Community Health Needs Assessment

2019

Carrington, North Dakota Service Area

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

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Executive Summary

To help inform future decisions and strategic planning, CHI St. Alexius Health, Carrington Medical Center (CMC) and Foster County Public Health conducted a community health needs assessment (CHNA) in 2018/2019, the previous CHNA was conducted in 2016. The Center for Rural Health (CRH) at the University of North Dakota School of Medicine & Health Sciences (UNDSMHS) facilitated the assessment process, which solicited input from area community members and healthcare professionals as well as analysis of community health-related data.

To gather feedback from the community, residents of the area were given the opportunity to participate in a survey. Two hundred twenty-six CMC service area residents completed the survey. Additional information was collected through eight key informant interviews with community members. The input from the residents, who primarily reside in Eddy County and Foster 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.

According to the U.S. Census, from the years 2010 to 2017, the population of Eddy County decreased 2.4% and in Foster County the population decreased by 2.9%.

The average of residents under age 18 (23.3%) for Eddy County is exactly the state average, and Foster County comes in 1.6 percentage points lower than the North Dakota average (23.3%). The percentage of residents ages 65 and older is about 7% higher for both Eddy County (22.0%) and Foster County (22.2%) than the North Dakota average (15.0%). Additionally, the rates of high school education are slightly lower for both Eddy County (89.1%) and Foster County (88.7%) than the North Dakota average (92.0%). The median household income in Eddy County ($55,489) and Foster County ($55,625) are right in line with the state average for North Dakota ($55,322).

Data compiled by County Health Rankings show Eddy and Foster Counties are doing better than or equal to North Dakota in health outcomes/factors for 11 indicators; Eddy County is doing better than or equal to North Dakota in health outcomes/factors for 2 indicators; and Foster County is doing better than or equal to North Dakota in health outcomes/factors for 6 indicators.

According to County Health Rankings, Eddy County is performing below the state average in 6 outcome/Foster and Eddy togetherare performing below the state average for 8 factor indicators, while Foster County is preforming below the average in 2 of the outcome/factor indicators.

The 226 CMC service area residents who completed the survey indicated the following ten community and health needs, out of the potential 82 set forth by the survey, as the most important (listed in alphabetical order):

- Adult smoking and tobacco use (second-hand smoke)
- Alcohol use and abuse – Youth and Adult
- Attracting and retaining young families
- 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
- Youth bullying/cyber-bullying

The survey results indicated the biggest barriers to receiving healthcare (as perceived by community members) are not enough providers (MD, DO, NP, PA) (N=46), not affordable (N=40), and not able to see same provider over time (N=38).

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

- Safe place to live, little/no crime
- Family-friendly, good place to raise kids
- People are friendly, helpful, and supportive
- Quality school system
- People who live here are involved in their community
- Active faith community

Input from community leaders, provided through key informant interviews, and the community focus group echoed similar concerns raised by survey respondents. Concerns emerging from these sessions were (listed in alphabetical order):

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

Overview and Community Resources

With assistance from the CRH at the UNDSMHS, CHI St. Alexius Health, CMC and FCPH completed a CHNA of the CMC service area. The hospital identifies its service area as Foster County and Eddy County in their entirety, plus portions of Stutsman, Wells and Griggs Counties – the last three have medical centers in the respective counties. Many community members and stakeholders worked together on the assessment process.

CHI St. Alexius Health, CMC is located in a frontier area. A frontier area is defined as a sparsely populated rural area, which is isolated from population centers and services. CMC is licensed as a critical access hospital with two provider-based rural health clinics. One clinic is attached to the Carrington hospital and the other is located 16 miles to the north in New Rockford, North Dakota. Carrington is located in east central North Dakota, just two hours from four major North Dakota cities: Fargo, Minot, Grand Forks, and Bismarck.

Along with the hospital, the economy is based on agri-business, service industries, and retail trade. Foster County is 644 square miles of land located in the center of North Dakota. It is one of the smallest of the state's 53 counties, 18 miles by 36 miles in dimension. It is bordered by Eddy, Griggs, Stutsman and Wells counties. Foster is divided into 18 townships with the seat of county government located in Carrington. Population of Foster County is 3,759.

According to the U.S. Census Bureau estimated census for 2017, Foster, Eddy and Wells counties are the three major counties that utilize CMC services. The three counties have a total area of 2,536 square miles and approximately 9,595 people, which is a slight decrease from 2010 census of 9,935. The racial makeup of the counties was 97.6% white. The number of households decreased from 4,806 to 4,538 households.

Other healthcare facilities and services in Foster, Eddy and Wells Counties include: five dentists, four chiropractors, two massage therapists, three optometrists, and each county has a long term healthcare center with various additional levels of care and services. Foster, Eddy and Wells County Social Services also offer bathing, housekeeping, and meal preparation services through Quality Service Providers.

Carrington has a number of physical assets and features to help address population health improvement including a bike path, fitness center, facility available for winter walking, swimming pool, city park, tennis courts, golf course, movie theatre, local winery and garden, and birding drives. Foster County offers several cultural attractions such as the Foster County Museum, which pays tribute to the early history of the city and region.

Carrington offers public transportation through South Central Transit and through Faith In Action – an entity of CHI St. Alexius Health, Carrington. The community also has a grocery store and two pharmacies with delivery services. The Carrington Public School system offers a comprehensive program for students K-12. They also offer preschool to a small population and a privately funded preschool is available in the community. Some licensed as well as unlicensed daycares are available in the area.

Additional health-related agencies in the service area include:

Hospice Agencies:

- CHI Health at Home

Home Health Agencies:

- CHI Health at Home
- Jamestown Medical Center Home Health & Hospice

Nursing Homes:

- Golden Acres Nursing Home/Assisted Living - Carrington
- Cooperstown Medical Center
- St. Aloisius Medical Center Nursing Home – Harvey
- Lutheran Home of the Good Shepard – New Rockford
- Evergreen – New Rockford

Senior Citizens Center:

- Carrington Senior Citizens Center (Meals on Wheels, Senior Center meals, activities)
- Eddy County Senior Services
- Griggs County Senior Services
- James River Senior Services
- Wells-Sheridan County Senior Services
- McHenry Senior Services
- Glenfield Senior Services

Public Health Services:

- Foster County Public Health
- Eddy County Public Health
- Griggs County Public Health
- Wells County Public Health
- Stutsman County Public Health

Home and Community Based Services:

- Foster & Eddy County Services for the disabled and elderly
- Wells County Services for the disabled and elderly
- Griggs County Services for the disabled and elderly
- Stutsman County Services for the disabled and elderly

County Social Service Agencies/Medicaid Providers:

- Foster County
- Eddy County
- Wells County
- Griggs County
- Stutsman County

Other Community Resources:

- Options – a resource center for independent living
- IPAT - The Interagency Program for Assistive Technology (IPAT)
- ND Dept. of Human Services and Regional Human Services Center
- ND Aging and Disability Resource Link
- Life Alert

Food Assistance:

- Carrington's Daily Bread Food Pantry
- Grocery delivery in Carrington from Leevers

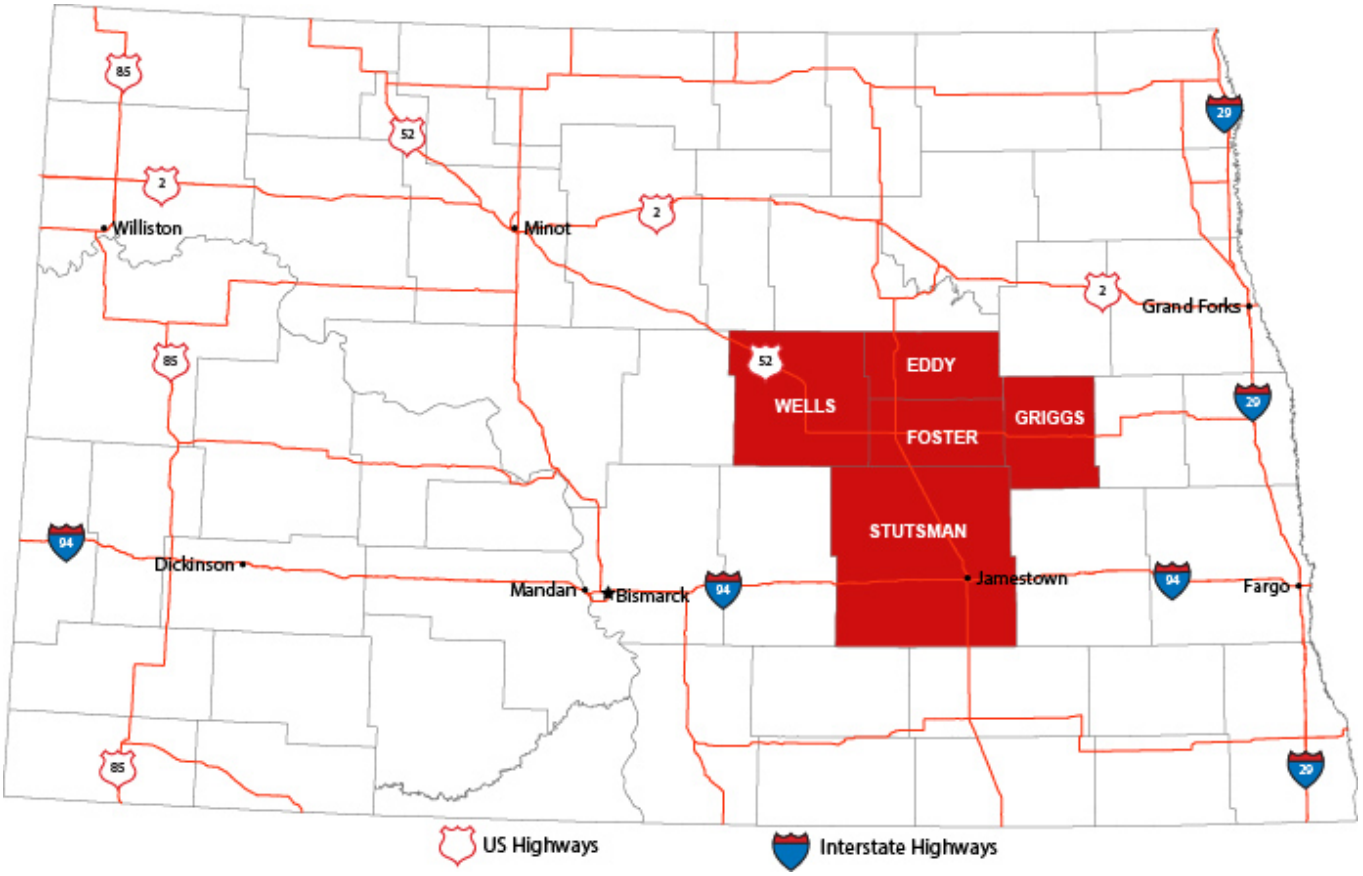
Help with Rides to Medical Appointments:

- Faith In Action – provides transportation to medical appointments in or out of town
- South Central Transit – provides transportation within Carrington city limits

Help for the Homeless:

- Bismarck – Homeless Coalition
- Fargo – Salvation Army
- Jamestown – Salvation Army

Figure 1: Eddy, Foster, Wells, Griggs, and Stutsman Counties



CHI St. Alexius Health, CMC

CHI St. Alexius Health, CMC began delivering its healthcare mission in 1916 as the Carrington Hospital. In 1941, the hospital was leased to the Presentation Sisters of the Fargo Diocese. The Presentation Sisters joined the Catholic Health Corporation of Omaha in 1980 and later became part of Catholic Health Initiatives. In 2014 and 2015, CMC was recognized as one of the top 100 Critical Access Hospitals in the United States. Additionally, CMC was named one of the top 20 Critical Access Hospitals four of the past five years by the National Rural Health Association.

CHI St. Alexius Health officially announced the formation of its regional healthcare system on April 19, 2016. The system is the largest healthcare delivery system in central and western North Dakota and is comprised of a tertiary hospital in Bismarck, and critical access hospitals (CAHs) in Carrington, Dickinson, Devils Lake, Garrison, Turtle Lake, Washburn and Williston and numerous clinics and outpatient services. CHI St. Alexius Health manages four CAHs in North Dakota- Ashley, Elgin, Linton, and Wishek, as well as Mobridge Regional Medical Center in Mobridge, S.D.

Catholic Health Initiatives, a nonprofit, faith-based health system formed in 1996 through the consolidation of four Catholic health systems. CHI expresses its mission each day by creating and nurturing healthy communities in the hundreds of sites across the nation where they provide care.

CHI is based in Englewood, Colorado. It is one of the nation's largest nonprofit health systems with operations in 18 states. The CHI is comprised of 101 hospitals, including two academic health centers and major teaching hospitals as well as 29 critical-access facilities; community health-services organizations; accredited nursing colleges; home-health agencies; living communities; and other facilities and services that span the inpatient and outpatient continuum of care.

In fiscal year 2017, CHI provided more than $1.2 billion in financial assistance and community benefit for programs and services for the poor, free clinics, education and research. Financial assistance and community benefit totaled approximately $2.1 billion with the inclusion of the unpaid costs of Medicare. The health system, which generated operating revenues of $15.5 billion in fiscal year 2017, has total assets of approximately $22 billion.

Mission

The mission of CHI is to nurture the healing ministry of the church, supported by education and research. Fidelity to the gospel emphasizes human dignity and social justice as a way to create healthier communities.

To fulfill this mission, CHI, as a values-driven organization, will:

- Assure the integrity of the healing ministry in both current and developing organizations and activities;
- Develop creative responses to emerging healthcare challenges;
- Promote mission integration and leadership formation throughout the entire organization;
- Create a national Catholic voice that advocates for systemic change and influences health policy with specific concern for persons who are poor, alienated and underserved; and
- Steward resources by general oversight of the entire organization.

Vision

Our Vision is to live up to our name as One CHI:

- Catholic: Living our Mission and Core Values.
- Health: Improving the health of the people and communities we serve.
- Initiatives: Pioneering models and systems of care to enhance care delivery.

CMC is one of the most important assets in the community and one of the largest charitable organizations in the Carrington area giving $557,352 back to the community in fiscal year 2018. CMC includes a 25-bed, CAH with various outpatient therapies and services located in Carrington and rural health clinics in Carrington and New Rockford. As a hospital, clinic, and designated level five trauma center, CMC provides comprehensive care through a physician, physician assistants, nurse practitioners, and consulting/visiting medical providers for a wide range of medical and emergency situations. With approximately 130 staff members, CMC along with the contracted healthcare agencies housed within CMC makes them one of the largest employers in the region.

Services offered locally by CHI St. Alexius Health, CMC include:

Clinic Services

- DOT Exams
- Family Practice
- Geriatric Care
- Health Maintenance Exams
- Joint Injections
- Nursing Home Rounds
- Pediatrics and Well Child Exams
- Prenatal Obstetrics
- Preoperative Exams
- Women's Health

Inpatient Services

- Inpatient Care
- Respite Care
- Swing Bed Services

Outpatient Services

- Ambulance Services - Paramedic and EMT Emergency Services
- Ambulance Services - Transfers
- Cardiac Services - Cardiac Rehabilitation
- Cardiac Services - Cardiac Support Group
- Cardiac Services - Stress Testing
- Diabetic Services - Diabetic Support Group
- Diabetic Services - Group Diabetes Education
- Diabetic Services - Individual Diabetes Education
- Emergency Room - Level 5 Trauma Center
- Endoscopes - Colonoscopies
- Endoscopes - Flexible Sigmoidoscopies
- Endoscopes - Gastroscopies
- Hospice and Home Health - Available by referral
- Imaging Services - Back and Joint Injections
- Imaging Services - CT Scans
- Imaging Services - DEXA Scans
- Imaging Services - Echocardiograms
- Imaging Services - EKG
- Imaging Services - Fluoroscopy
- Imaging Services - General X-rays
- Imaging Services - Holter Monitoring
- Imaging Services - Mammography 3D
- Imaging Services - MRI
- Imaging Services - Nuclear Medicine
- Imaging Services - Ultrasound
- IV Therapy - Antibiotic
- IV Therapy - Chemotherapy
- IV Therapy - Picc line cares

- IV Therapy - Port cares
- Laboratory Services
- Medical Nutrition Therapy - Dietitian Services
- Mental Health Services - Available by referral
- Organ Procurement
- Padnet
- Pastoral Care and Social Ministries
- Pharmacy
- Physical Therapy
- Pulmonary Rehabilitation
- Respiratory Therapy - Airway and Oxygen Management
- Respiratory Therapy - Asthma and COPD Management
- Respiratory Therapy - Pulmonary Functions
- Sleep Disorder/Apnea Testing
- Surgery and Anesthesia Services
- Telemedicine - Diabetes
- Telemedicine - Pharmacy
- Telemedicine - Sleep Study
- Telemedicine - Other specialties available by request
- Thoracentesis and Paracentesis
- Varicose Vein Procedure
- Visiting Specialists: Audiology, Cardiology, Counseling, Ear/Nose/Throat, General Surgery, Psychology, Urology
- Volunteer Auxiliary Services - Courtesy Cart
- Volunteer Auxiliary Services - Gift Shop
- Wellness Events
- Women's Way

Foster County Public Health

Foster County Public Health (FCPH) provides public health services that encompass all residents from birth to death. Services include environmental health, nursing services, WIC (women, infants, and children) program, health screenings and education services. Each of these programs provides a wide variety of services in order to accomplish the mission of public health, which is to assure that Foster County is a healthy place to live and that each person has an equal opportunity for optimal health. To accomplish this mission, FCPH is committed to the prevention of disease and injury, promotion of healthy lifestyles, protection and enhancement of the environment, and provision of quality healthcare services for the people of Foster County.

Public Health services in Foster County date back to 1920. During the 1920-1921 years, Sarah Zimmerman first provided nursing services to Foster County. A public health nurse provided services to the county sporadically over the subsequent years. In 1981, FCPH became its own public health department when it dissolved from being a part of Lake Region District Health. Since 1981, FCPH has provided continued public health nursing services to the county.

A medical health officer, a board of community health workers, as well as the board of county commissioners oversee the office. Currently the public health office employs five staff members. Services are available Monday through Friday 8:00 am to 12:00 pm and 1:00 pm to 4:00 pm.

Funding for public health services comes from a variety of funding sources. Programs and services are covered by county mill dollars, state funding, federal funding, and fees for services. FCPH actively applies for competitive funding dollars as well.

Services are available to all Foster County residents including all age groups and all economic statuses. FCPH

uses a sliding fee scale for services, based on financial income. Immunizations are available to all ages eligible for vaccinations, including those who do not have medical insurance.

Mission

The Mission of FCPH is to "Prevent, Promote and Protect for optimal community health". To fulfill this mission, FCPH uses its Core Values:

- Collaboration – Working with other facilities/services in the community to promote optimal health
- Communication – Promoting trust through mutual, honest and open dialogue
- Prevention – Using knowledge to prevent disease/injury and make smart decisions to maintain optimal health
- Respect – Appreciating the dignity, knowledge, and contributions of all persons
- Teamwork – Working together to share purpose and a common goal

Vision

The Vision at FCPH is "Building a Healthy Community…Together". In order to fulfill this vision, FCPH uses a set of guidelines known as the ten essential public health services.

10 Essential Public Health Services

1. Monitor health status to identify and solve community health problems
2. Diagnose and investigate health problems and health hazards in the community
3. Inform, educate and empower people about health issues
4. Mobilize community partnerships and action to identify and solve health problems
5. Develop polices and plans that support individual and community health efforts
6. Enforce laws and regulations that protect health and ensure safety
7. Link people to needed personal health services and assure the provision of healthcare
8. Assure competent public and personal healthcare workforce
9. Evaluate effectiveness, accessibility, and quality of personal and population-based health services
10. Research for new insights and innovative solutions to health problems

FCPH has been recognized on the North Dakota Department of Health Immunization Program Honor Roll multiple years for achieving high immunization rates for: infants, 4-6 year olds, and 13-17 year olds. FCPH was also named 1 of 3 recipients for the Adult Immunization Grant in North Dakota for 2017-2018.

Specific services that FCPH provides are:

- Alcohol prevention activities
- Blood pressure check
- Breastfeeding resources
- Car seat program
- Child health (well baby)
- Diabetes screening
- Emergency response & preparedness program
- Environmental health services (water, sewer, health hazard abatement)
- Family planning
- Flu shots

- Foot care
- Health Tracks (child health screening)
- Home visits
- Immunizations
- Medications setup—home visits
- Office visits and consults
- Preschool screening assistance
- Public healthcare
- School nursing services
- Tobacco education, prevention and control
- Tuberculosis testing and management
- Onsite business wellness clinic
- WIC (Women, Infants & Children) Program
- Youth education programs (First Aid, Bike Safety)

Assessment Process

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

A CHNA benefits the community by:

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

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

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

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

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

This assessment examines health needs and concerns in Foster County and Eddy County, as well as Griggs, Stutsman and Wells Counties, which are all included in the CHI St. Alexius Health, Carrington service area. In addition to Carrington, located in the service area are the communities of Bowdon, Fessenden, Glenfield, Grace City, Kensal, New Rockford, Pingree, and Woodworth.

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

Figure 2: Steering Committee

Mariann Doeling	CEO, CHI St. Alexius, Carrington Medical Center Administrator, Foster County Medical Center Clinic and New Rockford Community Clinic
Lisa Hilbert	Administrator/Director of Nursing, Foster County Public Health
Nicole Threadgold	Foundation Director and Marketing Coordinator, CHI St. Alexius, Carrington Medical Center
Lisa Weninger	Staff Nurse, Foster County Public Health
Jen Whitman	Community Benefit Coordinator, CHI St. Alexius, Carrington Medical Center

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

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

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

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

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

Community Group

A community group consisting of fourteen community members was convened and first met on September 5, 2018. 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 November 1, 2018 with fourteen 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 Eddy and Foster Counties. The group was then tasked with identifying and prioritizing the community's health needs.

Members of the Community Group represented the broad interests of the community served by CMC and FCPH. They included representatives of the health community, business community, political bodies, law enforcement, education, faith community, and social service agencies. Not all members of the group were present at both meetings.

Interviews

One-on-one interviews with four key informants were conducted in Carrington on September 5, 2018. Four additional key informant interviews were conducted over the phone in September of 2018. 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. The informants Included public health professionals with several years of direct experience in the community, including working with medically underserved, low income, and minority populations, as well as with populations with chronic diseases.

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

Survey

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

The community member survey was distributed to various residents of Foster County, as well as Eddy, Griggs, Stutsman, and Wells Counties which are all included in the CMC service area. The survey tool was designed to:

- Identify the positive factors 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.

The survey covered the following topics:

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

To promote awareness of the assessment process, press releases were disseminated and published articles in two newspapers in Foster and Eddy Counties including in the communities of Bowdon, Carrington, Fessenden, Glenfield, Grace City, Kensal, New Rockford, Pingree, and Woodworth. Additionally, information was published on CMC's and FCPH's websites and Facebook pages.

Approximately 120 community member surveys were available for distribution in Foster County, as well as Eddy, Griggs, Stutsman and Wells Counties. The surveys were distributed by Community Group members and at CMC, FCPH, and local churches.

To help ensure anonymity, included with each survey was a postage-paid return envelope to the CRH. In addition, to help make the survey as widely available as possible, residents also could request a survey by calling CMC or FCPH. The survey period ran from August 15, 2018 to October 7, 2018. Fourteen completed paper surveys were returned.

Area residents also were given the option of completing an online version of the survey, which was publicized in two community newspapers, emailed to at least 46 community groups, and available on the websites and Facebook pages of both CMC and FCPH. Two hundred twelve online surveys were completed. Five of those online respondents used the QR code to complete the survey. In total, counting both paper and online surveys, 226 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 U.S. Census Bureau; Robert Wood Johnson Foundation's County Health Rankings, which pulls data from 20 primary data sources (www.countyhealthrankings.org); the National Survey of Children's Health, which touches on multiple intersecting aspects of children's lives (www.childhealthdata.org/learn/NSCH); and North Dakota KIDS COUNT, which is a national and state-by-state effort to track the status of children, sponsored by the Annie E. Casey Foundation (www.ndkidscount.org).

Social Determinants of Health

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

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

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

Figure 3: Social Determinants of Health

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

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

Figure 4: Social Determinants of Health

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

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

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Demographic Information

Table 1 summarizes general demographic and geographic data about Eddy and Foster Counties.

Table 1: Eddy County and Foster County: Information and Demographics

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

	Eddy County	Foster County	North Dakota
Population (2017)	2,316	3,257	755,393
Population change (2010-2017)	-2.9%	-2.4%	12.3%
People per square mile (2010)	3.8	5.3	9.7
Persons 65 years or older (2016)	22.0%	22.2%	15.0%
Persons under 18 years (2016)	23.3%	21.7%	23.3%
Median age (2016 est.)	46.6	46.7	35.2
White persons (2016)	93.1%	96.9%	87.5%
Non-English speaking (2016)	2.6%	4.2%	5.6%
High school graduates (2016)	89.1%	88.7%	92.0%
Bachelor's degree or higher (2016)	22.2%	21.6%	28.2%
Live below poverty line (2016)	8.9%	10.1%	10.7%
Persons without health insurance, under age 65 years (2016)	7.2%	9.8%	8.1%

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

While the population of North Dakota has grown in recent years, Eddy and Foster Counties have seen a decrease in population since 2010. The U.S. Census Bureau estimates show that Eddy County's population decreased from 2,385 (2010) to 2,316 (2017) and Foster County's population decreased from 3,338 (2010) to 3,257 (2017).

County Health Rankings

The Robert Wood Johnson Foundation, in collaboration with the University of Wisconsin Population Health Institute, has developed County Health Rankings to illustrate community health needs and provide guidance for actions toward improved health. In this report, Eddy County and Foster 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 2017 County Health Rankings are from more than 20 data sources and compiled to create county rankings. Counties in each of the 50 states are ranked according to summaries of a variety of health measures. Those having high ranks, such as 1 or 2, are considered to be the "healthiest." Counties are ranked on both health outcomes and health factors. The following is a breakdown of the variables that influence a county's rank.

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

Table 2: County Health Rankings

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 Eddy and Foster Counties. All of the following statistics are based on the health behaviors and conditions of the county's residents, not necessarily the patients and clients of Foster County Public Health and CHI St. Alexius Health, Carrington Medical Center or of any particular medical facility. It is important to note that these statistics describe the population of a county, regardless of where county residents choose to receive their medical care.

For most of the measures included in the rankings, the County Health Rankings' authors have calculated the "Top U.S. Performers" for 2017. The Top Performer number marks the point at which only 10% of counties in the nation do better, i.e., the 90th percentile or 10th percentile, depending on whether the measure is framed positively (such as high school graduation) or negatively (such as adult smoking).

Eddy County and Foster County rankings within the state are included in the summary following. For example, Eddy County ranks 45th out of 49 ranked counties in North Dakota on health outcomes and 40th on health factors. Foster County ranks 32nd out of 49 ranked counties in North Dakota on health outcomes and 11th 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 asterisk (*) indicates that the county is faring better than the North Dakota average but is not meeting the U.S. Top 10% rate on that measure. Measures that are not marked with a bullet or asterisk but are marked with a plus sign (+) indicate that the county is doing better than the U.S. Top 10%.

The data from County Health Rankings shows that Foster County is doing better than many counties compared to the rest of the state on all of the outcomes that they have data for, landing at or above rates for other North Dakota counties. Eddy County is not meeting or exceeding the North Dakota average in two outcomes. However, both counties, like many North Dakota counties, are doing poor in many areas when it comes to the U.S. Top 10% ratings. One particular factor where Eddy and Foster Counties do not meet the U.S. Top 10% ratings is the percent of physical inactivity.

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

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

- poor or fair health
- poor physical health days
- poor mental health days

- adult smoking
- excessive drinking
- sexually transmitted infections
- teen birth rate
- dentists
- mammography screening (% of Medicare enrollees ages 67-69 receiving screening)
- violent crime
- severe housing problems

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

- low birth rate
- air pollution

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

- food environment index
- uninsured
- primary care physicians (not reported in Eddy County)
- unemployment
- income inequality
- drinking water violations (not reported in Eddy County)

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

- adult obesity
- physical inactivity
- access to exercise opportunities
- preventable hospital stays
- diabetic monitoring
- children in poverty
- children in single-parent households
- injury deaths

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

- premature death (not reported in Foster County)
- food environment index
- alcohol-impaired driving deaths (not reported in Foster County)
- uninsured
- unemployment
- income inequality

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

- low birth weight
- air pollution

Table 2: Selected Measures from County Health Rankings 2018 - Eddy County and Foster County

+ Meeting or exceeding U.S. top 10% performers
***** Not meeting U.S. top 10% performers
• Not meeting North Dakota average

TABLE 2: SELECTED MEASURES FROM *COUNTY HEALTH RANKINGS* 2017 – EDDY COUNTY and FOSTER COUNTY				
	Eddy County	**Foster County**	**U.S. Top 10%**	**North Dakota**
Ranking: Outcomes	**46th**	**21st**		**(of 49)**
Premature death	12,800 •*		5,300	6,600
Poor or fair health	13% *	11% +	12%	13%
Poor physical health days (in past 30 days)	3.1 •*	2.6 +	3.0	3.0
Poor mental health days (in past 30 days)	3.1 *	2.8 +	3.1	3.3
Low birth weight	7% •*		6%	6%
Ranking: Factors	**37th**	**13th**		**(of 49)**
Health Behaviors				
Adult smoking	17% *	15% *	14%	19%
Adult obesity	32% •*	31% *	26%	31%
Food environment index (10=best)	8.0 •*	8.9 +	8.6	8.4
Physical inactivity	26% •*	31% •*	20%	23%
Access to exercise opportunities	62% •*	68% *	91%	66%
Excessive drinking	18% *	22% *	13%	25%
Alcohol-impaired driving deaths	75% •*	0% +	13%	47%
Sexually transmitted infections		118.5 +	145.5	477.1
Teen birth rate	22 *	18*	15	27
Clinical Care				
Uninsured	11% •*	9% *	6%	9%
Primary care physicians		1,120:1*	1,030:1	1,280:1
Dentists	790:1 +	1,120:1+	1,280:1	1,630:1
Mental health providers			330:1	640:1
Preventable hospital stays	56 •*	71•*	35	46
Diabetic monitoring (% of diabetic Medicare enrollees ages 65-75 that receive HbA1c monitoring)	85% *	83% •*	91%	87%
Mammography screening (% of Medicare enrollees ages 67-69 receiving screening)	71% +	76% +	71%	69%
Social and Economic Factors				
Unemployment	4.6% •*	2.9% •	3.2%	2.7%
Children in poverty	15% •*	12% +	12%	12%
Income inequality	4.6 •*	3.8 *	3.7	4.4
Children in single-parent households	47% •*	37% •*	20%	27%
Violent crime	55 +	26 +	62	260
Injury deaths	168 •*	101 •*	55	66
Physical Environment				
Air pollution – particulate matter	7.5 *	7.6 •*	6.7	7.5
Drinking water violations	No +	No +	NA	
Severe housing problems	5% +	12% •*	9%	11%

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

Children's Health

The National Survey of Children's Health touches on multiple intersecting aspects of children's lives. Data are not available at the county level; listed below is information about children's health in North Dakota. The full survey includes physical and mental health status, access to quality healthcare, and information on the child's family, neighborhood, and social context. Data is from 2016-17. More information about the survey is found at www.childhealthdata.org/learn/NSCH.

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

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

Health Status	North Dakota	National
Children born premature (3 or more weeks early)	10.8%	11.5%
Children 10-17 overweight or obese	30.0%	31.0%
Children 0-5 who were ever breastfed	82.4%	79.2%
Children 6-17 who missed 11 or more days of school	3.0%	3.7%
Health Care		
Children currently insured	95.5%	93.9%
Children who had preventive medical visit in past year	**77.8%**	82.2%
Children (1-17 years) who had preventive dental visit in past year	**76.4%**	79.5%
Children (3-17 years) received mental health care	11.7%	9.8%
Children (3-17 years) with problems requiring treatment did not receive mental health care	1.1%	2.4%
Young children (9-35 mos.) receiving standardized screening for developmental problems	31.5%	31.1%
Family Life		
Children whose families eat meals together 4 or more times per week	75.5%	73.0%
Children who live in households where someone smokes	**16.1%**	15.5%
Neighborhood		
Children who live in neighborhood with a parks, recreation centers, sidewalks, and a library	**37.0%**	39.2%
Children living in neighborhoods with poorly kept or rundown housing	9.9%	12.8%
Children living in neighborhood that's usually or always safe	98.3%	94.5%

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

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

- Preventive primary care and dentist visits;
- Children living in neighborhoods with parks, recreation centers, sidewalks and a library;
- Children living in smoking households.

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

The data shows that Eddy County is performing more poorly than the North Dakota average on all of the examined measures except the percentage of the population who are Supplemental Nutrition Assistance Program (SNAP) recipients and the 4-year high school graduation rate. The most marked difference was on the measure of licensed childcare capacity (almost 20% lower rate in Eddy County).

Foster County is performing more poorly than the North Dakota average on only two factors: uninsured children below 200% and licensed childcare capacity (almost 16% lower rate in Foster County).

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

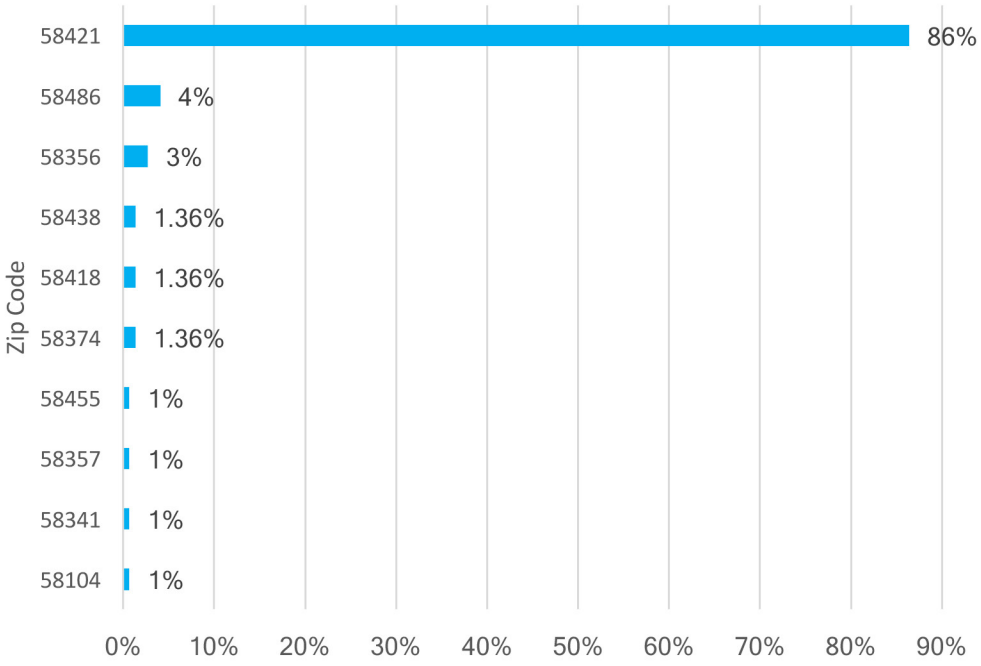
	Eddy County	Foster County	North Dakota
Uninsured children (% of population age 0-18), 2016	11%	8.3%	9.0%
Uninsured children below 200% of poverty (% of population), 2016	44.8%	45.2%	41.9%
Medicaid recipient (% of population age 0-20), 2017	37.4%	26.2%	28.3%
Children enrolled in Healthy Steps (% of population age 0-18), 2013	4.8%	2.4%	2.5%
Supplemental Nutrition Assistance Program (SNAP) recipients (% of population age 0-18), 2017	19.4%	13.7%	20.1%
Licensed childcare capacity (% of population age 0-13), 2018	22%	26.0%	41.9%
4-Year High School Cohort Graduation Rate, 2017	96.8%	97.4%	87.0%

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

Survey Results

As noted previously, 226 community members completed the survey in communities throughout the counties in the CMC service area. The survey requested that respondents list their home zip code. While not all respondents provided a zip code, 147 did, revealing that the large majority of respondents (86%, N=127) lived in Carrington. These results are shown in Figure 5.

Figure 5: Survey Respondents' Home Zip Code



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

Survey Demographics

To 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:

- 38% (N=61) were age 55 or older.
- The majority (78%, N=122) were female.
- Slightly more than half of the respondents (51%, N=82) had bachelor's degrees or higher.
- The number of those working full time (66%, N=106) was just less than five times higher than those who were retired (14%, N=23).
- 96% (N=152) of those who reported their ethnicity/race were white/Caucasian.
- 36% of the population (N=56) had household incomes of less than $50,000.

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

Figure 6: Age Demographics of Survey Respondents
Total respondents = 159

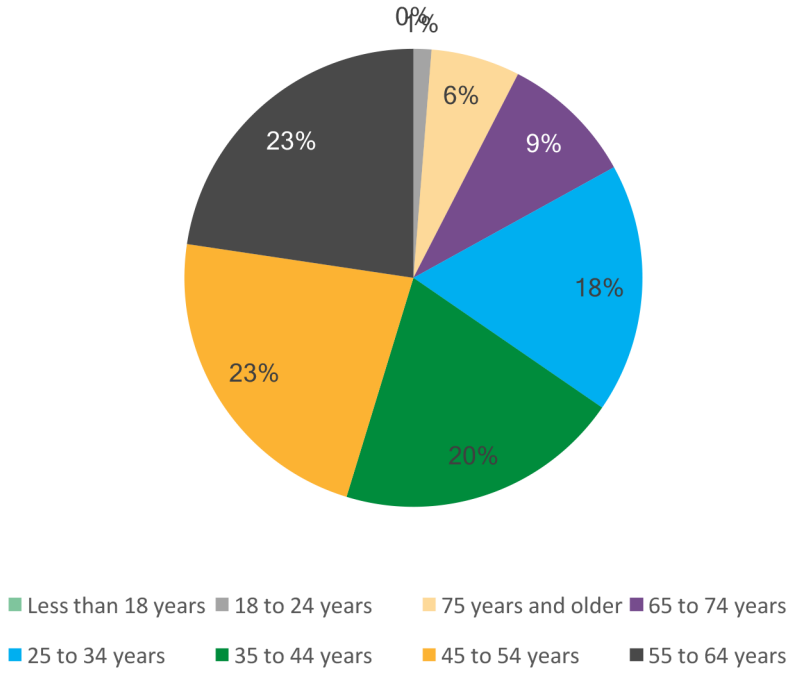


Figure 7: Gender Demographics of Survey Respondents
Total respondents = 157

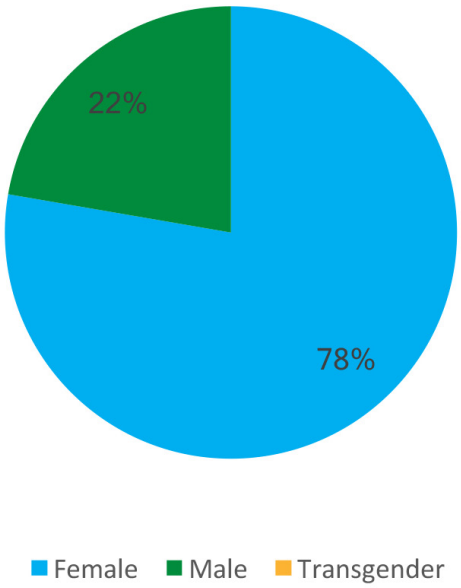


Figure 8: Educational Level Demographics of Survey Respondents
Total respondents = 161

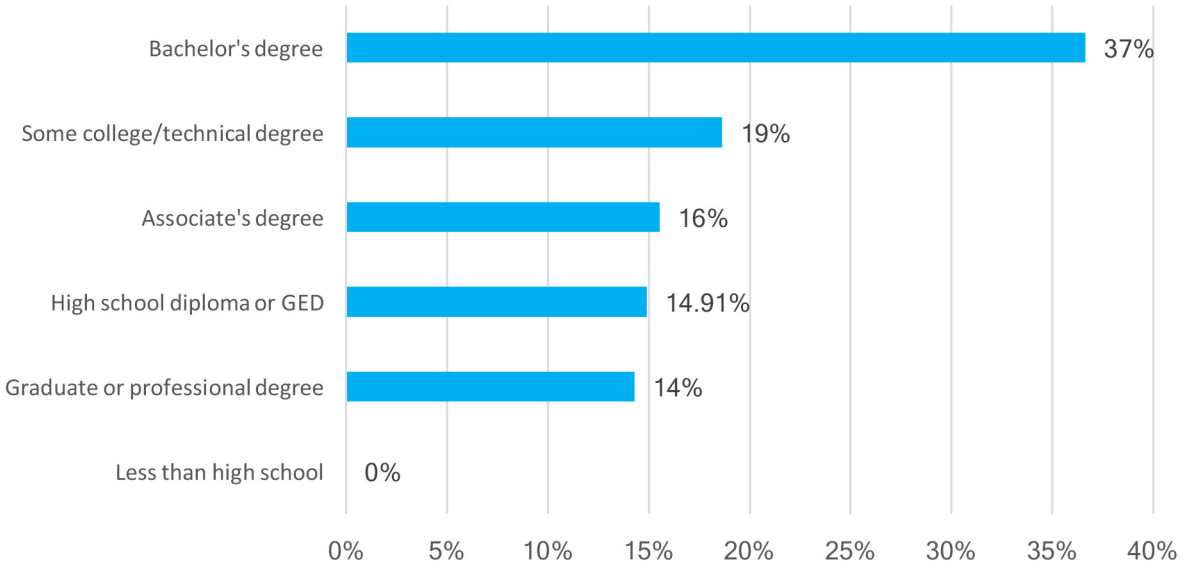
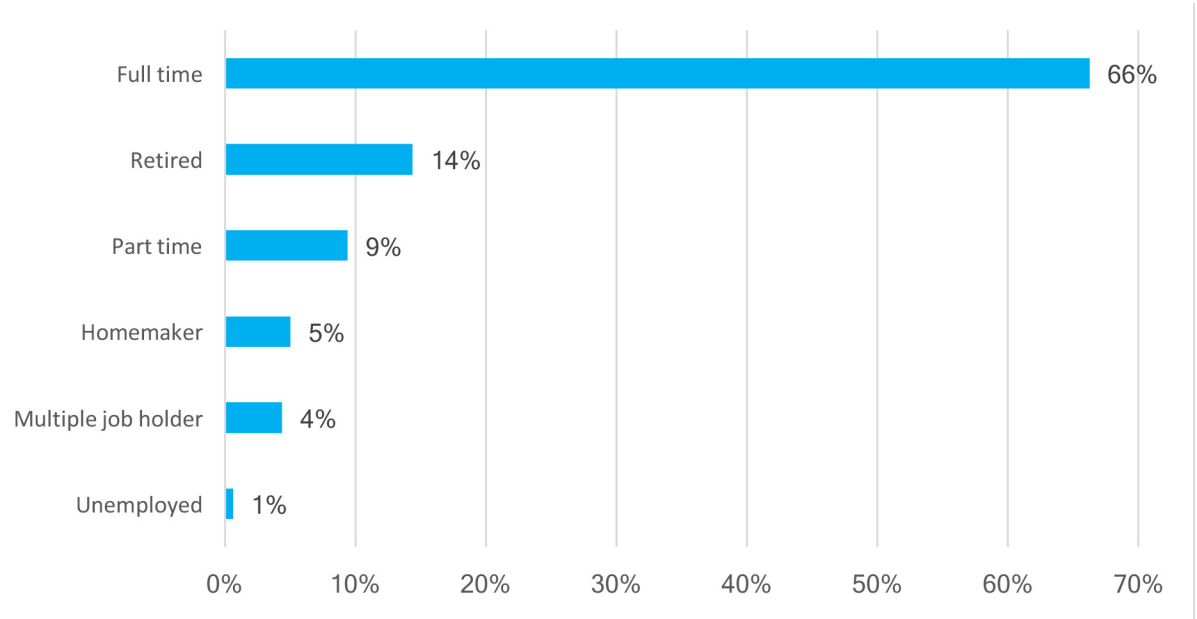
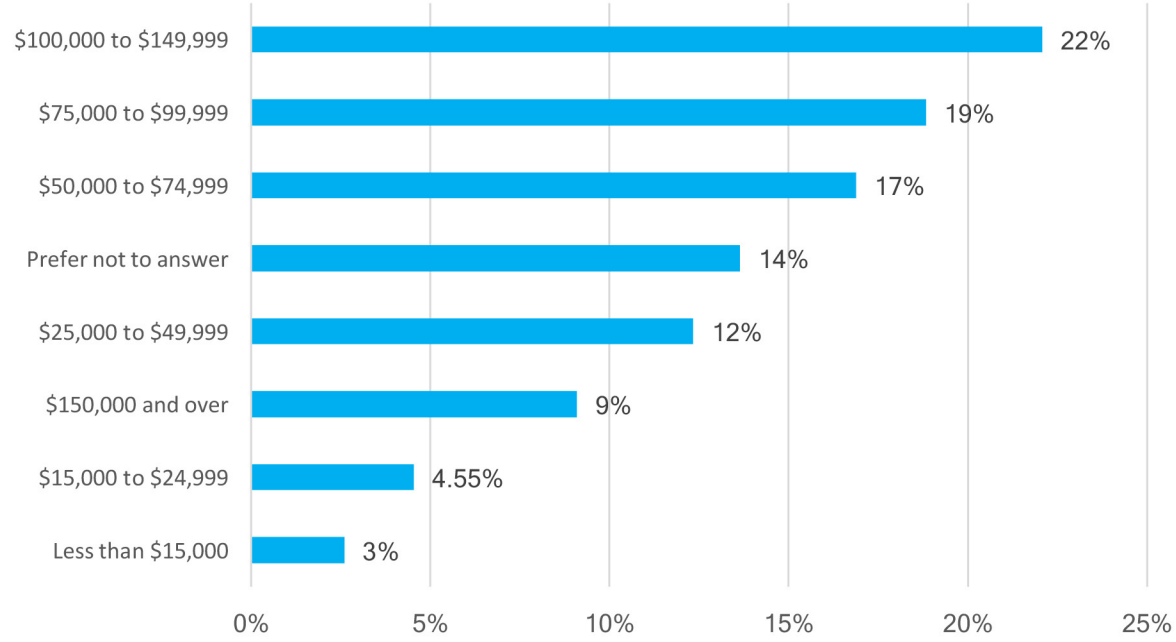


Figure 9: Employment Status Demographics of Survey Respondents
Total respondents = 160



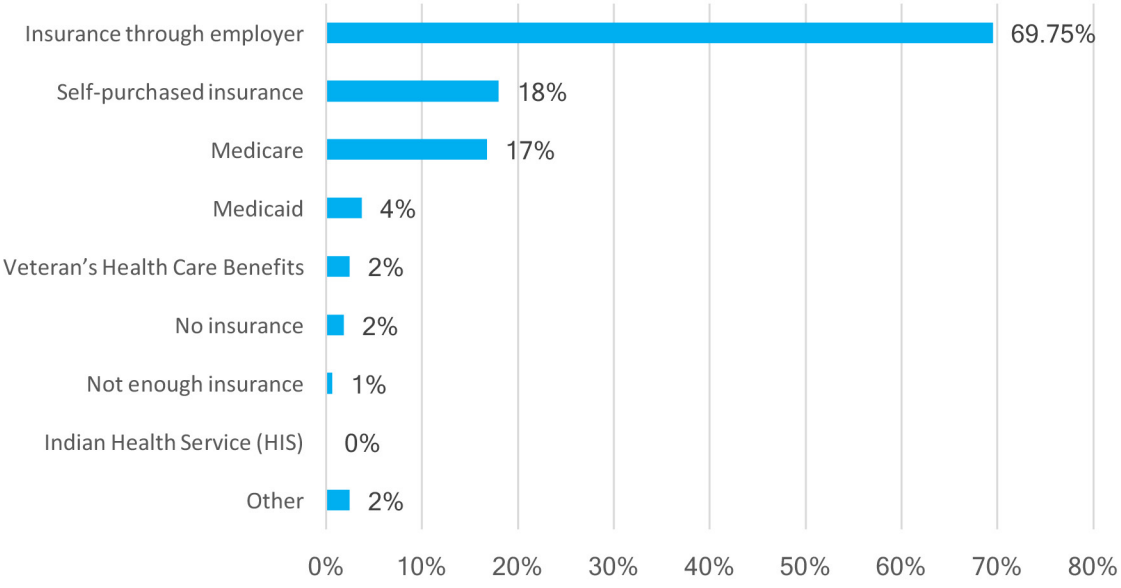
Of those who provided a household income, 8% (N=11) of the community members reported a household income of less than $25,000. Thirty-one percent (N=48) indicated a household income of $100,000 or more. This information is show in Figure 10.

Figure 10: Household Income Demographics of Survey Respondents
Total respondents = 154



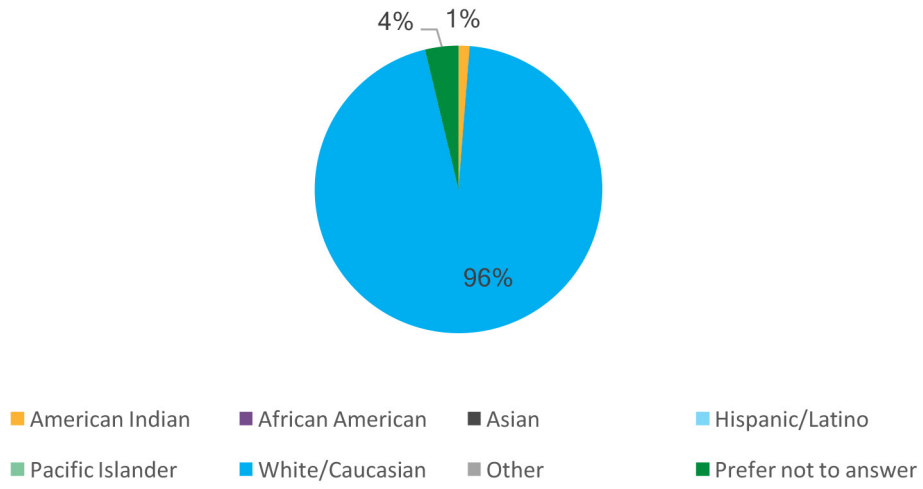
Community members were asked about their health insurance status, which is often associated with whether people have access to healthcare. Three percent (N=4) of the respondents reported having no health insurance or being under-insured. The most common insurance types were insurance through one's employer (N=112), followed by self-purchased (N=29) and Medicare (N=74).

Figure 11: Health Insurance Coverage Status of Survey Respondents
Total respondents = 182



As shown in Figure 12, nearly all of the respondents were white/Caucasian (96%). This was in-line with the race/ethnicity of the overall population of Eddy and Foster Counties; the US Census indicates that 96.9% of the population is white in Foster County and 93.1% in Eddy County.

Figure 12: Race/Ethnicity Demographics of Survey Respondents
Total respondents = 160



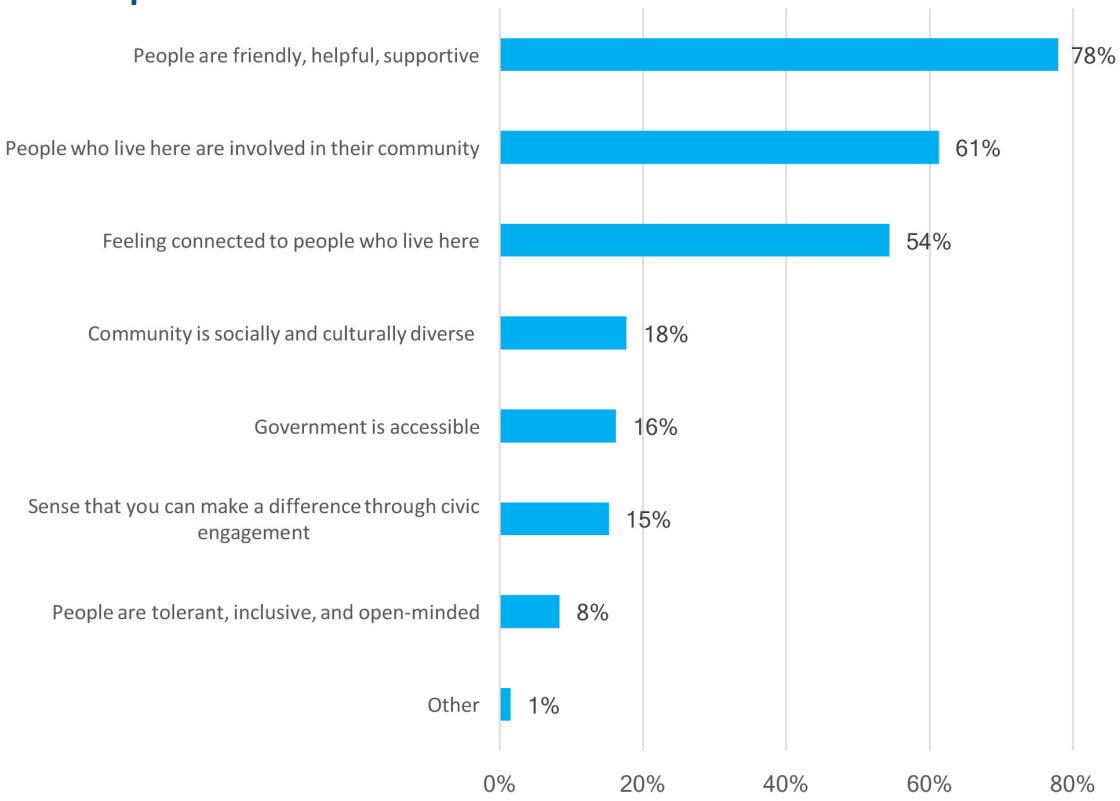
Community Assets and Challenges

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 125 respondents agreeing) that community assets include:

- Safe place to live, little/no crime (N=169);
- Family-friendly (N=166);
- People are friendly, helpful, supportive (N=159);
- Quality school systems (N=153); and
- People who live here are involved in their community (N=125).

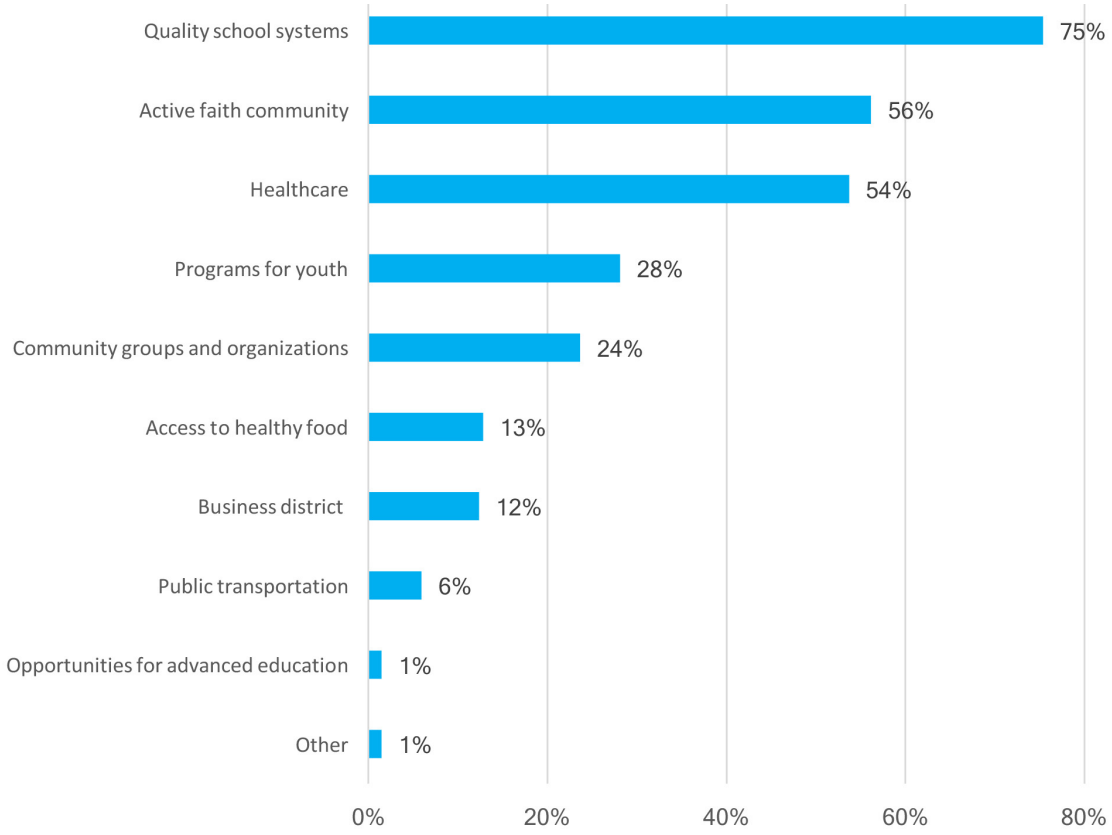
Figures 13 to 16 illustrate the results of these questions.

Figure 13: Best Things about the PEOPLE in Your Community
Total responses = 515



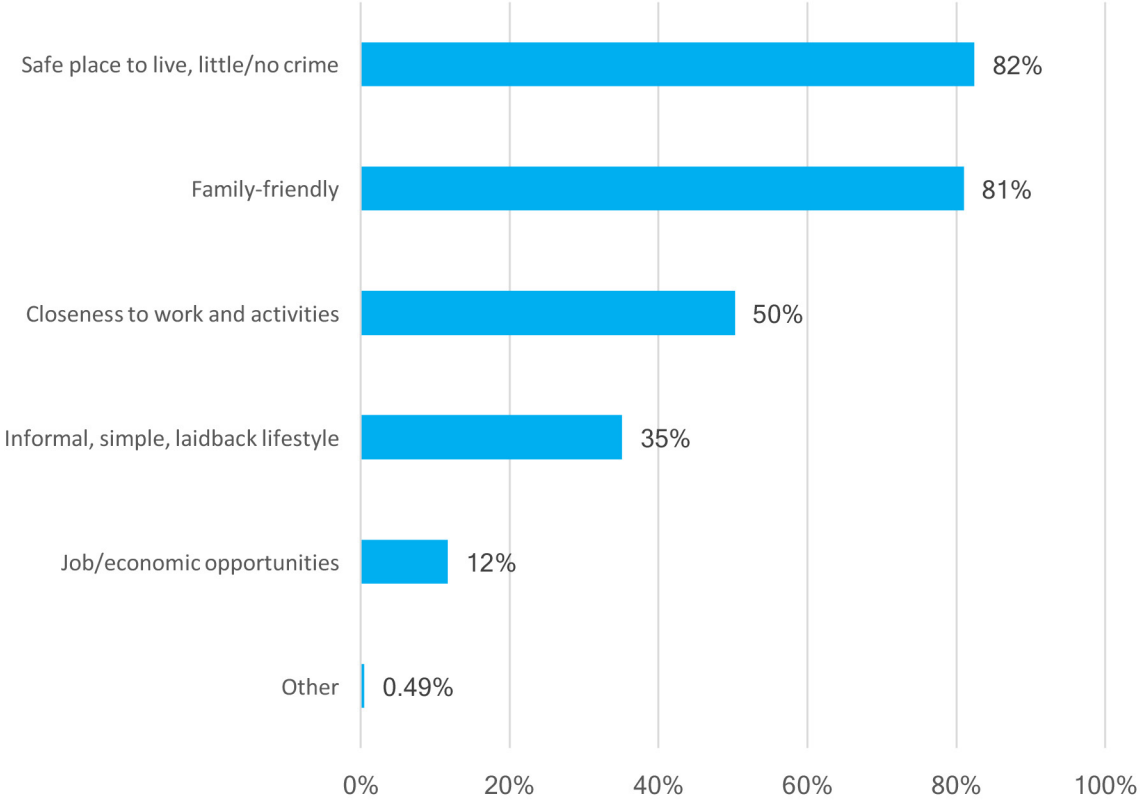
Included in the "Other" category of the best things about the people was that the people look out for one another.

Figure 14: Best Things about the SERVICES AND RESOURCES in Your Community
Total responses = 550



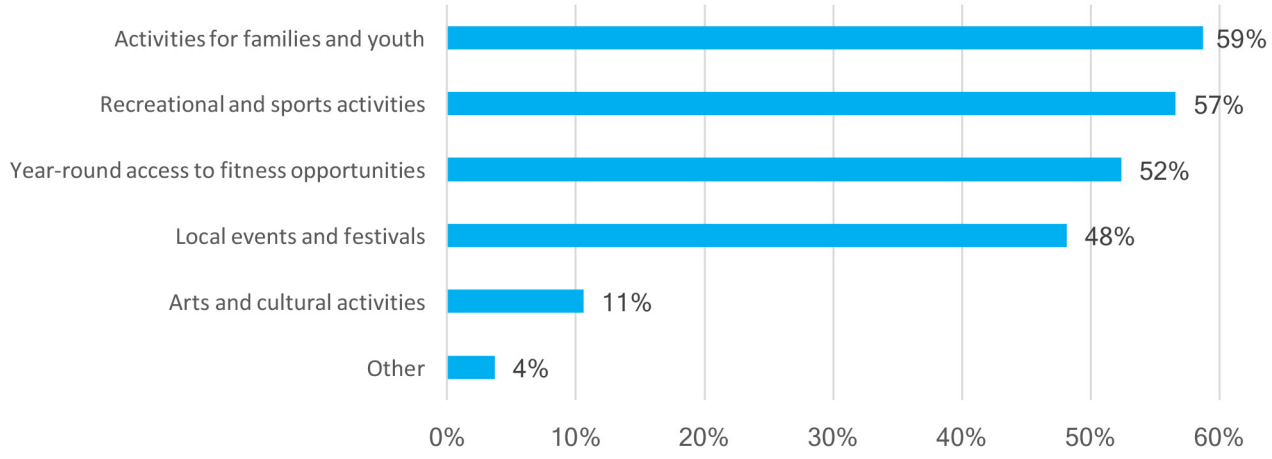
Respondents who selected "Other" specified that the best things about services and resources included fitness and agriculture.

Figure 15: Best Things about the QUALITY OF LIFE in Your Community
Total responses = 535



The one "Other" response regarding the best things about the quality of life in the community was education for the kids.

Figure 16: Best Thing about the ACTIVITIES in Your Community
Total responses = 435



Respondents who selected "Other" specified that the best things about the activities in the community included that it is safe to walk and hunting opportunities.

Community Concerns

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

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

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

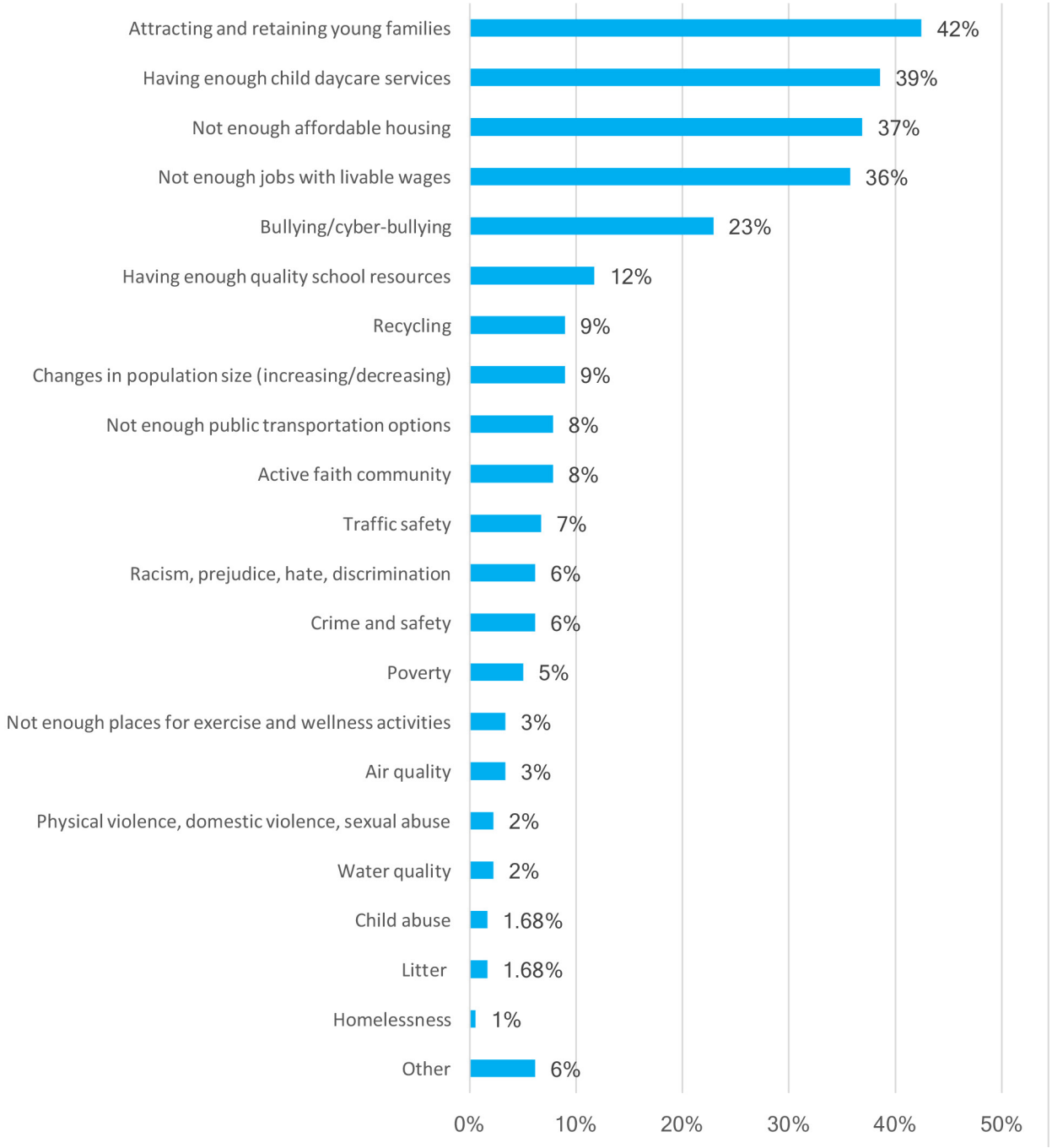
- Smoking and tobacco use (second-hand smoke) – Adults (N= 117);
- Alcohol use and abuse – Youth (N=108);
- Bullying/cyber-bullying – Youth (N=100);
- Drug use and abuse – Youth (N=95);
- Alcohol use and abuse – Adults (N=91);
- Drug use and abuse – Adult (N=83);
- Cost of long-term/nursing home care (N=83); and
- Attracting and retaining young families (N=76).

The other issues that had at least 45 votes included:

- Having enough child daycare services (N=69);
- Depression/anxiety – Youth (N=67);
- Not enough affordable housing (N=66);
- Availability of resources to help the elderly stay in their homes (N=66);
- Ability to retain primary care providers (MD, DO, NP, PA, nurses) in the community (N=65);
- Not enough jobs with livable wages (N=64);
- Depression/anxiety – Adult (N=55);
- Child abuse/neglect (N=48);
- Assisted living options (N=47);
- Cost of health insurance (N=46); and
- Stress – Adult (N=45).

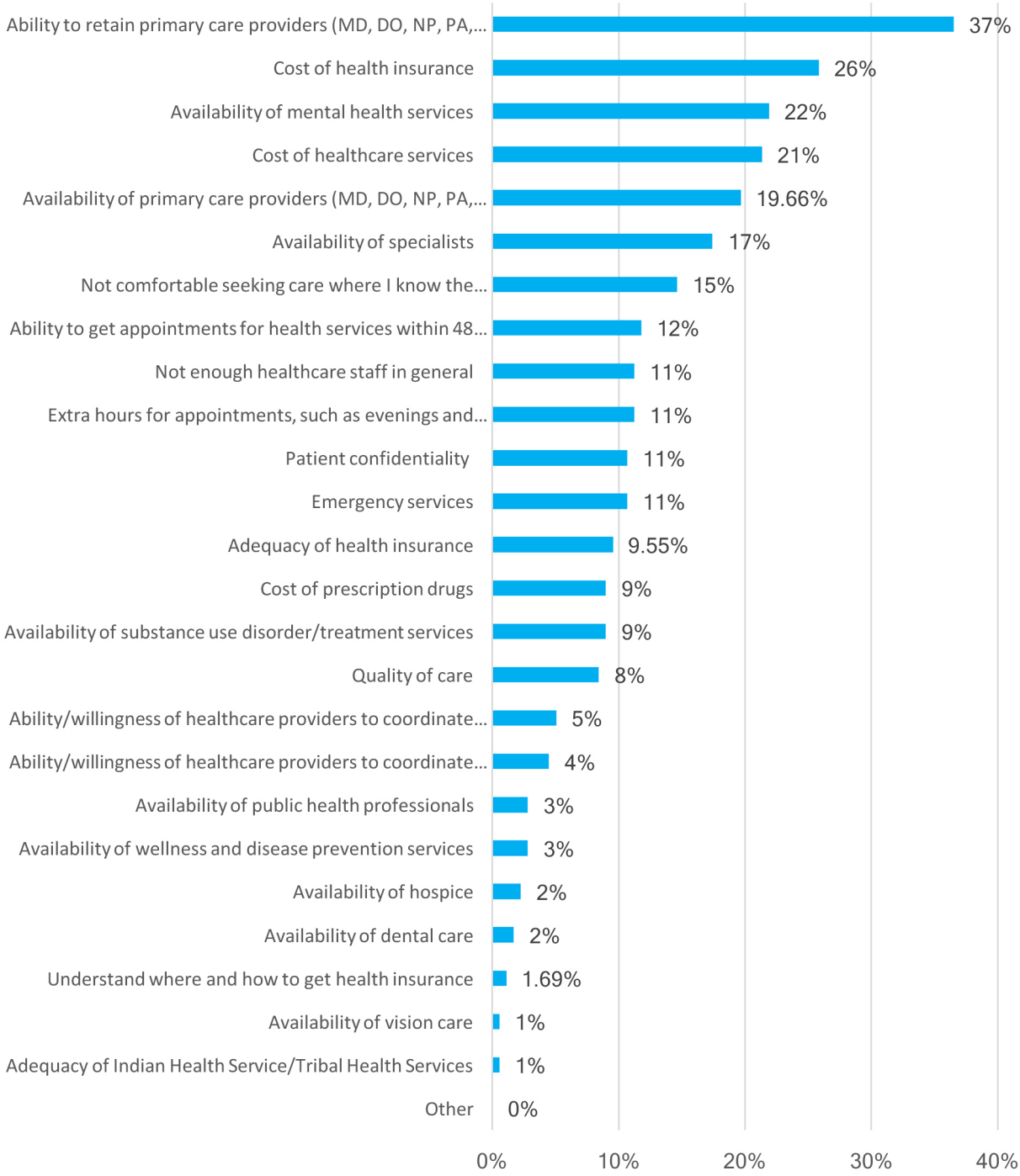
Figures 17 through 22 illustrate these results.

Figure 17: Community/Environmental Health Concerns
Total responses = 478



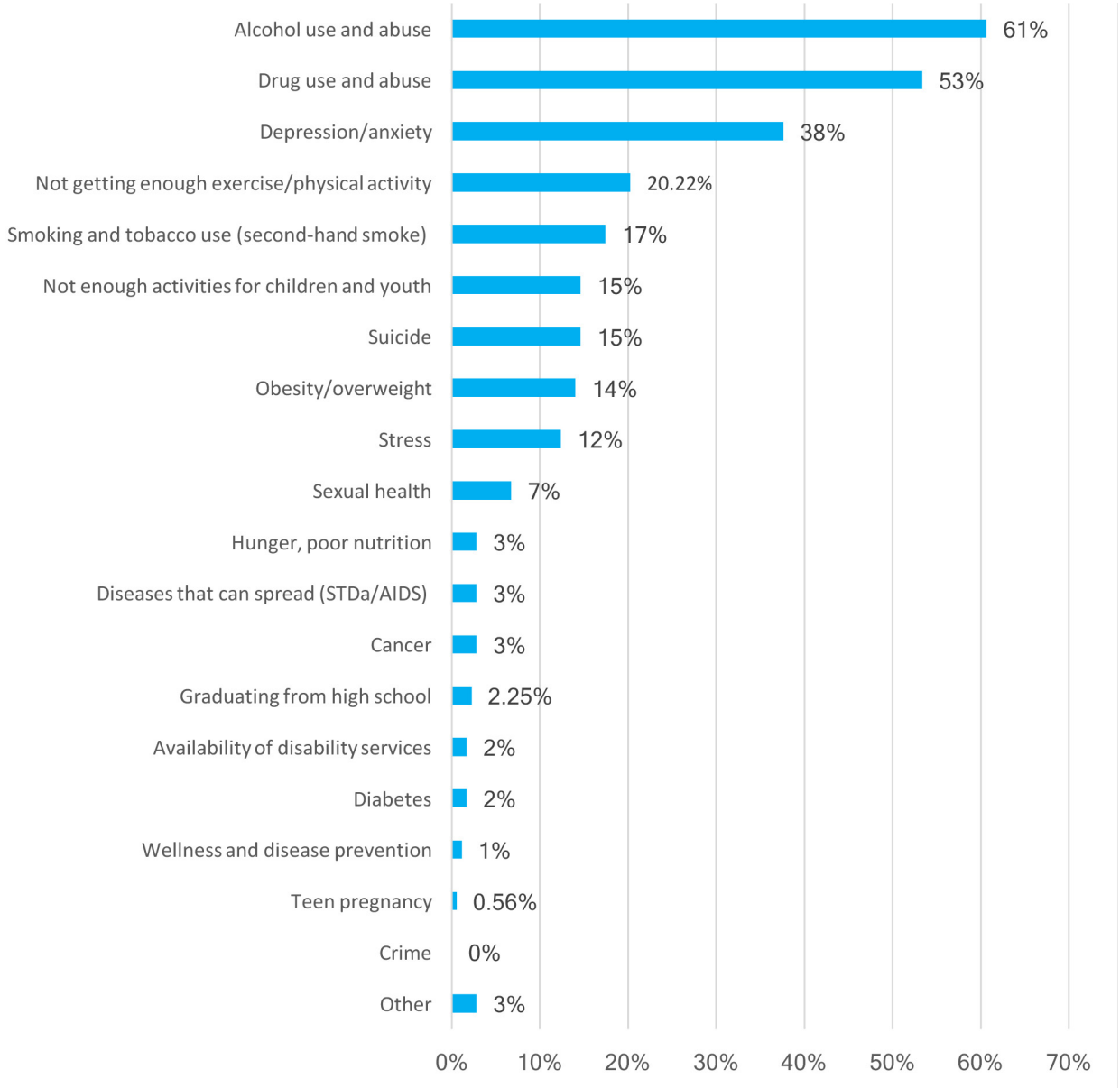
In the "Other" category for community and environmental health concerns, the following were listed: alcohol and drug issues, lack of doctors, junk food around home, lack of affordable daycare, no sidewalks for safe foot traffic anywhere in town, not enough culture and arts activities, high real estate taxes, and need more businesses.

Figure 18: Availability/Delivery of Health Services Concerns
Total responses = 478



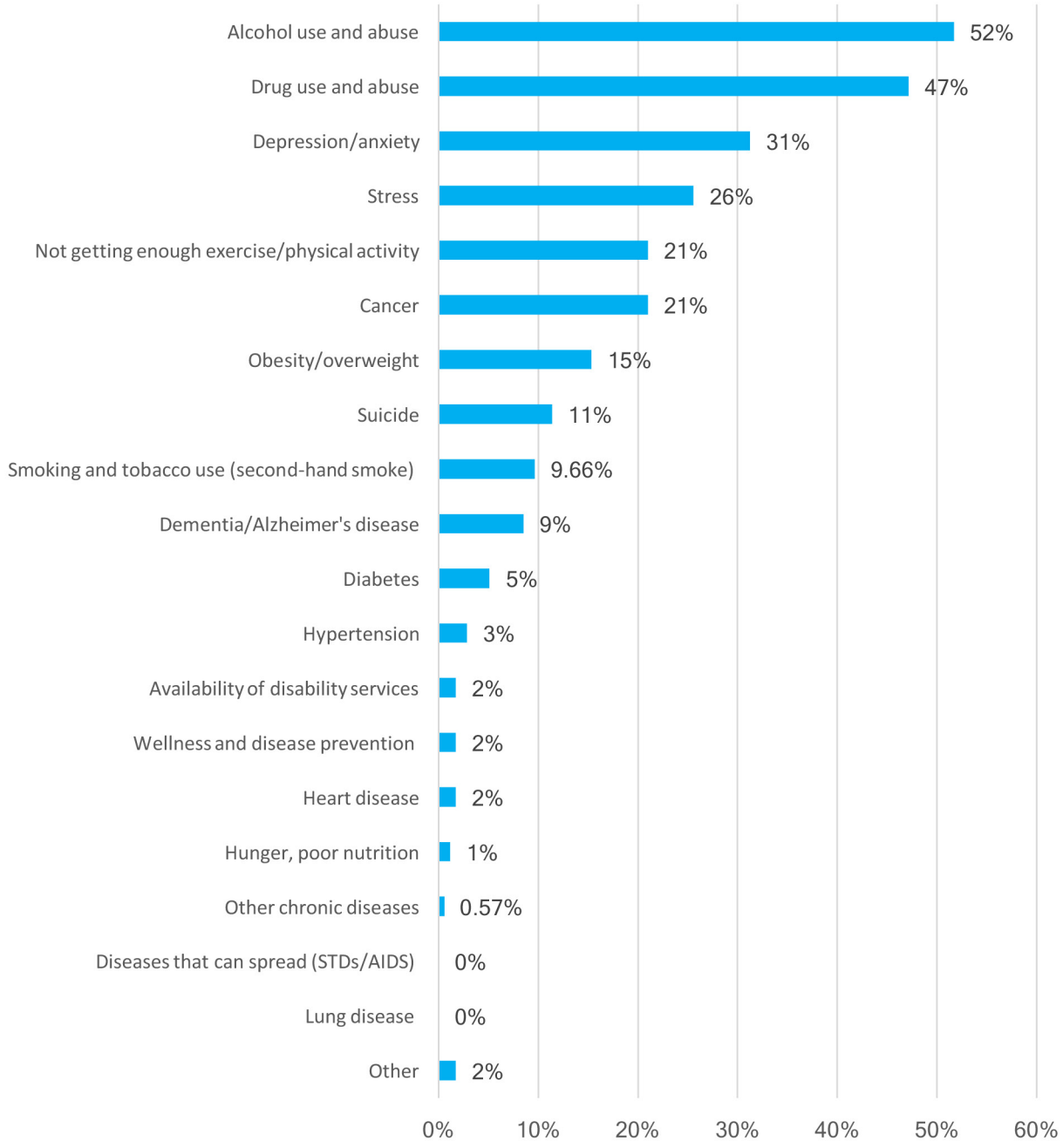
Respondents who selected "Other" identified concerns in the availability/delivery of health services as lack of physicians as the most frequently listed concern. Additional concerns included the lack communication of healthcare administrators with the public, the need for change in hospital administration to retain doctors, and lack of competent caregivers on the ambulance.

Figure 19: Youth Population Health Concerns
Total responses = 481



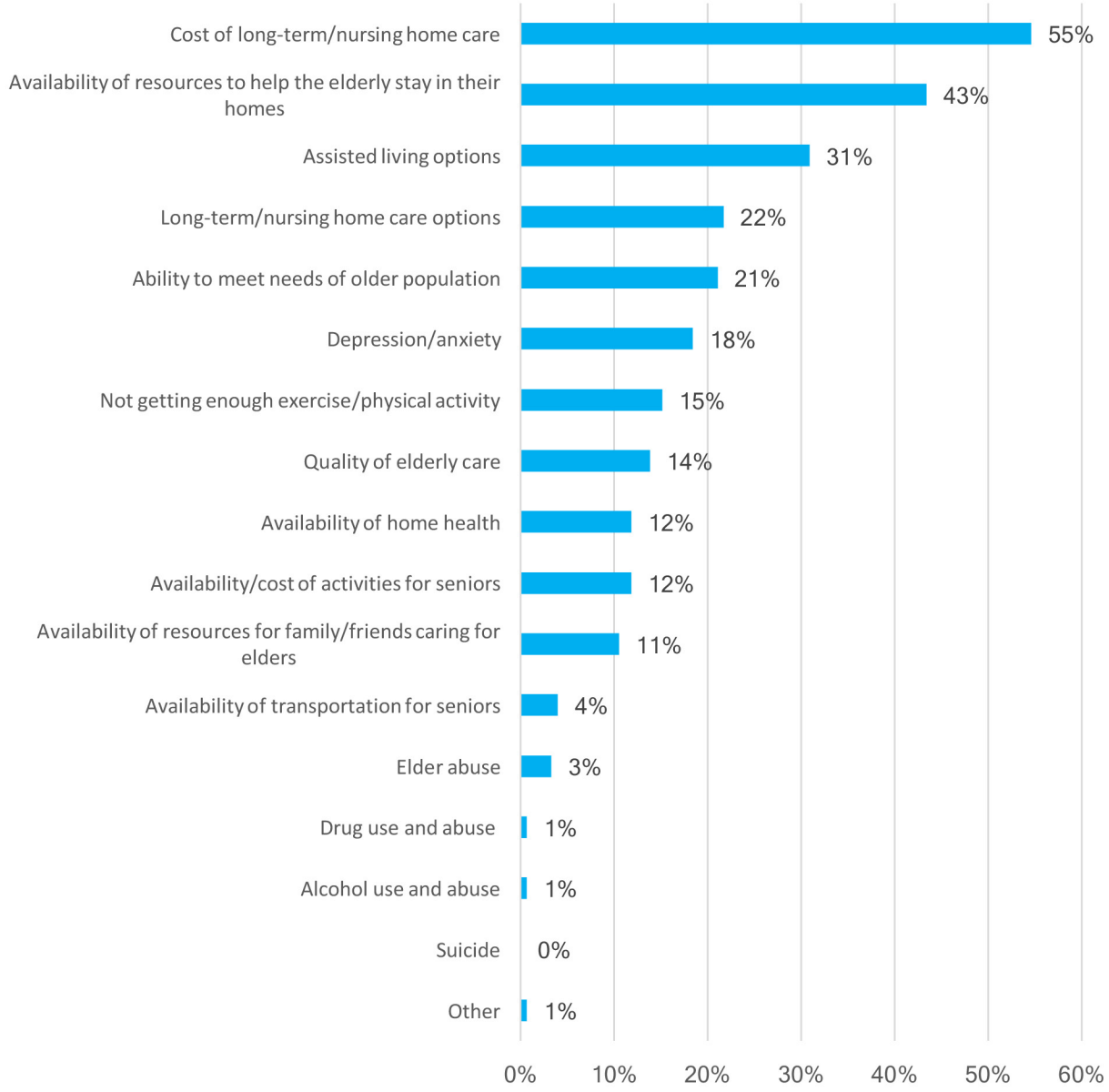
Listed in the "Other" category for youth population concerns were vaping, learning about healthy relationships, not wearing seatbelts, bullying, and that the community is mostly focused on sports and not culture and arts.

Figure 20: Adult Population Concerns
Total responses = 556



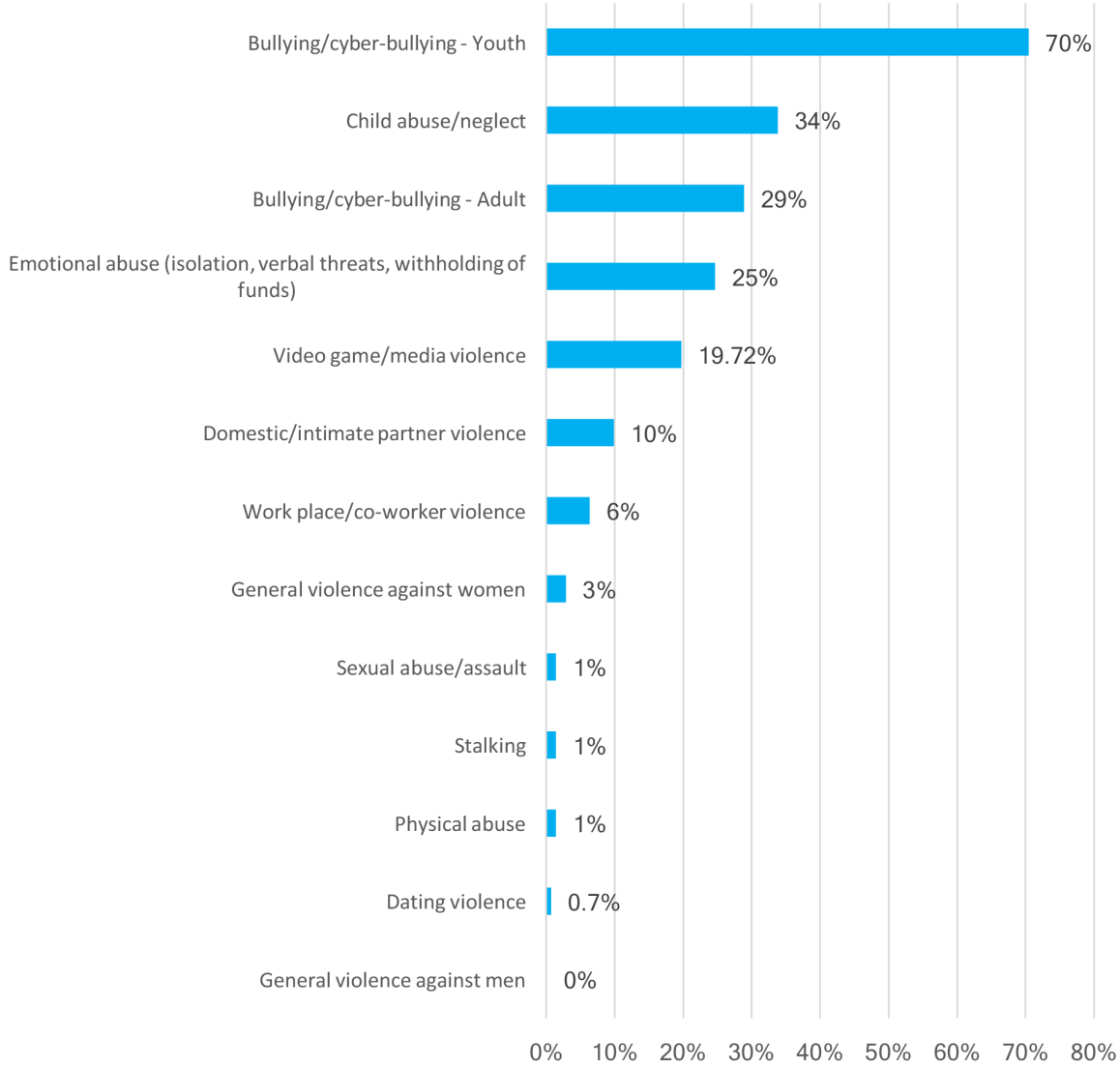
Healthcare and no available "public" exercise facility that is affordable to everyone were indicated in the "Other" category for adult population concerns.

Figure 21: Senior Population Concerns
Total responses = 399



In the "Other" category, the one concern listed was that there is not enough one-level housing for the elderly.

Figure 22: Violence Concerns
Total responses = 286



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:

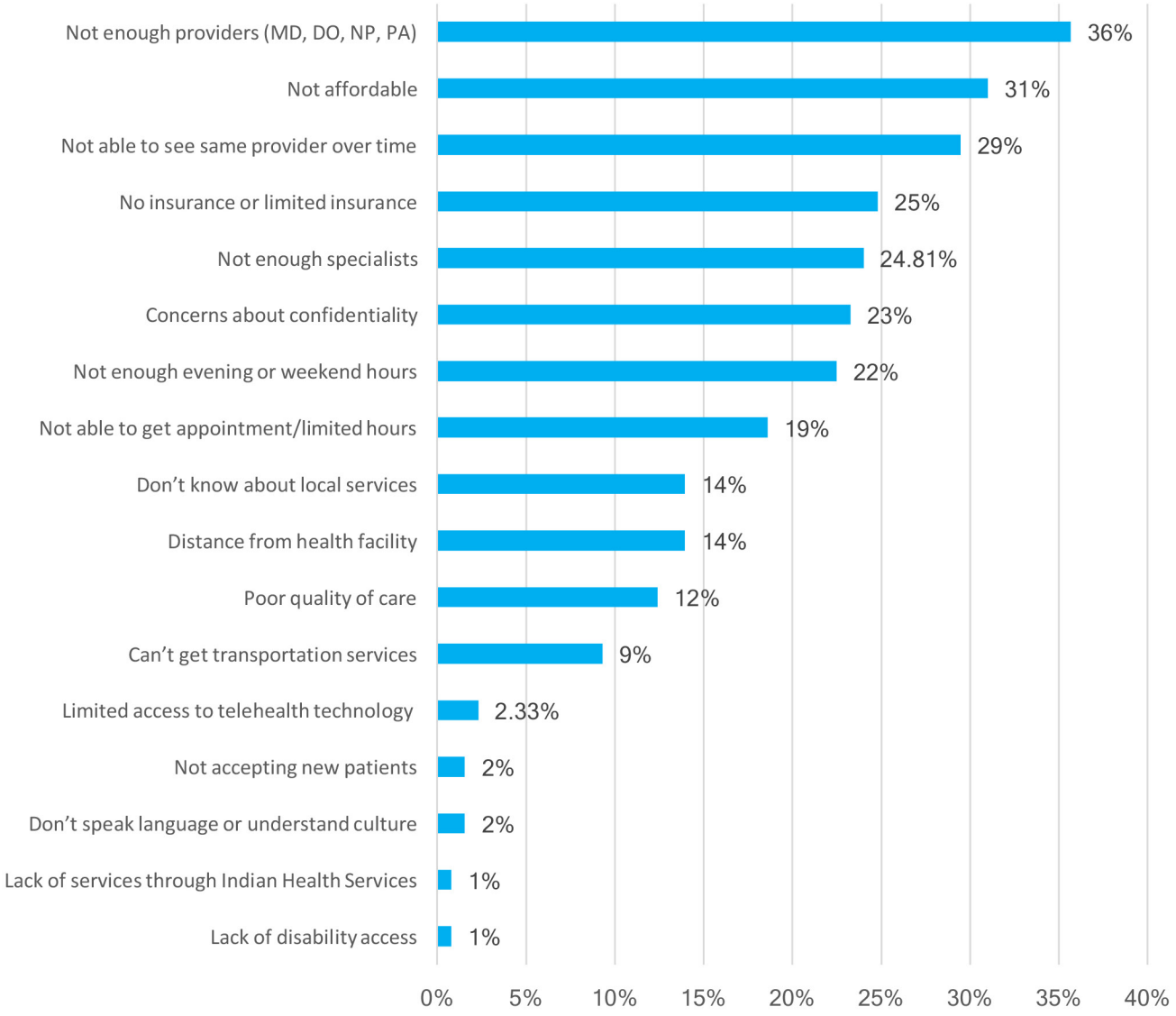
1. Lack of being able to retain providers and not filling their positions after they leave;
2. Drug/alcohol/substance abuse

Other biggest challenges identified were the population decline/inability to attract families to live in the community, poor wages, aging population, lack of activities for the family, more facilities to care for the elderly, change in hospital leadership, cost of healthcare/insurance, depression/suicide, and bullying.

Delivery of Healthcare

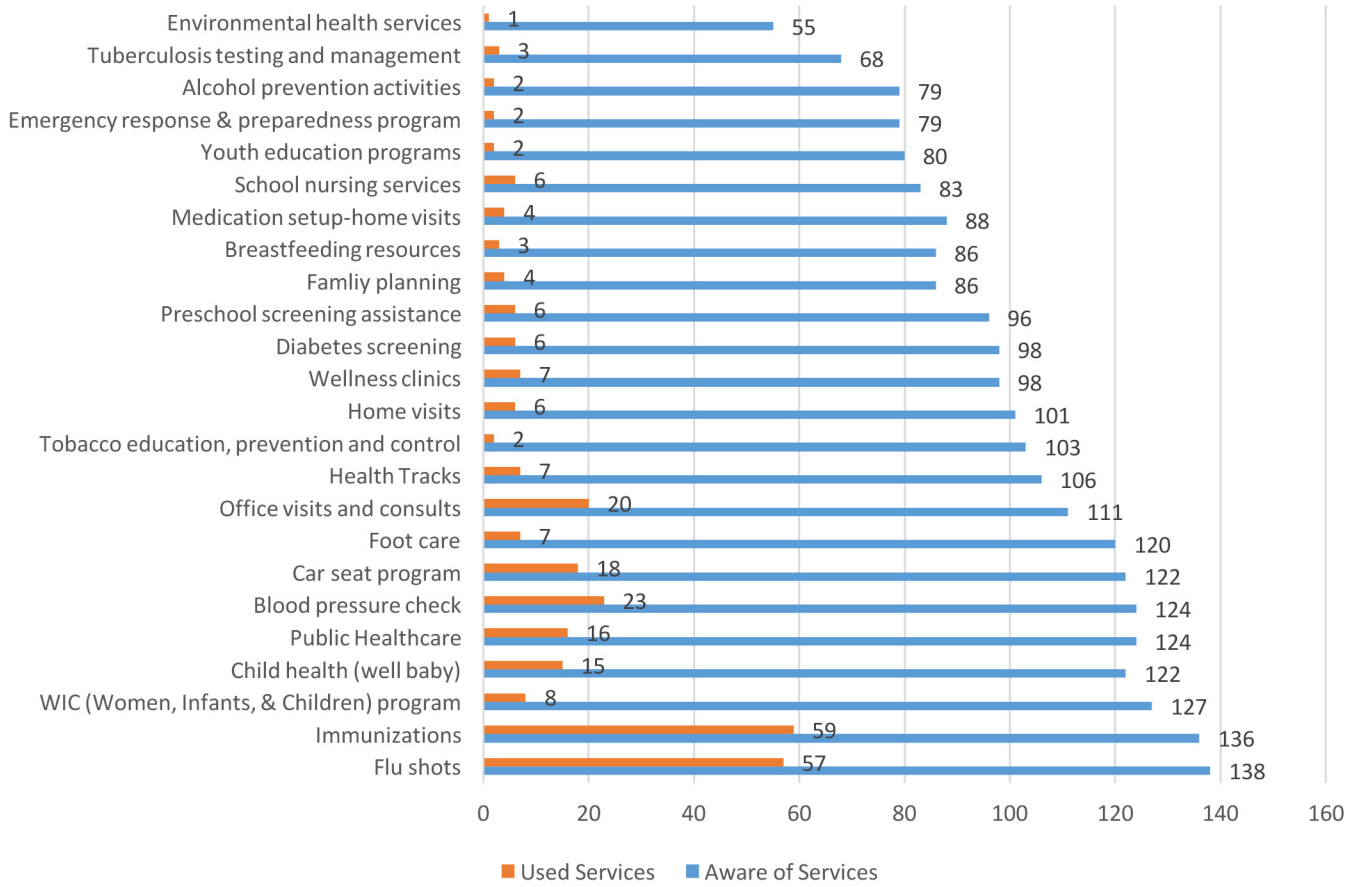
The survey asked residents what they see as barriers that prevent them, or other community residents, from receiving healthcare.

Figure 23: Perceptions about Barriers to Care
Total responses = 353



The most prevalent barrier perceived by residents was not enough providers (MD, DO, NP, PA) (N=46), with the second highest being not affordable (N=40). After these, the next most commonly identified barriers were not being able to see the same provider over time (N=38), no insurance or limited insurance (N=32), and not enough specialists (N=31). The majority of concerns indicated in the "Other" category were in regards to loss or lack of physicians, followed by a couple comments noting the lack of natural/holistic medicine options, and a poor billing system. Figure 23 illustrates these results.

Figure 24: Awareness and Utilization of Public Health Services



Considering a variety of healthcare services offered by Foster County Public Health (FCPH), respondents were asked to indicate if they were aware that the healthcare service is offered though FCPH and to also indicate what, if any, services they or a family member have used at FCPH, at another public health unit, or both (See Figure 24).

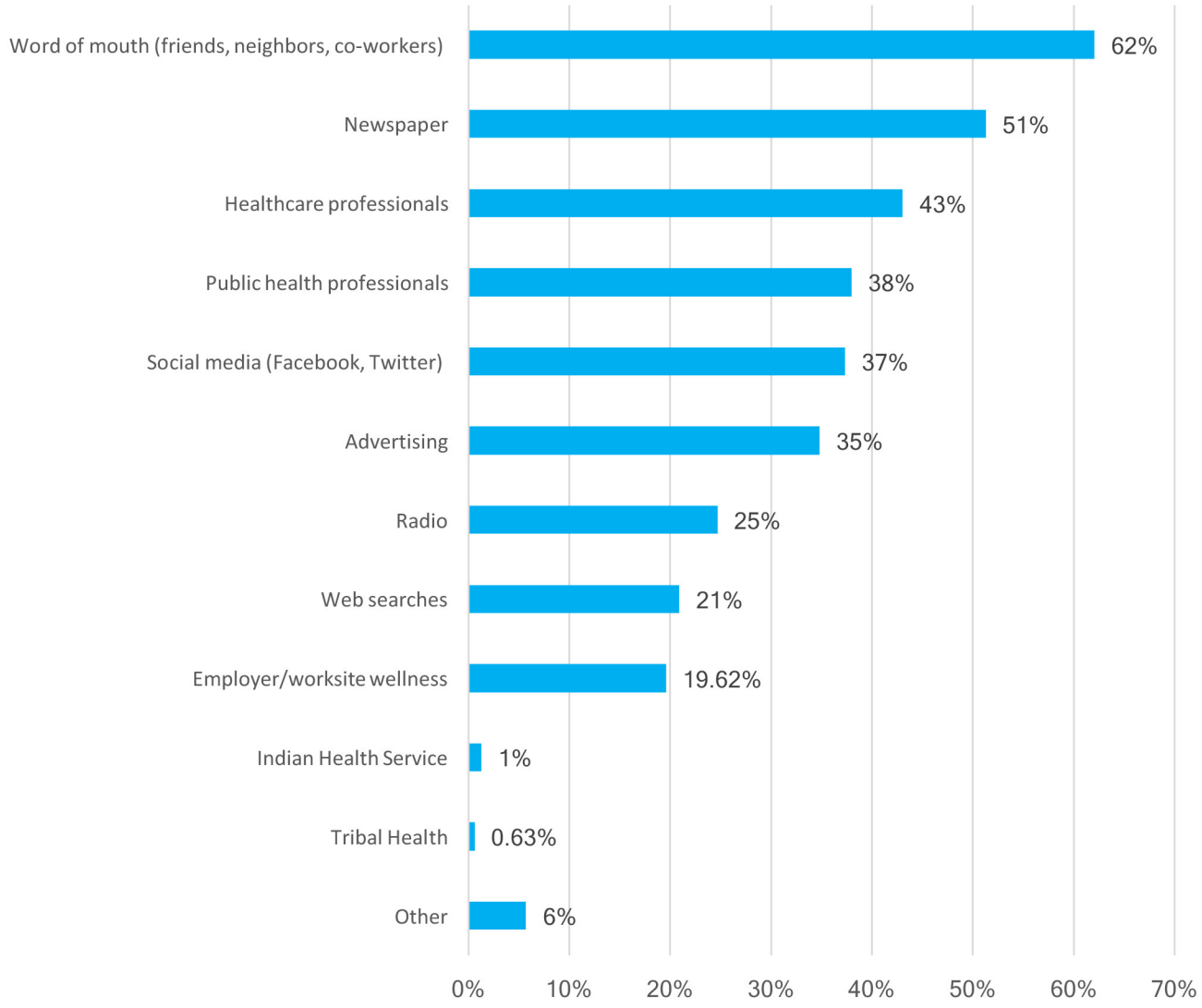
In an open-ended question, respondents were asked what specific healthcare services, if any, they think should be added locally. The number one desired service to add locally was mental health services.

- Artery screening (service similar to lifeline screening)
- Birth control
- Cancer treatments, cancer specialty providers
- City owned EMS, not hospital based
- Dermatology
- Dialysis
- Exercise and strength training for later life/ elderly
- Geriatric specialist
- Greater variety of surgeons
- Internal medicine specialist
- Lactation specialist
- Mental health professionals
- Natural medicine/homeopathic options
- Pulmonologist
- Pediatrics
- Podiatrists
- Support groups
- Vaccinations during well-baby exams in the clinic

While not a service, many respondents indicated that they would like physicians added. One person indicated the people should be able to go to FCPH and get a blood pressure check free of charge instead of having to pay, which is currently required. In regard to mental health professionals being added locally, it was also specifically noted that those professionals also need to accept Medicaid.

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 the new visiting surgeon, specialists that are brought in, back injections, cardiac rehab, chemo/pic line, respiratory/COPD services, well-child exams, and services for the elderly population (such as oxygen). It was also suggested that they include an "Ask a question" area in the paper where people can ask questions and the hospital provides responses.

Figure 25: Where do you find out about local health services? Total responses = 536



In the "Other" category, several respondents listed the Chamber of Commerce weekly email. Additional sources included television and their physician assistant.

Figure 26: Awareness of Ability to Have Local Labs and Tests Sent to Your Specialist
Total responses = 158

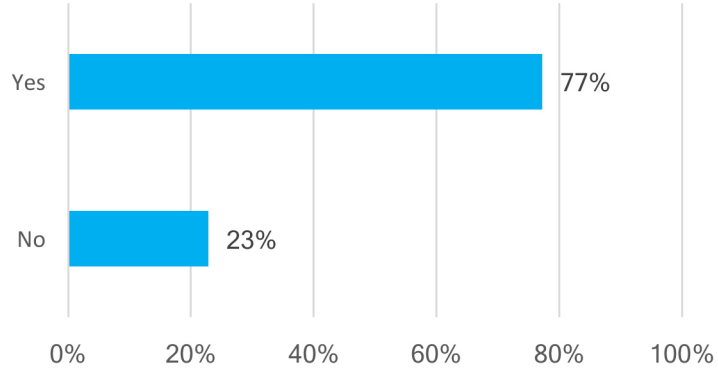


Figure 27: Awareness of CHI St. Alexius Health, Carrington Medical Center's Foundation
Total responses = 158

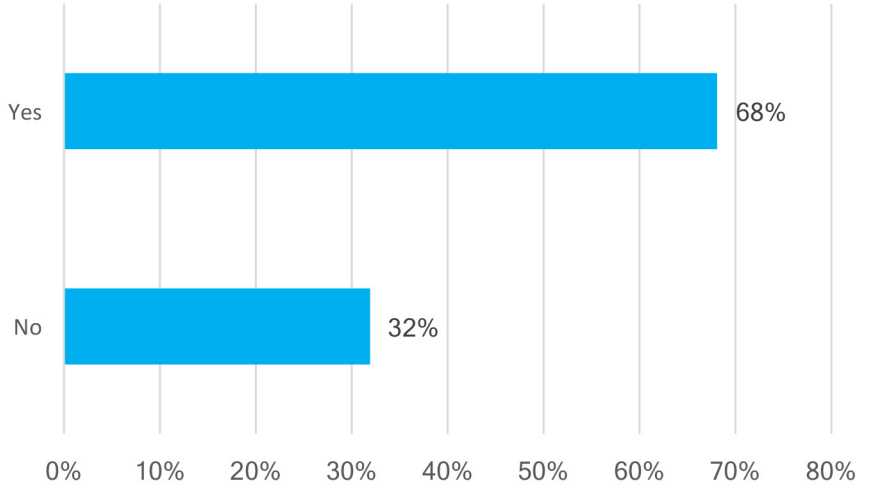
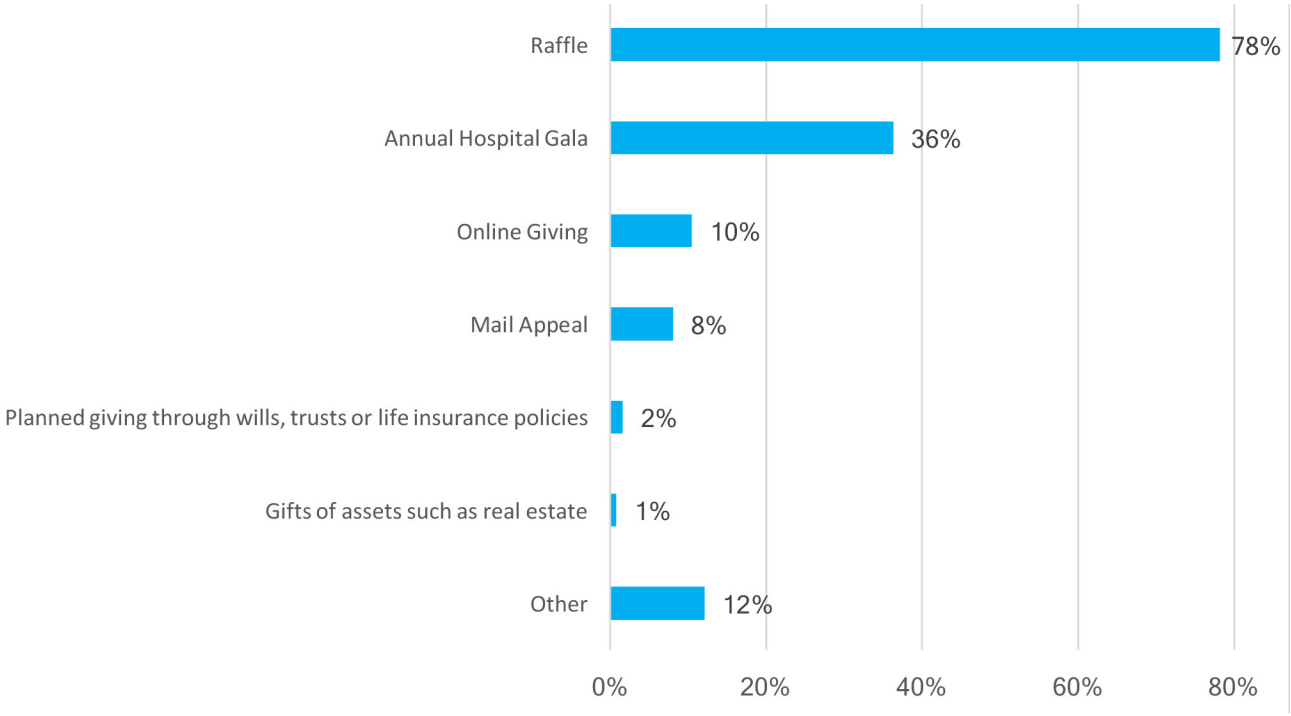
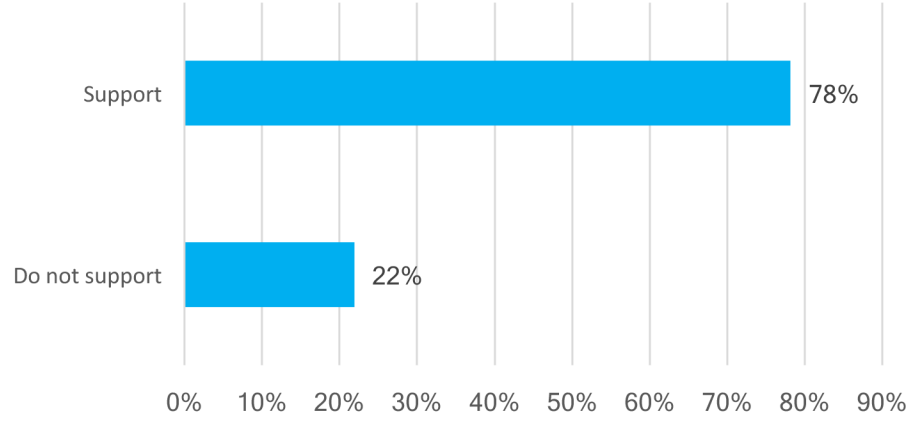


Figure 28: Ways to Financially Support Facility Improvements/New Equipment
Total responses = 183



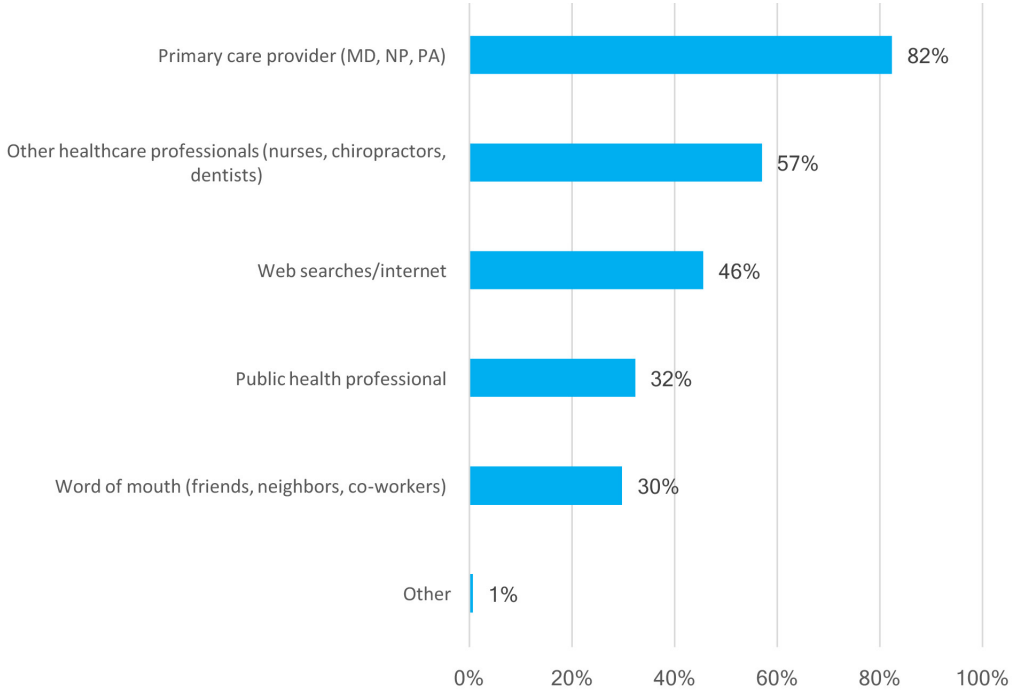
In an effort to gauge ways that community members' would be most likely to financially support facility improvements/new equipment they would most likely support, a question was included asking respondents to select ways they are most likely to support facility improvements/new equipment at CHI St. Alexius Health Carrington (see Figure 28). Recommendations in the "Other" category included fundraisers, public exercise at CHI, and auxiliary membership.

Figure 29: North Dakota Tobacco Tax Increase Support
Total responses = 160



Respondents were asked if they would support a Tobacco Tax increase in North Dakota. The funds would be used to address preventative health in all substance use areas, such as opioids, alcohol, tobacco, and others (Figure 29).

Figure 30: Sources of Trusted Health Information
Total responses = 391



Respondents were asked where they go to for trusted health information. Primary care providers (N=130) received the highest response rate, followed by other healthcare professionals (N=90), and then web/Internet searches (N=72). Results are shown in Figure 30.

In the "Other" category, pharmacist was listed as a source of trusted information.

The final question on the survey asked respondents to share concerns and suggestions to improve the delivery of local healthcare. The majority of responses focused on concern with the lack of physicians, physicians leaving the community to practice elsewhere, and that nothing is being done to address this issue. The comments included:

> Local providers are healthcare drivers in the community. The community needs to do all they can to retain existing providers and continue to recruit new ones even when there is no shortage. It will always draw new patients and help the whole community by providing an increased level of care and a business climate in Carrington and the surrounding towns. Because of the loss of physicians, the businesses in the community are being affected as well. When people travel to Harvey or elsewhere to seek medical care, they also shop in those towns instead of in Carrington. There is also a desire to have additional physicians hired and not just physician assistants.
>
> Some respondents stated that there is a lack of trust and confidence in the current CMC administration. It is felt that they are pushing providers out of the community. Employees at the facility need to be treated better. The quality of caregivers is always going to be the community's biggest asset. Something needs to be fixed fast, management changes need to be made. The physicians, physician assistants, nurse practitioners, and nurses are excellent; it is the management that is the problem.
>
> Additional suggestions for CMC include the addition of early morning, evening, and weekend appointments. Have shorter wait times for getting appointments. There should be a provider on duty at the hospital at all times. Stricter policies on confidentiality should be implemented.
>
> It was suggested that the ambulance service be run by the city or county. They feel that, in time, having it owned by the hospital is going to become detrimental to the service and ultimately end in closure of the ambulance service. In addition, it was indicated that having the hospital running the service hinders the

ability of the EMS staff to do their job properly. There is a need to have ambulance drivers available at all times; a lot of times the ambulance does not have drivers.

The health facilities should utilize the newspapers more for correspondence; many patients say, "I read it in the paper!" Inform the community that tests ordered by other providers (physicians, nurse practitioners, physician assistants) outside of CMC can be done in Carrington and sent to their out-of-town provider.

There needs to be continued promotion of the clinic and hospital in order to keep it financially stable. The community takes local healthcare for granted and if the community does not support and utilize healthcare, they risk losing it.

It is felt that over the last few years, the quality of care, customer service, and leadership has declined at CMC. While one of the respondents used to travel 30 miles to doctor in Carrington, they now drive to Fargo or Bismarck because they have been treated poorly and have not received quality care.

Others believe that CMC does a great job of identifying and delivering healthcare within its means and offers a wide variety of healthcare services.

Findings from Key Informant Interviews & the Community Meeting

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

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

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

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

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

- In the last few years we have had one doctor that was a life-long resident leave. The one doctor we have now was making plans to leave at that time but stayed, and another doctor that had been here for a real long time moved to Harvey. –What is going on that is causing the providers to want to leave here? The perception is that management is not treating the providers that are tied to the community appropriately. They haven't gotten anyone new hired and it puts a lot of pressure on the providers that are still here.
- This is the most important concern that we need to address.

- The local healthcare entity (CHI), may not share the same goals as the community. Such as, healthcare provider recruitment is controlled by the Fargo division office. The local CHI management has historically had a very antagonistic approach/relationship with local providers. Providers and their employers often have conflicting goals (making more money vs spending more money), but good management and communication skills can meet those goals (without the antagonism and conflict).

Alcohol use and abuse

- Top concern is addressing alcohol abuse in both adults and youth.
- Major concern in the youth population.
- Seems to be an increase in alcohol and drug use.

Availability of mental health and substance use disorder treatment services

- Mental health services are needed – It can take several years to find appropriate mental health services for depression and anxiety issues. It takes 2-3 months until you can see someone, short of saying you are going to commit suicide.
- Most people don't have any idea of where to go with these issues.
- Have recently hired someone locally to work with mental health issues.

Depression/anxiety

- Depression and anxiety lead to stress and suicide.
- Top concern is addressing depression/anxiety.
- Recurrent issue for people.
- Combined with stress, some is about lifestyle.
- Goes along with suicide, which has been very prevalent recently.
- Not enough resources locally.

Having enough child daycare services

- People are hiring nannies because they can't find anyone to care for their children.
- People move here to live and work but can't find a place for their kids to go.

Community Engagement and Collaboration

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

- Hospital (healthcare system) (4.5)
- Public Health (4.5)
- Schools (4.5)
- Emergency services, including ambulance and fire (4.25)
- Pharmacy (4.0)
- Faith-based (4.0)
- Business and industry (4.0)
- Other local health providers, such as dentists and chiropractors (4.0)
- Economic development organizations (3.75)
- Law enforcement (3.75)
- Long-term care, including nursing homes and assisted living (3.0)
- Social Services (3.0)
- Human services agencies (2.75)

Priority of Health Needs

A Community Group met on November 1, 2018. Fourteen community members attended the meeting. Representatives from the CRH presented the group with a summary of this report's findings, including background and explanation about the secondary data, highlights from the survey results (including perceived community assets and concerns, and barriers to care), and findings from the key informant interviews.

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

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

- Ability to retain primary care providers (MD, DO, NP, PA) (9 votes)
- Attracting and retaining young families (7 votes)
- Availability of resources to help elderly stay in their homes (4 votes)
- Alcohol use and abuse – all ages (3 youth votes, 3 adult votes)
- Not enough affordable housing (3 votes)

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

1. Ability to retain primary care providers (MD, DO, NP, PA) (6 votes)
2. Attracting and retaining young families (3 votes)

3. Not enough affordable housing (2 votes)
4. Availability of resources to help elderly stay in their homes (2 votes)

While it was felt that alcohol use and abuse for all ages is an important issue, it did not receive any top priority votes.

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

Comparison of Needs Identified Previously

Top Needs Identified 2016 CHNA Process	Top Needs Identified 2019 CHNA Process
Obesity/overweight	Ability to retain primary care providers (MD, DO, NP, PA)
Adequate childcare services	Attracting and retaining young families
Youth alcohol use and abuse	Not enough affordable housing
Adult cyberbullying	Availability of resources to help elderly stay in their homes
Adult alcohol use and abuse	
Lack of mental health providers	

The current process did not identify any identical common needs from 2016 based on the top four concerns identified in the second community meeting. However, alcohol use and abuse in both adult and youth age groups, which was a top need found in the 2016 process, was identified as a high priority area still, even though it ended up ranking just out of the top 4 needs.

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

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

Need 1: Obesity/Overweight – In the fall of 2016, CMC completed the pre-application process for the CHI Mission and Ministry Grant for the Blessings in a Backpack program. The full application process was completed in March of 2017. The grant was awarded to CMC in July of 2017. The purpose of the program is to provide for the weekend nutritional needs of children in our community's school system for grades K-12. Goals of the project are to provide nutritionally balanced food options for students to take home each weekend throughout the school year; introduce basic food prep skills and ideas on how to use the food in the backpacks; and, build sustainability for the program. The program has been successful and CMC will continue to find avenues to support this program.

In fall of 2017, CMC again completed the pre-application process for the CHI Mission and Ministry Grant for the Blessings in a Backpack program to secure a second year of funding for the program. The full application process was completed in March of 2018. The grant was awarded to CMC in June of 2018 and will fund the backpack program for the next two years.

In the winter of 2017, CMC applied for the BCBS-ND Caring Foundation Grant. The grant was received in March of 2017. The first activity in this grant was completed in June of 2017 with healthy snacks and snacking ideas presented at the CMC booth at the Foster County Fair for the community at large. Other activities completed in FY2018 include: healthy cooking and snacking classes with the Senior Citizens Center and

Carrington Elementary after school program students, and a summer recreation camp aimed toward creating healthy hobbies for life for students entering 1st-6th grade.

In the fall of 2017, CMC applied for the Medicare Rural Hospital Flexibility Program grant. The grant was received in November of 2017. This grant was used to improve well child exams and increase the number of children receiving them. In the spring of 2018, seven temporal thermometers were purchased for use in both clinics. Pediatric patients tolerate temporal thermometers better. To provide a more kid-friendly environment, wall activities for exam rooms were purchased. The Reach Out and Read program was also launched in the spring. This program follows a simple model of prescribing books and reading aloud as a means of fostering the language-rich interactions between parents and their young children, which stimulates early brain development and promotes lifelong literacy. These activities combined should boost the percentage of well-child exams administered in the community and promote a healthy lifestyle starting from birth.

In the winter of 2018, CMC applied for the BCBS-ND Caring Foundation Grant. The grant was received in February of 2018. The grant will be used towards the purchase of park equipment to enrich free, public opportunities for exercise in the community. As of the summer of 2018, the project has been fully funded through several different sources and community groups.

Need 2: Youth Alcohol Use and Abuse – A focus group of high school students hosted by CMC and FCPH was held on June of 2016. The participants voiced concerns about alcohol use and abuse in the community as well as suggested programming opportunities and healthy activities for youth.

FCPH is the recipient of the SAMHSA Partnership for Success Targeting Underage Drinking Grant (PFS), which aims to reduce substance misuse and strengthen prevention capacity at the state, tribe, and jurisdiction levels. This is accomplished by helping grantees leverage and realign statewide funding streams for prevention. Through collaboration, states and their PFS-funded communities of high need can overcome challenges associated with substance misuse. PFS programs also aim to bring SAMHSA's Strategic Prevention Framework to a national scale, giving grant recipients the chance to acquire more resources to implement the PFS. Work started on this grant in the late fall of 2016. In the winter and spring of 2017, community readiness and capacity assessments were completed. Other activities included gathering demographic and medical information about the local population, coalition orientation, and strategic planning. FCPH is the lead for this grant with some support from CMC.

In the fiscal year of 2018, work with the SAMHSA PFS grant continued. The scope of the project was narrowed to address two strategies; the implementation of a teen party ordinance and the creation of a social host liability law in the community. The Healthy Communities Coalition discussed 2017 Youth Risk Behavior Surveillance (YRBS) data, 2017 PFS survey data, tip line creation and implementation, and teen party ordinance and social host liability law benefits and consequences. A media campaign was implemented through live presentations, coalition partner websites, newspaper, church and school newsletters, radio, and social media (Facebook, Instagram, Snapchat, Twitter) about the risks and dangers of underage drinking. A tip line with a mobile device app was created and launched for the city of Carrington and Foster County with the hope that risky behaviors will be reported timely and anonymously to law enforcement. Youth in the community were invited to apply for a scholarship sponsored by the grant to help plan and promote healthy activities in the community. Five youth members were chosen and have helped plan and promote a healthy activity each month starting in December of 2017. Meetings with local law enforcement and stakeholders also occurred in the fiscal year of 2018 to help create awareness of the issues and to stimulate positive change for the community. FCPH continues to be the lead for this grant with some support from CMC.

Need 3: Adequate Childcare Services – The Job Development Authority through the Carrington City Council formed a sub-committee to work on incentives for daycares to open new businesses, expand current businesses, and/or become licensed. A community wide daycare needs survey was completed in April of 2017. The Consider Carrington Committee is actively looking for spaces in the community to house a daycare center.

Due to resource constraints, other organizations in the community addressing the need, and a relative lack of expertise or competency to effectively address the need, CMC will strive to create awareness about this need and assist and implement interventions when possible.

Need 4: Adult Cyber-bullying – In the fall of 2016, the Carrington Area Chamber Board organized a county commissioner candidate meet and greet. The goal was to help educate the community on the candidates in a positive way. Attendees were able to find their district on a map and visit with those candidates in their district. Board members believed this would be a positive effort for Carrington on behalf of the Workforce Recruitment and Retention Committee to negate adult cyberbullying related to the Foster County government.

In the fall of 2016, CMC applied for the Medicare Rural Hospital Flexibility Program grant. The grant was received in November of 2016. This grant was utilized for the Lutheran Social Services of North Dakota Restorative Justice Program to train local community members in the circle process. The trainings took place in the winter of 2017. The circle process training taught participants positive communication skills, and how to facilitate group discussion in a calm and understanding manner.

Due to a relative lack of expertise or competency to effectively address this need and a lack of identified effective interventions to address this need, CMC will strive to create awareness about this need, and assist and implement interventions when possible.

Need 5: Adult Alcohol Use and Abuse – CMC's Healthy Communities Coalition has ongoing, regularly scheduled Responsible Beverage Server Training available to all local establishments that sell and serve alcohol for a small fee.

Need 6: Lack of Mental Health Providers – In January 2017, the clinics of CMC started a focused effort to screen all patients ages twelve and older for depression. The screening questionnaire is repeated at least one time per year.

CMC recently hired a full time Certified Psychiatric Mental Health Nurse Practitioner that started treating patients in October 2018. She cares for patients of all ages with a special interest in working with youth and provides psychiatric evaluations and medication management. To provide additional behavioral health services locally, CMC rents space to a psychologist and a licensed professional clinical counselor that treat patients several days each month. Another a licensed professional clinical counselor/licensed addiction counselor opened a practice in Carrington in Fall of 2018.

The above implementation plan for CHI St. Alexius Health Carrington – Carrington Medical Center is posted on the CHI St. Alexius Health's website at https://www.chistalexiushealth.org/about-us/community-health-assessments.

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 a first step to identify needs and determine areas of priority. The second step will be to convene the steering committee, or other community group, to select an agreed upon prioritized need on which to begin working. The strategic planning process will begin with identifying current initiatives, programs, and resources already in place to address the identified community need(s). Additional steps include identifying what is needed and feasible to address (taking community resources into consideration) and what role and responsibility the hospital, clinic, and various community organizations play in developing strategies and implementing specific activities to address the community health need selected. Community engagement is essential for successfully developing a plan and executing the action steps for addressing one or more of the needs identified.

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

Community Benefit Report

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

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

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

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

What Are Community Benefits?

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

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

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

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

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

Appendix A – CHNA Survey Instrument

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

CHI St. Alexius Health
Imagine better health.℠
Carrington Medical Center

Public Health
Prevent. Promote. Protect.
Foster County Public Health

Carrington Area Survey

CHI St. Alexius Health, Carrington and Foster 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

Click here to take the survey online!

If you prefer, you may take the survey online at http://tinyurl.com/Carrington18 or by scanning 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 September 30, 2018. Your opinion matters – thank you in advance!

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

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

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

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

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

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

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

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

- ☐ Activities for families and youth
- ☐ Arts and cultural activities
- ☐ Recreational and sports activities
- ☐ Year-round access to fitness opportunities

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

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

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

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

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

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

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

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

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

_____

_____

Delivery of Healthcare

12. Considering each of the following health care services offered by Foster County Public Health (FCPH):
    a) Indicate whether you are aware that the health care service is offered through FCPH.
    b) Whether you have used the health care service at FCPH, at another public health unit, or both.

a) I am aware of services offered through FCPH.			**b) I have used services, either at FCPH or another facility. (check both if applicable)**	
Yes	No	**Type of service offered**	Used Services at FCPH	Used services at another Public Health Unit
		Alcohol prevention activities		
		Blood pressure check		
		Breastfeeding resources		
		Car seat program		
		Child health (well baby)		
		Diabetes screening		
		Emergency response & preparedness program		
		Environmental health services (water, sewer, health hazard abatement)		
		Family planning		
		Flu shots		
		Foot care		
		Health Tracks (child health screening)		
		Home visits		
		Immunizations		
		Medications setup—home visits		
		Office visits and consults		
		Preschool screening assistance		
		Public health care		
		School nursing services		
		Tobacco education, prevention and control		
		Tuberculosis testing and management		
		Wellness clinics		
		WIC (Women, Infants & Children) program		
		Youth education programs (First Aid, Bike Safety)		

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

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

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

_____

_____

15. Do you know you can choose to have labs and tests done at CHI St. Alexius Health Carrington and the results sent to your out of town specialist? This saves you time and extra trips out of town.

☐ Yes ☐ No

16. 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) _____

17. 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) _____

18. Are you aware of CHI St. Alexius Health Carrington's Foundation, which exists to financially support CHI St. Alexius Health Carrington?

☐ Yes ☐ No

19. What ways are you most likely to support facility improvements/new equipment at CHI St. Alexius Health Carrington? (check all that apply)

- ☐ Annual Hospital Gala
- ☐ Mail Appeal
- ☐ Online Giving
- ☐ Raffle
- ☐ Planned giving through wills, trusts or life insurance policies
- ☐ Gift of assets such as real estate
- ☐ Other (please specify) _____

20. Do you support a Tobacco Tax Increase in North Dakota, to be used to address preventative health in ALL substance use areas (opioids, alcohol, tobacco, etc.)?

☐ Yes ☐ No

Demographic Information: Please tell us about yourself.

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

☐ Yes ☐ No

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

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

23. 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

24. 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

25. Gender:

☐ Female ☐ Male ☐ Transgender

26. Employment status:

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

27. Your zip code: _____

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

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

29. Annual household income before taxes:

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

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

_____

_____

Thank you for assisting us with this important survey!

Appendix B – County Health Rankings Explained

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

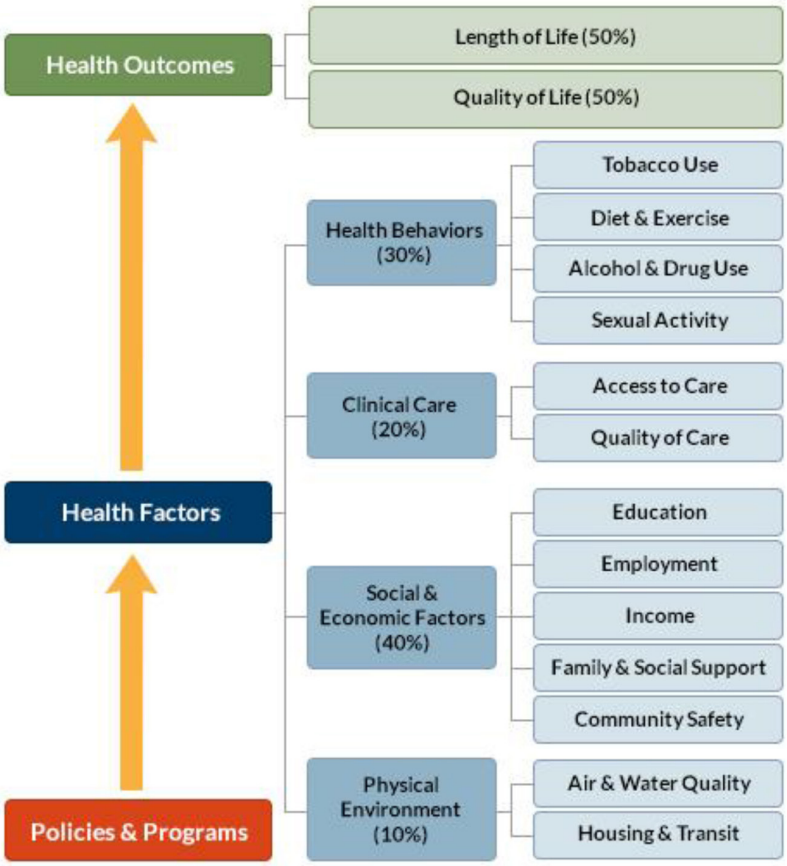
Methods

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

What is Ranked

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

Ranking System



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

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

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

Data Sources and Measures

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

Data Quality

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

Calculating Scores and Ranks

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

Health Outcomes and Factors

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

Health Outcomes

Premature Death (YPLL)

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

Reason for Ranking

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

Poor or Fair Health

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

Reason for Ranking

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

Poor Physical Health Days

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

Reason for Ranking

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

Poor Mental Health Days

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

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

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

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

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

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

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

Health Factors

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

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

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

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

Food Environment Index

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

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

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

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

Reason for Ranking

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

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

Physical Inactivity

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

Reason for Ranking

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

Access to Exercise Opportunities

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

Individuals who:

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

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

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

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

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

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

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

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

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

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

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

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

Uninsured

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

Reason for Ranking

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

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

Primary Care Physicians

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

Reason for Ranking

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

Dentists

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

Reason for Ranking

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

Mental Health Providers

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

Reason for Ranking

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Injury Deaths

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

Reason for Ranking

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

Air Pollution-Particulate matter

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

Reason for Ranking

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

Drinking Water Violations

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

Reason for Ranking

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

Severe Housing Problems

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

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

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

Reason for Ranking

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

Appendix C – Prioritization of Community's Health Needs

Community Health Needs Assessment
Carrington, North Dakota
Ranking of Concerns

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

	Priorities	Most Important
CONCERNS ABOUT COMMUNITY/ENVIRONMENTAL HEALTH CONCERNS		
Attracting & retaining young families	7	3
Having enough child daycare services		
Not enough affordable housing	3	2
Not enough jobs with livable wages	1	
Traffic safety		
AVAILABILITY/DELIVERY OF HEALTH SERVICES CONCERNS		
Ability to retain primary care providers (MD, DO, NP, PA)	9	6
Cost of health insurance	1	
Availability of mental health services		
Cost of healthcare services		
Availability of specialists	2	
YOUTH POPULATION HEALTH CONCERNS		
Alcohol use and abuse (combined with adult for second vote)	3	**0**
Drug use and abuse (including prescription drugs)		
Depression/anxiety	2	
Not getting enough exercise/physical activity		
Stress		
ADULT POPULATION HEALTH CONCERNS		
Alcohol use and abuse (combined with youth for second vote)	3	0
Drug use and abuse (including prescription drugs)	1	
Depression/anxiety	2	
Stress	1	
Not getting enough exercise/obesity and overweight		
SENIOR POPULATION HEALTH CONCERNS		
Cost of long-term/nursing home care	1	
Availability of resources to help elderly stay in their homes	4	2
Assisted living options		
Long-term/nursing home options		
Depression/anxiety		
Quality of elder care		
VIOLENCE CONCERNS		
Bullying/cyber-bullying (Youth)	1	
Child abuse/neglect	1	
Bullying/cyber-bullying (Adults)		
Emotional abuse (isolation, verbal threats, withholding of funds)		

Appendix D – Survey "Other" Responses

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

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

- None
- None of the above
- People look out for each other

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

- Fitness
- Nothing
- Agricultural

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

- Quality education for kids

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

- Hunting opportunities
- If you can afford it
- None
- Not a whole lot of activities
- Safe to walk

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:

- Alcohol and drugs are everywhere
- Alcoholism
- Doctors leaving
- Drugs
- Heath care doctors
- High real-estate taxes
- Junk found around homes
- Need affordable daycare
- Need more businesses
- No sidewalks for safe foot traffic ANYWHERE in town.
- Not enough culture and arts activities

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

- Communication of healthcare administrators with public.

- Doctors leaving
- Get rid of head of hospital to keep doctors
- Lack of competent caregivers on the ambulance
- Lack of MD's
- Need more doctors
- Need more than 1 family practice MD
- Not enough local MDs
- Only one doctor

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

- Bullying
- Learning about healthy relationships
- Most are geared towards sports. No culture and arts.
- Not wearing seatbelts
- Vaping

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

- Healthcare
- More than three major concerns....
- No "Public" exercise facility, not everyone can afford to pay

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

- Not enough housing for elderly with one level

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

- Ability to bring in new jobs that have middle class wages. Could use more of these jobs to attract young families.
- Ability to retain medical providers(MD,PA,NP)
- Access to good schools and medical care are paramount in any community. We have a medical facility, but my concern is that the administration is overworking the doctors and nurses that work there and not making an effort to recruit new employees or treat
- Activities for teens
- Affordable healthcare
- Affordable housing
- Alcohol use by youth and sanctioning of this behavior by parents. Many adults with kids do not know how to be parents. Plus potential of this leading to drug use.
- Attracting young families to fill our overbuilt school and other community facilities
- Bullying
- Cost of healthcare insurance
- Decline in doctors resulting in decline in patients coming to Carrington. Truly scared for our community.
- Depression and suicide
- Doctors leaving our hospital
- Don't know
- Drug use and abuse is the major cause of crime, child neglect, domestic situations.
- Drug use by adults, and not strict enough punishments. They end up back on our streets with little or no punishment.
- Drug/substance abuse
- Drugs
- Drugs and alcohol
- Equal opportunity

- Feeling unsafe due to increased talk about adult drug activity
- Getting and keeping young couples in our community!
- Getting doctors to come in and stay!
- Getting/keeping the younger population to stay/work/volunteer in rural areas
- Having a GOOD doctor on staff. One that LISTENS, CARES, and FOLLOWS THROUGH with health issues.
- High taxes
- Home maintenance for elderly who want to remain in their homes as long as they can.
- I feel like our community needs more activities for young kids to do.
- I feel our biggest challenge is getting a doctor to come to our community. Two doctors have left and haven't been replaced. I think people will go to a PA for minor issues, but prefer a doctor for major health concerns. Two things people look at when
- I'm not sure if it's the biggest challenge, but I have been hearing in the news the past 6 months or so about local drug busts in Carrington. This is alarming as a parent of elementary and middle school aged children.
- Keeping our clinic and hospital open. The majority of our community is not happy with the way our clinic and hospital are being run. Our head of operations is driving our physicians away and people from our community are trying to decide to go elsewhere
- Keeping people here and keeping our healthcare facility without any real doctors.
- Lack of MD
- Lack of a workforce that is willing to work for minimum wage
- Lack of daycare options.
- Lack of doctors
- Lack of family events/activities. Especially during times when family can all be together (evenings/weekends). Also cost of these.
- Lack of help or local healthcare. Doctors and nurses are leaving for various reasons. We need to keep our hospital open and available with sufficient help.
- Lose of long term MD with no replacement
- Many many job openings, not enough folks willing to fill these positions.
- Mental health professionals to work with youth.
- Meth
- Need more care facilities for the elderly, private rooms to honor their dignity.
- Not able to attract married people/ families from out of state.
- Not accepting of change
- Not being able to keep medical staff on board, and not being able to get new young medical professionals to come here. Not to mention everyone leaving the hospital/clinic in general. We are a thriving & prospering small town...What is going on up there? A
- Not enough Dr.s and fear of hospital closing
- Poor leadership at the hospital. Just because your were once a good nurse doesn't make you leader. They are totally different skill sets and the current leadership team doesn't have the skill sets to lead our hospital and clinic.
- Population decline and lack of workers in the community.
- Social Media
- Substance Use and Abuse
- The Drug use/trafficking in the community.
- The cost of all the local property taxes that us community members face!
- The rise in drug activity.
- Too many lazy people don't want to work, commit crimes, are shitty parents living in filth and we just give them more money to sit on their ass and pop out more kids just like them causing my hearth insurance to be as high as my fuckin house payment every

- Wages are poor. Can't make enough to pay bills. Have to work many jobs to make it.
- Aging population
- Alcohol use across all ages
- Alcoholism
- Drug use
- Funding and man power
- Getting or keeping good doctors
- Getting someone who can replace our hospital coordinator. She needs to go before we lose our hospital (this is urgent)
- Healthcare. having only one doctor
- High taxes for a school, not needed for kids we don't have
- Lack of things to do in the winter for kids
- My biggest concern is not being able to retain our doctors that we have as in the case of Dr. Geier, that should never have happened. It should never have been written in the paper from the hospital that he retired which he never did..
- The amount of drugs in and traveling through Carrington
- This is a very clicky community and since everyone is related it's really hard to be accepted unless you drink or do the bar scene.

Delivery of Healthcare

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

- Chamber of Commerce weekly email
- Chamber weekly email, website
- Community Event Email
- Email
- My PA
- Television
- Weekly email from Chamber

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

- A good physician.
- Another MD at the clinic
- Artery screening (a service similar to lifeline screening)
- Availability of mental health professionals who accept Medicaid in walking distance
- Birth Control
- Cancer treatments
- City owned EMS, not hospital based
- Dialysis for patients, cancer specialty providers
- Don't know
- Dr Rick Geier
- Exercise and strength training for later life and elderly
- Getting more doctors.
- I think people should be able to go in FPH and get a blood pressure checked FREE of charge. It is crazy they charge
- I think they are covered

- It would be nice to have an internal medicine specialist or geriatric specialist,
- Mental health
- Mental healthcare.
- Mental health, local lactation specialist
- More MD's and specialists
- More MD's less PA's
- More MDs
- More mental health
- Natural medicine options
- Pulmonologist
- Pediatrics
- Support group services
- Unsure
- We need Doctors, not just PAs. Big mistake running Dr. Geier out!
- We need more doctors! Get rid of CHI, they have ruined our clinic and hospital.
- We need to have 2 doctors or more. We just lost our second doctor and he should be replaced.
- Would like more medical doctors on staff. Mid levels are good, but can not replace medical doctors.
- Dermatology
- Getting more doctors and less pa
- Homeopathic care for a non-medicinal approach
- More variety of surgeons
- None come to mind
- Podiatrist
- Vaccinations at during well baby exams with in Carrington Health Clinic

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

- CHI getting rid of long term employees.
- Doctors leaving
- Health center billing systems
- Loss of medical doctor
- My doctor retired and don't like the only other doctor's bedside manner
- Need more MDs
- Not enough Natural Holistic Medicine approaches
- Not enough Natural/Homeopathic Doctors
- Poor billing at CHC
- Why did they let Dr. Geier go? We needed him here at Carrington

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

- Pharmacist

18. What ways are you most likely to support facility improvements/new equipment at CHI St. Alexius Health Carrington? "Other" responses:

- Auxiliary fundraisers
- Auxiliary membership and actively working to support the facility
- Do not support
- Don't know
- Fundraisers
- I can't even afford to go to the doctor even with insurance especially for a 3 minute appointment

- I pay my bills. Chi is for profit. Why do I have to give u more!
- None
- None
- Not sure
- Paying my bill
- Public exercise facility at CHI
- There needs to be changes in Administration starting at the top

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

- Concerned about having only one MD.
- Concerned of only 1 MD at CMC
- Don't let Nurse Practitioners act like doctors!
- Don't trust upper (top) management at CMC.
- Early morning or evening appointments for students for both PT and clinic.
- Figure out why everyone is leaving the clinic/hospital. Bring new people in, get & keep new doctors, and quit driving people away. Our Carrington Hospital has never been like this. Figure out the problem, address it, and move forward. I think all the physicians up there do a great job, but what are we doing to keep them? Next doc/PA to leave will kill the hospital.
- Fire the CHI Market President
- Get the Market President out. We shouldn't have lost Dr Geier.
- Get rid of the head of hospital
- Get rid of the CHI Market President and CHI. Together they have ruined our hospital and clinic by terminating senior staff. Especially doctors.
- Get some good doctors, since my doctor retired there is only one real doctor and I don't like his bedside manner and the rest are all PA's. 1 PA I have seen and he was very short so don't want to see him again, another I have known since she was little and that is just weird and I know nothing about the other PA's but they aren't actually doctors.
- Have a doctor or PA on duty at hospital 24/7. Several years ago my husband almost died because only nurses were there at 11pm and they couldn't treat him without calling a doctor for permission to treat anaphylactic shock. The nurse kept calling and calling to get someone on the phone... at least 15/20 minutes. My husband's eyes were swollen shut, throat was closing off, could hardly breathe, swollen welts/rash all over his body. I was watching him die! Why couldn't that nurse medicate him?!! Even I, as a teacher, had permission to administer an epi-pin in case of an emergency. Is it still that way in the emergency room here in Carrington? Another time a nurse refused to help me to surgery because of a personal issue/dislike involving one of my relatives. The nurse with her looked surprised and took over for her. Isn't there some way in the hiring process to eliminate someone with such a mental problem? She no longer works at the hospital, so perhaps the administration discovered her unprofessional
- I believe Carrington Health Center does a great job of identifying and delivering healthcare within its means.
- I believe this community offers a wide variety of healthcare.
- I can't believe Dr. Geier is not working at Carrington!!
- I feel that over the last few years, the quality of care, customer service and leadership has declined at CHI. We used to travel 30 miles to doctor in Carrington, but have been treated poorly and have not received quality care that we now drive to Fargo or Bismarck for healthcare.
- I think the ambulance should be taken over by the city or county in time having it owned by the hospital is going to become detrimental to the service and ultimately end in closure of the service. Also hospital running the service hinders the ability of the ems staff to do there job properly
- I wish we had another MD in our clinic/hospital. Also, the lack of having a MD(as opposed to a PA or NP) on for emergencies and weekend clinic.
- I would like to see an md that will stay until I don't need one any longer.
- Lack of MDs.

- Local providers are healthcare drivers in our community. Do all we can to retain existing providers and continue to recruit new ones even if no shortage. It will always draw new patients and help whole community with increased level of care and business climate in Carrington and surrounding towns.
- CHI Market President needs to be replaced. She not doing her job for our community. One of the reasons I will be taking my health needs to Harvey. Dr Geier.
- More Medical Doctors and better management at hospital and clinic
- More local MDs
- More newspaper correspondence, many patients say, " I read it in the paper!" I think it should be stated in plain English that tests from other doctors (most people don't know what provider means, I always have to explain) can be done here, they don't have to go to the doctor they normally see for him to get the results.
- My biggest concern for healthcare is the way the market president is running the hospital and the ambulance. She has forced out our oldest and one of the finest doctors, Dr. Rick Geier and a lot of times the ambulance doesn't have any drivers.
- N/A
- Open minded medical doctors, stricter policies on patient confidentiality, doctors who specialize in their fields and aren't just guessing.
- Primary Care Hours after 5 and Saturdays and Sundays
- Quit giving state prisons free healthcare. give free healthcare to honorable, hard working residents
- Recruit and retain medical doctors.
- Stop chasing away the good doctors we have had and leaving us with only 1
- Too much gossiping, lack of trust, waiting long for appointments
- The community takes local healthcare for granted. Not supporting is a risk the community takes when they don't use it.
- Treat employees better. We have a great facility but the quality of caregivers is always going to be the biggest asset.
- Treat your employees better, they are your key to prosperity
- Try keeping our doctors here instead of going elsewhere
- We don't have enough doctors.
- We have had multiple doctors misdiagnose our children at the Carrington clinic so we go to Sanford in Jamestown now.
- We need MORE doctors---PA's are good to have but people want to see a physician. You have people driving our of town so see a MD instead of always having to see a PA
- We need change in administration starting from the top. We need more top quality doctors to come her and stay here. you will be lucky to keep doctor Page if things don't change. You had Dr. Geier, Dr. Muscha, Dr. Covongton in the past--all great doctors who stayed her for years until things with administration started changing and they got tired of it and now we only have 1 doctor--something is wrong with this picture
- We need to continue to promote our clinic and hospital in order to keep it financially stable.
- We need to recruit and retain doctors and retain the professionals that already serve our community.
- We should have another primary care doctor. Just because 1 is too little
- Word on the Street says Administration has caused 2 Medical Drs. to leave the facility. Both Drs were very respected and had a good patient following. A former resident went through medical school wanted to work in the community. Administration was rude and he chose to go to Jamestown. Community lost out big time
- Get and keep more doctors. Letting Dr Gier go was bad for hospital an community
- Get more FULL time DOCTORS in the clinic
- More dr's and nurses
- Our entire hospital needs an overhaul.. I work for a business and since CHI got rid of Dr Gier we have lost customers who simply don't come back because they now go to Harvey to see him. you need to get something fixed fast, all the management of CHI need to go, the Dr's, PA's, nurse practitioners, nurses are excellent. The management is the problem.. CHI you should be ashamed of what you have done to this area.