Community Health Needs Assessment

CHI St. Alexius Health Devils Lake Hospital Service Area

Devils Lake, North Dakota

2022

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The board of directors for CHI St. Alexius Health Devils Lake Hospital approved this Community Health Needs Assessment in January 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 Devils Lake Hospital along with Lake Region District Health Unit (LRDHU) conducted a Community Health Needs Assessment (CHNA) in 2021, the previous CHNA having been conducted in 2019. The Center for Rural Health (CRH) at the University of North Dakota School of Medicine and Health Sciences (UNDSMHS) facilitated the assessment process, which solicited input from area community members and healthcare professionals as well as analysis of community health-related data.

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

With regard to demographics, Ramsey and Benson County's populations increased by 0.6% and 2.6% from 2010 to 2019, whereas Pierce and Eddy County's populations declined by 8.8% and 4.1% during that time. The average number of residents under age 18 (23.3%) for Ramsey County comes in slightly lower than the North Dakota average (23.6%); Benson is significantly higher at 35.2% with Eddy (23.4%) and Pierce (22.8%) being slightly less. The percentage of residents, ages 65 and older, is higher than the North Dakota average (15.7%) for Ramsey (20.3%), Pierce (23.8%), and Eddy (23.7%) and lower in Benson County (14.4%). The rate of education is lower for Ramsey (91.92%), Benson (86.3%), and Eddy Counties (89.4%) than the North Dakota average (92.6%) but slightly higher in Pierce County (93.3%). The median household income in all of the counties are significantly lower compared to the state average for North Dakota ($64,894) - Ramsey ($58,910), Benson ($47,667), Eddy ($54,868), and Pierce ($55,660).

Data compiled by County Health Rankings show Ramsey County is doing better than North Dakota in health outcomes/factors for 17 categories, and Benson County is doing better than North Dakota in 3 categories; Eddy County is doing better than North Dakota in 14 categories, and Pierce County is doing better than North Dakota in 10 categories.

Ramsey County, according to County Health Rankings data, is performing poorly relative to the rest of the state in 14 outcome/factor categories; Benson County is performing worse than the state average in 27 categories; Eddy County is performing worse than the state average in 14 categories, and Pierce County is performing worse than the state average in 18 categories.

Of 106 potential community and health needs set forth in the survey, the 184 Devils Lake service area residents who completed the survey indicated the following ten needs as the most important:

- Attracting and retaining young families
- Bullying/cyberbulling
- Crime and safety
- Having enough child daycare services
- Having enough quality school resources
- Not enough affordable housing
- Not enough jobs with livable wages
- Not enough public transportation options
- Physical violence, domestic violence, sexual abuse
- Poverty

The survey also revealed the biggest barriers to receiving healthcare (as perceived by community members). They included not able to get an appointment/limited hours (N=53), not enough specialists (N=50), and not enough evening or weekend hours (N=49).

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

- Active faith community
- Community groups and organizations
- Quality school system
- Opportunities for advanced education
- Healthcare
- Programs for youth

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:

- Ability to retain primary care providers (MD, DO, NP, PA) and nurses in the community
- Alcohol use and abuse (youth and adult)
- Attracting and retaining young families
- Depression/anxiety (youth and adult)
- Having enough child daycare services
- Cost of long-term/nursing home care

Overview and Community Resources

With assistance from CRH at the UNDSMHS, the CHI St. Alexius Health Devils Lake Hospital completed a CHNA of the Devils Lake service area. The hospital identifies its service area as a 50-mile radius around Devils Lake. Lake Region District Health Unit identifies its service area as Ramsey County, Benson County, Eddy County, and Pierce County. Zip codes within CHI Devils Lakes' service area include 58301, 58321, 58325, 58327, 58330, 58338, 58345, 58362, 58377, and 58382. Many community members and stakeholders worked together on the assessment.

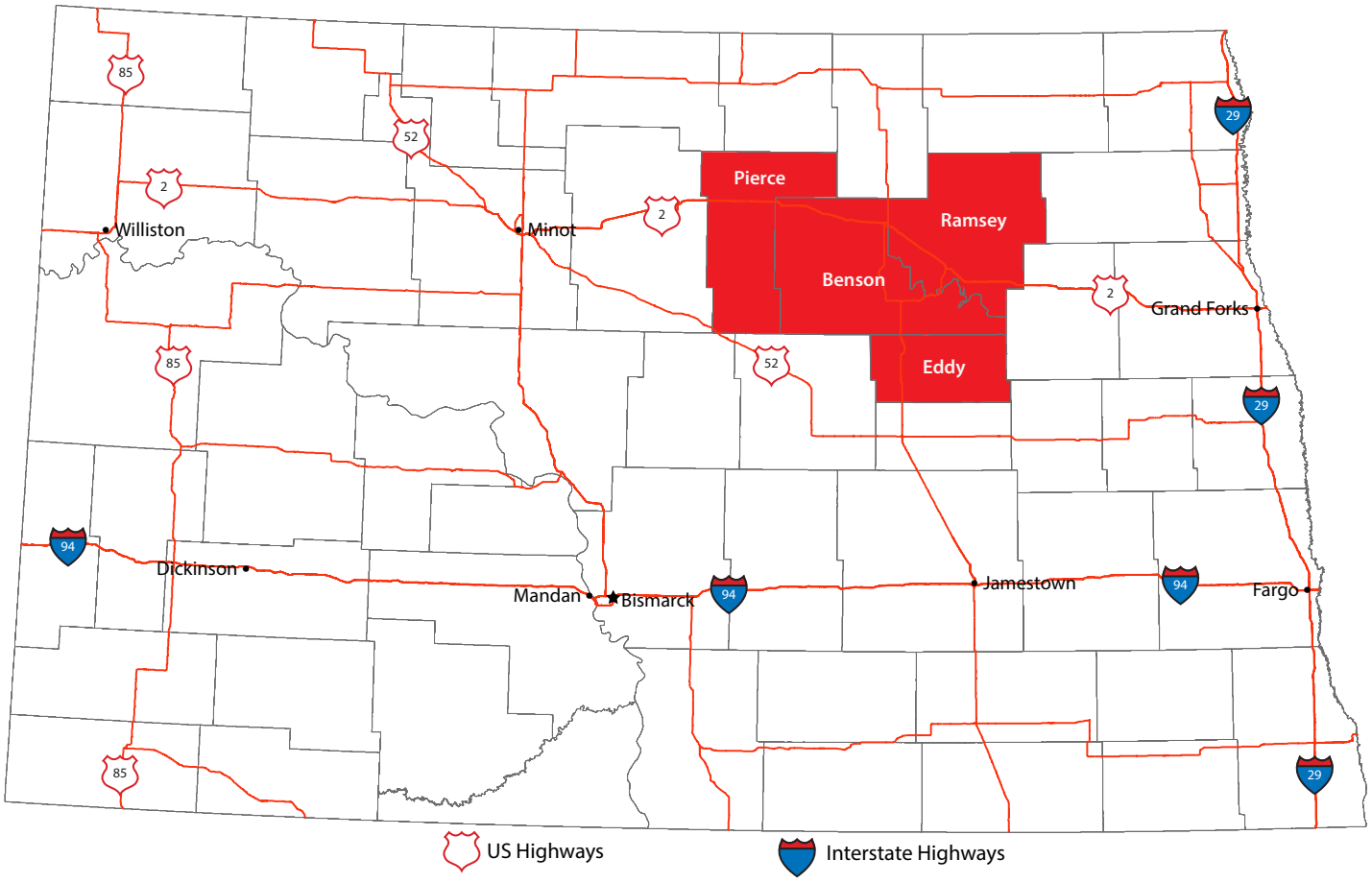
CHI St. Alexius Health Devils Lake Hospital is located in a frontier area and is licensed as a critical access hospital with a provider-based health clinic. Devils Lake is located in northeast North Dakota. Two major cities in North Dakota, Minot and Grand Forks, are less than two hours from Devils Lake.

Along with the hospital, the economy is based on agri-business, service industries, and retail trade. Ramsey County is 1,186 square miles of land located in northeast North Dakota. It the 26th-largest of the state's 53 counties. It is bordered by Benson, Towner, Cavalier, Walsh, and Nelson Counties. Ramsey is divided into 36 townships with the seat of county government located in Devils Lake. According to the U.S. Census Bureau, estimated census for 2019, the population of Ramsey County is 11,519. The racial makeup of the county was 83.0% White with 10.6% of the population being Native American.

Other healthcare facilities and services in the Devils Lake area include dental services, chiropractors, massage therapists, optometry services, mental health services, and long-term healthcare centers with various additional levels of care and services, including Altru Health Clinic and a Veterans Affairs clinic in Devils Lake as well as Spirit Lake Health Clinic in Fort Totten. Ramsey County Social Services also offers various services, such as senior services, disability services, mental health services, child protection services, and children's mental health services.

Devils Lake has a number of community assets and resources that are potentially available to address significant health needs. In terms of physical assets and features, the community includes a bike path, fitness center, swimming pool, outdoor parks, basketball courts, tennis courts, golf course, driving range, boat docks, shoreline fishing, beaches, and hiking trails. Ramsey County also offers several cultural attractions, such as the Fort Totten Little Theater, Graham's Island State Park, Lake Region Heritage Center, and White Horse Hill recreation area.

Figure 1: Ramsey, Benson, Eddy & Pierce Counties



CHI St. Alexius Health Devils Lake Hospital

CHI St. Alexius Health Devils Lake Hospital is a 25-bed Critical Access Hospital, accredited by The Joint Commission, licensed by the North Dakota State Department of Health, and certified by the Department of Health and Human Services for participation in the Medicare Program. The hospital has been committed to providing patients' quality medical treatment in the Lake Region area and surrounding communities since 1902. Patients have access to a state-of-the-art healthcare facility, including 24-7 emergency care, a swing bed program, extensive therapy services, a critical care unit, obstetrical care, and advanced radiology. The professional and caring staff is dedicated to ensuring patients have compassionate and excellent care. CHI St. Alexius Health Devils Lake Hospital was designated as a "Top 100 Critical Access Hospital" in 2016, 2018, and 2020. The Critical Access Hospital Profile for CHI St. Alexis Health Devils Lake Hospital that includes a summary of hospital-specific information is available in Appendix A.

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

CHI St. Alexius Health Devils Lake Hospital has a significant economic impact on the region. They directly employ 106 FTE employees with an annual payroll of over $10 million (including benefits). These employees create an additional 64 jobs and nearly $3.68 million in income as they interact with other sectors of the local

economy. This employment results in a total impact of 170 jobs and more than $13.68 million in income. Additional information is provided in Appendix B.

Mission

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

Vision

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

Values

Our Values are what brings our Mission to life and allows for our Vision to become reality:

- Compassion
- Inclusion
- Integrity
- Excellence
- Collaboration

CHI St. Alexius Health Devils Lake Hospital is one of the most important assets in the community and one of the largest charitable organizations in the Devils Lake area, giving $1,088,214 back to the community in fiscal year 2020. CHI St. Alexius Health Devils Lake Hospital includes a 25-bed, Critical Access Hospital with various outpatient therapies and services located in Devils Lake with a clinic also located right in Devils Lake. As a hospital, clinic, and designated level 5 trauma center, the medical center provides comprehensive care through a physician, physician assistants, nurse practitioners, and consulting/visiting medical providers for a wide range of medical and emergency situations. With approximately 140 staff members, CHI St. Alexius Health Devils Lake Hospital, along with contracted healthcare agencies housed within the facility, are one of the largest employers in the region.

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

General and Acute Services

1. Surgical Services
   - Ophthalmology
   - Obstetrics
   - Endoscopy
2. Radiology Services
   - Fluoroscopy
   - Magnetic Resonance Imaging (MRI)
   - Computed Tomography Imaging (CAT)
   - Sonography (Cardiac, OB, Vascular)
   - Nuclear Medicine Imaging
   - Mammography
3. Emergency Services
4. Outpatient Clinic
5. Physical Therapy
6. Occupational Therapy
7. Speech Therapy
8. Cardiac Rehabilitation
9. Respiratory Therapy
10. Laboratory Services
11. Obstetrics Unit
12. Medical/Surgical Unit
13. Swing bed Unit
14. Outpatient Dialysis (operated by Altru Health System)
15. Cancer Infusion Center (operated by Cancer Center of North Dakota)

Lake Region District Health Unit

Lake Region District Health Unit (LRDHU) is a four-county, district health unit, providing services to the people of Benson, Eddy, Pierce, and Ramsey counties. Public Health services in Ramsey County date back to 1934 when the County Public Health Nurse would perform the annual inspection of school children accompanied by the County Superintendent of Schools. In 1950, Ramsey County joined with Benson County to form the Lake Region District Health Unit. LRDHU is overseen by Dr. Wayman, Health Officer and eight board members, two from each county. Currently LRDHU has 18 employees and one administrator. Normal services are available Monday through Friday from 8:00 am to 12:00 pm and 1:00 to 5:00 pm. During the COVID-19 pandemic, all staff have been working evenings and weekends to provide testing, contact tracing, and vaccination to the public. LRDHU provides public health services that include environmental health, nursing services, and the WIC (women, infants and children) program. Each of these programs provides a wide variety of services in order to accomplish the mission of public health, which is to assure that North Dakota is a healthy place to live, and each person has an equal opportunity to enjoy good health. To accomplish this mission, Lake Region District Health Unit is committed to the promotion of healthy lifestyles, protection and enhancement of the environment, and provision of quality healthcare services for the people of North Dakota

Mission
The mission of public health is to make a positive impact on the health and welfare of the community by preventing the spread of disease, promoting good health, and protecting the environment.

Specific services that LRDHU provides are:

- Blood pressure check
- Breastfeeding resources
- Car seat program
- Child health (well-baby checks)
- Correction facility health
- Diabetes screening
- Emergency preparedness services-work with community partners as part of local emergency response team
- Environmental health services (water, sewer, health hazard abatement)
- Flu shots
- Foot care (Eddy and Benson)
- Health Tracks (child health screening)
- Home visits
- Immunizations
- Medications setup
- Member of Child Protection Team and County Interagency Team
- Newborn home visits
- Nutrition education
- School health- vision, hearing, scoliosis screenings in schools, health education and resource to the schools
- Preschool education programs & screening
- Substance abuse prevention
- Tobacco prevention and control
- Tuberculosis testing and management
- West Nile program- surveillance and education
- Women, Infants & Children (WIC) Program
- Worksite Wellness - coordinator for county employees and Sheriff's Department
- Women's Way - breast and cervical cancer screening

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 Ramsey County as well as Benson, Eddy, Towner, Cavalier, Walsh, and Nelson Counties, which are all included in the CHI St. Alexius Health Devils Lake service area. In addition to Devils Lake, located in the service area are the communities of Fort Totten, St. Michael, Minnewaukan, Lakota, Starkweather, Cando, Edmore, Sheyenne, and New Rockford.

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

Figure 2: Steering Committee

Mariann Doeling	Interim President, CHI St. Alexius, Devils Lake Hospital
Tony Dukart	Mission Director, CHI St. Alexius, Devils Lake Hospital
Terri Mertens	Purchasing Director, CHI St. Alexius, Devils Lake Hospital
Melanie Quinton	Marketing Manager, CHI St. Alexius, Devils Lake Hospital
Allen McKay	Administrator, Lake Region District Health Unit
Annette Groves	DON, Lake Region District Health Unit

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.

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

Members of the community group and key informants represented the broad interests of the community served by CHI St. Alexius Health Devils Lake Hospital and LRDHU. They included representatives of the health community, business community, political bodies, and education. 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. Specific names of the organizations that participated in the key informant interviews and community group meetings will not specifically be identified so that the interviewees freely share information because they will remain anonymous. Due to the rural nature of the community, it is easy to identify someone based on the name of their organization. Industry sectors will be identified in the report to show the variety of areas that the comments were solicited from within the community.

Community Group

A community group, consisting of seven community members, was convened and first met on July 15, 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 15, 2021, with ten 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 Ramsey, Benson, Eddy, and Pierce Counties. The group was then tasked with identifying and prioritizing the community's health needs.

Interviews

One-on-one interviews with four key informants were conducted in person in Devils Lake on July 15, 2021. Two additional key informant interviews were conducted over the phone in July of 2021. A representative from the CRH conducted the interviews. Interviews were held with selected members of the community who could provide insights into the community's health needs. Included among the informants were public health professionals with special knowledge in public health acquired through several years of direct experience in the community, including working with medically underserved, low income, and minority populations as well as with populations with chronic diseases.

Topics covered during the interviews included the general health needs of the community, the general health of

the community, community concerns, delivery of healthcare by local providers, awareness of health services offered locally, barriers to receiving health services, and suggestions for improving collaboration within the community.

Survey

A survey was distributed to solicit feedback from the community and was not intended to be a scientific or statistically valid sampling of the population. It was designed to be an additional tool for collecting qualitative data from the community at large, specifically, information related to community-perceived health needs. A copy of the survey instrument is included in Appendix C and a full listing of direct responses is 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 Ramsey County as well as Benson, Eddy, and Pierce Counties, which are all included in the CHI St. Alexius Health Devils Lake Hospital 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; and
- Suggestions to improve the delivery of local healthcare.

To promote awareness of the assessment process, CHI St. Alexius Health Devils Lake Hospital and LRDHU shared links of the survey on their websites and social media pages. A QR code was offered to patients who visited the CHI St. Alexius Health Devils Lake clinic and hospital in Devils Lake. The survey was also available at the LRDHU building. Emails of the survey link were sent to various community groups, and the survey was promoted via radio as well. Promotion was also done at the LRDHU COVID-19 vaccination pop-up clinics. The surveys were distributed by community group members and at CHI St. Alexius Health Devils Lake Hospital and LRDHU.

To help ensure anonymity, included with each survey was a postage-paid return envelope to CRH. In addition, to help make the survey as widely available as possible, residents also could request a survey by calling CHI St. Alexius Health Devils Lake Hospital or LRDHU. The survey period ran from July 1, 2021 to July 31, 2021. Thirty-five completed paper surveys were returned.

Area residents were also given the option of completing an online version of the survey. One hundred forty-nine online surveys were completed. Four of those online respondents used the QR code to complete the survey. In total, counting both paper and online surveys, 184 community member surveys were completed, equating to a 2% response rate. This response rate is low for this type of unsolicited survey methodology but is on par for this year. Lower response rates, responses at about half of what we typically see, are occurring throughout the state for surveys being conducted this year. We feel this low rate is largely due to the current pandemic, and people are not out interacting with the community as much as in a typical year, thus resulting in less surveys being disseminated and less knowledge of the survey availability.

Secondary Data

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

Social Determinants of Health

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

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

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

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

Figure 3: Social Determinants of Health

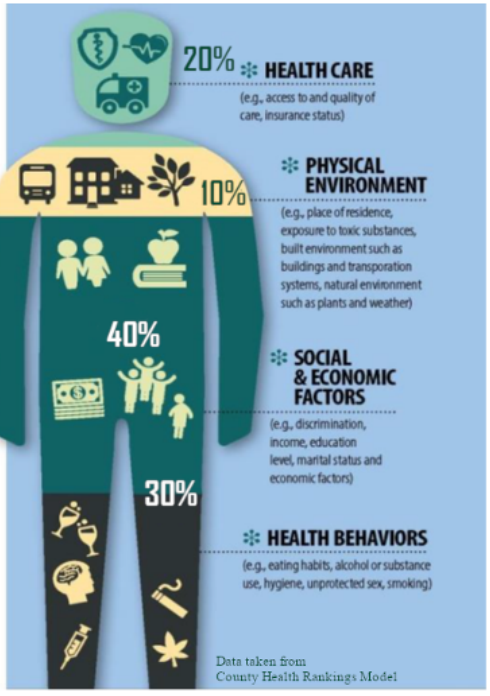


Figure 4 (Henry J. Kaiser Family Foundation, https://www.kff.org/disparitiespolicy/issue-brief/beyond-health-care-therole-of-social-determinantsin-promoting-health-andhealth-equity/), provides examples of factors that are included in each of the social determinants of health categories that lead to health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

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 Lake Region District Health Unit Service Area Counties

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

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

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

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

As of June 29, 2021, in North Dakota, the 623,118 doses of the COVID-19 vaccine have been administered. In the Lake Region District Health Unit service area (2,868 Pierce County; 1,883 Eddy County; 4,305 Benson County; 9,642 Ramsey County), there have been 18,698 COVID-19 vaccine doses administered. Statewide, the one dose coverage rate is 50.7%, and 48.0% are fully immunized. See Figure 2 for the Pierce, Eddy, Benson, and Ramsey County breakdown by age of one dose coverage and Figure 3 for fully vaccinated (up-to-date coverage). Pierce County has a 44.2%, Eddy County has a 54.9%, Benson County has a 50.9%, and Ramsey County has a 52.4% Up-to-Date Coverage Rate as of June 29, 2021.

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

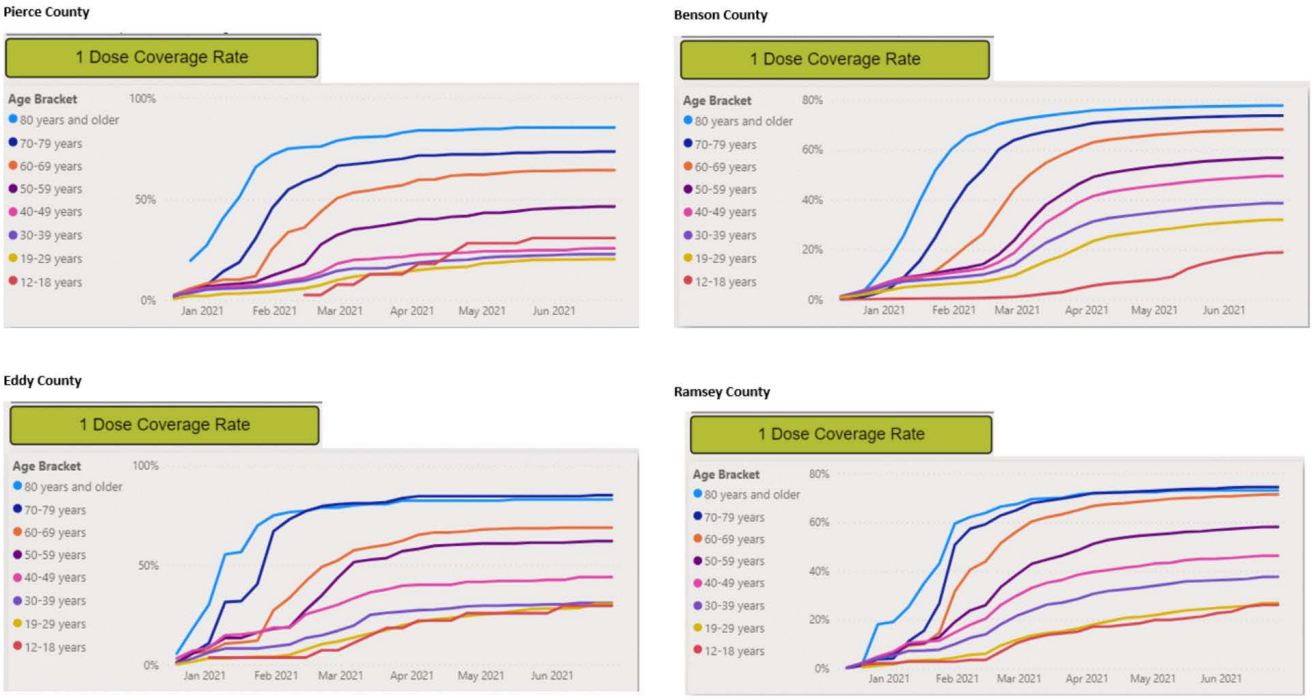
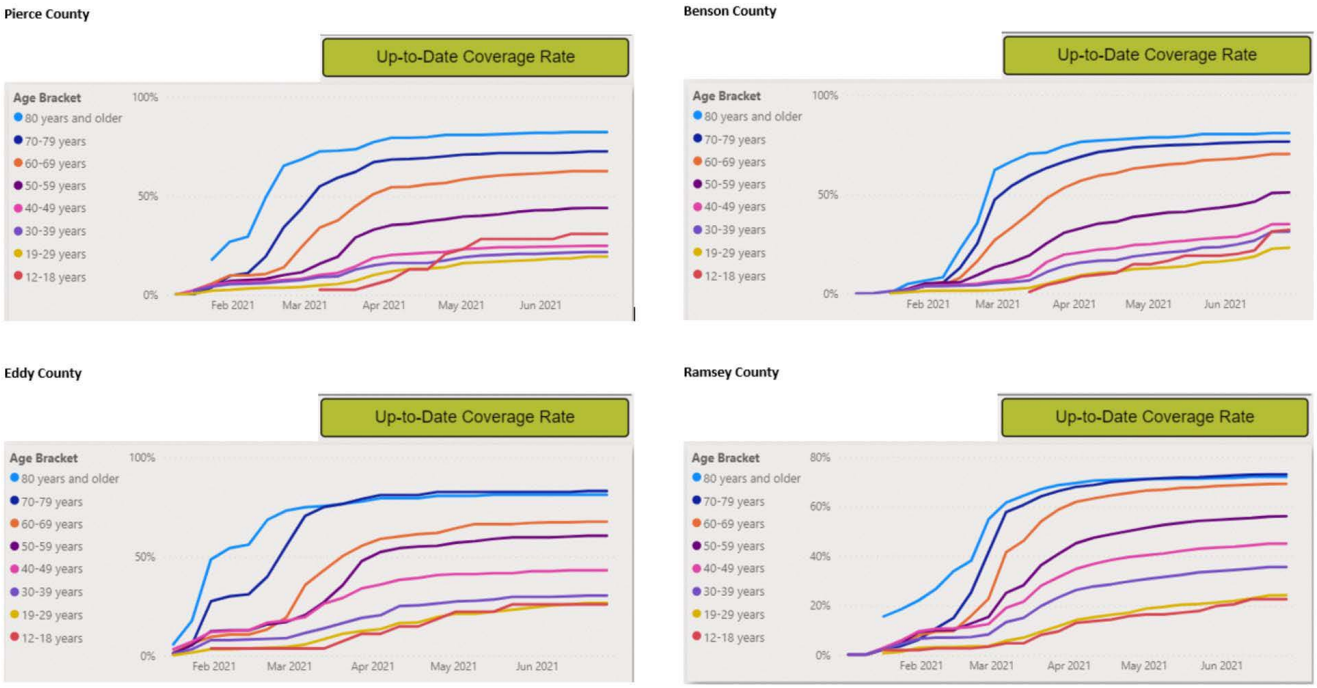


Figure 3: Up-to-Date Coverage Rate by County[2]



There are six COVID-19 vaccine enrolled provider sites in Pierce County: one in Eddy County, two in Benson County, 10 in Ramsey County, and 416 total in North Dakota.

Immunization Rates for Pierce, Benson, Eddy, and Ramseyy County

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

Figure 4. Percent of Pierce, Benson, Eddy, and Ramsey County children 19-35 months of age for 2021 Q1[3]

	Pierce County	Benson County	Eddy County	Ramsey County
Vaccine	Rate (in %)	Rate (in %)	Rate (in %)	Rate (in %)
4:3:1:3:3:1:4 Series	85.71	66.50	77.27	85.29
DTap	89.29	77.67	84.09	90.76
Hepatitis A	82.14	70.39	84.09	85.29
Hepatitis B	100.00	91.26	90.91	100.42
Hib UTD	91.07	82.52	84.09	92.86
MMR	92.86	88.35	88.64	95.38
PCV	87.50	70.39	88.64	90.34
Polio	100.00	90.29	88.64	100.00
Varicella	92.86	88.83	88.64	95.80

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

Figure 5. Percent of Pierce, Benson, Eddy, and Ramsey County Teens 14-17 years of age for 2021 Q1[3]

	Pierce County	Benson County	Eddy County	Ramsey County
Vaccine	Rate (in %)	Rate (in %)	Rate (in %)	Rate (in %)
HPV Female Start	73.17	91.41	85.71	89.38
HPV Female UTD	64.60	92.98	84.71	89.07
HPOV Male Start	64.60	92.98	84.71	89.07
HPV Male UTD	57.52	80.99	78.82	79.73
MCV4 dose 1	91.14	95.37	94.44	94.88
MCV4 dose 2	65.26	67.87	73.02	66.27
Men B dose 1	62.11	65.86	63.49	60.64
Men B UTD	43.16	41.37	47.62	43.78
Td/Tdap	93.67	95.07	95.14	96.26
Varicella	91.56	93.73	95.83	94.32

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

Figure 6. Percent of Pierce, Benson, Eddy, and Ramsey County Adults 19 years of age and older for 2021 Q1[3]

	Pierce County	Benson County	Eddy County	Ramsey County
Vaccine	Rate (in %)	Rate (in %)	Rate (in %)	Rate (in %)
PCV13 after 65 years	68.74	63.69	65.78	64.33
PPSV23 after 65 years	59.79	56.71	59.57	57.82
Shingrix® dose 1 after 50 years	24.34	36.24	29.33	28.81
Shingrix® UTD after 50 years	20.66	28.27	24.15	23.85
Tdap after 19 years	70.41	83.27	72.07	74.03
Zostavax after 60 years	40.43	38.02	43.24	41.01

Focus Group Discussion

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

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

Effects of COVID-19 and the Introduction of the COVID-19 Vaccine on the Community

At the beginning of the pandemic, Devils Lake largely shutdown; many businesses had to close for a while. Restaurants stayed open by making delivery an option. The places that could deliver made it through the best. Innovation helped businesses survive the pandemic.

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

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

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

When the vaccine first came out, there was an attitude toward the vaccine in the healthcare-related settings of excitement and skepticism, with similar responses from people in the community. The older population was very excited and lined up outside of the vaccination site, in the cold (negative 30 degrees at times), to receive it. However, there was initially not enough vaccine for everyone, so some had to go home and come back another

day. They were upset about not being able to get it right away, but they did come back to get it when there was more available. There were also people who came from out-of-state, prior to North Dakota putting restrictions on recipients needing to be residents, to get vaccinated. There was a busload of people that drove from Wisconsin to receive it. Businesses have asked public health to come to their facilities and offer the vaccine to employees, and public health has offered this service for many.

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

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

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

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

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

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

There are claims that the vaccine has endangered the lives of everyone who took it, and it also endangered the health and/or lives of those who are around the vaccinated. The medical industry, as a whole, will publicly deny the effects of "shedding," but this person claims to have read way too many articles, written by doctors,

speaking to the dangers of what this vaccine purports to do. They have seen first-hand some of the effects of "shedding," and they know others who have experienced first-hand the effects as well.

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

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

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

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

Refusal to get vaccinations, in general, by non-vaxxers, has been a hinderance. In addition to those already against vaccinations of any kind, there are additional people who just don't trust the COVID 19 vaccine. There are more non-vaxxers today than previously known. Public health has struggled with non-vaxxers for over 25 years. They get their information from social media, and often it isn't accurate, such as saying that vaccines cause autism.

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

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

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

There was a response from one person who felt that there was way too good of an ability to access the vaccine. They drove from Minot to Leeds in June, and at a rest area just east of Minot, there was a sign saying that Canadian truckers and anyone else can come to the rest area and get a free COVID-19 shot. They feel that there are people stupid enough to drive into a rest area, roll up their sleeve, and allow someone who claims to be qualified, inject them with a supposed vaccine that all along has been promoted by the "cientists" as needing to be kept at an outrageously cold temperature that only very sophisticated facilities could manage.

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

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

facilities haven't had any restrictions lifted, even though other businesses have.

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

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

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

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

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

General Thoughts
The county/city officials backing public health and communicating a consistent message must continue.

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

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

Demographic Information

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

	Ramsey County	Benson County	Eddy County	Pierce County	North Dakota
Population (2019)	11,519	6,832	3,975	2,287	762,062
Population change (2010-2019)	0.6%	2.6%	-8.8%	-4.1%	13.3%
People per square mile (2010)	9.6	4.8	4.3	3.8	9.7
Persons 65 years or older (2019)	20.3%	14.4%	23.8%	23.7%	15.7%
Persons under 18 years (2019)	23.3%	35.2%	22.8%	23.4%	23.6%
Median age (2019 est.)	40.7	30.5	45.8	45.8	35.1
White persons (2019)	83.7%	41.6%	92.2%	92.6%	86.9%
High school graduates (2019)	91.9%	86.3%	93.3%	89.4%	92.6%
Bachelor's degree or higher (2019)	26.4%	16.2%	21.0%	26.2%	30.0%
Live below poverty line (2019)	12.3%	23.3%	11.6%	10.0%	10.6%
Persons without health insurance, under age 65 years (2019)	8.6%	12.7%	8.4%	9.4%	8.1%
Persons without health insurance, under age 65 years (2016)		12.4%	6.3%	6.8%	8.1%

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

County Health Rankings

The Robert Wood Johnson Foundation, in collaboration with the University of Wisconsin Population Health Institute, has developed County Health Rankings to illustrate community health needs and provide guidance for actions toward improved health. In this report, Ramsey, Benson, Pierce, and Eddy Counties are compared to North Dakota rates and national benchmarks on various topics, ranging from individual health behaviors to the quality of healthcare.

The data used in the 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 having high ranks, such as 1 or 2, are considered to be the "healthiest." Counties are ranked on both health outcomes and health factors. Following is a breakdown of the variables that influence a county's rank.

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

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

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 Ramsey, Benson, Eddy, and Pierce Counties. It is important to note that these statistics describe the population of a county, regardless of where county residents choose to receive their medical care. In other words, all of the following statistics are based on the health behaviors and conditions of the county's residents, not necessarily the patients and clients of LRDHU and CHI St. Alexius Health Devils Lake Hospital, 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).

Ramsey, Benson, Eddy, and Pierce Counties rankings within the state are included in the summary following. For example, Ramsey County ranks 33rd out of 46 ranked counties in North Dakota on health outcomes and 21st on health factors. Benson County ranks 45th out of 46 ranked counties in North Dakota on health outcomes and 44th on health factors. Pierce County ranks 42nd out of 46 ranked counties in North Dakota on health outcomes and 42nd on health factors. Eddy County ranks 31st out of 46 ranked counties in North Dakota on health outcomes and 37th 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 Ramsey County is doing better than many counties, compared to the rest of the state on only one of the outcomes, landing at or above rates for other North Dakota counties. However, the county, similar to many North Dakota counties, is doing poorly in many areas when it comes to the U.S. Top 10% ratings. The only outcome where Ramsey County meets the U.S. Top 10% rating is the number of poor mental health days in the past 30 days.

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

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

- Poor mental health days
- Adult smoking
- Adult obesity
- Food environment index
- Access to exercise opportunities
- Excessive drinking
- Alcohol-impaired driving deaths
- Primary care physicians
- Dentists
- Mental health providers
- Mammography screening (% of Medicare enrollees ages 67-69 receiving screening)
- Preventable hospital stays
- Flu vaccinations
- Children in single-parent households
- Violent crime
- Drinking water violations
- Severe housing problems

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

- Premature death
- Poor or fair health
- Poor physical health days
- Low birth weight
- Physical inactivity
- Sexually transmitted infections
- Teen birth rate
- Uninsured
- Unemployment
- Children in poverty
- Income inequality
- Social associations
- Injury deaths
- Air pollution

North Dakota counties, is doing poorly in many areas when it comes to the U.S. Top 10% ratings as well. Benson County does not meet the U.S. Top 10% ratings in any outcomes.

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

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

- Excessive drinking
- Violent crime
- Drinking water violations

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

- Premature death
- Poor or fair health
- Poor physical health days
- Poor mental health days
- Low birth weight
- Adult smoking
- Adult obesity
- Food environment index
- Physical inactivity
- Access to exercise opportunities
- Alcohol-impaired driving deaths
- Sexually transmitted infections
- Teen birth rate
- Uninsured
- Dentists
- Mental health providers
- Preventable hospital stays
- Mammography screening (% of Medicare enrollees age 65-74 receiving screening)
- Flu vaccinations
- Unemployment
- Children in poverty
- Income inequality
- Children in single-parent households
- Social associations
- Injury deaths
- Air pollution
- Severe housing problems

TABLE 2: SELECTED MEASURES FROM COUNTY HEALTH RANKINGS 2021 – Ramsey County and Benson County

● = Not meeting North Dakota average

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

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

Blank values reflect unreliable or missing data

TABLE 2: SELECTED MEASURES FROM *COUNTY HEALTH RANKINGS* 2021 – RAMSEY COUNTY and BENSON COUNTY

	Ramsey County	Benson County	U.S. Top 10%	North Dakota
Ranking: Outcomes	**33rd**	**45th**		**(of 46)**
Premature death	7,100 ●■	17,900 ●■	5,400	6,600
Poor or fair health	16% ●■	28% ●■	14%	14%
Poor physical health days (in past 30 days)	3.5 ●■	5.3 ●■	3.4	3.2
Poor mental health days (in past 30 days)	3.6 +	4.8 ●■	3.8	3.8
Low birth weight	8% ●■	7% ●■	6%	6%
Ranking: Factors	**21st**	**44th**		**(of 45)**
Health Behaviors				
Adult smoking	20% ■	33% ●■	16%	20%
Adult obesity	34% ■	42% ●■	26%	34%
Food environment index (10=best)	8.9 +	6.3 ●■	8.7	8.9
Physical inactivity	28% ●■	34% ●■	19%	23%
Access to exercise opportunities	77% ■	63% ●■	91%	74%
Excessive drinking	24% ■	21% ■	15%	24%
Alcohol-impaired driving deaths	30% ■	77% ●■	11%	42%
Sexually transmitted infections	390.7 ●■	1,427.3 ●■	161.2	466.6
Teen birth rate	34 ●■	90 ●■	12	20
Clinical Care				
Uninsured	9% ●■	13% ●■	6%	8%
Primary care physicians	1,040:1 ■		1,030:1	1,300:1
Dentists	1,150:1 +	6,830:1 ●■	1,210:1	1,510:1
Mental health providers	240:1 +	1,710:1 ●■	270:1	510:1
Preventable hospital stays	3,610 ■	4,363 ●■	2,565	4,037
Mammography screening (% of Medicare enrollees ages 65-74 receiving screening)	63% +	47% ●■	51%	53%
Flu vaccinations (% of fee-for-service Medicare enrollees receiving vaccination)	51% ■	38% ●■	55%	50%
Social and Economic Factors				
Unemployment	2.9% ●■	4.2% ●■	2.6%	2.4%
Children in poverty	17% ●■	34% ●■	10%	11%
Income inequality	4.9 ●■	6.0 ●■	3.7	4.4
Children in single-parent households	20% ■	52% ●■	14%	20%
Social associations	14.8 ●■	4.3 ●■	18.2	16.0
Violent crime	143 ■	29 +	63	258
Injury deaths	75 ●■	134 ●■	59	71
Physical Environment				
Air pollution – particulate matter	5.1 +●	5.1 +●	5.2	4.7
Drinking water violations	No	No		
Severe housing problems	10% ■	16% ●■	9%	12%

The data from County Health Rankings show that Pierce County is doing better than some counties, compared to the rest of the state on only one of the outcomes, landing at or above rates for other North Dakota counties. However, the county, similar to many North Dakota counties, is doing poorly in many areas when it comes to the U.S. Top 10% ratings. The only outcome where Pierce County meets the U.S. Top 10% rating is the number of poor mental health days in the past 30 days.

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

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

- Poor mental health days
- Food environment index
- Sexually transmitted infections
- Uninsured
- Dentists
- Mammography screening (% of Medicare enrollees ages 67-69 receiving screening)
- Children in single-parent households
- Violent crime
- Drinking water violations
- Severe housing problems

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

- Poor or fair health
- Poor physical health days
- Low birth weight
- Adult smoking
- Adult obesity
- Physical inactivity
- Access to exercise opportunities
- Alcohol-impaired driving deaths
- Primary care physicians
- Preventable hospital stays
- Flu vaccinations
- Unemployment
- Children in poverty
- Income inequality
- Social associations
- Injury deaths
- Air pollution
- Severe housing problems

County Health Rankings show that Eddy County is doing better than many counties, compared to the rest of the state on all except for two of the outcomes, landing at or above rates for other North Dakota counties. The county, similar to many North Dakota counties, is doing poorly in many areas when it comes to the U.S. Top 10% ratings as well. The two particular outcomes where Eddy County does not meet the U.S. Top 10% ratings is poor or fair health and poor physical health days.

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

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

- Poor or fair health
- Poor mental health days
- Low birth weight
- Adult smoking
- Adult obesity
- Excessive drinking
- Sexually transmitted infections
- Teen birth rate

- Dentists
- Preventable hospital stays
- Mammography screening (% of Medicare enrollees ages 67-69 receiving screening)
- Flu vaccinations
- Income inequality
- Children in single-parent households
- Violent crimes
- Air pollution
- Drinking water violations
- Severe housing problems

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

- Poor physical health days
- Food environment index
- Physical inactivity
- Access to exercise opportunities
- Alcohol-impaired driving deaths
- Uninsured
- Unemployment
- Children in poverty
- Social associations
- Injury deaths

TABLE 2: SELECTED MEASURES FROM COUNTY HEALTH RANKINGS 2021 – Pierce County and Eddy County

● = Not meeting North Dakota average

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

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

Blank values reflect unreliable or missing data

TABLE 2: SELECTED MEASURES FROM *COUNTY HEALTH RANKINGS* 2021 – PIERCE COUNTY and EDDY COUNTY				
	Pierce County	**Eddy County**	**U.S. Top 10%**	**North Dakota**
Ranking: Outcomes	**42nd**	**31st**		**(of 46)**
Premature death			5,400	6,600
Poor or fair health	16% ●■	16% ●■	14%	14%
Poor physical health days (in past 30 days)	3.5 ●■	3.5 ●■	3.4	3.2
Poor mental health days (in past 30 days)	3.8 +	3.7 +	3.8	3.8
Low birth weight	12% ●■	6% +	6%	6%
Ranking: Factors	**42nd**	**37th**		**(of 45)**
Health Behaviors				
Adult smoking	21% ●■	21% ●■	16%	20%
Adult obesity	40% ●■	34% ■	26%	34%
Food environment index (10=best)	8.7 +	8.0 ●■	8.7	8.9
Physical inactivity	26% ●■	33% ●■	19%	23%
Access to exercise opportunities	72% ●■	70% ●■	91%	74%
Excessive drinking	23% ■	24% ■	15%	24%
Alcohol-impaired driving deaths	50% ●■	100% ●■	11%	42%
Sexually transmitted infections	146.4 +	215.9■	161.2	466.6
Teen birth rate		20 ■	12	20
Clinical Care				
Uninsured	8% ■	9% ●■	6%	8%
Primary care physicians	1,360:1 ●■		1,030:1	1,300:1
Dentists	990:1 +	760:1 +	1,210:1	1,510:1
Mental health providers			270:1	510:1
Preventable hospital stays	8,752 ●■	4,017 ■	2,565	4,037
Mammography screening (% of Medicare enrollees ages 65-74 receiving screening)	53% ■	60% +	51%	53%
Flu vaccinations (% of fee-for-service Medicare enrollees receiving vaccination)	28% ●■	31% ●■	55%	50%
Social and Economic Factors				
Unemployment	3.2% ●■	4.5% ●■	2.6%	2.4%
Children in poverty	14% ●■	14% ●■	10%	11%
Income inequality	6.5 ●■	4.4 ■	3.7	4.4
Children in single-parent households	20% ■	14% +	14%	20%
Social associations	12.3 ●■	13.0 ●■	18.2	16.0
Violent crime	138 ■	169 ■	63	258
Injury deaths	92 ●■	112 ●■	59	71
Physical Environment				
Air pollution – particulate matter	4.8 +●	4.8 +●	5.2	4.7
Drinking water violations	No	No		
Severe housing problems	10% ■	16% ●■	9%	12%

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

Children's Health

The National Survey of Children's Health touches on multiple intersecting aspects of children's lives. Data are not available at the county level; listed below is information about children's health in North Dakota. The full survey includes physical and mental health status, access to quality healthcare, and information on the child's family, neighborhood, and social context. Data are from 2019. More information about the survey may be found at www.childhealthdata.org/learn/NSCH.

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

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

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

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

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

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

Table 4 includes selected county-level measures regarding children's health in North Dakota. The data come from North Dakota KIDS COUNT, a national and state-by-state effort to track the status of children, sponsored by the Annie E. Casey Foundation. KIDS COUNT data focuses on the main components of children's well-

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 Ramsey County is performing more poorly than the North Dakota average on all of the examined measures except the number of licensed childcare capacity. The most marked difference was on the measure of victims of child abuse and neglect, requiring services (rate of 21.36 times more in Ramsey County).

Benson County is performing more poorly than the North Dakota average on all but two factors: licensed childcare capacity and victims of child abuse and neglect, requiring services (data from 2017). The most marked differences were on the measures of Medicaid recipient (50.7% higher in Benson County) and Supplemental Nutrition Assistance Program (SNAP) recipients (37.1% higher in Benson County).

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

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

	Ramsey County	Benson County	North Dakota
Child food insecurity, 2019	**12.1%**	**26.1%**	9.6%
Medicaid recipient (% of population age 0-20), 2019	**36.4%**	**76.7%**	26.6%
Children enrolled in Healthy Steps (CHIP) (% of population age 0-18), 2020	**2.1%**	**3.0%**	1.6%
Supplemental Nutrition Assistance Program (SNAP) recipients (% of population age 0-18), 2020	**23.9%**	**54.1%**	16.9%
Licensed childcare capacity (# of children), 2020	1,031	77	36,701
4-year high school cohort graduation rate, 2019/2020	**86.8%**	78.9%	89.0%
Victims of child abuse and neglect requiring services (rate per 1,000 children ages 0-17), 2019	**31.34**	**5.54 (2017)**	9.98

The data show Pierce County is performing more poorly than the North Dakota average on all except three of the examined measures. The most marked difference was on the measure of victims of child abuse and neglect, requiring services (rate of 14.46 more in Pierce County-2018 data).

Eddy County is performing more poorly than the North Dakota average on all but three factors. The most marked difference was on the measure of victims of child abuse and neglect, requiring services (rate of 6.69 more in Eddy County-2018 data).

	Pierce County	Eddy County	North Dakota
Child food insecurity, 2019	**15.0%**	**13.7%**	9.6%
Medicaid recipient (% of population age 0-20), 2019	**27.5%**	**25.1%**	26.6%
Children enrolled in Healthy Steps (CHIP) (% of population age 0-18), 2020	**2.4%**	**3.7%**	1.6%
Supplemental Nutrition Assistance Program (SNAP) recipients (% of population age 0-18), 2020	**13.3%**	**18.4%**	16.9%
Licensed childcare capacity (# of children), 2020	162	75	36,701
4-year high school cohort graduation rate, 2019/2020	**≥ 95%**	≥ 90%	89.0%
Victims of child abuse and neglect requiring services (rate per 1,000 children ages 0-17), 2019	**24.44 (2018)**	**16.67 (2018)**	9.98

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 as well as evaluate and improve school and community programs. North Dakota began participating in the YRBS survey in 1995. Students in grades 7-8 and 9-12 are surveyed in the spring of odd years. The survey is voluntary and completely anonymous.

North Dakota has two survey groups: selected and voluntary. The selected school survey population is chosen, using a scientific sampling procedure, which ensures that the results can be generalized to the state's entire student population. The schools that are part of the voluntary sample, selected without scientific sampling procedures, will only be able to obtain information on the risk behavior percentages for their school and not in comparison to all the schools.

Table 5 depicts some of the YRBS data that has been collected in 2015, 2017, and 2019. It is further broken down by rural and urban percentages. The trend column shows a "=" for statistically insignificant change (no change), "↑" for an increased trend in the data changes from 2017 to 2019, and "↓" for a decreased trend in the data changes from 2017 to 2019. The final column shows the 2019 national average percentage. For a more complete listing of the YRBS data, see Appendix E.

TABLE 5: Youth Behavioral Risk Survey Results

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

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

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

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

Low Income Needs

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

Top Needs Identified by People Experiencing Poverty Across North Dakota

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

2020 North Dakota LOW INCOME COMMUNITY NEEDS

Helping People. Changing Lives. Community Action Partnership — America's Poverty Fighting Network

NDSU North Dakota State University

Assessed by CAPND and NDSU, November 2020

KEY FINDINGS

1st Priority Need

Rental Assistance

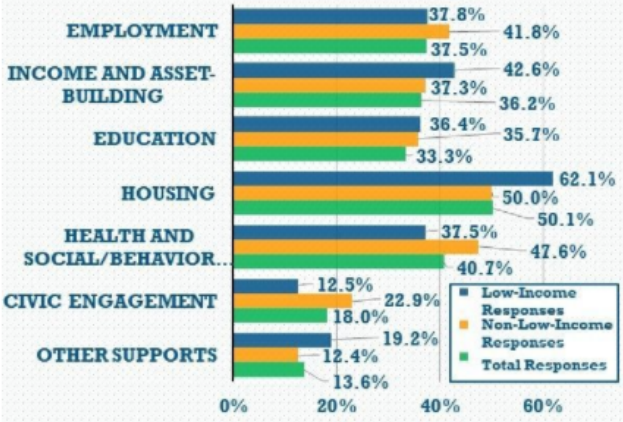
3,458 Total Survey Responses

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

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

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

STATEWIDE OVERALL NEEDS



TOP STATEWIDE SPECIFIC NEEDS

Low-Incomes

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

Non-Low-Incomes

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

Community (Low-Income & Non-Low-Income)

- **Health and Social/Behavior Development** - Dental Insurance/Affordable Dental
- **Health and Social/Behavior Development** - Health Insurance/Affordable Health Care
- **Health and Social/Behavior Development** - Mental Health Service

TOP REGIONAL OVERALL NEEDS FOR LOW-INCOMES

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

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

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

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

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

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

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

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

ACKNOWLEDGMENTS

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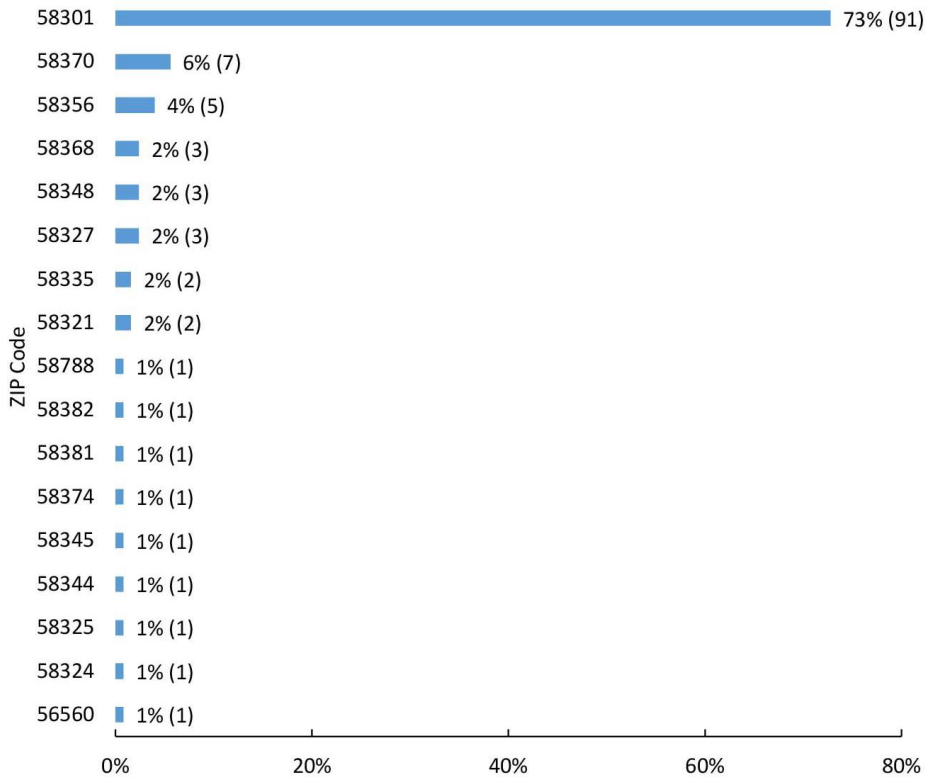
Survey Results

As noted previously, the 184 community members completed the survey in communities throughout the counties in the CHI St. Alexius Health Devils Lake Hospital service area. For all questions that contained an "Other" response, all of those direct responses may be found in Appendix G. In some cases, a summary of those comments is additionally included in the report narrative. The "Total respondents" number under each heading indicates the number of people who responded to that particular question, and the "Total responses" number under the heading depicts the number of responses selected for that question (some questions allow for selection of more than one response).

The survey requested that respondents list their home zip code. While not all respondents provided a zip code, participants, numbering 125, did, revealing that a large majority of respondents (73%, N=91) lived in Devils Lake. These results are shown in Figure 5.

Figure 5: Survey Respondents' Home Zip Code
Total respondents: 125



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

Survey Demographics

To better understand the perspectives 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.

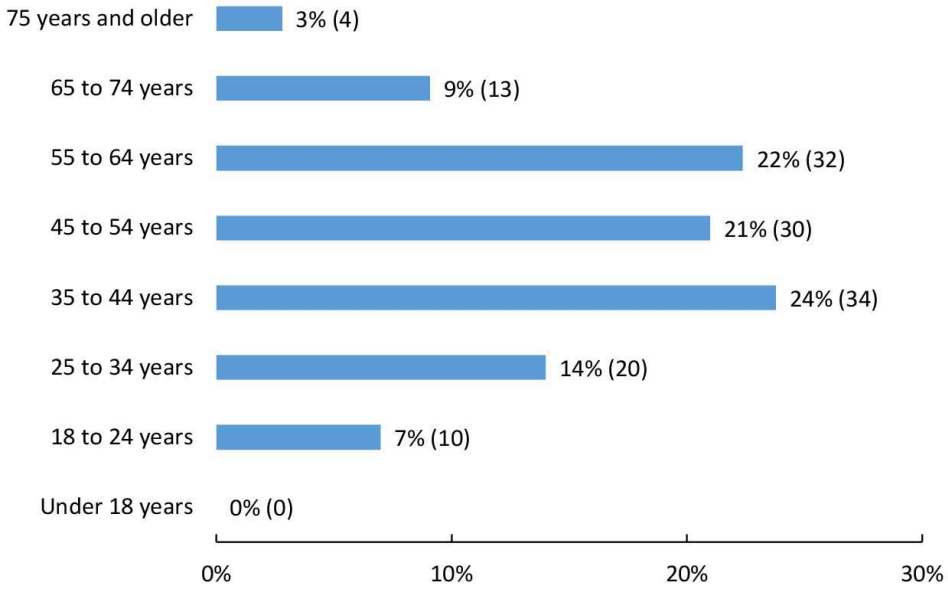
With respect to demographics of those who chose to complete the survey:

- 34% (N=49) were age 55 or older
- The majority (79%, N=112) were female
- Slightly more than one third of the respondents (33%, N=48) had bachelor's degrees or higher

- The number of those working full time (74%, N=106) was just over than nine times higher than those who were retired (8%, N=12)
- 90% (N=127) of those who reported their ethnicity/race were White/Caucasian
- 25% of the population (N=33) 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 indicate how this assessment took into account input from parties who represent the varied interests of the community served, including a balance of age ranges, those in diverse work situations, and community members with lower incomes.

Figure 6: Age Demographics of Survey Respondents
Total respondents = 143



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

Figure 7: Gender Demographics of Survey Respondents
Total respondents = 142

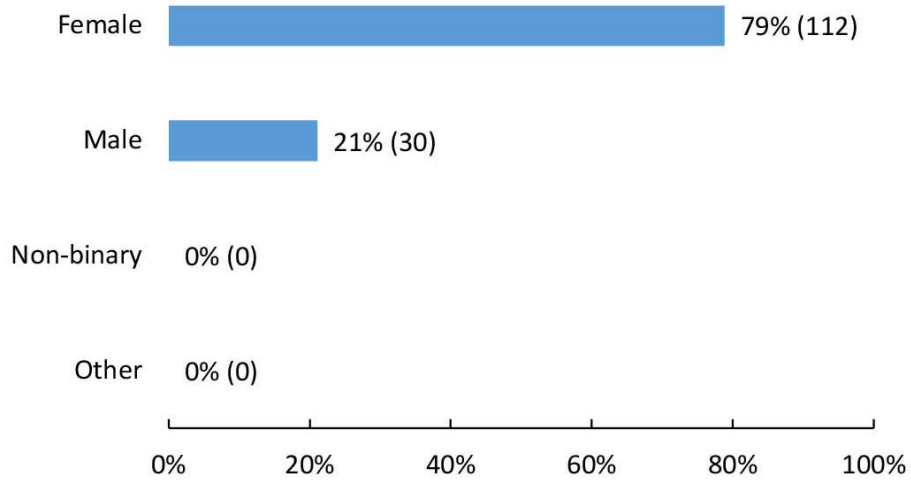


Figure 8: Educational Level Demographics of Survey Respondents
Total respondents = 144

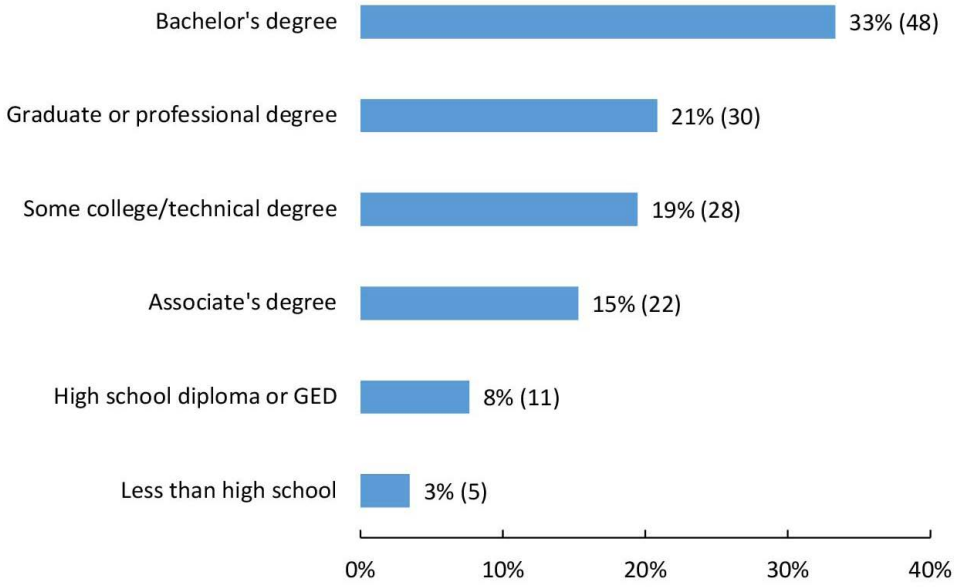
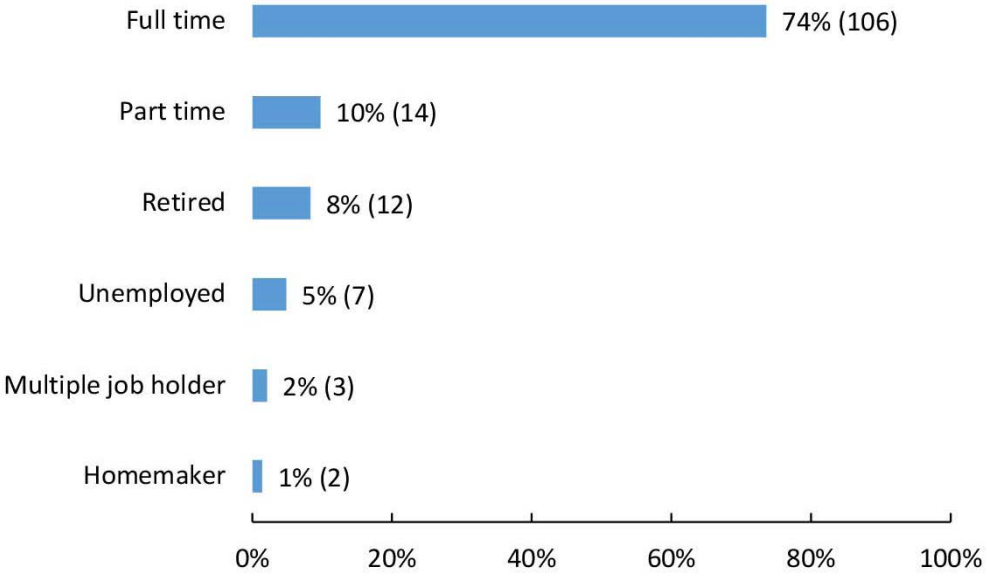
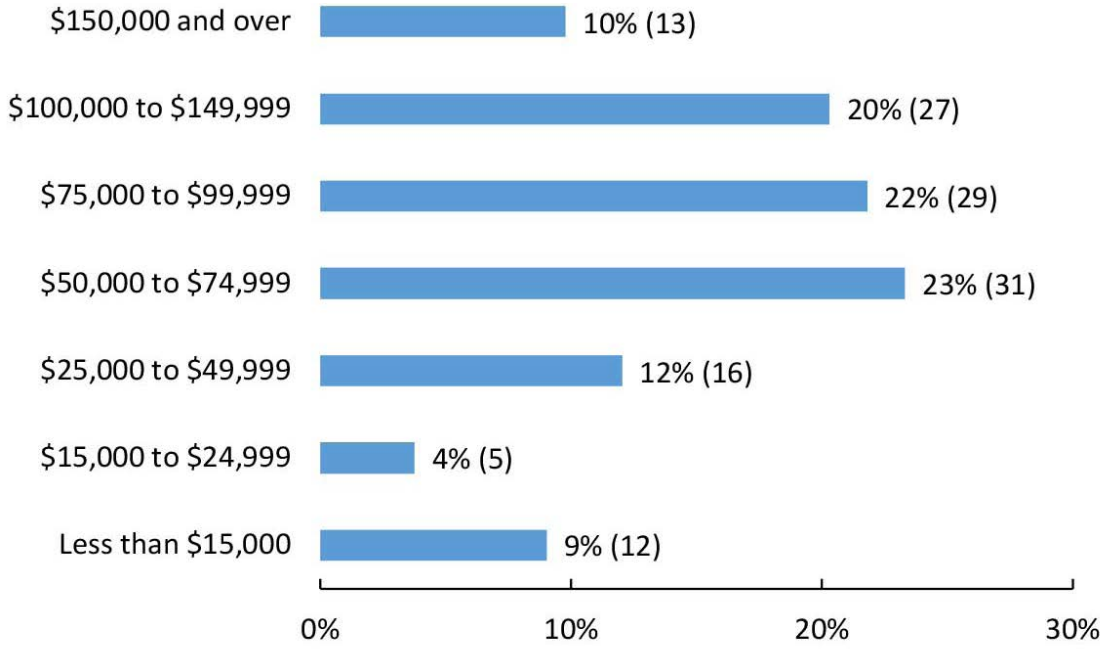


Figure 9: Employment Status Demographics of Survey Respondents
Total respondents = 144



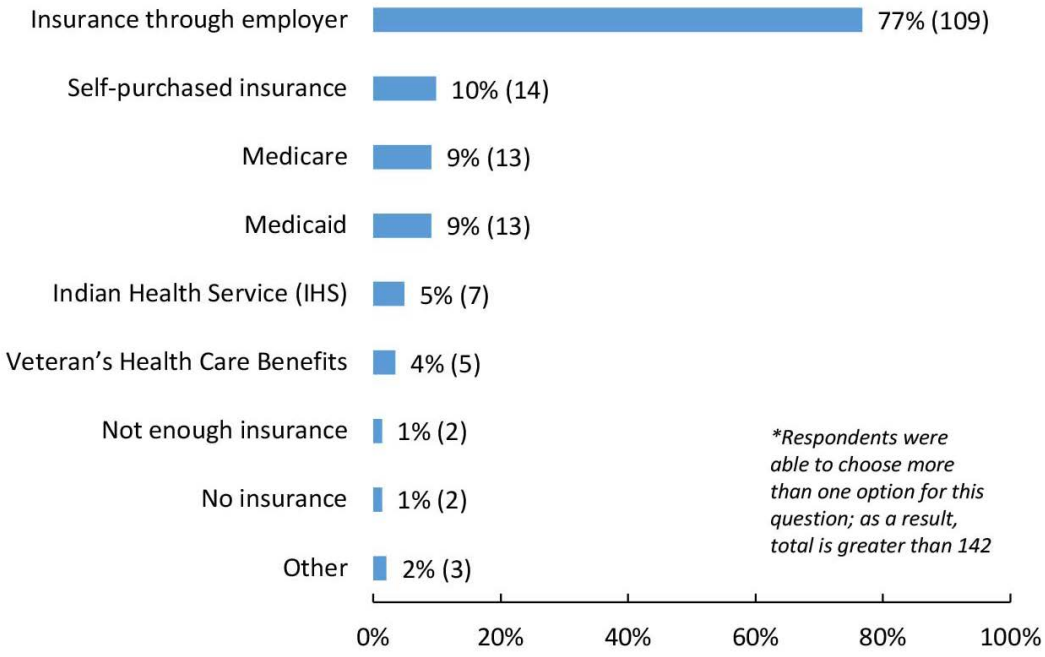
Of those who provided a household income, community members (13% (N=17)) reported a household income of less than $25,000. Thirty percent (N=40) indicated a household income of $100,000 or more. This information is shown in Figure 10.

Figure 10: Household Income Demographics of Survey Respondents
Total respondents = 133



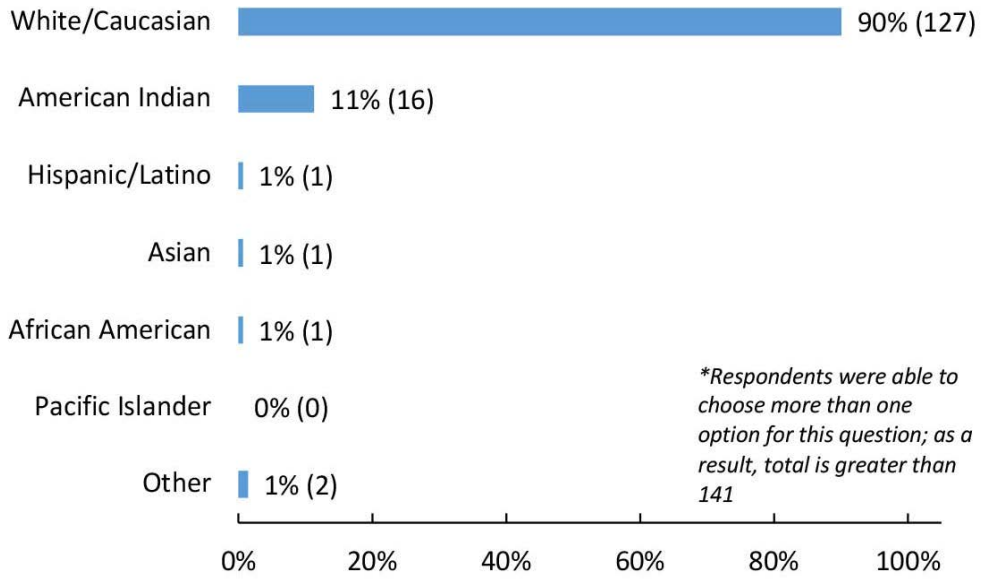
Community members were asked about their health insurance status, which is often associated with whether people have access to healthcare. Two percent (N=4) of the respondents reported having no health insurance or being under-insured. The most common insurance types were insurance through one's employer (N=109), followed by self-purchased (N=14), and Medicare and Medicaid (N=13 each).

Figure 11: Health Insurance Coverage Status of Survey Respondents
Total respondents = 168



As shown in Figure 12, nearly all of the respondents were White/Caucasian (90%). This number was in-line with the race/ethnicity of the overall population of Ramsey, Pierce, and Eddy Counties; the US Census indicates that 83.7% of the population is White in Ramsey County, 92.2% White in Pierce County, and 92.6% White in Eddy County. The U.S. Census indicates that 41.6% of the population is White in Benson County.

Figure 12: Race/Ethnicity Demographics of Survey Respondents
Total respondents = 148



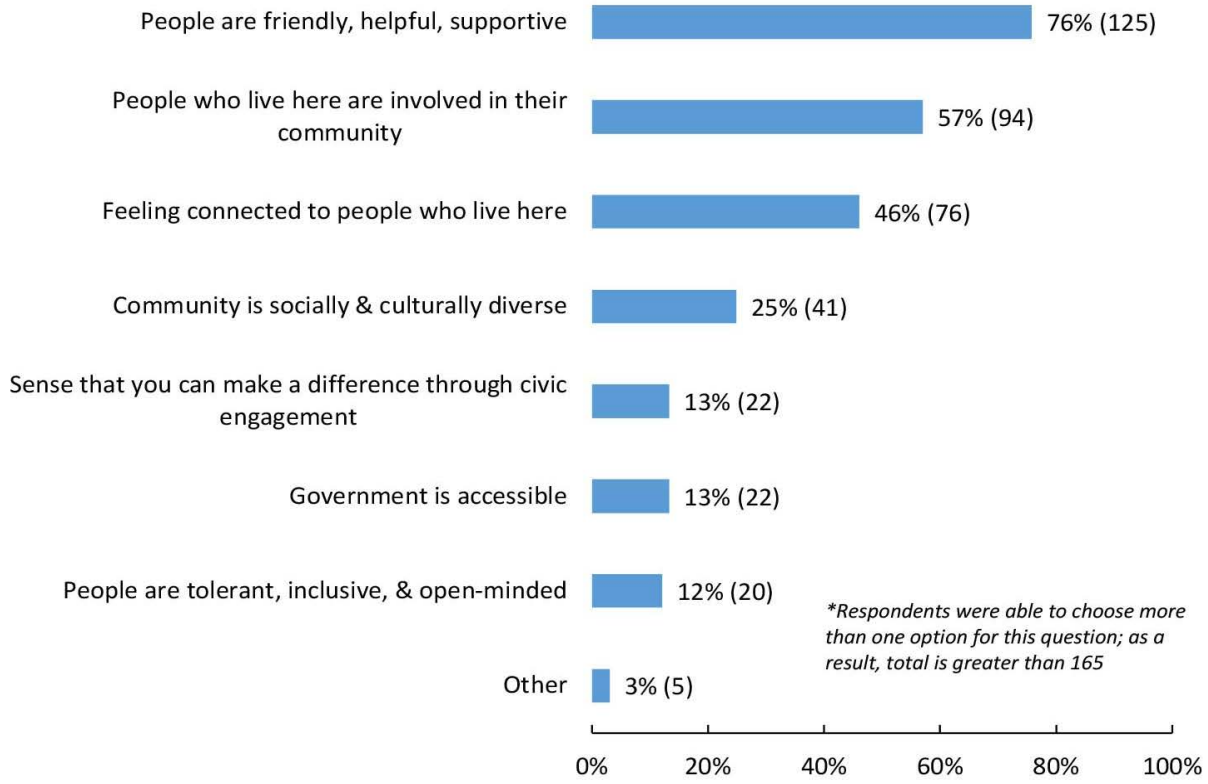
Community Assets and Challenges

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 100 respondents agreeing) that community assets include:

- People are friendly, helpful, supportive (N=125)
- Family-friendly (N=113)
- Closeness to work & activities (N=112)
- Recreational and sports activities (N=103)

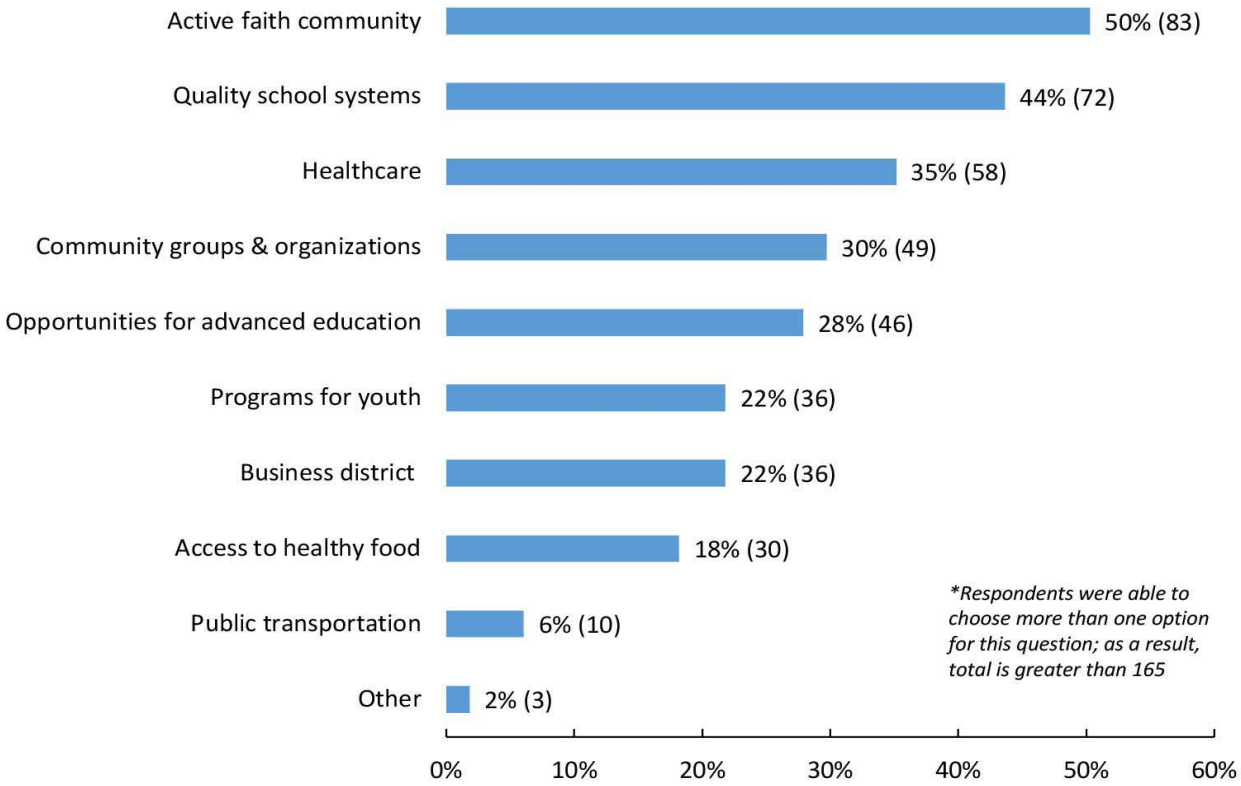
Figures 13 to 16 illustrate the results of these questions.

Figure 13: Best Things About the PEOPLE in Your Community
Total responses = 405



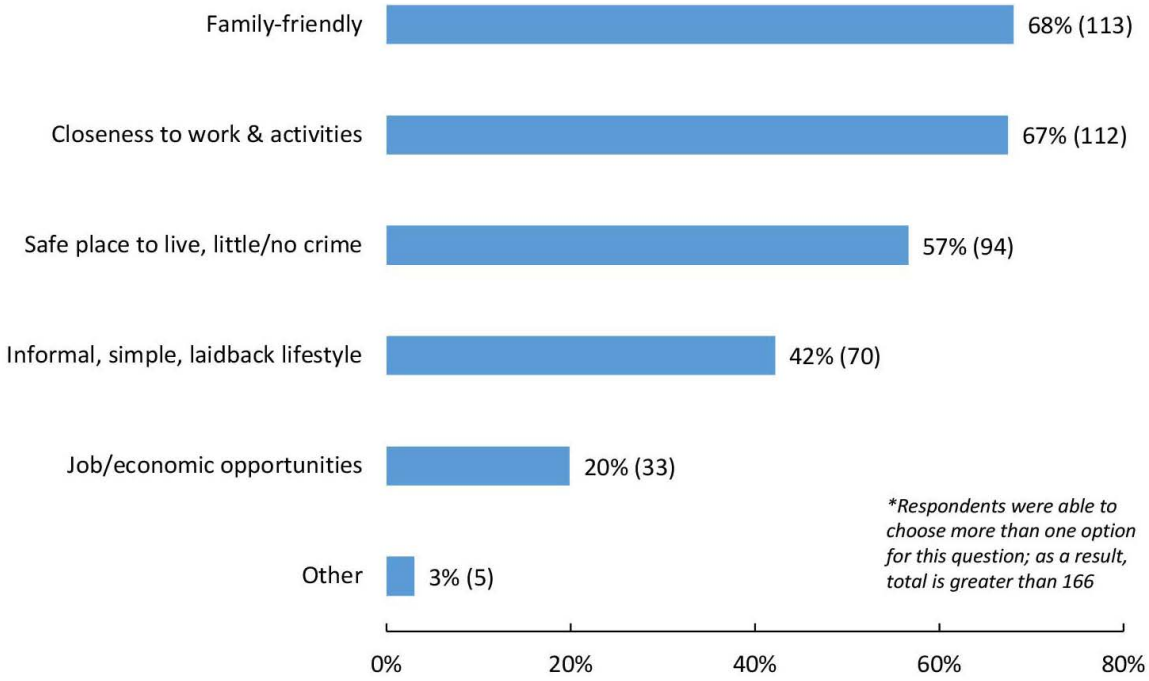
Included in the "Other" category of the best things about the people was that the community has the assets to become something much more family, patient-orientated, and the schools.

Figure 14: Best Things About the SERVICES AND RESOURCES in Your Community
Total responses = 423



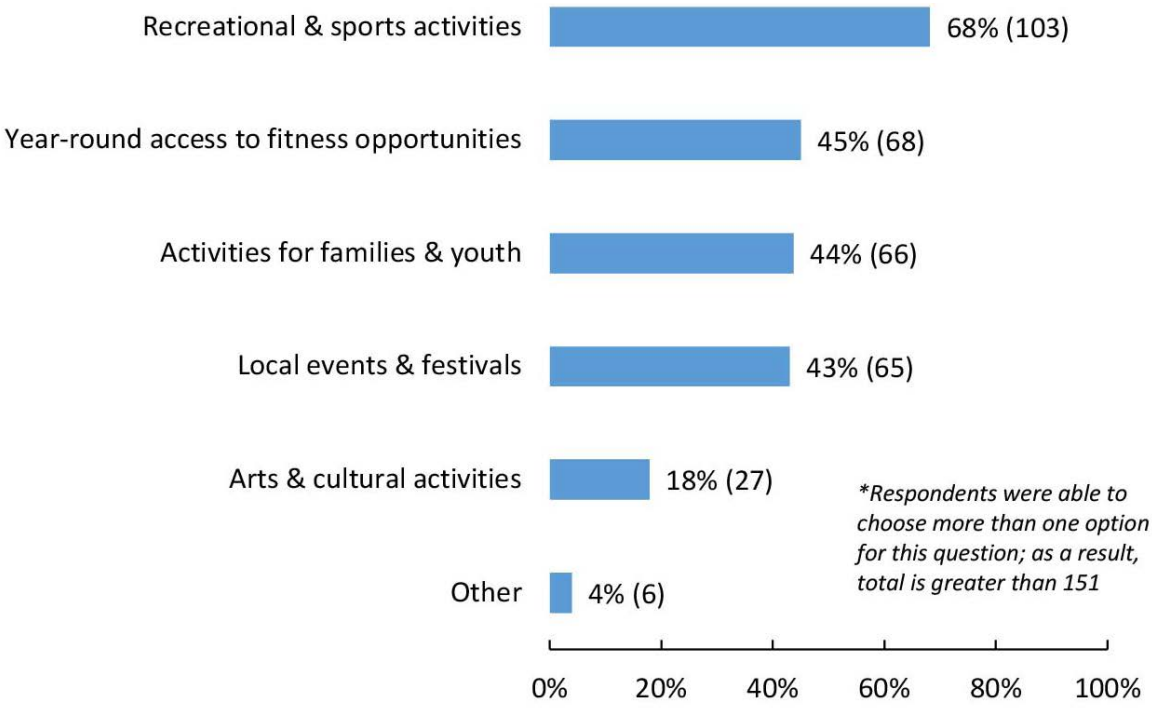
Respondents who selected "Other" specified that people mostly mind their own business.

Figure 15: Best Things About the QUALITY OF LIFE in Your Community
Total responses = 427



The "Other" responses, regarding the best things about the quality of life in the community, was the great park board opportunities, the medical services, and the sharing amongst the community.

Figure 16: Best Thing About the ACTIVITIES in Your Community
Total responses = 335



Respondents who selected "Other" specified that the best things about the activities in the community included the fishing and shooting sports availability.

Community Concerns

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

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

With regard to responses about community challenges, the most highly voiced concerns (those having at least 60 respondents) were:

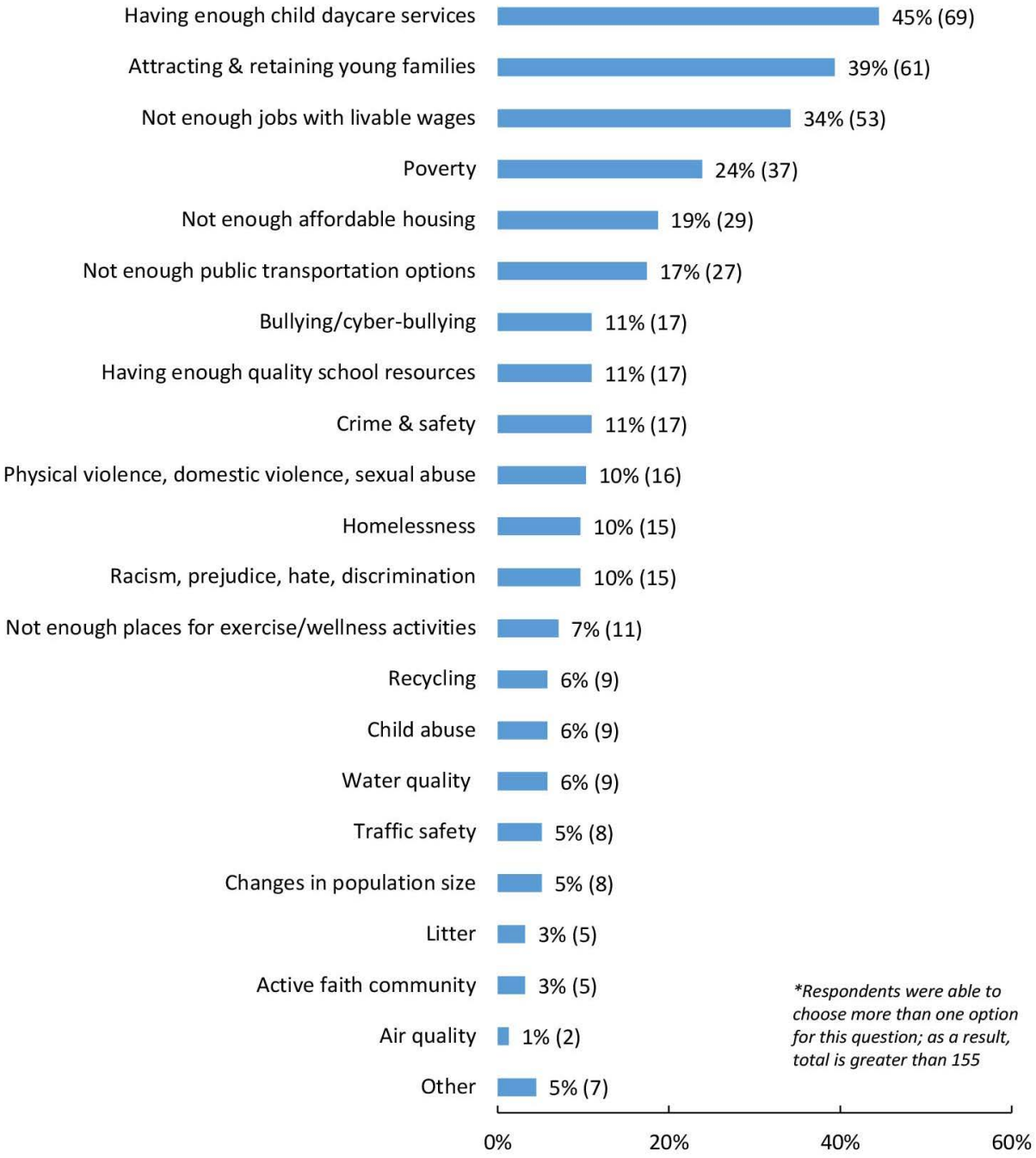
- Child abuse or neglect (N=94)
- Bully/cyberbulling (N=89)
- Drug use and abuse – Youth (N=89)
- Alcohol use and abuse – Adult (N=87)
- Alcohol use and abuse – Youth (N=84)
- Drug use and abuse – Adult (N=82)
- Cost of long-term/nursing home care (N=72)
- Having enough child daycare services (N= 69)
- Availability of resources to help the elderly stay in their homes (N=69)
- Depression/anxiety – Adult (N=64)
- Attracting and retaining young families (N=61)
- Suicide - Youth (N=60)

The other issues that had at least 40 votes included:

- Not enough jobs with livable wages (N=53)
- Ability to retain primary care providers (MD, DO, NP, PA, and nurses) in the community (N=45)
- Availability of specialists (N=41)
- Depression/anxiety – Youth (N=54)
- Not enough activities for children/youth (N=48)
- Domestic/intimate partner violence (N=50)

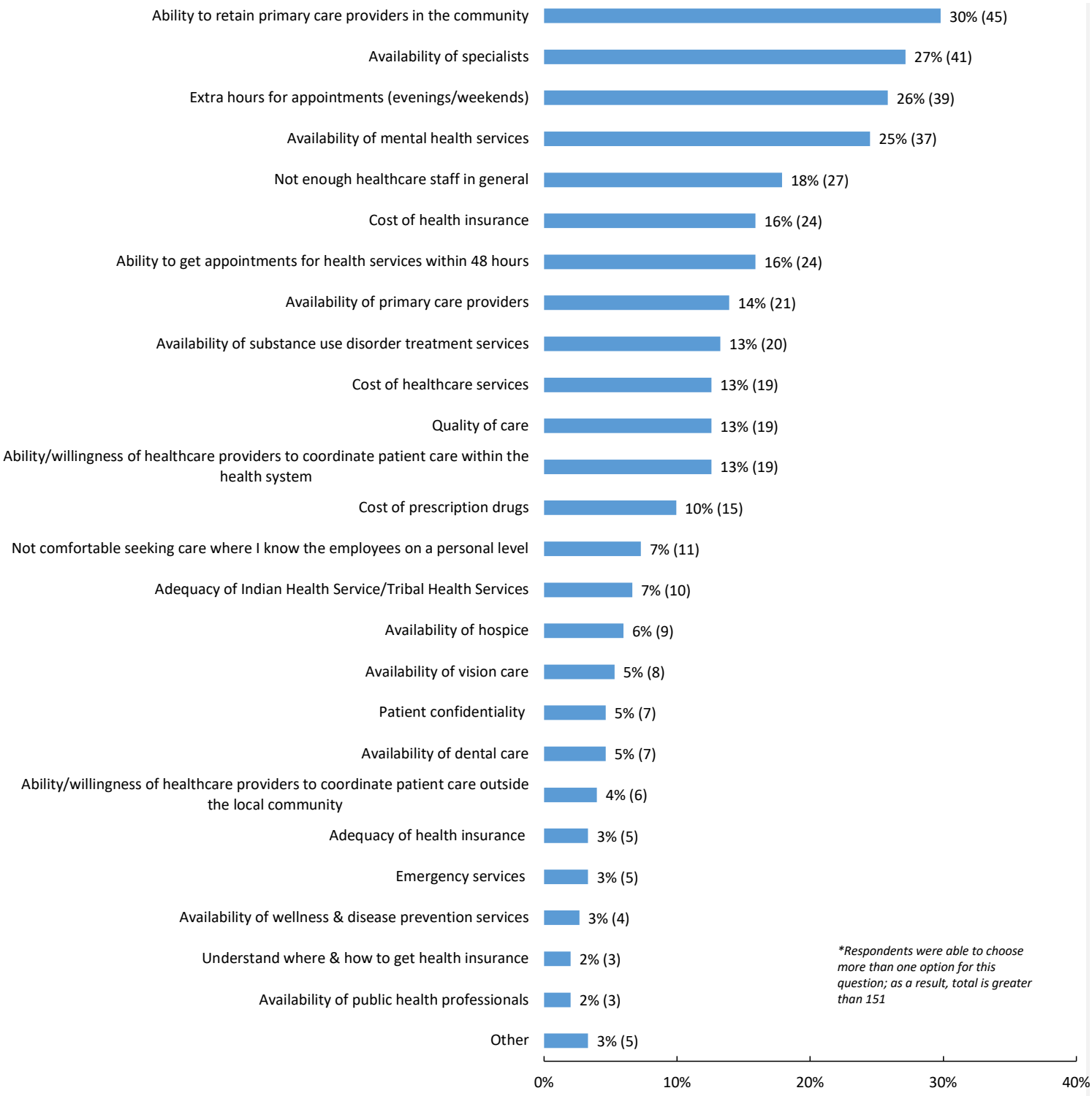
Figures 17 through 22 illustrate these results.

Figure 17: Community/Environmental Health Concerns
Total responses = 446



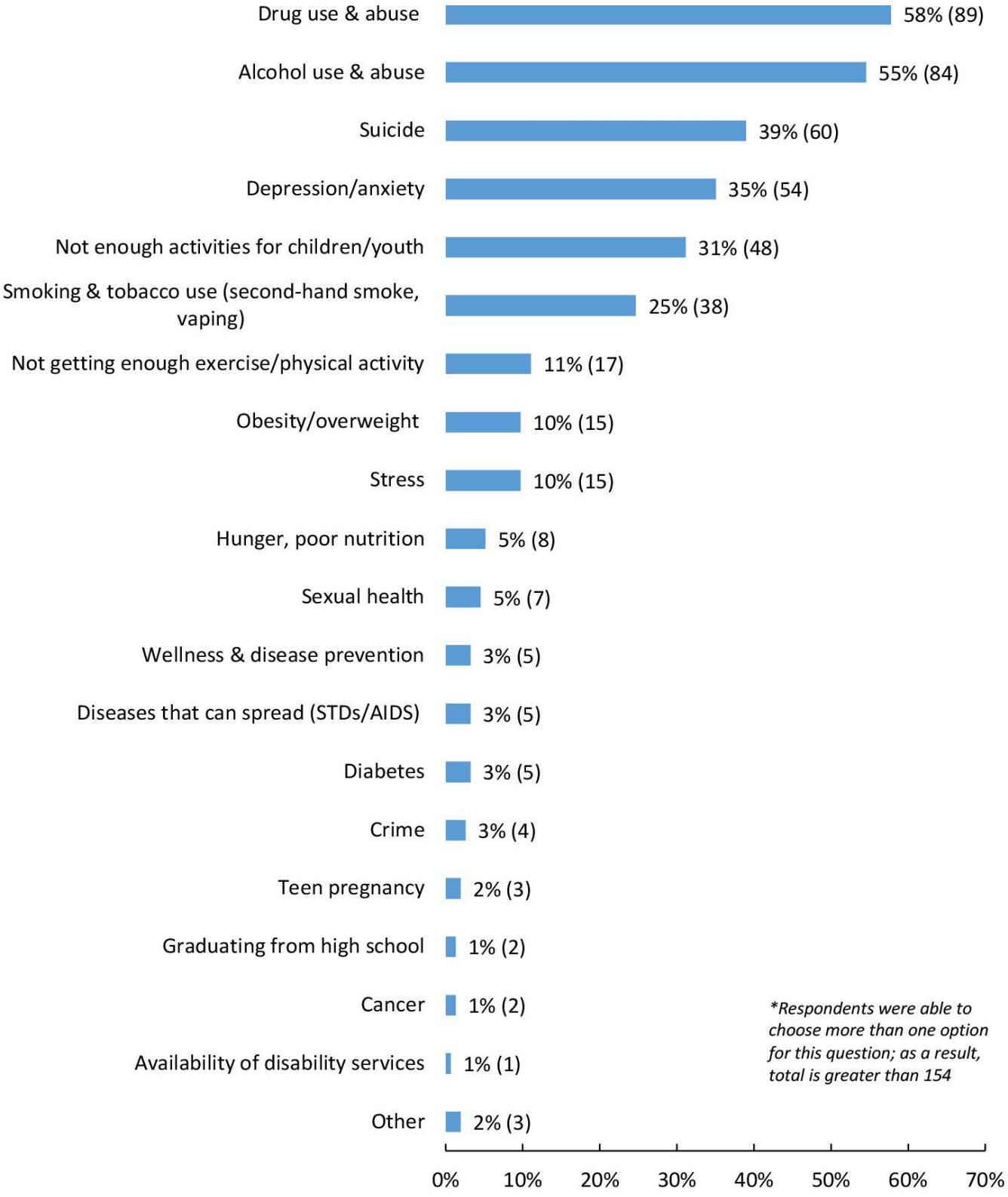
In the "Other" category for community and environmental health concerns, the following were listed: lack of daycare services, drug use, limited housing options as many houses on the market are very expensive, lack of mental health services, lack of a visual arts center, and not enough activities for the youth.

Figure 18: Availability/Delivery of Health Services Concerns
Total responses = 433



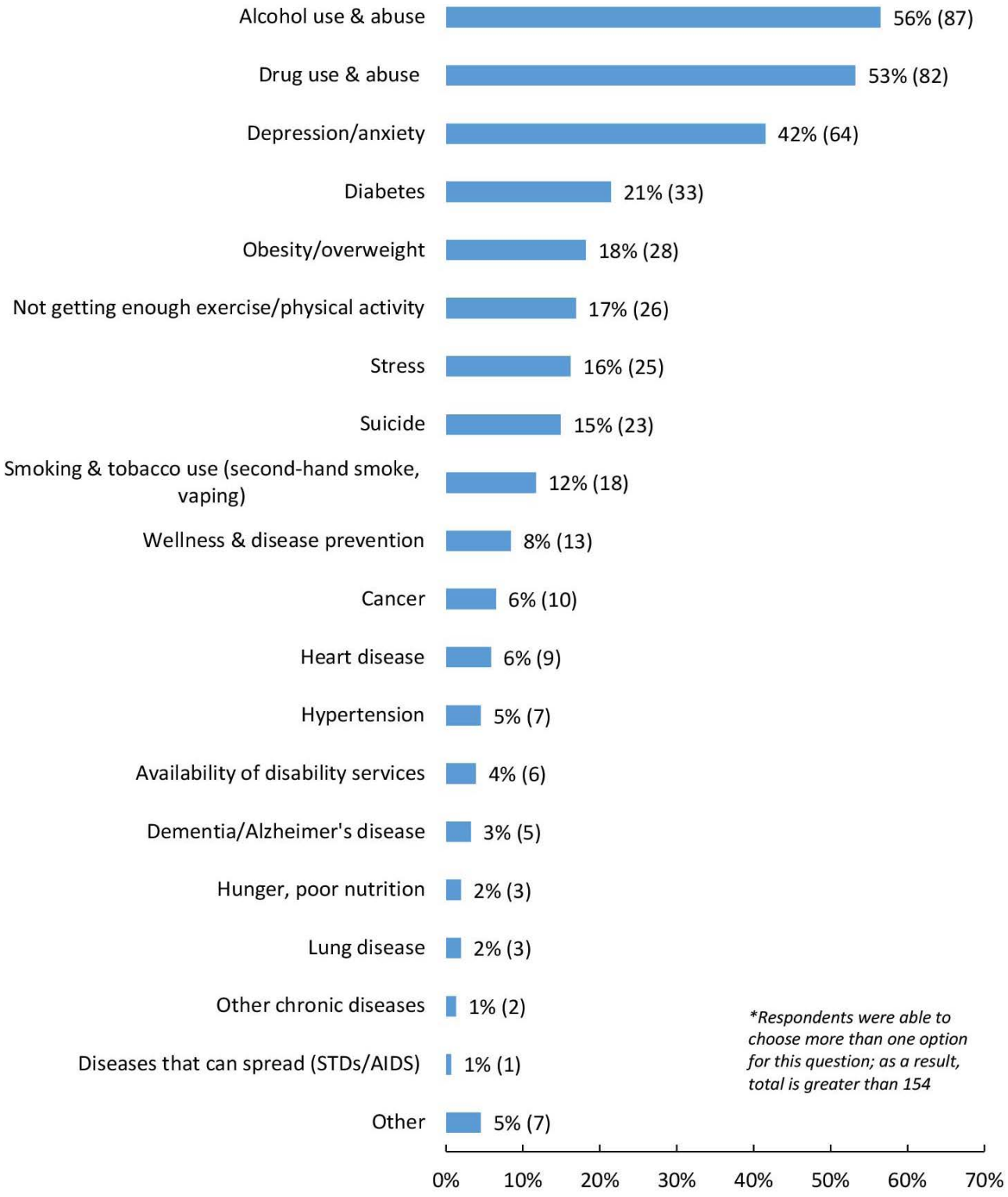
Respondents who selected "Other" identified concerns in needing a walk-in clinic, vision insurance not being accepted at the eye care entities, and lack of detox healthcare.

Figure 19: Youth Population Health Concerns
Total responses = 465



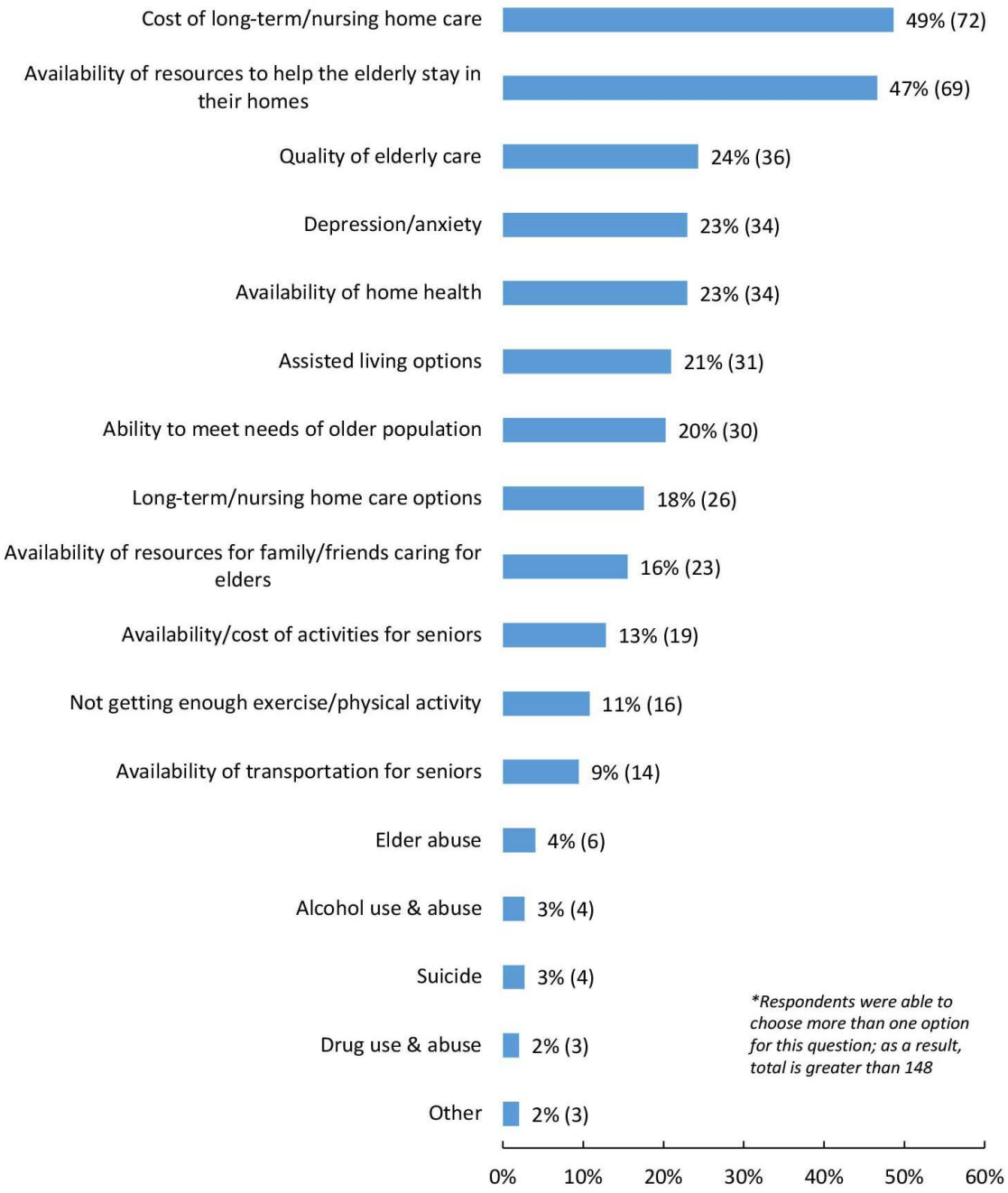
Listed in the "Other" category for youth population concerns were bulling in the school system and the lack of willingness to work.

Figure 20: Adult Population Concerns
Total responses = 452



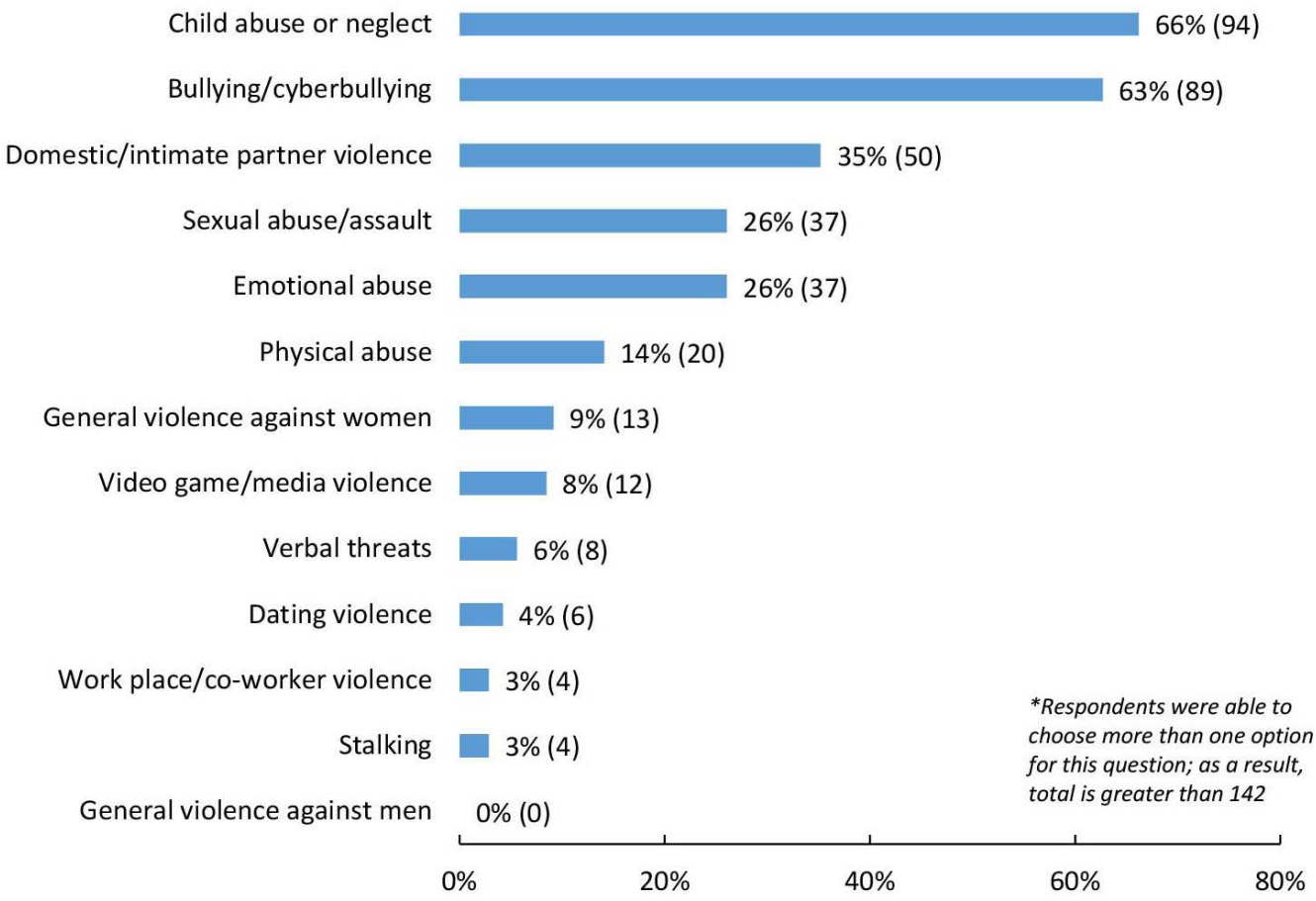
The lack of alcoholfree events, daycare, failure to take care of one's health, not being able to make a good wage to afford housing or insurance, poor decisions from social services when caring for mothers/babies on drugs, and lack of support for felons when entering back into the community were indicated in the "Other" category for adult population concerns.

Figure 21: Senior Population Concerns
Total responses = 424



In the "Other" category, the concerns listed were the cost of supplements being very expensive and the need for more quality assisted living areas that are attractive and inviting to others.

Figure 22: Violence Concerns
Total responses = 374



In an open-ended question, respondents were asked what single issue they feel is the biggest challenge facing their community. Two categories emerged above all others as the top concerns:

1. Drug/alcohol/substance use/abuse
2. Mental healthcare and providers

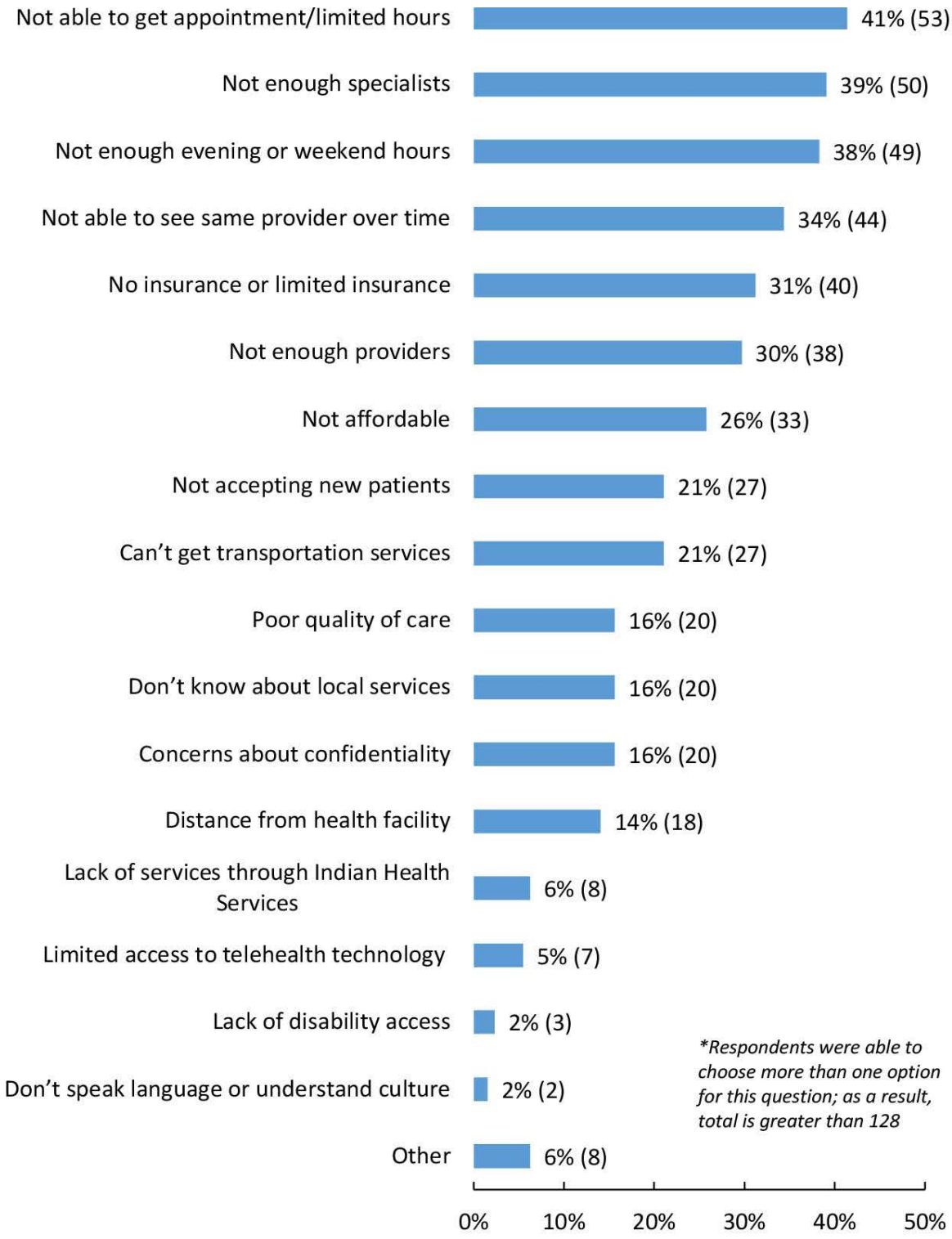
Other biggest challenges that were identified were not enough activities for kids and families, child abuse, affordable housing, aging population, adequate childcare and preschools, high poverty level, cost of health insurance/healthcare, and the healthcare entities (clinics/hospital) not working together.

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 able to get an appointment/limited hours (N=53), with the next highest being not enough specialists (N=50). After these two barriers, the next most commonly identified barriers were not enough evening or weekend hours (N=49), not being able to see the same provider over time (N=44), and no insurance or limited insurance (N=40). Concerns indicated in the "Other" category were the lack of mental health providers, not trusting management at the hospital, the emergency department not being adequate for seeing patients, and an issue with the emergency department needing help for those using it as a clinic because they couldn't get an appointment during the daytime or lack health insurance.

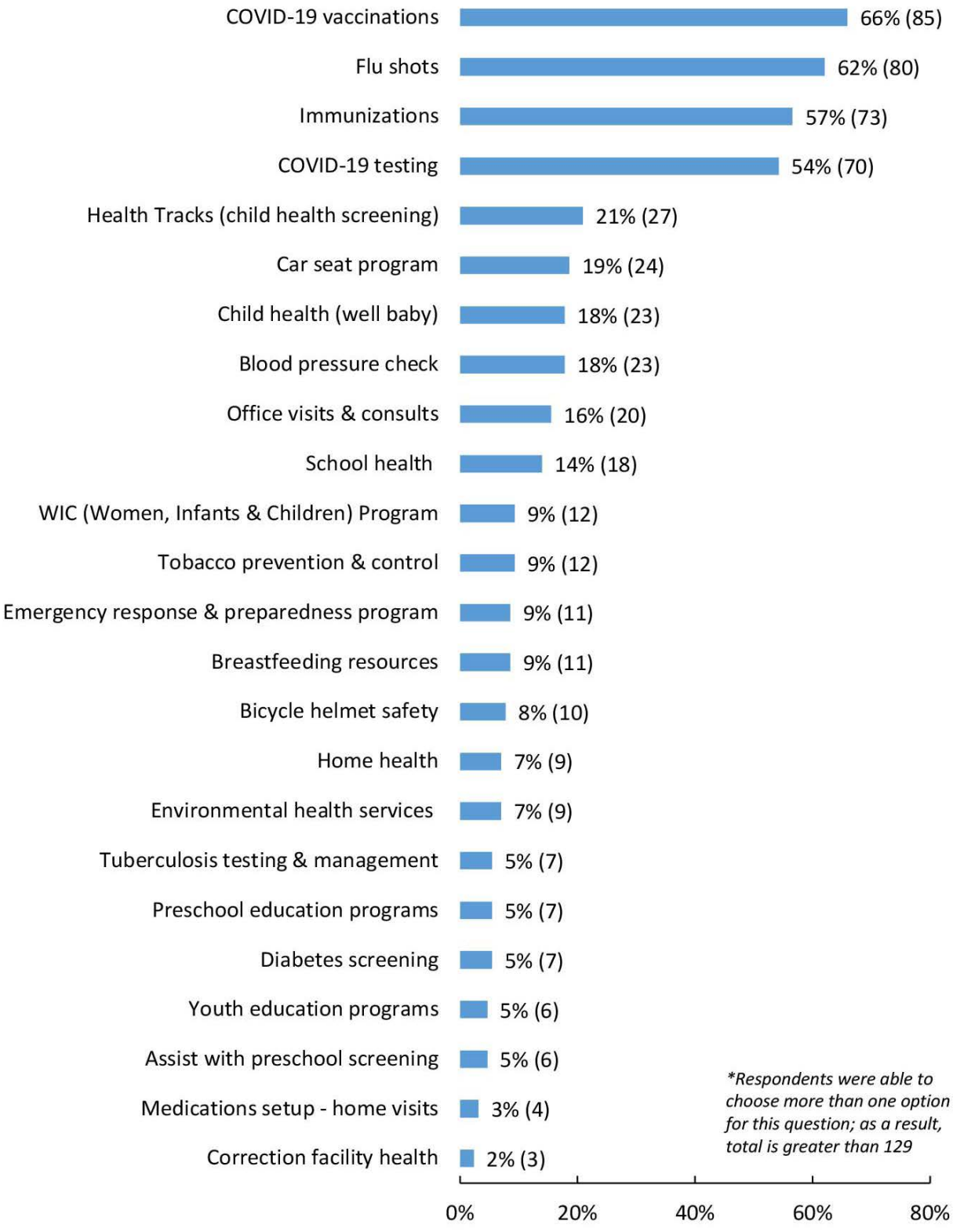
Figure 23 illustrates these results.

Figure 23: Perceptions about Barriers to Care
Total responses = 467



Considering a variety of healthcare services offered by Lake Region District Health Unit (LRDHU), respondents were asked to indicate if they were aware that the healthcare service is offered though LRDHU or what, if any, services they or a family member have used at LRDHU (see Figure 24).

Figure 24: Awareness and Utilization of Public Health Services
Total responses = 557

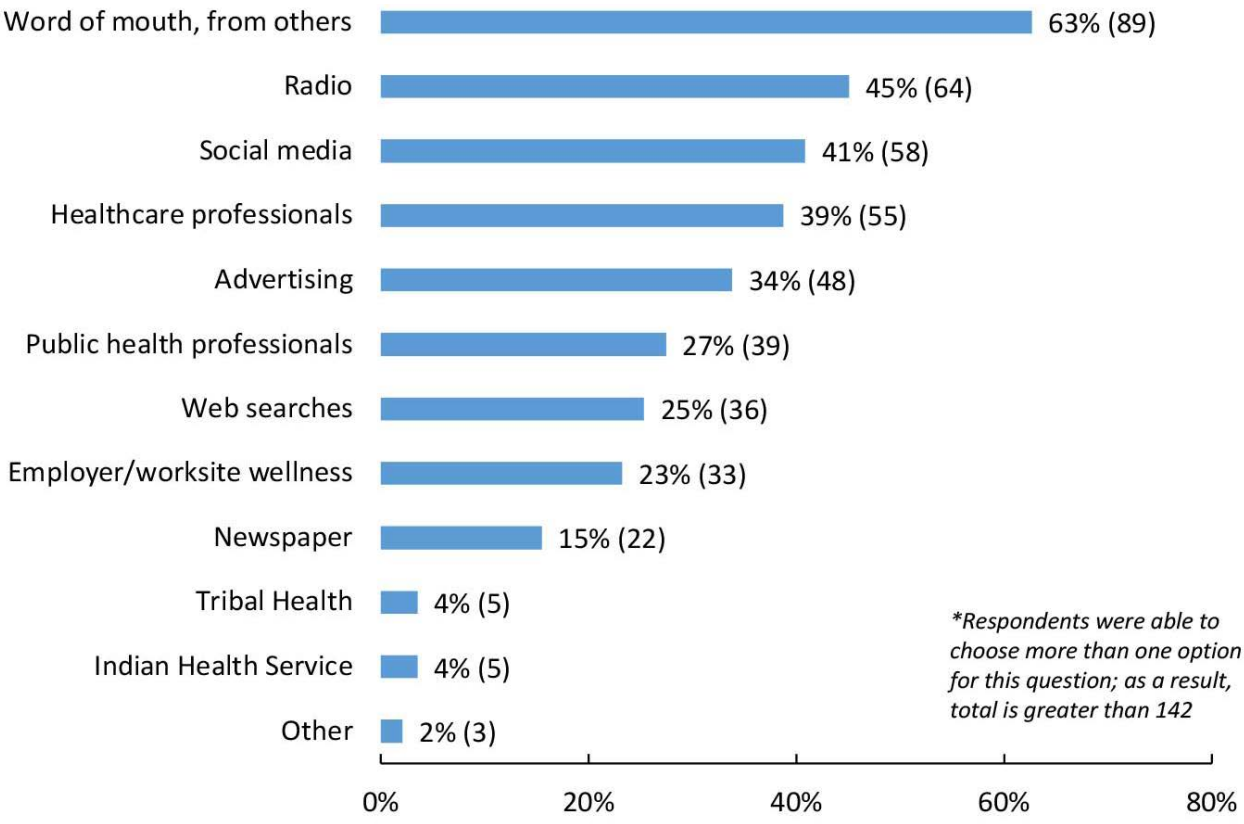


In an open-ended question, respondents were asked what specific healthcare services, if any, they think should be added locally. There were two services that stood out in the survey: specialty medicine and mental health services. Other requested services included:

- Addiction services
- Allergist
- Cancer treatment center
- Evening hours
- Diabetes education
- Increased mental health services
- Expanded dialysis facilities
- General surgery
- Hospice care
- More wellness prevention for youth
- Increased specialty medicine
- Nutrition/bariatric services
- Orthopedics
- Pediatrics
- Podiatry
- Neurosurgery
- Urgent care/walk-in clinics
- More childcare centers
- Vision clinics that take more insurance
- Wellness coaches

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. The services, where they felt the hospital should increase marketing efforts, included what surgical services can be done, cancer infusion services, MRI, and general awareness that the patient has a right to ask if services are available locally to avoid traveling to Grand Forks.

Figure 25: Where do you find out about local health services? Total responses = 457



In the "Other" category, respondents listed they also find out about local health services through their insurance.

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

Figure 26: Awareness/Use of Other Local Healthcare Services
Total responses = 545

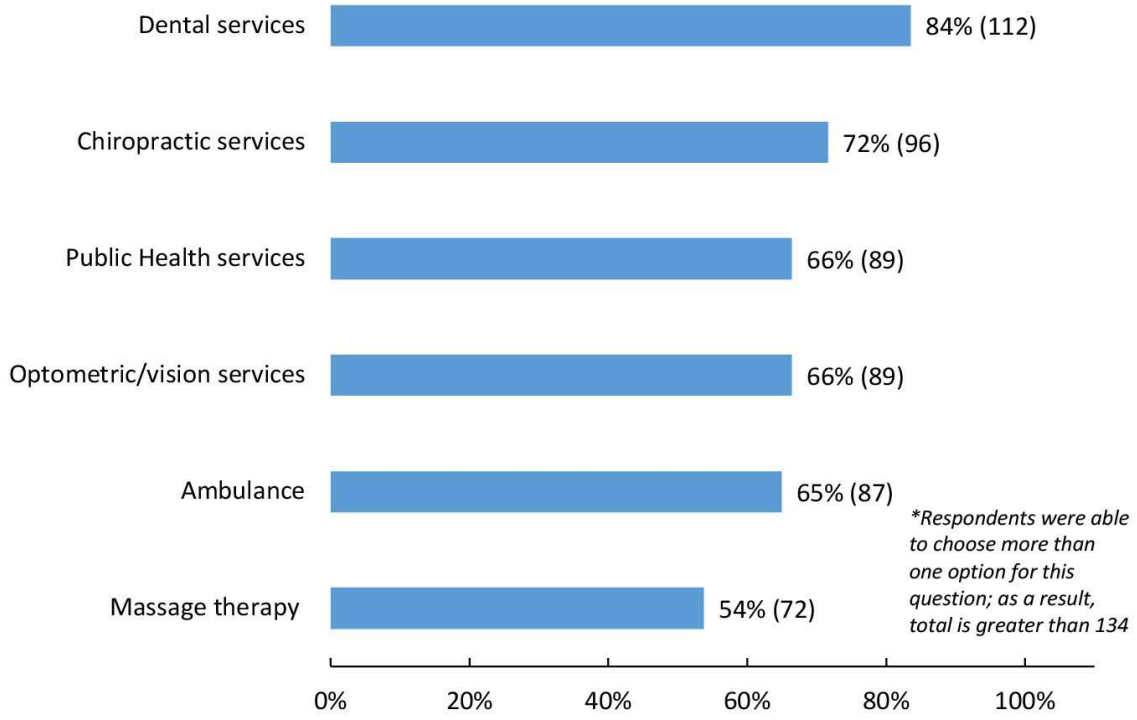


Figure 27: Awareness/Use of Screening/Therapy Services at CHI St. Alexius Health Devils Lake Hospital
Total responses = 377

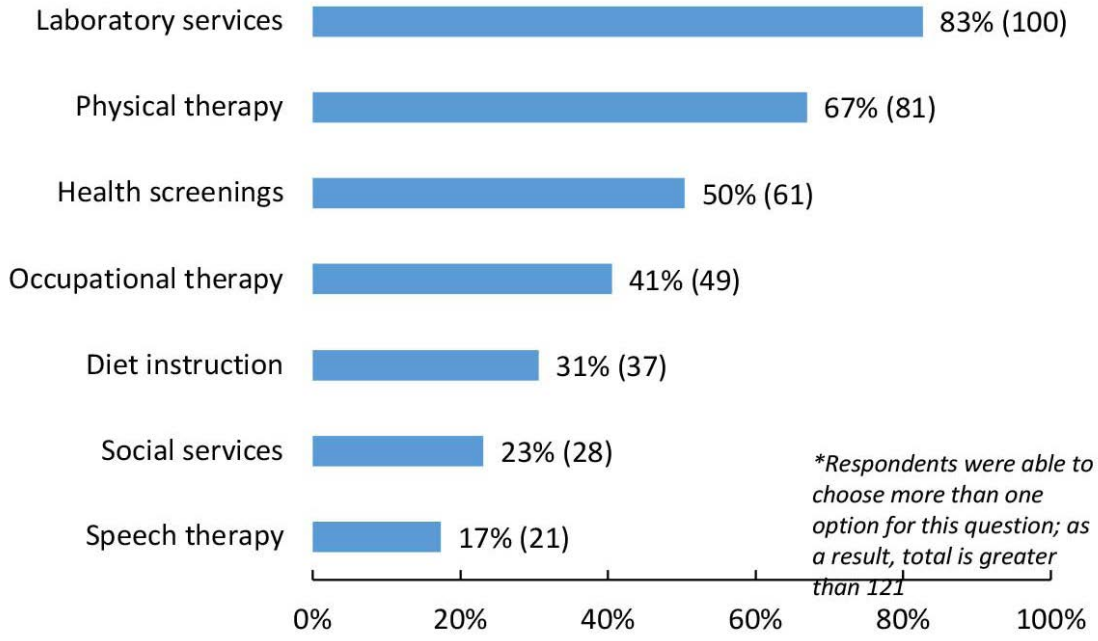


Figure 28: Use of CHI St. Alexius Health Devils Lake Clinic
Total responses = 130

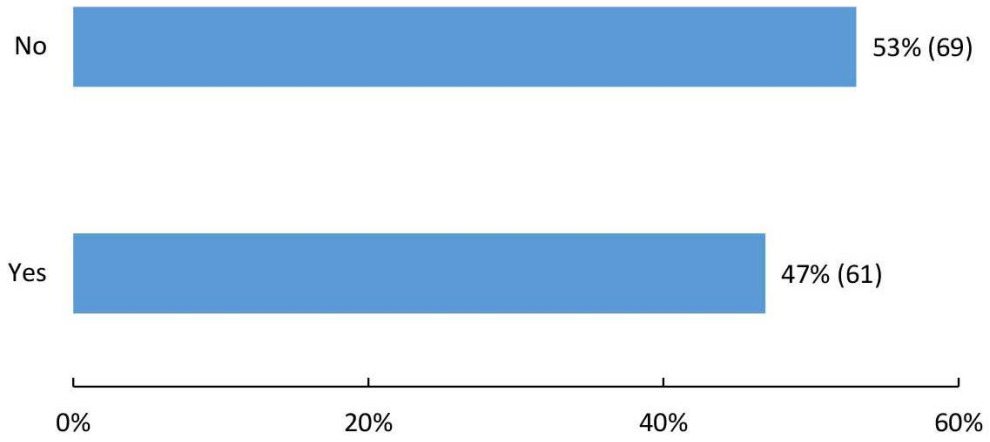


Figure 29: Why CHI St. Alexius Health Devils Lake Clinic is not used
Total responses = 57

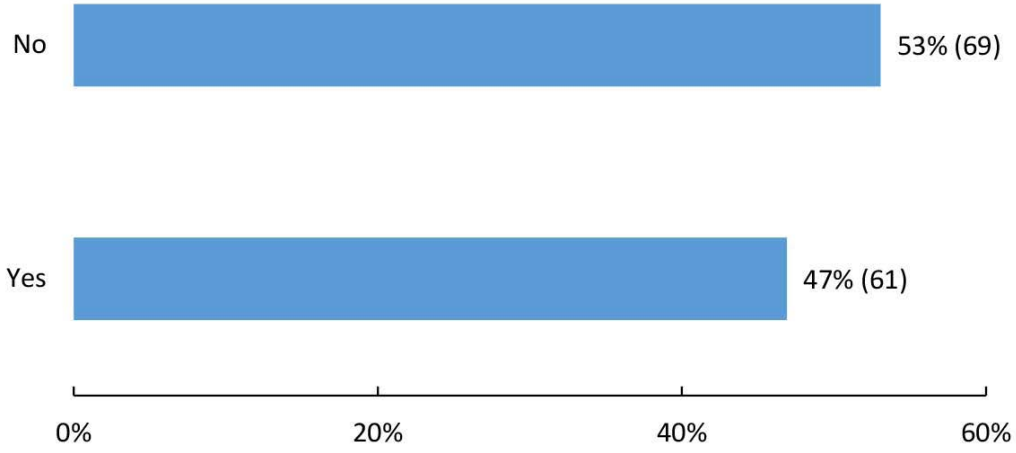


Figure 30: Best Option for Additional Clinic Hours
Total responses = 125

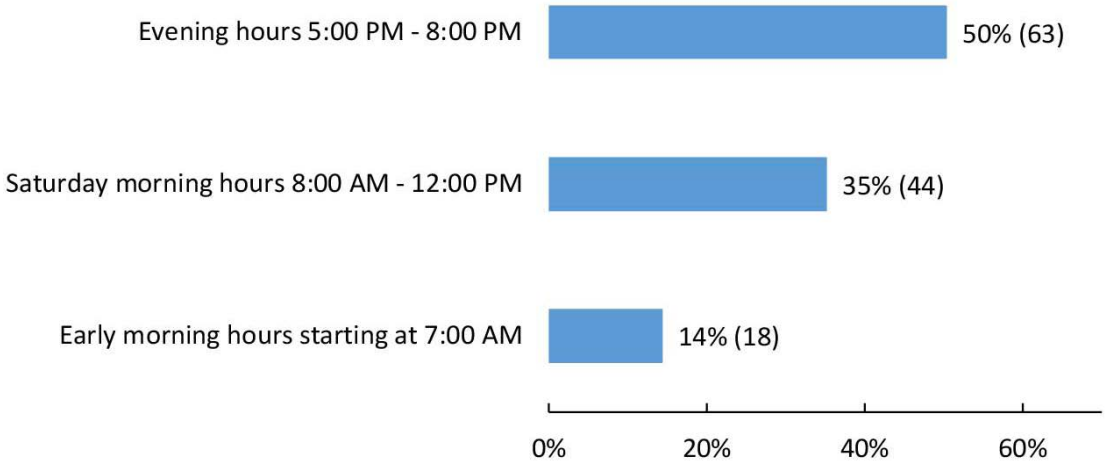
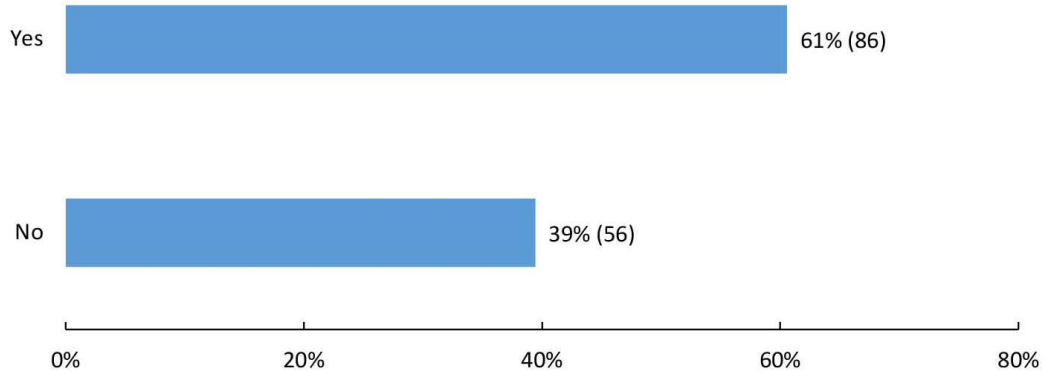
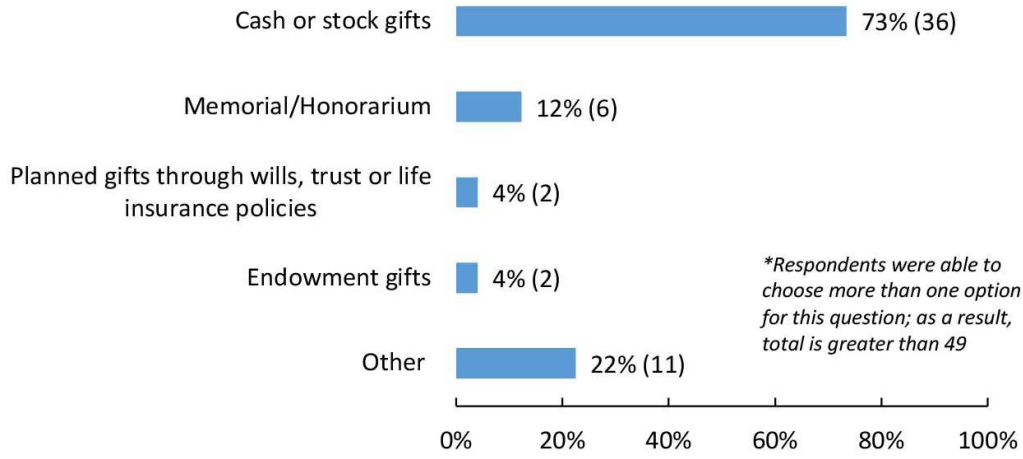


Figure 31: Awareness of CHI St. Alexius Health Devils Lake Hospital's Foundation
Total responses = 141



In an effort to gauge ways that community members have financially supported the CHI St. Alexius Health Devils Lake Hospital Foundation, a question was included, asking them to select ways they have supported the CHI St. Alexius Health Devils Lake Hospital Foundation (see Figure 32). Recommendations in the "Other" category included attending Foundation events, fundraisers, raffle tickets, and non-support of the foundation.

Figure 32: Ways to Financially Support the CHI St. Alexius Health Devils Lake Foundation
Total responses = 57



Respondents were asked additional questions, regarding whether they have received a COVID-19 vaccine and if they have not, what the reason was. The majority of respondents indicated they have received the vaccine (N=118) with 15% (N=21) indicating they have not (Figure 33).

Figure 33: Received a COVID-19 Vaccine
Total responses = 139

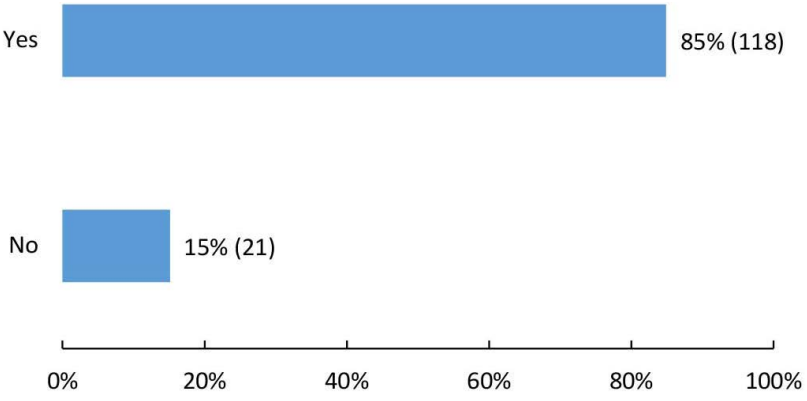
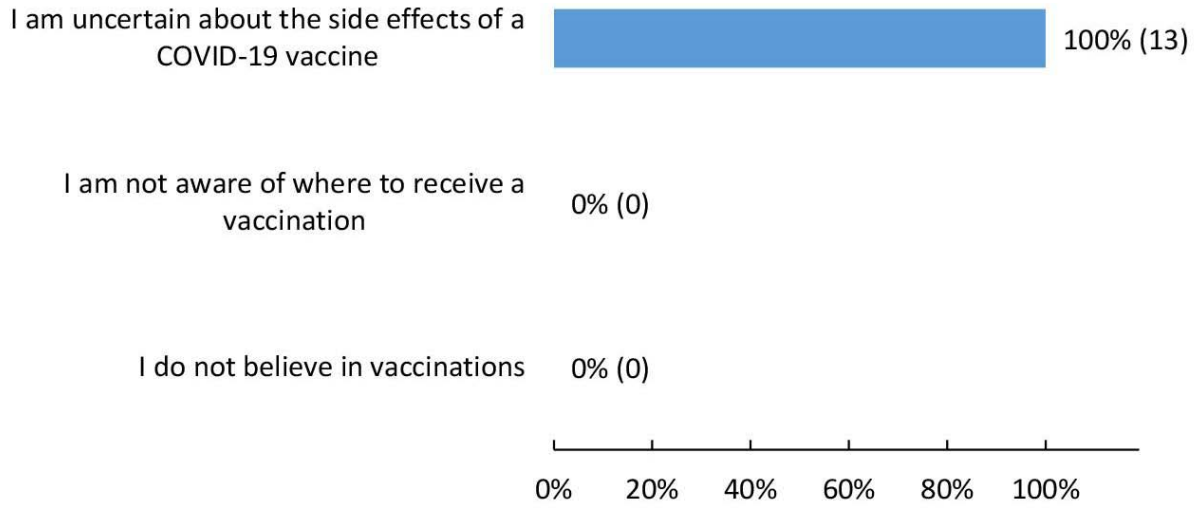


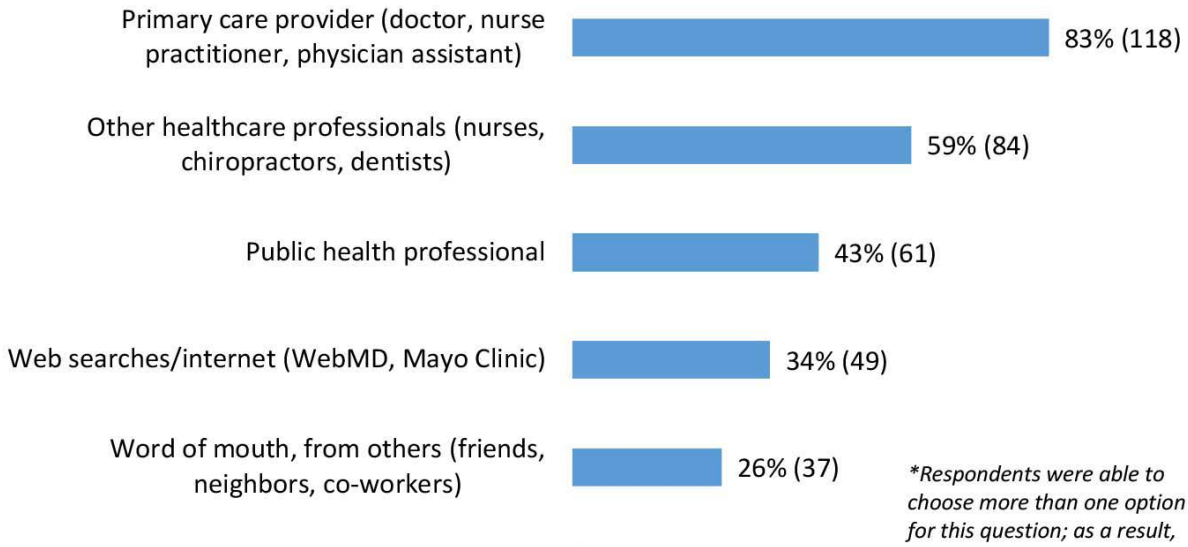
Figure 34: Why a COVID-19 vaccine was not received
Total responses = 13



Respondents were asked where they go to for trusted health information. Primary care providers (N=118) received the highest response rate, followed by other healthcare professionals (N=84), and third public health professionals (N=61).

Results are shown in Figure 35.

Figure 35: Sources of Trusted Health Information
Total responses = 351



In the "Other" category, the Grand Forks Clinic was listed as a source of trusted information.

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 of the hospital and clinic not working together to provide high quality of care and the need for more mental healthcare services.

There were many comments, regarding the need for the hospital and clinic to work together to increase the quality of healthcare and also minimize the number of patients being transferred to Grand Forks. Several respondents commented about the number of patients who were sent to Grand Forks for care or procedures. It was suggested that the hospital and Altru clinic should be run by one entity. Needing and retaining qualified providers, to include physicians and nurses, at all healthcare entities was expressed.

There is a lack of trust and confidence in the current CHI St. Alexius Health Devils Lake Hospital administration. They feel the employees at the facility need to be treated better. It was mentioned that the billing at the hospital is very bad; the front desk workers are rude on the telephone, and receiving test results back from the clinic or emergency room is terrible.

Many respondents expressed the need for a walk-in clinic or an urgent care clinic with longer or more flexible hours, so those persons who work can be seen. Some would like to see improved access for dental and eye care for lower income community members, and the need for better vision insurance coverage was requested, so they don't have to take their family out of town for appointments. Another issue identified by several respondents was the lack of transportation for those who need to get to their medical appointments. One person would like to see Altru providing transportation to Grand Forks to the patients who are referred to see a doctor who does not come to Devils Lake.

The lack of mental health and addiction treatment services in the community for all ages was expressed by many respondents. Many indicated that there are limited professionals or appointments, and only a "band aid" is being applied instead of addressing the actual problem.

There are concerns that the emergency department is being overused for urgent care visits, which could be helped if there were extended hours at the clinics in town. A need was also expressed to have some hospital security.

Others are happy with the healthcare in Devils Lake, and that the public health employees are amazing.

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):

- Ability to retain primary care providers (MD, DO, NP, PA) and nurses
- Attracting and retaining young families
- Availability of mental health services
- Availability of resources to help the elderly stay in their homes
- Cost of health insurance

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

Attracting and retaining young families

- This issue goes along with the lack of affordable jobs in the area.
- The lack of jobs doesn't make it possible to bring people to the community.

Ability to retain primary care providers (MD, DO, NP, PA) and nurses in the community

- We are not able to attract and retain providers.
- Providers need to work together and communicate with each other about the needs of their patients.
- Altru and CHI not working together, such as Altru holding a needs assessment meeting on the same day as the CHNA meeting. This overlapping meeting would have been a good opportunity to work together. There is too much competition.
- CHI uses Meditech, and other healthcare uses EPIC, which makes it harder to transfer patient data. Would like to see one integrated system.

Availability of resources to help the elderly stay in their homes

- It is hard to find people to help keep them in their homes. Not many options are available, and it forces them to go into a nursing home when they may not need to yet.

Cost of health insurance

- Healthcare costs make it too expensive that community members won't go get help when needed, so their health deteriorates.
- This cost will always be a problem. Some people are stuck or unhappy with their job but are too afraid to leave due to the lack on health insurance.

Availability of mental health services

- This need is for all ages. There is a shortage in our area, and many people are having to drive to see someone.
- There is a lot of unaddressed stress with young people, especially after COVID-19. We are seeing way too many suicides of young and young adults in the last year.

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 question was not intended to rank services provided. They were presented with a list of 13 organizations or community segments to score. According to these participants, the hospital, pharmacy, public health, and other long-term care (including nursing homes/assisted living) are the most engaged in the community. The averages of these scores (with 5 being "excellent" engagement or collaboration) were:

- Emergency services, including ambulance and fire (4.25)
- Business and industry (4.0)
- Schools (4.0)
- Public health (3.75)
- Economic development organizations (3.5)
- Faith-based (3.5)
- Hospital (healthcare system) (3.5)
- Law enforcement (3.25)
- Human/social Services (2.75)
- Long-term care, including nursing homes and assisted living (2.75)
- Other local health providers, such as dentists and chiropractors (2.75)
- Pharmacy (2.75)
- Clinics not affiliated with CHI (2.5)
- Tribal health/Indian Health Service (2.25)

Priority of Health Needs

A community group met on September 15, 2021, and 10 community members attended the meeting. Representatives from the CRH presented the group with a summary of this report's findings, including background and explanation about the secondary data, highlights from the survey results (including perceived community assets and concerns, and barriers to care), and findings from the key informant interviews.

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

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

- Having enough child daycare services (9 votes)
- Ability to retain primary care providers & nurses (6 votes)
- Availability of mental health and substance use disorder treatment services (4 votes)
- Suicide (3 votes)
- Drug use and abuse (including prescription drugs) (all ages) (3 votes)
- Smoking/tobacco use/vaping/second-hand smoke (3 votes)

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

1. Having enough child daycare services (4 votes)
2. Suicide (3 votes)
3. Availability of mental health and substance use disorder treatment services (2 votes)
4. Drug use and abuse (including prescription drugs) (all ages) (1 vote)

Following the prioritization process during the second meeting of the community group and key informants, the number one identified need was having enough child daycare services. A summary of this prioritization may be found in Appendix F.

Comparison of Needs Identified Previously

The current process identified two identical common needs from 2019, which was having enough child daycare services and availability of mental health services.

Top Needs Identified 2019 CHNA Process	Top Needs Identified 2021 CHNA Process
Substance use and abuse - all ages	Having enough child daycare services
Extra hours for appointments, such as evenings and weekends	Suicide
Availability of mental health services	Availability of mental health and substance use disorder treatment services
Having enough child daycare services	Drug use and abuse for all ages (including prescription drugs)

CHI St. Alexius Devils Lake 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 Devils Lake 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 web site, 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 Devils Lake Mission Director at 1031 7th Street Northeast, Devils Lake, North Dakota 58301.

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: Substance abuse and use all ages focus on teen vaping and marijuana abuse:
LRDHU, along with BreatheND, adopted the North Dakota My Life My Quit campaign that was implemented in the schools and the community. The Tobacco and Substance Abuse Prevention Coordinator served on a state-wide Youth Action Workgroup that worked on a new curriculum to be used in the schools.

LRDHU's Tobacco and Substance Abuse Coordinator and the two Devils Lake City Police Departments' School Resource Officers (SRO) developed a substance abuse prevention team. They also worked closely with the Students Against Destructive Decisions (SADD) group from the high school on the prevention team. If students were caught with vaping or other tobacco products in school, they were reported to the SRO and to the Tobacco and Substance Abuse Coordinator, who is a certified Tobacco Treatment Specialist, for punishment and treatment that increased per offense.

LRDHU's Tobacco and Substance Abuse Coordinator conducted a variety of educational outreach sessions throughout the past two years. They did assembly presentations, worked with the SADD group, and promoted Drug Abuse Resistance Education (DARE) and Red Ribbon weeks at the schools, had a booth at vendor shows and worked at large events in the community providing educational materials, and spoke at numerous community clubs' meetings on the dangers with vaping and marijuana.

Need 2: Expand hours for appointments focus on primary care, mental health, and outpatient dialysis appointments:
Altru Health System expanded their walk-in clinic hours to accommodate this community need, starting in September of 2019. The extended hours ran from Monday through Friday, 5:00 pm to 7:00 pm, with an additional four hours on Saturday morning from 8am to 12pm. Unfortunately, the extended services stopped due to the lack of staff to cover the hours. There has been no plan to reinstate the extended hours. CHI St. Alexius Health Devils Lake acquired a primary care clinic in September 2018. The clinic is still owned and operated by CHI. Spirit Lake Nation Tribal Clinic hired a psychiatrist in June of 2019 to focus on mental health for the Nation. While there has been talk between Altru Health Systems and CHI St. Alexius Health in expanding the dialysis, nothing has been done and there are no immediate plans for said expansion.

Need 3: Shortage of low-density medical specialties surgical and sonography technicians:
CHI St. Alexius Health Devils Lake Hospital and Altru Health Systems signed an as needed availability ultrasound call agreement in September of 2018. The agreement is still in place. The recruitment process is ongoing, and there has not been anything done to accommodate the need except the normal recruitment strategies.

Need 4: Expansion and renovation of hospital emergency department:
CHI St. Alexius Health Devils Lake Hospital took lead on this need. The local executive team expressed the need for renovation of the emergency department to the national executive team, which was CHI at the time. The national executive team granted the project of expanding and renovating the emergency department, starting the fiscal year of 2021. However, due to the 2020 COVID-19 pandemic, the project was put on hold. Local and national executive teams have budgeted for the expansion and renovation of the emergency department, starting in the fiscal year of 2022. No groundbreaking work has been done as of this writing, however.

Our team selected substance use and abuse as our primary significant health need to be addressed. We combined extra hours for appointments and availability of mental health services into a second significant health need. A third need identified outside of the CHNA process was the shortage low density medical specialties, in particular, surgical and sonography technicians. The shortage of child care services will not be addressed in this implementation plan. It is being addressed by other agencies in the community.

The above implementation plan for CHI St. Alexius Health Devils Lake Hospital is posted on the 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, the CRH strongly encourages a review of the most recent Community Benefit Report to determine how/if it aligns with the needs identified, through the CHNA, as well as the Implementation Plan.

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

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

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

What Are Community Benefits?

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

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

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

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

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

Appendix A – Critical Access Hospital Profile

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

Quick Facts

Administrator:
Mariann Doeling, Interim

Chief of Medical Staff:
Candelaria Martin-Arndt, M.D.

Board Chair: Mike Lefor

City Population:
7,320 (2019 estimate)[1]

County Population:
11,519 (2019 estimate)[1]

County Median Household Income:
$58,910 (2019 estimate)[1]

County Median Age:
40.7 (2019 estimate)[1]

Service Area Population:
18,443 (Ramsey and Benson County)

Owned by: CommonSpirit Health – Nonprofit

Hospital Beds: 25

Trauma Level: V

Critical Access Hospital Designation: 2007

Economic Impact on the Community[2]

Jobs:
Primary – 106
Secondary – 64
Total – 170

Financial Impact:
Primary – $10 Million
Secondary – $3.68 Million
Total – $13.68 Million

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

Core Values
Compassion, Inclusion, Integrity, Excellence, Collaboration

County: Ramsey
Address: 1031 Seventh Street NE
Devils Lake, ND 58301-2798
Phone: 701.662.2131
Fax: 701.662-9651
Web: www.CHIStAlexiusHealth.org

With state of the art technology and professional, caring staff, CHI St. Alexius Health Devils Lake Hospital provides "Quality Care, Close to Home" to serve the needs of the Lake Region Community.

CHI St. Alexius Health Devils Lake Hospital is an acute care, 25-bed hospital accredited by The Joint Commission. We are a 3 time recipient of the Top 100 Critical Access Hospital Award (2016, 2018, and 2020). We are sponsored by CommonSpirit Health, and are members of the following organizations: Catholic Health Association, American Hospital Association, and the North Dakota Hospital Association. We are an Equal Opportunity Employer.

Services
CHI St. Alexius Health Devils Lake Hospital provides the following services:

- **Surgical**
  - Ophthalmology
  - Obstetrics
  - Endoscopy
- **Radiology**
  - Fluoroscopy,
  - Magnetic Resonance
  - Imaging (MRI)
  - Computed Tomography
  - Imaging (CAT)
  - Sonography (Cardiac, OB,Vascular)
  - Nuclear Medicine
  - Imaging Mammography
- Emergency Services
- Outpatient clinic
- Outpatient dialysis (operated by Altru Health System)
- Cancer Infusion Center (operated by Cancer Center of North Dakota)
- Physical therapy
- Occupational therapy
- Speech therapy
- Cardiac rehabilitation
- Respiratory therapy
- Laboratory services
- Obstetrics units
- Medical/surgical unit
- Swingbed unit

Staffing

Physicians: 9
Nurse Anesthetists: 2
PAs: 3
NPs 4
RNs: 52
LPNs: 7
Ancillary Personnel: 61
Total Employees: 138

Local Sponsors and Grant Funding Sources

- Center for Rural Health-SHIP Grant (Small Hospital Improvement Program)-Flex Grant (Medicare Rural Hospital Flexibility Grant Program)
- Helmsley Charitable Trust
- Health Resources & Services Administration (HRSA) Grant

Sources

[1] US Census Bureau: American Fact-finder; Community Facts

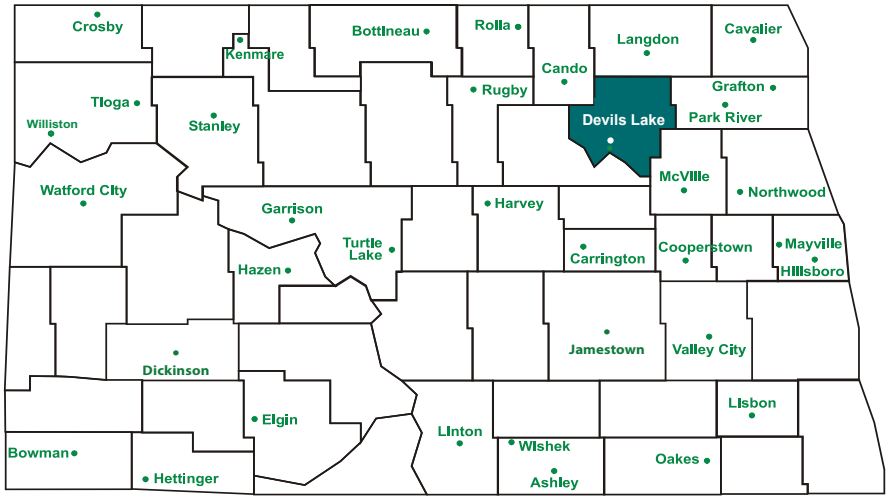
[2] Economic Impact 2020
Center for Rural Health
Oklahoma State University
and Center for Rural Health
University of North Dakota

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

This project is supported by the Medicare Rural Hospital Flexibility Grant Program and the State Office 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

North Dakota Critical Access Hospitals



History

The Sisters of Mercy arrived in North Dakota in 1884 from Omaha, Nebraska with the goal of starting a school for indigenous children in Belcourt. In 1895, Rev. Vincent Wehrle, O.S.B., asked the Sisters to come to Devils Lake to start a hospital. The first hospital was called St. Vincent DePaul Hospital. It was soon known that the facility was too small to meet the needs of the community and 80 acres of land was purchased on the edge of town. The cornerstone for Mercy Hospital was laid in June 1906. Mercy Hospital has been on this land since that time. In April of 2016, CHI Mercy Hospital of Devils Lake joined other CHI facilities in Carrington, Dickinson, Williston, Bismarck, Turtle Lake and Garrison to form CHI St. Alexius Health, the region's largest health care system.

Economy, Education and Recreation

Devils Lake is a vibrant community with a diverse economic base. Major industries include: manufacturing, retail, banking, education, healthcare, agriculture, and tourism. Educational opportunities include private and public options. St. Joseph Catholic Church operates St. Joseph Catholic School and St. Mary's Academy, a pre-K to 8th grade school. Devils Lake Public Schools operates a kindergarten center, two elementary schools, one middle school, and one high school. Lake Regional State College offers Associates Degrees in Arts, Science, and Business Administration and Associate of Applied Science Degrees in automotive technology, early childhood education, fitness trainer technician, information technology, law enforcement, marketing, nursing, precision agriculture, simulation technology, speech language pathology paraprofessional and wind energy technology as well as certificates in many of these disciplines. The North Dakota School for the Deaf is located in Devils Lake. More than 350 miles of lake shoreline and numerous private recreational facilities and state parks offer exceptional summer and winter activities such as: fishing, ice fishing, hunting, golf, cross country skiing, snowmobiling, ice skating, curling, hockey, and much more. There is an active arts council that provides many enjoyable activities such as the Fort Totten Little Theater.

Appendix B – Economic Impact Analysis

CHI St. Alexius Health

Imagine better health.℠

Devils Lake Hospital

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

Economic Impact

CHI St. Alexius Health Devils Lake is composed of a Critical Access Hospital (CAH) and a primary care clinic.

CHI St. Alexius Health Devils Lake **directly** employs **106 FTE employees** with an annual payroll of over **$10 million** (including benefits).

- After application of the employment multiplier of 1.6, these employees created an additional **64 jobs**.
- The same methodology is applied to derive the income impact. The income multiplier of 1.37 is applied to create nearly **$3.68 million** in income as they interact with other sectors of the local economy.
- **Total impacts = 170 jobs and more than $13.68 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

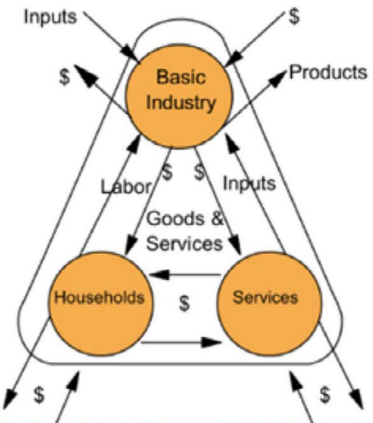
- Attracts retirees and families
- Appeals to businesses looking to establish and/or relocate
- High quality healthcare services and infrastructure foster community development
- Positive impact on retail sales of local economy
- Provides higher-skilled and higher-wage employment
- Increases the local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

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

CENTER FOR RURAL HEALTH
OSU Center for Health Sciences

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

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

Devils Lake Area Health Survey

CHI St. Alexius Health Devils Lake and Lake Region Public Health (Ramsey and Eddy Counties) 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/DevilsLake21.

Surveys will be tabulated by the Center for Rural Health at the University of North Dakota School of Medicine and Health Sciences. Your responses are anonymous, and you may skip any question you do not want to answer. Your answers will be combined with other responses and reported only in total. If you have questions about the survey, you may contact Amy Breigenzer at 701.777.8002.

Surveys will be accepted through July 31, 2021. Your opinion matters – thank you in advance!

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

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

- ☐ Community is socially and culturally diverse or becoming more diverse
- ☐ Feeling connected to people who live here
- ☐ Government is accessible
- ☐ People are friendly, helpful, supportive
- ☐ People who live here are involved in their community
- ☐ People are tolerant, inclusive, and open-minded
- ☐ Sense that you can make a difference through civic engagement
- ☐ Other (please specify): _____

2. Considering the **SERVICES AND RESOURCES** in your community, the best things are (choose up to THREE):

- ☐ Access to healthy food
- ☐ Active faith community
- ☐ Business district (restaurants, availability of goods)
- ☐ Community groups and organizations
- ☐ Healthcare
- ☐ Opportunities for advanced education
- ☐ Public transportation
- ☐ Programs for youth
- ☐ Quality school systems
- ☐ Other (please specify): _____

3. Considering the **QUALITY OF LIFE** in your community, the best things are (choose up to THREE):

- ☐ Closeness to work and activities
- ☐ Family-friendly; good place to raise kids
- ☐ Informal, simple, laidback lifestyle
- ☐ Job opportunities or economic opportunities
- ☐ Safe place to live, little/no crime
- ☐ Other (please specify): _____

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

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

_____

_____

Delivery of Healthcare

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

- ☐ Diet instruction
- ☐ Health screenings
- ☐ Laboratory services
- ☐ Occupational therapy
- ☐ Physical therapy
- ☐ Social services
- ☐ Speech therapy

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
- ☐ COVID-19 testing
- ☐ COVID-19 vaccinations
- ☐ 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. Considering services offered locally by **OTHER PROVIDERS/ORGANIZATIONS** in your community, which services are you aware of (or have you used in the past year)? (Choose ALL that apply)

- ☐ Ambulance
- ☐ Chiropractic services
- ☐ Dental services
- ☐ Massage therapy
- ☐ Optometric/vision services
- ☐ Public Health services

15. Have you used the clinic services owned by CHI St. Alexius Health Devils Lake?

- ☐ Yes
- ☐ No

16. If you answered "No" to the above question, why not?

- ☐ Not aware of the clinic
- ☐ Not a convenient location for me
- ☐ Had an unfavorable experience previously
- ☐ I use Altru's clinic

17. If the clinic offered additional hours, which would you use?

- ☐ Early morning hours starting at 7:00 AM
- ☐ Evening hours 5:00 – 8:00 PM
- ☐ Saturday morning hours 8:00 AM – 12:00 PM

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

_____

_____

19. 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): _____

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

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

21. 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): _____

22. Are you aware of the CHI St. Alexius Health Devils Lake Foundation, which exists to financially support services for the community?

- ☐ Yes
- ☐ No

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

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

24. Did you receive a COVID-19 vaccine?

- ☐ Yes
- ☐ No

25. If you answered "No" to the above question, why not?

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

Demographic Information: Please tell us about yourself.

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

- ☐ Yes
- ☐ No

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

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

28. 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): _____

29. 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

30. 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

31. Sex:

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

32. Employment status:

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

33. Your zip code: _____

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

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

35. 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

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

_____

_____

Thank you for assisting us with this important survey!

Appendix D – County Health Rankings Explained

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

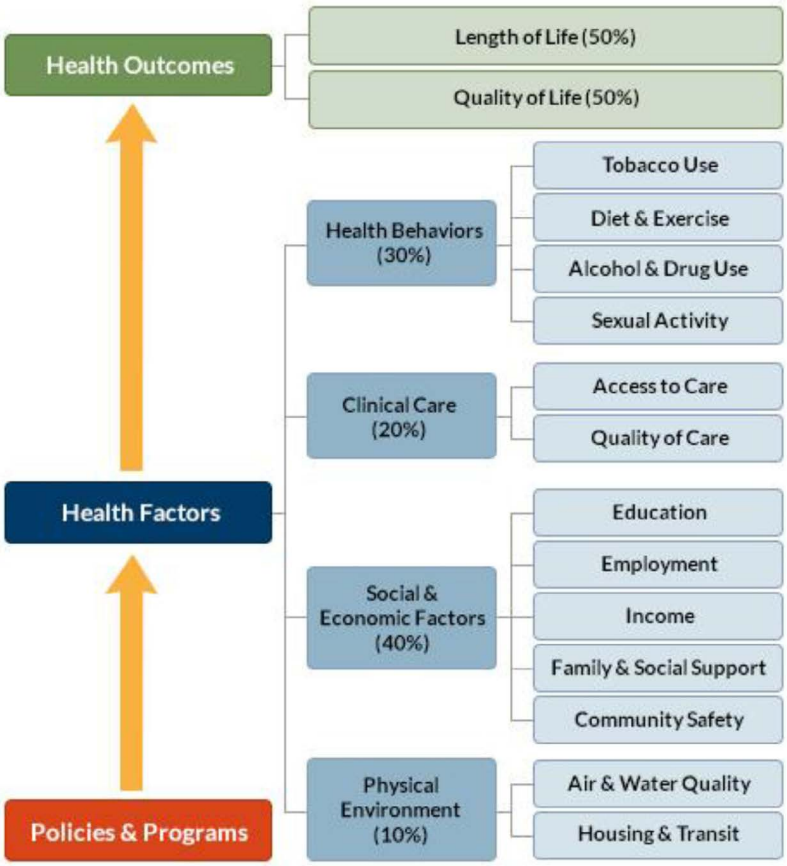
Methods

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.

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.

Diabetes Monitoring

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

Reason for Ranking

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

Mammography Screening

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

Reason for Ranking

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

Unemployment

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

Reason for Ranking

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

Children in Poverty

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

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

Reason for Ranking

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

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

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

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

Percentage of students who had sexual intercourse before age 13 years (for the first time)	2.6	2.8	NA	NA	NA	NA	3.0
Weight Management and Dietary Behaviors							
Percentage of students who were overweight (>= 85th percentile but <95th percentile for body mass index, based on sex and age-specific reference data from the 2000 CDC growth chart)	14.7	16.1	16.5	=	16.6	15.6	16.1
Percentage of students who had obesity (>= 95th percentile for body mass index, based on sex- and age-specific reference data from the 2000 CDC growth chart)	13.9	14.9	14.0	=	17.4	14.0	15.5
Percentage of students who described themselves as slightly or very overweight	32.2	31.4	32.6	=	35.7	33.0	32.4
Percentage of students who were trying to lose weight	NA	44.5	44.7	=	46.8	45.5	NA
Percentage of students who did not eat fruit or drink 100% fruit juices (during the seven days before the survey)	3.9	4.9	6.1	=	5.8	5.3	6.3
Percentage of students who ate fruit or drank 100% fruit juices one or more times per day (during the seven days before the survey)	NA	61.2	54.1	↓	54.1	57.2	NA
Percentage of students who did not eat vegetables (green salad, potatoes [excluding French fries, fried potatoes, or potato chips], carrots, or other vegetables, during the seven days before the survey)	4.7	5.1	6.6	=	5.3	6.6	7.9
Percentage of students who ate vegetables one or more times per day (green salad, potatoes [excluding French fries, fried potatoes, or potato chips], carrots, or other vegetables, during the seven days before the survey)	NA	60.9	57.1	↓	58.2	59.1	NA
Percentage of students who did not drink a can, bottle, or glass of soda or pop (such as Coke, Pepsi, or Sprite, not including diet soda or diet pop, during the seven days before the survey)	NA	28.8	28.1	=	26.4	30.5	NA
Percentage of students who drank a can, bottle, or glass of soda or pop one or more times per day (not including diet soda or diet pop, during the seven days before the survey)	18.7	16.3	15.9	=	17.4	15.1	15.1
Percentage of students who did not drink milk (during the seven days before the survey)	13.9	14.9	20.5	↑	14.8	20.3	30.6
Percentage of students who drank two or more glasses per day of milk (during the seven days before the survey)	NA	33.9	NA	NA	NA	NA	NA
Percentage of students who did not eat breakfast (during the seven days before the survey)							
Percentage of students who most of the time or always went hungry because there was not enough food in their home (during the 30 days before the survey)	NA	2.7	2.8	=	2.1	2.9	NA
	ND 2015	ND 2017	ND 2019	ND Trend ↑, ↓, =	Rural ND Town Average	Urban ND Town Average	National Average 2019
Physical Activity							
Percentage of students who were physically active at least 60 minutes per day on 5 or more days (doing any kind of physical activity that increased their heart rate and made them breathe hard some of the time during the seven days before the survey)							
Percentage of students who watched television three or more hours per day (on an average school day)	18.9	18.8	18.8	=	18.3	18.2	19.8
Percentage of students who played video or computer games or used a computer three or more hours per day (counting time spent on things such as Xbox, PlayStation, an iPad or other tablet, a smartphone, texting, YouTube, Instagram, Facebook, or other social media, for something that was not school work on an average school day)	38.6	43.9	45.3	=	48.3	45.9	46.1
Other							
Percentage of students who had eight or more hours of sleep (on an average school night)	NA	31.8	29.5	=	31.8	33.1	NA

Appendix F – Prioritization of Community's Health Needs

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

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

	Priorities	Most Important
COMMUNITY/ENVIRONMENTAL HEALTH CONCERNS		
Attracting & retaining young families	1	
Having enough child daycare services	9	4
Not enough affordable housing	0	
Poverty	0	
Not enough jobs with livable wages	2	
Bulling/Cyber bulling	1	
AVAILABILITY/DELIVERY OF HEALTH SERVICES CONCERNS		
Ability to retain primary care providers & nurses	6	0
Availability of Specialists	0	
Availability of mental health and substance use disorder treatment services	4	2
Extra hours for appointments, such as evenings and weekends	1	
YOUTH POPULATION HEALTH CONCERNS		
Alcohol use & abuse (all ages)	0	
Drug use & abuse (including prescription drugs) (all ages)	0	
Depression/Anxiety (all ages)	0	
Suicide	3	3
Smoking/tobacco use/vaping/second-hand smoke	0	
Not enough activities for children	2	
ADULT POPULATION HEALTH CONCERNS		
Alcohol use and abuse (all ages)	2	
Drug use and abuse (including prescription drugs) (all ages)	3	1
Depression/anxiety (all ages)	2	
Diabetes	0	
Smoking/tobacco use/vaping/second-hand smoke	3	0
SENIOR POPULATION HEALTH CONCERNS		
Cost of long-term/nursing home care	0	
Availability of resources to help elderly stay in their homes	2	
Quality of elderly care	0	
Depression/Anxiety (all ages)	0	
Seasonal viral outbreaks (influenza/COVID)	1	

Appendix G – Survey "Other" Responses

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

1. Considering the PEOPLE in your community, the best things are: "Other" responses:
    - Community has not drank the diversity, equity and inclusion kool-aid.
    - Have the assets to become something much more family, patient oriented
    - People are very clicky

2. Considering the SERVICES AND RESOURCES in your community, the best things are: "Other" responses:
    - People largely mind their own business.

3. Considering the QUALITY OF LIFE in your community, the best things are: "Other" responses:
    - Great Park Board Opportunities
    - Medical services
    - Sharing communities
    - Wellness/Community Center- wait we don't have one!

4. Considering the ACTIVITIES in your community, the best things are: "Other" responses:
    - CHI could build a community center. Before Altru or Sanford does!
    - Fishing
    - Shooting Sports availability
    - Sports and more sports

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:
    - Daycare
    - Drug use, pot, meth, opioids
    - Limited housing options in Devils Lake. Most apartment options are income based - and in rough shape. Houses are so expensive.
    - Mental Health services
    - Mental/behavior health services
    - No Visual Arts Center
    - Not enough activities for youth to do

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

- Daycare
- No concerns
- Superior eye/vision insurance acceptance
- Walk-in clinic needed and I feel like Devils Lake would benefit from a cancer center/infusion center
- What of healthcare is detox?

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

- Bullying in the school system
- Lack of willingness to work.

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

- Alcohol free activities
- Daycare and smoking
- Failure to take care of one's health
- Help transitioning to community/jobs for felons
- Lack of willingness to work.
- Not making a good wage to afford house, health insurance, food
- Social services decisions on babies on drug and moms
- Other chronic diseases

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

- Cost of supplements being very expensive.
- Daycare and smoking
- Need more quality assisted living areas that are attractive and inviting to others.

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

- Ability to make a living with salary
- Addiction resources including treatment and counseling
- Adequate availability of child care and preschools
- Adequate medical care, coordination between clinic & hospital
- Affordable housing
- Alcohol abuse
- Alcohol/drug abuse, child/domestic abuse
- Alcoholism
- Availability of medical doctors.
- Child abuse/neglect- providing resources to help families. Availability of foster care and inadequate response from child protective services.
- Covid-19 related inflation. The cost of living has increased dramatically due to the Covid-19 Pandemic. Resources for the community are expensive and mostly unattainable in the amount of supply needed due to the high cost. Expenses needs to be addressed for individuals to meet their health and nutritional needs as well as transportation and housing needs.
- Depression/anxiety
- Devils Lake would really benefit from having a walk-in clinic I feel. It would help cut down on the use of the ER as a walk-in clinic.
- Drug abuse
- Drug and alcohol abuse
- Effective services and education for ADHD and Bipolar disorders.
- Growth
- Having year-round events for all ages.
- Immediate access to mental/behavioral health services.

- Increase in crime
- Keeping businesses in town
- Kids are more into video games than into outside or inside pursuits that will lead to a fuller and more productive life. Education needs to provide more programs that kids can take that may prepare them for a life beyond high school if they do not or cannot attend college. I think this is true for most communities.
- Lack of diversity and cultural understanding. Openness and exposure to diversity is critical in preparing our young people as they leave our community to work in more diverse settings.
- Lack of hospital in the county
- Lack of mental health care
- Lack of mental health providers. (Lack of immediate appointments for community members in mental health crisis. Lack of therapist and counselor availability to immediately intervene in crisis)
- Lack of things to do for both youth and adults
- Lots of people can't cope with life without booze or drugs, lead to early death for many.
- Meth abuse
- Not enough activities or places for youth to hang out in the community. We closed the bowling alley to put up another liquor store for starters. The list goes on. The ER in our community is awful. We need to recruit better providers who won't put a band-aid on us until Altru Clinic opens the next morning or Monday morning.
- One of our biggest challenges is the inability of Altru clinic and St. Alexius Hospital to work closer together. It would be wonderful for patients to have their same health records available to both entities and have closer communication as well.
- Poverty level is high here yet employers/businesses can't get people to work. Plenty of good jobs available but then people lose their free services if they make too much. It's cyclic....their kids learn how to do it and we continue with poverty/low income families here.
- Prejudice against Native American population because of the high alcohol and drug abuse in their population. The poverty level on the reservation is very high and access to medical care for them is also difficult.
- Providing quality mental health care for our youth. Our community would benefit from a more/or more inclusive process to assist with services from home to school to community.
- Quality healthcare
- Separatism!
- Suicide
- The continued and widening gap between the poorest members of our community and the middle/upper class members of the community.
- The willingness to make changes to better the community because the leaders have "always done it this way" and don't lead change. Leaders seem to be against change that would better the community and grow it. Hard for new family to move to the area and feel welcome.
- There are not enough activities for the youth.
- There aren't enough options for the youth in our community to participate in. Sure, there are things for the younger age groups but once they reach their teens there become a lack of activities to attract and stimulate the young adolescent mind. Unless you like fishing and drinking there is little too do here.
- There is a larger drug problem here, than in more populous areas I have lived in.
- Too much disparity among social classes, whether food insecurity or available jobs, housing, etc
- Unemployment, people not wanting to work.
- We don't have enough activities/places for kids/teens. We lost the movie theater and bowling alley.
- We would benefit from a cancer center/infusion center and a walk-in clinic
- Youth programs to get kids included in sports, coachable kids are teachable kids but not enough volunteers - paid coaches to get all kids to play or community involvement

Delivery of Healthcare

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

- Grew up in DC
- Insurance

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

- Accessible detox center for narcotics
- Allergist
- Better cancer treatment options locally
- Breast screening event; mental health screenings and event of pet/service
- Cancer center/infusion center and more specialty services
- Check ups
- Combine Altru and CHI St Alexius in to one healthcare unit!
- Diabetes education, more mental health
- Evening hours 5-8pm
- Expanded & updated dialysis facilities
- Extended hours
- General surgery
- Healthy eating/diet prevention courses. I didn't know our hospital offered the services it does outside of hospital care.
- Hospice care, elder care, more youth health screening- wellness prevention
- Increased specialty availability
- Internal medicine
- It would be nice if CHI clinic could offer more providers.
- Mental health services
- Mental health services; therapy, medication mgmt.
- Mental health support for youth
- More mental health resources and addiction intervention/counseling.
- More OB and ER services.
- Nutrition and bariatric services.
- Orthopedics
- Peds, podiatry, general surgery
- Registered dietitian - pre-diabetic/diabetic counseling
- Simple surgery
- Specialty - podiatry, neurosurgery, orthopedic
- The ability to get a cast for a broken limb.
- Therapy
- Urgent care
- Urgent Care after hours
- Urgent Care, surgeon for surgeries to be done locally.
- Urgent Care, surgeon for surgeries to be done locally.
- Vision clinics that take CHI insurance. More child care centers. Infusion center
- Vision that is covered by most insurances. I have to go elsewhere.
- Walk-in clinic
- Wellness coaches like Sandford offers

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

- Do NOT have problem
- Don't trust management level at CHI
- Emergency Department is not adequate for patients to be seen
- Emergency room needs more help for others using it for emergency means and not appointments because they don't have health insurance.
- Lack of mental health providers
- No issues with receiving healthcare
- We are able to find healthcare

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

- Grand Forks Clinic

18. Have you supported the CHI St. Alexius Health ,Devils Lake Foundation in any of the following ways? "Other" responses:

- Attended events
- Fundraisers
- I paid my bill
- No due to legal setup
- No, they tell the community that funds will be used for one thing, then direct them outside of their chartered scope. The ND Attorney General should look into this.
- None
- Raffle tickets and Signature Event
- Raffles
- Support of Foundation Events
- Toy to kids

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

- After losing a close loved one in November 2020, my doctor referred me to a therapist in Grand Forks. I was told that I would be placed on a waitlist until May 2021. That's an issue. I needed someone to talk to - someone to help me work through my thoughts.
- Better vision coverage so I don't have to take my family out of town for services.
- Better, more adequate nurses. When she gave my daughter, her flu shot last year, she broke the needle off in my daughter's arm. I will not go to public health for any type of vaccination for anyone in my family.
- CHI clinic is terrible about getting test results back to patients. ER providers do not get back to patients about results after official readings. Hospital needs to focus on quality. Much better inpatient care when providers came from Grand Forks. Current providers that CHI contracts with are not knowledgeable and provide poor care.
- CHI needs to get their billing figured out---worst there is in the state. People who answer the phone are rude and are in desperate need of customer service training.
- Expensive even after insurance
- Flexibility with appointment times after hours availability
- Hospital offers very limited healthcare. Most people are sent on for care or procedures.
- I am happy with most of everything.
- I wasn't aware of services CHI provides outside of in hospital care. I dislike how our clinic and hospital have never been able to work better together with records. When our ENT from GF no longer did procedures at the hospital here that was a huge loss. No one in my family has a primary care provider anymore because every time we do, that doctor leaves. We aren't a big town so we need to work better together.
- I wish Altru would provide transportation to Grand Forks for doctors that do not come to Devils Lake (cost to the patient, not Altru)

- I work at CHI hospital and we have a lot of cancellations for procedures due to lack of transportation. Not sure if there is a lack of public transportation in general or if there is just a lack of advertising.
- Improved access for dental and eye care for the poor.
- Joining the clinic and hospital as one united facility making care smoother.
- Mental health services and an urgent care facility is a must in the area. Along with more transportation to appointments
- More affordable. Walk in clinic. Longer hours of service so working people can be seen.
- More and more immediate access to mental health care
- More mental health services is extremely needed to help not only the youth but also middle-aged members of the community.
- More public awareness
- More use of telehealth appointments
- Need a new Director of Nursing
- Need more time during appointments. Feel rushed, not fully heard.
- Need walk in clinics on the weekend
- Our healthcare systems need to work together and provide high quality of care. That is not happening at this time.
- Our public health service employees are amazing
- Retain quality healthcare professionals
- Somebody please buyout CHI and 1. Get rid of top-level management, 2 have outside people look at the nepotism in hiring, and 3, build up staffing, and 4 stopping lying to the staff and community.
- The ER is overused for urgent care visits which could be helped if had extended hours at health providers. I think also it is important to maybe have some or more hospital security.
- The hospital and clinic MUST work together. We need to provide more hospital services here in DL instead of shipping everyone to Grand Forks or Fargo
- The mental health needs of children are not being met. There are limited professionals in this area and appointments / availability is extremely limited. Oftentimes kids who need help are not able to be seen for months.
- We have a large void in treatment of addiction and mental health issues. It seems like we just put a band aid on the problem instead of supplying recourses to eradicate the problem.
- We need a more cohesive medical community in Devils Lake working toward the best interest of the patient not the entity.
- We need qualified providers that can promote a complete healthcare experience and allow patients in the community to stay in the community with friends and family instead of going many miles away.