Community Health Needs Assessment

St. Luke's Medical Center Service Area
Crosby, North Dakota

2022

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Executive Summary

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

To gather feedback from the community, residents of the area were given the opportunity to participate in a survey. One hundred seventeen St. Luke's Medical Center service area residents completed the survey. Additional information was collected through six key informant interviews with 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.

With regard to demographics, Divide County's population from 2020 to 2021 decreased by 0.3%. The average number of residents younger than age 18 (23.4%) for Divide County comes in 0.2 percentage points lower than the North Dakota average (23.6%). The percentage of residents ages 65 and older is almost 10% higher for Divide County (25.4%) than the North Dakota average (15.7%), and the rate of education is slightly lower for Divide County (92.5%) than the North Dakota average (93.1%). The median household income in Divide County ($64,650) is lower than the state average for North Dakota ($65,315).

Data, compiled by County Health Rankings, show Divide County is doing better than North Dakota in health outcomes/factors for 11 categories and is performing poorly, relative to the rest of the state, in 13 outcome/factor categories.

Of 106 potential community and health needs set forth in the survey, the 117 St. Luke's Medical Center service area residents who completed the survey indicated the following needs as the most important:

- Ability to retain primary care providers (MD, DO, NP, PA, nurses) in the community
- Alcohol use and abuse – youth and adult
- Attracting and retaining young families
- Availability of resources to help the elderly stay in their homes
- Bullying/cyberbullying
- Depression/anxiety – youth and adult
- Long-term/nursing home care options
- Not enough jobs with livable wages
- Smoking and tobacco use (second-hand smoke, vaping) – youth

The survey also revealed the biggest barriers to receiving healthcare (as perceived by community members). They included not able to see same provider over time (N=43), not enough specialists (N=33), and concerns about confidentiality (N=27).

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

- Family-friendly, good place to raise kids
- Local events and festivals
- People are friendly, helpful, and supportive
- People who live here are involved in their community
- Recreational and sports activities
- Safe place to live, little/no crime

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

- Alcohol use and abuse
- Availability of mental health services
- Bullying/cyberbullying
- Depression/anxiety

Overview and Community Resources

With assistance from the Center for Rural Health (CRH) at the University of North Dakota (UND) School of Medicine & Health Sciences (SMHS), St. Luke's Medical Center completed a Community Health Needs Assessment (CHNA) of their service area. The hospital identifies its service area as Divide, Burke, and Willliams Counties. Many community members and stakeholders worked together on the assessment.

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

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

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

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

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

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

The first wildcat oil venture was launched in 1926 north of Crosby, and mineral leasing hit record levels in 2004, only to be surpassed in 2008 and 2009. After early homesteaders built underground lignite mines, commercial strip mining began in 1930.

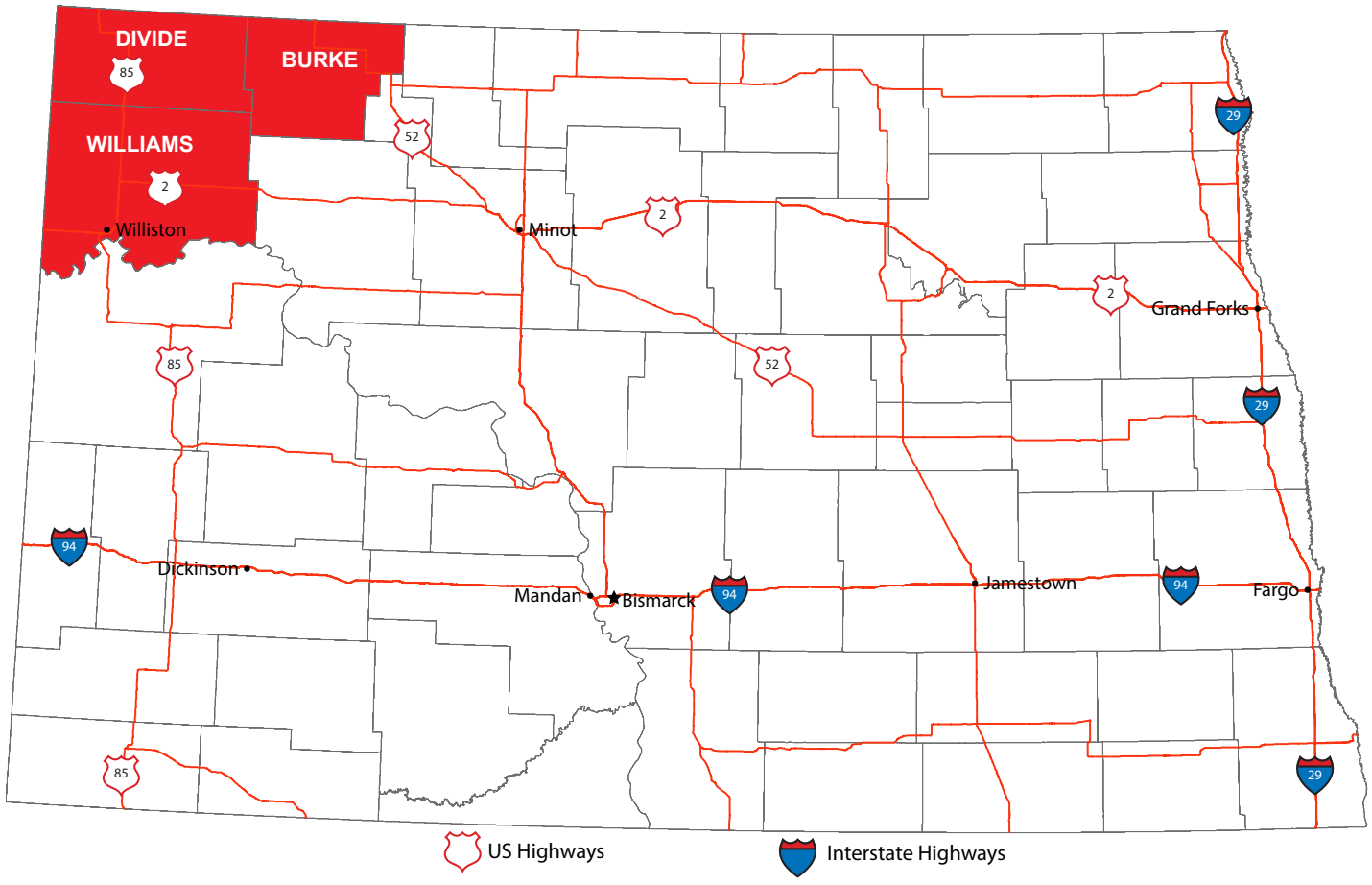
In the western half of the county, the federal government played a significant role, choosing a site west of Fortuna for a Cold War radar station. Many present-day residents of Divide County have family ties to the men who served at "the base," but it outlived its usefulness just as the Cold War era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

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

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

Figure 1 illustrates the location of the counties.

Figure 1: Divide, Burke, and Williams Counties



St. Luke's Medical Center

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

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

When the Benedictine Sisters of Sacred Heart Priority, Richardton, North Dakota, bought the building in 1938 from Mr. Person, it just had the basement and the first floor furnished; the second floor was just a "shell." For four years the Sisters operated it as St. Joseph's Home for the Aged. By 1941, the city of Crosby had grown to the extent that the townspeople and the surrounding area communities realized their need for a hospital and urged the Sisters to convert the Home into a hospital, which they did, opening the doors on February 11, 1942. At this time, the name was changed to St. Luke's Hospital. In 1965, they moved into a new 25-bed facility, as the old one would no longer meet the requirements of the State Department of Health of North Dakota. The Benedictine Sisters of Sacred Heart Priority transferred ownership and operation of the hospital to the Crosby community and area on July 1, 1984. It continues to be operated as a non-profit institution, which means that income in excess of operation is reinvested in salaries and benefits for employees, modern medical equipment, and expansion.

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

On May 1, 2013, the former Good Samaritan Society facility and employees were welcomed to the St. Luke's family, becoming the St. Luke's Sunrise Care Center. This facility closed permanently September 5, 2021.

The governing body of St. Luke's Medical Center consists of nine members from the community. This board defines the objectives for the medical center staff.

St. Luke's Medical Center has a significant economic impact on the region. They directly employ 91 FTE employees with an annual payroll of over $6.22 million (including benefits). These employees create an additional 32 jobs and nearly $1.12 million in income, as they interact with other sectors of the local economy. This employment results in a total impact of 123 jobs and more than $7.34 million in income. Additional information is provided in Appendix B.

Mission

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

Vision

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

- To improve spiritual, mental, and physical aspects and quality of life for individuals and families
- To develop high quality management, staff, and policy making that promotes a healthy working environment

- To conduct our mission of healthcare in an ethical manner by complying with all applicable laws and regulations
- To maintain a viable and profitable healthcare system
- To be a primary resource for information about healthcare
- To foster growth and adapt to healthcare changes
- To be a patient-focused organization providing exceptional care with respect and compassion
- To be contributors to the community through health awareness education

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

It has been, and will continue to be, the policy of this institution to render care to all those requiring our services without regard to sex, race, handicap, age, sexual preference, creed, national origin, or ability to pay. It shall, because of its status within the community, accept the position of leadership in initiating and developing health care programs within its geographic area of responsibility and shall cooperate with all other health organizations both within and outside our primary service area.

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

Core Values
Respect
- o We recognize the inherent dignity of each individual and will treat each person with the reference and respect. The personal privacy of each individual will be respected at all times.

Compassion
- o 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
- o 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
- o 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
- o We support, protect, and promote the rights of our patients, residents, family members, and staff giving them opportunities to provide input toward improving the quality of their lives. We will advocate for structures attuned to the needs of the vulnerable and disadvantaged and promote a sense of community among all persons.

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

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

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

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

General and Acute Services

- Acute care (hospital)
- Behavioral health
- Blood pressure and hypertension monitoring
- Chronic disease management
- Dermatology
  - o Acne treatment
  - o Botox
  - o Filler
  - o Cryotherapy
  - o Mole, wart, and skin lesion removal
- Emergency room
- General medical – surgical care
- Gynecology (per family practice providers)
- Holter monitoring
- Immunizations: allergy, influenza, pneumonia, shingles/Zostavax, tetanus, Tdap, COVID-19
- Long-term non-skilled swing bed (hospital)
- Lower extremity circulatory assessment
- Orthopedics
- Outpatient services (hospital)
- Outpatient surgery (hospital)
  - o Biopsies
  - o Colonoscopies
  - o EGDs
- Physicals: occupational, annual, DOT, insurance, sports
- Rural Health Clinic – general and routine exams
- Skilled swing bed (hospital)
- Social services
- Special care unit
- Trauma center (Level V)

Screening/Therapy Service

- Physical therapy

Radiology Services

- CT scan (mobile unit)
- Digital mammography (mobile unit)
- Echocardiogram
- EKG
- General X-ray
- Mammograms (mobile)
- Ultrasound (mobile)

Laboratory Services

- Blood typing, antibody screen, x-match
- General chemistry
- Hematology
- Immunoassay, PSA, TSH
- Prothrombin time/INR
- Urine testing

Services offered through OTHER providers/organizations

- Ambulance
- Chiropractic services
- Dental services
- Massage therapy
- Optometric/vision services
- Occupational therapy services

Assisted Living at Northern Lights Villa

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

Upper Missouri District Health Unit

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

Divide County Public Health is within UMDHU and provides public health services that encompass all residents, aged birth to death.

Mission

UMDHU, serving northwestern North Dakota, promotes healthy lifestyles through health education, prevention and control of disease, and the protection and enhancement of the environment.

Specific services that UMDHU provides are:

- Blood pressure checks
- Breastfeeding resources
- Car seat program
- COVID-19 vaccine administration
- Emergency preparedness services (work with community partners as part of local emergency response team)
- Environmental health services (mold inspection, sewer, health hazard abatement, school, and daycare inspections)
- Family planning (STD and HIV testing)
- Flu shots
- Foot care
- Foreign travel immunizations
- Immunizations
- Newborn home visits/clinic
- Nutrition education
- School health – health education and resources to the schools
- Tobacco prevention and control
- Tuberculosis testing and management
- WIC (Women, Infants, and Children) program
- Youth alcohol prevention

Assessment Process

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

A CHNA benefits the community by:

1. Collecting timely input from the local community members, providers, and staff.
2. Providing an analysis of secondary data, related to health-related behaviors, conditions, risks, and outcomes.
3. Compiling and organizing information to guide decision making, education, and marketing efforts, and to facilitate the development of a strategic plan.
4. Engaging community members about the future of healthcare.
5. Allowing the community hospital to meet the federal regulatory requirements of the Affordable Care Act, which requires not-for-profit hospitals to complete a CHNA at least every three years as well as helping the local public health unit meet accreditation requirements.

This assessment examines health needs and concerns in Divide County, the St. Luke's Medical Center service area.

The Center for Rural Health (CRH), in partnership with St. Luke's Medical Center and Upper Missouri District 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 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 CRH met and corresponded regularly by videoconference 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. Thirteen people, representing a cross section demographically, attended the focus group meeting. The meeting was highly interactive with good participation. St. Luke's Medical Center staff were in attendance as well but largely played a role of listening and learning.

Figure 2: Steering Committee

Melissa Nystuen	MSW, LICSW, Nystuen Counseling Services
Juliet Artman	Public health nurse, UMDHU
Sam Pulvermacher	Director, Divide County Social Services
Marianne Snell	Director of human resources, St. Luke's Medical Center
Megan Peterson	Controller, St. Luke's Medical Center

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

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

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

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

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

Community Group

A community group, consisting of 17 community members, was convened and first met on January 13, 2022. During this first community group meeting, group members were introduced to the needs assessment process, reviewed basic demographic information about the community, and served as a focus group. Focus group topics included community assets and challenges, the general health needs of the community, community concerns, and suggestions for improving the community's health.

The community group met again on March 9, 2022, with 13 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 UMDHU. They included representatives of the health community, mental health agencies, education, 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 virtually in January of 2022. A representative from CRH conducted the interviews. Interviews were held with selected members of the community who could provide insights into the community's health needs.

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 C, and a full listing of direct responses, provided for the questions that included "Other" as an option, are included in Appendix G.

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

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

Specifically, the survey covered the following topics:

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

To promote awareness of the assessment process, press releases led to published articles in two newspapers in Divide and Burke counties. Additionally, information was published on St. Luke's Medical Center's website and Facebook page.

Approximately 50 community member surveys were available for distribution in Divide County. The surveys were distributed at the local library, St. Luke's Medical Center, and the Divide County Court House.

To help ensure anonymity, included with each survey was a postage-paid return envelope to CRH. In addition, to help make the survey as widely available as possible, residents also could request a survey by calling St. Luke's Medical Center or UMDHU. The survey period ran from January 14, 2022, to January 24, 2022. Five completed paper surveys were returned.

Area residents were also given the option of completing an online version of the survey, which was publicized in two community newspapers, community employee email lists, on the website and Facebook page of St. Luke's Medical Center, and on flyers distributed at local businesses, organizations, schools, and post offices. One hundred seven online surveys were completed. Twenty-nine of those online respondents used the QR code to complete the survey. In total, counting both paper and online surveys, 117 community member surveys were completed, equating to just under a 13% response rate. This response rate is on par for this type of unsolicited survey methodology and indicates an engaged community.

Secondary Data

Secondary data were collected and analyzed to provide descriptions of: (1) population demographics, (2) general health issues (including any population groups with particular health issues), and (3) contributing causes of community health issues. Data were collected from a variety of sources, including the U.S. Census Bureau; Robert Wood Johnson Foundation's County Health Rankings, which pulls data from 20 primary data sources; the National Survey of Children's Health, which touches on multiple intersecting aspects of children's lives; 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; and Youth Risk Behavior Surveillance System (YRBSS) data, which is published by the Centers for Disease Control and Prevention.

Social Determinants of Health

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

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

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

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

Figure 3: Social Determinants of Health

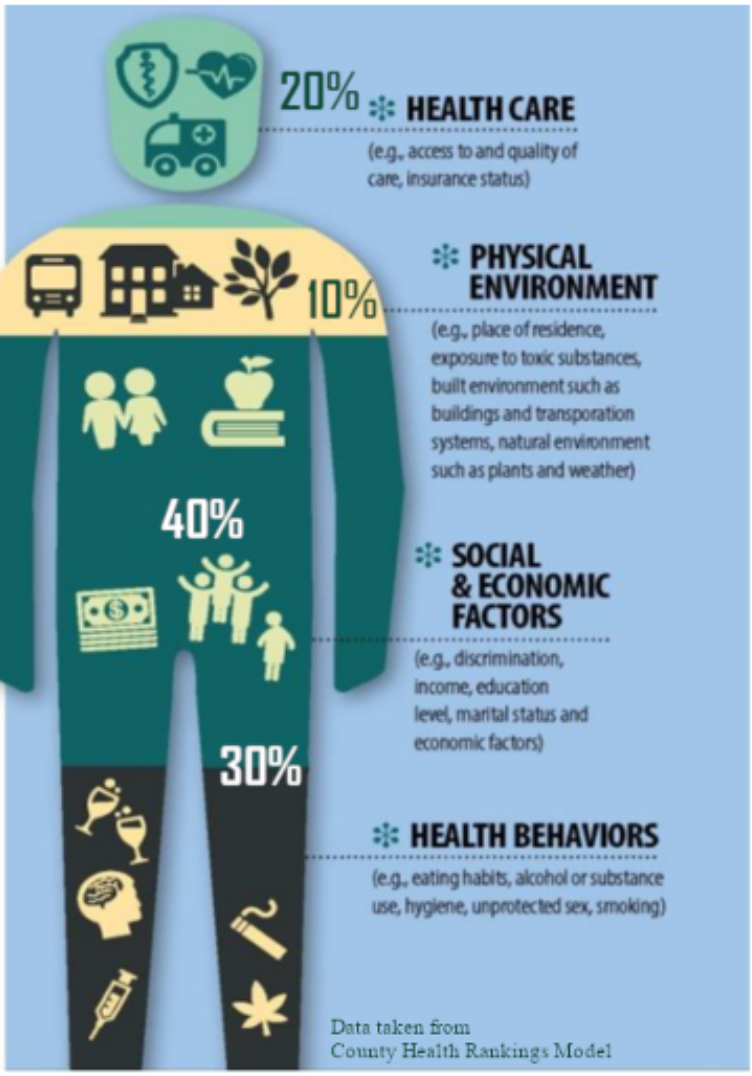
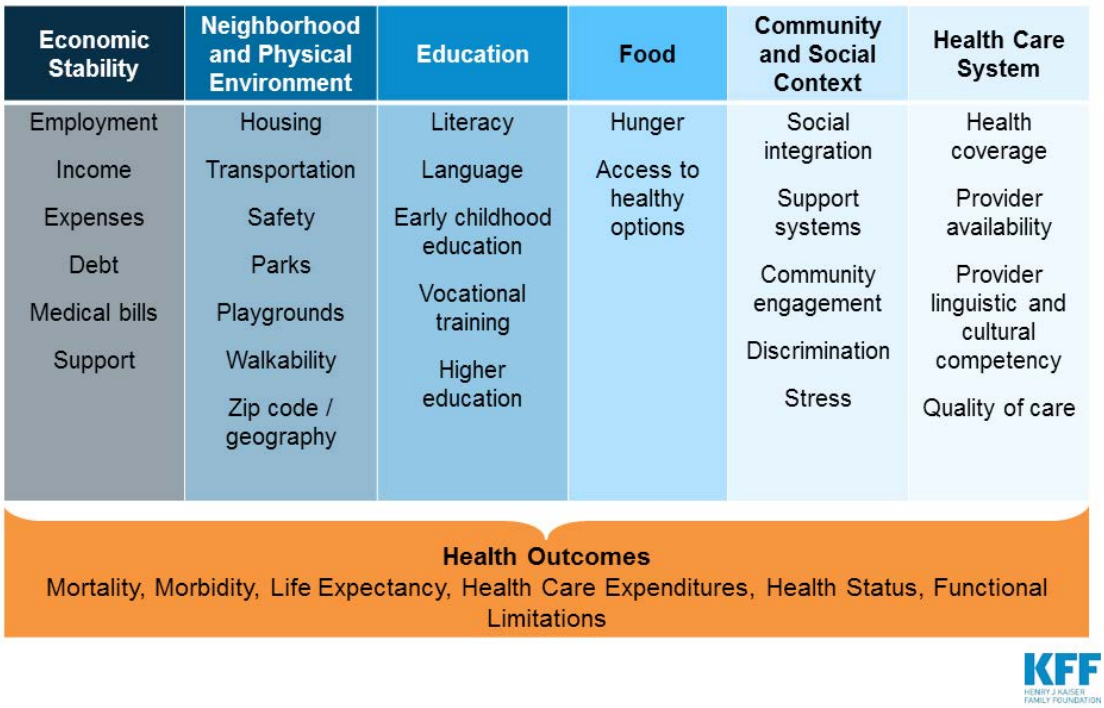


Figure 4 (Henry J. Kaiser Family Foundation, https://www.kff.org/disparities-policy/issue-brief/beyond-health-care-the-role-of-social-determinants-in-promoting-health-and-health-equity/), provides examples of factors that are included in each of the social determinants of health categories that lead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

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

Figure 4: Social Determinants of Health



Demographic Information

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

	Divide County	North Dakota
Population (2021)	2,188	779,948
Population change (2020-2021)	-0.3%	-0.5%
People per square mile (2010)	1.6	9.7
Persons 65 years or older (2020)	25.4%	15.7%
Persons younger than 18 years (2020)	23.4%	23.6%
Median age (2020)	48.1	35.2
White persons (2020)	93.4%	86.9%
High school graduates (2020)	92.5%	93.1%
Bachelor's degree or higher (2020)	16.2%	30.7%
Live below poverty line (2020)	10.7%	10.2%
Persons without health insurance, younger than age 65 (2019)	10.1%	8.1%
Households with a broadband internet subscription (2020)	68.4%	83.1%

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

The population of North Dakota has slightly decreased in recent years, and Divide County is no exception. Divide County has seen a slight decrease in population since 2020.

County Health Rankings

The Robert Wood Johnson Foundation, in collaboration with the University of Wisconsin Population Health Institute, has developed County Health Rankings to illustrate community health needs and provide guidance for actions toward improved health. In this report, 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 2021 County Health Rankings, are pulled from more than 20 data sources and then are compiled to create county rankings. Counties in each of the 50 states are ranked according to summaries of a variety of health measures. Those counties having high ranks, such as 1 or 2, are considered to be the "healthiest." Counties are ranked on both health outcomes and health factors. Following is a breakdown of the variables that influence a county's rank.

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

Health Outcomes

- Length of life
- Quality of life

Health Factors

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

Health Factors (continued)

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

Table 2 summarizes the pertinent information, gathered by County Health Rankings, as it relates to Divide County. It is important to note that these statistics describe the population of a county, regardless of where county residents choose to receive their medical care. In other words, all of the following statistics are based on the health behaviors and conditions of the county's residents, not necessarily the patients and clients of Upper Missouri District Health Unit (UMDHU) and St. Luke's Medical Center or of any particular medical facility.

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

Divide County rankings within the state are included in the summary following. For example, Divide County ranks 35th out of 46 ranked counties in North Dakota on health outcomes and 29th out of 45 on health factors. The measures, marked with a bullet point (•), are those where the county is not measuring up to the state rate/percentage; a square (■) indicates that the county is not meeting the U.S. Top 10% rate on that measure. Measures that are not marked with a colored shape but are marked with a plus sign (+) indicate that the county is doing better than the U.S. Top 10%.

The data from County Health Rankings show that Divide County is doing better than some counties, compared to the rest of the state on all but two of the outcomes, landing at or above rates for other North Dakota counties. However, similar to many North Dakota counties, Divide County is doing poorly in many areas when it comes to the U.S. Top 10% ratings. One particular outcome where Divide County does not meet

the U.S. Top 10% ratings is the number of poor physical health days in the past 30 days.

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

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

- Poor mental health days
- Adult obesity
- Excessive drinking
- Alcohol-impaired driving deaths
- Unemployment
- Social associations
- Violent crime
- Air pollution – particulate matter
- Drinking water violations
- Severe housing problems

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

- Poor or fair health
- Poor physical health days
- Adult smoking
- Food environment index
- Physical inactivity
- Access to exercise opportunities
- Uninsured
- Dentists
- Preventable hospital stays
- Mammography screening (% of Medicare enrollees ages 65-74 receiving screening)
- Flu vaccinations (% of fee-for-service Medicare enrollees receiving vaccination)
- Children in poverty
- Income inequality

TABLE 2: SELECTED MEASURES FROM COUNTY HEALTH RANKINGS 2021– DIVIDE COUNTY

● = Not meeting North Dakota average

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

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

Blank values reflect unreliable or missing data

TABLE 2: SELECTED MEASURES FROM *COUNTY HEALTH RANKINGS* 2021 – DIVIDE COUNTY			
	Divide County	**U.S. Top 10%**	**North Dakota**
Ranking: Outcomes	**35th**		**(of 46)**
Premature death		5,400	6,600
Poor or fair health	16% ■●	14%	14%
Poor physical health days (in past 30 days)	3.5 ■●	3.4	3.2
Poor mental health days (in past 30 days)	3.8 +	3.8	3.8
Low birth weight		6%	6%
Ranking: Factors	**29th**		**(of 45)**
Health Behaviors			
Adult smoking	21% ■●	16%	20%
Adult obesity	33% ■	26%	34%
Food environment index (10=best)	8.6 ■●	8.7	8.9
Physical inactivity	24% ■●	19%	23%
Access to exercise opportunities	55% ■●	91%	74%
Excessive drinking	24% ■	15%	24%
Alcohol-impaired driving deaths	25% ■	11%	42%
Sexually transmitted infections		161.2	466.6
Teen birth rate		12	20
Clinical Care			
Uninsured	10% ■●	6%	8%
Primary care physicians		1,030:1	1,300:1
Dentists	2,260:1 ■●	1,210:1	1,510:1
Mental health providers		270:1	510:1
Preventable hospital stays	5,281 ■●	2,565	4,037
Mammography screening (% of Medicare enrollees ages 65-74 receiving screening)	45% ■●	51%	53%
Flu vaccinations (% of fee-for-service Medicare enrollees receiving vaccination)	18% ■●	55%	50%
Social and Economic Factors			
Unemployment	1.4% +	2.6%	2.4%
Children in poverty	14% ■●	10%	11%
Income inequality	5.1 ■●	3.7	4.4
Children in single-parent households	15% ■	14%	20%
Social associations	30.7 +	18.2	16.0
Violent crime	0 +	63	258
Injury deaths		59	71
Physical Environment			
Air pollution – particulate matter	4.3 +	5.2	4.7
Drinking water violations	No		
Severe housing problems	9% +	9%	12%

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

Children's Health

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

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

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

Health Status	North Dakota	National
Children born premature (3 or more weeks early)	9.9%	11.2%
Children ages 10-17 overweight or obese	26.9%	32.1%
Children ages 0-5 who were ever breastfed	86.1%	80.8%
Children ages 6-17 who missed 11 or more days of school	2.9%	3.9%
Healthcare		
Children currently insured	93.6%	93.1%
Children who spent less than 10 minutes with the provider at a preventive medical visit	16.0%	18.1%
Children (1-17 years) who had preventive a dental visit in the past year	73.7%	77.5%
Children (3-17 years) received mental healthcare	10.5%	11.0%
Children (3-17 years) with problems requiring treatment did not receive mental healthcare	2.3%	2.5%
Young children (9-35 mos.) receiving standardized screening for developmental problems	31.1%	36.9%
Family Life		
Children whose families eat meals together 4 or more times per week	79.2%	75.2%
Children who live in households where someone smokes	16.1%	14.0%
Neighborhood		
Children who live in neighborhoods with parks or playgrounds	81.7%	74.9%
Children living in neighborhoods with poorly kept or rundown housing	9.1%	13.3%
Children living in neighborhood that's usually or always safe	97.3%	94.6%

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

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

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

Table 4 includes selected county-level measures regarding children's health in North Dakota. The data come from North Dakota KIDS COUNT, a national and state-by-state effort to track the status of children, sponsored by the

Annie E. Casey Foundation. KIDS COUNT data focuses on the main components of children's well-being; more information about KIDS COUNT is available at www.ndkidscount.org. The measures highlighted in blue in the table are those in which the counties are doing worse than the state average. The year of the most recent data is noted.

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

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

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

	Divide County	North Dakota
Child food insecurity, 2019	6.5%	9.6%
Medicaid recipient (% of population age 0-20), 2020	25.3%	26.0%
Children enrolled in Healthy Steps (% of population age 0-18), 2020	0.6%	1.7%
Supplemental Nutrition Assistance Program (SNAP) recipients (% of population age 0-18), 2020	13.6%	17.0%
Licensed childcare capacity (# of children), 2020	123	36,701
Four-year high school cohort graduation rate, 2020/2021	≥90%	87.0%
Victims of child abuse and neglect requiring services (rate per 1,000 children ages 0-17), 2020	NA	9.98

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

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

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

TABLE 5: Youth Risk Behavior Survey Results

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

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

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

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

Low Income Needs

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

Top Needs Identified by People Experiencing Poverty Across North Dakota

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

2020 North Dakota LOW INCOME COMMUNITY NEEDS

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

NDSU North Dakota State University

Assessed by CAPND and NDSU, November 2020

KEY FINDINGS

1st Priority Need

Rental Assistance

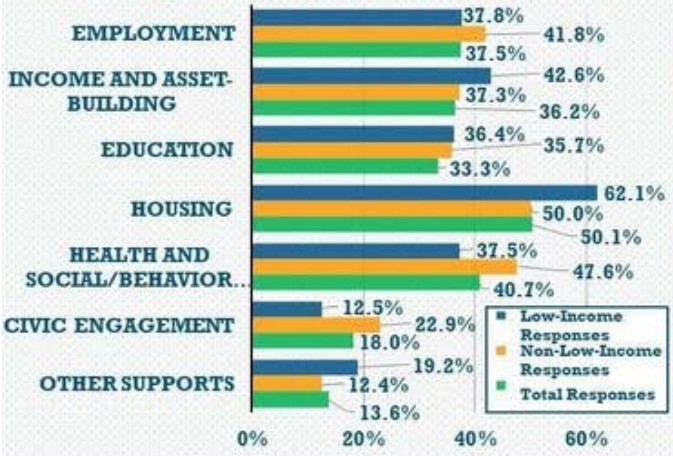
3,458 Total Survey Responses

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

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

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

STATEWIDE OVERALL NEEDS



TOP STATEWIDE SPECIFIC NEEDS

Low-Incomes

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

Non-Low-Incomes

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

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

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

TOP REGIONAL OVERALL NEEDS FOR LOW-INCOMES

ACKNOWLEDGMENTS

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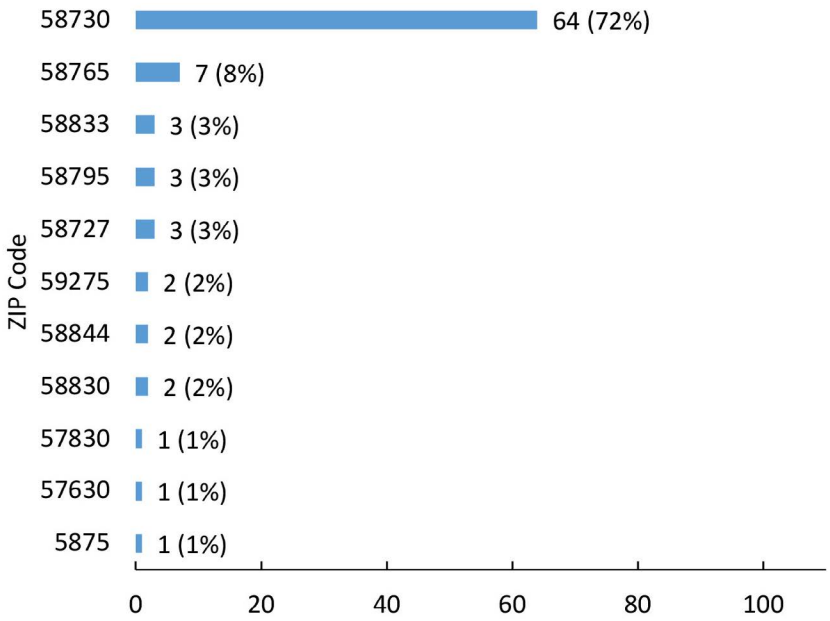
Survey Results

As noted previously, 117 community members completed the survey in communities throughout the counties in the St. Luke's Medical Center service area. For all questions that contained an "Other" response, those direct responses may be found in Appendix G. In some cases, a summary of those comments is additionally included in the report narrative. The "Total respondents" number under each heading indicates the number of people who responded to that particular question. Some questions allowed for selection of more than one response.

The survey requested that respondents list their home zip code. While not all respondents provided a zip code, 89 did, revealing that a large majority of respondents (72%, N=64) lived in Crosby. These results are shown in Figure 5.

Figure 5: Survey Respondents' Home Zip Code
Total respondents: 89



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

Survey Demographics

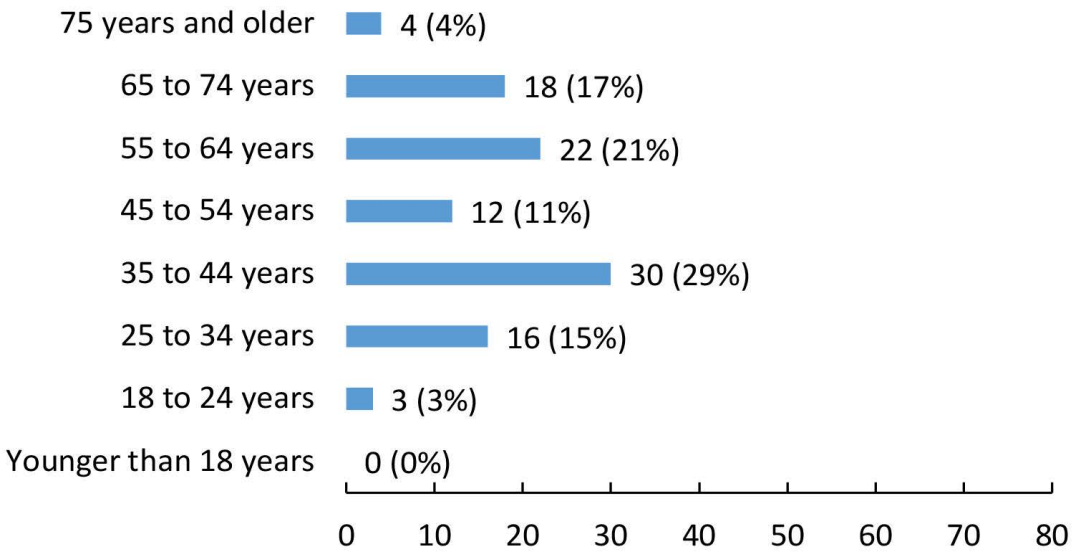
To better understand the perspectives being offered by survey respondents, survey-takers were asked a few demographic questions. Throughout this report, numbers (N) instead of just percentages (%) are reported because percentages can be misleading with smaller numbers. Survey respondents were not required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

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

- 42% (N=44) were age 55 or older
- The majority (81%, N=85) were female
- Slightly more than half of the respondents (53%, N=56) had bachelor's degrees or higher
- The number of those working full time (65%, N=68) was just over four times higher than those who were retired (15%, N=16)
- 99% (N=100) of those who reported their ethnicity/race were White/Caucasian
- 14% of the respondents (N=14) had household incomes of less than $50,000

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

Figure 6: Age of Survey Respondents
Total respondents = 105



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

Figure 7: Gender of Survey Respondents
Total respondents = 105

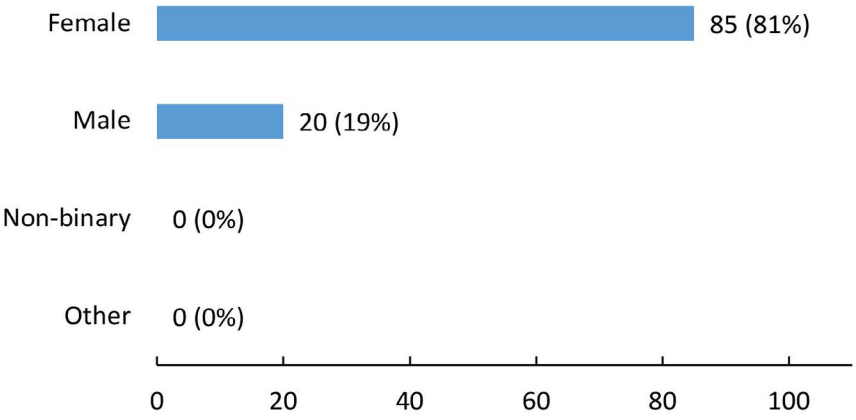


Figure 8: Educational Level of Survey Respondents
Total respondents = 105

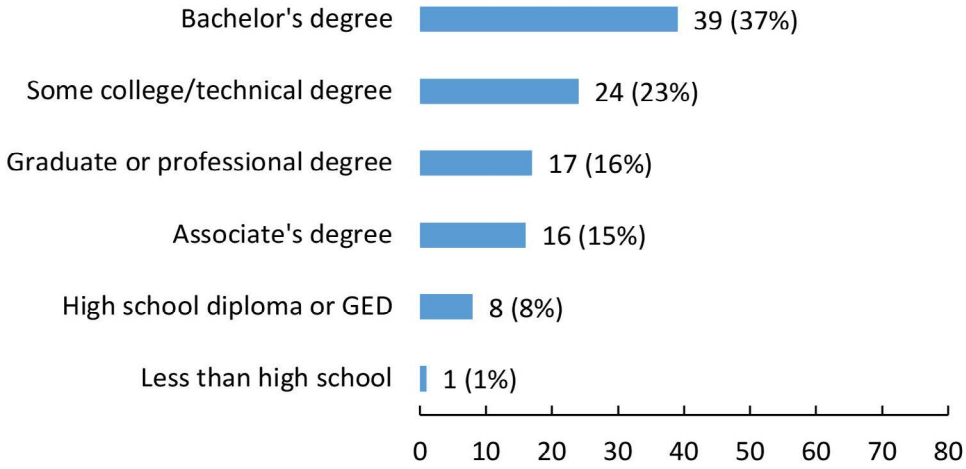
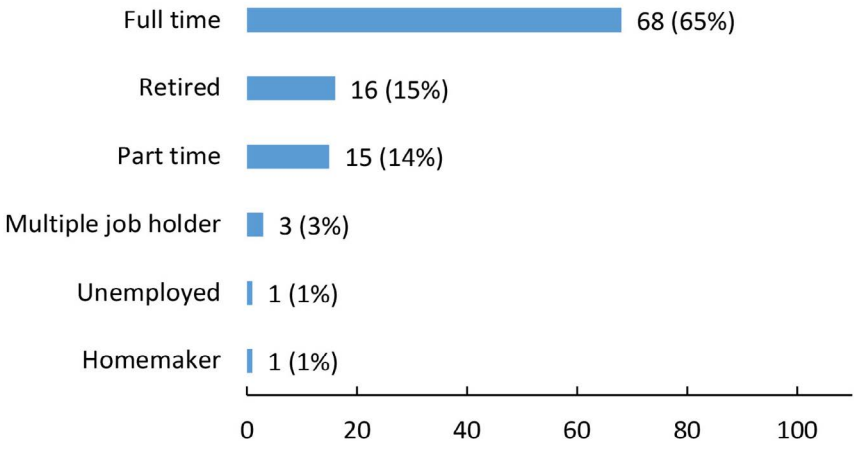
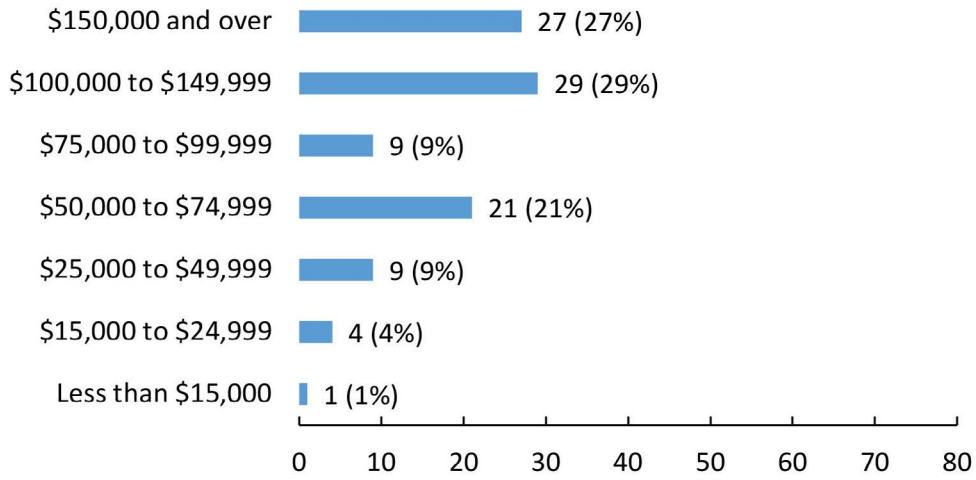


Figure 9: Employment Status of Survey Respondents
Total respondents = 104



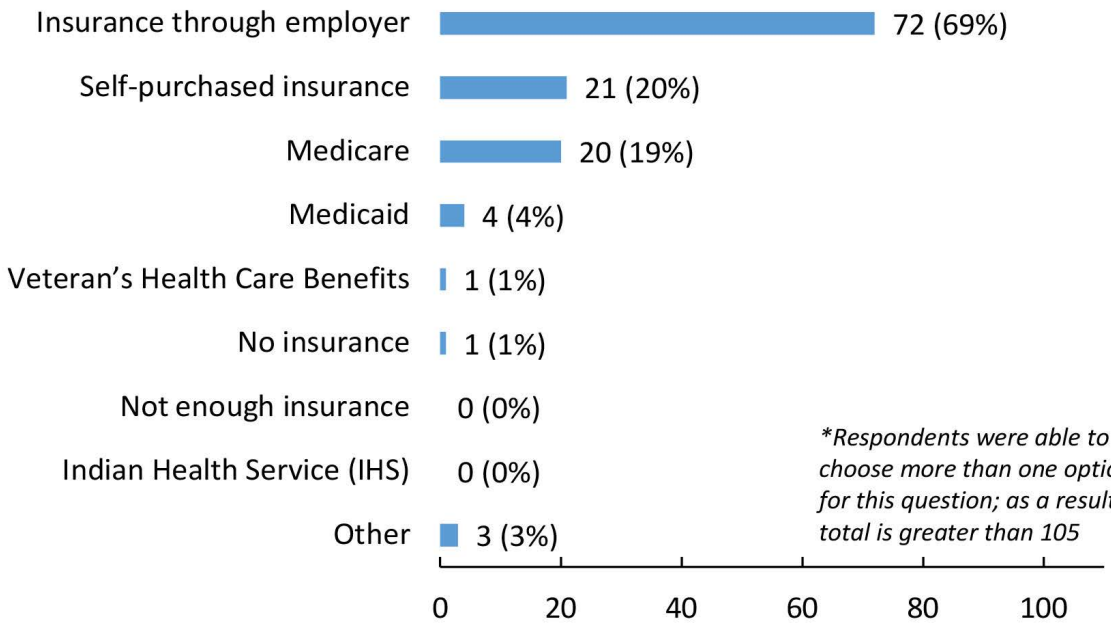
Of those who provided a household income, 5% (N=5) of community members reported a household income of less than $25,000. Fifty-six percent (N=56) indicated a household income of $100,000 or more. This information is shown in Figure 10.

Figure 10: Household Income of Survey Respondents
Total respondents = 100



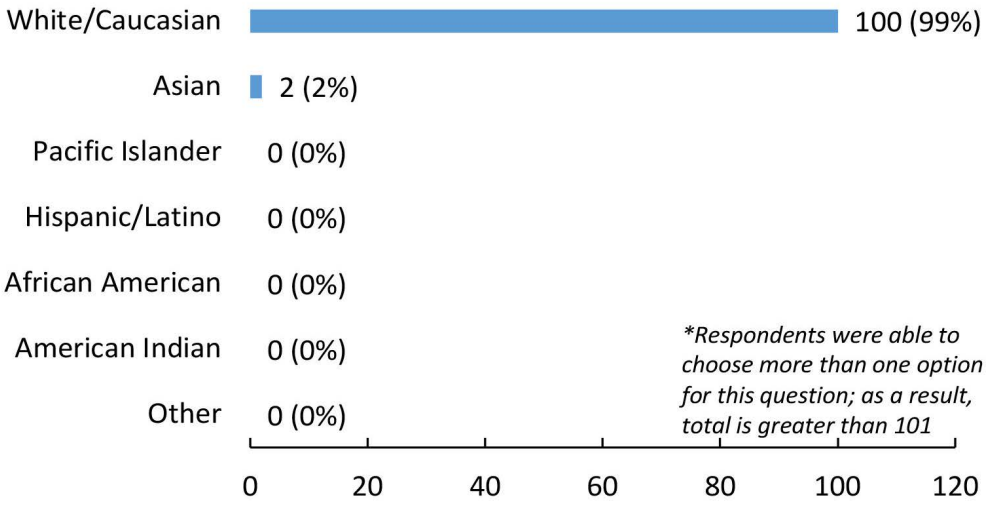
Community members were asked about their health insurance status, which is often associated with whether people have access to healthcare. One percent (N=1) of the respondents reported having no health insurance or being under-insured. The most common insurance types were insurance through one's employer (N=72), followed by self-purchased (N=21), and Medicare (N=20).

Figure 11: Health Insurance Coverage Status of Survey Respondents
Total respondents = 105*



As shown in Figure 12, nearly all of the respondents were White/Caucasian (99%). This statistic was not in-line with the race/ethnicity of the overall population of Divide County; the U.S. Census indicates that 93.4% of the population is White in Divide County, meaning those who are White/Caucasian were over-represented in this survey.

Figure 12: Race/Ethnicity of Survey Respondents
Total respondents = 101*



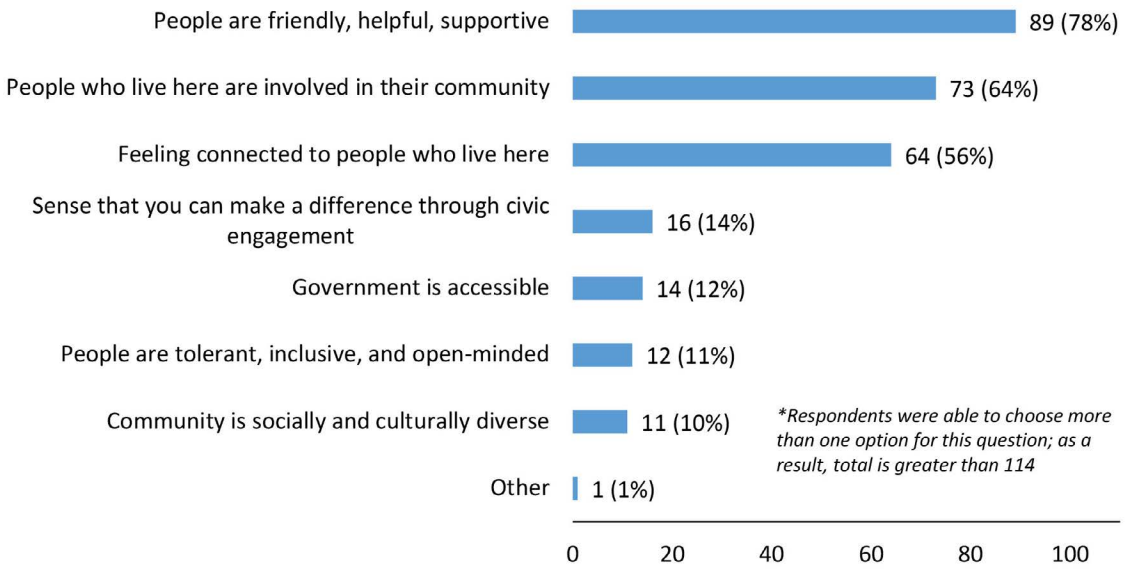
Community Assets and Challenges

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 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 71 respondents agreeing) that community assets include:

- Safe place to live, little/no crime (N=98)
- Family-friendly (N=96)
- People are friendly, helpful, supportive (N=89)
- Recreational and sports activities (N=75)
- People who live here are involved in their community (N=73)
- Local events and festivals (N=71)

Figures 13 to 16 illustrate the results of these questions.

Figure 13: Best Things About the PEOPLE in Your Community
Total respondents = 114*



The one "Other" response was not specified.

Figure 14: Best Things About the SERVICES AND RESOURCES in Your Community
Total respondents = 115*

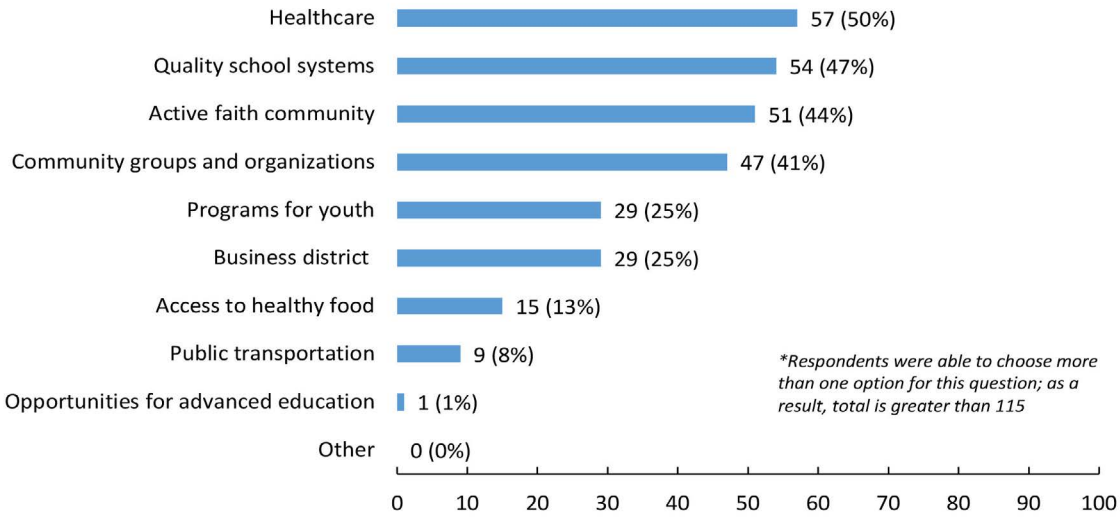


Figure 15: Best Things About the QUALITY OF LIFE in Your Community
Total respondents = 115*

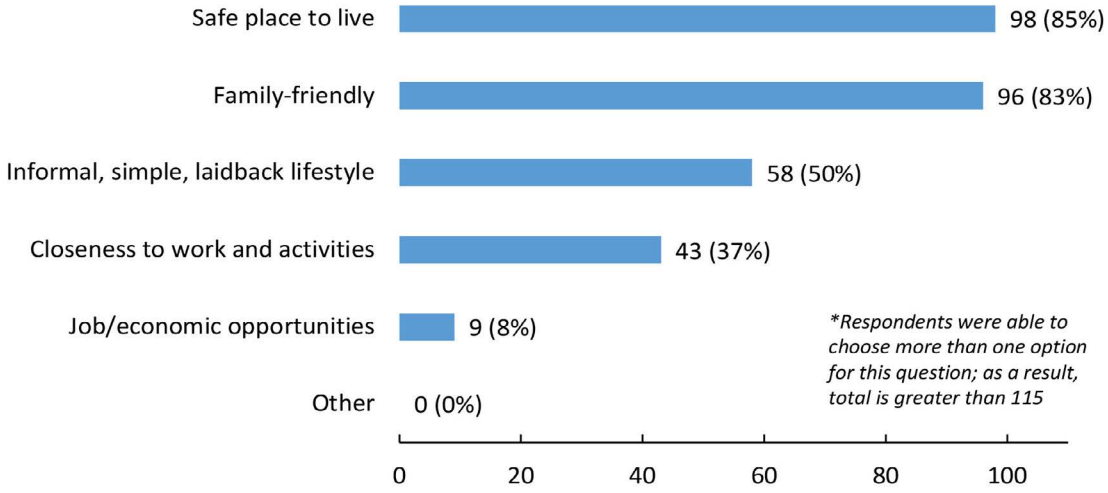
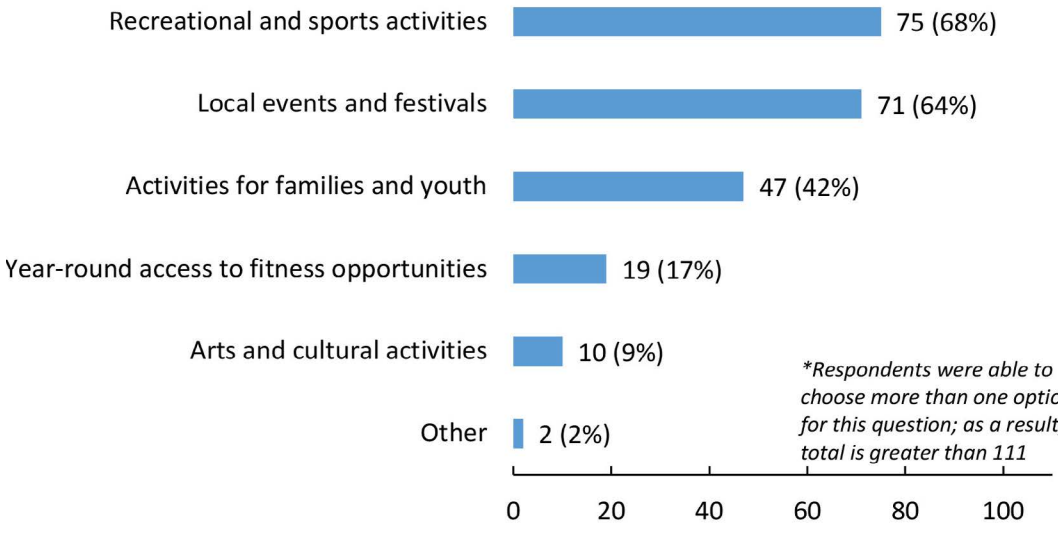


Figure 16: Best Things About the ACTIVITIES in Your Community
Total respondents = 111*



Community Concerns

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

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

With regard to responses about community challenges, the most highly voiced concerns (those having at least 40 respondents) were:

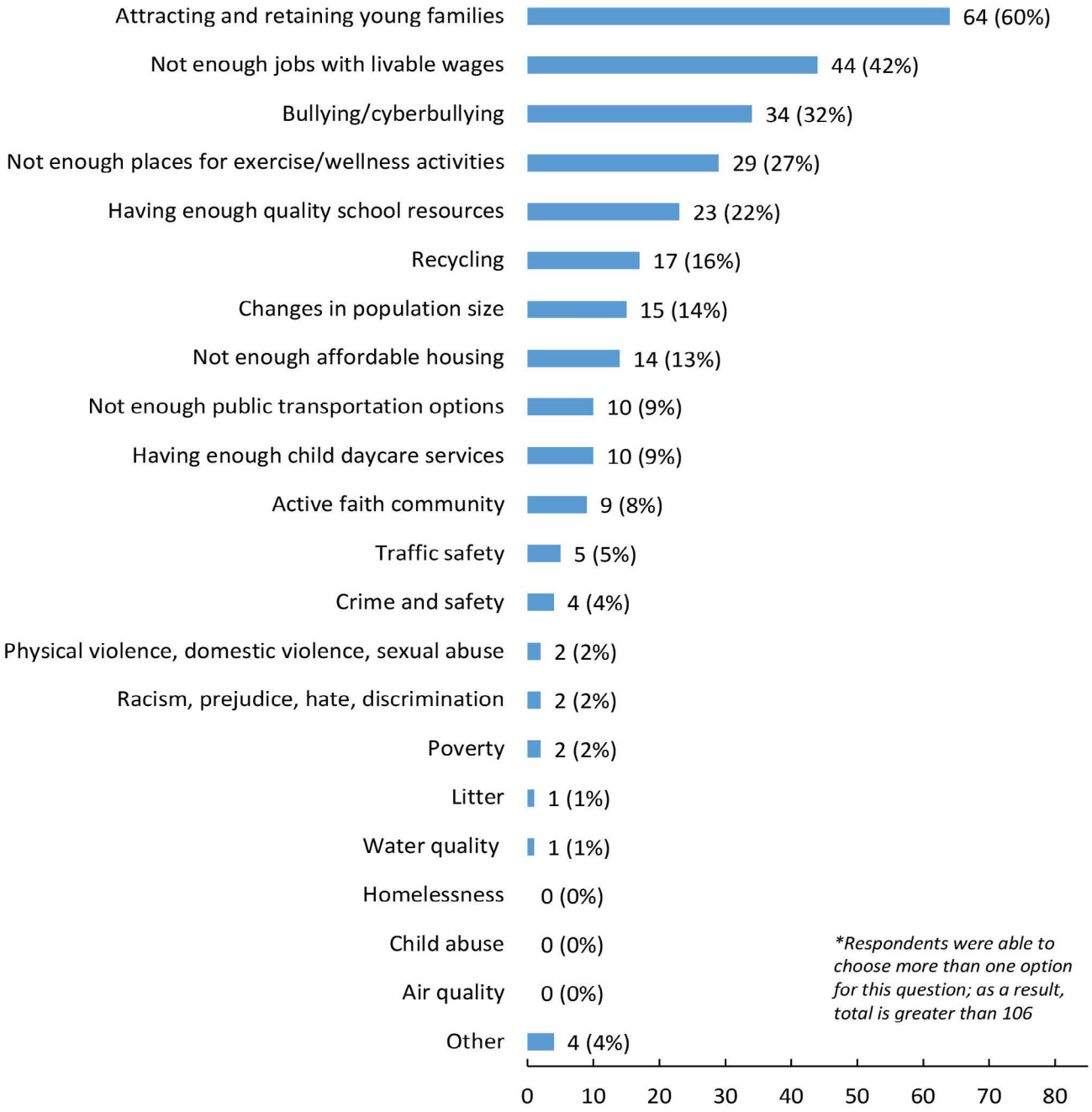
- Long-term/nursing home care options (N=68)
- Attracting and retaining young families (N=64)
- Depression/anxiety – youth (N=60)
- Alcohol use and abuse – adults (N=50)
- Depression/anxiety – adults (N=48)
- Not enough jobs with livable wages (N=44)
- Ability to retain primary care providers (MD, DO, NP, PA, nurses) in the community (N= 42)
- Availability of resources to help the elderly stay in their homes (N=41)

The other issues that had at least 23 votes included:

- Alcohol use and abuse – youth (N=36)
- Bullying/cyberbullying (N=34)
- Smoking and tobacco use (second-hand smoke, vaping) – youth (N=34)
- Not getting enough exercise/physical activity – adult (N=32)
- Ability to meet needs of older population (N=31)
- Availability of home health (N=30)
- Not enough places for exercise/wellness activities (N=29)
- Availability of mental health services (N=28)
- Not enough activities for children and youth (N=27)
- Availability of specialists (N=23)

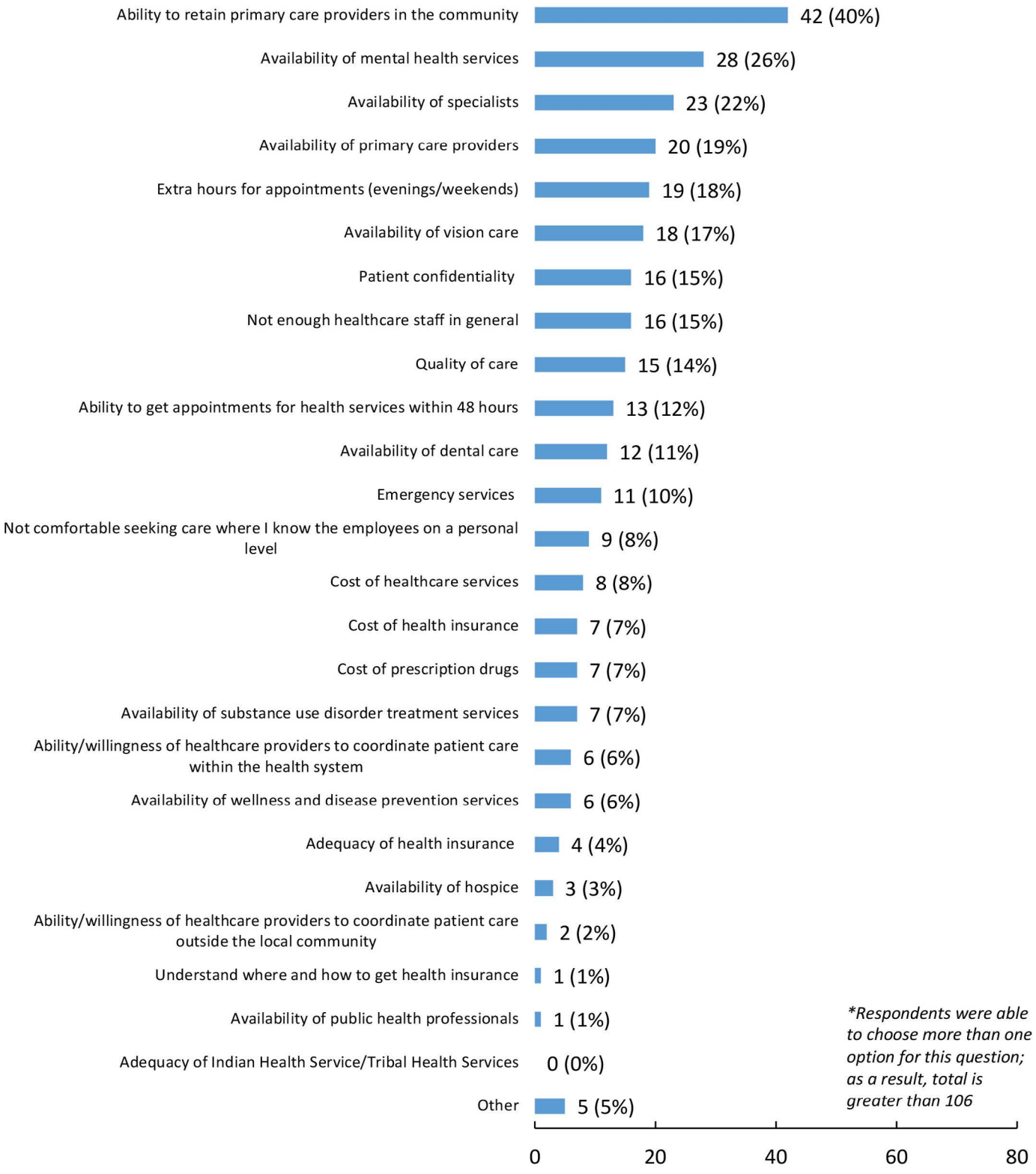
Figures 17 through 21 illustrate these results.

Figure 17: Community/Environmental Health Concerns
Total respondents = 106



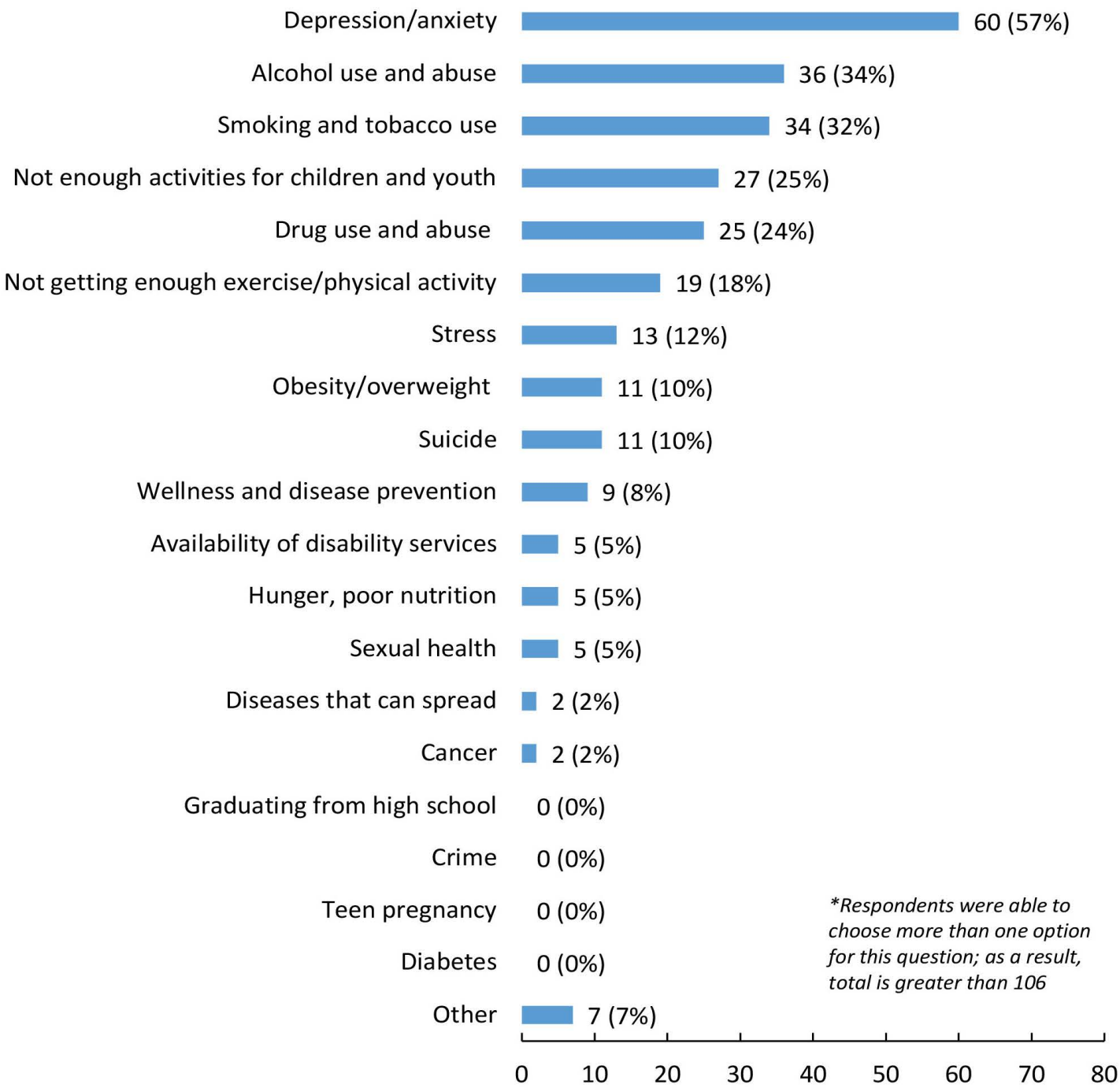
Included in the "Other" category for community and environmental health concerns were elder services and transportation not available outside core hours.

Figure 18: Availability/Delivery of Health Services Concerns
Total respondents = 106*



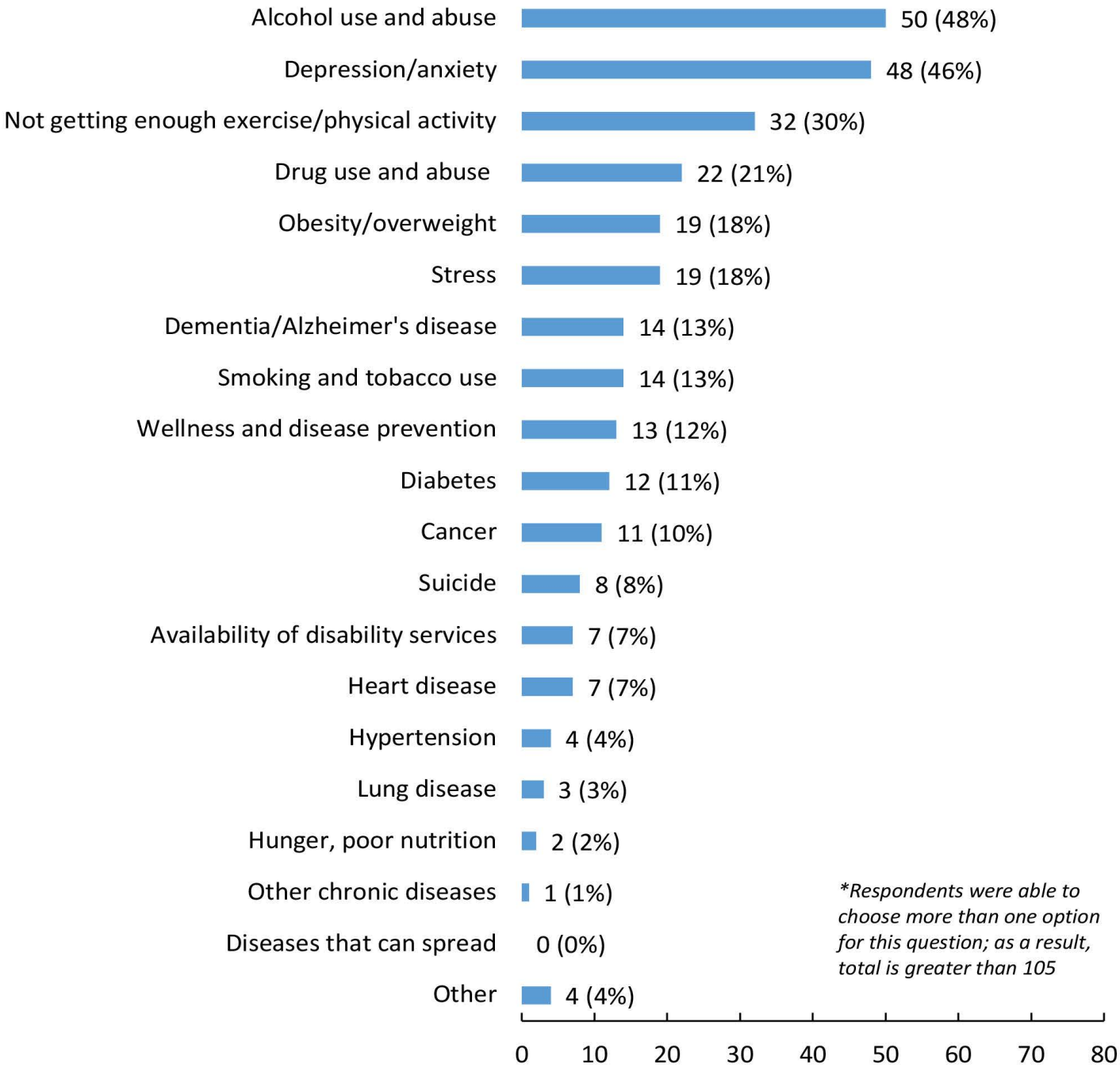
Respondents who selected "Other" identified concerns in the availability/delivery of health services as not comfortable with local counseling – personal information is talked about in the community, lack of professionalism in the medical facilities, possible loss of pharmacy, availability of hospice, and hospital administration does not follow confidentiality.

Figure 19: Youth Population Health Concerns
Total respondents = 106*



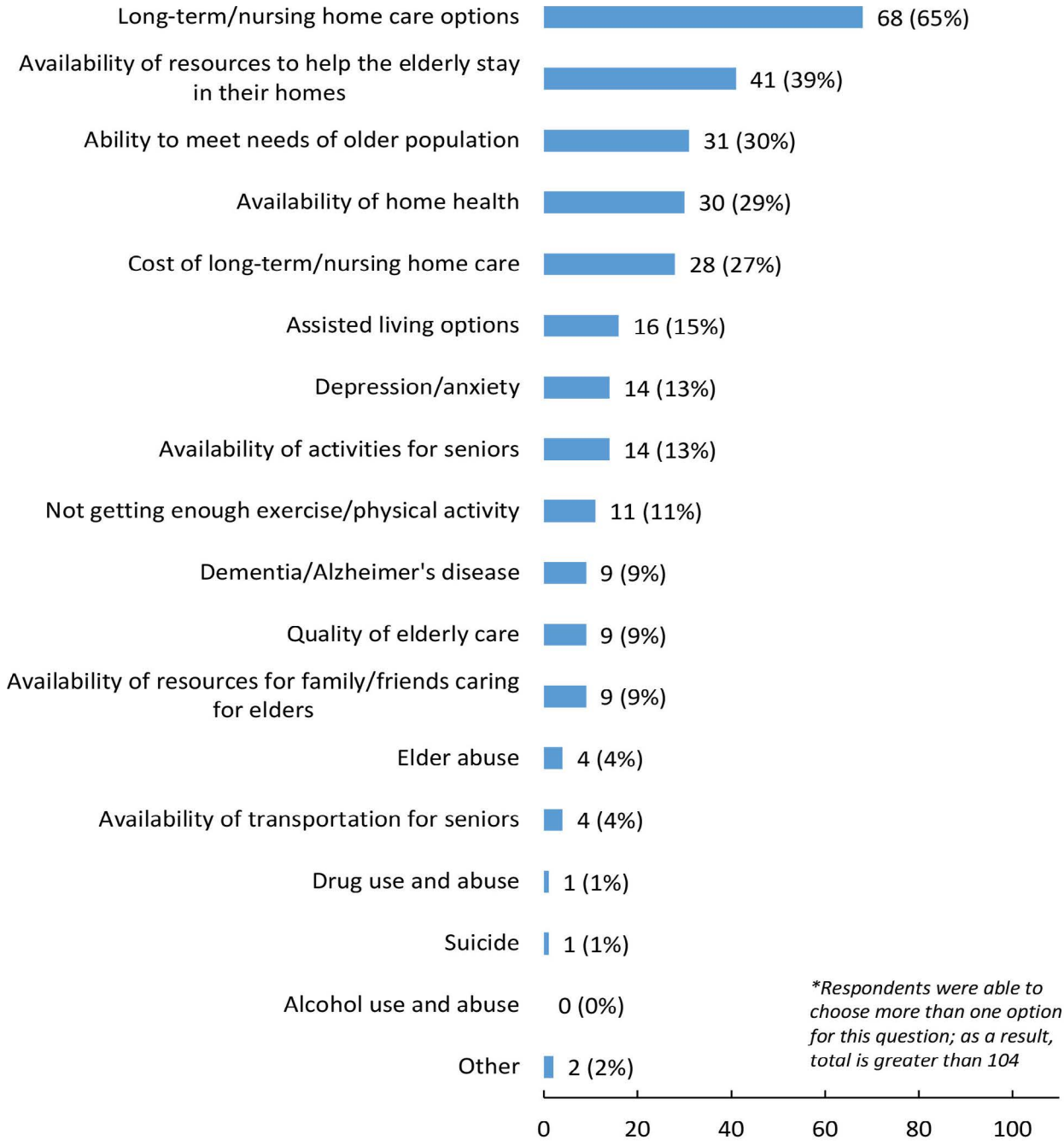
Listed in the "Other" category for youth population concerns were bullying, quality of school meals, and lack of coping skills.

Figure 20: Adult Population Concerns
Total respondents = 105*



Availability of nursing home services, long-term care, and more services for AA and their families were indicated in the "Other" category for adult population concerns.

Figure 21: Senior Population Concerns
Total respondents = 104*



In the "Other" category, the concerns listed were affordable assisted living and poor leadership in assisted living.

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

1. Attracting/retaining individuals to live and work locally
2. Lack of healthcare options/need to improve existing healthcare (confidentiality concerns, quality of care)
3. Lack of a nursing home/elder care options

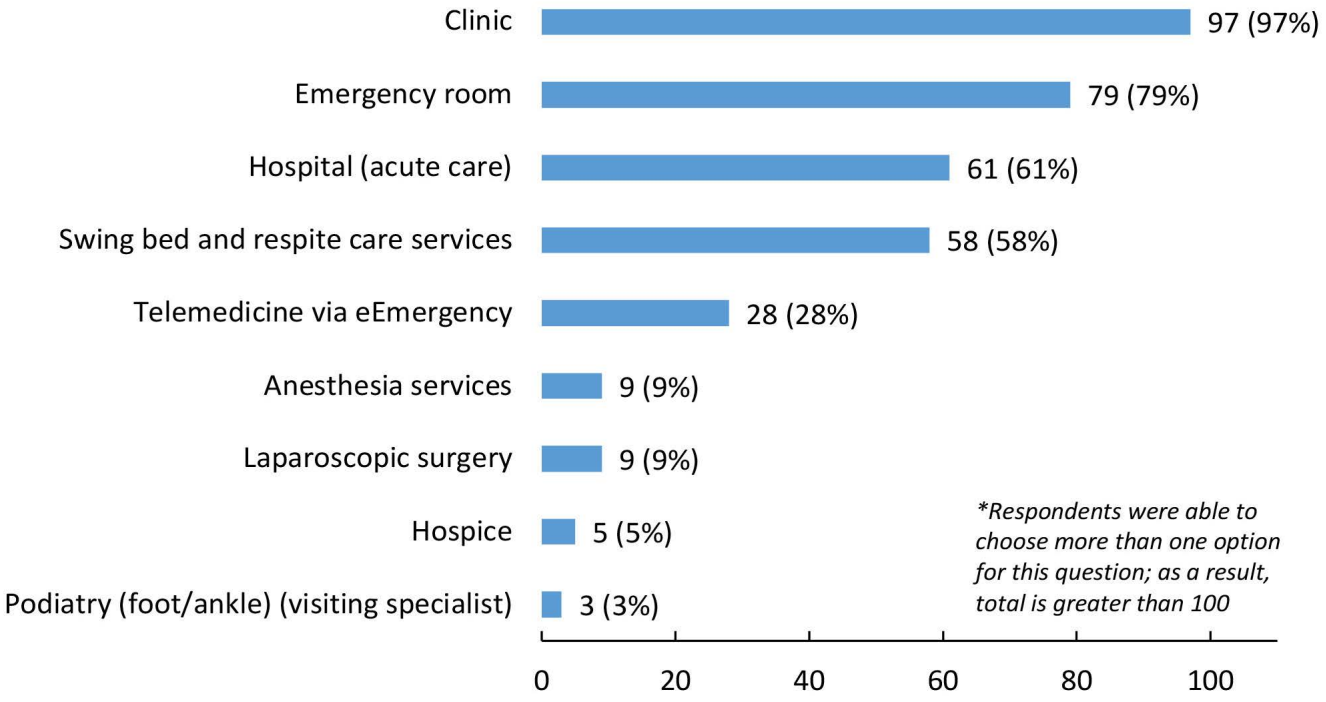
Other biggest challenges that were identified were bullying/cyberbullying, community is not welcoming, declining community opportunities, expensive groceries/gas, handicapped-accessible housing, isolated area, jobs that match the cost of living, lack of affordable daycare services, lack of affordable housing, mental health challenges, population decline, resistance to COVID-19 vaccines, speeding, and substance use.

Delivery of Healthcare

Survey respondents were asked what general and acute services at St. Luke's Medical Center of which they were aware or have used in the past year. Almost all respondents were aware of or had used the clinic.

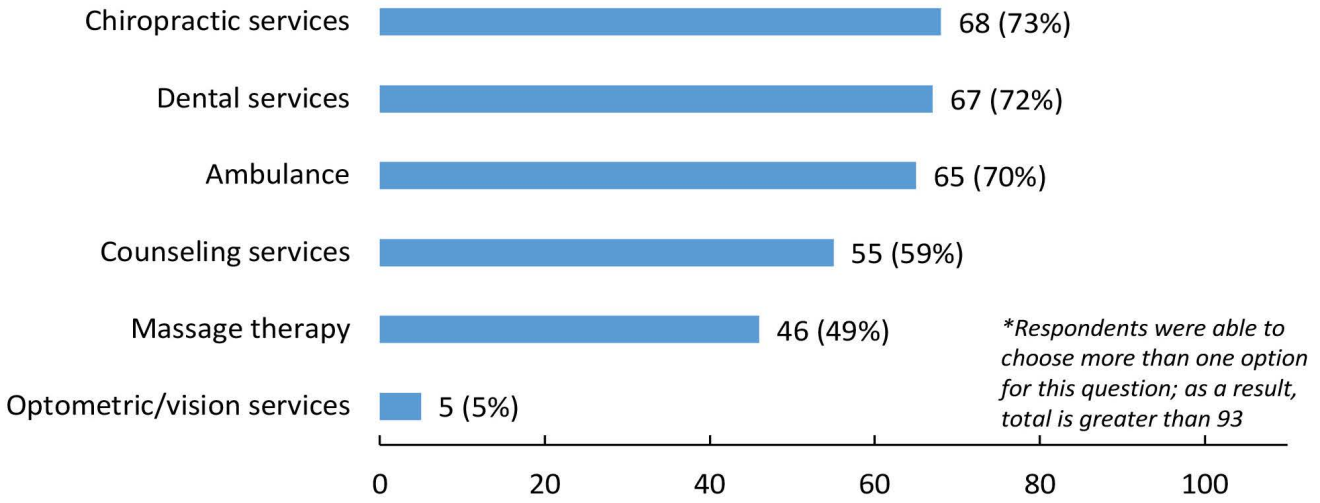
Figure 22 illustrates these results.

Figure 22: Awareness/Utilization of General and Acute Services
Total respondents = 100*



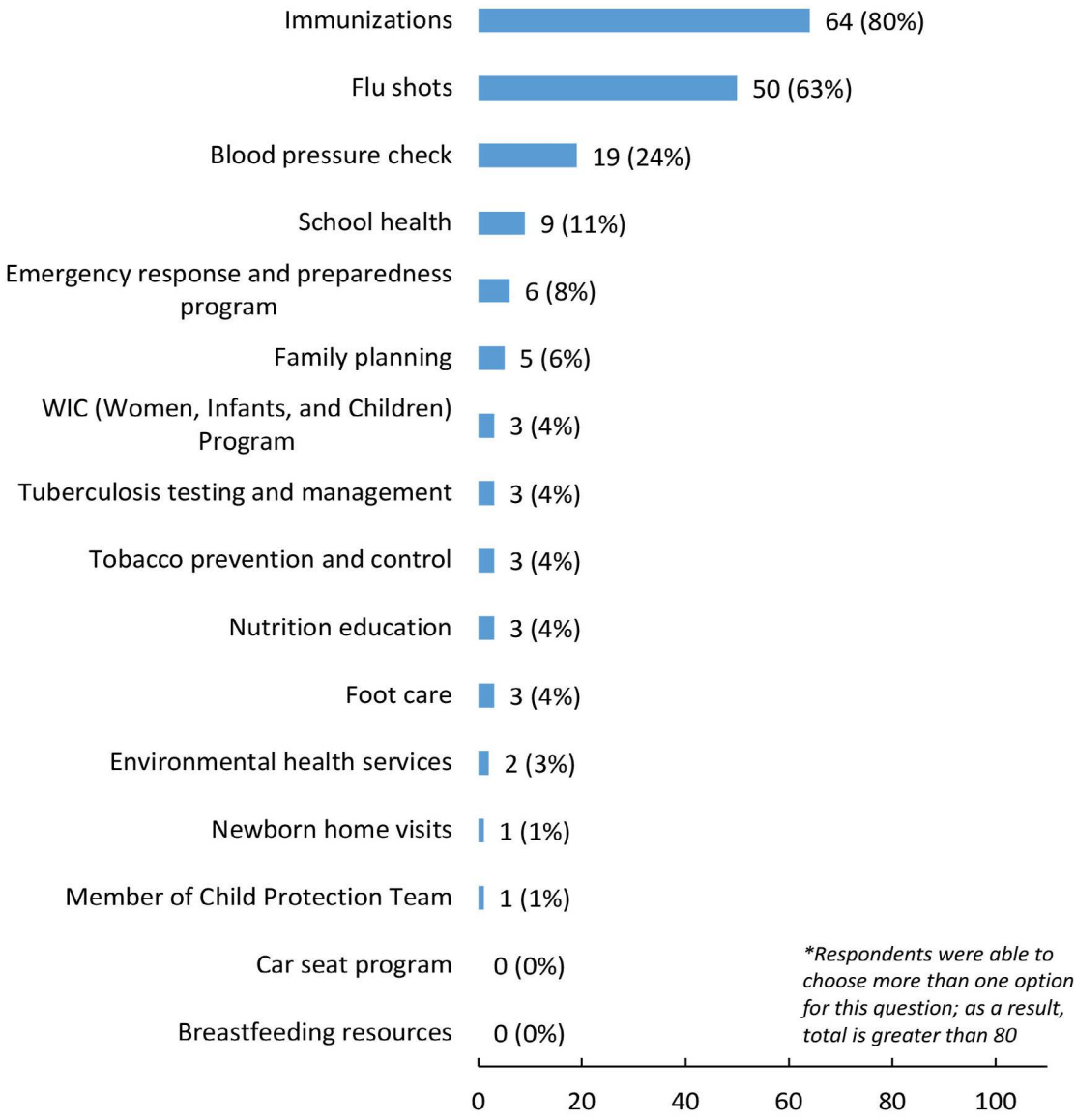
Respondents were also asked what services offered by other community providers and organizations of which they were aware or had used in the past year. Respondents were most aware of or had used chiropractic services. Results are shown in Figure 23.

Figure 23: Awareness/Utilization of Services by Other Local Services
Total respondents = 93*



Considering a variety of healthcare services offered by Upper Missouri District Health Unit (UMDHU), respondents were asked to indicate which services they or a family member have used at UMDHU (See Figure 24).

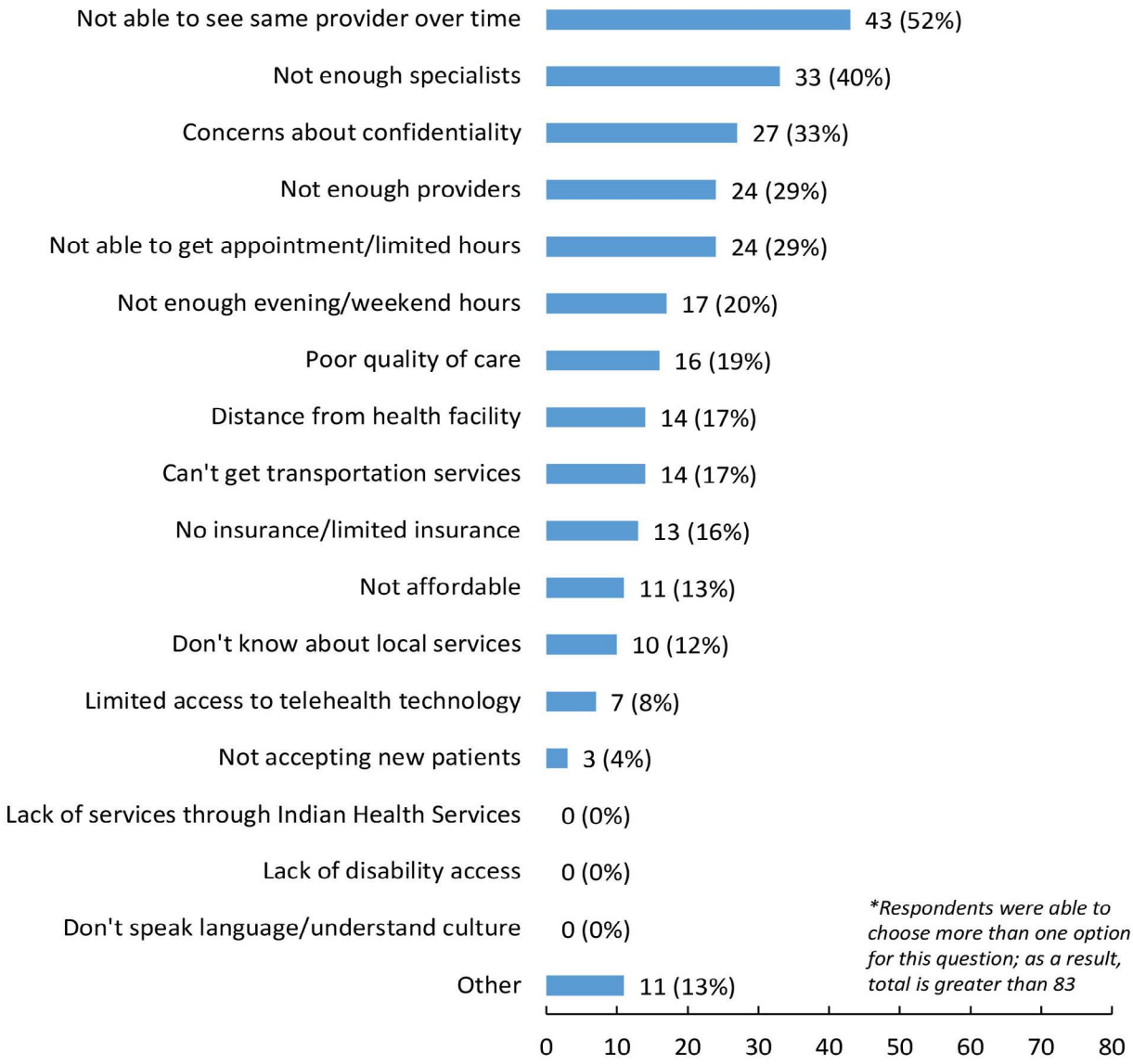
Figure 24: Utilization of Public Health Services
Total respondents = 80*



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 able to see same provider over time (N=43), with the next highest being not enough specialists (N=33). After these items, the next most commonly identified barriers were concerns about confidentiality (N=33), not enough providers (N=24), and not able to get appointment/limited hours (N=24). Concerns, listed in the "Other" category, included feeling like doctors always refer out of Crosby anyway, unable to use insurance, long wait times, poor leadership, not able to get all services needed, and inconsistent providers.

Figure 25 illustrates these results.

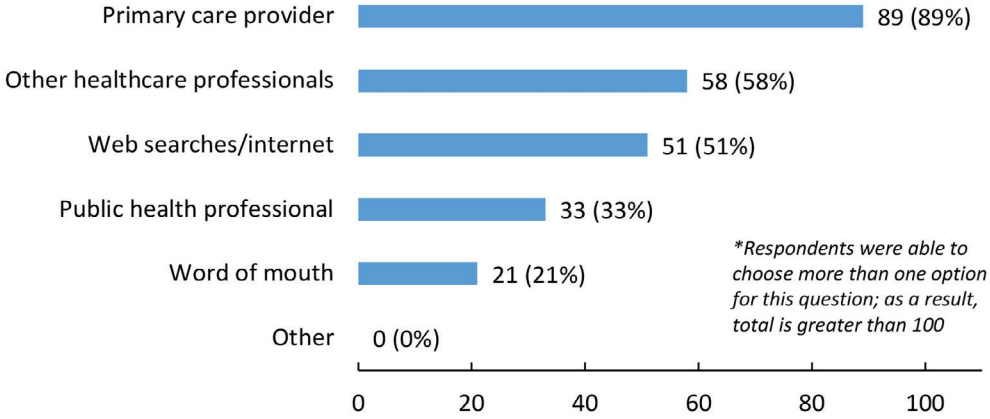
Figure 25: Perceptions About Barriers to Care
Total respondents = 83*



Respondents were asked where they go to for trusted health information. Primary care providers (N=89) received the highest response rate, followed by other healthcare professionals (N=58), and then web searches/ internet (N=51).

Results are shown in Figure 26.

Figure 26: Sources of Trusted Health Information
Total respondents = 100*



In an open-ended question, respondents were asked what specific healthcare services, if any, they think should be added locally. The number one desired service to add locally was vision services/optometry. Other requested services included:

- Additional diagnostic services
- Dental services
- Dermatology
- Endocrinology
- ENT
- Expanded clinic hours to include weekends
- Homeopathic options
- Hospice
- Inpatient psych services
- Long-term care/affordable assisted living
- Medical house calls
- Mental health services
- OB/GYN
- Pain clinic
- Pediatric occupational therapy
- Pediatrics
- Podiatry
- Transportation to the hospital
- Visiting specialist
- Walk-in clinic hours

While not a service, many respondents indicated that they would like consistent providers added. Rotational and part-time providers do not offer the continuity of care that community members would like.

The key informant and focus group members felt that the community members were mostly aware of the health system and public health services. There were a number of services where they felt the hospital should increase marketing efforts; these items included behavioral health services, dermatology, mental health services, orthopedics, radiology services, and gynecology.

The final question on the survey asked respondents to share concerns and suggestions to improve the delivery of local healthcare. The majority of responses focused on expanding and retaining local services as well as improving the quality of existing services. Many community members noted that they would like to see consistent providers who work full time in the hospital; continuity of care is hard to maintain when patients are unable to see the same provider. It was suggested that the community should focus on "growing their own" and encouraging local community members to pursue healthcare education to bring healthcare workers back to the community.

Survey respondents would like a number of services to be added in the community, such as dentists, optometrists, and transportation services. Some community members feel that expansion of healthcare services could bring in more income and generate more jobs in the community. It was noted that the loss of the pharmacy would be a huge loss for the community.

Patient confidentiality was stressed by survey respondents as an important concern. Community members feel healthcare employees need better adherence to HIPAA regulations, and more work needs to be done to protect patient privacy in such a small community.

Communication between providers and patients could be improved. Respondents indicated that long wait times at the clinic and hospital are frustrating and seem to be a result of miscommunication between different areas of the hospital. Some respondents indicated that long wait times and difficulty scheduling appointments because of it discourage community members from seeking healthcare services. Cost of healthcare services was also indicated as a barrier; community members noted that services are often unaffordable even with insurance. Emergency room visits often come with a very large cost, and there are no other options after hours.

Promotion of local services needs to increase; community members would like to see more advertising to increase awareness of services offered locally.

Overall, survey respondents expressed that they are thankful for local healthcare and think it is a great asset to the community.

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 with two categories including youth and adults listed (listed in alphabetical order):

- Alcohol use and abuse
- Availability of mental health services
- Bullying/cyberbullying
- Depression/anxiety

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

Alcohol use and abuse

- Happening way too early in the community
- There is a tremendous amount of alcohol abuse in the county
- Have seen it for years and years, it is not getting better
- People just ignore the issue until an accident happens

Availability of mental health services

- Availability to do it online exists, but need something in-person as well as geared towards children
- Need services for adults as well as children
- Need alcohol and drug use services as well

Bullying/cyberbullying

- Youth don't have the skills to manage tricky situations

Depression/anxiety

- Elderly people in the community can't get out of the house and have no visitors – this situation contributes to depression and anxiety issues
- Very big issue, see it firsthand a lot with youth and the elderly
- Many people don't feel comfortable telling others they have depression or anxiety – stigmatized in the community

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

- Clinics not affiliated with the main health system (4.25)
- Business and industry (4.0)
- Economic development organizations (3.75)
- Emergency services, including ambulance and fire (3.75)
- Law enforcement (3.75)
- Public health (3.75)
- Schools (3.5)
- Faith-based (3.0)
- Hospital (healthcare system) (3.0)
- Long-term care, including nursing homes and assisted living (3.0)
- Social/human services (3.0)
- Pharmacies (2.75)
- Other local health providers, such as dentists and chiropractors (2.0)

Priority of Health Needs

A community group met on March 9, 2022. Thirteen community members attended the meeting. Representatives from the Center for Rural Health (CRH) presented the group with a summary of this report's findings, including background and explanation about the secondary data, highlights from the survey results (including perceived community assets and concerns, and barriers to care), and findings from the key informant interviews and first community meeting.

Following the presentation of the assessment findings and after considering and discussing the findings, all members of the group were asked to identify what they perceived as the top four community health needs. All of the potential needs were presented at the Zoom meeting. Each member was asked to vote for their top four needs they considered the most significant and then select their most important concern from the top priorities.

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

- Depression/anxiety – all ages (7 votes)
- Bullying/cyberbullying (5 votes)
- Alcohol use and abuse – all ages (4 votes)
- Availability of mental health and substance use disorder treatment services (4 votes)

- Availability of resources to help the elderly stay in their homes (4 votes)

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

1. Depression/anxiety – all ages (12 votes)
2. Bullying/cyberbullying (0 votes)
3. Alcohol use and abuse – all ages (0 votes)
4. Availability of mental health and substance use disorder treatment services (0 votes)
5. Availability of resources to help the elderly stay in their homes (0 votes)

Following the prioritization process during the second meeting of the community group and key informants, the number one identified need was depression/anxiety for all ages. A summary of this prioritization may be found in Appendix E.

Comparison of Needs Identified Previously

Top Needs Identified 2019 CHNA Process	Top Needs Identified 2022 CHNA Process
Availability of mental health services	Depression/anxiety – all ages
Availability of resources to help the elderly stay in their homes	Bullying/cyberbullying
Alcohol use and abuse - adults	Alcohol use and abuse – all ages
Drug use and abuse - youth	Availability of mental health and substance use disorder treatment services
	Availability of resources to help the elderly stay in their homes

The current process identified three identical common needs from 2019: alcohol use and abuse, availability of mental health and substance use disorder treatment services, and availability of resources to help the elderly stay in their homes. These needs, being identified as top concerns again in 2022, suggests that more work is still needed in these areas. Repetition of needs over multiple CHNAs is not uncommon. These are complex issues that often require more work than can be accomplished in three years. Also, with a pandemic taking up a large amount of the three years that were allocated to work on the 2019 issues, it became an even bigger challenge.

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

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

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

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

Need 1: Availability of mental health resources – St. Luke's has partnered with a locum service to provide mental health counseling twice a month.

Need 2: Availability of resources to help the elderly stay in their homes – This need was not addressed in order to allocate resources to other needs.

Need 3: Alcohol use and abuse - adults – St. Luke's continues 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. Demonstrations and live drills have been conducted during this time frame at community events.

Need 4: Drug use and abuse - youth – St. Luke's Medical Center 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.

St. Luke's partnered with Community Medical Services to provide education to providers on bridging the gap with medicated-assisted treatment to help handle the opiate crisis by participating with the State Target Response grant. They earned free CEU credit and Rx certification and treated patients locally with fewer referrals, in appropriate situations.

The high school and Divide County Social Services arranged for speakers from local law enforcement as well as the state task force to educate students and community members on the opiate crisis as well as other addictive drugs. Upper Missouri Public Health provided material to help educate the community and students on the dangers of vaping.

Divide County Social Services created business cards and provided them to other agencies to distribute to those arrested with addiction resource information on it.

Need 5: Attracting and retaining young families – St. Luke's Medical Center consistently recruited staff to the area, educating on the scholarship and student loan repayment programs available for those interested in the nursing field. This staff includes CNAs, LPNs, and RNs. For every year worked at St. Luke's, a nursing school graduate received $,2500 per year student loan repayment, up to a maximum of $12,500. We paid out to one RN and one FNP during this time frame. Those persons, desiring to attend the Certified Nurse's Aide course, which we partner with Williston State College and Giving Hearts Homecare to provide, see a scholarship of $650 upon acceptance of a one-year service agreement with St. Luke's. Newly hired nurses, lab techs, and aides also qualify for sign-on bonus benefits. We paid out sign-on bonuses to seven CNA's, two lab techs, and one LPN during this timeframe.

The high school invited current tradesmen/women to speak at events to introduce more trade-oriented professions to the students.

All community organizations, schools, and government worked to keep their websites and apps updated and current so that families, looking to relocate to the area, are able to access information (i.e. high school calendar).

A resource list was completed for services in the surrounding area and distributed between public health, law enforcement, school, healthcare, mental heal agencies and the economic development dept.

Need 6: Bullying/cyberbullying – St. Luke's continues to provide additional education to staff once per year and upon incident through HealthStream, our educational modules for all employees. We also continue to monitor and report any incidents through our performance statement disciplinary process.

Schools educated and revised zero tolerance policies to demonstrate on what happens when this situation occurs and offer education to students and parents.

Need 7: Cost of health insurance – St. Luke's currently pays 100% of the health and dental insurance premium for employees. In addition, it offers group plan pricing for portable life, accident, critical illness, short- and long-term disability, and vision insurance. The health insurance boasts a choice of two plans, one with a low $500 annual deductible, and the other with the option of adding an HSA and the hospital contributes $1200 per year to the HSA. Employees are required to pay any dependent coverage costs.

The above implementation plan for St. Luke's Medical Center is posted on St. Luke's Medical Center website at https://www.dcstlukes.org/about-us/.

Next Steps – Strategic Implementation Plan

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

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

Community Benefit Report

While not required, the Center for Rural Health (CRH) strongly encourages a review of the most recent Community Benefit Report to determine how/if it aligns with the needs identified, through the CHNA, as well as the implementation plan.

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

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

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

What Are Community Benefits?

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

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

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

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

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

Appendix A – Critical Access Hospital Profile

Critical Access Hospital Profile

Spotlight on: Crosby North Dakota

St. Luke's Hospital

Quick Facts

CEO:
Jody Nelson

Chief of Medical Staff:
Dr. Benjamin Krogh

Board Chair:
Jerry King

City Population:
1,138 (2019 estimate)[1]

County Population:
2,264 (2019 estimate)[1]

County Median Household Income:
$62,865 (2019 estimate)[1]

County Median Age:
51.1 years (2019 estimate)[1]

Service Area Population:
3,814 miles

Owned by: Non-Profit

Hospital Beds: 15

Trauma Level: V

Critical Access Hospital Designation: 2002

Economic Impact on the County*

Employment:
Primary – 91
Secondary – 32
Total – 123

Financial Impact:
Primary – $6.22 million
Secondary – $1.12 million
Total – $7.34 million

Mission:

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

County: Divide
Address: 702 1st Street Southwest
Crosby, ND 58730
Phone: (701) 965-6384
Fax: (701) 965-4258
Web: www.dcstlukes.org

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

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

St. Luke's Hospital is a 15-bed critical access hospital located in Crosby, North Dakota. The hospital also operates a clinic in Crosby, North Dakota. St. Luke's Hospitals service area consists of Divide, Burke, and Northern Williams County in Northwestern North Dakota. St. Luke's provides needed medical services in the areas of acute, outpatient, and extended care. The core values of St. Luke's hospital are respect, compassion, stewardship, integrity, and justice. The hospital is recognized by the state of North Dakota as a non-profit organization and has been recognized by the Internal Revenue Service as exempt from Federal Income Taxes under Internal Revenue Section 501(c)(3). The Hospital is governed by a community Board of Directors consisting of nine elected Directors. The hospital is recognized by the state and federal government as a Critical Access Hospital.

Services

Services provides the following services directly:

- Cardiac Intensive Care
- Emergency Services
- General Medical -Surgical Care
- Health Screenings
- Lab & X-ray
- Meals on Wheels
- Other Special care
- Outpatient Surgery
- Patient Representative Services
- Physical Rehabilitation Outpatient Services
- Pediatric Medical -Surgical care
- Swing Bed Services
- Trauma Center (Level 5)

Staffing:

Physicians: 1
FNP-C 2
PA-C: 1
RNs: 4
CNA's 6
Total Employees: 56

Local Sponsors and Grant Funding Sources

Small Hospital Improvement Program, Flex – Trauma Certification

Sources

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

2 - Economic Impact 2020 Center for Rural Health Oklahoma State University and Center for Rural Health University of North Dakota

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

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

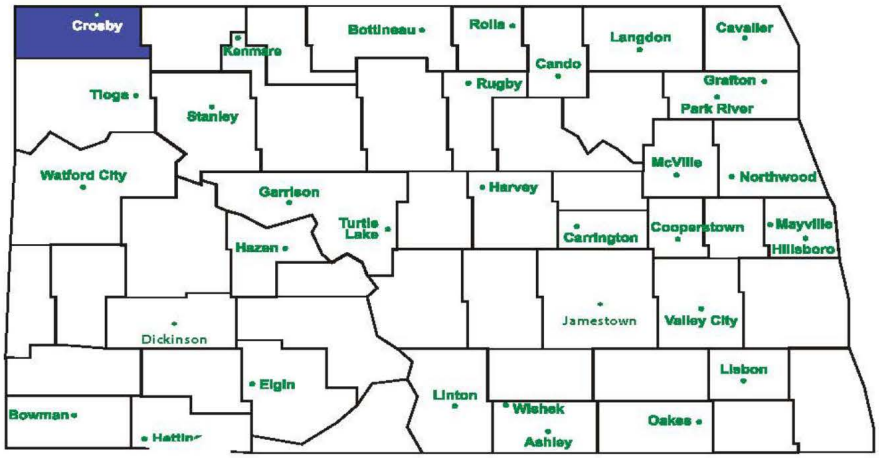
ruralhealth.und.edu

Services

Services provided through contrat or agreement:

- Additional Lab Services not provided in house
- Anesthesia
- CT Scans
- Hearing Screenings
- Occupational Therapy
- Physical Therapy
- Speech Therapy
- Ultra-sound

North Dakota Critical Access Hospitals



History

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

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

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

Updated 5/2021

Appendix B – Economic Impact Analysis

ST. LUKE'S MEDICAL CENTER

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

Economic Impact

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

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

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

Healthcare and Your Local Economy

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

Key contributions of the health system include

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

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

Fact Sheet Author: Kylie Nissen, BBA

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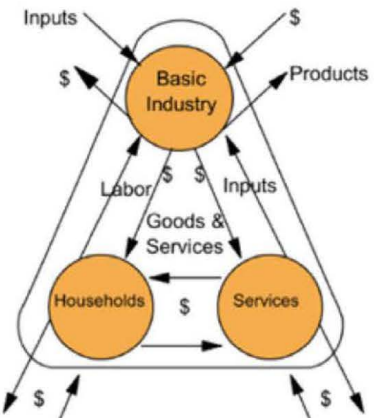
Figure 1. *An overview of the community economic system.*



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

CENTER FOR RURAL HEALTH
OSU Center for Health Sciences

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

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

Appendix C – CHNA Survey Instrument

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

ST. LUKE'S MEDICAL CENTER

Crosby Area Health Survey

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

The focus of this effort is to:

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

If you prefer, you may take the survey online at http://tinyurl.com/crosbychna2022.

Surveys will be tabulated by the Center for Rural Health at the University of North Dakota School of Medicine and Health Sciences. Your responses are anonymous, and you may skip any question you do not want to answer. Your answers will be combined with other responses and reported only in total. If you have questions about the survey, you may contact Kylie Nissen at 701.777.5380. ***Surveys will be accepted through January 24, 2022. Your opinion matters – thank you in advance!***

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

_____

_____

Delivery of Healthcare

11. Considering **GENERAL and ACUTE SERVICES** at St. Luke's Medical Center, which services are you aware of (or have you used in the past year)? (Choose ALL that apply):

- ☐ Clinic
- ☐ Emergency room
- ☐ Hospice
- ☐ Hospital (acute care)
- ☐ Laparoscopic surgery
- ☐ Podiatry (foot/ankle) (visiting specialist
- ☐ Swing bed and respite care services
- ☐ Telemedicine via eEmergency

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

- ☐ Ambulance
- ☐ Chiropractic services
- ☐ Counseling services
- ☐ Dental services
- ☐ Massage therapy
- ☐ Optometric/vision services

13. Which of the following **PUBLIC HEALTH SERVICES** have you or a family member used in the past year? (Choose ALL that apply)

- ☐ Blood pressure check
- ☐ Breastfeeding resources
- ☐ Car seat program
- ☐ Emergency response & preparedness services
- ☐ Environmental health services (water/sewer, health hazard abatement)
- ☐ Family Planning
- ☐ Flu shots
- ☐ Foot care
- ☐ Immunizations
- ☐ Member of Child Protection Team
- ☐ Newborn Home Visits
- ☐ Nutrition education
- ☐ School health (health education and resource to the schools)
- ☐ Tobacco prevention and control
- ☐ Tuberculosis testing and management
- ☐ WIC (Women, Infants, & Children) Program

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

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

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

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

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

_____

_____

26. Annual household income before taxes:

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

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

_____

_____

Thank you for assisting us with this important survey!

Appendix D – County Health Rankings Explained

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

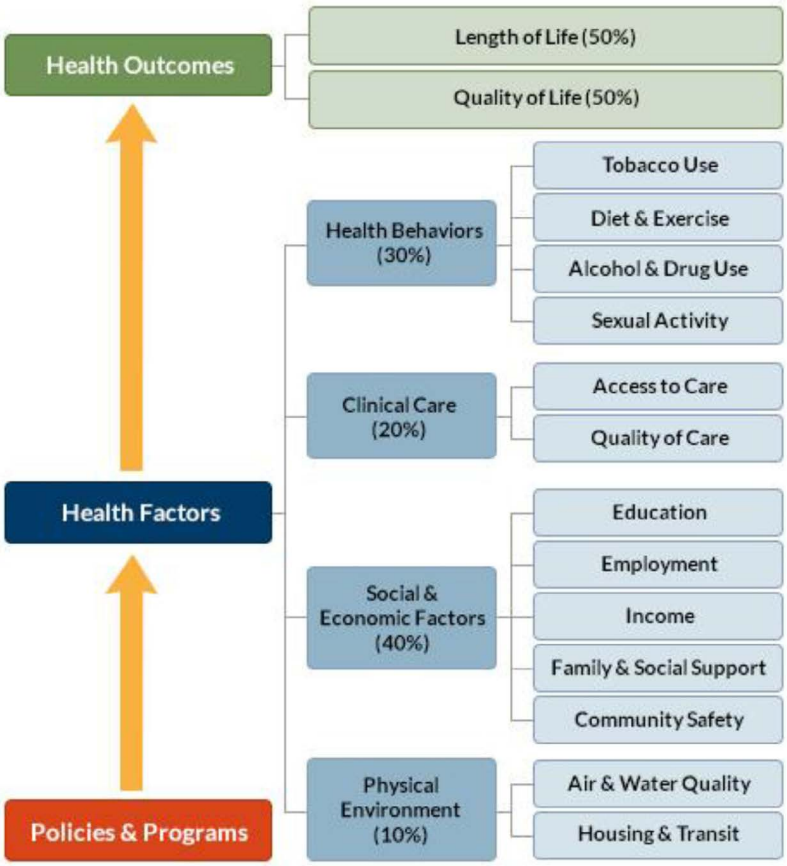
Methods

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

What is Ranked

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

Ranking System



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

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

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

Data Sources and Measures

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

Data Quality

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

Calculating Scores and Ranks

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

Health Outcomes and Factors

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

Health Outcomes

Premature Death (YPLL)

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

Reason for Ranking

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

Poor or Fair Health

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

Reason for Ranking

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

Poor Physical Health Days

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

Reason for Ranking

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

Poor Mental Health Days

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

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

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

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

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

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

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

Health Factors

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

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

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

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

Food Environment Index

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

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

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

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

Reason for Ranking

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

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

Physical Inactivity

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

Reason for Ranking

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

Access to Exercise Opportunities

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

Individuals who reside in a census block within a half mile of a park; in urban census blocks: reside within one mile of a recreational facility; and in rural census blocks: reside within three miles of a recreational facility are considered to have adequate access for opportunities for physical activity.

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

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

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

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

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

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

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

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

Reason for Ranking
Evidence suggests teen pregnancy significantly increases the risk of repeat pregnancy and of contracting a sexually transmitted infection (STI), both of which can result in adverse health outcomes for mothers, children, families, and communities. A systematic review of the sexual risk among pregnant and mothering teens concludes that pregnancy is a marker for current and future sexual risk behavior and adverse outcomes. Pregnant teens are more likely than older women to receive late or no prenatal care, have eclampsia, puerperal endometritis, systemic infections, low birthweight, preterm delivery, and severe neonatal conditions. Preterm delivery and low birthweight babies have increased risk of child developmental delay, illness, and mortality. Additionally, there are strong ties between teen birth and poor socioeconomic, behavioral, and mental outcomes. A teenage woman who bears a child is much less likely to achieve an education level at or beyond high school, much more likely to be overweight/obese in adulthood, and more likely to experience depression and psychological distress.

Uninsured

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

Reason for Ranking

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

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

Primary Care Physicians

Primary care physicians is the ratio of the population to total primary care physicians. Primary care physicians include nonfederal, practicing physicians (MDs and DOs) younger than age 75 specializing in general practice medicine, family medicine, internal medicine, and pediatrics. Note this measure was modified in the 2011 rankings and again in the 2013 rankings.

Reason for Ranking

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

Dentists

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

Reason for Ranking

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

Mental Health Providers

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

Reason for Ranking

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

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

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

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

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

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

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

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

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

Children in Poverty
Children in poverty is the percentage of children younger than age 18 living in poverty. Poverty status is defined by family; either everyone in the family is in poverty or no one in the family is in poverty. The characteristics of the family used to determine the poverty threshold are number of people, number of related children younger than age 18, and whether the primary householder is older than age 65. Family income is then compared to the poverty threshold; if that family's income is below that threshold, the family is in poverty. For more information, please see Poverty Definition and/or Poverty.

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

Reason for Ranking

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

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

Income Inequality

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

Reason for Ranking

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

Children in Single-Parent Households

Children in single-parent households is the percentage of children in families where the household is headed by a single parent (male or female head of household with no spouse present). Note that the methods for calculating this measure changed in the 2011 rankings.

Reason for Ranking

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

Violent Crime Rate

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

Reason for Ranking

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

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

Injury Deaths

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

Reason for Ranking

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

Air Pollution-Particulate matter

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

Reason for Ranking

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

Drinking Water Violations

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

Reason for Ranking

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

Severe Housing Problems

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

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

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

Reason for Ranking

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

Appendix E – Youth Risk Behavior Survey

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

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

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

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

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

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

Appendix F – Prioritization of Community's Health Needs

Community Health Needs Assessment
Crosby, North Dakota
Ranking of Concerns

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

	Priorities	Most Important
COMMUNITY/ENVIRONMENTAL HEALTH CONCERNS		
Attracting & retaining young families		
Bullying/cyberbullying	5	0
Having enough quality school resources	1	
Not enough jobs with livable wages	1	
Not enough places for exercise and wellness activities	3	
AVAILABILITY/DELIVERY OF HEALTH SERVICES CONCERNS		
Ability to retain primary care providers (MD, DO, NP, PA, nurses)	3	
Availability of primary care providers (MD, DO, NP, PA, nurses)	3	
Availability of mental health and substance use disorder treatment services	4	0
Availability of vision care	3	
Availability of specialists	3	
YOUTH POPULATION HEALTH CONCERNS		
Alcohol use and abuse – All ages	4	0
Depression/anxiety – All ages	7	12
Not enough activities for children and youth		
Smoking and tobacco use, exposure to second-hand smoke, juuling/vaping	1	
Suicide		
ADULT POPULATION HEALTH CONCERNS		
Dementia/Alzheimer's disease		
Drug use and abuse (including prescription drugs)		
Not getting enough exercise/physical activity	1	
SENIOR POPULATION HEALTH CONCERNS		
Availability of resources to help the elderly stay in their homes	4	0
Long-term/nursing home care options	2	
Cost of long-term/nursing home care	1	
Ability to meet needs of older population	1	
Availability of home health	1	

Appendix G – Survey "Other" Responses

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

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

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

- N/A not involved

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

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

- Day care services, affordable housing
- Daycare, transportation
- Elder services
- Transportation not available outside of core hours

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

- Hospital Admin is not confidential
- Lack of professionalism in the medical facilities
- Not comfortable with counseling in the community, personnel information talked about in the community
- Possible loss of pharmacy
- Possible loss of pharmacy. I also think that home health and nursing home needs to be with availability of hospice.

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

- (3) Bullying
- Bullying/cyberbullying
- Inability to cope-need to develop their coping skills
- NA Unknown
- School meals, need to better more home cooked and not so processed. Healthier choices.

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

- Availability of nursing home services
- Lack of long-term care in a homelike setting.
- Long term care for aging to stay in community
- More services for AA and their families

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

- Affordable assisted living
- Assisted living needs to be revamped. Poor leadership in the health sector.

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

- A remote area it's hard to attract and retain professionals
- Ability to attract and retain primary care providers and other healthcare workers.
- Being isolated from others so depression/anxiety develop
- Bringing or retaining families to stay/live here.
- Bullying/cyber bullying among youth and adults on social media, suicide risk among youth.
- Declining opportunities
- Different entities within the community not fully working together and not communicating fully.
- Difficulty attracting and retaining quality professionals (medical) or trade professionals (plumber, electrician, carpentry, mechanics, etc)
- Expensive to live here for groceries and gas
- Get long term care facility used
- Getting accepted if you are not friends with right people or group - unfortunately we are a town that can be hard to fit in
- Getting new trade people to replace the ones who are retiring.
- Getting trade people to come here to take over plumber, electrician, air condition/heating trade people who have retired or are getting close to retiring.
- Handicapped accessible housing
- Health care, HIPAA, jobs that match the cost of living.
- I feel a lot of people have depression and anxiety. Especially in the winter. It is cold, it gets dark early and you cannot get in the car and travel with ease because of the weather. You feel shut in.
- Inability to attract needed professions or trades (plumber, electrician, dr. Etc.)
- Jobs available to maintain quality of life issues here.
- Lack of elder care availability without the nursing home. Home care is great in theory but a majority of people will need facility care at some point despite availability of home care services.
- Lack of licensed nurses and CNA staff members that can be hired locally. Hiring travel staff is financially prohibitive and is hurting our medical facility.
- Lack of tradespeople—mechanics, plumbing, electricians, carpenters
- Lack of workers
- Loss of the nursing home.
- (2) No nursing home
- Poor quality in care from hospital.
- Population decline
- Progressive mind set to change and provide new/different services and activities.
- Providing necessary health care within the rising costs
- Quality health care providers and the ability to have urgent care or after-hours care
- Recent loss of long-term nursing home. This may cause some families to move out of area in the future to be closer to parents that need to enter a nursing home. Could possibly avoid this by having "in-home nurses" available to assist elderly even if it is just part time.
- Recruiting work force in areas of need (ie. plumber, electrician, marketing, healthcare) and employers higher folks interested in these fields when the opportunity arises.
- Resistance to securing COVID injections, all ages eligible.
- Retaining good health care
- Retaining what we have at the present time. We would like to grow but it is very important to be able to sustain the businesses and medical facilities that we have.
- Rural community with a lack of resources in all areas. Mental health, substance abuse, transportation, housing are all very limited.
- Senior population, I wanted to check almost all of the boxes. I feel we are failing our senior population.
- Significant lack of accessible and affordable housing for seniors.

- Social/emotional skills to handle adversity.
- Speeding in community especially once school is out.
- Staff shortages for hospitals and nursing home wing
- The fact there's a lot of HIPAA violations going on with your company and it's pretty sad when is the Valvoline in minor there is no excuses for this it should have never happened
- There are not enough well-paying jobs to attract new people.
- Transportation, local vision, dentist, affordable daycare service

Delivery of Healthcare

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

- Care is good once it is received. The wait time is ridiculous, mostly due to communication problems... in my opinion
- Consistent care by consistent local providers
- Do not provide all services needed.
- Doctors want to send you out of town for treatment instead of treating in Crosby
- Feeling guilty after appointments
- Insurance is out of area or not able to use insurance /Medicare in another state
- N/A
- (2) None
- Poor leadership

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

- Consistent care by consistent local providers. Rotational providers are not the answer when other options have presented themselves.
- Consistent healthcare; full time provider for continuity of care
- Dental
- Dental clinic with hygienist.
- Dental, eye care
- Dermatology, orthopedics
- Doctors going to homes of disabled individuals. Or having it available because of lack of transportation
- ENT
- ENT, vision
- Eye care optometrist
- Hospice
- If specialists could locally to prevent travel….most fly to destinations and airport is available here.
- It would be nice to have additional diagnostics locally such as full time CT services. Also podiatry, endocrine and dermatology.
- Mental health, wellness provider for nutrition, diet lifestyle
- More natural, homeopathic options
- OB GYN
- OB/GYN, pediatric, dentist, inpatient psych
- Pain clinic
- Pediatrician
- Pediatrician and optometrist
- Pediatrics. Lots of babies being born and have to travel out of town to see a pediatrician.

- Psychiatric/pediatric
- Regular access to a physician.
- Sat morning clinic hours
- Specialists, better environment by providers - it is always seemed that you are discouraged from utilizing emergency room or clinic
- Vision
- Vision/eyecare
- Vision care
- Vision care, an MD or at least a full time (lives locally) FNP
- Vision care, long term care, affordable assisted living, occupational therapy specifically for kids with sensory needs
- Vision, better transportation, affordable daycare services
- Vision, dental, assisting living, nursing home services
- Vision, more transportation, more affordable daycare, more affordable transportation, more affordable clothing, more affordable food/household items, less leaking of personal information,
- Walk in or after hour clinics- weekend walk in hours

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

- Another dentist who is full time. Optometrist - vision care
- Confidentiality should be addressed. Poor leadership will cause it all to crumble.
- Confidentiality, providers that listen to your concerns instead of pushing their opinion
- Consistent provider, improved communication within the healthcare facility.
- I recognize the fact that it is very difficult to secure a community based medical doctor, but hope that it might be possible at some time.
- I am well pleased with our health care in Crosby
- I believe that we could expand the services that we offer at our hospital. This would bring in more income and generate more jobs.
- I think for a small health care facility we provide some excellent care to our community and surrounding area!
- I think that it is important to work on growing our own, exploring ideas as to how we can train or offer local education opportunities for those that are interested or may be interested in the medical field.
- I would suggest finding ways to attract providers to our area
- Improve customer service, adhere to HIPAA, consistent provider hours
- It's a small community and everyone knows everyone so I feel more needs to be done to keep privacy sacred.
- Make tele-health readily available to those that have a hard time traveling out of town for care.
- More advertising of services and accomplishments of our facility, hospice and end of life services
- More health care options, better transportation to get there
- New providers who know something
- Not always being able to see a specific provider because they all travel in on a rotation.
- Promoting and bringing awareness to local services
- Recruit and grow local healthcare employees and stop hiring traveling staff. This would open up funds for other services. Pay the local staff more to help retain them so we don't have to pay travelers such high amounts. If local staff are paid more then that helps our local economy rather than travelers who aren't committed to our community. Establish a better suicide assessment process and connect them with services immediately rather than just giving them resources if they aren't committed. Create an expansion plan with several possible service options and survey the community to see what is most desired and would be used.
- Rotating providers do not provide continuity of care. Difficulty scheduling appts. Clinic visit are late and take an hour for routine visits
- Sounds like a broken record at this time: consistent care by consistent local providers

- The cost of healthcare even with great insurance is unaffordable. We have a revolving bill through the hospital. An ER visit should not cost us $1300. That is with insurance.
- Vision, better transportation, affordable daycare services, DMV
- We are fortunate for our local hospital/clinic, there are great employee's working there as well. From the patient seat, it appears there is a lack of communication between receptionist and nurses/doctors as we are told one thing over the phone but something different during office visit. Better communication most likely would cut back on waiting times as well. I understand things come up and available doctors is limited but one should not have to wait 10 to 15 mins. in lobby and then another 10 mins in the room. Some of this could be handled with following up over the phone to go over simple lab work instead of insisting on another office visit, even if the patient pays some for it (less than actual office visit). A lot of assumptions on my end here and ultimately, we as a community are very fortunate for our hospital, clinic and staff.
- We have a great healthcare system with consistent providers. Need to continue elder care and expand to retain that population and keeping ambulance services and a local pharmacy is a must
- We need to make sure we do not lose our pharmacy. We also need to try to get a provider that is here full time so that people in the community can feel comfortable opening up to them and can see them regularly rather than having to possibly wait till they come back on rotation to town. We also need to try to offer more services for our senior population and take care of them better.
- Would like to see a Dr., that does not rotate out, be able to be here full-time to be a primary care physician for patients. Some staff are great; some staff need lessons on being cheerful and helpful.