Community Health Needs Assessment

Northwood Deaconess Health Center Service Area
Northwood, North Dakota

2025

Holly Long, MSML, Project Coordinator
Kayli Gimse, Project Assistant

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

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Executive Summary

To help inform future decisions and strategic planning, Northwood Deaconess Health Center (NDHC) conducted a Community Health Needs Assessment (CHNA) in 2025, the previous CHNA having been conducted in 2022. 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. One hundred six NDHC service area residents completed the survey. Additional information was collected through five key informant interviews with community members. The input from the residents, who primarily reside in Grand Forks 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, Grand Forks County's population from 2020 to 2024 increased by 0.8%. The average number of residents younger than age 18 (21.1%) for Grand Forks County comes in 2.5 percentage points lower than the North Dakota average (23.6%). The percentage of residents ages 65 and older, is 2.2% higher for Grand Forks County (14.8%) than the North Dakota average (17.0%), and the rate of education is 1.9% higher for Grand Forks County (95.7%) than the North Dakota average (93.8%). The median household income in Grand Forks County ($72,536) is lower than the state average for North Dakota ($78,538).

Data compiled by County Health Rankings show Grand Forks County is doing better than North Dakota in health outcomes/factors for 18 categories.

Grand Forks County, according to County Health Rankings data, is performing poorly relative to the rest of the state in 12 outcome/factor categories.

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

- Alcohol use and abuse – youth and adult
- Attracting and retaining young families
- Availability of resources to help the elderly stay in their homes
- Cost of healthcare services
- Depression/anxiety – youth and adult
- Lack of affordable housing
- Lack of jobs with livable wages
- Lack of child daycare services
- Smoking and tobacco use – youth

The survey also revealed the biggest barriers to receiving healthcare (as perceived by community members). They included lack of transportation services (N=17), no evening or weekend hours (N=16), and not affordable (N=16).

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

- Safe place to live, little/no crime
- Healthcare
- Family-friendly

- People who live here are involved in their community
- People are friendly, helpful, and supportive
- Recreational and sports activities
- Informal, simple, laidback lifestyle
- Quality school systems

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:

- Availability of resources to help the elderly stay in their homes
- Alcohol use and abuse – youth
- Attracting and retaining young families
- Being able to meet the needs of older population
- Cost of healthcare services
- Cost of health insurance
- Depression/anxiety – youth
- Not getting enough child daycare services
- Not enough affordable housing
- Smoking and tobacco use, exposure to second-hand smoke, vaping/juuling

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), Northwood Deaconess Health Center (NDHC), in partnership with Grand Forks Public Health, completed a Community Health Needs Assessment (CHNA) of the NDHC service area. The hospital identifies its service area as the towns of Northwood, Larimore, Aneta, Arvilla, and Hatton, as well as several other small extending communities. Many community members and stakeholders worked together on the assessment.

NDHC is located in southwestern Grand Forks County, 35 miles from Grand Forks and 85 miles from Fargo. Residents of the service area seek additional tertiary care services in both of those communities. Residents are able to seek chiropractic care in Northwood with a local provider but seek services in neighboring communities for dental and vision care. Local communities providing these services include Larimore, Mayville, Park River, and Grand Forks. Local pharmacy services are available in both Northwood and Larimore where NDHC also has clinics.

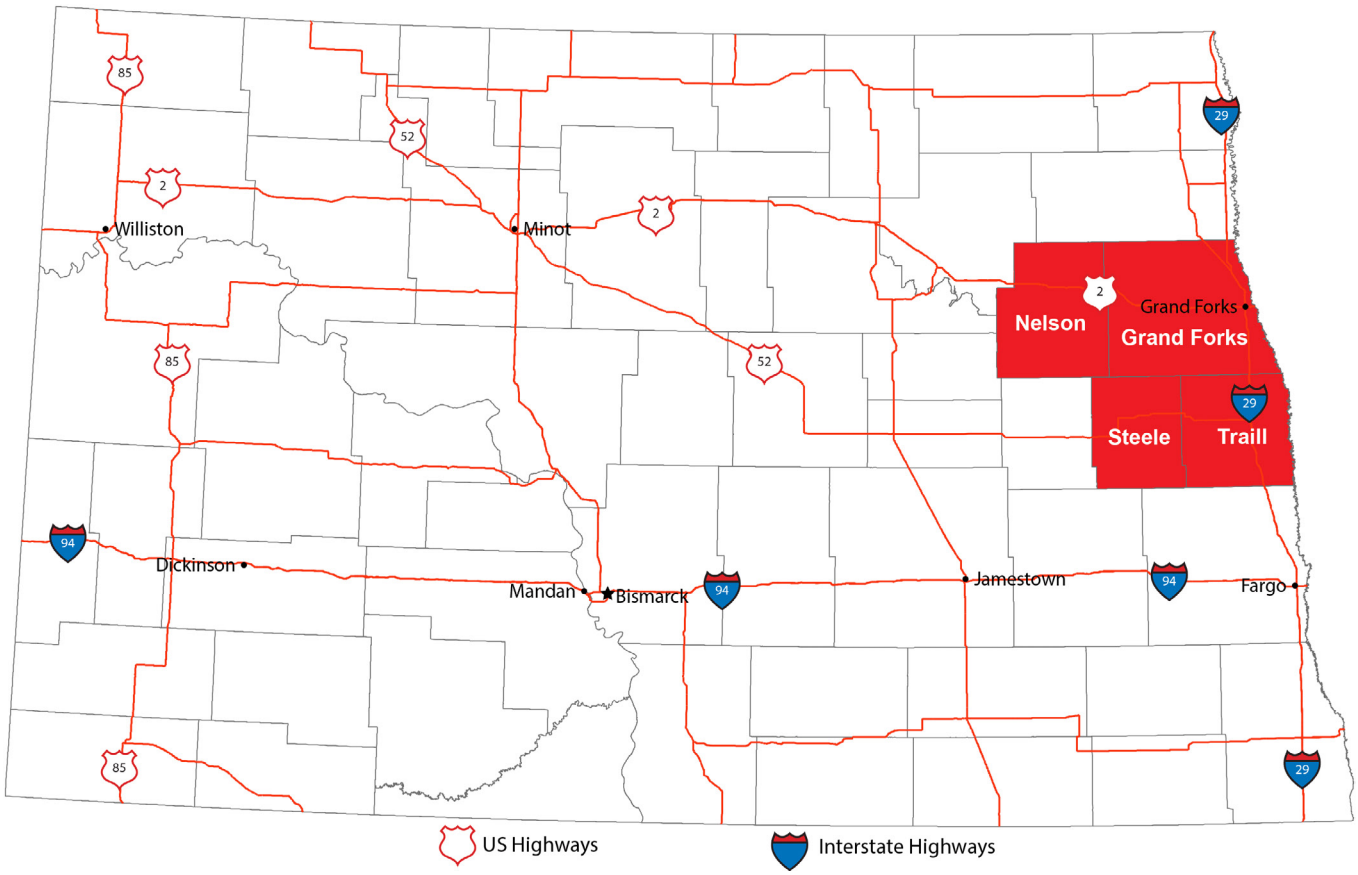
NDHC is in the process of a facility expansion, with a $39.6 million building project that will include a new 25-bed Critical Access Hospital (CAH) and living center, CT scanner, emergency department, operating room, and outpatient procedure area, along with renovated space for in-house pharmacy, therapies, and ultrasound technology. In total, almost 40,000 square feet of new and renovated space will be added to the current footprint.

The community of Northwood has a modern public school, constructed in 2009 with an addition to the elementary school constructed in 2019 to meet the needs of a growing enrollment. A Performing Arts Center was completed in 2020. The Performing Arts Center has provided an opportunity to expand the community's ability to secure and nurture the arts in its many forms. The community has the option to utilize the Performing Arts Center for a variety of

events. Enrollment has grown significantly over the past several years to an enrollment total of more than 300 students in grades K-12 with class sizes averaging between 20-35 students.

The local park district has a swimming pool, ball diamonds, and a 9-hole golf course. There are also walking paths, connecting the school to NDHC, as well as circulating the school area, the football field, and the hockey arena. NDHC supports a fitness center open to the community 24/7 with a nominal membership fee for access.

Figure 1: Grand Forks, Nelson, Steele, and Traill Counties, North Dakota



Northwood Deaconess Health Center

NDHC was started in 1902 by area Lutheran churches. It continues to be independently owned and operated by those Lutheran churches, nine in total, from the communities of Northwood, Sharon, and Larimore.

NDHC is licensed as a 25-bed CAH, with 9 acute beds and a 16-bed skilled living center. NDHC also has clinics in Northwood, Larimore, and Binford, six assisted living apartments and 10 independent living apartments which round out a full continuum of care on the NDHC campus. NDHC provides in-patient and out-patient therapy services to people of all ages, which includes lifespan from infancy to the elderly within the hospital, long-term care, area schools, and home atmospheres. NDHC also provides emergency services with ambulance and emergency room services available.

NDHC has a significant economic impact on the region. As of 2025, they directly employ 170 employees with an annual payroll of over $11.1 million (including benefits). These employees create an additional 230 jobs and nearly $4.2 million in income, as they interact with other sectors of the local economy.

The Mission of NDHC is to:

- Serve as local access to a full range of healthcare services.
- Continue as a leader in primary care for the whole family, in care of the elderly, and in emergency services.
- Function as a focal point for community health education and wellness.

NDHC provides these services in a Christian environment, respecting the dignity of all.

Services offered locally by NDHC include:
General and Acute Services

- Ambulance services
- Assisted Living
- Blood pressure checks
- Cervical and cancer screenings
- Chronic disease management
- Clinic
- Clinic mental health services
- Emergency room
- Ear lavage
- Foot care clinic
- Geriatric health
- Hospital swing bed
- Hospital acute care
- Hospital adult daycare
- Hospital respite care
- Injections: joint and allergy
- Lesion removals
- Lower extremity circulatory assessment
- Medi-Alerts
- Medical wellness visits
- Meals on Wheels
- Men's wellness
- Nutrition counseling
- Nebulizer treatments
- Outpatient/Inpatient infusions
- Oxygen administration
- Pharmacy services – inpatient
- Physicals: annual, DOT, sports, insurance, pre-op
- Preventative visits
- Removals: lesions, foreign body, skin tags, warts
- Respite care/adult daycare
- Senior life solutions – counseling
- Sleep studies
- Social services
- Sports medicine
- Suturing
- Splinting and casting
- Surgical services – outpatient colonoscopy and vascular
- Vaccine services – adult and pediatric
- Women's Health
- Well-child checks – infant and child

Therapy Services

- Hand therapy

- Occupational therapy
- Physical therapy
- Pelvic floor therapy
- Pediatric services
- Speech therapy

Specialty Providers

- Colonoscopy
- Cardiology
- Dermatology
- Endoscopy
- Oncology
- OB/GYN

DMS Imaging

- CT
- Dexa-Scan
- Mammography
- MRI

Laboratory Services

- Blood glucose
- Chemistry
- Coagulation
- DNA/RNA molecular testing
- Hemoccult
- HGC
- Heart monitors – Zio patch
- Occult blood
- Phlebotomy – inpatient and outpatient (all ages)
- Two O negative trauma blood units
- Urinalysis

Radiology Services

- X-rays
- EKG
- Ultrasounds
- Echocardiograms

Services Offered by Other Providers

- Chiropractic Services

Grand Forks Public Health

Grand Forks Public Health (GFPH) provides services to the city and county of Grand Forks, North Dakota. They believe in creating a culture in which all people have the means and the opportunity to make choices that lead to the healthiest lives possible. They facilitate policy, system, and environmental changes that are supported by businesses, government, individuals, and organizations all working together to foster healthy communities and lifestyles. Functioning with the vision of healthy people, healthy environment, and healthy community.

The mission of GFPH is to:

- Promote healthy environments and lifestyles.
- Prevent disease.
- Build community resilience through preparedness.
- Assure access to health services.

Values

GFPH aspires to be a consumer-focused agency delivering the highest quality public health services, which are science-informed and evidence-based. The department's work is focused on demonstrating these values:

- Client focused
- Respect
- Collaboration
- Integrity
- Evidence-based
- Advocacy

Specific services that GFPH provides are:

- Alcohol prevention and control
- Animal bite/rabies investigation and quarantine or testing of animals
- Breastfeeding resources
- Community Health Assessment
- Correctional health
- Counseling, Testing, and Referral (CTR) program – HIV testing and Hepatitis C testing
- Disease surveillance
- Emergency Preparedness services – work with community partners as part of local emergency response team
- Fit-testing and Personal Protective Equipment (PPE) training
- Food service inspections at county schools and childcare facilities
- Increase access to local foods through local farmer's markets and community gardens
- Investigate and abate public health nuisances
- Inspect and advise the public on housing and sanitation issues (pest, mold, radon, and lead)
- Immunizations for adult and pediatric populations
- Medication setup with Adult Home Visit Services
- Mental health coordination and wellness promotion
- Nutrition education
- Opioid response efforts including increasing access to Naloxone and recovery resources
- Preschool education health screening
- Ryan White Program
- School health – health education and resource to the schools
- Syringe service exchange program
- Test and inspect public pools
- Tobacco prevention and control
- Tuberculosis surveillance and management

- Wellness programs for city and county employees
- West Nile program – surveillance and education
- Women's Way breast and cervical cancer early detection program

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, as well as helping the local public health unit and federally qualified health center meet accreditation and assessment requirements.

TThis assessment examines health needs and concerns in Grand Forks County, which is included in the Northwood Deaconess Health Center (NDHC) service area.

The Center for Rural Health (CRH), in partnership with NHDC and Grand Forks Public Health (GFPH), 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 NHDC. A 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. Seven people, representing a cross section demographically, attended the focus group meeting. The meeting was highly interactive with good participation.

Figure 2: Steering Committee

Brock Serva	CFO, NDHC
Jill Trostad	Clinic Manager, NDHC
Kris Bilden	COO, NDHC
Doris Cooper	HR/Marketing Manager, NDHC
Kate Goldade	Public Health Team Leader, GFPH
Teresa Farmer	Public Health Team Leader, GFPH
Tess Wall	Director, GFPH

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 a North Dakota Health and Human Services 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, 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 21 community members was convened and first met on June 21, 2025. 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 August 13, 2025 with 19 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 Grand Forks 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 NDHC and GFPH. They included representatives of the health community, business community, political bodies, law enforcement, education, agriculture community, and faith community. Not all members of the group were present at both meetings.

Interviews

One-on-one interviews with five key informants were conducted in person in Northwood on June 21, 2025. 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 B and a full listing of direct responses provided for the questions that included "Other" as an option are included in Appendix F.

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

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

Specifically, the survey covered the following topics:

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

To promote awareness of the assessment process, a press release was submitted to the Northwood Gleaner, the local newspaper. Additionally, information was published on NDHC's website and Facebook pages. Information, regarding the survey, was also shared in flyers throughout the community of Northwood, Larimore, and Hatton. The survey was also shared with all staff internally through the staff newsletter.

Information was shared with area residents on how to complete the survey online, with the option to request a paper copy from NDHC. A QR code along with a link to the survey was shared on all advertisements.

Approximately 50 paper copies of the survey were available upon request from NDHC.

To help ensure anonymity, included with each survey was a postage-paid return envelope to CRH. The survey period ran from June 16, 2025 to July 7, 2025. No completed paper surveys were returned.

Area residents were also given the option of completing an online version of the survey, which was publicized in a press release to the local newspaper and on the websites and Facebook pages of both NDHC and GFPH. One hundred six online surveys were completed. Nine of those online respondents used the QR code to complete the survey. The total number of surveys completed equated to a 15% response rate. This response rate is on par for this type of unsolicited survey methodology and indicates an engaged community.

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."

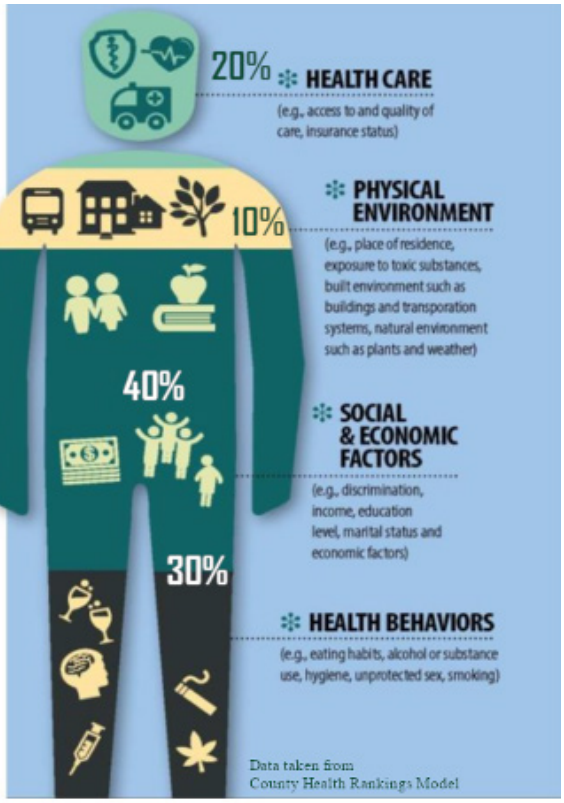
Income-level, educational attainment, race/ethnicity, and health literacy all impact the ability of people to access health services. Basic needs, such as clean air and water and safe and affordable housing, are all essential to staying healthy and are also impacted by the social factors listed previously. 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.

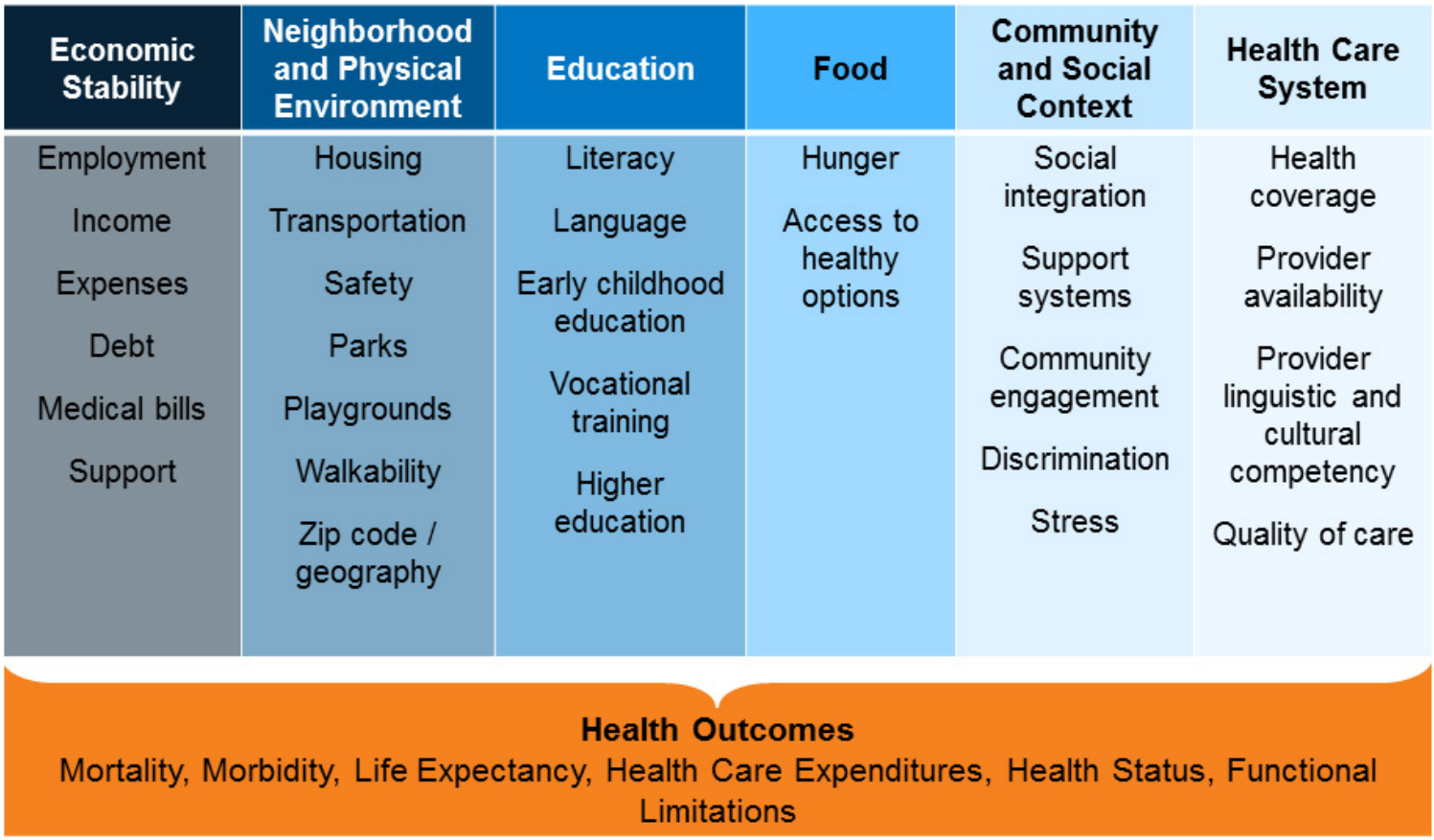
For Figure 3, data have been derived from the County Health Rankings model, (https://www.countyhealthrankings.org/resources/county-health-rankings-model), and it illustrates that healthcare, while vitally important, plays only one small role (approximately 20%) in the overall health of individuals and, 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



In Figure 4, 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



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Demographic Information

TABLE 1: summarizes general demographic and geographic data about Grand Forks County.
From 2020 Census/2024 American Community Survey; more recent estimates used where available

	Grand Forks County	North Dakota
Population (2024)	73,771	796,568
Population change (2020-2024)	+.06%	2.2%
People per square mile (2020)	50.9	11.3
Persons 65 years or older (2023)	14.8%	17.0%
Persons younger than 18 years (2023)	21.1%	23.6%
Median age (2023)	30.8	36.3
White persons (2023)	86.9%	86.4%
High school graduates (2019-23)	95.7%	93.8%
Bachelor's degree or higher (2019-23)	37.2%	32.3%
Live below poverty line (2023)	12.5%	9.8%
Persons without health insurance, younger than age 65 (2022)	6.4%	5.3%
Households with a broadband internet subscription (2019-2023)	87.5%	87.5%

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

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

The data used in the 2024 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. In 2024, County Health Rankings moved away from having ranks, such as 1 or 2, which would be considered the "healthiest." Their focus now is allowing users to find counties who are experiencing similar conditions, whether it be across state lines or across the county, to collaborate and create solutions.

A model of the 2024 County Health Rankings – a flow chart of how a county's rank is determined – may be found in Appendix C. For further information, visit the County Health Rankings website at www.countyhealthrankings.org.

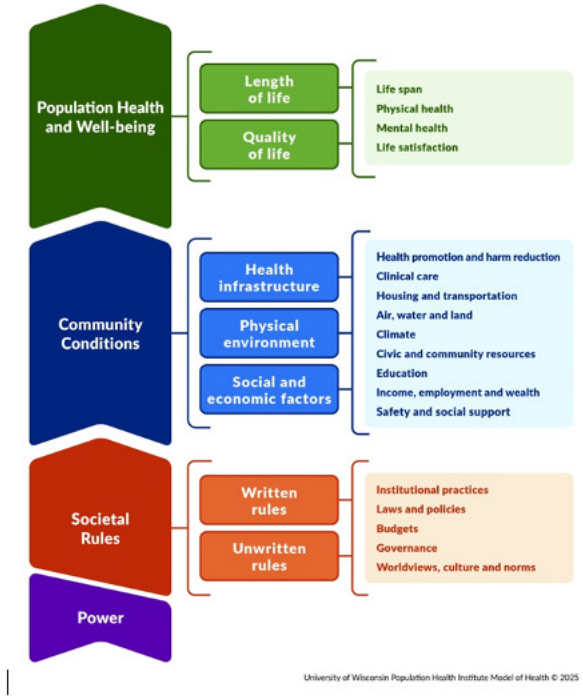


Table 2 summarizes the pertinent information gathered by County Health Rankings as it relates to Grand Forks County. It is important to note that these statistics describe the population of a county, regardless of where county residents choose to receive their medical care. In other words, all of the following statistics are based on the health behaviors and conditions of the county's residents, not necessarily the patients and clients of GFPH and NDHC 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 2022. 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).

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 Dunn, Mercer, and Oliver Counties, like many North Dakota counties, are doing poorly in many areas, when it comes to the U.S. Top 10% rankings and the rest of the state. One particular outcome where Dunn, Mercer, and Oliver Counties do not meet the U.S. Top 10% ratings is excessive drinking.

On health factors, Dunn, Mercer, and Oliver Counties perform below the North Dakota average for counties in several areas as well.

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

- Premature death
- Access to exercise opportunities
- Adult smoking
- Excessive drinking
- Alcohol-impaired driving deaths
- Teen birth rate
- Uninsured rate

- Primary care physicians to patient ratio
- Dentists to patient ratio
- Mental health provider to patient ratio
- Preventable hospital stays
- Mammography screening (Medicare enrollees)
- Flu vaccinations (Medicare enrollees)
- Unemployment rate
- Children in poverty
- Income inequality
- Injury deaths rate
- Drinking water violations

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

- Poor fair health
- Poor physical health days (in past 30 days)
- Poor mental health days (in past 30 days)
- Low birth weight
- Adult smoking
- Adult obesity
- Limited access to healthy foods
- Physical inactivity
- Sexually transmitted infections
- Social associations
- Air pollution – particular matter
- Severe housing problems

Table 2: Selected Measures from County Health Rankings 2024-GRAND FORKS COUNTY

COUNTY• = Not meeting North Dakota Average, ■ = Not meeting U.S. Top 10 % Performers + = Meeting or exceeding U.S. Top 10% performers.

	Grand Forks County	U.S. Top 10%	ND
Ranking: Outcomes			
Premature death	6,700 +	8,400	8,000
Poor or fair health	16% •+	17%	14%
Poor physical health days (in past 30 days)	3.7 •+	3.9	3.4
Poor mental health days (in past 30 days)	4.6 •+	5.1	4.5
Low birth weight	8% •+	8%	7%
Ranking: Factors			
Health Behaviors			
Adult smoking	17% •■	13%	16%
Adult obesity	37% •■	34%	36%
Food environment index (10=best)	8.6 •+	7.4	8.9
Physical inactivity	25% •■	23%	24%
Access to exercise opportunities	89% •■	84%	76%
Excessive drinking	23% ■	19%	25%
Alcohol-impaired driving deaths	26% +	26%	37%
Sexually transmitted infections	577.2 •■	495.0	475.3
Teen birth rate	9 +	16	14
Clinical Care			
Uninsured	6% +	10%	7%
Primary care physicians	820:1 +	1,330:1	1,290:1
Dentists	1,170:1 +	1,360:1	1,420:1
Mental health providers	260:1 +	300:1	420:1
Preventable hospital stays	2,685 ■	2,666	2,944
Mammography screening (% of Medicare enrollees aged 65-74 receiving screening)	58% +	44%	53%
Flu vaccinations (% of fee-for-service Medicare enrollees receiving vaccination)	57% +	48%	49%
Social and Economic Factors			
Unemployment	1.7% +	3.6%	1.9%
Children in poverty	9% +	16%	10%
Income inequality	4.3 +	4.9	4.5
Social associations	9.9 •+	25%	18%
Injury deaths	68 +	84	78
Physical Environment			
Air pollution – particulate matter	7.5 •■	5.9	6.4
Drinking water violations	No		
Severe housing problems	17% •+	17%	12%

Source: 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 is from 2022-23. 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 2: Selected Measures Regarding Children's Health

(For children ages 0-17 unless noted otherwise), 2021/2022

Health Status	North Dakota	National
Children born premature (three or more weeks early)	11.8%	11.3%
Children aged 6-17 who were overweight or obese	28%	32.2%
Children aged 0-5 who were ever breastfed	80.7%	82%
Children aged 6-17 who missed 11 or more days of school	6.2%	6.8%
Healthcare		
Children currently insured	94.6%	93.4%
Children who spent less than 10 minutes with the provider at a preventive medical visit	13.6%	19.1%
Children (1-17 years) who had preventive a dental visit in the past year	79.7%	79.2%
Children (3-17 years) received mental healthcare	14.2%	12.2%
Children (3-17 years) with problems requiring treatment did not receive mental healthcare	2.7%	3.0%
Young children (9-35 mos.) receiving standardized screening for developmental problems	45%	35.6 %
Family Life		
Children whose families eat meals together four or more times per week	74.8%	72.9%
Children who live in households where someone smokes	13.7%	11.5%
Neighborhood		
Children who live in neighborhoods with parks, recreation centers, sidewalks, and a library	90.8%	89.6%
Children living in neighborhoods with poorly kept or rundown housing	18%	23.9%
Children living in neighborhood that's usually or always safe	97.3%	95%

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 born premature (three or more weeks early)
- Children (aged 0-5 years) who were ever breastfed
- Children living in smoking households

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

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

The data show Grand Forks County is performing more poorly than the North Dakota average in several of the examined measures. The measures where Grand Forks County are not meeting the North Dakota average are child food insecurity, Supplemental Nutrition Assistance Program recipients ages 0-18, and suspected victims of child abuse and neglect ages 0-17.

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

	Grand Forks County	North Dakota
Child food insecurity, 2023	**14.3%**	13.5%
Medicaid recipients (% of population age 0-20), 2024	29.1%	33.2%
Children enrolled in Healthy Steps (CHIP) (% of population age 0-18), 2024	3.3%	3.6%
Supplemental Nutrition Assistance Program (SNAP) recipients (% of population age 0-18), 2024	**20.9%**	19.1%
Uninsured children (birth-18 yrs), 2023	3.6%	4.4%
Suspected victims of child abuse and neglect (ages 0-17), 2024	**4.7%**	3.1%

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

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

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

Table 5 depicts some of the YRBS data that has been collected in 2019, 2021, and 2023. 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 2021 to 2023, and "↓" for a decreased trend in the data changes from 2021 to 2023. The final column shows the 2023 national average percentage. For a more complete listing of the YRBS data, see Appendix D.

Table 5. Youth Risk Behavior Survey Results

North Dakota High School Survey

Rate Increase ↑, rate decrease ↓, or no statistical change = in rate from 2017-2019.

	ND 2019	ND 2021	ND 2023	ND Trend ↑, ↓, =	Rural ND Town Average	Urban ND Town Average	National Average 2023
Injury and Violence							
% of students who rarely or never wore a seat belt (when riding in a car driven by someone else)	5.9	49.6	49.6	↓	62.9	42.2	39.6
% 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)	14.2	13.1	14.3	↑	17.9	12.5	15.7
% of students who talked on a cell phone while driving (on at least one day during the 30 days before the survey)	59.6	64.4	66.4	↑	66.1	66.5	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)	53.0	55.4	56.5	↑	60.3	55.7	42.3
% 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 one day during the 30 days before the survey)	7.1	5.0	4.0	↓	4.9	3.5	4.2
% 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)	9.2	9.4	9.5	=	9.1	10.5	11.4
% of students who were bullied on school property (during the 12 months before the survey)	19.9	15.8	20.7	↑	23.5	20.8	19.2
% of students who were electronically bullied (includes texting, Instagram, Facebook, or other social media ever during the 12 months before the survey)	14.7	13.6	15.4	↑	12.5	13.3	16.3
% of students who made a plan about how they would attempt suicide (during the 12 months before the survey)	15.3	14.8	15.5	↑	15.0	15.0	16.4
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	31.6	↓	21.7	16.6	16.8
% 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	5.4	↓	7.0	4.8	17.9

% 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	10.3	↓	13.2	10.1	8.8
% of students who currently used marijuana (one or more times during the 30 days before the survey)	15.5	12.5	11.4	↓	12.0	11.4	17.0
% 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	9.2	↓	10.6	8.8	11.6
Weight Management, Dietary Behaviors, and Physical Activity							
% of students who were overweight (>= 85th percentile but <95th percentile for body mass index)	16.5	15.6	14.7	↓	15.6	15.2	14.7
% of students who had obesity (>= 95th percentile for body mass index)	14.0	16.3	16.3	=	18.1	14.3	15.9
% of students who did not eat fruit or drink 100% fruit juices (during the seven days before the survey)	6.1	5.0	4.7	=	6.0	6.1	6.7
% 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)	6.6	5.9	6.8	↑	6.5	7.2	6.8
% 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)	15.9	16.6	18.5	↑	18.0	16.8	14.5
% of students who did not eat breakfast (during the seven days before the survey)	14.4	15.1	16.7	↑	16.5	17.1	17.9
% 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)	2.8	2.1	2.3	=	2.7	2.8	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)	49.0	56.5	54.5	↓	54.7	54.3	46.3
% 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 three 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	75.7	77.2	↑	74.8	77.4	77.0

Other							
% of students who ever had sexual intercourse	38.3	36.6	35.2	↓	34.5	33.7	31.6
% of students who had eight or more hours of sleep (on an average school night)	29.5	24.5	27.5	↑	29.8	27.5	23.2

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 2023. The needs assessment study was accomplished through the collaboration of the CAAs and North Dakota State University 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.

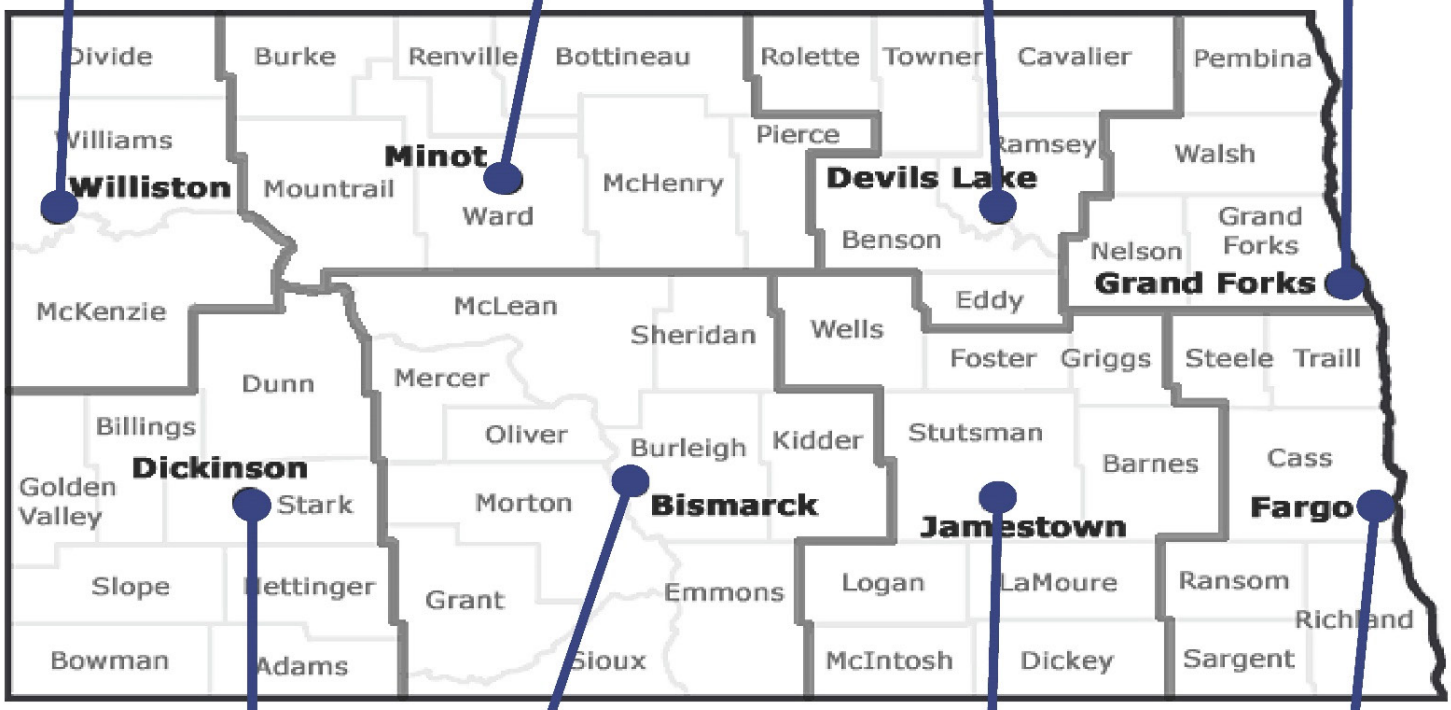
Top Regional Needs for Households Experiencing Poverty

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

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

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

Region 4
1. Housing
2. Health and Social/Behavior Development
3. Other Supports



Region 8
1. Housing
2. Health and Social/Behavior Development
3. Income and Asset-Building

Region 7
1. Housing
2. Employment
3. Income and Asset-Building

Region 6
1. Housing
2. Income and Asset-Building
3. Employment

Region 5
1. Housing
2. Income and Asset-Building
3. Health and Social/Behavior Development

Total Number of Survey Responses by Population Type

1,701 Households Experiencing Poverty
1,015 Households Not Experiencing Poverty
511 Other (Roles cannot be identified)

3227 Total Survey Responses

This 2023 Statewide Community Needs Assessment was conducted by the Community Action Partnership of North Dakota in conjunction with the North Dakota State University (NDSU) and the North Dakota Department of Commerce, Division of Community Service.

Community Action Partnership of North Dakota
3233 South University Drive | Fargo, ND 58104 | 701-232-2452
www.capnd.org

Helping People. Changing Lives. Community Action Partnership of North Dakota — North Dakota's Poverty Fighting Network

NDSU North Dakota State University

North Dakota Be Legendary. | Community Services — Commerce

2023 Statewide Community Needs Assessment

The Community Needs Assessment is a systematic process used to gather and analyze information about the needs and challenges of communities. These assessments are used in various fields, including public health, social services, urban planning, education, and economic development. They play a crucial role in ensuring that community resources are directed toward the most pressing issues and that community members' voices are heard in the decision-making process, ultimately leading to improved quality of life for the community as a whole.

Community Action Agencies conduct needs assessments every three years as a requirement for the Community Services Block Grant (CSBG) which supports community-based anti-poverty programs. The primary purpose of the study is to better understand the current conditions and priorities of a community so that local action plans can be developed and community resources/services can be allocated effectively to address those needs.

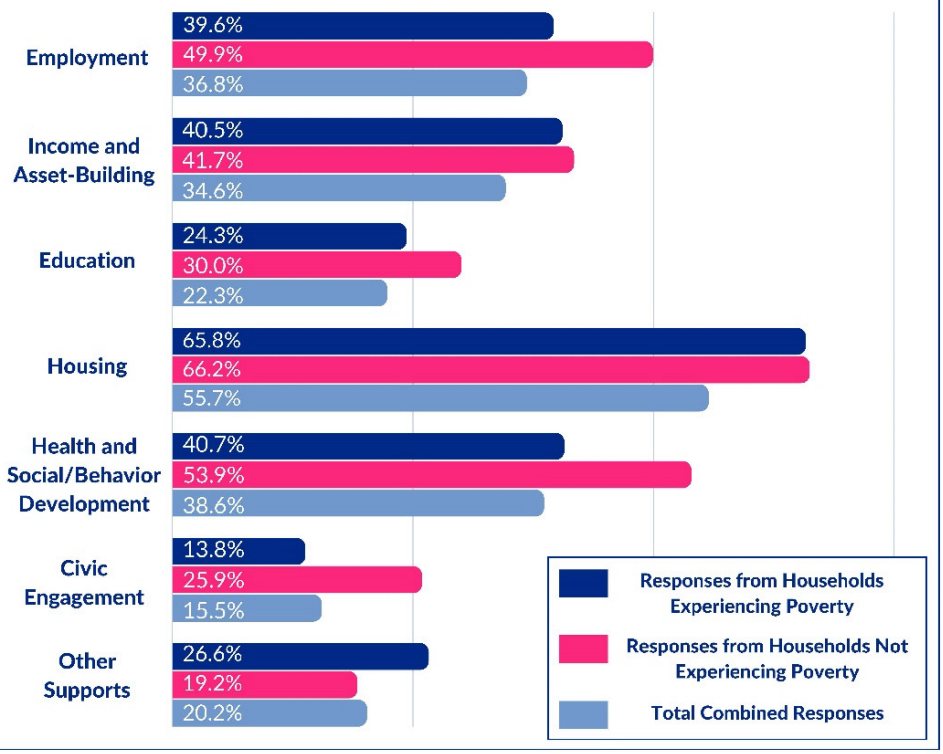
Statewide Specific Needs By Population Type

Households Experiencing Poverty	Households Not Experiencing Poverty	Overall Combined Community Needs
1. Rental Assistance	1. Mental Health Services	1. Rental Assistance
2. Food	2. Recreational Activities	2. Food
3. Dental Insurance/Affordable Dental Care	3. Safe Neighborhoods, Sidewalks, Parks	3. Dental Insurance/Affordable Dental Care

"Rental Assistance" remains the first priority for respondents experiencing poverty across the state.

"Mental Health Services" was the first priority need for respondents not experiencing poverty.

Statewide Overall Needs By Population Type



The comprehensive needs assessment was accomplished through surveys and focus groups in order to collect both quantitative and qualitative data. The surveys consist of both multiple-choice and open-ended questions with the intention of capturing both quantitative and qualitative data, and the focus groups are used to better understand the depth and breadth of the issue focusing on the collection of qualitative data.

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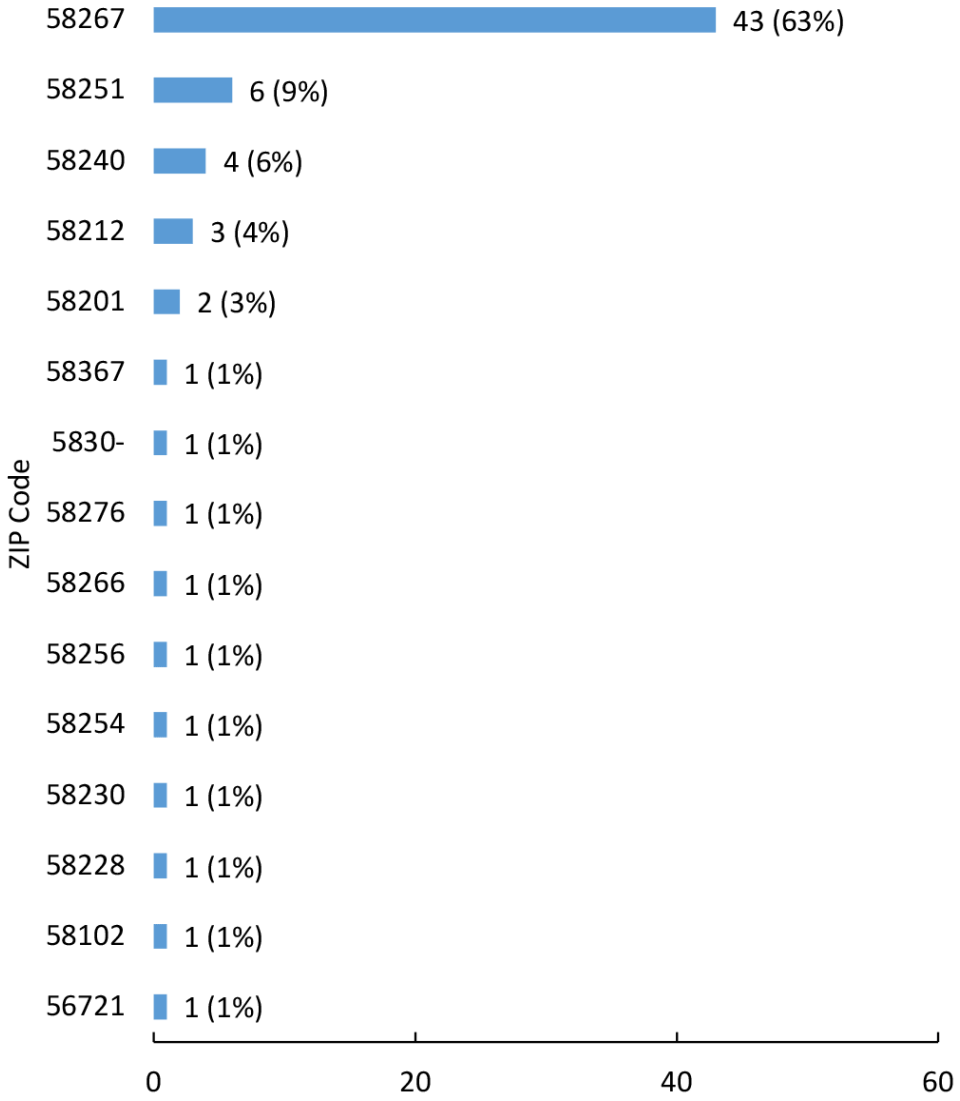
Survey Results

As noted previously, 106 community members completed the survey in communities throughout the counties in the NDHC service area. For all questions that contained an "Other" response, all of those direct responses may be found in Appendix F. 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, 68 did, revealing that a large majority of respondents (63%, N=43) lived in Northwood. These results are shown in Figure 5.

Figure 5: Survey Respondents' Home ZIP Code
Total respondents: 68



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

Survey Demographics

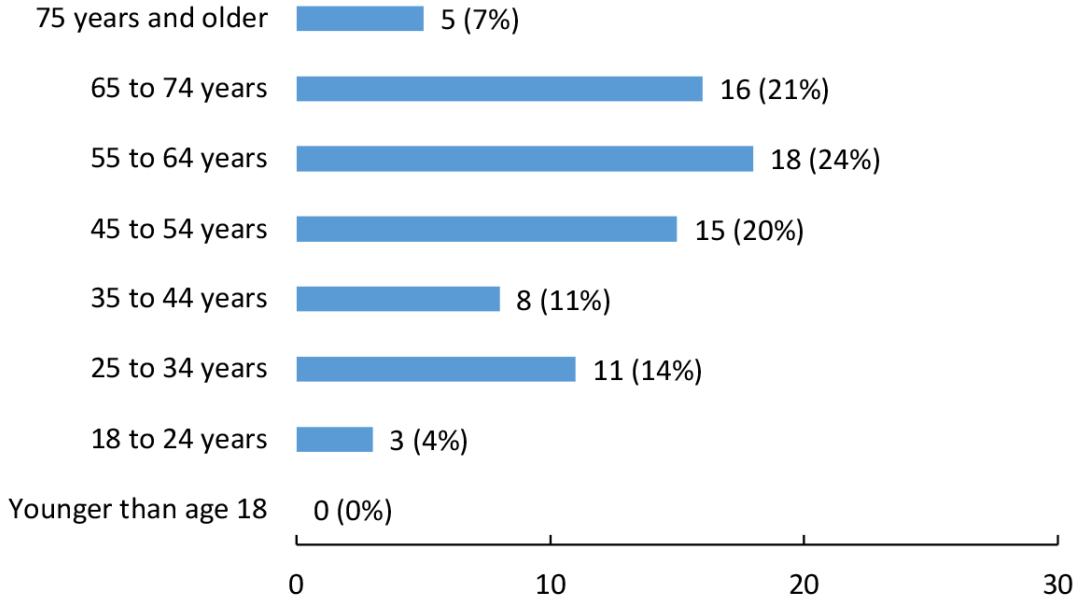
To better understand the perspectives offered by survey respondents, survey-takers were asked a few demographic questions. Throughout this report, numbers (N) instead of just percentages (%) are reported because percentages can be misleading with smaller numbers. Survey respondents were not required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

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

- Fifty-two percent (N=39) were age 55 or older.
- The majority (88%, N=66) were female.
- Over half of the respondents (56%, N=42) had bachelor's degrees or higher.
- The number of those working full time (63%, N=48) was nine times higher than those who were part-time (8%, N=6).
- One hundred percent (N=75) of those who reported their ethnicity/race were White/Caucasian.
- Eighteen percent of the population (N=12) 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 = 76



For the CHNA, people younger than age 18 are not questioned using this survey method.

Figure 7: Gender Demographics of Survey Respondents
Total respondents = 75

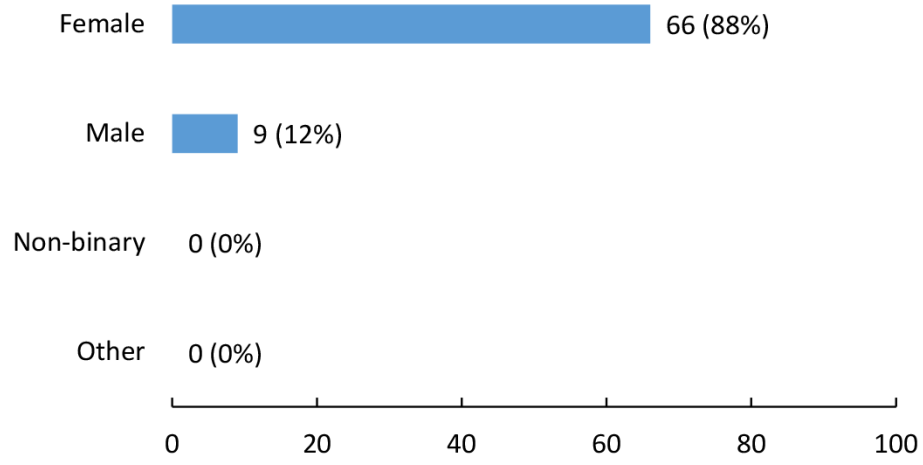


Figure 8: Educational Level Demographics of Survey Respondents
Total respondents = 76

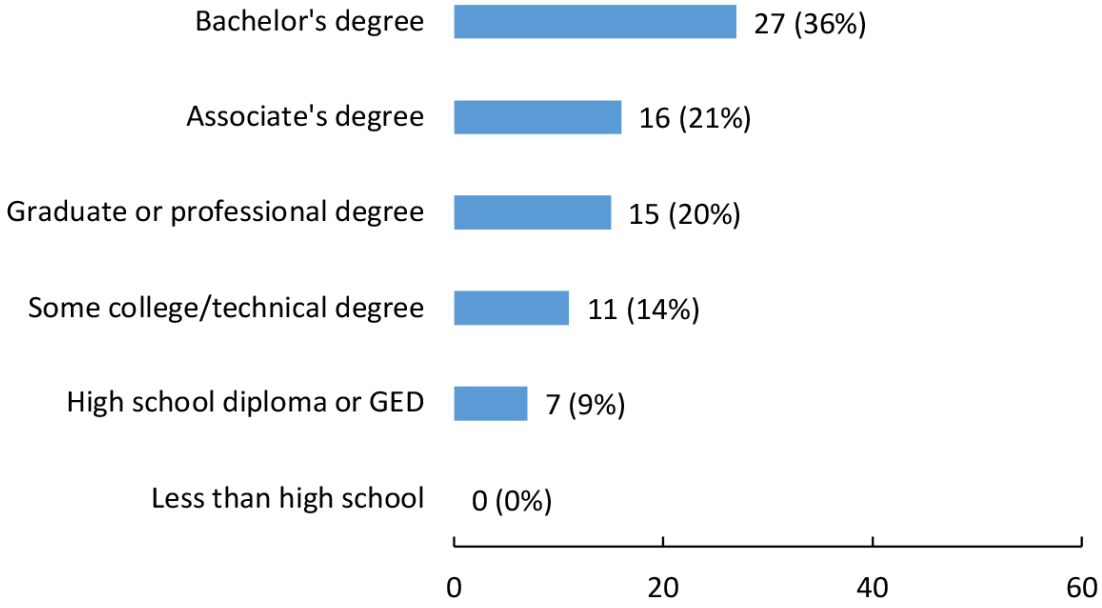
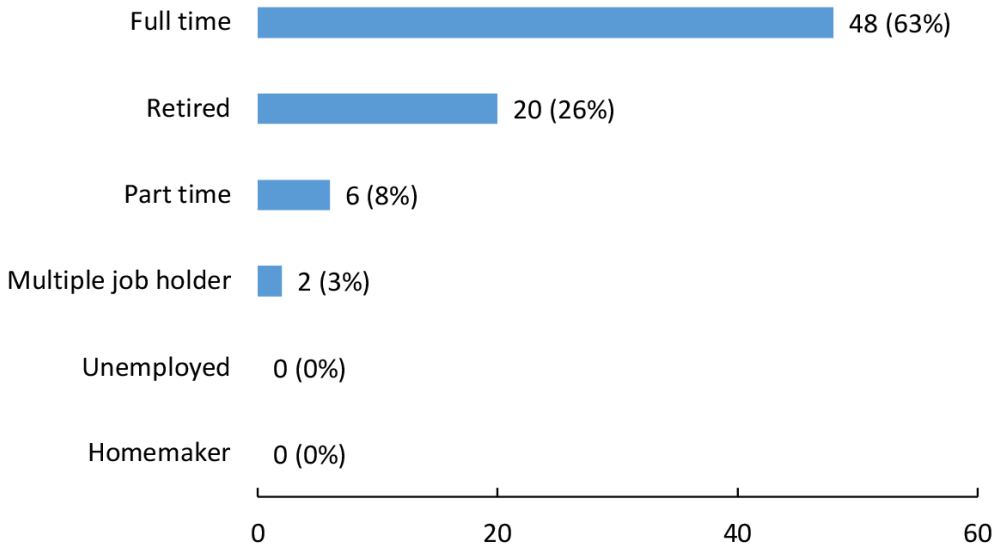
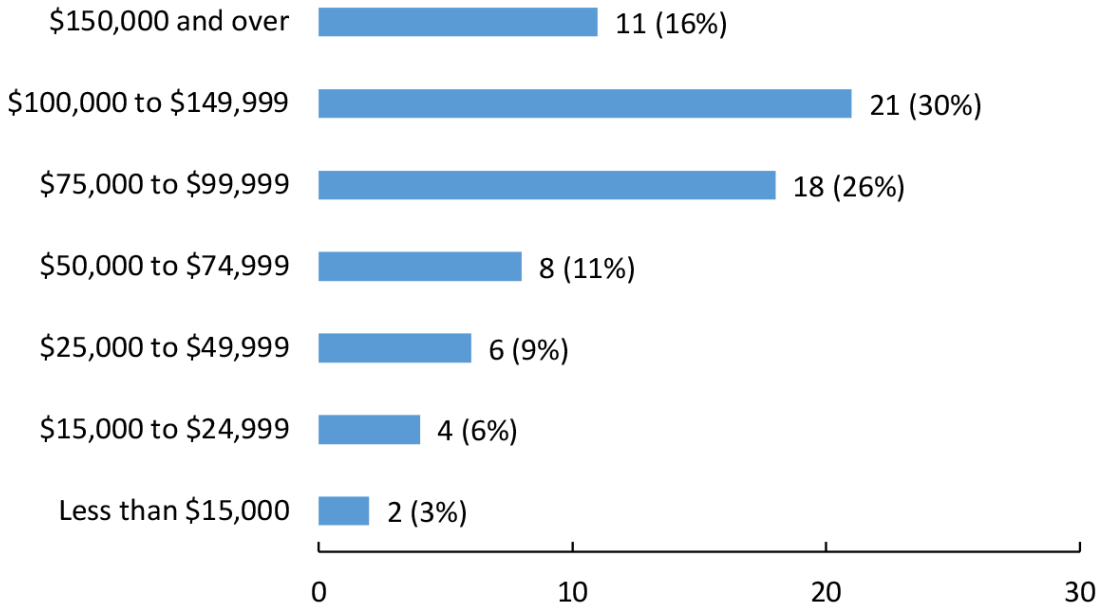


Figure 9: Employment Status Demographics of Survey Respondents
Total respondents = 76



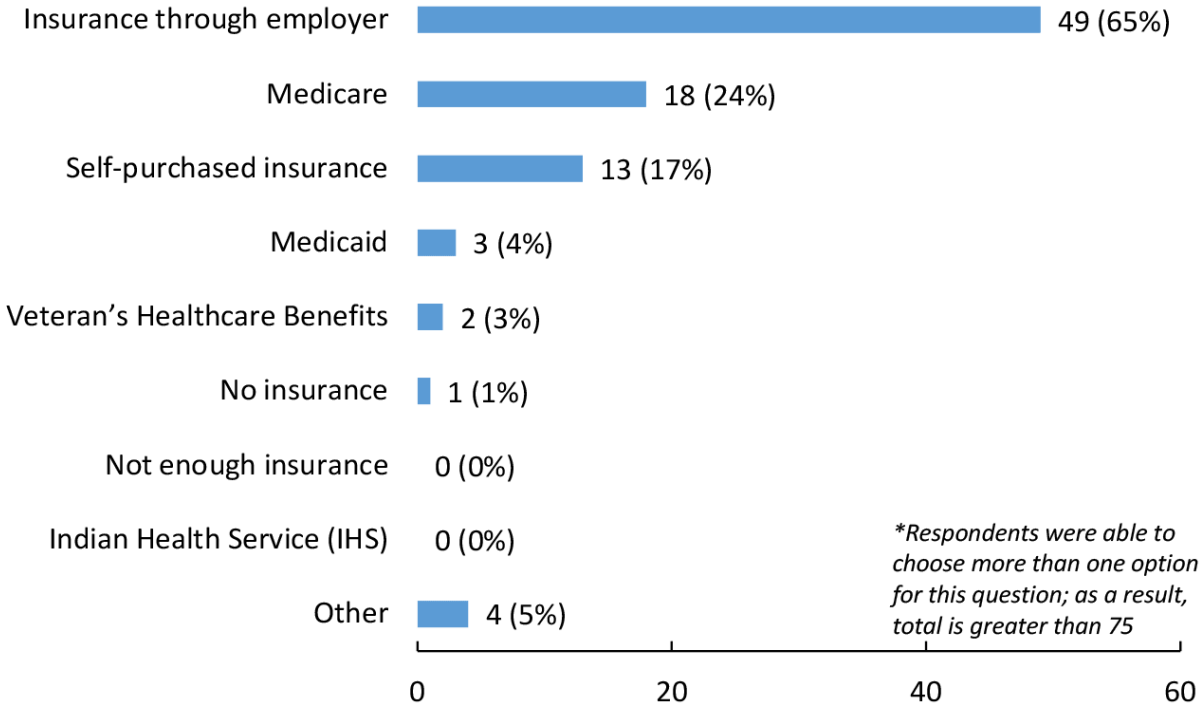
Of those who provided a household income, 9% (N=6) community members reported a household income of less than $25,000. Forty-six percent (N=32) indicated a household income of $100,000 or more. This information is shown in Figure 10.

Figure 10: Household Income Demographics of Survey Respondents
Total respondents = 70



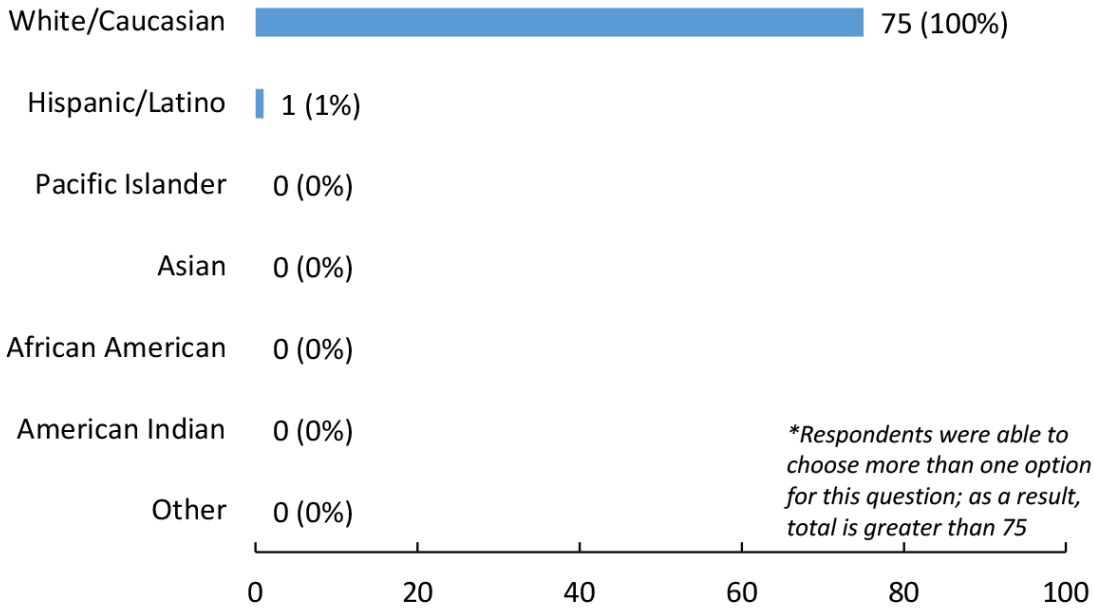
Community members were asked about their health insurance status, which is often associated with whether people have access to healthcare. One percent (N=1) of the respondents reported having no health insurance or being under-insured. The most common insurance types were insurance through one's employer (N=49), followed by Medicare (N=18), and self-purchased (N=13). Respondents who selected "Other" specified that Marketplace, Next Blue, and Health Share for their health insurance coverage.

Figure 11: Health Insurance Coverage Status of Survey Respondents
Total respondents = 75*



As shown in Figure 12, all of the respondents were White/Caucasian (100%). This was much higher with the race/ethnicity of the overall population of Grand Forks County; the U.S. Census indicates that 86.9% of the population is White in Grand Forks County.

Figure 12: Race/Ethnicity Demographics of Survey Respondents
Total respondents = 75*



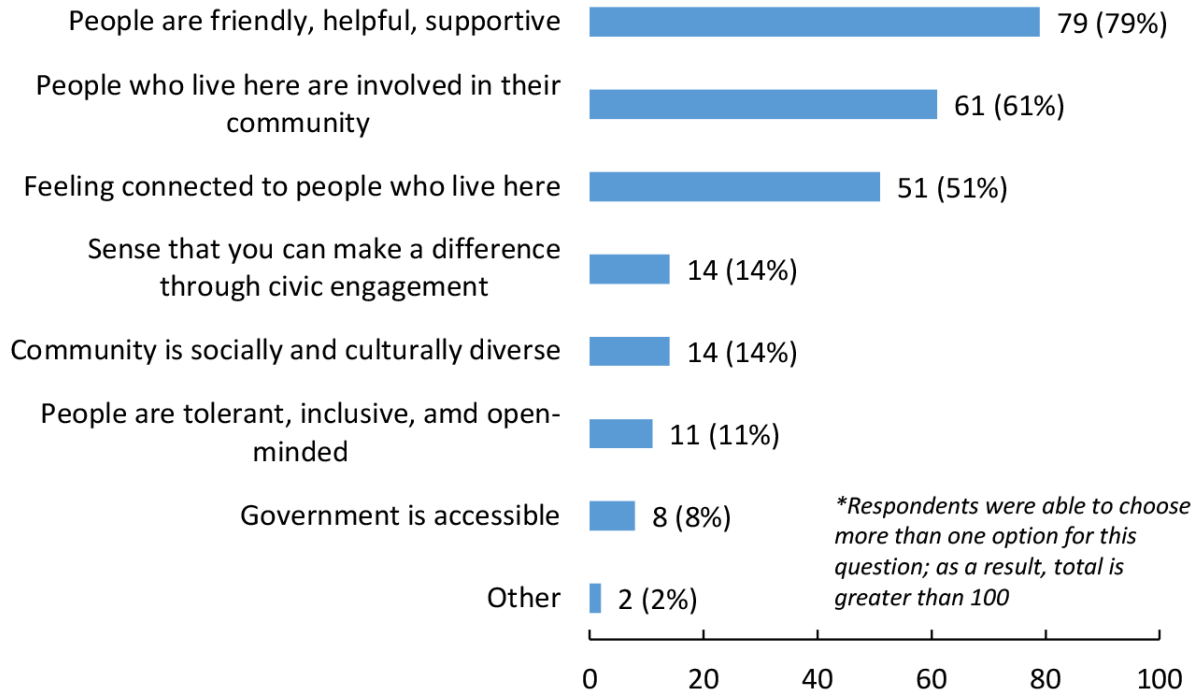
Community Assets and Challenges

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 60 respondents agreeing) that community assets include:

- Family-friendly (N=90)
- Healthcare (N=90)
- Safe place to live, little/no crime (N=81)
- People are friendly, helpful, supportive (N=79)
- People who live here are involved in their community (N=61)

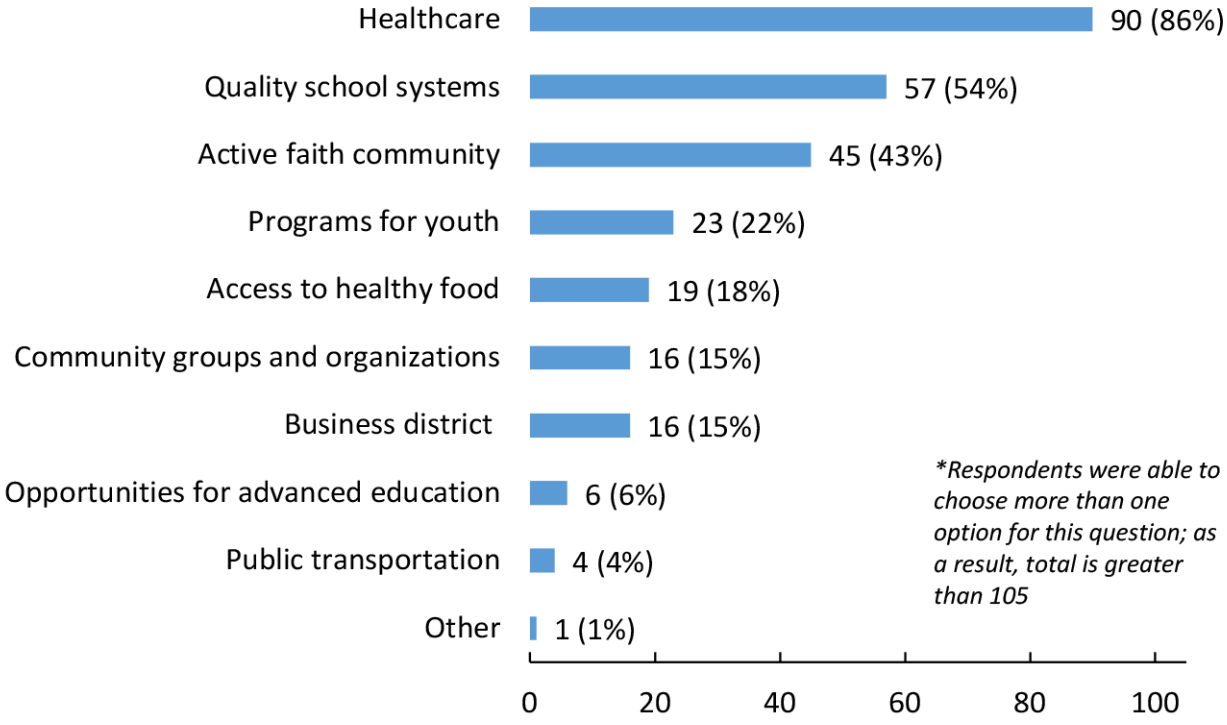
Figures 13 to 16 illustrate the results of these questions.

Figure 13: Best Things About the PEOPLE in Your Community
Total responses = 100*



Respondents who selected "Other" specified that the best things about the people in the community included available activities, senior center, library, and parks.

Figure 14: Best Things About the SERVICES AND RESOURCES in Your Community
Total responses = 105*



One respondent who selected "Other" mentioned only wanting to select more than three options

Figure 15: Best Things About the QUALITY OF LIFE in Your Community
Total responses = 105*

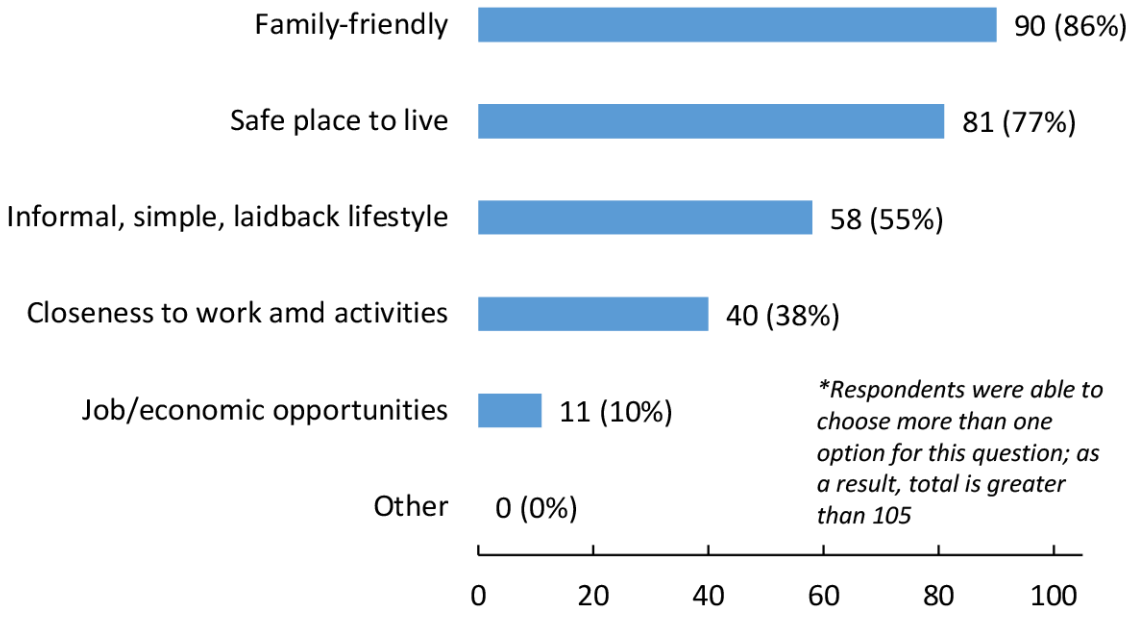
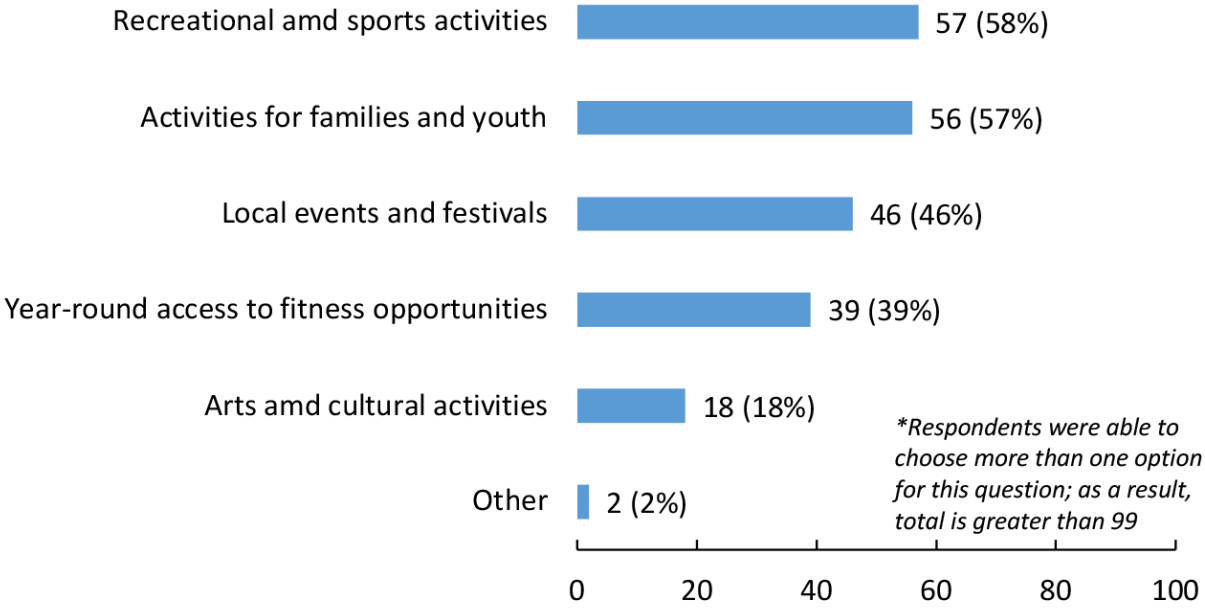


Figure 16: Best Thing About the ACTIVITIES in Your Community
Total responses = 99*



Respondents who selected "Other" specified that the best things about the activities in the community included access to nature, hunting, fishing, outdoors, church activities, and lakes and rivers.

Community Concerns

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

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

With regard to responses about community challenges, the most highly voiced concerns (those having at least 30 respondents) were:

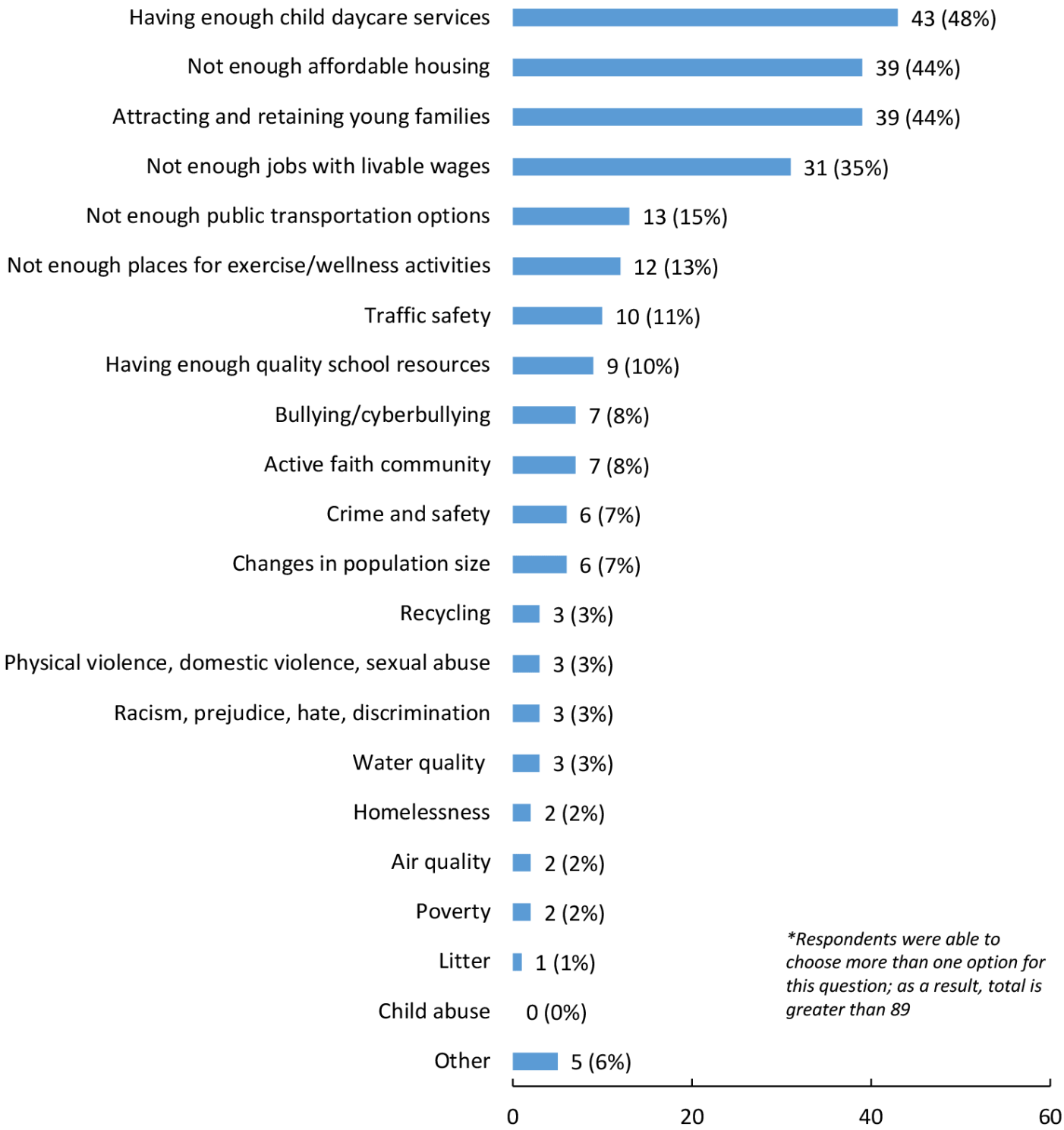
- Depression/anxiety – youth (N=48)
- Bullying/cyberbullying (N=43)
- Attracting and retaining young families (N=38)
- Alcohol use and abuse – adults (N=34)
- Depression/anxiety – adult (N=32)
- Cost of long-term/nursing home care (N=32)
- Not enough places for exercise/wellness activities (N=31)
- Availability of resources to help the elderly stay in their homes (N=30)

The other issues that had at least 24 votes included:

- Child abuse or neglect (N=27)
- Not enough jobs with livable wages (N=27)
- Smoking and tobacco use (second-hand smoke) – youth (N= 26)
- Stress (N=26);
- Assisted living options (N=25)
- Cost of healthcare services (N=24)

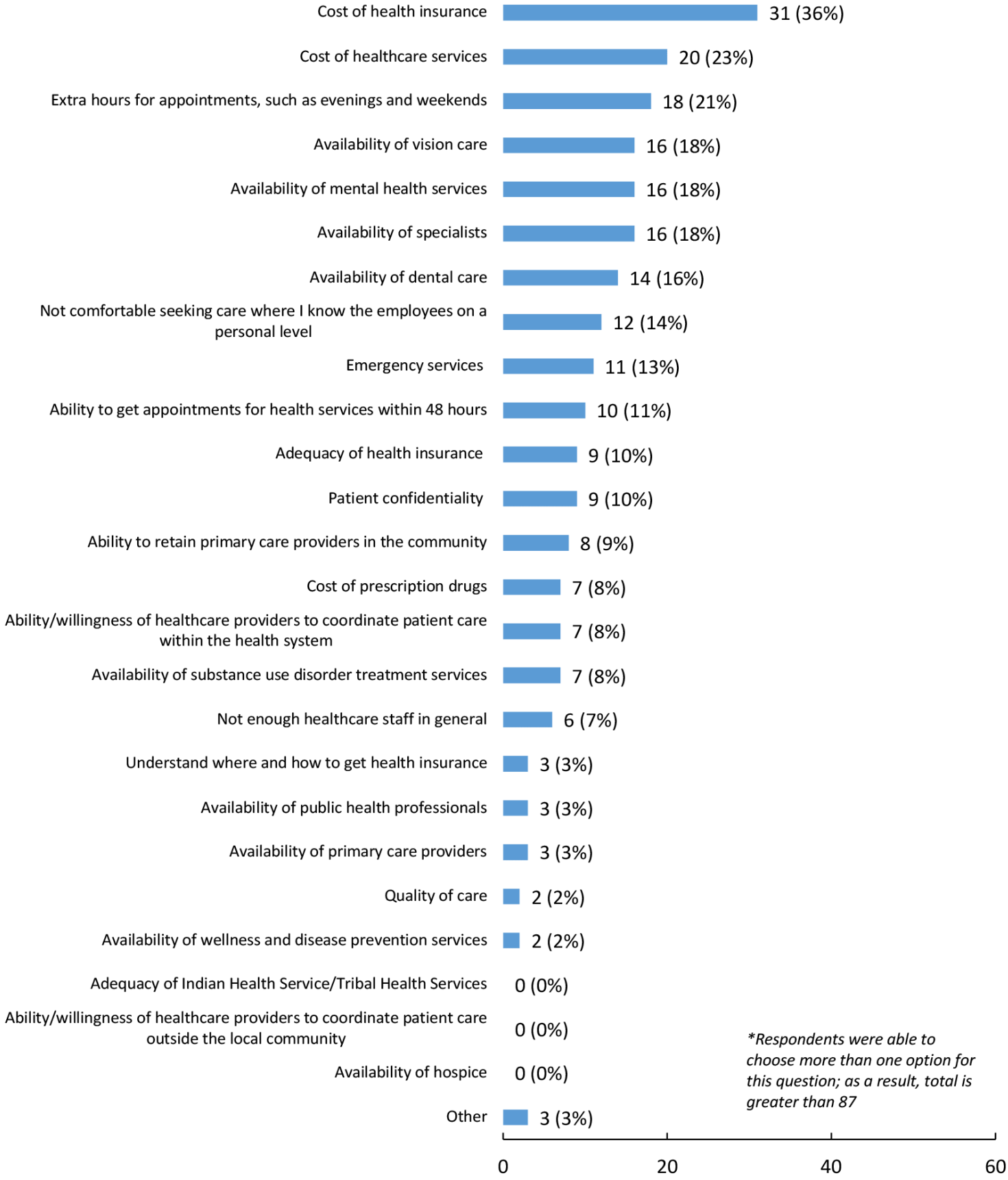
Figures 17 through 22 illustrate these results.

Figure 17: Community/Environmental Health Concerns
Total responses = 89*



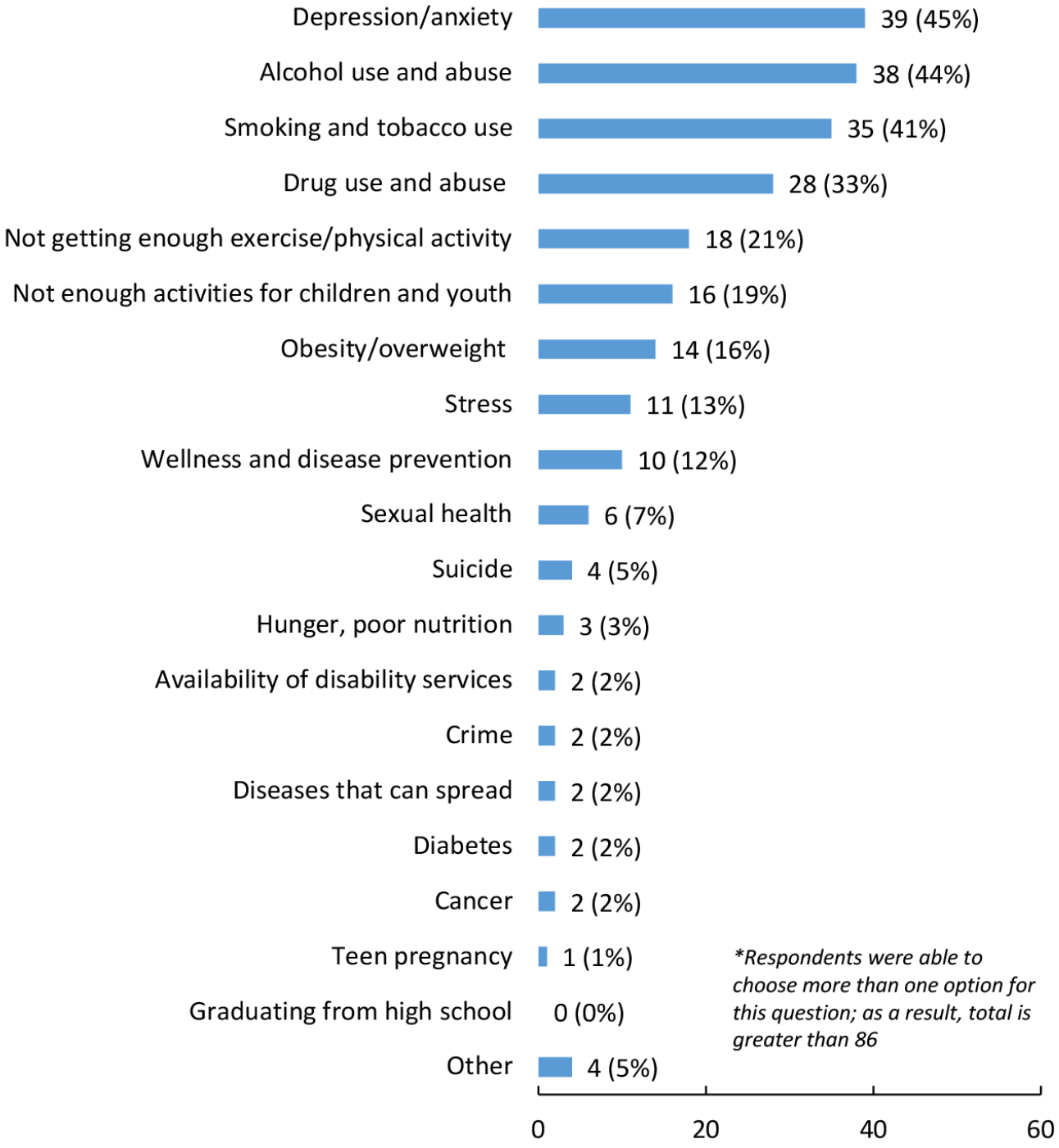
Respondents who selected "Other" for community and environmental concerns included streets, dangerous potholes, lack of dog warden, and senior exercise affordability.

Figure 18: Availability/Delivery of Health Services Concerns
Total responses = 87*



One respondent who selected "Other" for a concern in the availability/delivery of health services stated there needs to be more dentists in the area that accept Medicaid recipients.

Figure 19: Youth Population Health Concerns
Total responses = 86*



Respondents cited bullying, manners and politeness, and favoritism in youth sports as concerns for youth population.

Figure 20: Adult Population Concerns
Total responses = 88*

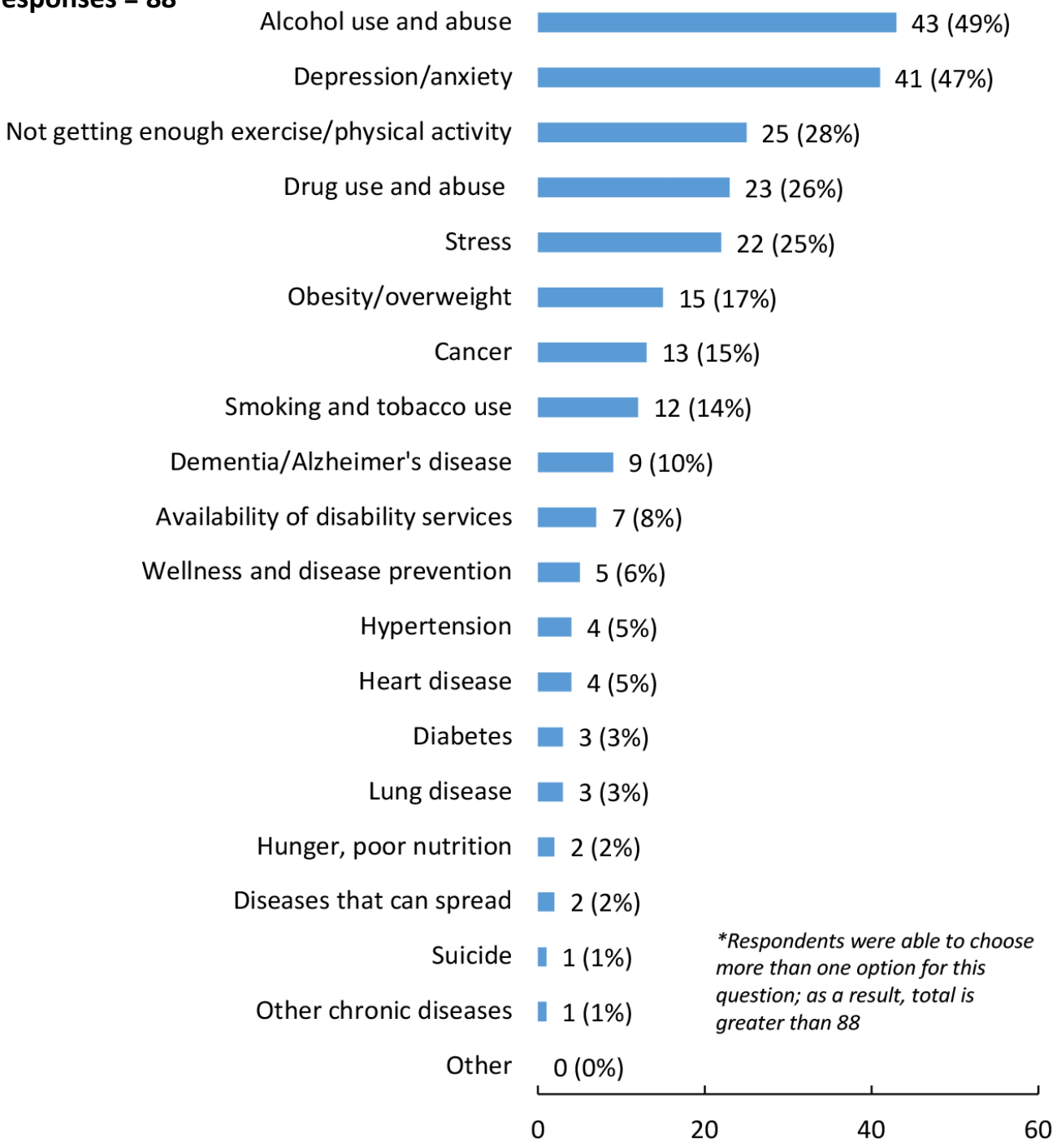
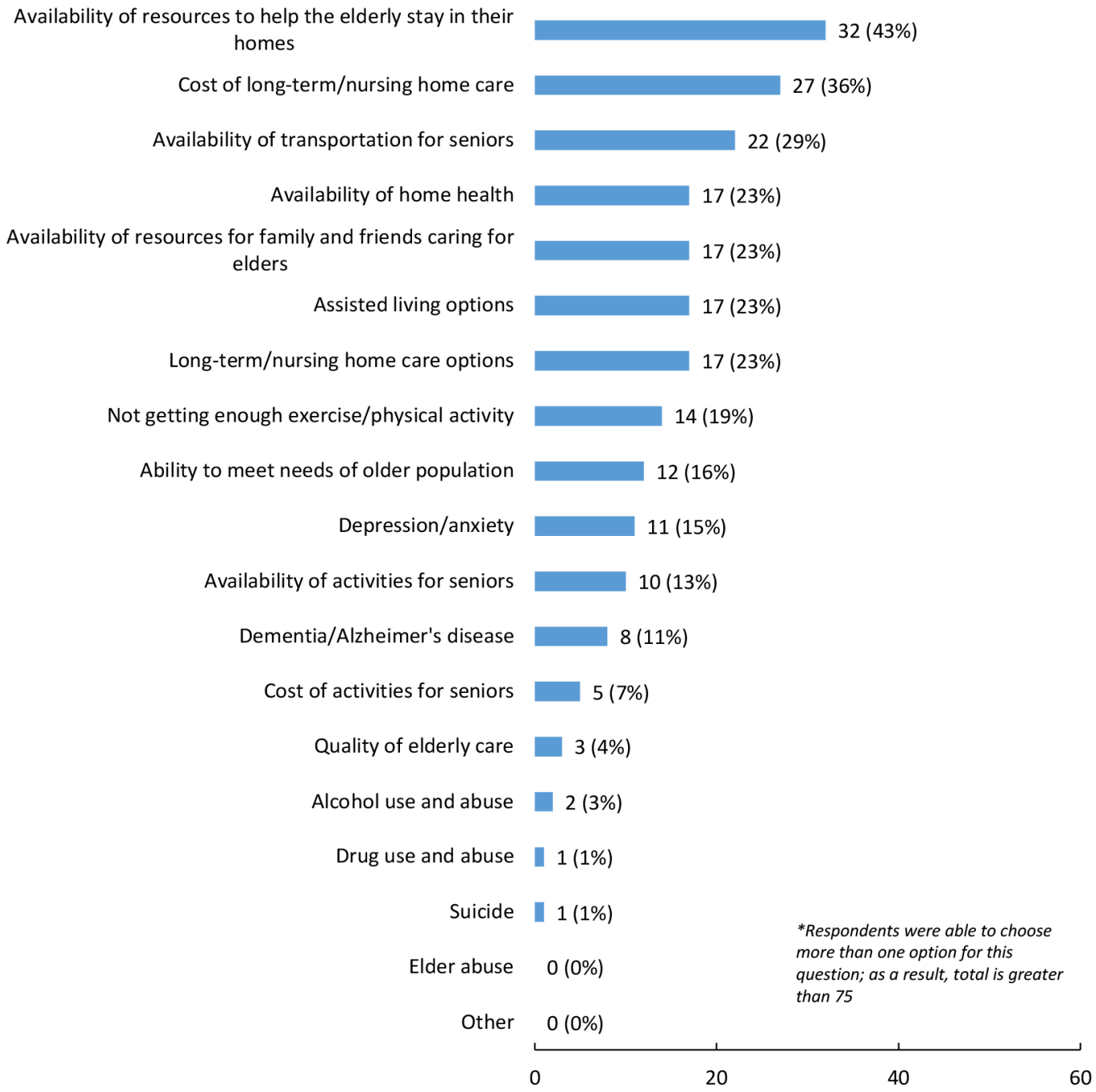


Figure 21: Senior Population Concerns
Total responses = 75*



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

1. Lack of housing
2. Lack of daycare options
3. Lack of resources to meet the needs of the elderly

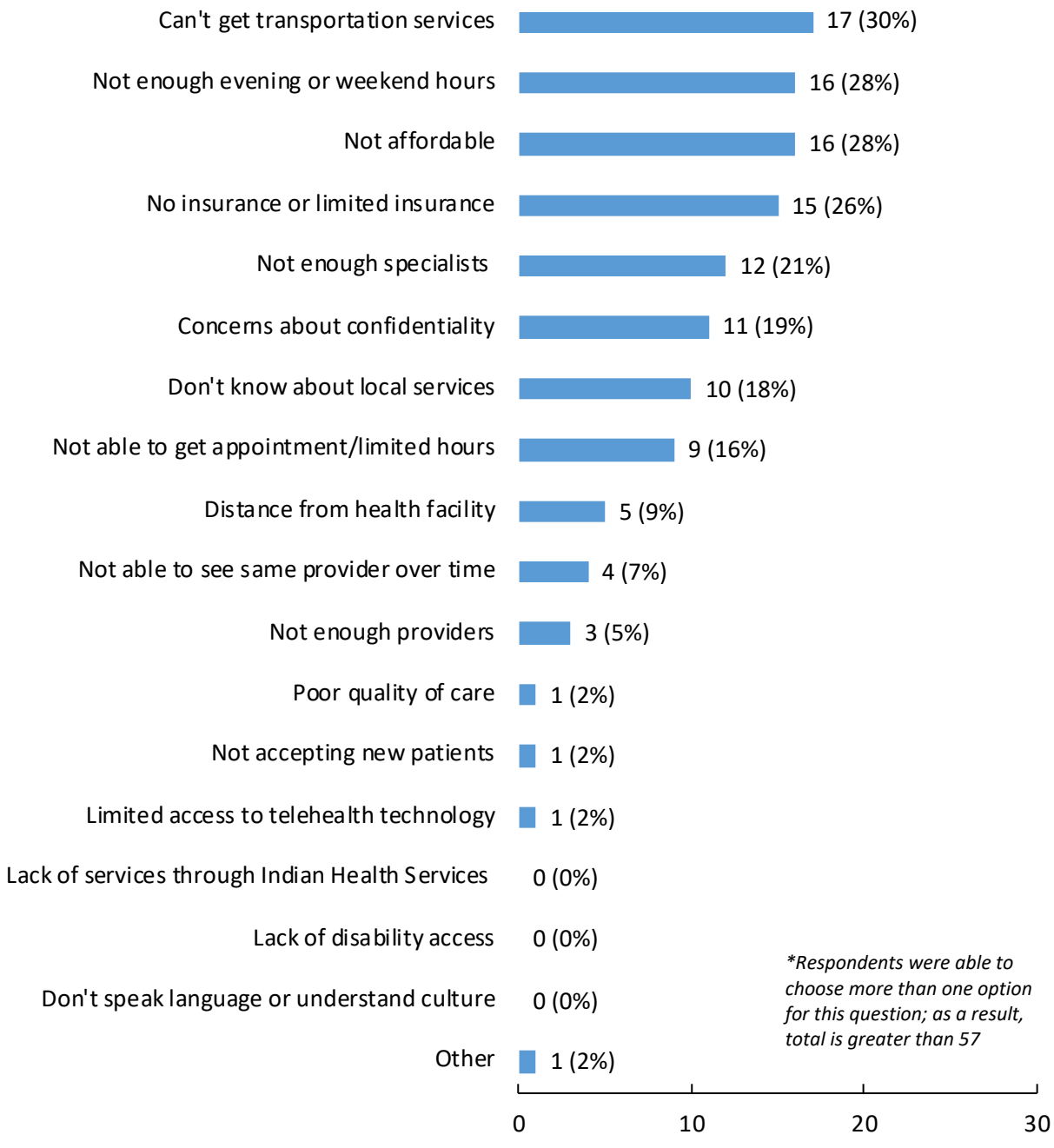
Other biggest challenges that were identified were alcohol and drug use, activities for people of all ages, infrastructure issues (mainly roads), few job openings, lack of transportation, and healthcare costs.

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 access to transportation services (N=17), with the next highest being not enough evening or weekend hours (N=16), and not affordable (N=16). After these, the next most commonly identified barriers were no insurance or limited insurance (N=15) and not enough specialists (N=12). One respondent selected "Other" but the barrier was not relevant to the question.

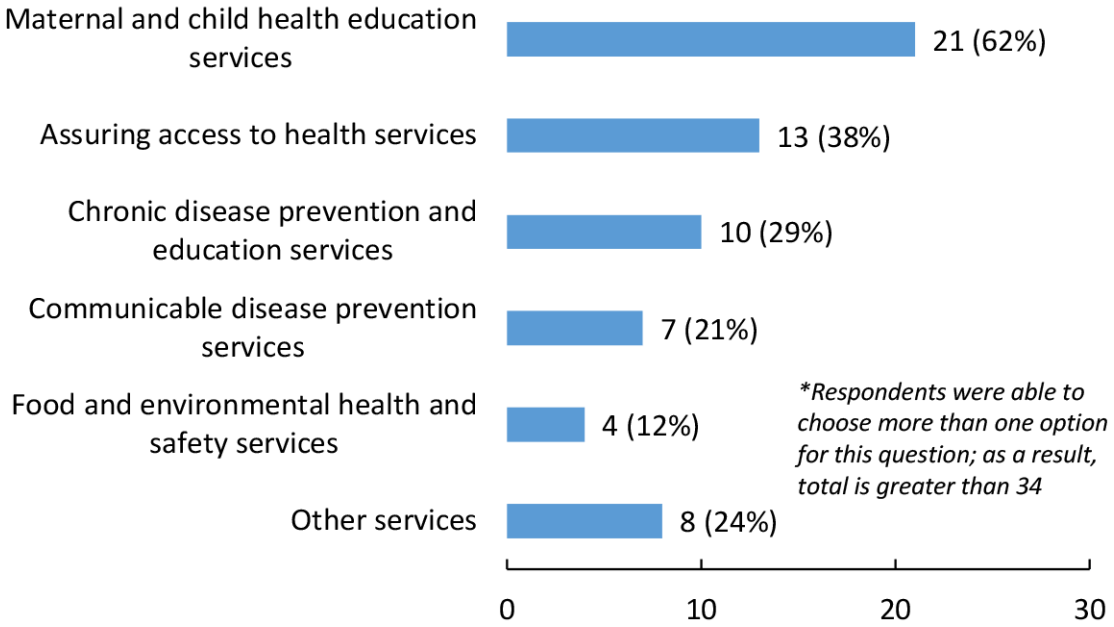
Figure 23 illustrates these results.

Figure 23: Perceptions About Barriers to Care
Total responses = 57*



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

Figure 24: Awareness and Utilization of Public Health Services
Total responses = 34*



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 dental services. Other requested services included:

- Cardiology
- Dental
- Vision
- Massage therapy
- Ophthalmology
- Mental health services
- Pediatric care
- Therapy
- Chiropractic
- Exercise options and activities

The key informant and focus group members felt that the community members were aware of the majority of the health system. Participants mentioned that they were not aware of chronic disease management, medical wellness visits, sleep studies, ear lavage, pelvic floor therapy, speech therapy, pediatric therapy, MRIs, CTs, chiropractic, and Dexa scan. The participants also said Northwood Deaconess Health Center (NDHC) does a great job marketing services to the community. A few participants suggest there needs to be more of an online presence and the marketing team should utilize social media platforms to engage the service area. When asked about GFPH, most of the key informants and community focus group were not aware of public health's available services. When discussing public health, participants were not sure how to utilize them or who qualifies to use their services. The participants suggested more marketing to the community, present information to them on who uses them, when to utilize them, and why should people use them.

NDHC chose to ask respondents questions regarding the awareness and utilization of services that are offered. For general and acute services, majority were aware of the family practice at 95% (N=71). For additional services, physical therapy services were selected the most at 87% (N=65). Respondents were also asked about the awareness and use of other services that are available in the area, optometric/vision services was selected the most at 81% (N=42). See figures below.

Figure 25: Awareness and Utilization of General and Acute Services
Total responses = 65*

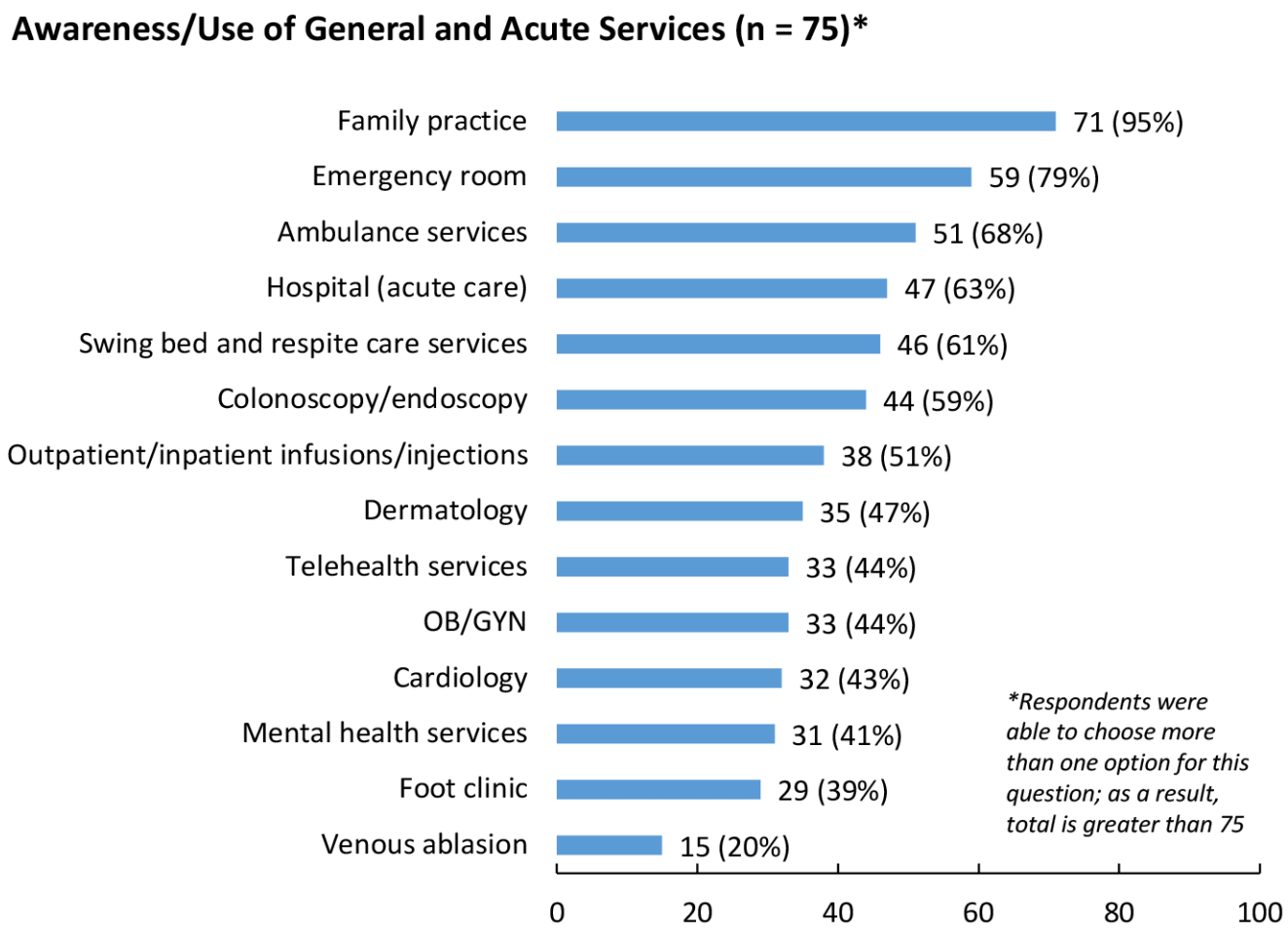


Figure 26: Awareness and Utilization of Additional Services
Total responses = 75*

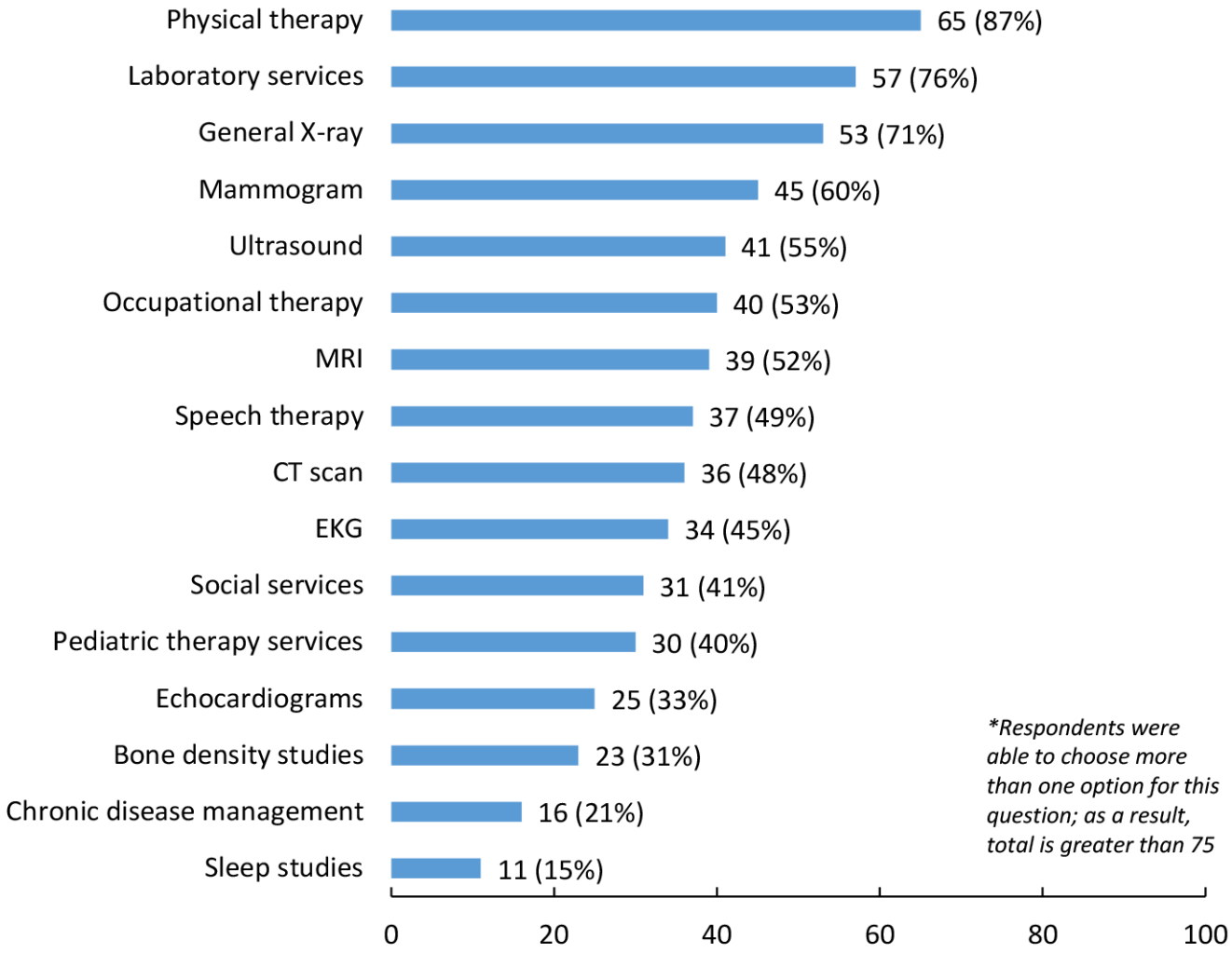
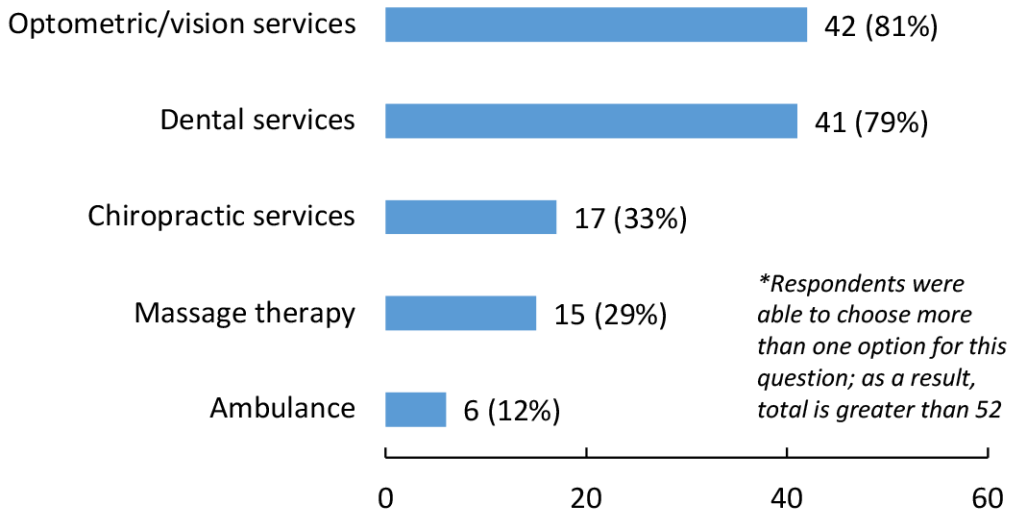


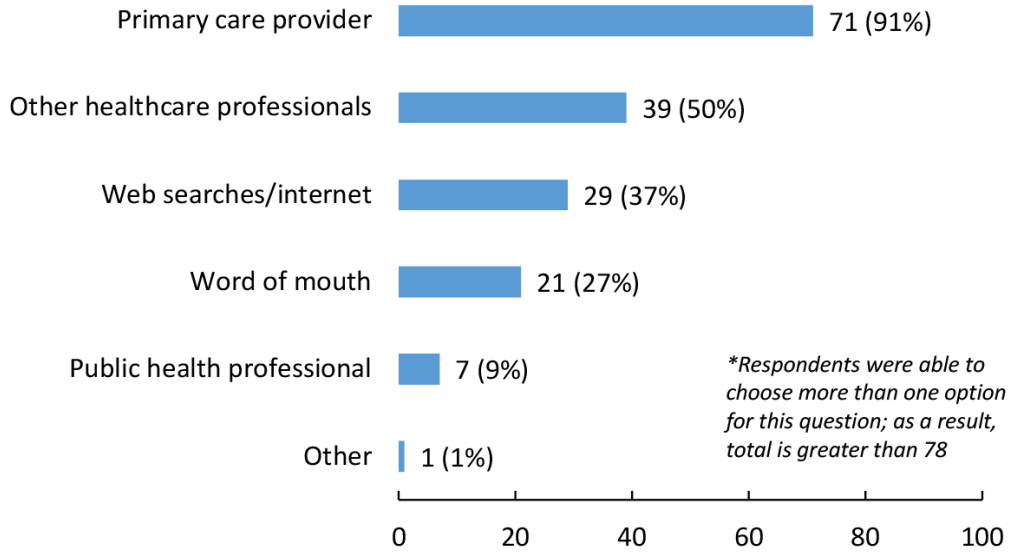
Figure 27: Awareness and Utilization of Other Providers
Total responses = 52*



Respondents were asked where they go to for trusted health information. Primary care providers (N=71) received the highest response rate, followed by other healthcare professionals (N=39), and then web/internet searches (N=29). In the "Other" category, one respondent mentioned holistic as a trusted source of health information.

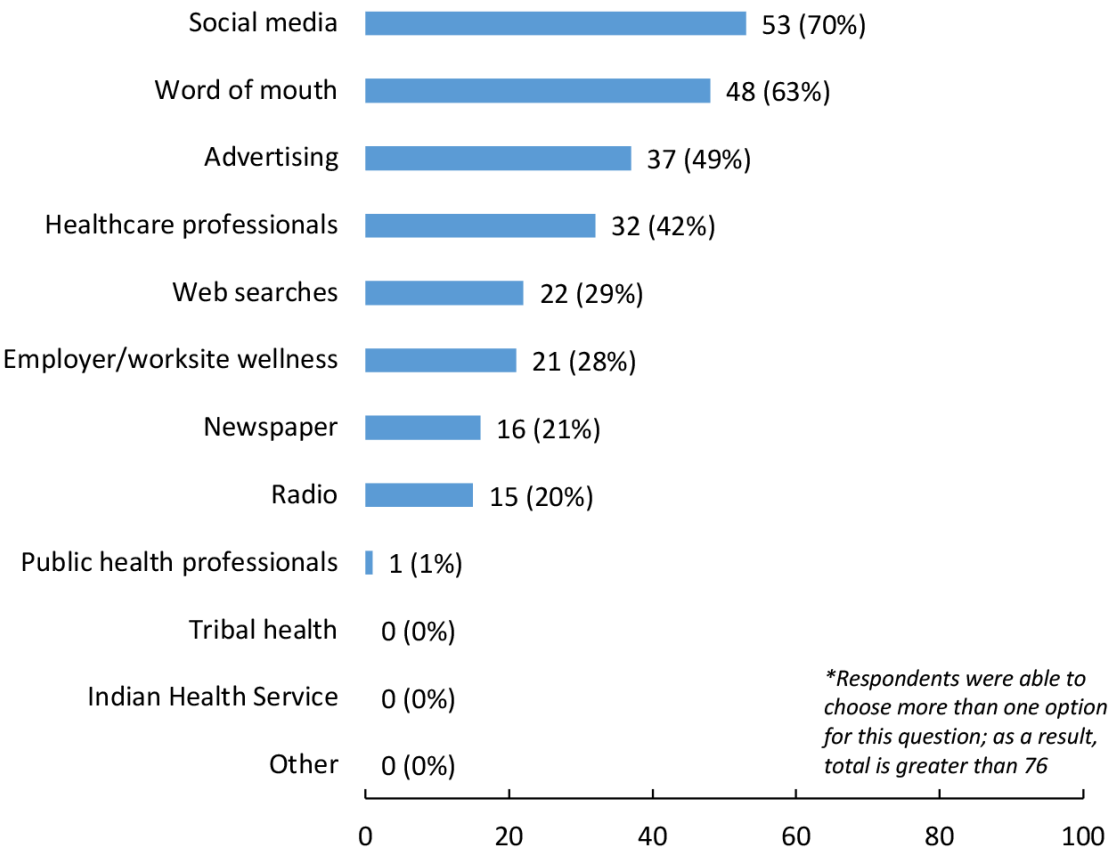
Results are shown in Figure 33.

Figure 33: Sources of Trusted Health Information
Total responses = 78*



Respondents were asked sources do they depend on to get information on local health services. Social media had the most responses at 70% (N=53), followed by word of mouth at 63% (N=48).

Figure 34: Sources of Information on Local Health Services
Total responses = 76*



The final question in the survey asked respondents to share concerns and suggestions to improve the delivery of local healthcare. Some community members expressed concerns about communication within care settings, particularly in hospitals and nursing homes. Respondents reported poor information sharing and limited staff engagement, contributing to dissatisfaction with the quality of care. These communication issues are seen as barriers to trust, service utilization, and continuity of care. One respondent mentioned the use of traveling nurses. While it is nice to ensure staffing is covered, since they are not from the area, they do not have knowledge to give to patients for more resources to reach out to once the patient leaves the hospital.

Improving outreach and staff-patient communication is a key opportunity to enhance health system transparency and ensure residents are better informed and engaged in their care.

Transportation remains a significant barrier to accessing healthcare in the community, particularly for seniors, low-income individuals, and those living in outlying rural areas. Residents reported challenges getting to medical appointments due to long distances, lack of public transportation, and limited access to reliable vehicles. These barriers contribute to missed appointments, delayed care, and increased reliance on emergency services. Community members emphasized the need for transportation assistance programs, mobile health services, or locally coordinated ride options to help bridge this gap and improve access to timely, routine care.

Findings from Key Informant Interviews and the Community Meeting

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

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

- Alcohol use and abuse
- Depression/anxiety
- Having enough child daycare services
- Lack of affordable housing
- Smoking and tobacco use, exposure to second-hand smoke, or vaping/juuling

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

Alcohol use and abuse

- Alcohol is a part of the high school culture
- Need to find something for youth to do recreationally, may help them move away from alcohol
- Usually connected to mental health issues

Depression/anxiety

- Leads to other problems such as substance use
- Youth are seeking help often now, less taboo
- High screen times and social media use lead to depression and anxiety

Having enough child daycare services

- Can't attract young professionals without a place to bring their children
- Two daycares in town have closed, which makes it hard for people to go to work
- Some families have to drive to neighboring towns to find care
- Cost of daycare is so high, people are working just to pay for daycare

Not enough affordable housing

- Housing is either too high or low, nothing in the middle
- Prices are high for a small town

Smoking and tobacco use, second-hand smoke, or vaping/juuling

- Vaping is big here
- Major issue in schools

Community Engagement and Collaboration

Key informants and focus group participants were asked to weigh in on community engagement and collaboration of various organizations and stakeholders in the community. Specifically, participants were asked, "On a scale of 1 to 5, with 1 being no collaboration/community engagement and 5 being excellent collaboration/community engagement, how would you rate the collaboration/engagement in the community among these various organizations?" This was not intended to rank services provided. They were presented with a list of 13 organizations or community segments to 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 (4.75)
- Pharmacy (4.75)
- Hospital (healthcare system) (4.5)
- Schools (4.5)
- Business and industry (4.0)
- Long-term care, including nursing homes and assisted living (4.0)
- Economic development organizations (3.5)
- Law enforcement (3.5)
- Faith-based (3.25)
- Public Health (3.25)
- Other local health providers, such as dentists and chiropractors (3.0)
- Social Services/Human services agencies (2.25)
- Clinics not affiliated with the main health system (1.5)
- Tribal Health/Indian Health Service (0.5)

Priority of Health Needs

A community group met on August 13, 2025. Nineteen 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 community health needs. All of the potential needs were listed on large poster boards and each member was given four stickers to place next to each of the four needs they considered the most significant.

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

- Cost of long-term/nursing home care (9 votes)
- Depression/anxiety – youth (8 votes)
- Having enough child daycare services (7 votes)
- Availability of mental health services (6 votes)
- Availability of resources to help elderly stay in their homes (6 votes)

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

1. Having enough child daycare services (8 votes)
2. Availability of resources to help elderly stay in their homes (4 votes)
3. Depression/anxiety – youth (3 votes)
4. Cost of long-term/nursing home care (2 votes)
5. Availability of mental health services (0 votes))

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

Comparison of Needs Identified Previously

Top Needs Identified 2022 CHNA Process	Top Needs Identified 2025 CHNA Process
Adults not getting enough exercise/ physical activity	Having enough child daycare services
Availability of mental health services	Availability of resources to help elderly stay in their homes
Depression/anxiety – all ages	Depression/anxiety – youth
Youth smoking and tobacco use, exposure to second-hand smoke, juuling/vaping	Cost of long-term/nursing home care
	Availability of mental health services

The current process did identify identical common needs from 2022. Availability of mental health services was identified in 2022 and 2025. Depression and anxiety for all ages was an identified need in the previous cycle, however, in 2025 this need was identified specifically for youth.

Northwood Deaconess Health Center (NDHC) 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 NDHC 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 NDHC.

Hospital and Community Projects and Programs Implemented to Address Needs Identified in 2022

In response to the needs identified in the 2022 community health needs assessment process the following actions were taken:

Increase awareness and availability of Adult Behavioral/Mental Health Services (18 years and older):

NDHC signed an agreement with Psychiatric Medical Care (PMC) to bring in the Senior Life Solutions (SLS) Mental Health Program to address the mental health needs of individuals older than 65 years of age. Outpatient Mental Health Clinic services started in April of 2025 available to all ages through Viatech Health, available from a PMC therapist

NDHC raises awareness for need and promotes mental health services in Medicare Wellness Visits, Women's Health, and Men's Health events.

NDHCs Senior Life Solutions (SLS) director has been very active in providing education within the community to local organizations in their service area (senior centers, churches, literary clubs, American legions) along with educating NDHC staff/partners on availability and need for services within their patient populations.

In 2024, North Dakota Health and Human Services invested in and implemented a telemedicine platform via Avel eCare which provides 24/7 rapid crisis assessment by behavioral health professionals for mental health calls that Grand Forks Sheriff's Office responds to. This service intends to reduce unnecessary transport to emergency rooms for mental health crisis assessment. Non-emergent referral pathways have been established through Northeast Human Service Center for follow up.

Grand Forks Public Health onboarded a community mental health coordinator in January 2025 which expanded their service area to Grand Forks County. This role serves as a connector to mental health services within communities, working to understand and identify current barriers to care. Additionally, part of their role involves distributing and educating about naloxone for those in crisis. Currently, there is free naloxone available at Northwood Drug. GFPH provides education to all Grand Forks County Sheriff Department sworn personnel who carry it with them on duty.

GFPH applied for a grant in 2024 which would have provided funding to implement evidence-based preventative education around mental health protective factors and support systems via the program, Sources of Strength. This would have been a collaboration with rural school districts (middle and high schools) within Grand Forks County. Unfortunately, the application was denied.

Increase awareness and availability of Youth Behavioral/Mental Health Services (17 years and younger):

NDHC has been involved in providing safe and fun activities to community youth, including working with the school by hosting a Scrubbs camp, hosting a family fun night, connecting families and staff through various games and activities.

Bring awareness to behavioral/mental health services currently offered by NDHC:

NDHC is actively advertising on its website, social media, direct mail, radio for these services, along with word-of-mouth advertising from in-house providers

Promote Physical Fitness and Activities:

The fitness center at NDHC has been promoted to the Northwood community through strategic marketing. Usage is monitored and new memberships are tracked.

NDHC's rehab department has assisted with the bone builders program, that meets regularly with community members. NDHC sports enhancement program is held at the Northwood Public School with NDHC staff running the 12-week program. Athletic training services to address athletic needs and provide education to students and parents are provided within the school year on Tuesdays and Thursdays at Northwood and Hatton schools.

Smoking and Tobacco Use:

2022-2024: GFPD provided annual education to county tobacco retailers on tobacco-related laws (underage sales and smoke-free law) and available resources to enhance compliance.

GFPH increased tobacco treatment resource promotion (NDQuits and This Is Quitting) through paid media with broad-spectrum reach within the county.

GFPH collaborated with Grand Forks County school nurses to promote integration of tobacco and vaping prevention education, youth tobacco treatment resources, and youth engagement/advocacy opportunities in the school setting.

2023 and 2025: Education with District 20 legislators on the importance of fully funded tobacco prevention programs, the public health benefits of increasing the price of tobacco products and maintaining the provisions of the state-wide smoke-free law.

The above implementation plan for NDHC is posted on the NDHC website at https://www.ndhc.net/community-health-needs-assessment.

Next Steps – Strategic Implementation Plan

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

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

Community Benefit Report

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

The community benefit requirement is a long-standing requirement of nonprofit hospitals and is reported in Part I of the hospital's Form 990. The strategic implementation requirement was added as part of the ACA's CHNA requirement. 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 the health of the community
- Advance the medical or health knowledge
- Relieve or reduce the burden of government or other community efforts

A program or activity should not be reported as a 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: Northwood, North Dakota

Northwood Deaconess Health Center

Administrator:
Brock Sherva

Chief of Medical Staff:
Dr. Erica Stein

Board Chair: Keith Groven

City Population:
950 (2024 estimate)[1]

County Population:
73,771 (2024 estimate)[1]

County Median Household Income:
$68,450 (2023 estimate)[1]

County Median Age:
30.6 years (2023 estimate)[1]

Service Area Population:
9,380 (625 square miles)

Owned by: Nonprofit
Hospital Beds: 25 (9 Acute, 16 Transitional)

Trauma Level: V

Critical Access Hospital Designation: 2001

Economic Impact on the Community[2]

Jobs:
Primary – 69
Secondary – 52
Total – 121

Financial Impact:
Net Patient Revenue–$5.79 million
Total Business Sales–$1.5 million

Mission

The mission of Northwood Deaconess Health Center (NDHC) is to: serve as local access to a full range of healthcare services; continue as a leader in primary care for the whole family, in care of the elderly, and in emergency services; and to function as a focal point for community health, education, and wellness. NDHC provides this in a Christian environment, respecting the dignity of all.

County: Grand Forks
Address: PO Box 190, 4 North Park Street Northwood, ND 58267
Phone: (701) 587-6060
Fax: (701) 587-6479
Web: www.ndhc.net

NDHC has a significant economic impact on the region. As of 2023, they directly employ 170 employees with an annual payroll of over $11.1 million (including benefits). These employees create an additional 230 jobs and nearly $4.2 million in income, as they interact with other sectors of the local economy. NDHC is the Northwood area's largest employer and is proud to be one of the "pioneers" of healthcare in the state of North Dakota.

Services

NDHC provides the following services directly:

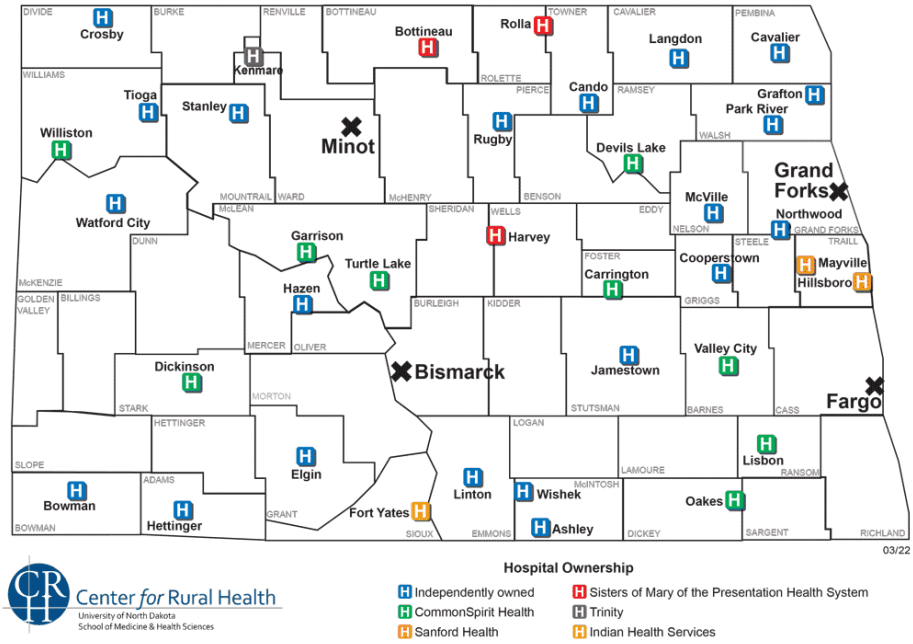
- Ambulance services
- Assisted living
- Blood pressure checks
- Cervical and cancer screenings
- Chronic disease management
- Clinic (Primary Care)
- Clinic mental health services
- Emergency room
- Ear lavage
- Foot care clinic
- Geriatric health
- Hospital swing bed
- Hospital acute care
- Hospital adult daycare
- Hospital respite care
- Injections: joint and allergies
- Lesion removals
- Lower Extremity Circulatory Assessment
- Medi-alerts
- Medical wellness visits
- Meals on Wheels
- Men's wellness
- Nutrition counseling
- Nebulizer treatments
- Outpatient/inpatient infusions
- Oxygen administration
- Pharmacy services - inpatient
- Physicals: annual, DOT, sports, insurance, pre-op
- Preventative visits
- Removals: lesions, foreign body, skin tags, warts
- Senior Life Solutions – counseling
- Sleep studies
- Social services
- Sports medicine
- Suturing
- Splinting and casting
- Surgical services – outpatient colonoscopy and vascular
- Vaccine services – adult and pediatric
- Women's health
- Well child checks – infant and child

List of Services

NDHC provides the following services through contract or agreement:

- Life Alert System
- Specialty providers (glenoscopy, cardiology, dermatology, edoscopy, oncology, OBGYN)
- Nuclear medicine (MRI, CT, Ultrasound)
- Mental health services
- Pharmacy

North Dakota Critical Access Hospitals



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

Hospital Ownership

- Independently owned
- CommonSpirit Health
- Sanford Health
- Sisters of Mary of the Presentation Health System
- Trinity
- Indian Health Services

History

NDHC was started in 1902 by area Lutheran churches. It continues to be independently owned by those Lutheran churches, nine in total, from the communities of Northwood, Sharon, and Larimore.

NDHC has a 25-bed Critical Access Hospital with nine acute beds and a 16-bed skilled living center. NDHC also has clinics in Northwood, Larimore, and Binford, six assisted living apartments, and 10 independent living apartments which round out a full continuum of care on the Northwood campus. NDHC also offers inpatient and outpatient therapy services to people of all ages, which includes lifespan from infancy to the elderly within the hospital, long-term care, area schools, and home atmospheres. NDHC also provides emergency services with ambulance and 24/7 emergency room services available.

Recreation

Northwood is located in eastern North Dakota. The economic base of this community is agriculture. The Northwood school system offers comprehensive programs for students K-12. The nearest university is 25 miles away. A medical university and a vocational training school are within approximately 45 miles, and three colleges or universities are within 90 miles. City parks offer a variety of facilities and activities such as swimming, softball diamonds, tennis courts, along with skating and hockey in the winter. There is a nine-hole golf course just three miles from town. Camping, fishing, and swimming are available at nearby Golden Lake. Northwood offers the opportunity to live in the quiet of a rural setting and yet have the amenities of a large town and university setting nearby.

Staff

Physicians: 1
Nurse Practitioners: 4
PAs: 2
RNs: 25
LPNs: 17
Total Employees: 166

Local Sponsors and Grant Funding Sources

- **Alerus Financial**
- **Blue Cross Blue Shield**
- **Center for Rural Health - SHIP Grant (Small Hospital Improvement Program) Flex Grant (Medicare Rural Hospital Flexibility Grant Program)**
- **Community Foundation**
- **Dakota Medical Foundation**
- **Myra Foundation**
- **Nellie J. Svee Foundation**
- **Nodak Electric Trust**
- **Otto Bremer Foundation**
- **Pederson Brothers Foundation**

Sources

[1] **US Census Bureau: American Factfinder; Community Facts**

[2] **Economic impact Analysis of FY2023 North Dakota Hospitals; North Dakota Hospital Association**

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

ruralhealth.und.edu

Updated 9/2025

Appendix B – CHNA Survey Instrument

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

NDHC
NORTHWOOD DEACONESS
HEALTH CENTER

Public Health
Prevent. Promote. Protect.
Grand Forks Public Health

Northwood Area Health Survey

Northwood Deaconess Health Center and Grand Forks Public Health want to know how you perceive the state of healthcare in your community.

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/northwoodchna25 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 June 30th, 2025. 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)
- ☐ Elder abuse
- ☐ Other (please specify): _____

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

_____

_____

Delivery of Healthcare

11. Considering **GENERAL and ACUTE SERVICES** at Northwood Deaconess Health Center, which services are you aware of (or have you used in the past year)? (Choose ALL that apply)

- ☐ Cardiology
- ☐ Family practice
- ☐ Emergency room
- ☐ Hospital (Acute Care)
- ☐ Ambulance Services
- ☐ Foot clinic
- ☐ OB/GYN
- ☐ Colonoscopy/Endoscopy services
- ☐ Venous Ablasion
- ☐ Swing bed and respite care services
- ☐ Telehealth services
- ☐ Outpatient/Inpatient infusions/injections
- ☐ Dermatology
- ☐ Mental health services

12. Considering **ADDITIONAL SERVICES** at Northwood Deaconess Health Center, which services are you aware of (or have you used in the past year? (Choose ALL that apply)

- ☐ Chronic disease management
- ☐ CT scan
- ☐ EKG
- ☐ General X-Ray
- ☐ Laboratory services
- ☐ Mammogram
- ☐ MRI
- ☐ Occupational therapy
- ☐ Physical therapy
- ☐ Speech therapy
- ☐ Echocardiograms
- ☐ Social services
- ☐ Bone density studies
- ☐ Pediatric therapy services
- ☐ Sleep studies
- ☐ Ultrasound

13. Have you received any of these **SERVICES** from a provider other than Northwood Deaconess Health Center in the past year? (Choose ALL that apply)

- ☐ Cardiology
- ☐ Family practice
- ☐ Dermatology
- ☐ OB/GYN
- ☐ Colonoscopy/endoscopy services
- ☐ Telehealth services
- ☐ Mental health services
- ☐ Outpatient/inpatient infusions/injections
- ☐ Venous ablasion
- ☐ Occupational therapy
- ☐ Physical therapy
- ☐ Pediatric therapy services
- ☐ Speech therapy
- ☐ Mammogram
- ☐ Echocardiograms
- ☐ Bone density studies
- ☐ MRI
- ☐ Ultrasound
- ☐ CT scan

14. Which of the following local PUBLIC HEALTH **SERVICES** provided by **Grand Forks Public Health** have you or a family member benefited from in the past year)? (Choose ALL that apply)

A. Communicable Disease Prevention Services such as:

- ☐ Counseling, Testing and Referral (CTR) program - HIV testing and Hepatitis C testing
- ☐ Disease Surveillance – community education and communication on communicable disease risk (prevention, protection, etc.)
- ☐ Assisting and supporting those living with HIV (Ryan White Program)
- ☐ Tuberculosis surveillance management

B. Food and Environmental Health and Safety services such as:

- ☐ Animal bite/rabies investigation and quarantine or testing of animal
- ☐ Investigate and abate public health nuisances (dog manure, excess trash, etc.)
- ☐ Inspect and advise the public on sanitation issues

C. Chronic Disease Prevention and Education such as:

- ☐ Alcohol Prevention and Control
- ☐ Breastfeeding resources
- ☐ Nutrition education
- ☐ Tobacco Prevention and Control

D. Maternal and Child Health Education services such as:

- ☐ Immunizations for adult and pediatric populations
- ☐ School health screenings
- ☐ School health— health education and resources to the school

E. Assuring Access to Health Services such as:

- ☐ Mental Health coordination and wellness promotion
- ☐ Opioid Response efforts including increasing access to Naloxone and recovery resources
- ☐ Syringe Service Exchange Program
- ☐ Women's Way Breast and Cervical Cancer Early Detection Program

F. Other

- ☐ Emergency Preparedness services-work with community partners as part of local emergency response team
- ☐ Medication setup with Adult Home Visit Services
- ☐ Wellness Programs for City and County Employees

15. 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): _____

16. In the past year, I have been made aware of services available at Northwood Deaconess Health Center through advertising in the following? (Choose ALL that appy)

- ☐ Newspaper
- ☐ Online streaming video or music channels
- ☐ Direct mail
- ☐ Local radio
- ☐ Social media (Facebook, X, etc.)
- ☐ None
- ☐ Other: (please specify) _____

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

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

18. 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): _____

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

_____

_____

Demographic Information: Please tell us about yourself.

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

- ☐ Yes
- ☐ No

21. 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): _____

22. 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): _____

23. Age:

- ☐ Less than 18 years
- ☐ 18 to 24 years
- ☐ 25 to 34 years
- ☐ 35 to 44 years
- ☐ 45 to 54 years
- ☐ 55 to 64 years
- ☐ 65 to 74 years
- ☐ 75 years and older

24. Highest level of education:

☐ Less than high school
☐ High school diploma or GED
☐ Some college/technical degree
☐ Associate's degree
☐ Bachelor's degree
☐ Graduate or professional degree

25. Gender:

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

26. Employment status:

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

27. Your zip code: _____

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

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

29. Annual household income before taxes:

☐ Less than $15,000
☐ $15,000 to $24,999
☐ $25,000 to $49,999
☐ $50,000 to $74,999
☐ $75,000 to $99,999
☐ $100,000 to $149,999
☐ $150,000 and over

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

_____

_____

Thank you for assisting us with this important survey!

Appendix C – County Health Rankings Explained

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

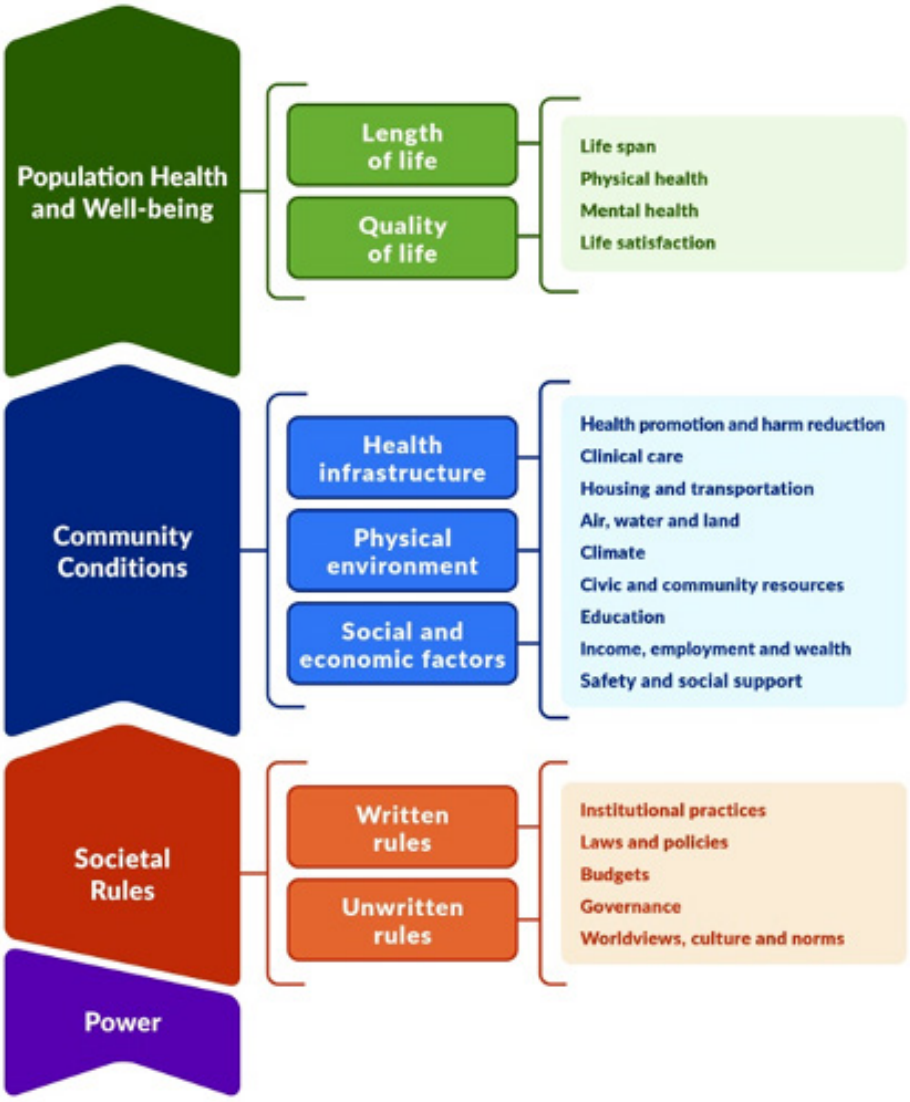
Methods

The County Health Rankings and Roadmaps, a collaboration between the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute, applies a cluster analysis approach to summary measures (also referred to as composite indicators or indices) of population health, specifically the composite Community Conditions and Population Health and Well-being z-score values for each county.

What is Ranked

The County Health Rankings and Roadmaps are based on counties and county equivalents. Any entity that has its own Federal Information Processing Standard (FIPS) county code is included in the Rankings and Roadmaps. In the prior model, County Health Rankings and Roadmaps only rank counties and county equivalents within a state.

Model of Health (2025-Present)



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

The goal is for counties that are similar in Population Health and Wellbeing or Community Conditions within and across states may be inspired to work together to advance health and equity under the new approach. Instead of communicating merely a frame of competition based on ordinal rankings within states, the updated approach to comparing counties may encourage partnership and solidarity, leading to resource allocation according to need.

County Health Rankings collect of over 80 measures of health is organized within topic areas according to the UW Population Health Institute Model of Health. Select measures are used to generate their Health Groups, they calculate and rank eight summary composite scores:

Population Health and Well-being includes:

- Length of life
- Quality of life

Community Conditions includes:

- Health Infrastructure
- Social and economic 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 and roadmaps. 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 and roadmaps.

Calculating Scores and Ranks

The County Health Rankings are compiled from many different types of data. To calculate the population health and well-being and community conditions, they first standardize each of the measures. The ranks are then calculated based on weighted sums of the standardized measures within each state.

Health Outcomes and Factors

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

Health Outcomes

Premature Death (YPLL)

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

Reason for Ranking

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

Poor or Fair Health

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

Reason for Ranking

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

Poor Physical Health Days

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

Reason for Ranking

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

Poor Mental Health Days

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

Reason for Ranking

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

Low Birth Weight

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

Reason for Ranking

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

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

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

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

Health Factors

Adult Smoking

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

Reason for Ranking

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

Adult Obesity

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

Reason for Ranking

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

Food Environment Index

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

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

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

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

Reason for Ranking

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

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

further addressing barriers to healthy eating. It is important to have adequate access to a constant food supply, but it may be equally important to have nutritious food available.

Physical Inactivity

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

Reason for Ranking

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

Access to Exercise Opportunities

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

Individuals who:

- reside in a census block within a half mile of a park or
- in urban census blocks: reside within one mile of a recreational facility or
- in rural census blocks: reside within three miles of a recreational facility
- are considered to have adequate access for opportunities for physical activity.

Reason for Ranking

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

Excessive Drinking

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

Reason for Ranking

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

Alcohol-Impaired Driving Deaths

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Unemployment

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

Reason for Ranking

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

Children in Poverty

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

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

Reason for Ranking

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

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

Income Inequality

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

Reason for Ranking

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

Children in Single-Parent Households

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

Reason for Ranking

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

Violent Crime Rate

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

Reason for Ranking

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

Injury Deaths

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

Reason for Ranking

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

Air Pollution-Particulate matter

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

Reason for Ranking

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

Drinking Water Violations

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

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

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

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

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

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

Appendix D – Youth Risk Behavior Survey

Youth Risk Behavior Survey Results. North Dakota High School Survey
Rate Increase "↑" rate decrease "↓", or no statistical change = in rate from 2021-2023

	ND 2019	ND 2021	**ND 2023**	ND Trend ↑, ↓, =	Rural ND Town Average	Urban ND Town Average	National Average 2023
Injury and Violence							
% of students who rarely or never wore a seat belt (when riding in a car driven by someone else)	5.9	49.6	**47.3**	↓	62.9	42.2	39.6
% 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)	14.2	13.1	**14.3**	↑	17.9	12.5	15.7
% of students who talked on a cell phone while driving (on at least one day during the 30 days before the survey)	59.6	64.4	**66.4**	↑	66.1	66.5	NA
% of students who texted or e-mailed while driving a car or other vehicle (on at least one day during the 30 days before the survey)	53.0	55.4	**56.5**	↑	60.3	55.7	42.3
% 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)	7.1	5.0	**4.0**	↓	4.9	3.5	4.2
% 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)	9.2	9.4	**9.5**	=	9.1	10.5	11.4
% of students who were bullied on school property (during the 12 months before the survey)	19.9	15.8	**20.7**	↑	23.5	20.8	19.2
% of students who were electronically bullied (includes texting, Instagram, Facebook, or other social media ever during the 12 months before the survey)	14.7	13.6	**15.4**	↑	12.5	13.3	16.3
% of students who made a plan about how they would attempt suicide (during the 12 months before the survey)	15.3	14.8	**15.5**	↑	15.0	15.0	16.4
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)	11.6	11.0	**12.2**	=	12.5	13.5	NA
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**	↑	33.5	35.8	39.7
	ND 2019	ND 2021	ND 2023	ND Trend ↑, ↓, =	Rural ND Town Average	Urban ND Town Average	National Average 2023
Tobacco Use							
Percentage of students who ever tried cigarette smoking (even one or two puffs)	29.3	22.3	**20.1**	↓	23.1	16.1	14.4
Percentage of students who currently smoked cigarettes (on at least one day during the 30 days before the survey)	8.3	5.9	**5.4**	↓	7.0	4.8	3.5
Percentage of students who currently smoked cigarettes daily (on all 30 days during the 30 days before the survey)	1.4	0.7	**0.5**	↓	1.0	0.8	0.5
Percentage of students who currently use an electronic vapor product (e-cigarettes, vape e-cigars, e-pipes, vape pipes, vaping pens, e-	33.1	21.2	**18.2**	↓	21.7	16.6	16.8

hookahs, and hookah pens at least one day during the 30 days before the survey)							
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)	4.5	4.3	**3.8**	↓	4.5	3.0	2.3
Percentage of students who currently smoked cigars (cigars, cigarillos, or little cigars on at least one day during the 30 days before the survey)	5.2	2.8	**4.2**	↑	5.5	3.6	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)	12.2	8.9	7.6	↓	10.6	7.3	17.9
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)	56.6	50.4	**46.2**	↓	50.4	45.3	NA
Percentage of students who drank alcohol before age 13 years (for the first time other than a few sips)	12.9	12.1	**11.4**	=	14.2	11.0	13.3
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)	27.6	23.7	**19.5**	↓	21.7	17.9	22.1
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)	15.6	14.0	**10.3**	↓	13.2	10.1	8.8
Percentage of students who tried marijuana before age 13 years (for the first time)	5.6	5.0	**4.1**	=	3.7	3.3	4.8
Percentage of students who currently used marijuana (one or more times during the 30 days before the survey)	12.5	10.7	**3.8**	↓	5.3	3.4	17.0
	ND 2019	ND 2021	ND 2023	ND Trend ↑, ↓, =	Rural ND Town Average	Urban ND Town Average	National Average 2023
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)	14.5	10.2	9.2	↓	10.6	8.8	11.6
Sexual Behaviors							
Percentage of students who ever had sexual intercourse	38.3	36.6	35.2	=	34.5	33.7	31.6
Percentage of students who have had sex education in school	NA	NA	64.1	NA	63.9	63.5	NA
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)	16.5	15.6	**16.3**	=	15.6	15.2	14.7
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)	14.0	16.3	**16.3**	=	18.1	14.3	15.9
Percentage of students who described themselves as slightly or very overweight	32.6	31.7	**32.8**	=	34.9	32.0	30.8
Percentage of students who were trying to lose weight.	44.7	21.6	**43.2**	↑	44.6	42.4	44.5
Percentage of students who did not eat fruit or drink 100% fruit juices (during the seven days before the survey)	6.1	5.0	4.7	=	60.	6.1	6.7
Percentage of students who ate fruit or drank 100% fruit juices one or more times per day (during the seven days before the survey)	54.1	25.4	53.8	↑	52.6	54.5	55.5
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)	6.6	5.9	**6.8**	=	6.5	7.2	6.8
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)	57.1	61.3	58.9	↓	58.3	57.5	57.5

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)	28.1	27.7	**27.0**	=	25.9	27.3	30.9
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)	15.9	16.6	**18.5**	↑	18.0	16.8	14.5
Percentage of students who did not eat breakfast (during the 7 days before the survey)	14.4	15.1	**16.7**	↑	16.5	17.1	17.9
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)	2.8	2.1	**2.3**	=	2.7	2.8	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)	49.0	56.5	54.5	↓	54.7	54.3	46.3
	ND 2019	ND 2021	ND 2023	ND Trend ↑, ↓, =	Rural ND Town Average	Urban ND Town Average	National Average 2023
Percentage of students who played video or computer games was combined with % of students who watch television 3 or more hours per day.	NA	75.7	**77.2**	↑	74.8	77.4	77.0
Other							
Percentage of students who had eight or more hours of sleep (on an average school night)	29.5	24.5	**27.5**	↑	29.8	27.5	23.2
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)	7.0	7.4	5.5	↓	5.8	6.2	NA

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

Appendix E – Prioritization of Community's Health Needs

Community Health Needs Assessment
Northwood, 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 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 5 highest ranked priorities.

	Priorities	Most Important
COMMUNITY/ENVIRONMENTAL HEALTH CONCERNS		
Attracting & retaining young families	5	
Having enough child daycare services	7	8
Not enough affordable housing	2	
Not enough jobs with livable wages	1	
AVAILABILITY/DELIVERY OF HEALTH SERVICES CONCERNS		
Availability of mental health services	6	0
Cost of healthcare insurance	3	
Cost of healthcare services	0	
Extra hours for appointments, such as evenings & weekends	3	
YOUTH POPULATION HEALTH CONCERNS		
Alcohol use and abuse	4	
Depression/anxiety	8	3
Drug use and abuse (including prescription drugs)	0	
Smoking and tobacco use, exposure to second-hand smoke, or vaping/juuling	2	
ADULT POPULATION HEALTH CONCERNS		
Alcohol use and abuse	2	
Depression/anxiety	2	
Drug use and abuse	0	
Not getting enough exercise/physical activity	5	
Stress	0	
SENIOR POPULATION HEALTH CONCERNS		
Cost of long-term/nursing home care	9	2
Availability of resources to help elderly stay in their homes	6	4
Availability of home health	3	
Availability of transportation for seniors	4	

Appendix F – Survey "Other" Responses

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

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

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

- Available activities...senior center, labrary parks, ...all age activity

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

- I wish I could have selected more then 3

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

- Need help with this
- There are really no activities in town

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:

- City streets are very dangerous due to pot holes and cracks. Mostly gravel, not much pavement
- Lack of a dog warden
- streets
- Senior exercise affordability...many seniors can not afford clubs
- Poor healthcare. Not enough doctors and specialists

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

- Dental for MA recipients
- None of the above
- I don't know

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

- Bullying
- Mean/bullying
- Manners and politenesses
- Sports which play only certain players even at young ages

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

- Housing and daycare. Wanting to get more young families in the community but all housing available is out dated and not move in ready. We have a couple home daycares in town but do have privilege of having a childcare center but hard to find workers because of wage they offer. "
- Day care
- The ability to have our streets repaired to make it safe to navigate them b
- Lack of Daycares
- Transportation for elderly
- The use of alcohol among all ages, especially those who have children and are leaving them unsupervised to be at the bar/out with friends.
- Transportation (2)

- Distance to specialty health care
- Alcohol & drug use
- Access to Wellness/fitness center for all ages.
- Public transportation
- Isolation for all ages esp. elderly ,poor families and children w special needs and their familiew
- Housing For new families
- care of the elderly
- Affordability for the elderly...health care, rx, transportation. Housing, food cost
- summer activities for kids
- Infrastructure
- More community wide activities involving all ages.
- Mental Health Services not being taken seriously and people not having an outlet. Also I think our community needs more carefree fun filled activities that don't involve drinking.
- Elderly needing help. Get as much healthcare in town as possible.
- Number of people with cancer in the area
- Active and healthy activities for kids, families, and adults to be a part of
- Lack of law enforcement
- Very few job openings
- Poor healthcare in Grand Forks. Altru does not have specialists or enough doctors and staff. Nice new building but not enough healthcare professionals. The patient ratio to hospital it's is very high and not regulated. Altru no longer provides adequate spiritual care to patients or families. The approach to care is not wholistic, mind, body and soul. We do not have enough behavioral health services for the poor and homeless.
- Lack of funding/resources
- No enforcement of leash laws. Hearing all the attacks lately and nothing being done makes people not want to go for walks.
- Elderly ability to stay in their home for as long as possible
- I don't live in Northwood but have had experience with the health care

Delivery of Healthcare

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

- We have already been established at another facility

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

- Cardiology
- Dentist and vision
- Eye doctor Dentist Massage Therapy
- NDHC IS AMAZING AND OFFERS A WIDE RANGE OF SERVICES!
- Massage therapy
- Affordable services for seniors...those without insurance...dental
- As much as possible. Having health care in the community is a terrific benefit! Wonderful
- mental health (2)
- Dental and vision services
- Pediatric care, not just pediatric PT
- Vision and dental
- Therapists
- Hormonal/menopause support
- I have heard great things about Northwood for swing beds and elderly long term care. I support rural

healthcare services and believe the future of Northwood is important.

- Chiropractic
- More exercise/ activity healthy lifestyle

21. How did you acquire the survey (or survey link) that you are completing? "Other" responses:

- Facebook (9)
- FB
- NDHC Facebook post
- Friend shared on personal Facebook account
- Northwood Deaconess
- At work
- email
- work email

22. Health insurance or health coverage status? "Other" responses:

- Marketplace
- Next Blue
- Health share

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

- Mail flyers listing all services available locally
- "Travel nurses. Little awareness of local services because they are temp and not invested.
- Care was minimal when hospitalized. No showers or bed baths substandard care in hospital
- Care and food in nursing home poor, shower 1x week, no fresh fruit or veggies available"
- Offering walk in hours earlier in the morning from 7:30am- until the clinic opens for regular hours.
- Affordable health and dental for seniors
- Rural health care is vital!!!!
- Would like to see dental and vision services. Can't always see your own provider and I don't think there is a fix for this. I am always willing to see any available provider. They all have given me quality care.
- Affordability for our community
- More available specialists at NDHC.
- Affordability and access to professional staff. In rural areas emergency services are very important and the ability to transfer to specialists.
- Dad was in swing bed at Northwood and my family was extremely grateful for. The care