Community Health Needs Assessment

West River Health Services Service Area
Hettinger, North Dakota

2021

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Executive Summary

To help inform future decisions and strategic planning, West River Health Services (WRHS) conducted a Community Health Needs Assessment (CHNA) in 2020/2021, the previous CHNA having been conducted in 2017/2018. The Center for Rural Health (CRH) at the University of North Dakota School of Medicine & Health Sciences (UNDSMHS) facilitated the assessment process, which solicited input from area community members and healthcare professionals, as well as analysis of community health-related data.

To gather feedback from the community, residents of the area were given the opportunity to participate in a survey. One hundred twenty-nine WRHS service area residents completed the survey. Additional information was collected through 15 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 2010 to 2019 decreased by 5.4%. The average number of residents younger than age 18 (19.3%) for Adams County comes in 4.3 percentage points lower than the North Dakota average (23.6%). The percentage of residents ages 65 and older is just under 13% higher for Adams County (28.5%) than the North Dakota average (15.7%), and the percentage of high school graduates is slightly higher for Adams County (94.5%) than the North Dakota average (92.6%). The median household income in Adams County ($56,681) is well below the state average for North Dakota ($64,894).

Data compiled by County Health Rankings show Adams County is performing better than North Dakota in health outcomes/factors for 16 categories, while the county is performing poorer than North Dakota in 10 categories.

Of 106 potential community and health needs set forth in the survey, the 126 WRHS service area residents who completed the survey indicated the following 10 needs as the most important:

- Attracting and retaining young families
- Alcohol use and abuse – Adults
- Alcohol use and abuse – Youth
- Depression/anxiety – Adults
- Ability to retain primary care providers (MD, DO, NP, PA) and nurses in the community
- Not enough jobs with livable wages, not enough to live on
- Stress – Adults
- Cost of long-term/nursing home care
- Depression/anxiety – Youth
- Not enough activities for children and youth

The survey also revealed the biggest barriers to receiving healthcare (as perceived by community members). They included not being able to see the same provider over time (N=32), not having enough providers (MD, DO, NP, PA) (N=26), and having no or limited insurance (N=25).

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

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

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

- Attracting and retaining young families
- Ability to retain primary care providers (MD, DO, NP, PA) and nurses
- Alcohol use and abuse – Youth
- Depression/anxiety – Adults
- Cost of long-term/nursing home care

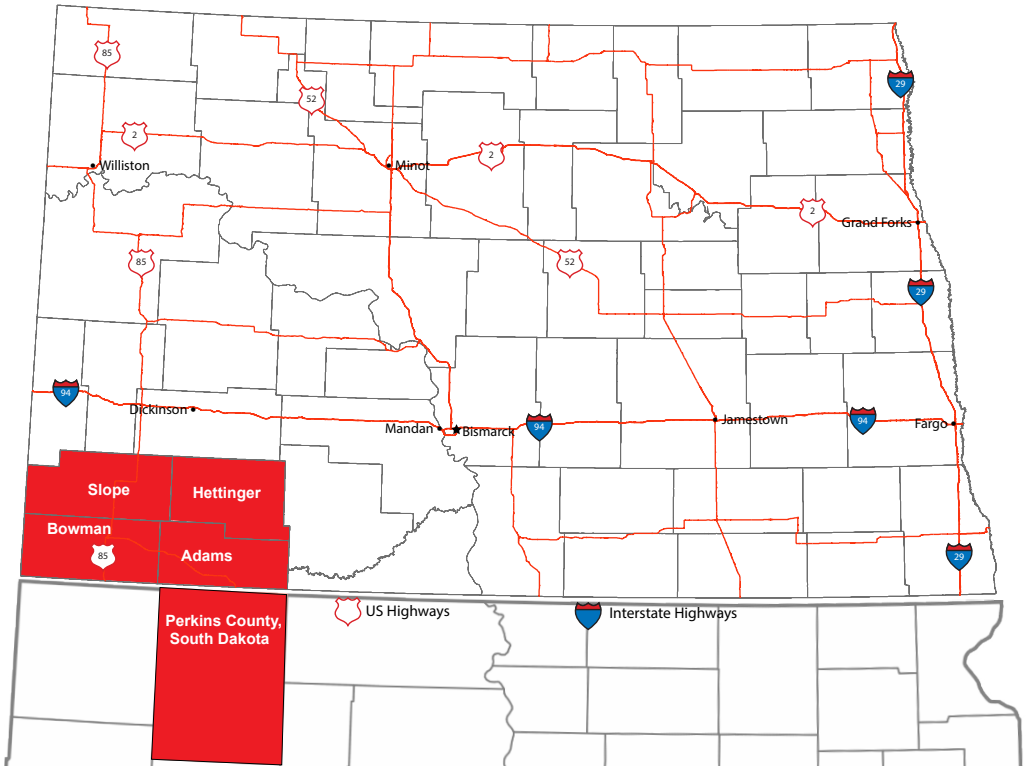
Overview and Community Resources

With assistance from the CRH at the UNDSMHS, WRHS completed a CHNA of the 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.

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.

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



West River Health Services

WRHS is composed of a Critical Access Hospital (CAH), five certified 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. A multispecialty group practice serves the area with 14 physicians, 13 advanced practice providers, and 7 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 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. It directly employs 222.2 full-time equivalent employees with an annual payroll of more than $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 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 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 Critical Access Hospital and a seven-time recipient as a TOP 100 Critical Access Hospital 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 AMC include:

Hospital Services

- 25-bed CAH
- Acute stroke ready hospital
- General acute
- Medical surgical unit
- Newborn nursey
- Palliative care room
- Pediatric patient services
- Surgery center
- Swing bed unit

Twenty-Four Hour Emergency Care

- Ambulance services – land and/or 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
- General surgery
- Geriatric medicine
- Internal medicine
- Obstetrics/birth and gynecological surgery
- Optometric medicine
- Pediatric medicine
- Podiatric medicine
- Radiology/diagnostic medicine

Surgical Services

- Breast – sentinel lymph node biopsy, benign breast disease, breast cancer
- Cesarean section/gynecological
- ENT – insertion of ear tubes, tonsillectomy/adenoidectomy
- Gastro-intestinal: Colonoscopy and gastroscopy
- General surgery – inpatient and outpatient
- Laparoscopic gallbladder, hernia, and appendix
- Ophthalmology
- Orthopedic
- Podiatric

Radiology Services

- 1.5T magnetic resonance imaging services (MRI)
- 3D mammography services
- 64-slice CT scanner
- Body composition exams
- Dexa/bone density scans
- Digital X-ray imaging
- Fluoroscopy procedures
- Injection therapy services
- Nuclear imaging
- Ultrasound (including Echo & OB)

Laboratory Services

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

Rehabilitation Services

- Athletic training
- Balance and dizziness treatments
- Certified lymphedema therapists (lower and upper extremities)
- 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 ND
- Transitional care calls
- Visiting nurse program
- Weight loss management
- 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
- Dance
- 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/senior care
- Social services
- Women, Infants, and Children (WIC) program

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:

- Alcohol prevention
- Behavioral health
- Blood pressure checks
- Breastfeeding resources
- Dental health
- Diabetes screening
- Emergency preparedness services – work with community partners as part of local emergency response team
- Environmental health services (water, sewer, health hazard abatement, inspections)
- Flu shots
- Health maintenance
- Health Tracks (child health screening)
- Immunizations
- Medication setup – home visits
- Member of Child Protection Team and County Interagency Team
- Newborn home visits
- Nutrition education
- Preschool education programs and screening
- School health – vision, health education and resource to the schools, school nursing support
- Tobacco prevention and control
- Tuberculosis testing and management
- West Nile program – surveillance and education
- WIC program
- Worksite wellness

Assessment Process

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

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

This assessment examines health needs and concerns in 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.

CRH, in partnership with WRHS and SDHU, facilitated the CHNA process. Community representatives met regularly in-person, by telephone conference, and email. A CHNA liaison was selected locally and 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 teleconference and/or via the eToolkit with the CHNA liaison. The key informant interviews (described in more detail as follows) 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. Fifteen people, representing a cross section demographically, were interviewed, and the interviews were highly interactive with good participation.

Figure 2: Steering Committee

Cindy Ham	Community Relations/Marketing, WRHS
Tammy Hruby	Executive Assistant, WRHS
Susan Price	CNO, WRHS
Eve Safratowich	ACO, WRHS
Kim Schalesky	Executive Assistant, WRHS
Matt Shahan	CEO, WRHS
Nathan Stadheim	CFO, 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 members representing the broad interests of the community took part in one-on-one key informant interviews; and
- A wide range of secondary sources of data were examined, providing information on a multitude of measures, including demographics, health conditions, indicators, outcomes, rates of preventive measures, rates of disease, and at-risk behavior.

CRH is one of the nation's most experienced organizations committed to providing leadership in rural health. Its mission is to connect resources and knowledge to strengthen the health of people in rural communities. CRH is the designated State Office of Rural Health and administers the Medicare Rural Hospital Flexibility (Flex) program, funded by the Federal Office of Rural Health Policy, Health Resources Services Administration,

and Department of Health and Human Services. CRH connects the UNDSMHS and other necessary resources to rural communities and other healthcare organizations in order to maintain access to quality care for rural residents. In this capacity, CRH works at a national, state, and community level.

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

Interviews

One-on-one interviews with 15 key informants were conducted via phone and videoconference in November and December 2020. 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 are 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;
- Understand perceptions and attitudes about the health of the community and hear suggestions for improvement; and
- Learn more about how local health services are used by residents.

Specifically, the survey covered the following topics:

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

To promote awareness of the assessment process, an informative ad was placed in the Ashley Tribune. 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 releasing 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. The survey period ran from November 1, 2020, to December 1, 2020. 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. One hundred twenty-four online surveys were completed. Two of those online respondents used the QR code to complete the survey. In total, counting both paper and online surveys, 126 community member surveys were completed, equating to a response rate of just more than 7%. This response rate is low for this type of unsolicited survey methodology and indicates a less-than-engaged community. However, this is on-trend for response rates during the COVID-19 pandemic.

Secondary Data

Secondary data was collected and analyzed to provide descriptions of: (1) population demographics, (2) general health issues (including any population groups with particular health issues), and (3) contributing causes of community health issues. Data was collected from a variety of sources, including the United States Census Bureau; Robert Wood Johnson Foundation's County Health Rankings, which pulls data from 20 primary data sources (www.countyhealthrankings.org); the National Survey of Children's Health, which touches on multiple intersecting aspects of children's lives (www.childhealthdata.org/learn/NSCH); North Dakota KIDS COUNT, which is a national and state-by-state effort to track the status of children, sponsored by the Annie E. Casey Foundation (www.ndkidscount.org); and Youth Risk Behavior Surveillance System (YRBSS) data, which is published by the Centers for Disease Control and Prevention (https://www.cdc.gov/healthyyouth/data/yrbs/index.htm).

Social Determinants of Health

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

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

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

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

Figure 3: Social Determinants of Health

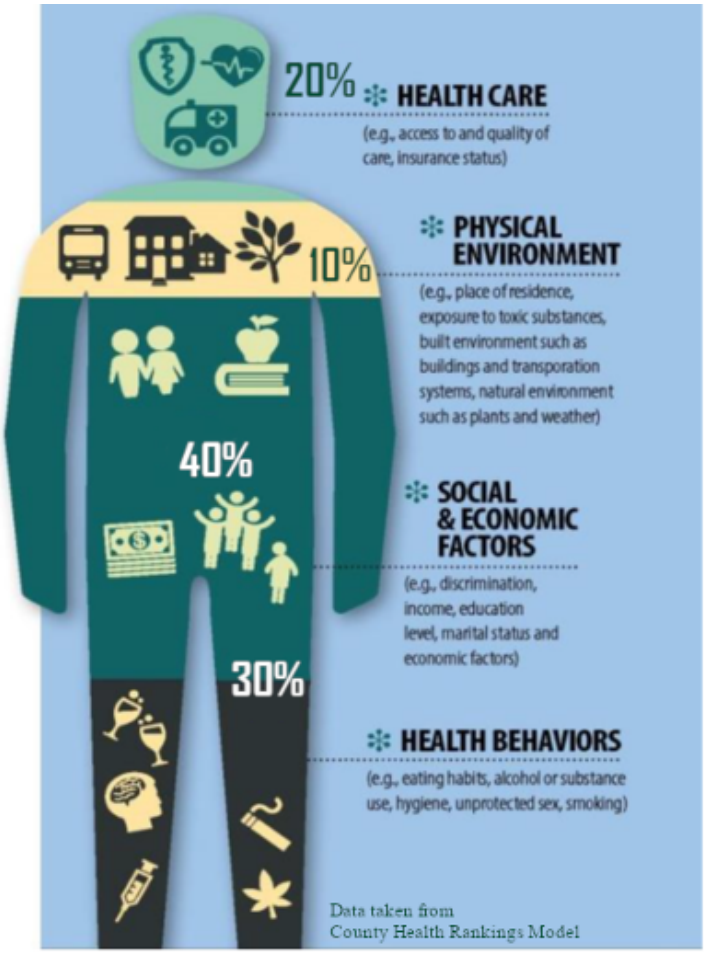


Figure 4 (Henry J. Kaiser Family Foundation, https://www.kff.org/disparities-policy/issue-brief/beyond-health-care-the-role-of-social-determinants-in-promoting-health-and-health-equity/), provides examples of factors that are included in each of the social determinants of health categories that lead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

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

Figure 4: Social Determinants of Health

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 summarizes general demographic and geographic data about Adams County.

	Adams County	North Dakota
Population (2019)	2,216	762,062
Population change (2010-2019)	-5.4%	13.3%
People per square mile (2010)	2.4	9.7
Persons 65 years or older (2019)	28.5%	15.7%
Persons younger than 18 years (2019)	19.3%	23.6%
Median age (2019)	45.6	35.1
White persons (2019)	92.2%	83.7%
High school graduates (2015-2019)	94.5%	92.6%
Bachelor's degree or higher (2015-2019)	25.6%	30.0%
Live below poverty line (2019)	10.7%	10.6%
Persons without health insurance, younger than age 65 years (2019)	9.4%	8.1%
Persons without health insurance, under age 65 years (2016)	14.5%	8.1%

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

While the population of North Dakota has grown in recent years, Adams County has seen a decrease in population since 2010. The U.S. Census Bureau estimates show that county's population decreased from 2,343 (2010) to 2,216 (2019).

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

The data used in the 2020 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 2020 County Health Rankings – a flow chart of how a county's rank is determined – may be found in Appendix C. For further information, visit the County Health Rankings website at www.countyhealthrankings.org.

Health Outcomes

- Length of life
- Quality of life

Health Factors

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

Health Factors (continued)

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

Table 2 summarizes the pertinent information gathered by County Health Rankings as it relates to 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 SDHUor WRHS or of any particular medical facility.

For most of the measures included in the rankings, the County Health Rankings' authors have calculated the "Top U.S. Performers" for 2019. 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).

Adams County rankings within the state are included in the summary following. For example, the county ranks 32nd out of 48 ranked counties in North Dakota on health outcomes and 2nd on health factors. The measures marked with a red bullet point (•) are those where a county is not measuring up to the state rate/percentage; a blue 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 checkmark but are marked with a plus sign (+) indicate that the county is doing better than the U.S. Top 10%.

The data from County Health Rankings shows that Adams County is doing better than many counties compared to the rest of the state on all of the outcomes with available data. However, the county, like many North Dakota counties, is doing poor in many areas when it comes to the U.S. Top 10% ratings. One particular outcome where Adams County does not meet the U.S. Top 10% ratings is the percentage of adults reporting poor or fair health.

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

- Percentage of adults reporting poor or fair health
- Poor physical health days (in past 30 days)
- Poor mental health days (in past 30 days)
- Adult smoking
- Adult obesity
- Excessive drinking

- Alcohol-impaired driving deaths
- Sexually transmitted infections
- Ratio of population per primary care physician
- Preventable hospital stays
- Flu vaccinations
- Unemployment
- Children in single-parent households
- Violent crime
- Air pollution – particulate matter
- Severe housing problems

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

- Food environment index
- Physical inactivity
- Access to exercise opportunities
- Uninsured individuals
- Ratio of population per dentist
- Ratio of population per mental health provider
- Mammography screenings
- Children in poverty
- Income inequality
- Social associations

TABLE 2: SELECTED MEASURES FROM *COUNTY HEALTH RANKINGS* 2020 – ADAMS COUNTY			
	Adams County	**U.S. Top 10%**	**North Dakota**
Ranking: Outcomes	**32nd**		**(of 48)**
Premature death		5,500	6,600
Poor or fair health	13% ■	12%	15%
Poor physical health days (in past 30 days)	2.8 +	3.1	3.3
Poor mental health days (in past 30 days)	3.2 +	3.4	3.5
Low birth weight		6%	6%
Ranking: Factors	**2nd**		**(of 48)**
Health Behaviors			
Adult smoking	15% ■	14%	18%
Adult obesity	30% ■	26%	33%
Food environment index (10=best)	8.9 +●	8.6	9.0
Physical inactivity	27% ●■	20%	24%
Access to exercise opportunities	42% ●■	91%	74%
Excessive drinking	20% ■	13%	24%
Alcohol-impaired driving deaths	0% +	11%	43%
Sexually transmitted infections	172.6 ■	161.4	433.9
Teen birth rate		13	21
Clinical Care			
Uninsured	10% ●■	6%	9%
Primary care physicians	230:1 +	1,030:1	1,300:1
Dentists	2,290:1 ●■	1,240:1	1,540:1
Mental health providers	1,150:1 ●■	290:1	530:1
Preventable hospital stays	2,843 ■	2,761	4,551
Mammography screening (% of Medicare enrollees ages 65-74 receiving screening)	47% ●■	50%	52%
Flu vaccinations (% of fee-for-service Medicare enrollees receiving vaccination)	52% ■	53%	49%
Social and Economic Factors			
Unemployment	2.1% +	2.6%	2.6%
Children in poverty	13% ●■	11%	11%
Income inequality	5.8 ●■	3.7	4.4
Children in single-parent households	12% +	20%	27%
Social associations	0.0 ●■	18.4	16.2
Violent crime	64 ■	63	258
Injury deaths		58	70
Physical Environment			
Air pollution – particulate matter	4.8 +	6.1	5.4
Drinking water violations	No		
Severe housing problems	7% +	9%	11%

Source: http://www.countyhealthrankings.org/app/north-dakota/2020/rankings/outcomes/overall

Children's Health

The National Survey of Children's Health touches on multiple intersecting aspects of children's lives. Data are not available at the county level; listed below is information about children's health in North Dakota. The full survey includes physical and mental health status, access to quality healthcare, and information on the child's family, neighborhood, and social context. Data is from 2017-18. 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 aged 0-17 unless noted otherwise)

Health Status	North Dakota	National
Children born premature (3 or more weeks early)	9.0%	11.4%
Children 10-17 overweight or obese	31.7%	30.8%
Children 0-5 who were ever breastfed	82.5%	80.9%
Children 6-17 who missed 11 or more days of school	3.5%	4.5%
Healthcare		
Children currently insured	91.8%	93.4%
Children who spent less than 10 minutes with the provider at a preventive medical visit	21.8%	19.8%
Children (1-17 years) who had a preventive dental visit in the past year	75.0%	79.1%
Children (3-17 years) received mental health care	12.9%	9.8%
Children (3-17 years) with problems requiring treatment did not receive mental health care	0.7%	2.2%
Young children (9-35 mos.) receiving standardized screening for developmental problems	42.2%	35.2 %
Family Life		
Children whose families eat meals together four or more times per week	71.7%	73.6%
Children who live in households where someone smokes	15.3%	15.0%
Neighborhood		
Children who live in neighborhoods with parks, recreation centers, sidewalks, and a library	35.1%	38.3%
Children living in neighborhoods with poorly kept or rundown housing	1.3%	3.8%
Children living in neighborhood that's usually or always safe	97.8%	95.5%

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 10-17 overweight or obese
- Children currently insured
- Children who spent less than 10 minutes with the provider at a preventative medical visit
- Children (1-17 years) who had a preventive dental visit in the past year
- Children whose families eat meals together four or more times per week
- Children living in smoking households
- Children living in neighborhoods with parks, recreation centers, sidewalks, and a library

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

The data show Adams County is performing more poorly than the North Dakota average on all of the examined measures except the percentage of the population who are Supplemental Nutrition Assistance Program (SNAP) recipients and children enrolled in Healthy Steps. The most marked difference was on the measure of uninsured children below 200% of poverty (11% higher rate in Adams County).

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

	Adams County	North Dakota
Uninsured children (% of population age 0-18), 2018	9.7%	6.3%
Uninsured children below 200% of poverty (% of population), 2018	20.6%	9.6%
Medicaid recipient (% of population age 0-20), 2019	27.0%	26.6%
Children enrolled in Healthy Steps (% of population age 0-18), 2019	0.4%	1.6%
Supplemental Nutrition Assistance Program (SNAP) recipients (% of population age 0-18), 2019	13.0%	16.9%
Licensed childcare capacity (% of population age 0-13), 2020	38.8%	39.9%
4-Year high school cohort graduation rate, 2018/19	80.0%	88.3%

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

Another means for obtaining data on the youth population is through the Youth Risk Behavior Survey (YRBS). The YRBS was developed in 1990 by the Centers for Disease Control and Prevention (CDC) to monitor priority health risk behaviors that contribute markedly to the leading causes of death, disability, and social problems among youth and adults in the U.S. The YRBS was designed to monitor trends and 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 has been collected in 2015, 2017, and 2019. It is 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 2017 to 2019, and "↓" for a decreased trend in the data changes from 2017 to 2019. The final column shows the 2019 national average percentage. For a more complete listing of the YRBS data, see Appendix D.

Youth Behavioral Risk Survey Results

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

	ND 2015	ND 2017	ND 2019	ND Trend ↑, ↓, =	Rural ND Town Average	Urban ND Town Average	National Average 2019
Injury and Violence							
% of students who rarely or never wore a seat belt (when riding in a car driven by someone else)	8.5	8.1	5.9	=	8.8	5.4	6.5
% of students who rode in a vehicle with a driver who had been drinking alcohol (one or more times during the 30 prior to the survey)	17.7	16.5	14.2	=	17.7	12.7	16.7
% of students who talked on a cell phone while driving (on at least one day during the 30 days before the survey)	NA	56.2	59.6	=	60.7	60.7	NA
% of students who texted or e-mailed while driving a car or other vehicle (on at least one day during the 30 days before the survey)	57.6	52.6	53.0	=	56.5	51.8	39.0
% of students who were in a physical fight on school property (one or more times during the 12 months before the survey)	5.4	7.2	7.1	=	7.4	6.4	8.0
% of students who experienced sexual violence (being forced by anyone to do sexual things [counting such things as kissing, touching, or being physically forced to have sexual intercourse] that they did not want to, one or more times during the 12 months before the survey)	NA	8.7	9.2	=	7.1	8.0	10.8
% of students who were bullied on school property (during the 12 months before the survey)	24.0	24.3	19.9	↓	24.6	19.1	19.5
% of students who were electronically bullied (includes texting, Instagram, Facebook, or other social media ever during the 12 months before the survey)	15.9	18.8	14.7	↓	16.0	15.3	15.7
% of students who made a plan about how they would attempt suicide (during the 12 months before the survey)	13.5	14.5	15.3	=	16.3	16.0	15.7
Tobacco, Alcohol, and Other Drug Use							
% of students who currently use an electronic vapor product (e-cigarettes, vape e-cigars, e-pipes, vape pipes, vaping pens, e-hookahs, and hookah pens at least one day during the 30 days before the survey)	22.3	20.6	33.1	↑	32.2	31.9	32.7
% of students who currently used cigarettes, cigars, or smokeless tobacco (on at least one day during the 30 days before the survey)	NA	18.1	12.2	**NA**	15.1	10.9	10.5
% of students who currently were binge drinking (four or more drinks for female students, five or more for male students within a couple of hours on at least one day during the 30 days before the survey)	NA	16.4	15.6	=	17.2	14.0	13.7
% of students who currently used marijuana (one or more times during the 30 days before the survey)	15.2	15.5	12.5	=	11.4	14.1	21.7
% of students who ever took prescription pain medicine without a doctor's prescription or differently than how a doctor told them to use	NA	14.4	14.5	=	12.8	13.3	14.3

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

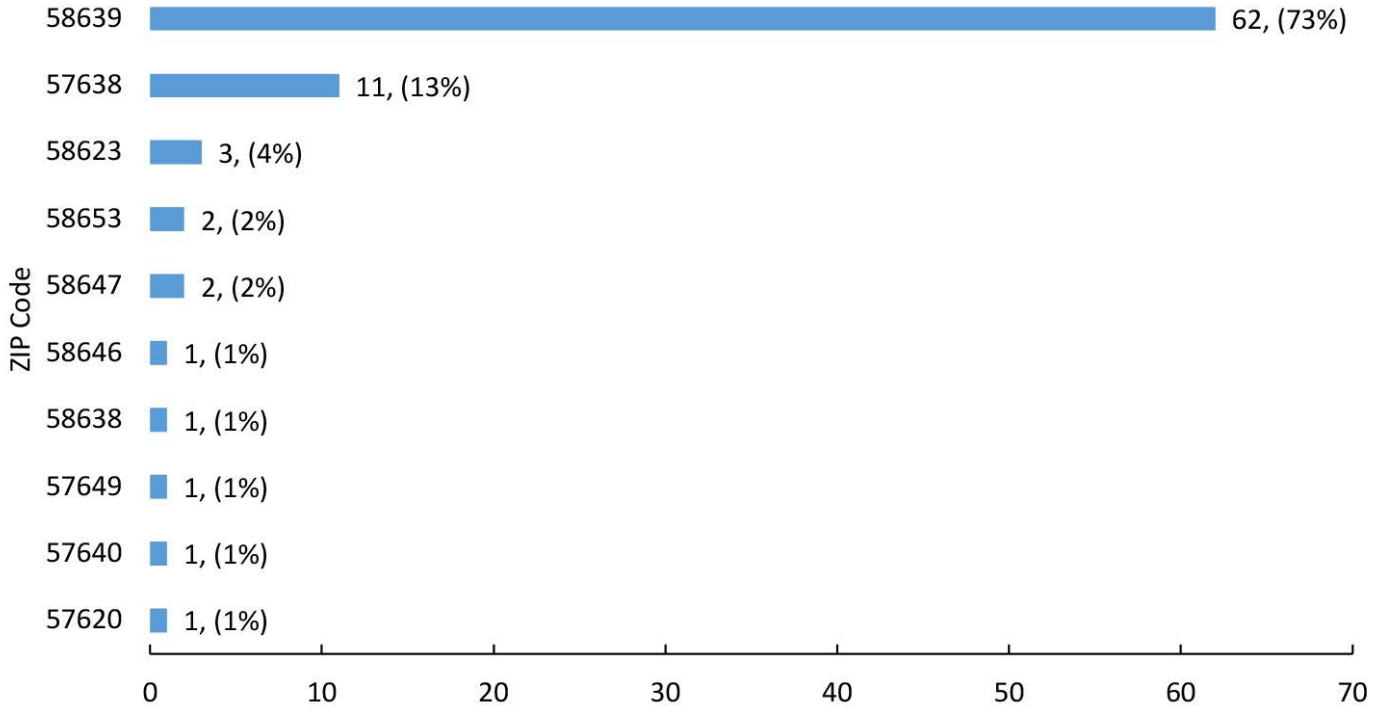
Weight Management, Dietary Behaviors, and Physical Activity							
% of students who were overweight (>= 85th percentile but <95th percentile for body mass index)	14.7	16.1	16.5	=	16.6	15.6	16.1
% of students who had obesity (>= 95th percentile for body mass index)	13.9	14.9	14.0	=	17.4	14.0	15.5
% of students who did not eat fruit or drink 100% fruit juices (during the seven days before the survey)	3.9	4.9	6.1	=	5.8	5.3	6.3
% of students who did not eat vegetables (green salad, potatoes [excluding French fries, fried potatoes, or potato chips], carrots, or other vegetables, during the seven days before the survey)	4.7	5.1	6.6	=	5.3	6.6	7.9
% of students who drank a can, bottle, or glass of soda or pop one or more times per day (not including diet soda or diet pop, during the seven days before the survey)	18.7	16.3	15.9	=	17.4	15.1	15.1
% of students who did not drink milk (during the seven days before the survey)	13.9	14.9	20.5	↑	14.8	20.3	30.6
% of students who did not eat breakfast (during the seven days before the survey)	11.9	13.5	14.4	=	13.3	14.1	16.seven
% of students who most of the time or always went hungry because there was not enough food in their home (during the 30 days before the survey)	NA	2.seven	2.8	=	2.1	2.9	NA
% of students who were physically active at least 60 minutes per day on 5 or more days (doing any kind of physical activity that increased their heart rate and made them breathe hard some of the time during the seven days before the survey)	NA	51.5	49.0	=	55.0	22.6	55.9
% of students who watched television 3 or more hours per day (on an average school day)	18.9	18.8	18.8	=	18.3	18.2	19.8
% of students who played video or computer games or used a computer 3 or more hours per day (for something that was not schoolwork on an average school day)	38.6	43.9	45.3	=	48.3	45.9	46.1
Other							
% of students who ever had sexual intercourse	38.9	36.6	38.3	=	35.4	36.1	38.4
% of students who had eight or more hours of sleep (on an average school night)	NA	31.8	29.5	=	31.8	33.1	NA
% of students who brushed their teeth on seven days (during the seven days before the survey)	NA	69.1	66.8	=	63.0	68.2	NA

Survey Results

As noted previously, 126 community members completed the survey in communities throughout the counties in the WRHS service area. For all questions that contained an "Other" response, all of those direct responses may be found in Appendix E. 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, 85 did, revealing that a large majority of respondents (73%, N=62) lived in Hettinger with the next highest being Lemmon, South Dakota, residents (13%, N=11). These results are shown in Figure 5.

Survey Respondents' Home ZIP Code
Total respondents: 85



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.

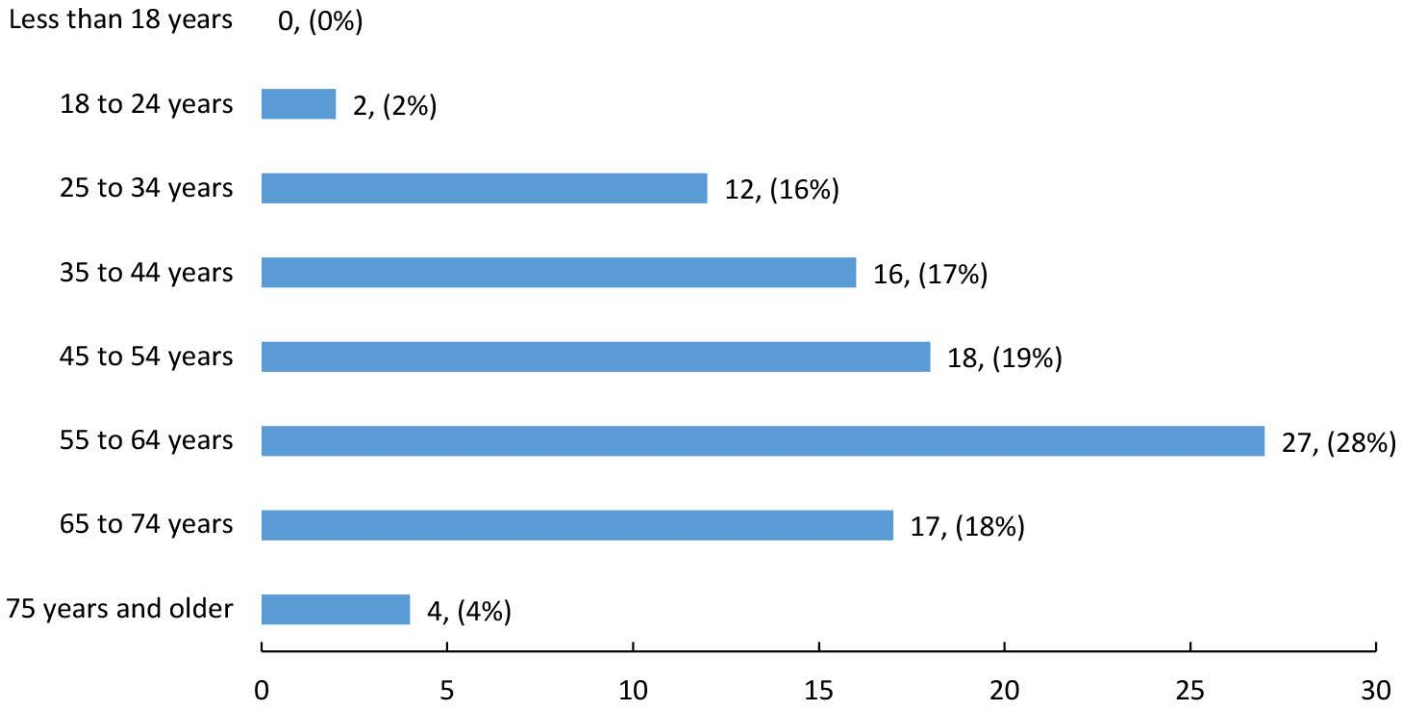
With respect to demographics of those who chose to complete the survey:

- 32% (N=31) were age 55 or older.
- The majority (76%, N=72) were female.
- Slightly more than half of the respondents (54%, N=52) had bachelor's degrees or higher.
- The number of those working full time (68%, N=63) was more than five times higher than those who were retired (13%, N=12).

- 96% (N=88) of those who reported their ethnicity/race were White/Caucasian.
- 27% (N=24) of the population had household incomes of less than $50,000.

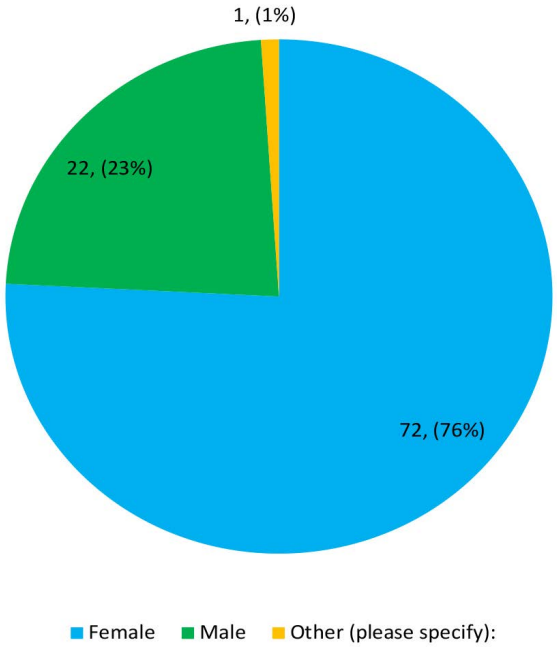
Figures 6 through 12 show these demographic characteristics. It illustrates the range of community members' household incomes and indicates how this assessment took into account input from parties who represent the varied interests of the community served, including a balance of age ranges, those in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

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



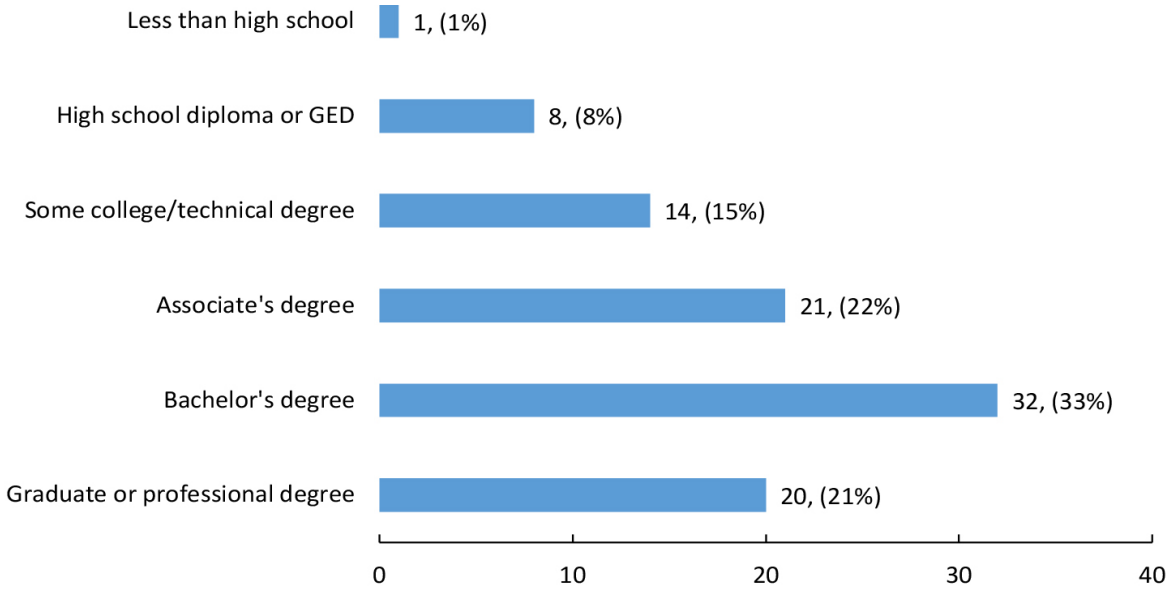
For the CHNA, people younger than age 18 are not questioned using this survey method.

Figure 7: Gender Demographics of Survey Respondents
Total respondents = 95



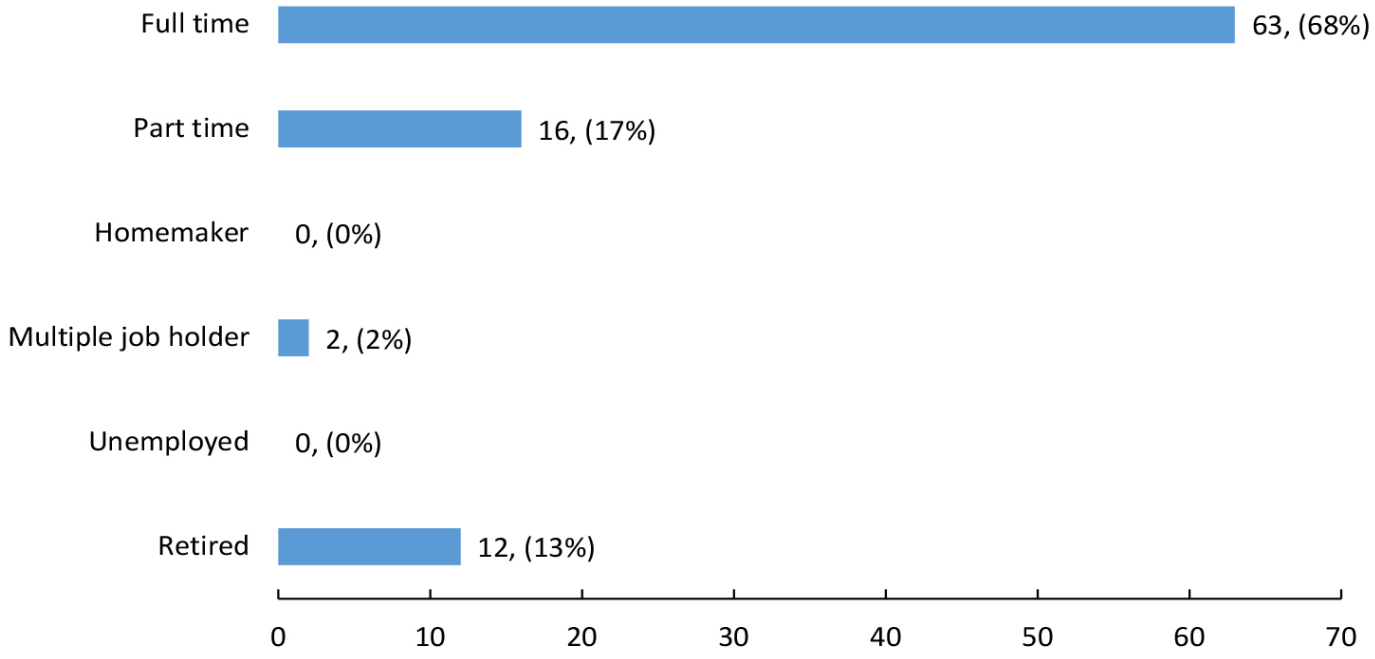
As is often the case, females were three times as likely to complete the survey as males. One responded indicated "Other" as their gender but did not provide any additional information.

Figure 8: Educational Level Demographics of Survey Respondents
Total respondents = 96



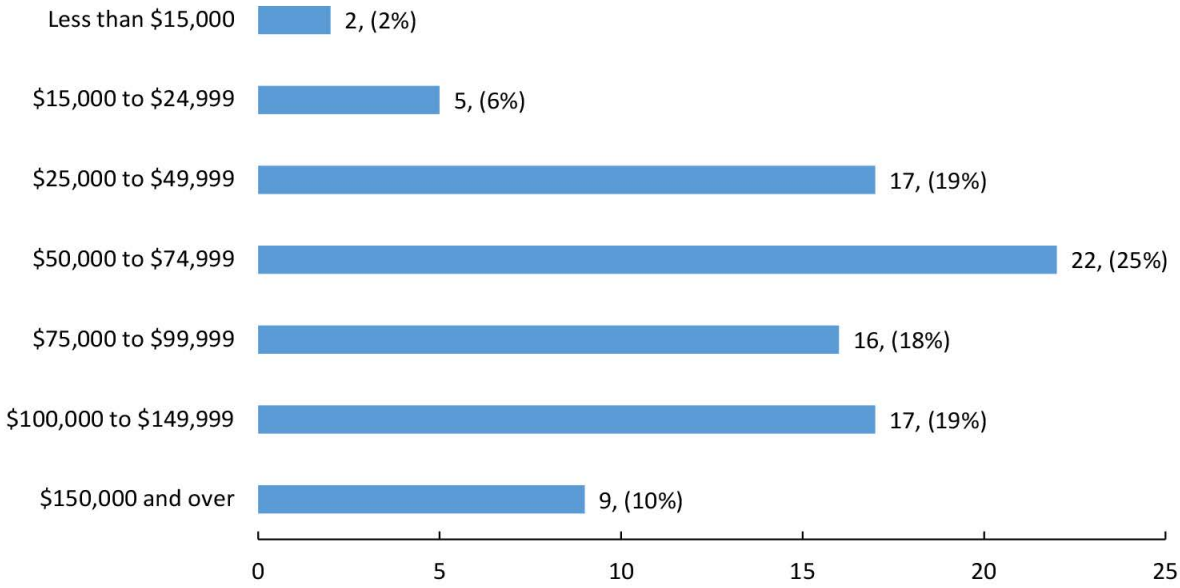
Ninety-one percent (87) of respondents had at least some college or a technical degree (Figure 8). Twelve (13%) indicated that they were retired, and all of the other survey takers reported that they worked, at minimum, part time (Figure 9).

Figure 9: Employment Status Demographics of Survey Respondents
Total respondents = 93



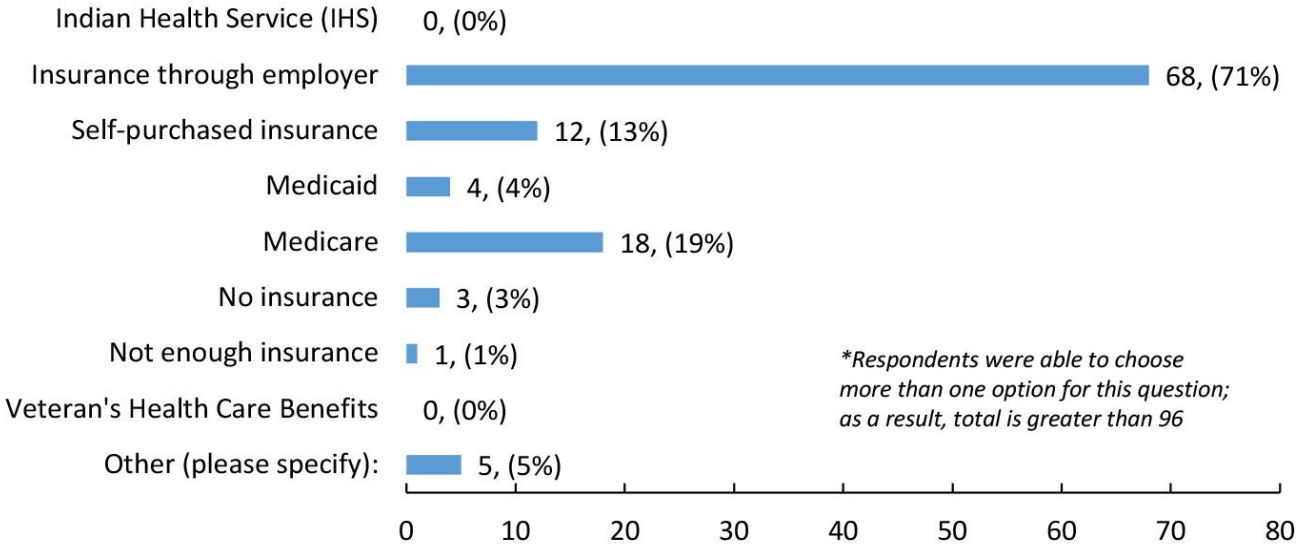
Of those who provided a household income, 8% (N=7) of community members reported a household income of less than $25,000. Twenty-nine percent (N=26) indicated a household income of $100,000 or more. This information is shown in Figure 10.

Figure 10: Household Income Demographics of Survey Respondents
Total respondents = 88



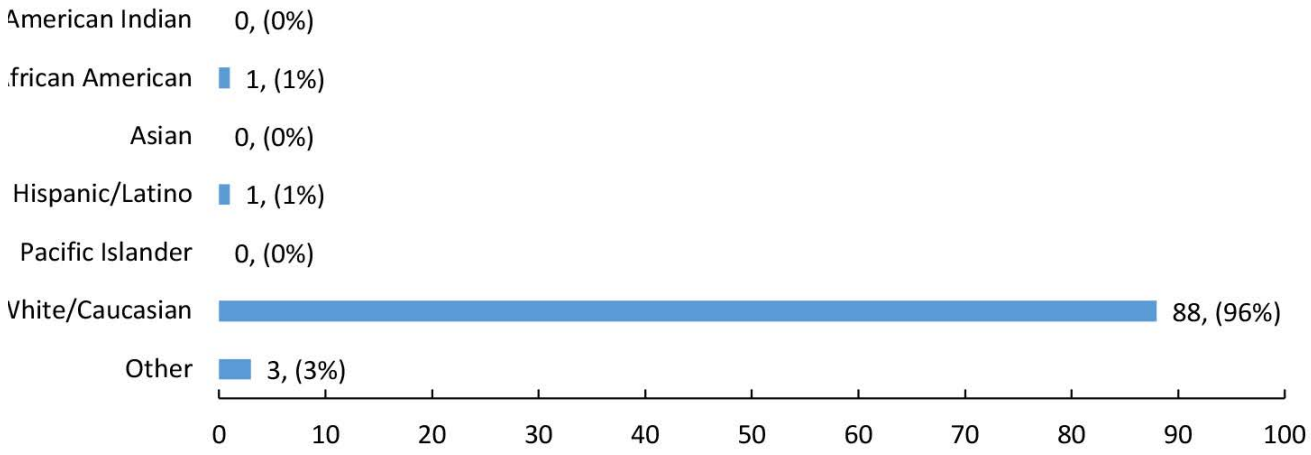
Community members were asked about their health insurance status, which is often associated with whether people have access to healthcare. Four percent (N=4) of the respondents reported having no health insurance or being underinsured. The most common insurance types were insurance through one's employer (N=68), followed by Medicare (N=18) and self-purchased (N=12). See Figure 11.

Figure 11: Health Insurance Coverage Status of Survey Respondents
Total respondents = 96*



As shown in Figure 12, nearly all of the respondents were White/Caucasian (96%). This was slightly greater than the race/ethnicity of the overall population of Adams County; the U.S. Census indicates that 92.2% of the county's population is White/Caucasian.

Figure 12: Race/Ethnicity Demographics of Survey Respondents
Total respondents = 92



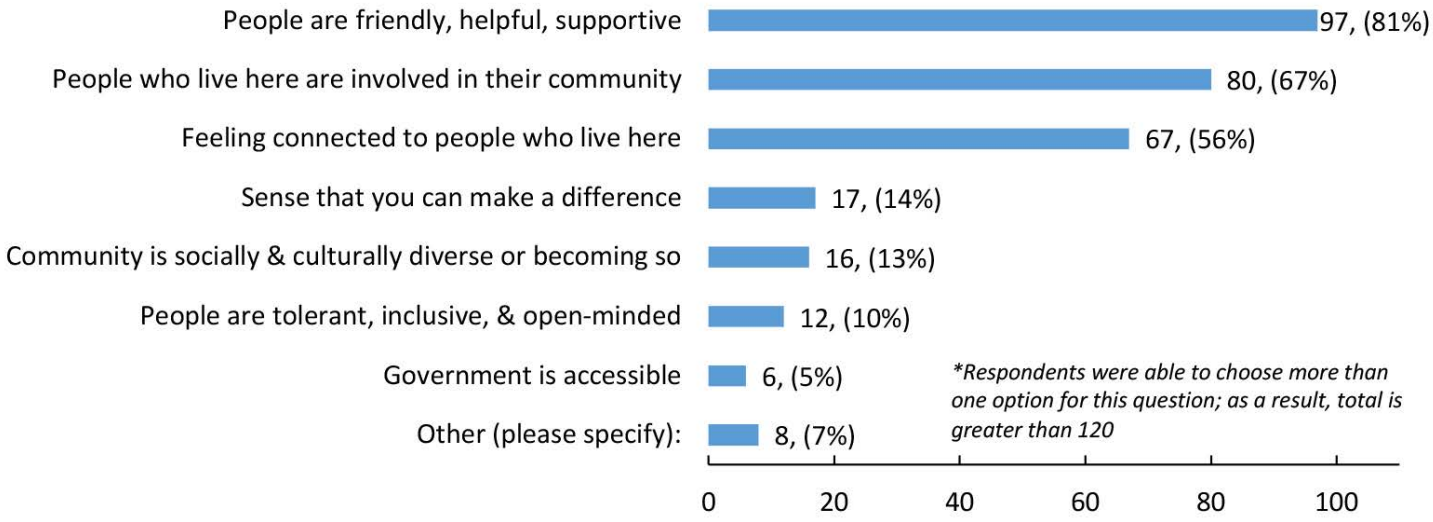
Community Assets and Challenges

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 95 respondents agreeing) that community assets include:

- Safe place to live, little/no crime (N=110);
- Healthcare (N=99);
- Family-friendly (N=99);
- People are friendly, helpful, and supportive (N=97).

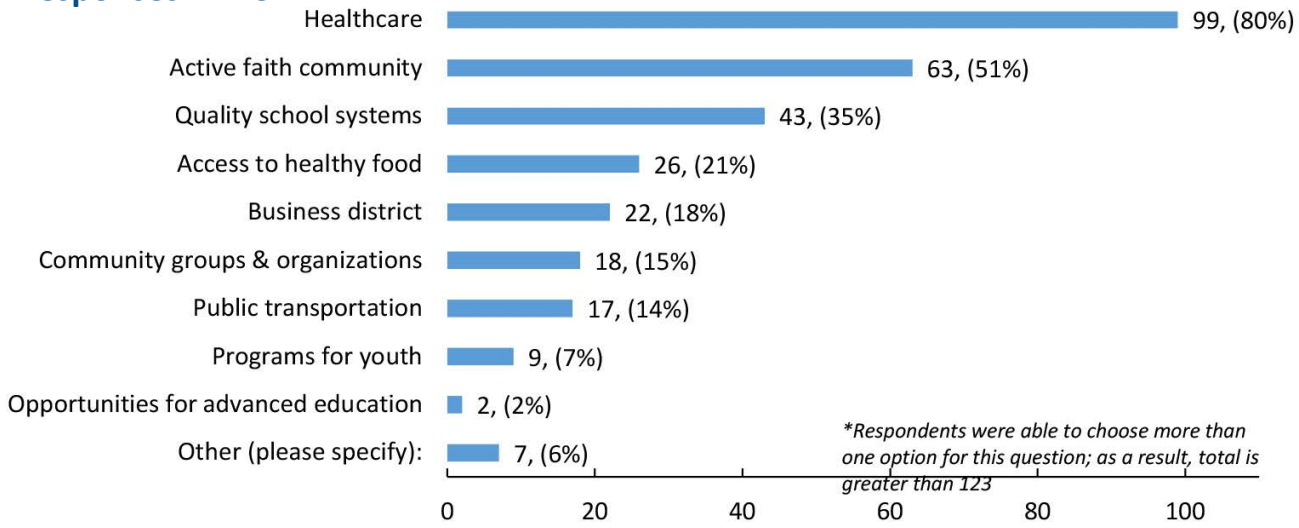
Figures 13 to 16 illustrate the results of these questions.

Figure 13: Best Things About the PEOPLE in Your Community
Total responses = 120*



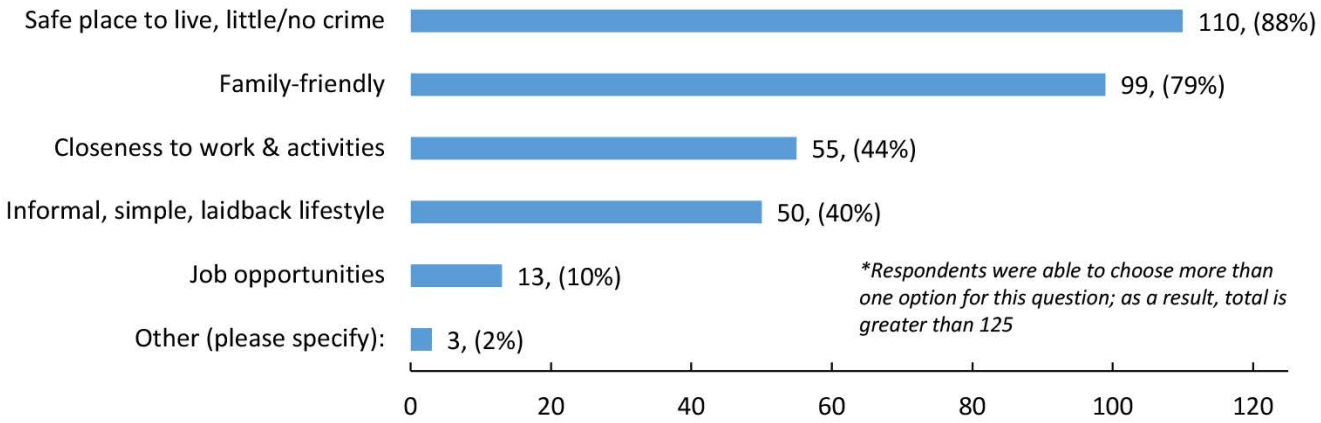
Included in the "Other" category of the best things about the people were that they care about one another, they work together, and low crime.

Figure 14: Best Things About the SERVICES AND RESOURCES in Your Community
Total responses = 123*



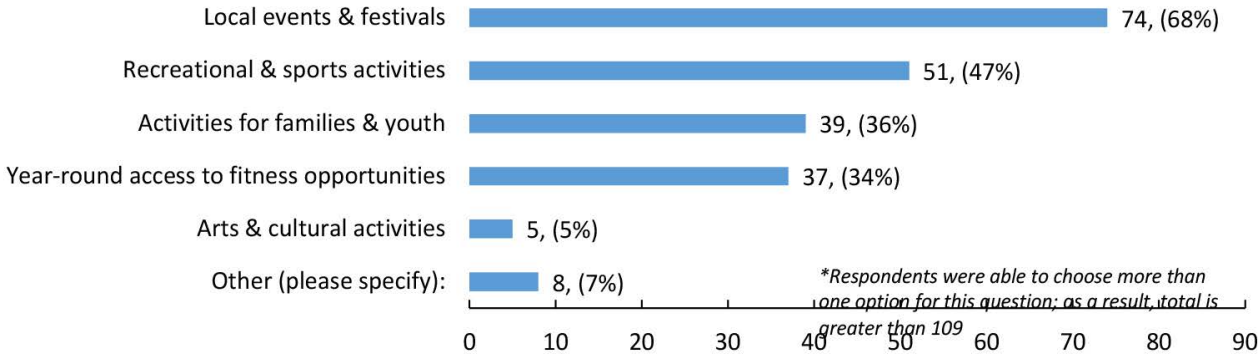
Respondents who selected "Other" specified that the library, clothes closet, radio station, the museum, and parks were among some of the best resources in the community.

Figure 15: Best Things About the QUALITY OF LIFE in Your Community
Total responses = 125*



For the "Other" responses, one community member stated that healthcare was one of the best aspects about quality of life in the area.

Figure 16: Best Thing About the ACTIVITIES in Your Community
Total responses = 109*



While some respondents who selected "Other" specified that COVID-19 had disrupted many activities, others mentioned the 4th of July tradition, golf, and school activities and athletics are some of the best activities in the community.

Community Concerns

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

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

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

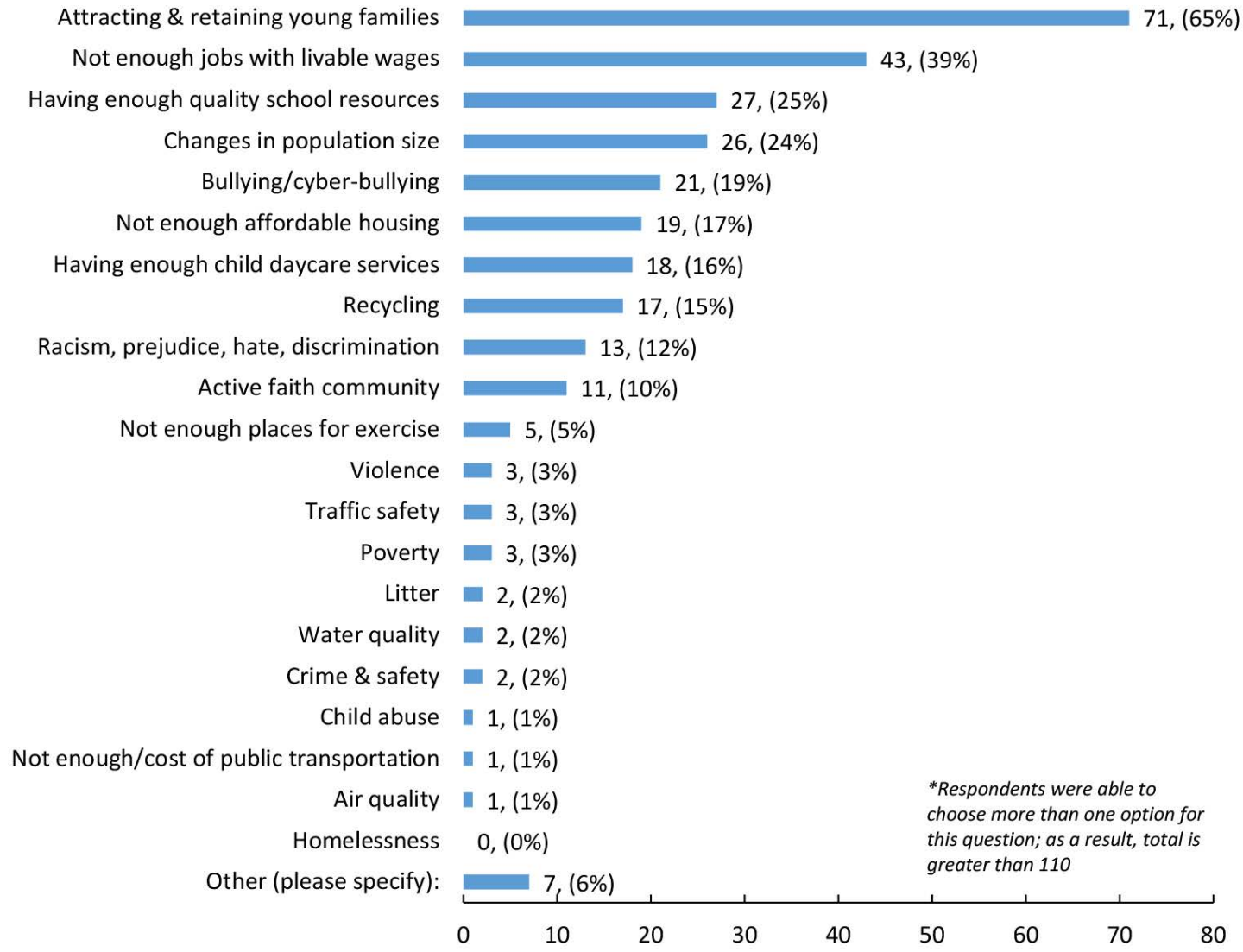
- Attracting and retaining young families (N=71)
- Alcohol use and abuse – Adults (N=55)
- Alcohol use and abuse – Youth (N=52)
- Depression/anxiety – Adults (N=49)
- Ability to retain physicians and nurses in the community (N=48)
- Not enough jobs with livable wages, not enough to live on (N=43)
- Cost of long-term/nursing home care (N=42)
- Stress – Adults (N=42)
- Depression/anxiety – Youth (N=41)

The other issues that had at least 25 votes included:

- Not enough activities for children and youth (N=39)
- Depression/anxiety – Seniors (N=38)
- Availability of resources to help the elderly stay in their homes (N=34)
- Long-term/nursing home care options (N=32)
- Smoking and tobacco use, exposure to secondhand smoke, or vaping/juuling – Youth (N=32)
- Cost of health insurance (N=31)
- Not enough healthcare staff in general (N=31)
- Ability to meet the needs of the older population (N=28)
- Having enough quality school resources (N=27)
- Changes in population size (N=26)
- Drug use and abuse (including prescription drugs) – Youth (N=26)
- Not getting enough exercise/physical activity – Youth (N=25)

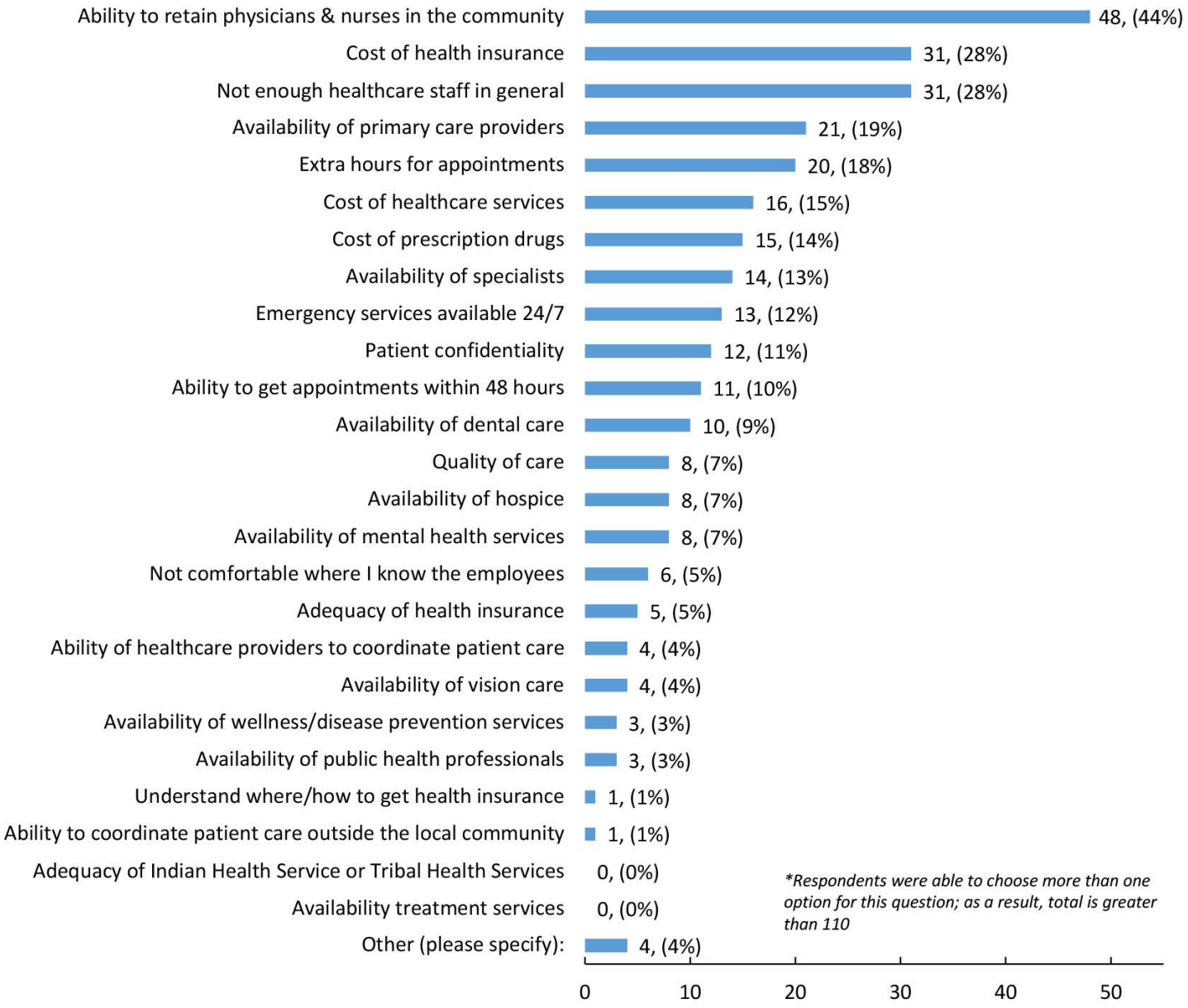
Figures 17 through 21 illustrate these results.

Figure 17: Community/Environmental Health Concerns
Total responses = 110*



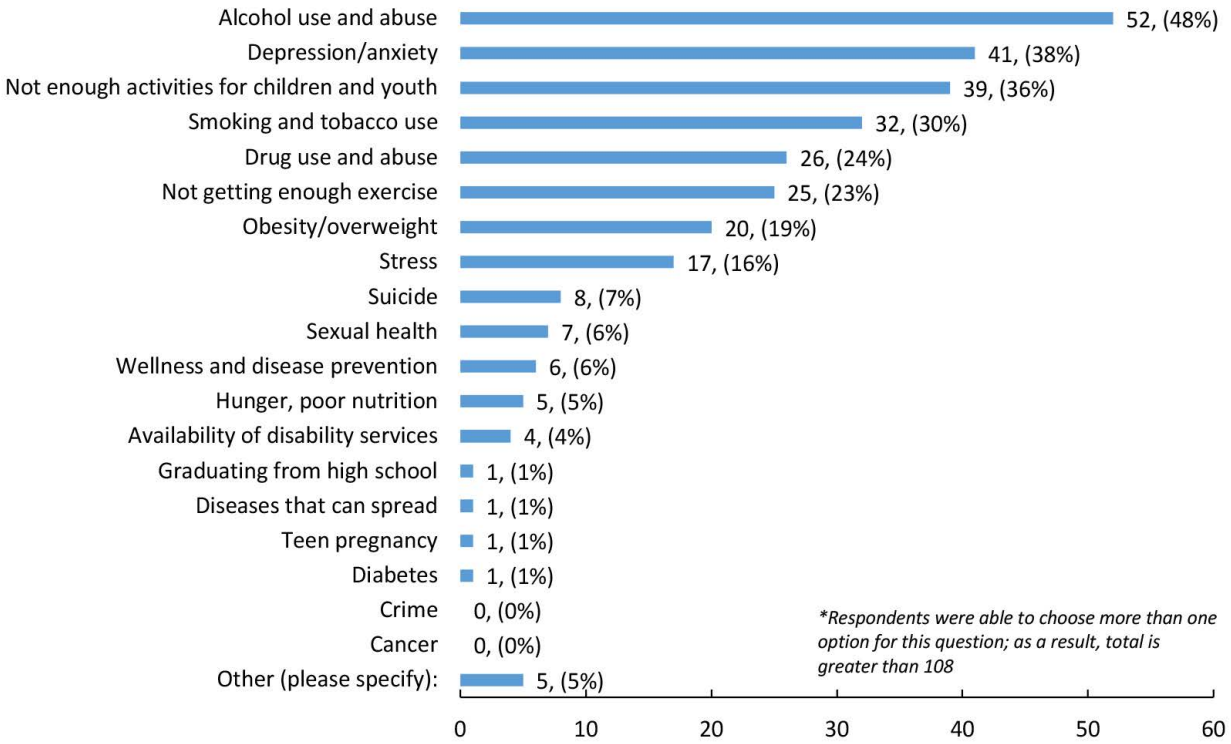
In the "Other" category for community and environmental health concerns, the following were listed: no/few activities for children outside of school, people not willing to work local jobs, poor efforts by the chamber and community to attract manufacturing, anti-intellectualism and not enough media literacy, and a reliance on the government.

Figure 18: Availability/Delivery of Health Services Concerns
Total responses = 110*



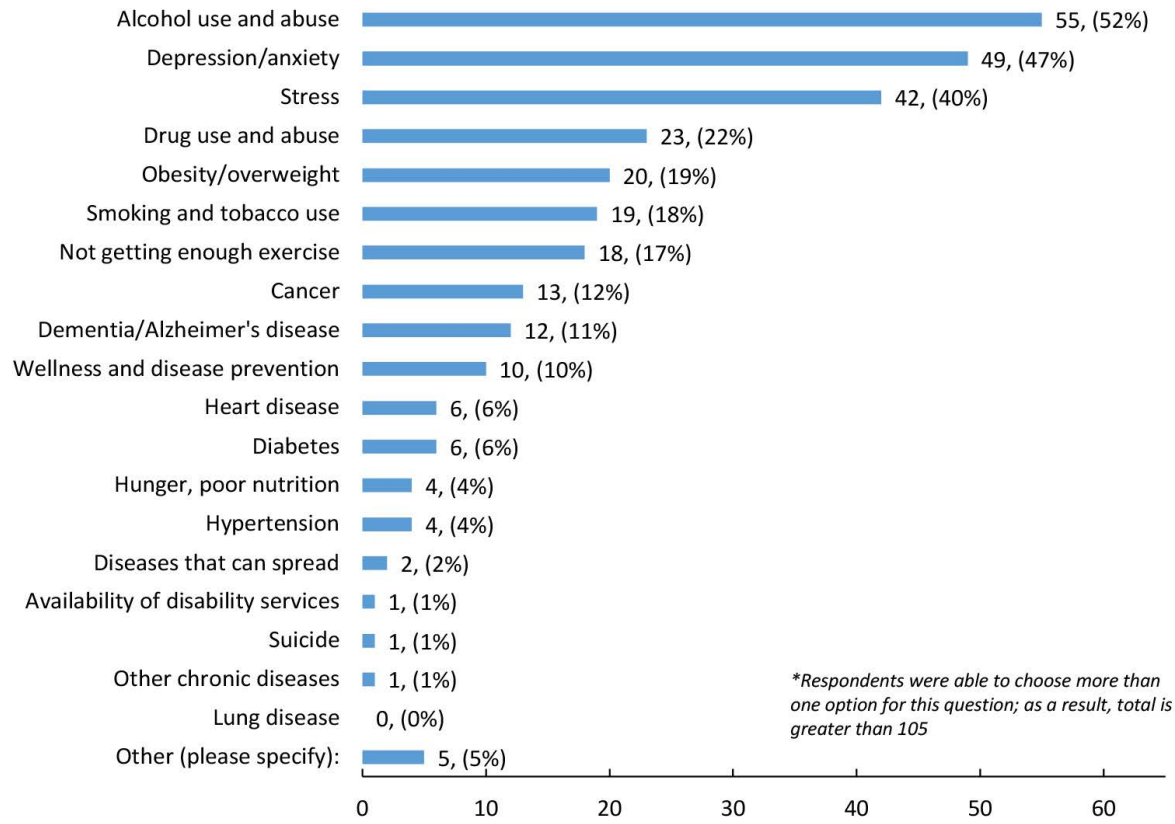
Respondents who selected "Other" identified concerns in the availability/delivery of health services stated that there are issues with the hospital not accepting state employee vision insurance, there is no energy medicine and not enough training in vitamins and healthy eating, the hospital is afraid to see patients unless they are screened for COVID-19, and simply "oncology services."

Figure 19: Youth Population Health Concerns
Total Responses = 108*



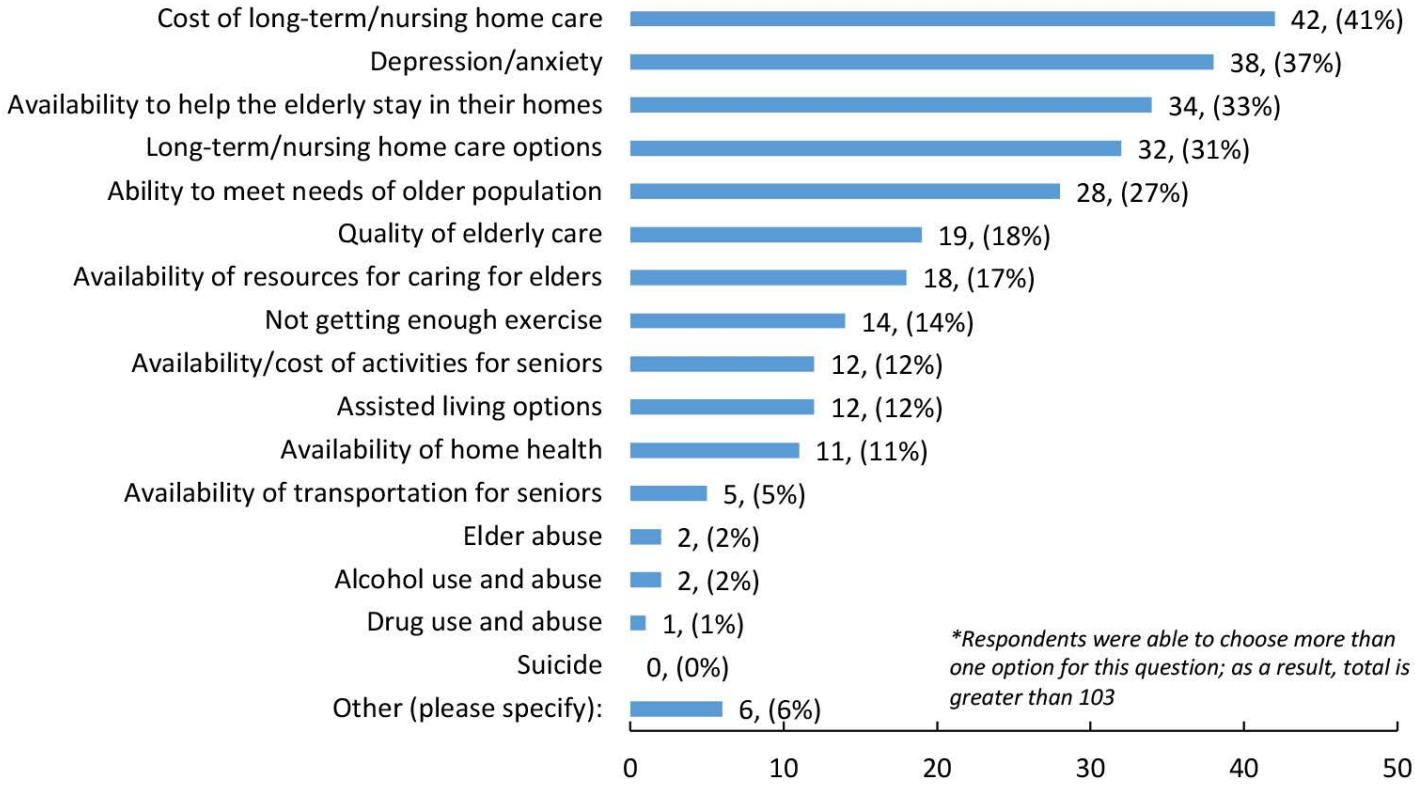
Listed in the "Other" category for youth population concerns were bullying, ignorance toward the larger world, and the Gardasil vaccine (and others) and their side effects.

Figure 20: Adult Population Concerns
Total responses = 105*



Disregard for COVID-19 guidelines, bullying, sexism, isolation, and iatrogenic diseases were indicated in the "Other" category for adult population concerns.

Figure 21: Senior Population Concerns
Total responses = 103*



In the "Other" category, the availability of durable medical equipment, enough staffing for the nursing home, COVID-19, fraud schemes that target the elderly, lack of access to technology, and treating everything with a drug instead of finding the cause were listed as senior population concerns.

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. COVID-19/community disregarding of COVID-19 guidelines
2. Attracting and retaining new families/businesses

Other biggest challenges that were identified were healthcare facilities being understaffed, not enough activities/amenities, the community not working together, local government not invested in the community's economic future, alcohol abuse, cost of health services, and lack of opportunities.

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 providers over time (N=32), with the next highest being not enough providers (MD, DO, NP, PA) and nurses (N=26). After these, the next most commonly identified barriers were having limited/no insurance (N=25), not able to get appointments/limited hours (N=24), and not enough weekend/evening hours (N=21). Several comments were concerned about the quality of care at the hospital, while other responses pointed to stigma, lack of time, concerns about confidentiality, long wait periods, fear over COVID-19, and not wanting to see a doctor who will treat using drugs and offers other options first.

Figure 22 illustrates these results.

Figure 22: Perceptions about Barriers to Care
Total responses = 92*

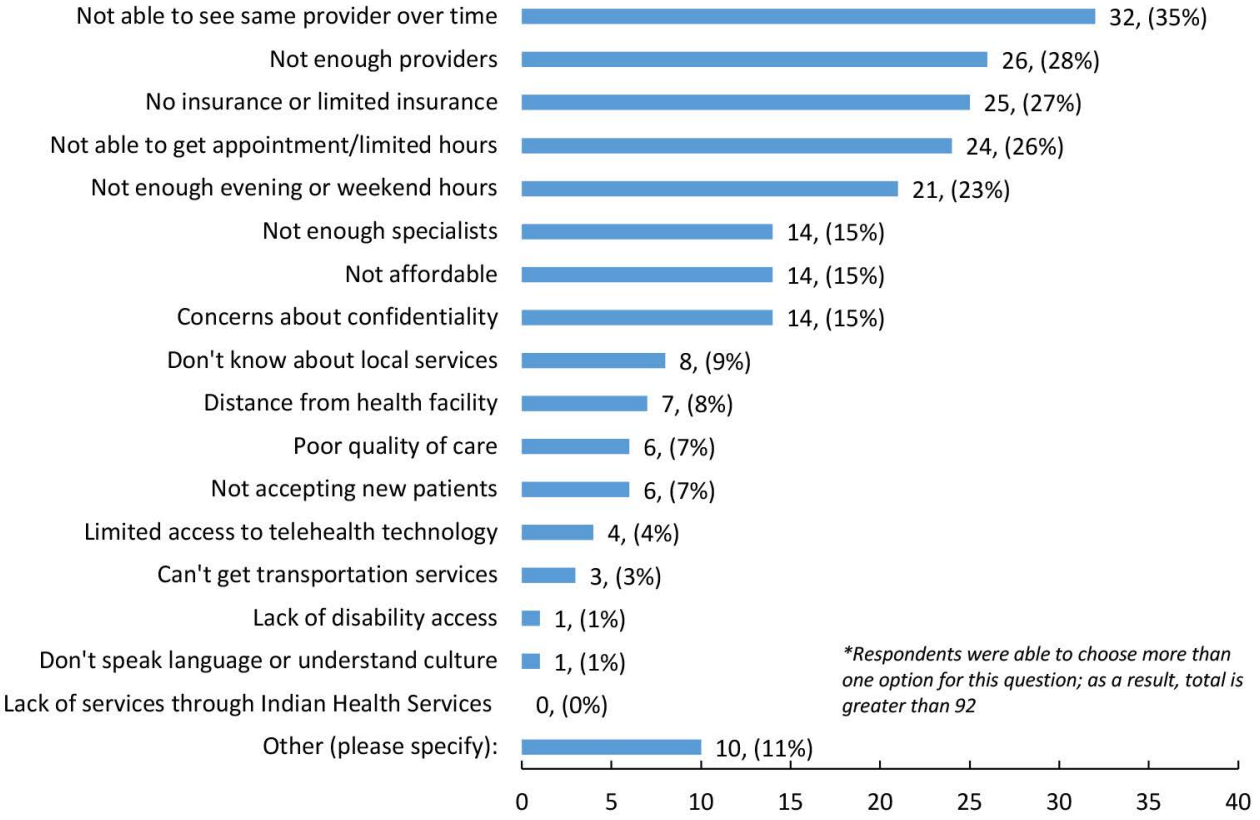
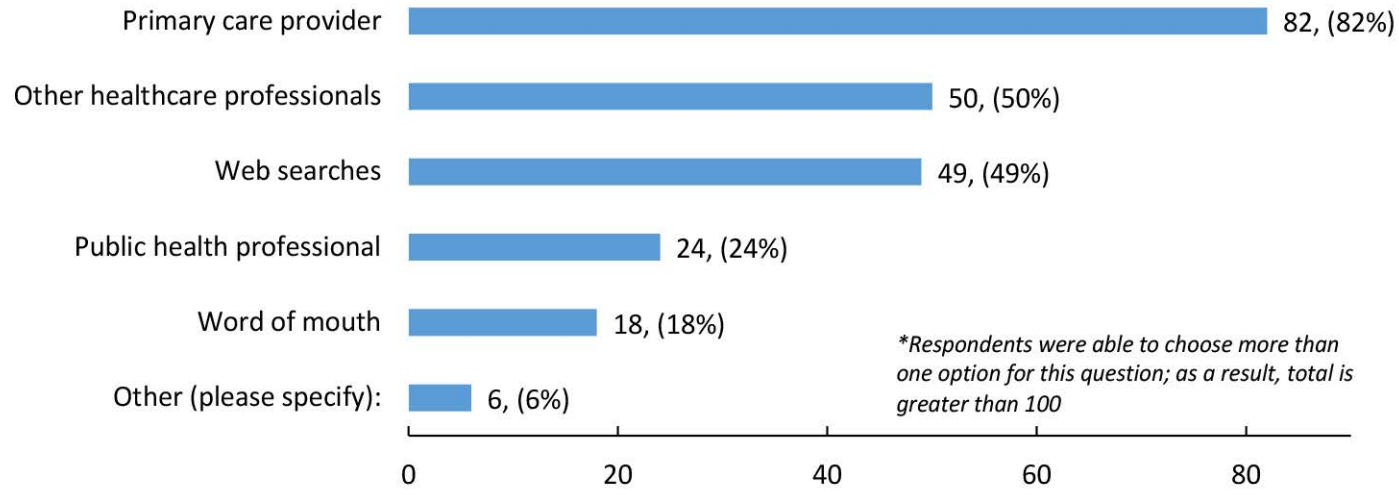


Figure 23 shows the results from asking respondents where they are most likely to seek out trustworthy health information.

Figure 23: Sources of Trusted Health Information
Total responses = 100*



"Other" responses for sources of trusted health information included literature, peer-reviewed articles, social media sites and the internet in general, and other facilities in the area.

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 oncology. Other requested services included:

- Addiction counseling
- Chiropractic services
- Dental services
- Dermatology
- Dialysis
- ENT services
- Home health
- Hospice
- Mental health services
- Ophthalmology
- Physical therapy
- Podiatry
- Social work
- Transportation
- Urgent care

While not services, many respondents indicated they would like more healthcare staff in general added, particularly specialists and physicians. Consistency with providers was also mentioned in support of adding physicians, stating a preference to see the same provider during multiple visits. Several respondents used this portion of the survey to mention that the quality of care also needs to be improved.

Although the key informants generally felt that the community members were aware of the majority of the health system and public health services, there were several services that were mentioned of which the interviewees were unaware. It was felt that the hospital should increase marketing efforts of several services too, including letting community members know specialists' schedules, gynecological services, mental/behavioral health services, and generally helping community members to better understand the scope of services offered by their providers as opposed to going straight to a specialist.

Community members were given a list of services not currently offered by WRHS and asked to prioritize their addition to the facility. Figure 24 shows these results.

Figure 24: Priority Services to Add
Total responses = 82

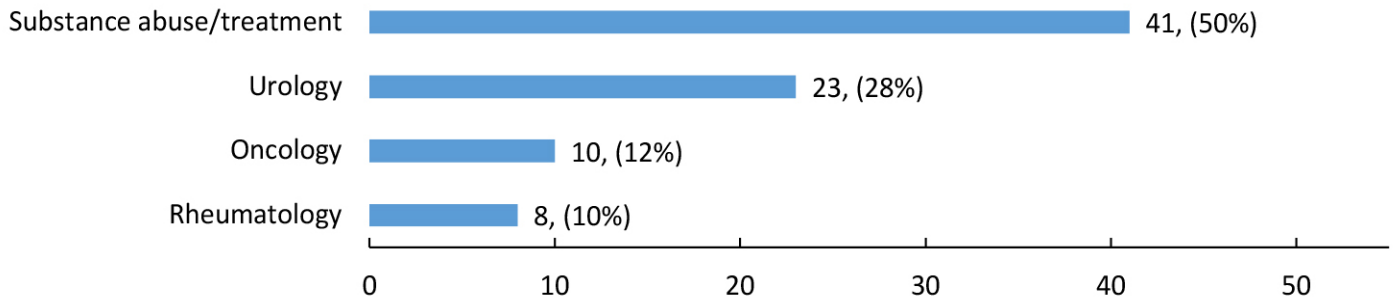
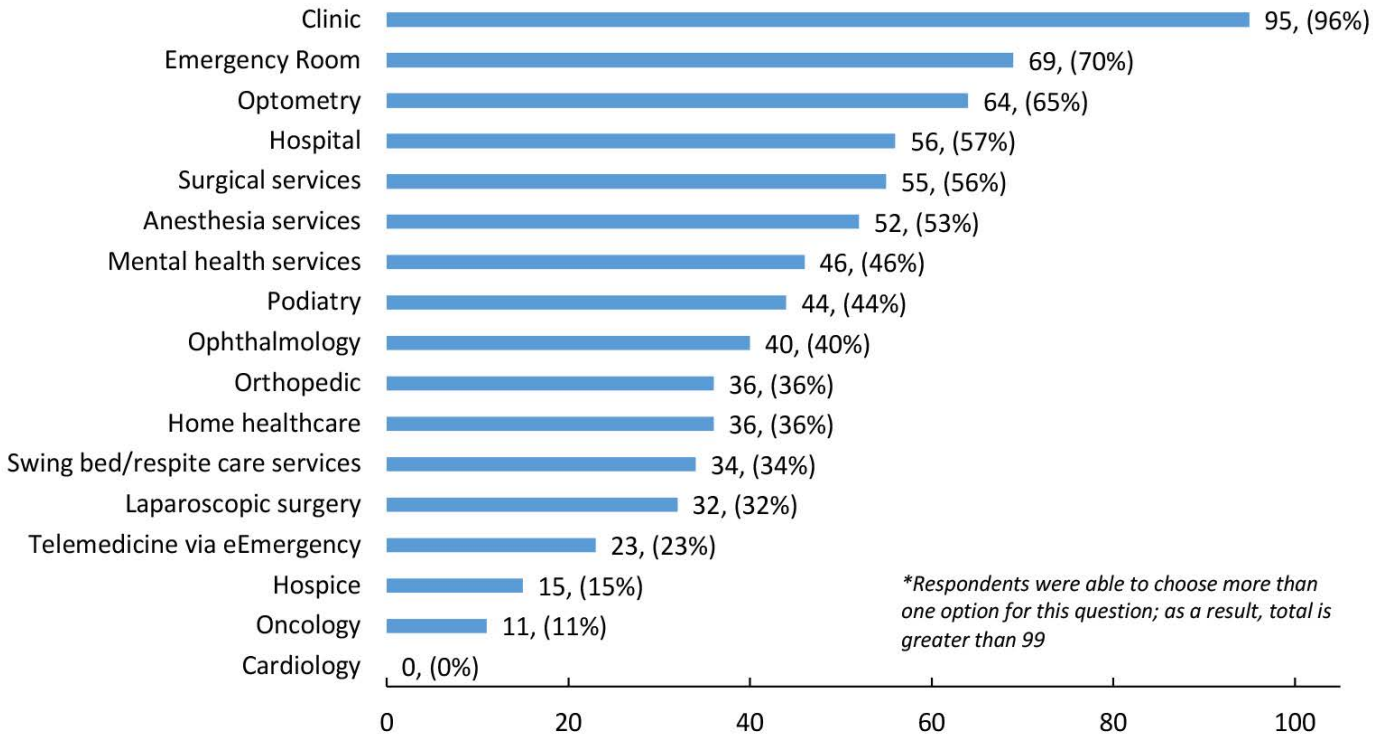


Figure 25 shows the results from asking community members of their awareness and utilization of general and acute services offered by WRHS during the past year.

Figure 25: Awareness of General and Acute Services
Total responses = 99*



Respondents were asked to rate their inclination to receive telemedicine care, via several different mediums, on a scale of one (not inclined) to five (very inclined). These results are shown in Figure 26.

Figure 26: Inclination to Receive Telemedicine Care
Total responses = 160

	Ranking (1 being least inclined, 5 being most inclined)				
Medium	**1**	**2**	**3**	**4**	**5**
Telephone only	20 (20%)	11 (11%)	25 (26%)	14 (29%)	28 (29%)
Videoconference	2 (13%)	7 (8%)	16 (17%)	27 (29%)	31 (33%)
Via phone/tablet app with health monitoring capability	13 (14%)	10 (11%)	17 (18%)	23 (24%)	32 (34%)
Other	4 (57%)	0	1 (14%)	0	2 (29%)

Respondents were also asked to rate, on the same scale, the importance of extended hours and services. Results are shown in Figure 27.

Figure 27: Importance of Services
Total responses = 391

	Ranking (1 being least important, 5 being most important)				
Service/times	**1**	**2**	**3**	**4**	**5**
Extended morning clinic hours	12 (13%)	22 (24%)	26 (29%)	17 (19%)	14 (15%)
Extended evening clinic hours	4 (4%)	11 (12%)	18 (20%)	35 (39%)	23 (25%)
Skilled nursing services, such as long-term care	1 (1%)	6 (7%)	6 (7%)	31 (34%)	48 (52%)
Increased assisted living capacity	2 (2%)	6 (7%)	15 (16%)	30 (32%)	40 (43%)
Basic care services (step between assisted living and long-term care)	4 (4%)	6 (7%)	15 (16%)	38 (41%)	30 (32%)

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 recruitment and retention of WRHS employees, pointing to the need for more providers and healthcare staff in general, including specialists. While certain services such as dialysis and oncology were mentioned, the responses heavily favored adding physicians and nurses to the WRHS staff.

In relation to access/availability of healthcare, extended services hours were requested. One community member referenced concerns regarding trust with providers with such limited choices, and another comment stated that confidentiality was also a concern.

Several respondents felt that WRHS does a great job, particularly lauding the doctors, and were grateful for the serviced provided to the area.

Findings from Key Informant Interviews

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 members and health professionals. 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 can be grouped into five categories (listed in alphabetical order):

- Alcohol use and abuse – all ages
- Attracting and retaining young families
- Depression/anxiety – all ages
- Drug use and abuse – all ages
- Retaining primary care physicians and nurses

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

Alcohol use and abuse

- Sober living and peer supports to address alcohol abuse would be great
- This issue affects families and kids

Attracting and retaining young families

- If we want quality health providers, we need to be attractive to young families. There is not enough for families and kids to do, our pool is broken and isn't going to be repaired, and our golf course may not reopen in the spring
- We need to have young people living in town to keep it going

Depression/anxiety

- With how isolated we have become, it is impacting people mentally, whether they realize it now or not, and people don't want to admit it or get help but it also impacts those around them
- For many different reasons, but all ages are going through it; people in all groups are struggling with it and you see that and are aware of it on a daily basis

Drug use and abuse

- It is difficult to find services locally. Great professionals, but it is outpatient and sometimes more aggressive treatments (inpatient) are needed to be more effective

Retaining primary care providers

- You can't do the rest without those providers in the community
- Hospital relies a lot on PAs and students, but they don't stay around long; too many experiences with doctors leaving within months—no continuity of care

Community Engagement and Collaboration

Key informants were asked to weigh in on community engagement and collaboration of various organizations and stakeholders in the community. Specifically, participants were asked, "On a scale of 1 to 5, with 1 being no collaboration/community engagement and 5 being excellent collaboration/community engagement, how would you rate the collaboration/engagement in the community among these various organizations?" This was not intended to rank services provided. They were presented with a list of 13 organizations or community segments to score. According to these participants, the hospital, emergency services, and economic development are the most engaged in the community. The averages of these scores (with 5 being "excellent" engagement or collaboration) were:

- Hospital (healthcare system) (4.25)
- Emergency services, including ambulance and fire (4.25)
- Economic development organizations (4.0)
- Schools (3.75)
- Business and industry (3.75)
- Social services (3.75)
- Law enforcement (3.5)
- Long-term care, including nursing homes and assisted living (3.5)
- Other local health providers, such as dentists and chiropractors (3.5)
- Faith-based (3.25)
- Public health (3.0)
- Pharmacy (2.75)
- Human services agencies (2.5)

Priority of Health Needs

A community group that consisted of the key informant interviewees was sent a prerecorded presentation on January 5, 2021. The presentation included CRH representatives presenting the interviewees with a summary of this report's findings, including background and explanation about the secondary data, highlights from the survey results (including perceived community assets and concerns and barriers to care), and findings from the key informant interviews.

Following the community group viewing the prerecorded presentation of the assessment findings, they completed an online survey in which they identified what they perceived as the top four community health needs. All of the potential needs were included in the online survey, and each member checked the four needs they considered the most significant. They were also given the opportunity to leave comments.

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

- Attracting and retaining young families (8 votes)
- Ability to retain primary care providers (MD, DO, NP, PA) and nurses (6 votes)
- Not enough jobs with livable wages (5 votes)
- Availability of primary care providers (MD, DO, NP, PA) and nurses (4 votes)

From those top four priorities, each person was emailed a second survey and was instructed to select the one item they felt was the most important. The rankings were:

1. Attracting and retaining young families (6 votes)
2. Ability to retain primary care providers (MD, DO, NP, PA) and nurses (3 votes)
3. Not enough jobs with livable wages (2 votes)
4. Availability of primary care providers (MD, DO, NP, PA) and nurses (2 votes)

Following the prioritization process, the number one identified need was attracting and retaining young families. A summary of this prioritization may be found in Appendix F.

Comparison of Needs Identified Previously

Top Needs Identified 2018 CHNA Process	Top Needs Identified 2021 CHNA Process
• Obesity/overweight	• Attracting and retaining young families
• Availability of substance abuse/ treatment services	• Availability of primary care providers (MD, DO, NP, PA) and nurses
• Cancer	• Ability to retain primary care providers (MD, DO, NP, PA) and nurses
• Attracting and retaining young families	• Not enough jobs with livable wages
• Adult alcohol use and abuse (including binge drinking)	

The current process did identify one identical common need from 2018. Attracting and retain young families continues to remain a concern that the community feels is important to continue to address.

Hospital and Community Projects and Programs Implemented to Address Needs Identified in 2018

In response to the needs identified in the 2018 CHNA process, the following actions were taken:

Need 1: Obesity/overweight – WRHS has expanded its wellness education services and utilized educators in diabetes, nutrition, and ideal protein services to assist the community in obtaining a healthy weight. The WRHS Rehab Center donated all of its fitness equipment to the city of Hettinger for use at the new fitness center in the Hettinger Armory. An Annual Fun Run has been implemented and held every Fourth of July, while fit camps for adults and kids in the area have also been presented to the community, in addition to the Hettinger Pool hosting free-of-charge swim times.

Need 2: Availability of substance abuse treatment Services – Medical staff have been utilized to properly support the needs of community members, and WRHS has worked with local churches and support groups to allow options for patients unwilling to seek medical care. The hospital's respiratory therapist was also trained to hold smoking cessation classes for patients.

Need 3: Cancer – WRHS continues to work with larger facilities to provide chemotherapy for patients in the service area. A tertiary partnership was established to start an oral chemotherapy program but was put on hold due to COVID-19. It is set to resume in spring 2021. Communities Kicking Cancer, a local nonprofit organization, also donated gas cards to ease patients' travel costs for out-of-area chemotherapy treatment.

Need 4: Attracting and retaining young families: Staff at WRHS have been encouraged to be more involved with the community so young families see an organization that fits their values, and "Community Benefit Time" has been implemented for employees to be more active in the community. Sign-on bonuses continue to be offered for new hires at WRHS, and a Dakota Nursing Program was started at the hospital to train the nursing staff locally. The WRHS Foundation also partnered with local stakeholders to install a seasonal ice-skating rink.

Need 5: Adult alcohol use and abuse (including binge drinking) – WRHS worked with the Nighthawk Drug and Alcohol Coalition to provide fun, alcohol-free activities for the youth in the area, and the hospital looks to hire an addiction counselor in the future.

The implementation plan just described for West River Health Services is posted on the WRHS website at https://www.wrhs.com/images/pdf/CHNA_Report_Hettinger-FINAL.pdf#page=53.

Next Steps – Strategic Implementation Plan

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

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

Community Benefit Report

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

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

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

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

What Are Community Benefits?

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

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

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

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

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

Appendix A – Critical Access Hospital Profile

Critical Access Hospital Profile
Spotlight on: Hettinger, North Dakota

WEST RIVER HEALTH SERVICES®

Quick Facts

Current Administrator:
Matthew R Shahan

Chief Medical Officer:
Dr. Catherine Houle

Board Chair:
Charley Reisenauer

City Population: 1,152

County Population: 2,311

County Median Household Income: $54,875

County Median Age: 45.6 years

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:
Jobs:
Primary - 222.2
Secondary - 42
Total - 313

Financial Impact:
Primary - $15.9 million
Secondary - $3.6 million
Total - $19.5 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 & Nutrition Services
- Geriatric Medicine
- Health Library
- 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)
- Optometric Services *(West River Eye Center)*
- Palliative Care
- Pediatric Care
- Pediatric Medicine
- Pharmacy
- Podiatric Services
- Rehabilition *(Physical, Occupational & Speech)*
- Respiratory Therapy Services
- Supporting Foundation *(West River Health Services Foundation)*
- Surgical Services (Laparoscopic surgery for stomach & esophagus, endrocrine, hernia, appendix &

Staffing

Physicians: 14
Midlevels 13
RNs: 71
LPNs: 15
Total Employees: 305

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; 2010 Profile of General and Housing Characteristics

[2] US Census Bureau; 2010 State and County QuickFacts: Adams County, ND

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

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

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

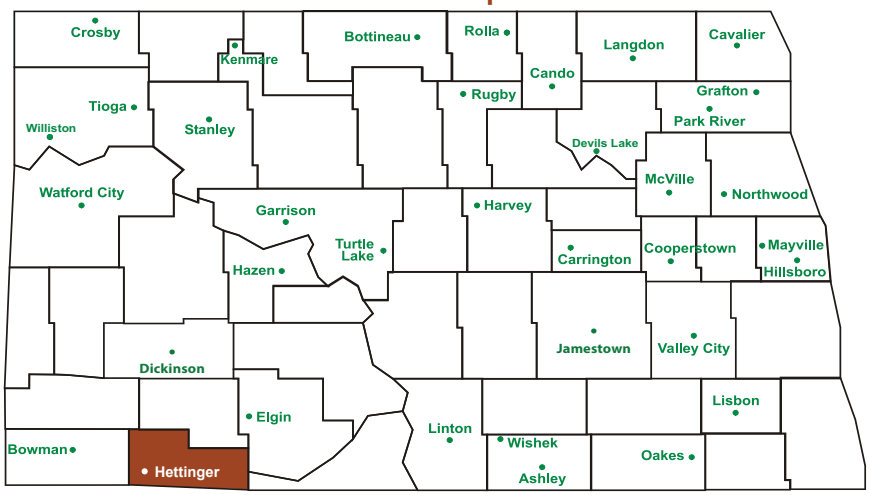
ruralhealth.und.edu

gallbladder, Sentinel lymph node biopsy, Inpatient surgery, General surgery, Orthopedic surgery, Ophthalmology, Pain management, Podiatry, Ear, nose & throat (ENT)
- Gynecological/Cesarean
- Swing Bed
- Telemedicine
- Visiting Nurses
- Rehabilitation & Wellness Center
- WIC (Women, Infant & 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, & 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 & 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 1/21

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

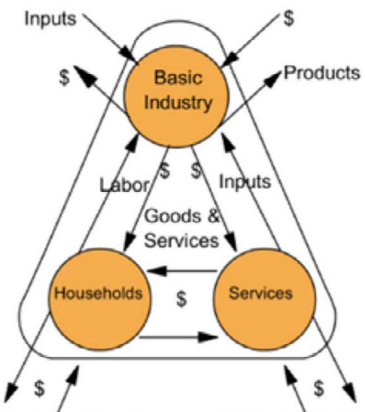
The health sector in a rural community, anchored by a CAH, is responsible for a number of full- and part-time jobs and the resulting wages, salaries, and benefits. Research findings from the National Center for Rural Health Works indicate that rural hospitals typically are one of the top employers in 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

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

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

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CENTER FOR RURAL HEALTH
OSU Center for Health Sciences

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

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

Appendix C – CHNA Survey Instrument

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

WEST RIVER HEALTH SERVICES

Hettinger Area Health Survey

West River Health Services are interested in hearing from you about community health concerns.

The focus of this effort is to:

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

If you prefer, you may take the survey online at http://tinyurl.com/HettingerND20 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 Shawn Larson at 701.330.0224.

Surveys will be accepted through November 26, 2020. Your opinion matters – thank you in advance!

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

_____

_____

Delivery of Healthcare

11. 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): _____

12. 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): _____

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

_____

_____

14. Which of the following services not currently offered at West River Health Services do you think should be a priority?

- ☐ Substance abuse treatment
- ☐ Urology
- ☐ Rheumatology
- ☐ Oncology

15. 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)

- ☐ Anesthesia services
- ☐ Cardiology (visiting specialist)
- ☐ Clinic
- ☐ Emergency room
- ☐ Home health care
- ☐ Hospice
- ☐ Hospital (acute care)
- ☐ Laparoscopic surgery
- ☐ Mental health services
- ☐ Oncology (visiting specialist)
- ☐ Ophthalmology (eye/vision) (visiting specialist)
- ☐ Optometry
- ☐ Orthopedic (visiting specialist)
- ☐ Podiatry (foot/ankle) (visiting specialist)
- ☐ Surgical services
- ☐ Swing bed and respite care services
- ☐ Telemedicine via eEmergency

16. On a scale of 1 (being least likely) to 5 (being most likely), how inclined are you to receive Telemedicine care via the following:

	1	2	3	4	5
Telephone only	○	○	○	○	○
Videoconference	○	○	○	○	○
Via phone/tablet app with health monitoring capability	○	○	○	○	○
Other (please specify):_____	○	○	○	○	○

17. On a scale of 1 (being least likely) to 5 (being most likely), how important is it to the community and surrounding areas to have the following services:

	1	2	3	4	5
Extended morning clinic hours	○	○	○	○	○
Extended evening clinic hours	○	○	○	○	○
Skilled nursing services such as long-term care	○	○	○	○	○
Increased assisted living capacity	○	○	○	○	○
Basic care services (step between assisted living and long-term care)	○	○	○	○	○

Demographic Information: Please tell us about yourself.

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

☐ Yes ☐ No

19. 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): _____

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

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

21. 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

22. 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

23. Sex:

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

24. Employment status:

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

25. Your zip code: _____

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

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

27. 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

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

_____

_____

Thank you for assisting us with this important survey!

Appendix D – County Health Rankings Explained

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

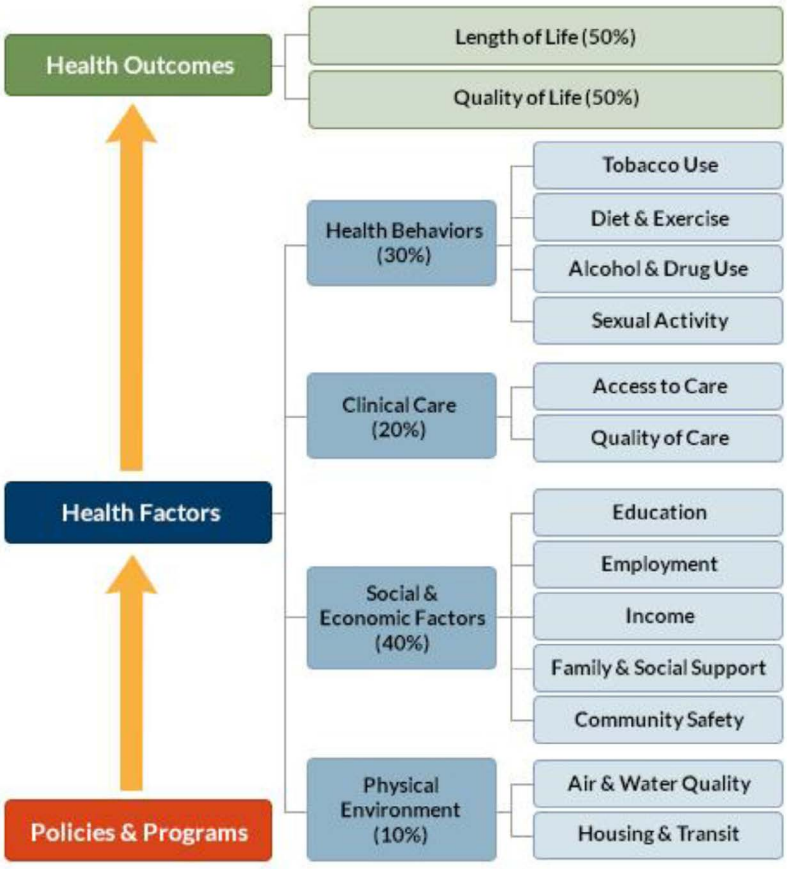
Methods

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

What is Ranked

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

Ranking System



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

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

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

Data Sources and Measures

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

Data Quality

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

Calculating Scores and Ranks

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

Health Outcomes and Factors

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

Health Outcomes

Premature Death (YPLL)

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

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

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

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

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

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

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

Health Factors

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

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

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

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

Food Environment Index

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

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

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

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

Reason for Ranking

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

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

Physical Inactivity

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

Reason for Ranking

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

Access to Exercise Opportunities

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

Individuals who:

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

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

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

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

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

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

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

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

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

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

Uninsured

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

Reason for Ranking

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

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

Primary Care Physicians

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

Reason for Ranking

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

Dentists

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

Reason for Ranking

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

Mental Health Providers

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

Reason for Ranking

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

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

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

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

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

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

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

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

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

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

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

Reason for Ranking

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

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

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

Reason for Ranking

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

Appendix E – Youth Behavioral Risk Survey Results

North Dakota High School Survey

*2017 YRBS North Dakota Data is not yet available, so the 2015 data was used.

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

	ND 2015	ND 2017	ND 2019	ND Trend ↑, ↓, =	Rural ND Town Average	Urban ND Town Average	National Average 2019
Injury and Violence							
Percentage of students who rarely or never wore a seat belt (when riding in a car driven by someone else)	8.5	8.1	5.9	=	8.8	5.4	6.5
Percentage of students who rode in a vehicle with a driver who had been drinking alcohol (one or more times during the 30 prior to the survey)	17.7	16.5	14.2	=	17.7	12.7	16.7
Percentage of students who talked on a cell phone while driving (on at least one day during the 30 days before the survey, among students who drove a car or other vehicle)	NA	56.2	59.6	=	60.7	60.7	NA
Percentage of students who texted or e-mailed while driving a car or other vehicle (on at least one day during the 30 days before the survey, among students who had driven a car or other vehicle during the 30 days before the survey)	57.6	52.6	53.0	=	56.5	51.8	39.0
Percentage of students who never or rarely wore a helmet (during the 12 months before the survey, among students who rode a motorcycle)	NA	20.6	NA	**NA**	NA	NA	NA
Percentage of students who carried a weapon on school property (such as a gun, knife, or club on at least one day during the 30 days before the survey)	5.2	5.9	4.9	=	6.2	4.2	2.8
Percentage of students who were in a physical fight on school property (one or more times during the 12 months before the survey)	5.4	7.2	7.1	=	7.4	6.4	8.0
Percentage of students who experienced sexual violence (being forced by anyone to do sexual things [counting such things as kissing, touching, or being physically forced to have sexual intercourse] that they did not want to, one or more times during the 12 months before the survey)	NA	8.7	9.2	=	7.1	8.0	10.8
Percentage of students who experienced physical dating violence (one or more times during the 12 months before the survey, including being hit, slammed into something, or injured with an object or weapon on purpose by someone they were dating or going out with among students who dated or went out with someone during the 12 months before the survey)	7.6	NA	NA	**NA**	NA	NA	8.2
Percentage of students who have been the victim of teasing or name calling because someone thought they were gay, lesbian, or bisexual (during the 12 months before the survey)	NA	11.4	11.6	=	12.6	11.4	NA
Percentage of students who were bullied on school property (during the 12 months before the survey)	24.0	24.3	19.9	↓	24.6	19.1	19.5
Percentage of students who were electronically bullied (including being bullied through texting, Instagram, Facebook, or other social media during the 12 months before the survey)	15.9	18.8	14.7	↓	16.0	15.3	15.7
Percentage of students who felt sad or hopeless (almost every day for two or more weeks in a row so that they stopped doing some usual activities during the 12 months before the survey)	27.2	28.9	30.5	=	31.8	33.1	36.7
	ND 2015	ND 2017	ND 2019	ND Trend ↑, ↓, =	Rural ND Town Average	Urban ND Town Average	National Average 2019
Percentage of students who seriously considered attempting suicide (during the 12 months before the survey)	16.2	16.7	18.8	=	18.6	19.7	18.8
Percentage of students who made a plan about how they would attempt suicide (during the 12 months before the survey)	13.5	14.5	15.3	=	16.3	16.0	15.7

Percentage of students who attempted suicide (one or more times during the 12 months before the survey)							
Tobacco Use							
Percentage of students who ever tried cigarette smoking (even one or two puffs)	35.1	30.5	29.3	=	32.4	23.8	24.1
Percentage of students who smoked a whole cigarette before age 13 years (even one or two puffs)	NA	11.2	NA	**NA**	NA	NA	NA
Percentage of students who currently smoked cigarettes (on at least one day during the 30 days before the survey)	11.7	12.6	8.3	↓	10.9	7.3	6.0
Percentage of students who currently frequently smoked cigarettes (on 20 or more days during the 30 days before the survey)	4.3	3.8	2.1	↓	2.3	1.7	1.3
Percentage of students who currently smoked cigarettes daily (on all 30 days during the 30 days before the survey)	3.2	3.0	1.4	↓	1.6	1.2	1.1
Percentage of students who usually obtained their own cigarettes by buying them in a store or gas station (during the 30 days before the survey among students who currently smoked cigarettes and who were aged <18 years)	NA	7.5	13.2	=	9.4	10.1	8.1
Percentage of students who tried to quit smoking cigarettes (among students who currently smoked cigarettes during the 12 months before the survey)	NA	50.3	54.0	=	52.8	51.4	NA
Percentage of students who currently use an electronic vapor product (e-cigarettes, vape e-cigars, e-pipes, vape pipes, vaping pens, e-hookahs, and hookah pens at least one day during the 30 days before the survey)	22.3	20.6	33.1	↑	32.2	31.9	32.7
Percentage of students who currently used smokeless tobacco (chewing tobacco, snuff, or dip on at least one day during the 30 days before the survey)	NA	8.0	4.5	↓	5.7	3.8	3.8
Percentage of students who currently smoked cigars (cigars, cigarillos, or little cigars on at least one day during the 30 days before the survey)	9.2	8.2	5.2	↓	6.3	4.3	5.7
Percentage of students who currently used cigarettes, cigars, or smokeless tobacco (on at least one day during the 30 days before the survey)							
Alcohol and Other Drug Use							
Percentage of students who ever drank alcohol (at least one drink of alcohol on at least one day during their life)	62.1	59.2	56.6	=	60.6	54.0	NA
Percentage of students who drank alcohol before age 13 years (for the first time other than a few sips)	12.4	14.5	12.9	=	16.4	13.2	15.0
Percentage of students who currently drank alcohol (at least one drink of alcohol on at least one day during the 30 days before the survey)	30.8	29.1	27.6	=	29.4	25.4	29.2
Percentage of students who currently were binge drinking (four or more drinks of alcohol in a row for female students, five or more for male students within a couple of hours on at least one day during the 30 days before the survey)	NA	16.4	15.6	=	17.2	14.0	13.7
Percentage of students who usually obtained the alcohol they drank by someone giving it to them (among students who currently drank alcohol)	41.3	37.7	NA	**NA**	NA	NA	40.5
	ND 2013	ND 2017	ND 2019	ND Trend ↑, ↓, =	Rural ND Town Average	Urban ND Town Average	National Average 2019
Percentage of students who tried marijuana before age 13 years (for the first time)	5.3	5.6	5.0	=	5.5	5.1	5.6
Percentage of students who currently used marijuana (one or more times during the 30 days before the survey)	15.2	15.5	12.5	=	11.4	14.1	21.7
Percentage of students who ever took prescription pain medicine without a doctor's prescription or differently than how a doctor told them to use it (counting drugs such as codeine, Vicodin, OxyContin, Hydrocodone, and Percocet, one or more times during their life)	NA	14.4	14.5	=	12.8	13.3	14.3
Percentage of students who were offered, sold, or given an illegal drug on school property (during the 12 months before the survey)							

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							
Percentage of students who had sexual intercourse before age 13 years (for the first time)	2.6	2.8	NA	NA	NA	NA	3.0
Weight Management and Dietary Behaviors							
Percentage of students who were overweight (>= 85th percentile but <95th percentile for body mass index, based on sex and age-specific reference data from the 2000 CDC growth chart)	14.7	16.1	16.5	=	16.6	15.6	16.1
Percentage of students who had obesity (>= 95th percentile for body mass index, based on sex- and age-specific reference data from the 2000 CDC growth chart)	13.9	14.9	14.0	=	17.4	14.0	15.5
Percentage of students who described themselves as slightly or very overweight	32.2	31.4	32.6	=	35.7	33.0	32.4
Percentage of students who were trying to lose weight	NA	44.5	44.7	=	46.8	45.5	NA
Percentage of students who did not eat fruit or drink 100% fruit juices (during the seven days before the survey)	3.9	4.9	6.1	=	5.8	5.3	6.3
Percentage of students who ate fruit or drank 100% fruit juices one or more times per day (during the seven days before the survey)	NA	61.2	54.1	↓	54.1	57.2	NA
Percentage of students who did not eat vegetables (green salad, potatoes [excluding French fries, fried potatoes, or potato chips], carrots, or other vegetables, during the seven days before the survey)	4.7	5.1	6.6	=	5.3	6.6	7.9
Percentage of students who ate vegetables one or more times per day (green salad, potatoes [excluding French fries, fried potatoes, or potato chips], carrots, or other vegetables, during the seven days before the survey)	NA	60.9	57.1	↓	58.2	59.1	NA
Percentage of students who did not drink a can, bottle, or glass of soda or pop (such as Coke, Pepsi, or Sprite, not including diet soda or diet pop, during the seven days before the survey)	NA	28.8	28.1	=	26.4	30.5	NA
Percentage of students who drank a can, bottle, or glass of soda or pop one or more times per day (not including diet soda or diet pop, during the seven days before the survey)	18.7	16.3	15.9	=	17.4	15.1	15.1
Percentage of students who did not drink milk (during the seven days before the survey)	13.9	14.9	20.5	↑	14.8	20.3	30.6
Percentage of students who drank two or more glasses per day of milk (during the seven days before the survey)	NA	33.9	NA	NA	NA	NA	NA
Percentage of students who did not eat breakfast (during the seven days before the survey)							
Percentage of students who most of the time or always went hungry because there was not enough food in their home (during the 30 days before the survey)	NA	2.7	2.8	=	2.1	2.9	NA
	ND 2015	ND 2017	ND 2019	ND Trend ↑, ↓, =	Rural ND Town Average	Urban ND Town Average	National Average 2019
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 seven days before the survey)							
Percentage of students who watched television three or more hours per day (on an average school day)	18.9	18.8	18.8	=	18.3	18.2	19.8
Percentage of students who played video or computer games or used a computer three or more hours per day (counting time spent on things such as Xbox, PlayStation, an iPad or other tablet, a smartphone, texting, YouTube, Instagram, Facebook, or other social media, for something that was not school work on an average school day)	38.6	43.9	45.3	=	48.3	45.9	46.1
Other							

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

Appendix F – Prioritization of Community's Health Needs

Community Health Needs Assessment
Hettinger, North Dakota
Ranking of Concerns

The top concerns for each of the six topic areas, based on the community survey and key informant interview results, were presented in a prerecorded presentation and in an online survey. The numbers below indicate the total number of votes by the key informants who participated in the survey which took place in lieu of a group meeting. The "Priorities" column lists the number of votes on the concerns indicating which areas are felt to be priorities. Each person was asked to choose their top four concerns. The "Most Important" column lists the top concerns after a second survey. After the first round of voting, the top five priorities were selected based on the highest number of votes. Each person was then asked to vote on the item they felt was the most important priority of the top five highest ranked priorities.

	Priorities	Most Important
COMMUNITY/ENVIRONMENTAL HEALTH CONCERNS		
Attracting & retaining young families	8	6
Not enough jobs with livable wages	5	2
Having enough quality school resources	1	
Changes in population size	1	
Seasonal viral outbreaks, such as influenza or coronavirus	0	
AVAILABILITY/DELIVERY OF HEALTH SERVICES CONCERNS		
Ability to retain providers (MD, DO, NP, PA) and nurses in the community	6	3
Cost of health insurance	1	
Not enough healthcare staff in general	3	
Availability of primary care providers	4	2
YOUTH POPULATION HEALTH CONCERNS		
Alcohol use and abuse	0	
Depression/anxiety	1	
Not enough activities for children and youth	1	
Smoking & tobacco use, exposure to second-hand smoking, or vaping/juuling	1	
ADULT POPULATION HEALTH CONCERNS		
Alcohol use and abuse	3	
Depression/anxiety	0	
Drug use and abuse (including prescription drugs)	0	
Stress	1	
SENIOR POPULATION HEALTH CONCERNS		
Cost of long-term/nursing home care	2	
Depression/anxiety	0	
Availability of resources to help elderly stay in their homes	1	
Long-term/nursing home care options	0	
Quality of elder care	2	

Appendix G – Survey "Other" Responses

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

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

1. Considering the PEOPLE in your community, the best things are: "Other" responses:
   - Apparent generalized apathy
   - None of the above
   - We care
   - Work together
   - If you are stuck on the side of the road, someone will pick you up
   - Low crime
   - Many reject science and medical fact because it is inconvenient for them
   - None of these
2. Considering the SERVICES AND RESOURCES in your community, the best things are: "Other" responses:
   - (2) None of the above
   - Library/clothes closet
   - Local radio station is excellent resource
   - Museum/library/parks
   - Programs for elders
   - Willing to try
3. Considering the QUALITY OF LIFE in your community, the best things are: "Other" responses:
   - Healthcare
   - In chronic economic decline
   - Eliminate sexism
4. Considering the ACTIVITIES in your community, the best things are: "Other" responses:
   - 4th of July tradition
   - Extremely limited due to COVID-19
   - Only activity is movie theater for children
   - Golf
   - Very limited
   - We are lacking in this category
   - School activities and athletics are about all we have
   - Create a place for artwork to be exhibited

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:
   - There is nothing for children to do

- Activities for youth
- Not enough people willing to work so local businesses are unable to say open; no one willing to do small maintenance jobs
- Poor efforts by the chamber and community promotion to attract manufacturing
- Anti-intellectualism, not enough media literacy
- Reliance on government
- Current access to healthcare

6. Considering the AVAILABILITY/DELIVERY OF HEALTH SERVICES in your community, concerns are: "Other" responses:
   - Oncology services
   - Facility does not take the state employee vision insurance
   - No energy medicine not enough training in vitamins, what to eat and not eat, what is toxic, no looking at the person as a whole
   - They are afraid to see people unless screened for COVID – we end up going to the ER first, it's faster to go to Dickinson
7. Considering the YOUTH POPULATION in your community, concerns are: "Other" responses:
   - (3) Bullying (bad in the school)
   - Ignorance toward the larger world
   - Gardasil vaccine and others and their side effect
8. Considering the ADULT POPULATION in your community, concerns are: "Other" responses:
   - Disregard for COVID, bullying
   - COVID
   - Isolation
   - Sexism that dehumanizes women
   - Iatrogenic diseases
9. Considering the SENIOR POPULATION in your community, concerns are: "Other" responses:
   - Availability of DME (durable medical equipment)
   - Enough staffing for nursing home
   - COVID
   - Fraud schemes that target the elderly
   - Lack of access to technology
10. What single issue do you feel is the biggest challenge facing your community?
    - A place for kids to enjoy healthy activity
    - Covid and related financial impact
    - Not enough staffing for long-term care or hospital
    - Providing a swimming pool for youth to attracting young professional families
    - At his point and time is COVID 19 limiting activities of any kind
    - The quick spread of Covid 19
    - The healthcare in our area seems very short staffed to serve out community
    - Community longevity related to the retention of younger families
    - Lack of rational local government involvement in the economic future of the community and most especially in the future of the school; too much short-term thinking and the "we've always done it this way" mindset
    - Recruiting next generations of physicians
    - Youth recreation—if we don't have activities for youth, then it will be difficult to attract young families to the area and to retain them
    - Health concerns
    - Right now it's the complete lack of cooperation on the general public's part in helping combat covid-19

- Decreasing population and the effects on the businesses and services
- Disregard for Covid public health guidelines; shortage of healthcare providers and workers
- Right now I think the biggest challenge is the pandemic and no guidance from local govt to stem the spread
- I feel the biggest challenge is our youth—there is nothing for them to do but be destructive to others or things, there is nothing for activities unless you are into sports or animals
- Not enough employment options; it looks like the hospital is circling the drain, when the get bought out and turned into an ER staffed by Pas, there will be way fewer good paying jobs and not much reason for new people to move here
- Lack of exercise
- Nothing to bring young families into the community—need an industry in the area
- Shortage of health workers due to Covid 19
- Educational opportunities for technical and trade careers
- Currently people not understanding or perhaps not caring about the consequences of their actions regarding Covid 19
- Getting care here for cancer
- COVID
- Lack of promotion of the community or trying to pursue manufacturing to relocate to our community
- Recruiting people to live here, no activities or amenities to entice them
- The community does not come together to look at issues. The community has too many embedded beliefs about who is right or wrong. OMG, is it still true that the librarian lives in Minnesota but keeps her job because of nepotism? Is it still true that everyone drives home drunk from the bars? Is it still true that the cost of an MRI can force a person into bankruptcy? Is it still true that the nursing home is inadequate? Is it still true that LGBTQ people are a novel part of the community and are not accepted by church folks? Is it still true that there is rape and domestic violence that is often a result of drug and alcohol abuse but you treat the TARGET of the violence as if they are the person in need? Is it still true that people are so afraid to wear masks that they are willing to risk contracting a preventable illness that might have catastrophic and/chronic effects? Is it still true that the racism at the Clinic is so severe that good workers relocated to find a more accepting atmosphere? Is it still true that patient complaints are handled by a review of medical protocol instead of actually LISTENING to the patient? Is it still true that patient complaints are handled by a nurse who handles a number of other tasks, and is unable to devote attention to real problem solving? Is it still true that the hospitals board has doctors and community members who are complicit in all of the local social problems? Is it still true that gossip hinders perception of patient potential thus limiting access due to prejudgment? Is it still true that the drive for change at this time is a result of economic difficulties instead of the honest need to do community development? Is it still true that this community might try to establish a drug treatment program when the efficacy for recovery programs is poor at best? Is it still true that the social workers in this county have little or no experience in teaching empowerment AND leadership skills as a means of accessing change? Is it still true ... ?
- Having primary care providers available in town more than one day a week; too many are farmed out to satellite sites and then you just have to see whoever unless you can wait 2 weeks for the here and then gone contracted doctors
- Not enough drs, nurses, etc. to see and care for people; everyone is retiring or leaving
- Having a viable economic base to keep a town alive; we need to recruit people to this different way of life from the cities and point out all of the good things about this type of life
- Lack of jobs with a livable wage
- Getting the people to believe Covid is real and following the guidelines laid out by the CDC
- Culture of alcohol abuse
- The failing healthcare system

Delivery of Healthcare

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

- Long wait periods to see primary care
- Healthcare is outstanding
- The healthcare is actually excellent, although many must travel up to 90 miles just to get there
- I think we have good services
- Lack of time
- Confidentiality
- Not the quality of care it used to be , can't get results back, hard to schedule, less after-hours clinic time so cheaper to go to Dickinson walk in ER here
- Covid fear preventing people from seeking care
- Stigma
- The access to quality care is terrible; the basic assessment does not help a patient think about specific strategies to achieve care goals
- I want to see a Dr that does not use drugs and offers other options first and foremost

12. Where do you turn for trusted health information? "Other" responses:
    - Irsfeld pharmacy staff/natural paths
    - Literature
    - I read peer reviewed articles for new discoveries and may clinic for well established questions that I need an answer to
    - TikTok and Facebook
    - Internet, but not the ones listed above, they are all pharmaceutically sponsored
13. What specific healthcare services, if any, do you think should be added locally? All responses:
    - Kidney dialysis, chemotherapy services, in-home care for seniors
    - ENT
    - Dialysis, more specialists come to clinic such as nephrology, oncology, etc. from bigger facility
    - Chemo/radiation
    - Chiropractor
    - We need better elder care, more consistently available OB care, and a few more family docs; we will likely soon lose our podiatrist in part caused by lack of admin support
    - Dietitians, social workers
    - Cancer treatment locally
    - Another internist to help Josh and Kent
    - Oncology
    - I really wish there was an ER in Lemmon but understand that staffing is an issue
    - Dermatology
    - Prefer to see the same provider not a different one each visit
    - I know we have palliative care but it needs to be more active in helping people
    - Training/re-education for WRHS staff on customer service and proper treatment of patients/customers
    - Dentists
    - Social work
    - Dermatology
    - Chemo, dialysis, urgent care clinic
    - Cancer treatment
    - Massage, chiropractor

- Get a good podiatrist who knows how to teach people to care for themselves. Get good physical therapist who inspire people to feel more whole again. Get a good patient advocate who can help people and families navigate through the system this means to access insurance, good physicians, transportation, medical adaptive equipment, and so on. Stop all the psychiatric stuff and evolve education so that people can find strength in their own human endeavor. If this means bring in a community activist to do preventative care, so be it. The habit of acknowledging a need, then attending to that need with learning (not patient compliance or control)... Make access to respect within the Heath care system possible! Stop the authoritarian assessment and evaluation which is conducted by the standards of the institution. Get a good ophthalmologist. When referrals to other institutions are made, find a way to communicate what the patient can expect in that facility, with that provider. - And how about that patient portal at WRHS? The patient portal is the only portal that I have ever seen that forces a patient to AUTOMATICALLY populate WRHS data into other systems. When a cursory diagnosis is put into the WRHS data base, that diagnosis follows a person. The quality of care is so random, it is better to have no records communicated
- Mental health groups without fees, full-time doctors at our facility and not a day here and there
- Dementia care
- Naturopathic Dr of osteopathic Dr much more quality nutritional information, energy information
- Drug and alcohol abuse counselor

19. How did you acquire the survey (or survey link) that you are completing? "Other" responses:
    - Facebook
    - Hettinger community page
    - WRHS
    - Radio (KNDC)
20. Health insurance coverage status
    - Ministry share plan
    - MCR supplement
    - Federal BC/BS
    - Both through employer and privately
    - None
26. Race/Ethnicity
    - Polish
    - American

West River Health Services CHNA Strategic Implementation Plan 2021

This implementation strategy summarizes WRHS' plans to address the prioritized needs from the 2021 Community Health Needs Assessment. We recognize that the implementation strategies in this report are to be used as a guide and will serve as a framework in addressing the identified needs. As the hospital moves forward, many resources, ongoing commitments, and partnerships will be necessary to effectively assist in promoting health and wellness in the communities we serve. These efforts compliment our other 2021 strategic planning work that clearly described our strategic goals under six foundational pillars: finance, communication, community, facility/assets, excellence, and strategy/innovation.

Priority	Identified Health Need	Current Activities	Strategy (Proposed Activities)	Intended Impact	Commitment of Resources	Collaboration
1	Attracting and retaining young families	WRHS is a longstanding, vibrant, and growing organization commited to the health and wellness of our communities. Our presence in Adams County and surrounding areas allows current residents and those moving to the area to have access to quality healthcare.	Encourage WRHS staff to be more involved with the communities we serve to improve alignment and cohesiveness. WRHS' health and wellness emphases will be attractive to young families.	Younger families are needed to replace our aging workforce, not just at WRHS, but in the communities we serve. Working towards a growing, vibrant community.	This is a community-wide issue and is not within the exclusive ability of WRHS to remedy, but we will play a part by committing marketing time and materials, family friendly events, and staff utilization of Community Benefit Time to be engaged with the community.	Local volunteer groups, family-based clubs, Burgers and Brats in the park. Chamber of Commerce. Economic development corporations (Adams, Bowman, Stark, Grant, and Perkins Counties).
2	Availability of primary care providers (MD, DO, NP, PA) and nurses	In addition to our hospital, there are a total of six medical clinics and one eye center in the WRHS system. The physicians group also oversees two additional clinics in Isabel and Faith, South Dakota.	Meet community needs by expanding clinic hours to the best of our ability. Aim to shorten appointment scheduling wait time.	Patients are able to see their preferred provider at convenient times without having to wait unreasonably long. Improved health and wellness in the community.	To the best of our ability we will increase available clinic visit slots and grow our provider base.	Schedulers, providers, patients, community members; learn desired additional clinic hours.
3	Ability to retain primary care providers (MD, DO, NP, PA) and nurses	Most of our physicians, advanced practice providers, and nurses are members of our community. This is key to building relationships and trust with patients and maintaining care continuity and low turnover. WRHS is committed to maintaining up-to-date facilities, technology, and equipment to provide physicians and other providers the optimal tools they need to provide excellent patient care.	Pursue a fully-staffed WRHS with optimal provider productivity and availability.	Long tenure and low turnover for WRHS providers and nurses; strong cohesion across the oragnization. Strong and consistent relationships between providers and patients. WHRS is a stabilizing presence in the community.	Create formal recruitment committee that focuses on all aspects of recruitment and retention. Continue annual salary reviews and make adjustments as necessary to remain competitive.	School health programs and classes, nursing and medical school partnerships. University of North Dakota School of Medicine medical students (ROAM program).
4	Not enough jobs with livable wages	WRHS employs aproximately 180 full time equivalents and 240 people and offers competitive wages. Brief employee engagement survey conducted in spring 2021.	Strive to be the employer of choice in the region. Offer competitive wages. Comprehesive employee engagement and satisfaction survey to be completed by end of 2021.	Low turnover, skilled and experienced WRHS providers and staff, high morale and enthusiasm across WRHS, high quality healthcare, health and wellness in the community.	WRHS' ability to impact this (community wide) is limited but efforts will be made to be a leader in the community as a great place to work that offers competitive wages. Continue annual salary reviews, make adjustments as necessary to remain competitive. Invest in marketing and communication efforts both internal and external.	Chamber of commerce, job postings on social media and local newspapers. Commit to posting at schools, North Dakota Job Service. Continue collaborations with economic development corporations (listed above).

West River Health Services Service Area

2021 Community Health Needs Assessment

December 2021

Each Critical Access Hospital must conduct a Community Health Needs Assessment (CHNA) once every three years, as mandated by law. Local public health units seeking to gain/maintain accreditation conduct an assessment every five years. CHNAs completed by Center for Rural Health (CRH) include secondary data review, community focus groups, key informant interviews, and a community survey. This fact sheet presents key community strengths and opportunities from the West River Health Services (WRHS) service area 2021 CHNA.

The WRHS service area is comprised of the towns of Bowman, Scranton, Reeder, Bucyrus, Hettinger, Haynes, Mott, New England, and Dickinson in North Dakota, and Lemmon, Bison, and Buffalo in South Dakota. This area includes the counties of Adams, Bowman, Hettinger, and Slope in North Dakota, and Perkins County in South Dakota.

Community Strengths

The top three assets identified in the community survey included the community being a safe place to live, with little to no crime, healthcare in this community is accessible, and the community is family friendly, meaning people are friendly, helpful, and supportive.

Health Outcomes and Factors

In review of secondary data, 16% of WRHS North Dakota service area* residents and 12% of Perkins County, South Dakota residents reported poor or fair health. This service area had a greater percentage of residents reporting excessive drinking, physical inactivity, adult smoking, and obesity than the top 10% of U.S. counties. See Table 1 for more data.

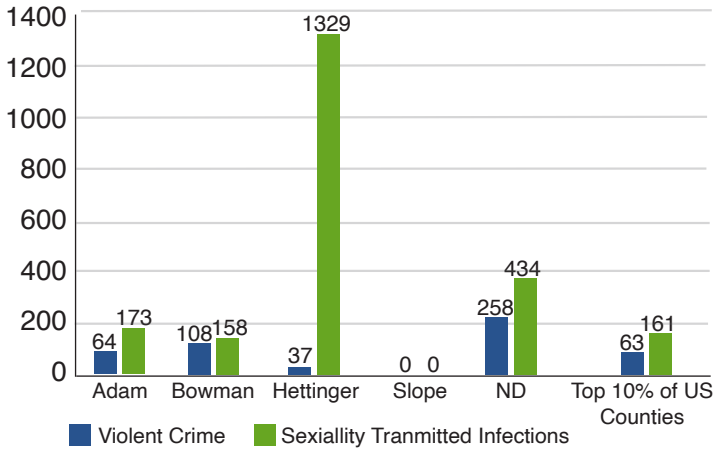
Table 1. Health Factors by % of Population, 2020

	Hettinger Service Area*	ND	Top 10% U.S
Uninsured	12%	9%	6%
Excessive drinking	21%	24%	13%
Access to exercise opportunities	44%	74%	91%
Physical inactivity	26%	24%	20%
Adult obesity	31%	33%	26%
Adult smokers	16%	18%	14%

**The Hettinger services area is a weighted average of Adams, Bowman, Hettinger and Slope counties.*

Incidence of violent crime was less prevalent in all counties compared to the North Dakota average, but higher than the top 10% of the U.S. counties with the exception of Hettinger County. For incidence of sexually transmitted infections, Hettinger County was higher than North Dakota counties, while Adams and Bowman counties were lower. Slope county had no record for either topic. See Figure 1.

Figure 1. Cases per 100,000 Population, 2020



In 2019, data shows children in poverty (ages 0-17) was 15% in the WRHS service area*, while ND was 10.9%. Medicaid recipients were 22.5% which is lower than the North Dakota average of 10.9%. See Table 2 for more information on children's health factors.

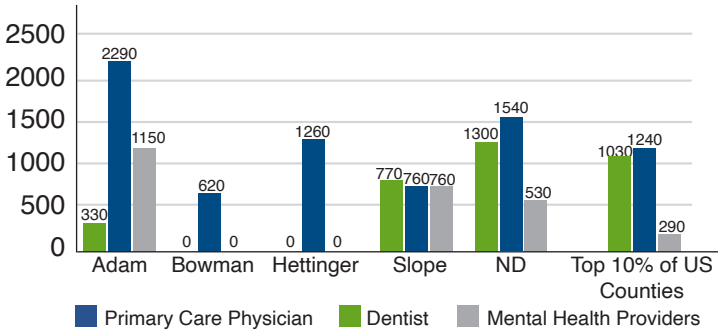
Table 2. Children's Health Factors by % of Population

	Hettinger Service Area*	ND
Children uninsured (2018)	11%	6.3%
Children in poverty (ages 0-17) (% of pop.) (2019)	15%	10.9%
Medicaid recipients (2019)	22.5%	26.6%
Children enrolled in Healthy Steps (2019)	0.9%	1.6%
Receiving SNAP (2019)	11%	16.9%

Healthcare Access

Based on the provider to population ratio, Traill and Steele Counties have more residents per single dentist than the state's average and the top 10% of U.S. counties (1,280 residents per one dentist). The same is true for both counties for the ratio of population per primary care provider and mental health provider. See Figure 2.

Figure 2. Provider to Population Ratios, 2020



In a survey conducted by CRH, residents identified up to three primary community concerns. The top two concerns were attracting and retaining young families to the area (65%) and the ability to retain primary care providers and nurses (44%). Alcohol use and abuse with youth, depression/anxiety among adults, and cost of long-term /nursing home care made the top five. See Table 3.

Table 3. Community Concerns, 2021

Community Concern	%
Attracting and retaining young families	65%
Alcohol use and abuse - adults	52%
Alcohol use and abuse—youth	48%
Depression/anxiety among adults	47%
Ability to retain primary care providers	44%
Cost of long term/nursing home care	41%
Not enough jobs with livable wages	39%
Depression/anxiety among youth	38%
Depression/anxiety among seniors	37%

In January 2021, a community focus group identified their top concerns as:
1. Attracting and retaining young families
2. Alcohol use and abuse - adults
3. Alcohol use and abuse - youth
4. Depression/anxiety - adults

In the survey, community members also identified perceived barriers (up to three) specifically related to accessing local healthcare. The top five barriers were:
1. Not able to see same provider over time (35%)
2. Not enough providers (28%)
3. No insurance/limited insurance (27%)
4. Not able to get appointment/limited hours (26%)
5. Not enough evening or weekend hours (23%)

Individuals also indicated which specific healthcare services, if any, they felt should be added locally. The most often cited service was oncology.

Steps Undertaken Since 2017/2018 CHNA

WRHS has taken steps to address all five of the top concerns identified in the 2017/2018 assessment. To combat obesity in the area, the hospital's rehab center donated all of their fitness equipment to the city of Hettinger, an annual fun run has been implemented, and fit camps for all ages have been presented to the community, as well as the Hettinger Pool hosting free-of-charge swim times. The hospital's respiratory therapist was trained to hold smoking cessation classes, and WRHS has worked with local churches and support groups to allow options for patients unwilling to seek medical care for substance abuse. In response to concerns over cancer rates in the community, WRHS continues to work with larger facilities to provide chemotherapy for patients, and a local non-profit organization donated gas cards to ease patients' travel costs. Staff at the hospital have been encouraged to be more involved with the community in order to attract and retain younger families, implementing "community benefit time" for employees to be more active. Sign on bonuses continue to be offered to new staff hires, and a Dakota Nursing Program was started at the hospital to bring the nursing staff up locally. WRHS has also worked to reduce adult alcohol use and abuse by working with the Nighthawk Drug and Alcohol Coalition to provide fun, alcohol-free activities for youth in the area.

Implementation Strategies

Hospitals and local public health units prepare implementation strategies as a blueprint for meeting needs identified in a CHNA. Access the complete and community-specific CHNA Reports and Implementation Strategies at, ruralhealth.und.edu/projects/community-health-needs-assessment/reports.

Full Report

Nissen, K. & Breigenzer, A. Hettinger Service Area: Community Health Needs Assessment, 2021.

For More Information

Visit the website, ruralhealth.und.edu/projects/community-health-needs-assessment or contact:

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