Community Health Needs Assessment

2019

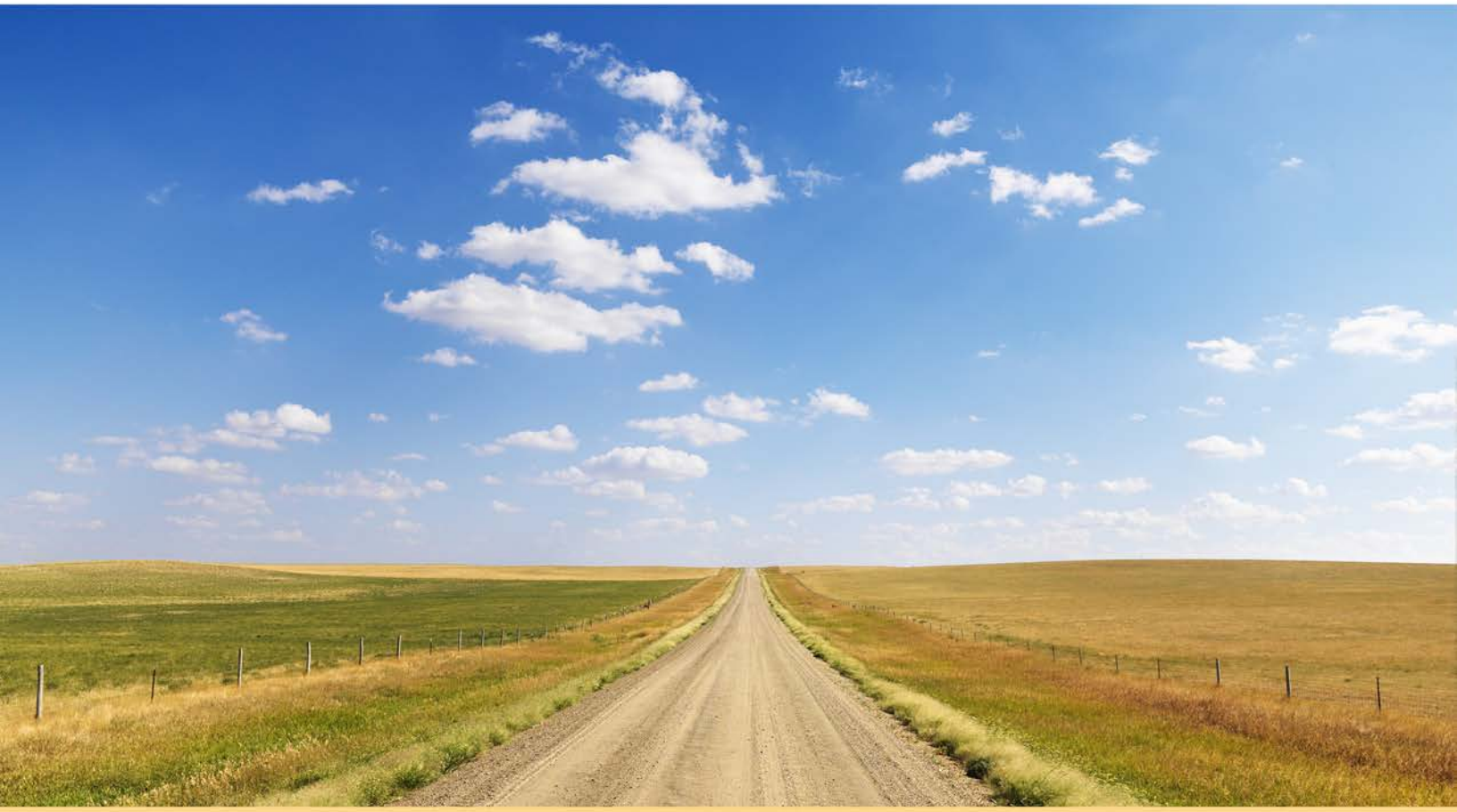

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Table of Contents

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Executive Summary

To help inform future decisions and strategic planning, Northwood Deaconess Health Center (NDHC) conducted a community health needs assessment (CHNA) in 2019, the previous CHNA having been conducted in 2016. The Center for Rural Health (CRH) at the University of North Dakota School of Medicine & 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. Seventy-three NDHC service area residents completed the survey. Additional information was collected through seven key informant interviews with community members. The input from the residents, who primarily reside in Grand Forks County, represented the broad interests of the communities in the service area. Together with secondary data gathered from a wide range of sources, the survey presents a snapshot of the health needs and concerns in the community.

With regard to demographics, Grand Forks County's population from 2010 to 2018 increased 5.8%. The average of residents under age 18 (21.1%) for the county is slightly lower than the North Dakota average (23.5%). The percentage of residents ages 65 and older is just under 3% lower for Grand Forks County (12.7%) than the North Dakota average (15.3%), and the rates of education are slightly higher for the county (94.3%) than the North Dakota average (92.3%). The median household income in Grand Forks County ($51,410) is nearly $10,000 lower than the state average for North Dakota ($61,285).

Data compiled by County Health Rankings show Grand Forks County is doing better than North Dakota in health outcomes/factors for 19 categories. According to the same rankings, the county is performing poorly relative to the rest of the state in 11 outcome/factor categories.

Of the 82 potential community and health needs set forth in the survey, the 73 NDHC service area residents who completed the survey indicated the following ten needs as the most important:

- Alcohol use and abuse – Youth
- Alcohol use and abuse – Adults
- Attracting and retaining young families
- Availability of resources to help the elderly stay in their homes
- Cost of health insurance
- Cost of long-term/nursing home care options
- Drug use and abuse – Youth
- Drug use and abuse – Adults
- Not enough jobs with livable wages/not enough to live on
- Smoking and tobacco use, exposure to second-hand smoke, or vaping/juuling – Youth

The survey also revealed the biggest barriers to receiving healthcare (as perceived by community members). They included no or limited insurance (N=18), can't get transportation (N=17), and not enough specialists (N=9).

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

- Family-friendly; good place to raise kids
- Feeling connected to people who live here
- Healthcare
- People are friendly, helpful and supportive
- Quality school systems
- Safe place to live, little/no crime

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

- Alcohol use and abuse – youth and adults
- Availability of mental health services
- Cost of health insurance
- Cost of long-term/nursing home care
- Depression/anxiety – youth and adults
- Stress – youth and adults

Overview and Community Resources

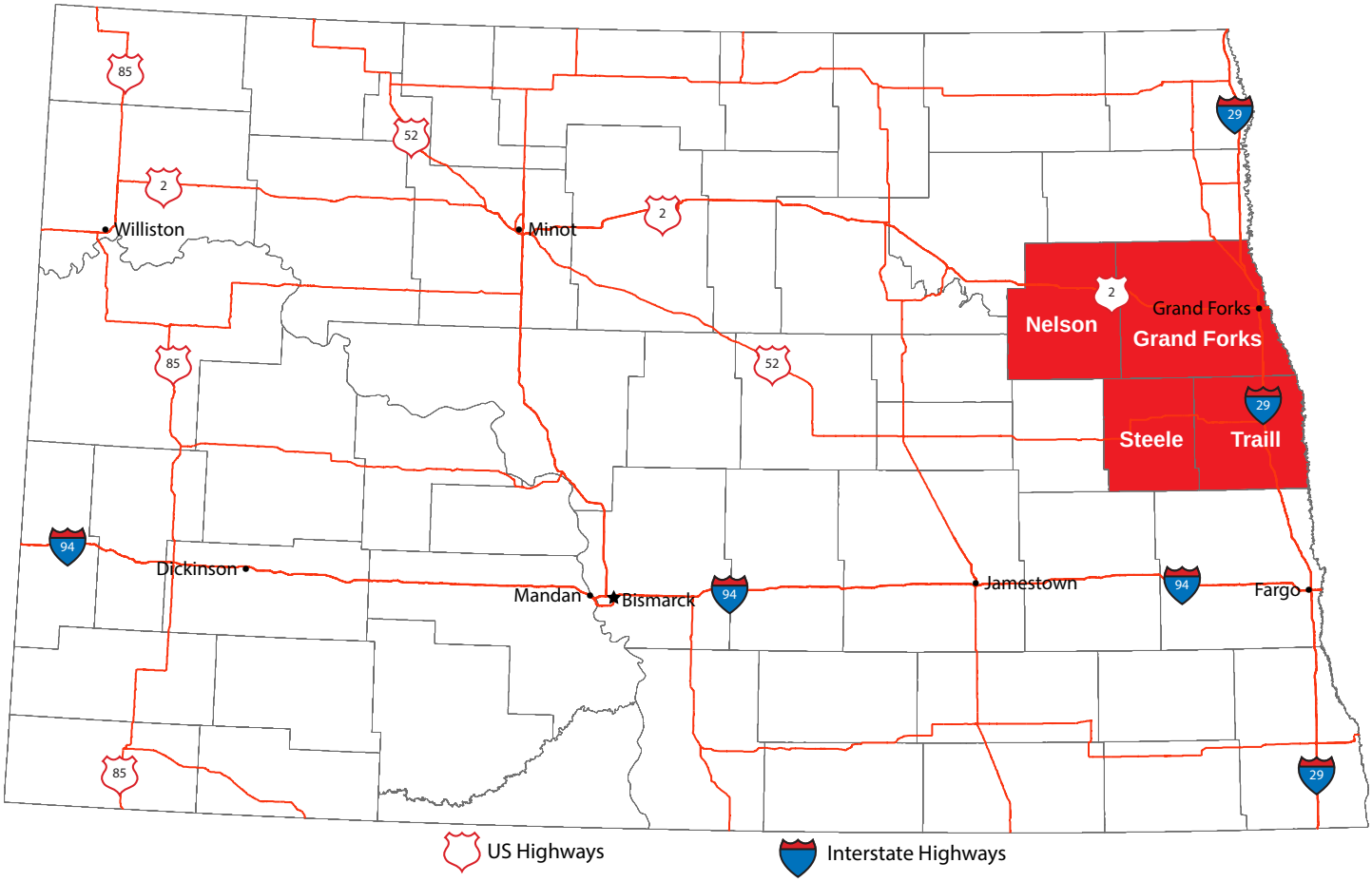
With assistance from the CRH at the UNDSMHS, Northwood Deaconess Health Center (NDHC) completed a community health assessment of the NDHC service area. The hospital identifies its service area as the towns of Northwood, Larimore, Aneta, Arvilla, and Hatton as well as several other small extending communities. Many community members and stakeholders worked together on the assessment.

NDHC is located in southwestern Grand Forks County, 35 miles from Grand Forks and 85 miles from Fargo. Residents of the service area seek additional tertiary care services in both of those communities. An optometrist from Valley Vision is at NDHC on Thursdays. A local chiropractor is also located on the NDHC campus. There is no dentist practicing locally. However, community members receive care in a number of neighboring communities including Larimore, Mayville, Park River, and Grand Forks. Local pharmacy services are available in both Northwood and Larimore where NDHC has clinics. There is also a community health center located in Larimore.

The community of Northwood has a new and modern public school constructed in 2009. Enrollment has grown significantly in the past five years from a total enrollment of just over 200 to now over 300. Classes entering school have typically been ten or more students larger than those graduating for the past several years.

The local Park District has a swimming pool, ball diamonds, and a 9-hole golf course. There are newly constructed walking paths connecting the school to NDHC as well as circulating the school area, the football field, and the hockey arena. NDHC provides a fitness center open 24/7 with a small monthly fee charged for access.

Figure 1: Grand Forks, Nelson, Steele & Traill County, North Dakota



Northwood Deaconess Health Center

NDHC was started in 1902 by area Lutheran churches. Its ownership today is still those Lutheran churches, 10 in total from the communities of Northwood, Hatton, Sharon, and Larimore.

NDHC has a 12-bed critical access hospital, supported by clinics in Northwood, Larimore, and Binford. The nursing home is a 45-bed facility providing skilled care. Six assisted living apartments and ten independent living apartments help round out a full continuum of care on campus.

The mission of NDHC is:
Service as local access to a full range of healthcare services; Continue as a leader in primary care for the whole family, in care of the elderly, and in emergency services. Function as a focal point for community health education and wellness. NDHC provides this in a Christian environment respecting the dignity of all.

Services offered locally by NDHC include:

General and Acute Services

- Ambulance
- Assisted living center
- Clinics (Northwood, Larimore, and Binford)
- Emergency room
- Independent living facility
- Skilled nursing home with special care dementia unit
- Swing bed

Screening/Therapy Services

- Physical therapy
- Occupational therapy
- Colonoscopy
- Speech therapy
- Laboratory services
- Endoscopy

Radiology Services

- CT scan (mobile unit)
- MRI
- Mammography
- Ultrasound

Grand Forks Public Health Department

The Grand Forks Public Health Department (GFPHD) provides services to the City and County of Grand Forks, North Dakota. We believe in creating a culture in which all people have the means and the opportunity to make choices that lead to the healthiest lives possible. We facilitate policy, system and environmental changes that are supported by businesses, government, individuals, and organizations all working together to foster healthy communities and lifestyles.

The mission of GFPHD is to:

- Promote healthy environments and lifestyles
- Prevent disease
- Build community resilience through preparedness
- Assure access to health services

Services offered by GFPHD include:

- Adult home visits
- Breast & cervical cancer screening
- Correctional health nursing services
- Emergency preparedness
- Environmental health
- Health Tracks
- HIV & Hepatitis C testing
- Immunizations
- Maternal & child health
- Mosquito control
- Opioid response
- Ryan White program
- Syringe service program
- Tobacco prevention & control
- Tuberculosis monitoring & treatment
- Withdrawal Management Center

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 Grand Forks County, which is included in the NDHC service area.

The CRH, in partnership with NDHC, facilitated the CHNA process. Community representatives met regularly in-person, by telephone conference, and email. A CHNA liaison was selected locally, who served as the main point of contact between the CRH and Northwood. A small steering committee (see Figure 2) was formed that was responsible for planning and implementing the process locally. Representatives from the CRH met and corresponded regularly by teleconference and/or via the eToolkit with the CHNA liaison. The community group (described in more detail below) provided in-depth information and informed the assessment process in terms of community perceptions, community resources, community needs, and ideas for improving the health of the population and healthcare services. Seventeen people, representing a cross section demographically, attended the focus group meeting. The meeting was highly interactive with good participation. NDHC staff and board members were in attendance as well, but largely played a role of listening and learning.

Figure 2: Steering Committee

Pete Antonson	CEO, NDHC
Wade Bilden	Community member
Tom Engen	Emergency Medical Services Manager, NDHC
Brad Pearson	NDHC board member

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

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

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

The CRH is one of the nation's most experienced organizations committed to providing leadership in rural health. Its mission is to connect resources and knowledge to strengthen the health of people in rural communities. The CRH is the designated State Office of Rural Health and administers the Medicare Rural Hospital Flexibility (Flex) program, funded by the Federal Office of Rural Health Policy, Health Resources

Services Administration, and Department of Health and Human Services. The CRH connects the UNDSMHS and other necessary resources, to rural communities and their healthcare organizations in order to maintain access to quality care for rural residents. In this capacity, the CRH works at a national, state, and community level.

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

Community Group

A community group consisting of 17 community members convened on August 28, 2019. 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 October 24, 2019 with 12 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 Grand Forks County. The group was then tasked with identifying and prioritizing the community's health needs.

Members of the community group represented the broad interests of the community served by NDHC. They included representatives of the health community, business community, law enforcement, education, and faith community. Not all members of the group were present at both meetings.

Interviews

One-on-one interviews with seven key informants were conducted in person in Northwood on August 28, 2019. Representatives from the CRH conducted the interviews. Interviews were held with selected members of the community who could provide insights into the community's health needs.

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

Survey

A survey was distributed to solicit feedback from the community and was not intended to be a scientific or statistically valid sampling of the population. It was designed to be an additional tool for collecting qualitative data from the community at large – specifically, information related to community-perceived health needs. A copy of the survey instrument is included in Appendix A and a full listing of direct responses provided for the questions that included "Other" as an option are included in Appendix D.

The community member survey was distributed to various residents of Grand Forks County, which is included in the NDHC service area and the town of Aneta in Nelson County.

The survey tool was designed to:

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

Specifically, the survey covered the following topics:

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

To promote awareness of the assessment process, press releases led to published articles in newspapers in Northwood and Larimore. Additionally, information was published on NDHC's website and Facebook page. Approximately 150 community member surveys were available for distribution in Grand Forks County and the towns of Aneta and Hatton. The surveys were distributed by community group members and at NDHC and local churches.

To help ensure anonymity, included with each survey was a postage-paid return envelope to the CRH. In addition, to help make the survey as widely available as possible, residents also could request a survey by calling NDHC. The survey period ran from August 19, 2019 to September 20, 2019. Twenty-five completed paper surveys were returned.

Area residents also were given the option of completing an online version of the survey, which was publicized in newspapers in Hatton, Aneta, Larimore, and Northwood and on the websites and Facebook pages of NDHC. Forty-eight 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, 73 community member surveys were completed, equating to a 4% response rate. This response rate is below average for this type of unsolicited survey methodology and indicates a less engaged community.

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). and Youth Risk Behavior Surveillance System (YRBSS) data, which is published by the Centers for Disease Control and Prevention (https://www.cdc.gov/healthyyouth/data/yrbs/index.htm).

Social Determinants of Health

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

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

Healthy People 2020, (https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health) illustrates that health and healthcare, while vitally important, play only one small role (approximately

20%) in the overall health of individuals, and ultimately of a community. Social and community context, education, economic stability, neighborhood and built environment play a much larger part (80%) in impacting health outcomes. Therefore, as needs or concerns were raised through this 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. See Figure 3.

Figure 3: Social Determinants of Health

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

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

Figure 4: Social Determinants of Health

Economic Stability	Neighborhood and Physical Environment	Education	Food	Community and Social Context	Health Care System
Employment	Housing	Literacy	Hunger	Social integration	Health coverage
Income	Transportation	Language	Access to healthy options	Support systems	Provider availability
Expenses	Safety	Early childhood education		Community engagement	Provider linguistic and cultural competency
Debt	Parks	Vocational training		Discrimination	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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Demographic Information

TABLE 1: Bottineau County: INFORMATION AND DEMOGRAPHICS

	Grand Forks County	North Dakota
Population (2018)	70,770	760,077
Population change (2010-2018)	5.8%	13.0%
People per square mile (2010)	46.5	9.7
Persons 65 years or older (2018)	12.7%	15.3%
Persons under 18 years (2018)	21.1%	23.5%
Median age (2017 est.)	29.5	35.4
White persons (2017)	86.5%	87.0%
Non-English speaking (2017)	6.1%	5.6%
High school graduates (2017)	94.3%	92.3%
Bachelor's degree or higher (2017)	34.0%	28.9%
Live below poverty line (2016)	14.8%	10.3%
Persons without health insurance, under age 65 years (2016)	7.9%	8.8%

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

Along with the population growth seen in North Dakota throughout recent years, Grand Forks County has also seen a rise in population. The U.S. Census Bureau estimates show that Grand Forks County's population increased from 66,861 (2010) to 70,770 (2018).

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, Grand Forks County is compared to North Dakota rates and national benchmarks on various topics ranging from individual health behaviors to the quality of healthcare.

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

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

Table 2 summarizes the pertinent information gathered by County Health Rankings as it relates to Grand Forks County. It is important to note that these statistics describe the population of a county, regardless of where county residents choose to receive their medical care. In other words, all of the following statistics are based on the health behaviors and conditions of the county's residents, not necessarily the patients and clients of NDHC or of any particular medical facility.

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

For most of the measures included in the rankings, the County Health Rankings' authors have calculated the "Top U.S. Performers" for 2019. The Top Performer number marks the point at which only 10% of counties in the nation do better, i.e., the 90th percentile or 10th percentile, depending on whether the measure is framed positively (such as high school graduation) or negatively (such as adult smoking).

Grand Forks County rankings within the state are included in the summary following. For example, the county ranks 21st out of 49 ranked counties in North Dakota on health outcomes and 17th on health factors. The measures marked with a with a bullet point (•) are those where a county is not measuring up to the state rate/percentage; a square (■) indicates that the county is not meeting the U.S. Top 10% rate on that measure. Measures that are not marked with a colored checkmark but are marked with a plus sign (+) indicate that the county is doing better than the U.S. Top 10%.

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

On *health factors*, Grand Forks County performs above the North Dakota average for counties in several areas as well.

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

- Premature death
- Poor or fair health
- Poor mental health days
- Adult smoking
- Adult obesity
- Physical inactivity
- Access to exercise opportunities
- Excessive drinking
- Alcohol-impaired driving deaths
- Teen birth rate
- Uninsured individuals
- Primary care physicians
- Dentists
- Mental health providers
- Preventable hospital stays
- Flu vaccinations
- Unemployment
- Violent crime
- Injury deaths

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

- Poor physical health days
- Low birth weight
- Food environment index
- Sexually transmitted infections
- Mammography screenings
- Children in poverty
- Income inequality
- Children in single-parent household
- Social associations
- Air pollution – particulate matter
- Severe housing problems

● = Not meeting North Dakota average

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

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

Blank values reflect unreliable or missing data

TABLE 2: SELECTED MEASURES FROM *COUNTY HEALTH RANKINGS* 2019 – GRAND FORKS COUNTY

	Grand Forks County	U.S. Top 10%	North Dakota
Ranking: Outcomes	**21st**		**(of 49)**
Premature death	5,700 ■	5,400	6,700
Poor or fair health	14% ■	12%	14%
Poor physical health days (in past 30 days)	3.4 ●■	3.0	3.0
Poor mental health days (in past 30 days)	3.1 +	3.1	3.1
Low birth weight	7% ●■	6%	6%
Ranking: Factors	**17th**		**(of 49)**
Health Behaviors			
Adult smoking	18% ■	14%	20%
Adult obesity	31% ■	26%	32%
Food environment index (10=best)	8.1 ●■	8.7	9.1
Physical inactivity	21% ■	19%	22%
Access to exercise opportunities	83% ■	91%	74%
Excessive drinking	26% ■	13%	26%
Alcohol-impaired driving deaths	27% ■	13%	46%
Sexually transmitted infections	507.6 ●■	152.8	456.5
Teen birth rate	14 +	14	23
Clinical Care			
Uninsured	7% ■	6%	8%
Primary care physicians	770:1 +	1,050:1	1,320:1
Dentists	1,240:1 +	1,260:1	1,530:1
Mental health providers	350:1 ■	310:1	570:1
Preventable hospital stays	4,087 ■	2,765	4,452
Mammography screening (% of Medicare enrollees ages 67-69 receiving screening)	49% +●	49%	50%
Social and Economic Factors			
Unemployment	2.2% +	2.9%	2.6%
Children in poverty	12% ●■	11%	11%
Income inequality	5.4 ●■	3.7	4.4
Children in single-parent households	33% ●■	20%	27%
Violent crime	243 ■	63	258
Injury deaths	53 +	57	69
Physical Environment			
Air pollution – particulate matter	6.9 ●■	6.1	5.4
Drinking water violations	No		
Severe housing problems	16% ●■	9%	11%

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

Children's Health

The National Survey of Children's Health touches on multiple intersecting aspects of children's lives. Data are not available at the county level; listed below is information about children's health in North Dakota. The full survey includes physical and mental health status, access to quality healthcare, and information on the child's family, neighborhood, and social context. Data is from 2016-17. More information about the survey 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 aged 0-17 unless noted otherwise)

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

Health Status	North Dakota	National
Children born premature (3 or more weeks early)	10.8%	11.5%
Children 10-17 overweight or obese	30.0%	31.0%
Children 0-5 who were ever breastfed	82.4%	79.2%
Children 6-17 who missed 11 or more days of school	3.0%	3.7%
Healthcare		
Children currently insured	95.5%	93.9%
Children who had preventive medical visit in past year	77.8%	82.2%
Children who had preventive dental visit in past year	76.4%	79.5%
Young children (10 mos.-5 yrs.) receiving standardized screening for developmental or behavioral problems	31.5%	31.1%
Children aged 2-17 with problems requiring counseling who received needed mental healthcare	11.7%	9.8%
Family Life		
Children whose families eat meals together 4 or more times per week	**75.5%**	73.0%
Children who live in households where someone smokes	16.1%	15.5%
Neighborhood		
Children who live in neighborhood with a parks, recreation centers, sidewalks and a library	37.0%	39.2%
Children living in neighborhoods with poorly kept or rundown housing	9.9%	39.2%
Children living in neighborhood that's usually or always safe	98.3%	12.8%

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

- Obese or overweight children ages 10-17;
- Children with health insurance;
- Preventive primary care and dentist visits;
- Developmental/behavioral screening for children 10 months to 5 years of age;

- Children ages 2-17 years who have received needed mental healthcare; and
- Children living in smoking households.

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

The data show that Grand Forks County is performing more poorly than the North Dakota average on over half of the examined measures. The most marked difference was on the measure of uninsured children below 200% of poverty (roughly 9% higher rate in than the state).

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

	Grand Forks County	North Dakota
Uninsured children (% of population age 0-18), 2016	5.2%	9.0%
Uninsured children below 200% of poverty (% of population), 2016	52.5%	41.9%
Medicaid recipient (% of population age 0-20), 2017	25.2%	28.3%
Children enrolled in Healthy Steps (% of population age 0-18), 2013	1.5%	2.5%
Supplemental Nutrition Assistance Program (SNAP) recipients (% of population age 0-18), 2017	20.7%	20.1%
Licensed childcare capacity (% of population age 0-13), 2018	43.9%	41.9%
4-Year High School Cohort Graduation Rate, 2017	86.5%	87.0%

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

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

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

Table 5 depicts some of the YRBS data that has been collected in 2013, 2015, and 2017. At this time, the North Dakota-specific data for 2017 is not available, so data for 2013 and 2015 are shown for North Dakota. They are further broken down by rural and urban percentages. The trend column shows a "=" for statistically insignificant change (no change), "↑" for an increased trend in the data changes from 2013 to 2015, and "↓" for a decreased trend in the data changes from 2013 to 2015. The final column shows the 2017 national average percentage. For a more complete listing of the YRBS data, see Appendix C.

TABLE 5: Youth Behavioral Risk Survey Results

North Dakota High School Survey

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

	ND 2013	ND 2015*	ND Trend ↑, ↓, =	Rural ND Town Average	Urban ND Town Average	National Average 2017
Injury and Violence						
% of students who rarely or never wore a seat belt.	11.6	8.5	↓	10.5	7.5	5.9
% of students who rode in a vehicle with a driver who had been drinking alcohol (one or more times during the 30 prior to the survey)	21.9	17.7	↓	21.1	15.2	16.5
% of students who talked on a cell phone while driving (on at least 1 day during the 30 days before the survey)	67.9	61.4	↓	60.7	58.8	NA
% of students who texted or e-mailed while driving a car or other vehicle (on at least 1 day during the 30 days before the survey)	59.3	57.6	=	56.7	54.4	39.2
% of students who were in a physical fight on school property (one or more times during the 12 months before the survey)	8.8	5.4	↓	6.9	6.1	8.5
% of students who were ever physically forced to have sexual intercourse (when they did not want to)	7.7	6.3	=	6.5	7.4	7.4
% of students who were bullied on school property (during the 12 months before the survey)	25.4	24.0	=	27.5	22.4	19.0
% of students who were electronically bullied (includes e-mail, chat rooms, instant messaging, websites, or texting during the 12 months before the survey)	17.1	15.9	=	17.7	15.8	14.9
% of students who made a plan about how they would attempt suicide (during the 12 months before the survey)	13.5	13.5	=	12.8	13.7	13.6
Tobacco, Alcohol, and Other Drug Use						
% of students who currently use an electronic vapor product (e-cigarettes, vape e-cigars, e-pipes, vape pipes, vaping pens, e-hookahs, and hookah pens at least 1 day during the 30 days before the survey)	NA	22.3	↑	19.7	22.8	13.2
% of students who currently used cigarettes, cigars, or smokeless tobacco (on at least 1 day during the 30 days before the survey)	27.5	20.9	↓	22.9	19.8	14.0
% of students who drank five or more drinks of alcohol in a row (within a couple of hours on at least 1 day during the 30 days before the survey)	21.9	17.6	↓	19.8	17.0	13.5
% of students who currently used marijuana (one or more times during the 30 days before the survey)	15.9	15.2	=	13.2	17.1	19.8
% of students who ever took prescription drugs without a doctor's prescription (such as OxyContin, Percocet, Vicodin, codeine, Adderall, Ritalin, or Xanax, one or more times during their life)	17.6	14.5	↓	13.2	16.0	14.0

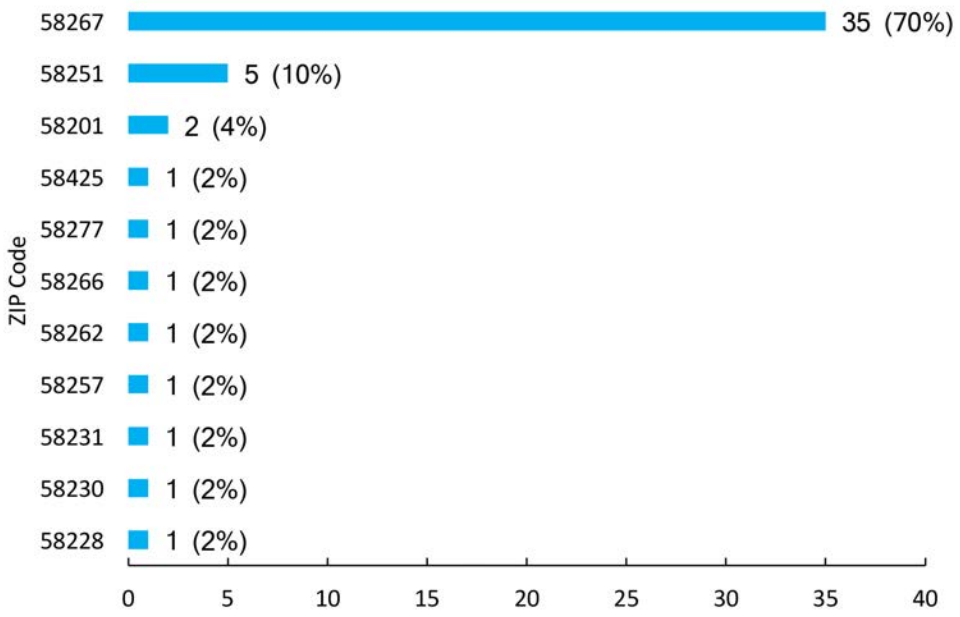
Weight Management, Dietary Behaviors, and Physical Activity						
% of students who were overweight (>= 85th percentile but <95th percentile for body mass index)	15.1	14.7	=	15.4	14.6	15.6
% of students who were obese (>= 95th percentile for body mass index)	13.5	14.0	=	16.3	12.9	14.8
% of students who did not eat fruit or drink 100% fruit juices (during the 7 days before the survey)	3.4	3.9	=	4.3	4.1	5.6
% of students who did not eat vegetables (green salad, potatoes [excluding French fries, fried potatoes, or potato chips], carrots, or other vegetables, during the 7 days before the survey)	6.0	4.7	=	4.5	5.2	7.2
% of students who drank a can, bottle, or glass of soda or pop one or more times per day (not including diet soda or diet pop, during the 7 days before the survey)	23.4	18.7	=	21.4	18.0	18.7
% of students who did not drink milk (during the 7 days before the survey)	11.1	13.9	↑	11.6	13.7	26.7
% of students who did not eat breakfast (during the 7 days before the survey)	10.5	11.9	=	10.7	11.8	14.1
% of students who most of the time or always went hungry because there was not enough food in their home (during the 30 days before the survey)	3.1	2.2	=	2.4	2.8	NA
% of students who were physically active at least 60 minutes per day on 5 or more days (doing any kind of physical activity that increased their heart rate and made them breathe hard some of the time during the 7 days before the survey)	50.6	51.3	=	51.7	50.1	46.5
% of students who watched television 3 or more hours per day (on an average school day)	21.0	18.9	=	20.7	18.2	20.7
% of students who played video or computer games or used a computer 3 or more hours per day (for something that was not school work on an average school day)	34.4	38.6	↑	39.4	38.0	43.0
Other						
% of students who ever had sexual intercourse	44.9	38.9	↓	39.3	39.1	39.5
% of students who had 8 or more hours of sleep (on an average school night)	30.0	29.5	=	34.5	28.7	25.4
% of students who brushed their teeth on seven days (during the 7 days before the survey)	71.5	71.0	=	67.8	70.1	NA

Survey Results

As noted previously, 73 community members completed the survey in communities throughout the areas in the NDHC service area. For all questions that contained an "Other" response, all of those direct responses may be found in Appendix D. 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.

The survey requested that respondents list their home zip code. While not all respondents provided a zip code, 50 did, revealing that the large majority of respondents (70%, N=35) lived in Northwood. These results are shown in Figure 5.

Figure 5: Survey Respondents' Home Zip Code
Total respondents: 50



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

Survey Demographics

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

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

- 52% (N=30) were age 55 or older.
- The majority, 71%, (N=42) were female.
- Slightly more than half of the respondents, 51% (N=31) had bachelor's degrees or higher.
- The number of those working full time, 50% (N=30) was slightly higher than those who were retired 37% (N=22).
- 98% (N=59) of those who reported their ethnicity/race were white/Caucasian.
- 13% of the population, (N=7) had household incomes of less than $50,000.

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

Figure 6: Age Demographics of Survey Respondents
Total respondents = 58

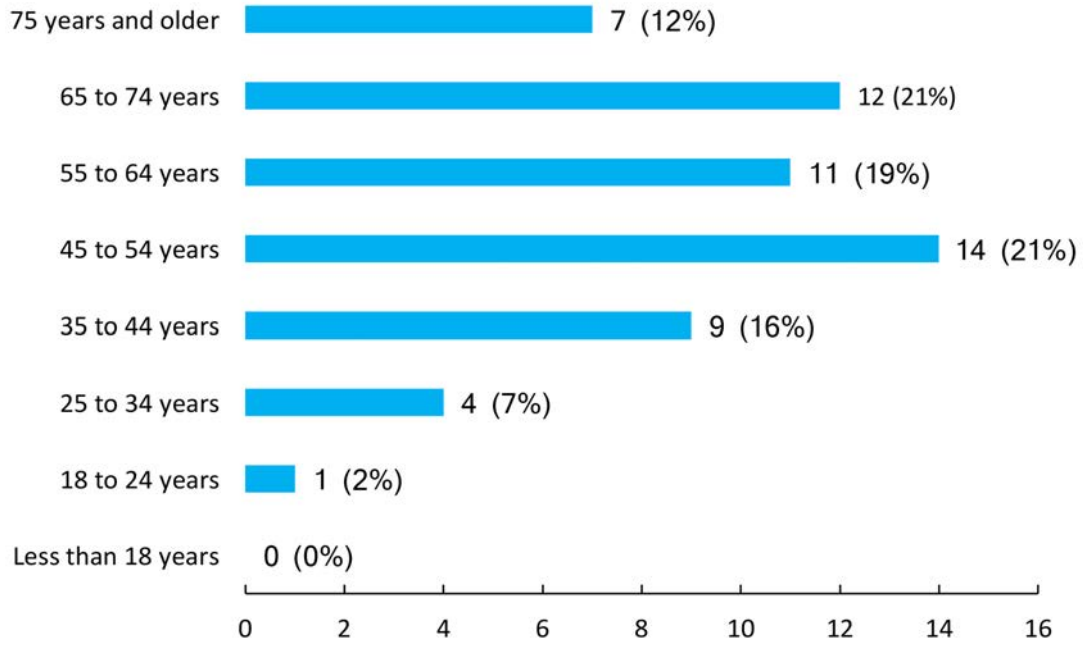


Figure 7: Gender Demographics of Survey Respondents
Total respondents = 59

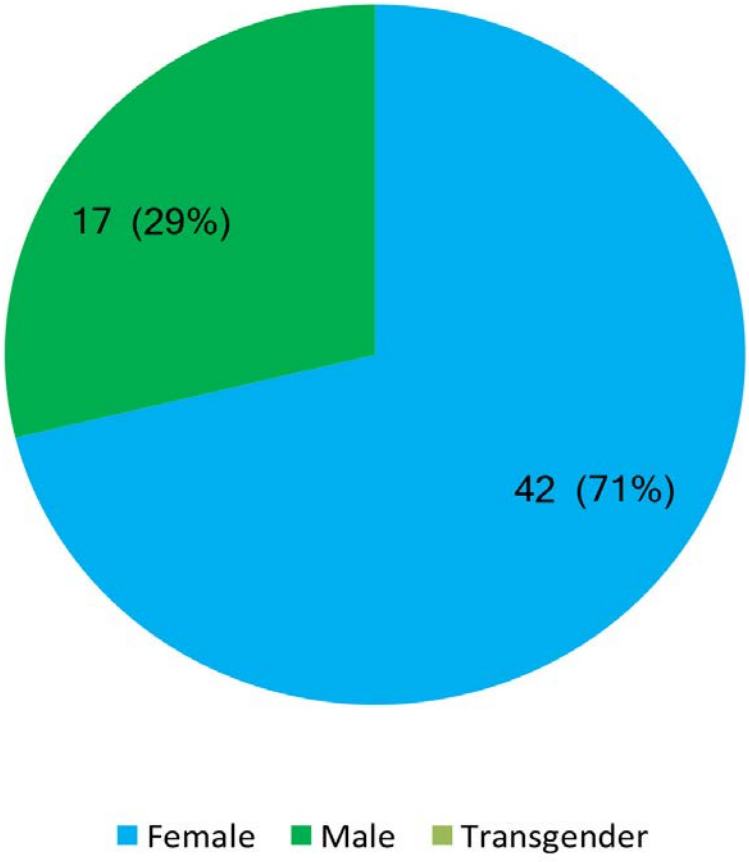


Figure 8: Educational Level Demographics of Survey Respondents
Total respondents = 61

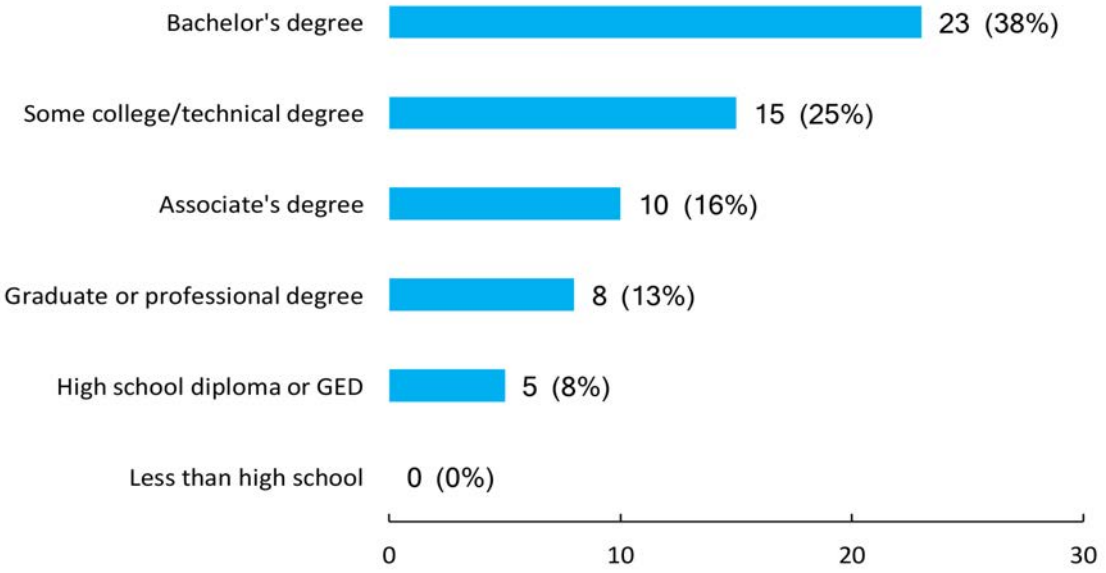
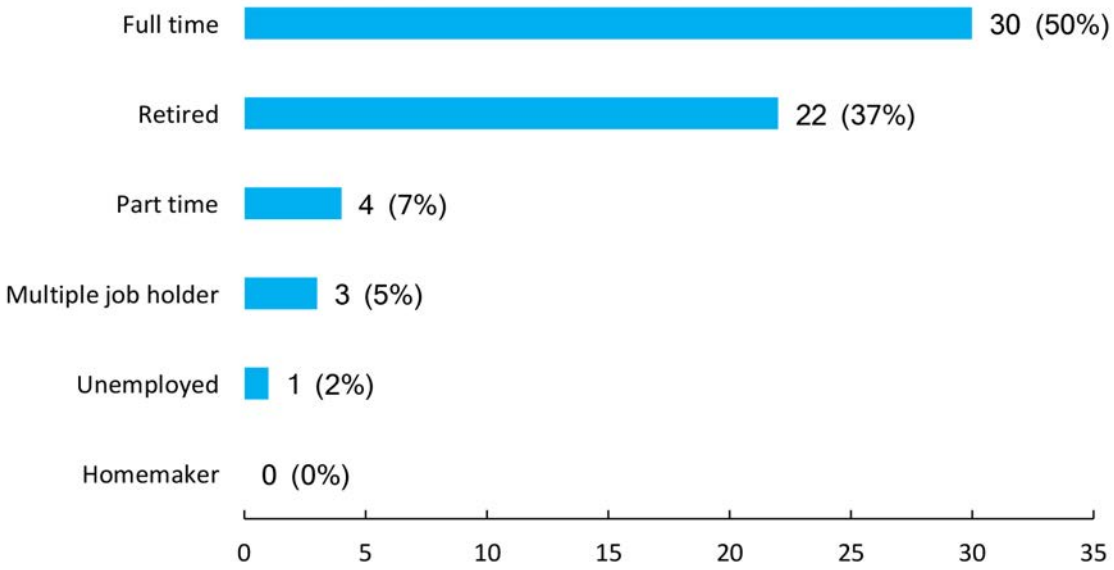
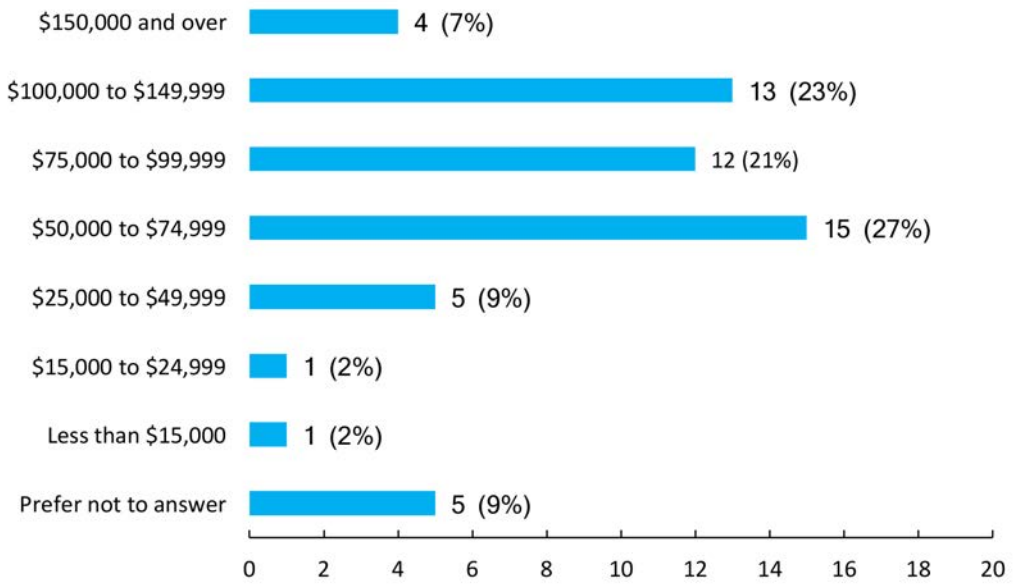


Figure 9: Employment Status Demographics of Survey Respondents
Total respondents = 60



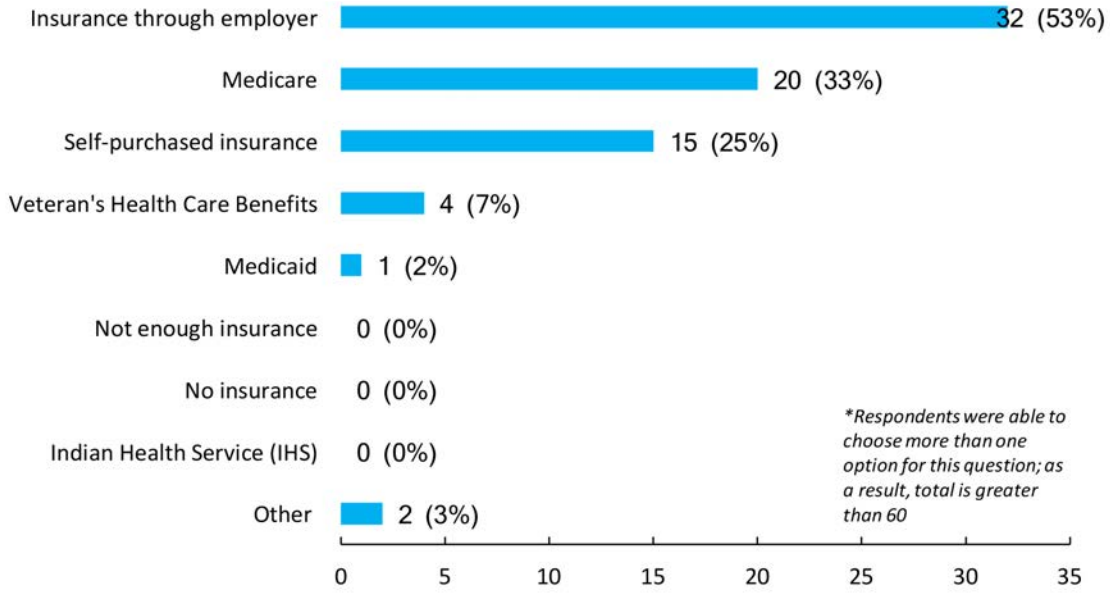
Of those who provided a household income, 4% (N=2) community members reported a household income of less than $25,000, 30% (N=17) indicated a household income of $100,000 or more. This information is show in Figure 10.

Figure 10: Household Income Demographics of Survey Respondents
Total respondents = 56



Community members were asked about their health insurance status, which is often associated with whether people have access to healthcare. None of the respondents reported having no health insurance or being under-insured. The most common insurance types were insurance through one's employer (N=32), followed by Medicare (N=20) and self-purchased (N=15).

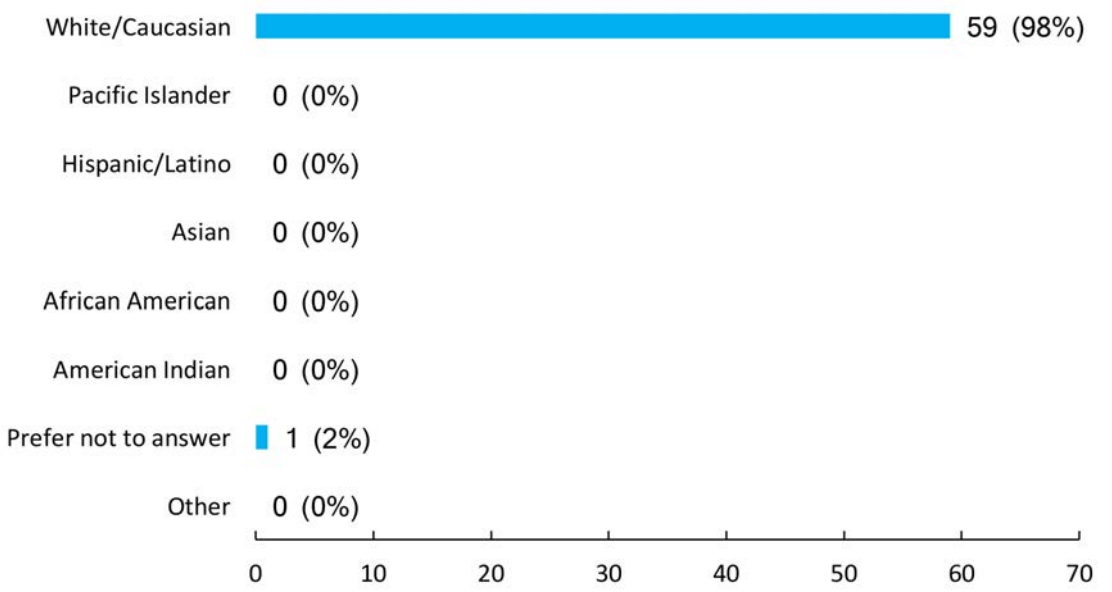
Figure 11: Health Insurance Coverage Status of Survey Respondents
Total respondents = 60



The two responses for the "Other" option were through spouse's retirement plan and via a medical sharing option.

As shown in Figure 12, all of the respondents that chose to answer were white/Caucasian (98%). This was significantly higher than the race/ethnicity of the overall population of Grand Forks County; the U.S. Census indicates that 86.5% of the population is white in Grand Forks County.

Figure 12: Race/Ethnicity Demographics of Survey Respondents
Total respondents = 60



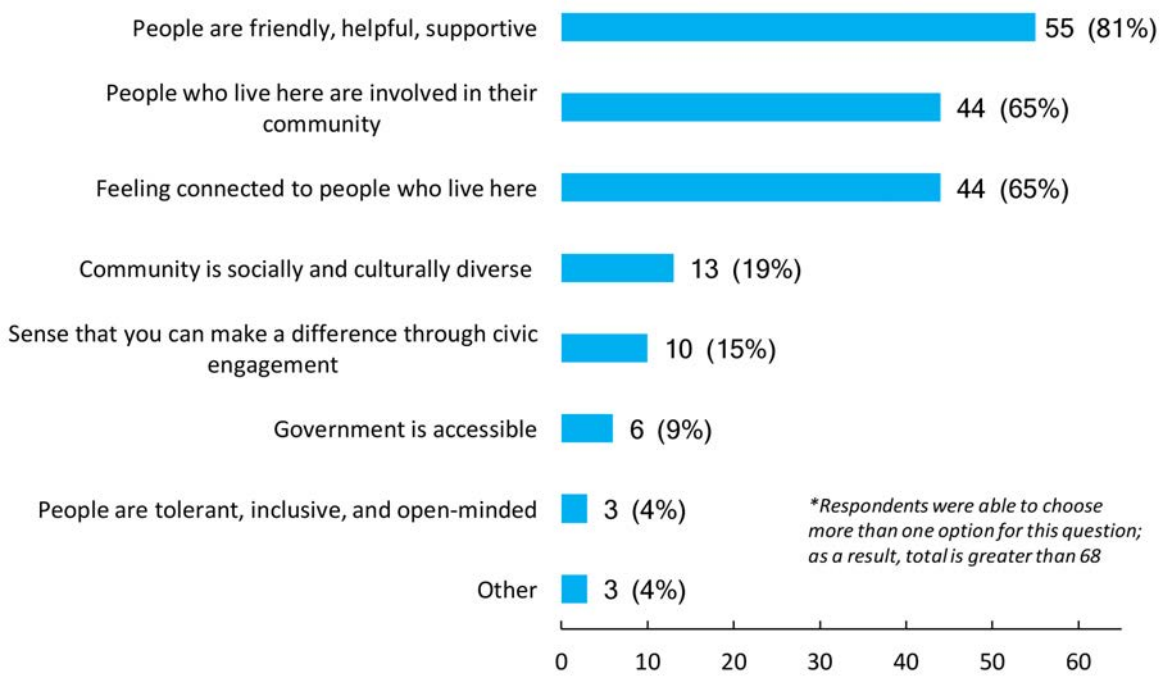
Community Assets and Challenges

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 50 respondents agreeing) that community assets include:

- Family-friendly (N=61);
- Healthcare (N=60);
- Quality school systems (N=56);
- People are friendly, helpful and supportive (N=55); and
- Safe place to live (N=50).

Figures 13 to 16 illustrate the results of these questions.

Figure 13: Best Things about the PEOPLE in Your Community
Total responses = 178



Included in the "Other" category of the best things about the people was that the faith community is strong and the community is a safe place to raise children.

Figure 14: Best Things about the SERVICES AND RESOURCES in Your Community
Total responses = 186

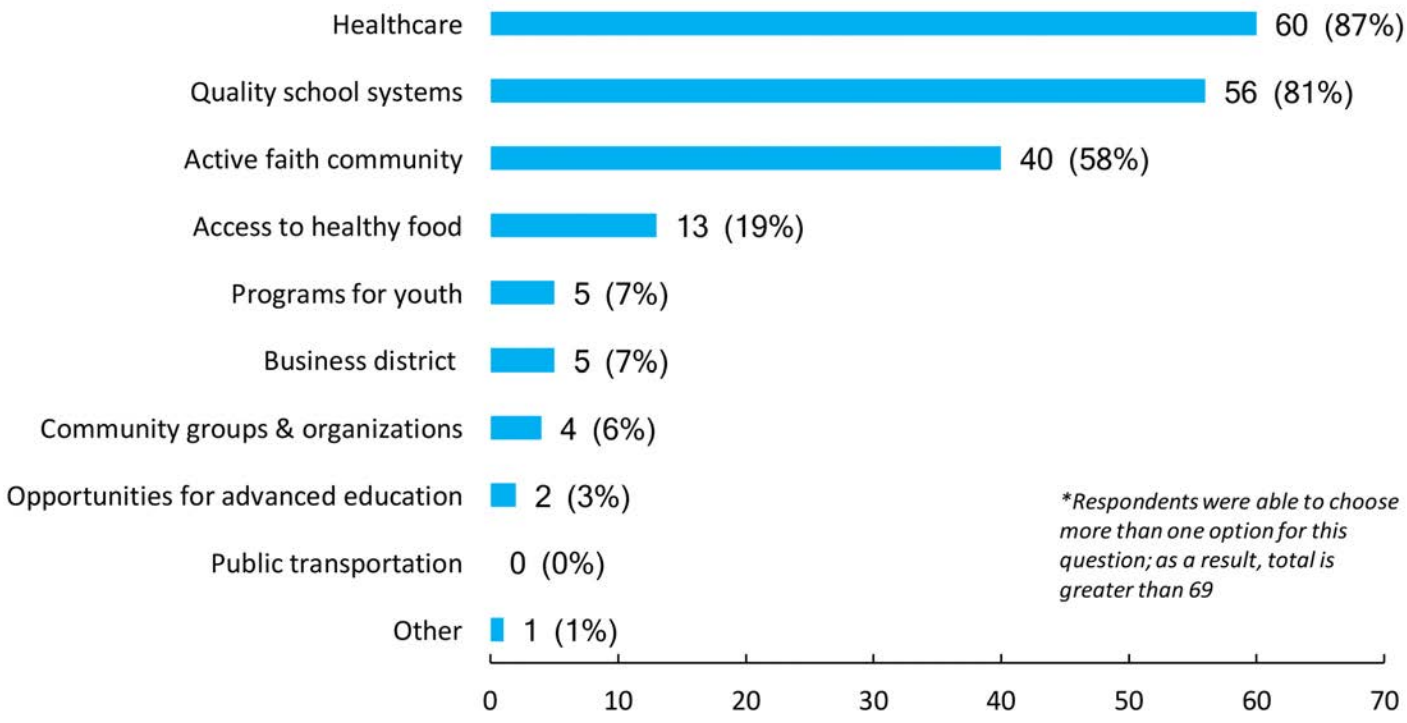
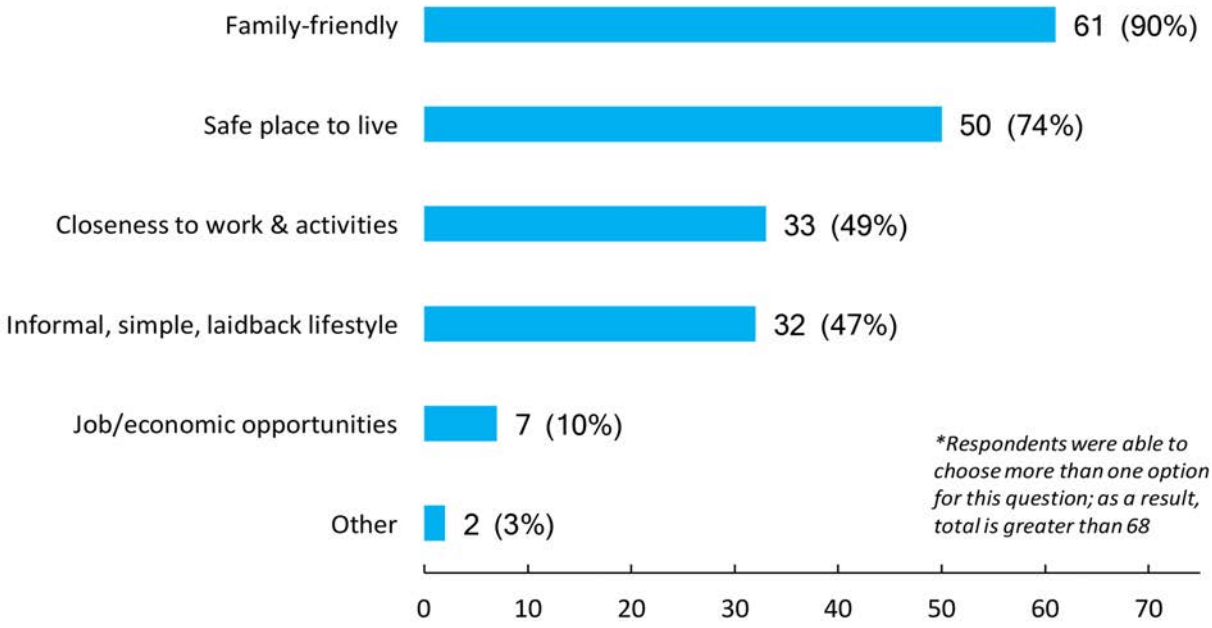
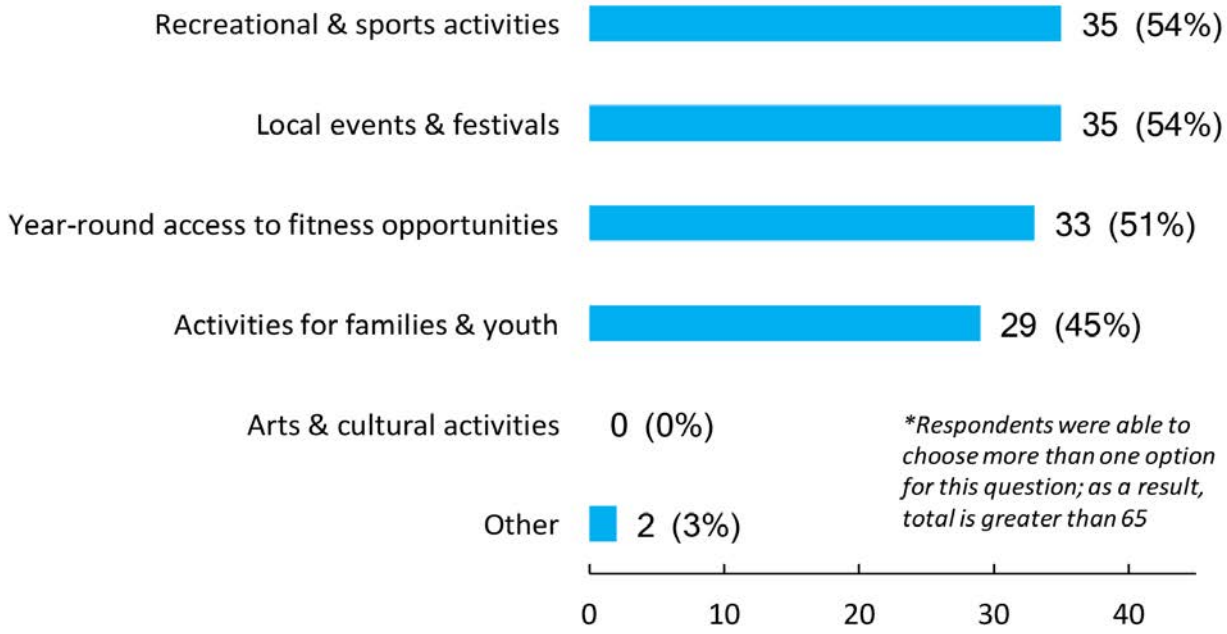


Figure 15: Best Things about the QUALITY OF LIFE in Your Community
Total responses = 185



The one "Other" response regarding the best things about the quality of life in the community was the park and pool.

Figure 16: Best Thing about the ACTIVITIES in Your Community
Total responses = 134



Respondents who selected "Other" specified that the best things about the activities in the community included fundraiser meals and social opportunities.

Community Concerns

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

- Community/environmental health
- Availability/delivery of health services
- Youth population
- Adult population
- Senior population

With regard to responses about community challenges, the most highly voiced concerns (those having at least 20 respondents) were:

- Cost of long-term/nursing home care (N= 35)
- Alcohol use and abuse – Youth (N=28)
- Drug use and abuse – Youth (N=27)
- Alcohol use and abuse – Adults (N=24)
- Availability of resources to help the elderly stay in their homes (N=23)
- Attracting and retaining young families (N=22)
- Not enough jobs with livable wages/not enough to live on (N=21)
- Smoking and tobacco use, exposure to second-hand smoke, or vaping (N=21)
- Drug use and abuse – Adults (N=21)
- Cost of health insurance (N=20)
- Depression/anxiety – Adults (N=20)

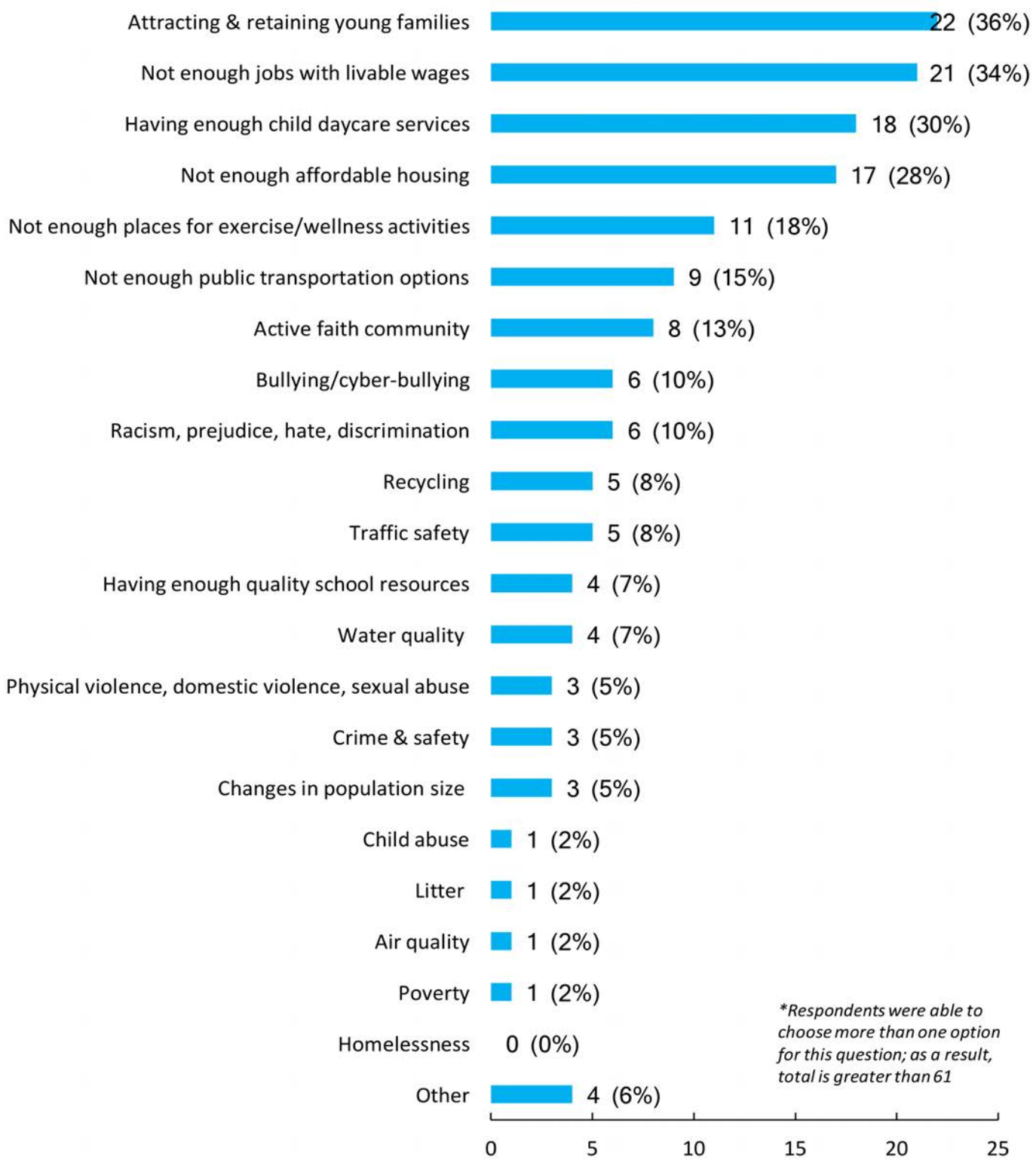
The other issues that had at least 15 votes included:

- Depression/anxiety – Youth (N=19)
- Not getting enough exercise/physical activity – Adults (N=19)
- Having enough child daycare services (N=18)
- Availability of transportation for seniors (N=17)
- Not enough affordable housing (N=17)
- Availability of mental health services (N=15)
- Availability of dental care (N=15)
- Stress – Adults (N=15)

Figures 17 through 21 illustrate these results.

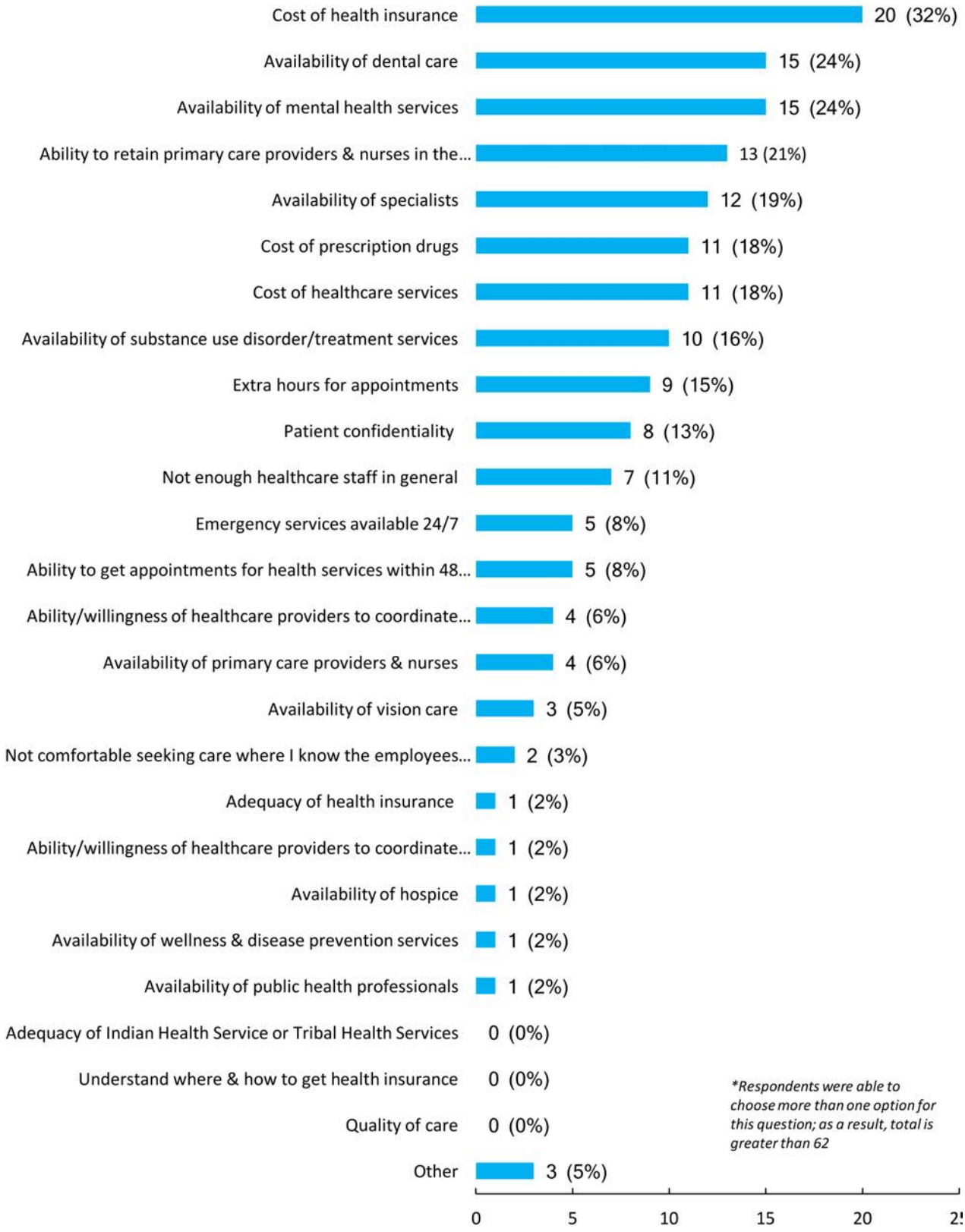
Figure 17: Community/Environmental Health Concerns

Total responses = 153



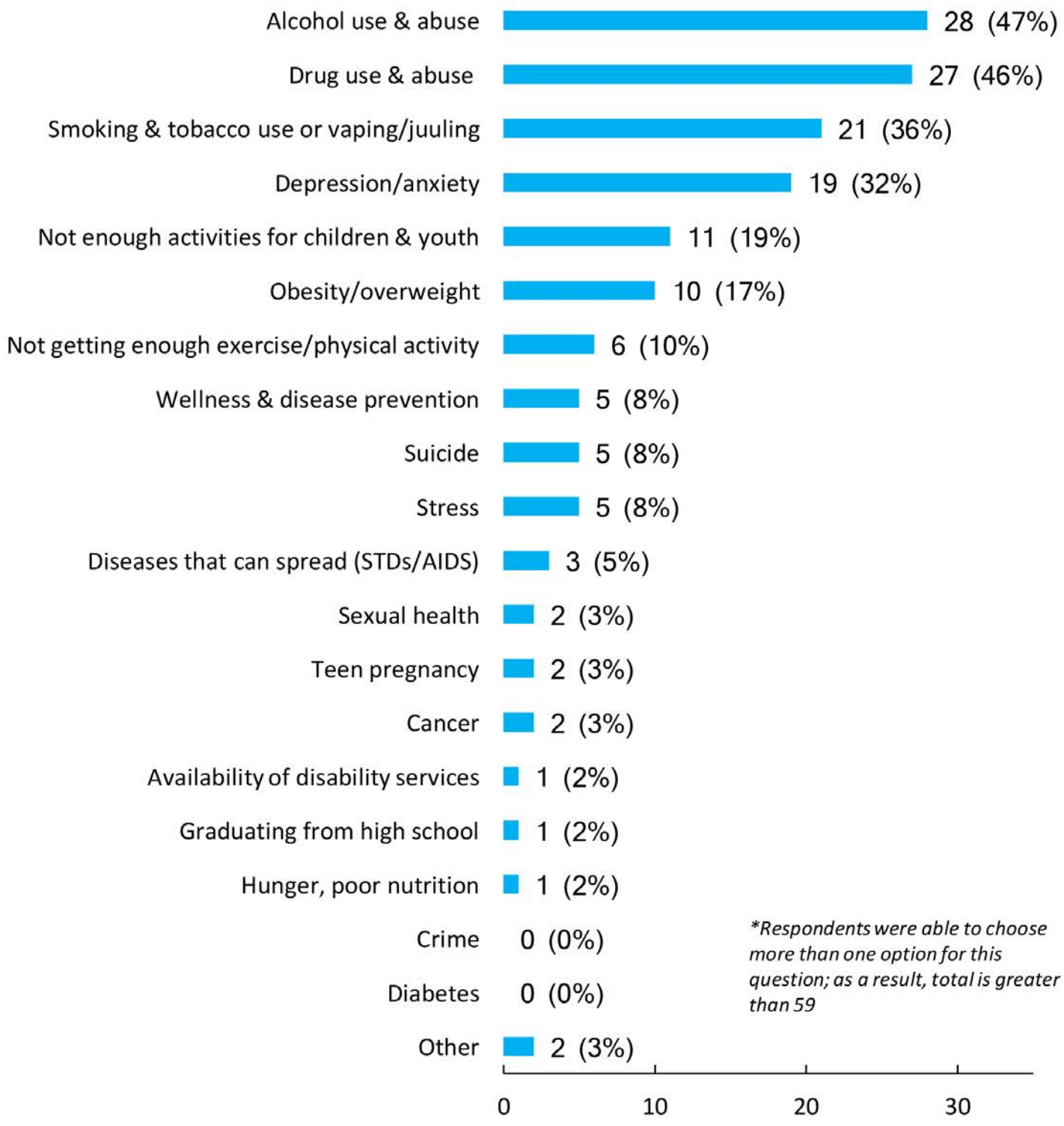
In the "Other" category for community and environmental health concerns, the following were listed: drug problem, mental health services, street safety/road quality, and a request for group fitness or personal trainers.

Figure 18: Availability/Delivery of Health Services Concerns
Total responses = 162



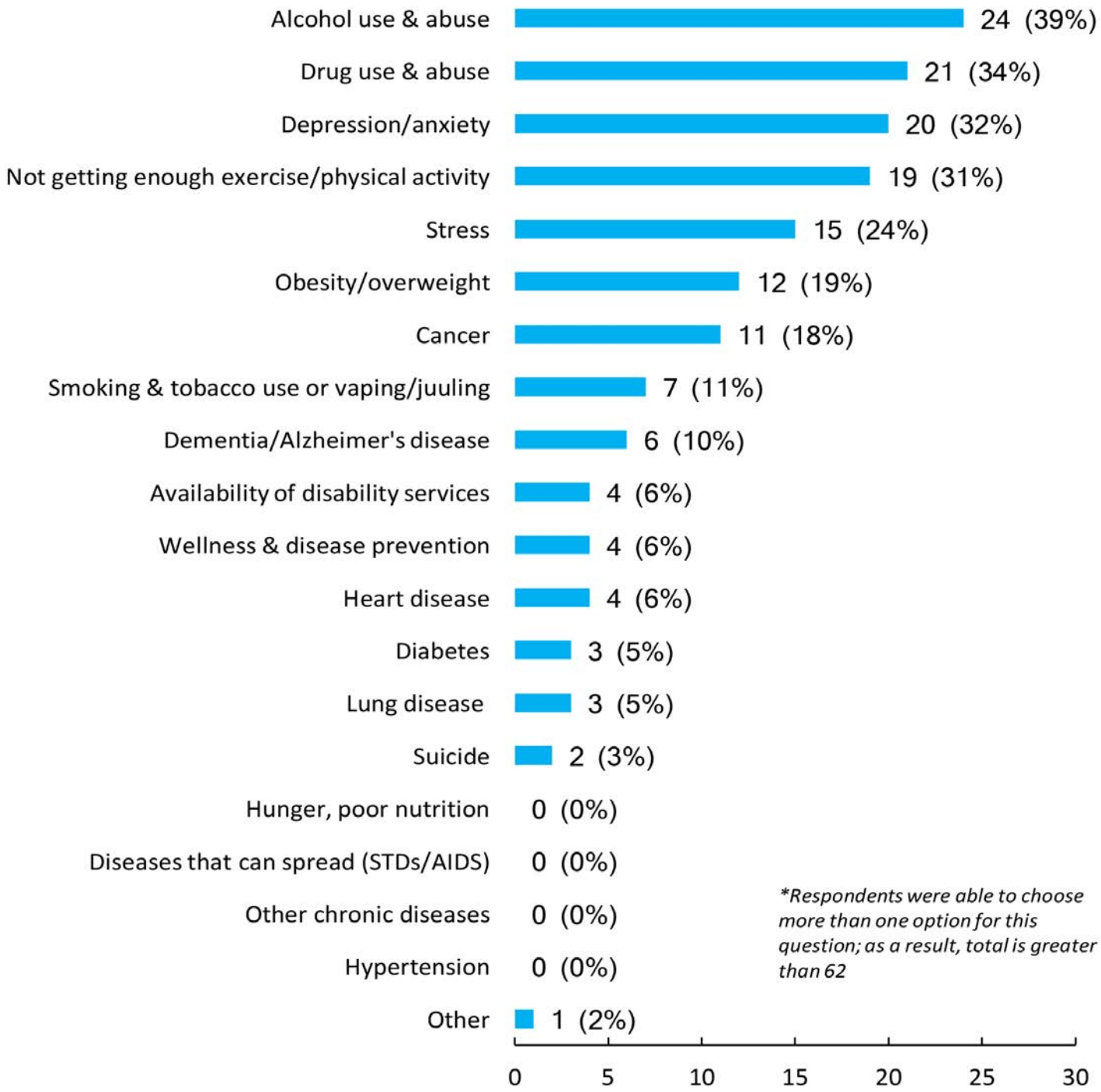
Respondents who selected "Other" identified concerns in the availability/delivery of health services as lack of MDs in the area and providers not responding to ER calls in a timely manner.

Figure 19: Youth Population Health Concerns



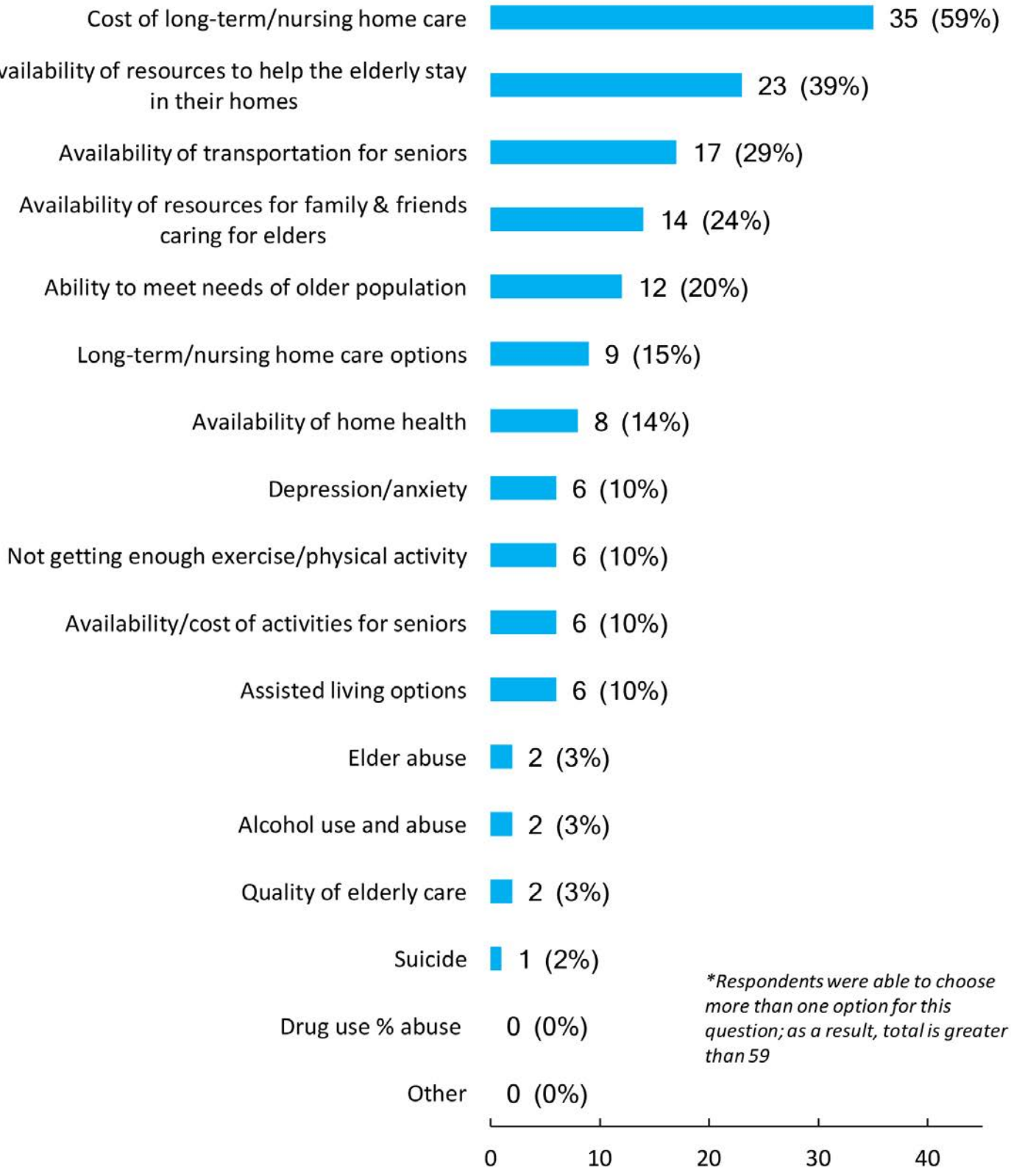
Listed in the "Other" category for youth population concerns were work ethic and homeschooled families being disconnected from the community.

Figure 20: Adult Population Concerns
Total responses = 156



The lone response in the "Other" category for adult population concerns was mental health.

Figure 21: Senior Population Concerns
Total responses = 149



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. Retaining young families
2. Drug use

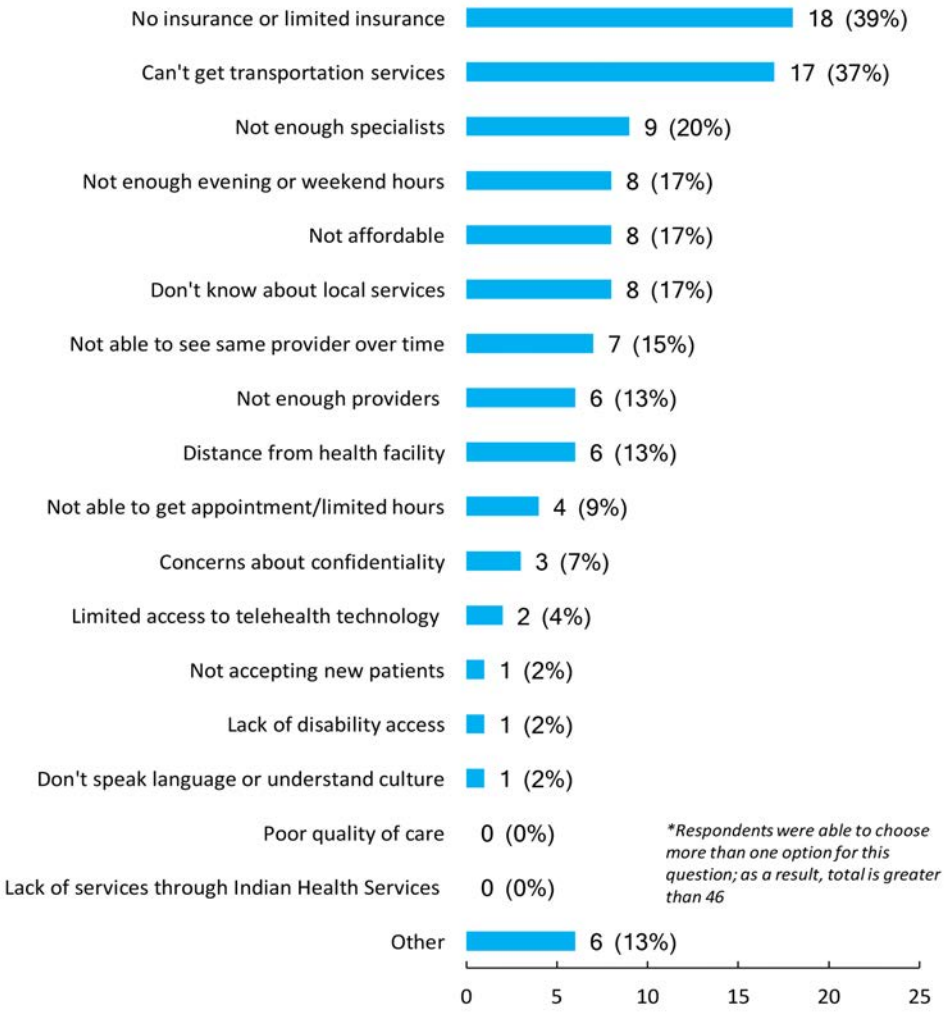
Other biggest challenges that were identified were a declining population, issues with city officials, long-term care for the elderly, not enough smaller homes for the elderly, retaining healthcare providers, transportation issues and street conditions.

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 having no or limited insurance (N=18), with the next highest being inability to get transportation services (N=17). After these, the next most commonly identified barriers were not having enough specialists (N=9), not enough evening or weekend hours (N=8), and not being affordable (N=8). The majority of concerns indicated in the "Other" category were in regards to not being able to see a medical doctor as opposed to a nurse practitioner.

Figure 22 illustrates these results.

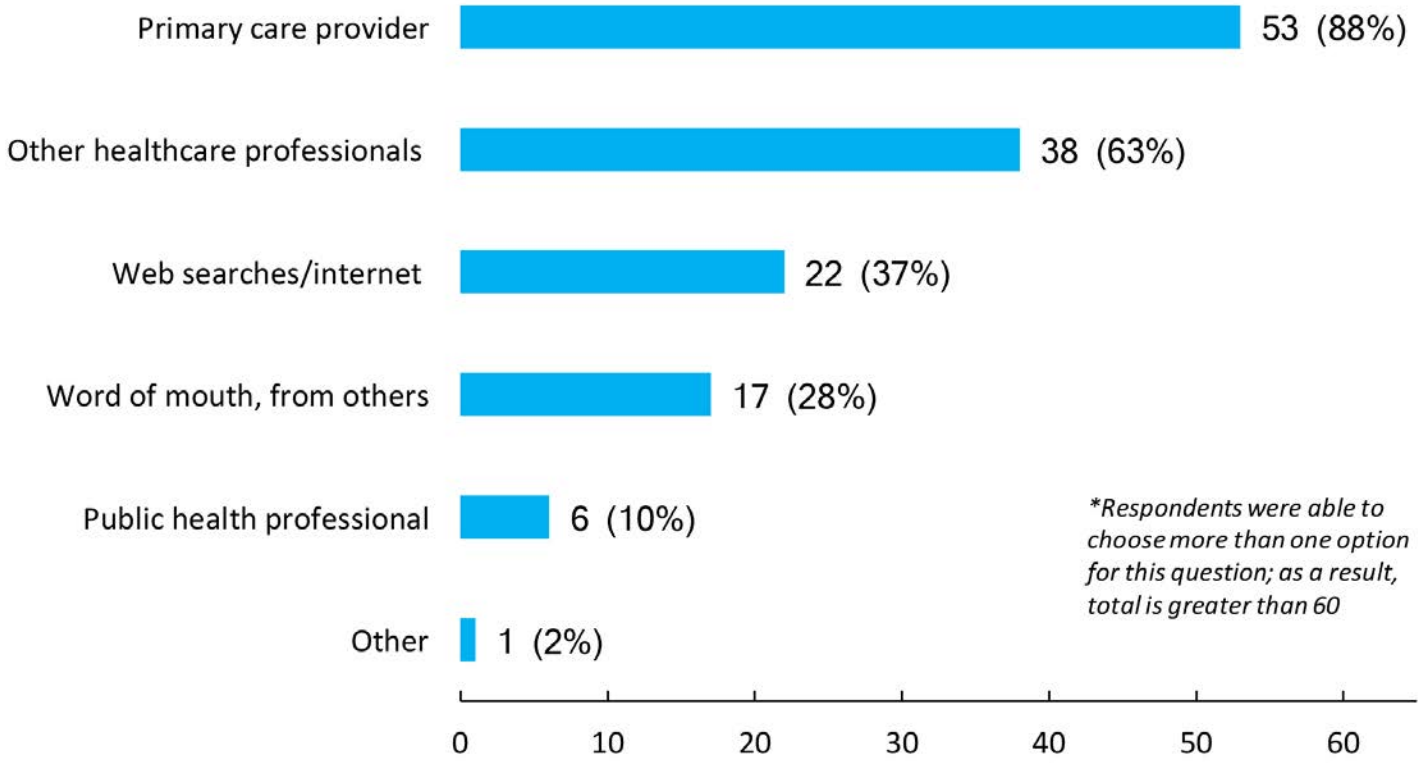
Figure 22: Perceptions about Barriers to Care
Total responses = 105



The "Other" category for this question revealed responses linked to out-of-pocket cost, conflicts with providers, and the desire to be seen by a medical doctor instead of a nurse practitioner.

Figure 23 shows the results from respondents being asked where they turn for trusted health information.

Figure 23: Sources of Trusted Health Information
Total responses = 105



In an open-ended question, respondents were asked what specific healthcare services, if any, they think should be added locally. The number one desired service to add locally was mental health services.

- Cardiology
- Dental services
- Dialysis
- Home healthcare
- Mental health services
- Dermatology (more than once a month)
- Nursing home care
- Optometry
- Orthopedics
- Pediatrics
- Psychiatry

Dental services was the clear runner up to mental health for services to add locally. One person indicated that the community would benefit from adding one additional MD and FNP, and another respondent felt that NDHC offers an adequate number of services, but residents are unaware of what is available.

The key informant and focus group members felt there were a number of services that the community may be unaware of and could use increased marketing. These services included speech therapy, endoscopy / colonoscopy, massage therapy, occupational therapy, bone density, and respiratory therapy.

Figure 24 shows the results from asking respondents to prioritize services should NDHC consider adding them.

Figure 24: Perceptions about Barriers to Care
Total responses = 407

Additional Service	High Priority	Moderate Priority	Low priority	Total Respondents
Cancer/chemotherapy	27 (49%)	20 (36%)	8 (15%)	55
Dialysis	30 (56%)	18 (33%)	6 (11%)	54
Varicose vein diagnosis/treatment	2 (4%)	17 (33%)	33 (65%)	51
Orthopedics	7 (13%)	28 (53%)	18 (34%)	53
Cardiology	28 (53%)	21 (40%)	5 (9%)	53
Urology	9 (17%)	33 (63%)	10 (19%)	52
Oncology	11 (22%)	32 (64%)	7 (14%)	50
Dental	12 (31%)	13 (36%)	13 (33%)	39

Considering a variety of services offered at NDHC, the survey asked community members which services they are aware of and if they have used those services locally or elsewhere (Figures 25-28).

Figure 25: Awareness/Utilization of Hospital/Clinic Services
Total responses = 485

Hospital/Clinic Services	Awareness	Used Locally	Use Elsewhere	Total Respondents
Clinic	24 (41%)	48 (81%)	14 (24%)	59
Emergency room	28 (47%)	39 (66%)	14 (24%)	59
Dermatology	27 (54%)	18 (36%)	17 (34%)	50
Colonoscopy/endoscopy	27 (53%)	9 (18%)	22 (43%)	51
Hospital inpatient	30 (55%)	19 (35%)	18 (33%)	55
Hospital swing bed	42 (86%)	7 (14%)	2 (4%)	49
Adult day care	36 (92%)	4 (10%)	1 (3%)	39
Respite care	37 (93%)	5 (13%)	1 (3%)	40
Medical life alert	40 (89%)	5 (11%)	1 (2%)	45
Telemedicine	34 (89%)	3 (8%)	2 (5%)	38

Figure 26: Awareness/Utilization of Screening/Therapy Services
Total responses = 432

Screening/Therapy Services	Awareness	Used Locally	Used Elsewhere	Total Respondents
Diabetes education	26 (66%)	12 (31%)	2 (5%)	39
Weight management	26 (68%)	10 (26%)	6 (16%)	38
Laboratory services	22 (39%)	45 (80%)	13 (23%)	56
Physical therapy	25 (48%)	35 (67%)	4 (8%)	52
Occupational therapy	36 (82%)	10 (23%)	1 (3%)	44
Speech therapy	35 (85%)	5 (12%)	3 (7%)	41
Cardiac/pulmonary rehab	37 (84%)	5 (11%)	4 (9%)	44
Sports physicals (children)	29 (67%)	20 (47%)	4 (9%)	43
Men's health days	33 (87%)	10 (26%)	0 (0%)	38
Women's health days	32 (86%)	8 (22%)	2 (5%)	37

Figure 27: Awareness/Utilization of Screening/Therapy Services
Total responses = 337

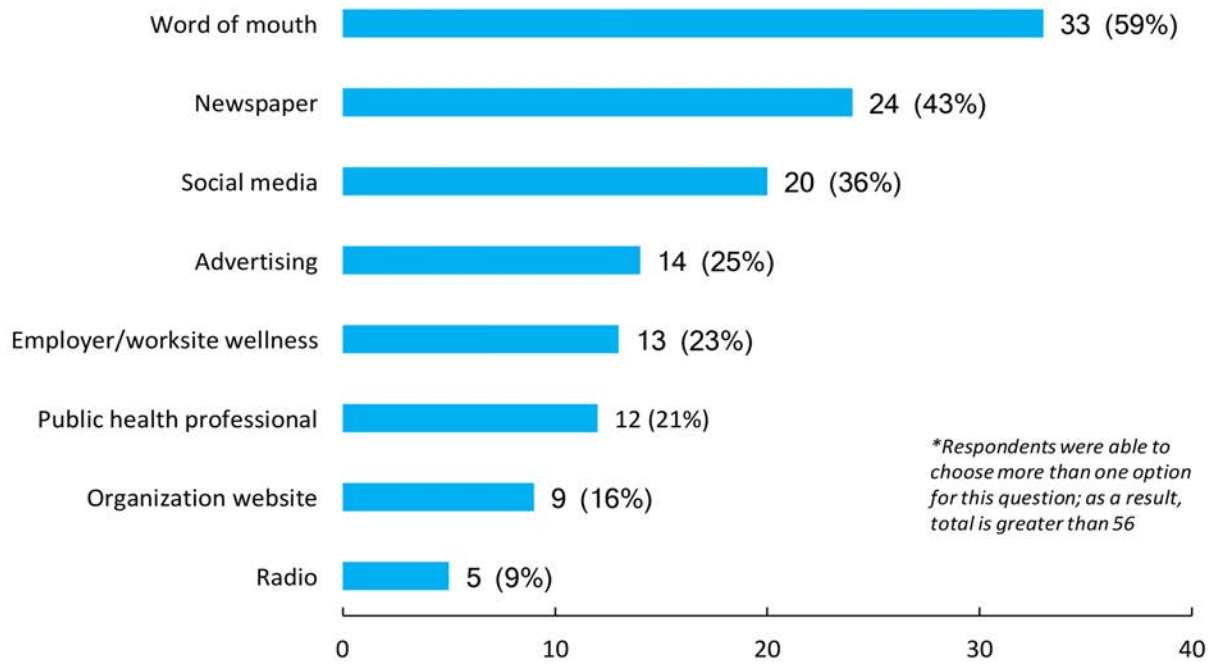
Radiology Services	Awareness	Used Locally	Used Elsewhere	Total Respondents
EKG	27 (59%)	16 (35%)	11 (24%)	46
CT	29 (62%)	13 (28%)	10 (21%)	47
MRI	24 (48%)	19 (38%)	17 (34%)	50
General x-ray	21 (41%)	37 (73%)	11 (22%)	51
Mammography	33 (63%)	22 (42%)	14 (27%)	52
Ultrasound	25 (51%)	18 (37%)	21 (43%)	49
Bone density	29 (69%)	13 (31%)	4 (10%)	42

Figure 28: Awareness/Utilization of Screening/Therapy Services
Total responses = 236

Other Community Providers	Awareness	Used Locally	Used Elsewhere	Total Respondents
Chiropractic	29 (54%)	35 (65%)	8 (15%)	54
Hospice	39 (91%)	3 (7%)	2 (5%)	43
Massage therapy	31 (69%)	17 (38%)	7 (16%)	45
Home health	35 (85%)	6 (15%)	5 (12%)	41
Optometry/vision care	27 (51%)	21 (40%)	21 (40%)	53

In order to gauge the most effective channels for disseminating information about services offered by NDHC, respondents were asked where they find out about local health services available in their area (Figure 29).

Figure 29: Sources of Local Health Information
Total responses = 130



Figures 30-32 show the results from asking respondents if they receive healthcare locally and, if not, where and why they receive healthcare elsewhere.

Figure 30: Individuals Receiving Clinic Care Locally
Total responses = 61

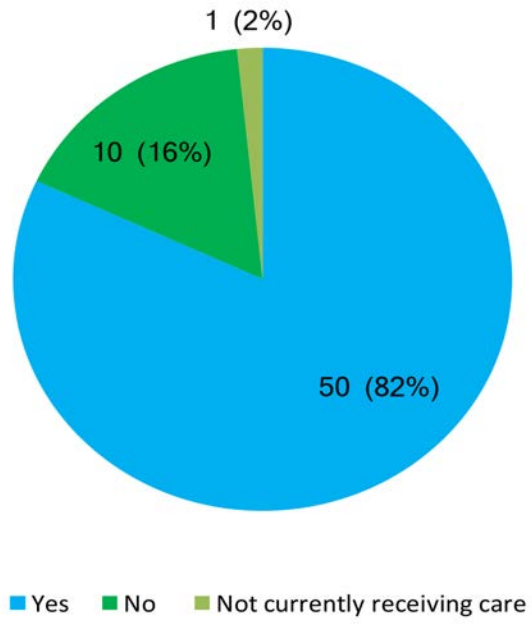
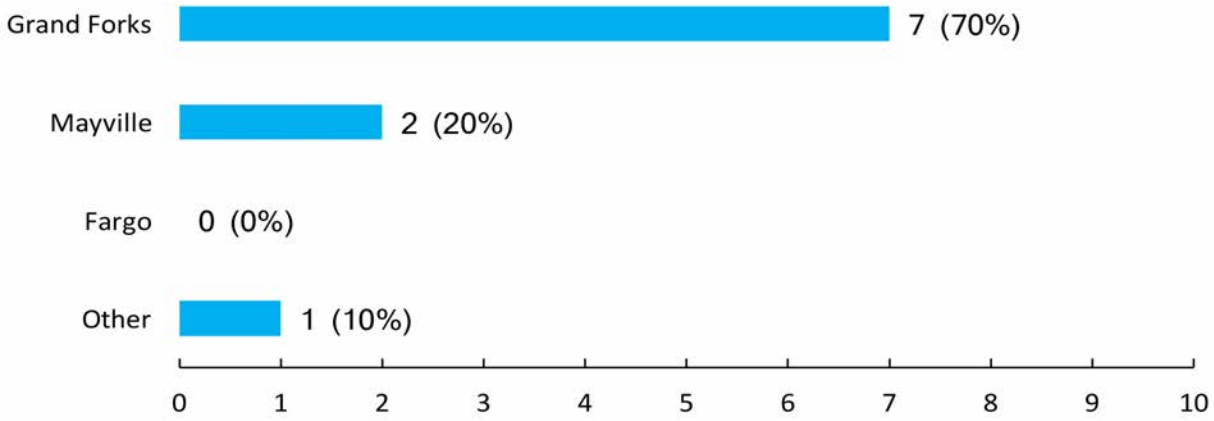
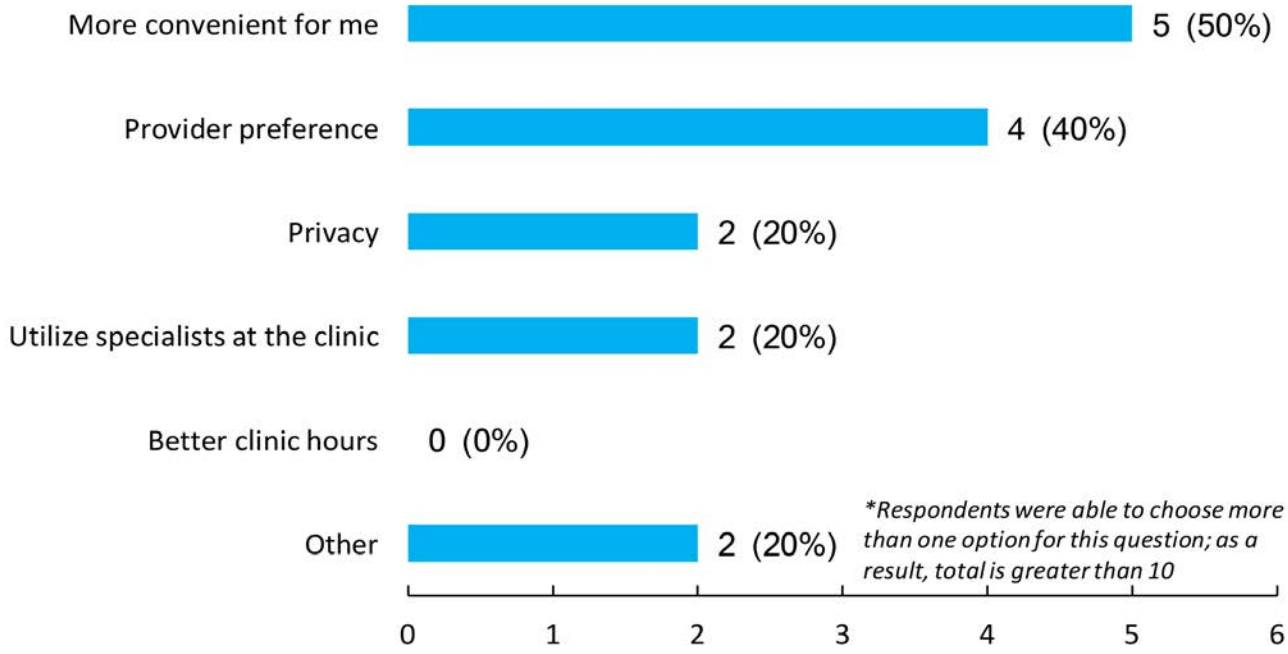


Figure 31: Where Care is Received Outside the Local Community
Total responses = 10



The sole response in the "Other" category was Arizona.

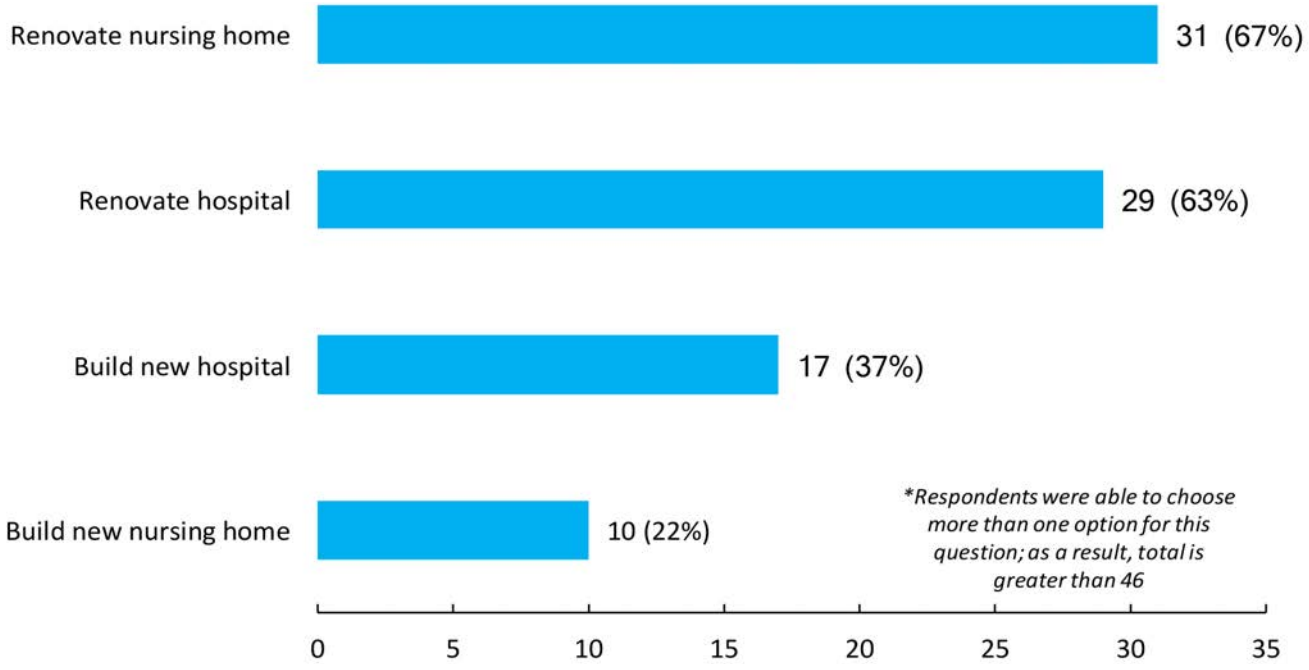
Figure 32: Why Care is Received Elsewhere
Total responses = 15



Respondents who filled out the "Other" section for why they receive healthcare elsewhere stated that they work out of town and that they have a strong relationship with their provider outside of the local area.

When considering a capital fund drive, community members were given several options and asked which they would be most likely to support financially (Figure 33).

Figure 33: Initiatives Supported for a Capital Fund Drive
Total responses = 87



Several questions dealt with prioritizing senior housing needs, as well as preferences towards purchasing or renting new builds and the associated costs, illustrated in Figures 34-37.

Figure 34: Grading Housing Needs
Total responses = 106

Housing Needs	High priority	Moderate priority	Low priority	Total Respondents
Additional assisted living apartments	21 (40%)	27 (51%)	5 (10%)	53
Senior independent living apartments	23 (43%)	25 (47%)	6 (11%)	53

Figure 35: Preference for Senior Housing off NDHC Campus
Total responses = 57

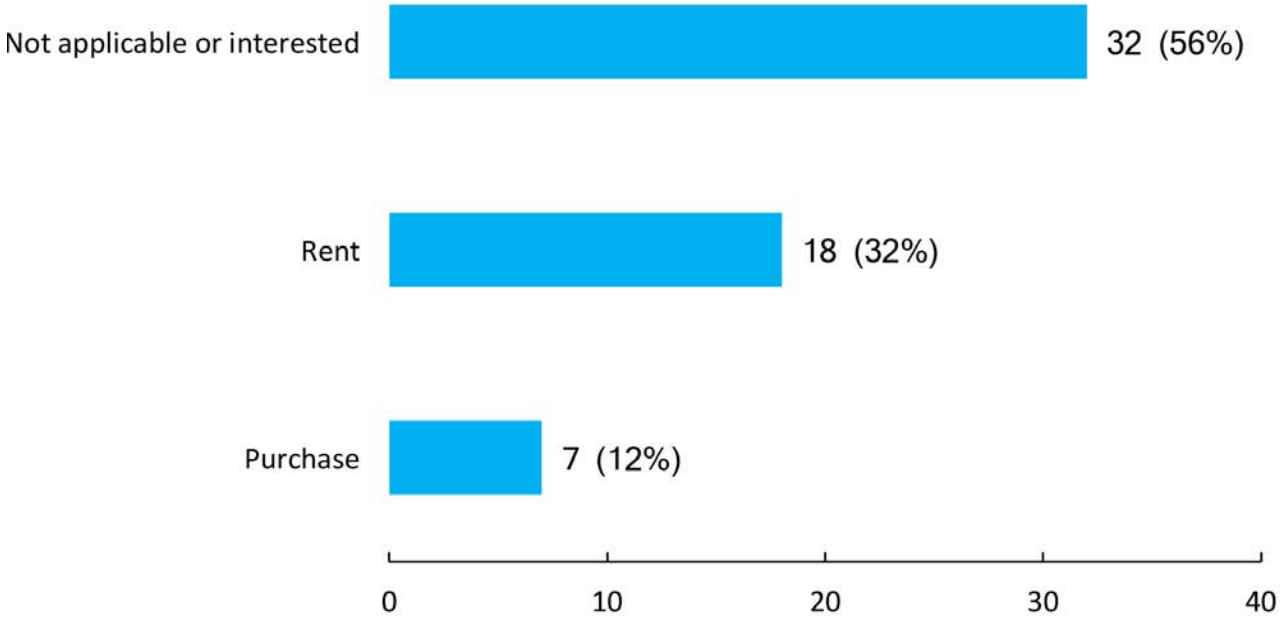


Figure 36: Amount Individuals Would Pay for a New Build
Total responses = 57

**Respondents were able to choose more than one option for this question; as a result, total is greater than 7*

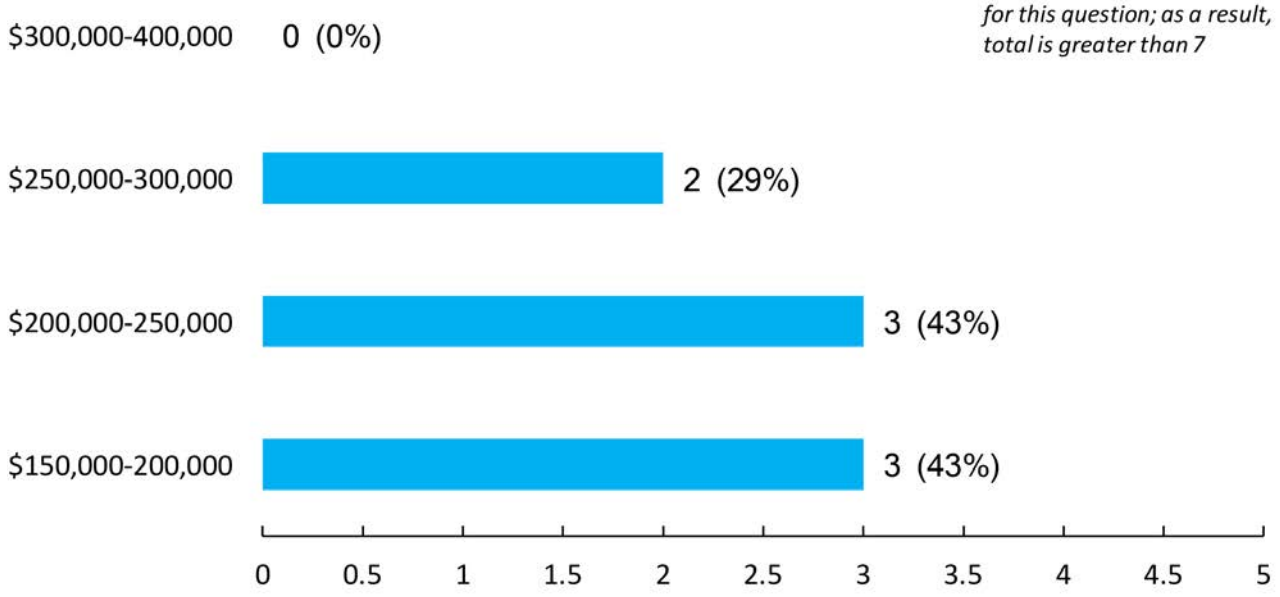
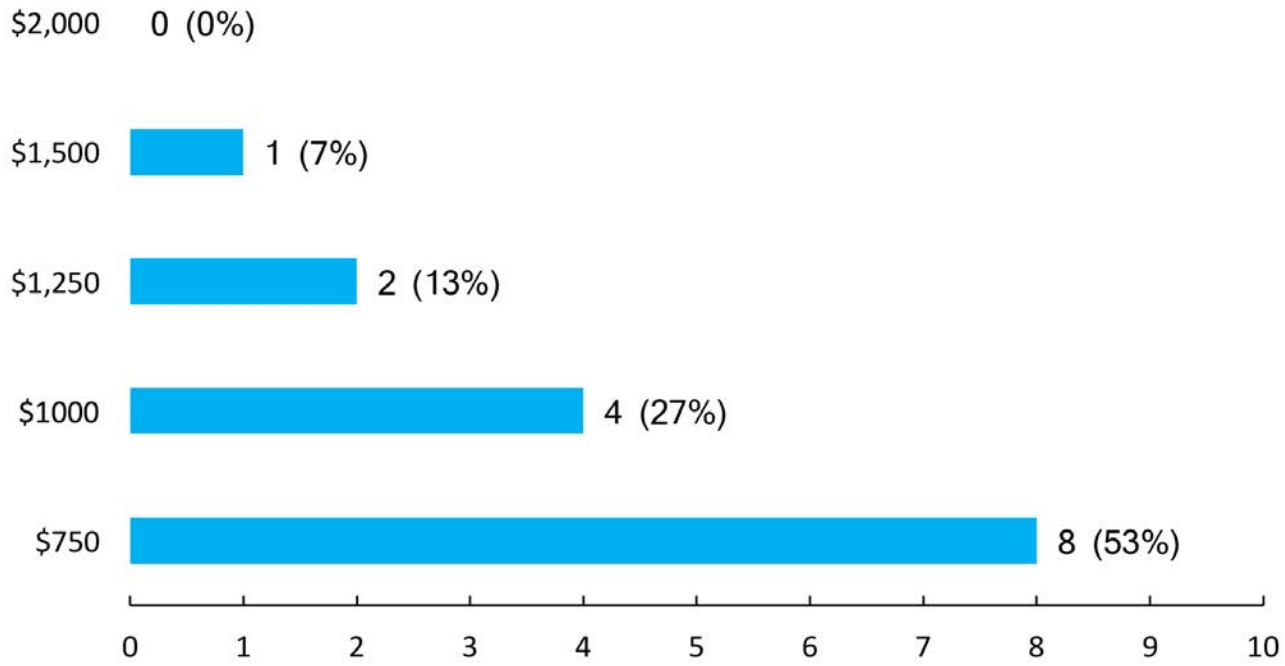


Figure 37: Amount Individuals Would Pay in Monthly Rent
Total responses = 57



The final question on the survey asked respondents to share concerns and suggestions to improve the delivery of local healthcare. While the responses covered a variety of areas, a theme throughout the comments was the concern over the availability of healthcare/providers. Comments about lack of staff were common throughout the survey, but in this particular area, some respondents feel that more providers need to be added, while others point out that the response time of doctors to the ER is lacking.

Building changes were also mentioned, citing a need to extend, renovate or build an entirely new nursing home. Some also feel the main hospital requires the same treatment, while others wanted to see an exercise room added.

Several community members lauded the amount of services offered, but the marketing of these services was also alluded to as a concern. Some respondents feel that the community is unaware of what NDHC offers, so members seek healthcare outside of the area instead of choosing local services. The same commenters were generally pleased with what was offered, especially for the size of the community, but thought the community should be more aware of what is going on at the hospital.

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 four categories (listed in alphabetical order):

- Ability to retain primary care providers (MD, DO, NP, PA) and nurses in the community
- Availability of mental health services
- Drug use and abuse – Youth
- Smoking and tobacco use, exposure to second-hand smoke, or vaping – Youth

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

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

- It would be nice to see more services brought in, but you have to have the staff for that
- Know from personal experience—we can't try other specialties without adequate staff
- If we don't have depth of providers, we can't address all of the issues

Availability of mental health and substance use disorder treatment services

- Mental health services are necessary, for both youth and adults, because it is such a big issue lately
- Mental health is a huge overlooked issue, and it's a problem that stems into many other issues

Drug use and abuse

- To me, educating these kids about the dangers of substance abuse and how one-time mistakes can become a lifetime of pain should be a priority
- State's attorney and county coroner and police attended a community forum, opening my eyes to a lot of the drug-related issues in the area

Smoking, exposure to second-hand smoke, or vaping

- Students are naïve to the dangers of vaping/juuling; we need to get it under control
- Vaping was brought up as well as a challenge for the schools and issues with the kids, even deaths (not locally)

Community Engagement and Collaboration

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

- Emergency services, including ambulance and fire (4.75)
- Schools (4.5)
- Hospital (healthcare system) (4.25)
- Pharmacy (4.25)
- Long-term care, including nursing homes and assisted living (4.25)
- Public Health (4.0)
- Economic development organizations (4.0)
- Faith-based (4.0)
- Law enforcement (4.0)
- Business and industry (3.75)
- Social Services (3.75)
- Clinics not affiliated with the main health system (3.75)
- Other local health providers, such as dentists and chiropractors (3.5)
- Human services agencies (3.25)

Priority of Health Needs

A community group met on October 24, 2019. Twelve community members attended the meeting. Representatives from the CRH presented the group with a summary of this report's findings, including background and explanation about the secondary data, highlights from the survey results (including perceived community assets and concerns, and barriers to care), and findings from the key informant interviews.

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

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

- Cost of health insurance (6 votes)
- Ability to retain primary care providers (4 votes)
- Attracting and retaining young families (3 votes)

- Cost of long-term/nursing home care (3 votes)
- Depression/anxiety – Adults (3 votes)
- Depression/anxiety – Youth (3 votes)
- Smoking and tobacco use, exposure to second-hand smoke, or vaping – Youth (3 votes)

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

1. Cost of health insurance (5 votes)
2. Attracting and retaining young families (2 votes)
3. Depression/anxiety – Youth (2 votes)
4. Depression/anxiety – Adults (1 vote)

Following the prioritization process during the second meeting of the Community group and key informants, the number one identified need was the cost of health insurance. A summary of this prioritization may be found in Appendix D.

Comparison of Needs Identified Previously

Top Needs Identified 2016 CHNA Process	Top Needs Identified 2019 CHNA Process
• Ability to recruit and retain primary care providers • Youth drug use and abuse • Attracting and retaining young families • Obesity/overweight	• Cost of health insurance • Attracting and retaining young families • Depression/anxiety – Youth & Adults

The current process saw one need carry over from the last CHNA in "Attracting and retaining young families." While the rest of the current needs differ from the last process, there is a possible link between drug use (2016 CHNA) and depression (current CHNA), which was recognized as being an issue for both youth and adults.

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

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

Need 1: Ability to recruit and retain primary care providers – Implemented the Epic program for electronic medical record system and signed a family practice physician to begin practice in August of 2020.

Need 2: Youth drug use and abuse – Increased the use of screening tools in the emergency room and in the clinic to identify abuse issues.

Need 3: Attracting and retaining young families – The NDHC CEO participates in economic development for the community, and has worked with local business individuals to build new homes and add a housing incentive from Economic Development as well as local businesses.

Need 4: Obesity/overweight – A Men's Health event was implemented each March, increasing emphasis on the fitness center. Senior fitness programs at the fitness center have also been ongoing.

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 – CHNA Survey Instrument

Appendix A – CHNA Survey Instrument

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

Northwood Deaconess Health Center

Northwood Area Health Survey

Northwood Deaconess Health Center is interested in hearing from you about community health concerns.

The focus of this effort is to:

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

If you prefer, you may take the survey online at http://tinyurl.com/NorthwoodND19 or by scanning on the QR Code at the right.

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

Surveys will be accepted through September 2, 2019. Your opinion matters – thank you in advance!

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

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

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

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

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

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

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

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

- ☐ Activities for families and youth
- ☐ Arts and cultural activities
- ☐ Local events and festivals
- ☐ Recreational and sports activities
- ☐ Year-round access to fitness opportunities
- ☐ Other: (please specify) _____

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

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

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

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

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

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

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

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

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

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

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

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

_____

_____

Delivery of Healthcare

11. 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) _____

12. 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) _____

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

_____

_____

14. If NDHC were to consider adding or hosting additional services, please grade the following:

SERVICE	High priority	Moderate priority	Low priority
Cancer/chemotherapy	☐	☐	☐
Dialysis	☐	☐	☐
Varicose vein diagnosis/treatment	☐	☐	☐
Orthopedics	☐	☐	☐
Cardiology	☐	☐	☐
Urology	☐	☐	☐
Oncology	☐	☐	☐
Dental	☐	☐	☐

15. Considering the following **HOSPITAL/CLINIC SERVICES**, which services are you aware of, have used locally, or used elsewhere? (Choose ALL that apply)

SERVICE	Aware of	Used locally	Used elsewhere
Clinic	☐	☐	☐
Emergency room	☐	☐	☐
Dermatology	☐	☐	☐
Colonoscopy/endoscopy	☐	☐	☐
Hospital inpatient	☐	☐	☐
Hospital swing bed	☐	☐	☐
Adult day care	☐	☐	☐
Respite care	☐	☐	☐
Medical life alert	☐	☐	☐
Telemedicine	☐	☐	☐

16. Considering the following **SCREENING/THERAPY SERVICES**, which services are you aware of, have used locally, or used elsewhere? (Choose ALL that apply)

SERVICE	Aware of	Used locally	Used elsewhere
Diabetes education	☐	☐	☐
Weight management	☐	☐	☐
Laboratory services	☐	☐	☐
Physical therapy	☐	☐	☐
Occupational therapy	☐	☐	☐
Speech therapy	☐	☐	☐
Cardiac/pulmonary rehab	☐	☐	☐
Sports physicals (children)	☐	☐	☐
Men's health days	☐	☐	☐
Women's health days	☐	☐	☐

17. Considering the following **RADIOLOGY SERVICES**, which services are you aware of, have used locally, or used elsewhere? (Choose ALL that apply)

SERVICE	Aware of	Used locally	Used elsewhere
EKG	☐	☐	☐
CT	☐	☐	☐
MRI	☐	☐	☐
General x-ray	☐	☐	☐
Mammography	☐	☐	☐
Ultrasound	☐	☐	☐
Bone density	☐	☐	☐

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

SERVICE	Aware of	Used locally	Used elsewhere
Chiropractic	☐	☐	☐
Hospice	☐	☐	☐
Massage therapy	☐	☐	☐
Home health	☐	☐	☐
Optometry/vision care	☐	☐	☐

19. Where do you find out about **LOCAL HEALTH SERVICES** available in your area?

☐ Advertising ☐ Public Health professional ☐ Word of mouth
☐ Newspaper ☐ Employer/worksite wellness ☐ Radio
☐ Social media ☐ Organization website

20. I receive my clinic care locally:

☐ Yes ☐ No ☐ Not currently receiving care

21. If no to question 20, where are you receiving your clinic care?

☐ Grand Forks ☐ Fargo ☐ Other: (please specify)
☐ Mayville _____

22. If no to question 20, why do you receive your care elsewhere?

☐ Provider preference ☐ More convenient for me ☐ Other: (please specify)
☐ Utilize specialists at the clinic ☐ Privacy _____
☐ Better clinic hours

23. Which of the following would you support financially for a capital fund drive? (Choose ALL that apply)

☐ Renovate hospital ☐ Renovate nursing home
☐ Build new hospital ☐ Build new nursing home

24. Please grade the following housing needs:

Housing Need	High priority	Moderate priority	Low priority
Additional assisted living apartments	☐	☐	☐
Senior independent living apartments	☐	☐	☐

25. Regarding senior housing off the NDHC campus, would you prefer to:

☐ Purchase ☐ Rent
☐ Not applicable or interested (skip to question 28)

26. If purchased, how much would you be willing to pay for a new build?

☐ $150,000-200,000 ☐ $250,000-300,000
☐ $200,000-250,000 ☐ $300,000-400,000

27. If rented, how much monthly rent would you be willing to pay per month?

☐ $750 ☐ $1,250 ☐ $2,000
☐ $1,000 ☐ $1,500

Demographic Information: Please tell us about yourself.

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

☐ Yes ☐ No

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

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

30. Age:

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

31. Highest level of education:

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

32. Gender:

☐ Female ☐ Male ☐ Transgender

33. Employment status:

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

34. Your zip code: _____

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

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

36. Annual household income before taxes:

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

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

_____

_____

Thank you for assisting us with this important survey!

Appendix B – County Health Rankings Explained

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

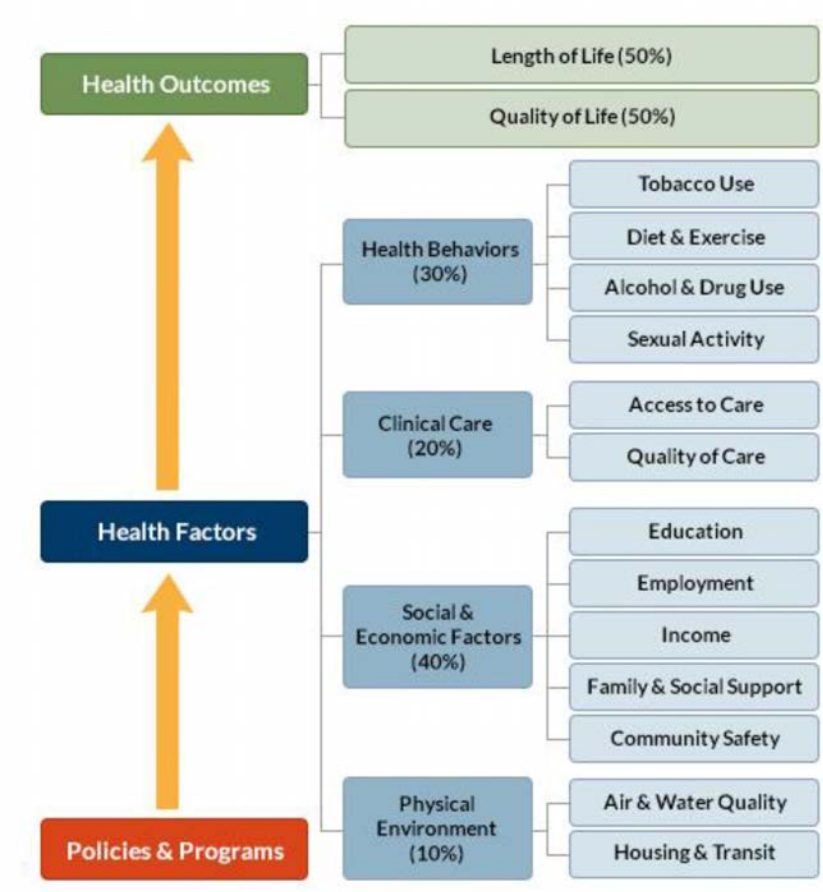
Methods

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

What is Ranked

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

Ranking System



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

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

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

Data Sources and Measures

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

Data Quality

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

Calculating Scores and Ranks

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

Health Outcomes and Factors

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

Health Outcomes

Premature Death (YPLL)

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

Reason for Ranking

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

Poor or Fair Health

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

Reason for Ranking

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

Poor Physical Health Days

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

Reason for Ranking

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

Poor Mental Health Days

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

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

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

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

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

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

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

Health Factors

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

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

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

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

Food Environment Index

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

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

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

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

Reason for Ranking

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

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

Physical Inactivity

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

Reason for Ranking

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

Access to Exercise Opportunities

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

Individuals who:

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

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

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

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

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

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

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

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

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

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

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

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

Uninsured

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

Reason for Ranking

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

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

Primary Care Physicians

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

Reason for Ranking

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

Dentists

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

Reason for Ranking

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

Mental Health Providers

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

Reason for Ranking

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Injury Deaths

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

Reason for Ranking

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

Air Pollution-Particulate matter

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

Reason for Ranking

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

Drinking Water Violations

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

Reason for Ranking

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

Severe Housing Problems

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

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

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

Reason for Ranking

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

Appendix C – Youth Behavioral Risk Survey Results

North Dakota High School Survey

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

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

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

	ND 2013	ND 2015*	ND Trend ↑, ↓, =	Rural ND Town Average	Urban ND Town Average	National Average 2017
Tobacco Use						
Percentage of students who ever tried cigarette smoking (even one or two puffs)	41.4	35.1	↓	37.3	32.5	28.9
Percentage of students who smoked a whole cigarette before age 13 years (for the first time)	7.9	7.2	=	7.3	6.7	9.5
Percentage of students who currently smoked cigarettes (on at least 1 day during the 30 days before the survey)	19.0	11.7	↓	13.2	11.8	8.8
Percentage of students who currently frequently smoked cigarettes (on 20 or more days during the 30 days before the survey)	6.6	4.3	↓	4.3	4.7	2.6
Percentage of students who currently smoked cigarettes daily (on all 30 days during the 30 days before the survey)	3.9	3.2	=	3.2	3.2	2.0
Percentage of students who usually obtained their own cigarettes by buying them in a store or gas station (during the 30 days before the survey among students who currently smoked cigarettes and who were aged <18 years)	7.8	16.9	↑	0.2	1.0	NA
Percentage of students who tried to quit smoking cigarettes (among students who currently smoked cigarettes during the 12 months before the survey)	55.5	47.4	=	49.1	52.7	NA
Percentage of students who currently use an electronic vapor product (e-cigarettes, vape e-cigars, e-pipes, vape pipes, vaping pens, e-hookahs, and hookah pens at least 1 day during the 30 days before the survey)	NA	22.3	↑	19.7	22.8	13.2
Percentage of students who currently used smokeless tobacco (chewing tobacco, snuff, or dip on at least 1 day during the 30 days before the survey)	13.8	10.6	↓	12.6	9.5	5.5
Percentage of students who currently smoked cigars (cigars, cigarillos, or little cigars on at least 1 day during the 30 days before the survey)	11.7	9.2	↓	9.7	9.7	8.0
Percentage of students who currently used cigarettes, cigars, or smokeless tobacco (on at least 1 day during the 30 days before the survey)	27.5	20.9	↓	22.9	19.8	14.0
Alcohol and Other Drug Use						
Percentage of students who ever drank alcohol (at least one drink of alcohol on at least 1 day during their life)	65.8	62.1	=	64.5	59.9	60.4
Percentage of students who drank alcohol before age 13 years (for the first time other than a few sips)	15.2	12.4	=	15.3	12.9	15.5
Percentage of students who currently drank alcohol (at least one drink of alcohol on at least 1 day during the 30 days before the survey)	35.3	30.8	↓	32.8	29.3	29.8
Percentage of students who drank five or more drinks of alcohol in a row (within a couple of hours on at least 1 day during the 30 days before the survey)	21.9	17.6	↓	19.8	17.0	13.5
Percentage of students who usually obtained the alcohol they drank by someone giving it to them (among students who currently drank alcohol)	37.0	41.3	=	41.1	40.4	43.5
Percentage of students who tried marijuana before age 13 years (for the first time)	5.6	6.3	=	5.8	5.8	6.8
Percentage of students who currently used marijuana (one or more times during the 30 days before the survey)	15.9	15.2	=	13.2	17.1	19.8
Percentage of students who ever took prescription drugs without a doctor's prescription (such as OxyContin, Percocet, Vicodin, codeine, Adderall, Ritalin, or Xanax, one or more times during their life)	17.6	14.5	↓	13.2	16.0	14.0
Percentage of students who were offered, sold, or given an illegal drug on school property (during the 12 months before the survey)	14.1	18.2	↑	15.9	19.9	19.8

	ND 2013	ND 2015*	ND Trend ↑, ↓, =	Rural ND Town Average	Urban ND Town Average	National Average 2017
Percentage of students who attended school under the influence of alcohol or other drugs (on at least one day during the 30 days before the survey)	9.9	8.6	=	7.9	9.0	NA
Sexual Behaviors						
Percentage of students who ever had sexual intercourse	44.9	38.9	↓	39.3	39.1	39.5
Percentage of students who had sexual intercourse before age 13 years (for the first time)	3.8	2.6	=	3.3	3.3	3.4
Weight Management and Dietary Behaviors						
Percentage of students who were overweight (>= 85th percentile but <95th percentile for body mass index, based on sex and age-specific reference data from the 2000 CDC growth chart)	15.1	14.7	=	15.4	14.6	15.6
Percentage of students who were obese (>= 95th percentile for body mass index, based on sex- and age-specific reference data from the 2000 CDC growth chart)	13.5	14.0	=	16.3	12.9	14.8
Percentage of students who described themselves as slightly or very overweight	32.0	32.2	=	34.2	31.5	31.5
Percentage of students who were trying to lose weight	45.4	44.7	=	45.0	43.0	47.1
Percentage of students who did not eat fruit or drink 100% fruit juices (during the 7 days before the survey)	3.4	3.9	=	4.3	4.1	5.6
Percentage of students who ate fruit or drank 100% fruit juices one or more times per day (during the 7 days before the survey)	64.7	62.5	=	8.5	8.8	60.8
Percentage of students who did not eat vegetables (green salad, potatoes [excluding French fries, fried potatoes, or potato chips], carrots, or other vegetables, during the 7 days before the survey)	6.0	4.7	=	4.5	5.2	7.2
Percentage of students who ate vegetables one or more times per day (green salad, potatoes [excluding French fries, fried potatoes, or potato chips], carrots, or other vegetables, during the 7 days before the survey)	62.8	58.5	↓	61.2	60.0	59.4
Percentage of students who did not drink a can, bottle, or glass of soda or pop (not including diet soda or diet pop, during the 7 days before the survey)	25.3	25.6	=	23.5	21.7	27.8
Percentage of students who drank a can, bottle, or glass of soda or pop one or more times per day (not including diet soda or diet pop, during the 7 days before the survey)	23.4	18.7	=	21.4	18.0	18.7
Percentage of students who did not drink milk (during the 7 days before the survey)	11.1	13.9	↑	11.6	13.7	26.7
Percentage of students who drank two or more glasses per day of milk (during the 7 days before the survey)	42.4	35.8	↓	36.6	35.3	17.5
Percentage of students who did not eat breakfast (during the 7 days before the survey)	10.5	11.9	=	10.7	11.8	14.1
Percentage of students who most of the time or always went hungry because there was not enough food in their home (during the 30 days before the survey)	3.1	2.2	=	2.4	2.8	NA
Physical Activity						
Percentage of students who were physically active at least 60 minutes per day on 5 or more days (doing any kind of physical activity that increased their heart rate and made them breathe hard some of the time during the 7 days before the survey)	50.6	51.3	=	51.7	50.1	46.5
Percentage of students who watched television 3 or more hours per day (on an average school day)	21.0	18.9	=	20.7	18.2	20.7
Percentage of students who played video or computer games or used a computer 3 or more hours per day (for something that was not school work on an average school day)	34.4	38.6	↑	39.4	38.0	43.0

	ND 2013	ND 2015*	ND Trend ↑, ↓, =	Rural ND Town Average	Urban ND Town Average	National Average 2017
Other						
Percentage of students who had 8 or more hours of sleep (on an average school night)	30.0	29.5	=	34.5	28.7	25.4
Percentage of students who brushed their teeth on seven days (during the 7 days before the survey)	71.5	71.0	=	67.8	70.1	NA
Percentage of students who most of the time or always wear sunscreen (with an SPF of 15 or higher when they are outside for more than one hour on a sunny day)	11.2	12.5	=	10.3	12.8	NA
Percentage of students who used an indoor tanning device (such as a sunlamp, sunbed, or tanning booth [not including getting a spray-on tan] one or more times during the 12 months before the survey)	19.6	12.2	↓	13.3	12.8	NA

Appendix D – Prioritization of Community's Health Needs

Appendix D – Prioritization of Community's Health Needs

Community Health Needs Assessment
Northwood, 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 seven 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 seven highest ranked priorities.

	Priorities	Most Important
COMMUNITY/ENVIRONMENTAL HEALTH CONCERNS		
Attracting & retaining young families	3	2
Having enough child daycare services	1	
Not enough affordable housing	2	
Not enough jobs with livable wages	1	
AVAILABILITY/DELIVERY OF HEALTH SERVICES CONCERNS		
Ability to retain primary care providers	4	
Availability of dental care	1	
Availability of mental health services	2	
Cost of health insurance	6	5
YOUTH POPULATION HEALTH CONCERNS		
Alcohol use and abuse	0	
Depression/anxiety	3	2
Drug use and abuse (including prescription drugs)	0	
Smoking and tobacco use, exposure to second-hand smoke, vaping	3	
ADULT POPULATION HEALTH CONCERNS		
Alcohol use and abuse	1	
Depression/anxiety	3	1
Drug use and abuse (including prescription drugs)	1	
Not getting enough exercise/physical activity	0	
SENIOR POPULATION HEALTH CONCERNS		
Availability of resources for family and friends caring for elders	2	
Availability of resources to help elderly stay in their homes	2	
Availability of transportation	1	
Cost of long-term/nursing home care	3	

Appendix E – Survey "Other" Responses

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

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

1. Considering the PEOPLE in your community, the best things are: "Other" responses:
    - Faith community is strong
    - None of the above are true
    - Safe place to raise children
2. Considering the SERVICES AND RESOURCES in your community, the best things are: "Other" responses:
    - None
3. Considering the QUALITY OF LIFE in your community, the best things are: "Other" responses:
    - None
    - Park and pool
4. Considering the ACTIVITIES in your community, the best things are: "Other" responses:
    - Fundraiser meals (social opportunities, raise money, and makeup for lack of diverse restaurants)

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:
    - Drug problem
    - Mental health services
    - Street safety/road quality
    - Would like group fitness or personal trainers available
6. Considering the AVAILABILITY/DELIVERY OF HEALTH SERVICES in your community, concerns are: "Other" responses:
    - No MDs in area just NPs
    - Providers not responding to ER when on call in a timely manner
    - We have a great healthcare team!
7. Considering the YOUTH POPULATION in your community, concerns are: "Other" responses:
    - Many homeschool families = some disconnect between them/the school (and community) it seems
    - Work ethic
8. Considering the ADULT POPULATION in your community, concerns are: "Other" responses:
    - Mental health

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

- Continuing to meet the challenges of providing quality healthcare to our community. The way we do healthcare today is fast changing which will require us to make significant investments in facilities, technology, and professional services. How will this be done and where will the money come from are questions that will need answers.
- Our city officials are very crooked, they do everything that's good for them and nothing that's good for the citizens of Northwood. If we're going to have a cop we need to have a cop not somebody that's a buddy with mayor.
- Available clinic appointments same day. Indoor swimming pool for all. School students could use for phy-ed class plus open to all community members. Too long winter to make use of outdoor facility.
- Could not narrow to only one issue
- Declining population
- Drugs (meth in particular)
- Drugs-meth & opioids
- Facility for quality exercise that is available to all
- Fairness
- Families where both parents have to work which entails daycare for kids and the cost of it. And the older kids being left alone with no guidance
- Keeping people here (not moving away) and also attracting new families (no available worthwhile jobs)
- Long-term care of the elderly
- Not enough smaller - NICE - homes for elderly wanting to movie into town. Like twin homes or condos that could be rented. Elderly don't want to invest in $300,000 homes. They want yard work and snow removal services as well.
- Only a few people running everything. Nobody has a voice. This is the only survey I have seen in ten years.
- Retaining quality healthcare providers and nurses
- Retaining young families
- Seniors not willing to engage in social or physical activities, high cost of prescription drugs
- Streets
- Taxation
- We need a community bus that could take community members to and from appointments

Delivery of Healthcare

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

- Cost out of pocket
- Healthcare is available
- MD
- Provider is a jerk
- Unknown
- Want a real doctor, not an NP

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

- Not necessarily trust but get opinions and double check

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

- An optometrist
- Another full-time MD and one FNP, PA to be at clinic five days a week to see overflow patients
- Counselors, mental health professionals

- Dental
- Dental care
- Dental services would be nice
- Dentistry, mental health, dialysis, more days for CT machine/ultrasound – I would have used locally if offered
- Dialysis, mental health
- Home healthcare outreach
- Mental health
- More mental healthcare
- More than one day a month for dermatology
- NDHC has services but people outside of Northwood don't know about hose services. Promote!
- Nursing home care
- Pediatric
- Psychiatry
- Therapy for anxiety and depression

21. Where are you receiving your clinic care? "Other" responses:

- Arizona

22. Why do you receive your healthcare elsewhere? "Other responses:

- I work in GF
- Love my Dr. and know she will always be there for me

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

- Ambulance coverage and home healthcare in rural North Dakota
- Another full-time MD, current providers are too full, hard to get in to see them in a timely manner
- Because of proximity, Larimore people go to GF primarily for medical services. I would say most people are also unaware of all the NDHC offers, but if you want a doctor you don't see one here, and if you need more tests, etc. you'll end up in GF anyway.
- Extended assisted living to nursing home basic wing, more pediatric therapy to NDHC, use old OR and ER for procedures! Light available in these areas keep Alzheimer's unit in current location.
- Good report. Who are the people who look at it?
- I think a new or renovated hospital/nursing home would really benefit our community
- Low income hinders quality of life
- Need to keep ambulance and ER thriving
- Provide quality care for hospital and LTC by paying a better wage to employees and do not hire agency help. Too much administration and not enough caregivers!
- Response time of doctor to ER
- Revamp hospital/nursing home. Weight room/bigger "therapy" room into workout facility
- Treat everybody fairly
- We are very fortunate to have the facilities out our back door considering the size of our community. Every aspect of the healthcare in this community is top notch, and the amount of services available here are also number one.