Community Health Needs Assessment

2019

Langdon, North Dakota

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Executive Summary

To help inform future decisions and strategic planning, Cavalier County Memorial Hospital (CCMH) conducted a community health needs assessment (CHNA) in 2019, the previous CHNA having been conducted in 2016. The Center for Rural Health (CRH) at the University of North Dakota School of Medicine and Health Sciences (UNDSMHS) facilitated the assessment process, which solicited input from area community members and healthcare professionals as well as analysis of community health-related data.

To gather feedback from the community, residents of the area were given the opportunity to participate in a survey. Thirty-three CCMH service area residents completed the survey. Additional information was collected through five key informant interviews with community members. The input from the residents, who primarily reside in Cavalier 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, Cavalier County's population from 2010 to 2018 decreased 4.1%. The average of residents under age 18 (21.5%) for the county is slightly less than the state average of 23.3%. The percentage of residents ages 65 and older (27.4%) is about 12.4% higher for Cavalier County than the North Dakota average (15.0%), and the rates of education for the county are exactly the same as North Dakota's at 92%. The median household income in Cavalier County ($65,505) is a little higher than the state average for North Dakota ($61,285).

Data compiled by County Health Rankings show Cavalier County is doing better than North Dakota in health outcomes/factors for 13 categories, while matching the state average in one category. According to the same rankings, Cavalier County is performing poorly relative to the rest of the state in 16 categories.

Of the 82 potential community and health needs set forth in the survey, the 33 CCMH service area residents who completed the survey indicated the following ten needs as the most important:

- Ability to retain primary care providers & nurses in the community
- Alcohol use and abuse – youth and adult
- Attracting and retaining young families
- Availability of primary care providers & nurses
- Cancer – adult
- Cost of long-term/nursing home care - seniors
- Depression/anxiety – youth and adult
- Drug use and abuse - youth
- Having enough child daycare services
- Not enough jobs with livable wages

The survey also revealed the biggest barriers to receiving healthcare (as perceived by community members). They included not being able to see same provider over time (N=18), not enough providers (MD, DO, NP, PA) (N=11) and poor quality of care (N=7).

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

- Active faith community
- Family-friendly
- People are friendly, helpful, supportive
- People who live here are involved in their community

- Recreational and sports activities
- Safe place to live

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:

- Ability to retain primary care providers (MD, DO, NP, PA) and nurses
- Alcohol use and abuse
- Availability/cost of activities for seniors
- Depression/anxiety
- Having enough child daycare services

Overview and Community Resources

With assistance from the CRH at the UND-SMHS, the Cavalier County Memorial Hospital completed a CHNA of the CCMH service area. The hospital identifies its service area as Cavalier County. Many community members and stakeholders worked together on the assessment.

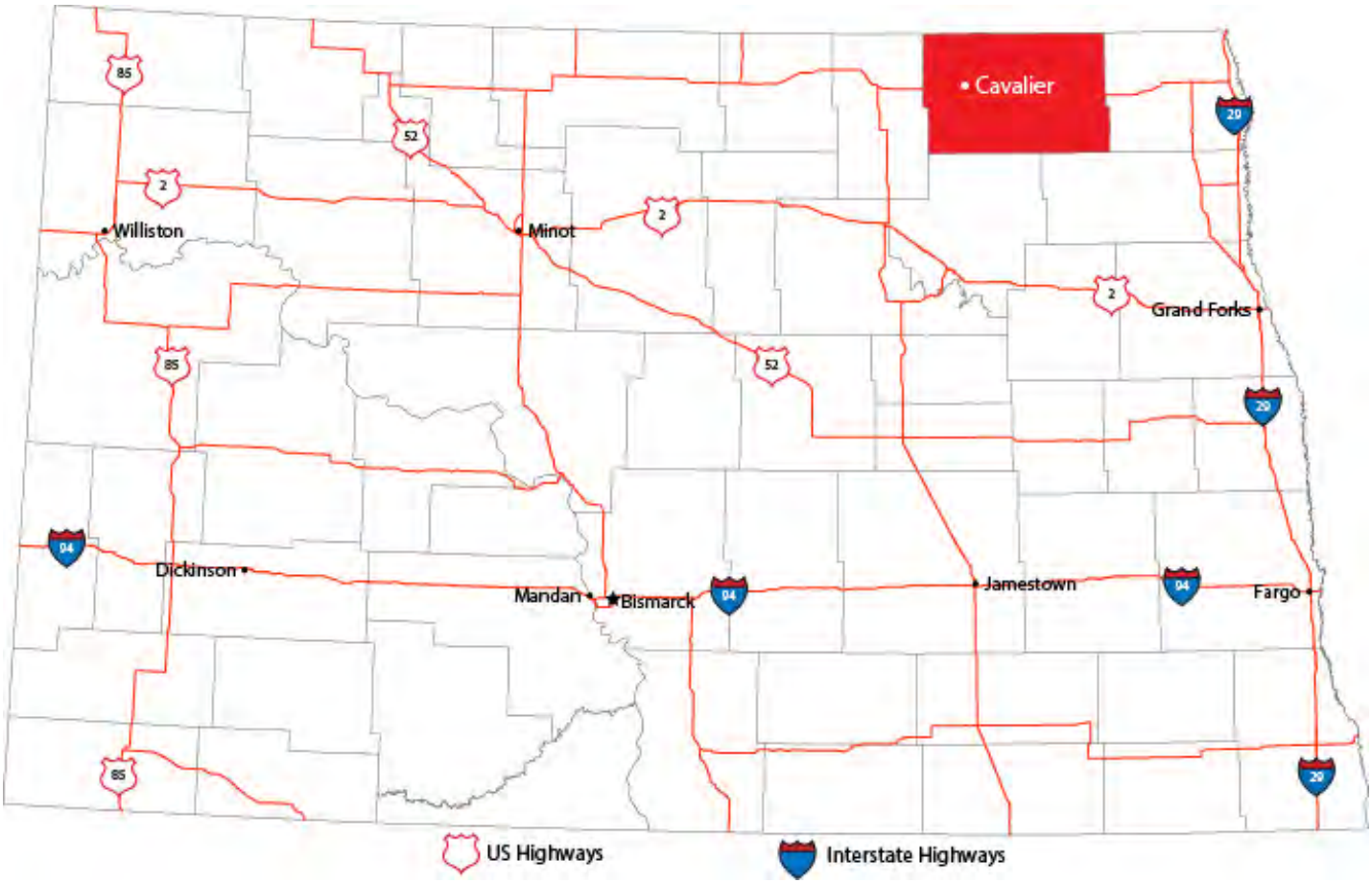
CCMH is located in northeastern North Dakota, approximately 140 miles north of Grand Forks and 17 miles from the Canadian border. Along with the hospital, agriculture provides the economic base for the town of Langdon and Cavalier County. According to the 2010 U.S. Census, Cavalier County had a population of 3,993.

Cavalier County has a number of community assets and resources that can be mobilized to address population health improvement. In terms of physical assets and features, the community includes a pool, city park, golf course, and movie theatre. Pembina Gorge State Recreation Area offers multi-use trails for biking, hiking, and ATV riding.

The Cavalier County school system offers a comprehensive program for students K-12.

Other healthcare facilities and services in the area include a pharmacy, an optometrist, dentist, and chiropractor.

Figure 1: : Cavalier County



Cavalier County Memorial Hospital

CCMH has been providing quality healthcare to the people of the area since 1939. The hospital is operated as a nonprofit corporation with a Board of Directors represented by people of the hospital's service area.

CCMH provides inpatient and emergency services as a Medicare Designated Critical Access Hospital in its 20 bed facility located in Langdon, North Dakota. In addition to the hospital, the nonprofit corporation operates outpatient clinics in Langdon and Walhalla.

Mission

CCMH's mission states; Standing proudly on the traditions and perseverance of our many hospital founders, Cavalier County Memorial Hospital & Clinics is dedicated to excel at providing high quality, compassionate healthcare to all that we serve.

Services offered locally by CCMH include:

General and Acute Services

- Allergy, flu, & pneumonia shots
- Blood pressure checks
- Cardiology (visiting physician)
- Clinic
- Emergency room
- Gynecology (visiting physician)
- Hospital (acute care)
- Mole/wart/skin lesion removal
- Nutrition counseling
- Orthopedics (visiting physician)
- Pharmacy
- Podiatry
- Prenatal care up to 32 weeks
- Physicals: annuals, D.O.T., sports & insurance
- Sports medicine
- Swing bed services

Screening/Therapy Services

- Chronic disease management
- Holter monitoring
- Laboratory services
- Occupational therapy
- Pediatric services
- Physical therapy
- Sleep studies
- Social services

Radiology Services

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

Laboratory Services

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

Services Offered by Other Providers/Organizations

- Ambulance
- Chiropractic services
- Dental services
- Massage therapy
- Optometric/vision services

Cavalier County Health District

Cavalier County Health District (CCHD) works to promote preventive community health through initiatives including increasing physical activity, promoting healthy nutrition and body weight, reducing injury, and environmental protection. Programs like worksite wellness are offered to businesses of Cavalier County.

Specific services that CCHD provides are:

- Bicycle helmet safety education
- Blood pressure checks
- Breastfeeding resources
- Car seat program
- Child health (well-baby checks)
- Correction facility health
- Diabetes screening
- Emergency preparedness services
- Environmental health services
- Flu shots
- Health Tracks
- Home health – in-home nursing care
- Immunizations
- Medication setup – home visits
- Member of child protection team and county interagency team
- Newborn home visits
- Nutrition education
- School health – vision, hearing, scoliosis screenings in schools, health education and resource to the schools
- Preschool education programs & screening
- Tobacco prevention and control
- Tuberculosis testing and management
- West Nile program – surveillance and education
- WIC (women, infants & children) program
- Worksite wellness – coordinator for county employees and sheriff's dept.
- Youth education programs (first aid, bike safety)

Assessment Process

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

A CHNA benefits the community by:

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

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

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

4) Engaging community members about the future of healthcare; and

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

This assessment examines health needs and concerns in Cavalier County. In addition to Langdon, located in the county are the cities of Alsen, Calico, Calvin, Hannah, Loma, Milton, Munich, Nekoma, Osnabrock, Sarles, and Wales.

The CRH, in partnership with CCMH and CCHD, 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 the CRH and Langdon. A steering committee of seven individuals (see Figure 2) was formed that was responsible for planning and implementing the process locally. Representatives from the CRH met and corresponded regularly by teleconference and/or via the eToolkit with the CHNA liaison. The community group (described in more detail below) provided in-depth information and informed the assessment process in terms of community perceptions, community resources, community needs, and ideas for improving the health of the population and healthcare services. Seven people, representing a cross section demographically, attended the focus group meeting. The meeting was highly interactive with good participation. CCMH staff and board members were in attendance as well, but largely played a role of listening and learning.

Figure 2: Steering Committee

Jeff Stanley	CEO, Cavalier County Memorial Hospital
Darla Roder	COO, Cavalier County Memorial Hospital
Jamie Nienhius	CNO, Cavalier County Memorial Hospital
Emily Balsdon	Population Health Nurse, Cavalier County Memorial Hospital
Terri Gustafson	Public Health Nurse, Cavalier County Health District
Morgan Zeis	Community Representative
Monica Heck	Administrative Assistant, Cavalier County Memorial Hospital

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

As part of the assessment's overall collaborative process, the 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 focus group, comprised of community leaders and area residents, was convened to discuss area health needs and inform the assessment process; and
- A wide range of secondary sources of data were examined, providing information on a multitude of measures, including demographics, health conditions, indicators, outcomes, rates of preventive measures; rates of disease; and at-risk behavior.

The 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. The 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. The CRH connects the UNDSMHS and other necessary resources, to rural communities and their healthcare organizations in order to maintain access to quality care for rural residents. In this capacity, the 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 seven community members was convened and first met on April 15, 2019. 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 May 22, 2019 with seven 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 Cavalier 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 CCMH and CCHD. They included representatives of the health and business communities. Not all members of the group were present at both meetings.

Interviews

One-on-one interviews with five key informants were conducted in person in Langdon on April 15, 2019. A representative from the CRH conducted the interviews. Interviews were held with selected members of the community who could provide insights into the community's health needs. Included among the informants were public health professionals with special knowledge in public health acquired through several years of direct experience in the community, including working with medically underserved, low income, and minority populations, as well as with populations with chronic diseases.

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

Survey

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

The community member survey was distributed to various residents of Cavalier County, which is covered by the CCMH service area.

The survey tool was designed to:

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

Specifically, the survey covered the following topics:

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

To promote awareness of the assessment process, information was published in the local newspaper, posted on social media, and promoted through radio spots.

Approximately 50 community member paper surveys were available for distribution in Cavalier County. The surveys were distributed by community group members and at CCMH, CCHD, and area business offices.

To help ensure anonymity, included with each survey was a postage-paid return envelope to the Center for Rural Health. The survey period ran from April 15 to May 15, 2019. Ten completed paper surveys were returned.

In addition, to help make the survey as widely available as possible, residents also could access the survey online. The online version of the survey was publicized in the community newspapers, social media, and the CCMH website. There were 23 online surveys completed. In total, counting both paper and online surveys, 33 community member surveys were completed, equating to a 1.8% response rate. This response rate is below expected rates for this type of unsolicited survey methodology and does not indicate an engaged community.

Secondary Data

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

KIDS COUNT, which is a national and state-by-state effort to track the status of children, sponsored by the Annie E. Casey Foundation (www.ndkidscount.org).

Social Determinants of Health

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

Income-level, educational attainment, race/ethnicity, and health literacy all impact the ability of people to access health services. Basic needs such as clean air and water and safe and affordable housing are all essential to staying healthy and 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.

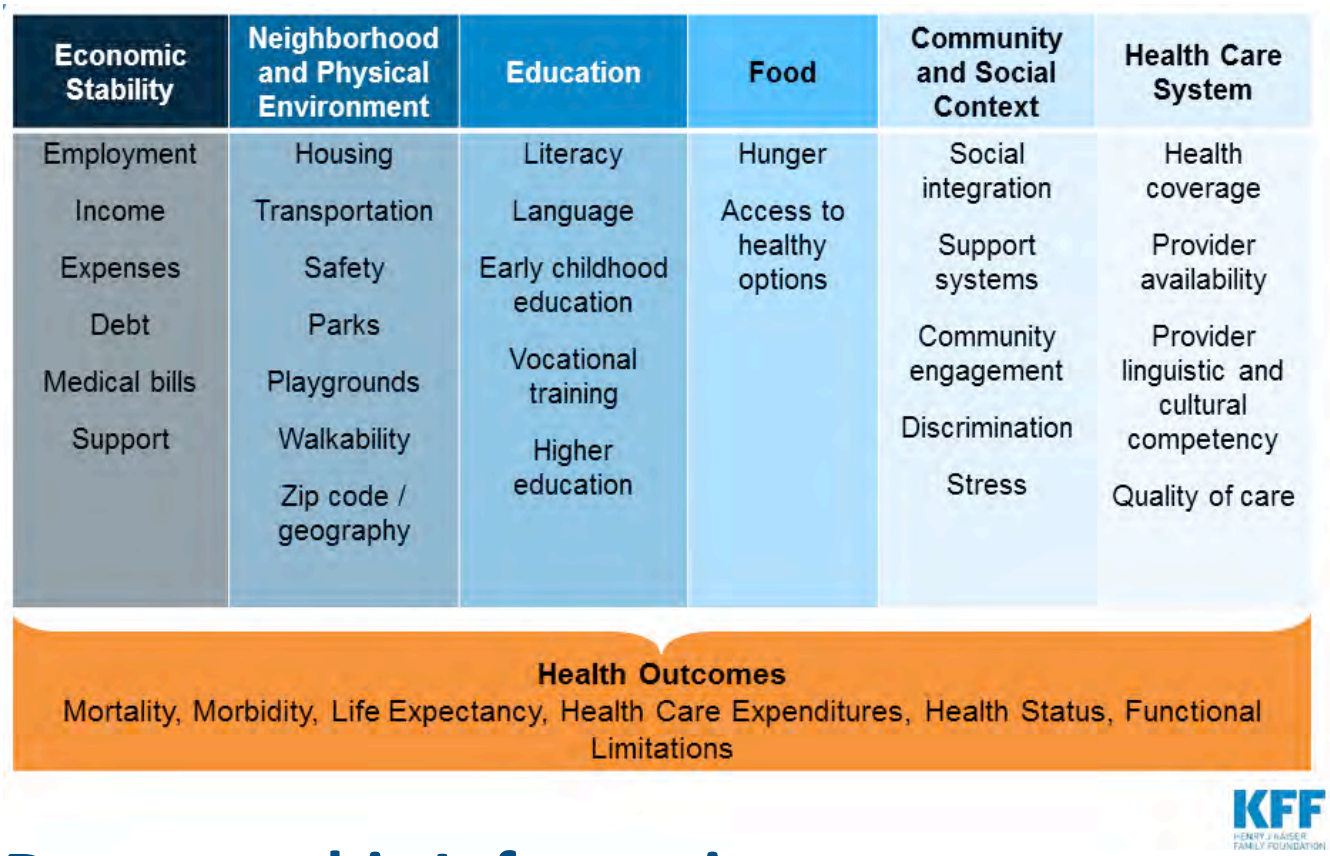
Healthy People 2020, (https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health) illustrates that health and healthcare, while vitally important, play only one small role (approximately 20%) in the overall health of individuals, and ultimately of a community. Social and community context, education, economic stability, neighborhood and built environment 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. See Figure 3.

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



Demographic Information

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

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(From 2010 Census/2017 American Community Survey; more recent estimates used where available)Source: https://www.census.gov/quickfacts/fact/table/ND,US/INC910216#viewtop and https://factfinder.census.gov/faces/nav/jsf/pages/community_facts.xhtml#

	Cavalier County	North Dakota
Population (2017)	3,829	755,393
Population change (2010-2017)	-4.1%	12.3%
People per square mile (2010)	2.7	9.7
Persons 65 years or older (2016)	27.4%	15.0%
Persons under 18 years (2016)	21.5%	23.3%
Median age (2016 est.)	50.1	35.2
White persons (2016)	96%	87.5%
Non-English speaking (2016)	3.2%	5.6%
High school graduates (2016)	92%	92.0%
Bachelor's degree or higher (2016)	18.8%	28.2%
Live below poverty line (2016)	9.6%	10.7%
Persons without health insurance, under age 65 years (2016)	8.9%	8.1%

While the population of North Dakota has grown in recent years, Cavalier County has seen a decrease in population since 2010. The U.S. Census Bureau estimates show that the county's population decreased from 3,994 (2010) to 3,829 (2018).

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, Cavalier 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 2019 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 2019 County Health Rankings – a flow chart of how a county's rank is determined – may be found in Appendix B. For further information, visit the County Health Rankings website at www.countyhealthrankings.org.

Health Outcomes

- Length of life
- Quality of life

Health Factors

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

Health Factors (continued)

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

Table 2 summarizes the pertinent information gathered by County Health Rankings as it relates to Cavalier 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 Cavalier County Health District and Cavalier County Memorial Hospital or of any particular medical facility.

For most of the measures included in the rankings, the County Health Rankings' authors have calculated the "Top U.S. Performers" for 2019. The Top Performer number marks the point at which only 10% of counties in the nation do better, i.e., the 90th percentile or 10th percentile, depending on whether the measure is framed positively (such as high school graduation) or negatively (such as adult smoking).

Cavalier County rankings within the state are included in the summary following. For example, the county ranks 43rd out of 49 ranked counties in North Dakota on health outcomes and 14th on health factors. The measures marked with a 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 checkmark but are marked with a plus sign (+) indicate that the county is doing better than the U.S. Top 10%.

The data from County Health Rankings shows that Cavalier County is doing better than many counties compared to the rest of the state on all but one of the outcomes, landing at or above rates for other North Dakota counties. Unlike many other counties in North Dakota, Cavalier County is also doing well in many areas when it comes to the U.S. Top 10% ratings.

On health factors, Cavalier County performs below the North Dakota average for counties in several areas, but also above the state average for a significant amount as well.

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

- Poor or fair health
- Poor physical health days
- Poor mental health days
- Adult smoking
- Food environment index
- Excessive drinking
- Sexually transmitted infections
- Mammography screenings
- Flu vaccinations
- Unemployment
- Children in single-parent households
- Social associations
- Severe housing problems

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

- Low birth weight
- Adult obesity
- Physical inactivity
- Access to exercise opportunities
- Alcohol-impaired driving deaths
- Teen birth rate
- Uninsured individuals
- Primary care physicians
- Dentists
- Mental health providers
- Preventable hospital stays
- Children in poverty
- Income inequality
- Injury deaths
- Air pollution – particulate matter

TABLE 2: SELECTED MEASURES FROM COUNTY HEALTH RANKINGS 2019 – CAVALIER 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* 2019 – CAVALIER COUNTY			
	Cavalier County	U.S. Top 10%	North Dakota
Ranking: Outcomes	**43rd**		**(of 49)**
Premature death		5,400	6,700
Poor or fair health	11% +	12%	14%
Poor physical health days (in past 30 days)	2.6 +	3.0	3.0
Poor mental health days (in past 30 days)	2.5 +	3.1	3.1
Low birth weight	9% ●■	6%	6%
Ranking: Factors	**14th**		**(of 49)**
Health Behaviors			
Adult smoking	14% +	14%	20%
Adult obesity	35% ●■	26%	32%
Food environment index (10=best)	9.3 +	8.7	9.1
Physical inactivity	29% ●■	19%	22%
Access to exercise opportunities	62% ●■	91%	74%
Excessive drinking	20% ■	13%	26%
Alcohol-impaired driving deaths	50% ●■	13%	46%
Sexually transmitted infections	104.5 +	152.8	456.5
Teen birth rate	26 ●■	14	23
Clinical Care			
Uninsured	9% ●■	6%	8%
Primary care physicians	3,830:1 ●■	1,050:1	1,320:1
Dentists	3,760:0 ●■	1,260:1	1,530:1
Mental health providers	3,760:1 ●■	310:1	570:1
Preventable hospital stays	5,224 ●■	2,765	4,452
Mammography screening (% of Medicare enrollees ages 65-74 receiving screening)	59% +	49%	50%
Flu vaccinations (% of fee-for-service Medicare enrollees receiving vaccination)	54% +	52%	47%
Social and Economic Factors			
Unemployment	2.6% +	2.9%	2.6%
Children in poverty	13% ●■	11%	11%
Income inequality	4.5 ●■	3.7	4.4
Children in single-parent households	20% +	20%	27%
Social associations	26.1 +	21.9	16.0
Violent crime	79 ■	63	258
Injury deaths	78 ●■	57	69
Physical Environment			
Air pollution – particulate matter	5.9 +●	6.1	5.4
Drinking water violations	No		
Severe housing problems	5% +	9%	11%

Source: http://www.countyhealthrankings.org/app/north-dakota/2018/rankings/outcomes/overall

Children's Health

The National Survey of Children's Health touches on multiple intersecting aspects of children's lives. Data is 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 2011-12. More information about the survey is found at www.childhealthdata.org/learn/NSCH.

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

Table 3: Selected Measures Regarding Children's Health (For children aged 0-17 unless noted otherwise)

Source: http://childhealthdata.org/browse/data-snapshots/nsch-profiles?geo=1&geo2=36&rpt=16

Health Status	North Dakota	National
Children born premature (3 or more weeks early)	10.8%	11.6%
Children 10-17 overweight or obese	35.8%	31.3%
Children 0-5 who were ever breastfed	79.4%	79.2%
Children 6-17 who missed 11 or more days of school	4.6%	6.2%
Healthcare		
Children currently insured	93.5%	94.5%
Children who had preventive medical visit in past year	78.6%	84.4%
Children who had preventive dental visit in past year	74.6%	77.2%
Young children (10 mos.-5 yrs.) receiving standardized screening for developmental or behavioral problems	20.7%	30.8%
Children aged 2-17 with problems requiring counseling who received needed mental healthcare	86.3%	61.0%
Family Life		
Children whose families eat meals together 4 or more times per week	83.0%	78.4%
Children who live in households where someone smokes	29.8%	24.1%
Neighborhood		
Children who live in neighborhood with a park, sidewalks, a library, and a community center	58.9%	54.1%
Children living in neighborhoods with poorly kept or rundown housing	12.7%	16.2%
Children living in neighborhood that's usually or always safe	94.0%	86.6%

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:

- Obese or overweight children ages 10-17;
- Children with health insurance;
- Preventive primary care and dentist visits;
- Developmental/behavioral screening for children 10 months to 5 years of age;

- Children who have received needed mental healthcare; and
- Children living in smoking households.

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

The data show that Walsh County is performing more poorly than the North Dakota average on all of the examined measures except the percentage of uninsured children below 200% of poverty. The most marked difference was on the number of Medicaid recipients (almost 10% higher than the state average).

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

	Cavalier County	North Dakota
Uninsured children (% of population age 0-18), 2016	10.5%	9.0%
Uninsured children below 200% of poverty (% of population), 2016	41.9%	41.9%
Medicaid recipient (% of population age 0-20), 2017	24.7%	28.3%
Children enrolled in Healthy Steps (% of population age 0-18), 2013	4.9%	2.5%
Supplemental Nutrition Assistance Program (SNAP) recipients (% of population age 0-18), 2017	11.9%	20.1%
Licensed childcare capacity (% of population age 0-13), 2018	41.8%	44.3%
4-Year High School Cohort Graduation Rate, 2017	93.9%	88.0%

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

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

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

Table 5 depicts some of the YRBS data that has been collected in 2013, 2015, and 2017. At this time, the North Dakota-specific data for 2017 is not available, so data for 2013 and 2015 are shown for North Dakota. They are further broken down by rural and urban percentages. The trend column shows a "=" for statistically insignificant change (no change), "↑" for an increased trend in the data changes from 2013 to 2015, and "↓" for a decreased trend in the data changes from 2013 to 2015. The final column shows the 2017 national average percentage. For a more complete listing of the YRBS data, see Appendix C.

TABLE 5: Youth Behavioral Risk Survey Results

North Dakota High School Survey

Sources: https://www.nd.gov/dpi/uploads/1298/2015NDHStatewideYRBSReport20151110FINAL2NoCover.pdf; https://www.nd.gov/dpi/uploads/1298/2015NDHTrendReportUpdated42016.pdf; https://www.cdc.gov/healthyyouth/data/yrbs/results.htm

	ND 2013	ND 2015*	ND Trend ↑, ↓, =	Rural ND Town Average	Urban ND Town Average	National Average 2017
Injury and Violence						
% of students who rarely or never wore a seat belt.	11.6	8.5	↓	10.5	7.5	5.9
% of students who rode in a vehicle with a driver who had been drinking alcohol (one or more times during the 30 prior to the survey)	21.9	17.7	↓	21.1	15.2	16.5
% of students who talked on a cell phone while driving (on at least 1 day during the 30 days before the survey)	67.9	61.4	↓	60.7	58.8	NA
% of students who texted or e-mailed while driving a car or other vehicle (on at least 1 day during the 30 days before the survey)	59.3	57.6	=	56.7	54.4	39.2
% of students who were in a physical fight on school property (one or more times during the 12 months before the survey)	8.8	5.4	↓	6.9	6.1	8.5
% of students who were ever physically forced to have sexual intercourse (when they did not want to)	7.7	6.3	=	6.5	7.4	7.4
% of students who were bullied on school property (during the 12 months before the survey)	25.4	24.0	=	27.5	22.4	19.0
% of students who were electronically bullied (includes e-mail, chat rooms, instant messaging, websites, or texting during the 12 months before the survey)	17.1	15.9	=	17.7	15.8	14.9
% of students who made a plan about how they would attempt suicide (during the 12 months before the survey)	13.5	13.5	=	12.8	13.7	13.6
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 1 day during the 30 days before the survey)	NA	22.3	↑	19.7	22.8	13.2
% of students who currently used cigarettes, cigars, or smokeless tobacco (on at least 1 day during the 30 days before the survey)	27.5	20.9	↓	22.9	19.8	14.0
% of students who drank five or more drinks of alcohol in a row (within a couple of hours on at least 1 day during the 30 days before the survey)	21.9	17.6	↓	19.8	17.0	13.5
% of students who currently used marijuana (one or more times during the 30 days before the survey)	15.9	15.2	=	13.2	17.1	19.8
% of students who ever took prescription drugs without a doctor's prescription (such as OxyContin, Percocet, Vicodin, codeine, Adderall, Ritalin, or Xanax, one or more times during their life)	17.6	14.5	↓	13.2	16.0	14.0
Weight Management, Dietary Behaviors, and Physical Activity						
% of students who were overweight (>= 85th percentile but <95th percentile for body mass index)	15.1	14.7	=	15.4	14.6	15.6
% of students who were obese (>= 95th percentile for body mass index)	13.5	14.0	=	16.3	12.9	14.8

% of students who did not eat fruit or drink 100% fruit juices (during the 7 days before the survey)	3.4	3.9	=	4.3	4.1	5.6
% of students who did not eat vegetables (green salad, potatoes [excluding French fries, fried potatoes, or potato chips], carrots, or other vegetables, during the 7 days before the survey)	6.0	4.7	=	4.5	5.2	7.2
% 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 7 days before the survey)	23.4	18.7	=	21.4	18.0	18.7
% of students who did not drink milk (during the 7 days before the survey)	11.1	13.9	↑	11.6	13.7	26.7
% of students who did not eat breakfast (during the 7 days before the survey)	10.5	11.9	=	10.7	11.8	14.1
% 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)	3.1	2.2	=	2.4	2.8	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 7 days before the survey)	50.6	51.3	=	51.7	50.1	46.5
% of students who watched television 3 or more hours per day (on an average school day)	21.0	18.9	=	20.7	18.2	20.7
% of students who played video or computer games or used a computer 3 or more hours per day (for something that was not school work on an average school day)	34.4	38.6	↑	39.4	38.0	43.0
Other						
% of students who ever had sexual intercourse	44.9	38.9	↓	39.3	39.1	39.5
% of students who had 8 or more hours of sleep (on an average school night)	30.0	29.5	=	34.5	28.7	25.4
% of students who brushed their teeth on seven days (during the 7 days before the survey)	71.5	71.0	=	67.8	70.1	NA

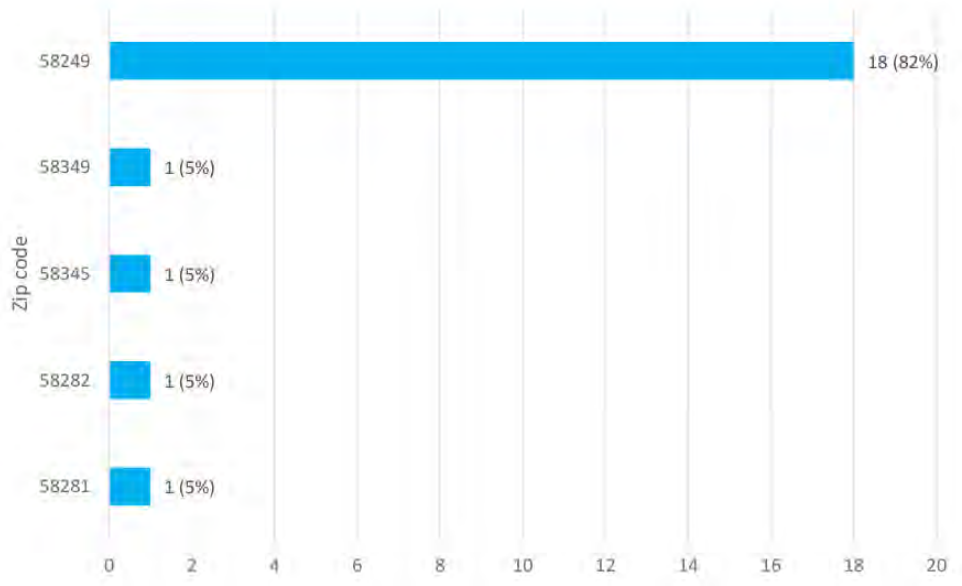
Sources: https://www.nd.gov/dpi/uploads/1298/2015NDHStatewideYRBSReport20151110FINAL2NoCover.pdf; https://www.nd.gov/dpi/uploads/1298/2015NDHTrendReportUpdated42016.pdf; https://www.cdc.gov/healthyyouth/data/yrbs/results.htm

Survey Results

As noted previously, 33 community members completed the survey in communities throughout the counties in the CCMH service area. For all questions that contained an "Other" response, all of those direct responses may be found in Appendix D. 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.

The survey requested that respondents list their home zip code. While not all respondents provided a zip code, 22 did, revealing that the large majority of respondents (82%, N=18) lived in Langdon. These results are shown in Figure 5.

Figure 5: Survey Respondents' Home Zip Code Total respondents: 370



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:

- 52% (N=14) were age 55 or older.
- The majority (77%, N=20) were female.
- Slightly less than half of the respondents (44%, N=12) had bachelor's degrees or higher.
- The number of those working full time (50%, N=14) was a little over twice the number of those who were retired (21%, N=6).
- 100% (N=28) of those who reported their ethnicity/race were white/Caucasian.
- 26% of the population (N=7) had household incomes of less than $50,000.

Figures 6 through 12 show these demographic characteristics. It illustrates the range of community members' household incomes and indicates how this assessment took into account input from parties who represent the

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

Figure 6: Age Demographics of Survey Respondents
Total respondents = 27

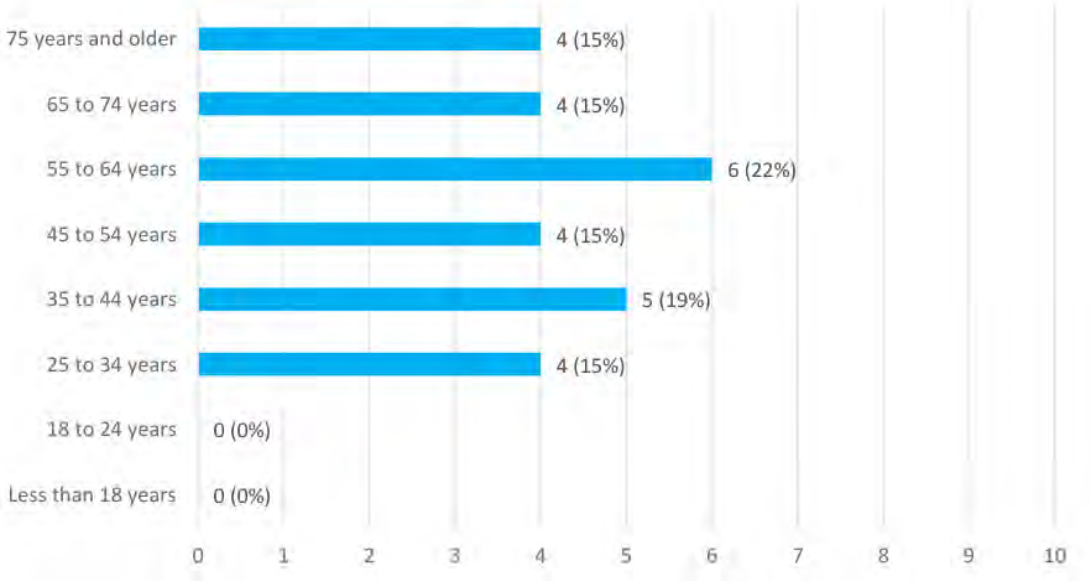


Figure 7: Gender Demographics of Survey Respondents
Total respondents = 26

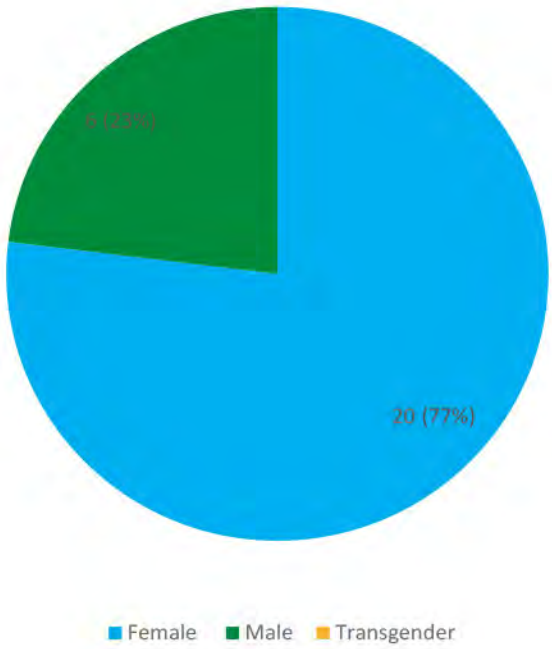


Figure 8: Educational Level Demographics of Survey Respondents
Total respondents = 27

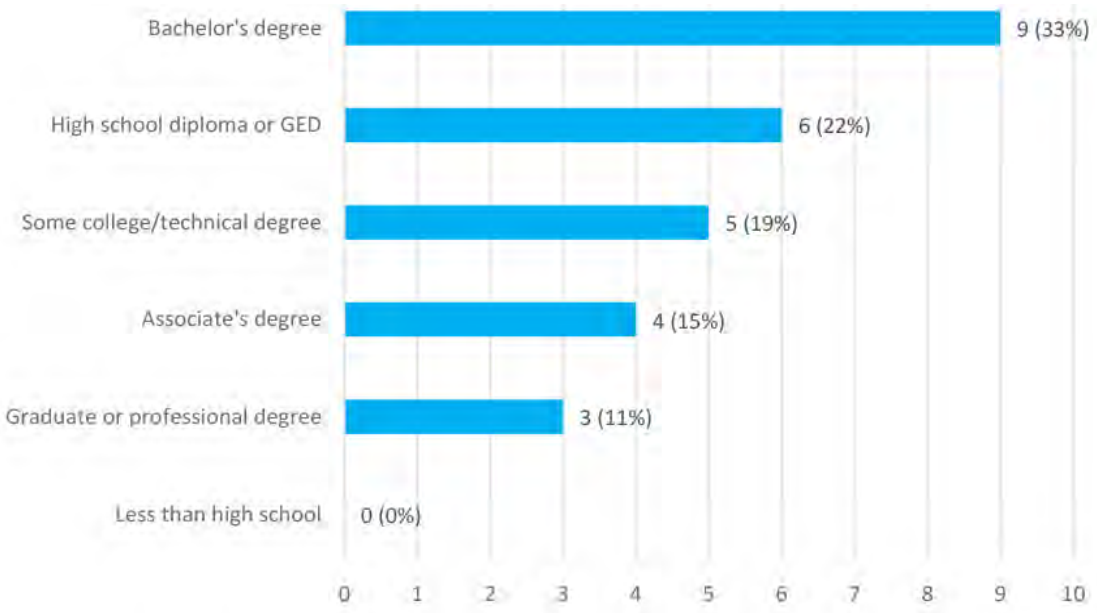
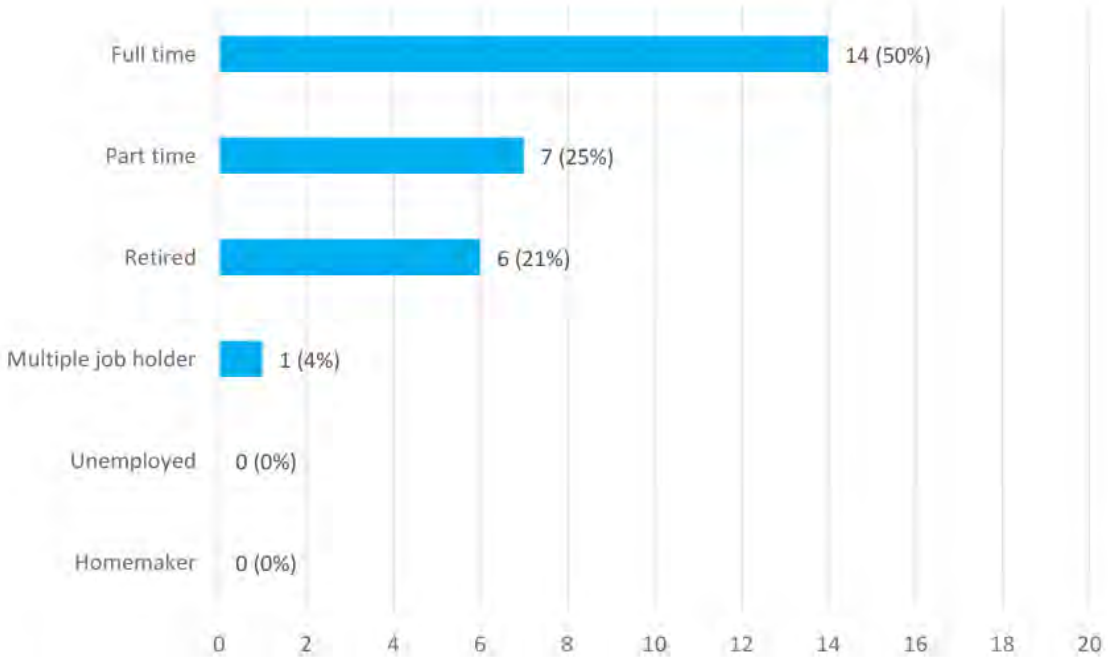
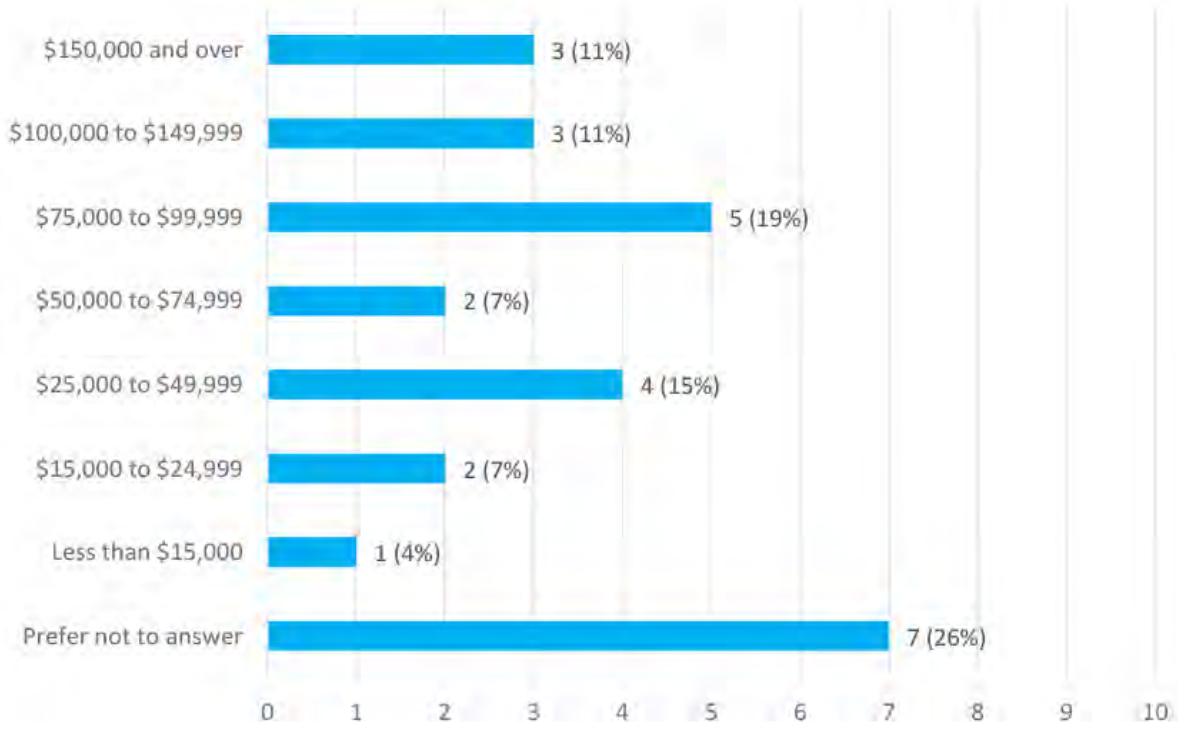


Figure 9: Employment Status Demographics of Survey Respondents
Total respondents = 28



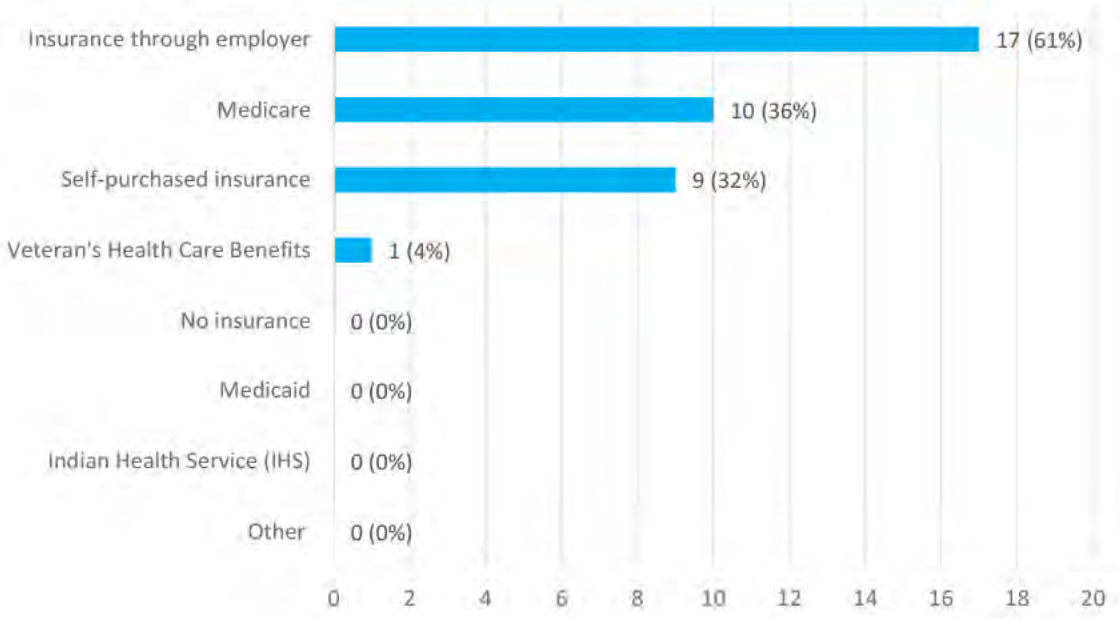
Of those who provided a household income, 11% (N=3) community members reported a household income of less than $25,000. Twenty-two percent (N=6) indicated a household income of $100,000 or more. This information is show in Figure 10.

Figure 10: Household Income Demographics of Survey Respondents



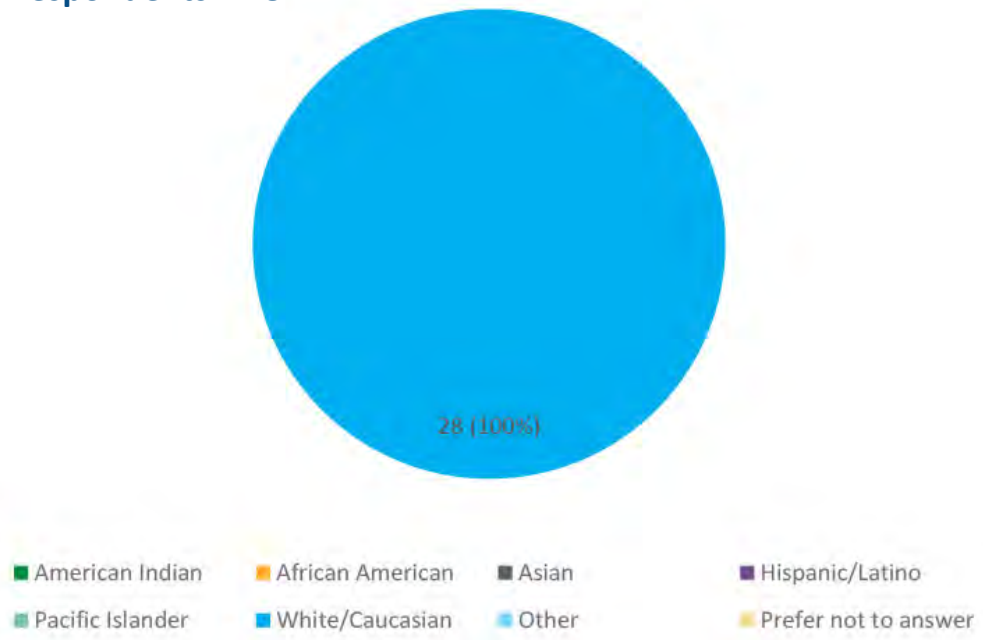
Community members were asked about their health insurance status, which is often associated with whether people have access to healthcare. All of those who responded carried insurance, with the most common insurance types being insurance through one's employer (N=17), followed by Medicare (N=10) and self-purchased (N=9)

Figure 11: Health Insurance Coverage Status of Survey Respondents Total respondents = 37



As shown in Figure 12, all of the respondents were white/Caucasian (100%). This was higher but still in-line with the race/ethnicity of the overall population of Cavalier County; the US Census indicates that 96.0% of the population is white in the county.

Figure 12: Race/Ethnicity Demographics of Survey Respondents
Total respondents = 28



Community Assets and Challenges

Survey-respondents were asked what they perceived as the best things about their community in four categories: people, services and resources, quality of life, and activities. In each category, respondents were given a list of choices and asked to pick the three best things. Respondents occasionally chose less than three or more than three choices within each category. If more than three choices were selected, their responses were not included. The results indicate there is consensus (with at least 100 respondents agreeing) that community assets include:

- Family-friendly (N=25)
- Safe place to live, little/no crime (N=24)
- People are friendly, helpful, supportive (N=23)
- People who live here are involved in their community (N=22)
- Active faith community (N=20).

Figures 13 to 16 illustrate the results of these questions.

Figure 13: Best Things about the PEOPLE in Your Community
Total responses = 75

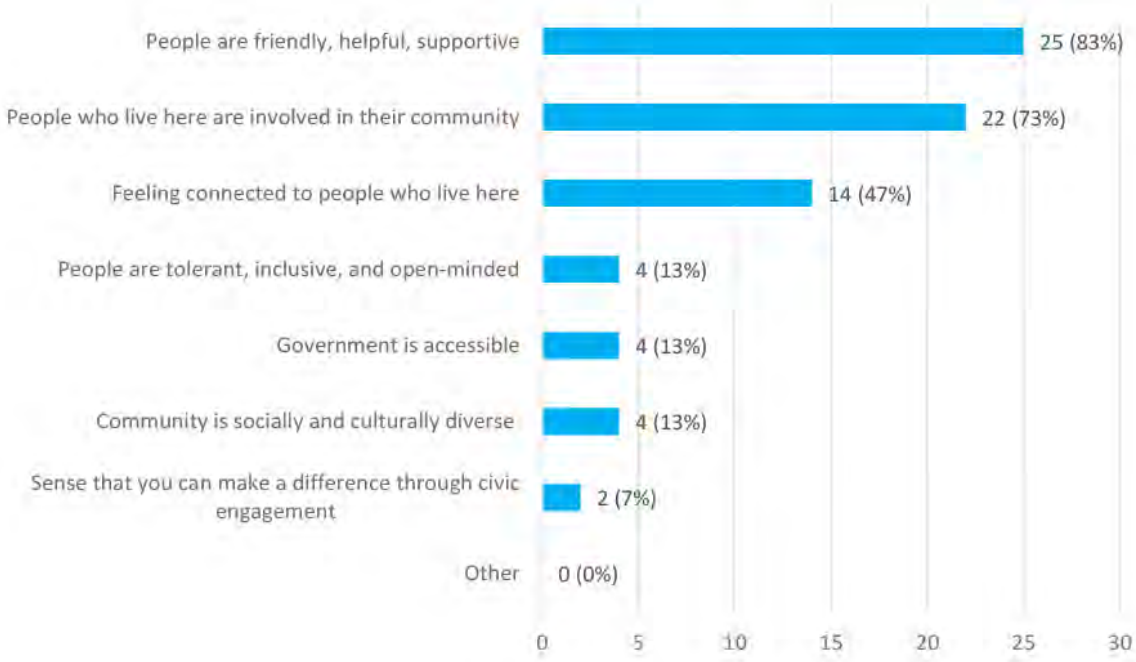
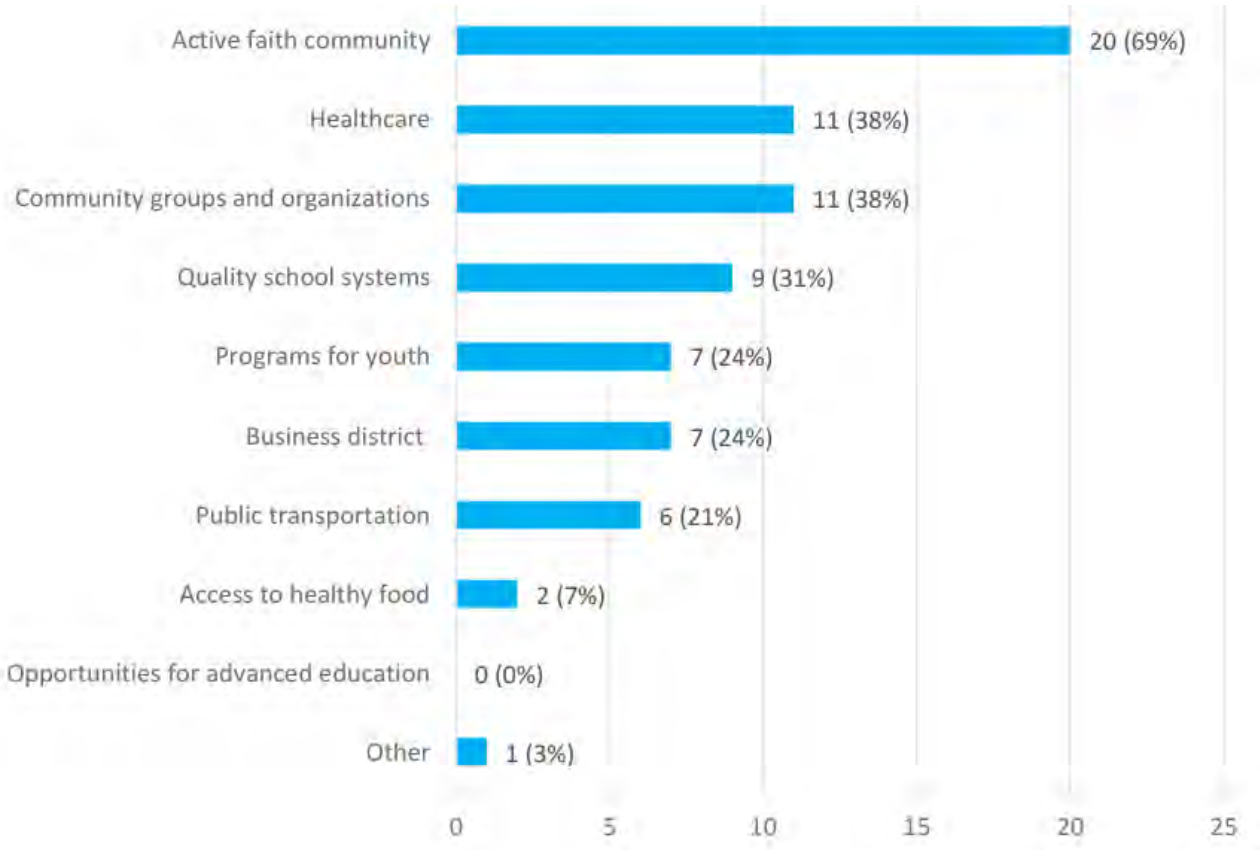
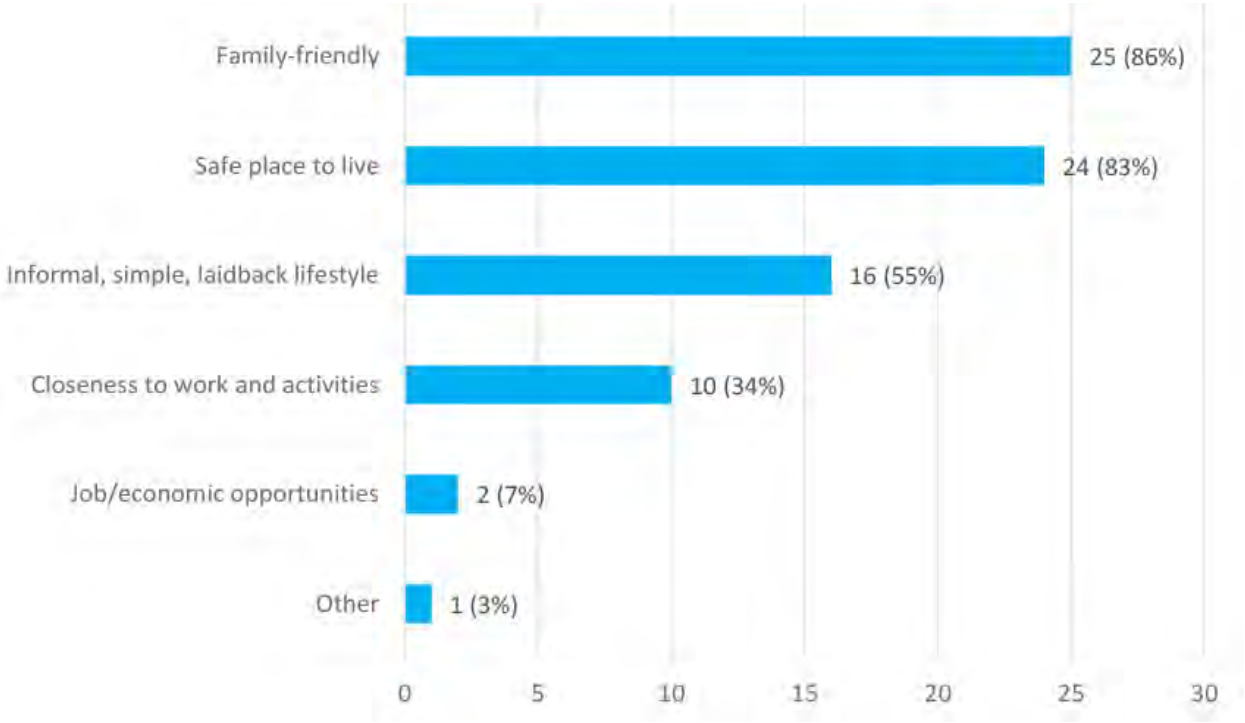


Figure 14: Best Things about the SERVICES AND RESOURCES in Your Community
Total responses = 74



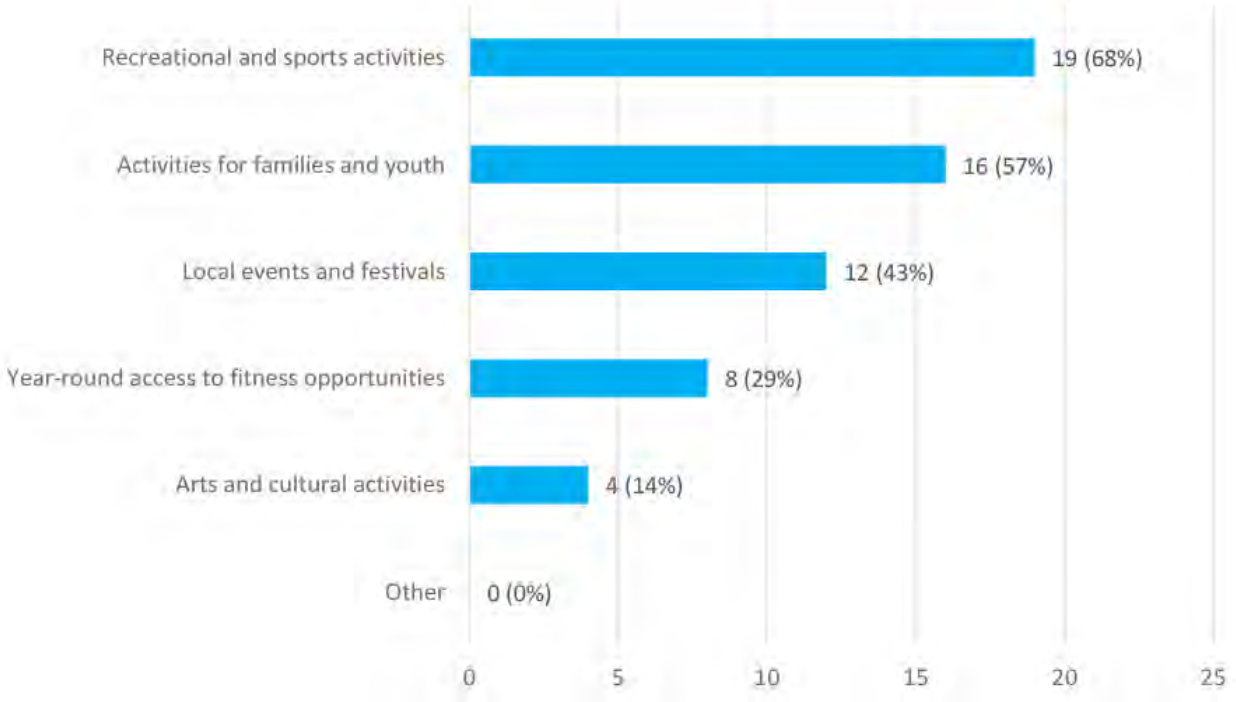
The only "Other" comment was that the movie theater has current movies.

Figure 15: Best Things about the QUALITY OF LIFE in Your Community
Total responses = 78



The one "Other" response regarding the best things about the quality of life in the community was that the community support is tremendous.

Figure 16: Best Thing about the ACTIVITIES in Your Community
Total responses = 59



Community Concerns

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

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

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

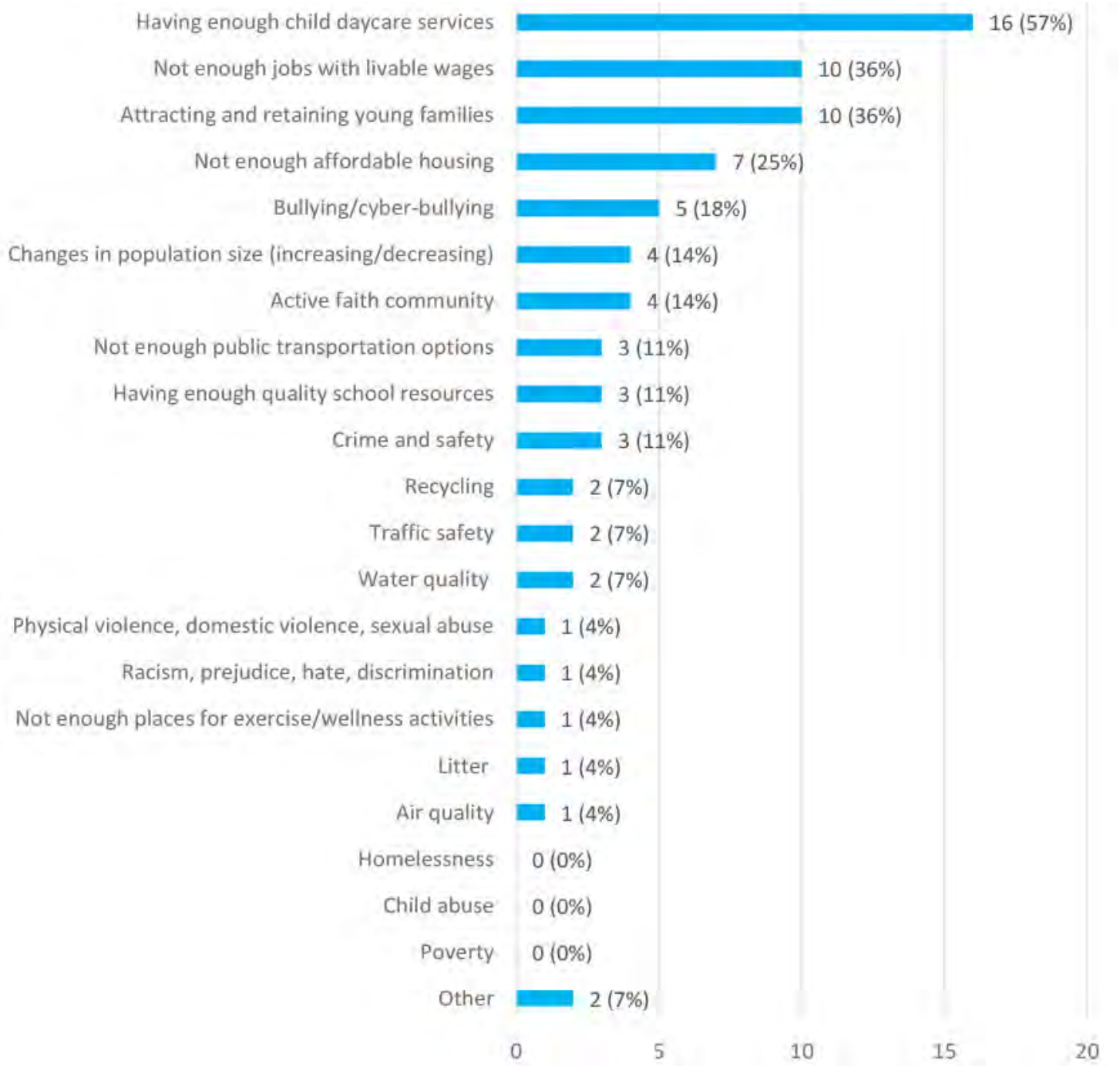
- Cost of long-term/nursing home care (74%, N=20)
- Ability to retain primary care providers (MD, DO, NP, PA) and nurses in the community (61%, N=17)
- Having enough child daycare services (57%, N=16)
- Alcohol use and abuse – Youth (59%, N=16)
- Alcohol use and abuse – Adult (56%, N=15)
- Cancer – Adults (56%, N=15)
- Smoking and tobacco use, exposure to second-hand smoke, or vaping/juuling – Adults (56%, N=10)

The other issues that had at least 30% of votes included:

- Depression/anxiety – Adults (48%, N=13)
- Availability of resources to help the elderly stay in their homes (44%, N=12)
- Drug use and abuse (including prescription drugs) – Youth (44%, N=12)
- Active faith community (36%, N=10)
- Attracting and retaining young families (36%, N=10)
- Depression/anxiety – Youth (37%, N=10)
- Assisted living options (33%, N=9)
- Smoking and tobacco use, exposure to second-hand smoke or vaping/juuling – Youth (33%, N=9)
- Availability of primary care providers (MD, DO, NP, PA) and nurses (32%, N=9)
- Obesity/overweight – Adults (30%, N=8)

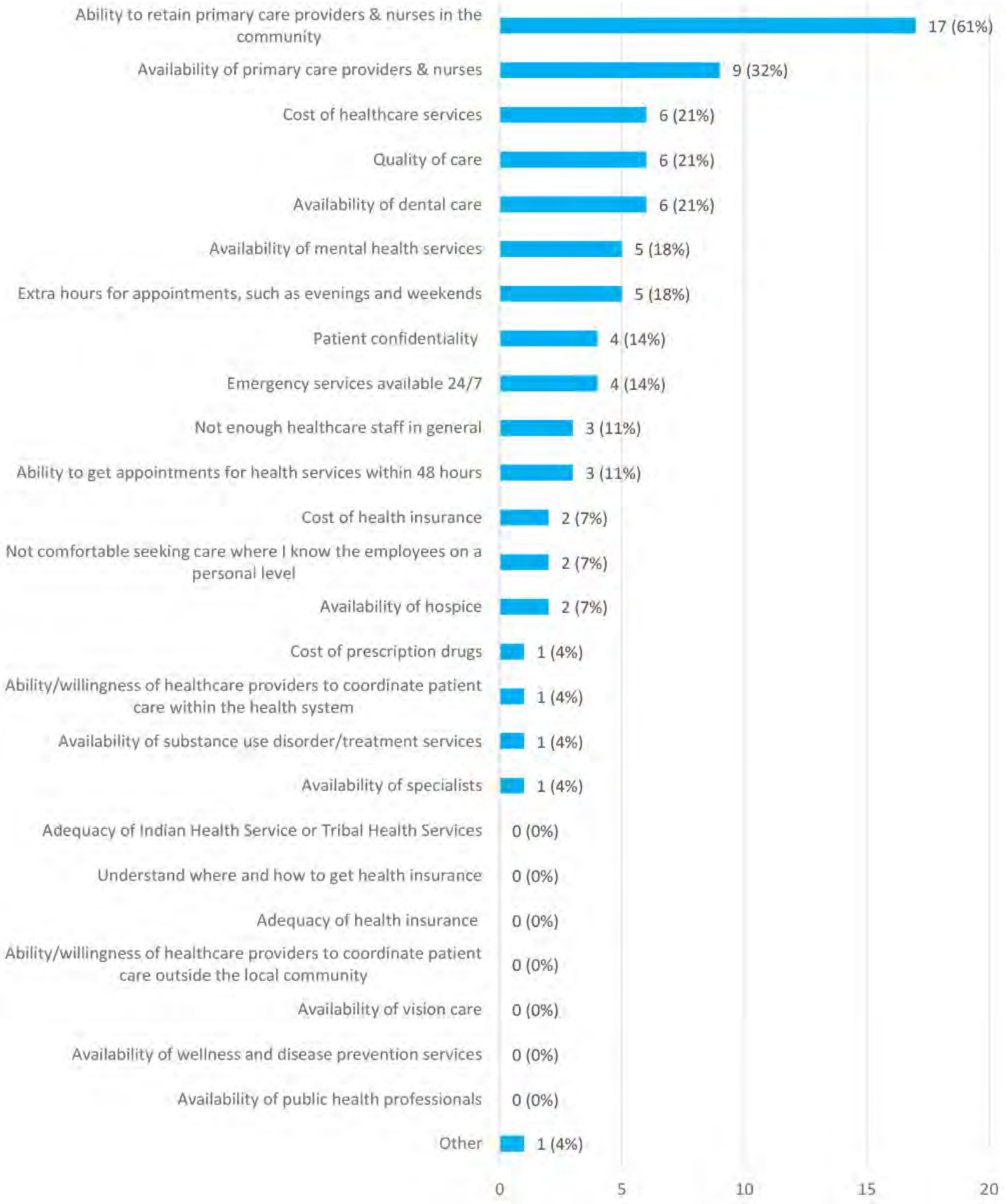
Figures 17 through 21 illustrate these results.

Figure 17: Community/Environmental Health Concerns
Total responses = 88



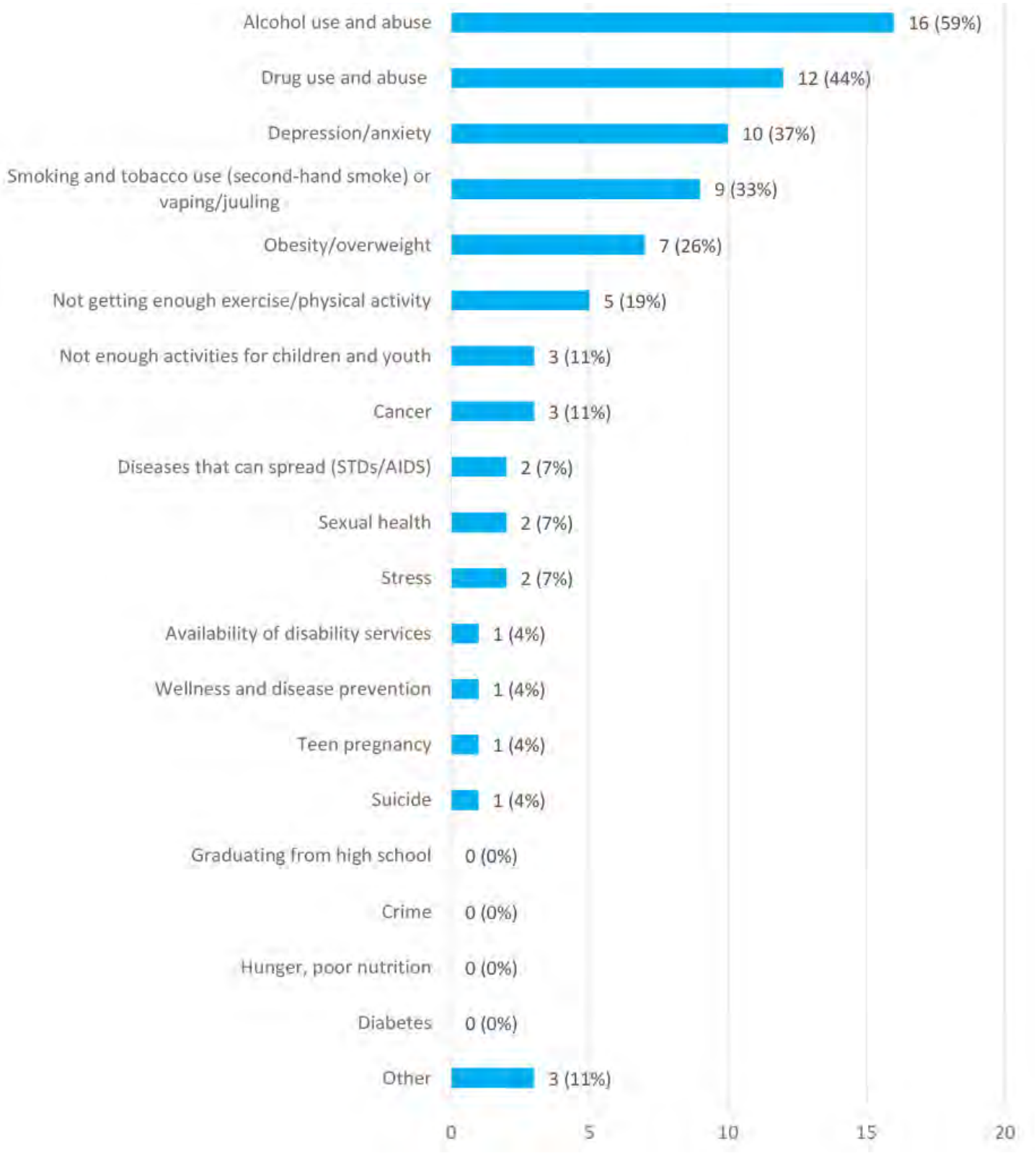
In the "Other" category for community and environmental health concerns, the following were listed: the hospital only has advanced practice providers, no doctors or qualified staff and there is a lack of long-term planning relative to the community goals.

Figure 18: Availability/Delivery of Health Services Concerns
Total responses = 89



The sole "Other" response was that CCMH hasn't been as attentive to patient concerns since 2016.

Figure 19: Youth Population Health Concerns



Listed in the "Other" category for youth population concerns were that there are few activities at the activity center and that it is often closed during school breaks, single parent families' lack of supervision and support, and too much social media.

Figure 20: Adult Population Concerns
Total responses = 80

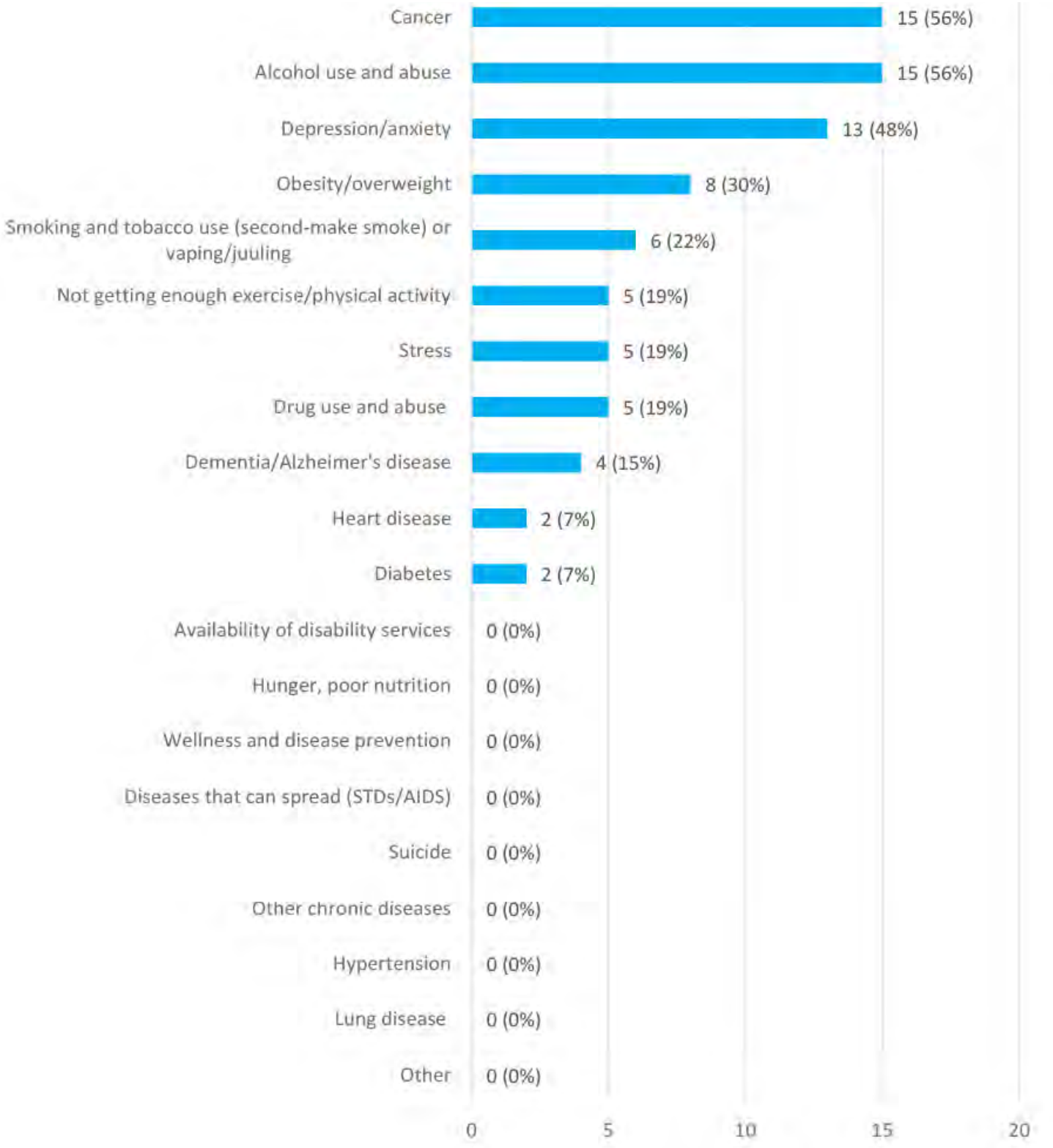
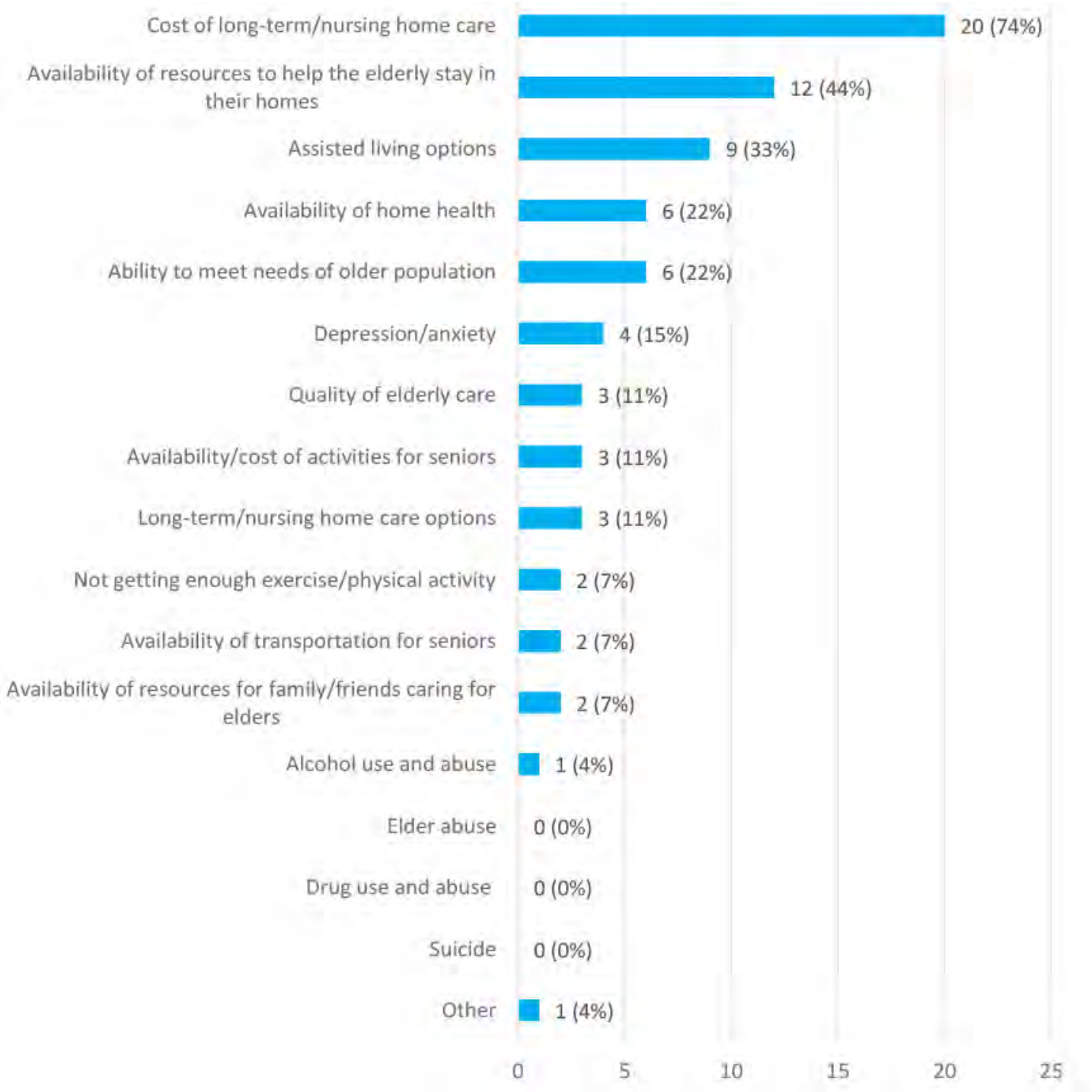


Figure 21: Senior Population Concerns
Total responses = 74



In the "Other" category, the one concern listed was staying connected to community members.

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

1. Ability to retain quality providers
2. Concerns over keeping the hospital running (due to staff leaving)

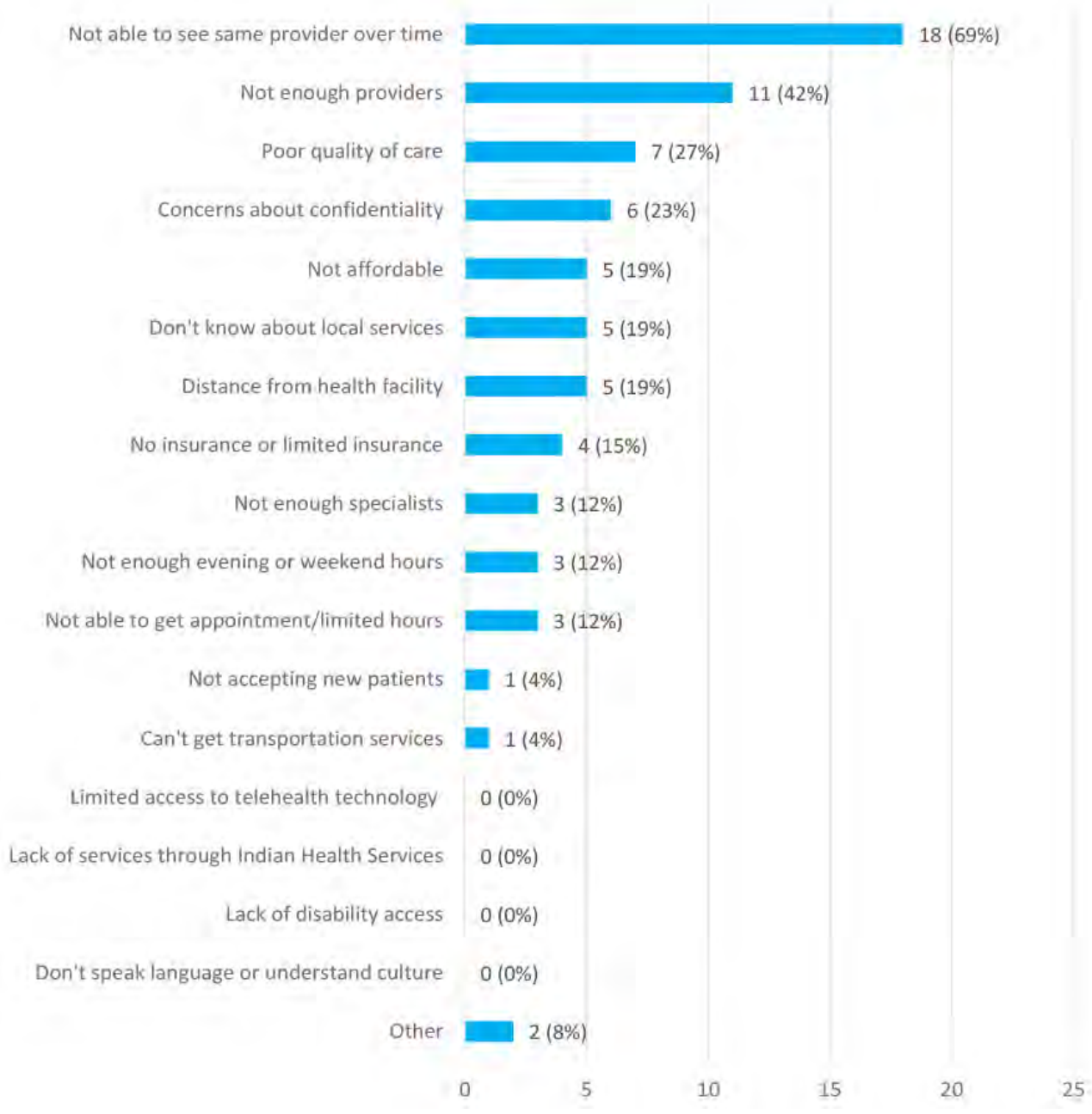
Other biggest challenges that were identified were alcohol abuse, lack of adequately paying jobs, farming-related stress of prices and input costs, and a declining/aging population.

Delivery of Healthcare

The survey asked residents what they see as barriers that prevent them, or other community residents, from receiving healthcare. The most prevalent barrier perceived by residents was not being able to see the same provider over time (69%, N=18), with the next highest being not enough providers (42%, N=11). After these, the next most commonly identified barriers were poor quality of care (27%, N=7), concerns about confidentiality (23%, N=6), and affordability (19%, N=5). The one concern listed in the "Other" category stated a lack of trust in the education of the providers.

Figure 22 illustrates these results.

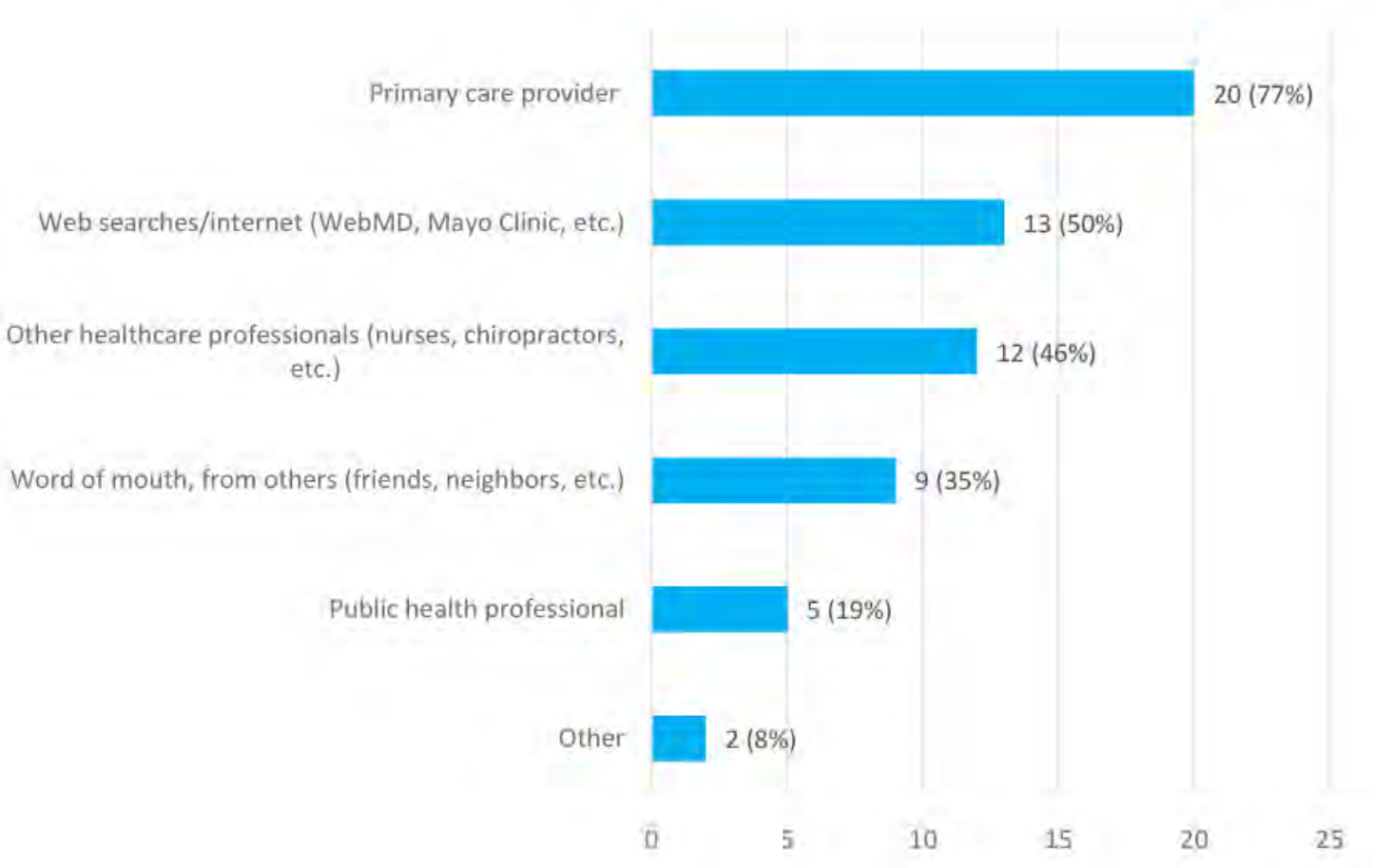
Figure 22: Perceptions about Barriers to Care
Total responses = 75



Respondents were asked where they go to for trusted health information. Primary care providers (77%, N=20) received the highest response rate, followed by web/Internet searches (50%, N=13), and then other healthcare professionals (46%, N=12).

Results are shown in Figure 23.

Figure 23: Sources of Trusted Health Information
Total responses = 61



Both of the "Other" responses mentioned using out-of-town facilities for information.

Several questions were asked about whether or not community members utilize providers outside of Langdon; the results are shown in Figures 24 through 26.

Figure 24: Utilization of Pediatric Providers Outside of Langdon
Total responses = 27

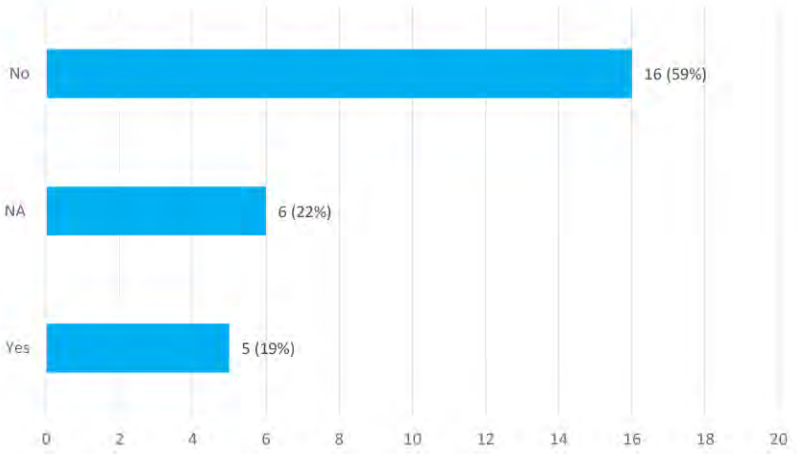


Figure 25: Utilization of Providers Outside of Langdon for Women's Services
Total responses = 26

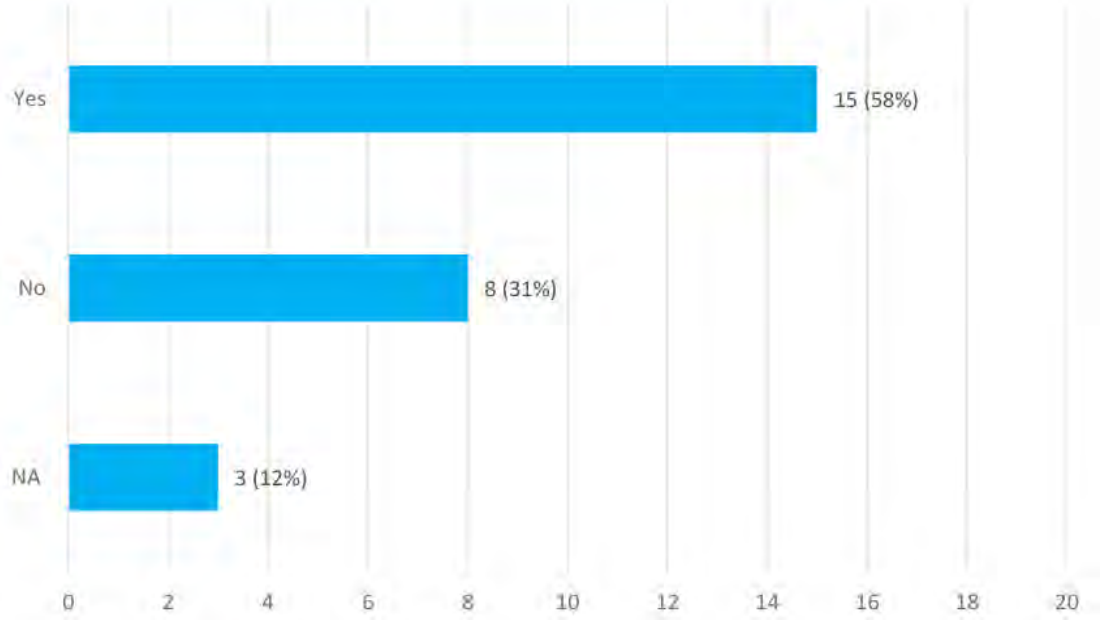
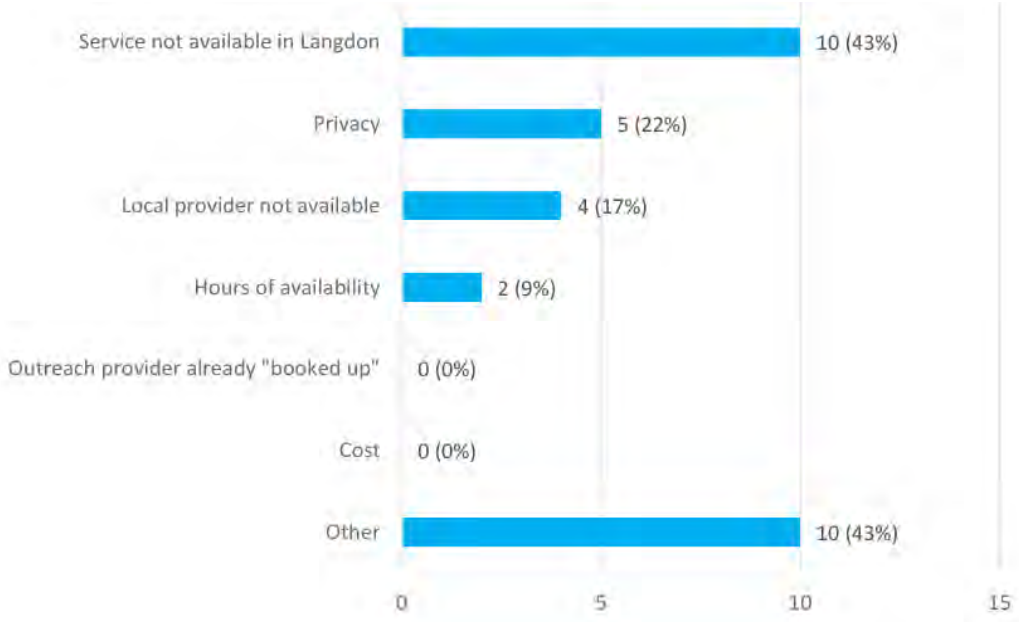


Figure 26: Reasons for Utilizing Providers Outside of Langdon
Total responses = 31



Some of the "Other" responses included using said providers prior to moving to Langdon, referrals to specialists, and issues with insurance.

Community members were asked whether or not they would use extended clinic hours at the Langdon clinic and if they are aware of their right as a patient to choose their provider and facility in which to receive care; Figures 27 and 28—respectively—show these results.

Figure 27: Utilization of Extended Clinic Hours Total responses = 27

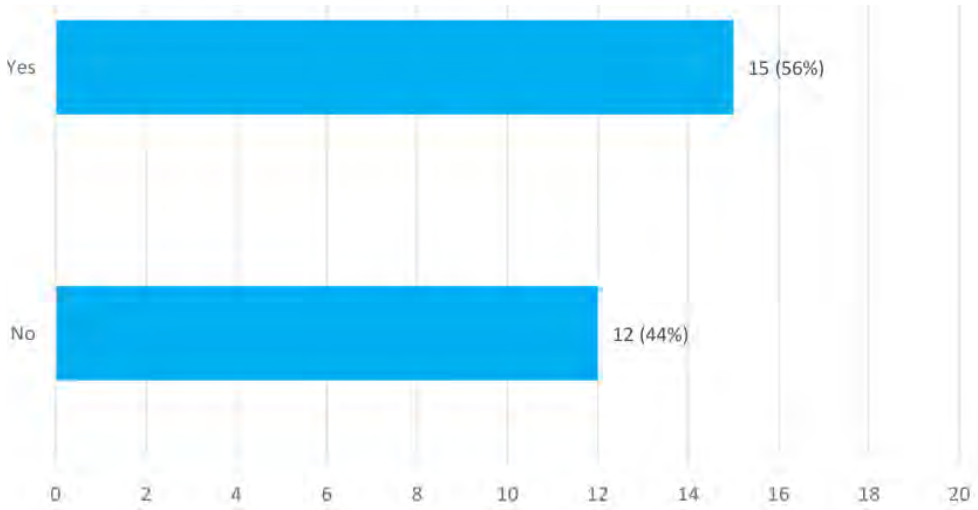
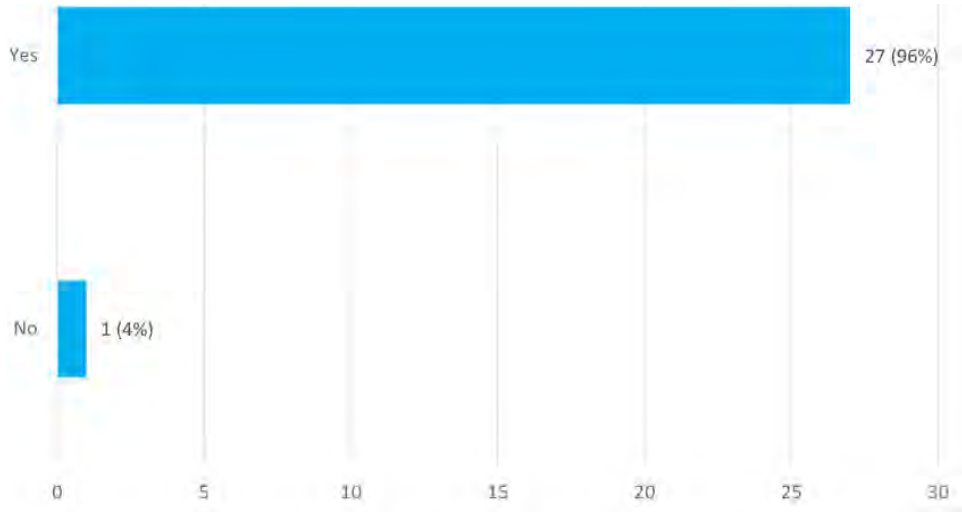


Figure 28: Awareness of Right to Choose Provider and Facility Total responses = 28



Figures 29 through 33 ask respondents of their awareness and/or utilization of services offered by CCMH and CCPH.

Figure 29: Awareness/Utilization of General and Acute Services at CCMH Total responses = 117

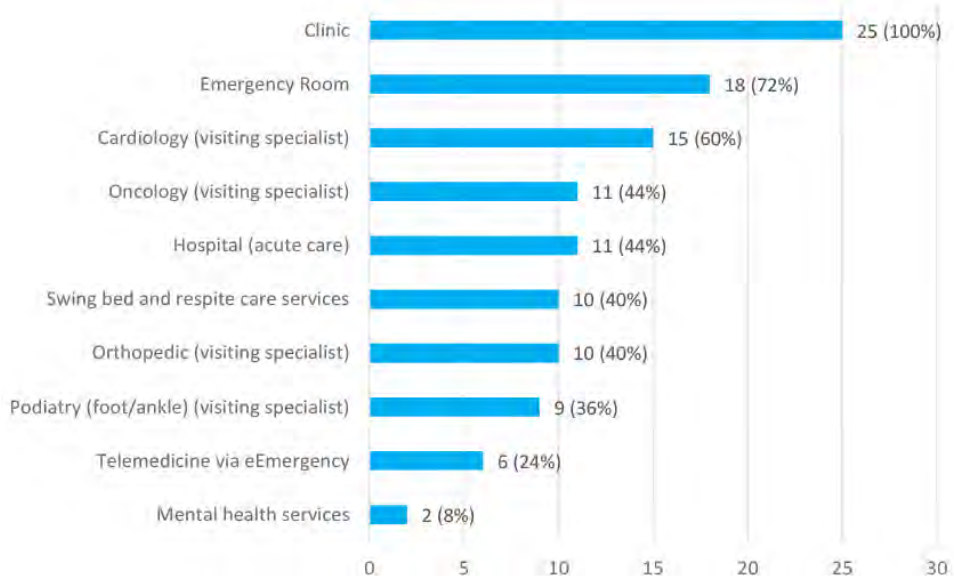


Figure 30: Awareness/Utilization of Screening/Therapy services at CCMH
Total responses = 88

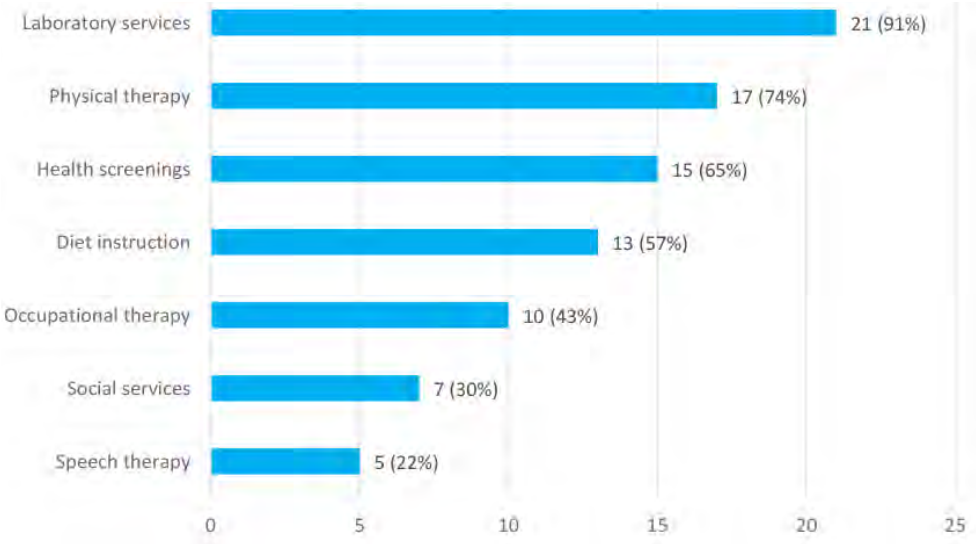


Figure 31: Awareness/Utilization of Radiology Services at CCMH
Total responses = 88

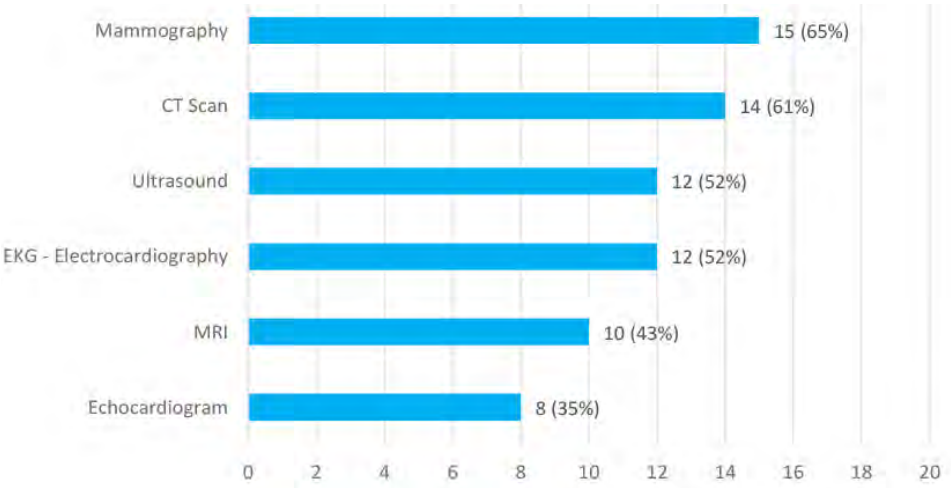


Figure 32: Awareness/Utilization of Other Providers/Organizations at CCMH
Total responses = 32

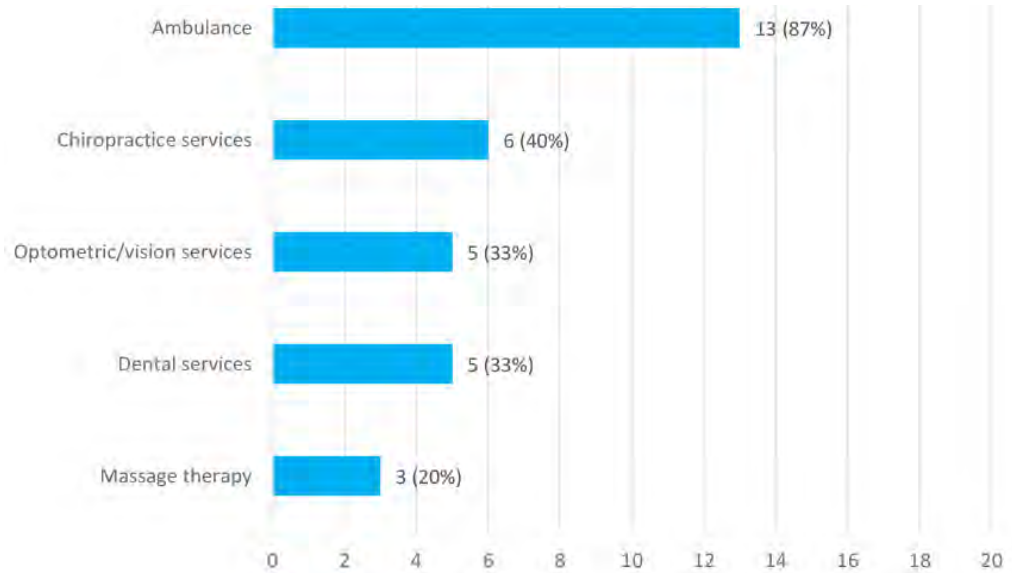
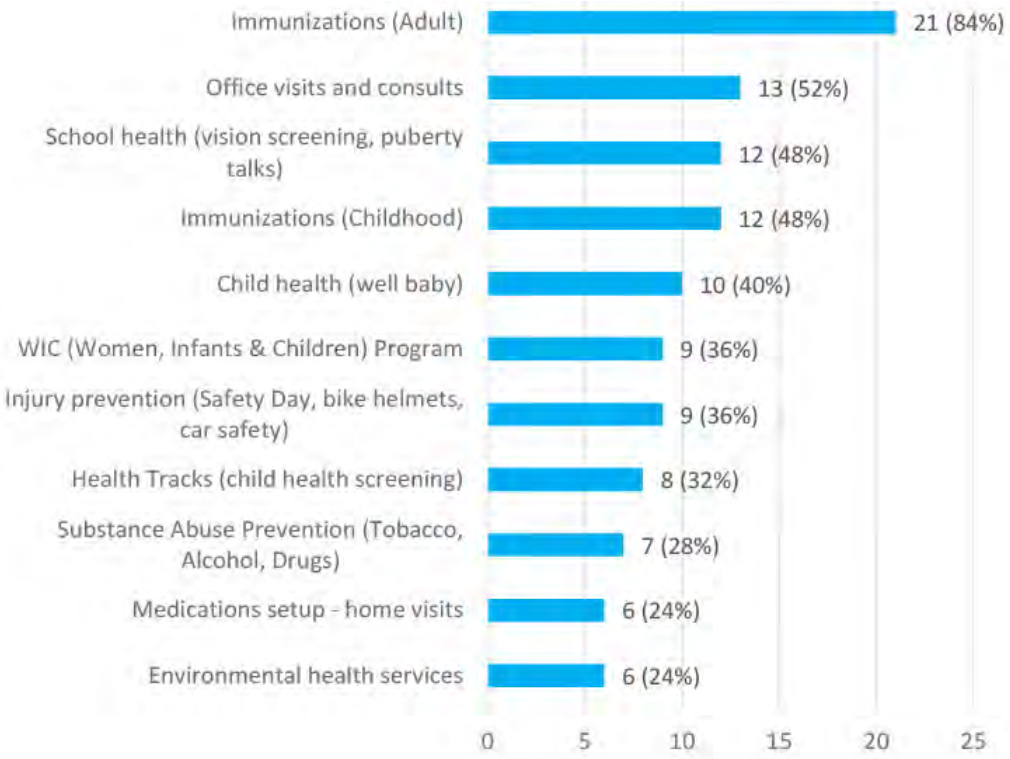


Figure 33: Awareness/Utilization of WCHD Services
Total responses = 113



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

- Cardiac rehab
- Chemotherapy
- Endoscopy
- Neurology
- Specialty in OB/GYN

While not a service, a majority of respondents indicated that they would like physicians added, also citing that the availability of providers was lacking. Some comments stated that consistency with providers was also needed in order to build a relationship with patients. One respondent recommended focusing on keeping the same general care that they currently have.

For the most part, the key informant and focus group members felt that the community members were aware of the majority of the health system and public health services. There were a number of services where they felt the hospital should increase marketing efforts, these included transportation services to larger cities, meal services, dry needling, prenatal care, and stress test services.

Figures 34 and 35 show results from questions asking respondents if they would use or appreciate an after-hours clinic that was open until 7 pm and visits by a provider in their home. The majority to both questions replied "no" by 64% (N=16) and 78% (N=21), respectively.

Figure 34: Utilization of After-Hours Clinic Total responses = 25

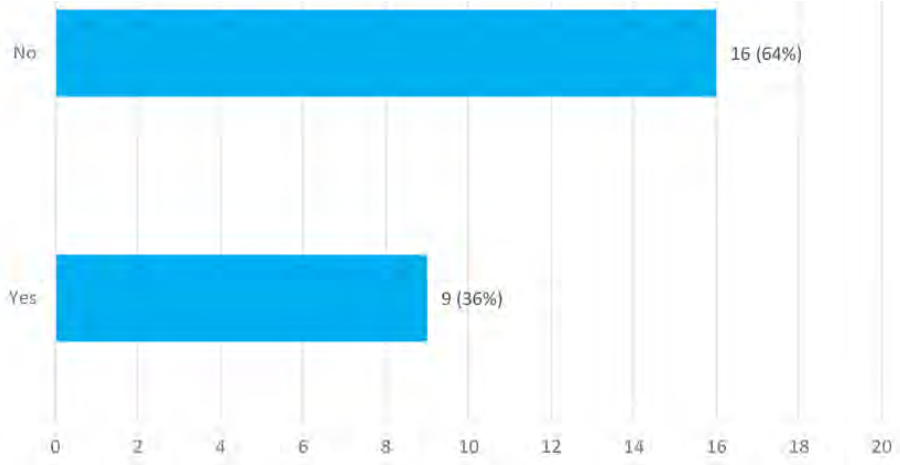
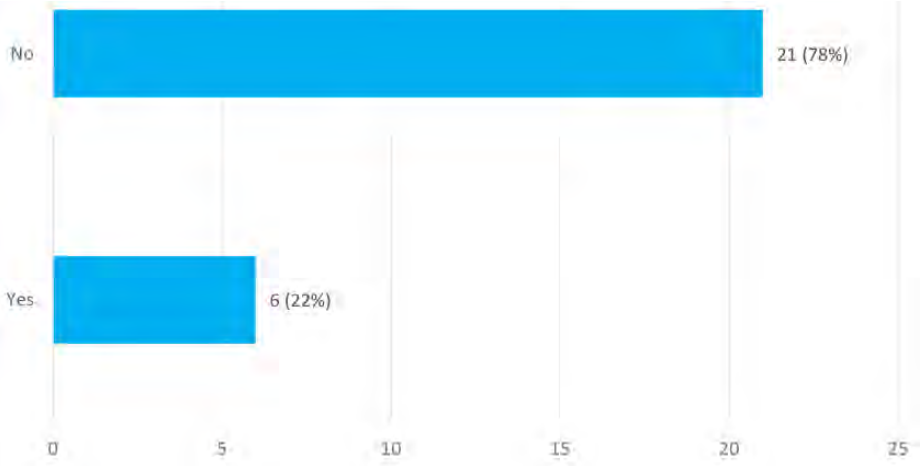
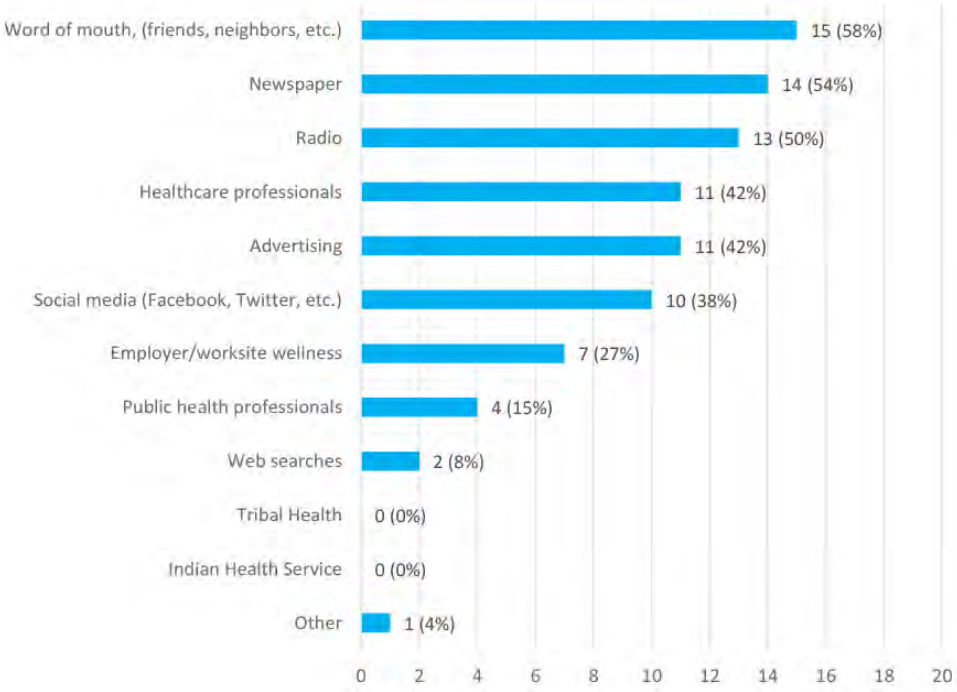


Figure 35: Utilization of Provider Home Visits Total responses = 27



Community members were asked where they find out about local health services. Word of mouth was the top response (58%, N=15), followed closely by the newspaper (54%, N=14), and radio (50%, N=13). Figure 36 shows the full results.

Figure 36: Finding out about Local Health Services Total responses = 88



Members were asked if they were aware of CCMH's foundation (Figure 37) and, in an effort to gauge ways that community engagement in supporting the foundation, members were asked in which ways they have shown support (see Figure 38).

Figure 37: Awareness of Cavalier County Memorial Hospital's Foundation
Total responses = 28

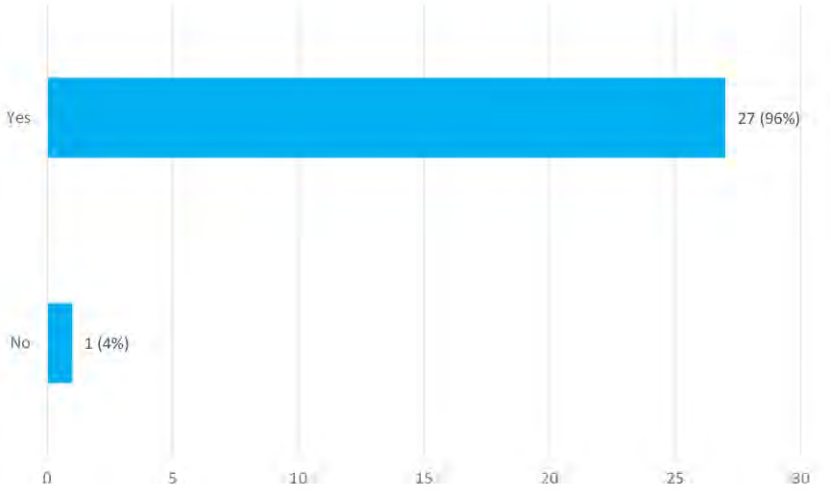
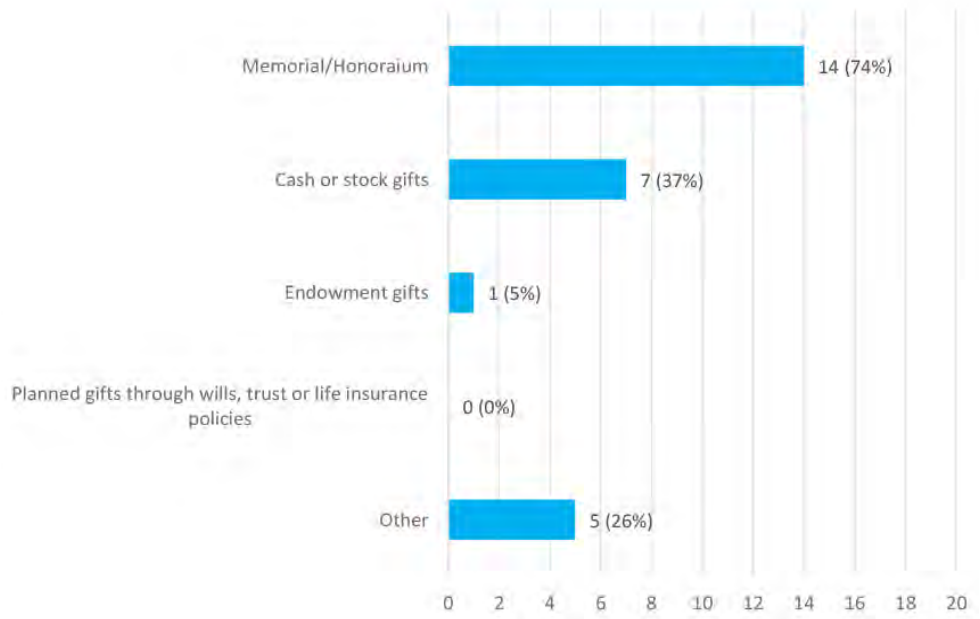


Figure 38: Ways to Financially Support CCMH's Foundation
Total responses = 27



The final question on the survey asked respondents to share concerns and suggestions to improve the delivery of local healthcare. Virtually all of the responses pointed to a lack of providers and the quality of the providers that do stay. Many members mentioned that the high rate of turnover contributes heavily to their concerns about being seen in a timely manner and by a provider they prefer, but also that they were reluctant to use CCMH due to the quality of care and experience of the physicians that do stay with the facility.

Respondents specifically pointed out the ER several times as a concern, again by referencing a shortage of providers and the experience they may have. They also commented on having healthcare professionals with a more recent knowledge and experience with family practices and internal medicine as opposed to those who have not updated their education in current medical practices.

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 five categories (listed in alphabetical order):

- Ability to retain primary care providers (MD, DO, NP, PA) and nurses in the community
- Alcohol use and abuse
- Availability of mental health and substance use disorder treatment services
- Depression/anxiety
- Having enough child daycare services

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

Ability to retain primary care providers (MD, DO, NP, PA) and nurses in the community

- Recruiting and retaining healthcare providers is one of the biggest problems we have here
- We have a lot of medical staff instability and high turnover of doctors

Alcohol use and abuse

- Alcohol use and abuse has been a problem for all ages

Availability of mental health and substance use disorder treatment services

- We desperately need a mental health system of care in ND
- There is an increasing need for behavioral and mental health services for all ages for both inpatient and outpatient services

Depression/anxiety

- A lot of young kids have to take on adult responsibilities, which leads to depression and stress

Having enough child daycare services

- There is a serious lack of daycare services in our area
- Child daycare is something that needs to be addressed, because there is not enough available

Community Engagement and Collaboration

Key informants and focus group participants were asked to weigh in on community engagement and collaboration of various organizations and stakeholders in the community. Specifically, participants were asked, "On a scale of 1 to 5, with 1 being no collaboration/community engagement and 5 being excellent collaboration/community engagement, how would you rate the collaboration/engagement in the community among these various organizations?" This was not intended to rank services provided. They were presented with a list of 13 organizations or community segments to rank. 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 rankings (with 5 being "excellent" engagement or collaboration) were:

- Business and industry (4.5)
- Faith-based (4.5)
- Public health (4.5)
- Emergency services, including ambulance and fire (4.5)
- Hospital (healthcare system) (4.25)
- Economic development organizations (4.25)
- Pharmacies (4.0)
- Schools (4.0)
- Law enforcement (3.75)
- Social services (3.5)
- Long-term care, including nursing homes and assisted living (3.25)
- Human services agencies (3.25)
- Other local health providers, such as dentists and chiropractors (3.25)

Priority of Health Needs

A Community Group met on May 22, 2019. Seven community members attended the meeting. Representatives from the 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 (7 votes)
- Ability to retain primary care providers (MD, DO, NP, PA) (5 votes)
- Alcohol use and abuse (4 votes)

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

1. Ability to retain primary care providers (MD, DO, NP, PA) (7 votes)
2. Depression/anxiety (0 votes)
3. Alcohol use and abuse (0 votes)

Following the prioritization process during the second meeting of the community group and key informants, the number one identified need was the ability to retain primary care providers (MD, DO, NP, PA). A summary of this prioritization may be found in Appendix C.

Comparison of Needs Identified Previously

Top Needs Identified 2016 CHNA Process	Top Needs Identified 2019 CHNA Process
Availability of our providers	Ability to retain primary care providers (MD, DO, NP, PA)
Availability of dental care	Depression/anxiety
Ability to recruit physicians to the area	Alcohol use and abuse
Lack of knowledge of services offered locally	
Loss of patients to competing health systems	
Obesity/diabetes/poor nutrition	
Depression/mental health	

The current process did identify one common need from 2016, depression. In 2016, depression/mental health was listed as a top priority and in 2019, depression/anxiety was identified. Also, the ability to retain primary care providers plays a role in the 2016 need "availability of our providers" because the lack of staffing would directly contribute to providers not being available. The 2016 need "ability to recruit physicians to the area" could also be linked the current need to retain physicians due to not being able to bring in new professionals with staff leaving the area.

Hospital and Community Projects and Programs Implemented to Address Needs Identified in 2016

In response to the needs identified in the 2016 CHNA process, the following actions were taken:

Need 1 – Expanded clinic hours: In response to community concern, the Langdon Clinic implemented a Saturday clinic from 8:00 am until noon every Saturday. The clinic has been very well utilized.

Need 2 – Provider recruitment: Since the 2016 CHNA, CCMH has been successful in recruiting three providers, Mark Hill, FNP; Courtney Short, FNP; and Megan Overby FNP. Courtney and Megan are from Langdon which has been a great win for the hospital.

Need 3 – Market plan: CCMH has partnered with Legato (a healthcare marketing firm) to develop a marketing plan to ensure the community knows the services that are provided. Services are now promoted through newspaper, radio, social media, and other media.

Need 4 – Lack of mental health resources: Since the last CHNA, CCMH has joined with the behavioral mental health task force. The task force is a local group that consists of representatives from Public Health, law enforcement, Social Services, the board of education and CCMH. The task force is working on several specific projects including: behavioral health resource guide, medication take-back event, applying for a prevention grant which focuses on alcohol binge drinking and underage drinking. The group meets every other month.

The above implementation plan for Cavalier County Memorial Hospital is posted on the CCMH website at https://www.cavaliercountyhospital.com/community-health-needs-assessment.

Next Steps – Strategic Implementation Plan

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

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

Community Benefit Report

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

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

- Free and discounted care to those unable to afford healthcare.
- Care to low-income beneficiaries of Medicaid and other indigent care programs.

- Services designed to improve community health and increase access to healthcare.

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

What Are Community Benefits?

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

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

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

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

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

Appendix A – CHNA Survey Instrument

Cavalier County Health Survey

Cavalier County Memorial Hospital and Clinics and Cavalier County Health District are interested in hearing from you about community health concerns.

The focus of this effort is to:

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

If you prefer, you may take the survey online at https://tinyurl.com/LangdonND19 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 May 1, 2019. 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
- ☐ 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
- ☐ Depression/anxiety
- ☐ Suicide
- ☐ Alcohol use and abuse
- ☐ Drug use and abuse (including prescription drug abuse)
- ☐ Availability of activities for seniors
- ☐ Elder abuse
- ☐ Other: (please specify) _____

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

_____

_____

Delivery of Healthcare

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

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

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

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

13. Do you utilize a pediatric medical provider somewhere outside of Langdon?

- ☐ Yes
- ☐ No
- ☐ NA

14. Do you utilize a medical provider outside of Langdon for women's services, such as mammography or GYN exams?

- ☐ Yes
- ☐ No
- ☐ NA

15. If you have utilized a medical provider outside Langdon, please tell us why.

- ☐ Hours of availability
- ☐ Cost
- ☐ Privacy
- ☐ Service not available in Langdon
- ☐ Local provider not available
- ☐ Outreach provider already "booked up"
- ☐ Other: (please specify) _____
  _____

16. Would you utilize extended clinic hours of 7:30 am to 6:00 pm Monday - Friday at the Langdon clinic?

- ☐ Yes
- ☐ No

17. Are you aware of your right as a patient to choose your provider and facility in which to receive care?

- ☐ Yes
- ☐ No

18. Considering **GENERAL and ACUTE SERVICES** at Cavalier County Memorial Hospital and Clinics, which services are you aware of (or have you used in the past year)? (Choose ALL that apply)

- ☐ Cardiology (visiting specialist)
- ☐ Clinic
- ☐ Emergency room
- ☐ Hospital (acute care)
- ☐ Mental health services
- ☐ Oncology (visiting specialist)
- ☐ Orthopedic (visiting specialist)
- ☐ Podiatry (foot/ankle) (visiting specialist)
- ☐ Swing bed and respite care services
- ☐ Telemedicine via eEmergency

19. Considering **SCREENING/THERAPY SERVICES** at Cavalier County Memorial Hospital and Clinics, which services are you aware of (or have you used in the past year)? (Choose ALL that apply)

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

20. Considering **RADIOLOGY SERVICES** at Cavalier County Memorial Hospital and Clinics, which services are you aware of (or have you used in the past year)? (Choose ALL that apply)

- ☐ EKG—Electrocardiography
- ☐ CT scan
- ☐ Echocardiogram
- ☐ General X-ray
- ☐ Mammography
- ☐ MRI
- ☐ Ultrasound

21. Considering services offered locally by **OTHER PROVIDERS/ORGANIZATIONS** at Cavalier County Memorial Hospital and Clinics, which services are you aware of (or have used in the past year)? (Choose ALL that apply)

- ☐ Ambulance
- ☐ Chiropractic services
- ☐ Dental services
- ☐ Massage therapy
- ☐ Optometric/vision services

22. Considering **the following services available at Cavalier County Public Health**, which services are you aware of (or have you used in the past year)? (Choose ALL that apply)

- ☐ Child health (well baby)
- ☐ Environmental health services (water, sewer, health hazard abatement)
- ☐ Health Tracks (child health screening)
- ☐ Immunizations (Adult)
- ☐ Immunizations
- ☐ Injury Prevention (Safety Day, bike helmets, car safety)
- ☐ Medications setup-home visits
- ☐ Office visits and consults
- ☐ School health (vision screening, puberty talks, school immunizations)
- ☐ Substance Abuse Prevention (Tobacco, Alcohol, Drugs)
- ☐ WIC (Women, Infants & Children) Program

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

_____

_____

24. Would you utilize an after-hours clinic that was open until 7 pm?

- ☐ Yes
- ☐ No

25. Would you utilize or appreciate visits by your provider in your home?

- ☐ Yes
- ☐ No

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

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

27. Are you aware of Cavalier County Memorial Hospital and Clinics' Foundation, which exists to financially support Cavalier County Memorial Hospital and Clinics?

- ☐ Yes
- ☐ No

28. Have you supported the Cavalier County Memorial Hospital and Clinics' Foundation in any of the following ways? (Choose ALL that apply)

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

Demographic Information: Please tell us about yourself.

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

☐ Yes ☐ No

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

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

31. 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

32. 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

33. Gender:

☐ Female ☐ Male ☐ Transgender

34. Employment status:

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

35. Your zip code: _____

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

☐ American Indian
☐ African American
☐ Asian
☐ Hispanic/Latino
☐ Pacific Islander
☐ White/Caucasian
☐ Other: _____
☐ Prefer not to answer

37. 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
☐ Prefer not to answer

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

_____

_____

Thank you for assisting us with this important survey!

Appendix B – County Health Rankings Explained

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

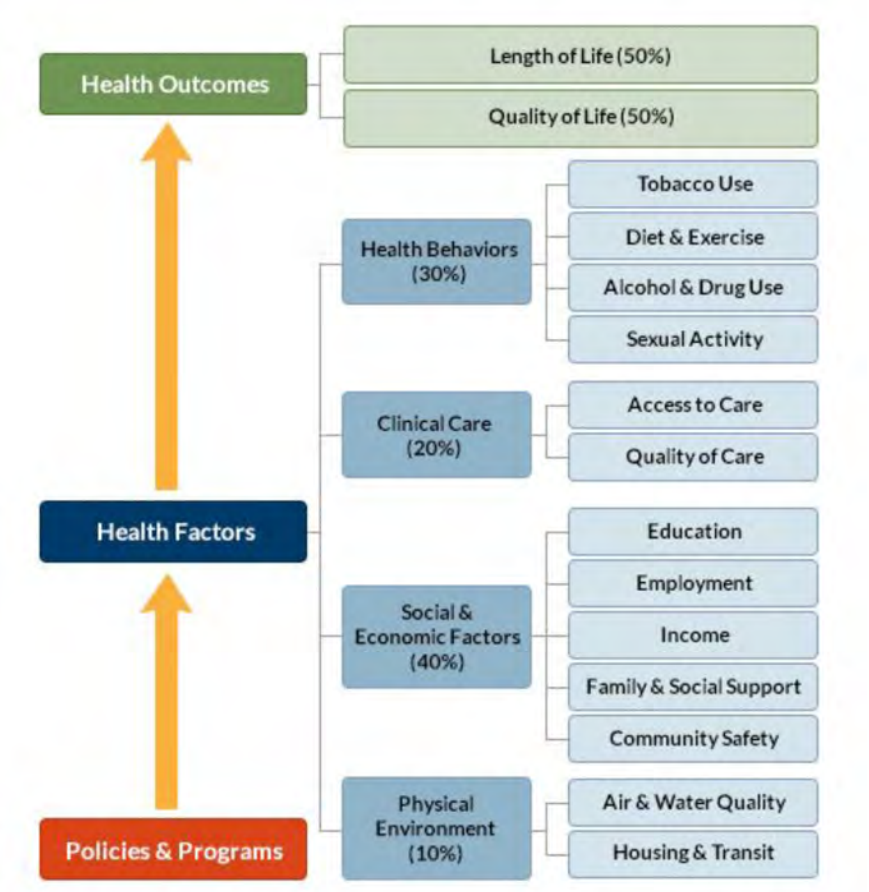
Methods

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

What is Ranked

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

Ranking System



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

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

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

Data Sources and Measures

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

Data Quality

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

Calculating Scores and Ranks

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

Health Outcomes and Factors

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

Health Outcomes

Premature Death (YPLL)

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

Reason for Ranking

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

Poor or Fair Health

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

Reason for Ranking

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

Poor Physical Health Days

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

Reason for Ranking

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

Poor Mental Health Days

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

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

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

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

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

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

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

Health Factors

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

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

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

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

Food Environment Index

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

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

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

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

Reason for Ranking

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

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

Physical Inactivity

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

Reason for Ranking

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

Access to Exercise Opportunities

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

Individuals who:

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

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

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

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

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

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

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

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

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

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

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

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

Uninsured

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

Reason for Ranking

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

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

Primary Care Physicians

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

Reason for Ranking

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

Dentists

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

Reason for Ranking

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

Mental Health Providers

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

Reason for Ranking

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Injury Deaths

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

Reason for Ranking

Injuries are one of the leading causes of death; unintentional injuries were the 4th leading cause, and intentional injuries the 10th leading cause, of US mortality in 2014.[1] The leading causes of death in 2014 among unintentional injuries, respectively, are: poisoning, motor vehicle traffic, and falls. Among intentional injuries, the leading causes of death in 2014, respectively, are: suicide firearm, suicide suffocation, and homicide firearm. Unintentional injuries are a substantial contributor to premature death. Among the following age groups, unintentional injuries were the leading cause of death in 2014: 1-4, 5-9, 10-14, 15-24, 25-34, 35-44.[2] Injuries account for 17% of all emergency department visits, and falls account for over 1/3 of those visits.[3]

Air Pollution-Particulate matter

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

Reason for Ranking

The relationship between elevated air pollution (especially fine particulate matter and ozone) and compromised health has been well documented.[1,2,3] Negative consequences of ambient air pollution include decreased lung function, chronic bronchitis, asthma, and other adverse pulmonary effects.[1] Long-term exposure to fine particulate matter increases premature death risk among people age 65 and older, even when exposure is at levels below the National Ambient Air Quality Standards.[3]

Drinking Water Violations

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

Reason for Ranking

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

Severe Housing Problems

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

- housing unit lacks complete kitchen facilities;
- housing unit lacks complete plumbing facilities;
- household is severely overcrowded; or

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

Reason for Ranking

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

Appendix C – Youth Behavioral Risk Survey Results

North Dakota High School Survey

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

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

	ND 2013	ND 2015*	ND Trend ↑, ↓, =	Rural ND Town Average	Urban ND Town Average	National Average 2017
Injury and Violence						
Percentage of students who rarely or never wore a seat belt.	11.6	8.5	↓	10.5	7.5	5.9
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)	21.9	17.7	↓	21.1	15.2	16.5
Percentage of students who talked on a cell phone while driving (on at least 1 day during the 30 days before the survey, among students who drove a car or other vehicle)	67.9	61.4	↓	60.7	58.8	NA
Percentage of students who texted or e-mailed while driving a car or other vehicle (on at least 1 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)	59.3	57.6	=	56.7	54.4	39.2
Percentage of students who never or rarely wore a helmet (during the 12 months before the survey, among students who rode a motorcycle)	29.8	28.7	=	32.8	24.7	NA
Percentage of students who carried a weapon on school property (such as a gun, knife, or club on at least 1 day during the 30 days before the survey)	6.4	5.2	=	6.6	4.5	3.8
Percentage of students who were in a physical fight on school property (one or more times during the 12 months before the survey)	8.8	5.4	↓	6.9	6.1	8.5
Percentage of students who were ever physically forced to have sexual intercourse (when they did not want to)	7.7	6.3	=	6.5	7.4	7.4
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)	9.7	7.6	=	6.9	8.0	8.0
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)	9.6	9.7	=	10.4	9.7	NA
Percentage of students who were bullied on school property (during the 12 months before the survey)	25.4	24.0	=	27.5	22.4	19.0
Percentage of students who were electronically bullied (including being bullied through e-mail, chat rooms, instant messaging, websites, or texting during the 12 months before the survey)	17.1	15.9	=	17.7	15.8	14.9
Percentage of students who felt sad or hopeless (almost every day for 2 or more weeks in a row so that they stopped doing some usual activities during the 12 months before the survey)	25.4	27.2	=	24.9	28.9	31.5
Percentage of students who seriously considered attempting suicide (during the 12 months before the survey)	16.1	16.2	=	15.8	16.7	17.2
Percentage of students who made a plan about how they would attempt suicide (during the 12 months before the survey)	13.5	13.5	=	12.8	13.7	13.6
Percentage of students who attempted suicide (one or more times during the 12 months before the survey)	11.5	9.4	↓	10.3	11.3	7.4

	ND 2013	ND 2015*	ND Trend ↑, ↓, =	Rural ND Town Average	Urban ND Town Average	National Average 2017
Tobacco Use						
Percentage of students who ever tried cigarette smoking (even one or two puffs)	41.4	35.1	↓	37.3	32.5	28.9
Percentage of students who smoked a whole cigarette before age 13 years (for the first time)	7.9	7.2	=	7.3	6.7	9.5
Percentage of students who currently smoked cigarettes (on at least 1 day during the 30 days before the survey)	19.0	11.7	↓	13.2	11.8	8.8
Percentage of students who currently frequently smoked cigarettes (on 20 or more days during the 30 days before the survey)	6.6	4.3	↓	4.3	4.7	2.6
Percentage of students who currently smoked cigarettes daily (on all 30 days during the 30 days before the survey)	3.9	3.2	=	3.2	3.2	2.0
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)	7.8	16.9	↑	0.2	1.0	NA
Percentage of students who tried to quit smoking cigarettes (among students who currently smoked cigarettes during the 12 months before the survey)	55.5	47.4	=	49.1	52.7	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 1 day during the 30 days before the survey)	NA	22.3	↑	19.7	22.8	13.2
Percentage of students who currently used smokeless tobacco (chewing tobacco, snuff, or dip on at least 1 day during the 30 days before the survey)	13.8	10.6	↓	12.6	9.5	5.5
Percentage of students who currently smoked cigars (cigars, cigarillos, or little cigars on at least 1 day during the 30 days before the survey)	11.7	9.2	↓	9.7	9.7	8.0
Percentage of students who currently used cigarettes, cigars, or smokeless tobacco (on at least 1 day during the 30 days before the survey)	27.5	20.9	↓	22.9	19.8	14.0
Alcohol and Other Drug Use						
Percentage of students who ever drank alcohol (at least one drink of alcohol on at least 1 day during their life)	65.8	62.1	=	64.5	59.9	60.4
Percentage of students who drank alcohol before age 13 years (for the first time other than a few sips)	15.2	12.4	=	15.3	12.9	15.5
Percentage of students who currently drank alcohol (at least one drink of alcohol on at least 1 day during the 30 days before the survey)	35.3	30.8	↓	32.8	29.3	29.8
Percentage of students who drank five or more drinks of alcohol in a row (within a couple of hours on at least 1 day during the 30 days before the survey)	21.9	17.6	↓	19.8	17.0	13.5
Percentage of students who usually obtained the alcohol they drank by someone giving it to them (among students who currently drank alcohol)	37.0	41.3	=	41.1	40.4	43.5
Percentage of students who tried marijuana before age 13 years (for the first time)	5.6	6.3	=	5.8	5.8	6.8
Percentage of students who currently used marijuana (one or more times during the 30 days before the survey)	15.9	15.2	=	13.2	17.1	19.8
Percentage of students who ever took prescription drugs without a doctor's prescription (such as OxyContin, Percocet, Vicodin, codeine, Adderall, Ritalin, or Xanax, one or more times during their life)	17.6	14.5	↓	13.2	16.0	14.0
Percentage of students who were offered, sold, or given an illegal drug on school property (during the 12 months before the survey)	14.1	18.2	↑	15.9	19.9	19.8

	ND 2013	ND 2015*	ND Trend ↑, ↓, =	Rural ND Town Average	Urban ND Town Average	National Average 2017
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)	9.9	8.6	=	7.9	9.0	NA
Sexual Behaviors						
Percentage of students who ever had sexual intercourse	44.9	38.9	↓	39.3	39.1	39.5
Percentage of students who had sexual intercourse before age 13 years (for the first time)	3.8	2.6	=	3.3	3.3	3.4
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)	15.1	14.7	=	15.4	14.6	15.6
Percentage of students who were obese (>= 95th percentile for body mass index, based on sex- and age-specific reference data from the 2000 CDC growth chart)	13.5	14.0	=	16.3	12.9	14.8
Percentage of students who described themselves as slightly or very overweight	32.0	32.2	=	34.2	31.5	31.5
Percentage of students who were trying to lose weight	45.4	44.7	=	45.0	43.0	47.1
Percentage of students who did not eat fruit or drink 100% fruit juices (during the 7 days before the survey)	3.4	3.9	=	4.3	4.1	5.6
Percentage of students who ate fruit or drank 100% fruit juices one or more times per day (during the 7 days before the survey)	64.7	62.5	=	8.5	8.8	60.8
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 7 days before the survey)	6.0	4.7	=	4.5	5.2	7.2
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 7 days before the survey)	62.8	58.5	↓	61.2	60.0	59.4
Percentage of students who did not drink a can, bottle, or glass of soda or pop (not including diet soda or diet pop, during the 7 days before the survey)	25.3	25.6	=	23.5	21.7	27.8
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 7 days before the survey)	23.4	18.7	=	21.4	18.0	18.7
Percentage of students who did not drink milk (during the 7 days before the survey)	11.1	13.9	↑	11.6	13.7	26.7
Percentage of students who drank two or more glasses per day of milk (during the 7 days before the survey)	42.4	35.8	↓	36.6	35.3	17.5
Percentage of students who did not eat breakfast (during the 7 days before the survey)	10.5	11.9	=	10.7	11.8	14.1
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)	3.1	2.2	=	2.4	2.8	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)	50.6	51.3	=	51.7	50.1	46.5
Percentage of students who watched television 3 or more hours per day (on an average school day)	21.0	18.9	=	20.7	18.2	20.7
Percentage of students who played video or computer games or used a computer 3 or more hours per day (for something that was not school work on an average school day)	34.4	38.6	↑	39.4	38.0	43.0

	ND 2013	ND 2015*	ND Trend ↑, ↓, =	Rural ND Town Average	Urban ND Town Average	National Average 2017
Other						
Percentage of students who had 8 or more hours of sleep (on an average school night)	30.0	29.5	=	34.5	28.7	25.4
Percentage of students who brushed their teeth on seven days (during the 7 days before the survey)	71.5	71.0	=	67.8	70.1	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)	11.2	12.5	=	10.3	12.8	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)	19.6	12.2	↓	13.3	12.8	NA

Appendix D – Prioritization of Community's Health Needs

Community Health Needs Assessment
Langdon, North Dakota
Ranking of Concerns

The top four concerns for each of the seven 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	2	
Having enough child daycare services	2	
Not enough affordable housing	2	
Not enough jobs with livable wages	1	
AVAILABILITY/DELIVERY OF HEALTH SERVICES CONCERNS		
Ability to retain primary care providers (MD, DO, NP, PA)	5	7
Availability of primary care providers and nurses	2	
Cost of healthcare services	0	
Quality of care	0	
YOUTH POPULATION HEALTH CONCERNS		
Alcohol use and abuse	0	
Drug use and abuse (including prescription drugs)	0	
Depression/anxiety	7	0
Smoking and tobacco use, exposure to secondhand smoke, or vaping/juuling	0	
ADULT POPULATION HEALTH CONCERNS		
Alcohol use and abuse	4	0
Cancer	1	
Depression/anxiety	0	
Obesity/overweight	1	
SENIOR POPULATION HEALTH CONCERNS		
Cost of long-term/nursing home care	0	
Availability of resources to help elderly stay in their homes	1	
Assisted living options	0	
Availability of home health	0	

Appendix E – Survey "Other" Responses

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

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

- Movie theater has current movies

3. Considering the QUALITY OF LIFE in your community, the best things are: "Other" responses:

- Community support is tremendous

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:

- Hospital turning into an NP clinic. No Doctors or qualified staff
- Lack of long-term planning, community goals

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

- CCMH does not listen to concerns of patients since early 2016

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

- Few activities at activity center for kids. It is often closed during school breaks
- Single parent families' lack of supervision and support
- Too much social media

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

- Staying connected to community members

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

- Ability to retain consistent quality healthcare providers…I have lived here 7 years and am on my 4th PCP.
- Alcohol abuse
- Declining, aging population
- Farming-related stress of prices and input costs.
- Getting professionals to return to our community. We will be in need of an ophthalmologist soon.
- Healthcare. Why have so many providers, nurses and other employees quit in the last 3 years? Will our hospital even be around for any of us? Patients do not want to keep finding a different provider because they keep leaving. When I can drive a half hour away and know that the staff has been there for years, I know my doctor will not leave me. Plus I can visit a waiting room full of Langdon people as I am waiting to see my doctor. As the largest employer in the county with such high turnover of staff, CCMH

is not a very enticing employer to attract families/employees to our community.
- Keeping medical providers.
- Lack of adequately paying jobs to support above average lifestyles.
- Lack of quality healthcare. Hospital will not listen to the concerns of patients when we tell them we are tired of losing our providers every year. Figure it out!
- Not hiring local people to do the job.
- Wondering if our hospital will survive. Too many patients have left and many will not come back.

Delivery of Healthcare

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

- None of the above
- We do not trust the education of our providers

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

- Clinic in Cavalier
- I have gone out of town for my healthcare due to the issues at CCMH

15. If you have utilized a medical provider outside Langdon, please tell us why. "Other" responses:

- 3 of my providers left in 3 years. I am done here.
- Continuity & quality of care
- Established relationship
- I was using them before I moved to Langdon
- I will not go back as the previous administration has run over thirteen doctors out of here. The board does not care about us so why would we support them?
- Insurance
- No one in Langdon I will go to. Trust. The only one I trust is too busy and hard to get into.
- Quality of care of providers; inconsistent providers; poor management/administration
- Referred to specialist
- Unhappy with Langdon

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

- Cardiac rehab, chemotherapy
- Colon
- Colonoscopy
- Continuity of local providers, good quality providers
- Doctors – there is only one part-time doctor. That is crazy!! Patients do not just want a NP clinic with no doctors 2 weeks out of every month.
- Doctors and providers. There is no one to go to.
- I think we should focus on keeping the same general care that we have now.
- More doctors (x2)
- Neurology
- Quality providers who stay
- Someone locally to do colonoscopy, endoscopy
- Specialty in OB/GYN

- We just need consistent doctors so there is a relationship and knowledge of my health history.

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

- Small community

28. Have you supported the Cavalier County Memorial Hospital and Clinics' Foundation in any of the following ways? "Other" responses:

- Donated in the past, will not donate anymore. Have other places I can send my donations to.
- Golf tournament
- I quit donating after previous administrator and the OIG fine
- Quit donating after the previous administrator team drove all the providers out
- Served on BOD for 10 years

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

- Get some providers we trust our healthcare to. It's run by locums and NPs. need some experienced doctors like Patel, Gwen, and Ashton. Liz is good but way too hard to get into. Need full time doctors who will stay. We used to have good providers who stayed for years and years and now they come and go like a revolving door. I am done with having to find a new provider every time mine leaves. My health is too important to just go to whoever happens to be at Langdon for the short term. I told my family I will take my chances on getting to Cavalier before I go to the ER in Langdon. A beautiful poorly run hospital.
- I sat in empty waiting room while NP was running back and forth to ER. No one else was working. I waited 45 min. Why is there only 1 working during the day?
- I want the same doctor for many years. We foolishly let two dedicated doctors go.
- I would suggest hiring good quality providers. Providers with family practice or internal medicine experience that is recent (not >15 years old). Value the employees so they stay, pay fair wages, listen to them, give them a voice. There are still two individuals on Administration whom have caused many problems and are the reason why many staff no longer are there. Valued employees work hard, and therefore hospital revenue increases. When you lose valuable staff = lost income. CCMH could be great and I believe in time it will be if positive changes continue.
- Keep excellent providers who care
- Need more doctors
- No continuity of care. Serious lack of quality care. I would be scared to have to go to ER in Langdon. Have heard too many nightmare stories from too many people who have had very bad experiences in the ER.
- Start listening to the concerns of the patients rather than trying to protect the administration.