Community Health Needs Assessment

2019

Crosby Service Area, North Dakota

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

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Executive Summary

To help inform future decisions and strategic planning, St. Luke's Medical Center and Upper Missouri District Health Unit conducted a community health needs assessment (CHNA) in 2018/2019, the previous CHNA having been conducted in 2016. The Center for Rural Health (CRH) at the University of North Dakota School of Medicine & Health Sciences (UNDSMHS) facilitated the assessment process, which solicited input from area community members and healthcare professionals as well as analysis of community health-related data.

To gather feedback from the community, residents of the area were given the opportunity to participate in a survey. There were 74 (electronic-47 and paper-27) St. Luke's Medical Center service area residents who completed the survey. Additional information was collected through 6 key informant interviews and an additional 11 community members. The input from the residents, who primarily reside in Divide County, represented the broad interests of the communities in the service area. Together with secondary data gathered from a wide range of sources, the survey presents a snapshot of the health needs and concerns in the community.

Divide County's population from 2010 to 2017 experienced a population change of 10.5% as compared to the state of North Dakota (12.3%). The average of residents under age 18 (22.4%) for Divide County comes in 1.9 percentage points lower than the North Dakota average (23.3%). The percentage of residents ages 65 and older is about 9.9% higher for Divide County (24.9.0%) than the North Dakota average (15.0%), and the rates of education are slightly lower for both Divide County (89.1% for high school graduates and 23.1% for bachelor's degrees or higher than the North Dakota average (92.0% and 28.2%). The median household income in Divide County ($62,470) which is higher than the median annual income in the United States and the state average for North Dakota ($60,656, according to Data USA).

Data compiled by County Health Rankings show the following specifics on indicators of community health.On health factors, Divide County performs below the North Dakota average for counties in ten areas.

On health outcomes, Divide County is doing better than North Dakota in health outcomes in 5 areas but is performing poorly relative to the rest of the state in 10 areas.

Of the 82 potential community and health needs set forth in the survey, the 74 St. Luke's Medical Center service area residents who completed the survey indicated the following 10 needs as the most important:

- Bullying/cyberbullying
- Attracting and retaining young families
- Cost of health insurance
- Availability of vision care
- Drug use and abuse-Youth
- Drug use and abuse-adults
- Stress in adults
- Cost of long-term/nursing home care
- Depression/anxiety-elderly
- Alcohol use and abuse-youth

The survey also revealed the biggest barriers to receiving healthcare (as perceived by community members). Those barriers included the availability of vision care (N=20), availability of dental care (N=18) and availability of mental health services (N=16).

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

- Safe place to live, little/no crime
- Family-friendly, good place to raise kids
- People are friendly, helpful, and supportive
- Healthcare
- Quality school system
- People who live here are involved in their community
- Active faith community
- Recreational and sports activities

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:

- Drug use and abuse-adults
- Alcohol use and abuse -youth
- Availability of mental health and substance use disorder treatment services
- Depression/anxiety
- Bullying/cyberbullying
- Cost of long-term/nursing home care

Overview and Community Resources

With assistance from the CRH at the UNDSMHS, the St. Luke's Medical Center completed a CHNA of their service area. The hospital identifies its service area as Divide County. Many community members and stakeholders worked together on the assessment.

Some say Divide County is at the end of the world. We say we are 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 primitive 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 the spring of 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. It's a town located just a stone's throw from Canada and Montana, where farming is king, black gold is a big, and the coffee pot is always on.

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 summon hunters from afar, a winter sports center, a swimming pool, gymnastics and fitness centers and endless sunsets.

Healthcare services in Crosby

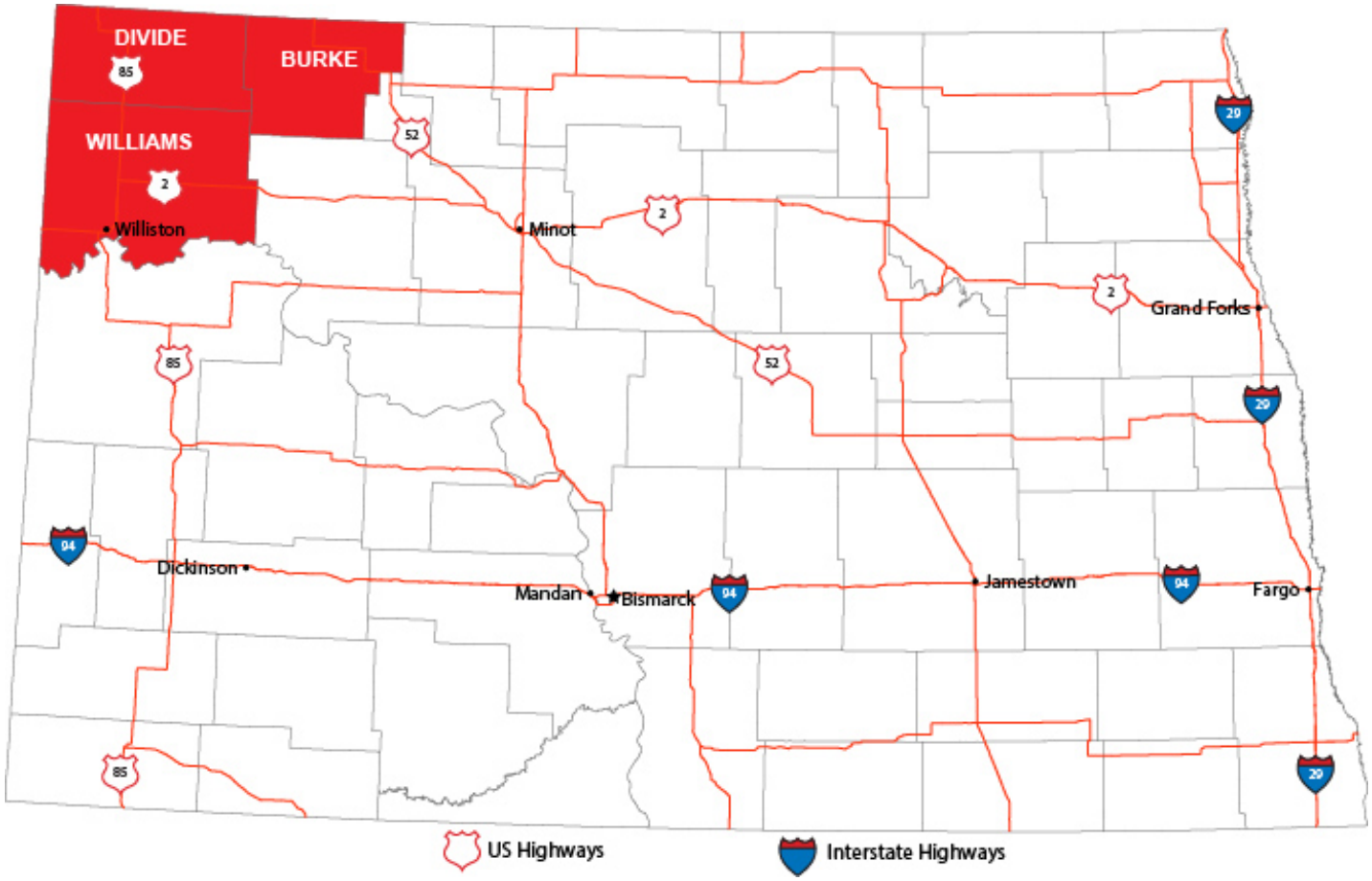
St. Luke's Care Center:

- 16 basic care beds
- 40 skilled care beds
- Discharge planning
- Admission counseling and support groups
- Individualized short-term rehab including physical, occupational and speech therapies offered by St. Luke's Medical Center and contracted staff
- Restorative nursing care program
- Planned recreational & social activities

Assisted Living at Northern Lights Villa, we can provide or arrange the following:

- 24-hour access to a registered nurse
- Emergency pendant system
- One well-balanced meal served daily
- Snacks morning and afternoon
- Medication management
- Assistance ordering medication
- Assistance monitoring blood pressure, sugar, weight, temperature
- Daily activities including physical fitness, creative, social, learning, and spiritual
- Bi-weekly housekeeping
- Laundry services
- Daily trash removal
- Snow removal
- Assistance in arranging transportation
- Secure and safe environment

Figure 1: Divide, Burke, and Williams Counties



St. Luke's Medical Center

In the Fall of 2018, the Chartis Center for Rural Health and the National Organization of State Offices of Rural Health (NOSORH) recognized 18 North Dakota rural hospitals for the 2018 Performance Excellence Awards. The awards spotlight high achievement in the areas of quality, outcomes, and patient perspective. The hospitals earning these awards also reflect top performance among all rural hospitals in the nation. St. Luke's Medical Center in Crosby, North Dakota was recognized as an award winner in the Quality category!

In 2017, St. Luke's Medical Center in Crosby, North Dakota was named one of the Top 20 Critical Access Hospitals (CAHs) out of 1,332 in the United States by iVantage Health Analytics and The Chartis Center for Rural Health. It was the first year in history that one rural CAH was selected in the Top 20 in more than one category!

The Top 20 Critical Access Hospital "winners" are those hospitals who have achieved success in the overall performance based on a composite rating from eight indices of strength: inpatient market share, outpatient market share, quality, outcomes, patient perspectives, costs, charges and financial stability.

St. Luke's Care Center

In 2018, the Centers for Medicare Services (Medicare.gov) acknowledged a four out of five star rating for St. Luke's Care Center! Nursing Home Compare provides details on nursing homes across the country. This includes nursing home inspection results, staffing levels, enforcement actions that the federal government have taken against the nursing homes and how well nursing home residents were treated in specific areas of care.

History of St. Luke's Medical Center

Mr. Renhard Hering homesteaded the present site of land where St. Luke's Medical Center is located in 1904. In 1914, it was surveyed as Hering Addition to the City of Crosby. Doctor 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 townspeople and 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 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.

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.

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

Vision- The 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 policymaking 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 healthcare 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 reverence 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 St. Luke's Medical Center 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 describes how the medical center provides 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 15 bed CAH, 56 bed care center, and clinic located in Crosby, North Dakota in central Divide County. Crosby is approximately 122 miles northwest of Minot, North Dakota, which is located 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. Long-term care is provided at our St. Luke's Care Center with 40 skilled and 16 basic-beds available.

Services Provided Directly

- General medical – surgical care
- Special care unit
- Emergency services
- Health screenings
- Trauma center (Level V)
- Outpatient surgery
- Swing bed services
- Laboratory and x-ray
- Pulmonary function testing
- Joint injection
- Physical therapy
- Occupational therapy
- Meals on Wheels

Services Provided through Contract

- CT scans
- Mammograms
- Ultra-sound
- Anesthesia
- Hearing screenings
- Additional lab services

Divide County Public Health

Divide County Public Health is within the Upper Missouri District Health Unit. And provides public health services that encompass all residents aged birth to death. Services include:

- Bicycle helmet safety
- Blood pressure check
- Breastfeeding resources
- Car seat program
- Child health (well-baby check-ups)
- Diabetes screening
- Emergency response & preparedness program
- Flu shots
- Environmental health services (water, sewer, health hazard abatement)
- Health Tracks (child health screening)
- Immunizations
- Medications setup—home visits
- Office visits and consults
- School health (vision screening, health education topics, school immunizations)
- Preschool education programs
- Assist with preschool screening
- Tobacco prevention and control
- Tuberculosis testing and management
- WIC (Women, Infants & Children) program
- Youth education programs (first aid, bike safety)

Assessment Process

The purpose of conducting a CHNA is to describe the health of local people, identify areas for health improvement, identify use of local healthcare services, determine factors that contribute to health issues, identify and prioritize community needs, and help healthcare leaders identify potential actions to address the community's health needs.

A CHNA benefits the community by:

1) Collecting timely input from the local community members, providers, and staff;

2) Providing an analysis of secondary data related to health-related behaviors, conditions, risks, and outcomes;

3) Compiling and organizing information to guide decision making, education, and marketing efforts, and to facilitate the development of a strategic plan;

4) Engaging community members about the future of healthcare; and

5) Allowing the community hospital to meet the federal regulatory requirements of the Affordable Care Act, which requires not-for-profit hospitals to complete a CHNA at least every three years, as well as helping the local public health unit meet accreditation requirements.

This assessment examines health needs and concerns in Divide County. In addition to Crosby, other incorporated communities are Ambrose, Fortuna and Noonan. Divide County has historically been a rural, agricultural community with the bulk of the local economy based on farming and ranching.

The CRH, in partnership with St. Luke's Medical Center and the Upper Missouri Health Unit, facilitated the CHNA process. Community representatives met regularly in-person, by telephone conference, and email. A CHNA liaison was selected locally, who served as the main point of contact between the CRH and St. Luke's Medical Center. A small steering committee (see Figure 2) was formed that was responsible for planning and implementing the process locally. Representatives from the CRH met and corresponded regularly by teleconference and/or via the eToolkit with the CHNA liaison. The community group (described in more detail below) provided in-depth information and informed the assessment process in terms of community perceptions, community resources, community needs, and ideas for improving the health of the population and healthcare services. There were 17 people, representing a cross section demographically, who attended the focus group meeting. The meeting was highly interactive with good participation. St. Luke's Medical Center staff and board members attended as well, but largely played a role of listening and learning.

Figure 2: Steering Committee

Melissa Nystuen, MSW, LICSW	Nystuen Counseling, Crosby, ND
Juliet Artman, PH RN	Upper Missouri Health Unit, Crosby, ND
Sam Pulvermacher, Director	Social Services, Crosby, ND
Marianne Wamhoff, Human Resources Director	St. Luke's Medical Center, Crosby, ND

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

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

- A survey solicited feedback from area residents;

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

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

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

Community Group

A Community Group consisting of 16 community members was convened and first met on August 15, 2018. During this first Community Group meeting, group members were introduced to the needs assessment process, reviewed basic demographic information about the community, and served as a focus group. Focus group topics included community assets and challenges, the general health needs of the community, community concerns, and suggestions for improving the community's health.

The Community Group met again on November 6, 2018 with 23 community members in attendance. At this second meeting the Community Group was presented with survey results, findings from key informant interviews and the focus group, and a wide range of secondary data relating to the general health of the population in Divide County. The group was then tasked with identifying and prioritizing the community's health needs.

Members of the Community Group represented the broad interests of the community served by St. Luke's Medical Center and Upper Missouri District Health Unit. They included representatives of the health community, business community, political bodies, law enforcement, education, faith community, and social service agencies. Not all members of the group were present at both meetings.

Interviews

One-on-one interviews with eight key informants were conducted all by phone the third week in August 2018. A representative from the CRH conducted the interviews. Interviews were held with selected members of the community who could provide insights into the community's health needs. The informant interviews included public health professionals with several years of direct experience in the community, including working with medically underserved, low income, and minority populations, as well as with populations with chronic diseases.

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

Survey

A survey was distributed to solicit feedback from the community and was not intended to be a scientific or statistically valid sampling of the population. It was designed to be an additional tool for collecting qualitative data from the community at large – specifically, information related to community-perceived health needs. A copy of the survey instrument is included in Appendix A.

The community member survey was distributed to various residents of Divide County which is the St. Luke's Medical Center and public health service area. The survey tool was designed to:

The survey tool was designed to:

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

Specifically, the survey covered the following topics:

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

To promote awareness of the assessment process, press releases were published in the local newspaper which serves the communities in Divide County. Additionally, information was posted on the medical center and public health websites and Facebook pages.

Approximately 150 community member surveys were available for distribution in Divide County. The surveys were distributed by Community Group members along with QR code flyers at the churches and elementary and high school open houses and were sent home with students and staff. In addition, surveys were available at the Crosby Public Library, placed in the lobbies of the St. Luke's Care Center's Business Office, St. Luke's Care Center's social service offices, the assisted living facility, the Divide County courthouse, and the local grocery store.

Additionally, table tents were placed in local bars, restaurants, and lounges.

To help ensure anonymity, included with each survey was a postage-paid return envelope to the CRH. To help make the survey as widely available as possible, residents also could request a survey by calling the medical center or public health. The survey period ran from August 15, 2018 to October 7, 2018. A total of 74 surveys were completed, 47 of them were completed electronically and 27 were written surveys. This response rate is on par for this type of unsolicited survey methodology and indicates an engaged community.

Secondary Data

Secondary data was collected and analyzed to provide descriptions of: (1) population demographics, (2) general health issues (including any population groups with particular health issues), and (3) contributing causes of community health issues. Data was collected from a variety of sources, including the U.S. Census Bureau; Robert Wood Johnson Foundation's County Health Rankings, which pulls data from 20 primary

data sources (www.countyhealthrankings.org); the National Survey of Children's Health, which touches on multiple intersecting aspects of children's lives (www.childhealthdata.org/learn/NSCH); and North Dakota KIDS COUNT, which is a national and state-by-state effort to track the status of children, sponsored by the Annie E. Casey Foundation (www.ndkidscount.org).

Social Determinants of Health

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

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

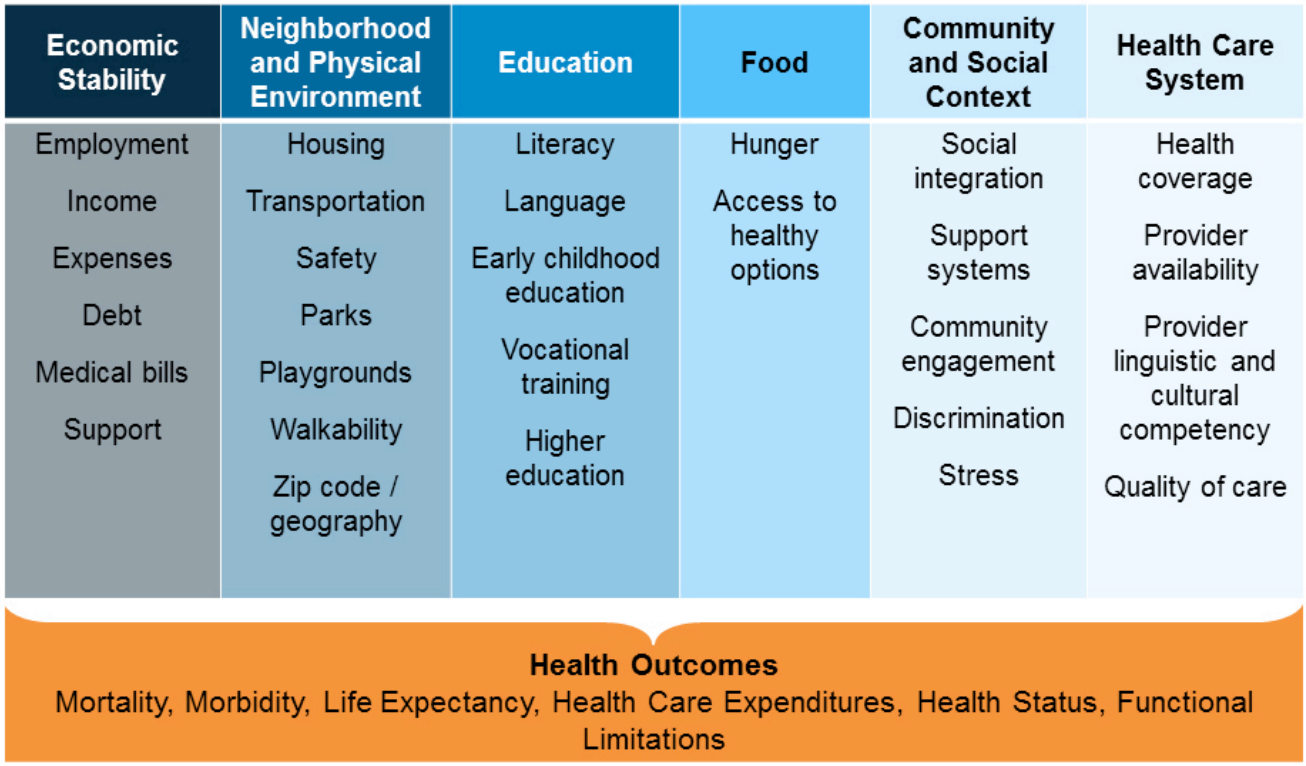
Healthy People 2020, (https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health) illustrates that health and healthcare, while vitally important, play only one small role (approximately 20%) in the overall health of individuals and ultimately of a community. Social and community context, education, economic stability, neighborhood and built environment play a much larger part (80%) in impacting health outcomes. Therefore, as needs or concerns were raised through this CHNA process, it was imperative to keep in mind how they impact the health of the community and what solutions can be implemented. See Figure 3.

Figure 3: Social Determinants of Health

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

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

Figure 4: Social Determinants of Health



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Demographic Information

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

	Divide County	North Dakota
Population (2017)	2,288	755,393
Population change (2010-2017)	10.5%	12.3%
People per square mile (2010)	1.6	9.7
Persons 65 years or older (2016)	24.9%	15.0%
Persons under 18 years (2016)	21.4%	23.3%
Median age (2016 est.)	50.3	35.2
White persons (2016)	94.5%	87.5%
Non-English speaking (2016)	5.2%	5.6%
High school graduates (2016)	88.2%	92.0%
Bachelor's degree or higher (2016)	23.1%	28.2%
Live below poverty line (2016)	10.0%	10.7%
Persons without health insurance, under age 65 years (2016)	10.2%	8.1%

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

While the population of North Dakota has grown in recent years, and there has been oil development in western Divide County, the percentages of youth and elderly closely balance each other.

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

The data used in the 2017 County Health Rankings are from more than 20 data sources and then are compiled to create county rankings. Counties in each of the 50 states are ranked according to summaries of a variety of health measures. Those having high ranks, such as 1 or 2, are considered to be the "healthiest." Counties are ranked on both health outcomes and health factors. Following is a breakdown of the variables that influence a county's rank.

A model of the 2017 County Health Rankings – a flow chart of how a county's rank is determined – may be found in Appendix B. For further information, visit the County Health Rankings website at www.countyhealthrankings.org.

Health Outcomes

- Length of life
- Quality of life

Health Factors

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

Health Factors (continued)

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

Table 2 summarizes the pertinent information gathered by County Health Rankings as it relates to Divide County. All of the following statistics are based on the health behaviors and conditions of the county's residents, not necessarily the patients and clients of St. Luke's Medical Center and Upper Missouri District Health Unit or of any particular medical facility.

It is important to note that these statistics describe the population of a county, regardless of where county residents choose to receive their medical care.

For most of the measures included in the rankings, the County Health Rankings' authors have calculated the "Top U.S. Performers" for 2017. 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).

Divide County rankings within the state are included in the summary following. Divide County ranks 25th out of 49 ranked counties in North Dakota on health outcomes and 6th on health factors. The measures marked with a bullet point (•) are those where a county is not measuring up to the state rate/percentage; a asterisk (*) indicates that the county is faring better than the North Dakota average but is not meeting the U.S. Top 10% rate on that measure. Measures that are not marked with a bullet or asterisk but are marked with a plus sign

(+) indicate that the county is doing better than the U.S. Top 10%.

The data from County Health Rankings shows that Divide County is doing better than many counties compared to the rest of the state on all but one (the percentage of individuals with diabetes) of the outcomes, landing at or above rates for other North Dakota counties. Divide County also falls below the U.S. Top 10% ratings in the reported number of individuals with diabetes.

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

- Having a lower unemployment rate
- Less children in single parent households
- Less violent crime
- No drinking water violations
- Less severe housing problems

Above it stated that Divide County is doing better in all categories, but % of people with diabetes, but now it lists 10 other areas where they are performing poorly.

Factors in which Divide County is performing poorly relative to the rest of the state include:

- Lower food environment
- Higher physical inactivity
- Less access to exercise opportunities
- Higher teen birth rate
- Less primary care physicians per resident
- Higher preventable hospital stays
- Less mammography screening
- Higher # of children in poverty
- Higher income inequality
- Less dentists per resident

Factors in which Divide County is performing worse than the top 10% National Performers include:

- Higher % of diabetics
- Higher adult smoking
- Higher adult obesity
- Higher level of physical inactivity
- Less access to exercise opportunities
- Higher excessive drinking
- More alcohol-impaired driving deaths
- Higher teen birth rate
- More uninsured
- Less primary care physicians
- Less dentists
- Higher preventable hospital stays
- Lower diabetic monitoring
- Lower mammography screening
- More children in poverty
- More income inequality
- More air pollution

Table 2: Selected Measures from County Health Rakings 2018 - Divide County

+ Meeting or exceeding U.S. top 10% performers

***** Not meeting U.S. top 10% performers

• Not meeting North Dakota average

	Divide County	U.S. Top 10%	North Dakota
Ranking: Outcomes	**25th**		**(of 49)**
Premature death		5,300	6,600
Poor or fair health	12% +	12%	14%
Poor physical health days (in past 30 days)	2.7 +	3.0	3.0
Poor mental health days (in past 30 days)	2.6 +	3.1	3.1
Low birth weight		6%	6%
% Diabetic	11% •*	8%	8%
Ranking: Factors	**6th**		**(of 49)**
Health Behaviors			
Adult smoking	15% *	14%	20%
Adult obesity	29% *	26%	32%
Food environment index (10=best)	8.9 •	8.6	9.1
Physical inactivity	32% •*	20%	24%
Access to exercise opportunities	55% •*	91%	75%
Excessive drinking	21% *	13%	26%
Alcohol-impaired driving deaths	33% *	13%	48%
Sexually transmitted infections		145.1	427.2
Teen birth rate	30 •*	15	25
Clinical Care			
Uninsured	9% *	6%	9%
Primary care physicians	2,450:1•*	1,030:1	1,330:1
Dentists	2,410:1•*	1,280:1	1,550:1
Mental health providers		330:1	610:1
Preventable hospital stays	50 •*	35	49
Diabetic monitoring (% of diabetic Medicare enrollees ages 65-75 that receive HbA1c monitoring)	89% *	91%	87%
Mammography screening (% of Medicare enrollees ages 67-69 receiving screening)	45% •*	71%	69%
Social and Economic Factors			
Unemployment	2.7% +	3.2%	3.2%
Children in poverty	13%•*	12%	12%
Income inequality	5.9 •*	3.7	4.3
Children in single-parent households	13% +	20%	28%
Violent crime	15 +	62	26
Injury deaths		55	68
Physical Environment			
Air pollution – particulate matter	7.0 *	6.7	7.5
Drinking water violations	No +	No	
Severe housing problems	7% +	9%	11%

Source: http://www.countyhealthrankings.org/app/north-dakota/2018/rankings/outcomes/overall

Children's Health

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

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

Table 3: Selected Measures Regarding Children's Health (For children aged 0-17 unless noted otherwise)

Health Status	North Dakota	National
Children born premature (3 or more weeks early)	10.8%	11.6%
Children 10-17 overweight or obese	35.8%	31.3%
Children 0-5 who were ever breastfed	79.4%	79.2%
Children 6-17 who missed 11 or more days of school	4.6%	6.2%
Healthcare		
Children currently insured	93.5%	94.5%
Children who had preventive medical visit in past year	78.6%	84.4%
Children who had preventive dental visit in past year	74.6%	77.2%
Young children (10 mos.-5 yrs.) receiving standardized screening for developmental or behavioral problems	20.7%	30.8%
Children aged 2-17 with problems requiring counseling who received needed mental healthcare	86.3%	61.0%
Family Life		
Children whose families eat meals together 4 or more times per week	83.0%	78.4%
Children who live in households where someone smokes	29.8%	24.1%
Neighborhood		
Children who live in neighborhood with a park, sidewalks, a library, and a community center	58.9%	54.1%
Children living in neighborhoods with poorly kept or rundown housing	12.7%	16.2%
Children living in neighborhood that's usually or always safe	94.0%	86.6%

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

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

- Obese or overweight children ages 10-17;
- Children with health insurance;
- Preventive primary care and dentist visits;
- Developmental/behavioral screening for children 10 months to 5 years of age;
- Children who have received needed mental healthcare; and
- Children living in smoking households.

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

The data show that Divide County is performing better than most North Dakota counties except two. Divide County uninsured children rate is 3.4% higher than other counties in North Dakota. Additionally, Divide County has almost double the rate of children enrolled in Healthy Steps according to the 2013 data.

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

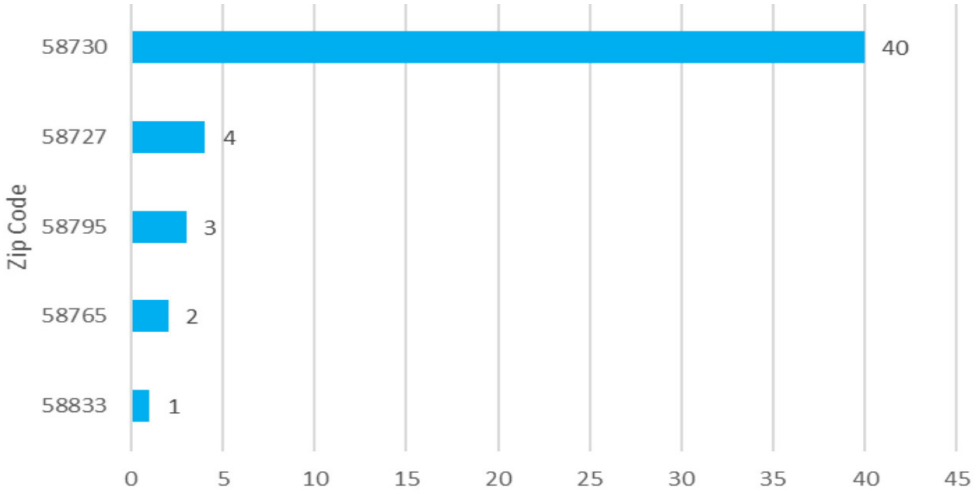
	Divide County	North Dakota
Uninsured children (% of population age 0-18), 2016	**12.4%**	9.0%
Uninsured children below 200% of poverty (% of population), 2016	40.3%	41.9%
Medicaid recipient (% of population age 0-20), 2017	24.9%	28.3%
Children enrolled in Healthy Steps (% of population age 0-18), 2013	**4.4%**	2.5%
Supplemental Nutrition Assistance Program (SNAP) recipients (% of population age 0-18), 2017	14.3%	20.1%
Licensed childcare capacity (% of population age 0-13), 2018	**42.4%**	41.9%
4-Year High School Cohort Graduation Rate, 2017	100.0%	87.0%

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

Survey Results

As noted previously, 74 community members completed the survey in communities throughout the St. Luke's Medical Center service area. The survey requested that respondents list their home zip code. While not all respondents provided a zip code, 50 did, revealing that the large majority of respondents (80%, N=40) lived in Crosby. These results are shown in Figure 5.

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



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

Survey Demographics

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

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

- 92% (N=56) were age 55 or older.
- The majority (87%, N=53) were female.
- Slightly more than half of the respondents (26%, N=16) had bachelor's degrees or higher.
- The number of those working full-time (66%, N=38) was slightly less than three times higher than those who were retired (19.6%, N=12).
- 92.4% (N=61) of those who reported their ethnicity/race were white/Caucasian.
- 46% of the population (N=56) had household incomes of less than $50,000. However, of those reporting, 36% (N=21) reported their incomes as over $100,000. Four (6.8%) individuals preferred not to answer the question.

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

Figure 6: Age Demographics of Survey Respondents
Total respondents = 61

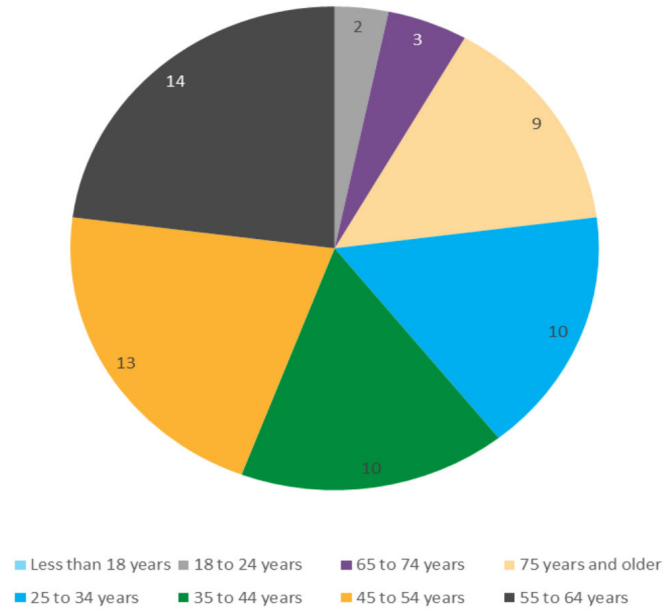


Figure 7: Gender Demographics of Survey Respondents
Total respondents = 61

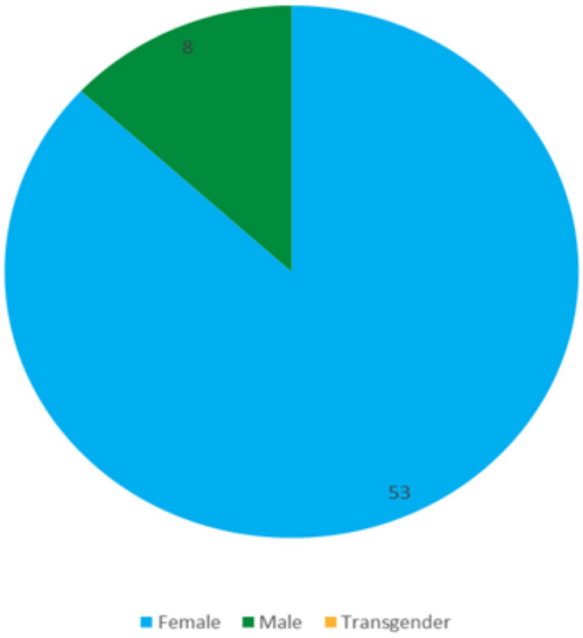


Figure 8: Educational Level Demographics of Survey Respondents
Total respondents = 61

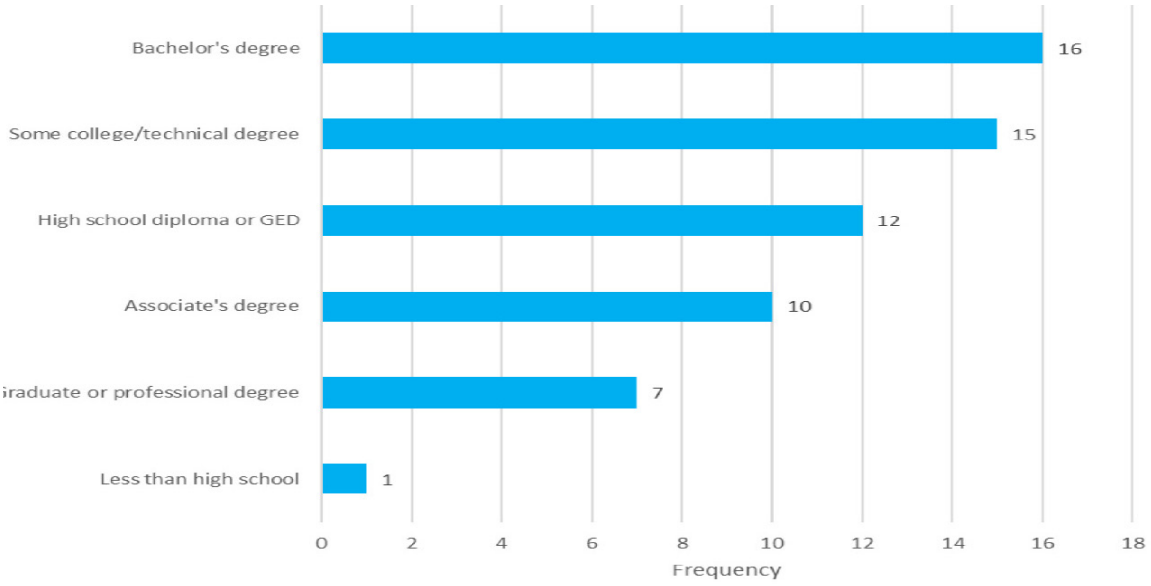


Figure 9: Employment Status Demographics of Survey Respondents
Total respondents = 61

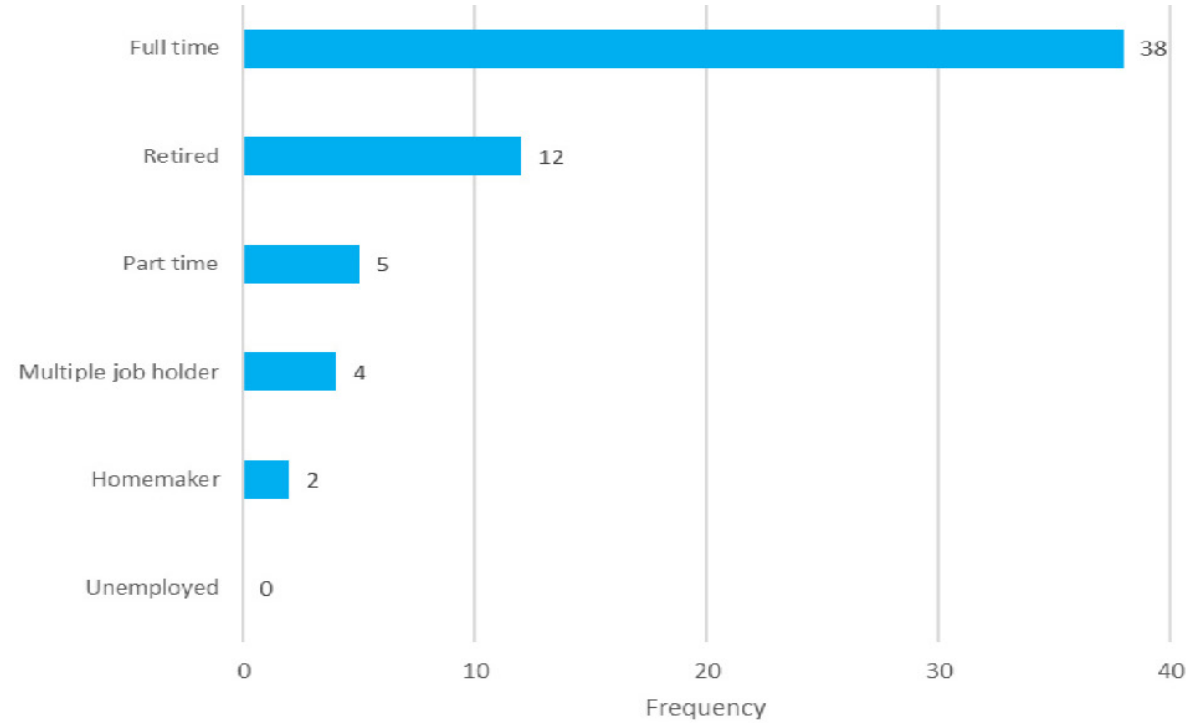
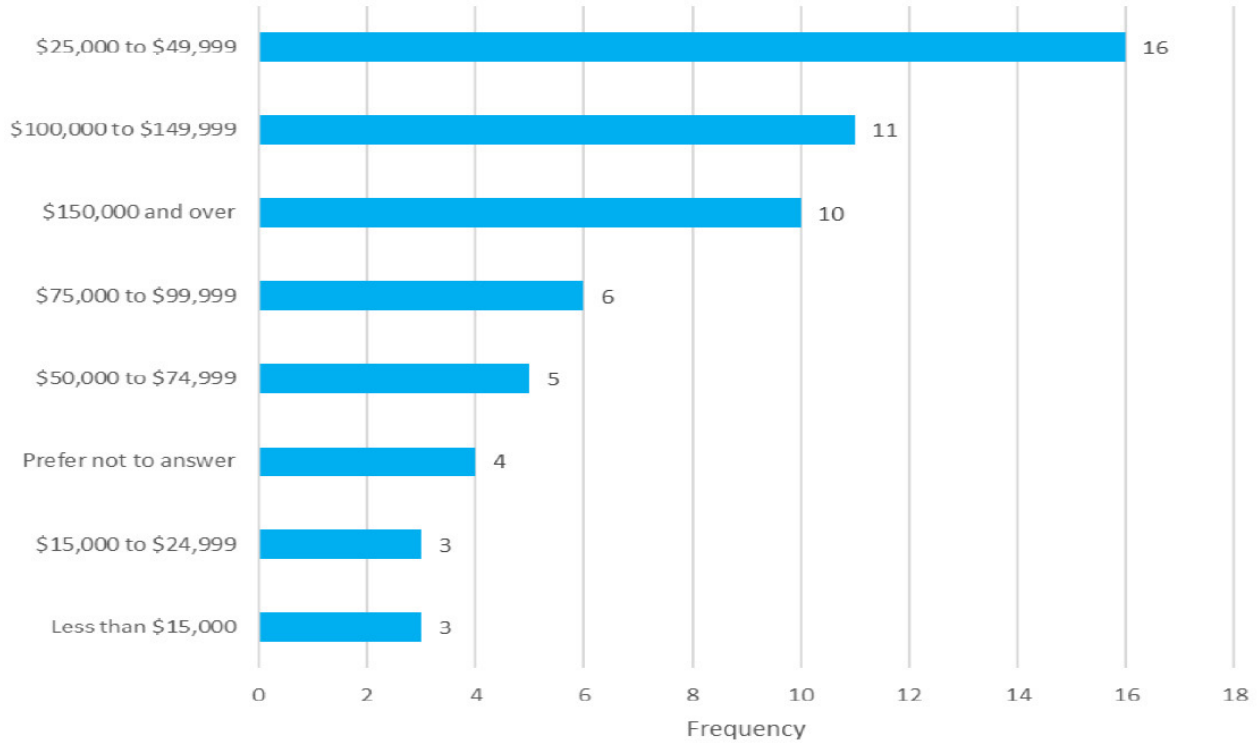


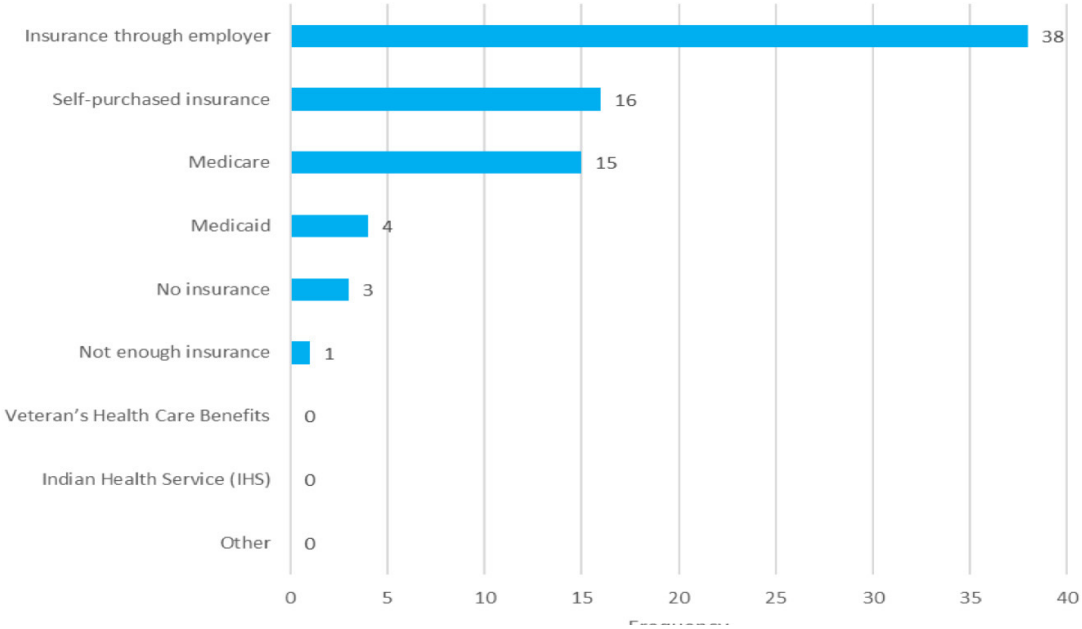
Figure 9 shows 4 individuals or 6.5% reported holding two jobs. Of those who provided a household income, 10% (N=6) of the community members reported a household income of less than $25,000. This information is show in Figure 10.

Figure 10: Household Income Demographics of Survey Respondents
Total respondents = 58



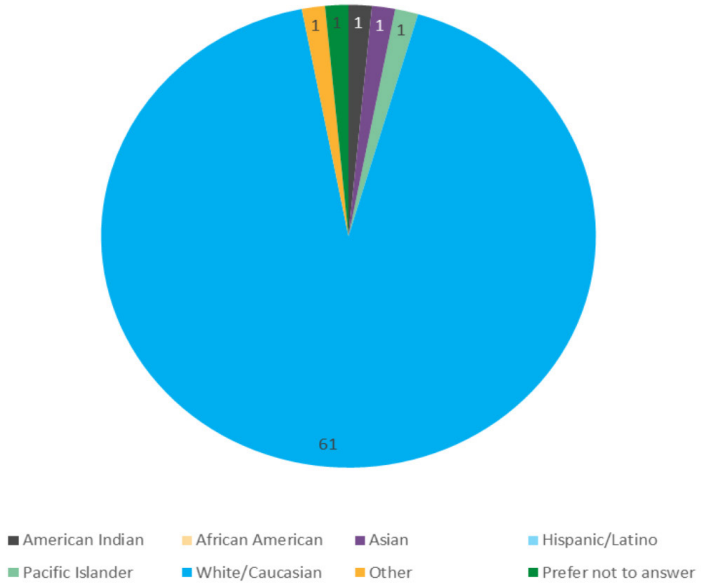
Community members were asked about their health insurance status, which is often associated with whether people have access to healthcare. A little over 10% (N=8) of the respondents reported having no health insurance, not enough insurance or being on Medicaid. The most common insurance type was insurance through one's employer at 49.35%(N=38), followed by self-purchased 21%(N=16) and Medicare 19.5%(N=15).

Figure 11: Health Insurance Coverage Status of Survey Respondents
Total respondents = 77



As shown in Figure 12, nearly all of the respondents were white/Caucasian (92%). This was in-line with the race/ethnicity of the overall population of Divide County.

Figure 12: Race/Ethnicity Demographics of Survey Respondents
Total respondents = 66



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 150 respondents agreeing) that community assets include:

- Safe place to live, little/no crime (N=62)
- Family-friendly (N=56)
- People are friendly, helpful, supportive (N=53)
- Quality school systems (N=34)
- People who live here are involved in their community (N=49)
- Recreational sports and activities (N=45)

Figures 13 to 16 illustrate the results of these questions.

Figure 13: Best Things about the PEOPLE in Your Community
Total responses = 179

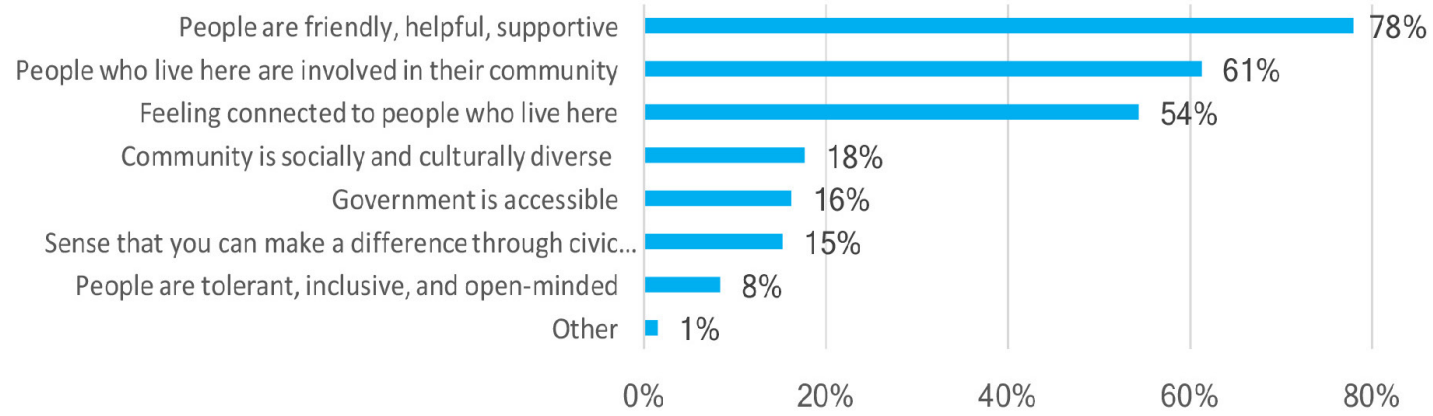


Figure 14: Best Things about the SERVICES AND RESOURCES in Your Community
Total responses = 177

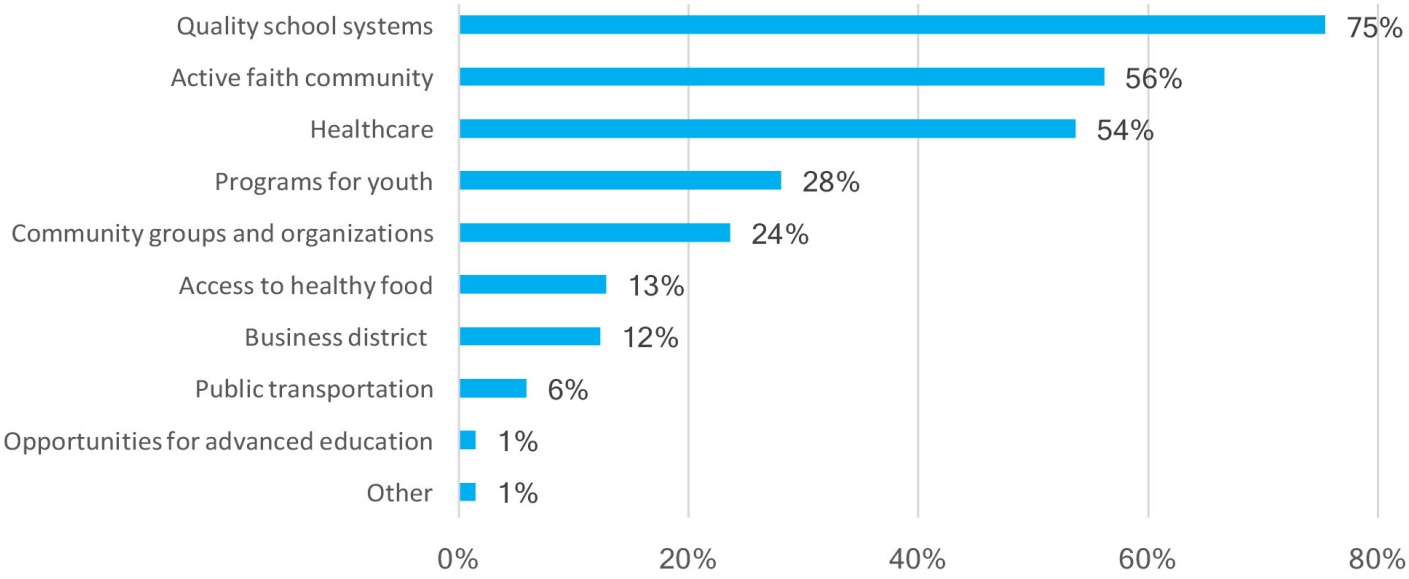
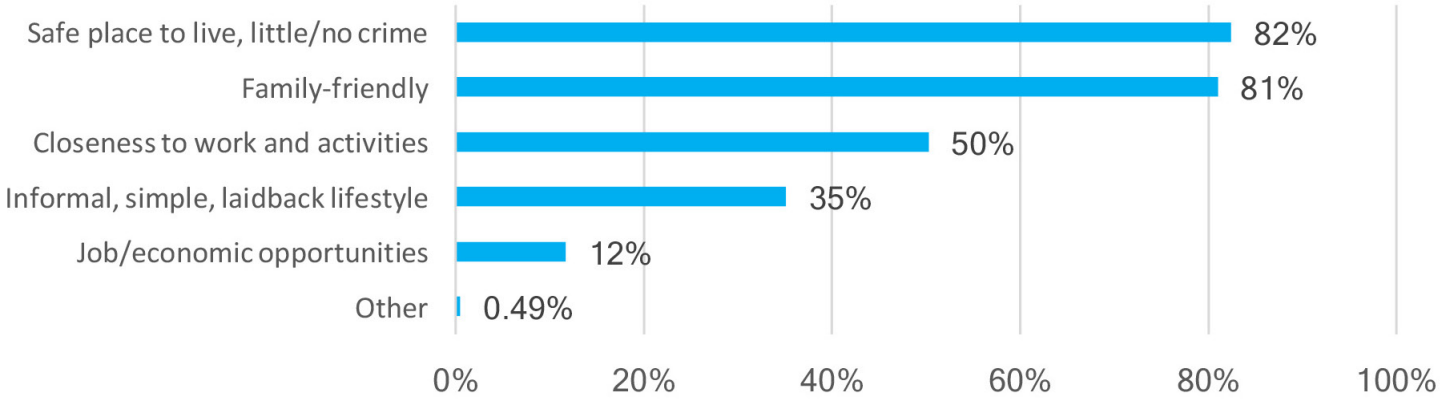
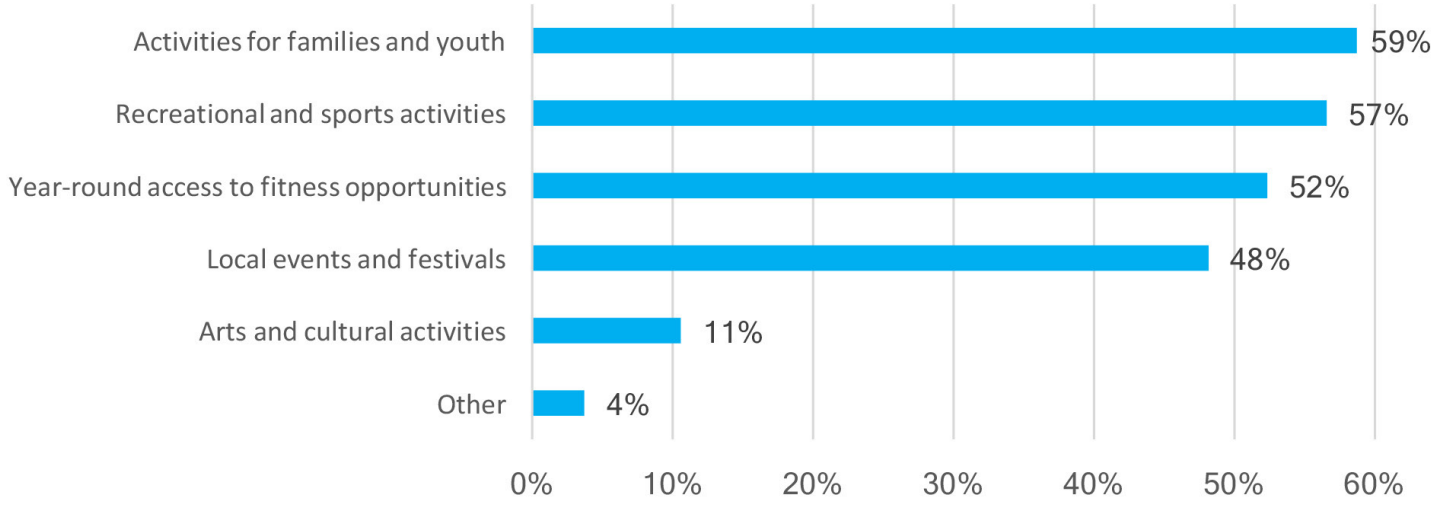


Figure 15: Best Things about the QUALITY OF LIFE in Your Community
Total responses = 181



The "Other" responses regarding the best things about the quality of life in the community; "It was even a better place to raise children before the oil came." And "There are lots of opportunities to be involved."

Figure 16: Best Thing about the ACTIVITIES in Your Community
Total responses = 150



Community Concerns

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

- Community/environmental health
- Availability/delivery of health services
- Youth population concerns
- Adult population concerns
- Senior population concerns
- Forms of violence in the community

With regard to responses about community challenges, the most highly voiced concerns (those having at least 114 respondents) with at least 33 votes were:

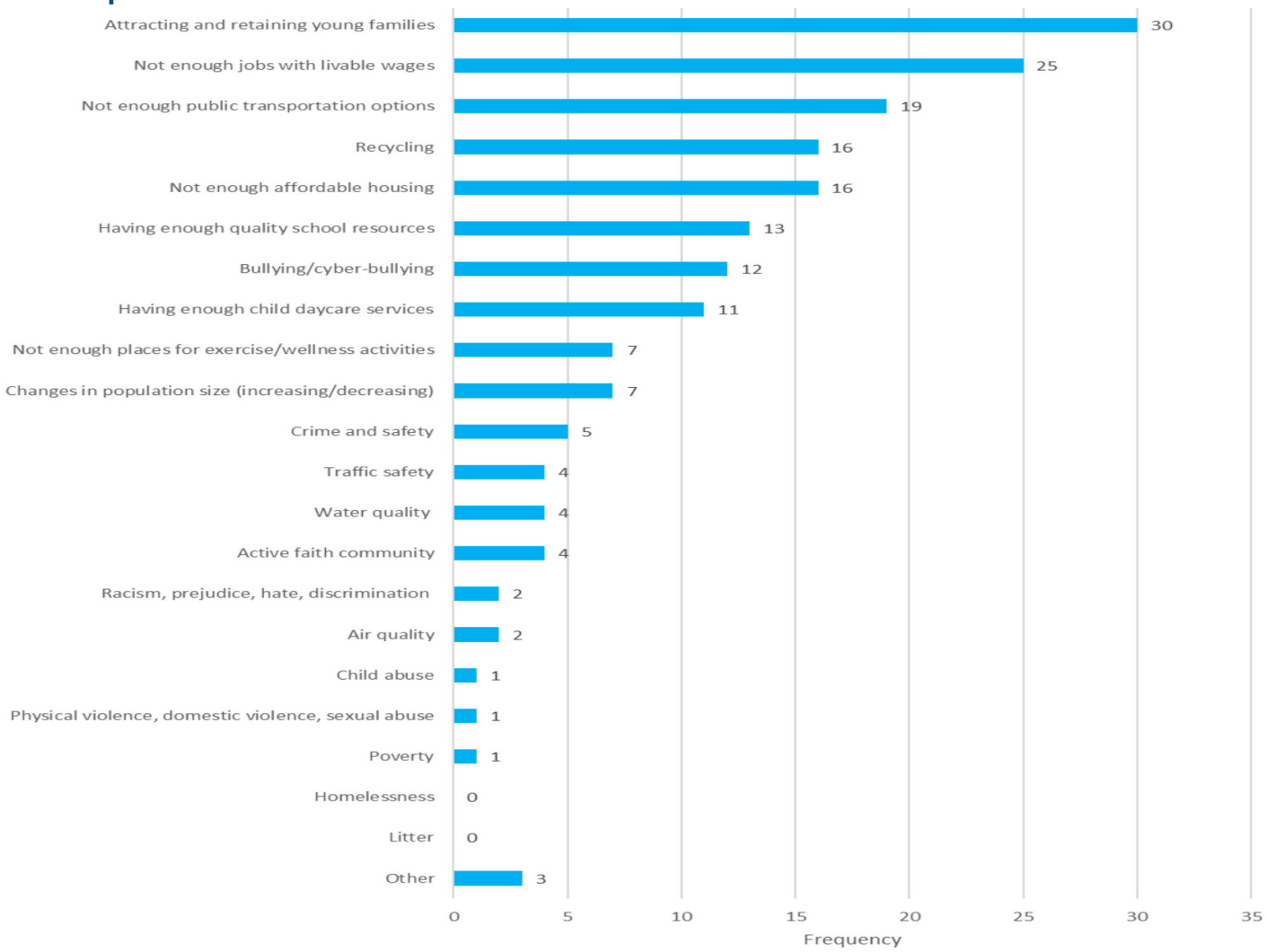
- Bullying/cyberbullying (N=45)
- Alcohol use and abuse – Youth (N=41)
- Availability of resources to help the elderly stay in their homes (N=37)
- Drug use and abuse – Youth (N=34)
- Alcohol use and abuse – Adults (N=33)

The other issues that had at least 20 votes included:

- Attracting and retaining young families (N=30)
- Not enough jobs with livable wages (N=25)
- Not enough exercise/obesity-adults (N=21)
- Availability of vision care (N=20)

Figures 17 through 27 illustrate these results.

Figure 17: Community/Environmental Health Concerns
Total responses = 183



In the "Other" category for community and environmental health concerns, the following were listed: alcohol use and lack of not enough healthy food such as shakes and meals in restaurants.

Figure 18: Availability/Delivery of Health Services Concerns
Total responses = 185

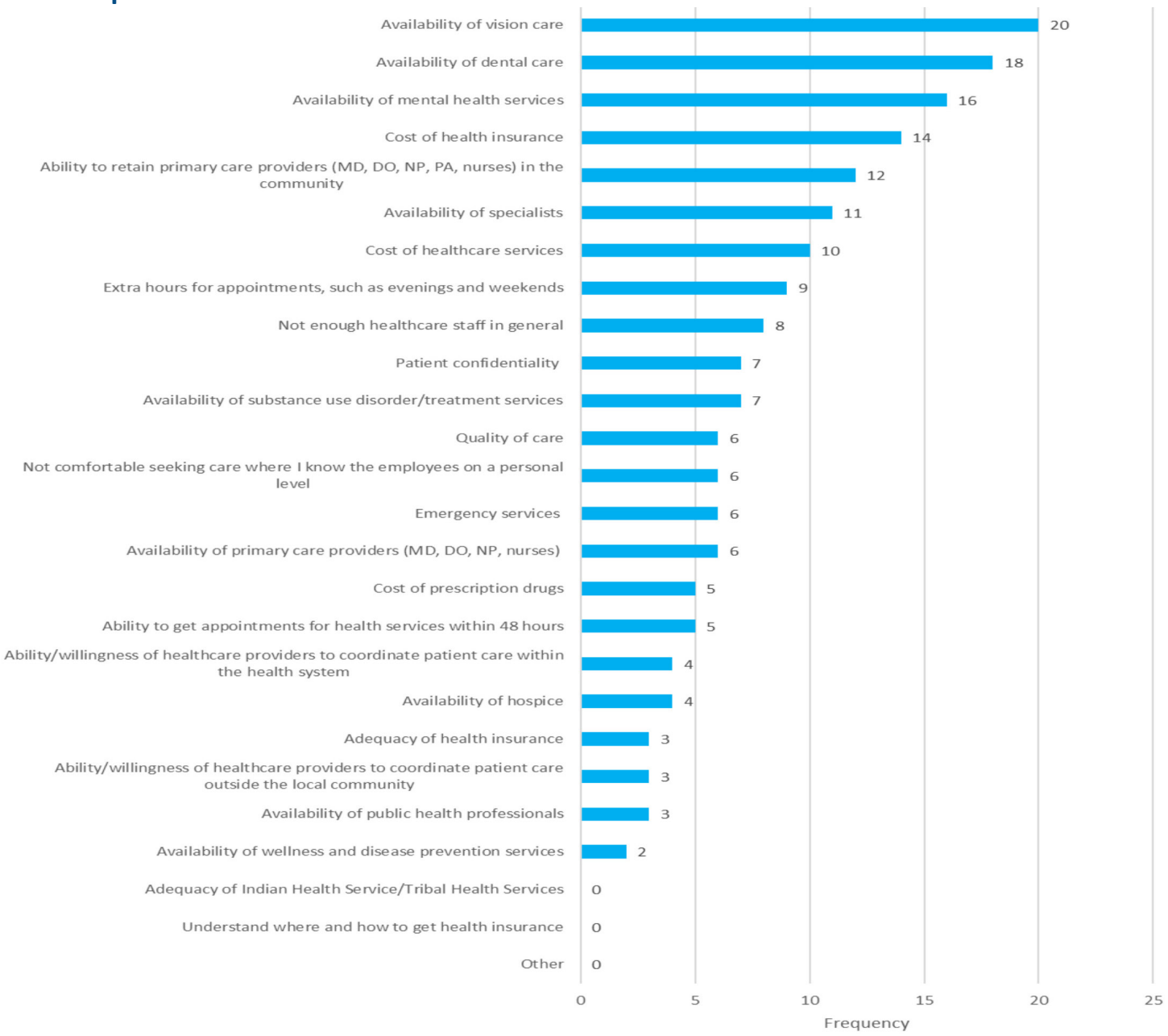
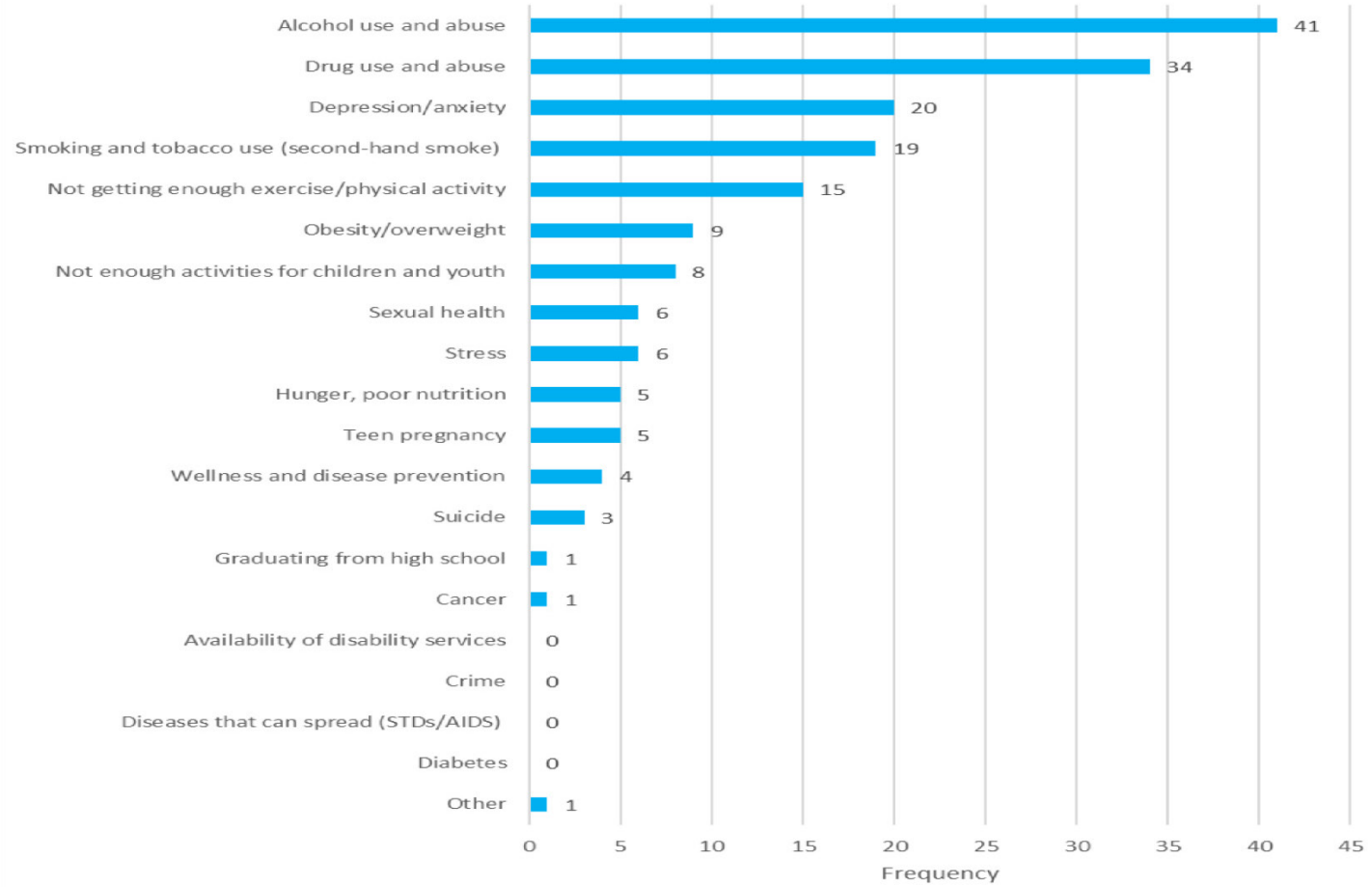


Figure 19: Youth Population Health Concerns
Total responses = 178



Listed in the "Other" category for youth population concerns were a sense of unfair sheriff deputy treatment of high school students.

Figure 20: Adult Population Concerns
Total responses = 174

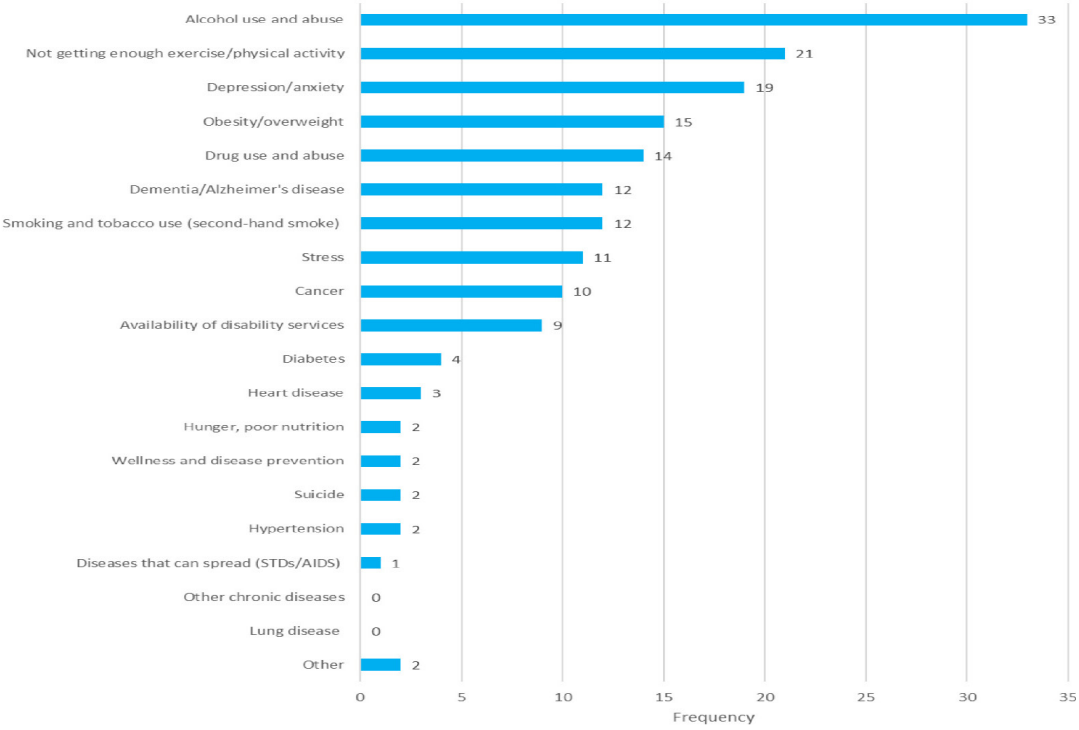
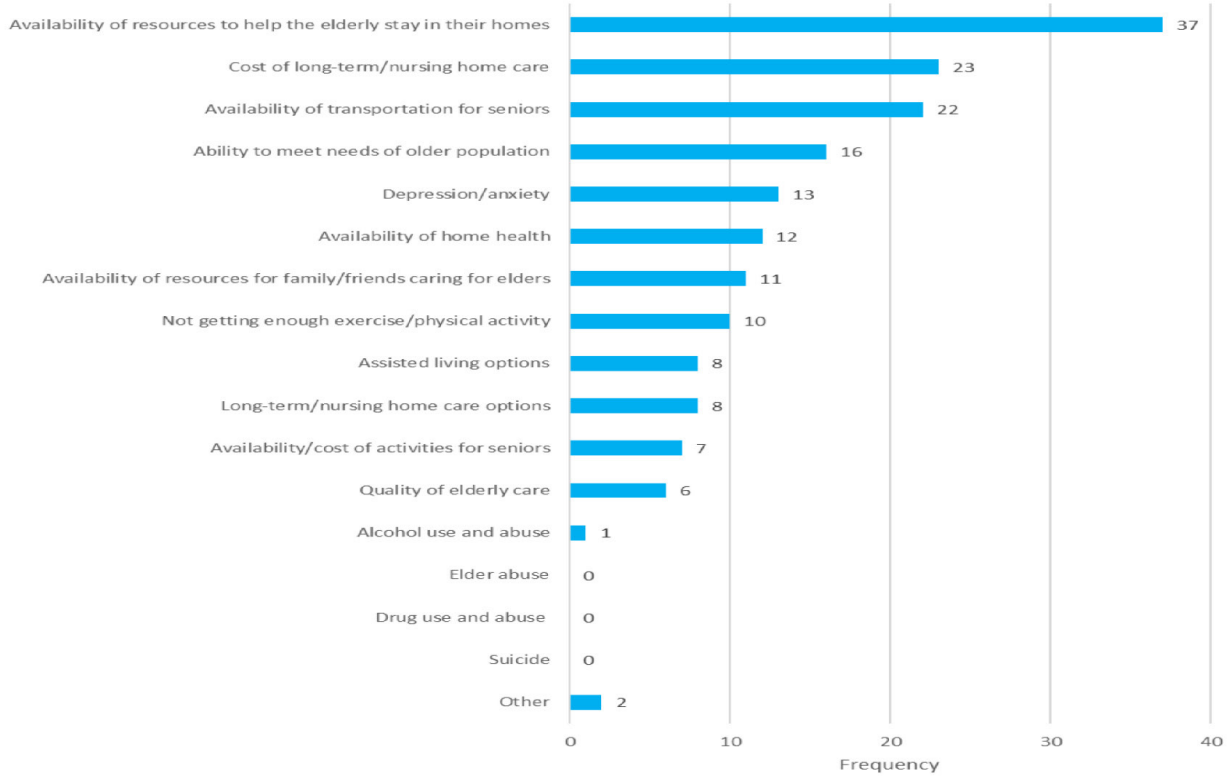
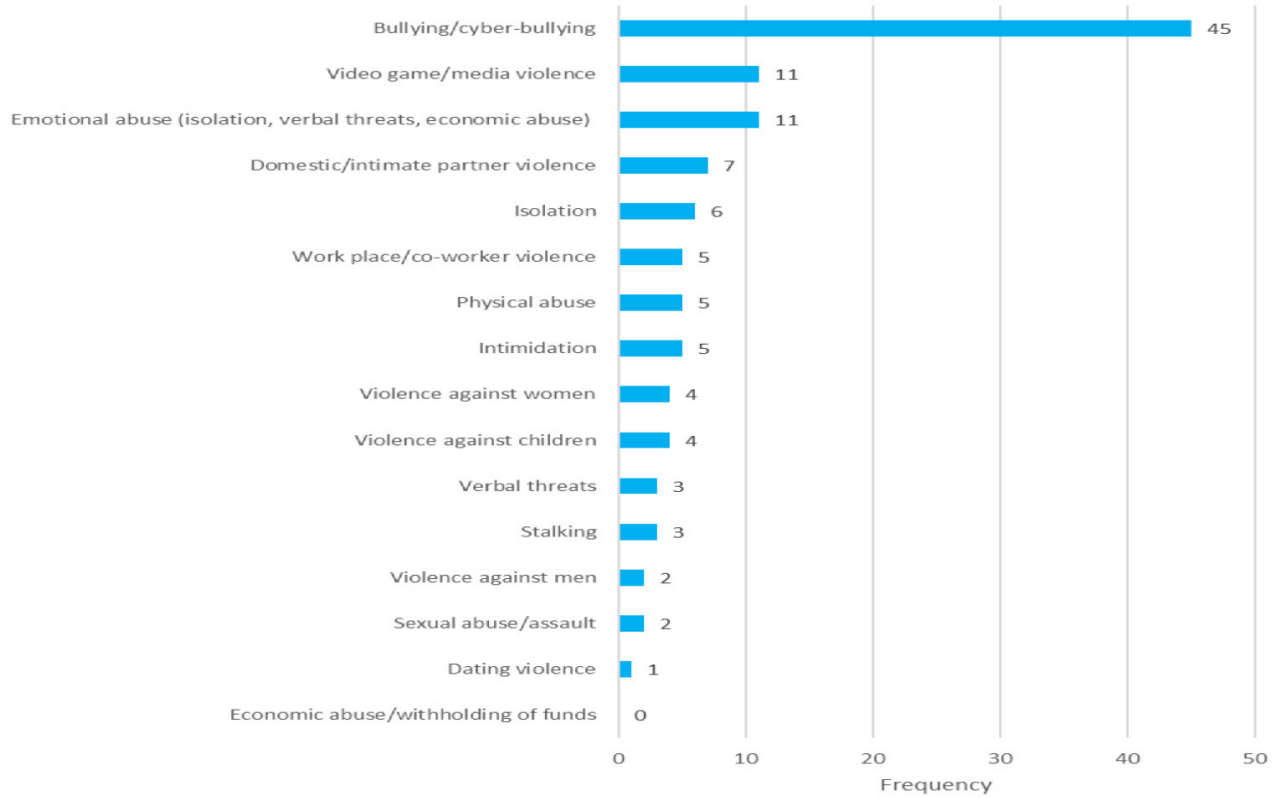


Figure 21: Senior Population Concerns
Total responses = 176



In the "Other" category, the one concern listed was the unavailability of a quality mental health provider and services.

Figure 22: Violence Concerns
Total responses = 114



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

1. Maintaining an active and vibrant community, which includes jobs with good salaries, industry, cost of living within reasonable levels (housing, utilities, food, gasoline, repairs), retaining and attracting young families, supporting local healthcare and staff;

2. Maintaining and adding healthcare services such as alcohol and chemical abuse services, mental and behavioral health services, wellness activities.

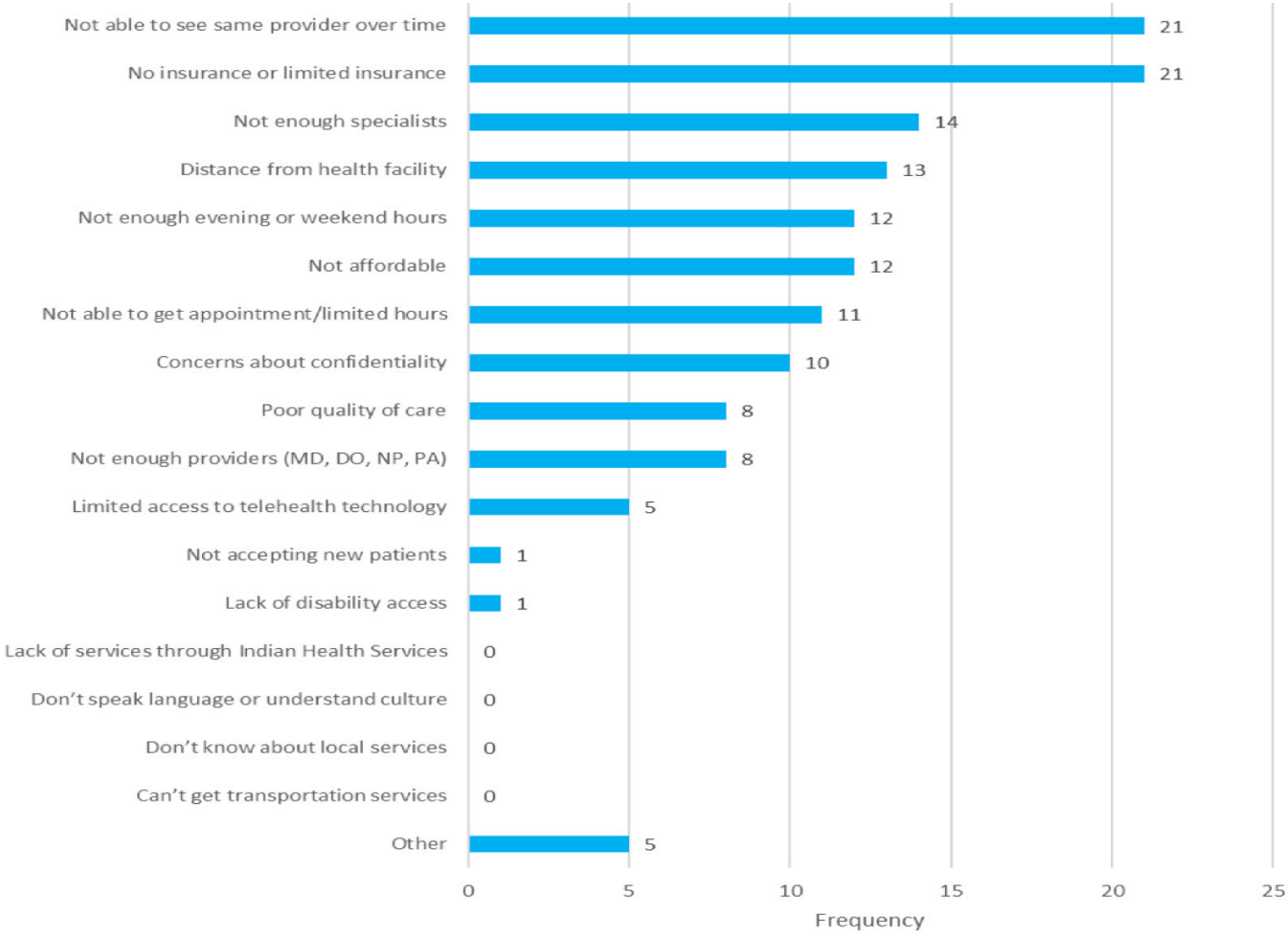
Other biggest challenges that were identified were social bullying, accepting new people in town, law enforcement shortages and attitudes, not having enough activities/things to do.

Delivery of Healthcare

The survey asked residents what they see as barriers that prevent them, or other community residents, from receiving healthcare. The most prevalent barrier perceived by residents was not enough providers (MD, DO, NP, PA) (N=46), with the next highest being not affordable (N=40). After these, the next most commonly identified barriers were not being able to see the same provider over time (N=38), no insurance or limited insurance (N=32), and not enough specialists (N=31). The majority of concerns indicated in the "Other" category were in regard to loss or lack of physicians, followed by a couple comments noting the lack of natural/holistic medicine options, and a poor billing system.

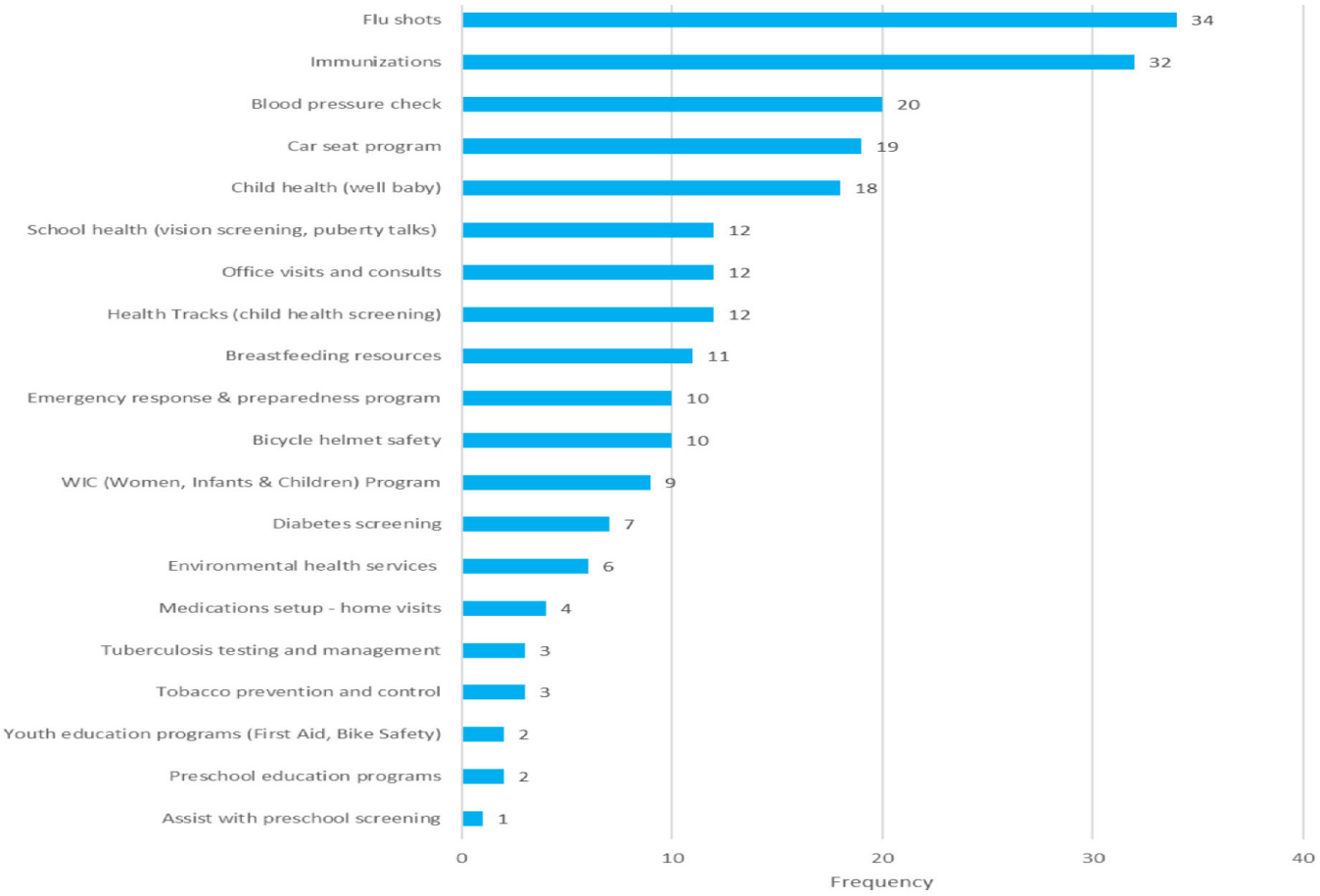
Figure 23 illustrates these results.

Figure 23: Perceptions about Barriers to Care
Total responses = 142



Considering a variety of healthcare services offered by the Upper Missouri District Health Unit/County Public Health, respondents were asked to indicate if a family member used them in the past year: (N=227).

Figure 24: Awareness and Utilization of Public Health Services



When the surveyors were asked," What specific healthcare services, if any, do you think should be added locally", the responses were;

- CPAP services, diabetes specialist, joint and bone specialists
- Home healthcare
- Indoor track and pool. Access to VA services.
- It would be great if more specialists would visit our clinic on a regular basis
- It would be nice to have a dentist full-time and an optometrist full-time
- Make sure we have doctors/nurse practitioners that stay in the area for a longer period of time. Less traveling doctors & nurses for a cost savings
- Mental health services including substance/alcohol abuse.
- NA
- Rotating specialists at Crosby Clinic
- Vision and dental
- Vision services are needed in this area. There is only a dentist in town one day per week. It would be nice to have other specialists here, but I understand that the population may not be able to support that provider.

- Vision, better dentist,
- Dental/vision
- Doctor availability (MD)
- Eye and dental
- Eye care would be nice, dentist.
- Eye doctor, different dental doctor
- Mental health providers for all ages
- Mental health, education for diabetes, nutrition, exercise, wellness
- Vision

Figure 25: Perceptions about Barriers to Care

When respondents were asked where they find health information, the majority stated word of mouth (N=40) and the second largest source of information was newspapers(N=30).
Total responses = 159

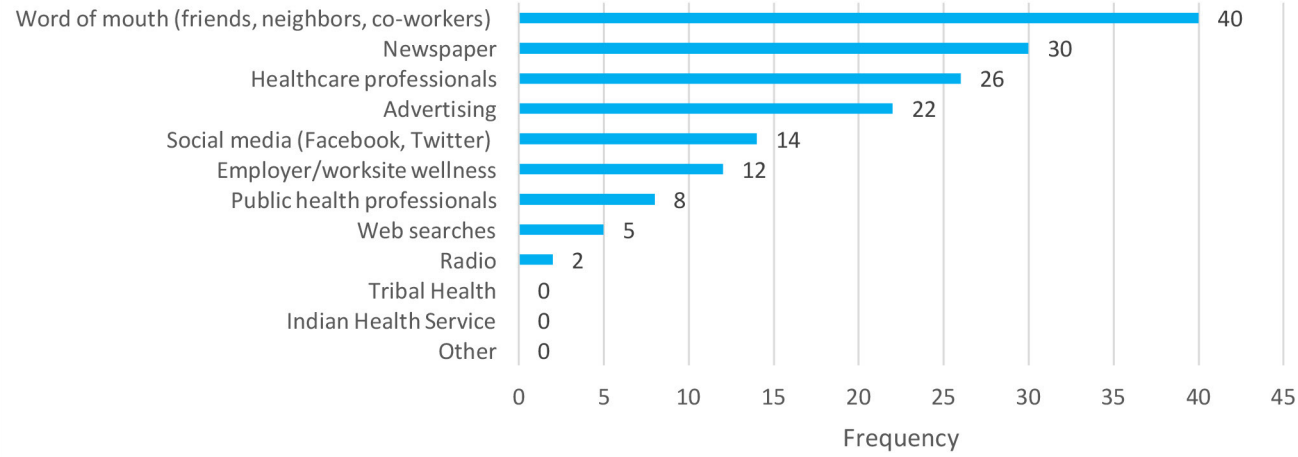


Figure 26: When asked if the respondents worked in healthcare (hospital, clinic or public health), the following percentages answered; Total responses = 62

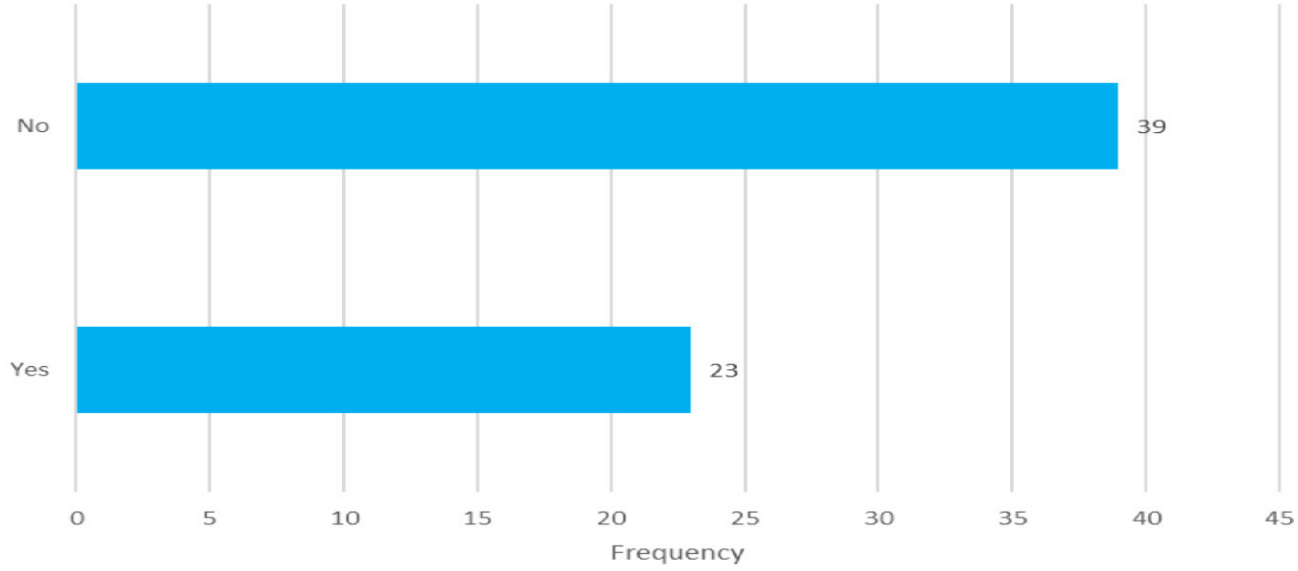
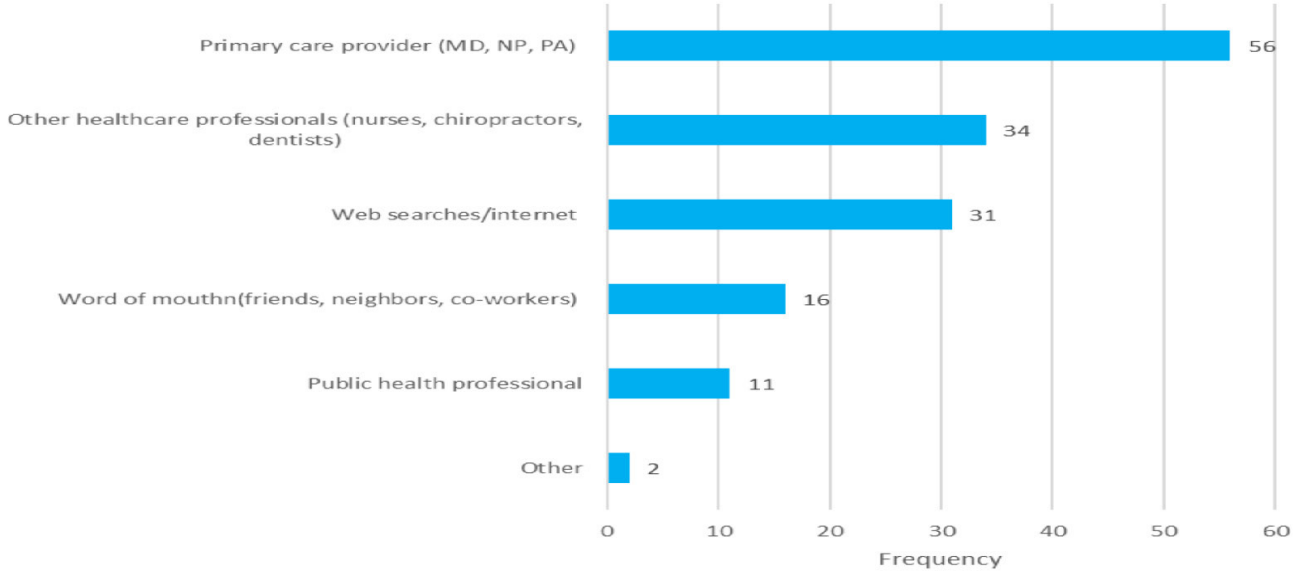


Figure 27: Sources of Trusted Health Information
Total responses = 150



Findings from Key Informant Interviews & the Community Meeting

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

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

- Behavioral health-drug and alcohol use and abuse
- Elderly care and services
- Medical staffing
- Mental health

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

Behavioral health-drug and alcohol use and abuse

- Drugs and alcohol. It's too easily accessible.
- Drugs and alcohol are very common in all ages. It's related to mental health issues.
- Many activities include alcohol- we need more positive activities.

Elderly care and services

- The cost of long-term care. Most individuals have limited resources.
- The cost of long-term care. To keep the elderly in their community near their family. It is good for employment in the community, too.
- Elderly care is a concern.

Medical staffing

- Drug and alcohol abuse and retaining our hospital staff.
- Having a facility and/or people capable of servicing elderly with conditions related to aging.
- Staffing of all our facilities/nursing/CNA and other direct staff.

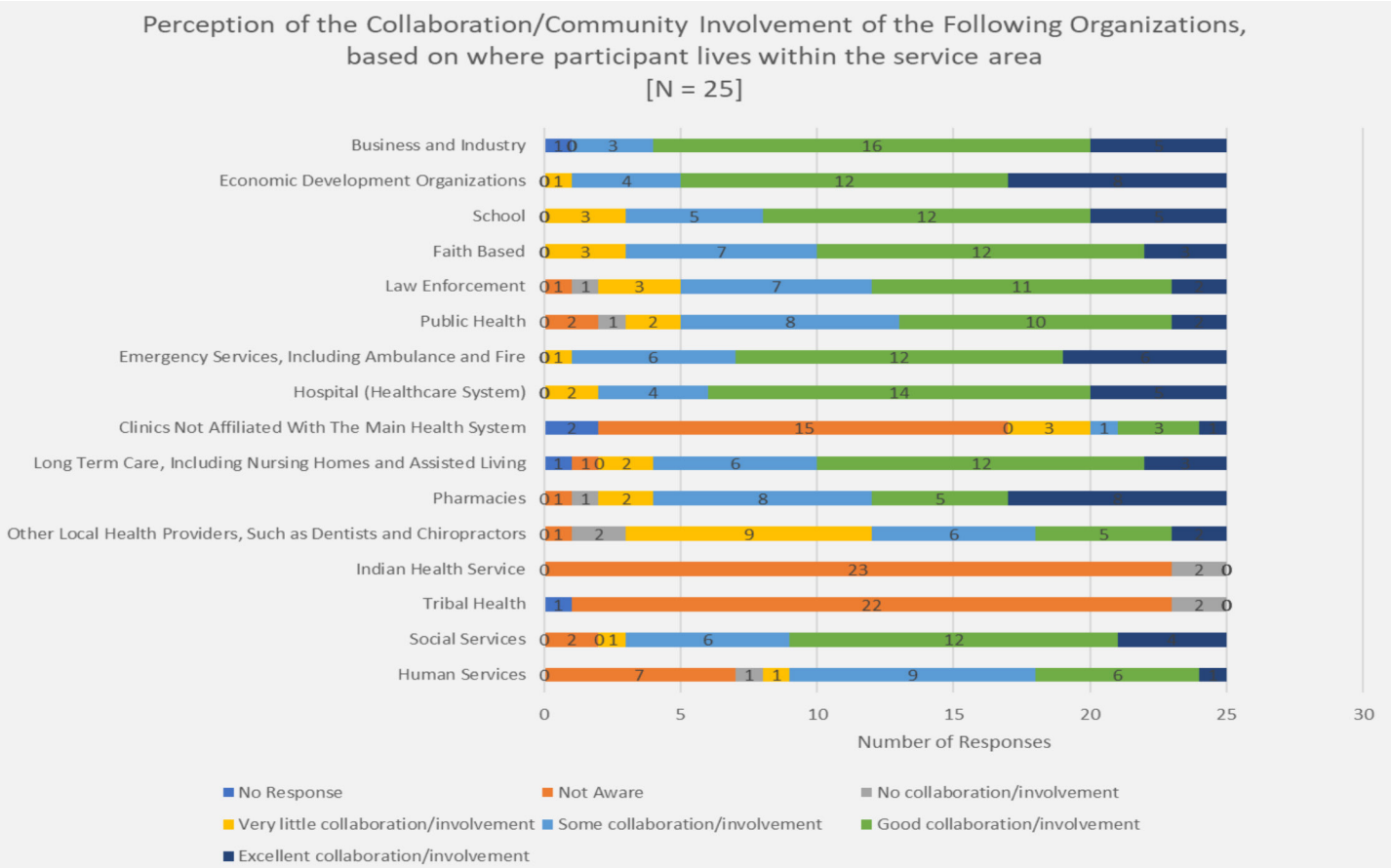
Mental health

- Everyone's mental health many suffer with depression/anxiety adjusting in the home, need more outside activities and young visitors (elderly).

- Dementia care/mental health issues. There are no providers. Its difficult at times to admit some clientele to the nursing home related to safety of the present community in the nursing home and the potential client to admit.
- Mental health, alcohol and drug abuse, lack of physical activity!

Community Engagement and Collaboration

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



Priority of Health Needs

A Community Group met on November 6, 2018. There were 23 community members who attended the meeting. Representatives from the CRH presented the group with a summary of this report's findings, including background and explanation about the secondary data, highlights from the survey results, including perceived community assets and concerns, and barriers to care, and findings from the key informant interviews.

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

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

- Alcohol use and abuse in the adult population (14 votes)
- Availability of resources to help elderly stay in their homes (11 votes)
- Availability of mental health services (9 votes)
- Bullying/cyberbullying (9 votes)

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

1. Availability of mental health resources (8 votes)
2. Availability of resources to help elderly stay in their homes (4 votes)
3. Alcohol use and abuse in the adult population (3 votes)
4. Drug use and abuse in the youth population (2 votes)

Following the prioritization process during the second meeting of the Community Group and key informants, the number one identified need was the availability of mental health resources. A summary of this prioritization may be found in Appendix C.

Comparison of Needs Identified Previously

Top Needs Identified 2016 CHNA Process	Top Needs Identified 2019 CHNA Process
Obesity/overweight	Availability of mental health resources
Adequate childcare services	Availability of resources to help the elderly stay in their homes
Youth alcohol use and abuse	Alcohol use and abuse by adults
Adult cyberbullying	Drug use and abuse by youth
Adult alcohol use and abuse	
Lack of mental health providers	

The current process identified drug and alcohol use and abuse issues similar to the study in 2014. Mental health also continued to be a recurring issue, only it is focused on resources, not only lack of mental health providers (which is providers and also other options potentially). Childcare (2016) has been replaced by concerns for the elderly (2019), which were both second-ranking. Also noted is that the concern about obesity/overweight did not make the list in 2018. Nor did cyberbullying which was on the 2016 list and tied for the third highest votes in concerns but was not on the priority list in the 2019 survey.

Hospital and Community Projects and Programs Implemented to Address Needs 2016

St. Luke's Medical Center Community Health Needs Assessment Implementation Strategy, Accomplishments, and Outcomes

The five priority concerns found in the July 2016 Community Health Needs Assessment were; attracting and retaining young families, adult alcohol use and abuse, adequate childcare services, depression, and youth alcohol use and abuse.

The survey also revealed that the biggest barriers to receiving healthcare as perceived by community members were not enough specialists (N=34), not able to see the same provider over time (N=32), not enough evening or weekend hours (N=28), not enough doctors (N=19), and concerns about confidentiality (N=16).

Attracting and Retaining Young Families:

Through the scholarship and student loan repayment programs available to St. Luke's Medical Center, they have consistently recruited staff to the area, particularly those interested in the nursing field. This includes CNA's, LPN's, and RN's. St. Luke's currently offers up to $5000 to anyone desiring to attend nursing school with priority given to current St. Luke's employees. In addition, for every year worked at St. Luke's, a nursing school graduate will receive $2500 per year student loan repayment up to a maximum of $12,500. Those desiring to attend the Certified Nurse's Aide course, which we partner with Williston State College to provide, sees a scholarship of $650 upon acceptance of a one-year service agreement with St. Luke's.

2016 Update: St. Luke's provided one RN a $5000 scholarship and one nurse practitioner a $5000 scholarship. In addition, three RN's and one nurse practitioner received $2500 student loan repayments for a total of $20,000 for the year. All recipients have families with young children. Eight certified nursing assistants completed training and received the $650 scholarship for the course.

2017 Update: St. Luke's provided one medical assistant a $5000 scholarship. In addition, three RN's and one nurse practitioner received $2500 student loan repayments for a total of $15,000 for the year. All recipients have families with young children. Two certified nursing assistants completed training and received the $650 scholarship for the course.

2018 Update: St. Luke's did not provide any $5000 scholarships, due to lack of requests. However, they did provide one RN and one nurse practitioner with $2500 student loan repayments for a total of $5,000 for the year. All recipients have families with young children. Three certified nursing assistants completed training and received the $850 scholarship for the course. The cost of the course increased due to not having an in-house instructor any longer.

Adult Alcohol Use and Abuse:

St. Luke's Medical Center has collaborated with CHI St. Alexius to provide employees with an employee assistance program whereby they and any immediate family member under the age of 27 may utilize eight free sessions annually. Addiction counselors also provide webinars and group educational services to our employees twice a year at no fee and any other time at a minimal travel charge. Likewise, St. Luke's has collaborated with a new addiction counselor who meets clients weekly in Crosby for services and are currently working with a local Alcoholics Anonymous group to provide meetings weekly in the area versus the current monthly status.

2016 Update: Ten anonymous employees, family members, or others have contacted CHI St. Alexius for Employee Assistance Program (EAP) services.

2017 Update: Fourteen anonymous employees, family members or others contacted CHI St. Alexis for EAP services. We saw a decline in requests by community residents for appointments with the addiction counselor coming to Crosby from Williston. Alcoholics Anonymous meetings began weekly on Mondays.

2018 Update: Four anonymous employees, family members or others contacted CHI St. Alexius for EAP services. At administration's request, due to staff complaints regarding the presenters content delivery styles, the educational webinars being presented twice per year have been stopped. We continued to see a decline in requests by community residents for appointments with the addiction counselor coming to Crosby from Williston. Alcoholics Anonymous meetings continue to be offered weekly on Mondays.

Adequate Childcare Services:

Although St. Luke's Medical Center is not able to provide childcare services at this time, a great deal of time is spent working with Crosby Kids Daycare, the current local center, to financially assist them in providing services. One example is donating 100% of all proceeds from the St. Luke's and Friends Annual Crosby Color Splash Family 5k Fun Run/Walk.

2016 Update: $6250 was raised and donated to the Crosby Kids Daycare through the St. Luke's and Friends Annual Crosby Color Splash Family 5K Fun Run/Walk.

2017 Update: Crosby Kids Daycare completed the construction of a new facility and opened for business in October. They are Now capable of serving up to 40 children.

2018 Update: St. Luke's developed a "Children in The Workplace" policy. This allows employee's children to be at work with them in restricted and safe areas for 1.5 hours daily, to assist employees with childcare options before and after school or other times when it is difficult to find child care. This continues to work well.

Depression:

Our providers continue to find new ways to screen patients for depression. St. Luke's has a depression screening tool integrated into their electronic medical record to make the process quick and easy for the patient. Yearly exams include discussion on mental health and the possible need for treatment. St. Luke's continues to expand treatment options by working with public health, licensed counselors, etc. to find ways to bring the services needed to the community. The idea of telemedicine has also been discussed and is a potential option in the future.

2016 Update: Tracking processes were not in place to measure the effectiveness of depression screenings.

2017 Update: St. Luke's completed a migration from one electronic health record to another in Crosby Clinic in July. St. Luke's providers in the hospital and emergency room performed 43 screens for depression with 8 needing further Public Health Questionnaire for Depression Assessments (PHQ9) screenings. Crosby Clinic began a quality improvement project in August, which measured the patients seen for a two-week period in age groups 16-40 who had a depression screening completed. The threshold was 80% completion. From 8/15 through 8/29, 25.5% were completed and from 10/23 through 11/6, providers completed 44.7%. Monitoring continued in 2018.

2018 Update: St. Luke's providers in the hospital and emergency room performed 84 screens for depression with 9 needing further PHQ9 screenings. Crosby Clinic continued the quality improvement project started in 2017, which measured the patients seen for a two-week period in age groups 16-40 who had a depression screening completed. The threshold was 80% completion. From 2/5 through 2/16, 65% were completed and from 4/2 through 4/16, 76% were completed and from 10/1 through 10/15, 61% were completed with one requiring the PHQ9 by providers.

Youth Alcohol Use and Abuse:

Addiction services for the young have certainly been a point of discussion in the community. St. Luke's has worked with a group of community services to try and obtain a grant to continue to study and work towards improvement. This was unfortunately turned down. A new addiction counselor has entered the community and will provide care for chemical addiction and substance abuse in all ages. St Luke's will continue to work with and encourage our law enforcement and ambulance services to provide community education and demonstrations related to youth alcohol use and motor vehicle accidents.

2016 Update: Unfortunately, just as for adults, there were very few appointment requests with the new addiction counselor visiting Crosby from Williston. Crosby Counseling will continue to work on informing the community of her services.

2017 Update: Prairie Tumbleweeds, Divide County Social Services, and Boogiehead entertainment hosted several events for area youth. These events ranged from dances, to bingo, haunted farm tours, pumpkin patch visits, and other activities. Unfortunately, just as for the adults, there were very few appointment requests with the new addiction counselor visiting Crosby from Williston. Crosby Counseling will continue to work on informing the community of her services.

2018 Update: Youth alcohol use and abuse was again identified in the 2019 CHNA. In addition to alcohol and drug concerns, vaping has been at an all-time high in the community and schools. St. Luke's will open discussions with public health, law enforcement, Crosby Counseling, and the schools to heighten family and community education. Divide County Social Services implemented a routine teen night for fun, games, dancing, and activities. Unfortunately, just as for the adults, there were very few appointment requests with the new addiction counselor visiting Crosby from Williston. Crosby Counseling will continue to work on informing the community of her services.

Perceived Biggest Barriers to Receiving Healthcare:

Not enough specialists – St. Luke's continues to work with regional providers regarding the potential to offer specialty services periodically at the clinic. Additional services have been added in 2016, including pulmonary function testing for those with breathing difficulties and the availability of others providing bone injection therapy services in order to keep this service local.

Not able to see the same provider over time – With the employment of an additional two providers this year and one in late 2015, St. Luke's is able to now provide consistent care with the same provider in order to achieve the continuity of care the community desperately requested and needs. St. Luke's Medical Center now has four providers, two from our locum team, that perform outpatient scope procedures, oversight, and nursing home visits.

Not enough evening or weekend hours – Expanded clinic hours continues to be discussed at St. Luke's and they will continue to work towards a solution that will serve both St Luke's and the community well.

Not enough doctors – This has been addressed by St. Luke's Medical Center and they are confident the community now sees a dramatic difference in the continuity of their care and appointment availability.

Concerns about confidentiality – St. Luke's prides themselves in being HIPAA compliant. The staff participates in annual training on HIPAA compliance. St. Luke's has a designated HIPAA Compliance Officer and continues to stay apprised of regulation changes and they work continuously to expand this program.

2016 Update: Discussions continued with St. Luke's administration to provide visiting specialist calendars. Discussions continue about offering evening or weekend hours at Crosby Clinic. At this time, it is not feasible.

2017 Update: Discussions continued with St. Luke's administration about providing visiting specialist calendars. The provider who joined the St. Luke's team in 2015, left employment. St. Luke's welcomed Benjamin Krogh, DO, as their medical director. Dr. Krogh consistently sees patients in the Crosby Clinic, as well as in the emergency room. St. Luke's has reduced the number of days the two locum tenens providers

see patients to each covering only one day per month. This allows patients to consistently see St. Luke's four employed providers. Discussions continue as to offering evening or weekend hours at Crosby Clinic. At this time, it is not feasible. A new HIPAA Compliance Officer was named due to the departure of the current officer. Two alleged HIPAA complaints were investigated and resulted in no breach in compliance. One HIPPA breach resulted in community notification and reporting to the Department of Health and Human Services for an information technology breach in one of our servers. St. Luke's entered an agreement with NorthStar Technology Group to provide information technology cyber-security and risk assessment/mitigation services.

2018 Update: The new CEO at St. Luke's began discussions with the medical director at Trinity Health in Minot to see what specialist programs could be partnered for services. Discussions involve offering dermatology, orthopedic, mental health, oncology, and IV therapy services, both in house and via tele-medicine. Additional discussions are pending with Avera in South Dakota for additional tele-medicine services. Grant funding for the first $17,500 was secured for the IV therapy services. St. Luke's has not experienced further turnover in providers. Discussions continue about offering evening or weekend hours at Crosby Clinic. At this time, it is not feasible. However, the scheduling of providers changed in the last quarter of the year, this may further the discussion on expanding clinic hours. Three alleged HIPAA complaints were investigated and resulted in no breach in compliance. Thanks to grant funding, St. Luke's entered into an agreement with NorthStar Technology Group to provide web-based information technology education and training services to employees in order to heighten awareness surrounding phishing, malware, and other dangers. This is being provided through KnowBe4.

https://www.chistalexiushealth.org/about-us/community-health-assessments.

Next Steps – Strategic Implementation Plan

Although a CHNA and strategic implementation plan are required by hospitals and local public health units considering accreditation, it is important to keep in mind the needs identified, at this point, will be broad community-wide needs along with healthcare system-specific needs. This process is simply a first step to identify needs and determine areas of priority. The second step will be to convene the steering committee, or other community group, to select an agreed upon prioritized need on which to begin working. The strategic planning process will begin with identifying current initiatives, programs, and resources already in place to address the identified community need(s). Additional steps include identifying what is needed and feasible to address (taking community resources into consideration) and what role and responsibility the hospital, clinic, and various community organizations play in developing strategies and implementing specific activities to address the community health need selected. Community engagement is essential for successfully developing a plan and executing the action steps for addressing one or more of the needs identified.

"If you want to go fast, go alone. If you want to go far, go together." Proverb

Community Benefit Report

While not required, the CRH strongly encourages a review of the most recent Community Benefit Report to determine how/if it aligns with the needs identified, through the CHNA, as well as the Implementation Plan.

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

- Free and discounted care to those unable to afford healthcare.

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

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

What Are Community Benefits?

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

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

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

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

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

Appendix A – CHNA Survey Instrument

Crosby Area Health Survey

St. Luke's Medical Center and Upper Missouri District Health Unit are interested in hearing from you about community health concerns.

The focus of this effort is to:

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

If you prefer, you may take the survey online at http://tinyurl.com/crosby.

Surveys will be tabulated by the Center for Rural Health at the University of North Dakota School of Medicine and Health Sciences. Your responses are anonymous, and you may skip any question you do not want to answer. Your answers will be combined with other responses and reported only in total. If you have questions about the survey, you may contact Kylie Nissen at 701.777.5380. ***Surveys will be accepted through September 30, 2018. Your opinion matters – thank you in advance!***

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

1. Considering the **PEOPLE** in your community, the 3 best things are (choose up to THREE):

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

2. Considering the **SERVICES AND RESOURCES** in your community, the 3 best things are (choose up to THREE):

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

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

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

4. Considering the **ACTIVITIES** in your community, the 3 best things are (choose up to THREE):

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

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

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

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

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

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

☐ Other (please specify) _____

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

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

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

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

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

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

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

- ☐ Bullying/cyber-bullying
- ☐ Dating violence
- ☐ Domestic/intimate partner violence
- ☐ Economic abuse/withholding of funds
- ☐ Emotional abuse
- ☐ Intimidation
- ☐ Isolation
- ☐ Physical abuse
- ☐ Stalking
- ☐ Sexual abuse/assault
- ☐ Verbal threats
- ☐ Video game/media violence
- ☐ Violence against children
- ☐ Violence against women
- ☐ Violence against men
- ☐ Work place/co-worker violence

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

_____

_____

Delivery of Healthcare

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

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

13. Which of the following **SERVICES** provided by Upper Missouri District Health Unit are you aware of? (Choose ALL that apply)

- ☐ Bicycle helmet safety
- ☐ Blood pressure check
- ☐ Breastfeeding resources
- ☐ Car seat program
- ☐ Child health (well baby)
- ☐ Diabetes screening
- ☐ Emergency response & preparedness program
- ☐ Flu shots
- ☐ Environmental health services (water, sewer, health hazard abatement)
- ☐ Health Tracks (child health screening)
- ☐ Immunizations
- ☐ Medications setup—home visits
- ☐ Office visits and consults
- ☐ School health (vision screening, health education topics, school immunizations)
- ☐ Preschool education programs
- ☐ Assist with preschool screening
- ☐ Tobacco prevention and control
- ☐ Tuberculosis testing and management
- ☐ WIC (Women, Infants & Children) Program
- ☐ Youth education programs (First Aid, Bike Safety)

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

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

15. Where do you find out about **LOCAL HEALTH SERVICES** available in your area? (Choose ALL that apply)

- ☐ Advertising
- ☐ Employer/worksite wellness
- ☐ Healthcare professionals
- ☐ Indian Health Service
- ☐ Newspaper
- ☐ Public health professionals
- ☐ Radio
- ☐ Social media (Facebook, Twitter, etc.)
- ☐ Tribal Health
- ☐ Web searches
- ☐ Word of mouth, from others (friends, neighbors, co-workers, etc.)
- ☐ Other: (please specify) _____

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

_____

_____

Demographic Information: Please tell us about yourself.

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

- ☐ Yes
- ☐ No

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

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

19. Age:

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

20. Highest level of education:

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

21. Gender:

- ☐ Female
- ☐ Male
- ☐ Transgender

22. Employment status:

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

23. Your zip code: _____

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

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

25. Annual household income before taxes:

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

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

_____

_____

Thank you for assisting us with this important survey!

Appendix B – County Health Rankings Explained

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

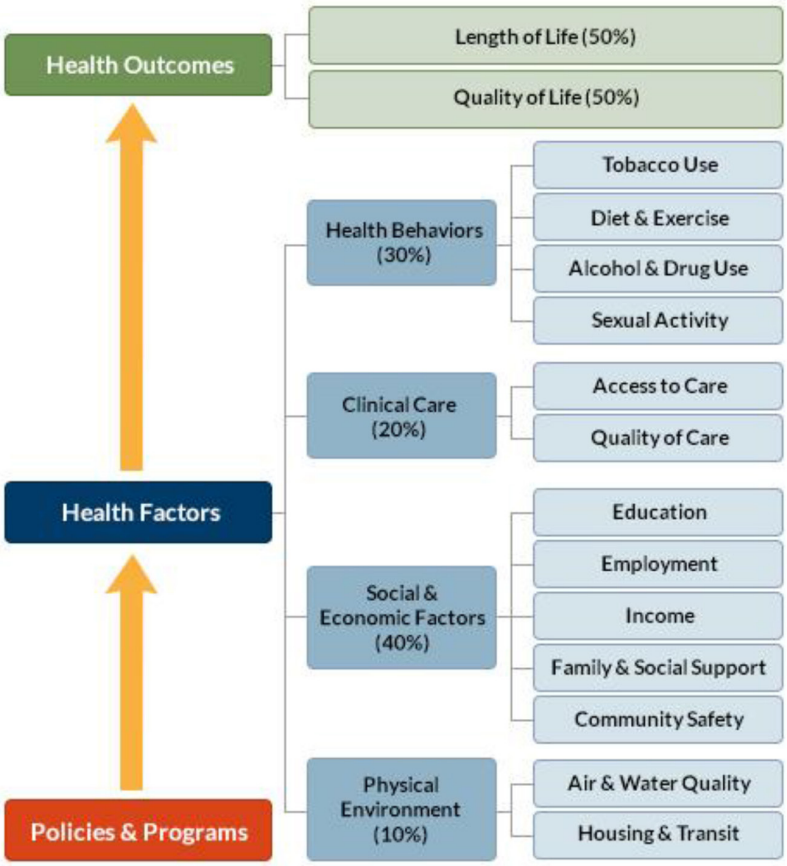
Methods

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

What is Ranked

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

Ranking System



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

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

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

Data Sources and Measures

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

Data Quality

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

Calculating Scores and Ranks

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

Health Outcomes and Factors

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

Health Outcomes

Premature Death (YPLL)

Premature death is the years of potential life lost before age 75 (YPLL-75). Every death occurring before the age of 75 contributes to the total number of years of potential life lost. For example, a person dying at age 25 contributes 50 years of life lost, whereas a person who dies at age 65 contributes 10 years of life lost to a county's YPLL. The YPLL measure is presented as a rate per 100,000 population and is age-adjusted to the 2000 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. Please note that the methods for calculating this measure changed in the 2016 Rankings.

Reason for Ranking

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

Poor Physical Health Days

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

Reason for Ranking

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

Poor Mental Health Days

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

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

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

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

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

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

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

Health Factors

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

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

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

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

Food Environment Index

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

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

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

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

Reason for Ranking

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

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

Physical Inactivity

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

Reason for Ranking

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

Access to Exercise Opportunities

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

Individuals who:

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

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

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

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

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

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

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

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

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

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

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

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

Uninsured

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

Reason for Ranking

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

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

Primary Care Physicians

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

Reason for Ranking

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

Dentists

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

Reason for Ranking

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

Mental Health Providers

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

Reason for Ranking

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Injury Deaths

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

Reason for Ranking

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

Air Pollution-Particulate matter

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

Reason for Ranking

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

Drinking Water Violations

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

Reason for Ranking

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

Severe Housing Problems

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

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

- household is severely cost burdened.

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

Reason for Ranking

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

Appendix C – Prioritization of Community's Health Needs

Community Health Needs Assessment

Crosby, North Dakota

Ranking of Concerns

The top four concerns for each of the six topic areas, based on the community survey results were listed on flipcharts. In the first round of ranking at the second community meeting, each person in attendance they were asked to place four small dots. The "Priorities column lists the number of small dots placed. In the second round of ranking, each person in attendance at the meeting was given one large dot to place on one of the four highest ranking concerns from the first round. The "Most important column lists the number of large dots placed on the flip chart which prioritized the final three concerns.

	Priorities	Most Important
Community/Environmental Health Concerns		
Attracting and retaining young families	6	
Not having jobs with livable wages	1	
Not enough public transportation options		
Recycling		
Not enough affordable housing	1	
Availability/Delivery of Health Services Concerns		
Availability of vision services	1	
Availability of dental services	2	
Availability of Mental Health services	9	8
Cost of healthcare services		
Adult Population Health Concerns		
Alcohol use and abuse	14	3
Not getting enough physical exercise	5	
Depression/anxiety		
Obesity	1	
Youth Population Health Concerns		
Alcohol use and abuse	6	
Drug use and abuse	8	2
Depression/anxiety	4	
Smoking and tobacco use (second-hand smoke)		
Senior Population Health Concerns		
Availability of resources to help elderly stay in their homes	11	4
Cost of long-term care/nursing home care	2	
Availability of transportation for older population	2	
Availability to meet the needs of the older population	2	
Violence Concerns		
Bullying/Cyber-bullying	9	
Emotional abuse (Isolation, verbal threats , with-holding of funds)		
Video game/media violence		
Domestic/Intimate partner violence	2	

Appendix D – Survey "Other" Responses

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

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

- None
- People in this community do not make new people 'feel at home"
- Push to have a better community

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

- It was even a better place to raise children before the oil came
- Lot of opportunities to be involved

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

- Need more to do

4. Considering the COMMUNITY /ENVIRONMENTAL HEALTH in your community, concerns are: "Other" responses:

- I like living in this place-I don't have concerns
- Alcohol use
- Not enough healthy food. EX. Shakes, meals, restaurants
- More recreation for families
- Industry with wages will attract families and support good wages
- If we could reduce prices to where they were (before the oil boom) I feel people would be apt to stay here and would in turn keep a thriving community.
- Percentage of low-income housing
- Can we line up available industries? Individuals needed to do jobs
- There is more drug abuse than you would think.
- Lots of litter, high fines for those who do.
- Need a school resource officer
- Not enough recreation. Too many bars and people drinking-also inactivity
- No driver for van to get to town appointments
- If people got to church, it may help other areas. Golden Rule.
- Public health more awareness on distracted driving and with school (adults texting while driving
- Empty city lots-city, law enforcement
- Mental health-need realistic solutions, school, healthcare

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

- Difficult to get health appointments for dental and mental health
- There are cost issues with urgent care vs ER visits suggest walk-in clinic on Sat. and/or Sun.
- Concerns about having enough primary care providers and nurses.
- Refer to specialists if need be-rotate then in from Minot
- Aging healthcare staff, need to encourage younger staff-? Start in high school
- Need nurses and CNAs

- Need more mental healthcare/awareness
- More counselors helping kids and adults
- Collaborate more
- Huge mental health issue-use telemedicine
- Community not using a CD (chemical-dependency) counselor
- Hospice building offsite hospice center
- Limited dental care-not daily
- No vision care in Crosby
- Cost of healthcare is main concern and is all too expensive. Lots of folks struggle.
- Sometimes you have not idea what an appt is going to cost when you come in
- Incentives for new businesses. i.e. dental, eye, Tax free.

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

- Sheriff deputies deliver unfair treatment of high school students
- Need more group discussion on alcohol use with speakers
- Involve ministerial society with medical and social services and counselors
- Drugs are to easily available and small town for kids leads to boredom and trying new things.
- Vaping
- Smoking and tobacco use are a big concern and more education is needed
- Poor coping skills
- More awareness and support for stress in school settings
- Stress leads to suicide. More help is needed—refer and educate!
- Sports and faith activities are good, but need speech, dance, liberal arts.
- Kids eat like crap!
- Different options for graduating from school such as home school, online, but need to follow through
- We are a very rural community and services are limited for students with disabilities
- We are not assessing children with disability needs.
- Counseling at school. Less "screen time." Backpack program for weekends, healthy meals.
- Teenagers think there is nothing to do even if available, so choose other such as drinking, etc.
- More information on programs. More collaboration with different entities to resolve.
- More youth and education on stress/anxiety. Schools more forward on resources they can offer to help kids.
- (1.) Combat the culture of socially acceptable risky behavior. Inform parents of current rampant behaviors. (2.) Parents - forum on how to approach, deal with and where to find help. (3.) Teach kids coping skills and not self-medication. Parents/schools/PH collaboration.
- Parental supervision. Mental health stigma. Access issues to mental health providers.

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

- A living wage
- The problem with our nursing home not accepting local residents
- Stronger AA program- is currently only old men
- Offer women's AA meetings and more AA meetings in general in Crosby
- Need more adult activities
- Public education for alcoholism
- Need stronger police enforcement
- More screenings for cancer
- Telemedicine and support group for families of dementia/Alzheimer's
- Educate the community on depression/anxiety

- Need more adult activities, recreation to help anxiety
- Not enough outlets to talk about stress
- Collaborate services to help with stress
- Refer suicides
- Offer monthly support groups to handle suicides
- More support groups for overweight individuals
- Disabled cannot get to appts or get workers to come see them from the Northwest Human Services Centerin Williston
- Get more information out for awareness of wellness programs
- More encouragement to self-care and takes advise

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

- Availability of mental health services
- No quality mental health provider
- Bring in specialists from outside to the community
- Need another assisted living
- Assisted living does not take diabetics.
- Need available resources for those who fall between private and state pay
- Need available resources to maintaining 24-hour help
- Cost of long-term/nursing home care is; huge issue, just too expensive and difficult for families who need assistance.
- Need more services for mental health

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

- Affordable quality housing
- Alcohol abuse tolerance in young kids
- Bullying from adults in superior rank to children and/or other adult subordinates in both the schools and sheriff's department.
- Bullying seems to be a big issue for our area from preschool to the elderly. Unfortunately, the kids do it because they saw their parents do it and so on. People have to remember that everyone has good qualities, sometimes we just have to look a little
- Having healthy activities. Our community has many activities that center around alcohol consumption.
- Keeping young families here and active in the community
- Lack of industry in the area which prohibits population growth.
- Limited accessibility to quality mental health services including substance and alcohol abuse.
- Not enough activities/things to do.
- Not enough tele-health options such as follow up provider visits with specialists or mental health where patients do not have to travel to receive services and can be more confidential than seeing someone in such a small community.
- Retaining/attracting young families
- Several people feel & act like they are so much better/important than some others. Don't include them in many church or community activities or many not excepted to be a part of anything. Some don't want to allow the older people to have a say, because
- The community is to set in their ways, they don't accept change or new people
- There are many, but we should start with police - no more "good old boy" attitude. Drinking and driving is a huge problem, but when the sheriff drinks and drives with them, it gets hard.
- There are not any healthy restaurants or shake places. No classes are provided. Majority of community is overweight.
- We need more good paying jobs/people to work them and lower housing rate as far as rent etc.
- We need more places to go and do family or even friend oriented activities. Bowling alley possibly?

- Assistance for elderly to remain in their homes
- Cost of healthcare.
- Cost of living is very high: housing, utilities, cable, phone, food, gasoline, repairs
- Dependable/quality healthcare staff
- Depression, domestic, bullying in school violence - police DO NOT deal with domestic and tell women's shelter in Williston, where she is to the abuser
- Drugs
- Filling open jobs
- Higher paying jobs
- Keep residents year to year
- Keeping a vibrant business district
- No preschool options within 70 miles except daycare...
- Retaining full time physicians

Delivery of Healthcare

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

- CPAP services. Diabetes specialist, joint and bone specialists
- Home Healthcare
- Indoor track and pool. Access to Veterans Administration services.
- It would be great if more specialists would visit our clinic on a regular basis
- It would be nice to have a dentist full time and an optometrist full time
- Make sure we have doctors/nurse practitioner that stay in the area for a longer period of time. Less traveling doctors & nurses. For a cost savings
- Mental health services including substance/alcohol abuse.
- NA
- Rotating specialists at Crosby Clinic
- Vision and dental
- Vision services are needed in this area. There is only a dentist in town one day per week. It would be nice to have other specialists here, but I understand that the population may not be able to support that provider.
- Vision, better dentist,
- Dental/vision
- Doctor availability (MD)
- Eye and dental
- Eye care would be nice. dentist.
- Eye doctor, different dental doctor
- Mental health providers for all ages
- Mental health, education for diabetes, nutrition, exercise, wellness
- Vision

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

- Don't provide services needed
- Not confident with healthcare here
- No mental health provider
- No VA healthcare

- Too far from specialist care

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

- Heartcare and gynecologist
- Newspaper

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

- Animal clinics for spay and neuter, for 2 times a year. animal neglect for cats is high - they deserve healthcare also
- Bill Veterans Administration and be able to take VA (veterans) patients so they don't have to commute so far. They have to go to Williston just for blood draw. If they are ever in an emergency and need ER services, the hospital WILL NOT bill the VA. So emergency services are billed STRAIGHT.
- It seems like collection letters come out before you even get a bill. It is very off-putting and makes a person not want to go to the local clinic. A simple call to arrange payment options would be sufficient, especially since there is no privacy to do so at the clinic.
- Look up Franciscan Medical Clinic in Washington. 360-874-5900. They run a very good and successful clinic and are affiliated with the hospitals in the area. They are amazing.
- NA
- Promoting healthy living. Maybe a shake bar? Similar to Herbalife? with fruit/veg. Restaurant or something similar to Power Plates? (Grand Forks) People want to be healthy but at times can't because of busy schedules. Maybe something similar to this?
- Upper Missouri Health Unit no longer provides Health Tracks screenings and Medication setup. Medication setup is a much-needed service in our area with increasing number of elderly persons.
- We are very lucky to have what we have, even if they can only patch you up and send you off to another facility - they have saved many lives! Thank God for our local healthcare facilities!
- We need to work very hard to make sure we are not hiring CEO's & etc. with top wages. A good wage is important but let's not stack a few & pay others very little. It's not good for keeping our hospital to afloat or fair to all the employees.
- When you call 911 - the dispatchers I believe are in Bismarck. They waste so much time and ask stupid questions. They will not give locations that residents know and understand. This is not a city - we are rural - we know our neighbors by name.
- Would like to see and MD on site at all times.
- Meals or food for people in retirement homes - no healthy diets!!
- Medical doctors and fiscal responsibility
- Permanent physicians
- Specialty services community education and improved healthcare involvement within community