January 2017

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

Fact Sheet

North Dakota's Significant Health Needs as Identified by Community Health Needs Assessments

Aggregate Results for Rural and Urban North Dakota Hospitals and Public Health Units

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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 non-profit hospitals are required to conduct and complete a community health needs assessment CHNA process and to identify an implementation plan. Additionally, throughout the country, and certainly in North Dakota a number of public health districts or units are engaged in efforts to achieve national accreditation. Public health, too, must conduct a community health assessment and develop an action plan. The ACA requirement for hospitals also states that the hospital must include public health in their process. In 2013, the Center for Rural Health issued findings from the first round of CHNAs covering the years 2011-2013 (December 2013). This fact sheet represents the second round covering 2014-2016.

Population health refers to the health outcomes of a group of individuals; the focus is to improve the health of an entire population. Our 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 our 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, 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 Center for Rural Health (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 and Roadmap). Under the CRH process a local steering committee or task force was formed to guide local efforts. The local group would also serve as a focus group. Of the 41 completed CHNAs, 24 were conducted by the Center for Rural Health (59%). The remaining 17 were done by health consultants, the hospital itself, or a larger regional health system with which they were affiliated. At the time of this fact sheet preparation, there were four outstanding CHNAs that will be completed in 2017. CRH was able to secure the actual assessment data for the 17 and combined that with the 24 CRH facilitated CHNAs in order to develop an aggregate or combined 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.

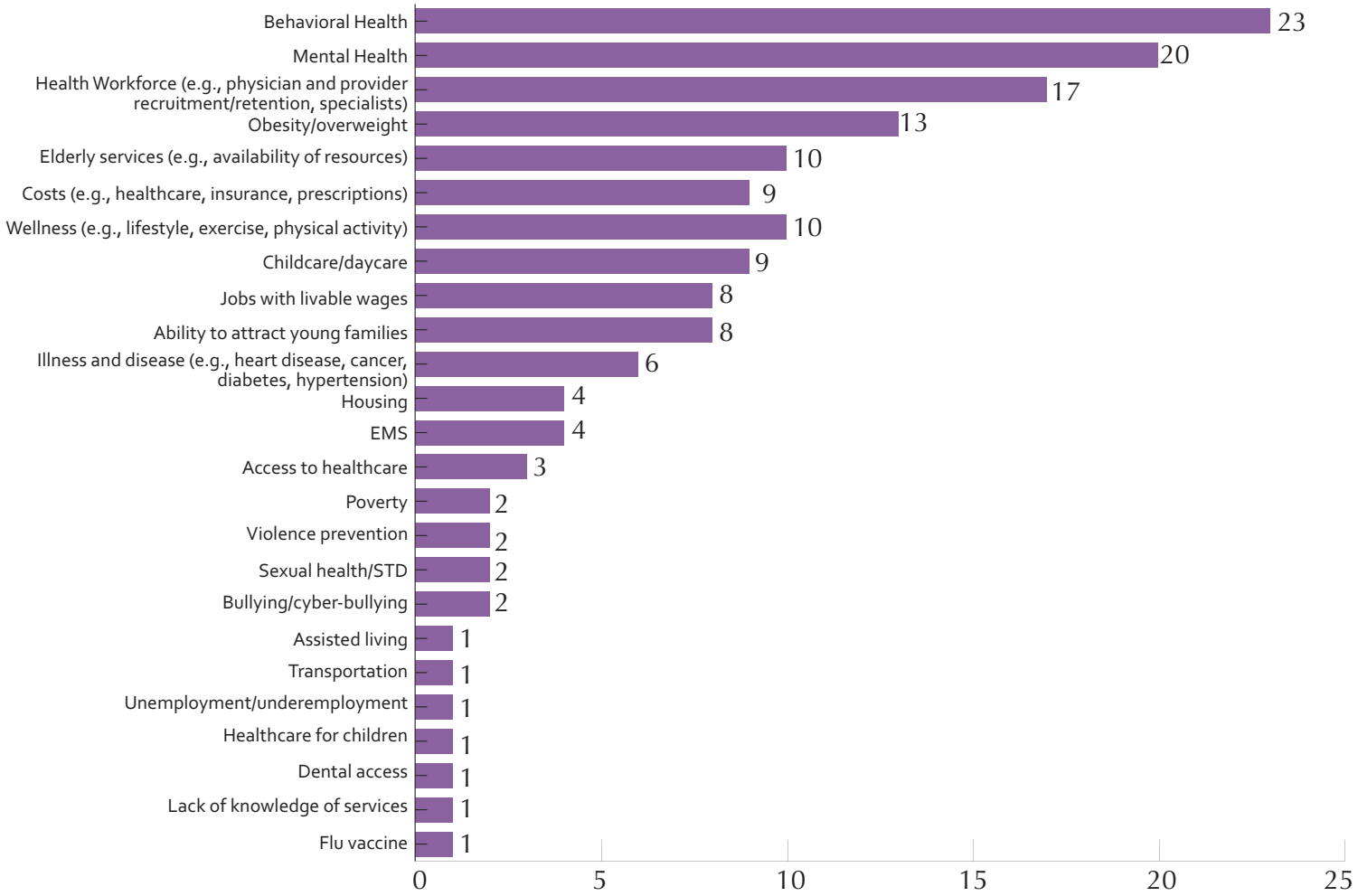
These aggregated needs are based on the results from 41 CHNAs. They reflect health concerns selected and ranked as most prevalent, most persistent, and most substantial. The community process may generate 20-30 separate needs, but a ranking process was used by the CRH to identify the most salient issues. On average the 41 CHNAs produced 4.4 ranked needs per community. With these prioritized statewide issues, policy makers and invested stakeholders can develop more targeted solutions to address the needs impacting North Dakota constituents.

Findings

The 41 CHNAs produced 182 ranked needs with an average of 4.4 per community. There were 25 need categories (e.g., behavioral health, mental health, health workforce, obesity/overweight, and more). Different facets of a community need may be identified multiple times and be ranked. For example, behavioral health can have many components such as youth alcohol use and abuse, adult alcohol use and abuse, binge drinking, addiction treatment, substance abuse, prescription drug abuse, and more. There were cases where a North Dakota community would rank more than one component of a broader need such as behavioral health. Thus, a community may have had five primary needs with a behavioral health need being identified two or even three times. The table below shows the aggregated health needs for North Dakota during the 2014-2016 period. It shows the number of CHNAs that identified that need as one of its most important.

Behavioral health was the most commonly ranked community health need and identified in 23 of the 41 CHNAs (56%). It was the only community need out of 25 ranked needs that had a majority of communities select it as a primary concern. Behavioral health for our purposes encompasses a variety of references to alcohol and/or drug use and abuse. This also covered references to access to treatment and behavioral health providers. In addition to the number of CHNAs where behavioral health was identified as a need, another way to analyze the data is to think of it in the context of the number of total needs. On average there were about four ranked needs in each of the 41 communities. Thus, there were 182 ranked needs. Behavioral health was identified as a need 34 times as a behavioral health attribute (e.g., youth alcohol use and abuse or prescription drug abuse) and was identified multiple times in the same CHNA. This means behavioral health represented 19% of all needs. Essentially, one out of every five ranked needs was behavioral health. This was present in

Identified Community Health Needs



rural and urban communities. In the first round of CHNAs (2011-2013) behavioral health was not an independent need category and when it was identified it was coded as part of mental health; thus, mental health during that period had a rather broad definition running the gamut of traditional psychological and physiological subjects such as depression to more sociological behavioral areas such as alcohol and/or drug use.

Mental health (e.g., availability of services, lack of providers, depression, tele-psychiatry, and more) was the second highest ranked need. Mental health was identified in 20 of 41 CHNAs or 49% of the CHNAs. It accounted for 22 of the 182 collective needs or 12% of all needs. During the previous CHNA effort (2011-2013), mental health (again inclusive of behavioral health) was the third highest ranked aggregate need.

Health workforce (e.g., physician and provider recruitment and retention, need for primary care providers, specialty care access, and more) was the third ranked statewide need. Workforce emerged in 17 CHNAs or 41%. Like mental health it had 22 mentions out of the 182 ranked needs (12%), but it was identified in fewer CHNAs. Health workforce can be seen as a chronic need as it has been identified by different groups (e.g., state associations and other key stakeholders) over many years as a need. For the CHNA process, the current rankings contrast with the 2011-2013 period. At that time, health workforce was the highest ranked aggregated need; however, for 2014-2016 it dropped to third.

Obesity/overweight was the fourth ranked issue accounting for 13 of the 41 CHNA (32%) and it accounted for 15 of the 182 needs or eight percent of the statewide needs. In the previous CHNA study it ranked second.

Elderly services (e.g., availability of resources to help the elderly, meet the needs of an older population, access to aging services, improve care center, Alzheimer's services, and services to stay in the elder's home) was identified in 10 CHNAs (24%) and accounted for 11 of the 182 needs. It was the fifth ranked need. In the previous CHNA study it was ranked seventh.

Costs which included references to insurance costs, healthcare in general, and prescription was ranked sixth. It was found in nine (22%) of the communities and accounted for 11 of the 182 needs. In the previous CHNA study it ranked fifth.

While the number of CHNAs or the number of times a need was identified was lower for the remaining needs, and they may not have the same resonance statewide, it is important to realize that at the community level these issues emerged as primary local concerns. If they are identified as a significant issue in even one community, that is an area of concern.

Conclusions

The social determinants of health that are associated with population health appear to be significant concerns in North Dakota. Human behavior - e.g., do we make the healthy choice and exercise, eat well, drink moderately or abstain, and not abuse drugs or do we make poor choices – is a factor for health. Improved population health is the ultimate outcome. Having healthy, thriving communities where people feel safe, can make a reasonable living, are able to attract and retain younger people and families, and where we address housing and income inequality concerns are other population health factors. The 2014-2016 round of CHNAs found these were all concerns in and throughout North Dakota.

The dominant issues were behavioral health, mental health, and health workforce. Health workforce dropped to third place (it was the number one issue in the previous aggregate study) which is not necessarily an indication that the concern has lessened, as it may be a reflection of the resurgence of behavior/mental health. It was identified as a top need in 17 communities (41%). However, behavioral health (56% of CHNAs) and mental health (49% of CHNAs) emerged as the top statewide concerns. In the previous aggregate study, behavioral health was not an independent category and was merged with mental health, and mental health at that time was the third highest issue. Something has changed. The issue has likely intensified affecting even more individuals and families; thus, in a community engagement process people are now more willing to identify and discuss behavioral and mental health issues. The North Dakota Legislature has had more policy focus on the behavioral and mental health system by concentrating on access issues such as availability of providers and a growing awareness of the opioid epidemic. North Dakota has had an active Behavioral Health Stakeholders process that has kept a focus on the issue and has been a springboard for policy. At the community level, the CHNAs indicated a high recognition for adult and youth alcohol use and abuse and adult and youth drug use and abuse.

In analyzing the CHNA aggregate data another finding is that some communities identified both behavioral health and mental health as distinct concerns. There were ten CHNAs where the community members identified both as issues. Both the volume of concerns for these two issues and the recognition that they are distinct indicates how profound the need is in some communities. One community had four primary ranked issues with behavioral health (substance abuse treatment and adult drug use and abuse) accounting for two and mental health (availability of services and youth mental

health) comprising the other two. Nothing else was ranked. In another community, three of their five ranked needs were behavioral health related. Behavioral and mental health emerged as a ranked need in 28 of 35 rural CHNAs (80%) and was ranked in all six urban hospitals (Bismarck, Fargo, Grand Forks, and Minot). While in a qualitative study such as this statistical correlation cannot be established, it is, however, a finding that in the two CHNAs that identified bullying/cyber bullying as an issue they also ranked behavioral or mental health as concerns. Likewise, in the two CHNAs that ranked violence/prevention of violence as concerns, they too identified behavioral or mental health.

Issues associated with community viability also relate to population health as where we live and work impacts our health status. Some needs that represent viability are attracting and retaining young families, jobs with a livable wage, childcare/daycare, housing, poverty, violence, and transportation. These are rural issues in that they only emerged as issues in rural-based CHNAs, with the exception of one urban community identifying violence. A viable rural health delivery system is dependent on the sustainability of other community sectors such as schools, businesses, government, and the faith community. Community viability issues such as good paying jobs, childcare, and younger families contribute to the lives of the local population, the growth and survivability of the community, and the viability of the health sector. They are part of the social determinants of health.

Recommendations

Hospitals and public health will bear the weight of addressing these concerns. The ACA requires an implementation plan from non-profit hospitals (and for both the CHNA and implementation plan to be displayed on the hospitals website for easy access to community members). The communities, involved with the CRH 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 the 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. Not only individual but also multi-community efforts can be supported through federal 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 Congress of the United States 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 and 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.

For More Information

More detail on the North Dakota CHNA process can be found at this website:
ruralhealth.und.edu/projects/community-health-needs-assessment

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