Community Health Needs Assessment

2019

Bowman County, North Dakota

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Executive Summary

To help inform future decisions and strategic planning, Southwest Healthcare Services (SWHS) conducted a community health needs assessment (CHNA) in 2019, the previous CHNA having been conducted in 2016. The Center for Rural Health (CRH) at the University of North Dakota School of Medicine & Health Sciences (UNDSMHS) facilitated the assessment process, which solicited input from area community members and healthcare professionals as well as analysis of community health-related data.

To gather feedback from the community, residents of the area were given the opportunity to participate in a survey. One hundred sixty-seven service area residents completed the survey. Additional information was collected through five key informant interviews with community members. The input from the residents, who primarily reside in Bowman County, represented the broad interests of the communities in the service area. Together with secondary data gathered from a wide range of sources, the survey presents a snapshot of the health needs and concerns in the community.

With regard to demographics, Bowman County's population from 2010 to 2018 decreased 2.4%. The average age of residents under 18 (24.5%) for the county is slightly higher than the North Dakota average (23.3%), and the percentage of residents ages 65 and older is about 6% higher for Bowman County (21.4%) than the state average (15.3%). The rates of education are slightly lower for the county (91.7%) than the North Dakota average (92.3%). The median household income in Bowman County ($65,435) is marginally higher than the state average for North Dakota ($61,285).

Data compiled by County Health Rankings show Bowman County is doing better than North Dakota in health outcomes/factors for 21 categories while performing poorly relative to the rest of the state in seven outcome/factor categories.

Of the 82 potential community and health needs set forth in the survey, the 167 SWHS service area residents who completed the survey indicated the following ten needs as the most important:

- Ability to retain primary care providers & nurses in the community
- Alcohol use and abuse – adults
- Alcohol use and abuse – youth
- Attracting and retaining young families
- Availability of resources to help the elderly stay in their homes
- Bullying/cyber-bullying
- Cancer – adults
- Child abuse/neglect
- Cost of long-term/nursing home care
- Smoking & tobacco use or vaping/juuling

The survey also revealed the biggest barriers to receiving healthcare (as perceived by community members). They included not being able to see the same provider over time (N=57), no/limited insurance (N=54), and not having enough providers (N=39).

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

- Family friendly
- Healthcare
- People are friendly, helpful and supportive
- Quality school systems
- Safe place to live, little/no crime

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

- Alcohol use and abuse – adults and youth
- Attracting and retaining young families
- Availability of mental health services
- Cost of long-term/nursing home care
- Depression/anxiety – youth
- Smoking & tobacco use, exposure to second-hand smoke, or vaping/juuling

Overview and Community Resources

With assistance from the CRH at the UNDSMHS, Southwest Healthcare Services completed a CHNA of the SWHS service area. The hospital identifies its service area as Bowman and Slope counties in North Dakota, and Harding County in South Dakota. Many community members and stakeholders worked together on the assessment.

Southwest Healthcare Services, a licensed critical access hospital, is located in the rural area of southwest North Dakota in the town of Bowman. The facility is comprised of seven different entities that include a rural health clinic, acute care hospital, emergency department, rehabilitation, long-term care, laboratory services, and radiology services. Southwest Healthcare Services also offers home nursing and ambulatory services.

Bowman sits in Bowman County and is approximately 40 miles from the Montana state border, and 20 miles from the South Dakota state border. Its nearest major city is Dickinson, which is approximately 75 miles north of Bowman.

SWHS is the largest employer in Bowman, but the area is also home to a farming and ranching community and features a wide variety of financial institutions, retail businesses, and multiple food service businesses.

Bowman County is approximately 1,167 sq. miles of land and water and according to the U.S. Census Bureau, is home to 3,076 residents. A majority of the racial makeup of Bowman County is Caucasian which makes up 96 percent of the population. Other race origins include Hispanic, African American, American Indian, Asian, Native Hawaiian/Pacific Islander, and those who are multi-racial.

Other healthcare services in Bowman County include an optometrist, two dental practices, three chiropractors, and multiple massage therapists. There are also numerous social programs including meal delivery.

Outside of healthcare services, there are numerous amenities in Bowman County that play a vital role in the overall health of the residents. There are two fitness centers, bike paths, and baseball and softball fields. The city of Bowman also has a robust parks and recreation center. The parks and rec manages three public playgrounds, and tennis courts. They also organize youth and adult sports leagues and hold open gym hours with a fitness center and a public pool, available during the summer months. Bowman also has a public golf course, Sweetwater Golf Course, which is located a few miles south of Bowman city limits.

Additionally, the city of Bowman also offers cultural amenities including the Pioneer Trails Regional Museum dedicated to the history of the region. The movie theater on main street provides a mode of entertainment with weekend show times of movies for all ages.

Bowman County Public School offers a comprehensive educational program for grades K -12 and includes students from Rhame, a town west of Bowman. The school system also offers a non-public funded preschool program for children ages 3-4 years old.

Also available throughout the county are numerous licensed and unlicensed childcare services.

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Figures 1 and 2 illustrate the location of the counties in the SWHS service area.

Figure 1: Bowman and Slope Counties, North Dakota

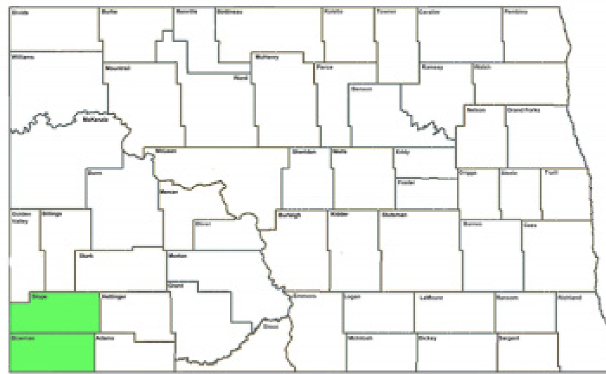

Figure 2: Harding County, South Dakota

Southwest Healthcare Services

SWHS is a multi-unit health system comprised of seven entities. Encompassed within the system is a rural medical clinic, a 23-bed acute care hospital, a 40-bed long-term care unit, independent living, assisted living, visiting nursing services, and emergency services.

Founded as a faith-based facility, the communities of Bowman and Slope counties began discussing the need for organized health services, and by July 1946, an area in Bowman was designated for a hospital to be built. Through community efforts, with Governor Norman Burnsdale on hand for the ceremonial ribbon cutting, Tri-State Hospital was opened on May 12, 1951. By 1955, this hospital was leased to the Episcopal Church and the new corporation was named St. Luke's Tri-State Hospital Association.

In 1964, a separate facility was built and the Sunset Nursing Home opened on July 21. The land was again donated with fundraising and grants supporting the opening of the facility.

The rural medical clinic was built in 1990 and opened on September 4. Dr. John Pate and Dr. John Hawronsky were the first two physicians to see patients at Southwest Medical Clinic.

The facility, as it stands today, began in January 2001, when the St. Luke's Tri-State Hospital and Sunset Care Corporation (Sunset Nursing Home), along with the Bowman Ambulance, consolidated and formed what is now known as Southwest Healthcare Services.

SWHS purchase and absorbed Jahner PT & Fitness, Inc. in 2011, creating another facet of services for the patients.

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In 2016, the facility embarked on a new chapter of the storied healthcare history and started a multi-million dollar expansion that would bring most of the seven entities under one roof. As it stood, the acute care facility and rural clinic were on a separate campus from the long-term care facility. In May of 2017, the new facility opened its doors.

SWHS serves multiple counties and multiple communities in the tristate area of southwest North Dakota, northwest South Dakota, and southeast Montana.

Mission
"Guided by faith-based leadership, we are a family of specialists, each performing a unique service. With the spirit of compassion, we provide excellence in healthcare to those we are privileged to serve."

Vision
We will distinguish ourselves as a unified healthcare family commanding excellence from each other in providing personalized care.

Guiding Expectations
We will, by our thoughts, words, and deeds, demonstrate these guiding expectations on a daily basis.

We Will Show:

- Respect for those we care for & work with, creating respectability within our service area.
- Integrity in our work by doing the right thing every time.
- Safety awareness of our surroundings and our work habits.
- Nurturing relationships through humor & kindness.
- Generosity in supporting: one another to achieve excellence, our organization's goals & objectives, and our communities by involvement.

SWHS includes a 23-bed, critical access hospital with various outpatient therapies and services located in Bowman. As a hospital, clinic, and designated level four trauma center, the medical center provides comprehensive care through physicians, physician assistants, nurse practitioners, and consulting/visiting medical providers for a wide range of medical and emergency situations. With approximately 170 staff members, SWHS along with contracted healthcare agencies housed within SWHS, is one of the largest employers in the region. Services offered locally by SWHS include:

General and Acute Services

- Acne treatment
- Allergy, flu & pneumonia shots
- Ambulance & emergency services
- Blood pressure checks
- Cardiology (visiting physician)
- Cardiac rehab
- Clinic
- Emergency room
- Gynecology (visiting physician)
- Hospital (acute care)
- Independent senior housing
- Mole/wart/skin lesion removal
- Nutrition counseling
- Obstetrics (visiting physician)
- Orthopedics (visiting physician
- Pharmacy
- Prenatal care up to 32 weeks
- Physicals: annuals, D.O.T., sports & insurance
- Sports medicine
- Surgical services – biopsies
- Surgical services – outpatient
- Surgical services – upper & lower endoscopy
- Swing bed services

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Screening/Therapy Services

- Chronic disease management
- Holter monitoring
- Laboratory services
- Lower extremity circulatory assessment
- Occupational therapy
- Pediatric services
- Physical therapy
- Respiratory care
- Speech/language pathology
- Sleep studies
- Social services

Radiology Services

- CT scan
- Digital mammography
- Echocardiograms (visiting service)
- EKG
- General x-ray
- Mammograms
- MRI (mobile unit)
- Ultrasound

Laboratory Services

- Blood bank
- Blood gasses
- Coagulation
- Chemistry
- D.O.T. & non-D.O.T. drug and breathe alcohol testing
- Hematology
- Urinalysis
- Quick kits

Services offered by OTHER providers/organizations

- Chiropractic services
- Dental services
- Massage therapy
- Optometric/vision services

Southwestern District Health Unit

Southwestern District Health Unit (SWDHU) provides public health services that include health, nursing services, the WIC (women, infants, and children) program, health screenings, and education services. Each of these programs provides a wide variety of services in order to accomplish the mission of public health, which is to ensure that North Dakota is a healthy place to live and each person has an equal opportunity to enjoy good health.

Mission

The Mission of the SWDHU is to "Prevent, Promote and Protect for optimal community health." To fulfill this mission, the SWDHU uses its Core Values:

- Collaboration – Working with other facilities/services in the community to promote optimal health
- Respect – Embrace the dignity and diversity of individuals, groups, and communities
- Science – Support and promote evidence-based practices
- Teamwork – Working together to share purpose and a common goal
- Excellence – Achieve the highest quality in what we do
- Innovation – Integrating new ideas and technology into practical processes to improve our effectiveness
- Prevention – Using knowledge to prevent disease and injury and make smart decisions to stay healthy

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Vision

Our Vision at SWDHU is to provide a variety of services and programs that maintain or improve the health status of the general population and environment.

Specific services that SWDHU provides are:

- Bicycle helmet safety education
- Blood pressure checks
- Breastfeeding resources
- Car seat program (referral only)
- Child health (well-baby checks)
- Correction facility health (educational programs)
- Dental health education
- Diabetes screening
- Emergency preparedness services – work with community partners as part of local emergency response team
- Environmental health services (water, sewer, health hazard abatement)
- Flu shots
- Health Maintenance Program
- Health Tracks
- Home health – in-home nursing care
- Medication setup—home visits
- Newborn home visits
- School health (vision, health education, and resource to the schools)
- Participate in education for local food pantry
- Preschool education programs & screening
- Tobacco prevention & control
- Tuberculosis testing and management
- West Nile program – surveillance and education
- WIC (Women, Infants & Children) program
- Worksite wellness – coordinator for county employees and Sheriff's Department
- Youth education programs (first aid, bike safety)

Assessment Process

The purpose of conducting a CHNA is to describe the health of local people, identify areas for health improvement, identify use of local healthcare services, determine factors that contribute to health issues, identify and prioritize community needs, and help healthcare leaders identify potential action to address the community's health needs.

A CHNA benefits the community by:

1) Collecting timely input from the local community members, providers, and staff;

2) Providing an analysis of secondary data related to health-related behaviors, conditions, risks, and outcomes;

3) Compiling and organizing information to guide decision making, education, and marketing efforts, and to facilitate the development of a strategic plan;

4) Engaging community members about the future of healthcare; and

5) Allowing the community hospital to meet the federal regulatory requirements of the Affordable Care Act, which requires not-for-profit hospitals to complete a CHNA at least every three years, as well as helping the local public health unit meet accreditation requirements.

This assessment examines health needs and concerns in Bowman & Slope counties in North Dakota, and Harding County in South Dakota. Within these three counties there are several communities including: Amidon, Bowman, Marmarth, Rhame, and Scranton in North Dakota and Buffalo, Camp Crook, Gascoyne, and Ludlow in South Dakota.

The CRH, in partnership with SWHS and SWDHU, facilitated the CHNA process. Community representatives met regularly in-person, by telephone conference, and email. A CHNA liaison was selected locally, who

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served as the main point of contact between the CRH and Bowman. A small steering committee (see Figure 3) was formed that was responsible for planning and implementing the process locally. Representatives from the CRH met and corresponded regularly by teleconference and/or via the eToolkit with the CHNA liaison. The community group (described in more detail below) provided in-depth information and informed the assessment process in terms of community perceptions, community resources, community needs, and ideas for improving the health of the population and healthcare services. The meeting was highly interactive with good participation. SWHS staff and board members were in attendance as well, but largely played a role of listening and learning.

Figure 2: Steering Committee

Cole Benz	Marketing Director, SWHS
Allison Engelhart	Human Resources Director, SWHS
Charlene Hanson	Quality Assurance, SWHS
Lisa Knopp	Rural Clinic Manager, SWHS
Amanda Loughman	CFO, SWHS
Jody Rajewski	Long-Term Care Director of Nursing, SWHS
Amy Smyle	Home Health Supervisor, SWHS
Amber Umbreit	COO, SWHS
Jerry Wiesner	CEO, SWHS

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

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

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

The CRH is one of the nation's most experienced organizations committed to providing leadership in rural health. Its mission is to connect resources and knowledge to strengthen the health of people in rural communities. The CRH is the designated State Office of Rural Health and administers the Medicare Rural Hospital Flexibility (Flex) program, funded by the Federal Office of Rural Health Policy, Health Resources Services Administration, and Department of Health and Human Services. The CRH connects the UNDSMHS and other necessary resources, to rural communities and their healthcare organizations in order to maintain access to quality care for rural residents. In this capacity, the CRH works at a national, state, and community level.

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Detailed below are the methods used to gather data for this assessment by convening a community group, conducting key informant interviews, soliciting feedback about health needs via a survey, and researching secondary data.

Community Group

A community group consisting of 12 community members was convened and first met on October 21, 2019. During this community group meeting, group members were introduced to the needs assessment process, reviewed basic demographic information about the community, and served as a focus group. Focus group topics included community assets and challenges, the general health needs of the community, community concerns, and suggestions for improving the community's health.

The community group met again on November 7, 2019 with nine community members in attendance. At this second meeting, the community group was presented with survey results, findings from key informant interviews and the focus group, and a wide range of secondary data relating to the general health of the population in Bowman County. The group was then tasked with identifying and prioritizing the community's health needs.

Members of the community group represented the broad interests of the community served by SWHS and SWDHU. They included representatives of the health community, business community, political bodies, law enforcement, education, and faith community. Not all members of the group were present at both meetings.

Interviews

One-on-one interviews with three key informants were conducted in person in Bowman on October 22, 2019. Two additional key informant interviews were conducted over the phone in October 24, 2019. A representative from the CRH conducted the interviews. Interviews were held with selected members of the community who could provide insights into the community's health needs. Included among the informants were public health professionals with special knowledge in public health acquired through several years of direct experience in the community, including working with medically underserved, low income, and minority populations, as well as with populations with chronic diseases.

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

Survey

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

The community member survey was distributed to various residents of Bowman County, which encompasses the SWHS service area.

The survey tool was designed to:

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

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Specifically, the survey covered the following topics:

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

To promote awareness of the assessment process, information was posted at most of the area businesses and a radio ad was produced. Information was also published on SWHS's website and Facebook page.

Approximately 50 community member surveys were available for distribution directly from SWHS.

To help ensure anonymity, included with each survey was a postage-paid return envelope to the CRH. In addition, to help make the survey as widely available as possible, residents also could request a survey by calling SWHS. The survey period ran from September 30, 2019 to October 14, 2019. Four completed paper surveys were returned.

Area residents also were given the option of completing an online version of the survey, which was publicized in two community newspapers and posted on the websites and Facebook pages of SWHS. Business cards, available for the taking, were also created and left at area businesses that featured the URL and the QR code for the survey.

One hundred sixty-three online surveys were completed. Two of those online respondents used the QR code to complete the survey. In total, counting both paper and online surveys, 167 community member surveys were completed, equating to a 7% response rate. This response rate is low for this type of unsolicited survey methodology.

Secondary Data

Secondary data was collected and analyzed to provide descriptions of: (1) population demographics, (2) general health issues (including any population groups with particular health issues), and (3) contributing causes of community health issues. Data was collected from a variety of sources, including the U. S. Census Bureau; Robert Wood Johnson Foundation's County Health Rankings, which pulls data from 20 primary data sources (www.countyhealthrankings.org); the National Survey of Children's Health, which touches on multiple intersecting aspects of children's lives (www.childhealthdata.org/learn/NSCH); and North Dakota KIDS COUNT, which is a national and state-by-state effort to track the status of children, sponsored by the Annie E. Casey Foundation (www.ndkidscount.org). and Youth Risk Behavior Surveillance System (YRBSS) data, which is published by the Centers for Disease Control and Prevention (https://www.cdc.gov/healthyyouth/data/yrbs/index.htm).

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Social Determinants of Health

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

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

Healthy People 2020, (https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health) illustrates that health and healthcare, while vitally important, play only one small role (approximately 20%) in the overall health of individuals, and ultimately of a community. Social and community context, education, economic stability, neighborhood and built environment play a much larger part (80%) in impacting health outcomes. Therefore, as needs or concerns were raised through this community health needs assessment process, it was imperative to keep in mind how they impact the health of the community and what solutions can be implemented. See Figure 3.

Figure 3: Social Determinants of Health

Figure 4 (Henry J. Kaiser Family Foundation, https://www.kff.org/disparities-policy/issue-brief/beyond-health-care-the-role-of-social-determinants-in-promoting-health-and-health-equity/), provides examples of factors that are included in each of the social determinants of health categories that lead to health outcomes.

For more information and resources on social determinants of health, visit the Rural Health Information Hub website, https://www.ruralhealthinfo.org/topics/social-determinants-of-health.

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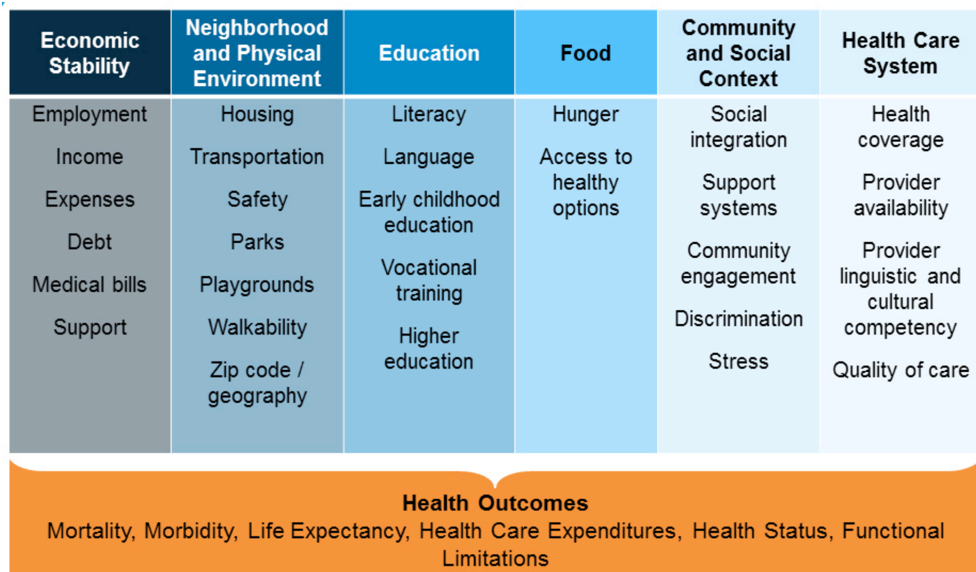
Figure 4: Social Determinants of Health



Demographic Information

TABLE 1: Bowman County: INFORMATION AND DEMOGRAPHICS

	Bowman County	North Dakota
Population (2018)	3,076	760,077
Population change (2010-2018)	-2.4%	13.0%
People per square mile (2010)	2.7	9.7
Persons 65 years or older (2018)	21.4%	15.3%
Persons under 18 years (2018)	24.5	23.5%
Median age (2017 est.)	42.2	35.4
White persons (2017)	96%	87.0%
Non-English speaking (2017)	4.6%	5.6%
High school graduates (2017)	91.7%	92.3%
Bachelor's degree or higher (2017)	24.5%	28.9%
Live below poverty line (2016)	8.4%	10.3%
Persons without health insurance, under age 65 years (2016)	11.8%	8.8%

Source: https://www.census.gov/quickfacts/fact/table/ND,US/INC910216#viewtop and https://factfinder.census.gov/faces/nav/jsf/pages/community_facts.xhtml#

While the population of North Dakota has grown in recent years, Bowman County has seen a decrease in population since 2010. The U.S. Census Bureau estimates show that the county's population decreased from 3,151 (2010) to 3,076 (2018).

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County Health Rankings

The Robert Wood Johnson Foundation, in collaboration with the University of Wisconsin Population Health Institute, has developed County Health Rankings to illustrate community health needs and provide guidance for actions toward improved health. In this report, Bowman County is compared to North Dakota rates and national benchmarks on various topics ranging from individual health behaviors to the quality of healthcare.

The data used in the 2019 County Health Rankings are pulled from more than 20 data sources and then are compiled to create county rankings. Counties in each of the 50 states are ranked according to summaries of a variety of health measures. Those having high ranks, such as 1 or 2, are considered to be the "healthiest." Counties are ranked on both health outcomes and health factors. Following is a breakdown of the variables that influence a county's rank.

A model of the 2019 County Health Rankings – a flow chart of how a county's rank is determined – is found in Appendix B. For further information, visit the County Health Rankings website at www.countyhealthrankings.org.

Health Outcomes

- Length of life
- Quality of life

Health Factors

- Health behavior
  - Smoking
  - Diet and exercise
  - Alcohol and drug use
  - Sexual activity

Health Factors (continued)

- Clinical care
  - Access to care
  - Quality of care
- Social and Economic Factors
  - Education
  - Employment
  - Income
  - Family and social support
  - Community safety
- Physical Environment
  - Air and water quality
  - Housing and transit

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

For most of the measures included in the rankings, the County Health Rankings' authors have calculated the "Top U.S. Performers" for 2019. The Top Performer number marks the point at which only 10% of counties in the nation do better, i.e., the 90th percentile or 10th percentile, depending on whether the measure is framed positively (such as high school graduation) or negatively (such as adult smoking).

Bowman County rankings within the state are included in the summary following. For example, the county ranks 17th out of 49 ranked counties in North Dakota on health outcomes and 1st on health factors. The measures marked with a with a bullet point (•) are those where a county is not measuring up to the state rate/percentage; a square (■) indicates that the county is not meeting the U.S. Top 10% rate on that measure. Measures that are not marked with a colored checkmark but are marked with a plus sign (+) indicate that the county is doing better than the U.S. Top 10%.

The data from County Health Rankings shows that Bowman County is doing better than many counties compared to the rest of the state on all of the outcomes, landing at or above rates for other North Dakota

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counties. The county is also performing well when it comes to the U.S. Top 10% ratings, either meeting or exceeding the averages in all areas. On health factors, Bowman County performs above the North Dakota average for counties in several areas as well.

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

- Poor or fair health
- Poor physical health days
- Poor mental health days
- Low birth weight
- Adult smoking
- Adult obesity
- Food environment index
- Access to exercise opportunities
- Excessive drinking
- Alcohol-impaired driving deaths
- Sexually transmitted infections
- Dentists per individual
- Preventable hospital stays
- Unemployment
- Children in poverty
- Income inequality
- Children in single-parent households
- Social associations
- Violent crime
- Air pollution – particulate matter
- Drinking water violations
- Severe housing problems

Outcomes and factors in which Bowman County is performing poorly relative to the rest of the state include:

- Physical inactivity
- Teen birth rate
- Uninsured individuals
- Primary care physicians per individual
- Mammography screenings
- Flu vaccinations
- Injury deaths

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● = Not meeting North Dakota average

■ = Not meeting U.S. Top 10% Performers

+ = Meeting or exceeding U.S. Top 10% Performers

Blank values reflect unreliable or missing data

TABLE 2: SELECTED MEASURES FROM *COUNTY HEALTH RANKINGS* 2019 – BOWMAN COUNTY			
	Bowman County	**U.S. Top 10%**	**North Dakota**
Ranking: Outcomes	**17th**		**(of 49)**
Premature death		5,400	6,700
Poor or fair health	11% +	12%	14%
Poor physical health days (in past 30 days)	2.5 +	3.0	3.0
Poor mental health days (in past 30 days)	2.4 +	3.1	3.1
Low birth weight	6% +	6%	6%
Ranking: Factors	**1st**		**(of 49)**
Health Behaviors			
Adult smoking	14% +	14%	20%
Adult obesity	30% ■	26%	32%
Food environment index (10=best)	9.6 +	8.7	9.1
Physical inactivity	26% ●■	19%	22%
Access to exercise opportunities	74% ■	91%	74%
Excessive drinking	23% ■	13%	26%
Alcohol-impaired driving deaths	0% +	13%	46%
Sexually transmitted infections	364.3 ■	152.8	456.5
Teen birth rate	34 ●■	14	23
Clinical Care			
Uninsured	9% ●■	6%	8%
Primary care physicians	1,620:1 ●■	1,050:1	1,320:1
Dentists	630:1 +	1,260:1	1,530:1
Mental health providers		310:1	570:1
Preventable hospital stays	2,053 +	2,765	4,452
Mammography screening (% of Medicare enrollees ages 65-74 receiving screening)	42% ●■	49%	50%
Flu vaccinations (% of fee-for-service Medicare enrollees receiving vaccination)	16% ●■	52%	47%
Social and Economic Factors			
Unemployment	1.7% +	2.9%	2.6%
Children in poverty	10% +	11%	11%
Income inequality	4.3 ■	3.7	4.4
Children in single-parent households	15% +	20%	27%
Violent crime	82 ■	63	258
Injury deaths	108 ●■	57	69
Physical Environment			
Air pollution – particulate matter	5.1 +	6.1	5.4
Drinking water violations	No		
Severe housing problems	5% +	9%	11%

Source: http://www.countyhealthrankings.org/app/north-dakota/2018/rankings/outcomes/overall

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Children's Health

The National Survey of Children's Health touches on multiple intersecting aspects of children's lives. Data are not available at the county level; listed below is information about children's health in North Dakota. The full survey includes physical and mental health status, access to quality healthcare, and information on the child's family, neighborhood, and social context. Data is from 2016-17. More information about the survey may be found at www.childhealthdata.org/learn/NSCH.

Key measures of the statewide data are summarized below. The rates highlighted in red signify that the state is faring worse on that measure than the national average.

Table 3: Selected Measures Regarding Children's Health (For children aged 0-17 unless noted otherwise)

Source: http://childhealthdata.org/browse/data-snapshots/nsch-profiles?geo=1&geo2=36&rpt=16

Health Status	North Dakota	National
Children born premature (3 or more weeks early)	10.8%	11.5%
Children 10-17 overweight or obese	35.8%	31.0%
Children 0-5 who were ever breastfed	79.4%	79.2%
Children 6-17 who missed 11 or more days of school	4.6%	3.7%
Healthcare		
Children currently insured	93.5%	93.9%
Children who had preventive medical visit in past year	78.6%	82.2%
Children who had preventive dental visit in past year	74.6%	79.5%
Young children (10 mos.-5 yrs.) receiving standardized screening for developmental or behavioral problems	20.7%	31.1%
Children aged 2-17 with problems requiring counseling who received needed mental healthcare	86.3%	9.8%
Family Life		
Children whose families eat meals together 4 or more times per week	83.0%	73.0%
Children who live in households where someone smokes	29.8%	15.5%
Neighborhood		
Children who live in neighborhood with a parks, recreation centers, sidewalks and a library	58.9%	39.2%
Children living in neighborhoods with poorly kept or rundown housing	12.7%	39.2%
Children living in neighborhood that's usually or always safe	94.0%	12.8%

The data on children's health and conditions reveal that while North Dakota is doing better than the national averages on a few measures, it is not measuring up to the national averages with respect to:

- Obese or overweight children ages 10-17;
- Children with health insurance;
- Preventive primary care and dentist visits;
- Developmental/behavioral screening for children 10 months to 5 years of age;

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- Children ages 2-17 years who have received needed mental healthcare; and
- Children living in smoking households.

Table 4 includes selected county-level measures regarding children's health in North Dakota. The data come from North Dakota KIDS COUNT, a national and state-by-state effort to track the status of children, sponsored by the Annie E. Casey Foundation. KIDS COUNT data focuses on the main components of children's well-being; more information about KIDS COUNT is available at www.ndkidscount.org. The measures highlighted in blue in the table are those in which the counties are doing worse than the state average. The year of the most recent data is noted.

The data show that Bowman County is performing better than the North Dakota average on four of the examined measures, performing more poorly on uninsured children, children enrolled in Healthy Steps, and licensed childcare capacity. The most marked difference was on the measure of licensed childcare capacity (almost 12% lower rate in the county).

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

	Bowman County	North Dakota
Uninsured children (% of population age 0-18), 2016	13.1%	7.5%
Uninsured children below 200% of poverty (% of population), 2016	34.0%	43.6%
Medicaid recipient (% of population age 0-20), 2017	18.4%	27.3%
Children enrolled in Healthy Steps (% of population age 0-18), 2013	1.9%	1.6%
Supplemental Nutrition Assistance Program (SNAP) recipients (% of population age 0-18), 2017	9.9%	20.1%
Licensed childcare capacity (% of population age 0-13), 2018	32.5%	44.3%
4-Year High School Cohort Graduation Rate, 2017	96.4%	88.0%

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

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

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

Table 5 depicts some of the YRBS data that has been collected in 2013, 2015, and 2017. At this time, the North Dakota-specific data for 2017 is not available, so data for 2013 and 2015 are shown for North Dakota. They are further broken down by rural and urban percentages. The trend column shows a "=" for statistically insignificant change (no change), "↑" for an increased trend in the data changes from 2013 to 2015, and "↓" for a decreased trend in the data changes from 2013 to 2015. The final column shows the 2017 national average percentage. For a more complete listing of the YRBS data, see Appendix C.

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TABLE 5: Youth Behavioral Risk Survey Results

North Dakota High School Survey

Sources: https://www.nd.gov/dpi/uploads/1298/2015NDHStatewideYRBSReport20151110FINAL2NoCover.pdf; https://www.nd.gov/dpi/uploads/1298/2015NDHTrendReportUpdated42016.pdf; https://www.cdc.gov/healthyyouth/data/yrbs/results.htm

	ND 2013	ND 2015*	ND Trend ↑, ↓, =	Rural ND Town Average	Urban ND Town Average	National Average 2017
Injury and Violence						
% of students who rarely or never wore a seat belt.	11.6	8.5	↓	10.5	7.5	5.9
% of students who rode in a vehicle with a driver who had been drinking alcohol (one or more times during the 30 prior to the survey)	21.9	17.7	↓	21.1	15.2	16.5
% of students who talked on a cell phone while driving (on at least 1 day during the 30 days before the survey)	67.9	61.4	↓	60.7	58.8	NA
% of students who texted or e-mailed while driving a car or other vehicle (on at least 1 day during the 30 days before the survey)	59.3	57.6	=	56.7	54.4	39.2
% of students who were in a physical fight on school property (one or more times during the 12 months before the survey)	8.8	5.4	↓	6.9	6.1	8.5
% of students who were ever physically forced to have sexual intercourse (when they did not want to)	7.7	6.3	=	6.5	7.4	7.4
% of students who were bullied on school property (during the 12 months before the survey)	25.4	24.0	=	27.5	22.4	19.0
% of students who were electronically bullied (includes e-mail, chat rooms, instant messaging, websites, or texting during the 12 months before the survey)	17.1	15.9	=	17.7	15.8	14.9
% of students who made a plan about how they would attempt suicide (during the 12 months before the survey)	13.5	13.5	=	12.8	13.7	13.6
Tobacco, Alcohol, and Other Drug Use						
% of students who currently use an electronic vapor product (e-cigarettes, vape e-cigars, e-pipes, vape pipes, vaping pens, e-hookahs, and hookah pens at least 1 day during the 30 days before the survey)	NA	22.3	↑	19.7	22.8	13.2
% of students who currently used cigarettes, cigars, or smokeless tobacco (on at least 1 day during the 30 days before the survey)	27.5	20.9	↓	22.9	19.8	14.0
% of students who drank five or more drinks of alcohol in a row (within a couple of hours on at least 1 day during the 30 days before the survey)	21.9	17.6	↓	19.8	17.0	13.5
% of students who currently used marijuana (one or more times during the 30 days before the survey)	15.9	15.2	=	13.2	17.1	19.8
% of students who ever took prescription drugs without a doctor's prescription (such as OxyContin, Percocet, Vicodin, codeine, Adderall, Ritalin, or Xanax, one or more times during their life)	17.6	14.5	↓	13.2	16.0	14.0

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Weight Management, Dietary Behaviors, and Physical Activity						
% of students who were overweight (>= 85th percentile but <95th percentile for body mass index)	15.1	14.7	=	15.4	14.6	15.6
% of students who were obese (>= 95th percentile for body mass index)	13.5	14.0	=	16.3	12.9	14.8
% of students who did not eat fruit or drink 100% fruit juices (during the 7 days before the survey)	3.4	3.9	=	4.3	4.1	5.6
% of students who did not eat vegetables (green salad, potatoes [excluding French fries, fried potatoes, or potato chips], carrots, or other vegetables, during the 7 days before the survey)	6.0	4.7	=	4.5	5.2	7.2
% of students who drank a can, bottle, or glass of soda or pop one or more times per day (not including diet soda or diet pop, during the 7 days before the survey)	23.4	18.7	=	21.4	18.0	18.7
% of students who did not drink milk (during the 7 days before the survey)	11.1	13.9	↑	11.6	13.7	26.7
% of students who did not eat breakfast (during the 7 days before the survey)	10.5	11.9	=	10.7	11.8	14.1
% of students who most of the time or always went hungry because there was not enough food in their home (during the 30 days before the survey)	3.1	2.2	=	2.4	2.8	NA
% of students who were physically active at least 60 minutes per day on 5 or more days (doing any kind of physical activity that increased their heart rate and made them breathe hard some of the time during the 7 days before the survey)	50.6	51.3	=	51.7	50.1	46.5
% of students who watched television 3 or more hours per day (on an average school day)	21.0	18.9	=	20.7	18.2	20.7
% of students who played video or computer games or used a computer 3 or more hours per day (for something that was not school work on an average school day)	34.4	38.6	↑	39.4	38.0	43.0
Other						
% of students who ever had sexual intercourse	44.9	38.9	↓	39.3	39.1	39.5
% of students who had 8 or more hours of sleep (on an average school night)	30.0	29.5	=	34.5	28.7	25.4
% of students who brushed their teeth on seven days (during the 7 days before the survey)	71.5	71.0	=	67.8	70.1	NA

Survey Results

As noted previously, 167 community members completed the survey in communities throughout the counties in the SWHS service area. For all questions that contained an "Other" response, all of those direct responses may be found in Appendix D. In some cases, a summary of those comments is additionally included in the report narrative. The "Total respondents" number under each heading indicates the number of people who responded to that particular question.

The survey requested that respondents list their home zip code. While not all respondents provided a zip

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code, 106 did, revealing that the large majority of respondents (86%, N=91) lived in Bowman. These results are shown in Figure 6.

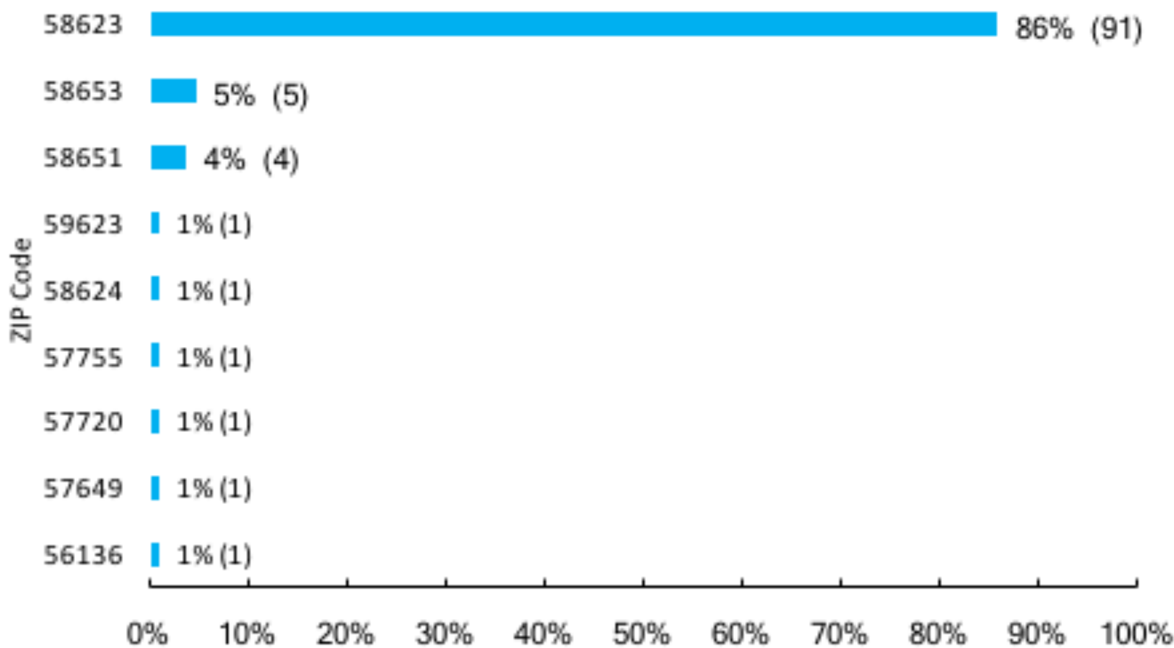

Figure 6: Survey Respondents' Home Zip Code
Total respondents: 106

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

Survey Demographics

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

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

- 41% (N=50) were age 55 or older
- The majority (91%, N=105) were female
- Slightly less than half of the respondents (48%, N=57) had bachelor's degrees or higher
- The number of those working full time (64%, N=75) was more than four times higher than those who were retired (15%, N=18)
- 92% (N=108) of those who reported their ethnicity/race were white/Caucasian
- 15% of the population (N=18) had household incomes of less than $50,000

Figures 7 through 13 show these demographic characteristics. It illustrates the range of community members' household incomes and indicates how this assessment took into account input from parties who represent the varied interests of the community served, including a balance of age ranges, those in diverse work situations, and community members with lower incomes.

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Figure 7: Age Demographics of Survey Respondents
Total respondents = 120

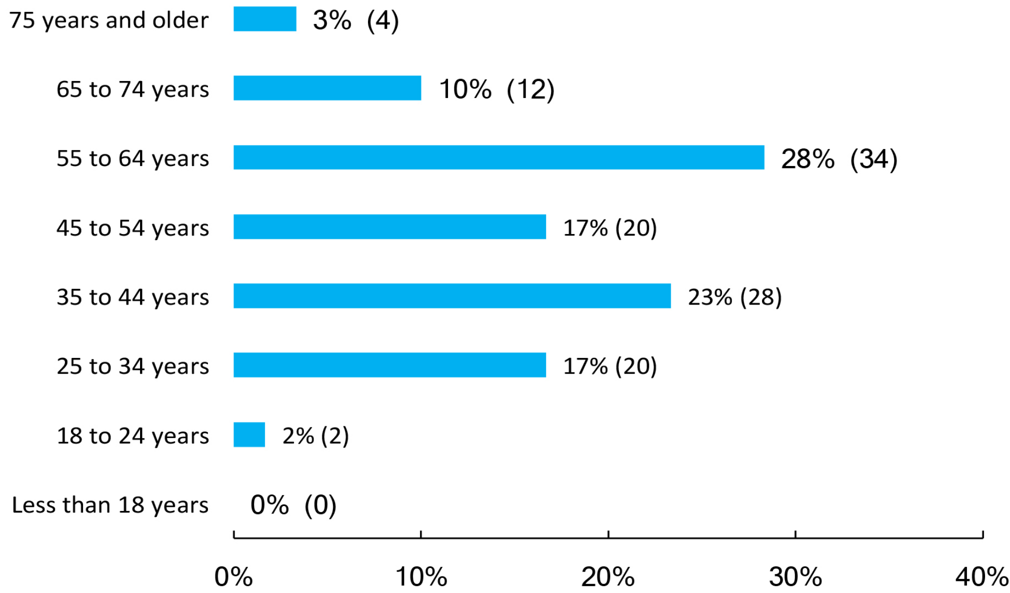
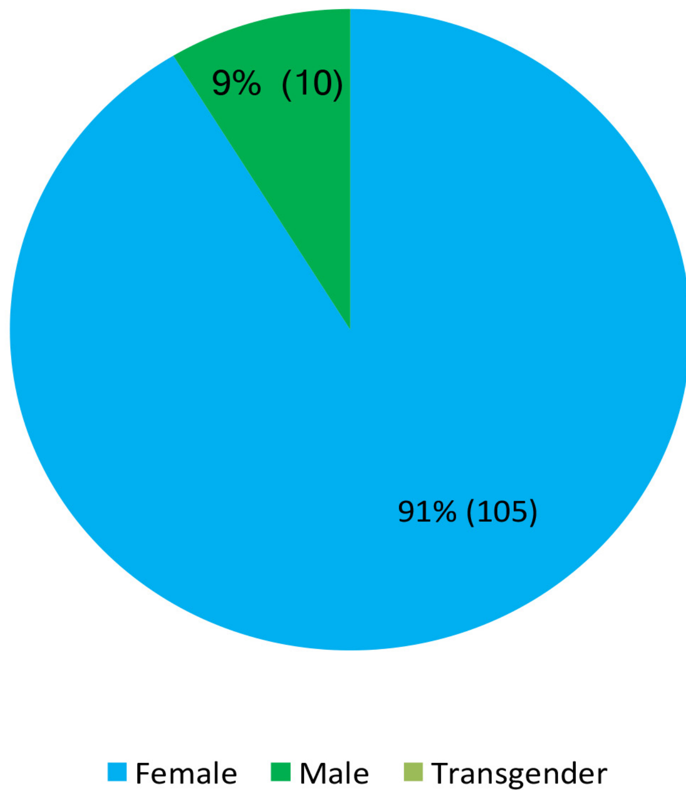


Figure 8: Gender Demographics of Survey Respondents
Total respondents = 115



Female Male Transgender

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Figure 9: Educational Level Demographics of Survey Respondents
Total respondents = 119

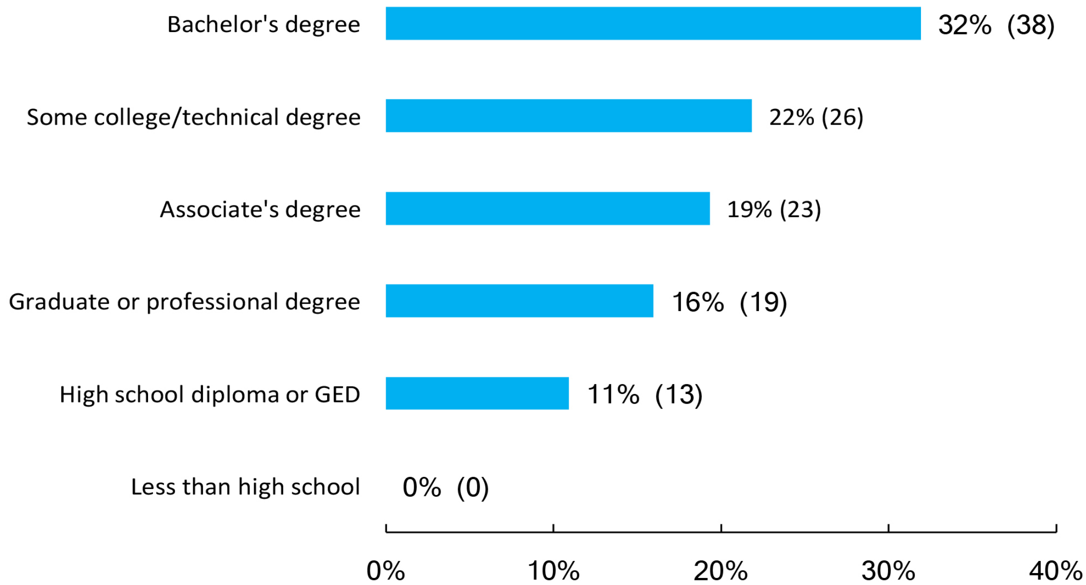
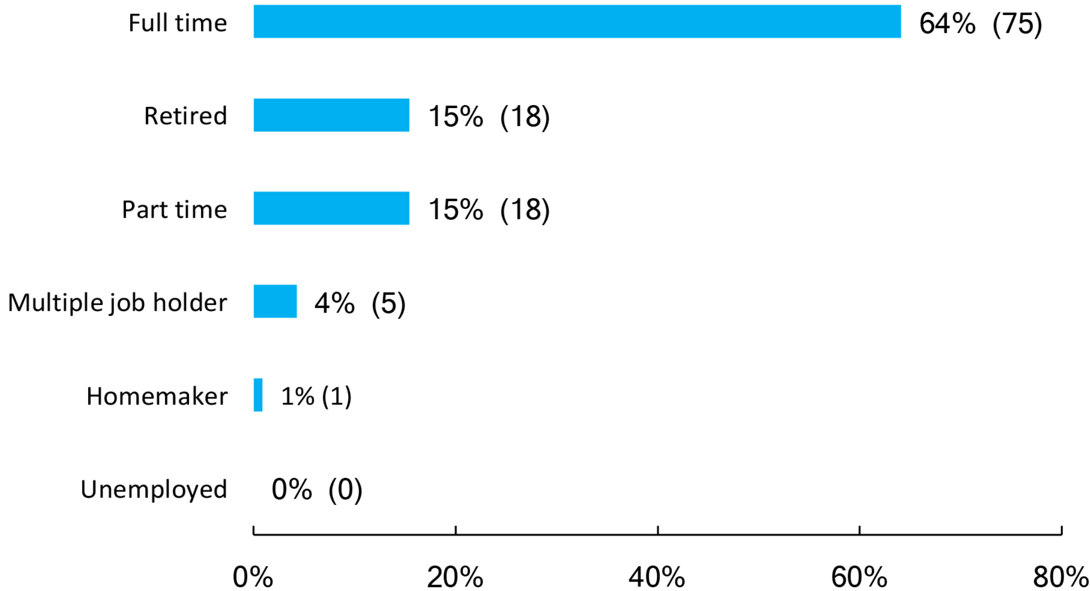


Figure 10: Employment Status Demographics of Survey Respondents
Total respondents = 117



Of those who provided a household income, 1% (N=1) community members reported a household income of less than $25,000. Thirty-five percent (N=441) indicated a household income of $100,000 or more. This information is show in Figure 11.

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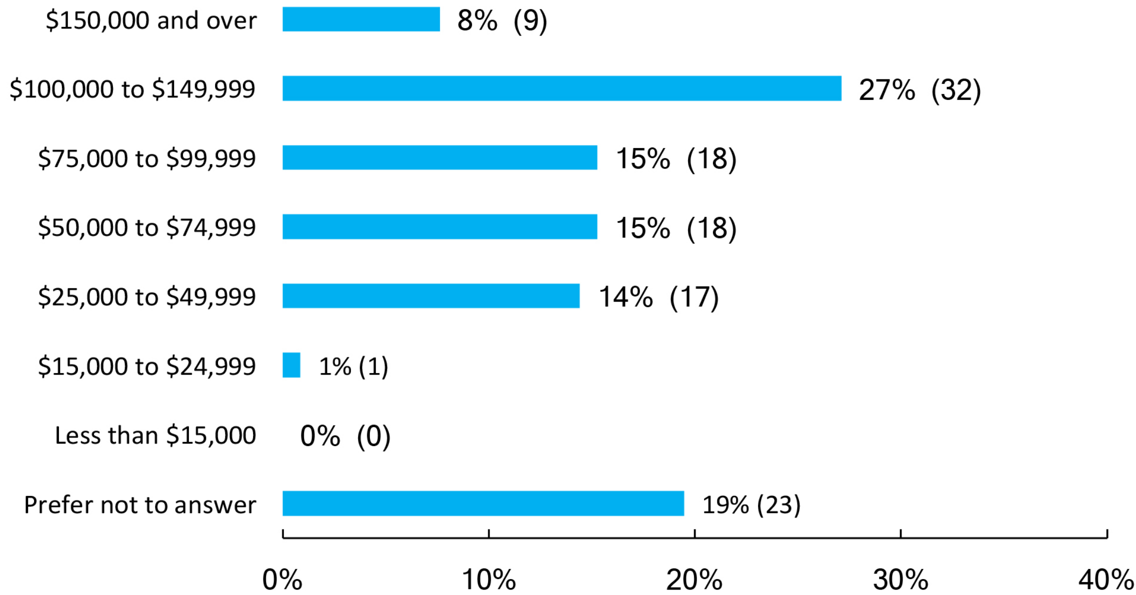
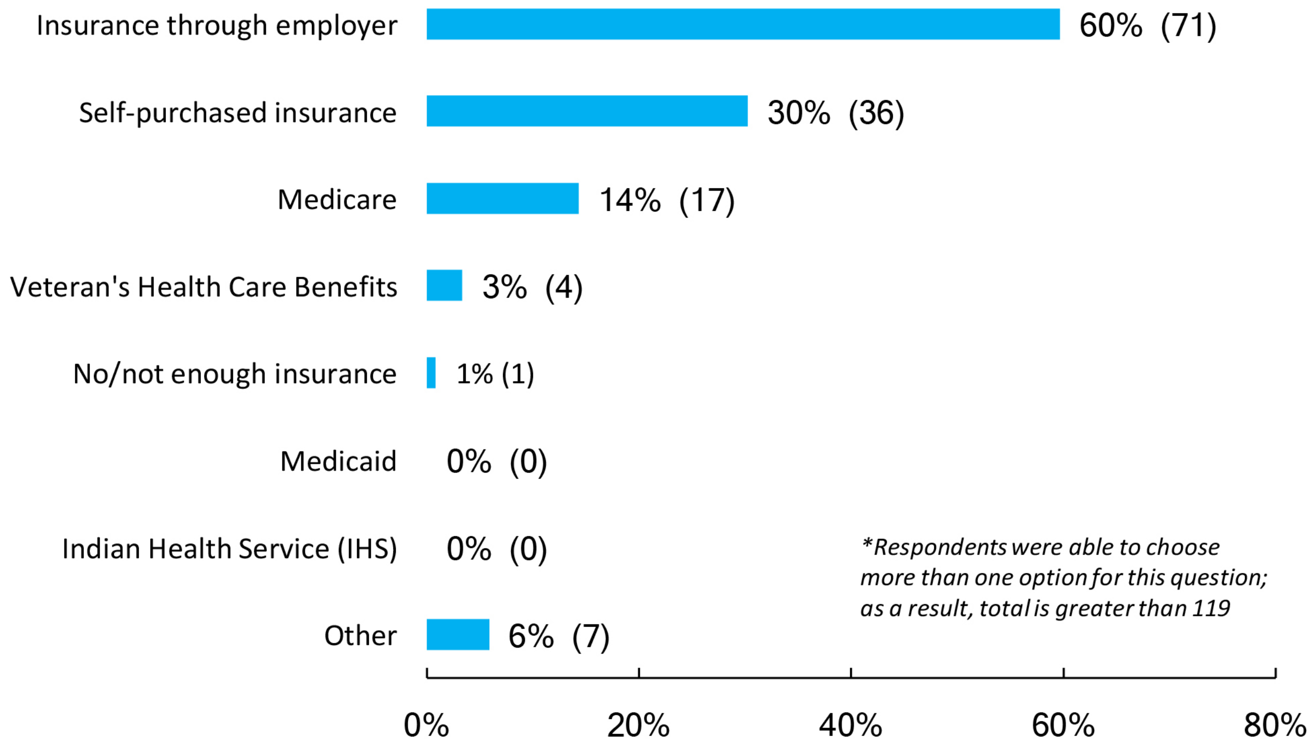
Figure 11: Household Income Demographics of Survey Respondents
Total respondents = 118



Community members were asked about their health insurance status, which is often associated with whether people have access to healthcare. One percent (N=1) of the respondents reported having no health insurance or being under-insured. The most common insurance types were insurance through one's employer (N=71), followed by self-purchased (N=36) and Medicare (N=17).

Figure 12: Health Insurance Coverage Status of Survey Respondents
Total respondents = 119



As shown in Figure 13, nearly all of the respondents were white/Caucasian (92%). This is only slightly lower than the race/ethnicity of the overall population of Bowman County; the U.S. Census indicates that 96.0% of the population is white in the county.

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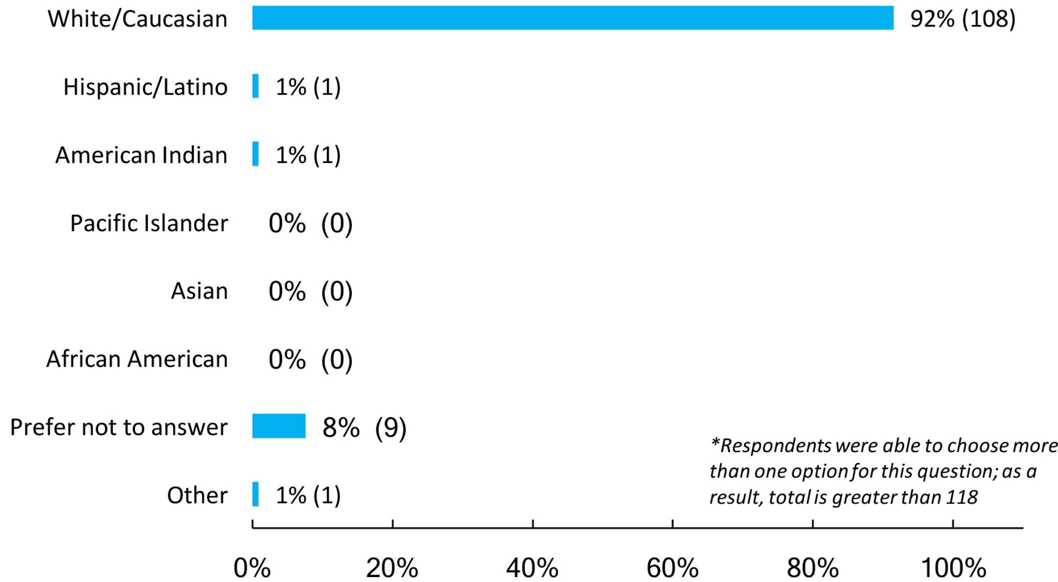
Figure 13: Race/Ethnicity Demographics of Survey Respondents
Total respondents = 118



Community Assets and Challenges

Survey respondents were asked what they perceived as the best things about their community in four categories: people, services and resources, quality of life, and activities. In each category, respondents were given a list of choices and asked to pick the three best things. Respondents occasionally chose less than three or more than three choices within each category. If more than three choices were selected, their responses were not included. The results indicate there is consensus (with at least 95 respondents agreeing) that community assets include:

- People are friendly, helpful and supportive (N=133)
- Family-friendly (N=129)
- Safe place to live, little/no crime (N=118)
- Quality school systems (N=109)
- Year-round access to fitness opportunities (N=98)
- Healthcare (N=95)

Figures 14 to 17 illustrate the results of these questions.

Figure 14: Best Things about the PEOPLE in Your Community
Total responses = 396

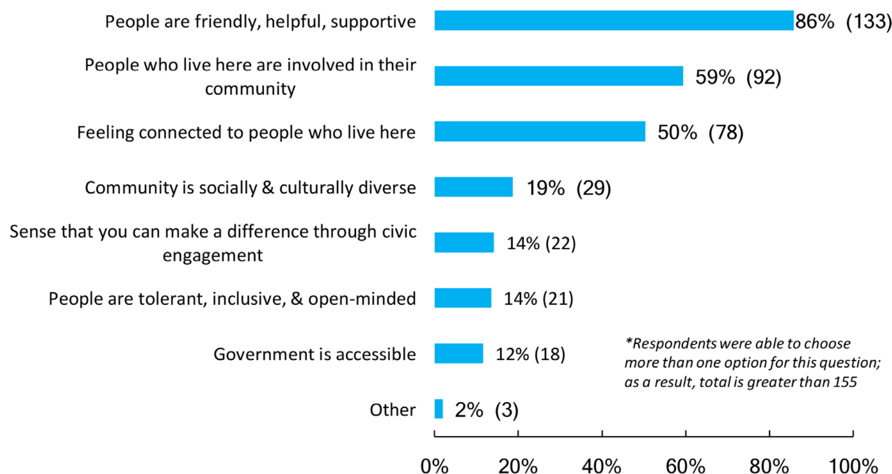


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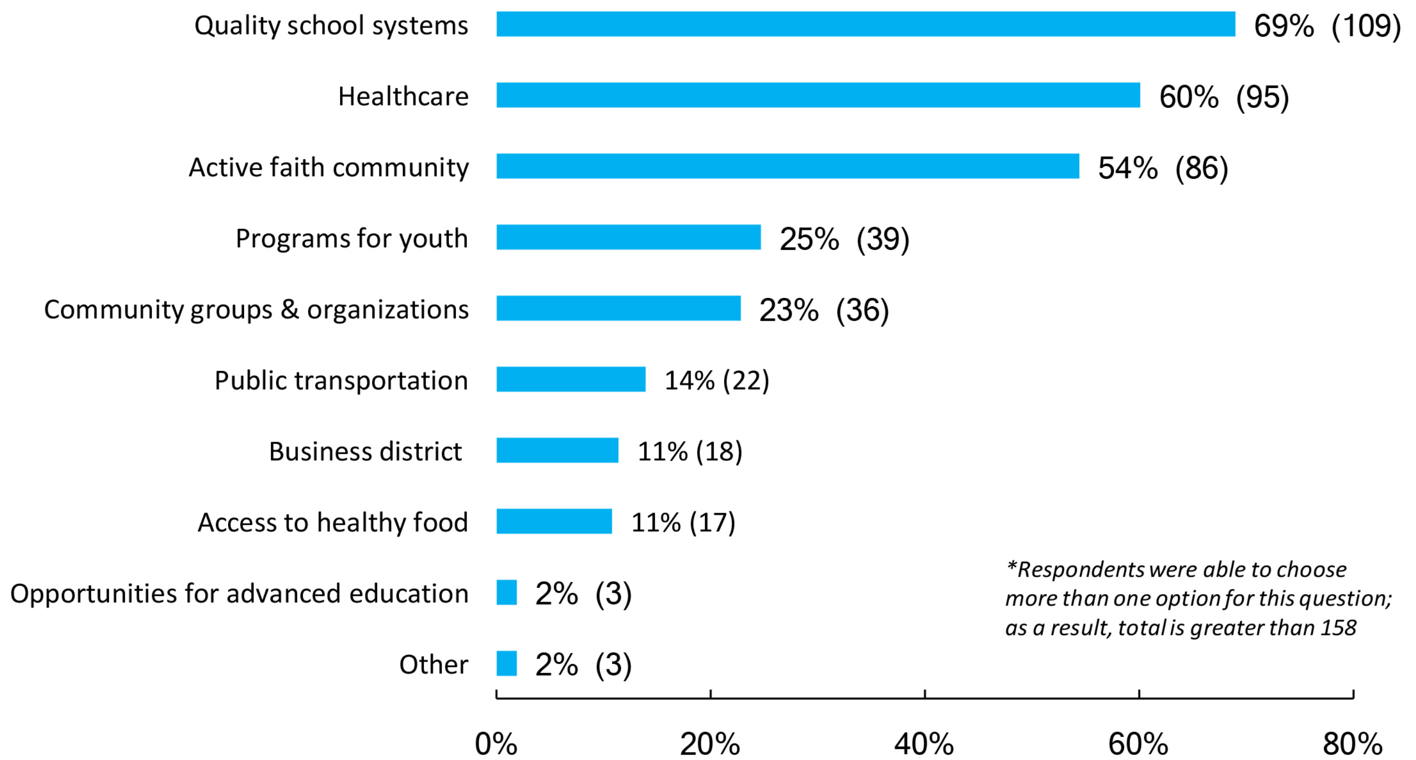
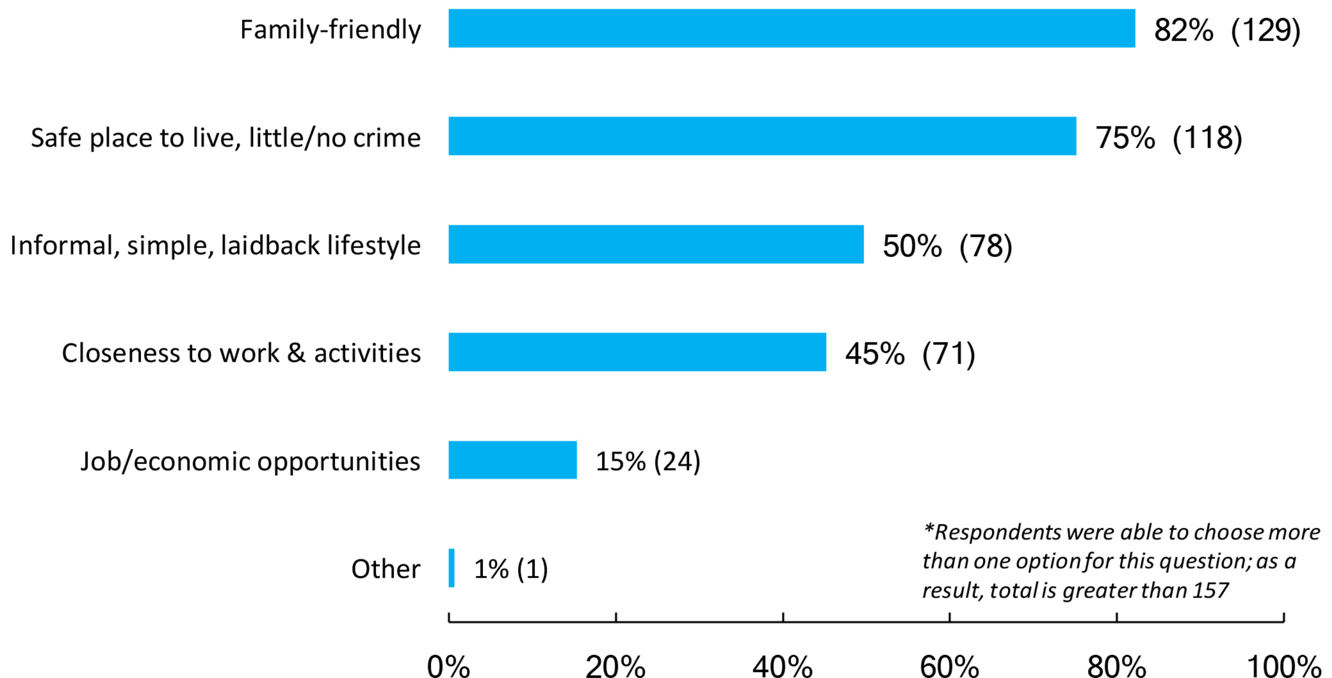
Figure 15: Best Things about the SERVICES AND RESOURCES in Your Community
Total responses = 428



Respondents who selected "Other" specified that the best things about services and resources included affordable healthcare and the public library.

Figure 16: Best Things about the QUALITY OF LIFE in Your Community
Total responses = 421



The one "Other" response regarding the best things about the quality of life in the community was the access to outdoor activities.

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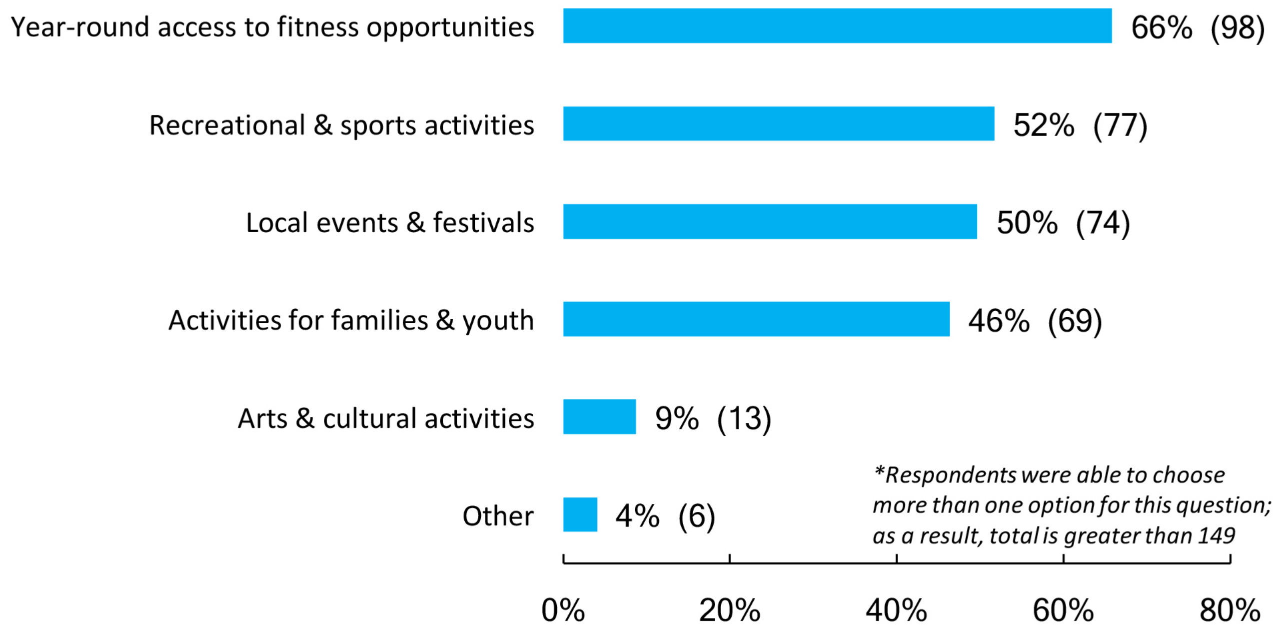
Figure 17: Best Thing about the ACTIVITIES in Your Community
Total responses = 337



Respondents who selected "Other" specified that the best things about the activities in the community included outdoor activities and the library.

Community Concerns

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

- Community/environmental health
- Availability/delivery of health services
- Youth population
- Adult population
- Senior population
- Violence
- Oil and gas development

With regard to responses about community challenges, the most highly voiced concerns (those having at least 50 respondents) were:

- Attracting and retaining young families (N=79)
- Bullying/cyber-bullying (N=77)
- Smoking and tobacco use (second-hand smoke) – Youth (N= 76)
- Alcohol use and abuse – Youth (N=73)
- Ability to retain primary care providers and nurses in the community (N=59)
- Cost of long-term/nursing home care (N=58)
- Availability of resources to help the elderly stay in their homes (N=53)
- Alcohol use and abuse – Adults (N=51)
- Cancer – Adult (N=51)
- Child abuse or neglect (N=51)

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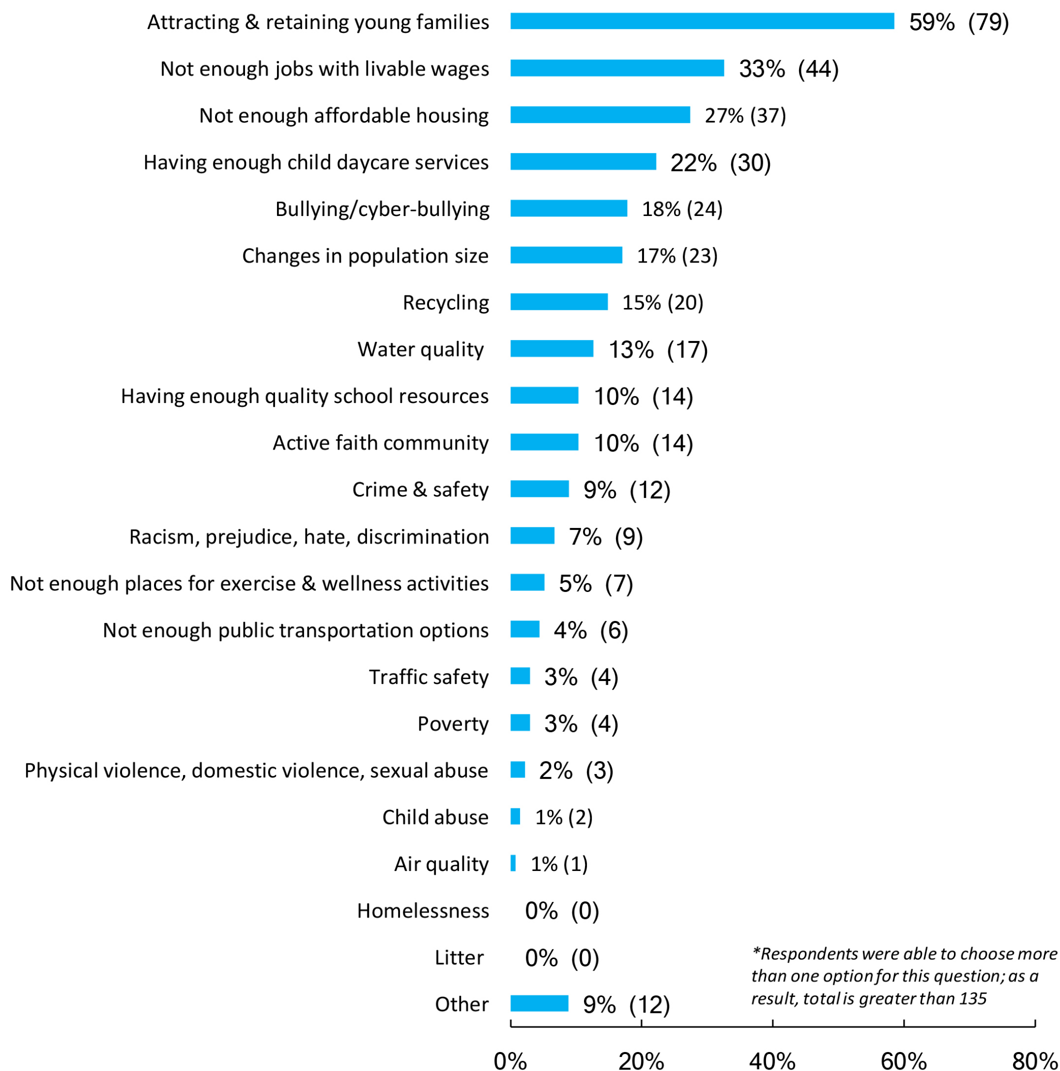
The other issues that had at least 30 votes included:

- Drug use and abuse – Youth (N=49)
- Depression/anxiety – Adults (N=48)
- Depression/anxiety – Youth (N=44)
- Not enough jobs with livable wages (N=44)
- Drug use and abuse – Adults (N=43)
- Cost of health insurance (N=38)
- Not enough affordable housing (N=37)
- Availability of mental health services (N=34)
- Stress – Adults (32)
- Dementia/Alzheimer's disease – Adults (31)
- Ability to meet the needs of the older population (N=31)
- Having enough child daycare services (N=30)

Figures 18 through 24 illustrate these results.

Figure 18: Community/Environmental Health Concerns
Total responses = 362



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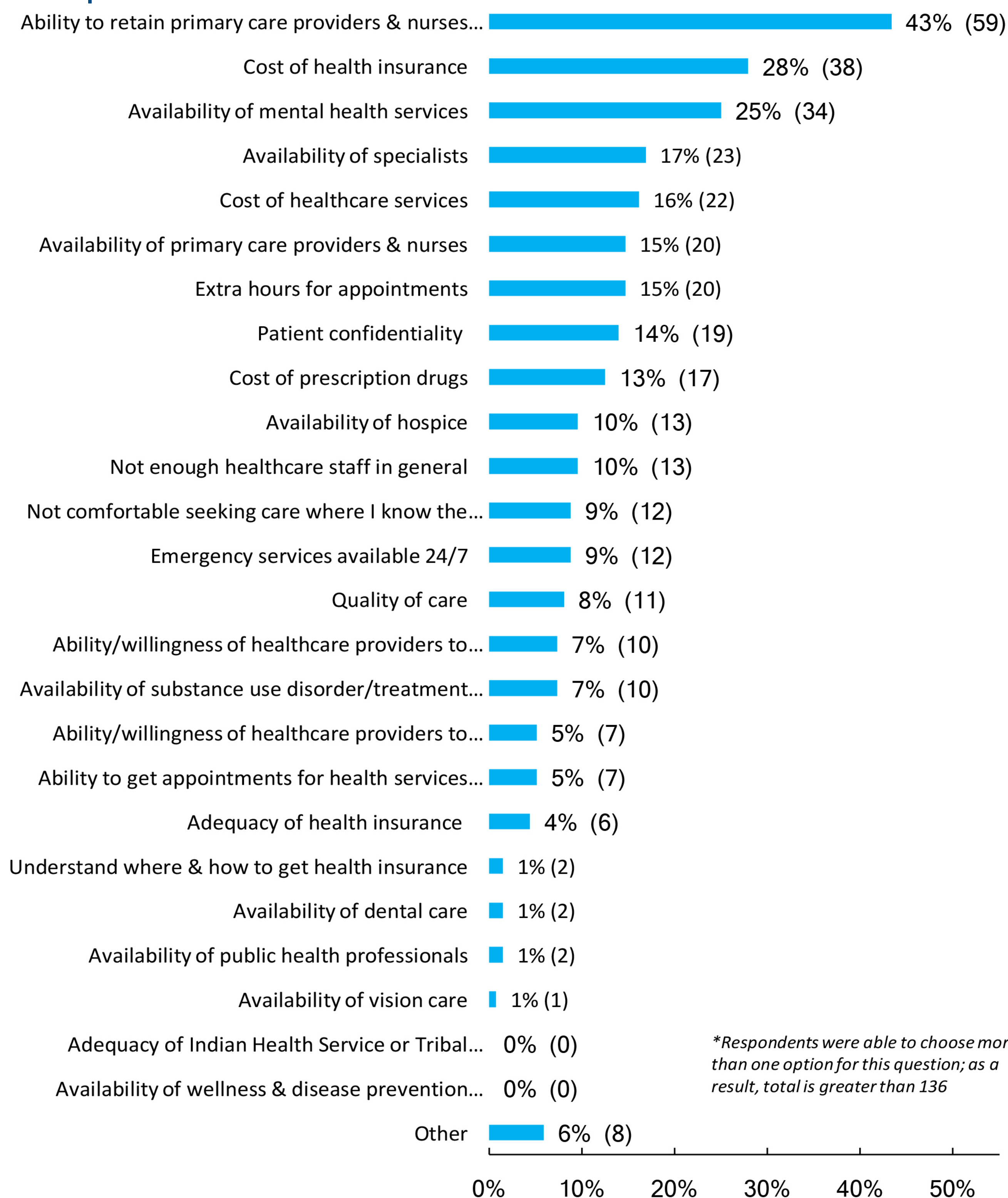
In the “Other” category for community and environmental health concerns, the following were listed: dining options, drug traffic concerns, the need for better shopping services, not enough access to mental health services, and lack of activities for senior citizens.

Figure 19: Availability/Delivery of Health Services Concerns
Total responses = 368



Respondents who selected “Other” identified concerns in the availability/delivery of health services as bedside manner of MDs and overall quality of providers, dementia support, and cost of services.

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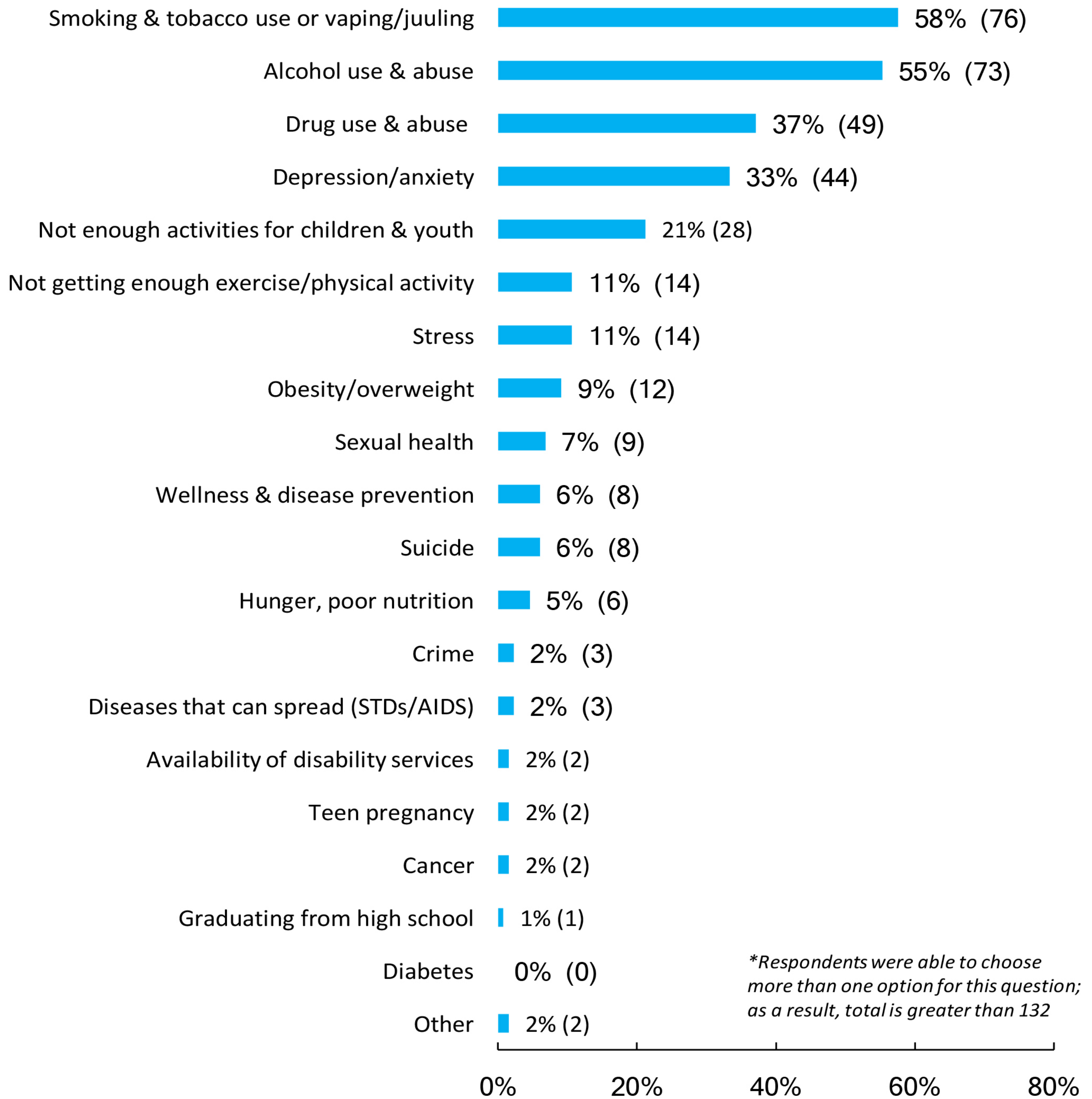
Figure 20: Youth Population Health Concerns
Total responses = 356



Listed in the "Other" category for youth population concerns were addiction to phones and gaming.

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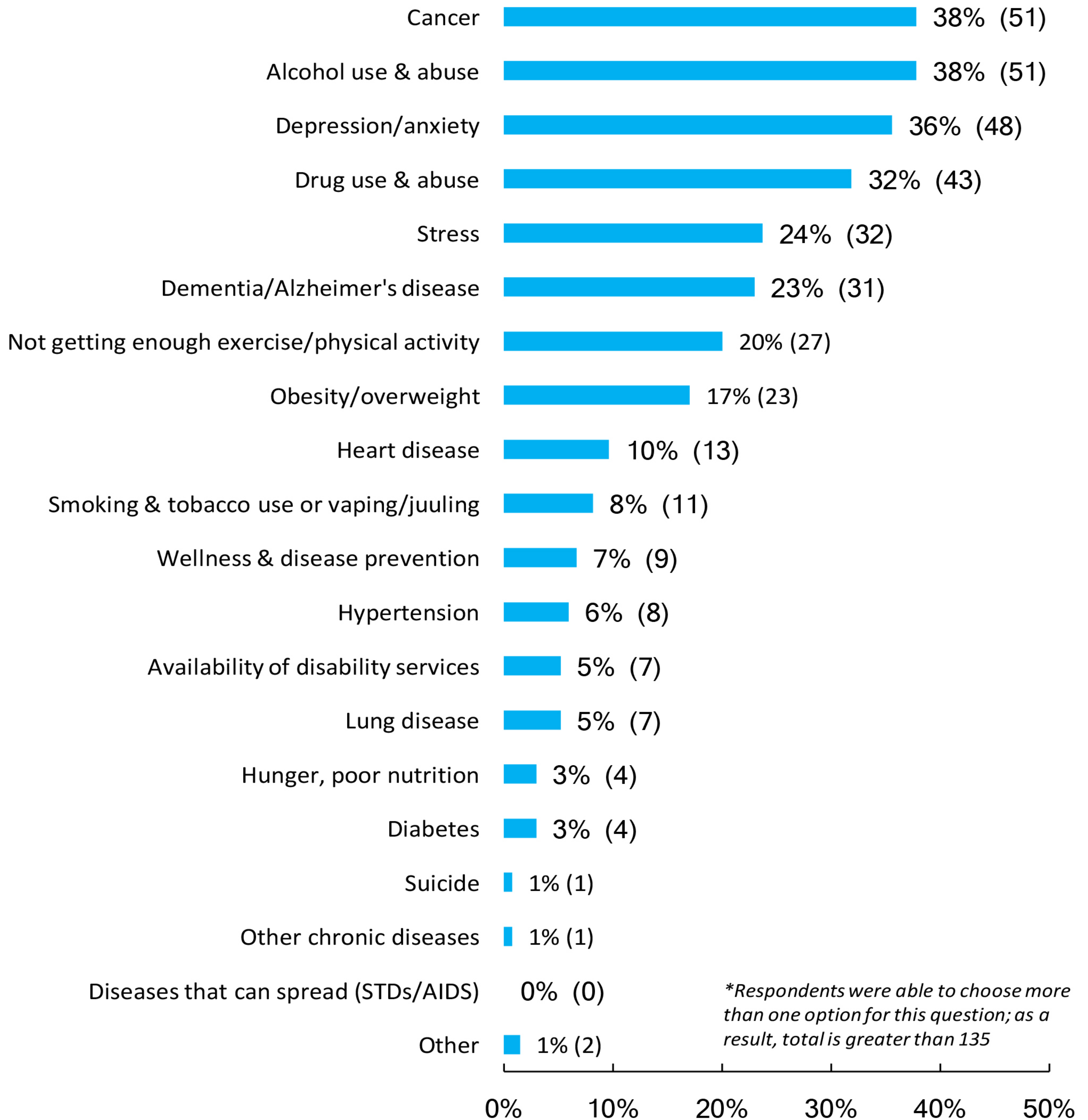
Figure 21: Adult Population Concerns
Total responses = 373



Meals for shut-ins and lack of providers specifically for mental health services were indicated in the "Other" category for adult population concerns.

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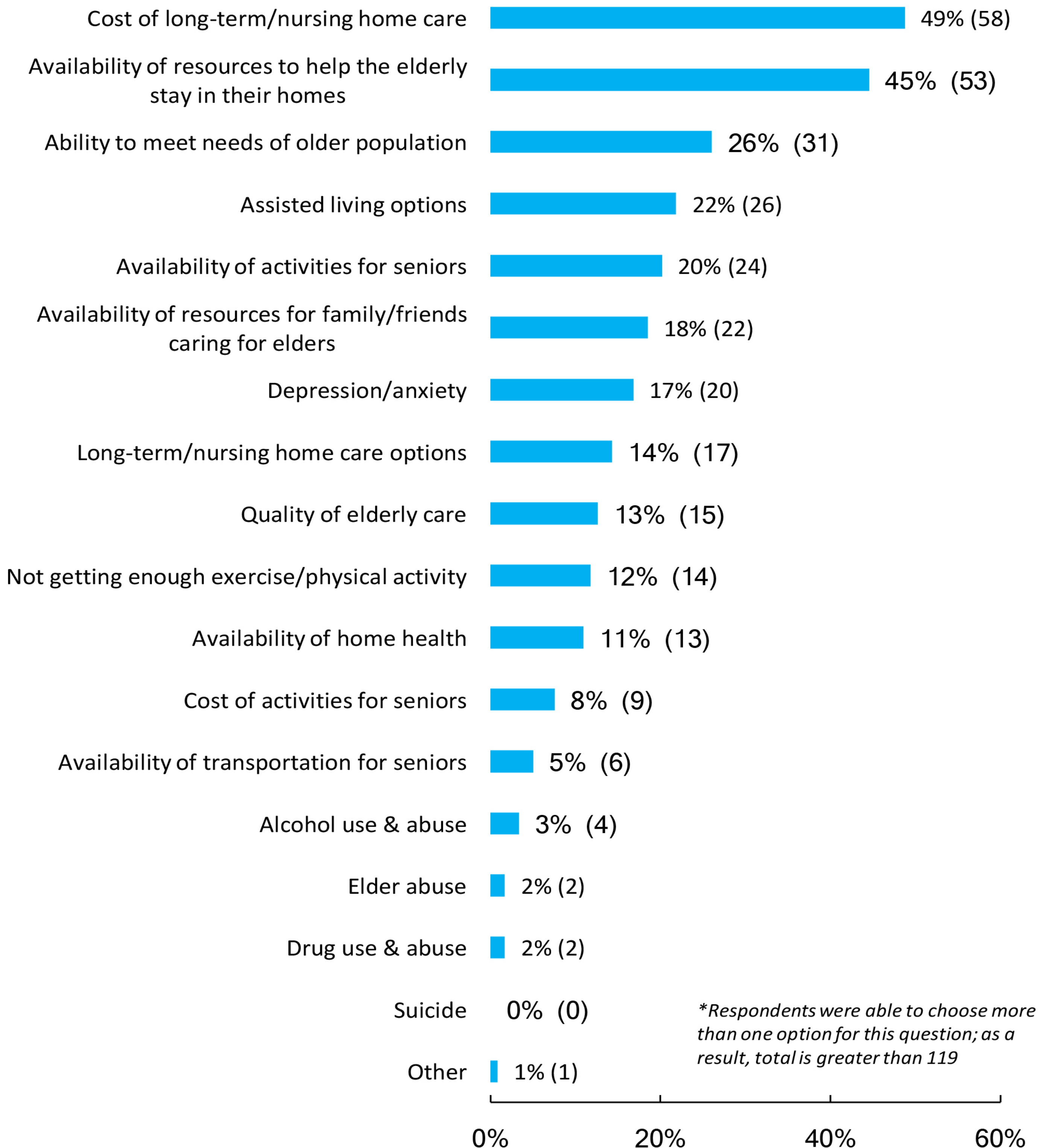
Figure 22: Senior Population Concerns
Total responses = 317



In the "Other" category, the one concern listed was the need for dementia care.

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Figure 23: Violence Concerns
Total responses = 234

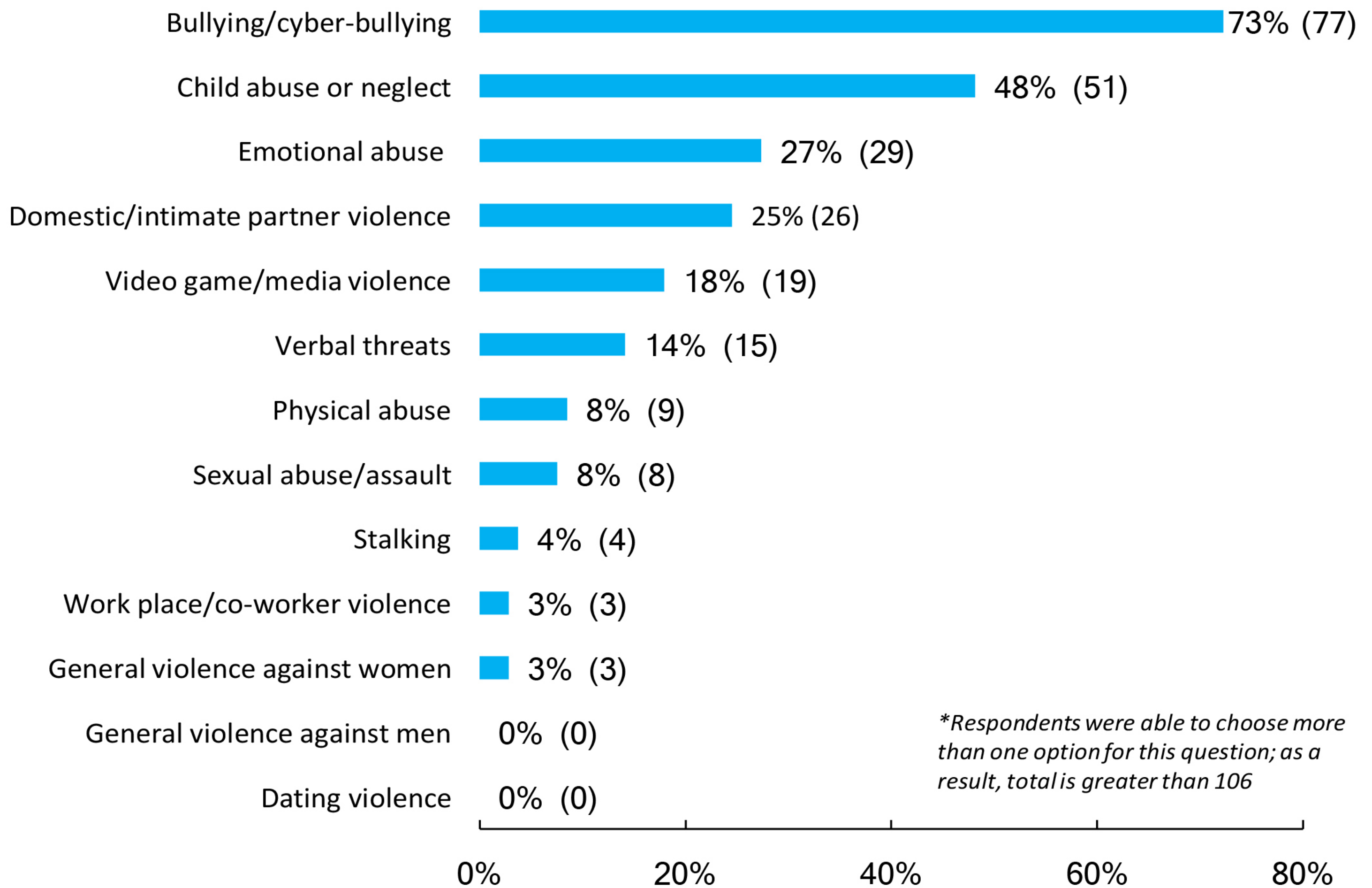

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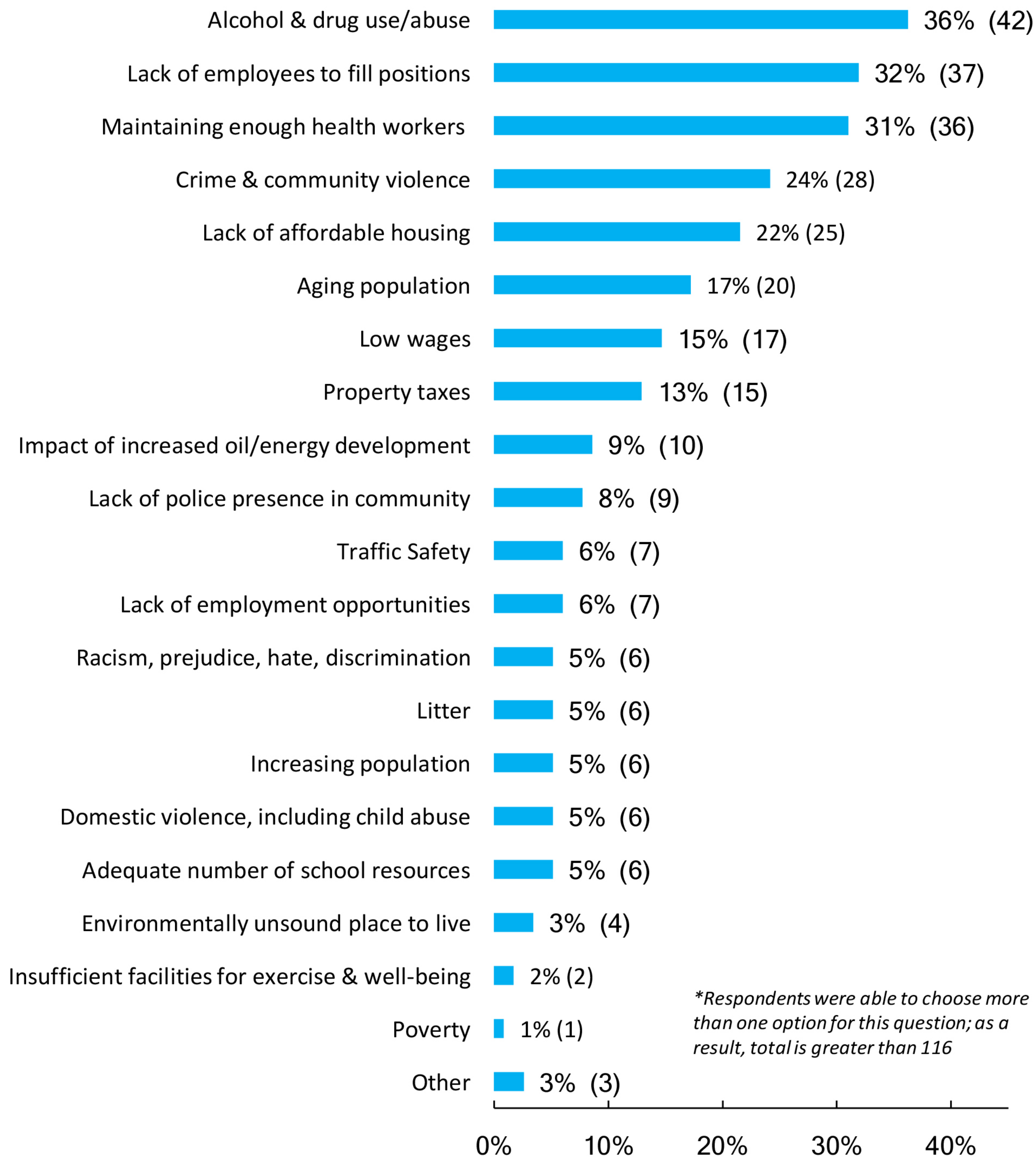
Figure 24: Oil and Gas Development Concerns
Total responses = 317



Some of the "Other" comments included in oil and gas development concerns were a lack of proactive law enforcement and messy yards.

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

1. Lack of being able to retain/bring in new businesses, particularly dining establishments
2. Being able to recruit and retain good healthcare employees

Other biggest challenges that were identified were finding enough employees to keep businesses going, lack of affordable housing, close-mindedness of community members, and drug usage.

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Delivery of Healthcare

With options under several categories, respondents were asked about their awareness and/or utilization of services provided by SWHC (seen in Figures 25-27).

Figure 25: Awareness and Utilization of General and Acute Services
Total responses = 663

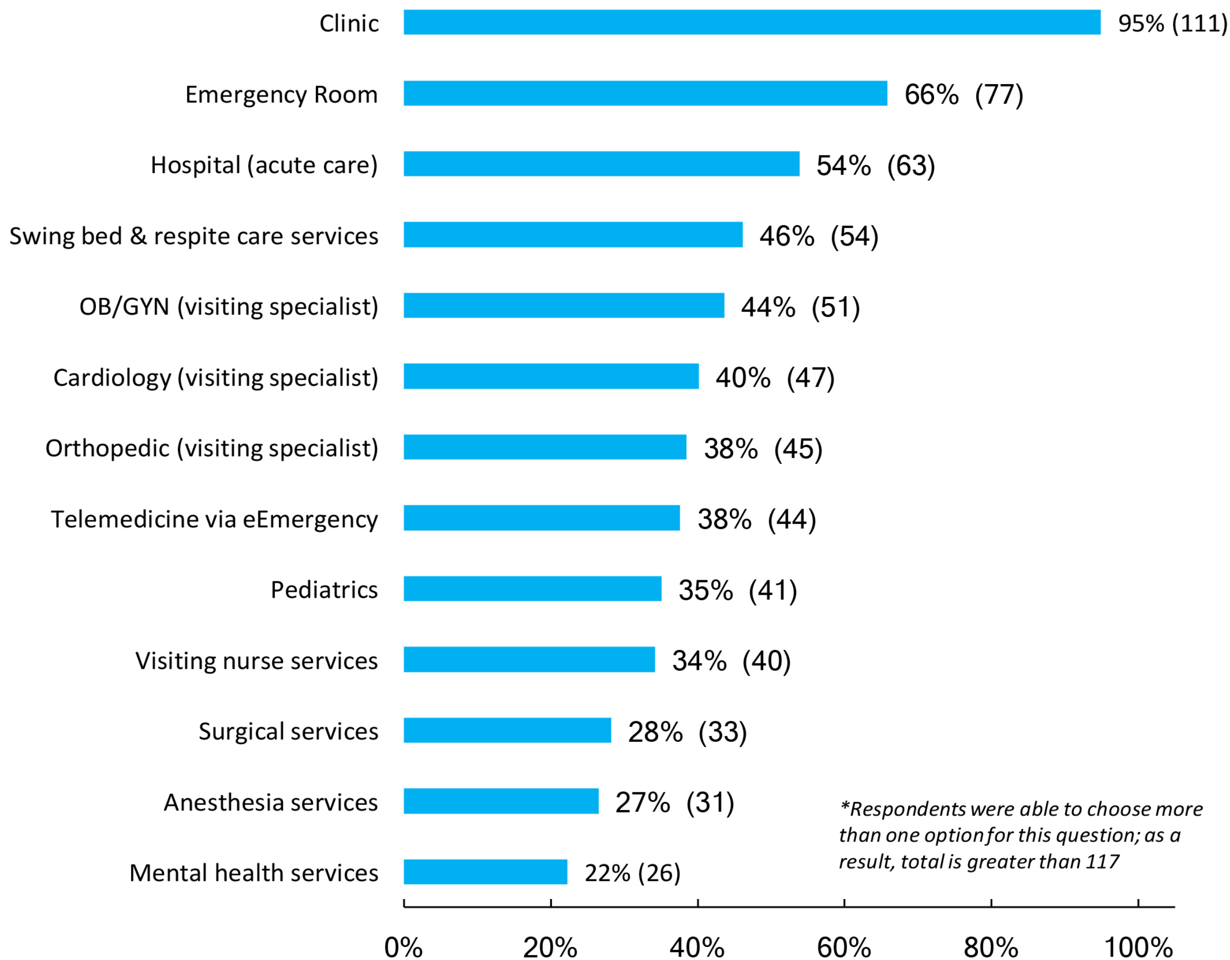

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Figure 26: Awareness and Utilization of Screening/Therapy Services
Total responses = 630

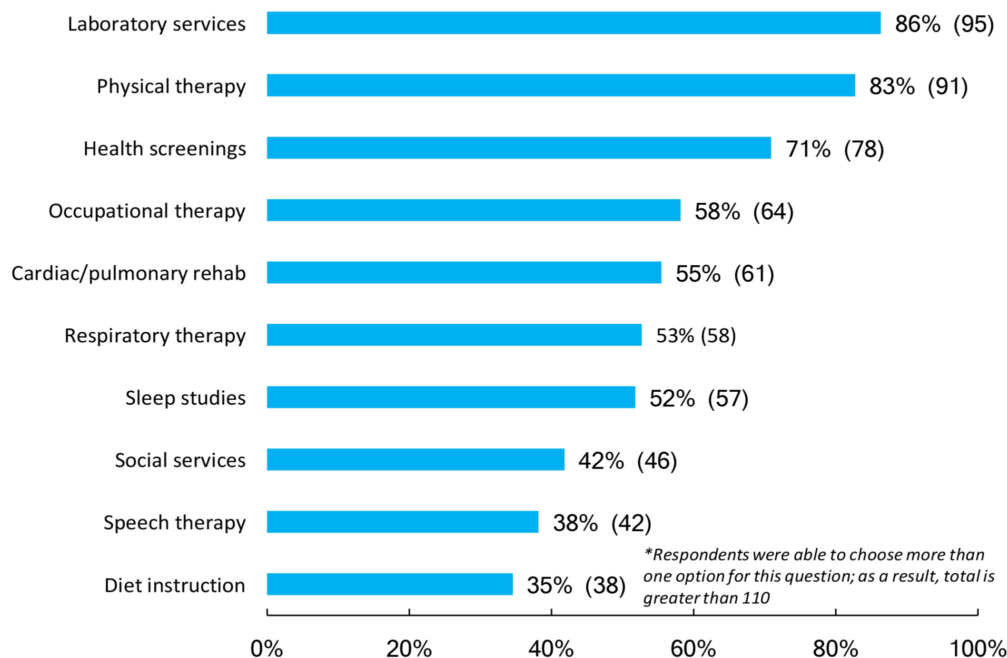
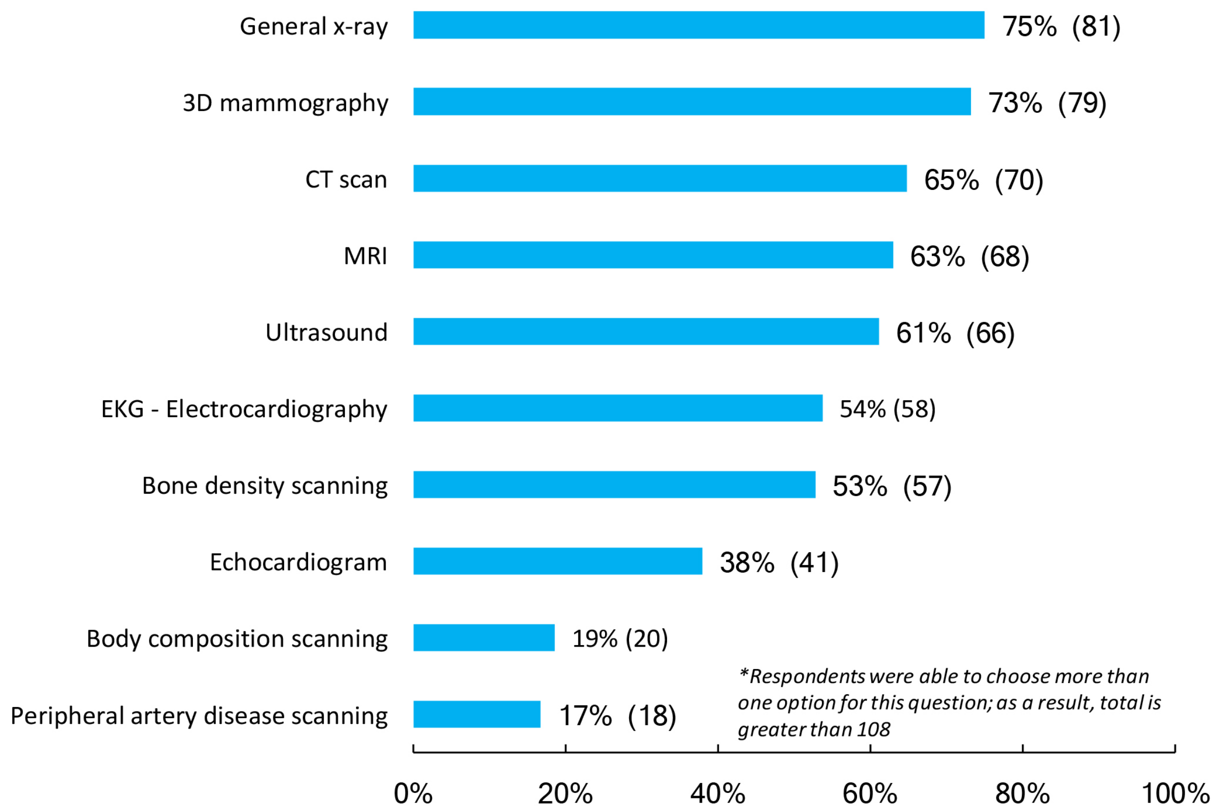


Figure 27: Awareness and Utilization of Radiology Services
Total responses = 558



Considering a variety of healthcare services offered by Southwestern District Health Unit, respondents were asked to indicate if they were aware that the healthcare service is offered though SWDHU and to also indicate what, if any, services they or a family member have used at SWDHU in the past year. The same question was presented about other providers/organizations (See Figures 28 and 29).

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Figure 28: Awareness and Utilization of Public Health Services
Total responses = 267

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Figure 29: Awareness and Utilization of Other Providers/Organizations
Total responses = 401

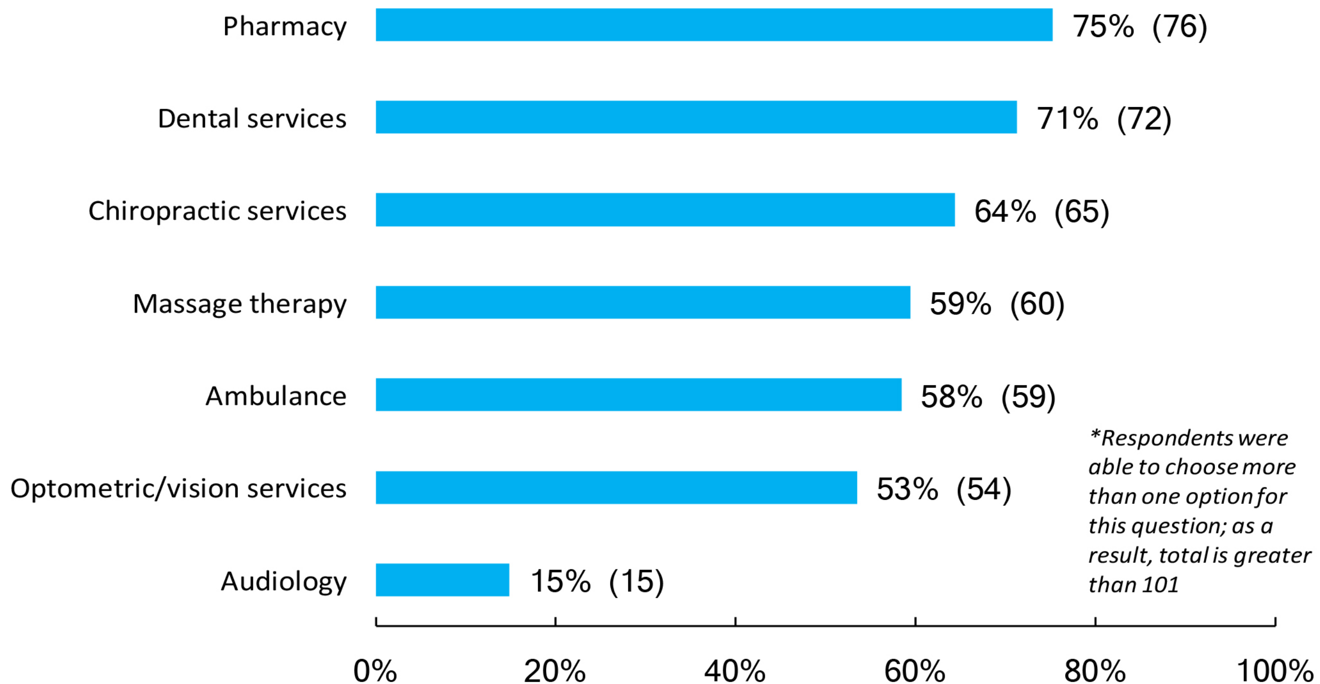
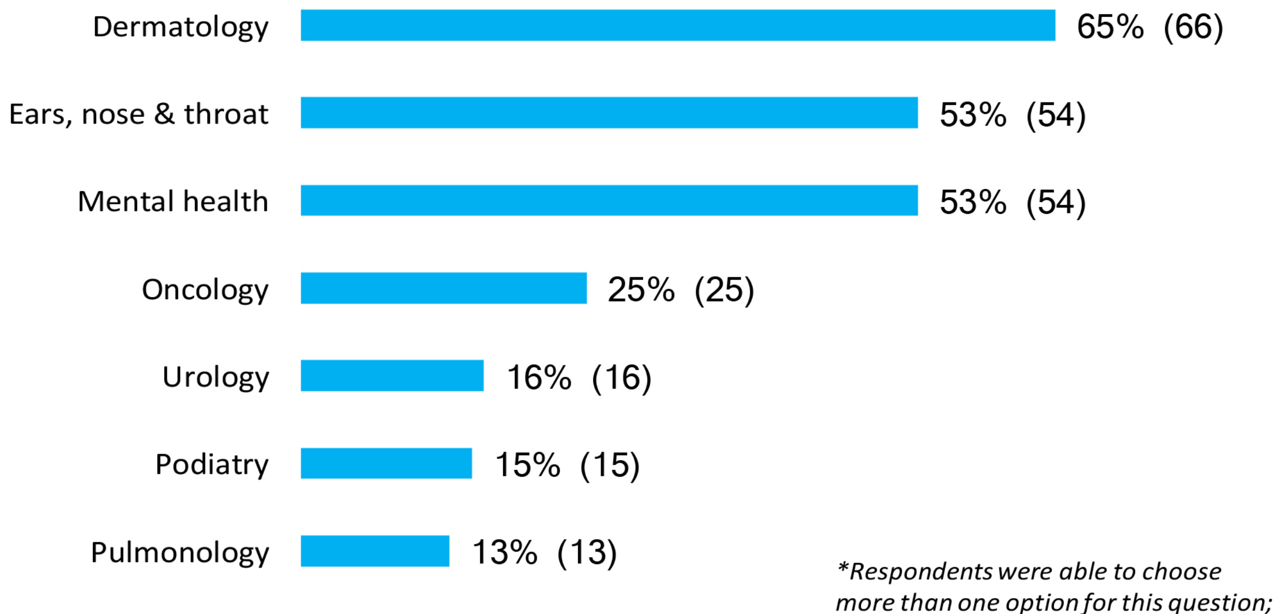


Figure 30 shows results from the respondents about what services they would like to see added.

Figure 30: Desired Services in the Community
Total responses = 252



Included in the "Other" category for desired services were colonoscopies, more massage therapy, neurology and OB/GYN.

Figures 31 and 32 show the results of being asked if community members are aware of SWHS's clinic hours and if they would utilize extended hours for the clinic.

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Figure 31: Awareness of Clinic Hours
Total responses = 119

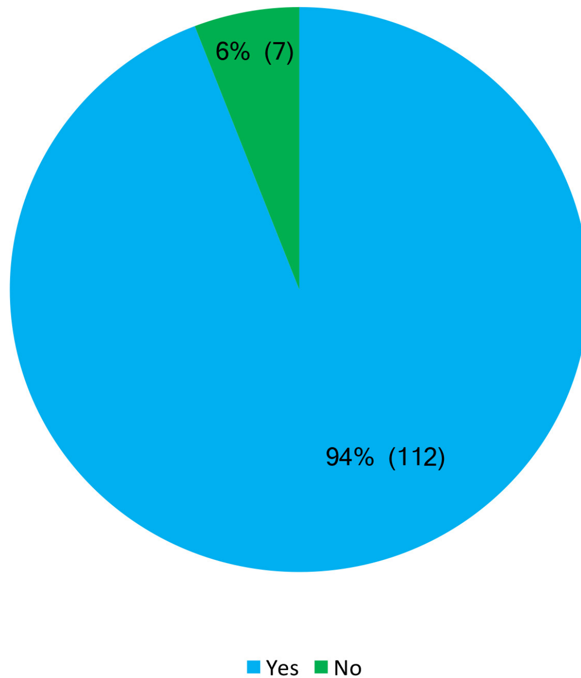
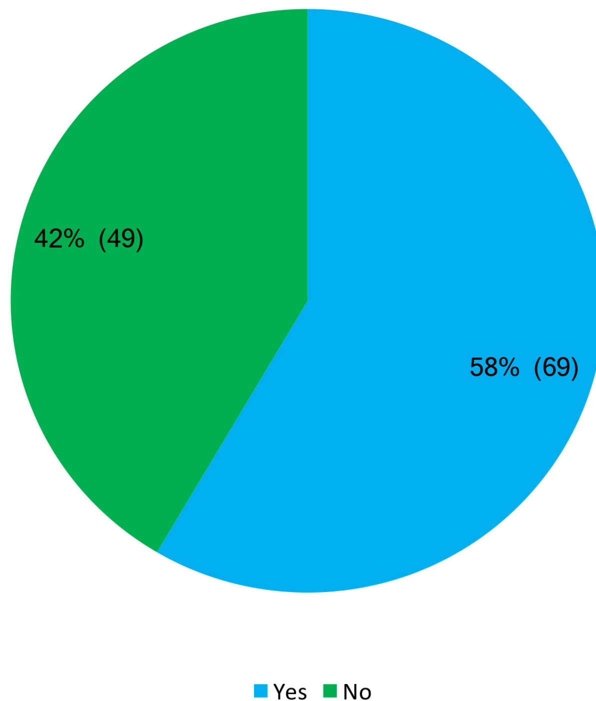


Figure 32: Utilization of Extended Clinic Hours
Total responses = 119



The survey asked residents what they see as barriers that prevent them, or other community residents, from receiving healthcare. The most prevalent barrier perceived by residents was not being able to see the same provider over time (N=57), with the next highest being no or limited insurance (N=54). After these, the next most commonly identified barriers were not having enough providers (N=39), not enough specialists (N=38), and being unaware of local services (N=36). Some of the concerns indicated in the "Other" category were in regards to provider attitudes towards patients being subpar, billing issues, and not enough advertising for specialty services. Figure 33 illustrates these results.

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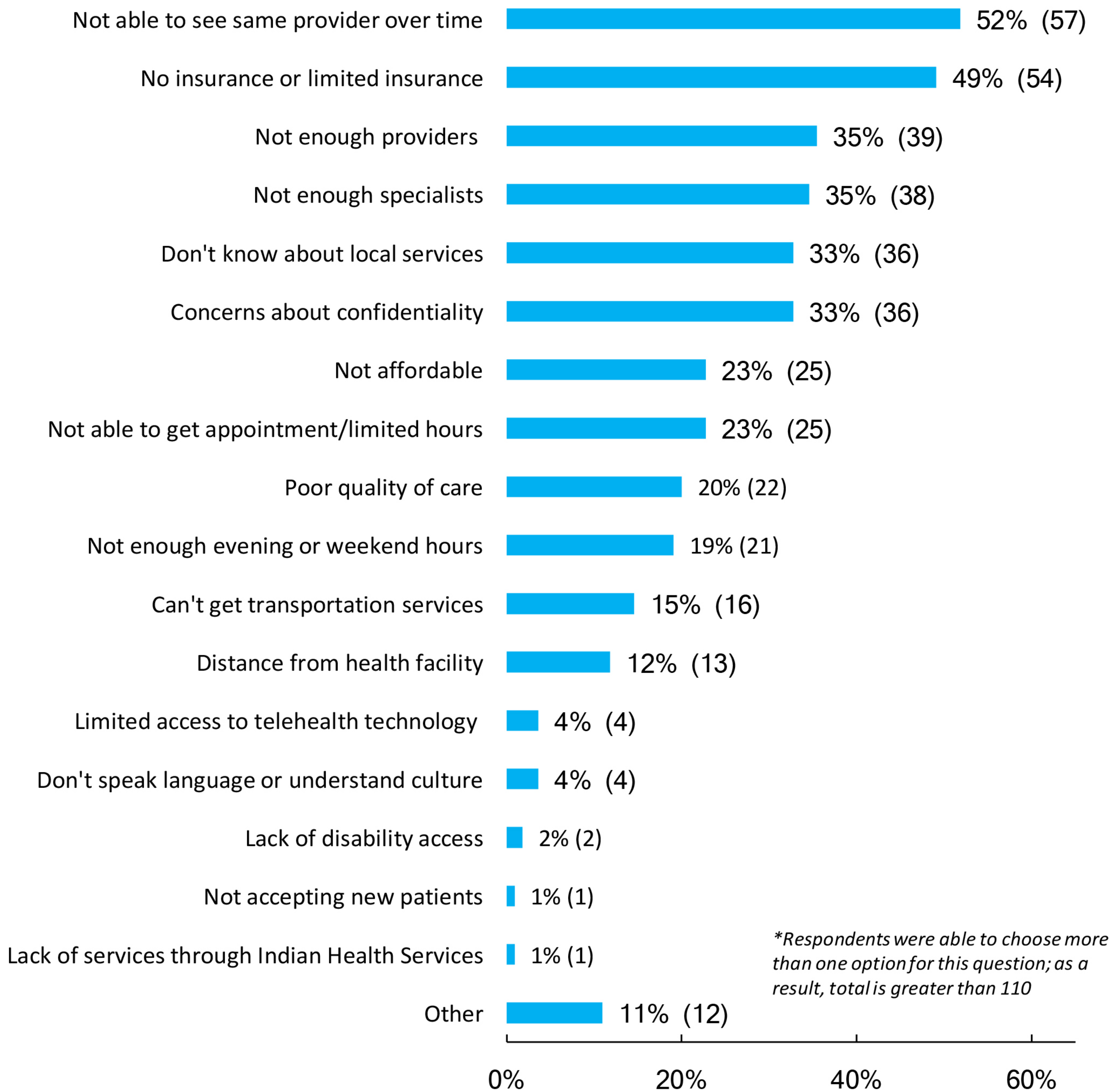

Residents were also asked what they perceive as barriers to receiving healthcare specifically in the local area, with not enough providers (N=51), concerns about confidentiality (N=45), and no evening or weekend hours (N=38) being the top answers (Figure 34).

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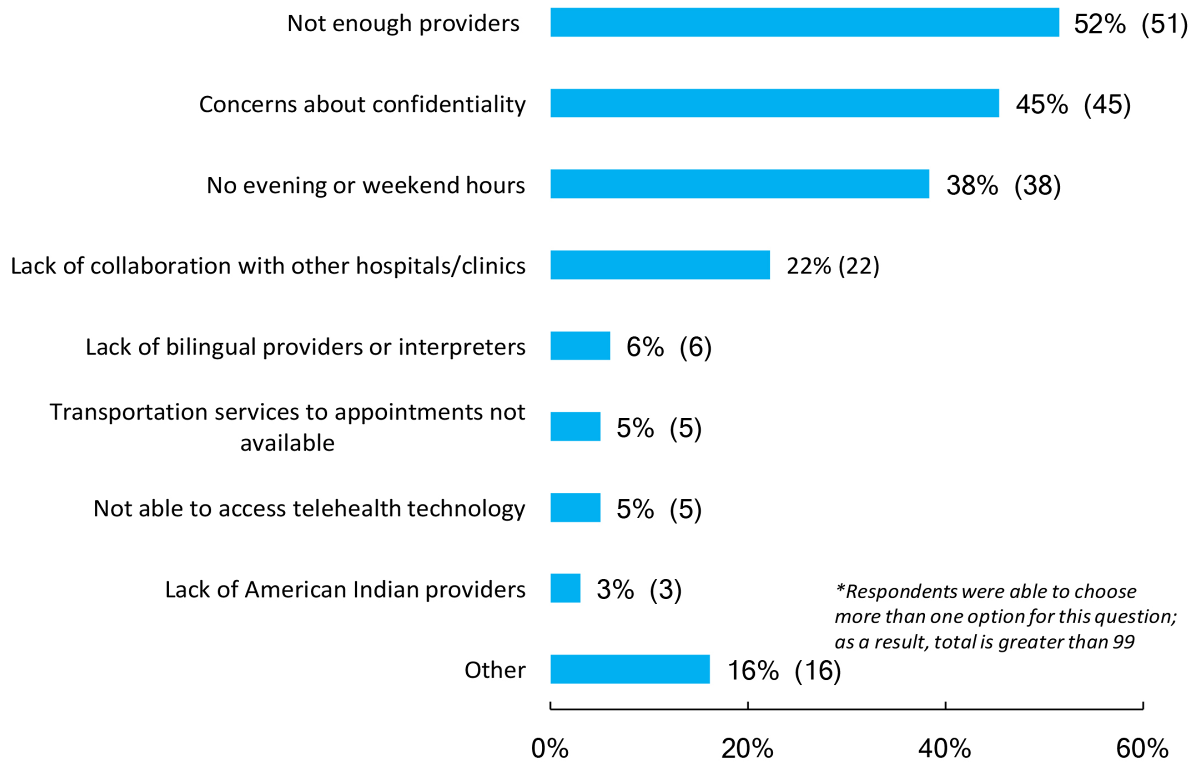
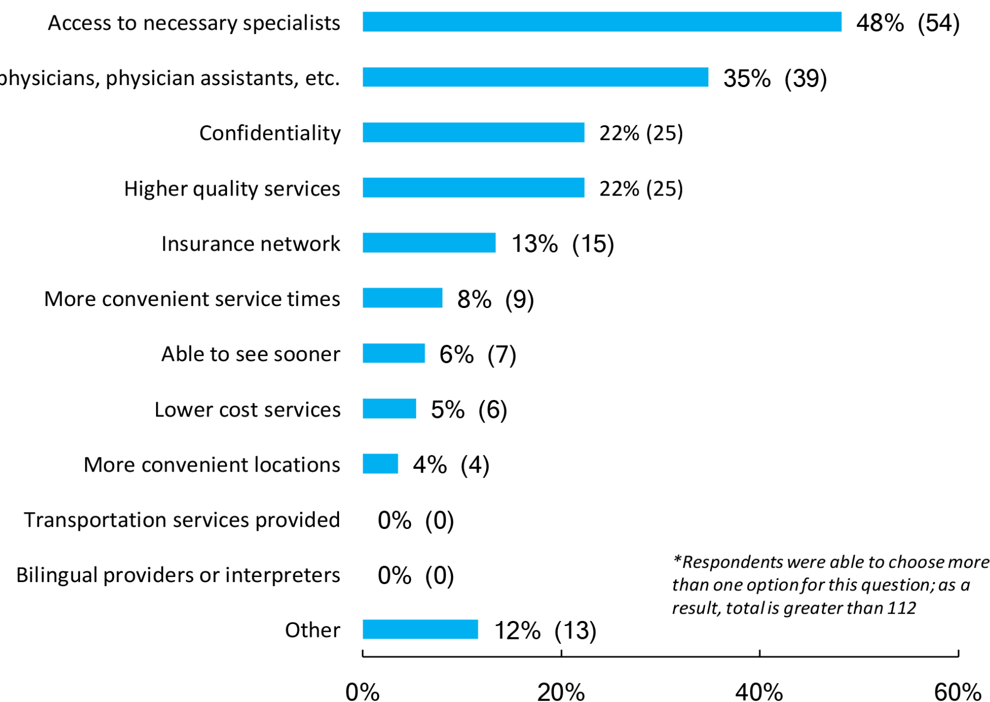
Figure 34: Barriers to Receiving Care Locally
Total responses = 175



Inability to see the same provider, long wait times, concerns over bedside manner and not having enough specialists were some of the "Other" responses.

In Figure 35, results are shown from community members being asked why they choose to receive care specifically outside of the local community.

Figure 35: Reasons for Seeking Care Outside the Community
Total responses = 175



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Similar to the questions about perceived barriers to receiving healthcare, the "Other" category yielded responses such as billing problems and issues with providers.

Respondents were asked where they go to for trusted health information. Primary care providers (N=97) received the highest response rate, followed by other healthcare professionals (N=63), and then web/Internet searches (N=47). The two "Other" responses were self-healthcare schooling and specialists.

Results are shown in Figure 36.

Figure 36: Sources of Trusted Health Information
Total responses = 247

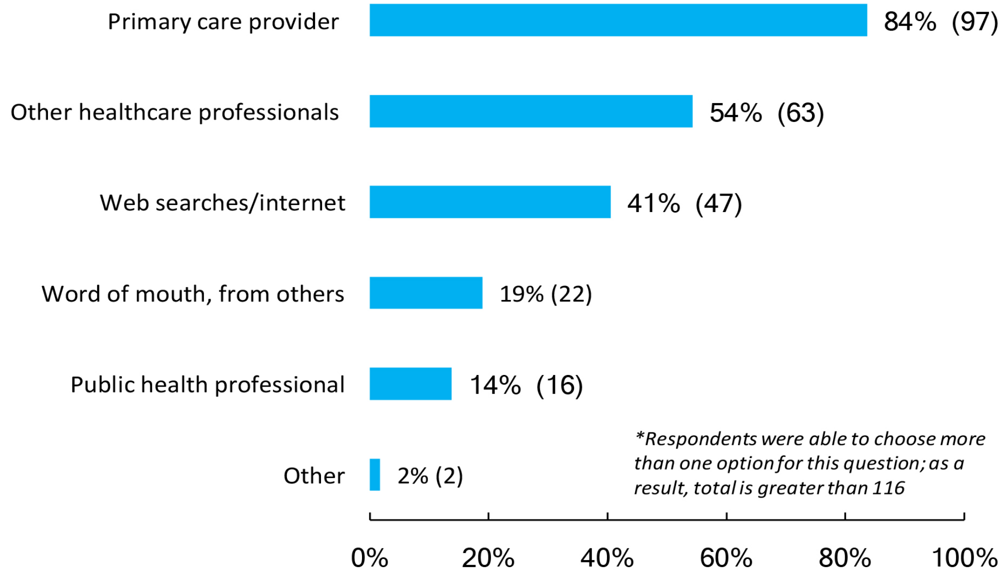
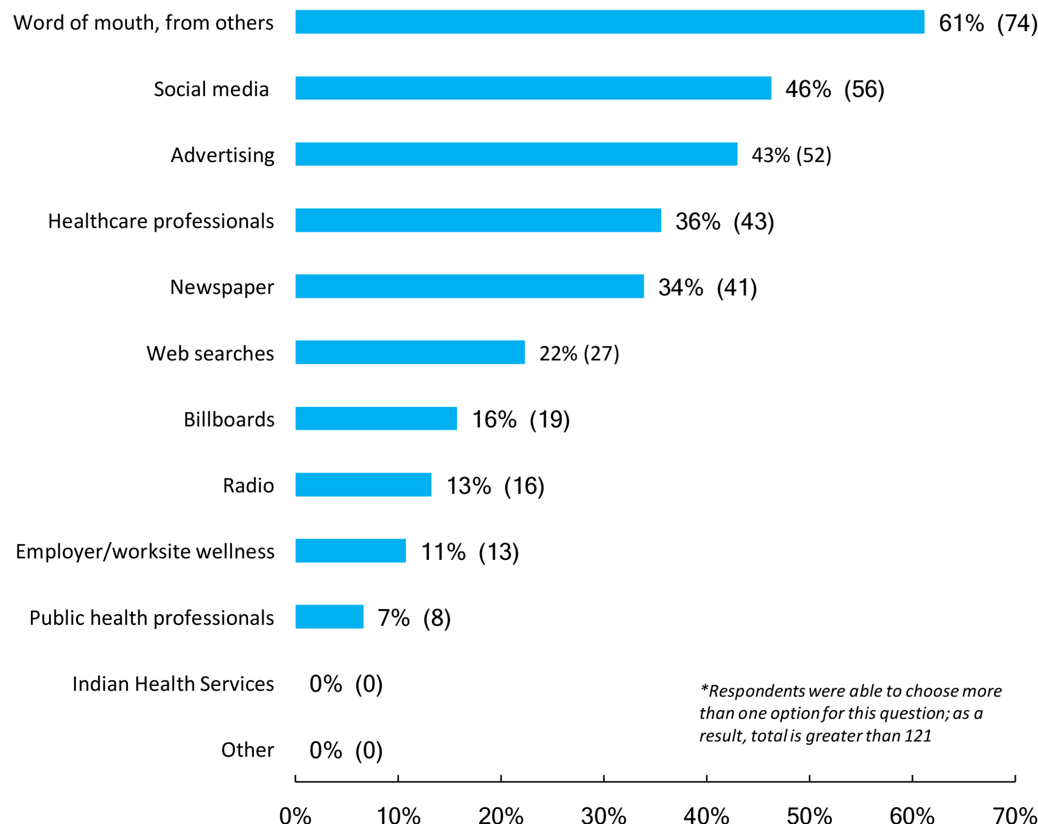


Figure 37: Where Availability of Local Health Services Information is Found
Total responses = 349



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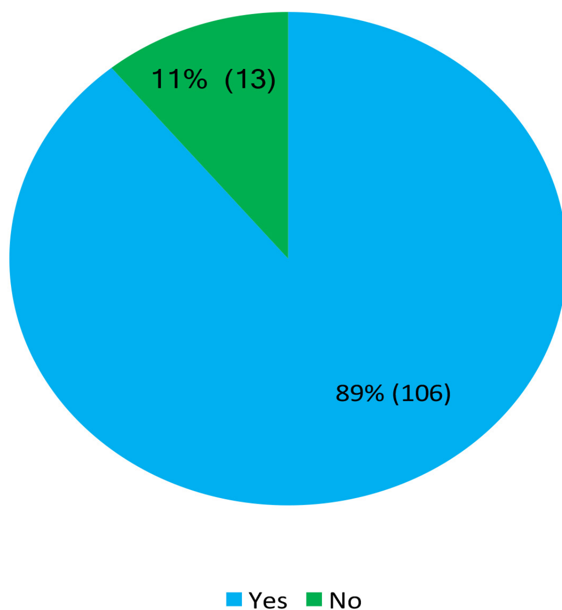
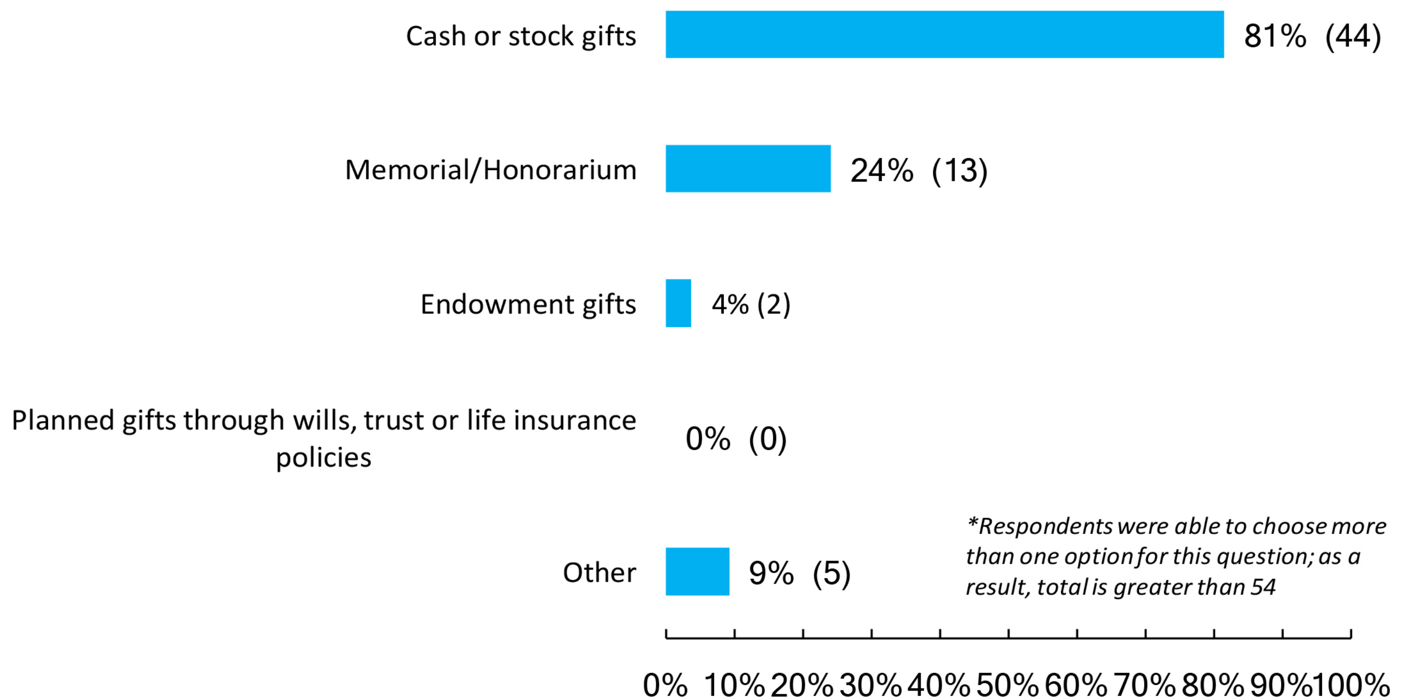
The key informant and focus group members felt that the community members were aware of the majority of the health system and public health services. However, with SWHS recently bringing in new providers and 3D mammography services, individuals felt that promotion should be increased for these additions.

Figure 38: Awareness of Sunrise Foundation
Total responses = 119



In an effort to gauge ways that community members have supported the Sunrise Foundation, a question was included asking them to identify how they have shown that support (see Figure 39).

Figure 39: Ways of Supporting Sunrise Foundation
Total responses = 64



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The final question on the survey asked respondents to share concerns and suggestions to improve the delivery of local healthcare. The majority of responses focused on two areas: needing to recruit and retain providers, and improving the customer services aspect of healthcare within the hospital. While many of the respondents suggested bringing in a more stable core of doctors, some pointed out that their attitudes—and at times those of the staff in general—towards those they are treating are subpar, as is the overall quality of care. Confidentiality was also mentioned as a critical matter to address, with some individuals worrying that their information might not be as safely guarded as they would like.

There was one more item brought up about providers that deserves attention. Some respondents feel that physicians should be aware of their limits and when it is the right time to refer a patient to a specialist. While many community members acknowledge the lack of specialists in the area as a concern, they would like to be referred as soon as necessary in order to improve patient outcomes.

There were also those that felt the hospital was doing a fine job in delivering quality healthcare to the community, and whose major concern was the lack of support in the community for SWHS. They cited the many people who leave the area for their healthcare and a need to keep people utilizing local services so they are kept in the community.

Findings from Key Informant Interviews & the Community Meeting

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

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

- Alcohol use and abuse
- Availability of mental health services
- Changes in population size
- Having enough child daycare services
- Vaping/juuling

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

Alcohol use and abuse

- You can't do anything around here without having a beer
- Three-fourths of the time people are under the influence in arrests in the last five years in Bowman
- North Dakota is #1 in binge drinking in the country
- Alcohol here is abused in all generations

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Availability of mental health services

- Used to be a robust mental health system; funding has been cut and services like halfway houses don't exist anymore
- Lots of other pressing issues fall under the umbrella of mental health services, such as depression, anxiety, and drug abuse
- Kids are struggling with mental health, would be good to get mental help in school. They won't be able to retain academic information if they are preoccupied with mental issues.

Changes in population size

- If decreasing, businesses struggle and we lose healthcare workers as well as funding for some of the other services
- This is worrisome as a business owner

Having enough child daycare services

- Cost is a big obstacle because there aren't many options
- Daycare laws in ND are strict, can't afford to be a daycare provider because the financial costs are so high
- Not that people aren't willing to be daycare providers, but they can't because it's so expensive and restrictive

Vaping/juuling

- Kids are doing it on the bus and all over in schools
- Parents get upset because they feel the school isn't doing anything about it
- Very discreet; it's hard to catch and hard to stop

Community Engagement and Collaboration

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

- Emergency services, including ambulance and fire (4.5)
- Faith-based (4.5)
- Hospital (healthcare system) (4.25)
- Other local health providers, such as dentists and chiropractors (4.25)
- Schools (4.0)
- Long-term care, including nursing homes and assisted living (4.0)

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- Economic development organizations (4.0)
- Law enforcement (4.0)
- Social Services (4.0)
- Public Health (3.75)
- Pharmacy (3.75)
- Business and industry (3.75)
- Human services agencies (3.5)
- Clinics not affiliated with the main health system (3.25)

Priority of Health Needs

A community group met on November 7, 2019 with nine community members in attendance. Representatives from the CRH presented the group with a summary of this report's findings, including background and explanation about the secondary data, highlights from the survey results (including perceived community assets and concerns, and barriers to care), and findings from the key informant interviews.

Following the presentation of the assessment findings, and after considering and discussing the findings, all members of the group were asked to identify what they perceived as the top four community health needs. All of the potential needs were listed on large poster boards and each member was given four stickers to place next to each of the four needs they considered the most significant.

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

- Ability to retain primary care providers (MD, DO, NP, PA) (7 votes)
- Availability of mental health services (6 votes)
- Attracting and retaining young families (5 votes)
- Depression/anxiety – Youth (5 votes)
- Bullying/cyber-bullying (3 votes)
- Depression/anxiety – Adults (2 votes)
- Not enough affordable housing (2 votes)
- Smoking and tobacco use, exposure to second-hand smoke, or vaping/juuling – Youth (2 votes)
- Alcohol use and abuse – Adults (1 vote)
- Availability of resources to help the elderly stay in their homes (1 votes)
- Having enough child daycare services (1 vote)

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

1. Ability to retain primary care providers (MD, DO, NP, PA) (4 votes)
2. Attracting and retaining young families (3 votes)
3. Availability of mental health services (2 votes)
4. Depression/anxiety (0 votes)

Following the prioritization process during the second meeting of the community group and key informants, the number one identified need was the ability to retain primary care providers (MD, DO, NP, PA). A summary of this prioritization may be found in Appendix D.

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Comparison of Needs Identified Previously

Top Needs Identified 2016 CHNA Process	Top Needs Identified 2019 CHNA Process
• Ability to recruit and retain primary care providers • Mental/behavioral health • Drug and alcohol use and abuse • Attracting and retaining young families	• Ability to retain primary care providers (MD, DO, NP, PA) • Attracting and retaining young families • Availability of mental health services • Depression/anxiety

The current process shared most of the same needs identified as the 2016, with the exception of drug and alcohol use and abuse. Although drug and alcohol use and abuse was not identified as a top need during the 2019 process, alcohol use was still cited as a concern in the adult category.

Hospital and Community Projects and Programs Implemented to Address Needs Identified in 2016

In response to the needs identified in the 2016 CHNA process, the following actions were taken:

Need 1: Ability to Recruit and Retain Primary Care Providers – SWHS successfully recruited an internal medicine physician, Dr. Matthew Feller, in the fall of 2018. Dr. William Arban, a family medicine physician, was also recruited, a process that started late in the spring of 2019. They also brought on another visiting specialist to serve the community. Dr. Emmitt McEleny is a visiting orthopedic specialist brought on to visit once every month.

Need 2: Mental/Behavioral Health – In summer of 2017, residents of Bowman were provided access to mental health treatment through SWHS's telemedicine services. With this service, patients and residents can be connected with necessary mental health treatment via video conference. As awareness of this service has grown, so has the traffic of those patients seeking mental health treatment.

Need 3: Drug and Alcohol Use and Abuse – The aforementioned telemedicine service also played a role in working towards alcohol and drug abuse, the third need from the 2016 process. Those who need treatment can go to SWHS and utilize the telehealth services.

Need 4: Attracting and Retaining Young Families – This is one of the most difficult hurdles facing rural healthcare today. To start working through this issue though, sign-on bonuses for certain positions were implemented. The amount depends on the position of hire. Also implemented were referral bonuses for their current employees. Along with these bonuses, the CEO serves on the Economic Development Corporation board of directors. This allows an exchange of ideas from inside the SWHS facility and from people who work outside and who have made improving the lives of the community their careers.

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Next Steps – Strategic Implementation Plan

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

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

Community Benefit Report

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

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

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

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

What Are Community Benefits?

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

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

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

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

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

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Appendix A – CHNA Survey Instrument

Bowman Area Health Survey

Southwest Healthcare Services and Southwestern District Health Unit are interested in hearing from you about community health concerns.

The focus of this effort is to:

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

If you prefer, you may take the survey online at https://tinyurl.com/BowmanND19 or by scanning on the QR Code at the right.

Surveys will be tabulated by the Center for Rural Health at the University of North Dakota School of Medicine and Health Sciences. Your responses are anonymous, and you may skip any question you do not want to answer. Your answers will be combined with other responses and reported only in total. If you have questions about the survey, you may contact Shawn Larson at 701.777.5588.

Surveys will be accepted through October 14, 2019. Your opinion matters – thank you in advance!

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

- ☐ Ability to meet needs of older population
- ☐ Long-term/nursing home care options
- ☐ Assisted living options
- ☐ Availability of resources to help the elderly stay in their homes
- ☐ Availability of activities for seniors
- ☐ Cost of activities for seniors
- ☐ Availability of resources for family and friends caring for elders
- ☐ Quality of elderly care
- ☐ Cost of long-term/nursing home care
- ☐ Availability of transportation for seniors
- ☐ Availability of home health
- ☐ Not getting enough exercise/physical activity
- ☐ Depression/anxiety
- ☐ Suicide
- ☐ Alcohol use and abuse
- ☐ Drug use and abuse (including prescription drug abuse)
- ☐ Availability of activities for seniors
- ☐ Elder abuse
- ☐ Other: (please specify) ___________________________

10. Regarding various forms of **VIOLENCE** in your community, concerns are (choose up to THREE):

- ☐ Bullying/cyber-bullying
- ☐ Child abuse or neglect
- ☐ Dating violence
- ☐ Domestic/intimate partner violence
- ☐ Emotional abuse (ex. intimidation, isolation, verbal threats, withholding of funds)
- ☐ General violence against women
- ☐ General violence against men
- ☐ Physical abuse
- ☐ Stalking
- ☐ Sexual abuse/assault
- ☐ Verbal threats
- ☐ Video game/media violence
- ☐ Work place/co-worker violence

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11. Regarding impacts from **OIL & GAS DEVELOPMENT** in your community, concerns are (choose up to THREE):

- ☐ Adequate number of school resources
- ☐ Aging population, lack of resources to meet growing needs
- ☐ Alcohol and drug use and abuse
- ☐ Crime and community violence
- ☐ Domestic violence, including child abuse
- ☐ Environmentally unsound (or unfriendly) place to live
- ☐ Impact of increased oil/energy development
- ☐ Increasing population, including residents moving in
- ☐ Insufficient facilities for exercise and well-being
- ☐ Lack of affordable housing
- ☐ Lack of employees to fill positions
- ☐ Lack of employment opportunities
- ☐ Lack of police presence in community
- ☐ Litter
- ☐ Low wages, lack of livable wages
- ☐ Maintaining enough health workers (e.g., medical, dental, wellness)
- ☐ Poverty
- ☐ Property taxes
- ☐ Racism, prejudice, hate, discrimination
- ☐ Traffic safety, including speeding, road safety and drunk driving
- ☐ Other: (please specify) ________________________

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

____

____

Delivery of Healthcare

13. Considering **GENERAL and ACUTE SERVICES** at Southwest Healthcare Services, which services are you aware of (or have you used in the past year)? (Choose ALL that apply)

- ☐ Anesthesia services
- ☐ Cardiology (visiting specialist)
- ☐ Clinic
- ☐ Emergency room
- ☐ Hospital (acute care)
- ☐ Mental health services
- ☐ Orthopedic (visiting specialist)
- ☐ OB/GYN (visiting specialist)
- ☐ Pediatrics (visiting specialist)
- ☐ Surgical services
- ☐ Swing bed and respite care services
- ☐ Visiting nurse services
- ☐ Telemedicine via eEmergency

14. Considering **SCREENING/THERAPY SERVICES** at Southwest Healthcare Services, which services are you aware of (or have you used in the past year? (Choose ALL that apply)

- ☐ Diet instruction
- ☐ Health screenings
- ☐ Laboratory services
- ☐ Occupational therapy
- ☐ Physical therapy
- ☐ Social services
- ☐ Speech therapy
- ☐ Respiratory therapy
- ☐ Cardiac/pulmonary rehab
- ☐ Sleep studies

15. Considering **RADIOLOGY SERVICES** at Southwest Healthcare Services, which services are you aware of (or have you used in the past year)? (Choose ALL that apply)

- ☐ EKG—Electrocardiography
- ☐ Bone Density Scanning
- ☐ Body Composition Scanning
- ☐ CT scan
- ☐ Echocardiogram
- ☐ General x-ray
- ☐ 3D Mammography
- ☐ MRI
- ☐ Peripheral Artery Disease Scanning
- ☐ Ultrasound

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16. Which of the following **SERVICES** offered through **SOUTHWESTERN DISCTRICT HEALTH UNIT** have you or a family member used in the past year? (Choose ALL that apply)

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

17. Considering services offered locally by **OTHER PROVIDERS/ORGANIZATIONS** at Southwest Healthcare Services, which services are you aware of (or have you used in the past year)? (Choose ALL that apply)

- ☐ Ambulance
- ☐ Chiropractic services
- ☐ Dental services
- ☐ Massage therapy
- ☐ Optometric/vision services
- ☐ Pharmacy
- ☐ Audiology

18. What other services would you like to be provided in your community?

- ☐ Mental health
- ☐ Podiatry
- ☐ Oncology
- ☐ Urology
- ☐ Pulmonology
- ☐ Dermatology
- ☐ Ears, nose & throat
- ☐ Other: (please specify) ____________________________ ____________________________

19. Are you aware of Southwest Healthcare Services' clinic hours (Monday – Friday from 7:30 am – 5:00 pm)?

- ☐ Yes
- ☐ No

20. Would you utilize the clinic at Southwest Healthcare Services during extended hours of Monday – Friday from 5 – 7 pm and Saturdays 10 am – 12 pm?

- ☐ Yes
- ☐ No

21. What **PREVENTS** community residents from receiving healthcare in general? (Choose ALL that apply)

- ☐ Can't get transportation services
- ☐ Concerns about confidentiality
- ☐ Distance from health facility
- ☐ Don't know about local services
- ☐ Don't speak language or understand culture
- ☐ Lack of disability access
- ☐ Lack of services through Indian Health Services
- ☐ Limited access to telehealth technology (patients seen by providers at another facility through a monitor/TV screen)
- ☐ No insurance or limited insurance
- ☐ Not able to get appointment/limited hours
- ☐ Not able to see same provider over time
- ☐ Not accepting new patients
- ☐ Not affordable
- ☐ Not enough providers (MD, DO, NP, PA)
- ☐ Not enough evening or weekend hours
- ☐ Not enough specialists
- ☐ Poor quality of care
- ☐ Other: (please specify) __________________________

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22. What **PREVENTS** community residents from receiving healthcare **LOCALLY**? (Choose ALL that apply)

- ☐ Concerns about confidentiality
- ☐ Lack of bilingual providers or interpreters
- ☐ Lack of American Indian providers
- ☐ Lack of collaboration with other hospitals/clinics
- ☐ No evening or weekend hours
- ☐ Not able to access telehealth technology (patients seen by providers at another facility through a monitor/TV screen)
- ☐ Not enough providers (MD, DO, NP, PA)
- ☐ Transportation services to appointments not available
- ☐ Other:____

23. What reasons would patients select healthcare services outside of the local community? (Select ALL that apply)

- ☐ Access to necessary specialists
- ☐ Higher quality services
- ☐ More convenient service times
- ☐ More convenient locations
- ☐ Confidentiality
- ☐ Bilingual providers or interpreters
- ☐ More physicians, physician assistants, etc.
- ☐ Lower cost services
- ☐ Transportation services provided
- ☐ Able to be seen sooner
- ☐ Insurance network
- ☐ Other: (please specify) ____________________________

24. Where do you turn for trusted health information? (Choose ALL that apply)

- ☐ Other healthcare professionals (nurses, chiropractors, dentists, etc.)
- ☐ Primary care provider (doctor, nurse practitioner, physician assistant)
- ☐ Public health professional
- ☐ Web searches/internet (WebMD, Mayo Clinic, Healthline, etc.)
- ☐ Word of mouth, from others (friends, neighbors, co-workers, etc.)
- ☐ Other: (please specify) __________________________

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

- ☐ Advertising
- ☐ Employer/worksite wellness
- ☐ Health care professionals
- ☐ Indian Health Service
- ☐ Newspaper
- ☐ Public health professionals
- ☐ Radio
- ☐ Social media (Facebook, Twitter, etc.)
- ☐ Billboards
- ☐ Web searches
- ☐ Word of mouth, from others (friends, neighbors, co-workers, etc.)
- ☐ Other: (please specify) ____________________________

26. Are you aware of the Sunrise Foundation, which exists to financially support healthcare in your community?

- ☐ Yes
- ☐ No

27. Have you supported the Sunrise Foundation in any of the following ways? (Choose ALL that apply)

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

Demographic Information: Please tell us about yourself.

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

- ☐ Yes
- ☐ No

29. Health insurance or health coverage status (choose ALL that apply):

- ☐ Indian Health Service (IHS)
- ☐ Insurance through employer
- ☐ Self-purchased insurance
- ☐ Medicaid
- ☐ Medicare
- ☐ No/not enough insurance
- ☐ Veteran's Healthcare Benefits
- ☐ Other: (please specify) ____________________________

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30. Age:

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

31. Highest level of education:

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

32. Gender:

- ☐ Female
- ☐ Male
- ☐ Transgender

33. Employment status:

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

34. Your zip code: ____________________

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

- ☐ American Indian
- ☐ African American
- ☐ Asian
- ☐ Hispanic/Latino
- ☐ Pacific Islander
- ☐ White/Caucasian
- ☐ Other: ____________________
- ☐ Prefer not to answer

36. Annual household income before taxes:

- ☐ Less than $15,000
- ☐ $15,000 to $24,999
- ☐ $25,000 to $49,999
- ☐ $50,000 to $74,999
- ☐ $75,000 to $99,999
- ☐ $100,000 to $149,999
- ☐ $150,000 and over
- ☐ Prefer not to answer

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

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Thank you for assisting us with this important survey!

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Appendix B – County Health Rankings Explained

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

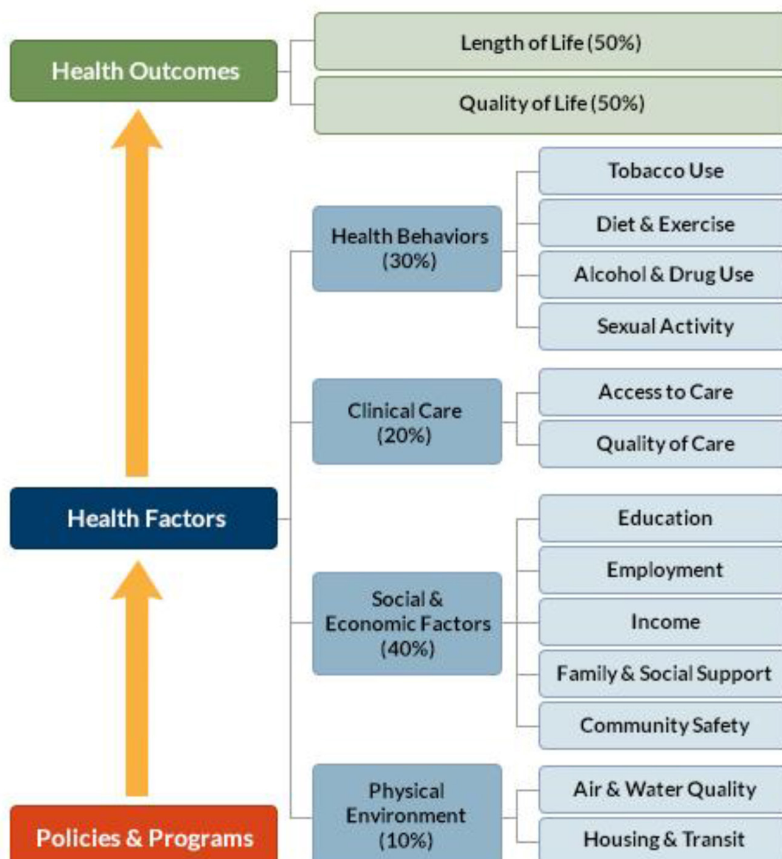
Methods

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

What is Ranked

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

Ranking System



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

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

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

Data Sources and Measures

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

Data Quality

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

Calculating Scores and Ranks

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

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Health Outcomes and Factors

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

Health Outcomes

Premature Death (YPLL)

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

Reason for Ranking

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

Poor or Fair Health

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

Reason for Ranking

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

Poor Physical Health Days

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

Reason for Ranking

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

Poor Mental Health Days

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

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

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

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

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

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

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

Health Factors

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

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

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

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

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Food Environment Index

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

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

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

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

Reason for Ranking

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

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

Physical Inactivity

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

Reason for Ranking

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

Access to Exercise Opportunities

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

Individuals who:

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

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

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

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

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

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

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

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

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

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

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

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beyond high school, much more likely to be overweight/obese in adulthood, and more likely to experience depression and psychological distress [5-7].

Uninsured

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

Reason for Ranking

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

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

Primary Care Physicians

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

Reason for Ranking

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

Dentists

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

Reason for Ranking

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

Mental Health Providers

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

Reason for Ranking

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

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Preventable Hospital Stays

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

Reason for Ranking

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

Diabetes Monitoring

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

Reason for Ranking

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

Mammography Screening

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

Reason for Ranking

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

Unemployment

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

Reason for Ranking

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

Children in Poverty

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

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

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

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

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

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

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

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

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

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

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

Injury Deaths

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

Reason for Ranking

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

Air Pollution-Particulate matter

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

Reason for Ranking

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

Drinking Water Violations

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

Reason for Ranking

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

Severe Housing Problems

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

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

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

Reason for Ranking

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

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Appendix C – Youth Behavioral Risk Survey Results

North Dakota High School Survey

*2017 YRBS North Dakota Data is not yet available, so the 2015 data was used.

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

	ND 2013	ND 2015*	ND Trend ↑, ↓, =	Rural ND Town Average	Urban ND Town Average	National Average 2017
Injury and Violence						
Percentage of students who rarely or never wore a seat belt.	11.6	8.5	↓	10.5	7.5	5.9
Percentage of students who rode in a vehicle with a driver who had been drinking alcohol (one or more times during the 30 prior to the survey)	21.9	17.7	↓	21.1	15.2	16.5
Percentage of students who talked on a cell phone while driving (on at least 1 day during the 30 days before the survey, among students who drove a car or other vehicle)	67.9	61.4	↓	60.7	58.8	NA
Percentage of students who texted or e-mailed while driving a car or other vehicle (on at least 1 day during the 30 days before the survey, among students who had driven a car or other vehicle during the 30 days before the survey)	59.3	57.6	=	56.7	54.4	39.2
Percentage of students who never or rarely wore a helmet (during the 12 months before the survey, among students who rode a motorcycle)	29.8	28.7	=	32.8	24.7	NA
Percentage of students who carried a weapon on school property (such as a gun, knife, or club on at least 1 day during the 30 days before the survey)	6.4	5.2	=	6.6	4.5	3.8
Percentage of students who were in a physical fight on school property (one or more times during the 12 months before the survey)	8.8	5.4	↓	6.9	6.1	8.5
Percentage of students who were ever physically forced to have sexual intercourse (when they did not want to)	7.7	6.3	=	6.5	7.4	7.4
Percentage of students who experienced physical dating violence (one or more times during the 12 months before the survey, including being hit, slammed into something, or injured with an object or weapon on purpose by someone they were dating or going out with among students who dated or went out with someone during the 12 months before the survey)	9.7	7.6	=	6.9	8.0	8.0
Percentage of students who have been the victim of teasing or name calling because someone thought they were gay, lesbian, or bisexual (during the 12 months before the survey)	9.6	9.7	=	10.4	9.7	NA
Percentage of students who were bullied on school property (during the 12 months before the survey)	25.4	24.0	=	27.5	22.4	19.0
Percentage of students who were electronically bullied (including being bullied through e-mail, chat rooms, instant messaging, websites, or texting during the 12 months before the survey)	17.1	15.9	=	17.7	15.8	14.9
Percentage of students who felt sad or hopeless (almost every day for 2 or more weeks in a row so that they stopped doing some usual activities during the 12 months before the survey)	25.4	27.2	=	24.9	28.9	31.5
Percentage of students who seriously considered attempting suicide (during the 12 months before the survey)	16.1	16.2	=	15.8	16.7	17.2
Percentage of students who made a plan about how they would attempt suicide (during the 12 months before the survey)	13.5	13.5	=	12.8	13.7	13.6
Percentage of students who attempted suicide (one or more times during the 12 months before the survey)	11.5	9.4	↓	10.3	11.3	7.4

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	ND 2013	ND 2015*	ND Trend ↑, ↓, =	Rural ND Town Average	Urban ND Town Average	National Average 2017
Tobacco Use						
Percentage of students who ever tried cigarette smoking (even one or two puffs)	41.4	35.1	↓	37.3	32.5	28.9
Percentage of students who smoked a whole cigarette before age 13 years (for the first time)	7.9	7.2	=	7.3	6.7	9.5
Percentage of students who currently smoked cigarettes (on at least 1 day during the 30 days before the survey)	19.0	11.7	↓	13.2	11.8	8.8
Percentage of students who currently frequently smoked cigarettes (on 20 or more days during the 30 days before the survey)	6.6	4.3	↓	4.3	4.7	2.6
Percentage of students who currently smoked cigarettes daily (on all 30 days during the 30 days before the survey)	3.9	3.2	=	3.2	3.2	2.0
Percentage of students who usually obtained their own cigarettes by buying them in a store or gas station (during the 30 days before the survey among students who currently smoked cigarettes and who were aged <18 years)	7.8	16.9	↑	0.2	1.0	NA
Percentage of students who tried to quit smoking cigarettes (among students who currently smoked cigarettes during the 12 months before the survey)	55.5	47.4	=	49.1	52.7	NA
Percentage of students who currently use an electronic vapor product (e-cigarettes, vape e-cigars, e-pipes, vape pipes, vaping pens, e-hookahs, and hookah pens at least 1 day during the 30 days before the survey)	NA	22.3	↑	19.7	22.8	13.2
Percentage of students who currently used smokeless tobacco (chewing tobacco, snuff, or dip on at least 1 day during the 30 days before the survey)	13.8	10.6	↓	12.6	9.5	5.5
Percentage of students who currently smoked cigars (cigars, cigarillos, or little cigars on at least 1 day during the 30 days before the survey)	11.7	9.2	↓	9.7	9.7	8.0
Percentage of students who currently used cigarettes, cigars, or smokeless tobacco (on at least 1 day during the 30 days before the survey)	27.5	20.9	↓	22.9	19.8	14.0
Alcohol and Other Drug Use						
Percentage of students who ever drank alcohol (at least one drink of alcohol on at least 1 day during their life)	65.8	62.1	=	64.5	59.9	60.4
Percentage of students who drank alcohol before age 13 years (for the first time other than a few sips)	15.2	12.4	=	15.3	12.9	15.5
Percentage of students who currently drank alcohol (at least one drink of alcohol on at least 1 day during the 30 days before the survey)	35.3	30.8	↓	32.8	29.3	29.8
Percentage of students who drank five or more drinks of alcohol in a row (within a couple of hours on at least 1 day during the 30 days before the survey)	21.9	17.6	↓	19.8	17.0	13.5
Percentage of students who usually obtained the alcohol they drank by someone giving it to them (among students who currently drank alcohol)	37.0	41.3	=	41.1	40.4	43.5
Percentage of students who tried marijuana before age 13 years (for the first time)	5.6	6.3	=	5.8	5.8	6.8
Percentage of students who currently used marijuana (one or more times during the 30 days before the survey)	15.9	15.2	=	13.2	17.1	19.8
Percentage of students who ever took prescription drugs without a doctor's prescription (such as OxyContin, Percocet, Vicodin, codeine, Adderall, Ritalin, or Xanax, one or more times during their life)	17.6	14.5	↓	13.2	16.0	14.0
Percentage of students who were offered, sold, or given an illegal drug on school property (during the 12 months before the survey)	14.1	18.2	↑	15.9	19.9	19.8

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	ND 2013	ND 2015*	ND Trend ↑, ↓, =	Rural ND Town Average	Urban ND Town Average	National Average 2017
Percentage of students who attended school under the influence of alcohol or other drugs (on at least one day during the 30 days before the survey)	9.9	8.6	=	7.9	9.0	NA
Sexual Behaviors						
Percentage of students who ever had sexual intercourse	44.9	38.9	↓	39.3	39.1	39.5
Percentage of students who had sexual intercourse before age 13 years (for the first time)	3.8	2.6	=	3.3	3.3	3.4
Weight Management and Dietary Behaviors						
Percentage of students who were overweight (>= 85th percentile but <95th percentile for body mass index, based on sex and age-specific reference data from the 2000 CDC growth chart)	15.1	14.7	=	15.4	14.6	15.6
Percentage of students who were obese (>= 95th percentile for body mass index, based on sex- and age-specific reference data from the 2000 CDC growth chart)	13.5	14.0	=	16.3	12.9	14.8
Percentage of students who described themselves as slightly or very overweight	32.0	32.2	=	34.2	31.5	31.5
Percentage of students who were trying to lose weight	45.4	44.7	=	45.0	43.0	47.1
Percentage of students who did not eat fruit or drink 100% fruit juices (during the 7 days before the survey)	3.4	3.9	=	4.3	4.1	5.6
Percentage of students who ate fruit or drank 100% fruit juices one or more times per day (during the 7 days before the survey)	64.7	62.5	=	8.5	8.8	60.8
Percentage of students who did not eat vegetables (green salad, potatoes [excluding French fries, fried potatoes, or potato chips], carrots, or other vegetables, during the 7 days before the survey)	6.0	4.7	=	4.5	5.2	7.2
Percentage of students who ate vegetables one or more times per day (green salad, potatoes [excluding French fries, fried potatoes, or potato chips], carrots, or other vegetables, during the 7 days before the survey)	62.8	58.5	↓	61.2	60.0	59.4
Percentage of students who did not drink a can, bottle, or glass of soda or pop (not including diet soda or diet pop, during the 7 days before the survey)	25.3	25.6	=	23.5	21.7	27.8
Percentage of students who drank a can, bottle, or glass of soda or pop one or more times per day (not including diet soda or diet pop, during the 7 days before the survey)	23.4	18.7	=	21.4	18.0	18.7
Percentage of students who did not drink milk (during the 7 days before the survey)	11.1	13.9	↑	11.6	13.7	26.7
Percentage of students who drank two or more glasses per day of milk (during the 7 days before the survey)	42.4	35.8	↓	36.6	35.3	17.5
Percentage of students who did not eat breakfast (during the 7 days before the survey)	10.5	11.9	=	10.7	11.8	14.1
Percentage of students who most of the time or always went hungry because there was not enough food in their home (during the 30 days before the survey)	3.1	2.2	=	2.4	2.8	NA
Physical Activity						
Percentage of students who were physically active at least 60 minutes per day on 5 or more days (doing any kind of physical activity that increased their heart rate and made them breathe hard some of the time during the 7 days before the survey)	50.6	51.3	=	51.7	50.1	46.5
Percentage of students who watched television 3 or more hours per day (on an average school day)	21.0	18.9	=	20.7	18.2	20.7
Percentage of students who played video or computer games or used a computer 3 or more hours per day (for something that was not school work on an average school day)	34.4	38.6	↑	39.4	38.0	43.0

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	ND 2013	ND 2015*	ND Trend ↑, ↓, =	Rural ND Town Average	Urban ND Town Average	National Average 2017
Other						
Percentage of students who had 8 or more hours of sleep (on an average school night)	30.0	29.5	=	34.5	28.7	25.4
Percentage of students who brushed their teeth on seven days (during the 7 days before the survey)	71.5	71.0	=	67.8	70.1	NA
Percentage of students who most of the time or always wear sunscreen (with an SPF of 15 or higher when they are outside for more than one hour on a sunny day)	11.2	12.5	=	10.3	12.8	NA
Percentage of students who used an indoor tanning device (such as a sunlamp, sunbed, or tanning booth [not including getting a spray-on tan] one or more times during the 12 months before the survey)	19.6	12.2	↓	13.3	12.8	NA

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Appendix D – Prioritization of Community's Health Needs

Community Health Needs Assessment

Bowman, North Dakota

Ranking of Concerns

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

	Priorities	Most Important
COMMUNITY/ENVIRONMENTAL HEALTH CONCERNS		
Attracting & retaining young families	5	3
Not enough jobs with livable wages	0	
Not enough affordable housing	2	
Having enough child daycare services	1	
AVAILABILITY/DELIVERY OF HEALTH SERVICES CONCERNS		
Ability to retain primary care providers (MD, DO, NP, PA)	7	4
Cost of health insurance	0	
Availability of mental health services	6	2
Availability of specialists	0	
YOUTH POPULATION HEALTH CONCERNS		
Smoking and tobacco use, exposure to second-hand smoke, or vaping/juuling	2	
Alcohol use and abuse	0	
Drug use and abuse (including prescription drugs)	0	
Depression/anxiety	5	0
ADULT POPULATION HEALTH CONCERNS		
Cancer	0	
Alcohol use and abuse	1	
Depression/anxiety	2	
Drug use and abuse (including prescription drugs)	0	
SENIOR POPULATION HEALTH CONCERNS		
Cost of long-term/nursing home care	0	
Availability of resources to help elderly stay in their homes	1	
Ability to meet the needs of the older population	0	
Assisted living options	0	
VIOLENCE CONCERNS		
Bullying/cyber-bullying (Youth)	3	
Child abuse/neglect	0	
Emotional abuse (isolation, verbal threats, withholding of funds)	0	
Domestic/intimate partner violence	0	

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Appendix E – Survey "Other" Responses

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

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

1. Considering the PEOPLE in your community, the best things are: "Other" responses:
   - Lived here for 4 years and this community is not friendly
   - Some think they are the only community in the country
   - There's a lot of racist people in Bowman with the Mexicans. I know all the Mexicans in Bowman. All good people. Would like to see more things in Bowman about racism.
2. Considering the SERVICES AND RESOURCES in your community, the best things are: "Other" responses:
   - Affordable healthcare
   - No weekend public transit
   - Public library
3. Considering the QUALITY OF LIFE in your community, the best things are: "Other" responses:
   - Access to outdoor activities
4. Considering the ACTIVITIES in your community, the best things are: "Other" responses:
   - Access to outdoor activities
   - Close to Spearfish canyon
   - Excellent library
   - None
   - Outdoor activities in surrounding area
   - Something to do most weekends

5. Considering the COMMUNITY/ENVIRONMENTAL HEALTH in your community, concerns are: "Other" responses
   - CAFÉ
   - Dining options
   - Drug traffic concerns
   - Drug use and related crime/violence
   - Eating places
   - Illegal drugs
   - Need better shopping choices, need to rejuvenate downtown
   - No entertainment
   - No restaurants
   - Not enough access to mental health providers
   - Senior citizen activities
   - Youth drug/alcohol rate

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

- Almost all of the above
- Bedside manner of MDs
- Clinic appointment, need lab work, it is billed as outpatient hospital. This requires higher deductibles and co-pays. Larger community's' clinics do not do this. At times cheaper to drive out of town.
- Dementia support
- My healthcare facility will schedule appointments for 8 a.m. on a Monday morning and yet the Dr will not show up until 8:20 or later!! Why schedule early when they can't get there!!
- Nothing in particular
- Poor leadership at local hospital with little they can turn it around financially
- There are providers available, just not quality providers. A warm body does not constitute a competent body.

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

- Addiction to phones, gaming
- Am not aware of major problems

8. Considering the ADULT POPULATION in your community, concerns are: "Other" responses

- All mental health concerns and lack of providers to specifically provide mental health services
- Meals for shut ins

9. Considering the SENIOR POPULATION in your community, concerns are: "Other" responses

- Dementia care

11. Regarding impacts from OIL & GAS DEVELOPMENT in your community, concerns are: "Other" responses

- Lack of proactive law enforcement
- Messy yards, no pride
- Only the one

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

- A challenge is the lack of good healthcare providers. Providers from Southwest Healthcare are either having a good day or a really bad week. There is no consistence. Providers have made some really bad decisions. The Board of Directors have no idea what is going on there. They have been lied to for years but they continue to believe the administration. Out of touch. The administration retaliates against staff who raise questions. That is not a good environment, yet they think they are the employer of choice.
- Adapting to change. There are a lot of houses for sale, will the community survive
- Affordable housing
- Agriculture
- Alcoholism and drug abuse
- Attracting healthcare doctors and nurses
- Average wage is low
- Bringing business in to stay
- Businesses closing very fast, it's becoming a ghost town
- Businesses not being able to get/retain employees to keep their business open
- Currently is having enough eating establishments to meet the needs of our community. We are in need of a steakhouse and a café. We also need to encourage our youth to join the workforce while getting an education
- Dependable workforce
- Drugs
- Drug abuse within the community

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- Eating establishments steakhouse and family restaurant
- Economic diversity to improve wages
- Finding and keeping physicians to staff our hospital permanently
- Finding enough employees to keep our businesses going
- Getting and keeping valuable business in our town. Also getting and keeping our doctor and nurses
- Having enough people to work restaurants and entry level jobs. Groceries are very expensive and usually not very fresh
- Having sufficient businesses to meet the needs of the community so that the community can survive without people taking business outside the community. Maintaining healthcare providers so that the elderly are not scared that their primary care provider is always someone new.
- Healthcare and the need to travel so far for specialist appointments
- Housing and keeping the infrastructure up to date for a growing population. Also the lack of a family restaurant and steakhouse
- I feel that at Southwest hospital they are not paying employees livable wages. I believe that just about every CAN that works there has at LEAST one other job to make ends meet
- I would say the lack of amenities (restaurants, shopping) is a big drawback in trying to attract new, younger families. Part of that is the ever-growing cost of starting businesses right now. It is a big financial commitment to open a business when it's unknown if it will be successful or not
- Inability to recruit and keep competent physicians for the brand new hospital
- Keeping businesses open due to lack of work ethic in employees
- Keeping Main Street alive; doctors that will actually stay in our community; a store that we can buy clothing, household items, OTC medicines, etc.
- Keeping our hospital running in the black
- Lack of affordable homes for families starting out
- Lack of affordable housing
- Lack of opportunities and growth in our community
- Lack of resources to address most of the concerns listed
- Lack of sit-down restaurant
- Lack of workers or lack of initiative from workers for businesses i.e. motels, restaurants, etc.
- Maintaining businesses, especially food industry
- Maintaining enough health workers
- Not being able to sustain viable businesses. When the local eating establishments start closing, the town slowly dies
- People leaving and businesses closing
- Qualified workers to fill job openings
- Restaurants and shopping stores closing
- Retaining good doctors
- Retaining stores, restaurants, etc.
- Taxes on real estate
- The biggest challenge currently is keeping businesses open. We live in a community that has no place to go for a cooked breakfast or have a steakhouse meal at the end of the day. Having such places would create jobs, attract people from near communities to come, and also be a place of social opportunities
- The close-minded attitude of citizens who have lived here their whole lives. It is a community of cliques and if you aren't in one, you are an "outsider." It is sad that Bowman cannot grow and keep an open mind about change. A lot of alcoholism and prejudice here and it will eventually kill this town.
- The disparity between the wages of those working in the oil and gas industry and those who do not and the direct effect this has on the cost of living in the community
- The local community accepting new people and offering jobs to the outside community who are qualified not just a local friend
- Too many families living off welfare programs and unwilling to work, teenagers aren't made to work if they're in sports

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- Transient population…many new people moving in with families that have special needs…very very taxing to the school system healthcare system etc. We don’t have the personnel and resources to meet the special needs
- Uncertainty of oil related employment

18. What other services would you like to be provided in your community: “Other” responses

- Any additional services would be a bonus
- Colonoscopies
- Endocrinologist
- I would be happy if we could keep the services that we have now going strong
- Mental health biggest need
- More massage therapist
- Neurology
- OB/GYN
- Weight loss by someone qualified to administer a program, not a provider who attends a weekend seminar

21. What PREVENTS community residents from receiving healthcare in general: “Other” responses

- Billing issues
- I have no idea why people wouldn’t use services that are so available to them rather than traveling if they don’t have to
- Need better doctors current staff is low quality
- No female MD
- No problems
- Noncompliance
- Not enough advertising on specialty providers
- Providers’ poor attitudes
- They feel they need it
- This is a poor community and very unaware of services available if any even are here on a regular basis. Most folks who do need medical care go to Bismarck or Rapid City
- Unknown
- We have a great clinic hospital and nursing home

22. What PREVENTS community residents from receiving healthcare LOCALLY: “Other” responses

- As long as a certain doctor is there my family will not use your hospital
- Can’t keep the same doctor
- Costs
- Doctors have terrible bedside manners
- Lack of regular full-time providers
- Local competition
- Long wait times, not receiving results timely
- None apply
- Not enough specialists; just send us to a different doc
- Perception. SWHS has everything available to receive healthcare locally
- Poor quality of care
- Poor service from providers preference
- PT needing to see a specialist
- They feel the other facility has more services and more stable
- West River presence

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23. What reasons would patients select healthcare services outside of the local community: “Other” responses

- A provider that is employed at SWHC
- Do not like MDs
- Ignorance
- Insurance billing. A clinic visit is just that! Stop billing as outpatient when we schedule a clinic visit! Insurance pays more if billed as clinic visit, regardless if an x-ray or lab is needed!
- Lower cost services
- They like West River better for some reason
- They started with another physician years ago and do not want to change
- All but bilingual and transportation are what I would choose
- Unknown
- I would choose access to specialists, higher quality
- All choices apply

24. Where do you turn for trusted health information: “Other” responses

- Self-healthcare schooling
- Specialist

29. Health insurance or health coverage status: “Other” responses

- BCBD
- (4) Insurance through spouse

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

- Better marketing to promote our local hospital
- Bowman is an isolated community and any additional educational health topics and services would be beneficial. Many old school folks live here and you have to have an “in” to break through some of the barriers here.
- Community needs to support local medical care/hospital
- Confidentiality
- Confidentiality is a big concern for me
- I feel that we need GOOD doctors who treat patients and coworkers with respect and know what they are doing. I have not been impressed with the doctors that southwest has brought into the community. I do really like one specific provider, who does fantastic and is very involved in our community. I feel that paying the CNAs and nurses a salary or hourly wage that they can actually live off of would be helpful in keeping good employees that do well at their jobs.
- I think we have excellent healthcare
- Keep providing quality healthcare with excellent staff
- More specialists and better advertising who is available and dates, confidentiality. Short wait time and better notification if provider is behind or on an emergency, people are mostly understanding if they are informed, staff should be aware within 15 minutes and contact the waiting patient. One provider can be very rude and this needs to be addressed!! Don’t get complacent and keep on top of things. I use this facility and want it to be the best so people will use it and want to work there.
- Need more stable doctors. Need to cooperate with West River in Hettinger more. For example, share big equipment (they have one, we have another). OB patients could deliver closer to home. When a referral to a service West River has, why not refer there instead of farther away? If both sides could cooperate it could help both to stay viable.
- Night clinics won’t work because there is no pharmacy available if I needed medicine. Stick to normal hours so those workers can spend time with their families.
- Not getting back to patients with answers in a timely manner or trying to find the answers to your questions
- Providers need to know their limits and refer out to specialists as soon as is necessary to improve patient outcomes. All laws and protocols should be followed (ex. Laboratory services)

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- Recruitment and retention of healthcare providers, including physicians, advanced practice practitioners, nurses and ancillary staff that actually take care of patients, instead of creating more and more admin positions.
- Retention of quality healthcare providers
- Southwest Healthcare Services continues to listen to the same group of community leaders and only certain staff. They need to visit how the Executive team works. From what I see there has been not change from doing business as usual. I believe they were financially stressed 2 years ago to the point of almost closing. The internal workings have not changed. Have they not learned from their mistakes? The new CEO is completely out of touch and micromanages the facility.
- Southwest healthcare Services needs reliable physicians who give quality care consistently
- Sustainability
- The improvement of Cultural change, excellent medical services, Great local doctors, Great experiences in Emergency Room, and Ambulance service will make people want to support our local Healthcare Services.
- Train staff on customer service, enforce confidentiality, recruit physicians who will engage with the community and stay, assess timeliness of getting test results back to patients, organization comes across as second rate by virtue of inability to quickly get results to patients so people go elsewhere with better service rather than wait.
- We need a strong board and strong admin that are transparent and committed to financial stability. It still is not financially stable.
- When I needed SW healthcare when I was sick they provided everything I need. Since I knew everyone they were very supportive and showed concern. SW healthcare is a great facility and if I don't have to go anywhere else I don't!!!
- When making an appointment at the clinic, all services should be billed through the clinic and NOT out patient hospital. This increases the copays and deductibles. SW appears to bill ALL lab work as outpatient hospital which increases costs for patient.
- Would like to see Southwest Healthcare and West River and Public Health work well together
- You need to look at your providers and their quality of care/concern and personality. One that is presently here has driven many people away with the number one reason is his personality and how he treats the patient.

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