Community Health Needs Assessment

CHI Mercy Health (Barnes County) Service Area

Valley City, North Dakota

2022

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The board of directors for CHI Mercy Health approved this Community Health Needs Assessment in April 2022.

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Executive Summary

To help inform future decisions and strategic planning, CHI Mercy Health conducted a Community Health Needs Assessment (CHNA) in 2021, the previous CHNA having been conducted in 2019. 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. Two hundred sixty-one service area residents responded to the survey with 251 results able to be analyzed. Additional information was collected through five key informant interviews with community members. The input from the residents, who primarily reside in Barnes 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, Barnes County's population from 2010 to 2019 decreased by 5.9%. The average number of residents under age 18 (19.6%) for Barnes County comes in 3.9 percentage points lower than the North Dakota average (23.5%). The percentage of residents, ages 65 and older, is much higher for Barnes County (23.2%) than the North Dakota average (15.3%), and the rate of high school graduates is very similar for Barnes County (92.3%) to the North Dakota average (92.5%). The median household income in Barnes County ($64,894) is slightly higher than the state average for North Dakota ($63,843).

Data compiled by County Health Rankings show Barnes County is doing better or equal to North Dakota in health outcomes/factors for 19 categories.

Barnes County, according to County Health Rankings data, is performing poorly relative to the rest of the state in 11 outcome/factor categories.

Of 106 potential community and health needs set forth in the survey, the 251 service area residents whose responses were analyzed indicated the following needs as the most important:

- Drug use and abuse – Youth
- Alcohol use and abuse – Adults
- Attracting and retaining young families
- Not enough jobs with livable wages
- Depression/anxiety – Youth
- Alcohol use and abuse – Youth
- Availability of resources to help the elderly stay in their homes
- Cost of long-term/nursing home care
- Drug use and abuse – Adult
- Depression/anxiety – Adult
- Quality of street/sidewalk

The survey also revealed the biggest barriers to receiving healthcare (as perceived by community members). The most prevalent barrier perceived by residents was not enough evening/weekend hours (N=62), with the next being no insurance or limited insurance (N=49). After these items, the next most commonly identified barriers were healthcare not being affordable (N=48), not enough specialists (N=46), and not able to get appointment/limited hours, and not knowing about local services, having the same number of responses (N=31).

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

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

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

- Alcohol use and abuse
- Availability of mental health services
- Availability of resources to help the elderly stay in their homes
- Depression/anxiety
- Drug use and abuse

Overview and Community Resources

With assistance from CRH at the UNDSMHS, CHI Mercy Health and City-County Health District completed a CHNA of their service areas. The hospital identifies its service area as Barnes County. Zip codes within the service area include: 58429, 58031, 58049, 58461, 58062, 58063, 58065, 58479, 58480, 58481, 58072, and 58492. Many community members and stakeholders worked together on the assessment.

Barnes County is located in southeastern North Dakota. The county seat is Valley City, which lies in the center of the county. The state capital, Bismarck, is located two hours to the west of Valley City. The 2019 estimated population of Barnes County was 10,415, which is a 5.9% decrease from 2010. Valley City's estimated population in 2019 was 6,323 (a 4.9% decrease from 2010). Rural Barnes County has several incorporated cities, including Wimbledon, Sanborn, Litchville, Oriska, and Dazey. Beyond City-County Health District and CHI Mercy Health, additional agencies who provide health services in Barnes County include Essentia Health – Valley City Clinic and Sanford Health Valley City Clinic. In addition to seeking healthcare in Barnes County, residents most frequently access healthcare services in Cass County and Stutsman County. The Valley City area has a number of community assets and resources that are potentially available to address significant health needs.

Valley City is nestled on the banks of the beautiful Sheyenne River. The 11 bridges in Valley City help tell its history. Interpretive panels have been placed at seven bridges in town and one north of Valley City, giving the details about how the valley was developed.

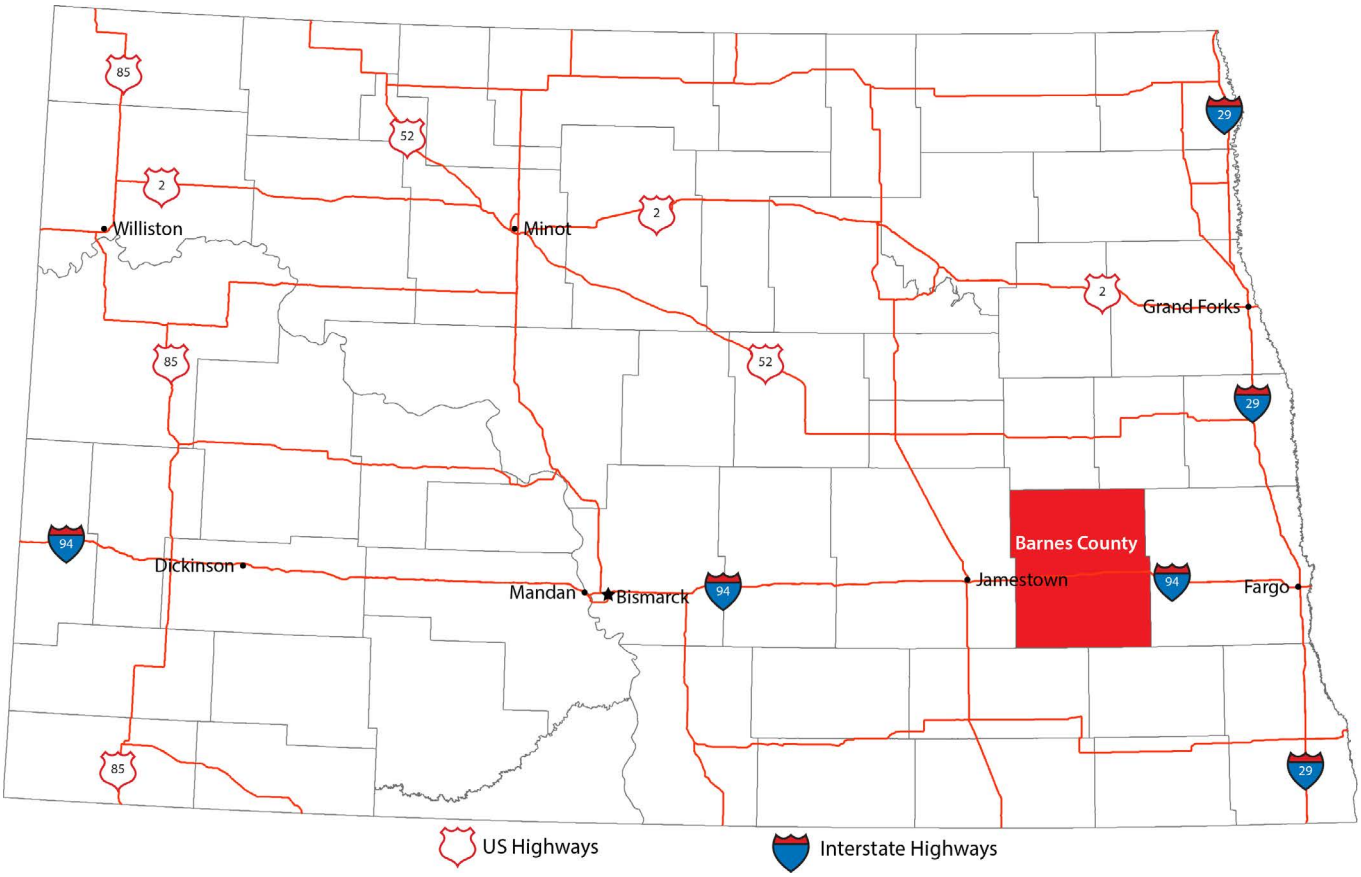
Valley City is also known for specialty shops– whether antiquing, looking for local art or quilting – Valley City has it covered! History buffs will enjoy the Rosebud Visitor Center, home to an 1881 Northern Pacific Superintendent's Railcar with the original furnishings, and the outdoor railroad display. Don't miss the Barnes County Museum right in the middle of downtown. They have a special guest - Gundy the Triceratops.

Remaining on the historic register, Old Main and the clock tower are Valley City State University's campus icons. Also, on campus visitors will find the planetarium. Up the hill, south of the campus on Winter Show Road is home to Medicine Wheel Park. A replica of a Native American solar calendar, a meridian calendar, burial mounds, and a walk among the plants with interpretation are all part of the park.

For those who love the outdoors, there are two beautiful golf courses along the river. Hikers enjoy the North Country Scenic Trail as well as several walkways around Valley City. Enjoy a beautiful drive on the Sheyenne River Valley National Scenic Byway, located north and south of Valley City.

A 2016 community addition, the Gaukler Wellness Center is a state of the art, 65,000 square foot center, which offers fitness classes, a three lane track, Matrix and Octane cardio equipment, Nautilus weight machines, free weights, two basketball courts, an indoor playground, and a swimming pool, featuring four lanes, a zero-depth area, and hot tub.

Figure 1: Barnes County



CHI Mercy Health

CHI Mercy Health is a member of Catholic Health Initiatives, which is a part of CommonSpirit Health. CommonSpirit is one of the largest nonprofit health systems in the U.S., with more than 1,000 care sites in 21 states coast to coast, serving 20 million patients in big cities and small towns across America. As CommonSpirit Health, we make the healing presence of God known in our world by improving the health of the people we serve, especially those who are vulnerable, while we advance social justice for all. The Critical Access Hospital Profile for CHI Mercy Health, which includes a summary of hospital-specific information, is available in Appendix A.

Services offered locally by CHI Mercy Health include:

General and Acute Services

- Ambulatory care/infusions
- Cardiac rehab
- Emergency room
- Hospital (acute care)
- Nutrition counseling
- Observation services
- Pharmacy
- Respite care
- Swing bed services

Screening/Therapy Services

- Occupational therapy
- Physical therapy
- Respiratory therapy
- Sleep studies
- Social services

Surgery Services

- Cataract surgery
- General and same day surgery
- Pain management injections

Radiology Services

- CT scan
- DEXA (bone density) Scans
- EKG
- Fluoroscopy (C-Arm)
- General x-ray
- Mammography (mobile unit)
- MRI (mobile unit)
- Nuclear medicine (mobile unit)
- Ultrasound

Laboratory Services

- Blood banking
- Chemistry
- Coagulation
- Hematology
- Microbiology
- Phlebotomy
- Urinalysis
- Workplace drug testing

Services offered by OTHER providers

- Ambulance
- Cataract surgery
- General surgery
- Sleep studies
- Tele-psychology screenings

City-County Health District

City-County Health District (CCHD) is a single-county health unit, providing services for the people of Barnes County. CCHD provides public health services that include environmental health, nursing services, many prevention programs, immunizations, and the WIC (women, infants, and children) program. Each of these programs provides a wide variety of services in order to accomplish the mission of public health, which is to assure that North Dakota is a healthy place to live, and each person has an equal opportunity to enjoy good health. To accomplish this mission, CCHD is committed to the promotion of healthy lifestyles, protection and enhancement of the environment, and provision of quality health care services for the people of North Dakota.

Specific services City-County Health District provides include:

- AED tracking
- Alcohol prevention program
- Blood pressure checks
- Breastfeeding resources
- Car seat program
- Child health (well-baby checks)

- Correction facility health
- Diabetes screening and management programs
- Emergency preparedness services-work with community partners as part of local emergency response team
- Environmental health services (water, sewer, health hazard abatement)
- Family planning
- Flu shots
- Foot care
- Health Tracks (child health screening)
- Home health
- Immunizations
- Medication setup
- Nutrition education
- ON THE MOVE community health program
- Opioid prevention program
- Rapid screens
- School health
- Tobacco prevention and control program
- WIC (Women, Infants & Children) program
- Worksite wellness
- Young people's healthy heart program

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 Barnes County. In addition to Valley City, located in the county are the communities of Dazey, Fingal, Kathryn, Leal, Litchville, Nome, Oriska, Pillsbury, Rogers, Sanborn, Sibley, Tower City, and Wimbledon.

CRH, in partnership with CHI Mercy Health and City-County Health District, facilitated the CHNA process. Community representatives met regularly in-person, by telephone conference, and email. A CHNA liaison was selected locally, who served as the main point of contact between CRH and CHI Mercy Health. A small steering committee (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. Eight people, representing a cross section demographically, attended the focus group meeting. The meeting was highly interactive with good participation. CHI Mercy Health staff were in attendance as well but largely played a role of listening and learning.

Figure 2: Steering Committee

Steve Spickenreuther	Mission/Foundation Director, CHI Mercy Health
Naomi Koch	Director of Case Management & Social Services, CHI Mercy Health
Theresa Will	City County Health District
Katie Beyer	City County Health District
Heather Schwehr	City County Health District
Emmy Isaackson	Pastor, Our Savior's Lutheran Church
Chelsea Modlin	Licensed Social Worker, South Central Human Service Center
Betty Tykwinski	Director for Health Services, Valley City State University
Colleen Jones	VP Patient Care Services, CHI Mercy Health
Jennifer Feist	Director of Development, Valley City Chamber of Commerce

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

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

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

The Center for Rural Health (CRH) provided substantial support to CHI Mercy Health and CCHD in conducting this needs assessment. The Center for Rural Health's involvement was funded partially through its Medicare Rural Hospital Flexibility (Flex) Program. The Flex Program is federally funded by the Office of Rural Health Policy, part of the Health Resources and Services Administration.

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

Members of the community group and key informant interviews represented the broad interests of the community and served by CHI Mercy Health and City-County Health District. They included representatives of the health community, business community, political bodies, law enforcement, education, faith community, and social service agencies. Not all members of the group were present at both meetings.

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

Community Group

A community group, consisting of eight community members, was convened and first met on August 3, 2021. During this first community group meeting, group members were introduced to the needs assessment process, reviewed basic demographic information about Barnes County, 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 via Zoom on September 24, 2021 with eleven 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 Barnes County. The group was then tasked with identifying and prioritizing the community's health needs.

Interviews

One-on-one interviews with five key informants were conducted in person in Valley City on August 3, 2021. 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 direct experience in the community, including working with medically underserved, low income, and minority populations as well as with populations with chronic diseases.

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

Survey

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

The community member survey was distributed to various residents of Barnes County, which is included in the CHI Mercy Health 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, press releases were published in the newspaper. Additionally, information was published on social media and CHI Mercy Health, CCHD, Valley City, and Barnes County websites.

Approximately 100 community member surveys were available for distribution in Barnes County. The surveys were distributed by community group members and at CHI Mercy Health, CCHD, the courthouse, and area business offices.

To help ensure anonymity, included with each paper survey was a postage-paid return envelope to CRH. The survey period ran from July 27, 2021 to August 15, 2021. Two completed paper surveys were returned.

Area residents were also given the option of completing an online version of the survey, which was publicized in the newspaper and on the websites of CHI Mercy Health, CCHD, Valley City, and Barnes County. Two hundred fifty-nine online surveys were completed. Fifteen of those online respondents used the QR code to complete the survey. In total, counting both paper and online surveys, 261 community member surveys were completed, equating to a 3% response rate. This response rate is sub-par for this type of unsolicited survey methodology but is a higher number of respondents than the community's 2019 survey.

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 United States Census Bureau; Robert Wood Johnson Foundation's County Health Rankings, which pulls data from 20 primary data sources (www.countyhealthrankings.org); the National Survey of Children's Health, which touches on multiple intersecting aspects of children's lives (www.childhealthdata.org/learn/NSCH); North Dakota KIDS COUNT, which is a national and state-by-state effort to track the status of children, sponsored by the Annie E. Casey Foundation (www.ndkidscount.org); and Youth Risk Behavior Surveillance System (YRBSS) data, which is published by the Centers for Disease Control and Prevention (https://www.cdc.gov/healthyyouth/data/yrbs/index.htm).

Social Determinants of Health

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.

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

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

Figure 3: Social Determinants of Health

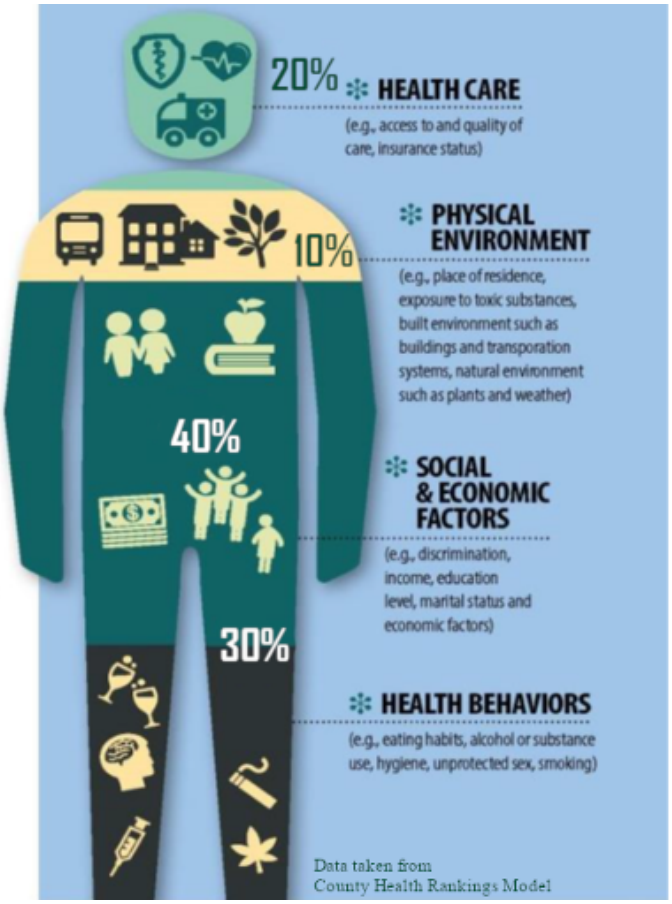


Figure 4 (Henry J. Kaiser Family Foundation, https://www.kff.org/disparities-policy/issue-brief/beyond-health-care-the-role-of-social-determinants-in-promoting-health-and-health-equity/), provides examples of factors that are included in each of the social determinants of health categories that lead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

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

Figure 4: Social Determinants of Health

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

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

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Health Equity and COVID-19 Assessment for Barnes County

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

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

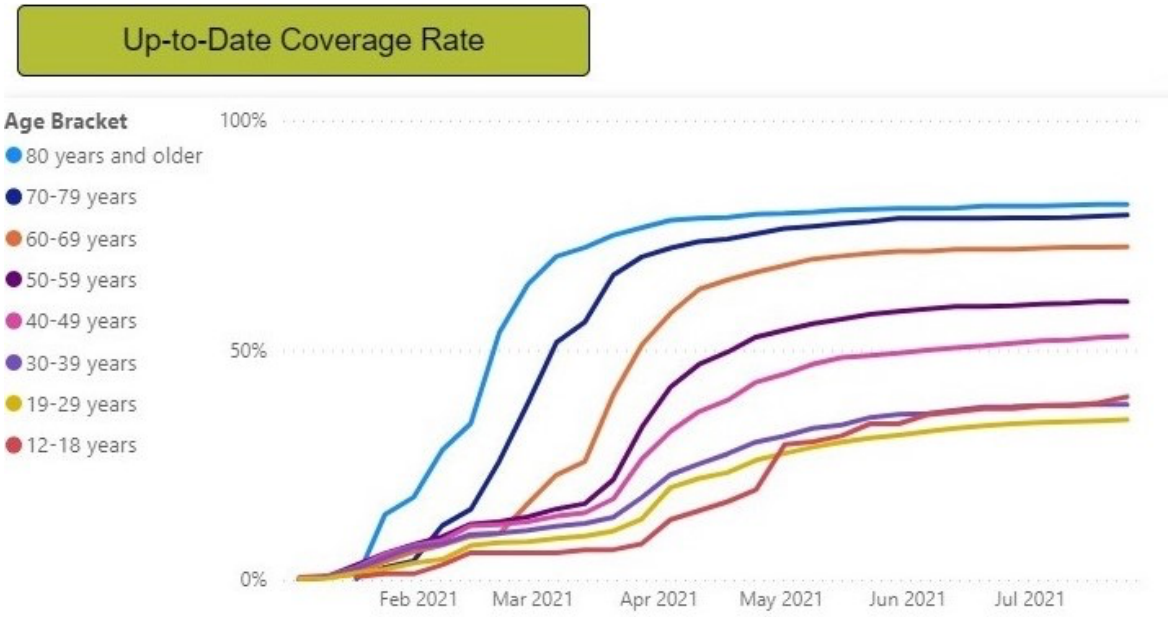
COVID-19 in Barnes County

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

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

As of July 23, 2021, in North Dakota, 641,472 doses of the COVID-19 vaccine have been administered. In Barnes County 9,741 COVID-19 vaccine doses have been administered. Statewide, the one dose coverage rate is 48.9%, and 46.2% are fully immunized. See Figure 2 for the Barnes County breakdown by age of one dose coverage and fully vaccinated (up-to-date coverage). Barnes County has a 57.3% Up-to-Date Coverage Rate as of July 18, 2021.

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



There are six COVID-19 vaccine-enrolled provider sites in Barnes County and 419, total, in North Dakota.

Immunization Rates for Barnes County

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

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

Vaccine	Rate (%)
4:3:1:3:3:1:4 Series	62.22
DTap	70.37
Hepatitis A	62.96
Hepatitis B	83.70
Hib UTD	70.37
MMR	82.96
PCV	78.52
Polio	82.96
Varicella	82.96

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

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

Vaccine	Rate (%)
HPV Female Start	76.36
HPV Female UTD	63.90
HPOV Male Start	77.14
HPV Male UTD	63.43
MCV4 dose 1	90.10
MCV4 dose 2	60.89
Men B dose 1	31.37
Men B UTD	18.45
Td/Tdap	90.55
Varicella	90.25

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

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

Vaccine	Rate (%)
PCV13 after 65 years	69.08
PPSV23 after 65 years	59.64
Shingrix® dose 1 after 50 years	28.55
Shingrix® UTD after 50 years	23.51
Tdap after 19 years	77.48
Zostavax after 60 years	40.67

Focus Group Discussion

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

Respondents within the focus group began discussions with the overall impact COVID-19 and the COVID-19 vaccine had on the Barnes County community. The conversation then continued as to reasons why residents received the vaccine and rationale for why other residents do not want the COVID-19 vaccine. A lot of controversy between advocates and skeptics of the vaccine exist due to the many opposing sources of information available through various trusted and distrusted media sources. Finally, discussions ended with strategies on how to raise awareness and access to vaccine resources throughout Barnes County.

Respondents of this focus group were primarily supporters of the COVID-19 vaccine, elaborating on what they hear as perceptions for why other residents do not want the vaccine. Overall, the tone is hopeful that future research and incentives will raise vaccination rates; however, many respondents are skeptical as they believe that those who do not want the vaccine are adamant in their position.

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

During the first nine months of the COVID-19 pandemic, the Barnes County area struggled with closed businesses, mental health, and staffing difficulties. Many respondents report that there was much concern, regarding availability of business resources, as many were forced to close during the pandemic. Unfortunately, for some this closure resulted in several businesses failing. Within assisted living facilities, many of the older residents suffered from mental health issues due to mandates on limiting visitation. This isolation spread throughout the community as one respondent voiced their concern about limited human contact, as they were unable to visit with their grandkids and other family members. As mental health issues increased, demand for services, such as counselors, were sought after by students, while others found other coping mechanisms seen through an increase in alcohol use disorders. Within healthcare facilities, staffing shortages caused difficulties, as one manager reported this situation was the worst one that they have had to deal with in the past 40 years of supervising.

While the introduction of the vaccine offered a hope towards ending the pandemic, many younger residents do not believe it is necessary, as they perceive themselves as healthy individuals. Similarly, other residents are unsure of the vaccine due to either political identity or skepticism within its safety. This division between those who want the vaccine and those who do not created a lot of controversy within the community, which lead to stigma. As such, some of the faith community are refusing to discuss the topic altogether so as to not anger their followers. For others, this refusal translates to a lower vaccination rate within the staff of assisted living facilities, which is estimated to be around 70%. On the other hand, many of the older population were among the first to receive the vaccine, as they perceive themselves as the most vulnerable. Similarly, vaccination rates are perceived to be higher in international students within the community as availability of the COVID-19 vaccine is lower in the countries they emigrated from. While many are unsure of which sources of information should be trusted, both advocates and skeptics of the vaccine are thankful for the efforts that City-County Public Health have put towards spreading awareness and access of the COVID-19 vaccine.

Reasons People in the Community Want to be Vaccinated

Many believe that becoming vaccinated offers many benefits including safety, travel, and normalcy. Respondents report that they feel receiving the vaccine is necessary in protecting their family and neighbors, while offering the freedom to socialize and visit. One community member voiced that if other residents received the COVID-19 vaccine, that the community can come together again for the first time in two years. By receiving the vaccine, many believe that restrictions on extracurricular activities will be lessened allowing for students, families, and friends to come together without the need for wearing masks. Additionally, mandates of the COVID-19 vaccine will increase vaccination rates for those who wish to travel either internationally or via plane. Other reasons for receiving the vaccine include convenience. As wellness checks with primary care are conducted, many providers are offering the vaccine in addition to their normal vaccine schedule. The cultural norm set by these providers is a large influence for those who would otherwise not have gone out of their way to receive the vaccine.

Reasons People in the Community Do Not Want to be Vaccinated

Community members who do not want to receive the vaccine report safety, religious beliefs, and political identity as factors against vaccination. Respondents report hearing from their community that the vaccine is dangerous as long-term effects have yet to be studied. Some believe that until the FDA approves the vaccine for non-emergency use, they will not receive the COVID-19 vaccine. Additionally, many younger families are concerned with fertility issues that the COVID-19 vaccine may cause. For faith-based communities, the utilization of stem-cells in the Johnson & Johnson has been listed as a reason to not receive the COVID-19 vaccine. Others community members believe that the worst of the COVID-19 pandemic is behind them, therefore, they do not feel it is necessary to receive the COVID-19 vaccine. Those who have already contracted COVID-19 report not wanting the vaccine because they believe they already are protected against any future infection of COVID-19.

Sources of COVID-19 Information

Community members are turning away from the CDC as a trusted source of information due to their often-changing recommendations on COVID-19. Instead, those who are looking for information often turn to social media, such as Facebook or TikTok to better understand COVID-19. Respondents fear that these sources of media are causing a spread of various misinformation, and community members should instead look toward local sources to better understand COVID-19 and the COVID-19 vaccine. Respondents also report that much information is being spread by word of mouth through stories that have affected neighbors or loved ones. While these accounts may be a more local source of information, respondents are also concerned that these stories only bring light to the negative impacts of the COVID-19 vaccine and that these impacts are often overreported via word of mouth.

Barriers to Receiving the COVID-19 Vaccination

The general consensus within the community is that the COVID-19 vaccine is readily accessible for those who want to receive it. Providers have a large supply of the COVID-19 vaccine, and transportation is not seen as an issue. Respondents reported that, if necessary, public health staff will drive out to homes to provide the vaccine for those who want to receive it. One possible barrier that was discussed involves the marketability of these services and advertising when clinics are available. Previously, after-hour clinics were offered as a way to increase vaccination rates, but as demand for these times decreased, they are now offered less frequently.

Ways to Increase Confidence and Vaccination Rates

To further increase vaccination rates, respondents believe that strategies should be aimed at collaboration and outreach across the community. By having more communication from a similar source of information, such as public health being provided to various institutions, outreach towards differing populations can be achieved. For example, one respondent noted that campaigns aimed toward rehabilitation resources, education services, or assisted living facilities will help enable members from these populations to receive information on the COVID-19 vaccine and its availability in their own respective central locations. Similarly, community members believe if providers of the COVID-19 vaccine offered booths for information and vaccination during community gatherings, COVID-19 vaccination rates would increase. To combat any barriers existing with accessibility of the COVID-19 vaccine, many members believe it would be beneficial to offer more frequent evening clinics.

Demographic Information

Table 1 summarizes general demographic and geographic data about Barnes County.
From 2010 Census/2019 American Community Survey; more recent estimates used where available

	Barnes County	North Dakota
Population (2019)	10,415	762,062
Population change (2010-2019)	-5.9%	13.3%
People per square mile (2010)	7.4	9.7
Persons 65 years or older (2019)	23.2%	15.7%
Persons under 18 years (2019)	19.6%	23.6%
Median age (2019 est.)	33.5	35.1
White persons (2019)	94.2%	86.9%
High school graduates (2019)	92.3%	92.6%
Bachelor's degree or higher (2019)	29.4%	30.0%
Live below poverty line (2019)	9.9%	10.6%
Persons without health insurance, under age 65 years (2019)	6.9%	8.1%
Households with a broadband Internet subscription (2019)	77.0%	80.7%

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

While the population of North Dakota has grown in recent years, Barnes County has seen a decrease in population since 2010. The U.S. Census Bureau estimates show that Barnes County's population decreased from 11,029 (2010) to 10,415 (2019).

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

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

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

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 Barnes 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 CHI Mercy Hospital and City County Health District or of any particular medical facility.

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

Barnes County rankings within the state are included in the following summary. For example, Barnes County ranks 9th out of 46 ranked counties in North Dakota on health outcomes and 16th on health factors. The measures marked with a bullet point (•) are those where a county is not measuring up to the state rate/percentage; a square (■) indicates the county is not meeting the U.S. Top 10% rate on that measure. Measures that are not marked with a colored shape but are marked with a plus sign (+) indicate that the county is doing better than the U.S. Top 10%.

The data from County Health Rankings shows that Barnes County is meeting or exceeding the U.S. Top 10% performers in nine measures; however, Barnes County is not meeting the North Dakota average on 11 of the measures.

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

- poor mental health days
- low birth weight
- adult smoking
- food environment index
- physical inactivity
- excessive drinking
- alcohol impaired driving deaths
- sexually transmitted infections
- teen birth rate
- primary care physicians
- dentists
- Mammography screening (% of Medicare enrollees ages 65-74 receiving screening)
- Flu vaccinations
- Children in poverty
- Children in single parent households

- Social associations
- violent crime
- drinking water violations
- severe housing problems

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

- premature death
- % of poor or fair health
- adult obesity
- access to exercise opportunities
- number of uninsured
- ratio of mental health providers
- preventable hospital stays
- unemployment
- income inequality
- injury deaths
- air pollution – particulate matter

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

● = Not meeting North Dakota average

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

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

Blank values reflect unreliable or missing data

TABLE 2: SELECTED MEASURES FROM *COUNTY HEALTH RANKINGS* 2021 – BARNES COUNTY			
	Barnes County	**U.S. Top 10%**	**North Dakota**
Ranking: Outcomes	**9th**		**(of 46)**
Premature death	7,200 ■●	5,400	6,600
Poor or fair health	15% ■●	14%	15%
Poor physical health days (in past 30 days)	3.3 ■	3.4	3.2
Poor mental health days (in past 30 days)	3.7 +	3.8	3.8
Low birth weight	6% +	6%	6%
Ranking: Factors	**16th**		**(of 45)**
Health Behaviors			
Adult smoking	19% ■	16%	20%
Adult obesity	35% ■●	26%	34%
Food environment index (10=best)	8.9 +	8.7	8.9
Physical inactivity	23% ■	19%	23%
Access to exercise opportunities	64% ■●	91%	74%
Excessive drinking	22% ■	15%	24%
Alcohol-impaired driving deaths	42% ■	11%	42%
Sexually transmitted infections	195.6 ■	161.2	46.66
Teen birth rate	13 ■	12	20
Clinical Care			
Uninsured	9% ■●	6%	8%
Primary care physicians	960:1 +	1,030:1	1,300:1
Dentists	1,300:1 ■	1,210:1	1,510:1
Mental health providers	1,160:1 ■●	270:1	510:1
Preventable hospital stays	4,065 ■●	2,565	4,037
Mammography screening (% of Medicare enrollees ages 65-74 receiving screening)	61% +	51%	53%
Flu vaccinations (% of fee-for-service Medicare enrollees receiving vaccination)	57% +	55%	50%
Social and Economic Factors			
Unemployment	3.0% ■●	2.6%	2.4%
Children in poverty	10% +	10%	11%
Income inequality	5.0 ■●	3.7	4.4
Children in single-parent households	15% ■	14%	20%
Social associations	19.9 +	18.2	16.0
Violent crime	181 ■	63	258
Injury deaths	74 ■●	59	71
Physical Environment			
Air pollution – particulate matter	5.3 ■●	5.2	4.7
Drinking water violations	No		
Severe housing problems	9% +	9%	12%

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

Children's Health

The National Survey of Children's Health touches on multiple intersecting aspects of children's lives. Data are not available at the county level; listed below is information about children's health in North Dakota. The full survey includes physical and mental health status, access to quality healthcare, and information on the child's family, neighborhood, and social context. Data is from 2018-19. More information about the survey may be found at www.childhealthdata.org/learn/NSCH.

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

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

Health Status	North Dakota	National
Children born premature (3 or more weeks early)	9.6%	11.2%
Children 10-17 overweight or obese	24.8%	31.4%
Children 0-5 who were ever breastfed	84.6%	80.6%
Children 6-17 who missed 11 or more days of school	3.9%	4.5%
Healthcare		
Children currently insured	93.4%	93.4%
Children who spent less than 10 minutes with the provider at a preventive medical visit	18.4%	19.0%
Children (1-17 years) who had preventive a dental visit in the past year	75.4%	79.6%
Children (3-17 years) received mental health care	12.0%	10.4%
Children (3-17 years) with problems requiring treatment did not receive mental health care	1.2%	2.3%
Young children (9-35 mos.) receiving standardized screening for developmental problems	32.6%	36.4 %
Family Life		
Children whose families eat meals together 4 or more times per week	75.5%	73.6%
Children who live in households where someone smokes	15.3%	14.4%
Neighborhood		
Children who live in neighborhoods with parks or playgrounds	81.1%	75.4%
Children living in neighborhoods with poorly kept or rundown housing	9.1%	13.3%
Children living in neighborhood that's usually or always safe	97.4%	95.0%

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

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

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

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

by the Annie E. Casey Foundation. KIDS COUNT data focuses on the main components of children's well-being; more information about KIDS COUNT is available at www.ndkidscount.org. The measures highlighted in blue in the table are those in which the counties are doing worse than the state average. The year of the most recent data is noted.

The data show Barnes County is performing more poorly than the North Dakota average on all of the examined measures except children enrolled in Healthy Steps, licensed childcare capacity, and the 4-year high school graduation rate. The most marked difference was on the measure of victims of child abuse and neglect, requiring services (almost two times higher rate than the North Dakota average.)

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

	Barnes County	North Dakota
Child food insecurity, 2018	11.6%	9.6%
Medicaid recipient (% of population age 0-20), 2020	27.7%	26.6%
Children enrolled in Healthy Steps (CHIP) (% of population age 0-18), 2020	1.6%	1.6%
Supplemental Nutrition Assistance Program (SNAP) recipients (% of population age 0-18), 2020	17.8%	16.9%
Licensed childcare capacity (# of children), 2020	513	36,701
4-year high school cohort graduation rate, 2019/2020	92.0%	89.0%
Victims of child abuse and neglect requiring services (rate per 1,000 children age 0-17), 2019	18.64	9.98

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

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

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

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

TABLE 5: Youth Behavioral Risk Survey Results

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

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

% of students who did not eat vegetables (green salad, potatoes [excluding French fries, fried potatoes, or potato chips], carrots, or other vegetables, during the seven days before the survey)	4.7	5.1	6.6	=	5.3	6.6	7.9
% of students who drank a can, bottle, or glass of soda or pop one or more times per day (not including diet soda or diet pop, during the seven days before the survey)	18.7	16.3	15.9	=	17.4	15.1	15.1
% of students who did not drink milk (during the seven days before the survey)	13.9	14.9	20.5	↑	14.8	20.3	30.6
% of students who did not eat breakfast (during the seven days before the survey)	11.9	13.5	14.4	=	13.3	14.1	16.7
% of students who most of the time or always went hungry because there was not enough food in their home (during the 30 days before the survey)	NA	2.7	2.8	=	2.1	2.9	NA
% of students who were physically active at least 60 minutes per day on 5 or more days (doing any kind of physical activity that increased their heart rate and made them breathe hard some of the time during the seven days before the survey)	NA	51.5	49.0	=	55.0	22.6	55.9
% of students who watched television 3 or more hours per day (on an average school day)	18.9	18.8	18.8	=	18.3	18.2	19.8
% of students who played video or computer games or used a computer 3 or more hours per day (for something that was not schoolwork on an average school day)	38.6	43.9	45.3	=	48.3	45.9	46.1
Other							
% of students who ever had sexual intercourse	38.9	36.6	38.3	=	35.4	36.1	38.4
% of students who had eight or more hours of sleep (on an average school night)	NA	31.8	29.5	=	31.8	33.1	NA
% of students who brushed their teeth on seven days (during the seven days before the survey)	NA	69.1	66.8	=	63.0	68.2	NA

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

Low Income Needs

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

Top Needs Identified by People Experiencing Poverty Across North Dakota

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

2020 North Dakota LOW INCOME COMMUNITY NEEDS

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

NDSU NORTH DAKOTA STATE UNIVERSITY

Assessed by CAPND and NDSU, November 2020

KEY FINDINGS

1st Priority Need

Rental Assistance

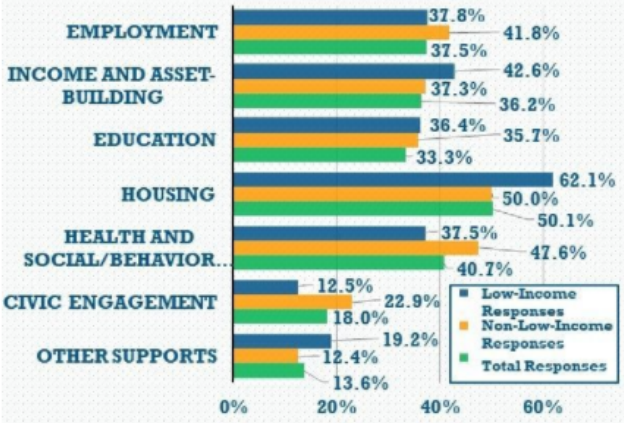
3,458 Total Survey Responses

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

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

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

STATEWIDE OVERALL NEEDS



TOP STATEWIDE SPECIFIC NEEDS

Low-Incomes

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

Non-Low-Incomes

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

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

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

TOP REGIONAL OVERALL NEEDS FOR LOW-INCOMES

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

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

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

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

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

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

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

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

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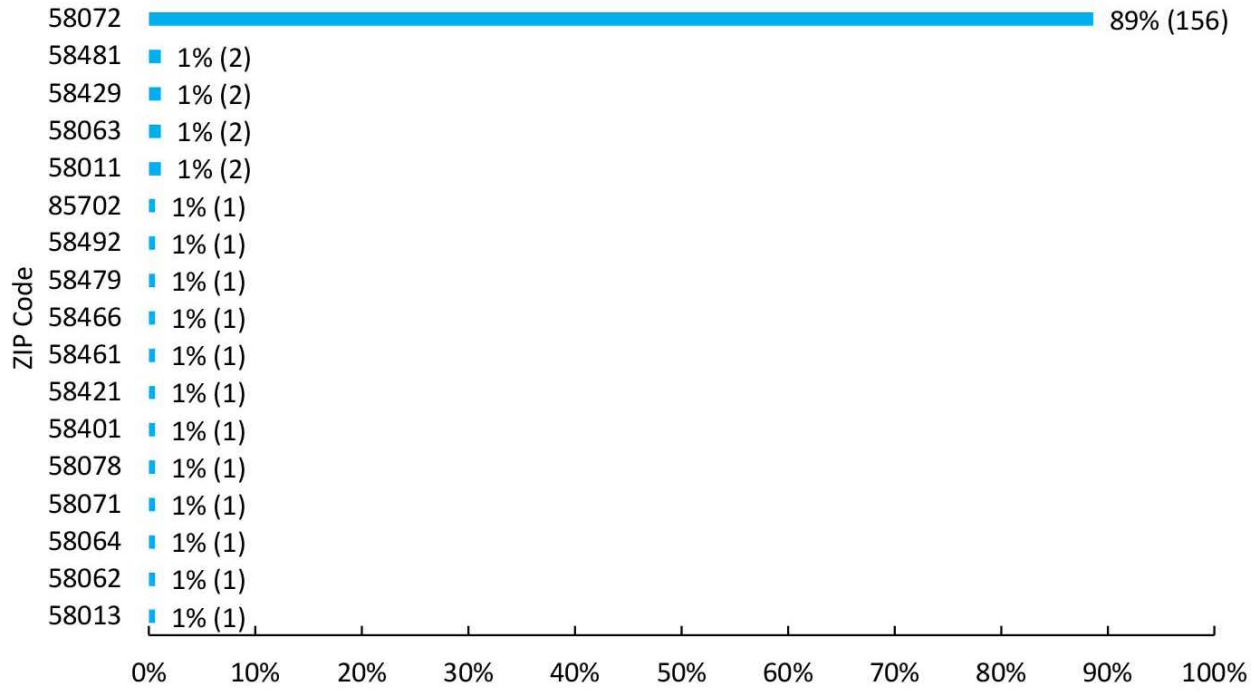
Survey Results

As noted previously, the 251 community members completed the survey in communities throughout the counties in the CHI Mercy Health service area. For all questions that contained an "Other" response, all of those direct responses may be found in Appendix G. In some cases, a summary of those comments is additionally included in the report narrative. The "Total respondents" number under each heading indicates the number of people who responded to that particular question and the "Total responses" number under the heading depicts the number of responses selected for that question (some questions allow for selection of more than one response).

The survey requested that respondents list their home zip code. While not all respondents provided a zip code, 176 did, revealing that a large majority of respondents (89%, N=156) lived in Valley City. These results are shown in Figure 5.

Figure 5: Survey Respondents' Home Zip Code
Total respondents: 176



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

Survey Demographics

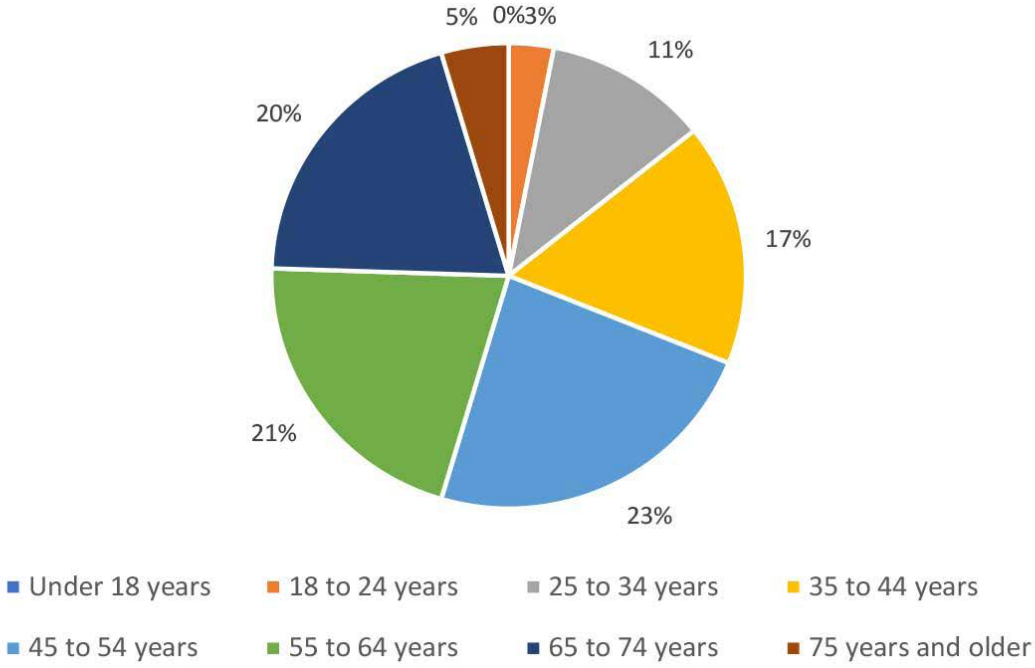
To better understand the perspectives offered by survey respondents, survey-takers were asked a few demographic questions. Throughout this report, numbers (N) instead of just percentages (%) are reported because percentages can be misleading with smaller numbers. Survey respondents were not required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

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

- 46% (N=89) were age 55 or older.
- The majority (74%, N=144) were female.
- More than half of the respondents (68%, N=133) had bachelor's degrees or higher.
- The number of those working full time (66%, N=130) was just over three times higher than those who were retired (20%, N=40).
- 99% (N=192) of those who reported their ethnicity/race were White/Caucasian.
- 23% of the population (N=43) had household incomes of less than $50,000.

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

Figure 6: Age Demographics of Survey Respondents
Total respondents = 196



For the CHNA, children under age 18 are not questioned, using this survey method.

Figure 7: Gender Demographics of Survey Respondents
Total respondents = 194

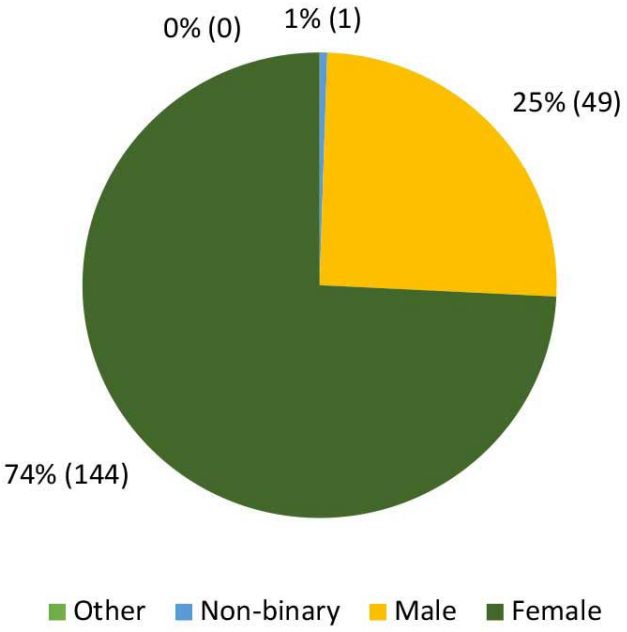


Figure 8: Educational Level Demographics of Survey Respondents
Total respondents = 195

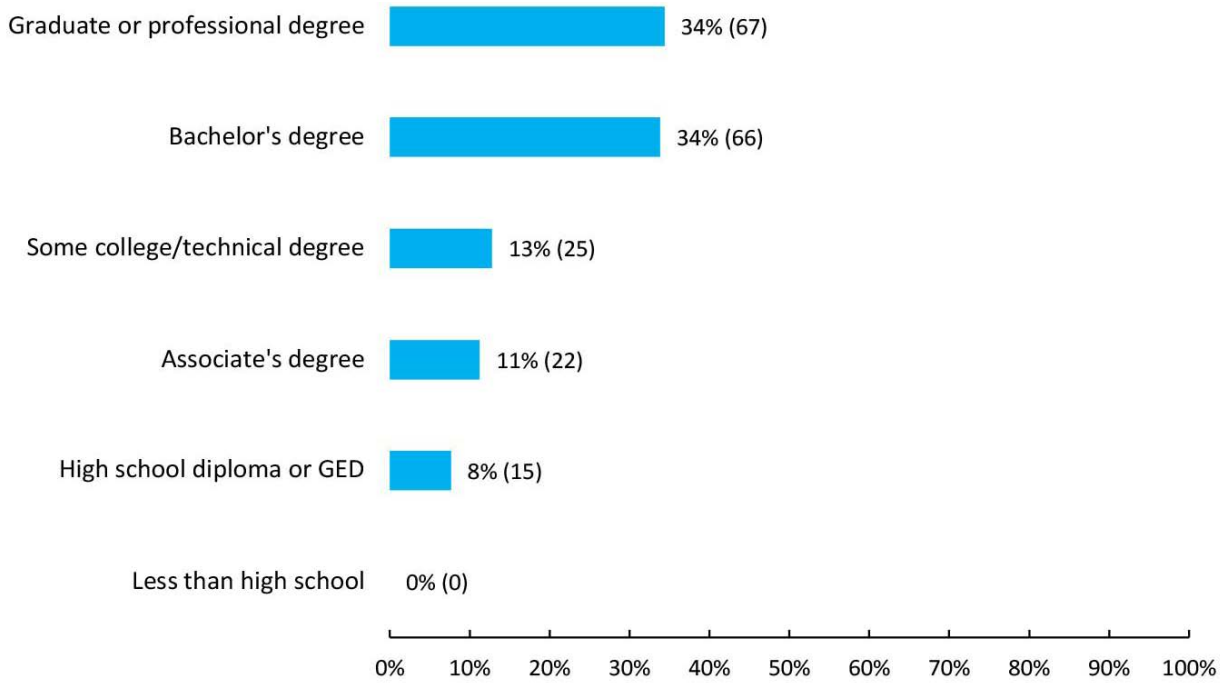
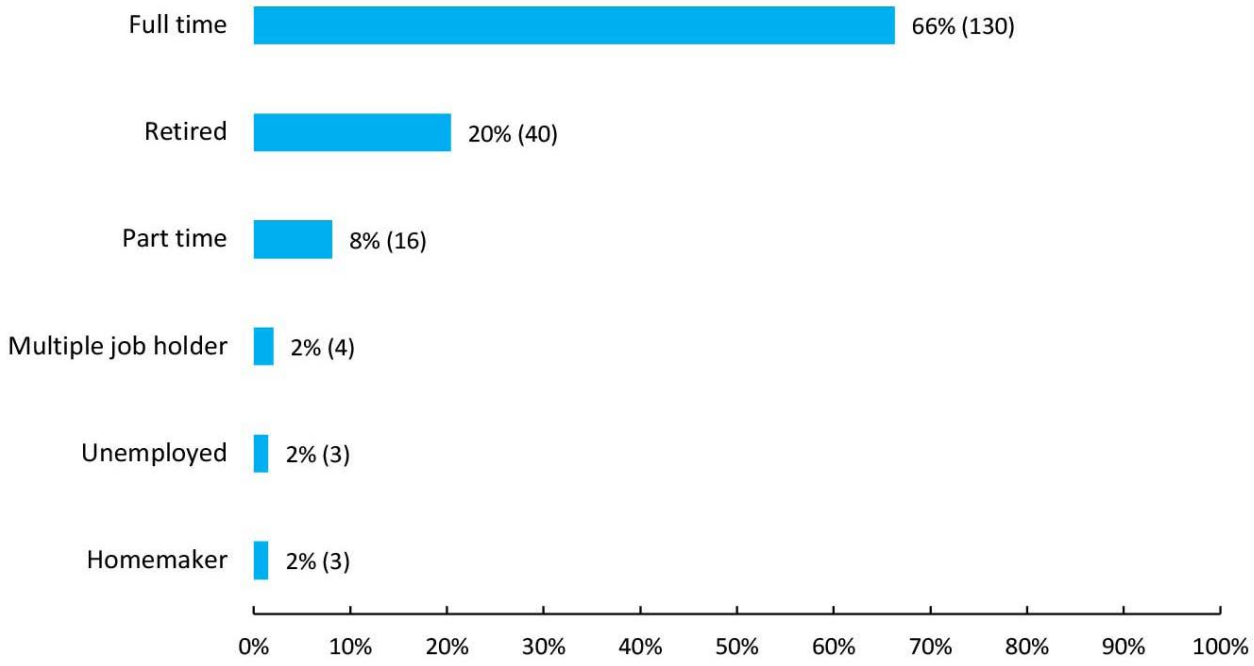
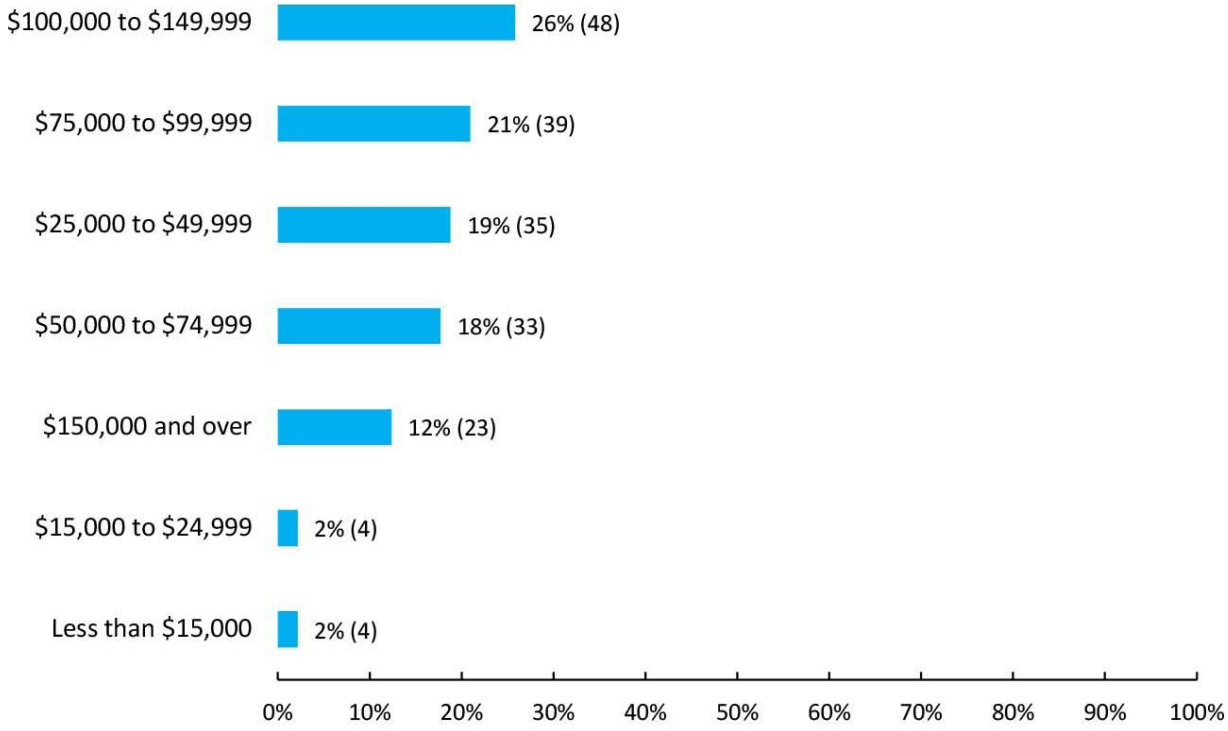


Figure 9: Employment Status Demographics of Survey Respondents
Total respondents = 196



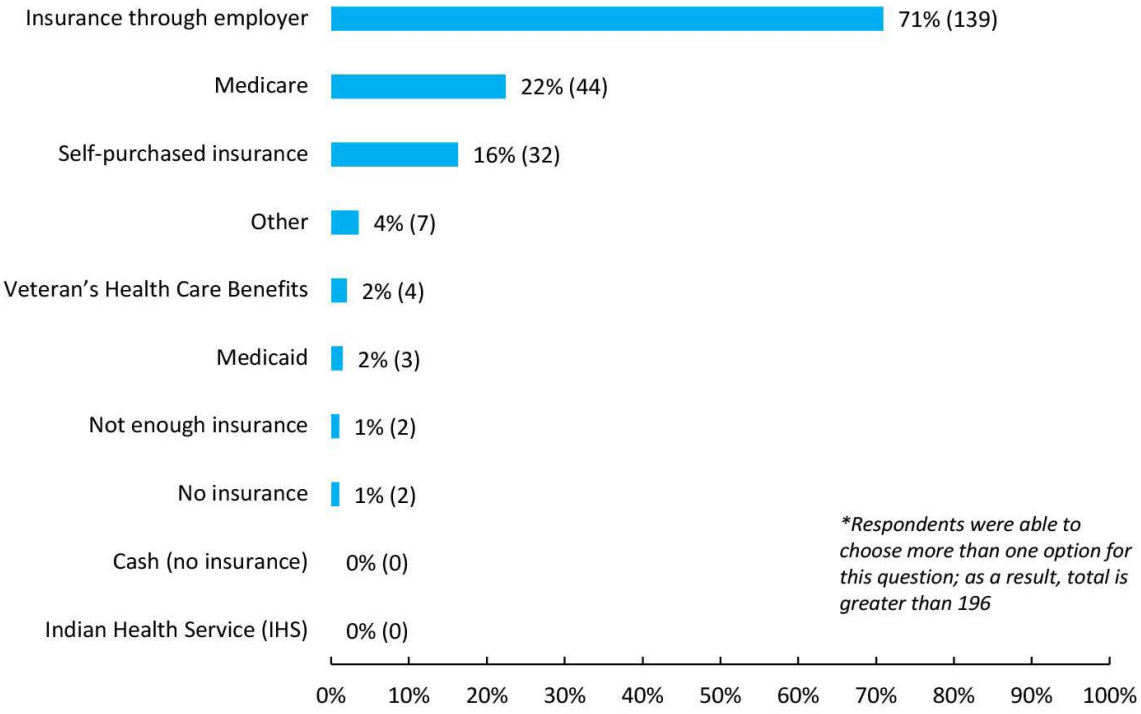
Of those who provided a household income, four percent (4%) (N=8) community members reported a household income of less than $25,000. Thirty-eight percent (N=71) indicated a household income of $100,000 or more. This information is show in Figure 10.

Figure 10: Household Income Demographics of Survey Respondents
Total respondents = 186



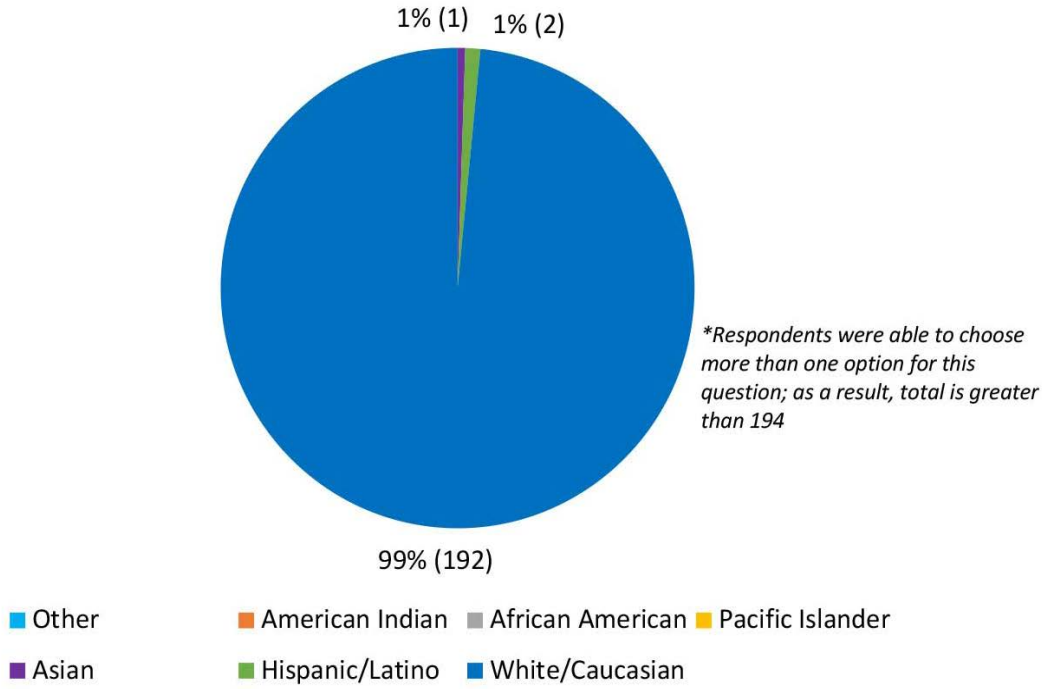
Community members were asked about their health insurance status, which is often associated with whether people have access to healthcare. Four percent (N=4) of the respondents reported having no health insurance or being under-insured. The most common insurance types were insurance through one's employer (N=139), followed by Medicare (N=44), and self-purchased (N=32).

Figure 11: Health Insurance Coverage Status of Survey Respondents
Total respondents = 196*



As shown in Figure 12, nearly all of the respondents were White/Caucasian (99%). This percent was higher than the race/ethnicity of the overall population of Barnes county; the US Census indicates that 94.2% of the population is White in Barnes County.

Figure 12: Race/Ethnicity Demographics of Survey Respondents
Total respondents = 194*



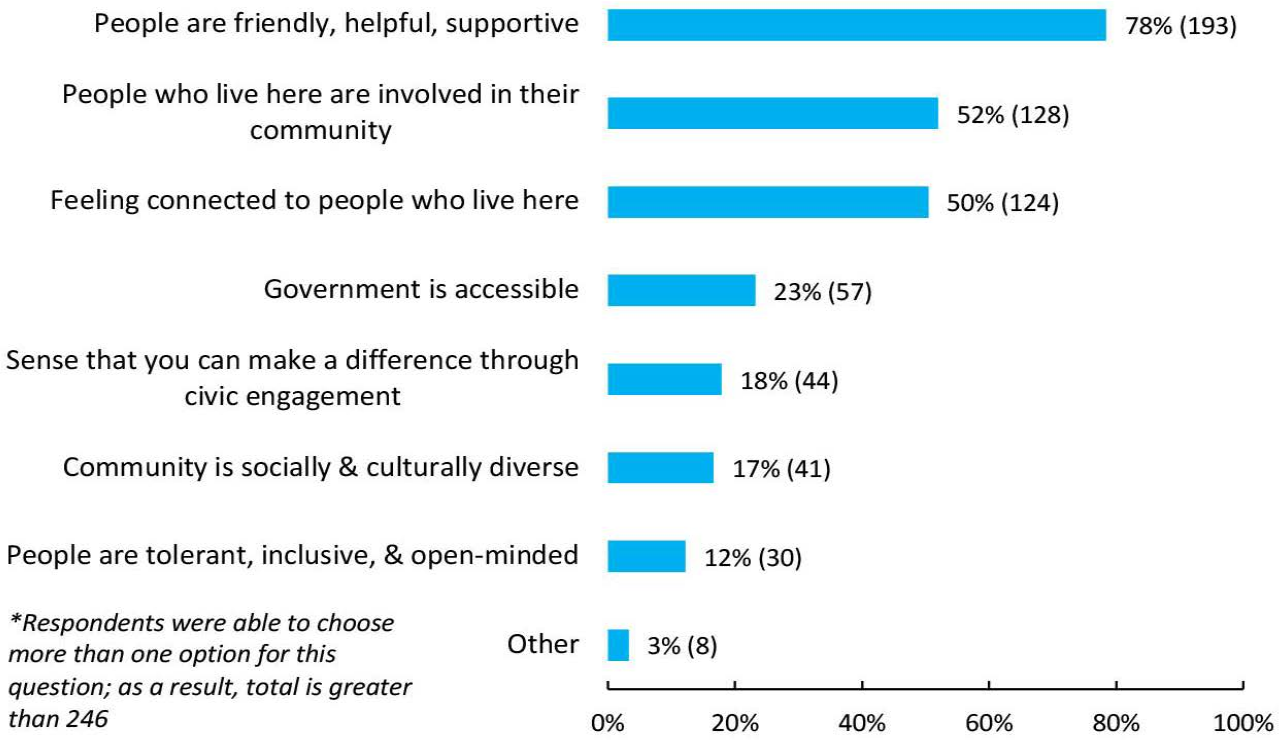
Community Assets and Challenges

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 246 respondents agreeing) that community assets include:

- People are friendly, helpful, supportive (N=193);
- Family-friendly (N=183);
- Safe place to live, little/no crime (N=182);
- Quality school systems (N=138); and
- People who live here are involved in their community (N=128).

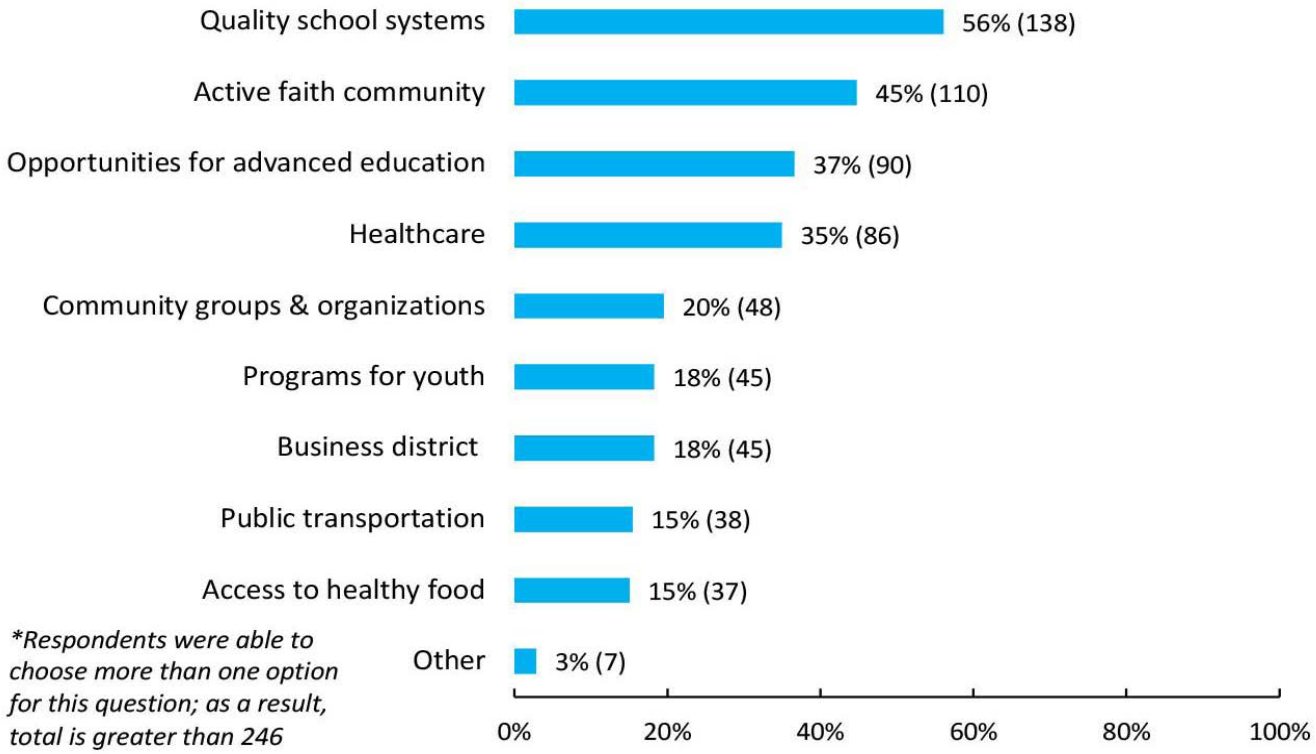
Figures 13 to 16 illustrate the results of these questions.

Figure 13: Best Things About the PEOPLE in Your Community
Total respondents = 246*



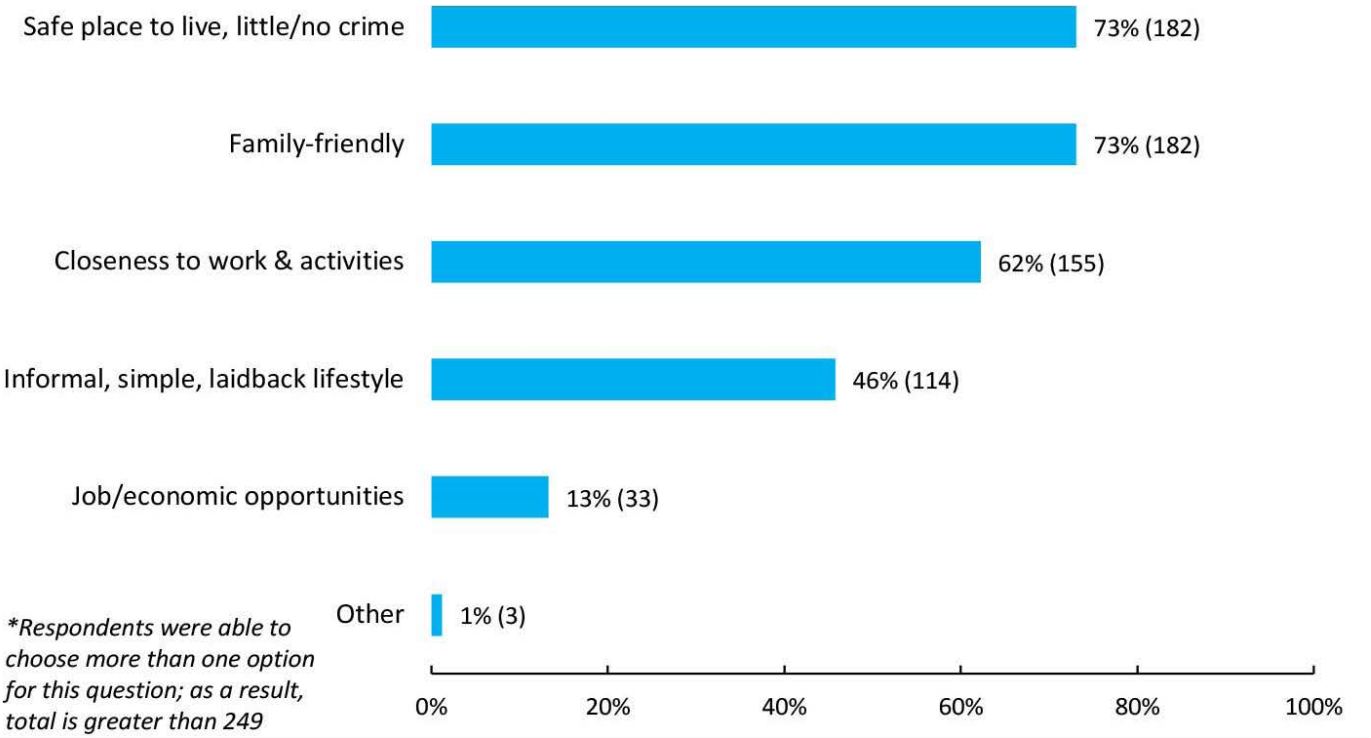
Included in the "Other" category of the best things about the people was that people are very connected to their families and their beginnings as family farms.

Figure 14: Best Things About the SERVICES AND RESOURCES in Your Community
Total respondents = 246*



Respondents who selected "Other" specified that the best things about services and resources included services for marginalized groups.

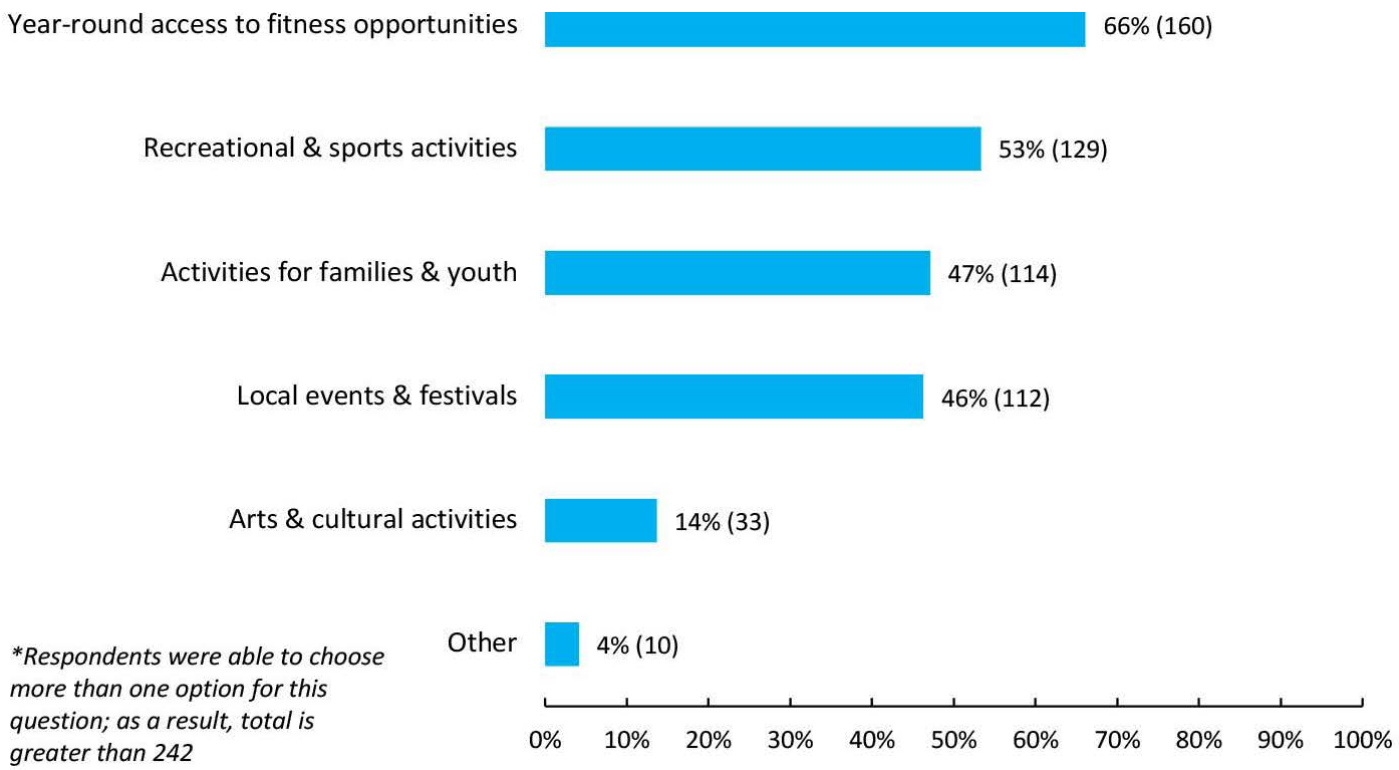
Figure 15: Best Things about the QUALITY OF LIFE in Your Community
Total respondents = 249*



Respondents were able to choose more than one option for this question; as a result, total is greater than 249

One of the "Other" responses, regarding the best things about the quality of life in the community, was outdoor recreational activities/options.

Figure 16: Best Thing About the ACTIVITIES in Your Community
Total respondents = 242*



Respondents were able to choose more than one option for this question; as a result, total is greater than 242

Community Concerns

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

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

With regard to responses about community challenges, the most highly voiced concerns (those having at least 75 respondents) were:

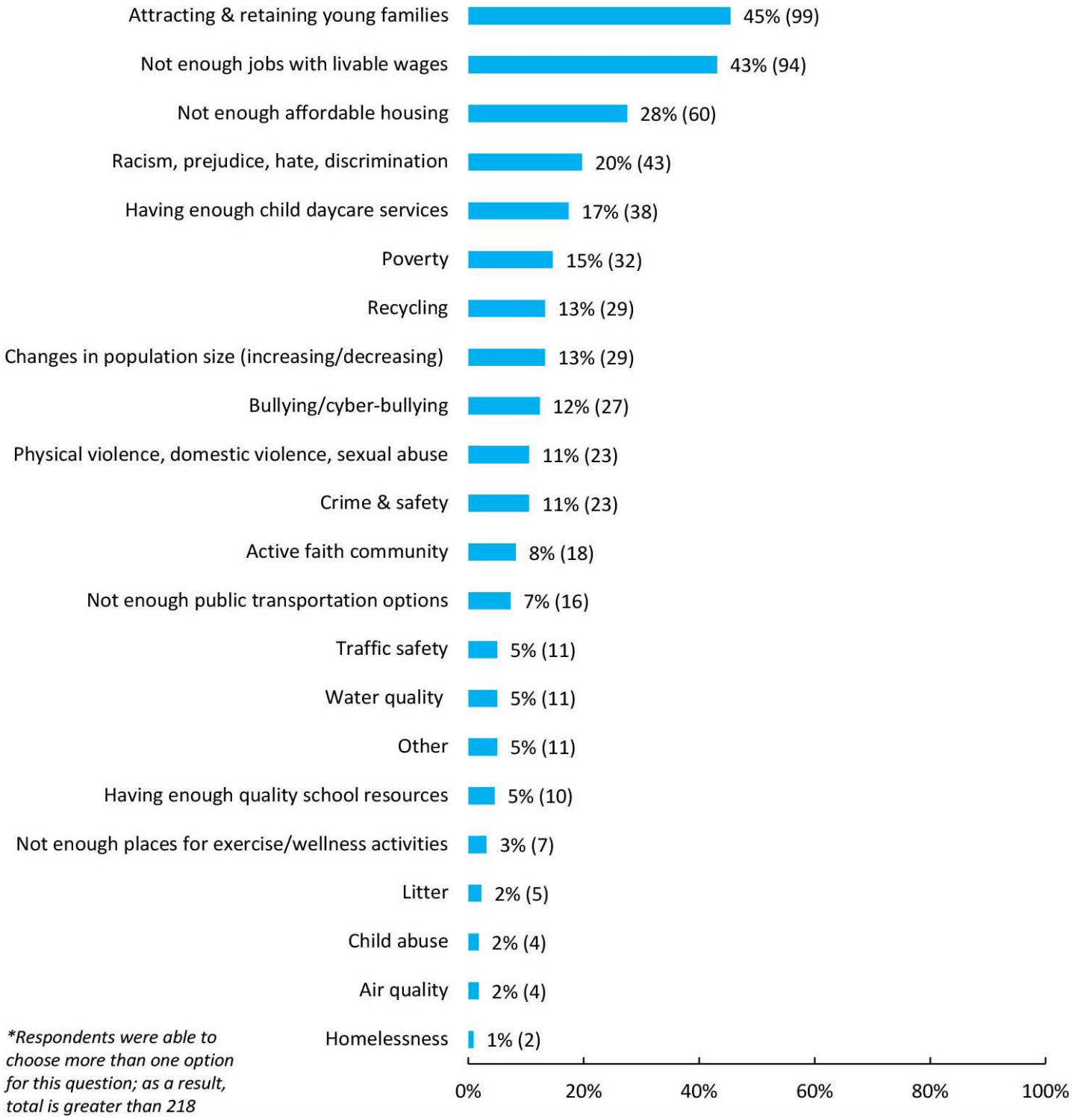
- Drug use and abuse – Youth (N=112)
- Alcohol use and abuse – Adults (N=101)
- Attracting and retaining young families (N=99)
- Not enough jobs with livable wages (N=94)
- Depression/anxiety - Youth (N=91)
- Alcohol use and abuse – Youth (N=89)
- Availability of resources to help the elderly stay in their homes (N=89)
- Cost of long-term/nursing home care (N=88)
- Drug use and abuse – Adult (N=86)
- Depression/anxiety - Adult (N=77)

The other issues that had at least 45 votes included:

- Obesity/overweight (N=68);
- Availability of mental health services (N=60);
- Not enough jobs with livable wages (N=60);
- Extra hours for appointments, such as evenings and weekends (N=55);
- Ability to retain primary care providers (MD, DO, NP, PA, nurses) in the community (N=55);
- Cost of health insurance (N=55);
- Smoking and tobacco use (second-hand smoke, vaping) – Youth (N=55);
- Cost of healthcare services (N=46);
- Availability of specialists (N=45); and,
- Not enough activities for children and youth (N=45).

Figures 17 through 21 illustrate these results.

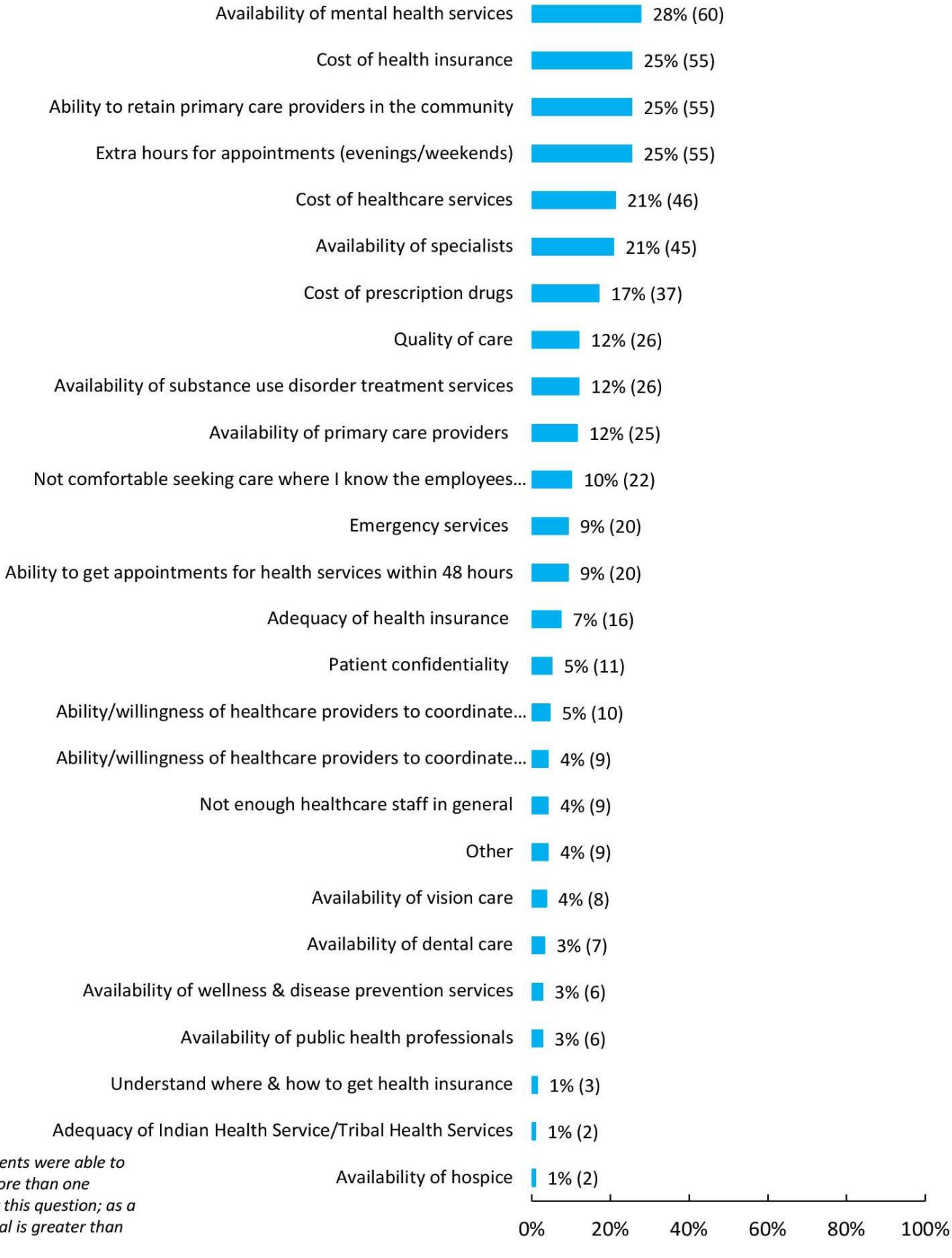
Figure 17: Community/Environmental Health Concerns
Total respondents = 218*



**Respondents were able to choose more than one option for this question; as a result, total is greater than 218*

In the "Other" category for community and environmental health concerns, the following were listed: a very vocal minority, with a silent majority, who promote misinformation, divisiveness, and general ignorance, chemical dependency, underage drinking, drug abuse/treatment, high price of goods and food, insufficient mental healthcare, outsiders do not feel welcome, and people in power take care of themselves.

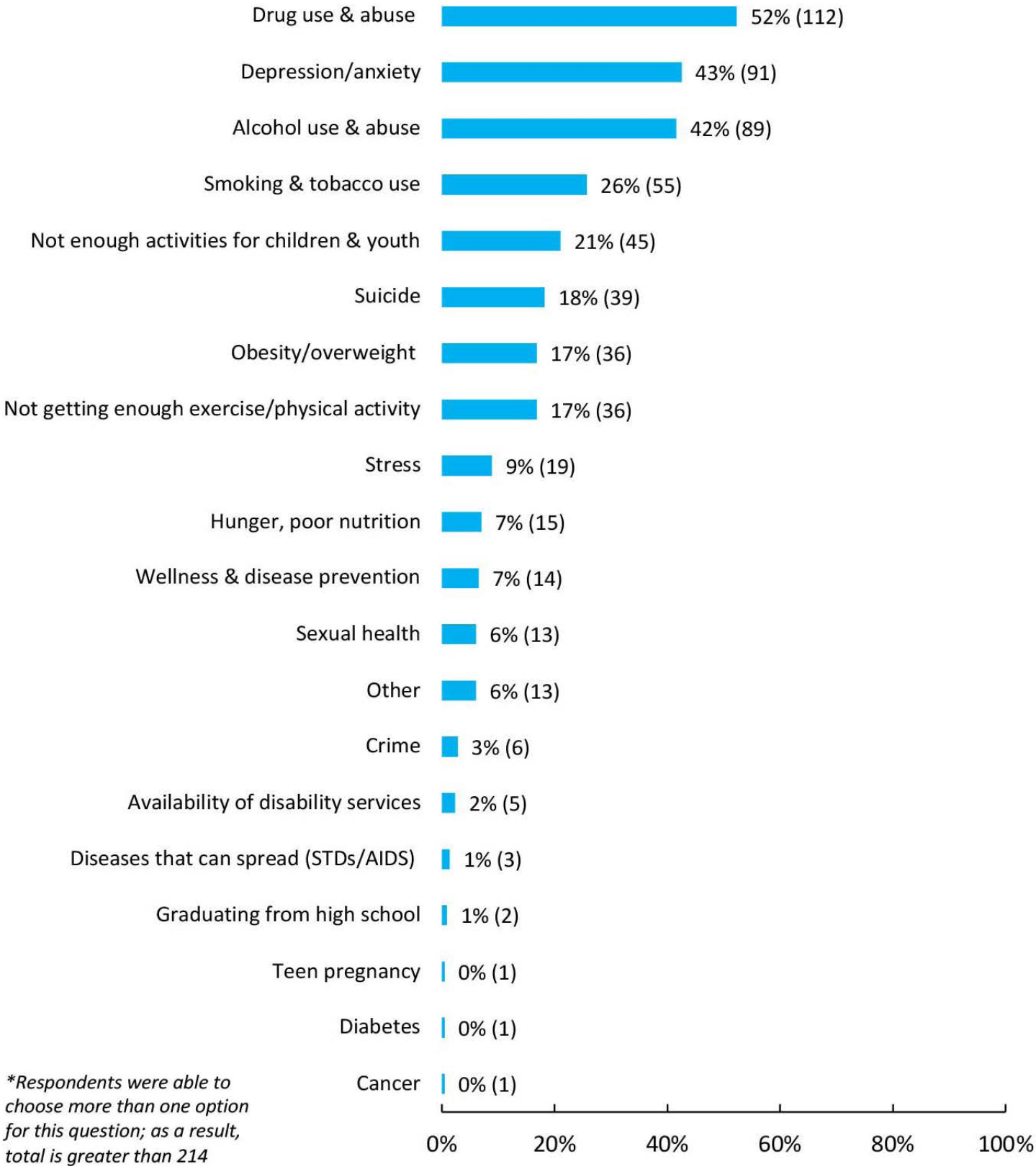
Figure 18: Availability/Delivery of Health Services Concerns
Total respondents = 217*



**Respondents were able to choose more than one option for this question; as a result, total is greater than 217*

Respondents who selected "Other" identified concerns as: having to drive 30+ miles for healthcare, lack of male primary care providers, lack of maternity services, lack of professionalism, quality of emergency room personnel, and too much paperwork for Medicaid people.

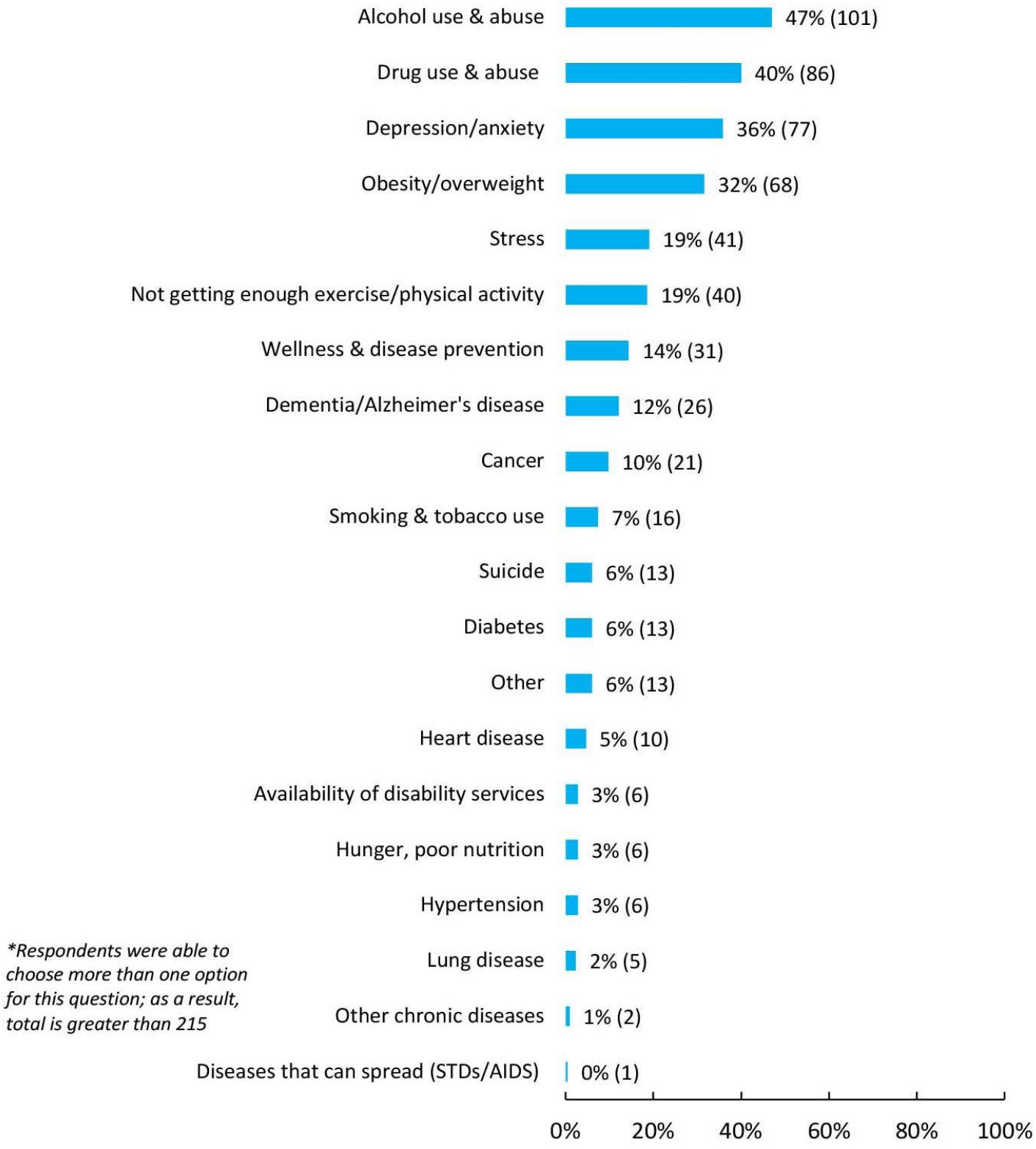
Figure 19: Youth Population Health Concerns
Total respondents = 214*



**Respondents were able to choose more than one option for this question; as a result, total is greater than 214*

Listed in the "Other" category for youth population concerns were bullying, counselors for schools, exposure to trauma, not enough activities that are not all about sports, too much device addiction, very little support for LGBTQ+ students, camps for elementary and middle school children but no summer "day care" while parents work, and the Valley City Park summer rec meets too often for young children and has different age rules than the school.

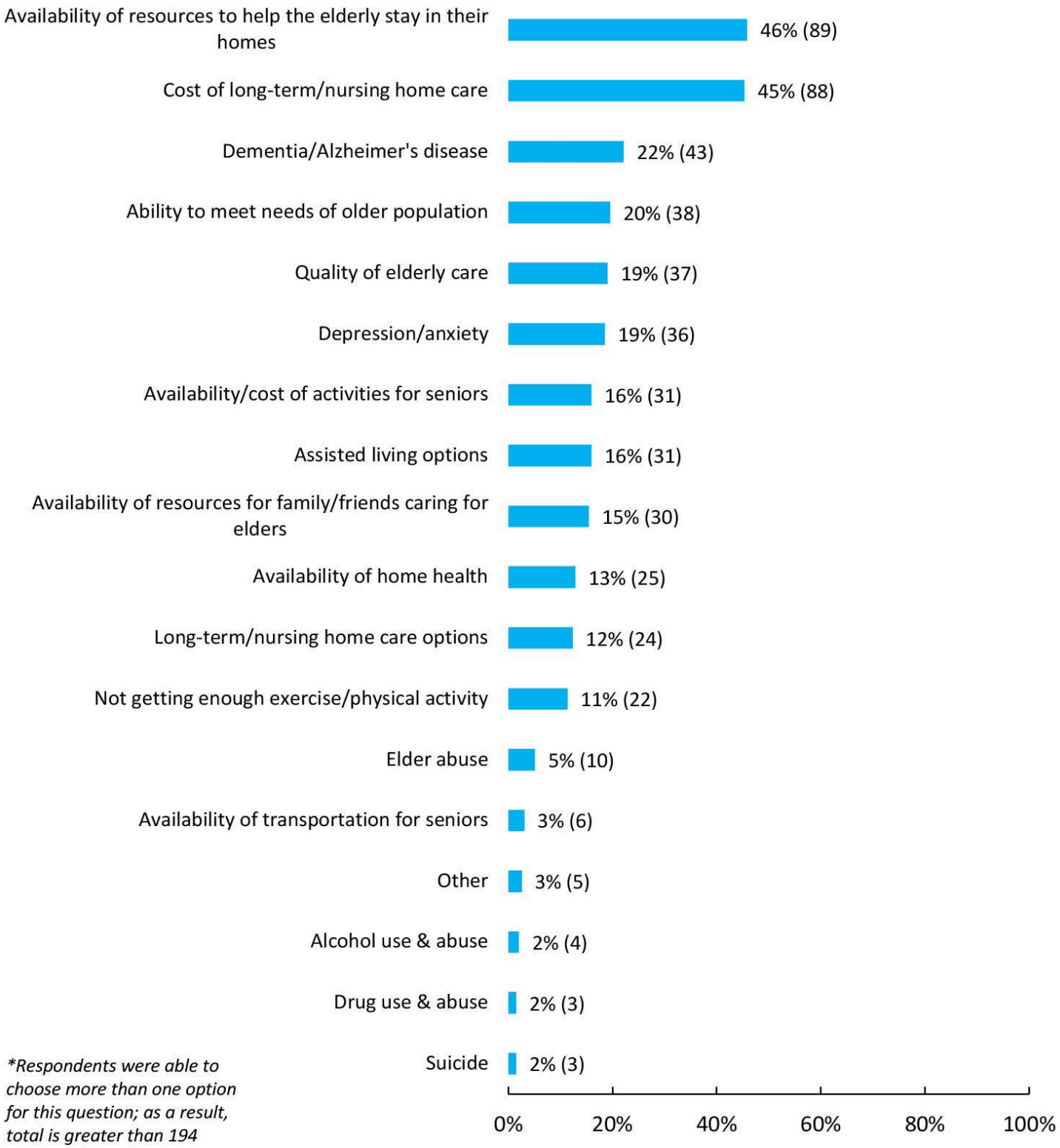
Figure 20: Adult Population Concerns
Total respondents = 215*



**Respondents were able to choose more than one option for this question; as a result, total is greater than 215*

Lack of mental health services, too long of mental health wait times, racism, homophobia, etc., parenting resources, domestic violence, and lack of people receiving the COVID vaccine were indicated in the "Other" category for adult population concerns.

Figure 21: Senior Population Concerns
Total respondents = 194*



**Respondents were able to choose more than one option for this question; as a result, total is greater than 194*

In the "Other" category, concerns included finding and keeping quality caregivers, need for adult daycare services, overall cost of care, racism, homophobia, etc., and the question of what do elders do who don't have willing family?

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

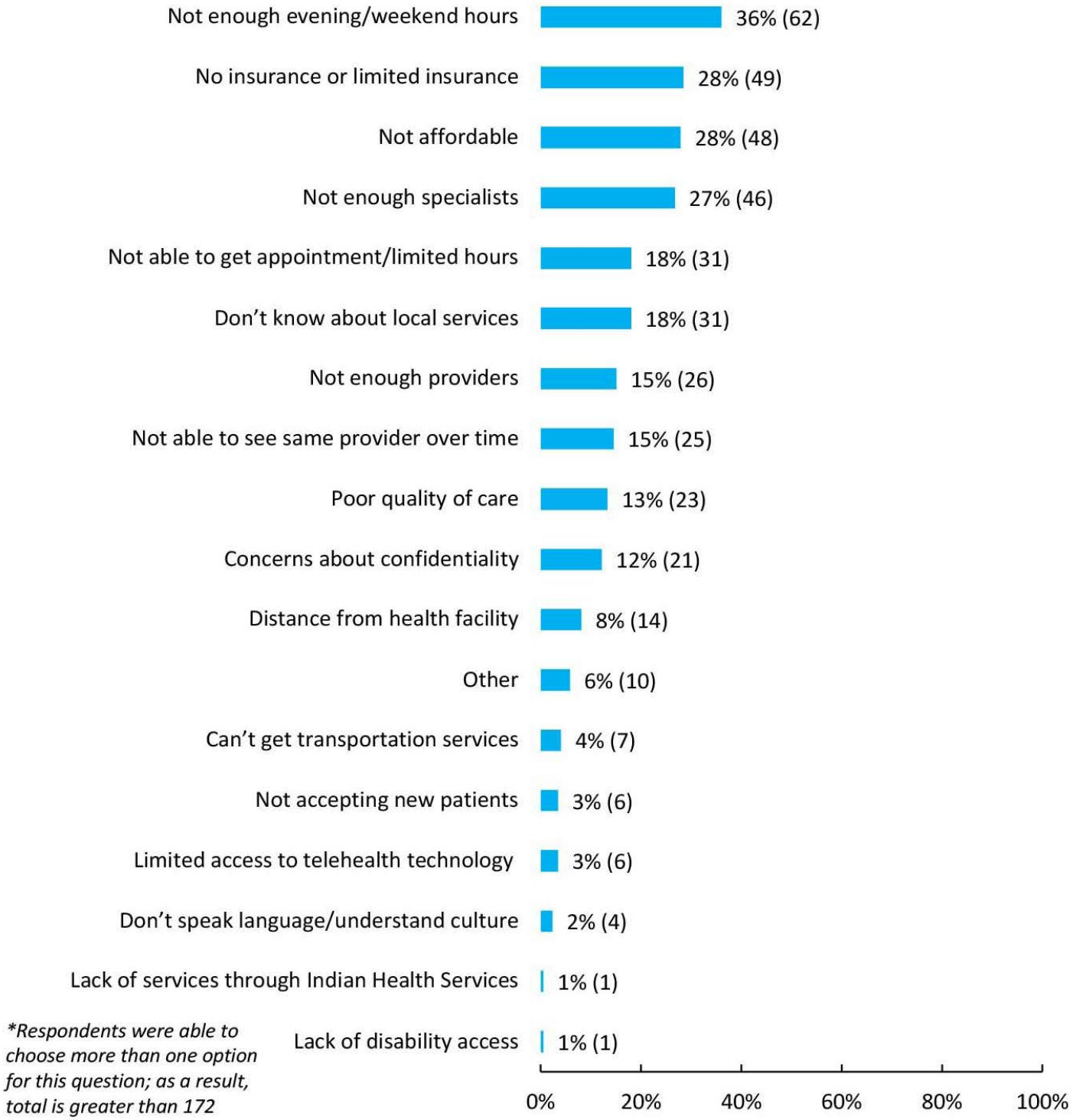
1. Community is divided/not welcoming
2. Cost of living
3. Drug/alcohol abuse
4. Improving community infrastructure
5. Maintaining/growing the population
6. Need for mental/behavioral health services
7. Need more business and community activities.

Delivery of Healthcare

The survey asked residents what they see as barriers that prevent them, or other community residents, from receiving healthcare. The most prevalent barrier, perceived by residents, was not enough evening/weekend hours (N=62), with the next being no insurance or limited insurance (N=49). After these items, the next most commonly identified barriers were healthcare not being affordable (N=48), not enough specialist (N=46), and not able to get appointment/limited hours and not knowing about local services, having the same number of responses (N=31). The majority of concerns indicated in the "Other" category were in regards their primary care doctor not being available for appointments, lacking transportation, or having to rely on public transportation to get to appointments. Lack of confidentially and professionalism was also mentioned.

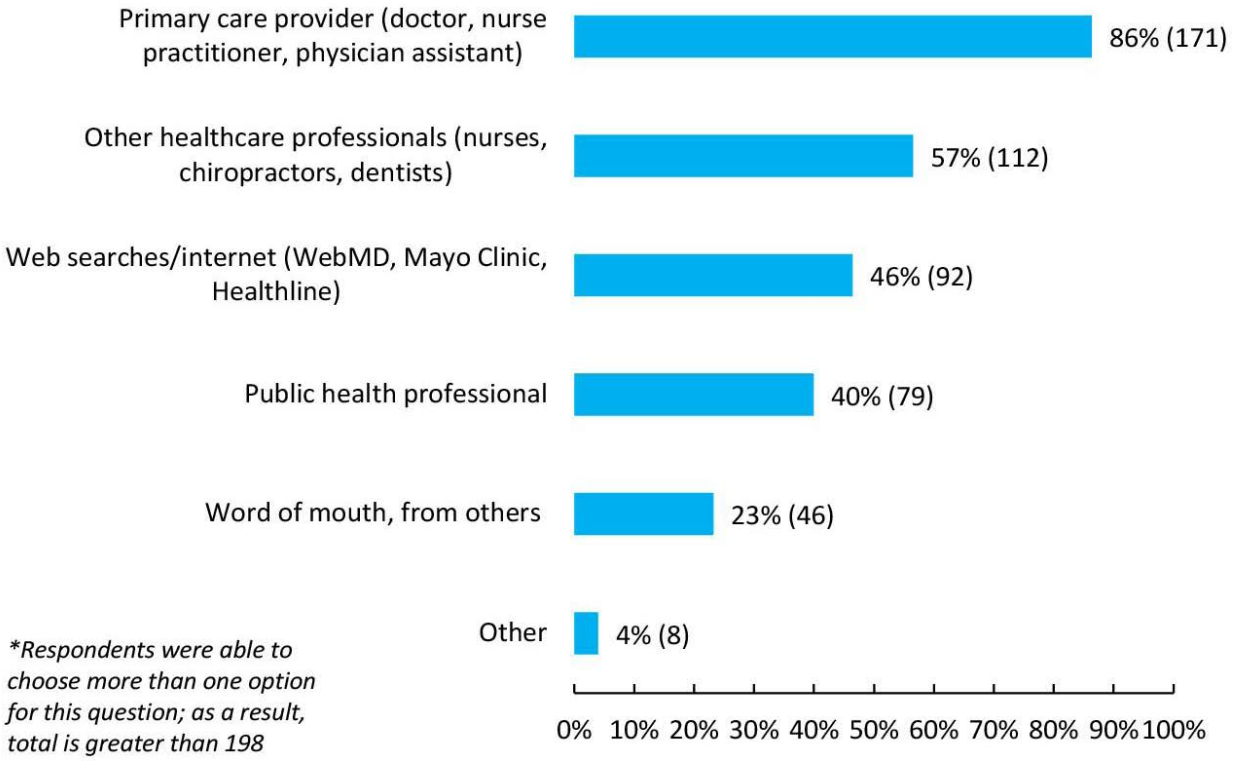
Figure 22 illustrates these results.

Figure 22: Perceptions about Barriers to Care
Total respondents = 172*



**Respondents were able to choose more than one option for this question; as a result, total is greater than 172*

Figure 23: Sources of Trusted Health Information
Total respondents = 198*



**Respondents were able to choose more than one option for this question; as a result, total is greater than 198*

In the "Other" category, family members and the Veterans Administration (VA) were listed.

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

- Affordable dental care and dental insurance
- Cancer treatments, cancer specialty providers
- Cardiology services
- Cataract surgery
- Dermatology
- Dialysis
- Elderly home health
- Greater variety of surgeons
- Increased staff for South Central Human Services
- Mental health professionals
- More extensive pain clinic
- Nutrition services
- Obstetrics and gynecology
- Orthopedic services
- Vaccinations
- Vision services
- Walk in clinic
- Weight loss/wellness coach

While not a service, many respondents indicated that they would like to see an increase in male providers added. One person indicated medical marijuana should be available, and another stated that prescription medications should be made more affordable.

CHI Mercy Health chose to include several elected survey questions, specific to their community. These are shown in Figures 24-34.

Figure 24: Preventative Procedures Received in Past 12 Months
Total respondents = 196*

Respondents were asked to choose which preventative procedures they have had in the past 12 months. The answers are as follows:

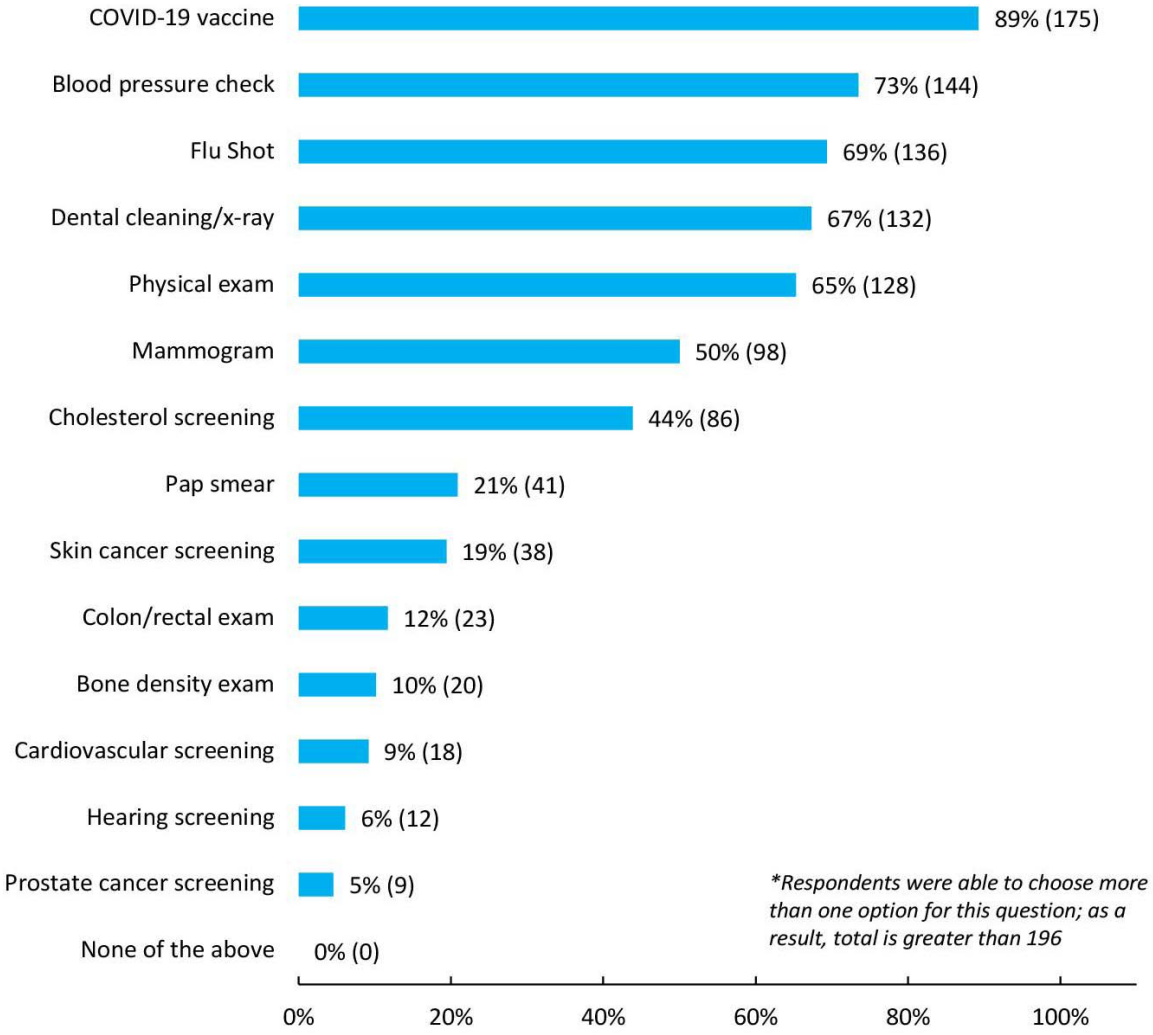


Figure 25: Safety in the Community Concerns
Total respondents = 147*

Considering the safety in their community, survey participants were asked to select up to three concerns. Below are the responses.

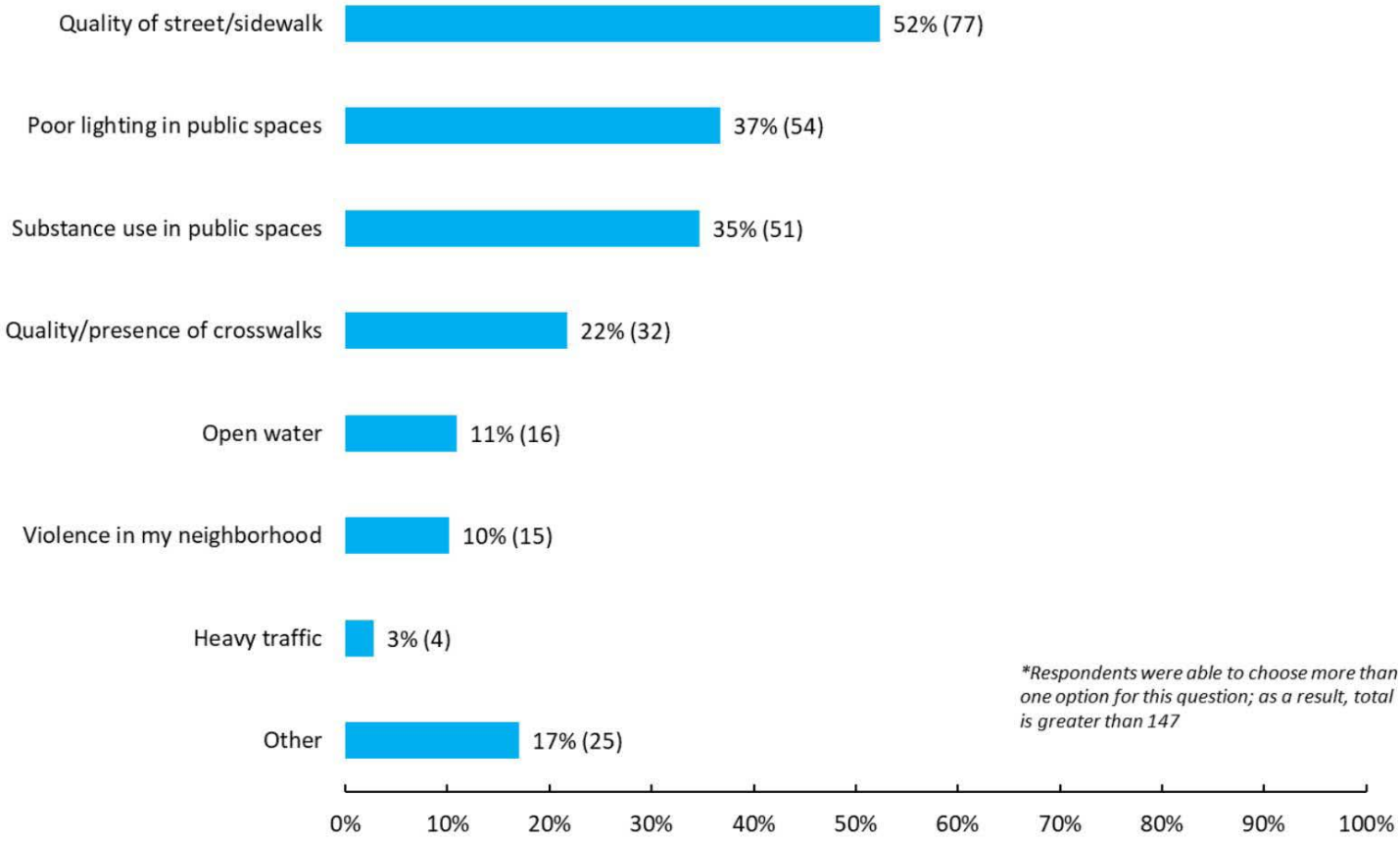
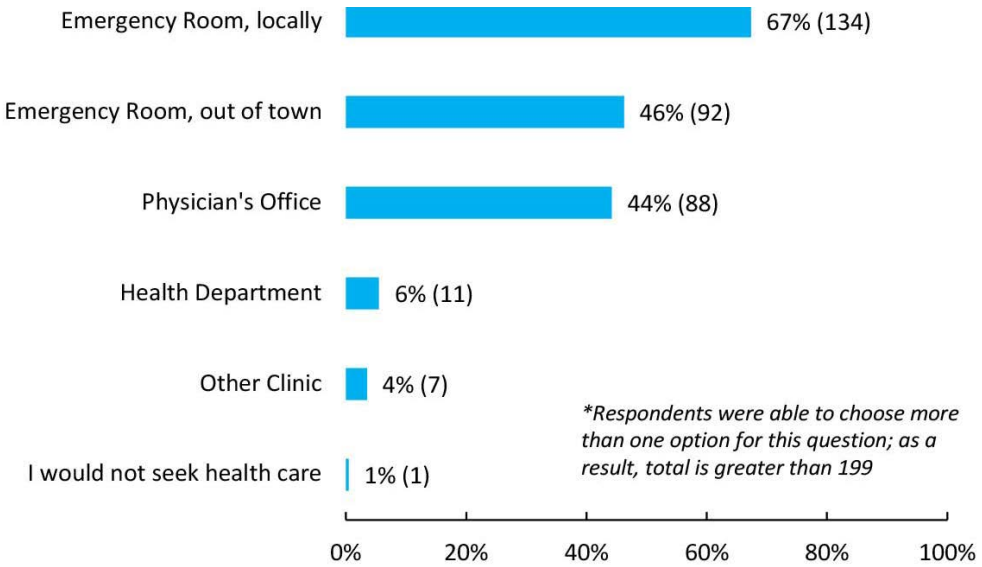


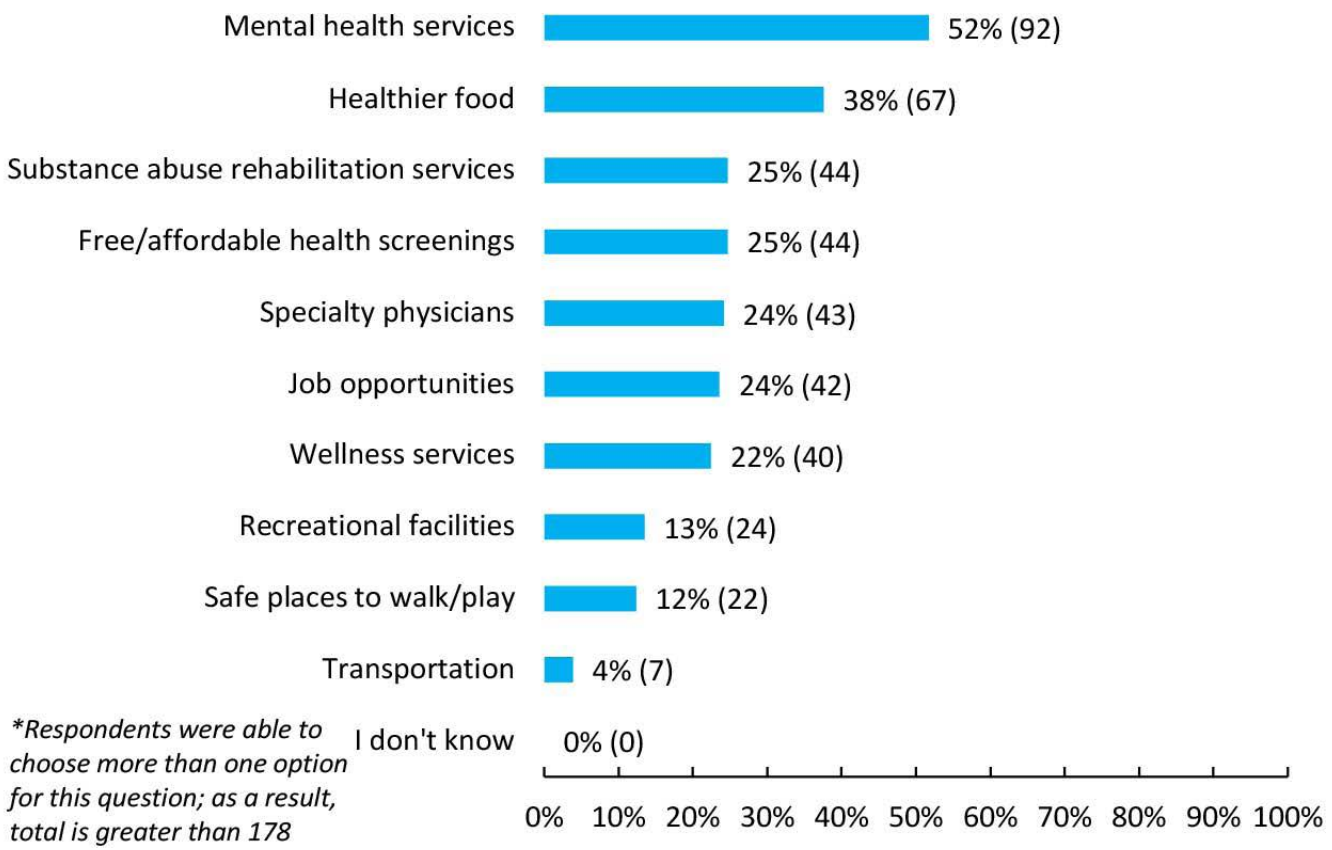
Figure 26: Where Emergency Care Would be Sought
Total respondents = 199*

Survey participants were asked where they would go for emergency medical services if they were able to take themselves. Below are the responses.



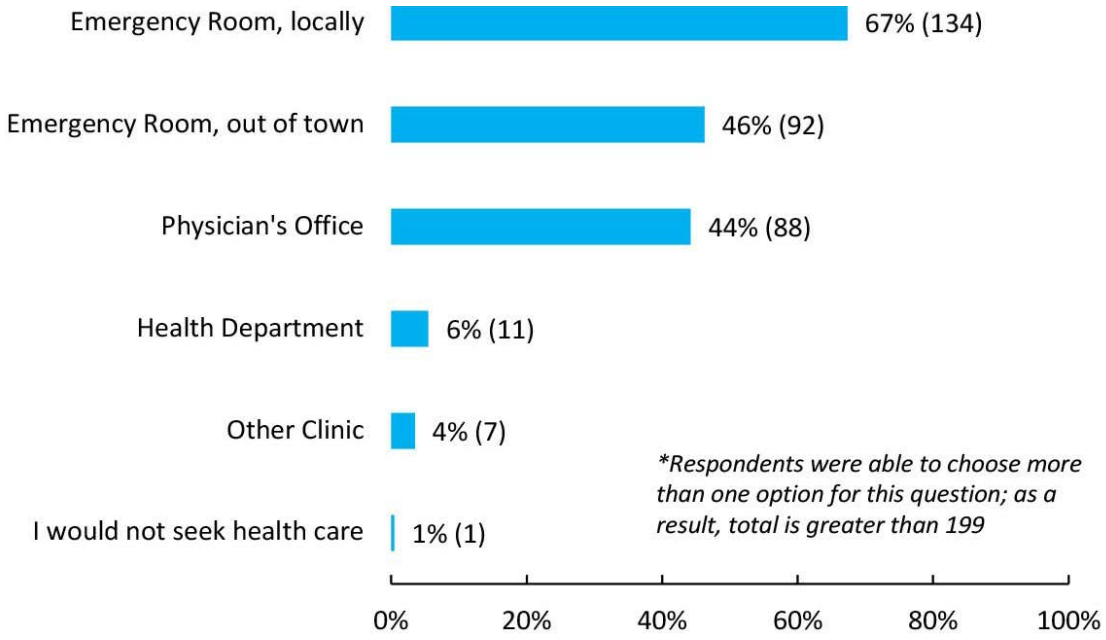
Community members were asked what they think is needed to improve the health of their family and neighbors. Participants were given a list of choices and were asked to choose three that they feel would be most beneficial. (Figure 27)

Figure 27: Ways to Improve Health of Family and Neighbors
Total respondents = 178*



Respondents were asked to choose from a list, which top three health challenges they currently face. Joint or back pain as well as overweigh/obesity tied for the highest response (N=86); these items were followed by other mental health issues (N=46), and then high blood pressure (N=41). (Figure 28).

Figure 28: Top Health Challenges of Respondents
Total respondents = 198*

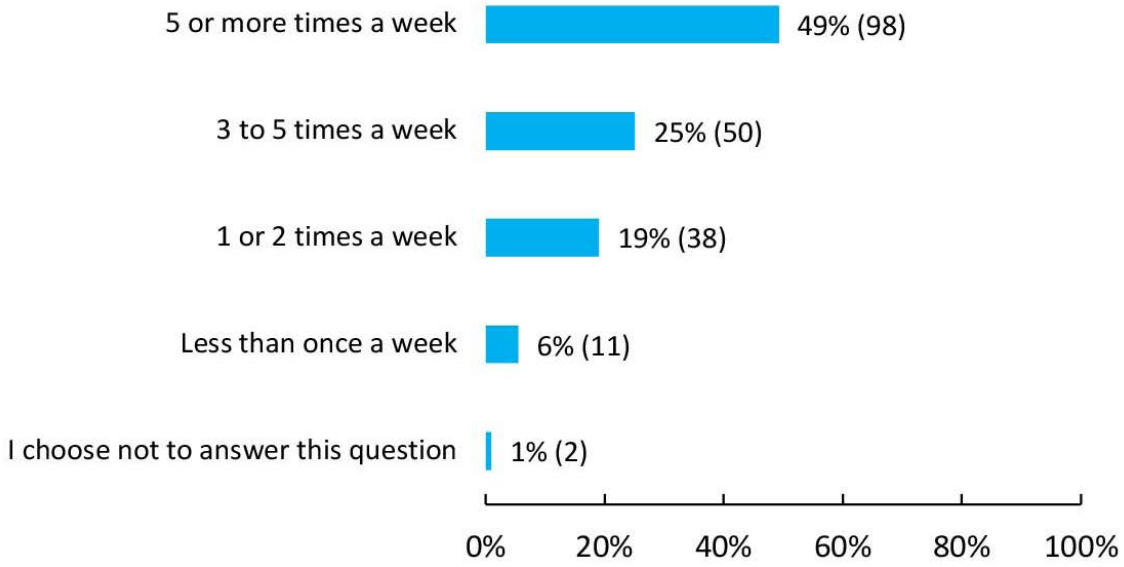


"Other" responses included fibromyalgia, high cholesterol, eating disorder, anxiety/stress, kidney disease, macular degeneration, and potential Alzheimer's issues.

Respondents were asked how often they visit with friends and family. Five or more times a week received the highest response (N=98), followed by three to five times a week (N=50), and then one or two times a week (N=38).

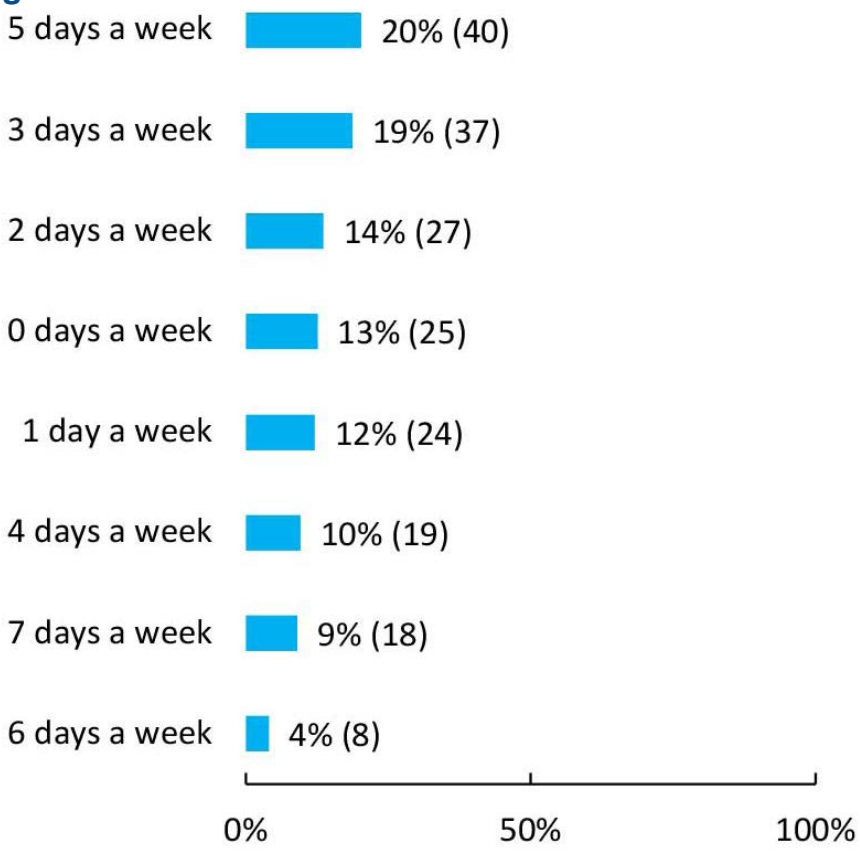
Results are shown in Figure 29.

Figure 29: Frequency of Talking to Close Friends/Family
Total responses = 199



Survey participants were asked to share how often they engage in moderate or vigorous exercise during the week. (Figure 30)

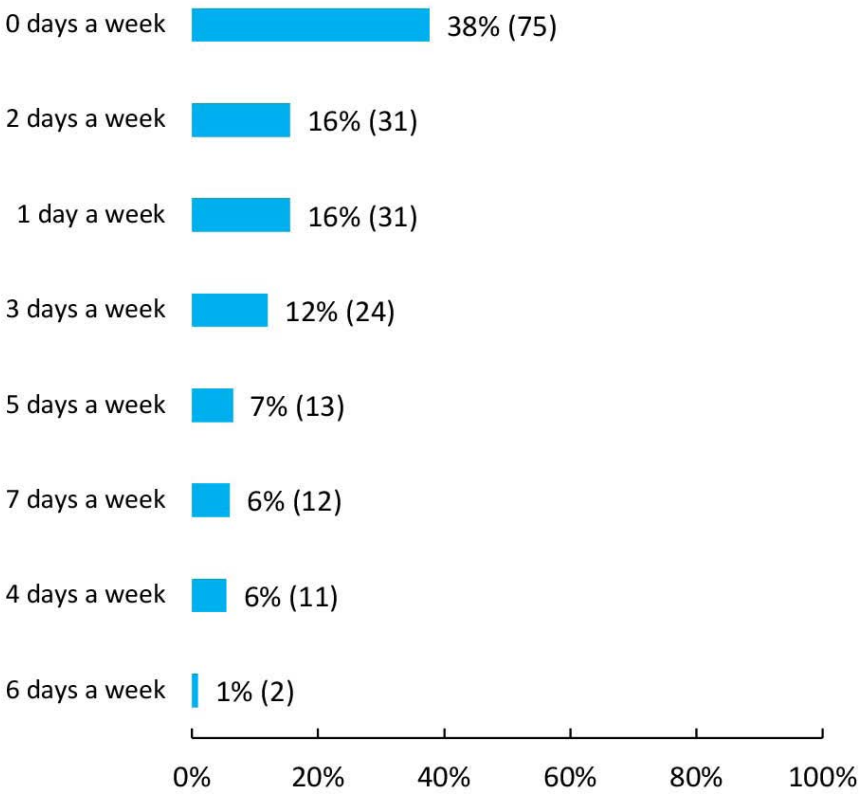
Figure 30: Average Days per Week Doing Moderate or Vigorous Intensity Exercise
Total responses = 198



Additionally, respondents were asked to share how many days a week they do strength exercise.

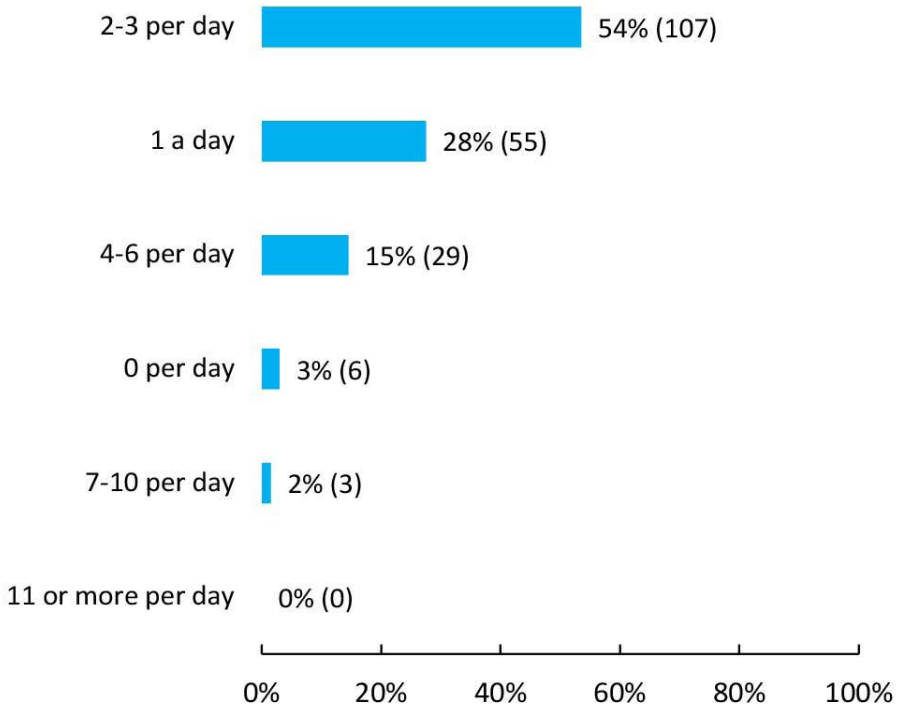
Results are shown in Figure 31.

Figure 31: Average Days per Week of Doing Strength Exercise
Total responses = 199



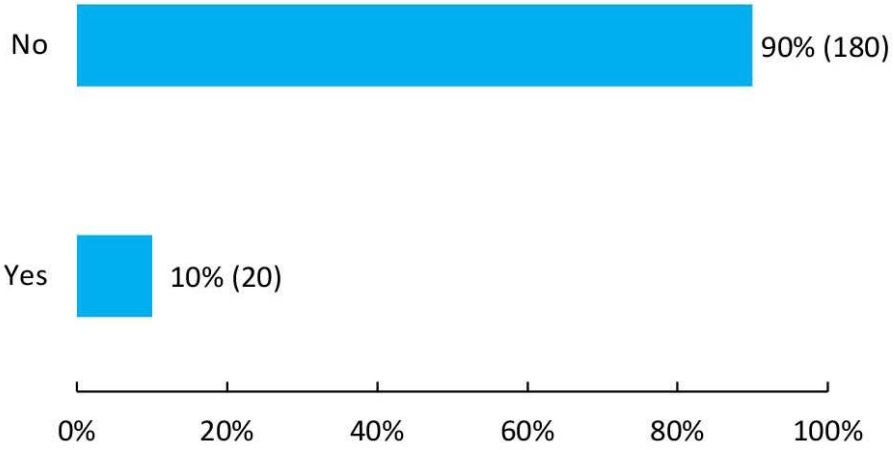
Survey participants were asked to share how many servings of fruits and vegetables they average per day. (Figure 32)

Figure 32: Average Number of Servings of Fruits and Vegetables per Day
Total responses = 200



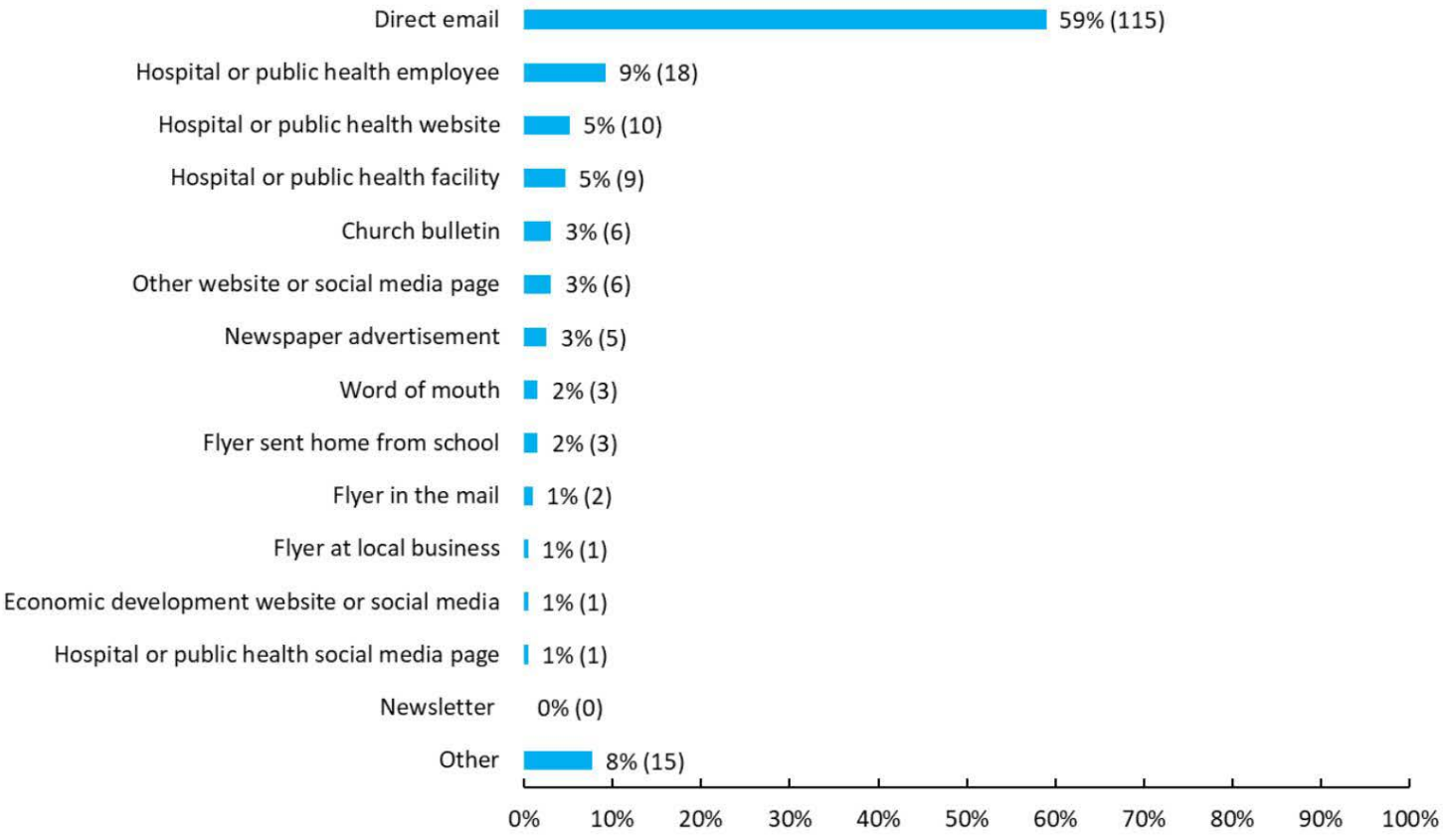
Survey participants were asked to share if they have ever experienced food insecurity on a regular basis for a period of time, lasting more than a month. (Figure 33)

Figure 33: Experienced Food Insecurity
Total responses = 200



In an effort to gauge marketing effectiveness of sharing the survey link and paper copies, participants were asked how they acquired the survey. (Figure 34)

Figure 34: Survey Source
Total responses = 195



Other responses included a forwarded email, the high school, a vaccination clinic, a person's workplace, coffee shop, and Chamber email.

The final question on the survey asked respondents to share concerns and suggestions to improve the delivery of local healthcare. The overarching themes focused on affordable healthcare services, better access to healthcare, improving community activities and resources, mental/behavioral health services, and more healthcare services in general.

Regarding affordable healthcare services, dental health services were specifically mentioned as needing to be better and less expensive. The cost of medication prescriptions prohibits some from finding a pharmacy that will fill their prescription while others work numerous jobs in order to have health insurance and enough money to cover out-of-pocket expenses.

Better access to healthcare highlighted respondents' desires for a clinic with afterhours availability; the long travel distance for basic care or specialists; lack of healthcare options for those who do not have insurance; an improved emergency room experience; confidentiality; and more male providers. One respondent commented on how the good local healthcare could only get better with more state and federal aid.

School age children on their own in the summer while parents work was a concern in the areas of improved community activities and resources. Other concerns in this area included elderly alone in their homes who mainly only had working children to assist/visit them; improved law enforcement and city focus on crime, poverty, mental health, drug and domestic abuse; healthcare collaboration; sidewalks and bike paths for safety; and a new hospital.

More counseling time in the schools was recommended as a good investment for mental/behavioral health services. Others highlighted the overall lack of sufficient mental health care in the community. There are few providers for this service, and it takes months to see one. Substance abuse was also cited as a concern with the community not having places for those in need to go.

Lastly, the area of more healthcare services, in general, highlighted the need for services for those with young dementia and their families; services for the elderly to stay in their homes; and more primary care MDs. Some respondents stated they were very pleased with their healthcare, and people know what they're doing and truly care.

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):

- Alcohol use and abuse
- Availability of mental health services
- Availability of resources to help the elderly stay in their homes
- Depression/anxiety
- Drug use and abuse

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

Alcohol use and abuse

- It hasn't changed
- It hasn't gotten any better in many years

Availability of mental health services

- Still need more

Availability of resources to help the elderly stay in their homes

- There's a lack of workers to do this.
- There should be a consolidated area counselor to know all the resources and help make it possible for them to stay in their home. Quality of life could improve greatly if they had someone they could call to rely on for support and navigating life. There is no dependent care. We are not prioritizing the resources for the older generation. We often rally around young families and forget about the elderly. By that time, they don't have a voice for themselves.

Depression/anxiety

- This goes along with stress and other things like alcohol use and abuse
- Depression and anxiety can lead to suicide

Drug use and abuse (including prescription drug abuse)

- It hasn't changed
- It hasn't gotten any better in many years
- These are unhealthy coping mechanisms and lack of resources even for those who seek help

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 couple of services where they felt the hospital should increase marketing efforts; these included respite care and sleep services. It was suggested that the public health department increase marketing around the syringe services and harm reduction program, medication assisted therapy, and peer support services.

Community Engagement and Collaboration

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

- Public health (4.8)
- Schools (4.6)

- Law enforcement (4.5)
- Hospital (healthcare system) (4.4)
- Emergency services, including ambulance and fire (4.4)
- Economic development organizations (4.3)
- Faith-based (4.1)
- Business and industry (3.8)
- Human/Social services (3.8)
- Clinics not affiliated with the main health system (3.6)
- Long-term care, including nursing homes and assisted living (3.3)
- Pharmacies (3.1)
- Other local health providers, such as dentists and chiropractors (3.1)

Priority of Health Needs

A community group met virtually on September 29, 2021. Eleven 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 in an online survey where each member was asked to select the four needs they considered the most significant.

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

- Availability of mental health services (6 votes)
- Not enough jobs with livable wages (5 votes)
- Drug use and abuse - youth (4 votes)
- Depression/anxiety - youth (4 votes)

From those top four priorities, each person then voted in a second online survey on the item they felt was the most important. One person chose to abstain from voting in the second survey. The rankings were:

1. Availability of mental health services (4 votes)
2. Not enough jobs with livable wages (2 votes)
3. Drug use and abuse - youth (2 votes)
4. Depression/anxiety - youth (2 votes)

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

Comparison of Needs Identified Previously

The current process did not identify any identical common needs from 2019; however, depression/anxiety and drug use and abuse, specifically in the youth population emerged in 2021, compared to substance use, abuse, depression, and anxiety in general.

Top Needs Identified 2019 CHNA Process	Top Needs Identified 2021 CHNA Process
Substance use and abuse (alcohol and drugs)	Availability of mental health services
Attracting and retaining young families	Not enough jobs with livable wages
Availability of substance abuse/ treatment services	Drug use and abuse - youth
Depression and anxiety	Depression/anxiety - youth

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

Upon adoption of this CHNA Report by the CHI Mercy Health Valley City Board vote, a notation will be documented in the board minutes reflecting the approval and then the report will be widely available to the public on the hospital's website and a paper copy will be available for inspection upon request at the hospital. Written comments on this report can be submitted to CHI Mercy Health Valley City Medical Center Mission Director at 570 Chautauqua Boulevard, Valley City, North Dakota 58072.

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

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

Need 1: Substance use and abuse (alcohol and other drugs) – Barnes County Behavioral Health Coalition, hosted by CHI Mercy Health with partnership from City County Public Health, consists of a varied group of leaders in Barnes County. These leaders include CHI Mercy Health, City-County Home Health, Economic Development, local and state representatives, state agencies, schools, business owners, law enforcement, Social Services, States Attorney, District 24 Representatives, physicians, clinics, SCHSC, and local behavioral health providers. The coalition meet quarterly and is open to all who wish to attend. The coalition works on the goals, captured from the CHNA, Opioid Grant, alcohol prevention group, and services and supports needed for our community members. Core coalition members were meeting monthly before pandemic to complete the "work" (Mission Director, Teresa Will, Katie from CCHD, Naomi Koch, Chelsea Modlin from SCHSC).

City-County Health District secured essential grant funds (prevention, treatment/recovery) to address persistent issues with substance use in Barnes County.

The National Leadership Academy for the Public's Health Project was applied for through the Centers for Disease Control national leadership development program to develop teams of people with a public health project, and Valley City was one of ten teams selected nationwide

The program, Bridges to Community, has the following members: Theresa Will, CCHH; Chelsea Modlin, SCHSC; Alicia Hoffarth, BCDC; and Naomi Koch, CHI. The group is completing a yearlong leadership development program, working on a project to reduce recidivism for justice-involved people and planning for a sober living house in Valley City.

The project captures accurate data to measure the challenges, faced by justice-involved people and partner with local law enforcement and jail staff to explore services and supports to assist justice-involved individuals, so they have the skills and supports needed to be successful and reduce recidivism.

The following challenges have been identified:

- Lack of addiction services and mental health services
- Lack of access to Medication Assisted Treatment services – Starting soon at Federally Qualified Health Clinic at CCHH
- Transportation challenges
- Lack of sober living housing for people exiting prison or jail
- Reduce biases impacting our community to increase the support for people re-entering the community
- Explore case management services for people who are justice-involved to ensure they have adequate resources for employment, housing, health care, MAT, behavioral health
- Explore providing education to people while incarcerated

Need 2: Attracting and retaining young families – City-County Health District supported Valley City Barnes County Development Corporation and Sheyenne Valley Community Foundation in efforts to assess and improve Valley/City Barnes County and the opportunities to live and grow locally. The Development Corporation and Chamber of Commerce have worked on affordable housing and employment opportunities. Daycare openings and options have increased in the community.

Need 3: Availability of substance abuse/treatment services – City-County Health District collaborated with South Central Human Service Center (SCHSC) and Family HealthCare to support availability of Medication Assisted Therapy (MAT) in Valley City.

The Barnes County Opioid Advisory Group work through City-County Public Health works to offer:

- Mental Health First Aid classes
- Syringe services program in Barnes County
- The ROPES Project - stigma free health services
    - » Medication Assisted Therapy
    - » Narcan and training
    - » Peer Support services in the community
    - » Prescription drug take back program

Need 4: Depression and anxiety – City-County Health District collaborated with South Central Human Service Center (SCHSC) and Family HealthCare to offer local support for depression and anxiety, both in-person and via telehealth.

The above implementation plan for CHI Mercy Health is posted on their website at Community Benefits - CHI Mercy Health (mercyhospitalvalleycity.org) .

Next Steps – Strategic Implementation Plan

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

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

Community Benefit Report

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

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

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

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

What Are Community Benefits?

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

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

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

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

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

Appendix A – Critical Access Hospital Profile

Spotlight on: Valley City, North Dakota

CHI Mercy Hospital

Quick Facts

Administrator:
Rebecca Thompson, Interim CEO

Chief of Medical Staff:
Misty Anderson, MD

Board Chair: Casey Stoudt

City Population:
6,460 (2019 Estimate)[1]

County Population:
10,415 (2019 Estimate)[1]

County Median Household Income:
$58,365 (2019 Estimate)[1]

County Median Age:
45.1 (2019 Estimate)[1]

Service Area Population:
15,000 (25 mile radius)

Owned by: Catholic Health Initiatives (Nonprofit)

Hospital Beds: 25

Trauma Level: IV

Critical Access Hospital Designation: 2002

Economic Impact on the County

Employment Impact:
Primary – 78
Secondary – 37
Total – 115

Financial Impact:
Primary – $4.75 Million
Total – $5.8 Million

Mission:

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

A healthier future for all – Inspired by faith, driven by innovation, and powered by our humanity.

Core Values:

Inclusion, Collaboration, Integrity, Compassion, Excellence.

County: Barnes
Address: 570 Chautauqua Blvd
Valley City, ND 58072
Phone: (701) 845-6400
Fax: (701) 845-6413
Web: www.mercyhospitalvalleycity.org

CHI Mercy Hospital is a 25-bed Critical Access Hospital. Services include medical, surgical (both inpatient and outpatient), swingbed, physical therapy, occupational therapy, cardiac rehab, home health, respiratory care, laboratory, ambulatory care, emergency department, and a radiology department which features a CT unit and the services of a mobile MRI. Other services available at CHI Mercy Hospital include outpatient clinics in podiatry and orthopedics through cooperating providers.

Services:

CHI Mercy Hospital provides the following services directly through the hospital:

- Acute Care
- Cardiac Rehab
- Cataract Surgery
- CT Scanning Education
- Emergency Room
- Faith in Action
- General Surgery
- Home Health
- Lab
- Occupational Therapy
- Radiology
- Respiratory Therapy
- Respite Care
- Same Day Surgery
- Sleep Studies
- Social Services
- Special Care Services
- Spiritual Services
- Sports Medicine
- Stress Testing
- Swing Bed Program

Other Services

- Hospice Services
- Mammography

Staffing

PAs: 0
RNs: 30
LPNs: 2
Total Employees: 94

Local Sponsors and Grant Funding Sources

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

Sources

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

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

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

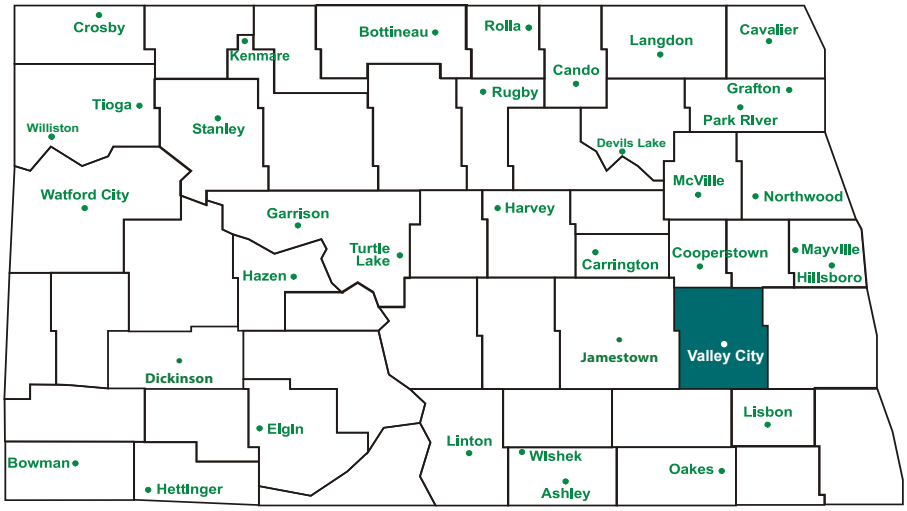
This project is supported by the Medicare Rural Hospital Flexibility Grant Programs and the State Office of Rural Health Grant Program at the Center for Rural Health, University of North Dakota School of Medicine & Health Sciences located in Grand Forks, North Dakota.

ruralhealth.und.edu

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

- MRI
- Nuclear Medicine
- Speech Therapy

North Dakota Critical Access Hospitals



History:

In 1926, a local Catholic priest, at the encouragement of community representatives, invited the Sisters of Mercy to come to Valley City and build and staff a hospital. After much prayer and planning, the Sisters of Mercy sent five Sisters to Valley City and the construction began on the hospital and on a nursing school for student nurses. The Sisters of Mercy and the community of Valley City took a leap of faith to establish a 5-story Spanish-style institution, which at that time was state-of-the-art. On May 15, 1928, Mercy Hospital first opened its doors to the public.

In 1952, the current 5-story north wing of the hospital was added to the building and in 1974 the original building was replaced with a 3-story addition to the 1952 wing.

In 1980, the Sisters of Mercy turned the management of Mercy Hospital over to the newly formed Catholic Health Corporation (CHC) headquartered in Omaha, NE. CHC managed the hospital until 1995, when the Sisters of Mercy signed a letter of intent to consolidate and be one of the founding members of Catholic Health Initiatives (CHI). Catholic Health Initiatives is now one of the largest Catholic health systems in the United States, and is continuing the tradition of the Sisters of Mercy through its core values.

Recreation:

Valley City is in southeastern North Dakota and is primarily dependent on agriculture and agri-business. The school system includes both public and parochial schools as well as a specialized curriculum for educable mentally handicapped children. Approximately 1,100 students attend Valley City State University, a state-funded liberal arts college. Excellent recreational opportunities include camping, picnicking, hiking, fishing, hunting, ice fishing, snowmobiling and cross country skiing. Valley City is just an hour away from Fargo, North Dakota's largest city.

Updated 05/2021

Appendix B – Economic Impact Analysis

December 2020

CHI Mercy Health Valley City

CHI Health at Home℠

Imagine better health.℠

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

Economic Impact

CHI Mercy Health Valley City is a Critical Access Hospital (CAH) located in Barnes County, North Dakota.

CHI Mercy Health Valley City **directly** employs **78 FTE employees** with an annual payroll of over **$4.75 million** (including benefits).

- After application of the employment multiplier of 1.48, these employees created an additional **37** jobs.
- The same methodology is applied to derive the income impact. The income multiplier of 1.22 is applied to create over **$1 million** in income as they interact with other sectors of the local economy.
- **Total impacts = 115 jobs and more than $5.8 million in income**.

Healthcare and Your Local Economy

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

Key contributions of the health system include

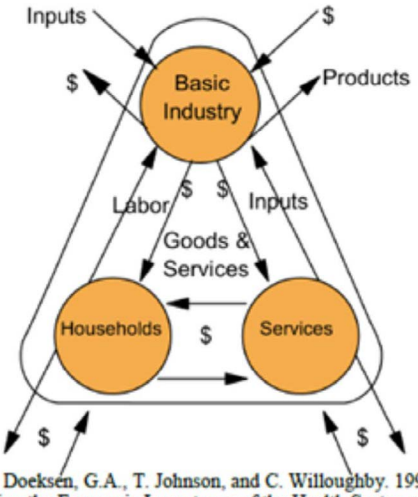
- Attracts retirees and families
- Appeals to businesses looking to establish and/or relocate
- High quality healthcare services and infrastructure foster community development
- Positive impact on retail sales of local economy
- Provides higher-skilled and higher-wage employment
- Increases the local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

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

Fact Sheet Author: Kylie Nissen, BBA

For additional information, please contact:
Kylie Nissen, Program Director, Center for Rural Health
kylie.nissen@und.edu • (701) 777-5380

Figure 1. An overview of the community economic system.



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

CENTER FOR RURAL HEALTH
OSU Center for Health Sciences

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

This project is/was supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) through the Medicare Rural Hospital Flexibility Grant Program and the State Office of Rural Health Grant.

Appendix C – CHNA Survey Instrument

Valley City Area Health Survey

CHI Mercy Hospital and City-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/ValleyCityCHNA21
or by scanning on the QR Code at the right.

Scan here to take the survey online!

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 August 10, 2021. Your opinion matters – thank you in advance!

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

10. Considering the **SAFETY** in your community, concerns are (choose up to THREE):

- ☐ Poor lighting in public spaces
- ☐ Open water
- ☐ Heavy traffic
- ☐ Quality of street/sidewalk
- ☐ Violence in my neighborhood
- ☐ Substance use in public spaces
- ☐ Quality/presence of crosswalks
- ☐ Other

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

_____

_____

Delivery of Healthcare

12. What **PREVENTS** you or 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): _____

13. 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): _____

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

_____

_____

15. Which of the following preventative procedures have you had in the past 12 months? (Choose ALL that apply)

- ☐ Mammogram
- ☐ Pap Smear
- ☐ Prostate cancer screening
- ☐ Flu shot
- ☐ Colon/rectal exam
- ☐ Blood pressure check
- ☐ Skin cancer screening
- ☐ Cholesterol screening
- ☐ Hearing screening
- ☐ Cardiovascular screening
- ☐ Dental cleaning/xray
- ☐ Bone density exam
- ☐ Physical exam
- ☐ COVID-19 vaccine
- ☐ None of the above

16. Where would you go for emergency medical services if you were able to take yourself? (Choose ALL that apply)

- ☐ Emergency Room, locally
- ☐ Emergency Room, out of town
- ☐ Physician's Office
- ☐ Health Department
- ☐ Other Clinic
- ☐ I would not seek health care

17. What is needed to improve the health of your family and neighbors? (Choose up to THREE):

- ☐ Healthier food
- ☐ Job opportunities
- ☐ Mental health services
- ☐ Recreational facilities
- ☐ Transportation
- ☐ Wellness services
- ☐ Specialty physicians
- ☐ Free or affordable health screenings
- ☐ Safe places to walk/play
- ☐ Substance abuse rehabilitation services
- ☐ I don't know

18. Please select the top three health challenges you face:

- ☐ Cancer
- ☐ Diabetes
- ☐ Overweight/obesity
- ☐ Lung disease
- ☐ High blood pressure
- ☐ Stroke
- ☐ Heart disease
- ☐ Joint pain or back pain
- ☐ Mental health issues
- ☐ Alcohol overuse
- ☐ Drug addiction
- ☐ I don't have any health challenges
- ☐ Other (please specify): _____

19. How often do you see or talk to people that you care about and feel close to? (For example: talking to friends on the phone, visiting friends or family, going to church or club meetings)

- ☐ Less than once a week
- ☐ 1 or 2 times a week
- ☐ 3 to 5 times a week
- ☐ 5 or more times a week
- ☐ I choose not to answer this question

20. How many days per week do you get a minimum of 30 minutes of moderate intensity exercise (aerobic walking, biking, etc.) or 15 minutes of vigorous intensity exercise (breathe hard and sweat)?:

- ☐ 0 days
- ☐ 1 day
- ☐ 2 days
- ☐ 3 days
- ☐ 4 days
- ☐ 5 days
- ☐ 6 days
- ☐ 7 days

21. On average, how many times per week do you do physical activities or exercises to strengthen your muscles (i.e. yoga, sit-ups, push-ups, weight machines, free weights, etc.)?

- ☐ 0 days
- ☐ 1 day
- ☐ 2 days
- ☐ 3 days
- ☐ 4 days
- ☐ 5 days
- ☐ 6 days
- ☐ 7 days

22. How many servings of fruits and vegetables do you usually eat each day (one serving is about the size of a tennis ball)?

- ☐ 0 per day
- ☐ 1 a day
- ☐ 2 -3 per day
- ☐ 4-6 per day
- ☐ 7-10 per day
- ☐ 11 or more per day

23. Have you ever experienced food insecurity, that is, not knowing where your next meal is coming from, or involuntarily eating less than you need, on a regular basis, for a period of time lasting more than a month?

- ☐ Yes
- ☐ No

24. Do you have access to affordable physical activity opportunities?

- ☐ Yes
- ☐ No

Demographic Information: Please tell us about yourself.

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

☐ Yes ☐ No

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

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

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

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

28. 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

29. 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

30. Gender:

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

31. Employment status:

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

32. Your zip code: _____

33. Your primary housing:

☐ Single family, own
☐ Single family, rent
☐ Apartment/condo, rent
☐ Apartment/condo, own
☐ Unhoused
☐ Other

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

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

35. 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

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

_____

Appendix D – County Health Rankings Explained

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

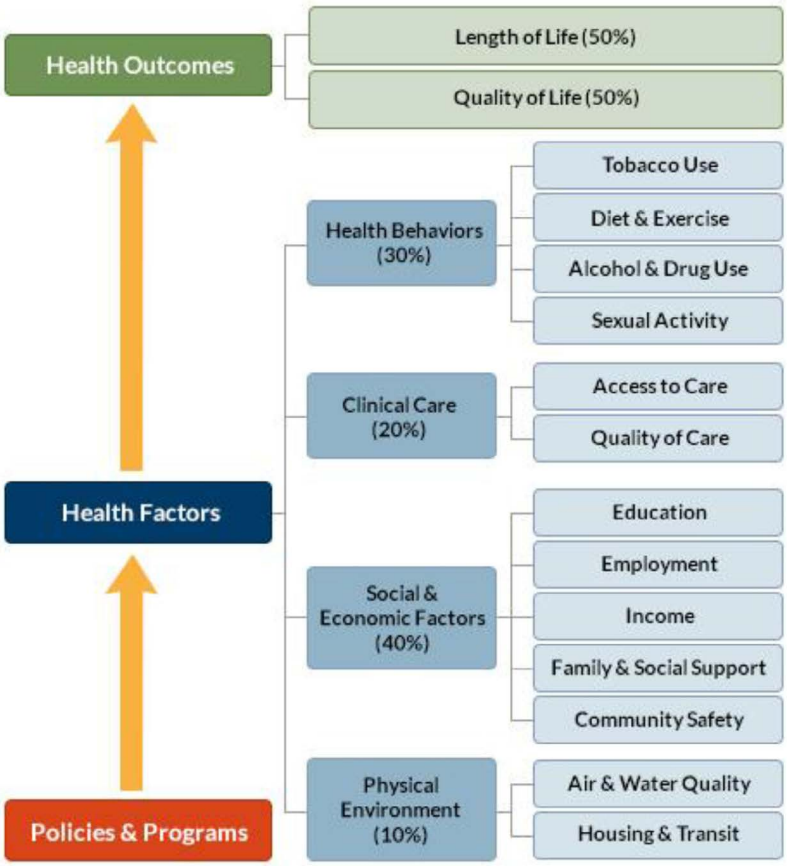
Methods

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

What is Ranked

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

Ranking System



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

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

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

Data Sources and Measures

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

Data Quality

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

Calculating Scores and Ranks

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

Health Outcomes and Factors

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

Health Outcomes

Premature Death (YPLL)

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

Reason for Ranking

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

Poor or Fair Health

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

Reason for Ranking

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

Poor Physical Health Days

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

Reason for Ranking

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

Poor Mental Health Days

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

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

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

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

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

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

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

Health Factors

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

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

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

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

Food Environment Index

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

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

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

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

Reason for Ranking

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

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

Physical Inactivity

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

Reason for Ranking

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

Access to Exercise Opportunities

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

Individuals who:

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

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

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

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

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

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

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

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

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

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

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

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

Uninsured

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

Reason for Ranking

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

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

Primary Care Physicians

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

Reason for Ranking

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

Dentists

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

Reason for Ranking

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

Mental Health Providers

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

Reason for Ranking

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

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

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

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.

Flu Vaccinations

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

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

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

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

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

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

Reason for Ranking

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

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

Income Inequality

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

Reason for Ranking

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

Children in Single-Parent Households

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

Reason for Ranking

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

Violent Crime Rate

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

Reason for Ranking

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

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

Injury Deaths

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

Reason for Ranking

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

Air Pollution-Particulate matter

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

Reason for Ranking

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

Drinking Water Violations

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

Reason for Ranking

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

Severe Housing Problems

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

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

- household is severely cost burdened.

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

Reason for Ranking

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

Appendix E – Youth Behavioral Risk Survey Results

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

	ND 2015	ND 2017	ND 2019	ND Trend ↑, ↓, =	Rural ND Town Average	Urban ND Town Average	National Average 2019
Injury and Violence							
Percentage of students who rarely or never wore a seat belt (when riding in a car driven by someone else)	8.5	8.1	5.9	=	8.8	5.4	6.5
Percentage of students who rode in a vehicle with a driver who had been drinking alcohol (one or more times during the 30 prior to the survey)	17.7	16.5	14.2	=	17.7	12.7	16.7
Percentage of students who talked on a cell phone while driving (on at least one day during the 30 days before the survey, among students who drove a car or other vehicle)	NA	56.2	59.6	=	60.7	60.7	NA
Percentage of students who texted or e-mailed while driving a car or other vehicle (on at least one day during the 30 days before the survey, among students who had driven a car or other vehicle during the 30 days before the survey)	57.6	52.6	53.0	=	56.5	51.8	39.0
Percentage of students who never or rarely wore a helmet (during the 12 months before the survey, among students who rode a motorcycle)	NA	20.6	NA	**NA**	NA	NA	NA
Percentage of students who carried a weapon on school property (such as a gun, knife, or club on at least one day during the 30 days before the survey)	5.2	5.9	4.9	=	6.2	4.2	2.8
Percentage of students who were in a physical fight on school property (one or more times during the 12 months before the survey)	5.4	7.2	7.1	=	7.4	6.4	8.0
Percentage of students who experienced sexual violence (being forced by anyone to do sexual things [counting such things as kissing, touching, or being physically forced to have sexual intercourse] that they did not want to, one or more times during the 12 months before the survey)	NA	8.7	9.2	=	7.1	8.0	10.8
Percentage of students who experienced physical dating violence (one or more times during the 12 months before the survey, including being hit, slammed into something, or injured with an object or weapon on purpose by someone they were dating or going out with among students who dated or went out with someone during the 12 months before the survey)	7.6	NA	NA	**NA**	NA	NA	8.2
Percentage of students who have been the victim of teasing or name calling because someone thought they were gay, lesbian, or bisexual (during the 12 months before the survey)	NA	11.4	11.6	=	12.6	11.4	NA
Percentage of students who were bullied on school property (during the 12 months before the survey)	24.0	24.3	19.9	↓	24.6	19.1	19.5
Percentage of students who were electronically bullied (including being bullied through texting, Instagram, Facebook, or other social media during the 12 months before the survey)	15.9	18.8	14.7	↓	16.0	15.3	15.7
Percentage of students who felt sad or hopeless (almost every day for two or more weeks in a row so that they stopped doing some usual activities during the 12 months before the survey)	27.2	28.9	30.5	=	31.8	33.1	36.7
Percentage of students who seriously considered attempting suicide (during the 12 months before the survey)	16.2	16.7	18.8	=	18.6	19.7	18.8

	ND 2015	ND 2017	ND 2019	ND Trend ↑, ↓, =	Rural ND Town Average	Urban ND Town Average	National Average 2019
Percentage of students who made a plan about how they would attempt suicide (during the 12 months before the survey)	13.5	14.5	15.3	=	16.3	16.0	15.7
Percentage of students who attempted suicide (one or more times during the 12 months before the survey)	9.4	13.5	13.0	=	12.5	11.7	8.9
Tobacco Use							
Percentage of students who ever tried cigarette smoking (even one or two puffs)	35.1	30.5	29.3	=	32.4	23.8	24.1
Percentage of students who smoked a whole cigarette before age 13 years (even one or two puffs)	NA	11.2	NA	**NA**	NA	NA	NA
Percentage of students who currently smoked cigarettes (on at least one day during the 30 days before the survey)	11.7	12.6	8.3	↓	10.9	7.3	6.0
Percentage of students who currently frequently smoked cigarettes (on 20 or more days during the 30 days before the survey)	4.3	3.8	2.1	↓	2.3	1.7	1.3
Percentage of students who currently smoked cigarettes daily (on all 30 days during the 30 days before the survey)	3.2	3.0	1.4	↓	1.6	1.2	1.1
Percentage of students who usually obtained their own cigarettes by buying them in a store or gas station (during the 30 days before the survey among students who currently smoked cigarettes and who were aged <18 years)	NA	7.5	13.2	=	9.4	10.1	8.1
Percentage of students who tried to quit smoking cigarettes (among students who currently smoked cigarettes during the 12 months before the survey)	NA	50.3	54.0	=	52.8	51.4	NA
Percentage of students who currently use an electronic vapor product (e-cigarettes, vape e-cigars, e-pipes, vape pipes, vaping pens, e-hookahs, and hookah pens at least one day during the 30 days before the survey)	22.3	20.6	33.1	↑	32.2	31.9	32.7
Percentage of students who currently used smokeless tobacco (chewing tobacco, snuff, or dip on at least one day during the 30 days before the survey)	NA	8.0	4.5	↓	5.7	3.8	3.8
Percentage of students who currently smoked cigars (cigars, cigarillos, or little cigars on at least one day during the 30 days before the survey)	9.2	8.2	5.2	↓	6.3	4.3	5.7
Percentage of students who currently used cigarettes, cigars, or smokeless tobacco (on at least 1 day during the 30 days before the survey)	NA	18.1	12.2	NA	15.1	10.9	10.5
Alcohol and Other Drug Use							
Percentage of students who ever drank alcohol (at least one drink of alcohol on at least one day during their life)	62.1	59.2	56.6	=	60.6	54.0	NA
Percentage of students who drank alcohol before age 13 years (for the first time other than a few sips)	12.4	14.5	12.9	=	16.4	13.2	15.0
Percentage of students who currently drank alcohol (at least one drink of alcohol on at least one day during the 30 days before the survey)	30.8	29.1	27.6	=	29.4	25.4	29.2
Percentage of students who currently were binge drinking (four or more drinks of alcohol in a row for female students, five or more for male students within a couple of hours on at least one day during the 30 days before the survey)	NA	16.4	15.6	=	17.2	14.0	13.7
Percentage of students who usually obtained the alcohol they drank by someone giving it to them (among students who currently drank alcohol)	41.3	37.7	NA	**NA**	NA	NA	40.5
Percentage of students who tried marijuana before age 13 years (for the first time)	5.3	5.6	5.0	=	5.5	5.1	5.6
Percentage of students who currently used marijuana (one or more times during the 30 days before the survey)	15.2	15.5	12.5	=	11.4	14.1	21.7

	ND 2013	ND 2017	ND 2019	ND Trend ↑, ↓, =	Rural ND Town Average	Urban ND Town Average	National Average 2019
Percentage of students who ever took prescription pain medicine without a doctor's prescription or differently than how a doctor told them to use it (counting drugs such as codeine, Vicodin, OxyContin, Hydrocodone, and Percocet, one or more times during their life)	NA	14.4	14.5	=	12.8	13.3	14.3
Percentage of students who were offered, sold, or given an illegal drug on school property (during the 12 months before the survey)	18.2	12.1	NA	NA	NA	NA	21.8
Percentage of students who attended school under the influence of alcohol or other drugs (on at least one day during the 30 days before the survey)	NA	NA	NA	NA	NA	NA	NA
Sexual Behaviors							
Percentage of students who ever had sexual intercourse	38.9	36.6	38.3	=	35.4	36.1	38.4
Percentage of students who had sexual intercourse before age 13 years (for the first time)	2.6	2.8	NA	NA	NA	NA	3.0
Weight Management and Dietary Behaviors							
Percentage of students who were overweight (>= 85th percentile but <95th percentile for body mass index, based on sex and age-specific reference data from the 2000 CDC growth chart)	14.7	16.1	16.5	=	16.6	15.6	16.1
Percentage of students who had obesity (>= 95th percentile for body mass index, based on sex- and age-specific reference data from the 2000 CDC growth chart)	13.9	14.9	14.0	=	17.4	14.0	15.5
Percentage of students who described themselves as slightly or very overweight	32.2	31.4	32.6	=	35.7	33.0	32.4
Percentage of students who were trying to lose weight	NA	44.5	44.7	=	46.8	45.5	NA
Percentage of students who did not eat fruit or drink 100% fruit juices (during the seven days before the survey)	3.9	4.9	6.1	=	5.8	5.3	6.3
Percentage of students who ate fruit or drank 100% fruit juices one or more times per day (during the seven days before the survey)	NA	61.2	54.1	↓	54.1	57.2	NA
Percentage of students who did not eat vegetables (green salad, potatoes [excluding French fries, fried potatoes, or potato chips], carrots, or other vegetables, during the seven days before the survey)	4.7	5.1	6.6	=	5.3	6.6	7.9
Percentage of students who ate vegetables one or more times per day (green salad, potatoes [excluding French fries, fried potatoes, or potato chips], carrots, or other vegetables, during the seven days before the survey)	NA	60.9	57.1	↓	58.2	59.1	NA
Percentage of students who did not drink a can, bottle, or glass of soda or pop (such as Coke, Pepsi, or Sprite, not including diet soda or diet pop, during the seven days before the survey)	NA	28.8	28.1	=	26.4	30.5	NA
Percentage of students who drank a can, bottle, or glass of soda or pop one or more times per day (not including diet soda or diet pop, during the seven days before the survey)	18.7	16.3	15.9	=	17.4	15.1	15.1
Percentage of students who did not drink milk (during the seven days before the survey)	13.9	14.9	20.5	↑	14.8	20.3	30.6
Percentage of students who drank two or more glasses per day of milk (during the seven days before the survey)	NA	33.9	NA	NA	NA	NA	NA
Percentage of students who did not eat breakfast (during the 7 days before the survey)	11.9	13.5	14.4	=	13.3	14.1	16.7
Percentage of students who most of the time or always went hungry because there was not enough food in their home (during the 30 days before the survey)	NA	2.7	2.8	=	2.1	2.9	NA
Physical Activity							
Percentage of students who were physically active at least 60 minutes per day on 5 or more days (doing any kind of physical activity that	NA	51.5	49.0	=	55.0	22.6	55.9

increased their heart rate and made them breathe hard some of the time during the 7 days before the survey)							
	ND 2015	ND 2017	ND 2019	ND Trend ↑, ↓, =	Rural ND Town Average	Urban ND Town Average	National Average 2019
Percentage of students who watched television three or more hours per day (on an average school day)	18.9	18.8	18.8	=	18.3	18.2	19.8
Percentage of students who played video or computer games or used a computer three or more hours per day (counting time spent on things such as Xbox, PlayStation, an iPad or other tablet, a smartphone, texting, YouTube, Instagram, Facebook, or other social media, for something that was not school work on an average school day)	38.6	43.9	45.3	=	48.3	45.9	46.1
Other							
Percentage of students who had eight or more hours of sleep (on an average school night)	NA	31.8	29.5	=	31.8	33.1	NA
Percentage of students who brushed their teeth on seven days (during the 7 days before the survey)	NA	69.1	66.8	=	63.0	68.2	NA
Percentage of students who most of the time or always wear sunscreen (with an SPF of 15 or higher when they are outside for more than one hour on a sunny day)	NA	12.8	NA	NA	NA	NA	NA
Percentage of students who used an indoor tanning device (such as a sunlamp, sunbed, or tanning booth [not including getting a spray-on tan] one or more times during the 12 months before the survey)	NA	8.3	7.0	=	6.0	5.9	4.5

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

Appendix F – Prioritization of Community's Health Needs

Community Health Needs Assessment
Valley City, North Dakota
Ranking of Concerns

The top concerns for each of the five topic areas, based on the community survey results, were listed in an online survey for meeting participants to rank. The numbers below indicate the total number of votes by the people in attendance at the second community meeting. The "Priorities" column lists the number of votes for the concerns indicating which areas are felt to be priorities. Each person was given four votes. The "Most Important" column lists the number of votes placed after the first round of voting was complete and the top four priorities were selected based on the highest number of votes. Each person was then asked to vote for the item they felt was the most important priority of the top four ranked priorities. One person abstained from voting in the second round.

	Priorities	Most Important
COMMUNITY/ENVIRONMENTAL HEALTH CONCERNS		
Attracting & retaining young families	3	
Not enough jobs with livable wages	5	2
Not enough affordable housing	0	
Racism, prejudice, hate, discrimination	1	
AVAILABILITY/DELIVERY OF HEALTH SERVICES CONCERNS		
Availability of mental health services	6	4
Cost of healthcare services	3	
Ability to retain primary care providers in the community	1	
Extra hours for appointments, such as evenings and weekends	3	
YOUTH POPULATION HEALTH CONCERNS		
Drug use and abuse (including prescription drugs)	4	2
Depression/anxiety	4	2
Alcohol use and abuse	1	
Smoking & tobacco use	1	
ADULT POPULATION HEALTH CONCERNS		
Alcohol use and abuse	3	
Drug use and abuse (including prescription drugs)	2	
Depression/anxiety	1	
Obesity/overweight	1	
Stress	3	
SENIOR POPULATION HEALTH CONCERNS		
Availability of resources to help elderly stay in their homes	0	
Cost of long-term/nursing home care	1	
Dementia/Alzheimer's Disease	0	
Ability to meet needs of older population	1	

Appendix G – Survey "Other" Responses

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

Community Concerns

3. Considering the PEOPLE in your community, the best things are: "Other" responses:
    - I have found a small group of people who are not backwards and closed minded.
    - People are very connected to their family's and their beginnings as family farms.
    - Safe
    - Safe Community
    - Small schools
    - Small town feel
    - We live in the country and do not go into Litchville much
4. Considering the SERVICES AND RESOURCES in your community, the best things are: "Other" responses:
    - Celebrate Recovery
    - Hunting, ice fishing, summer fishing.
    - n/a
    - Senior services
    - Services for marginalized groups
    - Sheyenne River
    - There are speciality's in health care that could have larger programs as the pain clinic the hospital offers.
5. Considering the QUALITY OF LIFE in your community, the best things are: "Other" responses:
    - Great place for single people
    - n/a
    - Outdoor recreational activities/options
6. Considering the ACTIVITIES in your community, the best things are: "Other" responses:
    - Bars, Closeness to outdoor activities/areas (Medicine Wheel, Ashtabula, Clausen Springs)
    - Beautiful Parks
    - Closeness to family members.
    - Fishing
    - Friendly people
    - n/a
    - Natural areas
    - Our public library
    - Outdoor recreation
    - Outdoor recreational activities

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

8. Considering the COMMUNITY /ENVIRONMENTAL HEALTH in your community, concerns are: "Other" responses:
    - A very vocal minority, with a silent majority, who promote misinformation, divisiveness, and general ignorance.

- Chemical dependency, underage drinking
- Drug abuse/treatment
- Drugs
- High price of goods and food
- Insufficient mental healthcare
- Lack of mental health services for children
- Lack of mental healthcare
- n/a
- Outsiders do not feel welcome
- People in power take care of themselves

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

- Have to drive 30+ miles for health care
- Lack of male primary care provider MDs
- Lack of maternity service at the hospital
- Multiple healthcare providers openly discussing their annoyance at "they/them" pronouns on forms & having to deal with LGBTQIA+ patients (this happened in a crowded room at city hall a few years ago during a morning flu shot clinic; several city employees were present to get their shots - some also participated in the conversation and laughed about "not knowing whether I should check male or female!" - but members of the public were present, like me - because the flu shot clinic was open to spouses, kids, etc. of the city employees. I will never forget sitting there like I was in a twilight zone, unable to comprehend the lack of professionalism happening in front of me.-
- n/a
- No OB services
- Quality of emergency room personnel. I would rather drive the half hour to Jamestown.
- Too much paperwork for medicaid people
- We have great healthcare with ease in accessibility

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

- Bullying
- Can't address the youth not involved in much youth activities
- Counselors for schools
- Exposure to trauma-domestic violence, child abuse/neglect-lack of mental health services
- Not enough activities that are not all about sports
- Personal responsibility and making poor choices that impact them long term
- Racism, homophobia, etc.
- Sexual abuse, neglect, domestic violence
- Teachers/coaches/adults in positions of power who mock kids whose interests include more than or fall outside the typical small-town main activity of sports
- The Valley City Park summer rec meets too often for young kids, and the rules about cut-off for age should follow the school's so that children don't need to be required to be in a grade younger than their school friends. Summer Rec at age 5 isn't about travel baseball when they are older, it's about having fun, exercising and learning about baseball.
- There are camps for elem and middle school kids but no summer "day' care while parents work
- Too Much Device Addiction
- Very little support for LGBTQ+ students

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

- Again - we have much to offer the adult population from healthcare to physical fitness to programs/activities such as talks put on by the museum, VCSU activities and the like

- Denial of science/denial that covid is real and harmful/Lack of vaccination against covid
- Domestic violence, sexual assault, human trafficking
- Elders staying in their home and not having visitors
- Intolerance/racism
- Lack of mental health services
- Lack of people getting COVID vaccine
- Mental health wait times are too long
- n/a
- Overall mental health
- Parenting Resources
- People not taking the covid vaccine!
- Racism, homophobia, etc.

12. Considering the SENIOR POPULATION in your community, concerns are: "Other" responses:
    - Finding and keeping quality caregivers
    - Need a Adult daycare services. Where family members can love ones during the day so they can get a break. Provide activities, exercise, and socialization.
    - Overall cost of care including supplemental health insurance
    - Racism, homophobia, etc.
    - What do elders do that don't have willing family?
13. Considering the SAFETY in your community, concerns are: "Other" responses:
    - Affect of alcohol and drugs on families and children
    - Approachability of police officers
    - Crime
    - Domestic violence
    - Drugs
    - Handicap accessibility of parks,schools, and public buildings.
    - Houses run down
    - I do not live in Valley City
    - Illegal drug use
    - Lack of sidewalks
    - Law enforcement, human trafficking, sexual assault
    - Loose dogs
    - More trash containers would be nice
    - No concerns
    - None
    - Poor response of law enforcement and courts
    - Poorly trained law enforcment
    - Public CPR, AED, choking training
    - Speed, lack of stopping at stop signs by drivers
    - Speeding traffic, reckless behavior, poor choices that lead to property damage
    - Stop signs and side walks are not consistent
    - We have a safe community
    - Widespread use of chemicals
14. What single issue do you feel is the biggest challenge facing your community?
    - A place for the homeless in Valley City. A place where they are safe
    - Activities/Clubs/Organizations, whether they are social or wellness based especially for adults and seniors are lacking and or non-existent. Also restaurants/stores/commercial area is very lacking,

especially in regards to access to healthy foods, variety of products, and accessibility.

- Aging population - need more young people
- Allowing outside franchises to start up a business in our community.
- Apartments where I don't have to walk up 3 flights of stairs to get to my apartment.
- Apathy.
- (2) Attracting and retaining young families.
- Availability and cost of quality food products at local grocery store. Specifically produce.
- Availability of mental health services local to the community.
- Behavioral health and the lack of resources to manage addiction and mental health issues. Lack of social detox options. Lack of behavioral health options for people with suicide attempt. Lack of options for adolescents. Lack of options for psychiatric placements locally and statewide.
- Can't pick one
- Challenges of businesses to find people to work.
- Clear communication about who is responsible for collecting our garbage in the trailer court on the outskirts of town.
- Close minded people
- Cost of exercise facilities
- Covid-19 and lack of seriousness regarding the dangerousness of it, vaccination hesitancy, etc.
- Definitely the hard drugs. We are young college students and our neighbor has kids. I have walked outside and across the street and seen needles and things, I don't want the little 10 year old boy to find things as such.
- Depression/anxiety.
- Discrimination against anyone who isn't a straight, white Christian.
- Drug and alcohol use
- Drug problems - You can hardly go anywhere without passing someone who is clearly using/high/addicted to drugs.
- Drug Usage
- Drug use, stress, depression, alcohol abuse. It's all connected
- Drugs and the drug abusers being parents- children are struggling Mental health services- amount of anxiety and depression
- Everyone needs to step up & get vaccinated for COVID. There is only a selfish, stubborn reason that this has not been accomplished.
- For me, it seems to be more and more difficult to purchase things here in Valley City and it seems that there are many many people purchasing on line and getting mail or FedEx delivery which then causes less to be available locally creating a continuing problem.
- Free or cheap after-school programming for kids and youth, recreational sports cost money and is tough for our low income families.
- Getting enough work force to keep our businesses healthy
- Good community for being elderly
- Good paying jobs to keep young people here.
- Gravel alleys instead of paved surfaces
- Having people aware of the resources that exist, related to mental health, disease prevention, and social opportunities in our community.
- Helping seniors stay in their homes
- Housing for families that relocate for job opportunity.
- I feel we are going backwards. There is very little diversity and the people who have attempted to integrate from more diverse backgrounds are leaving. We are caught in a time warp of intolerance and misunderstanding.
- Ignorance, to many people are stuck in their beliefs on topics because they refuse to educate themselves. These topics can range from vaccines to racism. There is seems to be a large group of community members whom are very close-minded.

- Inability to attract and retain young adults and families to relocate and stay in Valley City.
- Jobs and new families
- Jobs not providing livable wages
- Just a few at the top who run the city. Not only are they sometimes out of touch, but when they eventually leave, who is ready to step up and do what they do? Are younger leaders being trained and given authority to feel confident to fill those holes someday? The current leaders have to be okay stepping back at some point.
- Keeping up with street repair and/or replacement.
- Keeping young adults from leaving to seek jobs elsewhere
- Lack of a decent income/options. Low wages. High prices in grocery stores, high priced insurance rates with limited coverage, medication coverage, high priced prescriptions...
- Lack of adolescent crisis or treatment residential for mental health or substance abuse
- Lack of behavioral health and abuse resources. The availability of drugs and drug abuse here in Valley City
- Lack of clothing stores
- Lack of diversity
- Lack of leadership in acknowledging (therefore property addressing) violence as well as substance abuse & addiction. You must acknowledge there's a problem before you can fix it. I read letters/messages from the mayor about not littering banana peels & cigarette butts but nothing about the violence, homelessness, addiction, abuse, etc. (this is just an example) - our community is more concerned with how it looks & attracting people than it is with the actual well-being of those suffering & the less fortunate. These issues do impact the quality of life of everyone here whether or not people choose to recognize it. Our community is not getting safer for our children.
- Lack of long walking/biking paths and well lit areas for these paths. Sidewalks throughout the community for youth to safely ride to and from other places within city limits.
- Lack of mental health care and facilities/ providers
- Lack of progress in businesses.
- Lack of quality law enforcement services.
- Lack ofquality affordable housing available
- Liss of work force, many businesses can not fill open jobs
- Losing our businesses
- Maintaining the population
- (3) Mental health
- Mental health care
- Mental health concerns
- Mental health with drug abuse
- Meth
- Most, not all, of our law enforcement lack the basic knowledge to perform at a minimal standard when it comes to criminal investigations surrounding child abuse/neglect, sexual assaults and domestic violence. Instead of seeking training or asking for help from other agencies, the ball gets dropped, and offenders continue to roam the streets due to incompetency or ignorance of those who are not doing their jobs and not willing to grow within their capacities. There is a lack of working together among community agencies and partners; LE, HSC, HSZ, APOC, etc. There is too much pride and too big of egos. Lastly, there is a huge problem with lack of mental health services, especially for children. Our HSC is changing and not serving people other than their 'core' population. People are referred out for services, but we have no community providers to help. The problems keep compiling. There is no end in sight.
- New residents not getting involved in community
- Not enough health services and wellness opportunities available.
- Not having enough jobs to keep people here
- People are NOT taking the covid vaccine!

- People have to leave town to afford to buy groceries or even for all necessities such as back to school shopping we lost shopko and the dollar stores don't have enough to supply everyone we need a store similar to shopko with decent prices.
- People having kids and not caring for them properly
- Population decreasing
- Population going down due to no industry and an aging community
- Poverty
- Poverty and substance abuse leading to domestic violence and child neglect
- Probably lack of Single Family Housing right now.
- Respect for local government, transparency of the government, people working and earning a livable wage and affordable housing
- Retail business
- Retaining our young families in the community.
- Retaining population
- Retaining youth/ attracting young families to the community
- Stop signs are inconsistent in the town which leads to confusion at 4 way streets.
- Targeting head-on substance abuse at high school/college level
- The ability to offer affordable food and goods to keep business open and people shopping locally.
- The biggest challenge is the majority of the population is quite elderly, and all the things that go with that, meanwhile younger populations are outnumbered and feel there is "nothing for them" in our community. Developing active younger populations will help them feel valued in the plans for the community and elderly populations also want respect and to feel valued.
- The challenge of finding workers for local businesses, especially in the service industries, but also in the healthcare arena. It is difficult for a rural state to offer the types of wages/benefits that metropolitan areas can offer. Truly small businesses simply can't compete anymore. If people value a quieter lifestyle that rural in-town or farm life offers, we need to realize that some jobs just aren't going to offer high wages and endless benefits. This is a quandry. Do we need some kind of governmental incentive program to help with this issue?
- The community has become too divided. Instead of respecting each other's opinions, people tear each other down.
- The cost of living! Rent, food, etc the prices go up but the wages don't. You cant support a family on 12 dollars an hour. Also drug abuse in this town is horrible! There is Nothing in this town for teenagers to do, besides drinking, drugs. They have no where to hang out.. We can't even buy clothes in this town!
- The growing divide between the haves and the have nots. Young people not wanting to work. Elementary through HS age children on their own all summer while parents work... video games, (violent video games). Elders living alone in rural home.
- The smug, sour, and exclusionary nature of multigenerational families in embracing newcomers whether "White" Americans or people of color, and other sexual identities, and the ill concealed anti-science contempt shown toward those trying to mitigate COVID19 and COVID19-Delta infections. Pointedly there is an inbred faux religiosity and even phonier patriotism that invites any of us who've moved here from elsewhere to not unpack, simply pay for our bar tab and keep moving on...
- The years-long trend to deny facts and cling to ideas that, no matter how harmful to themselves or others in the community, come from a designated political "hero." Disinformation is a significant health concern. First and foremost, the lack of vaccinations and denials of its effectiveness and disinformation put all of us at risk. It prevents our economy from fully opening back up. It prevents our kids from being in the safest environment possible while in school. It puts our vulnerable friends and family at risk. We have certain business owners who berate customers if they think they're of a different political party - and will refuse service to them. In a town in this size, it either survives or it dies based on everyone's contributions or lack thereof. We have businesses who berate their employees who have disabilities in public. We have business owners who fly the Confederate flag. We are currently a "sick" community - physically, mentally, and emotionally. Our kids let us know regularly that moving to Valley City was the worst thing we've ever done to them.
- There are not enough grocery stores. We have two stores and they are both Leevers which isn't right. They can charge anything they want. Making people go out of town, but there are a lot of people who can't so they have to pay the price.

- There are so many problems and people suffering but everyone pretends or acts like it's not happening. The media, local government, etc. when you bring problems or concerns to the chief or court they're rude and dismissive and there's nothing you can do about it.
- This is the way we have always done things.
- Too few restaurants and lack of people willing to work so restaurants have limited hours.
- Unwillingness to consider another's perspective as valid
- Use of illegal drugs is our biggest challenge. You never hear about it, and yet the local court is filled with drug cases. Most of the crime is related to drug use. Drugs are here and are a real problem, and yet everyone seems to have their heads in the sand. If it doesn't affect you personally, it must not be a problem. We have a drug task force and CCHD has some services available, but I'm afraid it's going to have to get really bad before people wake up and take notice. The regular users aren't causing big problems, so they go unnoticed, whether that's intentional or not, I don't know. We have to get the cookers and the dealers and the kids and the parents. You can't ignore any of it. It's not a game and I just don't see anyone taking it very seriously.
- Viable retail stores
- We live near Litchville and people there have 2 bars, a gas station, an elementary school, 2 churches and a p/t post office. If you aren't born there you are an outsider so we do not go there often.
- We need to attract and retain young families.
- Wealth gap. Some very low poverty levels.
- Welcoming others new to the area/community who may have different race/culture/experiences.
- With the exception of the work of the health district, the community response (citizens, businesses, government) to the pandemic has been atrocious.
- Workers
- Youth being able to cope, make good choices, making a good life for themselves and being a productive member of society. People of any age being responsible. Taking a job and not showing up. There's so much opportunity, yet people squander them away.

Delivery of Healthcare

16. What PREVENTS community residents from receiving healthcare? "Other" responses:
    - Diversity in our providers-non white
    - Have a primary care dr but never available to see me.
    - Inadequate/nonexistent mental health care services
    - It can be challenging for some people to get to Fargo or Sioux Falls or elsewhere if they don't have a vehicle. The bus doesn't work for everyone.
    - Lack of affordable dental care beyond ordinary prophylaxis
    - None?
    - Possibly individuals who must rely on public transportation being able to coordinate theirvride with their appt. Also out of city persons needing ride to medical care.
    - Small talk with some healthcare providers - generally during initial part of appt when vitals are being taken, before doctor comes in - has veered into very unprofessional territory. When walking past the nurses station on my way to exam room I've heard things that should be confidential about other people; once while getting my vitals checked by a nurse before the doctor came into the exam room the nurse told me about her recent black Friday shopping experience and how a black woman was eyeing the same item as the nurse... and then the nurse began doing her imitation of how the black woman talked and moved her hands... in a very stereotypical way. I have no idea why this was viewed as appropriate in this setting and I sat there stunned. There was no recognition at all by the nurse that this was not okay. Also, because the lack of confidentiality in a small town has been personally experienced, it makes it literally impossible to seek out any local mental health services, forcing people to either take even more time off work to seek those services in Fargo or elsewhere or to not seek them out at all.
    - We need a weekend clinic!
17. Where do you turn for trusted health information? "Other" responses:
    - Family
    - Family members that are in the medical profession.

- I email my dr(s)
- Library
- My parents who don't live in Valley. They're both nurses
- (3) VA

18. What specific healthcare services, if any, do you think should be added locally?
    - ?
    - A hospital that can handle surgeries etc.
    - A more extensive pain clinic in Valley City.
    - A nearby, daily place for kids too old for daycare, a safe, busy, educational place. Volunteer visitors for the lonely elders.
    - After work hours urgent care
    - Alcohol and drug treatment- more mental health
    - Appropriate mental health & addiction services (one size does not fit all). Expansion of in-home health care services to better serve the elderly & their family caretakers.
    - Bariatric
    - Behavioral Health, Substance Abuse counselors
    - Birth Center
    - Cancer treatments
    - Cardiology services
    - Cataract surgery in Valley City
    - Chemo infusions, social detox option
    - Clinic for Basic Care with Expnaded Hours. ER Visit for some simple eye drops for eye infection was $900.00
    - Delivery babies at hospital locally
    - Detox
    - Drug addiction
    - Extended hours
    - Help to allow seniors to stay in their homes
    - I know significant barriers exist, but dialysis.
    - I would like to see our local OB department established again at CHI, but I don't think that is going to happen.
    - I'm not sure
    - Kidney dialysis
    - Make healthcare and perscription drugs more affordable
    - Medical marijuna avaliable
    - Mental health
    - Mental health - Addiction Counselling
    - Mental health care directly involved with the schools and nurses directly available at the schools.
    - Mental Health clinic
    - (2) Mental health counseling
    - Mental health resources
    - Mental health, general surgeon, pediatrician
    - Mental health, vision
    - Mental health/counseling services.
    - More access to mental health providers
    - More affordable dental care/dental insurance.
    - More counseling and drug and or alcohol treatment

- More counseling services
- More facility-associated mental health providers
- More male providers
- (2) More mental health services
- More services at the our hospital, Sanford in FARGO say the hospital is packed full, when our hospital in our home town is not thriving. Always driving to Fargo is a big expences for lower income families. We should better equip our community with quality care at our local hospital, the community does not trus it so they go to Fargo.
- (2) More specialists
- More staff for South Central Human Services
- Neurologist
- Nutrition
- OB to keep families here
- Obgyn
- Obstetrics
- Orthopedic
- Personally, I go to Jamestown, as I feel I get better care and better access there.
- Psychiatrist and dermatologist
- Psychologist
- Psychologists
- Substance abuse programs/ addiction counseling available in town,
- Vaccination booster shots.
- Vision therapy
- Walk in clinic for Saturdays.
- We need a walk in clinic. We need a clinic that is open until at least noon on Saturday/Sunday. There is no reason we should have to drive to Fargo for services on a weekend. I find myself going to the ER in VC for things that could be served in a clinic, because I do not want to waste 1/2 of my day, or more, in Fargo. My weekends are precious.
- We need more family practice physicians, mental health/addiction providers and more robust outpatient services at the hospital
- Weightloss specialists
- Wellness coaches

22. Please select the top three health challenges you face. "Other" responses:
    - Diabetes drugs can be very expensive. Currently taking Ozempic and Jardiance.
    - Eating disorder
    - Fibromyalgia need hip replacement and back surgery
    - Fortunately none at this time
    - General stress, lack of sleep
    - High cholesterol
    - HS
    - Kidney disease
    - Macular degeneration
    - Nicotine
    - Possibility of developing diabetes and Alzheimer's as I age.
    - Stress management
    - Uc
31. How did you acquire the survey (or survey link) that you are completing? "Other" responses:
    - Chamber Eblast

- Chamber email
- Coffee shop, Epworths
- Director of an organization
- (3) Email
- Email from friend
- Forwarded by college nurse
- High school
- Likely from Vaccination
- Sharon Buhr
- Vaccination Clinic

32. Health insurance or health coverage status (choose ALL that apply): "Other" responses:

BCBS

BC-BS

Medica supplement

Parent's Insurance

Truncate for Life

VA

Work

41. Overall, please share concerns and suggestions to improve the delivery of local healthcare. "Other" responses:

- A big concern is the lack of health care options for those that don't have insurance or local clinics do not accept the insurance or if from out of state/town and need a referral even before they can be seen even for simple visits for strep throat etc., - they are forced to go to an ER for care when not medically indicated.
- Add after hours services besides being seen in the Emergency Department. Improve mental health care opportunities for people in the community.
- Affordable and decent. Even with insurance, healthcare cost is insane. Pharmacies won't fill medication prescriptions because they lose money so you have to go to a different one. Mental health providers are few and the ability to get into one takes months. PCP in the community talk about a patient care openly and I seek healthcare out of town so they don't talk about my family and myself amid the daily coffee chat...many areas of improvement starting with the basics.
- Better and less expensive dental health ser ices..
- Could use a Clinic with Enhanced Hours for relatively minor health care needs
- Distance to health careâ€" 30+ miles to basic care, 100 + miles for specialists
- Have a nephew, 16, who is a Type 1 diabetic. The cost of his supplies/medical is very high. His mother has always worked numerous jobs to have health insurance and more money to cover out-of-pocket expenses. She worries about him covering his own expenses when he leaves home.
- Healthy food is expensive and not good quality in grocery stores.
- I don't have many concerns that i haven't already displayed in my previous answers
- I have had positive experiences with the clinics, chiropractors and eye doctors in Valley City, but would prefer to go or take family members to the ER in Jamestown or Fargo as I have had several negative experiences.
- Im going to be honest I live in Carrington, but all of my answers for this was directed to my last 4 years of living in valley city
- It would be nice to be able to purchase a variety of GOOD fruit and vegetables at a fair price.
- Male providers
- More access to mental healthcare is needed in this area.
- More counselling time in the schools would be a good investment.
- N/A
- Need greater access to speciality services here in Valley City.

- Need more home health care aides for elderly to stay at homes instead of in a care facility
- Need to develop services for young dementia cases and support for their families
- Need to replace old hospital
- People in community need to recognize the value of public health and the services they offer Recommend that organizations continue to work together like the 18 partners in ON THE MOVE and the Mental Health Consortium...together we can do so much more!
- Please consider of all the school age kids on their own all summer while parents are at work. Please consider all the elderly people alone in their homes, many with only working children to assist them and visit them.
- Probably the most pressing concern is lack of sufficient mental health care in our community. Patients who need emergency services are constantly being turned away. Crimes are typically not investigated adequately and proper enforcement rarely occurs. Our leaders ignore the major poverty, mental health, drug and domestic abuse problems in our city and instead focus on curb side beautification.
- Rural roads into town and edge of town areas could use bike paths - as more people are building houses close to town, it is too dangerous to walk or bike. Businesses building on edge of town also have expanded, but no sidewalks or bike paths. Have to drive to town to "exercise."
- The ER staff needs more training and better attitudes and doctors that know what they are doing. It seems like you go there and they have no idea what to do. This ER is good for a band aid.
- The local healthcare does a very good job and it would only get better with more state and federal aid.
- The overall cost of services.
- Very pleased with our Healthcare at Sanford Medical Center
- We have people who know what they're doing and truly care. Our community healthcare is top-notch, I think.
- We need more primary care MDs.
- We need to provide services for the elderly to stay in their homes
- We really need help with the substance abuse individuals in the community. There is no where for these people to get help. This includes, alcohol, meth, etc.