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

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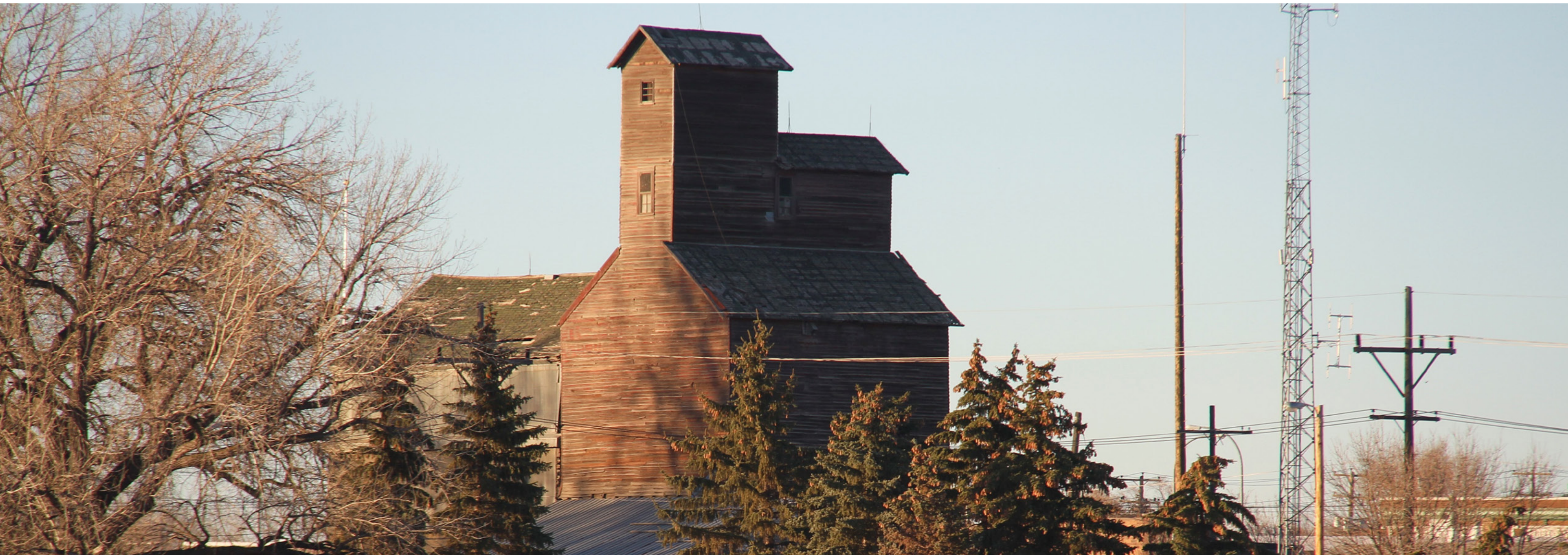


North Dakota's Significant Rural Health Needs as Identified by Critical Access Hospital Community Health Needs Assessments

2017-2019 Aggregate Results for Rural North Dakota Hospitals

Overview

Understanding what community members perceive as the primary health-related needs of a community, significantly influences how the local health system sets priorities, allocates resources, and builds local capacity. A focus of the Affordable Care Act (ACA) is population health and the American health system has been undergoing changes to make itself responsive to this national goal. Under the ACA, all nonprofit hospitals are required to complete a community health needs assessment (CHNA) and create an implementation plan. Accredited public health units, too, must conduct a community health assessment and develop an implementation plan every five years, whereas hospitals must do one every three years. The ACA requirement for hospitals also states that the hospital must include public health in their process. In 2013, the University of North Dakota Center for Rural Health (CRH) issued findings from the first round of CHNAs covering the years 2011-2013 (December 2013), then again representing the second round covering 2014-2016 (January 2017). This fact sheet will focus on the CHNA findings of 2017-2019.

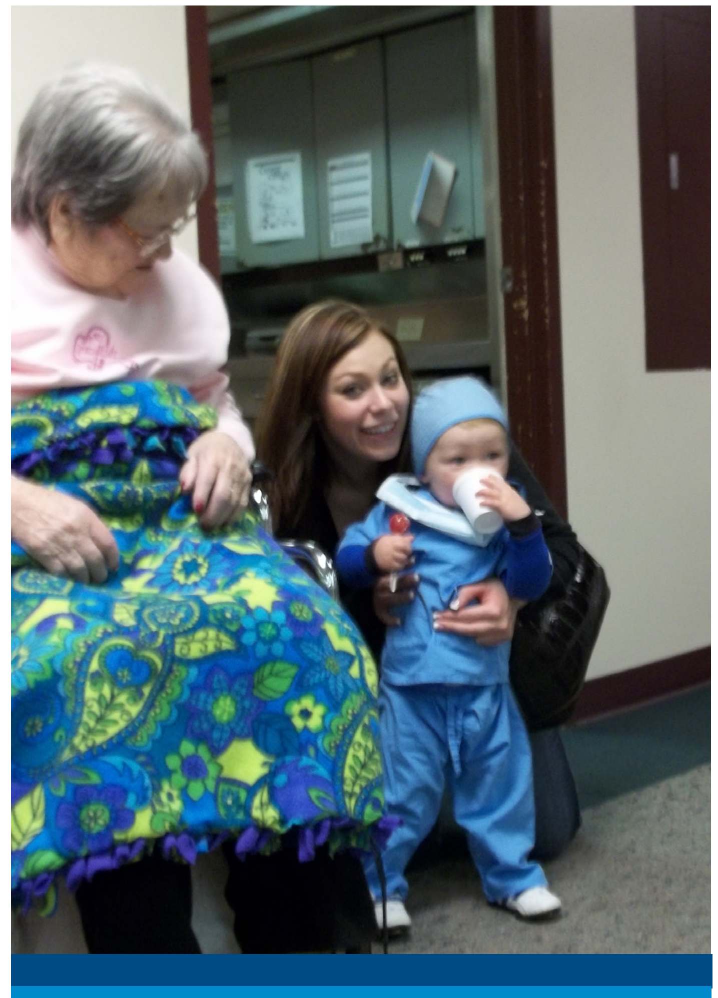
Population health refers to the health outcomes of a group of individuals; the focus is to improve the health of an entire population. Health status is dependent on the social determinants of health, which are the conditions in which people are born, grow, live, work, and age. Thus, factors such as income, poverty, housing, education, physical environment, and family genetic history come into play, as does the healthcare system. The CHNAs tend to elicit a number of community concerns that, while they may not seem to be health-related, actually are, as they influence health status for individuals and collectively the population health (e.g., jobs with a livable wage, and community viability such as attracting and retaining younger families).

Method

The North Dakota CHNA process emphasized community engagement with direct input from community members. Ideally the assessment is informed by both primary (e.g., surveys, focus groups, and community member interviews) and secondary (e.g., information that already exists for another use) data. The federal statute does not establish how a CHNA should be conducted. This comprehensive and inclusive process – primary and secondary data – is favored by the CRH as it maximizes community input and decision making opportunities and it builds on reliable existing health data (e.g., Robert Wood Johnson Foundation's County Health Rankings).

Under the CRH process, a liaison was selected to coordinate the process locally, with guidance from a community-formed steering committee. Of the 36 critical access, hospital-completed CHNAs, 31 were conducted by CRH (86%). The remaining five were done by health consultants, the hospital itself, or a larger regional health system with which they were affiliated. CRH was able to secure the actual

assessment data for the five and combined that with the 31 CRH facilitated CHNAs in order to develop an aggregate overview. A systematic review of all the significant needs collected from the CHNA process was conducted to establish a broader understanding of health needs in North Dakota. It is important for local health providers to understand their community and what residents feel are health concerns. It is the community health system that will take the lead on addressing those concerns. It is also important, particularly for health policy considerations, to have an overview of the collective views throughout the state. Federal and state policy makers can develop policy changes to address the concern and offer resources to be used nationally, statewide, and at the community level.



General Findings

From the 36 CHNAs, 139 total ranked needs were identified, with each community selecting between 2-5 needs, for an average of 3.9 per assessment. Overall, 25 unique categories were identified. Several needs have been combined under broader categories (i.e. depression under mental health, alcohol and drug abuse under substance abuse), which will be broken down in their respective segments. The table below shows the aggregated health needs for North Dakota during the 2017-2019 period by displaying the number of instances that those needs were identified as top concerns during CHNAs.

Identified Needs

Need	Count
Substance abuse	30
Mental health	30
Attracting & retaining young families	16
Having enough child daycare services	11
Ability to retain primary care providers	11
Availability of resources to help the elderly stay in their homes	6
Not enough jobs with livable wages	5
Cancer	4
Obesity	4
Affordable housing	3
Bullying/cyberbullying	3
Cost of health insurance	3
Not getting enough exercise/not enough places for exercise	2
Assisted living options	2
Availability of primary care providers	2
Cost of long-term/nursing home care	2
Extra hours for appointments	2
Ability to get appointments within 48 hours	1
Access to healthcare	1
Domestic violence	1
Family and social support	1
Heart disease	1
Services for seniors	1
Transportation	1

0 5 10 15 20 25 30

Mental health (and depression) was one of the most commonly reported concerns, showing up in 30 (83%) of the 36 CHNAs as a top concern. Depression on its own, was included in 12 of the 36 assessments. Although mental health is not a new entry, it has increasingly risen as a prominent need over the years. Compounding this issue is the lack of mental health providers in North Dakota which, according to 2020 County Health Rankings[1], has 530 residents per provider, as opposed to the top 10% of U.S. counties, which has a ratio of 290 to 1.

Substance abuse, including alcohol and drug use and abuse, came in even with mental health, also appearing in 30 (83%) of the 36 CHNAs. Drug use and abuse specifically carried more weight within communities, being identified by itself 18 times throughout the assessments, while alcohol use and abuse was listed ten times and the availability of substance treatment facilities was listed twice.

Attracting and retaining young families was also highly mentioned, despite there being a significant drop-off in instances of being identified from the top two identified needs. This concern was listed in 16 (44%) of the 36 assessments, highlighting the difficulties in bringing new members into rural communities. While this concern stands alone with no combining of categories, several other needs (lack of daycare services, lack of affordable housing, etc.) could be interpreted as being direct obstacles to attracting families.

Ability to recruit and retain primary care providers shares the fourth spot on the list of top concerns, being mentioned prominently in 11 (31%) of CHNAs. Like attracting families, this category also stands on its own as a need and, keeping up with similarities, shares some of the same needs as factors for the concern as attracting families.

Having enough child daycare services also lands at number four, tying with the previous concern with 11 assessment mentions. Along with being an issue itself, shortages of licensed child care facilities are also a factor in other top needs, having already been mentioned in their respective sections.

As shown in the table on the previous page, there are many other concerns that arise from these assessments that may not have seen the same level of attention as the top five. However, though some of these issues may be specific to certain communities, they are no less of a concern, thus every ranked need from this time period is included.

Conclusion

Upon review of the CHNAs, mental health and substance abuse received the most attention by far. A theme becomes clear that behavioral health, which is includes mental health and substance abuse, is being acknowledged as the most pressing concern throughout the state. This need also forms a relationship with several other issues in a cause and effect relationship, including—and in some cases especially--with substance abuse: of the 30 assessments that identified a form of substance abuse as a top concern, 13 also listed either mental health or depression. Key behavioral health legislation passed in North Dakota during 2019 included the 1915i Medicaid state plan amendment, certification of peer support specialists, expansion of the Free Through Recovery program, and investment in mental illness prevention and mental health promotion and recovery housing[2]. Although attracting and retaining families didn't see the numbers the other two did, it is important to note that it was the first need not to be combined with other related needs. It would still be positioned below the other two, but by a much narrower margin, speaking to its importance within these rural areas. Rural towns are concerned with the viability of the communities. Because the communities have a population that is aging, they need to have resources available to assist this group. They also must be able to attract young families that can grow the community through such things as utilizing local services, opening businesses, and providing a workforce. Part of being able to attract young families is having daycare available and jobs with livable wages. The resources needed to attract young families are also ones that will help to retain the healthcare workforce.

Recommendations

Although CHNAs encompass the entire community, hospitals and public health will often bear the weight of addressing these concerns. The ACA requires an implementation plan from non-profit hospitals (and for both the CHNA report and implementation plan to be easily accessible to the community members). The communities involved with CRH coordinating the process created a local steering committee or task force. As part of community engagement, it is important to gain not just community input, but also community ownership of the solutions to local issues. Incorporating community representatives in conversations with policy makers is advised as community members add another level of credibility to those opinions expressed by providers and administrators. Outside technical assistance through CRH and others is also available. There are grant resources that can be explored to help fund community processes and solutions. It is also recommended that communities explore multiple-community collaboration whereby communities with the same need, (e.g., behavioral health) can explore regional approaches to address the concern. Individual and multi-community efforts can be supported through rural health grants. Federal and state policy makers need to be aware of the concerns so as to develop policy solutions. Some of these issues will be before both the United States Congress and the North Dakota legislature. Many health associations, and associations representing other sectors, will be advocates for redressing these concerns. Community leaders typically meet with state legislators, congressional members, and their staff to outline concerns. The CHNA is an excellent resource not only for identifying local community needs, but also in providing evidence to policy makers.

References

1. Robert Wood Johnson Foundation (2020). North Dakota 2020 County Health Rankings. County Health Rankings & Roadmaps. **https://www.countyhealthrankings.org/reports/state-reports/2020-north-dakota-report**.

2. 2019 North Dakota Behavioral Health Conference reports record attendance (2019, February 15). ND.gov. Retrieved March 27, 2020 from **https://www.nd.gov/news/2019-north-dakota-behavioral-health-conference-reports-record-attendance**.

For More Information

More detail on the North Dakota CHNA process and results may can be found at this website: ndchna.org.

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