COMMUNITY HEALTH

Needs Assessment

2024

West River Health Services – Service Area
Hettinger, North Dakota

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Executive Summary

To help inform future decisions in strategic planning, West River Health Services (WRHS) conducted a Community Health Needs Assessment (CHNA) in 2023, the previous CHNA having been conducted in 2021. 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 one WRHS 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 Adams 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, Adams County's population from 2020 to 2021 decreased by 3.1 percent. The average number of residents younger than age 18 (24.4%) for Adams County comes in about 1 percentage point higher than the North Dakota average (23.5%). The percentage of residents ages 65 and older, is 7% higher for Adams County (23.7%) than the North Dakota average (16.7%), and the rate of education is lower for Adams County (88.7%) than the North Dakota average (93.3%). The median household income in Adams County ($52,896) is much lower than the state average for North Dakota ($71,970).

Data compiled by County Health Rankings show Adams County is doing better than North Dakota in health outcomes/factors for 11 categories.

Adams County, according to County Health Rankings data, is performing poorly, relative to the rest of the state in 13 outcome/factor categories.

Of 106 potential community and health needs outlined in the survey, the 101 WRHS service area residents who completed the survey indicated the following needs as the most important:

- Attracting and retaining young families
- Alcohol use and abuse – youth and adult
- Availability of resources to help the elderly stay in their homes
- Bullying/cyberbullying
- Cost of long-term/nursing home care
- Changes in population size
- Child abuse
- Depression/anxiety, stress – youth and adult
- Emotional abuse
- Not enough jobs with livable wages
- Not enough activities for children and youth
- Not enough healthcare staff in general, availability of primary care providers
- Suicide – 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=38), not able to get an appointment/limited hours (N=24), and not enough providers (N=23).

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

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

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:

- Ability to retain primary care providers (MD, DO, NP, PA) and nurses in the community
- Alcohol use and abuse
- Attracting and retaining young families
- Availability of resources to help the elderly stay in their homes
- Availability of mental health services
- Bullying/cyberbullying
- Cost of long-term/nursing home care
- Depression/anxiety
- Stress
- Suicide

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, West River Health Services (WRHS) completed a Community Health Needs Assessment (CHNA) of the WRHS service area. The hospital identifies its service area as the towns of Bowman, Scranton, Reeder, Bucyrus, Hettinger, Haynes, Mott, New England, and Dickinson, North Dakota, and Lemmon, Bison, and Buffalo, South Dakota.

Hettinger is located along Highway 12 in southwest North Dakota, four miles from the South Dakota border and 60 miles from Montana. The city is located in Adams County in the heart of agriculture and ranch country. This area promotes a strong, family-oriented lifestyle with friendly, honest people who take great pride in their community. The people of the area are the backbone of the community.

Hettinger has two schools, grades pre-kindergarten to high school, which has 288 students enrolled. The main street has a number of businesses, including a coffee shop, t-shirt shops, and other establishments for entertainment. New to the area is The Lost World dinosaur park for families to enjoy walking through the past. Hettinger is a popular spot for hunters to come and spend their weekends hunting, fishing, and enjoying other outdoor activities.

WRHS, through its hospital and clinic in Hettinger and clinics in Bowman, Scranton, New England, and Mott, North Dakota, and Lemmon, South Dakota, serves a large area in southwestern North Dakota and northwestern South Dakota.

West River Health Services is composed of a Critical Access Hospital (CAH), five certified Rural Health Clinics (RHCs) located in Mott, Bowman, New England, Scranton, and Lemmon, a provider-based clinic, a visiting nurse program, a rehab center, an ambulance service, a 45-bed skilled nursing facility, and a 16-unit assisted living facility. A multispecialty group practice serves the area with 12 physicians, 15 advanced practice providers, and eight visiting specialists independently providing professional services. WRHS serves a geographic area of roughly 20,000 square miles and roughly the same number of people.

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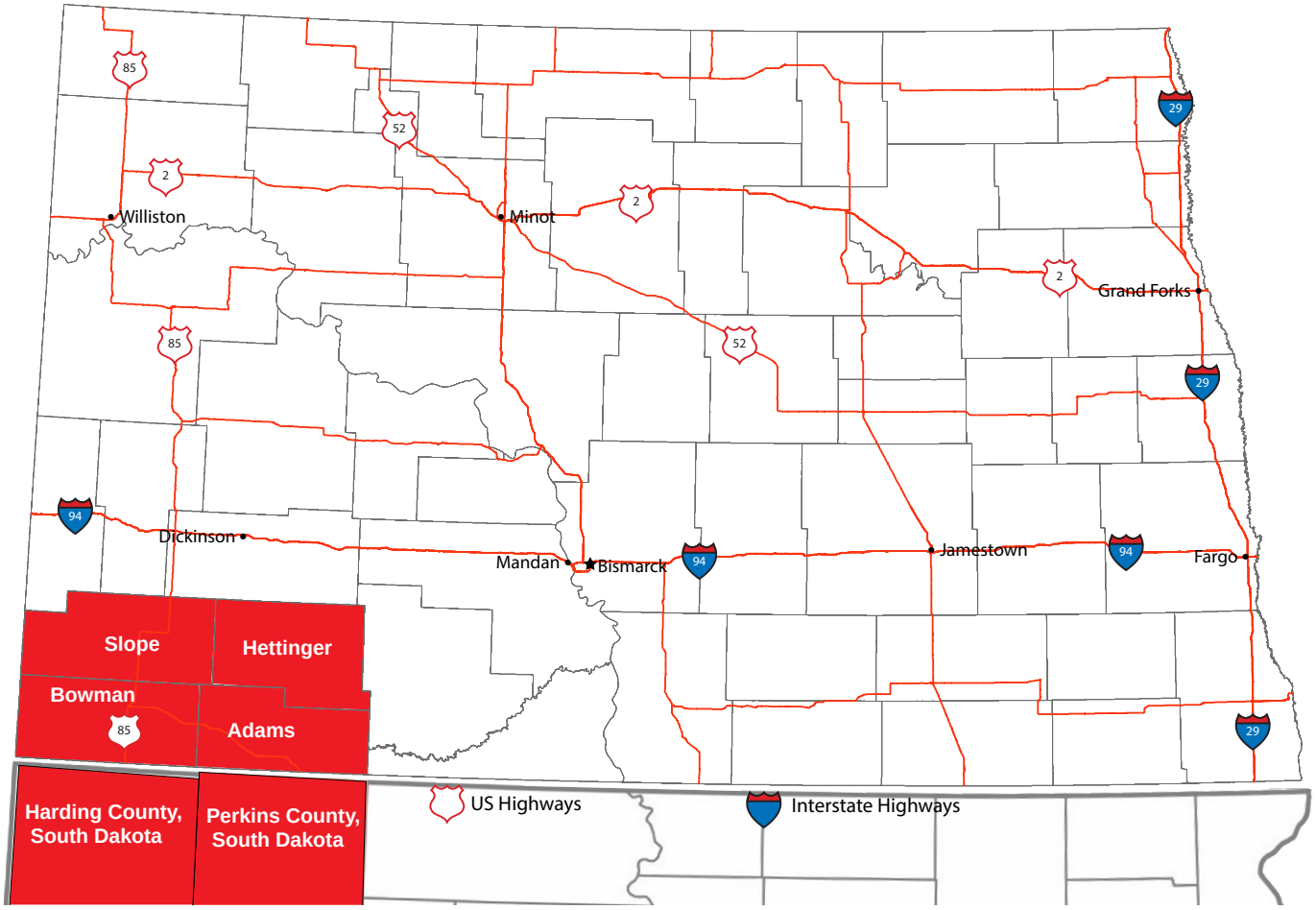
Figure 1: Adams, Bowman, Hettinger, and Slope Counties (North Dakota); Perkins and Harding Counties (South Dakota)



West River Health Services, WRHS

LWRHS is composed of a CAH, five certified RHCs (located in Mott, Bowman, New England, and Scranton, North Dakota and Lemmon, South Dakota), a provider-based clinic, a visiting nurse program, a rehab center, an ambulance service, a 45-bed skilled nursing facility, and a 16-unit assisted living facility. A multispecialty group practice serves the area with 14 physicians, 13 advanced practice providers, and seven visiting specialists independently providing professional services. WRHS serves a geographic area of roughly 20,000 square miles and roughly the same number of people. The CAH Profile for WRHS includes a summary of hospital-specific information and is available in Appendix A.

The corporate structure of the organization is comprised of three 501c3 (not-for-profit) corporations. West River Health Services Foundation is the foundation/fundraising and parent corporation.

WRHS has a significant economic impact on the region. In 2020, when the economic impact analysis was calculated, they directly employed 222.2 FTE employees with an annual payroll of over $15.9 million (including benefits). These employees create an additional 90 jobs and nearly $3.6 million in income as they interact with other sectors of the local economy. This economy results in a total impact of 313 jobs and more than $19.5 million in income. Additional information is provided in Appendix B.

The hospital element of WRHS, West River Regional Medical Center (WRRMC), is a 25-bed CAH with a Level IV Trauma Designated Center, certified through the North Dakota Department of Health. Level IV facilities

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are held to the same high standards as Level V in urban areas. Through the years, WRRMC has received recognition for quality and innovation in service and is a four-time recipient as a Top 20 CAH and a seven-time recipient as a Top 100 CAH in the nation from the National Rural Health Association.

Every day, all nurses, doctors, and staff provide comprehensive health and wellness services to the residents and visitors of the region. WRHS and its partners in healthcare are dedicated to excellence in practice, innovation in service, compassion for the people they serve, and respect for one another. Providing access to quality medicine in a rural environment has been the vision and goal of this medical system since its inception.

Services offered locally by WRHS include:

Hospital

- Acute stroke ready
- General acute
- Medical surgical unit
- Newborn nursery
- Palliative care room
- Pediatric patient services
- Surgery center
- Swing bed unit
- Twenty-five bed CAH

Twenty-Four Hour Emergency Care

- Acute stroke ready hospital
- Ambulance services – land and air flight
- Certified staff in trauma care, cardiac Life support and pediatric life support
- Level IV trauma center
- Nurses – certified in advanced cardiac life support and trauma nursing

Medical Providers

- Family medicine
- Family medicine and obstetrics
- Obstetrics/birth and gynecological surgery
- General surgery
- Geriatric medicine
- Internal medicine
- Optometric medicine
- Pediatric medicine
- Podiatric medicine
- Radiology/diagnostic medicine

Surgical Services

- Laparoscopic gallbladder, hernia, and appendix
- Breast: sentinel lymph node biopsy, benign breast disease, breast cancer
- Gastro-intestinal: colonoscopy and gastroscopy, and extensive colorectal procedures
- Orthopedic Surgery
- Ophthalmology
- Podiatry
- Cesarean sections/gynecological
- Tonsillectomy/adenoidectomy

Radiology Services

- 1.5T MRI services
- 64-slice CT scanner
- 3D mammography services
- Ultrasound imaging (including cardiac & OB)
- Nuclear imaging
- Digital X-ray imaging
- Fluoroscopy procedures
- Cardiac stress testing
- Injection therapy services
- Body composition exams
- Injection therapy services

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Laboratory Services

- Automated chemistry
- Blood banking
- Clinical microscopy
- Coagulation
- Hematology
- Microbiology
- Serology

Rehabilitation Services

- Balance and dizziness treatments
- Certified lymphedema therapists (lower and upper extremities)
- Dry needling
- Occupational therapy
- Physical therapy
- Speech-language pathology

Other Services

- Behavioral health – counseling/therapy
- Cardiac rehab services
- Cardiac stress testing
- Chronic care management
- Ambulatory cardiac monitoring
- Diabetes care and education
- DOT physicals
- Infusion therapy
- Medicare annual wellness awareness
- Medical nutrition therapy
- Population health nurse
- Respiratory care
- Sleep studies
- Specialized adult care
- Tobacco free
- Transitional care calls
- Visiting nurse
- YoMingo virtual education for expectant parents

Visiting Specialists

- Clinical audiologist
- Interventional cardiologist
- Ophthalmologist
- Orthopedic surgeon
- Tele-psychiatrist

Services Offered by OTHER Providers/Organizations

- ABLE – group home for developmentally disabled
- Chiropractic services
- Counseling
- Dakota Prairie Helping Hands
- Dental services
- Fitness training
- Massage therapy
- Meals on wheels
- Parks and recreation – swimming lessons, summer recreation, golf course
- Pharmacy
- Public health nurse
- Second 40 club
- Senior citizen center
- Specialized care/adult care
- Social services
- WIC is a program for pregnant and breastfeeding women, infants, and children

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Southwestern District Health Unit

North Dakota's public health system is decentralized, with 28 independent local public health units working in partnership with the North Dakota Department of Health. The 28 local public health units are organized into single or multi-county health districts, city/county health departments, or city/county health districts. Seventy-five percent of the local health units serve single county, city, or combined city/county jurisdictions, while the other 25% serve multi-county jurisdictions. The majority of the multi-county jurisdictions are in the western part of the state. In this decentralized approach, the units are required to meet state standards and follow state laws and regulations, but they can exercise their own powers and have administrative authority to make decisions to meet their local needs. The local public health infrastructure has the capacity and expertise necessary to carry out services and programs needed in their jurisdictions. Therefore, the health units function differently from one another, and each offers its own unique array of services. Southwestern District Health Unit (SDHU) is based out of Dickinson, North Dakota.

Specific services that SDHU provides are:

- Blood pressure checks
- Behavioral health (Narcan trg, opioid and alcohol prevention trg, suicide screening)
- Breastfeeding resources
- Car seat program (referral only)
- Child health
- COVID vaccinations and free test kits
- Diabetes screening
- Emergency preparedness services-work with community partners as part of local emergency response team
- Environmental health services (water, sewer, health hazard abatement)
- Flu shots
- Health Tracks (child health screening) (Medicaid eligible)
- Immunizations (includes in school immunizations, and travel vaccines)
- Medication setup—home visits
- Newborn Home Visits
- Nutrition education
- School health-- vision, health education and resource to the schools
- Preschool education programs and screening
- Tobacco prevention and control and cessation
- Tuberculosis management
- West Nile program—education
- WIC (Women, Infants, and Children) Program
- Health Maintenance Program
- Dental Health Education
- Health Equity Education

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.

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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 Adams County but includes the additional service-area counties of Hettinger, Slope, and Bowman Counties in North Dakota and Perkins and Harding Counties in South Dakota. Located in the North Dakota counties are the towns of Bowman, Scranton, Reeder, Bucyrus, Haynes, Mott, New England, and Dickinson, and located in the South Dakota counties are Lemmon, Bison, and Buffalo.

The Center for Rural Health (CRH), in partnership with West River Health Services (WRHS) and Southwestern District Health Unit (SDHU), 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 WRHS. A steering committee (see Figure 2) was formed that was responsible for planning and implementing the process locally. Representatives from CRH met and corresponded regularly by 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. WRHS staff and board members were in attendance as well but largely played a role of listening and learning.

Figure 2: Steering Committee

Alyson Kornele	CEO, WRHS
Nathan Stadheim	CFO, WRHS
Jezzele Salazar	ACO, WRHS
Carmin Erickson	CNO, WRHS
Tammy Roso	Executive Assistant, WRHS
Beth Erickson	Executive Assistant, WRHS
Cindy Ham	Community Relations/Marketing, WRHS

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.

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
- 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

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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 University of North Dakota (UND) School of Medicine & Health Sciences (SMHS) 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 13 community members, was convened and first met on October 4, 2023. 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 December 5, 2023, with 10 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 Adams 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 WRHS and SWHD. They included representatives of the health community, business community, education, and faith community. Not all members of the group were present at both meetings.

Interviews

One-on-one interviews with four key informants were conducted in person in Hettinger on October 4, 2023. Two additional key informant interviews were conducted over the phone in October of 2023. A representative from CRH conducted the interviews. Interviews were held with selected members of the community who could provide insights into the community's health needs. Included among the informants were public health professionals with special knowledge in public health, acquired through several years of direct experience in the community, including working with medically underserved, low-income, and minority populations as well as with populations with chronic diseases.

Topics covered during the interviews included the general health needs of the community, the general health of the community, community concerns, delivery of 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 is included in Appendix G.

The community member survey was distributed to various residents of the WRHS service area. The survey tool was designed to:

- Learn of the good things in the community and the community's concerns.

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- 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, the survey was advertised via a WRHS blog, Facebook page, Instagram, and website. Emails were also sent out. Print ads were put in the local paper as well as radio advertisements.

Approximately 50 community member surveys were available for distribution in the WRHS service area and were available at WRHS clinics in Scranton, New England, Mott, Hettinger, and Lemmon.

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 WRHS or SDHU. The survey period ran from October 1, 2023, to October 15, 2023. Two completed paper surveys were returned.

Area residents were also given the option of completing an online version of the survey, which was publicized in the newspaper, emailed, and included in the WRHS blog, Facebook, Instagram, and website. Ninety-nine online surveys were completed. Six of those online respondents used the QR code to complete the survey. In total, counting both paper and online surveys, 101 community member surveys were completed, equating to a 10.4% response rate. This response rate is low for this type of unsolicited survey methodology.

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.

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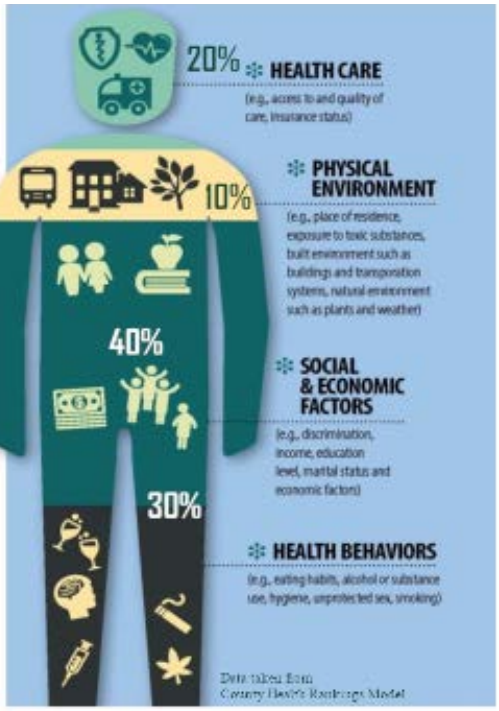
There are numerous models that depict the social determinants of health. While the models may vary slightly in the exact percentages that they attribute to various areas, the discrepancies are often because some models have combined factors when other models have kept them as separate factors.

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



In Figure 3, the 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, at https://www.ruralhealthinfo.org/topics/social-determinants-of-health.

Figure 4: Social Determinants of Health

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

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

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Demographic Information

TABLE 1: ADAMS COUNTY: INFORMATION AND DEMOGRAPHICS

	Adams County	North Dakota
Population (2022)	2,115	779,261
Population change (2020-2022)	-3.9%	<1%
People per square mile (2020)	2.2	11.3
Persons 65 years or older (2021)	29.8%	16.7%
Persons younger than 18 years (2021)	19.7%	23.5%
Median age (2021)	40.9	36.2
White persons (2021)	91.3%	86.6%
High school graduates (2021)	88.7%	93.3%
Bachelor's degree or higher (2021)	16.8%	31.1%
Live below poverty line (2021)	12.0%	11.5%
Persons without health insurance, younger than 65 years (2021)	12.5%	7.5%
Language other than English spoken at home (2021)	3.8%	6.3%

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

Adams County has seen a decrease in population since 2020. The U.S. Census Bureau estimates show that Adams County's population decreased from 2,200 (2020) to 2,115 (2022).

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

The data used in the 2023 County Health Rankings are pulled from more than 20 data sources and then are compiled to create county rankings. Counties in each of the 50 states are ranked according to summaries of a variety of health measures. Those having high ranks, such as 1 or 2, are considered to be the "healthiest." Counties are ranked on both health outcomes and health factors. Following is a breakdown of the variables that influence a county's rank.

A model of the 2023 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.

Table 2 summarizes the pertinent information, gathered by County Health Rankings as it relates to Adams 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 Southwestern District Health Unit and West River Health Services or 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 2022. 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).

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Health Outcomes

- Length of life
- Quality of life

Health Factors

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

Health Factors (continued)

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

Adams County rankings within the state are included in the summary following. For example, Adams County ranks 36th out of 48 ranked counties in North Dakota on health outcomes and 36th out of 48 on health factors. The measures, marked with a bullet point (•), are those where a county is not measuring up to the state rate/percentage; a square (■) indicates that the county is not meeting the U.S. Top 10% rate on that measure. Measures that are not marked with a colored shape but are marked with a plus sign (+) indicate that the county is doing better than the U.S. Top 10%.

The data from County Health Rankings show that Adams County is doing worse in three of the five outcomes when compared to North Dakota. Two of the five outcomes are blank for Adams County to reflect unreliable or missing data. Adams County is also doing better when it comes to the U.S. Top 10% ratings in two of the three outcomes.

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

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

- Adult obesity
- Alcohol-impaired driving deaths
- Excessive drinking
- Flu vaccinations rate
- Unemployment rate
- Physical inactivity
- Air pollution – particulate matter
- Primary care physicians to patient ratio
- Preventable hospital stays
- Children in single-parent households
- Uninsured
- Severe housing problems

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

- Poor or fair heath percentage
- Poor physical health days
- Poor mental health days
- Adult smoking percentage
- Food environment index
- Access to exercise opportunities
- Dentists per capita
- Mental health providers per capita
- Mammography screening percentage
- Percentage of children in poverty
- Income inequality
- Social associations
- Injury deaths

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● = 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* 2022 – ADAMS COUNTY

	Adams County	U.S. Top 10%	North Dakota
Ranking: Outcomes	**36th**		**(of 47)**
Premature death		5,600	7,100
Poor or fair health	13% ■	15%	13%
Poor physical health days (in past 30 days)	2.9 +	3.4	3.1
Poor mental health days (in past 30 days)	3.9 ●+	4.0	3.7
Low birth weight		6%	7%
Ranking: Factors	**36th**		**(of 48)**
Health Behaviors			
Adult smoking	20% ●■	15%	17%
Adult obesity	34% ■	30%	36%
Food environment index (10=best)	8.9 +	8.8	8.9
Physical inactivity	25% ■	23%	28%
Access to exercise opportunities	3% ●■	86%	64%
Excessive drinking	22% ■	15%	24%
Alcohol-impaired driving deaths	0% +	10%	41%
Sexually transmitted infections		161.8	509.1
Teen birth rate		11	18
Clinical Care			
Uninsured	8% ●■	6%	7%
Primary care physicians	240:1 +	1,010:1	1,290:1
Dentists	2,170:1 ●■	1,210:1	1,480:1
Mental health providers	1,080:1 ●■	250:1	470:1
Preventable hospital stays	2,420 ■	2,233	3,553
Mammography screening (% of Medicare enrollees ages 65-74 receiving screening)	39% ●■	52%	53%
Flu vaccinations (% of fee-for-service Medicare enrollees receiving vaccination)	53% ■	55%	50%
Social and Economic Factors			
Unemployment	3.4% +	4.0%	5.1%
Children in poverty	15% ●■	9%	11%
Income inequality	6.3 ●■	3.7	4.4
Children in single-parent households	14% +	14%	19%
Social associations	0.0 ●■	18.1	15.9
Violent crime	88■	63	258
Injury deaths		61	72
Physical Environment			
Air pollution – particulate matter	4.2 +	5.9	6.4
Drinking water violations	No		
Severe housing problems	10% ■	9%	12%

Source: http://www.countyhealthrankings.org/app/north-dakota/2022/rankings/outcomes/overall

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Children's Health

The National Survey of Children's Health touches on multiple intersecting aspects of children's lives. Data 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 2022-23. 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), 2020/21

Health Status	North Dakota	National
Children born premature (3 or more weeks early)	9.2%	11.4%
Children ages 10-17 overweight or obese	29.0%	33.4%
Children ages 0-5 who were ever breastfed	82.0%	81.6%
Children ages 6-17 who missed 11 or more days of school	3.3%	3.8%
Healthcare		
Children currently insured	91.2%	91.4%
Children who spent less than 10 minutes with the provider at a preventive medical visit	16.9%	18.0%
Children (1-17 years) who had preventive a dental visit in the past year	75.9%	78.6%
Children (3-17 years) received mental healthcare	11.1%	11%
Children (3-17 years) with problems requiring treatment did not receive mental healthcare	4.7%	5.4%
Young children (9-35 mos.) receiving standardized screening for developmental problems	41.2%	34.8%
Family Life		
Children whose families eat meals together four or more times per week	76.1%	75.8%
Children who live in households where someone smokes	16.9%	13.8%
Neighborhood		
Children who live in neighborhoods with parks or playgrounds	34.9%	35.5%
Children living in neighborhoods with poorly kept or rundown housing	2.2%	4.2%
Children living in neighborhood that's usually or always safe	98.3%	94.8%

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 currently insured
- 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 living in smoking households

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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 focus on the main components of children's well-being. 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 Adams County is performing more poorly than the North Dakota average on all of the examined measures. The most marked difference was on the measure of uninsured children (almost 4% higher rate in Adams County).

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

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

	Adams County	North Dakota
Uninsured children (% of population age 0-18), 2021	**11.4%**	7.5%
Children in poverty (ages 0-17), 2021	**14.6%**	11.5%
Medicaid recipient (% of population age 0-20), 2022	**32.9%**	28.8%
Children enrolled in Healthy Steps (% of population age 0-18), 2022	**2.9%**	2.2%
Supplemental Nutrition Assistance Program (SNAP) recipients (% of population age 0-18), 2021	**17.4%**	16.4%
4-year high school cohort graduation rate, 2021/22	**80%**	84.3%
4-year high school cohort graduation rate, 2021/22	**90%**	84.3%

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 2017, 2019, and 2021. They are further broken down by rural and urban percentages. The trend column shows a "=" for statistically insignificant change (no change), "↑" for an increased trend in the data changes from 2019 to 2021, and "↓" for a decreased trend in the data changes from 2019 to 2021. The final column shows the 2021 national average percentage. For a more complete listing of the YRBS data, see Appendix E.

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Table 5. Youth Risk Behavior Survey Results

North Dakota High School Survey

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

	ND 2017	ND 2019	ND 2021	ND Trend ↑, ↓, =	Rural ND Town Average	Urban ND Town Average	National Average 2021
Injury and Violence							
% of students who rarely or never wore a seat belt (when riding in a car driven by someone else)	8.1	5.9	49.6	↑	9.2	5.5	39.9
% of students who rode in a vehicle with a driver who had been drinking alcohol (one or more times during the 30 prior to the survey)	16.5	14.2	13.1	=	18.2	13.7	14.1
% of students who talked on a cell phone while driving (on at least one day during the 30 days before the survey)	56.2	59.6	5.0	↓	64.9	64.2	NA
% of students who texted or emailed while driving a car or other vehicle (on at least one day during the 30 days before the survey)	52.6	53.0	55.4	=	59.9	55.9	36.1
% of students who were in a physical fight on school property (one or more times during the 12 months before the survey)~2017/2019~ *in 2021 replaced by* % of students who carried a weapon on school property (such as a gun, knife, or club, on at least 1 day during the 30 days before the survey)	7.2	7.1	5.0	↓	6.2	4.4	3.0
% of students who experienced sexual violence (being forced by anyone to do sexual things [counting such things as kissing, touching, or being physically forced to have sexual intercourse] that they did not want to, one or more times during the 12 months before the survey)	8.7	9.2	9.4	=	9.7	11.6	11
% of students who were bullied on school property (during the 12 months before the survey)	24.3	19.9	15.8	↓	19.8	15.0	15.0
% of students who were electronically bullied (includes texting, Instagram, Facebook, or other social media ever during the 12 months before the survey)	18.8	14.7	13.6	↓	16.2	14.5	15.9
% of students who made a plan about how they would attempt suicide (during the 12 months before the survey)	14.5	15.3	14.8	=	15.1	17.2	17.6
Tobacco, Alcohol, and Other Drug Use							
% of students who currently use an electronic vapor product (e-cigarettes, vape e-cigars, e-pipes, vape pipes, vaping pens, e-hookahs, and hookah pens at least one day during the 30 days before the survey)	20.6	33.1	21.2	↓	24.2	23.6	18.0
% of students who currently used cigarettes, cigars, or smokeless tobacco (on at least one day during the 30 days before the survey)	18.1	12.2	5.9	↓	8.0	6.1	3.8
% of students who currently were binge drinking (four or more drinks for female students, five or more for male students within a couple of hours on at least one day during the 30 days before the survey)	16.4	15.6	14.0	=	17.8	14.6	10.5
% of students who currently used marijuana (one or more times during the 30 days before the survey)	15.5	12.5	10.7	=	10.2	12.9	15.8

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% of students who ever took prescription pain medicine without a doctor's prescription or differently than how a doctor told them to use it (counting drugs such as codeine, Vicodin, OxyContin, Hydrocodone, and Percocet, one or more times during their life)	14.4	14.5	10.2	↓	9.7	11.0	12.2
Weight Management, Dietary Behaviors, and Physical Activity							
% of students who were overweight (>= 85th percentile but <95th percentile for body mass index)	16.1	16.5	15.6	=	15.5	14.2	16.0
% of students who had obesity (>= 95th percentile for body mass index)	14.9	14.0	16.3	=	17.4	15.0	16.3
% of students who did not eat fruit or drink 100% fruit juices (during the seven days before the survey)	4.9	6.1	5.0	=	5.7	4.6	7.7
% of students who did not eat vegetables (green salad, potatoes [excluding French fries, fried potatoes, or potato chips], carrots, or other vegetables, during the seven days before the survey)	5.1	6.6	5.9	=	5.3	6.2	9.3
% of students who drank a can, bottle, or glass of soda or pop one or more times per day (not including diet soda or diet pop, during the seven days before the survey)	16.3	15.9	16.6	=	17.5	13.8	14.7
% of students who did not drink milk (during the seven days before the survey)	14.9	20.5	26.2	↑	21.2	29.4	35.7
% of students who did not eat breakfast (during the seven days before the survey)	13.5	14.4	15.1	=	14.5	17.3	22.0
% of students who most of the time or always went hungry because there was not enough food in their home (during the 30 days before the survey)	2.7	2.8	2.1	=	2.2	2.1	NA
% of students who were physically active at least 60 minutes per day on five 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)	51.5	49.0	56.5	↑	58.0	55.3	NA
% of students who watched television three or more hours per day (on an average school day) *In 2021 replaced by*Percentage of students who spent 3 or more hours per day on screen time (in front of a TV, computer, smart phone, or other electronic device watching shows or videos, playing games, accessing the internet, or using social media, not counting time spent doing schoolwork, on an average school day)	18.8	18.8	75.7	↑	75.8	78.6	75.7
% 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) *In 2021, % of students who played video or computer games was combined with % of students who watch television three or more hours per day.	43.9	45.3	NA	NA	NA	NA	NA
Other							
% of students who ever had sexual intercourse	36.6	38.3	36.6	=	36.5	37.0	30
% of students who had eight or more hours of sleep (on an average school night)	31.8	29.5	24.5	↓	28.3	23.2	22.7
% of students who brushed their teeth on seven days (during the seven days before the survey)	69.1	66.8	67.9	=	64.5	69.9	NA

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

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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 more 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 of which categories these needs belong to 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

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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

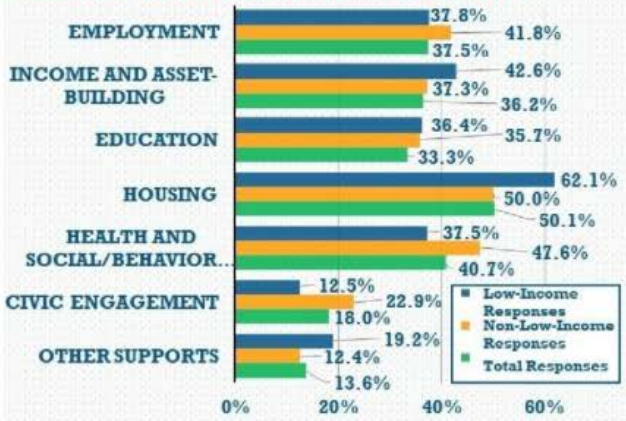
3,458 Total Survey Responses

- **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

1. Housing
2. Health and Social/Behavior Development
3. Income and Asset - Building

1. Housing
2. Income and Asset - Building
3. Employment

1. Housing
2. Employment
3. Health and Social/Behavior Development

1. Health and Social/Behavior Development
2. Income and Asset - Building
3. Housing

1. Housing
2. Income and Asset - Building
3. Education

1. Housing
2. Education
3. Income and Asset - Building

1. Housing
2. Health and Social/Behavior Development
3. Income and Asset - Building

1. Housing
2. Employment
3. Income and Asset - Building

ACKNOWLEDGMENTS

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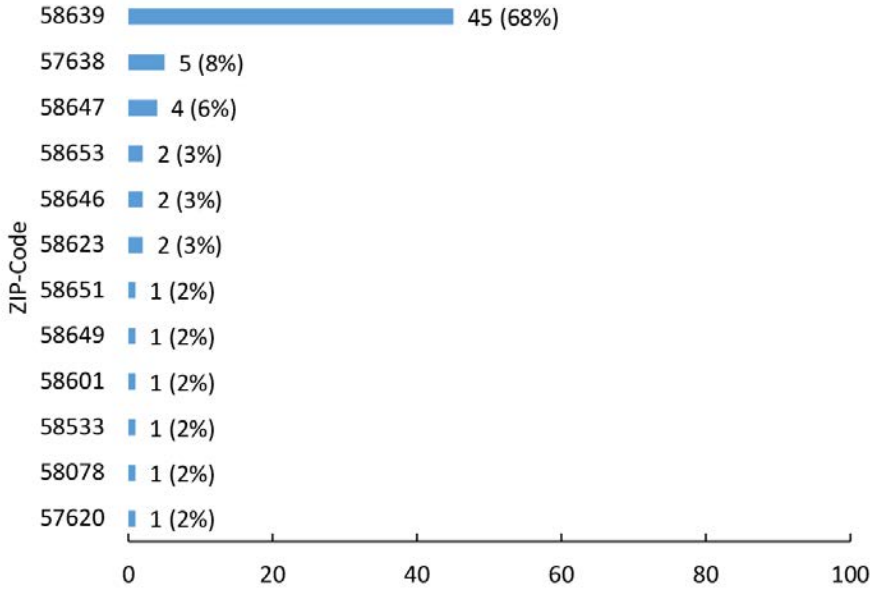
Survey Results

As noted previously, the 101 community members completed the survey in communities throughout the counties in the West River Health Services (WRHS) service area. For all questions that contained an "Other" response, all of those direct responses may be found in Appendix G. In some cases, a summary of those comments is additionally included in the report narrative. The "Total respondents" number under each heading indicates the number of people who responded to that particular question, and the "Total responses" number under the heading depicts the number of responses selected for that question (Some questions allow for selection of more than one response).

The survey requested that respondents list their home ZIP code. While not all respondents provided a ZIP code, 66 did, revealing that a large majority of respondents (68%, N=45) lived in Hettinger. These results are shown in Figure 5.

Figure 5: Survey Respondents' Home ZIP Code
Total respondents: 66



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:

- 51% (N=39) were aged 55 or older
- The majority (78%, N=59) were female
- Slightly more than half of the respondents (55%, N=42) had bachelor's degrees or higher
- The number of those working full time (66%, N=50) was just less than four times higher than those who were retired (18%, N=14)
- 97% (N=72) of those who reported their ethnicity/race were White/Caucasian
- 33% of the population (N=23) had household incomes of less than $50,000

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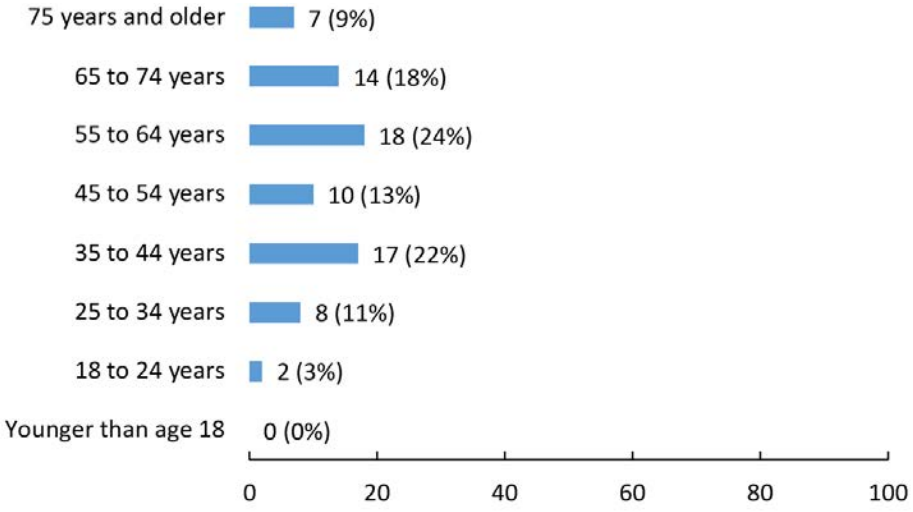
Figures 6 through 12 show these demographic characteristics. It illustrates the range of community members' household incomes and indicates how this assessment took into account input from parties who represent the varied interests of the community served, including a balance of age ranges, those in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

Figure 6: Age Demographics of Survey Respondents
Total respondents = 76



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

Figure 7: Gender Demographics of Survey Respondents
Total respondents = 76

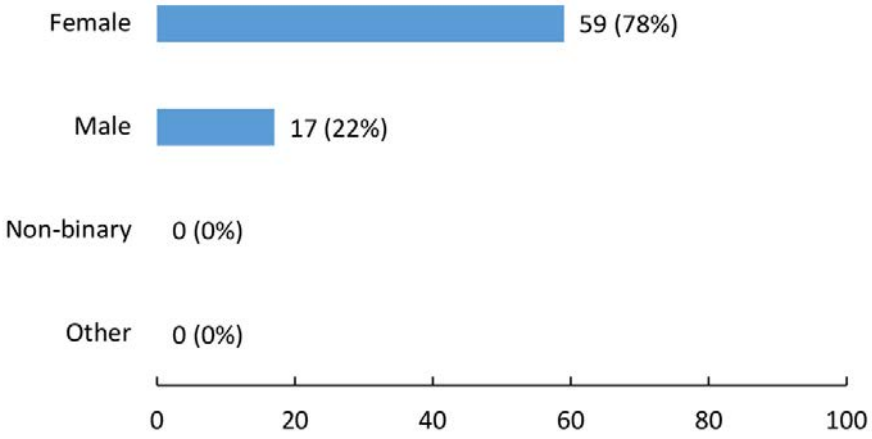


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Figure 8: Educational Level Demographics of Survey Respondents
Total respondents = 76

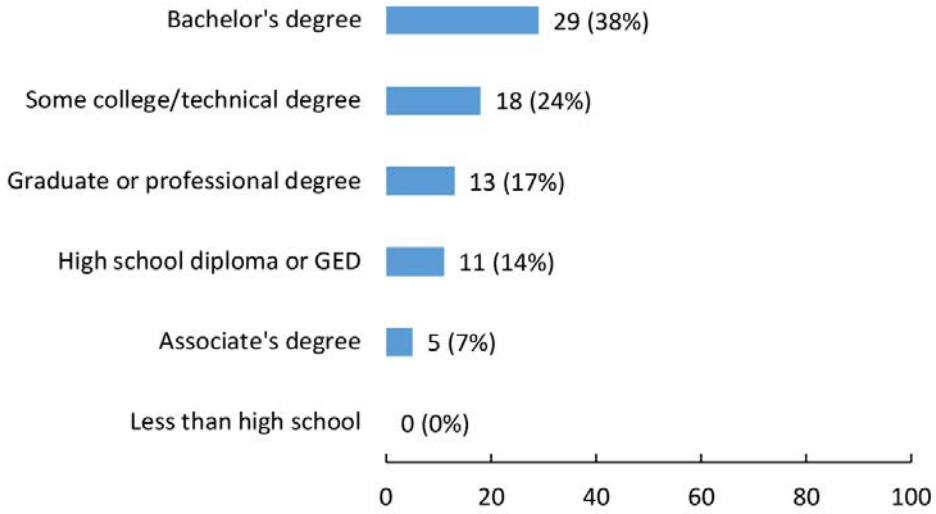


Figure 9: Employment Status Demographics of Survey Respondents
Total respondents = 76

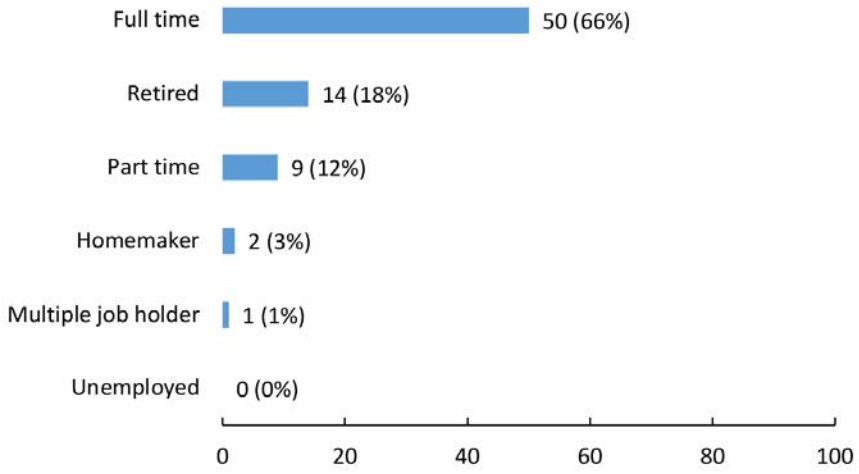
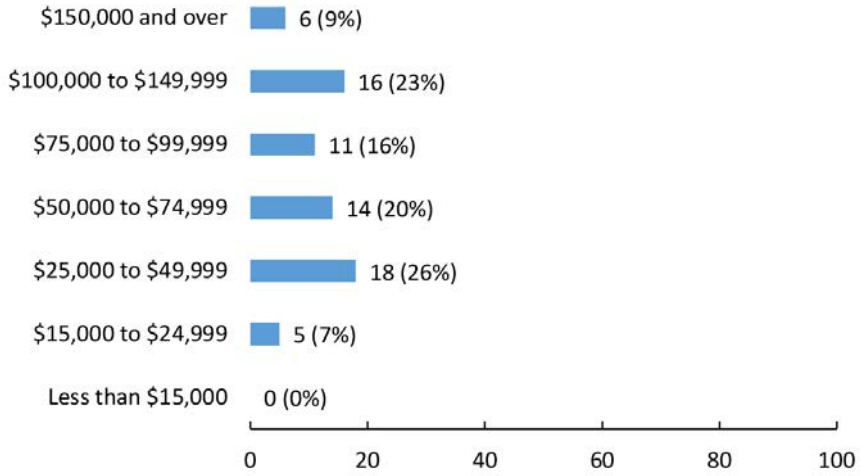


Figure 10: Household Income Demographics of Survey Respondents
Total respondents = 70



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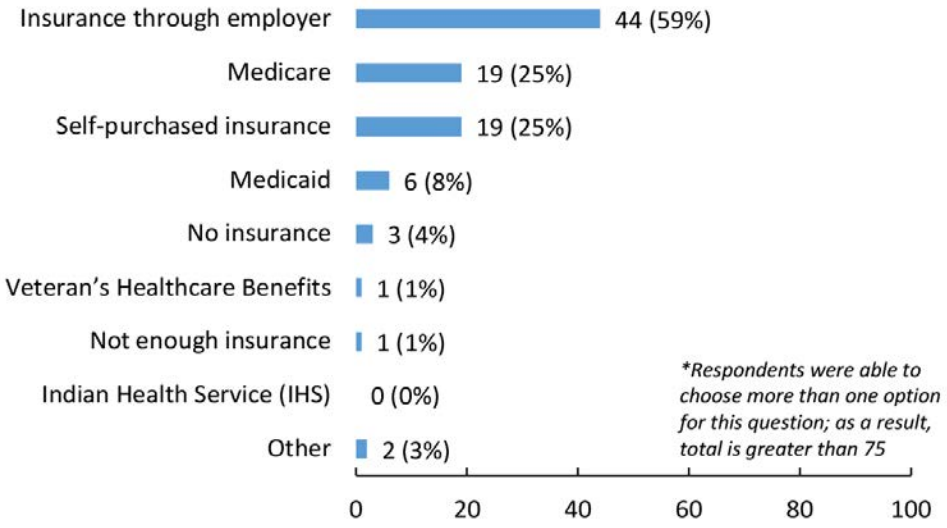
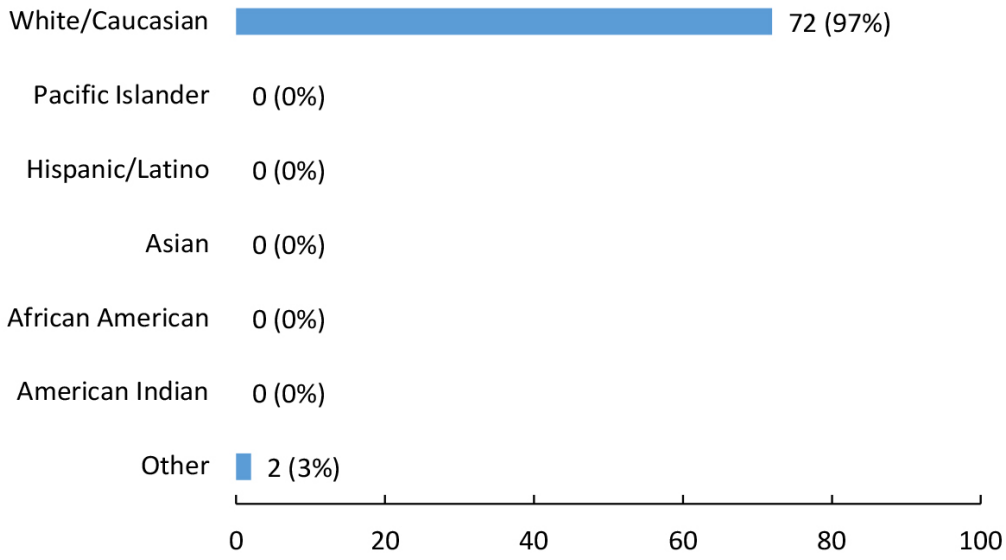
Community members were asked about their health insurance status, which is often associated with whether people have access to healthcare. Five percent (N=4) of the respondents reported having no health insurance or being under-insured. The most common insurance types were insurance through one's employer (N=44), followed by Medicare (N=19), and self-purchased (N=19). In the "Other" category, Tricare was written in.

Figure 11: Health Insurance Coverage Status of Survey Respondents
Total respondents = 75*



As shown in Figure 12, nearly all of the respondents were White/Caucasian (97%). This percentage was a slightly higher rate with the race/ethnicity of the overall population of Adams County; the U.S. Census indicates that 93.2% of the population is White in Adams County. In the "Other" category, one participant stated mixed northern European as their race.

Figure 12: Race/Ethnicity Demographics of Survey Respondents
Total respondents = 74



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Community Assets and Challenges

Survey-respondents were asked what they perceived as the best things about their community in four categories: people, services and resources, quality of life, and activities. In each category, respondents were given a list of choices and asked to pick the three best things. Respondents occasionally chose less than three or more than three choices within each category. If more than three choices were selected, their responses were not included. The results indicate there is consensus (with at least 60 respondents agreeing) that community assets include:

- Family-friendly (N=87)
- Safe place to live, little/no crime (N=79)
- People are friendly, helpful, supportive (N=75)
- Healthcare (N=66)
- Local events and festivals (N=63)
- People who live here are involved in their community (N=61)

Figures 13 to 16 illustrate the results of these questions.

Figure 13: Best Things About the PEOPLE in Your Community
Total responses = 99*

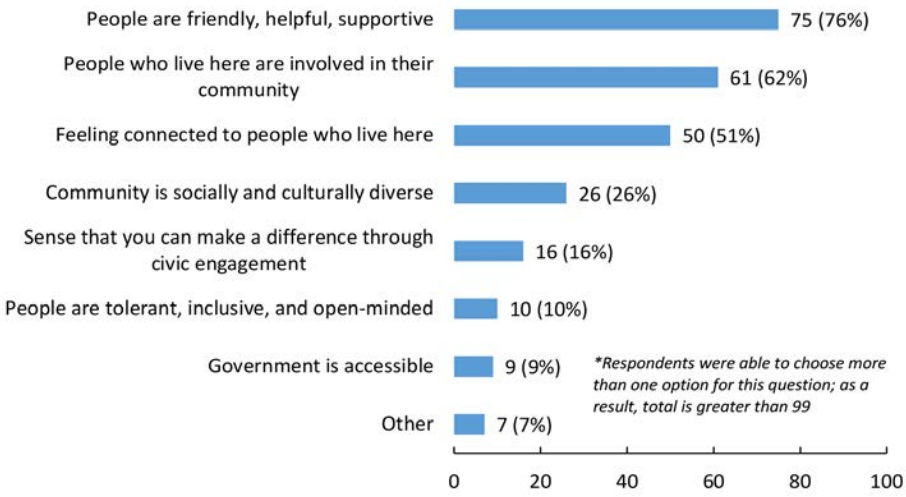
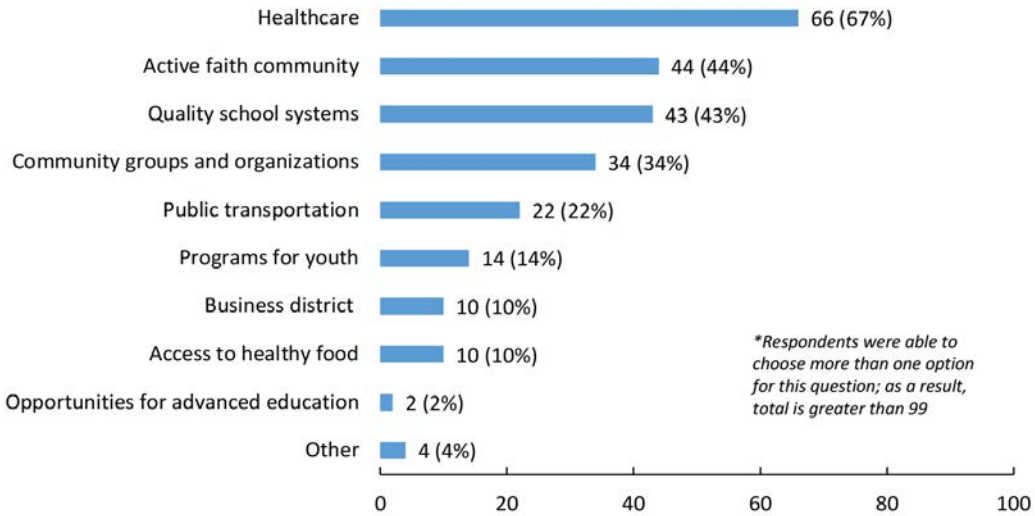


Figure 14: Best Things About the SERVICES AND RESOURCES in Your Community
Total responses = 99*



Respondents who selected "Other" specified that the best things about services and resources included parks are nice and being a small town.

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Figure 15: Best Things About the QUALITY OF LIFE in Your Community
Total responses = 101*

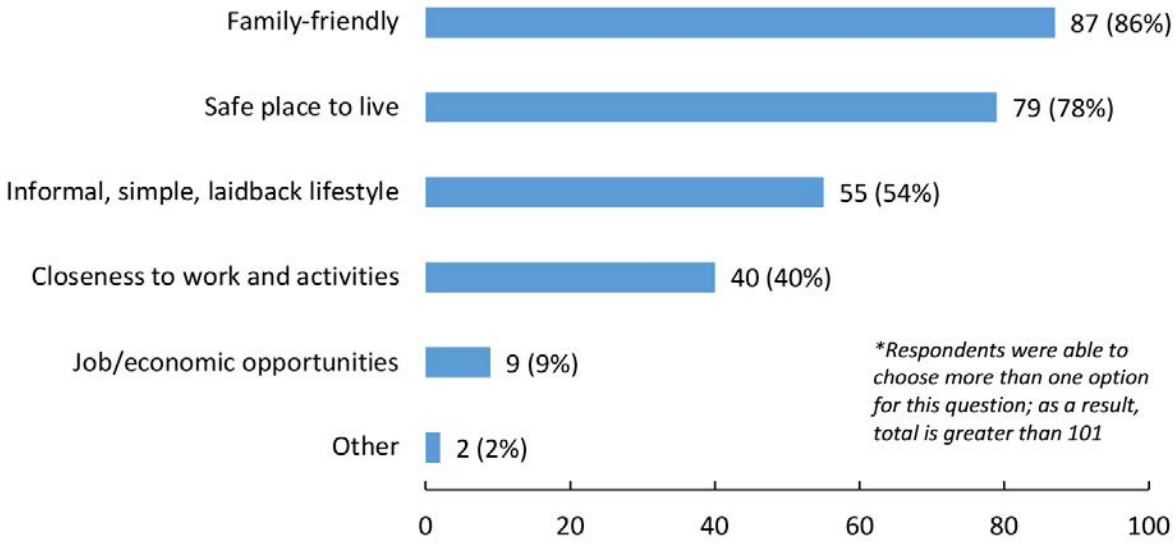
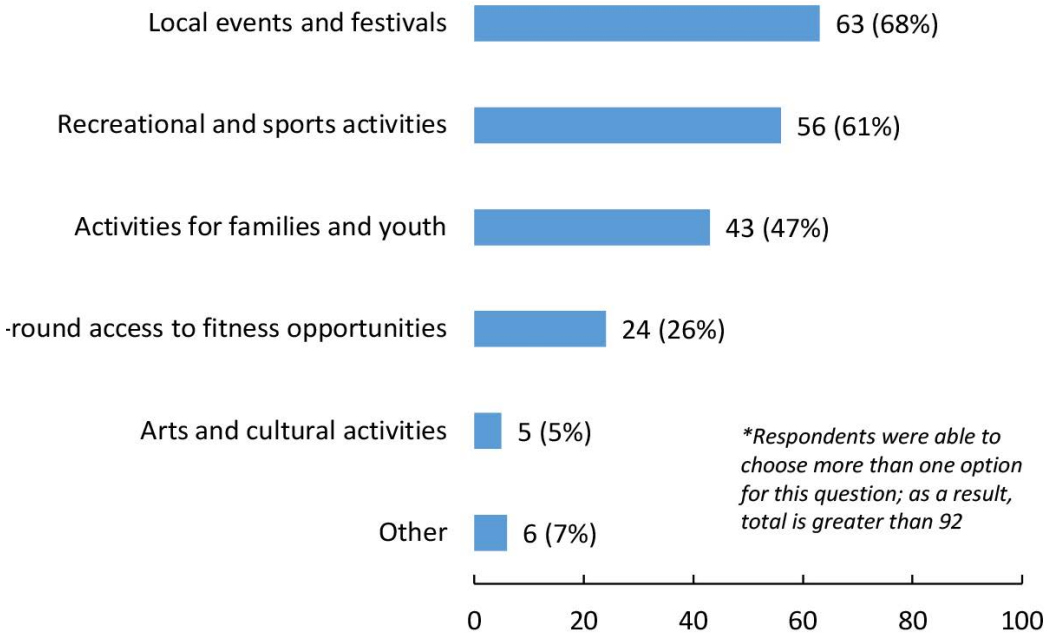


Figure 16: Best Thing About the ACTIVITIES in Your Community
Total responses = 92*



Respondents who selected "Other" specified that the best things about the activities in the community included hunting, fishing, and several churches.

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

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

With regard to responses about community challenges, the most highly voiced concerns (those having at least 35 respondents) were:

- Attracting and retaining young families (N=59)
- Bullying/cyberbullying – youth (N=52)
- Depression/anxiety – youth (N=51)
- Alcohol use and abuse – adults (N=40)
- Depression/anxiety – adult (N=40)
- Cost of long-term/nursing home care (N=38)
- Not enough jobs with livable wages (N=36)

The other issues that had at least 25 votes included:

- Ability to retain primary care providers (MD, DO, NP, PA, nurses) in the community (N=29)
- Alcohol use and abuse – youth (N=28)
- Not enough healthcare staff in general (N=28)
- Emotional abuse (N=27)
- Availability of resources to help the elderly stay in their homes (N=25)

Figures 17 through 22 illustrate these results.

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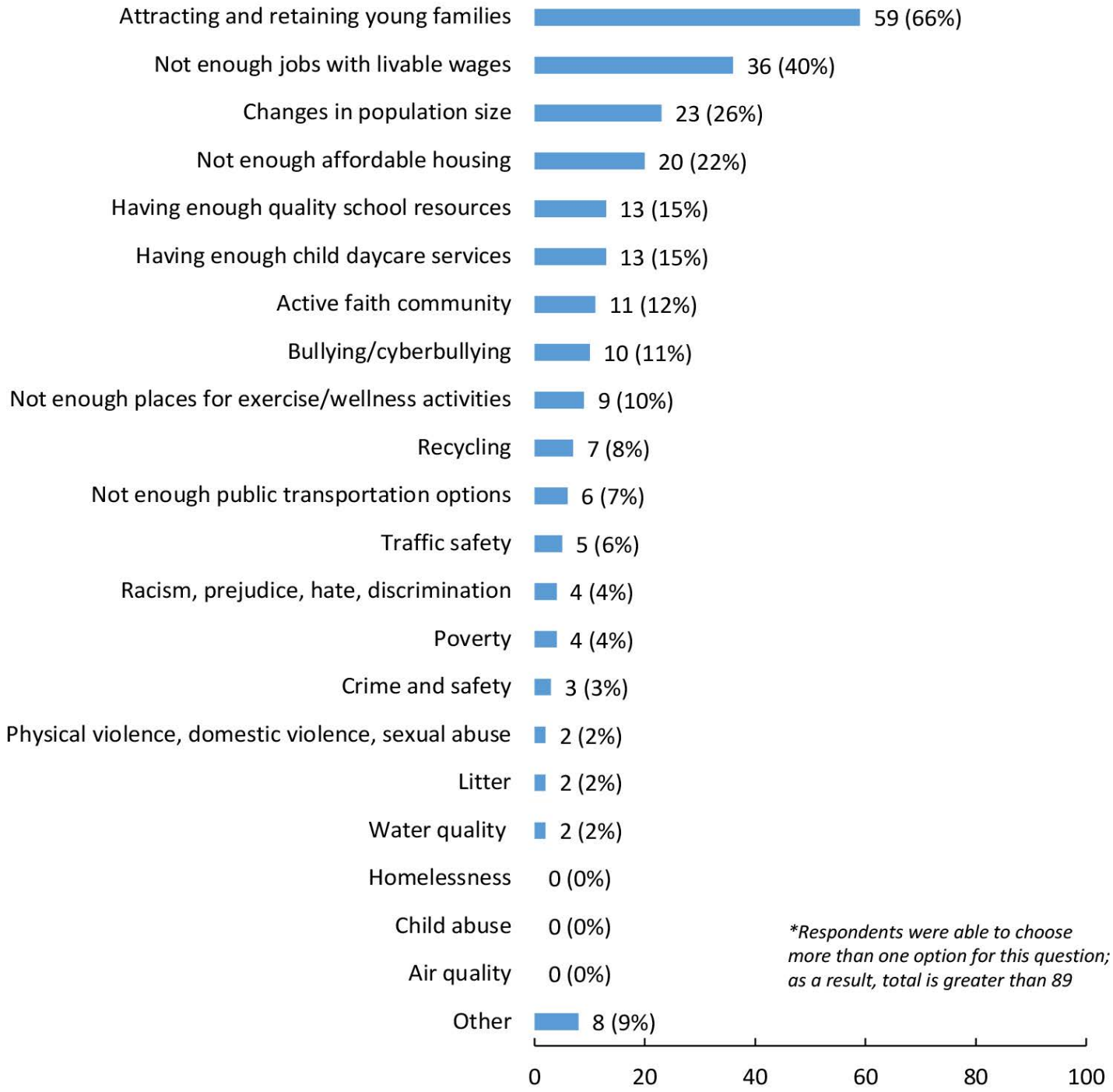
Figure 17: Community/Environmental Health Concerns
Total responses = 89*



In the "Other" category for community and environmental health concerns, the following were listed: alcohol and drug issues, affordable grocery stores and shopping, more food establishments, issues with local law enforcement, workforce shortage, and having enough mental health support programs.

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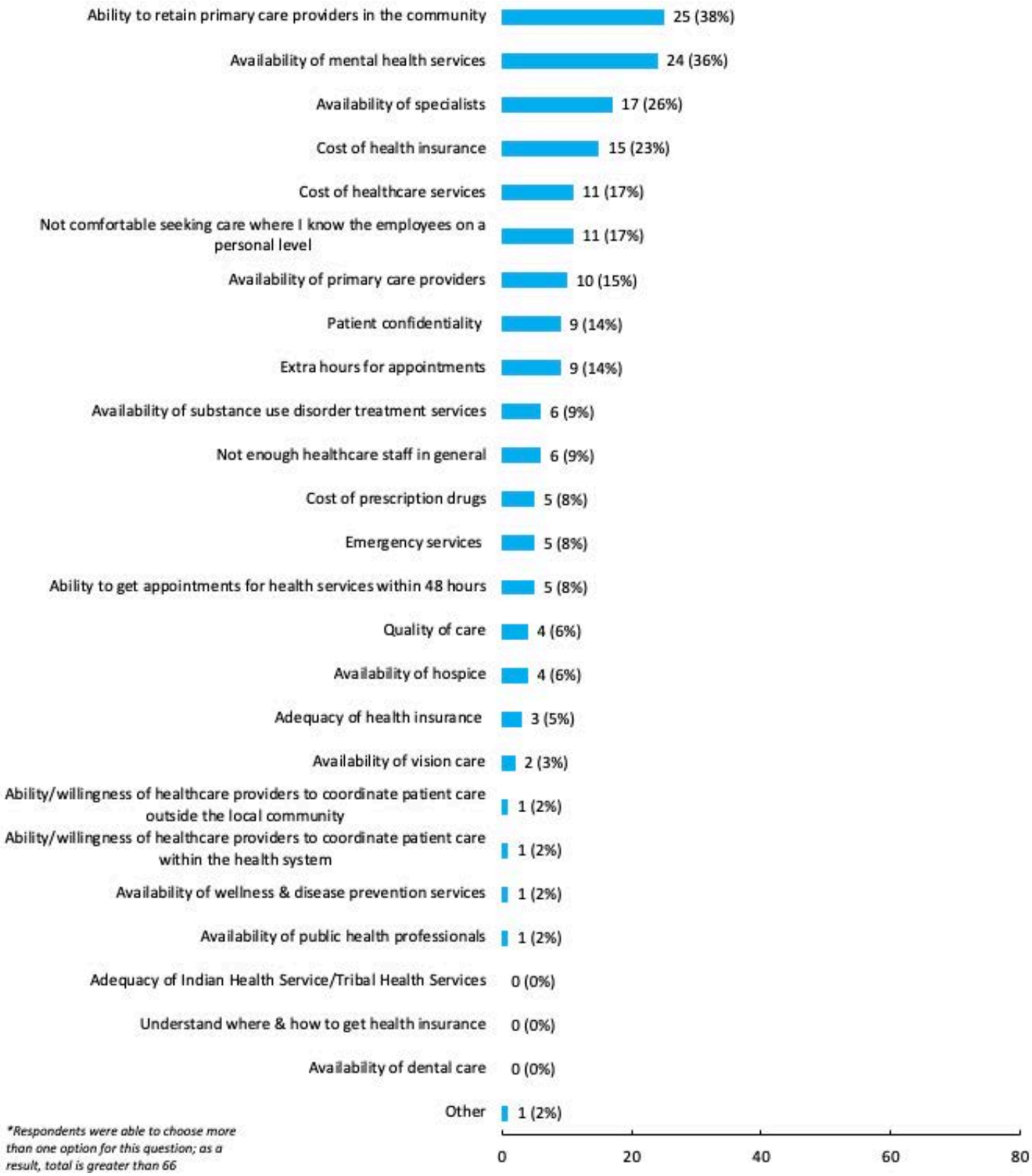
Figure 18: Availability/Delivery of Health Services Concerns
Total responses = 88*



Respondents who selected "Other" identified concerns in the availability/delivery of health services as shortage of nursing home staff, reliance on western medicine, availability of ICU beds, and availability of healthcare that does not add more health problems.

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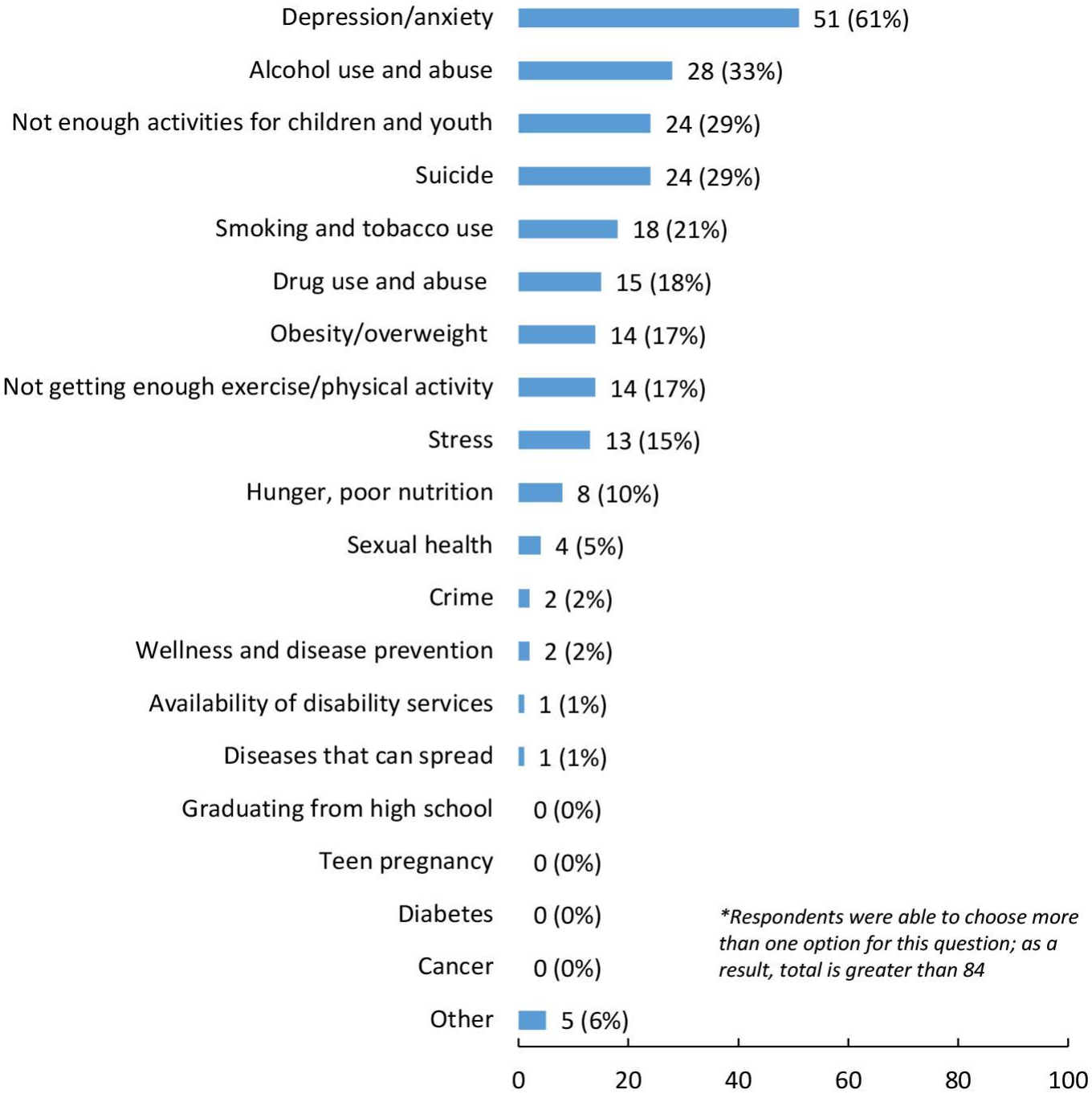
Figure 19: Youth Population Health Concerns
Total responses = 84*



Listed in the "Other" category for youth population concerns were bullying, not fitting in, and social skills.

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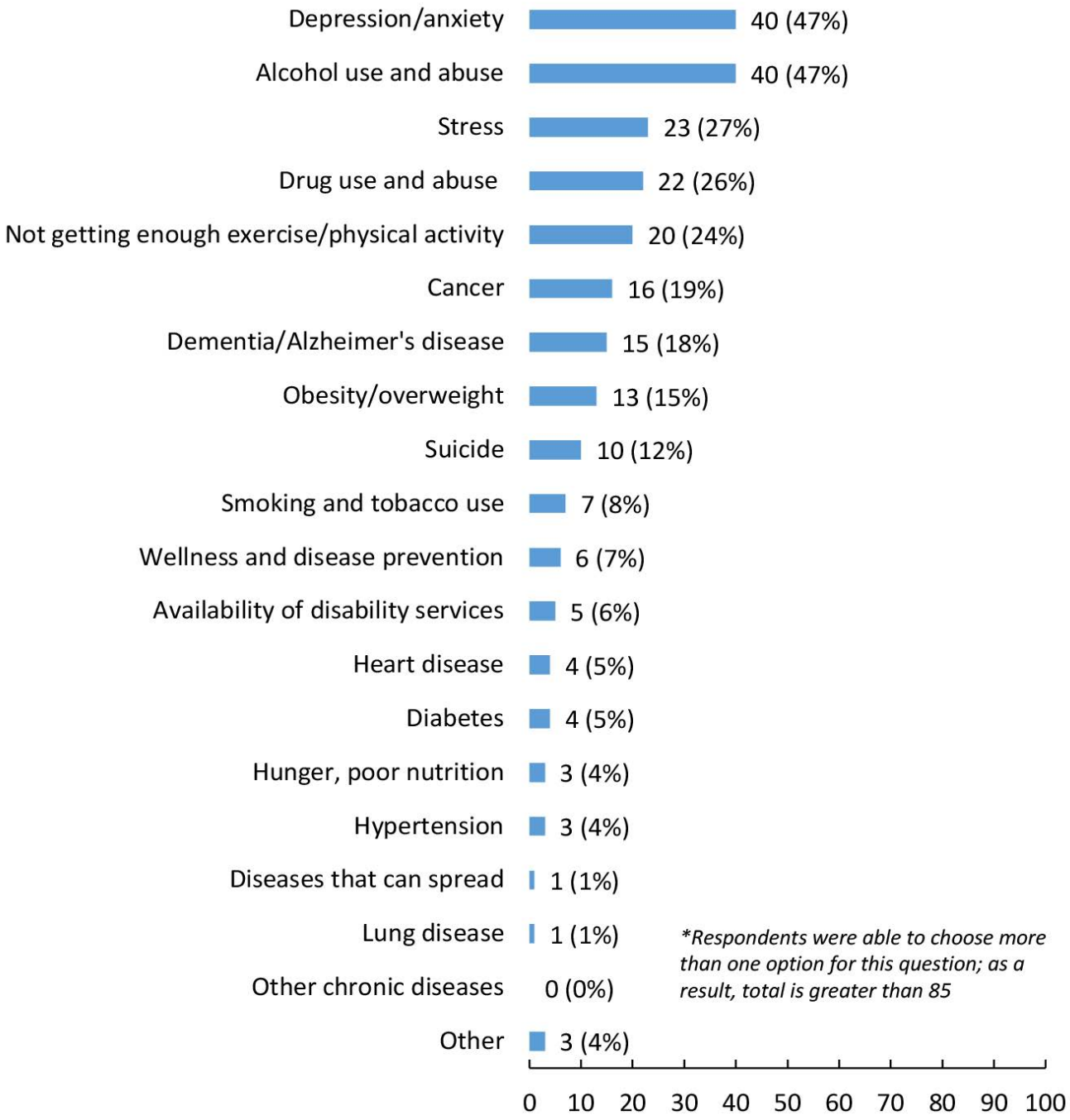
Figure 20: Adult Population Concerns
Total responses = 85*



Lack of adult activities was indicated in the "Other" category for adult population concerns.

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Figure 21: Senior Population Concerns
Total responses = 77*

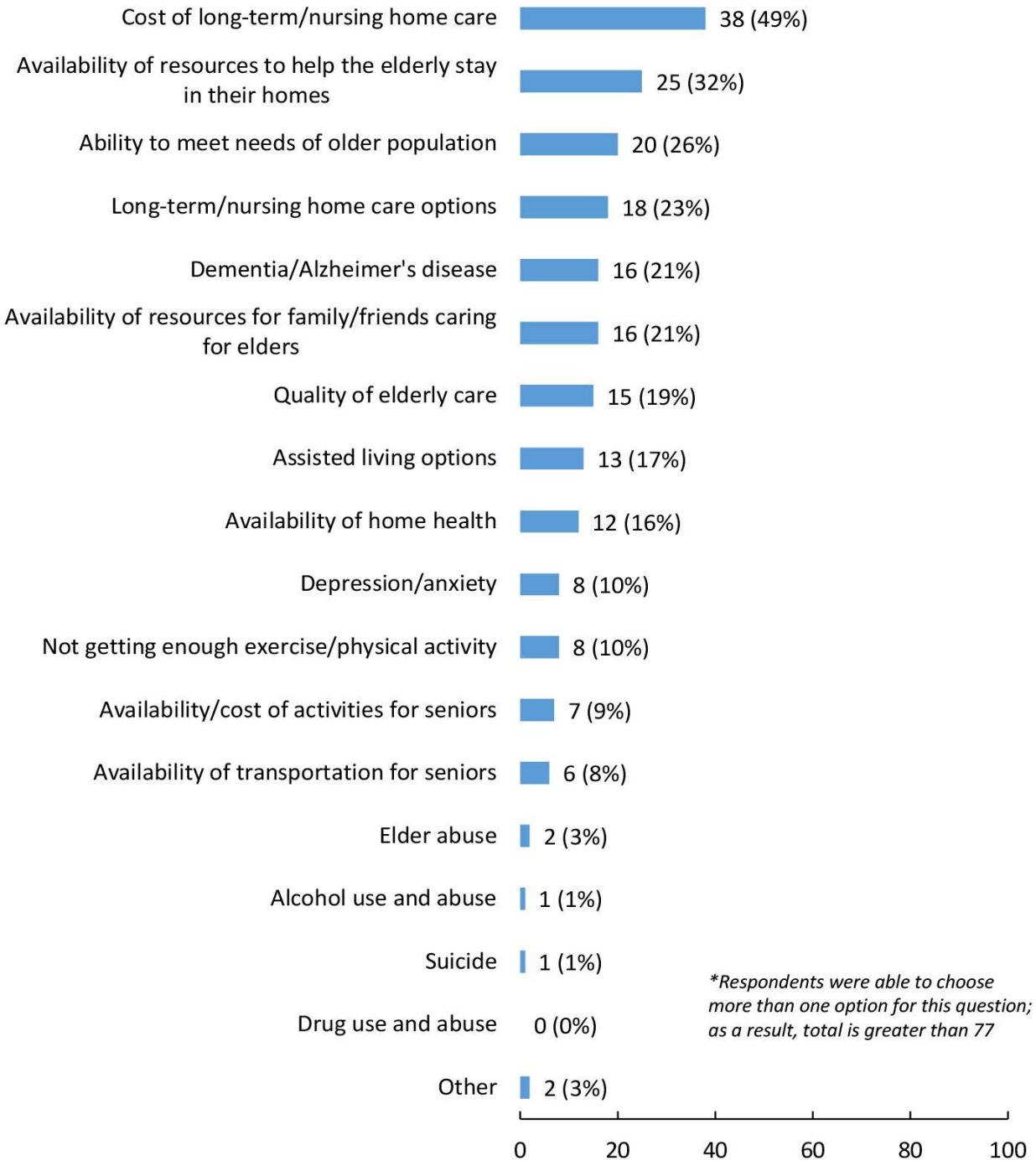

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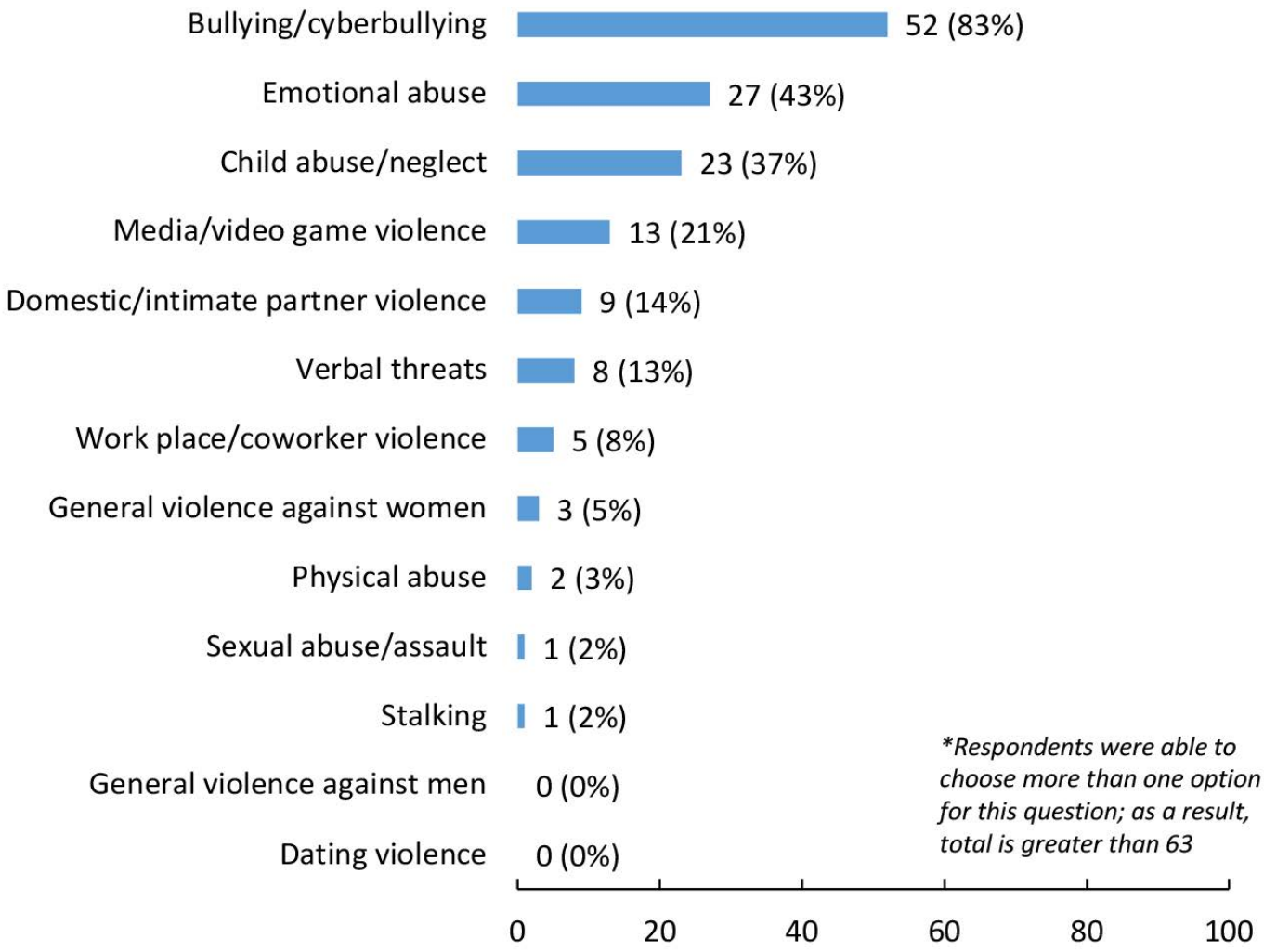
Figure 22: Violence Concerns
Total responses = 63*



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

1. Attracting and retaining young families
2. Lack of healthcare staff in general

Other biggest challenges that were identified were the population decline, lack of mental health services, aging population and meeting their needs, lack of quality jobs with livable wages, affordable housing, bullying and cyberbullying, loss of businesses, cost of health services, and depression and anxiety.

Delivery of Healthcare

The survey asked residents what they see as barriers that prevent them, or other community residents, from receiving healthcare. The most prevalent barrier perceived by residents was not being able to see the same provider over time (N=34), with the next highest being not able to get an appointment or limited hours (N=24). After these items, the next most commonly identified barriers were not enough providers (N=23) and not enough evening or weekend hours (N=17). The majority of concerns indicated in the "Other" category were in regards to loss or lack of physicians and only being able to see residents.

Figure 23 illustrates these results.

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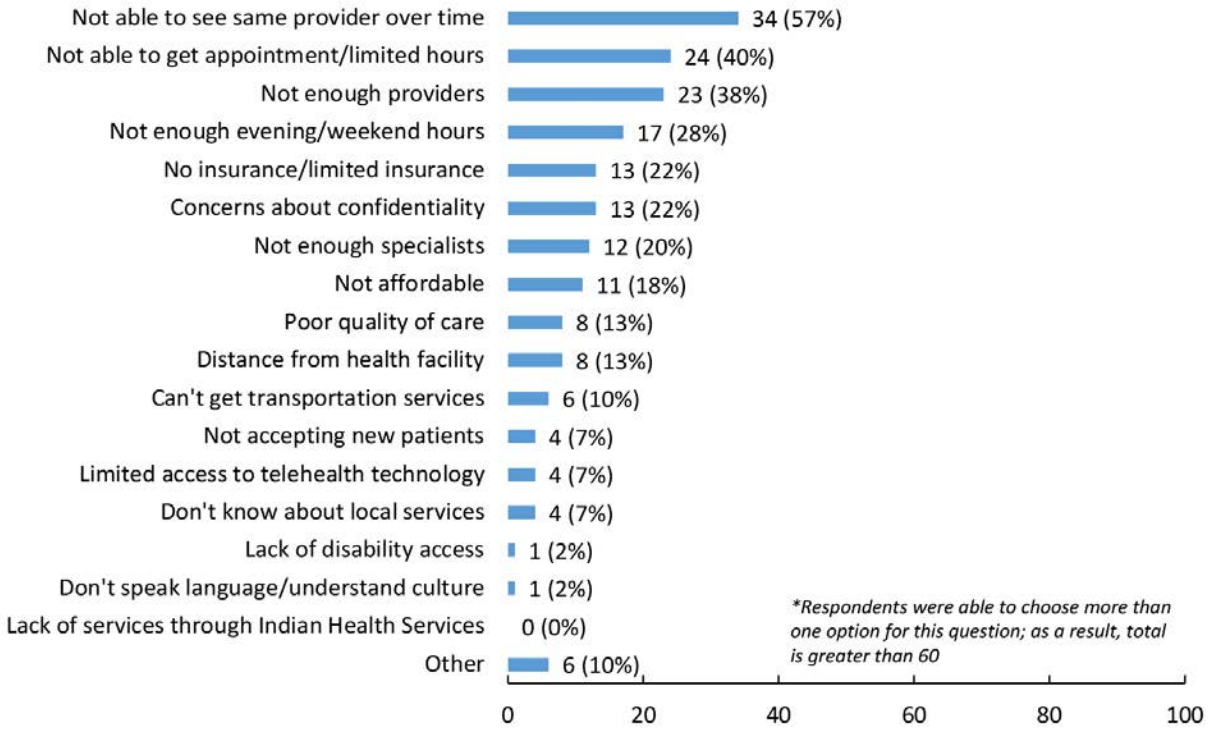
Figure 23: Perceptions About Barriers to Care
Total responses = 60*



Considering a variety of healthcare services offered by Southwestern District Health Unit (SDHU), respondents were asked to indicate if they were aware that the healthcare service is offered though SDHU and to also indicate what, if any, services they or a family member have used at SDHU, at another public health unit, or both (See Figure 24).

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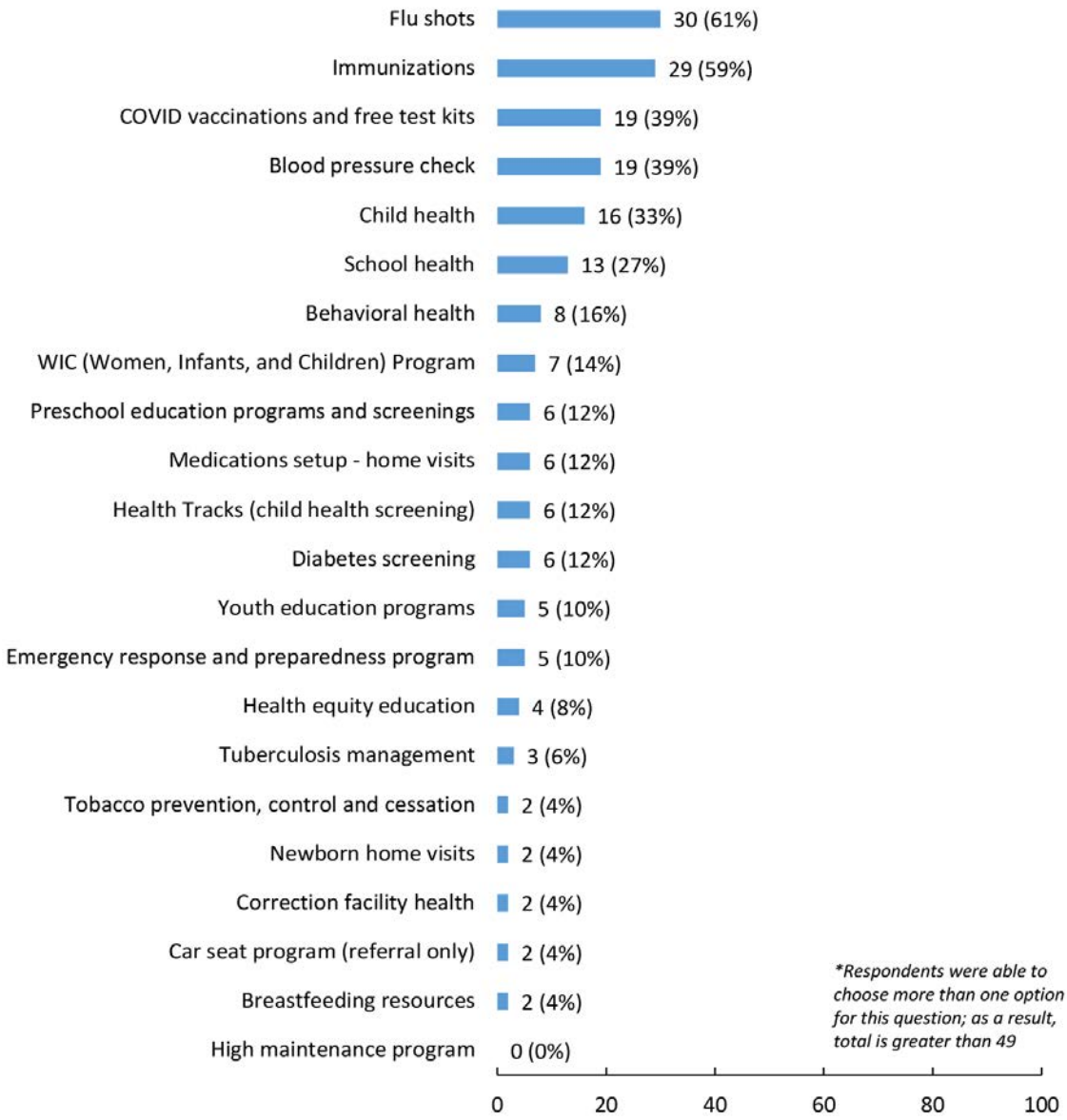
Figure 24: Awareness and Utilization of Public Health Services
Total responses = 49*



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 chiropractor services. Other requested services included:

- Cancer treatment options
- Cardiology
- Clinical nutrition
- Cosmetics (Botox/plastic surgery)
- Massage therapy
- Medical infusions
- Medical Spa
- Counseling
- Dermatology
- Dialysis
- ENT
- Extended clinic hours
- GI
- Holistic/naturopath
- Hospice
- Mental health resources
- More MRI availability
- Night clinic
- OBGYN
- Orthopedics
- OT/PT
- Sanford and affordable prices
- Wellness testing/preventative screenings

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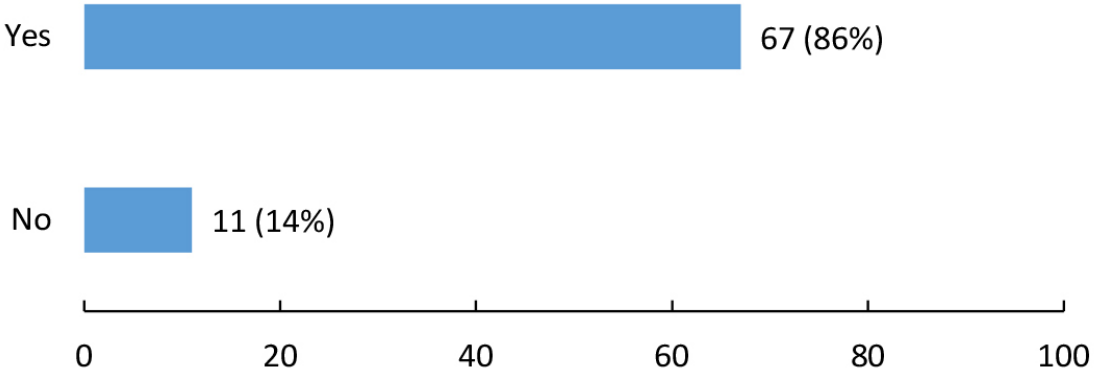
While not a service, several respondents indicated that they would like physicians added. The participants mentioned they do not want to see residents and wish they had a consistent doctor over time.

The key informant and focus group members felt that the community members were aware of the majority of the health system offerings. Participants were less aware of what is offered through SDHU. There were a number of services where they felt the public health should increase marketing efforts; these included medication set-up, newborn home visits, preschool screenings, tuberculosis management, health tracks, school health, West Nile program, and breast-feeding resources.

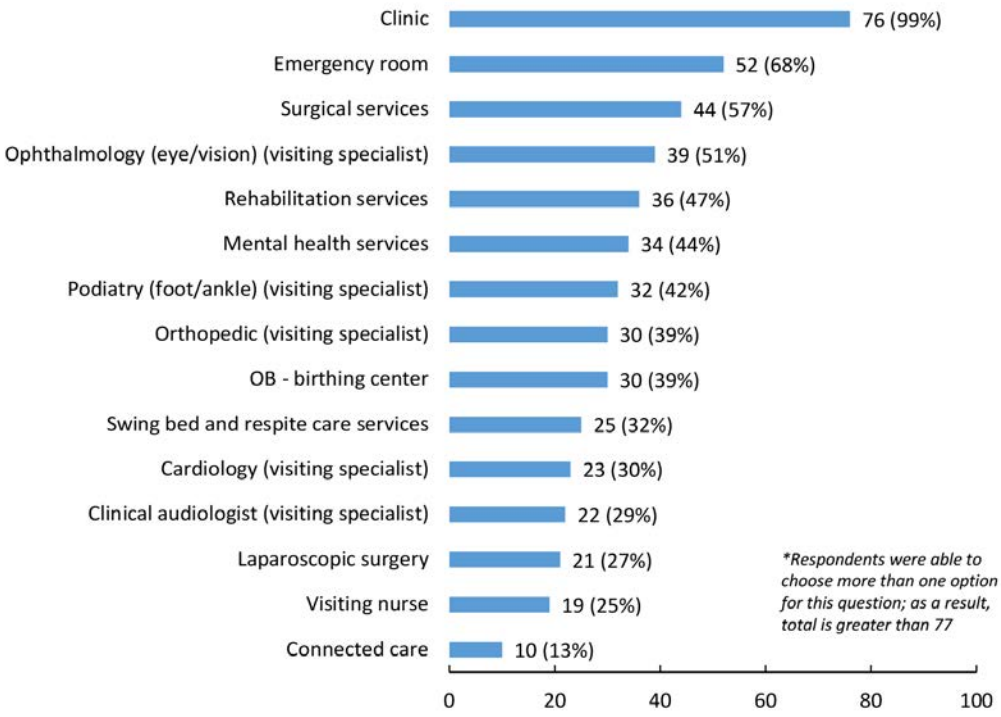
When asked if West River Health Services was their primary source of care, the majority of respondents selected "Yes" (N=67). See figure 25.

Figure 25: Primary Sources of Care is West River Health Services
Total responses = 78



Respondents were asked to indicate which general and acute services that are offered at WRHS they are aware of or they or a family member have used in the past year (See Figure 26).

Figure 26: Awareness and Utilization of General and Acute Services
Total responses = 77*



Respondents were asked to indicate which of the following screening and therapy services offered though WRHS of which were aware or they or a family member have used in the past year (See Figure 27).

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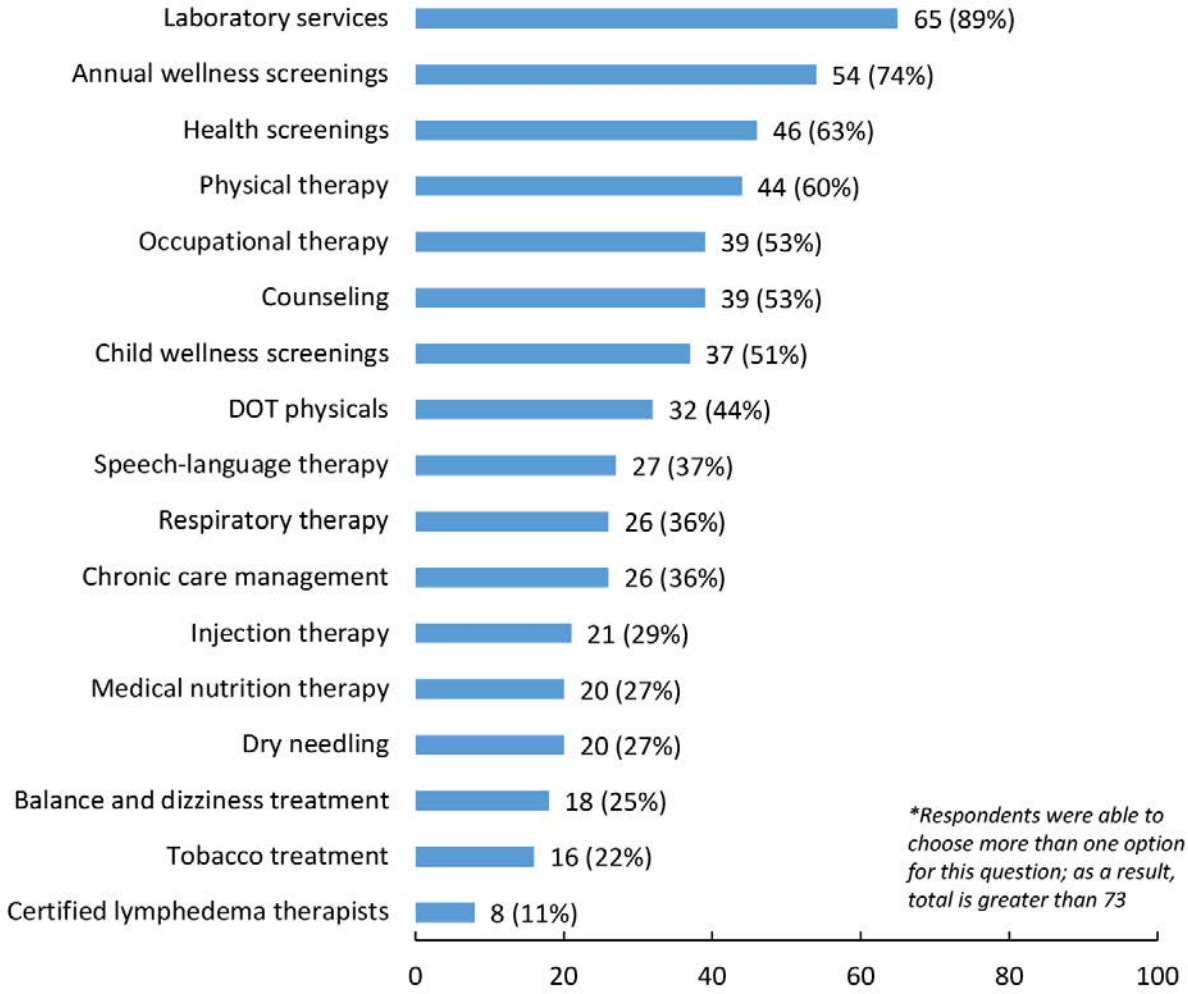
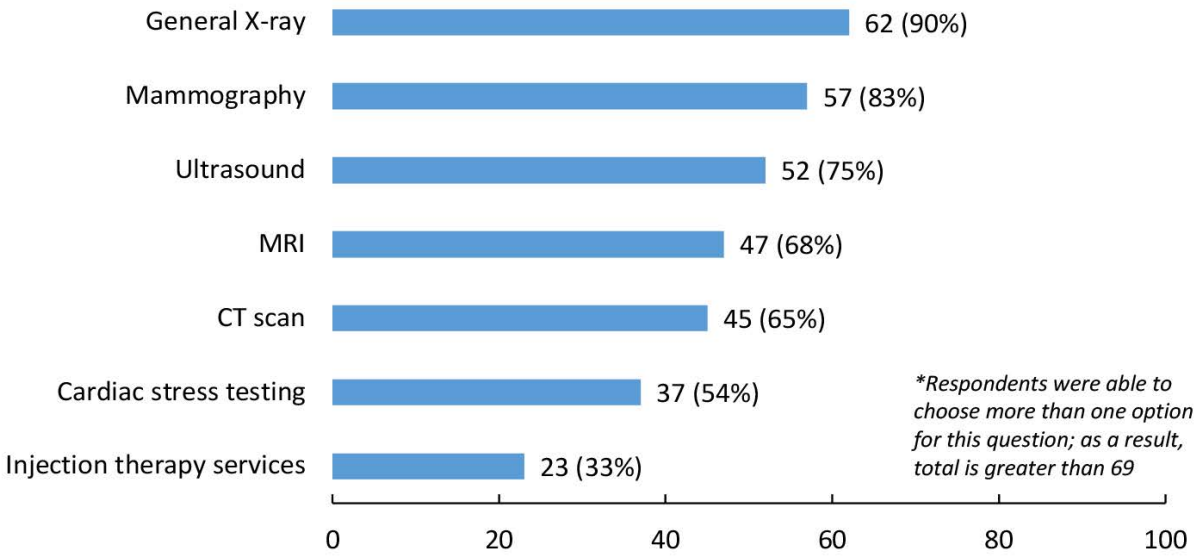
Figure 27: Awareness and Utilization of Screening and Therapy Services
Total responses = 73*



Respondents were asked to indicate which of the radiology services offered though WRHS of which they were aware or they or a family member have used within the past year (See Figure 28).

Figure 28: Awareness and Utilization of Radiology Services
Total responses = 69*



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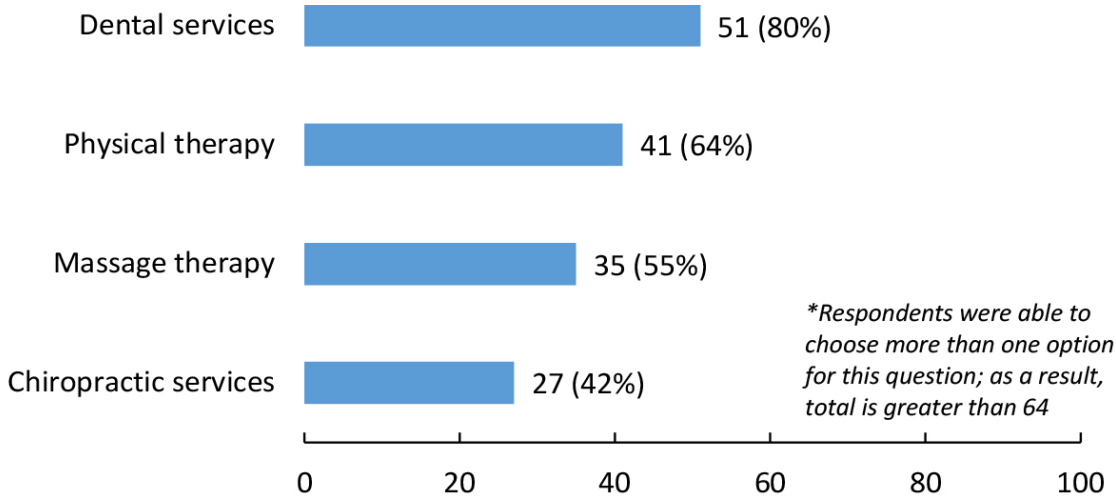
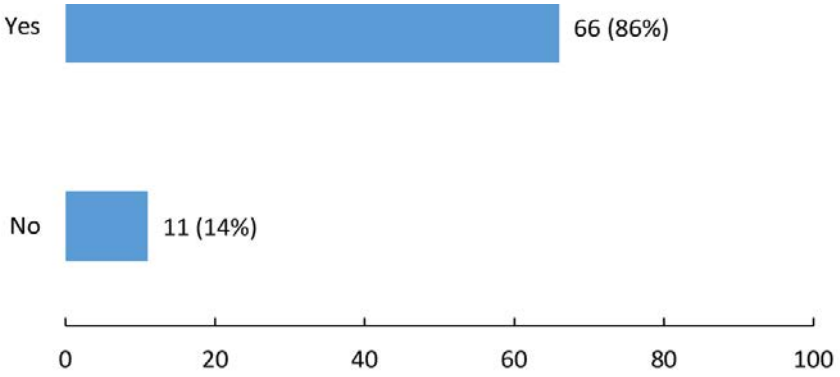
Respondents were asked to indicate which other local services of which they were aware or that they or a family member have used within the past year (See Figure 29).

Figure 29: Awareness and Utilization of Other Local Services
Total responses = 64*



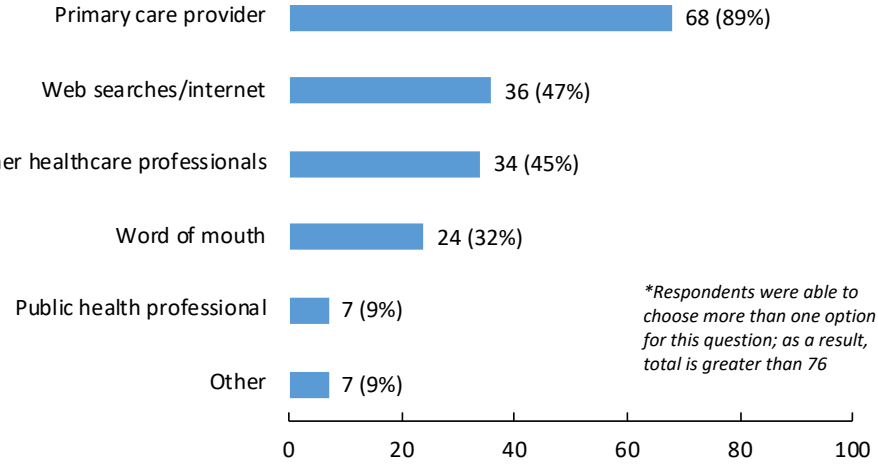
When asked about their awareness of WRHS Convenience Clinic, the majority of respondents were aware (See Figure 30).

Figure 30: Aware of West River Health Services Convenience Clinic
Total responses = 77



Respondents were asked what their sources of trusted health information are. Primary care provider was the top choice, followed by web searches, as shown in Figure 31.

Figure 31: Sources of Trusted Health Information
Total responses = 76*



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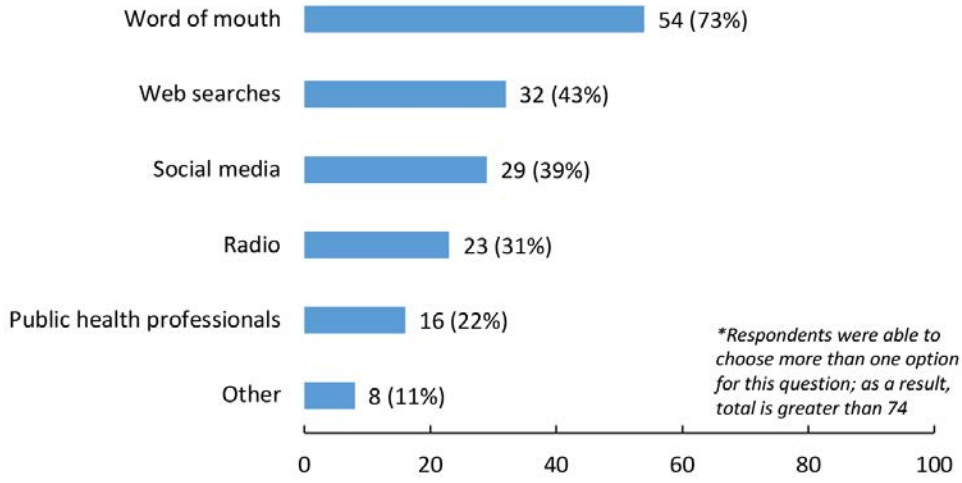
In the "Other" category, several respondents listed specialists, WRHS website, and medical journals.

Figure 32: Sources of Information about Local Health Services
Total responses = 74*



In the "Other" category, advertising, newspapers, and calling the clinic were listed as a source of information for local health services.

In figure 33 respondents were asked about their awareness of the WRHS's Foundation. A majority were aware of the foundation. Respondents were also asked how they would be most likely supporting the foundation (see Figure 34).

Figure 33: Awareness of West River Health Services' Foundation
Total responses = 78

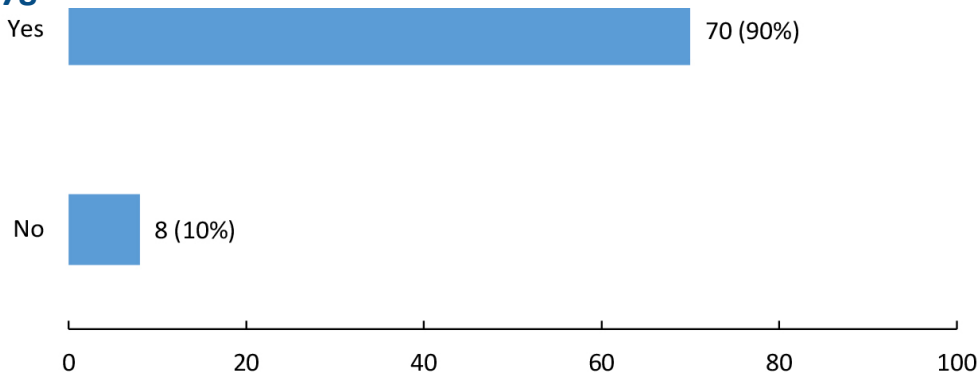
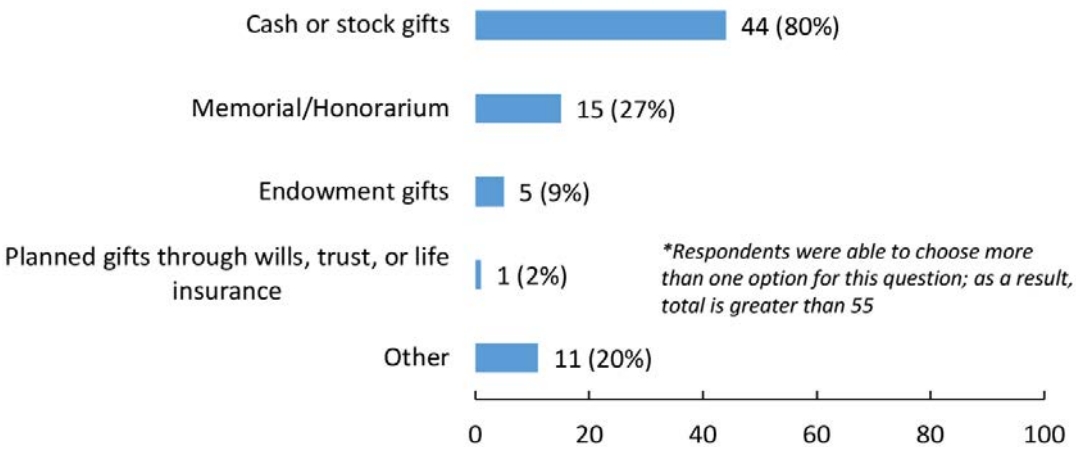


Figure 34: Forms of Support for West River Health Services' Foundation
Total responses = 55*



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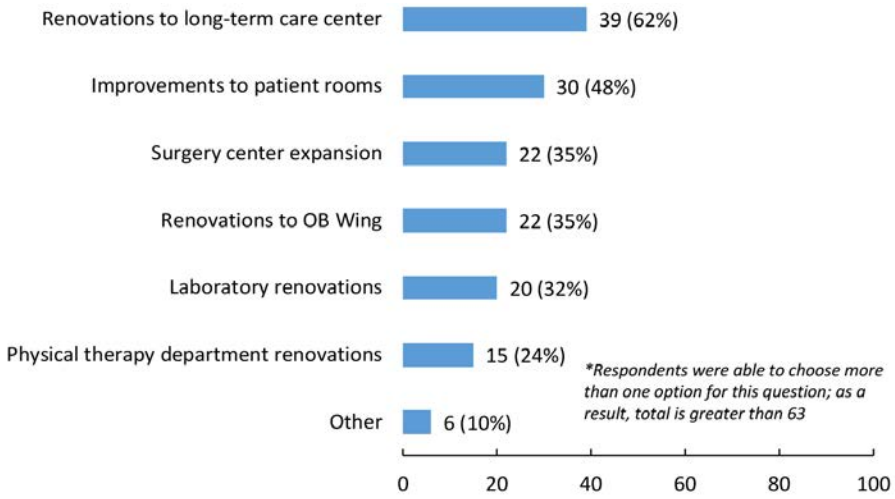
The "Other" category included payroll deduction, attend events, and volunteer work.

In an effort to gauge ways that community members would be most likely to financially support facility improvements/new equipment, a question was included, asking them to select ways they are most likely to support facility improvements/new equipment at WRHS (see Figure 35). Recommendations in the "Other" category included med beds, less traveling staff, and offer holistic and naturopathic options.

Figure 35: Capital Improvements the Community Would Financially Support
Total responses = 63*



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 concerns with the lack of physicians, physicians leaving the community to practice elsewhere, and the residency program. There were a number of people who felt there needs to be more focus on finding medical doctors who will stay in the community over residents who are only there for their training and leave once it is completed. There is a concern with staff shortage, including nurses and other medical staff. One person suggested the hospital should put more money into securing nursing staff instead of paying traveling nurses. Staff shortages is not unique to Hettinger, as this problem has been an issue across North Dakota and the U.S.

Another issue mentioned was concerns regarding the patient portal and the hospital's website. According to one of the respondents, the website is not easy to navigate. This issue may hinder a resident's ability to understand services offered, tasks that need to be completed, and how to contact their care team. Respondents also want the hospital to communicate with the community better. One person suggested WRHS hold health fairs like other nearby hospitals. Many participants would like more special services brought to the hospital and offer more clinic hours.

The cost of insurance, receiving healthcare, and more payment options were also listed as a concern for service-area residents. Some of the services needed for patients are not currently offered at WRHS, so they either have to travel or wait for a specialist to come to the hospital. Respondents would like more specialists to come to the Hettinger location, cutting down their traveling and time off from work. A participant stated they believe they should not be charged the same amount if being seen by a resident instead of a medical doctor. They say the price should be cheaper since they are not a full medical doctor.

It is felt that the quality of care, customer service, and professionalism has declined at WRHS. One of the respondents stated there is lack of professionalism when being seen, unprofessionally dressed, and lack of manners. There are staff having loud conversations in the halls that can be overheard by patients.

Others believe that WRHS does a great job of identifying and delivering healthcare within its means and offers a wide variety of healthcare services.

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Findings from Key Informant Interviews & the Community Meeting

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

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

- Attracting and retaining young families
- Changes in population size (increasing or decreasing)
- Cost of long-term/nursing home care
- Depression/anxiety – youth and adult

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

Attracting and Retaining Young Families

- Attracting and retaining young families gives the ability to get healthcare professionals here for a long period of time
- Need more things to do if there are more children
- If there are people here; there are jobs, money, things to do, etc.

Changes in Population Size (Increasing or Decreasing)

- Need to create jobs with livable wages for people to stay
- Currently have to travel 400 miles per week for work
- Need new businesses to entice people to the area

Cost of Long-term/Nursing Home Care

- Hettinger has to be able to meet the needs of the elderly population.
- It's an aging population, who need to have more long-term care options.

Depression/Anxiety (Youth and Adult)

- Stress affects all age groups, which lead to other issues.
- Lots of people don't want to speak about depression/anxiety, and it leads to other issues.

Community Engagement and Collaboration

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

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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:

- Emergency services, including ambulance and fire (4.25)
- Hospital (healthcare system) (4.25)
- Schools (4.0)
- Business and industry (3.75)
- Economic development organizations (3.75)
- Law enforcement (3.75)
- Faith-based (3.5)
- Social services/human services agencies (3.0)
- Long-term care, including nursing homes and assisted living (2.75)
- Other local health providers, such as dentists and chiropractors (2.5)
- Pharmacy (2.5)
- Public health (2.5)
- Clinics not affiliated with the main hospital system (1.0)

Priority of Health Needs

A community group met on December 5, 2023. Ten 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 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 listed on large poster boards, and each member was given four stickers to place next to each of the four needs they considered the most significant.

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

- Attracting and retaining young families (10 votes)
- Depression/anxiety (10 votes)
- Not getting enough exercise/physical activity (5 votes)

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

1. Attracting and retaining young families (10 votes)
2. Depression/anxiety – all ages (0 votes)
3. Not getting enough exercise/physical activity - youth (0 votes)

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Following the prioritization process during the second meeting of the community group and key informants, the number one identified need was attracting and retaining young families. A summary of this prioritization may be found in Appendix E.

Comparison of Needs Identified Previously

Top Needs Identified 2021 CHNA Process	Top Needs Identified 2024 CHNA Process
• Attracting retaining young families • Availability of primary care providers (MD, DO, NP, PA) and nurses • Ability to retain primary care providers and nurses • Not enough jobs with livable wages	• Attracting and retaining young families • Depression/anxiety – all ages • Not getting enough exercise/ physical activity – youth

The current process identified one identical common need from 2021. Attracting and retaining young families was the number one need in the CHNA 2021 report. Depression and anxiety for all ages and not getting enough exercise/physical activity for youth are two new needs that were identified in 2023.

West River Health Services (WRHS) 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 WRHS Board vote, a notation will be documented in the board minutes reflecting the approval, 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 WRHS.

Hospital and Community Projects and Programs Implemented to Address Needs Identified in 2021

In response to the needs identified in the 2021 CHNA process, the following actions were taken:

Need 1: Attracting and retaining young families: As a very rural community, this element is a common concern. Since implementing the Community Benefit Time, they have increased WRHS's involvement with community events. They offer sign-on bonuses to new hires at WRHS. Their local chamber office hosts Tuesday Night Lights in the month of September, which is a mini market with food, games, and locals selling their goods. This item has drawn a few younger families out. The school has just finished a new indoor pool to use year-round, which was a big selling point with a new provider. WRHS looks forward to looking into ways to promote and help fund this pool in the future to provide open swims, new swim equipment, and whatever safety devices are needed.

Need 2: Alcohol use and abuse: The community was concerned during the last CHNA process about alcohol use and abuse in both adults and adolescents. WRHS continues to participate in "Rock the Block" activities through the Drug and Alcohol Coalition to provide fun alcohol-free activities for the youth in the area.

Need 3: Depression and Anxiety: The community was concerned with the rise in depression and anxiety in the past few years. They implemented annual depression screening at clinic visits, and the West River Fun Run and Walk has funded speakers to come into the school and talk about anxiety and depression with the students. The Behavior Health Team meets quarterly to discuss these matters. For employees, they offer three free sessions through Employee Assistance Program.

The above implementation plan for WRHS is posted on the https://www.cavalierhospital.com/how-to-help/resources.html.

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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, 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 Affordable Care Act'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

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Appendix A – Critical Access Hospital Profile

Critical Access Hospital Profile
Spotlight on: Hettinger, North Dakota

WEST RIVER HEALTH SERVICES®

Quick Facts

Current Administrator:
Alyson (Aly) Kornele

Chief Medical Officer:
Dr. Mark Kristy

Board Chair:
Jonathon Eaton

City Population:
1,007 (2020 Estimate)[1]

County Population:
2,200 (2020 Estimate)[1]

County Median Household Income: $55,000 (2020 Estimate)[1]

County Median Age: 45.6 years (2019 Estimate)[1]

Service Area Population: 20,000

Owned by: Non-Profit

Hospital Beds:
- 19 Private Rooms/Acute/Swing-bed/Out-Patient
- Three Beds for Intensive Care Unit (ICU)
- Three Beds for Birthing Unit (OB)
- Two Patient Rooms with Visual/ Monitoring

Trauma Level: IV

Critical Access Hospital Designation: 2005

Economic Impact on the Community[2]
Jobs:
Primary - 278
Secondary – 95
Total – 373

Financial Impact:
Primary – $12.8 million
Secondary – $2.5 million
Total - $15.3 million

Mission

The mission of West River Health Services (WRHS) is to provide comprehensive health and wellness services to the residents and visitors of the region. West River Health Services and its partners in healthcare are dedicated to excellence in practice, innovation in service, compassion for the people we serve, and respect for one another.

County: Adams
Address: 1000 Highway 12
Hettinger, ND 58369-7530
Phone: (701) 567-4561
Web: www.wrhs.com

Providing access to quality medicine in a rural environment has been the vision and goal of this medical system since its inception.

The corporate structure of the organization is comprised of three 501C3 (not for profit) corporations. WRHSF is the foundation/fundraising and parent corporation. WRHS is the healthcare services (hospital, clinic and other healthcare services) corporation. Western Horizons Living Centers is the care center's (skilled and assisted living) Corporation. Each corporation has board members from across the geographic area served by the organization. It is the largest medical complex in Adams County and serves 20,000 people in 20,000 square miles.

Services

West River Health Services provides the following services directly

- 24 hour emergency room - certified
- Staff in trauma care and cardiac life support
- Acute stroke ready hospital
- Aesthetic treatments
- Basic life support ambulance service with ALS capabilities
- Cardiac rehab service
- Cardiac stress testing lab
- Chapel
- CLIA laboratory
- Community education
- Community medical clinics *(seven)*
- Counseling/therapy *(West River Health Services Behavioral Health)*
- Diabetes education
- Family medicine
- Food and nutrition services
- Imaging services *(MRI, CT scanner, mammography, dexa bone density, nuclear medicine, ultrasound, general X-ray, and flouroscopy)*
- Injection therapy
- Intensive care unit *(ICU)*
- Internal medicine
- IV therapy
- Medsurg unit
- Observation care
- Obstetric (OB)
- Online health library
- Optometric services *(West River Eye Center)*
- Palliative care
- Pediatric care
- Pediatric medicine
- Pharmacy
- Podiatric services
- Rehabilition *(physical, occupational and speech)*
- Supporting foundation *(West River Health Services Foundation)*
- Services
  · Laparoscopic gallbladder, hernia and appendix
  Breast: sentinel lymph node biopsy, benign breast disease, breast cancer

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Staffing

Physicians: 14
Midlevels 14
RNs: 44
LPNs: 29
Total Employees: 278

Local Sponsors and Grant Funding Sources

- Homeland Security
- WRHS Foundation
- Center for Rural Health
- SHIP Grant (Small Hospital Improvement Program)
- North Dakota Department of Health

**Statistics reported are for the WRHS Corporation only*

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

ruralhealth.und.edu

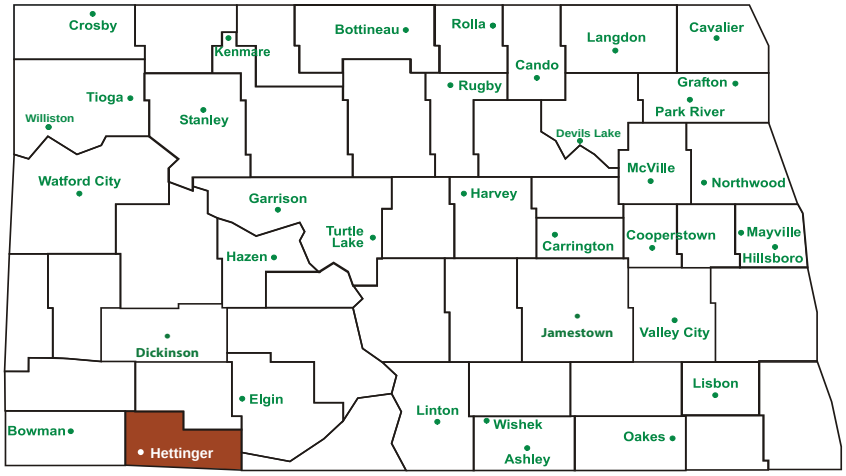
· Gastro-Intestinal: colonoscopy, gastroscopy, and extensive colo-rectal procedures·
· Orthopedic surgery
· Ophthalmology
· Podiatry
· Cesarean sections/gynecological
· Tonsillectomy/adenoidectomy

- Gynecological/cesarean
- Swing bed
- Telemedicine
- Visiting nurses
- Rehabilitation and wellness center
- WIC (women, infant and children)

West River Health Services system provides the following services through contract or agreement

- Assisted living facility *(Western Horizons Assisted Living)*
- Visiting specialists: orthopaedic surgeon, opthalmologist, interventional cardiologist, Obstetrics and gynecology, and clinical audiologist
- Skilled nursing facility *(Western Horizons Care Center)*

North Dakota Critical Access Hospitals



Lifestyle

- Rural community located in southwestern North Dakota, three miles from South Dakota border
- Low unemployment, excellent school system
- Safe, family centered life style
- Home of Dakota Buttes Museum
- Plentiful upland and big game hunting, and outstanding fishing
- Mirror Lake offers camping, boating, fishing and water activities
- Community offers concert series, indoor pool, theatre, a fitness center, 9-hole grass green golf course, bowling alley, and various restaurants and shops

Just Down the Road

- Urban shopping and airports
- Shadehill Reservoir
- Bowman Haley Dam
- Theodore Roosevelt National Park
- Lake Sakakawea
- Black Hills of South Dakota

Updated 1/23

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Appendix B – Economic Impact Analysis

September 2020

WEST RIVER HEALTH SERVICES®

Hettinger, North Dakota

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

Economic Impact

West River Health Services is composed of a critical access hospital (CAH), five rural health clinics (located in Mott, Bowman, New England, Lemmon, and Scranton), a provider-based clinic, a visiting nurse program, a rehab center, an ambulance service, a 45-bed skilled nursing facility, and a 16-unit assisted living facility.

West River Health Services **directly** employs **222.2 FTE employees** with an annual payroll of over **$15.9 million** (including benefits).

- After application of the employment multiplier of 1.40, these employees created an additional **90 jobs**.
- The same methodology is applied to derive the income impact. The income multiplier of 1.23 is applied to create nearly **$3.6 million** in income as they interact with other sectors of the local economy.
- **Total impacts = 313 jobs and more than $19.5 million in income.**

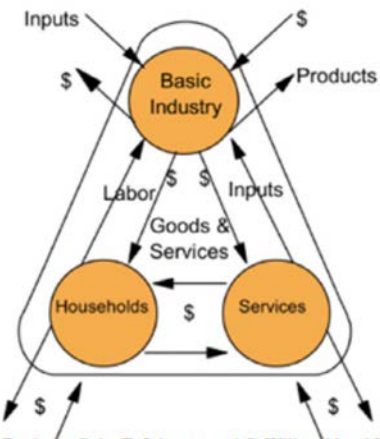
Healthcare and Your Local Economy

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

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

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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OSU 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.

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Appendix C – CHNA Survey Instrument

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

WEST RIVER HEALTH SERVICES

Public Health
Prevent. Promote. Protect.
Southwestern District Health Unit

Hettinger Area Health Survey

West River Health Services and Southwestern District Health Unit are interested in hearing from you about community health concerns.

The focus of this effort is to:

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

If you prefer, you may take the survey online at https://tinyurl.com/CHNAHettinger23 or by scanning on the QR Code at the right.

Surveys will be tabulated by the Center for Rural Health at the University of North Dakota School of Medicine and Health Sciences. Your responses are anonymous, and you may skip any question you do not want to answer. Your answers will be combined with other responses and reported only in total. If you have questions about the survey, you may contact Holly Long at 701.777.5588.

Surveys will be accepted through October 15, 2023. 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):

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

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

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

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

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

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

- ☐ Alcohol use and abuse
- ☐ Drug use and abuse (including prescription drug abuse)
- ☐ Smoking and tobacco use, exposure to second-hand smoke 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)
- ☐ Availability of activities for seniors
- ☐ Elder abuse
- ☐ Other (please specify): _____

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

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

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

_____

Delivery of Healthcare

12. Do you primarily rely on West River Health Services as a primary source to meet your healthcare needs?

☐ Yes
☐ No, please explain why

_____

_____

13. Considering **GENERAL and ACUTE SERVICES** at West River Health Services, which services are you aware of (or have you used in the past year)? (Choose ALL that apply)

- ☐ Clinical Audiologist (visiting specialist)
- ☐ Cardiology (visiting specialist)
- ☐ Clinic
- ☐ Emergency room
- ☐ Visiting Nurse
- ☐ OB – Birthing Center
- ☐ Laparoscopic surgery
- ☐ Mental health services
- ☐ Rehabilitation services
- ☐ Ophthalmology (eye/vision) (visiting specialist)
- ☐ Orthopedic (visiting specialist)
- ☐ Podiatry (foot/ankle)
- ☐ Surgical services
- ☐ Swing bed and respite care services
- ☐ Connected Care

14. Considering **SCREENING/THERAPY SERVICES** at West River Health Services, which services are you aware of (or have you used in the past year? (Choose ALL that apply)

- ☐ Counseling
- ☐ Health screenings
- ☐ Laboratory services
- ☐ Occupational therapy
- ☐ Physical therapy
- ☐ Dry needling
- ☐ Speech-language therapy
- ☐ Balance and dizziness treatment
- ☐ Certified lymphedema therapists
- ☐ Annual wellness screenings
- ☐ Child wellness screenings
- ☐ DOT physicals
- ☐ Tobacco treatment
- ☐ Chronic care management
- ☐ Injection therapy
- ☐ Respiratory therapy
- ☐ Medical nutrition therapy

15. Considering **RADIOLOGY SERVICES** at West River Health Services, which services are you aware of (or have you used in the past year)? (Choose ALL that apply)

- ☐ Injection Therapy Services
- ☐ CT scan
- ☐ Cardiac stress testing
- ☐ General x-ray
- ☐ Mammography
- ☐ MRI
- ☐ Ultrasound

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

- ☐ Behavioral health
- ☐ Blood pressure check
- ☐ Breastfeeding resources
- ☐ Car seat program (referral only)
- ☐ Child health
- ☐ Correction facility health
- ☐ Diabetes screening
- ☐ Emergency response & preparedness program
- ☐ Flu shots
- ☐ Health maintenance program
- ☐ Health Tracks (child health screening)
- ☐ Health equity education
- ☐ Immunizations
- ☐ Medications setup—home visits
- ☐ COVID vaccinations and free test kits
- ☐ School health (vision, health education, and resources)
- ☐ Preschool education programs and screenings
- ☐ Newborn home visits
- ☐ Tobacco prevention, control, and cessation
- ☐ Tuberculosis management
- ☐ WIC (Women, Infants and Children) Program
- ☐ Youth education programs (First Aid, Bike Safety)

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

- ☐ Chiropractic services
- ☐ Dental services
- ☐ Massage therapy
- ☐ Physical therapy

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

_____

19. Are you aware of West River Health Services Convenience Clinic, open Saturdays 8 am – 12 pm?

- ☐ Yes
- ☐ No

20. 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): _____

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

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

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

- ☐ Phonebook
- ☐ Google
- ☐ Health care professionals
- ☐ Newspaper
- ☐ Public health professionals
- ☐ Radio
- ☐ Social media (Facebook, etc.)
- ☐ Website searches
- ☐ Word of mouth, from others (friends, neighbors, co-workers, etc.)
- ☐ Other: (please specify): _____

23. Are you aware of West River Health Services Foundation, which exists to support West River Health Services and Western Horizons Living Centers as they provide comprehensive health and wellness services to the region by providing fund raising and development services.

- ☐ Yes
- ☐ No

24. Have you supported the West River Health Services Foundation in any of the following ways? (Choose ALL that apply)

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

25. Do you believe individuals in the community would financially support any of the following capital improvements by West River Health Services? (Choose ALL that apply)

- ☐ Renovations to OB Wing
- ☐ Laboratory renovations
- ☐ Surgery Center Expansion
- ☐ Renovations to long-term care center
- ☐ Physical therapy department renovations
- ☐ Improvements to patient rooms (e.g., larger bathrooms)
- ☐ Other (Please specify other capital improvements that you believe the community would financially support): _____

Demographic Information: Please tell us about yourself.

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

- ☐ Yes
- ☐ No

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

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

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

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

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☐ Other (please specify):

_____

29. Age:

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

30. Highest level of education:

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

31. Sex:

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

_____

32. Employment status:

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

33. Your zip code: _____

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

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

35. 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

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

_____

_____

Thank you for assisting us with this important survey!

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Appendix D – County Health Rankings Explained

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

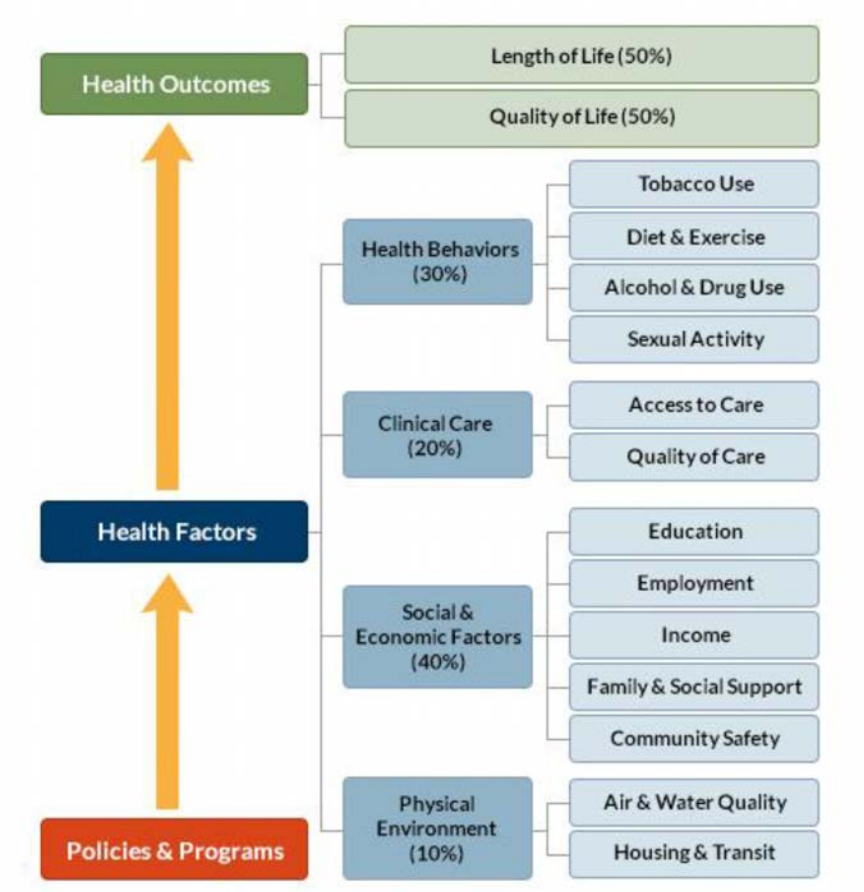
Methods

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



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

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

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

Data Sources and Measures

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

Data Quality

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

Calculating Scores and Ranks

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

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Health Outcomes and Factors

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

Health Outcomes

Premature Death (YPLL)

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

Reason for Ranking

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

Poor or Fair Health

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

Reason for Ranking

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

Poor Physical Health Days

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

Reason for Ranking

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

Poor Mental Health Days

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

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

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

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

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

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

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

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

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

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

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

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Food Environment Index

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

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

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

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

Reason for Ranking

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

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

Physical Inactivity

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

Reason for Ranking

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

Access to Exercise Opportunities

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

Individuals who:

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

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

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

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

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

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

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

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

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

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

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

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

Uninsured

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

Reason for Ranking

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

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

Primary Care Physicians

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

Reason for Ranking

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

Dentists

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

Reason for Ranking

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

Mental Health Providers

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

Reason for Ranking

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Injury Deaths

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

Reason for Ranking

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

Air Pollution-Particulate matter

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

Reason for Ranking

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

Drinking Water Violations

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

Reason for Ranking

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

Severe Housing Problems

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

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

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

Reason for Ranking

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

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Appendix E – Youth Behavioral Risk Survey Results

North Dakota High School Survey

Rate Increase ↑, rate decrease↓, or no statistical change = in rate.

	ND 2017	ND 2019	ND 2021	ND Trend ↑, ↓, =	Rural ND Town Average	Urban ND Town Average	National Average 2021
Injury and Violence							
Percentage of students who rarely or never wore a seat belt (when riding in a car driven by someone else)	8.1	5.9	**49.6**	=	9.2	5.0	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)	16.5	14.2	**13.1**	=	18.2	13.7	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)	56.2	59.6	**64.4**	=	64.9	64.2	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)	52.6	53.0	**55.4**	=	59.9	55.9	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)	20.6	NA	**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)	5.9	4.9	**5.0**	=	6.2	4.4	3.1
Percentage of students who were in a physical fight on school property (one or more times during the 12 months before the survey)	7.2	7.1	**NA**	**NA**	NA	NA	5.8
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)	8.7	9.2	**9.4**	=	9.7	11.6	9.7
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)	NA	NA	**NA**	**NA**	NA	NA	8.5
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)	11.4	11.6	**11.0**	=	11.2	11.1	NA
Percentage of students who were bullied on school property (during the 12 months before the survey)	24.3	19.9	**15.8**	↓	19.8	15.0	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)	18.8	14.7	**13.6**	↓	16.2	14.5	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)	28.9	30.5	**36.0**	↑	34.8	39.7	42.3
Percentage of students who seriously considered attempting suicide (during the 12 months before the survey)	16.7	18.8	**18.6**	=	18.5	20.6	22.2

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	ND 2017	ND 2019	ND 2021	ND Trend ↑, ↓, =	Rural ND Town Average	Urban ND Town Average	National Average 2021
Percentage of students who made a plan about how they would attempt suicide (during the 12 months before the survey)	14.5	15.3	**14.8**	=	15.1	17.2	15.7
Percentage of students who attempted suicide (one or more times during the 12 months before the survey)	13.5	13.0	6.1	↓	7.9	7.5	10.2
Tobacco Use							
Percentage of students who ever tried cigarette smoking (even one or two puffs)	30.5	29.3	**22.3**	↓	26.8	21.1	17.8
Percentage of students who smoked a whole cigarette before age 13 years (even one or two puffs)	11.2	NA	**NA**	**NA**	NA	NA	6.3
Percentage of students who currently smoked cigarettes (on at least one day during the 30 days before the survey)	12.6	8.3	**5.9**	↓	8.0	6.1	3.8
Percentage of students who currently frequently smoked cigarettes (on 20 or more days during the 30 days before the survey)	3.8	2.1	**0.8**	↓	1.7	1.3	0.7
Percentage of students who currently smoked cigarettes daily (on all 30 days during the 30 days before the survey)	3.0	1.4	**0.7**	↓	1.3	1.1	0.41
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) ~2021~ Usually got their electronic vapor products by buying them themselves in a convenience store, supermarket, discount store, or gas station	7.5	13.2	**NA**	**NA**	NA	NA	6.8
Percentage of students who tried to quit smoking cigarettes (among students who currently smoked cigarettes during the 12 months before the survey)	50.3	54.0	**30.9**	↓	30.4	29.9	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)	20.6	33.1	**21.2**	↓	24.2	23.6	18.0
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)	8.0	4.5	**4.3**	↓	5.2	3.7	2.5
Percentage of students who currently smoked cigars (cigars, cigarillos, or little cigars on at least one day during the 30 days before the survey)	8.2	5.2	**2.8**	↓	4.0	3.3	3.1
Percentage of students who currently used cigarettes, cigars, or smokeless tobacco (on at least 1 day during the 30 days before the survey)	18.1	12.2	8.9	↓	11.2	8.9	18.7
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)	59.2	56.6	**50.4**	↓	55.7	50.6	NA
Percentage of students who drank alcohol before age 13 years (for the first time other than a few sips)	14.5	12.9	**12.1**	=	13.7	10.9	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)	29.1	27.6	**23.7**	=	28.7	23.7	22.7
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)	16.4	15.6	**14.0**	=	17.8	14.6	10.5
Percentage of students who usually obtained the alcohol they drank by someone giving it to them (among students who currently drank alcohol)	37.7	NA	**NA**	**NA**	NA	NA	40.0
Percentage of students who tried marijuana before age 13 years (for the first time)	5.6	5.0	**4.1**	=	3.7	3.3	4.9

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Percentage of students who currently used marijuana (one or more times during the 30 days before the survey)	15.5	12.5	**10.7**	=	10.2	12.9	15.8
	ND 2017	ND 2019	ND 2021	ND Trend ↑, ↓, =	Rural ND Town Average	Urban ND Town Average	National Average 2021
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)	14.4	14.5	10.2	↓	9.7	11.0	12.2
Percentage of students who were offered, sold, or given an illegal drug on school property (during the 12 months before the survey)	12.1	NA	NA	NA	NA	NA	13.3
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	36.6	38.3	36.6	=	36.5	37.1	30.0
Percentage of students who had sexual intercourse before age 13 years (for the first time)	2.8	NA	NA	NA	NA	NA	3.2
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)	16.1	16.5	**15.6**	=	15.5	14.2	16.0
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)	14.9	14.0	**16.3**	=	17.4	15.0	16.3
Percentage of students who described themselves as slightly or very overweight	31.4	32.6	**31.7**	=	35.3	32.5	32.3
Percentage of students who were trying to lose weight.	44.5	44.7	**21.6**	↓	20.8	23.2	54.3
Percentage of students who did not eat fruit or drink 100% fruit juices (during the seven days before the survey)	4.9	6.1	5.0	=	5.8	4.6	7.7
Percentage of students who ate fruit or drank 100% fruit juices one or more times per day (during the seven days before the survey)	61.2	54.1	25.4	↓	21.9	27.0	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)	5.1	6.6	**5.9**	=	5.3	6.2	9.3
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)	60.9	57.1	61.3	=	60.0	59.3	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)	28.8	28.1	**27.7**	=	27.1	31.6	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)	16.3	15.9	**16.6**	=	17.5	13.8	14.7
Percentage of students who did not drink milk (during the seven days before the survey)	14.9	20.5	26.2	↑	21.2	29.4	35.7
Percentage of students who drank two or more glasses per day of milk (during the seven days before the survey)	33.9	NA	NA	NA	NA	NA	NA
Percentage of students who did not eat breakfast (during the 7 days before the survey)	13.5	14.4	**15.1**	=	14.5	17.3	22.0
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)	2.7	2.8	**2.1**	=	2.2	2.1	NA

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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)	51.5	49.0	**56.5**	↑	58.0	55.3	55.9
	ND 2017	ND 2019	ND 2021	ND Trend ↑, ↓, =	Rural ND Town Average	Urban ND Town Average	National Average 2021
Percentage of students who watched television three or more hours per day (on an average school day) *In 2021, % of students who played video or computer games was combined with % of students who watch television 3 or more hours per day.	18.8	18.8	**75.7**	**NA**	75.8	78.6	75.9
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). ~2021~ questioned combined with previous question regarding television.	43.9	45.3	NA	NA	NA	NA	NA
Other							
Percentage of students who had eight or more hours of sleep (on an average school night)	31.8	29.5	**24.5**	=	28.3	23.2	22.7
Percentage of students who brushed their teeth on seven days (during the 7 days before the survey)	69.1	66.8	**67.9**	=	64.5	69.9	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)	12.8	NA	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)	8.3	7.0	7.4	=	8.6	6.8	64.4

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

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Appendix F – Prioritization of Community's Health Needs

Community Health Needs Assessment
Hettinger, North Dakota
Ranking of Concerns

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

	Priorities	Most Important
COMMUNITY/ENVIRONMENTAL HEALTH CONCERNS		
Attracting & retaining young families	10	10
Having enough child daycare services	1	
Not enough jobs with livable wages		
Changes in population size	1	
Not enough affordable housing		
AVAILABILITY/DELIVERY OF HEALTH SERVICES CONCERNS		
Ability to retain primary care providers and nurse	2	
Availability of primary care providers		
Availability of mental health services		
Cost of health insurance	3	
Not enough healthcare staff in general		
YOUTH POPULATION HEALTH CONCERNS		
Alcohol use and abuse Not getting enough exercise/physical activity Suicide	5	0
ADULT POPULATION HEALTH CONCERNS		
Alcohol use and abuse Drug use and abuse (including prescription drugs) Stress		
SENIOR POPULATION HEALTH CONCERNS		
Availability of resources to help elderly stay in their homes	1	
Ability to meet needs of older population	2	
Cost of long-term/nursing home care	1	
VIOLENCE CONCERNS		
Bullying/cyber-bullying	3	
Child abuse or neglect	1	
Emotional abuse		
ALL AGES		
Depression/anxiety	10	0

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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.

1. Considering the PEOPLE in your community, the best things are: "Other" responses:
    - All: some are, some aren't
    - Don't like change
    - None of these describe Hettinger. Very negative community.
    - Easy to get around the town
    - Not a lot of people here
    - Grew up here. Familiarity. Roots.
    - Multi-talented
2. Considering the SERVICES AND RESOURCES in your community, the best things are: "Other" responses:
    - You have to go out of town for most things
    - Parks are nice
    - Being a small town
3. Considering the QUALITY OF LIFE in your community, the best things are: "Other" responses:
    - Even if there is crime sheriff or court don't do much about it
    - Quality of life has rapidly diminished over the last 5-10 years with loss of several key businesses, several primary care physicians retired, local law enforcement concerns etc.
4. Considering the ACTIVITIES in your community, the best things are: "Other" responses:
    - (2) Good hunting and fishing
    - None besides sports
    - Lacking!
    - None
    - Several churches

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:
    - need more food establishments
    - Affordable grocery stores and shopping
    - The negativity of the sheriff office. Adams county has a horrible sheriff office and it's known around the state how corrupt they are.

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- too many cats
- Need more people to work here.
- Having enough mental support programs like counseling/therapists
- alcohol and drug abuse

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

- Nursing staff are desperately needed
- Availability of ICU so patients don't have to be shipped out
- Availability of health care that does not create additional health problems
- Reliance on Western allopathic medicine

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

- Bullying
- Not many children involved in faith-based communities
- Not fitting in. No social group.
- Social skills

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

- Not involved in faith-based community
- Lack of adult activities

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

- We have a nice nursing home and assisted home

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

- • Cyber Bullying which includes snapchat with our youth
- Clinic closed on occasion do to lack of providers and knowing there is a ongoing concern for lack of quality nurses and not paying adequate to get more staff
- Population
- Attracting and keeping trained medical staff i.e. doctors, nurses and specialists who want to come once a month so people don't have to travel so far
- Affordable housing
- Bullying/cyber Bullying
- Services for elderly- transportation, groceries, housing, home health care, social connections
- Cost of living is rising faster than incomes, which will have an effect on everything from healthcare and nutrition to main street business availability.
- Employment
- Law enforcement posting issues on Facebook before a person has the chance to go to court.
- Aging population without adequate services
- We need to have available restaurants at meal times.
- The failing of our hospital.
- Loss of our hospital due to significant decline in quality of care
- The sheriff department issues. They are not a good organization and makes everyone have a negative view on them. They are so worried about their "drug busts" that they don't actual care for the citizens of Adams county.
- Loss of business

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- The hospitals confidentiality and the misdiagnosis of patients that has happened countless times.
- Continued population loss
- There are a lack of shopping options and restaurants.
- Lack of growth and costs of being rural
- Attracting retaining families
- The housing market and inflation
- We need a grocery store that serves non or expired food. Especially in the meat department. The prices are too high and most food rotten or expired. We need more variety of restaurants here as well.
- The biggest issue is getting young families to move to our community and stay here long term. The population is slowly getting older and older and there might be new families moving in but they don't seem to stay long term.
- Judgement from healthcare providers when you seek other healthcare in different towns because you are tired of being thrown into an appointment with residents rather than our local providers because they are busy with satellite clinics.
- Outmigration
- Population decline
- Isolation and lack of resources

Delivery of Healthcare

12. Do you primarily rely on West River Health Services as a primary source to meet your healthcare needs? "Explain" responses::
    - Lack of unsupervised residents and doctors to train them
    - Don't follow their "rules" for regular doctor care
    - Not enough doctors
    - Family experience with misdiagnosis and extremely poor-quality care
    - Too many residents, poor access to regular provider, no walk in clinic when needed, can't get results from tests or any information from physician after you see them, the follow my health app is worthless, nonuser friendly, not updated in a timely manner, when test results are posted there is no explanation, can't get questions answered, billing is very inefficient, been trying to get a mammo for 2 years but can't schedule one, just wait for a call but can't get off work with 1 day notice
    - I used to only go to west river health services but they have misdiagnosed me and people I know and love so many times I no longer feel safe going there, and the confidentiality is terrible.
    - Do not have health insurance, use the VA
    - Not anymore as we are seeking different healthcare in a different town
    - Too expensive, not quality care for the money paid
    - I refuse to get health care from a facility that has no problem injecting people with injury causing mystery shots without their consent and when they're unconscious. Legitimately can't believe you haven't been sued.
    - Personal responsibility

18. What specific healthcare services, if any, do you think should be added locally?
    - Medical Spa
    - (9) Chiropractors
    - ENT
    - OT & PT
    - Medical infusions
    - Any
    - More OB GYN, orthopedics
    - Bring back night clinic.
    - Dialysis
    - kidney dialysis

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- Dialysis
- cosmetic like Botox and plastic surgery
- Hospice
- More massage therapy
- holistic/naturopath
- Sanford and affordable prices
- more mental health resources
- More counseling and massage therapist.
- ENT
- Clinical nutrition
- GI; cardiology
- Energy healing, aromatherapy, essential oils, naturopathic doctor, supplemental counseling, other non invasive, non surgical, non pharmaceutical dug options. chelation therapy

20. What PREVENTS community residents from receiving healthcare? "Other" responses:
    - Limited MD's
    - Money
    - Can only see a midlevel or resident on short notice. have had bad experiences with all of them my family has seen. wish we could see a provider who knows something when we have an acute illness. our experiences with the residents and midlevel's has caused us to desire to take our healthcare elsewhere
    - Human rights violations
    - Don't provide services I want
21. Where do you turn for trusted health information? "Other" responses:
    - Specialists
    - West River Health Services website
    - I go to Sanford in Dickinson
    - I go to Bowman for dental services for insurance
    - Medical journals
    - My own experience and learning
22. Where do you find out about LOCAL HEALTH SERVICES available in your area? "Other" responses:
    - Advertising
    - (2) Paper
    - Call the clinic
    - Calling
    - (2) Newspaper
    - Healthcare professionals
24. Have you supported the West River Health Services Foundation in any of the following ways? "Other" responses:
    - (2) Payroll deduction
    - Donations as needed
    - As a previous employee
    - Paid my bill
    - No longer support the foundation since they started to raise money for outside projects, i prefer to support those directly
    - I used to go to the fall dinners but they are greedy and will not donate back to the church that they rent the building from and they used to say it was free will but would get upset if the elderly did not pay. The elderly has given the hospital enough money over the years to not pay for a 5 dollar meal once a year. So I will no longer support the foundation at all.

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- Volunteer work
- Attended events

25. Do you believe individuals in the community would financially support any of the following capital improvements by West River Health Services? "Other" responses:
    - None unless they can have a say in what happens
    - I think much of the community is tired of the nonstop fundraising the hospital has done over the last decade.
    - I do not think the community would because the hospital raises enough money for everything else to be able to make improvements here and there especially with grants.
    - The LTC needs a new facility with more Core staff and less Traveling staff with the help of continuing future education.
    - Offer something that people can't get without traveling 500 miles. Like naturopathy. That would draw a lot of people in who are currently forced to go to Denver, Minneapolis, phoenix etc. for this type of care.
    - Med beds

27. How did you acquire the survey (or survey link) that you are completing? "Other" responses:
    - (8) Facebook
    - FB Community Page
    - (11) Direct email: WHRS
    - Direct email: community relations

28. Health insurance or health coverage status "Other" responses:
    - TRICARE for life

34. Race/Ethnicity "Other" responses:
    - Mixed northern European

36. Overall, please share concerns and suggestions to improve the delivery of local healthcare.
    - Focus on patient care, convenience, comfort vs. focus on employee convenience. Staff focus on how busy they are, or how short-staffed or how much they hate the computer system doesn't feel like they care about you. Level of professionalism seems to have gone down; unprofessional dress, manners, loud discussions in the hospital halls overheard as a patient.
    - Competitive wages and more providers so that your able to see the same person more routinely. Also need to educate community of what a nurse practitioner and PA are and that they can be your primary provider
    - Under staff and or hiring the wrong person just to have a body and not having a big enough pool of candidates to pick from i drive over 400 miles of week to work so people are a big problem
    - More access chronic care management in surrounding towns with nurse support and provider availability
    - More visiting specialists. Provide more surgeries at home.
    - When I pay the price for a doctor I want to see the doctor not a resident. I know the residents have to check in with a doctor but they should be there doubling checking the treatments. To many things are being missed. It should be a cheaper price to see a resident. If you have an emergency and you go to ER, it should be a doctor there. I appreciate having a great clinic so close to home and I know it's difficult to find doctors and workers. It's especially hard to get kids in to see a doctor. There are a select few doctors that know how to interact with a kid so they aren't scared. The main doctors have to slam their schedule to accommodate everyone.
    - We need more staff, especially staff who live here -- not so many travelers and locums. We need a new Care Center for the elderly. We need to get more involved with the local public-school system and area universities.
    - The Patient Portal needs to be kept up to date by all providers and should be easier to see on the website.
    - Recruitment and retention of MD's. There are many mid-level providers, but as a person ages, they have health needs that often exceed what a mid-level can provide.
    - They need more physicians.
    - Get doctors who actually care about the community and aren't just using us as a learning experience.

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- Walk back the residency program, increase primary care physicians, offer at last a few night clinic options, get a mammo tech, fix the patient app to be functional
- This hospital needs to get rid of the doctors that are only here to get their degree and leave, if we got Doctors that cared more about the community itself and the people instead of their pocket books I believe more people would come to get care from their facility. Almost everyone I know goes to a different clinic because Hettinger has messed up so many times. The hospital also can't find enough workers because they do not pay well enough for local people to work there but yet they will pat traveling aids over $30 an hour which is a shame because local people care about the community and the people that they know and love and have grown up with and the traveling nurses and aids do not care because they do not know them on a personal level. I used to work for West River Health Services but I quit because they do not show appreciation to the community or their workers, no raises or even caring about their workers so why would anyone want to work for them. I really hope that they clean that hospital up with the cares and confidentiality because if they don't they will not get enough support to stay open and. That would really hurt our community.
- Employee morale, need to rebuild team approach
- Need MDs.
- Communication with the communities
- More special services for cancer treatment and kidney dialysis for example.
- I wish west river would offer health fairs like southwest healthcare does.
- There needs to be an updated LTC facility. The building is old and we need more Core staff to keep in our community and pay our Core staff more than the Traveling staff or at the very least pay increase for the people who live here.
- When a child was sick years ago, we would be able to call and get in with their primary care doctor and when she only works 1 day a week in Hettinger, then you decide to go to another doctor in another town and you have to get a Medicaid referral from the primary care provider and then they get mad and don't want to send a referral because we went elsewhere. I think If you want WRHS to succeed you need to focus on the clinic in Hettinger and keep your main providers providing in Hettinger rather than once a week.
- Over the past few years there has been a shift in the "feel" or "atmosphere" at WRHS- particularly clinic staff as that's who I've dealt with. Customer service and common sense seem to have gone out the window. There are never any appointments with providers who a person wants to see. We are usually offered an appointment with a resident. Our experience with the residents has not been favorable. The quality of care is not what it used to be and it seems patients aren't the #1 priority- convenience for staff is. There are still many great providers and employees, but our experiences over the last 3 years have been very poor.
- Cost. Availability. No specialists
- Have a cash pay option for people without insurance. Have more services available in the hospital so people don't have to travel 2hours away to see a specialist, get counseling, etc…
- The availability of GOOD providers. So many push you through like you are a number and not an actual person.
- Don't do things to people without giving them informed consent.
- You are a great group of wonderful people who need to get away from the CDC, FDA, and many more 3 letter agencies that rule the kind of medicine you can practice. You need to review the history of medical schools, especially the time period after 1913 and look at what all the symbols you see everywhere in healthcare really mean and their origins. You need to go back to critically thinking for yourself and not just follow directions. You need to ask why and find out. The information is out there, but you may be ostracized, criticized, loose your "license" and all the money you make. If you really rock the boat, you may be killed. It is not an easy road to go against the deep state and the medical cartels, but it is time to choose to do what is right and you will be rewarded. This organization needs to be and can be the leader of a new time in REAL healthcare, not just in treatment and management of symptoms. Don't keep doing things that only cause other problems. Strive for a body in balance, free from toxins of all kinds, mental, physical, emotional and spiritual.
- need more resident physicians and nurses

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