Community Health Needs Assessment

CHI Lisbon Health Service Area
Lisbon, North Dakota

2021

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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 2021, the previous CHNA having been conducted in 2019. The Center for Rural Health (CRH) at the University of North Dakota School of Medicine and Health Sciences (UNDSMHS) facilitated the assessment process, which solicited input from area community members and healthcare professionals as well as analysis of community health-related data.

To gather feedback from the community, residents of the area were given the opportunity to participate in a survey. One hundred fifty CHI Lisbon Health service area residents completed the survey. Additional information was collected through three key informant interviews with community members. 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.

With regard to demographics, Ransom County's population from 2010 to 2019 decreased by 4.4 percent, while Sargent County's population increased by 1.8 percent. The average number of residents under age 18 (22.4%) for Ransom County comes in 1.1 percentage points lower than the North Dakota average (23.5%), and Sargent County's number of residents under 18 (21.6%) is 1.9 percentage points lower than the North Dakota average. The percentage of residents, ages 65 and older, is almost 6% higher for Ransom County (21.2%) and almost 7.5% for Sargent County (22.7%) than the North Dakota average (15.3%). The rate of education is slightly lower for Ransom County (91.0%) and Sargent County (91.9%) than the North Dakota average (92.5%). The median household incomes in Ransom County ($63,903) and Sargent County ($63,073) are in line with the state average for North Dakota ($63,473).

Data compiled by County Health Rankings show Ransom County and Sargent County are doing better than North Dakota in health outcomes/factors for 36 categories; Ransom County is doing better than North Dakota in health outcomes/factors for 19 categories, and Sargent County is doing better than North Dakota in health outcomes/factors for 17 categories.

Ransom County and Sargent County, according to County Health Rankings data, are performing poorly, relative to the rest of the state in 19 outcome/factor categories; Ransom County is performing worse than the state average in 11 categories, and Sargent County is performing worse than the state average in 8 categories.

Of 106 potential community and health needs set forth in the survey, the 150 CHI Lisbon Health service area residents 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
- Availability of resources to help the elderly stay in their homes
- Cost of long-term/nursing home care
- Depression/anxiety – Youth and Adult
- Drug use and abuse – Youth and Adult
- Having enough child daycare services
- Not enough affordable housing

The survey also revealed the biggest barriers to receiving healthcare (as perceived by community members). They included not enough evening or weekend hours (N=40), not enough specialists (N=31), not affordable (N=25), and not able to get appointment/limited hours (N=25).

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

- Family-friendly, good place to raise kids
- Healthcare
- People are friendly, helpful, and supportive
- People who live here 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:

- Alcohol use and abuse in adults
- Availability of mental health and substance use disorder treatment services
- Depression/anxiety in all ages
- Drug use and abuse (including prescription drug abuse) in youth
- Having enough child daycare services

Overview and Community Resources

With assistance from 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 and Ransom Counties. Many community members and stakeholders worked together on the assessment. The area has a number of community assets and resources that are potentially available to address significant health needs.

Ransom County

CHI Lisbon Health and Ransom County Public Health are in Lisbon, North Dakota. Lisbon is at the intersection of State Highways 27 and 32. Ransom County is 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, agricultural, manufacturing, and retail trade operations provide the economic base for the town of Lisbon and Ransom County. According to the 2019 U.S. Census, Ransom County had a population of 5,218.

Ransom County has several community assets and resources that can be mobilized to address population health improvement. In terms of physical assets and features, the community includes a swimming pool, two city parks, a state park, tennis, volleyball and basketball courts, a golf course, skating and ice-skating rink, campgrounds, hiking trails, 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, ball diamond, skateboard 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 Ransom County Public Health, many other physicians and allied professionals help to serve Ransom County residents, which includes four clinics: CHI Lisbon Health 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, the 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

Sargent County District Health Unit is in Forman, North Dakota. Sargent County is 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 agriculture, 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 2,108 acres of Game and Fish land, and 10,485 acres are owned by the U.S. Fish and Wildlife Services.

Sargent County has several 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, a 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 a beach, swimming, boating, boat ramp, waterskiing, volleyball, fishing, and picnicking.

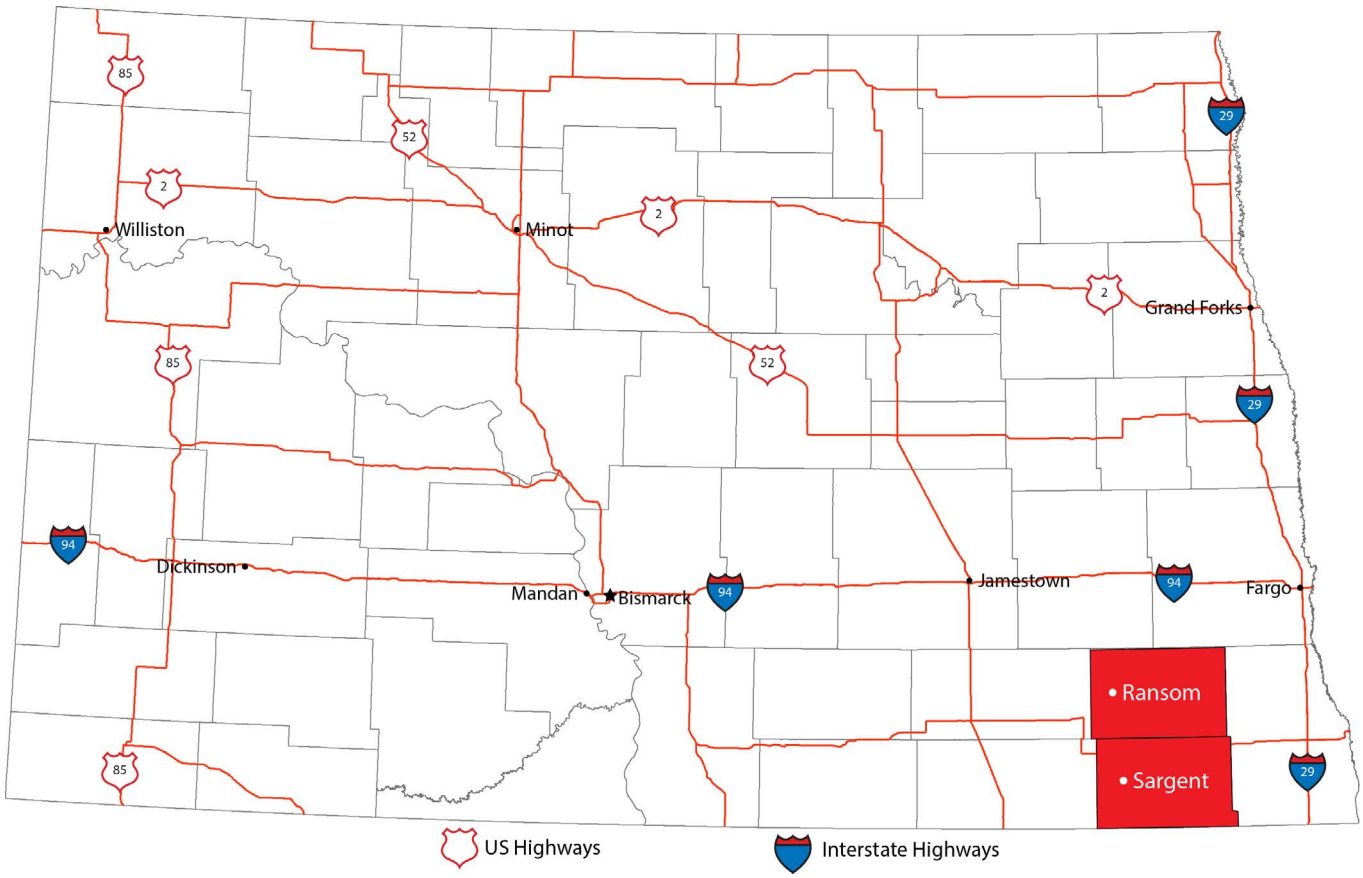
Tewaukon National Wildlife Refuge, located in southeastern North Dakota, encompasses grasslands and wetlands. The Wild Rice River winds its way through the refuge. Visitors are encouraged to see how the active habitat management provides a place for wildlife while getting outside and enjoying the natural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

Sargent County offers several cultural attractions, such as the Sargent County Museum. The Old Settlers Association formed in the early 1900s but was disbanded in the 1930s or 1940s. The Sargent County Historical Society was formed in the 1960s. 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

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 medical center is a state-designated Level V Trauma Center and a Stroke Ready Hospital. CHI Lisbon Health is part of a larger family of quality healthcare facility, Common Spirit Health, 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 9,286 people throughout 1,720.87 square miles. The Critical Access Hospital Profile for CHI Lisbon Health that includes a summary of hospital-specific information is available in Appendix A.

CHI Lisbon Health has a significant economic impact on the region. They directly employ 72 FTE employees with an annual payroll of over $3.9 million (including benefits). These employees create an additional 25 jobs and nearly $848,000 in income as they interact with other sectors of the local economy, which results in a total impact of 97 jobs and more than $4.78 million in income. Additional information is provided in Appendix B.

Mission
As Common Spirit Health, we make the healing presence of God known in our world by improving the health of the people we serve, especially those who are vulnerable, while we advance the social just for all.

Services offered locally by CHI Lisbon Health include:

General and Acute Services

- Allergy, flu, and pneumonia shots in clinic
- Cardiac rehab
- Clinic
- Emergency room
- Hospital (acute care)
- Nutrition counseling
- Pain management
- Pharmacy
- Physicals: annual, D.O.T., sports and insurance in clinic
- Surgical services
- Swing bed services

Screening/Therapy Services

- Cardiac stress testing
- Holter monitoring
- Laboratory services
- Lower extremity circulatory assessment
- Occupational therapy
- Physical therapy
- Respiratory therapy
- Sleep studies
- Speech therapy

Surgery Services

- General and same day surgery
- Pain management injections

Radiology Services

- CT scan
- DEXA (bone density) scans
- Digital 3D mammography
- Swallow study evaluations
- Echocardiograms
- EKG
- General x-ray
- Nuclear medicine (mobile unit)
- MRI (mobile unit)
- Ultrasound

Laboratory Services

- Blood draws
- Blood testing
- Inpatient/outpatient blood product transfusions
- Workplace drug testing collection site

Services offered by OTHER providers

- Ambulance
- Chiropractic services
- Dental services
- 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 health care services for the people of North Dakota.

Mission
The Mission of the Ransom County Public Health Department is to make a positive difference on the health of the individual and the county through promotion, prevention, and protection.

Specific services that RCPH provides are:

- Blood pressure and pulse
- Breastfeeding resources
- Car seat program
- Cholesterol screening
- Coordination of and referral to other helping agencies
- Doctor ordered injections, lab draws, and INR levels
- Dressing changes
- 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
- Preschool education programs & screening
- School health— vision, hearing, scoliosis screenings in schools, health education and resource to the schools
- Tobacco prevention and control
- Tuberculosis management
- 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

Sargent County District Health Unit (SCDHU) implements ten essential services: monitor health status to identify health problems; diagnose 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 services and assure the provision of healthcare when otherwise unavailable; assure a competent public health and personal healthcare workforce; evaluate effectiveness, accessibility, and quality of personal and population-based health services; and research for new insights and innovative solutions to health problems.

Mission
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.

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
- Footcare
- 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
- Preschool education programs & screening
- School health - vision, hearing, health education and resource to the schools
- Tobacco prevention and control
- Tuberculosis management
- West Nile program—surveillance and education
- WIC (Women, Infants & Children) program
- Worksite wellness - coordinator for SCDHU employees
- Youth education programs (first aid, babysitting clinic, and bike safety)

Assessment Process

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

A CHNA benefits the community by:

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

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

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

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

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

This assessment examines health needs and concerns in Ransom and Sargent Counties. In addition to Lisbon and Forman, located in the two counties, are the communities of Anselm, Buttzville, Cayuga, Cogswell, DeLamere, Enderlin, Elliot, Englevale, Fort Ransom, Geneseo, Gwinner, Havanna, McLeod, Milnor, Rutland, Sheldon, and Stirum. Zip codes in the service area include: 58027, 58033, 58054, 58068, 58013, 58017, 58032, 58040, 58043, 58060, 58067, and 58069.

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

Figure 2: Steering Committee

Steven Spickenreuther	Foundation, CHI Lisbon
Melissa Woinarowicz	Mission Integration/Human Resources, CHI Lisbon
Shari Saxerud	Administration – Corporate, CHI Lisbon Health
Brenda Peterson	Administrator, Sargent County District Health Unit
Brenna Welton	Administrator, Ransom County Public Health

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

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

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

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. CRH connects the UNDSMHS and other necessary resources to rural communities and other healthcare organizations in order to maintain access to quality care for rural residents. In this capacity, CRH works at a national, state, and community level.

Members of the community group and key informants represented the broad interests of the community, served by CHI Lisbon Health, RCPH, and SCDHU. They included representatives of the health community, business community, political bodies, education, and social service agencies. Not all members of the group were present at both meetings.

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

Community Group

A community group, consisting of nine community members, was convened and first met on August 24, 2021. During this first community group meeting, group members were introduced to the needs assessment process, reviewed basic demographic information about the community, and served as a focus group. Focus group topics included community assets and challenges, the general health needs of the community, community concerns, and suggestions for improving the community's health.

The community group met again on September 20, 2021 with ten community members in attendance. At this second meeting, the community group was presented with survey results, findings from key informant interviews and the focus group, and a wide range of secondary data, relating to the general health of the population in Ransom and Sargent Counties. The group was then tasked with identifying and prioritizing the community's health needs.

Interviews

One-on-one interviews with three key informants were conducted virtually in August 2021. A representative from the CRH conducted the interviews. Interviews were held with selected members of the community who could provide insights into the community's health needs.

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

Survey

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

The community member survey was distributed to various residents of Ransom and Sargent Counties, which are included in the CHI Lisbon Health service area. The survey tool was designed to:

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

Specifically, the survey covered the following topics:

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

To promote awareness of the assessment process, an ad ran in one newspaper in Ransom County. Additionally, information was published in a Facebook ad and in local church bulletins.

Approximately 50 community member surveys were available for distribution in Ransom and Sargent Counties. The surveys were distributed by community group members and at CHI Lisbon Health, RCPH, SCDHU, local businesses, and local churches.

To help ensure anonymity, included with each survey was a postage-paid return envelope to CRH. In addition, to help make the survey as widely available as possible, residents also could request a survey by calling CHI Lisbon Health, SCDHU, or RCPH. The survey period ran from July 27, 2021, to August 10, 2021. Ten completed paper surveys were returned.

Area residents were also given the option of completing an online version of the survey, which was publicized in a community newspaper, in area church bulletins, and on the websites and Facebook pages of both CHI Lisbon Health, SCDHU, and RCPH. One hundred forty online surveys were completed. Fifty-seven of those online respondents used the QR code to complete the survey. In total, counting both paper and online surveys, the 150 community member surveys were completed, equating to a 14% response rate. This response rate is on par for this type of unsolicited survey methodology and indicates an engaged community.

Secondary Data

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

Social Determinants of Health

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

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

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

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

Figure 3: Social Determinants of Health

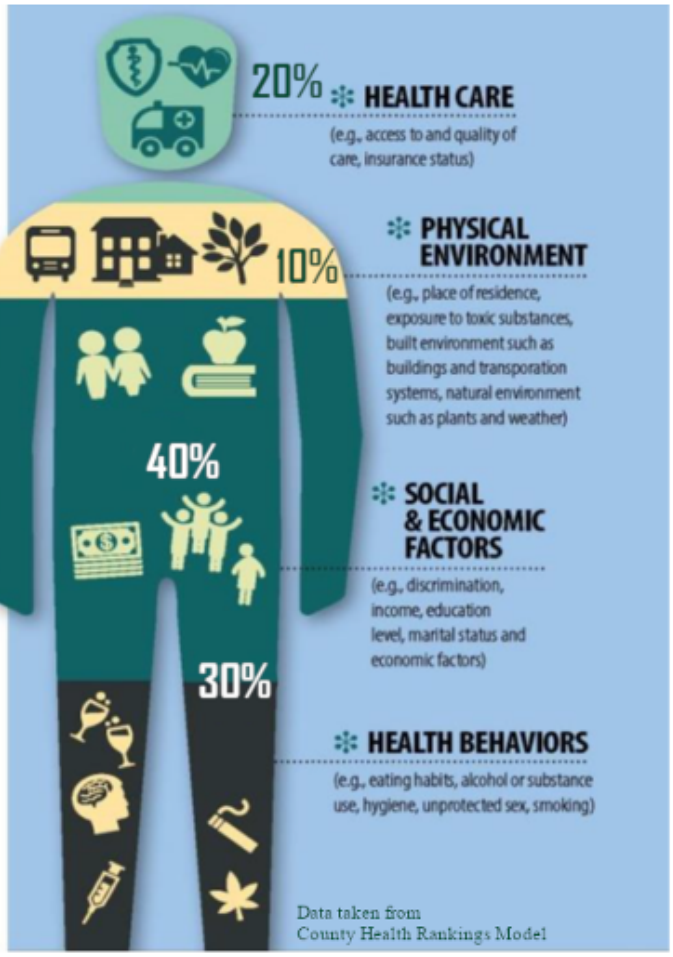


Figure 4 (Henry J. Kaiser Family Foundation, https://www.kff.org/disparities-policy/issue-brief/beyond-health-care-the-role-of-social-determinants-in-promoting-health-and-health-equity/), provides examples of factors that are included in each of the social determinants of health categories that lead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

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

Figure 4: Social Determinants of Health

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

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

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Health Equity and COVID-19 Assessment for Barnes County

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

On July 7, 2021, a focus group was held virtually via Zoom to assess the COVID-19 perceptions and immunization needs of Ransom County. The focus group was organized by Ransom County Public Health and facilitated by the Center for Rural Health (CRH) at the University of North Dakota (UND) School of Medicine & Health Sciences (SMHS). This report contains the findings from the focus group as well as secondary data, related to demographics, COVID-19, and immunization rates.

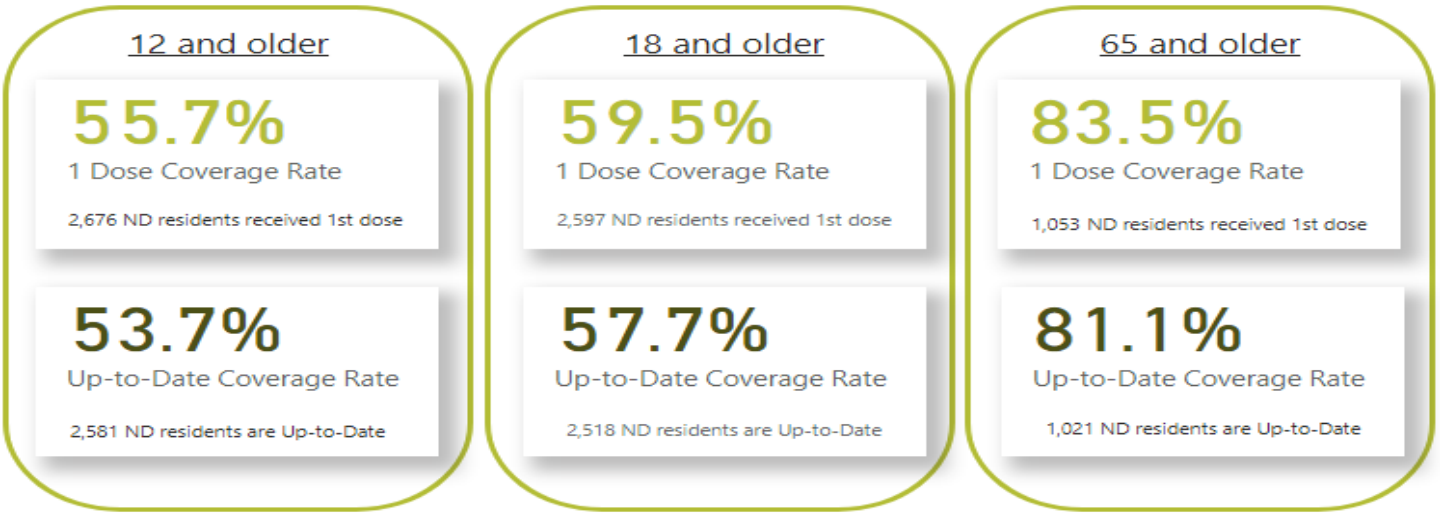
COVID-19 in Ransom County

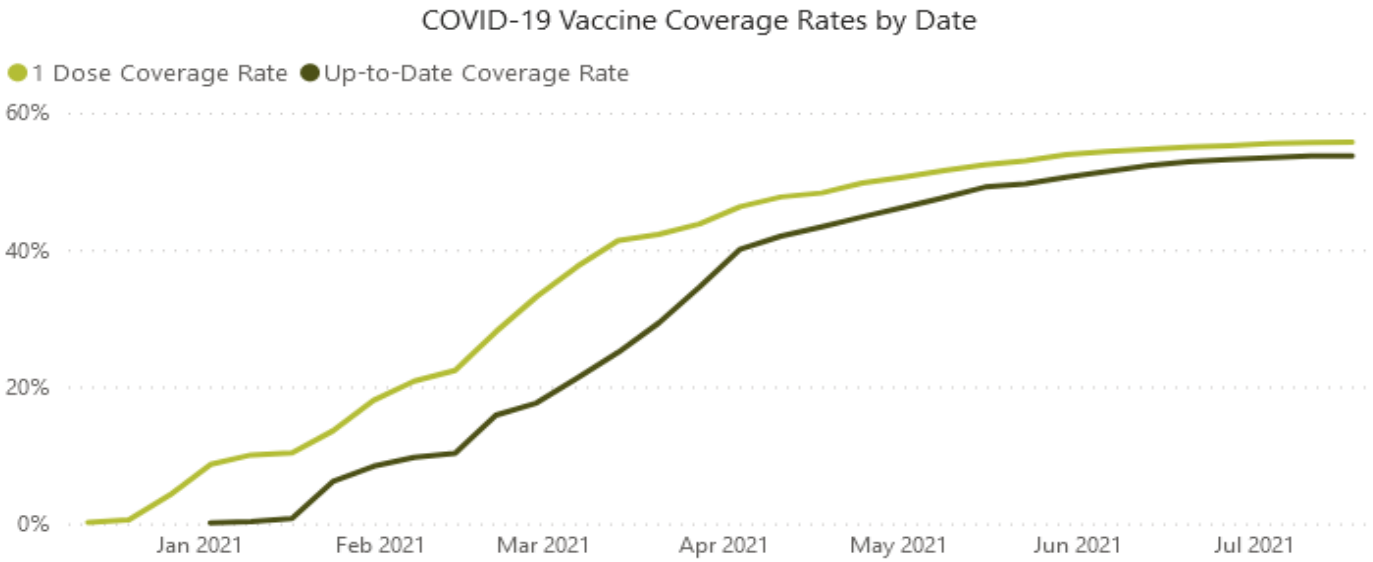
The COVID-19 vaccine data dashboard is administered by the North Dakota Department of Health and provides daily vaccine doses administered and weekly vaccine coverage rates for North Dakota. Dashboard data are based on COVID-19 vaccine doses reported to the North Dakota Immunization Information System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

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

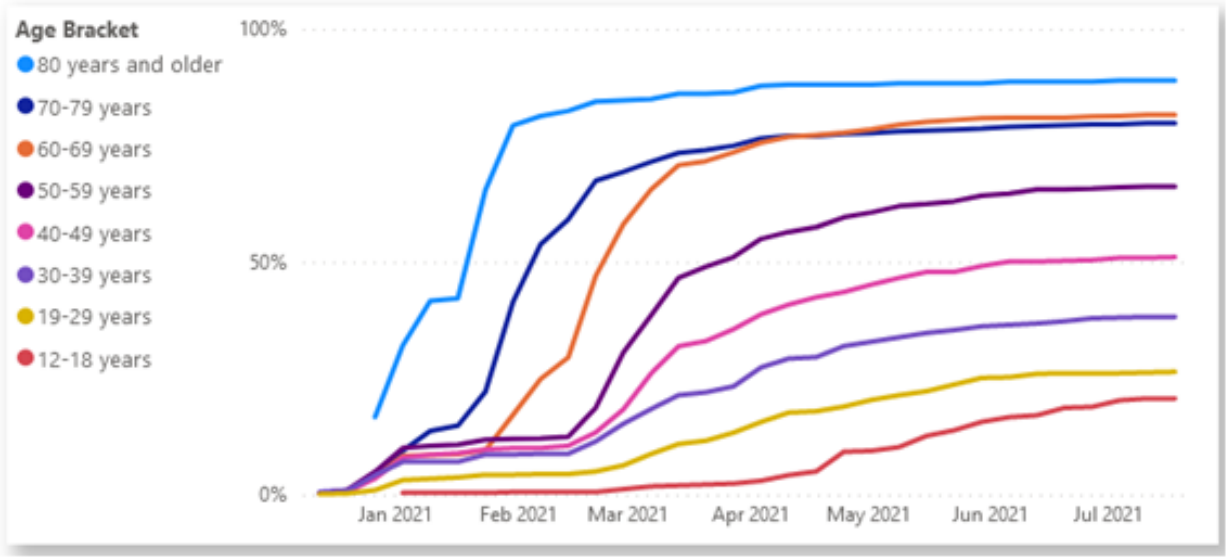
As of July 20, 2021, in North Dakota, the 637,180 doses of the COVID-19 vaccine have been administered. In Ransom County alone, the 4,863 COVID-19 vaccine doses have been administered. Statewide, the one dose coverage rate for 12 and over is 48.6%, 51.6% for 18 and older, and 75.9% for 65 and older. See Figure 2 for the Ransom County breakdown by age of one dose coverage and fully vaccinated (up-to-date coverage). Ransom County has a 55.7% for 12 and older, 59.5% for 18 and older, and 83.5% for 65 and older Up-to-Date Coverage Rate as of July 20, 2021.

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

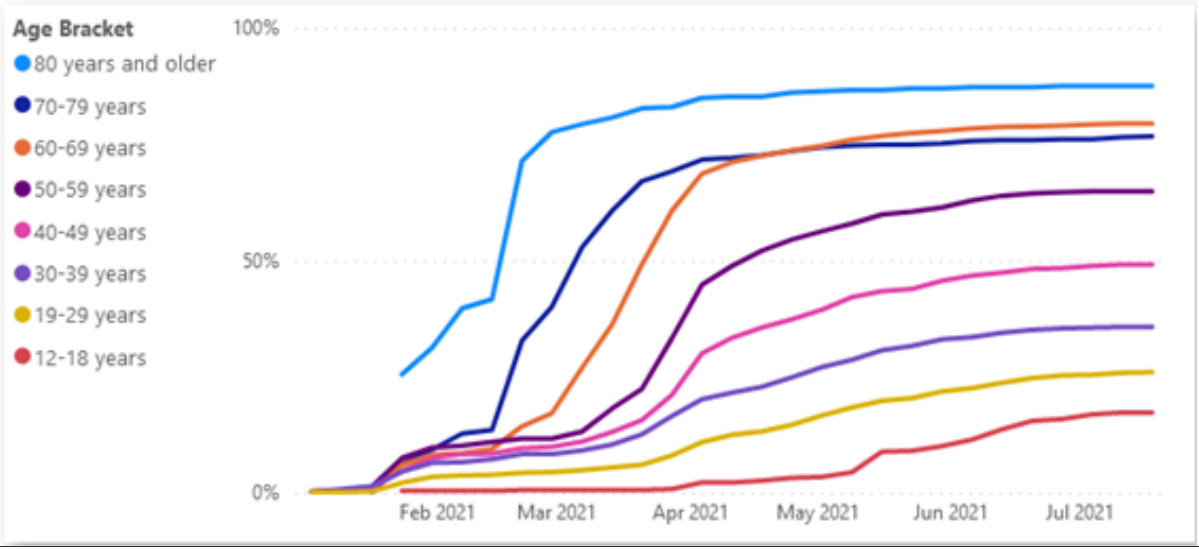




1 Dose Coverage Rate



Up-to-Date Coverage Rate



There are 10 COVID-19 vaccine enrolled provider sites in Ransom County and 419, total, in North Dakota.

Immunization Rates for Ransom County

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

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

Vaccine	Rate (in %) Ransom County	Rate (%) North Dakota
4:3:1:3:3:1:4 Series	59.04	60.99
DTap	68.67	66.84
Hepatitis A	62.65	59.54
Hepatitis B	80.72	82.24
Hib UTD	62.65	67.86
MMR	85.54	79.13
PCV	79.52	71.99
Polio	81.93	80.79
Varicella	86.75	79.09
Varicella	93.64	89.61

The following chart (Figure 4) depicts immunization rates for Ransom County during the 2021 first quarter, for Ransom County teens, 13-17 years, by the last day of the quarter who received the specified number of doses of the selected vaccine by the end of the quarter.

Vaccine	Rate (in %)	ND Average Rate (in %)
HPV Female Start	82.42	74.56
HPV Female UTD	66.67	62.29
HPV Male Start	79.41	72.63
HPV Male UTD	65.20	58.90
MCV4 dose 1	92.25	88.60
MCV4 dose 2	68.84	60.65
Men B dose 1	62.32	46.29
Men B UTD	25.36	19.65
Td/Tdap	93.32	88.77
Varicella	91.44	89.61

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

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

Vaccine	Rate (in %)	ND Average Rate (in %)
PCV13 after 65 years	63.57	59.91
PPSV23 after 65 years	56.37	52.95
Shingrix® dose 1 after 50 years	28.15	29.38
Shingrix® UTD after 50 years	23.00	22.77
Tdap after 19 years	75.10	70.76
Zostavax after 60 years	34.11	34.41

Focus Group Discussion

On July 7, 2021, a focus group was held virtually via Zoom to assess the COVID-19 perceptions and immunization needs of Ransom County. Ransom County Public Health invited members of the community with varying backgrounds and opinions to join in the focus group that was facilitated by CRH at the UND SMHS.

Present at the meeting were representatives from the area clinic, public school system, public health, and a bank manager.

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

At the beginning, all aspects of the community were affected in some way by the pandemic. A participant from the school stated they had just signed a contract to continue teaching for one more year in March 2020, right before the pandemic hit. Within a month, the North Dakota governor shutdown the state. The school had to figure out how to teach virtually. There were feelings that kids need to be with kids and adults need to be with other adults and the town needs to learn how to get back to normal. The virus is hard to manage even with protocols. One participant said that they followed all the guidelines and still ended up getting COVID-19.

Healthcare workers noticed the effect COVID-19 had and still has on the community member's mental health. The area doesn't have the resources to assist residents to receive help locally. A healthcare worker detailed that quarantine and isolation from others has left a lingering effect; people are suffering from depression and anxiety, caused from the uncertainty of the virus. A woman said that, as a nurse, this year was the most challenging year of her life and career. She loves the work she does, but working in the middle of all the chaos was too much at times. Since people reacted to the pandemic differently, she said she saw a different side of people you thought you knew. When listening to them, she would keep an open mind, reminding herself it's their opinion. Area healthcare workers got all COVID-19 information directly from the state health department. They tried to give people the facts and data, but according to one participant, she said people will get their information from anywhere without checking validity. Currently, vaccine rates are not where the county would like to be but are doing better than other counties in North Dakota.

From a business stand point, the town felt they were very lucky to be in the county. The town had shut down for a while, but it was short term; businesses learned to work alternatively. One participant stated that North Dakota fared better than most states. Kids were able to go back to school, unlike other states; that action helped the students, so they did not fall behind. They were also able to be around peers, which helped their mental health.

When the vaccine first became available, people were running to get the shot. One man stated he is a grandfather and has not been able to see his grandchildren for over a year and half. For him, getting the vaccine was a way to see his family again safely. A number of participants agreed with each other when stating the vaccine was like seeing the light at the end of a tunnel.

As the vaccine rolled out, North Dakota followed the tier system, putting elderly, healthcare workers, and most vulnerable populations at top. Since it took months for the tier systems to moved down to where everyone could get it, the excitement for the vaccine declined. Participants also indicated the timing of the vaccine release was bad; it had been a long winter, and spring was here. People were tired of the pandemic and ready to go back to normal. When restrictions were lifted, people felt like it was over. The younger generations did not feel like getting the vaccine was necessary since they did not see themselves as a vulnerable population.

Public health was very busy during the pandemic, and staff felt overwhelmed by the amount of people calling to ask questions. One staff member stated that they were getting around 80 phone calls a day from people, asking questions regarding COVID-19 and scheduling appointments to get the vaccine. Due to the amount of calls, they had to hire an extra person to handle phone calls. Currently, the calls are down to about 20 phone calls a day, which is much more manageable.

Participants noted that people they knew from other states would comment how well North Dakota did on the vaccine rollout. They mentioned people would come from other states to be able to get the vaccine before state restrictions came into place. One healthcare worker indicated the only reason the county did so well is because it is rural. People are able to communicate easily with each other to give updates, regarding the vaccine, such as when events would be happening.

Reasons People in the Community Want to be Vaccinated

Some participants indicated they were not worried about getting COVID-19 since they weren't in the vulnerable population. Some received their vaccine to prevent giving it to their patients, family, and friends. Others stated they felt a sense of responsibility, and it was their job to keep others safe. One participant viewed the vaccine as a medical miracle. He remembered being in kindergarten, standing in line for the Polio shot. People were grateful because they saw the damage that disease did to children back then. Others felt people just want to get back to normal. Some main reasons people got the vaccine was for their own health, family, and for their jobs. Another reason people got the vaccine was to avoid having to quarantine if they are exposed in the future. A participant stated that they have not been able to go fishing in Canada for two years, and when the border finally opens, they will demand proof of vaccination. This reasoning was an incentive to get the shot and may be a reason for others who want to travel internationally.

Reasons People in the Community Do Not Want to be Vaccinated

Reasons for not wanting to be vaccinated were distrust, perception, fear of needles, and conspiracy theories that people believed. Some people do not trust the vaccine because it is too new. Most vaccines take years to be given to the general population, and this vaccine was ready in less than a year. People are concerned about long-term side effects of the vaccine. Participants stated people have told them the vaccine causes infertility, and others say there is a microchip in the vaccine. One participant stated people don't care about their iPhones being tracked but freak out about a conspiracy theory of microchips in the vaccine. Others had heard people say they did not trust the government, and anything the government was pushing they'd go against. Healthcare workers said that people were fearful of the possible side effects of the vaccine. She said that the possible side effects are better than the possible symptoms of COVID-19.

Sources of COVID-19 Information

A source for COVID-19 information, that the group agreed from where everyone was getting their information, was Facebook. Most don't ever check the information that comes up on their newsfeed; they just believed everything they read. People do not seek out the CDC or Mayo website for valid information unless it is shared on Facebook. There is a feeling that it is hard for the average person to understand the CDC website and is hopeful that the CDC will change the layout to make it simplified and easy to understand. Others said people use Facebook because it's just one click to share on their newsfeed. Locally, people depended on word of mouth. People trust their neighbors and community members. Throughout the pandemic and vaccine rollout, people depended on local public health and their local provider for accurate information.

Barriers to Receiving the COVID-19 Vaccination

Accessibility to the vaccine was a barrier at first. When providers received their lot of vaccine, it was very chaotic. The communication between healthcare facilities was hard to manage, since no one knew who had vaccine or how much they had. People would call to be put on the waiting list for one place but go to another and receive their vaccine. They would forget to notify the first facility to remove their name from the waiting list, which resulted in healthcare workers spending needless time calling the patient multiple times to try to notify them that they could receive their vaccination. Now, instead of wasting time and doses, nurses will call once and leave a message to contact them within 3 days, or their name will be removed from the list.

Ways to Increase Confidence and Vaccination Rates

When discussing ways to increase confidence and vaccination rates, participants said that local clinics and public health should offer walk-ins. It is not currently available, and they may be able to reach people that way because some people are too lazy or unsure of their schedules to go through the effort of scheduling an appointment; however, if they are in town and know they can just walk in and get their shot, they may do just that because it is convenient. Participants also suggested going to work places. A person who works in healthcare stated that they are ready to do what is needed, especially with the coming fall and winter seasons. The goal is to increase vaccination rates to prevent another wave of COVID-19 patients being hospitalized.

During the discussion, a few participants were hesitant about pushing the vaccine onto people. One participant stated that if people have a reason to get the vaccine, then they'll get the vaccine; if they don't have any reason to get the vaccine, then they will not get the vaccine. A healthcare worker said that they plan to continue sitting down with people and have a conservation, but it is not being forced on patients. In her view, if she can get just one person who wasn't going to get the shot to change their minds, then that is a win. Participants said that only time will help increase rates. They have reached saturation level; whomever wanted a shot, got the shot. Those who have not got it will need something to change personally for them to change their minds. Healthcare workers at a nursing home were split on getting the vaccine. At first, some staff were against getting it. However, as time went on and their coworkers who did receive the shot are fine, they have been more open to receiving the vaccine. There was belief by those at the meeting that once the vaccine is fully approved by the FDA, more people will get vaccinated.

Participants discussed using various marketing ideas to reach youth. The vaccine campaign that the state health department is currently running was well-received by those persons who had seen it. The campaign is using athletes from NDSU to advertise the vaccine. They feel that teens and young adults would be more open to getting the vaccine if someone they look up to and view as strong (in their demographic) got the vaccine themselves.

Healthcare workers plan on speaking about all vaccines during teens' sport physicals, informing them and their parents of the pros and cons. One participant stated they are vaccinated; however, their 13-year-old child is not. He said he did not feel comfortable letting their child get it since they are not considered a vulnerable population, and, most importantly, it is not fully approved by the FDA. He stated it is a hard decision to make, and there are risks that need to be weighed out.

Participants mentioned there needed to be more information of the vaccine available to the public. The information should be very simple to understand. Many people don't realize that this research is almost 10 years old, and the SARS virus had been studied for many years before that time. People are unaware that because the technology was already there and a global pandemic was happening, the government removed the red tape that makes new vaccines take many years for approval by the FDA.

Healthcare facilities would like to streamline the vaccine through collaboration with public health. They would like them to be hub of information, directing residents on where to go for vaccines. This way, staff is not wasting their time trying to follow up with someone who decided to go to another facility. This method will make it more efficient for the healthcare facilities and for public health.

General Thoughts

There are mixed thoughts going into the fall and winter season. Some participants feel confident in their ability to handle what may come. One healthcare worker said they feel better because there is more information about COVID-19, how it spreads, how to treat it medically, and protocols are in place in case of another wave. Other participants were worried. With the state lifting all mandates, people feel that the pandemic is over, and everything is back to normal. The new variants that are being transmitted show to be more aggressive and easily transmitted. Healthcare workers fear of another wave coming, especially with flu season and other virus that usually come in the cold months.

Participants are worried about the upcoming school year. Some staff and students are over the restrictions and COVID-19 protocols. People are not sure what protocols, if any, will be in place when schools start.

A participant stated they have a friend who chose their vacation spot, depending on the state's vaccination rate. The state with the highest rate would be their vacation spot. Another participant said you have to lead by example. He does not do business in places that did not follow the guidelines during the pandemic. Leaders of the community need to show their support for protocols and also get their shot.

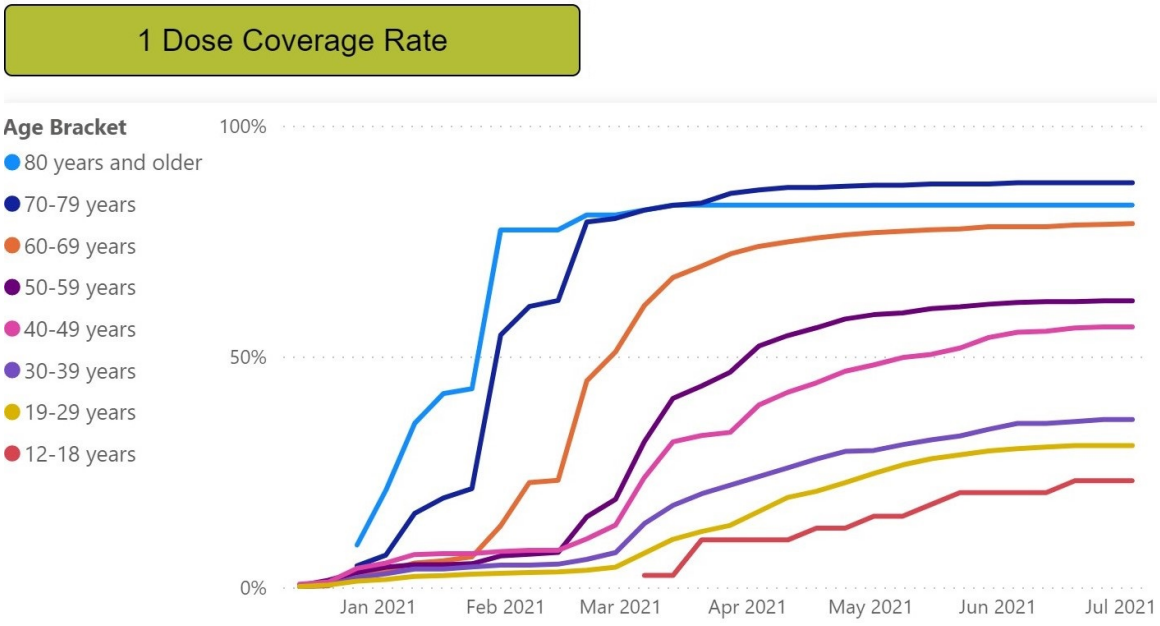
COVID-19 in Sargent County

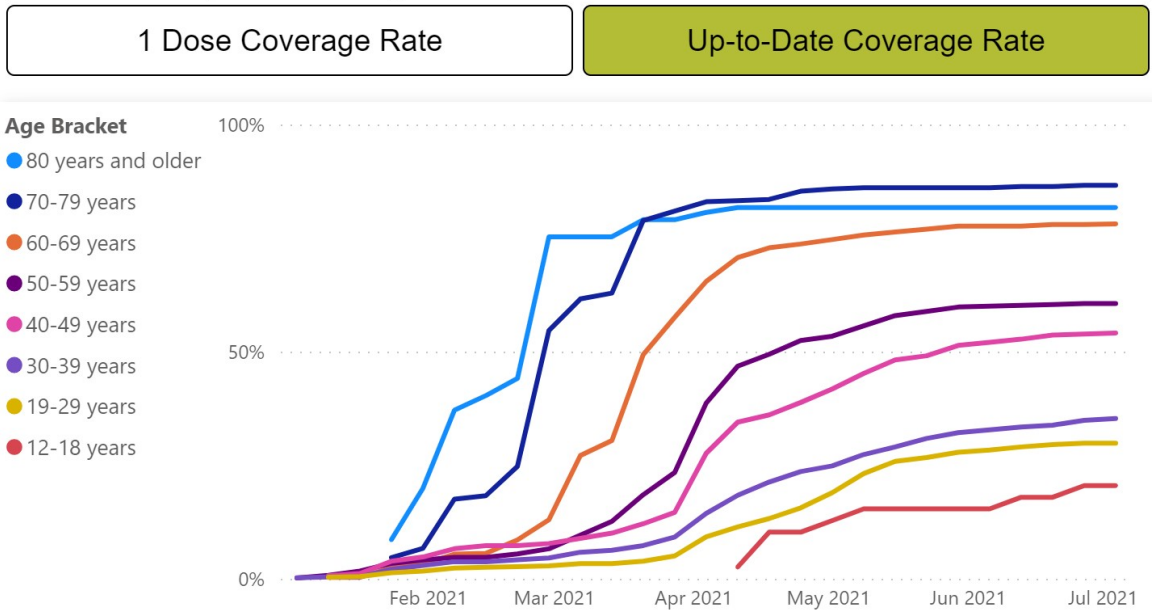
The COVID-19 vaccine data dashboard is administered by the North Dakota Department of Health and provides daily vaccine doses administered and weekly vaccine coverage rates for North Dakota. Dashboard data are based on COVID-19 vaccine doses, reported to the North Dakota Immunization Information System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

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

As of July 06, 2021, in North Dakota, the 629,044 doses of the COVID-19 vaccine have been administered. In Sargent County, the 3,496 COVID-19 vaccine doses have been administered. Statewide, the one dose coverage rate is 47.9% and 45.2% are fully immunized. See Figure 2 for the Sargent County breakdown by age of one dose coverage and fully vaccinated (up-to-date coverage). Sargent County has a 57.5% Up-to-Date Coverage Rate as of July 06, 2021.

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





There are four COVID-19 vaccine enrolled provider sites in Sargent County and 418, total, in North Dakota.

Immunization Rates for Sargent County

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

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

Vaccine	Rate (in %)
4:3:1:3:3:1:4 Series	37.21
DTap	48.84
Hepatitis A	33.72
Hepatitis B	55.81
Hib UTD	45.35
MMR	68.60
PCV	52.33
Polio	58.14
Varicella	67.44

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

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

Vaccine	Rate (in %)
HPV Female Start	77.98
HPV Female UTD	62.39
HPOV Male Start	70.59
HPV Male UTD	50.42
MCV4 dose 1	94.78
MCV4 dose 2	67.39
Men B dose 1	32.61
Men B UTD	8.70
Td/Tdap	96.52
Varicella	92.17

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

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

Vaccine	Rate (in %)
PCV13 after 65 years	59.51
PPSV23 after 65 years	53.87
Shingrix® dose 1 after 50 years	35.17
Shingrix® UTD after 50 years	30.13
Tdap after 19 years	74.82
Zostavax after 60 years	38.42

Focus Group Discussion

On July 1, 2021, a focus group was held over Zoom virtual conference to assess the COVID-19 perceptions and immunization needs of Sargent County. Sargent County Public Health invited members of the community with varying backgrounds and opinions to join in the focus group that was facilitated by CRH at the UND SMHS. Additionally, for those who could not attend, a Qualtrics survey, consisting of the same questions asked in the focus group, was sent to key informants in Sargent County.

Within this conversation, respondents discussed key topics, beginning with the effects of COVID-19 and the COVID-19 vaccine on Sargent County and its residents. Discussion then shifted toward the rational and perception on why some residents want to receive the vaccine while others did not want the vaccine. A large source of COVID-19 vaccine concern lies within the safety of the vaccine, which is controversial due to the varying centers of information and whether they can be trusted as a legitimate source of research. The focus group then ended on the topic of future strategies on how to mitigate access concerns and the development of new strategies to improve access and information dissemination within the Sargent County area.

Overall, the discussion centered around respondents who were advocates for taking the vaccine, reporting on stories, and perceptions of residents who do not want the vaccine. This discussion created a tone of optimism toward strategies on how to improve demand for the vaccine but skepticism in the ability to convince the resolute opponents of the vaccine. Instead, within the community, a feeling of partisanship developed, creating controversy between those who want the vaccine and those who do not want the vaccine.

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

Early within the COVID-19 pandemic, residents of Sargent County reported little change. With the spread of the virus, the perception within the community was that COVID-19 was real, but with slow rates, people did not believe that this virus could not be classified as a pandemic. It was not until the final months of 2020 when the community began feeling the impacts of the virus and, as such, compensation strategies developed. A large concern within the community was that a local machinery plant within town drew in many workers, which had the potential to spread the virus to residents. In preparation of this event, mass testing was undergone at this site, which yielded a positive reporting rate of 0.75%, leading to a sense of safety. This safety brought on continued prevention efforts as community members felt that their strategies towards preventing COVID-19 must be working because little to no cases resulted in drastic outcomes. While cases that were mild went untested because they were assumed to be the common cold, a sense of complacency developed; however, concern remained when family or friends would become ill. Therefore, when the vaccine first came out, everyone wanted it to protect their family and loved ones. This demand created supply issues early on, to the point where first responders wanted to save the vaccine for the elderly and immune compromised. This situation developed solidarity in the community, and trust was further expanded towards public health because of their efforts in ensuring that second dose follow-ups were maintained; outreach to those who would otherwise not be able to receive the vaccine allowed for improved vaccination rates.

However, with vaccination demand becoming more stagnant and with increasing supply, the community believes that those who want the vaccine received it, and those who do not, will not be easily persuaded. Instead, an us vs them mentality developed, which was further politicized due to sources of misinformation and opposing mainstream media viewpoints. Now within Sargent County, efforts have increased toward finding relevant and trusted sources of information, which will help slowly increase demand until more research on the long-term effects of the vaccine become available.

Reasons People in the Community Want to be Vaccinated

Respondents perceive the incentives toward becoming vaccinated, including social interaction, travel, and a return to normalcy are the main reasons residents receive the vaccine. With face-to-face interactions, developing rapport with customers and patients drive an increase in demand for the vaccine for social workers, business owners, and healthcare providers. So, when the vaccine was first open to the public, many in the workforce were excited to receive the vaccine, so they could meet in person with their clients, which lowered the need for virtual meetings. Similarly, many families within the community were worried of spreading illness to their loved ones, so throughout the pandemic, they remained isolated. When these residents were able to receive the vaccine, they felt safe seeing their families once again as the vaccine offered protection during socialization. Additionally, by receiving the vaccine, many employers were able to lift their mask mandates, which drove up demand for the vaccine. This lifting was, however, met with the controversy on whether employees were receiving the vaccine or not because employers have no way to know whether their employees received the vaccine.

Reasons People in the Community Do Not Want to be Vaccinated

Many community members are concerned about the safety of the COVID-19 vaccine and, as such, do not want to receive vaccine. Concerns primarily arise from pregnancy and fertility-related issues, caused by the vaccine, which is further emphasized through how quickly the vaccine was implemented. Instead, those who do not want the vaccine would feel safer, knowing the long-term effects have been heavily researched and would like to see the vaccine be Food and Drug Administration (FDA) approved for nonemergency use. This research created a dichotomy between older generations who felt the vaccine was a necessary component of safety and the younger generation who tend to be against the vaccine. Others who have received the vaccine and have had negative side effects are also worried about having to receive booster doses, which will lower the demand for future vaccination.

Because research on the safety and long-term effects of the vaccine is not readily available from trusted sources, community members take it upon themselves to find their own sources of information. This effort to find their own answers raises concerns within the community as a lot of misinformation is spread to those who

are on the fence about taking the vaccine and drives away people who would otherwise want the vaccine.

Sources of COVID-19 Information

For community members who are looking for answers about COVID-19 and the safety and efficacy of the vaccine, very few sources of information can be found. The Center for Disease Control and Prevention (CDC) is no longer seen as a trusted source of information due to their constant change in recommendations and research on COVID-19 and vaccine. Mainstream media is seen as a politicizing force instead of a scientific one; therefore, community members have turned to social media as a credible source of information. Because of the youth's tendency toward social media, trends of youth portrayed a population who did not want the vaccine, compared to older populations who did not look to social media as sources of platforms, such as Facebook, have been utilized as a speaking ground because it is easy to spread information. This evidence comes in the form of stories and statistics from trusted professionals, which causes worries to public health officials about the spread of misinformation. With misinformation through social media and the politics behind mainstream media, COVID-19 controversy within the community has been developing, causing even more contention between those who want the vaccine and those who are against receiving the vaccine.

Barriers to Receiving the COVID-19 Vaccination

Overall, community members feel that those who want the vaccine readily have the means to receive it. Transportation is available to get people to providers administering the vaccine, and often if unavailable, these providers will make home visits to ensure the vaccine is received. Additional flexibility comes in the form of pop-up clinics, sick time off from work if side effects are felt by those who receive the vaccine, and the addition of public health hours have, allowing for vaccine implementation throughout many hours of the day. Respondents are thankful for the services provided by public health and their employers, and gratitude is felt knowing that these sources are available due to their lower population rural environment. Many believe this service would not be possible in a more urban environment where resources may be scarcer.

Ways to Increase Confidence and Vaccination Rates

To increase vaccination rates, community members believe that strategies should be focused on convincing those who are on the fence about receiving the vaccine. For them, this concern means finding reliable, local, sources of information and making these readily accessible for those seeking it. Others believe that employers can continue to provide a vaccine-friendly culture by making it known that employees can take time off from work to become vaccinated, and taking sick days due to side effects from the vaccine will be seen in a positive light. Additionally, community members are optimistic about the county commission who repeatedly asks how they can be of service during this pandemic. A collaboration between public health and the commission would be seen favorably by the community for developing future strategies on how to mitigate the spread of COVID-19 and amplify vaccination rates.

Demographic Information

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

Table 1: RANSOM COUNTY AND SARGENT COUNTY: INFORMATION AND DEMOGRAPHICS

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

	Ransom County	Sargent County	North Dakota
Population (2019)	5,218	3,898	762,062
Population change (2010-2019)	-4.4%	1.8%	13.3%
People per square mile (2010)	6.3	4.5	9.7
Persons 65 years or older (2019)	21.2%	22.7%	15.7%
Persons under 18 years (2019)	22.4%	21.6%	23.6%
Median age (2019 est.)	48.5	45.2	35.1
White persons (2019)	95.5%	93.5%	86.9%
High school graduates (2019)	91.0%	91.9%	92.6%
Bachelor's degree or higher (2019)	19.1%	18.5%	30.0%
Live below poverty line (2019)	8.7%	7.5%	10.6%
Persons without health insurance, under age 65 years (2019)	6.6%	7.2%	8.1%
Households with a broadband Internet subscription (2019)	76.7%	81.2%	80.7%

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

While the population of North Dakota has grown in recent years, Ransom County has seen a decrease in population since 2010, while Sargent County has seen a population increase. The U.S. Census Bureau estimates show that Ransom County's population decreased from 5,457 (2010) to 5,218 (2019), and Foster County's population decreased from 3,829 (2010) to 3,898 (2019).

County Health Rankings

The Robert Wood Johnson Foundation, in collaboration with the University of Wisconsin Population Health Institute, has developed County Health Rankings to illustrate community health needs and provide guidance for actions toward improved health. In this report, Ransom County and Sargent County are compared to North Dakota rates and national benchmarks on various topics, ranging from individual health behaviors to the quality of healthcare.

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

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

Health Outcomes

- Length of life
- Quality of life

Health Factors

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

Health Factors (continued)

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

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

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

Ransom County and Sargent County rankings within the state are included in the summary following. For example, Ransom County ranks 16th out of 46 ranked counties in North Dakota on health outcomes and 11th out of 45 on health factors. Sargent County ranks 14th out of 46 ranked counties in North Dakota on health outcomes and 17th out of 45 on health factors. The measures, marked with a bullet point (•), are those where a county is not measuring up to the state rate/percentage; a square (■) indicates that the county is not meeting the U.S. Top 10% rate on that measure. Measures that are not marked with a colored shape but are marked with a plus sign (+) indicate that the county is doing better than the U.S. Top 10%.

The data from County Health Rankings show that Ransom County and Sargent County are doing better than many counties, compared to the rest of the state on all but three of the outcomes, landing at or above rates for other North Dakota counties. However, both counties, like many North Dakota counties, are doing poorly in many areas when it comes to the U.S. Top 10% ratings. One particular outcome where Ransom County does not meet the U.S. Top 10% ratings is the number 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 mental health
- Low birth weight
- Adult smoking
- Adult obesity
- Food environment index
- Uninsured

- Mammography screening
- Unemployment
- Children in poverty
- Income inequality
- Children in single-parent households
- Social associations
- Violent crime
- 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 indicators:

- Poor mental health days
- Low birth weight
- Adult smoking
- Adult obesity
- Food environment index
- Excessive drinking
- Alcohol-impaired driving deaths
- Sexually transmitted infections
- Teen birth rate
- Uninsured
- Dentists
- Mammography screening
- Unemployment
- Children in poverty
- Income inequality
- Children in single-parent households
- Social associations
- Violent crime
- Severe housing problems

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
- Poor physical health
- Poor mental health
- Low birth weight
- Adult smoking
- Adult obesity
- Food environment index
- Uninsured
- Mammography screening
- Unemployment
- Children in poverty
- Income inequality
- Children in single-parent households
- Social associations
- Injury deaths
- Severe housing problems

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

- Physical inactivity
- Access to exercise opportunities
- Preventable hospital stays
- Flu vaccinations
- Air pollution – particulate matter

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

- Premature death
- Poor or fair health
- Poor physical health days
- Physical inactivity
- Access to exercise opportunities
- Primary care physicians
- Mental health providers
- Preventable hospital stays
- Flu vaccinations
- Injury deaths
- Air pollution – particulate matter

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

- Physical inactivity
- Access to exercise opportunities
- Excessive drinking
- Alcohol-impaired driving deaths
- Dentists
- Preventable hospital stays
- Flu vaccinations
- Air pollution – particulate matter

TABLE 2: SELECTED MEASURES FROM COUNTY HEALTH RANKINGS 2021 – RANSOM COUNTY and SARGENT COUNTY

● = Not meeting North Dakota average

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

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

Blank values reflect unreliable or missing data

	Ransom County	Sargent County	U.S. Top 10%	North Dakota
Ranking: Outcomes	**16th**	**14th**		**(of 46)**
Premature death	9,200 ■●		5,400	6,600
Poor or fair health	15% ■●	14% +	14%	14%
Poor physical health days (in past 30 days)	3.3 ●	3.2 +	3.4	3.2
Poor mental health days (in past 30 days)	3.7 +	3.5 +	3.8	3.8
Low birth weight	5% +	5% +	6%	6%
Ranking: Factors	**11th**	**17th**		**(of 45)**
Health Behaviors				
Adult smoking	20% ■	19% ■	16%	20%
Adult obesity	33% ■	34% ■	26%	34%
Food environment index (10=best)	9.4 +	9.6 +	8.7	8.9
Physical inactivity	24% ■●	31% ■●	19%	23%
Access to exercise opportunities	71% ■●	62% ■●	91%	74%
Excessive drinking	24% ■	26% ■●	15%	24%
Alcohol-impaired driving deaths	25% ■	80% ■●	11%	42%
Sexually transmitted infections	264.3 ■		161.2	466.6
Teen birth rate	9 +		12	20
Clinical Care				
Uninsured	7% ■	8% ■	6%	8%
Primary care physicians	2,620:1 ■●		1,030:1	1,300:1
Dentists	1,300:1 ■	3,900:0 ■●	1,210:1	1,510:1
Mental health providers	1,740:1 ■●		270:1	510:1
Preventable hospital stays	5,028 ■●	4,516 ■●	2,565	4,037
Mammography screening (% of Medicare enrollees ages 65-74 receiving screening)	55% +	56% +	51%	53%
Flu vaccinations (% of fee-for-service Medicare enrollees receiving vaccination)	45% ■●	48% ■●	55%	50%
Social and Economic Factors				
Unemployment	1.7% +	1.8% +	2.6%	2.4%
Children in poverty	10% +	10% +	10%	11%
Income inequality	3.5 +	3.0 +	3.7	4.4
Children in single-parent households	17% ■	19% ■	14%	20%
Social associations	34.4 +	18.1 ■	18.2	16.0
Violent crime	129 ■	91 ■	63	258
Injury deaths	124 ■●	67 ■	59	71
Physical Environment				
Air pollution – particulate matter	5.4 ■●	5.3 ■●	5.2	4.7
Drinking water violations	No	No		
Severe housing problems	5% +	7% +	9%	12%

Children's Health

The National Survey of Children's Health touches on multiple intersecting aspects of children's lives. Data are not available at the county level; listed below is information about children's health in North Dakota. The full survey includes physical and mental health status, access to quality healthcare, and information on the child's family, neighborhood, and social context. Data are from 2017-18. More information about the survey may be found at www.childhealthdata.org/learn/NSCH.

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

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

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

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

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

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

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

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

The data show Ransom County is performing more poorly than the North Dakota average on two of the examined measures: children enrolled in Healthy Steps (CHIP) and Supplemental Nutrition Assistance Program (SNAP) recipients). The most marked difference was on the measure of Supplemental Nutrition Assistance Program (SNAP) recipients (almost 1% lower rate in Ransom County).

Sargent County is performing more poorly than the North Dakota average on three factors: Medicaid recipients, children enrolled in Healthy Steps (CHIP), and four-year high school cohort graduation rate.

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

	Sargent County	Ransom County	North Dakota
Child food insecurity, 2019	6.1%	8.3%	9.6%
Medicaid recipient (% of population age 0-20), 2020	**26.8%**	23.8%	26.6%
Children enrolled in Healthy Steps (CHIP) (% of population age 0-18), 2020	**2.6%**	**2.4%**	1.6%
Supplemental Nutrition Assistance Program (SNAP) recipients (% of population age 0-18), 2020	15.5%	**17.9%**	16.9%
Licensed childcare capacity (# of children), 2020	175	237	36,701
4-year high school cohort graduation rate, 2019/2020	**82.6%**	≥95%	89.0%
Victims of child abuse and neglect requiring services (rate per 1,000 children ages 0-17), 2019	NA	8.31 (2018)	9.98

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

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

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

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

TABLE 5: Youth Risk Behavior Survey Results

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

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

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

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

Low Income Needs

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

Top Needs Identified by People Experiencing Poverty Across North Dakota

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

2020 North Dakota LOW INCOME COMMUNITY NEEDS

Helping People. Changing Lives. Community Action Partnership — America's Poverty Fighting Network

NDSU North Dakota State University

Assessed by CAPND and NDSU, November 2020

KEY FINDINGS

1st Priority Need

Rental Assistance

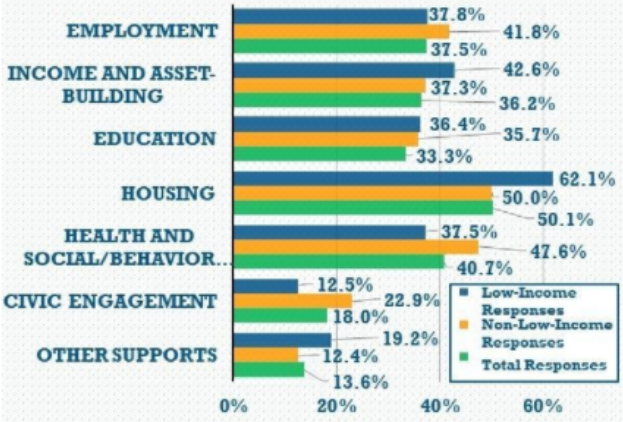
3,458 Total Survey Responses

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

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

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

STATEWIDE OVERALL NEEDS



TOP STATEWIDE SPECIFIC NEEDS

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

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

Community (Low-Income & Non-Low-Income)
- **Health and Social/Behavior Development** - Dental Insurance/Affordable Dental
- **Health and Social/Behavior Development** - Health Insurance/Affordable Health Care
- **Health and Social/Behavior Development** - Mental Health Service

TOP REGIONAL OVERALL NEEDS FOR LOW-INCOMES

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

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

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

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

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

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

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

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

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Survey Results

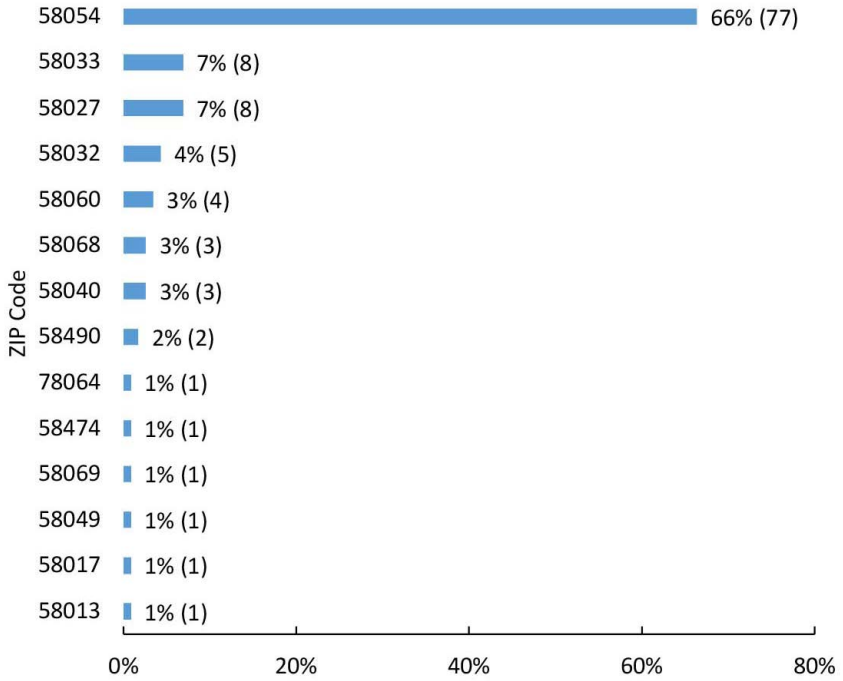
As noted previously, 150 community members completed the survey in communities throughout the counties in the CHI Lisbon Health service area. For all questions that contained an "Other" response, all of those direct responses may be found in Appendix G. In some cases, a summary of those comments is additionally included in the report narrative. The "Total respondents" number under each heading indicates the number of people who responded to that particular question, and the "Total responses" number under the heading depicts the number of responses selected for that question (some questions allow for selection of more than one response).

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

Survey Demographics

The survey requested that respondents list their home zip code. While not all respondents provided a zip code, 116 did, revealing that a large majority of respondents (66%, N=77) lived in Ransom County (Lisbon, Buttzville). These results are shown in Figure 5.

Figure 5: Survey Respondents' Home Zip Code
Total respondents: 116



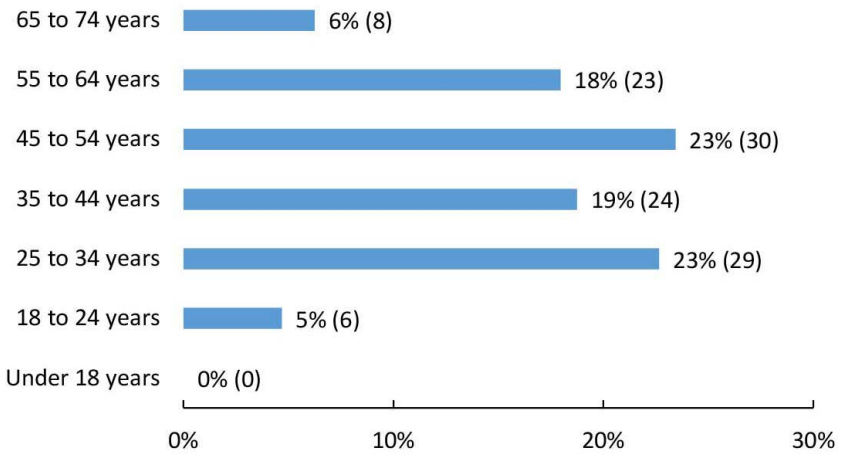
To better understand the perspectives being offered by survey respondents, survey-takers were asked a few demographic questions. Throughout this report, numbers (N) instead of just percentages (%) are reported because percentages can be misleading with smaller numbers. Survey respondents were not required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

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

- 30% (N=39) were age 55 or older
- The majority (80%, N=103) were female
- Almost half of the respondents (46%, N=59) had bachelor's degrees or higher
- The number of those working full time (71%, N=91) was just over five times higher than those who were retired (13%, N=17)
- 95% (N=121) of those who reported their ethnicity/race were White/Caucasian
- 20% of the population (N=24) had household incomes of less than $50,000

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

Figure 6: Age of Survey Respondents
Total respondents = 128



For the CHNA, people under age 18 are not questioned.

Figure 7: Gender of Survey Respondents
Total respondents = 128

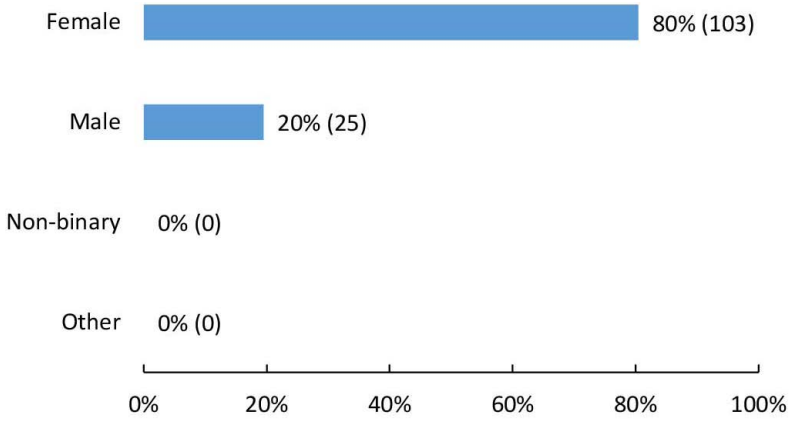


Figure 8: Highest Education Level of Survey Respondents
Total respondents = 128

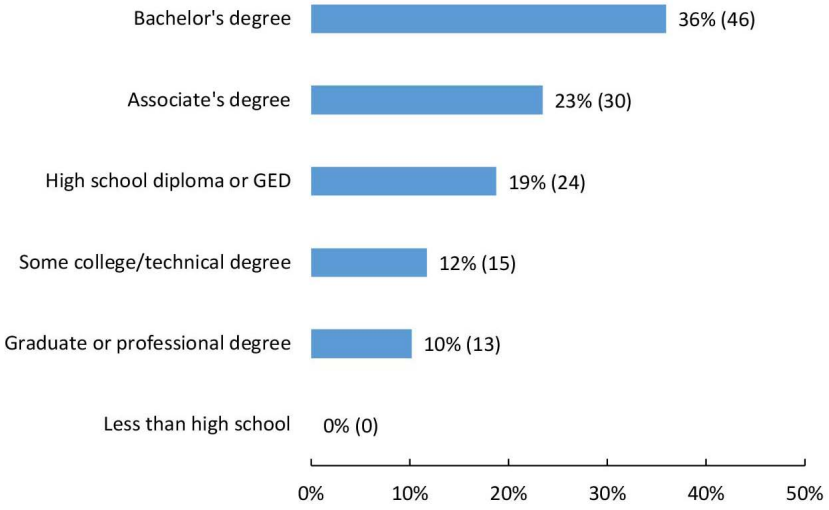
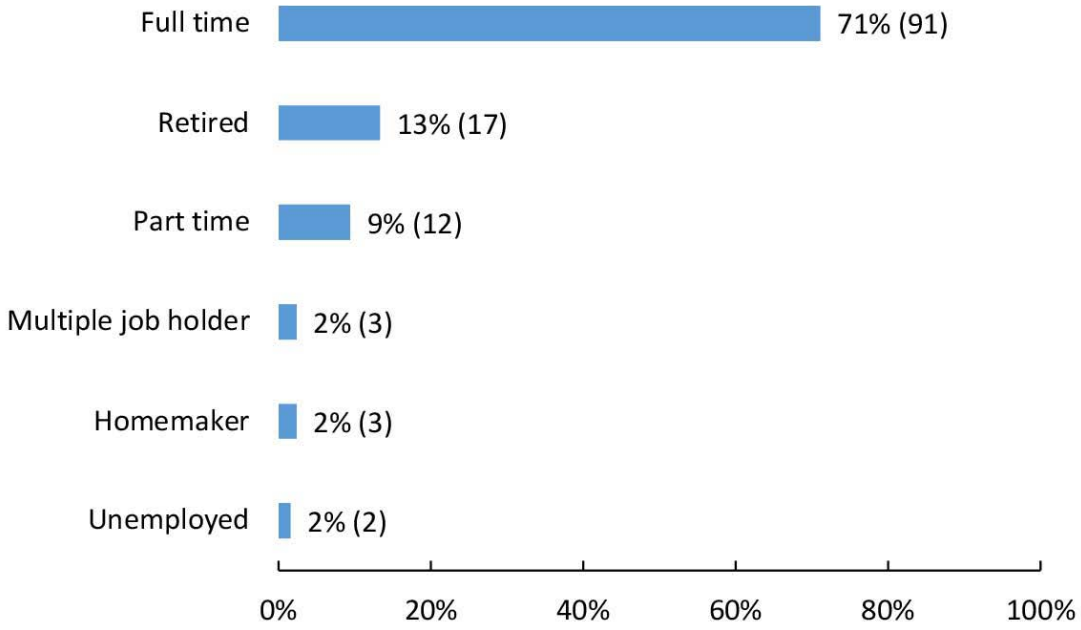
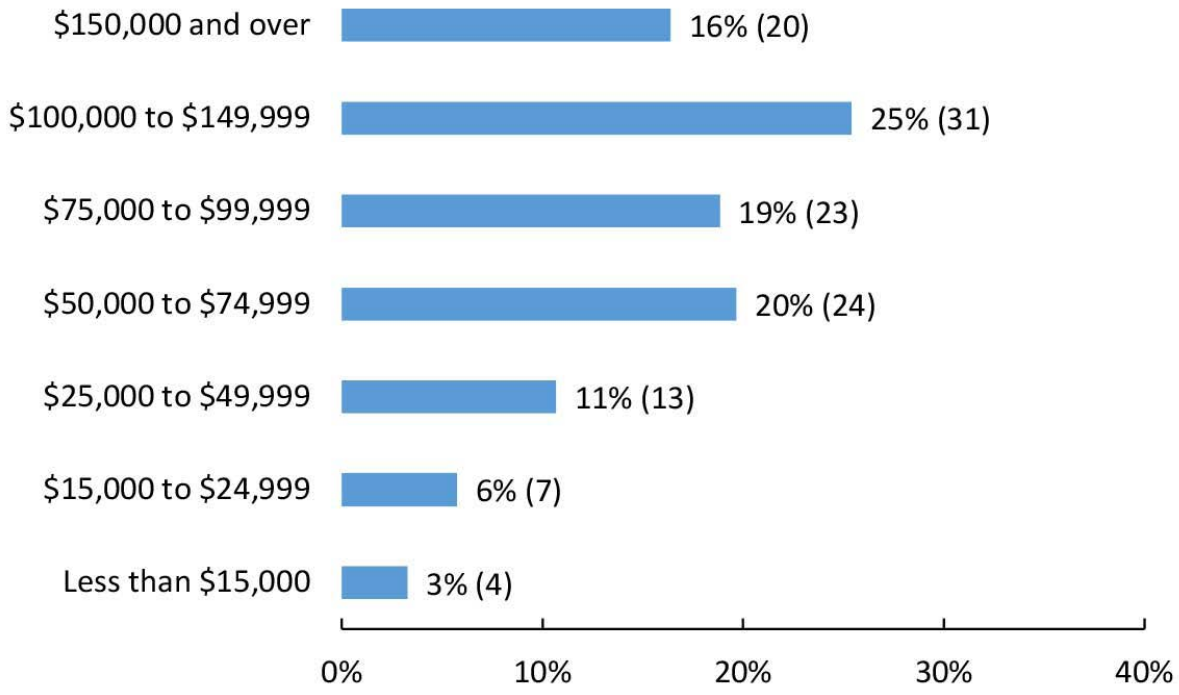


Figure 9: Employment Status of Survey Respondents
Total respondents = 128



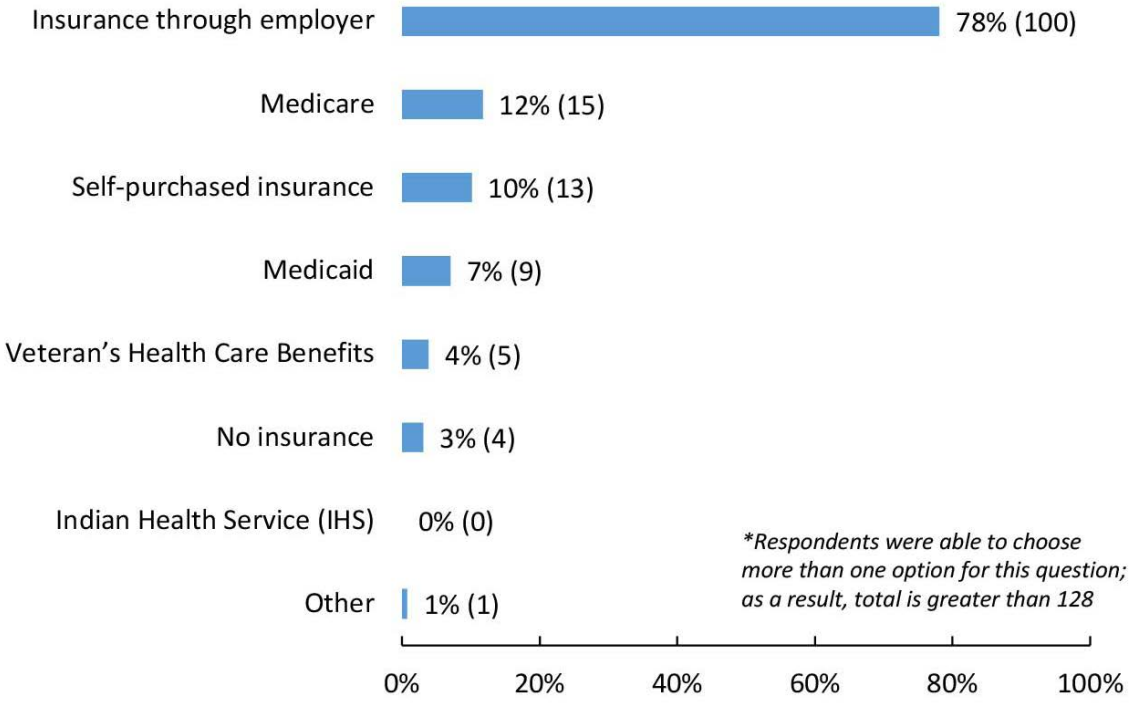
Of those who provided a household income, 9% (N=11) of community members reported a household income of less than $25,000. Forty-one percent (N=51) indicated a household income of $100,000 or more. This information is shown in Figure 10.

Figure 10: Household Income of Survey Respondents
Total respondents = 122



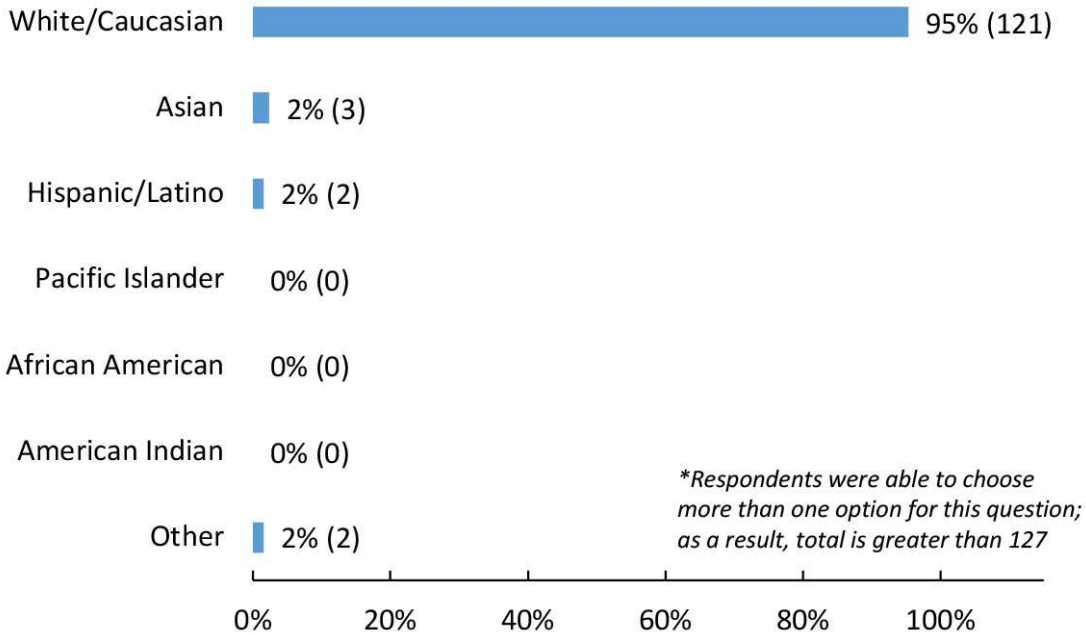
Community members were asked about their health insurance status, which is often associated with whether people have access to healthcare. Three percent (N=4) of the respondents reported having no health insurance. The most common insurance types were insurance through one's employer (N=100), followed by Medicare (N=15), and self-purchased insurance (N=13).

Figure 11: Health Insurance Coverage Status of Survey Respondents
Total respondents = 128*



As shown in Figure 12, nearly all of the respondents were White/Caucasian (95%). This percent was in-line with the race/ethnicity of the overall population of Ransom and Sargent Counties; the US Census indicates that 95.5% of the population is white in Ransom County and 93.5% in Sargent County.

Figure 12: Race/Ethnicity of Survey Respondents
Total respondents = 127*



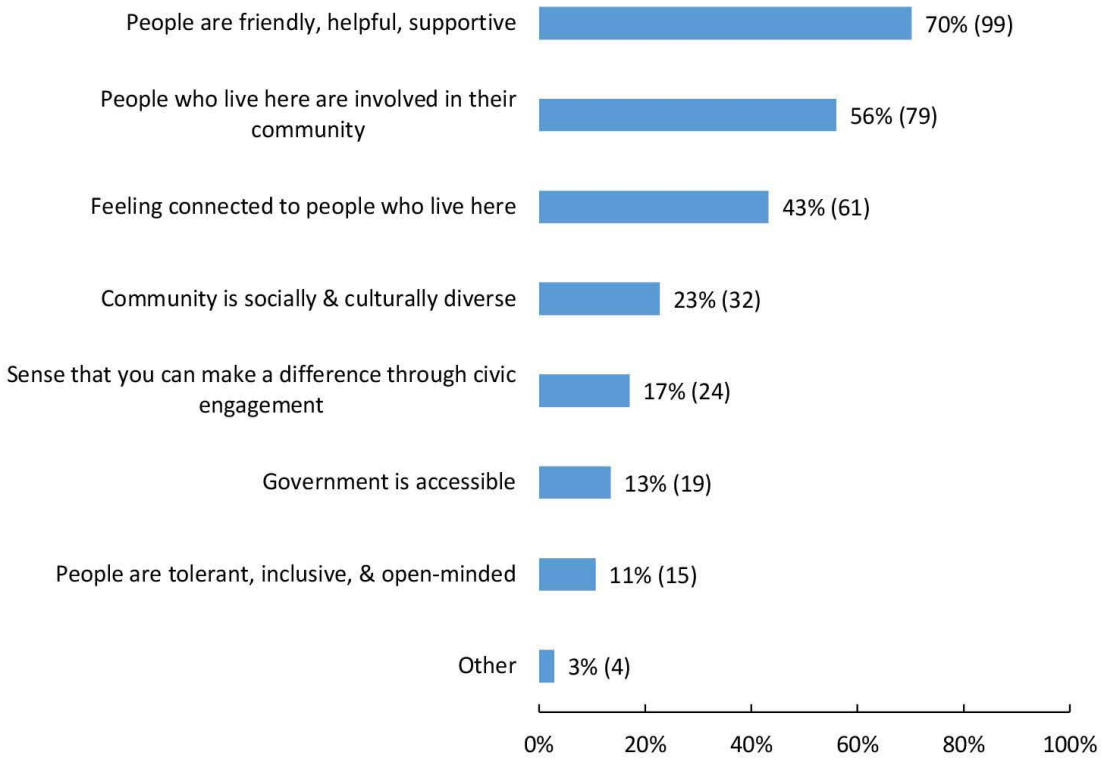
Community Assets and Challenges

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 90 respondents agreeing) that community assets include:

- Safe place to live, little/no crime (N=111);
- Family-friendly (N=105);
- People are friendly, helpful, supportive (N=99); and
- Recreational and sports activities (N=90).

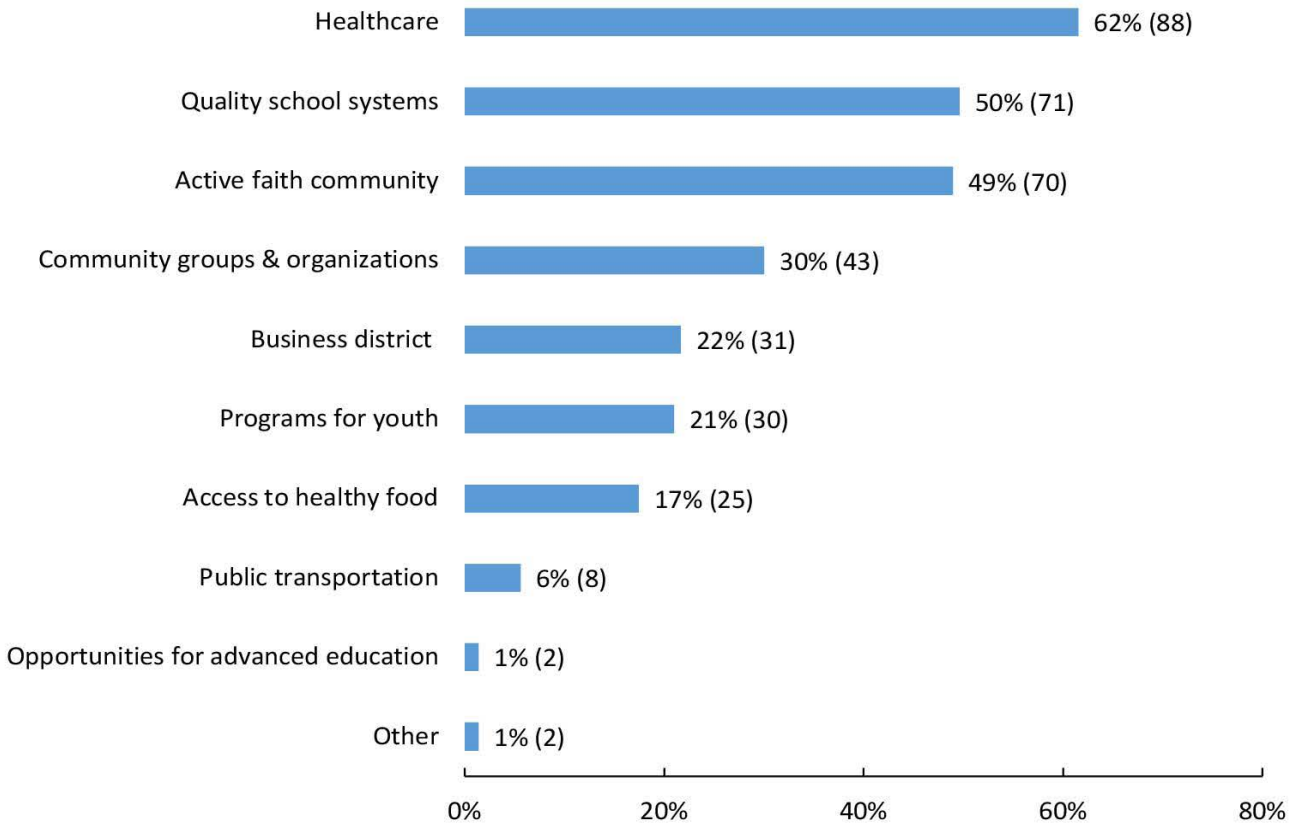
Figures 13 to 16 illustrate the results of these questions.

Figure 13: Best Things About the PEOPLE in Your Community
Total responses = 333



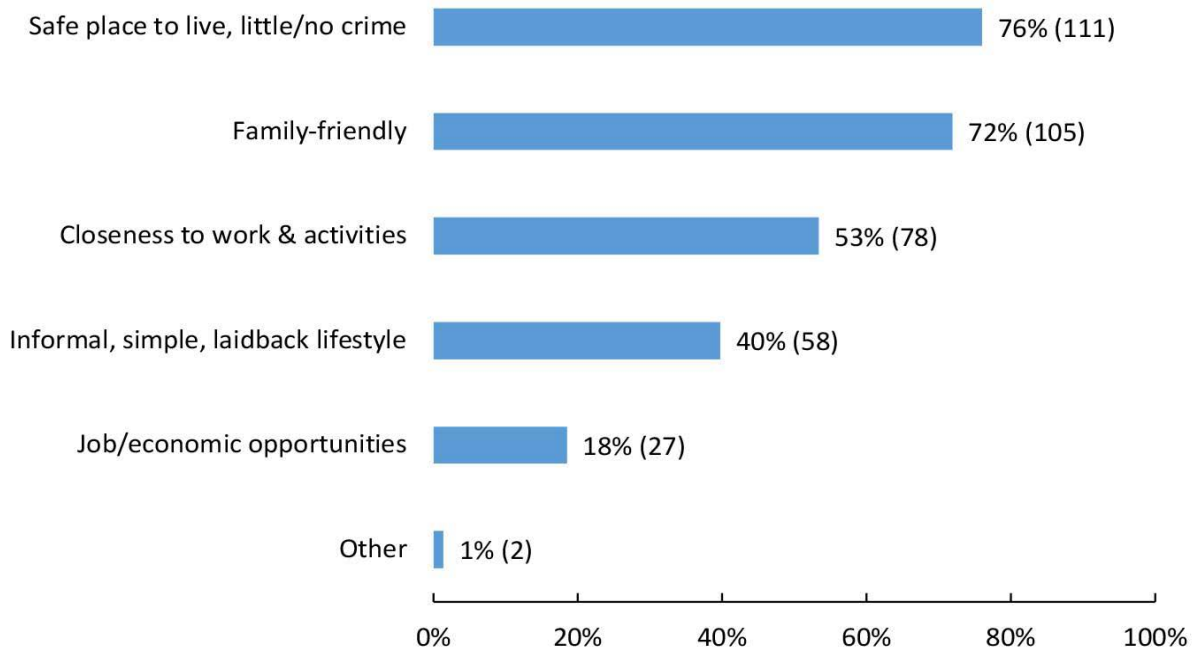
Included in the "Other" category of the best things about the people was that beer sales are outstanding and none of the above.

Figure 14: Best Things About the SERVICES AND RESOURCES in Your Community
Total responses = 370



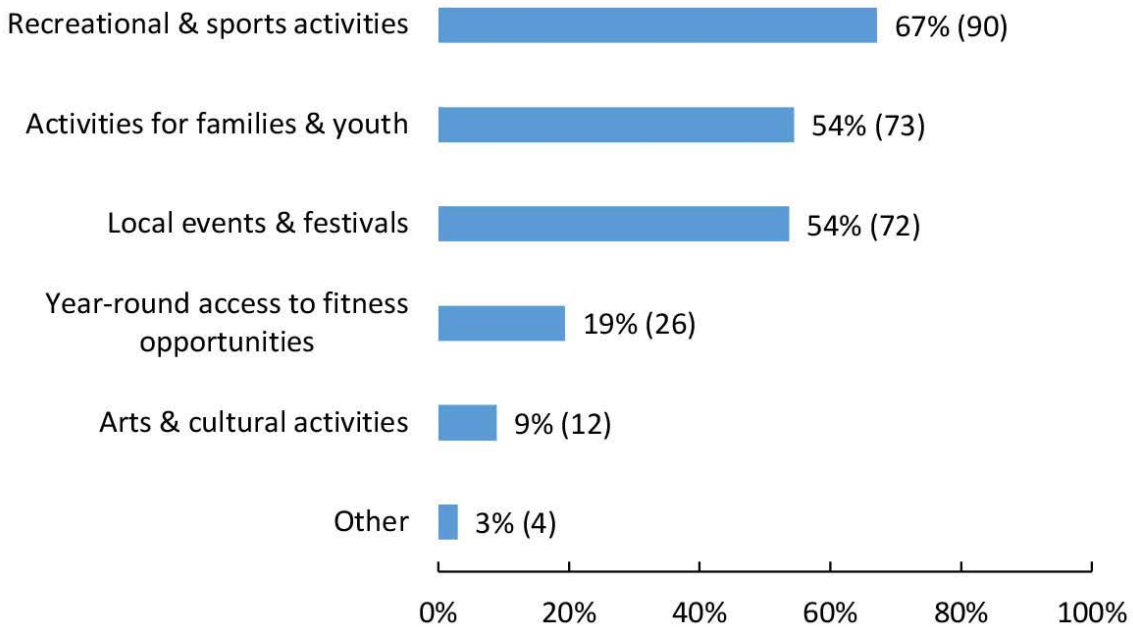
Respondents who selected "Other" specified that the best things about services and resources included the roads.

Figure 15: Best Things About the QUALITY OF LIFE in Your Community
Total responses = 381



The "Other" responses, regarding the best things about the quality of life in the community, were none of the above.

Figure 16: Best Thing About the ACTIVITIES in Your Community
Total responses = 277



Respondents who selected "Other" specified that the best things about the activities in the community included the movie theater and none of the above.

Community Concerns

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

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

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

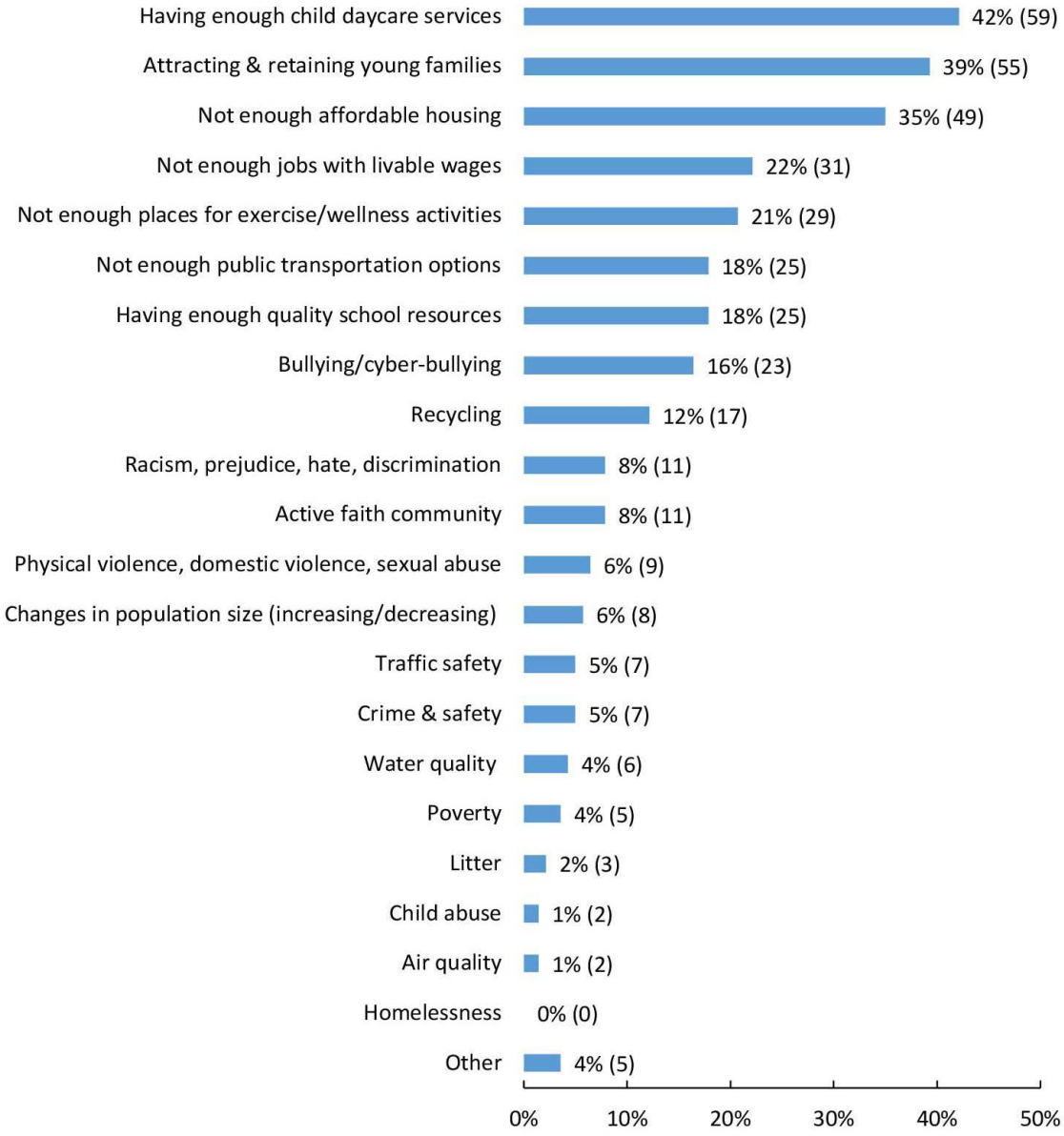
- Alcohol use and abuse – Adults (N=68);
- Drug use and abuse – Youth (N=64);
- Having enough child daycare services (N=59);
- Depression/anxiety – Youth (N=56);
- Attracting and retaining young families (N=55);
- Cost of long-term/nursing home care (N=55);
- Alcohol use and abuse – Youth (N=53); and
- Depression/anxiety – Adult (N=50).

The other issues that had at least 38 votes included:

- Not getting enough exercise/physical activity - Adults (N=39);
- Not enough affordable housing (N=49);
- Extra hours for appointments, such as evenings and weekends (N=39);
- Availability of mental health services (N=47);
- Not enough activities for children and youth (N=39);
- Not getting enough exercise/physical activity – Youth (N=39);
- Smoking and tobacco use (second-hand smoke, vaping (N=38); and
- Stress – Adults (N=38).

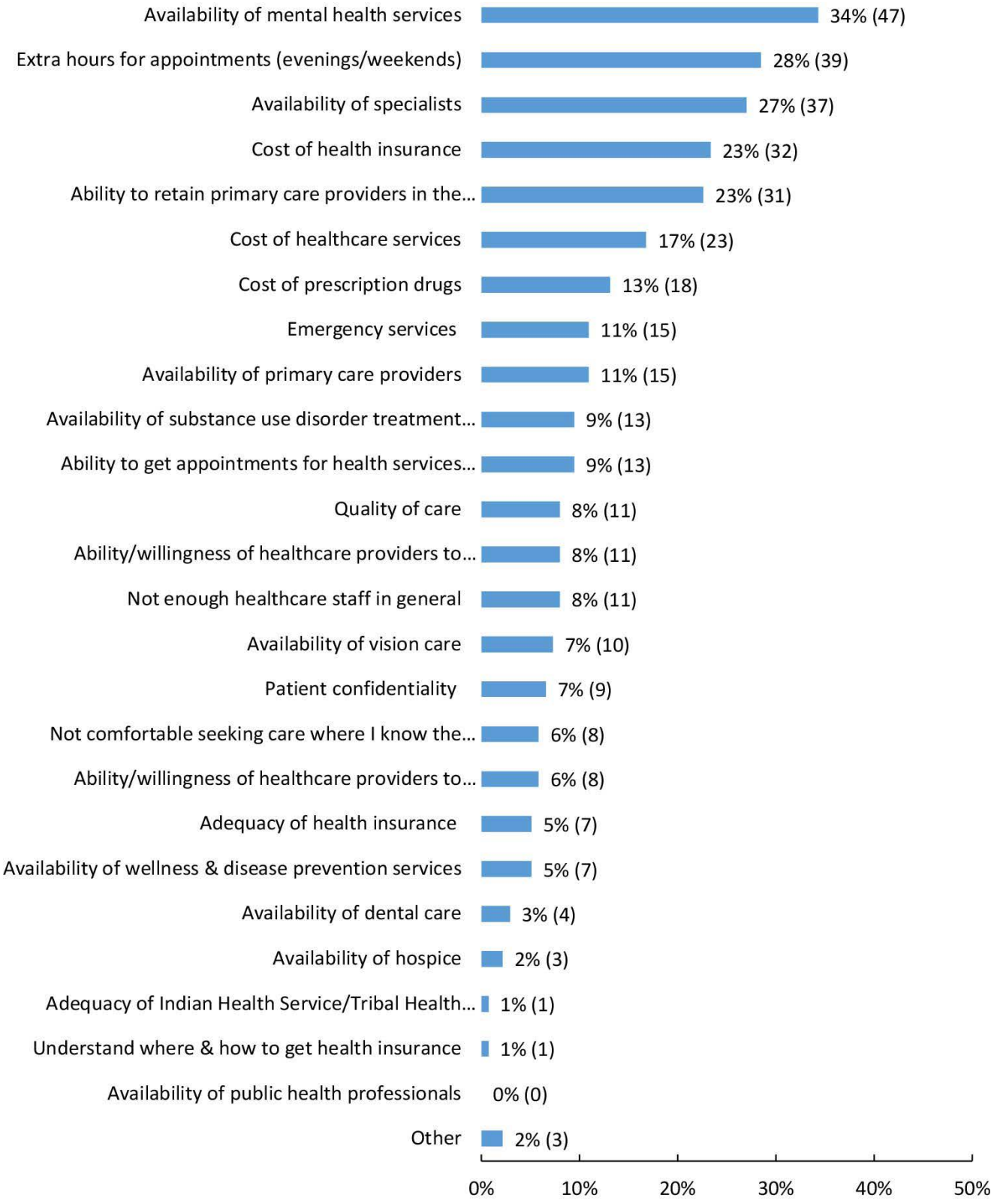
Figures 17 through 21 illustrate these results.

Figure 17: Community/Environmental Health Concerns
Total responses = 389



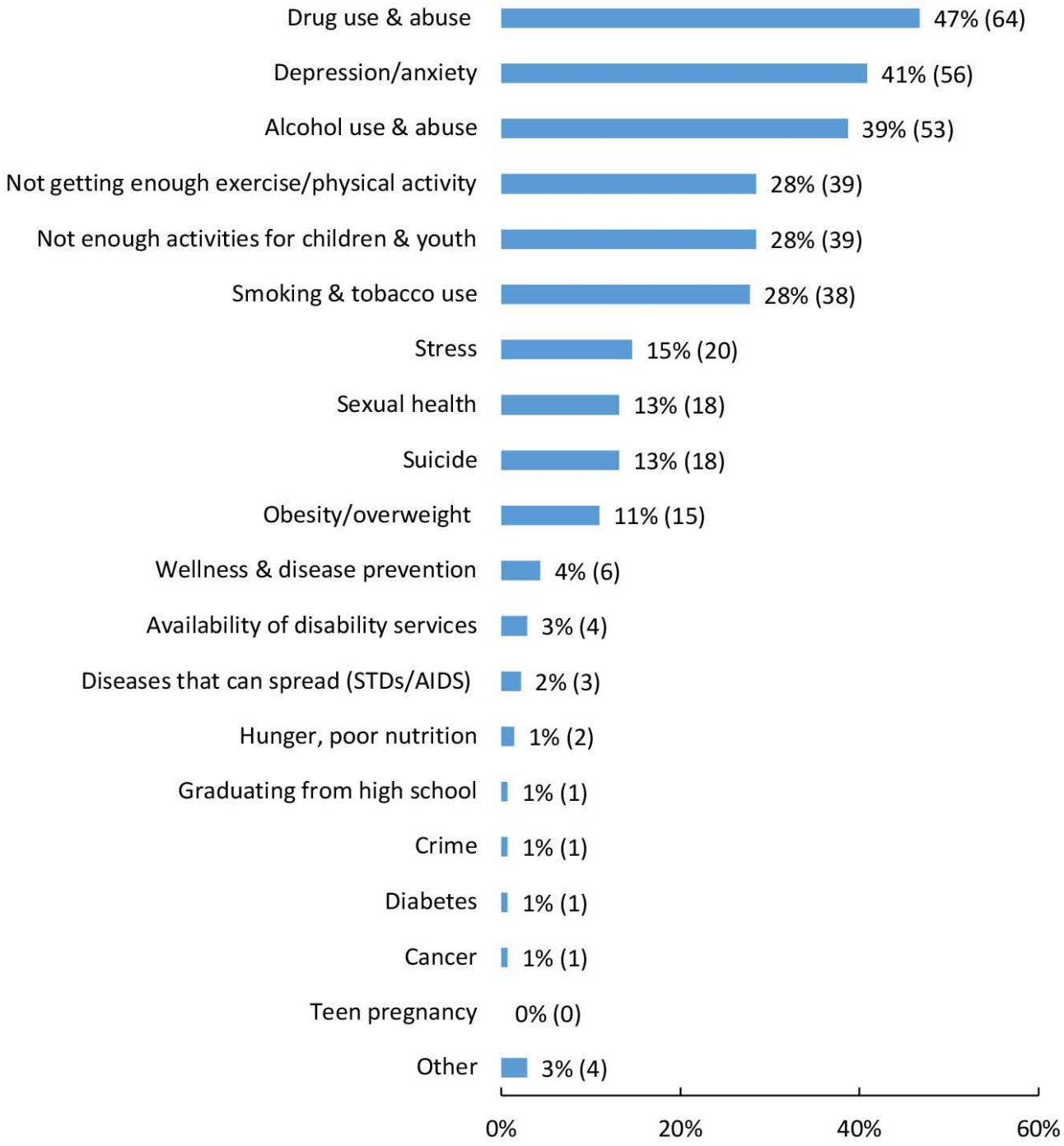
In the "Other" category for community and environmental health concerns, the following items were listed: indoor activities for kids, mental healthcare, not enough options for affordable clothes and shoes shopping, not enough people vaccinated against COVID-19, and proper access to emergency food resources.

Figure 18: Availability/Delivery of Health Services Concerns
Total responses = 377



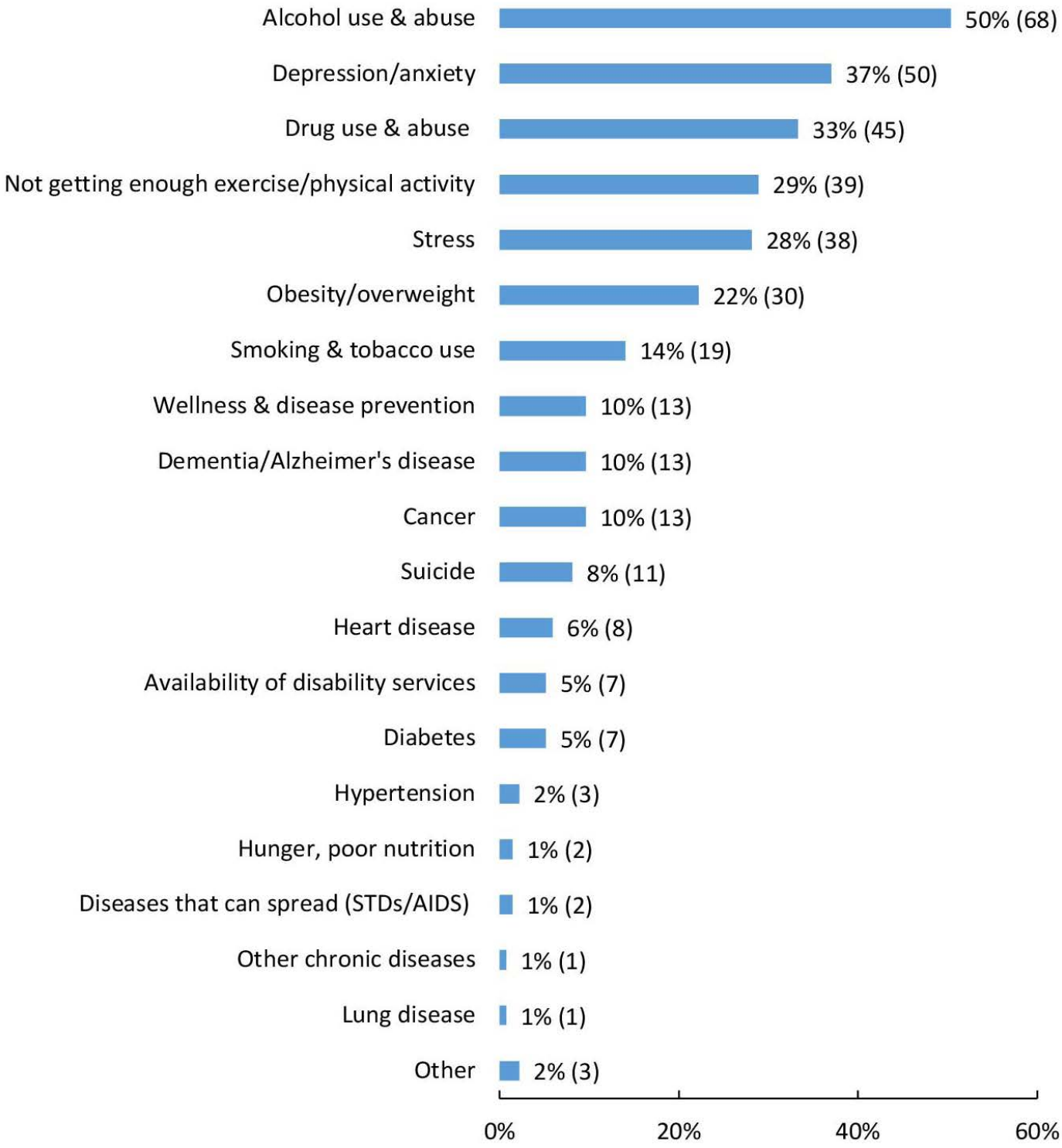
Respondents who selected "Other" identified concerns in the availability/delivery of health services as billing is a hassle and doctors turning patients away with mental health issues at the ER.

Figure 19: Youth Population Health Concerns
Total responses = 383



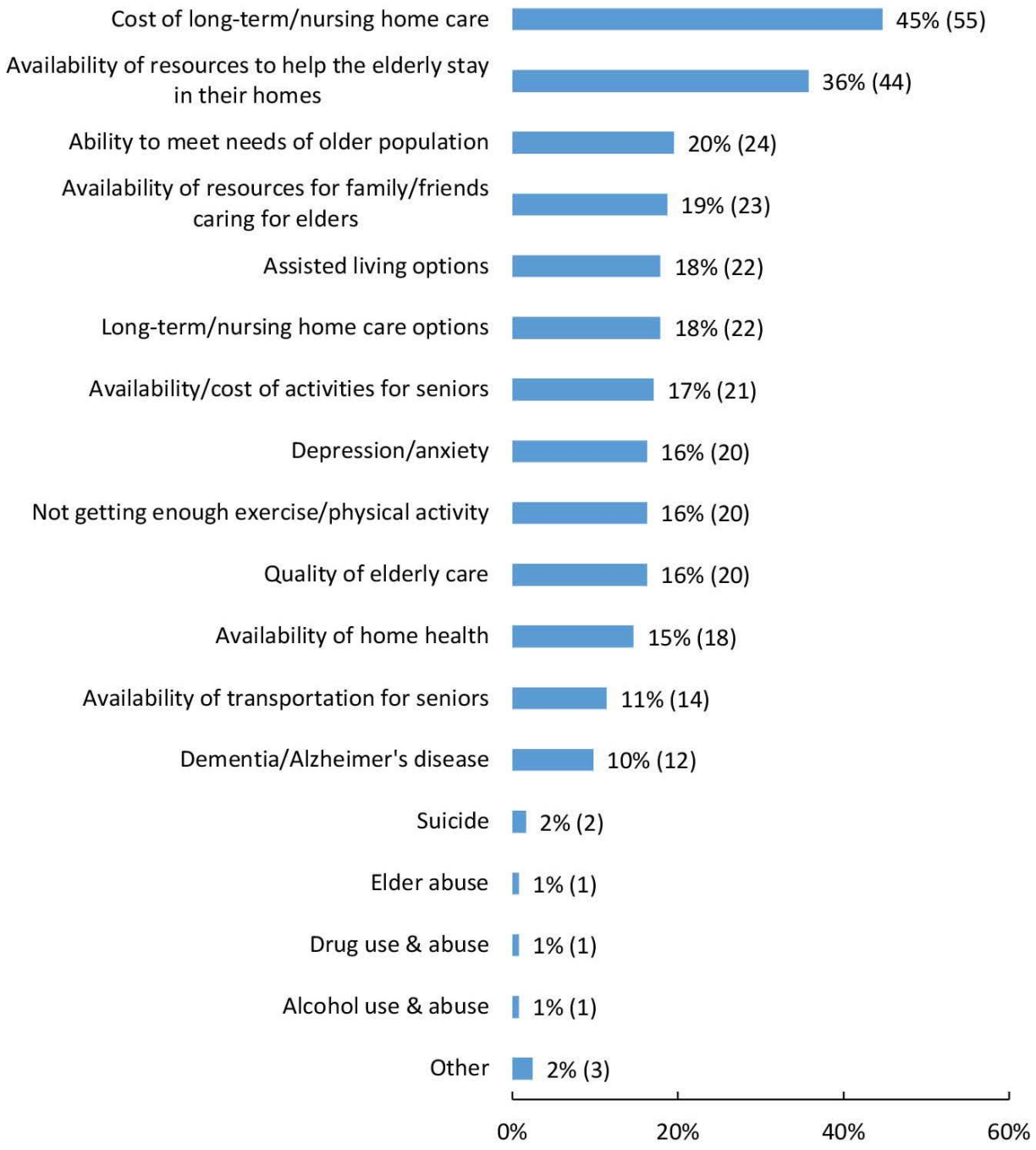
Listed in the "Other" category for youth population concerns were mental health services for children, bullying, lack of tutors in the Lisbon school, and engaging youth and families in the community.

Figure 20: Adult Population Concerns
Total responses = 373



Support for families with development disabilities and mental health issues, medical help for mental health issues, and parental classes were indicated in the "Other" category for adult population concerns.

Figure 21: Senior Population Concerns
Total responses = 323



In the "Other" category, the concerns listed were elder abuse and loneliness.

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. Lack of mental health services
2. Lack of community events, especially for youth and families

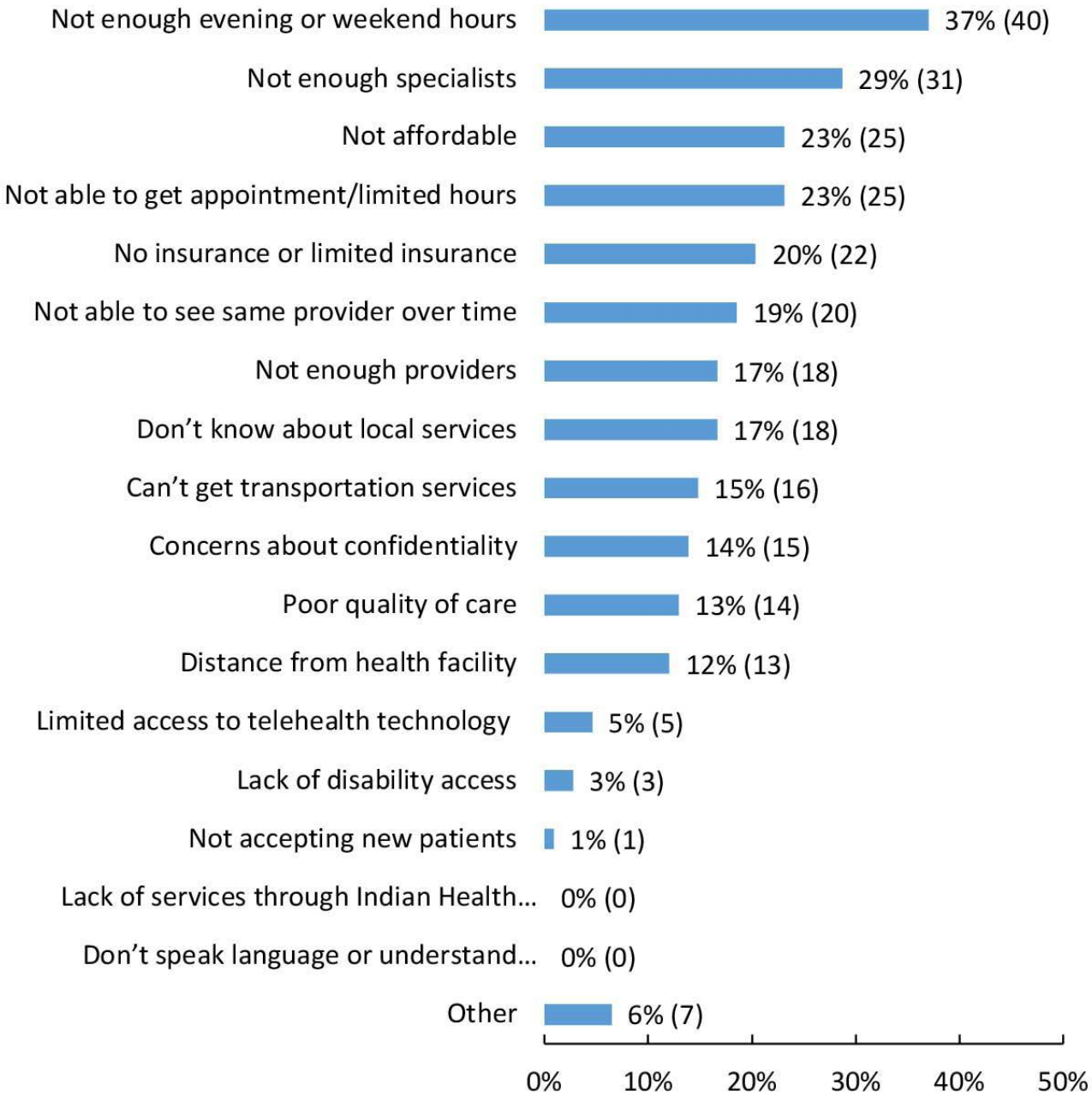
Other biggest challenges that were identified were alcohol and drug abuse, affordable houses for purchase (not rent), attracting and retaining young families, better community leaders, daycare, discrimination, lack of economic growth, vandalism, cost of elder care, no wellness/recreation center, and politics.

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=40) with the next highest being not enough specialists (N=31). After these two items, the next most commonly identified barriers were not affordable (N=25), not able to get appointment/limited hours (N=25), and no insurance or limited insurance (N=22). The majority of concerns indicated in the "Other" category were too expensive even with insurance, length of time it takes to get test results back, no pharmacy access, and bad experiences with the hospital.

Figure 22 illustrates these results.

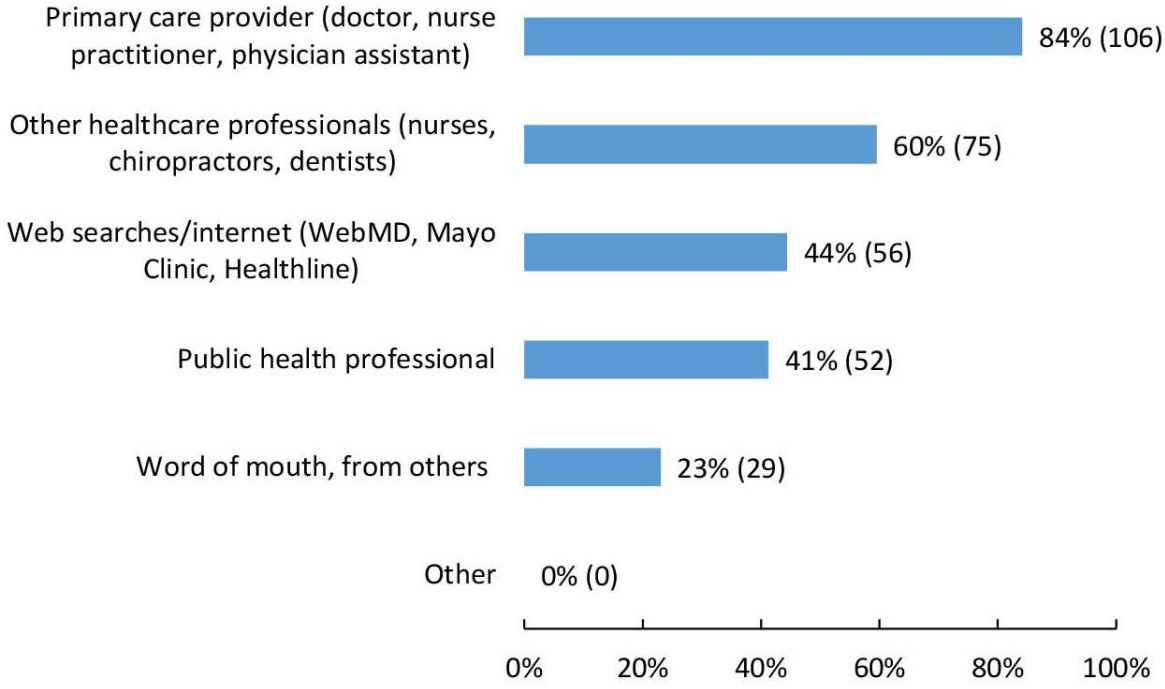
Figure 22: Perceptions About Barriers to Care
Total responses = 273



Respondents were asked where they go to for trusted health information. Primary care providers (N=106) received the highest response rate, followed by other healthcare professionals (N=75), and then web/Internet searches (N=56).

Results are shown in Figure 23.

Figure 23: Sources of Trusted Health Information
Total responses = 318



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

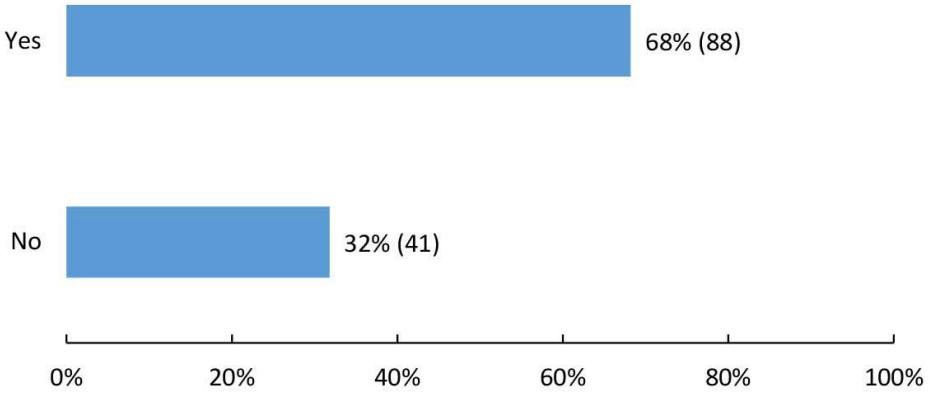
- Birthing center/ability to deliver babies
- Cancer center
- Chiropractor
- Diet/nutrition services
- Emergency care
- Extended clinic hours
- Eye clinic
- Family counseling
- Gastroenterologist
- Hearing aid support
- Improved billing and set cost system
- NICU
- OB/GYN
- Optometrist
- Orthopedic services
- Pediatrician
- Pharmacy
- Physical therapy/rehab services
- Substance use treatment services
- Urology
- Wellness center

While not a service, some respondents indicated that they would like physicians and specialists added as well as better staffing in general. Regarding extended clinic hours, it was specifically noted that Saturdays, nights, and weekends would be good options.

The key informant and focus group members felt that the community members were aware of the majority of the health system and public health services. There were a number of services where they felt the hospital should increase marketing efforts; these included mental health resources, home health, hospice, and telehealth.

Just over two-thirds of survey respondents were aware of the CHI Lisbon Health Foundation, as shown in Figure 24.

Figure 24: Awareness of CHI Lisbon Health Foundation
Total responses = 129



The final question on the survey asked respondents to share concerns and suggestions to improve the delivery of local healthcare. Respondents felt that there was a need for flyers and more public information about what services are available to the public. Cost of medical services such as imaging, lab work, and medication was noted as a concern; many community members are still paying a high bill even after insurance. A few respondents brought up getting turned away at the ER, and that is a problem. Respondents feel that some of the healthcare workers who are coming to the hospital are not quality or not trained enough. The need for a walk-in clinic for evenings and weekends was noted as a big need for the community in this question and throughout the survey results. Respondents also stated the need to retain local doctors and the need for more mental health and substance abuse services. They also noted it would be helpful to apply for grants to provide space or equipment to make it easy for a dentist or an optometrist to have a part-time office in town.

Findings from Key Informant Interviews & the Community Meeting

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

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

- Alcohol use and abuse
- Availability of mental health and substance use disorder treatment services
- Depression/anxiety
- Having enough child daycare services

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

Alcohol use and abuse

- There is a curiosity in youth in small towns – alcohol is abundant and a norm
- Youth grow up seeing adults doing it
- A lot of alcohol use in minors in the area
- Drinking and driving is a norm
- A lot of bars and heavy drinkers in town
- Need more events for the community, not a lot of activities going on, so alcohol use continues

Availability of mental health and substance use disorder treatment services

- Only one counselor who is certified
- A lot of stigma in the community that is a barrier to accessing services
- Lot of issues in the community but no one wants to address them
- Not a lot of coaching or education on what mental health is and prevention
- Especially bad with COVID-19 isolation and anxiety and depression
- It is hard to get access to mental health services, especially in crisis situations. They may be stuck in the ER for 72 hours because there is nowhere to go
- Try to normalize mental health issues, it often takes until a crisis to get something done so need to try to prevent the crisis

Depression/anxiety

- Seems to be becoming more common
- Overuse of social media is a contributor

- Stigma prevents people from seeking help
- Bullying is a big issue, especially with social media now
- Suicides are a big issue
- Families are busier and not as connected so seeing more depression/anxiety

Having enough child daycare services

- Should work with young teachers
- It's a scramble to see who will have openings
- Existing services have long waiting lists and no openings
- Given major employers and long shifts in the area, there needs to be more daycare services

Drug use and abuse (including prescription drug abuse)

- Seeing a lot of this abuse in youth and adults, and it has worsened with COVID-19.
- This abuse is always a challenge and includes vaping.

Community Engagement and Collaboration

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

- Public health (4.5)
- Hospital (healthcare system) (4.0)
- Business and industry (3.75)
- Emergency services, including ambulance and fire (3.75)
- Economic development organizations (3.5)
- Faith-based (3.5)
- Human services agencies (3.5)
- Law enforcement (3.5)
- Long-term care, including nursing homes and assisted living (3.5)
- Schools (3.5)
- Social services (3.5)
- Pharmacies (3.5)
- Clinics not affiliated with the main health system (3.25)
- Other local health providers, such as dentists and chiropractors (2.75)

Priority of Health Needs

A community group met on September 20, 2021. Nine 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 flip charts, and each member was given four stickers to place next to each of the four needs they considered the most significant.

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

- Availability of mental health services (9 votes)
- Depression/anxiety – all ages (5 votes)
- Having enough child daycare services (5 votes)
- Availability of substance use disorder treatment services (3 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 (9 votes)
2. Having enough child daycare services (1 vote)
3. Availability of substance use disorder treatment services (0 votes)
4. Depression/anxiety – all ages (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 may be found in Appendix F.

Comparison of Needs Identified Previously

Top Needs Identified 2019 CHNA Process	Top Needs Identified 2021 CHNA Process
Availability of mental health services	Availability of mental health services
Attracting and retaining young families	Having enough child daycare services
Depression/anxiety – all ages	Availability of substance use disorder treatment services
Drug use and abuse – youth	Depression/anxiety – all ages

The current process identified two identical common needs from 2019, availability of mental health services and depression/anxiety in all ages. The top concern in 2021 was the same as 2019, indicating that more needs to be done in this area. Availability of mental health services and depression/anxiety are interconnected needs, so it is not surprising to see them together, appearing as top needs in the community.

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

Upon adoption of this CHNA Report by the CHI Lisbon Health Board vote, a notation will be documented in the board minutes reflecting the approval and then the report will be widely available to the public on the hospital's website and a paper copy will be available for inspection upon request at the hospital. Written comments on this report can be submitted to CHI Lisbon Health CEO at 905 Main Street, Lisbon, North Dakota 58054.

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

In response to the needs identified in the 2019 CHNA process, the following actions were taken:
Needs 1 and 2: Availability of mental health services/depression and anxiety in all ages – The community was concerned about lack of mental health resources in Ransom and Sargent counties as well as lack of education, counseling, and treatment. Grant money was received through CHI Mission fund for the "Make it OK" program to increase awareness of mental health issues and decrease the stigma. Presentations in five schools and two community presentations were planned. Due to COVID-19, only one community program was provided to a youth babysitting clinic, but all five schools are now scheduled for presentations in November 2021. Promotional items have been ordered and received for these presentations. RCPH developed and distributed resource brochures to educate on available resources to include mental health providers. CHI Lisbon Health developed a mental health resource binder with all counseling services, treatment centers as well as inpatient and outpatient programs. CHI Lisbon Health has collaborated with Carrington on telehealth psych as well as implementation of E-emergency, which provided one-on-one live video counseling and emergency psychiatric evaluations. The steering committee identified multiple mental health resources in Ransom County to include Sheyenne Valley Counseling, Abound Counseling, SE Human Service Center, Village Family services at schools, and ARN resources. In Sargent County the following were identified and in use: SE Human Services Telehealth at courthouse and Diane Persons. There was collaboration with North Dakota extension office to order multiple mental health brochures and education materials for use at presentation and throughout the communities. She also had a booth at the Ransom County Fair on "Farm Stress" to increase awareness and provide education on resources for farm families, related to the unique stresses of farm life.

Need 3: Attracting and retaining young families – The hospital and public health chose not to address this need in this implementation cycle.

Need 4: Drug use and abuse in youth – The community was also concerned about drug use and abuse among area youth. The following programs were implemented or continued: Ransom and Sargent County Public Health secured a two-year SOAR grant that worked to decrease the stigma of seeking help for substance abuse. Sargent County Public Health was able to provide Narcan training to area schools, businesses, and EMS workers, and provide funding for the Narcan. The "Parents Lead" program also continues in Sargent County. They ran radio ads to try to lessen the stigma of addiction and mental health. Public health has also been able to obtain grants to help fund area SADD programs, which continue to be active. A mock crash was held on September 29, 2021 with multiple agency involvement. The Lisbon Police Department and Sargent County Public Health continue to have "drug take back" programs. The Lisbon Police Department also provided education at student drivers education classes to include safety and substance use while driving and used vision impairment devices to simulate "driving impaired" to increase awareness of driving impaired.

Need 5: Violence Prevention – The community was concerned with the prevalence of violence. Grant money from the CHI Mission and Ministry has allowed the continued collaboration with CHI, Abuse Resource Network, and Ransom County Public Health to provide education to the community, using evidence-based curriculum to include the "Futures" program, which has reached 16 community leaders and 172 professional people. Five individuals have been trained to teach the curriculum. The "Within my Reach" program also continues to be active and provides education on relationships. Ten presentations have been completed with program coordination through the CHNA network. Mental health presentations at all five schools will also include education on bullying and conflict resolution. The Violence Prevention Coalition has not been meeting regularly due to COVID-19 restrictions but plans to regroup are in the works. A violence prevention education summit was attended on May 2, 2021, and STOP training was attended by two individuals for seven hours of education also.

The above implementation plan for CHI Lisbon Health is posted on the CHI Lisbon Health website at https://lisbonhospital.com/.

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 – Critical Access Hospital Profile

Critical Access Hospital Profile Spotlight on: Lisbon, North Dakota

CHI Lisbon Health
Imagine better health.℠

Quick Facts

Administrator:
Keith Heuser

Chief of Medical Staff:
Dr. Rudy Loperena

Board Chair: Jason Enger

City Population:
2009 (2019 Estimate)[1]

County Population:
5314 (2019 Estimate)[1]

County Median Household Income:
$63,903 (2019 Estimate)[1]

County Median Age:
46.6 (2019 Estimate)[1]

Service Area Population:
40 miles

Owned by: Catholic Health Initiatives

Hospital Beds: 25

Trauma Level: V

Critical Access Hospital Designation: 2001

Economic Impact on the Community[2]

Jobs:
Primary – 72
Secondary – 25
Total – 97

Financial Impact:
Primary – $3.9 million
Secondary – $848,000
Total – $4.78 million

Mission

The mission of CHI Lisbon Health is to nurture the healing ministry of the Church supported by education and research. Fidelity to the Gospel urges us to emphasize human dignity and social justice as we move to create healthier communities.

County: Ransom
Address: 905 Main Street
Lisbon, ND 58054
Phone: 701.683.6400
Fax: 701.683.4345
Web: www.lisbonhospital.com

CHI Lisbon Health is a not-for profit, 25-bed Critical Access Hospital, sponsored by Catholic Health Initiatives, providing selected health care services. As a provider of community based, family oriented healthcare, CHI Lisbon Health believes it can best maintain this level of service through a customer focus, where we continually strive to understand and exceed the expectations of our customers. This focus is enabled through effective communication systems, staff education, team building, process improvement, work redesign and an empowered work force.

Emergency care is always available in our Level V Trauma Emergency Department 24 hours per day-seven days per week. Registered Nurses are on site at all times. Physicians, along with other support staff, are on site or on call to meet emergency needs.

Core Values

Compassion
- Care with listening, empathy, and love
- Accompany and comfort those in need of healing

Inclusion
- Celebrate each person's gift and voice
- Respect the dignity of all Integrity
- Inspire trust through honesty
- Demonstrate courage in the face of inequity

Excellence
- Serve with fullest passion, creativity, and stewardship
- Exceed expectations of other and ourselves

Services

CHI Lisbon Health provides the following services directly:

- Emergency Care
- General Surgery
- Clinic
- Sleep studies
- Cardiac Rehab
- Pain Injections
- Radiology: MRI, DEXA (Bone Density), EKG, Fluroscopy, Nuclear Medicine, Segmental Blood Pressure, 3D Mammography, In-house CT Scan, In-house Ultrasound

Staffing

Physicians: 1
Nurse Practitioners: 1
RNs: 25
LPNs: 5
Total Employees: 100

Local Sponsors and Grant Funding Sources

- Center for Rural Health
  - SHIP Grant (Small Hospital Improvement Program)
- Otto Bremer Foundation
- Workforce Safety Grant

Sources

[1] US Census Bureau; American Fact-finder; Community Facts

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

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

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

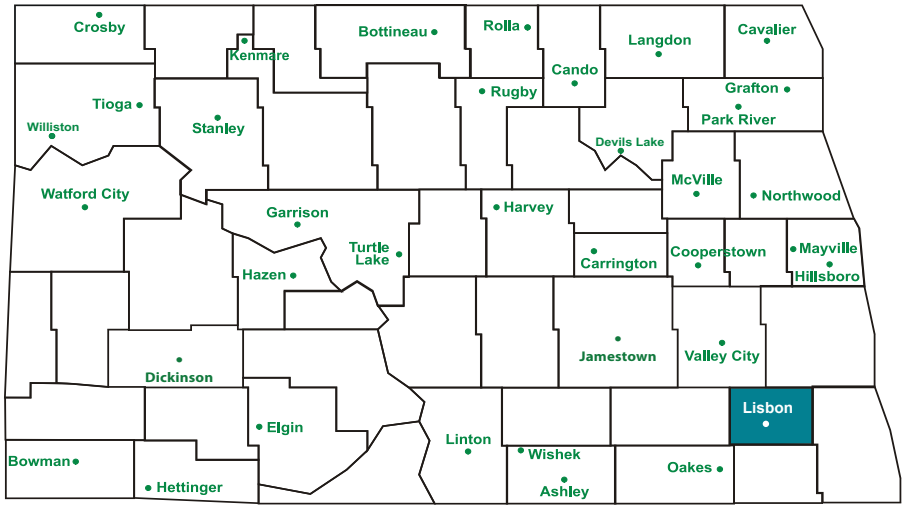
ruralhealth.und.edu

Services:

Continued from front:

- Outpatient Services: chemotherapy treatments, blood transfusions, discontinuation of chemo therapy pumps, lab draws by PICC lines or porta caths, IV hydration therapy, IV antibiotic therapy, wound care, dressing changes, temporal artery biopsy, paracentesis, thoracentesis, finger reductions, medication administration, PICC Line Insertions

North Dakota Critical Access Hospitals



History

CHI Lisbon Health originally known as Community Memorial Hospital opened its doors on February 1, 1952. Lutheran Hospitals & Homes Society of Fargo worked on this project with the local Community Memorial Hospital Association and assumed operations of the hospital.

In 1967 an addition was added to the northeast portion of the hospital which became a 20 bed nursing home wing. Because increased space was needed, a hospital wing was added to the south of the existing structure in 1976. The previous hospital wing was converted to 25 nursing home beds.

In 1992, Community Memorial Hospital and Nursing Home celebrated 40 years of dedicated service to the sick. By 1996 a remodeling project had been completed and a clinic was moved into the facility. At this time the facility's name changed to Lisbon Medical Center.

CHI Lisbon Health changed to Critical Access Hospital status effective January 1, 2001. The facility was acquired by Catholic Health Initiatives on October 1, 2002 and changed their name to Lisbon Area Health Services.

Many specialized services have been added over the past years for the benefits of the patients. CHI Lisbon Health is served by providers from Sanford Clinic, Essentia Health, and CHI Lisbon Health Clinic.

Recreation

Lisbon is located in southeastern North Dakota, 70 miles from Fargo, the state's largest city. Lisbon is primarily an agricultural community; however, the processing and manufacturing of farm products in and around Lisbon employ a significant number of residents. The educational system provides services for K-12, special education classes, college preparatory programs, vocational education and computer literacy classes. Within easy driving distance, Fort Ransom State Park provides camping and skiing, while Dead Colt Creek Lake provides boating and other water recreation. Little Yellowstone Park has hiking and camping available and the Sheyenne Valley Grasslands provides an opportunity to experience upland prairie in its virgin state.

Updated 4/21

Appendix B – Economic Impact Analysis

CHI Lisbon Health

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

CHI Lisbon Health
Imagine better health.℠

Economic Impact

CHI Lisbon Health is composed of a critical access hospital (CAH) and a clinic in Lisbon, North Dakota.

CHI Lisbon Health **directly** employs **72 FTE employees** with an annual payroll of over **$3.9 million** (including benefits).

- After application of the employment multiplier of 1.35, these employees created an additional **25** jobs.
- The same methodology is applied to derive the income impact. The income multiplier of 1.22 is applied to create over **$848,000** in income as they interact with other sectors of the local economy.
- **Total impacts = 97 jobs and nearly $4.78 million in income.**

Healthcare and Your Local Economy

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

Key contributions of the health system include

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

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

Fact Sheet Author: Kylie Nissen, BBA

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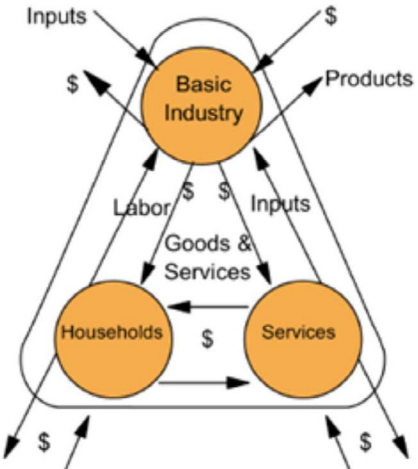
Figure 1. An overview of the community economic system.



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

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

Appendix C – CHNA Survey Instrument

Lisbon Area Health Survey

CHI Lisbon Health, Sargent County 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 https://tinyurl.com/LisbonCHNA2021 or by scanning on the QR Code at the right.

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

Surveys will be accepted through August 10, 2021. Your opinion matters – thank you in advance!

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

_____

_____

Delivery of Healthcare

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

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

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): _____

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

_____

_____

13. 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.

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

- ☐ Yes
- ☐ No

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

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

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

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

17. 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

18. 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

19. Gender:

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

20. Employment status:

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

21. Your zip code: _____

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

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

23. 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

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

_____

_____

Appendix D – County Health Rankings Explained

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

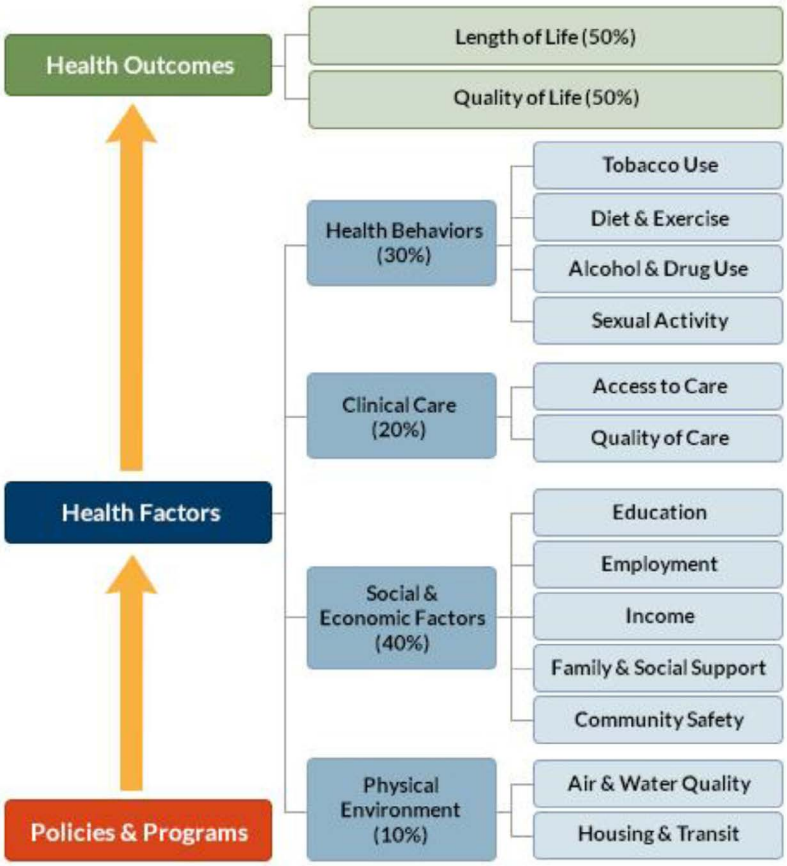
Methods

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

What is Ranked

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

Ranking System



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

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

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

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

Data Sources and Measures

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

Data Quality

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

Calculating Scores and Ranks

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

Health Outcomes and Factors

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

Health Outcomes

Premature Death (YPLL)

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

Reason for Ranking

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

Poor or Fair Health

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

Reason for Ranking

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

Poor Physical Health Days

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

Reason for Ranking

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

Poor Mental Health Days

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

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

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

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

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

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

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

Health Factors

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

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

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

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

Food Environment Index

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

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

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

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

Reason for Ranking

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

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

Physical Inactivity

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

Reason for Ranking

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

Access to Exercise Opportunities

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

Individuals who:

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

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

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

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

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

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

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

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

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

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

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

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

Uninsured

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

Reason for Ranking

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

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

Primary Care Physicians

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

Reason for Ranking

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

Dentists

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

Reason for Ranking

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

Mental Health Providers

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

Reason for Ranking

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

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

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

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

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

Flu Vaccinations

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

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

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

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

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

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

Reason for Ranking

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

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

Income Inequality

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

Reason for Ranking

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

Children in Single-Parent Households

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

Reason for Ranking

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

Violent Crime Rate

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

Reason for Ranking

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

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

Injury Deaths

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

Reason for Ranking

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

Air Pollution-Particulate matter

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

Reason for Ranking

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

Drinking Water Violations

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

Reason for Ranking

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

Severe Housing Problems

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

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

- household is severely cost burdened.

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

Reason for Ranking

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

Appendix E – Youth Risk Behavior Survey Results

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

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

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

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

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

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

Appendix F – Prioritization of Community's Health Needs

Community Health Needs Assessment
Lisbon, North Dakota
Ranking of Concerns

The top concerns for each of the five 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		
Not enough affordable housing	1	
Having enough child daycare services	5	1
Not enough jobs with livable wages	1	
Attracting and retaining youth families	1	
Bullying/cyber-bullying	2	
Physical violence, domestic violence, sexual abuse	2	
AVAILABILITY/DELIVERY OF HEALTH SERVICES CONCERNS		
Cost of health insurance		
Availability of specialists	1	
Availability of mental health services	9	9
Extra hours for appointments- evenings/weekends	1	
Availability of substance use disorder treatment services	3	0
YOUTH POPULATION HEALTH CONCERNS		
Depression/Anxiety – all ages	5	0
Alcohol use and abuse- all ages	2	
Drug use and abuse (including prescription drugs) – all ages	2	
Stress – all ages	2	
Not getting enough exercise/physical activity – all ages		
Not enough activities for children and youth		
ADULT POPULATION HEALTH CONCERNS		
Depression/Anxiety		
Alcohol use and abuse		
Drug use and abuse (including prescription drugs)		
Stress		
Not getting enough exercise/physical activity		
Suicide		
SENIOR POPULATION HEALTH CONCERNS		
Availability of resources to help the elderly stay in their homes	1	
Availability of home health		
Cost of long-term/nursing home care		
Availability of resources for family and friends caring for elders	1	
Availability for transportation for seniors	1	
Availability to meet the needs of older population		

Appendix G – Survey "Other" Responses

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

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

1. Considering the PEOPLE in your community, the best things are: "Other" responses:
   - Beer sales are outstanding
   - (2) None of the above
   - Not good here
2. Considering the SERVICES AND RESOURCES in your community, the best things are: "Other" responses:
   - None of the above
   - Roads
3. Considering the QUALITY OF LIFE in your community, the best things are: "Other" responses:
   - None of the above
   - Not good here
4. Considering the ACTIVITIES in your community, the best things are: "Other" responses:
   - Movie theater
   - None of the above
   - None of these are available enough to meet the community's needs
   - Not good here

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:
   - Having more things for kids to do indoors
   - Mental health care
   - Not enough options for shopping for affordable clothing/shoes
   - Not enough people are vaccinated against Covid
   - Proper access to emergency food resources. It is difficult to get ahold of pantry resources and at times it is inaccessible altogether. In certain instances, individuals have been turned away due to financial disqualification.

6. Considering the AVAILABILITY/DELIVERY OF HEALTH SERVICES in your community, concerns are: "Other" responses:
   - Billing process at local hospital has been a big enough issue that we choose services in Fargo rather than the hassle of the Lisbon Hospital for the same services also provided in Lisbon
   - Doctors turning away patients with mental health before even entering the ER
   - I feel for this community we have adequate coverage.

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

- A place to take children with mental health issues
- Bullying/cyber bullying
- Lack of tutors in Lisbon school
- Mental and behavioral health; Engaging youth and their families in the wide variety of opportunities available- too many are disengaged from community!!

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

- Community based support for families with development disabilities and severe mental health issues
- Medical facilities to care for those who have mental health issues
- Parental classes to teach them how to parent.

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

- Elder neglect, not safe at home
- Loneliness
- We have great caregivers for the elderly.

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

- Affordable, single family housing. We have WAY too many rental properties, making it hard for lower income families to buy their own home and build equity in something that is theirs, throwing money away on rent monthly, raising transiency rates as well as adding to family instability. We want families to buy a home, put down roots, invest in our community, pay taxes, hold jobs, not pay rent and move every year or two.
- Alcohol abuse, vaping
- All is well
- Assisted elderly care
- Availability of mental health services and specialty providers such as obgyn.
- Community leaders who are just maintaining and not planning for our present or future
- Concerning healthcare. I feel a great need for obtaining doctors and primary care doctors on a longer term basis. I need to have a longer relationship with my healthcare provider than what is offered in my community. I presently, and have for a number of years. travel an hour from home because I seek the care of a physician that used to practice in my community but has since moved his/her practice to another community. Our community needs to be able to retain these reliable healthcare professionals so the the doctor has a chance to get to know the needs/personality of the patient.
- Cooperation
- Corruption in city council.
- Covid 19
- Covid has made me realize that stupidity and lack of trusting experts is the biggest challenge facing my community.
- Daycare
- Drug abuse both legal and illegal drugs
- Drug use
- Drugs
- Elderly not being able to move into assisted living/long-term care due to costs. This then increases at home injuries from having to steps or not having someone there to look out for them.
- Few local activities, nothing to do, need more for people to participate in
- Finding daycare!!!
- Getting younger families to stay and or move in, need more active fun activities for 18-50 year olds
- Healthcare staff shortage.
- Housing for elderly
- Increase in drug/alcohol use in the youth and younger adults.

- Lack of community involvement by those who live here
- Lack of economic growth and development on local level.
- Lack of family friendly activities
- Lack of housing
- Lack of mental health resources
- Lack of mental health services for all age ranges.
- Lack of programs for kids to do during the summer.
- Lack of public gathering space/wellness opportunities. A rec center with a community room and potential child care center would be a great addition to our community.
- Lack of respect and acceptance of others, no matter from out of town or another country or race. Much discrimination here.
- Little to no recreational activities in the winter
- Maintaining community interactions/events
- Meeting the needs for families in regards to finding daycare, not just daytime hours, but evening hours as well.
- (2) Mental health
- Mental health access and stigma.
- Mental health issues and no or VERY limited resources, ESP. if you do not have healthcare coverage
- Mental health services
- Need better emergency room. The health care provided there is not good.
- Not enough mental health care options
- Not enough variety of activities for kids in the winter
- Not feeling welcome when you move to town. People already have their groups/friends.
- Obesity
- People are getting less and less connected and not willing to participate in community things.
- Price of care for elderly. Med. price and to pay for the home with prices.
- Retaining families to live and work in our community.
- Strong child-centered school system with plan to strengthen well-rounded learning.
- Suicide
- Teals market
- The elites
- The idiots running the country in Washington DC
- The same people are involved in all of the groups with little support from a vast majority of the community.
- There is nothing for older children to do. A community rec center would do wonders for our kids who have nothing to do but turn to other than causing mischief.
- This community has a lot of people with mental health issue and when they are turned away at the doors of the ER because the hospital does not have staff to care for people with said mental health issues and puts a strain on other resources in the community.
- Vandalism
- We need more businesses.

Delivery of Healthcare

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

- Everyone in the community has equal opportunity to health care here.
- It's too expensive, after insurance costs.
- Length of time it takes to get test results when they have to be sent out to Oakes, Fargo, etc.

- No pharmacy access
- Sometimes doctors are way off on diagnosis, push meds too much and too long
- With my dealings with the hospital here I will drive to Fargo

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

- A more equipped and better staffed hospital
- Another doctor
- Better hearing aides
- Cancer center
- Clinic open more hours during the day.
- Clinic open on saturdays. At least saturday mornings.
- Deliver babies
- Dentist, optometrist, chiropractor, physical therapy/rehab services
- Diet/nutrition and excerise
- Doctors
- Emergency care
- Family counseling, behavioral health
- Mental and behav health services
- (3) Mental health
- (4) Mental health services
- Mental health services for patients of all age ranges. Increased counseling at the local schools.
- Mental health services, orthopedic services, urology services
- Mental health staff
- Mental health!!!
- Mental health, obgyn, urology.
- Mental well being service
- Milnor has no pharmacy
- More pediatric services
- Need for more healthcare providers such as md, pa and np
- Nicu, new born mothers, birthing center
- Night and weekend care
- Obgyn
- Ortho,eye clinic
- Our community needs to have more help with drug and alcohol addiction.
- Pediatrician, obstetrics
- Psych
- Psychiatrist or gastroenterologist
- Remove insurance contracts, create an affordable set cost system. Paying insurance, co-pays, and still getting bills is ridiculous!
- (2) Specialists
- Walk in clinic hours and pharmacy on weekends
- Wellness center

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

- Any way to make healthcare services such as getting imaging or lab work done more affordable would be amazing, since some healthcare insurances do not cover things like that.
- Daycare shortages, School bus driver shortages, OBGYN so don't have to travel so far for care. On the job training for healthcare positions, more elderly services, and more free preschool opportunities, more youth activities for child under the age of 4, more mentor availability for youth, families, and elderly
- Don't force healthcare workers to get COVID vaccine
- Grants to provide space or equipment made available to make it easy for a dentist or optometrist to have part-time office hours in our town. Right now the investment in a building or equipment is too great to make it viable for someone to travel here for office hours.
- Have trusted management at the local Healthcare facilities, not management that talks out of both ends of their mouth
- Have your doctors not turn patients away at the ER
- Healthcare is good locally.
- I appreciate having hospital in Lisbon but...quality of care for non- emergency needs has been poor.
- I feel more could be done with the adolescent population to promote healthcare and disease prevention. Also, awareness of mental health could be taught at a younger age.
- Lack of mental health care providers
- Make it affordable. So I don't have to miss work to go pay for a bill I can't afford, after paying insurance and everything else.
- Meds for seniors are way too expensive, mostly some special meds are in the many thousands of dollars.
- More events
- More flyers showing what is offered.
- More public information on what services are available and more public transportation
- Need more mental health and substance abuse services
- Need more!
- New honest doctors that find out what the root of a problem is instead of throwing pills at the patient
- Secure local MDs
- Seems that health care workers are not getting quality
- Staff shortage. incentives to keep staff.
- The need to retain Doctors in our community
- Walk-in clinic for evening and weekends is much needed.
- We are fortunate to have so many quality health care workers in our community. From public health, the hospital and clinics, nursing homes, we have a wealth of compassionate and professional providers in our community!