Community Health Needs Assessment

2019

Grafton, North Dakota

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Executive Summary

To help inform future decisions and strategic planning, Unity Medical Center (UMC) conducted a community health needs assessment (CHNA) in 2018/2019, the previous CHNA having been conducted in 2016. The Center for Rural Health (CRH) at the University of North Dakota School of Medicine and Health Sciences (UND-SMHS) 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. 487 UMC 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 Walsh 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, Walsh County's population from 2010 to 2017 decreased 2.4%. The average of residents under age 18 (22.7%) for Walsh County is .6% lower than the state average. The percentage of residents ages 65 and older is almost 6% higher for Walsh County (20.8%) than the North Dakota average (15.0%), and the rates of education are slightly lower for Walsh County (87.3%) than the North Dakota average (92.3%). The median household income in Walsh County ($50,781) is nearly $11,000 lower the state average for North Dakota ($61,285).

Data compiled by County Health Rankings show Walsh County is doing better than North Dakota in health outcomes/factors for eight categories, while meeting the state average for three categories.

Walsh County, according to County Health Rankings data, is performing poorly relative to the rest of the state in 17 outcome/factor categories.

Of the 82 potential community and health needs set forth in the survey, the 487 UMC service area residents who completed the survey indicated the following ten needs as the most important:

- Alcohol use and abuse – Youth and Adult
- Attracting and retaining young families
- Availability of mental health services
- Availability of resources to help the elderly stay in their homes
- Bullying/cyber-bullying – Youth and Adult
- Child abuse/neglect
- Depression/anxiety – Youth and Adult
- Drug use and abuse – Youth and Adult
- Emotional abuse
- Not enough jobs with livable wages

The survey also revealed the biggest barriers to receiving healthcare (as perceived by community members). They included no or limited insurance (N=170), not affordable (N=124), and can't get transportation services (N=89).

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

- Safe place to live, little/no crime
- Quality school system

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- Family-friendly, good place to raise kids
- People who live here are involved in their community
- People are friendly, helpful, and supportive
- Healthcare

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:

- Availability of mental health services
- Alcohol use and abuse
- Bullying/cyber-bullying
- Depression/anxiety
- Drug use and abuse
- Having enough child daycare services

Overview and Community Resources

With assistance from the CRH at the UND-SMHS, Unity Medical Center completed a CHNA of the UMC service area. The hospital identifies its service area as Walsh County. Many community members and stakeholders worked together on the assessment.

Walsh County is a large county located in northeastern North Dakota. It is part of the Red River Valley, which is known to have some of the most productive farmland in North Dakota. Walsh County is primarily a rural county, with a number of small cities and miles of open space. Two rural hospitals are located in Walsh County. First Care Health Center (FCHC) is located in Park River and Unity Medical Center (UMC) is located in Grafton. There are a number of other healthcare agencies located in Walsh County. They include a private medical clinic in Park River, two chiropractic and optometry clinics, a community health center that serves low-income people, five dental clinics, a VA clinic, three pharmacies, and a state center that serves developmentally disabled individuals. Grand Forks is within 45-70 miles for residents of Walsh County, and people are referred for specialty health services such as cardiology or neurology when they are not available as a specialty clinic at either UMC or FCHC. Some people also access specialty services in Fargo and at Mayo Clinic in Rochester, Minnesota. Currently UMC and FCHC do not routinely deliver babies, but they do provide prenatal care through a specific week of pregnancy either by primary care medical providers or in Grafton a visiting OB/GYN. After delivery, the local provider resumes the patient's care again.

The hospitals, agricultural, and other large businesses such as Marvin Windows and Polar Communications provide the economic base for Walsh County. According to the 2017 U.S. Census estimates, Walsh County had a population of 10,920 while Grafton, the county seat, had a population of 4,243 and the next largest city, Park River, had a population of 1,452.

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Walsh County has a number of community assets and resources that can be mobilized to address population health improvement, including bike paths, swimming pools, city parks, camping, tennis courts, golf courses, skating rinks, and movie theatres. There are also many private fitness facilities and classes available in the cities of Grafton and Park River, with small facilities in some of the smaller communities as well. Homme Dam is located three miles west of Park River and has great opportunities for boating, camping, biking, swimming and fishing.

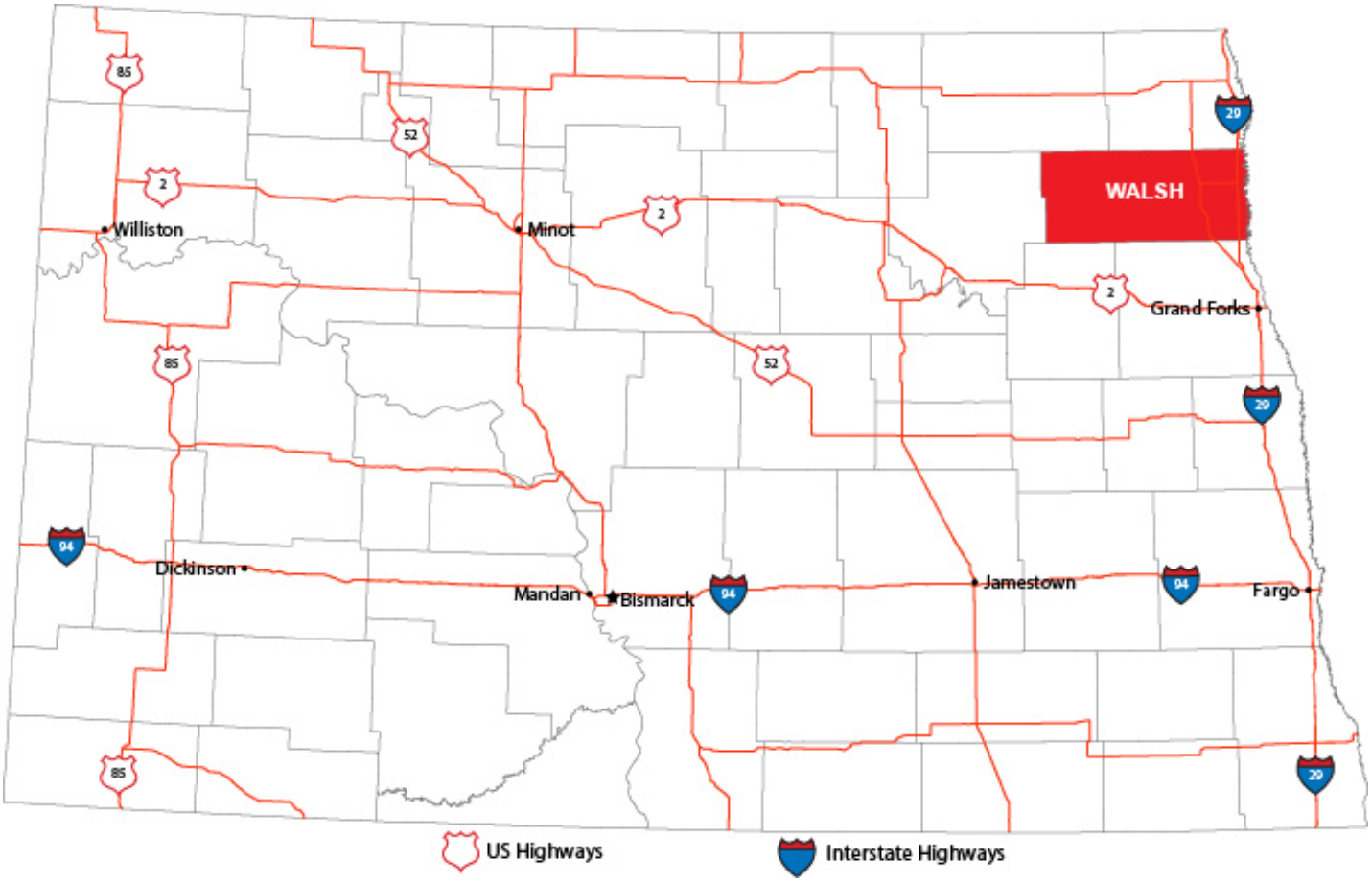
Walsh County has a public transportation bus that provides transportation to anyone regardless of age. All vehicles are handicapped accessible. They provide transportation to Grafton, Grand Forks, Park River, and Fargo. People can enjoy recreation/shopping or go to medical appointments utilizing the public transportation buses. The Veteran's Administration (VA) also has a transport van that stops weekly in Grafton to assist veterans to get to the Fargo VA for medical care.

There are grocery stores in four cities in Walsh County. Smaller communities have added staples such as milk, bread, cereals, canned foods, etc. at some of the gas stations or local café's to meet the needs of the elderly who do not want to go out of town to shop.

There are excellent K-12 schools in Minto, Grafton, Park River, and Fordville. The towns of Edinburg, Hoople and Crystal, located in Pembina County, have a joint school district so that they can serve K-12 in those communities. Grafton and Park River have preschool programs and there is a Head Start located in Grafton.

Figure 1 illustrates the location of the counties.

Figure 1: Walsh County



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Unity Medical Center

Grafton has had a hospital in its community for over 110 years. In the mid 1900's, there were actually two hospitals in the community. Unity Medical Center is a not-for-profit, 14-bed designated Level IV trauma hospital and family care clinic. The facility offers 24-hour acute care, swing bed, emergency care, and respite services and is staffed by a team of over 130 employees.

UMC has benefitted from a remodel, completed in 2011 and will be breaking ground in June 2019 for a major expansion project. Plans include an expansion to the current building, new inpatient, surgery, physical therapy and emergency departments, along with a clinical education conference/training center.

According to its mission statement, Unity Medical Center is committed to "serving Grafton and its surrounding area with a dedicated and caring staff, promoting healthcare for the community, and serving its needs through all stages of life.

Services offered locally by UMC include:

General and Acute Services

- 24-hour emergency room
- Anesthesia
- Clinic
- Dermatology
- Family medicine
- General surgery
  - o Appendectomy
  - o Bowel surgery
  - o Breast surgery – benign and malignant problems
  - o Gallbladder surgery
  - o Gynecological
  - o Hand injury – including carpal tunnel repair
  - o Hernia surgery
  - o Laparoscopic diagnostic procedures – abdomen and pelvic problems
  - o Colonoscopies
  - o Nissen Fundoplication surgery
- Hospital (acute care)
- Oncology (visiting specialist)
- Podiatry (visiting specialist)
- Social services
- Specialty clinics
- Swing bed and respite care
- Telemedicine via eEmergency

Screening/Therapy Services

- Cardiac rehab
- Chemotherapy/antibiotic therapy
- Diabetic services/education support group & screenings
- Drug testing
- Hearing services
- Laboratory services
- Nutritional services
- Occupational therapy
- Foot care
- Blood pressure checks
- Physical therapy
  - o Post-surgical orthopedic rehab
  - o Treatment of spinal pain and dysfunction
  - o Sacroiliac dysfunction
  - o Sports injuries

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- o Musculoskeletal and myofascial pain disorder
- o Orthopedic injuries to shoulder, elbow, wrist, and hand
- o Orthopedic injuries to hip, knee, ankle, and feet
- o Vertigo
- o Stroke rehab
- o Overuse injuries burn and wound care
- o Joint sprains, strains, and stiffness
- o Muscle and tendon injuries
- o Tendonitis and bursitis
- o Arthritis
- o Neurological disorder
- o Gait and orthotic assessment
- • Respiratory therapy
- o Drug screening
- o Home oxygen
- o C-pap
- • Sleep apnea services
- • Speech therapy
- • Stress testing

Radiology Services

- • Bone scan-nuclear medicine
- • CT scan
- • DEXA (bone density)
- • Digital x-ray
- • Digital mammography
- • Echocardiogram
- • MRI-Contrast, non-contrast
- • Ultrasound
  - o Pregnancy
  - o Pelvic
  - o Renal
  - o Upper abdomen
  - o Gallbladder
  - o Pancreas

Walsh County Health District

Walsh County Health District (WCHD) works to assure the health of Walsh County residents through health promotion, disease prevention, and protection of the public utilizing best practice population health strategies. WCHD works in a collaborative relationship with other healthcare providers and community leaders/organizations to accomplish these health strategies. Examples include. coalitions that address tobacco prevention, substance abuse prevention, and chronic disease prevention. WCHD also provides services in a variety of community settings such as public schools, private businesses, senior citizen programs, etc. WCHD provides a wide variety of services in order to accomplish the mission of public health, which is to assure that Walsh County is a healthy place to live and that each person has an equal opportunity to enjoy good health.

Specific services that WCHD provides are:

- • Substance abuse prevention (alcohol and drugs)
- • Tobacco prevention
- • Injury prevention education/activities (bike helmets, life jackets, poison prevention, etc.)
- • Car seat program-certified technician for fitting seats
- • Immunizations-adult, child, infant, school
- • Health screenings/referral

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- Environmental health (septic systems, nuisance, mold, radon, water quality, etc.)
- School health
- WIC (Women, Infants, & Children) nutrition program including breastfeeding support
- Chronic disease prevention (worksite wellness coalition, blood pressure and blood sugar screenings)
- Correctional health
- Emergency response and preparedness
- Youth and adult health promotion/education programs
- Home visits/referral-high risk infants, adults
- Tuberculosis treatment and case management

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 Walsh County. In addition to Grafton and Park River, located in the county are the communities of Minto, Conway, Warsaw, Forest River, Adams, Edinburg, Fairdale, Hoople, Lankin, Fordville, and Pisek.

The CRH, in partnership with UMC and WCHD, 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 Grafton. A 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. Ten people, representing a cross section demographically, attended the focus group meeting. The meeting was highly interactive with good participation. UMC staff and board members were in attendance as well but largely played a role of listening and learning.

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Figure 2: Steering Committee

Wanda Kratochvil	RN, Administrator, Walsh County Health District
Kristi Torgerson	Project Coordinator, Unity Medical Center
Alan O'Neil	Unity Medical Center's CEO
Marcus Lewis	CEO, First Care Health Center
Wendy Blasky	RN, Surgical Supervisor, First Care Health Center
Megan Thompson	RN, Patient Care Coordinator, First Care Health Center

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 focus 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 10 community members was convened and first met on January 15, 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 April 3, 2019 with 15 community members in attendance. At this second meeting the community group was presented with survey results, findings from key informant interviews and the focus group, and a wide range of secondary data relating to the general health of the population in Walsh

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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 UMC and WCHD. They included representatives of the health community, business community, political bodies, and education. Not all members of the group were present at both meetings.

Interviews

One-on-one interviews with six key informants were conducted in person in Grafton on January 15, 2019. A representative from the Center for Rural Health conducted the interviews. Interviews were held with selected members of the community who could provide insights into the community's health needs. Included among the informants were public health professionals with special knowledge in public health acquired through several years of direct experience in the community, including working with medically underserved, low income, and minority populations, as well as with populations with chronic diseases.

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

Survey

A survey was distributed to solicit feedback from the community. It 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.

The community member survey was distributed to various residents of Walsh County, which is included in the UMC service area. The survey tool was designed to:

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 two county newspapers in Walsh County. Additionally, information was published in WCHD's newsletter and on its website.

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Approximately 500 community member surveys were available for distribution in Walsh County. The surveys were distributed by community group members and by WCHD, UMC, and FCHC. Surveys were also available online and the Q code and online site were posted at all places the surveys were made available.

To help ensure anonymity, included with each survey was a postage-paid return envelope to the Center for Rural Health. In addition, to help make the survey as widely available as possible, residents also could request a survey by calling UMC or WCHD. The survey period ran from January 4, 2019 to January 31, 2019. One hundred eighty completed paper surveys were returned.

Area residents also were given the option of completing an online version of the survey, which was publicized in two community newspapers and on the websites and Facebook pages of both UMC and WCHD. Three hundred twenty seven online surveys were completed. Six of those online respondents used the QR code to complete the survey. In total, counting both paper and online surveys, 487 community member surveys were completed, equating to an 11.1% response rate. This response rate is slightly lower than the expected 13% for this type of unsolicited survey methodology and indicates the community was somewhat less engaged than expected.

Secondary Data

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

Social Determinants of Health

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

Income-level, educational attainment, race/ethnicity, and health literacy all impact the ability of people to access health services. Basic needs such as clean air and water and safe and affordable housing are all essential to staying healthy and 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.

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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 summarizes general demographic and geographic data about Walsh County.

Table 1 summarizes general demographic and geographic data about Walsh County.

(From 2010 Census/2017 American Community Survey; more recent estimates used where available)While the population of North Dakota has grown in recent years, Walsh County has seen a decrease in population since

	Walsh County	North Dakota
Population (2017)	10,855	755,393
Population change (2010-2017)	2.4%	12.3%
People per square mile (2010)	8.7	9.7
Persons 65 years or older (2016)	20.8%	15.0%
Persons under 18 years (2016)	22.7%	23.3%
Median age (2016 est.)	45.2	35.2
White persons (2016)	94.6%	87.5%
Non-English speaking (2016)	9.2%	5.6%
High school graduates (2016)	86.9%	92.0%
Bachelor's degree or higher (2016)	16.7%	28.2%
Live below poverty line (2016)	11.0%	10.7%
Persons without health insurance, under age 65 years (2016)	10.0%	8.1%

2010. The U.S. Census Bureau estimates show that Walsh County's population decreased from 11,125 (2010) to 10,855 (2017).

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, Walsh 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.

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Health Outcomes

- Length of life
- Quality of life

Health Factors

- Health behavior
  - Smoking
  - Diet and exercise
  - Alcohol and drug use
  - Sexual activity

Health Factors (continued)

- Clinical care
  - Access to care
  - Quality of care
- Social and Economic Factors
  - Education
  - Employment
  - Income
  - Family and social support
  - Community safety
- Physical Environment
  - Air and water quality
  - Housing and transit

Table 2 summarizes the pertinent information gathered by County Health Rankings as it relates to Walsh 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 WCHD or FCHC or of any particular medical facility.

For most of the measures included in the rankings, the County Health Rankings' authors have calculated the "Top U.S. Performers" for 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).

Walsh County rankings within the state are included in the summary following. For example, Walsh County ranks 37th out of 49 ranked counties in North Dakota on health outcomes and 41st 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 Walsh County is fairing poorer than many counties compared to the rest of the state on all but two of the outcomes, landing at the same rates for other North Dakota counties. Walsh County, like many North Dakota counties, is also doing poor in many areas when it comes to the U.S. Top 10% ratings. One particular outcome where Walsh County does not meet the U.S. Top 10% ratings is the number of premature deaths.

On *health factors*, Walsh County perform below the North Dakota average for counties in several areas as well.

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

- Adult smoking
- Food environment index
- Excessive drinking
- Alcohol-impaired driving deaths
- Sexually transmitted infections
- Income inequality

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- Violent crime
- Drinking water violations
- Severe housing problems

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

- Premature death
- Poor or fair health
- Poor physical health
- Adult obesity
- Physical inactivity
- Access to exercise opportunities
- Mammography screenings
- Unemployment
- Children in poverty
- Teen birth rate
- Uninsured individuals
- Primary care physicians
- Dentists
- Mental health providers
- Preventable hospital stays
- Injury deaths
- Air pollution

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TABLE 2: SELECTED MEASURES FROM COUNTY HEALTH RANKINGS 2019 – WALSH COUNTY

● = Not meeting North Dakota average

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

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

Blank values reflect unreliable or missing data

TABLE 2: SELECTED MEASURES FROM *COUNTY HEALTH RANKINGS* 2019 – WALSH COUNTY			
	Walsh County	**U.S. Top 10%**	**North Dakota**
Ranking: Outcomes	**37th**		**(of 49)**
Premature death	8,100 ●■	5,400	6,700
Poor or fair health	15% ■	12%	14%
Poor physical health days (in past 30 days)	3.1 ●■	3.0	3.0
Poor mental health days (in past 30 days)	3.1 +	3.1	3.1
Low birth weight	6% +	6%	6%
Ranking: Factors	**41st**		**(of 49)**
Health Behaviors			
Adult smoking	15% ■	14%	20%
Adult obesity	35% ●■	26%	32%
Food environment index (10=best)	9.4 +	8.7	9.1
Physical inactivity	27% ●■	19%	22%
Access to exercise opportunities	66% ●■	91%	74%
Excessive drinking	21% ■	13%	26%
Alcohol-impaired driving deaths	33% ■	13%	46%
Sexually transmitted infections	100.9 +	152.8	456.5
Teen birth rate	33 ●■	14	23
Clinical Care			
Uninsured	10% ●■	8%	9%
Primary care physicians	2,180:1 ●■	1,040:1	1,280:1
Dentists	1,810:1 ●■	1,320:1	1,630:1
Mental health providers	2,170:1 ●■	360:1	640:1
Preventable hospital stays	5,866 ●■	2,765	4,452
Mammography screening (% of Medicare enrollees ages 67-69 receiving screening)	46% ●■	49%	50%
Social and Economic Factors			
Unemployment	3.3% ●■	2.9%	2.6%
Children in poverty	13% ●■	11%	11%
Income inequality	4.0 ■	3.7	4.4
Children in single-parent households	27% ■	20%	27%
Violent crime	165 ■	63	258
Injury deaths	110 ●■	57	69
Physical Environment			
Air pollution – particulate matter	6.5 ●■	6.1	5.4
Drinking water violations	No	NA	NA
Severe housing problems	7% +	9%	11%

Source: http://www.countyhealthrankings.org/app/northdakota/2019/rankings/walsh/county/outcomes/overall

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Children's Health

The National Survey of Children's Health touches on multiple intersecting aspects of children's lives. Data is 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 2011-12. More information about the survey is 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%	11.6%
Children 10-17 overweight or obese	35.8%	31.3%
Children 0-5 who were ever breastfed	79.4%	79.2%
Children 6-17 who missed 11 or more days of school	4.6%	6.2%
Healthcare		
Children currently insured	93.5%	94.5%
Children who had preventive medical visit in past year	78.6%	84.4%
Children who had preventive dental visit in past year	74.6%	77.2%
Young children (10 mos.-5 yrs.) receiving standardized screening for developmental or behavioral problems	20.7%	30.8%
Children aged 2-17 with problems requiring counseling who received needed mental healthcare	86.3%	61.0%
Family Life		
Children whose families eat meals together 4 or more times per week	83.0%	78.4%
Children who live in households where someone smokes	29.8%	24.1%
Neighborhood		
Children who live in neighborhood with a park, sidewalks, a library, and a community center	58.9%	54.1%
Children living in neighborhoods with poorly kept or rundown housing	12.7%	16.2%
Children living in neighborhood that's usually or always safe	94.0%	86.6%

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;

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- Children 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 Walsh County is performing more poorly than the North Dakota average on all of the examined measures except the percentage of uninsured children below 200% of poverty. The most marked difference was on the number of Medicaid recipients (almost 10% higher than the state average).

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

	Walsh County	North Dakota
Uninsured children (% of population age 0-18), 2016	9.5%	9.0%
Uninsured children below 200% of poverty (% of population), 2016	37.3%	41.9%
Medicaid recipient (% of population age 0-20), 2017	38.6%	28.3%
Children enrolled in Healthy Steps (% of population age 0-18), 2013	4.1%	2.5%
Supplemental Nutrition Assistance Program (SNAP) recipients (% of population age 0-18), 2017	25.1%	20.1%
Licensed childcare capacity (% of population age 0-13), 2018	36.6%	41.9%
4-Year High School Cohort Graduation Rate, 2017	84.1%	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 broken down further 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.

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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

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% 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

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

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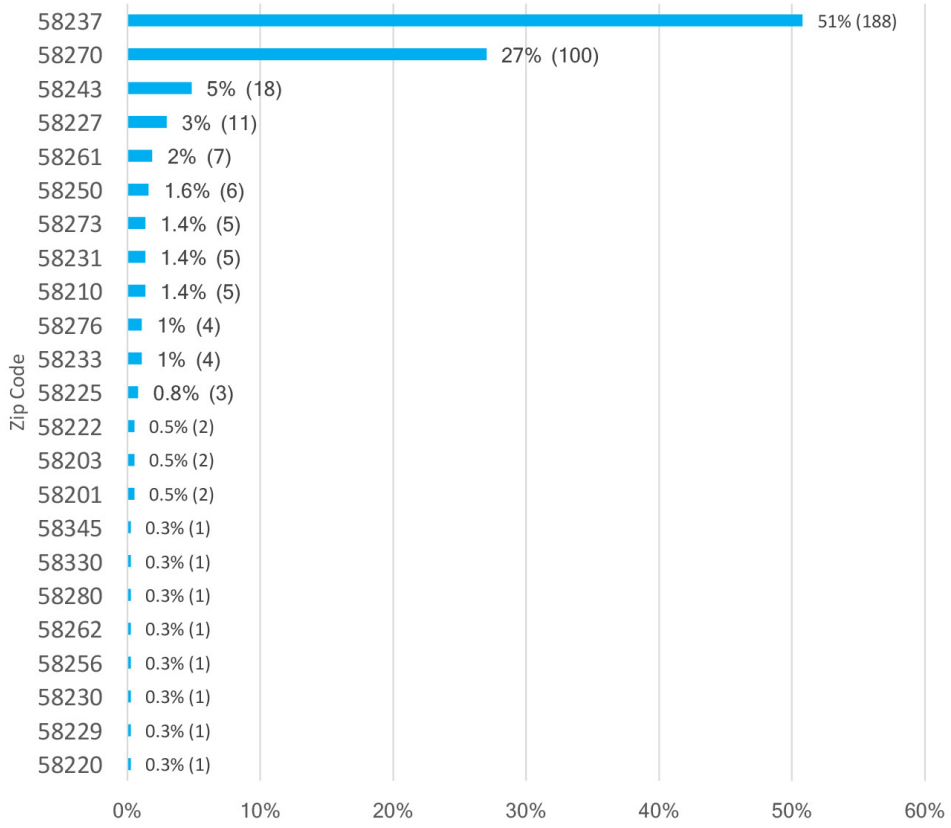
Survey Results

As noted previously, 487 community members completed the survey in communities throughout the UMC service area. The survey requested that respondents list their home zip code. While not all respondents provided a zip code, 370 did, revealing that the large majority of respondents (51%, N=188) lived in Grafton. These results are shown in Figure 5.

Figure 5: Survey Respondents' Home Zip Code Total respondents: 370



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.

The demographics of those who chose to complete the survey are as follows:

- 42% (N=171) were age 55 or older.
- The majority (78%, N=320) were female.
- Less than half of the respondents (235%, N=141) had bachelor's degrees or higher.
- The number of those working full time (74%, N=300) was more than six times higher than those who were retired (12%, N=47).
- 93% (N=382) of those who reported their ethnicity/race were white/Caucasian.

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- 28% of the population (N=110) 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 = 408

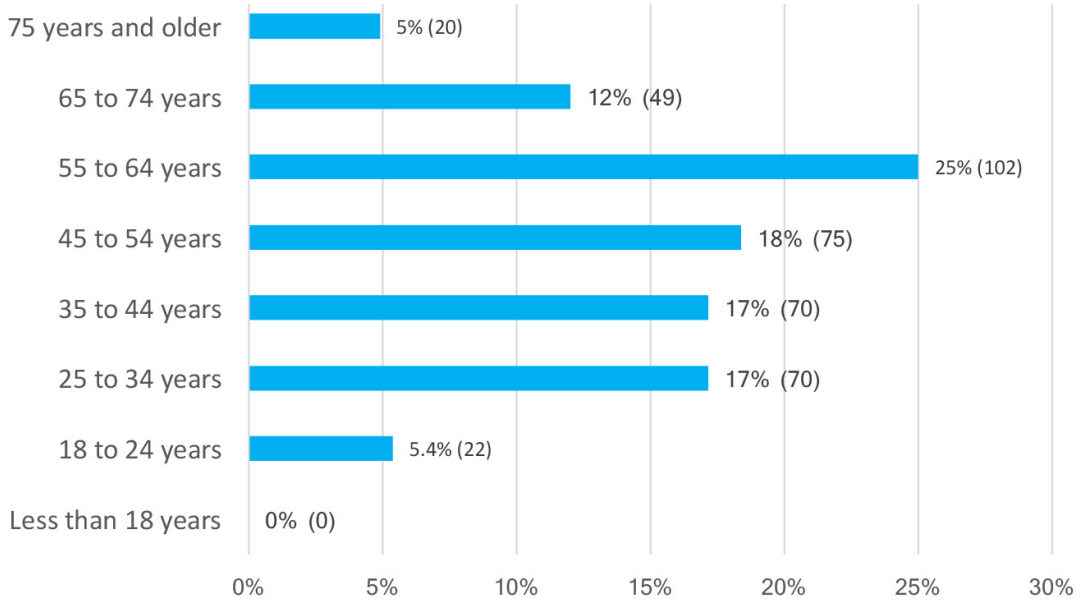

Figure 7: Gender Demographics of Survey Respondents
Total respondents = 408

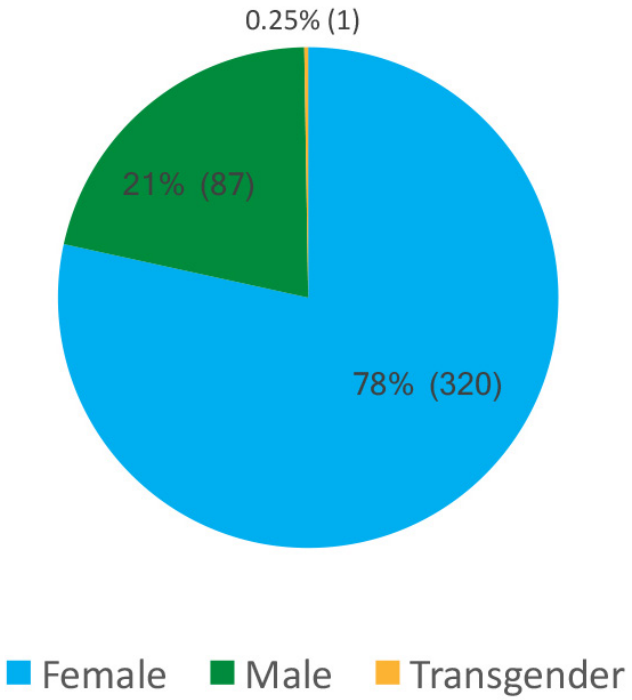

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Figure 8: Educational Level Demographics of Survey Respondents
Total respondents = 408

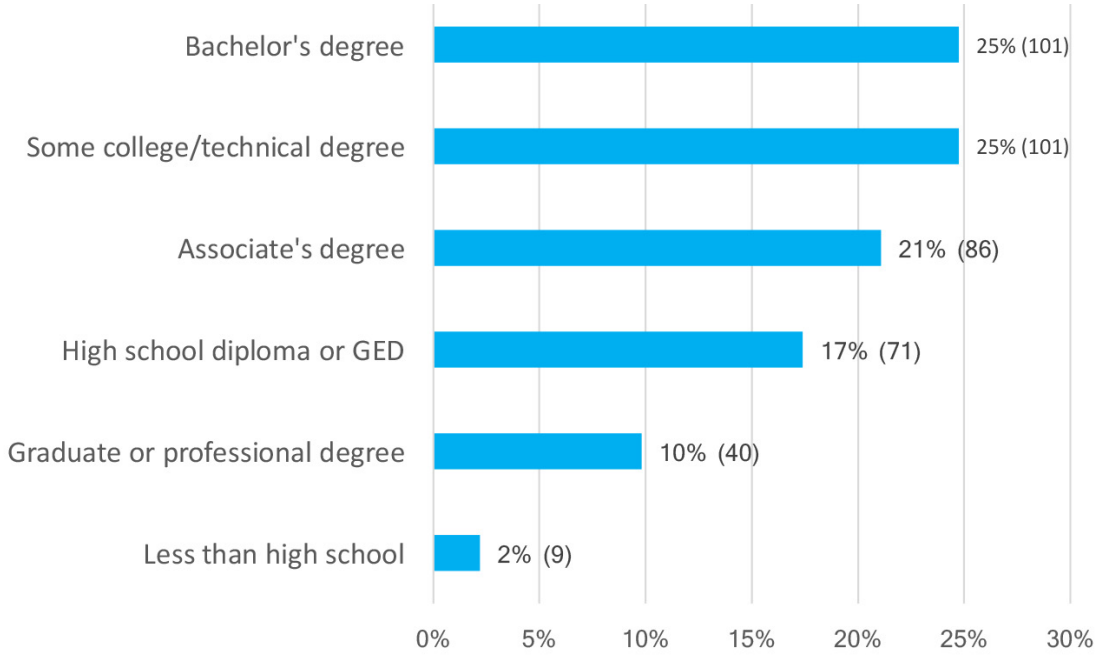
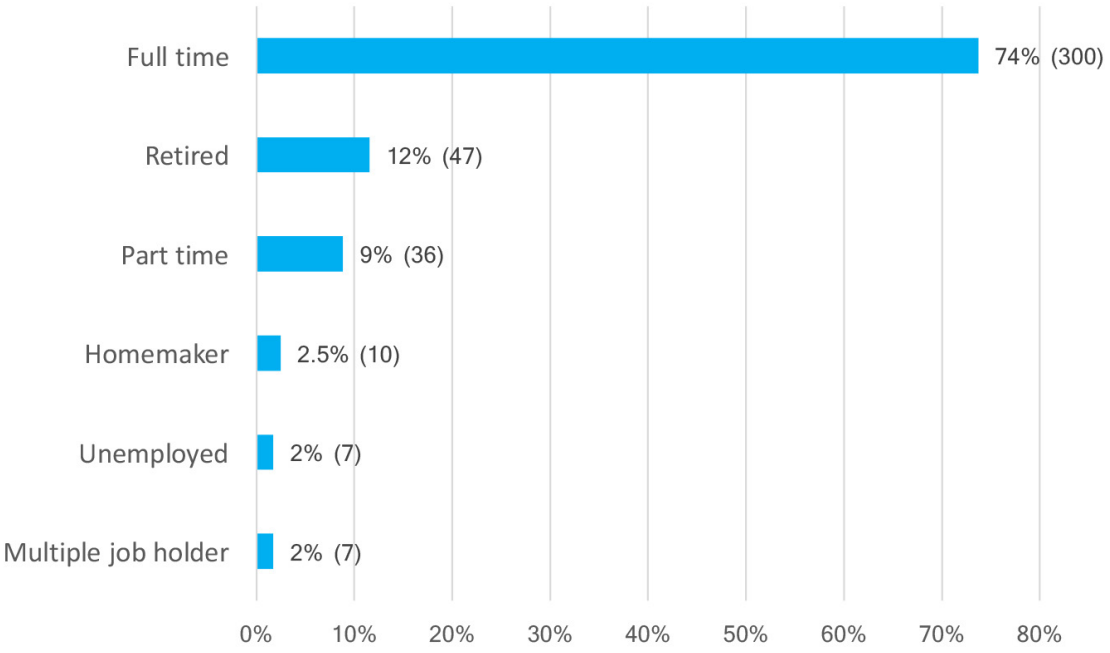


Figure 9: Employment Status Demographics of Survey Respondents
Total respondents = 407



Of those who provided a household income, 4% (N=17) community members reported a household income of less than $25,000. Sixteen percent (N=64) indicated a household income of $100,000 or more. This information is show in Figure 10.

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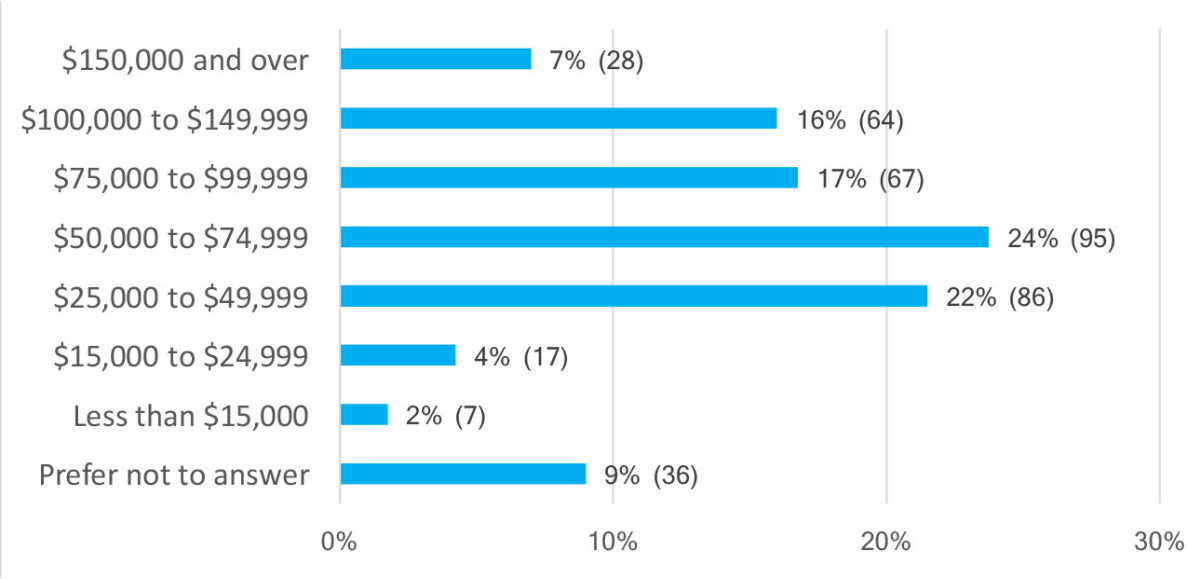
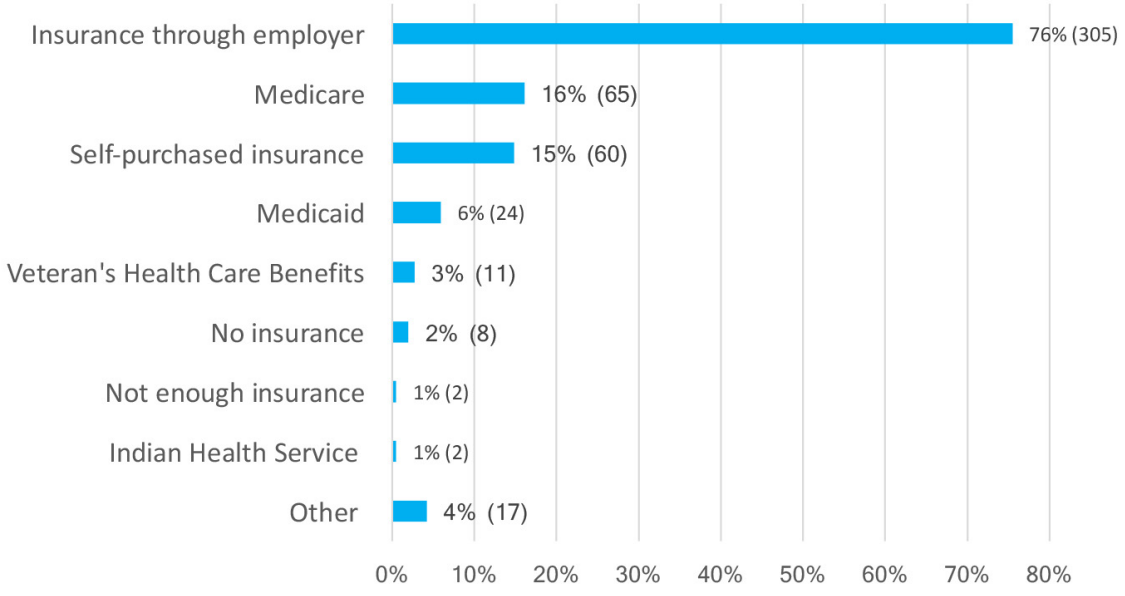
Figure 10: Household Income Demographics of Survey Respondents
Total respondents = 400



Community members were asked about their health insurance status, which is often associated with whether people have access to healthcare. Two percent (N=8) of the respondents reported having no health insurance or being under-insured. The most common insurance types were insurance through one's employer (N=305), followed by Medicare (N=65) and self-purchased insurance (N=60).

Figure 11: Health Insurance Coverage Status of Survey Respondents



As shown in Figure 12, nearly all of the respondents were white/Caucasian (93%). This was in-line with the race/ethnicity of the overall population of Walsh County; the U.S. Census indicates that 94.6% of the population is white in Walsh County.

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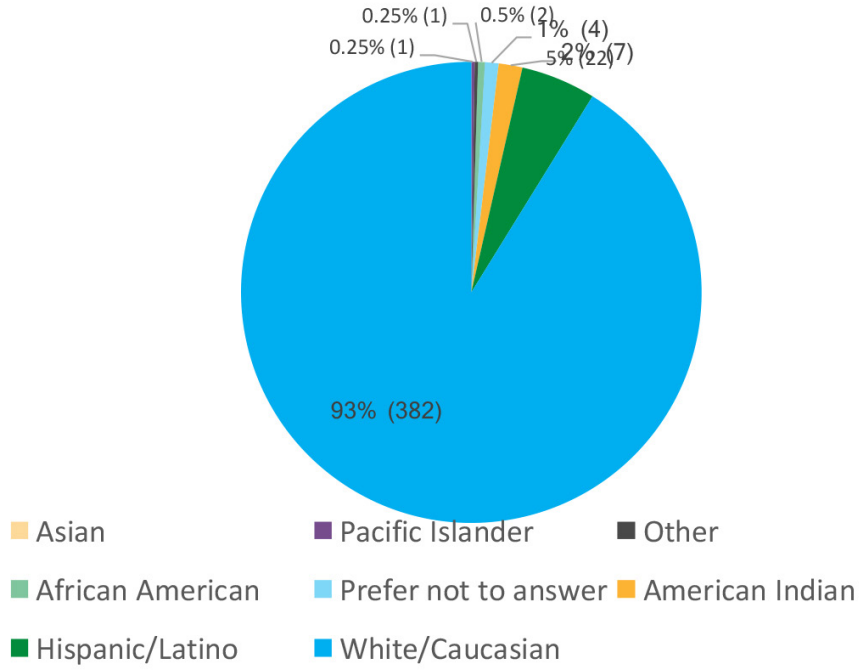
Figure 12: Race/Ethnicity Demographics of Survey Respondents
Total respondents = 419



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 260 respondents agreeing) that community assets include:

- People are friendly, helpful, supportive (N=358)
- Family-friendly (N=347)
- Safe place to live, little/no crime (N=315)
- People who live here are involved in their community (N=265)
- Quality school systems (N=261)

Figures 13 to 16 illustrate the results of these questions.

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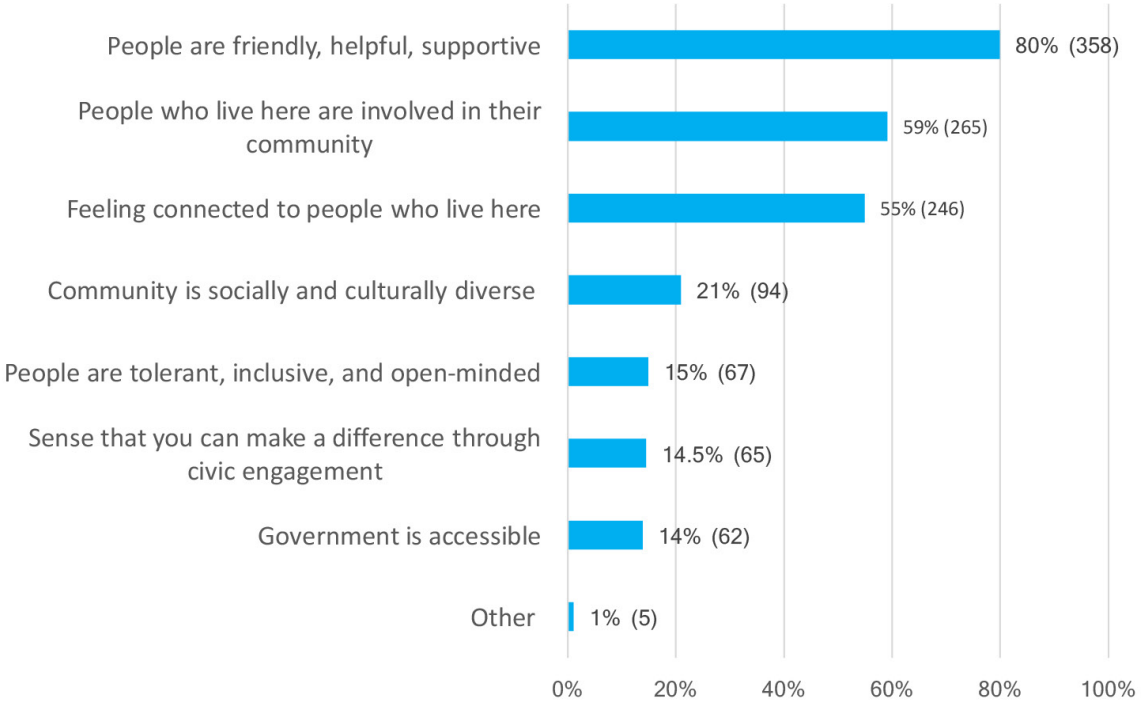
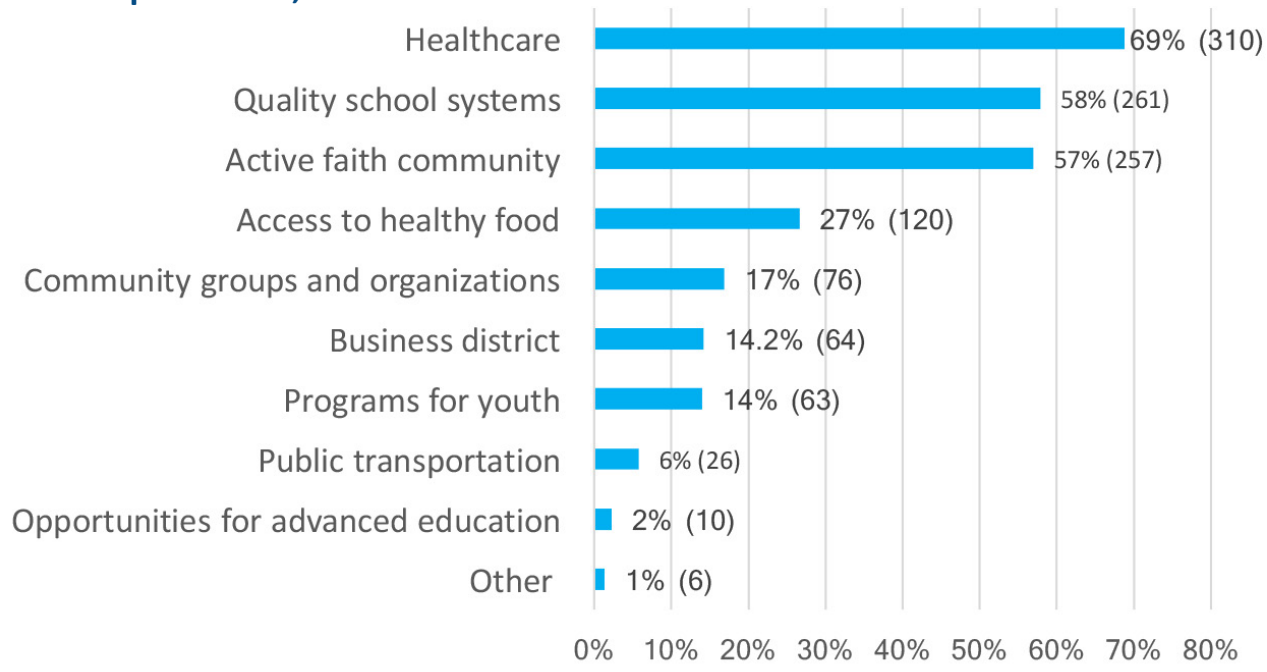
Figure 13: Best Things about the PEOPLE in Your Community
Total responses = 1,162



Included in the "Other" category of the best things about the people was that they are relatable.

Figure 14: Best Things about the SERVICES AND RESOURCES in Your Community
Total responses = 1,193



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

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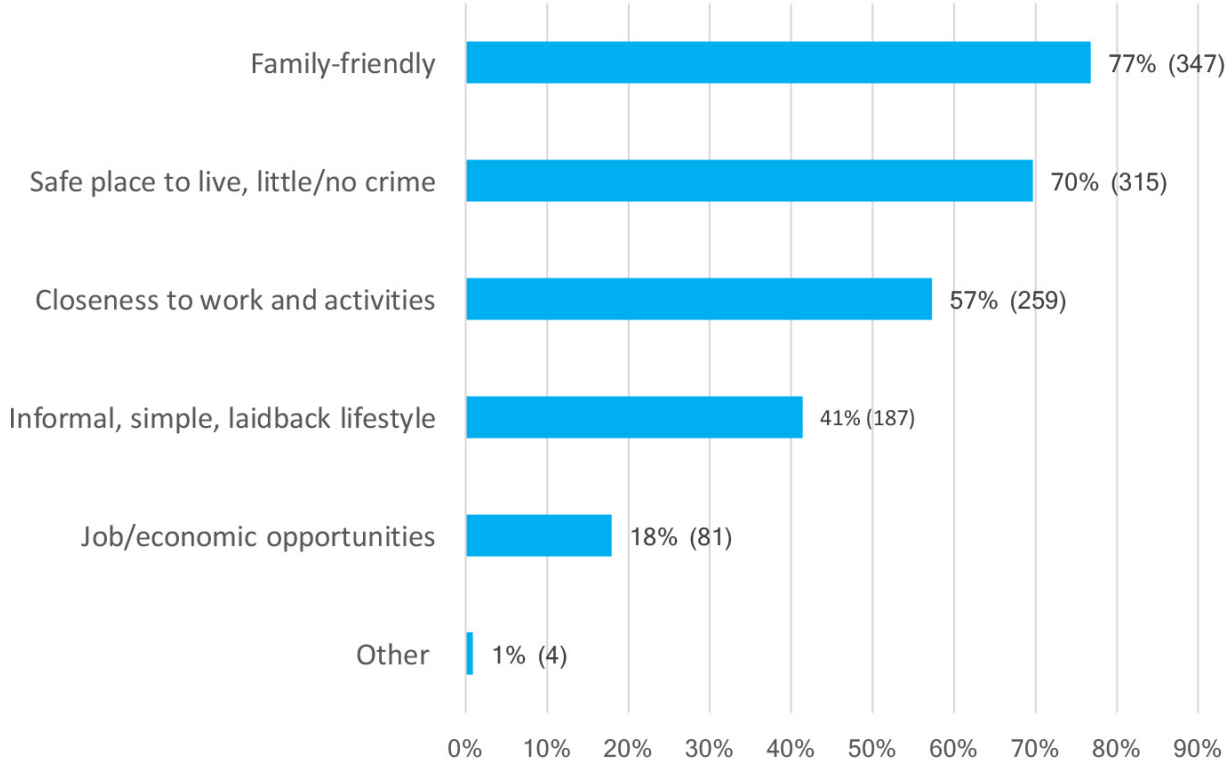
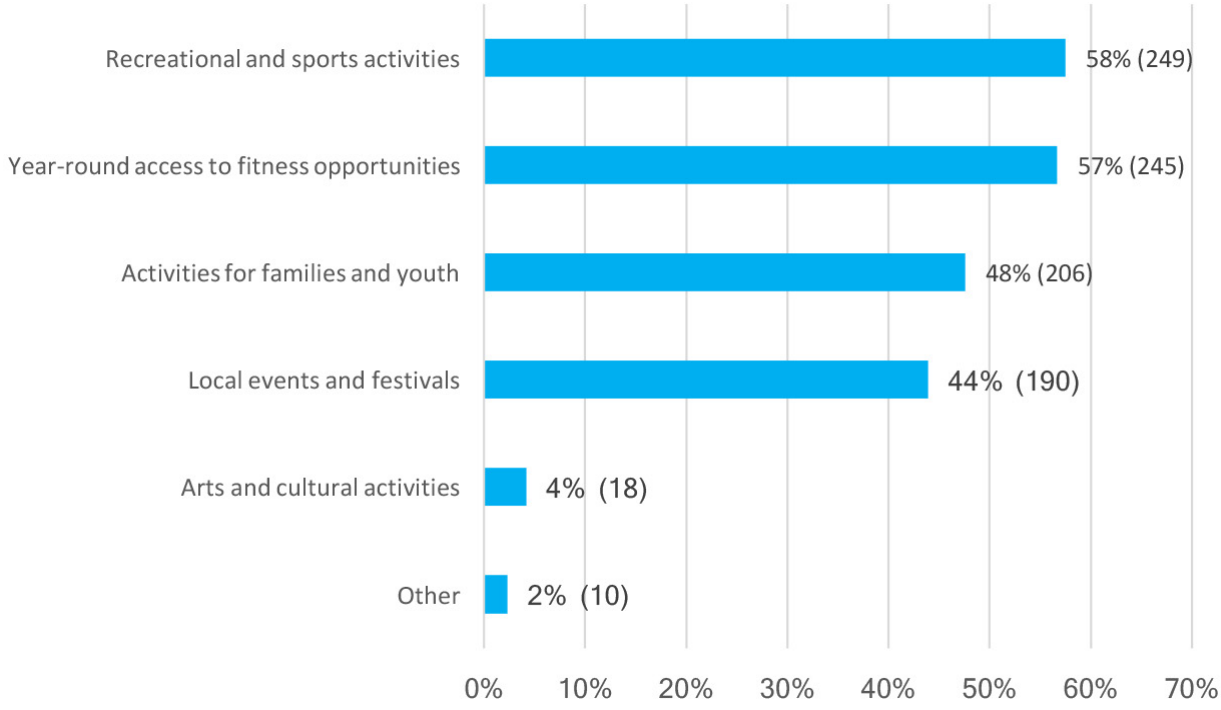
Figure 15: Best Things about the QUALITY OF LIFE in Your Community
Total responses = 1,193



Some of the "Other" responses include excellent healthcare, proximity to work and school, and living near friends and family.

Figure 16: Best Thing about the ACTIVITIES in Your Community
Total responses = 918



Respondents who selected "Other" specified that the best things about the activities in the community included access to outdoor activities and experiencing the four seasons.

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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 six categories and pick their top three concerns. The six categories of potential concerns were:

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

With regard to responses about community challenges, the most highly voiced concerns (those having at least 150 respondents) were:

- Bullying/cyber-bullying (N=256)
- Drug use and abuse – Youth (N=232)
- Cost of long-term/nursing home care – Seniors (N=202)
- Attracting/retaining young families (N=198)
- Alcohol use and abuse – Adult (N=194) Youth (193)
- Drug use and abuse – Adult (N=184)
- Not enough jobs with livable wages (N=156)
- Availability of resources to help the elderly stay in their homes (N=155)
- Depression/anxiety (N=150)

The other issues that had at least 100 votes included:

- Availability of mental health services (N=145)
- Emotional abuse (N=138)
- Depression/anxiety (N=136)
- Cost of health insurance (N=133)
- Assisted living options (N=132)
- Child abuse/neglect (N=132)
- Domestic/intimate partner violence (N=116)
- Suicide – Youth (N=113)
- Having enough child daycare services (N=104)
- Not getting enough exercise/physical activity – Adult (N=100)

Figures 17 through 22 illustrate these results.

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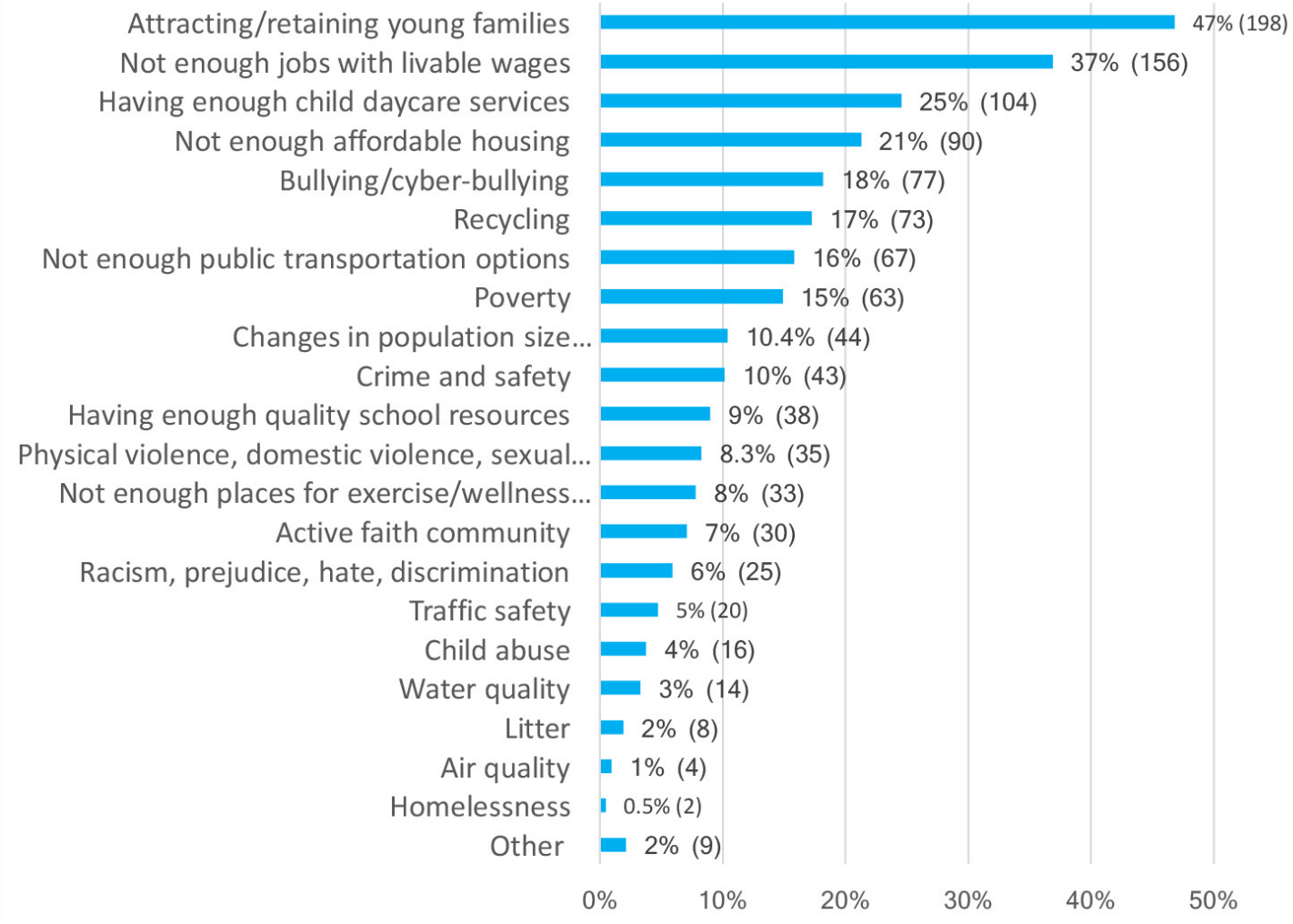
Figure 17: Community/Environmental Health Concerns
Total responses = 1,149



In the "Other" category for community and environmental health concerns, the following were listed: drug abuse, high cost and outdated healthy food choices, high utility and property taxes, no smoke-free parks, not enough mental health resources, and taxes are out of control.

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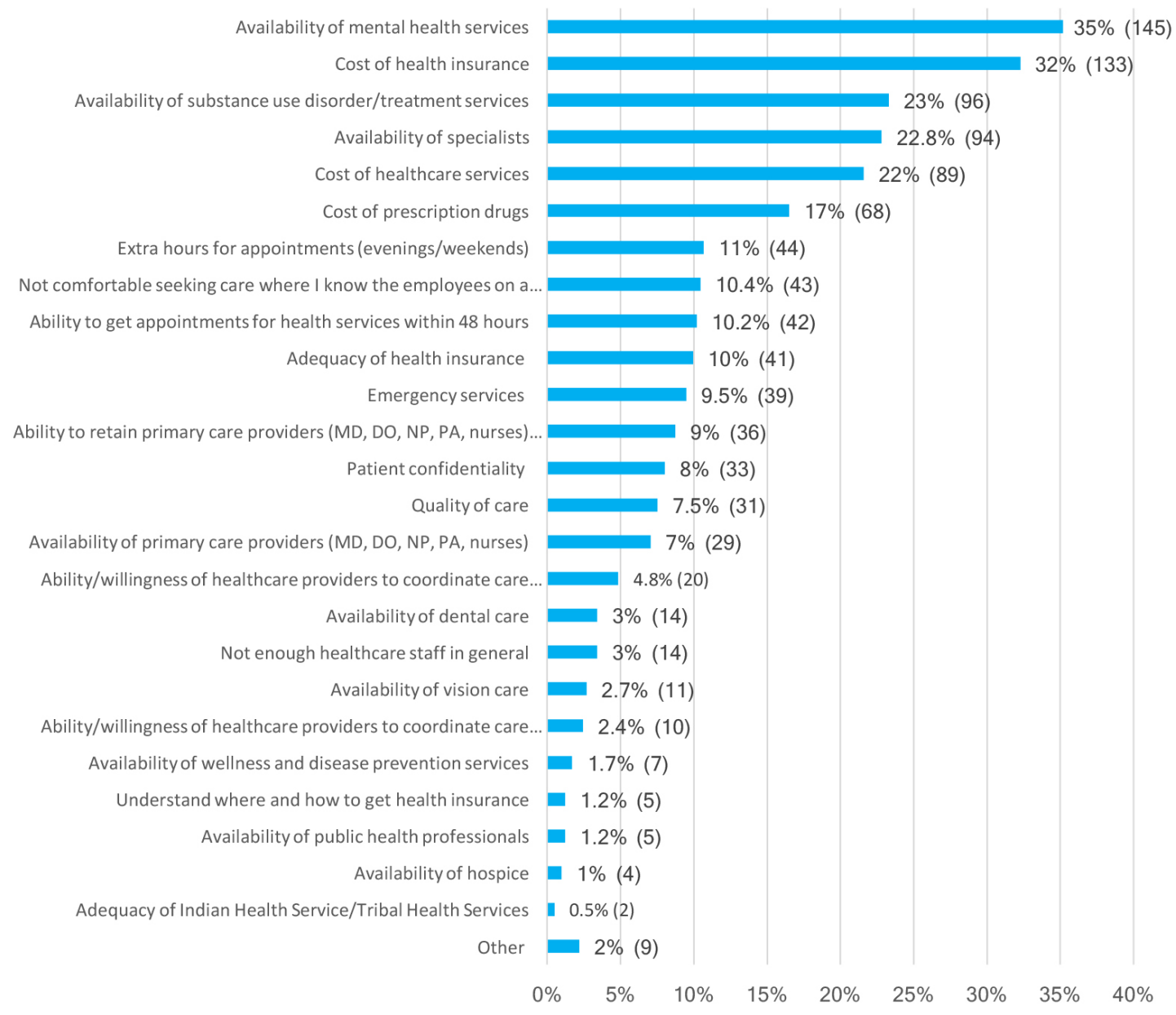
Figure 18: Availability/Delivery of Health Services Concerns
Total responses = 1,064



Respondents who selected "Other" identified concerns in the availability/delivery of health services as lack of affordable dental and/or vision services, the need for labor and delivery services, and that both hospitals are small and so close to each other.

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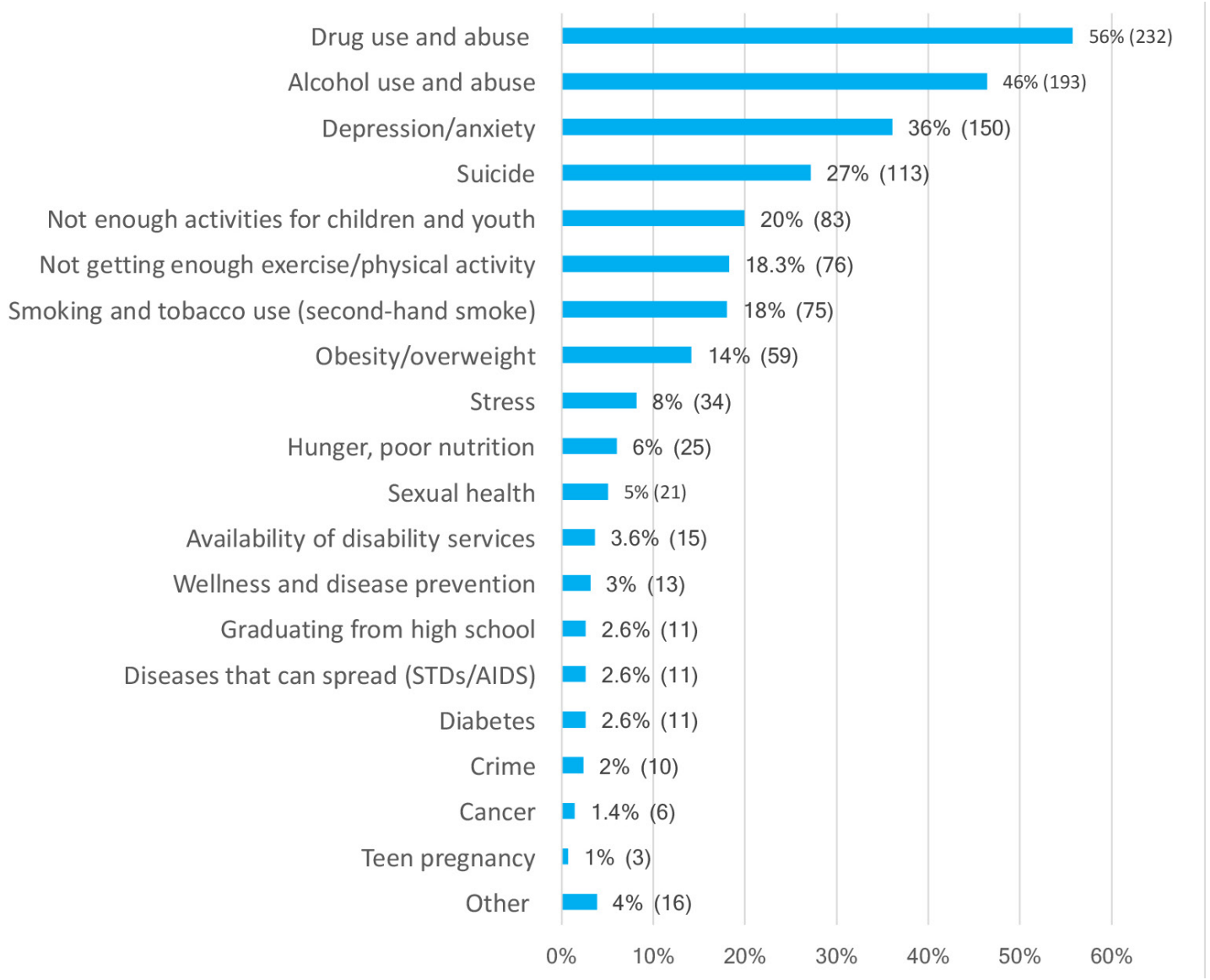
Figure 19: Youth Population Health Concerns
Total responses = 1,157



Listed in the "Other" category for youth population concerns were discipline, vaping, lack of supervision, living in poverty, teachers knowing about bullying, but not addressing the issue, social media's interference in learning, and video game addiction.

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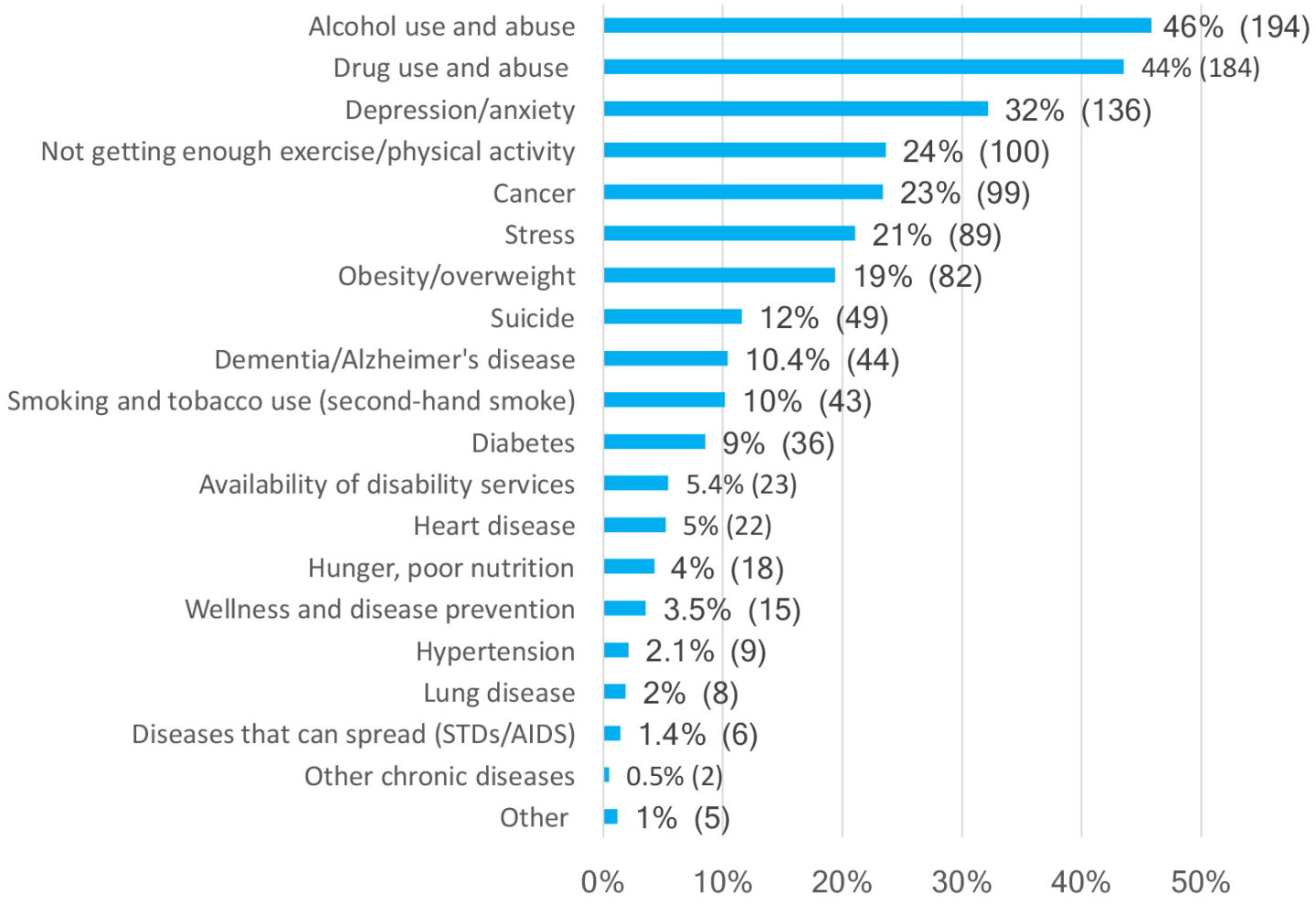
Figure 20: Adult Population Concerns



Job availability and lack of adult home care were indicated in the "Other" category for adult population concerns.

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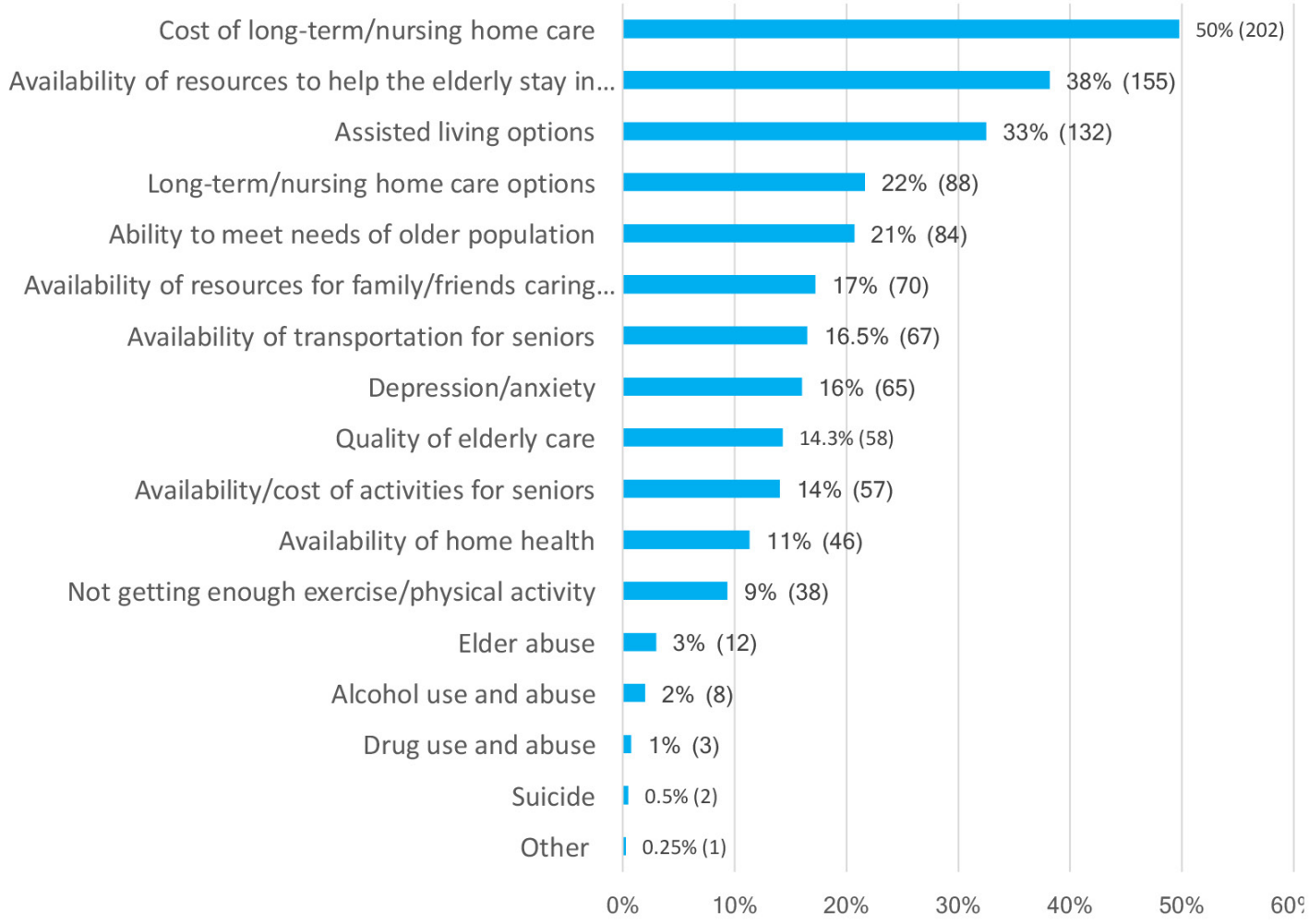
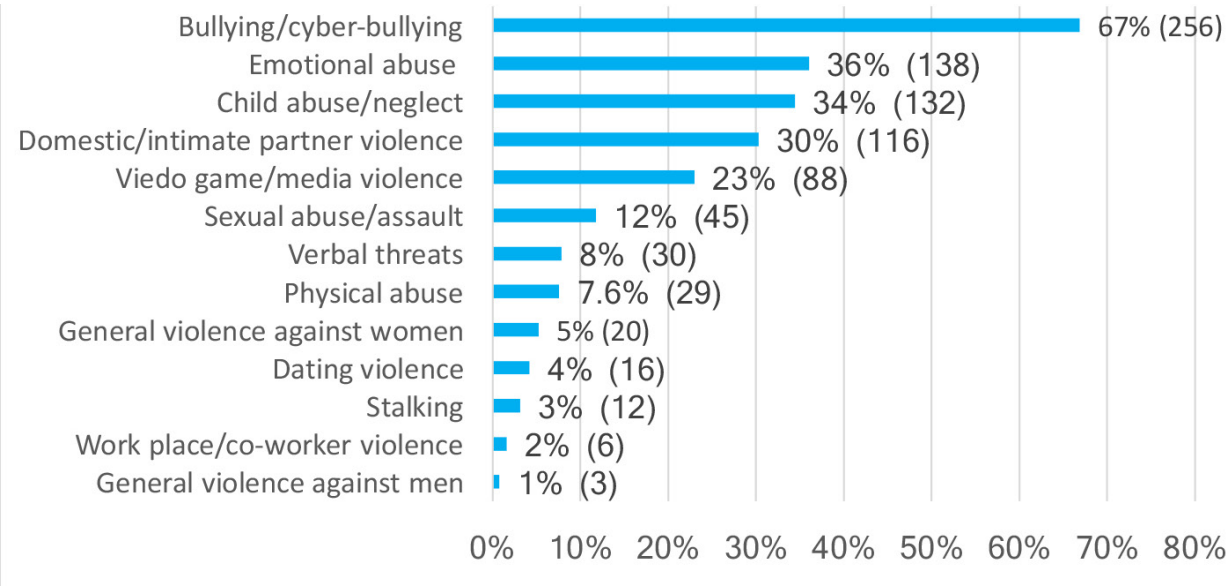
Figure 21: Senior Population Concerns
Total responses = 1,088



In the "Other" category, the one concern listed was dementia.

Figure 22: Violence Concerns
Total responses = 891



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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. The need to increase mental health services
2. Alcohol and drug abuse/substance use treatment services

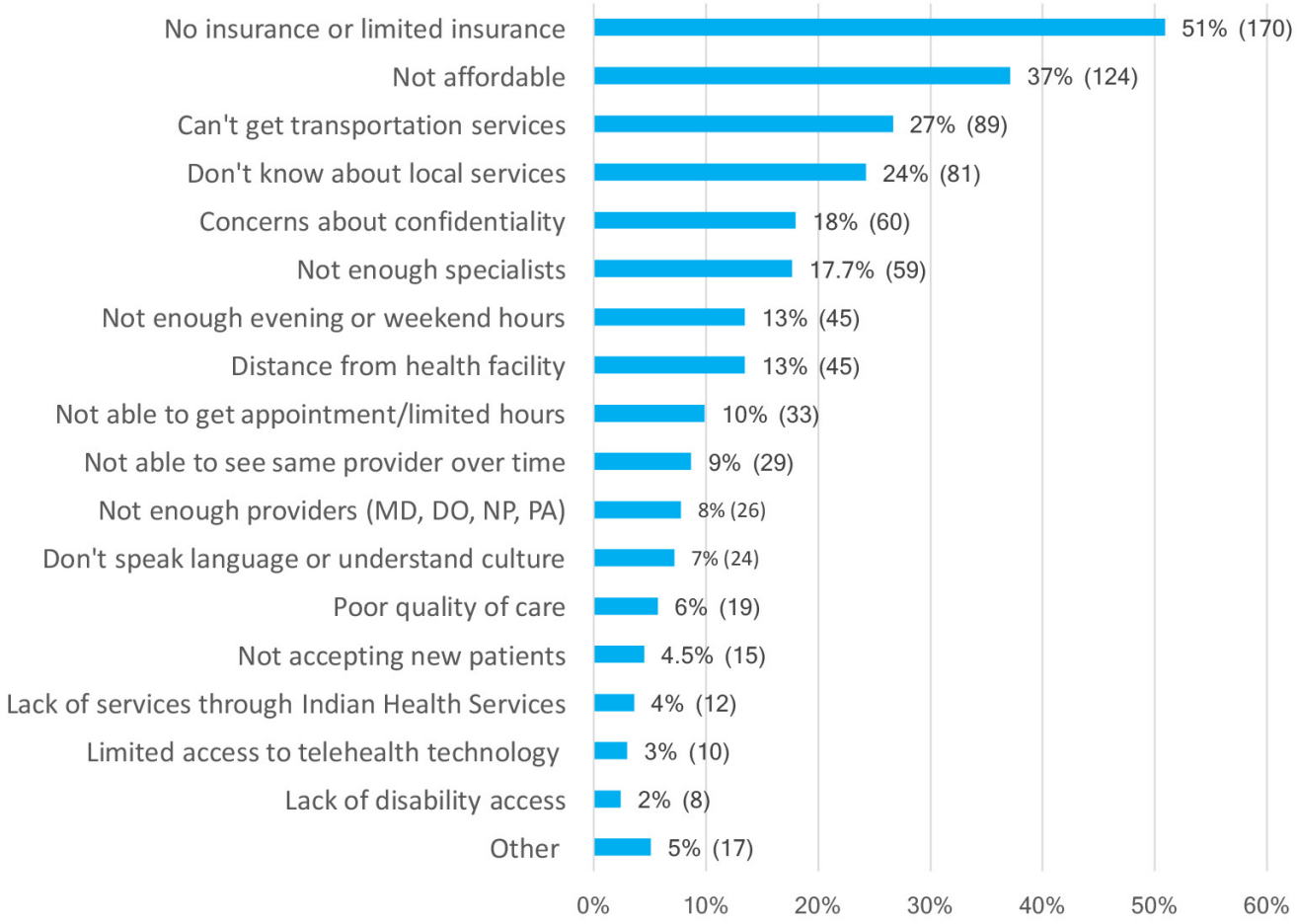
Other biggest challenges that were identified were not enough jobs with livable wages, depression/anxiety, bullying/cyber-bullying, cost of healthcare and associated costs, water quality, attracting and retaining young families, suicide, and not enough affordable housing.

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 no or limited insurance (N=170), with the next highest being not affordable (N=124). After these, the next most commonly identified barriers were inability to get transportation services (N=89), don't know about local services (N=81), and concerns about confidentiality (N=60). A few of the concerns stated in the "Other" category included the affordability of services and high deductibles, lack of mental health services, and staff attitudes.

Figure 23 illustrates these results.

Figure 23: Perceptions about Barriers to Care
Total responses = 866



Considering a variety of healthcare services offered by UMC, respondents were asked to indicate if they were aware of the healthcare services offered by UMC. (See Figure 24). Over three-fourths of the respondents were aware that emergency room, physical therapy, laboratory, mammography, swing bed/respite care, and CT scan services are offered.

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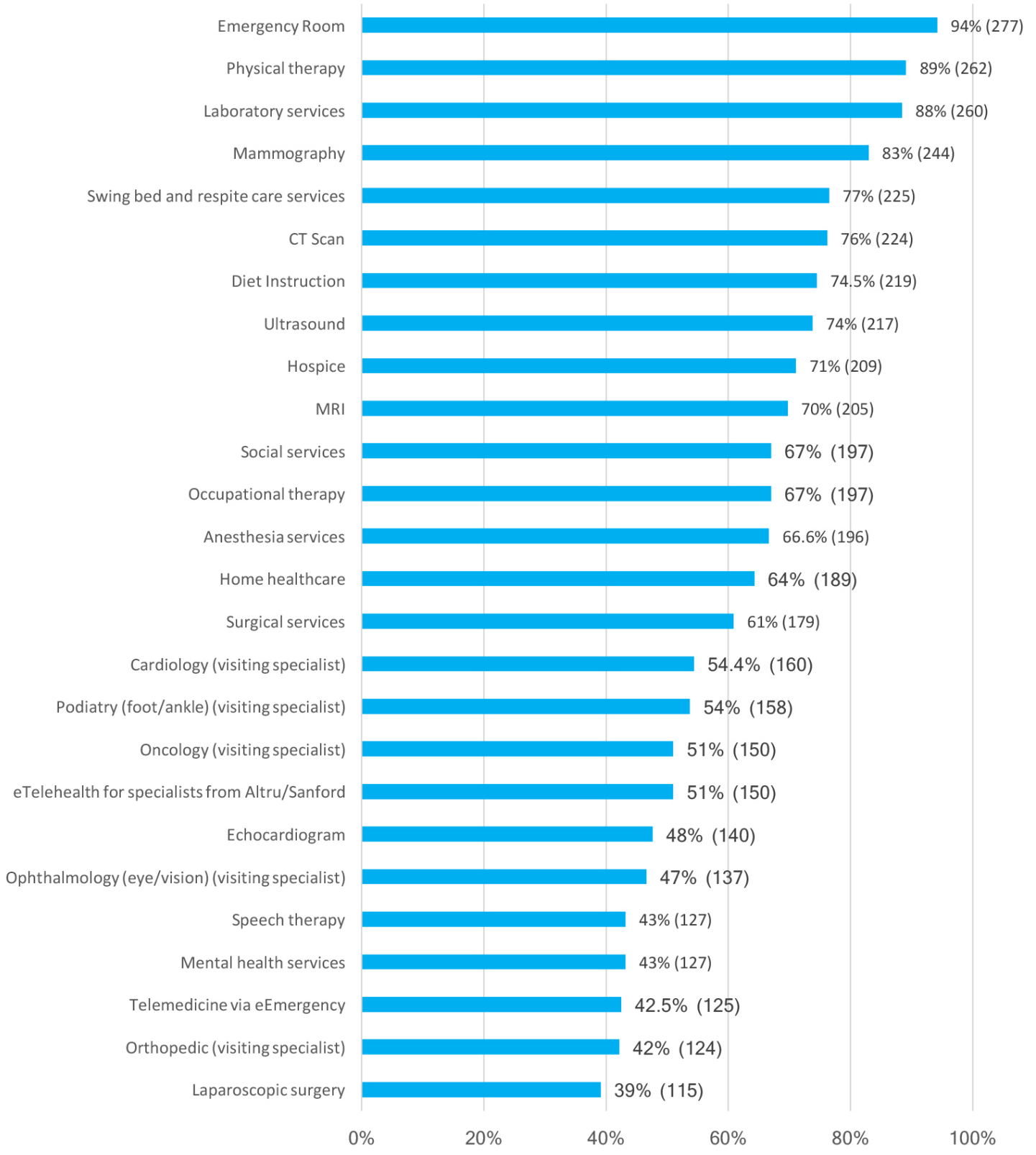
Figure 24: Awareness of Hospital Services



Respondents were also asked which services they are aware of that are provided by Walsh County Public Health District. Work-site wellness programs, WIC and adult tobacco cessation were the services of which most respondents were aware.

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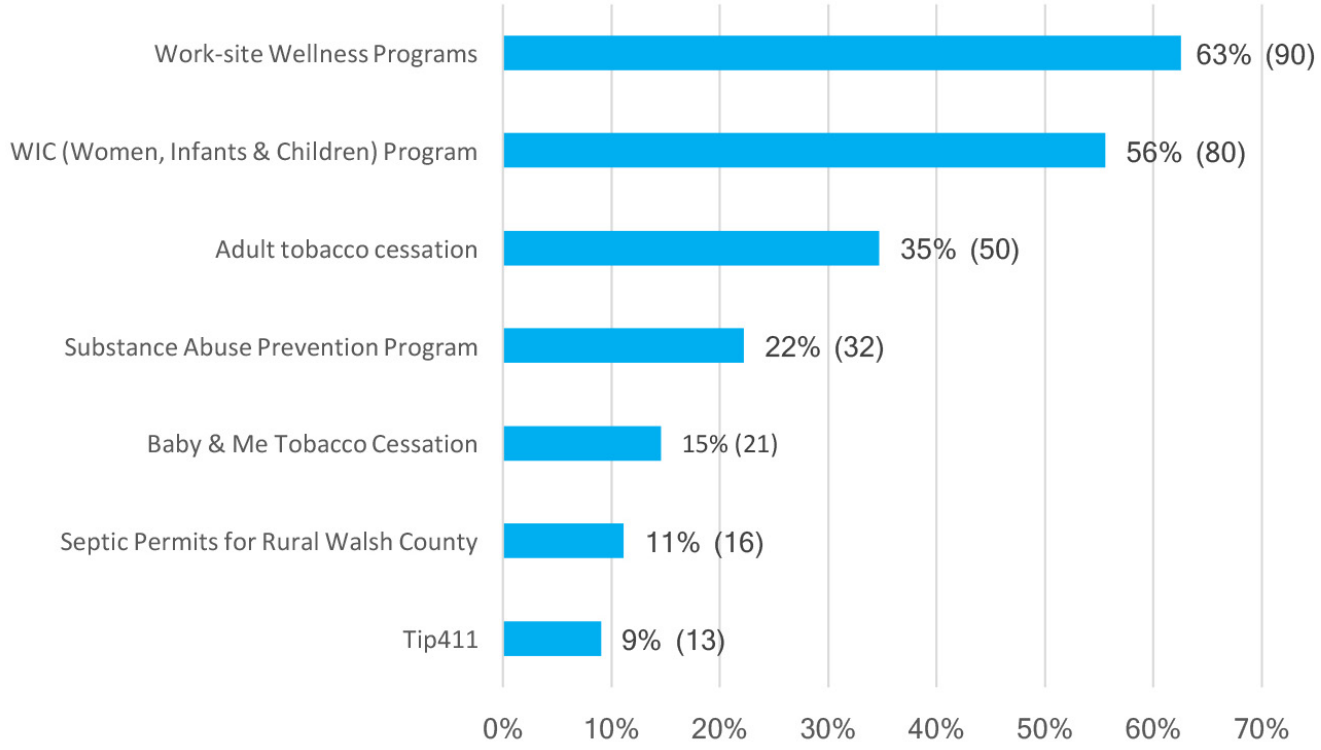
Figure 25: Awareness of Public Health Services



In an open-ended question, respondents were asked what specific healthcare services, if any, they think should be added locally. The number one desired service to add locally was mental health services. Respondents also stated that dialysis services, ENT specialists and full-time OB/GYNs were important additions, as well as pediatricians and cancer treatment specialists. Baby delivery, psychiatry and orthopedic services were also notable inclusions in the surveys

The key informant and focus group members felt that the community members were aware of the majority of the health system and public health services. There were a number of services where they felt the hospital should increase marketing efforts, these included explaining to the community what role social services employees play in the healthcare system to broaden the perception of what social workers do, increasing the visibility of transportation services, pediatric services, and to a lesser extent, telemedicine and psychology services with University of North Dakota health professional students.

Respondents were asked where they go to for trusted health information. Primary care providers (N=340) received the highest response rate, followed by other healthcare professionals (N=220), and then web/Internet searches (N=186).

Results are shown in Figure 26.

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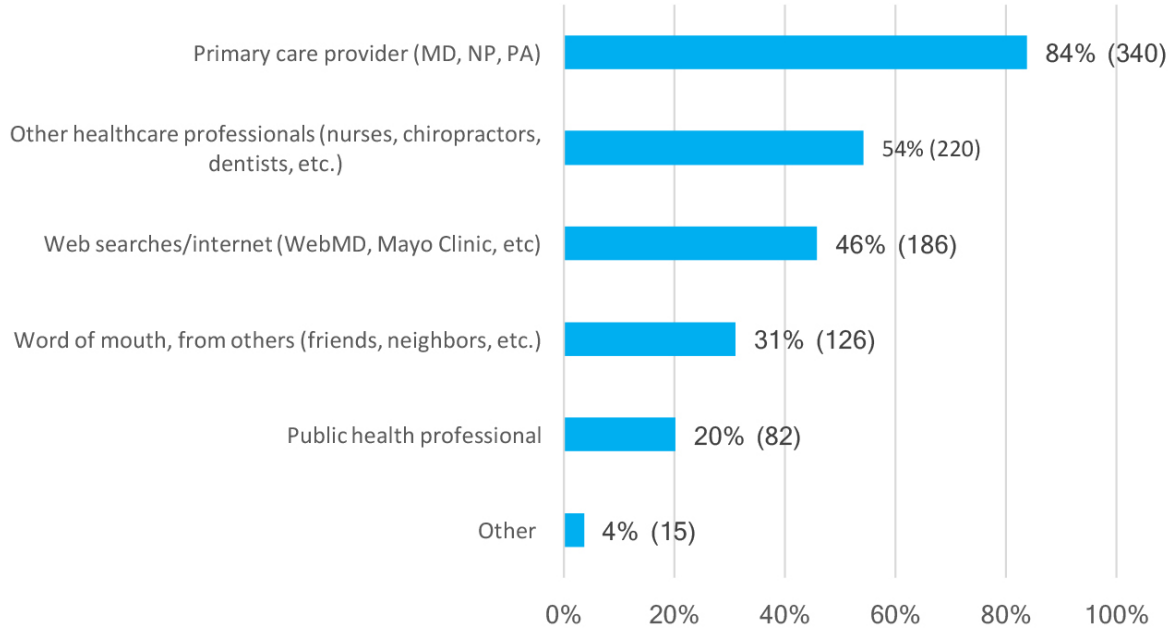
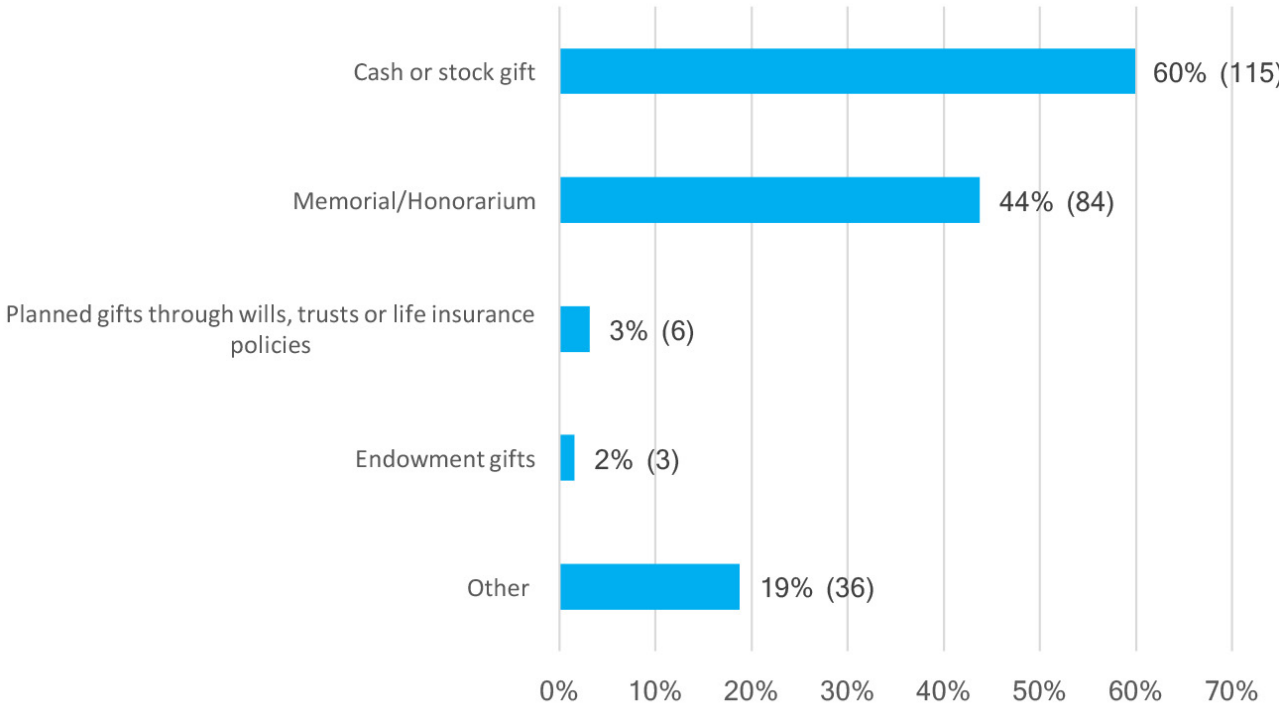
Figure 26: Sources of Trusted Health Information



Community members were asked in which ways they have supported UMC's foundation/fund-raising efforts (see Figure 27). Responses in the "Other" category included annual auctions, donations, and attendance at fundraisers.

Figure 27: Ways You Have Supported Hospital's Foundation/Fund-Raising Efforts



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The final question on the survey asked respondents to share concerns and suggestions to improve the delivery of local healthcare. While a number of responses indicated that the community is happy with the quality of care from their providers, concerns arose with a lack of physicians. Although the need for greater staffing in general received a few mentions, recruiting and retaining quality doctors stood atop the rest of the comments. Many respondents feel that the lack of availability of doctors is an important barrier to receiving timely healthcare.

In addition to strengthening the amount of physicians, community members also felt strongly about the need to bring in more specialists. Respondents included ENT and pain specialists, as well as OB/GYNs and general and orthopedic surgeons, among others, with several comments asking for a health insurance specialist to assist with health insurance questions. Transportation and associated costs were often cited as reasons to add specialists, and was included as a response on its own.

Transportation was also an issue for other areas of healthcare. In what was a common topic throughout the CHNA process, the need for mental health services and substance abuse/addiction counselors was frequently mentioned by the community. Respondents are concerned that people suffering with these issues are already bearing a lot of personal weight without the addition of needing to go to other communities due to lack of local services.

Privacy when using local services was brought up several times. Some community members stated that confidentiality was lacking in when using local hospital (and ambulance) services. Considering the sensitive nature of personal medical information, respondents felt that the staff could do a better job of keeping patients' privacy.

While there were a few community members who would like to see more collaboration between local healthcare facilities—with some even alluding to wanting them merged together—quite a few of the respondents felt that local healthcare was either adequate or they were quite pleased with the services and quality of care.

Findings from Key Informant Interviews & the Community Meeting

Questions about the health and well-being of the community, similar to those posed in the survey, were explored during key informant interviews with community leaders and health professionals and also with the community group at the first meeting. The themes that emerged from these sources were wide-ranging, with some directly associated with healthcare and others more rooted in broader social and community matters.

Generally, overarching issues that developed during the interviews and community meeting can be grouped into five categories (listed in alphabetical order):

- Attracting and retaining young families
- Availability of mental health services
- Availability of substance use disorder/treatment services
- Depression/anxiety
- Drug use and abuse

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

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Attracting and retaining young families

- While there are other important issues, I would love to see this happen in Grafton.
- We don't see as much growth because younger families aren't sticking around and building relationships.

Availability of mental health services

- It would be nice to coordinate some things with the schools, especially children with behavioral or mental health issues.
- We need to support mental health for youth in the community.

Availability of substance use disorder/treatment services

- I have to go with substance abuse treatment services. Mental health is up there, but not as much as substance abuse.
- There aren't many local services to help with the growing drug use issue in the county.

Depression/anxiety

- I think it's linked to mental health, but depression in our area and schools is such a big problem right now.

Drug use and abuse

- It's on the news all of the time, and something needs to be done.
- The drug problem in our county is outrageous.

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:

- Hospital (healthcare system) (4.25)
- Public Health (4.25)
- Long-term care (4.0)
- Faith-based (3.75)
- Law enforcement (3.75)
- Schools (3.75)
- Clinics (3.75)

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- Emergency services (3.75)
- Other local health providers (3.75)
- Social Services (3.75)
- Pharmacies (3.5)
- Human Services (3.5)
- Business and industry (3.5)
- Economic development organizations (3.5)

Priority of Health Needs

A Community Group met on April 3, 2019. Fifteen 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:

- Availability of mental health services (8 votes)
- Alcohol use and abuse (adults) (7 votes)
- Attracting and retaining young families (7 votes)
- Depression/anxiety (7 votes)
- Drug use and abuse (youth) (7 votes)

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

1. Attracting and retaining young families (6 votes)
2. Availability of mental health services (6 votes)
3. Alcohol use and abuse (2 votes)
4. Drug use and abuse (1 votes)
5. Depression/anxiety (0 votes)

Following the prioritization process during the second meeting of the Community Group and key informants, the number one identified need was the availability of resources to help the elderly stay in their homes. A summary of this prioritization may be found in Appendix D.

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Comparison of Needs Identified Previously

Top Needs Identified 2016 CHNA Process	Top Needs Identified 2019 CHNA Process
•Alcohol use and abuse	• Attracting and retaining young families
• Traffic safety	• Availability of mental health services
• Assisted living options	• Alcohol use and abuse
• Jobs with livable wages	• Drug use and abuse
• Obesity/overweight	• Depression/anxiety

The current process did not identify any identical common needs from 2016. However, the availability of mental health services could be linked to alcohol use and abuse, as there are connections between mental illness and substance abuse, and addiction services are sometimes a part of mental health services.

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:

Behavioral Health/Adult and Youth Alcohol and Drug Misuse: Since the last CHNA process, UMC has participated on a Walsh County Substance Abuse Prevention Coalition to address Adult and Youth Substance Misuse. UMC providers have reviewed and updated their use of the Prescription Drug Monitoring Program in an effort to decrease access to prescription opioids by people who misuse them. UMC participated in a Community and School Forum at the Grafton School to address Opioid Misuse. In conjunction with the Walsh County Substance Abuse Prevention Coalition, a Community Resource Guide was developed that provides behavioral health information/contacts for the local communities.

Nutrition and Physical Inactivity: UMC staff worked with the Walsh County Worksite Wellness Coalition to develop their worksite wellness program. Employees received training at the ND Worksite Wellness Conference and/or the Gaining Ground trainings. A Diabetes Prevention Program was implemented at UMC, and healthy cooking classes were conducted by the dietitian for the community. A Resource Guide was developed that listed the Community Fitness Facilities available in the Grafton Community.

Recruiting and Retaining Medical Providers: While this was not determined to be a CHNA priority at the time of the 2016 CHNA, UMC was challenged with a number of staffing changes/retirements and prioritized the recruitment and retention of the following: 2 MDs, 2 PACs, and after-hours emergency room providers. A new dermatology/aesthetics practice was also developed and staffed by a FNP. Due to demand from the community, UMC also expanded their walk-in clinic hours to include hours during the week as well as on Saturday mornings.

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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.

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- Required of all healthcare providers by rules or standards.
- Questionable as to whether it should be reported.
- Unrelated to health or the mission of the organization.

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Appendix A – CHNA Survey Instrument

Walsh County Health Survey

First Care Health Center, Unity Medical Center, and Walsh County Health District are interested in hearing from you about community health concerns.

The focus of this effort is to:

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

Scan here to take the survey online!

If you prefer, you may take the survey online at http://tinyurl.com/18WalshCounty 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 January 25, 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) _____

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

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

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

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

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

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

- ☐ Alcohol use and abuse
- ☐ Drug use and abuse (including prescription drug abuse)
- ☐ Smoking and tobacco use, exposure to second-hand smoke
- ☐ 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. Regarding various forms of **VIOLENCE** in your community, concerns are (choose up to THREE):

- ☐ Bullying/cyber-bullying
- ☐ Dating violence
- ☐ Domestic/intimate partner violence
- ☐ Stalking
- ☐ Emotional abuse (includes: intimidation, isolation, verbal threats, economic abuse/withholding of funds)
- ☐ Sexual abuse/assault
- ☐ Video game/media violence
- ☐ Child abuse/neglect
- ☐ General violence against women
- ☐ General violence against men
- ☐ Work place/co-worker violence

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

_____

_____

Delivery of Healthcare

12. Considering **SERVICES** at your hospital, which services are you aware of? (Choose ALL that apply)

- ☐ Anesthesia services
- ☐ Cardiology (visiting specialist)
- ☐ CT Scan
- ☐ Diet instruction
- ☐ Echocardiogram
- ☐ Emergency room
- ☐ eTelehealth for specialists from Altru/Sanford
- ☐ Home healthcare
- ☐ Hospice
- ☐ Laboratory services
- ☐ Laparoscopic surgery
- ☐ Mammography
- ☐ Mental health services
- ☐ MRI
- ☐ Occupational therapy
- ☐ Oncology (visiting specialist)
- ☐ Ophthalmology (eye/vision) (visiting specialist)
- ☐ Orthopedic (visiting specialist)
- ☐ Physical therapy
- ☐ Podiatry (foot/ankle) (visiting specialist)
- ☐ Social services
- ☐ Speech therapy
- ☐ Surgical services
- ☐ Swing bed and respite care services
- ☐ Telemedicine via eEmergency
- ☐ Ultrasound

13. Which of the following **SERVICES** provided by your local **PUBLIC HEALTH UNIT** are you aware of? (Choose ALL that apply)

- ☐ Adult tobacco cessation
- ☐ Baby & Me Tobacco Cessation
- ☐ Tip411
- ☐ WIC (Women, Infants & Children) Program
- ☐ Substance Abuse Prevention Program
- ☐ Septic Permits for Rural Walsh County
- ☐ Worksite Wellness Programs

14. 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) _____

15. Where do you turn for trusted health information? (Choose ALL that apply)

- ☐ Other healthcare professionals (nurses, chiropractors, dentists, etc.)
- ☐ Primary care provider (doctor, nurse practitioner, physician assistant)
- ☐ Public health professional
- ☐ Web searches/internet (WebMD, Mayo Clinic, Healthline, etc.)
- ☐ Word of mouth, from others (friends, neighbors, co-workers, etc.)
- ☐ Other (please specify) _____

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

_____

_____

17. Have you supported your hospital's Foundation/fund raising efforts in any of the following ways? (Choose ALL that apply)

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

Demographic Information: Please tell us about yourself.

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

- ☐ Yes
- ☐ No

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

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

20. Age:

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

21. Highest level of education:

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

22. Gender:

- ☐ Female
- ☐ Male
- ☐ Transgender

23. Employment status:

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

24. Your zip code: _____

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

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

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26. Annual household income before taxes:

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

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

_____

_____

Thank you for assisting us with this important survey!

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Appendix B – County Health Rankings Explained

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

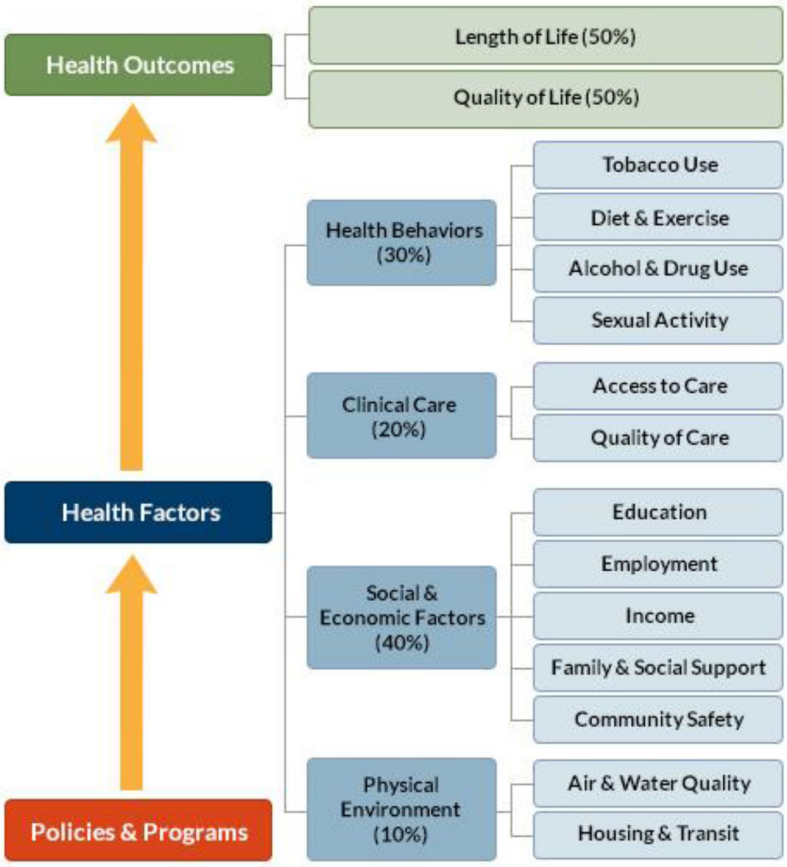
Methods

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



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

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

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

Data Sources and Measures

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

Data Quality

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

Calculating Scores and Ranks

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

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Health Outcomes and Factors

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

Health Outcomes

Premature Death (YPLL)

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

Reason for Ranking

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

Poor or Fair Health

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

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

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

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

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

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

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

Health Factors

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

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

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

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

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Food Environment Index

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

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

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

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

Reason for Ranking

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

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

Physical Inactivity

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

Reason for Ranking

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

Access to Exercise Opportunities

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

Individuals who:

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

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

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

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

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

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

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

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

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

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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.

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

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

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

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

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

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

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

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

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

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

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

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

Injury Deaths

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

Reason for Ranking

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

Air Pollution-Particulate matter

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

Reason for Ranking

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

Drinking Water Violations

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

Reason for Ranking

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

Severe Housing Problems

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

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

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

Reason for Ranking

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

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Appendix 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

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	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

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	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

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	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

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Appendix D – Prioritization of Community's Health Needs

Ranking of Concerns

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

	Priorities	Most Important
COMMUNITY/ENVIRONMENTAL HEALTH CONCERNS		
Attracting and retaining young families	7	6
Having enough child daycare services		
Not enough affordable housing		
Not enough jobs with livable wages		
AVAILABILITY/DELIVERY OF HEALTH SERVICES CONCERNS		
Ability to retain primary care providers (MD, DO, NP, PA)		
Cost of health insurance	4	
Availability of mental health services	8	6
Cost of healthcare services		
YOUTH POPULATION HEALTH CONCERNS		
Alcohol use and abuse	4	
Drug use and abuse	7	1
Depression/anxiety	3	
Not getting enough exercise/physical activity	2	
ADULT POPULATION HEALTH CONCERNS		
Alcohol use and abuse	7	2
Drug use and abuse (including prescription drugs)		
Depression/anxiety	7	0
Stress		
SENIOR POPULATION HEALTH CONCERNS		
Cost of long-term/nursing home care	2	
Availability of resources to help elderly stay in their homes	4	
Assisted living options		
Long-term nursing home options		
VIOLENCE CONCERNS		
Bullying/cyber-bullying (youth)	3	
Child abuse/neglect	2	
Bullying/cyber-bullying (adults)		
Emotional abuse (isolation, verbal threats, withholding of funds)		

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Appendix E – Survey "Other" Responses

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

1. Considering the PEOPLE in your community, the best things are: "Other" responses:

- 4th Gen-lifer, never leaving!
- No Comment!
- People are relatable
- Small towns are gossips
- Volunteers

2. Considering the SERVICES AND RESOURCES in your community, the best things are: "Other" responses:

- Fitness Centers and Park
- Fitness opportunities
- Helpful people
- I feel that there are a lot of things that need to change in this community. There is such a segregation at times of social classes. I don't believe there are enough community programs for families or teenage children. I think there is still a bullying problem in the school system.
- Law enforcement
- North Valley Career and Technology Center

3. Considering the QUALITY OF LIFE in your community, the best things are: "Other" responses:

- Closeness to work and school
- Excellent healthcare
- Friends and family live here

4. Considering the ACTIVITIES in your community, the best things are: "Other" responses:

- Access to outdoor activities
- Cold
- Four different seasons of outdoor
- None of the above
- Not many options
- Outdoor activities
- There aren't a lot of activities here
- There is very little to do here all year round

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 abuse

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- Drugs
- High cost and outdated healthy food choices
- High utility and property taxes
- Honestly I could have chosen 5 or 6 for this category. Racism, bullying (impersonal bullying behavior by adults online), lack of public transport, lack of childcare (no options for those who need childcare periodically, most daycares are full, no drop-ins) and littering
- No smoke-free parks
- Not enough mental health resources/too much turnover in this area
- People are not attending church-sports-too involved
- Taxes are out of control

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

- 2 small hospitals so close to each other
- Affordable dental and/or vision that is not offered by your employer
- Cost of healthcare, prescriptions & health insurance and alternative holistic medicine practitioners
- My wife was brought np (swing bed) and I pointed out that she may have had a stroke and the on-duty personnel stated "oh we'll keep an eye on her"
- Need birthing center. Having to travel to GF to give birth is sad when we have a beautiful facility and hospital here
- Our healthcare is great
- Really, really wish we had labor and delivery services here. Hard to plan ahead, facilitate schedules, etc. when you have to go all the way to Altru
- Satisfied
- Would Iike to see the hospital/clinics and nursing homes in each town have more to do with each other. Coordinating health fairs and events to show they work with each other.

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

- All of them
- Discipline
- E-cigarettes (vaping)
- Getting them connected to our community and keeping them here after school
- Intelligence is declining
- Lack of supervision
- Living in poverty
- Poor parenting skills
- Spiritual opportunities
- Teachers knowing about bullying and not addressing it even when the parents inform them
- Unfairness within the school system for example certain classes of students get away with a lot more than students who don't have the prominent last name or the prominent parents even the troublemakers or the ones breaking the rules get away with it if they're from the "right" family
- Use of social media and its interference in learning social skills
- Vaping
- Video game addiction and/or overuse

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

- Adult home care lacking
- Church opportunities

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- Job availability
- Unemployed individuals who are capable of working

10. Considering the SENIOR POPULATION in your community, concerns are: "Other" responses:
    - Dementia
11. What single issue do you feel is the biggest challenge facing your community?
    - Accepting of others who are different, live a different lifestyle, have different religious beliefs, have different political beliefs, have different social skills
    - Bullying
    - Our ability to attract new families, flood insurance, vibrant downtown
    - The workforce does not offer high enough pay to meet the cost of living standards or to get ahead. Nor is there any opportunity for members of the community to try redeem themselves from their past mistakes. Such as a DUI or criminal charges. It makes it very hard for them to find work or acceptance to be able to move on.
    - A lot of child abuse going on
    - Ability to attract and keep long-term healthcare providers
    - Abuse
    - Access to behavioral health services, narcotics anonymous
    - Access to mental health professionals
    - Access to specialists in the medical field
    - Acquiring labor force to assist local businesses
    - Activities and events, fitness center
    - Activity for youth
    - Activity possibility
    - Addiction
    - Affordable health insurance for everyone
    - Affordable housing
    - Affordable housing and childcare
    - Affordable housing and employment wages
    - Aging community not having growth and new families moving to improve population, and drugs are a major problem in America
    - Aging population and services available to them
    - Alcohol abuse
    - Alcoholism
    - Anxiety, depression and suicide among our youth. Lack of education and abuse of government handout among adults
    - Attracting young families
    - Attracting young families to move here
    - Availability of mental health services
    - Available housing
    - Boredom – drug/alcohol abuse, overweight/obesity, lack of work ethic among young adults and teens
    - Bullying
    - Businesses not working together
    - Can't pick just one
    - Caregivers for the elderly in their own home such as respite providers
    - Child abuse, nothing is done about this and is never taken seriously
    - Child abuse/neglect, with the ongoing drug issues in our community. Also, sexual abuse on children

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- Cost for health insurance and copays
- Cost of healthcare
- Cost of living (housing, groceries, healthcare, etc.)
- Cost of living increases
- Costs of housing in the area, living from paycheck to paycheck on no government assistance
- Declining population
- Declining youth population, graduates moving away
- Demographics is the biggest issue. We have a community of haves and have-nots, there really isn't a middle ground. The poor are very poor and I worry about the kiddos in those environments
- Disappearance of business district
- Diversity/tolerance, breaking down redneck attitude
- Domestic violence
- Domestic/interpersonal emotional abuse
- Drug abuse
- Drug abuse and alcohol
- Drug addiction
- Drug issue
- Drug use and abuse and how it is affecting families
- Drug/alcohol abuse, especially in youth
- Drugs
- Drugs and alcohol, and they lead to crimes, child abuse/neglect, and domestic violence
- Drugs are a huge issue
- Drugs are a large issue in our country
- Ease of obtaining illegal drugs
- Education regarding physical and mental health and also financial health
- Empathy
- Employment
- Engaging our youth in healthy activities, concerned about vaping, tobacco, drinking-wish we had a large Christian youth center
- Enough childcare so that parents are able to work
- Finding money to keep infrastructure operating and in good shape
- Getting home services for elderly or disabled (cleaning, laundry, getting groceries, etc.) activities for all age groups so they do not isolate themselves-especially in the winter months
- Getting younger persons to go to work
- Good jobs
- Good jobs and pay
- Having a hospital where one has to climb steps to enter the clinic/hospital-hard for elderly people that have to drive themselves
- Having a reliable workforce
- Having enough people to meet the needs/provide resources/work, declining population, aging population
- Having equitable access to state government programs/services in rural North Dakota when 2/3rds of legislators are from the state's 10 largest cities
- Hearing about kids getting bullied at schools
- High taxes on property
- Housing
- Housing affordability for single people/one-income households
- Housing for low-income families

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- I believe the lack of mental health services, including drug and alcohol treatment options, is the biggest challenge
- I believe the single greatest challenge is the need for jobs that pay well enough to bring youth back to work. Better paying jobs would also keep those who live here as they would be able to support themselves. There are a lot of jobs available, but most of them remain unfilled because they don't pay well enough for people to support themselves and their families.
- I don't know
- I feel it is way more than a single issue
- I think a huge problem in our area is that in our small towns there are too many run-down houses, making property cheap, unsafe and accessible to a population of "unsafe" or "unstable" people.
- I would love to see recycling in our town. With the school, hospital, nursing home and the restaurants in town there is such a high amount that could be recycled
- Increasing our local population
- It's a really small community, so not a lot of support or activities for teenagers, kids today, especially in the winter
- Jobs
- Keeping families involved in church; sports have taken over everything
- Keeping people here
- Keeping population
- Labor force. Lack of skilled and qualified workers to fill positions
- Lack of addiction services
- Lack of affordable child care—especially in the summer
- Lack of mental health assistance
- Lack of mental health services
- Lack of money in the community
- Lack of parent education
- Lack of quality of health care
- Lack of services and long-term support for mental health and substance abuse
- Limited access to basic grocery needs and fresh fruits and vegetables
- Location and not enough new "hip" places to go to
- Looking appealing and sustainable to an outsider looking to move here, retaining ones that do, and marketing our strengths
- Losing population that we are now under 5,000 people and local businesses not supported enough and also reputation with drugs
- Loss of population
- Low wages, high cost of living. High expectations of financial support for businesses and organizations from residents
- Maintaining enough jobs to employ young people with good paying jobs. It seems that the number of college educated jobs are declining except at the school
- Maintaining the younger generation
- Mental health
- Mental health and the lack of availability for counseling services or inpatient facilities
- Mental health crisis services
- Mental health issues and subsequent use of drugs or alcohol to cope
- Mental health options
- Mental health resources
- Mental health services
- More variety of jobs for the middle age class with livable pay
- Need for more activities in our community

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- No affordable childcare
- No filters regarding social media use
- No recreation for youth
- No town hall meetings to discuss issues. Would like community events to bring us together and share resources, put on classes/workshops and learn from each other
- Not accepting of change even if it is a positive change, treating kids as beings without rights, respecting their right to consent (dominance behavior by adults in charge of sports and other activities) I think this is a huge contributor to learning about bullying behavior and depression and suicide in our youth
- Not enough activities for kids, adults and elderly. Not much for daycare providers that will work the hours of a 12-hour shift
- Not enough mental health options/drug/alcohol programs
- Not enough mental health services
- Not enough resources for drug addicts and/or alcoholics. Need a treatment center in our area
- Not enough stores to do personal shopping

Delivery of Healthcare

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

- "Grief sessions" that have not been provided for in this community for 10 years. Very important—they helped me very much when my husband died
- A full-time gynecologist
- Effect of drug use…and actions to prevent or say no
- Assisted living facility
- Behavioral health services
- Better staffed ER. Too many patients referred to Grand Forks or Fargo. The ability and experience by our doctors and nurses to treat certain medical conditions
- Cancer specialists
- Cancer treatments such as chemotherapy and radiation so you wouldn't have to travel to receive services
- Caregiver stress management, support groups for parents of kids with behavior issues, kid group with counseling so they can help each other
- Chemotherapy, radiation
- Childbirth in small towns
- (2)Chiropractic care/services
- Christian-based counseling and addiction recovery services
- Confidential substance abuse treatment facility
- Consolidate Grafton and Park River healthcare into one more capable facility
- (3)Delivering babies
- Dental care
- (7)Dialysis
- Direct primary care
- (5) ENT
- Food pantries, family assistance
- Free healthcare, community health services does
- Full-service emergency doctor, natural path for hormones, natural grocers, education/classes from NDSU extension on healing herbs and gardening
- General surgeon

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- Have plenty
- Health and medical insurance help systems
- Healthcare in our community are great and really don't think they could do more as they are here 24-7 for us
- Holistic/alternative health services
- I am exceedingly grateful for Dr. Joel Johnson and the entire team at First Care health Center in Park River. I can't over-state that.
- I think having different specialists come to local doctors' offices is a fantastic way for patients to see them and limit the out-of-town driving
- I think we are very fortunate to have the health care options we have
- I think we do well for Park River
- I think we need options as in another owned health facility instead of only having the one option
- Install dialysis service. Perhaps other nearby hospitals will have it if we don't. Getting to dialysis can be a problem if it is too far away. Many in area travel to dialysis. Make trip shorter by starting a program in Grafton.
- Low-cost dental
- Make it affordable
- (31) Mental health services
- Midwife
- More counseling
- More exercise options and specialists
- More kids' speech
- More nutrition/exercise related programs
- More sensory services-pediatric-little miracles is a way to go for services
- More specialists such as cardiology, oncology, ophthalmology, etc. in the local community (not just GF)
- More therapists for children with special needs such as autism, ADD, ADHD, etc.
- Nephrology and internal medicine
- Newborn delivery
- Newsletters from the county nurse
- None at this time; we have a lot of services available now
- Not a healthcare service in particular, but the service of transporting patients
- (7) OB/GYN
- Occupational therapy access—pediatric
- On-site, 24/7 MRI, CT scan, ultrasound. Doctors in the ER
- Orthodontist
- (2) Orthopedic services
- Pain specialist
- (3) Pediatric specialty
- Podiatrist
- Prescription assistance program
- Preventative care, fitness activity
- Provide daily dialysis for people
- (3) Psychiatry
- Psychologist available five days a week
- Rheumatologist
- Same-day surgeries
- School nurse

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- Services for people experiencing anxiety. So many people have moderate/extreme anxiety, which in return causes more issues
- Substance abuse and mental health
- Telehealth for mental health & substance abuse/recovery
- Telehealth technology for all areas of healthcare, especially for mental health and drug/alcohol counseling
- Treatment centers
- Vision/dental/OB/GYN
- We have a very good hospital. Would be nice if they still delivered babies
- We have very good access to healthcare in our region—also great providers
- We need a mental health and chemical dependency long-term facility
- We need more mental health services, especially evaluation and treatment for drug and alcohol
- Weight-loss clinic
- When it comes to Medicaid I feel like it shouldn't matter which hospital I go to. Altru most times now or else I get billed. Even though I prefer Altru, but if I or my son is really sick I would rather go somewhere local so he can get cared for right away

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

- Can't afford services even with insurance—high deductibles
- Cost, high deductible
- Do not apply
- Embarrassment to ask for help
- Have been refused at hospital due to disability
- Healthcare is great
- High deductibles under Obamacare
- I am not aware of any problems
- I receive great healthcare
- I'm always healthy
- Lack of mental health services and support
- Quality of care
- Staff attitudes
- We receive great healthcare here

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

- Two brothers are doctors
- Alternative health providers
- (2) Community healthcare
- Marvin provides many sources
- (3) Mayo Clinic
- My sister
- People I trust
- Professionals outside of Walsh County
- Self
- Thetruthaboutcancer.com, mercola.com, naturalnews.com, Erin-healthnutnews, alternative physicians

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18. What ways are you most likely to support facility improvements/new equipment at CHI St. Alexius Health Carrington? "Other" responses:

- (2) Annual auction
- (8) Attend fundraisers
- Donating baked goods for fundraisers
- Donation to silent auction
- (2) Donations for events
- Events and building donations
- (6) Giving Hearts day
- Silent auction
- Supporting events
- UMC Harvest Auction
- Unity banquet
- (2) Volunteer

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

- A way to follow up on a patients at home
- Access to pain specialists. Access to a neurologist is a four-hour drive from home. The cost of getting to a specialist (time off, gas, lodging and meals). You have to save up and use that as a vacation most times, woo hoo (not).
- Arrogant attitudes of some of the longer-term healthcare professionals
- As previously stated, we have a huge void in local services for person with substance abuse and mental health issues. These people are often marginalized already, with no driver's license, no money, no insurance. They are unable to access services in Grand Forks. We need local services desperately.
- As stated before, consolidate the small local hospitals into one more viable one
- Assisted living space
- Be reasonable and more compassionate
- Better ambulance services
- Better ambulance/hospital service. Both are lacking skill and keeping confidentiality
- Better hours/availability
- Better quality of local healthcare
- Clean house at the cop shop (too much favoritism) and get people who care at the hospital not just collect a paycheck
- Confidentiality
- Continue to provide excellent care in our smaller towns! So many people rely on good, local medical services!
- Coordinate care among providers and follow up on medication changes as well as hospitalizations
- Functional/prevention-minded healthcare providers/services
- Get and retain quality doctors
- Good overall – more to some services for kids to teens, also more training and understanding in elderly area
- Group home for children with disabilities and more doctors to choose from
- Have less emphasis on building projects and more emphasis on expanding and starting new health programs. This increase in scope of services should also help the bottom line. Hospitals should not only be about building projects, yet it seems to be the main concern.
- Healthcare needs to be affordable and health insurance needs to be cheaper
- Health coverage should include vision and dental

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- I believe we have one of the best healthcare systems. Liaison with Mayo – good ideas
- I feel there needs to be more help for people with mental health/addiction in our area and overall nationwide
- I feel we desperately need more professionals in the mental health field, and also more affordable assisted living facilities
- I have an HAS in which I or my children only go to the doctor if I EXTREMELY need to. HAS is hardly enough to pay for the doctor's visit, nevertheless another checkup appointment to follow. I see on social media all the time, friends and their children continuously havening doctor's appointments for pretty much anything. Not sure how anything can be done about it though.
- I like the classes at FCHC – cooking and DPP
- I personally believe here in Park River we are very blessed to have three great doctors, hospital, and staff, as well as dentist and eye doctors – an awesome EMT group as well as fire and police department
- I think it would be great if the hospital took a leadership role and invited all area health providers for a meet and greet. They could share the services they provide and area providers could get to know one another.
- I think it's pretty darned good the way it is! They do a great job!
- I would like more involvement with elderly and help with low income families
- I would really like to see more involvement together between the hospitals and nursing homes. From some health events or community gathering. Something that shows they are united in our towns not divided.
- I'm satisfied with our healthcare!
- Insurance specialist to help find affordable coverage
- It would be great to have a general surgeon available in Walsh County especially Park River, ND
- It would be nice if we could have specialists to come in for ENT and orthopedic
- Loan repayment programs for healthcare providers – expand if available; CNA classroom/testing financial assistance; any financial assistance towards education/career advancement opportunities
- Local care is adequate; MD, dental, vision, etc. good size for the community. Other choices are within easy reach so you have a choice of caregivers
- Lower cost of medications
- Mental health services
- Mental healthcare as well as addiction counselors
- More awareness of public health and what they have to offer. State/county could provide services that would aim to mental health – drug/alcohol dependency
- More docs x2
- More evening and weekend hours for walk ins with non-life threatening conditions
- More focus on senior healthcare and services like hospice
- More home health services are needed in the community. Dialysis provided locally would be a nice service.
- More mental healthcare/psychiatrist
- More space for traffic at hospital/clinic door. People park and stay in places for long times, not considering other people needing to get into the clinic.
- My family loves Community Health, we will continue to go there!
- Need more education for youth to prevent alcohol and substance abuse
- Need more staff
- Need to incorporate methods/education of good work ethic. Quality of nursing care is poor and a genuine concern for patients. Lack of professionalism – "line" on phone and internet during work hours
- Need to keep and add doctors
- OB/GYN would be my main concerns since we'd have to drive to Grand Forks/weather can affect and I don't have family here just my daughter, boyfriend and me
- Options for people in the community who do not have health insurance because can't afford to or don't qualify for ND Medicaid or Medicare to have access to affordable healthcare and prescription drugs

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- Our local healthcare is great. We need to continue to support them and keep it that way
- Our young adults who come off their parents' health insurance and do not have one full-time job with health benefits and cannot afford a policy on their own. Plus the cost of out-of-pocket care and prescription prices
- Possible abilities to complete more telehealth services for therapies – OT, PT, SLP
- Preventative screenings and wellness programs for our community
- Privacy is a concern
- Privacy is a major concern when using local services
- Satisfactory local and area healthcare
- So expensive – had a miscarriage, was $553 and was at clinic for 30 minutes for ultrasound – didn't see a provider! Still had $200 in "professional fees."
- Social media is great, but the older population isn't online very much, so I'd continue with newspapers too
- Sometimes I feel that healthcare in general has become to myopic, focusing on one small issue rather than considering the individual as a whole and working towards a solution to the real problem rather than prescribing an antibiotic every time or other narrow treatment options. I would like to see more in-depth problem solving, not just whatever initial option is covered by insurance
- Sorry to say better care at nursing home for those who need it; need more staff I guess
- The local healthcare system needs to plan for, recruit, and support additional specialists based in the local community
- The more services available the more people will use
- There is plenty healthcare available if people would seek it out
- There should be more done to provide physical activities in this area
- Transportation for elderly
- Transportation improvements to ease making to/from appointments
- Unavailability of doctors. The lack of a walk-in clinic outside of normal business hours
- Very pleased with healthcare available in our region; wish there were more bathrooms conveniently available for public use
- We are 30 miles from ambulance service, so it would take one hour and 20 minutes to get to an ER
- We are fortunate to have excellent healthcare services in a community of this size
- We have elderly that have challenges in getting to other location for specialized healthcare. Transportation is an increasing concern
- We have great medical care
- We have had all our healthcare needs met; thank you
- We have issues with drugs, alcohol and mental health in our community, schools and outlying areas. There is bullying in the schools that create issues with mental health. We need to accept there are these problems and work together to address them properly with awareness events and ways the community can help each other. It can be anyone that needs help!
- We have top-notch providers and program directors. My only suggestion is to keep up the good work!
- We need good experienced doctors and nurses making good sound decisions. We send too many patients to other medical facilities. We need to be able to treat the simple stuff here instead of sending money out of the community
- We need inpatient services for mental and chemical dependency patients
- We need more MDs. PACs are great, but they are frontline
- We need more sources of transportation in our town; there really isn't any

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