Community Health Needs Assessment

Ashley Medical Center Service Area

Ashley, North Dakota

2022

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Executive Summary

To help inform future decisions and strategic planning, Ashley Medical Center (AMC) conducted a Community Health Needs Assessment (CHNA) in 2021, the previous CHNA having been conducted in 2019. The Center for Rural Health (CRH) at the University of North Dakota (UND) School of Medicine & Health Sciences (SMHS) facilitated the assessment process, which solicited input from area community members and healthcare professionals as well as analysis of community health-related data.

To gather feedback from the community, residents of the area were given the opportunity to participate in a survey. Thirty-nine AMC service area residents completed the survey. Additional information was collected through six key informant interviews with community members. The input from the residents, who primarily reside in McIntosh County, represented the broad interests of the communities in the service area. Together with secondary data, gathered from a wide range of sources, the survey presents a snapshot of the health needs and concerns in the community.

With regard to demographics, McIntosh County's population from 2010 to 2019 decreased by 10%. The average number of residents younger than age 18 (18.5%) for McIntosh County comes in 5.1 percentage points lower than the North Dakota average (23.6%). The percentage of residents, ages 65 and older, is almost 17% higher for McIntosh County (32.2%) than the North Dakota average (15.7%), and the rate of education is lower for McIntosh County (83.6%) than the North Dakota average (93.1%). The median household income in McIntosh County ($52,587) is much lower than the state average for North Dakota ($64,894).

Data, compiled by County Health Rankings, show McIntosh County is doing better than North Dakota in health outcomes/factors for 10 categories while performing poorly, relative to the rest of the state in 17 outcome/factor categories.

Of 106 potential community and health needs set forth in the survey, the 39 Ashley Medical Center service area residents who completed the survey indicated the following 10 needs as the most important:

- Having enough child daycare services
- Not enough jobs with livable wages
- Attracting and retaining young families
- Availability of resources to help the elderly stay in their homes
- Depression/anxiety – youth and adult
- Alcohol use and abuse – youth and adult
- Assisted living options
- Availability of home health
- Drug use and abuse
- Not enough activities for children and youth

The survey also revealed the biggest barriers to receiving healthcare (as perceived by community members). They included not able to get appointment/limited hours (N=10), not enough evening/weekend hours (N=9), and concerns about confidentiality (N=9).

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

- People are friendly, helpful, and supportive
- Active faith community
- Healthcare
- Safe place to live
- Local events and festivals
- Family-friendly

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

- Having enough child daycare services
- Stress – adults
- Availability of mental health services
- Assisted living options
- Smoking and tobacco use, exposure to second-hand smoke, or vaping/juuling - youth

Overview and Community Resources

With assistance from the Center for Rural Health (CRH) at the University of North Dakota (UND) School of Medicine & Health Sciences (SMHS), the Ashley Medical Center (AMC) completed a Community Health Needs Assessment (CHNA) of the AMC service area. The hospital identifies its service area as McIntosh County. Many community members and stakeholders worked together on the assessment.

AMC is located in southcentral North Dakota, approximately 120 miles southeast of Bismarck and six miles north of the South Dakota border. Along with the hospital, the courthouse, school, and agriculture provide the economic base for the town of Ashley and McIntosh County. According to the 2010 U.S. Census, McIntosh County had a population of 2,809, while Ashley, the county seat, had a population of 689.

AMC has a number of community assets and resources that can be mobilized to address population health improvement. The community also has a number of physical assets and features, including a fitness trail, swimming pool, city park, tennis courts, golf course, and fitness center. Lake Hoskins Park and Dry Lake offer recreation, fishing, and camping opportunities. McIntosh County offers prime hunting opportunities. Ashley offers cultural attractions with the Heritage Center, which pays tribute to the early history of the area.

Each major town in McIntosh County has a fitness center. Public transportation is provided by South Central Services. Progressive downtown Ashley businesses provide necessary services and retail goods and are valued assets of the community. The Ashley Public School system offers a comprehensive program for students in pre-K through grade 12.

Other healthcare facilities and services in the area include AMC Clinic in Zeeland and Ashley, pharmacy, optometrist, chiropractor, massage therapy, and Women, Infants, and Children (the WIC Program is based at AMC). Wishek Hospital Clinic Association also provides healthcare services to the county with a 24-bed Critical Access Hospital (CAH) and clinic, located in Wishek. The Wishek Living Center has a 60-bed nursing home and operates the Prairie Hills Assisted Living with 19 assisted living units, serving residents of McIntosh County.

Ashley has a volunteer ambulance service that provides advanced life support services with paramedics who are also employed by AMC. The Ashley Ambulance Service provides emergency services throughout the county and are the primary responders and emergency responder educators for the Acciona Wind Farm, 24 miles southeast of Ashley.

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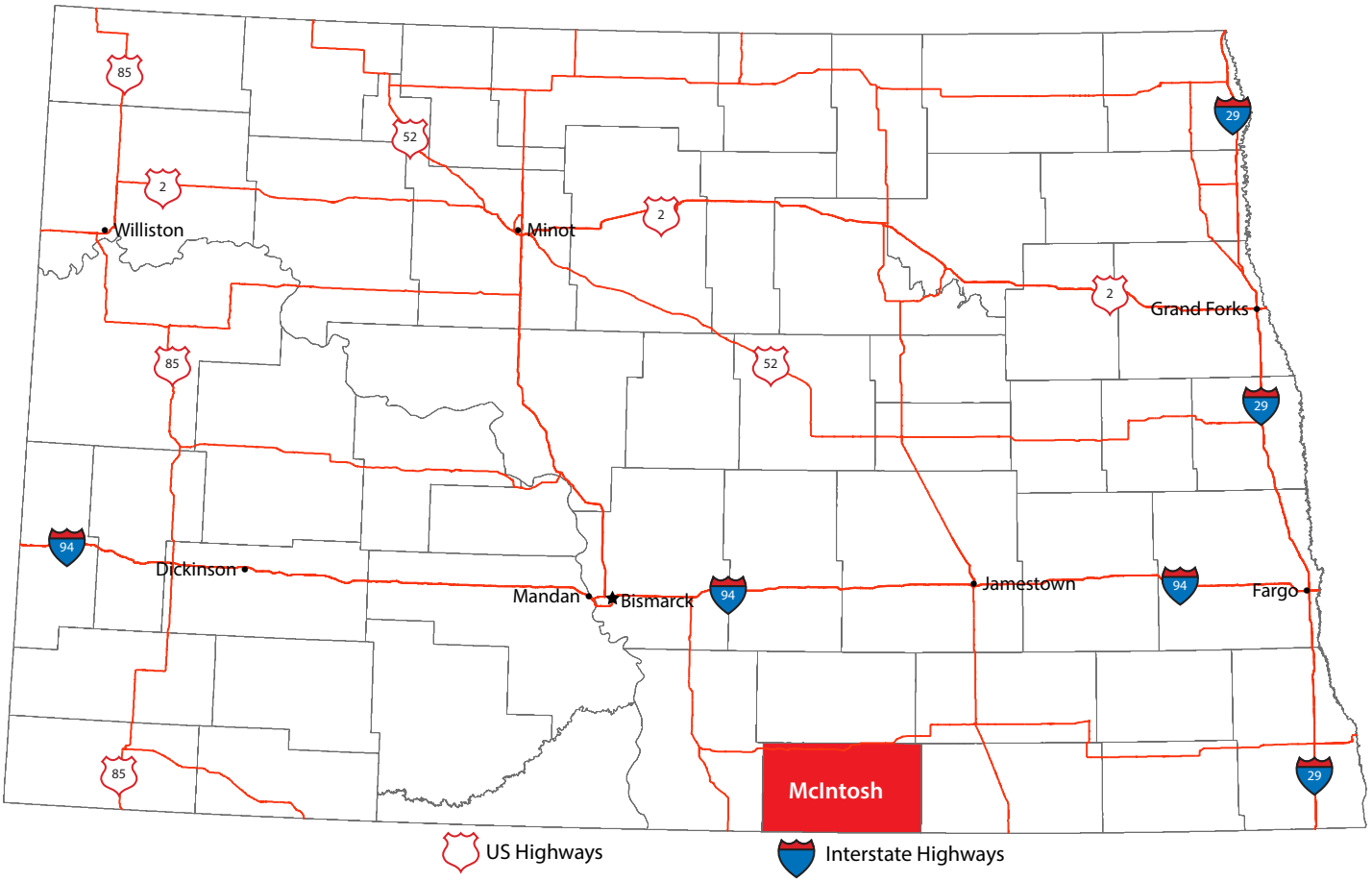
Figure 1: McIntosh County, North Dakota



Ashley Medical Center (AMC)

Ashley Medical Center (AMC) opened its door in 1952. Today, AMC has grown into a fully integrated healthcare system with a 20-bed CAH along with swing beds and a level V trauma emergency room. Our skilled nursing home has 30 beds. AMC operates two Rural Health Clinics (RHCs) and provides low income housing with a 25-unit Harmony Home Apartment Complex and an eight-unit apartment area within the main facility.

AMC provides acute care services, including inpatient, outpatient, swing bed, and 24/7 emergency room care, as well as staffs AMC Ashley Clinic and AMC Zeeland Clinic. A 30-bed attached skilled nursing home is also part of AMC and serviced by the provider staff. AMC manages a professional building with a chiropractor and an ophthalmologist practice. In addition, they provide surgical consultations and outpatient surgery, provided by a general surgeon. Monthly clinic hours are also available with a general practice physician at the AMC Clinic. AMC is a healthcare organization with a mission to provide preventative, curative, supportive, and educational healthcare that meets the physical, emotional, and spiritual needs of the people we serve. AMC serves as a "hub" for community-based health services, integrating different levels of care and services through one organizational structure. They are essential to their patients, not only for acute and emergency care services but also as the link for primary care, nursing home services, elder care services, and living structures. AMC extends beyond the standard definition of a hospital.

AMC's long-term goal is to provide patients with the best quality of care, regardless of geographic barriers. They have the motivation to overcome the challenges of rural healthcare and provide patients with care that is equal to or better than they would receive in an urban facility.

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AMC Recent Recognition and Awards

In July of 2017, AMC was recognized for their exemplary commitment to their employee safety and health under the OSHA Safety and Health Achievement Recognition Program (SHARP). They were nominated for this award through the North Dakota Consultation Program at Bismarck State College. Through their fire and safety committee, AMC demonstrated their commitment to employee safety and health by establishing and maintaining an effective safety and health management system.

AMC is Stroke Ready and a Level V trauma-certified facility.

IVantage also recognized AMC in April of 2015 when they were named a 2015 Top 100 CAH, achieving top performance among their peers and earning national recognition. The news release for this award stated that AMC scored in the top 100 of CAHs on the IVantage Hospital Strength INDEX. The INDEX is the industry's most comprehensive rating of U.S. acute care hospitals and the only one to include the country's 1300 CAHs. The results recognize that the top 100 CAHs provide a safety net to communities across rural America, measuring them across 62 different performance metrics, including quality, outcomes, patient perspective, affordability, population risk, and efficiency.

In May of 2015, AMC was designated by the National Rural Health Association (NRHA) as a Top 20 Best Practice in Patient Satisfaction among all CAHs in the U.S. They received the award at the NRHA Conference in Kansas City, Missouri, on October 2, 2015.

The CAH Profile for AMC that includes a summary of hospital-specific information is available in Appendix A.

Services offered locally by AMC include:

General and Acute Services

- Acne treatment
- Allergy, flu, and pneumonia shots
- Blood pressure checks
- Botox
- Clinic
- Emergency Room (immediate access to Level I Trauma physicians)
- Facial fillers
- Full skin exams
- Hospital (acute care)
- Independent senior housing
- Joint injections
- Mole, wart, and skin lesion removal
- Ophthalmology evaluation and surgical services (visiting physician)
- Pharmacy
- Physicals – annual, DOT, sports, and insurance
- Prenatal care up to 32 weeks
- Sports medicine
- Surgical services – biopsies, outpatient
- Surgical services – visiting physician
- Swing bed services
- Weight loss/weight management program

Screening/Therapy Service

- Chronic disease management
- Holter monitoring
- Laboratory services
- Lower extremity circulatory assessment
- Medical nutrition therapy (dietary consults)
- Occupational physicals
- Pediatric services
- Physical therapy
- Psychiatric services
- Social services

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Radiology Services

- CT scans
- DEXA Scan (bone density, mobile unit)
- Digital mammography
- Echocardiograms (mobile unit)
- EKG
- General X-ray
- MRI (mobile unit)
- Ultrasound (mobile unit)

Laboratory Services

- Blood types
- Chemistry
- Clot times
- COVID-19 antibody testing
- Emergency blood transfusions only (no longer blood bank)
- Hematology
- Rapid cardiac diagnostics
- Rapid COVID-19 testing
- Urine testing

Services Offered by Other Providers/Organizations

- Ambulance
- Chiropractic services
- Hospice/palliative (Hospice of the Red River Valley)
- Massage therapy
- Nursing training program
- Optometric/vision services (visiting physician)
- Telehealth service

McIntosch District Health Unit

McIntosh District Health Unit provides public health services that include environmental health, nursing services, health screenings, and educational services. The health unit works primarily with ages 0-18 and patients aged 55 and older. Each of these programs provides a wide variety of services in order to accomplish the mission of public health, which is to assure that North Dakota is a healthy place to live, and each person has an equal opportunity to enjoy good health.

Specific services McIntosh District Health Unit provide are:

- Bicycle helmet safety
- Blood pressure check
- Breastfeeding resources
- Car seat program
- Child health (well-baby)
- Covid-19 testing (rapid and PCR)
- Covid-19 vaccinations
- Emergency response and preparedness program
- Flu shots
- Foot care
- Environmental health services (water, sewer, health hazard abatement)
- Health Tracks (child health screening)
- Immunizations
- Medications setup – home visits
- Office visits and consults
- School health (vision screening, puberty talks, school immunizations)
- Preschool education programs
- Assist with preschool screening
- Tobacco prevention and control
- Tuberculosis testing and management
- Wellness check with law enforcement
- Youth education programs (First Aid, Bike Safety)

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Assessment Process

The purpose of conducting a Community Health Needs Assessment (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 McIntosh County. In addition to Ashley, located in the county are the communities of Lehr, Venturia, Wishek, and Zeeland.

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

Figure 2: Steering Committee

Lucy Meidinger	CHNA coordinator/ QA coordinator, AMC
Corey Ulmer	Administrative assistant, AMC
Sherrece Golz	McIntosh District Health Unit
Jerry Lepp	CFO, AMC
Eric Heupel	CEO, AMC

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

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

- A survey solicited feedback from area residents

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- Community leaders representing the broad interests of the community took part in one-on-one key informant interviews
- The community group, comprised of community leaders and area residents, was convened to discuss area health needs and inform the assessment process
- 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

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

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 13 community members, was convened and first met on November 22, 2021. During this first community group meeting, group members were introduced to the needs assessment process, reviewed basic demographic information about the community, and served as a focus group. Focus group topics included community assets and challenges, the general health needs of the community, community concerns, and suggestions for improving the community's health.

The community group met again on February 2, 2022, with 10 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 McIntosh County. The group was then tasked with identifying and prioritizing the community's health needs.

Members of the community group represented the broad interests of the community served by AMC and McIntosh District Health Unit. They included representatives of the health community, business community, political bodies, law enforcement, education, faith community, EMS, agriculture, elderly, and young families. Not all members of the group were present at both meetings.

Interviews

One-on-one interviews with six key informants were conducted by Zoom or phone the week of November 22, 2021. A representative from CRH conducted the interviews. Interviews were held with selected members of the community who could provide insights into the community's health needs. Included among the informants were public health professionals with special knowledge in public health, acquired through several years of direct experience in the community, including working with medically underserved, low income, and minority populations as well as with populations with chronic diseases.

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

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Survey

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

The community member survey was distributed to various residents of McIntosh County, as this inquiry includes the AMC service area. The survey tool was designed to:

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

Specifically, the survey covered the following topics:

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

To promote awareness of the assessment process, an informative ad was placed in the Ashley Tribune throughout the survey processes as well as the AMC Facebook Page and website. Paper surveys were distributed at local business and hospital and clinics. CHNA posters and business cards with the survey information were also taken to local businesses. AMC staff were reminded to participate in the survey process with posters and at staff meetings.

Approximately 75 community member surveys were available for distribution in McIntosh County. The surveys were distributed in several locations in the community, including the café, banks, grocery store, city office, public health, clinics, AMC lobby, and C-store. Decorative drop boxes were placed with an informative overview of the survey, and a business card with the online survey link and QR code were available at the business sites.

To help ensure anonymity, included with each survey was a postage-paid return envelope to CRH. The survey period ran from November 22, 2021 to December 16, 2021. Thirty-nine surveys were completed. The majority of surveys were completed online.

Area residents also were given the option of completing an online and QR code application version of the survey, which was publicized in the same manner as the paper survey.

Thirty-nine online surveys were completed. None of those online respondents used the QR code to complete the survey. In total, counting both paper and online surveys, the 39 community member surveys were completed, equating to a 7.1% response rate. This response rate is below average for this type of unsolicited survey methodology, but with the COVID-19 pandemic, survey responses have been lower.

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

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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.

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

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

Figure 3: Social Determinants of Health

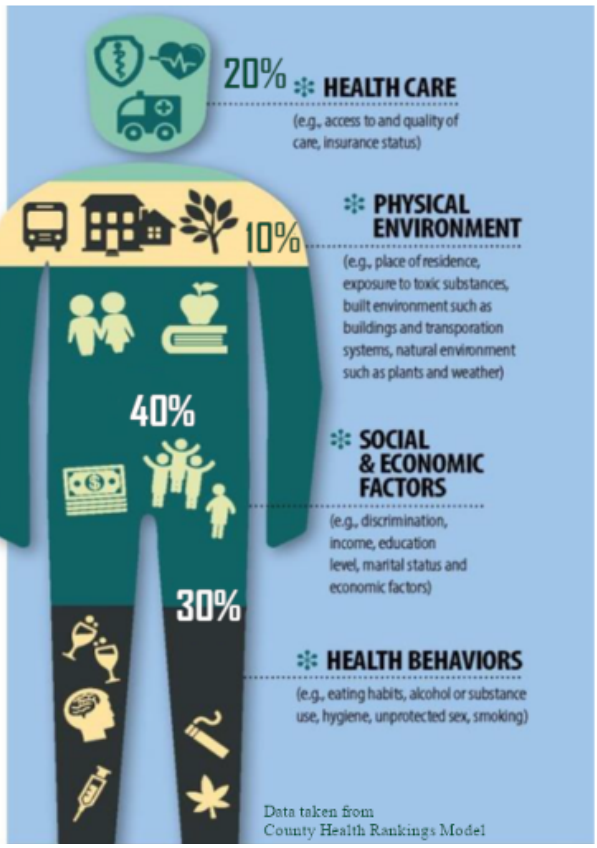

Figure 4 (Henry J. Kaiser Family Foundation, https://www.kff.org/disparities-policy/issue-brief/beyond-health-care-the-role-of-social-determinants-in-promoting-health-and-health-equity/), provides examples of factors that are included in each of the social determinants of health categories that lead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

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

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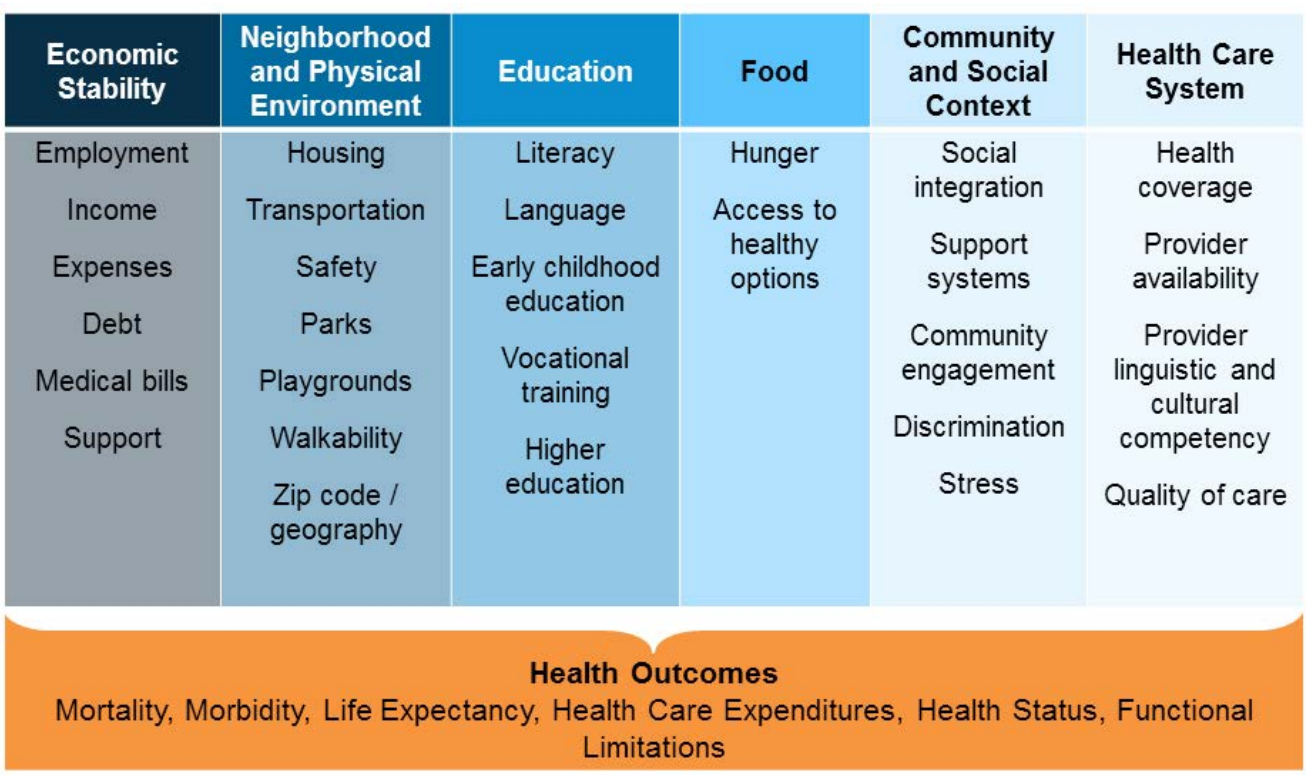
Figure 4: Social Determinants of Health



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Demographic Information

Table 1 summarizes general demographic and geographic data about McIntosh Counties.

	McIntosh County	North Dakota
Population (2020)	2,530	779,094
Population change (2010-2019)	-11.2%	13.3%
People per square mile (2010)	2.9	9.7
Persons aged 65 or older (2019)	32.2%	15.7%
Persons younger than age 18 (2019)	18.5%	23.6%
Median age (2020 est.)	53.9	35.2
White persons (2020)	96.6%	86.9%
High school graduates (2020)	83.6%	93.1%
Bachelor's degree or higher (2020)	14.9%	30.7%
Live below poverty line (2020)	12.2%	10.2%
Persons without health insurance, younger than age 65 years (2020)	10.2%	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, McIntosh County have seen a decrease in population since 2010. The U.S. Census Bureau estimates show that McIntosh County population decreased from 2,809 (2010) to 2,530 (2020).

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

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

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

Health Outcomes

- Length of life
- Quality of life

Health Factors

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

Health Factors (continued)

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

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

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

McIntosh County rankings within the state are included in the summary following. For example, McIntosh County ranks 39th out of 46 ranked counties in North Dakota on health outcomes and 43rd out of 45 on health factors. The measures, marked with a bullet point (•), are those where a county is not measuring up to the state rate/percentage; a square (■) indicates that the county is not meeting the U.S. Top 10% rate on that measure. Measures that are not marked with a colored shape but are marked with a plus sign (+) indicate that the county is doing better than the U.S. Top 10%.

The data from County Health Rankings show that McIntosh County is doing poorer than many counties, compared to the rest of the state on all of the outcomes, landing at or below rates for other North Dakota counties. However, like many North Dakota counties, they are doing better in many areas when it comes to the U.S. Top 10% ratings.

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

- Adult obesity
- Food environment index
- Alcohol impaired driving deaths
- Primary care physicians
- Children in single-parent households
- Social associations
- Violent crime
- Air pollution (particulate matter)
- Severe housing problems

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

- Poor or fair health
- Poor physical health days
- Poor mental health days
- Low birth weight
- Adult smoking
- Physical inactivity
- Access to exercise opportunities
- Uninsured
- Dentists
- Preventable hospital stays
- Mammography screening
- Flu vaccinations
- Unemployment
- Children in poverty
- Income inequality
- Injury deaths

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

● = Not meeting North Dakota average

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

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

Blank values reflect unreliable or missing data

TABLE 2: SELECTED MEASURES FROM *COUNTY HEALTH RANKINGS* 2021 – MCINTOSH COUNTY			
	McIntosh County	**U.S. Top 10%**	**North Dakota**
Ranking: Outcomes	**39th**		**(of 46)**
Premature death		5,400	6,600
Poor or fair health	17% ●■	14%	14%
Poor physical health days (in past 30 days)	3.6 ●■	3.4	3.2
Poor mental health days (in past 30 days)	3.9 ●■	3.8	3.8
Low birth weight	8% ●■	6%	6%
Ranking: Factors	**43rd**		**(of 45)**
Health Behaviors			
Adult smoking	22% ●■	16%	20%
Adult obesity	26% +	26%	34%
Food environment index (10=best)	9.1 +	8.7	8.9
Physical inactivity	31% ●■	19%	23%
Access to exercise opportunities	73% ●■	91%	74%
Excessive drinking	22% ■	15%	24%
Alcohol-impaired driving deaths	0% +	11%	42%
Sexually transmitted infections		161.2	466.6
Teen birth rate		12	20
Clinical Care			
Uninsured	13% ●■	6%	8%
Primary care physicians	1,290:1 ■	1,030:1	1,300:1
Dentists	2,500:1 ●■	1,210:1	1,510:1
Mental health providers		270:1	510:1
Preventable hospital stays	6,757 ●■	2,565	4,037
Mammography screening (% of Medicare enrollees ages 65-74 receiving screening)	38% ●■	51%	53%
Flu vaccinations (% of fee-for-service Medicare enrollees receiving vaccination)	18% ●■	55%	50%
Social and Economic Factors			
Unemployment	3.0% ●■	2.6%	2.4%
Children in poverty	16% ●■	10%	11%
Income inequality	4.7 ●■	3.7	4.4
Children in single-parent households	14% +	14%	20%
Social associations	23.2 +	18.2	16.0
Violent crime	74 ■	63	258
Injury deaths	153 ●■	59	71
Physical Environment			
Air pollution – particulate matter	4.7 +	5.2	4.7
Drinking water violations	No		
Severe housing problems	10% ■	9%	12%

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

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Children's Health

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

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

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

Health Status	North Dakota	National
Children born premature (3 or more weeks early)	9.6%	11.2%
Children 10-17 overweight or obese	24.8%	31.4%
Children 0-5 who were ever breastfed	84.6%	80.6%
Children 6-17 who missed 11 or more days of school	3.9%	4.5%
Healthcare		
Children currently insured	18.4%	93.4%
Children who had preventive medical visit in past year	75.4%	19.0%
Children who had preventive dental visit in past year	12.0%	79.6%
Young children (10 mos.-5 yrs.) receiving standardized screening for developmental or behavioral problems	1.2%	10.4%
Children aged 2-17 with problems requiring counseling who received needed mental healthcare	32.6%	2.3%
Family Life		
Children whose families eat meals together 4 or more times per week	75.5%	73.6%
Children who live in households where someone smokes	15.3%	14.4%
Neighborhood		
Children who live in neighborhood with a park, sidewalks, a library, and a community center	81.1%	75.4%
Children living in neighborhoods with poorly kept or rundown housing	9.1%	13.3%
Children living in neighborhood that's usually or always safe	97.4%	95.0%

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

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

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

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

The data show McIntosh County is performing more poorly than the North Dakota average on two of the examined measures. The most marked difference was on the measure of licensed childcare capacity (almost 20% lower rate in McIntosh County).

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

	McIntosh County	North Dakota
Child food insecurity, 2019	**10.6%**	9.6%
Medicaid recipient (% of population age 0-20), 2019	**37.6%**	26.6%
Children enrolled in Healthy Steps (CHIP) (% of population age 0-18), 2020	1.5%	1.6%
Supplemental Nutrition Assistance Program (SNAP) recipients (% of population age 0-18), 2020	15.8%	16.9%
Licensed childcare capacity (# of children), 2020	110	36,701
4-year high school cohort graduation rate, 2019/2020	>= 80%	89.0%
Victims of child abuse and neglect requiring services (rate per 1,000 children ages 0-17), 2019	NA	9.98

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

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

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

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

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TABLE 5: Youth Behavioral Risk Survey Results

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

	ND 2015	ND 2017	ND 2019	ND Trend ↑, ↓, =	Rural ND Town Average	Urban ND Town Average	National Average 2019
Injury and Violence							
% of students who rarely or never wore a seat belt (when riding in a car driven by someone else)	8.5	8.1	5.9	=	8.8	5.4	6.5
% of students who rode in a vehicle with a driver who had been drinking alcohol (one or more times during the 30 prior to the survey)	17.7	16.5	14.2	=	17.7	12.7	16.7
% of students who talked on a cell phone while driving (on at least one day during the 30 days before the survey)	NA	56.2	59.6	=	60.7	60.7	NA
% of students who texted or e-mailed while driving a car or other vehicle (on at least one day during the 30 days before the survey)	57.6	52.6	53.0	=	56.5	51.8	39.0
% of students who were in a physical fight on school property (one or more times during the 12 months before the survey)	5.4	7.2	7.1	=	7.4	6.4	8.0
% of students who experienced sexual violence (being forced by anyone to do sexual things [counting such things as kissing, touching, or being physically forced to have sexual intercourse] that they did not want to, one or more times during the 12 months before the survey)	NA	8.7	9.2	=	7.1	8.0	10.8
% of students who were bullied on school property (during the 12 months before the survey)	24.0	24.3	19.9	↓	24.6	19.1	19.5
% of students who were electronically bullied (includes texting, Instagram, Facebook, or other social media ever during the 12 months before the survey)	15.9	18.8	14.7	↓	16.0	15.3	15.7
% of students who made a plan about how they would attempt suicide (during the 12 months before the survey)	13.5	14.5	15.3	=	16.3	16.0	15.7
Tobacco, Alcohol, and Other Drug Use							
% of students who currently use an electronic vapor product (e-cigarettes, vape e-cigars, e-pipes, vape pipes, vaping pens, e-hookahs, and hookah pens at least one day during the 30 days before the survey)	22.3	20.6	33.1	↑	32.2	31.9	32.7
% of students who currently used cigarettes, cigars, or smokeless tobacco (on at least one day during the 30 days before the survey)	NA	18.1	12.2	**NA**	15.1	10.9	10.5
% of students who currently were binge drinking (four or more drinks for female students, five or more for male students within a couple of hours on at least one day during the 30 days before the survey)	NA	16.4	15.6	=	17.2	14.0	13.7
% of students who currently used marijuana (one or more times during the 30 days before the survey)	15.2	15.5	12.5	=	11.4	14.1	21.7
% of students who ever took prescription pain medicine without a doctor's prescription or differently than how a doctor told them to use it (counting drugs such as codeine, Vicodin, OxyContin, Hydrocodone, and Percocet, one or more times during their life)	NA	14.4	14.5	=	12.8	13.3	14.3
Weight Management, Dietary Behaviors, and Physical Activity							
% of students who were overweight (>= 85th percentile but <95th percentile for body mass index)	14.7	16.1	16.5	=	16.6	15.6	16.1
% of students who had obesity (>= 95th percentile for body mass index)	13.9	14.9	14.0	=	17.4	14.0	15.5
% of students who did not eat fruit or drink 100% fruit juices (during the seven days before the survey)	3.9	4.9	6.1	=	5.8	5.3	6.3
% of students who did not eat vegetables (green salad, potatoes [excluding French fries, fried potatoes, or potato chips], carrots, or other vegetables, during the seven days before the survey)	4.7	5.1	6.6	=	5.3	6.6	7.9

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% of students who drank a can, bottle, or glass of soda or pop one or more times per day (not including diet soda or diet pop, during the seven days before the survey)	18.7	16.3	15.9	=	17.4	15.1	15.1
% of students who did not drink milk (during the seven days before the survey)	13.9	14.9	20.5	↑	14.8	20.3	30.6
% of students who did not eat breakfast (during the seven days before the survey)	11.9	13.5	14.4	=	13.3	14.1	16.seven
% of students who most of the time or always went hungry because there was not enough food in their home (during the 30 days before the survey)	NA	2.seven	2.8	=	2.1	2.9	NA
% of students who were physically active at least 60 minutes per day on 5 or more days (doing any kind of physical activity that increased their heart rate and made them breathe hard some of the time during the seven days before the survey)	NA	51.5	49.0	=	55.0	22.6	55.9
% of students who watched television 3 or more hours per day (on an average school day)	18.9	18.8	18.8	=	18.3	18.2	19.8
% of students who played video or computer games or used a computer three or more hours per day (for something that was not schoolwork on an average school day)	38.6	43.9	45.3	=	48.3	45.9	46.1
Other							
% of students who ever had sexual intercourse	38.9	36.6	38.3	=	35.4	36.1	38.4
% of students who had eight or more hours of sleep (on an average school night)	NA	31.8	29.5	=	31.8	33.1	NA
% of students who brushed their teeth on seven days (during the seven days before the survey)	NA	69.1	66.8	=	63.0	68.2	NA

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

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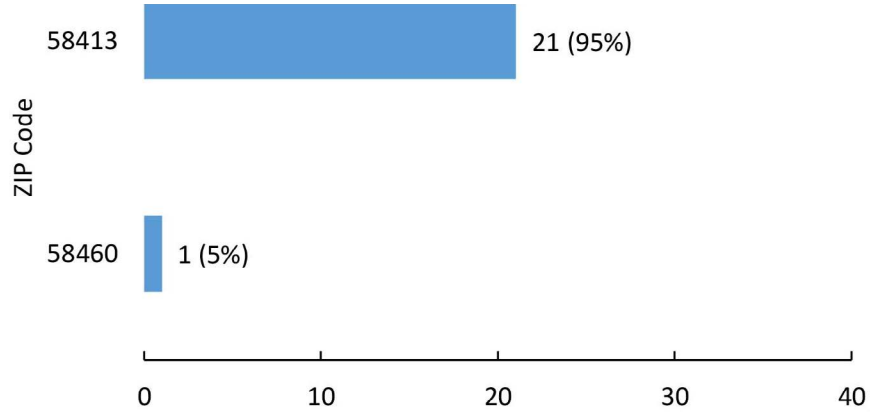
Survey Results

As noted previously, 39 community members completed the survey in communities throughout the counties in the Ashley Medical Center (AMC) service area. For all questions that contained an "Other" response, all of those direct responses may be found in Appendix G. In some cases, a summary of those comments is additionally included in the report narrative. The "Total respondents" number under each heading indicates the number of people who responded to that particular question; some questions allow for selection of more than one response.

The survey requested that respondents list their home zip code. While not all respondents provided a zip code, 22 persons did, revealing that a large majority of respondents (95%, N=22) lived in Ashley. These results are shown in Figure 5.

Figure 5: Survey Respondents' Home Zip Code
Total respondents: 22



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

Survey Demographics

To better understand the perspectives 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:

- 26% (N=7) were age 55 or older
- The majority (78%, N=27) were female
- 33% of the respondents (N=9) had bachelor's degrees or higher
- The number of those working full time (93%, N=25) was much higher than those who were retired (4%, N=1)
- 96% (N=24) of those who reported their ethnicity/race were White/Caucasian
- 32% of the population (N=8) had household incomes of $50,000 to $74,999
- 54% (N26) worked for a hospital, clinic or public health. Healthcare workers will most likely have a different perception of health needs versus community members who don't work in healthcare

Figures 6 through 13 show these demographic characteristics. It illustrates the range of community members' household incomes and indicates how this assessment considered input from parties who represent the varied interests of the community served, including a balance of age ranges, those in diverse work situations, and community members with lower incomes.

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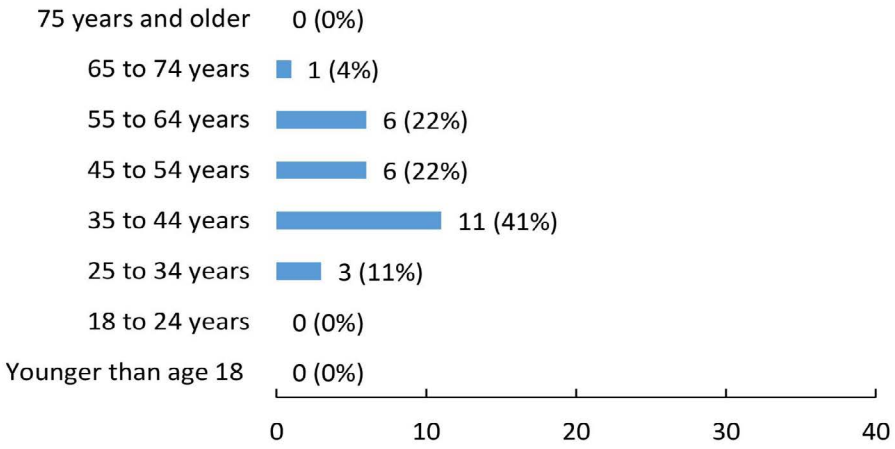
Figure 6: Age Demographics of Survey Respondents
Total respondents = 27



Children younger than 18 are not questioned, using this survey method.

Figure 7: Gender Demographics of Survey Respondents
Total respondents = 27

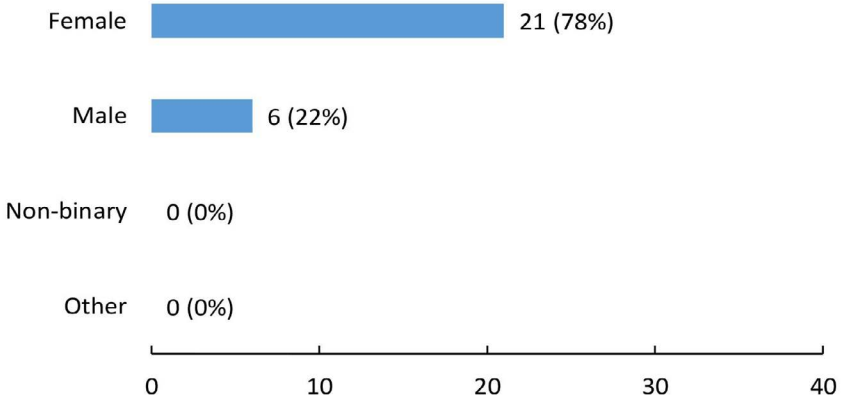


Figure 8: Educational Level Demographics of Survey Respondents
Total respondents = 27

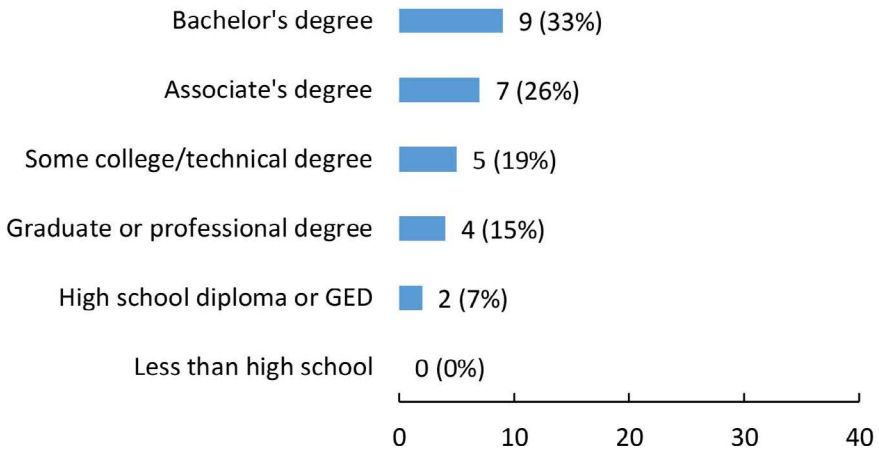


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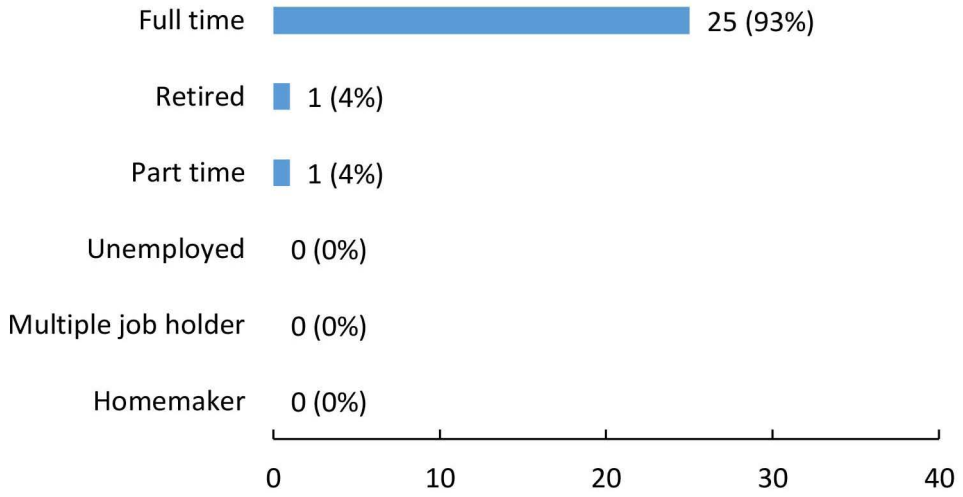
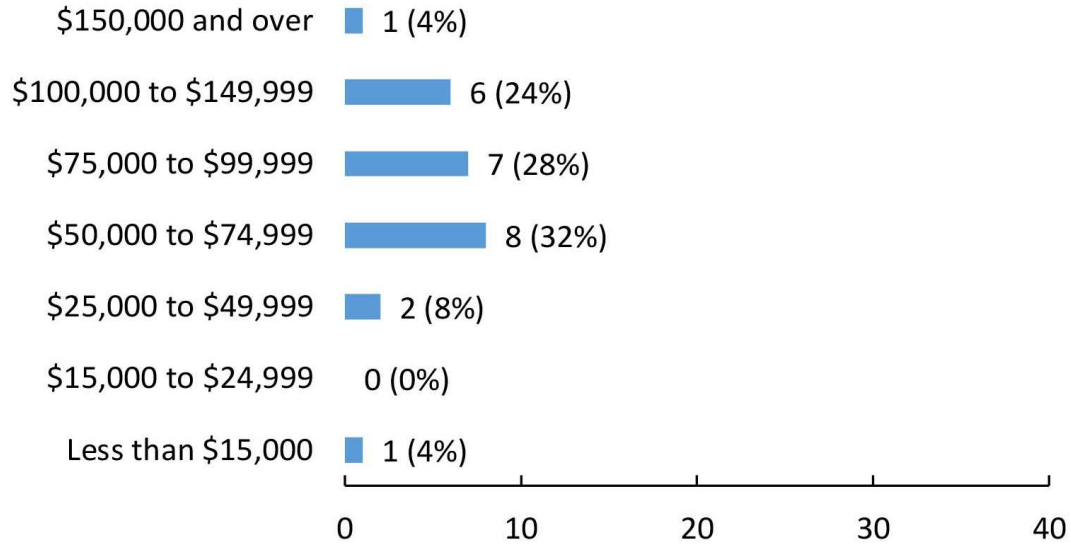
Figure 9: Employment Status Demographics of Survey Respondents
Total respondents = 27



Of those who provided a household income, 4% (N=1) of community members reported a household income of less than $25,000. Thirty two percent (N=8) indicated a household income of $50,000-74,999. This information is shown in Figure 10.

Figure 10: Household Income Demographics of Survey Respondents
Total respondents = 25



Community members were asked about their health insurance status, which is often associated with whether people have access to healthcare. The most common insurance types were insurance through one's employer (N=22), followed by Medicaid (N=2).

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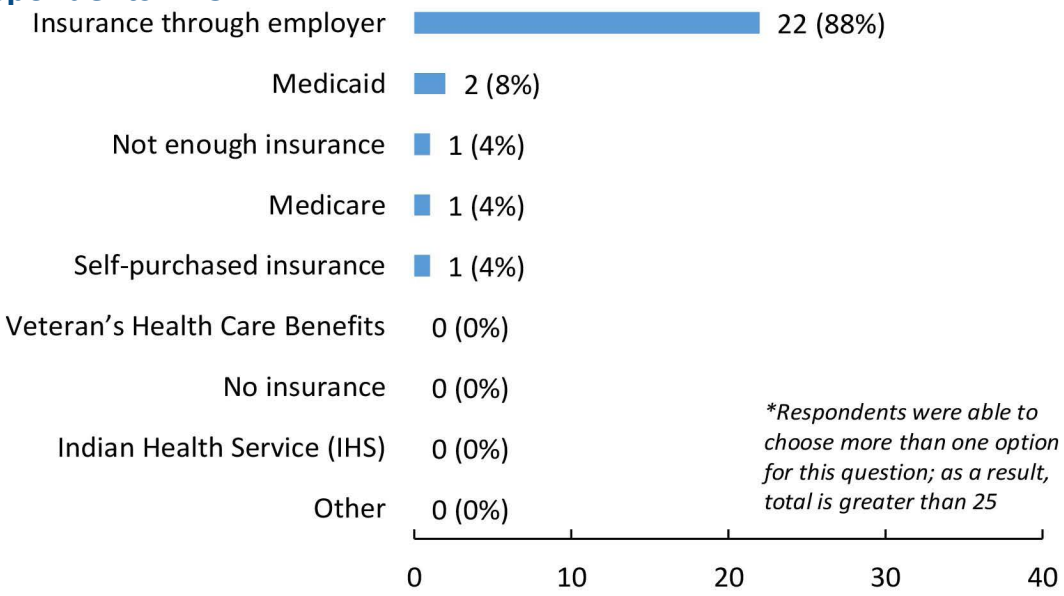
Figure 11: Health Insurance Coverage Status of Survey Respondents
Total respondents = 25*



As shown in Figure 12, nearly all of the respondents were White/Caucasian (96%). This statistic was in-line with the race/ethnicity of the overall population of McIntosh County; the U.S. Census indicates that 96.6% of the population is White in McIntosh County.

Figure 12: Race/Ethnicity Demographics of Survey Respondents
Total respondents = 25

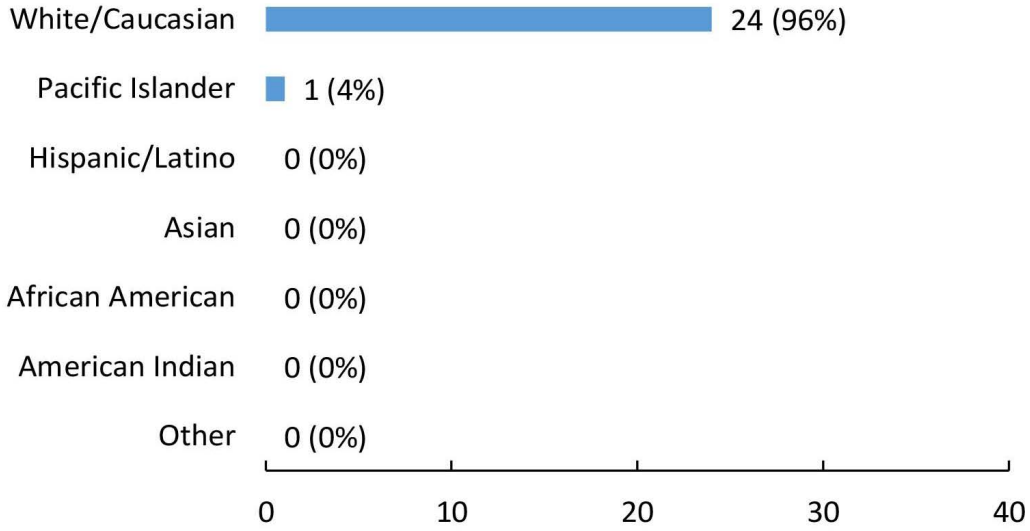
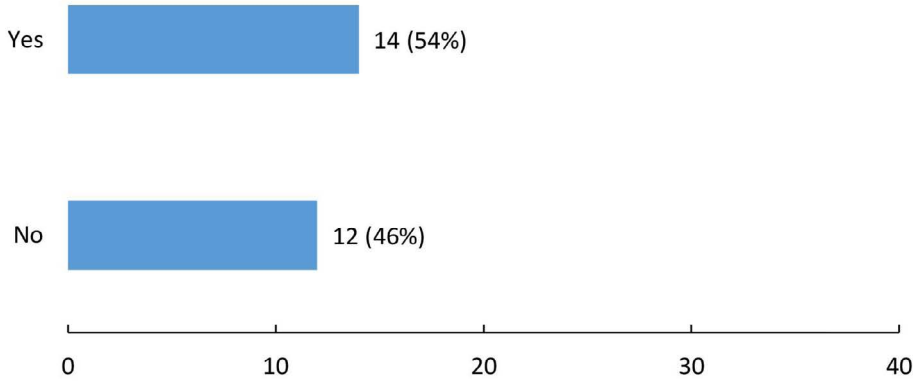


Figure 13: Work for a Hospital, Clinic, or Public Health Unit
Total respondents: 26



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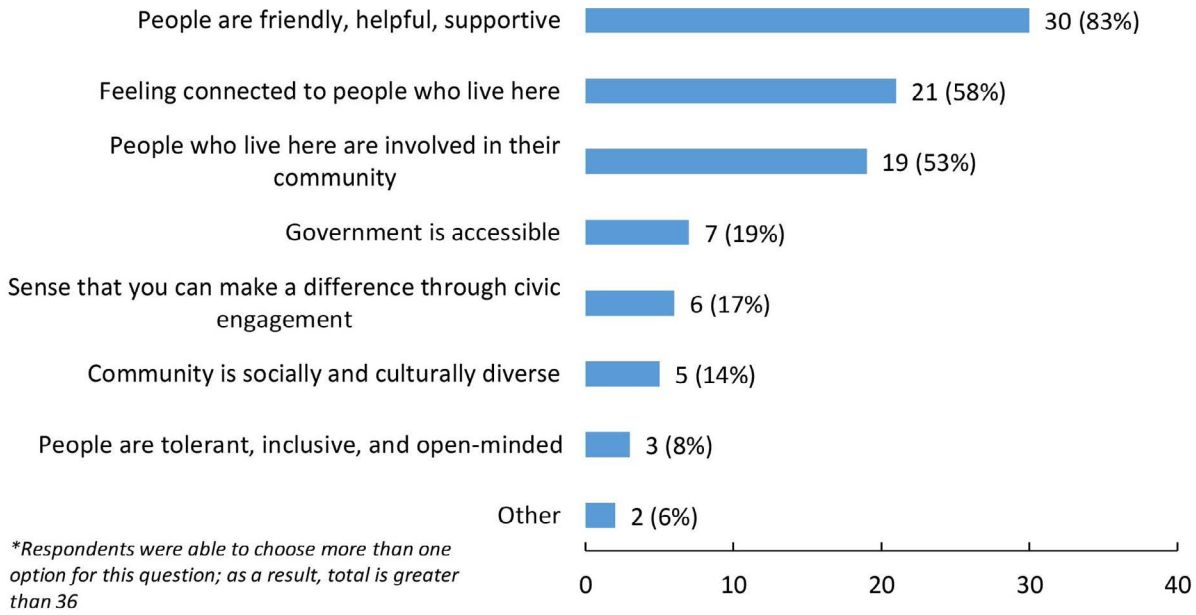
Community Assets and Challenges

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 23 respondents agreeing) that community assets include:

- People are friendly, helpful, supportive (N=30)
- Safe place to live (N=32)
- Family-friendly (N=30)
- Healthcare (N=28
- Local events and festivals (N=25)
- Active faith community (N=23)

Figures 14 to 17 illustrate the results of these questions.

Figure 14: Best Things About the PEOPLE in Your Community
Total responses = 36*



**Respondents were able to choose more than one option for this question; as a result, total is greater than 36*

Included in the "Other" category of the best things about the people was that people are involved, but 95% is based around drinking.

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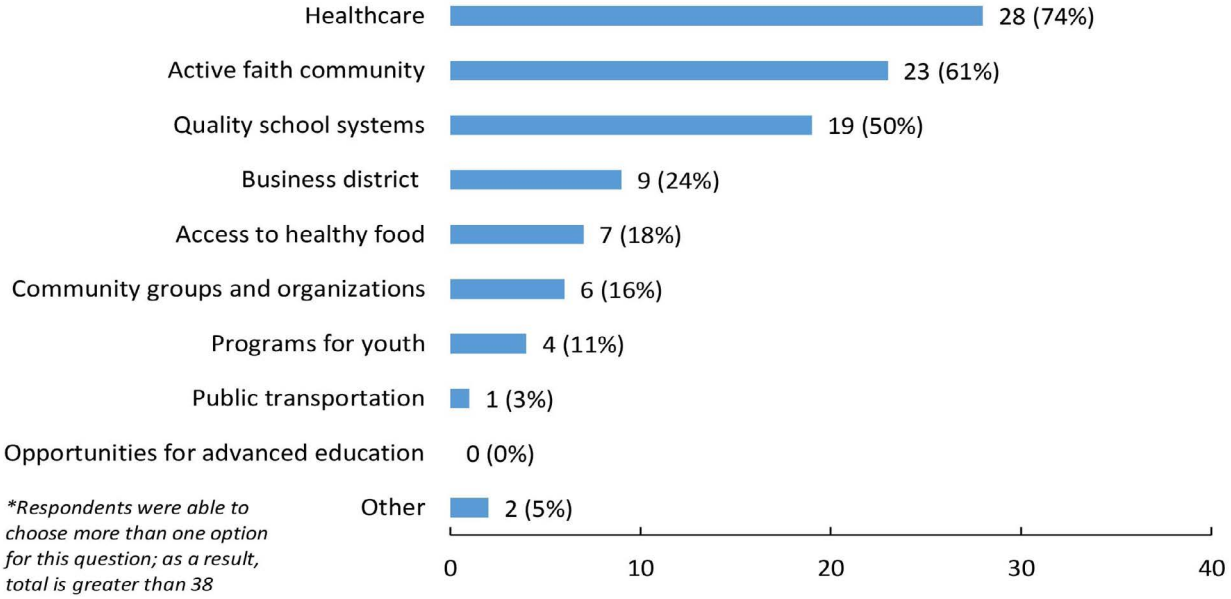
Figure 15: Best Things About the SERVICES AND RESOURCES in Your Community
Total responses = 38*



Respondents who selected "Other" specified that the ones we have are horrible: Ashley needs to have someone to come into people's homes to check on them, make sure they are taking their medications, so they can stay at their homes as long as they can.

Figure 16: Best Things About the QUALITY OF LIFE in Your Community
Total responses = 38*

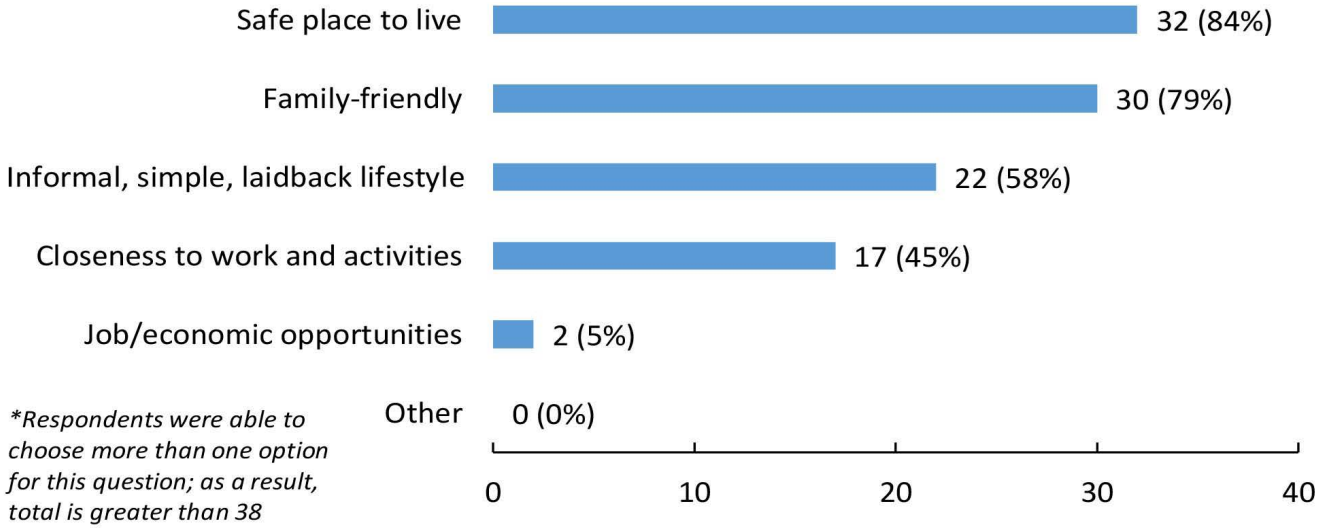


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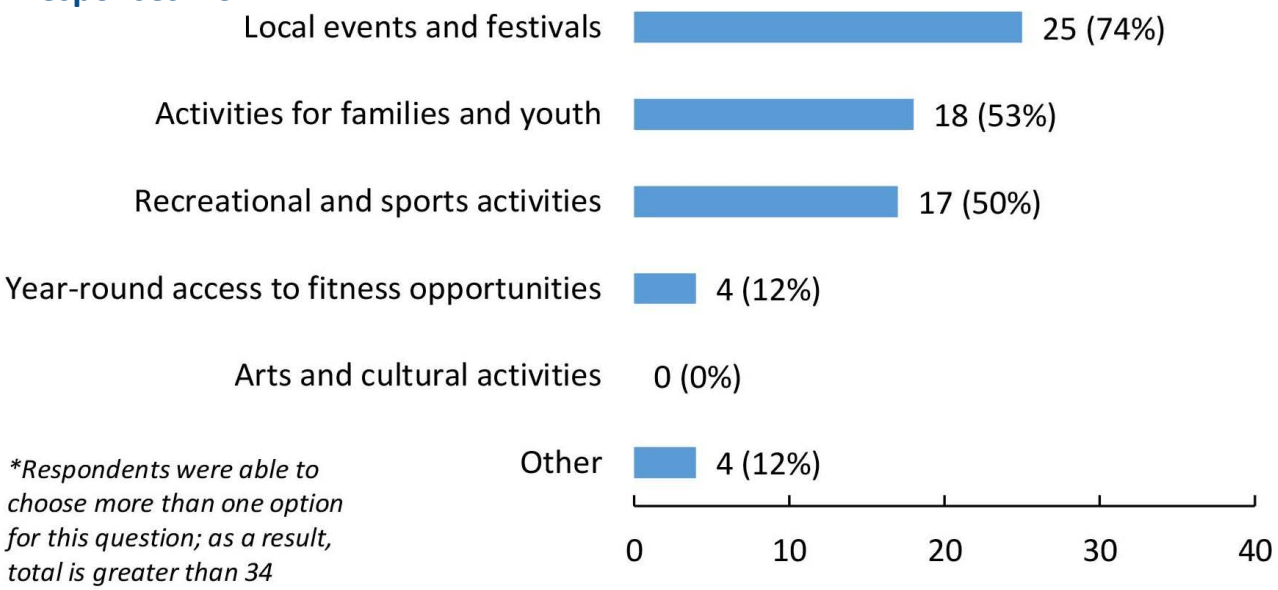
Figure 17: Best Thing About the ACTIVITIES in Your Community
Total responses = 34*



**Respondents were able to choose more than one option for this question; as a result, total is greater than 34*

Respondents who selected "Other" specified that the best things about the activities in the community included there is zero fitness opportunities, and no gyms or programs available. There are local events and festivals, but again a majority is based around drinking.

Community Concerns

At the heart of this CHNA was a section on the survey, asking survey respondents to review a wide array of potential community and health concerns in 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
- Violence

With regard to responses about community challenges, the most highly voiced concerns (those having at least 13 respondents) were:

- Attracting and retaining young families (N=20)
- Not enough jobs with livable wages (N=18)
- Having enough child daycare services (N=17)
- Assisted living options (N=16)
- Depression/anxiety in adults (N=15)
- Alcohol use and abuse in adults (N=13)
- Availability of resources to help the elderly (N=13)

The other issues that had at least eight votes included:

- Bullying/cyberbullying (N=12)
- Cost of long-term/nursing home care (N=11)

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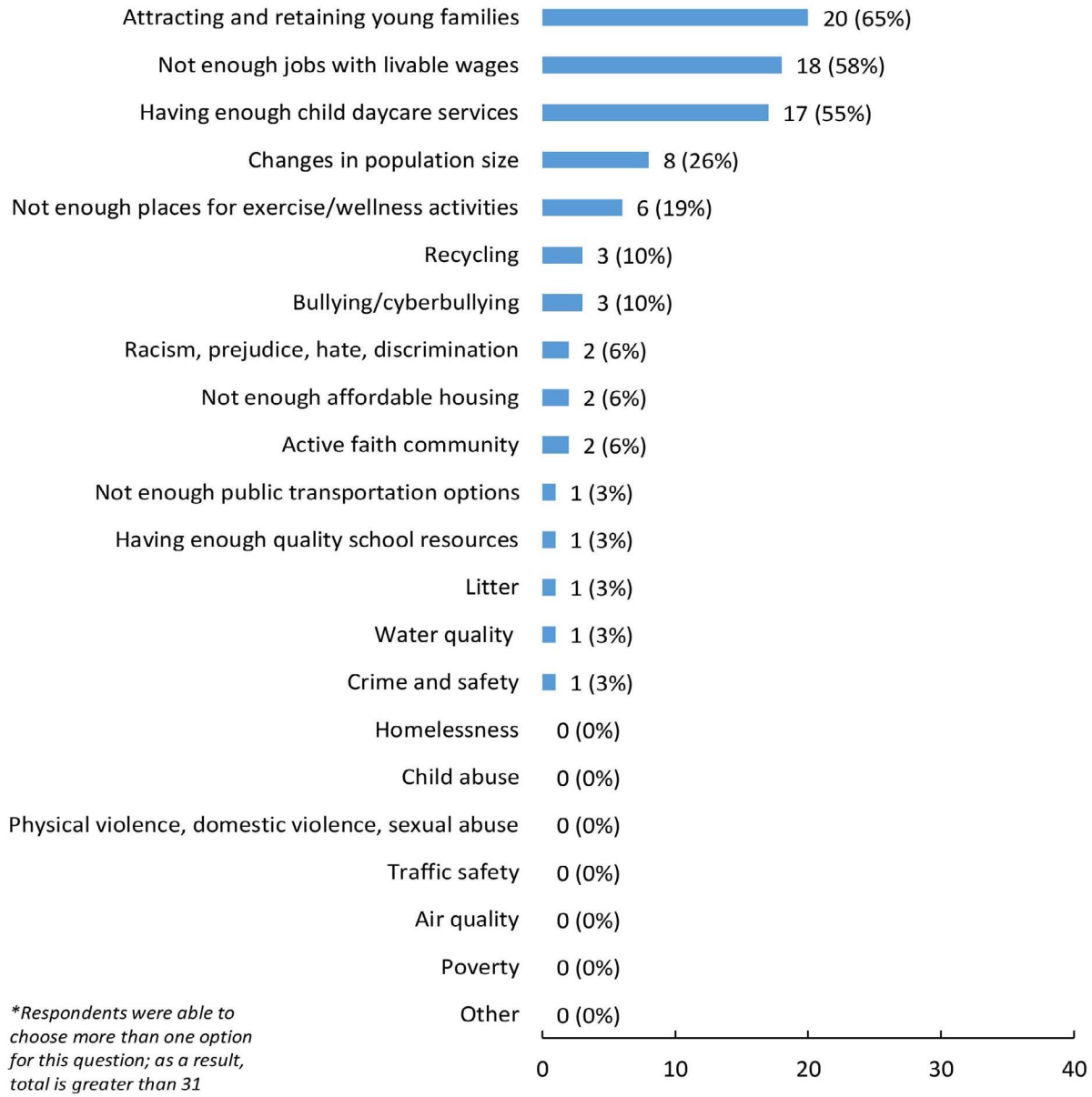
- Emotional abuse (N=10)
- Not getting enough exercise/physical activity – adults (N=9)
- Alcohol use and abuse in youth (N=11)
- Drug use and abuse in youth (N=11)
- Depression/anxiety in youth (N=11)
- Not enough activities for children and youth (N=11)
- Ability to get appointments for health services within 48 hours (N=9)
- Cost of health insurance (N=9).
- Change population size (N=8)
- Availability of dental care (N=8)
- Sexual health (N=8)

Figures 18 through 23 illustrate these results.

Figure 18: Community/Environmental Health Concerns
Total responses = 31



**Respondents were able to choose more than one option for this question; as a result, total is greater than 31*

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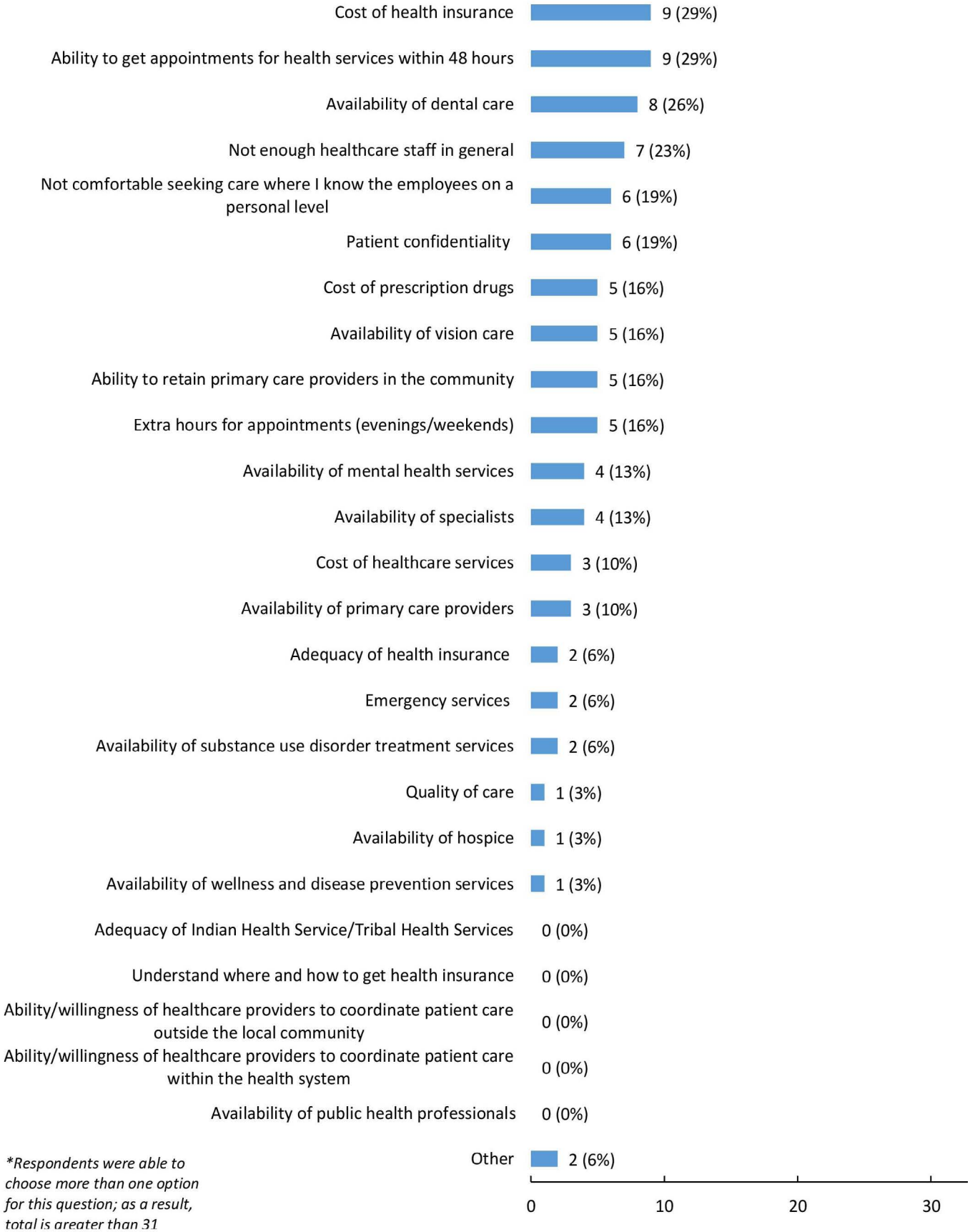
Figure 19: Availability/Delivery of Health Services Concerns
Total responses = 31*



**Respondents were able to choose more than one option for this question; as a result, total is greater than 31*

Respondents who selected "Other" identified concerns about letting a great nurse practitioner go to save money when others should go first and not retaining a great nurse practitioner when they have one.

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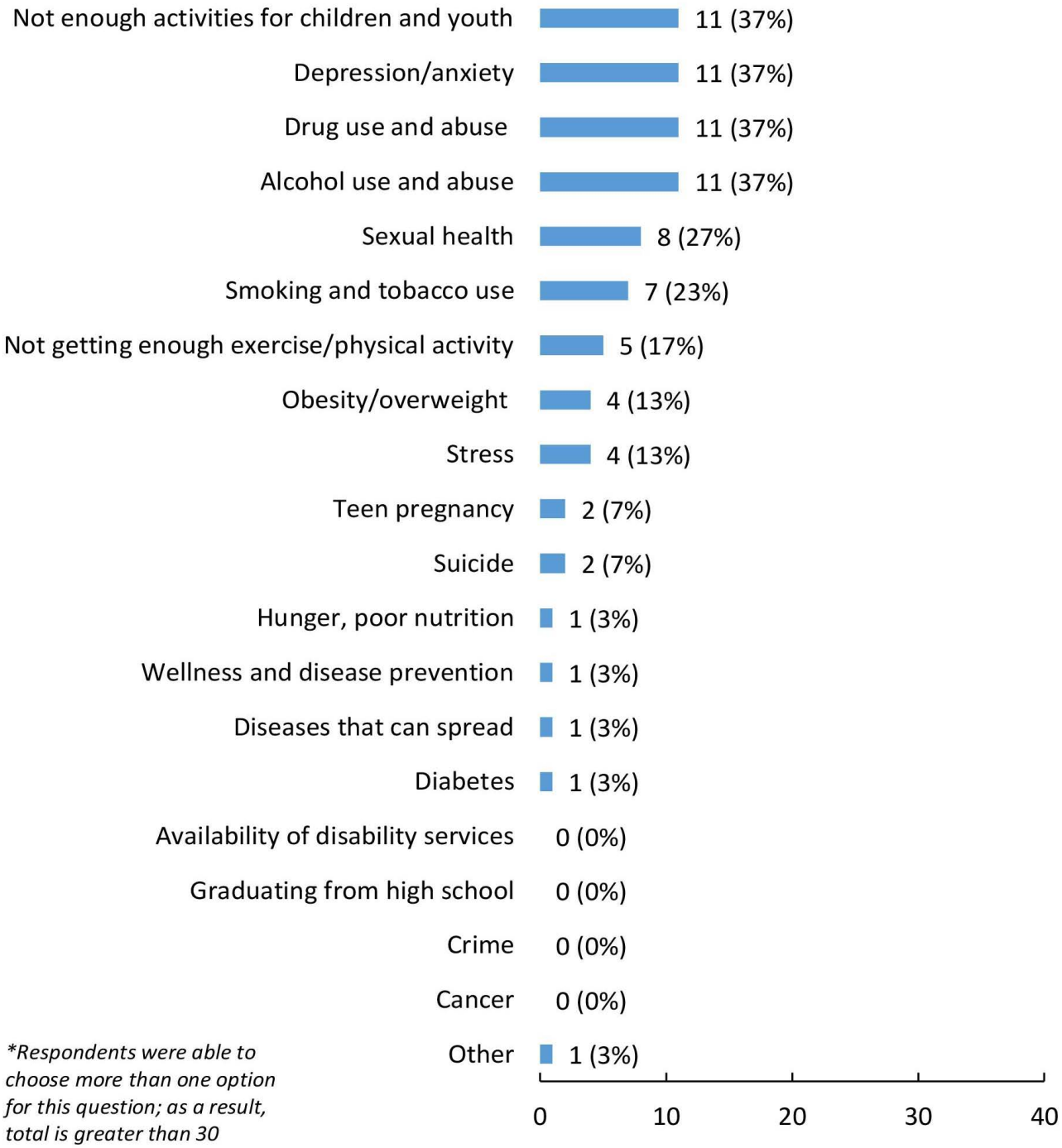
Figure 20: Youth Population Health Concerns
Total responses = 30*



**Respondents were able to choose more than one option for this question; as a result, total is greater than 30*

Listed in the "Other" category for youth population concerns are the lack of two parent homes and guidance/ church attendance.

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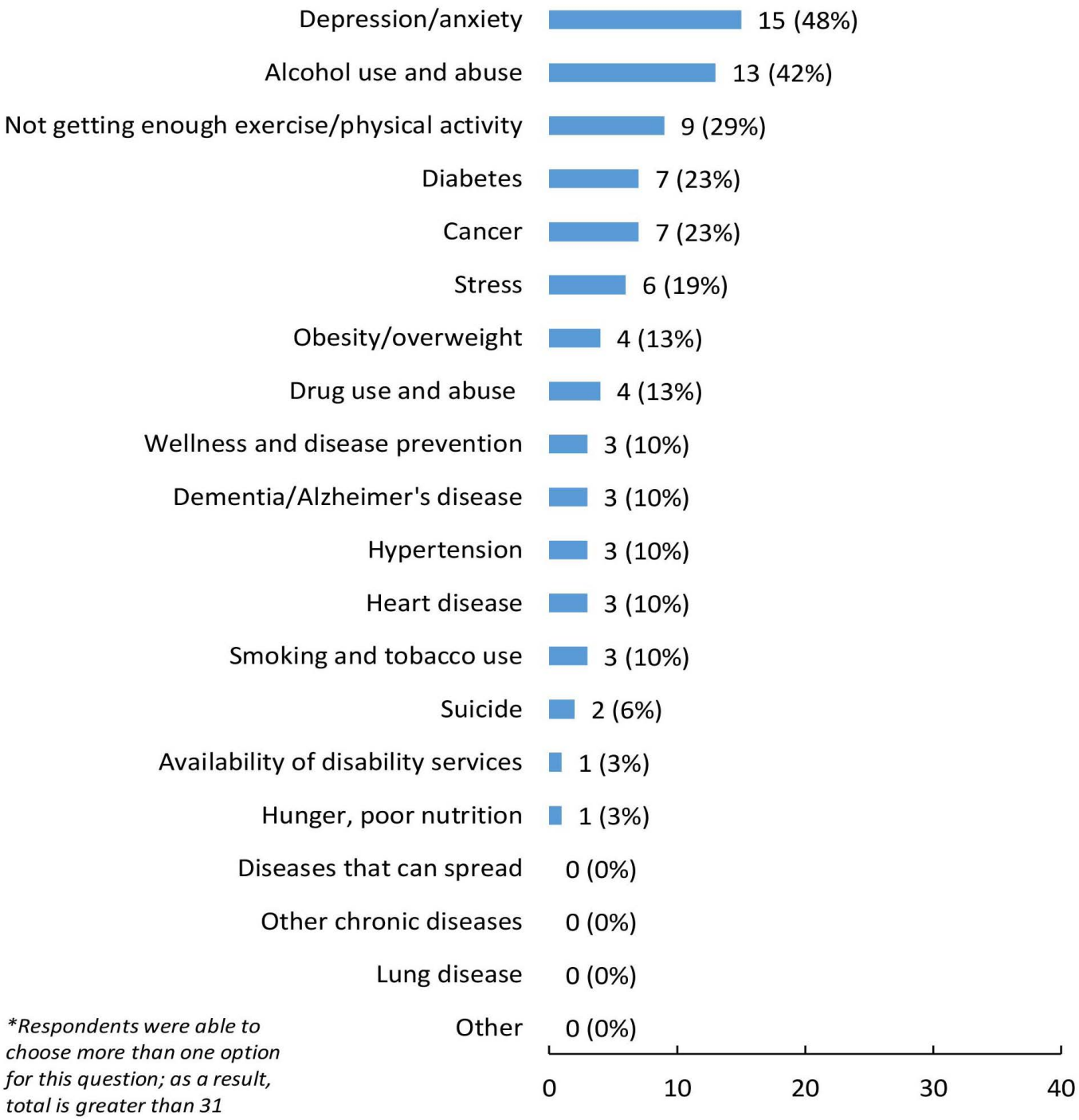
Figure 21: Adult Population Concerns
Total responses = 31*



**Respondents were able to choose more than one option for this question; as a result, total is greater than 31*

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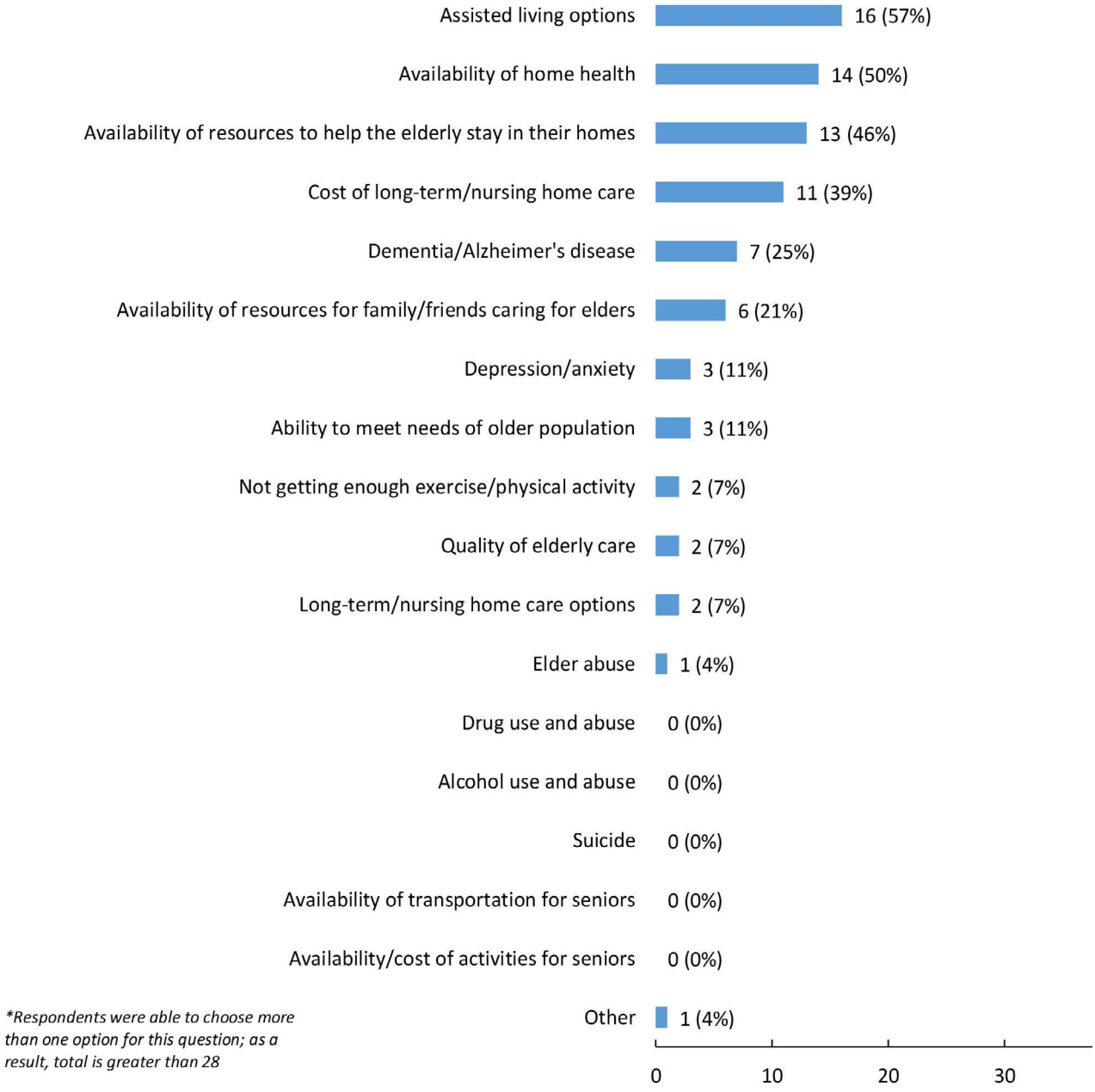
Figure 22: Senior Population Concerns
Total responses = 28*



**Respondents were able to choose more than one option for this question; as a result, total is greater than 28*

In the "Other" category, the one concern listed was cost of prescriptions for the elderly.

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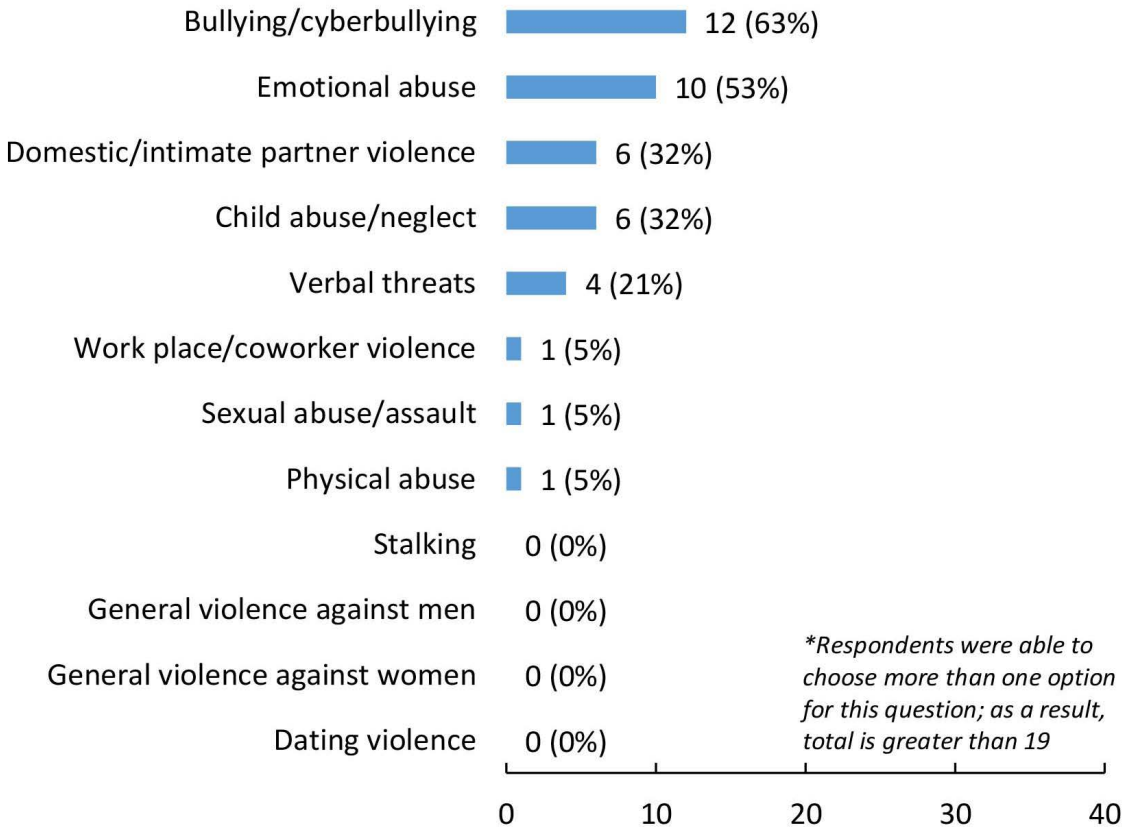
Figure 23: Violence Concerns
Total responses = 19*



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 housing
2. Change in population and demographics

Other biggest challenges that were identified were the aging population, decreasing population, cost of prescription drugs, home health services, housing needs, limited jobs, lower wages, bullying, availability of fresh fruit and vegetables, high grocery prices, lack of medical staff, lack of workers, price of healthcare and meds, lack of volunteers or community members getting involved, transportation for the elderly, day care availability, cost of long-term care, quality of care for the elderly, smoking/tobacco use in youth, and lack of assisted living facilities.

Delivery of Healthcare

The survey asked residents what they see as barriers that prevent them, or other community residents, from receiving healthcare. The most prevalent barrier perceived by residents was not able to get appointment/limited hours (N=10), with the next highest being not enough evening/weekend hours (N=9) and concerns about confidentiality (N=9), followed by not being able to see same provider of time (N=8).

Figure 24 illustrates these results.

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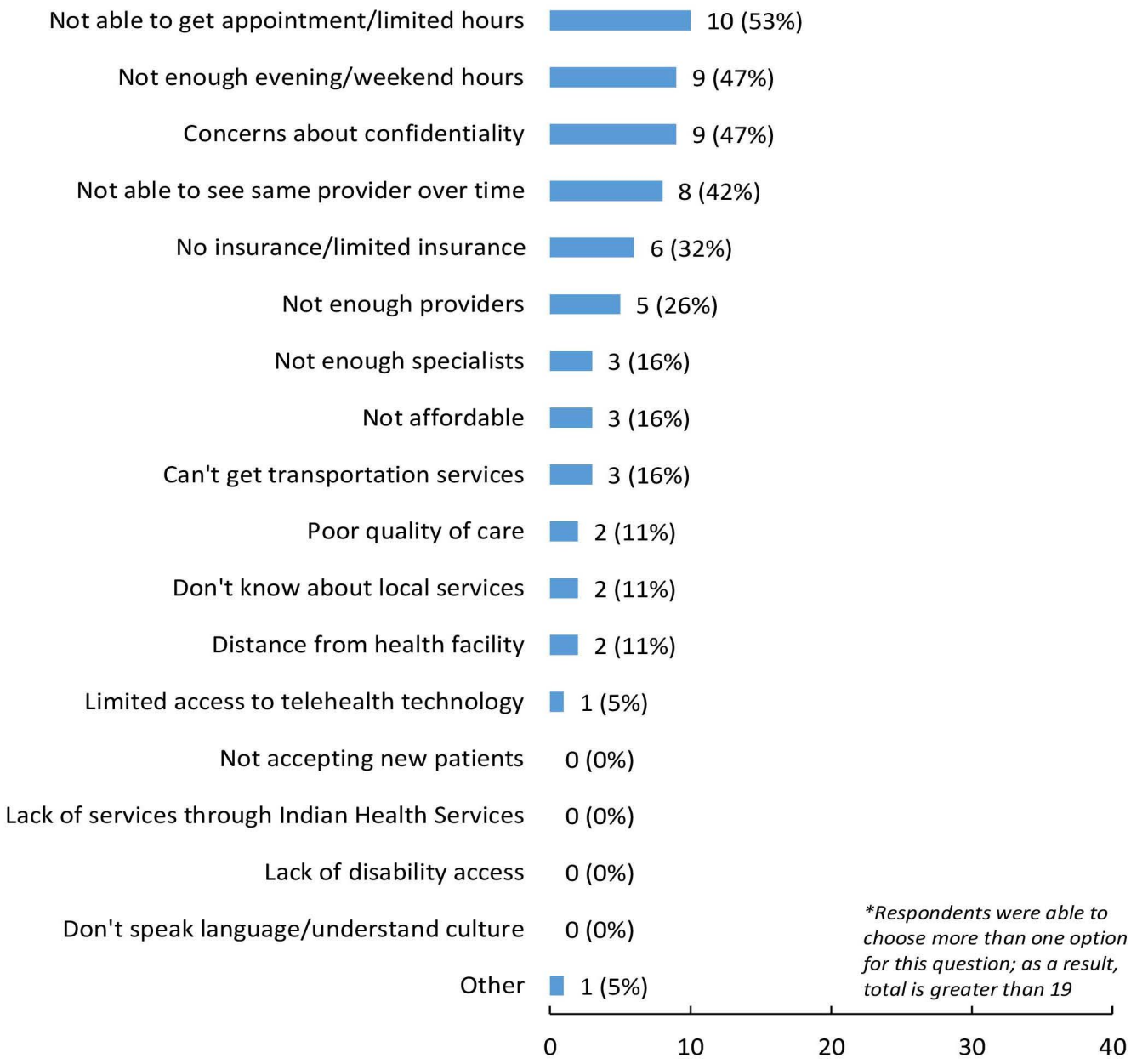
Figure 24: Perceptions About Barriers to Care
Total responses =19*



Considering a variety of healthcare services offered by McIntosh District Health Unit, respondents were asked to indicate what services they or a family member have used at MDHU (See Figure 25).

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Figure 25: Awareness of Ashley Medical Center Foundation
Total responses =25

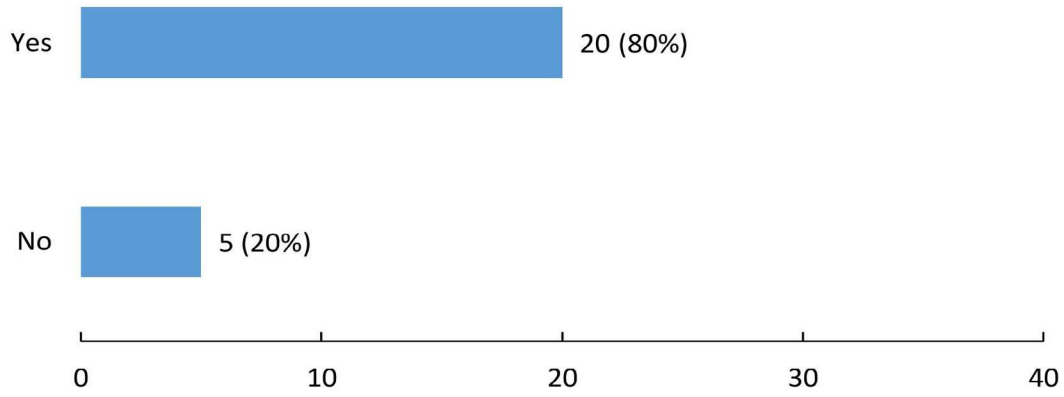

Figure 26: Awareness of Volunteer Opportunities Through Ashley Medical Center Foundation
Total responses = 25

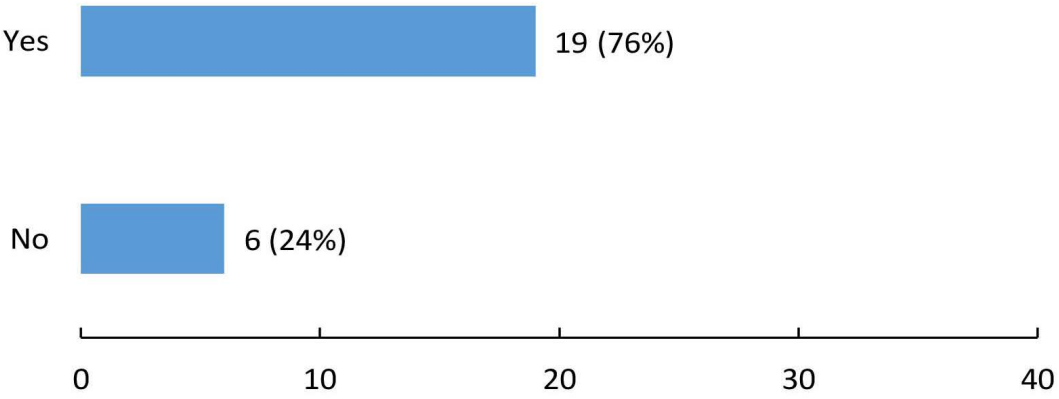

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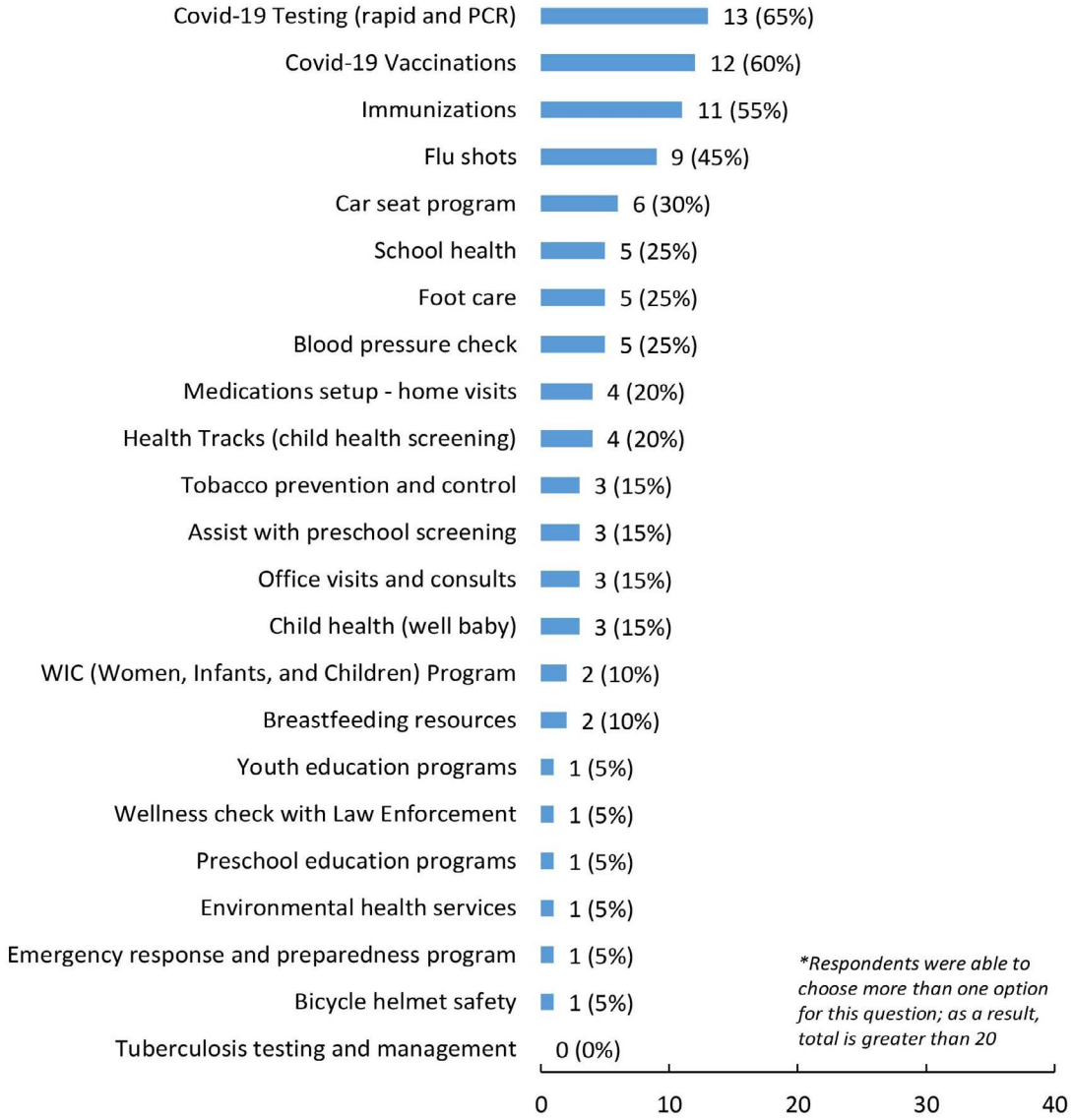
Figure 27: Utilization of Public Health Services
Total responses =20*



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 adding an optometrist/eye doctor to the area. Other requested services included:

- 24/7 secure access to exercise for the community
- Home health
- Specialists
- Evening hours until 7:00 pm at least twice a week
- Dentist
- Youth counselling services
- In home care for elderly
- A physician in house
- Assisted living
- General surgeon
- Mental health services

Home health was the next desired service, next to optometry. While not a service, many respondents indicated that they would like a physician added and a new general surgeon, as the current one will be retiring. They also commented about having access to exercise for the community, not just students, 24 hours a day.

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, but word of mouth may diminish as the new, younger people, moving to town aren't connecting well with other people in the community. One person indicated they would like to see counseling services added for youth and that the mental health services available now rarely talk to patients about what's going on but are more than willing to prescribe medications.

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Figure 28: Sources of Trusted Health Information
Total responses = 24*

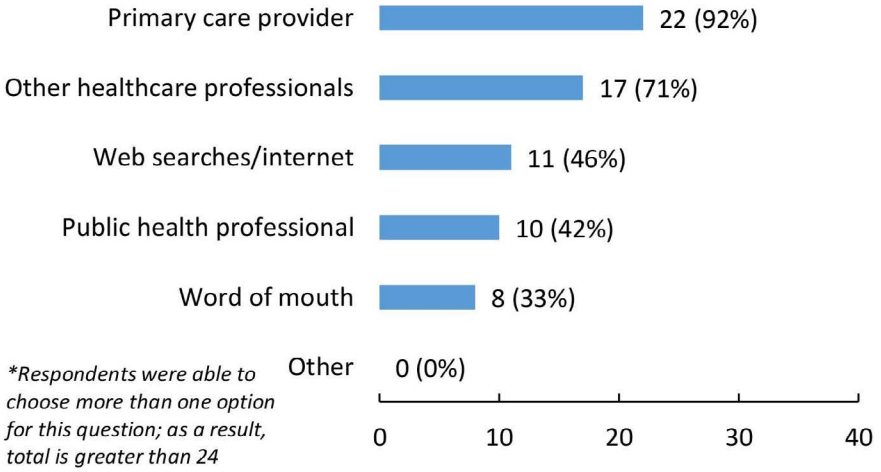


Figure 29: Awareness of Ashley Medical Center Foundation
Total responses = 25*

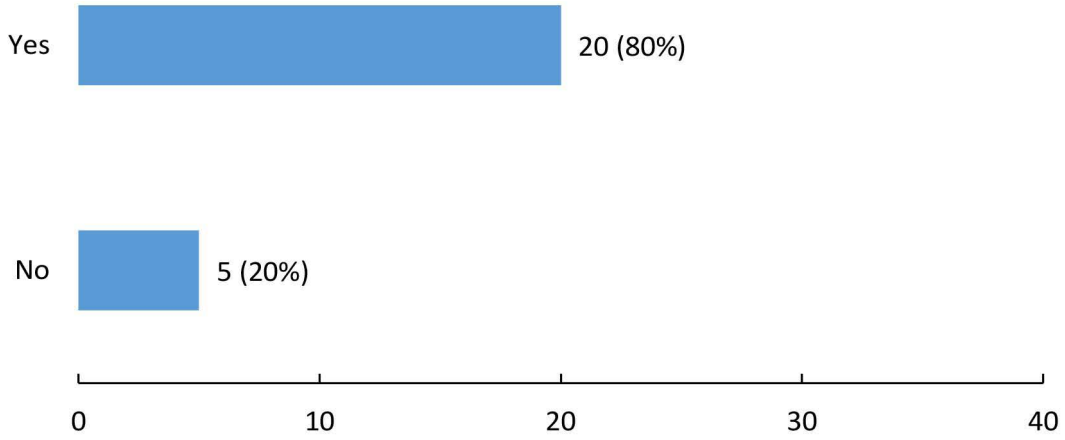
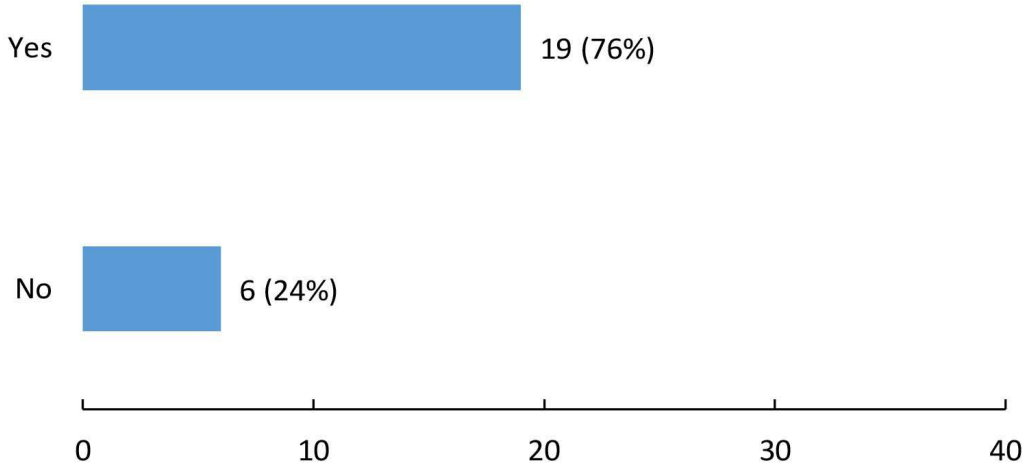


Figure 30: Awareness of Volunteer Opportunities Through Ashley Medical Center Foundation
Total responses = 25*



In an effort to gauge ways that community members would be most likely to financially support facility improvements/new equipment, a question was included asking them to select ways they are most likely to support facility improvements/new equipment at AMC (see Figure 31). Recommendations in the "Other" category included AMC needs a new facility, as it is literally falling apart, assisted living establishment, floor by ER needs to be replaced, and walls by door two area look awful.

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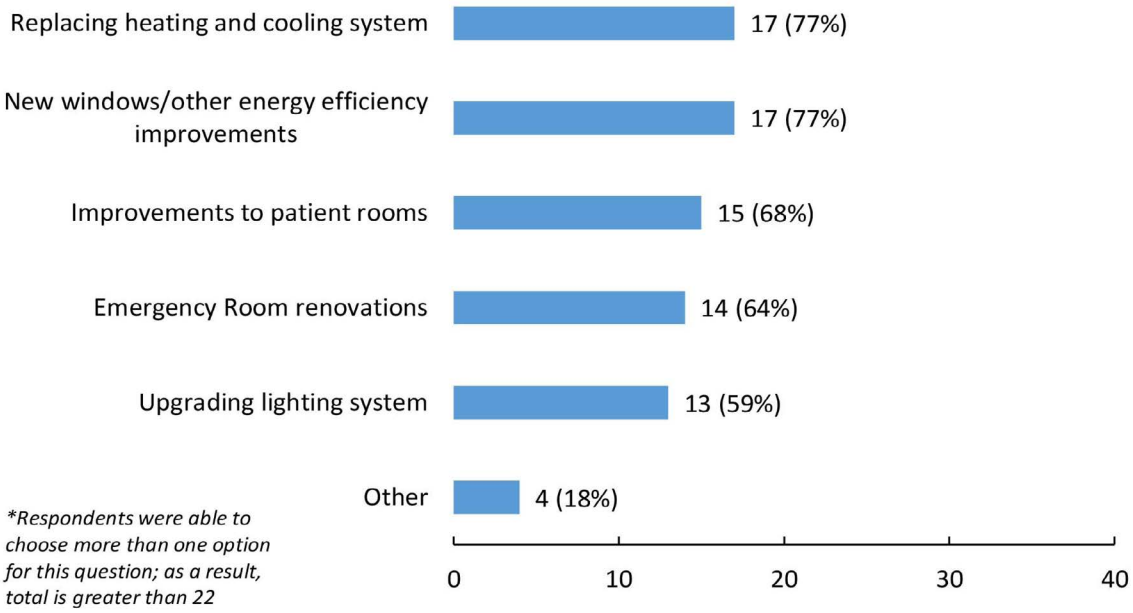
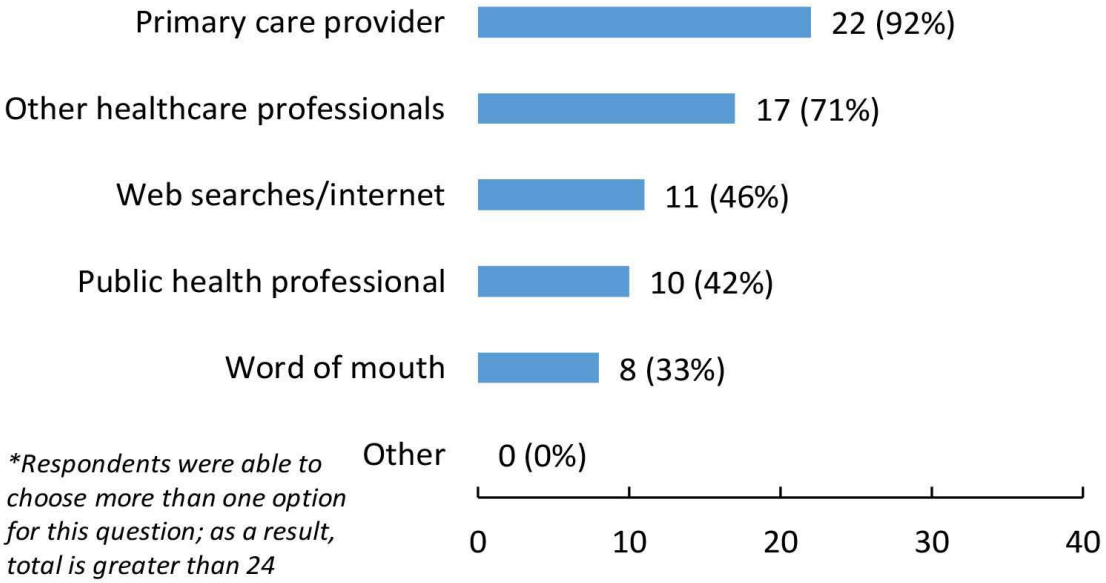
Figure 31: Capital Improvements the Community Would Support
Total responses = 22*



Respondents were asked where they go to for trusted health information. Primary care providers (N=22) received the highest response rate, followed by other healthcare professionals (N=17), and then web/internet searches (N=11).

Results are shown in Figure 32.

Figure 32: Sources of Trusted Health Information
Total responses = 24*



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The final question on the survey asked respondents to share concerns and suggestions to improve the delivery of local healthcare. There was concern about the clinic running more efficiently, as there are days where there are no patients in waiting room, but on other days patients can't get appointments. They felt it was difficult to schedule an appointment after 3:00 pm or prior to 9:00 am. There is also a desire to have additional physicians hired and not just physician assistants who are local, home-grown providers. The hospital needs to acquire grants and other funding that is readily available. They felt the community would benefit greatly with some type of home health/in home care services or assisted living for the elderly. One questioned whether AMC should get a more business qualified board, as they need to think about the community and not their own feelings.

They also expressed a need for better activities, so the residents have a better quality of life. In addition, if AMC could find a way to have some assisted living options, it would take the stress off some people and add comfort to those who have family in those situations.

Others believe that Ashley has a very active community, and most are out and about. The golf course is a great addition to our community. Community members felt they could use more volunteers to help the community: fire, city council, meals on wheels, and elderly companions. Help in these areas would make it a better community.

Increased communication about available services would be a bonus, as not everyone in this community is from this area; therefore, they feel there is lack of information available on services provided within the community. Communication/marketing is missing.

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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 four categories (listed in alphabetical order):

- Assisted living options
- Having enough child daycare services
- Not enough jobs with livable wages, not enough to live on
- Smoking and tobacco use, exposure to second-hand smoke, or vaping/juuling

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

Assisted living options

- The cost of long-term care is high.
- Cost of long-term/nursing home care. Sometimes you hear that this elderly people say it cost them a lot of money. If they are a farmer then they have to give up their land.
- Housing in our community. The availability of resources to support the elderly living in their own homes. Oldest county in North Dakota.

Having enough child daycare services

- Currently working on application to the state to convert apartments to assisted living. Not sure if it is going to be well received.
- Daycare spots are full. Only one daycare center in town and they have a waiting list and lots of babies being born. Huge shortage.

Smoking and tobacco use

- Smoking/tobacco use with children, they are destroying their lungs as they are developing. They are affecting their future without realizing it.

Community Engagement and Collaboration

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

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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 February 2, 2022. Ten community members attended the meeting, which was held via Zoom to accommodate a surge in COVID-19 cases. Representatives from the Center for Rural Health (CRH) presented the group with a summary of this report's findings, including background and explanation about the secondary data, highlights from the survey results (including perceived community assets and concerns, and barriers to care), and findings from the key informant interviews.

Following the presentation of the assessment findings and after considering and discussing the findings, all members of the group were asked to identify what they perceived as the top four community health needs. All of the potential needs were listed in an online survey, where each member was asked to select the four needs that they considered the most significant.

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

- Availability of resources to help the elderly stay in their homes (9 votes)
- Ability to recruit and retain primary care providers (7 votes)
- Availability of primary care providers (6 votes)
- Alcohol use and abuse for all ages (5 votes)

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

1. Availability of resources to help the elderly stay in their homes (6 votes)
2. Availability of primary care providers (4 votes)
3. Ability to recruit and retain primary care providers (2 votes)
4. Alcohol use and abuse for all ages (0 votes)

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Following the prioritization process during the second meeting of the community group and key informants, the number one identified need was the availability of resources to help the elderly stay in their homes. A summary of this prioritization may be found in Appendix E.

Comparison of Needs Identified Previously

Top Needs Identified 2019 CHNA Process	Top Needs Identified 2022 CHNA Process
Attracting and retaining young families	Attracting and retaining young families
Having enough child daycare services	Not enough jobs with livable wages
Not enough jobs with livable wages	Change in population size
Assisted living options	Not enough healthcare staff in general

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

In response to the needs identified in the 2019 Community Health Needs Assessment (CHNA) process, the following actions were taken:

Need 1: Attracting and retaining young families to the community: Ashley Medical Center (AMC) cannot address local economical attractions other than maintaining financial viability. They offer competitive wages at the medical center. Ashley is an agriculturally-based community, and the struggling farm economy is a major concern. The AMC board consists of members from the business sector, agriculture, public school, public health, animal health, and retirees. AMC is a member of the chamber of commerce. There has been an influx of younger families to the community. In the past couple of years, we have expanded the business community that the community has added: a bookstore, off-sale bottle shop, boutique with a silk screening business, and shipping container pros. The new businesses were welcomed to the community.

Need 2: Adequate childcare services: There are two daycares in the community; one is home based and is at capacity. The second daycare is assisted by the JDA to provide a building to operate the daycare. The daycare has made modifications to enable housing additional children.

Need 3: Assisted living options: Assisted living options continue to be on the radar of AMC. The board has discussed this concern again recently. There would be issues with staffing assisted living, as the facility struggles to staff the acute and long-term care facilities that currently exist.

Need 4: Lack of jobs with livable wages: The issue of not enough jobs with livable wages is an issue that AMC can't rectify alone. They continue to review and adjust wages. AMC is competitive with wages in the area.

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Next Steps – Strategic Implementation Plan

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

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

Community Benefit Report

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

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

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

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

What Are Community Benefits?

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

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

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

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

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

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Appendix A – Critical Access Hospital Profile

Critical Access Hospital Profile

Spotlight on: Ashley, North Dakota

Ashley Medical Center

Quick Facts

Administrator:
Eric Heupel, CEO

Chief of Medical Staff:
Dr. Bradly Skari

Board Chair: Polly Ulrigh

City Population:
749 (2019 estimate)[1]

County Population:
2,809 (2019 estimate)[1]

County Median Household Income:
$37,500 (2019 estimate)[1]

County Median Age:
52.7 years (2019 estimate)[1]

Service Area Population:
2,000-2,500

Owned by: Community

Hospital Beds: 20

Skilled Nursing Facility Beds: 40

Trauma Level: V

Critical Access Hospital Designation: 2001

Economic Impact on the Community[2]

Jobs:
Primary – 92
Secondary – 39
Total – 131

Financial Impact:
Primary – $5.79 million
Secondary – $1.5 million
Total – $7.19 million

Mission

Ashley Medical Center is a community service organization which provides preventative, curative, supportive and educational health care that meets the physical, emotional, and spiritual needs of the people we serve.

County: McIntosh
Address: PO Box 450, 612 Center Ave. North
Ashley, ND 58413
Phone: 701.288.3433
Fax: 701.288.3938
Web: www.amctoday.org

The Ashley Medical Center (AMC) is a non-profit, community owned hospital located in Ashley, North Dakota. AMC is governed by a publicly elected board of directors. It is the largest hospital complex in McIntosh County and serves an approximate 50 mile radius around Ashley.

Services

Ashley Medical Center provides the following services directly:

- Acute Care
- Swing Bed
- Obstetrics (emergency only)
- Pediatric Care
- Observation Care
- Physical Therapy
- Social Services
- Dietary
- Radiology
- Cardiac Rehabilitation
- Surgery
- Mammography
- Cat Scan
- Anesthesia
- Emergency Room
- IV Therapy
- EMS Services
- Chemotherapy Administration
- Out Reach Physician Services (Internal Medicine)
- Telemedicine (Speech Therapy, Education, Medical)
- Laboratory
- EKG
- WIC
- Health Information
- Community Education
- Cardiac Stress Testing
- Wellness Program
- Preferred Service Provider
- Clinic Prenatal Care
- Home Health Care
- Hospice
- Skilled Nursing Facility
- PT/OT Outside Contracts

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Staffing

Physicians: 1
Nurse Practitioners: 3
RNs: 17
LPNs: 10
Total Employees: 134

Local Sponsors and Grant Funding Sources

- Blue Cross Blue Shield
- Center for Rural Health
  - SHIP Grant (Small Hospital Improvement Program)
  - Flex Grant (Medicare Rural Hospital Flexibility Grant Program)
- Community Endowment Grants
- North Dakota Health Department Scholarship
- North Dakota Health Flex (HRSA)
- USDA Community Facility Grant
- Workforce Safety Grant

Sources

1 - US census Bureau; 2010 Stateand County QuickFacts

2 - Economic Impact 2020 Centerfor Rural Health OklahomaState University and Center forRural Health University of NorthDakota

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

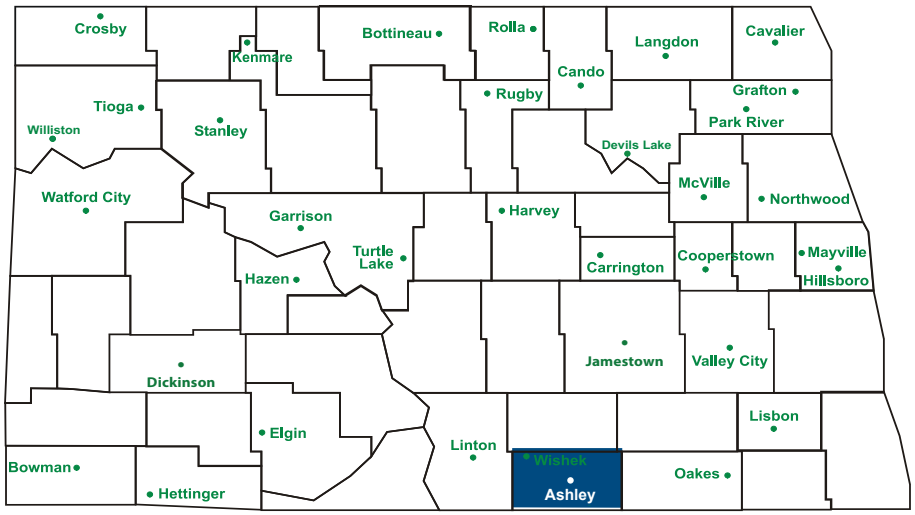
This project is supported by the Medicare Rural Hospital Flexibility Grant Program and the State Office of Rural Health Grant Program at the Center for Rural Health, The University of North Dakota School of Medicine & Health Sciences located in Grand Forks, North Dakota.

ruralhealth.und.edu

The following services are provided through contract or agreement:

- Rural Mental Health
- Speech and Hearing Services
- Medic Alert System
- Prosthetics & Orthotics
- Cardiac Ultrasound
- Nuclear Medicine (MRI, Dexiscan)
- Telemetry
- Radiology (Radiography, Fluoroscopy Ultrasound)
- Ophthalmology
- Orthopedics
- Cardiology
- Oncology
- Laboratory (Microbiology, Specialty Laboratory Tests, Pathology)

North Dakota Critical Access Hospitals



History

In 1952, The McIntosh County Memorial Hospital (as it was then known) opened its doors. Today the Ashley Medical Center (AMC) has grown into a complex of a 20 bed critical access hospital, with the capability of utilizing swing beds; a level 4 trauma center; 44 skilled nursing home beds; home health; hospice; quality service providers; one clinic in Ashley, one clinic in Zeeland, and one clinic in Kulm, North Dakota. There are 10 apartments attached to the hospital, and 25 apartments in the remodeled Harmony Homes complex. The AMC also owns two professional buildings where a surgeon, an optometrist, an ophthalmologist, and two chiropractors practice.

McIntosh County has been designated as a health care professional shortage area. AMC employs 95 full time and 39 part time people.

An Ashley-based general surgeon, an internal medicine physician, and two licensed family nurse practitioner comprise the immediate medical staff. Nine consulting physicians come to the AMC on a regular basis. Their specialties area ophthalmolog, orthopedic, cardiolog, patholog, optometr, chiropractic care, a clinical audiolog and radiolog.

Recreation

AMC is located in a rural area that is a hunter's paradise. Deer, pheasant, geese, duck and quail are abundant. Numerous lakes provide quality fishing all year around. Many bird watchers are drawn to the area for the large variety of birds that make their homes here. Ashley also boasts a state of the art Fitness Center.

Updated 08/2021

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Appendix B – Economic Impact Analysis

Ashley Medical Center

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

ASHLEY MEDICAL CENTER

Working for a Healthier You

Economic Impact

Ashley Medical Center is composed of a Critical Access Hospital (CAH) and a clinic in Ashley, a Rural Health Clinic in Zeeland, a nursing home, rental property for visiting specialists, and apartments.

Ashley Medical Center **directly** employs **91.65 FTE employees** with an annual payroll of almost **$5.79 million** (including benefits).

- After application of the employment multiplier of 1.43, these employees created an additional **39** jobs.
- The same methodology is applied to derive the income impact. The income multiplier of 1.24 is applied to create nearly **$1.5 million** in income as they interact with other sectors of the local economy.
- **Total impacts = 131 jobs and more than $7.19 million in income.**

Healthcare and Your Local Economy

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

Key contributions of the health system include

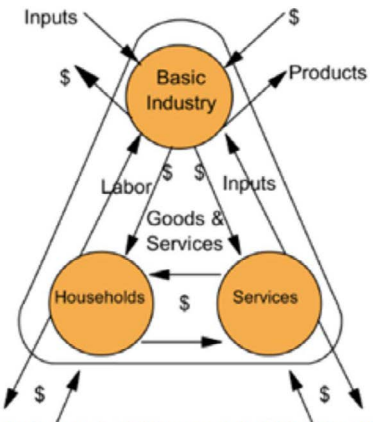
- Attracts retirees and families
- Appeals to businesses looking to establish and/or relocate
- High quality healthcare services and infrastructure foster community development
- Positive impact on retail sales of local economy
- Provides higher-skilled and higher-wage employment
- Increases the local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

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

Fact Sheet Author: Kylie Nissen, BBA

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

Figure 1. *An overview of the community economic system.*



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

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

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Appendix C – CHNA Survey Instrument

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

ASHLEY MEDICAL CENTER
Working for a Healthier You

Public Health
Prevent. Promote. Protect.
Walsh County Health District

Ashley Area Health Survey

Ashley Medical Center and McIntosh District Health Unit are interested in hearing from you about community health concerns.

The focus of this effort is to:

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

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

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

Surveys will be accepted through December 15, 2021. Your opinion matters – thank you in advance!

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

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

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

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

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

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

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

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

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

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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): _____

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

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

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

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

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

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

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

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

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

_____

_____

Delivery of Healthcare

12. Considering **GENERAL and ACUTE SERVICES** at Ashley Medical Center hospital, which services are you aware of (or have you used in the past year)? (Choose ALL that apply)

- ☐ Anesthesia services
- ☐ Clinic
- ☐ Emergency room
- ☐ Hospice
- ☐ Hospital (acute care)
- ☐ Mental health services
- ☐ Ophthalmology (eye/vision) (visiting specialist)
- ☐ Surgical services
- ☐ Swing bed and respite care services
- ☐ Telemedicine

13. Considering **SCREENING/THERAPY SERVICES** at Ashley Medical Center hospital, which services are you aware of (or have you used in the past year? (Choose ALL that apply)

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

14. Considering **RADIOLOGY SERVICES** at Ashley Medical Center hospital, which services are you aware of (or have you used in the past year)? (Choose ALL that apply)

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

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

- ☐ Bicycle helmet safety
- ☐ Blood pressure check
- ☐ Breastfeeding resources
- ☐ Car seat program
- ☐ Child health (well baby)
- ☐ Covid-19 Testing (rapid & PCR)
- ☐ Covid-19 Vaccinations
- ☐ Emergency response & preparedness program
- ☐ Flu shots
- ☐ Foot Care
- ☐ Environmental health services (water, sewer, health hazard abatement)
- ☐ Health Tracks (child health screening)
- ☐ Immunizations
- ☐ Medications setup—home visits
- ☐ Office visits and consults
- ☐ School health (vision screening, puberty talks, school immunizations)
- ☐ Preschool education programs
- ☐ Assist with preschool screening
- ☐ Tobacco prevention and control
- ☐ Tuberculosis testing and management
- ☐ WIC (Women, Infants & Children) Program
- ☐ Wellness check with Law Enforcement
- ☐ Youth education programs (First Aid, Bike Safety)

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16. Considering services offered locally by **OTHER PROVIDERS/ORGANIZATIONS** in your community, which services are you aware of (or have you used in the past year)? (Choose ALL that apply)

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

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

_____

_____

18. 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): _____

19. 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): _____

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

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

21. Are you aware of Ashley Medical Center's Foundation, which exists to financially support Ashley Medical Center?

☐ Yes ☐ No

22. Are you aware there are opportunities to provide support through volunteering with the Ashley Medical Center Foundation, Auxiliary, or Board?

☐ Yes ☐ No

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23. Do you believe individuals in the community would financially support any of the following capital improvements by Ashley Medical Center? (Choose ALL that apply)

- ☐ Emergency room renovations
- ☐ Upgrading lighting system
- ☐ New windows/other energy efficiency improvements
- ☐ Replacing heating & cooling system
- ☐ Improvements to patient rooms (e.g., larger bathrooms)
- ☐ Other (Please specify other capital improvements that you believe the community would financially support): _____

Demographic Information: Please tell us about yourself.

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

- ☐ Yes
- ☐ No

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

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

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

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

27. 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

28. 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

29. Sex:

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

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30. Employment status:

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

31. Your zip code: _____

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

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

33. 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

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

_____

_____

Thank you for assisting us with this important survey!

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Appendix D – County Health Rankings Explained

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

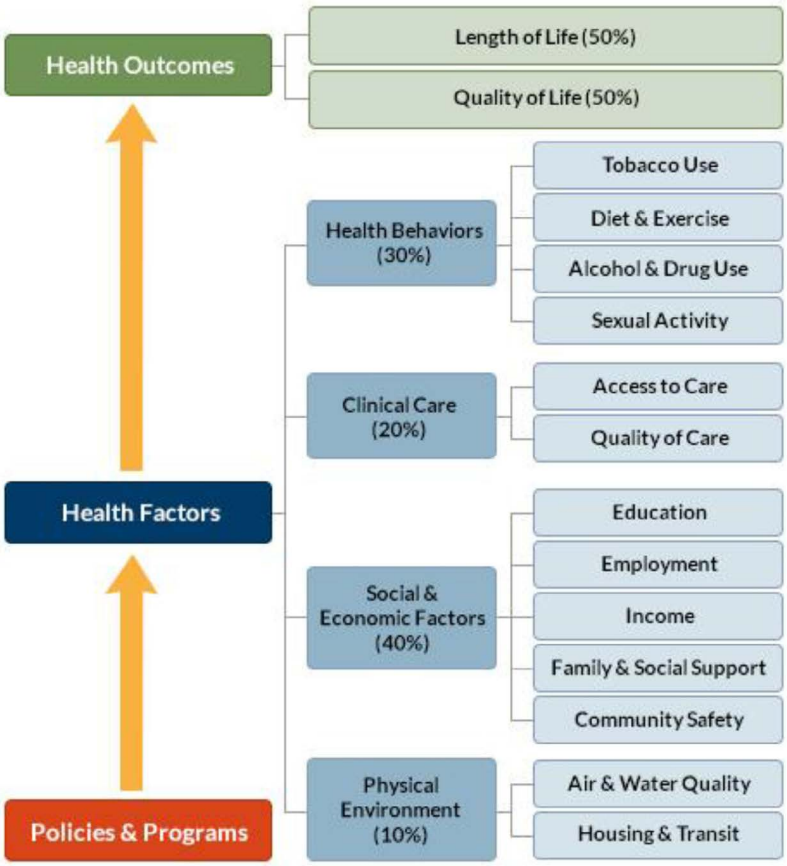
Methods

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

What is Ranked

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

Ranking System



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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.

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Health Outcomes and Factors

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

Health Outcomes

Premature Death (YPLL)

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

Reason for Ranking

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

Poor or Fair Health

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

Reason for Ranking

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

Poor Physical Health Days

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

Reason for Ranking

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

Poor Mental Health Days

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

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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:

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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.

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

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

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

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

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

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

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

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

Reason for Ranking
Evidence suggests teen pregnancy significantly increases the risk of repeat pregnancy and of contracting a STI, both of which can result in adverse health outcomes for mothers, children, families, and communities. A systematic review of the sexual risk among pregnant and mothering teens concludes that pregnancy is a marker for current and future sexual risk behavior and adverse outcomes [1]. Pregnant teens are more likely than older women to receive late or no prenatal care, have eclampsia, puerperal endometritis, systemic infections, low birthweight, preterm delivery, and severe neonatal conditions [2, 3]. Pre-term delivery and low birthweight babies have increased risk of child developmental delay, illness, and mortality [4]. Additionally, there are strong ties between teen birth and poor socioeconomic, behavioral, and mental outcomes. Teenage women who bear a child are much less likely to achieve an education level at or beyond high school, much more likely to be overweight/obese in adulthood, and more likely to experience depression and psychological distress [5-7].

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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-

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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

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

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

Income Inequality

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

Reason for Ranking

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

Children in Single-Parent Households

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

Reason for Ranking

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

Violent Crime Rate

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

Reason for Ranking

High levels of violent crime compromise physical safety and psychological well-being. High crime rates can also deter residents from pursuing healthy behaviors, such as exercising outdoors. Additionally, exposure to crime and violence has been shown to increase stress, which may exacerbate hypertension and other stress-related disorders and may contribute to obesity prevalence.[1] Exposure to chronic stress also contributes to the increased prevalence of certain illnesses, such as upper respiratory illness, and asthma in neighborhoods with high levels of violence.[2]

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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.

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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.

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Appendix E – Youth Behavioral Risk Survey Results

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

	ND 2015	ND 2017	ND 2019	ND Trend ↑, ↓, =	Rural ND Town Average	Urban ND Town Average	National Average 2019
Injury and Violence							
Percentage of students who rarely or never wore a seat belt (when riding in a car driven by someone else)	8.5	8.1	5.9	=	8.8	5.4	6.5
Percentage of students who rode in a vehicle with a driver who had been drinking alcohol (one or more times during the 30 prior to the survey)	17.7	16.5	14.2	=	17.7	12.7	16.7
Percentage of students who talked on a cell phone while driving (on at least one day during the 30 days before the survey, among students who drove a car or other vehicle)	NA	56.2	59.6	=	60.7	60.7	NA
Percentage of students who texted or e-mailed while driving a car or other vehicle (on at least one day during the 30 days before the survey, among students who had driven a car or other vehicle during the 30 days before the survey)	57.6	52.6	53.0	=	56.5	51.8	39.0
Percentage of students who never or rarely wore a helmet (during the 12 months before the survey, among students who rode a motorcycle)	NA	20.6	NA	**NA**	NA	NA	NA
Percentage of students who carried a weapon on school property (such as a gun, knife, or club on at least one day during the 30 days before the survey)	5.2	5.9	4.9	=	6.2	4.2	2.8
Percentage of students who were in a physical fight on school property (one or more times during the 12 months before the survey)	5.4	7.2	7.1	=	7.4	6.4	8.0
Percentage of students who experienced sexual violence (being forced by anyone to do sexual things [counting such things as kissing, touching, or being physically forced to have sexual intercourse] that they did not want to, one or more times during the 12 months before the survey)	NA	8.7	9.2	=	7.1	8.0	10.8
Percentage of students who experienced physical dating violence (one or more times during the 12 months before the survey, including being hit, slammed into something, or injured with an object or weapon on purpose by someone they were dating or going out with among students who dated or went out with someone during the 12 months before the survey)	7.6	NA	NA	**NA**	NA	NA	8.2
Percentage of students who have been the victim of teasing or name calling because someone thought they were gay, lesbian, or bisexual (during the 12 months before the survey)	NA	11.4	11.6	=	12.6	11.4	NA
Percentage of students who were bullied on school property (during the 12 months before the survey)	24.0	24.3	19.9	↓	24.6	19.1	19.5
Percentage of students who were electronically bullied (including being bullied through texting, Instagram, Facebook, or other social media during the 12 months before the survey)	15.9	18.8	14.7	↓	16.0	15.3	15.7
Percentage of students who felt sad or hopeless (almost every day for two or more weeks in a row so that they stopped doing some usual activities during the 12 months before the survey)	27.2	28.9	30.5	=	31.8	33.1	36.7
	ND 2015	ND 2017	ND 2019	ND Trend ↑, ↓, =	Rural ND Town Average	Urban ND Town Average	National Average 2019
Percentage of students who seriously considered attempting suicide (during the 12 months before the survey)	16.2	16.7	18.8	=	18.6	19.7	18.8
Percentage of students who made a plan about how they would attempt suicide (during the 12 months before the survey)	13.5	14.5	15.3	=	16.3	16.0	15.7
Percentage of students who attempted suicide (one or more times during the 12 months before the survey)							
Tobacco Use							
Percentage of students who ever tried cigarette smoking (even one or two puffs)	35.1	30.5	29.3	=	32.4	23.8	24.1

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Percentage of students who smoked a whole cigarette before age 13 years (even one or two puffs)	NA	11.2	NA	**NA**	NA	NA	NA
Percentage of students who currently smoked cigarettes (on at least one day during the 30 days before the survey)	11.7	12.6	8.3	↓	10.9	7.3	6.0
Percentage of students who currently frequently smoked cigarettes (on 20 or more days during the 30 days before the survey)	4.3	3.8	2.1	↓	2.3	1.7	1.3
Percentage of students who currently smoked cigarettes daily (on all 30 days during the 30 days before the survey)	3.2	3.0	1.4	↓	1.6	1.2	1.1
Percentage of students who usually obtained their own cigarettes by buying them in a store or gas station (during the 30 days before the survey among students who currently smoked cigarettes and who were aged <18 years)	NA	7.5	13.2	=	9.4	10.1	8.1
Percentage of students who tried to quit smoking cigarettes (among students who currently smoked cigarettes during the 12 months before the survey)	NA	50.3	54.0	=	52.8	51.4	NA
Percentage of students who currently use an electronic vapor product (e-cigarettes, vape e-cigars, e-pipes, vape pipes, vaping pens, e-hookahs, and hookah pens at least one day during the 30 days before the survey)	22.3	20.6	33.1	↑	32.2	31.9	32.7
Percentage of students who currently used smokeless tobacco (chewing tobacco, snuff, or dip on at least one day during the 30 days before the survey)	NA	8.0	4.5	↓	5.7	3.8	3.8
Percentage of students who currently smoked cigars (cigars, cigarillos, or little cigars on at least one day during the 30 days before the survey)	9.2	8.2	5.2	↓	6.3	4.3	5.7
Percentage of students who currently used cigarettes, cigars, or smokeless tobacco (on at least one day during the 30 days before the survey)							
Alcohol and Other Drug Use							
Percentage of students who ever drank alcohol (at least one drink of alcohol on at least one day during their life)	62.1	59.2	56.6	=	60.6	54.0	NA
Percentage of students who drank alcohol before age 13 years (for the first time other than a few sips)	12.4	14.5	12.9	=	16.4	13.2	15.0
Percentage of students who currently drank alcohol (at least one drink of alcohol on at least one day during the 30 days before the survey)	30.8	29.1	27.6	=	29.4	25.4	29.2
Percentage of students who currently were binge drinking (four or more drinks of alcohol in a row for female students, five or more for male students within a couple of hours on at least one day during the 30 days before the survey)	NA	16.4	15.6	=	17.2	14.0	13.7
Percentage of students who usually obtained the alcohol they drank by someone giving it to them (among students who currently drank alcohol)	41.3	37.7	NA	**NA**	NA	NA	40.5
	ND 2013	ND 2017	ND 2019	ND Trend ↑, ↓, =	Rural ND Town Average	Urban ND Town Average	National Average 2019
Percentage of students who tried marijuana before age 13 years (for the first time)	5.3	5.6	5.0	=	5.5	5.1	5.6
Percentage of students who currently used marijuana (one or more times during the 30 days before the survey)	15.2	15.5	12.5	=	11.4	14.1	21.7
Percentage of students who ever took prescription pain medicine without a doctor's prescription or differently than how a doctor told them to use it (counting drugs such as codeine, Vicodin, OxyContin, Hydrocodone, and Percocet, one or more times during their life)	NA	14.4	14.5	=	12.8	13.3	14.3
Percentage of students who were offered, sold, or given an illegal drug on school property (during the 12 months before the survey)							
Percentage of students who attended school under the influence of alcohol or other drugs (on at least one day during the 30 days before the survey)	NA	NA	NA	NA	NA	NA	NA
Sexual Behaviors							
Percentage of students who ever had sexual intercourse							

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Percentage of students who had sexual intercourse before age 13 years (for the first time)	2.6	2.8	NA	NA	NA	NA	3.0
Weight Management and Dietary Behaviors							
Percentage of students who were overweight (>= 85th percentile but <95th percentile for body mass index, based on sex and age-specific reference data from the 2000 CDC growth chart)	14.7	16.1	16.5	=	16.6	15.6	16.1
Percentage of students who had obesity (>= 95th percentile for body mass index, based on sex- and age-specific reference data from the 2000 CDC growth chart)	13.9	14.9	14.0	=	17.4	14.0	15.5
Percentage of students who described themselves as slightly or very overweight	32.2	31.4	32.6	=	35.7	33.0	32.4
Percentage of students who were trying to lose weight	NA	44.5	44.7	=	46.8	45.5	NA
Percentage of students who did not eat fruit or drink 100% fruit juices (during the seven days before the survey)	3.9	4.9	6.1	=	5.8	5.3	6.3
Percentage of students who ate fruit or drank 100% fruit juices one or more times per day (during the seven days before the survey)	NA	61.2	54.1	↓	54.1	57.2	NA
Percentage of students who did not eat vegetables (green salad, potatoes [excluding French fries, fried potatoes, or potato chips], carrots, or other vegetables, during the seven days before the survey)	4.7	5.1	6.6	=	5.3	6.6	7.9
Percentage of students who ate vegetables one or more times per day (green salad, potatoes [excluding French fries, fried potatoes, or potato chips], carrots, or other vegetables, during the seven days before the survey)	NA	60.9	57.1	↓	58.2	59.1	NA
Percentage of students who did not drink a can, bottle, or glass of soda or pop (such as Coke, Pepsi, or Sprite, not including diet soda or diet pop, during the seven days before the survey)	NA	28.8	28.1	=	26.4	30.5	NA
Percentage of students who drank a can, bottle, or glass of soda or pop one or more times per day (not including diet soda or diet pop, during the seven days before the survey)	18.7	16.3	15.9	=	17.4	15.1	15.1
Percentage of students who did not drink milk (during the seven days before the survey)	13.9	14.9	20.5	↑	14.8	20.3	30.6
Percentage of students who drank two or more glasses per day of milk (during the seven days before the survey)	NA	33.9	NA	NA	NA	NA	NA
Percentage of students who did not eat breakfast (during the seven days before the survey)							
Percentage of students who most of the time or always went hungry because there was not enough food in their home (during the 30 days before the survey)	NA	2.7	2.8	=	2.1	2.9	NA
	ND 2015	ND 2017	ND 2019	ND Trend ↑, ↓, =	Rural ND Town Average	Urban ND Town Average	National Average 2019
Physical Activity							
Percentage of students who were physically active at least 60 minutes per day on 5 or more days (doing any kind of physical activity that increased their heart rate and made them breathe hard some of the time during the seven days before the survey)							
Percentage of students who watched television three or more hours per day (on an average school day)	18.9	18.8	18.8	=	18.3	18.2	19.8
Percentage of students who played video or computer games or used a computer three or more hours per day (counting time spent on things such as Xbox, PlayStation, an iPad or other tablet, a smartphone, texting, YouTube, Instagram, Facebook, or other social media, for something that was not school work on an average school day)	38.6	43.9	45.3	=	48.3	45.9	46.1
Other							
Percentage of students who had eight or more hours of sleep (on an average school night)	NA	31.8	29.5	=	31.8	33.1	NA

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Appendix F – Prioritization of Community's Health Needs

Community Health Needs Assessment

Ashley, North Dakota

Ranking of Concerns

The top concerns for each of the six topic areas, based on the community survey results, were listed in an online survey for meeting participants to rank. The numbers below indicate the total number of votes by the people in attendance at the second community meeting. The "Priorities" column lists the number of votes for the concerns indicating which areas are felt to be priorities. Each person was given four votes. During this online prioritization, votes were taken in regard to the items they felt were priorities. The "Most Important" column lists the number of votes for each category. After the first round of voting, the top four priorities were selected based on the highest number of votes. Each person was given one vote to place on the item they felt was the most important priority of the top four highest ranked priorities.

	Priorities	Most Important
COMMUNITY/ENVIRONMENTAL HEALTH CONCERNS		
Attracting & retaining young families	7	2
Not enough jobs with livable wages	5	1
Having enough child daycare services	3	
Changes in population size	4	1
AVAILABILITY/DELIVERY OF HEALTH SERVICES CONCERNS		
Ability to get appointments for health services within 48 hours	0	
Cost of health insurance	2	
Availability of dental care	1	
Not enough healthcare staff in general	4	6
YOUTH POPULATION HEALTH CONCERNS		
Alcohol use and abuse - **All Ages**	1	
Depression/anxiety – **All Ages**	0	
Drug use and abuse (including prescription drugs)	0	
Not enough activities for children and youth	0	
Smoking and tobacco use, exposure to secondhand smoke, or vaping	0	
ADULT POPULATION HEALTH CONCERNS		
Not getting enough exercise/physical activity - Adult Population	2	
Diabetes - Adult Population	0	
Stress - Adult Population	1	
SENIOR POPULATION HEALTH CONCERNS		
Assisted living options -	3	
Availability of Home Health-	2	
Availability of resources to help elderly stay in their homes-	2	
Cost of long-term/nursing home care	0	
VIOLENCE CONCERNS		
Bullying/cyber-bullying (all ages)	0	
Emotional abuse	0	

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Appendix G – 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:
    - People are involved, but 95% is based round drinking
    - Look out for each other
2. Considering the SERVICES AND RESOURCES in your community, the best things are: "Other" responses:
    - None, the ones we have are horrible
    - Ashley needs to have someone to come in to people's homes to check on them, make sure they are taking their medications so they can stay at their homes as long as they can. There is no one to do that.
4. Considering the ACTIVITIES in your community, the best things are: "Other" responses:
    - We have none of these
    - There are zero fitness opportunities, no gyms or programs available. There is local events and festivals but again a majority it based around drinking.
    - We have none

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

6. Considering the AVAILABILITY/DELIVERY OF HEALTH SERVICES in your community, concerns are: "Other" responses:
    - Letting great NP go to save money when others should go first
    - Not retaining a great NP when they have one

8. Considering the YOUTH POPULATION in your community, concerns are: "Other" responses:
    - Lack of two parent homes and guidance/Church attendance
10. Considering the SENIOR POPULATION in your community, concerns are: "Other" responses:
    - Cost of prescriptions
11. What single issue do you feel is the biggest challenge facing your community?
    - Aging population
    - Decreasing population
    - Cost of prescription drugs
    - Home health services
    - The growth of people needing housing, limited jobs, and lower wages.
    - Bullying my other kids and school staff!!! And the availability of fresh fruit and vegetables and high grocery prices
    - Lack of medical staff
    - Lack of workers
    - Price of health care and meds

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- Clinic not scheduling people for 7–10 days if they knew how many patients most clinic providers see it comes as a joke for the way our clinic is run
- We are an elderly community and therefore there are not enough volunteers to keep churches and organizations going. The middle aged are not that involved or have kids in school and are busy. We really need a nice assisted living for those who do not need a nursing home. Also, they are not utilizing the medical personal in the community like a great NP just to hold on to old, nonproductive, non-money-making employees.

Delivery of Healthcare

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

- Optometry
- 24/7 secure access to exercise for the community not just students
- Home health
- Specialist
- Evening hours until 7 pm at least twice a week
- Eye doctor and dentist
- In home care for Elderly
- MD's, vision
- Home Health
- Dental & Eye Dr
- Eye exams eye doctor, assisted living
- Home Health

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

- We have enough local providers many times no patients and full staff

18. Do you believe individuals in the community would financially support any of the following capital improvements by Ashley Medical Center? "Other" responses:

- AMC needs a new facility. This place is literally falling apart
- Assisted living establishment
- Floor by ER needs to be replaced. Walls by door 2 area look awful

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

- Retain local, homegrown, providers
- difficult to schedule an appointment after 3 pm or prior to 9 am.
- Our community would benefit greatly with some type of home health / in home care services or assisted living
- Need to have clinic run more efficiently many days no patients in waiting room and yet can't get an appointment. Providers seem to have a lot of days off.
- They need to be more on the ball about getting grants and other funding that is available. They also need better activities directors so the residents have a better quality of life. Also, they need to think about the community and not their own feelings and get a more business qualified board.

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