



2025 Community Health Needs Assessment

Crosby, North Dakota



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St. Luke's Medical Center

Community Health Needs Assessment

Executive Summary

A community health needs assessment (CHNA) is a crucial tool for understanding and improving the health and well-being of a community by identifying key health issues, informing strategic planning, and fostering collaborative efforts among various stakeholders. The St. Luke's Medical Center (St. Luke's) CHNA focused on identifying and addressing the health needs of their service area by gathering data and input from the community to identify the most pressing health issues, including chronic diseases, mental health, access to healthcare services, and social determinants of health.

St. Luke's executed a CHNA process that included collecting primary and secondary data. The CHNA steering committee composed of St. Luke's human resource director, social worker, registered nurse, physical therapist, a local public health nurse, and a Synodically Authorized Minister from a local church oversaw the CHNA along with the project consultant, Cibolo Health. Organizations and community stakeholders within the primary service area were engaged in identifying the needs of the community. Community organizations, government agencies, educational systems, health and human services entities, as well as others, were engaged throughout the CHNA. The comprehensive primary data collection phase resulted in contributions from a multitude of regional community stakeholders and representatives from organizations.

Input from the community was sought through a community survey, key informant interviews, and focus groups (community meetings). Community input was aligned with secondary data collections and presented to the CHNA Steering Committee, focus group participants, and key informant interviewees as a framework for assessing current community needs, identifying new/emerging health issues, and advancing health improvement efforts to address identified needs.

Specifically, the primary data collection consisted of several project components. In total, 133 surveys were collected, seven key informant interviews were conducted, and 12 community members participated in the data collection focus group. All collection modes involved individuals who represented a) broad interests of the community, b) populations of need, or c) people with specialized knowledge in public health.

A second community meeting composed of the key informant interviewees and those that attended the first focus group/community meeting met on February 5, 2025, where the data analysis was presented and attendees voted on the top priorities for 2025 based on primary and secondary data results. There were 12 people in attendance. St. Luke's Medical Center recognized its needs from the previous assessment and will build upon those issues, but most importantly, St. Luke's Medical Center identified additional areas of concern that require attention. Based on collective information from the previous implementation strategy plan along with the needs identified in the current cycle St. Luke's Medical Center will reinforce and create new strategies to bridge the gap and address the needs of those in their service area.



With regard to demographics, Divide County's population in 2022 (2,187) grew 5.1% from the 2,080 people who lived there in 2010. For comparison, the population in the US grew 7.7% and the population in North Dakota grew 15.5% during that period (<https://usafacts.org/>). Divide County's population increased 5 out of the 12 years between 2010 and 2022. Its largest annual population increase was 4.9% between 2011 and 2012. The county's largest decline was between 2016 and 2017 when the population dropped 4.3%. Between 2010 and 2022, the county grew by an average of 0.5% per year. In 2022, the largest racial or ethnic group in Divide County was the white (non-Hispanic) group, which had a population of 1,923. Between 2010 and 2022, the Hispanic/Latino population had the most growth increasing by 58 from 34 in 2010 to 92 in 2022. Among six age groups — 0 to 4, 5 to 19, 20 to 34, 35 to 49, 50 to 64, and 65 and older — the 5 to 19 group was the fastest growing between 2010 and 2022 with its population increasing 44.4%. The 50 to 64 age group declined the most dropping 20.1% between 2010 and 2022. The share of the population that is 0 to 4 years old increased from 5% in 2010 to 6.2% in 2022, while the population that is 65 and older decreased from 26.3% in 2010 to 25.5% in 2022. The US Census Bureau reported that the median household income in Divide County (\$70,500) is a little less than the state average for North Dakota (\$73,959).

The community is valued for being a safe place with little crime, friendly and supportive people, family-friendly environment, and strong connections among residents.

Of 106 potential community and health needs set forth in the survey, the 133 St. Luke's service area residents who completed the survey indicated the following ten needs as the most important:

- Alcohol use and abuse – Adults
- Long-term/nursing home care options
- Depression/anxiety – Youth
- Cost of long-term/nursing home care
- Availability of resources to help the elderly stay in their homes
- Depression/anxiety - Adults
- Attracting and retaining young families
- Smoking and tobacco use, exposure to second-hand smoke or vaping (juuling) - Youth
- Availability of home health
- Alcohol use and abuse – Youth

The survey also revealed the biggest barriers to receiving healthcare (as perceived by community members). They included no insurance or limited insurance (N=52), not enough specialists (N=38), and not being able to see the same provider over time (N=34).

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

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

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

- Alcohol use and abuse – all ages
- Depression/anxiety – all ages
- Long-term care/nursing home care options and costs
- Home health availability

Through community input, the top identified community concerns were:

1. Mental health and addiction services
2. Availability of specialists
3. Having enough child daycare services

St. Luke's, along with Upper Missouri District Health Unit, and community partners, will work to put together an Implementation Plan. The Implementation Plan will lay out how the community plans to address the concerns brought forward through the CHNA process.

Introduction

A community health needs assessment (CHNA) is a crucial tool for understanding and improving the health and well-being of a community by identifying key health issues, informing strategic planning, and fostering collaborative efforts among various stakeholders. The St. Luke's Medical Center CHNA focused on identifying and addressing the health needs of Divide County, as well as Burke and Williams Counties, by gathering data and input from the community to identify the most pressing health issues, including chronic diseases, mental health, access to healthcare services, and social determinants of health.

A CHNA involves community members, healthcare providers, and other stakeholders in the assessment process, fostering collaboration and ensuring that the community's voice is heard in identifying health priorities.

The legal and regulatory context of a Community Health Needs Assessment (CHNA) is primarily shaped by the requirements established under the Affordable Care Act (ACA) in the United States. The ACA requires all non-profit hospitals to conduct a CHNA every three years, and all accredited public health units to conduct a CHNA every five years. This provision is aimed at ensuring that hospitals remain accountable to the communities they serve by addressing local health needs that are systematically identified.

The hospitals must produce a written report documenting the CHNA. This report should include a description of the community served, the process and methods used to conduct the assessment, and a prioritized list of identified health needs. Alongside the CHNA, hospitals must develop an implementation strategy that outlines how they plan to address the identified health needs. This strategy must be approved by the hospital's governing body and included in the hospital's annual IRS Form 990 Schedule H submission. The CHNA report and implementation strategy must be made widely available to the public.

The CHNA encompasses a range of benefits aimed at improving public health and fostering a more informed, engaged, and healthier community. A comprehensive profile of the health of the community as well as an identification of the most pressing health issues and priorities from the community member's perspective will result from the CHNA. By including community involvement in the assessment, residents/stakeholders will have a greater awareness of the health issues and challenges facing the community. Engagement by this population during the assessment will also increase the likelihood that they will be willing to assist in the implementation of interventions designed to improve the findings that were a top concern. The implementation plan will layout the roadmap to addressing the top concerns found in the CHNA.

Ultimately, the outcome most anticipated is that implementation of targeted health interventions and programs designed to address specific health concerns will improve overall community health. The plan should also lead to decreased health disparities among different population groups, leading to more equitable health outcomes.

Another outcome of a CHNA is strengthened partnerships and collaborations among healthcare providers, public health agencies, community organizations, and other stakeholders. The result is an enhanced collective impact through coordinated efforts to address community health issues.

Methodology

To ensure community engagement in the data collection, information was collected in a variety of ways:

- A survey solicited feedback from residents within the hospital's service area;
- Key informant interviews of community leaders representing the broad interests of the community;
- Focus groups, comprised of community leaders and area residents, convened to discuss area health needs and inform the assessment process in a community meeting.

Community engagement is essential to a successful CHNA. Community involvement ensures that the assessment accurately reflects the health needs and priorities of the population it serves. The hospital, along with the local public health unit, works to identify and involve a diverse group of stakeholders, including healthcare providers, public health officials, community organizations, educators, business leaders, and residents to participate in the key informant interviews and the focus groups/community meetings. These participants 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.

As previously described, 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 behaviors.

A common approach to survey research is online survey. However, this approach is not without limitations. There is always the concern of non-response as it may affect the representativeness of the sample as well as having to eliminate any surveys completed by those outside of the service area being assessed. Thus, a mixture of different data collection methodologies is recommended.

Conducting key informant interviews in addition to the random sample survey allows for a more robust sample, and ultimately, these efforts help to increase the community response rate. Partnering with local community organizations such as public health, schools, churches, and senior centers, just to name a few, assists in reaching segments of the population that might not otherwise respond to a survey.

While key informant data can offer invaluable insight into the perception of a community or group of individuals, qualitative data can be difficult to analyze. For this reason, key informant data are grouped into common themes.

Given the low population in the service area, key informant interview participants may still be hesitant to express their opinions freely even though the reporting of any comments is de-identified.

Another barrier in relation to the low population density of rural communities often requires regional reporting of many major health indices, including chronic disease burden and behavior health indices. The North Dakota BRFSS, through a cooperative agreement with the CDC, is used to identify regional trends in health-related behaviors. The fact that many health indices for rural and frontier counties are reported regionally makes it impossible to set the target population aside from the most developed North Dakota counties.

Process

A CHNA characteristically involves four key steps to ensure a comprehensive understanding of the community's health needs and priorities: 1) planning and preparation, 2) data collection, 3) data analysis, and 4) identify and prioritize health needs.

Planning and Preparation

In March 2024, St. Luke's selected Cibolo Health to facilitate the 2025 CHNA process. Cibolo Health helps independent rural hospitals create networks with their peers to overcome the obstacles rural healthcare providers face. At that time, a CHNA liaison was selected locally, who served as the main point of contact with Cibolo Health for the CHNA process. A steering committee composed of a diverse group of stakeholders, including representatives from healthcare, public health, and a community organization (see Figure 1), was formed that was responsible for planning and implementing the process locally.

Figure 1: Steering Committee

Name	Title	Organization
Marissa Loucks	HR Director	St. Luke's Medical Center
Nicole Johnson	Social Worker	St. Luke's Medical Center
Leda Brodal	Registered Nurse	St. Luke's Medical Center
Kayla Jacobs	Physical Therapist	St. Luke's Medical Center
Juliet Artman	Public Health Nurse	Upper Missouri District Health Unit
Jean Nygaard	Synodically Authorized Minister	NW United Lutheran Parish

Data Collection

Once the framework for the process was in place, data collection began. There are two types of data that were collected, primary data that is gathered first-hand, and secondary data that is collected from existing data sources such as County Health Rankings and the US Census. This can include data on demographics, health status, healthcare access, and social determinants of health.

Primary Data Collection

Primary data was collected directly from the community through surveys, key informant interviews, and focus groups/community meetings. This helps to gather firsthand information on community perceptions and experiences. This was done in three ways: key informant interviews, community meetings/focus groups, and a survey.

Key Informant Interviews

On November 19, 2024, a representative from Cibolo Health conducted seven key informant interviews in person in Cando. Interviews were held with invited 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

Focus Groups/Community Meetings

A community group consisting of twelve community members convened and first met on November 19, 2024. During this first focus group/community meeting, attendees were introduced to the needs assessment process, reviewed basic demographic information about the community, and served as a focus group. Focus group topics were very similar to those included in the key informant interviews, including community assets and challenges, the general health needs of the community, community concerns, and suggestions for improving the community's health. This first data gathering focus group represented a cross section demographically. St. Luke's staff were in attendance as well but largely played a role of listening and learning.

The community group met again on February 5, 2025, with twelve community members in attendance. At this second community meeting the attendees, which consisted of those that attended the first community meeting as well as the key informants, were presented with survey results, findings from key informant interviews and the first community meeting, and a wide range of secondary data relating to the general health of the population in the service area. The group was then tasked with identifying and prioritizing the community's health needs.



Members of the second community meeting represented the broad interests of the service area of St. Luke's and Upper Missouri District Health Unit. They included representatives of the health community, business community, agriculture, law enforcement, education, faith community, and social service agencies. Not all members of the group were present at both meetings.

Survey

A survey was distributed throughout the hospital service area, which included residents of Divide, Burke, and Williams Counties. It was designed to be an additional tool for collecting qualitative data from the community at large – specifically, information related to community-perceived health needs. A copy of the survey instrument is included in Appendix A and a full listing of direct responses provided for the questions that included “Other” as an option are included in Appendix B.

The original survey tool was developed and used by the State Office of Rural Health at the Center for Rural Health (CRH). In order to revise the original survey tool to ensure the data gathered met the needs of hospitals and public health, the CRH worked with the North Dakota Department of Health's public health liaison. CRH representatives also participated in a series of meetings that garnered input from the state's health officer, local North Dakota public health unit professionals, and representatives from North Dakota State University. The survey has since been edited by Cibolo to reflect changes in health practices and the data needs of the communities.

Similar to the questions asked in the key informant interviews and during the first focus group/community meeting, the survey was designed to:

- Learn of the community's assets and concerns;

- Gather perceptions and attitudes about the health of the community as well as collect suggestions for improvement; and
- Learn how local health services are used by residents.

Specifically, the survey covered the following topics:

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

The survey was open from October 1, 2024 to November 22, 2024. While the primary survey collection tool was an online survey utilizing Survey Monkey, paper surveys were also available upon request. Thirty-eight completed paper surveys were returned. The survey link was distributed by posters were hung at local businesses, publications were ran in the local paper, posts were made on the St. Luke’s social media site, and surveys were collected during a community blood draw. Ninety-five online surveys were completed. In total, counting both paper and online surveys, 133 community member surveys were completed, equating to a 16% response rate. This response rate is a little above the average for this type of unsolicited survey methodology and indicates an engaged community.

Secondary Data Collection

In a CHNA, secondary data sources are crucial for providing a comprehensive overview of the health status and needs of the community. Secondary data was collected and analyzed to provide descriptions of: (1) population demographics, (2) general health issues of the population, and (3) contributing causes of community health issues. The data was collected from a variety of sources, such as census, public health, and socio-economic data, as well as Behavioral Risk Factor Surveillance System and the Youth Risk Behavior Surveillance System. Specific sources include:

The U.S. Census Bureau, which provides demographic data including age, gender, race, income, and education levels, which are essential for understanding the population's structure and socio-economic status (<https://data.census.gov/>).

County Health Rankings & Roadmaps, a program of the University of Wisconsin Population Health Institute, draws attention to why there are differences in health within and across communities (www.countyhealthrankings.org). Annually since 2010, the University o

f Wisconsin Population Health Institute and the Robert Wood Johnson Foundation have produced the County Health Rankings—a “population health checkup” for the nation’s over 3,000 counties. They base the Rankings on a conceptual model of population health that includes both health outcomes (mortality and morbidity) and health factors (health behaviors, clinical care, social and economic factors, and the physical environment). Data for over 30 measures available at the county level are assembled from a number of national sources. Composite scores are then ordered and counties are ranked from best to worst health within each state.

The Centers for Disease Control and Prevention (CDC) provides data on disease prevalence, vaccination rates, and health behaviors in a publication called the Youth Risk Behavior Surveillance System (YRBSS). The YRBSS is a set of surveys that track behaviors that can lead to poor health in students grades 9 through 12

(<https://www.cdc.gov/healthyyouth/data/yrbs/index.htm>).



The National Survey of Children’s Health (NSCH) provides rich data on multiple, intersecting aspects of children’s lives—including physical and mental health, access to and quality of health care, and the child’s family, neighborhood, school, and social context. The National Survey of Children’s Health is funded and directed by the Health Resources and Services Administration Maternal and Child Health Bureau (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), compiles and shares current, comprehensive data on child and family well-being in each of North Dakota’s 53 counties. The data addresses six domains: demographics, health, education, family and community, economic well-being, and safety.

It is important that sufficient secondary source data on youth is collected for the community’s CHNA because the surveys conducted as part of the primary data collection are not collected for people under the age of 18.

By utilizing these diverse sources of secondary data, a CHNA can develop a detailed and accurate picture of the community’s health needs and resources, which is essential for planning effective health interventions and policies.

Data Analysis

Data collected during the CHNA process was utilized through both quantitative and qualitative analysis. Through quantitative analysis, numerical data was used to identify trends, disparities, and key health indicators. This involved statistical analysis and comparisons to state or national benchmarks. Qualitative data from community groups and key informant interviews, as well as open ended survey questions was used to identify common themes and insights into the community’s health needs and priorities.

Identifying and Prioritizing Health Needs

Key health issues were identified based on the data analysis by identifying the most pressing health issues affecting the community. During the second community meeting, the attendees from the first focus group/community meeting and the key informants gather at a second meeting to prioritize the health concerns based on the CHNA findings that were presented to them. The meeting attendees consider numerous factors, such as the severity of the issue, the number of people affected, and the ability to make an impact. The top concerns that the community members feel should be addressed in the next three years were identified.



Community Profile

The hospital identifies its service area as Divide, Burke, and Williams Counties. Many community members and stakeholders worked together on the assessment. Divide County is the county where St. Luke's resides, so this report looks the most in-depth in this county, although the service area extends into the neighboring counties of Burke and Williams. The demographics of Divide County, have been taken from the

United States Census Bureau (<https://data.census.gov/>), 2022 American Community Survey 5-Year Estimates, unless otherwise specified.

Some say they're at the end of the world. They say they're at the center of the continent. Crosby is the county seat of Divide County, the northwesternmost county in North Dakota. It's a town of about 1,400 mostly Scandinavian people located just a stone's throw from Canada and Montana.



Here, farming is king, black gold is big, and nobody's a stranger for long. Divide County has the distinction of being one of the latest formed counties of the Homestead era, but evidence left behind at the famed Writing Rock south of Fortuna indicates people have inhabited this land for many centuries. The earliest records by white men show the area was occupied before 1800 largely by the Assiniboine "stone boiler" Indians, a sect of the Sioux.

In 1873, when the territory of Dakota was first created, the future Divide County was included in a large tract known as "Wallette County". Later, the Northern Pacific Railroad organized and platted two smaller counties to give settlers the impression the area was well-settled. By 1891, the land now known as Divide County was encompassed within the borders of neighboring Williams County. A well-known Williston attorney in 1910 is credited with coining Divide's name at the time a vote was held on the division of Williams County. The name recognized the new county's division from the old, as well as the Continental Divide, which runs through the county from northwest to southeast.

The first homesteaders didn't arrive until spring 1903 but by the following winter, the eastern two-thirds of the county was full of claim shacks. A peak population of 9,637 people occupied the county in 1920.

The main industry has always been agriculture, but natural resources such as coal and oil are also part of the county's history. Crosby, named for a partner in the firm that developed the original townsite, became the county seat in 1912, following ambitious campaigns by the people of Noonan, Crosby, and Ambrose.

In 1917, the Divide County Courthouse and several of Crosby's most prominent buildings were constructed.

The first wildcat oil venture was launched in 1926 north of Crosby, and mineral leasing hit record levels in 2004, only to



be surpassed in 2008 and 2009. After early homesteaders built underground lignite mines, commercial strip mining began in 1930.

In the western half of the county, the federal government played a significant role, choosing a site west of Fortuna for a Cold War radar station. Many present-day residents of Divide County have family ties to the men who served at “the base,” but it outlived its usefulness just as the Cold War era ended.

Today, agriculture dominates Divide County’s economy, but a mix of technology provides good diversity. In 1993, Crosby established a home-rule charter and, subsequently, levied a local sales tax to encourage economic development.

The third weekend in July is time for celebrating our agrarian roots, as the biggest collection anywhere of working antique steam engines is on display at the annual Threshing Bee and Antique Show. Crosby has a beautiful golf course, wildlife that summons hunters from afar, a winter sports center, a swimming pool, gymnastics and fitness centers, and endless sunsets.



Figure 1. Divide, Burke, and Williams Counties



Snapshots of Divide, Burke, and Williams Counties

Divide County



Populations and People

Total Population

1,065

P1 | 2020 Decennial Census



Education

Bachelor's Degree or Higher

13.6%

S1501 | 2022 American Community Survey 5-Year Estimates



Housing

Total Housing Units

626

H1 | 2020 Decennial Census



Families and Living Arrangements

Total Households

436

DP02 | 2022 American Community Survey 5-Year Estimates



Income and Poverty

Median Household Income

\$82,656

S1901 | 2022 American Community Survey 5-Year Estimates



Employment

Employment Rate

62.5%

DP03 | 2022 American Community Survey 5-Year Estimates



Health

Without Health Care Coverage

9.8%

S2701 | 2022 American Community Survey 5-Year Estimates



Race and Ethnicity

Hispanic or Latino (of any race)

29

P9 | 2020 Decennial Census

Burke County



Populations and People

Total Population

2,201

P1 | 2020 Decennial Census



Education

Bachelor's Degree or Higher

24.7%

S1501 | 2022 American Community Survey 5-Year Estimates



Housing

Total Housing Units

1,378

H1 | 2020 Decennial Census



Business and Economy

Total Employer Establishments

75

CB2100CBP | 2021 Economic Surveys Business Patterns



Race and Ethnicity

Hispanic or Latino (of any race)

59

P9 | 2020 Decennial Census



Income and Poverty

Median Household Income

\$94,583

S1901 | 2022 American Community Survey 5-Year Estimates



Employment

Employment Rate

62.4%

DP03 | 2022 American Community Survey 5-Year Estimates



Health

Without Health Care Coverage

3.8%

S2701 | 2022 American Community Survey 5-Year Estimates



Families and Living Arrangements

Total Households

950

DP02 | 2022 American Community Survey 5-Year Estimates

Williams County



Populations and People

Total Population

40,950

P1 | 2020 Decennial Census



Education

Bachelor's Degree or Higher

24.5%

S1501 | 2022 American Community Survey 5-Year Estimates



Housing

Total Housing Units

20,227

H1 | 2020 Decennial Census



Business and Economy

Total Employer Establishments

1,577

CB2100CBP | 2021 Economic Surveys Business Patterns



Race and Ethnicity

Hispanic or Latino (of any race)

3,897

P9 | 2020 Decennial Census



Income and Poverty

Median Household Income

\$86,139

S1901 | 2022 American Community Survey 5-Year Estimates



Employment

Employment Rate

72.1%

DP03 | 2022 American Community Survey 5-Year Estimates



Health

Without Health Care Coverage

12.4%

S2701 | 2022 American Community Survey 5-Year Estimates



Families and Living Arrangements

Total Households

15,599

DP02 | 2022 American Community Survey 5-Year Estimates

Divide, Burke, Williams County Demographics

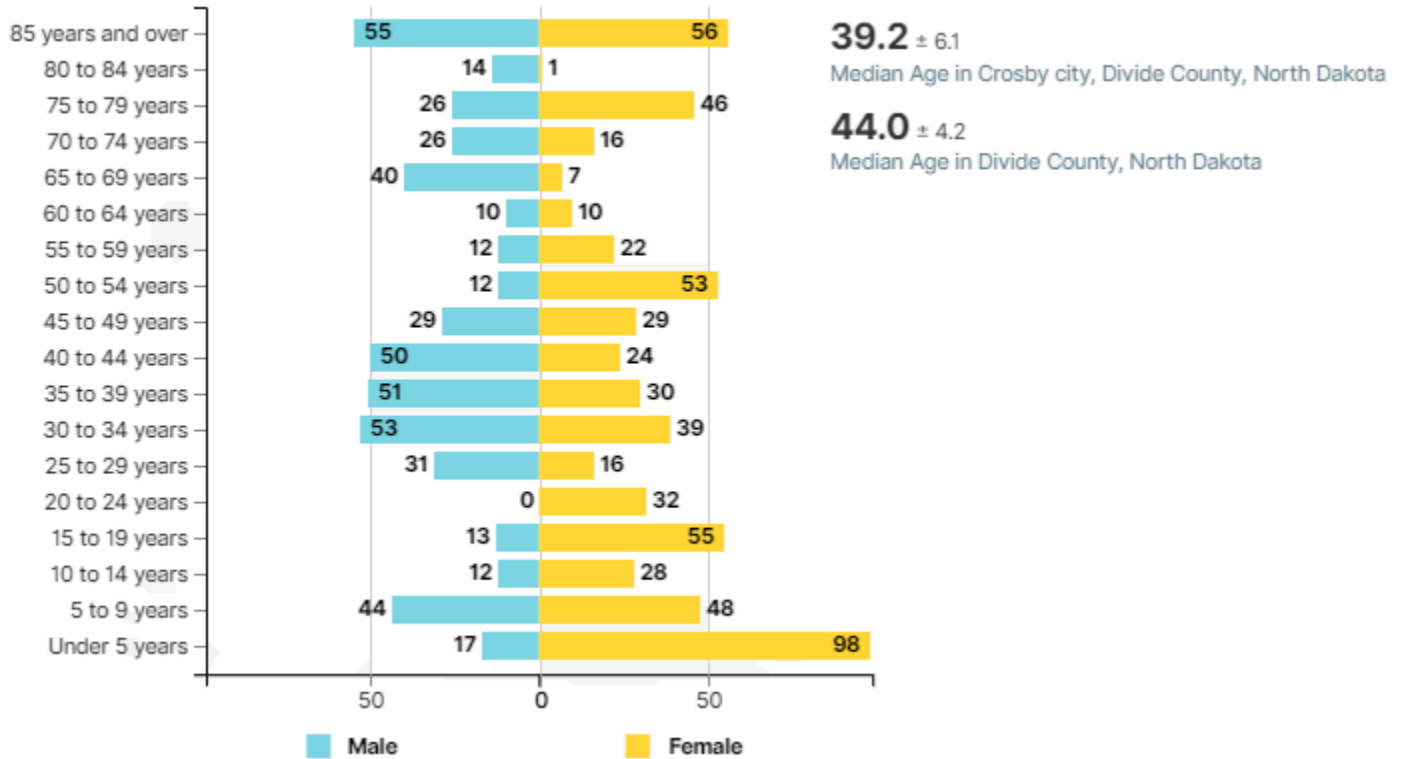
Divide, Burke, Williams County Demographics

Source: <https://www.countyhealthrankings.org/> (2024)

	Divide County	Burke County	Williams County	North Dakota
Population (2023)	2,187	2,155	38,109	779,261
% Below 18 Years of Age	24.1%	24.7%	29.9%	23.50%
% 65 and Older	25.5%	22.6%	10.6%	16.70%
% Non-Hispanic Black	2.0%	0.7%	4.7%	3.40%
% American Indian or Alaska Native	1.2%	1.7%	4.4%	5.30%
% Asian	2.2%	0.8%	1.3%	1.70%
% Native Hawaiian or Other Pacific Islander	0.2%	0.2%	0.3%	0.10%
% Hispanic	4.2%	3.3%	9.9%	4.60%
% Non-Hispanic White	87.9%	91.4%	76.7%	83.00%
% Not Proficient in English	0%	1%	1%	1%
% Female	46.9%	47.6%	46.8%	48.60%
% Rural	100.0%	100.0%	27.9%	39.00%

Population Pyramid: Population by Age and Sex

Divide County



Burke County

44.8 ± 4.7
Median Age in Burke County, North Dakota

36.2 ± 0.3
Median Age in North Dakota

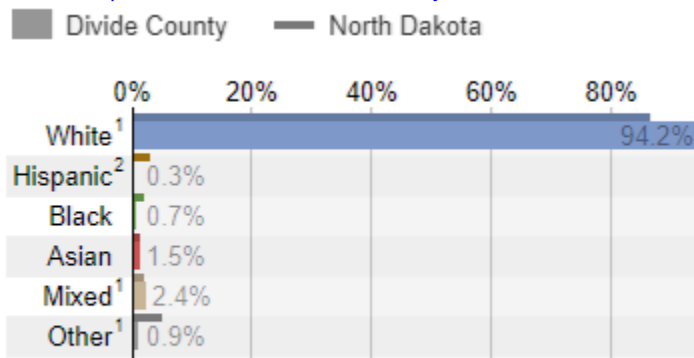
Williams County

31.9 ± 0.5
Median Age in Williams County, North Dakota

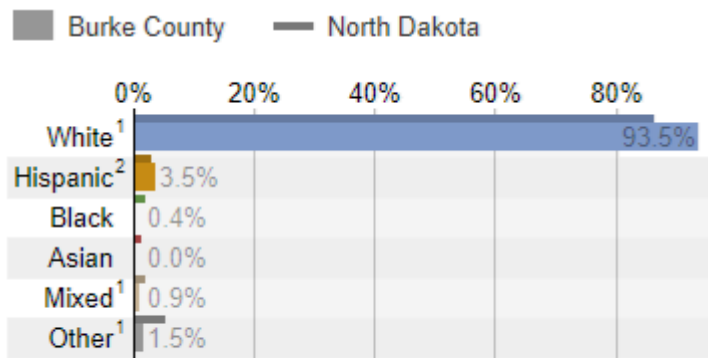
36.2 ± 0.3
Median Age in North Dakota

Race and Ethnicity (% of total population) – Divide, Burke, Williams Counties

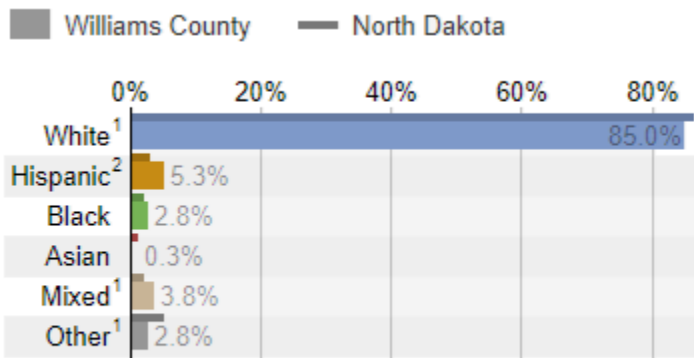
Source: <https://statisticalatlas.com/county/North-Dakota/>



Count number of members in ethno-racial group
¹ non-Hispanic ² excluding black and Asian Hispanics



Count number of members in ethno-racial group
¹ non-Hispanic ² excluding black and Asian Hispanics



Count number of members in ethno-racial group
¹ non-Hispanic ² excluding black and Asian Hispanics

Types of Language Spoken at Home

Divide County



Burke County

4.2% ± 1.5%
 Language Other Than English Spoken at Home in Burke County

7.1% ± 0.6%
 Language Other Than English Spoken at Home in North Dakota

Williams County

9.3% ± 1.6%
 Language Other Than English Spoken at Home in Williams County

7.1% ± 0.6%
 Language Other Than English Spoken at Home in North Dakota

Income and Earnings

Divide County

\$95,938 ± \$24,599

Median Household Income in Divide County, North Dakota

\$71,970 ± \$2,072

Median Household Income in North Dakota

Burke County

\$94,583 ± \$11,960

Median Household Income in Burke County, North Dakota

\$71,970 ± \$2,072

Median Household Income in North Dakota

Williams County

\$86,139 ± \$5,773

Median Household Income in Williams County, North Dakota

\$71,970 ± \$2,072

Median Household Income in North Dakota

Poverty

Divide County

Families - \$108,500



Married-couple families - \$118,611



Nonfamily households - \$44,375



\$0 \$20K \$40K \$60K \$80K \$100K \$120K

Education Attainment (Population 25 Years and Older)

Divide County

High school or equivalent degree - 28.2%



Some college, no degree - 23.1%



Associate's degree - 17.1%



Bachelor's degree - 13.8%

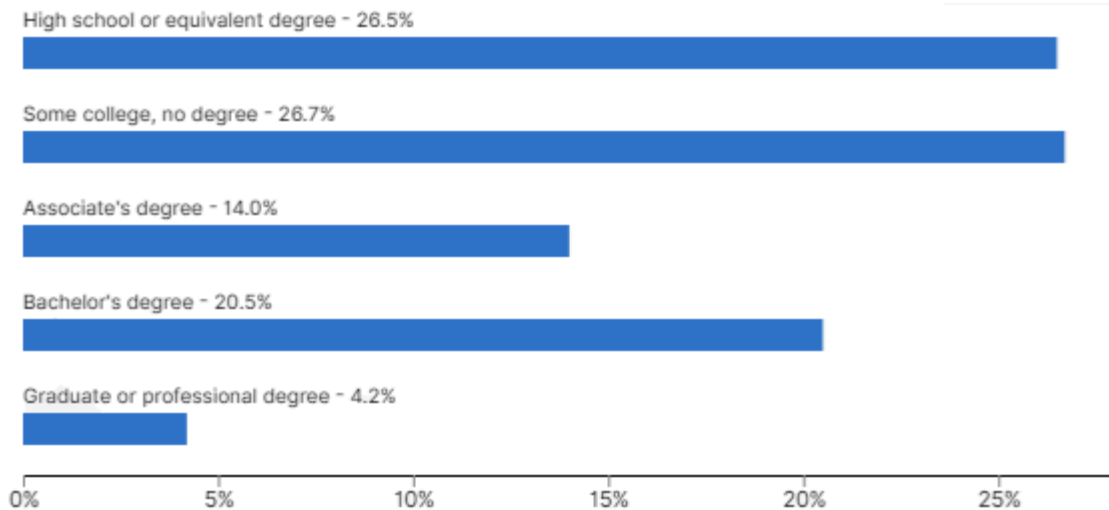


Graduate or professional degree - 3.3%

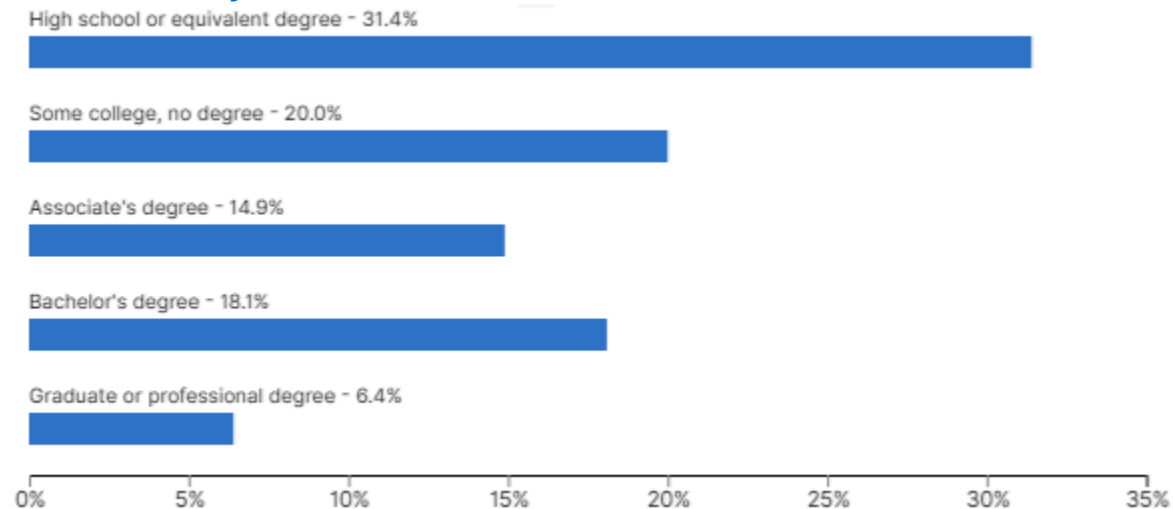


0% 5% 10% 15% 20% 25% 30%

Burke County



Williams County



Class of Worker	Divide County	Burke County	Williams County
Employee of private company workers	55.50%	44.20%	69.00%
Self-employed in own incorporated business workers	5.00%	4.80%	4.30%
Private not-for-profit wage and salary workers	8.60%	11.80%	8.50%
Local, state, and federal government workers	21.90%	24.20%	11.90%
Self-employed in own not incorporated business workers and unpaid family workers	9.00%	15.00%	6.30%

Employment Rate

Divide County	56.9% ± 5.7%	Employment Rate in Divide County, North Dakota
Burke County	62.4% ± 4.2%	Employment Rate in Burke County, North Dakota
Williams County	72.1% ± 2.5%	Employment Rate in Williams County, North Dakota
North Dakota	66.1% ± 0.9%	Employment Rate in North Dakota

Means of Transportation to Work (Workers 16 Years and Over)

	<i>Divide County</i>	<i>Burke County</i>	<i>Williams County</i>
Drove alone	92.8%	72.6%	85.9%
Carpool	0.8%	8.6%	7.6%
Public transportation	0.0%	0.0%	0.2%
Walked	2.9%	8.4%	2.5%
Bicycle	0.0%	0.2%	0.0%
Taxicab, motorcycle, or other means	0.0%	0.4%	0.9%
Worked from home	3.5%	9.9%	2.9%

Industry for the Civilian Employed Population (16 Years and Over)

	<i>Divide County</i>	<i>Burke County</i>	<i>Williams County</i>
Agriculture, forestry, fishing and hunting, and mining	18.7%	26.7%	22.3%
Educational services, and health care and social assistance	13.0%	9.5%	6.1%
Retail trade	0.0%	2.5%	3.2%
Transportation and warehousing, and utilities	3.7%	4.3%	4.9%
Wholesale trade	11.8%	4.4%	9.1%
Other services, except public administration	6.9%	6.7%	7.9%
Manufacturing	0.6%	0.1%	0.0%
Public administration	3.2%	1.8%	3.3%
Construction	7.3%	2.6%	5.3%
Arts, entertainment, and recreation, and accommodation and food services	17.0%	17.6%	22.2%
Professional, scientific, and management, and administrative and waste management services	5.9%	5.4%	8.5%
Finance and insurance, and real estate and rental and leasing	1.0%	4.8%	4.5%
Information	11.6%	13.8%	1.6%

Median Gross Rent

Divide County	\$1,032 ± \$311 Median Gross Rent in Divide County, North Dakota
Burke County	\$669 ± \$48 Median Gross Rent in Burke County, North Dakota
Williams County	\$1,097 ± \$46 Median Gross Rent in Williams County, North Dakota
North Dakota	\$863 ± \$21 Median Gross Rent in North Dakota

Homeownership Rate

71.4% ± 6.7% Homeownership Rate in Divide County, North Dakota
82.3% ± 3.9% Homeownership Rate in Burke County, North Dakota
53.7% ± 4.0% Homeownership Rate in Williams County, North Dakota
65.1% ± 1.2% Homeownership Rate in North Dakota

Health Insurance - Percent Without Health Insurance

Divide County	9.5% ± 3.9% Without Health Care Coverage in Divide County, North Dakota
Burke County	3.8% ± 1.7% Without Health Care Coverage in Burke County, North Dakota
Williams County	12.4% ± 2.4% Without Health Care Coverage in Williams County, North Dakota
North Dakota	6.4% ± 0.7% Without Health Care Coverage in North Dakota

Disabled Populations & Top Disability in the County

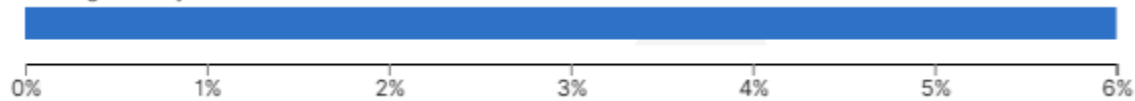
Divide County

11.0% ± 3.6%
Disabled Population in Divide County, North Dakota
Cognitive difficulty - 8.3%



Burke County

12.2% ± 2.7%
Disabled Population in Burke County, North Dakota
Hearing difficulty - 6.0%



Williams County

10.4% ± 1.6%

Disabled Population in Williams County, North Dakota

Independent living difficulty - 5.3%



North Dakota

12.2% ± 0.7%

Disabled Population in North Dakota

Women with Births in the Past 12 Months

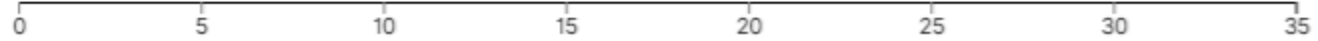
15 to 19 years - 3



20 to 34 years - 33



35 to 50 years - 3



Children

Divide County

24.1% ± 3.8%

Under 18 years old in Divide County, North Dakota

Children Under 18 By Age Range

Under 5 years - 10.4%



5 to 14 years - 11.9%



15 to 17 years - 6.2%



Burke County

24.7% ± 3.2%

Under 18 years old in Burke County, North Dakota

Under 5 years - 5.6%



5 to 14 years - 15.0%



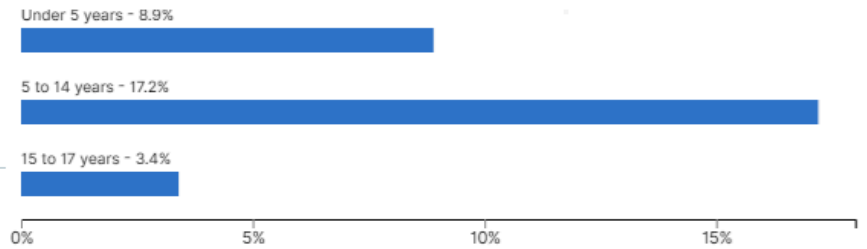
15 to 17 years - 4.1%



Williams County

29.5% ± 0.1%

Under 18 years old in Williams County, North Dakota



North Dakota

23.2% ± 0.1%

Under 18 years old in North Dakota

Families and Household Characteristics – Average Family Size

Divide County

2.92 ± 0.35

Average Family Size in Divide County, North Dakota

Williams County

3.19 ± 0.22

Average Family Size in Williams County, North Dakota

Burke County

2.96 ± 0.24

Average Family Size in Burke County, North Dakota

North Dakota

2.93 ± 0.05

Average Family Size in North Dakota

Daycare

Daycare plays a role in many communities, including two of the three counties (Williams and Burke) in St. Luke's service area. As shown below, according to the North Dakota Health & Human Services report titled, "Supporting Working Families Strengthening Our Workforce" (January 2023), Williams County and Burke County are considered childcare deserts. A childcare desert means that the shortage of licensed childcare slots (as compared to the number who are likely to need childcare based on parental workforce participation) is at least 3 to 1. Meaning there are three children who are likely to need care for every one care slot available in the community. Appendix C provides the 2024 ND Health & Human Services Child Care Profile for Divide, Burke, and Williams Counties.

■ Not a child care desert ■ Child care desert



St. Luke’s Medical Center

In 2021, the Chartis Center for Rural Health and the National Rural Health Association recognized the Top 20 Critical Access Hospitals. The awards spotlight high achievement in the areas of quality and patient satisfaction. The hospitals earning these awards also reflect top performance among all rural hospitals in the nation. St. Luke’s Medical Center was recognized as an award winner in the Quality category. The Critical Access Hospital Profile for St. Luke’s Medical Center that includes a summary of hospital-specific information is available in Appendix A.

In 1904, Mr. Renhard Hering homesteaded the present site St. Luke’s Medical Center. In 1914, it was surveyed as Hering Addition to the City of Crosby. Dr. Blake Lancaster erected and operated the original brick structure as a medical and surgical facility from 1915 to 1917, at which time M. Allen Person purchased the property from Dr. Lancaster and leased the building for apartments.

When the Benedictine Sisters of Sacred Heart Priority, Richardton, North Dakota, bought the building in 1938 from Mr. Person, it just had the basement and the first floor furnished; the second floor was just a “shell.” For 4 years the Sisters operated it as St. Joseph’s Home for the Aged. By 1941, the City of Crosby had grown to the extent that the townspeople and the surrounding area communities realized their need for a hospital and urged the Sisters to convert the Home into a hospital; which they did, opening the doors on February 11, 1942. At this time, the name was changed to St. Luke’s Hospital. In 1965 they moved into a new 25-bed facility, as the old one would no longer meet the requirements of the State Department of Health of North Dakota.

The Benedictine Sisters of Sacred Heart Priority transferred ownership and operation of the hospital to the Crosby community and area on July 1, 1984. It continues to be operated as a non-profit institution, which

means that income in excess of operation is reinvested in salaries and benefits for employees, modern medical equipment, and expansion.

In 2011, St. Luke's Hospital welcomed Crosby Clinic from their downtown location to a new facility located on the St. Luke's Medical Complex. Along with the Crosby Clinic moving to the medical complex, St. Luke's Hospital underwent major renovations adding a new emergency center entrance and ambulance garage attached.

On May 1st, 2013, the former Good Samaritan Society facility and employees were welcomed to the St. Luke's family, becoming the St. Luke's Sunrise Care Center. This facility closed permanently September 5, 2021. At that time, St. Luke's Hospital converted one wing into a long-term swing bed unit that provides 24-hours care to 9 residents.

On August 1, 2023, St. Luke's Hospital assumed operations of Northern Lights Villa, LLC. Northern Lights Villa is an assisted living facility that is attached to the hospital. This facility consists of 14 apartments connected by shared living space and can house up to 24 residents.

The Governing Body of St. Luke's Medical Center consists of 9 members from the community. This Board defines the objectives for the medical center staff.

St. Luke's Medical Center has a significant economic impact on the region. They directly employ over 90 employees with an annual payroll of over \$6.1 million (including benefits). These employees create an additional 32 jobs and nearly \$1.12 million in income as they interact with other sectors of the local economy. This results in a total impact of 123 jobs and more than \$7.34 million in income. Additional information is provided in Appendix B.

Mission

The mission of St. Luke's Medical Center and Crosby Clinic is to provide comprehensive and compassionate health care for individuals and families in cooperation with the area medical community.

Vision

Our vision is to be recognized as a community leader by delivering quality healthcare through a team of dedicated professionals in a friendly, compassionate, and growing environment.

- To improve spiritual, mental, and physical aspects and quality of life for individuals and families.
- To develop high quality management, staff, and policy making that promotes a healthy working environment.
- To conduct our mission of healthcare in an ethical manner by complying with all applicable laws and regulations.
- To maintain a viable and profitable healthcare system.
- To be a primary resource for information about healthcare.
- To foster growth and adapt to healthcare changes.
- To be a patient-focused organization providing exceptional care with respect and compassion.
- To be contributors to the community through health awareness education.

Statement of Philosophy

St. Luke's Medical Center accepts the responsibility upon it by the community it serves to provide needed medical services in the areas of acute, outpatient, and extended (swing bed) care. It pledges itself to provide the highest quality of care as economically as possible. Every effort will be made to meet or exceed the standards set for by the various licensing and accreditation agencies.

It has been, and will continue to be, the policy of this institution to render care to all those requiring our services without regard to sex, race, handicap, age, sexual preference, creed, national origin, or ability to pay.

It shall, because of its status within the community, accept the position of leadership in initiating and developing health care programs within its geographic area of responsibility and shall cooperate with all other health organizations both within and outside our primary service area.

It accepts the concept and philosophy that all our citizens are entitled to the enjoyment of good health through the provision of health services, and it pledges to always pursue the implementation of this concept.

Core Values

- **Respect**
 - We recognize the inherent dignity of each individual and will treat each person with the reference and respect. The personal privacy of each individual will be respected at all times.
- **Compassion**
 - We are committed to treating all individuals with genuine compassion and understanding, personalizing their care and treatment as they cope with their health-related issues.
- **Stewardship**
 - We will use fiscal, material, and human resources to provide the greatest benefit to the individuals, families, and community we serve. We will be responsible for our use of resources and our care for the environment.
- **Integrity**
 - We will be honest and direct with one another to treat each other with honor in a genuine and open manner, while being true to our own ideals, value and vision.
- **Justice**
 - We support, protect, and promote the rights of our patients, residents, family members, and staff giving them opportunities to provide input toward improving the quality of their lives. We will advocate for structures attuned to the needs of the vulnerable and disadvantaged and promote a sense of community among all persons.

It is the mission of this facility to provide charity care to those people in need and will not discriminate or deny medical necessary care to people based on ability to pay or financial circumstances. St. Luke's Medical Center's Financial Assistance Policy and Plain Language Summary states to provide necessary medical care at a reduced rate to those patients who have documented limited resources to pay the facility's usual and customary charges as approved by the Medical Center's management.

St. Luke's Medical Center is a 20 bed Critical Access Hospital and Clinic located in Crosby, North Dakota. Crosby, North Dakota, in central Divide County, is approximately 122 miles northwest of Minot, North Dakota, which is in Ward County in north central North Dakota.

St. Luke's Medical Center is a Critical Access Medical Center that also encompasses the Crosby Clinic. Residential living is provided within the hospital.

Services offered locally by St. Luke's Medical Center include:

General/Acute Services

- General Medical – Surgical Care
- Emergency Room
- Level V Trauma Center
- Special Care Unit
- Acute Care (Hospital)
- Skilled Swing Bed (Hospital)
- Long-Term Non-Skilled Swing Bed (Hospital)
- Outpatient Surgery (Hospital)
 - Biopsies
 - Colonoscopies
 - EGD's
- Social Services
- Rural Health Clinic – General & Routine Exams
- Medicare Wellness Visits
- Well Child Visits
- Gynecology (per Family Practice Providers)
- Orthopedics
- Dermatology
 - Acne Treatment
 - Botox
 - Cryotherapy
 - Mole, Wart, Skin Lesion Removal
- Immunizations: Influenza, Pneumonia, Shingles/Zostavax, Tetanus, Tdap, Covid-19, Allergy Shots
- Iron Infusions
- Joint Injections
- Physicals: Occupational, Annual, DOT, Sports, Insurance
- Blood Pressure & Hypertension Monitoring
- Holter Monitor
- Chronic Disease Management
- Endocrine Services
- Lower Extremity Circulatory Assessment
- Negative Pressure Wound Therapy
- Nutrition Counseling
- Assisted Living
- Telemedicine
- Sleep Studies

Therapy Services

- Physical Therapy
- Pelvic Floor Therapy
- Dry Needling

Radiology Services

- CT Scan (mobile unit)
- Echocardiograms
- EKG
- General X-Ray
- Ultrasound

Laboratory Services

- Hematology
- Blood typing, Antibody Screen, X-Match
- Prothrombin Time/INR
- General Chemistry
- Urine Testing
- Immunoassay, PSA, TSH

Services offered at St. Luke's through other providers/organizations

- Audiology
- Senior Life Solutions – mental/behavioral health for seniors
- Headache Clinic visits and treatment
- Speech Therapy
- Rural Psychiatry Associates

Services offered by other providers/organizations

- Ambulance
- Chiropractic Care
- Dental Services
- Massage Therapy
- Counseling Services

Upper Missouri District Health Unit

The Upper Missouri District Health Unit (UMDHU) was founded and began offering sanitation and nursing services in Divide, McKenzie and Williams Counties in 1947. It was the third public health unit formed in the state. Mountrail County joined the health unit in 1949. The central office is located in Williston; satellite offices are maintained in Crosby, Stanley and Watford City (all are county seats).

Divide County Public Health is within Upper Missouri District Health Unit and provides public health services that encompass all residents aged birth to death.

Mission

The Upper Missouri District Health Unit, serving Northwestern North Dakota, promotes healthy lifestyles through health education, prevention and control of disease and the protection and enhancement of the environment.

Specific services that UMDHU provides are:

- Blood pressure checks
- Breastfeeding consultation and resources (WIC and Bringing Baby Home)
- Car seat program and Baby's First Ride Class
- Cribs for Kids
- Emergency Preparedness services-work with community partners as part of local emergency response team, fit testing, planning and exercises.
- Health Maintenance (footcare by a health professional) for seniors
- Environmental Health Services (water, sewer, health hazard abatement)
- Family Planning
- HIV.HCV Counseling, Testing and Referral
- Flu and COVID-19 shots
- Immunizations from infant to adults
- Nutrition education through WIC
- School health-- vaccinations, health education and resource to the schools
- Substance Abuse Prevention and Control, including Narcan training and distribution
- Assist with Responsible Beverage Server Training
- Tuberculosis testing and management (skin and IGRA)
- West Nile program—education
- WIC (Women, Infants & Children) Program
- Worksite Wellness-- Coordinator for County Employees and Sheriff's Dept.

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, Divide County, being the county that the hospital resides in, is compared to North Dakota rates and national benchmarks on various topics ranging from individual health behaviors to the quality of healthcare.

Social determinants of health (SDOH) are the conditions in which people are born, grow, live, work, and age that affect a wide range of health, functioning, and quality-of-life outcomes (economic stability, education access and quality, social and community context, health care access and quality, neighborhood and built environment).

SDOH are fundamental factors that influence outcomes and disparities. Addressing these determinants is necessary for creating healthier communities, achieving health equity, and ensuring that all individuals have the opportunity lead healthy lives. By focusing on SDOH, we can develop more effective and comprehensive health strategies that go beyond medical care to address the broader factors affecting health. County Health Rankings help depict where each county sits in regards to the SDOH of their population.

The data used in the 2024 County Health Rankings are pulled from more than 30 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 measures. Those having high ranks, such as 1 or considered to be the “healthiest.” Counties are ranked on both health outcomes and health factors. The data reflected is from 2022 – there is a two-year lag in the data.

A model of the 2024 County Health Rankings – a flow chart of how a county’s rank is determined – may be found in Appendix F. For further information, visit the County Health Rankings website at www.countyhealthrankings.org.

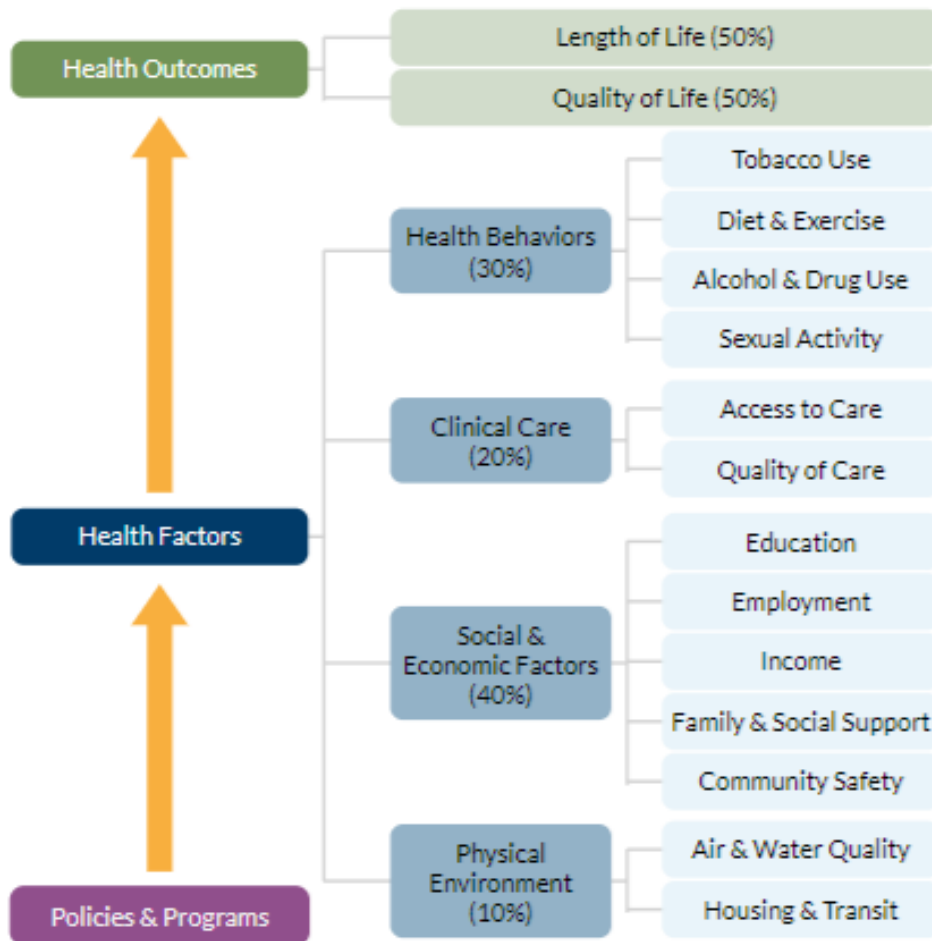
Health Outcomes tell us how long people live on average within a community, and how much physical and mental health people experience in a community while they are alive. They are influenced by many factors, such as clean water, affordable housing, the quality of medical care and the availability of good jobs. Programs and policies at the local, state and federal levels influence these factors. Many things influence how well and how long we live. Health Factors represent those things we can improve to live longer and healthier lives. They are indicators of the future health of our communities. Figure 1 shows the County Health Rankings Model.



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Figure 4. County Health Rankings Model

Source: <https://www.countyhealthrankings.org/what-impacts-health/county-health-rankings-model>



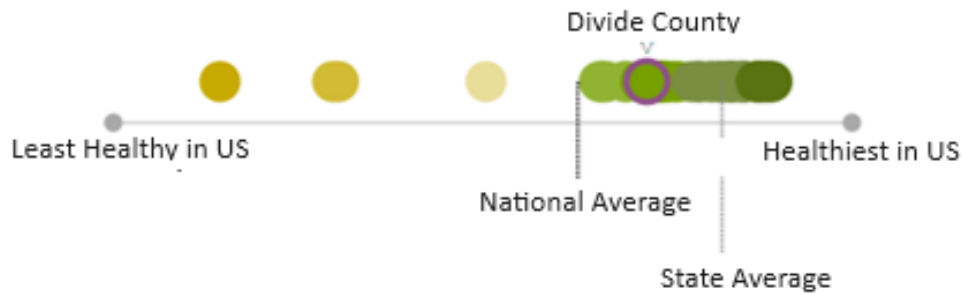
Divide County is faring worse than the average county in North Dakota for Health Outcomes and Health Factors, and better than the average county in the nation. Figure 2 depicts where Divide County falls in regard to health outcomes and health factors compared to the least healthy in the US, the healthiest in the U.S., the state average, and the national average.

Figure 5. Divide County Health Outcomes and Factors

Source: www.countyhealthrankings.org

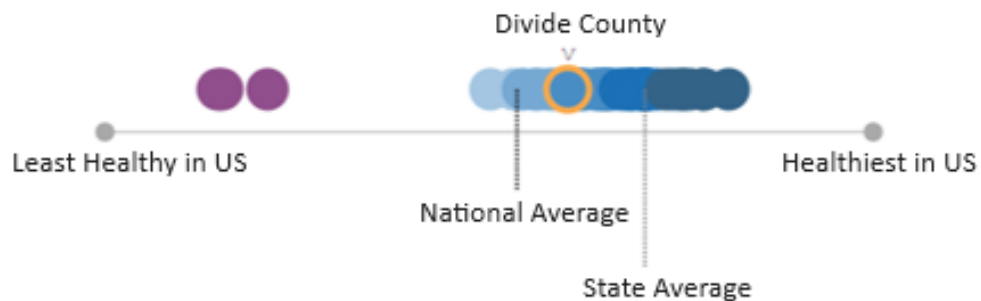
Health Outcomes:

- Length of life
- Quality of life



Health Factors:

- Health behavior
- Clinical care
- Social & Economic Factors
- Physical Environment



The following is a chart showing the County Health Rankings of Divide County relative to the North Dakota average and the U.S. top 10% performers. For most of the measures included in the rankings, the County Health Rankings' authors have calculated the "Top U.S. Performers" for 2024. 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).

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%.

TABLE 1: SELECTED MEASURES FROM COUNTY HEALTH RANKINGS 2024 DIVIDE COUNTY

● = Not meeting North Dakota average
 ■ = Not meeting U.S. Top 10% Performers
 † = Meeting or exceeding U.S. Top 10% Performers
 Note: Blank values reflect unreliable or missing data

	Divide County	North Dakota	United States
HEALTH OUTCOMES			
<i>Length of Life</i>			
Premature Death		7,600	8,000
Life Expectancy	81.1 †	78.1	77.6
<i>Quality of Life</i>			
Poor or Fair Health	14% ● †	13%	14%
Poor Physical Health Days	3.1 †	3.1	3.3
Poor Mental Health Days	3.8 †	4.0	4.8
Low Birthweight		7%	8%
Diabetes Prevalence	9% †	9%	10%
HEALTH FACTORS			
<i>Health Behaviors</i>			
Adult Smoking	16% ■	16%	15%
Adult Obesity	40% ● ■	36%	34%
Food Environment Index	9.4 †	9.1	7.7
Physical Inactivity	25% ■	25%	23%
Access to Exercise Opportunities	53% ● ■	76%	84%
Excessive Drinking	19% †	23%	18%
Alcohol-impaired Driving Deaths	100% ● ■	39%	26%
Sexually Transmitted Infections	182.8 †	511.5	495.5
Teen Births		15	17
<i>Clinical Care</i>			
Uninsured	13% ● ■	9%	10%
Uninsured Adults	12% ● †	10%	12%
Uninsured Children	13% ● ■	8%	5%
Primary Care Physicians		1,290:1	1,330:1
Dentists	2,190:1 ● ■	1,420:1	1,360:1
Mental Health Providers		450.0:1	320.0:1
Other Primary Care Providers	1,090:1 ● ■	540.0:1	760.0:1
Preventable Hospital Stays	6,237 ● ■	2,945	2,681
Mammography Screening	35% ● ■	53%	43%
Flu Vaccinations	22% ● ■	49%	46%

TABLE 1: SELECTED MEASURES FROM COUNTY HEALTH RANKINGS 2024 DIVIDE COUNTY (cont.)

● = Not meeting North Dakota average
 ■ = Not meeting U.S. Top 10% Performers
 + = Meeting or exceeding U.S. Top 10% Performers
 Note: Blank values reflect unreliable or missing data

	Divide County	North Dakota	United States
Social & Economic Factors			
High School Completion	90% ● +	93%	89%
Unemployment	1.3% +	2.1%	3.7%
Children in Poverty	12% †	12%	16%
Income Inequality	4.0 †	4.4	4.9
Social Associations	18.3 +	15.5	9.1
Injury Deaths		75	80
School Funding Adequacy	\$4,695 +	\$3,128	\$634
Gender Pay Gap	0.6 +	0.79	0.87
Median Household Income	\$70,500 ● ■	\$73,200	\$74,800
Living Wage	\$50.16	\$43.37	
Child Care Centers	6 ● ■	7	7
Homicides		3	6
Suicides		19	14
Physical Environment			
Air Pollution - Particulate Matter	4.2 +	5.0	7.4
Drinking Water Violations	No		
Homeownership	71% +	63%	65%
Severe Housing Problems	10% +	12%	17%
Severe Housing Cost Burden	5% +	10%	14%
>30 minute Drive to Work	16% ● +	15%	36%
Traffic Volume	1 +	83	108
Broadband Access	75% ● ■	86%	88%

Children’s Health

The National Survey of Children’s Health (NSCH) provides rich data on multiple, intersecting aspects of children’s lives—including physical and mental health, access to and quality of health care, and the child’s family, neighborhood, school, and social context. The NSCH is funded and directed by the Health Resources and Services Administration (HRSA) Maternal and Child Health Bureau. A revised version of the survey was conducted as a mail and web-based survey by the Census Bureau in 2016, 2017, 2018, 2019, 2020, 2021 and 2022. Data reported in Table 3 is from 2021-2022. Items noted in red show where North Dakota is fairing more poorly than the national average.

**Table 2. Data Resource Center for Child & Adolescent Health
2021-2022 National Survey of Children's Health**

Source: <https://www.childhealthdata.org/>

Health Status	North Dakota	National
Children born premature (3 or more weeks early)	11.0%	11.4%
Children 10-17 overweight or obese	28.0%	33.7%
Children 0-5 who were ever breastfed	77.6%	81.5%
Community and School Activities		
Children 6-17 who missed 11 or more days of school	5.9%	5.7%
Children 12-17 who work for pay	53.4%	35.6%
Health Care		
Children currently insured	94.3%	93.1%
Children that had one or more preventative visits in the past year	73.6%	76.8%
Children who spent less than 10 minutes with the provider at a preventive medical visit	16.1%	18.8%
Children (1-17 years) who had a preventive dental visit in the past year	77.7%	77.0%
Children (0-17 years) who have seen an eye doctor in the past 2 years	51.7%	39.4%
Children (3-17 years) received mental health care	13.4%	11.6%
Children (3-17 years) who had difficulties getting the mental health treatment/counseling needed and did not obtain care	5.0%	5.5%
Young children (9-35 mos.) receiving standardized screening for developmental problems in the past year	46.1%	33.7%
Children who have received coordinated, ongoing, comprehensive care within a medical home	52.3%	46.1%
Family Life		
On most weekdays, children who usually spend 4 or more hours in front of a TV, computer, cellphone or other electronic device watching programs, playing games, accessing the internet or using social media, not including schoolwork	18.4%	22.9%
Children who live in households where someone smokes	17.1%	12.7%
Children who have, during the past year, not afford to eat	3.1%	4.5%
Neighborhood		
Children who live in neighborhoods with parks, recreation centers, sidewalks, and a library	33.6%	36.1%
Children living in neighborhoods with poorly kept or rundown housing	19.5%	24.7%
Children living in a safe neighborhood	76.3%	66.2%

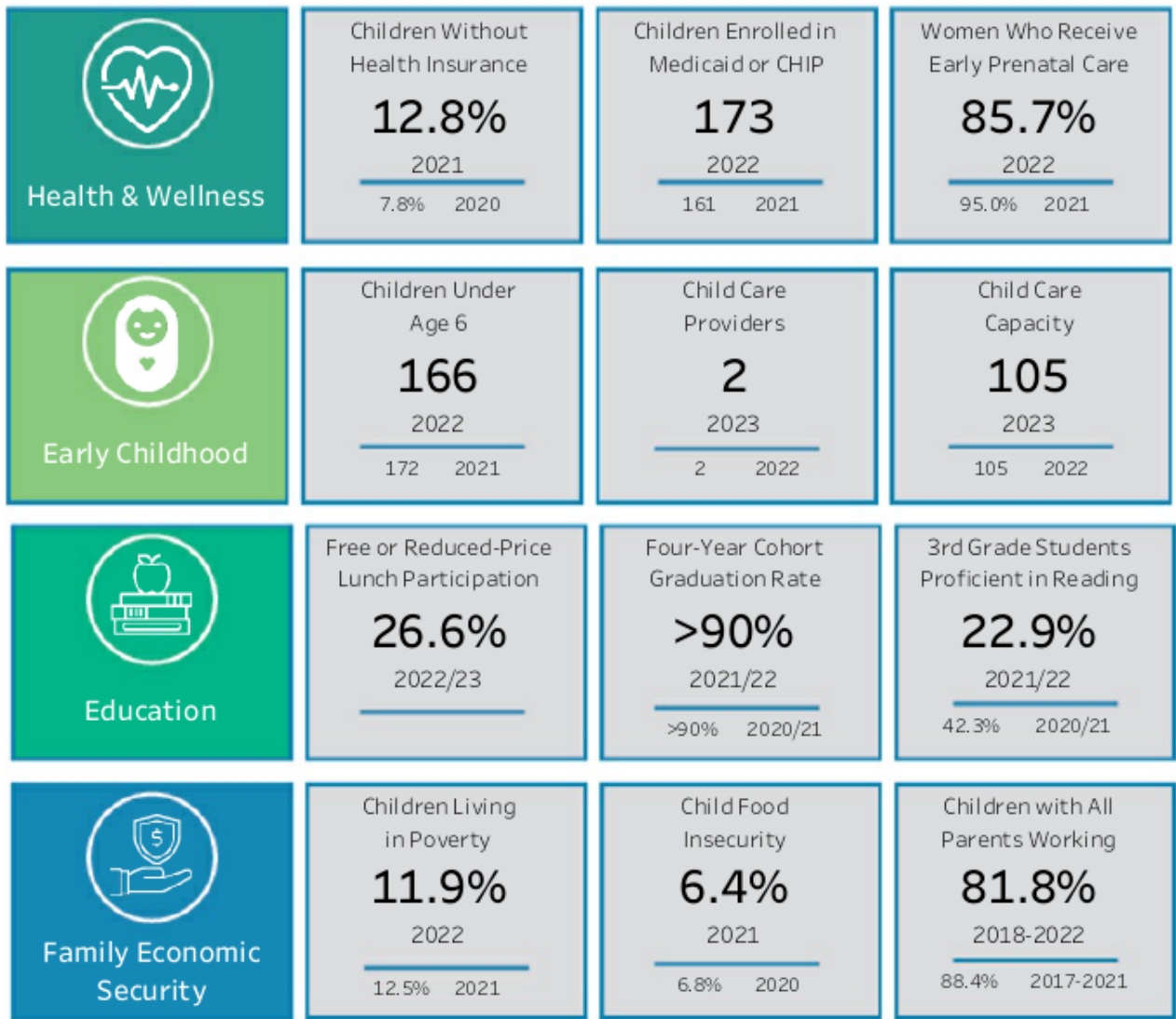
North Dakota KIDS COUNT is dedicated to providing current, relevant, and reliable data to shape the issues affecting North Dakota children and families. North Dakota KIDS COUNT also regularly updates the KIDS COUNT Data Center to include the most recent statistics for children and families. The KIDS COUNT Data Center is a project of the Annie E. Casey Foundation, and KIDS COUNT is a comprehensive source for data on child and family well-being in the United States (<https://ndkidscount.org/county-data>). See Appendix G. Burke and Williams County KIDS COUNTY Data Reports have also been included in Appendix G. In addition to the population demographics of children in Divide County and North Dakota, Figure 3 shows the 2021-2022 results versus the 2020-2021 results when available.

Figure 6. Divide County KIDS COUNT Data Report

Source: <https://ndkidscount.org/county-data>

Divide County

Population Estimates for: 2022	Divide	North Dakota
Child Population (under 18):	527	182,775
American Indian/Alaska Native:	1.8%	8.0%
Black:	3.7%	4.9%
White:	84.6%	79.9%
2+ Races or Other:	9.9%	7.3%



Another means for obtaining data on the youth population is through the CDC’s Youth Risk Behavior Survey (YRBS). 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 3 depicts some of the YRBS data that has been collected in 2017, 2019, and 2021 (most recent published data). They are further broken down by rural and urban percentages. The trend column shows a “=” for statistically

insignificant change (no change), “↑” for an increased trend in the data changes from 2019 to 2021, and “↓” for a decreased trend in the data changes from 2019 to 2021. The final column shows the 2021 national average percentage. For a more complete listing of the YRBS data, see Appendix H.

Table 3. Youth Behavioral Risk Survey Results

North Dakota High School Survey

Rate Increase ↑, rate decrease ↓, or no statistical change = in rate from 2019-2021.

	ND 2019	ND 2021	ND Trend ↑, ↓, =	Rural ND Town Average	Urban ND Town Average	National Average 2021
% of students who rarely or never wore a seat belt (when riding in a car driven by someone else)	5.9	49.6	↑	9.2	5.5	39.9
% of students who rode in a vehicle with a driver who had been drinking alcohol (one or more times during the 30 prior to the survey)	14.2	13.1	=	18.2	13.7	14.1
% of students who talked on a cell phone while driving (on at least one day during the 30 days before the survey)	59.6	5.0	↓	64.9	64.2	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)	53.0	55.4	=	59.9	55.9	36.1
% of students who were in a physical fight on school property (one or more times during the 12 months before the survey)~2017/2019~ *in 2021 replaced by* % of students who carried a weapon on school property (such as a gun, knife, or club, on at least 1 day during the 30 days before the survey)	7.1	5.0	↓	6.2	4.4	3.0
% 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)	9.2	9.4	=	9.7	11.6	11
% of students who were bullied on school property (during the 12 months before the survey)	19.9	15.8	↓	19.8	15.0	15.0
% of students who were electronically bullied (includes texting, Instagram, Facebook, or other social media ever during the 12 months before the survey)	14.7	13.6	↓	16.2	14.5	15.9
% of students who made a plan about how they would attempt suicide (during the 12 months before the survey)	15.3	14.8	=	15.1	17.2	17.6
% 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)	33.1	21.2	↓	24.2	23.6	18.0
% of students who currently used cigarettes, cigars, or smokeless tobacco (on at least one day during the 30 days before the survey)	12.2	5.9	↓	8.0	6.1	3.8
% 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)	15.6	14.0	=	17.8	14.6	10.5
% of students who currently used marijuana (one or more times during the 30 days before the survey)	12.5	10.7	=	10.2	12.9	15.8
% 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)	14.5	10.2	↓	9.7	11.0	12.2

% of students who were overweight (\geq 85th percentile but $<$ 95 th percentile for body mass index)	16.5	15.6	=	15.5	14.2	16.0
% of students who had obesity (\geq 95th percentile for body mass index)	14.0	16.3	=	17.4	15.0	16.3
% of students who did not eat fruit or drink 100% fruit juices (during the seven days before the survey)	6.1	5.0	=	5.7	4.6	7.7
% 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)	6.6	5.9	=	5.3	6.2	9.3
% 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)	15.9	16.6	=	17.5	13.8	14.7
% of students who did not drink milk (during the seven days before the survey)	20.5	26.2	↑	21.2	29.4	35.7
% of students who did not eat breakfast (during the seven days before the survey)	14.4	15.1	=	14.5	17.3	22.0
% 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)	2.8	2.1	=	2.2	2.1	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)	49.0	56.5	↑	58.0	55.3	NA
% of students who watched television 3 or more hours per day (on an average school day) *In 2021 replaced by*Percentage of students who spent 3 or more hours per day on screen time (in front of a TV, computer, smart phone, or other electronic device watching shows or videos, playing games, accessing the Internet, or using social media, not counting time spent doing schoolwork, on an average school day)	18.8	75.7	↑	75.8	78.6	75.7
% of students who played video or computer games or used a computer 3 or more hours per day (for something that was not schoolwork on an average school day) *In 2021, % of students who played video or computer games was combined with % of students who watch television 3 or more hours per day.	45.3	NA	NA	NA	NA	NA
% of students who ever had sexual intercourse	38.3	36.6	=	36.5	37.0	30
% of students who had eight or more hours of sleep (on an average school night)	29.5	24.5	↓	28.3	23.2	22.7
% of students who brushed their teeth on seven days (during the seven days before the survey)	66.8	67.9	=	64.5	69.9	NA

Sources: <https://www.cdc.gov/healthyouth/data/yrbs/results.htm>; <https://www.nd.gov/dpi/districtschools/safety-health/youth-risk-behavior-survey>

Low Income

The 2023 Needs Assessment Study of Low-Income North Dakota Individuals and Families, was a collaborative effort between the Community Action Agencies (CAAs) and North Dakota State University (NDSU). It was carried out through the utilization of surveys and focus groups, followed by statistical analysis. Specifically, the assessment involved a variety of survey methods, including both online and paper surveys, chosen based on their appropriateness for different respondent groups, targeting low-income individuals and families across the state of North Dakota.

Findings from the study found that “Rental Assistance” remained the top priority need among people experiencing poverty throughout the state under the category of “Housing”. Inconsistencies between the responses from low-income or non-low-income respondents were found, which reflect distinct needs within these two groups. For example, the top priority need for the non-low-income respondents is “Mental Health Service”, while “Rental Assistance” stands as the top need for the low-income people, as well as the broader community, including both low-income and non-low-income people. Individuals and families with higher incomes tend to prioritize Civic Engagement and Community Involvement, including aspects like “Recreational Activities” and “Safe Neighborhoods, Sidewalks, Parks”. Conversely, those with lower incomes are more inclined to place greater emphasis on fundamental necessities such as “Rental Assistance”, “Food”, and “Dental Insurance/Affordable Dental”. This divergence in priorities reflects varying needs and concerns across income levels.

Increased living costs and inflation have emerged as significant contributing factors to the causes of poverty across the state, and they could also be the key drivers behind the top priority need for “Rental Assistance”. The frequently mentioned causes of poverty, derived from analysis of the qualitative data collected across the state, are listed below in order of frequency (with the most frequently mentioned causes listed first).

1. Increasing living costs/Inflation
2. Disability, Mental Illness, Severe Anxiety/Depression, etc.
3. Childcare Issue for Working Parents
4. Family Instability
5. Less/No Skills for Jobs (with better pay and benefits)
6. Lack of Affordable Transportation (to and from work)
7. Generational Poverty
8. Lack of Education
9. Bad Record/Background

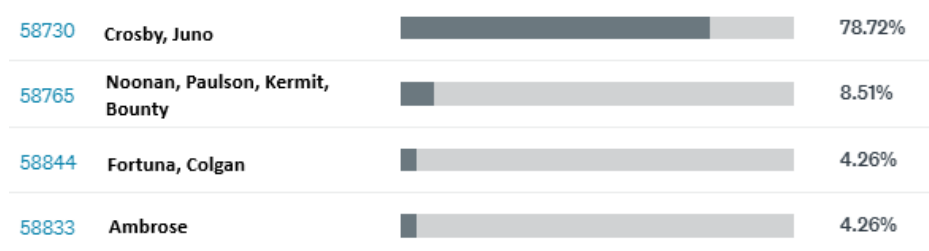
Survey Results

A total of 133 community members completed the survey in communities throughout the counties in the St. Luke’s Medical Center service area. For all questions that contained an “Other” response, all of those direct responses may be found in Appendix B. In some cases, a summary of those comments is additionally included in the report narrative. The “Total respondents” number under each heading indicates the number of people who responded to that particular question and the “Total responses” number under the heading depicts the number of responses selected for that question (some questions allow for selection of more than one response). An asterisk (*) indicates that survey respondents were able to select more than one answer response.

The survey requested that respondents list their home zip code. While not all respondents provided a zip code, 94 did, revealing that a large majority of respondents (79%, N=74) lived in Crosby or Juno. These results are shown in Figure 7.

Figure 7: Survey Respondents’ Home Zip Code

Total respondents: 94



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

Survey Demographics

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

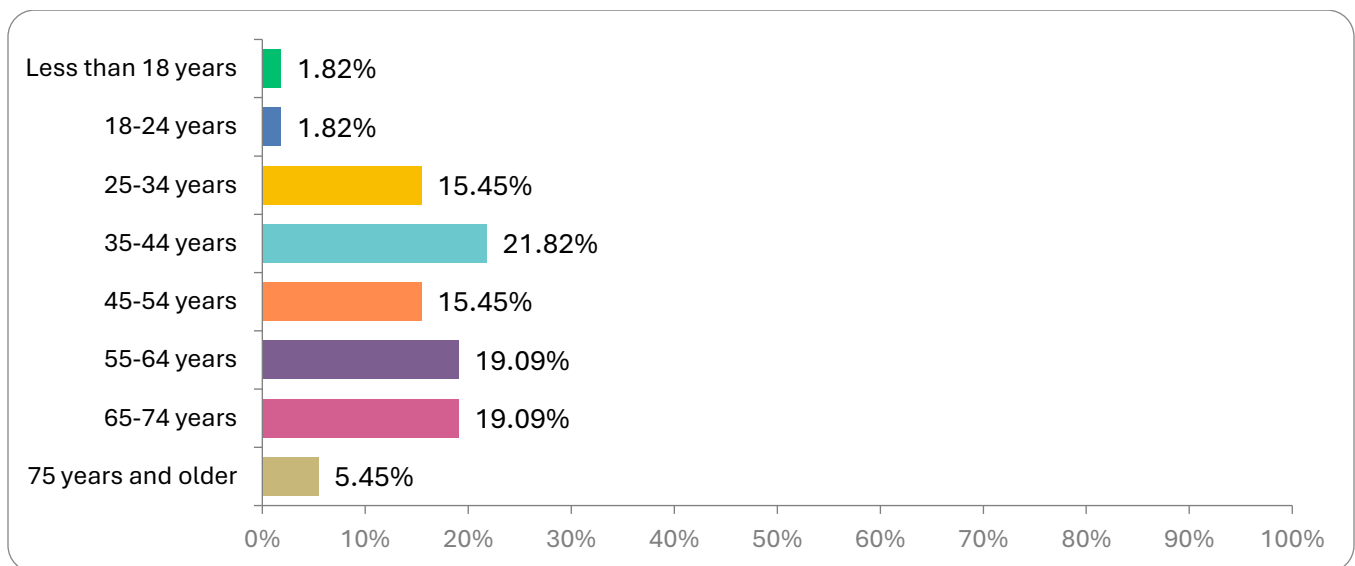
With respect to the demographics of those who chose to complete the survey:

- 43% (N=48) were age 55 or older.
- The majority (87%, N=96) were female.
- Slightly less than half of the respondents (46%, N=51) had bachelor’s degrees or higher.
- The number of those working full time (61%, N=67) was more than three times higher than those who were retired (17%, N=19).
- 94% (N=100) of those who reported their ethnicity/race were white/Caucasian.
- 22% of the population (N=22) had household incomes of less than \$50,000.
- Two-thirds had insurance through their employer.

Figures 8 through 14 show these demographic characteristics. It illustrates the range of community members’ household incomes and indicates how this assessment took into account input from parties who represent the varied interests of the community served, including a balance of age ranges, those in diverse work situations, and community members with lower incomes.

Figure 8: Age Demographics of Survey Respondents

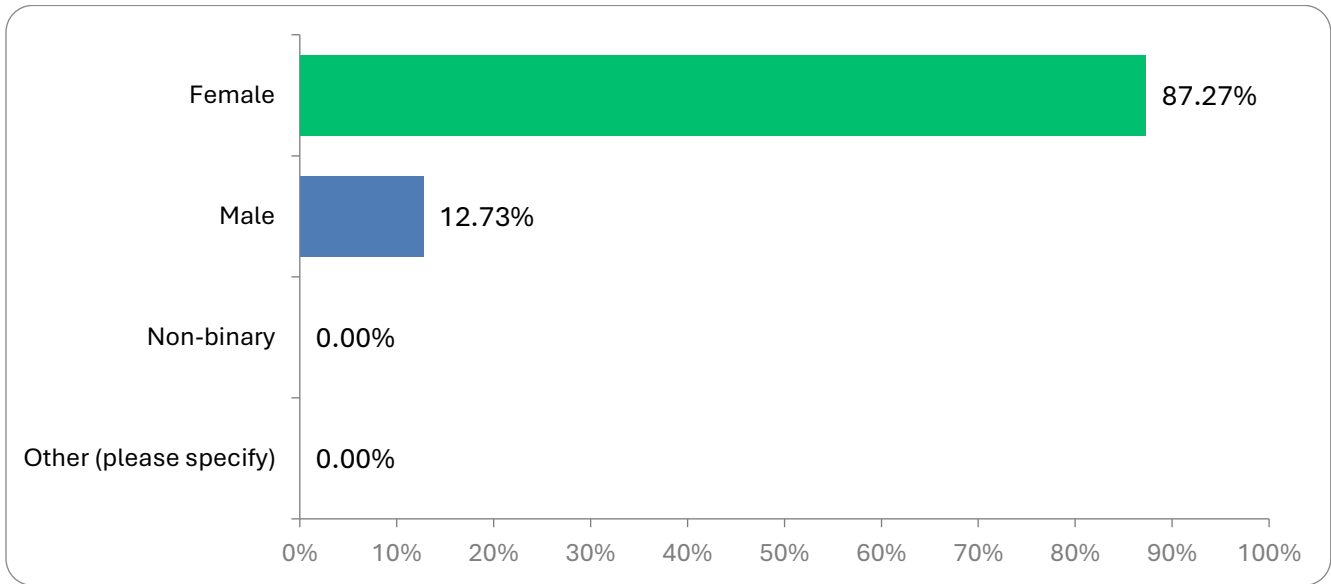
Total respondents = 110



People under age 18 are not targeted using this survey method. Youth data is gathered from secondary sources.

Figure 9: Gender Demographics of Survey Respondents

Total respondents = 110



As shown in Figure 10, nearly all of the respondents were white/Caucasian (93%). This is less the race/ethnicity of the overall population of Divide County; the 2020 US Census indicates that 98% of the population is white in Divide County.

Figure 10: Race/Ethnicity Demographics of Survey Respondents

Total respondents = 107*

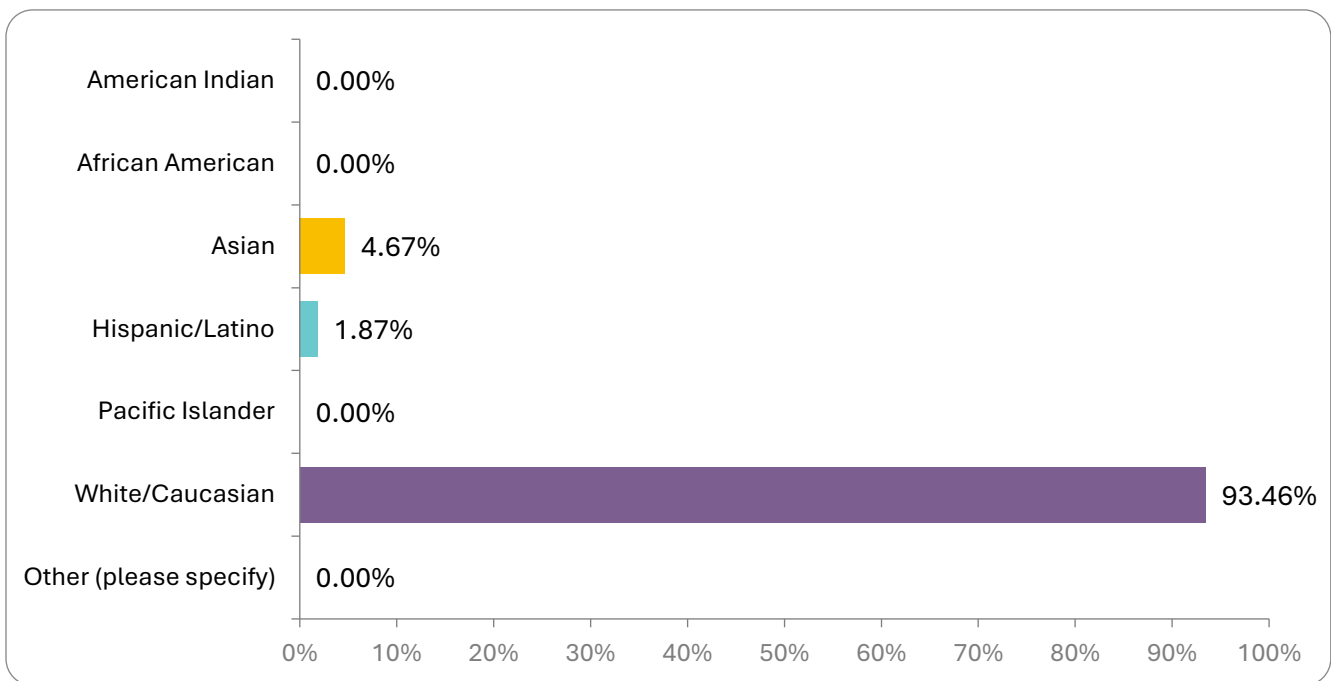


Figure 11: Educational Level Demographics of Survey Respondents

Total respondents = 110

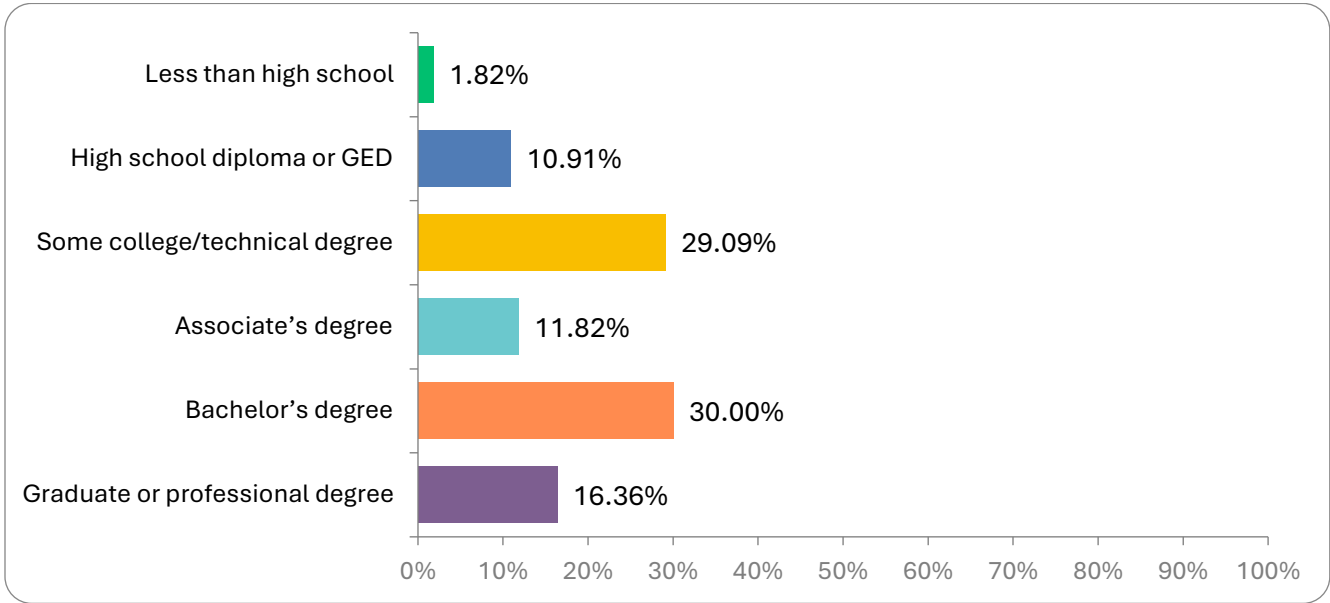
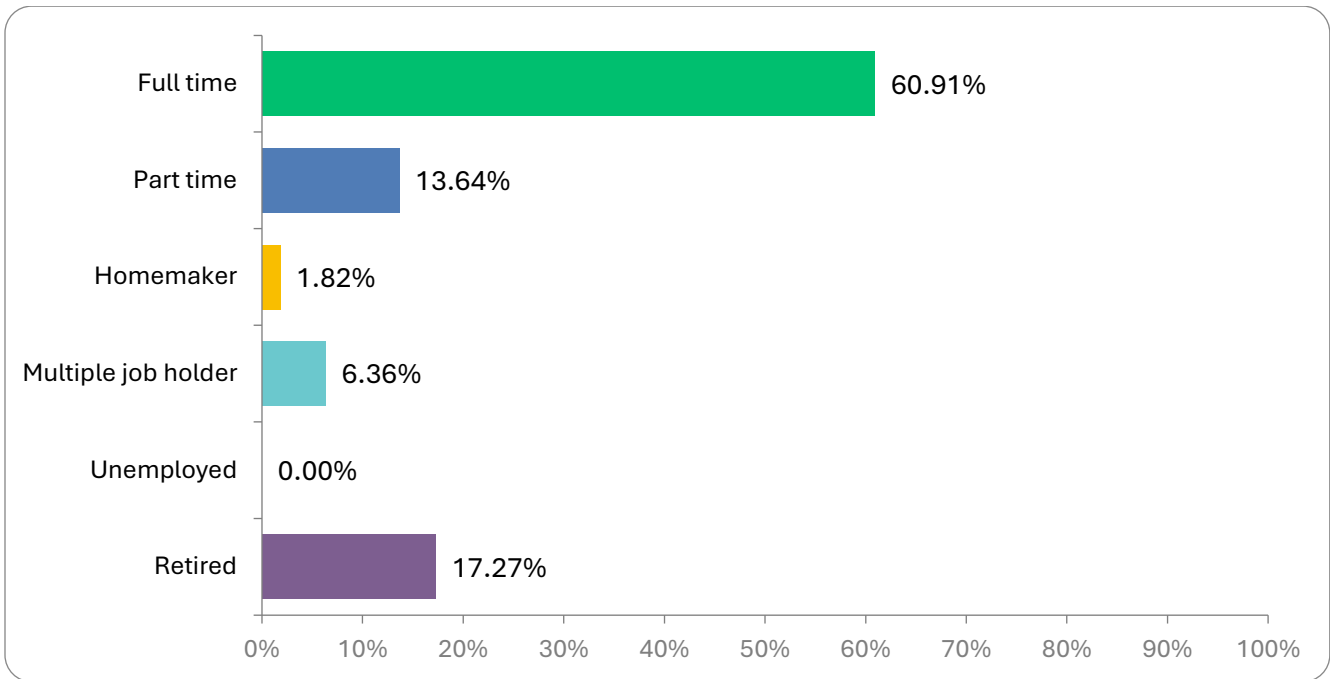


Figure 12: Employment Status Demographics of Survey Respondents

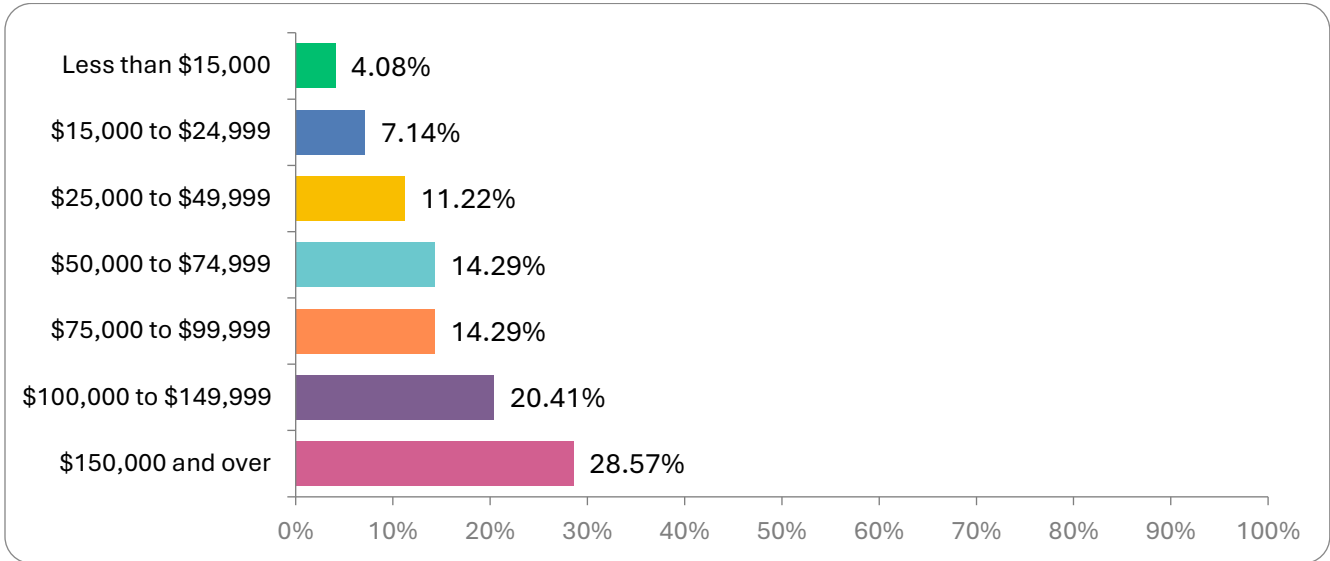
Total respondents = 110



Of those who provided a household income, 11% (N=11) community members reported a household income of less than \$25,000. Almost half, 49% (N=48) indicated a household income of \$100,000 or more. This information is shown in Figure 13.

Figure 13: Household Income Demographics of Survey Respondents

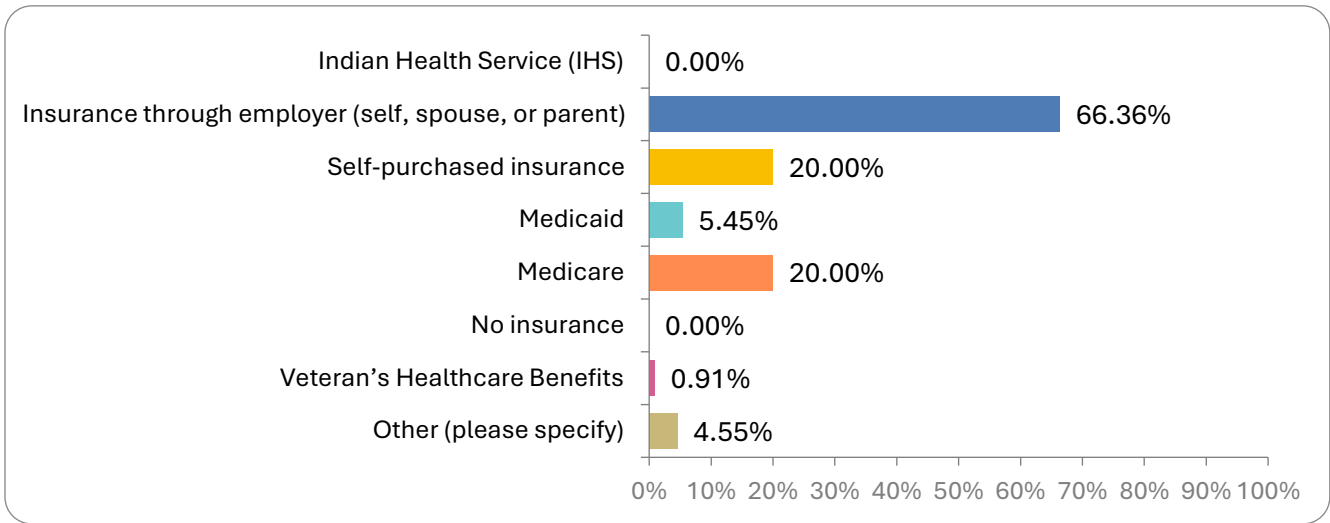
Total respondents = 98



Community members were asked about their health insurance status, which is often associated with whether people have access to healthcare. None of the respondents reported having no health insurance. The most common insurance types were insurance through one’s employer (N=73), followed by self-purchased (N=22) and Medicare (N=22). The “Other” responses were supplemental plans or commercial plans.

Figure 14: Health Insurance Coverage Status of Survey Respondents

Total respondents = 110



Community Assets and Challenges

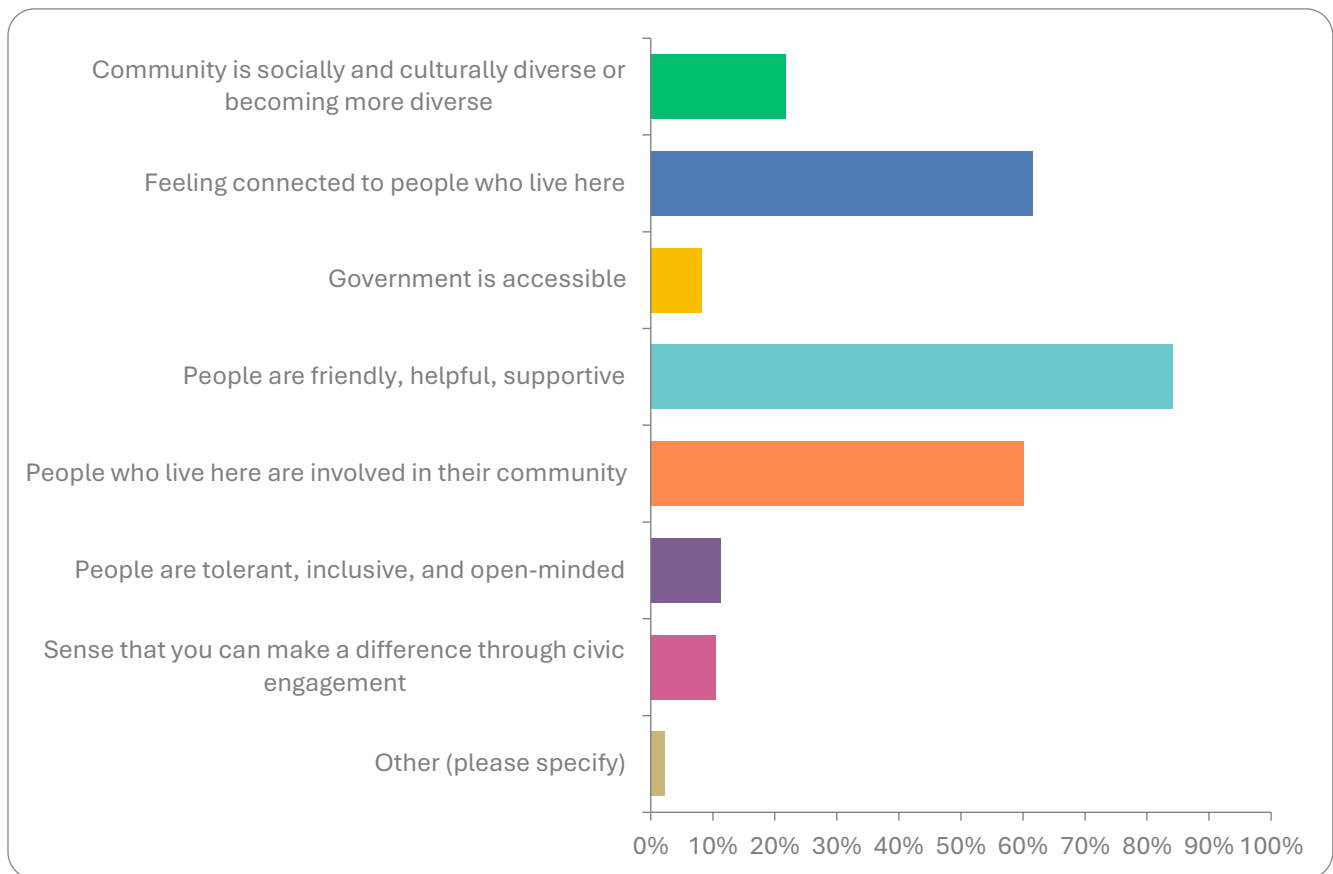
Survey-respondents were asked what they perceived as the best things about their community in four categories: people, services and resources, quality of life, and activities. In each category, respondents were given a list of choices and asked to pick the three best things. Respondents occasionally 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 80 respondents agreeing) that community assets include:

- Safe place to live, little/no crime (N=121);
- People are friendly, helpful, supportive (N=112);
- Family-friendly (N=111);
- Feeling connected to the people who live here (N=82); and
- People who live here are involved in their community (N=80); and
- Recreational and sports activities (N=80).

Figures 15 to 17 illustrate the results of these questions.

Figure 15: Best Things about the PEOPLE in Your Community

Total responses = 133*



Included in the “Other” category of the best things about the people was that they are cheerful.

Figure 16: Best Things about the SERVICES AND RESOURCES in Your Community

Total responses = 128*

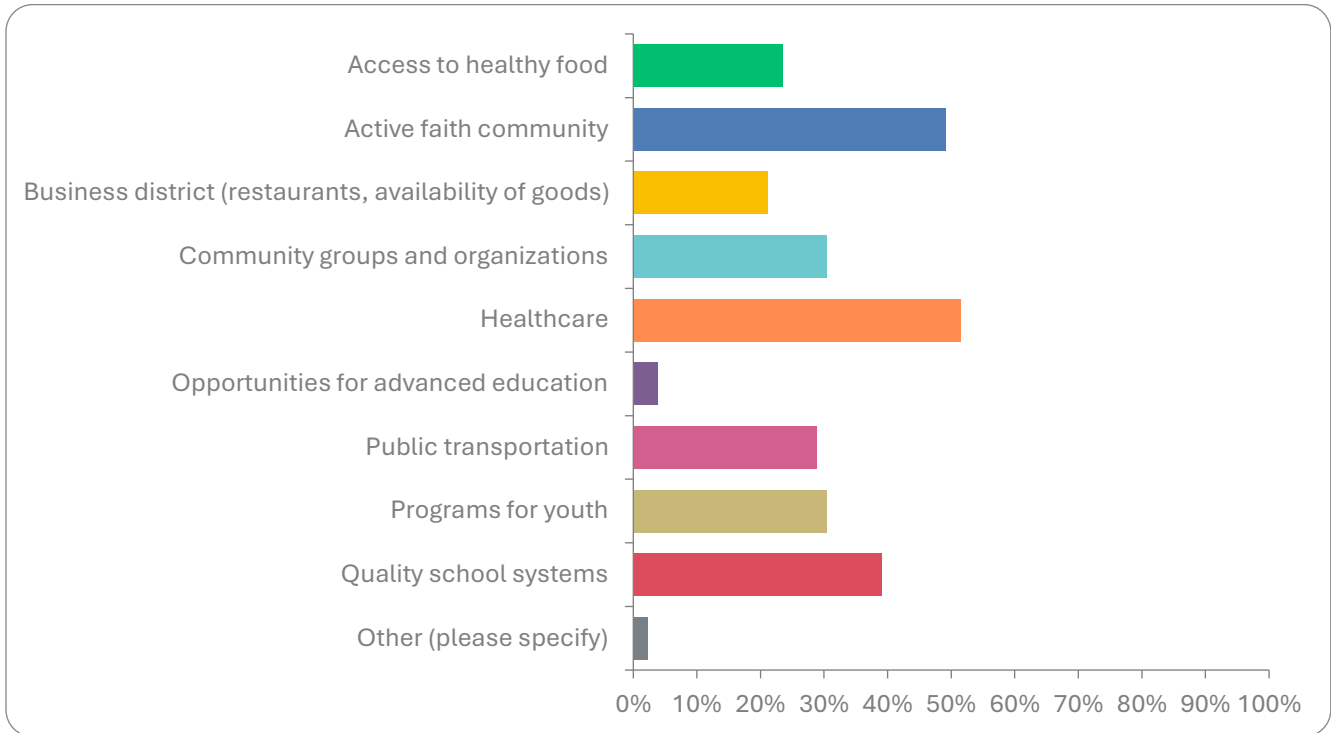


Figure 17: Best Things about the QUALITY OF LIFE in Your Community

Total responses = 131*

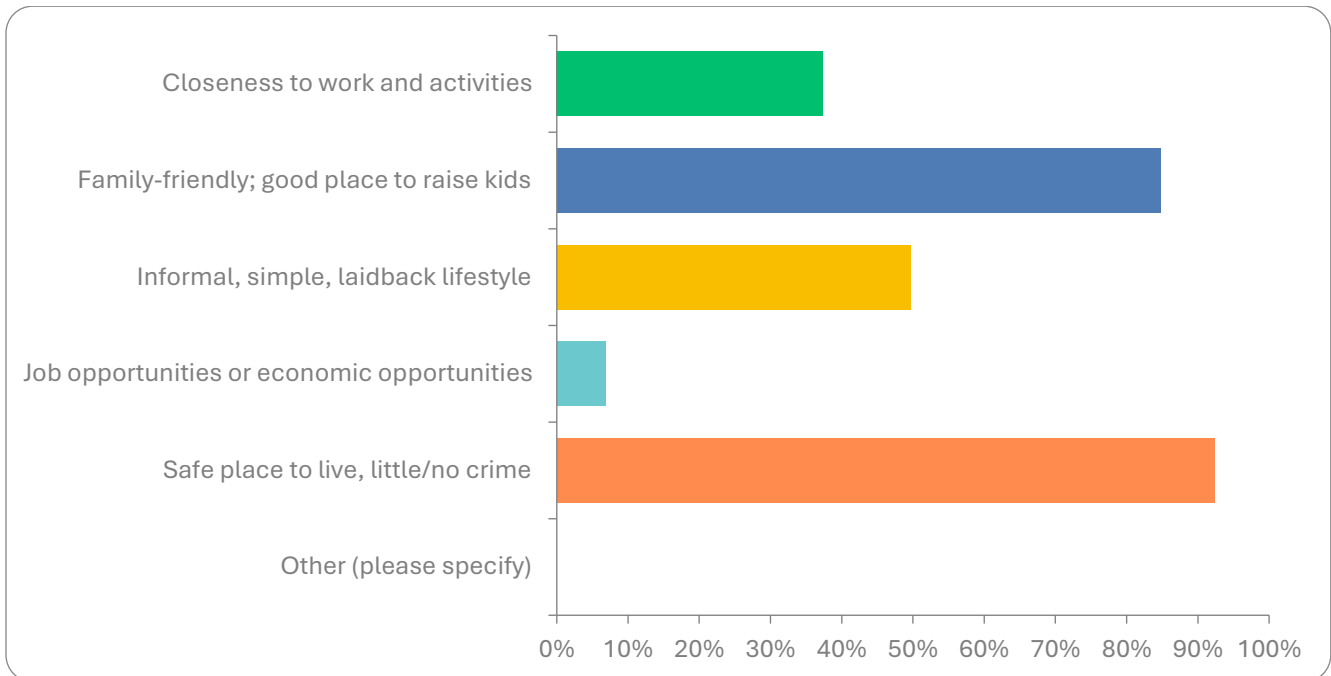
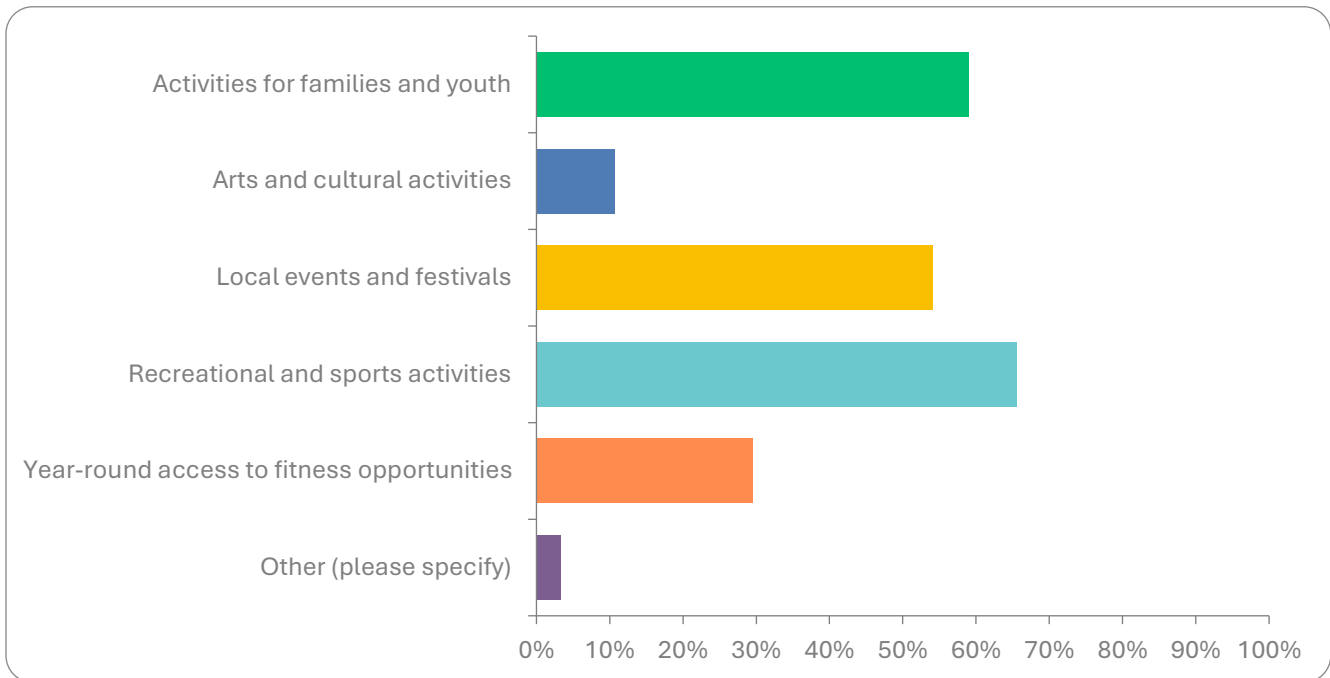


Figure 18: Best Thing about the ACTIVITIES in Your Community

Total responses = 122*



Respondents who selected “Other” specified that the best things about the activities in the community included outdoor pool and great park.

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

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

With regard to responses about community challenges, the most highly voiced concerns (those having at least 50 respondents) were:

- Alcohol use and abuse – Adults (N=72);
- Long-term/nursing home care options (N=69);
- Depression/anxiety – Youth (N=68);
- Cost of long-term/nursing home care (N=63);
- Availability of resources to help the elderly stay in their homes (N=52);
- Depression/anxiety - Adults (N=51); and
- Attracting and retaining young families (N=51).

The other issues that had at least 35 votes included:

- Smoking and tobacco use, exposure to second-hand smoke or vaping (juuling) - Youth (N= 42);
- Availability of home health (N=40);
- Alcohol use and abuse – Youth (N=40);

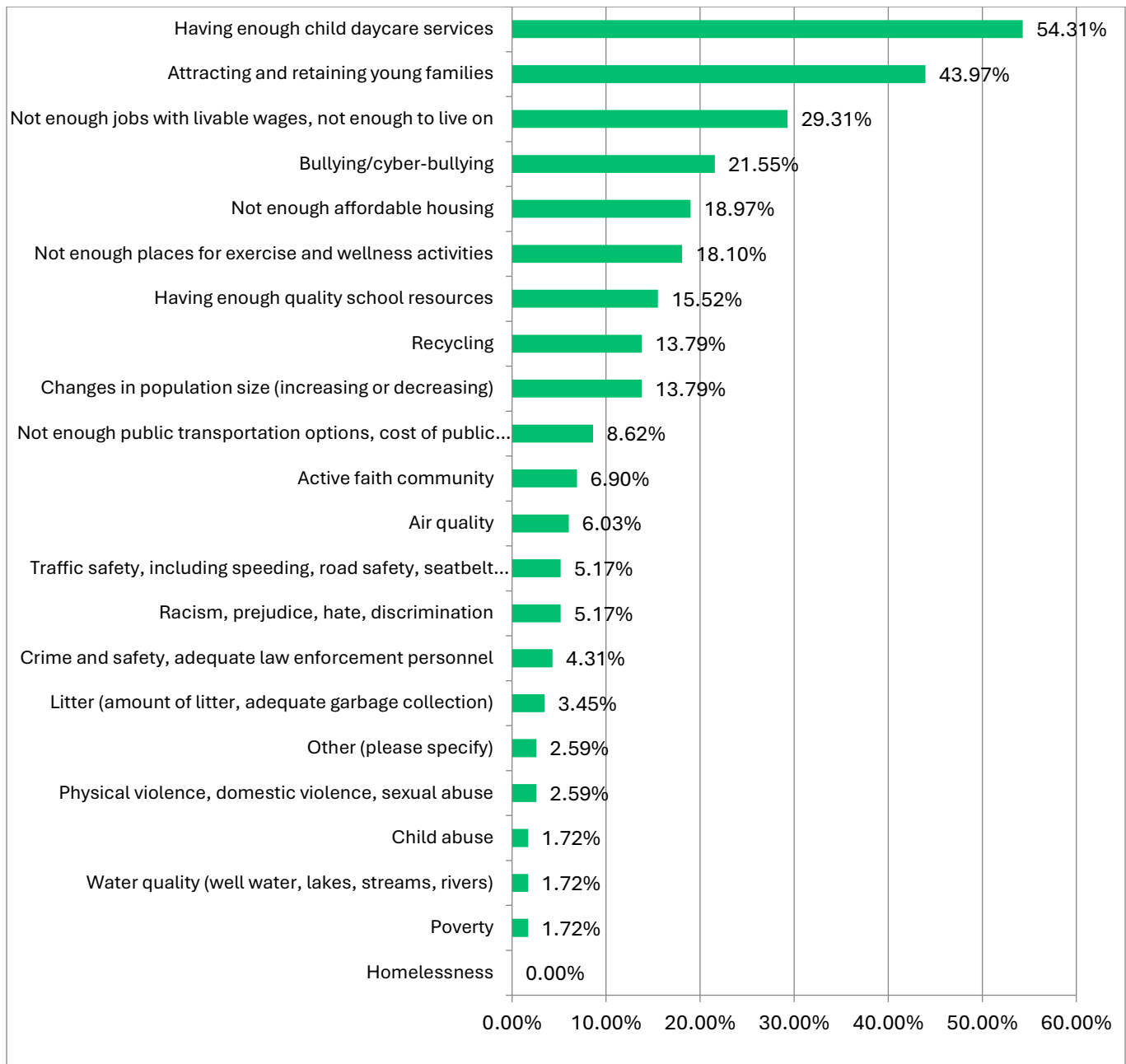
- Availability of specialists (N=38);
- Availability of mental health services (N=36); and
- Availability of vision care (N=36).

For questions that had long responses that are truncated in the charts, the full text is in italics below each chart.

Figures 19 through 24 illustrate these results.

Figure 19: Community/Environmental Health Concerns

Total responses = 118*



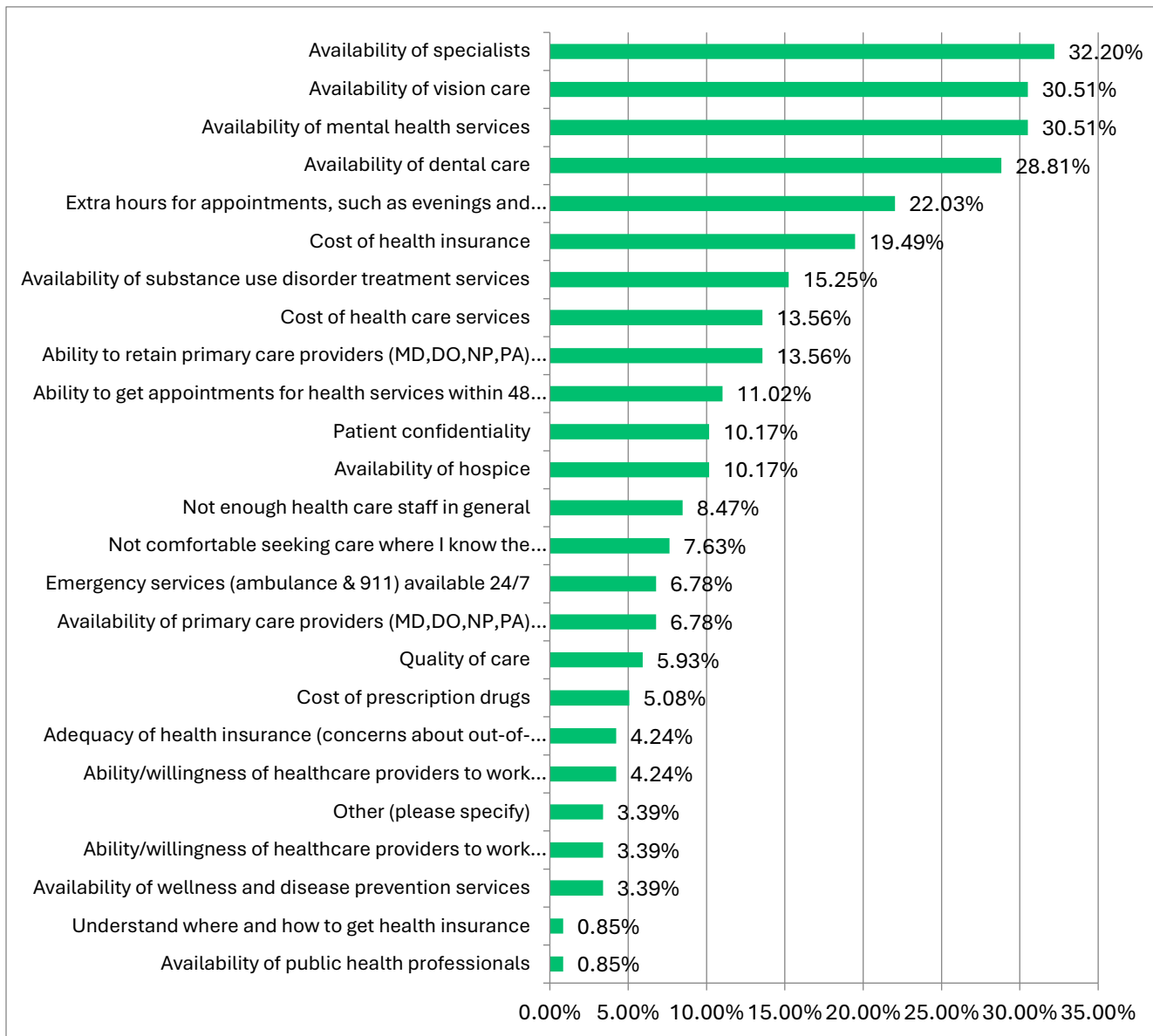
Cut-off chart text:

- *Not enough public transportation options, cost of public transportation*
- *Traffic safety, including speeding, road safety, seatbelt use, and drunk/distracted driving*

In the “Other” category for community and environmental health concerns, the following were listed: lack of nightlife, inability of adults in the community to get along, lack of high-quality dentist and eye doctor.

Figure 20: Availability/Delivery of Health Services Concerns

Total responses = 118*



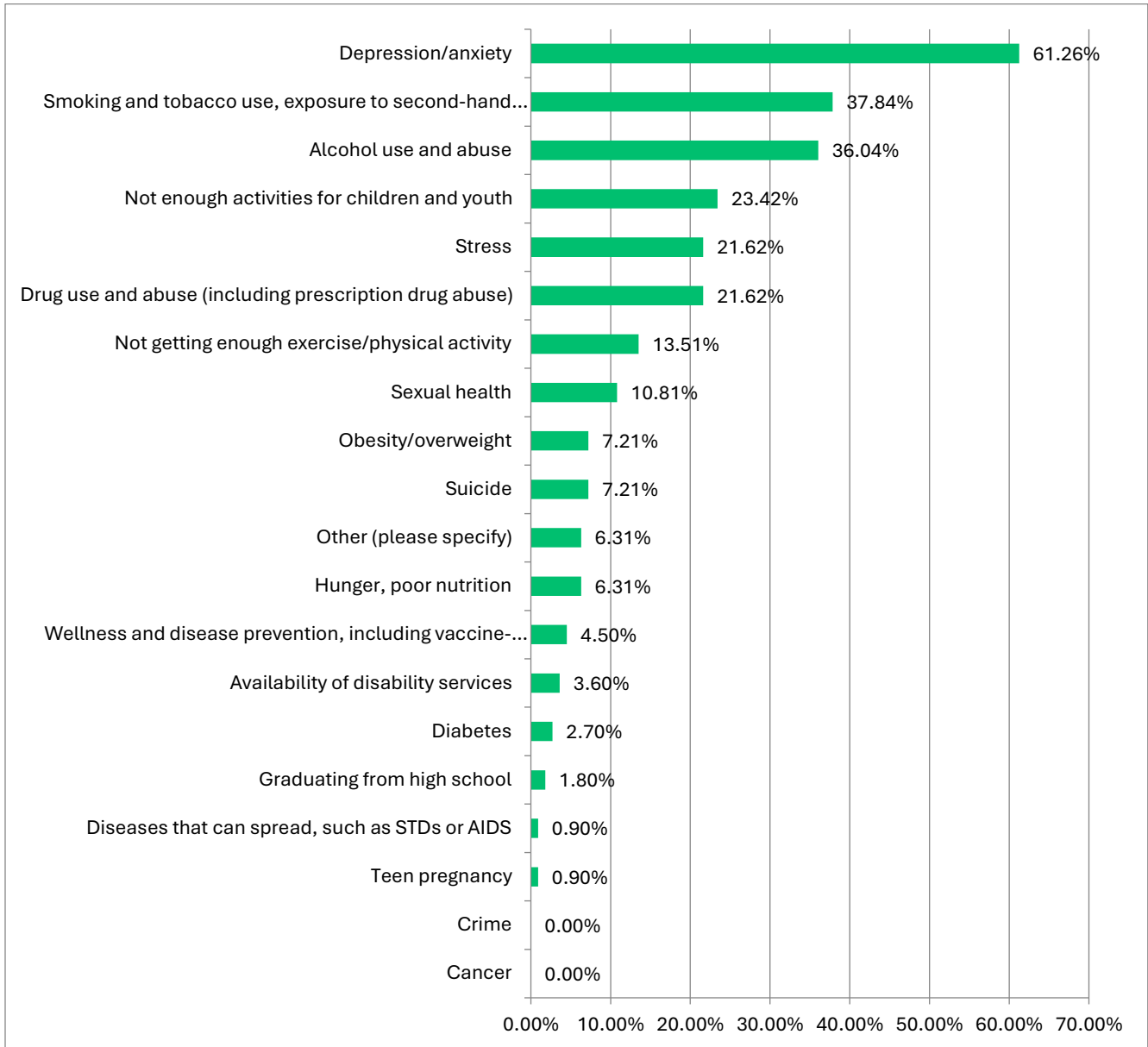
Cut-off chart text:

- *Extra hours for appointments, such as evenings and weekends*
- *Ability to retain primary care providers (MD,DO,NP,PA) and nurses in the community*
- *Ability to get appointments for health services within 48 hours*
- *Not comfortable seeking care where I know the employees at the facility on a personal level*
- *Availability of primary care providers (MD,DO,NP,PA) and nurses*
- *Adequacy of health insurance (concerns about out-of-pocket costs)*
- *Ability/willingness of healthcare providers to work together to coordinate patient care within the health system*

In the “Other” category for Availability/Delivery of Health Services Concerns were pre/post natal care and pharmacy concerns.

Figure 21: Youth Population Health Concerns

Total responses = 111*



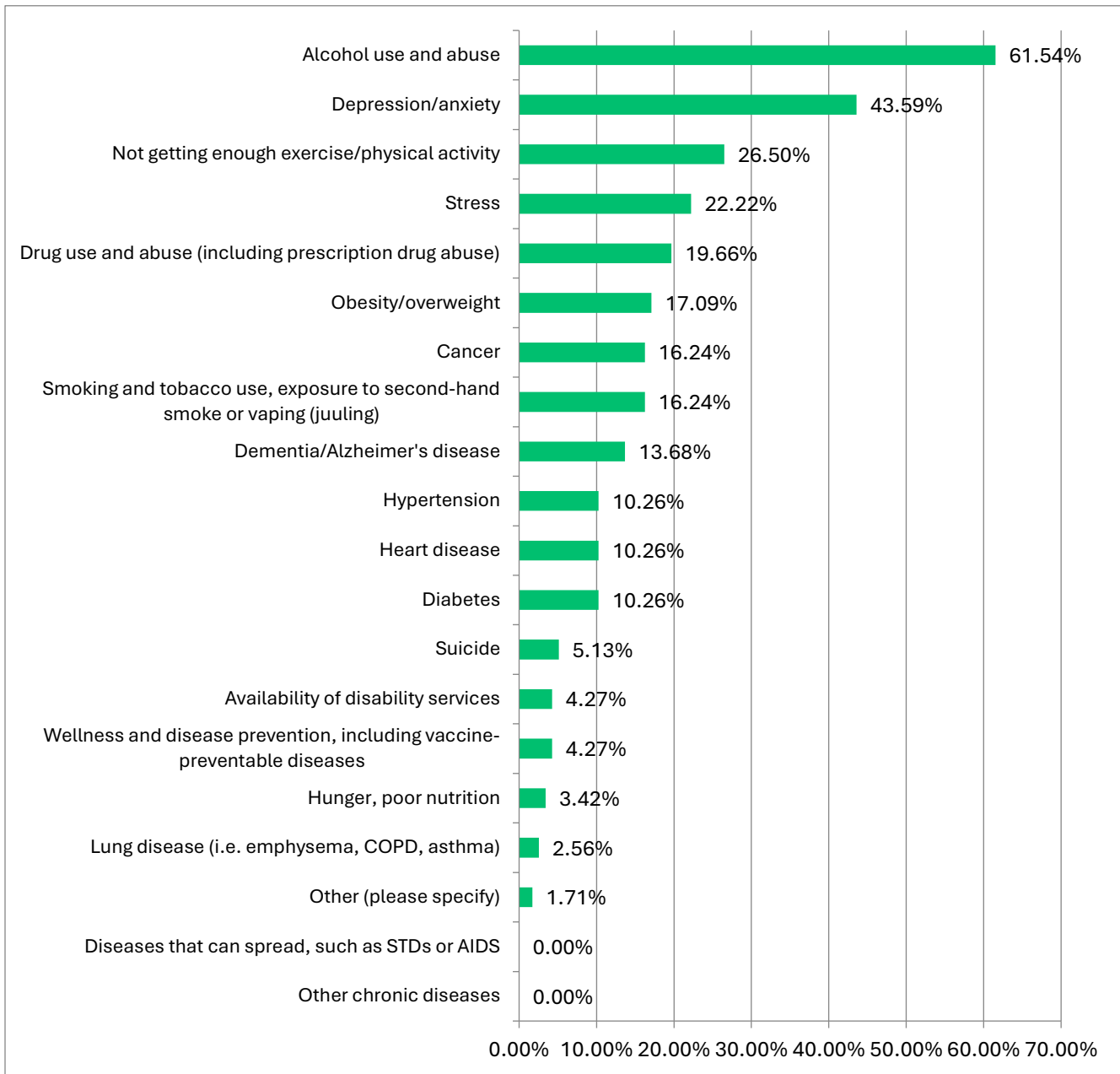
Cut-off chart text:

- *Smoking and tobacco use, exposure to second-hand smoke or vaping (juuling)*
- *Wellness and disease prevention, including vaccine-preventable diseases*

Comments included in the “Other” category for the Youth Population included bullying/cyberbullying, social media, mental health, and lack of work ethic/motivation to work.

Figure 22: Adult Population Concerns

Total responses = 117*



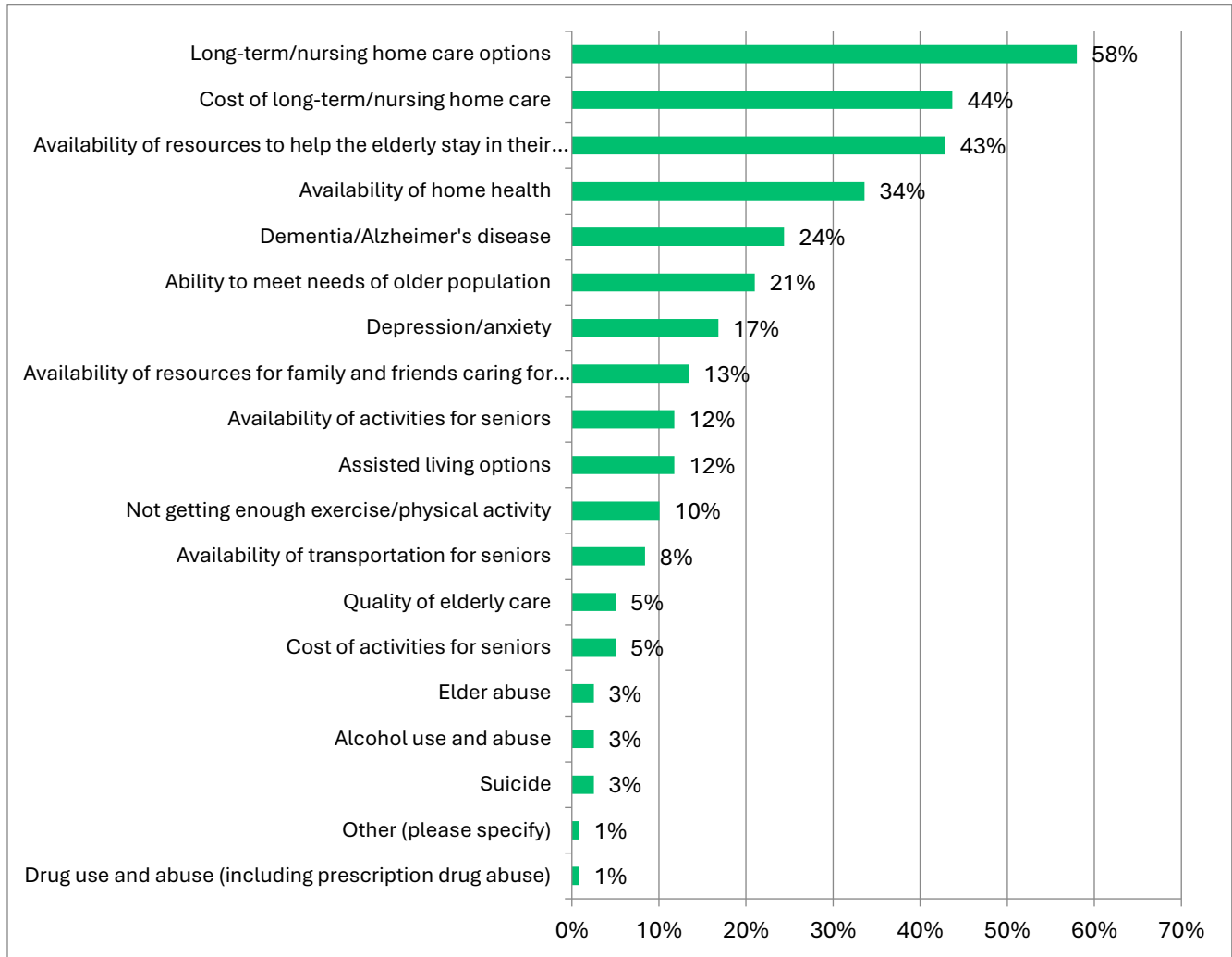
Cut-off chart text:

- *Smoking and tobacco use, exposure to second-hand smoke or vaping (juuling)*
- *Wellness and disease prevention, including vaccine-preventable diseases*

Comments included in the “Other” category for the Adult Population Concerns included cost of living and lack of mental health services.

Figure 23: Senior Population Concerns

Total responses = 119*



Cut-off chart text:

- Availability of resources to help the elderly stay in their homes
- Availability of resources for family and friends caring for elders

In the “Other” category, the one concern listed lack of services for elderly who do not need nursing home but would benefit from and cannot afford Assisted Living.

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. Substance abuse; and
2. Mental Health.
3. Housing for the elderly
4. Community growth/retention
5. Cost of living

Other biggest challenges that were identified were housing for the elderly, community growth/retention, cost of living, and pride in the community/community mindset. Community mindset includes progressive attitude and goal setting to improve the community.

Delivery of Healthcare

The survey asked about the health and health care of the survey respondents. They were asked to rate their overall health from poor to excellent. In another question they were asked to indicate any chronic conditions that applied to them. Finally, they were asked if they had a primary care physician. A primary care provider manages chronic diseases, promotes comfort and transparency of medical history, lower overall healthcare costs, ensures routine screenings for early detection before minor issues become big concerns, and refers to specialty care when necessary.

Figure 24-26 illustrates the results of each.

Figure 24: How would you rate your overall health?

Total responses = 117

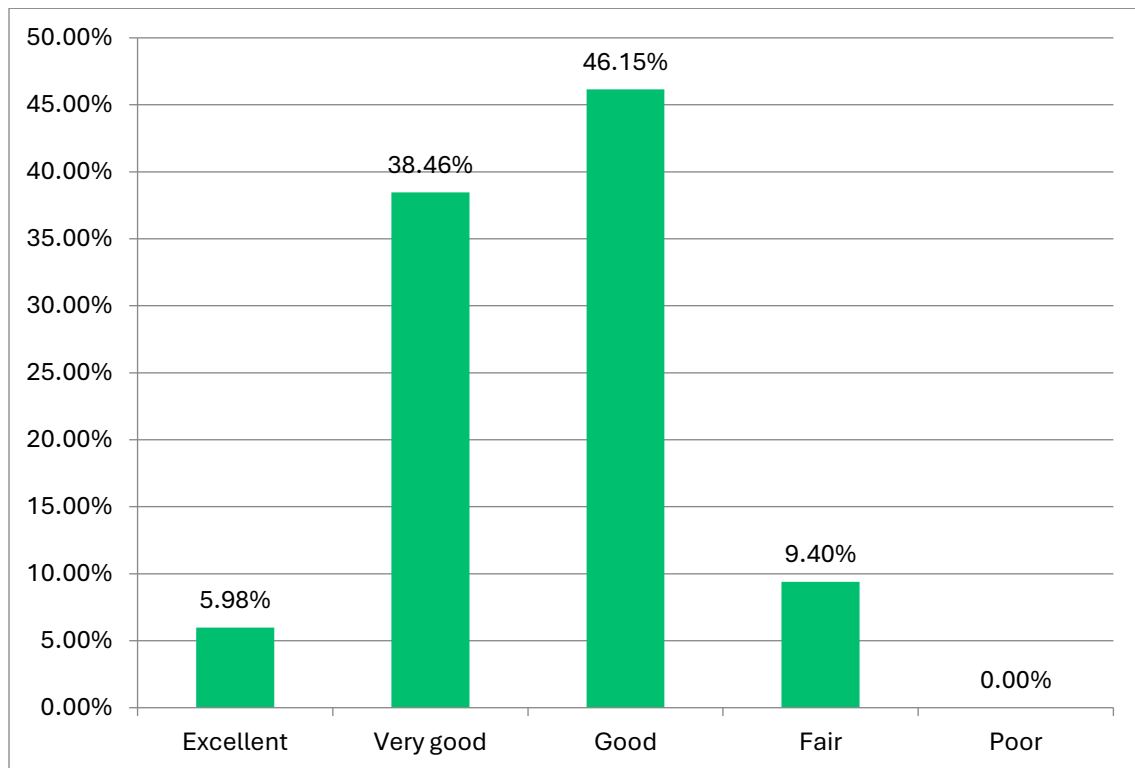
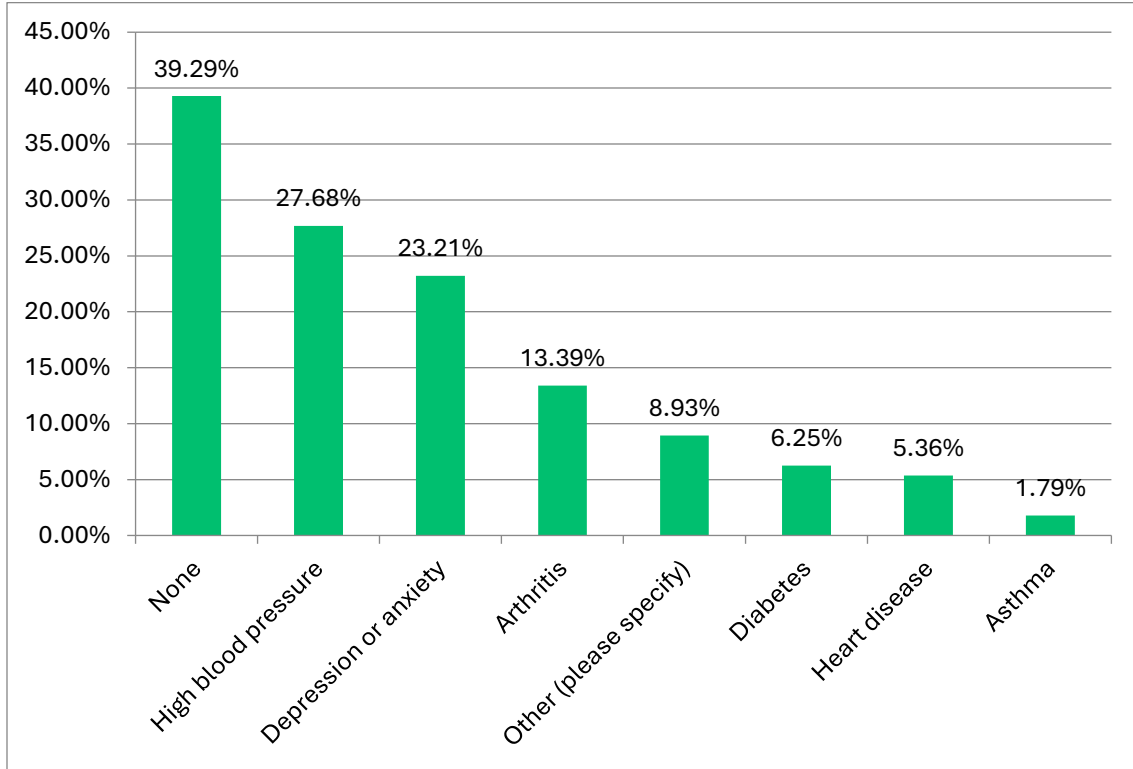


Figure 25: Do you have any chronic conditions (check all that apply)

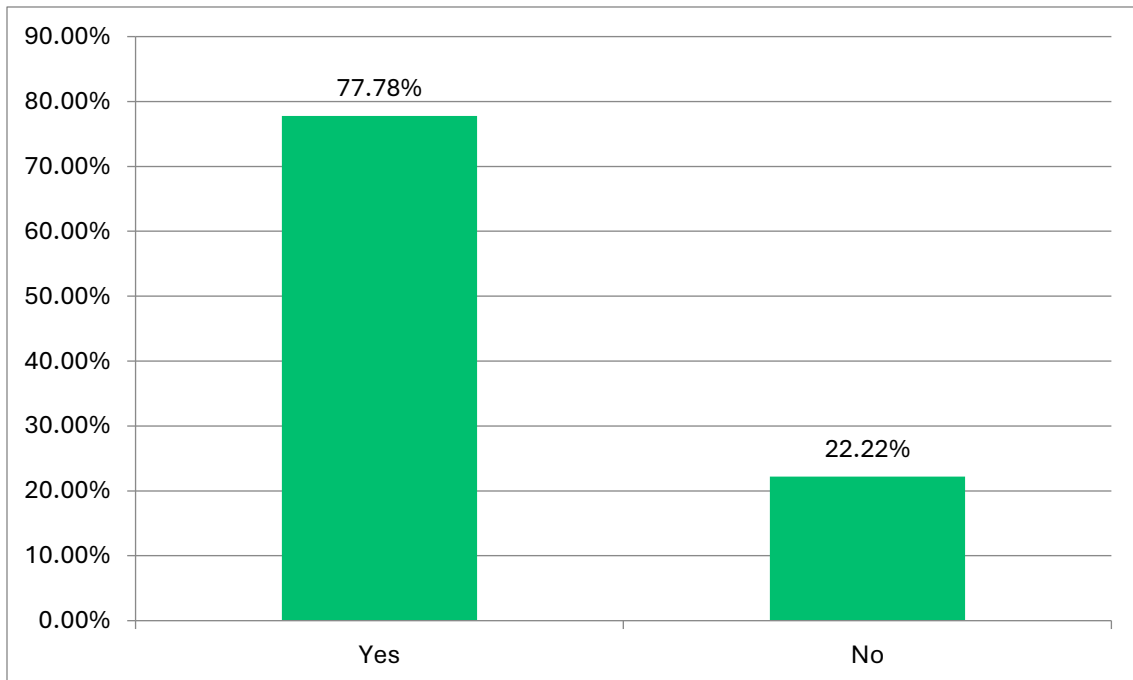
Total responses = 117*



Other responses included, but weren't limited to: chronic migraine, cancer, thyroid issues, ADHD, Rheumatoid disease, and high cholesterol.

Figure 26: Do you have a primary care physician?

Total responses = 117

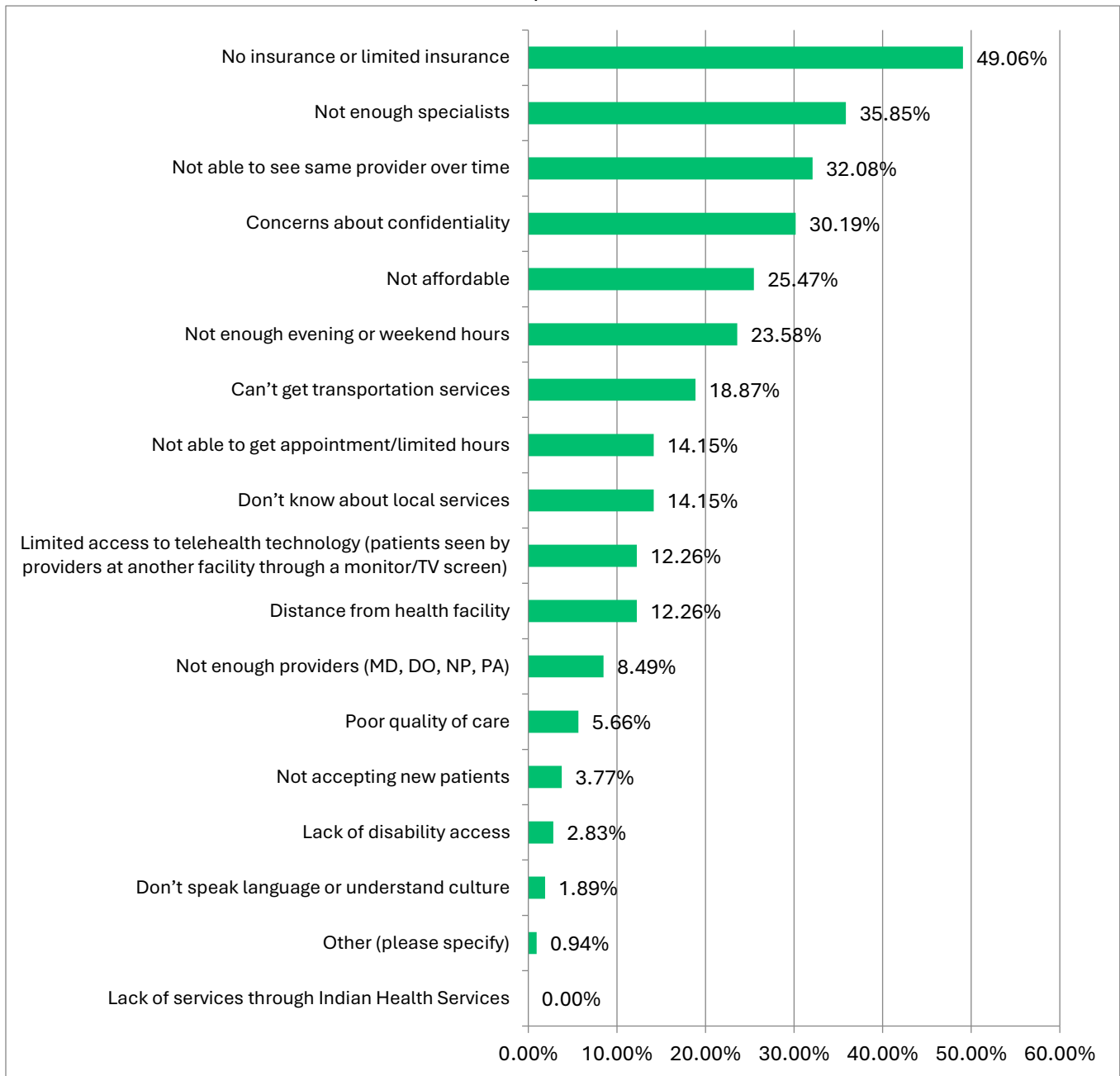


The survey asked residents what they see as barriers that prevent them, or other community residents, from receiving healthcare. The most prevalent barrier perceived by residents was no insurance or limited insurance (N=52), not enough specialists (N=38), and not able to see the same provider over time (N=34). After these, the next most commonly identified barriers were concerns about confidentiality (N=32), not affordable (N=27), and not enough evening or weekend hours (N=25). The concern in the “Other” category was that many elderly have cognitive and physical issues that prevent them from being able to understand what they need to do to maintain/follow-up on health issues or get to appointments.

Figure 27 illustrates these results.

Figure 27: Perceptions about Barriers to Care

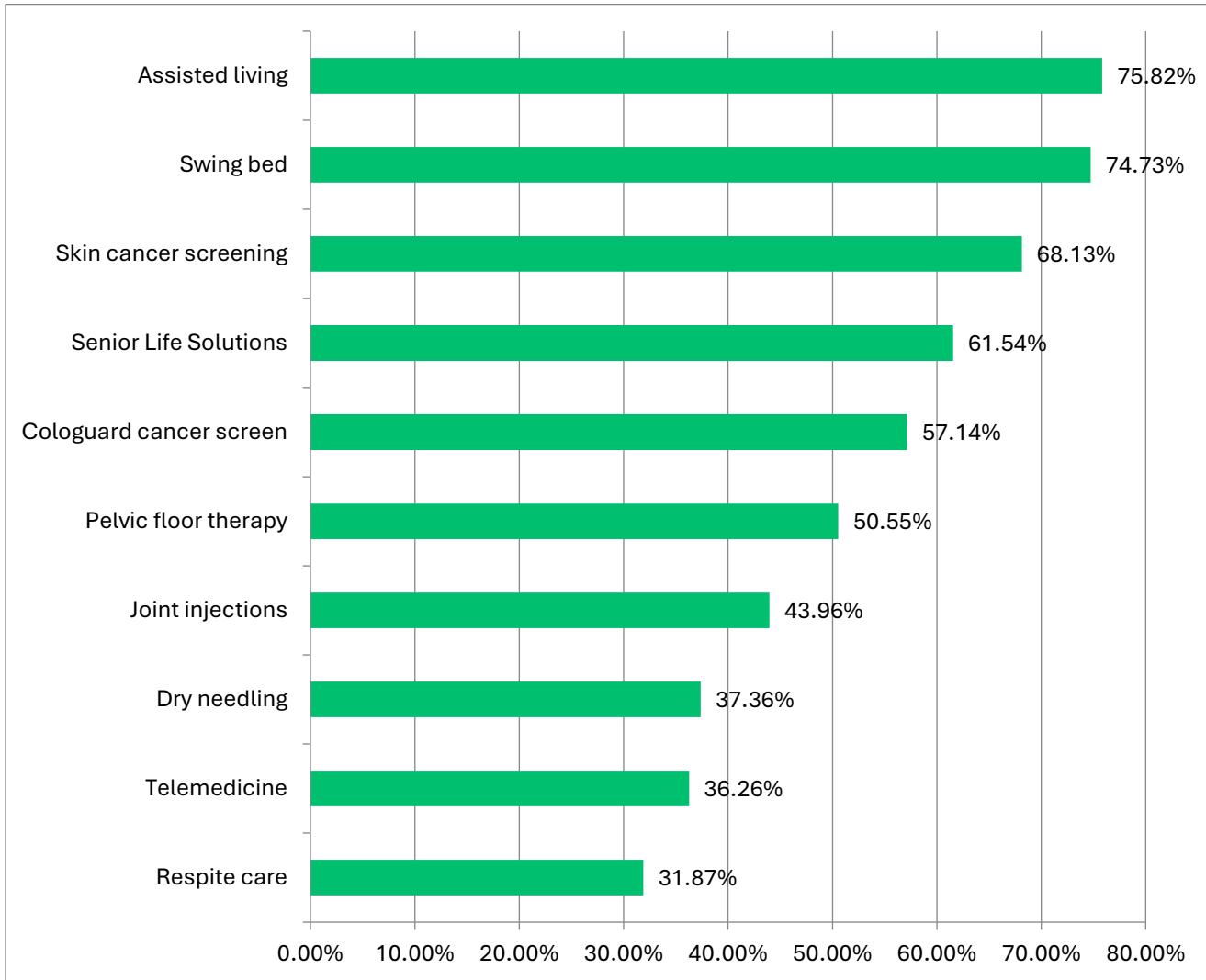
Total responses = 106*



Survey takers were asked to consider services offered at St. Luke’s Medical Center, and then indicate which services they are aware of or have used in the past year. Assisted living and swing bed with the most recognized services. See Figure 28 for the full list.

Figure 28: Services Utilized/Aware of at St. Luke's

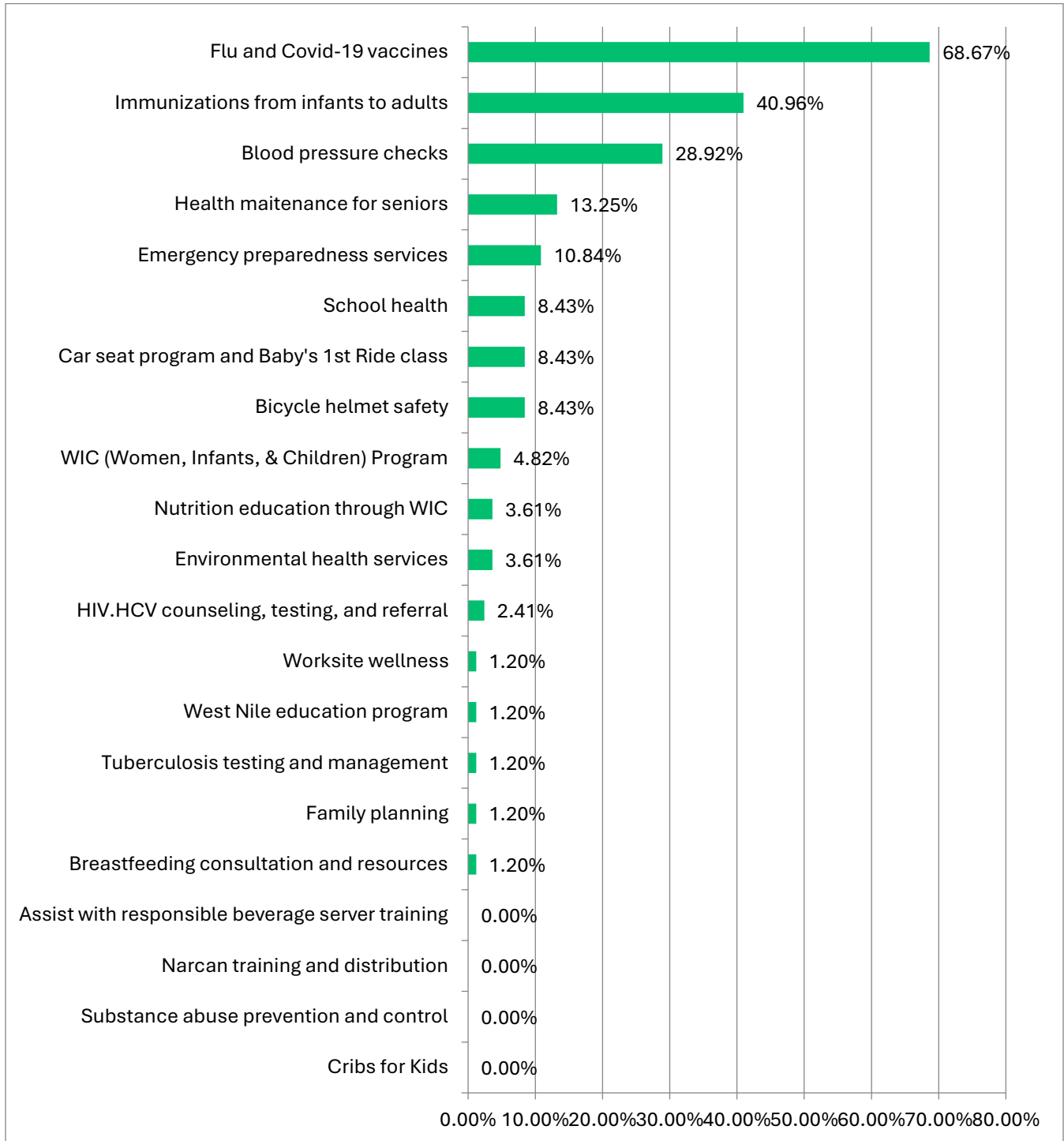
Total responses = 91*



Similarly, survey takers were asked to consider services provided by Upper Missouri District Health Unit, and then indicate which services they or their family have utilized in the past year. The top utilization was for flu and COVID-19 shots, followed by immunizations and then blood pressure checks. See Figure 29.

Figure 28: UMDHU Services Utilized in the Past Year

Total responses = 83*



In an open-ended question, respondents were asked what specific healthcare services, if any, they think should be added locally. The most desired service to add locally was mental/behavioral health services. This includes substance abuse treatment and mental health medication management. The next most requested was optometry services. Other requested services included:

- Women's health
- Dentist
- More specialists (dermatology, podiatry, sports physician, cardiology, pulmonology, etc.)

- Adult seminars/trainings on health
- Diabetes management
- CT
- MRI
- Sleep studies
- Walk in clinic hours for nights and weekends
- IV infusion therapy for specialty meds

A full list of survey responses is provided in Appendix B.

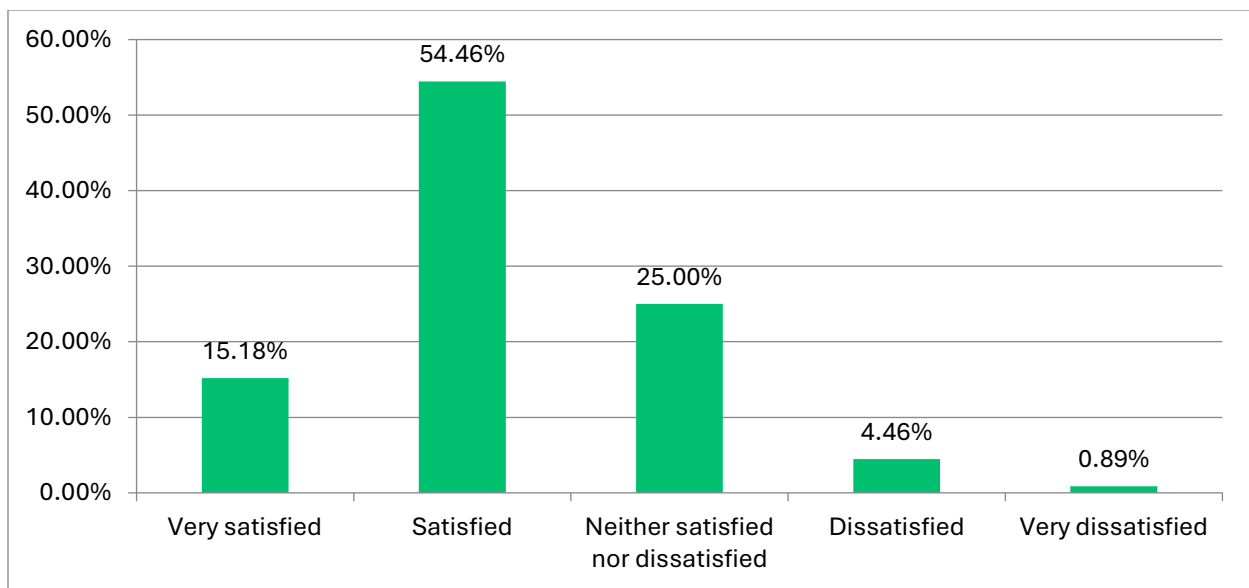
The key informant and community group members felt that dialysis and mental health services and substance use disorder treatment would be good services to add to the community. Daycare continues to be difficult to find locally. Additional ideas of services to add include addiction treatment (i.e. gambling), a family liaison to assist families in need to help them connect to services and ensuring they follow-through, and therapeutic groups, such as bereavement, parent with addiction, incarcerated family.

The key informant and focus group members felt that the community members were aware of the majority of the health system services but had mixed opinions of whether the public health services were widely known throughout the service area. A service that was felt the hospital should increase marketing efforts on was well-child visits. Following COVID, some felt that people forgot that their children should be receiving these annually. Also, promotion of adult wellness exams, especially to the young adults would be beneficial. The Employee Assistance Program is another service that could utilize additional promotion to St. Luke’s staff.

Survey respondents rated how satisfied they are with the healthcare services in their community from very satisfied to very dissatisfied. The majority of respondents were satisfied.

Figure 29: Satisfaction with the Community’s Healthcare Services

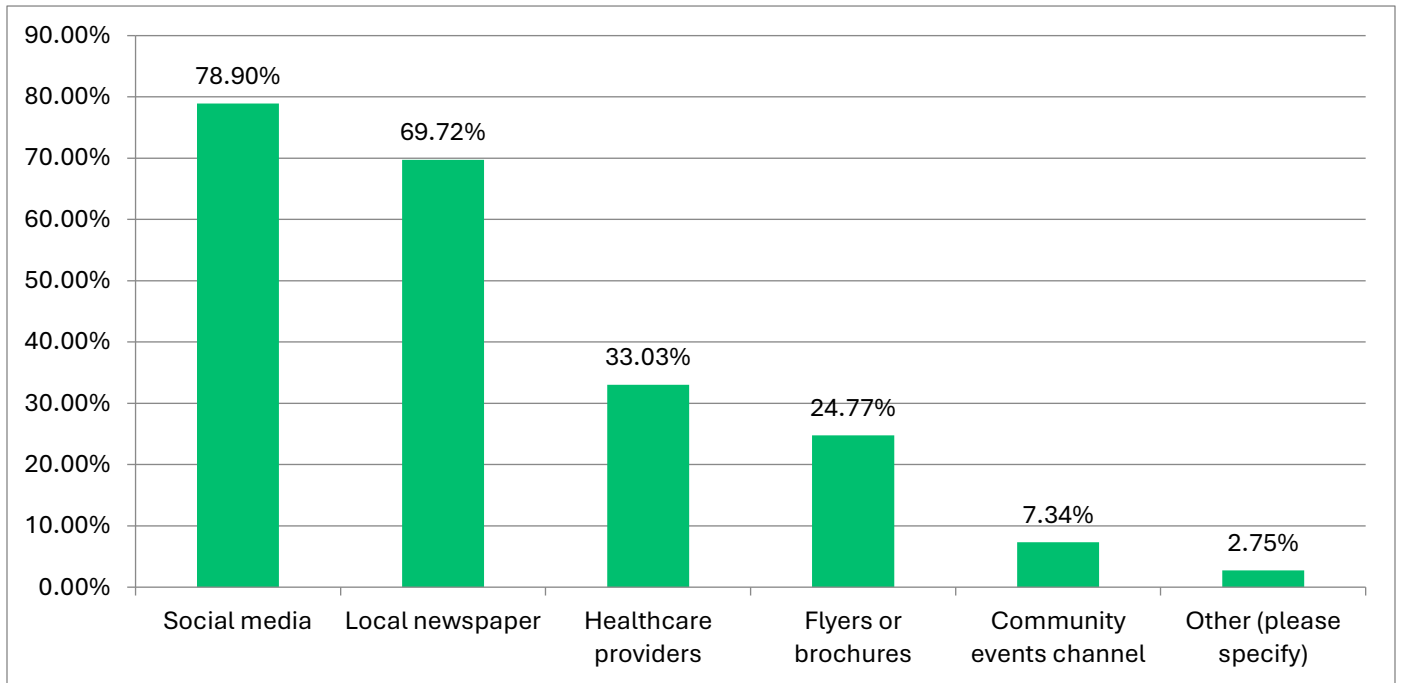
Total responses = 112



When asked what the best way for you to receive information about health services and resources, respondents indicates social media followed by local newspaper as the top sources. Figure 30 illustrates these results. Other responses included community resources page, their child, newsletter, email, and text messages.

Figure 30: Best Way to Receive Information about Health Services and Resources

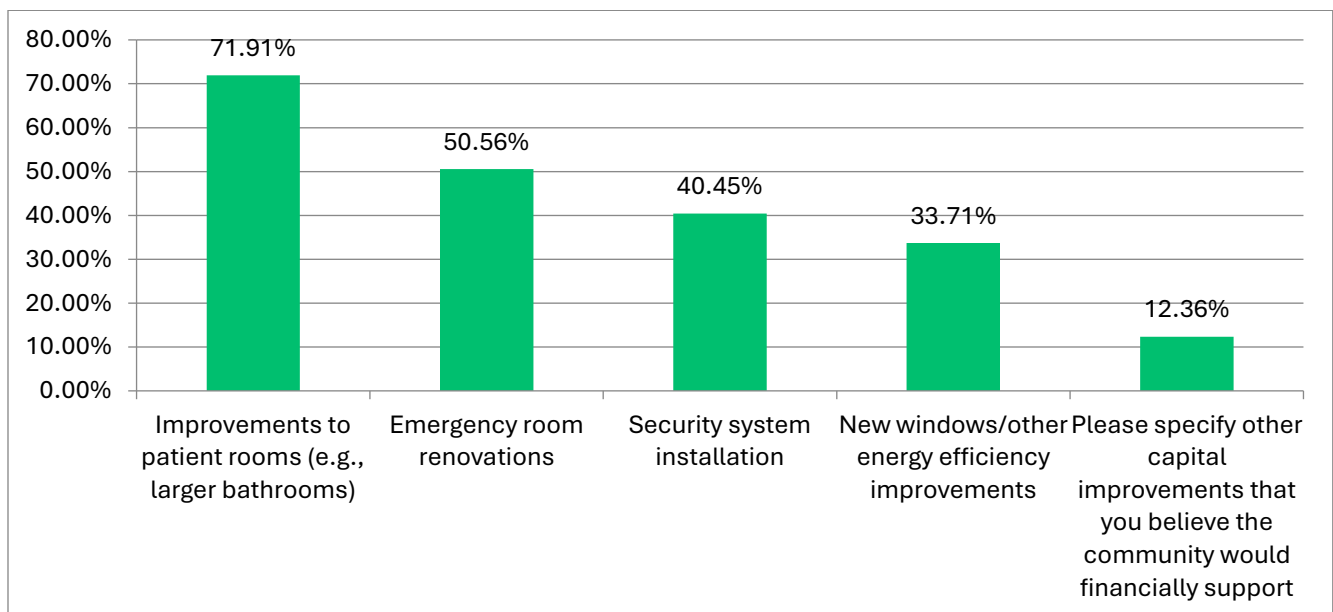
Total responses = 109*



In an effort to gauge how individuals in the community would financially support capital improvements by St. Luke’s Medical Center, a question was asked that provided options for people to choose ways that they believed the community would be financially supportive (see Figure 31).

Figure 31: Financial Support for Capital Improvements by St. Luke’s

Total responses = 89



Other types of capital improvements that were recommended were: equipment to add services, full time health care provider, ultrasound, CT scanner, indoor/outdoor cameras, more seminars/trainings with wellness (speakers), occupational therapy facility, larger living room and activity room space for Living Center residents, higher toilets, alarm that sounds when patient walks from long-term care hall to notify staff, and all private rooms.

The final question on the survey asked respondents to share concerns and suggestions to improve the delivery of local healthcare. Only 12 responses were received, and a quarter of those indicated that they were happy with how things were going.

Recommendations for changes included adding access to telehealth for working patients due to limited appointment hours as well as adding access to migraine treatment and specialists. Additional education was requested for the providers so they can keep up with advanced treatments that are available to help keep the patients locally. Suggestions of adding a CT scanner, a radiology technologist, a gynecologist, and a full-time doctor were provided.

There was a concern with the slow emergency response time.

Finally, they noted that St. Luke's should continue improving and maintaining access to care as well as retaining local doctors.

Findings from Key Informant Interviews & the Focus Group

Questions about the health and well-being of the community, similar to those posed in the survey, were explored during key informant interviews with community leaders and health professionals and also with the focus 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 focus group can be grouped into four categories (listed in alphabetical order):

- Depression/anxiety – all ages
- Alcohol use and abuse – youth and adult
- Long-term/nursing home care options and costs
- Availability of home health

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

Depression/anxiety

- Mental health issues need to be addressed.
- This was the top concern last CHNA, had a telehealth provider at one time and was used a lot and now don't have that available. Mental health care is a big need in the surrounding area. Mental health is more recognized and a bigger concern now. Have some good services, but more are needed.
- Stress, anxiety, depression – life is stressful and this includes kids, which is scary to have them under so much stress at such a young age.
- Talking about mental health still has a stigma, especially in a small community, even though it has improved. Once you get that label it doesn't go away.
- There is a need for therapeutic support groups for teens where they feel comfortable sharing.
- Parents need mental health support and are unwilling or unable to get the help they need.

- There is a lack of mental health providers – only two in the county with a huge waiting list and telehealth doesn't work well for kids.

Alcohol use and abuse

- This is a problem for both youth and adults.
- Significant alcoholism rate in ND goes hand in hand with mental health. People have an “I'm going to handle it myself” mentality.
- Alcohol in the community affects everything and it is a problem here. See a lot of kids drinking at a young age because that is the norm here. Family cycle of alcoholism.

Long-term/nursing home care options and costs

- People have to leave because there are no local options and can't afford to stay in assisted living. The distance they have to move is getting pretty far away.
- Cost for nursing homes isn't controlled by the facility, they can't pick the rates and the rates keep going up.

Availability of home health

- Very limited (1 employee at social services, a couple in Columbus). Most of those services are self-pay, insurance won't cover it, which is a problem for many.
- Need to have more Qualified Service Providers to help. Make process to be certified easier – it is difficult to get the qualification.
- People want to age in place but don't have the services available to be able to keep them in their home.

Community Engagement and Collaboration

Key informants and focus group participants were asked to weigh in on community engagement and collaboration of various organizations and stakeholders in the community. Specifically, participants were asked, “On a scale of 1 to 5, with 1 being no collaboration/community engagement and 5 being excellent collaboration/community engagement, how would you rate the collaboration/engagement in the community among these various organizations?” This was not intended to rank services provided. They were presented with a list of 13 organizations or community segments to score. According to these participants, the hospital, pharmacy, public health, and other long-term care (including nursing homes/assisted living) are the most engaged in the community. The averages of these scores (with 5 being “excellent” engagement or collaboration) were:

- Law enforcement (4.21)
- Business and industry (4.18)
- Long-term care, including nursing homes and assisted living (4.12)
- Faith-based (4.0)
- Hospital (healthcare system) (3.92)
- Economic development organizations (3.84)
- Emergency services, including ambulance and fire (3.84)
- Schools (3.63)
- Public health (3.59)
- Human/Social Services (3.53)

- Other local health providers, such as dentists and chiropractors (2.79)
- Pharmacy (2.5)

Limitations

The Community Survey results are meant to represent the opinions and needs of the general population in St. Luke's service area. This survey used a convenience sampling method as it was distributed and made broadly available throughout the service area. It should be noted that when looking at survey demographics, most respondents were white females. Nearly half had at least a bachelor's degree or higher. Most respondents were also fully employed and over half reported income exceeding \$74,999. As a convenience sampling method was employed, data findings may not necessarily represent the entire community.

Prioritization of Health Needs

A community group composed of those that attended the first community meeting as well as the key informants met on February 5, 2025. Twelve community members attended the meeting. A facilitator from Cibolo Health presented the group with a summary of this report's findings, including background and explanation about the secondary data, highlights from the survey results (including perceived community assets and concerns, and barriers to care), and findings from the key informant interviews.

Following the presentation of the assessment findings, and after considering and discussing the findings, all members of the group were asked to identify what they perceived as the top four community health needs. All of the potential needs were listed and attendees noted their four items of biggest concern.

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

- Depression/anxiety (9 votes)
- Alcohol use and abuse (8 votes)
- Availability of mental health services (6 votes)
- Having enough child daycare services (5 votes)
- Availability of substance use disorder treatment services (4 votes)
- Availability of specialists (4 votes)
- Availability of resources to help the elderly stay in their homes (4)

The community group chose to combine availability of mental health services, availability of substance use disorder treatment services, alcohol use and abuse, and depression/anxiety into "Mental health and addiction services."

From those four three priorities, each attendee voted on the one item they felt was the most important to address in the next three years. The rankings were:

1. Mental health and addiction services (10 votes)
2. Availability of specialists (5 votes)
3. Having enough child daycare services (2 votes)
4. Availability of resources to help the elderly stay in their homes (0)

Upon completion of the prioritization process, the number one identified need, as voted on by those attending the second community meeting, was the availability of mental health and addiction services. A summary of this prioritization may be found in Appendix I.

Comparison of Needs Identified Previously

Top Needs Identified 2022 CHNA Process	Top Needs Identified 2025 CHNA Process
Depression/anxiety – all ages	Mental health and addiction services (10 votes)
Bullying/cyberbullying	Availability of specialists (5 votes)
Alcohol use and abuse – all ages	Having enough child daycare services (2 votes)
Availability of mental health and substance use disorder treatment services	Availability of resources to help the elderly stay in their homes
Availability of resources to help the elderly stay in their homes.	

The current process did identify a couple of the same concerns from the previous cycle. The availability of mental health and addiction services, which includes depression/anxiety, alcohol use and abuse, and availability of mental health and substance use disorder treatment services combined. Also from the 2022 CHNA process was the availability of resources to help the elderly stay in their homes.

St. Luke’s Medical Center invited written comments on the 2022 CHNA report and implementation strategy both in the documents and on the website where they are widely available to the public. No written comments have been received.

Upon adoption of this CHNA Report by the St. Luke’s Medical Center Board vote, a notation will be documented in the board minutes reflecting the approval and then the report will be widely available to the public on the hospital’s website, and a paper copy will be available for inspection upon request at the hospital. Written comments on this report can be submitted to St. Luke’s Medical Center.

Hospital and Community Projects and Programs Implemented to Address Needs Identified in 2022

In response to the needs identified in the 2022 CHNA process, the following actions were taken:

Need 1: Depression/anxiety – all ages – Since the last CHNA process, St. Luke’s Hospital has partnered with Psychiatric Medical Care to launch Senior Life Solutions. This program provides outpatient mental health treatment for seniors. Employees of Senior Life Solutions spend significant time doing community outreach and mental health education for community members of all ages. In partnering with Senior Life Solutions, St. Luke’s has increased social media posts to spread awareness, educate, and provide support to those with depression and anxiety.

St. Luke’s has also started utilizing Rural Psychiatry Associates for residents or patients with complex mental health needs. These patients are seen by Rural Psychiatry Associates providers via telehealth.

Need 2: Bullying/cyberbullying – An assembly was held at Divide County Elementary School titled ‘Hashtag Big Bad Bully’. This interactive presentation educated students on the effects of bullying and how to stop it. Each student received a Big Bad Bully Book and was asked to sign a pledge against bullying.

Need 3: Alcohol use and abuse – all ages – St. Luke’s continues to utilize an employee assistance program (EAP) through CHI to provide free counseling to St. Luke’s employees and their immediate family members. Since the last CHNA, efforts have been made to increase awareness and to promote the use of this program.

Need 4: Availability of mental health and substance use disorder treatment services – The Senior Life Solutions Program is located inside of St. Luke’s Medical Center and serves patients throughout our service area. The utilization of Rural Psychiatry Associates has provided mental health treatment for residents who have limited transportation options.

Need 5: Availability of resources to help the elderly stay in their homes – Resources were directed towards the other identified needs/concerns.

The 2022-20224 implementation plan for St. Luke’s Medical Center is posted on the St. Luke’s website at <https://www.dcstlukes.org>.

Recommendations and Action Plan

Within five months and 15 days, an implementation plan mapping out how the community will address the findings of the CHNA has to be approved by the St. Luke’s Medical Center board of directors. Although a CHNA and strategic implementation plan are required by hospitals and accredited local public health units, 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 next step is to convene the steering committee, or other community group that includes those that will be valuable in enacting changes, to outline the path that will be taken to implement change to improve the health of the community. A 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.

All activities proposed in the implementation plan will need to be monitored and evaluated to see if the plan is working or if modifications need to be made. The implementation plan is a starting place, it will need to be refined as you travel through the three years of application.

Appendix A – Community Survey Instrument

St. Luke's Medical Center Service Area Health Survey

Community Health Needs Assessment

St. Luke's Medical Center and Upper Missouri District Health Unit are interested in hearing from you regarding the community health needs in your area. A Community Health Needs Assessment (CHNA) survey is designed to gather information about the health needs and priorities of a community. It is important that we have the thoughts of those within the community providing their opinions. These questions help identify the health needs of the community, the barriers to accessing healthcare, and the resources that are most needed. The survey results are then used to inform community health improvement plans and strategies.

Surveys will be tabulated by Cibolo Health (<https://cibolohealth.com/>). Your responses are completely 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 aggregate. If you have questions about the survey or the process, please contact Kylie Nissen at kylie.nissen@cibolohealth.com or 701.330.0464.

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):

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

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

- | | |
|---|---|
| <input type="checkbox"/> Access to healthy food | <input type="checkbox"/> Opportunities for advanced education |
| <input type="checkbox"/> Active faith community | <input type="checkbox"/> Public transportation |
| <input type="checkbox"/> Business district (restaurants, availability of goods) | <input type="checkbox"/> Programs for youth |
| <input type="checkbox"/> Community groups and organizations | <input type="checkbox"/> Quality school systems |
| <input type="checkbox"/> Healthcare | |
| <input type="checkbox"/> Other (please specify) | |

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

- | | |
|--|--|
| <input type="checkbox"/> Closeness to work and activities | <input type="checkbox"/> Job opportunities or economic opportunities |
| <input type="checkbox"/> Family-friendly; good place to raise kids | <input type="checkbox"/> Safe place to live, little/no crime |
| <input type="checkbox"/> Informal, simple, laidback lifestyle | |
| <input type="checkbox"/> Other (please specify) | |

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

- | | |
|--|---|
| <input type="checkbox"/> Activities for families and youth | <input type="checkbox"/> Recreational and sports activities |
| <input type="checkbox"/> Arts and cultural activities | <input type="checkbox"/> Year-round access to fitness opportunities |
| <input type="checkbox"/> Local events and festivals | |
| <input type="checkbox"/> Other (please specify) | |



UPPER MISSOURI
DISTRICT HEALTH UNIT
Your local health professionals



St. Luke's Medical Center Service Area Health Survey

Community Concerns

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):

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

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

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

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

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

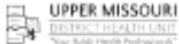
8. Considering the **ADULT POPULATION** in your community, concerns are (choose up to **THRE E**):

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

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

- | | |
|---|---|
| <input type="checkbox"/> Ability to meet needs of older population | <input type="checkbox"/> Availability of transportation for seniors |
| <input type="checkbox"/> Long-term/nursing home care options | <input type="checkbox"/> Availability of home health |
| <input type="checkbox"/> Assisted living options | <input type="checkbox"/> Not getting enough exercise/physical activity |
| <input type="checkbox"/> Availability of resources to help the elderly stay in their homes | <input type="checkbox"/> Dementia/Alzheimer's disease |
| <input type="checkbox"/> Cost of activities for seniors | <input type="checkbox"/> Depression/anxiety |
| <input type="checkbox"/> Availability of activities for seniors | <input type="checkbox"/> Suicide |
| <input type="checkbox"/> Availability of resources for family and friends caring for elders | <input type="checkbox"/> Alcohol use and abuse |
| <input type="checkbox"/> Quality of elderly care | <input type="checkbox"/> Drug use and abuse (including prescription drug abuse) |
| <input type="checkbox"/> Cost of long-term/nursing home care | <input type="checkbox"/> Elder abuse |
| <input type="checkbox"/> Other (please specify) | |

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



St. Luke's Medical Center Service Area Health Survey

Health Status and Behaviors

11. How would you rate your overall health?

- | | |
|---------------------------------|----------------------------|
| <input type="radio"/> Excellent | <input type="radio"/> Fair |
| <input type="radio"/> Very good | <input type="radio"/> Poor |
| <input type="radio"/> Good | |

12. Do you have any chronic conditions (check all that apply)

- | | |
|---|--|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> Depression or anxiety |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> None |
| <input type="checkbox"/> Arthritis | |
| <input type="checkbox"/> Other (please specify) | |

13. Do you have a primary care physician?

- Yes
- No



St. Luke's Medical Center Service Area Health Survey

Delivery of Healthcare

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

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

15. Considering services offered at St. Luke's Medical Center, which services are you aware of (or have you used in the past year)? (Choose ALL that apply)

- | | |
|--|--|
| <input type="checkbox"/> Cologuard cancer screen | <input type="checkbox"/> Respite care |
| <input type="checkbox"/> Assisted living | <input type="checkbox"/> Telemedicine |
| <input type="checkbox"/> Pelvic floor therapy | <input type="checkbox"/> Skin cancer screening |
| <input type="checkbox"/> Senior Life Solutions | <input type="checkbox"/> Joint injections |
| <input type="checkbox"/> Swing bed | <input type="checkbox"/> Dry needling |

16. Which of the following SERVICES provided by your local PUBLIC HEALTH unit have you or a family member used in the past year? (Choose ALL that apply)

- | | |
|---|---|
| <input type="checkbox"/> Bicycle helmet safety | <input type="checkbox"/> Nutrition education through WIC |
| <input type="checkbox"/> Breastfeeding consultation and resources | <input type="checkbox"/> School health |
| <input type="checkbox"/> Car seat program and Baby's 1st Ride class | <input type="checkbox"/> Substance abuse prevention and control |
| <input type="checkbox"/> Cribs for Kids | <input type="checkbox"/> Narcan training and distribution |
| <input type="checkbox"/> Emergency preparedness services | <input type="checkbox"/> Assist with responsible beverage server training |
| <input type="checkbox"/> Health maintenance for seniors | <input type="checkbox"/> Tuberculosis testing and management |
| <input type="checkbox"/> Environmental health services | <input type="checkbox"/> West Nile education program |
| <input type="checkbox"/> Family planning | <input type="checkbox"/> WIC (Women, Infants, & Children) Program |
| <input type="checkbox"/> HIV/HCV counseling, testing, and referral | <input type="checkbox"/> Worksite wellness |
| <input type="checkbox"/> Flu and Covid-19 vaccines | <input type="checkbox"/> Blood pressure checks |
| <input type="checkbox"/> Immunizations from infants to adults | |

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

18. How satisfied are you with the healthcare services in your community?

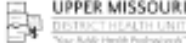
- | | |
|--|---|
| <input type="radio"/> Very satisfied | <input type="radio"/> Dissatisfied |
| <input type="radio"/> Satisfied | <input type="radio"/> Very dissatisfied |
| <input type="radio"/> Neither satisfied nor dissatisfied | |

19. What is the best way for you to receive information about health services and resources? (check all that apply)

- | | |
|---|---|
| <input type="checkbox"/> Local newspaper | <input type="checkbox"/> Healthcare providers |
| <input type="checkbox"/> Social media | <input type="checkbox"/> Flyers or brochures |
| <input type="checkbox"/> Community events channel | |
| <input type="checkbox"/> Other (please specify) | |

20. Do you believe individuals in the community would financially support any of the following capital improvements by St. Luke's Medical Center? (Choose ALL that apply)

- Emergency room renovations
- Security system installation
- New windows/other energy efficiency improvements
- Improvements to patient rooms (e.g., larger bathrooms)
- Please specify other capital improvements that you believe the community would financially support



St. Luke's Medical Center Service Area Health Survey

Demographic Information:

Please tell us about yourself.

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
- Other (please specify)
- Medicare
- No insurance
- Veteran's Healthcare Benefits

22. Age:

- Less than 18 years
- 18-24 years
- 25-34 years
- 35-44 years
- 45-54 years
- 55-64 years
- 65-74 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. Gender:

- 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
- Other (please specify)
- Hispanic/Latino
- Pacific Islander
- White/Caucasian

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 health care.

Thank you for assisting us with this important survey!

Appendix B – Open-Ended Survey Question & Other Responses

Appendix G – Survey “Other” Responses & Open Ended Responses

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

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

- Cheerful
- none of the above
- None of the above

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

- Free transportation for seniors
- I always say how much Crosby has to offer - had to check all the boxes!
- none of the above

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

- Church-Related Activities for Youth and Adults
- NA
- None
- none of the above

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):

- Adults in the community who can't get along for the common good
- high quality dentist, eye dr.
- Lack of night life. Is after 6:00? Everything is closed but the bar.

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

- Drug store employees
- Lack of pharmacy services for the hospital and community on weekends and holidays.
- pharmacy concerns
- Pre/post natal care

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

- A lot of bullying
- Bullying
- bullying by kids
- lack of work ethic/low percentage of youth in workforce

- Social Media, snapchat etc.
- Youth Mental Health to include depression, anxiety, suicidal ideation etc./ Youth Bullying and Cyberbullying/ Lack of an indoor activity space for families and youth to utilize that doesn't include organized sports
- Youth not motivated to work

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

- Cost of living
- Lack of mental health services

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

- Lack of services for elderly who do not need nursing home but would benefit from and cannot afford Assisted Living.

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

- ?
- Access to mental health services
- Access to services
- Affordable housing whether buying or renting
- (2) Alcohol abuse
- Alcohol use/abuse
- assisted living/nursing home/home health
- Bullying, needed help for single parents with one income, kids being unsupervised and not being held accountable for there actions with Bullying and criminal issues
- child care
- (2) Cost of living
- Cost of nursing home and assisted living
- Costs
- Current community leaders with the goal to keep things the same as they were 30 years ago.
- Depression
- finding jobs
- getting placement soon enough for the elderly before they get injured at home
- Getting professional and service people and families here for the available jobs. Plumbing..nurses...even waiter/waitresses! May job openings cannot be filled!
- Getting young families.
- Growth
- Housing that isn't accessible to individuals living with disabilities
- I haven't been here long. There's nothing as far as I know.
- It's all about sports. What about the kids that don't like sports. They are pushed to the side and all the money goes into sports.
- Jobs
- Lack of daycare to be able to work.
- Lack of Mental Health services for all ages.
- Lack of resources to provide services
- Lack of understanding of mental illness and substance abuse

- Location
- long term care
- (2) mental health
- Mental health services and resources for all ages. Addiction resources. Resources for economically disadvantaged families and people in the community.
- Money
- No physical wellness. Not many options for indoor physical activities. Also mental health-alcohol abuse
- No sense of community or pride
- Not enough to draw young families into the area
- Not getting enough physical activity.
- population
- Progressive attitude and goal setting to improve opportunities for rec and work
- Progressive thinking is lacking by most citizens.
- (2) Resources for elderly care
- Retaining farming families
- Sky high Bakken prices
- The recent racist comments from someone in high standing office that is supposed to be for the good of people
- The youth and drug and alcohol and tobacco use
- Too set in their ways. Don't like change.
- Underage tobacco/alcohol use
- We do not have hospice
- Winter Blues
- Younger generation that sometimes involves in illegal activities

Delivery of Healthcare

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

- Many elderly have cognitive and physical issues that prevent them from being able to understand what they need to do to maintain/follow-up on health issues or get to appointments.

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

- Adults 40-60 seminars/training on health (mental, physical, etc.)
- Better doctors
- CT Scan
- Dental, Vision, mental health
- Dermatology
- Diabetes management
- female health doctor
- Gynecologist
- Increased behavioral health services
- IV infusion therapy. Not just fluids but specialty meds

- Mental health providers - all ages
- More mental health services that are affordable for all ages.
- More specialty services where possible.
- MRI, Sports Physician specialist
- Na
- (2) None
- Optometry Dental services that actually provide all services, including cleaning, in Crosby. Well-child visits Podiatry
- Pediatric services
- Pediatrician or OBGYN
- quality occupational therapy facility
- Sexual health for children of all appropriate ages
- Sleep studies
- Substance abuse treatment services, mental health medication management
- Telehealth services for Mental Health.
- Urgent care
- (2) Vision
- Visits from specialties such as OBGYN, cardiology, pulmonology, etc.
- Walk in clinic hours for nights and weekends
- Women's health (hormone checks)

19. What is the best way for you to receive information about health services and resources? (check all that apply)

- community resources page
- my daughter
- newsletter, email, text messages

20. Do you believe individuals in the community would financially support any of the following capital improvements by St. Luke's Medical Center? (Choose ALL that apply)

- Alarm that sounds when patient walk from long care hall to he'll notify staff
- All rooms should be private
- CT Scan
- Equipment to add services
- Full time health care provider. Ultrasound.
- Higher toilets
- Indoor/outdoor cameras
- Larger living room and activity room space for Living Center residents
- more seminars/trainings with wellness (speakers, etc.)
- No. You just redid that whole building.
- Occupational therapy facility

Demographic Information

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

- (2) Aetna
- BCBS
- BCBS supplement
- Self purchase for kid

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

- Access to telehealth for working patients due to limited appointment hours. Access to migraine treatment. Access to specialists.
- Blessed to have what we have! Maybe a full time dr.
- CT Scans
- Education. Educate the providers so they can keep up with advanced treatments that are available to help keep the patients local.
- Gynecologist
- Haven't have a suggestion for now I am satisfied and happy to have a good facility and community
- Hire a Radiologist Technologist.
- Improving and maintaining access to care, retaining local doctors
- Love Facebook posts of whats coming up or new services.
- Not knowledgeable doctors and high prices
- Slow emergency response time
- We are lucky to have healthcare available and it seems like they are trying to bring in new services.

Appendix C – NDDHHS 2024 Child Care Profile

Children Potentially Needing Child Care

	0-2 yrs	3 yrs	4-5 yrs	6-12 yrs	Total
Children in County by Age ¹	93	36	58	213	364
% of Children Ages 0 to 5 with All Parents in the Labor Force ¹					97.0%
% of Children Ages 6 to 13 with All Parents in the Labor Force ¹					74.9%
Children Ages 0 to 5 potentially needing child care due to parents in workforce					187
Children Ages 6 to 12 potentially needing child care due to parents in workforce					134
Capacity of state-licensed child care programs (family, group, center, school-age ³)					108
Current Child Care Assistance Program Recipients Age 0-13					
Percent to which supply meets potential demand					34%

State-Licensed Early Childhood Program Type and Capacity² (2024)

	Family	Group in a home	Group in a facility	Center	Total
Number of Programs	0	1	0	1	2
Licensed Capacity	0	12	0	96	108
Reported Vacancies ⁴	0	0	0	0	0
Programs open before 7:00 a.m.	0	0	0	0	0
Programs open after 6:00 p.m.	0	0	0	0	0
Programs open on Weekends	0	0	0	0	0
Reported Size of Workforce	0	1	0	15	16
State-licensed school-age programs ³	0	with a licensed capacity of			0

Annual Cost of State-Licensed Child Care² (Due to the limited number of programs, rates reflect a regional average)

Age of Child	Home-based Programs		Centers and Group Facilities	
	Average	Highest Rate	Average	Highest Rate
Ages 0 to 17 months	\$9,100	\$10,400	\$11,336	\$14,820
18 to 35 months	\$11,267	\$15,600	\$10,677	\$13,520
Ages 3 to 5	\$11,267	\$15,600	\$10,140	\$13,000
Ages 6 to 12 (Annual costs for school-age children vary greatly based on hours needed.)				

1. 2022 ND Kids Count Fact Book
2. ChildCare Aware® of North Dakota WorkLife Systems Database
3. School-age care numbers reflect programs licensed exclusively as before and after school programs under Early Childhood Services rules. Not all school-age programs are required to be licensed. In addition, many school-age children are enrolled in family/group programs and child carecenters.
4. Vacancies change daily and may not match the location or program characteristics desired by families needing care. A 10% vacancy rate allows families some choice among programs.

Children Potentially Needing Child Care

	0-2 yrs	3 yrs	4-5 yrs	6-12 yrs	Total
Children in County by Age ¹	86	41	69	204	359
% of Children Ages 0 to 5 with All Parents in the Labor Force ¹					82.0%
% of Children Ages 6 to 13 with All Parents in the Labor Force ¹					82.7%
Children Ages 0 to 5 potentially needing child care due to parents in workforce					196
Children Ages 6 to 12 potentially needing child care due to parents in workforce					182
Capacity of state-licensed child care programs (family, group, center, school-age ³)					30
Current Child Care Assistance Program Recipients Age 0-13					
Percent to which supply meets potential demand					8%

State-Licensed Early Childhood Program Type and Capacity² (2024)

	Family	Group in a home	Group in a facility	Center	Total
Number of Programs	0	0	1	0	1
Licensed Capacity	0	0	30	0	30
Reported Vacancies ⁴	0	0	0	0	0
Programs open before 7:00 a.m.	0	0	0	0	0
Programs open after 6:00 p.m.	0	0	0	0	0
Programs open on Weekends	0	0	0	0	0
Reported Size of Workforce	0	0	5	0	5
State-licensed school-age programs ³	0	with a licensed capacity of			0

Annual Cost of State-Licensed Child Care² (Due to the limited number of programs, rates reflect a regional average)

Age of Child	Home-based Programs		Centers and Group Facilities	
	Average	Highest Rate	Average	Highest Rate
Ages 0 to 17 months	\$8,371	\$10,400	\$9,353	\$12,870
18 to 35 months	\$8,134	\$10,400	\$8,930	\$12,740
Ages 3 to 5	\$7,898	\$10,400	\$8,623	\$12,610
Ages 6 to 12 (Annual costs for school-age children vary greatly based on hours needed.)				

Children Potentially Needing Child Care

	0-2 yrs	3 yrs	4-5 yrs	6-12 yrs	Total
Children in County by Age ¹	2338	756	1552	4422	8312
% of Children Ages 0 to 5 with All Parents in the Labor Force ¹					58.7%
% of Children Ages 6 to 13 with All Parents in the Labor Force ¹					80.0%
Children Ages 0 to 5 potentially needing child care due to parents in workforce					4646
Children Ages 6 to 12 potentially needing child care due to parents in workforce					3328
Capacity of state-licensed child care programs (family, group, center, school-age ³)					1529
Current Child Care Assistance Program Recipients Age 0-13					
Percent to which supply meets potential demand					19%

State-Licensed Early Childhood Program Type and Capacity² (2024)

	Family	Group in a home	Group in a facility	Center	Total
Number of Programs	7	10	12	14	43
Licensed Capacity	54	157	334	984	1529
Reported Vacancies ⁴	0	15	30	19	64
Programs open before 7:00 a.m.	0	1	1	2	4
Programs open after 6:00 p.m.	0	2	1	2	5
Programs open on Weekends	0	1	0	2	3
Reported Size of Workforce	6	18	64	172	260
State-licensed school-age programs ³	0	with a licensed capacity of			0

Annual Cost of State-Licensed Child Care²

Age of Child	Home-based Programs		Centers and Group Facilities	
	Average	Highest Rate	Average	Highest Rate
Ages 0 to 17 months	\$10,896	\$15,600	\$13,971	\$16,900
18 to 35 months	\$9,951	\$12,220	\$12,848	\$15,600
Ages 3 to 5	\$9,833	\$12,220	\$12,372	\$15,600
Ages 6 to 12 (Annual costs for school-age children vary greatly based on hours needed.)				

1. 2022 ND Kids Count Fact Book
2. ChildCare Aware® of North Dakota WorkLife Systems Database
3. School-age care numbers reflect programs licensed exclusively as before and after school programs under Early Childhood Services rules. Not all school-age programs are required to be licensed. In addition, many school-age children are enrolled in family/group programs and child carecenters.
4. Vacancies change daily and may not match the location or program characteristics desired by families needing care. A 10% vacancy rate allows families some choice among programs.

Appendix D – St. Luke’s CAH Profile



Critical Access Hospital Profile Spotlight on: Crosby, North Dakota

St. Luke's Hospital

CEO: Jody Nelson

Chief of Medical Staff:
Dr. Benjamin Krogh

Board President:
Jerry King

City Population:
1,023 (2024 estimate)¹

County Population:
2,101 (2024 estimate)¹

**County Median Household
Income:**
\$95,938 (2022)

County Median Age:
44 (2022)

Service Area Population:
3,814

Owned by: Nonprofit

Hospital Beds: 20

Trauma Level: V

**Critical Access Hospital
Designation:** 2002

Mission:

The mission of St. Luke's Hospital and Clinics is to provide comprehensive and compassionate healthcare for individuals and families in cooperation with the area medical community.

County: Divide

Address: 702 1st Street Southwest, Crosby, ND 58730

Phone: (701) 965-6384

Fax: (701) 965-4258

Web: www.dcstlukes.org

Our vision is to be recognized as a community leader by delivering quality healthcare through a team of dedicated professionals in a friendly, compassionate, and growing environment.

- To improve spiritual, mental and physical aspects and quality of life for individuals and families.
- To develop high quality management, staff, and policy making that promotes a health working environment.
- To conduct our mission of healthcare in an ethical manner by complying with all applicable laws and regulations.
- To maintain a viable and profitable healthcare system.
- To be a primary resource for information about healthcare.
- To foster growth and adapt to healthcare changes.
- To be a patient-focused organization providing exceptional care with respect and compassion.
- To be contributors to the community through health awareness education.

St. Luke's Hospital is a 20-bed Critical Access Hospital (CAH) located in Crosby, North Dakota. The hospital also operates a clinic in Crosby, North Dakota. St. Luke's Hospital's service area consists of Divide, Burke, and Northern Williams County in northwestern North Dakota. St. Luke's provides needed medical services in the areas of acute, outpatient, and extended care. The core values of St. Luke's hospital are respect, compassion, stewardship, integrity, and justice. The hospital is recognized by the state of North Dakota as a non-profit organization and has been recognized by the Internal Revenue Service as exempt from Federal Income Taxes under Internal Revenue Section 501(c)(3). The hospital is governed by a community Board of Directors consisting of nine elected directors. The hospital is recognized by the state and federal government as a CAH. St. Luke's is also a National Health Service Corp location.

Services:

St. Luke's Hospital provides the following services directly:

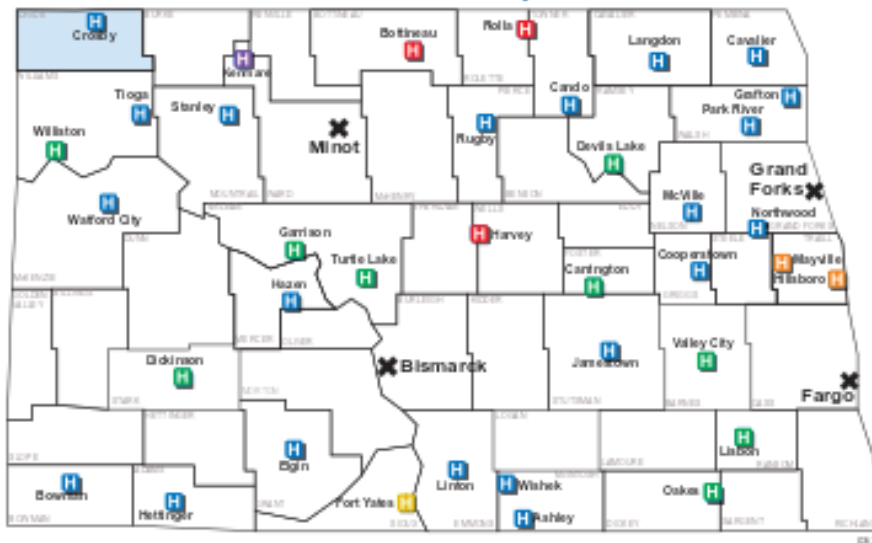
- Emergency services
- General medical surgical care
- Health screenings
- Lab and X-ray
- Meals on Wheels
- Other special care
- Outpatient surgery
- Patient representative services
- Physical rehabilitation outpatient services
- Pediatric medical care
- Swing bed services
- Trauma center (level 5)

Services:

Services provided through contract or agreement:

- Additional lab services not provided in house
- Anesthesia
- CT scans
- Hearing screenings
- Occupational therapy
- Physical therapy
- Speech therapy
- Ultra-sound
- Sleep studies
- Mental Health Therapy for seniors

North Dakota Critical Access Hospitals



Hospital Ownership

- Independently owned
- CommonSpirit Health
- Sanford Health
- Sisters of Mary of the Presentation Health System
- Trinity
- Indian Health Services

History

Mr. Renhard Hering homesteaded the present site of land where St. Luke's Hospital is located in 1904. In 1914, it was surveyed as Hering Addition to the City of Crosby. Dr. Blake Lancaster erected and operated the original brick structure as a medical and surgical facility from 1915 to 1917, at which time M. Allen Person purchased the property from Dr. Lancaster and leased the building for apartments.

When the Benedictine Sisters of Sacred Heart Priority, Richardton, North Dakota, bought the building in 1938 from Mr. Person, it just had the basement and the first floor furnished; the second floor was just a "shell." For four years the Sisters operated it as St. Joseph's Home for the Aged. By 1941, the City of Crosby had grown to the extent that the townspeople and the surrounding communities realized their need for a hospital and urged the Sisters to convert the Home into a hospital; which they did, opening the doors on February 11, 1942. At this time, the name changed to St. Luke's Hospital. In 1965, the moved into a new 25-bed facility, as the old one would no longer meet the requirements of the ND Department of Health.

The Benedictine Sisters of Sacred Heart Priority transferred ownership and operation of the hospital to the Crosby community and area on July 1, 1984. It continues to be operated as a non-profit institution.



Staff

Physicians: 1
 PAs: 3
 RNs: 2
 LPNs: 13
 CNA's: 18
 Total Employees: 106

Sources

¹ US Census Bureau; American Factfinder; Community Facts



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

ruralhealth.und.edu

Updated 10/2024

Appendix E – Towner County Brief Economic Impact



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



Economic Impact

St. Luke's Medical Center is composed of a Critical Access Hospital (CAH), a rural health clinic, and a 35-bed skilled nursing facility.

St. Luke's Medical Center **directly** employs **91 FTE employees** with an annual payroll of **\$6.22 million** (including benefits).

- After application of the employment multiplier of 1.35, these employees created an additional **32 jobs**.
- The same methodology is applied to derive the income impact. The income multiplier of 1.18 is applied to create more than **\$1.12 million** in income as they interact with other sectors of the local economy.
- **Total impacts = 123 jobs and more than \$7.34 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

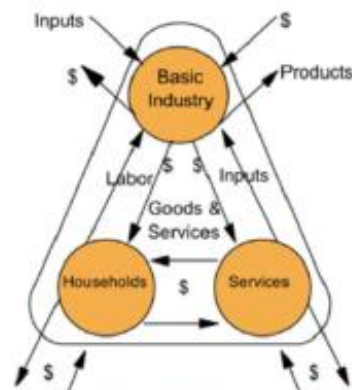
- Attracts retirees and families
- Appeals to businesses looking to establish and/or relocate
- High quality healthcare services and infrastructure foster community development
- Positive impact on retail sales of local economy
- Provides higher-skilled and higher-wage employment
- Increases the local 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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kylie.nissen@und.edu • (701) 777-5380

Figure 1. An overview of the community economic system.



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



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 F - County Health Rankings Explained

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

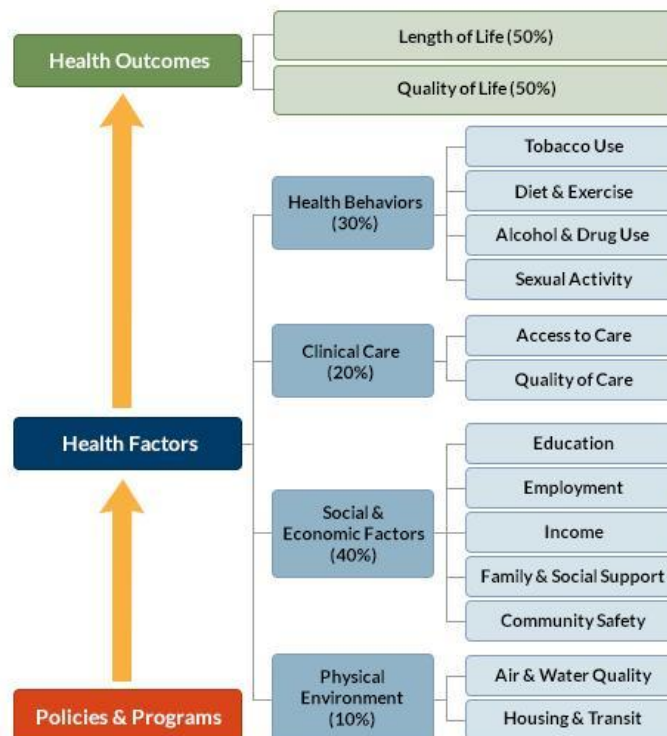
Methods

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 G – North Dakota KIDS COUNT

[View State Profile](#)

Select a county on the map below:



Light blue shading shows the five American Indian reservations within North Dakota.

North Dakota County Profiles Divide County

Population Estimates for: 2022	Divide	North Dakota
Child Population (under 18):	527	182,775
American Indian/Alaska Native:	1.8%	8.0%
Black:	3.7%	4.9%
White:	84.6%	79.9%
2+ Races or Other:	9.9%	7.3%



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[View State Profile](#)

Select a county on the map below:



Light blue shading shows the five American Indian reservations within North Dakota.

North Dakota County Profiles

Burke County

Population Estimates for: 2022	Burke	North Dakota
Child Population (under 18):	533	182,775
American Indian/Alaska Native:	1.4%	8.0%
Black:	1.4%	4.9%
White:	92.7%	79.9%
2+ Races or Other:	4.5%	7.3%



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[View State Profile](#)

Select a county on the map below:



Light blue shading shows the five American Indian reservations within North Dakota.

North Dakota County Profiles

Williams County

Population Estimates for: 2022	Williams	North Dakota
Child Population (under 18):	11,386	182,775
American Indian/Alaska Native:	4.5%	8.0%
Black:	5.5%	4.9%
White:	81.0%	79.9%
2+ Races or Other:	8.9%	7.3%



KIDS COUNT
NORTH DAKOTA



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Appendix H – Youth Behavioral Risk Survey Results

Youth Behavioral Risk Survey Results

North Dakota High School Survey

Rate Increase ↑, rate decrease ↓, or no statistical change = in rate from 2017-2019

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

Percentage of students who felt sad or hopeless (almost every day for two or more weeks in a row so that they stopped doing some usual activities during the 12 months before the survey)	27.2	28.9	30.5	=	31.8	33.1	36.7
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	NA	16.4	15.6	=	17.2	14.0	13.7

male students within a couple of hours on at least one day during the 30 days before the survey)							
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/healthyouth/data/yrbs/results.htm>;
<https://www.nd.gov/dpi/districtschools/safety-health/youth-risk-behavior-survey>

Appendix I – St. Luke’s Medical Center Prioritization

Community Health Needs Assessment Crosby, North Dakota Ranking of Concerns

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

The highlighted and * concerns were combined into “Mental health and addiction services”

	Priorities	Most Important
COMMUNITY/ENVIRONMENTAL HEALTH CONCERNS		
Having enough child daycare services	5	2
Attracting and retaining young families	3	
Not enough jobs with livable wages	2	
Bullying/cyber-bullying	2	
AVAILABILITY/DELIVERY OF HEALTH SERVICES CONCERNS		
Mental health and addiction services		10*
Availability of mental health services*	6	
Availability of substance use disorder treatment services*	4	
Availability of specialists	4	5
Availability of vision care	0	
Availability of dental care	0	
YOUTH POPULATION HEALTH CONCERNS		
Smoking and tobacco use, exposure to second-hand smoke, juuling/vaping	2	
Not enough activities for children and youth	0	
ADULT POPULATION HEALTH CONCERNS		
Not getting enough exercise/physical activity	2	
Stress	0	
SENIOR POPULATION HEALTH CONCERNS		
Long-term/nursing home options	1	
Cost of long-term/nursing home care	1	
Availability of resources to help elderly stay in their homes	4	0
Availability of home health	0	
ALL AGES		
Alcohol use and abuse*	8	
Depression/anxiety*	9	