Community Health Needs Assessment

2019

Lisbon, North Dakota Service Area

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

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Executive Summary

To help inform future decisions and strategic planning, CHI Lisbon Health conducted a community health needs assessment (CHNA) in 2018/2019, the previous CHNA having been conducted in 2016. The Center for Rural Health (CRH) at the University of North Dakota School of Medicine & 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. Of the 281 surveys completed by CHI Lisbon Health service area residents, 222 responses were utilized. The remaining 59 surveys were completed by people under the age of 18 and were not eligible to be analyzed. Additional information was collected through six key informant interviews with community leaders including those with knowledge of public health. The input from the residents, who primarily reside in Ransom County and Sargent 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.

Ransom County's population from 2010 to 2017 decreased 2.9%. The average of residents under age 18 (22.7%) is less than one percentage point lower than the North Dakota average (23.3%). The percentage of residents ages 65 and older is considerably higher (20.4%) than the North Dakota average (15.0%), and the rates of education are 2% lower than the North Dakota average (92.0%). The median household income in Ransom County ($57,088) is slightly lower than the state average for North Dakota ($59,114).

Sargent County is the other county serviced by CHI Lisbon Health. Sargent County's population from 2010 to 2017 increased 0.8%. The average of residents under age 18 (21.3%) is two percentage points lower than the North Dakota average (23.3%). The percentage of residents ages 65 and older is considerably higher (22.4%) than the North Dakota average (15.0%), and the rates of education (91.7%) are very close to the North Dakota average (92.0%). The median household income in Sargent County ($57,472) is slightly lower than the state average for North Dakota ($59,114).

Data compiled by County Health Rankings show Ransom County and Sargent County are meeting or exceeding North Dakota in health outcomes/factors for 7 indicators; Ransom County is doing better than North Dakota in one additional health indicator; and Sargent County is doing better than North Dakota in health outcomes/factors for an additional 7 indicators.

Ransom County and Sargent County, according to County Health Rankings data, are performing poorly relative to the rest of the state in 13 outcome/factor indicators; Ransom County is performing more poorly than the state average in 11 indicators; and Sargent County is performing more poorly than the state average in 9 indicators.

Of the 82 potential community and health needs set forth in the survey, 222 CHI Lisbon Health service area residents 18 years of age or older who completed the survey indicated the following needs as the most important:

- Alcohol use and abuse – Youth and Adult
- Attracting and retaining young families
- Availability of mental health services
- Bullying/cyber-bullying
- Cost of long-term/nursing home care
- Depression/anxiety – Youth and Adult
- Having enough child daycare services
- Youth drug use and abuse

The survey also revealed some of the biggest barriers to receiving healthcare (as perceived by community members), there are not enough evening or weekend hours (N=43), no insurance or limited insurance (N=35), not affordable (N=35), and concerns about confidentiality (N=28).

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

- Family-friendly
- People are friendly, helpful, and supportive
- People are involved in their community
- Recreational and sports activities
- Safe place to live, little/no crime

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

- Adult and youth alcohol use and abuse
- Adult and youth depression and anxiety
- Adult and youth drug use and abuse
- Assisted living options
- Attracting and retaining young families
- Availability of mental health/substance abuse treatment services
- Having enough child daycare services
- Not enough activities for children
- Not enough affordable housing

Overview and Community Resources

With assistance from the CRH at the UNDSMHS, CHI Lisbon Health completed a CHNA of the CHI Lisbon Health service area. The hospital identifies its service area as a 40-mile radius of Lisbon, which includes Sargent County and Ransom County. Many community members and stakeholders worked together on the assessment.

Ransom County

CHI Lisbon Health and Ransom County Public Health (RCPH) are located in Lisbon, ND. Lisbon is at the intersection of State Highways 27 and 32. Ransom County is located in southeastern North Dakota, approximately 70 miles south of Fargo. It is bordered on the south by Sargent County, on the east by Richland County, on the north by Barnes and Cass County, and on the west by LaMoure County. Along with the hospital, the economic base for the town of Lisbon and Ransom County includes agricultural, manufacturing, and retail trade operations. According to the 2017 U.S. Census, Ransom County had a population of 5,297 while Lisbon, the county seat, had a population of 2,073.

Ransom County has a number of physical assets and features to help address population health improvement including, a swimming pool, two city parks, a state park, tennis, volleyball, and basketball courts, a golf

course, skating and ice-skating rink, camp grounds, hiking trials, and a movie theatre. The Lisbon Public School System offers curriculum for students K-12 and a variety of sports, music, and drama. Each major town in Ransom County has at least one fitness center, public transportation, and grocery store, which are additional, valued community assets.

The Lisbon Opera House, listed on the National Register of Historic Places, hosts several cultural events throughout the year. The Lisbon Scenic Theatre is the oldest continuously run theater in America, and it offers a variety of movie selections for diverse ages. The Lisbon Park Board maintains two city parks, a swimming pool, campground, baseball diamond, skate board park, basketball court, and tennis court. Dead Colt Creek is an excellent recreational area for boating, fishing, ice fishing, camping, picnics, and swimming. Fort Ransom State Park is located on one of North Dakota's officially designated Scenic Byways and Backways, the Sheyenne River Valley National Scenic Byway. Fort Ransom State Park is popular for canoeing and horse trails in the summer months, and snowmobiling and cross-country skiing in the winter months.

In addition to CHI Lisbon Health and RCPH, many other physicians and allied professionals help to serve Ransom County residents. This includes five clinics - CHI Lisbon Health Clinic, Family Medical Clinic, Sanford Clinic-Lisbon, Sanford Clinic-Enderlin, and Essentia Health Clinic-Lisbon. There are two home care agencies - Sanford Home Care and CHI Health Connect at Home, and two Hospice agencies - Hospice of the Red River Valley and CHI Health Hospice. Ransom County has three long-term care facilities – Parkside Lutheran Home, North Dakota Veterans Home, and Maryhill Manor in Enderlin. Parkside Lutheran Home and the North Dakota Veterans Home also offer basic care. Lisbon has an assisted living facility as well – the Beverly Anne.

Other healthcare facilities and services in the area include two pharmacies, multiple dentists and chiropractors, and an optometrist. Physical and occupational therapy are available through Mobility Plus. In addition, Ransom County has numerous massage therapists.

Sargent County

The Sargent County District Health Unit is located in Forman, ND. Sargent County is located in southeastern North Dakota, bordered on the south by South Dakota, on the east by Richland County, on the north by Ransom County and on the west by Dickey County. Along with agricultural, the main industry is Doosan Bobcat in Gwinner. The county is 864 square miles with a total of 547,200 acres. 523,815 acres of farmland, (which includes 2108 acres of Game and Fish land) 10,485 acres are owned by the U.S. Fish and Wildlife Services.

Sargent County has a number of community assets and resources that can be utilized to address population health improvement. Physical assets and features within the communities include: bike paths, swimming pools, city parks, tennis courts, golf courses, skating rink, and wellness centers.

Silver Lake is a public park owned by Sargent County. They offer 32 RV/Tent campsites with electric hookups on 100 acres. Leisure activities include: beach, swimming, boating, boat ramp, waterskiing, volleyball, fishing, and picnicking.

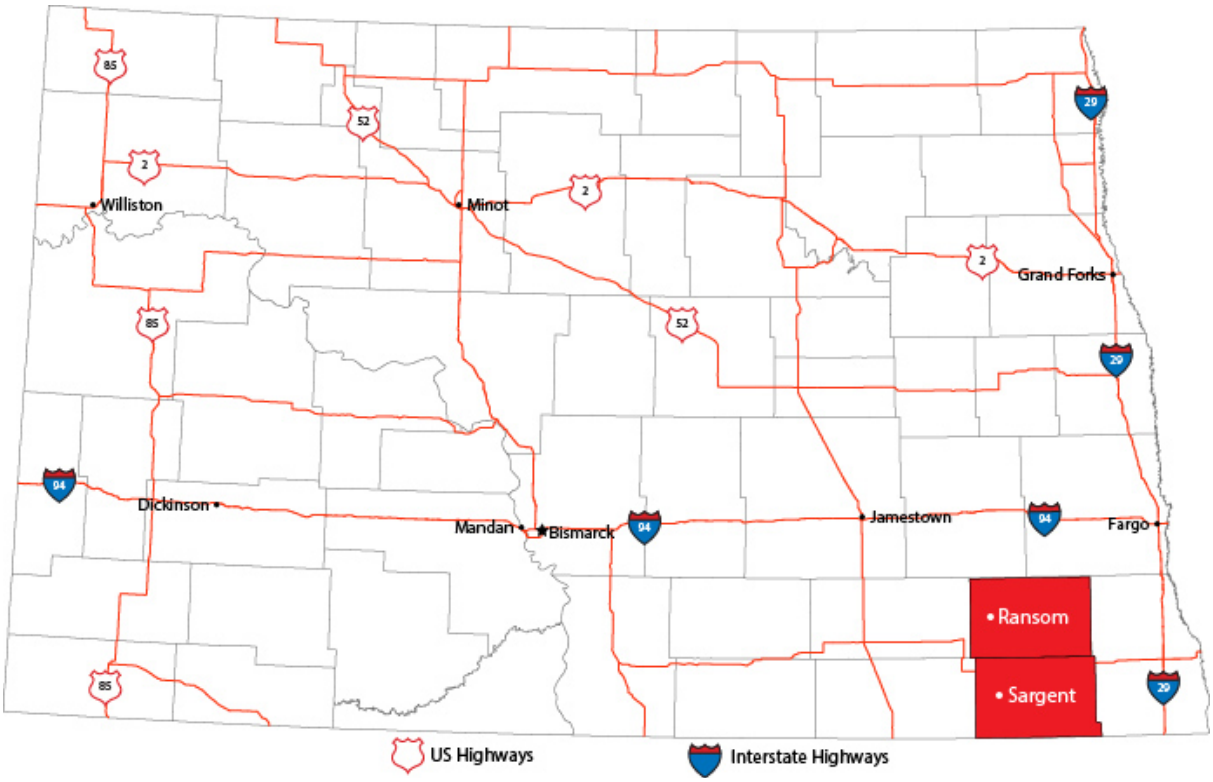
Tewaukon National Wildlife Refuge located in southeastern North Dakota encompasses grasslands and wetlands. The Wild Rice River winds its way through the Refuge. Visitors are encouraged to see how the active habitat management provides a place for wildlife, while getting outside and enjoying the natural beauty of the area.

Sargent County offers several cultural attractions such as the Sargent County Museum. The Old Settlers Association formed in the early 1900's but was disbanded in the 1930's or 1940's. The Sargent County Historical Society was formed in the 1960's. Artifacts were originally stored in the Sargent County Museum. The museum is located at 8987 Hwy 32 in Forman, and about 90 percent of the items on display were used by residents of Sargent County. Three of the major cities: Forman, Gwinner and Milnor have a fitness center and a grocery store that are valued community assets. There are three school districts within Sargent County: Sargent Central in Forman, North Sargent in Gwinner, and Milnor.

Healthcare facilities within Sargent County include Sanford Clinics in Forman and Gwinner: and CHI St. Francis Health Rural Clinic in Milnor. Mobility Plus offers physical and occupational therapy in Gwinner. Waswick Chiropractic Clinic is also located in Gwinner. Forman Drug and Gwinner Gifts are pharmacies located within the county. Four Seasons Health Care Center, Inc. is a skilled nursing facility located in Forman, ND. It is connected to the Four Seasons Villas, an assisted living center. Local hospitals include CHI Oakes Hospital and CHI Lisbon Health. St. Francis Hospital is located in Breckenridge, MN."

Figure 1 illustrates the location of the counties.

Figure 1: Ransom and Sargent Counties



CHI Lisbon Health

CHI Lisbon Health originally known as Community Memorial Hospital opened its doors on February 1, 1952. CHI Lisbon Health in Lisbon, North Dakota is a 25-bed critical access hospital, with 12 acute beds and 13 Swing beds. This is a state-designated Level V Trauma Center and a Stroke Ready Hospital. CHI Lisbon Health is part of a larger family of quality Catholic Health Initiatives healthcare facilities and employs approximately 76 people. In addition, CHI Lisbon Health houses a clinic and is home to 11 consulting/visiting medical providers. CHI Lisbon Health is the only hospital in Ransom and Sargent counties and serves 9,155 people throughout 1,731 square miles.

The mission of CHI Lisbon Health is to nurture the healing ministry of the Church, supported by education and research. Fidelity to the Gospel emphasizes human dignity and social justice to create healthier communities.

Services offered locally by CHI Lisbon Health include:

General and Acute Services

- Allergy shots
- Blood pressure checks
- Cardiac rehab
- Cardiac stress test
- Clinic
- Emergency room (level V Trauma center, stroke certified)
- Emergency telemedicine
- Hospital (acute care)
- Limited chemotherapy
- Nutrition counseling (inpatient or resident)
- Outpatient IV meds and injections
- Pain clinic (injections)
- Pharmacy
- Physicals: annuals, D.O.T., sports, insurance
- Port access and flushes
- Respite-end of life care
- Surgical services-general and same day
- Swing bed services
- Telemetry
- Wound care

Screening/Therapy Services

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

Radiology Services

- CT scan
- Dexa scans
- Digital 3D mammography
- Echocardiograms
- EKG
- General x-ray
- Nuclear medicine (mobile unit)
- MRI (mobile unit)
- Swallow studies
- Ultrasound

Laboratory Services

- Hematology
- Blood types
- Clot times
- Chemistry
- Urine testing
- Inpatient and outpatient blood transfusions
- Workplace drug testing (collections site)

Services offered by OTHER providers/organizations

- Ambulance
- Chiropractic services
- Dental services
- Home care
- Hospice
- Massage therapy
- Optometric/vision services

Ransom County Public Health

Ransom County Public Health (RCPH) provides public health services that include Immunizations, Environmental Health, Reproductive Health and Family Planning, the WIC (women, infants, and children) Program, Health Tracks, the Car Seat Program, Home Visits, the Tobacco Prevention & Control Program, School Health, Health Care Case Management, and Newborn Home Visits. 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, RCPH is committed to the promotion of healthy lifestyles, protection and enhancement of the environment, and provision of quality healthcare services for the people of North Dakota.

The Mission of the RCPH department is to make a positive difference on the health of the individual and the county through promotion, prevention and protection. This is accomplished through professional staff services and the collaboration with other health and community leaders.

Specific services that DCHD provides are:

- Blood pressure and pulse
- Breastfeeding resources
- Car seat program
- Cholesterol screening
- Coordination of and referral to other helping agencies
- Dressing changes
- Doctor ordered injections, lab draws, and INR levels
- Emergency preparedness services— work with community partners as part of local emergency response team
- Environmental health services (water, sewer, pool, health hazard abatement)
- Family planning
- Flu shots
- Foot care
- Health Tracks (child health screening)
- Hemoglobin screenings
- Immunizations
- Lead screenings
- Medication setup—home visits
- Member of Child Protection Team
- Newborn home visits
- School health— vision, hearing, scoliosis screenings in schools, health education and resource to the schools
- Preschool education programs & screening
- Tobacco Prevention and Control
- Urinalysis
- West Nile program—surveillance and education
- WIC (Women, Infants & Children) Program
- Worksite Wellness— Coordinator for County Employees
- Youth education programs (first aid, babysitting clinic)

Sargent County District Health Unit

The Sargent County District Health Unit's mission is to promote physical and mental health and prevent disease, injury and disability to the residents of Sargent County. The Sargent County District Health Unit (SCDHU) implements ten essential services. Monitor health status to identify health problems. Diagnosis and investigate health problems and health hazards in the community. Inform, educate, and empower people about health issues. Mobilize community partnerships to identify and solve health problems. Develop policies and plans that support individual and community health efforts. Enforce laws and regulations that protect health and ensure safety. Link people to needed personal health service and assure the provision of health care when otherwise unavailable. Assure a competent public health and personal health care workforce. Evaluate effectiveness, accessibility, and quality of personal and population based health services. Research for new insights and innovative solutions to health problems.

Specific services that SCDHU provides are:

- Bicycle helmet safety education
- Blood pressure checks
- Breastfeeding resources
- Car seat program
- Child health (well baby checks)
- Diabetes screening
- Doctor ordered injections
- Emergency preparedness services-work with community partners as part of local emergency response team
- Environmental health services (water, sewer, health hazard abatement)
- Flu shots
- Foot care
- Health Tracks (child health screening)
- Hemoglobin screenings
- Immunizations
- Lead screenings
- Lipid profiles
- Medication setup—home visits
- Member of Child Protection Team and County Interagency Team
- Newborn home visits
- Nutrition education
- Physical assessments
- School health-- vision, hearing, scoliosis screenings in schools, health education and resource to the schools
- Preschool education programs & screening
- Tobacco Prevention and Control
- Tuberculosis testing and management
- Urinalysis
- West Nile program—surveillance and education
- WIC (women, infants & children) Program
- Worksite Wellness-- Coordinator for District Health Unit Employees
- Youth education programs (first aid, bike safety, babysitting clinic)

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 actions 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 Sargent County and Ransom County, which are included in the CHI Lisbon Health service area. In addition to Lisbon, located in the service area are the communities of Cayuga, Coburn, Cogswell, De Lamere, Elliott, Forman, Fort Ransom, Gwinner, Havana, McLeod, Milnor, Rutland, and Sheldon.

The CRH, in partnership with CHI Lisbon Health, facilitated the CHNA process. Community representatives met regularly in-person, by telephone conference, and email. A CHNA liaison was selected locally, who served as the main point of contact between the CRH and Lisbon. A small steering committee was formed, 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 community perceptions, community resources, community needs, and ideas for improving the health of the population and healthcare services. Nineteen people, representing a cross section demographically, attended the focus group meeting. The meeting was highly interactive with good participation. CHI Lisbon Health staff were in attendance as well, but largely played a role of listening and learning.

Figure 2: Steering Committee

Betsy Enger	Community member
Brenna Welton	Administrator, Ransom County Public Health
LeAnn Fix	Case Manager, CHI Lisbon Health
Brenda Peterson	Administrator, Sargent County District Health Unit
Julie Mallett	VP for Patient Services, CHI Lisbon Health

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

As part of the assessment's overall collaborative process, the CRH spearheaded efforts to collect data

for the assessment in a variety of ways:

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

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

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

Community Group

A community group consisting of 19 community members convened and met for the first time on September 4, 2018. During this meeting, group members were introduced to the needs assessment process, reviewed basic demographic information about the CHI Lisbon Health service area, and served as a focus group. Focus group topics included community assets and challenges, the general health needs of the community, concerns, and suggestions for improving the community's health.

The Community Group met again on November 20, 2018, with 17 community members in attendance. At this second meeting, the Community Group was presented with survey results, findings from 5 key informant interviews and the focus group, and a wide range of secondary data relating to the general health of the population in Ransom County and Sargent County. The group was tasked with identifying and prioritizing the community's health needs.

Members of the Community Group represented broad interests of the community served by CHI Lisbon Health. They included representatives from a number of businesses as well as those in emergency services, extension, law enforcement, social services, commerce, education, local government, religion, retired, and CHI Lisbon Health staff. Not all members of the group were present at both meetings.

Interviews

Representatives from the CRH conducted one-on-one in-person interviews with six key informants on September 4, 2018. Interviews were held with selected members to include individuals from the fire department, public health, education, and two individuals from area businesses.

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

Survey

A survey was distributed to solicit feedback from the community. It was not intended to be a scientific or statistically valid sampling of the population. It was designed to be an additional tool for collecting qualitative data from the community at large – specifically, information related to community-perceived health needs. A copy of the survey instrument is included in Appendix A.

The community member survey was distributed, electronically and paper copy, to a variety of residents of the CHI Lisbon Health service area, described in detail below.

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 raise awareness of the assessment process and promote the importance of the process, the web link for completing the survey was shared on the following websites and Facebook pages: Civic and Commerce in Lisbon, Bobcat in Gwinner, CHI Lisbon Health, Ransom County Public Health, Sargent County Health Unit, and all area schools in Lisbon, Gwinner, Milnor, and Enderlin.

A total of 120 paper surveys were available for distribution in the service area. They were located at all four clinics in Lisbon (Family Medical Clinic, CHI Clinic, Sanford Clinic, and Essentia Clinic), and Sanford clinics in Enderlin, Gwinner, and Forman. Additional paper surveys were available at RCPH in Lisbon and Sargent County District Health Unit in Forman. To ensure anonymity, a postage paid return envelope to the CRH was provided with each survey.

Online surveys were submitted directly to the CRH. The survey was available from August 27 through September 24, 2018.

The online version of the survey was publicized with the link or URL disseminated in all press releases. A total of 264 online surveys and 17 paper surveys were completed. In total, paper and online, 281 community member surveys were completed. This equates to a response rate of 17.5% of the Lisbon population, which is better than average (13%) for this type of survey methodology.

Secondary Data

Secondary data was collected and analyzed to provide descriptions of: (1) population demographics, (2) general health issues (including any population groups with particular health issues), and (3) contributing causes of community health issues. Data was collected from a variety of sources, including the U. S. Census

Bureau; Robert Wood Johnson Foundation's County Health Rankings, which pulls data from 20 primary data sources (www.countyhealthrankings.org); the National Survey of Children's Health, which touches on multiple intersecting aspects of children's lives (www.childhealthdata.org/learn/NSCH); and North Dakota KIDS COUNT, which is a national and state-by-state effort to track the status of children, sponsored by the Annie E. Casey Foundation (www.ndkidscount.org).

Social Determinants of Health

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

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

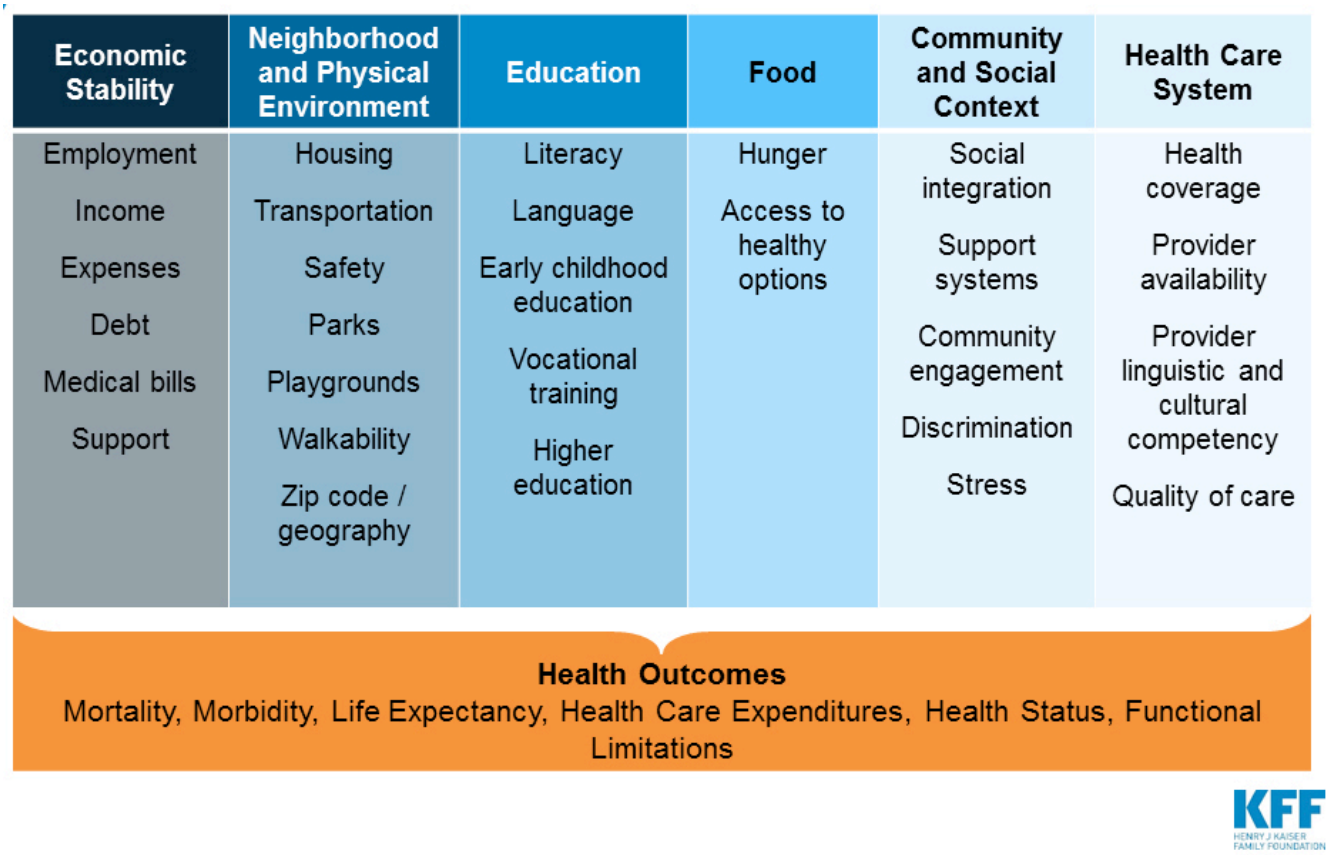
Healthy People 2020, (https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health) illustrates that health and healthcare, while vitally important, play only one small role (approximately 20%) in the overall health of individuals, and ultimately of a community. Social and community context, education, economic stability, neighborhood and built environment play a much larger part (80%) in impacting health outcomes. Therefore, as needs or concerns were raised through this community health needs assessment process, it was imperative to keep in mind how they impact the health of the community and what solutions can be implemented. See Figure 3.

Figure 3: Social Determinants of Health

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

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

Figure 4: Social Determinants of Health



Demographic Information

Table 1 summarizes general demographic and geographic data about Ransom and Sargent Counties.

Table 1: Ransom and Sargent Counties: Information and Demographics

(From 2010 Census/2017 American Community Survey; more recent estimates used where available)

	Ransom County	Sargent County	North Dakota
Population (2017)	5,297	3,858	755,393
Population change (2010-2017)	-2.9%	0.8%	12.3%
People per square mile (2010)	6.3	4.5	9.7
Persons 65 years or older (2016)	20.4%	22.4%	15.0%
Persons under 18 years (2016)	22.7%	21.3%	23.3%
Median age (2016 est.)	44.8	45.3	35.2
White persons (2016)	96.2%	94.9%	87.5%
Non-English speaking (2016)	3.6%	3.8%	5.6%
High school graduates (2016)	90.0%	91.7%	92.0%
Bachelor's degree or higher (2016)	17.2%	19.0%	28.2%
Live below poverty line (2016)	9.2%	7.7%	10.7%
Persons without health insurance, under age 65 years (2016)	6.8%	7.8%	8.1%

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

While the population of North Dakota has grown in recent years, Ransom County has seen a decrease in population since 2010 and Sargent County has only seen a very minimal increase. The U.S. Census Bureau estimates show that the Ransom County's population decreased from 5,457 (2010) to 5,297 (2017) and Sargent County's increased from 3,829 (2010) to 3,858 (2017).

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, Ransom County and Sargent 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 2017 County Health Rankings are from more than 20 data sources and compiled to create county rankings. Counties in each of the 50 states are ranked according to summaries of a variety of health measures. Those having high ranks, such as 1 or 2, are considered to be the "healthiest." Counties are ranked on both health outcomes and health factors. The following is a breakdown of the variables that influence a county's rank.

A model of the 2017 County Health Rankings – a flow chart of how a county's rank is determined – is in Appendix B. For further information, visit the County Health Rankings website at www.countyhealthrankings.org.

Health Outcomes

- Length of life
- Quality of life

Health Factors

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

Health Factors (continued)

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

Table 2 summarizes the pertinent information gathered by County Health Rankings as it relates to Ransom and Sargent Counties. 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 Ransom County Public Health, Sargent County District Health Unit, and CHI Lisbon Health or of any other medical facility.

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.

For most of the measures included in the rankings, the County Health Rankings' authors have calculated the "Top U.S. Performers" for 2017. 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).

Ransom County and Sargent County rankings within the state are included in the following summary. For example, Ransom County ranks 30th out of 49 ranked counties in North Dakota on health outcomes and 26th on health factors and Sargent County ranks 6th out of 49 ranked counties in North Dakota on health outcomes and 9th on health factors. The measures marked with a bullet (•) are those where a county is not measuring up to the state rate/percentage; a blue checkmark (*) indicates that the county is faring better than the North Dakota average but is not meeting the U.S. Top 10% rate on that measure. Measures that are not marked with bullet or asterisk 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 Ransom County and Sargent County are doing better than many counties compared to the rest of the state on all but one of the outcomes for Sargent County and three outcomes for Ransom County, landing at or above rates for other North Dakota counties. However, both counties, like many North Dakota counties, are doing poor in many areas when it comes to the U.S. Top 10% ratings. One particular outcome where Ransom and Sargent Counties do not meet the U.S. Top 10% ratings is the percent of premature deaths.

On *health factors*, Ransom and Sargent Counties perform below the North Dakota average for counties in several areas as well.

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

- poor physical health days
- poor mental health days
- food environment index
- unemployment

- children in poverty
- drinking water violations
- severe housing problems

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

- income inequality

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

- poor or fair health
- low birth weight
- sexually transmitted infections
- uninsured
- diabetic monitoring
- violent crime rate
- injury deaths

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

- premature death
- adult obesity
- physical inactivity
- alcohol-impaired driving deaths
- preventable hospital stays
- mammography screening
- air pollution (particulate matter)

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

- low birth rate
- mental health providers (no data for Sargent County)
- injury deaths
- primary care physicians (no data for Sargent County)

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

- access to exercise opportunities
- dentists

Table 2: Selected Measures from *County Health Rackings 2017* - Dickey County

+ Meeting or exceeding U.S. top 10% performers

***** Not meeting U.S. top 10% performers

• Not meeting North Dakota average

	Ransom County	Sargent County	U.S. Top 10%	North Dakota
Ranking: Outcomes	**30th**	**6th**		**(of 49)**
Premature death	7,400 •*	8,500 •*	5,200	6,600
Poor or fair health	13% *	12% +	12%	13%
Poor physical health days (in past 30 days)	2.8 +	2.7 +	3.0	3.0
Poor mental health days (in past 30 days)	2.7 +	2.5 +	3.0	3.3
Low birth weight	7% •*	4% +	6%	6%
Ranking: Factors	**26th**	**9th**		**(of 49)**
Health Behaviors				
Adult smoking	16% *	16%*	14%	19%
Adult obesity	36% •*	36% •*	26%	31%
Food environment index (10=best)	9.2 +	9.5 +	8.4	8.4
Physical inactivity	28% •*	30% •*	19%	23%
Access to exercise opportunities	71% *	60% •*	91%	66%
Excessive drinking	21% *	24% *	12%	25%
Alcohol-impaired driving deaths	50% •*	67% •*	13%	47%
Sexually transmitted infections	348.9 *	127.2 +	145.5	477.1
Teen birth rate	21 *		17	27
Clinical Care				
Uninsured	9% *	8% +	8%	9%
Primary care physicians	1,820:1 •*		1,040:1	1,280:1
Dentists	1,350:1 *	3,890:0 •*	1,320:1	1,630:1
Mental health providers	2,700:1 •*		360:1	640:1
Preventable hospital stays	73 •*	71 •*	36	46
Diabetic monitoring (% of diabetic Medicare enrollees ages 65-75 that receive HbA1c monitoring)	88% *	94% +	91%	87%
Mammography screening (% of Medicare enrollees ages 67-69 receiving screening)	56% •*	68% •*	71%	69%
Social and Economic Factors				
Unemployment	2.3% +	2.0% +	3.3%	2.7%
Children in poverty	11% +	11% +	12%	12%
Income inequality	3.5 +	3.8 *	3.7	4.4
Children in single-parent households	23% *	24% *	21%	27%
Violent crime	84 *	17 +	62	260
Injury deaths	110 •*	51 +	53	66
Physical Environment				
Air pollution – particulate matter	8.4 •*	8.2 •*	6.7	7.5
Drinking water violations	No +	No +	NA	
Severe housing problems	7% +	5% +	9%	11%

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

Children's Health

The National Survey of Children's Health touches on multiple intersecting aspects of children's lives. Data is not available at the county level; listed below is information about children's health in North Dakota. The full survey includes physical and mental health status, access to quality healthcare, and information on the child's family, neighborhood, and social context. Data is from 2011-12. More information about the survey is found at www.childhealthdata.org/learn/NSCH.

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

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

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

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

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

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

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

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

The data show that Ransom and Sargent Counties are performing more poorly than the North Dakota average on uninsured children below the 200% of poverty. Sargent County is also more poorly than the North Dakota average on uninsured children and licensed childcare capacity.

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

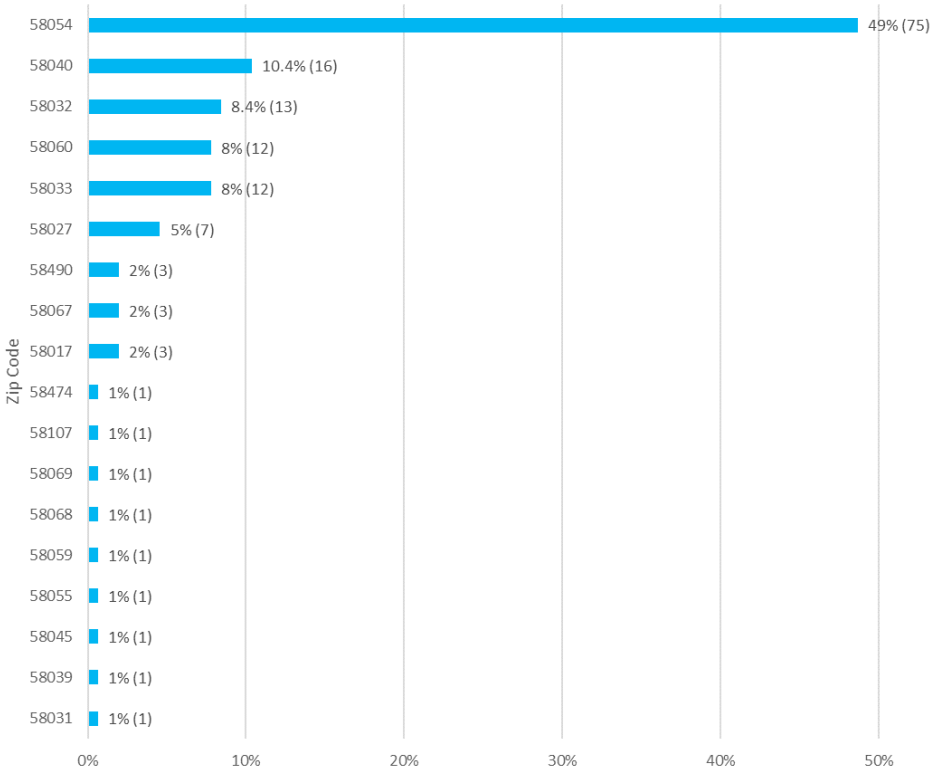
	Ransom County	Sargent County	North Dakota
Uninsured children (% of population age 0-18), 2016	7.3%	9.3%	9.0%
Uninsured children below 200% of poverty (% of population), 2016	44.7%	43.6%	41.9%
Medicaid recipient (% of population age 0-20), 2017	21.0%	23.7%	28.3%
Children enrolled in Healthy Steps (% of population age 0-18), 2013	2.1%	0.3%	2.5%
Supplemental Nutrition Assistance Program (SNAP) recipients (% of population age 0-18), 2017	15.1%	15.8%	20.1%
Licensed childcare capacity (% of population age 0-13), 2018	43.1%	32.9%	41.9%
4-Year High School Cohort Graduation Rate, 2017	94.7%	91.9%	87.0%

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

Survey Results

Of the 281 surveys completed by community members throughout the counties in the CHI Lisbon Health service area, 222 responses were utilized because 59 surveys were removed because people under the age of 18 years completed them. The survey was only for adults in the CHI Lisbon Health service area. The survey requested that respondents list their home zip code. While not all respondents provided a zip code, 154 did, revealing that nearly half of respondents (49%, N=75) lived in Lisbon. These results are shown in Figure 5.

Figure 5: Survey Respondents' Home Zip Code
Total respondents: 154



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

Survey Demographics

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

The demographics of those who chose to complete the survey are as follows:

- 21% (N=36) were age 55 or older, and over half (56%, N=96) being between the ages of 25 to 44 years.
- The majority (83%, N=139) were female.
- Half of the respondents (50%, N=85) had bachelor's degrees or higher.
- The number of those working full time (68%, N=115) was over eight times higher than those who were retired (8%, N=14).
- 96% (N=164) of those who reported their ethnicity/race were white/Caucasian.
- 20% of the population (N=34) had household incomes of less than $50,000.

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

Figure 6: Age Demographics of Survey Respondents
Total respondents = 170

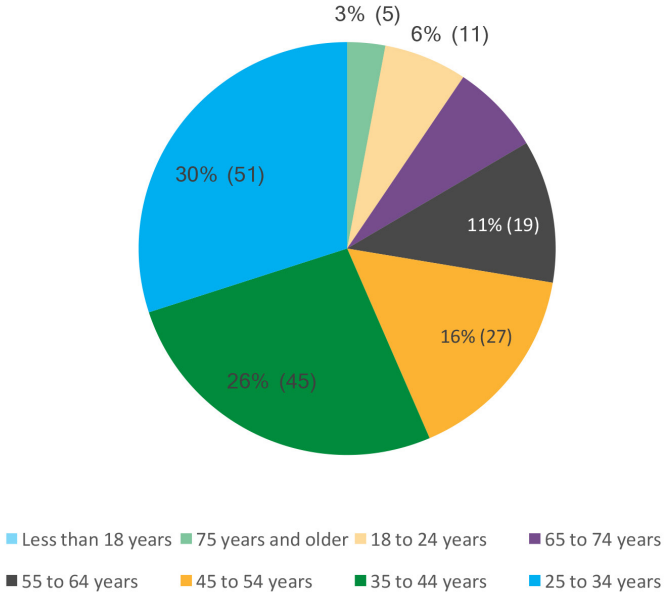


Figure 7: Gender Demographics of Survey Respondents
Total respondents = 374

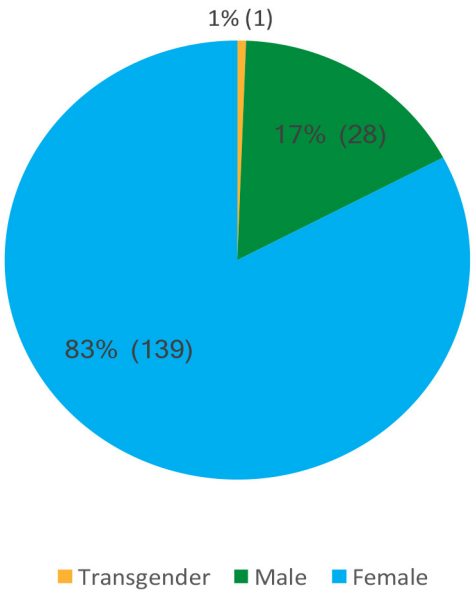


Figure 8: Educational Level Demographics of Survey Respondents
Total respondents = 169

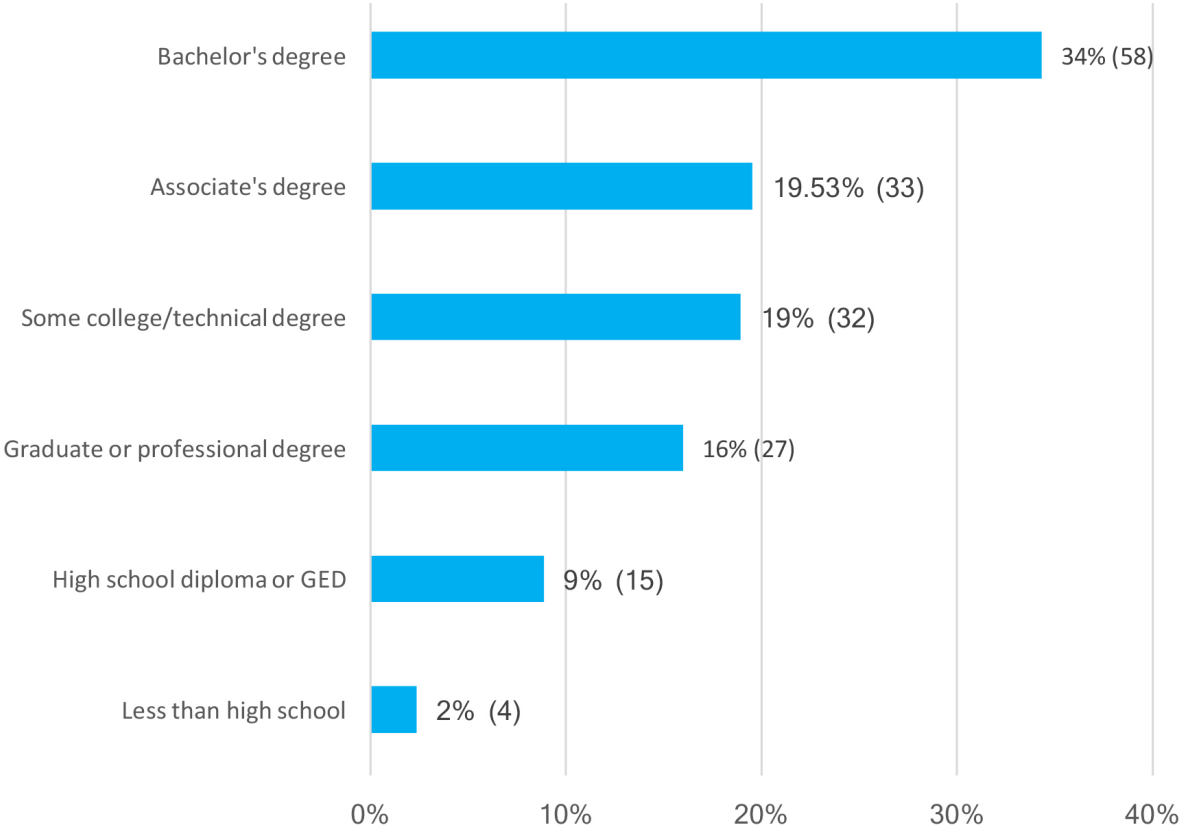
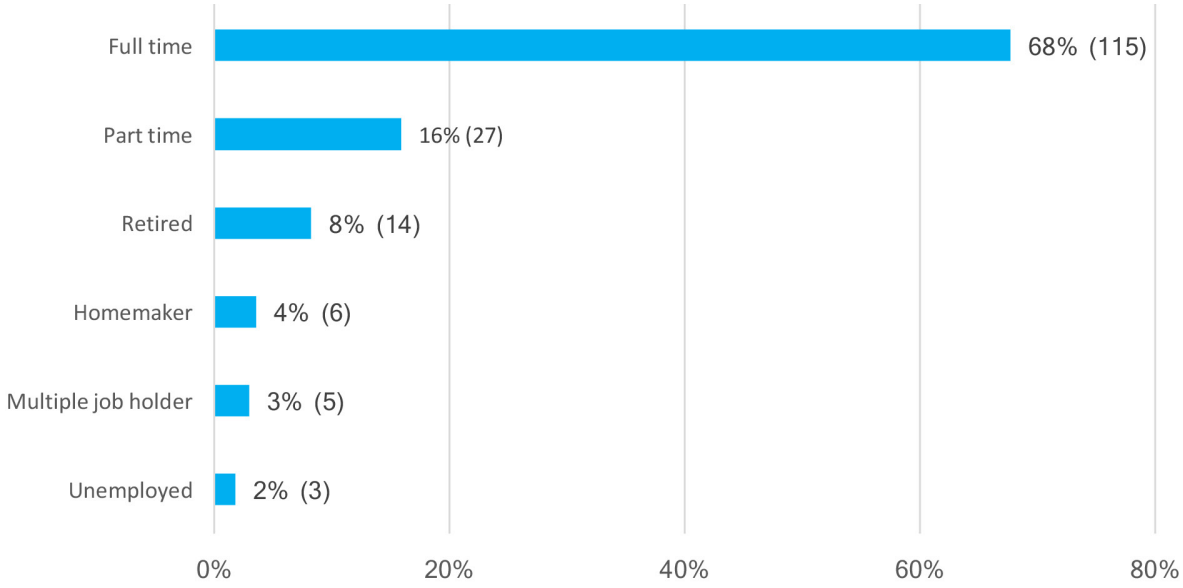
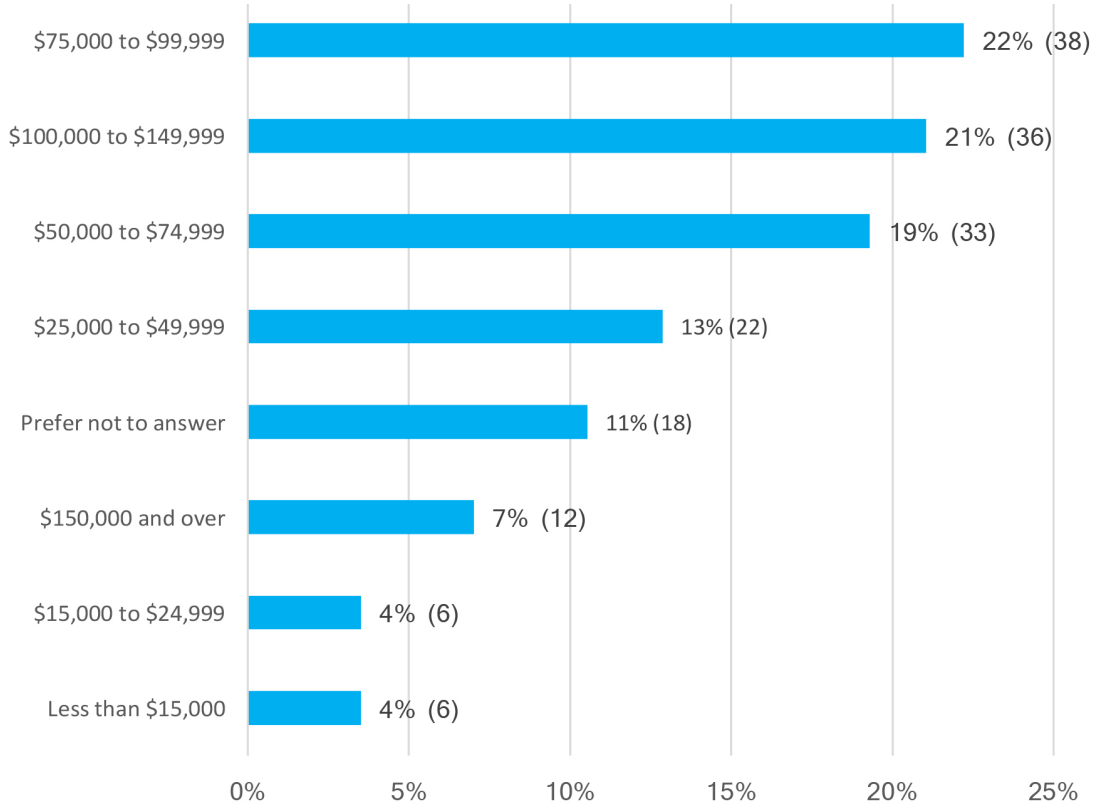


Figure 9: Employment Status Demographics of Survey Respondents
Total respondents = 375



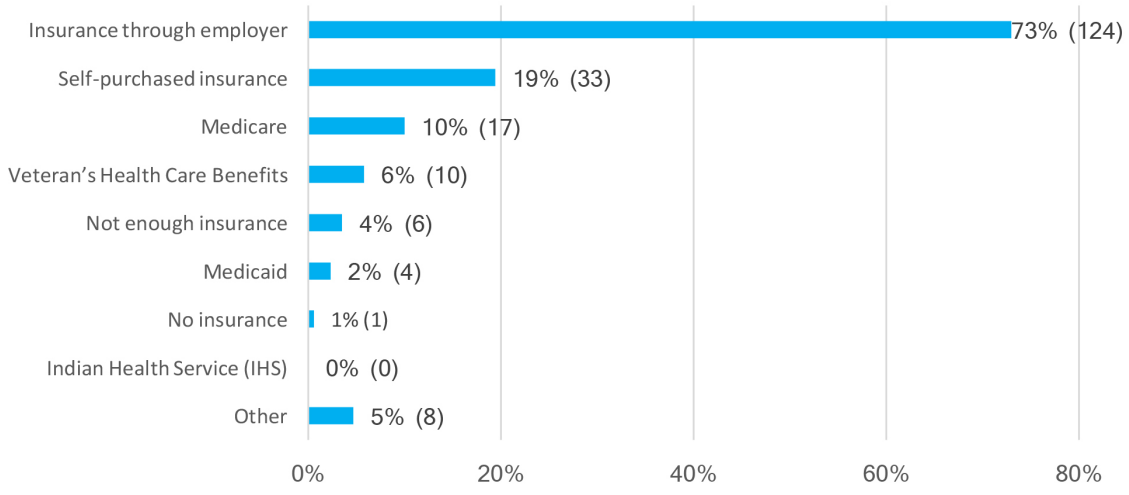
Of those who provided a household income, 8% (N=12) community members reported a household income of less than $25,000. 28% (N=48) indicated a household income of $100,000 or more. This information is show in Figure 10.

Figure 10: Household Income Demographics of Survey Respondents
Total respondents = 171



Community members were asked about their health insurance status, which is often associated with whether people have access to healthcare. 5% (N=7) of the respondents reported having no health insurance or being under-insured. The most common insurance types were insurance through one's employer (N=124), followed by self-purchased (N=33) and Medicare (N=17).

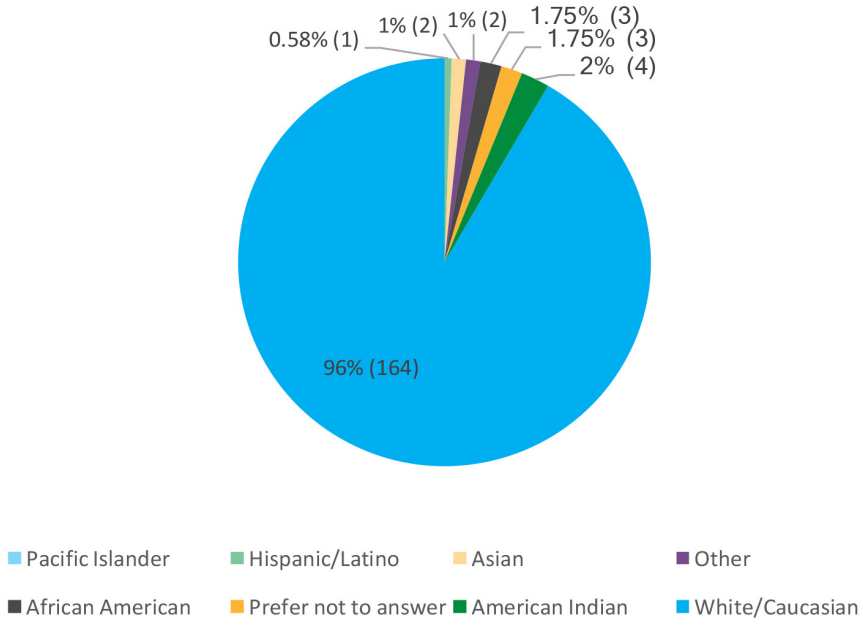
Figure 11: Health Insurance Coverage Status of Survey Respondents
Total respondents = 203



Other sources of insurance covered included Veteran's Health Care Benefits, supplemental insurance, spouse's employer, and on the verge of no health insurance because it is so expensive and their employer doesn't cover it.

As shown in Figure 12, nearly all of the respondents were white/Caucasian (96%). This was in-line with the race/ethnicity of the overall population of Ransom and Sargent Counties; the U.S. Census indicates that 96.2% of the population is white in Ransom County and 94.9% in Sargent County.

Figure 12: Race/Ethnicity Demographics of Survey Respondents
Total respondents = 179



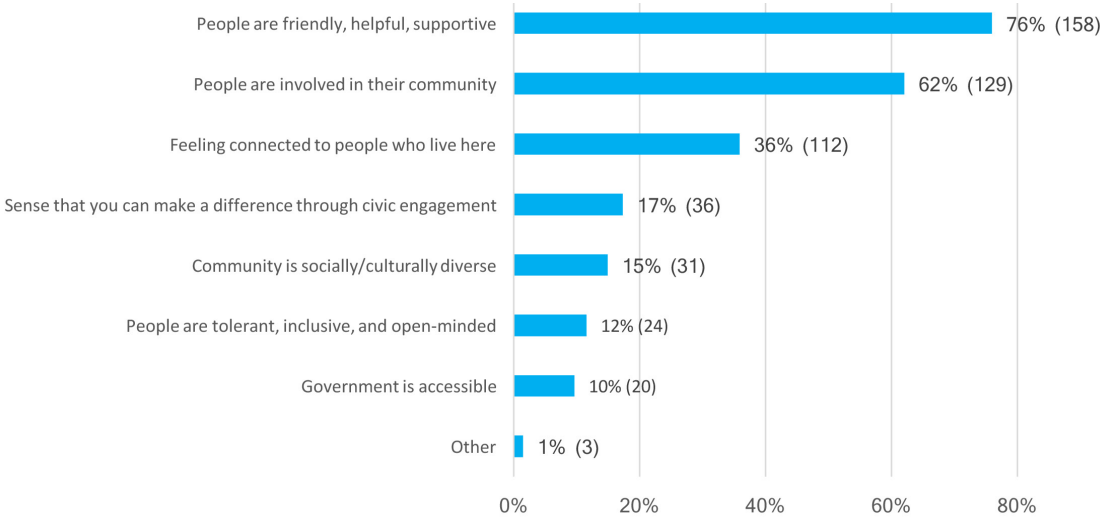
Community Assets and Challenges

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 120 respondents agreeing) that community assets include:

- Family-friendly (N=163);
- People are friendly, helpful, supportive (N=158);
- Safe place to live, little/no crime (N=141);
- People who live here are involved in their community (N=129); and
- Recreational and sports activities (N=122).

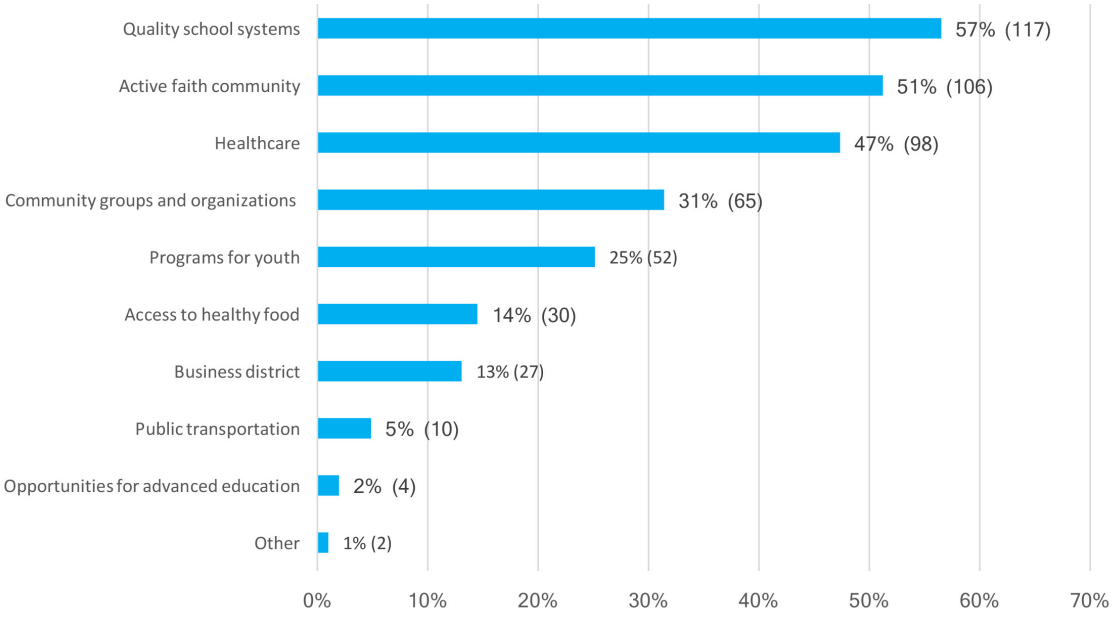
Figures 13 to 16 illustrate the results of these questions.

Figure 13: Best Things about the PEOPLE in Your Community
Total responses = 513



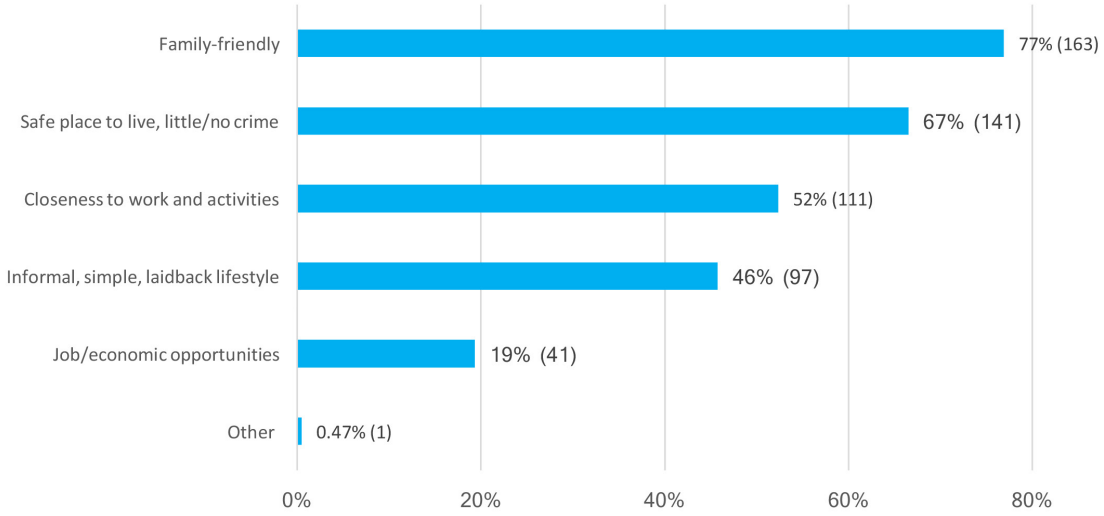
Included in the "Other" category of the best things about the people, were that the community is safe and has low crime.

Figure 14: Best Things about the SERVICES AND RESOURCES in Your Community
Total responses = 511



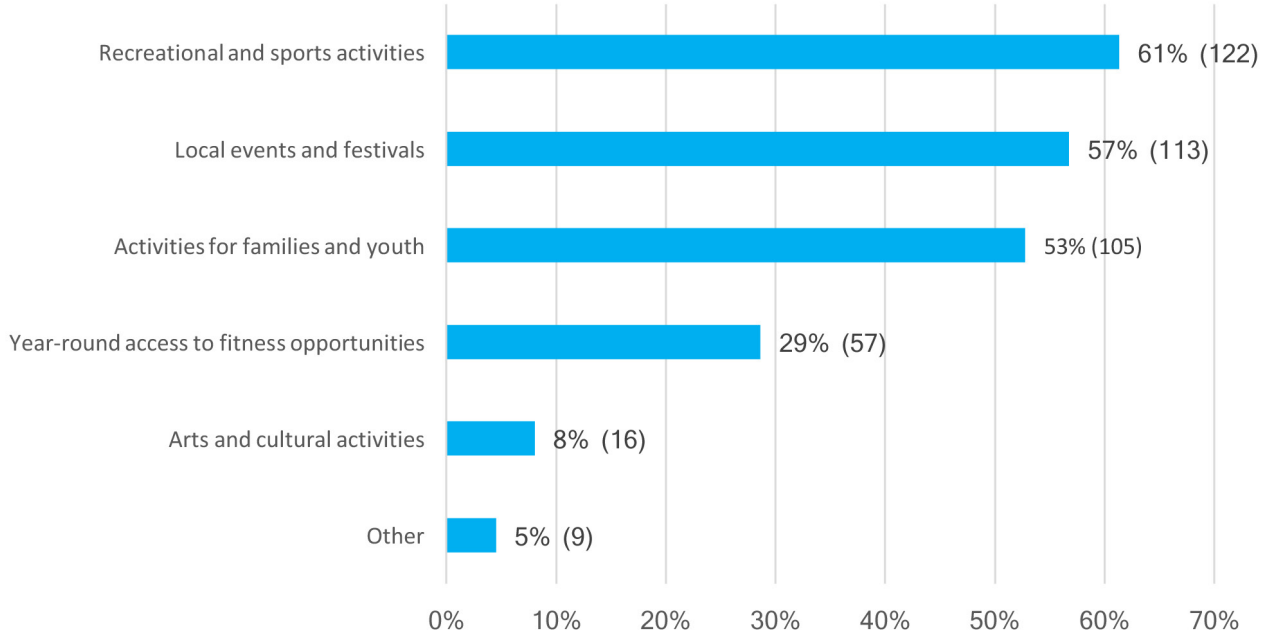
Respondents who selected "Other" specified that the best things about services and resources in the community are the local clinic and hospital care. And they have a grocery store, gas station, and a post office.

Figure 15: Best Things about the QUALITY OF LIFE in Your Community
Total responses = 554



The one "Other" response regarding the best things about the quality of life in the community is quiet.

Figure 16: Best Thing about the ACTIVITIES in Your Community
Total responses = 422



Respondents who selected "Other" specified that the best things about the activities in the community included having a movie theatre, school activities, the Sheyenne River Speedway, church, and roads to ride on.

Community Concerns

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

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

With regard to responses about community challenges, the most highly voiced concerns (those having at least 68 respondents) were:

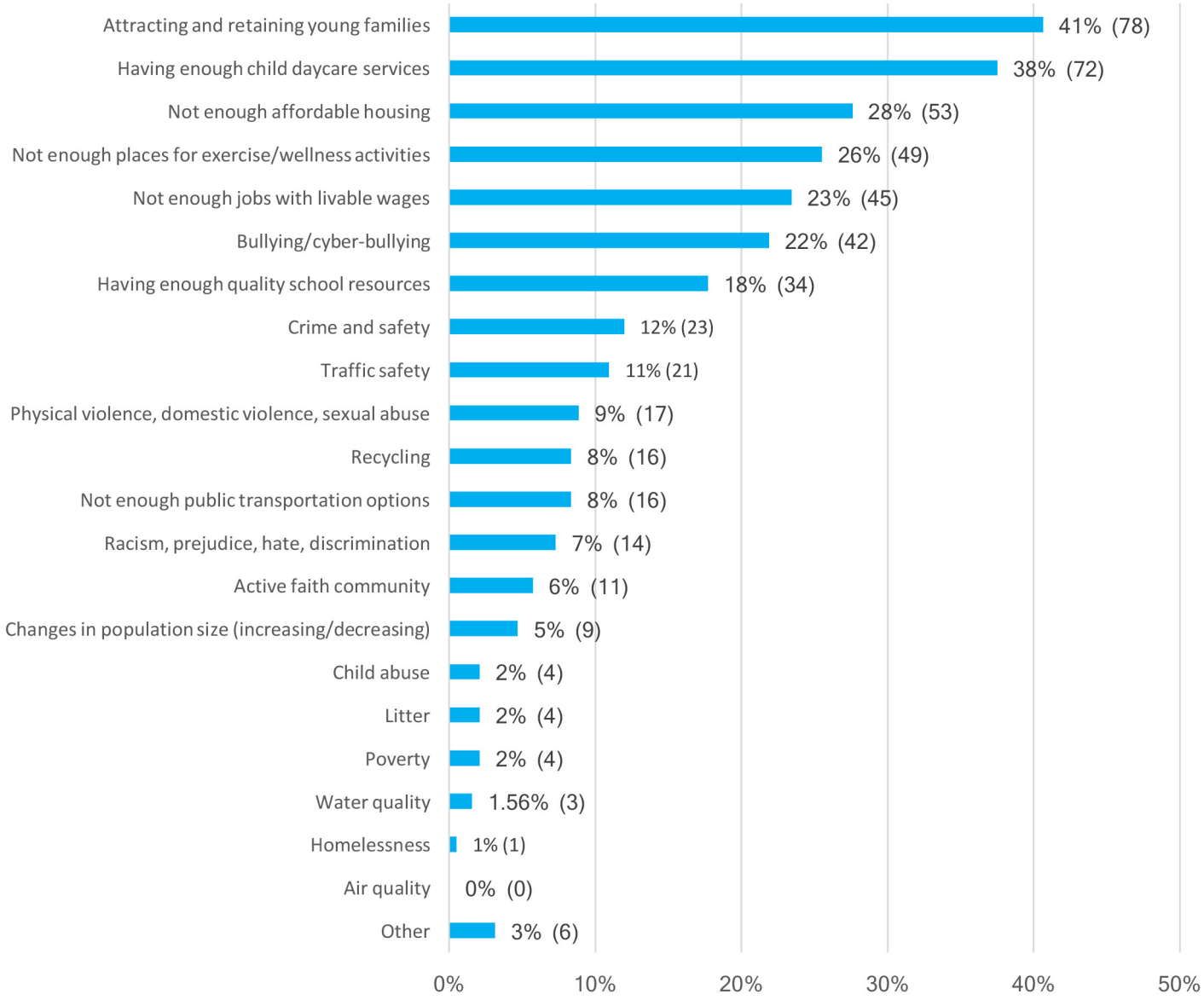
- Drug use and abuse – Youth (N=111);
- Bullying/cyber-bullying (N=109)
- Alcohol use and abuse – Adults (N=87);
- Cost of long-term/nursing home care (N=87);
- Alcohol use and abuse – Youth (N=86);
- Attracting and retaining young families (N=78);
- Having enough child daycare services (N=72);
- Availability of mental health services (N=71);
- Depression/anxiety – Youth (N=70);
- Depression/anxiety – Adult (N=68).

The other issues that had at least 50 votes included:

- Drug use and abuse - Adult (N=66);
- Availability of resources to help the elderly stay in their homes (N=60);
- Emotional abuse (intimidation, isolation, economic abuse) (N=60);
- Child abuse/neglect (N=60);
- Extra hours for appointments (evenings/weekends) (N=59);
- Not enough affordable housing (N=53);
- Not enough activities for children and youth (N=53);
- Not getting enough exercise/physical activity – Adult (N=51); and
- Domestic/intimate partner violence (N=50).

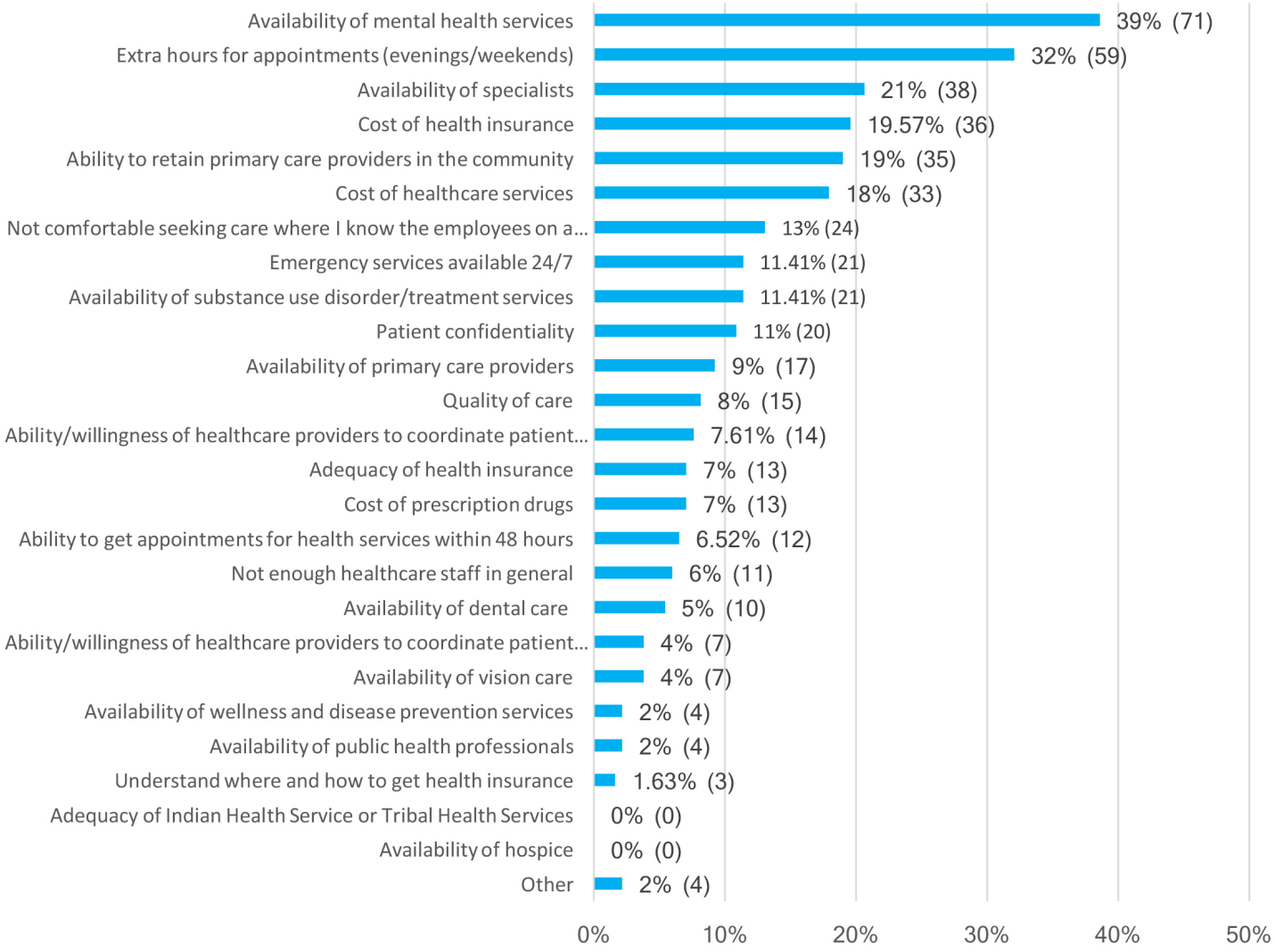
Figures 17 through 22 illustrate these results.

Figure 17: Community/Environmental Health Concerns
Total responses = 522



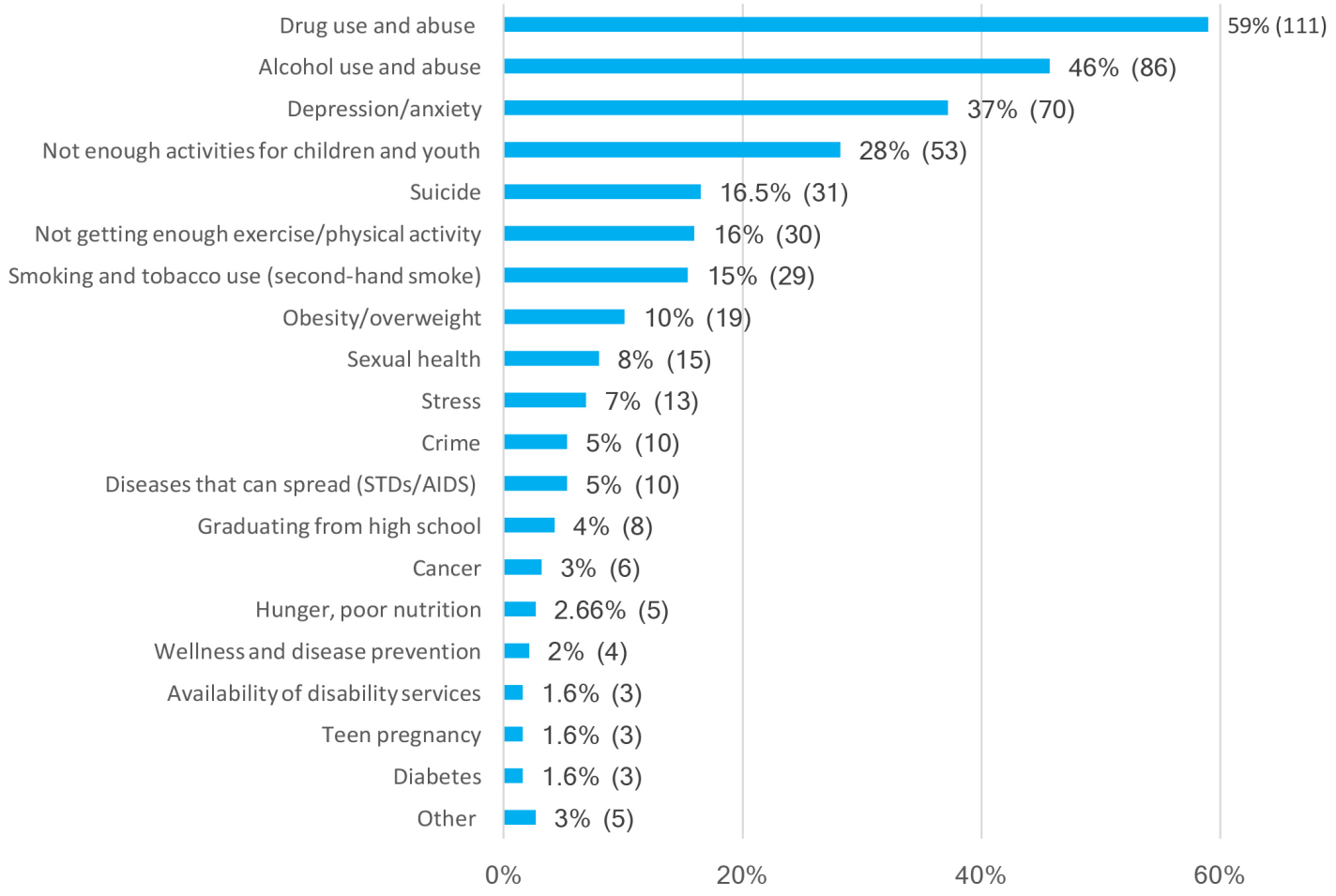
In the "Other" category for community and environmental health concerns, the following were listed: substance abuse problem; the need for more activities or a recreational center, there are not enough restaurants, and walking/bike paths are needed.

Figure 18: Availability/Delivery of Health Services Concerns
Total responses = 492



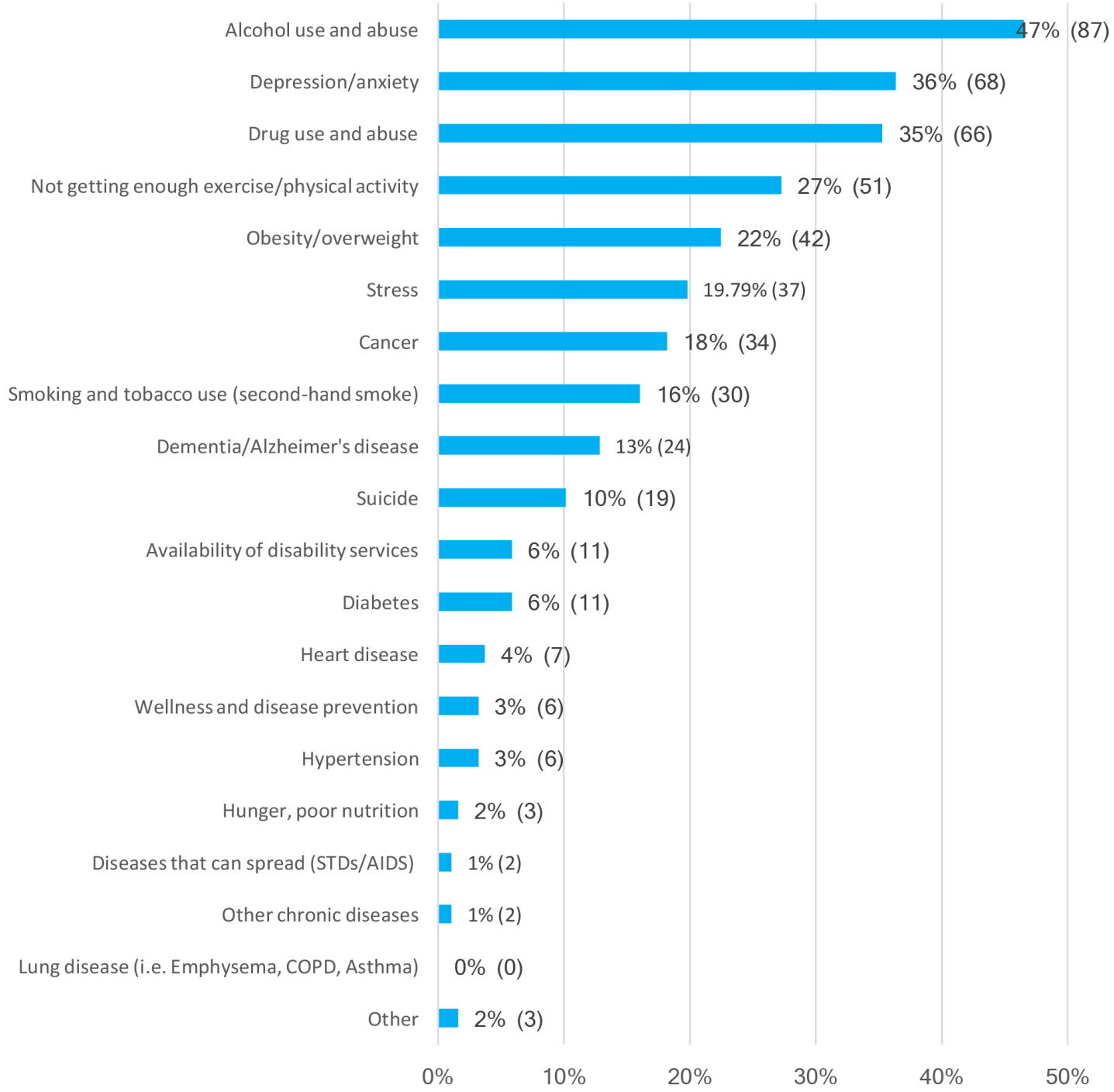
Respondents who selected "Other" identified concerns in the availability of doctors/nurses who are highly qualified with experience, there is no mental health assistance, and a lack of a pharmacy.

Figure 19: Youth Population Health Concerns
Total responses = 514



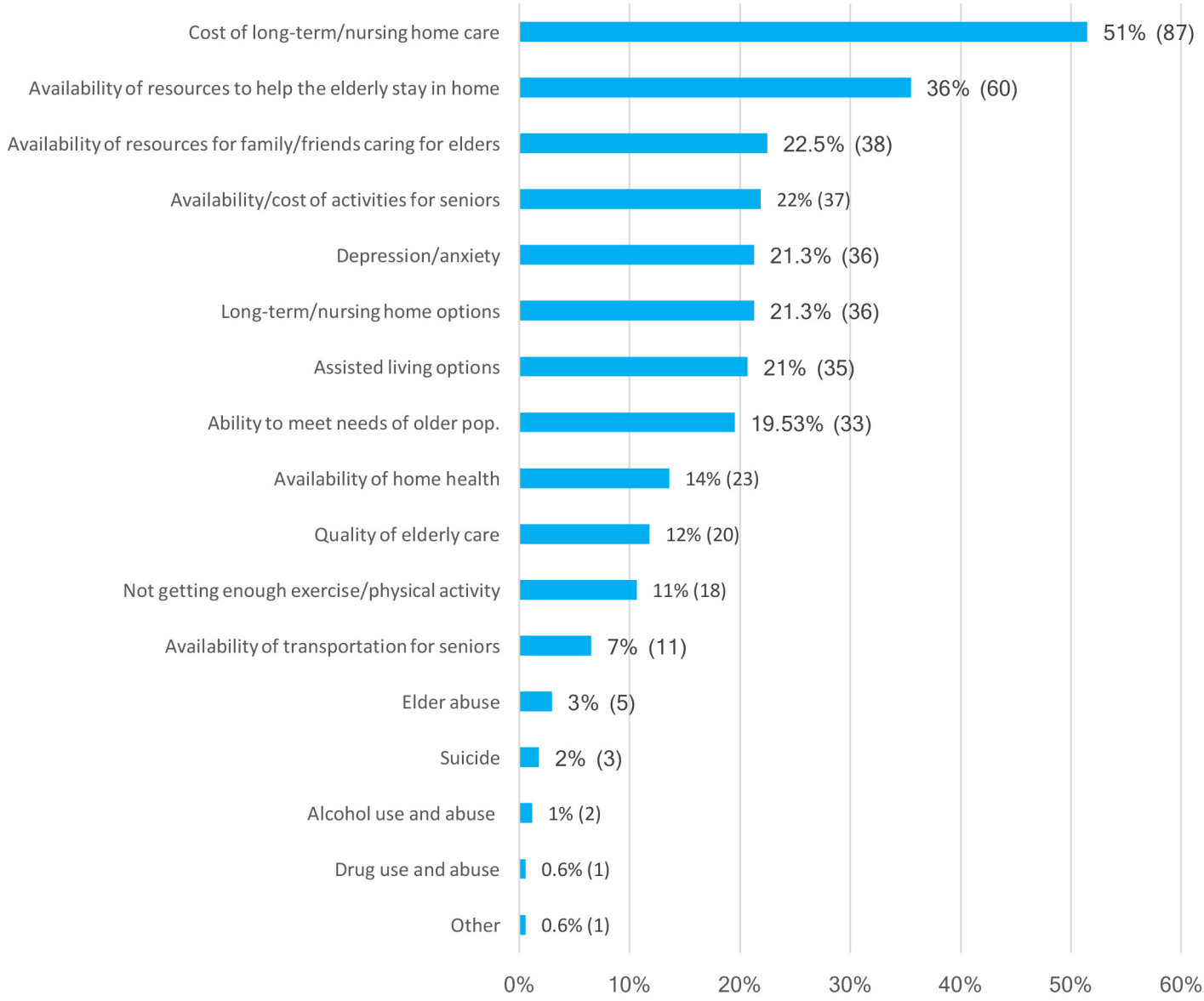
Listed in the "Other" category for youth population concerns were vandalism, cyber gaming addiction, access to mental health professions, bullying, and that there is not enough diversity in things for youth to do if they are not interested in sports.

Figure 20: Adult Population Concerns
Total responses = 509



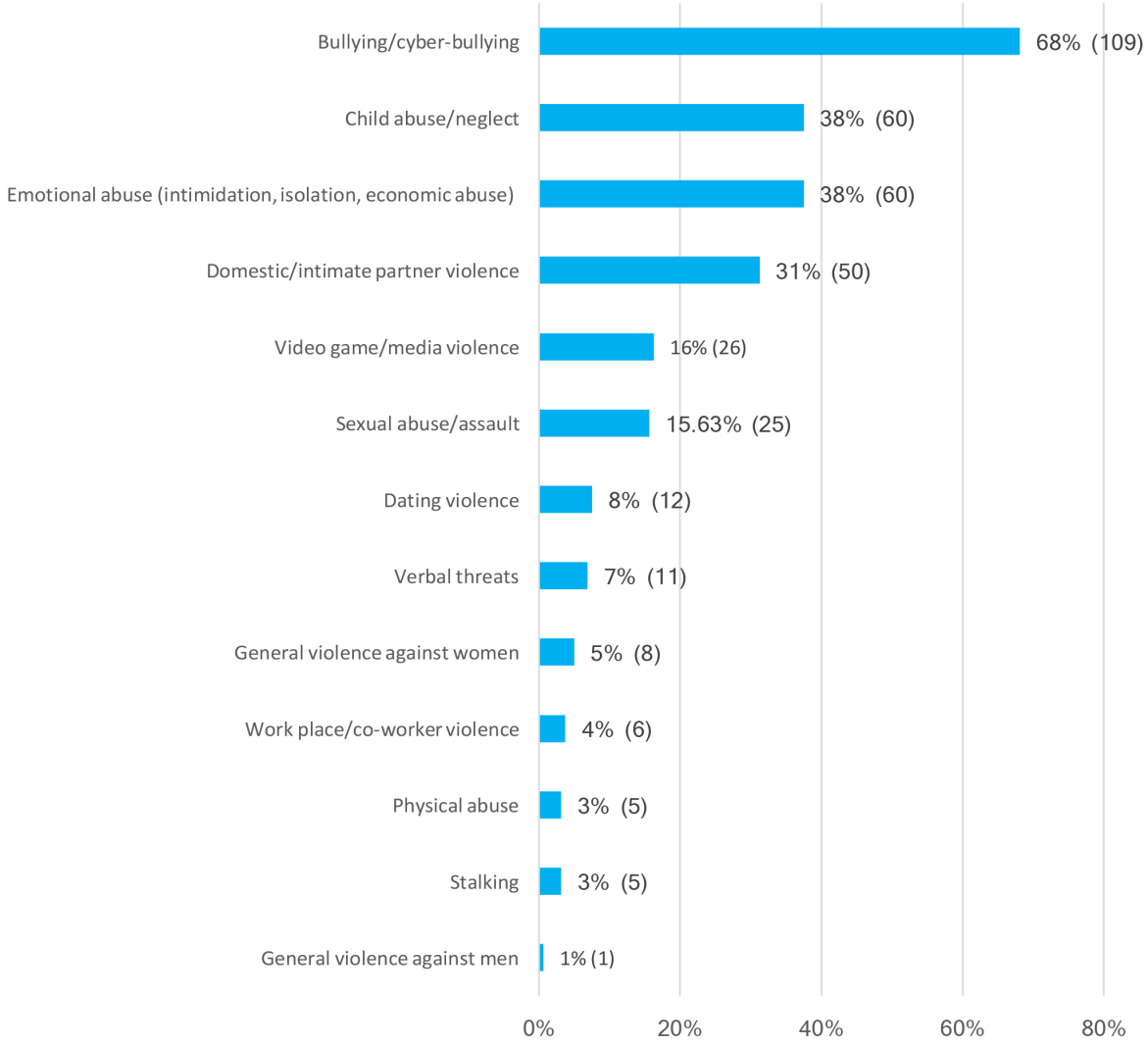
Livable wages (jobs with health insurance) and access to mental health professionals were indicated in the "Other" category for adult population concerns.

Figure 21: Senior Population Concerns
Total responses = 446



In the "Other" category, the one response indicated that activities available for seniors were a concern.

Figure 22: Violence Concerns
Total responses = 378



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

1. Drug abuse;
2. Availability of affordable mental health services.

Other biggest challenges identified were:

- Acceptance
- Activities for senior citizens
- Activities for youth who aren't interested in sports
- Adequate jobs
- Affordable housing
- Alcohol abuse
- Bullying
- City council members lack leadership skills
- Community exercise facility
- Disappearing small businesses
- Healthcare quality
- Lack of quality day care
- Need more restaurants open for supper

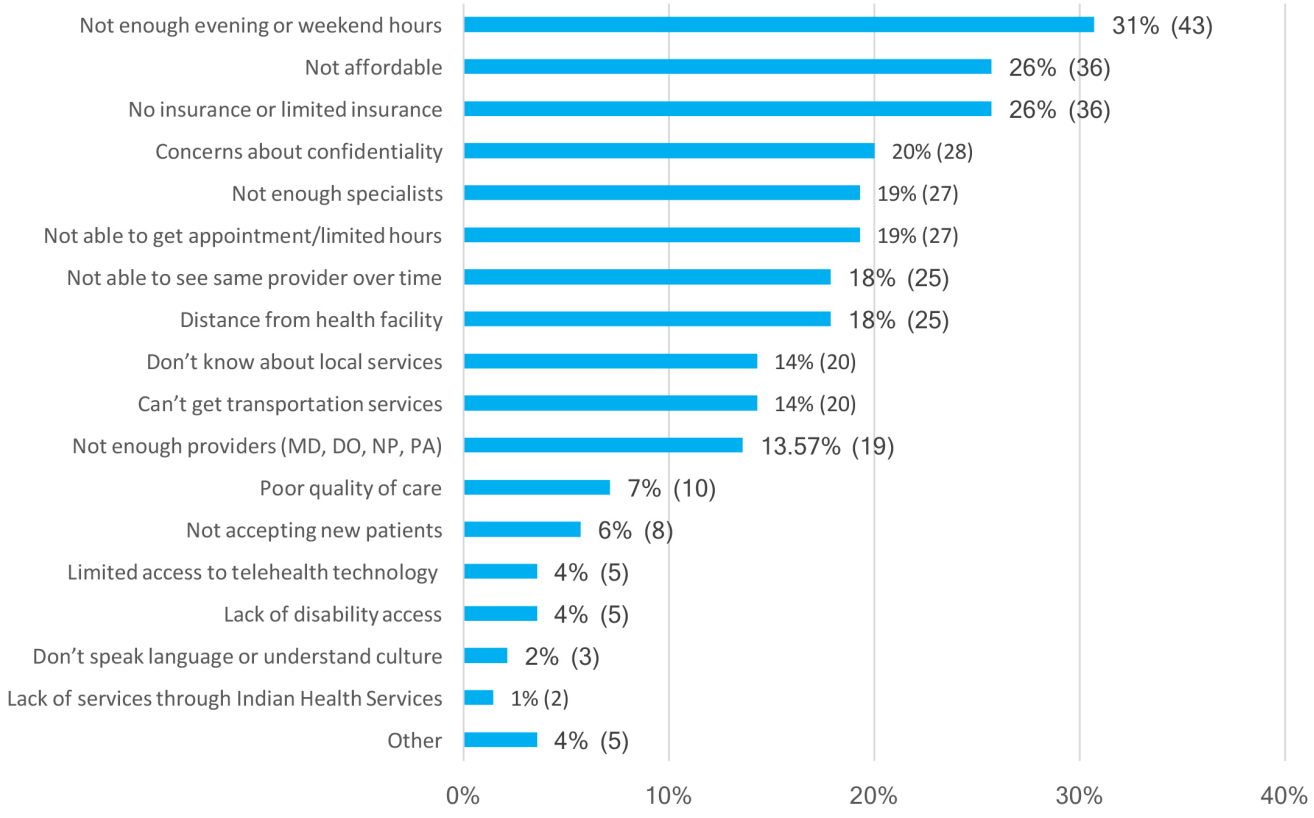
- No young families
- Population decline
- Retaining a full time physician
- Road construction
- Sexual harassment
- Suicide, depression
- Volunteerism/participation/apathy

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 or weekend hours (N=43), with the next highest being no insurance or limited insurance (N=36) and not affordable (N=36). After these, the next most commonly identified barriers were concerns about confidentiality (N=28), not able to get an appointment/limited hours (N=27), and not enough specialists (N=27). The concerns indicated in the "Other" category were hours for the clinic not being advertised, no pharmacy, insurance doesn't cover CHI, know the providers on a personal level, lack of qualified doctors with experience, and lack of updated medical technology.

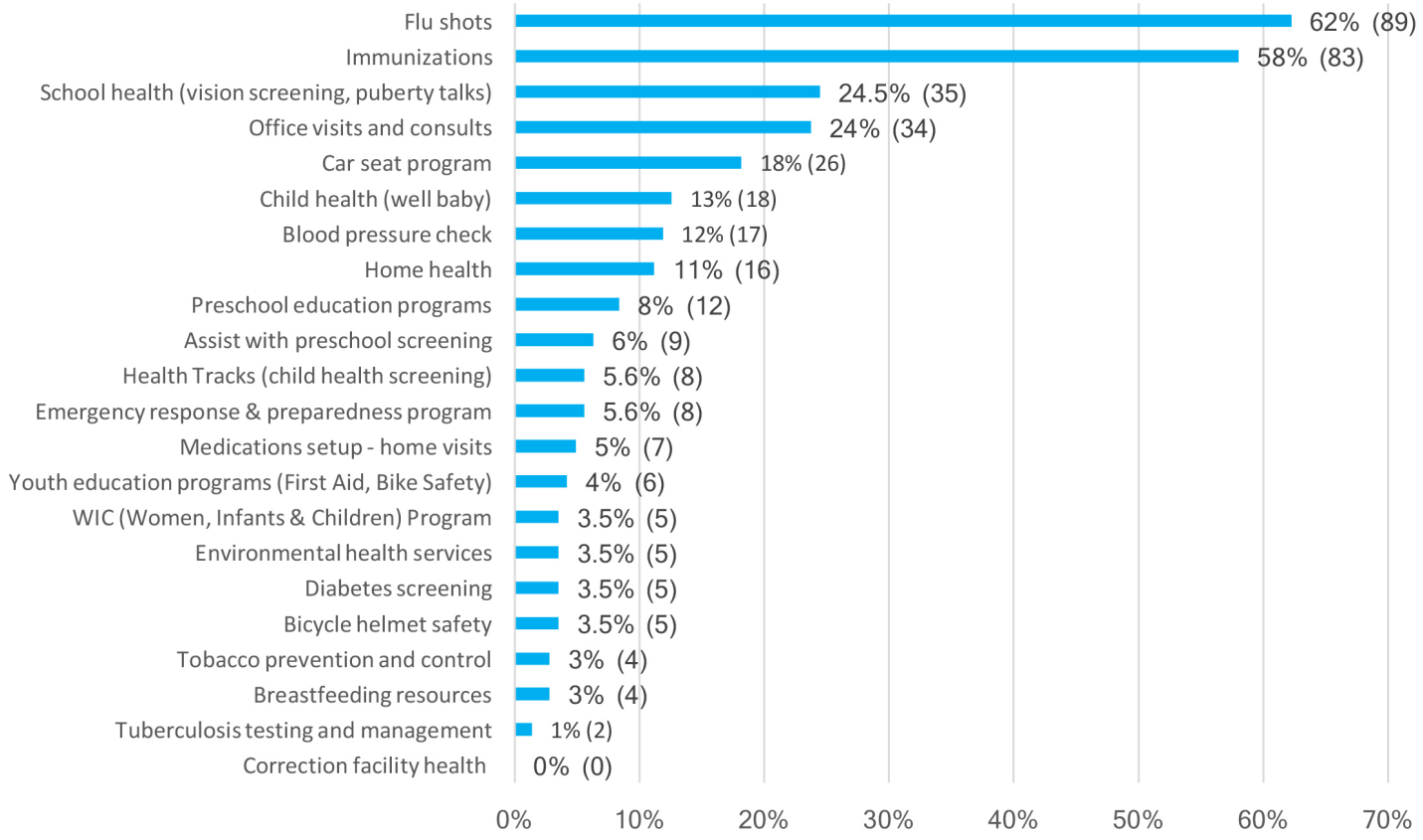
Figure 23 illustrates these results.

Figure 23: Perceptions about Barriers to Care
Total responses = 344



Considering a variety of healthcare services offered by the local public health units, respondents were asked to indicate if they or a family member had used their services in the past year (see Figure 24). Flu shots and immunizations were the highest utilized public health services.

Figure 24: Awareness and Utilization of Public Health Services



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/substance abuse services. Other categories of healthcare services requested included:

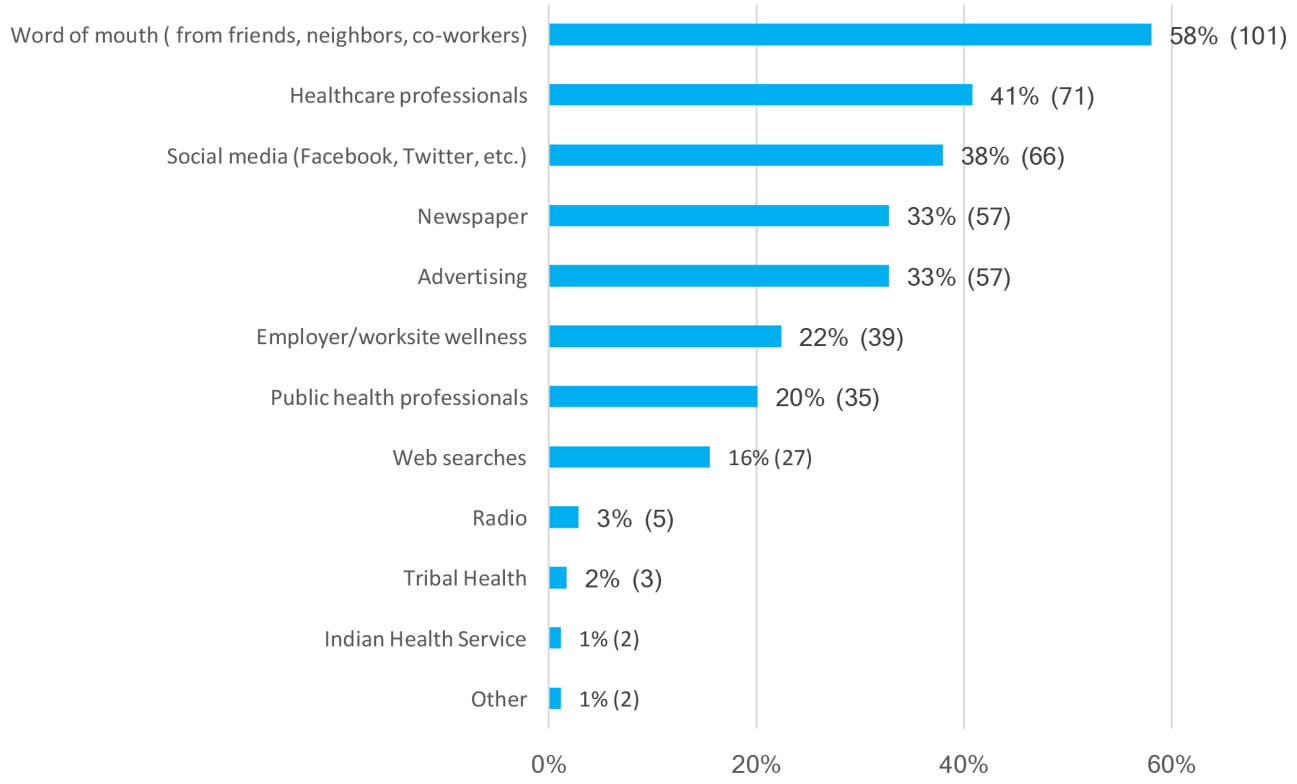
- Financial consultant for family caring for relative in nursing home
- Dental care
- Dermatology
- Exercise facility/Wellness Center
- Longer/extended clinic hours
- Naturopathic doctor
- OB/GYN
- Orthopedics
- Pediatrics
- Sleep studies
- More specialists
- Pharmacy
- Transportation for patients to appointments
- Walk-in services/Urgent care

The key informant and focus group members listed psychiatry for inpatient/outpatient and obstetrics as services they thought CHI Lisbon Health should add locallly. For public health, it was recommended that family planning be added as a service in Sargent County. Ransom County currently provides this service. Additional public health services they wanted to see added included a lifeline system (alert system they wear a button and it calls 911 if needed, available 24/7) and more alcoholics anonymous/support group and drugs anonymous/support groups.

A full list of specific healthcare services requested by respondents in the survey is in Appendix D.

Survey respondents were asked where community members find out about local health services. The top response was word of mouth, with 58% (N=101) selecting that option (see Figure 25).

Figure 25: Find Local Health Services



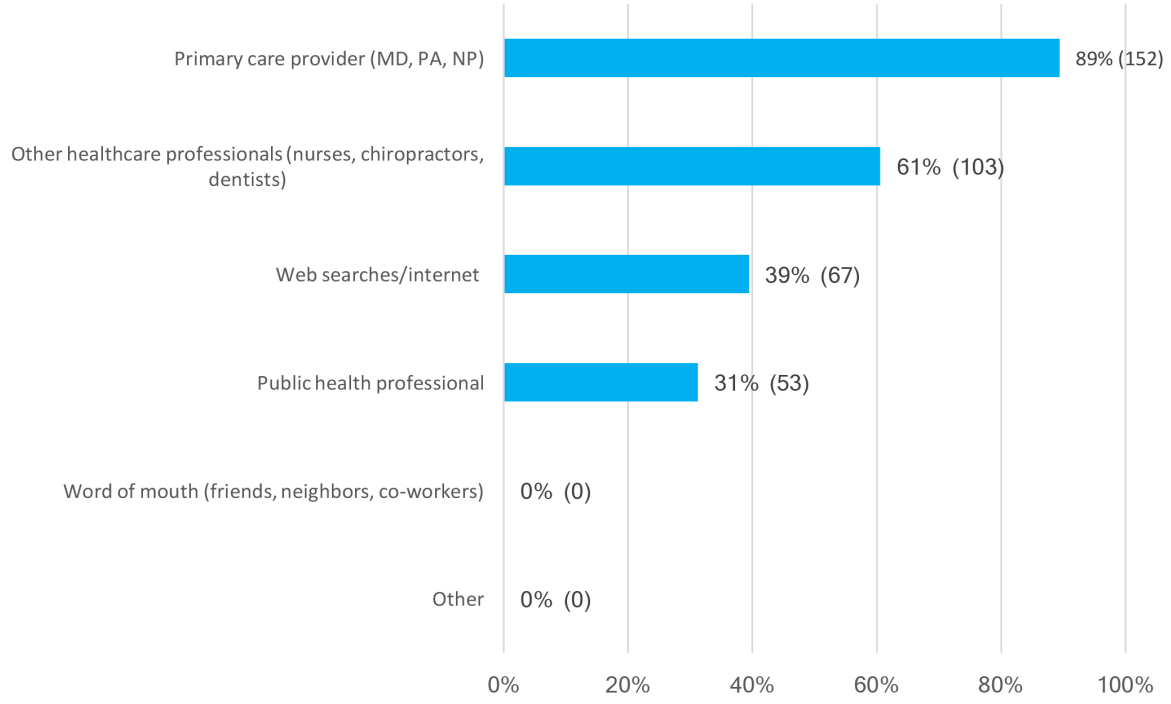
In the "Other" category, Google was indicated.

The key informant and focus group members felt that the community members were mostly aware of the health system and public health services available in the area. They reported that the clinic and the hospital's Facebook page has done a good job of promoting their services to the younger generation. Public Health does a good job of promoting the services when they are in people's homes. They felt CHI Lisbon Health would benefit by increasing marketing of the following services: surgeries performed locally; the clinic, radiology, and physicals and other services through social media; Avera telemedicine services; cardiac rehab services; and sleep studies.

Respondents were asked where they go for trusted health information. Primary care providers (N=152) received the highest response rate, followed by other healthcare professionals (N=103), and then web/Internet searches (N=67).

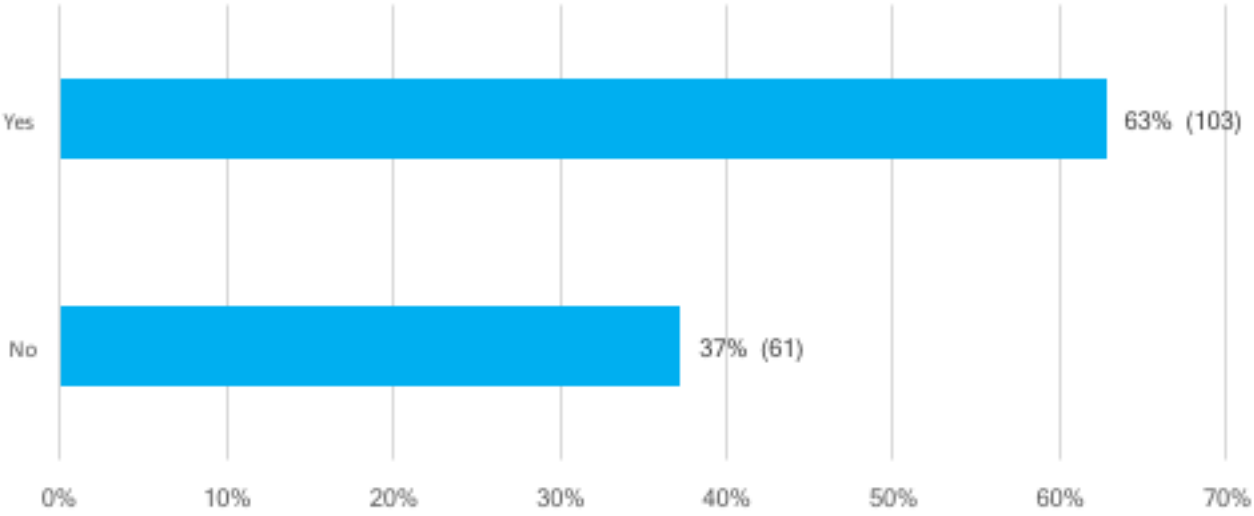
Results are shown in Figure 26.

Figure 26: Sources of Trusted Health Information
Total responses = 375



Respondents were asked if they are aware of the CHI Lisbon Health Foundation, which exists to financially support CHI Lisbon Health. Nearly two-thirds of respondents indicated they were aware of the Foundation (see Figure 27).

Figure 27: Awareness of the CHI Lisbon Health Foundation
Total responses = 164



The final question on the survey asked respondents to share concerns and suggestions to improve the delivery of local healthcare. The majority of responses focused on concern with the lack of providers, the lack of mental health services available locally, and more clinic hours.

There is a need for additional providers that are available for appointments. Additionally, there needs to be better retention of providers so they stay for more than a year or two. It was indicated that communication between providers within the health facilities needs to be improved. There was need for specialists (even visiting once a month) and pediatricians expressed in the comments.

A suggestion was made to provide tuition reimbursement or some incentive so the community can have a shared mental health counselor that accepts Medicaid. Many patients can't afford driving to Fargo for outpatient counseling.

It was expressed by many respondents that they would like extended clinic hours and weekend hours. The hours of the local clinic vary by day and the providers available vary by day. It is felt that more clinic hours would reduce the usage of the emergency room. The increased hours would be very beneficial for off shift bobcat employees. They would also like to see the Gwinner clinic open five days a week instead of a few half days.

It is believed by some that the lack of affordable housing, daycare, amenities such as restaurants, good paying jobs, mental health services, the increase in overall living expenses, and drug activity in this area is resulting in a population decrease. There needs to be mentoring programs for children, summer camps, and more learning opportunities available. In addition, more daycares are needed.

One respondent indicated they have been very impressed with the quality of healthcare for themselves and their family's needs in the area. However, the cost of healthcare even with insurance is, and has always been, an issue. If it is costing someone that has a good insurance policy this much, what about those who are without good health insurance. Several respondents cited lack of affordable health insurance as an issue.

There is a need for more accessibility and pharmacy options in Milnor. When you're sick the last thing you want to do is drive a 50 mile (or more) round trip to fill a prescription.

It was stated that people who work for the hospital or clinic deserve to be appreciated. The services are available, but the community needs to promote and assist these resources to make sure they are utilized. If additional services are needed, people need to work with the facilities to obtain the needed services.

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 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 the community meeting can be grouped into five categories (listed in alphabetical order):

- Alcohol and drug use and abuse (including prescription drug abuse)
- Availability of mental health and substance use disorder treatment services
- Lack of child daycare services
- Need for preventative wellness/increased physical activity
- Senior living options

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

Alcohol and Drug use and abuse (including prescription drug abuse)

- Top concern is addressing alcohol abuse in both adults and youth.
- Alcohol is always a problem in our community.
- Alcohol use and abuse in adults and youth is the biggest concern. In a small community it is more common. People don't understand the dangers and think they are invincible.
- Drug use and abuse for adults, children, and elderly
- Kids that aren't involved in activities or don't have parents involved in things have nothing to do – they feel like an outcast. May turn to drugs and alcohol abuse if they aren't able to find other activities to be involved in.
- There is more awareness now that this is a problem.
- Drug abuse has gotten out of hand. People move to the smaller areas/fringes where there isn't a school or significant law enforcement presence.

Availability of mental health and substance use disorder treatment services

- Availability of mental health services is the most important concern.
- Need to utilize mental health therapy services – Abound Counseling out of Fargo travels to Lisbon every Thursday. People don't have to travel to Fargo for the initial assessment.
- Mental health always comes up. If you try to really get down to the root cause of the concern, what is the problem and what can we do about it? Many say they don't feel there are enough counseling services. Where are they, who do they serve, what kinds of things do they address? Would be wonderful to have a psychiatrist that could be here or is there something that Human Services does and they need to be more visible? Many people can't afford to go to Fargo for services once a week for care.
- Mental health/substance abuse – more aware now that it is a problem, so there is an effort to make it better, but there is a lot to do. The governor's efforts are helping to raise awareness.

Lack of child daycare services

- Don't have enough quality daycare. Get stuck going to whoever has an opening.

Need for preventative wellness/increased physical activity

- Need to promote and encourage physical activity - increase physical activity, less screen time, more volunteering.
- If all the communities could come together and build an indoor pool. There are a lot of kids that don't play sports and adults that don't want to walk on a treadmill. Especially in the winter.

Senior living options

- People avoid going into a nursing home because of the cost, but they don't have the ability to safely stay in their homes.
- Services must be from outside of the community coming in – there isn't respite care within the community. Many of these people probably should be in the home at this point but won't go until something forces them to. Their family member can't take care of them as well as they want. Home health and home care can't go in 24 hours per day.

Community Engagement and Collaboration

Key informants and focus group participants were asked to weigh in on community engagement and collaboration of various organizations and stakeholders in the community. Specifically, participants were asked, "On a scale of 1 to 5, with 1 being no collaboration/community engagement and 5 being excellent collaboration/community engagement, how would you rate the collaboration/engagement in the community among these various organizations?" This was not intended to rank services provided. They were presented with a list of 13 organizations or community segments to rank. According to these participants, the hospital, pharmacy, public health, and other long-term care (including nursing homes/assisted living) are the most engaged in the community. The averages of these rankings (with 5 being "excellent" engagement or collaboration) were:

- Hospital (5)
- Public Health (5)
- Business and industry (4)
- Clinics not affiliated with the main health system (4)
- Economic development organizations (4)
- Emergency services, including ambulance and fire (4)
- Faith-based organizations (4)
- Law enforcement (4)
- Long term care, including nursing homes and assisted living (4)
- Pharmacies (4)
- Schools (4)
- Social Services (4)
- Human services agencies (3.5)
- Other local health providers, (i.e. dentists and chiropractors) (3)

Priority of Health Needs

A Community Group met on November 20, 2018. Seventeen community members attended the meeting. Representatives from the CRH presented the group with a summary of this report's findings, including background and explanation about the secondary data, highlights from the survey results (including perceived community assets and concerns, and barriers to care), and findings from the key informant interviews.

Following the presentation of the assessment findings, and after considering and discussing the findings, all members of the group were asked to identify what they perceived as the top four community health needs. All of the potential needs were listed on large poster boards and each member was given four stickers to place next to each of the four needs they considered the most significant. There were two concerns that had the highest number of votes and a five-way tie. Each attendee was given an additional sticker to vote on just the five items that tied in order to indentify the top four concerns.

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

- Availability of mental health services (14 votes)

- Depression and anxiety in adults (6 votes)
- Depression and anxiety in youth (5 votes initially, tie-breaker resulted in 11 votes)

Note: for the final voting on the most significant need, depression and anxiety in adults and depression and anxiety in youth were combined into one category – Depression and anxiety (all ages)

- Drug use and abuse in youth (5 votes initially, tie-breaker resulted in 10 votes)
- Attracting and retaining young families (5 votes initially, tie-breaker resulted in 9 votes)
- Having enough child daycare services (5 votes initially, tie-breaker resulted in 0 votes)

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

1. Availability of mental health services (11 votes)
2. Attracting and retaining young families (3 votes)
3. Depression and anxiety (all ages) (3 votes)
4. Drug use and abuse in youth (0 votes)

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

Comparison of Needs Identified Previously

Top Needs Identified 2016 CHNA Process	Top Needs Identified 2019 CHNA Process
• Obesity, poor nutrition, and inactivity • Mental health services • Violence prevention • Cost of healthcare • Access and cost of childcare and infant care • Bullying	• Availability of mental health services • Attracting and retaining young families • Depression and anxiety (all ages) • Drug use and abuse in youth

The current process identified one identical common need from 2016, the availability of mental health services. This ranked as the top need for 2019 in the CHI Lisbon Health service area for this CHNA cycle. This is a common need found throughout the state and the nation.

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

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

Obesity, Poor Nutrition and inactivity: The community was concerned with the obesity rate, poor nutrition and amount of inactivity of the residents. The goal was to decrease obesity by 3%. A grant was written to collaborate with local organizations to provide education on nutrition and healthy choices. The grant was not secured. Funding options were also explored to implement a walking path. No funds were secured. CHI Lisbon Health sponsored water stations at one 5k race and one triathlon. Nurse practitioner, Sierra DeVries presented on preventative health and making good choices.

Violence Prevention: The community was concerned with the prevalence of violence. The goal was to decrease reported incidents of personal violence by 20%. Grant money was secured through CHI Mission and Ministry. This grant money allowed CHI Lisbon Health to collaborate with Abuse Resource Network to provide education to the community using two evidence based curriculums. The first curriculum, Futures reached 27 community leaders and 197 professional people. Seven people have been trained to teach the second curriculum, Within My Reach. There have been 17 events held, reaching 327 people. A violence prevention coalition has also been formed. They meet quarterly to discuss the success of these two programs. The coalition also acts as a liaison between the community and the trainers of the curriculums.

Mental Health: The community was concerned with mental health and caring for patients with addictions and mental health needs. A mental health coalition was formed in collaboration with law enforcement, ambulance staff, state and city attorneys, South East Human Service Center, and Prairie St. John's. The focus of the group was to address obstacles that prevent patients with mental health and addiction concerns from getting the help they require. The concept of a "safe room" for mental health was explored. Five CHI staff members were trained in "Mental Health First Aid". CHI nursing staff received "Handle With Care" training provided by Prairie St. Johns.

The above implementation plan for CHI Lisbon Health is posted on the CHI St. Alexius Health's website at http://www.lisbonhospital.com/chna-report.htm.

Next Steps – Strategic Implementation Plan

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

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

Community Benefit Report

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

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

their commitment to community service through organized and sustainable community benefit programs providing:

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

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

What Are Community Benefits?

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

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

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

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

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

Appendix A – CHNA Survey Instrument

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

CHI Lisbon Health
Imagine better health.℠

Public Health
Prevent. Promote. Protect.
Sargent County
District Health Unit

Public Health
Prevent. Promote. Protect.
Ransom County Public Health

Lisbon Area Health Survey

CHI Lisbon Health, Sargent County District Health Unit, and Ransom County Public Health are interested in hearing from you about community health concerns.

The focus of this effort is to:

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

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

Scan here to take the survey

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 September 17, 2018. 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
- ☐ Cancer
- ☐ Diabetes
- ☐ Depression/anxiety
- ☐ Stress
- ☐ Suicide
- ☐ Not enough activities for children and youth
- ☐ Teen pregnancy
- ☐ Sexual health
- ☐ Diseases that can spread, such as sexually transmitted diseases or AIDS
- ☐ Wellness and disease prevention, including vaccine-preventable diseases
- ☐ Not getting enough exercise/physical activity
- ☐ Obesity/overweight
- ☐ Hunger, poor nutrition
- ☐ Crime
- ☐ Graduating from high school
- ☐ Availability of disability services
- ☐ Other (please specify) _____

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

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

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

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

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

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

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

_____

_____

Delivery of Healthcare

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

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

13. Which of the following **SERVICES** provided by your local **PUBLIC HEALTH** unit have you or a family member used in the past year? (Choose ALL that apply)

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

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

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

15. 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) _____

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

_____

_____

17. Are you aware of the CHI Lisbon Health Foundation, which exists to financially support CHI Lisbon Health?

☐ Yes ☐ No

Demographic Information: Please tell us about yourself.

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

☐ Yes ☐ No

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

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

20. 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

21. 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

22. Gender:

- ☐ Female
- ☐ Male
- ☐ Transgender

23. Employment status:

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

24. Your zip code: _____

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

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

26. Annual household income before taxes:

- ☐ Less than $15,000
- ☐ $15,000 to $24,999
- ☐ $25,000 to $49,999
- ☐ $50,000 to $74,999
- ☐ $75,000 to $99,999
- ☐ $100,000 to $149,999
- ☐ $150,000 and over
- ☐ Prefer not to answer

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

_____

_____

Thank you for assisting us with this important survey!

Appendix B – County Health Rankings Explained

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

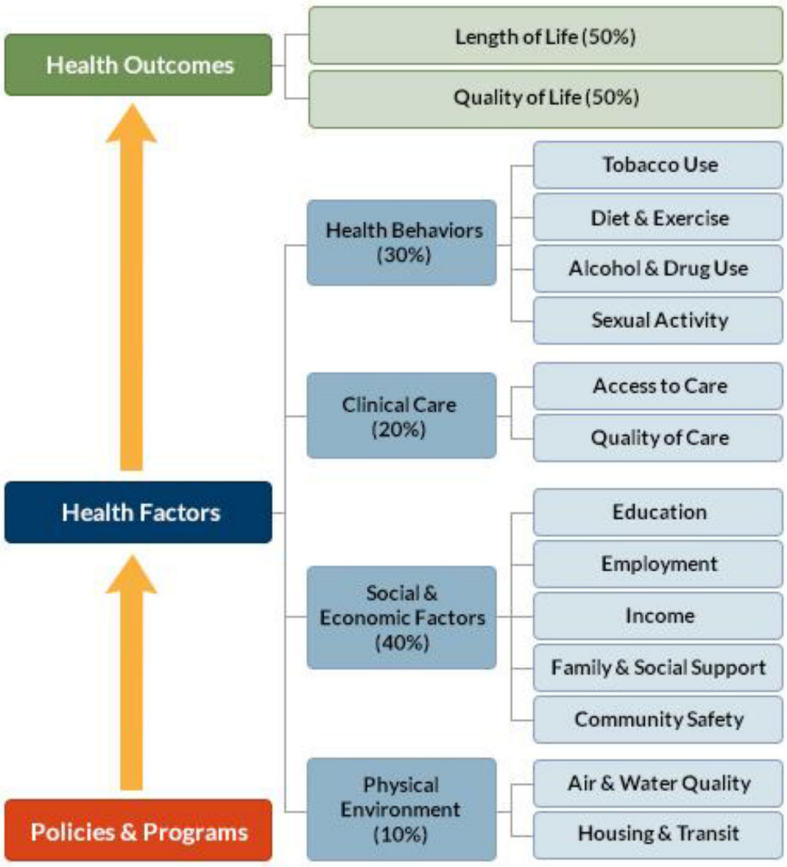
Methods

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

What is Ranked

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

Ranking System



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

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

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

Data Sources and Measures

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

Data Quality

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

Calculating Scores and Ranks

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

Health Outcomes and Factors

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

Health Outcomes

Premature Death (YPLL)

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

Reason for Ranking

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

Poor or Fair Health

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

Reason for Ranking

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

Poor Physical Health Days

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

Reason for Ranking

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

Poor Mental Health Days

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

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

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

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

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

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

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

Health Factors

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

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

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

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

Food Environment Index

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

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

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

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

Reason for Ranking

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

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

Physical Inactivity

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

Reason for Ranking

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

Access to Exercise Opportunities

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

Individuals who:

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

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

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

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

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

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

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

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

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

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

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

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

Uninsured

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

Reason for Ranking

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

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

Primary Care Physicians

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

Reason for Ranking

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

Dentists

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

Reason for Ranking

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

Mental Health Providers

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

Reason for Ranking

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Injury Deaths

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

Reason for Ranking

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

Air Pollution-Particulate matter

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

Reason for Ranking

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

Drinking Water Violations

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

Reason for Ranking

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

Severe Housing Problems

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

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

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

Reason for Ranking

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

Appendix C – Prioritization of Community's Health Needs

Community Health Needs Assessment

Lisbon, North Dakota

Ranking of Concerns

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

	Priorities	Most Important
COMMUNITY/ENVIRONMENTAL HEALTH CONCERNS		
Attracting & retaining young families	5 (broke tie) - 9	**3**
Having enough child daycare services	5 (broke tie) - 0	
Not enough affordable housing	2	
Not enough places for exercise/wellness activities	0	
Physical violence, domestic violence, sexual abuse	1	
AVAILABILITY/DELIVERY OF HEALTH SERVICES CONCERNS		
Availability of mental health services	14	**11**
Extra hours for appointments (evening/weekends)	1	
Availability of specialists	0	
Cost of health insurance	0	
Cost of prescription drugs	0	
Availability of substance use disorder treatment services	0	
YOUTH POPULATION HEALTH CONCERNS		
Drug use and abuse	5 (broke tie) - 10	**0**
Alcohol use and abuse	0	
Depression/anxiety *(combined with adult for ALL AGES on most important vote)*	5 (broke tie) - 11	**3**
Not enough activities for children and youth	1	
Suicide	3	
ADULT POPULATION HEALTH CONCERNS		
Alcohol use and abuse	5 (broke tie) - 0	
Depression/anxiety	6	
Drug use and abuse	3	
Not getting enough exercise/physical activity	0	
Obesity/overweight	1	
SENIOR POPULATION HEALTH CONCERNS		
Cost of long-term/nursing home care	3	
Availability of resources to help elderly stay in their homes	0	
Availability of resources for family/friends caring for elders	0	
Availability/cost of activities for seniors	0	
Assisted living options	0	
Depression/anxiety	1	
Quality of elder care	0	
VIOLENCE CONCERNS		
Domestic/intimate partner violence	1	
Emotional abuse (isolation, verbal threats, withholding of funds)	0	
Child abuse/neglect	1	
Bullying/cyber-bullying	1	

Appendix D – Survey "Other" Responses

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

1. Considering the PEOPLE in your community, the best things are: "Other" responses:

- Not a lot goes on to attend and meet others
- Not as friendly as previous places I have lived.
- Safe, low crime

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

- Local clinic hospital care
- We have a grocery store, gas station, and a post office

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

- Quiet

4. Considering the ACTIVITIES in your community, the best things are: "Other" responses:

- Church
- Having the movie theatre
- In small town often most masked your often fun
- None of these are really available
- Roads to ride on
- School activities
- Sheyenne River speedway
- Sports if they would let you play

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

5. Considering the COMMUNITY /ENVIRONMENTAL HEALTH in your community, concerns are: "Other" responses:

- Drug problem
- Need more activities/Center for youth, other than movie theatre not much for youth to do
- Nice to have indoor recreation center
- Not enough restaurants
- Substance abuse
- Walking and or bike paths

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

- Availability of doctors/nurses who are highly qualified with experience.

- I believe our healthcare is very good in Lisbon
- Lack of pharmacy
- No mental health assistance

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

- Access to mental health professionals
- Bully/not enough diversity in things for youth to do if they are not interested in sports
- Bullying
- Cyber gaming addiction (Xbox addiction)
- Vandalism

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

- Access to mental health professionals
- Livable wages-jobs/health insurance

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

- Activities

10. What single issue do you feel is the biggest challenge facing your community? (If there is a "(#)" behind a comment, it means that that comment was made using the exact same language as another respondent. The total number that made that comment is noted behind the comment.)

- A full time Dr.
- A wellness center & youth community center would be a great addition to the community. Also a sit down restaurant would be nice. A public preschool program would also be great and in town and busing for school age kids would be convenient.
- Access to local mental health services
- Activities for senior citizens. No meals together anymore.
- Activities for youth, community exercise facility
- Adequate jobs to keep people
- Adults bulling and they do not know they are doing it.
- Affordable housing
- Alcohol
- Alcohol and other drug abuse among all ages.
- Apathy, the idea to let someone else do it!
- Attracting and keeping young families in our community.
- Biggest challenge is getting new people that move in to the community for available work to become participants in community culture growth.
- Bullying and how to alleviate it - or at least cut down on it.
- Class system
- Community growth
- Continuing to meet the needs of the community but still attract younger families
- Crimes - drugs.
- Decline in population. Not enough to keep people employed and living here. Not enough to entice families to the area or to retain the younger families to stay. Employment opportunities
- Decreasing population (2)

- Disappearing small businesses with nothing to replace them.
- Drug abuse (2)
- Drug use
- Drugs (2)
- Drugs! Huge problem! Need an undercover agent!
- Economic stability for new community members
- Finish getting the streets repaired
- Flood
- Getting help from our police
- Healthcare accessibility
- I feel like the biggest challenge facing my community would be meth. It has been rampant in our community for years. And it seems as if our law enforcement doesn't take any real action. They make "deals" with repeat offenders and then let them off the hook for their help. We need to be offering more help for addicts and their families.
- I feel that compared to neighboring communities, we are falling short/behind in some cases. Particularly when it comes to businesses, restaurants, daycares. How are we supposed to keep people and families here?
- I feel that those who complain about not having what they need in our community, are also not willing to help with the efforts. It's always the same people who are working so hard to get things done.
- Inclusion of everyone no matter what, but suicide/depression is a very close second.
- It's not bad here yet... but addiction/recovery
- Keeping youth to stay here or come here to start a family
- Lack of a community center for exercise, meetings, youth activities
- Lack of activities to provide for families to get to know other families.
- Lack of community pride. I want people to be proud of our community
- Lack of doctors who are willing to stay long term
- Lack of mental health services (2)
- Lack of mental health/substance abuse resources.
- Lack of options and availability. No grocery store, no clinic, no restaurants that aren't bars, no businesses.
- Lack of quality childcare is one of the biggest challenges in our community - this includes the need for an after school program for school aged children.
- Lack of quality childcare
- Lack of resources and knowledge of programs and services
- Maintaining local services and retail businesses in the age of internet shopping and mobile society
- Maintaining the population in our community. Our community is shrinking, therefore our class sizes are shrinking. Therefore, opportunities for our kids in their schools are being more of a challenge.
- Mental health access and child care availability.
- Mental healthcare
- Mental healthcare availability
- Mental health issues and lack of services
- Mental health. Need for counseling services, psychiatric services, and support services, Affordable
- More programs for children not interested in sports.
- NA
- NA
- Need for more supper places/healthier options
- No place to shop
- None
- Not a big or diverse enough population to provide services like 24/7 fitness facilities, public

transportation, downtown beautification, activities for young adults - not kids and families, cafes and restaurants, access to organic food or healthy, pre-prepared options.

- Not enough affordable housing and quality daycare. It would be hard for a new family to move to town for a job, if they couldn't afford to live here or didn't have daycare for their children.
- Not enough competition
- Not enough daycare options
- Not enough to do in the community so people turn to alcohol / drug use which leads to other problems.
- Not having enough for the youth to do. Thank goodness we have the Lisbon Scenic Theatre. We also need more restaurants that are open for supper & Sundays, especially after church.
- Nothing/Drugs
- Our city council members lack the leadership skills and vision and drive to map out a strategic plan for our wonderful community and its residents.
- Population decline
- Providing quality services in many areas of community
- Retaining or getting healthcare providers to come and stay in a small rural community
- Suicide
- the growing use of drugs among the young
- The growth of drug use and the lack of respect for the laws with the drug use.
- The poor quality of healthcare that is provided. Our community out numbers the amount of good quality primary care providers offered within this community. There are many individuals that travel to surrounding areas to establish quality primary care with a provider outside of our community.
- There is not adequate mental health services and or chemical dependency treatment.
- Volunteerism/participation
- Young families lacking
- Youth involvement other than sports.

Delivery of Healthcare

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

- Google

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

- Clinic hours are haphazard. Insurance doesn't cover CHI. No pharmacy. Hours not advertised for clinic.
- Know most on personal level
- Lack of qualified doctors with experience and updated medical technology.
- Lack of whole life service with medical FOCTORS
- No limit

14. What specific healthcare services, if any, do you think should be added locally? (If there is a "(#)" behind a comment, it means that that comment was made using the exact same language as another respondent. The total number that made that comment is noted behind the comment.)

- Alcohol abuse
- Alternative healthcare opportunities.
- Availability of consultation about financial care topics for family members caring for relative in a nursing home.
- Better hours to accommodate off shifts

- Dental care part time.
- Dermatologist
- Drug treatment & family support
- Full time clinic hours, a pharmacy
- full time doctor
- Full time medical doctor
- I feel that we are fortunate to have clinics in the three larger communities in the county and three hospitals in the region-Oakes, Lisbon, and Britton. I think that we need to promote those facilities and what services they have to offer and to assist those that need healthcare to be able to get to those facilities. I support the CHI in Oakes.
- I think having more specialists locally would be nice.
- It's nice to see the same faces in the hospital. When staff members live in Lisbon we have the chance to get to know them. It's nice to have people vested in the community
- Long hours in clinic
- Longer hours in the clinics
- Mental health (5)
- mental health (7)
- Mental health access
- Mental health and chemical dependency treatments
- Mental health and MD providers
- Mental health and substance abuse
- Mental Health Counseling Services
- Mental health help
- Mental Health Services (4)
- Mental health services are desperately needed.
- Mental health, both in patient and ongoing outpatient therapy
- More counselors
- More physicians locally
- More services for Mental Health
- More specialists who travel out of Fargo to see people in town. Essentia recently arranged to have OB/GYN come to Lisbon monthly
- Much more access to mental health services, also a large need for activity / gyms for exercise since the winter is so long and cold
- NA
- Naturopathic Doctor, Local clinics not provided by Catholic Health Services.
- None
- Nothing
- OB
- OB GYN, Ortho
- Obstetrics
- Orthopedics, psychiatry
- Orthopedics, derma
- Pediatricians - many families go out of town for pediatric and children's appointments
- Pediatrics (2)
- Pediatrics or women's health
- Prenatal and maternity services
- Psych and more days of specialists to be available
- Public Health providing more services in all Sargent County towns not just where the office is located.

- Quicker response to rural areas
- Sanford or Essentia Clinic as an overwhelming number of people want one of these clinics/ (Based on local survey taken)
- Sleep apnea testing
- Specialty mental health services, 7 day a week walk in clinic.
- Transportation or elderly advocates
- Urgent Care Walk In
- Vasectomy
- Walk in services nights and weekends
- Wellness center

Demographic Information: Please tell us about yourself.

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

- Additional providers at each of the facilities, longer hours, evening hours.
- Advice availability by phone for concerning events that do not rise to the level of a 911 call.
- Availability
- Doc at hospital are rude and the care there is terrible
- Employ doctors who are willing to stay just get use to one and within a year or two they are gone
- Evening and weekend times, so that the ER is not the only option.
- Funding to bring in or retain more healthcare providers such as MD's or Nurse Practitioners
- Get the communication better between clinics doctors-hard to use same one all the time at ones local clinic
- I believe that we have the resources- A clinic in Milnor, Gwinner, and Forman. A hospital in Oakes, Lisbon and Britton. We need to promote and assist these resources in making sure that they are used and if additional services are needed work with them to try to bring the services to the existing facilities within this local area, not to drive the residents up to Fargo and take them away from our local services. If that continues, we will no longer have anything in the local area.
- I believe the lack of affordable housing, daycare, amenities such as restaurants, good paying jobs, mental health services and the increase in overall living expenses and drug activity in this area is resulting in a population decrease. This is very sad because I would love to see a future for my children here, but unfortunately, I don't believe that will happen if these trends continue.
- I have been very impressed with the quality of healthcare for my own and my family's needs in the area. Cost of healthcare even with insurance is, and has always been, an issue. If it's costing me this much, what about those who are without good health insurance, have larger families, or with serious medical confusions?
- I worry about the lack of volunteers for local ambulance services.
- If possible full time doctor
- Lack of access to mental health. community wellness center would be very beneficial
- Mental health providers needed locally. Drug programs needed locally. Affordable health insurance - $900 monthly for one person is not affordable.
- Mentoring Programs for Children / Summer Camps / More Learning Opportunities and MORE daycares needed!
- More full time doctors
- NA
- Need evening hours and weekend hours
- Need more accessibility and pharmacy options in Milnor. When you're sick the last thing you want to do I drive a 50 mile round trip at least.
- Nothing

- Our community needs a wellness center
- People who work for the hospital or clinic deserve to be appreciated
- Privacy confidential
- Sucks
- The hours of the local clinic vary by day and the providers that are available also vary by day. NP and PA care is all that is available in the community. Also, mental healthcare providers and awareness of mental health needs is nearly nonexistent
- There should be tuition reimbursement or some incentive so that we can have a shared county cd mental health counselor that accepts Medicaid. The clients I work with need services but can't afford driving to Fargo for outpatient counseling and the local ones don't accept Medicaid.
- Transportation to appointments, etc., longer clinic hours to prevent ED visits that are more like clinic and not emergency
- Walk in services nights and weekends, more pediatrics
- We do not take our children to Lisbon for any reason. Time and time again, local doctors have been proven to be wrong. We travel to Fargo for pediatricians. We can't even go locally for simple things like ear infections and pink eye. Very frustrating.
- We need more mental health services.
- We need more specialists to provide services locally. Even if they could only come one day a month. That would still be great.
- Would like to see better hours for off shift bobcat employees and have the Gwinner clinic open all day 5 days a week instead of a few half days.