Community Health Needs Assessment

Towner County Medical Center
Cando, North Dakota

2022

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Executive Summary

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

To gather feedback from the community, residents of the area were given the opportunity to participate in a survey. One hundred nineteen TCMC service area residents completed the survey. Additional information was collected through four key informant interviews with community members. The input from the residents, who primarily reside in Towner County, represented the broad interests of the communities in the service area. Together with secondary data gathered from a wide range of sources, the survey presents a snapshot of the health needs and concerns in the community.

With regard to demographics, Towner County's population from 2020 to 2021 decreased by 1%. The average number of residents younger than age 18 (21.7%) for Towner County comes in 1.9 percentage points lower than the North Dakota average (23.6%). The percentage of residents ages 65 and older is almost 10% higher for Towner County (25.3%) than the North Dakota average (15.7%), and the rate of education for Towner County (89.1%) is slightly lower than the North Dakota average (93.1%). The median household income in Towner County ($49,464) is much lower than the median household income for North Dakota ($65,315).

Data compiled by County Health Rankings show Towner County is doing better than North Dakota in health outcomes/factors for 12 categories and performing poorly relative to the rest of the state in 14 outcome/factor categories.

Of 106 potential community and health needs set forth in the survey, the 119 TCMC service area residents who completed the survey indicated the following ten needs as the most important:

- Alcohol use and abuse – youth and adult
- Assisted living options
- Attracting and retaining young families
- Availability of resources to help the elderly stay in their homes
- Bullying/cyberbullying
- Child abuse/neglect
- Cost of long-term/nursing home care
- Depression/anxiety – youth and adult
- Having enough child daycare services
- Not getting enough exercise/physical activity – adult

The survey also revealed the biggest barriers to receiving healthcare (as perceived by community members). They included concerns about confidentiality (N=25), not affordable (N=24), and not enough evening or weekend hours (N=20).

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

- Family-friendly
- Healthcare
- People are friendly, helpful, supportive
- People who live here are involved in their community
- Quality school systems
- Safe place to live, little/no crime

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

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

Overview and Community Resources

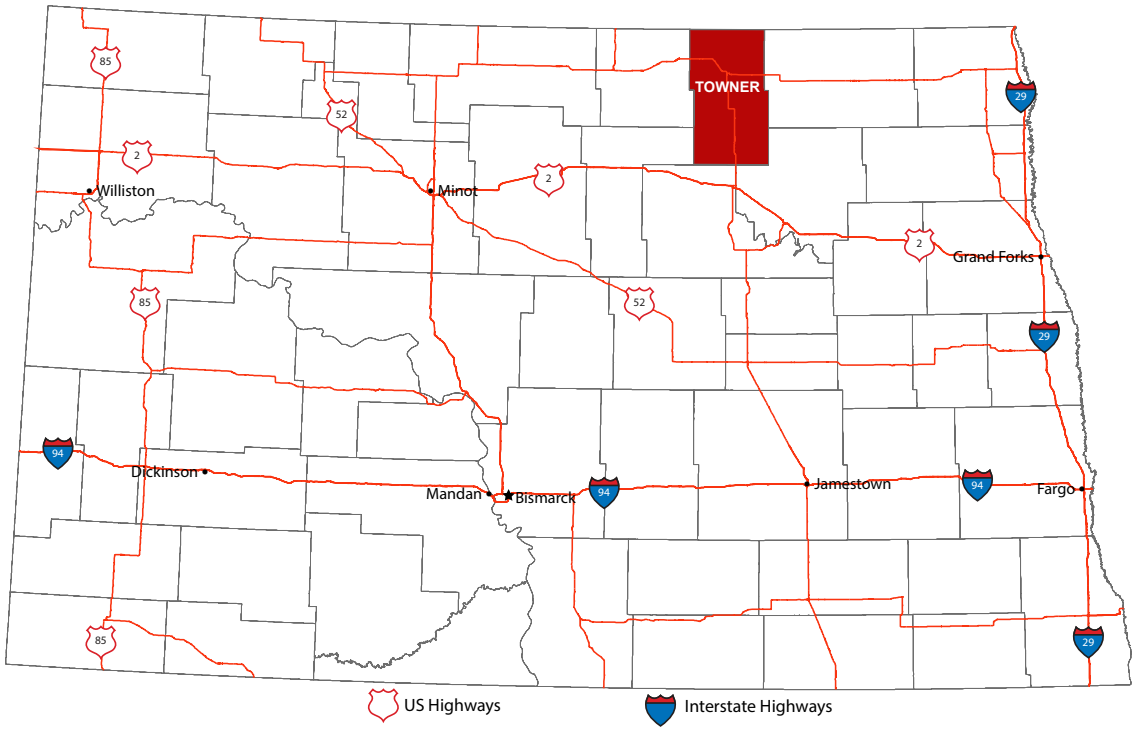
With assistance from the Center for Rural Health (CRH) at the University of North Dakota (UND) School of Medicine & Health Sciences (SMHS), Towner County Medical Center (TCMC) and Towner County Public Health District completed a Community Health Needs Assessment (CHNA) of the TCMC service area. The hospital identifies its service area as a 60-mile radius surrounding Cando. Many community members and stakeholders worked together on the assessment.

Cando, located in northeastern North Dakota, is the county seat of the largest durum wheat-producing county in the world. Access to major cities is within reasonable driving distance of Cando. Winnipeg, Manitoba, is less than three hours away, while access to major shopping and medical facilities in North Dakota is within 40 miles. The Cando public school system prepares students for vocational and post-secondary training.

Numerous recreational activities are available for residents of Cando with its city parks, participatory and observational sports, athletic fields, a swimming pool, and nine-hole golf course. Its city parks include facilities for tennis, baseball, volleyball, basketball, and horseshoes. The Cando All Seasons Arena offers skating and hockey. Some of the state's best fishing may be found within 40 miles, and the area is abundant with waterfowl, geese, and deer.

Healthcare facilities and services in the area (Benson, Ramsey, and Towner counties) include the following: basic care facilities in Cando – five-bed basic care facility, Devils Lake – 43-bed, 13-bed, and seven-bed basic care facilities, Edmore – 15-bed basic care facility, and Maddock – 21-bed basic care facility; nursing homes in Cando – 26-bed nursing home and Devils Lake – 82-bed and 48-bed nursing homes; rural health clinics in Cando and Maddock; and pharmacies in Cando – one retail pharmacy in addition to the TCMC pharmacy, Devils Lake – three retail pharmacies in addition to the hospital and clinic pharmacies, and Maddock.

Figure 1: Towner County



Towner County Medical Center, TCMC

TCMC is a 20-bed, Critical Access Hospital (CAH) located in Cando, North Dakota. As a hospital and accredited Level V trauma center, TCMC provides comprehensive care for a wide range of medical and emergency situations. TCMC offers many services, including inpatient and outpatient treatment facility, retirement housing, and childcare. With approximately 130 employees, TCMC is one of the largest employers in the region.

The original Towner County Memorial Hospital was a 26-bed hospital built in 1952 with funds raised by the people of Towner County and the Order of the Sisters of St. Francis. The hospital nearly doubled in size in 1968 with an addition that included new patient rooms, an ambulance garage, an emergency room, a new laboratory, and a radiology room. In 1992, the ownership and direction of the hospital changed based on a community initiative, and physical changes to the facility were made in 1995 to ensure handicapped accessibility; also added were a new medical clinic, dental clinic, emergency room, a drive-through emergency garage, X-ray suite, physical therapy room, nursing station, laboratory, medical records area, and birthing room. In addition to the rural health clinic and the hospital, TCMC also includes senior independent living housing, basic care residential service, and skilled nursing residential service in Cando. Currently underway are plans to build a new hospital/clinic with the long-term care facility attached. Construction began in May 2022. The CAH Profile for TCMC includes a summary of hospital-specific information and is available in Appendix A.

TCMC has a significant economic impact on the region. They directly employ 95 FTE employees with an annual payroll of over $6.35 million (including benefits). These employees create an additional 36 jobs and nearly $1.5 million in income as they interact with other sectors of the local economy. This results in a total impact of 131 jobs

and more than $7.8 million in income. Additional information is provided in Appendix B.

Mission
TCMC defines its mission as follows:

TCMC provides: total quality comprehensive healthcare; caring and compassionate health services for patients, residents, families, and healthcare workers; medical care for all life stages delivered by a professional and expert healthcare team; and a commitment to our communities to maintain and ensure the ongoing provision of quality health services.

Services offered locally by TCMC include:

General and Acute Services

- Acne treatment
- Allergy shots
- Adult and child vaccinations
- Basic care facility (nursing home)
- Blood pressure checks
- Cardiology (visiting physician)
- Clinic
- COVID-19 testing
- Diabetes education
- Emergency room 24 hours per day
- Endocrine services (type I and II diabetes)
- Endoscopy (EGD, colonoscopy)
- Gynecology
- Hospital (acute care)
- Independent senior housing
- Iron infusions
- Joint injections
- Medicare wellness visits
- Medication Assisted Treatment (MAT)
- Mole/wart/skin lesion removal
- Negative wound pressure therapy
- Nutrition counseling
- Oncology/hematology/chemotherapy
- Ophthalmology evaluation and surgery services
- Orthopedics (visiting physician)
- Pharmacy
- Physicals: annuals, DOT, sports, and insurance
- Podiatry evaluation
- Skilled nursing facility (nursing home)
- Sports medicine
- Surgical services – biopsies
- Surgical services – outpatient
- Swing bed services
- Telemedicine
- Well child visits

Screening/Therapy Service

- Cardiac stress testing
- Chiropractic services
- Chronic disease management
- Colonoscopy screening
- Holter monitoring
- Laboratory services
- Lower extremity circulatory assessment
- Massage therapy
- Occupational physicals
- Occupational therapy
- Pediatric services
- Physical therapy
- Respiratory care
- Sleep studies
- Social services

Radiology Services

- CT scan
- Dexa bone density scans
- 3D mammography
- Echocardiograms
- EKG
- General X-ray
- Nuclear medicine (mobile unit)
- MRI (mobile unit)
- Ultrasound (mobile unit)

Laboratory Services

- Blood types
- Chemistry
- Clot times
- Hematology
- Specialty labs
- Urine testing

Towner County Public Health District

Towner County Public Health (TCPH) provides public health services that include environmental health, nursing services, the WIC (women, infants, and children) program, health screenings and education services. Each of these programs provides a wide variety of services in order 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, TCPH is committed to the promotion of healthy lifestyles, protection and enhancement of the environment, and provision of quality healthcare services for the people of North Dakota.

Mission
The mission of TCPH is, "Working together promoting healthy lifestyles and living well."

Vision
The vision at TCPH is, "Partner in education and disease prevention."

Specific services that TCPH provides are:

- Bicycle helmet safety education
- Blood pressure checks
- Breastfeeding resources
- Child health (well-baby checks)
- COVID-19 testing
- COVID-19 vaccines
- Diabetes screening
- Emergency preparedness services – work with community partners as part of local emergency response team
- Environmental health services (water, sewer, health hazard abatement)
- Flu shots
- Health Tracks (child health screening – located in Devils Lake)
- Immunizations
- Member of Child Protection Team and County Interagency Team
- Nutrition education
- Preschool education programs and screening
- School health – vision, hearing, scoliosis screenings in schools, health education and resource to the schools
- Tobacco prevention and control
- Tuberculosis testing and management
- West Nile program – surveillance and education
- WIC (women, infants and children) program
- Worksite wellness
- Youth education programs

Assessment Process

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

A CHNA benefits the community by:

1. Collecting timely input from the local community members, providers, and staff.
2. Providing an analysis of secondary data, related to health-related behaviors, conditions, risks, and outcomes.
3. Compiling and organizing information to guide decision making, education, and marketing efforts, and to facilitate the development of a strategic plan.
4. Engaging community members about the future of healthcare.
5. Allowing the community hospital to meet the federal regulatory requirements of the Affordable Care Act, which requires not-for-profit hospitals to complete a CHNA at least every three years as well as helping the local public health unit meet accreditation requirements.

This assessment examines health needs and concerns in primarily Towner County, as well as Benson and Ramsey counties, which are all included in the Towner County Medical Center (TCMC) service area. In addition to Cando, located in the service area are the communities of Bisbee, Devils Lake, Edmore, Esmond, Leeds, Maddock, Minnewaukan, Rocklake, and Starkweather.

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

Figure 2: Steering Committee

Ben Bucher	CEO, TCMC
Chantel Parker	DON, TCMC
Majusta Kleven	RN, TCPH
Lee Bjornstad	LSW, Towner County Living Center
Carey Lynn Tyndall	Administrative Assistant, TCMC

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

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

- A survey solicited feedback from area residents
- Community leaders, representing the broad interests of the community, took part in one-on-one key informant interviews
- The community group, comprised of community leaders and area residents, was convened to discuss area health needs and inform the assessment process
- A wide range of secondary sources of data were examined, providing information on a multitude of measures, including demographics, health conditions, indicators, outcomes, rates of preventive measures, rates of disease, and at-risk behavior

CRH is one of the nation's most experienced organizations committed to providing leadership in rural health. Its mission is to connect resources and knowledge to strengthen the health of people in rural communities. CRH is the designated State Office of Rural Health and administers the Medicare Rural Hospital Flexibility (Flex) program, funded by the Federal Office of Rural Health Policy, Health Resources Services Administration, and Department of Health and Human Services. CRH connects the University of North Dakota (UND) School of Medicine & Health Sciences (SMHS) and other necessary resources to rural communities and other healthcare organizations in order to maintain access to quality care for rural residents. In this capacity, CRH works at a national, state, and community level.

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

Community Group

A community group consisting of 21 community members was convened and first met on December 1, 2021. During this first community group meeting, group members were introduced to the needs assessment process, reviewed basic demographic information about the community, and served as a focus group. Focus group topics included community assets and challenges, the general health needs of the community, community concerns, and suggestions for improving the community's health.

The community group met again on February 16, 2022, with 15 community members in attendance. At this second meeting, the community group was presented with survey results, findings from key informant interviews and the focus group, and a wide range of secondary data relating to the general health of the population in Towner County. The group was then tasked with identifying and prioritizing the community's health needs.

Members of the community group represented the broad interests of the community served by TCMC and TCPH. They included representatives of the health community, business community, political bodies, law enforcement, education, faith community, and economic development agencies. Not all members of the group were present at both meetings.

Interviews

One-on-one interviews with four key informants were conducted in person in Cando on December 1, 2021. A representative from CRH conducted the interviews. Interviews were held with selected members of the community who could provide insights into the community's health needs. Included among the informants were public health professionals.

Topics covered during the interviews included the general health needs of the community, the general health of the community, community concerns, delivery of healthcare by local providers, awareness of health services offered locally, barriers to receiving health services, and suggestions for improving collaboration within the community.

Survey

A survey was distributed to solicit feedback from the community and was not intended to be a scientific or statistically valid sampling of the population. It was designed to be an additional tool for collecting qualitative data from the community at large – specifically, information, related to community-perceived health needs. A copy of the survey instrument is included in Appendix C, and a full listing of direct responses, provided for the questions that included "Other" as an option, are included in Appendix G.

The community member survey was distributed to various residents of McKenzie County, which includes the MCHS service area. The survey tool was designed to:

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

Specifically, the survey covered the following topics:

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

To promote awareness of the assessment process, press releases led to published articles in one newspaper in Towner County. Additionally, information was published in community flyers and TCMC's website and Facebook page.

Approximately 50 community member surveys were available for distribution in Towner County, which includes the communities of Bisbee, Perth, Maza, Rocklake, Egeland, and Hansboro. The surveys were distributed at TCMC and TCPH.

To help ensure anonymity, included with each survey was a postage-paid return envelope to CRH. In addition, to help make the survey as widely available as possible, residents also could request a survey by calling TCMC or TCPH. The survey period ran from November 3, 2021 to December 3, 2021. Sixteen completed paper surveys were returned.

Area residents were also given the option of completing an online version of the survey, which was publicized in one newspaper, emailed to healthcare staff and local businesses, and advertised on the websites and Facebook pages of both TCMC and TCPH. One hundred three online surveys were completed. Thirty-six of

those online respondents used the QR code to complete the survey. In total, counting both paper and online surveys, 119 community member surveys were completed, equating to a 13% response rate. This response rate is on par for this type of unsolicited survey methodology and indicates an engaged community.

Secondary Data

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

Social Determinants of Health

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

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

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

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

Figure 3: Social Determinants of Health

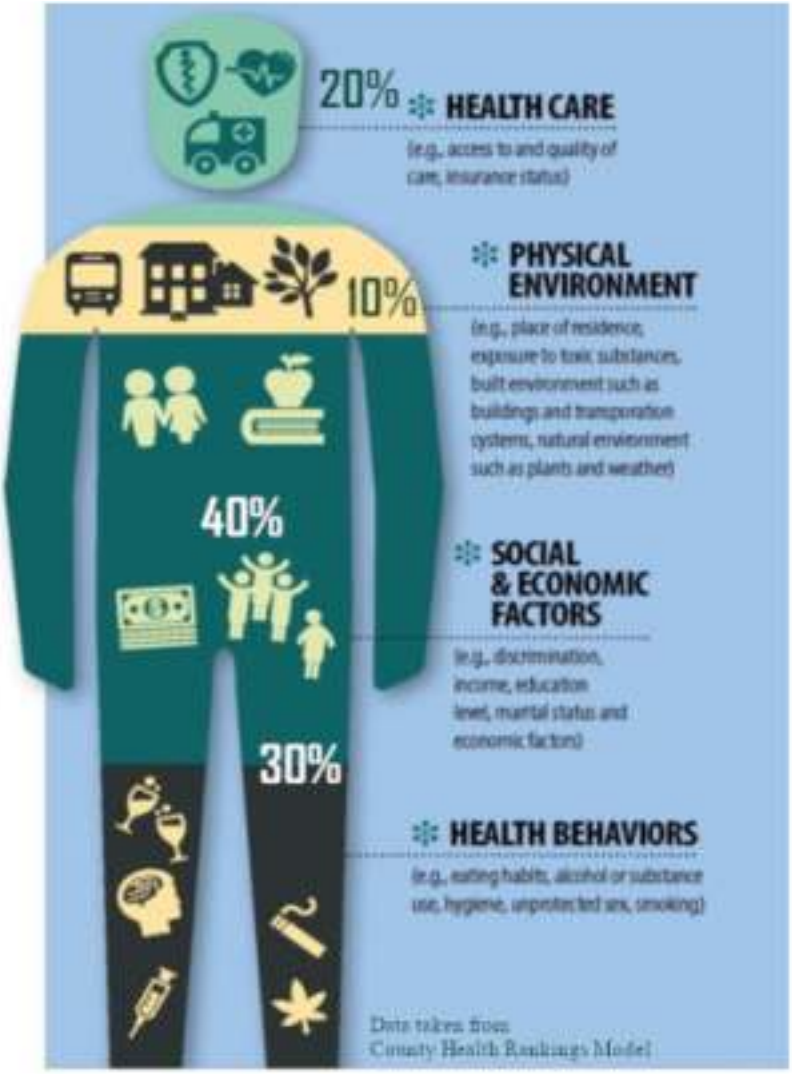


Figure 4 (Henry J. Kaiser Family Foundation, https://www.kff.org/disparities-policy/issue-brief/beyond-health-care-the-role-of-social-determinants-in-promoting-health-and-health-equity/), provides examples of factors that are included in each of the social determinants of health categories that lead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

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

Figure 4: Social Determinants of Health

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

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

KFF

Health Equity and COVID-19 Assessments for Towner County

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

On July 23, 2021, a focus group was held in Cando, North Dakota, to assess the COVID-19 perceptions and immunization needs of Towner County. The focus group was organized by Towner County Public Health (TCPH) and facilitated by the Center for Rural Health (CRH) at the University of North Dakota (UND) School of Medicine & Health Sciences (SMHS). This report contains the findings from the focus group as well as secondary data related to demographics, COVID-19, and immunization rates.

COVID-19 in Towner County

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

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

As of July 24, 2021, in North Dakota, 639,744 doses of the COVID-19 vaccine have been administered. In Towner County alone, 1,653 COVID-19 vaccine doses have been administered. Statewide, the one dose coverage rate for people ages 12 and over is 48.8%, 51.8% for ages 18 and older, and 76.0% for ages 65 and older. See Figure 2 for the Towner County breakdown by age of one dose coverage and fully vaccinated (up-to-date coverage). Towner County has a 51.0% for people ages 12 and older, 51.0% for ages 18 and older, and 69.6% for ages 65 and older. The Up-to-Date Coverage Rate is as of July 24, 2021.

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

There are two COVID-19 vaccine enrolled provider sites in Towner County and 419 total in North Dakota.

Immunization Rates for Towner County

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

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

Vaccine	Rate (in %) Towner County	Rate (in%) North Dakota
4:3:1:3:3:1:4 Series	71.43	60.99
DTap	80.00	66.84
Hepatitis A	71.43	59.54
Hepatitis B	88.57	82.24
Hib UTD	82.86	67.86
MMR	88.57	79.13
PCV	77.14	71.99
Polio	85.71	80.79
Varicella	88.57	79.09

The following chart (Figure 4) depicts immunization rates for Towner County during the 2021 first quarter for Towner County teens ages 14-17 years who received the specified number of doses of the selected vaccine by the end of the quarter.

Figure 4. Percent of Towner County Teens 14-17 Years of Age for 2021 Q1[3]

Vaccine	Rate (%)	Rate (%) North Dakota
HPV Female Start	73.21	74.56
HPV Female UTD	64.29	62.29
HPV Male Start	85.71	72.63
HPV Male UTD	64.29	58.90
MCV4 dose 1	93.10	88.60
MCV4 dose 2	72.09	60.65
Men B dose 1	46.51	46.29
Men B UTD	30.23	19.65
Td/Tdap	93.10	88.77
Varicella	89.66	89.61

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

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

Vaccine	Rate (%) Towner County	Rate (%) North Dakota
PCV13 after 65 years	58.03	59.91
PPSV23 after 65 years	51.42	52.95
Shingrix® dose 1 after 50 years	29.73	29.38
Shingrix® UTD after 50 years	25.05	22.77
Tdap after 19 years	69.70	70.76
Zostavax after 60 years	36.08	34.41

Focus Group Discussion

On July 23, 2021, a focus group was held in Cando, North Dakota to assess the COVID-19 perceptions and immunization needs of Towner County. Towner County Public Health(TCPH) invited members of the community with varying backgrounds and opinions to join in the focus group that was facilitated by CRH at the UND SMHS.

Present at the meeting were representatives from emergency response team, city government, long-term care, the hospital, clinic, local public health, area businesses, food pantry, and K-12 education.

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

At the beginning, Towner County had a higher rate of COVID-19 cases and death rate than some other North Dakota counties. There were a number of people that left the area. One participant stated that a lot of the low-income families left the area. Places were closed down and there was there was limited availability of places to work to earn an income. There are currently many openings for HUD and the local food pantry isn't seeing as many people come in as before the pandemic. Once the restrictions were lifted, some of the businesses were able to open. A participant noted that the businesses who were able to meet COVID-19 protocols, such as plexiglass and limited customers and social distancing, were able to remain open. The local Veterans services had protocols for COVID-19 in place before the county implemented them as a means to protect the clients. The county finally agreed to implement COVID protocols when the number of positive cases in the area started to increase. The community was able to get small grants for COVID-19- related items, such as disinfectants. The group agreed that the state and local government were slow to act but did great once they did.

The focus group agreed that the schools have done a great job throughout the pandemic. The school had to make many changes to ensure safety for students and staff. All persons in the school had to wear masks. Each desk had shields, during recess only one class was let out at a time, and they tried to keep students only with their own classmates to minimize exposure. A school affiliate stated that lunches were hard to coordinate, trying to ensure students stay with their own class. The school also implemented temperature checks when boarding the bus and once more before entering the school doors. The school also limited fan attendance at sporting events. The school only had to implement distance learning twice for brief periods. The school staff is small, so if five staff members were out because of either having COVID-19 or being a close contact, the school struggled with finding substitute teachers to fill-in for the COVID-19 positive teachers, and this led to the school briefly implementing distance learning. The substitute teachers were older, so they did not want to risk going into a setting where there were many people, despite precautions that had been put into place.

The group agreed that people's attitude towards COVID-19 was divided. One participant stated that people from Rocklake thought it was a hoax. That changed when three people from that community all died from COVID-19 within a week. Once people started dying, the community took it seriously. There are still some that have not changed their minds and do not believe it is real.

The area churches also ranged throughout the spectrum. Some didn't follow any of the guidelines that were recommended by the Centers for Disease Control and Prevention (CDC). A woman stated some congregations believed it was a hoax and more extreme thoughts were that they didn't need the vaccine because it was not God's will. Some churches did not mandate masking or social distancing during services. It was stated by one that they currently were not going to church because they are uncomfortable and do not feel it's safe. There were also churches that did take it seriously and switched to online services; others enforced masking and distancing when in the church.

When the vaccine became available, it was mostly the elderly who received the shot. There was a feeling that the older generation is more likely to get the shot because they remember when the polio vaccine came out. They trust the science behind the vaccine. Now, the community is split. The participants believe that people who have not gotten it more than likely won't unless something personally happens to them. One woman stated she has a friend whose husband became very sick and was in the hospital for over a month and still has lingering problems which he'll more than likely deal with for a long time. When she asked her friend why she hasn't gotten vaccinated yet, her friend responded that God will protect them. Another participant reported that they had one of the first cases in the area and was very ill for six weeks. People know the numbers are going up again as the variants make their way through communities. It was stated that the pandemic happening now is only those who are unvaccinated.

Reasons People in the Community Want to be Vaccinated

There are people that got the vaccine so they could see their parents, protect their kids (family) and friends, and protect their employees and clients. Others received it because they wanted to be able to travel. One participant stated they saw on the news that over 300 people were removed from airplanes because they refused to wear masks. Some noted that the Canadian border was supposed to open soon, and everyone will need to be vaccinated in order to cross. People have gotten the vaccine because they have other underlying health conditions. One of participants stated they work with children and interact with various people all day and felt it was their responsibility to get vaccinated. One participant had COVID-19 last year and only had minor symptoms. He said that if he got it again and gave to another staff member or a student's family member, and they didn't not fare as well as him, he would feel horrible.

Reasons People in the Community Do Not Want to be Vaccinated

Reasons people heard for not getting the vaccine included there being a microchip in the vaccine, COVID-19 is a hoax, it sterilizes people, and it is not God's plan. One participant detailed an interaction with a man that they encountered that wasn't wearing a mask. They asked why he did not have a mask on and replied that he was not a democrat so he wouldn't get COVID-19. Some people do not trust the government and certain news outlets, while others feel the vaccine is too new and didn't know what the long-term effects of the vaccine would do to them. Public healthcare workers were told by people that they had COVID-19 already and are now immune from getting it again. Teens and young adults feel that they are invincible and do not believe COVID-19 will affect them like it does the older generation. There is also misinformation being fed to the community via social media. One participant said they have friends who have not gotten any vaccines, whether for religious reasons or believe that vaccines cause autism.

Participants also reported that some worry about possible side effects from the vaccine, such as heart enlargement and blood clots. It was noted that all drugs have side effects, but it doesn't stop people from using them. Someone else mentioned they had a grandson and didn't feel comfortable about them receiving the vaccine. People feel they need to weigh out the options and decide what is best for their family.

Sources of COVID-19 Information

A main source for information, whether valid or not, is Facebook. Healthcare workers stated they had community members using specific stories to justify their positions; these stories weren't always first-hand experiences, but many were, instead, stories that they had "heard" from others. People also mentioned word-of-mouth from their friends and family, people they trust. Some participants stated they call public health and the medical center with questions regarding COVID-19. The North Dakota Department of Health website is also used to access the COVID-19 dashboard. There is a lot of misinformation being spread on social media platforms. When a school official first polled the school staff on who was getting vaccinated when able, there was about 20 that were not planning to vaccinate. After December 2020, 10 more people were added to that list. People began believing what they were reading online, and public health and other healthcare workers could not keep up with the sheer amount of misinformation being spewed at the community.

Barriers to Receiving the COVID-19 Vaccination

Participants stated there are no barriers in the community that would prevent someone from getting the vaccine and receiving it is very easy. Community members are offered rides and veterans are also able to get rides with the Veterans Administration. However, the ride services have not been utilized as many people are able to drive themselves or get a ride from friends and family.

Ways to Increase Confidence and Vaccination Rates

When asked about ways for public health to increase confidents and vaccination rates, the group said the local public health has done an amazing job with the resources available to them. Participants also stated those who want the vaccine, either already got it or know where they can get it. There is hope that with the new variants making their way through the nation, people will change their minds.

Participants mentioned the town could do drawings and offer some sort of coupon for people who do get vaccine. One of the tribal reservations in the state was offering $500 to their members if they got vaccinated, and in Ohio they were entering people into a drawing if they got vaccinated. Other ideas would be to mandate vaccinations in specific jobs. People may not support mandates and believe it is their right to refuse being vaccinated. Participants stated that nursing home staff not being required to get the vaccine could be an issue because COVID-19 could be brought into the facility from staff. However, the nursing home staff vaccination rate is quite high (over 70%); one of the highest in the state. Once outside of work, staff would go into the community and bring the virus back into the workplace. People worry about what mandatory vaccination would do to staffing issues that already exist. There was a feeling that mandates would not be a good option for healthcare workers because if people refused to get vaccinated then the facility would lose that employee and there just are not enough workers to fill those positions. The facilities, like many businesses, would have to shut down because they wouldn't have enough employees and the community cannot lose their healthcare services.

Participants agreed that they would like the state to be more open about disclosing where variants are in the state. One public health worker informed others that testing for variants is randomly selected, and not all samples are tested to see if they're a variant. Another person wished areas would get notified when variants have been identified in the area like silver alerts or other emergency-type notifications.

General Thoughts

There were comments regarding the upcoming school year. People hope teens are getting the vaccine before school starts because they don't want the school to close. One school official stated they could talk to parents and other stakeholders of the school about one topic, and they would completely trust him. Once he would mention COVID-19, they suddenly don't trust or believe what he is saying.

Demographic Information

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

	Towner County	North Dakota
Population (2021)	2,140	779,948
Population change (2020-2021)	-1.0%	-0.5%
People per square mile (2010)	2.2	9.7
Persons 65 years or older (2020)	25.3%	15.7%
Persons younger than 18 years (2020)	21.7%	23.6%
Median age (2020)	49.2	35.2
White persons (2020)	92.9%	86.9%
High school graduates (2020)	89.1%	93.1%
Bachelor's degree or higher (2020)	14.5%	30.7%
Live below poverty line (2020)	9.8%	10.2%
Persons without health insurance younger than 65 years (2019)	10.7%	8.1%
Households with a broadband internet subscription (2020)	66.1%	83.1%

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

The population of North Dakota has slightly decreased in recent years, and Towner County has also seen a decrease in population since 2020. The U.S. Census Bureau estimates show that Towner County's population decreased by 1%.

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

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

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

Table 2 summarizes the pertinent information gathered by County Health Rankings as it relates to Towner County. It is important to note that these statistics describe the population of a county, regardless of where county residents choose to receive their medical care. In other words, all of the following statistics are based on the health behaviors and conditions of the county's residents, not necessarily the patients and clients of Towner County Medical Center (TCMC) and Towner County Public Health (TCPH) or of any particular medical facility.

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

Health Outcomes

- Length of life
- Quality of life

Health Factors

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

Health Factors (continued)

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

Towner County rankings within the state are included in the summary following. For example, Towner County ranks 37th out of 46 ranked counties in North Dakota on health outcomes and 32nd out of 45 on health factors. The measures marked with a bullet point (•) are those where a county is not measuring up to the state rate/percentage; a square (■) indicates that the county is not meeting the U.S. Top 10% rate on that measure. Measures that are not marked with a colored shape but are marked with a plus sign (+) indicate that the county is doing better than the U.S. Top 10%.

The data from County Health Rankings shows that Towner County is doing better than many counties compared to the rest of the state on one of the outcomes, landing at or above the rate for other North Dakota counties. However, like many North Dakota counties, the county doing poor in many areas when it comes to the U.S. Top 10% ratings. One particular outcome where Towner County does not meet the U.S. Top 10% ratings is the number of poor physical health days in the past 30 days. On health factors, Towner County performs below the North Dakota average for counties in several areas as well.

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

- Poor mental health days
- Adult obesity
- Food environment index
- Excessive drinking
- Sexually transmitted infections
- Mental health providers
- Children in single-parent households
- Social associations
- Drinking water violations
- Severe housing problems

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

- Poor or fair health
- Poor physical health days
- Adult smoking
- Physical inactivity
- Access to exercise opportunities
- Alcohol-impaired driving deaths
- Uninsured
- Dentists
- Preventable hospital stays
- Mammography screening (% of Medicare enrollees ages 67-69 receiving screening)
- Flu vaccinations (% of fee-for-service Medicare enrollees receiving screening)
- Unemployment
- Children in poverty
- Injury deaths
- Air pollution – particulate matter

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

● = Not meeting North Dakota average

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

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

Blank values reflect unreliable or missing data

TABLE 2: SELECTED MEASURES FROM *COUNTY HEALTH RANKINGS* 2021 – TOWNER COUNTY			
	Towner County	U.S. Top 10%	North Dakota
Ranking: Outcomes	**37th**		**(of 46)**
Premature death		5,400	6,600
Poor or fair health	17% ●■	14%	14%
Poor physical health days (in past 30 days)	3.7 ●■	3.4	3.2
Poor mental health days (in past 30 days)	3.8 +	3.8	3.8
Low birth weight		6%	6%
Ranking: Factors	**32nd**		**(of 45)**
Health Behaviors			
Adult smoking	22% ●■	16%	20%
Adult obesity	30% ■	26%	34%
Food environment index (10=best)	8.9 +	8.7	8.9
Physical inactivity	35% ●■	19%	23%
Access to exercise opportunities	60% ●■	91%	74%
Excessive drinking	23% ■	15%	24%
Alcohol-impaired driving deaths	50% ●■	11%	42%
Sexually transmitted infections	266.3 ■	161.2	466.6
Teen birth rate		12	20
Clinical Care			
Uninsured	9% ●■	6%	8%
Primary care physicians		1,030:1	1,300:1
Dentists	2,190:0 ●■	1,210:1	1,510:1
Mental health providers	270:1 +	270:1	510:1
Preventable hospital stays	4,667 ●■	2,565	4,037
Mammography screening (% of Medicare enrollees ages 65-74 receiving screening)	45% ●■	51%	53%
Flu vaccinations (% of fee-for-service Medicare enrollees receiving vaccination)	20% ●■	55%	50%
Social and Economic Factors			
Unemployment	2.8% ●■	2.6%	2.4%
Children in poverty	16% ●■	10%	11%
Income inequality	3.8 ■	3.7	4.4
Children in single-parent households	9% +	14%	20%
Social associations	22.8 +	18.2	16.0
Violent crime		63	258
Injury deaths	125 ●■	59	71
Physical Environment			
Air pollution – particulate matter	5.1 +●	5.2	4.7
Drinking water violations	No		
Severe housing problems	6% +	9%	12%

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

Children's Health

The National Survey of Children's Health touches on multiple intersecting aspects of children's lives. Data are not available at the county level; listed below is information about children's health in North Dakota. The full survey includes physical and mental health status, access to quality healthcare, and information on the child's family, neighborhood, and social context. Data is from 2019-20.

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

TABLE 3: SELECTED MEASURES REGARDING CHILDREN'S HEALTH (For children ages 0-17 unless noted otherwise), 2020

Health Status	North Dakota	National
Children born premature (3 or more weeks early)	9.9%	11.2%
Children 10-17 overweight or obese	26.9%	32.1%
Children 0-5 who were ever breastfed	86.1%	80.8%
Children 6-17 who missed 11 or more days of school	2.9%	3.9%
Healthcare		
Children currently insured	93.6%	93.1%
Children who spent less than 10 minutes with the provider at a preventive medical visit	16.0%	18.1%
Children (1-17 years) who had preventive a dental visit in the past year	73.7%	77.5%
Children (3-17 years) received mental healthcare	10.5%	11.0%
Children (3-17 years) with problems requiring treatment did not receive mental healthcare	2.3%	2.5%
Young children (9-35 mos.) receiving standardized screening for developmental problems	31.1%	36.9%
Family Life		
Children whose families eat meals together 4 or more times per week	79.2%	75.2%
Children who live in households where someone smokes	16.1%	14.0%
Neighborhood		
Children who live in neighborhood with a park, sidewalks, a library, and a community center	81.1%	74.9%
Children living in neighborhoods with poorly kept or rundown housing	9.1%	13.3%

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

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

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

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

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

The data show Towner County is performing more poorly than the North Dakota average on two of the examined measures: child food insecurity and victims of child abuse and neglect requiring services. The most marked difference was on the measure of victims of child abuse and neglect requiring services (almost 1.7x higher rate in Towner County).

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

	Towner County	North Dakota
Child food insecurity, 2019	**10.4%**	9.6%
Medicaid recipient (% of population age 0-20), 2020	25.6%	26.1%
Children enrolled in Healthy Steps (% of population age 0-18), 2020	0.4%	2.1%
Supplemental Nutrition Assistance Program (SNAP) recipients (% of population age 0-18), 2020	14.7%	16.5%
Licensed childcare capacity (# of children), 2020	44	37,701
Four-year high school cohort graduation rate, 2020/2021	≥90%	89.0%
Victims of child abuse and neglect requiring services (rate per 1,000 children ages 0-17), 2020	**16.88 (2019)**	9.98

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

Another means for obtaining data on the youth population is through the Youth Risk Behavior Survey (YRBS). The YRBS was developed in 1990 by the Centers for Disease Control and Prevention (CDC) to monitor priority health risk behaviors that contribute markedly to the leading causes of death, disability, and social problems among youth and adults in the U.S. The YRBS was designed to monitor trends, compare state health risk behaviors to national health risk behaviors, and intended for use to plan, evaluate, and improve school and community programs. North Dakota began participating in the YRBS survey in 1995. Students in grades 7-8 and 9-12 are surveyed in the spring of odd years. The survey is voluntary and completely anonymous.

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

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

TABLE 5: Youth Risk Behavior Survey Results

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

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

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

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

Low Income Needs

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

Top Needs Identified by People Experiencing Poverty Across North Dakota

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

2020 North Dakota LOW INCOME COMMUNITY NEEDS

Helping People. Changing Lives. community Action PARTNERSHIP
AMERICA'S POVERTY FIGHTING NETWORK

NDSU NORTH DAKOTA STATE UNIVERSITY

Assessed by CAPND and NDSU, November 2020

KEY FINDINGS

1st Priority Need

Rental Assistance

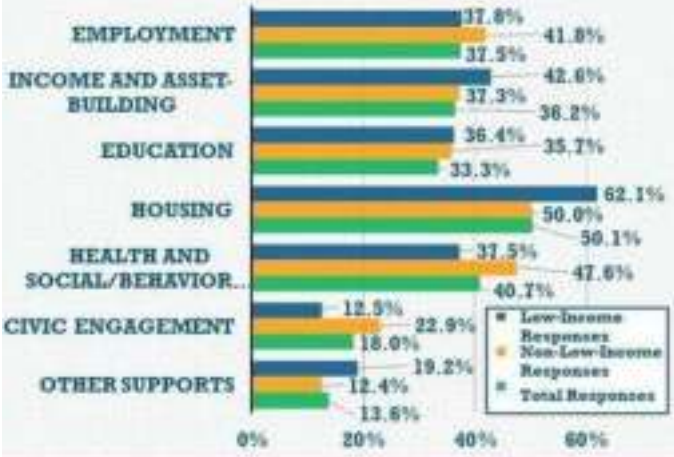
3,458 Total Survey Responses

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

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

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

STATEWIDE OVERALL NEEDS



TOP STATEWIDE SPECIFIC NEEDS

Low-Incomes

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

Non-Low-Incomes

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

Community (Low-Income & Non-Low-Income)

- **Health and Social/Behavior Development** - Dental Insurance/Affordable Dental
- **Health and Social/Behavior Development** - Health Insurance/Affordable Health Care
- **Health and Social/Behavior Development** - Mental Health Service

TOP REGIONAL OVERALL NEEDS FOR LOW-INCOMES

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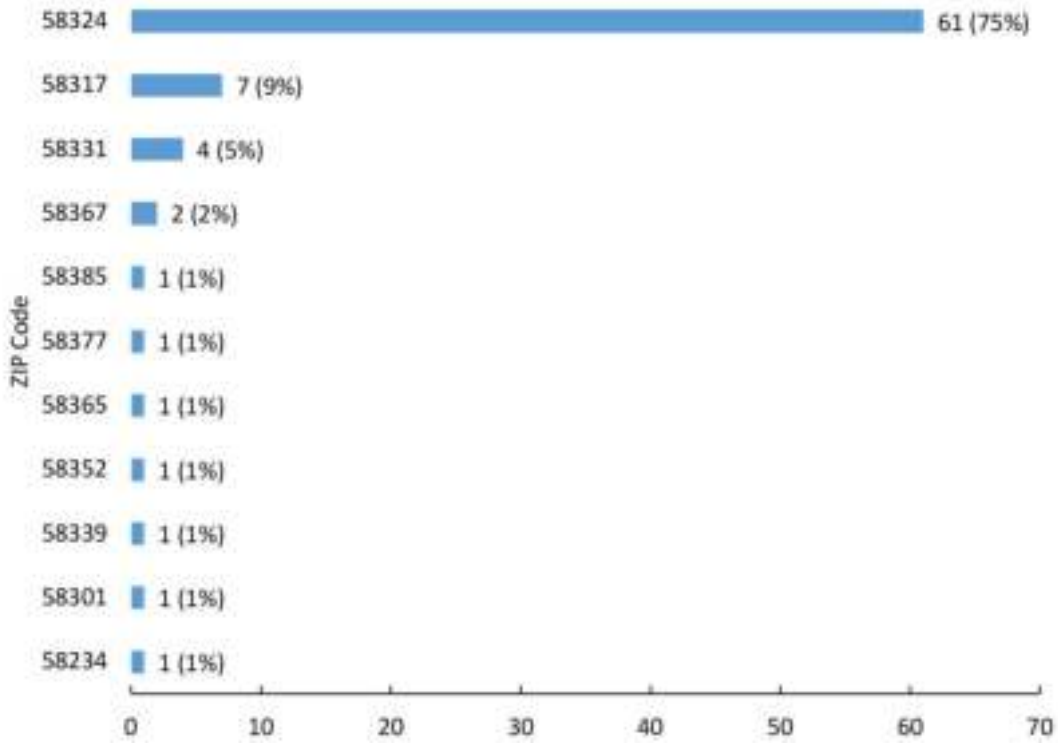
https://www.capnd.org/

Survey Results

As noted previously, 119 community members completed the survey in communities throughout the counties in the Towner County Medical Center (TCMC) service area. For all questions that contained an "Other" response, all of those direct responses may be found in Appendix G. In some cases, a summary of those comments is additionally included in the report narrative. The "Total respondents" number under each heading indicates the number of people who responded to that particular question and the "Total responses" number under the heading depicts the number of responses selected for that question (some questions allow for selection of more than one response).

The survey requested that respondents list their home ZIP code. While not all respondents provided a ZIP code, 90 did, revealing that a large majority of respondents (75%, N=61) lived in Cando. These results are shown in Figure 5.

Figure 5: Survey Respondents' Home ZIP Code
Total respondents: 90



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

Survey Demographics

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

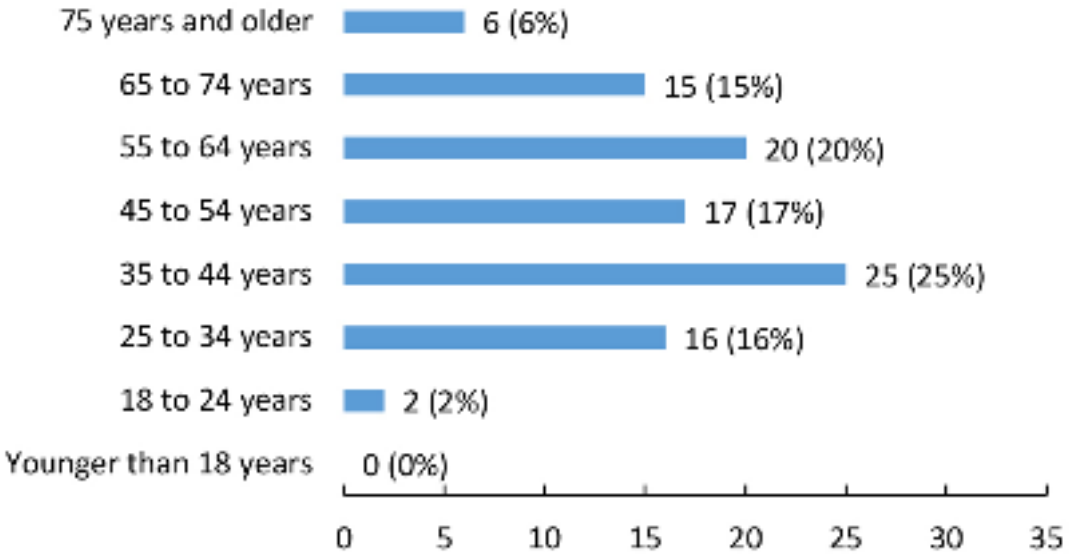
With respect to demographics of those who chose to complete the survey:

- 41% (N=41) were age 55 or older
- The majority (72%, N=70) were female
- Slightly less than half of the respondents (44%, N=44) had bachelor's degrees or higher

- The number of those working full time (70%, N=69) was five times higher than those who were retired (14%, N=14)
- 98% (N=95) of those who reported their ethnicity/race were White/Caucasian
- 20% of the population (N=18) had household incomes of less than $50,000

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

Figure 6: Age of Survey Respondents
Total respondents = 101



Using this survey method, people younger than age 18 are not questioned.

Figure 7: Gender of Survey Respondents
Total respondents = 97

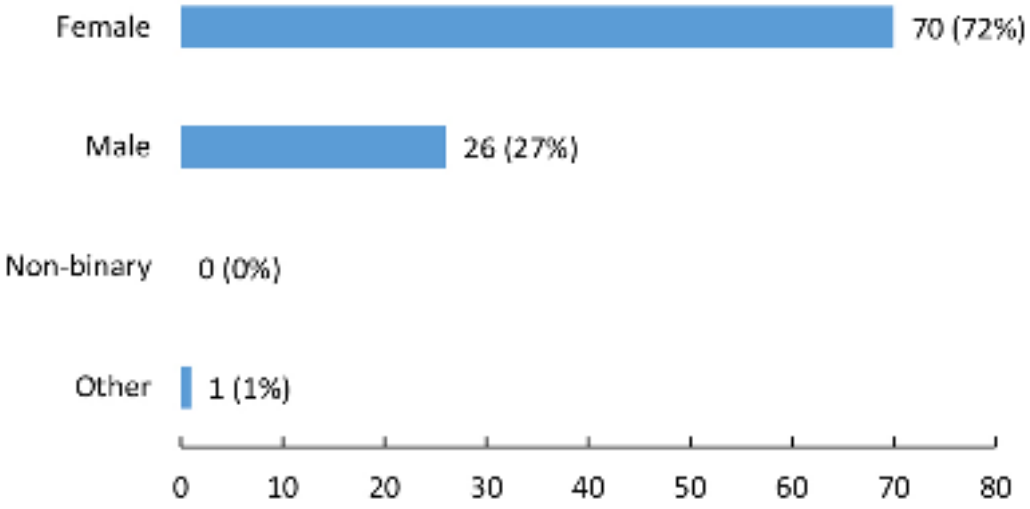


Figure 8: Educational Level of Survey Respondents
Total respondents = 99

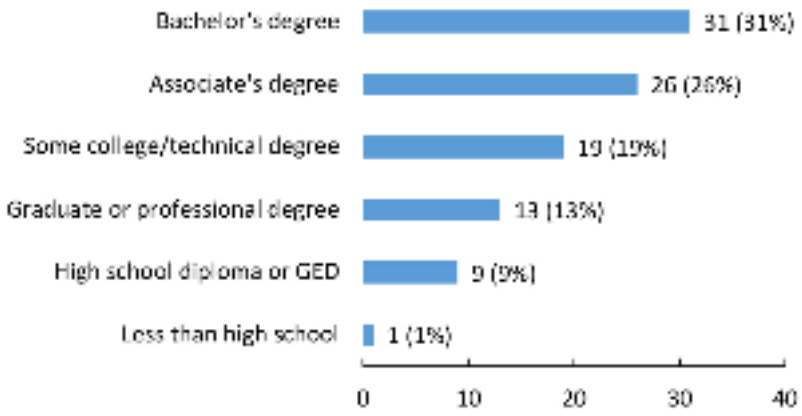
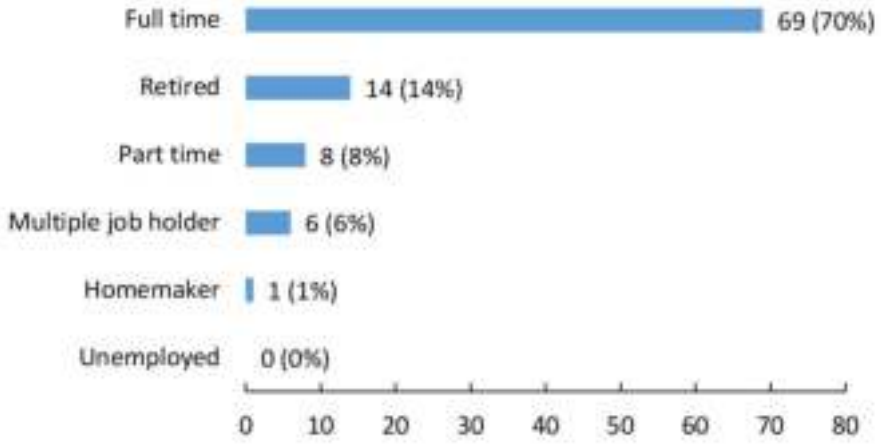
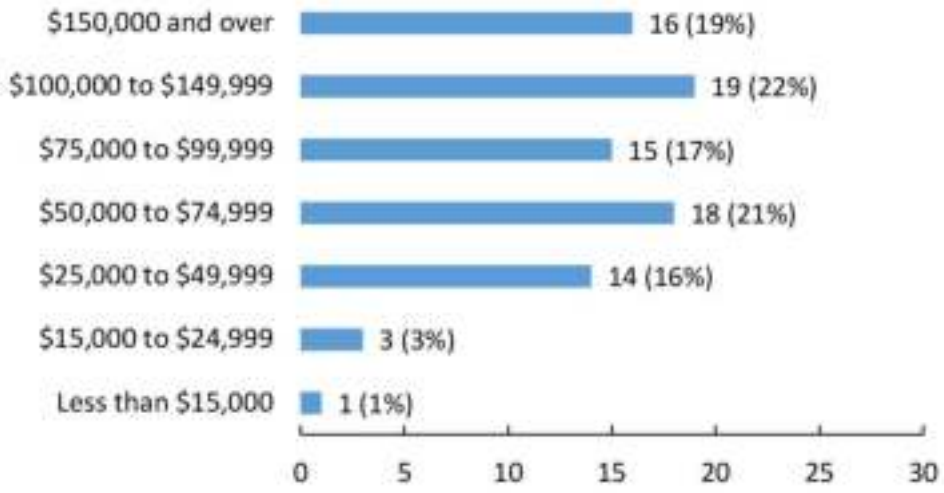


Figure 9: Employment Status Demographics of Survey Respondents
Total respondents = 98



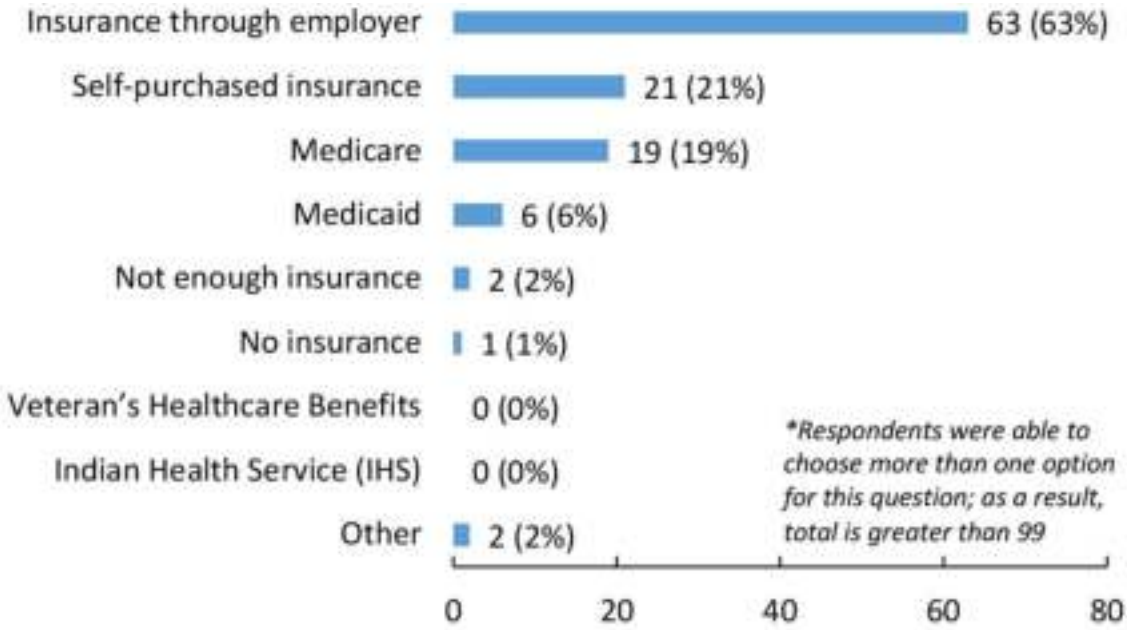
Of those who provided a household income, 4% (N=4) community members reported a household income of less than $25,000. Forty-one percent (N=35) indicated a household income of $100,000 or more. This information is show in Figure 10.

Figure 10: Household Income Demographics of Survey Respondents
Total respondents = 86



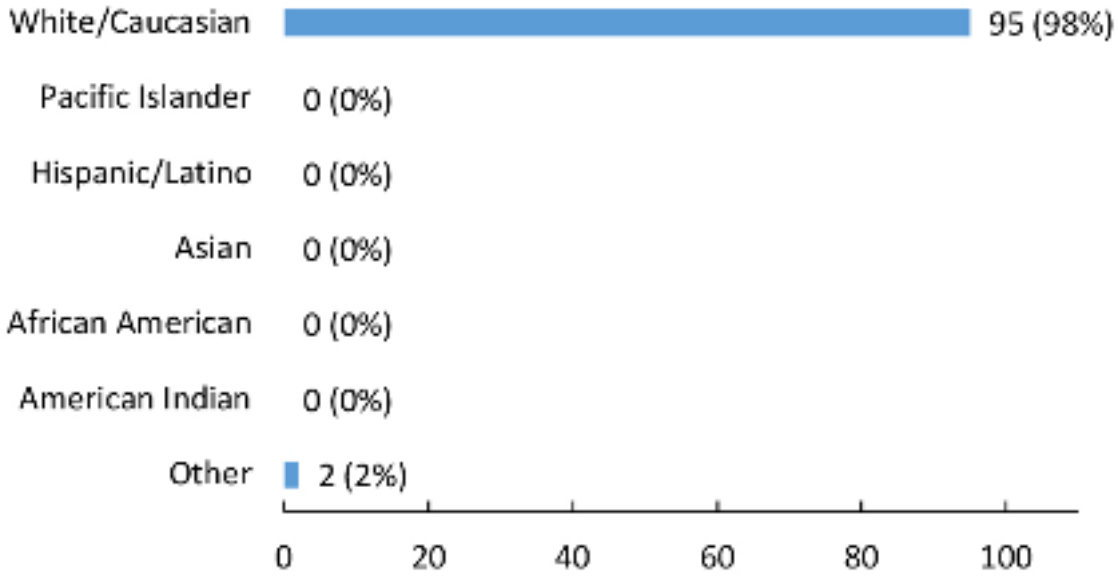
Community members were asked about their health insurance status, which is often associated with whether people have access to healthcare. Three percent (N=3) of the respondents reported having no health insurance or being under-insured. The most common insurance types were insurance through one's employer (N=63), followed by self-purchased (N=21) and Medicare (N=19).

Figure 11: Health Insurance Coverage Status of Survey Respondents
Total respondents = 99*



As shown in Figure 12, nearly all of the respondents were White/Caucasian (98%). This was slightly higher than the race/ethnicity of the overall population of Towner County; the U.S. Census indicates that 92.9% of the population is White in Towner County.

Figure 12: Race/Ethnicity Demographics of Survey Respondents
Total respondents = 97



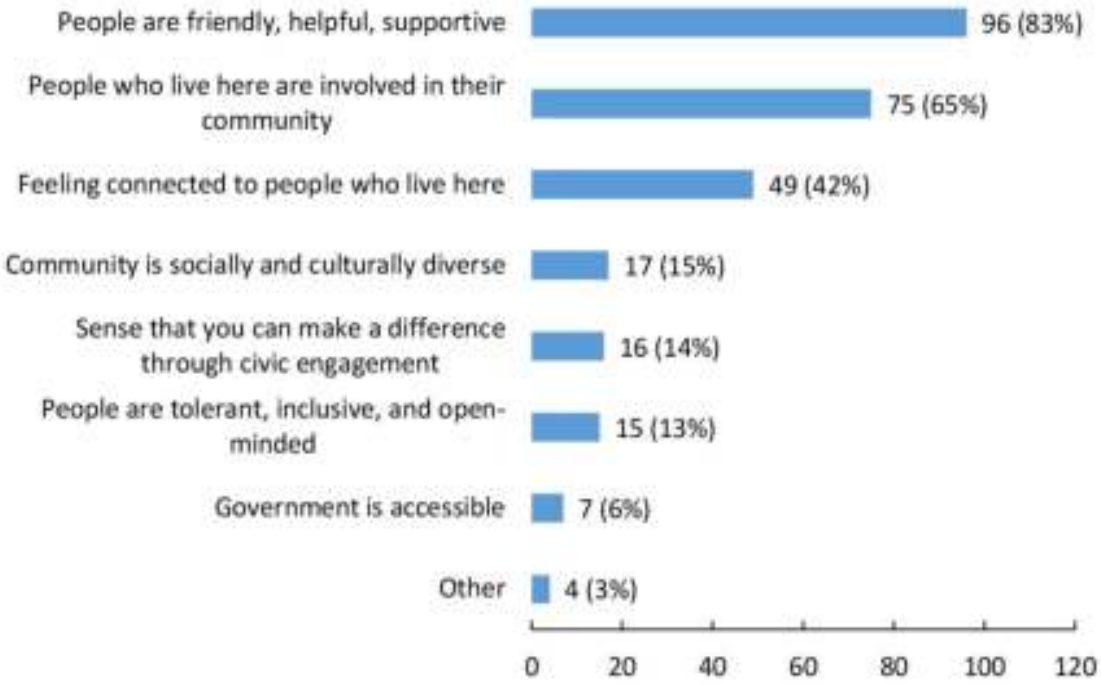
Community Assets and Challenges

Survey-respondents were asked what they perceived as the best things about their community in four categories: people, services and resources, quality of life, and activities. In each category, respondents were given a list of choices and asked to pick the three best things. Respondents occasionally chose less than three or more than three choices within each category. If more than three choices were selected, their responses were not included. The results indicate there is consensus (with at least 74 respondents agreeing) that community assets include:

- Safe place to live, little/no crime (N=97)
- People are friendly, helpful, supportive (N=96)
- Family-friendly (N=92)
- Healthcare (N=88)
- People who live here are involved in their community (N=75)
- Quality school systems (N=74)

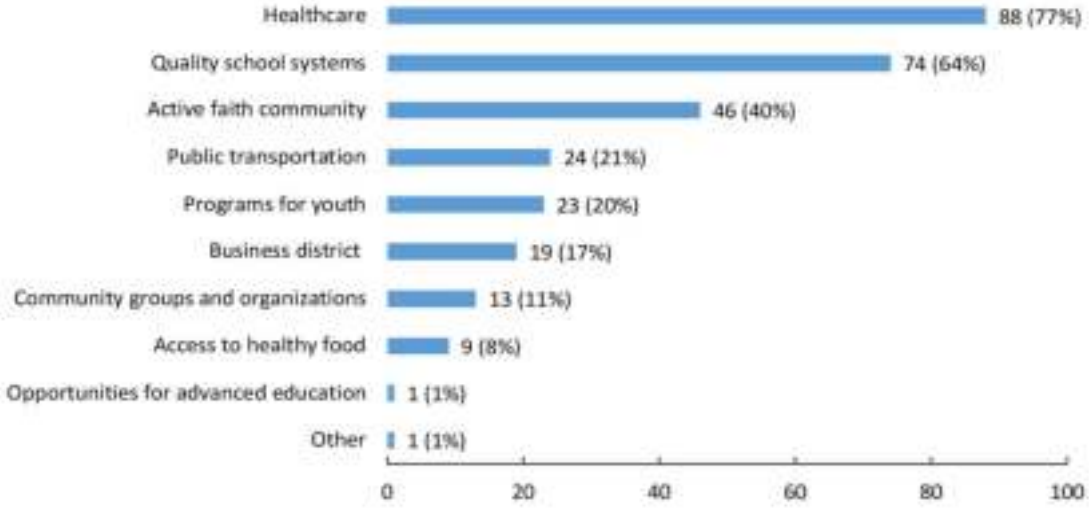
Figures 13 to 16 illustrate the results of these questions.

Figure 13: Best Things About the PEOPLE in Your Community
Total responses = 279



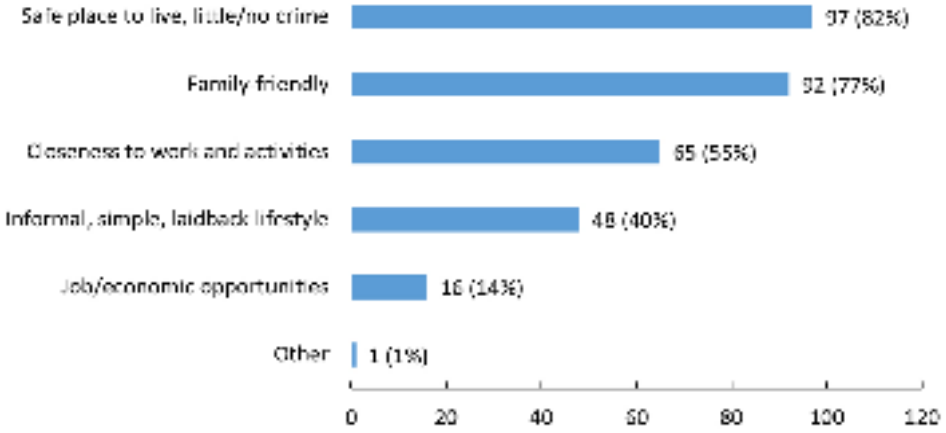
Included in the "Other" category of the best things about the people was that church is available, there is less traffic, wonderful volunteer services, and the community is "clique-y", especially the medical staff.

Figure 14: Best Things About the SERVICES AND RESOURCES in Your Community
Total responses = 298



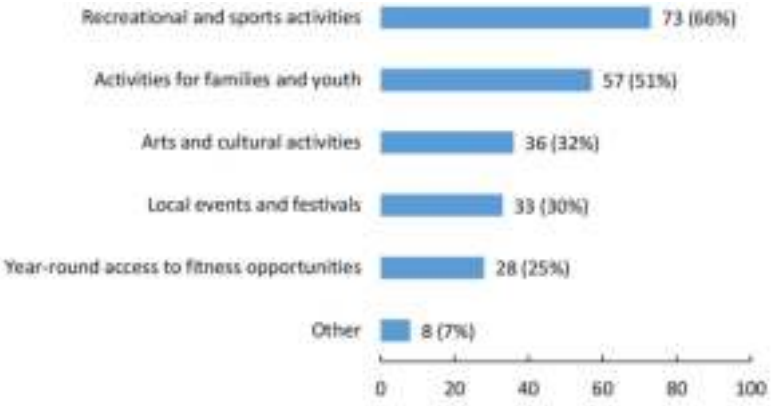
Respondents who selected "Other" specified that the best things about services and resources included outdoor activities.

Figure 15: Best Things About the QUALITY OF LIFE in Your Community
Total responses = 319



The one "Other" response regarding the best things about the quality of life in the community was that you do not have to deal with anyone you if you do not want to.

Figure 16: Best Thing About the ACTIVITIES in Your Community
Total responses = 235



Respondents who selected "Other" specified that the best things about the activities in the community included hunting, and other responses noted a lack of activities, especially for youth, recreational drugs available, and there are very little of these options available.

Community Concerns

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

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

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

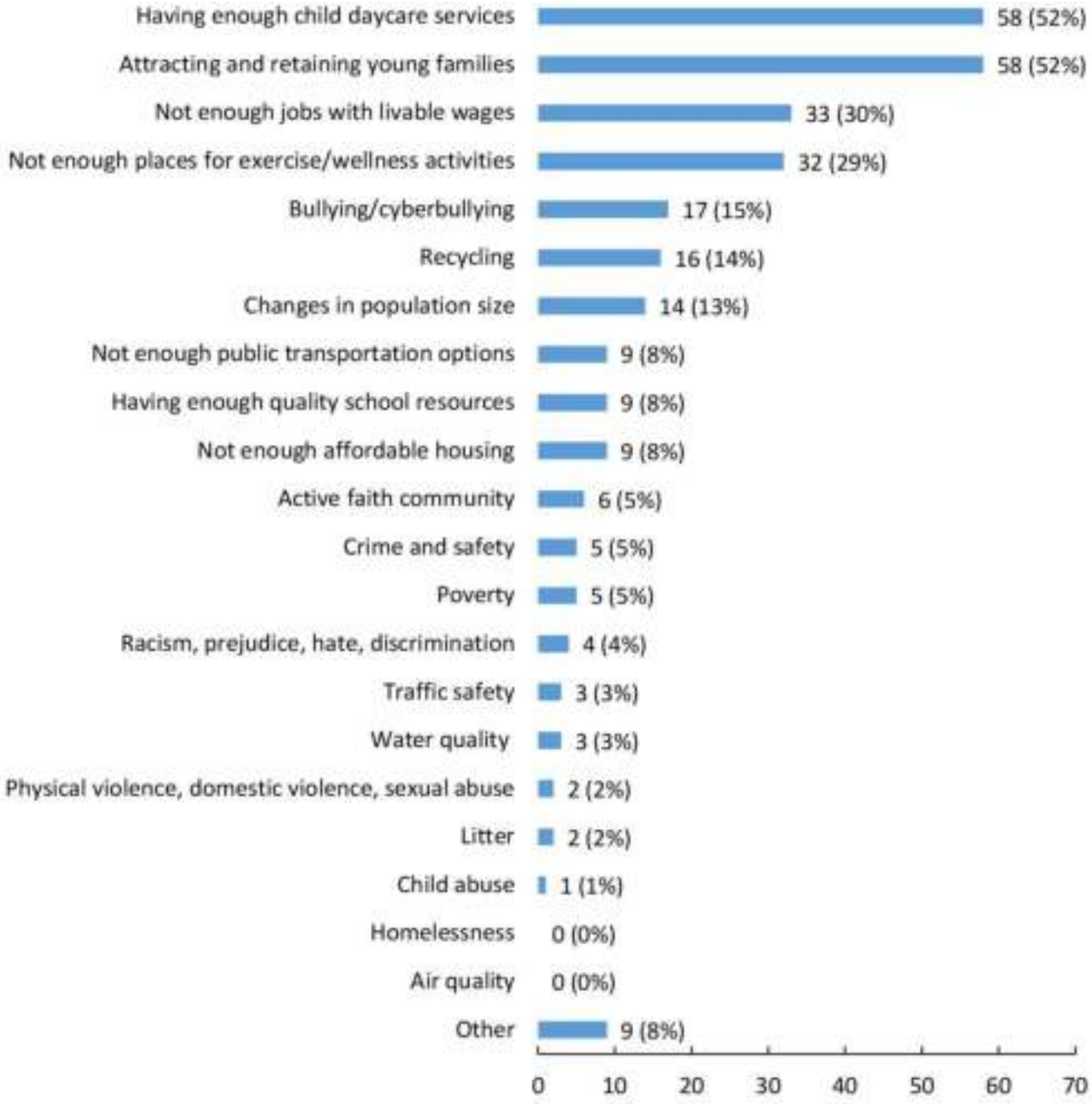
- Bullying/cyberbullying (N=65)
- Depression/anxiety – youth (N=60)
- Attracting and retaining young families (N=58)
- Having enough child daycare services (N=58)
- Depression/anxiety – adult (N=54)
- Alcohol use and abuse – adult (N=53)
- Availability of resources to help the elderly stay in their homes (N= 47)
- Child abuse or neglect (N=41)
- Alcohol use and abuse – youth (N=40)

The other issues that had at least 30 votes included:

- Assisted living options (N=36)
- Cost of long-term/nursing home care (N=36)
- Not getting enough exercise/physical activity – adult (N=35)
- Not getting enough exercise/physical activity – youth (N=34)
- Availability of home health (N=33)
- Not enough jobs with livable wages (N=33)
- Not enough places for exercise/wellness activities (N=32)
- Emotional abuse (N=30)

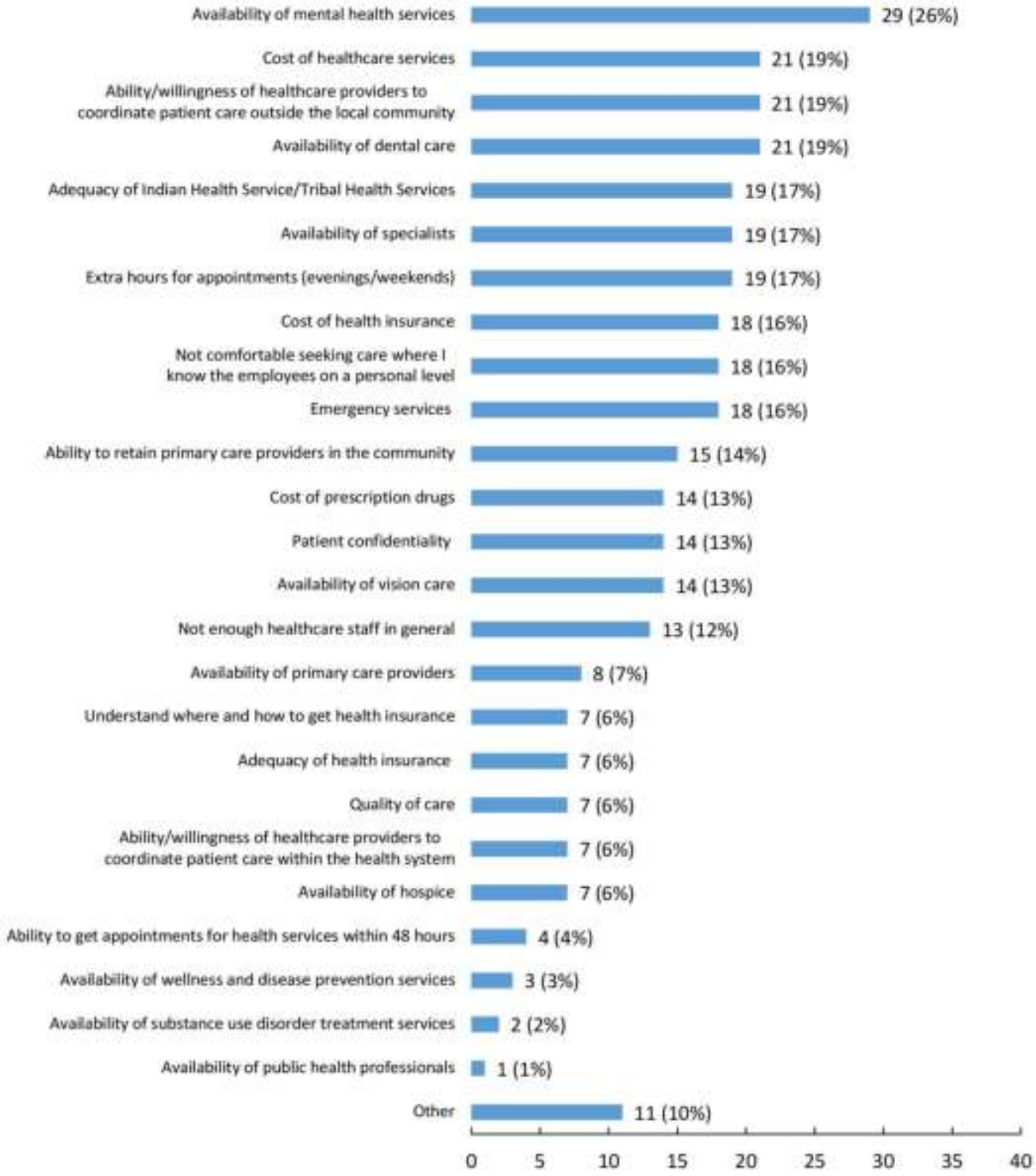
Figures 17 through 22 illustrate these results.

Figure 17: Community/Environmental Health Concerns
Total responses = 295



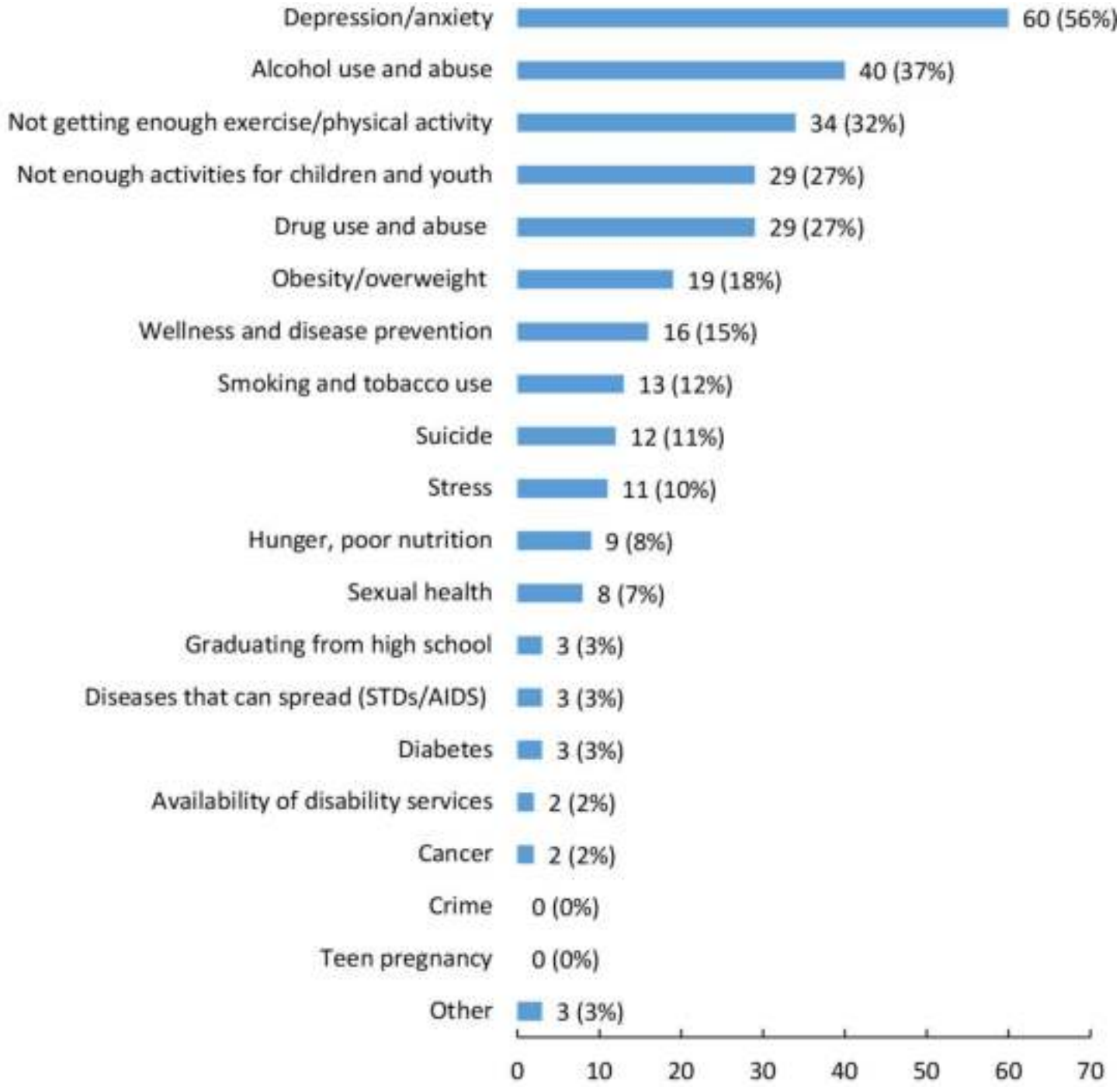
In the "Other" category for community and environmental health concerns, the following were listed: eating establishments, lack of activities, need for PAs and other medical professionals to work more often during the week, need for recycling in town, lack of employees, bad streets, too many open jobs, and the need for walking or biking paths.

Figure 18: Availability/Delivery of Health Services Concerns
Total responses = 337



Respondents who selected "Other" identified concerns in the availability/delivery of health services as limited available hours for drug prescription services.

Figure 19: Youth Population Health Concerns
Total responses = 296



Listed in the "Other" category for youth population concerns were bullying at school and peer pressure.

Figure 20: Adult Population Concerns
Total responses = 292

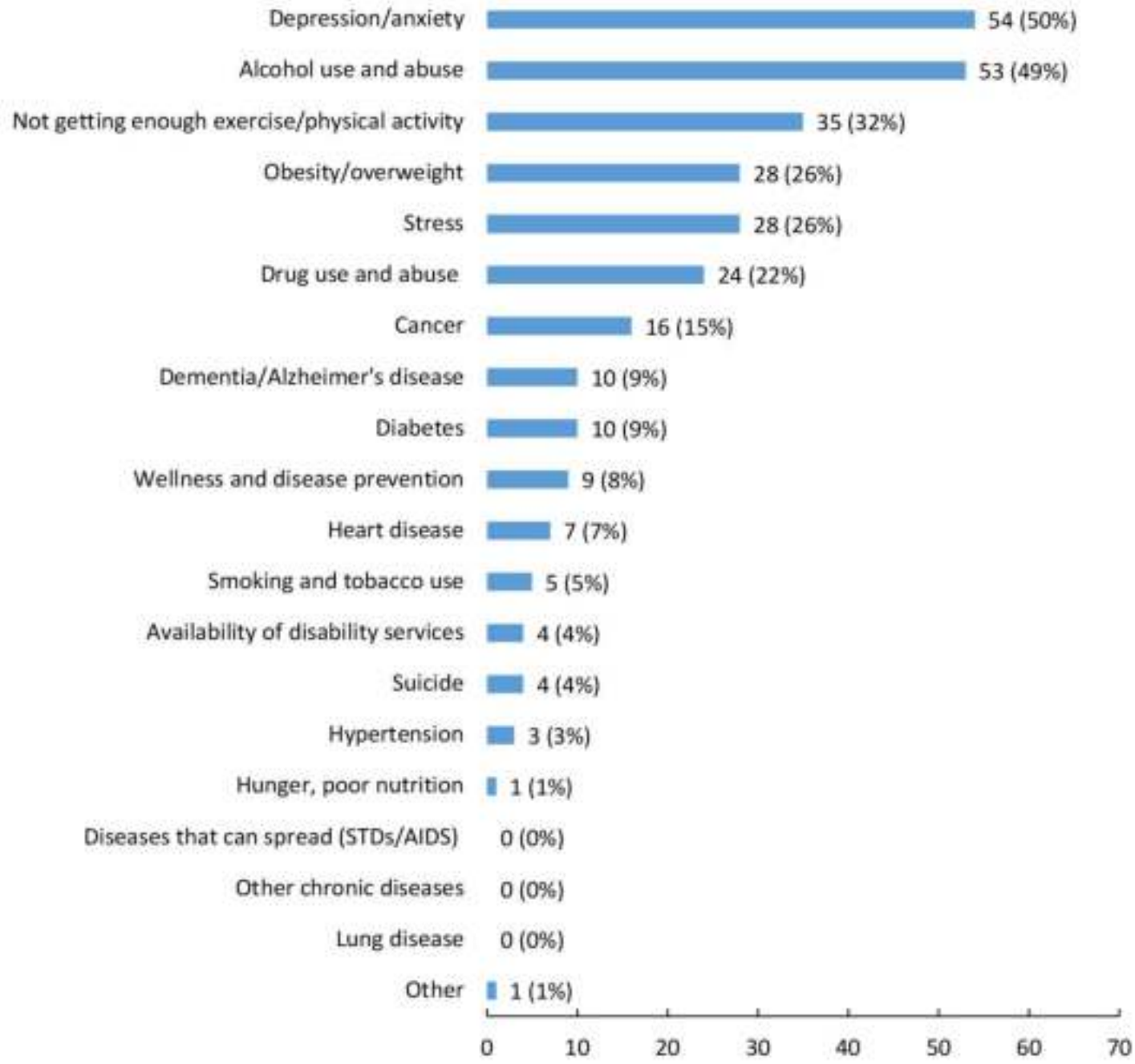
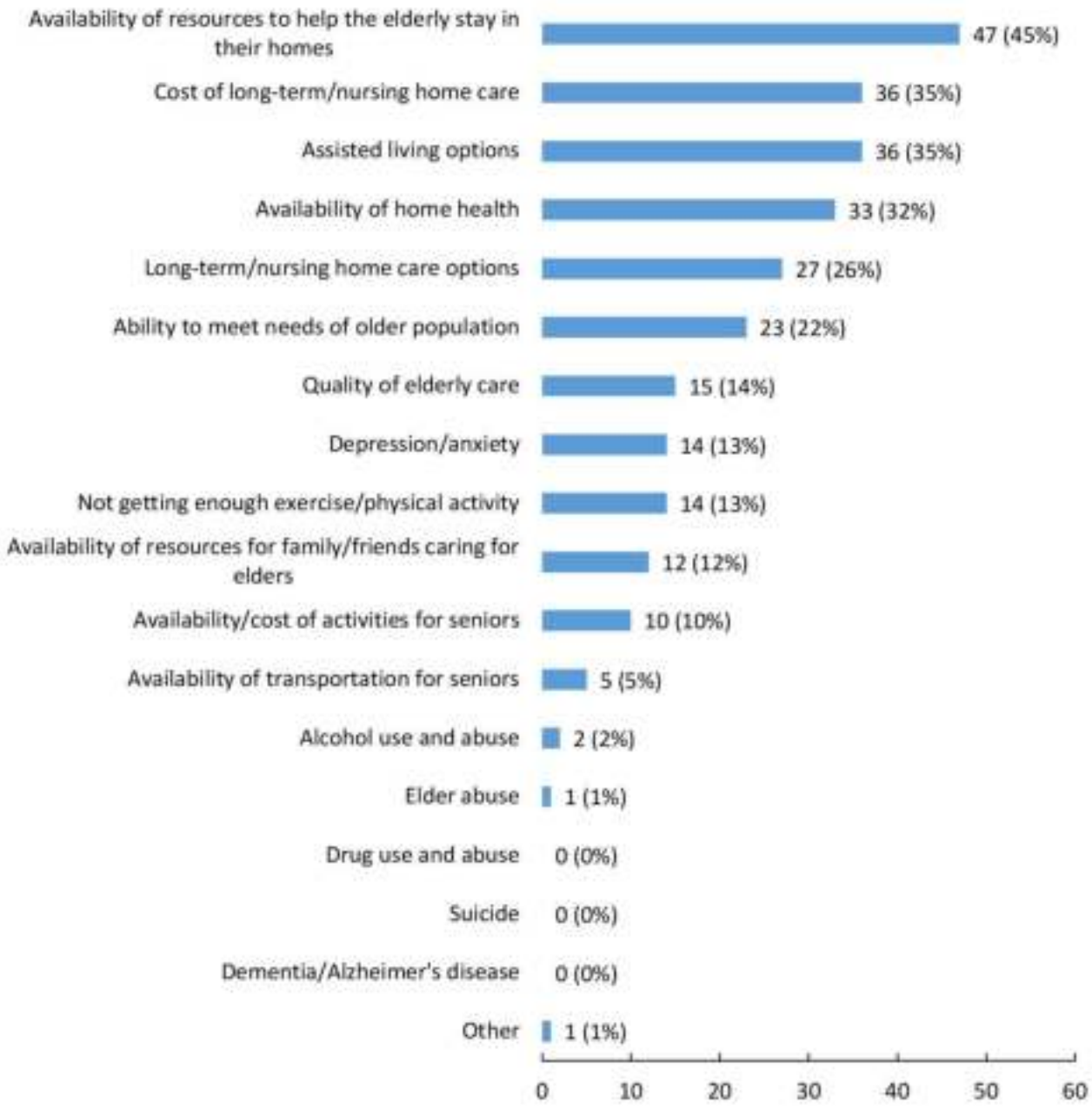
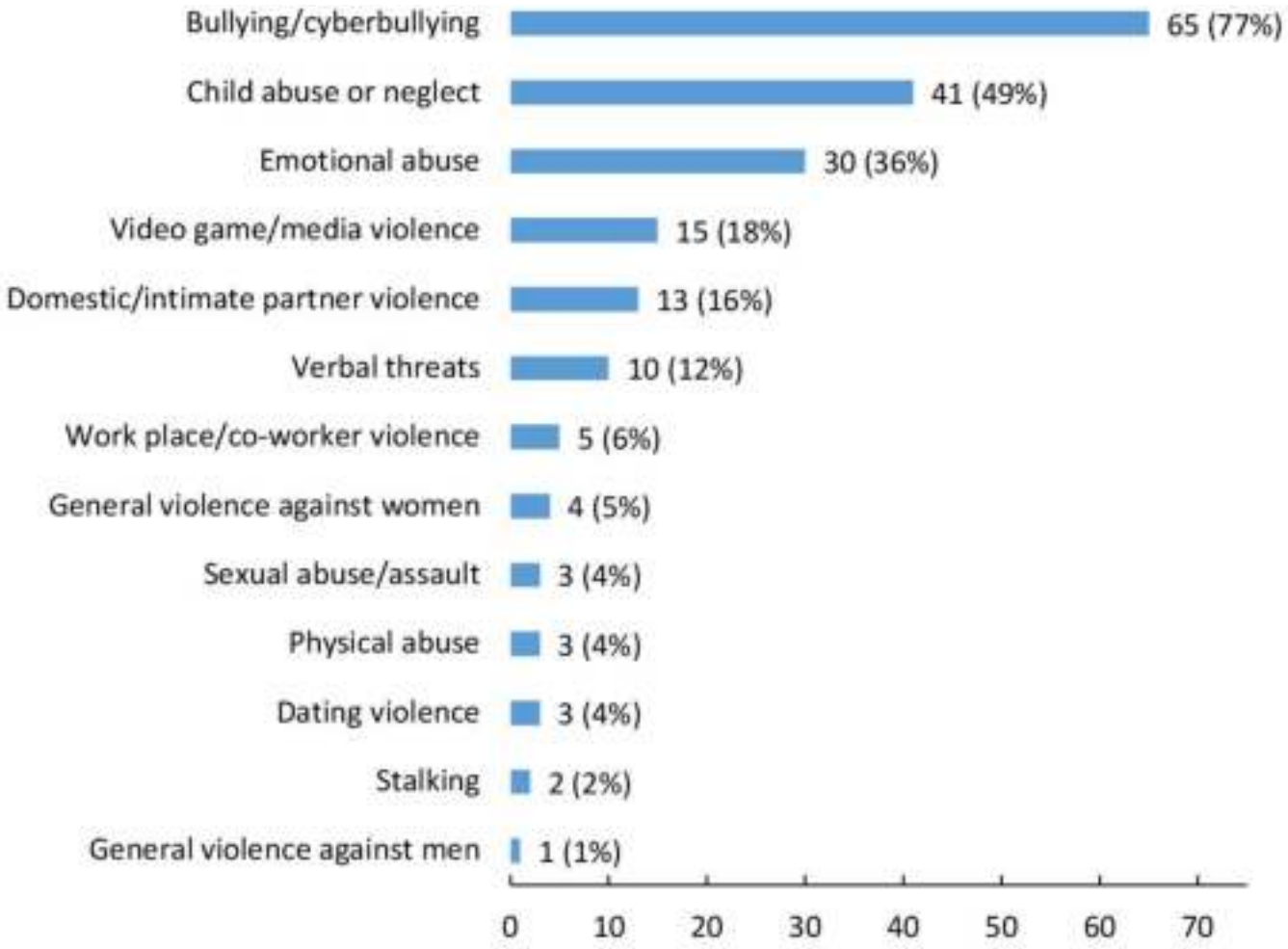


Figure 21: Senior Population Concerns
Total responses = 276



In the "Other" category, the one concern listed was that there is a lack of concern for independent elder living expansion with the new hospital plans.

Figure 22: Violence Concerns
Total responses = 195



In an open-ended question, respondents were asked what single issue they feel is the biggest challenge facing their community. One theme emerged above all others as the top concern: community growth – population decline, attracting and retaining families, lack of employees, lack of livable wages, and lack of social activities for all ages.

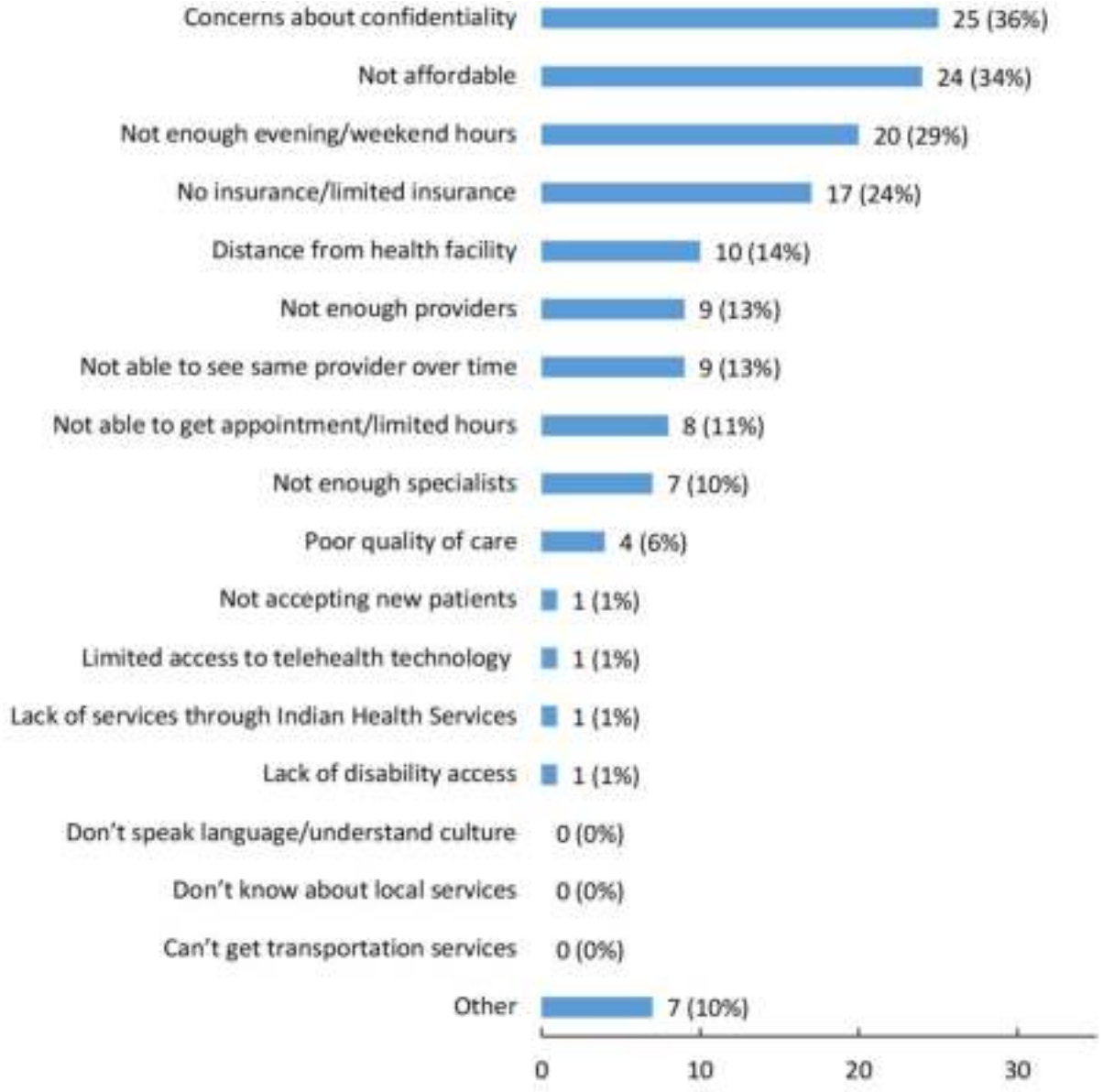
Other biggest challenges that were identified were alcohol and drug use, availability of healthcare appointments, childcare, deterioration of quality services/products by local businesses, access to specialists, low quality of senior care, increased crime, lack of mental health resources, lack of home health, cliques, poor physical appearance of town, concerns about healthcare confidentiality, lagging communication between patients and healthcare providers, and businesses that are not motivated to grow.

Delivery of Healthcare

The survey asked residents what they see as barriers that prevent them, or other community residents, from receiving healthcare. The most prevalent barrier perceived by residents was concerns about confidentiality (N=25). After these, the next most commonly identified barriers were not affordable (N=24), not enough evening/weekend hours (N=20), and no insurance/limited insurance (N=17). The majority of concerns indicated in the "Other" category included inability to get off work, no regular doctor, high prices, concerns about anonymity, and no insurance.

Figure 23 illustrates these results.

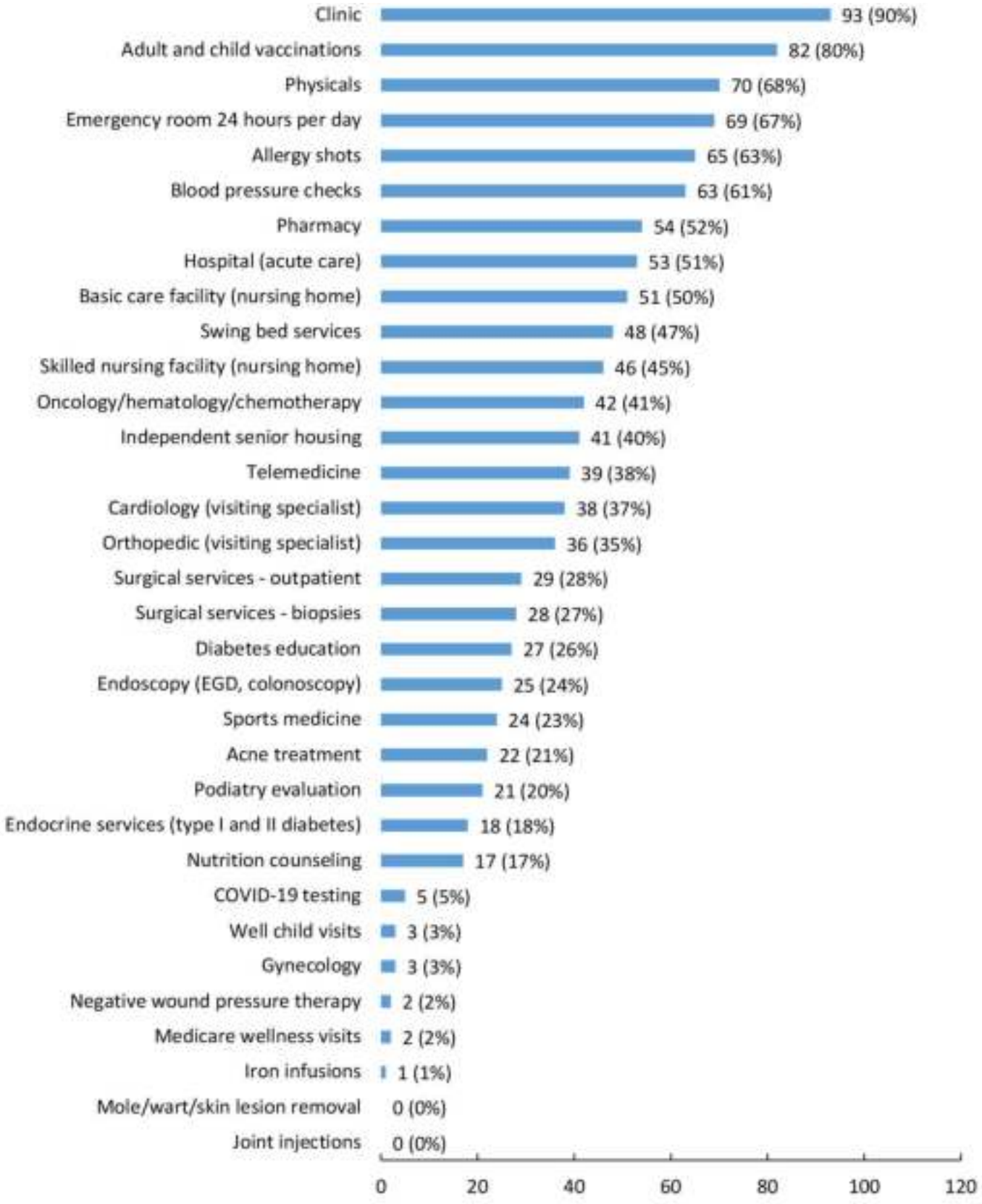
Figure 23: Perceptions About Barriers to Care
Total responses = 144



Survey respondents were asked what general and acute services at TCMC they were aware of or have used in the past year (See Figure 24).

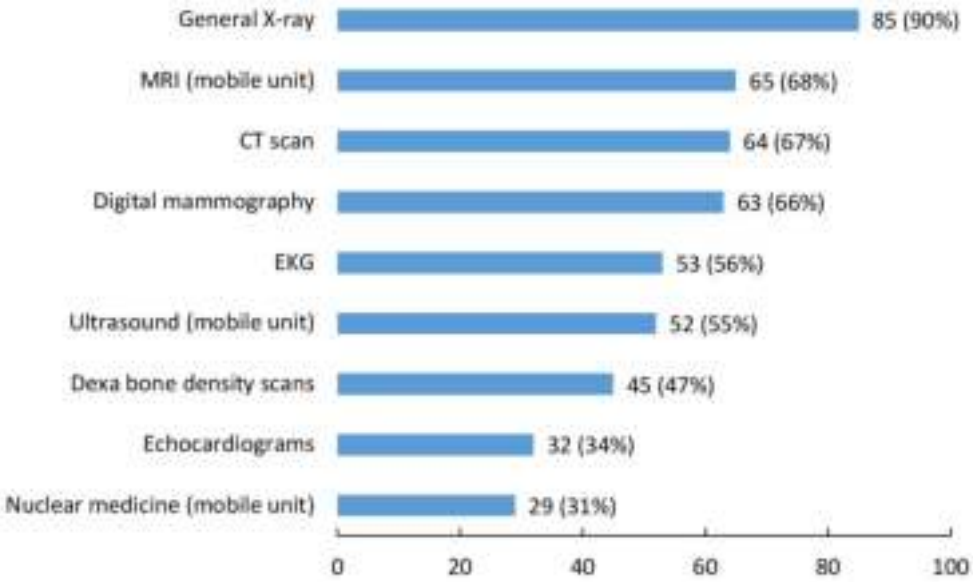
Figure 24: Awareness/Utilization of General and Acute Services at Towner County Medical Center

Total responses = 1117



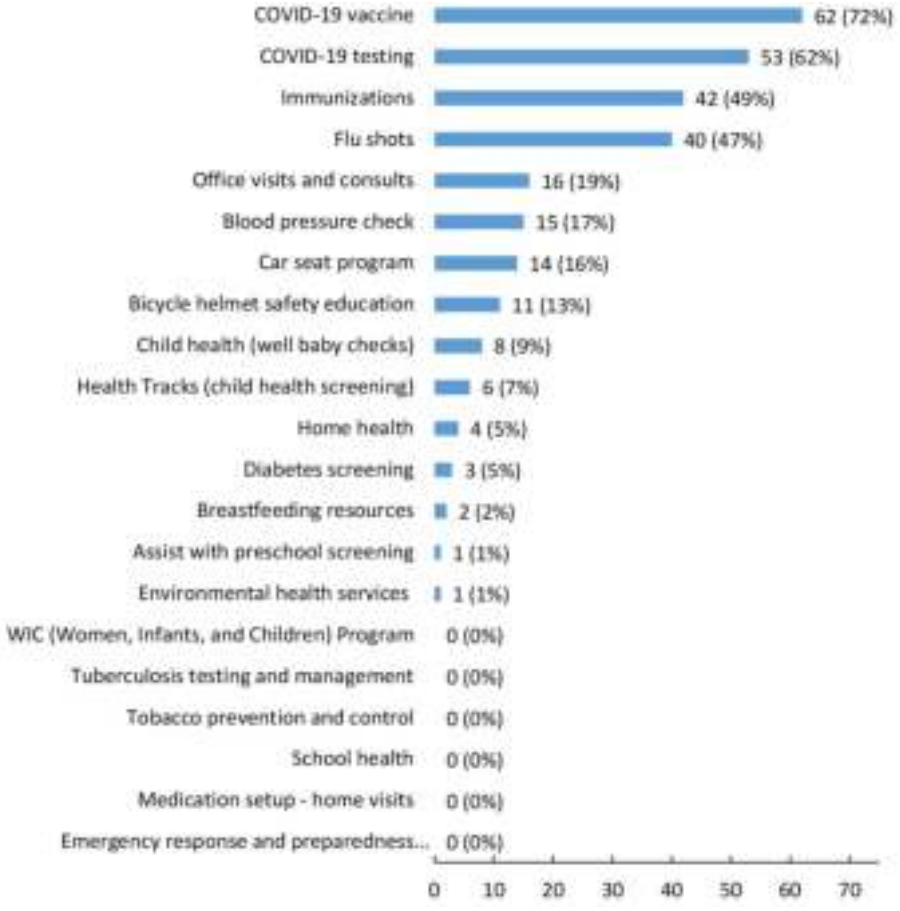
Respondents were also asked which radiology services at TCMC they were aware of or have used in the past year. Figure 25 illustrates the results.

Figure 25: Awareness/Utilization of Radiology Services at Towner County Medical Center
Total responses = 488



Considering a variety of healthcare services offered by TCPH, respondents were asked to indicate what, if any, services they or a family member have used at TCPH (See Figure 26).

Figure 26: Utilization of Public Health Services
Total responses = 278



The survey asked community members if they were aware that TCPH provides vaccinations for all ages for the insured, uninsured, and under-insured. As shown in Figure 27, most respondents were aware.

Figure 27: Awareness of Vaccines
Total responses = 101

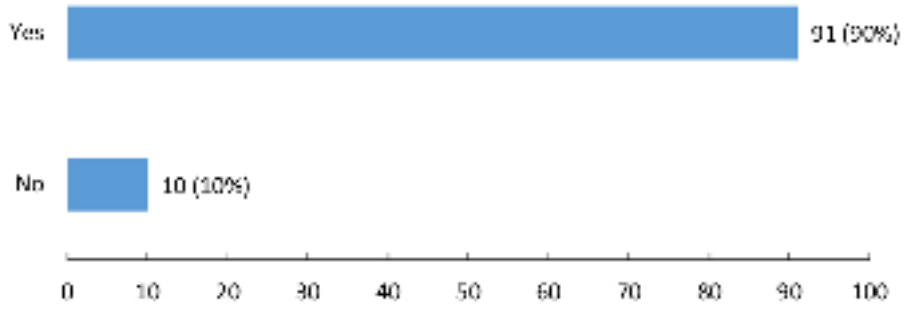
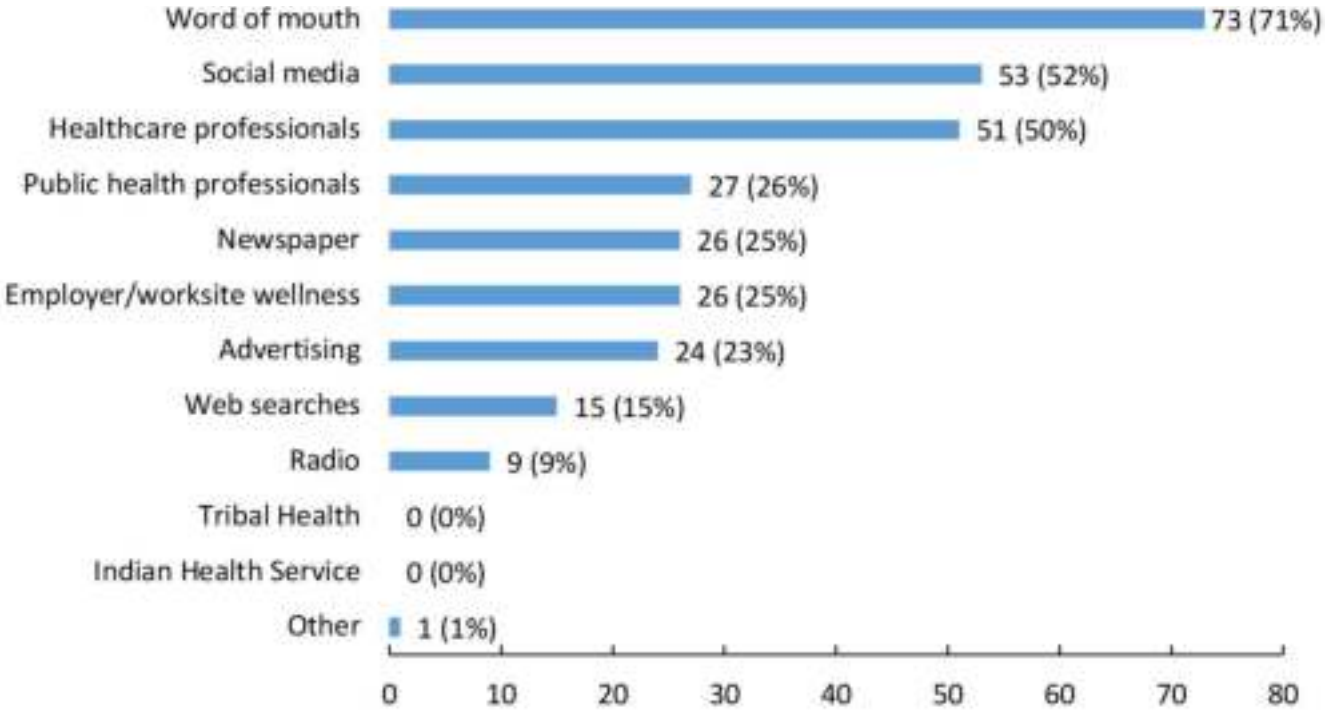


Figure 28: Sources of Information About Local Health Services
Total responses = 305



In the "other" category, family members were listed.

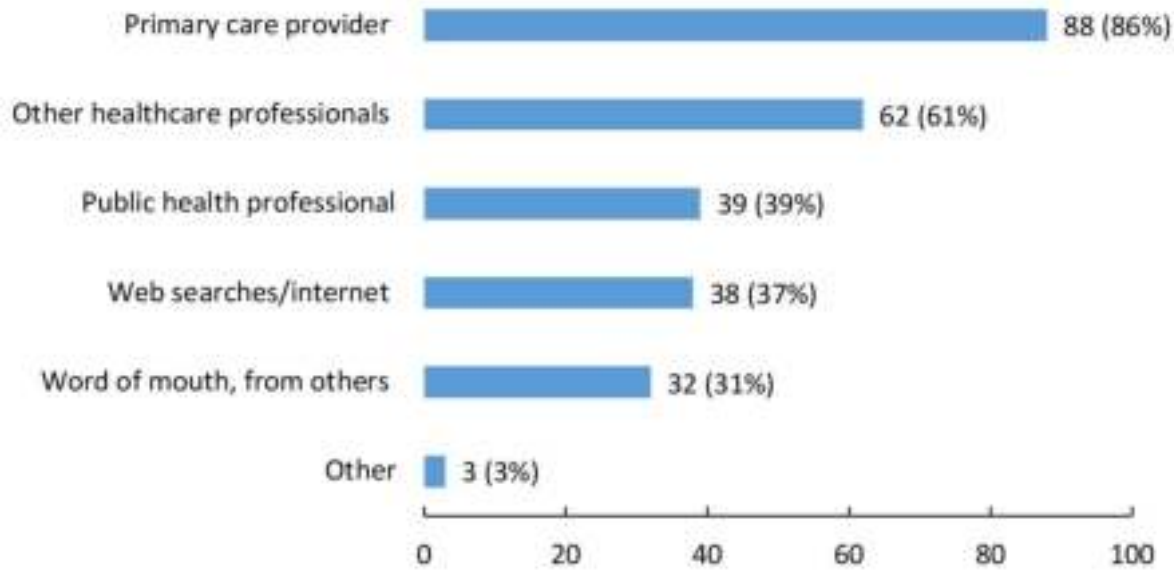
In an open-ended question, respondents were asked what specific healthcare services, if any, they think should be added locally. The top desired services to add locally were mental health services and dental care. Other requested services included:

- Cancer care
- COVID-19 testing at public health instead of the clinic
- Dental care
- Dermatology
- Dialysis
- Dietician
- Doctor
- Evening counseling
- Exercise instructor
- General surgeries
- Gynecology
- In-person mental health
- Internal med doctor
- Mental health professional
- More assisted living arrangements
- Nurse help line
- Pre-natal care
- Specialists
- Transportation options for those outside Cando
- Youth mental health and counseling

The key informant and focus group members felt that the community members were aware of the majority of the health system and public health services, but that younger community members may not be as aware of available services. Community members felt the hospital could increase marketing for diabetes education and dermatology/skin cancer services.

Respondents were asked where they go to for trusted health information. Primary care providers (N=88) received the highest response rate, followed by other healthcare professionals (N=62), and then public health professionals (N=39). See Figure 29 for full results.

Figure 29: Sources of Trusted Health Information
Total responses = 262



Survey respondents were asked in an open-ended question what services they would like to see in a new hospital. The most common responses were an exercise/wellness center open extended hours with classes and activities, mental health services, and dental care. Other services community members would like to see in a new hospital included a cafeteria, counseling services, dermatology/Botox, dialysis, dietician, doctors, expanded daycare, homeopathy, increased activities, increased massage availability, a larger ER, medical marijuana providers, more fixed diagnostics like MRI, ultrasound, and nuclear, occupational therapy, podiatry, speech therapy, a therapy swim pool, and a visiting priest.

While not necessarily services, survey respondents also indicated they would like to see better quality care, better wages for receptionists and staff, accessible toilets in all bathrooms, an improved parking lot, increased attention given to congregate housing residents, and a single large facility to house the clinic, hospital, and nursing home.

The survey also asked respondents what they would like to see added to Living Center services. The most common response was increased activities. Other answers included a bigger area for activities, a naturopath, adult daycare and respite services, hospice, assisted living, better quality care, better single occupancy rooms, fitness center/exercise room, recreation/tv center, better showers/bathing, accessible toilets in all bathrooms, more imaging available, more staff to improve quality of care, new assisted living building combined with congregate housing, opened visitation, separate wing for assisted living, swimming pool, order by menu, open kitchen, and daycare interaction.

The final question on the survey asked respondents to share concerns and suggestions to improve the delivery of local healthcare. It was suggested that an updated clinic and hospital would attract more people and staff members. Low staffing numbers are a concern – it seems there often aren't enough clinic staff to answer phone calls. It was noted that receptionists and staff need to be paid better wages as it has been a struggle to fill those positions.

Respondents indicated that they would like to see medical doctors recruited to the community. It was noted that since there is not a physician on staff, there needs to be more of a willingness to work with out-of-network providers, even when their test interpretations and recommendations may differ from those at the local facility. Respondents would like to see healthcare professionals working more days so it's possible to see the same professional when needed. Community members would also like to see more specialist providers coming to rural locations on a regular basis. It can be very hard for people to travel two to four hours for those appointments. Keeping as many appointments local as possible was noted as a priority.

Other suggestions brought up that sometimes it seems doctors do not see the whole picture of health and can be lax in diagnosing and treating. Homeopathy was suggested as a remedy for this. It was also brought up that healthcare needs to be accessible, especially emergency services. Respondents indicated that Cando healthcare seems to be the most expensive in the area, with some services being double the price of other places. Confidentiality was also brought up as a concern.

Respondents also noted that they are thankful for the hospital and all it can provide. Some think it does a nice job currently but could always be improving. Respondents noted they appreciate the excellent healthcare providers and nurses.

Findings from Key Informant Interviews & the Community Meeting

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

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

- Alcohol use and abuse
- Attracting and retaining young families
- Availability of mental health services
- Depression/anxiety

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

Alcohol use and abuse

- Top concern – a lot of binge drinking in the area

Attracting and retaining young families

- Population decrease is top concern – school enrollment, businesses, utilization of healthcare all go down
- Housing prices are very expensive
- Not enough jobs

Availability of mental health services

- There is nowhere for people to go for these services in an emergency
- Getting an appointment anywhere is impossible

Depression/anxiety

- This is a problem for all age groups in our community
- Seems to be more apparent now than it used to be. People aren't hiding it as much
- Know so many people affected by depression or constant worry

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 12 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:

- Hospital (healthcare system) (4.5)
- Emergency services, including ambulance and fire (4.25)
- Schools (4.25)
- Economic development organizations (4.0)
- Faith-based (4.0)
- Pharmacies (4.0)
- Public health (4.0)
- Business and industry (3.75)
- Long-term care, including nursing homes and assisted living (3.5)
- Other local health providers, such as dentists and chiropractors (3.5)
- Human/social services (3.0)
- Law enforcement (2.0)

Priority of Health Needs

A community group met on February 16, 2022. Fifteen community members attended the meeting. Representatives from the Center for Rural Health (CRH) presented the group with a summary of this report's findings, including background and explanation about the secondary data, highlights from the survey results (including perceived community assets and concerns, and barriers to care), and findings from the key informant interviews.

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

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

- Depression/anxiety (10 votes)
- Availability of mental health services (8 votes)
- Attracting and retaining young families (7 votes)
- Cost of health insurance (7 votes)
- Having enough child daycare services (7 votes)

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

1. Availability of mental health services (9 votes)
2. Attracting and retaining young families (3 votes)
3. Cost of health insurance (2 votes)

4.Depression/anxiety (1 vote)

5. Having enough child daycare services (0 votes)

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

Comparison of Needs Identified Previously

Top Needs Identified 2019 CHNA Process	Top Needs Identified 2022 CHNA Process
Cost of health insurance	Availability of mental health services
Having enough childcare services	Attracting and retaining young families
Adult drug use and abuse (including prescription drug abuse)	Cost of health insurance
Bullying/cyberbullying	Depression/anxiety
Attracting and retaining young families	Having enough childcare services

The current process identified two identical common needs from 2019. Cost of health insurance and attracting and retaining young families were identified as needs again in 2022, suggesting there is more to be done in those areas. The two new needs identified, availability of mental health services and depression/anxiety, are closely related to each other, emphasizing a growing need to address mental health in the county.

Towner County Medical Center (TCMC) invited written comments on the most recent Community Health Needs Assessment (CHNA) report and implementation strategy both in the documents and on the website where they are widely available to the public. No written comments have been received.

Upon adoption of this CHNA Report by the TCMC 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 TCMC.

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

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

Need 1: Cost of health insurance – The TCMC board chose not to address this need during this cycle.

Need 2: Having enough child daycare services – TCMC daycare continues to provide daycare services license for 26, ages newborn to age 12, to surrounding areas, employing Child Development Associate certification personnel. Cando Community Childcare is Bright and Early Step four level care certified, being the highest-level care possible. All employees are First Aid and CPR trained. A local community member continues to supply the daycare needs through grants offered from state and federal governments.

Need 3: Adult drug use and abuse (including prescription drug abuse) – Since the last CHNA process, TCMC has added a fourth medication-assisted treatment (MAT) provider. TCMC also continues to work with Heartview Treatment Center, located in Cando. A TCMC employee sits on the board at Heartview. MAT visits continue to increase at TCMC as many adults seeking treatment request one of the four MAT providers. TCMC

also provides the injectable buprenorphine extended release serving this population from all over the state of North Dakota. The pharmacy is able to receive this treatment and have it on hand for patients when needed. TCMC continues to work with TCPH on the State Opioid Response (SOR) grant. These funds bring assistance to patients for travel expenses. Don't Quit the Quit is also another program TCMC participates in by helping mothers by supplying diapers for their children. Lastly, TCMC expanded its services by providing telehealth services to patients when appointments can't be made in person in a timely manner.

Need 4: Bullying/cyberbullying – This need was unable to directly be addressed during this cycle due to a change in focus to address COVID-19.

Need 5: Attracting and retaining young families – One of the community's greatest concerns was for adequate daycare for young families. The Economic Development Corporation is directly involved in assisting businesses with new or expansion ideas, including licensed daycares. Towner County Public Health (TCPH) remains the only provider of the Vaccines for Children program in Towner County which provides an economically friendly alternative to families with no insurance or meet the program requirements. TCPH serves as a bimonthly site for the Lake Region WIC program which provides nutritional supports to families meeting their income guidelines. TCMC operates a licensed daycare providing skilled daycare to families.

The above implementation plan for Towner County Medical Center is posted on the TCMC website at http://tcmedcenter.org/forms-documents/.

Next Steps – Strategic Implementation Plan

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

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

Community Benefit Report

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

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

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

Community benefit is also the basis of the tax-exemption of not-for-profit hospitals. The Internal Revenue

Service (IRS), in its Revenue Ruling 69–545, describes the community benefit standard for charitable tax-exempt hospitals. Since 2008, tax-exempt hospitals have been required to report their community benefit and other information, related to tax-exemption on the IRS Form 990 Schedule H.

What Are Community Benefits?

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

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

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

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

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

Appendix A – Critical Access Hospital Profile

Critical Access Hospital Profile

Spotlight on: Cando, North Dakota

Towner County Medical Center

Quick Facts

Administrator:
Ben Bucher, FNP-BC, MBA, LNHA

Chief of Medical Staff:
Anil Potti, MD

Board Chair: Dave Wolsky

City Population:
1,083 (2019 estimate)[1]

County Population:
2,189 (2019 estimate)[1]

County Median Household Income:
$52,300 (2019 estimate)[1]

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

Service Area Population:
60 mile radius of Cando

Owned by: Nonprofit

Hospital Beds: 20

Skilled Nursing Facility Beds: 30

Trauma Level: V

Critical Access Hospital Designation: 2007

Economic Impact on the County[2]

Employment Impact:
Direct – 95
Secondary – 36
Total – 131

Financial Impact:
Direct – $6.35 million
Secondary – $1.5 million
Total – $7.8 million

Mission:

Towner County Medical Center (TCMC) provides: total quality comprehensive healthcare; caring and compassionate health services for patients, residents, families and healthcare workers; medical care for all life stages delivered by a professional and expert healthcare team, and a commitment to our communities to maintain and ensure the ongoing provision of quality health services.

County: Towner
Address: PO Box 688
Cando, ND 58324
Phone: (701) 968-4411 or Toll-free (800) 943-3337
Fax: (701) 968-2574
Web: www.tcmedcenter.org

Towner County Medical Center has many services available including inpatient and outpatient hospital care, long term care, clinical services, retirement housing, and child care.

Top quality care with a personal touch . . .
Our staff of practitioners specialize in family practice, gynecology, pediatrics, and geriatrics.

The Cando Clinic offers robust family practice, and a full array of medical experts uniquely qualified to diagnose and treat you and your family for a broad spectrum of illnesses. When it is necessary, they will not hesitate to consult with or refer you to a sub-specialist.

We offer a hometown friendly atmosphere. We know our patients by name and many are our neighbors and friends. The medical center combines medical expertise with careful attention to each individual patient. This combination results in our thorough yet personal approach to medical diagnosis and treatment.

Services:

Towner County Medical Center provides the following services directly:

- Chiropractic
- Outpatient
- Laboratory
- Podiatry
- Independent senior housing
- Physical therapy
- Inpatient
- Advanced radiology
- Skilled nursing
- Fitness center
- Swing bed
- Daycare
- Nutritional services
- Endoscopy
- Surgery
- Basic care
- Massage therapy
- Pediatrics'
- Ophthalmology
- Telemedicine
- Oncology

Staffing

Physicians: 0
Nurse Practitioners: 4
PAs: 2
RNs: 20
LPNs: 13
Total Employees: 104

Local Sponsors and Grant Funding Sources

- Center for Rural Health
  - SHIP Grant (Small Hospital Improvement Program)
  - Flex Grant (Medicare Rural Hospital Flexibility Grant Program)

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.

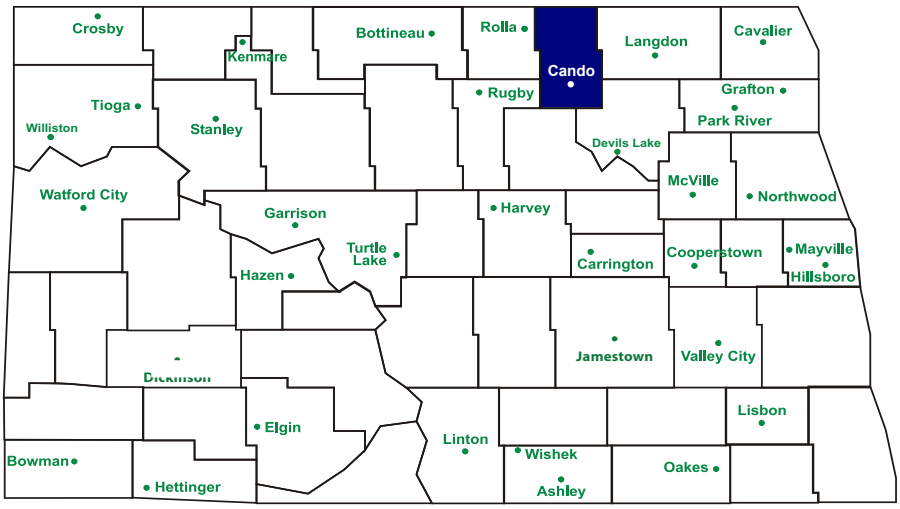
ruralhealth.und.edu

Services:

Towner County Medical Center provides the following services through contract or agreement:

- Cardiology
- Orthopedics
- Oncology
- Occupational therapy

North Dakota Critical Access Hospitals



History:

Towner County Memorial Hospital (TCMH) was first constructed on land donated by Phil and Julianne Belzer. The people of Towner County and the Order of the Sisters of St. Francis raised the needed funds to build the original 26-bed hospital. A few years later, a new chapel and chaplain's suite was completed. The size of the hospital nearly doubled in 1968 with an addition that included new patient rooms, an ambulance garage and emergency room, a new laboratory, and a radiology room.

The ownership and direction of the hospital changed in 1992 when the citizens of Towner County pulled together to insure continued access to healthcare. On May 11, 1995, a ground breaking ceremony was held to meet new regulations on handicapped accessibility. Construction began on land donated by the Terry and Babe Belzer Family that included a new medical clinic, dental clinic, emergency room, x-ray suite, physical therapy room, nursing station, a drive through emergency garage, laboratory, medical records, and birthing room. In addition to the new construction, the existing facilities have been renovated, creating a medical center that meets and exceeds all the standards in the industry today.

Special thanks to the patients of Towner County Medical Center for your loyalty to local services and for allowing us the opportunity to meet your healthcare needs today and into the future.

Recreation:

Cando, located in northeastern North Dakota, is the county seat of the largest durum wheat-producing county in the world. Access to major cities is within a reasonable driving distance of Cando. Winnipeg, Manitoba, is just three hours away, while access to major shopping and medical facilities in North Dakota is within 40 miles. The Cando public school system prepares students for vocational and post secondary training. Adult education courses are also offered. Numerous recreational activities are available for residents of Cando with its city parks, participatory and observational sports, athletic fields, swimming pool, and golf course. Some of the state's best fishing can be found within 40 miles, and the area is abundant with waterfowl, geese, and deer.

Updated 8/2021

Appendix B – Economic Impact Analysis

Towner County Medical Center

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

Economic Impact

Towner County Medical Center is composed of a Critical Access Hospital (CAH), a Rural Health Clinic, a skilled nursing facility, a basic care facility, and an independent living facility located in Cando, North Dakota.

Towner County Medical Center **directly** employs **95 FTE employees** with an annual payroll of over **$6.35 million** (including benefits).

- After application of the employment multiplier of 1.38, these employees created an additional **36** jobs.
- The same methodology is applied to derive the income impact. The income multiplier of 1.23 is applied to create nearly **$1.5 million** in income as they interact with other sectors of the local economy.
- **Total impacts = 131 jobs and more than $7.8 million in income.**

Healthcare and Your Local Economy

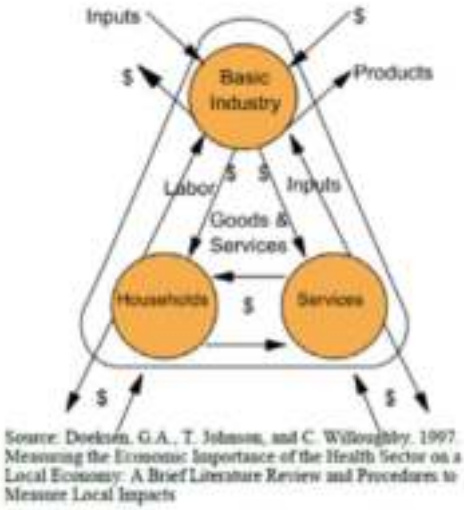
The health sector in a rural community, anchored by a CAH, is responsible for a number of full- and part-time jobs and the resulting wages, salaries, and benefits. Research findings from the National Center for Rural Health Works indicate that rural hospitals typically are one of the top employers in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

Key contributions of the health system include

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

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

Figure 1. *An overview of the community economic system.*



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

Fact Sheet Author: Kylie Nissen, BBA

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Appendix C – CHNA Survey Instrument

Center for Rural Health

Public Health

Towner County Medical Center

Towner County Medical Center Area Health Survey

Towner County Medical Center and Towner County Public Health District are interested in hearing from you about community health concerns.

The focus of this effort is to:

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

If you prefer, you may take the survey online at http://tinyurl.com/TownerCounty21 or by scanning on the QR Code at the right.

Surveys will be tabulated by the Center for Rural Health at the University of North Dakota School of Medicine and Health Sciences. Your responses are anonymous, and you may skip any question you do not want to answer. Your answers will be combined with other responses and reported only in total. If you have questions about the survey, you may contact Kylie Nissen at 701.777.5380.

Surveys will be accepted through December 3, 2021. Your opinion matters – thank you in advance!

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Delivery of Healthcare

12. Considering **GENERAL and ACUTE SERVICES** at Towner County Medical Center, which services are you aware of (or have you used in the past year)? (Choose ALL that apply)

- ☐ Acne treatment
- ☐ Allergy shots
- ☐ Adult and child vaccinations
- ☐ Basic care facility (nursing home)
- ☐ Blood pressure checks
- ☐ Cardiology (visiting specialist)
- ☐ Clinic
- ☐ COVID 19 Testing
- ☐ Diabetes education
- ☐ Emergency room 24 hours per day
- ☐ Endocrine services (type I and II diabetes)
- ☐ Endoscopy (EGD, colonoscopy)
- ☐ Gynecology
- ☐ Hospital (acute care)
- ☐ Independent senior housing
- ☐ Iron infusions
- ☐ Joint injections
- ☐ Medicare wellness visits
- ☐ Mole/wart/skin lesion removal (including cryotherapy)
- ☐ Negative wound pressure therapy
- ☐ Nutrition counseling
- ☐ Oncology/hematology/chemo-therapy
- ☐ Orthopedics (visiting specialist)
- ☐ Pharmacy
- ☐ Podiatry evaluation
- ☐ Physicals: annual, DOT, sports, insurance
- ☐ Skilled nursing facility (nursing home)
- ☐ Sports medicine
- ☐ Surgical services – biopsies
- ☐ Surgical services – outpatient
- ☐ Swing bed services
- ☐ Telemedicine
- ☐ Well child visits

13. Considering **RADIOLOGY SERVICES** at Towner County Medical Center, which services are you aware of (or have you used in the past year)? (Choose ALL that apply)

- ☐ CT scan
- ☐ Dexa bone density scans
- ☐ Digital mammography
- ☐ Echocardiograms
- ☐ EKG
- ☐ General x-ray
- ☐ Nuclear medicine (mobile unit)
- ☐ MRI (mobile unit)
- ☐ Ultrasound (mobile unit)

14. Which of the following **SERVICES** provided by your local **PUBLIC HEALTH** unit are you aware of (or 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)
- ☐ COVID-19 testing
- ☐ COVID-19 vaccines
- ☐ 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)
- ☐ Assist with preschool screening
- ☐ Tobacco prevention and control
- ☐ Tuberculosis testing and management
- ☐ WIC (Women, Infants & Children) Program

15. Are you aware that Towner County Public Health District provides vaccinations for all ages, for the insured, uninsured, and under-insured?

☐ Yes ☐ No

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

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

17. What services would you like to see in a new hospital?

_____

_____

18. What would you like to see added to Living Center services?

_____

19. 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 other facility through monitor/TV screen)
☐ No insurance or limited insurance
☐ Not able to get appointment/limited hours
☐ Not able to see same provider over time
☐ Not accepting new patients
☐ Not affordable
☐ Not enough providers (MD, DO, NP, PA)
☐ Not enough evening or weekend hours
☐ Not enough specialists
☐ Poor quality of care
☐ Other (please specify):

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

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

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

_____

_____

Demographic Information: Please tell us about yourself.

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

☐ Yes ☐ No

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

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

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

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

25. Age:

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

26. Highest level of education:

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

27. Sex:

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

28. Employment status:

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

29. Your zip code: _____

30. Race/Ethnicity (choose ALL that apply)

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

31. Annual household income before taxes:

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

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

_____

_____

Thank you for assisting us with this important survey!

Appendix D – County Health Rankings Explained

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

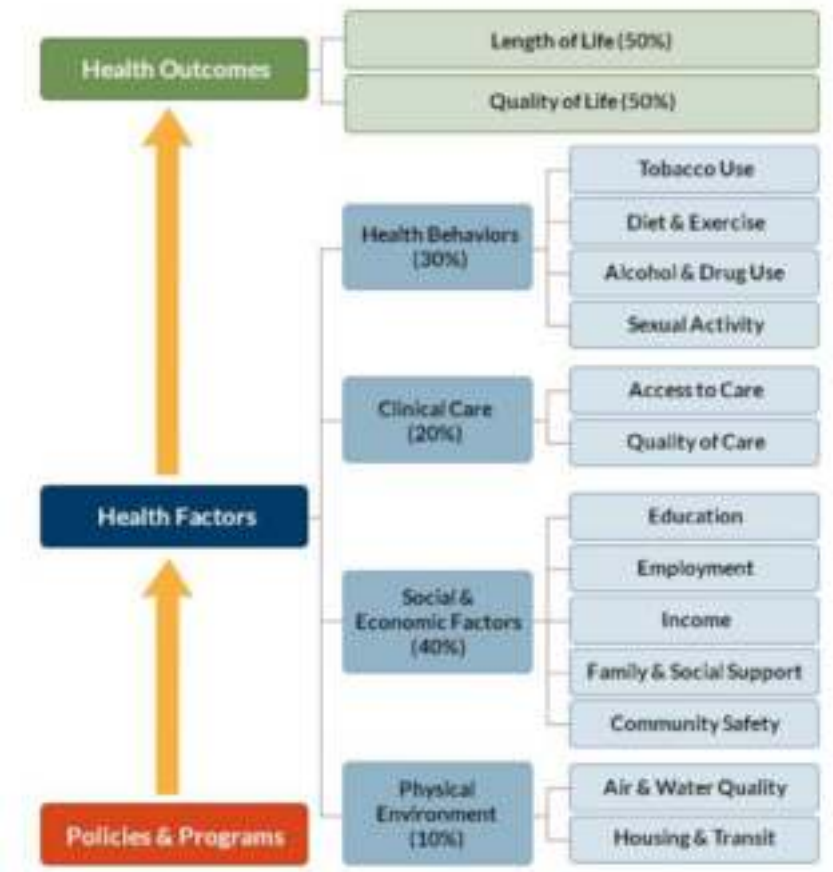
Methods

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

What is Ranked

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

Ranking System



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

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

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

Data Sources and Measures

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

Data Quality

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

Calculating Scores and Ranks

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

Health Outcomes and Factors

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

Health Outcomes

Premature Death (YPLL)

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

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

	ND 2015	ND 2017	ND 2019	ND Trend ↑, ↓, =	Rural ND Town Average	Urban ND Town Average	National Average 2019
Injury and Violence							
Percentage of students who rarely or never wore a seat belt (when riding in a car driven by someone else)	8.5	8.1	5.9	=	8.8	5.4	6.5
Percentage of students who rode in a vehicle with a driver who had been drinking alcohol (one or more times during the 30 prior to the survey)	17.7	16.5	14.2	=	17.7	12.7	16.7
Percentage of students who talked on a cell phone while driving (on at least one day during the 30 days before the survey, among students who drove a car or other vehicle)	NA	56.2	59.6	=	60.7	60.7	NA
Percentage of students who texted or e-mailed while driving a car or other vehicle (on at least one day during the 30 days before the survey, among students who had driven a car or other vehicle during the 30 days before the survey)	57.6	52.6	53.0	=	56.5	51.8	39.0
Percentage of students who never or rarely wore a helmet (during the 12 months before the survey, among students who rode a motorcycle)	NA	20.6	NA	**NA**	NA	NA	NA
Percentage of students who carried a weapon on school property (such as a gun, knife, or club on at least one day during the 30 days before the survey)	5.2	5.9	4.9	=	6.2	4.2	2.8
Percentage of students who were in a physical fight on school property (one or more times during the 12 months before the survey)	5.4	7.2	7.1	=	7.4	6.4	8.0
Percentage of students who experienced sexual violence (being forced by anyone to do sexual things [counting such things as kissing, touching, or being physically forced to have sexual intercourse] that they did not want to, one or more times during the 12 months before the survey)	NA	8.7	9.2	=	7.1	8.0	10.8
Percentage of students who experienced physical dating violence (one or more times during the 12 months before the survey, including being hit, slammed into something, or injured with an object or weapon on purpose by someone they were dating or going out with among students who dated or went out with someone during the 12 months before the survey)	7.6	NA	NA	**NA**	NA	NA	8.2
Percentage of students who have been the victim of teasing or name calling because someone thought they were gay, lesbian, or bisexual (during the 12 months before the survey)	NA	11.4	11.6	=	12.6	11.4	NA
Percentage of students who were bullied on school property (during the 12 months before the survey)	24.0	24.3	19.9	↓	24.6	19.1	19.5
Percentage of students who were electronically bullied (including being bullied through texting, Instagram, Facebook, or other social media during the 12 months before the survey)	15.9	18.8	14.7	↓	16.0	15.3	15.7
Percentage of students who felt sad or hopeless (almost every day for two or more weeks in a row so that they stopped doing some usual activities during the 12 months before the survey)	27.2	28.9	30.5	=	31.8	33.1	36.7
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 male students within a couple of hours on at least one day during the 30 days before the survey)	NA	16.4	15.6	=	17.2	14.0	13.7
Percentage of students who usually obtained the alcohol they drank by someone giving it to them (among students who currently drank alcohol)	41.3	37.7	NA	**NA**	NA	NA	40.5
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 F – Prioritization of Community's Health Needs

Community Health Needs Assessment
Cando, North Dakota
Ranking of Concerns

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

	Priorities	Most Important
COMMUNITY/ENVIRONMENTAL HEALTH CONCERNS		
Attracting & retaining young families	7	3
Having enough child daycare services	7	0
Not enough jobs with livable wages	1	
Not enough places for exercise/wellness activities	0	
AVAILABILITY/DELIVERY OF HEALTH SERVICES CONCERNS		
Availability of mental health services	8	9
Availability of dental care	3	
Cost of healthcare services	4	
Cost of health insurance	7	2
Ability/willingness of providers to coordinate patient care outside the local community	0	
ALL AGES		
Depression/Anxiety	10	1
Alcohol use & abuse	0	
Drug use & abuse	4	
Not getting enough exercise/physical activity	2	
YOUTH POPULATION HEALTH CONCERNS		
Not enough activities for children & youth	0	
ADULT POPULATION HEALTH CONCERNS		
Obesity/overweight	1	
SENIOR POPULATION HEALTH CONCERNS		
Availability of resources to help elderly stay in their homes	4.5	
Assisted living options	.5	
Cost of long-term/nursing home care	0	
Availability of home health	0	
Availability of activities for seniors	0	
VIOLENCE CONCERNS		
Bullying/cyber-bullying	0	
Child abuse/neglect	1	

Appendix G – Survey "Other" Responses

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

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

1. Considering the PEOPLE in your community, the best things are: "Other" responses:
    - Church is available
    - Clique-y. Especially the medical staff.
    - There is less traffic
    - Wonderful volunteer services
2. Considering the SERVICES AND RESOURCES in your community, the best things are: "Other" responses:
    - Outdoor activities
3. Considering the QUALITY OF LIFE in your community, the best things are: "Other" responses:
    - I don't have to deal with anyone if I don't want to.
4. Considering the ACTIVITIES in your community, the best things are: "Other" responses:
    - Not enough for kids to do in Cando
    - Our town really lacks activities in the community worse and worse every year.
    - Recreational drugs are readily available.
    - There are not a lot of activities available.
    - There aren't really a lot of activities available
    - There is very little
    - While there are awesome of these things here, there are not enough of them.
    - You can hunt

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

5. Considering the COMMUNITY /ENVIRONMENTAL HEALTH in your community, concerns are: "Other" responses:
    - Eating establishments
    - Lack of activities
    - Need PAs other medical professionals to work more than one-two days a week so you can see the same professional if you need to go back that same week.
    - Need recycling in this town
    - Need walking or biking paths
    - No one to work all the jobs in our community
    - Not enough people to fill positions in the community
    - The bad streets help prevent speeding
    - Too many open jobs

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

- Limited available hours for drug prescription services.

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

- Alcohol use and abuse, Depression/anxiety, Obesity/overweight
- Bullying at school
- Peer pressure/bullied

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

- Lack of concern for independent elder living expansion with new hospital plans

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

- A meaningful living wage/earnings to cover all costs of a decent lifestyle through retirement.
- Alcohol
- Attracting families to our town
- Availability of appointments pushed us to travel 40 miles to our primary care clinic instead of using the one in our community. And we feel we are getting better care also.
- Availability of fair wage jobs.
- Childcare- activities for youth
- Childcare/daycare
- Children not getting the care they need at home.
- Communication between general public (patients) and healthcare providers is lagging and could use reform. Nursing home living facility
- Deterioration of quality of services/products offered by local businesses.
- Drug and alcohol abuse
- Drugs - meth houses and the people delivering the drugs.
- Drugs in and around the community
- Grow the population
- Growing community
- Growth, people and families coming to the community. Not enough people that are willing to work.
- Health care and jobs
- I feel the challenge is being able to access specialists in the community rather than having to drive out of town.
- In the living centers, the quality of care senior residents receive and the absence of outside communication and visits is disappointing. Among other activities. It is not only the needs of the elderly, but also their care, which includes the structure of the building in which they reside. Next, the providers, like TCMC are in need of some training on listening and communicating with local and external customers. In addition to the advice provided by patients who must consult with SPECIALISTS from other regional hospitals who also possess the specific credentials and degrees with regard to their particular health condition... factors that this local clinic/hospital does not seem to take into consideration. The nurses can be rude, and when there are biases and unfriendly encounters, it is uncomfortable. A further concern is confidentiality. There is no listening, empathy, or sympathy provided by the health care in Towner County. A large ego exists here. As such, it is detrimental to the health of our local residents if they are in a life or death situation. Including qualifications and training (education).
- Increased crime
- Jobs that pay enough to live on.
- Keeping a hospital and nursing home maintaining health care providers having a school grades K-12
- Lack of consistent mental health resources
- Lack of home health providers.
- Lack of initiative in many businesses to do better. Many seem to be complacent with where they

are, with little interest in attracting out of town clientele or expanding to draw more people in to the community.

- Lack of involvement
- Mental health
- Mental health help for all ages in the community. There is a huge gap when people need in patient treatment.
- Need young families in the community.
- No people, youth leaving
- Not anything for younger kids to do.
- Not enough for youth to do in town.
- Our community is very divided. You have very strong groups of people and they are the ones who seem to speak louder than the rest. They don't allow others into the group unless you have money or "have the right last name" as some people say. They act like they are entitled and have a way of belittling the others. Unfortunately it was once a very friendly town that I enjoyed being a part of. But the past 10 years it has got harder and harder to enjoy the small town life here.
- People not wanting to work. Staff turnover
- Population decline
- Prejudice and privilege with cliques galore. But thank the Lord for some of the good people in this community.
- Shortage of help
- Staffing to fill open job positions. poor wages
- The community needs to come together and not care about who has money or who are the popular people. We all should care and be considerate of everyone in the community. If we came together, I feel this town could really thrive it has so much potential.
- The impression our town makes; The physical appearance is bad. Many unkept yards and homes
- The medical staff talking about patients in the local bars and the medical staff thinking they are superior to everyone else in the community.
- The people running the city
- There a few I being an outsider concerned this town a clique if you're not in clique you don't know what this town offers
- There are not enough social activities outside of going to a bar.
- Unfortunately it's not just in the community, it's across the country. The biggest challenge is people wanting to work!

Delivery of Healthcare

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

    - Family member

17. What services would you like to see in a new hospital?

    - A doctor. Occupational therapy. Speech Therapy
    - An exercise area, weight room.
    - At least one day a week of extended hours in the clinic
    - Better quality care
    - Better wages for receptionists
    - Continue massages and increase availability
    - Dental
    - Dental, dermatology
    - Dental, exercise facility, coffee shop, podiatry
    - Dental services

- Dentist- as we have at least one that plans to live in our community. Counseling services- not sure how this would go over in a small town where everyone knows everyone, possible concerns with confidentially or trust, but important for mental health
- Dermatology facials/botox
- Dialysis
- Dietician
- Doctor!
- Employment of some medical doctors/physicians.
- Everything we now have plus visiting priest
- Exercise classes, dentist
- Exercise classes, mental health care
- Exercise room available more hours and weekends. More attention given to Congregate Housing residents. More activities, more fresh fruits and vegetables.
- Expanded daycare for ease of the growing younger family population.
- Face to face mental health care/counseling
- Group exercise
- Handicap accessible bathrooms, hot water in showers, comfortable temps in rooms and hallways.
- Handicap toilets in all the bathrooms. Therapy swim pool with easy access and warmer water. Handicapped accessible too
- Higher education. Better communication and meeting the health care needs with quality and professionally as well as follows care. Not ego driven.
- Homeopathic medicine, herbal medicine.
- It's good
- Larger ER, larger ER waiting area, better parking lot, an adjacent building for TC ambulance.
- Less gossip and more quality care. Being able to do the favorable paperwork begets awards but quality care is invaluable. People have to live here to understand this community and have the fortitude not to become a peacock because the inside is still the same and you have to live with yourself.
- Medical doctorate degree doctors. 24/7 exercise/weight training room, a swimming pool and jacuzzi wellness bath,
- Medical marijuana providers
- Mental health services
- Mental health services that are not tele-health
- More fixed diagnostics- MRI, ultrasound, nuclear
- MRIs
- One large facility to house the clinic, hospital, indoor connection to the elderly housing unit, nursing home, etc. Fitness center.
- Pharmacy with extended evening/weekend hours.
- Podiatry, cafeteria
- Podiatry
- We are in desperate need of a bigger gym that is available earlier and later, so people who have jobs can have access to it.
- Wellness center- senior activities yoga etc.

18. What would you like to see added to Living Center services?

- A bigger area for the elderly to enjoy more/different activities
- A naturopath.

- Accessibility to seeing outside activities. Don't make them look out the window to no activity.
- Adult daycare and respite services and hospice services, which are not offered readily or at all
- All the above
- Assisted living
- Better quality care
- Better single occupancy rooms
- Fitness center. Recreation-tv center. Better showers and bathing areas. Connected to the hospital.
- Handicapped toilet in all the bathrooms.
- I don't know.
- It's good
- Like to see more imaging available with a in house reader (forget at the moment what the heck they are called)
- More activities
- More activities. Exercise room
- More family activities with residents.
- More staff, seems like the staff is always complaining about being short staff and being unable to complete high quality care due to being short staffed.
- More stuff, dependable
- (2) N/A
- New assisted living building combined with congregate housing
- Nothing
- Open up visitation
- Order by menu - open kitchen daycare interaction
- Separate attached wing for assisted living.
- Swimming pool
- Wing for assisted living

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

- Anonymity
- Can't get off work
- Healthy
- NA
- No regular MD
- Price for services is way higher than surrounding clinics.
- Uninsured

20. Where do you turn for trusted health information? "Other" responses
- ND state health dept, CDC, and Mayo Clinic
- Out of town specialist
- Trusted family members who are doctors

21. What specific healthcare services, if any, do you think should be added locally?
- Cancer care
- Childhood/student mental health. Counseling services
- Dental
- Dental care
- Dentist and evening counseling
- Dermatology
- Dialysis

- Dialysis unit
- Dietician
- Exercise instructor, mental health professional
- General surgeries
- Get a dr. in town
- Gynecology
- Internal organ doctors and specialists. Mental health professional.
- MD
- (2) Mental health
- Mental/behavioral health
- More assisted living arrangements
- More options for those who don't live in Cando but need transportation.
- More specialists and dental
- NA
- Non telemed mental health
- Nurse help line
- Pre-natal
- Public health being open to providing all services, such as COVID-19 testing and shots, when they are open. Would prefer to just run in to public health and get that done instead of having to make an appointment at the clinic. The clinic does a fine job, but I thought that was a service public health was supposed to do. The limited times they offer it makes it difficult to use them for it and then it puts more work on the clinic staff.

32. Overall, please share concerns and suggestions to improve the delivery of local healthcare.
    - Already have.
    - An updated clinic and hospital would attract more people and staff members
    - Chiropractor prices are double those of other places, Cando healthcare seems highest in the area
    - Confidentiality!
    - I'm thankful for our hospital and all it can provide. I think adding anything to keep as many appointments as possible local is huge. Although I do believe the hospital does a nice job currently.
    - It would be great to see more specialist providers come out to rural locations on a regular basis. It can be very hard for people to travel 2-4 hours for those appointments.
    - Keeping up is a major challenge.
    - Make it accessible, especially emergency services.
    - More nursing staff- to cover "respiratory clinic" and especially clinic staff to answer phone calls. Better wage for receptionists- struggling to find anyone to fill positions
    - Personally I would like to see the healthcare professionals work more days so you can see the same one when you need too.
    - Recruit some medical doctors to our community.
    - Since this is a small facility which does not have a physician on staff, there must be more than a willingness to work with out of network practitioners, especially specialists whose test interpretations and recommendations may differ from that of this medical center--there must be the DESIRE to accommodate patients who trust and depend on their specialists, and those patients must know beyond any doubt that their specialists directives will be respected.
    - Sometimes, it seems the "doctors" don't see the whole picture on health. They want the quickest, easiest fix rather than treating the entire person (homeopathy). They are sometimes lax in doing research to diagnose and treat. The billing system is ridiculous. It should be kept local and not handled by some company out of state.
    - We have excellent healthcare providers and nurses. My concern is having enough staff such as CNAS, dietary help, housekeeping.
    - We need a doc.
    - Whole survey