Nelson County Health System

2025 Community Health Needs Assessment

McVille, North Dakota

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Community Health Needs Assessment

Executive Summary

A community health needs assessment (CHNA) is a crucial tool for understanding and improving the health and well-being of a community by identifying key health issues, informing strategic planning, and fostering collaborative efforts among various stakeholders. The Nelson County Health System (NCHS) CHNA focused on identifying and addressing the health needs of Nelson County by gathering data and input from the community to identify the most pressing health issues, including chronic diseases, mental health, access to healthcare services, and social determinants of health.

NCHS executed a CHNA process that included collecting primary and secondary data. The CHNA steering committee composed of the CEO, clinic manager, and local public health administrator oversaw the CHNA along with the project consultant, Cibolo Health. Organizations and community stakeholders within the primary service area were engaged in identifying the needs of the community. Community organizations, government agencies, educational systems, health and human services entities, as well as others, were engaged throughout the CHNA. The comprehensive primary data collection phase resulted in contributions from a multitude of regional community stakeholders and representatives from organizations.

Input from the community was sought through a community survey, key informant interviews, and focus groups (community meetings). Community input was aligned with secondary data collections and presented to the CHNA Steering Committee, focus group participants, and key informant interviewees as a framework for assessing current community needs, identifying new/emerging health issues, and advancing health improvement efforts to address identified needs.

Specifically, the primary data collection consisted of several project components. In total, 125 surveys were collected, 7 key informant interviews were conducted, and 17 community members participated in the data collection focus group. All collection modes involved individuals who represented a) broad interests of the community, b) populations of need, or c) persons with specialized knowledge in public health.

A second community meeting composed of the key informant interviewees and those that attended the first focus group/community meeting met on January 6, 2025 where the data analysis was presented and attendees voted on the top priorities for 2025 based on primary and secondary data results. There were 10 people in attendance. Nelson County Health System recognized its needs from the previous assessment and will build upon those issues, but most importantly, Nelson County Health System identified additional areas of concern that require attention. Based on collective information from the previous implementation strategy plan along with the needs identified in the current cycle Nelson County Health System will reinforce and create new strategies to bridge the gap and address the needs of those in their service area.

With regard to demographics, Nelson County's population in 2024 declined by 15.9% from the 3,126 people who lived there in 2010. For comparison, the population in the US grew 7.7% and the population in North Dakota grew 15.5% during that period (https://usafacts.org/). The average number of residents under age 18 (19.9%) for Nelson County comes in 3.6 percentage points lower than the North Dakota average (23.5%). The percentage of residents ages 65 and older, is 11.5% higher for Nelson County (28.2%) than the North Dakota average (16.7%). The median household income in Nelson County ($68,051) is a little lower than the state average for North Dakota ($71,970).

Data compiled by County Health Rankings show Nelson County is doing better than the North Dakota average in health outcomes/factors for 17 categories. It is scoring poorer than the North Dakota average in health outcomes/factors for 18 categories.

Of 106 potential community and health needs set forth in the survey, the 125 NCHS service area residents who completed the survey indicated the following ten needs as the most important:

- Attracting and retaining young families
- Bullying/cyber-bullying
- Alcohol use and abuse – All ages
- Depression/anxiety – Youth
- Smoking and tobacco use, exposure to second-hand smoke, vaping - Youth
- Cost of long-term/nursing home care
- Ability to retain primary care providers (MD,DO,NP,PA) and nurses in the community
- Drug use and abuse – Youth and Adult
- Availability of resources to help the elderly stay in their homes
- Not enough jobs with livable wages, not enough to live on

The survey also revealed the biggest barriers to receiving healthcare (as perceived by community members). They included (N=55), don't know about local services (N=34) and distance from health facility (N=30).

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

- Safe place to live, little/no crime
- Family friendly; good place to raise kids
- People are friendly, helpful, and supportive
- Healthcare
- Local events & festivals, activities for families & youth
- Feeling connected to people who live here
- Quality school systems
- People who live here are involved in their community

Input from community leaders, provided via key informant interviews, and the community focus group echoed many of the top 10 concerns raised by survey respondents. Concerns emerging from these sessions were:

- Attracting & retaining young families
- Cost of long-term/nursing home care
- Not enough jobs with livable wages, not enough to live on
- Availability of resources to help the elderly stay in their homes
- Not enough affordable housing
- Availability of specialists
- Smoking and tobacco use, exposure to second-hand smoke, vaping
  Depression/anxiety – Youth
- Alcohol use and abuse
- Not getting enough exercise/physical activity
- Ability to retain primary care providers (MD,DO,NP,PA) and nurses in the community

Through community input, the top identified community concerns were:
1. Ability to retain primary care providers (MD, DO, NP, PA) and nurses
2. Not enough affordable housing
3. Attracting and retaining young families
4. Youth smoking and tobacco use, exposure to second-hand smoke, vaping

At NCHS, the commitment is to the patients and their families, whatever their needs might be. The goal is to achieve the highest degree of healthcare for these patients and their families. They are rural America where they provide hometown values committed to quality services, continuity of care, assurance of qualified staff and family involvement for individual patients and clients. Nelson County Health System has 12 locations, 54 departments, and over 320 health experts to achieve this goal.

NCHS, along with Nelson County Public Health (TCPH), and community partners, will work to put together an Implementation Plan. The Implementation Plan will lay out how the community plans to address the concerns brought forward through the CHNA process.

Introduction

A community health needs assessment (CHNA) is a crucial tool for understanding and improving the health and well-being of a community by identifying key health issues, informing strategic planning, and fostering collaborative efforts among various stakeholders. The Nelson County Health System CHNA focused on identifying and addressing the health needs of Nelson County by gathering data and input from the community to identify the most pressing health issues, including chronic diseases, mental health, access to healthcare services, and social determinants of health.

A CHNA involves community members, healthcare providers, and other stakeholders in the assessment process, fostering collaboration and ensuring that the community's voice is heard in identifying health priorities.

The legal and regulatory context of a Community Health Needs Assessment (CHNA) is primarily shaped by the requirements established under the Affordable Care Act (ACA) in the United States. The ACA requires all non-profit hospitals to conduct a CHNA every three years, and all accredited public health units to conduct a CHNA every five years. This provision is aimed at ensuring that hospitals remain accountable to the communities they serve by addressing local health needs that are systematically identified.

The hospitals must produce a written report documenting the CHNA. This report should include a description of the community served, the process and methods used to conduct the assessment, and a prioritized list of identified health needs. Alongside the CHNA, hospitals must develop an implementation strategy that outlines how they plan to address the identified health needs. This strategy must be approved by the hospital's governing body and included in the hospital's annual IRS Form 990 Schedule H submission. The CHNA report and implementation strategy must be made widely available to the public.

The CHNA encompasses a range of benefits aimed at improving public health and fostering a more informed, engaged, and healthier community. A comprehensive profile of the health of the community as well as an identification of the most pressing health issues and priorities from the community member's perspective will result from the CHNA. By including community involvement in the assessment, residents/stakeholders will have a greater awareness of the health issues and challenges facing the community. Engagement by this population during the assessment will also increase the likelihood that they will be willing to assist in the implementation of interventions designed to improve the findings that were a top concern. The implementation plan will layout the roadmap to addressing the top concerns found in the CHNA.

Ultimately, the outcome most anticipated is that implementation of targeted health interventions and programs designed to address specific health concerns will improve overall community health. The plan should also lead to decreased health disparities among different population groups, leading to more equitable health outcomes.

Another outcome of a CHNA is strengthened partnerships and collaborations among healthcare providers, public health agencies, community organizations, and other stakeholders. The result is an enhanced collective impact through coordinated efforts to address community health issues.

Methodology

To ensure community engagement in the data collection, information was collected in a variety of ways:

- A survey solicited feedback from residents within the hospital's service area;
- Key informant interviews of community leaders representing the broad interests of the community;
- Focus groups, comprised of community leaders and area residents, convened to discuss area health needs and inform the assessment process in a community meeting.

Community engagement is essential to a successful CHNA. Community involvement ensures that the assessment accurately reflects the health needs and priorities of the population it serves. The hospital, along with the local public health unit, works to identify and involve a diverse group of stakeholders, including healthcare providers, public health officials, community organizations, educators, business leaders, and residents to participate in the key informant interviews and the focus groups/community meetings. These participants 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.

As previously described, 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 behaviors.

A common approach to survey research is online survey. However, this approach is not without limitations. There is always the concern of non-response as it may affect the representativeness of the sample as well as having to eliminate any surveys completed by those outside of the service area being assessed. Thus, a mixture of different data collection methodologies is recommended.

Conducting key informant interviews in addition to the random sample survey allows for a more robust sample, and ultimately, these efforts help to increase the community response rate. Partnering with local community organizations such as public health, schools, churches, and senior centers, just to name a few, assists in reaching segments of the population that might not otherwise respond to a survey.

While key informant data can offer invaluable insight into the perception of a community or group of individuals, qualitative data can be difficult to analyze. For this reason, key informant data are grouped into common themes.

Given the low population in the service area, key informant interview participants may still be hesitant to express their opinions freely even though the reporting of any comments is de-identified.

Another barrier in relation to the low population density of rural communities often requires regional reporting of many major health indices, including chronic disease burden and behavior health indices. The North Dakota BRFSS, through a cooperative agreement with the CDC, is used to identify regional trends in health-related behaviors. The fact that many health indices for rural and frontier counties are reported regionally makes it impossible to set the target population aside from the most developed North Dakota counties.

Process

A CHNA characteristically involves four key steps to ensure a comprehensive understanding of the community's health needs and priorities: 1) planning and preparation, 2) data collection, 3) data analysis, and 4) identify and prioritize health needs.

Planning and Preparation

In March 2024, NCHS selected Cibolo Health to facilitate the 2025 CHNA process. Cibolo Health helps independent rural hospitals create networks with their peers to overcome the obstacles rural healthcare providers face. At that time, a CHNA liaison was selected locally, who served as the main point of contact with Cibolo Health for the CHNA process. A steering committee composed of a diverse group of stakeholders, including representatives from healthcare, public health, community organizations, and the community at large (see Figure 1), was formed that was responsible for planning and implementing the process locally.

Figure 1: Steering Committee

Name	Title	Organization
Penny Lippert	Clinic Manager	NCHS
Samantha Harding	CEO	NCHS
Cassondra Schock	RN Administrator	Nelson-Griggs District Health Unit

Data Collection

Once the framework for the process was in place, data collection began. There are two types of data that were collected, primary data that is gathered first-hand, and secondary data that is collected from existing data sources such as County Health Rankings and the US Census. This can include data on demographics, health status, healthcare access, and social determinants of health.

Primary Data Collection

Primary data was collected directly from the community through surveys, key informant interviews, and focus groups/community meetings. This helps to gather first-hand information on community perceptions and experiences. This was done in three ways: key informant interviews, community meetings/focus groups, and a survey.

Key Informant Interviews

On January 6, 2025, a representative from Cibolo Health conducted four key informant interviews in person in McVille. Three additional key informant interviews were conducted over videoconference the following week. Interviews were held with invited 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 health care by local providers, awareness of health services offered locally, barriers to receiving health services, and suggestions for improving collaboration within the community

Focus Groups/Community Meetings

A community group consisting of fifteen community members convened and first met on January 6, 2024. During this first focus group/community meeting, attendees were introduced to the needs assessment process, reviewed basic demographic information about the community, and served as a focus group. Focus group topics were very similar to those included in the key informant interviews, including community assets and challenges, the general health needs of the community, community concerns, and suggestions for improving the community's health. This

first data gathering focus group represented a cross section demographically. NCHS staff were in attendance as well.

The community group met again on April 17, 2025 with ten community members in attendance. At this second community meeting the attendees, which consisted of those that attended the first community meeting as well as the key informants, were presented with survey results, findings from key informant interviews and the first community meeting, and a wide range of secondary data relating to the general health of the population in the service area. The group was then tasked with identifying and prioritizing the community's health needs.

Members of the second community meeting represented the broad interests of the service area of NCHS and NGDHU. They included representatives of the health community, business community, political bodies, education, faith community, and social service agencies. Not all members of the group were present at both meetings.

Survey

A survey was distributed throughout the hospital service area, which included residents of Nelson County. 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 A and a full listing of direct responses provided for the questions that included "Other" as an option are included in Appendix B.

The original survey tool was developed and used by the State Office of Rural Health at the Center for Rural Health (CRH). In order to revise the original survey tool to ensure the data gathered met the needs of hospitals and public health, the 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. The survey has since been edited by Cibolo to reflect changes in health practices and the data needs of the communities.

Similar to the questions asked in the key informant interviews and first community meeting, the survey was designed to:

- Learn of the community's assets and concerns;
- Gather perceptions and attitudes about the health of the community as well as collect suggestions for improvement; and
- Learn how local health services are used by residents.

Specifically, the survey covered the following topics:

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

The survey was open from December 15, 2024 to January 31, 2025. While the primary survey collection tool was an online survey utilizing Survey Monkey, paper surveys were also available upon request. One paper survey was completed. The survey link was distributed by community group members and by NCHS, NGDHU, school system, via Facebook on the Lakota and McVille community pages, advertised on the McVIlle channel, hung posters in the Lakota American, put an insert in employee paychecks, emailed employees with the link and the poster to share, asked patients to take the survey that came to our providers retirement party, and reminded people to also have

their spouses complete the survey. One hundred twenty-four online surveys were completed. In total, counting both paper and online surveys, 125 community member surveys were completed, equating to a 10% response rate. This response rate is about average for this type of unsolicited survey methodology and indicates an engaged community.

Secondary Data Collection

In a CHNA, secondary data sources are crucial for providing a comprehensive overview of the health status and needs of the community. Secondary data was collected and analyzed to provide descriptions of: (1) population demographics, (2) general health issues of the population, and (3) contributing causes of community health issues. The data was collected from a variety of sources, such as census, public health, and socio-economic data, as well as Behavioral Risk Factor Surveillance System and the Youth Risk Behavior Surveillance System. Specific sources include:

The U.S. Census Bureau, which provides demographic data including age, gender, race, income, and education levels, which are essential for understanding the population's structure and socio-economic status (https://data.census.gov/).

County Health Rankings & Roadmaps, a program of the University of Wisconsin Population Health Institute, draws attention to why there are differences in health within and across communities (www.countyhealthrankings.org). Annually since 2010, the University of Wisconsin Population Health Institute and the Robert Wood Johnson Foundation have produced the County Health Rankings—a "population health checkup" for the nation's over 3,000 counties. They base the Rankings on a conceptual model of population health that includes both health outcomes (mortality and morbidity) and health factors (health behaviors, clinical care, social and economic factors, and the physical environment). Data for over 30 measures available at the county level are assembled from a number of national sources. Composite scores are then ordered and counties are ranked from best to worst health within each state.

The Centers for Disease Control and Prevention (CDC) provides data on disease prevalence, vaccination rates, and health behaviors in a publication called the Youth Risk Behavior Surveillance System (YRBSS). The YRBSS is a set of surveys that track behaviors that can lead to poor health in students grades 9 through 12 (https://www.cdc.gov/healthyyouth/data/yrbs/index.htm).

The National Survey of Children's Health (NSCH) provides rich data on multiple, intersecting aspects of children's lives—including physical and mental health, access to and quality of health care, and the child's family, neighborhood, school, and social context. The National Survey of Children's Health is funded and directed by the Health Resources and Services Administration Maternal and Child Health Bureau (www.childhealthdata.org/learn/NSCH).

North Dakota KIDS COUNT, which is a national and state-by-state effort to track the status of children, sponsored by the Annie E. Casey Foundation (www.ndkidscount.org), compiles and shares current, comprehensive data on child and family well-being in each of North Dakota's 53 counties. The data addresses six domains: demographics, health, education, family and community, economic well-being, and safety.

It is important that sufficient secondary source data on youth is collected for the community's CHNA because the surveys conducted as part of the primary data collection are not collected for people under the age of 18.

By utilizing these diverse sources of secondary data, a CHNA can develop a detailed and accurate picture of the community's health needs and resources, which is essential for planning effective health interventions and policies.

Data Analysis

Data collected during the CHNA process was utilized through both quantitative and qualitative analysis. Through quantitative analysis, numerical data was used to identify trends, disparities, and key health indicators. This involved statistical analysis and comparisons to state or national benchmarks. Qualitative data from community groups and key informant interviews, as well as open ended survey questions was used to identify common themes and insights into the community's health needs and priorities.

Identifying and Prioritizing Health Needs

Key health issues were identified based on the data analysis by identifying the most pressing health issues affecting the community. During the second community meeting, the attendees from the first community meeting and the key informants gather at a second meeting to prioritize the health concerns based on the CHNA findings that were presented to them. The meeting attendees consider numerous factors, such as the severity of the issue, the number of people affected, and the ability to make an impact. The top concerns that the community members feel should be addressed in the next three years were identified.

Community Profile

Cibolo Health, in coordination with Nelson County Health System and Nelson-Griggs Public Health District, completed a CHNA of the NCHS service area.

Nelson County is a land of gently rolling wheat fields and boundless recreation opportunities. It was founded in the spring of 1883 at the Territorial Legislature in Grand Forks, North Dakota. It is comprised of approximately 982 square miles and is situated in the Northeast part of the state. Surrounding counties are Ramsey, Walsh, Griggs, Benson, Eddy, Steele and Grand Forks.

Cities in Nelson County include: Aneta, Lakota, McVille, Michigan, Pekin, Petersburg and Tolna. There are also several Town Sites and Villages in the County including: Dahlen, Kloten, Mapes, and Whitman. These communities were formed when the Burlington Northern and Sioux Railroads became established in the County. Lakota is the Official County Seat of Nelson County.

Nelson County relies heavily on the agricultural industry. Spring wheat and soybeans are the most popular produced products in the area, but other crops such as canola, corn and edible beans are also grown. The livestock industry is also quite integral in the economy of the County.

For recreation, Nelson County has ample opportunities for the outdoor enthusiast. Stump Lake is a local attraction for fishing and hunting along with other areas such as Lake Laretta, McVille Dam, Tolna Dam and Whitman Dam.

The demographics of Nelson County, the county where the majority of NCHS resides, have been taken from the United States Census Bureau (https://data.census.gov/), 2022 American Community Survey 5-Year Estimates, unless otherwise specified.

Nelson County has 982 square miles of land area and is the 41st largest county in North Dakota by land. Nelson County is bordered by Ramsey, Walsh, riggs, Benson, Eddy, Steele, and Grand Forks Counties. According to

countyhealthrankings.org, Nelson County is rural, with 100% of the population living a low population (under 10,000) density area. Figure 1 illustrates the location of the county.

Figure 2. Nelson County

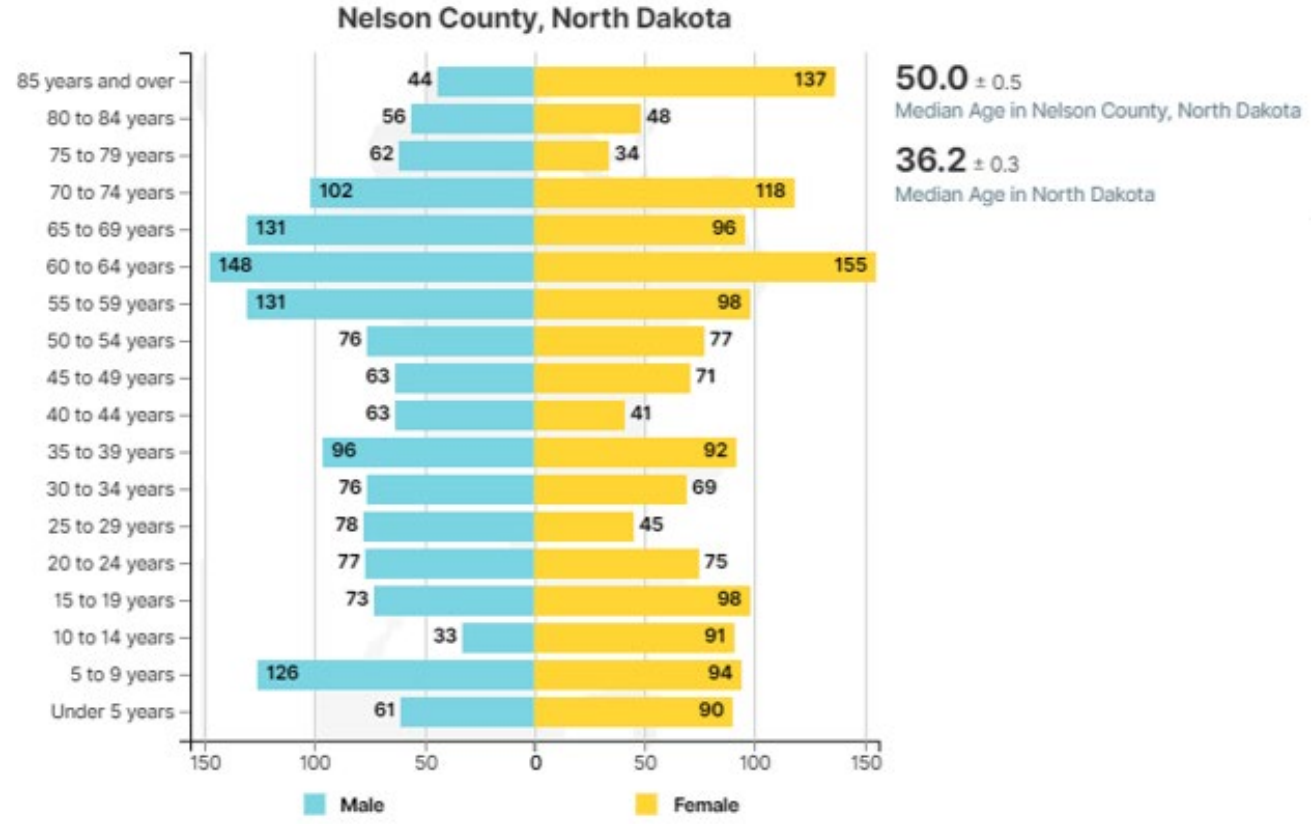
Snapshot of Nelson County

Nelson County Demographics

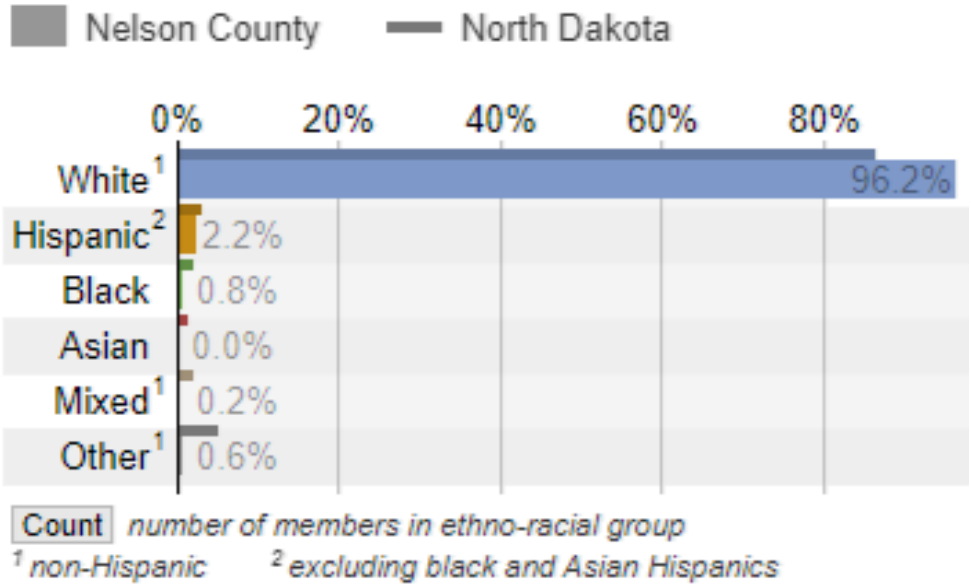
Nelson County Demographics
Source: https://www.countyhealthrankings.org/ (2024)

	Nelson County	North Dakota
Population (2023)	2,995	779,261
% Below 18 Years of Age	20.2%	23.50%
% 65 and Older	27.4%	16.70%
% Non-Hispanic Black	0.8%	3.40%
% American Indian or Alaska Native	2.7%	5.30%
% Asian	0.4%	1.70%
% Native Hawaiian or Other Pacific Islander	0.0%	0.10%
% Hispanic	4.1%	4.60%
% Non-Hispanic White	90.9%	83.00%
% Not Proficient in English	0%	1%
% Female	48.2%	48.60%
% Rural	100.0%	39.00%

Population Pyramid: Population by Age and Sex

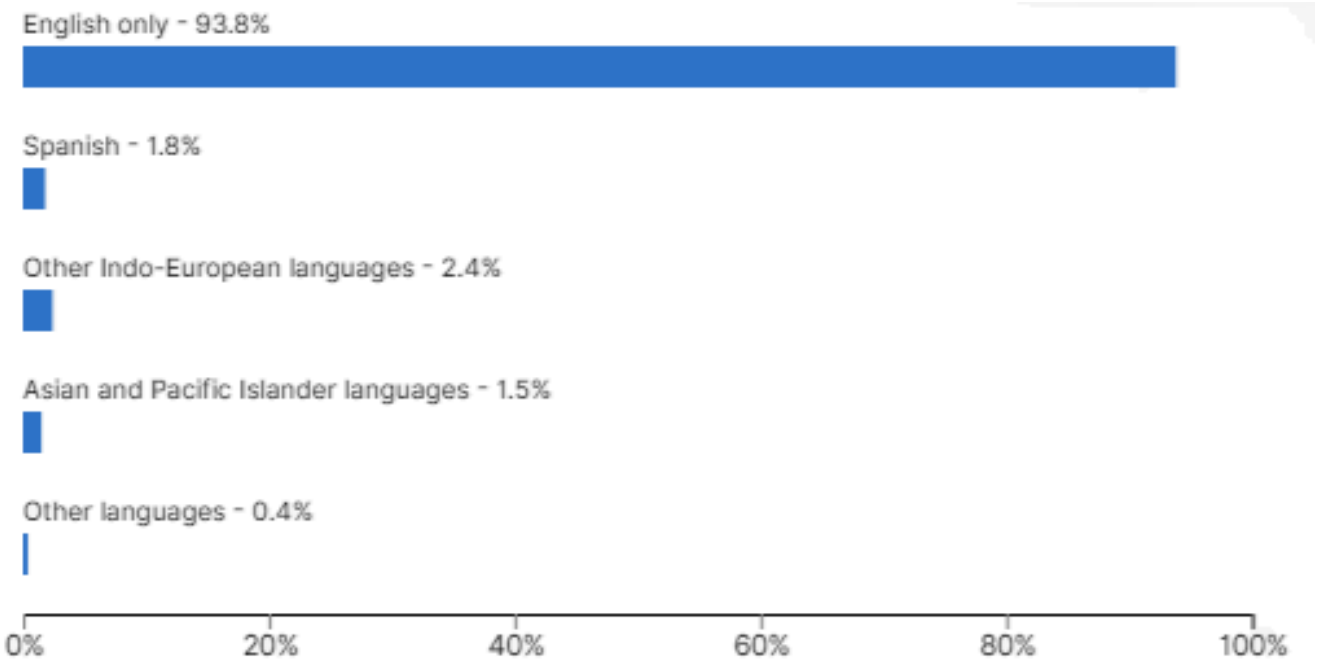


Race and Ethnicity (% of total population)



Source: https://statisticalatlas.com/county/North-Dakota/Towner-County/Race-and-Ethnicity

Types of Language Spoken at Home



Income and Earnings

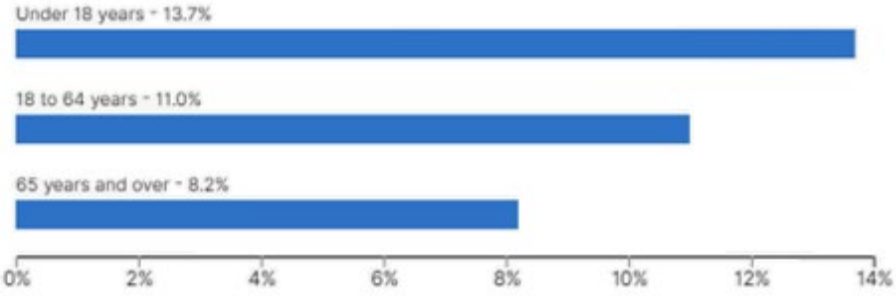
$62,219 ± $5,000
Median Household Income in Nelson County, North Dakota

$71,970 ± $2,072
Median Household Income in North Dakota

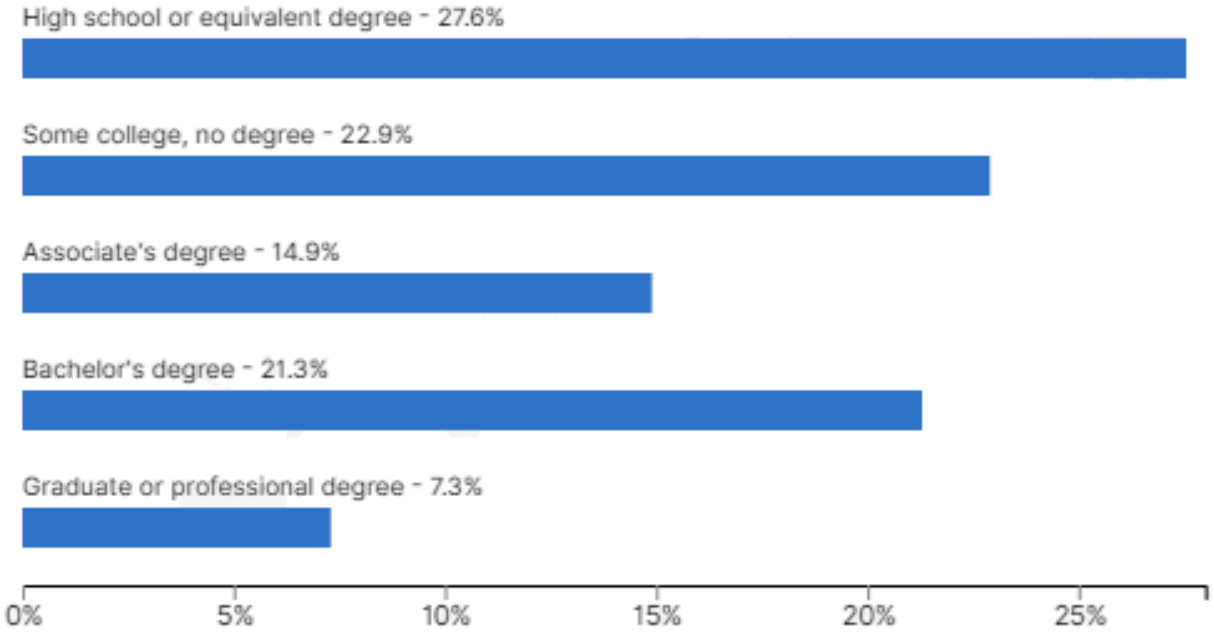
Poverty

10.8% ± 3.5%
Poverty, All people in Nelson County, North Dakota

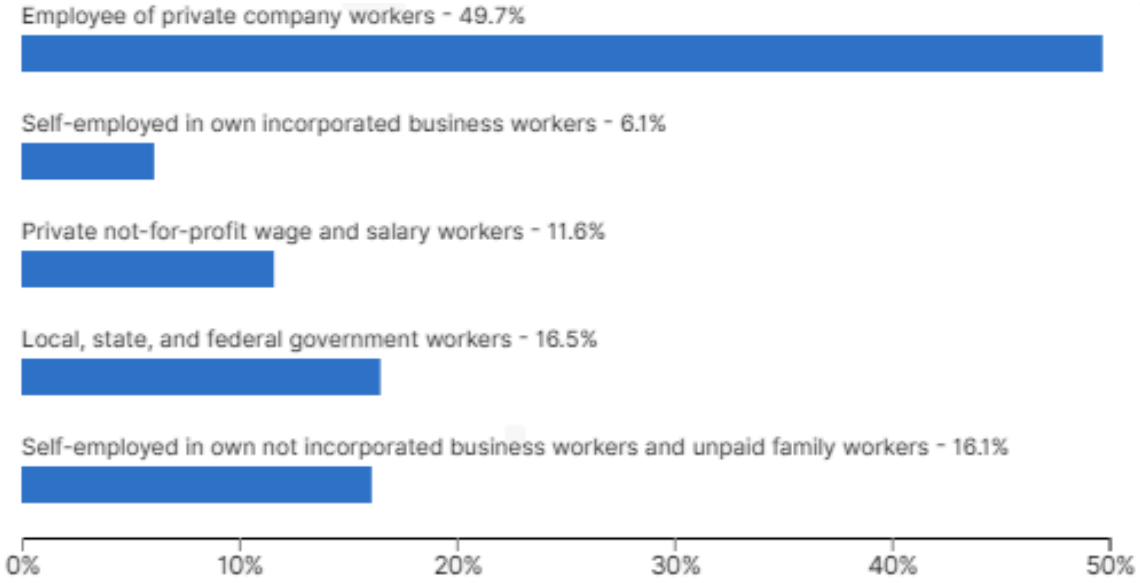
11.5% ± 0.9%
Poverty, All people in North Dakota



Education Attainment (Population 25 Years and Older)



Class of Worker



Employment and Labor Force Status

55.0% ± 3.8%
Employment Rate in Nelson County, North Dakota

66.1% ± 0.9%
Employment Rate in North Dakota

Means of Transportation to Work (Workers 16 Years and Over)

Measure	Value
Drove alone	69.1%
Carpool	9.7%
Public transportation	0.3%
Walked	10.3%
Bicycle	1.6%
Taxicab, motorcycle, or other means	2.0%
Worked from home	7.0%

Industry for the Civilian Employed Population (16 Years and Over)

Measure	Value
Agriculture, forestry, fishing and hunting, and mining	15.2%
Construction	8.8%
Manufacturing	4.8%
Wholesale trade	5.6%
Retail trade	11.9%
Transportation and warehousing, and utilities	2.4%
Information	0.5%
Finance and insurance, and real estate and rental and leasing	5.1%
Professional, scientific, and management, and administrative and waste management services	6.4%
Educational services, and health care and social assistance	28.2%
Arts, entertainment, and recreation, and accommodation and food services	4.6%
Other services, except public administration	2.3%
Public administration	4.3%

Financial Characteristics of Home Rental

$539 ± $42
Median Gross Rent in Nelson County, North Dakota

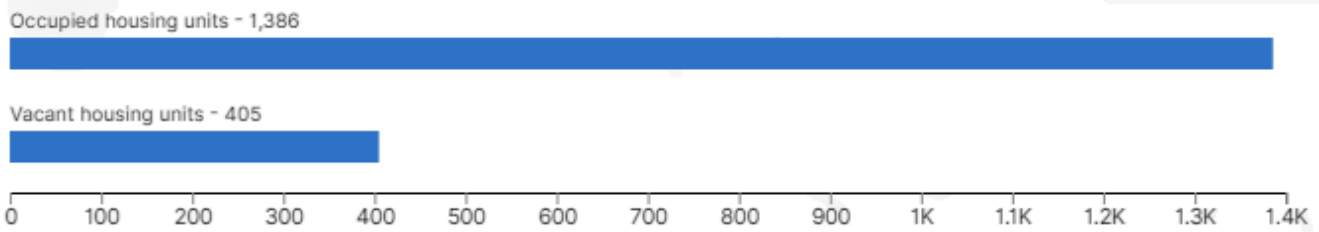
$863 ± $21
Median Gross Rent in North Dakota

Homeownership Rate

75.1% ± 3.3%
Homeownership Rate in Nelson County, North Dakota

65.1% ± 1.2%
Homeownership Rate in North Dakota

House Occupancy



Health Insurance

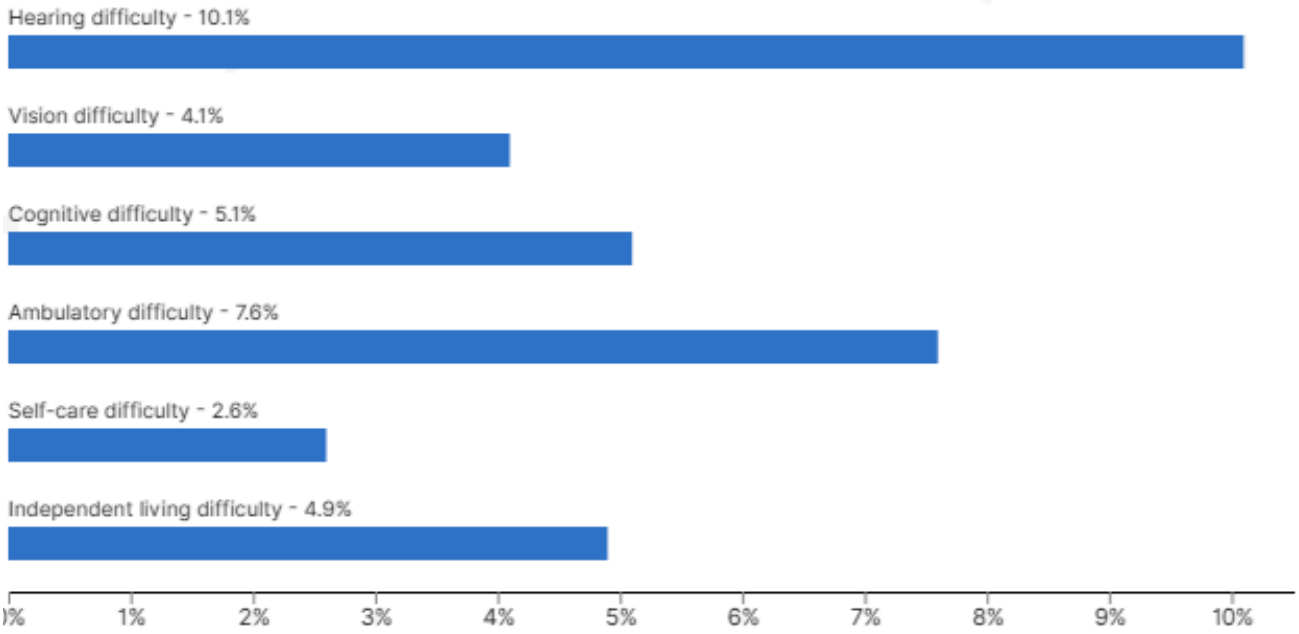
15.7% ± 3.3%
Without Health Care Coverage in McKenzie County, North Dakota

6.4% ± 0.7%
Without Health Care Coverage in North Dakota

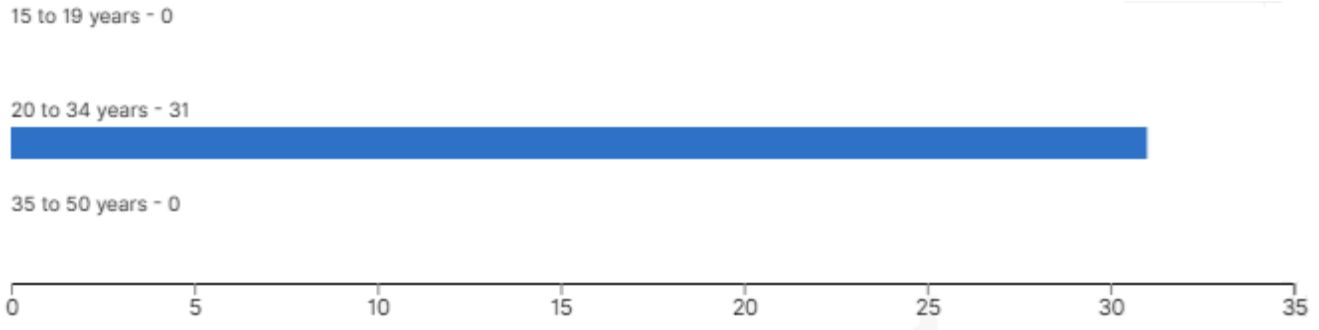
Disability & Types of Disability

18.4% ± 2.7%
Disabled Population in Nelson County, North Dakota

12.2% ± 0.7%
Disabled Population in North Dakota



Women with Births in the Past 12 Months

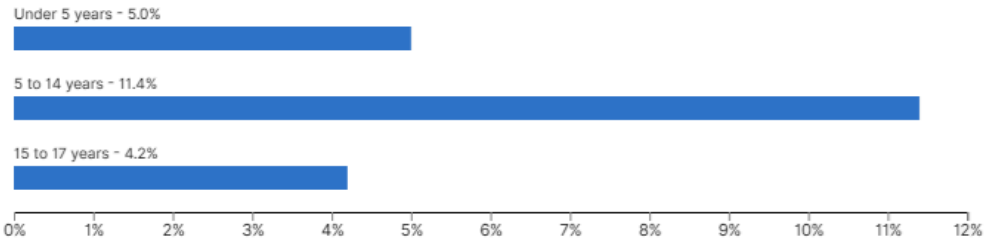


Children

20.6% ± 1.0%
Under 18 years old in Nelson County, North Dakota

23.2% ± 0.1%
Under 18 years old in North Dakota

Children Under 18 By Age Range



Families and Household Characteristics

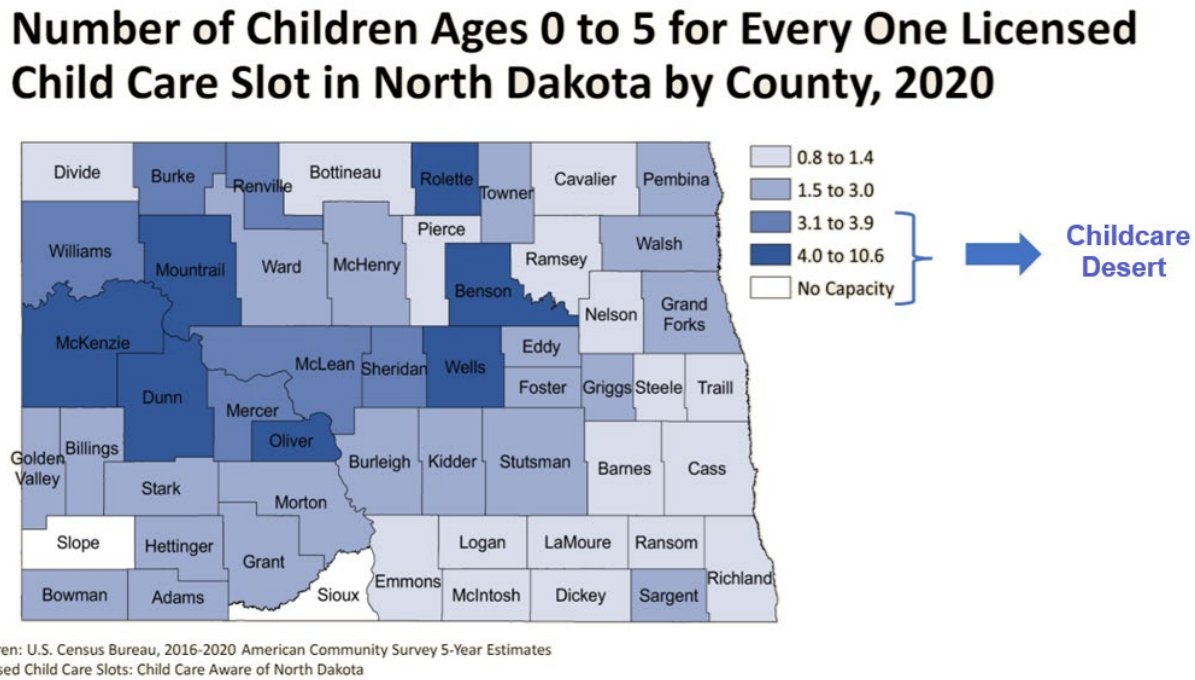
3.11 ± 0.28
Average Family Size in Nelson County, North Dakota

2.93 ± 0.05
Average Family Size in North Dakota

Daycare

Daycare plays a role in many communities, including those in NCHS's service area. As shown below in Figure 3, according to the North Dakota Health & Human Services report titled, "Supporting Working Families Strengthening Our Workforce" (January 2023), Nelson County is not considered a childcare desert. A childcare desert means that the shortage of licensed childcare slots (as compared to the number who are likely to need childcare based on parental workforce participation) is at least 3 to 1. Meaning there are three children who are likely to need care for every one care slot available in the community. Appendix C provides the 2024 ND Health & Human Services Child Care Profile for Nelson County.

Figure 3. ND Child Care Deserts



Children: U.S. Census Bureau, 2016-2020 American Community Survey 5-Year Estimates
Licensed Child Care Slots: Child Care Aware of North Dakota

Nelson County Health System (NCHS)

Established in 1917, Nelson County Health System 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, two Rural Health Clinics, 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 we serve. NCHS includes licensed and certified staff consisting of family practice physicians, nurse practitioner, nurses, nursing assistants, paramedics, laboratory, radiology, respiratory, and ancillary staff to provide 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 our community.

Although small in size, Nelson County Health System 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.

Nelson County Health System 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 $705,000.00 in income as they interact with other sectors of the local economy. This 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 Nelson County Health System is to enhance the health status and quality of life for peoples and communities served.

Vision
Nelson County Health System's vision is to provide leadership, working in partnership with others, to ensure continued access to a quality continuum of health care and related services.

Nelson County Health System provides the following services:

General and Acute Services

1. Acne Treatment
2. Allergy shots
3. Adult and child vaccinations
4. Blood pressure checks
5. Cardiac Rehab
6. Clinic
7. COVID-19 Testing
8. Diabetes education
9. Emergency room 24 hours per day
10. Hospital (acute care)
11. Independent senior housing
12. Joint injections
13. Medicare wellness visits
14. Mole/wart/skin lesion removal (including cryotherapy)
15. Nutrition counseling
16. Physicals: annuals, DOT, sports, and insurance
17. Skilled nursing facility (nursing home)
18. Surgical services – biopsies
19. Swing bed services
20. Telemedicine

21. Well child visits

Screening/Therapy Services

1. Chronic disease management
2. Colonoscopy screening
3. Holter monitoring
4. Laboratory services
5. Lower extremity circulatory assessment
6. Occupational physicals
7. Occupational therapy
8. Pediatric services
9. Physical therapy
10. Respiratory care
11. Sleep studies
12. Social services
13. Cardiac stress testing

Radiology Services

1. CT scans
2. Dexa bone density scans
3. 3D mammography
4. Echocardiograms
5. EKG
6. General x-ray
7. Nuclear medicine (mobile unit)
8. MRI (mobile unit)
9. Ultrasound (mobile unit)

Laboratory Services

1. Hematology
2. Blood types
3. Clot times
4. Chemistry
5. Urine testing
6. Specialty labs

Services offered by OTHER providers/organizations

1. Ambulance
2. Cardiology

Nelson-Griggs District Health Unit (NGDHU)

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 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 that Nelson-Griggs District Health Unit provides are:

1. Immunizations - offers recommended immunizations to people of all ages. NGDHU is able to bill most insurances and immunizations are offered at no cost to uninsured or underinsured children and adults.
    a. Monthly Immunization Clinics at 3 locations (Lakota 2nd Tuesday, McVille 3rd Tuesday, Cooperstown 4th Tuesday) from 9:30am-10:30am.

    b. When requested, we may provide immunizations at additional locations throughout our service area including but not limited to schools and businesses
2. Home Visits (may include medication setup or assessment /monitoring of health conditions)
3. Office visits (may include Blood Pressure Monitoring)
4. School Health
    a. Vision Screening (preschool age through 6th grade**,** or upon request)
    b. Health Education (including puberty/hygiene talks for 4th, 5th, and/or 6th graders)
    c. Maintain all student's immunization records
    d. Other topics upon requests
5. Cribs for kids and Car seats (*qualification may apply*)
6. Health Education presentations to individuals and groups as requested
7. Head Lice screening and education for individuals and families as needed/requested
8. Respond to requests for health information and refer to appropriate agencies
9. Distribute quarterly newsletter to businesses and agencies
10. Worksite Wellness Program

Working with partners:

1. Disease Control
    a. Assist with follow up investigations as needed, such as Tuberculosis, Food-borne Illnesses, Rabies, etc.
2. Environmental Health Program
    a. Information and referral to regional Environmental Health staff on topics such as onsite sewers, nuisances, or facility inspections
3. Emergency Preparedness and Response
    a. Attend tabletop, functional or full-scale exercises as requested
    b. Maintain local Emergency Plans for community response
    c. Work with local Emergency Managers on event & exercise planning

Grant Specific:

1. Boosting Immunizations
    a. Improving access to COVID-19 and other vaccinations
    b. Working with small amount of local churches/food pantries who are distributing information to the public
2. COVID
    a. Vaccinations and home test kits
3. Healthy Brain Initiative
    a. Increase early detection of dementia
4. Maternal Child Health (MCH)
    a. Working to increase physical activity/healthy nutrition options for youth
5. Substance Use Prevention
    a. Tobacco Prevention and Control
        i. Referrals to NDQuits for tobacco cessation
        ii. Assess businesses' compliance with state clean indoor law
        iii. Increase number of tobacco free buildings and grounds
        iv. Provide signage if comprehensive tobacco free or smoke free policies adopted
        v. Maintain schools' comprehensive tobacco free buildings and grounds policies
        vi. Tobacco Treatment Specialist on site
    b. Substance Abuse: targeting underage drinking
        i. Increase public awareness
        ii. Educate parents
        iii. Increase law enforcement capacity and resource tools
        iv. Review school policies
    c. State Opioid Response Grant (SOR)

i. Decrease overdose deaths in North Dakota through education, Naloxone Training, and Deterra Bags
ii. Mental Health

6. Workforce infrastructure
    a. Increase workforce within NGDHU

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

Social determinants of health (SDOH) are the conditions in which people are born, grow, live, work, and age that affect a wide range of health, functioning, and quality-of-life outcomes (economic stability, education access and quality, social and community context, health care access and quality, neighborhood and built environment). SDOH are fundamental factors that influence health outcomes and disparities. Addressing these determinants is necessary for creating healthier communities, achieving health equity, and ensuring that all individuals have the opportunity to lead healthy lives. By focusing on SDOH, we can develop more effective and comprehensive public health strategies that go beyond medical care to address the broader factors affecting health. County Health Rankings help depict where each county sits in regards to the SDOH of their population.

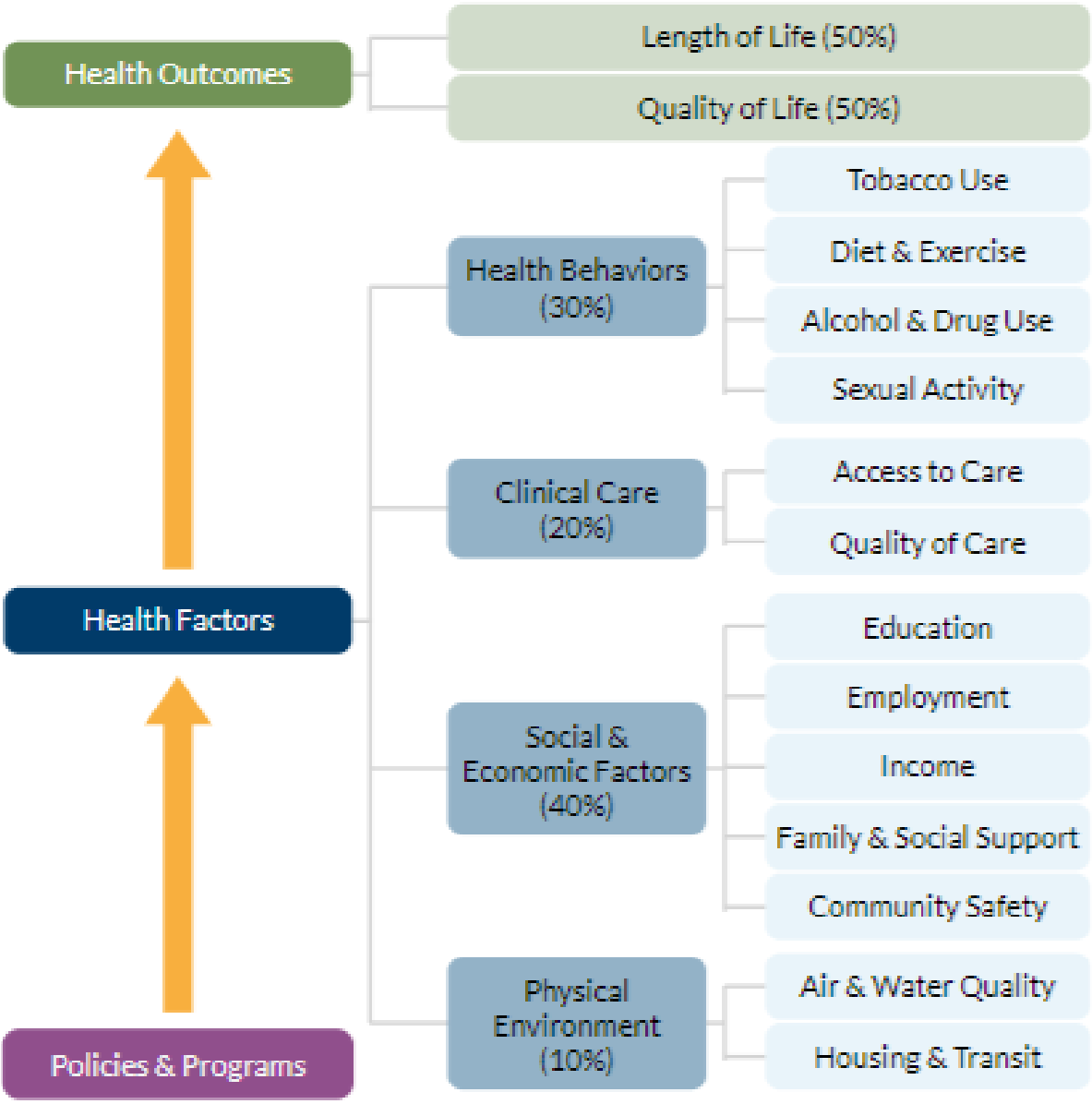
The data used in the 2024 County Health Rankings are pulled from more than 30 data sources and then are compiled to create county rankings. Counties in each of the 50 states are ranked according to summaries of a variety of health measures. Those having high ranks, such as 1 or 2, are considered to be the "healthiest." Counties are ranked on both health outcomes and health factors. The data reflected is from 2022 – there is a two-year lag in the data.

A model of the 2024 County Health Rankings – a flow chart of how a county's rank is determined – may be found in Appendix F. For further information, visit the County Health Rankings website at www.countyhealthrankings.org.

Health Outcomes tell us how long people live on average within a community, and how much physical and mental health people experience in a community while they are alive. They are influenced by many factors, such as clean water, affordable housing, the quality of medical care and the availability of good jobs. Programs and policies at the local, state and federal levels influence these factors. Many things influence how well and how long we live. Health Factors represent those things we can improve to live longer and healthier lives. They are indicators of the future health of our communities. Figure 1 shows the County Health Rankings Model.

Figure 4. County Health Rankings Model

Source: https://www.countyhealthrankings.org/what-impacts-health/county-health-rankings-model



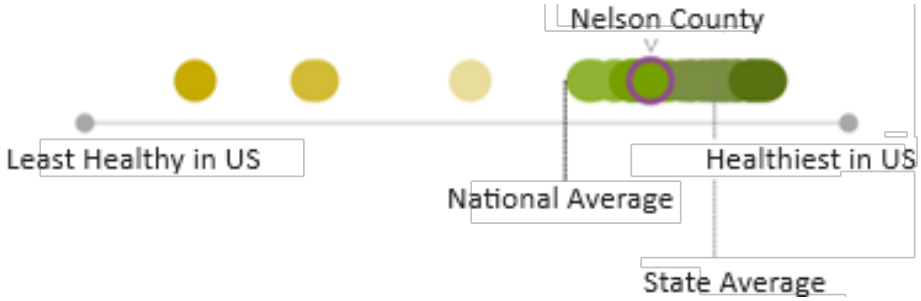
Nelson County is faring worse than the average county in North Dakota for Health Outcomes and Health Factors, and better than the average county in the nation. Figure 2 depicts where Nelson County falls in regard to health outcomes and health factors compared to the least healthy in the US, the healthiest in the U.S., the state average, and the national average.

Figure 5. Nelson County Health Outcomes and Factors

Source: www.countyhealthrankings.org

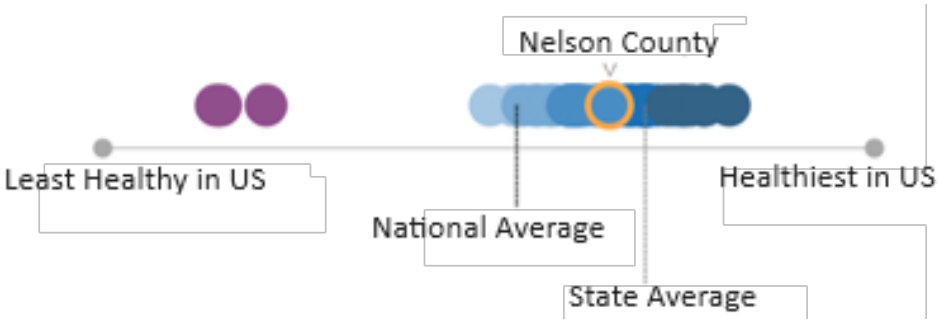
Health Outcomes:

- Length of life
- Quality of life



Health Factors:

- Health behavior
- Clinical care
- Social & Economic Factors
- Physical Environment



The following is a chart showing the County Health Rankings of Nelson County relative to the North Dakota average and the U.S. top 10%per performers. For most of the measures included in the rankings, the County Health Rankings' authors have calculated the "Top U.S. Performers" for 2024. 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).

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%.

TABLE 1: SELECTED MEASURES FROM *COUNTY HEALTH RANKINGS* 2024
NELSON COUNTY

● = Not meeting North Dakota average
■ = Not meeting U.S. Top 10% Performers
\+ = Meeting or exceeding U.S. Top 10% Performers
Note: Blank values reflect unreliable or missing data

	Nelson County	North Dakota	United States
HEALTH OUTCOMES			
Length of Life			
Premature Death		7,600	8,000
Life Expectancy	79.4 +	78.1	77.6
Quality of Life			
Poor or Fair Health	13% +	13%	14%
Poor Physical Health Days	3.0 +	3.1	3.3
Poor Mental Health Days	3.5 +	4.0	4.8
Low Birthweight		7%	8%
Diabetes Prevalence	9% +	9%	10%
HEALTH FACTORS			
Health Behaviors			
Adult Smoking	16% ■	16%	15%
Adult Obesity	42% ● ■	36%	34%
Food Environment Index	6.7 ● ■	9.1	7.7
Physical Inactivity	26% ● ■	25%	23%
Access to Exercise Opportunities	59% ● ■	76%	84%
Excessive Drinking	19% ■	23%	18%
Alcohol-Iimpaired Driving Deaths	100% ● ■	39%	26%
Sexually Transmitted Infections		511.5	495.5
Teen Births		15	17
Clinical Care			
Uninsured	11% ● ■	9%	10%
Uninsured Adults	11% ●	10%	12%
Uninsured Children	10% ● ■	8%	5%
Primary Care Physicians		1,290:1	1,330:1
Dentists	3,000:1 ● ■	1,420:1	1,360:1
Mental Health Providers		450.0:1	320.0:1
Other Primary Care Providers	1,000: ● ■	540.0:1	760.0:1
Preventable Hospital Stays	1,885 +	2,945	2,681
Mammography Screening	54% ● +	53%	43%
Flu Vaccinations	51% +	49%	46%

TABLE 1: SELECTED MEASURES FROM *COUNTY HEALTH RANKINGS* 2024
NELSON COUNTY

● = Not meeting North Dakota average
■ = Not meeting U.S. Top 10% Performers
\+ = Meeting or exceeding U.S. Top 10% Performers
Note: Blank values reflect unreliable or missing data

	Nelson County	North Dakota	United States
Social & Economic Factors			
High School Completion	94% +	93%	89%
Unemployment	2.9% ● +	2.1%	3.7%
Children in Poverty	12% +	12%	16%
Income Inequality	4.9 ●	4.4	4.9
Social Associations	22.9 +	15.5	9.1
Injury Deaths		75	80
School Funding Adequacy	$5,164+	$3,128	$634
Gender Pay Gap	0.73 +	0.79	0.87
Median Household Income	$59,900 ● ■	$73,200	$74,800
Living Wage	$39.86	$43.37	
Child Care Centers	27 +	7	7
Homicides		3	6
Suicides		19	14
Physical Environment			
Air Pollution - Particulate Matter	5.1 ● +	5.0	7.4
Drinking Water Violations	No		
Homeownership	75% +	63%	65%
Severe Housing Problems	6% +	12%	17%
Severe Housing Cost Burden	5% ● +	10%	14%
>30 minute Drive to Work	34% ● +	15%	36%
Traffic Volume	2 +	83	108
Broadband Access	78% ● ■	86%	88%

Children's Health

The National Survey of Children's Health (NSCH) provides rich data on multiple, intersecting aspects of children's lives - including physical and mental health, access to and quality of health care, and the child's family, neighborhood, school, and social context. The NSCH is funded and directed by the Health Resources and Services Administration (HRSA) Maternal and Child Health Bureau. A revised version of the survey was conducted as a mail and web-based survey by the Census Bureau in 2016, 2017, 2018, 2019, 2020, 2021 and 2022. Data reported in Table 3 is from 2021-2022. Items noted in red show where North Dakota is fairing more poorly than the national average.

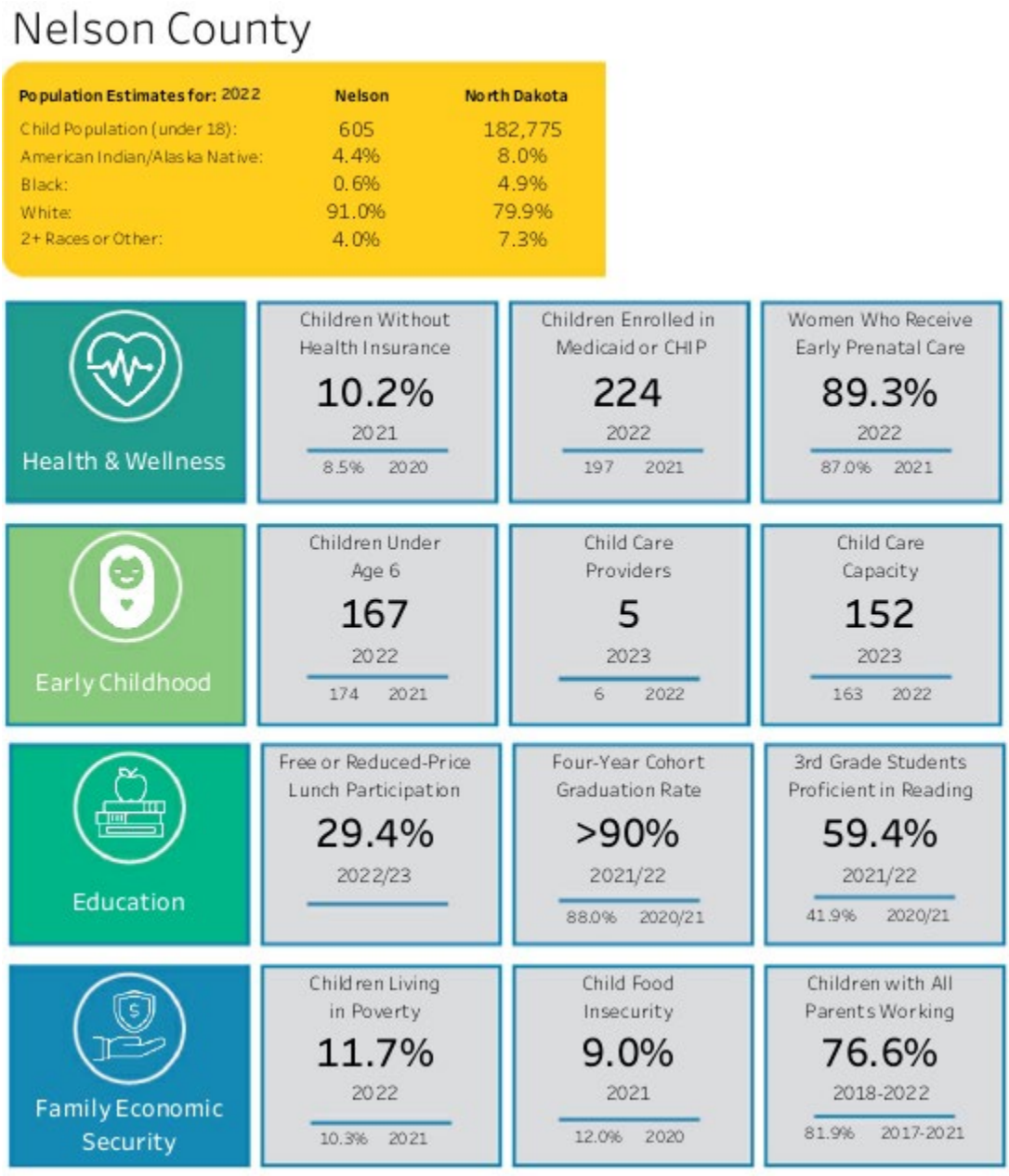
Table 2. Data Resource Center for Child & Adolescent Health
2021-2022 National Survey of Children's Health
Source: https://www.childhealthdata.org/

Health Status	North Dakota	National
Children born premature (3 or more weeks early)	11.0%	11.4%
Children 10-17 overweight or obese	28.0%	33.7%
Children 0-5 who were ever breastfed	77.6%	81.5%
Community and School Activities		
Children 6-17 who missed 11 or more days of school	**5.9%**	5.7%
Children 12-17 who work for pay	53.4%	35.6%
Health Care		
Children currently insured	94.3%	93.1%
Children that had one or more preventative visits in the past year	**73.6%**	76.8%
Children who spent less than 10 minutes with the provider at a preventive medical visit	16.1%	18.8%
Children (1-17 years) who had a preventive dental visit in the past year	77.7%	77.0%
Children (0-17 years) who have seen an eye doctor in the past 2 years	51.7%	39.4%
Children (3-17 years) received mental health care	13.4%	11.6%
Children (3-17 years) who had difficulties getting the mental health treatment/counseling needed and did not obtain care	5.0%	5.5%
Young children (9-35 mos.) receiving standardized screening for developmental problems in the past year	46.1%	33.7%
Children who have received coordinated, ongoing, comprehensive care within a medical home	52.3%	46.1%
Family Life		
On most weekdays, children who usually spend 4 or more hours in front of a TV, computer, cellphone or other electronic device watching programs, playing games, accessing the internet or using social media, not including schoolwork	18.4%	22.9%
Children who live in households where someone smokes	**17.1%**	12.7%
Children who have, during the past year, not afford to eat	3.1%	4.5%
Neighborhood		
Children who live in neighborhoods with parks, recreation centers, sidewalks, and a library	**33.6%**	36.1%
Children living in neighborhoods with poorly kept or rundown housing	19.5%	24.7%
Children living in a safe neighborhood	76.3%	66.2%

North Dakota KIDS COUNT is dedicated to providing current, relevant, and reliable data to shape the issues affecting North Dakota children and families. North Dakota KIDS COUNT also regularly updates the KIDS COUNT Data Center to include the most recent statistics for children and families. The KIDS COUNT Data Center is a project of the Annie E. Casey Foundation, and KIDS COUNT is a comprehensive source for data on child and family well-being in the United States (https://ndkidscount.org/county-data). See Appendix B. In addition to the population demographics of children in Nelson County and North Dakota, Figure 3 shows the 2021-2022 results versus the 2020-2021 results when available.

Figure 6. Nelson County KIDS COUNT Data Report

Source: https://ndkidscount.org/county-data



Another means for obtaining data on the youth population is through the CDC's Youth Risk Behavior Survey (YRBS). 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 3 depicts some of the YRBS data that has been collected in 2017, 2019, and 2021(most recent published data). They are further broken down by rural and urban percentages. The trend column shows a "=" for statistically insignificant change (no change), "↑" for an increased trend in the data changes from 2019 to 2021, and "↓" for a decreased trend in the data changes from 2019 to 2021. The final column shows the 2021 national average percentage. For a more complete listing of the YRBS data, see Appendix H.

Table 3. Youth Behavioral Risk Survey Results

North Dakota High School Survey

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

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

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

The 2023 Needs Assessment Study of Low-Income North Dakota Individuals and Families was a collaborative effort between the Community Action Agencies (CAAs) and North Dakota State University (NDSU). It was carried out through the utilization of surveys and focus groups, followed by statistical analysis. Specifically, the assessment involved a variety of survey methods, including both online and paper surveys, chosen based on their appropriateness for different respondent groups, targeting low-income individuals and families across the state of North Dakota.

Findings from the study found that "Rental Assistance" remained the top priority need among people experiencing poverty throughout the state under the category of "Housing". Inconsistencies between the responses from low-income or non-low-income respondents were found, which reflect distinct needs within these two groups. For example, the top priority need for the non-low-income respondents is "Mental Health Service", while "Rental Assistance" stands as the top need for the low-income people, as well as the broader community, including both low-income and non-low-income people. Individuals and families with higher incomes tend to prioritize Civic Engagement and Community Involvement, including aspects like "Recreational Activities" and "Safe Neighborhoods, Sidewalks, Parks". Conversely, those with lower incomes are more inclined to place greater emphasis on fundamental necessities such as "Rental Assistance", "Food", and "Dental Insurance/Affordable Dental". This divergence in priorities reflects varying needs and concerns across income levels.

Increased living costs and inflation have emerged as significant contributing factors to the causes of poverty across the state, and they could also be the key drivers behind the top priority need for "Rental Assistance". The frequently mentioned causes of poverty, derived from analysis of the qualitative data collected across the state, are listed below in order of frequency (with the most frequently mentioned causes listed first).

1. Increasing living costs/Inflation
2. Disability, Mental Illness, Severe Anxiety/Depression, etc.
3. Childcare Issue for Working Parents
4. Family Instability
5. Less/No Skills for Jobs (with better pay and benefits)
6. Lack of Affordable Transportation (to and from work)
7. Generational Poverty
8. Lack of Education
9. Bad Record/Background

Survey Results

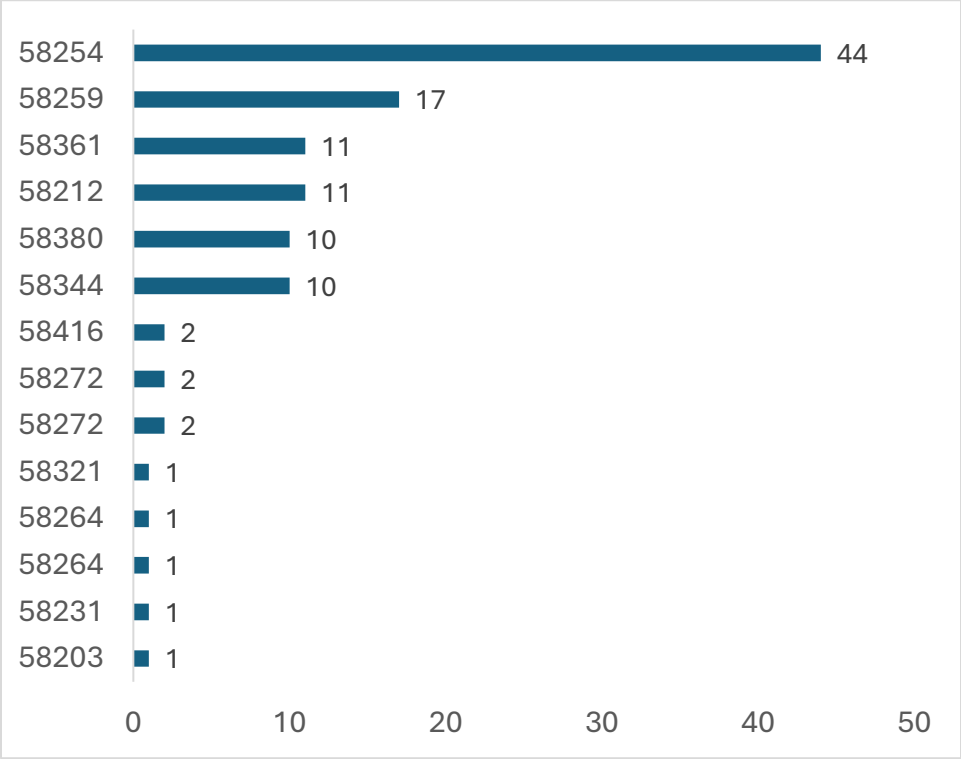
A total of 125 community members completed the survey in communities throughout the counties in the Nelson County Health System service area. For all questions that contained an "Other" response, all of those direct responses may be found in Appendix B. In some cases, a summary of those comments is additionally 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). An asterisk (*) indicates that survey respondents were able to select more than one answer response.

The survey requested that respondents list their home zip code. While not all respondents provided a zip code, 112 did, revealing that a large majority of respondents (N=44) lived in McVille/Klotten, followed by Michigan (17), Pekin

(11), Aneta (11), and Lakota and Tolna with ten respondents each. The remaining respondents lived outside of these zip codes. These results are shown in Figure 4.

Figure 7: Survey Respondents' Home Zip Code

Total respondents: 112



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.

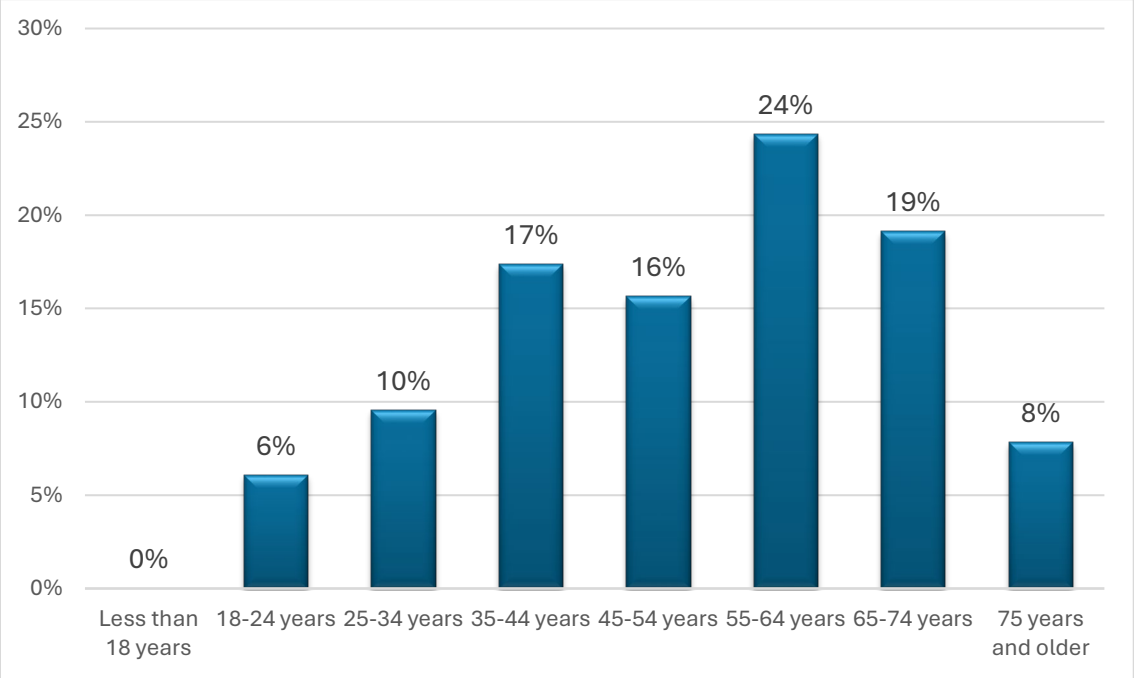
With respect to the demographics of those who chose to complete the survey:

- 51% (N=59) were age 55 or older.
- The majority (82%, N=94) were female.
- Just under half of the respondents (49%, N=57) had bachelor's degrees or higher.
- The number of those working full time (65%, N=75) was a little more than two-and-a-half times higher than those who were retired (24%, N=28).
- 98% (N=110) of those who reported their ethnicity/race were white/Caucasian.
- 26% of the population (N=28) had household incomes of less than $50,000.
- Nearly two-thirds (63%) have insurance through their employer.

Figures 8 through 14 show these demographic characteristics. It illustrates the range of community members' household incomes and indicates how this assessment took into account input from parties who represent the

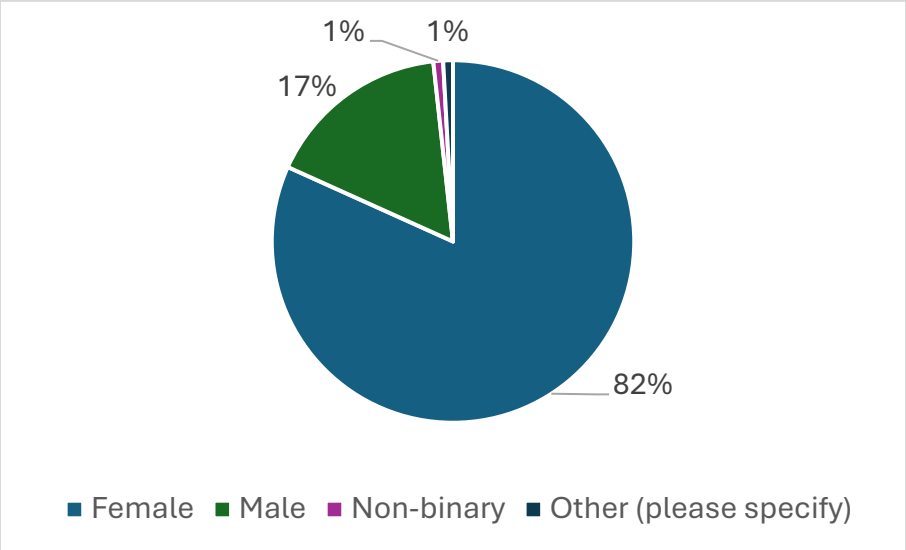
varied interests of the community served, including a balance of age ranges, those in diverse work situations, and community members with lower incomes.

Figure 8: Age Demographics of Survey Respondents
Total respondents = 115



People under age 18 are not questioned using this survey method.

Figure 9: Gender Demographics of Survey Respondents
Total respondents = 115



As shown in Figure 10, nearly all of the respondents were white/Caucasian (98%). This is a little more than the race/ethnicity in the overall population of Nelson County; the 2023 US Census estimates indicates that 94% of the population is white in Nelson County.

Figure 10: Race/Ethnicity Demographics of Survey Respondents
Total respondents = 112

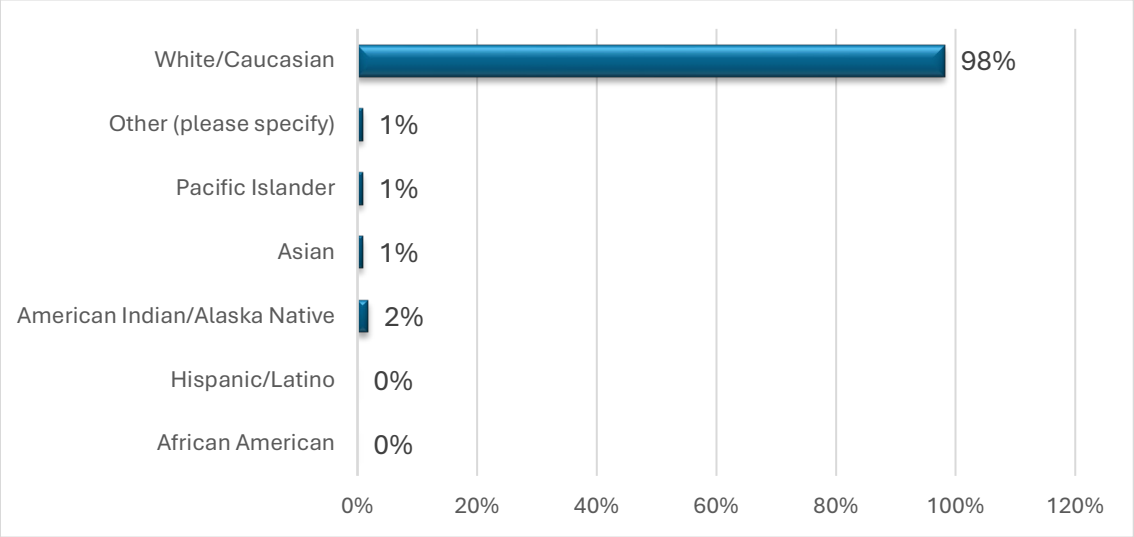


Figure 11: Educational Level Demographics of Survey Respondents
Total respondents = 115

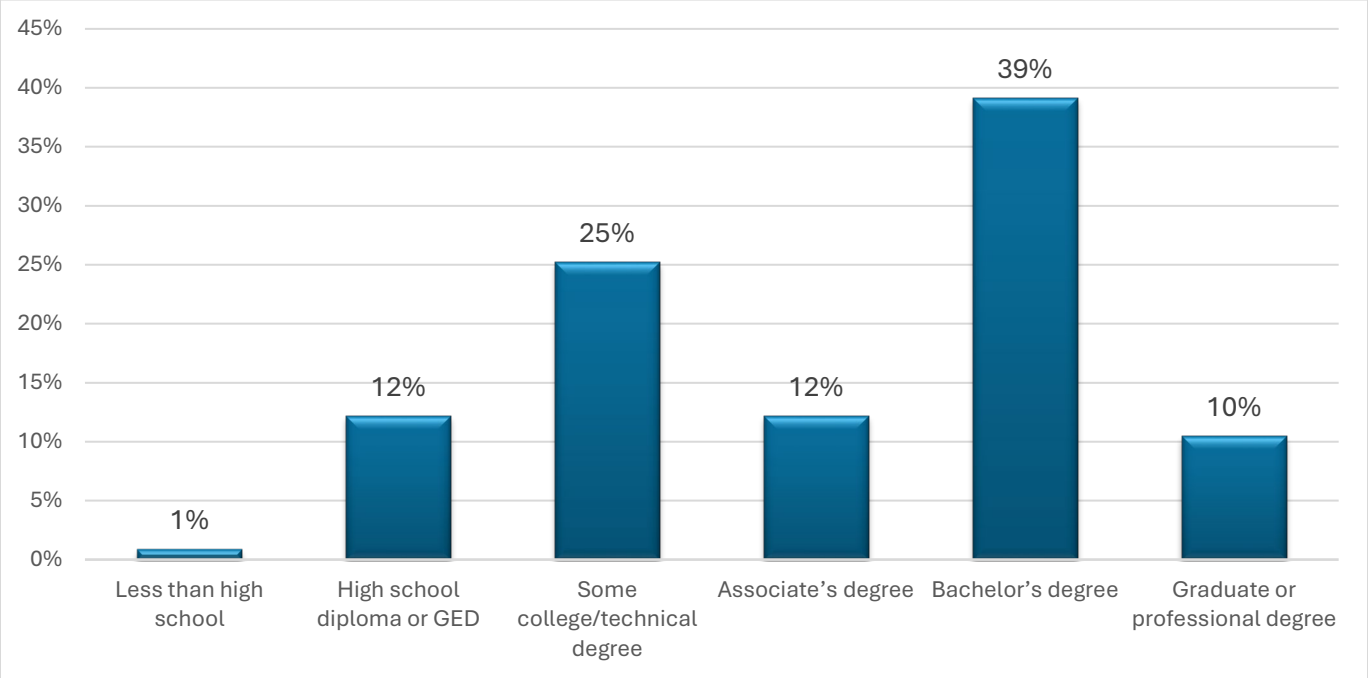
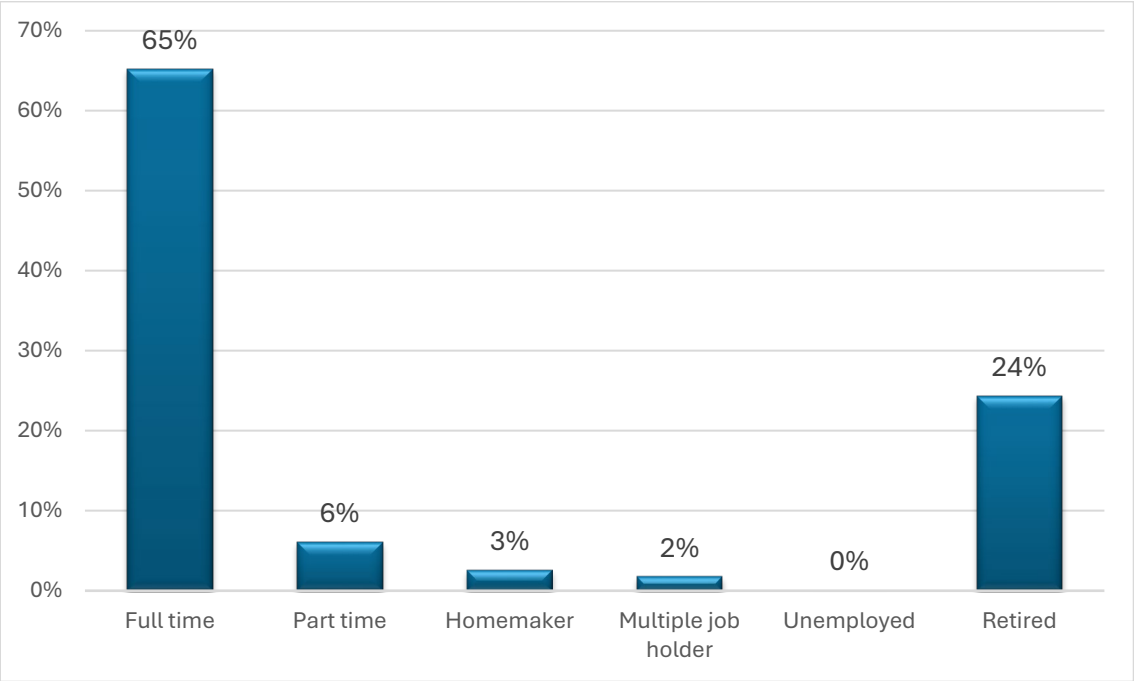
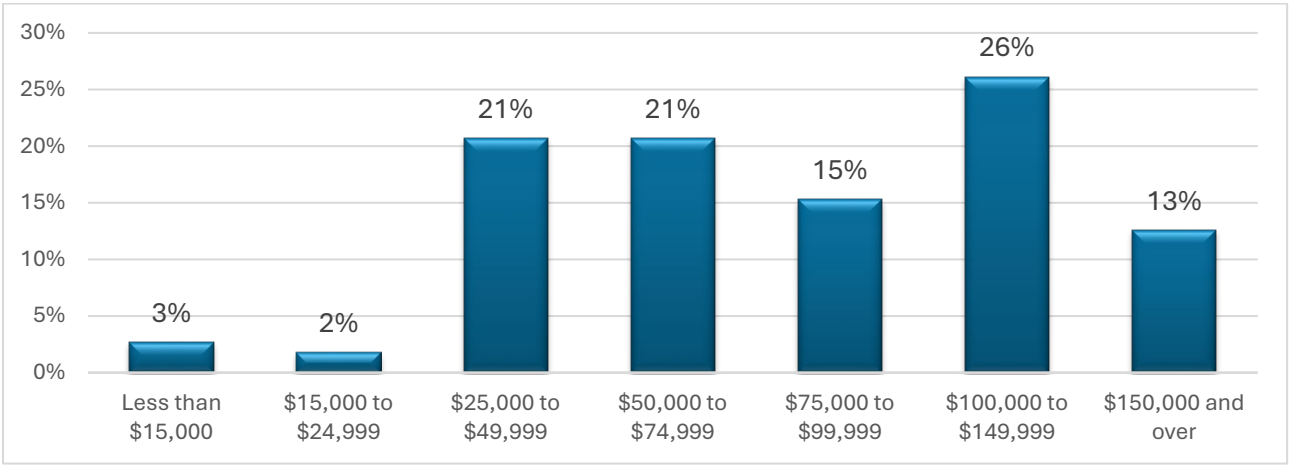


Figure 12: Employment Status Demographics of Survey Respondents
Total respondents = 115



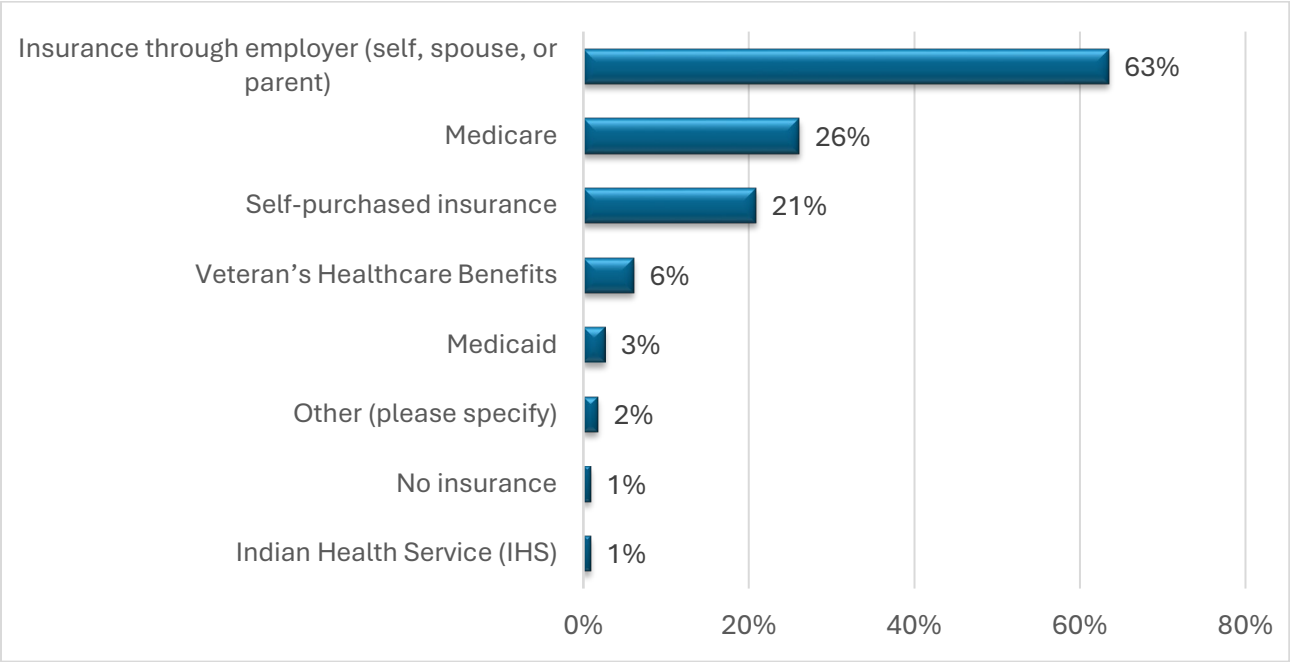
Of those who provided a household income, 5% (N=5) community members reported a household income of less than $25,000. Thirty-nine percent (N=43) indicated a household income of $100,000 or more. This information is shown in Figure 13.

Figure 13: Household Income Demographics of Survey Respondents
Total respondents = 111



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

Figure 14: Health Insurance Coverage Status of Survey Respondents
Total respondents = 115



Community Assets and Challenges

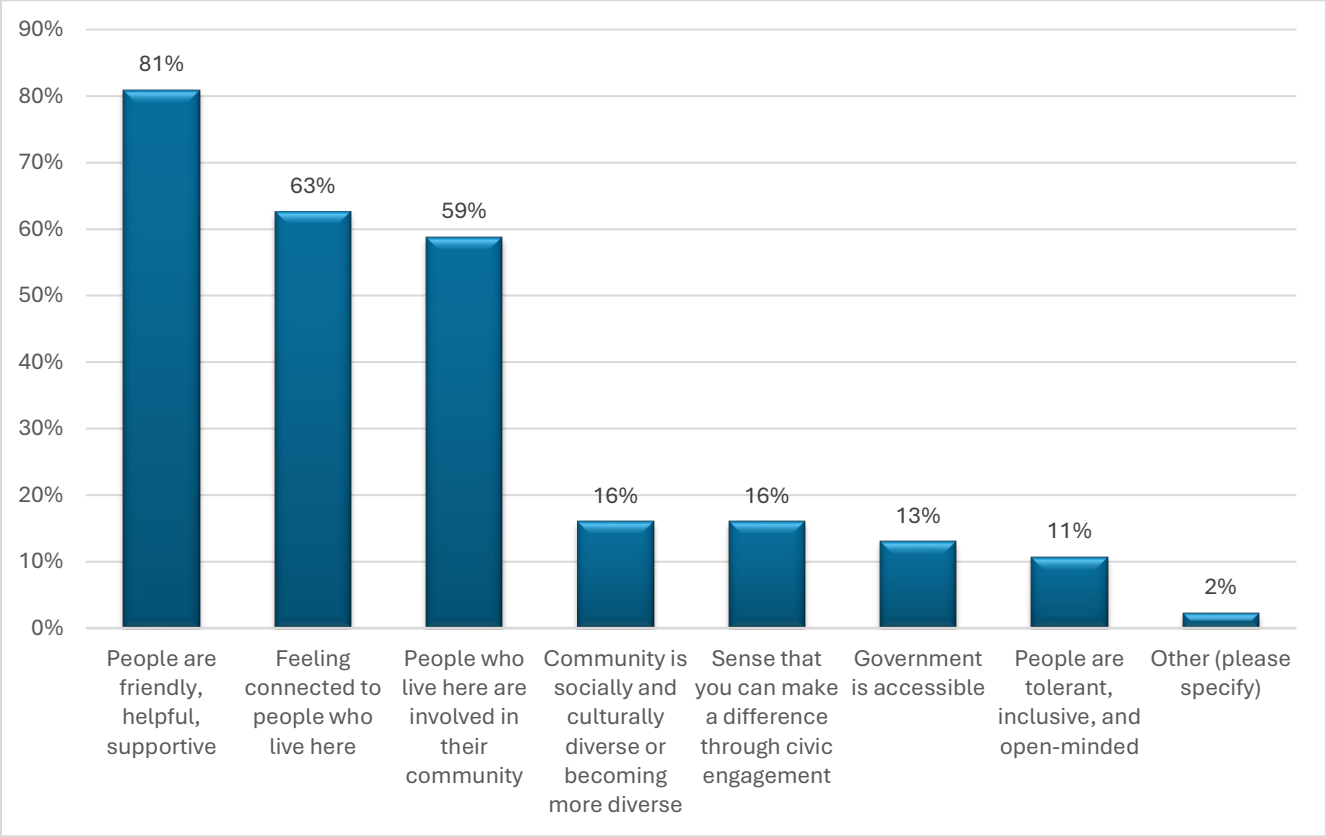
Survey-respondents were asked what they perceived as the best things about their community in four categories: people, services and resources, quality of life, and activities. In each category, respondents were given a list of choices and asked to pick the three best things. Respondents occasionally chose less than three or more than three choices within each category. The results indicate there is consensus (with at least 80 respondents agreeing) that community assets include:

- Safe place to live, little/no crime (N=112);
- Family-friendly, good place to raise kids (N=111);
- People are friendly, helpful, supportive (N=106);
- Healthcare (N=90);
- Local events and festivals (N=83); and
- Feeling connected to the people who live here (N=82).

Figures 15 to 17 illustrate the results of these questions.

Figure 15: Best Things about the PEOPLE in Your Community

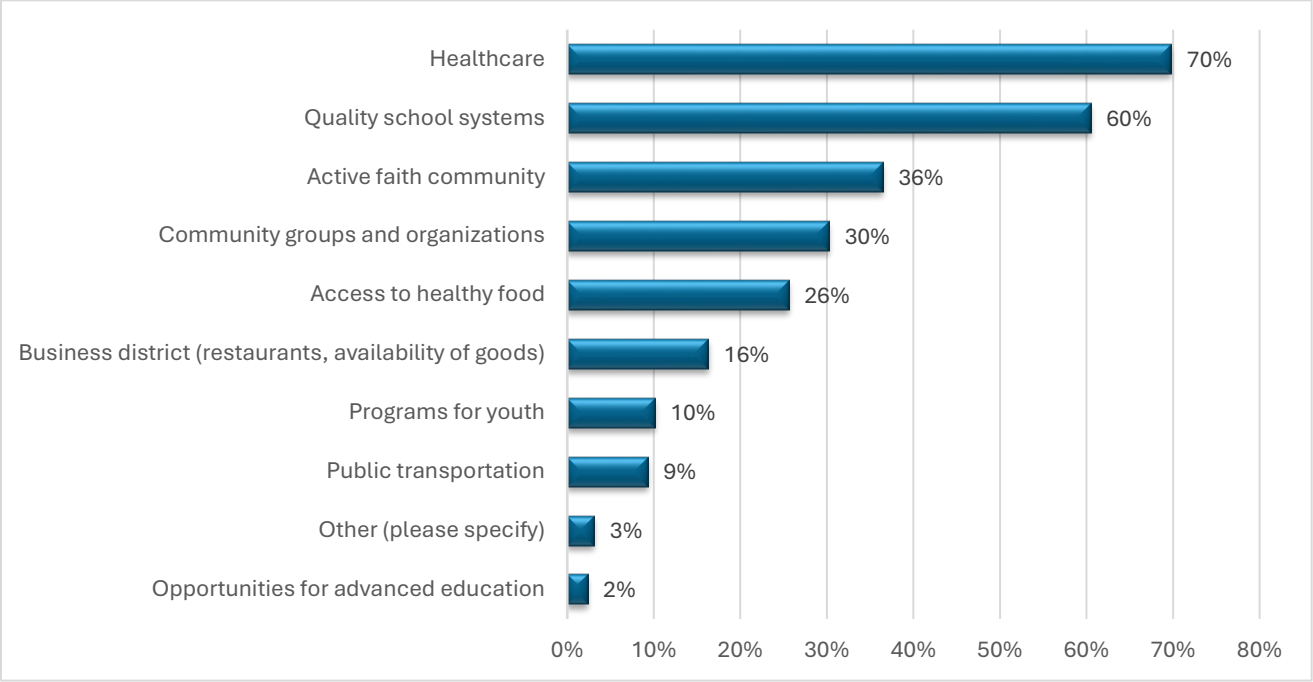
Total responses = 131



Included in the "Other" category of the best things about the people the small-town feel, you know your neighbors and look out for one another, and people are self-reliant.

Figure 16: Best Things about the SERVICES AND RESOURCES in Your Community

Total responses = 129



Safe environment, simplicity, community groups, and local daycare services were identified in the "Other" category.

Figure 17: Best Things about the QUALITY OF LIFE in Your Community
Total responses = 130

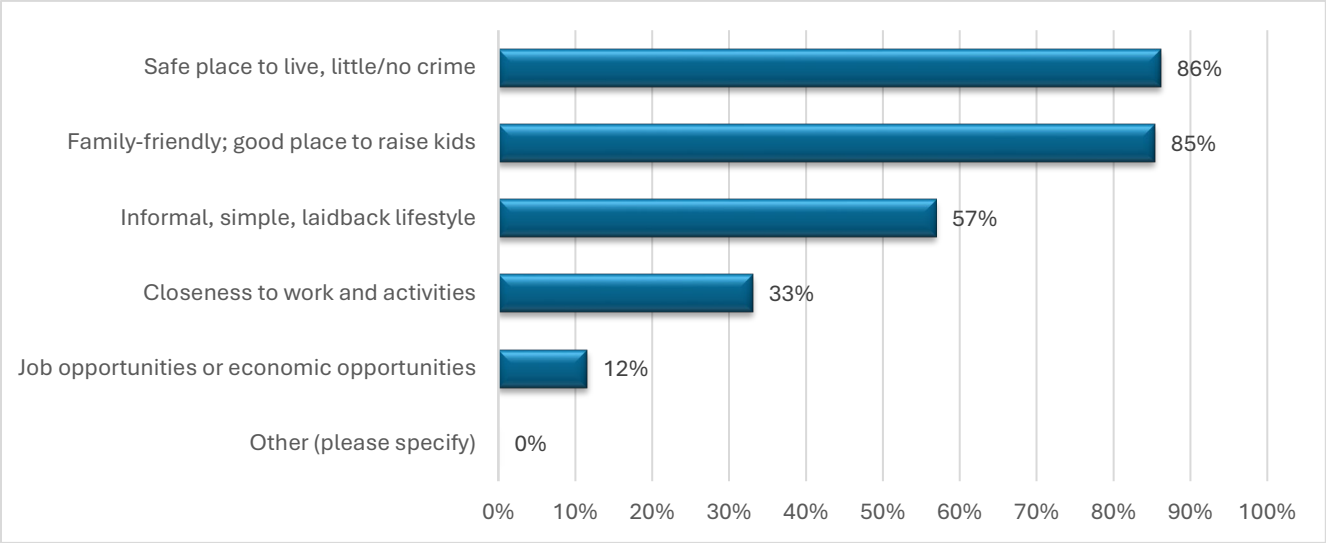
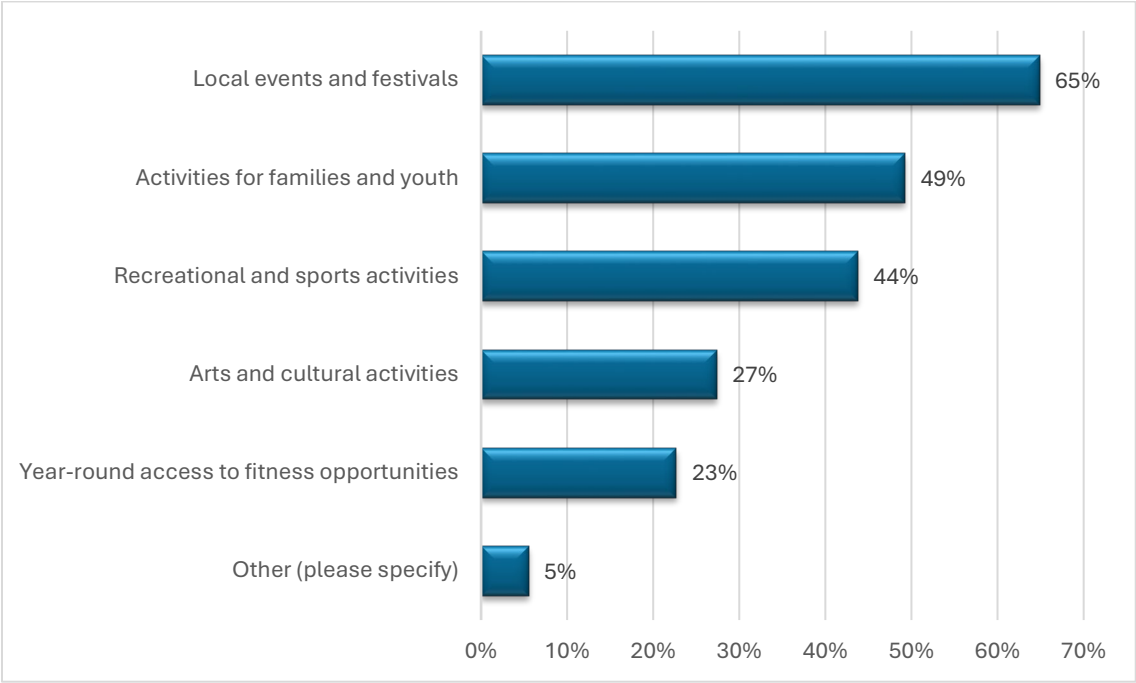


Figure 18: Best Thing about the ACTIVITIES in Your Community
Total responses = 128



Respondents who selected "Other" specified that the best things about the activities in the community included lake activities, easy walking areas, the outdoor activities, church and related 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 five categories and pick their top three concerns. The five categories of potential concerns were:

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

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

- Attracting and retaining young families (N=70);
- Bullying/cyber-bullying (N=66);
- Alcohol use and abuse – Adults (N=64);
- Alcohol use and abuse – Adults (N=58);
- Depression/anxiety – Youth (N=53); and
- Smoking and tobacco use, exposure to second-hand smoke or vaping – Youth (N= 51).

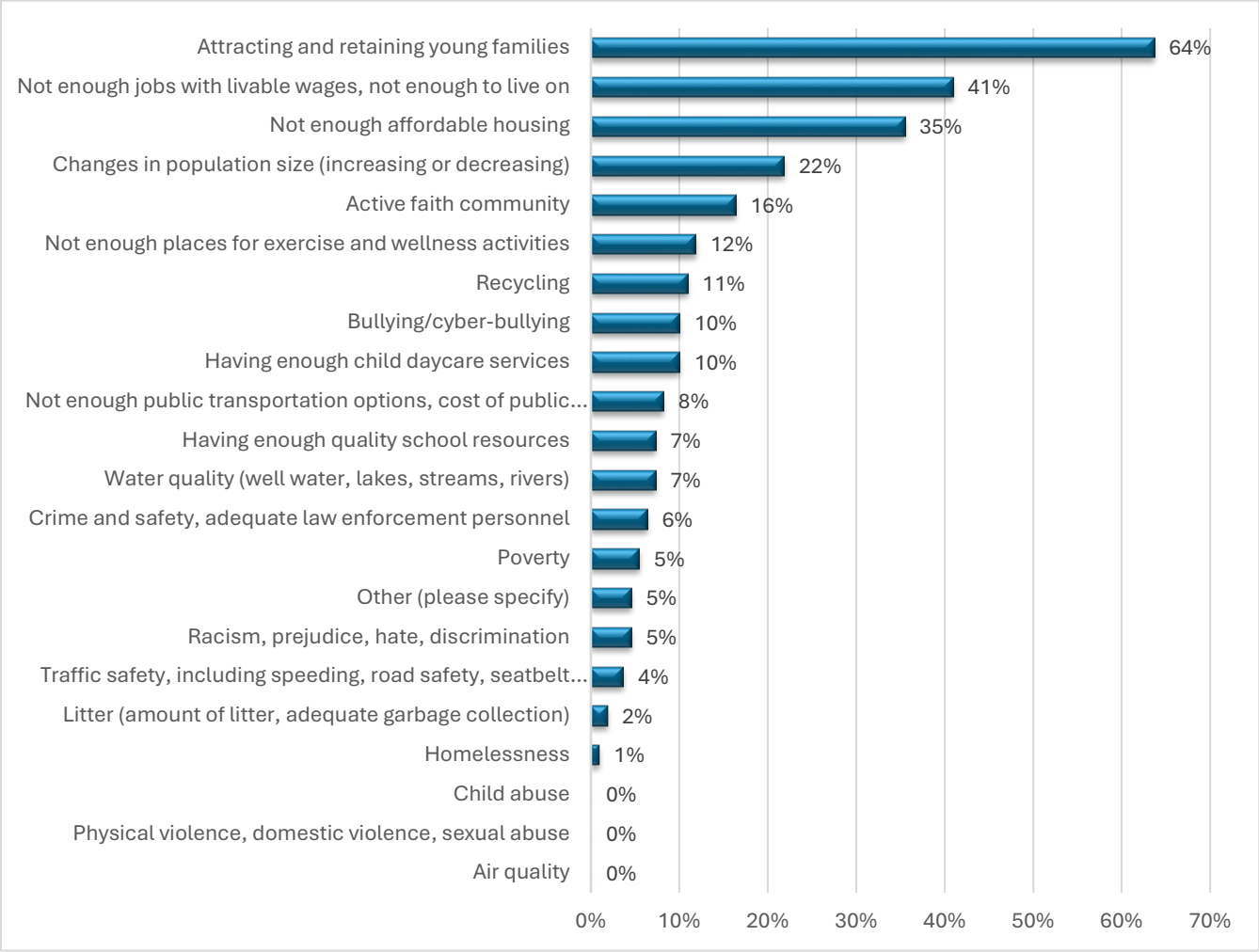
The other issues that had at least 40 votes included:

- Cost of long-term/nursing home care (N=49);
- Ability to recruit and retain primary care providers (MD, DO, PA, NP) and nurses (N=47);
- Drug use and abuse, including prescription drugs (N=47);
- Availability of resources to help the elderly stay in their homes (N=47);
- Drug use and abuse, including prescription drugs – Youth (N=47);
- Drug use and abuse, including prescription drugs – Adult (N=46);
- Not enough jobs with livable wages (N=45); and
- Depression/anxiety - Adults (N=41).

For questions that had long responses that are truncated in the charts, the full text is in italics below each chart.

Figures 19 through 24 illustrate these results.

Figure 19: Community/Environmental Health Concerns
Total responses = 110

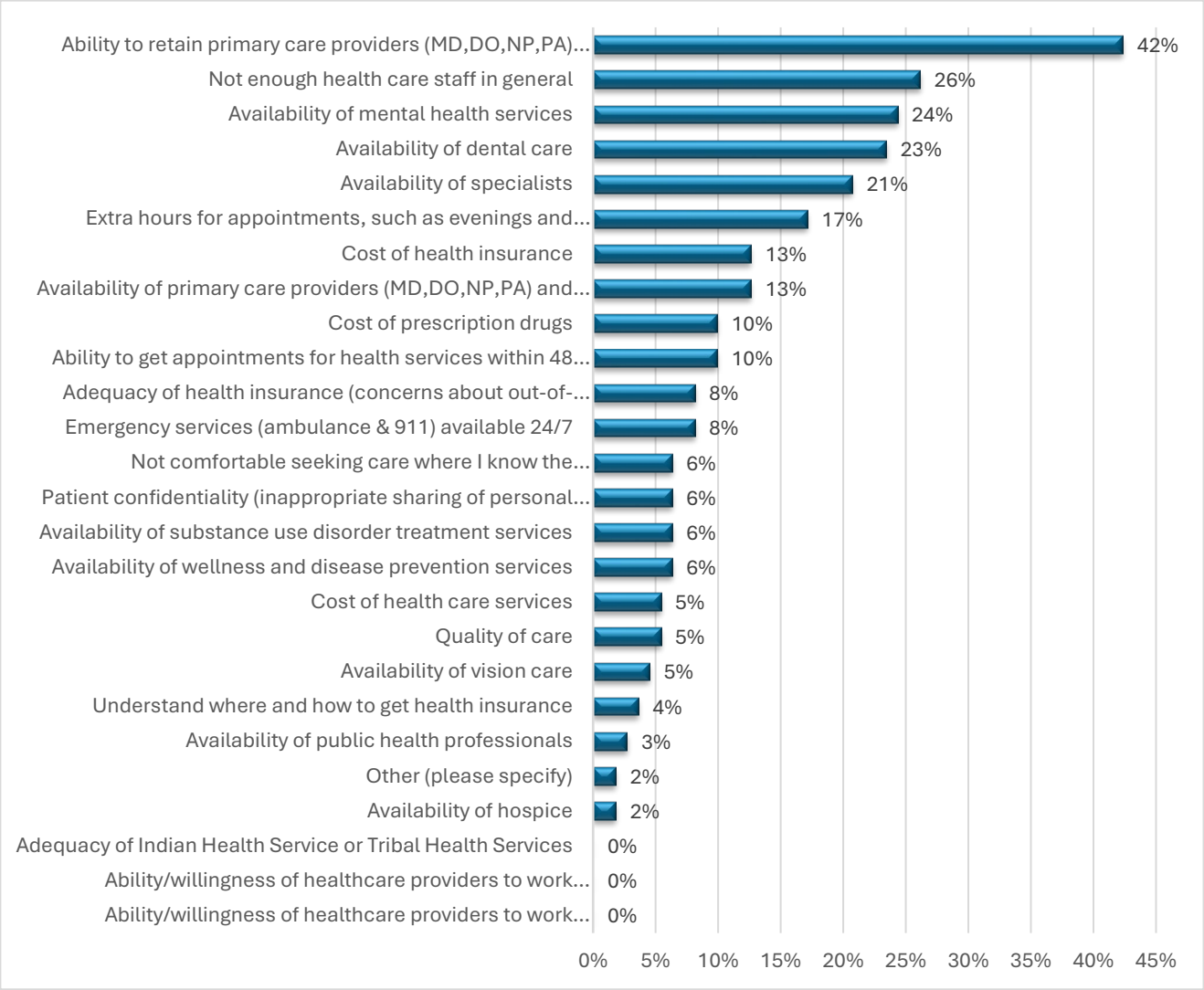


Cut-off chart text:

- *Not enough public transportation options, cost of public transportation*
- *Traffic safety, including speeding, road safety, seatbelt use, and drunk/distracted driving*

In the "Other" category for community and environmental health concerns, the following were listed: Decrease in population and the quality of the community members we have, places to get reliable restaurant service, drugs, discrimination based on your last name, utility prices.

Figure 20: Availability/Delivery of Health Services Concerns
Total responses = 111

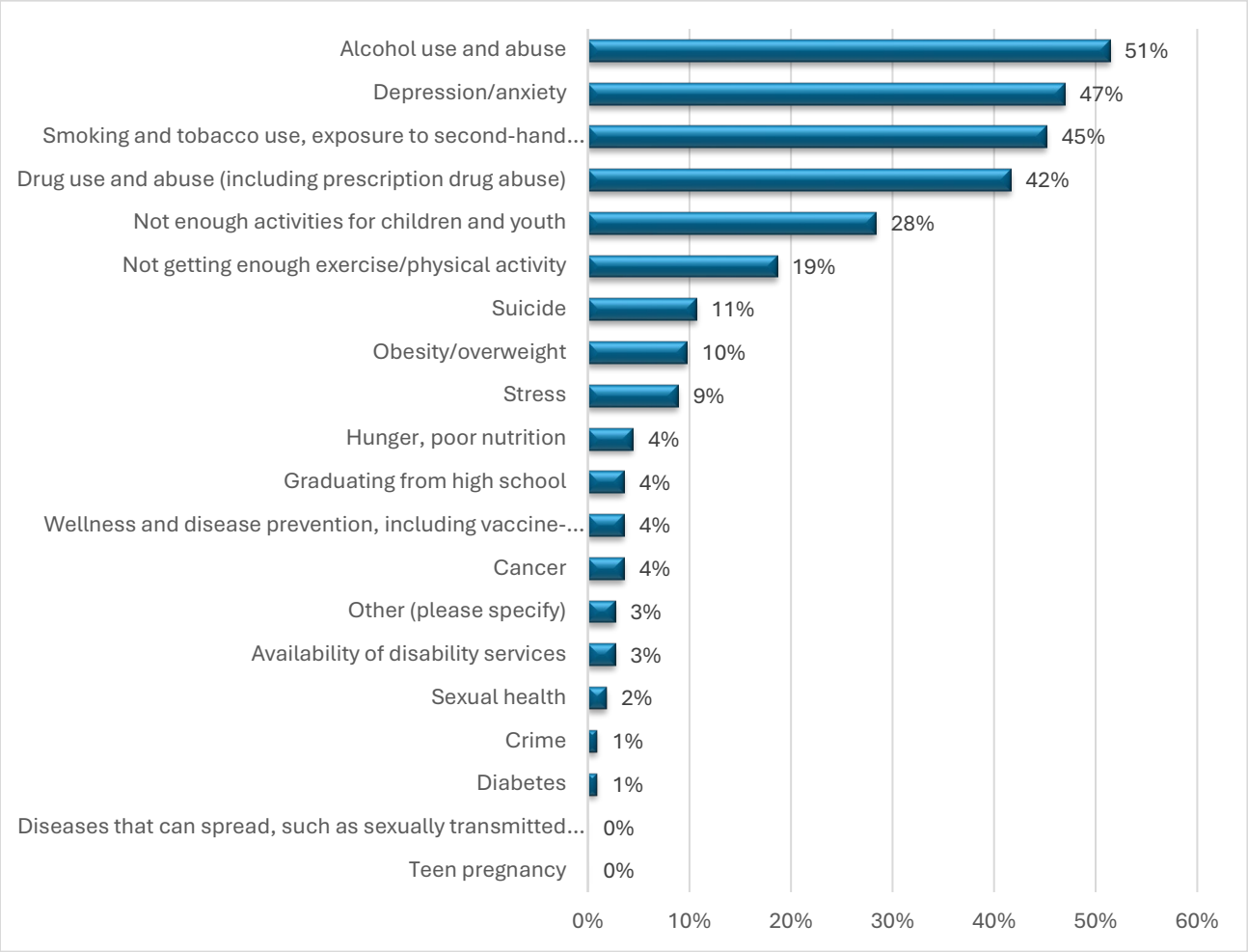


Cut-off chart text:

- *Ability to get appointments for health services within 48 hours*
- *Ability to retain primary care providers (MD,DO,NP,PA) and nurses in the community*
- *Extra hours for appointments, such as evenings and weekends*
- *Availability of primary care providers (MD, DO, NP, PA) and nurses*
- *Adequacy of health insurance (concerns about out-of-pocket costs)*
- *Not comfortable seeking care where I know the employees at the facility on a personal level*
- *Ability/willingness of healthcare providers to work together to coordinate patient care within the health system*

In the "Other" category for Availability/Delivery of Health Services Concerns were that there was not a local pharmacy and having to use travel staff too often.

Figure 21: Youth Population Health Concerns
Total responses = 113

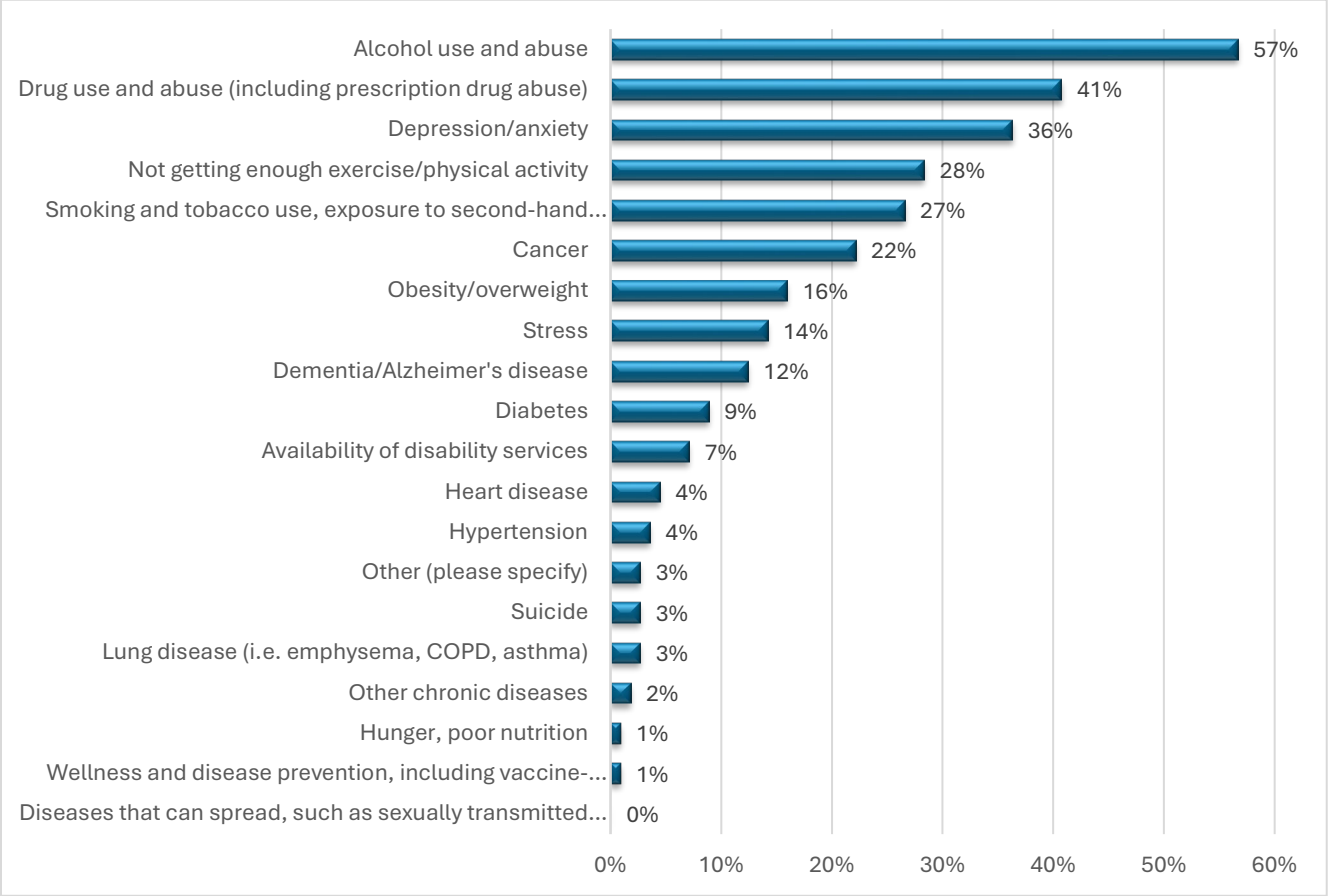


Cut-off chart text:

- *Smoking and tobacco use, exposure to second-hand smoke or vaping (juuling)*
- *Wellness and disease prevention, including vaccine-preventable diseases*
- *Diseases that can spread, such as sexually transmitted diseases or AIDS*

Comments included in the "Other" category for the Youth Population included witnessing unhealthy romantic and family relationships and spending too much on devices such as phones and gaming systems.

Figure 22: Adult Population Concerns
Total responses = 113

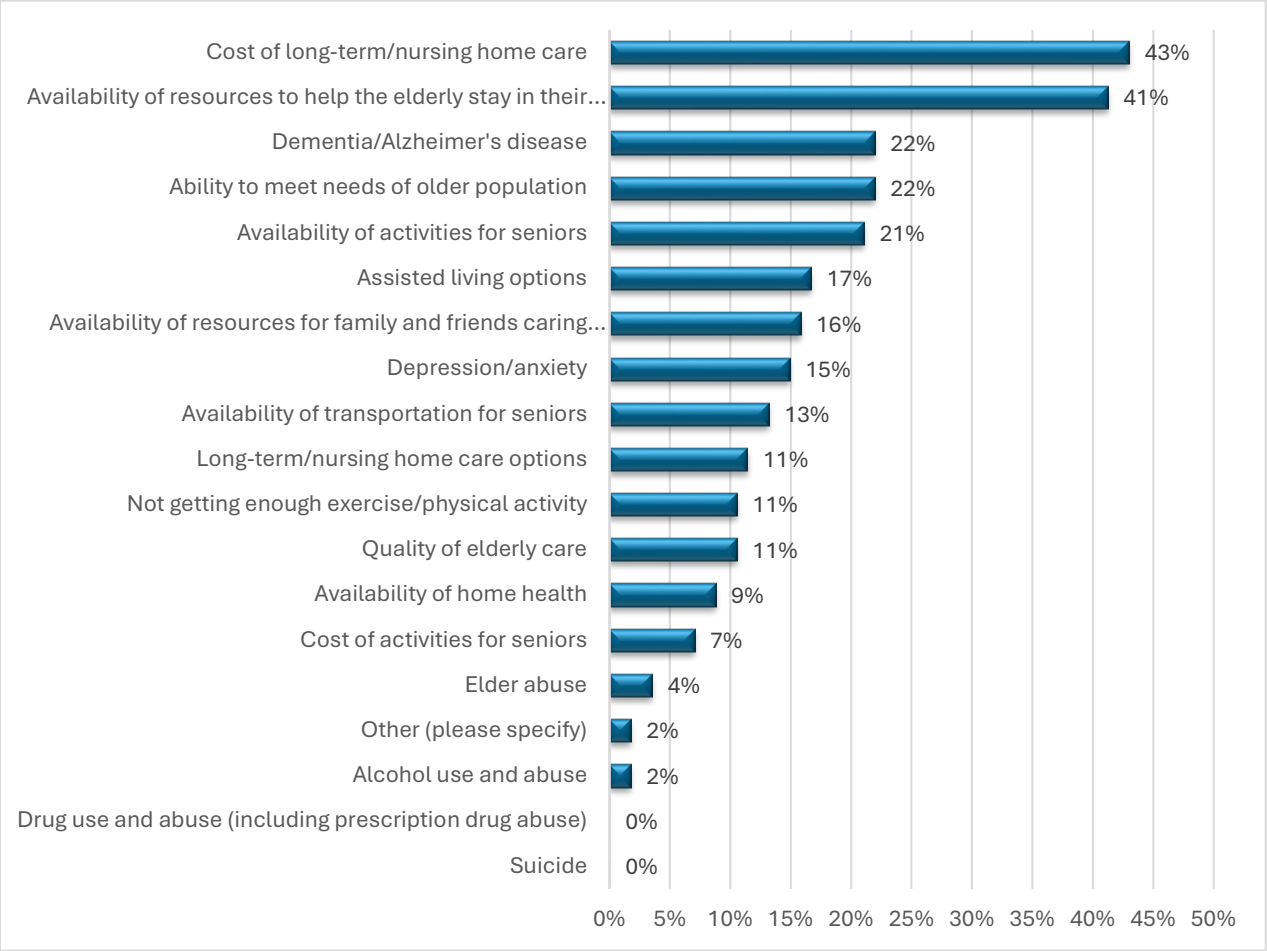


Cut-off chart text:

- *Smoking and tobacco use, exposure to second-hand smoke or vaping (juuling)*
- *Wellness and disease prevention, including vaccine-preventable diseases*
- *Diseases that can spread, such as sexually transmitted diseases or AIDS*

Comments included in the "Other" category for the Adult Population Concerns included quality welfare programs for those with end-stage cancer.

Figure 23: Senior Population Concerns
Total responses = 114



Cut-off chart text:

- *Availability of resources to help the elderly stay in their homes*
- *Availability of resources for family and friends caring for elders*

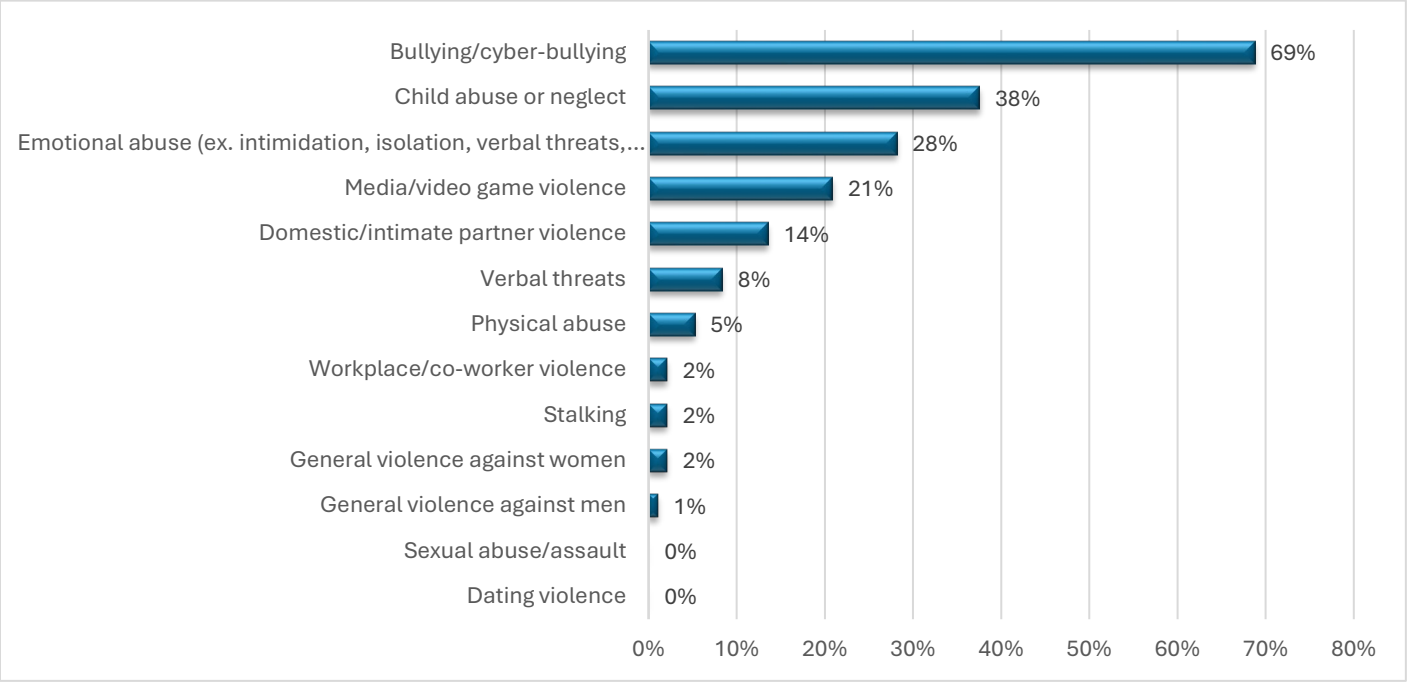
In the "Other" category, the one concern was affordable assisted living.

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

1. Housing
2. Elderly care

Other biggest challenges that were identified were housing and care for the elderly. Housing was by far the biggest concern listed. Elderly care had a significant number of mentions, and other challenges not identified as often were mental health, drugs, healthcare, things to do for youth, stress, events to meet people, and costs of healthcare and long-term/nursing home care.

Figure 24: Violence Concerns
Total responses = 96



Delivery of Healthcare

The survey asked about the health and health care of the survey respondents. They were asked to rate their overall health from poor to excellent. In another question they were asked to indicate any chronic conditions that applied to them. Finally, they were asked if they had a primary care physician. A primary care provider manages chronic diseases, promotes comfort and transparency of medical history, lower overall healthcare costs, ensures routine screenings for early detection before minor issues become big concerns, and refers to specialty care when necessary.

Figure 25-27 illustrates the results of each.

Figure 25: How would you rate your overall health?
Total responses = 117

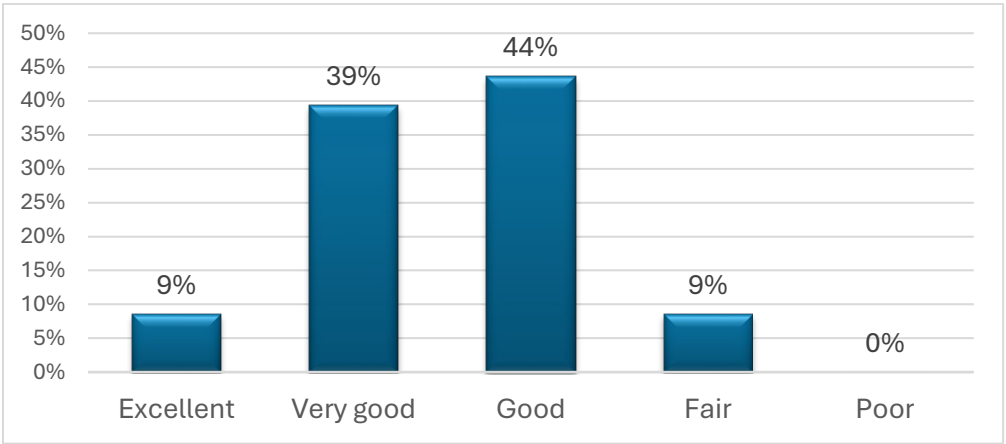
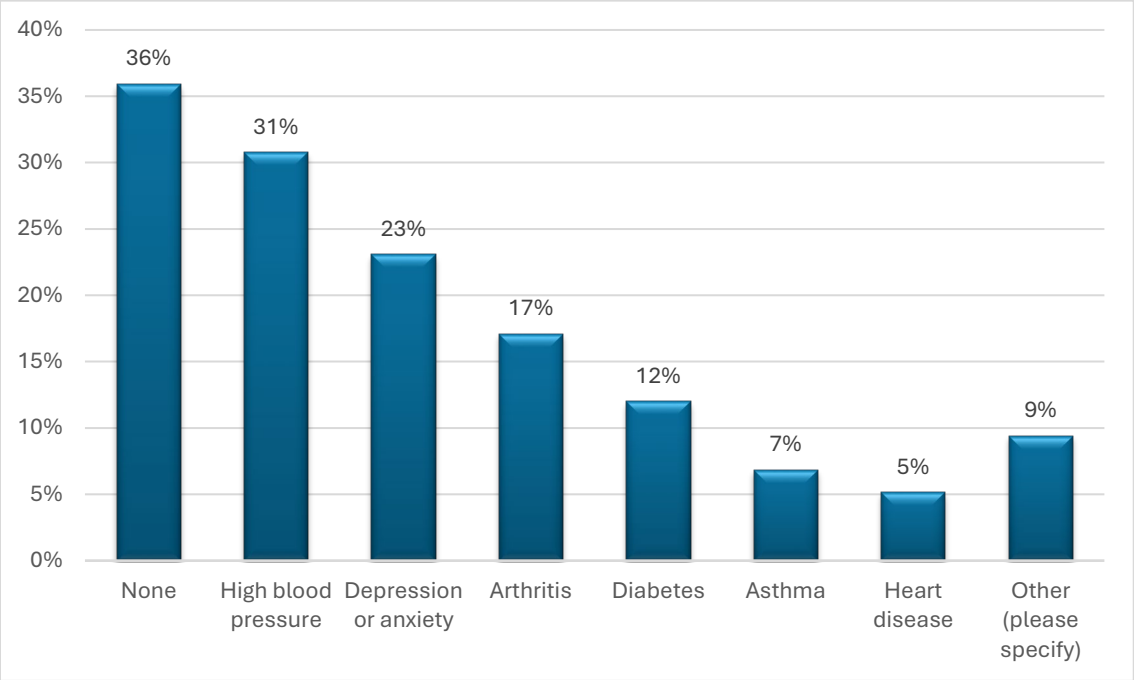
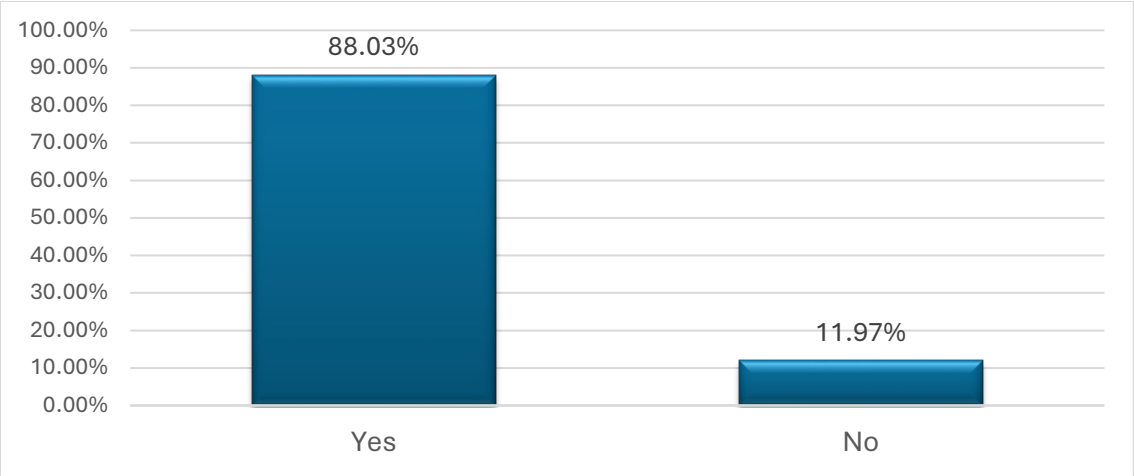


Figure 26: Do you have any chronic conditions (check all that apply)
Total responses = 117



Other responses included, but weren't limited to: Lymes, obesity, chronic migraines, OCD, lupus, leukemia, chronic lung disease, PCOS, A fib, and auto immune disease.

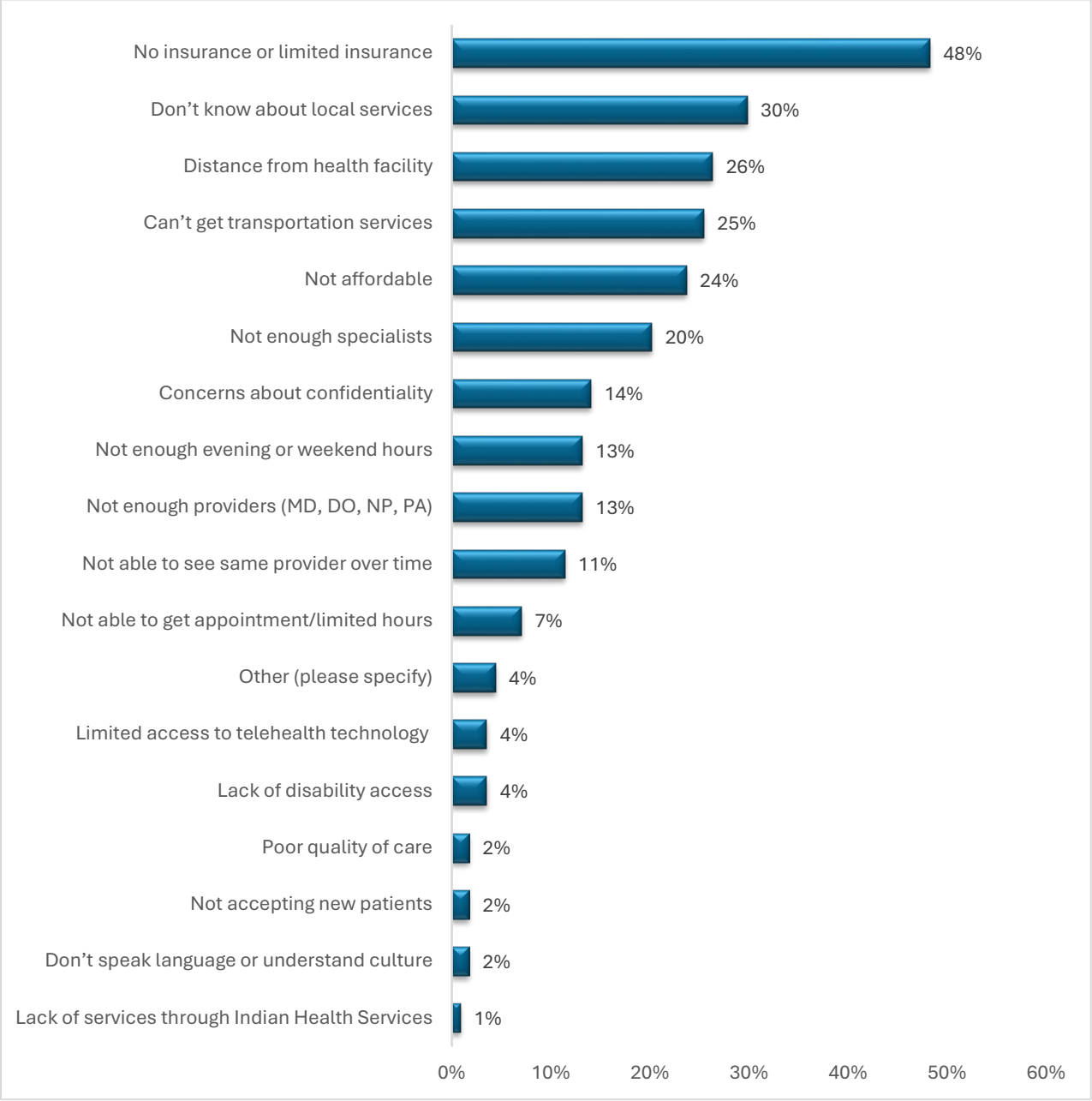
Figure 27: Do you have a primary care physician?
Total responses = 117



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 no insurance or limited insurance (N=55), don't know about local facilities (N=34), Distance from the health facility (N=30), and can't get transportation services (N=29). After these, the next most commonly identified barriers were not affordable (N=27), not enough specialists (N=23), and concerns about confidentiality (N=16). The concerns in the "Other" category were that people don't know how to help themselves and patient management and follow-up is lacking.

Figure 28 illustrates these results.

Figure 28: Perceptions about Barriers to Care
Total responses = 114

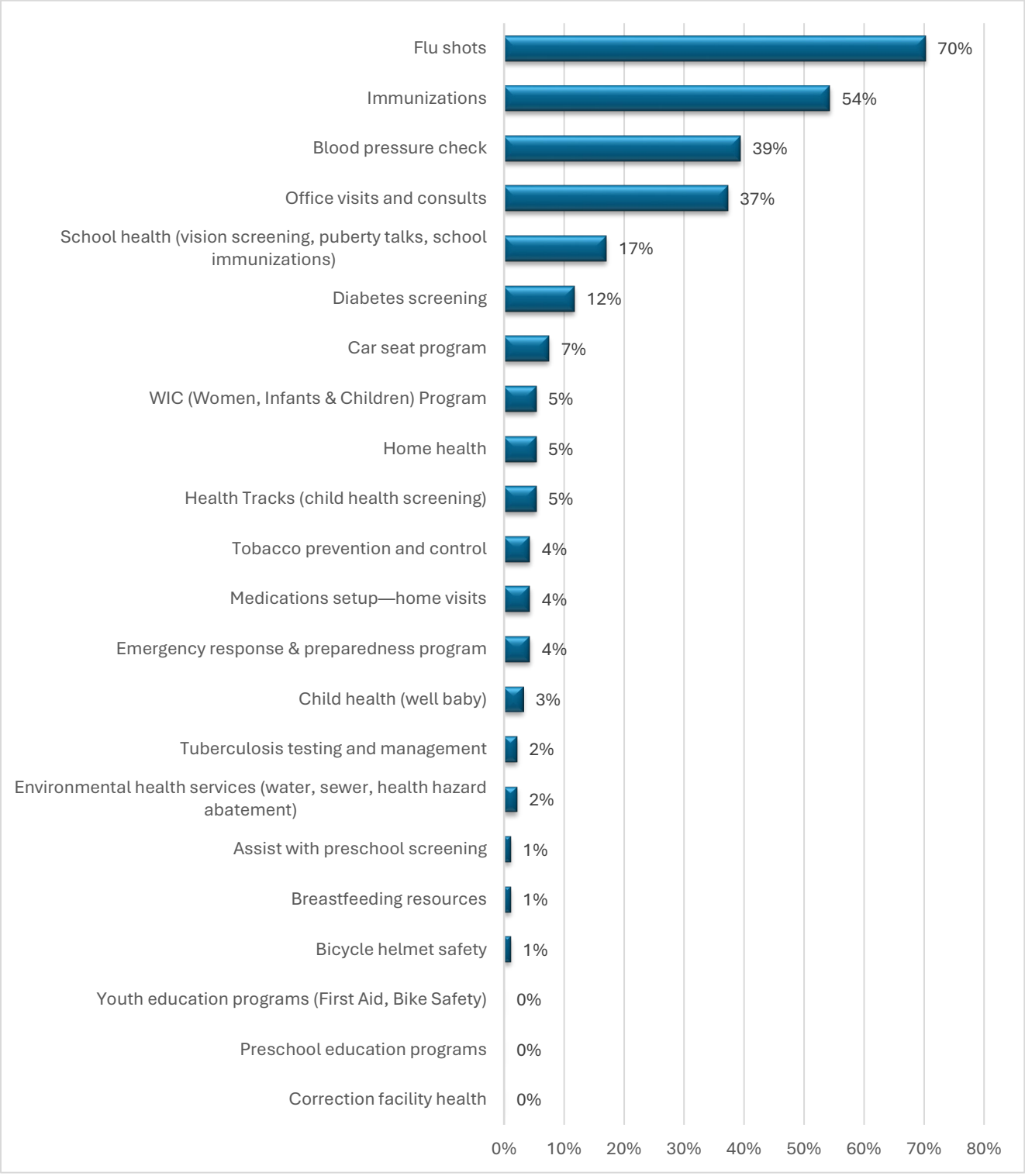


Cut-off chart text:

- *Limited access to telehealth technology (patients seen by providers at another facility through a monitor/TV screen)*

Survey takers were asked to consider services offered at Nelson-Griggs District Health and then indicate which services they are aware of or have used in the past year. Flu shots, immunizations, blood pressure checks, and office visits and consults were the most recognized services. See Figure 29 for the full list.

Figure 29: Services Provided by Nelson-Griggs District Health That Were Used Within the Past Year
Total responses = 94



In looking at services offered by Nelson County Health System, survey takers were asked to consider what services they were aware of being offered for screening/therapy services as well as radiology services offered at NCHS. Figures 30-31 depict the results.

Figure 30: Screening/Therapy Services Utilized/Aware of at NCHS
Total responses = 106

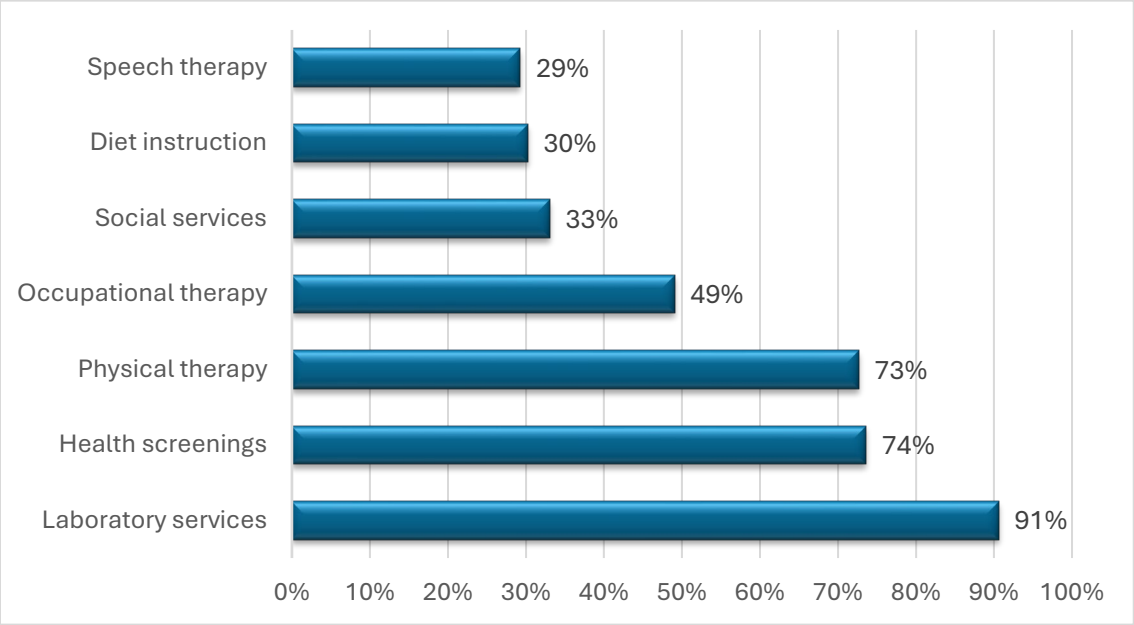
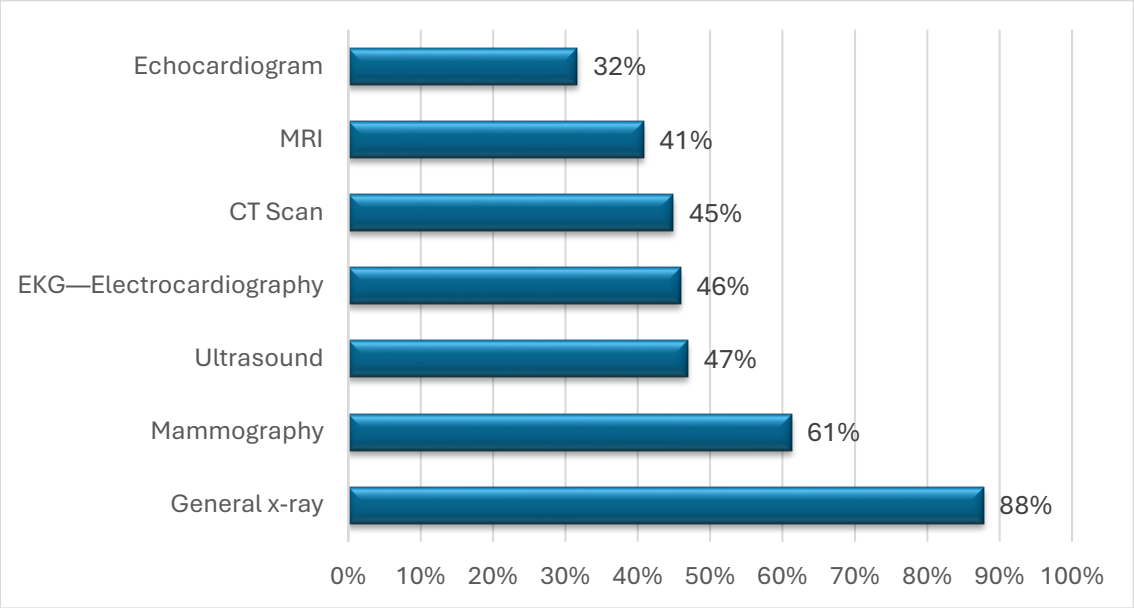


Figure 31: Radiology Services Utilized/Aware of at NCHS
Total responses = 98



In an open-ended question, respondents were asked what specific healthcare services, if any, they think should be added locally. The most desired service to add locally was dentistry followed closely by mental health services and then behavioral health services. Behavioral health includes substance abuse treatment. Other top services requested include:

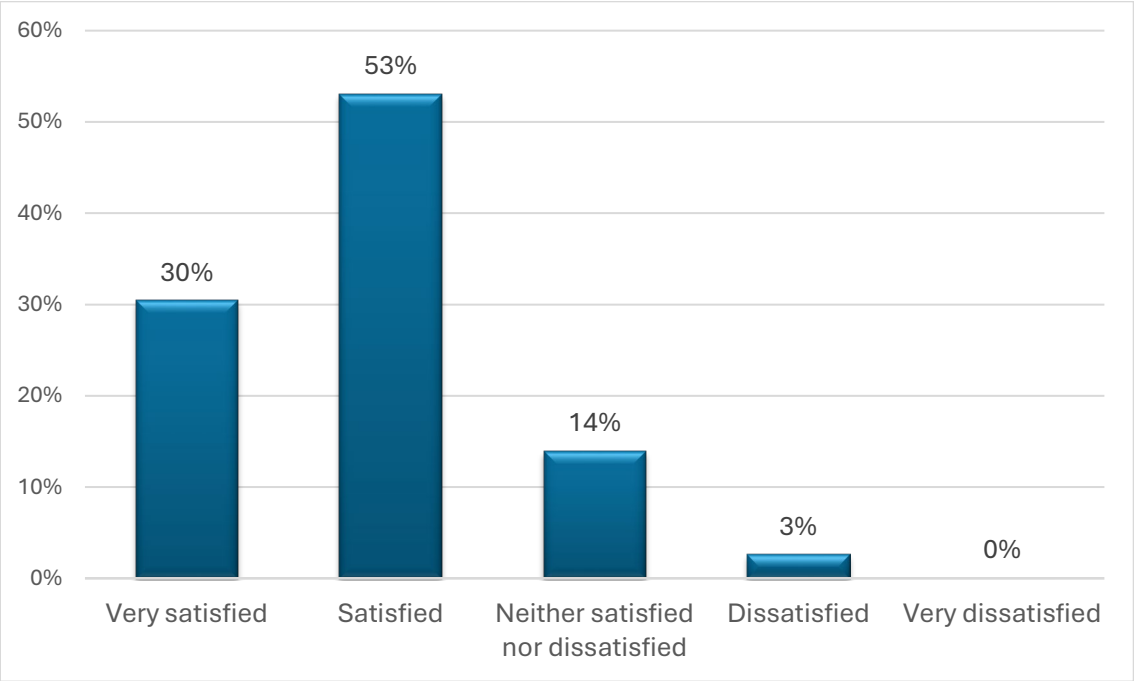
- More telehealth
- Chiropractor
- Family therapy
- Allergist

- Aesthetic services
- School social worker
- Weight loss group
- More physicians
- More preventative care
- Peer support programs, AA
- Women's health/pregnancy planning

A full list of survey responses is provided in Appendix B.

Survey respondents rated how satisfied they are with the healthcare services in their community from very satisfied to very dissatisfied. The majority of respondents were satisfied or very satisfied.

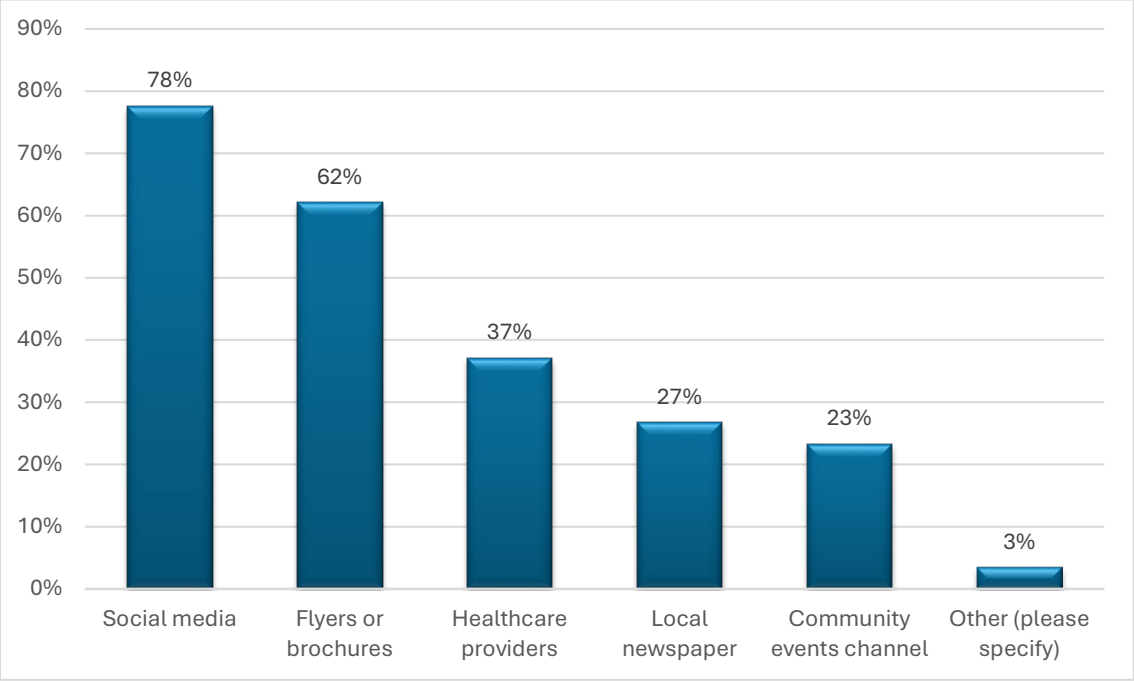
Figure 32: Satisfaction with the Community's Healthcare Services
Total responses = 115



To get a better understanding of how community members prefer to receive information about what health services are available locally a question was, respondents indicated social media followed by flyers and brochures as the top sources. Figure 33 illustrates these results. Other responses included hospital app, website, and mailbox flyer.

Figure 33: Best Way to Receive Information about Health Services and Resources

Total responses = 116



The only age category that that didn't have social media as number one was 65 and older, their number one preference was flyers and brochures with social media second.

The final question of the survey asked respondents to share concerns and suggestions to improve the delivery of local healthcare. Forty-four responses were received.

Recommendations for changes include having extended hours such as before and after school, evening clinic once a week, and weekend walk-in clinic. Also, if possible, have a clinic in Petersburg so high school students could utilize it and not have to travel so far. Several suggested that there be more specialists available and also more healthcare providers. Another would like to have more help available to the residents at the care enter. Finally, the retention of providers is important and that may be done by recruiting from the Midwest. The community has a need for more local first responders, EMTs, and paramedics.

Some finance-related suggestions were made. One was that it would be beneficial to have access to financial assistance to keep, improve and upgrade the services already available to area residents. The other was providing health care cost assistance. Providing housing incentive for new families may help bring in additional residents.

When it comes to advertising, there were multiple mentions of the need for more advertising of services. Facebook was indicated as a preferred means of learning about what services are available. It was suggested that providers attend community events to build relationships.

As was discussed in the question of desired services, the need for dental care locally was brought up. Availability of transportation was also indicated as a need, but it was also said that it would be nice if the residents used the transportation van and home health services (such as medication set up) more.

An employee at NCHS indicated that they have health insurance through their work, but the deductible is so high that it hinders them from utilizing it unless absolutely necessary. They felt is would be nice to have lower out-of-pocket expenses.

Several people indicated that overall, the local health care services are very nice and greatly appreciated. They like how quickly they can get an appointment when needed and ensure that continues.

Findings from Key Informant Interviews & the Focus Group

Questions about the health and well-being of the community, similar to those posed in the survey, were explored during key informant interviews with community leaders and health professionals and also with the focus 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 focus group can be grouped into five categories (listed in alphabetical order):

- Attracting and retaining young families
- Health insurance
- Ability to recruit and retain healthcare staffing
- Mental health services

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

- Hard to bring people in to work and stay if they can't find a home to stay in.
- Attracting and retaining young families – goes with availability of houses, a lot that are coming back are taking over farms or family businesses – so they have a reason to come back and a place to live.
- Hard to find housing that is decent and affordable which makes it hard for people to move here.
- Aging population with businesses decreasing there isn't places for the younger people to come here and work.

Health Insurance

- Health insurance dictating where they can/can't go and how much it will cost, so they may just not go.
- Understanding of what health insurance they have. They get so much thrown at them during enrollment via commercials. It is so confusing and expensive. Very confusing. Some don't have a physical address (homeless don't have one often).
- Health insurance understanding.
- Cost of health insurance and obesity and overweight – doesn't help the cost of health insurance.

Ability to recruit and retain healthcare staffing

- Keeping healthcare providers and being able to afford to keep them in the community. Keeping up with their salary needs.
- Not enough healthcare staff in general, especially CNAs for the care center – again hard to find housing and pay for travel nurses

Mental Health

- Depression and anxiety – all ages is a big concern
- Lack mental health services.
- Hard to get mental health help.

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 was not intended to rank services provided. They were presented with a list of 13 organizations or community segments to score. According to these participants, the hospital, pharmacy, public health, and other long-term care (including nursing homes/assisted living) are the most engaged in the community. The averages of these scores (with 5 being "excellent" engagement or collaboration) were:

- Public Health (4.29)
- Emergency services, including ambulance and fire (4.00)
- Hospital (healthcare system) (3.93)
- Business and industry (3.92)
- Long-term care, including nursing homes and assisted living (3.87)
- Schools (3.80)
- Law enforcement (3.80)
- Faith-based (3.69)
- Economic development organizations (3.54)
- Social/Human Service agencies (2.79)
- Pharmacy (2.40)
- Other local health providers, such as dentists and chiropractors (1.86)

Limitations

The Community Survey results are meant to represent the opinions and needs of the general population in Nelson County and service area. This survey used a convenience sampling method as it was distributed and made broadly available throughout the service area. It should be noted that when looking at survey demographics, most respondents were white females and over half of total respondents were 55 years or older. As a convenience sampling method was employed, data findings may not necessarily represent the entire community.

Prioritization of Health Needs

A community group composed of those that attended the first community meeting as well as the key informants met on April 17, 2025. Ten community members attended the meeting. A facilitator from Cibolo Health presented the group with a summary of this report's findings, including background and explanation about the secondary data, highlights from the survey results (including perceived community assets and concerns, and barriers to care), and findings from the key informant interviews.

Following the presentation of the assessment findings, and after considering and discussing the findings, all members of the group were asked to identify what they perceived as the top four community health needs. All of the potential needs were listed and attendees noted their four items of biggest concern.

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

- Ability to retain primary care providers (MD, DO, NP, PA) and nurses (7 votes)
- Youth Smoking and tobacco use, exposure to second-hand smoke, vaping (7 votes)
- Not enough affordable housing (6 votes)
- Attracting and retaining young families (4 votes)

From those top four priorities, each attendee voted on the one item they felt was the most important to address in the next three years. The rankings were:

1. Ability to recruit and retain primary care providers (MD, DO, NP, PA) and nurses (6 votes)
2. Not enough affordable housing (3 votes)
3. Attracting and retaining young families (1 votes)
4. Youth Smoking and tobacco use, exposure to second-hand smoke, vaping (0 votes)

Upon completion of the prioritization process, the number one identified need, as voted on by those attending the second community meeting, was the ability to recruit and retain primary care providers (MD, DO, NP, PA) and nurses. A summary of this prioritization may be found in Appendix I.

Comparison of Needs Identified Previously

Top Needs Identified 2022 CHNA Process	Top Needs Identified 2025 CHNA Process
Availability of mental health services	Ability to recruit and retain primary care providers (MD, DO, NP, PA) and nurses
Availability of resources to help elderly stay in their homes	Not enough affordable housing
Alcohol use and abuse – youth	Attracting and retaining young families
Attracting and retaining young families	Youth Smoking and tobacco use, exposure to second-hand smoke, vaping

The current process did identify one identical common needs from the previous cycle, attracting and retaining young families was identified in the 2022 CHNA process.

Nelson County Health System invited written comments on the 2022 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 Nelson County Health System Board vote, a notation will be documented in the board minutes reflecting the approval and then the report will be widely available to the public on the hospital's website, and a paper copy will be available for inspection upon request at the hospital. Written comments on this report can be submitted to Nelson County Health System.

Hospital and Community Projects and Programs Implemented to Address Needs Identified in 2022

In response to the needs identified in the 2022 CHNA process, the following actions were taken:

Need 1: Availability of mental health services – Since the last CHNA process, Nelson County Health System has telemedicine services available for behavioral health and mental health services. We continue to work with Public Health about getting into the community and what resources are needed and available to patients.

Need 2: Availability of Resources to Help the Elderly Stay in their Home – Nelson County Health System providers have been educated to discuss with their patients' options available if resources are needed. If specific resources are needed, public health is notified. Brochures and flyers of all of NCHS options as well as public health services are available in the clinic and in the hospital.

Need 3: Youth/Adult Alcohol use and abuse – Public Health provided referrals to NDQuits for tobacco cessation, assed businesses' compliance with state clean indoor law, increased the number of tobacco free buildings and grounds, maintains the schools' comprehensive tobacco free buildings and grounds policies, and provides a Tobacco Treatment Specialist in McVille.

Need 4: Attracting and retaining young families – Nelson County has taken steps into helping with this cause by brining in housing options. Nelson County Health System has a benefit of $10/day/child for daycare to entice families to work for NCHS while getting money off on childcare. Promotion of community and things to do has been pushed by different organizations.

The above implementation plan for Nelson County Health System is posted on the NCHS website at www.nelsoncountyhealthsystem.org

Recommendations and Action Plan

Within five months and 15 days, an implementation plan mapping out how the community will address the findings of the CHNA has to be approved by the Nelson County Health System board of directors. Although a CHNA and strategic implementation plan are required by hospitals and accredited local public health units, 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 next step is to convene the steering committee, or other community group that includes those that will be valuable in enacting changes, to outline the path that will be taken to implement change to improve the health of the community. A 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.

All activities proposed in the implementation plan will need to be monitored and evaluated to see if the plan is working or if modifications need to be made. The implementation plan is a starting place, it will need to be refined as you travel through the three years of application.

Appendix A – Community Survey Instrument

Nelson County Health System Service Area Health Survey

Community Health Needs Assessment

Nelson County Health System and Nelson-Griggs District Health Unit are interested in hearing from you regarding the community health needs in your area. A Community Health Needs Assessment (CHNA) survey is designed to gather information about the health needs and priorities of a community. It is important that we have the thoughts of those within the community providing their opinions. These questions help identify the health needs of the community, the barriers to accessing healthcare, and the resources that are most needed. The survey results are then used to inform community health improvement plans and strategies.

Surveys will be tabulated by Cibolo Health (https://cibolohealth.com/). Your responses are completely 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 aggregate. If you have questions about the survey or the process, please contact Kylie Nissen at kylie.nissen@cibolohealth.com or 701.330.0464.

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
- ☐ Other (please specify)
- ☐ Opportunities for advanced education
- ☐ Public transportation
- ☐ Programs for youth
- ☐ Quality school systems

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

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

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

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

Nelson County Health System Service Area Health Survey

Community Concerns

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
- ☐ Other (please specify)
- ☐ 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

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
- ☐ Other (please specify)
- ☐ 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

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
- [ ] Other (please specify)
- [ ] Availability of transportation for seniors
- [ ] Availability of home health
- [ ] Not getting enough exercise/physical activity
- [ ] Dementia/Alzheimer's disease
- [ ] Depression/anxiety
- [ ] Suicide
- [ ] Alcohol use and abuse
- [ ] Drug use and abuse (including prescription drug abuse)
- [ ] Elder abuse

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?

Nelson County Health System Service Area Health Survey

Health Status and Behaviors

12. How would you rate your overall health?

- ◯ Excellent
- ◯ Very good
- ◯ Good
- ◯ Fair
- ◯ Poor

13. Do you have any chronic conditions (check all that apply)

- ☐ Diabetes
- ☐ Heart disease
- ☐ Asthma
- ☐ Arthritis
- ☐ Other (please specify)
- ☐ High blood pressure
- ☐ Depression or anxiety
- ☐ None

14. Do you have a primary care physician?

- ◯ Yes
- ◯ No

Nelson County Health System Service Area Health Survey

Delivery of Healthcare

15. 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
- ☐ Other (please specify)
- ☐ 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

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

- [ ] Diet instruction
- [ ] Health screenings
- [ ] Laboratory services
- [ ] Occupational therapy
- [ ] Physical therapy
- [ ] Social services
- [ ] Speech therapy

17. Considering **RADIOLOGY SERVICES** at NCHS, which services are you aware of (or have you used in the past year)? (Choose ALL that apply)

- [ ] CT Scan
- [ ] Echocardiogram
- [ ] EKG—Electrocardiography
- [ ] General x-ray
- [ ] Mammography
- [ ] MRI
- [ ] Ultrasound

18. Which of the following **SERVICES** provided by Nelson-Griggs District Health Unit have you or a family member used in the past year? (Choose ALL that apply)

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

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

20. How satisfied are you with the healthcare services in your community?

- ( ) Very satisfied
- ( ) Satisfied
- ( ) Neither satisfied nor dissatisfied
- ( ) Dissatisfied
- ( ) Very dissatisfied

21. What is the best way for you to receive information about health services and resources? (check all that apply)

- [ ] Local newspaper
- [ ] Healthcare providers
- [ ] Social media
- [ ] Flyers or brochures
- [ ] Community events channel
- [ ] Other (please specify)

Nelson County Health System Service Area Health Survey

Demographic Information:

Please tell us about yourself.

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

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

23. Age:

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

24. Highest level of education:

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

25. Gender:

- ◯ Female
- ◯ Male
- ◯ Non-binary
- ◯ Other (please specify)

26. Employment status:

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

27. Your zip code:

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

- ☐ American Indian
- ☐ African American
- ☐ Asian
- ☐ Other (please specify)
- ☐ Hispanic/Latino
- ☐ Pacific Islander
- ☐ White/Caucasian

29. 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

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

Thank you for assisting us with this important survey!

Appendix B – Open-Ended Survey Question Responses

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):

- Small town feel
- You know your neighbors and look out for one another.
- People are self reliant.

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

- Safe environment
- When my kids were in school, it was the quality school system. Now it's the community groups & organizations.
- Simplicity
- Local daycare services.

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

- Few to no activities
- Lake activities and easy walking areas
- None
- The outdoors. Not much else for activities for adults
- None of the above
- Outdoor activities
- Church and related activities

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):

- Decrease in population and the quality of the community members we have
- Places to get reliable restaraunt service
- Drugs
- Discrimination - based on your last name - or lack of a reputable name
- utility prices are monopolized and very pricey

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

- No pharmacy
- having to use travel staff too often because of lack of staff

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

- N/A
- Witnessing unhealthy romantic and family relationships
- Spending too much time on devices - phones, gaming systems etc.

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

- N/A
- Quality welfare programs for those with stage 4 cancer
- <

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

- N/A
- Affordable assisted living

11. What single issue do you feel is the biggest challenge facing your community?
    - Addiction
    - Affordable housing opportunities
    - (3) Alcohol abuse
    - Alcohol abuse with the youth and adults in the community.
    - Alcohol Use and Abuse starting from a young age
    - Attracting and keeping young families.
    - Competitive jobs, aging populations, not enough community involvement from younger population
    - Corrupt management of the health care system. Mcville Health care facilities excluded.
    - cost of operation of health care facilites/
    - Declining work ethic
    - Decreasing population
    - Drugs
    - Due to remote locations, many aging adults don't get out of town as much in the winter. This leads to depression, which leads to a host of other health issues. A public transportation bus to Devils Lake or Grand Forks where people could go the movies, or out to eat or shopping would be helpful.
    - Dwindling services
    - Employees to work in the health system
    - everybody knowing everybody no one wants to uphold rules/policies at work places. loosing local workers
    - finding work close by
    - Getting young families to stay in the area... opportunities
    - Having enough variety of activities for everyone!
    - Healthy recreation
    - Heavy narcotics
    - High gas prices.
    - (5) Housing
    - Housing availability
    - Housing lack of and affordability
    - Incompetent law enforcement for nelson county.
    - Isolation and social norms here
    - Jobs
    - Jobs that have decent wages and benefits.

- Keeping the community young with the lack of housing.
- Keeping young people here.
- knowledge of resources
- Lack of high paying jobs.
- Lack of business‘s to keep people in too
- lack of concern for mental health issues
- Lack of employment opportunities.
- Lack of engagement in community opportunities (ie- joining EMS services, community clubs, church organizations)
- lack of involvement in faith-based activities, therefore lack of spiritual health and emotional/psychological wellbeing
- Lack of job opportunities to bring in people.
- Lack of people to keep health care going
- Lack of people to work
- Lack of resources
- Lack of viable jobs
- Lack of vision and energy to build for future.
- Lack of young people.
- Low wage and church membership significantly declined thus no church income
- Making it affordable and safe.
- (2) Mental health
- Need a place for exercise during winter months.
- Not enough businesses
- Not enough employment opportunities and wages.
- Not enough local jobs with adequate pay to sustain life
- Not enough people live here, communities are not growing
- Not enough resources
- Not sure
- Nothing open on Sundays
- Our location we are far away from everything. Good paying jobs too retain our youth workers
- Passivity & fear. People would be more vocal about issues if they weren’t afraid of backlash or if they were not passive
- People stepping up
- (3) Population
- Population declining
- Seems to be meth in a lot of places and even our deputy who lives in town could care less. Sheriffs office actively does nothing while wasting so much money. Huge need for some form of actual law enforcement.
- The 1% believing they are the only voice in our community and making it known their pet projects are always taken care of.
- The community needs support in developing activities that promote community participation in civic events and volunteering
- The drugs at sunlac
- The fact that the pay rates of jobs in the area are wildly disproportionate to the cost of housing.
- The increase in anxiety and depression among all the age groups.
- There aren't any that i know of
- Transportation
- Transportation availability
- Undiagnosed and untreated mental health concerns

- wages are too low
- Wages/housing for healthcare workers.

Delivery of Healthcare

13. Do you have any chronic conditions (check all that apply)
    - A fib
    - Lymes
    - Obesity
    - Chronic migraine
    - Fibromyalgia
    - OCD
    - Lupus
    - Cml Lukemia
    - Chronic lung disease
    - PCOS
    - Auto immune

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

    - Fear
    - N/A
    - They don't know how to help themselves
    - Patient management and follow up has gotten terrible the last few years especially when a referral is made.
    - None of the above is a concern.

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

    - A school social worker. Mental health. More psychiatrists in general.
    - Aesthetic services
    - Alcohol dependence services
    - Allergist
    - Availability of More Telehealth
    - Behavioral health consults in person or telehealth.
    - Behavioral health services.
    - Behavioral Health, Mental Health
    - Chiro
    - Chiropractor
    - CT scanner for ERs
    - (5) Dental
    - (2) Dental care
    - Dental Checkups
    - (3) Dentist
    - Doctors
    - Don't know
    - Family therapy, psychotherapy

- I think we have a great healthcare system
- I would love to see a local weight loss group- an opportunity to network, share resources, weigh in - accountability and support really help
- Information session for the public
- Just keeping the community informed about available services.
- Keeping staff
- mental health for adults and children
- Mental health provider
- (2) Mental health services
- Mental health specialists
- More main level providers verses just mid-level providers. I know MD and DO are hard to get.
- More physicians
- More Preventive care
- (2) Na
- (6) None
- (2) Not sure
- Not sure at the moment.
- Nothing i can think of
- PEER Support programs, mental health care providers, substance abuse prevention (AA)
- Provide additional care locally before sending to another facility.
- Provider that can see pregnant women and hand off to OB when closer to keep care close to home.
- Psych and substance abuse
- Psych/substance abuse services
- PT/OT
- (2) Unsure
- We have been very pleased with our care
- Women's health, pregnancy planning

21. What is the best way for you to receive information about health services and resources? (check all that apply)

- Advertising is key to success
- Hospital App
- website
- Mailbox flyer

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

- Blue cross/Blue shield
- Supplement-Aetna

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

- Availability of transportation, psych and substance abuse services
- Dental checkups nearby
- Don’t know
- Earlier hours before school and later hours for after school
- Evening clinic hours one day/week

- For a very small town, we have a lot of medical facilities available.

- Get better transportation
- Get providers out in the community at events to build relationships
- Having access to financial assistance to keep, improve and upgrade the services already available to area residents.
- Health care cost assistance
- Hours of operation
- Housing incentive for new family's
- I check Facebook regularly so that would be an easy way for me to get information.
- I have insurance through my job with NCHS, but the deductable is so high. I understand that I do not pay for the coverage, but an almost 10k out-of-pocket is ridiculous. Would be nice to have a lower out-of-pocket expenses.
- I honestly do not have a clue what is offered here.
- I live in Walsh and doctor there. However I work in Nelson at the high school. I think people should be grateful to have access to healthcare here. I've often wondered how successful or efficient it would be to have appointments in Petersburg for teens.
- I'm happy with out healthcare
- It would be nice if the residents used the transportation van and home health services (such as medication set up) more.
- It's available to all but some need more specialized care
- Keep providers who spend time with patients and actually care
- Knowledge of staff
- Lack of access due to distance. Sometimes inexperience of staff with certain conditions.
- Make people more aware of what you offer
- More avaliable
- More specialists, longer clinic hours.
- (2) N/a
- Need more local first responders, EMTs, paramedics. Overall, the local health care services are very nice and greatly appreciated.
- No suggestions that aren't already known
- (4) None
- Not sure
- Not sure about this. The only thing I can think of is to get social media ads? No idea beyond that
- Our town has a library and coffee time visit then
- Overall, my husband and I are very satisfied wuth the healthcare we receive through the Nelson County HealthCare System. We would like to have more help available to the residents at the care enter.
- Paying attention to all ages and circumstances and welcome inclusion. Making sure the residents are informed of all the services they are entitled to receive.
- Publicity re the health services offered. try to recruit Midwest providers, in the long term they are the only ones that will stay
- Retain providers.
  Make known all of the services available.
- The hospital wasn't hippa compliant as the aides child was sitting behind the intake desk with them. The charge nurse was there also. Very dissapointing
- The need of more healthcare providers.

- We are so blessed by the resources available and how quickly we can get an appointment when needed- we just need to ensure that continues
- Weekend walk in clinic.

Appendix C – NDDHHS 2024 Child Care Profile

NORTH Dakota | Health & Human Services
Be Legendary.

Child Care Profile
2024
NELSON County

Children Potentially Needing Child Care

	0-2 yrs	3 yrs	4-5 yrs	6-12 yrs	Total
Children in County by Age[1]	74	34	55	219	348
% of Children Ages 0 to 5 with All Parents in the Labor Force[1]					76.1%
% of Children Ages 6 to 13 with All Parents in the Labor Force[1]					74.6%
Children Ages 0 to 5 potentially needing child care due to parents in workforce					163
Children Ages 6 to 12 potentially needing child care due to parents in workforce					154
Capacity of state-licensed child care programs (family, group, center, school-age[3])					134
Current Child Care Assistance Program Recipients Age 0-13					
Percent to which supply meets potential demand					42%

State-Licensed Early Childhood Program Type and Capacity[2] (2024)

	Family	Group in a home	Group in a facility	Center	Total
Number of Programs	0	0	3	1	4
Licensed Capacity	0	0	79	55	134
Reported Vacancies[4]	0	0	4	0	4
Programs open before 7:00 a.m.	0	0	1	0	1
Programs open after 6:00 p.m.	0	0	0	0	0
Programs open on Weekends	0	0	0	0	0
Reported Size of Workforce	0	0	14	7	21
State-licensed school-age programs[3]	0	with a licensed capacity of			0

Annual Cost of State-Licensed Child Care[2] (Due to the limited number of programs, rates reflect a regional average)

	Home-based Programs		Centers and Group Facilities	
Age of Child	**Average**	**Highest Rate**	**Average**	**Highest Rate**
Ages 0 to 17 months	$8,450	$9,100	$9,954	$11,700
18 to 35 months	$7,800	$7,800	$9,880	$11,700
Ages 3 to 5	$7,800	$7,800	$9,249	$11,700
Ages 6 to 12 (Annual costs for school-age children vary greatly based on hours needed.)				

1. 2022 ND Kids Count Fact Book
2. ChildCare Aware® of North Dakota WorkLife Systems Database
3. School-age care numbers reflect programs licensed exclusively as before and after school programs under Early Childhood Services rules. Not all school-age programs are required to be licensed. In addition, many school-age children are enrolled in family/group programs and child carecenters.
4. Vacancies change daily and may not match the location or program characteristics desired by families needing care. A 10% vacancy rate allows families some choice among programs.

Appendix D – NCHS CAH 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: 35

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
- Skilled nursing services
- Speech therapy
- Occupational therapy
- Physical therapy
- QSP/ Home Health Program

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

- Assisted living
- 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:	3
PAs:	1
RNs:	7
LPNs:	2
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

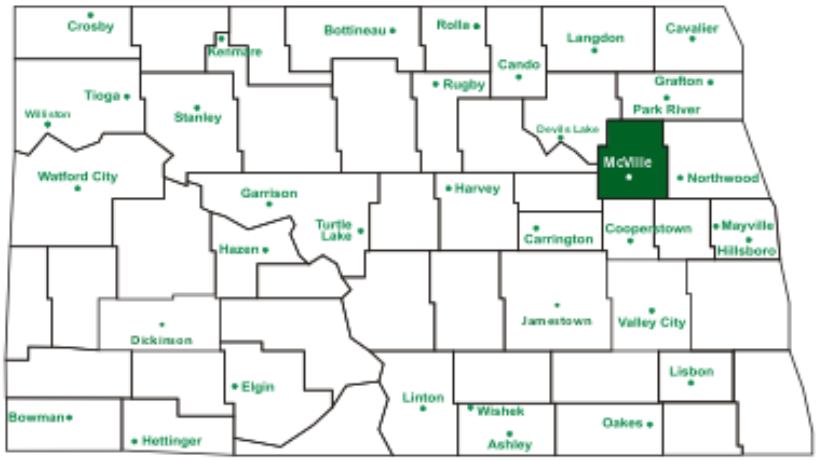
2 - Economic Impact 2020 Center for Rural Health Oklahoma State University and Center for Rural Health University of North Dakota

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 healthcare 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 10/2023

December 2020

Nelson County Health System

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.

Fact Sheet Author: Kylie Nissen, BBA

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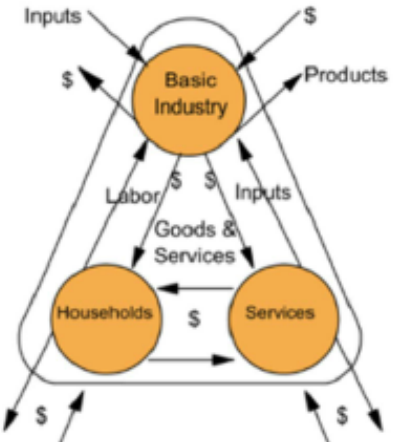
CENTER FOR RURAL HEALTH
OSU Center for Health Sciences

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

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

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 F - County Health Rankings Explained

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

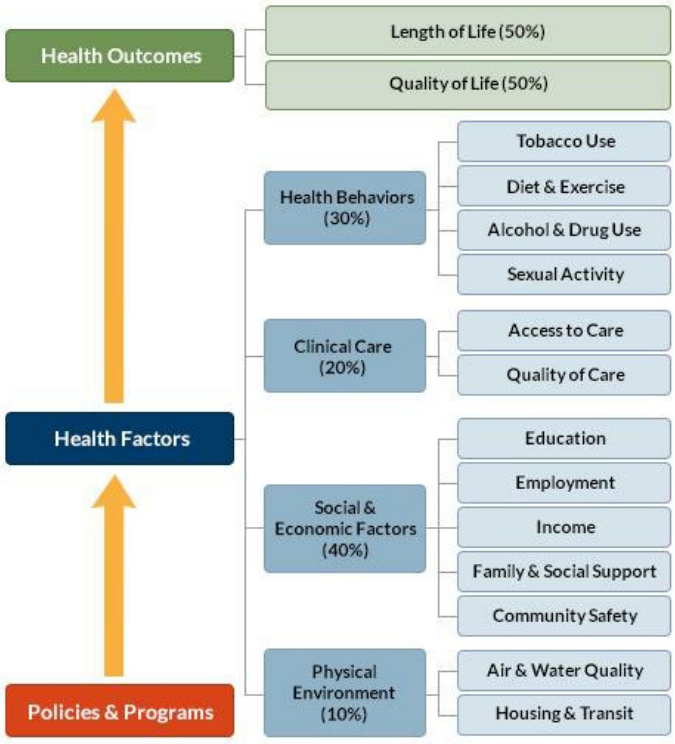
Methods

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

What is Ranked

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

Ranking System



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

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

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

Data Sources and Measures

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

Data Quality

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

Calculating Scores and Ranks

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

Health Outcomes and Factors

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

Health Outcomes

Premature Death (YPLL)

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

Reason for Ranking

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

Poor or Fair Health

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

Reason for Ranking

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

Poor Physical Health Days

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

Reason for Ranking

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

Poor Mental Health Days

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

Reason for Ranking

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

Low Birth Weight

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

Reason for Ranking

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

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

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

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

Health Factors

Adult Smoking

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

Reason for Ranking

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

Adult Obesity

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

Reason for Ranking

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

Food Environment Index

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

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

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

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

Reason for Ranking

There are many facets to a healthy food environment, such as the cost, distance, and availability of healthy food options. This measure includes access to healthy foods by considering the distance an

individual lives from a grocery store or supermarket. There is strong evidence that food deserts are correlated with high prevalence of overweight, obesity, and premature death. Supermarkets traditionally provide healthier options than convenience stores or smaller grocery stores.

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

Physical Inactivity

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

Reason for Ranking

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

Access to Exercise Opportunities

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

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

Reason for Ranking

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

Excessive Drinking

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

Reason for Ranking

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

Alcohol-Impaired Driving Deaths

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

Reason for Ranking

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

Sexually Transmitted Infection Rate

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

Reason for Ranking

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

Teen Births

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

Reason for Ranking

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

Uninsured

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

Reason for Ranking

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

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

Primary Care Physicians

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

Reason for Ranking

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

Dentists

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

Reason for Ranking

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

Mental Health Providers

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

Reason for Ranking

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

Preventable Hospital Stays

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

Reason for Ranking

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

Mammography Screening

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

Reason for Ranking

Evidence suggests that mammography screening reduces breast cancer mortality, especially among older women. A physician's recommendation or referral—and satisfaction with physicians—are major

factors facilitating breast cancer screening. The percent of women ages 40-69 receiving a mammogram is a widely endorsed quality of care measure.

Flu Vaccinations

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

Reason for Ranking

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

Unemployment

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

Reason for Ranking

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

Children in Poverty

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

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

Reason for Ranking

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

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

Income Inequality

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

Reason for Ranking

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

Children in Single-Parent Households

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

Reason for Ranking

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

Violent Crime Rate

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

Reason for Ranking

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

Injury Deaths

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

Reason for Ranking

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

Air Pollution-Particulate Matter

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

Reason for Ranking

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

Drinking Water Violations

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

Reason for Ranking

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

Severe Housing Problems

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

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

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

Reason for Ranking

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

Appendix G – North Dakota KIDS COUNT

View State Profile

Select a county on the map below:

Light blue shading shows the five American Indian reservations within North Dakota

North Dakota County Profiles

Nelson County

Population Estimates for: 2022	Nelson	North Dakota
Child Population (under 18):	605	182,775
American Indian/Alaska Native:	4.4%	8.0%
Black:	0.6%	4.9%
White:	91.0%	79.9%
2+ Races or Other:	4.0%	7.3%

Health & Wellness

Children Without Health Insurance	Children Enrolled in Medicaid or CHIP	Women Who Receive Early Prenatal Care
10.2%	224	89.3%
2021	2022	2022
8.5% 2020	197 2021	87.0% 2021

Early Childhood

Children Under Age 6	Child Care Providers	Child Care Capacity
167	5	152
2022	2023	2023
174 2021	6 2022	163 2022

Education

Free or Reduced-Price Lunch Participation	Four-Year Cohort Graduation Rate	3rd Grade Students Proficient in Reading
29.4%	>90%	59.4%
2022/23	2021/22	2021/22
	88.0% 2020/21	41.9% 2020/21

Family Economic Security

Children Living in Poverty	Child Food Insecurity	Children with All Parents Working
11.7%	9.0%	76.6%
2022	2021	2018-2022
10.3% 2021	12.0% 2020	81.9% 2017-2021

KIDS COUNT NORTH DAKOTA

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For more information on this data or North Dakota KIDS COUNT, contact ndkidscount@gmail.com or visit ndkidscount.org

Appendix H – 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
Percentage of students who seriously considered attempting suicide (during the 12 months before the survey)	16.2	16.7	18.8	=	18.6	19.7	18.8
	ND 2015	ND 2017	ND 2019	ND Trend ↑, ↓, =	Rural ND Town Average	Urban ND Town Average	National Average 2019
Percentage of students who made a plan about how they would attempt suicide (during the 12 months before the survey)	13.5	14.5	15.3	=	16.3	16.0	15.7
Percentage of students who attempted suicide (one or more times during the 12 months before the survey)	9.4	13.5	13.0	=	12.5	11.7	8.9
Tobacco Use							
Percentage of students who ever tried cigarette smoking (even one or two puffs)	35.1	30.5	29.3	=	32.4	23.8	24.1
Percentage of students who smoked a whole cigarette before age 13 years (even one or two puffs)	NA	11.2	NA	**NA**	NA	NA	NA
Percentage of students who currently smoked cigarettes (on at least one day during the 30 days before the survey)	11.7	12.6	8.3	↓	10.9	7.3	6.0
Percentage of students who currently frequently smoked cigarettes (on 20 or more days during the 30 days before the survey)	4.3	3.8	2.1	↓	2.3	1.7	1.3
Percentage of students who currently smoked cigarettes daily (on all 30 days during the 30 days before the survey)	3.2	3.0	1.4	↓	1.6	1.2	1.1
Percentage of students who usually obtained their own cigarettes by buying them in a store or gas station (during the 30 days before the survey among students who currently smoked cigarettes and who were aged <18 years)	NA	7.5	13.2	=	9.4	10.1	8.1
Percentage of students who tried to quit smoking cigarettes (among students who currently smoked cigarettes during the 12 months before the survey)	NA	50.3	54.0	=	52.8	51.4	NA
Percentage of students who currently use an electronic vapor product (e-cigarettes, vape e-cigars, e-pipes, vape pipes, vaping pens, e-hookahs, and hookah pens at least one day during the 30 days before the survey)	22.3	20.6	33.1	↑	32.2	31.9	32.7
Percentage of students who currently used smokeless tobacco (chewing tobacco, snuff, or dip on at least one day during the 30 days before the survey)	NA	8.0	4.5	↓	5.7	3.8	3.8
Percentage of students who currently smoked cigars (cigars, cigarillos, or little cigars on at least one day during the 30 days before the survey)	9.2	8.2	5.2	↓	6.3	4.3	5.7
Percentage of students who currently used cigarettes, cigars, or smokeless tobacco (on at least 1 day during the 30 days before the survey)	NA	18.1	12.2	NA	15.1	10.9	10.5
Alcohol and Other Drug Use							
Percentage of students who ever drank alcohol (at least one drink of alcohol on at least one day during their life)	62.1	59.2	56.6	=	60.6	54.0	NA
Percentage of students who drank alcohol before age 13 years (for the first time other than a few sips)	12.4	14.5	12.9	=	16.4	13.2	15.0
Percentage of students who currently drank alcohol (at least one drink of alcohol on at least one day during the 30 days before the survey)	30.8	29.1	27.6	=	29.4	25.4	29.2
Percentage of students who currently were binge drinking (four or more drinks of alcohol in a row for female students, five or more for	NA	16.4	15.6	=	17.2	14.0	13.7

male students within a couple of hours on at least one day during the 30 days before the survey)							
Percentage of students who usually obtained the alcohol they drank by someone giving it to them (among students who currently drank alcohol)	41.3	37.7	NA	**NA**	NA	NA	40.5
Percentage of students who tried marijuana before age 13 years (for the first time)	5.3	5.6	5.0	=	5.5	5.1	5.6
Percentage of students who currently used marijuana (one or more times during the 30 days before the survey)	15.2	15.5	12.5	=	11.4	14.1	21.7
	ND 2013	ND 2017	ND 2019	ND Trend ↑, ↓, =	Rural ND Town Average	Urban ND Town Average	National Average 2019
Percentage of students who ever took prescription pain medicine without a doctor's prescription or differently than how a doctor told them to use it (counting drugs such as codeine, Vicodin, OxyContin, Hydrocodone, and Percocet, one or more times during their life)	NA	14.4	14.5	=	12.8	13.3	14.3
Percentage of students who were offered, sold, or given an illegal drug on school property (during the 12 months before the survey)	18.2	12.1	NA	NA	NA	NA	21.8
Percentage of students who attended school under the influence of alcohol or other drugs (on at least one day during the 30 days before the survey)	NA	NA	NA	NA	NA	NA	NA
Sexual Behaviors							
Percentage of students who ever had sexual intercourse	38.9	36.6	38.3	=	35.4	36.1	38.4
Percentage of students who had sexual intercourse before age 13 years (for the first time)	2.6	2.8	NA	NA	NA	NA	3.0
Weight Management and Dietary Behaviors							
Percentage of students who were overweight (>= 85th percentile but <95th percentile for body mass index, based on sex and age-specific reference data from the 2000 CDC growth chart)	14.7	16.1	16.5	=	16.6	15.6	16.1
Percentage of students who had obesity (>= 95th percentile for body mass index, based on sex- and age-specific reference data from the 2000 CDC growth chart)	13.9	14.9	14.0	=	17.4	14.0	15.5
Percentage of students who described themselves as slightly or very overweight	32.2	31.4	32.6	=	35.7	33.0	32.4
Percentage of students who were trying to lose weight	NA	44.5	44.7	=	46.8	45.5	NA
Percentage of students who did not eat fruit or drink 100% fruit juices (during the seven days before the survey)	3.9	4.9	6.1	=	5.8	5.3	6.3
Percentage of students who ate fruit or drank 100% fruit juices one or more times per day (during the seven days before the survey)	NA	61.2	54.1	↓	54.1	57.2	NA
Percentage of students who did not eat vegetables (green salad, potatoes [excluding French fries, fried potatoes, or potato chips], carrots, or other vegetables, during the seven days before the survey)	4.7	5.1	6.6	=	5.3	6.6	7.9
Percentage of students who ate vegetables one or more times per day (green salad, potatoes [excluding French fries, fried potatoes, or potato chips], carrots, or other vegetables, during the seven days before the survey)	NA	60.9	57.1	↓	58.2	59.1	NA
Percentage of students who did not drink a can, bottle, or glass of soda or pop (such as Coke, Pepsi, or Sprite, not including diet soda or diet pop, during the seven days before the survey)	NA	28.8	28.1	=	26.4	30.5	NA
Percentage of students who drank a can, bottle, or glass of soda or pop one or more times per day (not including diet soda or diet pop, during the seven days before the survey)	18.7	16.3	15.9	=	17.4	15.1	15.1

Percentage of students who did not drink milk (during the seven days before the survey)	13.9	14.9	20.5	↑	14.8	20.3	30.6
Percentage of students who drank two or more glasses per day of milk (during the seven days before the survey)	NA	33.9	NA	NA	NA	NA	NA
Percentage of students who did not eat breakfast (during the 7 days before the survey)	11.9	13.5	14.4	=	13.3	14.1	16.7
Percentage of students who most of the time or always went hungry because there was not enough food in their home (during the 30 days before the survey)	NA	2.7	2.8	=	2.1	2.9	NA
Physical Activity							
Percentage of students who were physically active at least 60 minutes per day on 5 or more days (doing any kind of physical activity that increased their heart rate and made them breathe hard some of the time during the 7 days before the survey)	NA	51.5	49.0	=	55.0	22.6	55.9
	ND 2015	ND 2017	ND 2019	ND Trend ↑, ↓, =	Rural ND Town Average	Urban ND Town Average	National Average 2019
Percentage of students who watched television three or more hours per day (on an average school day)	18.9	18.8	18.8	=	18.3	18.2	19.8
Percentage of students who played video or computer games or used a computer three or more hours per day (counting time spent on things such as Xbox, PlayStation, an iPad or other tablet, a smartphone, texting, YouTube, Instagram, Facebook, or other social media, for something that was not school work on an average school day)	38.6	43.9	45.3	=	48.3	45.9	46.1
Other							
Percentage of students who had eight or more hours of sleep (on an average school night)	NA	31.8	29.5	=	31.8	33.1	NA
Percentage of students who brushed their teeth on seven days (during the 7 days before the survey)	NA	69.1	66.8	=	63.0	68.2	NA
Percentage of students who most of the time or always wear sunscreen (with an SPF of 15 or higher when they are outside for more than one hour on a sunny day)	NA	12.8	NA	NA	NA	NA	NA
Percentage of students who used an indoor tanning device (such as a sunlamp, sunbed, or tanning booth [not including getting a spray-on tan] one or more times during the 12 months before the survey)	NA	8.3	7.0	=	6.0	5.9	4.5

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

Appendix I – Nelson County Health System Prioritization

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 blue dots placed on the concerns indicating which areas are felt to be priorities. Each person was given four dots to place on the items they felt were priorities. The "Most Important" column lists the number of red dots placed on the flipcharts. After the first round of voting, the top five priorities were selected based on the highest number of votes. Each person was given one dot to place on the item they felt was the most important priority of the top five highest ranked priorities.

	Priorities	Most Important
COMMUNITY/ENVIRONMENTAL HEALTH CONCERNS		
Attracting and retaining young families	4	1
Not enough jobs with livable wages	0	
Not enough affordable housing	6	3
Changes in population size	0	
AVAILABILITY/DELIVERY OF HEALTH SERVICES CONCERNS		
Ability to recruit/retain primary care providers (MD, DO, NP, PA) and nurses	7	6
Not enough healthcare staff in general	2	
Availability of mental health services	2	
Availability of dental care	0	
Availability of specialists	0	
Cost of health insurance	0	
YOUTH POPULATION HEALTH CONCERNS		
Smoking and tobacco use, exposure to second-hand smoke, vaping	7	0
ADULT POPULATION HEALTH CONCERNS		
Not getting enough exercise/physical activity	0	
SENIOR POPULATION HEALTH CONCERNS		
Cost of long-term/nursing home care	2	
Availability of resources to help elderly stay in their homes	2	
Dementia/Alzheimer's disease	1	
Availability of transportation for seniors	2	
Ability to meet the needs of the older population	0	
ALL AGES		
Alcohol use and abuse*	0	
Depression/anxiety*	3	
Drug use and abuse, including prescription drugs*	0	
VIOLENCE		
Bullying/Cyber-bullying	2	