Community Health Needs Assessment

Linton Regional Medical Center Service Area
Linton, North Dakota

2023

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Executive Summary

To help inform future decisions and strategic planning, Linton Regional Medical Center (LRMC) conducted a Community Health Needs Assessment (CHNA) in 2023, the previous CHNA having been conducted in 2020. 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. Eighty-three LRMC service area residents completed the survey. Additional information was collected through four key informant interviews with community members. The input from the residents, who primarily reside in Emmons 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, Emmons County's population from 2020 to 2021 decreased by 0.9%. The average number of residents younger than age 18 (20.5%) for Emmons County comes in 3.5 percentage points lower than the North Dakota average (24%). The percentage of residents ages 65 and older is almost 12% higher for Emmons County (27.9%) than the North Dakota average (16.1%), and the rate of education is lower for Emmons County (88.7%) than the North Dakota average (93.3%). The median household income in Emmons County ($56,713) is much lower than the state average for North Dakota ($68,131).

Data, compiled by County Health Rankings, show Emmons County is doing better than North Dakota in health outcomes/factors for eight categories.

Emmons County, according to County Health Rankings data, is 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 83 LRMC service area residents who completed the survey indicated the following ten needs as the most important:

- Ability to retain primary care providers in the community
- Alcohol use and abuse – youth and adult
- Attracting and retaining young families
- Availability of mental health services
- Availability of resources to help the elderly stay in their homes
- Bullying/cyberbullying
- Drug use and abuse – youth and adult
- Having enough child daycare services
- Not enough jobs with livable wages
- Youth smoking and tobacco use (second-hand smoke)

The survey also revealed the biggest barriers to receiving healthcare (as perceived by community members). They included concerns about confidentiality (N=16), not affordable (N=14), and no insurance or limited insurance (N=10).

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

- Family-friendly, safe place to live
- Feeling connected to people who live here
- Healthcare
- People who live here are involved in their community
- People are friendly, helpful, and supportive
- Active faith community

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

- Alcohol use and abuse – youth and adult
- Availability of mental health services
- Availability of resources to help the elderly stay in their homes
- Cost of long-term/nursing home care
- Depression/anxiety – youth and adult
- Drug use and abuse – adult
- Having enough child daycare services
- Smoking and tobacco use (second-hand smoke) – youth
- Substance use disorder treatment services

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), Linton Regional Medical Center (LRMC) completed a Community Health Needs Assessment (CHNA) of the LRMC service area. The hospital identifies its service area as Emmons County in its entirety and portions of Campbell County, South Dakota. Many community members and stakeholders worked together on the assessment.

LRMC is licensed as a Critical Access Hospital (CAH) with three provider-based rural health clinics. The Linton Clinic is attached to the LRMC, the Hazelton Clinic is located 16 miles to the north in Hazelton, North Dakota, and the Campbell County Clinic is located 33 miles to the south in Herreid, South Dakota. Linton is located in south central North Dakota, 65 miles southeast of Bismarck, North Dakota and 25 miles north of the South Dakota border.

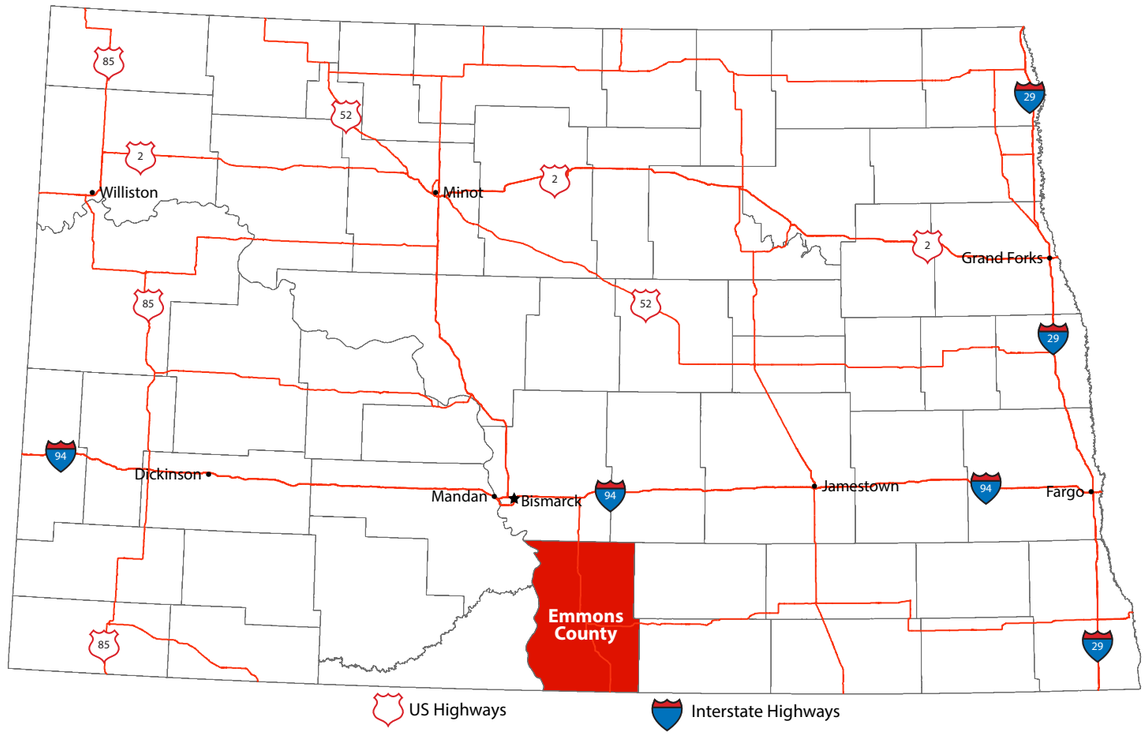
Along with the hospital, the economy is based on agri-business, service industries, and retail trade. According to the U.S. Census Bureau's decennial 2020 census, Emmons County has a population of 3,301, which is a decrease of 249 from the 2010 census. The racial makeup of the county is 96.3% white. Linton is the county seat, and its 2020 population was 1071, a decrease of 26 from the 2010 census. 2020's median household income was $56,713, and there were 1,507 households, down from 1,594 in 2010. Emmons County is 1,555 square miles of land located in south central North Dakota.

Other healthcare facilities and services in Emmons County include the following: a pharmacy, optometrist, dentist, two chiropractors, two massage therapists, a long-term healthcare center, and an assisted living facility. The Emmons County Public Health Department is located on the hospital campus. Home services available in Emmons County include Meals on Wheels, Dakota Travel Nurse Home Care, Home Help provided through Social Services (bathing, light cleaning, laundry, cooking, grocery shopping), Hospice Red River Valley, Hands of Angels Home Healthcare and Staffing, varied free home equipment (toilet risers, life alert buttons) through the Linton Senior Center, and private service providers for non-medical needs.

Emmons County has a number of community assets and resources that can be mobilized to address population health improvement. In terms of physical assets and features, the community includes a bike/walking path, fitness center, swimming pool, city park, golf course, and a baseball/softball diamond. To the north of Linton, Appert Lake National Wildlife Refuge and Long Lake National Refuge offer excellent birding and fishing opportunities. The Missouri River is within a short drive of Linton and offers boating, fishing, swimming, and camping. The area's terrain is suitable for cross country skiing, snowmobiling, and hunting. Pheasant, grouse, turkey, antelope, and deer abound in the area as well as a variety of raptors, waterfowl, and songbirds. Emmons County also offers cultural attractions, such as the Emmons County Museum, located in Linton and pays tribute to the early history of the region and the Lawrence Welk Homestead outside Strasburg, North Dakota.

Linton offers public transportation to and from surrounding areas through South Central Transit. Hazelton, Strasburg, and Linton all have grocery stores, while Linton's offers delivery services. Linton is also home to a pharmacy that has curb-side pick-up and home delivery via USPS. The communities of Linton, Hazelton, and Strasburg offer k-12 education with pre-K education also being available in Linton and Strasburg. Some licensed as well as unlicensed daycares are available in the area.

Figure 1: Pembina County



Linton Regional Medical Center

LRMC was opened in 1953 by the Seven Sisters of St. Francis of Tiffin, Ohio, and it was managed by them until an administrator was hired in 1962. It is one of the most important assets in the community and the largest charitable organization in the Linton area. LRMC includes a 14-bed CAH located in Linton. The National Rural Health Association named LRMC as a top 100 CAH for 2017, 2018, 2019, 2020, and 2021 as well as a top 20 CAH in 2019 and 2021. As a hospital and designated Level V trauma center, as well as a certified Acute Stroke Ready Hospital by the American Heart Association, the hospital provides comprehensive care for a

wide range of medical and emergency situations. LRMC also has three affiliated clinics. The Hazelton Clinic in Hazelton, North Dakota and the Linton Clinic in Linton, North Dakota offer health services to Emmons County, North Dakota as well as surrounding areas, and the Campbell County Clinic, located in Herreid, South Dakota, offers health services to Campbell County, South Dakota. LRMC and clinics provide comprehensive medical care with physician and mid-level medical providers and consulting/visiting medical providers. With nearly 110 employees, LRMC is the largest employer in the region. It has one full-time physician, three nurse practitioners, two physician assistants, and nine registered nurses for a combined total of 15 healthcare providers. As of 2017, LRMC had a total labor income impact of $4.7 million. The CAH Profile for LRMC includes a summary of hospital-specific information and is available in Appendix A.

LRMC has a significant economic impact on the region. In 2020, when the economic impact analysis was calculated, they directly employed 63.82 FTE employees with an annual payroll of over $4.4 million (including benefits). These employees create an additional 26 jobs and nearly $1.27 million in income, as they interact with other sectors of the local economy. This economy results in a total impact of 90 jobs and more than $5.68 million in income. Additional information is provided in Appendix B.

Mission

The mission of the LRMC is to enhance the health, well-being, and quality of life of the people we serve. This will be achieved through a philosophy which values and supports:

- Quality and continuous improvements in patient care
- Professionalism, education, and career development of our staff
- Responsible, efficient, and effective use of our resources
- Respect for the contribution each staff member/volunteer makes to the delivery of patient care
- Recognize the rights of patients, families, public, staff, and allied professionals to be treated in a dignified, courteous, confidential, and respectful manger
- A strong commitment through service and education to the people and communities we serve

Vision

We will focus on primary healthcare services and the development of our skills to provide the best possible service and to improve the healthcare of the people that we serve.

We will continue to adapt to the ever-changing needs of the people we serve, recognizing that public information and education will be an integral part of our services.

Services offered locally by LRMC include:

General and Acute Services

- Acne treatment
- Allergy, flu, and pneumonia shots
- Ambulance-24/7 ALS ambulance service
- Cardiology (visiting provider)
- Clinic
- Diabetic Education
- Drug testing
- Emergency room services-including eEmergency
- Hospital (acute care)
- Mole/wart/skin lesion removal
- Nutrition counseling
- OB/GYN (visiting provider)
- Orthopedics (visiting provider)
- Pharmacy
- Physicals: annuals, D.O.T., sports, and insurance
- Podiatry (visiting provider) – evaluation and surgery
- Prenatal care
- Stress Testing
- Surgical services—biopsies
- Surgical services—outpatient
- Swing bed services

Screening/Therapy Services

- Chronic disease management
- Zio patch cardiac monitoring device
- Laboratory services
- Lower extremity circulatory assessment
- Occupational physicals
- Occupational therapy
- Pediatric services
- Physical therapy-including sports preventative and post-injury, dry needling
- Respiratory care
- Sleep studies (visiting service)
- Social services

Radiology Services

- Bone Density
- CT scan
- 3D mammography
- Echocardiograms
- EKG
- General X-ray
- MRI (mobile unit)

Laboratory Services

- Blood types
- Clot times
- Chemistry
- Hematology Microbiology
- Urine testing

Services Offered by OTHER Providers/Organizations

- Assisted Living
- Chiropractic services
- Dental services
- Fitness Center
- Massage therapy
- Optometric/vision services
- Personal Training
- Pharmacy

Emmons County Public Health

Emmons County Public Health (ECPH) provides comprehensive public health services to the residents of Emmons County and surrounding areas. Located in south central North Dakota, ECPH is a single county district health unit. The health unit was organized in 1983 to fill a necessary void of much needed community health and nursing services. They are governed by a local Board of Health and have a local Health Officer, all appointed by the Emmons County Commissioners. A staff of three registered nurses, an administrative assistant, and a contract for environmental health services compose the public health office. The public health services are available Monday through Friday.

The public health office works collaboratively with other health and community partners in Emmons County. Referrals are accepted from healthcare providers, other community agencies, or self-referrals. Public health services include in-home nursing services with medication management, monthly senior citizen health maintenance clinics, routine infant, child, and adult immunizations, school nursing, rapid inspection, Health Tracks screenings, newborn home visits, well child checks, lifestyle coaching, health education and promotion,

tobacco prevention and cessation programs, substance use prevention, environmental health, and WIC (Women, Infant, Children) services. Emergency preparedness activities include pandemic and other public health emergencies planning as well as testing and vaccinating for COVID-19. The nursing staff also serve on many local committees, such as child protection, Interagency, school advisory committees, statewide SACCHO (State Association of County and City Officials), and public health association.

Funding for public health services comes from a variety of funding sources, including local mill levy county funds, state and federal funding, and competitive applicable grants. Client donations are accepted for services, but no one is refused services due to inability to pay.

Specific services that ECPH provides are:

- Blood pressure screenings and education
- Breastfeeding resources and education
- Car safety seat program
- Child health (Healthy baby clinics)
- Correction facility health-resource only for Sheriff's Dept.
- Diabetes screening at monthly senior citizen clinics and anytime in the office
- Emergency Preparedness services – work with community partners as part of local emergency response team/COVID testing, education, and vaccination
- Environmental Health Services (water, sewer, health hazard abatement, public nuisances)
- Flu shots
- Footcare – home or community setting
- Heart Health Education
- Health Tracks (child health screening – Medicaid participants)
- Home health – In-home nursing care for elderly and disabled
- Immunizations – for infants, children, and adults
- Life-style coaching classes for diabetes Prevention
- Medication setup – home visits
- Member of Child Protection Team and County Interagency Team
- Newborn home visits
- Preschool education programs and screening
- School health – hearing, health education, and resource to the schools
- Substance abuse prevention
- Tobacco prevention, cessation, and control
- Tuberculosis monitoring
- WIC (Women, Infants, and Children) Program
- Worksite Wellness – Coordinator for County Employees and Sheriff's Dept.
- Youth education programs (first aid, bike safety, babysitting classes, farm safety, etc)

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.

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 Emmons County. In addition to Linton, located in the service area, are the communities of Braddock, Hazelton, Strasburg, Hague, and Westfield.

The Center for Rural Health (CRH), in partnership with Linton Regional Medical Center (LRMC) and Emmons County Public Health (ECPH), 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 LRMC. 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. Twelve people, representing a cross section demographically, attended the focus group meeting. The meeting was highly interactive with good participation. LRMC staff and board members were in attendance as well but largely played a role of listening and learning.

Figure 2: Steering Committee

Sandy Meidinger	Board President/teacher, LRMC, Linton Public School
Lisa Edholm-Moch	Administrator/RN, ECPH
Kasandra Wald	Chief Nursing Officer, LRMC
Liz Hanson	Quality and Compliance Manager, LRMC

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

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

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

CRH is one of the nation's most experienced organizations, committed to providing leadership in rural health. Its mission is to connect resources and knowledge to strengthen the health of people in rural communities. 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 University of North Dakota (UND) School of Medicine & Health Sciences (SMHS) 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 twelve community members, was convened and first met on August 10, 2023. 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 October 17, 2023, with six 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 Emmons 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 LRMC and ECPH. They included representatives of the health community, business community, law enforcement, education, faith community, and social service agencies. Not all members of the group were present at both meetings.

Interviews

Four key informant interviews were conducted over the phone in August and September of 2023. 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.

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

Survey

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

The community member survey was distributed to various residents of Emmons County, which are all included in the LRMC service area. The survey tool was designed to:

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

Specifically, the survey covered the following topics:

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

To promote awareness of the assessment process, press releases led to published articles in the Emmons County Record. Additionally, information was published on the LRMC's website and Facebook page. Fliers were also placed in area businesses.

Approximately 50 community member paper surveys were available for distribution in Emmons County. The surveys were available at the LRMC and satellite clinics.

To help ensure anonymity, included with each survey was a postage-paid return envelope to CRH. In addition, to help make the survey as widely available as possible, residents also could request a survey by calling LRMC or ECPH. The survey period ran from August 1, 2023 to August 25, 2023. Three completed paper surveys were returned.

Area residents were also given the option of completing an online version of the survey, which was publicized in the Emmons County Record, on fliers in area businesses, and on the LRMC website and Facebook page. Eighty online surveys were completed. Three of those online respondents used the QR code to complete the survey. In total, counting both paper and online surveys, 83 community member surveys were completed, equating to an 8% response rate. This response rate is low for this type of unsolicited survey methodology.

Secondary Data

Secondary data were collected and analyzed to provide descriptions of: (1) population demographics, (2) general health issues (including any population groups with particular health issues), and (3) contributing causes of community health issues. Data were 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; the National Survey of Children's Health, which touches on multiple intersecting aspects of children's lives; 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; and Youth Risk Behavior Surveillance System (YRBSS) data, which is published by the Centers for Disease Control and Prevention.

Social Determinants of Health

Social determinants of health are, according to the World Health Organization,

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

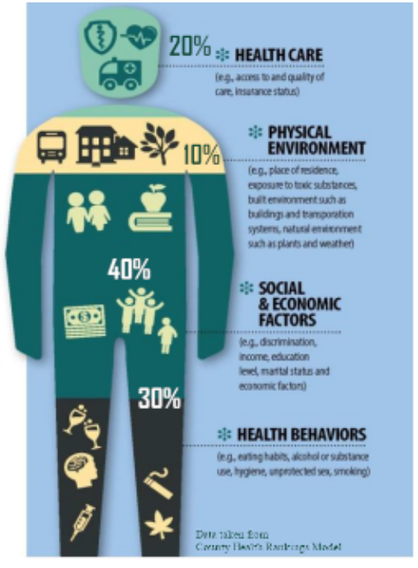
Income-level, educational attainment, race/ethnicity, and health literacy all impact the ability of people to access health services. Basic needs such as clean air and water and safe and affordable housing are all essential to staying healthy and are also impacted by the social factors listed previously.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

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

For Figure 3, data have 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 CHNA 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



In Figure 3, the 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, at https://www.ruralhealthinfo.org/topics/social-determinants-of-health.

Figure 4: Social Determinants of Health

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

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

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Demographic Information

TABLE 1: Emmons County

	Emmons County	North Dakota
Population (2021)	3,271	779,261
Population change (2020-2021)	0.9%	2.2%
People per square mile (2010)	2.2	9.7
Persons 65 years or older (2020)	27.9%	16.1%
Persons younger than age 18 (2020)	20.5%	24%
Median age (2020)	52.1	35.8
White persons (2020)	94.6%	83.2%
High school graduates (2020)	88.7%	93.3%
Bachelor's degree or higher (2020)	18%	31.1%
Live below poverty line (2020)	13.3%	11.1%
Persons without health insurance, under age 65 years (2019)	9.4%	9.2%
Language other than English spoken at home (2021)	70.3%	84.2%

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

As the population of North Dakota has grown in recent years, Emmons County has also seen an increase in population since 2020. The U.S. Census Bureau estimates show that Emmons County's population increased from 3,187 (2020) to 3,271 (2021).

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

The data used in the 2023 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 2023 County Health Rankings – a flow chart of how a county's rank is determined – may be found in Appendix D. For further information, visit the County Health Rankings website at www.countyhealthrankings.org.

Table 2 summarizes the pertinent information gathered by County Health Rankings as it relates to Pembina 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 Pembina County Public Health (PCPH) and Pembina County Memorial Hospital (PCMH) 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 2023. 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).

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

Emmons County rankings within the state are included in the summary following. For example, Emmons County ranks 21st out of 48 ranked counties in North Dakota on health outcomes and 42nd out of 48 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 Emmons County is doing better than many counties, compared to the rest of the state, on two of the outcomes, landing at or above rates for other North Dakota counties. However, like many North Dakota counties, Emmons County is doing poorly in many areas when it comes to the U.S. Top 10% ratings.

On health factors, Emmons County performs below the North Dakota average for counties in several areas as well.

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

- Poor or fair health rate
- Low birth weight rate
- Adult obesity
- Excessive drinking
- Alcohol-impaired driving deaths
- Children in single-parent households
- Severe housing problems
- Air pollution (particulate matter)

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

- Poor physical health days (in past 30 days)
- Poor mental health days (in past 30 days)
- Adult smoking
- Food environment index
- Physical inactivity
- Uninsured
- Primary care physicians to patient ratio
- Dentists to patient ratio
- Preventable hospital stays
- Mammography screening (% of Medicare enrollees ages 65-74 receiving screening)
- Flu vaccinations (% of fee-for-service Medicare enrollees receiving vaccination)
- Unemployment
- Children in poverty
- Income inequality
- Social associations
- Injury deaths

● = 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* 2023 – EMMONS COUNTY

	Emmons County	U.S. Top 10%	North Dakota
Ranking: Outcomes	**21st**		**(of 48)**
Premature death		7,300	7,100
Poor or fair health	12% +	12%	12%
Poor physical health days (in past 30 days)	2.9 ●	3.0	2.6
Poor mental health days (in past 30 days)	3.7 ●	4.4	3.6
Low birth weight	5%+	8%	7%
Ranking: Factors	**42nd**		**(of 48)**
Health Behaviors			
Adult smoking	19% ●■	16%	18%
Adult obesity	34% ■	32%	34%
Food environment index (10=best)	8.3 ●	7.0	9.1
Physical inactivity	26% ●■	22%	25%
Access to exercise opportunities	2% ●■	84%	73%
Excessive drinking	23% ■	19%	23%
Alcohol-impaired driving deaths	33% ■	27%	41%
Sexually transmitted infections		481.3	467.4
Teen birth rate		19	18
Clinical Care			
Uninsured	9% ●	10%	8%
Primary care physicians	1,590:1 ●■	1,310:1	1,290:1
Dentists	3,270:0 ●■	1,380:1	1,440:1
Mental health providers		380:1	470:1
Preventable hospital stays	3,564 ●■	2,809	2,687
Mammography screening (% of Medicare enrollees ages 65-74 receiving screening)	35% ●■	37%	49%
Flu vaccinations (% of fee-for-service Medicare enrollees receiving vaccination)	36% ●■	51%	52%
Social and Economic Factors			
Unemployment	4.6% ●	5.4%	3.7%
Children in poverty	16% ●	17%	12%
Income inequality	5.4 ●■	4.9	4.5
Children in single-parent households	4% +	25%	19%
Social associations	9.4 ●	9.1	15.3
Injury deaths	134 ●■	76	72
Physical Environment			
Air pollution – particulate matter	4.8 +	7.4	5.0
Drinking water violations	No		
Severe housing problems	9% +	17%	12%

Source: http://www.countyhealthrankings.org/app/north-dakota/2022/rankings/outcomes/overall

Children's Health

The National Survey of Children's Health touches on multiple intersecting aspects of children's lives. Data are not available at the county level; listed below is information about children's health in North Dakota. The full survey includes physical and mental health status, access to quality healthcare, and information on the child's family, neighborhood, and social context. Data are from 2020-21. 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), 2020/21

Health Status	North Dakota	National
Children born premature (3 or more weeks early)	9.2%	11.4%
Children ages 10-17 overweight or obese	29.0%	33.4%
Children ages 0-5 who were ever breastfed	82.0%	81.6%
Children ages 6-17 who missed 11 or more days of school	3.3%	3.8%
Healthcare		
Children currently insured	91.2%	91.4%
Children who spent less than 10 minutes with the provider at a preventive medical visit	16.9%	18.0%
Children (1-17 years) who had preventive a dental visit in the past year	75.9%	78.6%
Children (3-17 years) received mental healthcare	11.1%	11%
Children (3-17 years) with problems requiring treatment did not receive mental healthcare	4.7%	5.4%
Young children (9-35 mos.) receiving standardized screening for developmental problems	41.2%	34.8%
Family Life		
Children whose families eat meals together four or more times per week	76.1%	75.8%
Children who live in households where someone smokes	16.9%	13.8%
Neighborhood		
Children who live in neighborhoods with parks or playgrounds	34.9%	35.5%
Children living in neighborhoods with poorly kept or rundown housing	2.2%	4.2%
Children living in neighborhood that's usually or always safe	98.3%	94.8%

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 currently insured
- Children (1-17 years) who had preventive dentist visit in the past year
- Children living in smoking households
- Children who live in neighborhoods with parks or playgrounds

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. 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 Emmons County is performing more poorly than the North Dakota average on all but three of the examined measures. The most notable measurement is children in poverty, which is almost 5% higher than the state average.

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

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

	Emmons County	North Dakota
Uninsured children (% of population age 0-18), 2021	10.4%	7.5%
Uninsured children below 200% of poverty (% of population), 2021	16.4%	11.8%
Medicaid recipient (% of population age 0-20), 2022	27.7%	28.8%
Children enrolled in Healthy Steps (% of population age 0-18), 2020	1.7%	2.2%
Supplemental Nutrition Assistance Program (SNAP) recipients (% of population age 0-18), 2020	11.0%	16.4%
Licensed childcare capacity (% of population age 0-13), 2020	38%	40%
4-year high school cohort graduation rate, 2021/22	90%	84.3%

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 2017, 2019, and 2021. 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 2019 to 2021, and "↓" for a decreased trend in the data changes from 2019 to 2021. The final column shows the 2021 national average percentage. For a more complete listing of the YRBS data, see Appendix E.

Table 5. Youth Risk Behavior Survey Results

North Dakota High School Survey

Rate Increase ↑, rate decrease ↓, or no statistical change = in rate from 2019-2021.

	ND 2017	ND 2019	ND 2021	ND Trend ↑, ↓, =	Rural ND Town Average	Urban ND Town Average	National Average 2021
Injury and Violence							
% of students who rarely or never wore a seat belt (when riding in a car driven by someone else)	8.1	5.9	49.6	↑	9.2	5.5	39.9
% 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)	16.5	14.2	13.1	=	18.2	13.7	14.1
% of students who talked on a cell phone while driving (on at least one day during the 30 days before the survey)	56.2	59.6	5.0	↓	64.9	64.2	NA
% of students who texted or emailed while driving a car or other vehicle (on at least one day during the 30 days before the survey)	52.6	53.0	55.4	=	59.9	55.9	36.1
% of students who were in a physical fight on school property (one or more times during the 12 months before the survey)~2017/2019~ *in 2021 replaced by* % of students who carried a weapon on school property (such as a gun, knife, or club, on at least 1 day during the 30 days before the survey)	7.2	7.1	5.0	↓	6.2	4.4	3.0
% 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)	8.7	9.2	9.4	=	9.7	11.6	11
% of students who were bullied on school property (during the 12 months before the survey)	24.3	19.9	15.8	↓	19.8	15.0	15.0
% of students who were electronically bullied (includes texting, Instagram, Facebook, or other social media ever during the 12 months before the survey)	18.8	14.7	13.6	↓	16.2	14.5	15.9
% of students who made a plan about how they would attempt suicide (during the 12 months before the survey)	14.5	15.3	14.8	=	15.1	17.2	17.6
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)	20.6	33.1	21.2	↓	24.2	23.6	18.0
% of students who currently used cigarettes, cigars, or smokeless tobacco (on at least one day during the 30 days before the survey)	18.1	12.2	5.9	↓	8.0	6.1	3.8
% 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)	16.4	15.6	14.0	=	17.8	14.6	10.5
% of students who currently used marijuana (one or more times during the 30 days before the survey)	15.5	12.5	10.7	=	10.2	12.9	15.8
% 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)	14.4	14.5	10.2	↓	9.7	11.0	12.2
Weight Management, Dietary Behaviors, and Physical Activity							
% of students who were overweight (>= 85th percentile but <95th percentile for body mass index)	16.1	16.5	15.6	=	15.5	14.2	16.0
% of students who had obesity (>= 95th percentile for body mass index)	14.9	14.0	16.3	=	17.4	15.0	16.3
% of students who did not eat fruit or drink 100% fruit juices (during the seven days before the survey)	4.9	6.1	5.0	=	5.7	4.6	7.7
% 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)	5.1	6.6	5.9	=	5.3	6.2	9.3
% 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)	16.3	15.9	16.6	=	17.5	13.8	14.7
% of students who did not drink milk (during the seven days before the survey)	14.9	20.5	26.2	↑	21.2	29.4	35.7
% of students who did not eat breakfast (during the seven days before the survey)	13.5	14.4	15.1	=	14.5	17.3	22.0
% 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)	2.7	2.8	2.1	=	2.2	2.1	NA
% of students who were physically active at least 60 minutes per day on five 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)	51.5	49.0	56.5	↑	58.0	55.3	NA
% of students who watched television three or more hours per day (on an average school day) *In 2021 replaced by*Percentage of students who spent 3 or more hours per day on screen time (in front of a TV, computer, smart phone, or other electronic device watching shows or videos, playing games, accessing the internet, or using social media, not counting time spent doing schoolwork, on an average school day)	18.8	18.8	75.7	↑	75.8	78.6	75.7
% 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) *In 2021, % of students who played video or computer games was combined with % of students who watch television three or more hours per day.	43.9	45.3	NA	NA	NA	NA	NA
Other							
% of students who ever had sexual intercourse	36.6	38.3	36.6	=	36.5	37.0	30
% of students who had eight or more hours of sleep (on an average school night)	31.8	29.5	24.5	↓	28.3	23.2	22.7
% of students who brushed their teeth on seven days (during the seven days before the survey)	69.1	66.8	67.9	=	64.5	69.9	NA

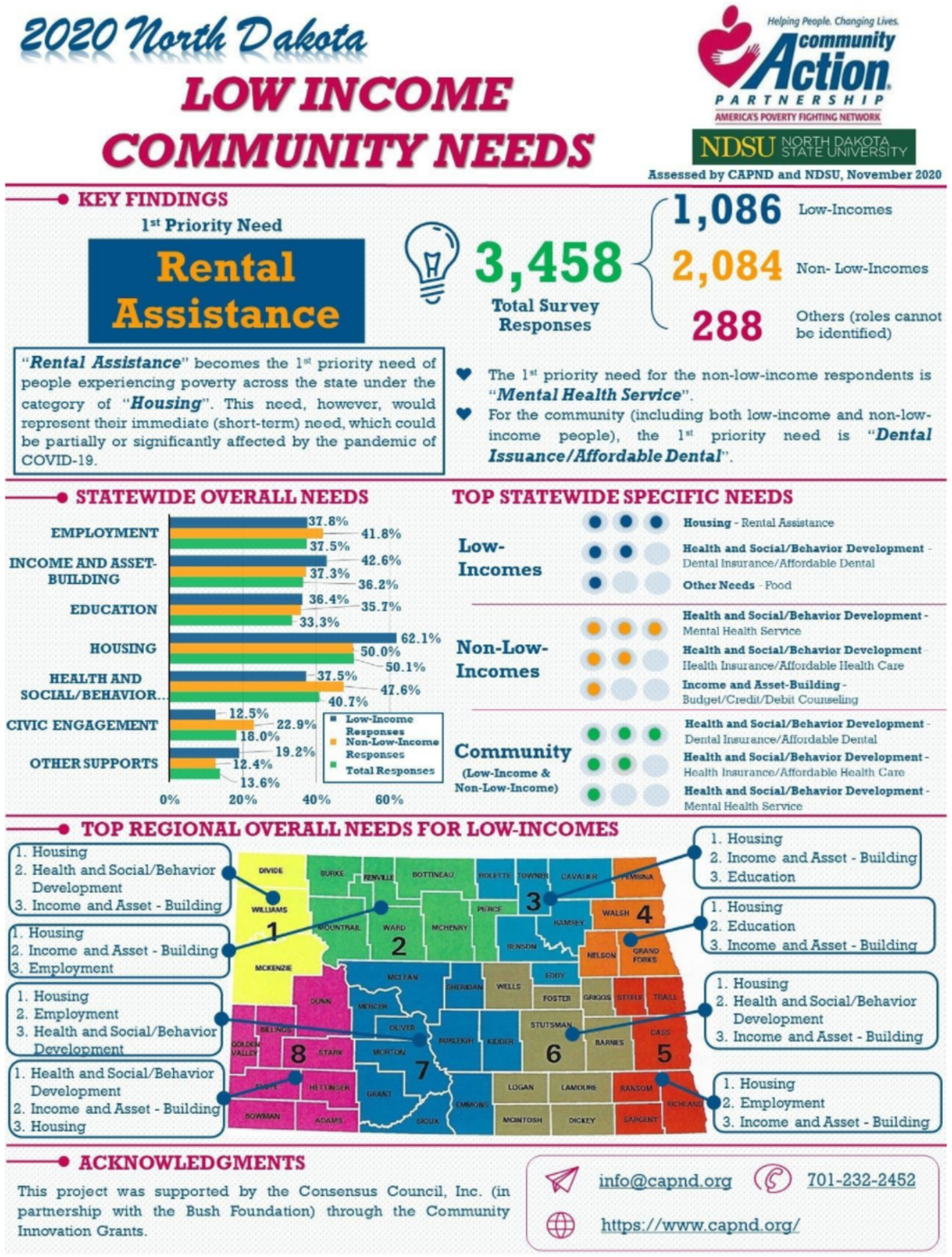
Source: https://www.cdc.gov/healthyyouth/data/yrbs/results.htm; https://www.nd.gov/dpi/districtsschools/safety-health/youth-risk-behavior-survey

Low Income Needs

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

Top Needs Identified by People Experiencing Poverty Across North Dakota

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

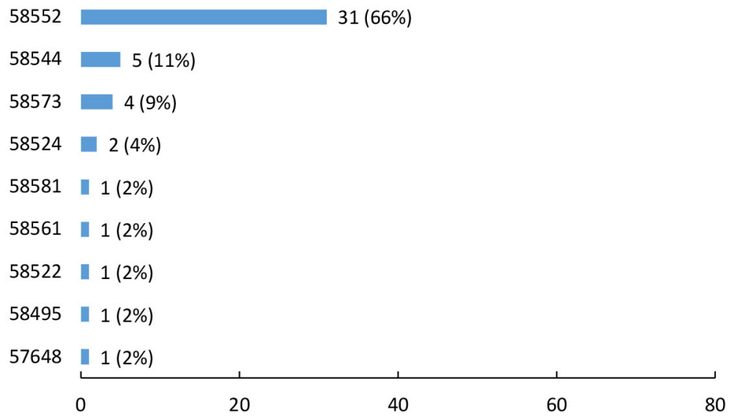


Survey Results

As noted previously, 83 community members completed the survey in communities throughout the counties in the Linton Regional Medical Center (LRMC) service area. For all questions that contained an "Other" response, all of those direct responses may be found in Appendix G. In some cases, a summary of those comments is additionally included in the report narrative. The "Total respondents" number under each heading indicates the number of people who responded to that particular question, and the "Total responses" number under the heading depicts the number of responses selected for that question (some questions allow for selection of more than one response).

The survey requested that respondents list their home ZIP code. While not all respondents provided a ZIP code, 47 did, revealing that a large majority of respondents (66%, N=31) lived in Linton. These results are shown in Figure 5.

Figure 5: Survey Respondents' Home ZIP Code
Total respondents: 47



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

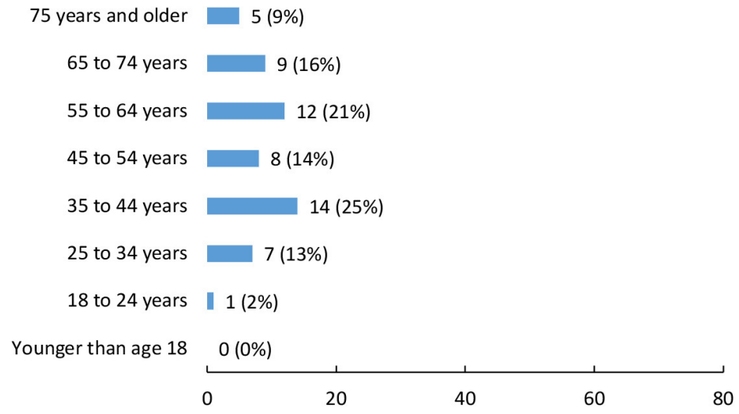
To better understand the perspectives being offered by survey respondents, survey-takers were asked a few demographic questions. Throughout this report, numbers (N) instead of just percentages (%) are reported because percentages can be misleading with smaller numbers. Survey respondents were not required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

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

- 46% (N=26) were aged 55 or older
- The majority (78%, N=43) were female
- Slightly more than half of the respondents (55%, N=31) had bachelor's degrees or higher
- The number of those working full time (61%, N=34) was almost three times higher than those who were retired (21%, N=12)
- 100% (N=56) of those who reported their ethnicity/race were White/Caucasian
- 14% of the population (N=7) had household incomes of less than $50,000

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

Figure 6: Age Demographics of Survey Respondents
Total respondents = 56



People younger than age 18 are not questioned using this survey method.

Figure 7: Gender Demographics of Survey Respondents
Total respondents = 55

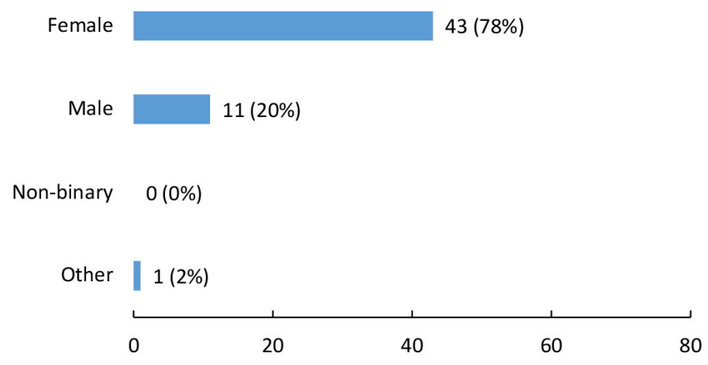


Figure 8: Educational Level Demographics of Survey Respondents
Total respondents = 56

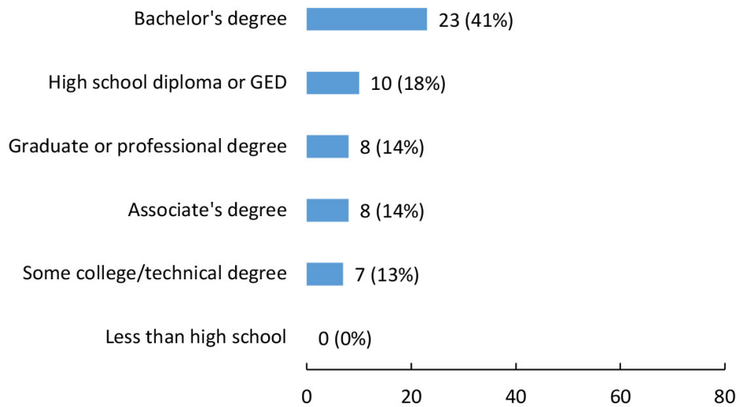
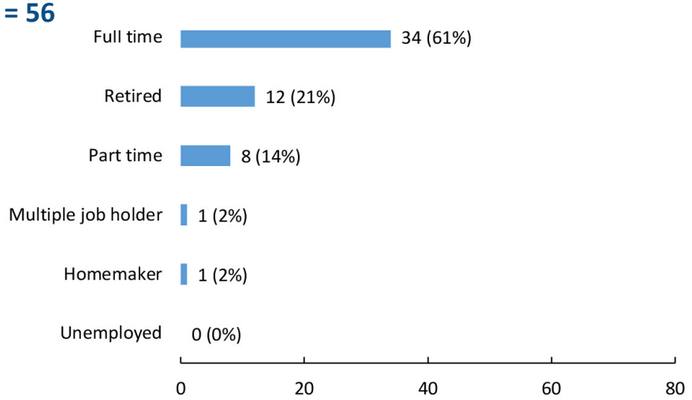
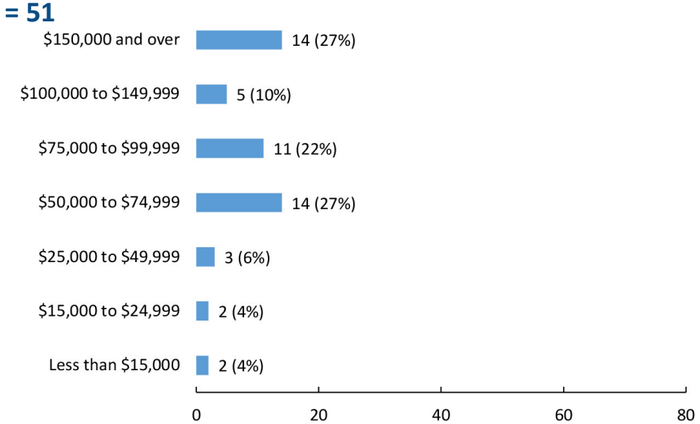


Figure 9: Employment Status Demographics of Survey Respondents
Total respondents = 56



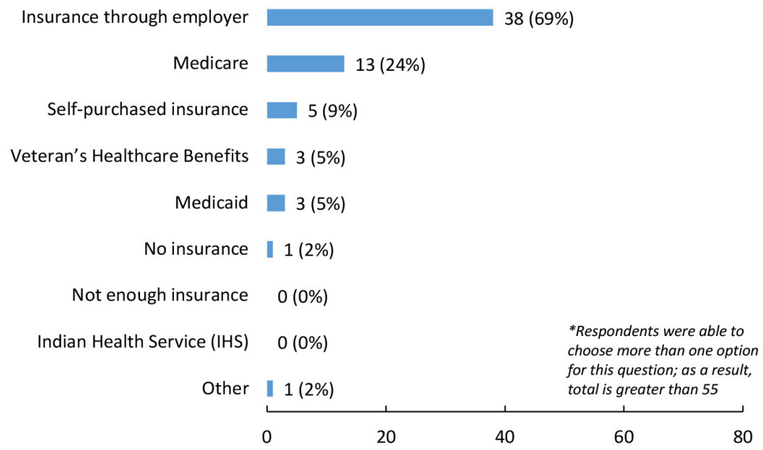
Of those who provided a household income, 8% (N=4) of community members reported a household income of less than $25,000. Thirty-seven percent (N=19) indicated a household income of $100,000 or more. This information is shown in Figure 10.

Figure 10: Household Income Demographics of Survey Respondents
Total respondents = 51



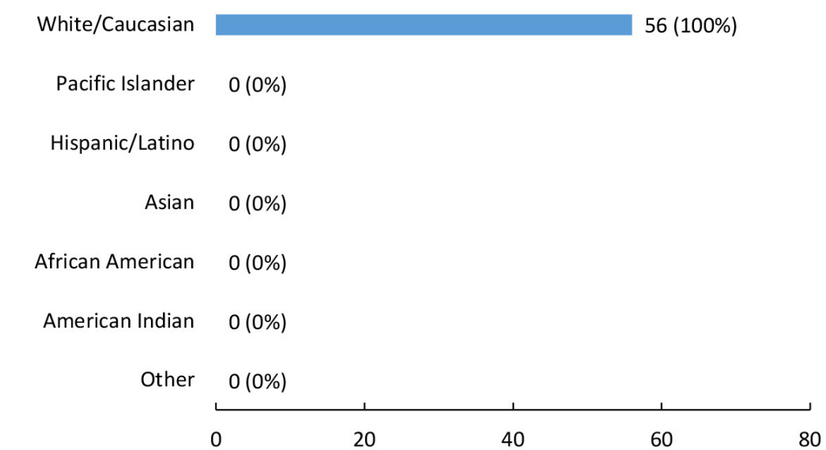
Community members were asked about their health insurance status, which is often associated with whether people have access to healthcare. Two percent (N=1) of the respondents reported having no health insurance or being under-insured. The most common insurance types were insurance through one's employer (N=38), followed by Medicare (N=13), and self-purchased (N=5).

Figure 11: Health Insurance Coverage Status of Survey Respondents
Total respondents = 55*



As shown in Figure 12, all of the respondents were White/Caucasian (100%). This higher percentage was consistent with the race/ethnicity of the overall population of Emmons County; the U.S. Census indicates that 94.6% of the population is White in Emmons County.

Figure 12: Race/Ethnicity Demographics of Survey Respondents
Total respondents = 56



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 45 respondents agreeing) that community assets include:

- Family-friendly (N=72)
- People are friendly, helpful, supportive (N=62)
- Safe place to live, little/no crime (N=61)
- Feeling connected to people who live here (N=52)
- Active faith community (N=51)
- Healthcare (N=51)
- People who live here are involved in their community (N=51)

Figures 13 to 16 illustrate the results of these questions. "Other" category of figures 13 to 16 can be found in Appendix

Figure 13: Best Things About the PEOPLE in Your Community
Total responses = 81*

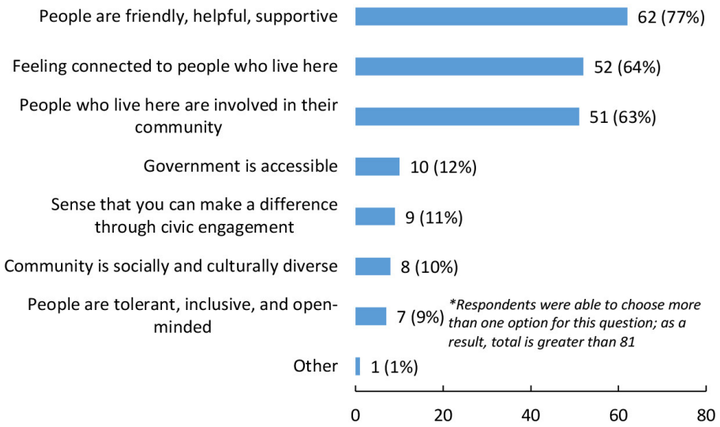


Figure 14: Best Things About the SERVICES AND RESOURCES in Your Community
Total responses = 83*

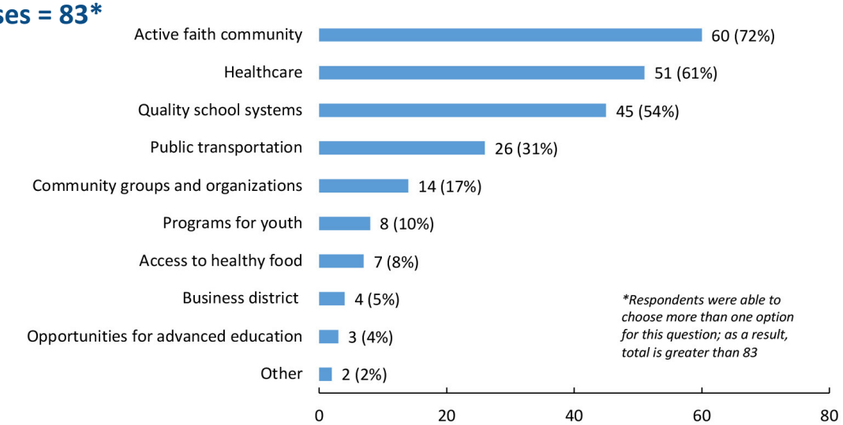


Figure 15: Best Things About the QUALITY OF LIFE in Your Community
Total responses = 83*

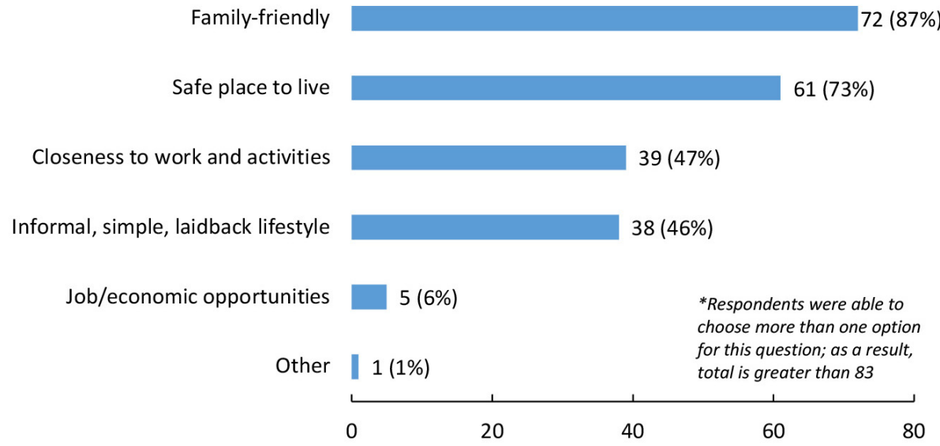
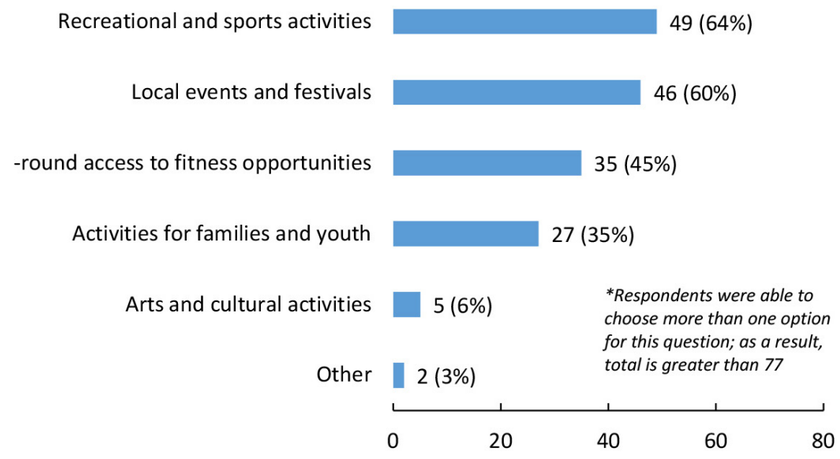


Figure 16: Best Thing About the ACTIVITIES in Your Community
Total responses = 77*



Community Concerns

At the heart of this Community Health Needs Assessment (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 30 respondents) were:

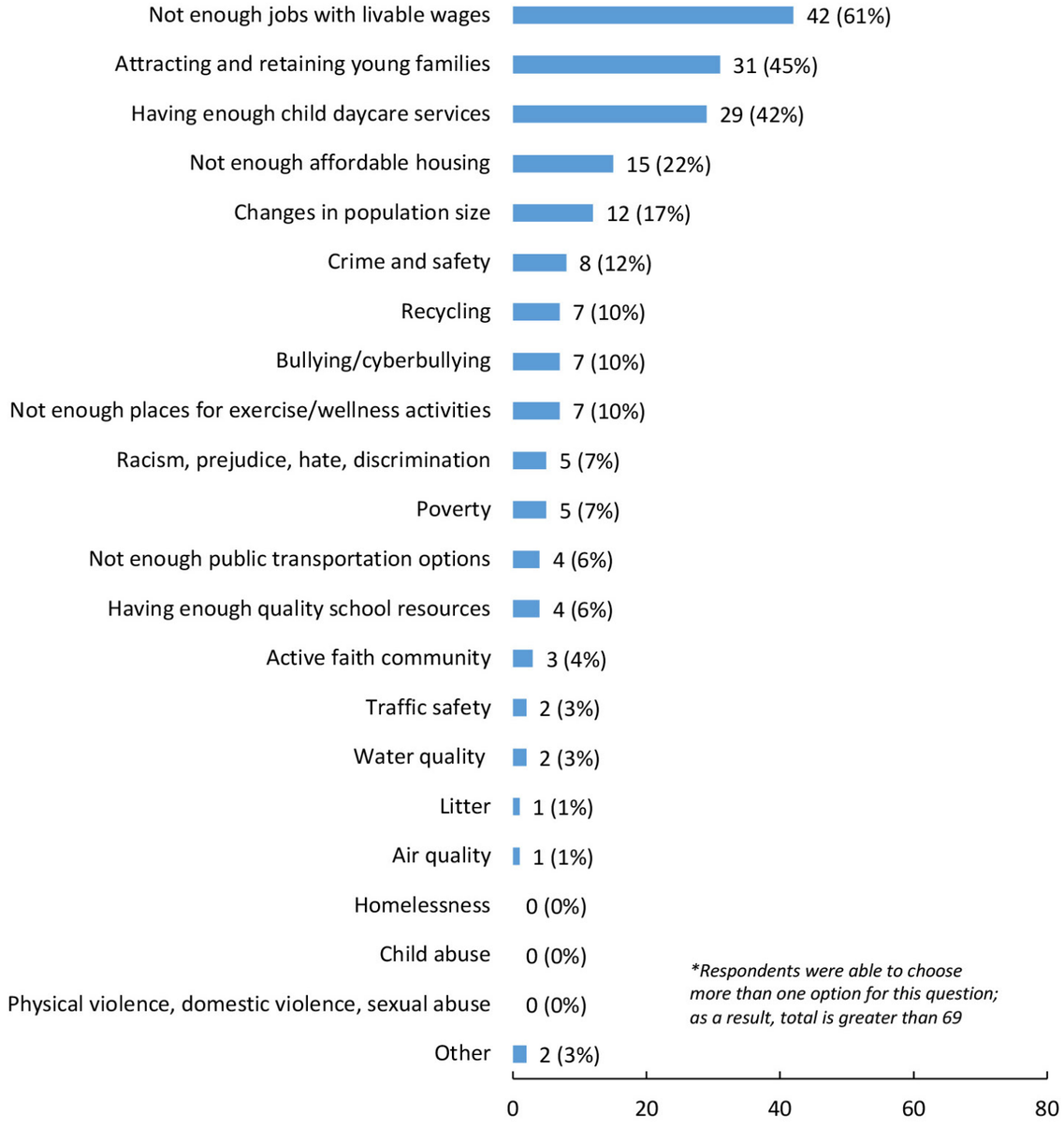
- Not enough jobs with livable wages (N=42)
- Alcohol use and abuse – youth (N=41)
- Bullying/cyberbullying – youth (N=39)
- Alcohol use and abuse – adults (N=37)
- Attracting and retaining young families (N=31)
- Availability of resources to help the elderly stay in their homes (N=30)

The other issues that had at least 20 votes included:

- Having enough child daycare services (N=29)
- Smoking and tobacco use – youth (N=28)
- Drug use and abuse – adult (N=26)
- Ability to retain primary care providers in the community (N=25)
- Availability of mental health services (N=24)
- Depression/anxiety – youth (N=24)
- Drug use and abuse – youth (N=24)
- Child abuse (N=20)
- Cost of long-term/nursing home care (N=20)
- Not enough activities for children and youth (N=20)

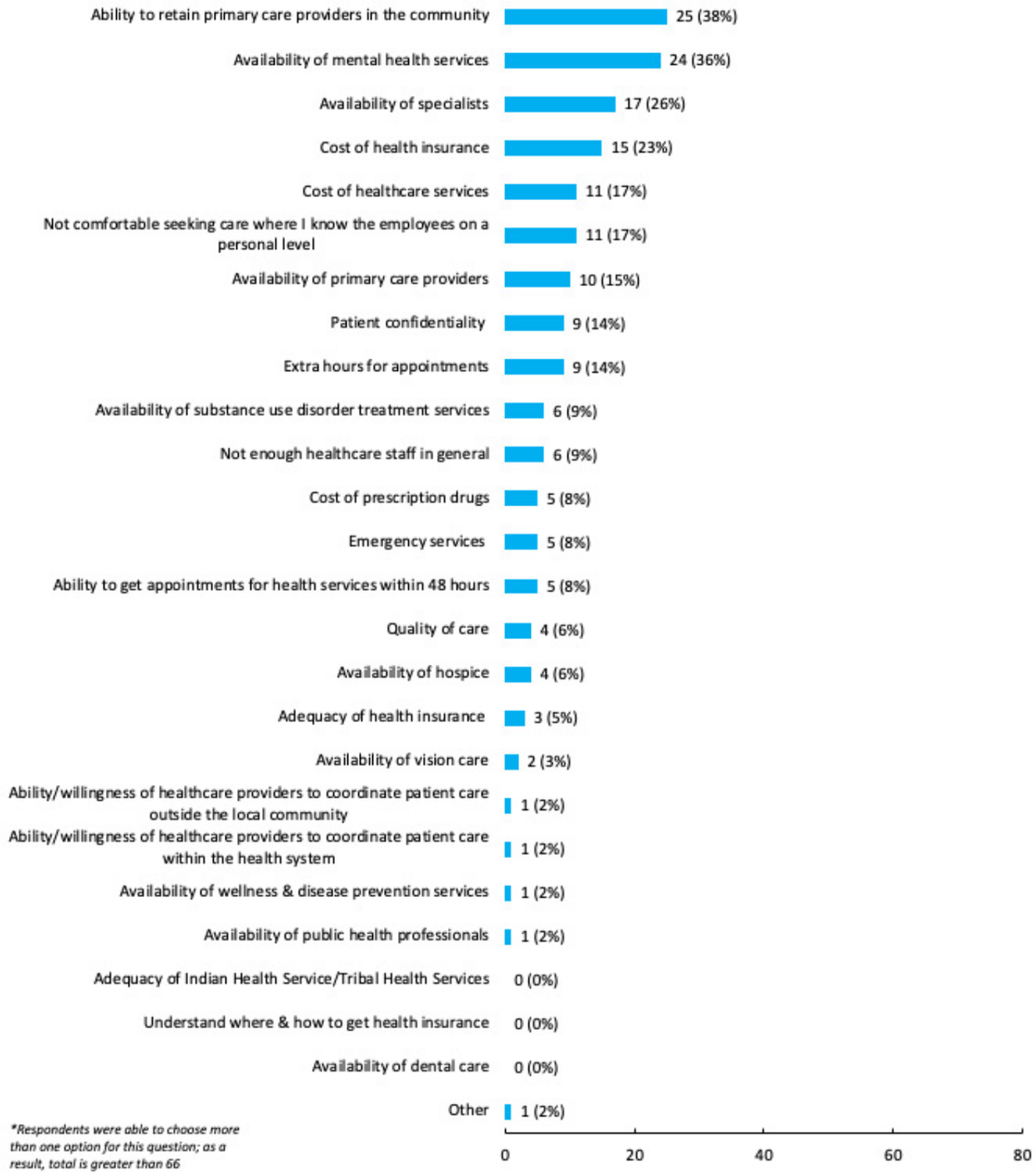
Figures 17 through 22 illustrate these results.

Figure 17: Community/Environmental Health Concerns
Total responses = 69*



In the "Other" category for community and environmental health concerns, drug problems and after school care were listed.

Figure 18: Availability/Delivery of Health Services Concerns
Total responses = 66*



One respondent who selected "Other" identified a concern in the availability/delivery of health services as intolerance to more natural healthcare.

Figure 19: Youth Population Health Concerns
Total responses = 66*

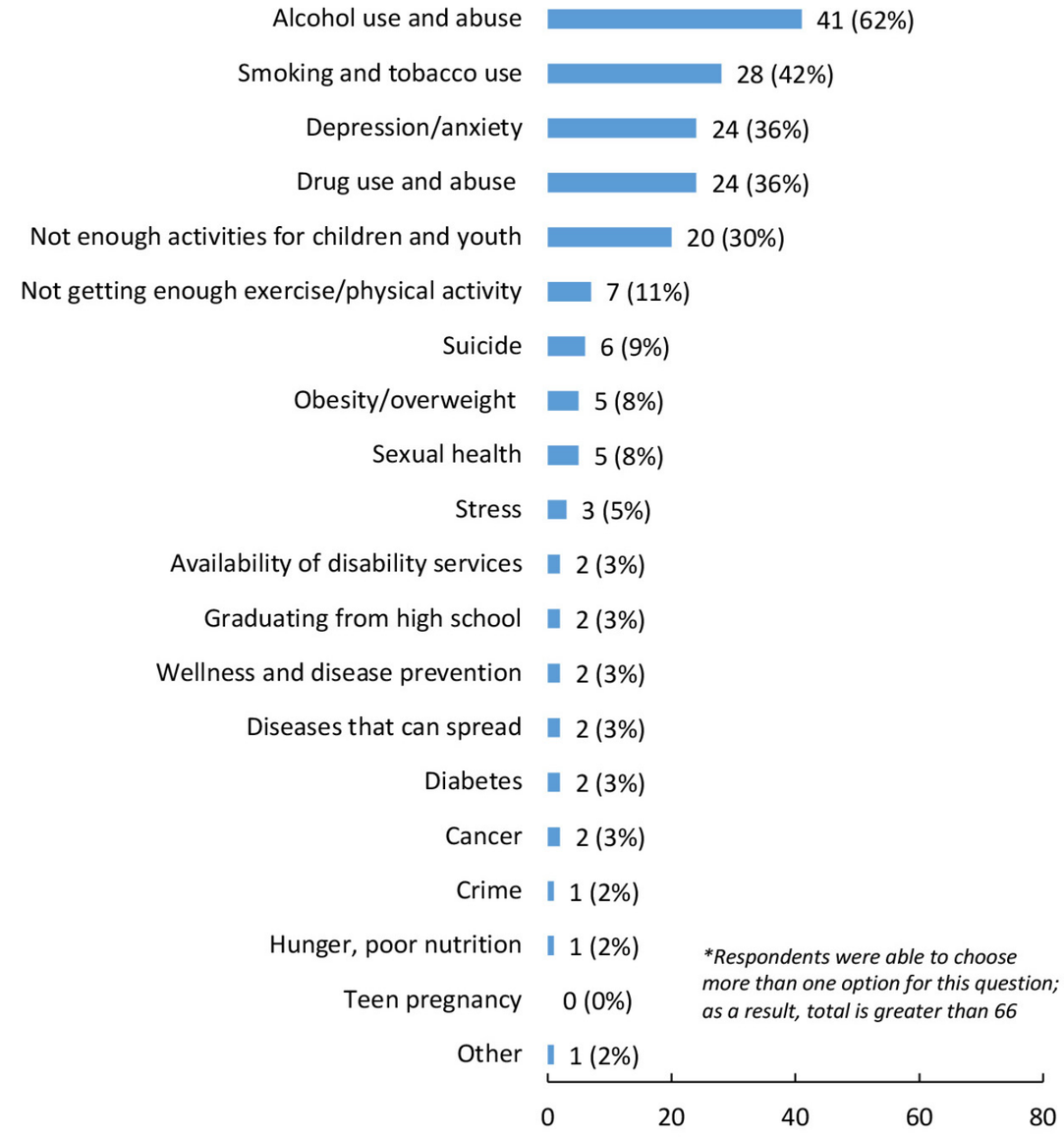
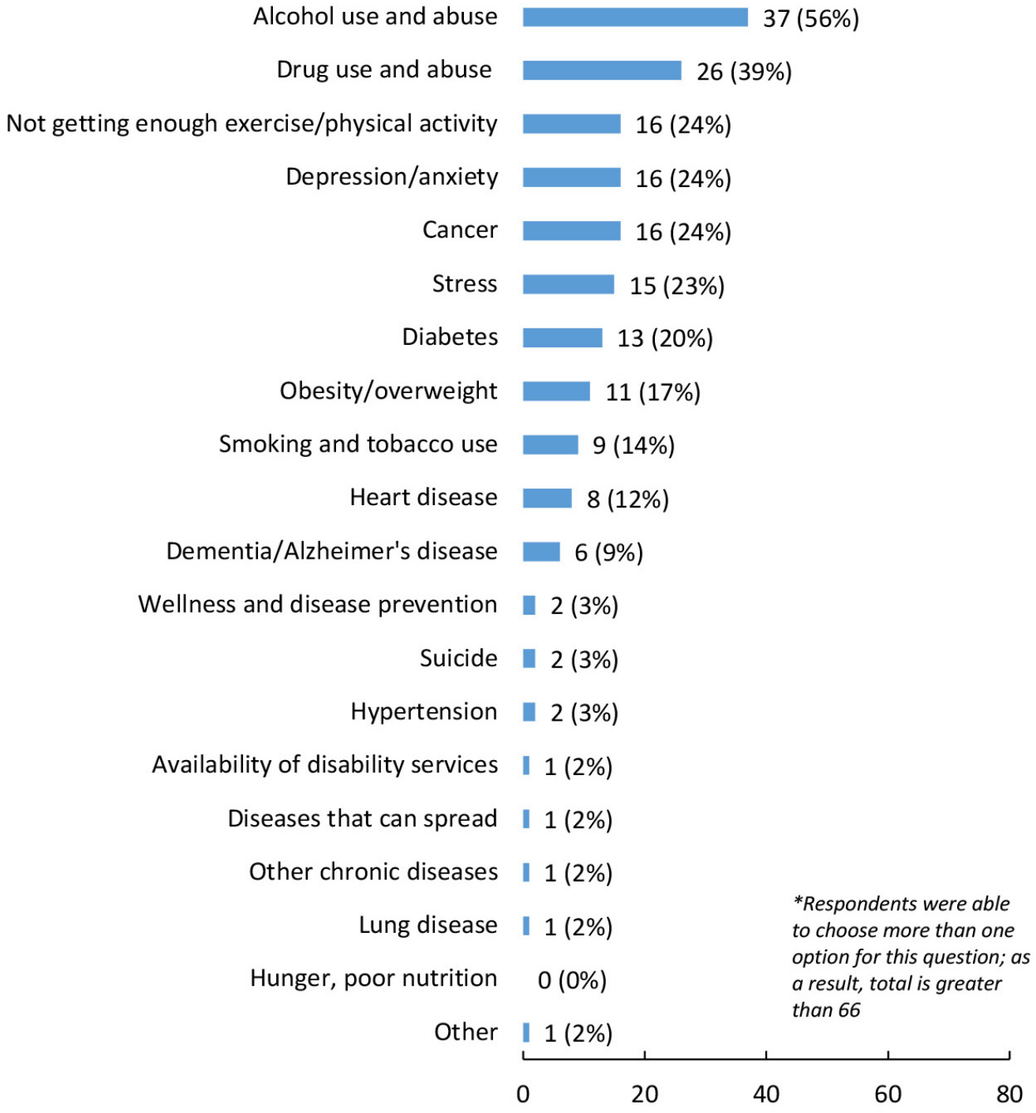
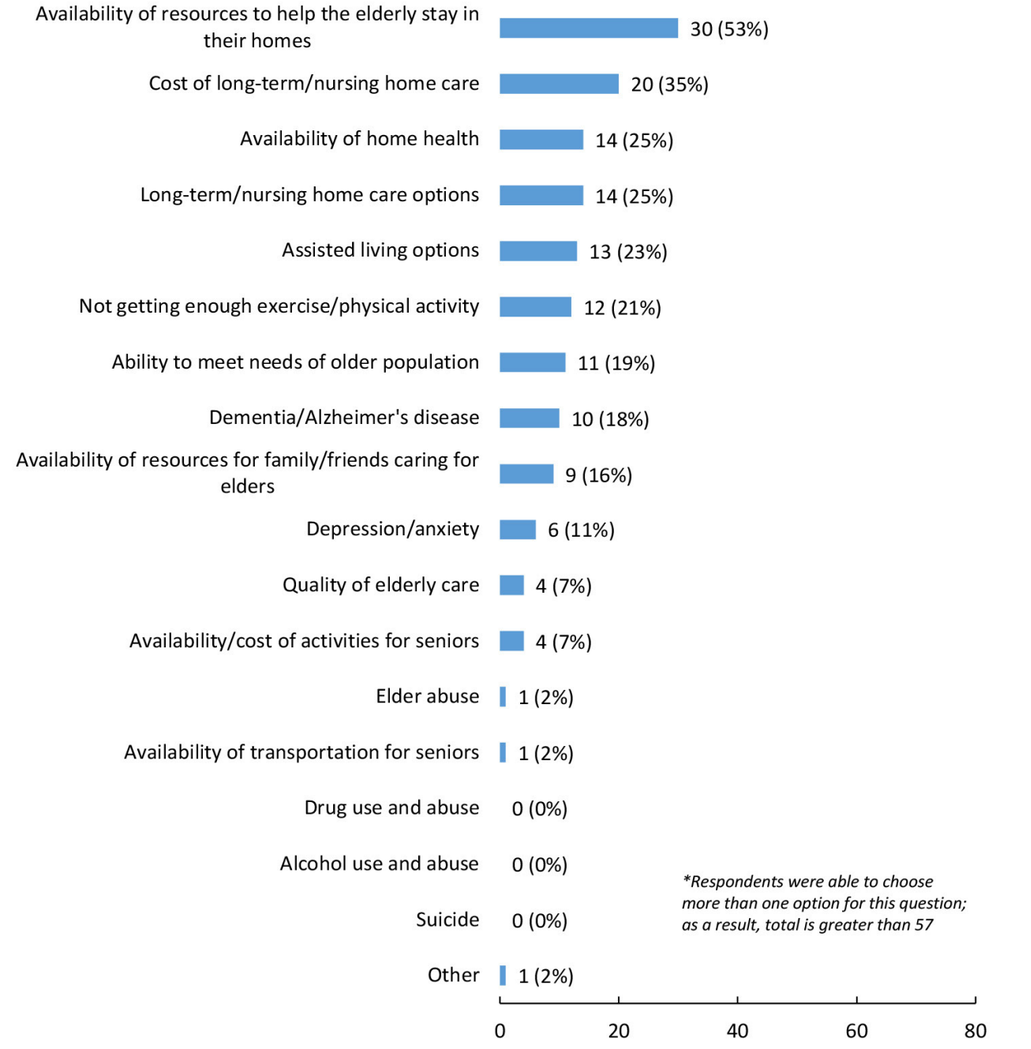


Figure 20: Adult Population Concerns
Total responses = 66*



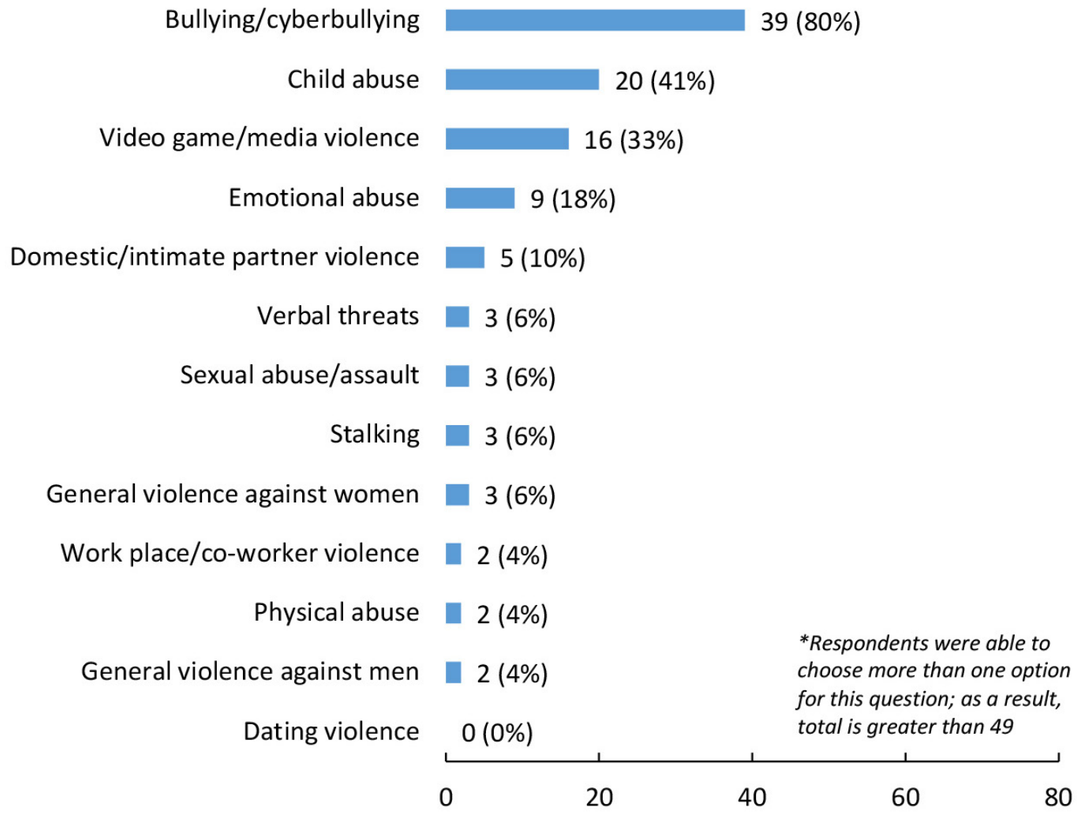
Lacking in entertainment, especially in winter months, was indicated in the "Other" category for adult population concerns.

Figure 21: Senior Population Concerns
Total responses = 57*



In the "Other" category, the one concern listed was that senior meals are needed in all communities.

Figure 22: Violence Concerns
Total responses = 49*



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. Declining population
2. Drug use and abuse

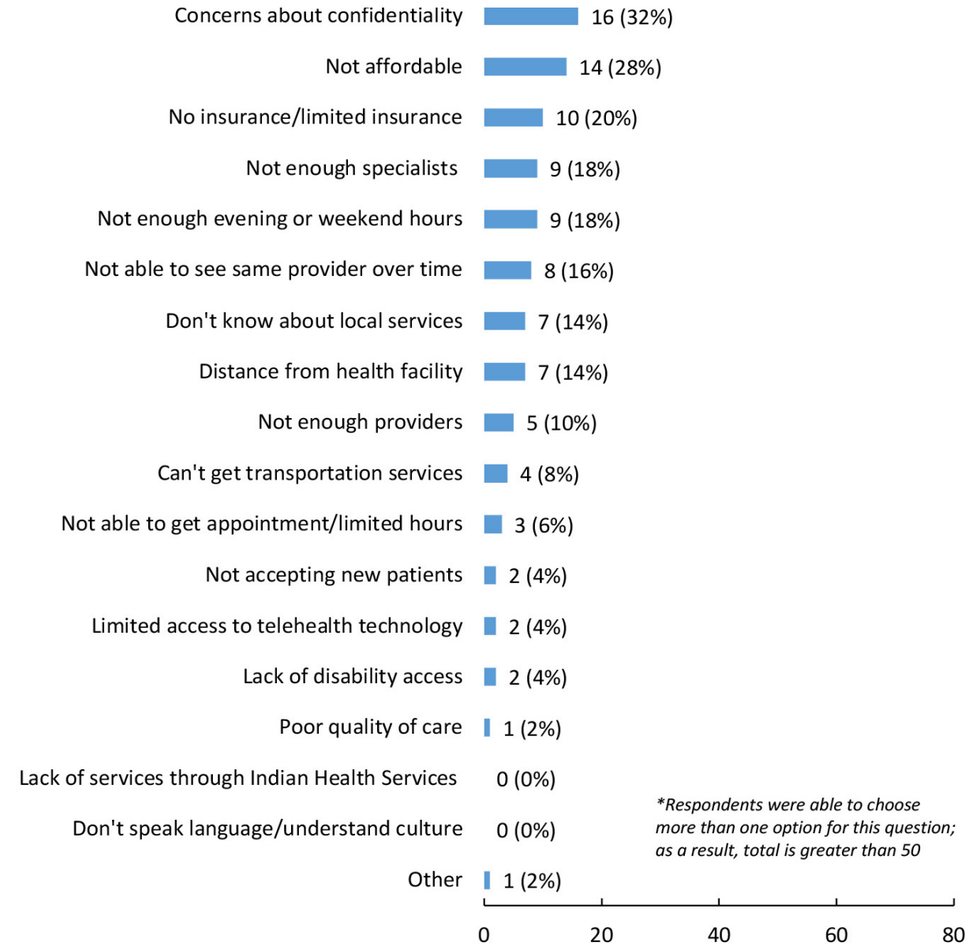
Other biggest challenges that were identified were wellness and disease prevention, not enough activities, lack of mental health resources, lack of diversity, jobs with livable wages, lack of childcare, drug related crimes, alcohol use, retaining young families, lack of workforce, bullying, obesity/overweight population, not enough businesses and places for entertainment, prescription drug costs, high cost of living, smoking/vaping, and depression/anxiety.

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 concerns about confidentiality (N=16), with the next highest being not affordable (N=14). After these items, the next most commonly identified barriers were no insurance or limited insurance (N=10), not enough specialists (N=9), and not enough evening or weekend hours (N=9). The concern, indicated in the "Other" category, is listed in Appendix G.

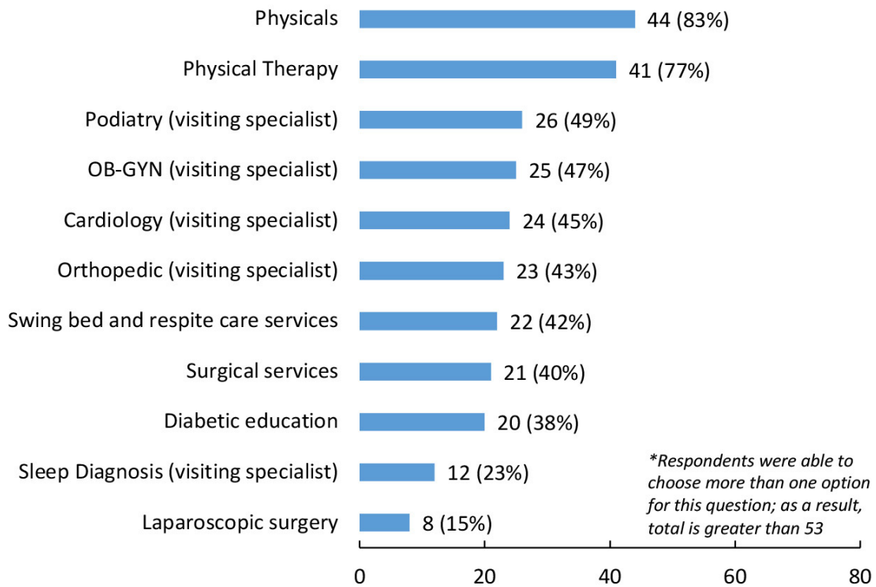
Figure 23 illustrates these results.

Figure 23: Perceptions About Barriers to Care
Total responses = 50*



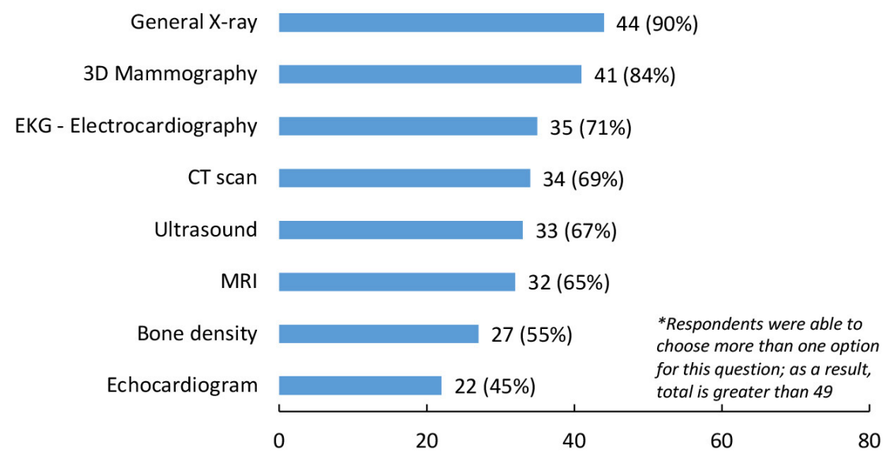
Respondents were asked to indicate if they were aware of the general and acute services that are offered at Linton Regional Medical Center (LRMC) and to also indicate what, if any, services they or a family member have used (See Figure 24).

Figure 24: Awareness and Utilization of General and Acute Services
Total responses = 53*



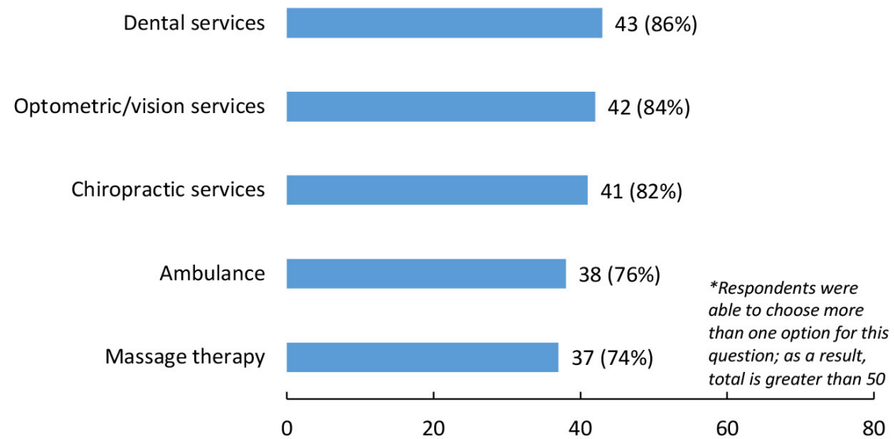
Respondents were asked to indicate if they were aware of the radiology service offered though LRMC and to also indicate what, if any, services they or a family member have used (See Figure 25).

Figure 25: Awareness and Utilization of Radiology Services
Total responses = 39*



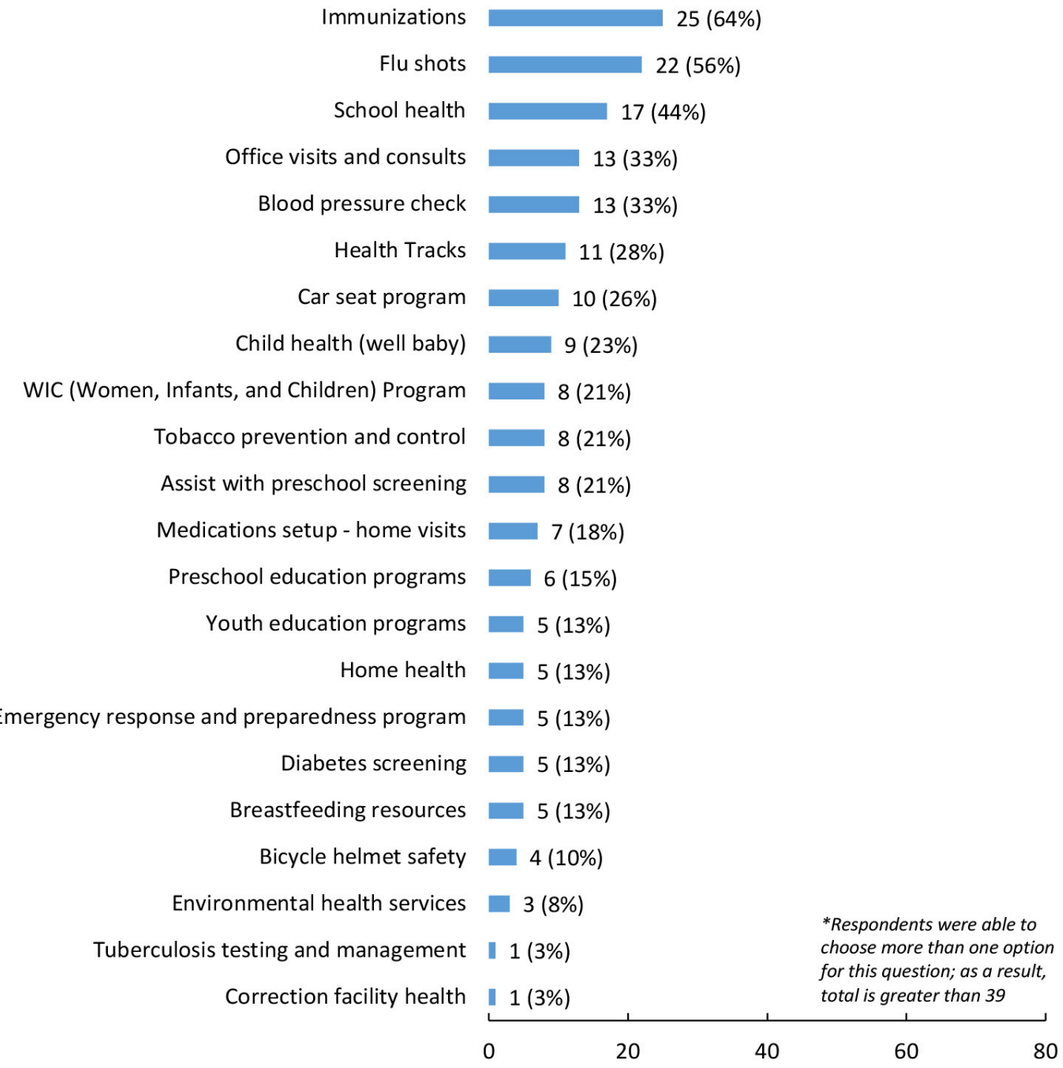
Respondents were asked to indicate if they were aware of other local services and to also indicate what, if any, services they or a family member have used (See Figure 26).

Figure 26: Awareness and Utilization of Other Local Services
Total responses = 50*



Considering a variety of healthcare services offered by Emmons County Public Health (ECPH), respondents were asked to indicate if they were aware that the healthcare service is offered though ECPH and to also indicate what, if any, services they or a family member have used at ECPH, at another public health unit, or both (See Figure 27).

Figure 27: Awareness and Utilization of Public Health Services
Total responses = 39*

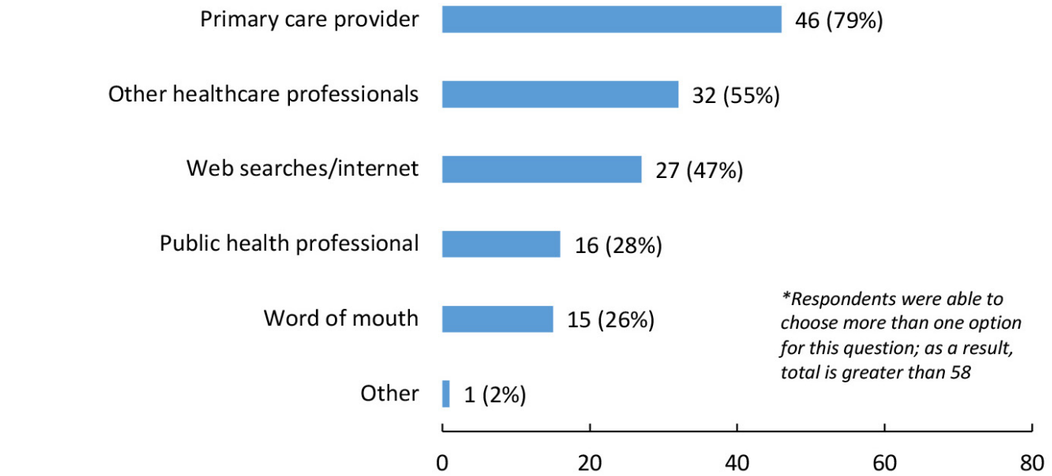


In an open-ended question, respondents were asked what specific healthcare services, if any, they think should be added locally. The number one desired service to add locally was mental health services. Other requested services included:

- AA
- Addiction services
- Diabetic nurse
- Functional medicine
- Home health
- Hospice
- Pediatric services
- Rheumatology
- Visiting MD

The key informant and focus group members felt that the community members were aware of the majority of the health system and public health services. There were a number of services where they felt the hospital and public health should increase marketing efforts.

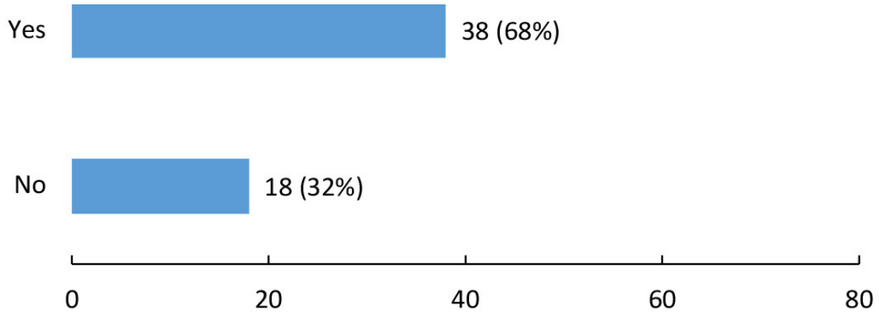
Figure 28: Sources of Trusted Health Information
Total responses = 58*



In the "Other" category, one respondent stated naturopathic and homeopathic providers as a trusted source for health information.

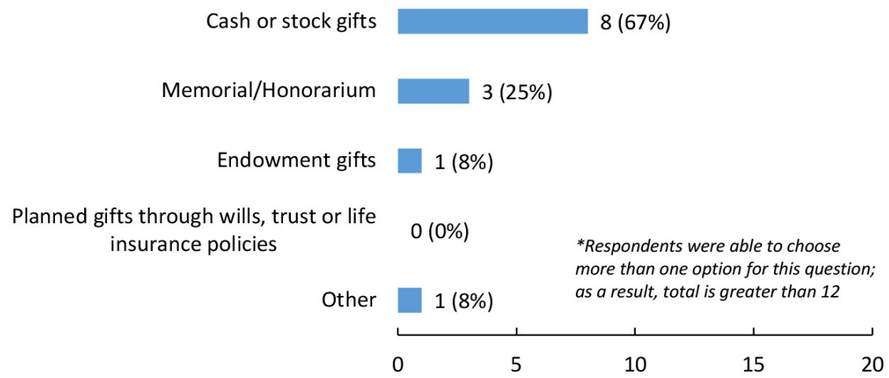
Respondents were asked about their awareness of the LRMC Foundation. The majority were aware of the foundation.

Figure 29: Awareness of Linton Regional Medical Center's Foundation
Total responses = 56



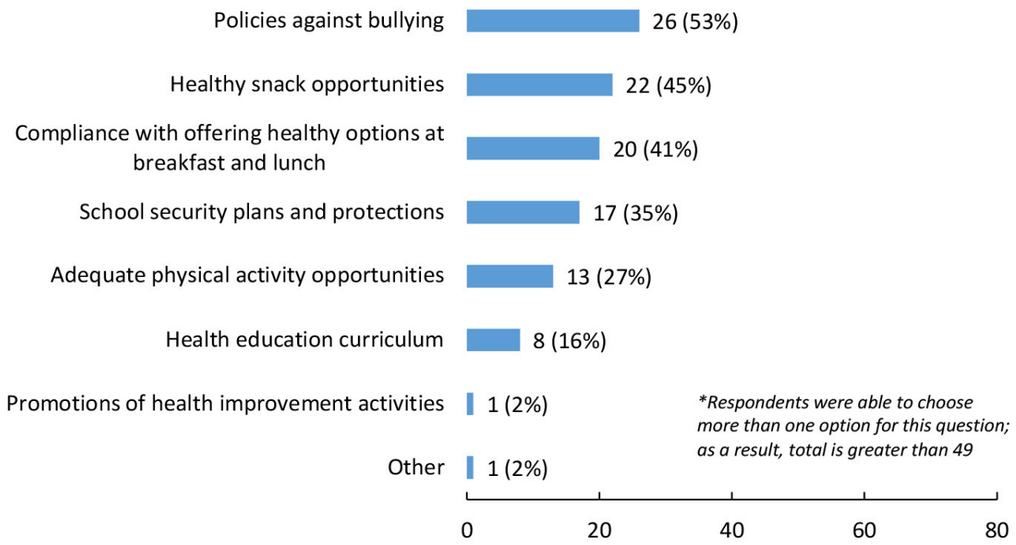
In an effort to gauge ways that community members would be most likely support the foundation, a question was included asking them to select ways they are most likely to support the foundation (see Figure 30).

Figure 30: Ways of Support for Linton Regional Medical Center Foundation
Total responses = 12*



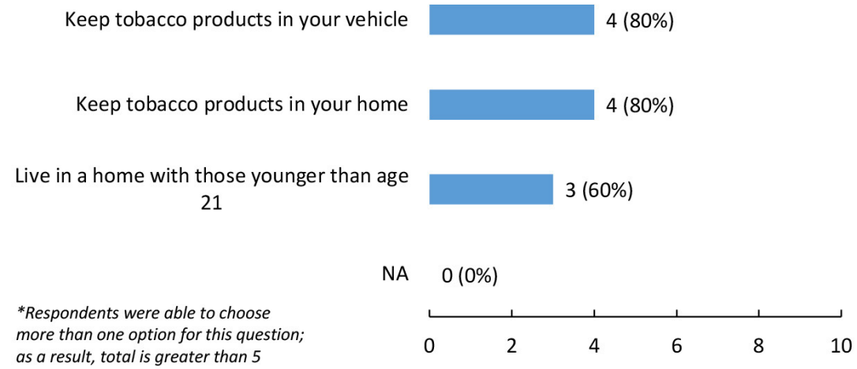
Respondents were asked what concerns they had considering the school system's dedication to health. The number one concern was policies against bullying, followed by healthy snack opportunities. See Figure 31.

Figure 31: Concerns About School System's Dedication to health
Total responses = 49*



Respondents were asked characteristics of those who smoke, vape, or use other tobacco products.

Figure 32: Characteristics of Those Who Smoke/Vape
Total responses = 5*



The final question on the survey asked respondents to share concerns and suggestions to improve the delivery of local healthcare. One response focused on concern with the lack of physicians at the hospital. Local providers are healthcare drivers in the community. The community needs to figure out how to retain existing providers and continue to recruit new ones to the area. Having providers in the community will always draw new patients and provide an increased level of care and a business climate in Linton and the surrounding towns.

Another suggestion was for the hospital to contract with mental health providers to come into town like other visiting specialists. Having a mental health provider come into town would remove the burden of travel and finding time off from work for families. It would also keep their care local.

The last suggestion listed was for healthier food options at schools and school-related functions. When families go to watch games or attend an event the school is holding, the concession stand only offers junk food. They could add in fresh fruit or baked chips. One respondent stated they would like easier, affordable access to healthy food.

Findings from Key Informant Interviews & the Community Meeting

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

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

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

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

Alcohol use and abuse

- Major problem in the area. People think there is nothing else to do, so they drink.
- People are suffering with these addictions and their children have to deal with their issues.
- There is nothing for kids to do here, so they just drive around and drink.

Availability of mental health and substance use disorder treatment services

- There is nothing close if treatment is needed.
- Major concern for all ages.
- Seems to be an increase in alcohol and drug use.

Availability of resources to help the elderly stay in their homes

- Families are struggling with the cost of nursing home and home care.

Depression/anxiety

- Depression and anxiety are a top issue for teens.
- Top concern is addressing depression/anxiety.
- Substance use is related to mental health issues.

Drug use and abuse

- Drugs are becoming an increasingly worse.
- Kids are struggling, they don't understand the harm they are doing to themselves.

Community Engagement and Collaboration

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

- Emergency services, including ambulance and fire (4.5)
- Law enforcement (4.5)
- Public health (4.5)
- Schools (4.25)
- Business and industry (4.0)
- Economic development organizations (4.0)
- Hospital (healthcare system) (4.0)
- Pharmacy (4.0)
- Faith-based (3.75)
- Other local health providers, such as dentists and chiropractors (3.5)
- Social services (3.5)
- Long-term care, including nursing homes and assisted living (2.75)
- Clinics not affiliated with the main health system (1.75))

Priority of Health Needs

A community group met on October 17, 2023. Six community members attended the meeting. 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 on large poster boards and each member was given four stickers to place next to each of the four needs they considered the most significant. In the meeting, participants decided to put alcohol use and abuse, drug use and abuse, and smoking/vaping into one group and named that concern substance abuse.

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

- Substance abuse (7 votes)
- Depression/anxiety – all ages (5 votes)
- Attracting and retaining young families (4 votes)
- Availability of mental health services (4 votes)

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

1. Availability of mental health services (4 votes)
2. Attracting and retaining young families (1 vote)
3. Depression and anxiety (1 vote)
4. Substance abuse (0 votes)

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

Comparison of Needs Identified Previously

Top Needs Identified 2020 CHNA Process	Top Needs Identified 2023 CHNA Process
• Availability of mental health services	• Availability of mental health services
• Adult alcohol use and abuse	• Attracting and retaining young families
• Having enough child daycare services	• Depression/anxiety – all ages
	• Substance abuse – all ages

The current process did identify one common needs from 2020. Mental health services were identified in 2020 and in 2023. Depression and anxiety and substance abuse issues are also related to mental health services. Attracting and retaining young families is a new need that was identified.

Linton Regional Medical Center (LRMC) invited written comments on the most recent CHNA report and Implementation Strategy, both in the documents and on the website, where they are widely available to the public. No written comments have been received.

Upon adoption of this CHNA Report by the LRMC board vote, a notation will be documented in the board minutes, reflecting the approval, and then the report will be widely available to the public on the hospital's website, and a paper copy will be available for inspection upon request at the hospital. Written comments on this report can be submitted to LRMC.

Hospital and Community Projects and Programs Implemented to Address Needs Identified in 2020

In response to the needs identified in the 2020 CHNA process, the following actions were taken:

Availability of mental health services: LRMC has continued collaborating with Emmons County Public Health (ECPH) to compile their mental health resources. These were also shared with members of Linton's Interagency, which includes the pastoral association. The North Dakota Department of Health and Human Services has created a list of statewide mental health services, and this link was shared on Facebook and is on the LRMC website under patient resources. LRMC is also currently in the process of contracting with Rural Psychiatry Associates to provide psychiatric and psychotherapy services through telemedicine.

Having enough child daycare services: LRMC staff continues to be on the board for the Little Lion's Daycare and provides CPR/first aid training to daycare providers. LRMC staff also collaborated with ECPH and Emmons County Social Services to provide a youth babysitting course.

Adult alcohol use and abuse: LRMC continued to collaborate with ECPH to share resources for alcohol/substance use and abuse with the same process as the mental health services. They provided education to the community, regarding the results of the last CHNA.

The above implementation plan for LRMC is posted on the LRMC website at https://www.cavalierhospital.com/how-to-help/resources.html.

Next Steps – Strategic Implementation Plan

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

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

Community Benefit Report

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

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

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

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

What Are Community Benefits?

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

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

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

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

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

Appendix A – Critical Access Hospital Profile

Critical Access Hospital Profile Spotlight on: Linton, North Dakota

Linton Regional Medical Center

Quick Facts

Administrator:
Lukas Fischer, CEO

Chief of Medical Staff:
John Knecht, MD

Board Chair:
Sandy Meidinger

City Population:
997 (2018 estimate)[1]

County Population:
3,422 (2019 estimate)[1]

County Median Household Income: $38,477 (2013 estimate)[1]

County Median Age:
51.2 years (2013 estimate)[1]

Service Area Population:
4,500

Owned by: Private Nonprofit

Hospital Beds: 14 acute

Trauma Level: V

Critical Access Hospital Designation: 2004

Economic Impact on the Community*

Jobs:
Primary – 93
Secondary – 46
Total – 139

Financial Impact:
Primary – $2 million
Secondary – $1 million
Total – $3 million

** The impact of jobs and expenditures generated by the hospital within the community was estimated using payroll information and an economic multiplier of 1.5.*

Mission

Our mission is to enhance the health, well-being, and quality of life of the people we serve.

Vision

We will focus on primary healthcare services and the development of our skills to provide the best possible service and to improve the healthcare of the people that we serve.

We will continue to adapt to the ever changing needs of the people we serve, recognizing that public information and education will be an integral part of our services.

County: Emmons
Address: 111 West Elm Ave
Linton, ND 58552
Phone: (701) 254-4511
Fax: (701) 254-0112
Web: lintonregionalmedicalcenter.org

Linton Regional Medical Center (LRMC) employs over 100 people. LRMC also has three affiliated clinics, which offer a wide variety of medical services to the residents of Emmons County, North Dakota and Campbell County, South Dakota.

Services

- Emergency care
- Trauma
- Advanced Cardiac Life Support
- Pediatric Advanced Life Support
- Emmons County Advanced Life Support Ambulance Service
- Physical therapy
  - Sports preventative and post-injury
  - Dry needling
- Radiology
  - Bone density, CT, 3D mammography, general x-ray, echocardiogram, EKG, and mobile unit MRI, and ultrasound
- Lab
  - Chemistry, hematology, microbiology, outpatient/referral labs (regular business hours), and PCR testing for respiratory pathogens
- Surgical (colonoscopy and endoscopy)
- Nursing
- Swing-bed
- Rural Health Clinics
  - Department of Transportation (DOT) physicals
  - Diabetic education
  - Drug testing
  - Primary care
  - Walk-in

Staffing

Physicians: 2
Nurse Practitioners: 4
PAs: 2
RNs: 11
Total Employees: 110

Local Sponsors and Grant Funding Sources

- Center for Rural Health
  - SHIP Grant *(Small Hospital Improvement Program)*
  - Flex Grant *(Medicare Rural Hospital Flexibility Grant Program)*
- Leona M. & Harry B. Helmsley Charitable Trust
- Homeland Security Grant
- North Dakota Trauma Foundation
- Rural Health Network Development (HRSA)
- Blue Cross/Blue Shield Rural Health Grant Program

Sources

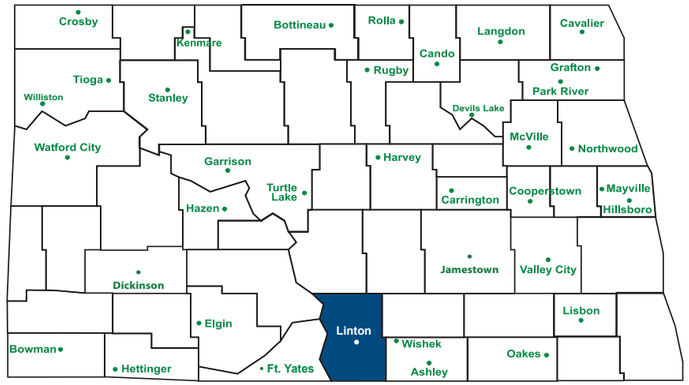
1 U.S. Census Bureau; American Factfinder, Community Facts

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

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

ruralhealth.und.edu

North Dakota Critical Access Hospitals



History

Linton Hospital was opened in 1953 by the Seven Sisters of St. Francis of Tiffin, Ohio. The sisters managed the hospital until an administrator was hired in 1962. In 1967 the attached clinic was constructed. In 1975 an addition was added and the hospital was remodeled. In 2015 and 2016, the hospital nurse's station and the clinic and hospital waiting rooms were remodeled.

In 2022 a remodel of the hospital was completed and included the lab department, ER, and patient rooms. Today Linton Regional Medical Center (LRMC) employs over 100 people. LRMC also has three affiliated clinics, which offer a wide variety of medical services to the residents of Emmons County, North Dakota and Campbell County, South Dakota.

Recreation

Linton is in south central North Dakota. The economy is based on agricultural and related activities. The Linton school system offers K-12 and Pre-K education for students. Fishing, boating, swimming, and camping facilities are available on the Missouri River within a short drive of Linton. Other available facilities include a golf course, swimming pool, baseball/softball diamonds, cross country skiing, snowmobiling, and hunting.

Updated 10/2023

Appendix B – Economic Impact Analysis

Linton Regional Medical Center

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

Economic Impact

Linton Regional Medical Center is composed of a Critical Access Hospital (CAH), two Rural Health Clinics, a provider-based clinic, the county ambulance service, and Prairie Rose Assisted Living and home health.

Linton Regional Medical Center directly employs **63.82 FTE employees** with an annual payroll of over **$4.4 million** (including benefits).

- After application of the employment multiplier of 1.41, these employees created an additional **26** jobs.
- The same methodology is applied to derive the income impact. The income multiplier of 1.29 is applied to create just over **$1.27 million** in income as they interact with other sectors of the local economy.
- **Total impacts = 90 jobs and nearly $5.68 million in income**.

Healthcare and Your Local Economy

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

Key contributions of the health system include

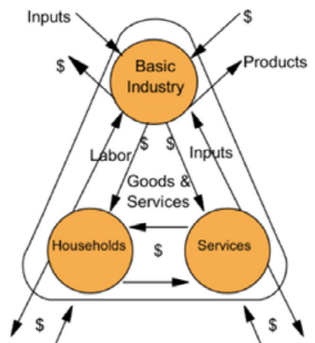
- Attracts retirees and families
- Appeals to businesses looking to establish and/or relocate
- High quality healthcare services and infrastructure foster community development
- Positive impact on retail sales of local economy
- Provides higher-skilled and higher-wage employment
- Increases the local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

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

Fact Sheet Author: Kylie Nissen, BBA

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

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



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

CENTER FOR RURAL HEALTH OSU Center for Health Sciences
Center for Rural Health University of North Dakota School of Medicine & Health Sciences

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

Appendix C – CHNA Survey Instrument

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

Linton Regional Medical Center

EMMONS COUNTY PUBLIC HEALTH
Public Health
Prevent. Promote. Protect.

Linton Area Health Survey

Linton Regional Medical Center and Emmons County Public Health are interested in hearing from you about community health concerns.

The focus of this effort is to:

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

If you prefer, you may take the survey online at http://tinyurl.com/CHNALinton2023 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 Holly Long at 701.777.3848.

Surveys will be accepted through August 15, 2023. Your opinion matters – thank you in advance!

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

9. Considering the **ELDERLY 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
- ☐ Dementia/Alzheimer's disease
- ☐ 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

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

_____

_____

Delivery of Healthcare

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

- ☐ Cardiology (visiting specialist)
- ☐ Diabetic Education
- ☐ Laparoscopic surgery
- ☐ OB-GYN (visiting specialist)
- ☐ Orthopedics (visiting specialist)
- ☐ Podiatry—foot/ankle (visiting specialist)
- ☐ Physicals (annuals, DOT, sports, and insurance)
- ☐ Physical Therapy
- ☐ Sleep Diagnostics (visiting specialist)
- ☐ Surgical services
- ☐ Swing bed and respite care services

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

- ☐ 3D Mammography (new service 2020)
- ☐ Bone density
- ☐ CT scan
- ☐ Echocardiogram
- ☐ EKG – Electrocardiography
- ☐ General x-ray
- ☐ MRI
- ☐ Ultrasound

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

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

15. Which of the following **SERVICES** provided by **Emmons County Public Health** have you or a family member used in the past year? (Choose ALL that apply)

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

16. Are you aware of Linton Regional Medical Center's Foundation, which exists to financially support Linton Regional Medical Center?

- ☐ Yes
- ☐ No

17. Have you supported the Linton Regional Medical Center Foundation in any of the following ways? (Choose ALL that apply)

- ☐ Cash or stock gift
- ☐ Endowment gifts
- ☐ Memorial/Honorarium
- ☐ Planned gifts through wills, trusts or life insurance policies
- ☐ Other (please specify): _____

18. Considering the **SCHOOL SYSTEM's** dedication to health, concerns are (choose up to THREE):

- ☐ Healthy snack opportunities
- ☐ Compliance with offering healthy options at breakfast and lunch
- ☐ Adequate physical activity opportunities
- ☐ Promotions of health improvement activities (ex. NDSU Extension Services)
- ☐ Health Education Curriculum
- ☐ Policies against bullying
- ☐ School security plans and protections
- ☐ Other (please specify):

19. If you smoke, vape or use other tobacco products, do you...(select all that apply)

- ☐ NA
- ☐ Live in a home with those under age 21
- ☐ Keep tobacco products in your house
- ☐ Keep tobacco products in your vehicle

20. 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): _____

21. 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): _____

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

_____

_____

Demographic Information: Please tell us about yourself.

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

- ☐ Yes
- ☐ No

24. 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): _____

25. 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): _____

26. 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

27. 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

28. Sex:

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

29. Employment status:

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

30. Your zip code: _____

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

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

32. 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

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

_____

_____

Appendix D – County Health Rankings Explained

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

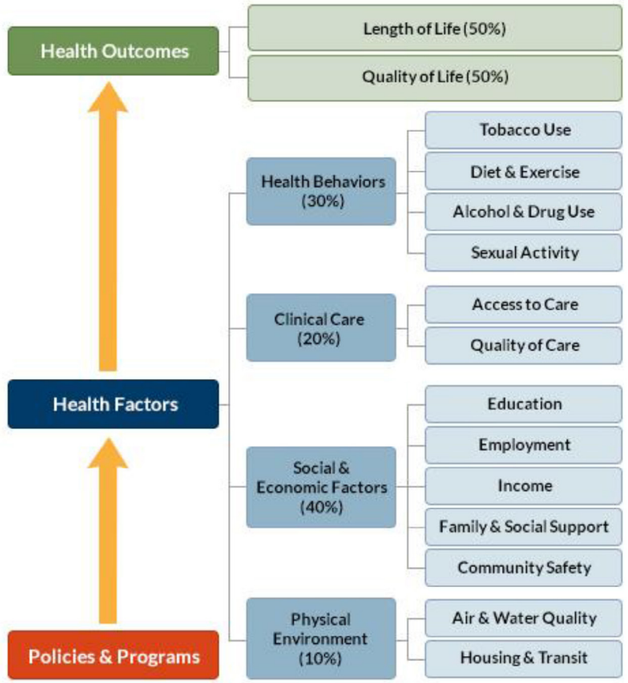
Methods

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

What is Ranked

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

Ranking System



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

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

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

Data Sources and Measures

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

Data Quality

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

Calculating Scores and Ranks

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

Health Outcomes and Factors

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

Health Outcomes

Premature Death (YPLL)

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

Reason for Ranking

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

Poor or Fair Health

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

Reason for Ranking

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

Poor Physical Health Days

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

Reason for Ranking

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

Poor Mental Health Days

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Individuals who:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Preventable Hospital Stays

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

Reason for Ranking

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

Mammography Screening

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

Reason for Ranking

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

Flu Vaccinations

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

Reason for Ranking

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

Unemployment

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

Reason for Ranking

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

Children in Poverty

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

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

Reason for Ranking

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

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

Income Inequality

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

Reason for Ranking

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

Children in Single-Parent Households

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

Reason for Ranking

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

Violent Crime Rate

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

Reason for Ranking

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

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

Injury Deaths

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

Reason for Ranking

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

Air Pollution-Particulate matter

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

Reason for Ranking

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

Drinking Water Violations

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

Reason for Ranking

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

Severe Housing Problems

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

- housing unit lacks complete kitchen facilities;
- housing unit lacks complete plumbing facilities;
- household is severely overcrowded; or
- household is severely cost burdened.
- Severe overcrowding is defined as more than 1.5 persons per room. Severe cost burden is defined as monthly housing costs (including utilities) that exceed 50% of monthly income.

Reason for Ranking

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

Appendix E – Youth Behavioral Risk Survey Results

North Dakota High School Survey

Rate Increase ↑, rate decrease↓, or no statistical change = in rate.

	ND 2017	ND 2019	ND 2021	ND Trend ↑, ↓, =	Rural ND Town Average	Urban ND Town Average	National Average 2021
Injury and Violence							
Percentage of students who rarely or never wore a seat belt (when riding in a car driven by someone else)	8.1	5.9	**49.6**	=	9.2	5.0	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)	16.5	14.2	**13.1**	=	18.2	13.7	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)	56.2	59.6	**64.4**	=	64.9	64.2	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)	52.6	53.0	**55.4**	=	59.9	55.9	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)	20.6	NA	**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)	5.9	4.9	**5.0**	=	6.2	4.4	3.1
Percentage of students who were in a physical fight on school property (one or more times during the 12 months before the survey)	7.2	7.1	**NA**	**NA**	NA	NA	5.8
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)	8.7	9.2	**9.4**	=	9.7	11.6	9.7
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)	NA	NA	**NA**	**NA**	NA	NA	8.5
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)	11.4	11.6	**11.0**	=	11.2	11.1	NA
Percentage of students who were bullied on school property (during the 12 months before the survey)	24.3	19.9	**15.8**	↓	19.8	15.0	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)	18.8	14.7	**13.6**	↓	16.2	14.5	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)	28.9	30.5	**36.0**	↑	34.8	39.7	42.3
Percentage of students who seriously considered attempting suicide (during the 12 months before the survey)	16.7	18.8	**18.6**	=	18.5	20.6	22.2
Percentage of students who made a plan about how they would attempt suicide (during the 12 months before the survey)	14.5	15.3	**14.8**	=	15.1	17.2	15.7
Percentage of students who attempted suicide (one or more times during the 12 months before the survey)	13.5	13.0	6.1	↓	7.9	7.5	10.2
Tobacco Use							
Percentage of students who ever tried cigarette smoking (even one or two puffs)	30.5	29.3	**22.3**	↓	26.8	21.1	17.8
Percentage of students who smoked a whole cigarette before age 13 years (even one or two puffs)	11.2	NA	**NA**	**NA**	NA	NA	6.3
Percentage of students who currently smoked cigarettes (on at least one day during the 30 days before the survey)	12.6	8.3	**5.9**	↓	8.0	6.1	3.8
Percentage of students who currently frequently smoked cigarettes (on 20 or more days during the 30 days before the survey)	3.8	2.1	**0.8**	↓	1.7	1.3	0.7
Percentage of students who currently smoked cigarettes daily (on all 30 days during the 30 days before the survey)	3.0	1.4	**0.7**	↓	1.3	1.1	0.41
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) ~2021~ Usually got their electronic vapor products by buying them themselves in a convenience store, supermarket, discount store, or gas station	7.5	13.2	**NA**	**NA**	NA	NA	6.8
Percentage of students who tried to quit smoking cigarettes (among students who currently smoked cigarettes during the 12 months before the survey)	50.3	54.0	**30.9**	↓	30.4	29.9	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)	20.6	33.1	**21.2**	↓	24.2	23.6	18.0
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)	8.0	4.5	**4.3**	↓	5.2	3.7	2.5
Percentage of students who currently smoked cigars (cigars, cigarillos, or little cigars on at least one day during the 30 days before the survey)	8.2	5.2	**2.8**	↓	4.0	3.3	3.1
Percentage of students who currently used cigarettes, cigars, or smokeless tobacco (on at least 1 day during the 30 days before the survey)	18.1	12.2	8.9	↓	11.2	8.9	18.7
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)	59.2	56.6	**50.4**	↓	55.7	50.6	NA
Percentage of students who drank alcohol before age 13 years (for the first time other than a few sips)	14.5	12.9	**12.1**	=	13.7	10.9	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)	29.1	27.6	**23.7**	=	28.7	23.7	22.7
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)	16.4	15.6	**14.0**	=	17.8	14.6	10.5
Percentage of students who usually obtained the alcohol they drank by someone giving it to them (among students who currently drank alcohol)	37.7	NA	**NA**	**NA**	NA	NA	40.0
Percentage of students who tried marijuana before age 13 years (for the first time)	5.6	5.0	**4.1**	=	3.7	3.3	4.9

Percentage of students who currently used marijuana (one or more times during the 30 days before the survey)	15.5	12.5	**10.7**	=	10.2	12.9	15.8
	ND 2017	ND 2019	ND 2021	ND Trend ↑, ↓, =	Rural ND Town Average	Urban ND Town Average	National Average 2021
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)	14.4	14.5	10.2	↓	9.7	11.0	12.2
Percentage of students who were offered, sold, or given an illegal drug on school property (during the 12 months before the survey)	12.1	NA	NA	NA	NA	NA	13.3
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	36.6	38.3	36.6	=	36.5	37.1	30.0
Percentage of students who had sexual intercourse before age 13 years (for the first time)	2.8	NA	NA	NA	NA	NA	3.2
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)	16.1	16.5	**15.6**	=	15.5	14.2	16.0
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)	14.9	14.0	**16.3**	=	17.4	15.0	16.3
Percentage of students who described themselves as slightly or very overweight	31.4	32.6	**31.7**	=	35.3	32.5	32.3
Percentage of students who were trying to lose weight.	44.5	44.7	**21.6**	↓	20.8	23.2	54.3
Percentage of students who did not eat fruit or drink 100% fruit juices (during the seven days before the survey)	4.9	6.1	5.0	=	5.8	4.6	7.7
Percentage of students who ate fruit or drank 100% fruit juices one or more times per day (during the seven days before the survey)	61.2	54.1	25.4	↓	21.9	27.0	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)	5.1	6.6	**5.9**	=	5.3	6.2	9.3
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)	60.9	57.1	61.3	=	60.0	59.3	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)	28.8	28.1	**27.7**	=	27.1	31.6	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)	16.3	15.9	**16.6**	=	17.5	13.8	14.7
Percentage of students who did not drink milk (during the seven days before the survey)	14.9	20.5	26.2	↑	21.2	29.4	35.7
Percentage of students who drank two or more glasses per day of milk (during the seven days before the survey)	33.9	NA	NA	NA	NA	NA	NA
Percentage of students who did not eat breakfast (during the 7 days before the survey)	13.5	14.4	**15.1**	=	14.5	17.3	22.0
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)	2.7	2.8	**2.1**	=	2.2	2.1	NA

Physical Activity							
Percentage of students who were physically active at least 60 minutes per day on 5 or more days (doing any kind of physical activity that increased their heart rate and made them breathe hard some of the time during the 7 days before the survey)	51.5	49.0	**56.5**	↑	58.0	55.3	55.9
	ND 2017	ND 2019	ND 2021	ND Trend ↑, ↓, =	Rural ND Town Average	Urban ND Town Average	National Average 2021
Percentage of students who watched television three or more hours per day (on an average school day) *In 2021, % of students who played video or computer games was combined with % of students who watch television 3 or more hours per day.	18.8	18.8	**75.7**	**NA**	75.8	78.6	75.9
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). ~2021~ questioned combined with previous question regarding television.	43.9	45.3	NA	NA	NA	NA	NA
Other							
Percentage of students who had eight or more hours of sleep (on an average school night)	31.8	29.5	**24.5**	=	28.3	23.2	22.7
Percentage of students who brushed their teeth on seven days (during the 7 days before the survey)	69.1	66.8	**67.9**	=	64.5	69.9	NA
Percentage of students who most of the time or always wear sunscreen (with an SPF of 15 or higher when they are outside for more than one hour on a sunny day)	12.8	NA	NA	NA	NA	NA	NA
Percentage of students who used an indoor tanning device (such as a sunlamp, sunbed, or tanning booth [not including getting a spray-on tan] one or more times during the 12 months before the survey)	8.3	7.0	7.4	=	8.6	6.8	64.4

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

Appendix F – Prioritization of Community's Health Needs

Community Health Needs Assessment
Linton, North Dakota
Ranking of Concerns

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

	Priorities	Most Important
COMMUNITY/ENVIRONMENTAL HEALTH CONCERNS		
Attracting & retaining young families	4	1
Having enough child daycare services		
Not enough jobs with livable wages		
Changes in population size		
Not enough affordable housing		
AVAILABILITY/DELIVERY OF HEALTH SERVICES CONCERNS		
Ability to retain primary care providers		
Availability of mental health services	4	4
Availability of substance use disorder/treatment services		
Cost of health insurance	1	
Availability of specialists		
YOUTH POPULATION HEALTH CONCERNS		
Substance abuse *all ages	7	0
Smoking & tobacco use, exposure to second-hand smoke, or vaping/juuling		
Depression/anxiety *all ages	5	1
Drug use and abuse		
ADULT POPULATION HEALTH CONCERNS		
Alcohol use and abuse		
Drug use and abuse	3	
Cancer		
Not getting enough exercise/physical activity		
SENIOR POPULATION HEALTH CONCERNS		
Availability of resources to help elderly stay in their homes	3	
Availability of home health		
Cost of long-term/nursing home care		
Assisted living options		
VIOLENCE CONCERNS		
Bullying/cyber-bullying		
Child abuse or neglect		
Media violence		
Emotional abuse		

Appendix G – Survey "Other" Responses

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

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

1. Considering the PEOPLE in your community, the best things are: "Other" responses:
   - None of these
2. Considering the SERVICES AND RESOURCES in your community, the best things are: "Other" responses:
   - Youth are rarely considered
   - Everything is TOO expensive
3. Considering the QUALITY OF LIFE in your community, the best things are: "Other" responses:
   - Faith
4. Considering the ACTIVITIES in your community, the best things are: "Other" responses:
   - None of the above
   - There is limited access to activities

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

5. Considering the COMMUNITY /ENVIRONMENTAL HEALTH in your community, concerns are: "Other" responses:
   - Drug problems
   - After school care
6. Considering the AVAILABILITY/DELIVERY OF HEALTH SERVICES in your community, concerns are: "Other" responses:
   - Intolerance to more natural healthcare.

8. Considering the YOUTH POPULATION in your community, concerns are: "Other" responses:
   - Job availability
9. Considering the ADULT POPULATION in your community, concerns are: "Other" responses:
   - Lacking in entertainment, especially in the winter months.

10. Considering the SENIOR POPULATION in your community, concerns are: "Other" responses:
    - Senior meals are needed in all communities

11. What single issue do you feel is the biggest challenge facing your community?
    - Wellness and disease prevention
    - not enough activities
    - Lack of overall and various healthcare resources or access to them; specifically, mental health and home help/health

- Lack of diversity and diverse voices involved in decisions and government
- Lack of hospice/home health
- Population decreasing
- The hospital and clinic are more concerned with what they can bill the insurance company for than they are concerned with helping their patients. I work at the hospital, so I see it firsthand.
- Child care
- Drug related crimes
- Places to work with good pay
- Jobs that pay enough to live on
- Drug usage
- Drug use in families with children.
- Alcohol usage
- Aging demographic and dwindling population, older people passing away and all the young people move to Bismarck
- Drug use
- Need more residents
- Retaining healthy, involved families
- ?
- childcare, not having local medical doctor
- Aging
- Lack of workforce, child care for workers
- Bullying. At all levels
- The number of overweight children and adults.
- Not having enough businesses in town, like restaurants, movie theaters, bowling. Lack of entertainment. The only thing to do for entertainment in the winter is to socialize at the local Bar.
- There are no large companies or industry.
- Youth and alcohol, they think it's okay cause young and old are alcoholics. Parents don't care.

Delivery of Healthcare

13. Have you supported the Linton Regional Medical Center Foundation in any of the following ways? "Other" responses:
    - would like to but money is very tight
13. Considering the school systems dedication to health, concerns are? "Other" responses:
    - teacher bullying
13. What prevents you or other community residents from receiving healthcare? "Other" responses:
    - Quality of care at Linton
13. Where do you turn for trusted health information? "Other" responses:
    - Naturopathic, homeopathic providers
14. What specific healthcare services, if any, do you think should be added locally?
    - Home health, respite
    - Hospice
    - Functional medicine
    - Rheumatology
    - A visiting MD -- a consistent person in this role
    - (2) Mental health
    - Mental/behavioral health
    - Recovery from addiction like AA or something of that nature
    - Pediatrics
    - Pediatrician
    - Holistic
    - Addiction care
    - peds doctor
    - Diabetic nurse
    - Mental Health Services
    - Counseling!!
16. How did you acquire the survey (or survey link) that you are completing? "Other" responses:
    - (12) Facebook
    - Fb
    - Instagram
    - Direct email: Linton Medical, Linton regional medical center, LRMC
14. Health insurance or health coverage status. "Other" responses:
    - BCBS 18. If child daycare is a hinderance to your family, what is the issue?
14. Gender. "Other" responses:
    - We are only male or a female
30. Overall, please share concerns and suggestions to improve the delivery of local healthcare.
    - Continue to look for new resources and ways/methods to provide care to the community that needs it most.
    - Specialist availability
    - We need a full time MD.
    - People are concerned they will need to go to Bismarck to get all of their health care needs taken care of under one roof so they skip the Linton hospital all together and go straight to Bismarck
    - Improve ER services at Linton's hospital