We are of this place, not just from it.

COMMUNITY HEALTH NEEDS ASSESSMENT
FY 2020-2022
Essentia Health-Fargo
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Appendix A – Greater Fargo Moorhead Community Health Needs Assessment Summary
Appendix B – Survey Questions
Appendix C – Key Stakeholder & Resident Survey Findings
Appendix D – Community Stakeholder Presentation
Lead Parties on the Assessment

Jackie Buboltz, Director Mission Integration
Leah Deyo, Community Health Program Manager
Karen Pifher, Community Health Program Manager
Kasi Eisenzimmer, Community Health Specialist

Acknowledgements

This report is based on a collaborative process with the following community members and organizations. Essentia Health would like to express our gratitude to the many steering committee members and community members for their contribution to planning, development, and analysis of community health needs. Additional thanks to the community members who shared their expertise and helped us include the voices of diverse sectors of our community.

- Sanford Health
- United Way
- Fargo Cass Public Health
- Clay County Public Health
- Family HealthCare Center
- ND State Senate
- Native American Commission
- FirstLink
- SENDCAA Headstart
- Fargo Park District
- Health Partners
- Blue Cross Blue Shield
- FM Ambulance
- Moorhead City Council
- Cass County Social Services
- American Cancer Society
- Cass County Commission
- Lakes & Prairies Community Action Partnership
- Minnesota State University Moorhead
- Mayor’s Blue Ribbon Commission on Addiction
- Cass County Social Services
- Glady’s Ray Shelter
- Dorothy Day House
- Red River Child Advocacy Center
- West Fargo Commission
- Fargo Board of Health
- Fargo Moorhead MetroCog
- Fargo Fire Department
- FM Visitors & Convention Bureau
- Jeremiah Program
- Emergency Food Pantry
- Great Plains Food Bank
- Jail Chaplains
- Fargo School Board
Executive Summary

Essentia Health-Fargo is part of Essentia Health, a nonprofit, integrated health system caring for patients in Minnesota, Wisconsin, North Dakota and Idaho. Essentia Health is called to make a healthy difference in people’s lives. To fulfill that mission, we seek opportunities to both enhance the care we provide and improve the health of our communities.

Every three years, each Essentia Health hospital conducts a Community Health Needs Assessment (CHNA) to systematically identify, analyze and prioritize community health needs. The process is conducted in collaboration with many community partners including other health care systems, local public health departments, and organizations or individuals that represent broad interests in the community, including those members of medically underserved, low-income, and populations that are at higher health risk.

Once priority health needs are identified, Essentia Health–Fargo designed an implementation strategy to address the needs with internal stakeholders and community partners. The plan is designed to leverage existing community strengths and resources available to improve health.

From December 2017 to December 2018, Essentia Health-Fargo analyzed data, convened community partners, sought input from community members, and led a process to identify the following priority areas for the 2020-2022 Community Health Needs Assessment:

1. Mental health
2. Youth and young adult substance use

The 2020-2022 Implementation Plan outlines the multiple objectives, activities and strategies to address each priority area.

**Mental health goal:** The environment of Cass and Clay Counties supports mental health and well-being of its residents.

**Youth and young adult substance use goal:** Drug-free communities thrive in Cass and Clay counties.
Introduction

Essentia Health is called to make a healthy difference in people’s lives. To fulfill that mission, we seek opportunities to both enhance the care we provide and improve the health of our communities. In conducting the Community Health Needs Assessment, Essentia Health has collaborated with community partners to embrace these guiding principles.
Headquartered in Duluth, Minnesota, Essentia Health combines the strengths and talents of 14,400 employees, who serve our patients and communities through the mission of being called to make a healthy difference in people’s lives.

Essentia Health-Fargo is part of Essentia Health. The 133-bed hospital opened November 1, 2000, and primarily serves southeastern North Dakota and west-central Minnesota including the Essentia Health clinics in Jamestown, Valley City, Jamestown, Wahpeton, Lisbon, Casselton, West Fargo, Fargo, North Dakota, and Moorhead, Minnesota. It also serves as the tertiary care center for the other four Essentia Health hospitals in the Essentia Health West Region – Detroit Lakes, Ada, Fosston, and Graceville.

Essentia Health-Fargo is a Level II Trauma Center, Comprehensive Stroke Center, Baby-friendly designated birthplace, and Breast Imaging Center of Excellence. It offers 24-hour emergency care, birthing center, and neonatal intensive care. The hospital is co-located with the Essentia Health-32nd Ave Clinic to offer a wide range of outpatient specialty care services including Heart and Vascular Center and orthopedics walk-in clinic.

**Caring for our Community:** Our commitment to our community’s health and wellness goes well beyond the work of the Community Health Needs Assessment. Through contributions of over $1 million annually to numerous community organizations, we’re working together with our communities to improve the health and vitality of our neighborhoods. In addition, we’re proud to say our employees donated more than 22,000 hours of their time and talents to a variety of programs and outreach efforts. Our community investments are designed to promote better health, help lessen inequities in our communities, improve access to health care and strengthen the fabric of our communities.
Hospital Service Area

For the purposes of this assessment, community is defined as the Essentia Health-Fargo planning area combined with the ZIP codes where 80 percent of inpatients resided for fiscal year 2018. Essentia Health-Fargo largely serves the Fargo-Moorhead metropolitan statistical area with 63% of hospital patients residing in Cass County, North Dakota, and Clay County, Minnesota.

Other regional communities making up the lesser portion of the 80th percentile for the Essentia Health-Fargo hospital service area include Detroit Lakes (3.3%), Park Rapids (2.3%), Frazee (1.0%), Ada (0.8%), Pelican Rapids (0.8%), Menahga (0.7%), Fergus Falls (0.7%), and Breckenridge (0.7%) in west-central Minnesota and Jamestown (1.8%), Lisbon (1.5%), Wahpeton (1.4%), Valley City (1.3%), and Hankinson (0.7%) in southeastern North Dakota. The community was defined based on the hospital’s ability to have the greatest impact with the available resources. The hospital is committed to building and sustaining partnerships with area organizations to extend its reach to all areas within this region.
Demographics & Socioeconomic Factors

Table A. Overall demographics (2016)

<table>
<thead>
<tr>
<th>Total Population</th>
<th>Fargo</th>
<th>Cass County</th>
<th>North Dakota</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population</td>
<td>115,950</td>
<td>166,852</td>
<td>736,162</td>
</tr>
<tr>
<td>Population age 65 and over (%)</td>
<td>10.90%</td>
<td>10.70%</td>
<td>14.20%</td>
</tr>
<tr>
<td>Poverty</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Median household income</td>
<td>$48,060</td>
<td>$54,926</td>
<td>$59,114</td>
</tr>
<tr>
<td>People of all ages living in poverty (%)</td>
<td>14.60%</td>
<td>11.80%</td>
<td>11.20%</td>
</tr>
<tr>
<td>People under 18 years living in poverty (%)</td>
<td>14.90%</td>
<td>11.90%</td>
<td>13.00%</td>
</tr>
<tr>
<td>Unemployment rate</td>
<td>2.70%</td>
<td>2.20%</td>
<td>1.90%</td>
</tr>
<tr>
<td>Educational Attainment</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>High School graduate or higher, person’s age 25+ years (%)</td>
<td>93.80%</td>
<td>94.30%</td>
<td>92.30%</td>
</tr>
<tr>
<td>Population ages 25+ with bachelor’s degree or higher</td>
<td>38.20%</td>
<td>37.40%</td>
<td>28.20%</td>
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<tr>
<td>Housing</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Percent of owner-occupied homes (%)</td>
<td>43.10%</td>
<td>51.80%</td>
<td>63.50%</td>
</tr>
<tr>
<td>Population spending more than 30% of income on rent (%)</td>
<td>41.50%</td>
<td>40.10%</td>
<td>38.60%</td>
</tr>
<tr>
<td>Transportation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Households with no motor vehicle available (%)</td>
<td>8.20%</td>
<td>6.80%</td>
<td>5.20%</td>
</tr>
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</table>

Source: U.S. Census Bureau 2016, American Community Survey

Table B. Race/Ethnicity Distribution (2016)

<table>
<thead>
<tr>
<th>Race Distribution – Fargo, ND</th>
<th>2016</th>
<th>Percent</th>
<th>2015</th>
<th>Percent</th>
<th>% Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Population</td>
<td>115,950</td>
<td>100.00%</td>
<td>113,464</td>
<td>100.00%</td>
<td>2.19%</td>
</tr>
<tr>
<td>One Race</td>
<td>112,477</td>
<td>97.00%</td>
<td>110,373</td>
<td>97.30%</td>
<td>1.91%</td>
</tr>
<tr>
<td>White</td>
<td>100,963</td>
<td>87.10%</td>
<td>100,304</td>
<td>88.40%</td>
<td>0.66%</td>
</tr>
<tr>
<td>Black or African American</td>
<td>5,344</td>
<td>4.60%</td>
<td>4,195</td>
<td>3.70%</td>
<td>27.39%</td>
</tr>
<tr>
<td>American Indian and Alaska Native</td>
<td>1,397</td>
<td>1.20%</td>
<td>1,505</td>
<td>1.30%</td>
<td>-7.18%</td>
</tr>
<tr>
<td>Asian</td>
<td>3,981</td>
<td>3.40%</td>
<td>3,695</td>
<td>3.30%</td>
<td>7.74%</td>
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<tr>
<td>Native Hawaiian/Pacific Islander</td>
<td>8</td>
<td>0.00%</td>
<td>8</td>
<td>0.00%</td>
<td>0.00%</td>
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<tr>
<td>Other Race</td>
<td>784</td>
<td>0.70%</td>
<td>666</td>
<td>0.60%</td>
<td>17.72%</td>
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<td>Two or More Races</td>
<td>3,473</td>
<td>3.00%</td>
<td>3,091</td>
<td>0.10%</td>
<td>12.36%</td>
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<td>Hispanic or Latino</td>
<td>3,486</td>
<td>3.00%</td>
<td>3,315</td>
<td>2.90%</td>
<td>5.16%</td>
</tr>
</tbody>
</table>

Source: U.S. Census Bureau 2014-2016, American Community Survey
Table B. Overall demographics (2016)

<table>
<thead>
<tr>
<th>Total Population</th>
<th>Moorhead</th>
<th>Clay County</th>
<th>Minnesota</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population</td>
<td>41,321</td>
<td>58,999</td>
<td>5,450,868</td>
</tr>
<tr>
<td>Population age 65 and over (%)</td>
<td>11.80%</td>
<td>7.74%</td>
<td>14.29%</td>
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**Poverty**

<table>
<thead>
<tr>
<th></th>
<th>Moorhead</th>
<th>Clay County</th>
<th>Minnesota</th>
</tr>
</thead>
<tbody>
<tr>
<td>Median household income</td>
<td>$55,343</td>
<td>$59,614</td>
<td>$63,217</td>
</tr>
<tr>
<td>People of all ages living in poverty (%)</td>
<td>14.90%</td>
<td>16.90%</td>
<td>10.80%</td>
</tr>
<tr>
<td>People under 18 years living in poverty (%)</td>
<td>15.40%</td>
<td>4.30%</td>
<td>13.69%</td>
</tr>
<tr>
<td>Unemployment rate</td>
<td>3.40%</td>
<td>2.20%</td>
<td>3.40%</td>
</tr>
</tbody>
</table>

**Educational Attainment**

<table>
<thead>
<tr>
<th></th>
<th>Moorhead</th>
<th>Clay County</th>
<th>Minnesota</th>
</tr>
</thead>
<tbody>
<tr>
<td>High School graduate or higher, person’s age 25+ years (%)</td>
<td>95.00%</td>
<td>94.70%</td>
<td>92.80%</td>
</tr>
<tr>
<td>Population ages 25+ with bachelor’s degree or higher</td>
<td>37.10%</td>
<td>24.10%</td>
<td>34.30%</td>
</tr>
</tbody>
</table>

**Housing**

<table>
<thead>
<tr>
<th></th>
<th>Moorhead</th>
<th>Clay County</th>
<th>Minnesota</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percent of owner-occupied homes (%)</td>
<td>63.20%</td>
<td>69.80%</td>
<td>71.40%</td>
</tr>
<tr>
<td>Population spending more than 30% of income on rent (%)</td>
<td>7.90%</td>
<td>18.00%</td>
<td>47.30%</td>
</tr>
</tbody>
</table>

**Transportation**

<table>
<thead>
<tr>
<th></th>
<th>Moorhead</th>
<th>Clay County</th>
<th>Minnesota</th>
</tr>
</thead>
<tbody>
<tr>
<td>Households with no motor vehicle available (%)</td>
<td>1.60%</td>
<td>1.40%</td>
<td>7.00%</td>
</tr>
</tbody>
</table>

*Source: U.S. Census Bureau 2016, American Community Survey*

Table B. Race/Ethnicity Distribution (2016)

<table>
<thead>
<tr>
<th>Race Distribution – Moorhead, MN</th>
<th>2016</th>
<th>Percent</th>
<th>2015</th>
<th>Percent</th>
<th>% Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Population</td>
<td>41,321</td>
<td>100.00%</td>
<td>40,935</td>
<td>100.00%</td>
<td>0.94%</td>
</tr>
<tr>
<td>One Race</td>
<td>39,968</td>
<td>96.70%</td>
<td>39,909</td>
<td>97.50%</td>
<td>0.15%</td>
</tr>
<tr>
<td>White</td>
<td>37,466</td>
<td>90.70%</td>
<td>37,292</td>
<td>91.10%</td>
<td>0.47%</td>
</tr>
<tr>
<td>Black or African American</td>
<td>1,154</td>
<td>2.80%</td>
<td>1,110</td>
<td>2.70%</td>
<td>3.96%</td>
</tr>
<tr>
<td>American Indian and Alaska Native</td>
<td>516</td>
<td>1.20%</td>
<td>488</td>
<td>1.20%</td>
<td>5.74%</td>
</tr>
<tr>
<td>Asian</td>
<td>566</td>
<td>1.40%</td>
<td>668</td>
<td>1.60%</td>
<td>-15.27%</td>
</tr>
<tr>
<td>Native Hawaiian/Pacific Islander</td>
<td>23</td>
<td>0.10%</td>
<td>19</td>
<td>0.00%</td>
<td>21.05%</td>
</tr>
<tr>
<td>Other Race</td>
<td>243</td>
<td>0.60%</td>
<td>332</td>
<td>0.80%</td>
<td>-26.81%</td>
</tr>
<tr>
<td>Two or More Races</td>
<td>1,353</td>
<td>3.30%</td>
<td>1,026</td>
<td>2.50%</td>
<td>31.87%</td>
</tr>
<tr>
<td>Hispanic or Latino</td>
<td>2,063</td>
<td>5.00%</td>
<td>2,008</td>
<td>4.90%</td>
<td>0.24%</td>
</tr>
</tbody>
</table>

*Source: U.S. Census Bureau 2014-2016, American Community Survey*

The Fargo-Moorhead metropolitan community spans across the border of North Dakota and Minnesota with the cities of Fargo and West Fargo located in Cass County, North Dakota, and the cities of Moorhead and Dilworth located in Clay County, Minnesota. The Red River, which runs north through the community, serves as the natural border between the two states. This is a relatively young community with a lower percentage of persons age 65 and over as compared to the state percentages. The community has also experienced a significant population growth in recent years, especially in Fargo. While the overall population is still predominantly white, the community has a significant new American population and continues to become more racially and ethnically diverse with Black or African American and Hispanic or Latino making up the largest minority populations.
Evaluation of 2016–2019 Implementation Plan

During 2016–2019, Essentia Health addressed significant needs identified in the 2016 assessment: physical health, mental health, and aging services. Some activities were led by the hospital, while others were part of larger collaborative efforts with local partners. The following describes significant accomplishments and outcomes.

Priority Area #1: Physical health with a focus on fitness and diet

**Partners:** SHIP, Cass Clay Alive, City of Fargo, City of Moorhead, NDSU, Sanford Health, University of Minnesota Extension, Public Schools, Concordia, MSUM,

**Results:** The Cass Clay Alive initiative was a collaboration of several organizations in the Fargo-Moorhead community including Essentia Health-Fargo that focused on promoting physical activity and healthy eating to reduce childhood obesity. Although the initiative dissolved during the 2016-2019 CHNA implementation period, the participating organizations continue to partner to carry on key activities of the Cass Clay Alive initiative. One key activity that has lived on is the popular Streets Alive events, which closes streets in downtown Fargo-Moorhead to vehicles to encourage walking, running, biking, rollerblading, dancing, and family fun along the route. Essentia Health-Fargo supports the Streets Alive as a major event sponsor and through the volunteerism of the Essentia Health staff. Since its beginning in 2010, nearly 82,000 people have attended StreetAlive events including 2,500 attendees at the most recent event on June 24, 2018.

In 2016, representatives of Essentia Health-Fargo met with partners from the Cass Clay Alive initiative to develop curriculum for a new Building Healthier Babies program. The program’s goal was to encourage healthy habits from the very beginning of life by teaching parents-to-be and new parents the skills they would need to help their baby grow as a social and emotional learner, adventurous taster, and confident mover. In 2018, Essentia Health-Fargo partnered with TNT Kids Fitness and others from the Cass Clay Alive initiative to pilot the Building Healthier Babies program as a three-part educational series. Although attendance was lower than expected, participants’ course evaluations indicated that they increased their knowledge and identified tips they would use to help their babies live healthy now and as they grow.

In addition to the Building Healthier Babies education, Essentia Health-Fargo supports new mothers with evidence-based feeding and infant care in its birthing center and offers “Tender Transitions,” a breastfeeding support service, which is open to the community. In May 2018, Essentia Health-Fargo became the first Baby Friendly hospital in the region. Essentia Health-Fargo has made significant improvements in exclusive breastfeeding rates. In 2016, the rate of exclusive breastfeeding at Essentia Health-
Fargo was 68% (Joint Commission benchmark was 53%), and in 2018, the rate continued to increase to 76% (Joint Commission benchmark 51%).

Essentia Health-Fargo collaborates with NDSU Extension and Sanford Health to offer the National Diabetes Prevention Program (NDPP) in the Fargo-Moorhead community. Essentia Health-Fargo also supports NDPP in the communities of Jamestown, Valley City, and Wahpeton, ND. This is an evidence-based lifestyle change program for type 2 diabetes prevention. The anticipated impact of NDPP is reduced body weight and increased physical activity in participants, resulting in lowered risk of Type 2 diabetes. Essentia Health-Fargo provides a lifestyle coach to lead classes offered free to those at risk. The program in Wahpeton received full recognition by the CDC on April 23, 2018, meaning that the program has demonstrated effectiveness by achieving all the performance criteria including an average weight loss over the entire 12-month intervention period of a minimum of 5% of starting body weight.

Our goal for NDPP was to increase attendance by 10% over the three-year period, and we have far exceeded that goal. In 2015, 42 individuals enrolled in the program; and in 2017, there were 164 individuals. At the end of July 2018, 82 individuals had already enrolled this year.

We Can, a National Institute of Health program, was incorporated into a children’s 10-week program in collaboration with the Fargo Parks District. Children already trending toward obesity, and their parents, were eligible for the program at the Fargo Parks fitness facility, Court’s Plus. Program sessions consisted of 30 minutes of exercise followed by 30 minutes of healthy eating information. One cohort of the We Can program was held in spring 2017. Although the partnership was discontinued with the Fargo Parks following the completion of the one cohort, the course was adapted for 60 children attending English as a Second Language summer school in June and July of 2017.

Priority Area #2: Mental health and addiction services

Partners: Mayor’s Blue Ribbon Commission, Dakota Medical Foundation, White Earth Indian Reservation, SHIP, Re-Think Mental Health, Public Schools, Worksite Wellness programs, State of North Dakota

Results: Essentia Health-Fargo has been a founding member of the Mayor’s Blue Ribbon Commission on Addiction, which was formed to address the rising opioid addiction in Cass and Clay counties. The commission is working to address the continuum of addiction including prevention, early intervention, treatment/recovery, and transitional housing. While opioid addiction led to the formation of the commission, we recognize that there is a need to address all addiction including alcohol and other drugs. One major accomplishment of the commission has been establishing a community addiction navigator housed at FirstLink to help those with addiction get connected with services and support. Another accomplishment has been the formation of the mobile outreach program at the withdrawal management unit in Fargo. The program provides specially trained staff of the withdrawal unit to transport those in need of detox services in Fargo or Moorhead. The mobile outreach program also helps to alleviate the burden of transports by ambulance and police.
Reduction in opioid prescriptions and expansion of medication-assisted treatment for those with opioid addiction have been the focus of the treatment and recovery workgroup. Essentia Health also continues to work within our health care system to reduce the number of patients started on opioid therapy and currently on opioids for chronic pain as well as reduce diversion and abuse of opioids. From September 2015 to September 2017, Essentia Health saw a 35% decrease in new patients starting opioids for chronic pain and a 35% decrease in patients on opioids for chronic pain.

Essentia Health-Fargo provides tobacco cessation services and has a dedicated tobacco cessation counselor position for addressing tobacco use. The hospital works with a community coalition to engage teens in helping drive tobacco cessation.

Essentia Health-Fargo is a leading member of the ReThink Mental Health Initiative, which was formed after the 2013 community health needs assessment identified mental health as a priority issue. Community leaders agreed to work together to improve a fragmented, crisis-driven service system and invest in prevention. The group convenes an annual mental health summit that emphasizes key mental health best practice initiatives. ReThink Mental Health has sponsored several community-wide educational sessions to promote community-wide adoption of the Columbia Suicide Severity Rating Scale (CSSRS). CSSRS training was given to first responders including FM Ambulance, FirstLink Emergency Phone Line, police departments, and schools. Training has been expanded to faith communities, shelters, and mobile crisis units. In addition to the training, community partners came together to develop a community triage plan for each level of suicide risk identified on the CSSRS. Essentia Health has adopted the CSSRS system-wide in both hospital and clinic settings. In addition, the ReThink Mental Health collaborative completed a 2017-2018 trauma-sensitive pilot project called “Building Compassionate Schools” with 18 school and afterschool programs. Each school building had a team of at least five people, including the principal, participate in four educational and action-planning sessions over a six-month period. Each organization completed an initial trauma-sensitive checklist and then completed it again in May of 2018. All 18 teams agreed to continue into a second year and 15 new schools began in the fall of 2018. The mental well-being workgroup has developed its mental well-being initiative, “The People Project,” and is engaging local businesses to provide it to their employees in the 2019 pilot year. The recovery workgroup hosts quarterly “Recovery Roundups” to provide networking opportunities among the recovery community and increase community awareness of recovery resources. It attendance continues to grow.
**Priority Area #3: Aging Services**

**Partners:** Sanford Health, Cass and Clay County Services, NDSU Extension, Area Agency on Aging, Stratis Health, Hospice of the Red River Valley

**Results:** The Aging Services Collaborative with Sanford Health, Cass and Clay Social Services, NDSU Extension and other stakeholders continue to meet and strategically plan interventions that focus on keeping our aging population in their homes, preventing falls, and supporting their caregivers.

Essentia Health-Fargo and Hospice of the Red River Valley are co-leading a community workgroup to increase awareness for advance care planning. In 2018, the group created a promotional toolkit for National Healthcare Decisions Day that included sample social media postings, a “before I die” interactive display banner template, and sample press releases. The toolkit was available on both the North Dakota and Minnesota Honoring Choices websites. Many businesses and individuals used the toolkit to spread the word throughout the month of April about the importance of completing a health care directive. The social media campaign yielded over 30,000 impressions. Five “Before I Die” banners were displayed in prominent public areas throughout the Fargo-Moorhead community, including one at the West Acres Mall, and individuals were encouraged to write something they wish to do before they die and to think about how they want to live towards the end of their life. Other activities of the advance care planning workgroup included hosting a community showing of the documentary, “Being Mortal,” at a movie theatre in 2016 and distributing “Let’s Talk Turkey” flyers during Thanksgiving to encourage families to discuss their health care wishes. During the survey cycle, two staff members became certified through Respecting Choices to train First Steps ACP facilitators. Three training sessions were held certifying an additional 23 facilitators with five facilitators for the Fargo-Moorhead area.

In addition to the community awareness activities, Essentia Health-Fargo conducted two pilots in the clinic setting to include an advance care planning (ACP) assessment of patients during the rooming process for a clinic appointment. Swimlanes were developed for the nurses to determine what the patient needed as far as ensuring a health care directive (HCD) was completed and included in the patient’s electronic medical record (EMR). The nurse provided different levels of support and resources depending on the patient’s engagement in completing a HCD and the clinics resources as well. The outcomes of the pilots were difficult to measure due the technical difficulties with the reports from the electronic medical record. However, resources such as informational packets that included HCD forms and postage-paid envelopes have been given to patients during their visits. Advance care planning appointments have been scheduled from the rooming process with trained facilitators.
2020-2022 CHNA Process and Timeline

Essentia Health’s Community Health Advisory Committee developed a shared plan for the 15 hospitals within the system. The plan was based on best practices from the Catholic Hospital Association and lessons learned from the 2016-2019 CHNA process. The process was designed to:

- Incorporate input from persons representing broad interests of the community
- Collaborate with local public health and other health care providers
- Utilize multiple sources of public health data to make data-driven decisions

Each individual hospital worked with community partners to carry out the plan in their service area. Aspects of the plan were adapted to meet the unique needs of each location. Hospital leadership teams and local hospital boards received and approved each implementation plan, followed by final approval by the Essentia Health Board of Directors. The following visual describes the assessment steps and timeline.

### Timeline

<table>
<thead>
<tr>
<th>Period</th>
<th>Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ASSESS</strong> (April - July 2018)</td>
<td>Define Service Area, Service Area Demographics, Select Health Status Indicators, Analyze Data &amp; Inventory available resources</td>
</tr>
<tr>
<td><strong>PRIORITIZE</strong> (August - December 2018)</td>
<td>Choose Prioritization Process, Prioritize Issues, Justify needs that will not be addressed and provide reasoning why, Gather Community Input on Priority Issues</td>
</tr>
<tr>
<td><strong>DESIGN</strong> (January-April 2019)</td>
<td>Develop Goals and Measurable Objectives, Choose Strategies and Tactics, Identify the “team” and resources for each strategy, Identify Performance Indicators</td>
</tr>
<tr>
<td><strong>FINALIZE</strong> (May - June 2019)</td>
<td>Prepare reports, and review with key stakeholders for final feedback, Present to Hospital Board for Approval May 1st, 2019, Share results and action plans with key stakeholders and leaders systemwide, Post to website, and share plan with the broader community</td>
</tr>
</tbody>
</table>

### Adoption of implementation strategy:
The Community Health Needs Assessment and Implementation Strategy were approved by the Essentia Health-West Board of Directors on May 1, 2019.
Assess

The community health needs assessment process included collecting data from a two-part survey and utilizing secondary sources of data. The Greater Fargo-Moorhead Community Health Needs Assessment Collaborative collected primary data by administrating two surveys; one to key community stakeholders and one to residents of Cass and Clay Counties (Appendix B). The key stakeholder survey was developed in collaboration with public health experts, and the survey was conducted through a partnership between the Greater Fargo-Moorhead Community Health Needs Assessment Collaborative and the Center for Social Research (CSR) at North Dakota State University. Questions were focused on identifying the perception of the need of various health indicators including economy, transportation, child care access, health behaviors, mental health and substance abuse and more. The data was collected by online survey during the month of December 2017, and a total of 222 key stakeholders participated. A summary of the results is available in Appendix A.

The second part of the survey for residents was secured through a qualified vendor, Qualtrics. Deliberate effort was made to seek input from members of medically underserved, low-income, and minority populations in the community, or organizations serving or representing the interest of such populations by targeting additional survey responses from clients of the Family Wellness Center’s New American Clinic, specific groups through public health, and by paper surveys distributed at the New American Clinic through Family HealthCare and through Clay County Public Health. Questions were focused on individual health behaviors and demographics. Data collection for the resident survey occurred during December 2017 and January 2018, and a total of 547 responses were received (Appendix B).

Secondary data was prepared in a presentation to community stakeholders (Appendix D) through Community Commons, which is a web-based community level data and visualization platform with an array of social, demographic, education, economic, health, transportation and environmental data that can be mapped and placed into reports including the health indicators report prepared for the Greater Fargo-Moorhead Community Health Needs Assessment.
Prioritize

After initial data review by the key stakeholders, Essentia Health-Fargo convened a strategic planning meeting of internal and external stakeholders representing primary care, emergency services, behavioral health and substance use, public health, health promotion, charitable feeding, nursing, quality, and case management. The representatives reviewed the primary and secondary data as well as themes from the key stakeholder discussions and then through further discussion reached agreement on ten community health issues. Leaders rated each of the health issues from highest priority to lowest priority using a prioritization matrix and dotmocracy. Through this process, two priorities were identified for action.

1. Mental health
2. Youth and young adult substance use

Significant needs not addressed in the CHNA: Other issues identified through the process but not included in the priorities included access and affordability of health care, obesity, childhood trauma, children not having access to healthy foods, housing, vaping in schools, availability of quality child care, and lack of parenting skills/ supervision. These needs will be addressed in part through the selected priorities as they are interrelated. Additionally, Essentia Health already collaborates with local partners to address many of these specific issues in the community.

Community Input

On July 31, 2018, 56 key stakeholders representing the broad interest of the community gathered to review the results of the surveys and the secondary data. At the meeting, the Collaborative steering members facilitated table discussions to seek further input from the community leaders and to identify emerging themes of community health issues. Agencies represented at the key stakeholder meeting included:

- Essentia Health
- Sanford Health
- United Way
- Fargo Cass Public Health
- Clay County Public Health
- Family HealthCare Center
- Red River Child Advocacy Center
- West Fargo Commission
- Fargo Board of Health
- Fargo Moorhead MetroCog
- Fargo Fire Department
- FM Visitors & Convention Bureau
Key Findings

**Priority #1 Mental Health**

Supporting Data:

**Key Stakeholder Survey Results:** The stakeholder survey (Appendix A) asked residents to rank issues they felt were the top priority on a scale of 1-5, 1 being not a priority and 5 being an immediate priority.

### Mental Health and Substance Abuse

#### Youth Risk Behavior Student Survey of Fargo-Jamestown area, ND:

28.9% of students in grade 9-12 feel sad or hopeless almost every day for more 2 weeks in a row so they stopped doing some usual activities in 2017 vs. 23.8% in 2015.

16.7% of students in grades 9-12 have seriously considered attempting suicide in the past 12 months vs. 13.7% in 2015.

**Community Input:** Key stakeholders noted the factors that exacerbate the issue and the factors that relieve the issue. Factors that exacerbate the issue that were identified include adverse childhood experiences (ACES) and trauma, suicide rates, social isolation, substance abuse and socioeconomic factors. Factors that relieve the rate include access to therapy, medication, social connections and caring adults, early intervention and screenings, health insurance coverage, services near, care coordination and expertise to know what to look for and what resources are available.

**Community Strengths and Resources Available:**

The Re-Think mental health initiative is leading work to address mental well-being, specifically with a focus on youth, and is a strong community asset with multiple partners. Additional resources include schools, corrections, churches, health care/ behavioral health care, police/ambulance, homeless shelters, mobile crisis, and higher education.
Priority #2: Youth and Young Adult Substance Use

Supporting Data:

Youth Risk Behavior Student Survey for Cass County, ND

- 59.2% of 9-12 grade students have drank alcohol in 2017 vs. 58.2% in 2015, and 29.1% currently drink alcohol in 2017 vs 28.8% in 2015.
- 15.5% of 9-12 grade students have used marijuana in the past 30 days in 2017 vs. 13.8% in 2015.

Resident Survey Data: The survey asked residents to identify drug and alcohol related issues or effects (Appendix B).

Drug and Alcohol Issues

- Has alcohol use had a harmful effect on you or a family member in the past two years? 21% Yes, 79% No
- Do you have drugs in your home that are not being used? 17% Yes, 83% No
- Has prescription or non-prescription (over-the-counter) drug use had a harmful effect on you or a family member? 7% Yes, 93% No
- Has a family member or friend ever suggested that you get help for substance use? 7% Yes, 93% No
- Have you ever wanted help with a prescription or non-prescription (over-the-counter) drug use? 5% Yes, 95% No

Community Input: Key stakeholders identified factors that exacerbate the issue and factors that help minimize the issue. Factors that exacerbate the issue include peer pressure, poor parenting accountability/skills, easy access to substances, mental health issues, social media pressure, lack of youth alcohol-free activities, cultural and social norms that promote drinking, poor coping skills, progression of addiction, policies that promote access or use including marijuana legalization. Factors that minimize are reduced opioid prescribing, increased awareness of opioid issues, increasing access to drug takeback sites, increased education and awareness of substance abuse issues, and responsible beverage server training.

Community Strengths and Resources Available:

The Mayor’s Blue Ribbon Commission is leading the community in working to reduce addiction in Cass and Clay counties. The commission is a strong partnerships including schools, health organizations, public health, TNT, neighborhood association, Level Up Fargo, Sharehouse, Prairie St. Johns, Drake, and Southeast Human Services.
Design

Essentia Health worked with internal stakeholders as well as community partners to design a strategy to address each of the priority needs identified in the CHNA process. The plan outlines actions that will be taken to respond to the identified community needs including goals and measurable objectives, strategies, tactics, and performance indicators.

The implementation plan is a three-year plan to address priority needs. The implementation plan will be reviewed annually, with progress shared with hospital leadership and the Board of Directors on an annual basis.

Additionally, the following three priorities were determined by the Community Health Advisory Committee (CHAC) at a retreat in January 2019. The retreat included input from Community Health staff from across the Essentia Health system. Prioritization was based on common themes from the 15 Community Health Needs Assessments.

- Mental health and wellness
- Substance use
- Nutrition and physical activity

During the FY2020-FY2022 assessment cycle, some activities will be led by the individual hospitals/markets, while others will be coordinated across the health system. This will help Essentia Health make the greatest impact with available resources.

No written comments were received from the 2013 CHNA. Any comments would have been taken into consideration in this report.

Conclusion

As a nonprofit health system, Essentia Health is called to make a healthy difference in people’s lives. This needs assessment illustrates the importance of collaboration between our hospitals and community partners. By working collaboratively, we can have a positive impact on the identified health needs in our community in FY 2020-2022.

For questions or comments about the community health needs assessment, please contact: chna.comments@essentiahealth.org

Copies of this plan can be downloaded from our website: https://www.essentiahealth.org/about/chna/
CHNA 2020-2022 Implementation Plan

Cass & Clay County Community Health Committee

Essentia Health will work together with partners to address each aspect of this implementation plan. The Essentia Health system has outlined an allocation of resources available to each hospital as a percentage of net revenue to address the priorities set forth in the Community Health Needs Assessments. A committee within the Essentia Health West Market will best determine the ways to utilize resources to address the priority needs. Progress will be monitored by Clear Impact, the West Market Community Health software for tracking success in community health.

Our Results

Cass & Clay counties support mental health and well-being of residents

Drug-free communities thrive in Cass & Clay counties

Our Indicators

- Severity of depression, suicide and stress
- Percentage of students feeling sad or hopeless almost every day
- Percentage of students who have seriously considered suicide within the past 12 months
- Percentage of youth using alcohol in the past and currently
- Percentage of youth using marijuana in the past 30 days
- Percentage of adults reporting drug and alcohol issues

Essentia Health will work together with partners to address each aspect of this implementation plan. The Essentia Health system has outlined an allocation of resources available to each hospital as a percentage of net revenue to address the priorities set forth in the Community Health Needs Assessments. A committee within the Essentia Health West Market will best determine the ways to utilize resources to address the priority needs. Progress will be monitored by Clear Impact, the West Market Community Health software for tracking success in community health.
## Result: Cass & Clay Counties support mental health and wellbeing of residents

<table>
<thead>
<tr>
<th>Indicators</th>
<th>Partners who can help</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Youth Risk Behavioral Student Survey of Cass County, ND. 2017:</strong></td>
<td>Mayor’s Blue Ribbon on Drug Addiction, Sharehouse, Prairie St. Johns Drake Counseling, Churches, Schools, Re-Think Mental Health, Sheriffs Dept, Police Department, Jail, Court System, North Dakota Suicide Prevention Network PrairieOne, TNT Kids Fitness &amp; Gymnastics, Level Up Fargo, Southeast Human Services, Health Organizations</td>
</tr>
<tr>
<td>• 28.9% of students in grade 9-12 feel sad or hopeless almost every day for more than 2 weeks in a row so they stopped doing some usual activities in 2017 vs. 23.8% in 2015.</td>
<td></td>
</tr>
<tr>
<td>• 16.7% of students in grades 9-12 have seriously considered attempting suicide in the past 12 months vs. 13.7% in 2015</td>
<td></td>
</tr>
</tbody>
</table>

## Story behind the data

### Factors that have contributed to improvements:

- Adverse childhood experiences (ACEs and trauma)
- Suicide rates (copycat, clusters)
- Social isolation
- Substance abuse
- Socioeconomic factors (food, housing, etc.)

### Limiting factors:

- Therapy
- Medication
- Social connection/Caring adult
- Screening/early intervention
- Health insurance
- Services in close proximity
- Care coordination
- Expertise to know what to look for and who to connect with

## What we are going to do

### Strategy #1: Improve timely access to behavioral health services and supports

**Action Steps:**

1. Support the integration of behavioral health workers in community settings where mental health concerns are identified and can be addressed without delay, including in primary care clinics.
2. Engage community partners to work towards zero suicides in the community.

### Strategy #2: Promote mental well-being in schools and worksites

**Actions:**

1. Continue to engage in the ReThink Mental Health initiative with representation on the steering committee to provide direction for the four workgroups addressing the mental health continuum.
2. Work with community organizations and experts to develop and promote the mental wellbeing movement, The People Project, in worksites across the community.
Result: Drug-free communities thrive in Cass & Clay counties

<table>
<thead>
<tr>
<th>Indicators</th>
<th>Partners who can help</th>
</tr>
</thead>
<tbody>
<tr>
<td>Youth Risk Behavior Survey, Clay County, 2017.</td>
<td>Re-Think Mental Health, Northwest Mental Health Services, Mayor’s Blue Ribbon on Drug Addiction, Sharehouse, Prairie St. Johns, Drake Counseling, Churches, Schools, Churches United, Sheriff’s Dept, Police Department, Jail, Court System, North Dakota Suicide Prevention Network, PrairieOne, TNT Kids Fitness and Gymnastics, Level Up Fargo, Southeast Human Services Health Organizations</td>
</tr>
<tr>
<td>59.2% of 9-12 grade students have drank alcohol in 2017 vs. 58.2% in 2015, and 29.1% currently drink alcohol in 2017 vs 28.8% in 2015.</td>
<td></td>
</tr>
<tr>
<td>15.5% of 9-12 grade students have used marijuana in the past 30 days in 2017 vs. 13.8% in 2015</td>
<td></td>
</tr>
</tbody>
</table>

Story behind the data

Factors that have contributed to improvements:
- Education regarding resources
- Appropriate referrals
- Availability of clinic and providers
- Financial assistance – sliding scale, financial counseling
- Community partnerships
  - Relationships with primary care provider

Limiting factors:
- Increased cost of health care and insurance
- Fear
- Transportation
- Lack of common electronic medical record – challenges in community partnership communication
- Personal accountability
- Social determinants
- Chronic disease

What we are going to do

Strategy #1: Strengthen collaboration among community partners to prevent and reduce youth substance abuse

Actions Steps:
1. Engage in the Mayor’s Blue Ribbon Commission on Addiction and support local drug free communities.
2. Address factors in the community that increase the risk of substance use and promote factors that minimize the risk of substance abuse.

Strategy #2: Apply harm-reduction principles in caring for those with addiction to reduce risky substance use and morbidity and mortality

Actions Steps:
1. Increase access to medication-assisted treatment by providing training assistance to primary care providers to become waivered to prescribe medication-assisted treatment for opioid use disorder.
2. Improve care coordination among community partners (e.g. community clinics, social services, health care) for pregnant women who are on medication-assisted treatment to encourage prenatal care and reduce fetal drug exposure.
2019 Greater Fargo Moorhead Community Health Needs Assessment Data Summary

Key Stakeholder Survey:

Background: Key stakeholders were asked to rate their perceptions of issues in the community using a Likert scale with 1 meaning “no attention needed” and 5 meaning “immediate attention needed”.

Data collection period: December 2017. Number of respondents and demographics: 222 respondents. 70% Female, 28.2% 55-64 age, 93.5% White. 62.4% annual household income $70,000+. 88.6% bachelor’s degree or higher.

Resident Survey:

Background: Residents were asked about their own health and their perceptions of health-related issues in the community. Resident data was obtained from a representative sample of the population secured through Qualtrics using an online survey. Additional survey responses were collected through the Family Wellness Center’s New Americans Clinic, and survey links were also distributed through public health agencies. Additional paper surveys were distributed at the New American Clinic through Family Healthcare and through Clay County Public Health. Data collection period: December 2017 – January 2018. Number of respondents and demographics: 547 respondents. 73% Female, 25% 25-34 age, 88% White, 24% annual household income $50,000 to $74,999, 43% bachelor’s degree or higher.

Secondary Data:

Background: Data for Cass County ND and Clay County MN accessed on July 12, 2018 through Community Commons from sources as footnoted. Data for the Fargo Moorhead Metropolitan Statistical Area (FM Metro) obtained from the Centers for Disease Control and Prevention’s Behavioral Risk Factor Surveillance System (BRFSS).

Data Summary:

Drug use and abuse was the most urgent community health issue identified by key stakeholders, and it was also an important community issue for residents. Particularly, prescription drug abuse and alcohol use and abuse were areas of concern. 50% of residents reported binge drinking in the past month, and the secondary data also shows that the FM metro continues to have one of the highest binge drinking rates among U.S. cities. Death rate by drug poisoning was relatively high in Clay County as compared to the overall rate for MN.

Availability of mental health / behavioral health providers was another area that the key stakeholders expressed as an urgent community health issue including services for youth with behavioral health problems. Anxiety and depression were the most frequent health conditions reported by residents, and 22.3% of the Medicare population in Cass and Clay counties have depression. Cass and Clay Counties have a relatively high death rate due to suicide as compared to the state and national levels; therefore, it was not surprising that the key stakeholders also noted urgency to address suicide.
Availability of affordable housing was a key concern by stakeholders as well as the cost of quality daycare. Another socioeconomic concern for residents was with food insecurity.

Cost of healthcare and health insurance were concerns for both stakeholders and residents. Cost was a significant barrier for residents who did not seek medical and dental care. 1 in 4 residents did not have a routine check-up with a healthcare provider in the past year, and 1/3 of those residents expressed cost as a barrier for getting a checkup.

Physical Health & Nutrition: Although the vast majority of residents (90%) reported their health as good to excellent, 29% reported high cholesterol and 26% reported hypertension. There were also significant risk factors for chronic diseases reported by the residents including 39% with obesity and 21% current smokers. According to the BRFSS, many adults in the FM Metro consume less than one fruit and vegetable per day (42.5% and 28.2% respectively).

Built environment: Cass and Clay Counties have a relatively high density of recreational and fitness facilities as compared to the state and national statistics; however, there are also an overabundance of fast food and liquor stores in this area.

Education: The density of Head Start programs in Cass County is below the state and national levels; whereas, the density of Head Start programs in Clay County is above the state and national levels.
## Indicators

### SubSTANCE USE

<table>
<thead>
<tr>
<th>Description</th>
<th>Stakeholders</th>
<th>Residents</th>
<th>Secondary Data</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drug use and abuse (e.g. prescription drugs, synthetic opioids, marijuana, heroin, cocaine)</td>
<td>4.40</td>
<td>Community issue (13%)</td>
<td></td>
</tr>
<tr>
<td>Housing that accepts people with chemical dependency, mental health problems, criminal history or victims of domestic violence</td>
<td>4.22</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Abuse of prescription drugs</td>
<td>4.17</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alcohol use and abuse</td>
<td>4.15</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Binge drinking (at least once a month)</td>
<td></td>
<td>50%</td>
<td>24.8% (FM Metro)&lt;sup&gt;1&lt;/sup&gt;</td>
</tr>
<tr>
<td>Drug poisoning - death rate per 100,000 pop</td>
<td></td>
<td></td>
<td>7.1 (Cass), 15.4 (Clay)&lt;sup&gt;2&lt;/sup&gt;</td>
</tr>
</tbody>
</table>

### MENTAL HEALTH/ BEHAVIORAL HEALTH

<table>
<thead>
<tr>
<th>Description</th>
<th>Stakeholders</th>
<th>Residents</th>
<th>Secondary Data</th>
</tr>
</thead>
<tbody>
<tr>
<td>Availability of mental health providers</td>
<td>4.28</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Availability of behavioral health providers</td>
<td>4.21</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental health care provider rate per 100,000 pop</td>
<td></td>
<td>245.2 (Cass and Clay)&lt;sup&gt;3&lt;/sup&gt;</td>
<td></td>
</tr>
<tr>
<td>Availability of services for at-risk youth (e.g. homeless, youth with behavioral health problems)</td>
<td>4.11</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Depression (past diagnosis)</td>
<td>4.10</td>
<td>40%</td>
<td>22.3% (Medicare population Cass and Clay)&lt;sup&gt;4&lt;/sup&gt;</td>
</tr>
<tr>
<td>Anxiety, stress, etc. (past diagnosis)</td>
<td></td>
<td>46%</td>
<td></td>
</tr>
<tr>
<td>Suicide - death rate per 100,000 pop</td>
<td>4.01</td>
<td></td>
<td>14 (Cass), 10.6 (Clay)&lt;sup&gt;5&lt;/sup&gt;</td>
</tr>
</tbody>
</table>

### ECONOMIC STABILITY

<table>
<thead>
<tr>
<th>Description</th>
<th>Stakeholders</th>
<th>Residents</th>
<th>Secondary Data</th>
</tr>
</thead>
<tbody>
<tr>
<td>Availability of affordable housing</td>
<td>4.21</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cost of quality child care</td>
<td>4.08</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Food that we bought just didn’t last, and didn’t have money to get more (sometimes, often true)</td>
<td></td>
<td>30%</td>
<td></td>
</tr>
<tr>
<td>Worried whether food would run out before we got money to buy more (sometimes, often true)</td>
<td></td>
<td>35%</td>
<td></td>
</tr>
</tbody>
</table>

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<sup>1</sup> As compared to 24.8% for ND, 21.3% for MN, 16.9% for US. Centers for Disease Control and Prevention. National Center for Chronic Disease Prevention and Health Promotion, Division of Population Health. BRFSS Prevalence & Trends Data, 2015.

<sup>2</sup> As compared to 6.35 for ND, 10.25 for MN, 15.6 for US. Centers for Disease Control and Prevention, National Vital Statistics System. Accessed via CDC WONDER, 2012-16.

<sup>3</sup> As compared to 181.2 for ND, 204.8 for MN, 202.8 for US. University of Wisconsin Population Health Institute, County Health Rankings, 2018.

<sup>4</sup> As compared to 17.6% for ND, 19.9% for MN, 17% for US. Centers for Medicare and Medicaid Services, 2015.

<sup>5</sup> As compared to 4.48 for MN, 13 for US. Centers for Disease Control and Prevention, National Vital Statistics System. Accessed via CDC WONDER, 2012-16.
### HEALTH & HEALTHCARE

<table>
<thead>
<tr>
<th>Service</th>
<th>Score</th>
<th>Concern</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cost of long-term care</td>
<td>4.15</td>
<td>Concern for age 65+ (19%)</td>
</tr>
<tr>
<td>Cost of memory care</td>
<td>4.08</td>
<td></td>
</tr>
<tr>
<td>Access to affordable health insurance</td>
<td>4.05</td>
<td>Family issue (15%)</td>
</tr>
<tr>
<td>Access to affordable healthcare</td>
<td>4.01</td>
<td>Community issue (43%), Family issue (44%), Concern for age 65+ (20%)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Health Outcome</th>
<th>Percentage</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adults reporting fair or poor health</td>
<td>9%</td>
<td>12.9% (FM Metro)6</td>
</tr>
<tr>
<td>More than one year since last visit with a doctor or healthcare provider</td>
<td>25%7</td>
<td></td>
</tr>
<tr>
<td>More than one year since last visit with a dentist</td>
<td>29%8</td>
<td></td>
</tr>
<tr>
<td>In the past year, reported that they or a family member needed medical care, but did not receive the care they needed</td>
<td>12%9</td>
<td></td>
</tr>
</tbody>
</table>

### PHYSICAL HEALTH & NUTRITION

<table>
<thead>
<tr>
<th>Health Outcome</th>
<th>Percentage</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adults reporting obesity (BMI ≥ 30.0)</td>
<td>39%</td>
<td>31.1% (FM Metro)10</td>
</tr>
<tr>
<td>Adults who consumed fruit &lt; 1x per day</td>
<td>42.5% (FM Metro)11</td>
<td></td>
</tr>
<tr>
<td>Adults who consumed a vegetable &lt; 1x per day</td>
<td>28.2% (FM Metro)12</td>
<td></td>
</tr>
<tr>
<td>Adults who report 3 or more days of moderate physical activity</td>
<td>55%</td>
<td></td>
</tr>
<tr>
<td>Adults who with enough aerobic and muscle strengthening exercises to meet guidelines</td>
<td>20.5% (FM Metro)13</td>
<td></td>
</tr>
<tr>
<td>Current cigarette use (every day or some days)</td>
<td>21%</td>
<td></td>
</tr>
</tbody>
</table>

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6 As compared to 14.8% for ND, 12.7% for MN, 16.4% for US. Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion. [BRFSS Prevalence & Trends Data](https://www.cdc.gov/brfss/prevalence/trends_data.html), 2015.

7 Most frequent barriers to doctor visit for routine checkup were: did not need to see a doctor (43%), cost (33%), time not convenient (22%).

8 Most frequent barriers to dentist visit were: cost (50%), no insurance (30%), time not convenient (22%).

9 As compared to 31.9% for ND, 27.8% for MN, 29.9% for US. Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion. [BRFSS Prevalence & Trends Data](https://www.cdc.gov/brfss/prevalence/trends_data.html), 2015.

10 As compared to 40.4% for ND, 37.1% for MN, 39.7% for US. Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion. [BRFSS Prevalence & Trends Data](https://www.cdc.gov/brfss/prevalence/trends_data.html), 2015.

11 As compared to 27.5% for ND, 22.4% for MN, 22.1% for US. Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion. [BRFSS Prevalence & Trends Data](https://www.cdc.gov/brfss/prevalence/trends_data.html), 2015.

12 As compared to 17.7% for ND, 21.8% for MN, 20.3% for US. Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion. [BRFSS Prevalence & Trends Data](https://www.cdc.gov/brfss/prevalence/trends_data.html), 2015.
### Current smokers
- **15.6% (FM Metro)**

### High cholesterol (past diagnosis)
- 29%

### Hypertension (past diagnosis)
- 26%

### BUILT ENVIRONMENT

<table>
<thead>
<tr>
<th>Facility Type</th>
<th>Data Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recreational and Fitness Facilities per 100,000 pop</td>
<td>15.81 (Cass and Clay)</td>
</tr>
<tr>
<td>Beer, Wine, and Liquor Stores per 100,000 pop</td>
<td>16.29 (Cass and Clay)</td>
</tr>
<tr>
<td>Fast Food Restaurants per 100,000 pop</td>
<td>78.55 (Cass and Clay)</td>
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### EDUCATION

<table>
<thead>
<tr>
<th>Education Measure</th>
<th>Data Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rate of Head Start programs (per 10,000 children)</td>
<td>3.84 (Cass), 7.4 (Clay)</td>
</tr>
<tr>
<td>High school graduation rate</td>
<td>88% (Cass), 81.1% (Clay)</td>
</tr>
</tbody>
</table>

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14 As compared to 19.8% for ND, 15.2% for MN, 17.1% for US. Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Division of Population Health. *BRFSS Prevalence & Trends Data*, 2015.

15 As compared to 14.57 for ND, 12.56 for MN, 11.01 for US. US Census Bureau, *County Business Patterns*. Additional data analysis by *CARES*, 2016.

16 As compared to 13.38 for ND, 17.69 for MN, 11 for US. US Census Bureau, *County Business Patterns*. Additional data analysis by *CARES*, 2016.

17 As compared to 70.62 for ND, 66.18 for MN, 77.06 for US. US Census Bureau, *County Business Patterns*. Additional data analysis by *CARES*, 2016.

18 As compared to 8.97 for ND, 7.4 for MN, 7.18 for US. US Department of Health Human Services, Administration for Children and Families. 2018.

19 As compared to 85.6% for ND, 86% for MN, 86.1% for US. US Department of Education, *EDFacts*. Accessed via *DATA.GOV*. Additional data analysis by *CARES*, 2015-16.
Key Stakeholder & Resident Survey Questionnaires

Key Stakeholder Survey

Dear Stakeholder:

The Community Health Needs Assessment Collaborative is conducting a Community Health Needs Assessment of community stakeholders. This process assists community leaders in understanding the health status of the area and identifying priority health issues affecting residents. Your opinion about the health in our community is important, so we are inviting you to participate in our survey.

By participating in this Community Health Needs Assessment survey, you can help shape the future health, well-being, and quality of life of the residents in the area. The survey is about general health and wellness concerns of residents in your community. The information gathered from this survey will help us identify unmet needs in the community. Survey results will also help to develop plans to address any gaps in services.

This survey is voluntary. All answers to the questions are strictly confidential, and no identifying information will ever be linked to any of the responses. Responses will be used to develop community-wide strategies to help residents live healthier lives.

Please take a few minutes of your time now to complete the survey – It should take you no more than 10 minutes.

If you have any questions about the survey, please contact Nancy Hodur, PhD, Director of the Center for Social Research, at (701) 231-8621 or by email at nancy.hodur@ndsu.edu.

Thank you for taking the time to complete this Community Health Needs Assessment survey and for helping us create a healthier community.

The following questions are regarding various issues important for community health needs. Based on your knowledge, please check the option that best describes your understanding of the current state of each issue. Use a scale from 1 to 5, with 1 being "No
attention needed" (this is not a problem in my community), and 5 being "Immediate attention needed" (this is a huge issue in my community).

**ECONOMIC WELL-BEING ISSUES**

<table>
<thead>
<tr>
<th>Issue</th>
<th>(1) No attention needed</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>(5) Immediate attention needed</th>
<th>Not applicable</th>
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</thead>
<tbody>
<tr>
<td>Availability of affordable housing</td>
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<td>〇</td>
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<tr>
<td>Employment options</td>
<td>〇</td>
<td>〇</td>
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<tr>
<td>Help for renters with landlord and tenants' rights issues</td>
<td>〇</td>
<td>〇</td>
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<tr>
<td>Homelessness</td>
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<td>〇</td>
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<tr>
<td>Housing which accepts people with chemical dependency, mental health problems, criminal history, or victims of domestic violence</td>
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<td>〇</td>
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<td>〇</td>
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<tr>
<td>Household budgeting and money management</td>
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<tr>
<td>Hunger</td>
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<tr>
<td>Maintaining livable and energy efficient homes</td>
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<tr>
<td>Skilled labor workforce</td>
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**TRANSPORTATION ISSUES**

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<th>4</th>
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### Appendix B

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<th></th>
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<th>4</th>
<th>(5) Immediate attention needed</th>
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<tbody>
<tr>
<td>Availability of door-to-door transportation services for those unable to drive (e.g. elderly, disabled)</td>
<td>○</td>
<td>○</td>
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<td>○</td>
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<tr>
<td>Availability of public transportation</td>
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<tr>
<td>Availability of walking and biking options</td>
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<tr>
<td>Cost of door-to-door transportation services for those unable to drive (e.g. elderly, disabled)</td>
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<tr>
<td>Driving habits (e.g. speeding, road rage)</td>
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### CHILDREN AND YOUTH

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<th>(5) Immediate attention needed</th>
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<tbody>
<tr>
<td>Availability of activities (outside of school and sports) for children and youth</td>
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<td>Availability of education about birth control</td>
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<td>Availability of quality child care</td>
<td>○</td>
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<td>Issue</td>
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<tr>
<td>Availability of services for at-risk youth (e.g. homeless youth, youth with behavioral health problems)</td>
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<tr>
<td>Bullying</td>
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<tr>
<td>Childhood obesity</td>
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<tr>
<td>Cost of activities (outside of school and sports) for children and youth</td>
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<tr>
<td>Cost of quality child care</td>
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<tr>
<td>Cost of services for at-risk youth (e.g. homeless youth, youth with behavioral health problems)</td>
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<tr>
<td>Crime committed by youth</td>
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<td>Opportunities for youth- adult mentoring</td>
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<tr>
<td>Parental custody, guardianships and visitation rights</td>
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<tr>
<td>School absenteeism (truancy)</td>
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<td>School dropout rates</td>
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<tr>
<td>Substance abuse by youth</td>
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<tr>
<td>Teen pregnancy</td>
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### Appendix B

#### THE AGING POPULATION

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<th>3</th>
<th>4</th>
<th>5 Immediate attention needed</th>
<th>Not applicable</th>
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</thead>
<tbody>
<tr>
<td>Availability of activities for seniors (e.g. recreational, social, cultural)</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
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<tr>
<td>Availability of long-term care</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
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<tr>
<td>Availability of memory care</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
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<tr>
<td>Availability of resources for family and friends caring for and helping to make decisions for elders (e.g. home care, home health)</td>
<td>○</td>
<td>○</td>
<td>○</td>
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<tr>
<td>Availability of resources for grandparents caring for grandchildren</td>
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<tr>
<td>Availability of resources to help the elderly stay safe in their homes</td>
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<tr>
<td>Cost of activities for seniors (e.g. recreational, social, cultural)</td>
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<tr>
<td>Cost of in-home services</td>
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### Appendix B

<table>
<thead>
<tr>
<th>Cost of long-term care</th>
<th>(1) No attention needed</th>
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<tbody>
<tr>
<td>Cost of memory care</td>
<td></td>
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<tr>
<td>Help making out a will or health care directive</td>
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### SAFETY

<table>
<thead>
<tr>
<th>Abuse of prescription drugs</th>
<th>(1) No attention needed</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>(5) Immediate attention needed</th>
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<tbody>
<tr>
<td>Availability of emergency medical services</td>
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<tr>
<td>Child abuse and neglect</td>
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<tr>
<td>Criminal activity</td>
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<tr>
<td>Culture of excessive and binge drinking</td>
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<tr>
<td>Domestic violence</td>
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<tr>
<td>Elder abuse</td>
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<td>Lack of police or delayed response of police</td>
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<td>Presence of drug dealers</td>
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<tr>
<td>Presence of gang activity</td>
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<tr>
<td>Presence of street drugs</td>
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### Appendix B

**HEALTHCARE AND WELLNESS**

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<tr>
<td>Sex trafficking</td>
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<tr>
<td>Ability of healthcare providers to meet the needs of Native people</td>
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<td>Ability of healthcare providers to meet the needs of New Americans</td>
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<tr>
<td>Access to affordable dental insurance coverage</td>
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<td>Access to affordable health insurance coverage</td>
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<td>Access to affordable healthcare</td>
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<td>Access to affordable prescription drugs</td>
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<td>Access to affordable vision insurance coverage</td>
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<td>Access to technology for health records and health education</td>
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<td>Availability of behavioral health (substance abuse) providers</td>
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<td>Availability of doctors, physician assistants, or nurse practitioners</td>
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<td>(5) Immediate attention needed</td>
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<tr>
<td>Availability of healthcare services for Native people</td>
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<td>Availability of healthcare services for New Americans</td>
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<td>Availability of mental health providers</td>
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<td>Availability of non-traditional hours (e.g. evenings, weekends)</td>
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<tr>
<td>Availability of prevention programs and services (e.g. Better Balance, Diabetes Prevention)</td>
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</tr>
<tr>
<td>Availability of specialist physicians</td>
<td>◯</td>
<td>◯</td>
<td>◯</td>
<td>◯</td>
<td>◯</td>
<td>◯</td>
</tr>
<tr>
<td>Coordination of care between providers and services</td>
<td>◯</td>
<td>◯</td>
<td>◯</td>
<td>◯</td>
<td>◯</td>
<td>◯</td>
</tr>
<tr>
<td>Timely access to medical care providers</td>
<td>◯</td>
<td>◯</td>
<td>◯</td>
<td>◯</td>
<td>◯</td>
<td>◯</td>
</tr>
<tr>
<td>Timely access to dental care providers</td>
<td>◯</td>
<td>◯</td>
<td>◯</td>
<td>◯</td>
<td>◯</td>
<td>◯</td>
</tr>
<tr>
<td>Timely access to vision care providers</td>
<td>◯</td>
<td>◯</td>
<td>◯</td>
<td>◯</td>
<td>◯</td>
<td>◯</td>
</tr>
<tr>
<td>Use of emergency room services for primary health care</td>
<td>◯</td>
<td>◯</td>
<td>◯</td>
<td>◯</td>
<td>◯</td>
<td>◯</td>
</tr>
</tbody>
</table>
### MENTAL HEALTH AND SUBSTANCE ABUSE

<table>
<thead>
<tr>
<th>Condition</th>
<th>(1) No attention needed</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>(5) Immediate attention needed</th>
<th>Not applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol use and abuse</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Dementia and Alzheimer's disease</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Depression</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Drug use and abuse (e.g., prescription drugs, synthetic opioids, marijuana, heroin, cocaine)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Exposure to secondhand smoke</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Smoking and tobacco use</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Stress</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Suicide</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

Please tell us about you.

What is your current age?

- ☐ 16 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 or older
Prefer to not answer

What is your biological sex?

Male
Female
Prefer to not answer

Which of the following best describes you?

White
Black or African American
American Indian or Alaska Native
Asian
Native Hawaiian or Pacific Islander
Other
Prefer to not answer

Are you of Hispanic or Latino origin?

Yes
No
Prefer to not answer

What is your current marital status?

Married
Appendix B

- Widowed
- Divorced
- Separated
- Never married

Which of the following best describes your current living situation?

- I own my home, with mortgage
- I own my home, no mortgage
- I rent
- Other

What is the highest level of education you have completed?

- Less than 9th grade
- Grades 9 through 11 (some high school)
- Grade 12 or GED (high school graduate)
- Some college (1-3 years) or technical/vocational school, no degree
- Completed technical or vocational school
- Bachelor's degree
- Master's degree or higher

Your current employment status is best described as:

- Employed for wages
- Self-employed
- Out of work for less than 1 year
- Out of work for 1 year or more
- Homemaker
○ Student
○ Retired
○ Unable to work

Are you a military veteran?

○ Yes
○ No

What is your annual household income from all sources before taxes?

○ Less than $20,000
○ $20,000 - $39,999
○ $40,000 - $69,999
○ $70,000 - $119,999
○ $120,000 or more
○ Prefer to not answer

What is your zip code?

If you have any comments or concerns in addition to the above questions, please use the space below to share that information.

PLEASE PROVIDE THE FOLLOWING INFORMATION. (Optional)
Resident Survey

1. You must be 18 years of age or older to participate in the survey. Are you 18 years of age or older?
   ☐ Yes   ☐ No   If NO, thank you for your time.

2. Please select the county in which you live.
   (listed in alphabetical order)
3. Please enter your 5-digit zip code.


4. In general, how would you rate your health?

   Excellent  Very Good  Good  Fair  Poor
   O          O          O        O

5. How tall are you (without shoes)?

   Feet:  
   Inches: 

6. How much do you weigh (without shoes)?

   Weight in pounds: 

7. VEGETABLES: A serving of vegetables – not including French fries – is one cup of salad greens or a half cup of vegetables.

   How many servings of vegetables did you have yesterday?

   
<table>
<thead>
<tr>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
8. **JUICE:** A serving of 100% fruit juice with no sugar added is 6 ounces.

   How many servings of fruit juice did you have yesterday?

<table>
<thead>
<tr>
<th>Servings of fruit juice</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
</tbody>
</table>

9. **FRUIT:** A serving of fruit is a medium-sized piece of fruit or a half cup of chopped, cut or canned fruit.

   How many servings of fruit did you have yesterday?

<table>
<thead>
<tr>
<th>Servings of fruit</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
</tbody>
</table>

10. **SUGAR-SWEETENED BEVERAGES:** Sugar-sweetened beverage consumption is the leading contributor to added sugar intake in American diets.

   How often do you drink the following sugar-sweetened beverages?

<table>
<thead>
<tr>
<th>Beverage Type</th>
<th>Never</th>
<th>Less than once per week</th>
<th>Once per week</th>
<th>2-4 times per week</th>
<th>5-6 times per week</th>
<th>Once per day</th>
<th>2-3 times per day</th>
<th>4+ times per day</th>
</tr>
</thead>
<tbody>
<tr>
<td>FRUIT DRINKS: Snapple, favored teas, Capri Sun, etc.</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>SPORTS DRINKS: Gatorade, Powerade, etc.</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>REGULAR SODA OR POP: Coke, Pepsi, 7-Up, etc.</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>ENERGY DRINKS: Rockstar, Red Bull, Monster, etc.</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
</tbody>
</table>

11. **Within the past 12 months, we worried whether our food would run out before we got money to buy more.**

    | Often True | Sometimes True | Never True |
    | O          | O              | O          |

12. **Within the past 12 months, the food that we bought just didn't last, and we didn't have money to get more.**

    | Often True | Sometimes True | Never True |
    | O          | O              | O          |
13. **MODERATE PHYSICAL ACTIVITY**: Moderate activities cause only light sweating and a small increase in breathing or heart rate.

During an average week, other than your regular job, how many days do you get at least 30 minutes of moderate physical activity?

<table>
<thead>
<tr>
<th>Days per week of moderate physical activity</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

14. **VIGOROUS PHYSICAL ACTIVITY**: Vigorous activities cause heavy sweating and a large increase in breathing and heart rate.

During an average week, other than your regular job, how many days do you get at least 30 minutes of moderate physical activity?

<table>
<thead>
<tr>
<th>Days per week of vigorous physical activity</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

15. **Have you ever been told by a doctor or health professional that you have any of the following? (Select all that apply)**

- Panic attacks
- Other mental health problems
- Stroke
- Asthma
- Diabetes
- Alzheimer’s
- High cholesterol
- Depression
- Arthritis
- Anxiety, stress, etc.
- Hypertension
- Congestive heart failure
- COPD
- None of the above

16. **Over the past two weeks, how often have you been bothered by either of the following issues?**

<table>
<thead>
<tr>
<th></th>
<th>Not at all</th>
<th>Several days</th>
<th>More than half the days</th>
<th>Nearly every day</th>
</tr>
</thead>
<tbody>
<tr>
<td>Little interest or pleasure in doing things</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Feeling down, depressed or hopeless</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

17. **Have you smoked at least 100 cigarettes (equal to 5 packs) in your entire life?**

- Yes
- No

18. **Has someone, including yourself, smoked cigarettes, cigars or used vape pens anywhere inside your home?**

- Yes
- No

19. **Have you smelled tobacco smoke in your apartment that comes from another apartment?**

- Yes
- No

20. **Do you currently.....**

<table>
<thead>
<tr>
<th></th>
<th>Not at all</th>
<th>Some days</th>
<th>Every day</th>
</tr>
</thead>
<tbody>
<tr>
<td>Smoke cigarettes?</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Use chewing tobacco</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>
21. Where would you first go for help if you wanted to quit using tobacco products (cigarettes, e-cigarettes, chewing tobacco, etc.)?
   O NA / Not a smoker
   O Doctor
   O Pharmacy
   O Private counselor or therapist
   O Quitline
   O Health Department or Public Health Unit
   O Don’t know
   O Other ___________________________

22. During the past 12 months, have you stopped smoking for one day or longer because you were trying to quit?
   O Yes
   O No
   O NA / Not a smoker

23. During the past 30 days, approximately how many days did you have at least one drink of an alcoholic beverage?

<table>
<thead>
<tr>
<th>Days in which you had at least 1 drink during the past 30 days</th>
<th>0</th>
<th>1-2</th>
<th>3-5</th>
<th>6-9</th>
<th>10-14</th>
<th>15-24</th>
<th>25+</th>
</tr>
</thead>
<tbody>
<tr>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
</tbody>
</table>

24. During the past 30 days, when you drank, how many drinks did you consume on average?
   (A drink is one 12 oz. can of beer, one 6 oz. glass of wine, or a drink with one shot of liquor)

| # of drinks on average during the past 30 days | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 |
|------------------------------------------------|---|---|---|---|---|---|---|---|---|---|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|
| O                                              | O | O | O | O | O | O | O | O | O | O   | O   | O   | O   | O   | O   | O   | O   | O   | O   | O   | O   |

25. During the past 30 days, how many times did you drink 4 or more (for females) or 5 or more (for males) alcoholic drinks on the same occasion (at the same time, or within a couple of hours of each other)?
   O Almost every day
   O 2-3 times per week
   O Once a week
   O Once a month
   O Never

26. Has alcohol use had a harmful effect on you or a family member in the past 2 years?
   O Yes
   O No

27. Have you ever wanted help with prescription or non-prescription (over-the-counter) drug use?
   O Yes
   O No

28. Has a family member or friend ever suggested that you get help for substance use?
29. Has prescription or non-prescription (over-the-counter) drug use had a harmful effect on you or a family member in the past 2 years?
   - Yes
   - No

30. Do you have drugs in your home that are not being used?
   - Yes
   - No

The next series of questions is about preventative services.
Preventive care includes health services like screenings, check-ups, and patient counseling that are used to prevent illnesses, disease and other health problems, or to detect illness at an early stage when treatment is likely to work best. Getting preventive services at the recommended ages and making healthy lifestyle choices are key steps to good health and well-being.

ROUTINE CHECK-UP: A routine check-up is a general physical exam, not an exam for a specific injury, illness or condition.

31. About how long has it been since you last visited a doctor or health care provider for a routine check-up?
   - Within the past year (skip to question 33)
   - Within the past 2 years
   - Within the past 5 years
   - 5 or more years ago
   - Never
   - Don’t know / Unsure

32. What has kept you from having a routine check-up during the past year? (Select all that apply)
   - Did not need to see a doctor
   - Time not convenient
   - Cost
   - Distance to travel to provider
   - Other (specify)

33. Has your medical provider reviewed the risks and benefits of screenings and preventive services with you?
   - Yes
   - No
   - Don’t know / Unsure

34. Has your medical provider allowed you to make a choice about having the screenings or preventive services?
   - Yes
   - No
   - Don’t know / Unsure

35. Have you had any of the following preventive procedures in the past year? (Select all that apply)
   - Women’s pelvic exam
   - Dental cleaning or x-rays
   - Glaucoma test
   - Blood sugar check
36. What are the barriers that prevent you from having routine screenings or procedures done? (Select all that apply)
   - I’m up-to-date on all screenings & procedures
   - I’m unable to access care
   - I’m not due this year
   - Fear of the screening or procedure
   - Cost
   - I haven’t had time
   - Fear of the results
   - Doctor has not suggested the screenings
   - Other (please specify)_______________________________

37. Do you have children under the age of 18 living in your household?
   - Yes
   - No (skip to question 43)

38. If your children are younger (car seat size and age), how often do they use a car seat when riding in a car?
   - Always
   - Nearly always
   - Sometimes
   - Seldom
   - Never
   - Not applicable

39. If your children are older, how often do they use seat belt when riding in a car?
   - Always
   - Nearly always
   - Sometimes
   - Seldom
   - Never
   - Not applicable

40. Do you have health care coverage for your children or dependents?
   - Yes
   - No

41. Please check the preventive services your children have received within the last year. (Select all that apply)
   - Hearing check-ups
   - Medical check-ups
   - Dental check-ups
   - Vision check-ups
   - None of the above

42. Where do you most often take your children when they are sick and need to see a health care provider?
O Urgent care
O A free or discounted clinic
O Walk-in clinic
O City Health/Public Health Department (Community Health)
O Physician’s office
O Hospital emergency room
O Other (please specify): _________________________________________________

43. What are the barriers that prevent you and your family from getting adequately immunized? (Select all that apply)
O No barriers
O Don’t know where to get immunizations
O Lack of insurance
O Transportation
O Physician’s office
O Moral/religious/philosophical beliefs
O Money
O Other (please specify): _________________________________________________

44. Have you ever been diagnosed with cancer?
O Yes
O No (skip to question 46)

45. What type of cancer were you diagnosed with? (Select all that apply)
O Acute leukemia
O Bladder cancer
O Bone cancer
O Brain cancer
O Breast cancer
O Cervical cancer
O Chronic leukemia
O Colon cancer
O Hodgkin’s Lymphoma
O Lung cancer
O Melanoma
O Neuroblastoma
O Non-Hodgkin’s Lymphoma
O Oral cancer
O Other skin cancer
O Ovarian cancer
O Pharyngeal (throat) cancer
O Prostate cancer
O Rectal cancer
O Renal (kidney) cancer
O Stomach cancer
O Testicular cancer
O Thyroid cancer
O Other: (please specify) _______________________

46. Do you currently have any kind of health insurance (private, public or government insurance)?
O Yes
O No (skip to question 48)

47. Please indicate the types of health insurance you currently have. (Select all that apply)
O Health insurance or coverage through your employer or spouse, parent, or someone else’s employer
O Health insurance or coverage bought directly by you or your family
O Indian or Tribal Health Service
O Medicare
O Medicare A (Hospital insurance)
O Medicare B (Medical insurance)
O SSI/SSDI (Supplemental Security Income, Social Security Disability Insurance)
O Medicaid, Medical Assistance (MA), or Prepaid Medical Assistance Program (PMAP)
O Minnesota Care
O CHAMPUS, TRICARE or Veteran Benefits
O Healthy Steps or CHIP for your children
O Other (please specify): _______________________


48. Do you have an established primary health care provider (physician, nurse practitioner, physician’s assistant)?
   O Yes
   O No

49. In the past year, did you or someone in your family need medical care, but did not receive the care they needed?
   O Yes
   O No (skip to question 51)

50. What were the reasons you or your family member did not receive the care they needed?
   (Select all that apply)
   O No appointment was available
   O Did not need to see a doctor
   O Inability to pay
   O No insurance
   O Location of the provider (e.g. too far)
   O Fear
   O No disability services
   O Cost
   O No transportation
   O Appointment was not available at a convenient time
   O No child care
   O Language barrier
   O Other (please specify)
   __________________________________________
   __________________________________________

51. How long has it been since you last visited a dentist or dental clinic? (include visits to dental specialists, such as orthodontists)
   O Within the past year (skip to question 53)
   O Within the past 2 years
   O Within the past 5 years
   O 5 or more years ago
   O Never
   O Don’t know / Unsure

52. What barriers have kept you from seeing a dentist within the last year?
   (Select all that apply)
   O Fear
   O No insurance
   O There are no dentists near me
   O Did not need to see a dentist
   O Location of the provider (e.g. too far)
   O Location of the provider (e.g. distance)
   O Dentist would not accept my insurance
   O Transportation
   O Cost
   O No access
   O Location of the provider (e.g. distance)
   O Time not convenient
   O Other (please specify)
   __________________________________________

53. Do you have any kind of dental care or oral health insurance coverage?
   O Yes
   O No
   O Don’t know / Not sure

54. Do you have a dentist that you see for routine care?
   O Yes, only one
   O Yes, more than one
   O No
   O Don’t know / Not sure
55. In your opinion, what is the most important health care issue your community needs to solve?

56. What is the biggest health care concern you or your family faces on a regular basis?

DEMOGRAPHICS

57. What is your biological sex?
   - Male
   - Female

58. What is your current age?
   
   Age in years: 
   
   (skip to question 62 if under the age of 65)

59. What is your biggest concern(s) as you age in your community?
   (Select all that apply)
   - Cost of long term care
   - Financial problems
   - Transportation
   - Access to health care
   - Access to long term care
   - Cost of health care
   - Maintaining physical and mental health
   - Affording your medications
   - Feeling depressed, lonely, sad, isolated
   - Other (please specify)

60. Which of these tasks do you need assistance with?
(Select all that apply)
O Understanding / taking medication
O Socialization
O Meals
O Transportation
O Shopping
O Bathing / dressing
O Affording a place to live
O None of the above

61. Do you know where to go to get help with the tasks you need assistance with?
   O Yes
   O No

62. How long have you lived in the United States?
   Years lived in the United States:

63. How many people live in your house, including yourself?

| # of people in household | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 |
|-------------------------|---|---|---|---|---|---|---|---|---|---|----|----|----|----|----|----|----|----|----|----|----|---|
|                         | O | O | O | O | O | O | O | O | O | O | O   | O   | O   | O   | O   | O   | O   | O   | O   | O   | O   | O   |
64. How many children under age 18 currently live with you in your household?

<table>
<thead>
<tr>
<th># of children in household</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
<th>11</th>
<th>12</th>
<th>13</th>
<th>14</th>
<th>15</th>
<th>16</th>
<th>17</th>
<th>18</th>
<th>19</th>
<th>20</th>
</tr>
</thead>
</table>

65. Which of the following best describes you?
- O White
- O Black or African American
- O Asian
- O American Indian, Alaska Native
- O Hawaiian or Pacific Islander
- O Hispanic or Latino origin
- O Other (please specify)

66. What language is mostly spoken in your home?
- O English
- O Spanish
- O Other:

67. What is your current marital status?
- O Never married
- O Married
- O Divorced
- O Widowed
- O Separated
- O A member of an unmarried couple living together

68. Which of the following best describes your current living situation?
- O House (owned)
- O House (rented)
- O Apartment (rented)
- O Homeless
- O Some other arrangement

69. What is the highest grade or level of education you have completed?
- O Never attended school or only kindergarten
- O Grades 1 through 8 (elementary)
- O Grades 9 through 11 (some high school)
- O Grade 12 or GED (high school graduate)
- O Some college (1-3 years) or technical/vocational school
- O Completed technical or vocational school
- O College graduate (4 or more years)
- O Postgraduate degree

70. Your current employment status is best described as:
- O Employed for wages
- O Self-employed
- O Out of work for less than 1 year
- O Out of work for 1 year or more
- O A homemaker
- O A student
O Retired
O Unable to work

71. What is your total household income from all sources?
   O Less than $10,000   O $35,000 - $49,999
   O $10,000 - $14,999  O $50,000 - $74,999
   O $15,000 - $19,999  O $75,000 - $99,999
   O $20,000 - $24,999  O $100,000 - $199,999
   O $25,000 - $29,999  O $200,000 or more
   O $30,000 - $34,999  O Prefer not to answer

72. What method(s) would you prefer to get health information
   (Select all that apply)
   O Written materials
   O Online websites
   O Group education/workshop/seminar
   O Videos for home use
   O Email
   O Social media
   O One-on-one teaching
   O Text messages
   O Other (please specify)

73. If you have any comments or concerns in addition to the above questions, please use the space below to share that information.

AMERICAN INDIAN QUESTIONS

The next series of questions is specific to people who identify as American Indian.

74. Do you identify as an American Indian?
   O Yes
   O No  (IF NO, your survey is COMPLETE. Thank you for your time)

75. Are you enrolled in a Federal recognized tribe, State recognized tribe, First Nation Band (Canada), or Alaska Native shareholder or descendant?
   O Yes
   O No (skip to question 77)

76. What is your enrolled Federal recognized tribe, State recognized tribe, First Nations Band (Canada), or Alaska Native shareholder or descendant?
77. If you are not enrolled in a tribe, but are a descendant of a tribe(s), please enter the tribe name here:

78. Do you live on a reservation or off the reservation?
   O On  (skip to question 81)
   O Off

79. How long have you lived off the reservation?
   O All my life
   O Majority of my life
   O Just temporarily, planning to return within 90 days
   O I have lived in an urban area all my life
   O I have lived in an urban area a majority of my life
   O Other: __________________________________________________________

80. If you return to the reservation to live part of the year, how often do you return to the urban area to stay 30 days or more?
   O 1-2 times a year
   O 3-4 times a year
   O 5 or more times a year

81. Where do you go to receive most of your health care services?
   O Indian Health Service facility (could be hospital)
   O Private health clinic (Doctor in private practice, HMO)
   O Community Health Center (free clinic, public clinic)
   O Emergency care at local hospital
   O Tribal health facility (clinic on reservation)
   O Hospital (non-IHS)
   O Don’t go anywhere
   O Other (please specify) _____________________________________________

82. Please indicate the health care services you have personally used from any facility in the past 12 months.  
   (Select all that apply)
   O Traditional healing
   O Hearing testing
   O Emergency care
   O Family planning
   O Doctor visit (e.g. for physical examination, pains and aches)
   O Special needs such as handicapped needs
   O Prescriptions
   O Hospitalization (which hospital?)
   O Alcohol/drug treatment
   O Prevention/education services
   O Mental/emotional health
   O Eye care
   O Dental care
   O Other (please specify) _____________________________________________
   O None of the above

83. On average, how many times per month did you receive health care services within the past year?
84. **If 0, Why have you not received any health care services in the past 12 months? (Select all that apply)**

- Didn’t need services
- No insurance
- Cost
- Transportation
- Safety
- Didn’t have time
- Other (please specify): __________________________________________
- Not applicable

85. **Do you have health care insurance coverage for yourself?**

- Yes
- No (skip to question 89)

86. **What type of health care insurance coverage do you have?**

- Private insurance (for example, provided by your employer, an HMO, etc.)
- Medicaid (i.e. MnSure, Medical Assistance)
- Medicare A (Hospital insurance)
- Medicare B (Medical insurance)
- Medicare D (Prescription insurance)
- VA (Veteran’s Affairs)
- State Disability
- SSI/SSDI (Supplemental Security Income, Social Security Disability Insurance)
- Tribal Insurance
- Other (please specify): _______________________

87. **Does your health care insurance plan meet your needs?**

- Yes (skip to question 89)
- No
- Don’t Know / Not Sure

88. **What does your health care plan not cover?**

89. **Do you have children that you claim as dependents? (Dependents can be either birth children or foster children)**

- Yes
- No

90. **Please indicate the health care services your children or dependents have used from any facility in the past 12 months. (Select all that apply)**

- Hearing testing
- Dental care
- Hospitalization (which hospital?)
O Traditional healing  
O Doctor/provider visit (e.g. for physical examination, pains and aches)  
O Prevention/education services  
O Alcohol/drug treatment  
O Emergency care  
O Eye care  
O Prescriptions  
O Help with a personal problem  
O Special needs such as handicapped needs  
O Other (please specify)  

______________________________  
O None of the above

91. Do you have health care insurance for your children or dependents?  
O Yes  
O No

92. What type of health care coverage do you have for your children or dependents?  
O Private insurance (for example, provided by your employer, an HMO, etc.)  
O Medicaid (i.e. MnSure, Medical Assistance)  
O Medicare A (Hospital insurance)  
O Medicare B (Medical insurance)  
O Medicare D (Prescription insurance)  
O VA (Veteran’s Affairs)  
O State Disability  
O SSI/SSDI (Supplemental Security Income, Social Security Disability Insurance)  
O Tribal Insurance  
O Other (please specify): _______________________

93. Is your health care coverage for your children or dependents adequate?  
O Yes (skip to question 95)  
O No  
O Don’t Know / Not Sure

94. What does the health care plan for your children or dependents not cover?  

95. Please rank the items below on how important they are when choosing where you receive health care.  
(1 is most important / 6 least important)  
___ Cost  
___ Transportation (e.g. how easy it is to get to)  
___ Culturally sensitive care (e.g. they are open to traditional medicine or practices)  
___ Quality  
___ Convenience (e.g. hours, location)  
___ Access to a specialist

96. Do most Native people in your community have access to health care resources?  
O No  
O Yes
97. Have you been to the dentist in the past 12 months?
   O Yes (skip to question 99)
   O No

98. Why have you not been to the dentist in the past 12 months?
   O Didn’t need services
   O Didn’t have time
   O Cost
   O Transportation
   O No insurance
   O Other (please specify): _______________________

99. Have you been refused medical care from a tribal health care or an IHS-funded urban program?
   O Yes – please indicate reason: _______________________________________________
   O No
   O Don’t know / not sure

100. Have you been refused medical care at a non-Indian clinic?
    O Yes – please indicate reason: _______________________________________________
    O No
    O Don’t know / not sure

101. How satisfied are you with the health care services you receive?
    Excellent Very Good Good Fair Poor
    O O O O O

102. How would you rate the ability of your health care provider to meet the needs of Indian people in your community?
    Excellent Very Good Good Fair Poor
    O O O O O

103. How do you get to the clinic where you receive care?
    O Taxi O Bus
    O Your car O Walk
    O Other car (e.g. family or friend) O Other - please specify:

104. Would you like more information regarding insurance and how it works with the Indian Health Service?
    O Yes
    O No

105. Would you like to know if you qualify for insurance at little to no cost?
    O Yes
    O No

106. Do you know where to go or who to contact about enrolling for insurance?
    O Yes
107. If you were eligible for insurance at little to no cost, would you sign up (separate insurance does not affect your ability to use the Indian Health Service)
   O Yes
   O No

108. OPTIONAL: Please provide the following information so we can contact you about the information you are requesting:

   Name: 
   Address: 
   Address 2: 
   City: 
   State: 
   Zip code: 
   Phone number: 
   Email address: 
Stakeholder Key Findings

Economic Well-Being

- Housing which accepts people with chemical dependency, mental health problems, criminal history, or victims of domestic violence (N=214) - Mean attention needed: 4.22
- Availability of affordable housing (N=218) - Mean attention needed: 4.21
- Homelessness (N=216) - Mean attention needed: 3.88
- Hunger (N=216) - Mean attention needed: 3.64

Mean attention needed (1=No attention needed; 5=Critical attention needed)
Transportation

Availability of door-to-door transportation services for those unable to drive (e.g., elderly, disabled) (N=205)

Cost of door-to-door transportation services for those unable to drive (e.g., elderly, disabled) (N=210)

Children and Youth

Availability of services for at-risk youth (e.g., homeless youth, youth with behavioral health problems) (N=202)

Cost of quality child care (N=199)

Availability of quality child care (N=200)

Cost of services for at-risk youth (e.g., homeless youth, youth with behavioral health problems) (N=189)

Substance abuse by youth (N=192)

Teen suicide (N=186)

Childhood obesity (N=203)

Bullying (N=201)

Mean attention needed (1=No attention needed; 5=Critical attention needed)
Aging Population

| Availability of resources to help the elderly stay safe in their homes (N=185) | 3.52 |
| Cost of long-term care (N=185) | 4.15 |
| Cost of memory care (N=184) | 4.08 |
| Cost of in-home services (N=185) | 3.83 |
| Availability of resources for family and friends caring for and helping to make decisions for elders (e.g., home care, home health) (N=184) | 3.58 |

Mean attention needed (1=No attention needed; 5=Critical attention needed)

Safety

| Abuse of prescription drugs (N=195) | 4.17 |
| Culture of excessive and binge drinking (N=197) | 3.81 |
| Domestic violence (N=196) | 3.80 |
| Child abuse and neglect (N=193) | 3.68 |
| Sex trafficking (N=190) | 3.59 |
| Presence of street drugs (N=190) | 3.55 |

Mean attention needed (1=No attention needed; 5=Critical attention needed)
Healthcare and Wellness

- Availability of mental health providers (N=196)
- Availability of behavioral health (e.g., substance abuse) providers (N=198)
- Access to affordable health insurance coverage (N=196)
- Access to affordable healthcare (N=198)
- Access to affordable prescription drugs (N=195)
- Access to affordable dental insurance coverage (N=195)
- Availability of non-traditional hours (e.g., evenings, weekends) (N=195)
- Access to affordable vision insurance coverage (N=189)
- Use of emergency room services for primary healthcare (N=189)
- Availability of healthcare services for Native people (N=178)
- Coordination of care between providers and services (N=193)

Mental Health and Substance Abuse

- Drug use and abuse (e.g., prescription drugs, synthetic opioids, marijuana, heroin, cocaine) (N=200)
- Alcohol use and abuse (N=200)
- Depression (N=196)
- Suicide (N=194)
- Stress (N=195)
- Dementia and Alzheimer’s disease (N=188)
Key Stakeholder Demographics

Race

<table>
<thead>
<tr>
<th>Race</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>93.5%</td>
</tr>
<tr>
<td>American Indian or Alaska Native</td>
<td>1.0%</td>
</tr>
<tr>
<td>Black or African American</td>
<td>1.0%</td>
</tr>
<tr>
<td>Asian</td>
<td>0.5%</td>
</tr>
<tr>
<td>Native Hawaiian or Pacific Islander</td>
<td>0.0%</td>
</tr>
<tr>
<td>Other*</td>
<td>0.5%</td>
</tr>
<tr>
<td>Prefer to not answer</td>
<td>3.5%</td>
</tr>
</tbody>
</table>

Hispanic or Latino

<table>
<thead>
<tr>
<th>Preference</th>
<th>Percent</th>
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<tbody>
<tr>
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<tr>
<td>No</td>
<td>96.5%</td>
</tr>
<tr>
<td>Prefer to not answer</td>
<td>3.0%</td>
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</table>

Key Stakeholder Demographics

Age

<table>
<thead>
<tr>
<th>Age</th>
<th>Percent</th>
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</thead>
<tbody>
<tr>
<td>18 to 24 years</td>
<td>2.0%</td>
</tr>
<tr>
<td>25 to 34 years</td>
<td>19.3%</td>
</tr>
<tr>
<td>35 to 44 years</td>
<td>19.3%</td>
</tr>
<tr>
<td>45 to 54 years</td>
<td>17.3%</td>
</tr>
<tr>
<td>55 to 64 years</td>
<td>28.2%</td>
</tr>
<tr>
<td>65 to 74 years</td>
<td>10.4%</td>
</tr>
<tr>
<td>75 years or older</td>
<td>2.0%</td>
</tr>
<tr>
<td>Prefer to not answer</td>
<td>1.5%</td>
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Gender

<table>
<thead>
<tr>
<th>Gender</th>
<th>Percent</th>
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<tbody>
<tr>
<td>Male</td>
<td>26.6%</td>
</tr>
<tr>
<td>Female</td>
<td>70.0%</td>
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Prefer to not answer | 3.4%
Key Stakeholder Demographics

Household Income

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<th>Income Range</th>
<th>Percent</th>
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<tr>
<td>Less than $20,000</td>
<td>1.0</td>
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<tr>
<td>$20,000 to $39,999</td>
<td>5.9</td>
</tr>
<tr>
<td>$40,000 to $69,999</td>
<td>19.8</td>
</tr>
<tr>
<td>$70,000 to $119,999</td>
<td>33.7</td>
</tr>
<tr>
<td>$120,000 or more</td>
<td>28.7</td>
</tr>
<tr>
<td>Prefer to not answer</td>
<td>10.9</td>
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Education

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<tr>
<th>Education Level</th>
<th>Percent</th>
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<tbody>
<tr>
<td>Less than 9th grade</td>
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<tr>
<td>Grades 9 through 11 (some high school)</td>
<td>0.5</td>
</tr>
<tr>
<td>Grade 12 or GED (high school graduate)</td>
<td>0.0</td>
</tr>
<tr>
<td>Some college (1-3 years) or technical/vocational...</td>
<td>5.9</td>
</tr>
<tr>
<td>Completed technical or vocational school</td>
<td>5.0</td>
</tr>
<tr>
<td>Bachelor's degree</td>
<td>48.5</td>
</tr>
<tr>
<td>Master's degree or higher</td>
<td>40.1</td>
</tr>
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</table>

Resident Key Findings
How would you rate your health?

- Excellent: 11%
- Very Good: 45%
- Good: 34%
- Fair: 8%
- Poor: 1%

Sample size = 546

BMI

- Obese: 39%
- Overweight: 27%
- Normal weight: 32%
- Underweight: 2%

Sample size = 545
Total Servings of Fruits, Vegetables and Juice

The food that we bought just didn’t last, and we didn’t have money to get more

Often True (n=41), Sometimes True (n=122), Never True (n=382), Sample Size = 545
Days Per Week of Physical Activity

Past Diagnosis

Anxiety, stress, etc. (n=169), Arthritis (n=71), Asthma (n=59), Congestive heart failure (n=7), COPD (n=4), Depression (n=147), Diabetes (n=40), High cholesterol (n=106), Hypertension (n=95), Other mental health problems (n=33), Panic attacks (n=68), Stroke (n=2), Sample Size = 371
Cigarette Use/ Exposure to Tobacco Smoke

- **Personally smoked at least 100 cigarettes in lifetime?**
  - Yes: 17%
  - No: 83%

- **Exposed to cigarettes, cigars or vape pens inside home?**
  - Yes: 23%
  - No: 77%

- **Exposed to tobacco smoke in your apartment from another apartment?**
  - Yes: 40%
  - No: 60%

**Current Cigarette Use**

- **Every day:** 15%
- **Some days:** 6%
- **Not at all:** 79%
Almost every day (n=10), 2-3 times a week (n=34), Once a week (n=50), Once a month (n=89), Never (n=183), Sample Size = 366

Almost every day (n=44), 25-34 (n=100), 35-44 (n=71), 45-54 (n=50), 55-64 (n=54), 65-74 (n=44), 75+ (n=3), Sample Size = 366
Drug and Alcohol Issues

- Has alcohol use had a harmful effect on you or a family member in the past two years?
  - Yes: 21%
  - No: 79%

- Do you have drugs in your home that are not being used?
  - Yes: 17%
  - No: 83%

- Has prescription or non-prescription (over-the-counter) drug use had a harmful effect on you or a family member in the past two years?
  - Yes: 7%
  - No: 93%

- Has a family member or friend ever suggested that you get help for substance use?
  - Yes: 7%
  - No: 93%

- Have you ever wanted help with a prescription or non-prescription (over-the-counter) drug use?
  - Yes: 5%
  - No: 95%

How long has it been since you last visited a doctor or health care provider for a routine checkup?

- Within the past year: 75%
- Within the past two years: 13%
- Within the past five years: 6%
- Five or more years ago: 4%
- Never: 1%

Within the past year (n=406), Within the past two years (n=70), Within the past five years (n=31), Five or more years ago (n=24), Never (n=8), Sample Size = 539
Barriers to Routine Checkup

- Did not need to see a doctor: 43%
- Cost: 33%
- Time not convenient: 22%
- Other (specify): 12%
- Fear: 11%
- Transportation: 7%
- No access: 3%
- Distance to travel to provider: 1%

No access (n=4), Distance to travel to provider (n=2), Cost (n=46), Fear (n=15), Transportation (n=10), Time not convenient (n=31), Did not need to see a doctor (n=60), Other (specify) (n=17), Sample Size = 140

Do you currently have any type of health insurance?

- Yes (n=492)
- No (n=53)

Yes (n=492), No (n=53), Sample Size = 545
Children’s preventive services within the past year

- Medical checkups: 92%
- Dental checkups: 74%
- Vision checkups: 62%
- Hearing checkups: 43%

In the past year, did you or someone in your family need medical care, but did not receive the care they needed?

- Yes: 12%
- No: 88%

Yes (n=65), No (n=482), Sample Size = 547
Barriers to Receiving Care Needed

- Cost: 41%
- Inability to pay: 40%
- No insurance: 29%
- Other (specify): 14%
- Fear: 13%
- No transportation: 13%
- Appointment not at a convenient time: 13%
- No appointment was available: 5%
- Did not need to see a doctor: 3%
- Location of the provider: 3%
- No child care: 2%

Inability to pay (n=25), No child care (n=1), No appointment was available (n=3), Appointment not at a convenient time (n=8), No insurance (n=18), No transportation (n=8), Location of the provider (n=2), Cost (n=26), Fear (n=8), Did not need to see a doctor (n=2), Other (specify) (n=9)

How long has it been since you last visited a dentist?

- Within past year: 71%
- Within past 2 years: 11%
- Within past 5 years: 9%
- 5 or more years ago: 9%
- Never: 1%

Within past year (n=381), Within past 2 years (n=56), Within past 5 years (n=46), 5 or more years ago (n=47), Never (n=3), Sample Size = 553
Barriers to Visiting the Dentist

- Cost: 50%
- Time not convenient: 30%
- Fear: 22%
- Location of the provider: 16%
- Dentist would not accept my insurance: 16%
- Other (specify): 7%
- Transportation: 6%
- No access: 4%
- No insurance: 2%
- There are no dentists near me: 1%

No access (n=4), No insurance (n=49), Location of the provider (n=11), Cost (n=83), Fear (n=26), Transportation (n=6), Time not convenient (n=36), There are no dentists near me (n=1), Dentist would not accept my insurance (n=10), Did not need to see a dentist (n=27), Other (specify) (n=7), Sample Size = 166

Do you have any kind of dental care or oral health insurance?

- Yes: 32%
- No: 68%

Yes (n=358), No (n=170), Sample Size = 528
Most Important Community Issues

Economic well-being (n=12), Transportation (n=2), Children and youth (n=2), Aging population (n=1), Safety (n=1), Healthcare access (n=64), Mental Health (n=13), Substance Abuse (n=55), Chronic diseases (n=20), Healthcare costs (n=176), Dental (n=14), Prevention (n=8), Vision (n=2), Nutrition and Exercise (n=3), Other (n=65), Sample Size = 468

Most Important Issue for Family

Access (n=28), Addiction and substance abuse (n=6), Aging services (n=8), Cancer (n=9), Chronic diseases (n=36), Communicable diseases (n=17), Healthcare costs (n=145), Dental care (n=12), Nutrition and Exercise (n=7), Insurance cost and coverage (n=50), Mental health (n=9), Pain management (n=3), Transportation (n=4), Physician time and communication (n=4), Vision care (n=4), Other (n=17), Sample Size = 462
What is your biggest concern as you age? (Age 65+)

Maintaining physical and mental health 29%
Cost of health care 20%
Cost of long term care 19%
Access to long term care 7%
Affording your medications 6%
Transportation 5%
Financial problems 5%
Access to health care 4%
Feeling depressed, lonely, sad, isolated 3%
Other (specify) 2%

Access to health care (n=5), Cost of health care (n=26), Affording your medications (n=8), Maintaining physical and mental health (n=38), Feeling depressed, lonely, sad, isolated (n=4), Access to long term care (n=9), Cost of long term care (n=25), Financial problems (n=8), Transportation (n=7), Other (specify) (n=3), Sample Size = 65

Demographics

Age

Gender

18-24 (n=65), 25-34 (n=138), 35-44 (n=113), 45-54 (n=79), 55-64 (n=86), 65-74 (n=58), 75+ (n=5), Sample Size = 544

Male (n=149), Female (n=398), Sample Size = 547
Demographics

Race and Hispanic Origin

- White: 88%
- American Indian, Alaska Native: 4%
- Asian: 3%
- Black or African American: 2%
- Hispanic or Latino origin: 1%
- Other: 1%

White (n=479), Black or African American (n=13), Asian (n=16), American Indian, Alaska Native (n=22), Hispanic or Latino origin (n=8), Other (n=6), Sample Size = 544

Annual Income Demographic

- Less than $10,000: 7%
- $10,000 to $14,999: 5%
- $15,000 to $19,999: 9%
- $20,000 to $24,999: 10%
- $25,000 to $49,999: 15%
- $50,000 to $74,999: 24%
- $75,000 to $99,999: 13%
- $100,000 to $199,999: 15%
- $200,000 or more: 2%

Less than $10,000 (n=35), $10,000 to $14,999 (n=25), $15,000 to $19,999 (n=46), $20,000 to $24,999 (n=51), $25,000 to $49,999 (n=74), $50,000 to $74,999 (n=124), $75,000 to $99,999 (n=67), $100,000 to $199,999 (n=76), $200,000 or more (n=12), Sample Size = 510
### Key Findings

<table>
<thead>
<tr>
<th>Drug use and abuse</th>
<th>4.40</th>
</tr>
</thead>
<tbody>
<tr>
<td>Availability of mental health providers</td>
<td>4.28</td>
</tr>
<tr>
<td>Housing that accepts people with chemical dependency, mental health problems, criminal history or victims of domestic violence</td>
<td>4.22</td>
</tr>
<tr>
<td>Availability of behavioral health providers</td>
<td>4.21</td>
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<tr>
<td>Availability of affordable housing</td>
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<tr>
<td>Abuse of prescription drugs</td>
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<tr>
<td>Alcohol use and abuse</td>
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<tr>
<td>Cost of long-term care</td>
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</tr>
<tr>
<td>Availability of services for at-risk youth</td>
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</tr>
<tr>
<td>Depression</td>
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</tr>
<tr>
<td>Cost of memory care</td>
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<tr>
<td>Cost of quality child care</td>
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<tr>
<td>Access to affordable health insurance coverage</td>
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<tr>
<td>Suicide</td>
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</tr>
<tr>
<td>Access to affordable healthcare</td>
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</tbody>
</table>

| Availability of quality child care    | 3.99 |
| Cost of services for at-risk youth    | 3.96 |
| Access to affordable prescription drugs | 3.91 |
| Substance abuse by youth              | 3.89 |
| Teen suicide                          | 3.89 |
| Homelessness                          | 3.88 |
| Childhood obesity                     | 3.86 |
| Cost of in-home services.             | 3.83 |
| Access to affordable dental insurance coverage | 3.82 |
| 30% report not having seen a dentist in >1yr | 3.81 |
| Culture of excessive and binge drinking | 3.81 |
| Stress                                | 3.81 |
| Domestic violence                     | 3.80 |
| Child abuse and neglect               | 3.78 |
| Bullying                              | 3.65 |
| Hunger                                | 3.64 |
| Availability of non-traditional hours | 3.63 |
| Dementia and Alzheimer's Disease      | 3.61 |
| Sex trafficking                       | 3.59 |
| Access to affordable vision insurance coverage | 3.58 |
### Key Findings

<table>
<thead>
<tr>
<th>Key Findings</th>
<th>Score</th>
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<tbody>
<tr>
<td>Availability of resources for family and friends caring for and helping make decisions for elders</td>
<td>3.58</td>
</tr>
<tr>
<td>Availability of door-to-door transportation services for those unable to drive</td>
<td>3.55</td>
</tr>
<tr>
<td>Presence of street drugs</td>
<td>3.55</td>
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<tr>
<td>Use of emergency room services for primary healthcare</td>
<td>3.53</td>
</tr>
<tr>
<td>Availability of resources to help the elderly stay safe in their homes</td>
<td>3.52</td>
</tr>
<tr>
<td>Availability of healthcare services for Native people</td>
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<tr>
<td>Coordination of care between providers and services</td>
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<table>
<thead>
<tr>
<th>Health Indicators</th>
<th>Percentage</th>
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- Food didn’t last for 30%
- Tobacco use - 21%
- Presence of street drugs
- Use of emergency room services for primary healthcare
- Availability of resources to help the elderly stay safe in their homes

Health Indicators:
- Only 57% report having flu shot in the last year
- 27% Overweight
- 39% Obese
- 45% Not getting enough exercise
- 60% Not getting enough fruits and vegetables
- 45% Not getting enough exercise

- High cholesterol
- Hypertension