physician assistants, or nurse practitioners (N=64)	3.11	6.3	26.6	31.3	21.9	14.1	0.0	100.2
Availability of health care services for Native people (N=64)	3.27	6.3	20.3	32.8	15.6	21.9	3.1	100.0
Availability of healthcare services for New Americans (N=64)	3.29	6.3	17.2	34.4	20.3	18.8	3.1	100.1
Availability of mental health providers (N=62)	4.27	0.0	9.7	11.3	21.0	58.1	0.0	100.1
Availability of non-traditional hours (e.g., evenings, weekends) (N=64)	3.56	7.8	14.1	28.1	14.1	35.9	0.0	100.0
Availability of prevention programs and services (e.g., Better Balance, Diabetes Prevention) (N=64)	3.17	7.8	17.2	39.1	21.9	14.1	0.0	100.1
Availability of specialist physicians (N=64)	3.06	7.8	26.6	32.8	17.2	15.6	0.0	100.0

Statements	Mean**	Percent of respondents*						
		Level of attention needed						Total
		1 None	2 Little	3 Moderate	4 Serious	5 Critical	NA	
Coordination of care between providers and services (N=64)	3.64	3.1	15.6	25.0	26.6	29.7	0.0	100.0
Timely access to medical care providers (N=64)	3.17	4.7	25.0	35.9	17.2	17.2	0.0	100.0
Timely access to dental care providers (N=64)	3.09	4.7	32.8	26.6	20.3	15.6	0.0	100.0
Timely access to vision care providers (N=63)	2.52	12.7	41.3	33.3	6.3	6.3	0.0	99.9
Use of emergency room services for primary health care (N=62)	3.47	1.6	17.7	35.5	22.6	22.6	0.0	100.0
MENTAL HEALTH AND SUBSTANCE ABUSE								
Alcohol use and abuse (N=64)	4.19	0.0	3.1	20.3	31.3	45.3	0.0	100.0
Dementia and Alzheimer's disease (N=63)	3.63	0.0	11.1	33.3	34.9	19.0	1.6	99.9
Depression (N=63)	3.90	0.0	4.8	25.4	44.4	25.4	0.0	100.0
Drug use and abuse (e.g., prescription drugs, synthetic opioids, marijuana, heroin, cocaine) (N=64)	4.53	0.0	0.0	6.3	34.4	59.4	0.0	100.1
Exposure to secondhand smoke (N=64)	2.80	6.3	42.2	25.0	18.8	7.8	0.0	100.1
Smoking and tobacco use (N=64)	3.08	4.7	29.7	32.8	18.8	14.1	0.0	100.1
Stress (N=63)	3.41	3.2	15.9	36.5	25.4	19.0	0.0	100.0
Suicide (N=64)	3.89	0.0	4.7	32.8	31.3	31.3	0.0	100.1

*Percentages may not total 100.0 due to rounding.

**NA (not applicable) responses were excluded when calculating the Means. As a result, the number of responses (N) in Appendix Table 1, which reflects total responses, may differ from the Ns in Figures 1 through 7, which exclude NA.

Secondary Research

The findings in this study provide an overall snapshot of behaviors, attitudes and perceptions of residents living in Burleigh and Morton counties in North Dakota. A good faith effort was made to secure input from a broad base of the community. However, when comparing certain demographic characteristics (i.e., age, gender, income, minority status) with the current population estimates from the U.S. Census Bureau, there was improvement over the last several CHNAs, but there is still a need to capture demographics that better represent the community.

Those community members specified in the statute include persons who represent the broad interests of the community served by the hospital facility including those with special expertise in public health; Federal, tribal, regional, state and/or local health or other departments or agencies with information relevant to the health needs of the community served; and leaders, representatives, or members of medically underserved, low income, and minority populations. We extended a good faith effort to engage all of the aforementioned community representatives in the survey process. We worked closely with the local hospitals and public health experts throughout the assessment process.

Limitations of the Study

The findings in this study provide an overall snapshot of behaviors, attitudes, and perceptions of residents living in Burleigh and Morton counties in North Dakota. A good faith effort was made to secure input from a broad base of the community. However, when comparing certain demographic characteristics (i.e., age, gender, income, minority status) with the current population estimates from the U.S. Census Bureau, there was improvement over the last several CHNAs, but there is still a need to capture demographics that better represent the community.

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Significant Health Needs

The community health needs assessment identified the following significant community health needs:

- Housing for homeless, for people with chemical dependency, mental health, criminal history and domestic abuse victims
- Services for at-risk youth including obesity, substance abuse, availability of child care
- Cost of long-tern, in-home and memory services
- Safety concerns including prescription drugs, binge drinking, accessible health care
- Access to affordable health care for behavioral and mental health needs
- Wellness issues, such as obesity, diabetes, high cholesterol
- Mental health and substance abuse

Significant Needs the Hospital Does Not Intend to Address

The hospital intends to take actions to address all of the prioritized significant health needs in the CHNA report, both through its own programs and services and in collaboration with community partners. Lists and descriptions of those planned actions are included in this report.

Homelessness: CHI St. Alexius Health works collaboratively with institutions who are providing housing for homeless and those who are implementing housing for those who are impaired. We pay particular attention to our sister institution, Ministry on the Margin. Another concern is discharge of homeless persons.

Children and Youth: We will continue to work with our programs with nutrition and diabetes with children.

Safety: Violence prevention programs; domestic violence and sex trafficking – active plan for violence prevention

Wellness: Clinics
Abuse of prescription drugs – included in opioid plan, and all “take back” drug programs

2019 Implementation Strategy

This section presents strategies and program activities the hospital intends to deliver, fund or collaborate with others to address significant community health needs over the next three years. It summarizes planned activities with statements on anticipated impacts and planned collaboration. Program Digests provide additional detail on select programs.

This report specifies planned activities consistent with the hospital’s mission and capabilities. The hospital may amend the plan as circumstances warrant. For instance, changes in significant community health needs or in community assets and resources directed to those needs may merit refocusing the hospital’s limited resources to best serve the community.

The anticipated impacts of the hospital’s activities on significant health needs are summarized below, and for select program initiatives are stated in Program Digests. Overall, the hospital anticipates that actions taken to address significant health needs will: improve health knowledge, behaviors, and status; increase access to needed and beneficial care; and help create conditions that support good health. The hospital works to evaluate impact and sets priorities for its community health programs in triennial Community Health Needs Assessments.

Creating the Implementation Strategy

CHI St. Alexius Health is dedicated to improving community health and delivering community benefit with the engagement of its management team, board, clinicians and staff, and in collaboration with community partners.

Following the prioritization of needs, the Community Health Collaborative Core Group Members met to discuss the priorities and how to best address the health needs in our community. Concerns addressed would focus on each agency's individual ability to make the biggest impact on improving the concern identified. CHI St. Alexius Health chose the following concerns as priorities to include in our strategic plan.

Strategy by Health Need

The tables below present strategies and program activities the hospital intends to deliver to help address significant health needs identified in the CHNA report.

They are organized by health need and include statements of the strategies' anticipated impact and any planned collaboration with other organizations in our community.

Strategy or Program Name	Summary Description
Decrease inappropriate use of opioids	• Assess what CHI St. Alexius Health is currently doing to combat inappropriate opioid usage • Design an educational program for reduction of opioid usage/availability • Create a plan for working with others to reduce opioid dependence
Increase provider education	• Create a teaching module • Identify providers who tend to order more opioids
Special attention given to Emergency Providers	• Identify types of patients and associated complaints as a trigger to assess more carefully opioid usage

Anticipated Impact: Decrease the misuse of opioid

Planned Collaboration: Collaboration with the following to plan and implement this program:

- Emergency & Trauma unit
- Medical staff
- Collaborate with another hospital in the system (Dignity)

Health Need: Food Insecurity	
Strategy or Program Name	**Summary Description**
Improve the dietary quality of kidney dialysis patients	• Assess the food concerns of present kidney dialysis patients • Measure the effect of poor dietary choices on effectiveness of dialysis • Create a plan for each patient to enable them to eat healthier meals

Anticipated Impact: Better management of diet will influence the length of dialysis and ultimately improve the results of the treatment with result of higher satisfaction and wellbeing.

Planned Collaboration: Dietary, Social Work

Program Digests

The following pages include Program Digests describing key programs and initiatives that address one or more significant health needs in the most recent CHNA report. The digests include program descriptions and intervention actions, statements of which health needs are being addressed, any planned collaboration, and program goals and measurable objectives.

Hunger	
Significant Health Needs Addressed	❑ CHNA study 2018 - Hunger scored 3.64 (5-point scale) for elders ❑ In-house assessment reflected large number of dialysis patients with poor dietary habits
Program Description	An ongoing study of reasons given for poor nutrition habits of dialysis patients. Ongoing education of proper nutrition, access to hospital's community garden, etc.

Community Benefit Category	Community Health Improvement
Planned Actions for 2019 – 2021	
Program Goal / Anticipated Impact	Improve the diet of dialysis patients
Measurable Objective(s) with Indicator(s)	More closely following dietary requirements reduces the time and intensity of dialysis
Intervention Actions for Achieving Goal	Assess, plan and implement patient-specific diet along with assistance in purchasing and preparing appropriate foods
Planned Collaboration	Dietary, community health groups

Hospital Board

Timothy Bopp, MD
Michael Cassidy, MD
Kevin Dahmen, MD, Secretary/Treasurer
John Giese, Chair
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Mike Lefor
Tessa Marburger, MD
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Kurt Schley
Pat Sogard
Julie Traynor
Sr. Thomas Welder

Notes: