Community Health Needs Assessment

Unity Medical Center Service Area
Grafton, North Dakota

2022

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This project was supported, in part, by the Federal Office of Rural Health, Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS), Medicare Rural Flexibility Hospital grant program and State Office of Rural Health grant program. This information content and conclusions are those of the author and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS, or the U.S. Government.

Executive Summary

To help inform future decisions and strategic planning, Unity Medical Center (UMC) conducted a Community Health Needs Assessment in 2022. The previous CHNA was conducted in 2019. The Center for Rural Health (CRH) at the University of North Dakota School of Medicine & Health Sciences (UNDSMHS) facilitated the assessment process, which solicited input from area community members and healthcare professionals as well as analysis of community health-related data.

To gather feedback from the community, residents of the area were given the opportunity to participate in a survey. Three hundred thirteen UMC service area residents completed the survey. Additional information was collected through five 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 2020 to 2021 decreased by almost 1%. The average number of residents younger than age 18 (23.0%) for Walsh County comes in 0.6 percentage points lower than the North Dakota average (23.6%). The percentage of residents ages 65 and older is approximately 6% higher for Walsh County (21.5%) than the North Dakota average (15.7%), and the high school graduation rate is lower for Walsh County (86.8%) than the North Dakota average (93.1%). The median household income in Walsh County ($55,428) is lower than the state average for North Dakota ($65,315).

Data, compiled by County Health Rankings, show Walsh County is doing better than North Dakota in health outcomes/factors for 10 categories and performing poorly, relative to the rest of the state, in 21 outcome/factor categories.

Of 106 potential community and health needs set forth in the survey, the 313 UMC service area residents who completed the survey indicated the following 10 needs as the most important:

- Having enough child daycare services
- Depression/anxiety – youth and adult
- Bullying/cyberbullying
- Attracting and retaining young families
- Child abuse/neglect
- Availability of mental health services
- Drug use and abuse – youth
- Alcohol use and abuse – youth and adult
- Cost of long-term/nursing home care
- Assisted living options

The survey also revealed the biggest barriers to receiving healthcare (as perceived by community members). They included no insurance/limited insurance (N=68), can't get transportation services (N=55), and not affordable (N=53).

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 systems
- Family-friendly
- Recreational and sports activities
- 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:

- Attracting and retaining young families
- Availability of resources to help the elderly stay in their homes
- Availability of mental health services
- Depression/anxiety
- Having enough child daycare services

Overview and Community Resources

With assistance from the Center for Rural Health (CRH) at the University of North Dakota (UND) School of Medicine & Health Sciences (SMHS), Unity Medical Center (UMC) completed a Community Health Needs Assessment (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.

UMC, located in Grafton, is licensed as a Critical Access Hospital (CAH) with two provider-based rural health clinics. One clinic is attached to the Grafton hospital and the other is located 15 miles to the west in Park River, North Dakota. Grafton is located 40 miles northwest of Grand Forks.

Walsh County is located in northeastern North Dakota and 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 rural 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 UMC is located in Grafton. There are a number of other healthcare agencies available for patients in the area. These facilities include two chiropractic and optometry clinics, a dermatology clinic and aesthetics med spa, a community health center that serves low-income people, four dental clinics, a Veterans Affairs (VA) clinic, three pharmacies, and a state center that serves developmentally disabled individuals. Grand Forks is within 40-70 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 28-35 weeks of pregnancy, either by primary care medical providers or in Grafton with a visiting OB/GYN. After delivery, the local provider resumes the patient's care again.

The healthcare, agricultural, and other large businesses, such as Marvin Windows and Polar Communications, provide the economic base for Walsh County. According to the 2020 U.S. Census estimates, Walsh County has a population of 10,563 while Grafton, the county seat, has a population of 4,170. The next largest city, Park River, has a population of 1,342.

Walsh County has a number of community assets and resources that can be utilized to address population health improvement, including bike paths, hiking trails, swimming pools, city parks, camping, tennis courts, golf courses, ice skating rinks, and movie theatres. There are also many private fitness facilities and classes

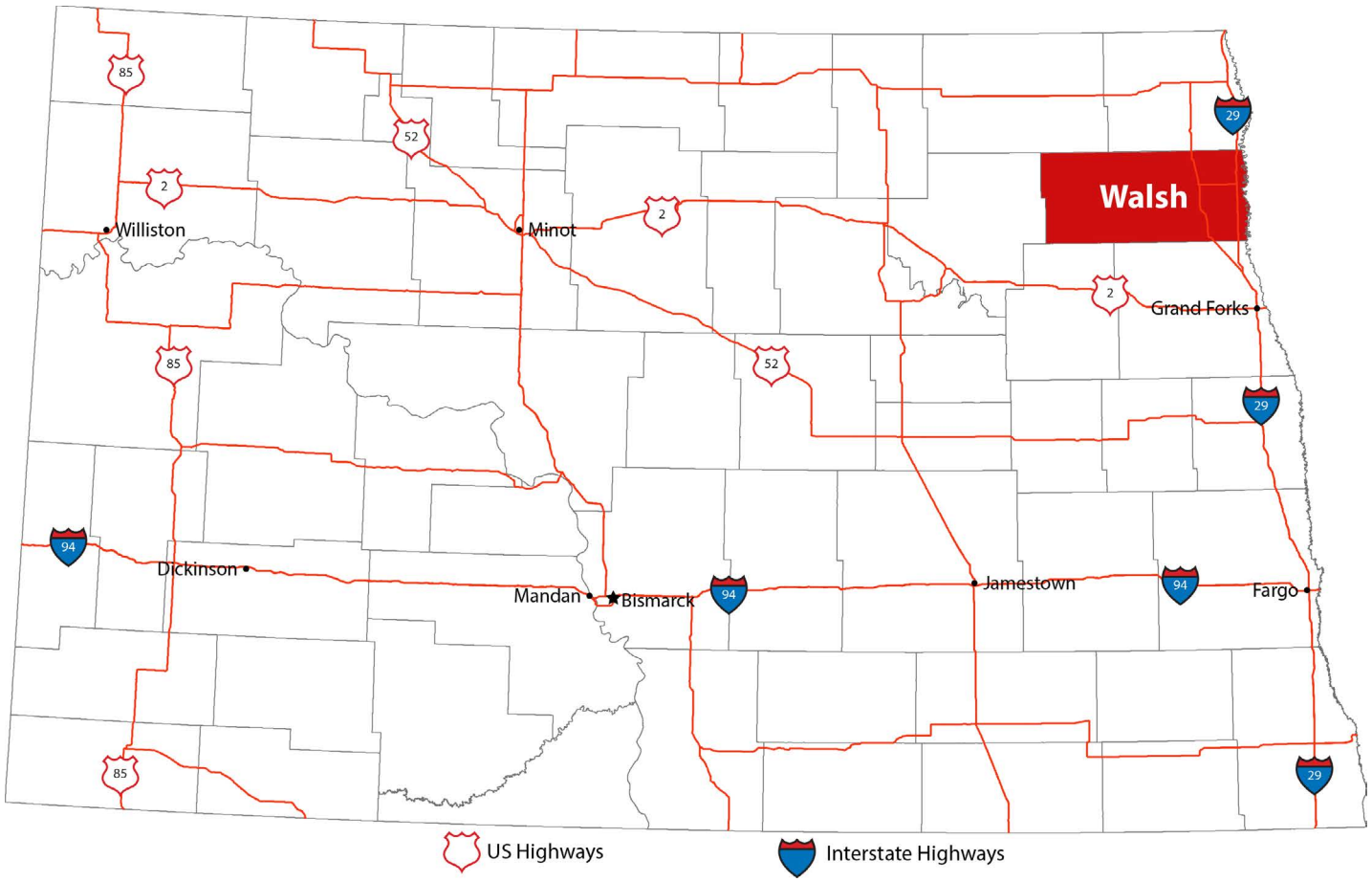
available in the cities of Grafton and Park River, with small facilities in some of the smaller communities as well. Homme Dam is located three miles west of Park River and has great opportunities for boating, camping, biking, swimming, curling, and fishing.

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 Disabled American Veterans has a van that stops weekly in Grafton to assist veterans with transportation to the Fargo VA Medical Center 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 cafés 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 the Tri-Valley Opportunity Council in Grafton offers Head Start and Migrant/Seasonal Head Start.

Figure 1: Walsh County



Unity Medical Center (UMC)

Unity Medical Center (UMC) and its predecessors, Grafton Deaconess Hospital, St. Joseph's Hospital, and Grafton Family Clinic, have been a vital part of the Grafton community for more than 119 years. UMC was founded to serve a growing segment of the community in need of accessible services. The Critical Access Hospital (CAH) Profile for UMC includes a summary of hospital-specific information and is available in Appendix A.

Today, UMC is an incorporated, community-owned, and operated healthcare facility. Included within UMC is a 14-bed acute care hospital and two family-care clinics, licensed by the North Dakota Department of Health. UMC is a non-profit 501(c)(3) corporation and employs more than 150 people.

UMC has a significant economic impact on the region. Based on an economic impact analysis conducted in 2020 they directly employ 103 FTE employees with an annual payroll of over $8.7 million (including benefits). These employees create an additional 44 jobs and nearly $2.5 million in income, as they interact with other sectors of the local economy. This employment results in a total impact of 147 jobs and more than $11.2 million in income. Additional information is provided in Appendix B. Since the economic impact analysis conducted in 2020, UMC has experienced additional growth of employees resulting in a greater economic impact.

UMC has continued to grow with the help of donors and volunteers that make their mission possible. UMC has the support of the Auxiliary, UMC Foundation, and the people of Grafton and the surrounding region. Funds, raised through UMC's donors, are used to purchase needed items and equipment as well as for continuing education for our staff.

UMC's purpose remains the same: bring services to those in need.

Mission
UMC provides access to quality healthcare for the region.
"Our mission is simple. We want to make our community a better place through education and the enlisting of our citizens to bring services to those in need. We accomplish our mission through our core values."

Philosophy
UMC believes that each individual is a unique person who deserves to be treated with dignity and respect. UMC recognizes that people are the most important resource and, therefore, places a major emphasis on staff development. UMC makes a commitment to consumer-focused care and seeks opportunities to serve the healthcare needs of the community. UMC believes that continuous quality improvement is essential in all they do and is a vital measurement of what they want to be.

Services offered locally by UMC include:

General and Acute Services

- 24-hour emergency room
- Allergy testing and treatment
- Anesthesia
- Clinic
- Dermatology
- Family medicine
- General surgery
  - Appendectomy
  - Bowel surgery
  - Breast surgery – benign and malignant problems
  - Gallbladder surgery
  - Gynecological
  - Hand injury – including carpal tunnel repair
  - Hernia surgery
  - Laparoscopic diagnostic procedures – abdomen and pelvic problems
  - Colonoscopies
  - Nissen Fundoplication surgery

- Hospital (acute care)
- Pharmacy
- Prenatal care up to 28-35 weeks
- Physicals: annuals, D.O.T., sports, and insurance
- Social services
- Specialty clinics
- Swing bed and respite care services
- Telemedicine via eEmergency
- Vaccines

Screening/Therapy Service

- Blood pressure checks
- Cardiac rehab
- Chemotherapy/antibiotic therapy
- Chronic disease management
- Diabetic services/education support group and screenings
- Drug testing
- Foot care
- Hearing services
- Nutrition counseling and services
- Occupational physicals
- Occupational therapy
- Physical therapy
  - Arthritis
  - Burn and wound care
  - Gait and orthotic assessment
  - Joint sprains, strains, and stiffness
  - Muscle and tendon injuries
  - Musculoskeletal and myofascial pain disorder
  - Neurological disorder
  - Orthopedic injuries to hip, knee, ankle, and feet
  - Orthopedic injuries to shoulder, elbow, wrist, and hand
  - Overuse injuries
  - Post-surgical orthopedic rehab
  - Sacroiliac dysfunction
  - Sports injuries
  - Stroke rehab
  - Tendonitis and bursitis
  - Treatment of spinal pain and dysfunction
  - Vertigo
- Respiratory therapy
  - C-pap
  - Home oxygen
- Sleep apnea services
- Speech therapy
- Stress testing

Radiology Services

- 3D mammography
- CT scan
- DEXA Scan (bone density)
- Digital X-ray
- Echocardiogram
- MRI
- Nuclear Medicine
- Ultrasound

Laboratory Services

- Antibody screening
- Blood typing
- Chemistry
- Coagulation
- Cultures
- DNA testing collection
- Drug testing
- Hematology
- Microbiology
- Serology
- Urinalysis

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 Walsh County Health District provides are:

Services provided by WCHD:

- Bicycle helmet safety education
- Blood pressure checks
- Breastfeeding resources
- Car seat program
- Child health (well-baby checks)
- Correction facility health
- COVID-19 pandemic response
- Diabetes screening
- Emergency preparedness services-work with community partners as part of local emergency response team
- Environmental health services (water, sewer, health hazard abatement)
- Flu shots
- Immunizations
- Member of Child Protection Team and County Interagency Team
- Opioid and substance abuse prevention
- School health – vision, hearing, scoliosis screenings in schools, health education and resource to the schools
- Preschool education programs and screening
- Tobacco prevention and control
- Tuberculosis testing and management
- WIC (Women, Infants, and Children) Program
- Worksite wellness – coordinator for County Employees and Sheriff's Dept.
- Youth education programs (First Aid, Bike Safety)

Assessment Process

The purpose of conducting a Community Health Needs Assessment (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.
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, the Unity Medical Center (UMC) service area. In addition to Grafton and Park River, located in the service area are the communities of Adams, Conway, Edinburg, Fordville, Forest River, Hoople, Lankin, Minto, Pisek, and Warsaw.

The Center for Rural Health (CRH), in partnership with UMC and Walsh County Health District (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 CRH and UMC. A steering committee (see Figure 2) was formed that was responsible for planning and implementing the process locally. Representatives from CRH met and corresponded regularly by teleconference and/or via the eToolkit with the CHNA liaison. The community group (described in more detail below) provided in-depth information and informed the assessment process in terms of community perceptions, community resources, community needs, and ideas for improving the health of the population and healthcare services. Eight 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.

Figure 2: Steering Committee

Allen Anderson	Administrator, WCHD
Merideth Bell	Quality and Patient Experience Director, UMC
Mary LaHaise	VP of Ancillary Services, UMC
Alan O'Neil	CEO, UMC
Marcus Lewis	CEO, First Care Health Center (FCHC)
Lori Seim	RN, DON, FCHC
Megan Thompson	RN, Nurse Manager, FCHC
Kristi Holm	RN, Population Health, FCHC

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

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

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

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

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 13 community members, was convened and first met on January 11, 2022. 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 March 29, 2022, with 20 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 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, education, and social service agencies. Not all members of the group were present at both meetings.

Interviews

One-on-one interviews with five key informants were conducted by phone on several different dates between January 11 to February 2, 2022. A representative from CRH conducted the interviews. Interviews were held with selected members of the community who could provide insights into the community's health needs. Included among the informants were public health professionals with special knowledge in public health acquired through several years of direct experience in the community, including working with medically underserved, low income, and minority populations as well as with populations with chronic diseases.

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

Survey

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

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

- Learn of the good things in the community and the community's concerns.
- Understand perceptions and attitudes about the health of the community and hear suggestions for improvement.
- 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
- Suggestions for capital improvements

To promote awareness of the assessment process, press releases led to published articles in three newspapers in Walsh County. Additionally, information was published on the FCHC, UMC, and WCHD websites and Facebook pages.

Approximately 50 community member surveys were available for distribution in Walsh County. The surveys

were distributed by community group members and at WCHD, UMC, and FCHC.

To help ensure anonymity, included with each survey was a postage-paid return envelope to CRH. In addition, to help make the survey as widely available as possible, residents also could request a survey by calling FCHC, UMC, or WCHD. The survey period ran from January 3 to February 10, 2022. Three completed paper surveys were returned.

Area residents were also given the option of completing an online version of the survey, which was publicized in two community newspapers, flyers at local businesses, emails to local employees, and on the websites and Facebook pages of FCHC, UMC, and WCHD. Three hundred ten online surveys were completed. Two hundred forty-one of those online respondents used the QR code to complete the survey. In total, counting both paper and online surveys, the 313 community member surveys were completed, equating to a 7% response rate. This response rate is below average for this type of unsolicited survey methodology but is in line with survey responses during the pandemic.

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 were collected from a variety of sources, including the United States Census Bureau; Robert Wood Johnson Foundation's County Health Rankings, which pulls data from 20 primary data sources (www.countyhealthrankings.org); the National Survey of Children's Health, which touches on multiple intersecting aspects of children's lives (www.childhealthdata.org/learn/NSCH); North Dakota KIDS COUNT, which is a national and state-by-state effort to track the status of children, sponsored by the Annie E. Casey Foundation (www.ndkidscount.org); and Youth Risk Behavior Surveillance System (YRBSS) data, which is published by the Centers for Disease Control and Prevention (https://www.cdc.gov/healthyyouth/data/yrbs/index.htm).

Social Determinants of Health

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

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

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

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

Figure 3: Social Determinants of Health

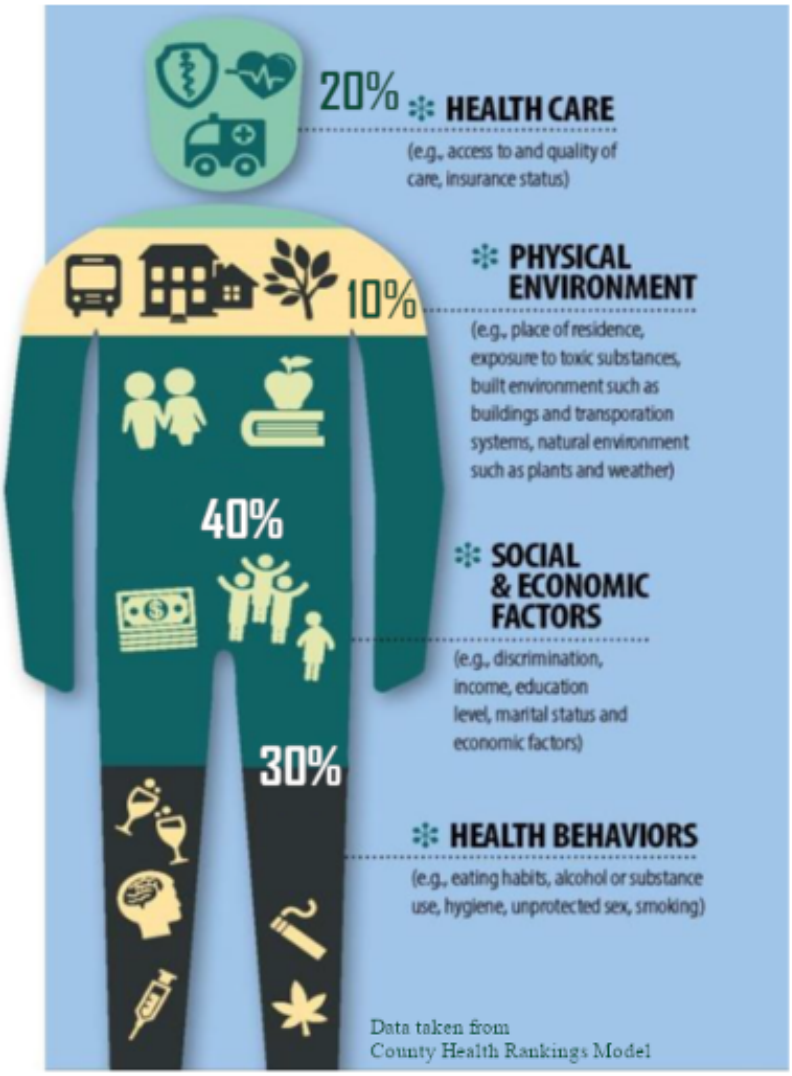


Figure 4 (Henry J. Kaiser Family Foundation, https://www.kff.org/disparities-policy/issue-brief/beyond-health-care-the-role-of-social-determinants-in-promoting-health-and-health-equity/), provides examples of factors that are included in each of the social determinants of health categories that lead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

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

Figure 4: Social Determinants of Health

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

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

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Demographic Information

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

	Walsh County	North Dakota
Population (2021)	10,469	779,948
Population change (2020-2021)	-0.9%	-0.5%
People per square mile (2010)	8.7	9.7
Persons 65 years or older (2020)	21.5%	15.7%
Persons younger than 18 years (2020)	23.0%	23.6%
Median age (2020)	44.3	35.2
White persons (2020)	94.3%	86.9%
High school graduates (2020)	85.4%	93.1%
Bachelor's degree or higher (2020)	17.2%	30.7%
Live below poverty line (2020)	10.6%	10.2%
Persons without health insurance, younger than age 65 (2019)	9.6%	8.1%
Households with a broadband internet subscription (2020)	70.1%	83.1%

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

The population of North Dakota has slightly decreased in recent years; Walsh County has also seen a slight decrease in population since 2020.

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 2021 County Health Rankings, are pulled from more than 20 data sources and then are compiled to create county rankings. Counties in each of the 50 states are ranked, according to summaries of a variety of health measures. Those items having high ranks, such as 1 or 2, are considered to be the "healthiest." Counties are ranked on both health outcomes and health factors. Following is a breakdown of the variables that influence a county's rank.

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

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 and UMC or of any particular medical facility.

For most of the measures included in the rankings, the County Health Rankings' authors have calculated the "Top U.S. Performers" for 2021. The Top Performer number marks the point at which only 10% of counties in the nation do better, i.e., the 90th percentile or 10th percentile, depending on whether the measure is framed positively (such as high school graduation) or negatively (such as adult smoking).

Walsh County rankings within the state are included in the summary following. For example, Walsh County ranks 28th out of 46 ranked counties in North Dakota on health outcomes and 40th out of 45 on health factors. The measures, marked with a bullet point (•), are those where a county is not measuring up to the state rate/percentage; a square (■) indicates that the county is not meeting the U.S. Top 10% rate on that measure. Measures that are not marked with a colored shape but are marked with a plus sign (+) indicate that the county is doing better than the U.S. Top 10%.

The data from County Health Rankings show that Walsh County is doing better than many counties, compared to the rest of the state. In addition, Walsh County, similar to many North Dakota counties, is doing poorly 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 rate of premature deaths.

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

- Poor mental health days
- Food environment index
- Excessive drinking
- Alcohol-impaired driving deaths
- Sexually transmitted infections
- Income inequality
- Social associations
- 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 days
- Low birth weight
- Adult smoking
- Adult obesity
- Physical inactivity
- Access to exercise opportunities
- Teen birth rate
- Uninsured
- Primary care physicians
- Dentists
- Mental health providers
- Preventable hospital stays
- Mammography screening
- Flu vaccinations
- Unemployment
- Children in poverty
- Injury deaths
- Air pollution-particulate matter

TABLE 2: SELECTED MEASURES FROM COUNTY HEALTH RANKINGS 2021– 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* 2021– WALSH COUNTY			
	Walsh County	**U.S. Top 10%**	**North Dakota**
Ranking: Outcomes	**28th**		**(of 46)**
Premature death	7,300 ●■	5,400	6,600
Poor or fair health	17% ●■	14%	14%
Poor physical health days (in past 30 days)	3.6 ●■	3.4	3.2
Poor mental health days (in past 30 days)	3.7 +	3.8	3.8
Low birth weight	7% ●■	6%	6%
Ranking: Factors	**40th**		**(of 45)**
Health Behaviors			
Adult smoking	21% ●■	16%	20%
Adult obesity	35% ●■	26%	34%
Food environment index (10=best)	9.2 +	8.7	8.9
Physical inactivity	27% ●■	19%	23%
Access to exercise opportunities	66% ●■	91%	74%
Excessive drinking	24% ■	15%	24%
Alcohol-impaired driving deaths	29% ■	11%	42%
Sexually transmitted infections	193.5 ■	161.2	466.6
Teen birth rate	27 ●■	12	20
Clinical Care			
Uninsured	11% ●■	6%	8%
Primary care physicians	2,130:1 ●■	1,030:1	1,300:1
Dentists	1,520:1 ●■	1,210:1	1,510:1
Mental health providers	3,550:1 ●■	270:1	510:1
Preventable hospital stays	5,823 ●■	2,565	4,037
Mammography screening (% of Medicare enrollees ages 65-74 receiving screening)	51% ●+	51%	53%
Flu vaccinations (% of fee-for-service Medicare enrollees receiving vaccination)	40% ●■	55%	50%
Social and Economic Factors			
Unemployment	3.3% ●■	2.6%	2.4%
Children in poverty	12% ●■	10%	11%
Income inequality	4.2 ■	3.7	4.4
Children in single-parent households	13% +	14%	20%
Social associations	16.9 ■	18.2	16.0
Violent crime	165 ■	63	258
Injury deaths	93 ●■	59	71
Physical Environment			
Air pollution – particulate matter	5.8 ●■	5.2	4.7
Drinking water violations	No		
Severe housing problems	7% +	9%	12%

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

Children's Health

The National Survey of Children's Health touches on multiple intersecting aspects of children's lives. Data are not available at the county level; listed below is information about children's health in North Dakota. The full survey includes physical and mental health status, access to quality healthcare, and information on the child's family, neighborhood, and social context. Data are from 2019-20. More information about the survey may be found at www.childhealthdata.org/learn/NSCH.

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

TABLE 3: SELECTED MEASURES REGARDING CHILDREN'S HEALTH (For children ages 0-17 unless noted otherwise), 2020

Health Status	North Dakota	National
Children born premature (3 or more weeks early)	9.9%	11.2%
Children 10-17 overweight or obese	26.9%	32.1%
Children 0-5 who were ever breastfed	86.1%	80.8%
Children 6-17 who missed 11 or more days of school	2.9%	3.9%
Healthcare		
Children currently insured	93.6%	93.1%
Children who spent less than 10 minutes with the provider at a preventive medical visit	16.0%	18.1%
Children (1-17 years) who had preventive a dental visit in the past year	73.7%	77.5%
Children (3-17 years) received mental healthcare	10.5%	11.0%
Children (3-17 years) with problems requiring treatment did not receive mental healthcare	2.3%	2.5%
Young children (9-35 mos.) receiving standardized screening for developmental problems	31.1%	36.9%
Family Life		
Children whose families eat meals together 4 or more times per week	79.2%	75.2%
Children who live in households where someone smokes	16.1%	14.0%
Neighborhood		
Children who live in neighborhood with a park, sidewalks, a library, and a community center	81.1%	74.9%
Children living in neighborhoods with poorly kept or rundown housing	9.1%	13.3%

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

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

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

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

The data show Walsh County is performing more poorly than the North Dakota average on more than half of the examined measures except the percentage of child food insecurity and the four-year high school graduation rate. The most marked difference was on the measure of Medicaid recipients (almost 13% higher rate in Walsh County).

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

	Walsh County	North Dakota
Child food insecurity, 2019	**9.1%**	9.3%
Medicaid recipient (% of population age 0-20), 2020	**38.7%**	26.0%
Children enrolled in Healthy Steps (% of population age 0-18), 2020	**2.7%**	1.7%
Supplemental Nutrition Assistance Program (SNAP) recipients (% of population age 0-18), 2020	**21.9%**	17.0%
Licensed childcare capacity (# of children), 2020	403	36,701
Four-year high school cohort graduation rate, 2020/2021	90.4%	87.0%
Victims of child abuse and neglect requiring services (rate per 1,000 children ages 0-17), 2020	**14.52**	8.89

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 U.S. 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 and 9-12 are surveyed in the spring of odd years. The survey is voluntary and completely anonymous.

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

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

TABLE 5: Youth Risk Behavior Survey Results

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

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

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

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

Low Income Needs

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

Top Needs Identified by People Experiencing Poverty Across North Dakota

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

2020 North Dakota LOW INCOME COMMUNITY NEEDS

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

NDSU North Dakota State University

Assessed by CAPND and NDSU, November 2020

KEY FINDINGS

1st Priority Need

Rental Assistance

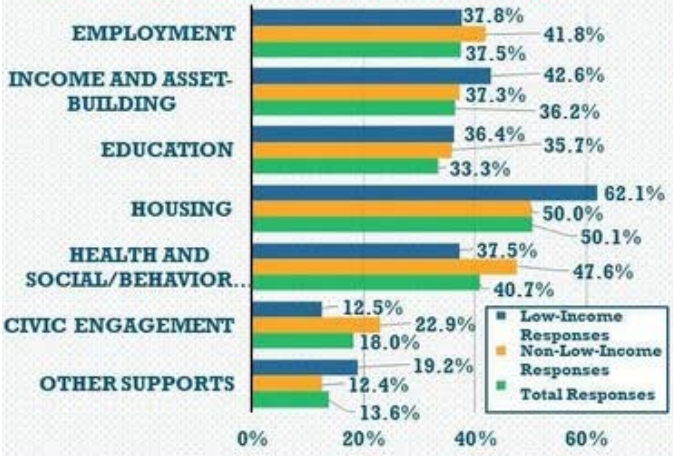
3,458 Total Survey Responses

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

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

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

STATEWIDE OVERALL NEEDS



TOP STATEWIDE SPECIFIC NEEDS

Low-Incomes

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

Non-Low-Incomes

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

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

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

TOP REGIONAL OVERALL NEEDS FOR LOW-INCOMES

ACKNOWLEDGMENTS

This project was supported by the Consensus Council, Inc. (in partnership with the Bush Foundation) through the Community Innovation Grants.

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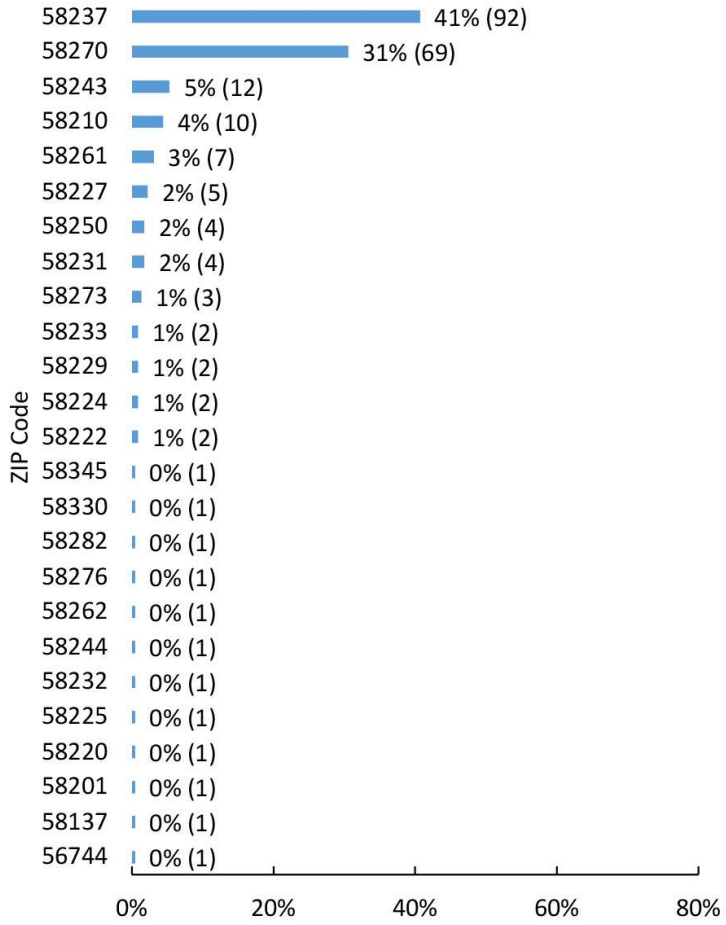
Survey Results

As noted previously, 313 community members completed the survey in communities throughout the Unity Medical Center (UMC) and First Care Health Center (FCHC) service area, as the survey was a collaborative effort. For all questions that contained an "Other" response, all of those direct responses may be found in Appendix G. In some cases, a summary of those comments is additionally included in the report narrative. The "Total respondents" number under each heading indicates the number of people who responded to that particular question; some questions allow for selection of more than one response.

The survey requested that respondents list their home zip code. While not all respondents provided a zip code, several did, revealing that a large majority of respondents (41%, N=92) lived in Grafton. These results are shown in Figure 5.

Figure 5: Survey Respondents' Home Zip Code
Total respondents: 226



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

Survey Demographics

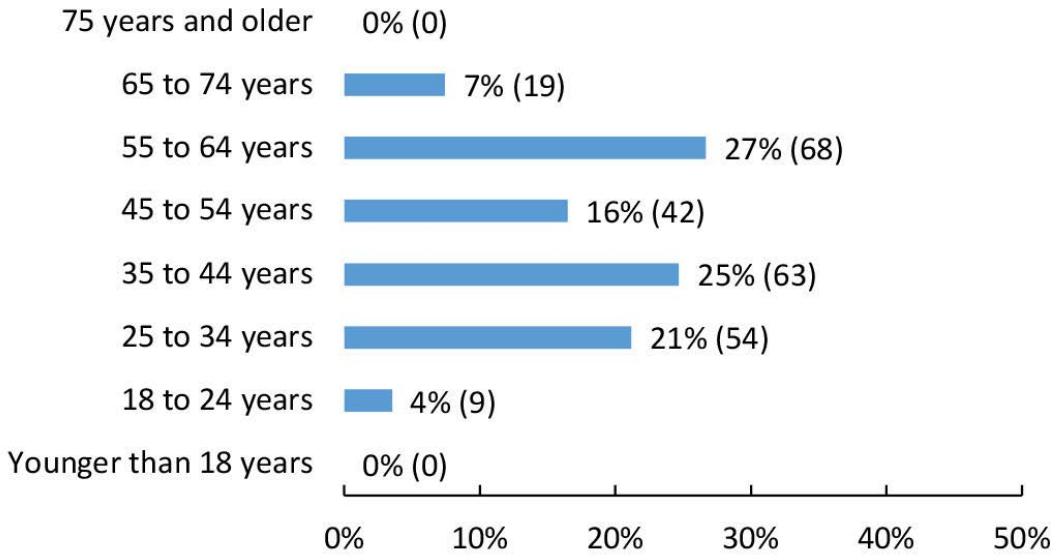
To better understand the perspectives, offered by survey respondents, survey-takers were asked a few demographic questions. Throughout this report, numbers (N) instead of just percentages (%) are reported because percentages can be misleading with smaller numbers. Survey respondents were not required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

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

- 34% (N=87) were age 55 or older
- The majority (82%, N=207) were female
- Less than half of the respondents (45%, N=114) had bachelor's degrees or higher
- The number of those working full time (83%, N=211) was 14 times higher than those who were retired (6%, N=15)
- 95% (N=239) of those who reported their ethnicity/race were White/Caucasian
- 19% of the population (N=47) 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 considered input from parties who represent the varied interests of the community served, including a balance of age ranges, those in diverse work situations, and community members with lower incomes.

Figure 6: Age of Survey Respondents
Total respondents = 341



Children younger than age 18 are not questioned using this survey method.

Figure 7: Gender of Survey Respondents
Total respondents = 255

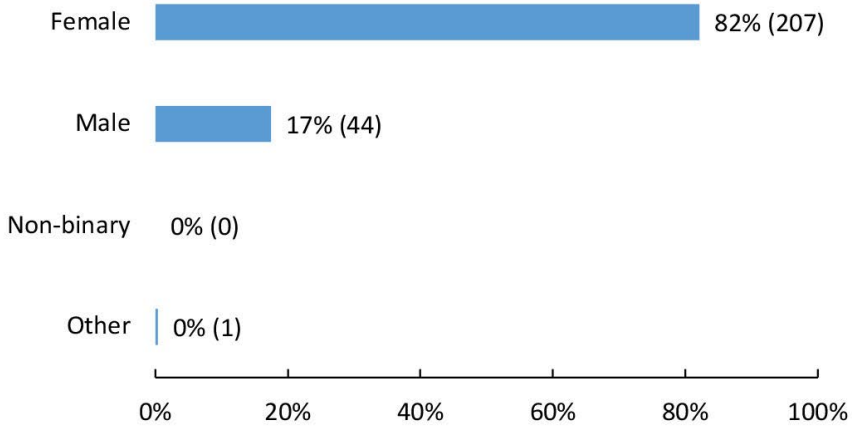


Figure 8: Educational Level of Survey Respondents
Total respondents = 255

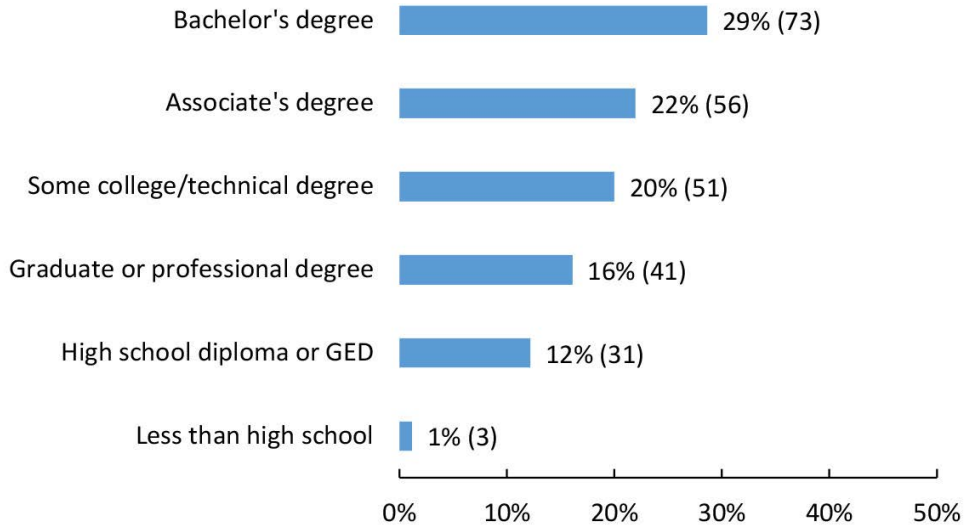
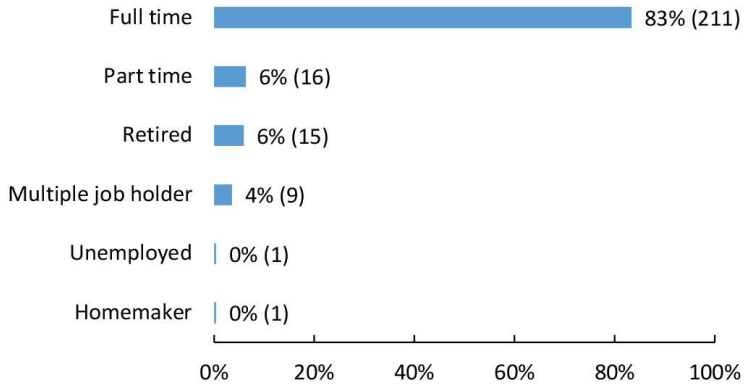
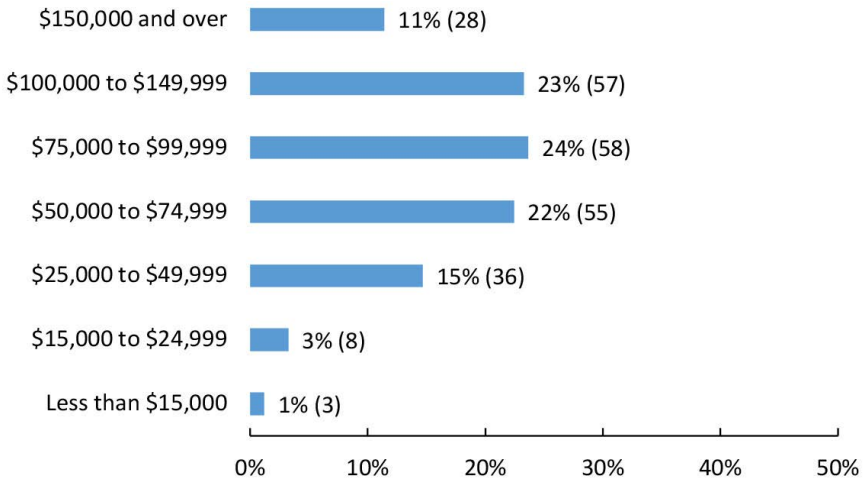


Figure 9: Employment Status of Survey Respondents
Total respondents = 253



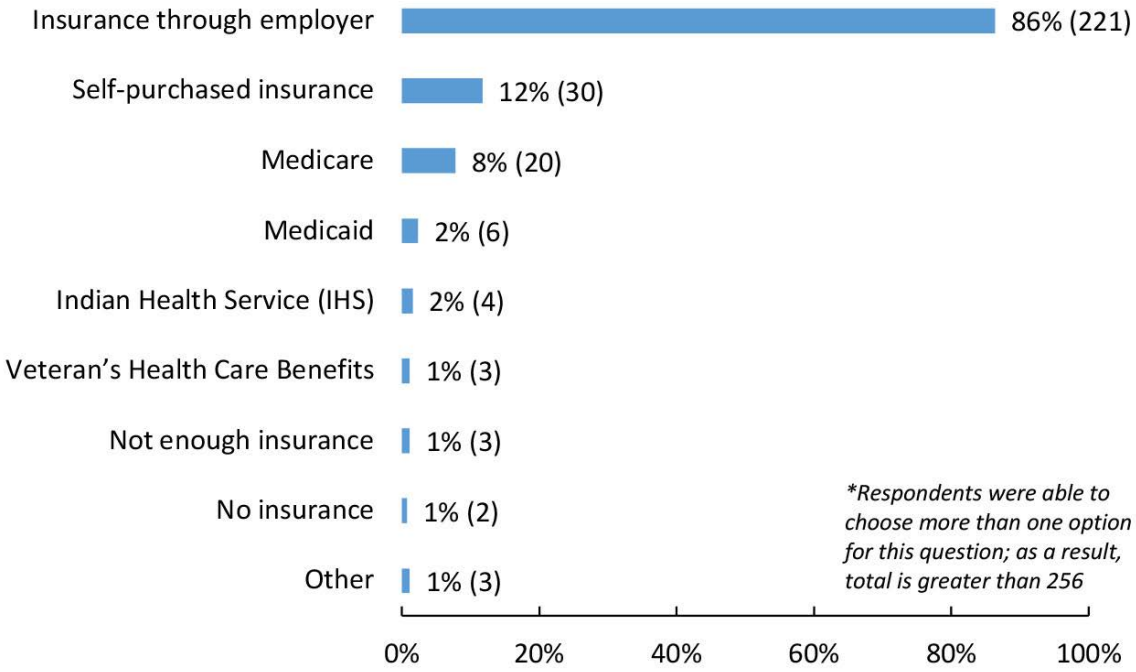
Of those who provided a household income, 4% (N=11) of community members reported a household income of less than $25,000. Thirty four percent (N=85) indicated a household income of $100,000 or more. This information is shown in Figure 10.

Figure 10: Household Income of Survey Respondents
Total respondents = 245



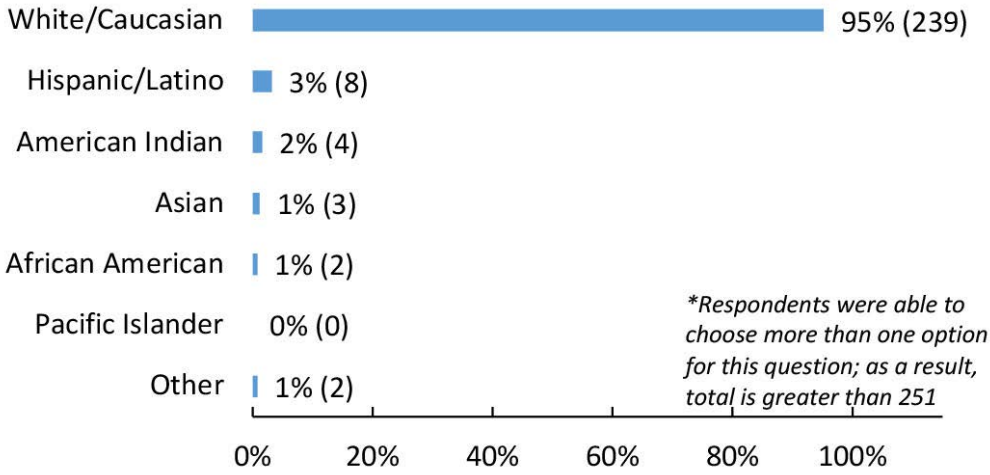
Community members were asked about their health insurance status, which is often associated with whether people have access to healthcare. Two percent (N=5) of the respondents reported having no health insurance or being under-insured. The most common insurance types were insurance through one's employer (N=221), followed by self-purchased (N=30), and Medicare (N=20).

Figure 11: Health Insurance Coverage Status of Survey Respondents
Total respondents = 256*



As shown in Figure 12, nearly all of the respondents were White/Caucasian (95%). This statistic was in-line with the race/ethnicity of the overall population of Walsh County; the U.S. Census indicates that 94.3% of the population is White in Walsh County.

Figure 12: Race/Ethnicity of Survey Respondents
Total respondents = 251*



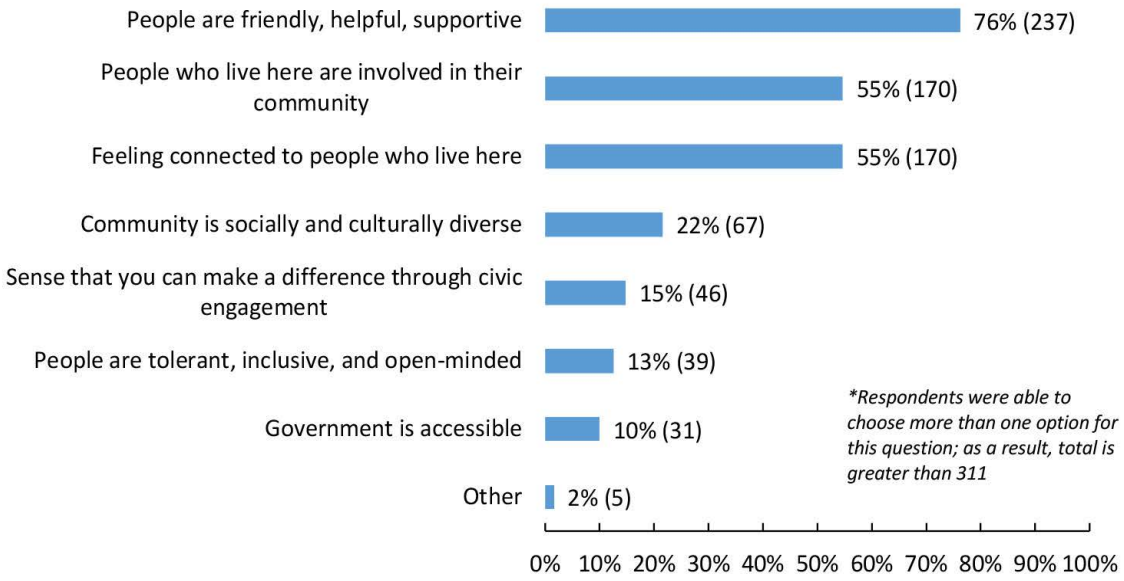
Community Assets and Challenges

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 182 respondents agreeing) that community assets include:

- People are friendly, helpful, supportive (N=237)
- Family-friendly (N=231)
- Healthcare (N=230)
- Safe place to live, little/no crime (N=228)
- Quality school systems (N=191)
- Recreational and sports activities (N=182)

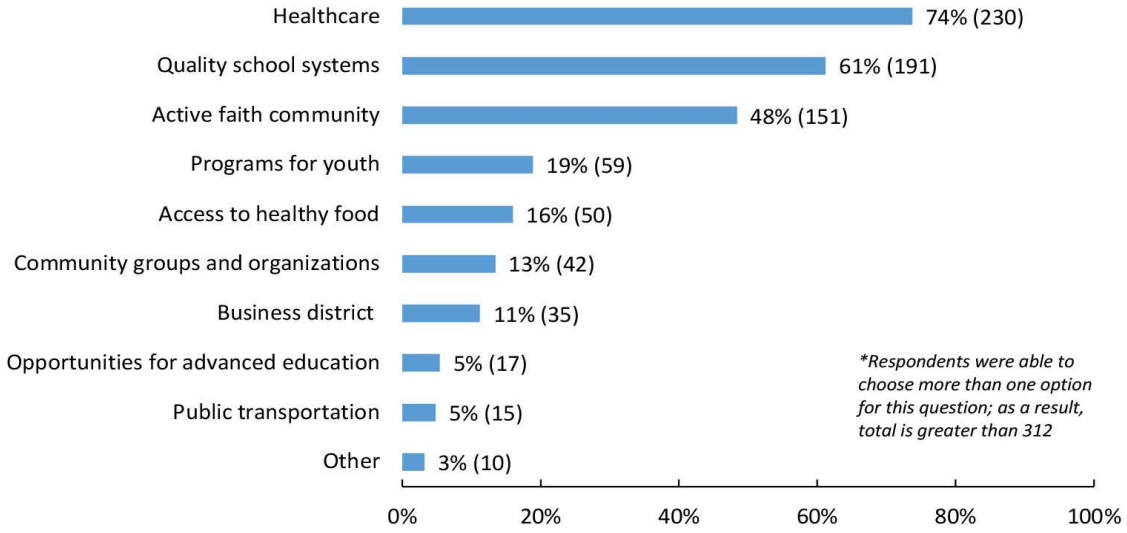
Figures 13 to 16 illustrate the results of these questions.

Figure 13: Best Things about the PEOPLE in Your Community
Total respondents = 311*



Included in the "Other" category of the best things about the people were responses that indicated none of the above apply to the community.

Figure 14: Best Things about the SERVICES AND RESOURCES in Your Community
Total respondents = 312*



Respondents who selected "Other" specified that there is excellent EMS service, veterinary services, access to quality professional services, parks, critical thinkers, the community is always willing to help others, and responses that indicated none of the options applied in the community.

Figure 15: Best Things About the QUALITY OF LIFE in Your Community
Total respondents = 311*

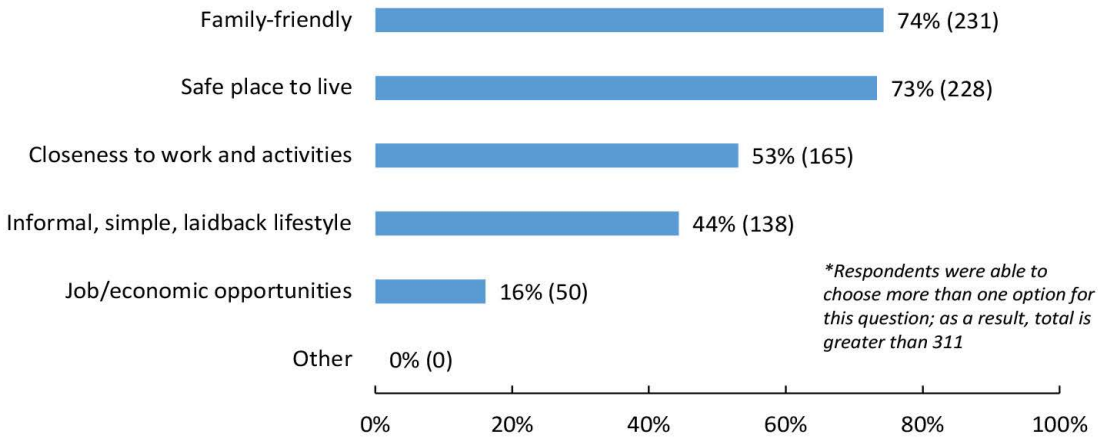
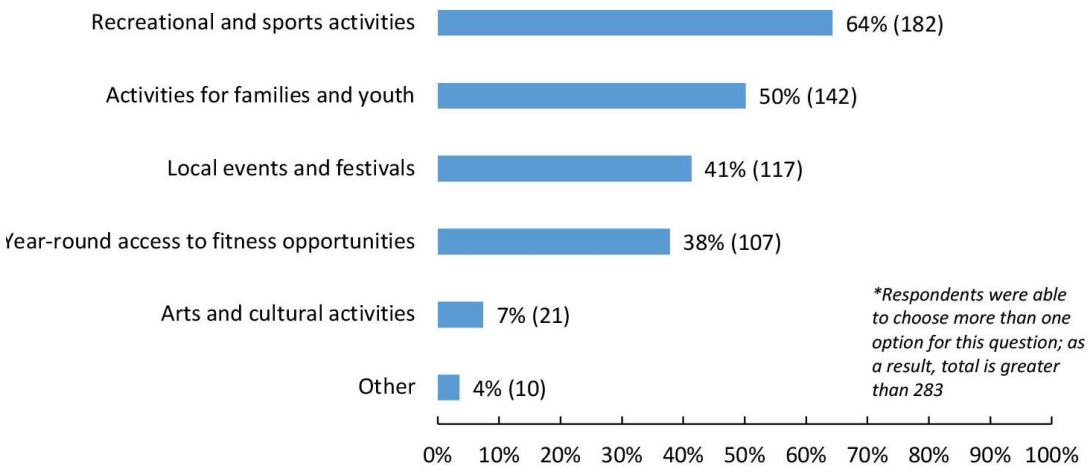


Figure 16: Best Thing About the ACTIVITIES in Your Community
Total respondents = 283*



Respondents who selected "Other" specified that the best things about the activities in the community included holiday festivals, parades, all the Chamber events, everything on the list, space and freedom in the community, and responses that indicated none of the options applied in the community.

Community Concerns

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

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

With regard to responses about community challenges, the most highly voiced concerns (those having at least 109 respondents) were:

- Bullying/cyberbullying (N=160)
- Having enough child daycare services (N= 156)
- Depression/anxiety – youth (N=149)
- Attracting and retaining young families (N=132)
- Alcohol use and abuse – adults (N=130)
- Depression/anxiety – adults (N=129)
- Drug use and abuse – youth (N=110)
- Availability of mental health services (N=109)

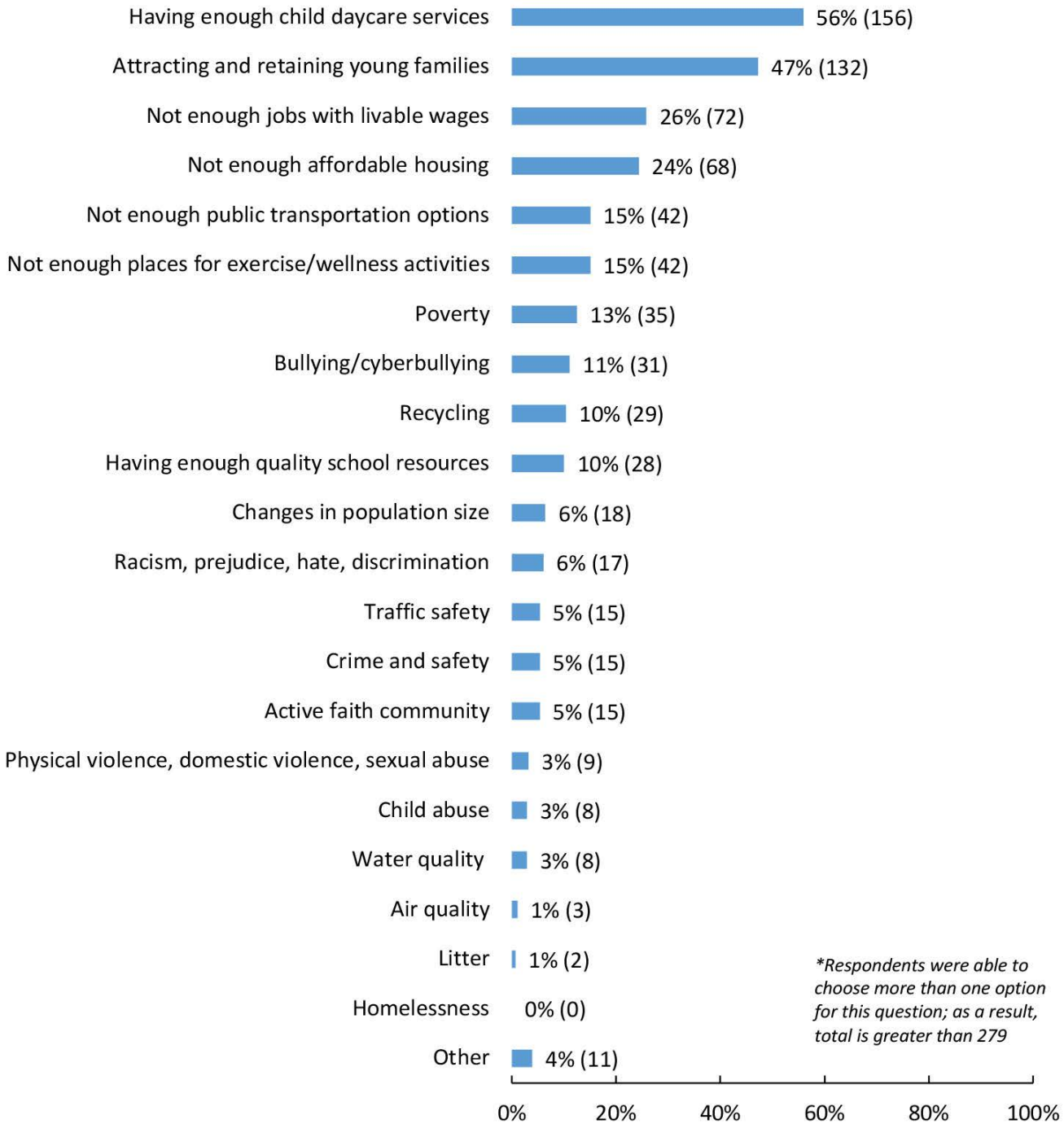
The other issues that had at least 72 votes included:

- Alcohol use and abuse – youth (N=104)
- Child abuse or neglect (N=104)
- Cost of long-term/nursing home care (N=101)
- Assisted living options (N=91)
- Availability of resources to help the elderly stay in their homes (N=86)
- Cost of health insurance (N=85)
- Stress – adult (N=77)
- Emotional abuse (N=76)
- Drug use and abuse – adult (N=76)
- Smoking and tobacco use – youth (N=73)

- Long-term/nursing home care options (N=72)
- Not enough jobs with livable wages (N=72)

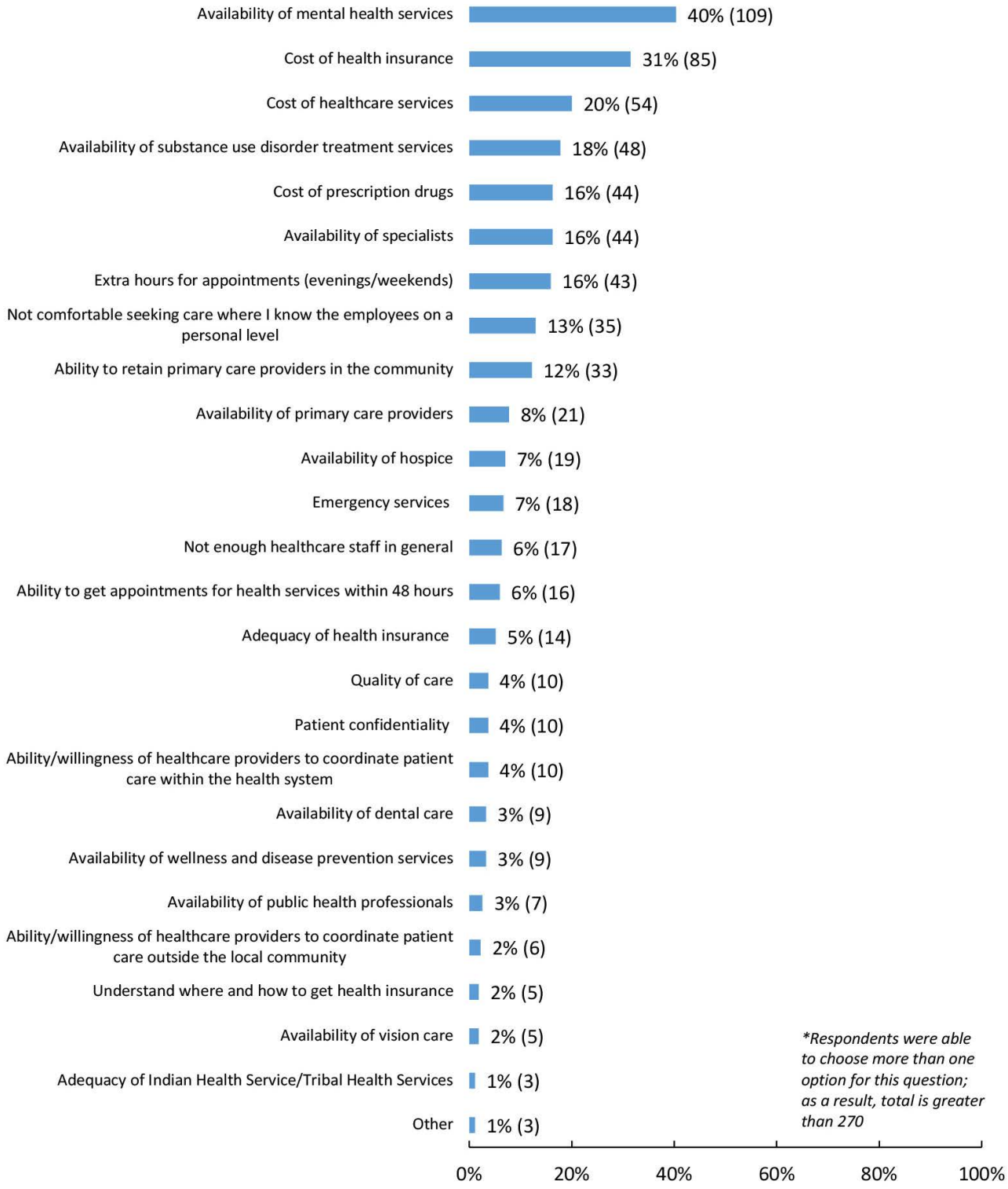
Figures 17 through 22 illustrate these results.

Figure 17: Community/Environmental Health Concerns
Total respondents = 279*



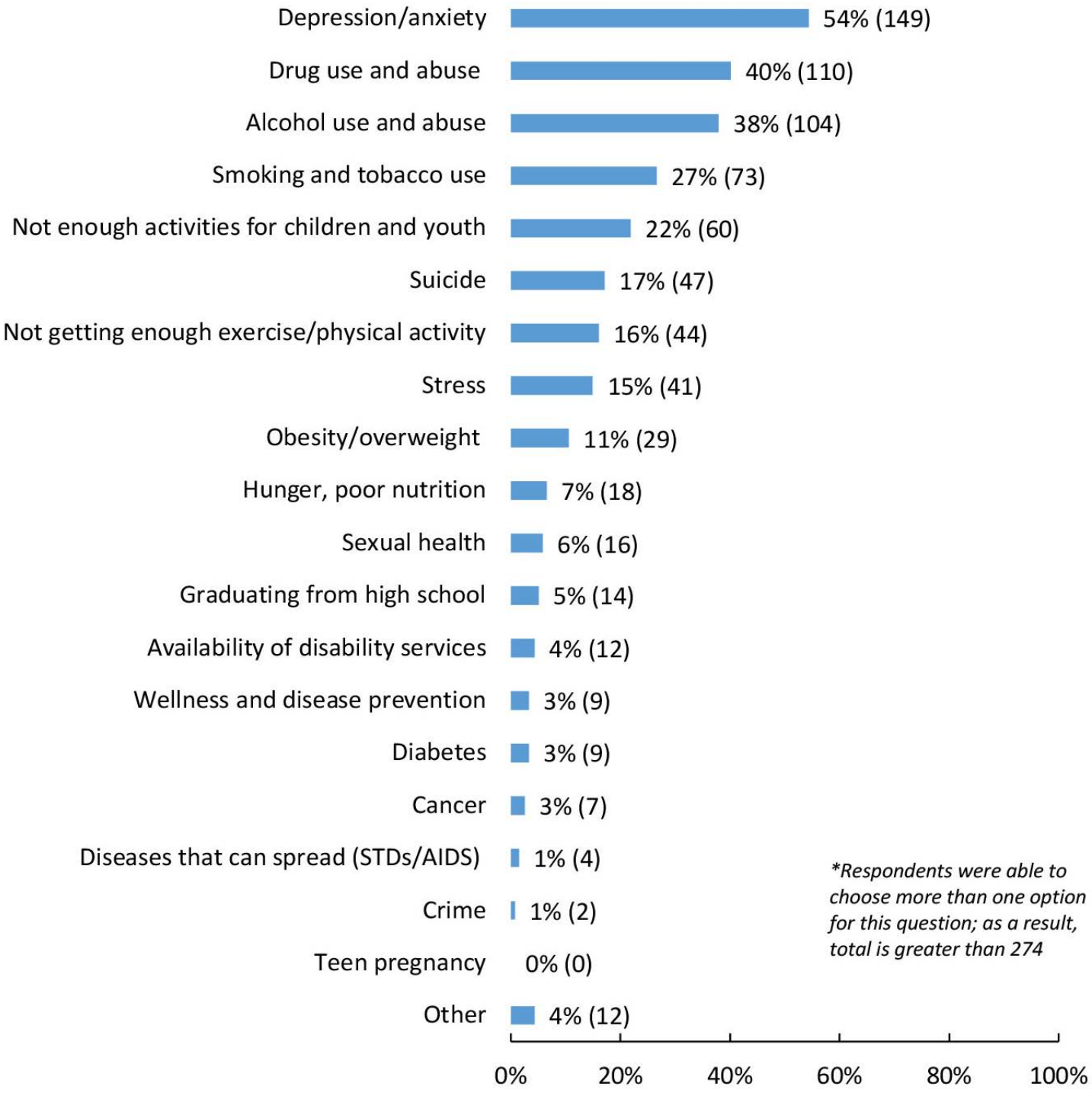
In the "Other" category for community and environmental health concerns, responses included a lack of mental health resources, EMS viability, home care, drug prevalence, too much affordable housing (which attracts poverty and drugs), negative attitude towards women, accessibility, and the need for more shopping opportunities.

Figure 18: Availability/Delivery of Health Services Concerns
Total respondents = 270*



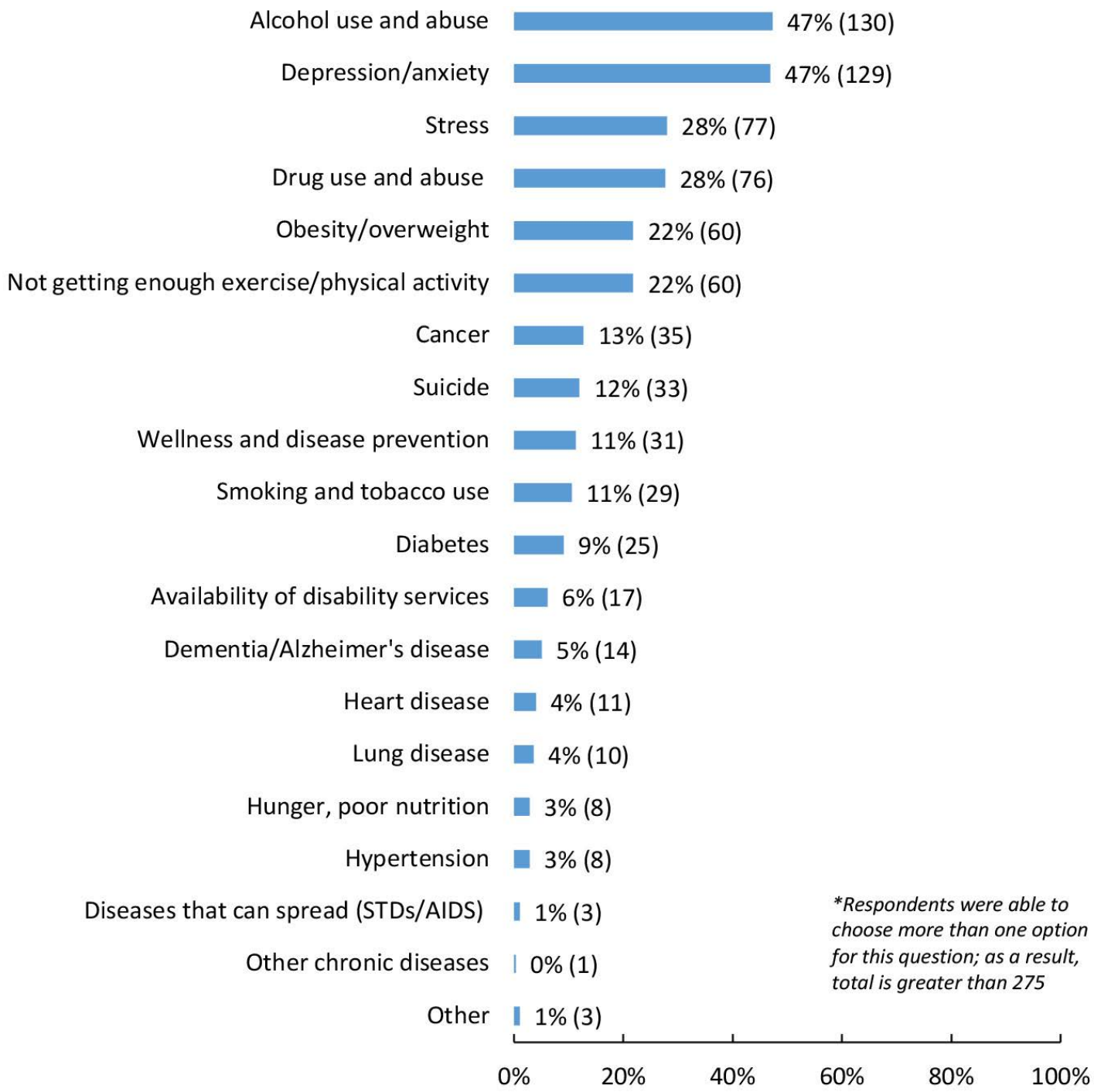
Respondents who selected "Other" identified concerns with healthcare employees on their cell phones and the lack of follow through with patients, lack of mental health services, and too many people working at the facility.

Figure 19: Youth Population Health Concerns
Total respondents = 274*



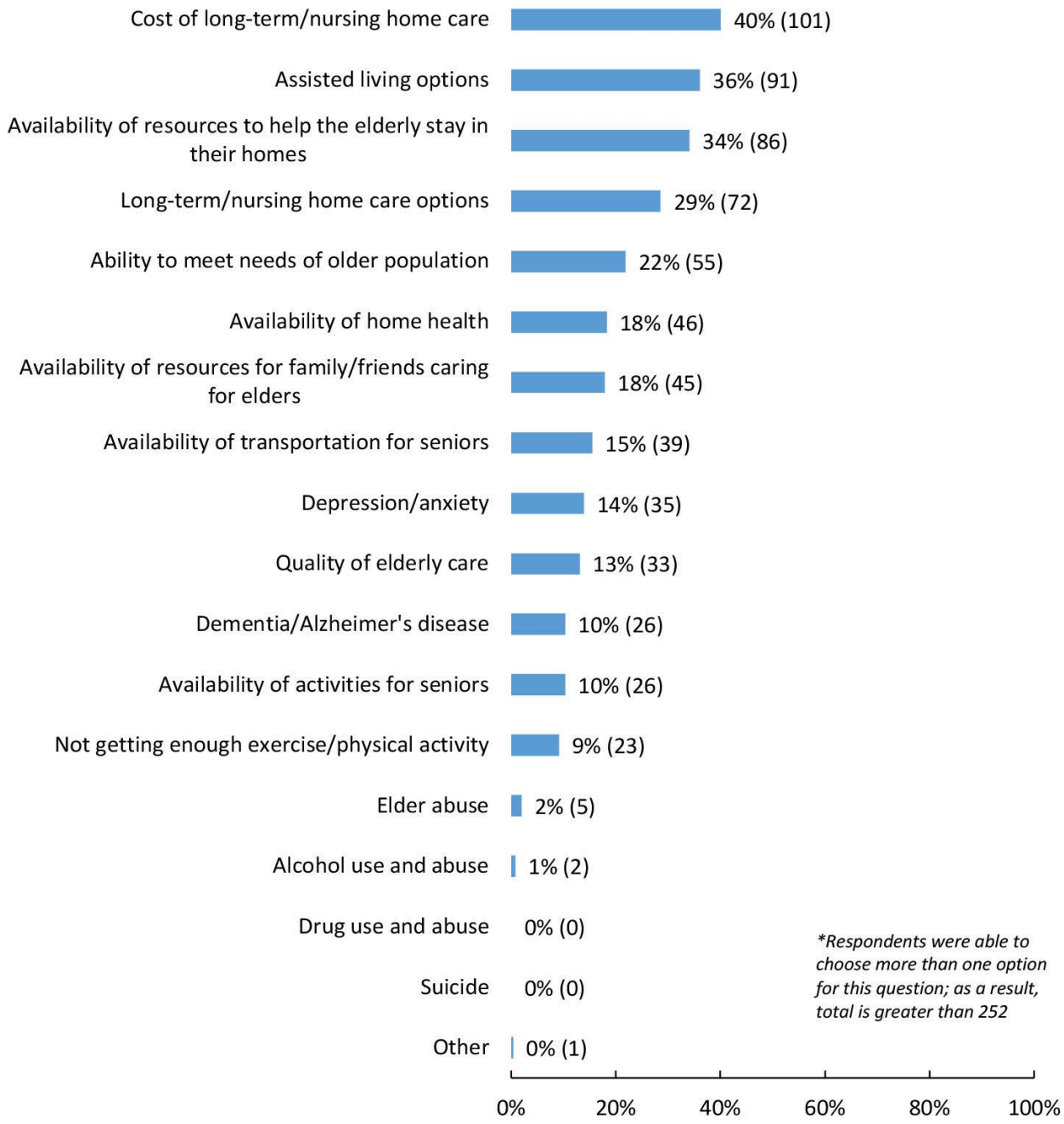
Listed in the "Other" category for youth population concerns were not enough places for youth employment, bullying/cyberbullying, access to mental health services, social media addictions, lack of focus on/desire for education, not getting enough unstructured outside time, school sports extending to summer and taking away from summer activities, neglect, and lack of financial education.

Figure 20: Adult Population Concerns
Total responses = 393*



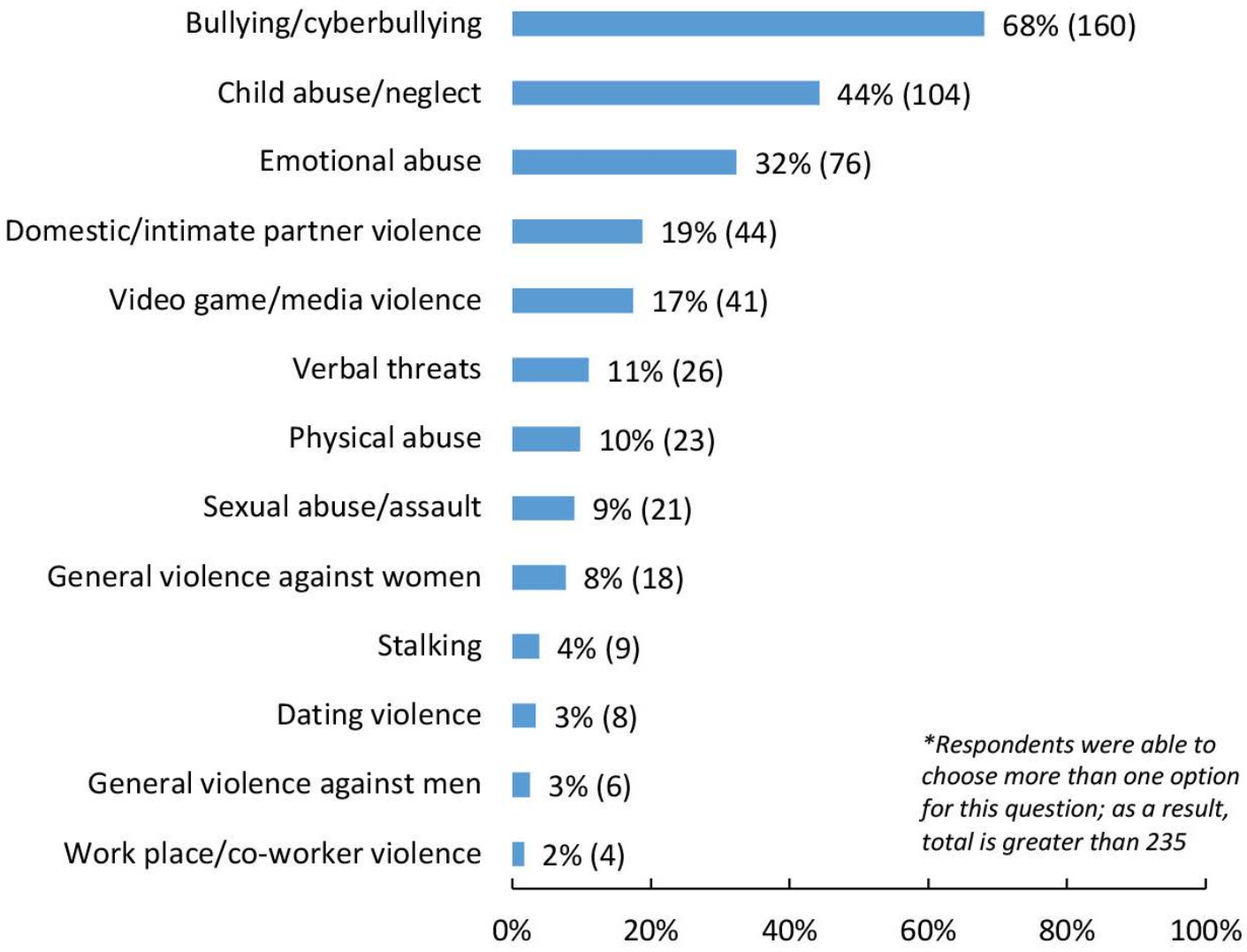
Social media addiction, mental health, and lack of financial education/poor financial choices were indicated in the "Other" category for adult population concerns.

Figure 21: Senior Population Concerns
Total respondents = 252*



In the "Other" category, the one concern listed was accessibility for seniors.

Figure 22: Violence Concerns
Total respondents = 235*



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. Lack of mental health and substance use services
2. Economic concerns – poverty and a lack of businesses and workforce

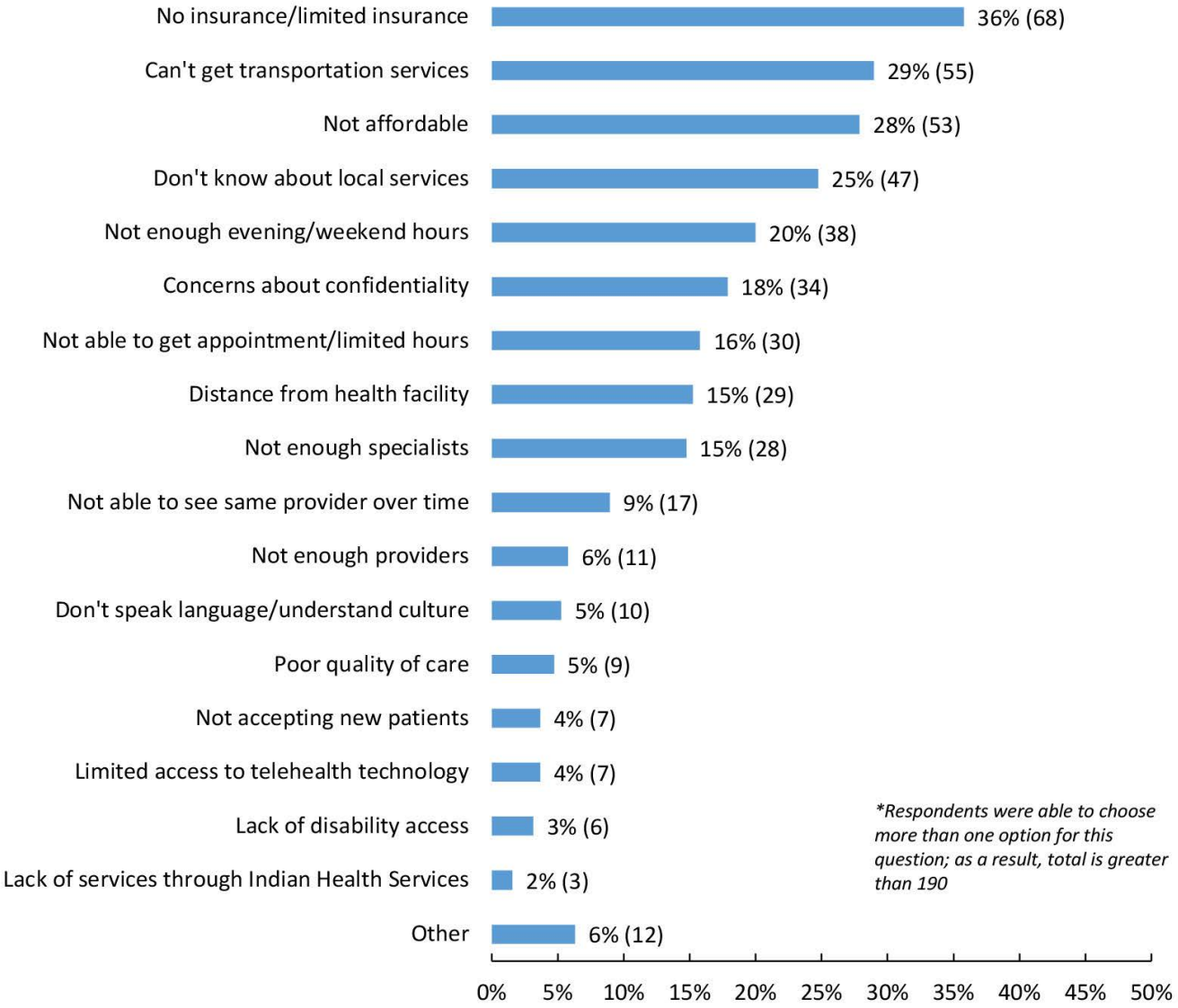
Other biggest challenges that were identified were acceptance of minorities, access to fresh food, affordable housing options, bullying, community involvement, help for aging population, lack of daycare services, lack of restaurant/dining options, lack of retail shopping options, not enough activities for children in the winter, and quality school resources.

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 insurance or limited insurance (N=68), with the next highest being can't get transportation services (N=55). After these items, the next most commonly identified barrier was not affordable (N=53). The majority of concerns in the "Other" category indicated that respondents use healthcare services in a different area, feel healthcare in the community is accessible, delay care due to COVID-19, and belief that health issues will pass.

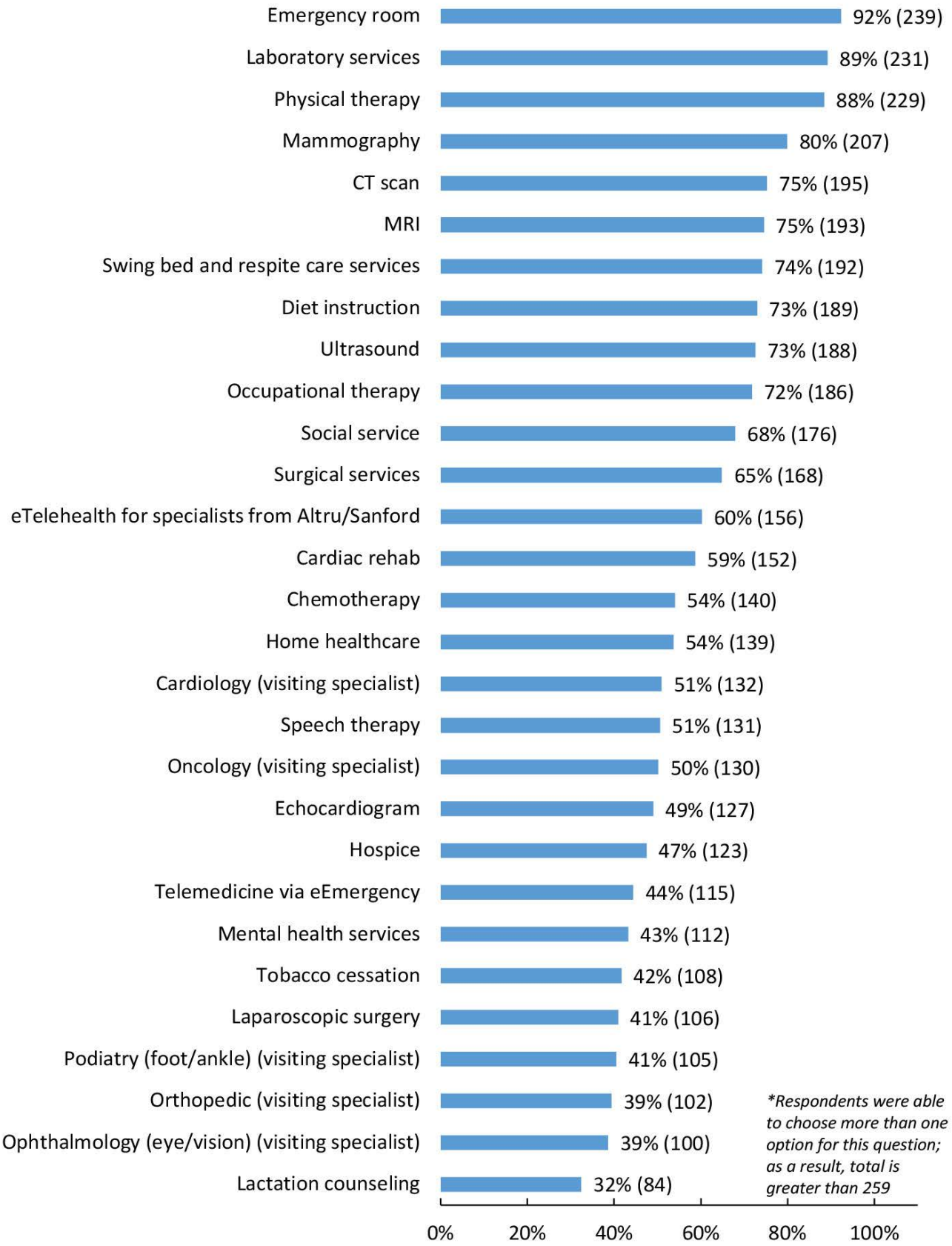
Figure 23 illustrates these results.

Figure 23: Perceptions about Barriers to Care
Total respondents = 190*



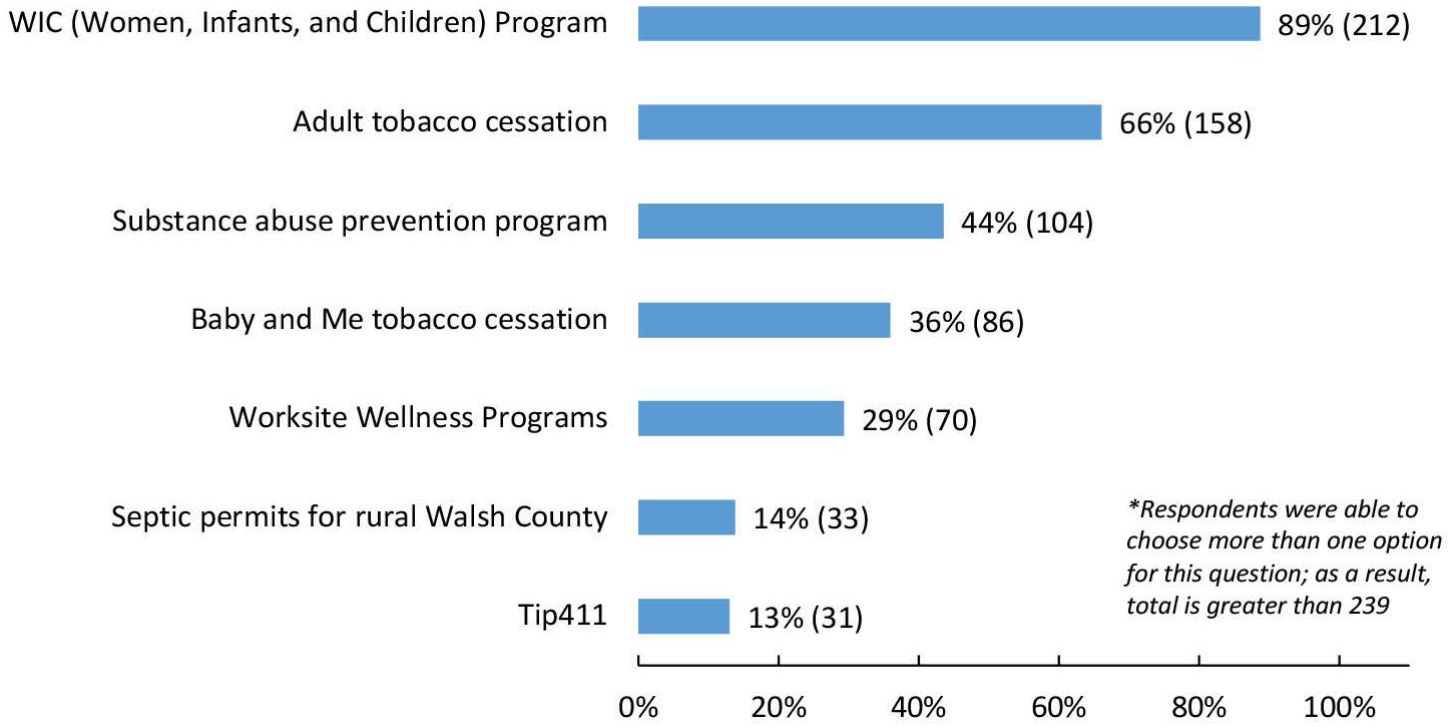
Considering the variety of services offered at local hospitals in Walsh County, survey respondents were asked to indicate of which services they were aware at FCHC and UMC (See Figure 24).

Figure 24: Awareness of Hospital Services
Total respondents = 259*



Considering a variety of healthcare services offered by WCHD, respondents were asked to indicate if they were aware that the healthcare service is offered though WCHD (See Figure 25).

Figure 25: Awareness of Public Health Services
Total respondents = 239*



In an open-ended question, respondents were asked what specific healthcare services, if any, they think should be added locally. The top desired services to add locally were mental/behavioral health and addiction treatment services, with OB/GYN services as the second-most requested. Other requested services included:

- Affordable addiction counseling
- After hours/weekend walk-in clinic
- Behavioral/mental health/detox services
- Birthing services
- Cancer services
- Financial wellness services
- Healthcare legal consultation
- Home health
- Increased specialist visits
- Indoor walking facility
- Mental health in schools
- More VA services
- OB/GYN
- Ophthalmologist
- Orthodontics
- Orthopedics
- Outpatient pediatric occupational therapy
- Pediatrics
- Podiatry
- Rheumatologist
- School sexual health clinics
- Urology
- Visiting neurologist
- Visiting pain management specialist
- Women's health services

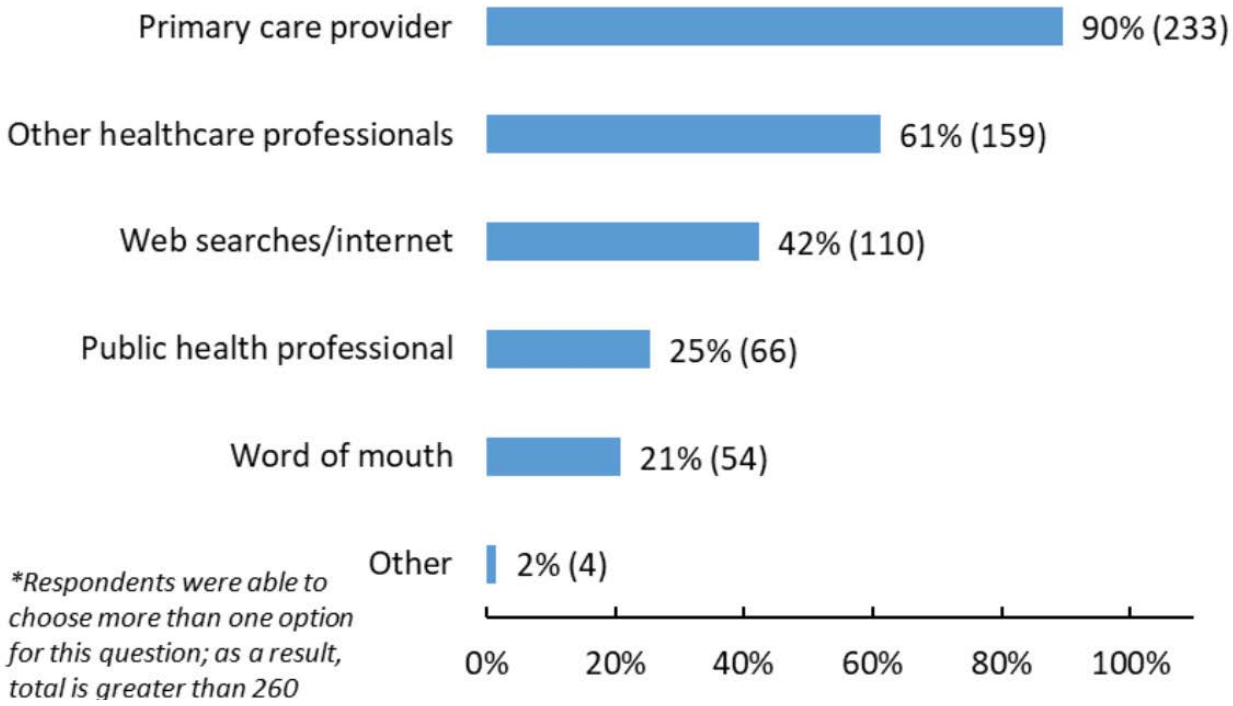
Regarding mental health services being added, there were several comments, regarding adding types of professionals, such as psychiatrists, psychologists, and counselors. Mental health services for varying ages were mentioned (elderly, adult, adolescents, and children) along with substance abuse treatment services.

The key informant and focus group members felt that the community members were aware of the majority of the health system services. Public health services they felt of which community members were unaware were diabetes screenings, tuberculosis services, opioid/substance abuse program, correction facility health, worksite wellness, emergency preparedness, young mother services, environmental health services, and worksite wellness. They felt the hospital should increase marketing efforts for a variety of services, including chemotherapy, foot care, community programs, caregiver programs, cardiac rehab, telemedicine/video visits, respite care, and breath testing for gastrointestinal conditions.

Respondents were asked to where they go for trusted health information. Primary care providers (N=233) received the highest response rate, followed by other healthcare professionals (N=159), and then web/internet searches (N=110).

Results are shown in Figure 26.

Figure 26: Sources of Trusted Health Information
Total respondents = 260*



Respondents were able to choose more than one option for this question; as a result, total is greater than 260

In the "Other" category, alternative health providers and nursing journals were listed as sources of trusted information.

As shown in figure 27, most survey respondents felt that little to no local residents struggle with food insecurity each month. Only 11% (N=27) answered that 20 or more residents struggle per month.

Figure 27: Number of Local Residents Struggling with Food Insecurity Every Month
Total respondents = 249

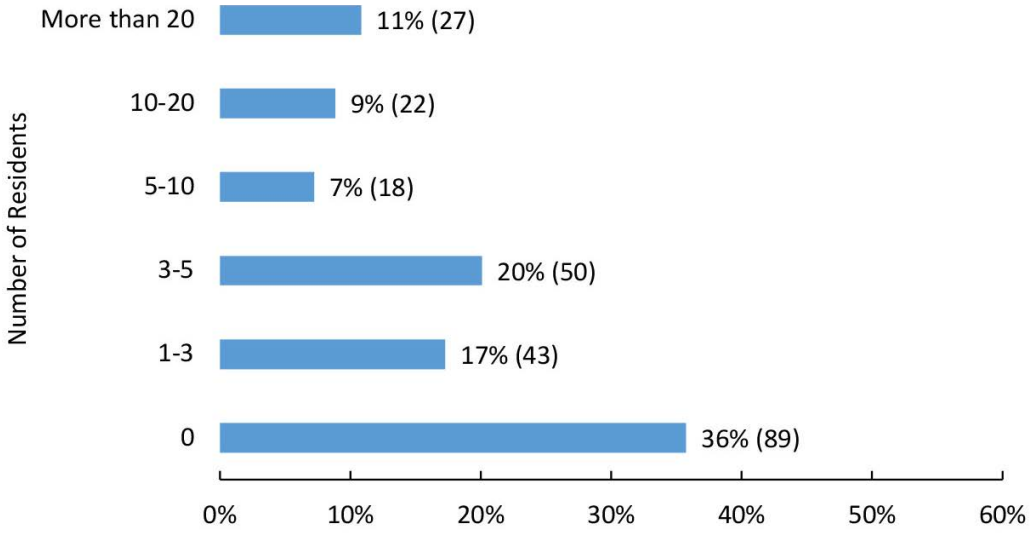
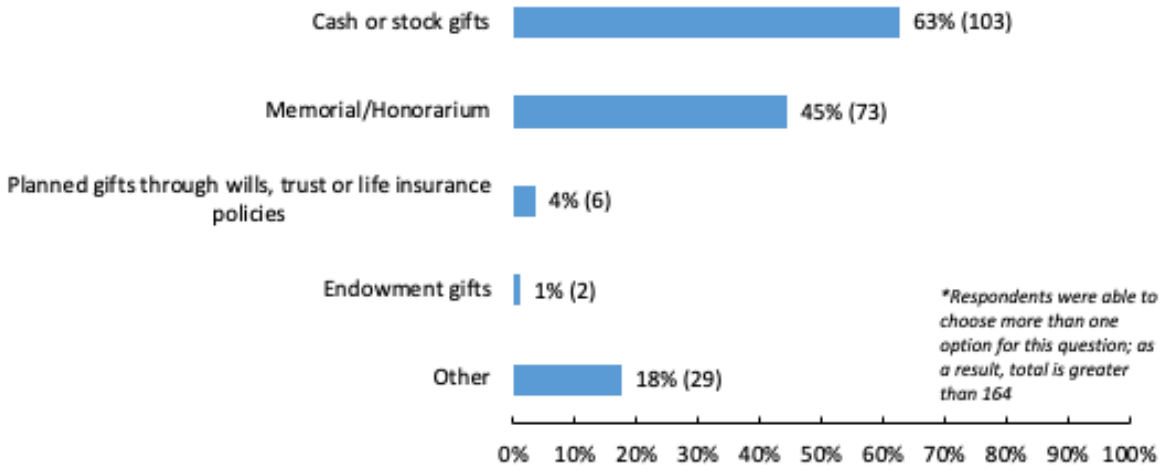


Figure 28: Forms of Support for Hospital Foundation
Total respondents = 164*



In an effort to gauge ways community members have supported the hospital's foundation/fundraising efforts, (see Figure 28), responses in the "Other" category included fundraisers, auctions, foundation events, Harvest Fest Activities, and Giving Hearts Day.

The final question on the survey asked respondents to share concerns and suggestions to improve the delivery of local healthcare. The majority of responses focused on bringing in more services and providers and improving awareness and accessibility of local services.

There were some complaints about staff at the local healthcare facilities regarding confidentiality and community knowing about patients; some felt they needed to be more caring and trusting. Several complaints focused on affordable healthcare, such as less expensive clinic visits for general wellness check-ups. Additional suggestions for clinic included the addition of expanded hours or the option to call a nurse/provider line and OB services. One person felt having more services within the county would alleviate travel to Grand Forks. There was also concern about keeping the EMT services in the future. It was suggested that mask requirements are a barrier to some people seeking medical treatment. One suggestion was offered in regard to having screenings done at the post office, grocery store, the Armory, or courthouse.

Some responses focused on the need for more providers, the need for the community to retain existing providers, and continue to recruit new ones, even when there is no shortage by offering competitive salaries for healthcare workers to retain them. Having doctors who care and will provide good services to patients is a priority.

Several respondents did comment on how great of a hospital and clinic there was and that everyone tries their best at helping others. It was noted that hospital leadership is working hard to improve the quality of healthcare in all areas. It was suggested that keeping good administrators in our healthcare facilities will maintain great staff and staff morale.

The health facilities should continue to post local newspaper articles about services, classes offered, and keep listing specialists and their schedules at the hospital/clinic. There needs to be continued promotion of the clinic and hospital.

Findings from Key Informant Interviews & the Community Meeting

Questions about the health and well-being of the community, similar to those posed in the survey, were explored during key informant interviews with community leaders, health professionals, and 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 six categories (listed in alphabetical order):

- Alcohol use and abuse – youth
- Attracting and retaining young families
- Availability of resources to help the elderly stay in their homes
- Availability of mental health services
- Depression / anxiety – youth
- Having enough child daycare services

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

Alcohol use and abuse – youth

- This is a top concern, as you hear about alcohol use particularly from students

Attracting and retaining young families

- It seems like there is more demand for businesses than there are qualified employees. In order for the community to thrive, need to find a way to draw in new residents or retain young graduates to the community
- No middle-income properties available makes it hard to attract and retain workers
- Lots of jobs but no homes for young families or new professionals to move into
- Population has decreased over the last decade

Availability of resources to help the elderly stay in their homes

- Adding palliative care may help in this area – there is a palliative care program in startup
- Top concern, hearing from home health groups that there are not a lot of home visiting services
- Need elderly accessible housing, such as single-level housing options
- Need to collaborate resources and funding to get nurses for elderly home care services, such as pill setup

Availability of mental health services

- Top issue in the community – related to availability of substance use disorder treatment services
- Seeing increase in prevalence and severity – lack of resources and timing of resources

- Mental health needs of the community are unmet – little to no treatment or places to people to go to meet their needs

Depression/anxiety – youth

- Need youth services
- Big concern – linked to many other concerns as well
- Need to increase/add mental health professionals to the community, especially in the school system

Having enough child daycare services

- Need extended hours
- Employers are losing good employees because they don't have childcare
- Main daycare center, closed due to not enough workers, has been a huge issue

Community Engagement and Collaboration

Key informants and focus group participants were asked to weigh in on community engagement and collaboration of various organizations and stakeholders in the community. Specifically, participants were asked, "On a scale of 1 to 5, with 1 being no collaboration/community engagement and 5 being excellent collaboration/community engagement, how would you rate the collaboration/engagement in the community among these various organizations?" This question was not intended to rank services provided. They were presented with a list of 12 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:

- Economic development organizations (4.25)
- Hospital (healthcare system) (4.25)
- Schools (4.25)
- Business and industry (4.0)
- Emergency services, including ambulance and fire (4.0)
- Law enforcement (4.0)
- Long-term care, including nursing homes and assisted living (4.0)
- Public health (4.0)
- Faith-based (3.75)
- Pharmacies (3.75)
- Other local health providers, such as dentists and chiropractors (3.5)
- Human/social services (3.0)

Priority of Health Needs

A community group met on March 29, 2022. Twenty community members attended the meeting. Representatives from the Center for Rural Health (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, concerns, and barriers to care), and findings from the key informant interviews and first community meeting.

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. Each member was given four votes to indicate each of the four needs they considered the most significant.

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

- Availability of resources to help the elderly stay in their homes (9 votes)
- Obesity/overweight – adults (9 votes)
- Availability of specialists (8 votes)
- Having enough child daycare services (8 votes)
- Not enough healthcare staff in general (8 votes)

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

1. Obesity/overweight – adults (9 votes)
2. Not enough healthcare staff in general (5 votes)
3. Having enough child daycare services (3 votes)
4. Availability of resources to help the elderly stay in their homes (0 votes)
5. Availability of specialists (0 votes)

Following the prioritization process during the second meeting of the community group and key informants, the number one identified need was obesity/overweight – adults. A summary of this prioritization may be found in Appendix F.

Comparison of Needs Identified Previously

Top Needs Identified 2019 CHNA Process	Top Needs Identified 2022 CHNA Process
Attracting and retaining young families	Obesity/overweight – adults
Availability of mental health services	Not enough healthcare staff in general
Alcohol use and abuse	Having enough child daycare services
Drug use and abuse	Availability of resources to help the elderly stay in their homes
Depression/anxiety	Availability of specialists

The current process did not identify any identical common needs from 2019.

Hospital and Community Projects and Programs Implemented to Address Needs Identified in 2019

In response to the needs identified in the 2019 CHNA process, the following actions were taken:

Unity Medical Center (UMC) chose not to address Need 1: Attracting and retaining young families due to limited resources and the need to allocate significant resources to other priority needs. Nutrition and physical inactivity were addressed instead.

Need 2: Availability of mental health services and Need 5: Depression/anxiety – UMC is happy to host telemedicine visits in their clinic locations for patients who are seeking treatment from mental health provider services. Online grief support is also available through Altru and Hospice of the Red River Valley. Other new contracts have been established, and opportunities to expand these offerings continue to be discussed.

All patients over the age of 12 who are seen in the Grafton Family Clinic or the Park River Family Clinic are now screened with a brief mental health questionnaire (PHQ-2). A positive screening leads to patients receiving a more detailed assessment form (PHQ-9) and referrals for other services as appropriate. The Walsh County Health Department (WCHD) keeps an updated list of local behavioral health contacts and resources for our patients and all community members.

Walsh County Public Health, along with local healthcare agencies, led a campaign for mental health and suicide awareness. The suicide awareness film, Jumper, was shown at the local movie theaters. Those persons in attendance received resources for services available in our community and the surrounding area. In addition, Walsh County Public Health nurses and local counselors were available for questions after the showings. This event highlighted a strong bond between the schools, the county, and the local healthcare facilities and brought about further partnerships with the school systems.

Northeast Human Service Center has begun intake visits with patients in local healthcare facilities before the patient is discharged. The in-person evaluations are provided to initiate the intake process, while the patient is in the hospital or emergency department.

Motivated UMC staff attended NAMI (National Alliance for Mentally Ill) training to bring further resources to our community. A support group was formed to provide support for families caring for the mentally ill and was well-received. The group is looking to revitalize the program and expand offerings in 2022.

Need 3: Alcohol use and abuse and Need 4: Drug use and abuse – The WCHD regularly promotes alcohol, tobacco, and other substance abuse programs and resources. UMC continues to participate in the Walsh County Substance Abuse Prevention Coalition to reduce adult binge drinking, underage drinking, and illicit drug use. UMC providers limit the quantity of opioids they prescribe, and they utilize the prescription drug monitoring program before ordering a controlled substance. Medication Assisted Treatment is now offered locally through Community Health Services, Inc. in Grafton for adults with substance abuse disorder.

UMC offers a tobacco cessation program, led by the Respiratory Therapy department. Recently, two nursing staff attended training to become certified Tobacco Cessation Specialists and will assist the patients enrolled in this growing program.

Need 6: Nutrition and Physical Activity – Since the last CHNA in 2019, Diabetes Education and Medical Nutrition Therapy services at UMC have grown. These programs, led by a registered nurse and a licensed dietician weekly, are offered to our patients through provider referrals.

The UMC dietician consistently offers nutrition-focused events for the community. Most recently, culinary cooking classes and weight loss classes have been open for community member enrollment. Participation in UMC Kids Clinic showcases healthy food choices for children. In addition, YouTube instructional videos for healthy snack preparation were developed for children, aged five and up, and posted on social media and UMC's website. The partnership between UMC and Walsh County Social Services was extended through

collaborative classes, focused on utilizing healthy food substitutes and alternative cooking methods. This information was then provided to their clients.

The Walsh County Food Pantry, located in Grafton, is available to members of the community. The local church communities, the WCHD, and the school districts are partnering with the food pantry to increase access to the services and products for citizens in need across the county.

The physical therapy department has also expanded to provide numerous new programs for many different patient populations. UMC now offers the LSVT BIG Program to assist people with Parkinson's Disease. Women's Health and Birth Fit classes were added to improve the health of female patients. Therapists have also enhanced already close relationships with local businesses through worksite wellness and industrial medicine assessments and activities offered onsite. Special attention is given to each patient through the individualized programming, such as functional movement screening for school athletes and athletic injury screening. Patients of all ages seek treatment, rehabilitation, and performance enhancement coaching from the large team of providers.

The above implementation plan for UMC is posted on their website at https://www.unitymedcenter.com/about-us/patientresources.html.

Next Steps – Strategic Implementation Plan

Although a Community Health Needs Assessment (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 Center for Rural Health (CRH) strongly encourages a review of the most recent Community Benefit Report to determine how/if it aligns with the needs identified, through the CHNA, as well as the implementation plan.

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

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

Community benefit is also the basis of the tax-exemption of not-for-profit hospitals. The Internal Revenue Service (IRS), in its Revenue Ruling 69–545, describes the community benefit standard for charitable tax-

exempt hospitals. Since 2008, tax-exempt hospitals have been required to report their community benefit and other information, related to tax-exemption on the IRS Form 990 Schedule H.

What Are Community Benefits?

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

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

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

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

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

Appendix A – Critical Access Hospital Profile

Critical Access Hospital Profile

Spotlight on: Grafton, North Dakota

Unity Medical Center

Quick Facts

Administrator/CEO:
Alan O'Neil

City Population:
4,182 (2019 Estimate)[1]

County Population:
10,641 (2019 Estimate)[1]

County Median Household Income:
$55,700 (2019 Estimate)[1]

County Median Age:
44.5 (2019 Estimate)[1]

Hospital Beds: 14

Trauma Level: V

Critical Access Hospital Designation: 2001

Economic Impact on the County[2]
Employment Impact:
Direct: 103
Secondary: 44
Total: 147

Financial Impact:
Direct: $8.7 million
Secondary: $2.5 million
Total: $11.2 million

Mission

Unity Medical Center provides access to quality health care for the region

County: Walsh
Address: 164 W 13th Street
Grafton, ND 58237
Phone: 701.352.1620
Fax: 701.352.1671
Web: www.unitymedcenter.com

Unity Medical Center and its predecessors, Grafton Deaconess Hospital, St Joseph's Hospital and Grafton Family Clinic have been a vital part of the Grafton community for more than 119 years. We were founded to serve a growing segment of our community in need of accessible services. Today, Unity Medical Center is an incorporated, community-owned and operated health care facility that recently completed a $20 million, 36,000-square foot expansion to the current building which is 70 years old. The new space added a Surgery Center, Emergency Department, Rehab Services, dedicated patient floor with 11 private rooms, and a Rural Medical Education Center.

Our providers and nurses are educated to handle a wide variety of cases, putting their experience to work for you. In addition, Unity Medical Center has access to some of the area's most respected specialists. You don't have to leave home to get the care you deserve - healing happens right here in Grafton, with your friends at Unity Medical Center, where you can count on the highest level of medical care available, all day, every day.

Services

- 24-hour Emergency Department (Trauma V)
- Acute, Swingbed, & Respite
- Cardiac Rehab
- Chemotherapy
- Chronic Disease Management
- Diabetic Services and Education
- Family Medicine Clinics – Grafton & Park River
- Foot Care Clinic
- General Surgery
- Laboratory & Pathology
- Nutritional Counseling and Services
- Pharmacy
- Physical, Speech & Occupational Therapy
- Radiology - Nuclear Medicine, DEXA, CT, Digital X-ray, Ultrasound, MRI, and 3D Mammography
- Respiratory Therapy – Home Oxygen, C-pap, Sleep apnea services
- Specialty Services including Cardiology, Gastroenterology, Podiatry, Obstetrics, Orthopedics, Oncology/Hematology, Audiology, Psychiatry, Psychology, Home care
- Telemedicine
- Unity Medical Center Foundation

Local Sponsors and Grant Funding Sources

- Center for Rural Health -SHIP Grant (Small Hospital Improvement Program

Sources

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

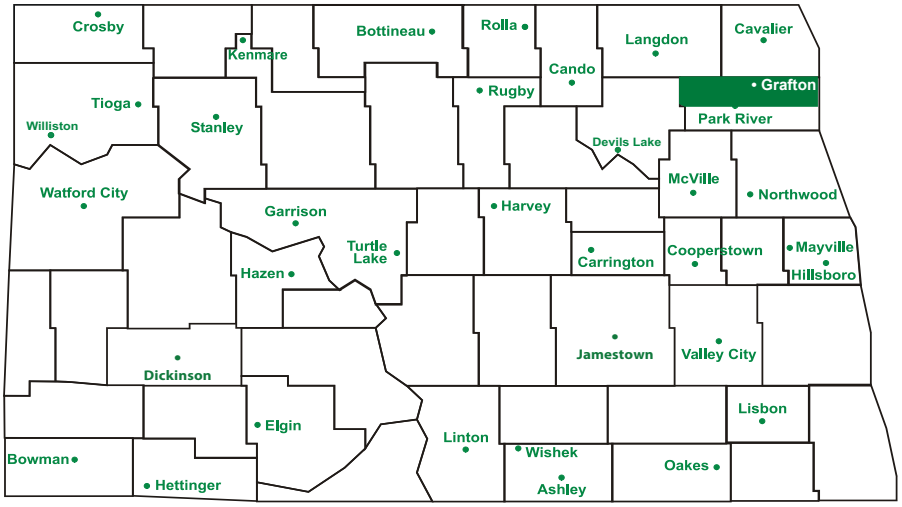
[2] Economic Impact 2020, Oklahoma State University and Center for Rural Health, University of North Dakota

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

This project is supported by the Medicare Rural Hospital Flexibility Grant Program at the Center for Rural Health, University of North Dakota School of Medicine & Health Sciences located in Grand Forks, North Dakota.

ruralhealth.und.edu

North Dakota Critical Access Hospitals



Grafton is located in northeastern North Dakota, the heart of the Red River Valley, which comprises some of the richest soil in the world. The city, an attractive residential community, is a major retail trade center, and a primary market and distribution center for agricultural commodities produced in the surrounding area. Grafton's school system provides educational opportunities to students K-12. Grafton Parks and Recreation Department offers an extensive number of organized sports programs and activities for all ages. Facilities include a heated swimming pool, eight tennis courts, lighted football and track field, two supervised outdoor skating rinks and two parks. Other facilities include bowling, curling, baseball and softball, an armory gymnasium, winter sports arena, gun club and overnight camping.

Appendix B – Economic Impact Analysis

December 2020

Unity Medical Center

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

Economic Impact

Unity Medical Center, located in Grafton, North Dakota, is composed of a Critical Access Hospital (CAH) and two Rural Health Clinics.

Unity Medical Center **directly** employs **103 FTE employees** with an annual payroll of over **$8.7 million** (including benefits).

- After application of the employment multiplier of 1.42, these employees created an additional **44** jobs.
- The same methodology is applied to derive the income impact. The income multiplier of 1.29 is applied to create nearly **$2.5 million** in income as they interact with other sectors of the local economy.
- **Total impacts = 147 jobs and more than $11.2 million in income.**

Healthcare and Your Local Economy

The health sector in a rural community, anchored by a CAH, is responsible for a number of full- and part-time jobs and the resulting wages, salaries, and benefits. Research findings from the National Center for Rural Health Works indicate that rural hospitals typically are one of the top employers in the rural community. The employment and the resulting wages, salaries, and benefits from a CAH are critical to the rural community economy. Figure 1 depicts the interaction between an industry like a healthcare institution and the community, containing other industries and households.

Key contributions of the health system include

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

Data analysis was completed by the Center for Rural Health at the Oklahoma State University Center for Health Sciences utilizing IMPLAN data.

Fact Sheet Author: Kylie Nissen, BBA

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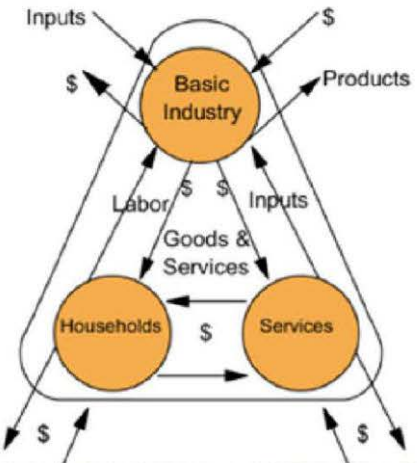
Figure 1. An overview of the community economic system.



Source: Doeksen, G.A., T. Johnson, and C. Willoughby. 1997. Measuring the Economic Importance of the Health Sector on a Local Economy: A Brief Literature Review and Procedures to Measure Local Impacts

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

Appendix C – CHNA Survey Instrument

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

If you prefer, you may take the survey online at https://tinyurl.com/WalshCo2021 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 29, 2022. Your opinion matters – thank you in advance!

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

10. Regarding various forms of **VIOLENCE** in your community, concerns are (choose up to THREE):

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

Delivery of Healthcare

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

- ☐ Cardiac Rehab
- ☐ Cardiology (visiting specialist)
- ☐ Chemotherapy
- ☐ CT Scan
- ☐ Diet instruction
- ☐ Echocardiogram
- ☐ Emergency room
- ☐ eTelehealth for specialists from Altru/Sanford
- ☐ Home healthcare
- ☐ Hospice
- ☐ Laboratory services
- ☐ Lactation Counseling
- ☐ 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
- ☐ Tobacco Cessation
- ☐ 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): _____

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

_____

_____

17. Regarding the people that you associate with in your community, what is the number of people struggling with hunger and adequate food on a monthly basis:

- ☐ 0
- ☐ 1-3
- ☐ 3-5
- ☐ 5-10
- ☐ 10-20
- ☐ More than 20

18. 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.

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

- ☐ Yes
- ☐ No

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

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

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

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

22. Age:

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

23. Highest level of education:

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

24. Sex:

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

25. Employment status:

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

26. Your zip code: _____

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

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

28. Annual household income before taxes:

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

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

_____

_____

Thank you for assisting us with this important survey!

Appendix D – County Health Rankings Explained

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

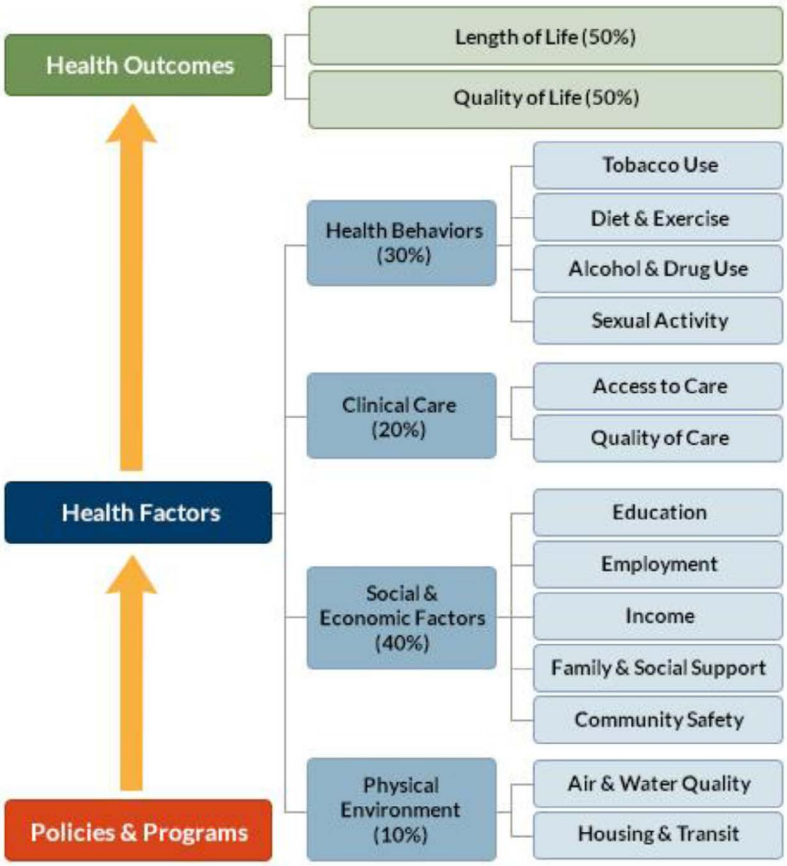
Methods

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

What is Ranked

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

Ranking System



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

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

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

Data Sources and Measures

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

Data Quality

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

Calculating Scores and Ranks

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

Health Outcomes and Factors

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

Health Outcomes

Premature Death (YPLL)

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

Reason for Ranking

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

Poor or Fair Health

Self-reported health status is a general measure of health-related quality of life (HRQoL) in a population. This measure is based on survey responses to the question: "In general, would you say that your health is excellent, very good, good, fair, or poor?" The value reported in the County Health Rankings is the percentage of adult respondents who rate their health "fair" or "poor." The measure is modeled and age-adjusted to the 2000 U.S. population. 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" are based on survey responses to the question: "Thinking about your physical health, which includes physical illness and injury, for how many days during the past 30 days was your physical health not good?" The value reported in the County Health Rankings is the average number of days a county's adult respondents report that their physical health was not good. The measure is age-adjusted to the 2000 U.S. population. 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" are based on survey responses to the question: "Thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental health not good?" The value reported in the County Health Rankings is the average number of days a county's adult respondents report that their mental health was not good. The measure is age-adjusted to the 2000 U.S. population. Note that the methods for calculating this measure changed in the 2016 rankings.

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

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

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

In terms of the infant's health outcomes, LBW serves as a predictor of premature mortality and/or morbidity during the life course. 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.

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.

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. 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."

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.

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% of the federal poverty threshold for the family size.

2) Food insecurity estimates the percentage of the population that 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. Supermarkets traditionally provide healthier options than convenience stores or smaller grocery stores.

Additionally, access in regard 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. 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 ages 20 and older 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 U.S. and caused more than 5.3 million of the 57 million deaths that occurred worldwide in 2008. In addition, physical inactivity at the county level is related to healthcare expenditures for circulatory system diseases.

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 are comprised of 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; in urban census blocks: reside within one mile of a recreational facility; and 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.

Excessive Drinking
Excessive drinking is the percentage of adults that report either binge drinking, defined as consuming more than four (women) or five (men) alcoholic beverages on a single occasion in the past 30 days, or heavy drinking, defined as drinking more than one (women) or two (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. Approximately 80,000 deaths are attributed annually to excessive drinking. Excessive drinking is the third leading lifestyle-related cause of death in the U.S.

Alcohol-Impaired Driving Deaths
Alcohol-impaired driving deaths are 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.

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. STIs are associated with a significantly increased risk of morbidity and mortality, including increased risk of cervical cancer, infertility, and premature death. STIs also have a high economic burden on society. The direct medical costs of managing STIs and their complications in the U.S., for example, was approximately $15.6 billion in 2008.

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. 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. Preterm delivery and low birthweight babies have increased risk of child developmental delay, illness, and mortality. Additionally, there are strong ties between teen birth and poor socioeconomic, behavioral, and mental outcomes. A teenage woman who bears a child is much less likely to achieve an education level at or beyond high school, much more likely to be overweight/obese in adulthood, and more likely to experience depression and psychological distress.

Uninsured

Uninsured is the percentage of the population younger than 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? 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."

Primary Care Physicians

Primary care physicians is the ratio of the population to total primary care physicians. Primary care physicians include nonfederal, practicing physicians (MDs and DOs) younger than age 75 specializing in general practice medicine, family medicine, internal medicine, and pediatrics. 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.

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.

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 who treat alcohol and other drug abuse, and advanced practice nurses specializing in mental healthcare. In 2015, marriage and family therapists and mental health providers who treat alcohol and other drug abuse were added to this measure.

Reason for Ranking

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

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

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

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

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

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

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

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

Reason for Ranking
The unemployed population experiences worse health and higher mortality rates than the employed population. 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. 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 younger than 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 younger than age 18, and whether the primary householder is older than age 65. Family income is then compared to the poverty threshold; if that family's income is below that threshold, the family is in poverty. For more information, please see Poverty Definition and/or Poverty.

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

Reason for Ranking

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

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 such as ADHD, behavior disorders, and anxiety, which can limit learning opportunities and social competence, leading to academic deficits that may persist into adulthood. 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. Note that the methods for calculating this measure changed in the 2015 rankings.

Reason for Ranking

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

Children in Single-Parent Households

Children in single-parent households is the percentage of children in families where the household is headed by a single parent (male or female head of household with no spouse present). 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). 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. Children in single-parent households are at greater risk of severe morbidity and all-cause mortality than their peers in two-parent households.

Violent Crime Rate

Violent crime rate 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. 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. Exposure to chronic stress also contributes to the

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

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 U.S. mortality in 2014. 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. Injuries account for 17% of all emergency department visits and falls account for more than 1/3 of those visits.

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. Negative consequences of ambient air pollution include decreased lung function, chronic bronchitis, asthma, and other adverse pulmonary effects. 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.

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. 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, and kidney, liver, and nervous system damage.

Severe Housing Problems

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

- Housing unit lacks complete kitchen facilities;
- Housing unit lacks complete plumbing facilities;
- Household is severely overcrowded; or
- Household is severely cost burdened.

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

Reason for Ranking

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

Appendix E – Youth Risk Behavior Survey

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

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

	ND 2015	ND 2017	ND 2019	ND Trend ↑, ↓, =	Rural ND Town Average	Urban ND Town Average	National Average 2019
Percentage of students who made a plan about how they would attempt suicide (during the 12 months before the survey)	13.5	14.5	15.3	=	16.3	16.0	15.7
Percentage of students who attempted suicide (one or more times during the 12 months before the survey)	9.4	13.5	13.0	=	12.5	11.7	8.9
Tobacco Use							
Percentage of students who ever tried cigarette smoking (even one or two puffs)	35.1	30.5	29.3	=	32.4	23.8	24.1
Percentage of students who smoked a whole cigarette before age 13 years (even one or two puffs)	NA	11.2	NA	**NA**	NA	NA	NA
Percentage of students who currently smoked cigarettes (on at least one day during the 30 days before the survey)	11.7	12.6	8.3	↓	10.9	7.3	6.0
Percentage of students who currently frequently smoked cigarettes (on 20 or more days during the 30 days before the survey)	4.3	3.8	2.1	↓	2.3	1.7	1.3
Percentage of students who currently smoked cigarettes daily (on all 30 days during the 30 days before the survey)	3.2	3.0	1.4	↓	1.6	1.2	1.1
Percentage of students who usually obtained their own cigarettes by buying them in a store or gas station (during the 30 days before the survey among students who currently smoked cigarettes and who were aged <18 years)	NA	7.5	13.2	=	9.4	10.1	8.1
Percentage of students who tried to quit smoking cigarettes (among students who currently smoked cigarettes during the 12 months before the survey)	NA	50.3	54.0	=	52.8	51.4	NA
Percentage of students who currently use an electronic vapor product (e-cigarettes, vape e-cigars, e-pipes, vape pipes, vaping pens, e-hookahs, and hookah pens at least one day during the 30 days before the survey)	22.3	20.6	33.1	↑	32.2	31.9	32.7
Percentage of students who currently used smokeless tobacco (chewing tobacco, snuff, or dip on at least one day during the 30 days before the survey)	NA	8.0	4.5	↓	5.7	3.8	3.8
Percentage of students who currently smoked cigars (cigars, cigarillos, or little cigars on at least one day during the 30 days before the survey)	9.2	8.2	5.2	↓	6.3	4.3	5.7
Percentage of students who currently used cigarettes, cigars, or smokeless tobacco (on at least 1 day during the 30 days before the survey)	NA	18.1	12.2	NA	15.1	10.9	10.5
Alcohol and Other Drug Use							
Percentage of students who ever drank alcohol (at least one drink of alcohol on at least one day during their life)	62.1	59.2	56.6	=	60.6	54.0	NA
Percentage of students who drank alcohol before age 13 years (for the first time other than a few sips)	12.4	14.5	12.9	=	16.4	13.2	15.0
Percentage of students who currently drank alcohol (at least one drink of alcohol on at least one day during the 30 days before the survey)	30.8	29.1	27.6	=	29.4	25.4	29.2
Percentage of students who currently were binge drinking (four or more drinks of alcohol in a row for female students, five or more for male students within a couple of hours on at least one day during the 30 days before the survey)	NA	16.4	15.6	=	17.2	14.0	13.7
Percentage of students who usually obtained the alcohol they drank by someone giving it to them (among students who currently drank alcohol)	41.3	37.7	NA	**NA**	NA	NA	40.5
Percentage of students who tried marijuana before age 13 years (for the first time)	5.3	5.6	5.0	=	5.5	5.1	5.6
Percentage of students who currently used marijuana (one or more times during the 30 days before the survey)	15.2	15.5	12.5	=	11.4	14.1	21.7

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

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

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

Appendix F – Prioritization of Community's Health Needs

Community Health Needs Assessment
Grafton, North Dakota
Ranking of Concerns

The top concerns for each of the six topic areas, based on the community survey results, were presented to meeting attendees. The numbers below indicate the total number of votes by the people in attendance at the second community meeting. The "Priorities" column lists the number of votes on the concerns indicating which areas are felt to be priorities. Each person was given four votes to place on the items they felt were priorities. The "Most Important" column lists the number of votes for the most important concern. After the first round of voting, the top five priorities were selected based on the highest number of votes. Each person was given one vote to place on the item they felt was the most important priority of the top five highest ranked priorities.

	Priorities	Most Important
COMMUNITY/ENVIRONMENTAL HEALTH CONCERNS		
Attracting & retaining young families	-	
Having enough child daycare services	8	3
Not enough affordable housing	-	
Not enough jobs with livable wages	-	
AVAILABILITY/DELIVERY OF HEALTH SERVICES CONCERNS		
Availability of mental health and substance use disorder treatment services	-	
Availability of specialists	8	0
Cost of health insurance	-	
Extra hours for appointments, such as evenings and weekends	-	
Cost of healthcare services	-	
Not enough healthcare staff in general	8	5
YOUTH POPULATION HEALTH CONCERNS		
Alcohol use and abuse		
Drug use and abuse (including prescription drugs)		
Depression/anxiety		
Smoking and tobacco use, exposure to second-hand smoke, juuling/vaping		
ADULT POPULATION HEALTH CONCERNS		
Alcohol use and abuse	-	
Drug use and abuse (including prescription drugs)	-	
Depression/anxiety	-	
Stress	-	
Obesity/overweight	9	9
SENIOR POPULATION HEALTH CONCERNS		
Cost of long-term/nursing home care	-	
Long-term/nursing home options	-	
Availability of resources to help elderly stay in their homes	9	0
Availability of resources for family and friends caring for elders	-	
Assisted living options	-	
Depression/anxiety	-	
VIOLENCE CONCERNS		
Bullying/cyber-bullying		

Appendix G – Survey "Other" Responses

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

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

1. Considering the PEOPLE in your community, the best things are: "Other" responses:
    - Negative in thinking things can change
    - No resources
    - None apply in Grafton - biased question
    - None of these are true
    - These don't apply to Grafton
2. Considering the SERVICES AND RESOURCES in your community, the best things are: "Other" responses:
    - Access to quality professional services
    - Community always willing to help others
    - Critical thinkers
    - Excellent EMS services
    - Grafton barely has these things
    - Grafton doesn't have these things besides a "faith community". I don't see that as a best thing, I guess.
    - Need more of all of the items here
    - Parks
    - Veterinary services
4. Considering the ACTIVITIES in your community, the best things are: "Other" responses:
    - Activities are for the youth only
    - All Chamber events
    - Everything on this list are the best in Grafton
    - Few activities
    - Holiday festivals....parades
    - Need more
    - No resources
    - There is space and freedom around here
    - These don't apply to Grafton

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:
    - Accessibility
    - Drug prevalence
    - Drugs (huge problem)

- EMS viability
- Home care
- Lack of access to mental health care
- Lack of mental health resources
- Mental health awareness and support
- More shopping opportunities
- Negative attitude towards women
- Too much affordable housing which attracts poverty and drug/drug sales/abuse

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

- Mental health specialists
- None, I believe our local health services are meeting these needs
- Seems like they have too many people working there, employees on their cell phones, lack of follow thru with patients

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

- Access to mental health services
- Bullying in the school. Principal does not care.
- Bullying, mental health care, support
- Cyber bullying
- Lack of focus on education, lack of financial education
- Lack of focus on/desire for education; Social media addiction
- Mental health support
- Neglect
- Not enough places for youth employment
- Not getting enough unstructured outside time
- Open jobs for teenagers
- School sports extending to summer taking away from summer activities

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

- Lack of financial education, poor financial choices
- Mental health
- Social media addiction

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

- Accessibility

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

- Ability for families to find consistent daycare services. People can't work if they can't find care for their kids, but there is NEVER enough childcare availability for all families, therefore the economy suffers due to lack of available workers.
- Acceptance of others for whoever they are
- Acceptance of people who don't fit the idea of "normal". That means culturally, members of the lgbtq+ community, people with different faith. etc.
- Access to affordable childcare cripples our local workforce.
- Access to quality, fresh food
- Adequate and affordable housing options.
- Affordable housing
- Affordable housing and daycare options

- Affordable housing, drug/alcohol abuse
- Alcohol abuse
- Alcoholism
- Attracting and retaining professionals
- Attracting good quality labor force to meet the needs of local businesses grow and meet current demands.
- Bullying/cyber-bullying
- Child abuse
- Child abuse and neglect.
- Childcare
- Community activities for both adults and youth. Lack of restaurant / dining choices.
- Community involvement by residents
- Covid
- Cultural diversity
- Day care availability
- Daycare availability - this then becomes a big issue for current families and then a huge issue in attracting new families to the area
- Daycare services and adequate mental health services
- Depopulation and advanced age of the community as a whole.
- Diversity/ inclusion. Accepting and judging those who beat their own drum
- Drug and alcohol abuse
- (3) Drugs
- Drugs and addiction
- Easy access to drugs.
- Economy
- Elderly housing-lower cost duplexes, town houses etc.
- Fox News and social media are turning people into angry zombies. There's a huge lack of understanding of how addictive and manipulative media can be. In the past 2.5 years, people have grown much angrier and less open to each others views. It's especially high with older-than-millennial generations who are new/inexperienced with social media and/or watch a lot of news media. Not sure how to fix it, but it might be worse than/contributing to the pandemic.
- Getting businesses to move to Grafton so we can increase our population. Who would want to move here with a small hand full of stores open on main street
- Good ole boy sheriff & state patrol, town police. was rear-ended, totaled my truck and she didn't receive a citation, (boyfriend was a cop in another town.)
- Help for our aging population, rides cleaning, groceries, little things needing to be done. daycare for kids.
- Help of shut-ins.
- High cost of prescription drugs
- High risk behaviors - alcohol abuse, drug use, not wearing seatbelts, children not being restrained in appropriate car seat/booster, etc.
- Housing - our community lacks available housing that would attract people to our community and also to retain people to continue living in the community.
- I don't know
- I feel like mental health of kids during this pandemic. I feel like a full time counselor for kids and adults could be kept busy. Also OT therapist. I drive with my son to GF once a week for these services.
- I feel that there are not enough places for younger adults.. example: Kids moving back from college. There are very little places to rent and very little places for younger family to rent/own. It's hard to want to expand the community when there isn't any housing available where people are comfortable living.
- Illegal healthcare mandates

- In regards to healthcare- keeping quality people in the community
- Job salaries keeping up with living cost
- Jobs with adequate pay
- Keeping generations wanting to stay in our community. Lack of activities, jobs, restaurants that impact what they find important.
- Keeping local business open and more variety of products.
- Keeping quality workers in all areas
- keeping sources available to keep elderly in their homes
- Kids billing each other and adults turning their backs not dealing with what needs to be dealt with. Also kids be disrespectful to other kids with disabilities!!
- Lack of access to mental health professionals, which would include detox. These issues are almost always comingled in patients with one affecting the other. There is a huge care gap for this population- with pts having to travel for hours to get to appts.
- Lack of affordable housing leads to a lack of skilled and available workforce.
- Lack of childcare services for shift work parents and just in general lack of availability for childcare.
- Lack of local resources within close proximity - people without transportation means cannot access resources because they are in other towns.
- Lack of long-term care options
- Lack of mental health services
- Lack of mental health services for children. No local therapists.
- Lack of professional jobs to attract family that will stay long term and give back to the community
- Lack of resources for mental health and addiction services.
- Lack of resources to help people with mental health.
- Lack of restaurants.
- Limited Resources for mental health issues, drug/alcohol abuse.
- Little to no childcare options
- Living arrangements for those who are in need of help, especially health wise. Assisted living, home health, nursing home, HUD housing- all of these are very difficult to get any one person started on (I know that's not just our community, it's everywhere) just to have more of a push and delivery to the people about services, to be stern.
- Local and available mental health resources such as counseling for the general public.
- Losing of any retail stores and dining options limited, and so many more options the closeness to grand forks where you can buy for much cheaper and many more options our options here in grafton are so limited
- Maintaining our population
- Market rate rental properties and affordable family homes.
- (2) Mental health
- Mental health issues leading to alcoholism and drug abuse.
- Mental health issues.
- Mental health services across all ages and in different formats to allow access and engagement
- Mental health treatment
- Need for affordable living
- No one wants to work. Plenty of jobs just lazy people.
- Not enough activities for children to keep busy and active during the winter months
- Not enough businesses, clothing, food
- Not enough childcare
- Not enough job opportunities
- Not enough or any resources for mental health therapy to physically go in and see a therapist.
- Not enough restaurants/places for people to hang out.

- Not very welcoming to new families
- Overcrowded school - enrollment has increased a lot in past 2 years. Let's keep quality education a priority.
- People accepting new people in town. Having your own opinion of someone not what you may hear from others.
- People who are willing to work
- Places of employment are short staffed and everyone in the community is getting burnt out.
- Places to eat.
- (5) Poverty
- Poverty and quality of life for middle income people and below.
- Poverty and the effects on our residents
- Poverty, drug abuse, and child neglect.
- Quality employees/workforce-In all areas of our community. Quality childcare. Quality early childhood learning.
- School and cyber bullying
- Something for seniors to do.
- Substance use and adequate treatment
- Suicide/depression among teens/young adults. Not enough mental health beds within the state.
- Support of the geriatric/elder population
- Supporting and keeping small town businesses going.
- The ability to get people interested in living here in Grafton. Most new employees at Marvin find somewhere to live in Park River or other surrounding towns.
- The decline in population and the lack of businesses. City hall pushing the blame on someone else and not taking responsibility for their poor leadership in the community. Not willing to try new things.
- The drugs in the community, lot from the locals.
- The lack of availability for mental/emotional help and the availability for substance abuse help. It is becoming increasingly easier to obtain illicit substances in our area, and with the lack of help available to people struggling with mental or emotional issues they are turning to substance use to help them cope.
- The lack of people willing to wok
- The lack of restaurants and eating establishments.
- There are no resources for outpatient or inpatient treatment for addiction or mental health. We have a campus (LSTC) that is mostly empty which would be a great place for a treatment facility or transition center. These particular individuals can't afford the insurance that is required by many treatment facilities or they don't have a drivers license or vehicle to drive to Grand Forks which is the closest treatment facilities.
- There seems to be a high amount of children in school feeling bullied here. I've heard it from multiple families during my 6 years here.
- Volunteers
- We need to try and keep our younger families in our communities!
- Willingness of community members to seek mental health support, if needed.
- With the amount of drugs going through town, nothing is being done about it, the lack of action by social services to get kids out of these homes, or the lack of help to the families who take in kids and they cant afford the day care. stress over money to take care of these kids. but there is no hesitation to hand out more money or food stamps to drug homes, so people can sell it for drugs. and the kids are still left with nothing.
- Work force
- Youth programs

Delivery of Healthcare

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

- Belief it will pass
- I delay care cause I don't want to do the Covid-19 dance
- I do not use healthcare at this time for any existing conditions
- I don't go to the doctor in my community.
- I feel our healthcare facilities are accessible and meeting my and my family's needs.
- I have no problem accessing care
- NA
- No reason to switch from previous provider
- noncompliance
- (2) None
- None issue

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

- Alternative health providers
- My doctor
- Nursing journals

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

- Additional mental health services for youth within the school setting
- Affordable addiction counseling.
- After-hours walk-in clinic and weekend walk in clinic
- Availability of mental health care providers for both youth and adults. I've heard it's really hard to get it, maybe a 3+ month wait. Telehealth services don't always work for the youth.
- Behavioral health services therapy
- Cancer and also for children with disabilities
- Child & adult psychiatry and other mental / behavioral health services and counseling.
- Childbirth
- Child delivery
- Consumer driven Legal consultation should be included before any medical procedure to assure healthcare facilities are following the law
- (2) Counseling
- Counseling, psychiatry, addiction treatment
- Detox
- Dialysis, birthing
- Dialysis
- Drug/alcohol treatment services
- Eye surgeon
- Financial wellness isn't talked about enough. Usually the "health care system" solutions to physical or mental wellness are extremely expensive and ignore the fact that a foundational element of the patients' problems is related to financial wellness. Tell me how you're supposed to eat healthy, work out, and come out of depression when you're in crippling medical debt from medication/therapy?
- Free Indoor walking facility
- Hl,j,lyhmkjyj
- Home health
- I think they do a good job of offering a wide variety of services.

- Lactation, OBGYN (televisits)
- Maternity
- (3) Mental health
- Mental health and support for substance abusers
- Mental health for all ages.
- (5) Mental health services
- Mental health services, detox/alcohol abuse/addiction services and counseling
- Mental health therapists for children
- Mental health, chemical dependency treatment center
- Mental health/substance abuse
- Mental health/substance abuse resources
- Mental health; I have a friend that was referred to a therapist and had to wait months to see one
- Mental health; wellness
- Mental health Services
- More mental health care services
- (2) More mental health services
- More mental health services that are affordable
- More mental health specialists and addiction counselors.
- More VA opportunities for veterans
- (2) OB
- OB - Maternity
- OB (delivery specifically)
- OB, surgical
- OB/Gyn specialist
- (2) Obgyn
- Obstetrician and pediatrics
- OP department
- Orthodontics
- Orthodontics. OB/GYN. Neuro.
- Orthopedic and podiatry
- Outpatient pediatric occupational therapy
- Physical wellness/ therapy services
- Podiatry
- (2) Psychiatry
- Psychologist
- Public pace for exercising/gym
- Rheumatologist
- Specialty doctors coming once a month
- Substance abuse outreach and mental illness outreach
- Unsure
- Urology
- Visiting neurologist, visiting pain management specialist
- Women's health / ob/gyn, lactation consult
- Women's health clinic, mental health counselling/ support groups, school sexual health clinics
- Youth services and activities

18. Have you supported your hospital's Foundation/fund raising efforts in any of the following ways? "Other" responses:

- Administration salaries are too high
- Attended events
- Auctions, giving hearts day
- Buy from fundraisers
- Donation gift baskets
- Donations
- Foundation events like Giving Hearts, Auction, Golf Tourney
- Fund raisers like harvest fest, etc.
- Fundraiser
- (2) Fundraisers
- Fundraising
- Fundraising events
- (3) Giving Hearts Day
- Giving hearts day & harvest fest
- Giving hearts day, Christmas family
- (2) Harvest fest
- Harvest Fest / Giving Hearts
- Harvest Fest Activities
- (2) None
- On-line auctions
- Projects within our facility.

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

- 1
- Access to high quality, affordable fruits and vegetables.
- Affordable
- Allowing access to the information or activities without requiring the appointment format. Bringing access to the schools, with parent permission, would alleviate additional stress on families while still providing the services to youth. Creating a Mental Health - Life Health course for high school students where they learn about managing stress, basic care skills for children, behavioral strategies for self and others, etc.
- Caring and trusting health workers
- Concerned about the future of ENTs/ambulance services. Hospice services. Prof Work force
- Continue local newspaper articles about services, classes offered, keep listing specialists and their schedules at our hospital/clinic, be competitive with salaries for healthcare workers to retain them, and hire new staff. Keep good administrators in our healthcare facilities to maintain great staff and staff morale.
- Delivery is good, concern is depth of staff, particularly doctors.
- Even though we have insurance, the co-pays and deductibles make you think twice about whether or not you need to see a doctor.
- Expanded hours, call a nurse/provider lines, control health care costs
- Have more services within the county instead of having to go to Grand Forks.
- Having doctors who care and will provide good services to patients.
- Hospital leadership is working hard to improve the quality of healthcare in all areas!
- I don't have trouble with my personal healthcare, but I would like to understand the challenges of others so I better understand how I can help them.
- I know this will make someone's eyes roll, but mask requirements are a barrier to some people seeking medical treatment. One suggestion I would offer is to have screenings done at the post office, grocery

store, the Armory, or courthouse.

- I think it's fine but we need and OB department back in town.
- I think more attainable childcare would open up the ability of those that work in healthcare to continue their jobs. I know some nurses/cnas end up quitting after having kids because they no longer can sustain and job and/or childcare at the same time
- It would have been nice if the nurses could recognize the signs of a stroke when my previous wife was in their care, in swing bed status fighting colon cancer.
- {One of the physicians} needs to be legally reprimanded for his illegal implementation of a county mask mandate in 2020, in which he failed to disclose his scientific basis for the act. Walsh County Health Department needs to be held accountable for their lack of legal premise of not holding an open public forum before issuing a mask mandate.
- Less expensive clinic visits for general wellness check-ups, etc.
- Many live alone. Satellite clinics, rural delivery of senior meals
- MD's who actually care when mistakes are made and don't blame the patients!
- More flexibility
- More providers , so no one burns out
- More providers and specialists that are able to come into the hospital and provide care
- Need for mental health services, health services for the needs of the elderly and affordable healthcare
- Need more providers
- Really need more confidential people working in hospital, clinic and ambulance services! Sad when all you got to do is make a phone call and you know what happened
- Receptionist asking why to be seen. Told them its personal but still pushes for a reason.
- Services for mental health, alcohol abuse/detox, and substance abuse outside of the hospital.
- the hospital does an excellent job for park river and other communities
- The overall biggest need is mental health services for all ages. I know it is difficult to recruit
- We are in need of mental health services badly.
- We have a GREAT healthcare system for a town of our size
- We have a great hospital and clinic everyone tries there best at helping others
- We need more mental health and substance abuse providers/programs