Community Health Needs Assessment

CHI Oakes Hospital Service Area
Oakes, North Dakota

2022

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The board of directors for CHI Oakes Hospital approved this Community Health Needs Assessment in June 2022.

Center *for* Rural Health
University of North Dakota
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Executive Summary

To help inform future decisions and strategic planning, CHI Oakes Hospital conducted a Community Health Needs Assessment (CHNA) in 2021/2022, with the previous CHNA having been conducted in 2019. 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 sixty-seven CHI Oakes Hospital service area residents completed the survey. Additional information was collected through two key informant interviews with community members. The input from the residents, who primarily reside in Dickey 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, Dickey County's population from 2010 to 2019 decreased by 7.8%. The average number of residents younger than age 18 for Dickey County (24.4%) comes in less than 1% more than the North Dakota average (23.5%). The percentage of residents age 65 and older is slightly over 5% higher for Dickey County (20.7%) than the North Dakota average (15.3%), and the rate of education is slightly lower for Dickey County (91.3%) than the North Dakota average (92.5%). The median household income in Dickey County ($65,492) is slightly higher than the state average for North Dakota ($63,473).

Data compiled by County Health Rankings show Dickey County is doing better than North Dakota in health outcomes/factors in 14 categories. The county is performing poorly relative to the rest of the state in 13 outcome/factor categories.

Of 106 potential community and health needs set forth in the survey, the 167 CHI Oakes Hospital service area residents who completed the survey indicated the following eleven needs as the most important:

- Bullying/cyberbullying
- Availability of vision care
- Depression/anxiety
- Alcohol use and abuse
- Attracting and retaining young families
- Availability of resources to help the elderly stay in their homes
- Not enough jobs with livable wages
- Cost of long-term/nursing home care
- Availability of mental health services
- Child abuse or neglect
- Emotional abuse

The survey also revealed the biggest barriers to receiving healthcare (as perceived by community members). They included not enough evening/weekend hours (N=36), not affordable (N=36), not able to see same provider over time (N=33), and not able to get appointments/limited hours (N=33).

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

- Safe place to live, little/no crime
- Family-friendly
- People are friendly, helpful, and supportive
- People who live here are involved in their community
- Healthcare
- Active faith community

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

- Alcohol use and abuse
- Attracting and retaining young families
- Availability of mental health services
- Availability of vision care
- Cost of health insurance
- Depression/anxiety
- Having enough child daycare services
- Cost of long-term/nursing home care

Overview and Community Resources

With assistance from CRH at the UNDSMHS, the CHI Oakes Hospital completed a CHNA of the Oakes Community Hospital service area. The hospital identifies its service area as Dickey County. ZIP codes within the service area include 58436, 58439, 58441, and 58474. Many community members and stakeholders worked together on the assessment. The CHI Oakes Hospitalarea has several community assets and resources that are potentially available to address significant health needs.

CHI Oakes Hospital , DBA Oakes Community Hospital, is a 20-bed Critical Access Hospital that provides various inpatient and outpatient services to approximately 14,000 people in southeastern North Dakota. It is also a 24-Hour Emergency Level V Trauma Center. The hospital building was newly constructed in 2007, replacing a 50-year old building, and in 2010, Oakes Community Clinic was opened within the hospital building. The hospital is part of a larger values-based organization, Catholic Health Initiatives (CHI).

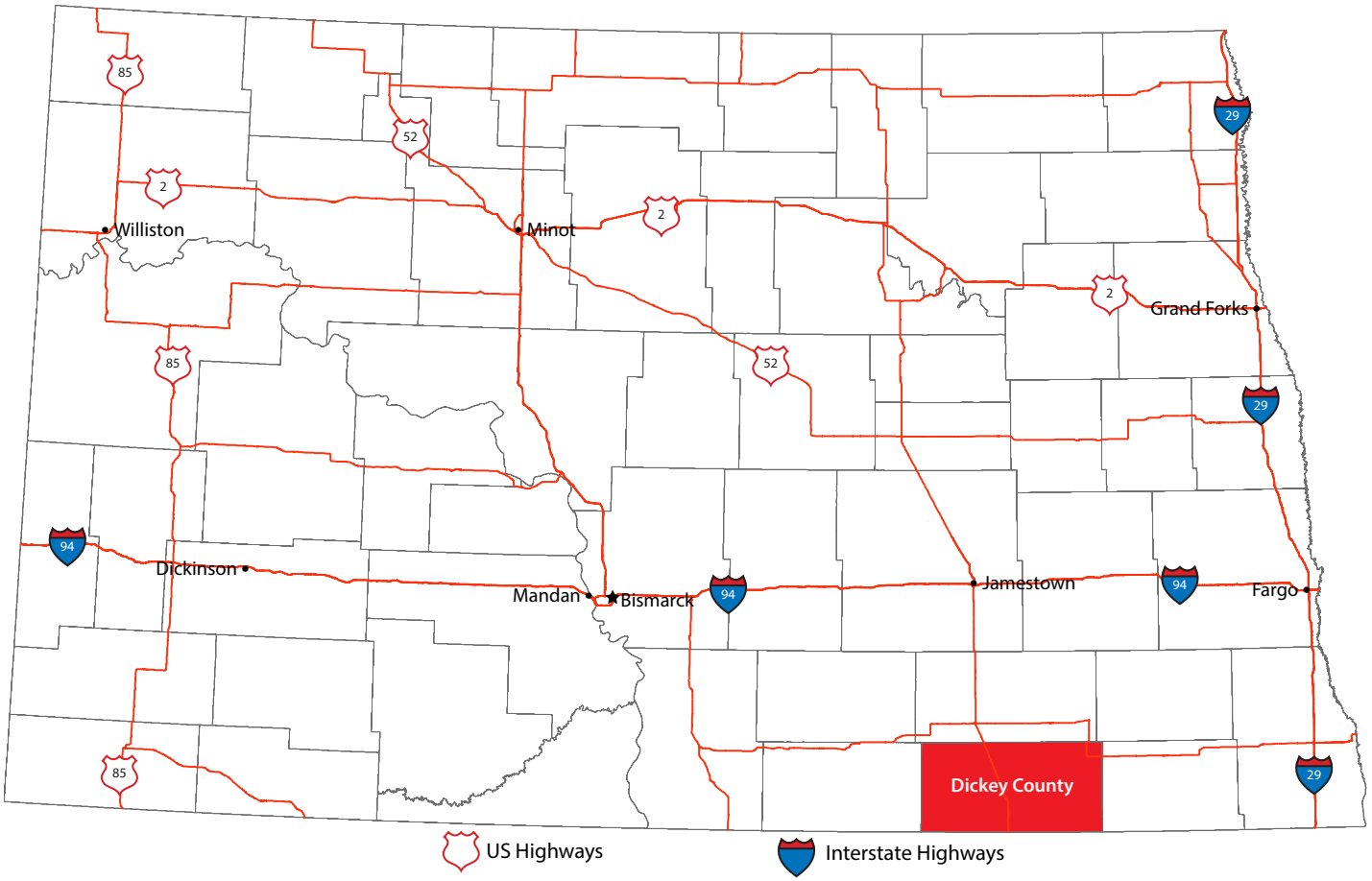
Dickey County is located in southeastern North Dakota along the border with South Dakota. Along with the hospital, agriculture and industry provide the economic base for the county. According to the 2010 U.S. Census, Dickey County had a population of 5,289. Its two largest communities contain 3,250 of those residents: Ellendale, the county seat, had a population of 1,394, and Oakes had a population of 1,856.

Primarily an agricultural area, Dickey County is a farm and ranch community with many acres of corn and soybeans produced each year. Oakes is proud to have two 110-car grain elevator facilities. Both Oakes and Ellendale boast a large industrial sector as well as progressive main streets with a variety of items available.

The medical facilities in the county are like none other in rural North Dakota, with well-established clinics, dental offices, chiropractors, an ambulance service, pharmacies, all levels of retirement living, access to home health and hospice services, and, of course, a hospital. Education is highly valued, as evidenced by the modernized K-12 public school systems in both Oakes and Ellendale, Trinity Bible College, and the Southeast Region Career and Technology Center.

Dickey County has several community assets and resources, including modern swimming pools, park facilities, a fitness center, grocery stores, walking paths, hotels, tennis courts, golf courses, and a movie theatre. Hunting and fishing opportunities abound.

Figure 1: Dickey County



CHI Oakes Hospital

CHI Oakes Hospital began delivering its healthcare mission in 1923 as the St. Anthony Hospital. In 1950, the Sisters of St. Francis of the Immaculate Heart of Mary purchased the hospital and, eventually, opened a new facility. The Sisters of St. Francis transferred the sponsorship of the Oakes Community Hospital to CHI in 1998. The Critical Access Hospital Profile for CHI Oakes Hospital, which includes a summary of hospital-specific information, is available in Appendix A.

CommonSpirit Health is a nonprofit, Catholic health system, dedicated to advancing health for all people. It was created in February 2019 through the alignment of CHI and Dignity Health. CommonSpirit Health is committed to creating healthier communities, delivering exceptional patient care, and ensuring every person has access to quality healthcare. With its national office in Chicago and a team of approximately 150,000 employees, 25,000 physicians, and advanced practice clinicians, CommonSpirit Health operates 137 hospitals and more than 1,000 care sites across 21 states. In FY 2018, CHI and Dignity Health had combined revenues of $29.2 billion and provided $4.2 billion in charity care, community benefit, and unreimbursed government programs.

Mission

The mission of CommonSpirit Health is making the healing presence of God known in our world by improving the health of the people we serve, especially those who are vulnerable, while we advance social justice for all.

Vision
Our vision is to provide a healthier future for all inspired by faith, driven by innovation, and powered by our humanity.

Values
Our values are what brings our mission to life and allows for our vision to become reality:
• Compassion • Inclusion • Integrity • Excellence • Collaboration

CHI Oakes Hospital has a significant economic impact on the region. They directly employ 79 full-time employees with an annual payroll of over $4.15 million (including benefits). These employees create an additional 33 jobs and over $717,000 million in income as they interact with other sectors of the local economy. This employment results in a total impact of 112 jobs and more than $4.87 million in income. Additional information is provided in Appendix B.

Services offered locally by CHI Oakes Hospital include:

General and Acute Services

1. Chemotherapy
2. Critical care
3. General/family/internal medicine
4. Hospital (acute care)
5. Nutrition counseling
6. Outpatient services
7. Pain management
8. Pediatric care
9. Pharmacy
10. Social services
11. Surgical services – anesthesia services
12. Surgical services – ear, nose, throat (ENT)
13. Surgical services – endoscopy (gastroscopy, colonoscopy)
14. Surgical services – general/laparoscopic
15. Surgical services – gynecologic
16. Swing bed (sub-acute care)
17. Telepharmacy (contracted service)

Clinical Care

1. Allergy, flu, and pneumonia shots
2. Audiology (visiting specialist)
3. Blood pressure checks
4. Family medicine
5. General surgery (visiting specialist)
6. Immunizations
7. Internal medicine
8. Joint injections
9. Mole/wart/skin lesion removal
10. Orthopedics (visiting specialist)
11. Physicals – annuals, DOT, sports, insurance
12. Podiatry (visiting specialist)

Emergency Services

1. Emergency department (level V trauma)
2. eEmergency (contracted service)
3. SANE provider
4. Stroke ready protocols

Screening/Therapy Services

1. Laboratory services
2. Occupational therapy
3. Physical therapy – inpatient, outpatient, swing bed
4. Respiratory therapy
5. Smoking cessation
6. Speech therapy
7. Sleep studies (contracted service)
8. Stress testing
9. Telepsychiatry (contracted service)

Radiology Services

1. Computed axial tomography (CT) Scan
2. Digital mammography
3. Electrocardiogram
4. General imaging/fluoroscopy/picture archiving and communication system (PACS)
5. Magnetic resonance imaging (MRI) (contracted service)
6. Nuclear medicine (contracted service)
7. Teleradiology (contracted service)
8. Ultrasound (contracted service)

Laboratory Services

1. Biofluids
2. Blood Bank
3. Chemistry
4. Department of Transportation Testing
5. Hematology
6. Microbiology

Services offered by OTHER providers/organizations

1. Ambulance
2. Chiropractic services
3. Dental services
4. Hospice (contracted service)
5. Massage therapy

Dickey County Health District

Dickey County Health District (DCHD) was formed September 1, 1999. The health district is governed by a health board and operates under the direction of a health officer. The public health district strives to promote wellness and protect the health of the people and communities in which they live, work, and play.

DCHD is located in Ellendale, North Dakota, the county seat of Dickey County. Situated in rural southeast North Dakota, Dickey County is the home to 5,064 people. DCHD currently employs four full-time staff.

Mission
We believe that prevention and early detection of illness is a most cost-effective approach to keep people healthy through education, workshops, visits, screening, etc. By working together with the community to create healthy lifestyles, we can all live better, healthier lives.

Vision
Its vision is working together to live healthier lives.

Specific services that DCHD provides are:

- Adult education programs
- Bicycle helmet safety education
- Blood pressure checks
- Breastfeeding resources
- Car seat program
- Child health (well-baby checks)
- Diabetes screening
- Emergency preparedness services
- Environmental Health Services (water, sewer, health hazard abatement)
- Flu shots
- Health Tracks (child health screening)
- Immunizations
- Medication setup—home visits

- Newborn Home Visits
- Nutrition education
- Preschool education programs & screening
- School health – screenings, health education, and resources
- Substance abuse and prevention program
- Tobacco prevention and control
- Tuberculosis testing and management
- West Nile program—surveillance and education
- WIC (Women, Infants & Children) Program
- Worksite Wellness – county employees
- Youth education programs

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 Dickey County.

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

Figure 2: Steering Committee

Becki Thompson	President, CHI Oakes Hospital
Julie Entzminger	Human Resources Director and Mission Coordinator, CHI Oakes Hospital
Roxanne Holm	Administrator, Dickey County Health District
Renee Seyer	Projects Administrative Coordinator, CHI Oakes Hospital
Alison Peterson	Clinic Manager, CHI Oakes Hospital
Kerry Waldo	Administrative Assistant, Dickey County Health District

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

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

- A survey solicited feedback from area residents;
- Community leaders representing the broad interests of the community took part in one-on-one key informant interviews;
- The community group, comprised of community leaders and area residents, was convened to discuss area health needs and inform the assessment process; 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.

Members of the community group and key informant interviews represented the broad interests of the community served by CHI Oakes Hospital and DCHD. They included representatives of the health community, business community, education, and faith community. Not all members of the group were present at both meetings.

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

Community Group

A community group, consisting of nine community members, was convened and first met on October 19, 2021. During this first community group meeting, group members were introduced to the needs assessment process, reviewed basic demographic information about the community, and served as a focus group. Focus group topics included community assets and challenges, the general health needs of the community, community concerns, and suggestions for improving the community's health.

The community group met again on November 16, 2021, with eight community members in attendance. At this second meeting, the community group was presented with survey results, findings from key informant interviews and the focus group, and a wide range of secondary data, relating to the general health of the population in Dickey County. The group was then tasked with identifying and prioritizing the community's health needs.

Interviews

One-on-one interviews with two key informants were conducted via videoconference in November 2021. 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 Dickey County, which is included in the CHI Oakes Hospital service area. The survey tool was designed to:

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

Specifically, the survey covered the following topics:

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

To promote awareness of the assessment process, press releases led to published articles in the newspaper in Oakes. Information was published on CHI Oakes Hospital's and DCHD's websites and Facebook pages as well as broadcast on the local radio station.

Approximately 50 community member surveys were available for distribution in Dickey County. The surveys were distributed by community group members and at CHI Oakes Hospital , Sanford Clinics, local businesses, the fitness center, and other local health organizations, including pharmacies, home health, and hospice care.

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 CHI Oakes Hospital or DCHD. The survey period ran from July 1, 2021 to October 10, 2021. There were 30 completed paper surveys returned.

Area residents also were given the option of completing an online version of the survey, which was publicized in the Oakes community newspaper, emailed to community groups, on the websites and Facebook pages of both CHI Oakes Hospital and DCHD, and publicized at various community events. There were 137 surveys completed. Twenty of those online respondents used the QR code to complete the survey. In total, counting both paper and online surveys, 167community member surveys were completed, equating to a 5% response rate. This response rate is low for this type of unsolicited survey methodology but is on par for this year. Lower response rates, responses at about half of what we typically see, are occurring throughout the state for surveys conducted this year. We feel this response is largely due to the current pandemic and not being out interacting with the community as much as in a typical year, thus resulting in less surveys having been disseminated and less knowledge of the survey availability.

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 were 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 Community Health Needs Assessment 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

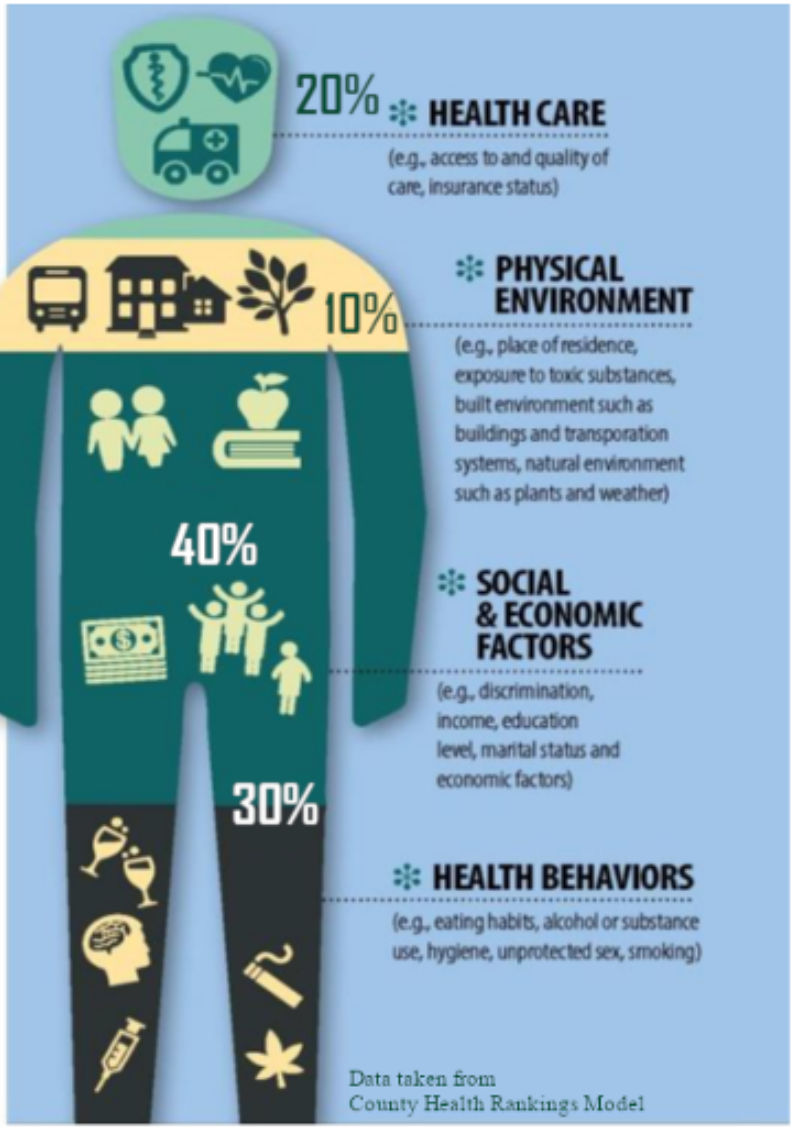
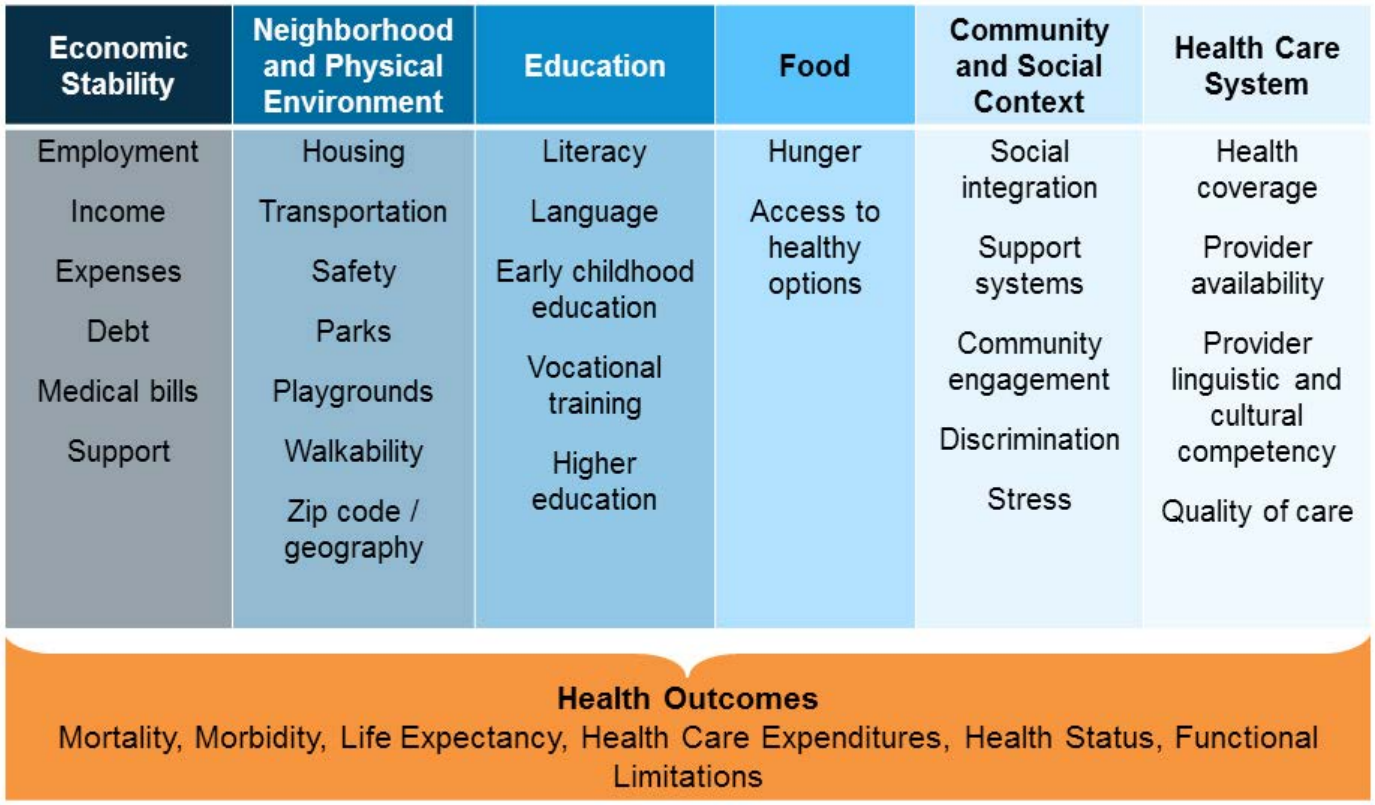


Figure 4 (Henry J. Kaiser Family Foundation, https://www.kff.org/disparities-policy/issue-brief/beyond-health-care-the-role-of-social-determinants-in-promoting-health-and-health-equity/), provides examples of factors that are included in each of the social determinants of health categories that lead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



Health Equity and COVID-19 Assessments for Dickey County

The COVID-19 pandemic has brought social and racial injustice and inequity to the forefront of public health. It has highlighted that health equity is still not a reality as COVID-19 has unequally affected many minority groups, putting them more at risk of getting sick and dying from COVID-19. Many factors, such as poverty and healthcare access, are intertwined and have a significant influence on the people's health and quality-of-life. "Essential workers" are those who conduct a range of operations and services in industries that are essential to ensure the continuity of critical functions in the U.S., from keeping us safe, to ensuring food is available at markets, and to taking care of the sick. A majority of these workers belong to and live within communities disproportionately affected by COVID-19. Essential workers are inherently at higher risk of being exposed to COVID-19 due to the nature of their work, and they are disproportionately representative of racial and ethnic minority groups.

In August 2021, a survey was disseminated to assess the COVID-19 perceptions and immunization needs of Dickey County. The survey was organized by Dickey County Health District (DCHD) and the completed surveys were submitted to the Center for Rural Health (CRH) at the University of North Dakota School of Medicine & Health Sciences (UNDSMHS) for analysis and compiled into a report. This report contains the findings from the survey as well as secondary data, related to demographics, COVID-19, and immunization rates.

COVID-19 in Dickey County

The COVID-19 vaccine data dashboard is administered by the North Dakota Department of Health and provides daily vaccine doses administered and weekly vaccine coverage rates for North Dakota. Dashboard data is based on COVID-19 vaccine doses reported to the North Dakota Immunization Information System (NDIIS). North Dakota immunization providers who are not receiving COVID-19 vaccine allocations through the North Dakota Department of Health Division of Immunizations, including Indian Health Services, Veteran's Affairs (VA), and Department of Defense facilities, may not be entering COVID-19 vaccine

information into the NDIIS, and their doses administered will not be accounted for in this data.

County-level doses administered, and coverage rate data is based on the vaccine recipient's county of residence, not the location of the administering provider site.

As of August 10, 2021, in North Dakota 656,638 doses of the COVID-19 vaccine have been administered. In Dickey County alone, 4,046 COVID-19 vaccine doses have been administered. Statewide, the one dose coverage rate for residents age 12 and over is 50.2%, 53.0% for age 18 and older, and 76.6% for age 65 and older. See Figure 2 for the Dickey County breakdown by age of one dose coverage and fully vaccinated (up-to-date coverage). Dickey County has an up-to-date coverage rate of 65.2% for age 12 and older, 70.4% for age 18 and older, and 94.0% for age 65 and older as of August 10, 2021.

Figure 2: 1 Dose Coverage Rate | Up-to-Date Coverage Rate[2]

There are seven COVID-19 vaccine-enrolled provider sites in Dickey County and 420 total in North Dakota.

Of the 5,229 tests completed (2,653 unique individuals) in Dickey County, 813 persons were found to be PCR positive. Seven hundred seventy-two of those people have recovered, eight are still active cases, and 33 have died.

Immunization Rates for Dickey County

The following chart (Figure 3) depicts immunization rates for Dickey County during the 2021 first quarter for children 19-35 months of age by the last day of the quarter who are up-to-date with the selected vaccine by the end of the quarter.

Figure 3. Percent of Dickey County Children 19-35 Months of Age for 2021 Q1[3]

Vaccine	Rate (%)	Rate (%) North Dakota
4:3:1:3:3:1:4 Series	76.67	60.99
DTap	80.00	66.84
Hepatitis A	66.67	59.54
Hepatitis B	90.00	82.24
Hib UTD	78.33	67.86
MMR	86.67	79.13
PCV	81.67	71.99
Polio	88.33	80.79
Varicella	86.67	79.09

The following chart (Figure 4) depicts immunization rates for Dickey County during the 2021 first quarter for Dickey County teens 13-17 years by the last day of the quarter who received the specified number of doses of the selected vaccine by the end of the quarter.

Figure 4. Percent of Dickey County Teens 13-17 Years of Age for 2021 Q1[3]

Vaccine	Rate (%)	Rate (%) North Dakota
HPV Female Start	81.01	74.56
HPV Female UTD	75.95	62.29
HPV Male Start	85.63	72.63
HPV Male UTD	80.24	58.09
MCV4 dose 1	93.56	88.60
MCV4 dose 2	50.00	60.65
Men B dose 1	14.41	46.29
Men B UTD	5.93	19.65
Td/Tdap	95.09	88.77
Varicella	94.17	89.61

The following chart (Figure 5) depicts immunization rates for Dickey County during the 2021 first quarter for Dickey County adults 19 years of age and older who received the specified number of doses of the selected vaccine by the end of the quarter.

Figure 5. Percent of Dickey County Adults 19 Years of Age and Older for 2021 Q1[3]

Vaccine	Rate (%)	Rate (%) North Dakota
PCV13 after 65 years	66.87	59.91
PPSV23 after 65 years	60.40	52.95
Shingrix® dose 1 after 50 years	38.66	29.38
Shingrix® UTD after 50 years	34.64	22.77
Tdap after 19 years	76.13	70.76
Zostavax after 60 years	42.21	34.41

Survey Results

In August 2021, a survey was disseminated to assess the COVID-19 perceptions and immunization needs of Dickey County. DCHD invited members of the community with varying backgrounds and opinions to complete the survey.

Effects of COVID-19 and the Introduction of the COVID-19 Vaccine on the Community

COVID-19 caused issues in schools, trying to figure out the best way to open safely. Parents and students had many questions. Schools were able to open and have classes with modifications. The community was hit hard by COVID-19, which was at the top of the list per capita for deaths. This loss was huge for the community. People who were able to work from home didn't feel much of a change. Some community members felt the vaccine didn't change much either.

Community members felt that the community is split when it comes to acceptance about receiving the vaccine. It seems the younger population is not as supportive as the older population. People who have received the vaccine are pleased that they can go out without a mask, and it has lessened the fear of COVID-19. The introduction of the vaccine made many community members excited and caused many questions. People felt a sense of relief that things may get back to normal with the vaccine finally available, but there were others who were very concerned about the vaccine and the effectiveness of it. The vaccine has given people more hope; they seem to be more willing to go out and conduct normal activities of daily living. Some feel attitudes towards the vaccine are positive, while others feel the community has mixed feelings towards it. There has been some concern in the community about nursing home residents automatically getting vaccinated.

Reasons People in the Community Want to be Vaccinated

People in the community want to be vaccinated against COVID-19 because they don't want to get sick and want to be able to go out without masking. Some feel it is the best protection against COVID-19 available. With the resurgence of the Delta variant, more people are wanting to be vaccinated now. People also don't want to be regularly tested for COVID-19 and want to be able to attend certain events and visit certain places that require vaccination. Others want to be vaccinated because they want to see their family members. Community members also wanted to be vaccinated when the community started seeing more deaths from COVID-19. Some people wanted to get vaccinated so children wouldn't have to miss school for quarantining.

Reasons People in the Community Do Not Want to be Vaccinated

Some people in the community think that the COVID-19 vaccine contains a "chip," and that COVID-19 is not real. Younger people of child-bearing age fear that the COVID-19 vaccine will somehow hurt future pregnancies and babies. People in the community are afraid that the vaccine will make them sick. Some community members felt that people don't want the vaccine because there has not been enough education about the COVID-19 vaccine and vaccines in general. Many people have questions about the side effects and longevity of the vaccine. Many felt it is too politically charged. There are concerns about the timeline of vaccine research, as well as mistrust in the government or certain political parties supporting the vaccine.

Some individuals are leery of one specific COVID-19 vaccine due to the rumor that this vaccine was created with aborted fetal cells. It was indicated that there is a feeling, for some, that the vaccine hasn't been tested long enough and will not receive it because of that basis. Other reasons that people do not want to be vaccinated include that the vaccine does not give full immunity against COVID-19, and some people think COVID-19 has been blown out of proportion by the media. People do not understand why they should get vaccinated if they'd still have to wear masks. Some people are still getting COVID-19, even though they have received the vaccine. The U.S. Food and Drug Administration has not fully approved the vaccine, which makes some people wary of it. Some individuals think they do not need to be vaccinated against COVID-19 because they have already had it, so they believe they have the natural antibodies. Those persons who believe they would not get very sick with COVID-19 don't feel the need to be vaccinated.

Sources of COVID-19 Information

Community members get their COVID-19 information from the internet, social media, and medical professionals whom they trust. Some people have asked their doctor about their specific situations. Information is also found on the news or Facebook, which may not always be accurate. Other sources include the Centers for Disease Control and Prevention (CDC) and public health departments. Some sources of information, such as social media or national news, seem to instill fear into people.

Barriers to Receiving the COVID-19 Vaccination

Community members felt that there were not many barriers to receiving a COVID-19 vaccination. They felt it is very easy to get a vaccine, as anyone could call or walk-in to the clinics, public health, or pharmacies, many of which will travel to individuals to give vaccines. Misinformation was noted as a barrier to receiving a vaccine, as people may not be sure where to get accurate health information. The single-shot vaccine has not been available in the area, which has been a barrier to vaccination for some that are looking specifically to only get one injection.

Ways to Increase Confidence and Vaccination Rates

Community members felt that providing COVID-19 vaccine access at the schools, combined with education about vaccinations, could increase vaccine rates and confidence in the community. Posting on social media and in high traffic areas, such as clinics, would be beneficial; information as to where, when, and how to receive a vaccine and who to contact with any questions could be posted. Marketing the percentage of the county's population that are vaccinated, compared to the rest of the nation, might be good. Some community members suggested that the health district offering incentives for vaccination might improve rates. It might also be worth looking at minorities who are underserved and send a postcard or call unvaccinated individuals to encourage them to get vaccinated.

Sharing stories of people who have chosen to get vaccinated and why may be a good idea. Stories of people who got COVID-19 and how miserable it was might encourage vaccinations as well. Targeting those who have gotten other vaccines but are hesitant about the COVID-19 vaccination might be a good place to start; asking why they haven't gotten vaccinated against COVID-19 and education could result in more vaccinations. Some community members shared that open forum meetings to explain the science in simple terms, not political terms, may help increase vaccine education in the community.

Health Equity Strategic Plan

North Dakota public health units were charged with creating a health equity strategic plan in 2021. Dickey County Public Health created one plan for Oakes and another plan for Ellendale.

Oakes Health Equity Strategic Plan:

1. Public transportation – the goal is to increase the availability by 5-10% in a year. Currently, the public bus runs every third Monday to Aberdeen, South Dakota, and can pick up patients at home or anywhere in Dickey County. On Tuesday, it transports to Oakes from 9:00 AM - 1:00 PM and on Wednesdays and Fridays from 9:00 AM - 4:00 PM. There is a need to have both busses running full time. Action Steps:

    i. Coordinate services utilizing a central office

    ii. Continuity going forward

    iii. Communicate the availability for all through marketing (newspaper/radio, providers will designate a person to do the scheduling at all facilities, advertise in school newsletter)

2. Recruit a local optometrist

3. Recruit a mental health counselor – Psych patients have doubled at CHI Oakes Hospital . There is a need for the following: a counselor in Dickey County, personal connections, community awareness to

"normalize" the issue, youth mentorship, 211 awareness, life skills/coping mechanisms, substance abuse training, Mental Health First Aid training, reduction of state line barriers, and a reduction in language barriers.

4) Food Insecurity – have a food bank available for everyone. Develop a summer food program for school-aged children.

Ellendale Health Equity Strategic Plan findings:

1. Dental – there are Medicaid issues for reimbursement, making it challenging to find a provider who will accept patients using Medicaid.
2. Mental health – services are lacking for all ages. A number of issues exist: there is no counselor in Dickey County, lack of mental health providers of all types – from psychiatrists to counselors, issues with crossing the North Dakota/South Dakota border, transportation, lack of funding, stigma, and awareness of the issue. Need access to Mental Health First Aid, grief counseling, and education on coping skills. Action step: Create a mental health toolkit to advertise to the public what is available.
3. Drug and alcohol issues – all ages are affected by this issue. There needs to be an increase in police action and drug prevention in schools.
4. Lack of community services:

    a. Transportation – trouble accessing public transportation to medical appointment (physical and mental). Funding is needed to provide more transportation services. This position could be full time. The services could be advertised through the Chamber newsletter.

    b. Availability of exercise – need an indoor gym (recreation center) open to the community and walking paths outside.

    c. No optometry available in the area.

    d. Medicaid patients have trouble accessing services because the reimbursement issues for providers.

5. Communication with elderly due to lack of technology can lead to miscommunication and lack of awareness of issues and resources.
6. Food pantry is needed to help combat food insecurities, including those of school-age children.

Demographic Information

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

	Dickey County	North Dakota
Population (2019)	4,872	762,062
Population change (2010-2019)	-7.8%	13.3%
People per square mile (2010)	4.7	9.7
Persons 65 years or older (2019)	20.7%	15.7%
Persons younger than 18 years (2019)	24.4%	23.6%
Median age (2019 est.)	36.5	35.1
White persons (2019)	95.7%	86.9%
High school graduates (2019)	91.3%	92.6%
Bachelor's degree or higher (2019)	28.8%	30.0%
Live below poverty line (2019)	10.6%	10.6%
Persons without health insurance, under age 65 years (2019)	7.9%	8.1%
Households with a broadband Internet subscription (2019)	79.0%	80.7%

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, Dickey County has seen a decrease in population since 2010. The U.S. Census Bureau estimates show that Dickey County's population decreased from 5,289 (2010) to 4,872 (2019).

County Health Rankings

The Robert Wood Johnson Foundation, collaborating 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, Dickey County is compared to North Dakota rates and national benchmarks on various topics, ranging from individual health behaviors to the quality of healthcare.

The data used in the 2021 County Health Rankings are pulled from more than 20 data sources and then are compiled to create county rankings. Counties in each of the 50 states are ranked according to summaries of a variety of health measures. Those having high ranks, such as 1 or 2, are considered the "healthiest." Counties are ranked on both health outcomes and health factors. Following is a breakdown of the variables that influence a county's rank.

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

Health Outcomes

- Length of life
- Quality of life

Health Factors

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

Health Factors (continued)

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

Table 2 summarizes the pertinent information gathered by County Health Rankings, as it relates to Dickey 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 the following statistics are based on the health behaviors and conditions of the county's residents, not necessarily the patients and clients of Dickey County Public Health and CHI Oakes Hospital or of any particular medical facility.

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

Dickey County rankings within the state are included in the summary following. For example, they rank 8th out of 48 ranked counties in North Dakota on health outcomes and 13th on health factors. The measures marked with a bullet point (•) are those where a county is not measuring up to the state rate/percentage; a square (■) indicates that the county is not meeting the U.S. Top 10% rate on that measure. Measures that are not marked with a colored shape but are marked with a plus sign (+) indicate that the county is doing better than the U.S. Top 10%.

The data from County Health Rankings show that Dickey County is doing better than many counties, compared to the rest of the state on about half of the outcomes, landing at or above rates for other North Dakota counties. However, like many North Dakota counties, they are doing poorly in many areas when it comes to the U.S. Top 10% ratings. One particular outcome, where Dickey County does not meet the U.S. Top 10% ratings, is the number of mental health providers. Dickey County has a ratio of 4,870:1, and the U.S. Top 10% ratio is 270:1.

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

- Poor mental health days
- Low birth weight
- Adult smoking
- Food environment index
- Sexually transmitted infections
- Teen birth rate
- Primary care physician ratio
- Income inequality
- Children in single-parent households
- Social associations
- Violent crime
- Injury deaths
- Severe housing problems

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

- Poor physical health days
- Adult obesity
- Physical inactivity
- Access to exercise opportunities
- Excessive drinking
- Alcohol-impaired driving deaths
- Uninsured
- Dentists ratio
- Mammography screening
- Children in poverty
- Air pollution

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

● = Not meeting North Dakota average

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

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

Blank values reflect unreliable or missing data

TABLE 2: SELECTED MEASURES FROM *COUNTY HEALTH RANKINGS* 2021 – DICKEY COUNTY			
	Dickey County	**U.S. Top 10%**	**North Dakota**
Ranking: Outcomes	**8th**		**(of 46)**
Premature death		5,400	6,600
Poor or fair health	14% +	14%	14%
Poor physical health days (in past 30 days)	3.3 +●	3.4	3.2
Poor mental health days (in past 30 days)	3.5 +	3.8	3.8
Low birth weight	4% +	6%	6%
Ranking: Factors	**13th**		**(of 45)**
Health Behaviors			
Adult smoking	19% ■	16%	20%
Adult obesity	36% ■●	26%	34%
Food environment index (10=best)	9.7 +	8.7	8.9
Physical inactivity	26% ■●	19%	23%
Access to exercise opportunities	72% ■●	91%	74%
Excessive drinking	25% ■●	15%	24%
Alcohol-impaired driving deaths	80% ■●	11%	42%
Sexually transmitted infections	82.3 +	161.2	466.6
Teen birth rate	13 ■	12	20
Clinical Care			
Uninsured	9% ■●	6%	8%
Primary care physicians	1,230:1 ■	1,030:1	1,300:1
Dentists	1,620:1 ■●	1,210:1	1,510:1
Mental health providers	4,870:1 ■●	270:1	510:1
Preventable hospital stays	4,477 ■●	2,565	4,037
Mammography screening (% of Medicare enrollees ages 65-74 receiving screening)	48% ■●	51%	53%
Flu vaccinations (% of fee-for-service Medicare enrollees receiving vaccination)	50% ■	55%	50%
Social and Economic Factors			
Unemployment		2.6%	2.4%
Children in poverty	13% ■●	10%	11%
Income inequality	3.8 ■	3.7	4.4
Children in single-parent households	16% ■	14%	20%
Social associations	26.5 +	18.2	16.0
Violent crime	69 ■	63	258
Injury deaths	69 ■	59	71
Physical Environment			
Air pollution – particulate matter	5.3 ■●	5.2	4.7
Drinking water violations	No		
Severe housing problems	7% +	9%	12%

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

Children's Health

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

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

TABLE 3: SELECTED MEASURES REGARDING CHILDREN'S HEALTH (For children ages 0-17 unless noted otherwise), 2019

Health Status	North Dakota	National
Children born premature (3 or more weeks early)	9.6%	11.2%
Children 10-17 overweight or obese	24.8%	31.4%
Children 0-5 who were ever breastfed	84.6%	80.6%
Children 6-17 who missed 11 or more days of school	3.9%	4.5%
Healthcare		
Children currently insured	18.4%	93.4%
Children who had preventive medical visit in past year	75.4%	19.0%
Children who had preventive dental visit in past year	12.0%	79.6%
Young children (10 mos.-5 yrs.) receiving standardized screening for developmental or behavioral problems	1.2%	10.4%
Children aged 2-17 with problems requiring counseling who received needed mental healthcare	32.6%	2.3%
Family Life		
Children whose families eat meals together 4 or more times per week	75.5%	73.6%
Children who live in households where someone smokes	15.3%	14.4%
Neighborhood		
Children who live in neighborhood with a park, sidewalks, a library, and a community center	81.1%	75.4%
Children living in neighborhoods with poorly kept or rundown housing	9.1%	13.3%
Children living in neighborhood that's usually or always safe	97.4%	95.0%

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

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

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

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

being.; more information about KIDS COUNT is available at www.ndkidscount.org. The measures, highlighted in blue in the table, are those in which the counties are doing worse than the state average. The year of the most recent data is noted.

The data show Dickey County is performing better than the North Dakota average on all of the examined measures, except the number of children enrolled in Healthy Steps (CHIP) and victims of child abuse and neglect, requiring services.

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

	Dickey County	North Dakota
Child food insecurity, 2019	5.5%	9.6%
Medicaid recipient (% of population age 0-20), 2019	20.8%	26.6%
Children enrolled in Healthy Steps (CHIP) (% of population age 0-18), 2020	3.2%	1.6%
Supplemental Nutrition Assistance Program (SNAP) recipients (% of population age 0-18), 2020	12.0%	16.9%
Licensed childcare capacity (# of children), 2020	380	36,701
4-year high school cohort graduation rate, 2019/2020	≥95%	89.0%
Victims of child abuse and neglect requiring services (rate per 1,000 children ages 0-17), 2019	15.07	9.98

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 United States. The YRBS was designed to monitor trends, compare state health risk behaviors to national health risk behaviors, and intended for use to plan, evaluate, and improve school and community programs. North Dakota began participating in the YRBS survey in 1995. Students in grades 7-8 and 9-12 are surveyed in the spring of odd years. The survey is voluntary and completely anonymous.

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

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

TABLE 5: Youth Risk Behavior Survey Results

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

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

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

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

Low Income Needs

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

Top Needs Identified by People Experiencing Poverty Across North Dakota

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

2020 North Dakota LOW INCOME COMMUNITY NEEDS

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

NDSU North Dakota State University

Assessed by CAPND and NDSU, November 2020

KEY FINDINGS

1st Priority Need

Rental Assistance

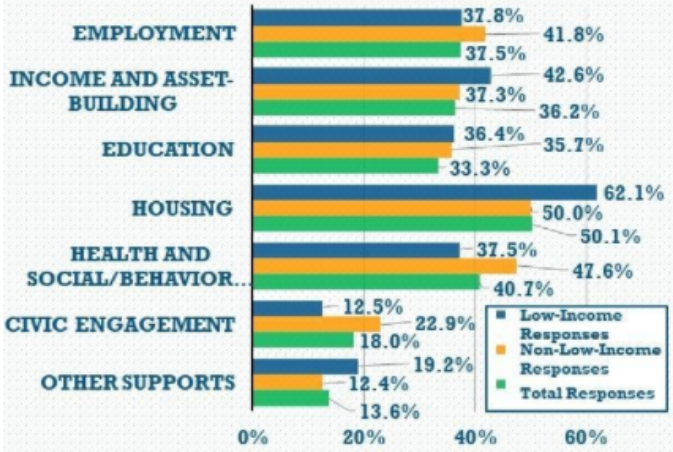
3,458 Total Survey Responses

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

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

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

STATEWIDE OVERALL NEEDS



TOP STATEWIDE SPECIFIC NEEDS

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

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

Community (Low-Income & Non-Low-Income)
- **Health and Social/Behavior Development** - Dental Insurance/Affordable Dental
- **Health and Social/Behavior Development** - Health Insurance/Affordable Health Care
- **Health and Social/Behavior Development** - Mental Health Service

TOP REGIONAL OVERALL NEEDS FOR LOW-INCOMES

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

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

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

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

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

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

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

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

ACKNOWLEDGMENTS

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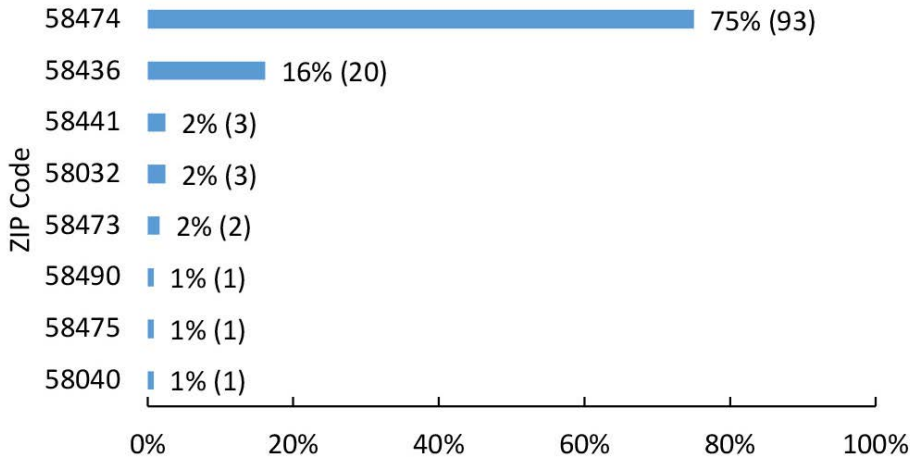
https://www.capnd.org/

Survey Results

As noted previously, the 167 community members completed the survey in communities throughout the counties in the CHI Oakes Hospital service area. For all questions that contained an "Other" response, all of those direct responses may be found in Appendix G. In some cases, a summary of those comments is additionally included in the report narrative. The "Total respondents" number under each heading indicates the number of people who responded to that particular question, and the "Total responses" number under the heading depicts the number of responses selected for that question (some questions allow for selection of more than one response).

The survey requested that respondents list their home ZIP code. While not all respondents provided a ZIP code, 124, revealing that a large majority of respondents (75%, N=93) lived in the 58421 (Oakes) area, followed by 58486 (Ellendale) area. These results are shown in Figure 5.

Figure 5: Survey Respondents' Home Zip Code
Total respondents: 124



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

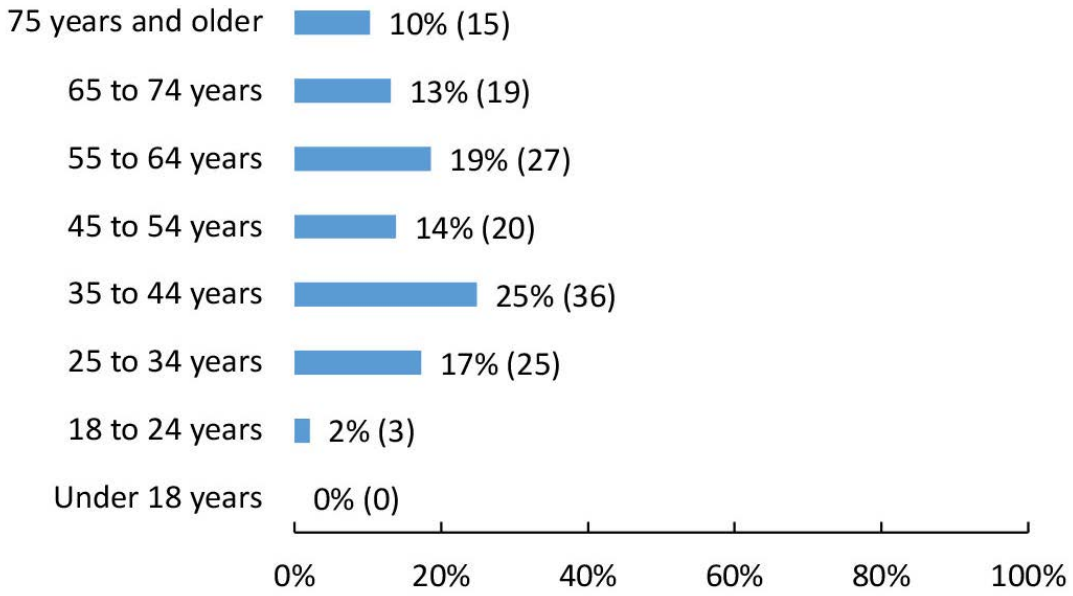
To better understand the perspectives offered by survey respondents, survey-takers were asked a few demographic questions. Throughout this report, numbers (N) instead of just percentages (%) are reported because percentages can be misleading with smaller numbers. Survey respondents were not required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

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

- 42% (N=61) were age 55 or older
- The majority (84%, N=122) were female
- Slightly more than half of the respondents (55%, N=79) had bachelor's degrees or higher
- The number of those working full time (57%, N=82) was just over twice as high as those who were retired (25%, N=36)
- 99% (N=137) of those who reported their ethnicity/race were White/Caucasian
- 49% of the reporting population (N=29) 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 = 145



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

Figure 7: Gender Demographics of Survey Respondents
Total respondents = 145

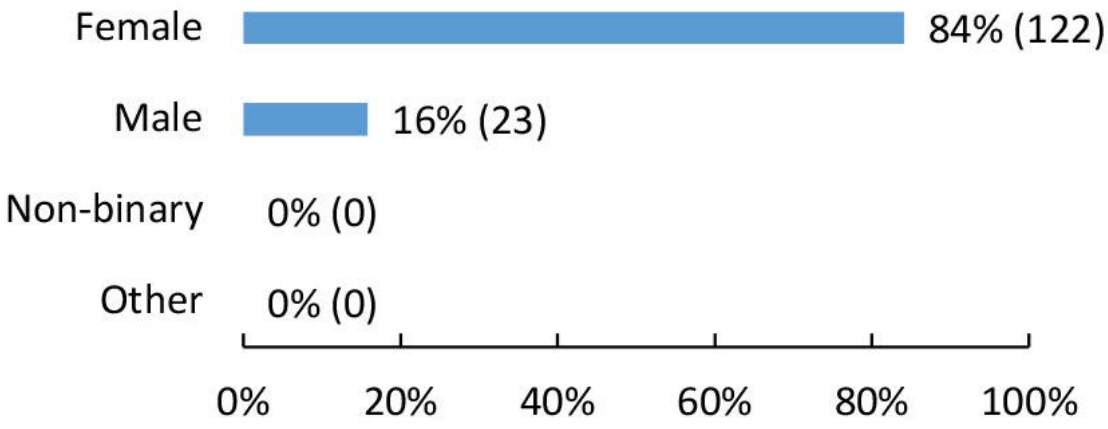


Figure 8: Educational Level Demographics of Survey Respondents
Total respondents = 145

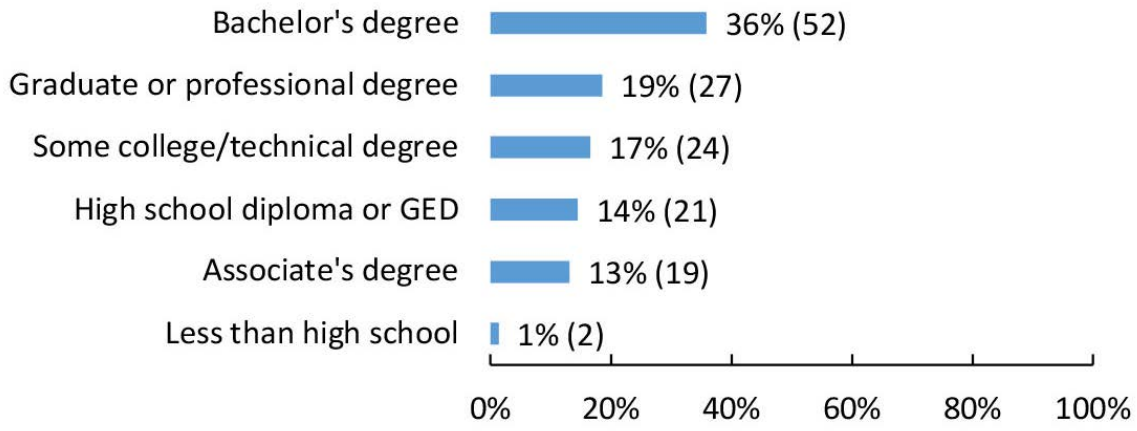
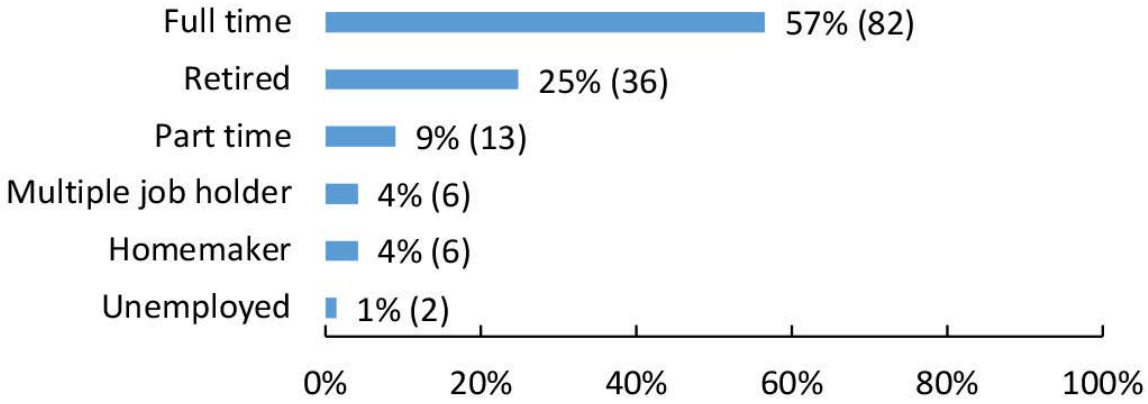
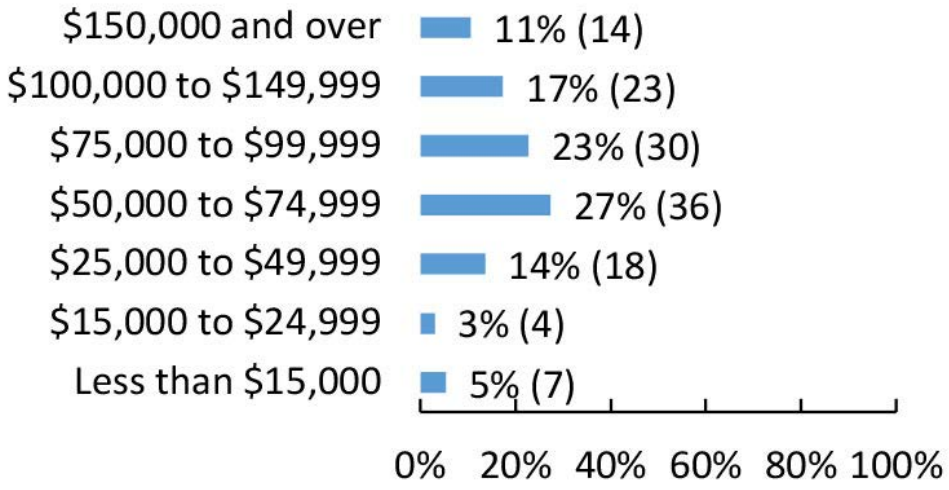


Figure 9: Employment Status Demographics of Survey Respondents
Total respondents = 144



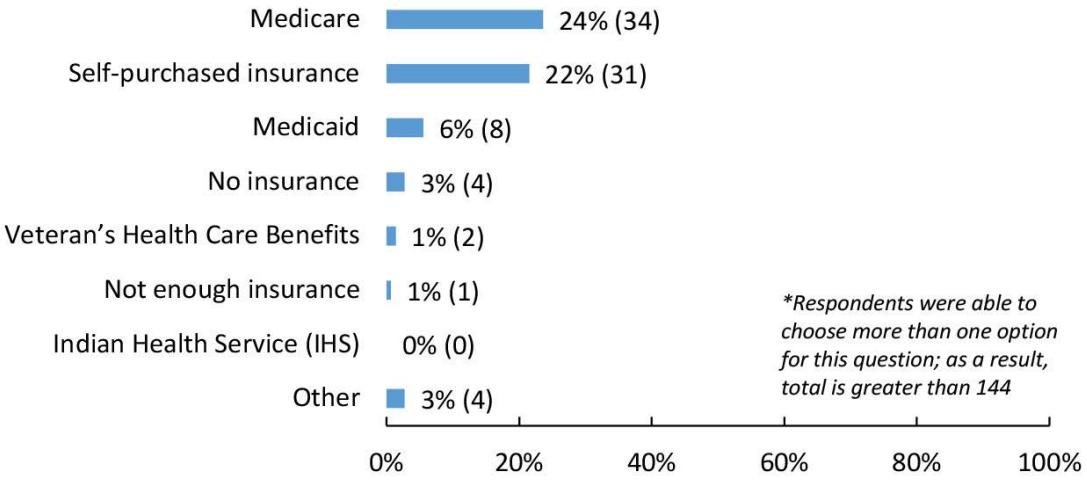
Of those who provided a household income, 8% (N=11) of community members reported a household income of less than $25,000. 28% (N=37) indicated a household income of $100,000 or more. This information is shown in Figure 10.

Figure 10: Household Income Demographics of Survey Respondents
Total respondents = 132



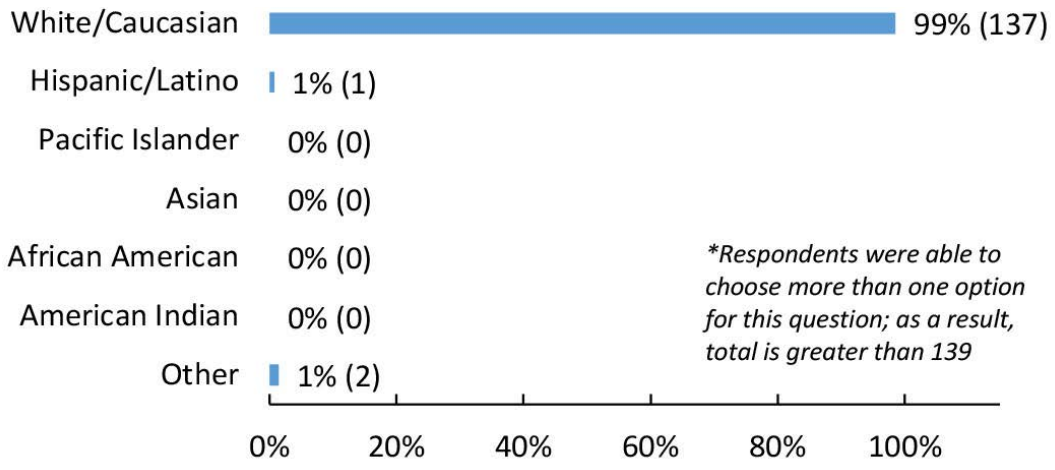
Community members were asked about their health insurance status, which is often associated with whether people have access to healthcare. Four percent (N=5) of the respondents reported having no health insurance or being under-insured. The most common insurance types were insurance through one's employer (N=93), followed by Medicare (N=34), and self-purchased (N=31).

Figure 11: Health Insurance Coverage Status of Survey Respondents
Total respondents = 144



As shown in Figure 12, nearly all of the respondents were White/Caucasian (99%). This number was somewhat above the race/ethnicity of the overall population of Dickey County; the U.S. Census indicates that 95.7% of the population is White.

Figure 12: Race/Ethnicity Demographics of Survey Respondents
Total respondents = 139



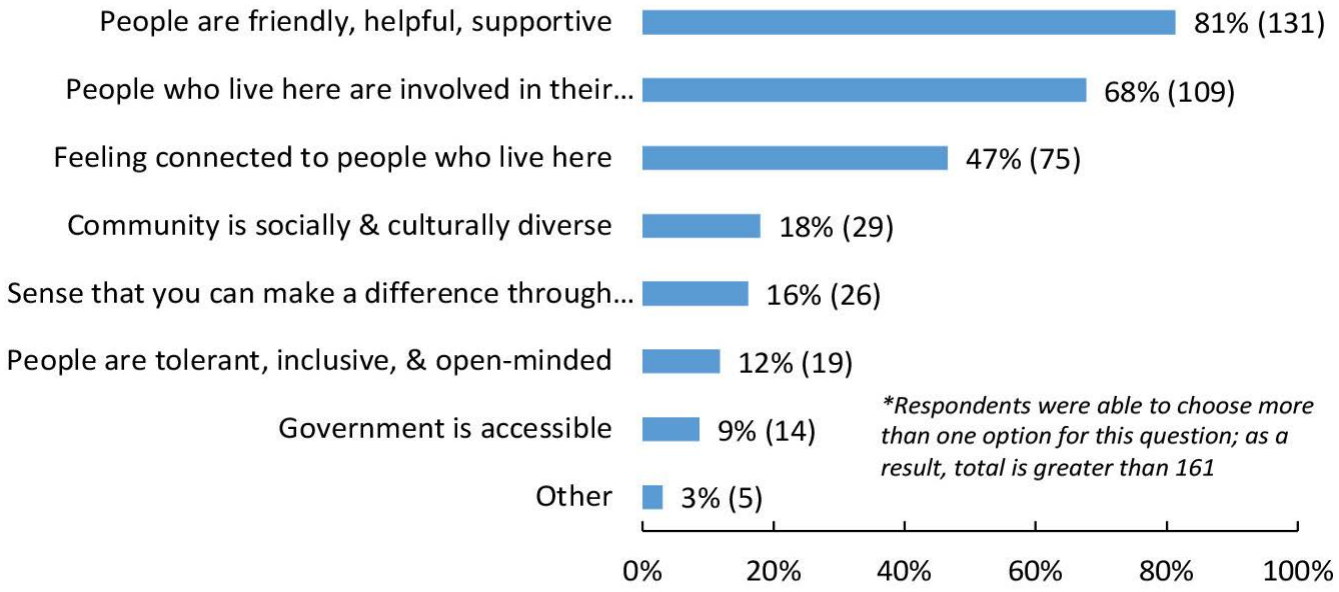
Community Assets and Challenges

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 100 respondents agreeing) that community assets include:

- Safe place to live, little/no crime (N=139)
- Family-friendly (N=132)
- People are friendly, helpful, supportive (N=131)
- People who live here are involved in their community (N=109)
- Healthcare (N=103)
- Active faith community (N=101)

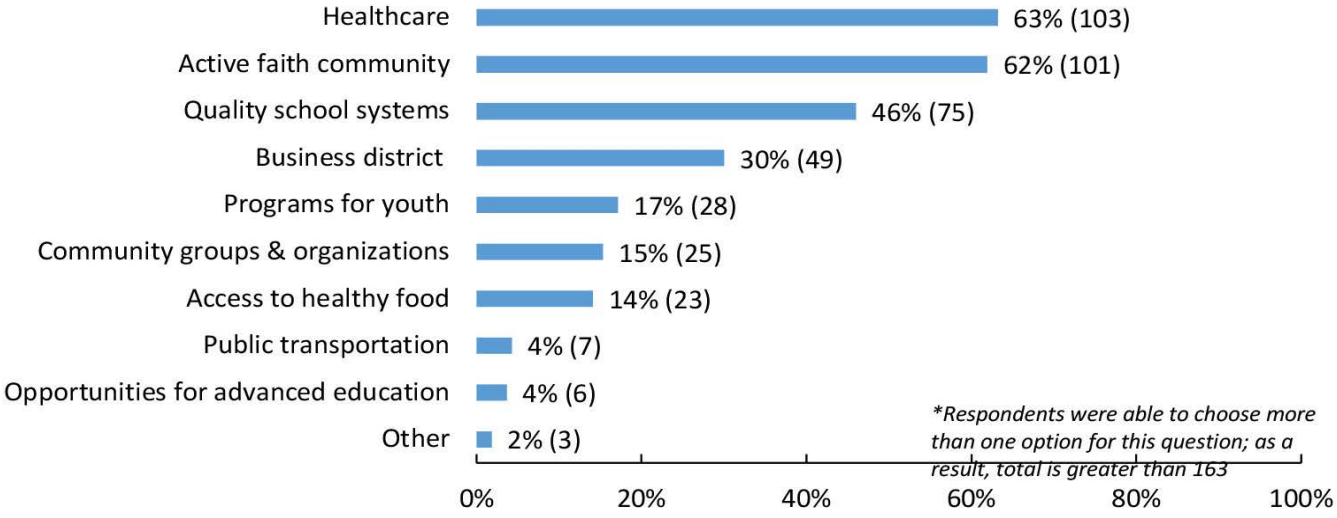
Figures 13 to 16 illustrate the results of these questions.

Figure 13: Best Things About the PEOPLE in Your Community
Total respondents = 161



Included in the "Other" category of the best things about the people was that there is a genuine concern and caring for those who have struggles or hardship.

Figure 14: Best Things About the SERVICES AND RESOURCES in Your Community
Total respondents = 163



Respondents who selected "Other" specified that the best things about services and resources were the excellent EMS system and the clean water.

Figure 15: Best Things about the QUALITY OF LIFE in Your Community
Total respondents = 167

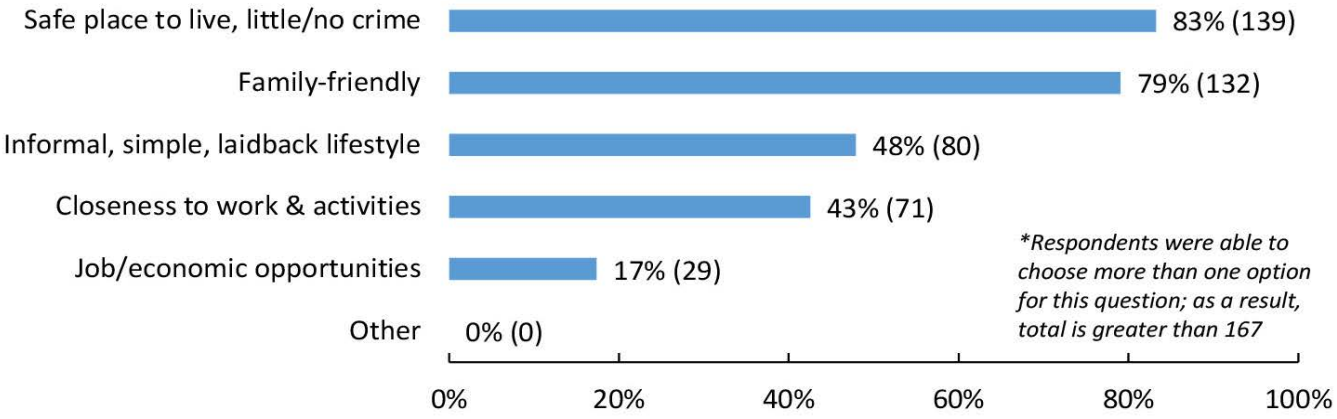
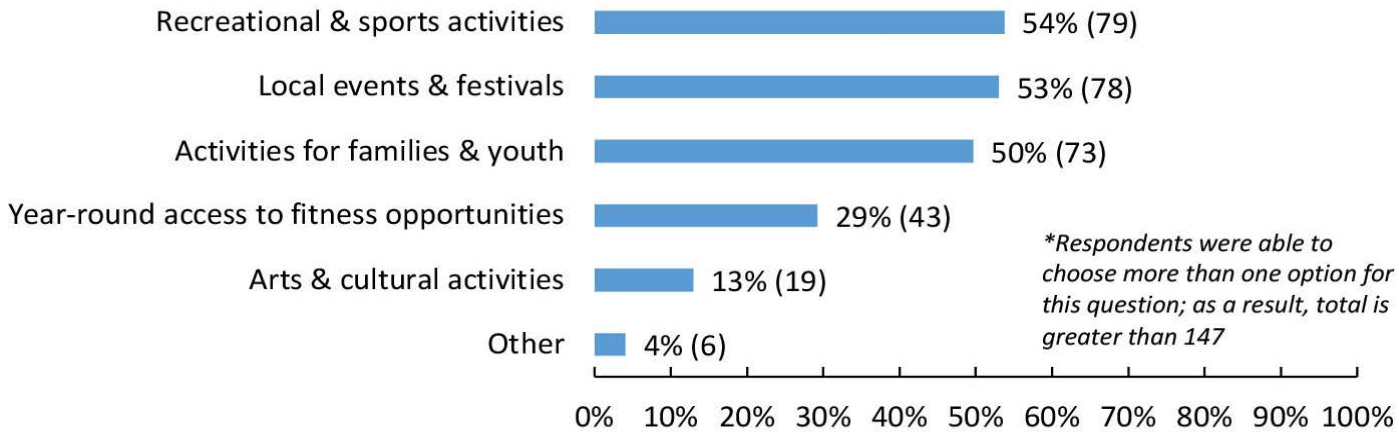


Figure 16: Best Thing About the ACTIVITIES in Your Community
Total respondents = 147



Respondents who selected "Other" specified that the best things about the activities in the community included the libraries, horse arena, museum, adult summer swim classes, bowling alley, and movie theater.

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

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

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

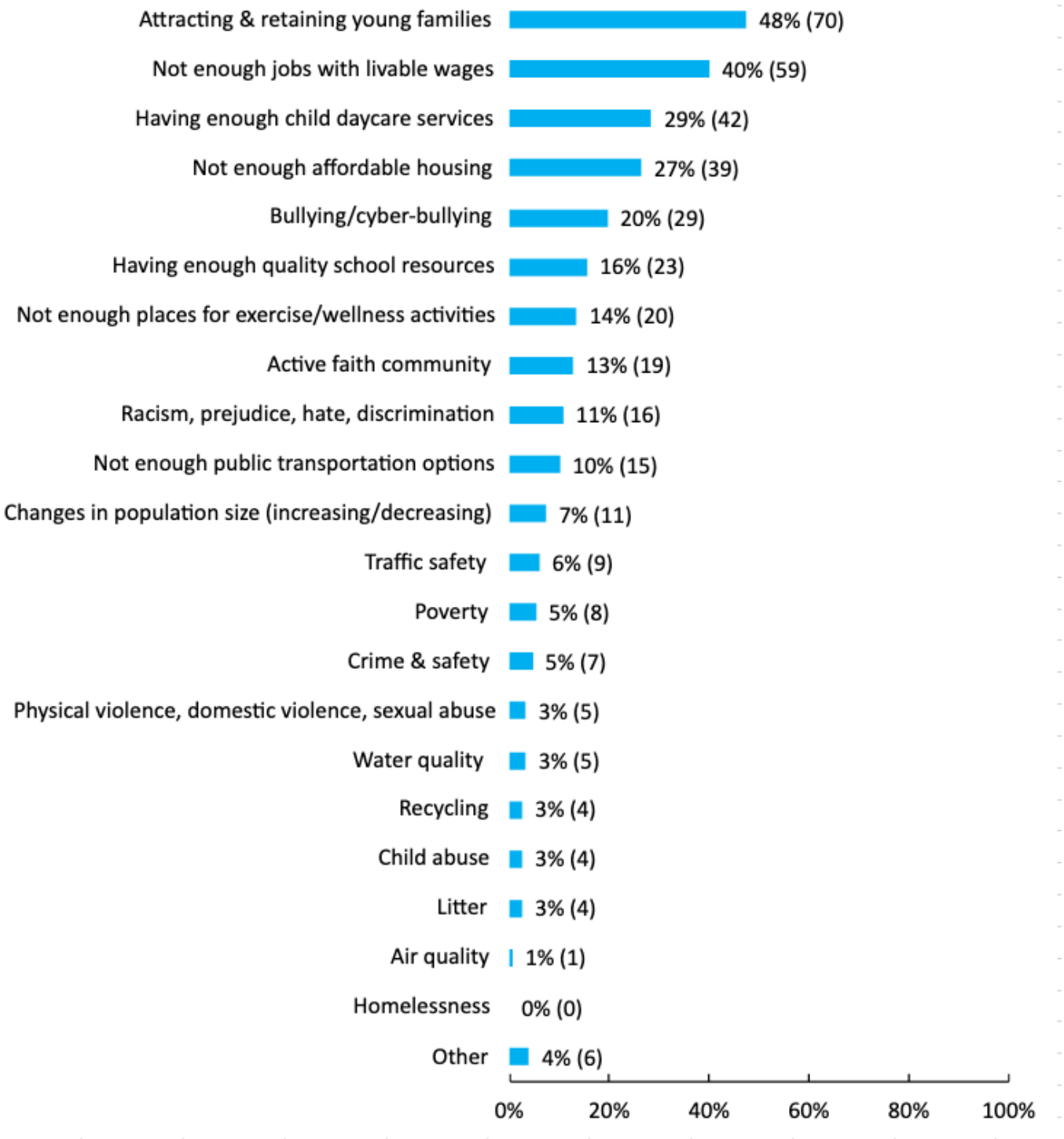
- Bullying/cyberbullying (N=88)
- Availability of vision care (N=80)
- Depression/anxiety – youth (N=73)
- Alcohol use and abuse – youth (N=71)
- Attracting and retaining young families (N=70)
- Availability of resources to help the elderly stay in their homes (N=68)
- Depression/anxiety – adult (N=66)
- Not enough jobs with livable wages (N=59)
- Alcohol use and abuse – adult (N=54)
- Cost of long-term/nursing home care (N=53)

The other issues that had at least 40 votes included:

- Availability of mental health services (N=48)
- Child abuse or neglect (N=47)
- Emotional abuse (N=47)
- Drug use and abuse – youth (N=45)
- Having enough child daycare services (N=42)
- Not getting enough exercise/physical activity (N=40)

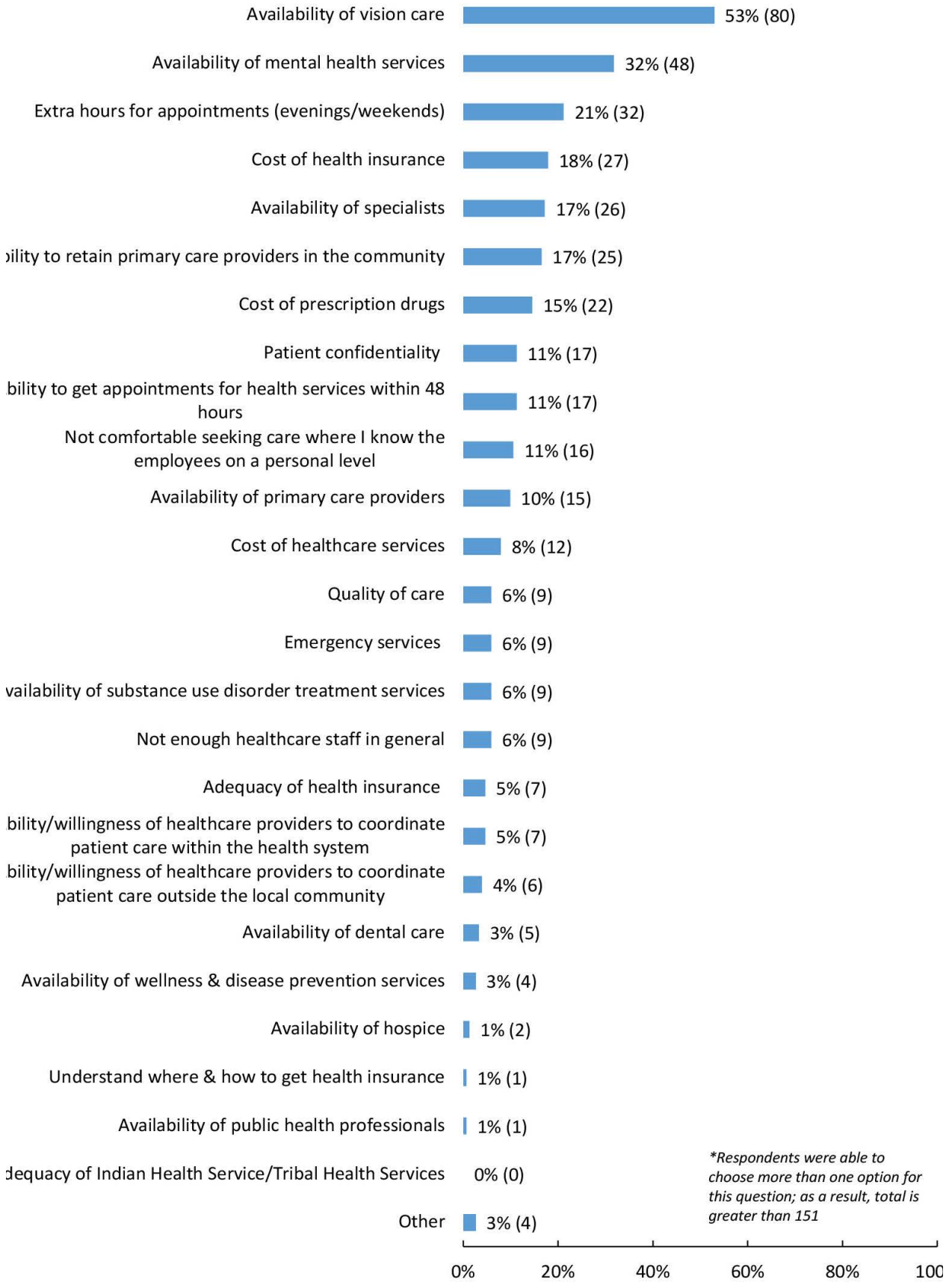
Figures 17 through 22 illustrate these results.

Figure 17: Community/Environmental Health Concerns
Total respondents = 147



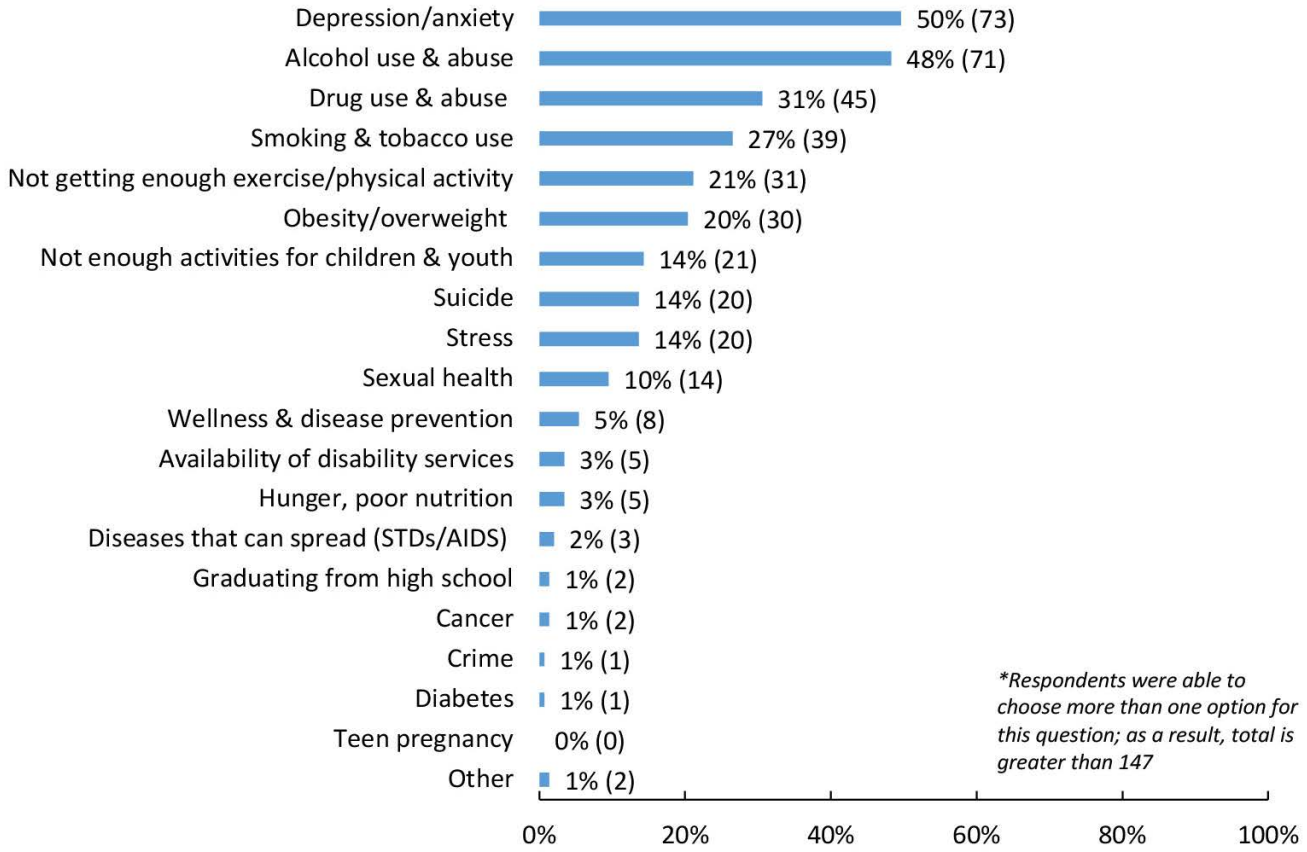
In the "Other" category for community and environmental health concerns, the following were listed: ability of school to retain staff and difficulty of having so many youth in the classrooms who have behavioral issues – there is a need for the community to be focused on healthy family dynamics and less on sports; adequate medical providers; drugs; equitable access to child care/preschool; not enough quality grocery options, especially produce; and desire to have a new neighborhood of real estate lots to buy and on which to build houses.

Figure 18: Availability/Delivery of Health Services Concerns
Total respondents = 151



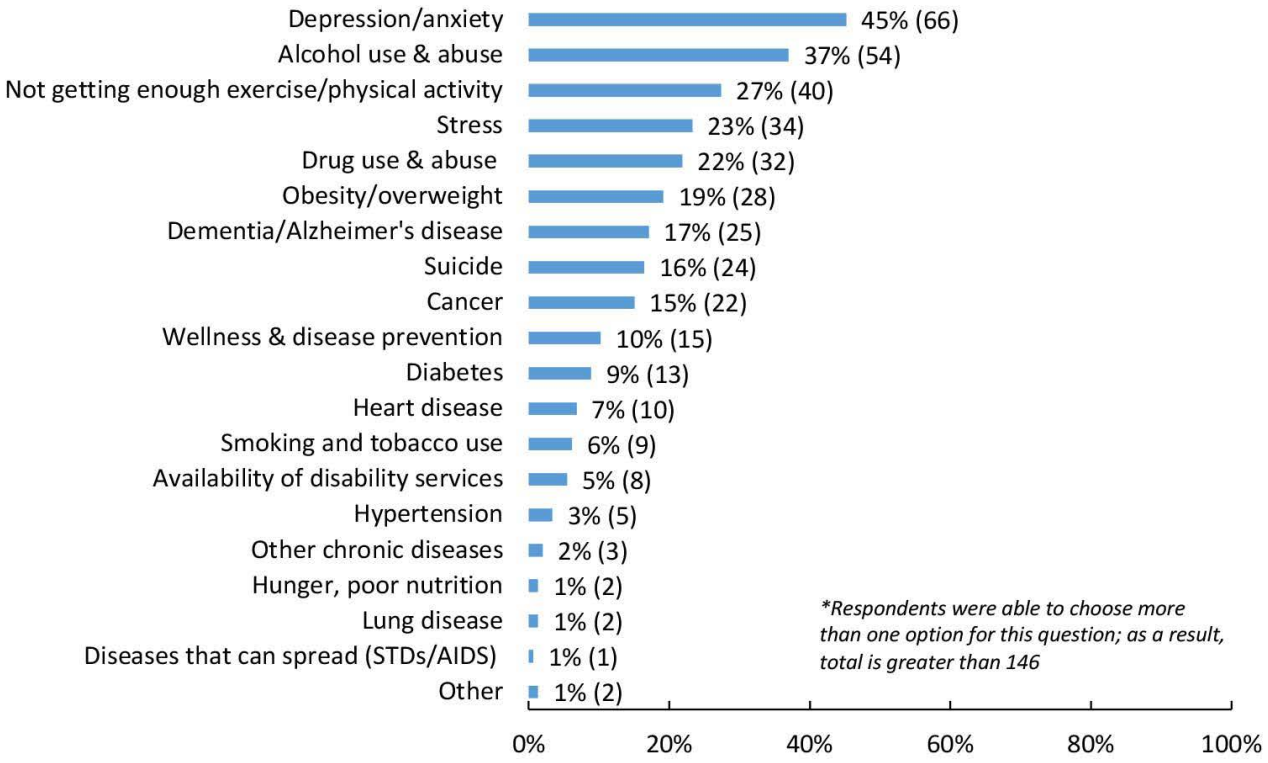
Respondents who selected "Other" identified concerns over prescription of medication instead of preventative care through dietary or lifestyle changes, no OB/delivery of babies, and lifestyle changes need to be made.

Figure 19: Youth Population Health Concerns
Total respondents = 147



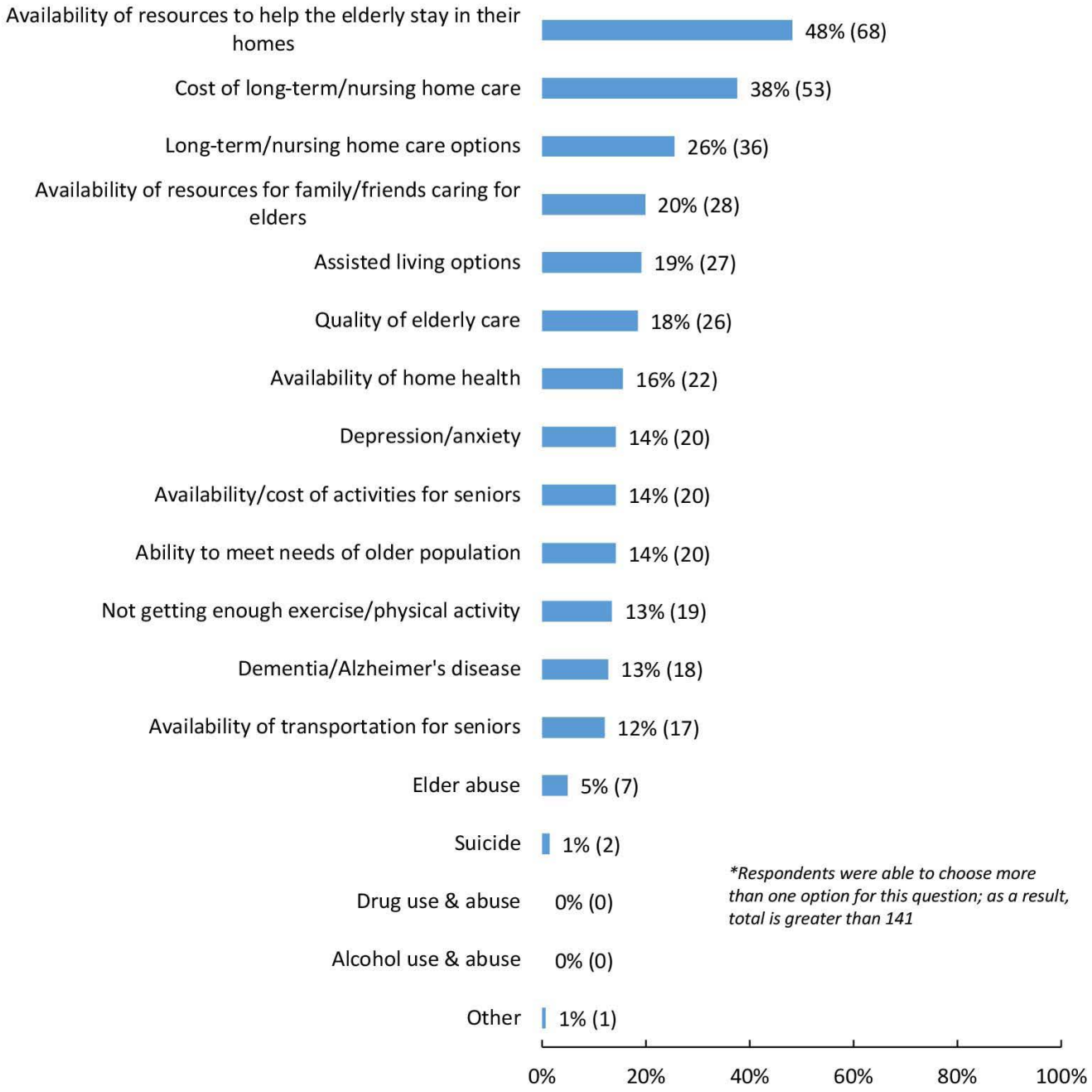
Listed in the "Other" category for youth population concerns were both related to bullying and cyberbullying.

Figure 20: Adult Population Concerns
Total respondents = 146



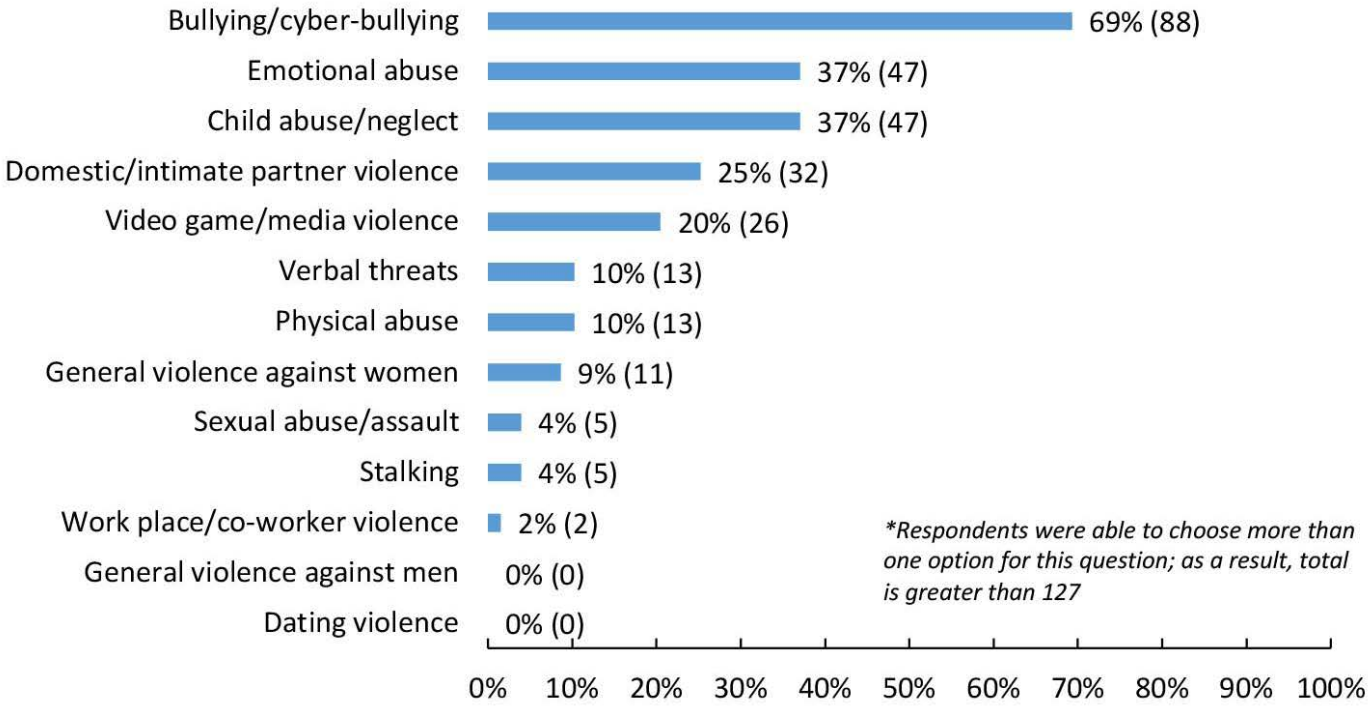
Listed in the "Other" category for adult population concerns were healthy food options and having a dialysis center again.

Figure 21: Senior Population Concerns
Total responses = 141



In the "Other" category, the one concern listed was quality long-term/nursing home options.

Figure 22: Violence Concerns
Total respondents = 127



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. Mental health
2. Loss of population

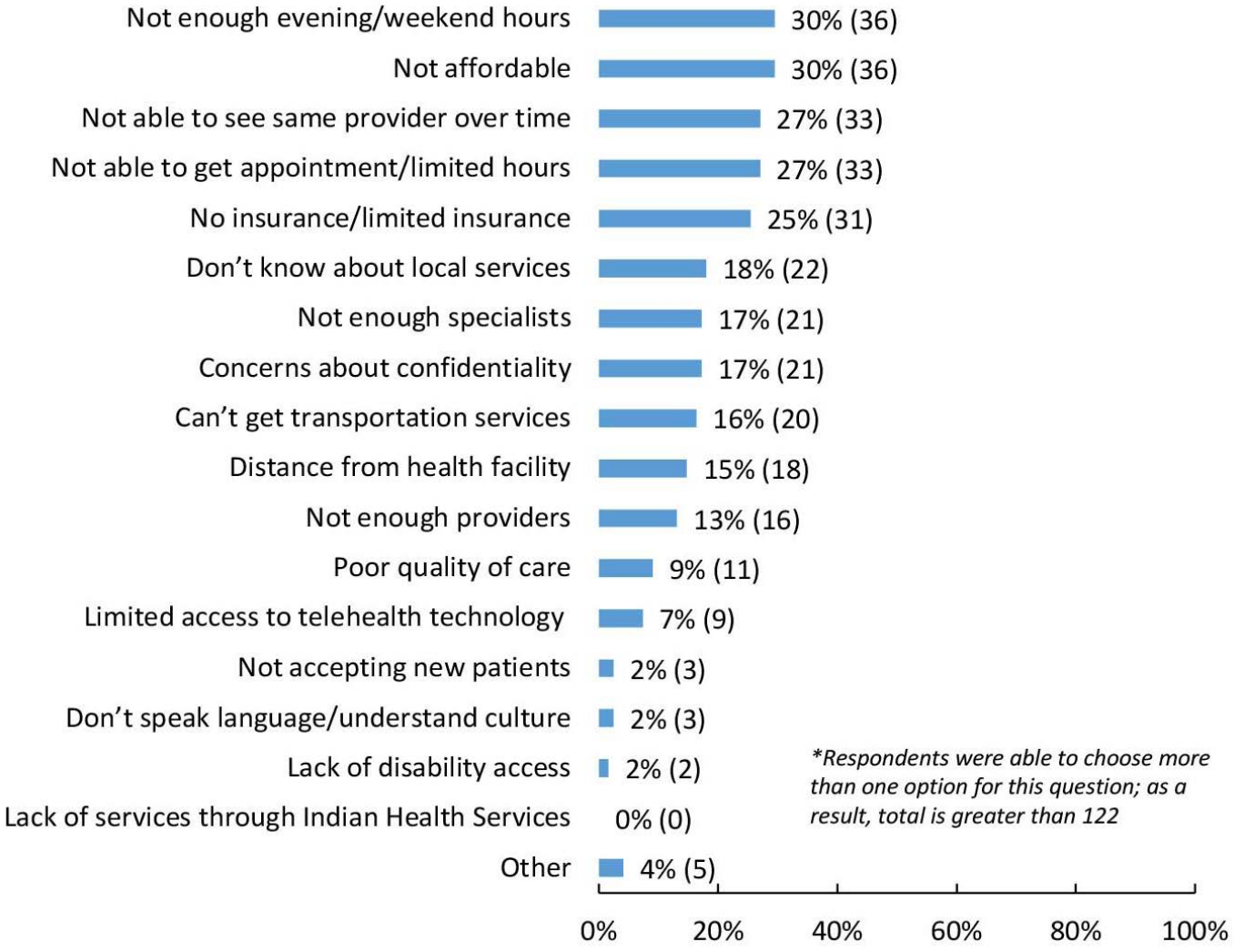
Mental health, along with behavioral health, was overwhelmingly the biggest issue most often cited. However, loss of population arose significantly and was felt to be caused by other issues, such as lack of jobs with a livable wage and housing costs. Other biggest challenges that were identified were lack of jobs that paid a livable wage and had opportunities for growth, lack of pediatric care, and lack of physical activity/indoor activities.

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 barriers perceived by residents was a tie between not enough evening/weekend hours and not affordable (N=36). After these items, the next most commonly identified barriers were not being able to see the same provider over time (N=33) and not able to get appointments/limited hours (N=33), followed by no insurance or limited insurance (N=31). There were few "Other" responses, but what was stated were lack of trust in overall healthcare system and transparency with medications being prescribed, pediatrician needed, and healthcare is accessible except for vision at this time.

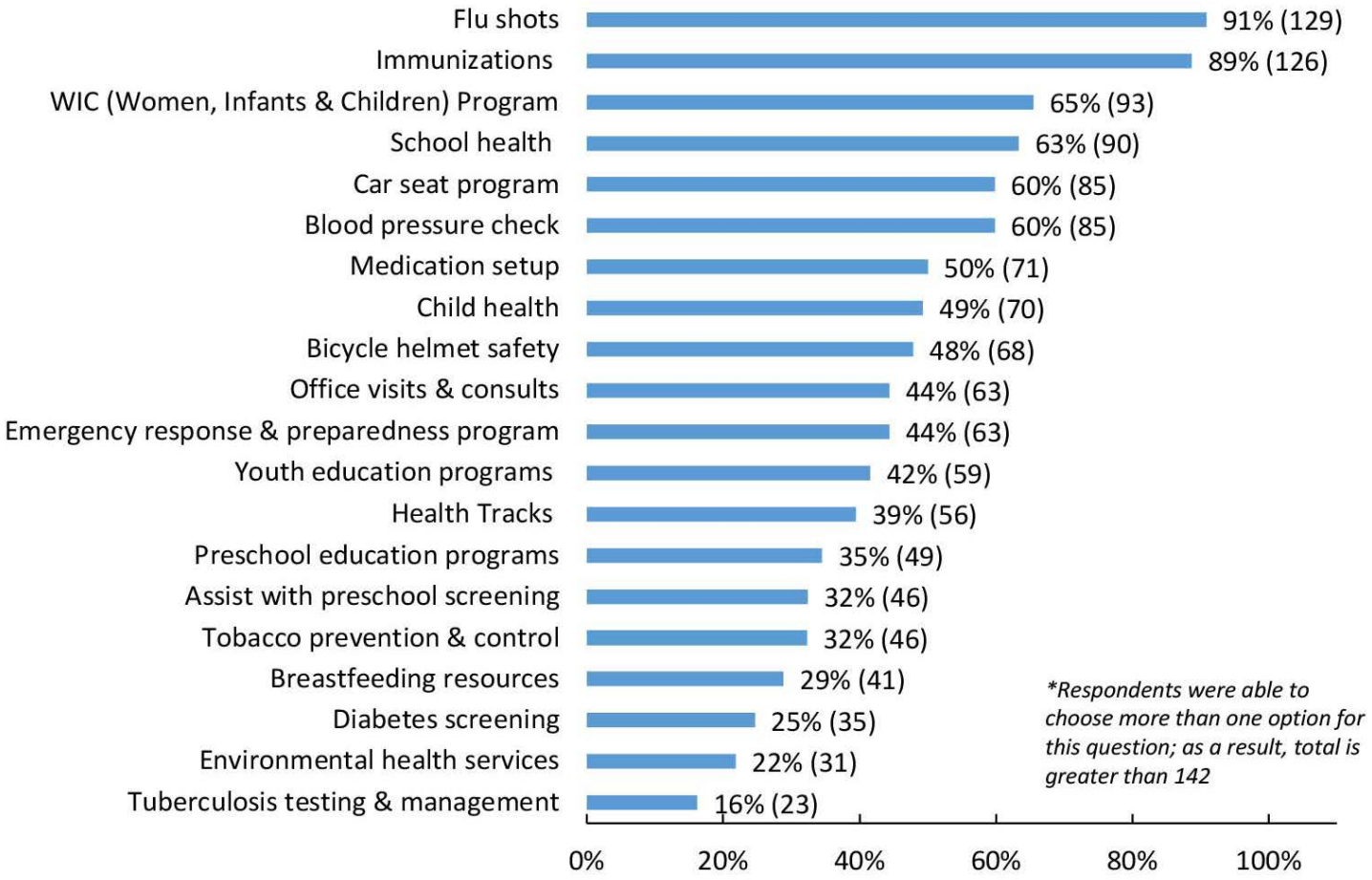
Figure 23 illustrates these results.

Figure 23: Perceptions About Barriers to Care
Total responses = 122



Considering a variety of healthcare services offered by DCHD, respondents were asked to indicate which of the listed services provided by DCHD have you or a family member used in the past year (see Figure 24).

Figure 24: Utilization of Public Health Services
Total respondents = 142



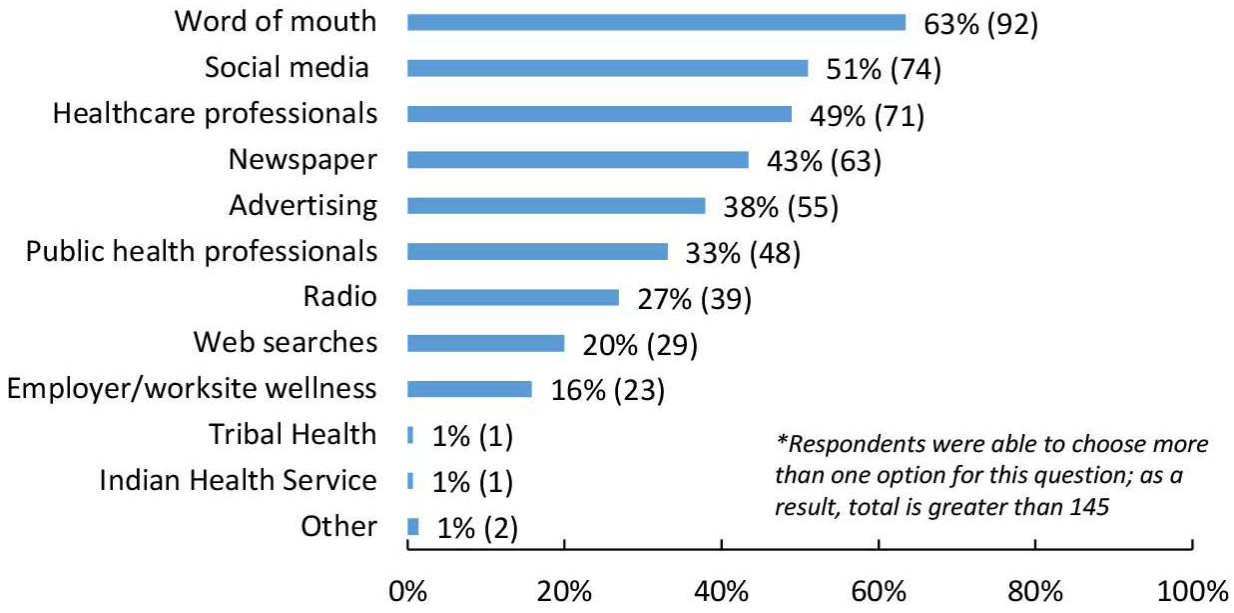
In an open-ended question, respondents were asked what specific healthcare services, if any, they think should be added locally. The number one desired service to add locally was mental health services. Other requested services included:

- After hours clinic and pharmacy
- Assisted living facility with more care options
- Birthing unit
- More transportation to appointments
- More testing ability (ex. ultrasound)
- Mental health/counseling
- Dermatology
- Ophthalmology/optometry
- Nights/weekends acute care
- Naturopathy treatment
- Increased telehealth at expanded hours

While not a service, many respondents indicated that they would like physicians added instead of just physician assistants and nurse practitioners.

The key informant and focus group members felt that the community members were not very aware of the majority of the health system and public health services until they were in need of them. The organizations do a nice job of being involved in the community, but overall marketing should be increased.

Figure 25: Sources of Information About Local Health Services
Total respondents = 145

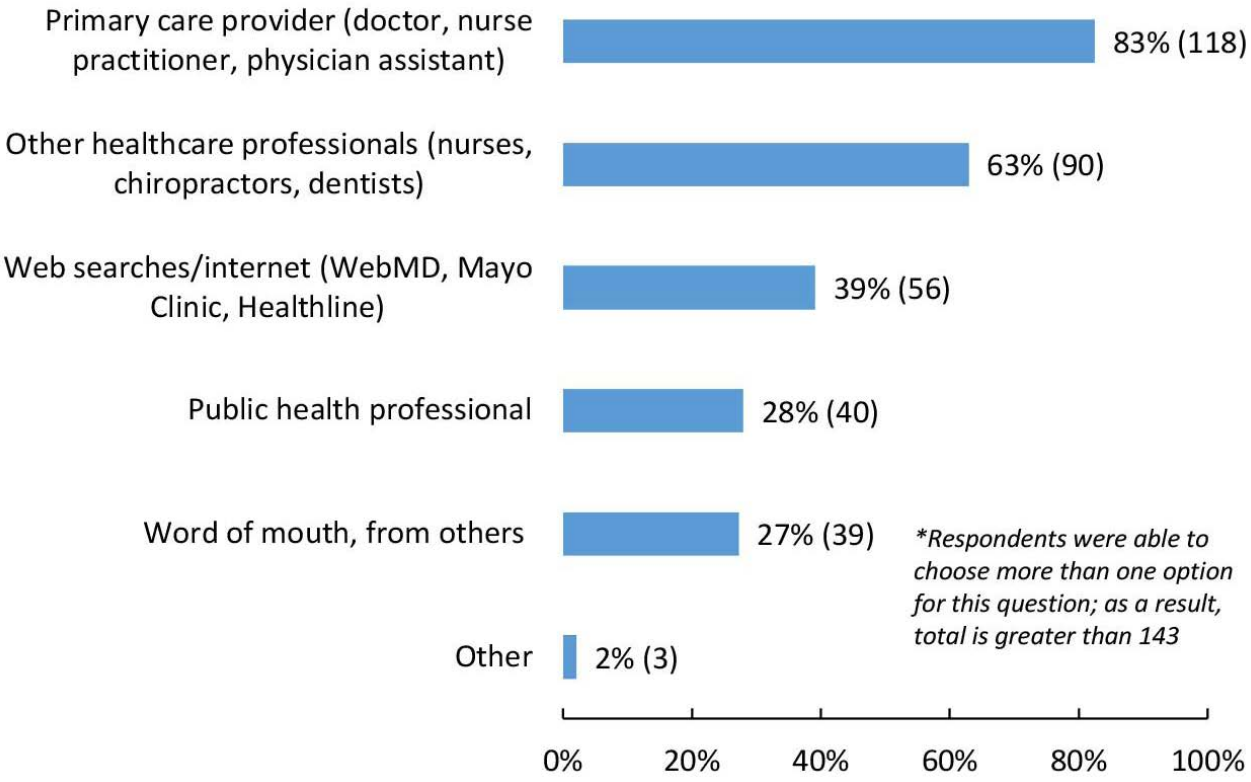


In the "Other" category, letters from the county health district and senior citizens were identified.

Respondents were asked where they go for trusted health information. Primary care providers (N=118) received the highest response rate, followed by other healthcare professionals (N=90), and then web/internet searches (N=56).

Results are shown in Figure 26.

Figure 26: Sources of Trusted Health Information
Total respondents = 143



In the "Other" category, family and personal intuition, medical journals, research articles, and specialists in the field of concern were identified.

In the "Other" category, family and personal intuition, medical journals, research articles, and specialists in the field of concern were identified.

The final question on the survey asked respondents to share concerns and suggestions to improve the delivery of local healthcare. A couple of responses mentioned that they would like the clinic and hospital to work better together to keep patients at the local hospital instead of being referred off to a larger facility.

There is a need to keep a watch out for confidentiality issues. It is felt that in a small town, this lack is always a concern.

Some indicated that there should be a focus on development of integrative and preventative healthcare. Put a focus on healthcare and not on social engineering and institutional preservation. One response indicated that healthcare mandates should be opposed.

There is a desperate need for optometric services in the community, a desire to have more male and female physicians, higher quality emergency room care, pediatricians, and more mental health options. Someone indicated that the nursing home has lost many residents and has several community members in neighboring facilities. They feel the hospital staff turnover seems unusually high for a small community and that public health keeps adding more staff and growing their budget, but Dickey County was the deadliest during the 2020 pandemic, and they want to know who should be accountable for those dismal numbers. They also said that this survey [CHNA] appears to be through the work of public health or UND and asked where other healthcare and community organizations are in gathering this input – hospital, nursing home, public safety and emergency services, clinics, dental, and the school. They wanted to know if these entities even knew about the survey effort. Obviously, the hospital is the lead on the CHNA, so they are very aware, and others mentioned also participated in the process, but this sign indicates that there may need to be additional communication to the community about what the CHNA is and how it is conducted.

Rural elderly with limited transportation struggle to get to and from appointments, even though there is good healthcare available locally. Making healthcare and health insurance remotely affordable was requested.

Others believe that the local clinics, hospital, EMS, and other services in Oakes are fantastic. More advertisement in the newspaper and social media for the services that are available locally, including pricing, were recommended to increase awareness of what is available. Also, possibly providing the opportunity for the public to voice what they would like to have for access as far as services, programs, and such.

Findings from Key Informant Interviews & the Community Meeting

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

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

- Depression and anxiety for all ages
- Availability of mental health services
- Availability of vision care
- Alcohol use and abuse

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

Depression and anxiety for all ages

- Often compounded by stress
- So many people are affected by this issue. Seems to be more prevalent over the past few years, or it is being more recognized

Availability of mental health services

- No mental health service clinicians in the county other than school counselors
- There has been a huge uptick in patients with mental health issues in the ER, from teens through people in their eighties, and from depression to suicide. There is nowhere to send people for help
- Stress in the high school setting is enormous. They are carrying more stress than in earlier years, and COVID has compounded it
- When help is wanted, there is no place to send the patients, so they aren't able to get the desired and needed help
- Major need in the area

Availability of vision care

- There is no eye care in the area.
- Must travel to get any optometric care, and that isn't feasible for some people.

Alcohol use and abuse

- See the impact on kids and adults
- Always seems to be a problem
- Maybe if there were more things to do, such as a recreation center, people would rely less on alcohol for entertainment

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

- Schools (4.8)
- Public health (4.5)
- Pharmacy (4.2)
- Business and industry (4.1)
- Emergency services, including ambulance and fire (4.1)
- Law enforcement (4.1)
- Clinics not affiliated with CHI (4.0)
- Economic development organizations (4.0)
- Hospital (healthcare system) (4.0)
- Faith-based (3.6)
- Long-term care, including nursing homes and assisted living (3.6)
- Human/Social services agencies (3.4)
- Other local health providers, such as dentists and chiropractors (3.2)

Priority of Health Needs

A community group met on November 16, 2021. Eight community members attended the meeting. Representatives from CRH presented the group with a summary of this report's findings, including background and explanation about the secondary data, highlights from the survey results (including perceived community assets and concerns, and barriers to care), and findings from the key informant interviews.

Following the presentation of the assessment findings and after considering and discussing the findings, all members of the group were asked to identify what they perceived as the top four community health needs. All of the potential needs were listed, and each member had four votes to select each of the four needs they considered the most significant.

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

- Availability of mental health services (6 votes)
- Depression/anxiety (5 votes)

- Availability of vision care (4 votes)
- Stress (3 votes)

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

1. Availability of mental health services (7 votes)
2. Stress (1 vote)
3. Depression/anxiety (0 votes)
4. Availability of vision care (0 votes)

Following the prioritization process during the second meeting of the community group and key informants, the number one identified need was the availability of mental health services. A summary of this prioritization may be found in Appendix E.

Comparison of Needs Identified Previously

Top Needs Identified 2019 CHNA Process	Top Needs Identified 2022 CHNA Process
Availability of mental health/substance abuse treatment services	Availability of mental health services
Attracting and retaining young families	Stress
Not enough jobs with livable wages	Depression/anxiety
Having enough child daycare services	Availability of vision care

The current process revealed the availability of mental health services is still a top priority that has carried forward from 2019. Stress and depression/anxiety go along with mental health, and all three were ranked as top priorities for the 2022 CHNA.

CHI Oakes Hospital invited written comments on the most recent CHNA report and Implementation Strategy, both in the documents and on the website where they are widely available to the public. No written comments have been received.

Upon adoption of this CHNA report by the CHI Oakes Hospital Board of Director's votes, a notation will be documented in the board minutes, reflecting the approval; then the report will be widely available to the public on the hospital's website, and a paper copy will be available for inspection upon request at the hospital. Written comments on this report can be submitted to the Mission Director atCHI Oakes Hospital , 1200 7th Street North, Oakes, North Dakota 58474.

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

Availability of mental health/substance abuse treatment services: CHI Oakes Hospital and Clinic have partnered with a telehealth psychiatrist, Dr. David Lopez, and their resources for emergency mental health needs, as well as offering telehealth visits with a provider from a sister facility in our area. Members of our staff

have completed courses in Mental Health First Aid, Applied Suicide Intervention Skills Training, and worked closely with the state of North Dakota to provide data on the current needs, as well as developing strategy and resources to help patients and community members in crisis. CHI Oakes Hospital and Clinic also distributed information and education about the resources that are currently available in our area. Following a death by suicide of a provider at our facility, we held awareness education and provided tools to our local community and school. We continue to work with a local business that is pursuing positive activities for local youth, such as BioGirls, which is set to being implemented within the year. This unit is an age group with higher needs and statistics, regarding mental health that will be served well by starting this local support. We continue to partner with Dickey County Public Health, local law enforcement and EMS, as well as area schools to promote mental wellness and identify areas of concern. The Violence Prevention Program continues to be supported by CHI Oakes Hospital by providing education, regarding healthy choices and healthy relationships. We have also pursued grant opportunities to better educate our patients and their families about the struggles of mental health and substance abuse. We continue to partner with Tornado Watch, a local nonprofit that provides for some of the basic needs of families in our service area to lessen the strain of difficult circumstances and tangible needs. We also partner with our local food pantry to help with identified food insecurity concerns. We have also worked to educate governmental leaders about the need to provide more resources for those needing assistance in all age categories. This effort includes inpatient bed availability and affordable and easily accessible outpatient therapies, as well as general education and counseling.

Not enough jobs with livable wages: Items two and three are closely related and will be addressed together. Members of our staff are very involved with local Economic Development and Chamber of Commerce to help improve the overall economy, health, and attractiveness of our community. Through these collaborative efforts, better publicity of what our health community and general community have to offer to families. The economic development members are pursuing ways to offer jobs for trailing spouses coming to our area, better opportunities for remote work positions, and educational opportunities for those wishing to enhance their skills. We strive to be competitive with other markets to attract and retain high quality healthcare workers and strive to cultivate a healthy culture within our facility. This endeavor has been especially challenging during COVID; however, we have provided Employee Assistance Programs, financial support, and links to other local resources when needs were made known.

Having enough child daycare services: One of our staff members is very active with the local daycare and childcare providers in our area. We continue to emphasize the importance of this service for overall employment, business growth, and viability of our communities.

Other areas of focus: All healthcare entities in our communities and surrounding areas are working to provide better education on healthy living, exercise opportunities, and health living. There is a 5K race held during Irrigation Days, a summer community event to promote health and physical fitness; staff and providers supply education and information through local papers, radio advertising, and local community events.

The above implementation plan for CHI Oakes Hospital is posted on the CHI Oakes Hospital website at https://oakeshospital.com/community-benefits/chna.

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, 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?

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

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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: Oakes, North Dakota

CHI Oakes Hospital

Imagine better health.℠

Quick Facts

Administrator:
Becki Thompson

Chief of Medical Staff:
Tara Mertz-Hack, MD

Board Chair:
Lorraine Ptacek

City Population:
2,129 (2019 estimate)[1]

County Population:
4,872 (2019 estimate)[1]

County Median Household Income:
65,492 (2019 estimate)[1]

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

Service Area Population:
14,000

Owned by: Nonprofit

Hospital Beds: 20

Trauma Level: V

Critical Access Hospital Designation: 2001

Economic Impact on the Community[2]

Jobs:
Primary – 79
Secondary – 33
Total – 112

Financial Impact:
Primary – $4.19 million
Secondary – $717,000
Total – $4.87 million

Mission

As CommonSpirit Health, we make the healing presence of God known in our world by improving the health of the people we serve, especially those who are vulnerable, while we advance social justice for all.

County: Dickey
Address: 1200 North 7th Street
Oakes, ND 58474
Phone: 701.742.3291
Fax: 701.742.3639
Web: www.oakeshospital.com

Core Values
- Compassion
- Inclusion
- Integrity
- Excellence
- Collaboration

CHI Oakes Hospital is a not-for profit, 20-bed Critical Access Hospital, sponsored by CommonSpirit Health, providing selected health care services. As a provider of community based, family oriented healthcare, CHI Oakes Hospital believes it can best maintain this level of service through a customer focus, where we continually strive to understand and exceed the expectations of our customers. This focus is enabled through effective communication systems, staff education, team building, process improvement, work redesign and an empowered work force.

Services

CHI Oakes Hospital provides the following services directly:

- Rural Health Clinic
- Emergency care
- Pain management
- Chemotherapy
- Surgical (General/Laparoscopic,
- Colonoscopy, and Endoscopy)
- Swing bed
- SANE provider
- Respiratory therapy
- Physical therapy
- Radiology (General imaging, CT scan, Ultrasound/Echo-cardiogram, Mammography)
- Clinical lab (Chemistry, Hematology, Blood Banking, Microbiology)
- Stress testing
- Department of Transportation (DOT) testing
- Health care directives
- Notary public

Staffing

Physicians: 1
Nurse Practitioners: 2
PAs: 4
RNs: 28
LPNs: 3
Total Employees: 86

Local Sponsors and Grant Funding Sources

- Center for Rural Health
  - SHIP Grant (Small Hospital Improvement Program)
  - Flex Grant (Medicare Rural Hospital Flexibility Grant Program)
- CHI Oaks Hospital is sup ported by a variety of local and national sponsors.

Sources

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

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

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

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

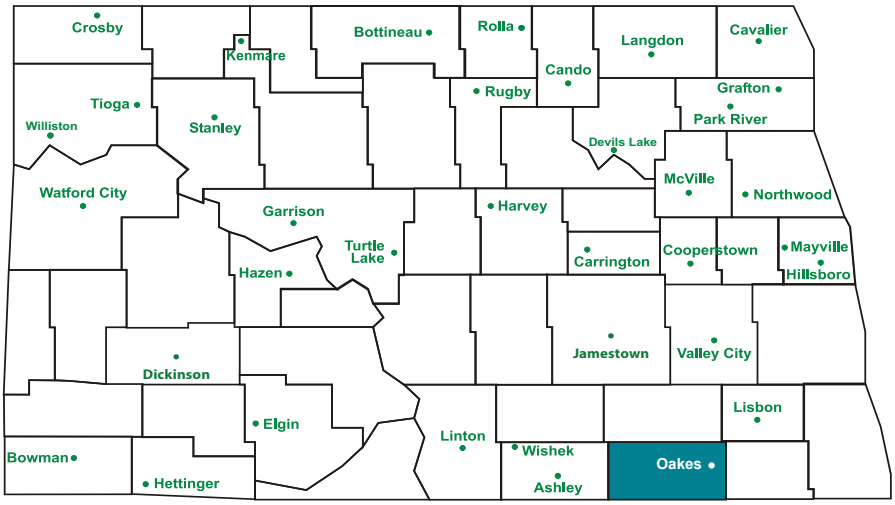
ruralhealth.und.edu

List of Contract/Agreement Services

CHI Oakes Hospital provides the following services through contract or agreement:

- Podiatry
- Sleep medicine
- Interpretive services
- Audiology
- Orthopedics

North Dakota Critical Access Hospitals



History

In 1923, the Benedictine Sisters of Manitoba, Canada bought the residence of Mr. W.T. Noonan, the President of the North American Creameries, and established St. Anthony's Hospital. In 1937, the Sisters of Mercy of Valley City took over the hospital and named it Mercy Hospital. On September 22, 1950 the first Franciscan Sisters took over the operation of the hospital and named it St. Joseph's Hospital. In 1954 plans were made and construction began on Oakes Community Hospital with completion of the 36-bed hospital on October 14, 1956. In 1972, space was once again needed and an addition was built. Dedication of a new wing housing the laboratory, CT scanner, emergency rooms, outpatient services and lobby took place May 1, 1994.

In 2001, Oakes Community Hospital converted to a Critical Access Hospital with state certification. Recognizing the importance of maintaining holistic care, as well as the changes of healthcare in today's world, the Sisters of St. Francis transferred the sponsorship of the hospital to Catholic Health Initiatives. In 2005, Catholic Health Initiatives announced that it would help the community build a new facility. The blessing of the site and ground breaking celebration was held on August 16, 2006. A clinic within the CHI Oakes Hospital building was opened in 2010. Dr Katie O'Brien-Paradis joined the Medical Staff in 2011. To better identify with being part of the strong healthcare system of Catholic Health Initiatives, the hospital's name was changed in 2014 to CHI Oakes Hospital. In early 2019, Catholic Health Initiatives and Dignity Health aligned to form CommonSpirit Health, with facilities in 21 states. The CHI Oakes Hospital is also served by physicians and allied health professional staff from the Sanford Clinic - Oakes.

Recreation

Oakes is located in the southeast corner of North Dakota. Oakes is a very beautiful town with friendly people. The community is accessible by three highways, two railways and a municipal airport. An excellent school system is available with many opportunities in the area of sports, music, etc. A progressive, full-service, four-season community offers a plethora of activities for young and old. Oakes is the business, medical and service hub for the surrounding region. Our medical facilities are like none other in rural North Dakota, with a well established clinic and new hospital facility.

Appendix B – Economic Impact Analysis

December 2020

Oakes Hospital

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

CHI Oakes Hospital
Imagine better health.℠

Economic Impact

CHI Oakes Hospital is composed of a Critical Access Hospital (CAH) and a Rural Health Clinic located in Oakes, North Dakota.

CHI Oakes Hospital **directly** employs **79 FTE employees** with an annual payroll of over **$4.15 million** (including benefits).

- After application of the employment multiplier of 1.42, these employees created an additional **33** jobs.
- The same methodology is applied to derive the income impact. The income multiplier of 1.17 is applied to create over **$717,000** in income as they interact with other sectors of the local economy.
- **Total impacts = 112 jobs and more than $4.87 million in income.**

Healthcare and Your Local Economy

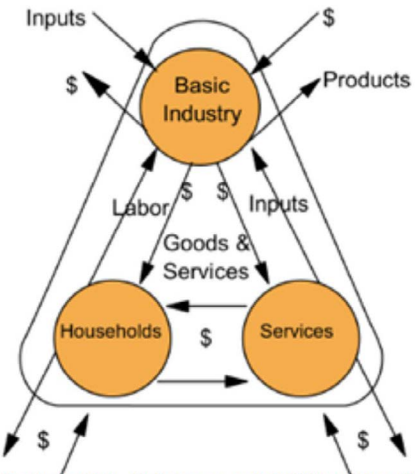
The health sector in a rural community, anchored by a CAH, is responsible for a number of full- and part-time jobs and the resulting wages, salaries, and benefits. Research findings from the National Center for Rural Health Works indicate that rural hospitals typically are one of the top employers in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

Fact Sheet Author: Kylie Nissen, BBA

For additional information, please contact:
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kylie.nissen@und.edu • (701) 777-5380

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

CHI Oakes Hospital
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Public Health
Prevent. Promote. Protect.
Dickey County Health District

Oakes Area Health Survey

CHI Oakes Hospital and Dickey County Health District are interested in hearing from you about community health concerns.

The focus of this effort is to:

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

If you prefer, you may take the survey online at https://tinyurl.com/Oakesarea 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 Kylie Nissen at 701.777.5380.

Surveys will be accepted through October 3, 2021. 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):

35\

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

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

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

_____

_____

Delivery of Healthcare

12. Which of the following **SERVICES** provided by your local **PUBLIC HEALTH** unit are you aware of? (Choose ALL that apply)

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

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

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

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

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

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

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

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

Demographic Information: Please tell us about yourself.

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

☐ Yes ☐ No

18. 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): _____

19. 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): _____

20. 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

21. 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

22. Sex:

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

23. Employment status:

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

24. Your zip code: _____

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

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

26. Annual household income before taxes:

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

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

_____

_____

Thank you for assisting us with this important survey!

Appendix D – County Health Rankings Explained

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

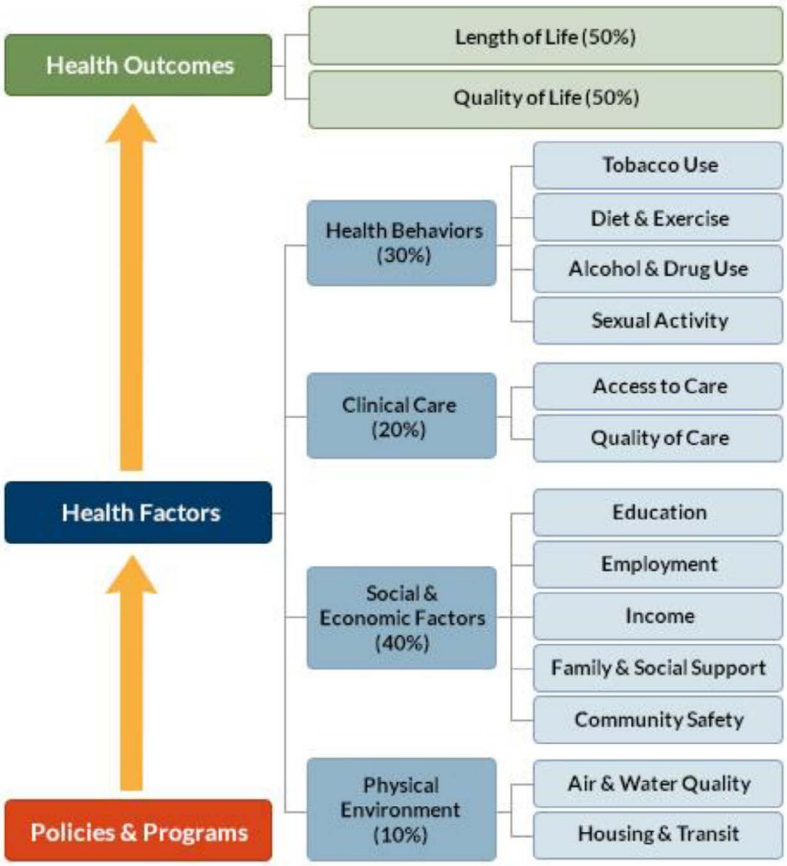
Methods

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

What is Ranked

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

Ranking System



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

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

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

Data Sources and Measures

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

Data Quality

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

Calculating Scores and Ranks

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

Health Outcomes and Factors

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

Health Outcomes

Premature Death (YPLL)

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

Reason for Ranking

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

Poor Physical Health Days

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

Reason for Ranking

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

Poor Mental Health Days

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

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

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

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

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

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

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

Health Factors

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

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

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

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

Food Environment Index

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

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

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

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

Reason for Ranking

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

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

Physical Inactivity

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

Reason for Ranking

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

Access to Exercise Opportunities

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

Individuals who:

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

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

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

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

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

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

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

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

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

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

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

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

Uninsured

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

Reason for Ranking

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

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

Primary Care Physicians

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

Reason for Ranking

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

Dentists

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

Reason for Ranking

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

Mental Health Providers

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

Reason for Ranking

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

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

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

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

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

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

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

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

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

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

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

Reason for Ranking

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

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

Income Inequality

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

Reason for Ranking

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

Children in Single-Parent Households

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

Reason for Ranking

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

Violent Crime Rate

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

Reason for Ranking

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

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

Injury Deaths

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

Reason for Ranking

Injuries are one of the leading causes of death; unintentional injuries were the 4th leading cause, and intentional injuries the 10th leading cause, of 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 Risk Behavior Survey

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

	ND 2015	ND 2017	ND 2019	ND Trend ↑, ↓, =	Rural ND Town Average	Urban ND Town Average	National Average 2019
Injury and Violence							
Percentage of students who rarely or never wore a seat belt (when riding in a car driven by someone else)	8.5	8.1	5.9	=	8.8	5.4	6.5
Percentage of students who rode in a vehicle with a driver who had been drinking alcohol (one or more times during the 30 prior to the survey)	17.7	16.5	14.2	=	17.7	12.7	16.7
Percentage of students who talked on a cell phone while driving (on at least one day during the 30 days before the survey, among students who drove a car or other vehicle)	NA	56.2	59.6	=	60.7	60.7	NA
Percentage of students who texted or e-mailed while driving a car or other vehicle (on at least one day during the 30 days before the survey, among students who had driven a car or other vehicle during the 30 days before the survey)	57.6	52.6	53.0	=	56.5	51.8	39.0
Percentage of students who never or rarely wore a helmet (during the 12 months before the survey, among students who rode a motorcycle)	NA	20.6	NA	**NA**	NA	NA	NA
Percentage of students who carried a weapon on school property (such as a gun, knife, or club on at least one day during the 30 days before the survey)	5.2	5.9	4.9	=	6.2	4.2	2.8
Percentage of students who were in a physical fight on school property (one or more times during the 12 months before the survey)	5.4	7.2	7.1	=	7.4	6.4	8.0
Percentage of students who experienced sexual violence (being forced by anyone to do sexual things [counting such things as kissing, touching, or being physically forced to have sexual intercourse] that they did not want to, one or more times during the 12 months before the survey)	NA	8.7	9.2	=	7.1	8.0	10.8
Percentage of students who experienced physical dating violence (one or more times during the 12 months before the survey, including being hit, slammed into something, or injured with an object or weapon on purpose by someone they were dating or going out with among students who dated or went out with someone during the 12 months before the survey)	7.6	NA	NA	**NA**	NA	NA	8.2
Percentage of students who have been the victim of teasing or name calling because someone thought they were gay, lesbian, or bisexual (during the 12 months before the survey)	NA	11.4	11.6	=	12.6	11.4	NA
Percentage of students who were bullied on school property (during the 12 months before the survey)	24.0	24.3	19.9	↓	24.6	19.1	19.5
Percentage of students who were electronically bullied (including being bullied through texting, Instagram, Facebook, or other social media during the 12 months before the survey)	15.9	18.8	14.7	↓	16.0	15.3	15.7
Percentage of students who felt sad or hopeless (almost every day for two or more weeks in a row so that they stopped doing some usual activities during the 12 months before the survey)	27.2	28.9	30.5	=	31.8	33.1	36.7
	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							
Percentage of students who had eight or more hours of sleep (on an average school night)	NA	31.8	29.5	=	31.8	33.1	NA

Appendix F – Prioritization of Community's Health Needs

Oakes, North Dakota
Ranking of Concerns

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

	Priorities	Most Important
COMMUNITY/ENVIRONMENTAL HEALTH CONCERNS		
Attracting & retaining young families	1	
Having enough child daycare services	2	
Not enough affordable housing	2	
Not enough jobs with livable wages	2	
AVAILABILITY/DELIVERY OF HEALTH SERVICES CONCERNS		
Availability of mental health services	6	7
Extra hours for appointments, such as evenings and weekends	0	
Cost of healthcare insurance	0	
Availability of vision care	4	0
YOUTH POPULATION HEALTH CONCERNS		
Alcohol use and abuse	1	
Depression/anxiety- all ages	6	0
Suicide	1	
Smoking and tobacco use	0	
Drug use and abuse (including prescription drugs)	0	
ADULT POPULATION HEALTH CONCERNS		
Alcohol use and abuse	1	
Stress	3	1
Wellness and disease prevention, including vaccine-preventable disease	0	
Not getting enough exercise/physical activity	2	
SENIOR POPULATION HEALTH CONCERNS		
Cost of long-term/nursing home care	0	
Availability of resources to help elderly stay in their homes	1	
Long-term/nursing home options	0	
Availability of transportation for seniors	1	
Availability of resources for family and friends caring for elders	1	
VIOLENCE CONCERNS		
Domestic/intimate partner violence	0	
Bullying/cyber-bullying	1	
Child abuse/neglect	0	
Emotional abuse (isolation, verbal threats, withholding of funds)	0	

Appendix G – Survey "Other" Responses

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:

- Genuine concern and caring for those who have struggles or hardship
- Narrow minded
- None
- People here are ignorant.
- Senior services

2. Considering the SERVICES AND RESOURCES in your community, the best things are: "Other" responses:

- Family lives here

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

- Libraries, horse arena, museum, adult summer swim classes,
- None
- There is a bowling alley and movie theater

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:

- Ability of school to retain staff and difficulty of having so many youth in the classrooms who gave behavioral issues. Need community to be focused on healthy family dynamics and less on sports
- Adequate medical providers
- Drugs
- Equitable access to child care/preschool
- Not enough quality grocery options, especially produce
- Wish there was a new neighborhood of lots to buy and build houses on

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

- Finding an answer for a health issue
- No Ob-delivery of babies
- Over prescription of medication instead of preventative care through dietary or lifestyle changes

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

- Bullying
- Bullying/cyberbullying

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

- Health food options/availability both eateries and produce at grocer
- There used to be a dialysis center here, but it closed

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

- Quality long-term/nursing home options

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

- Affordable housing due to jobs where salary is low.
- Availability of mental health resources
- Being able to keep businesses open/new businesses with livable wages
- Bullying that starts in school
- Cost of living in your own home after retirement
- Covid 19 and combating the ill-conceived notions that most people have towards vaccination and masking.
- Cyber bullying
- Declining population because of lack of jobs with living wage
- Depression resources
- Developing strong local leaders and using them effectively
- Doesn't really seem like the community cares about the 20-30 year old range; not enough activities not enough resources for the depression/anxiety/stress we feel day to day!
- Drug abuse
- Drug and alcohol abuse, depression, anxiety
- Elderly services
- Good paying jobs
- Health care! Closest hospitals are 1/2 hr away.
- Health care.
- Housing affordable and convenient
- Inaccessible healthcare, nearest doctors tend to be 45+ minutes away
- Keeping population to a number to support business
- Lack of community center/hub outside of the School (not as inclusive for people or families without school age children). There are a few silos or segmented groups, but we don't have a central group/association/facility that allows for people of all walks and stages of life to possibly cross paths or share information.
- Lack of community involvement
- Lack of counseling services available
- Lack of education regarding basic needs of self and other regarding true understanding of mutual respect and dignity for all.
- Lack of good jobs
- Lack of higher paying job opportunities
- Lack of indoor activities (swimming, basketball, gyms, etc.)
- Lack of mental health services
- Lack of physical activity
- Loss of people
- Loss of population. Sustainability
- Maintain population numbers
- Mental and behavioral health
- (2) Mental health

- Mental health care
- Mental Health in general - you can visibly see stress in the eyes of so many community members. There is a considerable amount of alcohol abuse, depression, and anxiety all tied to mental health in general. The community has gone from the "friendly folks from Oakes" to the "cranky folks from Oakes". I don't believe this can be attributed to Covid as I've been observing this over the past 2 to 3 years and the general unfriendliness from business leaders, healthcare staff, educators, and elsewhere.
- Mental health issues
- Mental health of all ages.
- Mental Health resources/support group
- Mental health services
- Mental health/substance abuse care
- No mental health care
- No pediatrician
- Not enough job opportunities for growth
- Not enough jobs and wage to pay bills
- Overall isolation and people living disconnected from each other
- Places to shop and get good food to eat
- Police do not appear to watch to keep everyone happy so too relaxed for chargers. Lack of trustable doctors and quality of care within hospital.
- Police force- need changes
- Poor communication around the city
- Poor quality ER healthcare and lack of eye doctor
- Property taxes are too high!
- Receiving quality pediatric care in the local ER.
- Retaining Main Street businesses
- Small town gossip. I am constantly worried about who is talking about me behind my back. So many untrue rumors are started around our community causing big issues.
- Supporting young families with childcare, medical help, and good paying jobs, be it part or full time.
- Suicide
- Support for spouses/family members caring for individuals in their homes

Delivery of Healthcare

13. Where do you find out about LOCAL HEALTH SERVICES available in your area? "Other" responses:

- Letter from the county health district. Senior citizens

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

- After hour clinic and pharmacy
- An assisted living facility with more care options
- Birthing unit
- (2) Counseling
- (2) Eye doctor
- Greater access to telehealth from providers who do not reside in the community and at expanded hours. More providers who either have some specialty, or have more experience. Nurse Practitioners and PA's with 2 years experience as a nurse, going back to school, then jumping to being a clinic provider is concerning. I'm surprised they don't have to do more clinicals/training at busier sites.....
- MD for pediatrics at CHI Clinic

- (3) Mental health
- Mental health clinicians and maybe dermatology or ophthalmology.
- Mental health counseling
- Mental health services
- More doctors and less PAs / NPs
- More hours at clinic, more transportation to appts.
- More mental health services/counseling
- More testing abilities - ultrasound, etc.
- New eye doctor
- Nights/weekends acute type care
- OB services-tell CHI to bring back baby delivery!
- Ophthalmologist
- Optometrist
- Pediatrician- family practice drs just don't cut it.
- Pediatrician, eye dr
- Pediatrics, dermatology
- Prevention of disease with natural measures, not medications
- Psychiatrist/therapist
- Vision
- Vision care
- Vision care. We need local eye doctor
- Vision; mental health
- Well, they used to deliver babies here, now they don't.

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

- Don't have this problem
- Lack of trust in overall healthcare system and transparency with medications being prescribed.
- N/A
- None of these; healthcare is accessible except vision care at this time
- Pediatrician needed

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

- Family and personal intuition.
- Medical journals
- Research articles, specialists in their field

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

- Confidentiality is a huge concern in small towns
- Desperate need of an optometrist locally
- Does anyone even read these? I feel like the issues I have commented on in past surveys are still prevalent.
- Fight healthcare mandates
- Focus on development of integrative and preventative healthcare.
- Focus on Healthcare, not on social engineering and institutional preservation
- Get doctors for men and women

- Healthcare providers don't maintain professional confidentiality. They talk about things they should keep private.
- Higher quality ER care.
- Hospital needs to work with clinic to admit and treat patients locally to build entire medical community back up.
- I believe our healthcare in the community is declining overall. The nursing home has lost so many residents, and has several of our community members in neighboring facilities (why?). We no longer have local access to vision care (why? - no one is communicating what is being done). The hospital staff turnover seems unusually high for a small community. It seems like every nurse I see at the clinic or elsewhere in the community once worked for the hospital, and no longer does. (why - morale, pay, leadership?). Driving by I see 25 or more vehicles in the back parking lot and maybe 2 in the front, seems like a lot of staff for just 1 or 2 patients. Public health keeps adding more staff and growing their budget, but our county was the deadliest during the 2020 pandemic (who should be accountable for those dismal numbers?) The saving grace is the high vaccination rate, but undoubtedly that can mostly be attributed to the death rate and not their diligence. Finally, this survey appears to be through the work of public health, or UND. Where are other healthcare and community organizations in gathering this input? Hospital, nursing home, public safety and emergency services, clinics, dental, and heck even the school. Do these groups know about this survey effort? Thank goodness I seen the share on Facebook.
- Local pediatrician for primary care as well as pediatrician for ER visits.
- Make health care and health insurance remotely affordable. Thank goodness I go to the VA! Unfortunately, my wife and kids have to suffer through the for profit healthcare system.
- MENTAL HEALTH options are needed, specialists needed, less negativity
- More advertisement via newspaper and social media for the services that are available locally including pricing. Opportunity for the public to voice what they would like to have access to as far as services, good, programs, etc.
- Not utilizing our wonderful new hospital - seems it sets empty everyone is sent out to larger hospitals
- Some healthcare facilities are very rude if you or a family member calls with symptoms of COVID, even if it does not end up being COVID. :(
- We have fantastic clinics, hospital, EMS and other services in Oakes, but rural elderly with limited transportation can struggle with the need for frequent appointments. There is also a lack of resources to help elderly people stay in their own homes.