Community Health Needs Assessment

Nelson County Health System Service Area

McVille, North Dakota

2022

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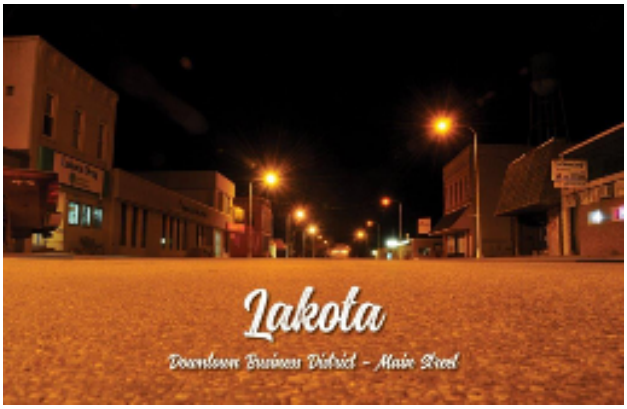
Table of Contents

This project was supported, in part, by the Federal Office of Rural Health, Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS), Medicare Rural Flexibility Hospital grant program and State Office of Rural Health grant program. This information content and conclusions are those of the author and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS, or the U.S. Government.

Executive Summary



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

To gather feedback from the community, residents of the area were given the opportunity to participate in a survey. Eighty-eight NCHS service area residents completed the survey. Additional information was collected through eight key informant interviews with community members. The input from the residents, who primarily reside in Nelson 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, Nelson County's population from 2010 to 2020 decreased by 3.7%. The average number of residents younger than age 18 (19.3%) for Nelson County comes in 4.3 percentage points lower than the North Dakota average (23.6%). The percentage of residents, ages 65 and older, is almost 11% higher for Nelson County (26.5%) than the North Dakota average (15.7%), and the rate of education is slightly lower for Nelson County (91.8%) than the North Dakota average (92.6%). The median household income in Nelson County ($53,063) is lower than the state average for North Dakota ($65,315).

Data, compiled by County Health Rankings, show Nelson County is doing better than North Dakota in health outcomes/factors for 12 categories, while performing poorly relative to the rest of the state in 13 outcome/factors.

Of 106 potential community and health needs set forth in the survey, the 88 NCHS service area residents who completed the survey indicated the following eleven needs as the most important:

- Alcohol use and abuse – youth and adult
- Attracting and retaining young families
- Availability to retain primary care providers (MD, DO, NP, PA)
- Availability of resources to help the elderly stay in their homes
- Bullying/cyberbullying
- Child abuse/neglect
- Cost of long-term/nursing home care
- Emergency services
- Not getting enough exercise/physical activity - adult
- Not enough jobs with livable wages
- Smoking and tobacco use - youth

The survey also revealed the biggest barriers to receiving healthcare (as perceived by community members). They included don't know about local services (N=34), no insurance/limited insurance (N=33), and can't get transportation services (N=22).

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

- Safe place to live
- Family-friendly
- Quality school system
- Informal, simple, laidback lifestyle
- Healthcare
- People are friendly, helpful, and supportive

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:

- Attracting and retaining young families
- Alcohol use and abuse in youth
- Availability of mental health services
- Depression/anxiety in youth
- Wellness and disease prevention, including vaccine-preventable disease in adults

Overview and Community Resources

With assistance from the Center for Rural Health (CRH) at the University of North Dakota (UND) School of Medicine & Health Sciences (SMHS), Nelson County Health System (NCHS) completed a Community Health Needs Assessment (CHNA) of the NCHS service area. The hospital identifies its service area as Nelson County. Many community members and stakeholders worked together on the assessment.

Nelson County Health System

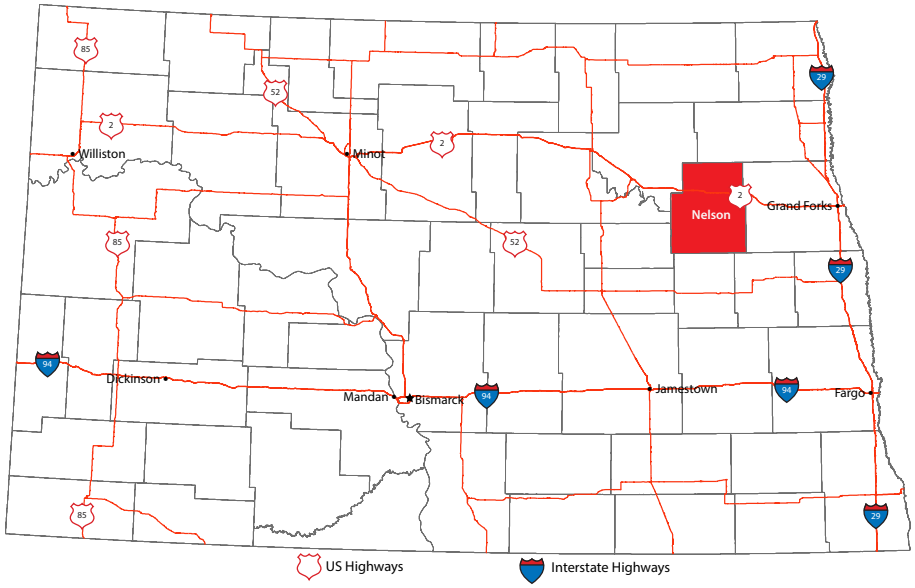
Established in 1917, Nelson County Health System (NCHS) is the sole community hospital of Nelson County. Licensed by the state of North Dakota and certified by Medicare and Medicaid, NCHS consists of a 19-bed Critical Access Hospital (CAH), two Rural Health Clinics, a 39-bed skilled nursing facility, and a 12-unit assisted living facility. NCHS provides local access and meets the rural healthcare needs of the people it serves. NCHS includes licensed and certified staff, consisting of family practice physicians, a nurse practitioner, nurses, nursing assistants, paramedics, laboratory, radiology, respiratory, and ancillary staff, and provides preventative, chronic, emergency, and outpatient services.

As a designated Level V Trauma Center, NCHS provides comprehensive care for a wide range of medical and trauma emergency situations. NCHS works collaboratively with local EMS services from McVille, Tolna, Pekin, Michigan, Lakota, and Aneta as well as regionally utilizing Life Flight air transport to regional referral health care hospitals. Services are available 24 hours/day and 7 days/week to meet the health care needs of the communities NCHS serves.

Although small in size, NCHS utilizes resources, such as telemedicine, to enable patient appointments onsite with specialists in other facilities. Also available is e-Emergency for immediate access to Trauma and other Medical consultant specialists.

NCHS continues to meet the healthcare needs of the community, as they proudly celebrated their 100th year of healthcare services in 2017.

Figure 1: Nelson County



NCHS has a significant economic impact on the region. They directly employ 70.92 FTE employees with an annual payroll of over $4.15 million (including benefits). These employees create an additional 26 jobs and nearly $705,000 in income as they interact with other sectors of the local economy. This economy results in a total impact of 96 jobs and more than $4.85 million in income. Additional information is provided in Appendix B.

Mission
The mission of the NCHS is to enhance the health status and quality of life for peoples and communities served.

Vision
NCHS's vision is to provide leadership, working in partnership with others, to ensure continued access to a quality continuum of healthcare and related services.

NCHS provides the following services directly through the hospital:
General and Acute Services

- Acne treatment
- Allergy, flu, and pneumonia shots
- Assisted living apartments
- Blood pressure checks
- Cardiac rehab
- Clinic
- Emergency room
- E-Emergency connection to Avera Hospital in Sioux Falls, SD
- Gynecology
- Hospital (acute care)
- Long-term care at the Care Center
- Mole/wart/skin lesion removal
- Nutrition counseling
- Outpatient IV therapy/ port care
- Pediatrics
- Pharmacy
- Podiatry
- Physicals: annuals, D.O.T., sports, and insurance
- Sports medicine
- Surgical services—biopsies
- Swing bed services
- Telemedicine
- Work Force Safety injury evaluations
- Wound care

Screening/Therapy Service

- Chronic disease management
- Diabetic education
- Holter monitoring
- Hospice care
- Lower extremity circulatory assessment
- Occupational therapy
- Physical therapy
- Respiratory care
- Respite care
- Sleep studies
- Social services
- Speech therapy

Radiology Services

- CT scan (mobile unit)
- Digital mammography (mobile unit)
- Echocardiograms
- EKG
- General X-ray
- Nuclear medicine (mobile unit)
- Mammograms
- MRI (mobile unit)
- Ultrasound (mobile unit)

Laboratory Services

- Hemoglobin A1C
- Hematology
- Cardiac monitors
- Clot times
- Chemistry
- Microscopic examinations

Services Offered by Other Providers/Organizations

- Ambulance
- First Responders
- Funeral Home
- Home Health
- Hospice
- Life Flight
- Vision Services

Nelson-Griggs District Health Unit

Nelson-Griggs District Health Unit (NGDHU) provides public health services that include environmental health, nursing services, health screenings, and education services. NGDHU utilizes evidence-based practices as public health transitions to population-based services. This changeover means there is a shift to changing systems and the environment by implementing good public health policies. There is still a wide variety of services to accomplish the mission of public health, which is to assure that North Dakota is a healthy place to live, and each person has an equal opportunity to enjoy good health. To accomplish this mission, NGDHU is committed to the promotion of healthy lifestyles, protection and enhancement of the environment, and provision of quality health care services for the people of North Dakota.

Specific services Nelson-Griggs District Health Unit provide are:

- Baby and child health (newborn visits, Cribs for Kids program)
- Blood pressure checks
- Breastfeeding resource and referrals
- Car seat education and referral program

- Community influenza clinics
- Emergency preparedness and response program (work with community partners)
- Environmental health services (water, sewer, health hazard abatement)
- Health education programs
- Home visits (in-home medication set-up, monitor health status)
- Immunizations (infants, youth, adults)
- Office visits (consultation and referrals)
- School health (vision screening, health education, school immunizations)
- Strategic Planning and Community Engagement: Health Equity and Immunizations
- Substance abuse prevention (prescription drugs)
- Pandemic response, including education, case investigation, contact tracing, and vaccinations
- Preschool screenings
- Tobacco prevention and control program (signage, policies, youth activities, newsletters)
- Tobacco Treatment Specialist (cessation services)

Assessment Process

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

A CHNA benefits the community by:

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

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

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

4) Engaging community members about the future of healthcare.

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

This assessment examines health needs and concerns in Nelson County. In addition to McVille, located in the county, are the communities of Petersburg, Michigan, Lakota, Tolna, Pekin, Aneta, Dahlen, Kloten, Mapes, and Whitman.

The Center for Rural Health (CRH), in partnership with Nelson County Health System (NCHS) and Nelson-Griggs District Health Unit (NGDHU), 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 NCHS. A small steering committee (see Figure 2) was formed that was responsible for planning and implementing the process locally. Representatives from CRH met and corresponded regularly by videoconference and/or via the eToolkit with the CHNA liaison. The community group (described in more detail below) provided in-depth information and informed the assessment process in terms of community perceptions, community resources, community needs, and ideas for improving the health of the population and healthcare services. Twelve people, representing a cross section demographically, attended the focus group meeting. The meeting was highly interactive with good participation.

Figure 2: Steering Committee

Julie Ferry	RN, NGDHU
Cassondra Schock	RN, NGDHU
Jill Trostad	Clinic manager, NCHS
Steve Forde	CFO, NCHS
Judy Twete	Former board member, NCHS
Betty Ann Bina	Former board member, NCHS
Anna Halvorson	CEO, Good Samaritan Society
Gail Nielsen	Former employee, NCHS

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

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

- A survey solicited feedback from area residents.
- Community leaders, representing the broad interests of the community, took part in one-on-one key informant interviews.
- The community group, comprised of community leaders and area residents, was convened to discuss area health needs and inform the assessment process.
- 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 University of North Dakota (UND) School of Medicine & Health Sciences (SMHS) and other necessary resources to rural communities and other healthcare organizations in order to maintain access to quality care for rural residents. In this capacity, CRH works at a national, state, and community level.

Detailed below are the methods undertaken to gather data for this assessment by convening a community group, conducting key informant interviews, soliciting feedback about health needs via a survey, and researching secondary data. Specific names of the organizations that participated in the key informant interviews and community group meetings will not specifically be identified so that the interviewees freely share information because they will remain anonymous. Due to the rural nature of the community, it is easy to identify someone, based on the name of their organization. Industry sectors will be identified in the report to show the variety of areas where the comments were solicited from within the community.

Community Group

A community group, consisting of 12 community members, was convened and first met on December 8, 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 March 23, 2022, with seven community members in attendance. At this second meeting, the community group was presented with survey results, findings from the key informant interviews and focus group, and a wide range of secondary data, relating to the general health of the population in Nelson County. The group was then tasked with identifying and prioritizing the community's health needs.

Members of the community group represented the broad interests of the community, served by NCHS and NGDHU. Not all members of the group were present at both meetings.

Interviews

One-on-one interviews with eight key informants were conducted by Zoom or phone between December 5, 2021 and February 2, 2022. Representatives 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 Nelson County, which are all included in the NCHS service area. The survey tool was designed to:

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

Specifically, the survey covered the following topics:

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

To promote awareness of the assessment process, press releases led to published articles in two newspapers in Nelson County. Additionally, information was published on the NCHS website, McVille Channel, and on both NCHS and NGDHU Facebook pages.

Approximately 50 community member surveys were available for distribution in Nelson County. The surveys were distributed by community group members and at NCHS, NGDHU, banks, and area business offices. NCHS also sent a bulk mailing to Nelson County area residents. 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 NCHS or NGDHU. The survey period ran from December 1, 2021 through January 14, 2022. Eighty-eight completed surveys were returned.

Area residents also were given the option of completing an online version of the survey, which was publicized in two community newspapers, on the NCHS website, McVille Channel, and on both NCHS and NGDHU Facebook pages. Sixty-four online surveys were completed. In total, counting both paper and online surveys, the 88 community member surveys were completed, equating to a 3% response rate. This response rate is low for this type of unsolicited survey methodology and does not indicate an engaged community.

Secondary Data

Secondary data was collected and analyzed to provide descriptions of: (1) population demographics, (2) general health issues (including any population groups with particular health issues), and (3) contributing causes of community health issues. Data was collected from a variety of sources, including the U.S. Census Bureau; Robert Wood Johnson Foundation's County Health Rankings, which pulls data from 20 primary data sources (www.countyhealthrankings.org); the National Survey of Children's Health, which touches on multiple intersecting aspects of children's lives (www.childhealthdata.org/learn/NSCH); and North Dakota KIDS COUNT, which is a national and state-by-state effort to track the status of children, sponsored by the Annie E. Casey Foundation (www.ndkidscount.org).

Social Determinants of Health

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

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

There are numerous models that depict 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

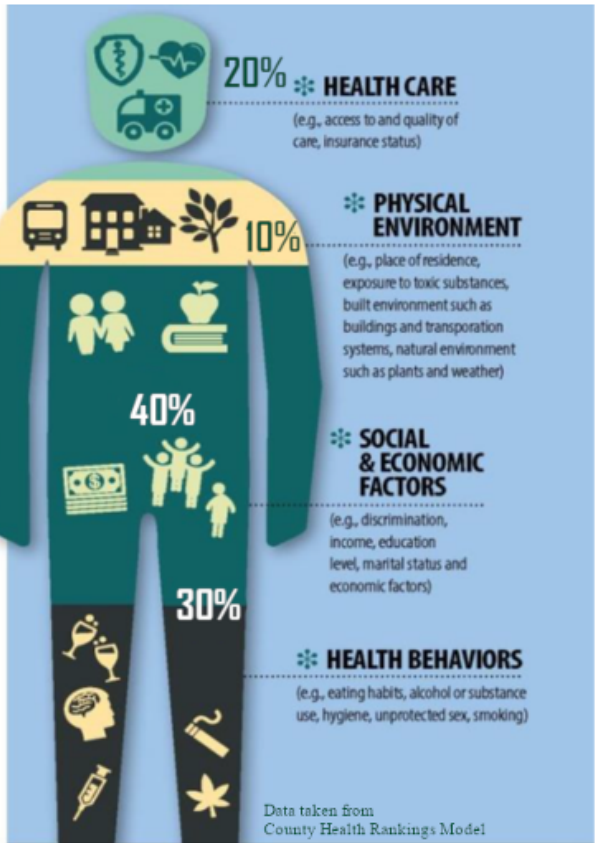


Figure 4 (Henry J. Kaiser Family Foundation, https://www.kff.org/disparities-policy/issue-brief/beyond-health-care-the-role-of-social-determinants-in-promoting-health-and-health-equity/), provides examples of factors that are included in each of the social determinants of health categories that lead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

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

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

KFF
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Demographic Information

Table 1 summarizes general demographic and geographic data about Nelson County

	Nelson County	North Dakota
Population (2020)	3,015	762,062
Population change (2010-2019)	-3.7%	13.3%
People per square mile (2010)	3.2	9.7
Persons 65 years or older (2019)	26.5%	15.7%
Persons younger than 18 years (2019)	19.3%	23.6%
Median age (2019 est.)	52.4	35.1
White persons (2019)	95.0%	86.9%
High school graduates (2019)	91.8%	92.6%
Bachelor's degree or higher (2019)	25.0%	30.0%
Live below poverty line (2019)	9.8%	10.6%
Persons without health insurance, under age 65 (2019)	8.1%	8.1%
Households with a broadband internet subscription (2019)	69.5%	80.7%

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

While the population of North Dakota has grown in recent years, Nelson County has seen a decrease in population since 2010. The U.S. Census Bureau estimates show that Nelson County population decreased from 3,126 (2010) to 3,015 (2020).

Figure 4: Social Determinants of Health

County Health Rankings

The Robert Wood Johnson Foundation, in collaboration with the University of Wisconsin Population Health Institute, has developed County Health Rankings to illustrate community health needs and provide guidance for actions toward improved health. In this report, McIntosh 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 to be the "healthiest." Counties are ranked on both health outcomes and health factors. Following is a breakdown of the variables that influence a county's rank.

A model of the 2021 County Health Rankings – a flow chart of how a county's rank is determined – may be found in Appendix D. For further information, visit the 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 Nelson County. It is important to note that these statistics describe the population of a county, regardless of where county residents choose to receive their medical care. In other words, all of the following statistics are based on the health behaviors and conditions of the county's residents, not necessarily the patients and clients of NGDHU and NCHS 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).

Nelson County rankings within the state are included in the summary following. For example, Nelson County ranks 25th out of 46 ranked counties in North Dakota on health outcomes and 31st 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 and Factors show that Nelson County is doing worse on approximately half of the outcomes than many counties in North Dakota. But like many North Dakota counties, Nelson County is doing poorly in many areas when it comes to the U.S. Top 10% ratings.

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

- Poor mental health days
- Adult smoking
- Excessive drinking
- Sexually transmitted infections
- Flu vaccinations (% of fee-for-service Medicare enrollees receiving vaccination
- Income inequality
- Preventable hospital stays
- Mammography screening (% of Medicare enrollees, ages 67-69, receiving screening)
- Violent crime
- Social associations
- Children in single-parent households
- Severe housing problems

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

- Poor or fair health
- Poor physical health days
- Adult obesity
- Food environmental index
- Physical inactivity
- Access to exercise opportunities
- Alcohol-impaired driving deaths
- Uninsured
- Dentists
- Unemployment
- Children in poverty
- Injury deaths
- Air pollution – particulate matter

TABLE 2: SELECTED MEASURES FROM COUNTY HEALTH RANKINGS 2021 – NELSON 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 – NELSON COUNTY			
	Nelson County	**U.S. Top 10%**	**North Dakota**
Ranking: Outcomes	**25th**		**(of 46)**
Premature death	Missing Data	5,400	6,600
Poor or fair health	15% ●■	14%	14%
Poor physical health days (in past 30 days)	3.3 +●	3.4	3.2
Poor mental health days (in past 30 days)	3.6 +	3.8	3.8
Low birth weight	Missing Data	6%	6%
Ranking: Factors	**31st**		**(of 45)**
Health Behaviors			
Adult smoking	20% ■	16%	20%
Adult obesity	41% ■●	26%	34%
Food environment index (10=best)	7.1 ■●	8.7	8.9
Physical inactivity	30% ●■	19%	23%
Access to exercise opportunities	34% ●■	91%	74%
Excessive drinking	23% ■	15%	24%
Alcohol-impaired driving deaths	50% ●■	11%	42%
Sexually transmitted infections	136.2 +	161.2	466.6
Teen birth rate	Missing Data	12	20
Clinical Care			
Uninsured	10% ●■	6%	8%
Primary care physicians	Missing Data	1,030:1	1,300:1
Dentists	2,880:0 ●■	1,210:1	1,510:1
Mental health providers	Missing Data	270:1	510:1
Preventable hospital stays	3,148 ■	2,565	4,037
Mammography screening (% of Medicare enrollees ages 65-74 receiving screening)	56% +	51%	53%
Flu vaccinations (% of fee-for-service Medicare enrollees receiving vaccination)	52% ■	55%	50%
Social and Economic Factors			
Unemployment	3.1% ●■	2.6%	2.4%
Children in poverty	15% ●■	10%	11%
Income inequality	4.3 ■	3.7	4.4
Children in single-parent households	15% ■	14%	20%
Social associations	24.4 +	18.2	16.0
Violent crime	143 ■	63	258
Injury deaths	89 ●■	59	71
Physical Environment			
Air pollution – particulate matter	5.0 +●	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, and information on the child's family, neighborhood, and social context. Data is from 2018-19. 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	93.4%	93.4%
Children who spent less than 10 minutes with the provider at a preventive medical visit	18.4%	19.0%
Children (1-17 years) who had preventive a dental visit in the past year	75.4%	79.6%
Children (3-17 years) received mental healthcare	12.0%	10.4%
Children (3-17 years) with problems requiring treatment did not receive mental health care	1.2%	2.3%
Young children (9-35 mos.) receiving standardized screening for developmental problems	32.6%	36.4 %
Young children (9-35 mos.) receiving standardized screening for developmental problems		
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 focus 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 Nelson County is performing more poorly than the North Dakota average on three of the examined measures: child food insecurity, 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

	Nelson County	North Dakota
Child food insecurity, 2019	**13.6%**	9.6%
Medicaid recipient (% of population age 0-20), 2021	**28.6%**	26.6%
Children enrolled in Healthy Steps (CHIP) (% of population age 0-18), 2021	**3.5%**	1.7%
Supplemental Nutrition Assistance Program (SNAP) recipients (% of population age 0-18), 2021	**15.4%**	17.0%
Licensed childcare capacity (# of children), 2020	**141**	36,701
4-year high school cohort graduation rate, 2020/2021	**88%**	89.0%
Victims of child abuse and neglect requiring services (rate per 1,000 children ages 0-17), 2020	**12.82**	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 U.S. The YRBS was designed to monitor trends, compare state health risk behaviors to national health risk behaviors, and intended for use to plan, evaluate, and improve school and community programs. North Dakota began participating in the YRBS survey in 1995. Students in grades 7-8 and 9-12 are surveyed in the spring of odd years. The survey is voluntary and completely anonymous.

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

Table 5 depicts some of the YRBS data that have been collected in 2015, 2017, and 2019. They are further broken down by rural and urban percentages. The trend column shows 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 Behavioral Risk Survey Results

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

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

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

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

Low Income Needs

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

Top Needs Identified by People Experiencing Poverty Across North Dakota

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

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

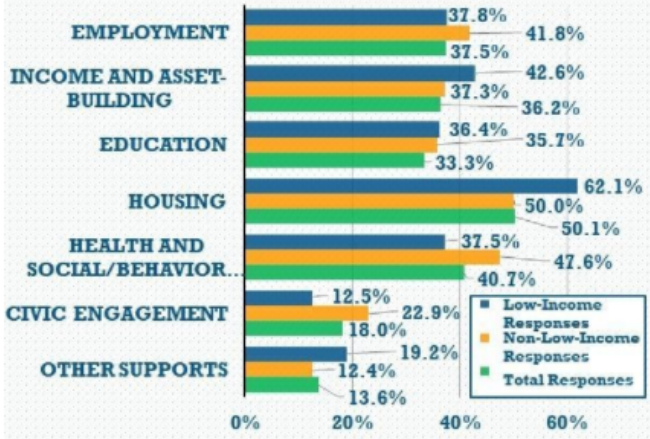
3,458 Total Survey Responses

- **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

This project was supported by the Consensus Council, Inc. (in partnership with the Bush Foundation) through the Community Innovation Grants.

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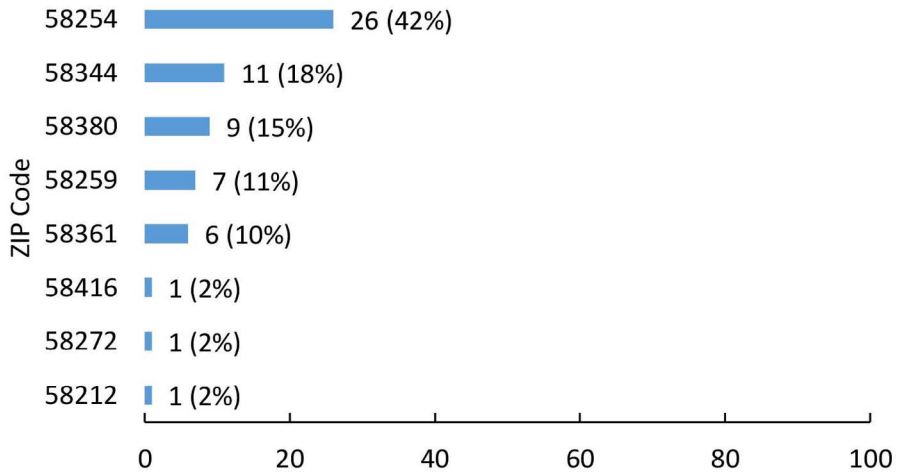
Survey Results

As noted previously, the 88 community members completed the survey in communities throughout the McVille 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, 62 respondents did, revealing that a large majority of respondents (42%, N=62) lived in McVille. These results are shown in Figure 5.

Figure 5: Survey Respondents' Home Zip Code
Total respondents: 62



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

Survey Demographics

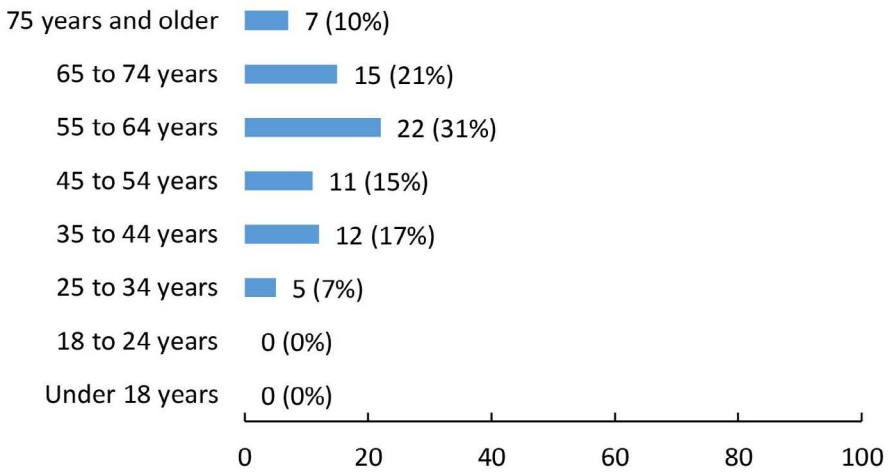
To better understand the perspectives being offered by survey respondents, survey-takers were asked a few demographic questions. Throughout this report, numbers (N) instead of just percentages (%) are reported because percentages can be misleading with smaller numbers. Survey respondents were not required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

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

- 62% (N=44) were age 55 or older
- The majority (75%, N=54) were female
- 47% (N=34) had bachelor's degrees or higher
- The number of those working full time (53%, N=38) was slightly higher than those who were retired (33%, N=24)
- 97% (N=70) of those who reported their ethnicity/race were White/Caucasian
- 27% of the population (N=18) had household incomes of less than $50,000

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

Figure 6: Age Demographics of Survey Respondents
Total respondents = 72



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

Figure 7: Gender Demographics of Survey Respondents
Total respondents = 72

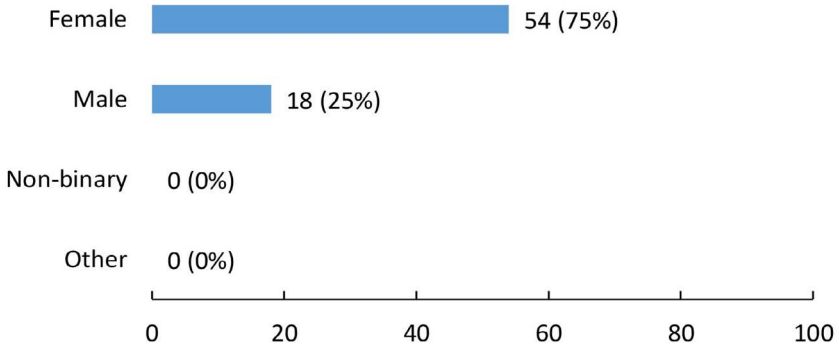


Figure 8: E
Total respc

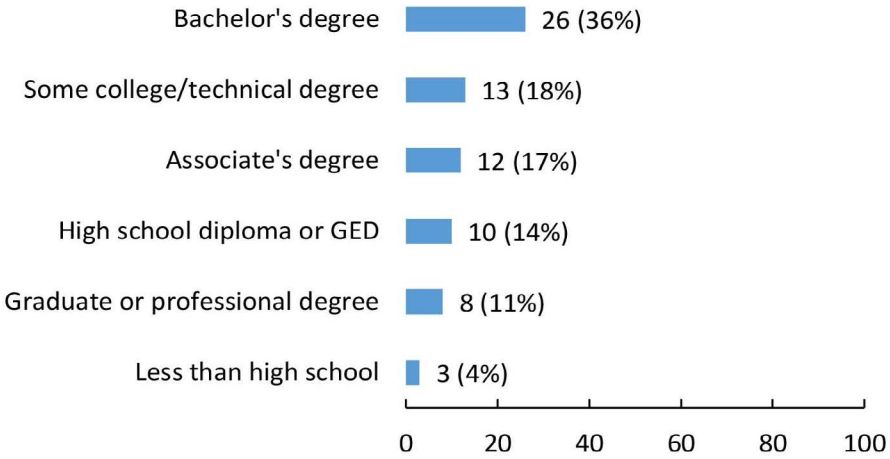
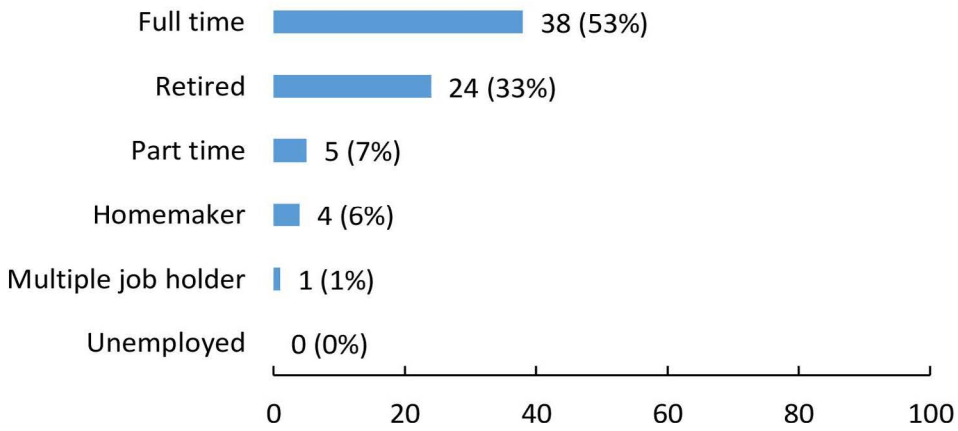
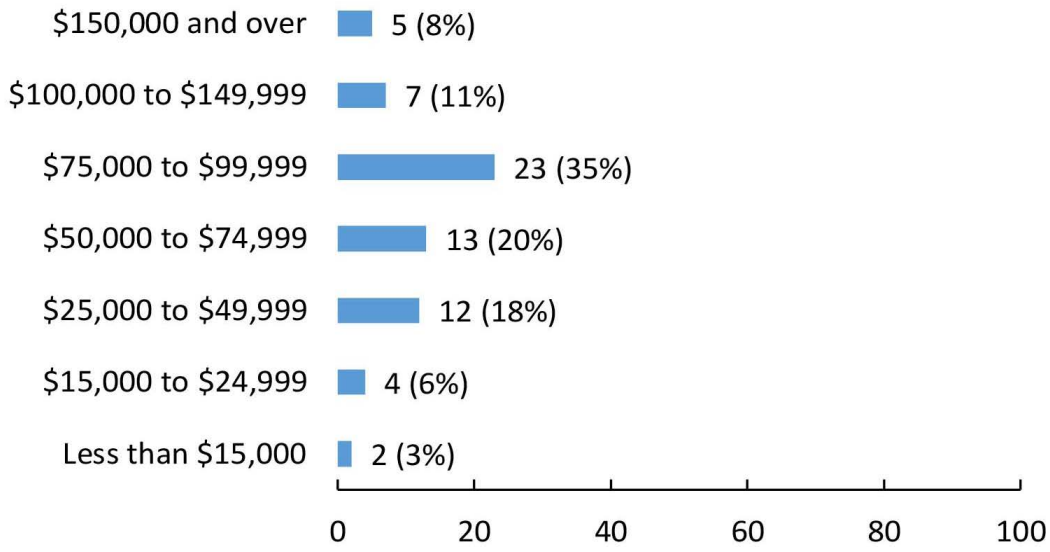


Figure 9: Employment Status Demographics of Survey Respondents
Total respondents = 72



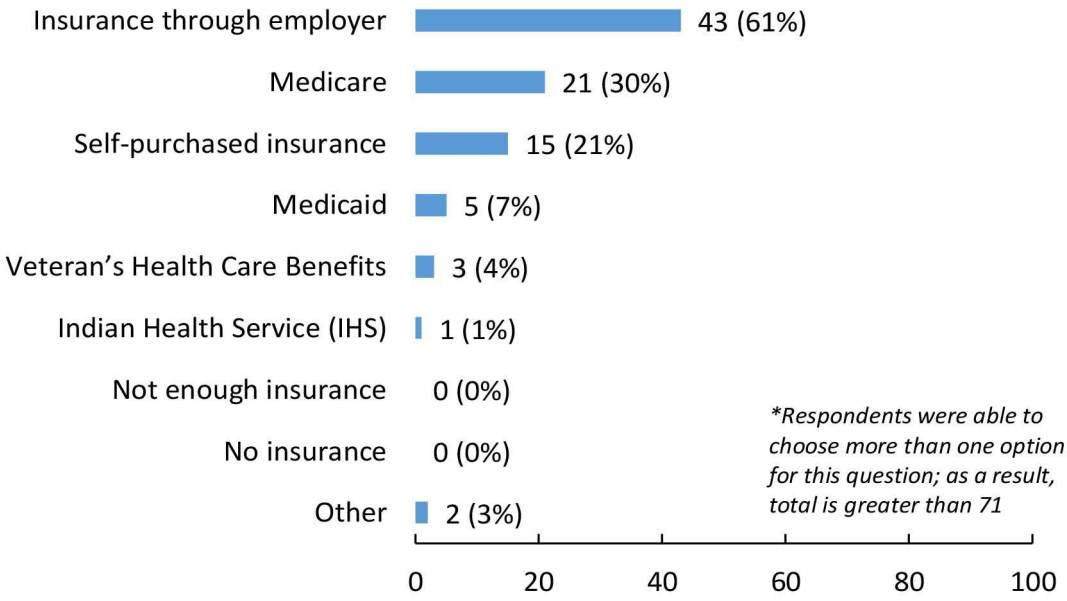
Of those who provided a household income, 9% (N=6) of the community members reported a household income of less than $25,000. Nineteen percent (N=12) indicated a household income of $100,000 or more. This information is shown in Figure 10.

Figure 10: Household Income Demographics of Survey Respondents
Total respondents = 66



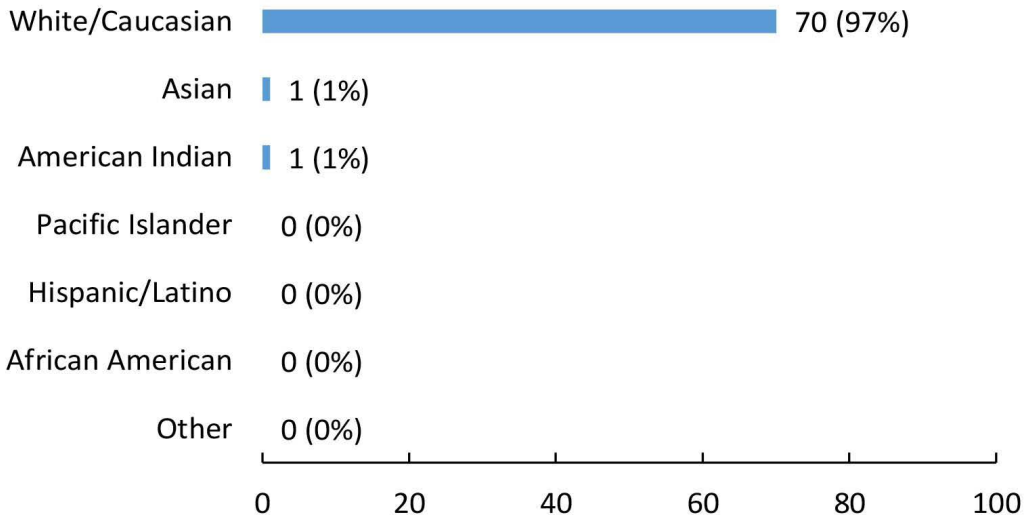
Community members were asked about their health insurance status, which is often associated with whether people have access to healthcare. The most common insurance types were insurance through one's employer (N=43), followed by Medicare (N=21), and self-purchased (N=15). Other responses included Tricare and BCBS.

Figure 11: Health Insurance Coverage Status of Survey Respondents
Total respondents = 71*



As shown in Figure 12, nearly all of the respondents were White/Caucasian (97%). This number was in-line with the race/ethnicity of the overall population of Nelson County; the U.S. Census indicates that 95% of the population is White in Nelson County.

Figure 12: Race/Ethnicity Demographics of Survey Respondents
Total respondents = 72



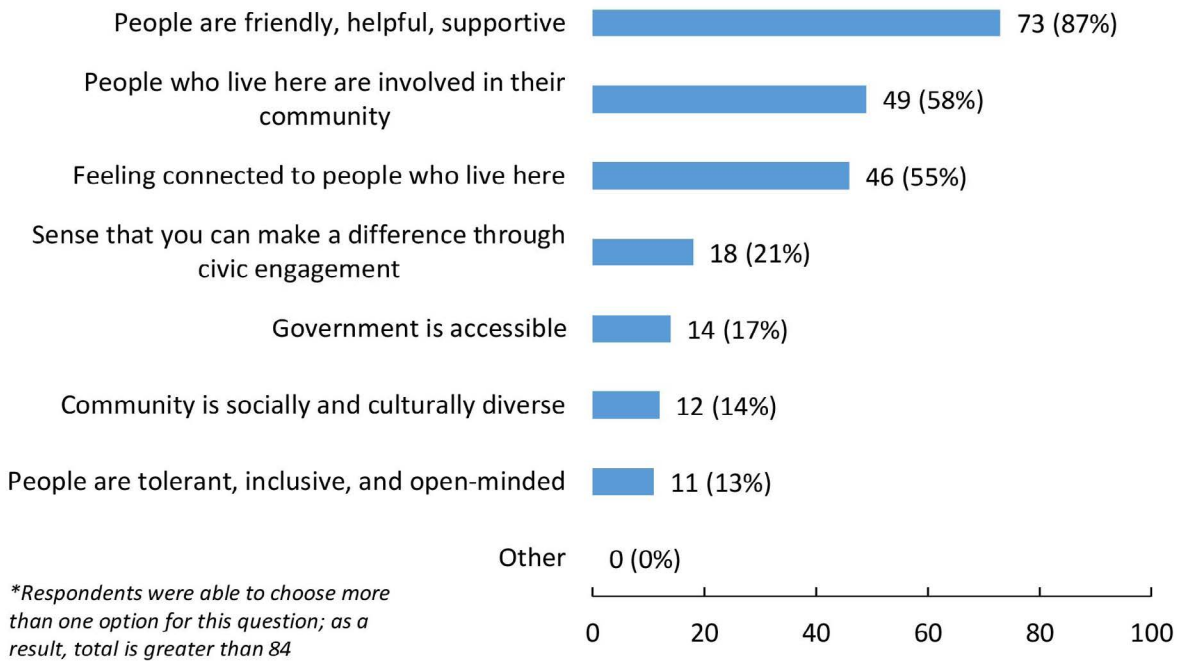
Community Assets and Challenges

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 that community assets include:

- People are friendly, helpful, supportive (N=73)
- Safe place to live, little/no crime (N=79)
- Family friendly (N=72)
- Healthcare (N=59)
- Quality school systems (N=59)

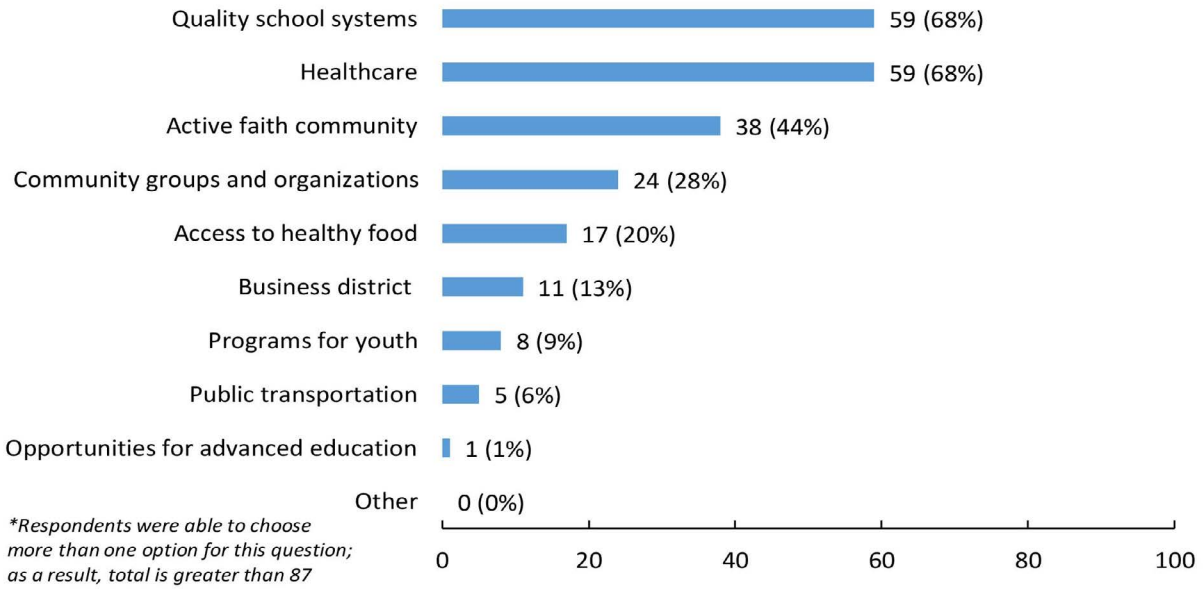
Figures 13 to 16 illustrate the results of these questions.

Figure 13: Best Things About the PEOPLE in Your Community
Total responses = 84*



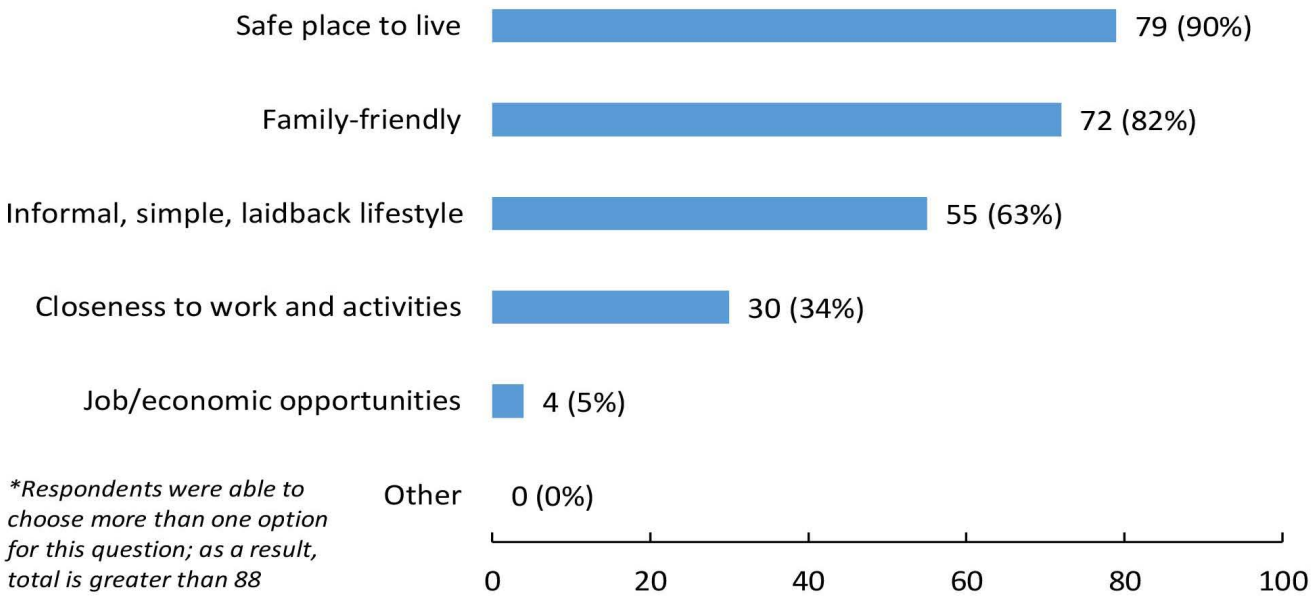
**Respondents were able to choose more than one option for this question; as a result, total is greater than 84*

Figure 14: Best Things About the SERVICES AND RESOURCES in Your Community
Total responses = 87*



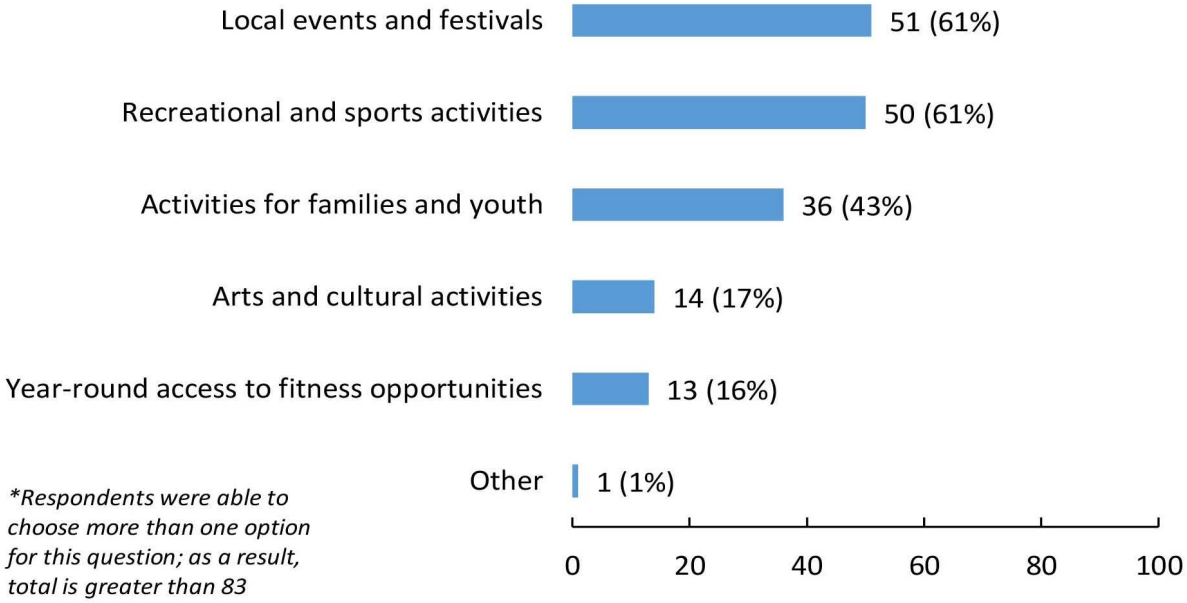
*Respondents were able to choose more than one option for this question; as a result, total is greater than 87

Figure 15: Best Things About the QUALITY OF LIFE in Your Community
Total responses = 88*



*Respondents were able to choose more than one option for this question; as a result, total is greater than 88

Figure 16: Best Thing About the ACTIVITIES in Your Community
Total responses = 83*



**Respondents were able to choose more than one option for this question; as a result, total is greater than 83*

Respondents who selected "Other" specified that the best things about the activities in the community included local library activities.

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 27 respondents) were:

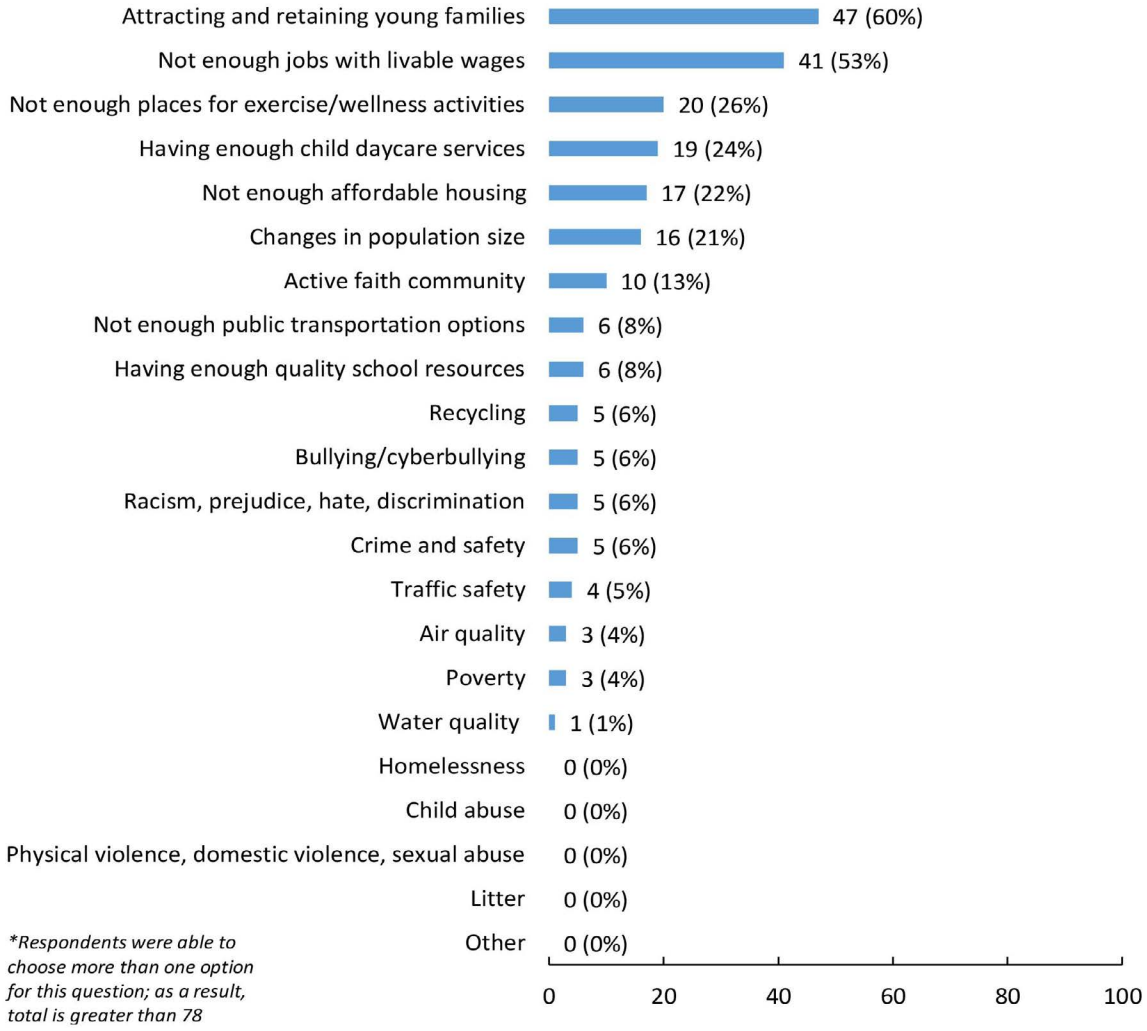
- Attracting and retaining young families (N= 47)
- Bullying/cyberbullying (N=42)
- Not enough jobs with livable wages (N=41)
- Alcohol use and abuse – adult (N=41)
- Alcohol use and abuse – youth (N=40)
- Availability of resources to help the elderly stay in their homes (N=31)
- Smoking and tobacco use – youth (N=30)
- Cost of long-term/nursing home care (N=30)
- Ability to retain primary care providers (MD, DO, NP, PA, nurses) in the community (N=27)
- Depression/anxiety – youth (N=27)

The other issues that had at least 18 votes included:

- Not getting enough exercise/physical activity – adults (N=26)
- Emergency services (N=25)
- Depression/anxiety – adults (N=25)
- Not enough activities for children and youth (N=24)
- Availability of activities for seniors (N=22)
- Drug use/abuse – youth (N=22)
- Obesity/overweight – adults (N=21)
- Child abuse/neglect (N=21)
- Emotional abuse (N=20)
- Not enough places for exercise/wellness activities (N=20)
- Having enough child daycare services (N=19)
- Availability of dental care (N=18)

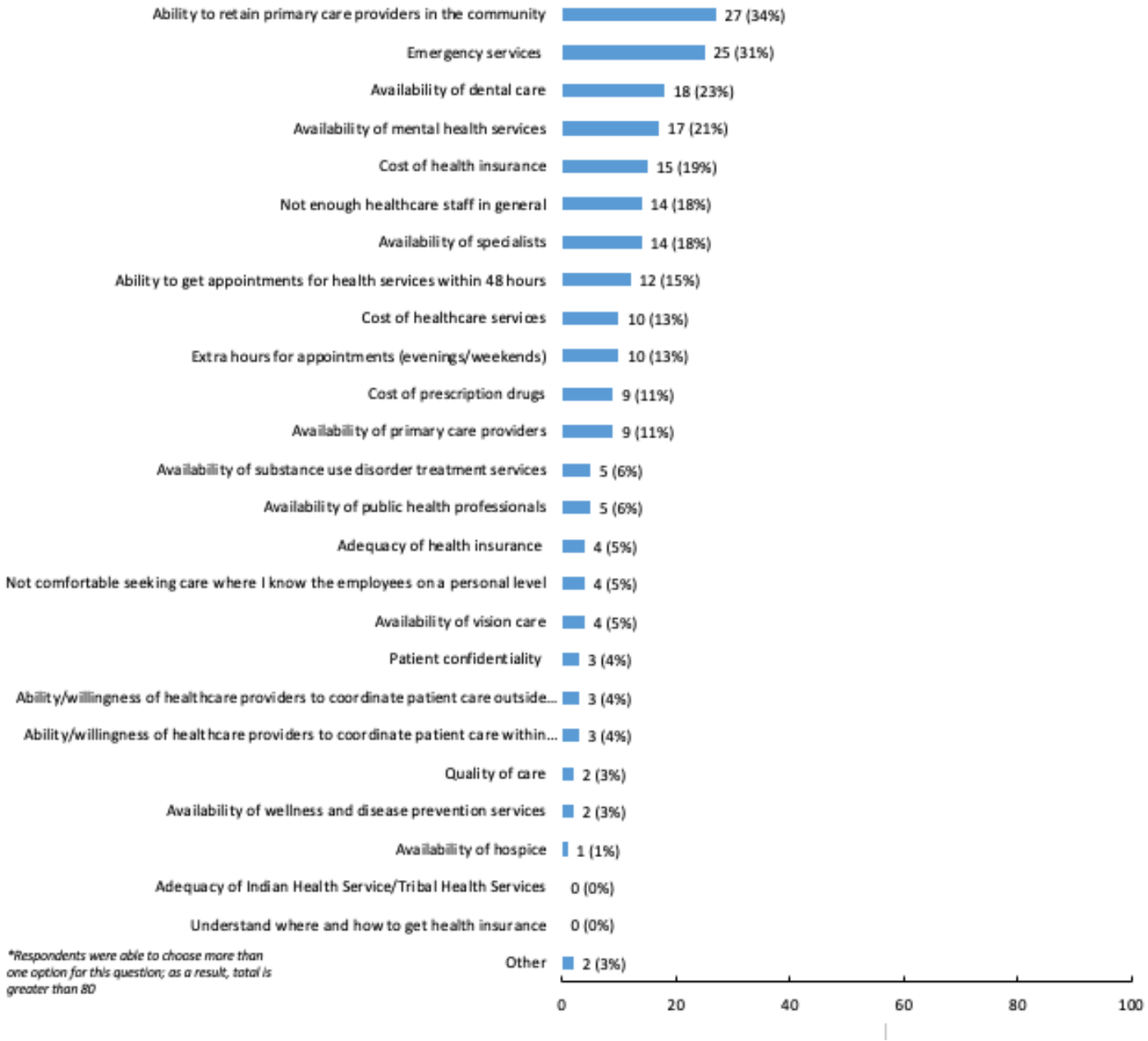
Figures 17 through 22 illustrate these results.

Figure 17: Community/Environmental Health Concerns
Total responses = 78*



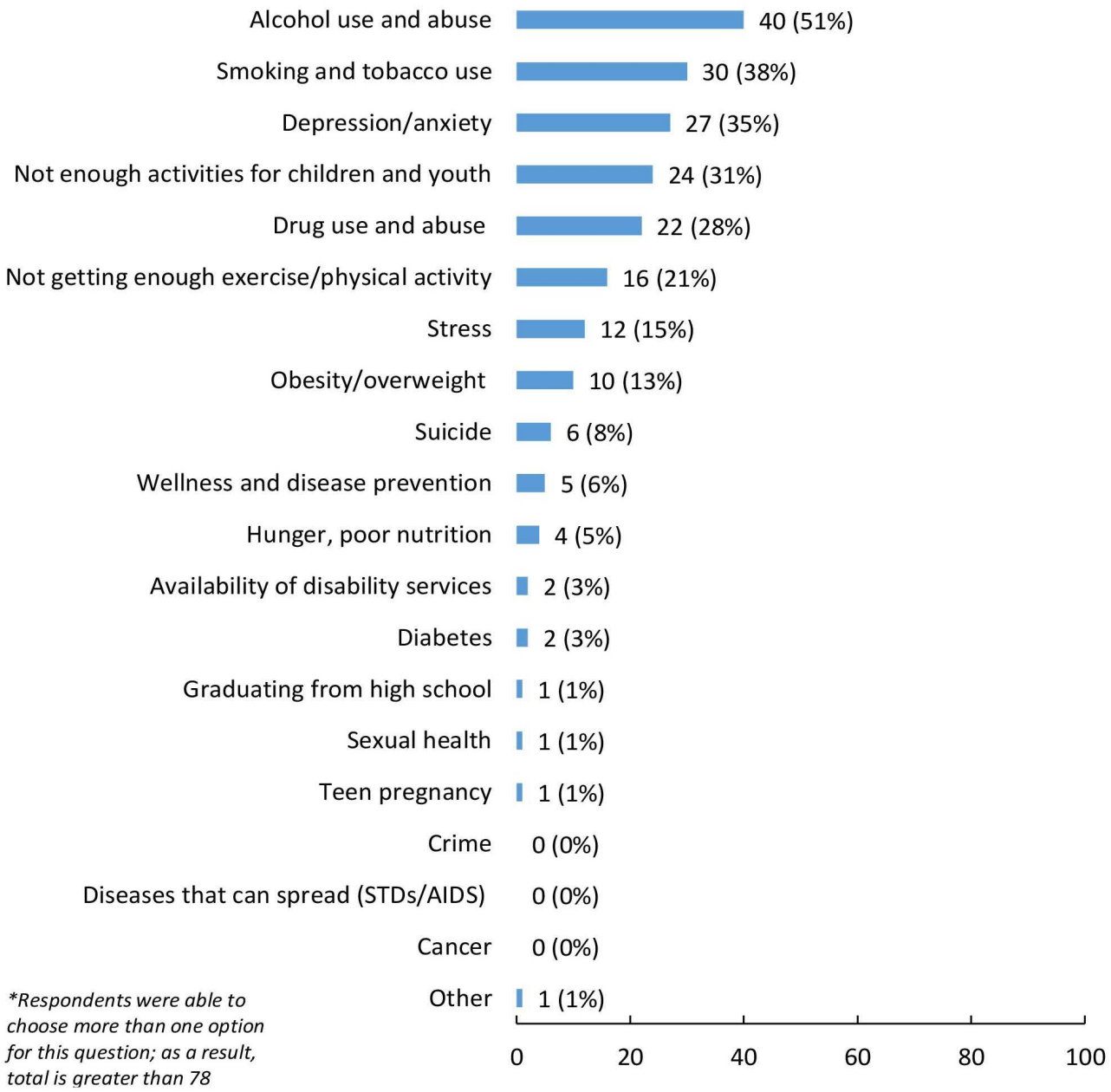
Respondents were able to choose more than one option for this question; as a result, total is greater than 78

Figure 18: Availability/Delivery of Health Services Concerns
Total responses = 80*



Respondents who selected "Other" identified concerns in our community stated they do not have healthcare available for patients, and there is not a clinic in the town; we have to travel anytime we need medical attention. They also stated transportation services for elderly and homebound in the community to include medical appts, food shopping, and activities.

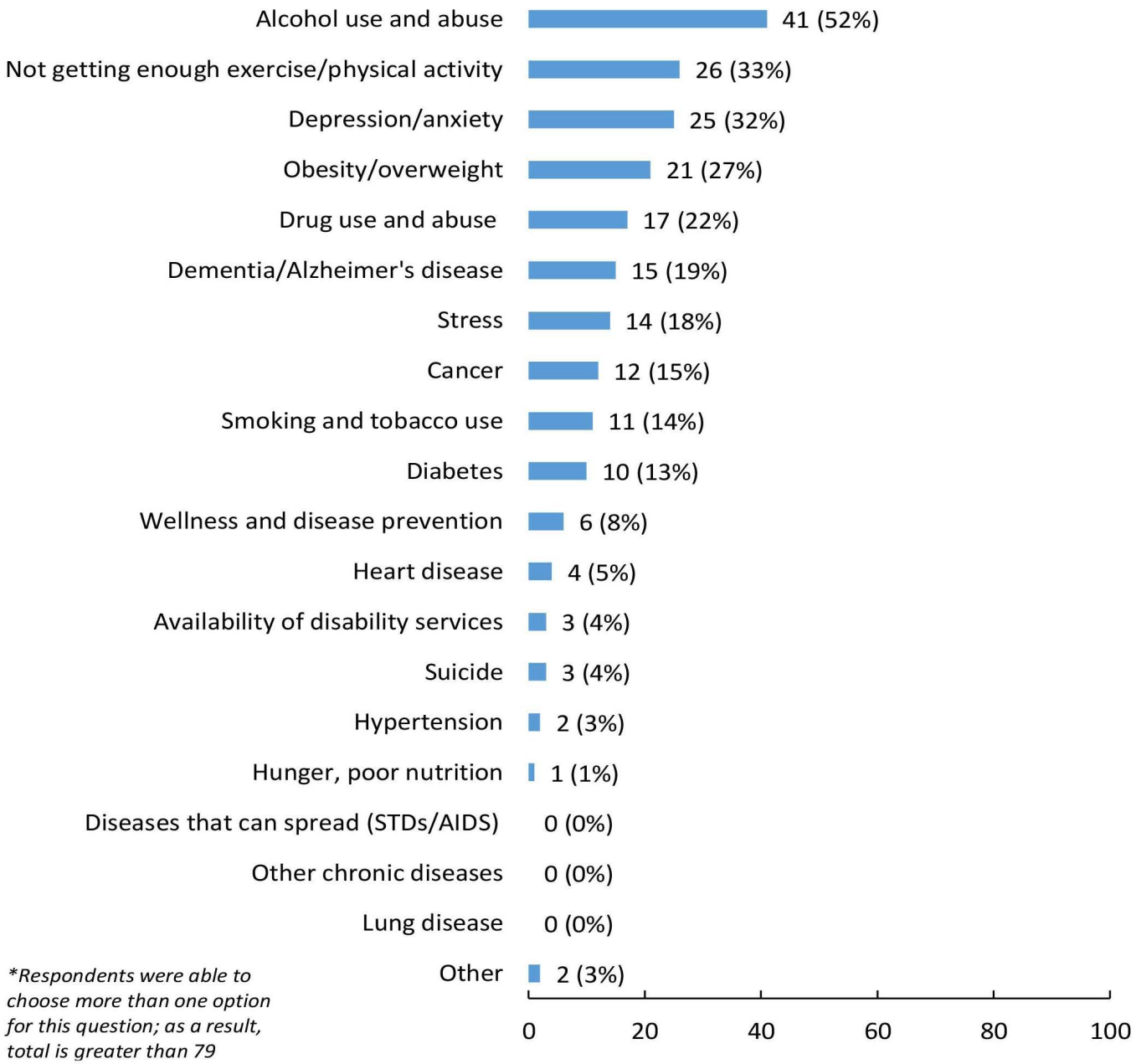
Figure 19: Youth Population Health Concerns
Total responses = 78*



**Respondents were able to choose more than one option for this question; as a result, total is greater than 78*

Listed in the "Other" category for youth population concerns were lack of respect and obeying rules.

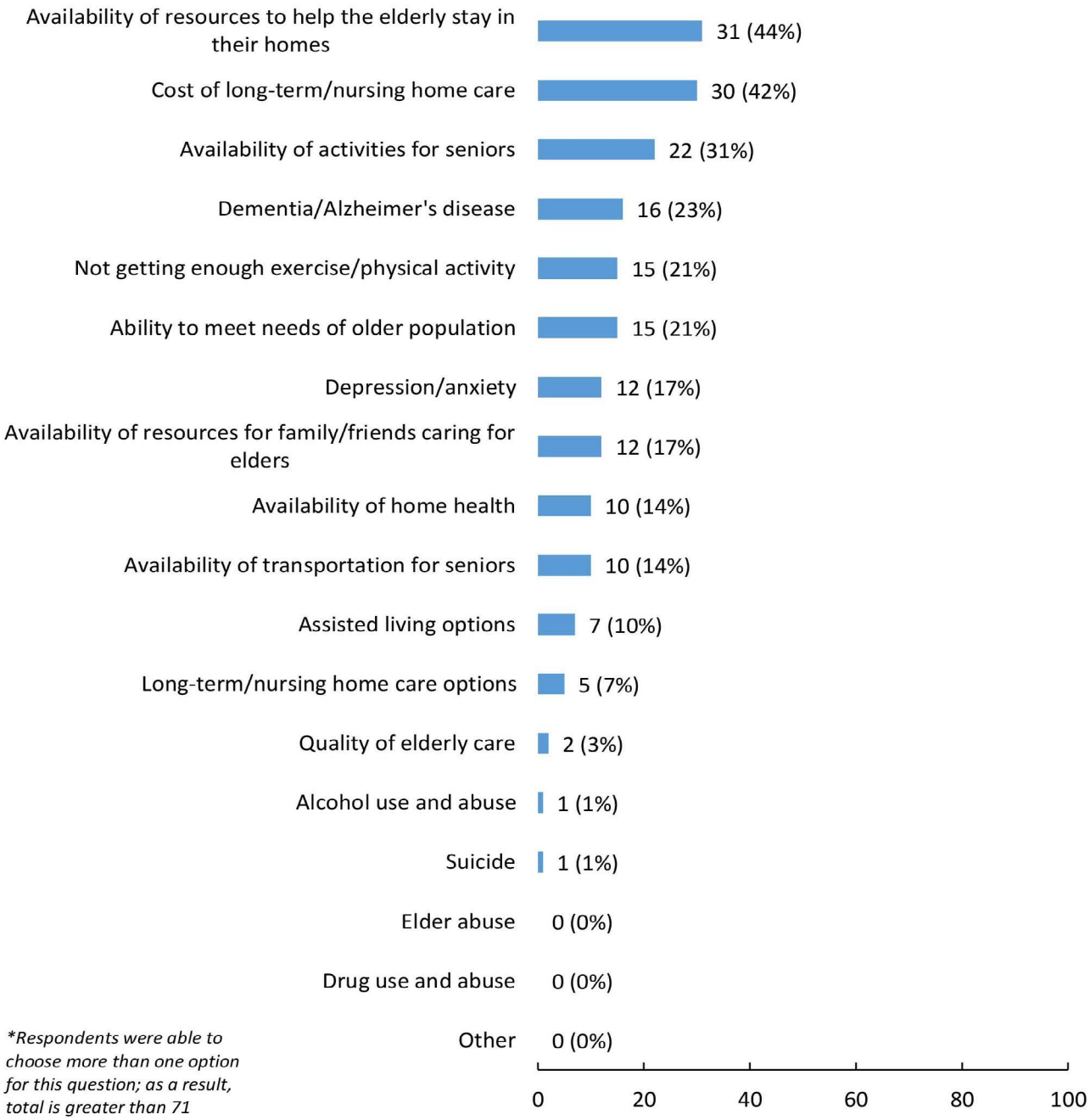
Figure 20: Adult Population Concerns
Total responses = 79*



**Respondents were able to choose more than one option for this question; as a result, total is greater than 79*

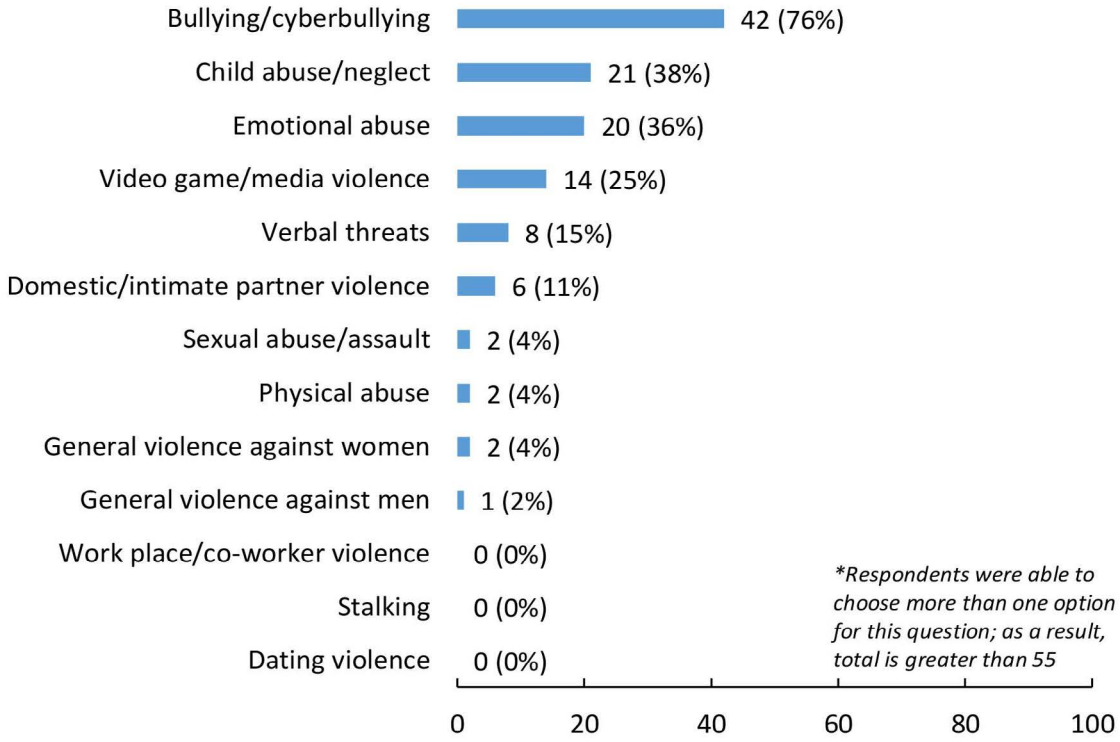
Lack of local transportation for those who don't drive to local medical appointments, supermarket, etc,. and lonely elderly were indicated in the "Other" category for adult population concerns.

Figure 21: Senior Population Concerns
Total responses = 71*



**Respondents were able to choose more than one option for this question; as a result, total is greater than 71*

Figure 22: Concerns About Violence in the Community
Total responses = 55*



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

1. Mental health
2. Lack of jobs in the community
3. Lack of healthcare staff in the community

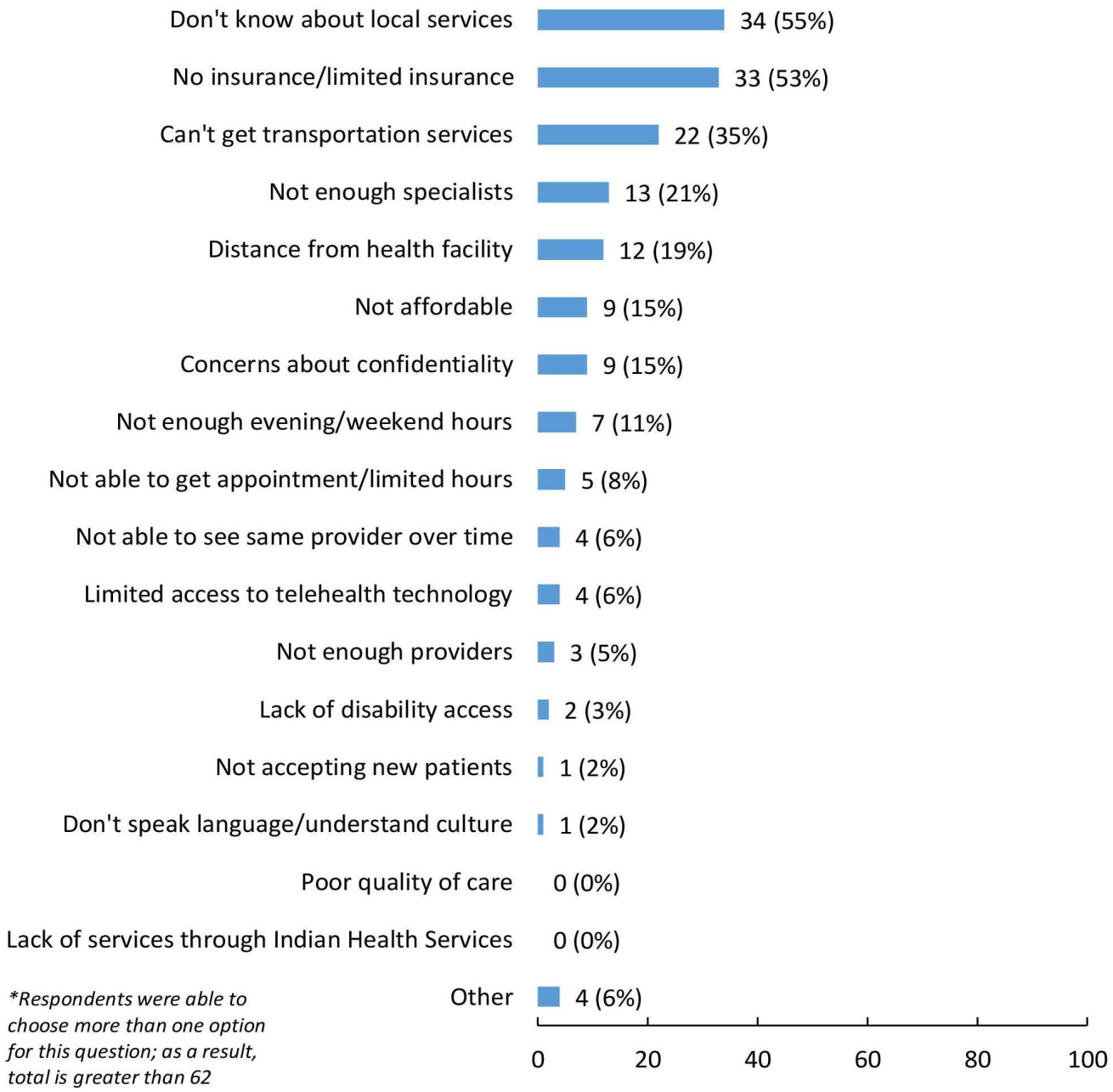
Other biggest challenges identified were rural and in-town residents can be shut in or isolated due to the lack of transportation or a support network to provide access to health care or food security, lack of primary care providers and healthcare staff in the community, no progress, limited resources, lack of wellness/exercise options, lack of things to do for all ages, lack of religious/spiritual wellness in younger population, opportunity for socializing outside of a bar atmosphere, mental health challenges, having the business climate that used to be on Main street, getting people vaccinated, diminishing population, city government not real involved, child and elder care, bullying/cyberbullying of all ages, attracting businesses, and access to fresh, healthy foods.

Delivery of Healthcare

The survey asked residents what they see as barriers that prevent them or other community residents from receiving healthcare. The most prevalent barrier perceived by residents was that they don't know about local services (N=34), with the next highest item being no insurance/limited insurance (N=33). After these items, the next most commonly identified barriers were can't get transportation services (N=22), not enough specialists (N=13), and distance from health facility (N=12).

Figure 23 illustrates these results.

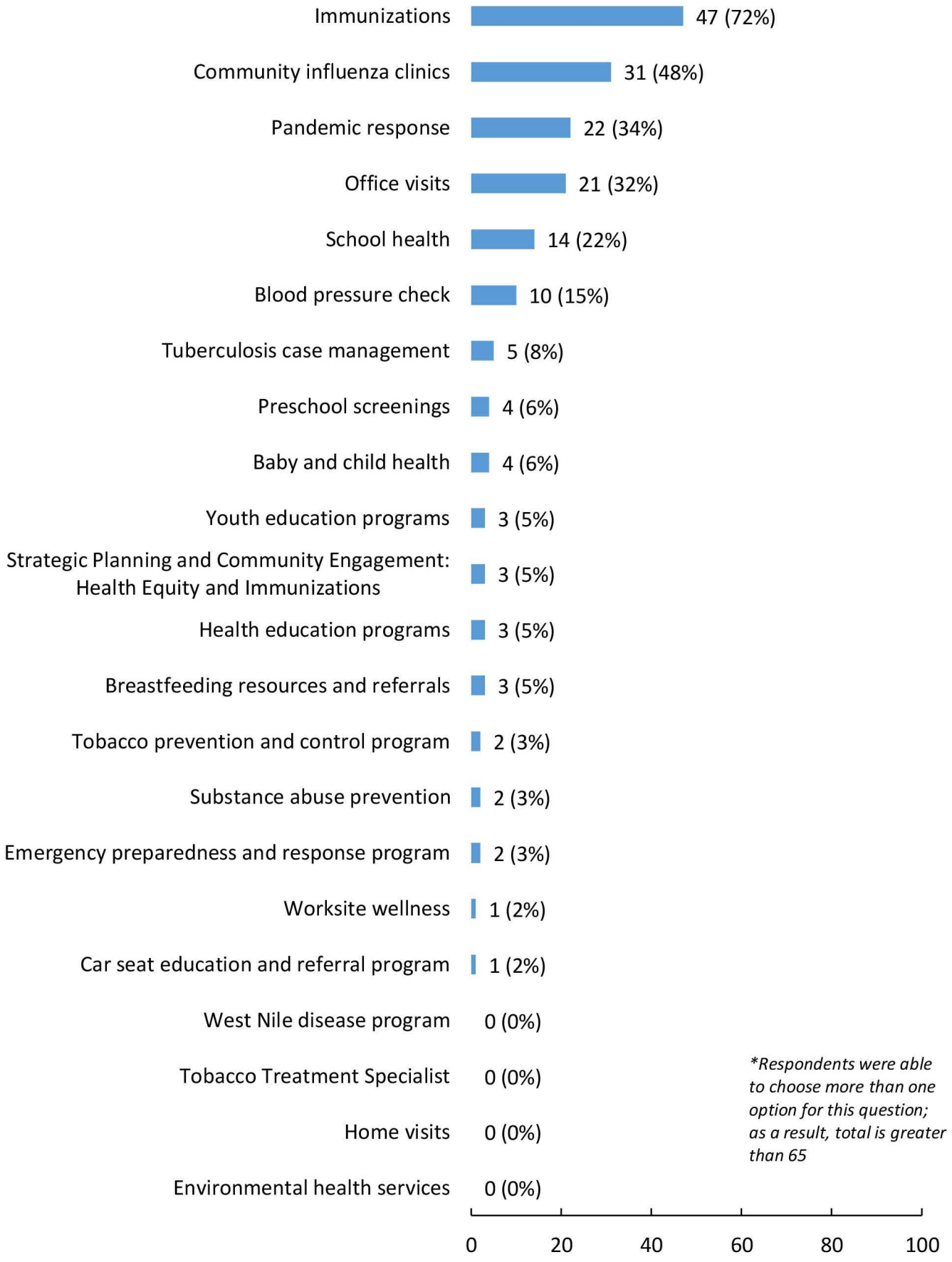
Figure 23: Barriers to Receiving Healthcare
Total responses = 62*



**Respondents were able to choose more than one option for this question; as a result, total is greater than 62*

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

Figure 24: Use of Local Public Health Unit Services
Total responses = 65*



In an open-ended question, respondents were asked what specific healthcare services, if any, they think should be added locally. The responses included:

- Weekend clinic during flu season
- Specialist service providers (cardiology, podiatry, mental health, orthopedics)
- Senior preventive health and remaining in their homes if able
- Chiropractic/massage
- Children immunizations at all clinic locations
- Assistance with toenail care for elderly

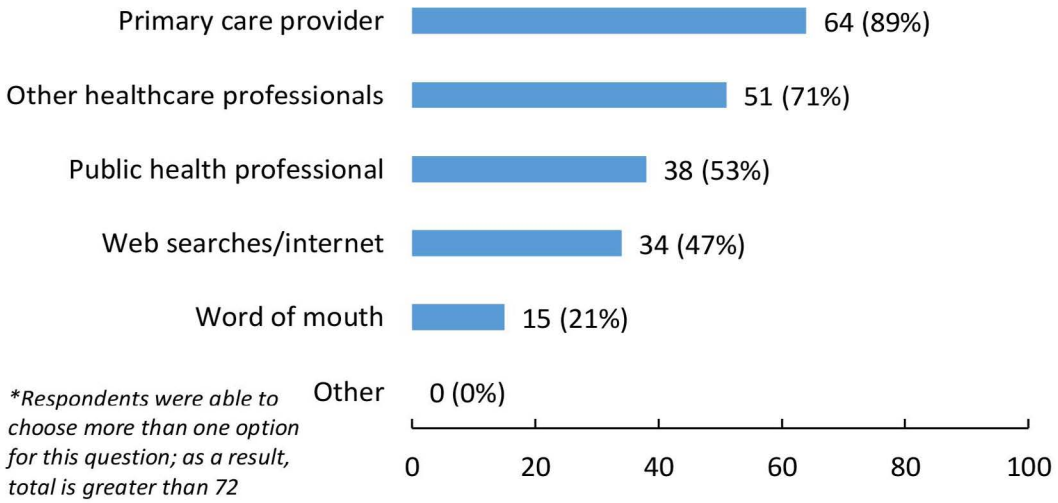
Two people indicated no services needed to be added, while one respondent indicated that they would like the services offered currently to work together better.

The key informant and focus group members felt that the community members were aware of the majority of the health system and public health services. There were a number of services they felt the hospital should increase marketing efforts. These services included: lab services, services outside family practice (IV therapy, OT/ PT, sleep study), respite care, telemedicine, mobile units (mammography, ultrasound), and mental health/wellness. Several suggested that all services be introduced to the public continuously. It was also suggested that during sports season, advertise sports physicals more so people don't have to go out of town for them.

Respondents were asked where they go to for trusted health information. Primary care providers (N=64) received the highest response rate, followed by other healthcare professionals (N=51), and then public health professionals (N=38).

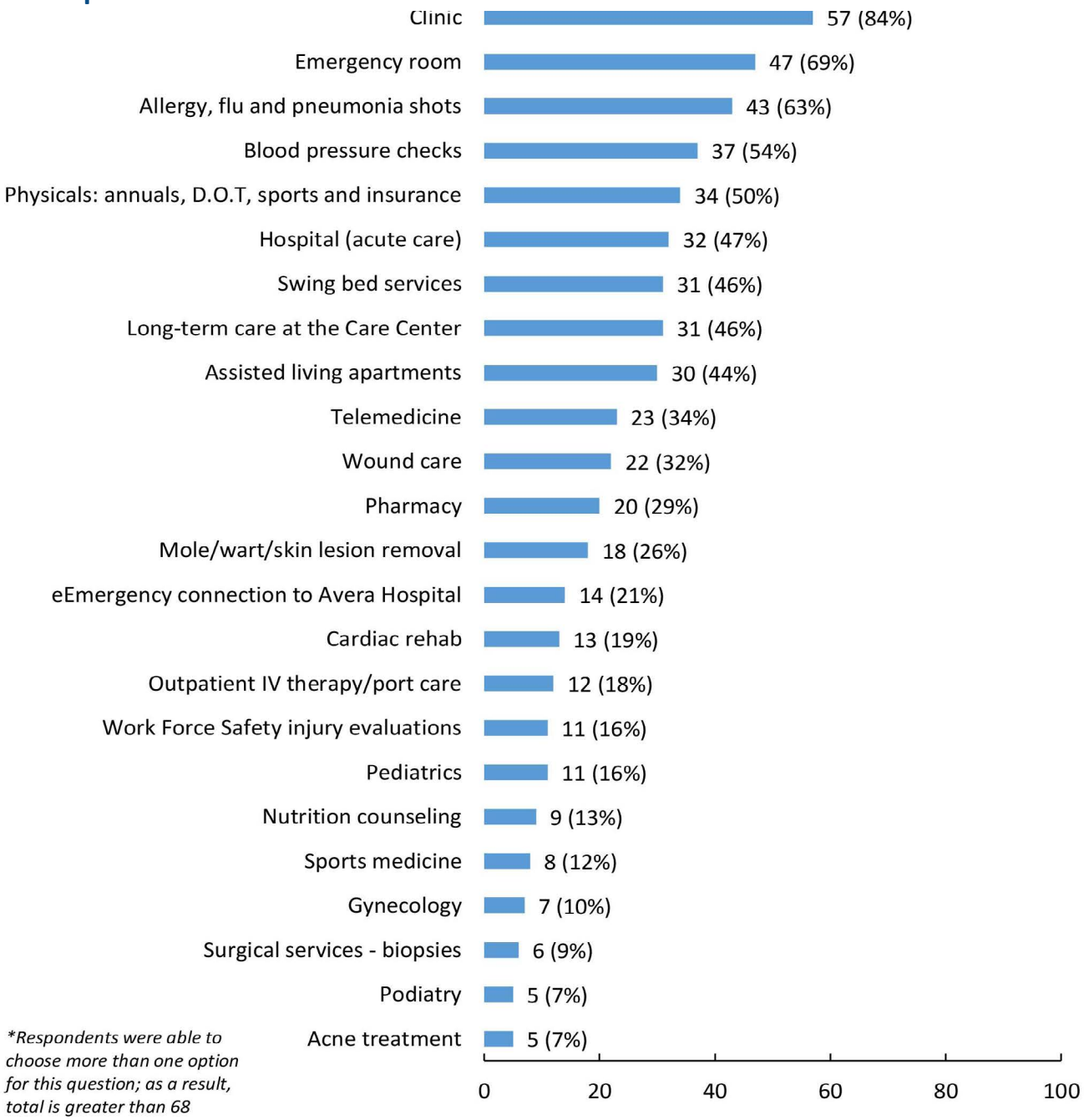
Results are shown in Figure 25.

Figure 25: Sources of Trusted Health Information
Total responses = 72*



Nelson County Health System (NCHS) offers a variety of healthcare services; respondents were asked to indicate if they were aware that the healthcare service is offered through NCHS and to also indicate what, if any, services they or a family member have used at NCHS along with awareness/use of other services. (See Figure 26-28).

Figure 26: Awareness/Use of General and Acute Services
Total responses = 68*



**Respondents were able to choose more than one option for this question; as a result, total is greater than 68*

Figure 27: Awareness/Use of Screening and Therapy Services
Total responses = 46*

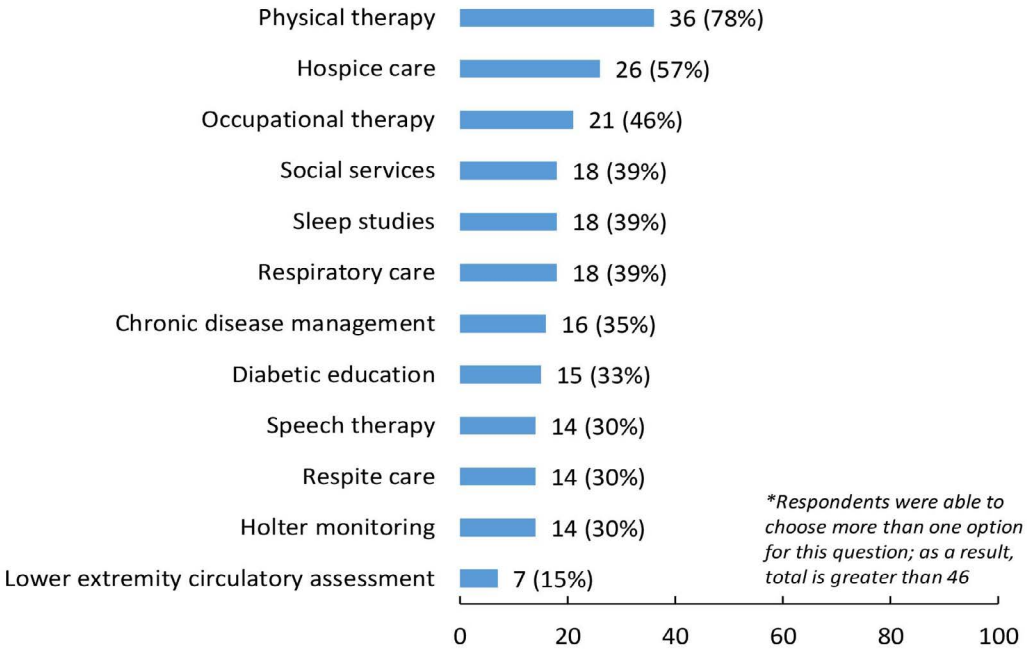
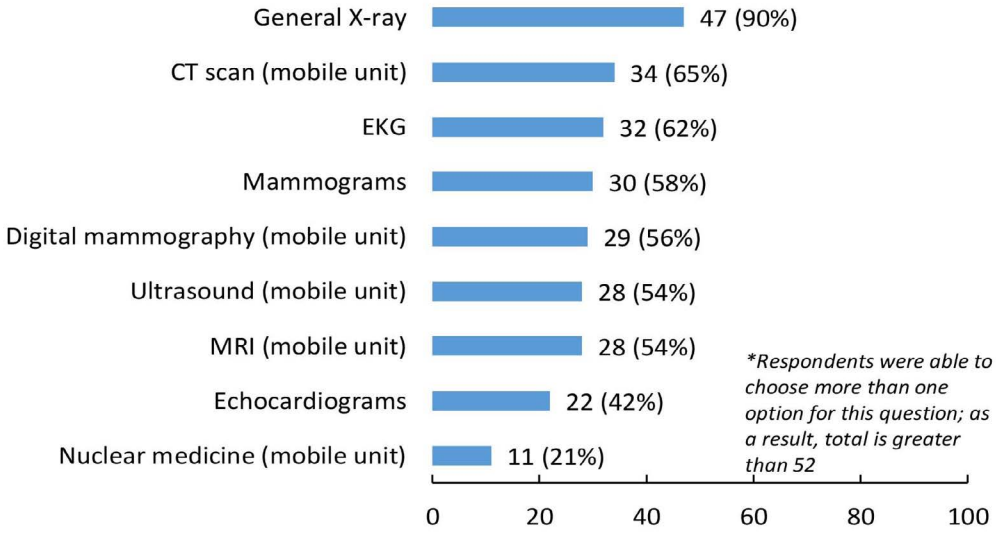
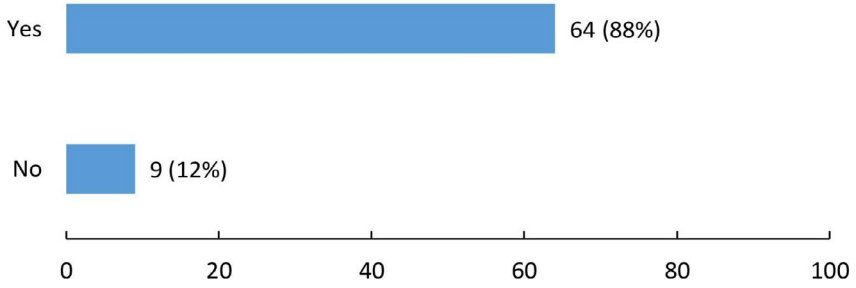


Figure 28: Awareness/Use of Radiology Services
Total responses = 52*



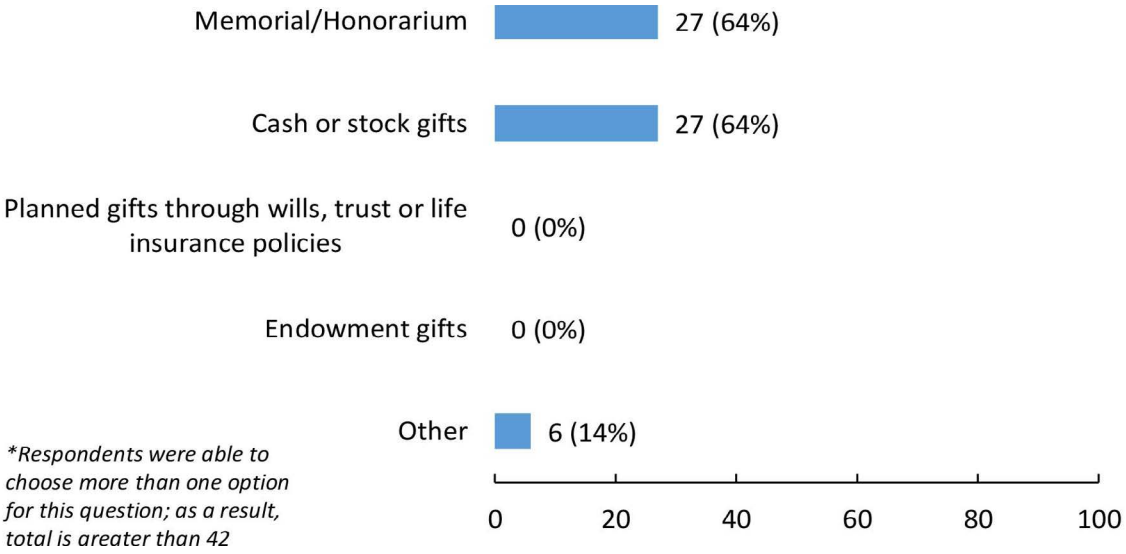
Community members were asked if they were aware of the Nelson County Health System Foundation (see Figure 29).

Figure 29: Awareness of Nelson County Health System Foundation
Total responses = 73*



In an effort to gauge ways that community members have financially supported the Nelson County Health System Foundation, a question was included in the survey (see Figure 30). Recommendations in the "Other" category included events, employee gifting fund, payroll deduction, and support fundraising.

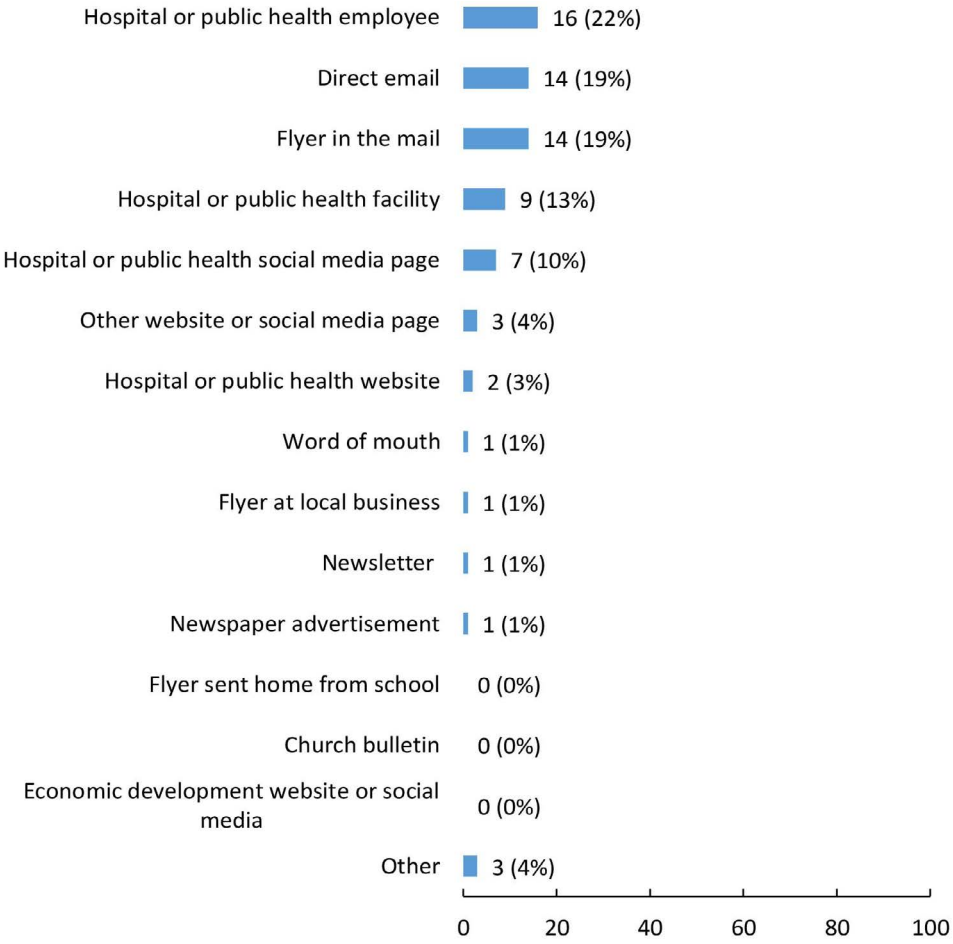
Figure 30: Forms of Support for the Nelson County Health System Foundation
Total responses = 42*



**Respondents were able to choose more than one option for this question; as a result, total is areater than 42*

Respondents were asked how they acquired the survey. Responses in the "Other" category included Pekin's Post Office and a foundation board member (see Figure 31).

Figure 31: How the Survey was Acquired
Total responses = 72



The final question on the survey asked respondents to share concerns and suggestions to improve the delivery of local healthcare. Many of the responses focused on positivity for the current services that are offered in such a small community. Some said patients were referred out if the services they needed weren't available.

There were a few responses about having and needing more professional providers and acquiring a doctor, full time. One person mentioned paying the current employees what they deserved to keep them here instead of paying large bonuses for those coming from somewhere else to work here.

Those with no family members or whose friends are also elderly have challenges with local transportation to and from local medical services. Along with this item, it was suggested that there be easier access to a clinic in Lakota or possibly a satellite clinic. There was mention about distance and geographical area, keeping local healthcare tied to Altru, Sanford, and Essentia, and that experiences with all three had been negative.

There needs to be continued promotion of the services offered. One comment felt that being "local community -minded" would help all medical entities work together.

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 with the community group at the first meeting. The themes that emerged from these sources were wide-ranging, with some directly associated with healthcare and others more rooted in broader social and community matters.

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

- Attracting and retaining young families
- Availability of dental care
- Availability of resources to help the elderly stay in their homes
- Changes in population size (increasing or decreasing)
- Not enough health care staff in general

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

Attracting and retaining young families

- Without the people, we keep getting smaller and then can't sustain what we already have. How do we get people to come here? We have to be seen as growing. BUT how do we incorporate young families into town activities. It would be neat if the communities in the county could join together and operate as a county instead of individual community. Get younger people on town boards and to be part of the Legion post. Need more entertainment – a movie theater to keep people in town instead of traveling frequently to Grand Forks or Fargo. How do you kindle the Nelson county community?
- Been a top priority in any small town I've lived in, but need to have items to attract, ties into housing affordability

Availability of resources to help the elderly to stay in their homes

- Exploring different options
- Utilizing resources outside the box
- There are a lot of times we aren't busy, therefore I can do other things in the community as a healthcare professional, like help organize meds

Changes in population size

- If we want to keep young families, we have to have something to bring them here

Not enough healthcare staff in general

- Merging ambulance services together
- Coordinating ambulance services between towns in county. EMS assessments in the home
- We are very low on staff and see people being overworked, don't have good communication skills with each other

Community Engagement and Collaboration

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

- Public health (4.75)
- Hospital (healthcare system) (4.57)
- Emergency services, including ambulance and fire (4.5)
- Schools (4.25)
- Long-term care, including nursing homes and assisted living (4.0)
- Clinics not affiliated with the main health system (4.0)
- Law enforcement (3.86)
- Faith-based (3.53)
- Human/social services (3.46)
- Business and industry (3.0)
- Economic development organizations (2.92)
- Pharmacy (2.63)
- Other local health providers, such as dentists and chiropractors (2.27)

Priority of Health Needs

A community group met on March 23, 2022. Seven community members attended the meeting. Representatives from the Center for Rural Health (CRH) presented the group with a summary of this report's findings, including background and explanation about the secondary data, highlights from the survey results (including perceived community assets and concerns, and barriers to care), and findings from the key informant interviews.

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

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

- Alcohol use and abuse – youth (4 votes)
- Availability of resources to help elderly stay in their homes (4 votes)
- Attracting and retaining young families (3 votes)
- Not enough jobs with livable wages (3 votes)
- Availability of mental health services (3 votes)
- Availability of activities for seniors (3 votes)

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

- Availability of mental health services (2 votes)
- Availability of resources to help elderly stay in their homes (2 votes)
- Attracting and retaining young families (1 vote)
- Alcohol use and abuse - youth (1 vote)
- Availability of activities for seniors (1 vote)

Since two ranked the highest and the other three were tied, attendees were then asked to vote again from the lowest ranking three in order to identify the additional two top priorities. The additional voting results identified the following two items:

- Alcohol use and abuse - youth (5 votes)
- Attracting and retaining young families (2 votes)
- Availability of activities for seniors (0 votes)

Following the prioritization process during the second meeting of the community group and key informants, the top four identified needs were:

- Availability of mental health services
- Availability of resources to help elderly stay in their homes
- Alcohol use and abuse - youth
- Attracting and retaining young families

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
Ability to meet the needs of the older population	Availability of mental health services
Bullying/cyberbullying	Availability of resources to help the elderly stay in their homes
Adult population not getting enough exercise and physical activity	Alcohol use and abuse - youth
Cost of long-term/nursing home care	Attracting and retaining young families

The current process did not identify any identical common needs from 2019. However, there is similarity between the 2019 need of "ability to meet the needs of the older population" to the 2021 need of "availability of resources to help the elderly stay in their homes."

Nelson County Health Systems (NCHS) invited written comments on the most recent Community Health Needs Assessment (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 NCHS board vote, a notation will be documented in the board minutes reflecting the approval, and then the report will be widely available to the public on the hospital's website; a paper copy will be available for inspection upon request at the hospital. Written comments on this report can be submitted to NCHS.

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

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

Need 1: Ability to meet the needs of the older population; increase the number of primary care providers and proportion of persons with a primary care provider: Since the last CHNA process, NCHS has increased the number of practicing primary care providers by 1.75 FTE, implemented a rural health clinic in Michigan, North Dakota, assisted in home assistance programs, and are in the process of finalizing a Home Health Program and transportation for medical appointments.

Need 2: Bullying and cyberbullying; reduce and prevent bullying and to improve peer relations at school: To implement this priority area, NCHS has worked with NGDHU to help children understand bullying by holding a symposium and encouraging communication. We have also worked in collaboration by encouraging others to take part in activities, interests, and hobbies.

Need 3: Adult population not getting enough exercise and physical activity; preventing disease, lower risks of falls, improve mental health and well-being, strengthen social ties: Ways to improve this objective are to open a gym or exercise facility in the community, which Dakota Prairie Elementary has facilitated. Also, the McVille auditorium is available for events. Organize walks for seniors and have worked with the city of McVille to keep sidewalks free of debris and other obstructing objects.

Need 4: Cost of long-term or nursing home; increase awareness and access to long-term care insurance: NCHS has started this priority area by encouraging young adults to purchase long-term care insurance, designing brochures and media posts for the target audience, and educating the community with the differences between Medicare, Medicaid, commercial insurances, and LTC insurance.

The above implementation plan for NCHS is available to view by contacting the hospital directly.

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?

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: McVille, North Dakota

Nelson County Health System

Quick Facts

Administrator:
Samantha Harding

Chief of Medical Staff:
Dr. Erling Martinson

Board Chair: Ivan Berg

City Population:
322 (2019 Estimate)[1]

County Population:
2,879 (2019 Estimate)[1]

County Median Household Income:
$52,039 (2019 Estimate)[1]

County Median Age:
52.4 (2019 Estimate)[1]

Service Area Population:
Nelson County and part of Griggs County

Owned by: Non-profit

Hospital Beds: 19

Skilled Nursing Facility Beds: 39

Trauma Level: V

Critical Access Hospital Designation: 2000

Economic Impact on the Community*

Employment:
Primary – 92
Secondary – 46
Total – 138

Financial:
Primary – $2.6 Million
Secondary –$1.3 Million
Total – $3.9 Million

Mission Statement:

Enhance the health status and quality of life for peoples and communities served.

Vision Statement:

Provide leadership, working in partnership with others, to ensure continued access to a quality continuum of health care and related services.

County: Nelson
Address: 200 North Main, PO Box 367
McVille, ND 58254
Phone: (701) 322-4328
Fax: (701) 322-2250
Web: www.nelsoncountyhealthsystem.org

Nelson County Health System – Hospital is a 19 bed Primary Care Critical Access Hospital certified by Medicare and Medicaid. Offering 24 hour acute care, swing bed, emergency care, and respite services and staffed by a dedicated team of licensed and certified professional staff, including our physicians, nurse practitioner, nurses, technicians, and therapists.

Services:

Nelson County Health System provides the following services directly through the hospital:

- 24 hour ER Service
- Advance trauma life support
- Advanced cardiac life support
- Paramedic Transfers
- General acute medical inpatient care
- Inpatient and outpatient rehabilitation services
- Cardiac rehabilitation program
- General diagnostic services
- Swing bed care program
- Respite care program
- Diabetes education
- Respiratory therapy
- Sleep apnea studies
- Outpatient medical treatment
- Chiropractic care
- Podiatry
- Digital Radiology/EKG
- Mobile CAT Scan
- Digital mammography
- DexScan services (bone density test)
- Mobile ultrasound
- Speech therapy
- Occupational therapy
- Physical therapy
- QSP/ Home Health Program

Nelson County Health System provides the following services through contract or agreement:

- Assisted Living
- Skilled Nursing Services
- Physical Services
- Occupational Therapy
- Speech Therapy
- Hospice
- Social Services
- Nurse Aid Services/Personal Care
- Home Oxygen Therapy
- Home Health
- Home Care Services

Staffing

Physicians: 1
Nurse Practitioners: 2
PAs: 2
RNs: 14
LPNs: 5
Ancillary Personnel: 78
Total Employees: 102

Local Sponsors and Grant Funding Sources

- Center for Rural Health
  - SHIP Grant (Small Hospital Improvement Program)
  - Flex Grant (Medicare Rural Hospital Flexibility Grant Program
- Blue Cross Blue Shield of North Dakota

Sources

1 - US Census Bureau; American Factfinder; Community Facts

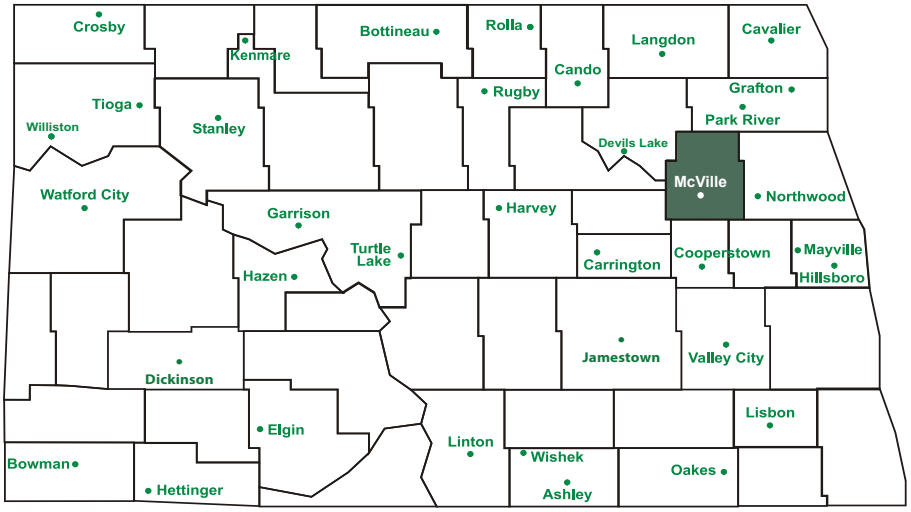
2 - Economic Impact 2020 Center for Rural Health Oklahoma State University and Center for Rural Health University of North Dakota

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

ruralhealth.und.edu

North Dakota Critical Access Hospitals



History:

Construction on the McVille Community Hospital began in 1916 and was dedicated on Tuesday, February 6, 1917. It was given the name "Community Hospital" because, according to Mr E. C. Olsgaard, then president of the board, emphasized that the institution was not built by McVille alone nor for McVille alone but was given its name because it was built by the entire community and for a community as large as its service can reach. Dr A.O Arneson began practicing as a physician in McVille in 1906. He continued until his death in 1942. Following Dr. Arneson's death, Dr. Muus began his practice. In 1957 a 6 bed addition was constructed onto the hospital. It was modernized in 1974, the original unit razed, and a replacement built. Nelson County Health Center Care Center was dedicated on July 3, 1963 and was originally designed to serve the area as a Rehabilitation Center. In April of 1966, the Center was purchased by Friendship Homes Inc., and began to serve as a skilled nursing home. The City of McVille purchased the Center on January 1, 1998. It is a 39 bed facility offering skilled nursing care, rehabilitation, hospice, and respite care. The clinic facility in McVille was completed in 1968 and Dr. Dale Iverson was welcomed to the community as physician in 1970. Currently it is staffed by one physician and a nurse practitioner. In 1972, the name was changed from Community Hospital at McVille to Community Hospital in Nelson County and an effort was made to better serve the health needs of the entire area. In 1974, the assets of the hospital were deeded to the city of McVille in order to better-enable the financing of the building project. Since that time, the debt has been retired and the hospital has been deeded back to the organization. The name was later changed to Nelson County Health System.

In 2000, the hospital was designated as a 19-bed Critical Access Hospital with a Swing Bed program. This allowed cost-based reimbursement and improved efficiencies. The McVille Medical Clinic became a Rural Health Clinic. In a time of changing health care and financing in rural areas, changes continue to be made in services provided by NCHS. A 12 unit Assisted Living facility was opened in 2011.

Recreation:

McVille has a number of recreational facilities. We offer an excellent nine hole grass green municipal golf course, lighted baseball/softball field, paved running track and football field. The McVille Dam facility located east of town offers swimming, fishing, camping, and small horsepower boating. Our newly paved, well lighted streets, top ranked schools, churches, clinic, hospital and nursing home, and a new restaurant all contribute to our better way of life. McVille maintains a local "McVille Channel" to keep you up to date on what is happening around the area. The region abounds in outdoor activities – including hunting, fishing, and snowmobiling.

Updated 06/2022

Appendix B – Economic Impact Analysis

December 2020

Nelson County Health System

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

Economic Impact

Nelson County Health System is composed of a Critical Access Hospital (CAH), a Rural Health Clinic, a nursing home, an assisted living facility, home and community-based services, and Veterans transportation in McVille, North Dakota.

Nelson County Health System **directly** employs **70.92 FTE employees** with an annual payroll of over **$4.15 million** (including benefits).

- After application of the employment multiplier of 1.36, these employees created an additional **26** jobs.
- The same methodology is applied to derive the income impact. The income multiplier of 1.17 is applied to create nearly **$705,000** in income as they interact with other sectors of the local economy.
- **Total impacts = 96 jobs and more than $4.85 million in income.**

Healthcare and Your Local Economy

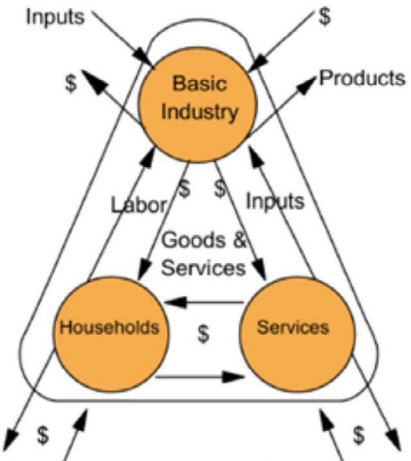
The health sector in a rural community, anchored by a CAH, is responsible for a number of full- and part-time jobs and the resulting wages, salaries, and benefits. Research findings from the National Center for Rural Health Works indicate that rural hospitals typically are one of the top employers in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

Key contributions of the health system include

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

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

Figure 1. An overview of the community economic system.



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

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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

Appendix C – CHNA Survey Instrument

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

Nelson County Health System

Public Health
Nelson-Griggs District Health Unit

Nelson County Area Health Survey

Nelson County Health System and Nelson-Griggs District Health Unit are interested in hearing from you about community health concerns.

The focus of this effort is to:

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

If you prefer, you may take the survey online at https://tinyurl.com/McVille2021CHNA 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 December 15, 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):

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

- ☐ Ability to meet needs of older population
- ☐ Long-term/nursing home care options
- ☐ Assisted living options
- ☐ Availability of resources to help the elderly stay in their homes
- ☐ Cost of activities for seniors
- ☐ Availability of activities for seniors
- ☐ Availability of resources for family and friends caring for elders
- ☐ Quality of elderly care
- ☐ Cost of long-term/nursing home care
- ☐ Availability of transportation for seniors
- ☐ Availability of home health
- ☐ Not getting enough exercise/physical activity
- ☐ Dementia/Alzheimer's disease
- ☐ Depression/anxiety
- ☐ Suicide
- ☐ Alcohol use and abuse
- ☐ Drug use and abuse (including prescription drug abuse)
- ☐ 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 have you or a family member used in the past year? (Choose ALL that apply)

- ☐ Baby and child health (newborn visits, Cribs for Kids program)
- ☐ Blood pressure checks
- ☐ Breastfeeding resource and referrals
- ☐ Car seat education and referral program
- ☐ Community influenza clinics
- ☐ Emergency preparedness and response program (work with community partners)
- ☐ Environmental health services (water, sewer, health hazard abatement)
- ☐ Health education programs
- ☐ Home visits (in-home medication setup, monitor health status)
- ☐ Immunizations (infants, youth, adults)
- ☐ Office visits (consultation and referrals)
- ☐ School health (vision screening, health education, school immunizations)
- ☐ Strategic Planning & Community Engagement: Health Equity and Immunizations
- ☐ Substance abuse prevention (prescription drugs)
- ☐ Pandemic response, including education, case investigation, contact tracing and vaccinations
- ☐ Preschool screenings
- ☐ Tobacco prevention and control program (signage, policies, youth activities, newsletters)
- ☐ Tobacco Treatment Specialist (cessation services)
- ☐ Tuberculosis case management
- ☐ West Nile disease program (education)
- ☐ Worksite wellness
- ☐ Youth education programs (Progressive Ag Safety Day)

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

- ☐ Acne treatment
- ☐ Allergy, flu & pneumonia shots
- ☐ Assisted living apartments
- ☐ Blood pressure checks
- ☐ Cardiac rehab
- ☐ Clinic
- ☐ Emergency room
- ☐ eEmergency connection to Avera Hospital in Sioux Falls, SD
- ☐ Gynecology
- ☐ Hospital (acute care)
- ☐ Long-term care at the Care Center
- ☐ Mole/wart/skin lesion removal
- ☐ Nutrition counseling
- ☐ Outpatient IV therapy/port care
- ☐ Pediatrics
- ☐ Pharmacy
- ☐ Podiatry
- ☐ Physicals: annuals, D.O.T., sports & insurance
- ☐ Sports medicine
- ☐ Surgical services – biopsies
- ☐ Swing bed services
- ☐ Telemedicine
- ☐ Work Force Safety injury evaluations
- ☐ Wound care

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

- ☐ Chronic disease management
- ☐ Diabetic education
- ☐ Holter monitoring
- ☐ Hospice care
- ☐ Lower extremity circulatory assessment
- ☐ Occupational therapy
- ☐ Physical therapy
- ☐ Respiratory care
- ☐ Respite care
- ☐ Sleep studies
- ☐ Social services
- ☐ Speech therapy

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

- ☐ CT scan (mobile unit)
- ☐ Digital mammography (mobile unit)
- ☐ Echocardiograms
- ☐ EKG
- ☐ General x-ray
- ☐ Nuclear medicine (mobile unit)
- ☐ Mammograms
- ☐ MRI (mobile unit)
- ☐ Ultrasound (mobile unit)

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

_____

_____

17. 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): _____

18. 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): _____

19. 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): _____

20. Are you aware of Nelson County Health System's Foundation, which exists to financially support Nelson County Health System?

- ☐ Yes
- ☐ No

21. Have you supported the Nelson County Health System Foundation in any of the following ways? (Choose ALL that apply)

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

Demographic Information: Please tell us about yourself.

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

- ☐ Yes
- ☐ No

23. 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): _____

24. 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): _____

25. 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

26. 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

27. Sex:

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

28. Employment status:

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

29. Your zip code: _____

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

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

31. 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

32. 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/

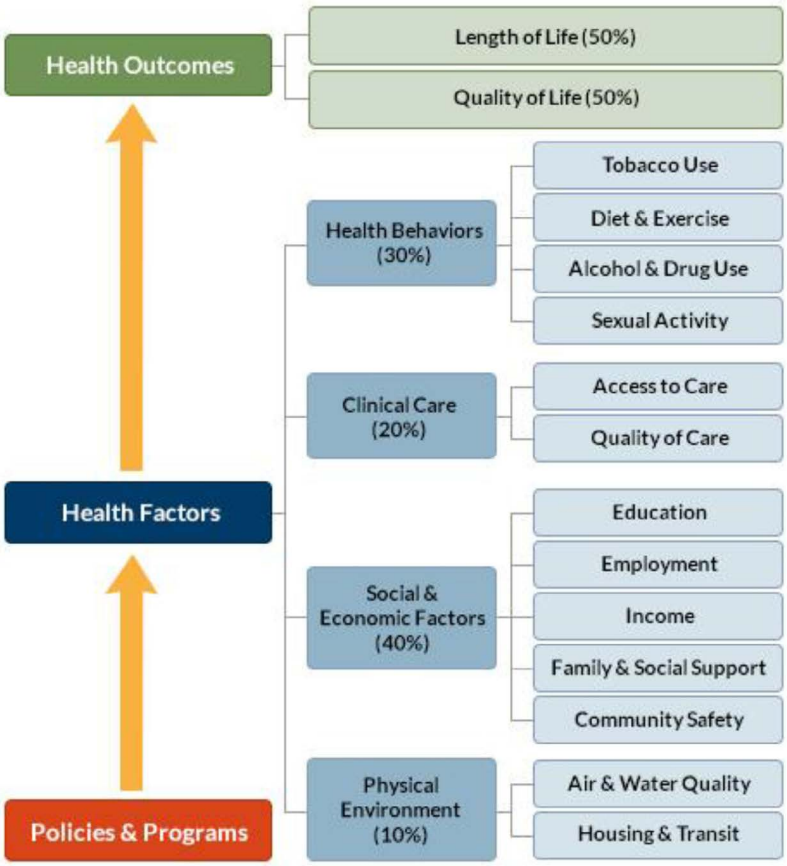
Methods

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 Behavioral Risk Survey Results

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

McVille, 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 vote. After the first round of voting, the top six priorities were selected based on the highest number of votes. Each person was then given one dot to place on the item they felt was the most important priority of the top six highest ranked priorities. The "Most Important, 1st vote" column lists the number of red dots placed on the flipcharts. Since only two ranked the highest, and the other three were tied, attendees were then asked to vote again from the lowest ranking three in order to identify the additional two top priorities. This is reflected in the "Most Important, 2nd vote" column.

	Priorities	Most Important, 1st vote	Most Important, 2nd vote
COMMUNITY/ENVIRONMENTAL HEALTH CONCERNS			
Attracting & retaining young families	3	1	2
Not enough jobs with livable wages	3		
Not enough places for exercise/wellness activities			
Having enough child daycare services			
AVAILABILITY/DELIVERY OF HEALTH SERVICES CONCERNS			
Ability to retain primary care providers (MD, CO, NP, PA)			
Emergency services	1		
Availability of dental care			
Availability of mental health services	3	2	
YOUTH POPULATION HEALTH CONCERNS			
Alcohol use and abuse	4	1	5
Smoking & tobacco use			
Depression/anxiety			
Not enough activities for children & youth	1		
ADULT POPULATION HEALTH CONCERNS			
Alcohol use and abuse	2		
Not getting enough exercise/physical activity	1		
Depression/anxiety			
Obesity/overweight	1		
SENIOR POPULATION HEALTH CONCERNS			
Availability of resources to help elderly stay in their homes	4	2	
Cost of long-term/nursing home care			
Availability of activities for seniors	3	1	0
Dementia/Alzheimer's disease			
VIOLENCE CONCERNS			
Bullying/cyber-bullying	1		
Child abuse/neglect			
Emotional abuse	1		
Video game/media violence			

Appendix G – Survey "Other" Responses

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

Community Concerns

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

- Our community does not have health care available for patients. There is not a clinic in the town, we have to travel anytime we need medical attention.
- Transportation to services for elderly and homebound in the community to include medical appointments, food shopping, and activities

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

- Lack of respect, obeying rules

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

- Lonely elderly
- Lack of local transportation for those who don't drive to local med appts, supermarket, etc.

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

- Rural and in town residents can be shut in or isolated due to the lack of transportation or a support network to provide access to health care or food security
- Primary care provider
- No progress
- Need to attract younger families with the job market
- Mental health challenges, many people are experiencing stress, anxiety and depression after COVID
- Mental health
- Limited resources
- Lack of wellness/exercise options
- Lack of things to do
- Lack of religious/spiritual wellness in younger population
- Lack of quality employment
- Lack of people willing to volunteer, ambulances in all of our communities
- Lack of jobs that would keep our younger generation in the community and be able to pay them a livable wage, opportunity for socializing outside of a bar atmosphere
- Lack of healthcare staff in community
- Keeping jobs and people in the community
- Involvement of the community in the community, it seems like it is the same small group of people doing everything
- I feel the biggest challenge in our community is getting the younger people involved with the fire department and ambulance. We need those services to continue. Those services are currently being provided mainly by people 50 and older.
- Having the business climate, they used to be on main street
- Having jobs that could bring in families
- Good earning jobs
- Getting people vaccinate, too many naysayers
- Diminishing population

- City government not real involved
- Child and elder care
- Bullying/cyber-bullying due to lack of respect
- Bullying with youth & lack of activities/programs for youth
- Attracting businesses
- Access to fresh, healthy foods

Delivery of Healthcare

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

- Weekend clinic during flu season
- We have a lot of services for a small facility - none come to mind
- Specialist Service providers like Cardiology, Podiatry, Mental Health, Orthopedics
- Senior preventive health and remaining in their homes if able
- None
- Help the services we have work together better
- Chiropractic/massage
- Children immunizations at all clinic locations
- Assistance with toenail care for elderly who are unable to properly manage their own

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

- Lived here most of my life, so pretty aware of what is offered

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

- Community residents' lack of interest
- Ignorance
- Have to get people aware of services NCHS has to offer
- Ignorance towards healthcare right now

21. Have you supported Nelson County Health System's Foundation in any of the following ways? "Other" responses:

- Events
- Employee gifting fund
- Payroll deduction
- Support fundraising events
- NA

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

"Other" website responses

- Facebook (3)

"Other" newsletter responses:

- Mail flyer

"Other" responses:

- Pekin's Post Office
- Foundation board member

24. Health insurance or health coverage status "Other responses":

- Tri care for life
- BCBS

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

- Work on getting the information of all services our Hospital has to offer
- We love the services available locally through NCHS!
- We have good health care here
- We are so lucky to have the great services we have for a small rural community.
- Those with no family members and/or whose friends are also old have challenges with local transportation to/from local medical services
- Think they all do very good job, just need to pay the ones working good wage to keep them instead of paying extra bonuses to come work there
- Satellite day clinics
- Overall, the community is providing quality healthcare, if they cannot provide the service they are able to refer you elsewhere
- Need to acquire a full-time doctor
- More professional providers and services
- Grateful for their presence and hope it continues
- Easier access clinic in Lakota
- Distance and geographical area has kept local healthcare tied to Altru/Sanford/Essnetia. Experiences with these 3 have been negative.
- Be more local community minded, all medical entities work together