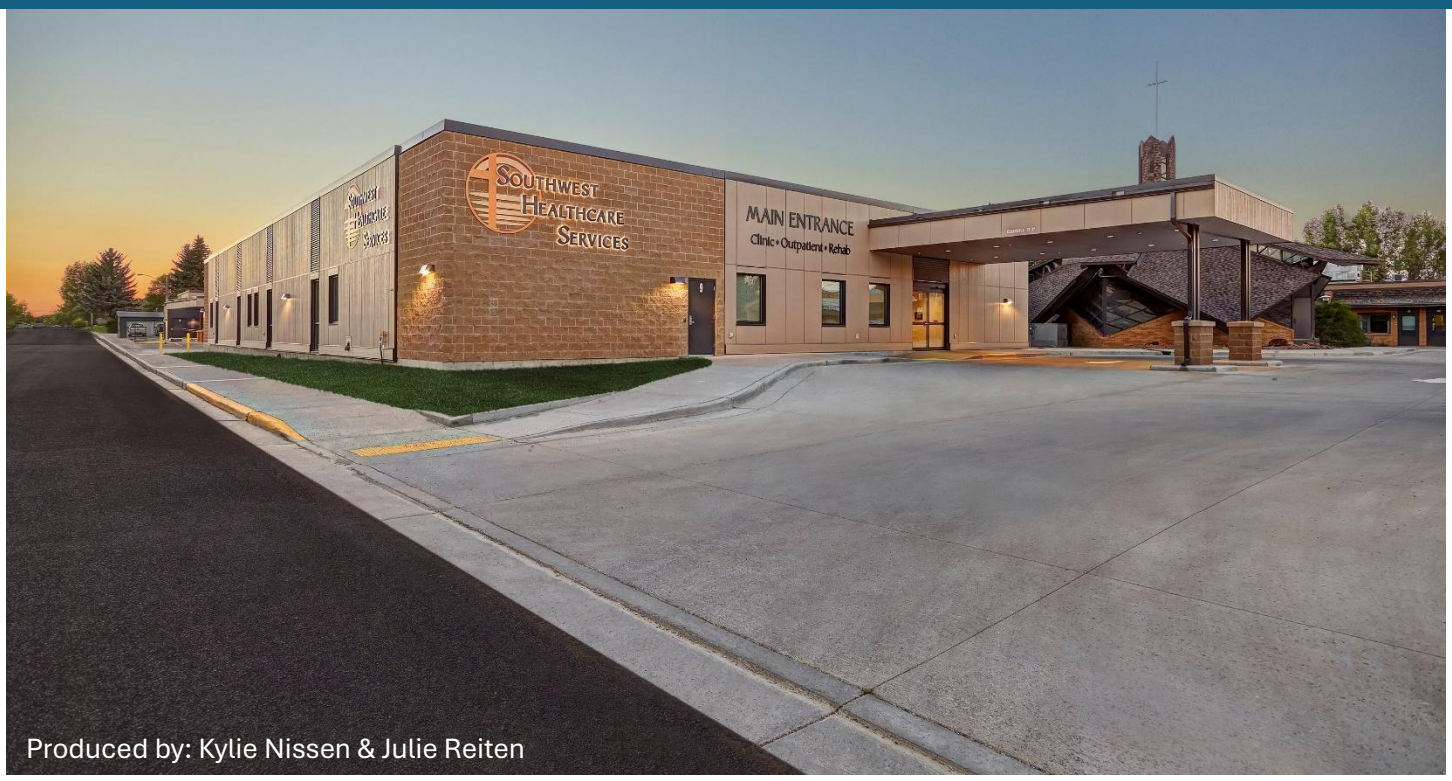
Southwest Healthcare Services
Complete Healthcare Today, For a Better Tomorrow

2025 Community Health Needs Assessment

Bowman, North Dakota



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Executive Summary

A community health needs assessment (CHNA) is a crucial tool for understanding and improving the health and well-being of a community by identifying key health issues, informing strategic planning, and fostering collaborative efforts among various stakeholders. The Southwest Healthcare Services (SWHS) CHNA focused on identifying and addressing the health needs of Bowman County by gathering data and input from the community to identify the most pressing health issues, including chronic diseases, mental health, access to healthcare services, and social determinants of health.

SWHS executed a CHNA process that included collecting primary and secondary data. The CHNA steering committee composed of the chief executive officer, director of nursing, human resources, purchasing, information technology, and public health administrator and nurse oversaw the CHNA along with the project consultant, Cibolo Health. Organizations and community stakeholders within the primary service area were engaged in identifying the needs of the community. Community organizations, government agencies, educational systems, health and human services entities, as well as others, were engaged throughout the CHNA. The comprehensive primary data collection phase resulted in contributions from a multitude of regional community stakeholders and representatives from organizations.

Input from the community was sought through a community survey, key informant interviews, and focus groups (community meetings). Community input was aligned with secondary data collections and presented to the CHNA Steering Committee, focus group participants, and key informant interviewees as a framework for assessing current community needs, identifying new/emerging health issues, and advancing health improvement efforts to address identified needs.

Specifically, the primary data collection consisted of several project components. In total, 45 surveys were collected, four key informant interviews were conducted, and 11 community members participated in the data collection focus group. All collection modes involved individuals who represented a) broad interests of the community, b) populations of need, or c) persons with specialized knowledge in public health.

A second community meeting composed of the key informant interviewees and those that attended the first focus group/community meeting met on October 14, 2025, where the data analysis was presented and attendees voted on the top priorities for 2025 based on primary and secondary data results. There were 11 people in attendance. Southwest Healthcare Services recognized its needs from the previous assessment and will build upon those issues, but most importantly, Southwest Healthcare Services identified additional areas of concern that require attention. Based on collective information from the previous implementation strategy plan along with the needs identified in the current cycle, Southwest Healthcare Services will reinforce and create new strategies to bridge the gap and address the needs of those in their service area.

With regard to demographics, the population of Bowman County, North Dakota in 2022 was 2,894, 7.9% down from the 3,142 who lived there in 2010. For comparison, the US population grew 7.7% and North Dakota's population grew 15.5% during that period. (https://usafacts.org/). Bowman County’s population from 2010 to 2022 decreased by 7.9%. The average number of residents under age 18 (24.5%) for Bowman County comes in 0.9% higher than the North Dakota average (23.6%). The percentage of residents ages 65 and older is 8.8% higher for Bowman County (25.82%) than the North Dakota average (17%). The median household income in Bowman County ($83,773) is higher than the state average for North Dakota ($75,949).

Data compiled by County Health Rankings show Bowman County is doing better than the North Dakota average in health outcomes/factors for 15 categories. It is scoring poorer than the North Dakota average in health outcomes/factors for 23 categories.

Of the list of potential community and health needs set forth in the survey, the 45 SWHS service area residents who completed the survey indicated the following needs as the most important:

- Attracting and retaining young families
- Having enough child daycare services
- Not enough jobs with livable wages
- Ability to retain primary care providers (MD, DO, NP, PA)
- Availability of specialists
- Cost of health insurance / Availability mental health services
- Not enough health care staff in general
- Depression/anxiety (youth and adult)
- Smoking and tobacco use, exposure to 2nd hand smoke or vaping (youth)
- Alcohol use and abuse (youth and adult)
- Not enough activities for children and youth
- Stress (adult)
- Cancer (adult)
- Drug use and abuse (adult)
- Cost of long-term/nursing home care
- Availability of resources to help elderly stay in their homes
- Assisted living options
- Ability to meet needs of older population

The survey also revealed the biggest barriers to receiving healthcare (as perceived by community members). They included no insurance or limited insurance (N=18), not able to see the same provider over time (N=12), and not enough specialists (N=11).

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

- People who live here are involved in their community
- Quality school systems
- Healthcare
- Family-friendly; good place to raise kids
- Year-round access to fitness opportunities

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:

- Having enough child daycare services
- Not enough affordable housing
- Attracting and retaining young families
- Availability of specialists
- Cost of health insurance
- Ability to retain primary care providers (MD, DO, NP, PA) and nurses
- Not enough healthcare staff in general
- Depression/anxiety
- Alcohol use and abuse
- Smoking and tobacco use, exposure to second-hand smoke, or vaping/juuling
- Cost of long-term/nursing home care

- Being able to meet needs of older population

Through community input, the top identified community concerns were:

- Availability of mental health services
- Attracting and retaining young families
- Not enough jobs with livable wages, not enough to live on

Southwest Healthcare Services is comprised of six facilities in separate locations which include: a 23-bed Critical Access Hospital, a 40-bed long-term care facility, 12 independent living apartments, a 12-unit assisted living facility, a Rural Health Clinic, and emergency ambulance services; providing over 50 services.

SWHS, along with Southwest District Health Unit (SWDHU), and community partners, will work to put together an Implementation Plan. The Implementation Plan will lay out how the community plans to address the concerns brought forward through the CHNA process.

Introduction

A community health needs assessment (CHNA) is a crucial tool for understanding and improving the health and well-being of a community by identifying key health issues, informing strategic planning, and fostering collaborative efforts among various stakeholders. The Southwest Healthcare Services CHNA focused on identifying and addressing the health needs of Bowman County by gathering data and input from the community to identify the most pressing health issues, including chronic diseases, mental health, access to healthcare services, and social determinants of health.

A CHNA involves community members, healthcare providers, and other stakeholders in the assessment process, fostering collaboration and ensuring that the community's voice is heard in identifying health priorities.

The legal and regulatory context of a Community Health Needs Assessment (CHNA) is primarily shaped by the requirements established under the Affordable Care Act (ACA) in the United States. The ACA requires all non-profit hospitals to conduct a CHNA every three years, and all accredited public health units to conduct a CHNA every five years. This provision is aimed at ensuring that hospitals remain accountable to the communities they serve by addressing local health needs that are systematically identified.

The hospitals must produce a written report documenting the CHNA. This report should include a description of the community served, the process and methods used to conduct the assessment, and a prioritized list of identified health needs. Alongside the CHNA, hospitals must develop an implementation strategy that outlines how they plan to address the identified health needs. This strategy must be approved by the hospital's governing body and included in the hospital's annual IRS Form 990 Schedule H submission. The CHNA report and implementation strategy must be made widely available to the public.

The CHNA encompasses a range of benefits aimed at improving public health and fostering a more informed, engaged, and healthier community. A comprehensive profile of the health of the community as well as an identification of the most pressing health issues and priorities from the community member's perspective will result from the CHNA. By including community involvement in the assessment, residents/stakeholders will have a greater awareness of the health issues and challenges facing the community. Engagement by this population during the assessment will also increase the likelihood that they will be willing to assist in the implementation of interventions designed to improve the findings that were a top concern. The implementation plan will layout the roadmap to addressing the top concerns found in the CHNA.

Ultimately, the outcome most anticipated is that implementation of targeted health interventions and programs designed to address specific health concerns will improve overall community health. The plan should also lead to decreased health disparities among different population groups, leading to more equitable health outcomes.

Another outcome of a CHNA is strengthened partnerships and collaborations among healthcare providers, public health agencies, community organizations, and other stakeholders. The result is an enhanced collective impact through coordinated efforts to address community health issues.

Methodology

To ensure community engagement in the data collection, information was collected in a variety of ways:

- A survey solicited feedback from residents within the hospital's service area;
- Key informant interviews of community leaders representing the broad interests of the community;
- Focus groups, comprised of community leaders and area residents, convened to discuss area health needs and inform the assessment process in a community meeting.

Community engagement is essential to a successful CHNA. Community involvement ensures that the assessment accurately reflects the health needs and priorities of the population it serves. The hospital, along with the local public health unit, works to identify and involve a diverse group of stakeholders, including healthcare providers, public health officials, community organizations, educators, business leaders, and residents to participate in the key informant interviews and the focus groups/community meetings. These participants 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.

As previously described, 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 behaviors.

A common approach to survey research is online survey. However, this approach is not without limitations. There is always the concern of non-response as it may affect the representativeness of the sample as well as having to eliminate any surveys completed by those outside of the service area being assessed. Thus, a mixture of different data collection methodologies is recommended.

Conducting key informant interviews in addition to the random sample survey allows for a more robust sample, and ultimately, these efforts help to increase the community response rate. Partnering with local community organizations such as public health, schools, churches, and senior centers, just to name a few, assists in reaching segments of the population that might not otherwise respond to a survey.

While key informant data can offer invaluable insight into the perception of a community or group of individuals, qualitative data can be difficult to analyze. For this reason, key informant data are grouped into common themes.

Given the low population in the service area, key informant interview participants may still be hesitant to express their opinions freely even though the reporting of any comments is de-identified.

Another barrier in relation to the low population density of rural communities often requires regional reporting of many major health indices, including chronic disease burden and behavior health indices. The North Dakota BRFSS, through a cooperative agreement with the CDC, is used to identify regional trends in health-related behaviors. The fact that many health indices for rural and frontier counties are reported regionally makes it impossible to set the target population aside from the most developed North Dakota counties.

Process

A CHNA characteristically involves four key steps to ensure a comprehensive understanding of the community's health needs and priorities: 1) planning and preparation, 2) data collection, 3) data analysis, and 4) identify and prioritize health needs.

Planning and Preparation

Cibolo Health helps independent rural hospitals create networks with their peers to overcome the obstacles rural healthcare providers face. At that time, a CHNA liaison was selected locally, who served as the main point of contact with Cibolo Health for the CHNA process. A steering committee composed of a diverse group of stakeholders, including representatives from healthcare, public health, community organizations, and the community at large (see Figure 1), was formed that was responsible for planning and implementing the process locally.

Figure 1: Steering Committee

Member First & Last Name	Title	Organization
Dennis Goebel	CEO	SWHS
Kayla Pauley	Quality Assurance	SWHS
Amy Smyle	Home Care/Assisted	SWHS
Lacy Nass	Living Social Worker	SWHS
Lisa Knopp	Clinic Manager	SWHS
Allison Pretzer	Accounting/Controller	SWHS

Data Collection

Once the framework for the process was in place, data collection began. There are two types of data that were collected, primary data that is gathered first-hand, and secondary data that is collected from existing data sources such as County Health Rankings and the US Census. This can include data on demographics, health status, healthcare access, and social determinants of health.

Primary Data Collection

Primary data was collected directly from the community through surveys, key informant interviews, and focus groups/community meetings. This helps to gather firsthand information on community perceptions and experiences. This was done in three ways: key informant interviews, community meetings/focus groups, and a survey.

Key Informant Interviews

On August 15, 2025, a representative from Cibolo Health conducted four key informant interviews in person in Bowman. Interviews were held with invited members of the community who could provide insights into the community's health needs. Included among the informants were healthcare and public health professionals, law enforcement, and members of the community with young families.

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

Focus Groups/Community Meetings

A community group consisting of eleven community members convened and first met on August 15, 2025. During this first focus group/community meeting, attendees were introduced to the needs assessment process, reviewed basic demographic information about the community, and served as a focus group. Focus group topics were very similar to those included in the key informant interviews, including community assets and challenges, the general health needs of the community, community concerns, and suggestions for improving the community's health. This first data gathering focus group represented a cross section demographically. SWHS staff were in attendance as well but largely played a role of listening and learning.

The community group met again on October 14, 2025, with 11 community members in attendance. At this second community meeting the attendees, which consisted of those that attended the first community meeting as well as the key informants, were presented with survey results, findings from key informant interviews and the first community meeting, and a wide range of secondary data relating to the general health of the population in the service area. The group was then tasked with identifying and prioritizing the community's health needs.

Members of the second community meeting represented the broad interests of the service area of SWHS and SWDHU. They included representatives of the health community, business community, political leaders, law enforcement, economic development, faith community, and social service agencies. Not all members of the group were present at both meetings.

Survey

A survey was distributed throughout the hospital service area, which included residents of Bowman County. 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 B.

The original survey tool was developed and used by the State Office of Rural Health at the Center for Rural Health (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. The survey has since been edited by Cibolo to reflect changes in health practices and the data needs of the communities.

Similar to the questions asked in the key informant interviews and first community meeting, the survey was designed to:

- Learn of the community's assets and concerns;
- Gather perceptions and attitudes about the health of the community as well as collect suggestions for improvement; and
- Learn how local health services are used by residents.

Specifically, the survey covered the following topics:

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

To promote awareness of the assessment process, press releases led to published articles in the local newspaper in Bowman County. Additionally, information was published on Southwestern District Health Unit's website and Facebook page and flyers were posted around the county.

The survey was open from February 19, 2025, to March 31, 2025. While the primary survey collection tool was an online survey utilizing Survey Monkey, paper surveys were also available upon request. No completed paper surveys were returned. The survey link was distributed by community group members and at SWHS, SWDHUD, local churches, publicized in the local paper, as well as shared on the SWHS website and Facebook page. Fifty-two online surveys were completed. In total, counting both paper and online surveys, 45 community member surveys were completed, equating to a 7% response rate. This response rate is somewhat low for this type of unsolicited survey methodology and indicates a community that doesn't have a desire to provide input, which is often found when people do not have major concerns they want addressed.

Secondary Data Collection

In a CHNA, secondary data sources are crucial for providing a comprehensive overview of the health status and needs of the community. Secondary data was collected and analyzed to provide descriptions of: (1) population demographics, (2) general health issues of the population, and (3) contributing causes of community health issues. The data was collected from a variety of sources, such as census, public health, and socio-economic data, as well as Behavioral Risk Factor Surveillance System and the Youth Risk Behavior Surveillance System. Specific sources include:
The U.S. Census Bureau, which provides demographic data including age, gender, race, income, and education levels, which are essential for understanding the population's structure and socio-economic status (https://data.census.gov/).

County Health Rankings & Roadmaps, a program of the University of Wisconsin Population Health Institute, draws attention to why there are differences in health within and across communities (www.countyhealthrankings.org). Annually since 2010, the University of Wisconsin Population Health Institute and the Robert Wood Johnson Foundation have produced the County Health Rankings—a "population health checkup" for the nation's over 3,000 counties. They base the Rankings on a conceptual model of population health that includes both health outcomes (mortality and morbidity) and health factors (health behaviors, clinical care, social and economic factors, and the physical environment). Data for over 30 measures available at the county level are assembled from a number of national sources. Composite scores are then ordered and counties are ranked from best to worst health within each state.

The Centers for Disease Control and Prevention (CDC) provides data on disease prevalence, vaccination rates, and health behaviors in a publication called the Youth Risk Behavior Surveillance System (YRBSS). The YRBSS is a set of surveys that track behaviors that can lead to poor health in students grades 9 through 12 (https://www.cdc.gov/healthyyouth/data/yrbs/index.htm).

The National Survey of Children's Health (NSCH) provides rich data on multiple, intersecting aspects of children's lives—including physical and mental health, access to and quality of health care, and the child's family, neighborhood, school, and social context. The National Survey of Children's Health is funded and directed by the Health Resources and Services Administration Maternal and Child Health Bureau (www.childhealthdata.org/learn/NSCH).

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), compiles and shares current, comprehensive data on child and family well-being in each of North Dakota's 53 counties. The data addresses six domains: demographics, health, education, family and community, economic well-being, and safety.

It is important that sufficient secondary source data on youth is collected for the community's CHNA because the surveys conducted as part of the primary data collection are not collected for people under the age of 18.

By utilizing these diverse sources of secondary data, a CHNA can develop a detailed and accurate picture of the community's health needs and resources, which is essential for planning effective health interventions and policies.

Data Analysis

Data collected during the CHNA process was utilized through both quantitative and qualitative analysis. Through quantitative analysis, numerical data was used to identify trends, disparities, and key health indicators. This involved statistical analysis and comparisons to state or national benchmarks. Qualitative data from community groups and key informant interviews, as well as open ended survey questions was used to identify common themes and insights into the community's health needs and priorities.

Identifying and Prioritizing Health Needs

Key health issues were identified based on the data analysis by identifying the most pressing health issues affecting the community. During the second community meeting, the attendees from the first community meeting and the key informants gather at a second meeting to prioritize the health concerns based on the CHNA findings that were presented to them. The meeting attendees consider numerous factors, such as the severity of the issue, the number of people affected, and the ability to make an impact. The top concerns that the community members feel should be addressed in the next three years were identified.

Community Profile

Cibolo Health, in coordination with Southwest Healthcare Services and Southwest District Health Unit District, 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.

SWHS, a licensed Critical Access Hospital, is located in the rural area of southwest North Dakota in the town of Bowman. The facility comprises seven different entities that include a Rural Health Clinic, a 35-bed acute care hospital, emergency department, rehabilitation, laboratory services, and radiology services. SWHS 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 of 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 2,993 residents. A majority of the racial makeup of Bowman County is Caucasian, which makes up over 92% 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 of Bowman County include an optometrist, two dental practices, two chiropractors, and multiple massage therapists. There are also numerous social programs.

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 three fitness centers, bike paths, and baseball and softball fields. The city of Bowman also has a robust parks and recreation center, and since 2022 they have opened a new rec center and trampoline jump park inside a repurposed big box retail store. The location also includes a community room and an indoor playground. The parks and rec manage 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.

The city of Bowman also includes cultural amenities, including the Pioneer Trails Regional Museum, dedicated to the history of the region. The movie theater on Main Street also provides a mode of entertainment with weekend showtimes of movies for all ages, young and old.

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

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

The demographics of Bowman County, the county where SWHS resides, have been taken from the United States Census Bureau (https://data.census.gov/), 2022 American Community Survey 5-Year Estimates, unless otherwise specified.

According to countyhealthrankings.org, Bowman County is rural, with 100% of the population living a low population (under 10,000) density area. Figure 1 illustrates the location of the counties in North Dakota.

Figure 1. Bowman County & Slope

Snapshot of Bowman County

Populations and People
Total Population
2,993
P1 | 2020 Decennial Census

Income and Poverty
Median Household Income
$83,773
S1901 | 2023 American Community Survey 5-Year Estimates

Education
Bachelor's Degree or Higher
27.3%
S1501 | 2023 American Community Survey 5-Year Estimates

Employment
Employment Rate
62.9%
DP03 | 2023 American Community Survey 5-Year Estimates

Housing
Total Housing Units
1,633
H1 | 2020 Decennial Census

Health
Without Health Care Coverage
7.8%
S2701 | 2023 American Community Survey 5-Year Estimates

Business and Economy
Total Employer Establishments
153
CB2100CBP | 2021 Economic Surveys Business Patterns

Families and Living Arrangements
Total Households
1,237
DP02 | 2023 American Community Survey 5-Year Estimates

Race and Ethnicity
Hispanic or Latino (of any race)
129
P9 | 2020 Decennial Census

Bowman County Demographics

Source: https://www.countyhealthrankings.org/ (2024)

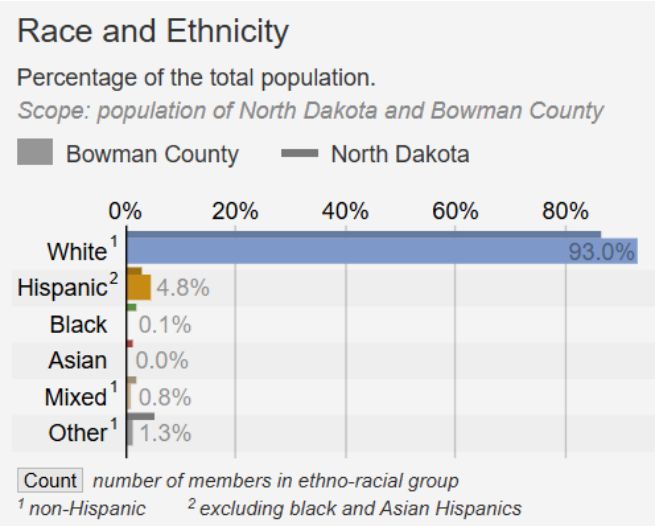
	Bowman County	North Dakota
Population (2023)	2,867	**783,926**
% Below 18 Years of Age	24.5%	23.6%
% 65 and Older	25.8%	17%
% Non-Hispanic Black	0.5%	3.6%
% American Indian or Alaska Native	2.9%	5.3%
% Asian	0.1%	1.70%
% Native Hawaiian or Other Pacific Islander	0.1%	0.2%
% Hispanic	4.8%	4.9%
% Non-Hispanic White	91.8%	82.6%
% Not Proficient in English	0%	1%
% Female	48.6%	48.7%
% Rural	100.0%	39.00%

According to https://datausa.io/, the median property value in Bowman County was $176,400 in 2023, which is 0.581 times smaller than the national average of $303,400. Between 2022 and 2023 the median property value increased from $168,200 to $176,400, a 4.88% increase. The homeownership rate in Bowman County is 83%, which is higher than the national average of 65%.

People in Bowman County have an average commute time of 17.6 minutes, and they drove alone to work. Car ownership in Bowman County is approximately the same as the national average, with an average of 2 cars per household.

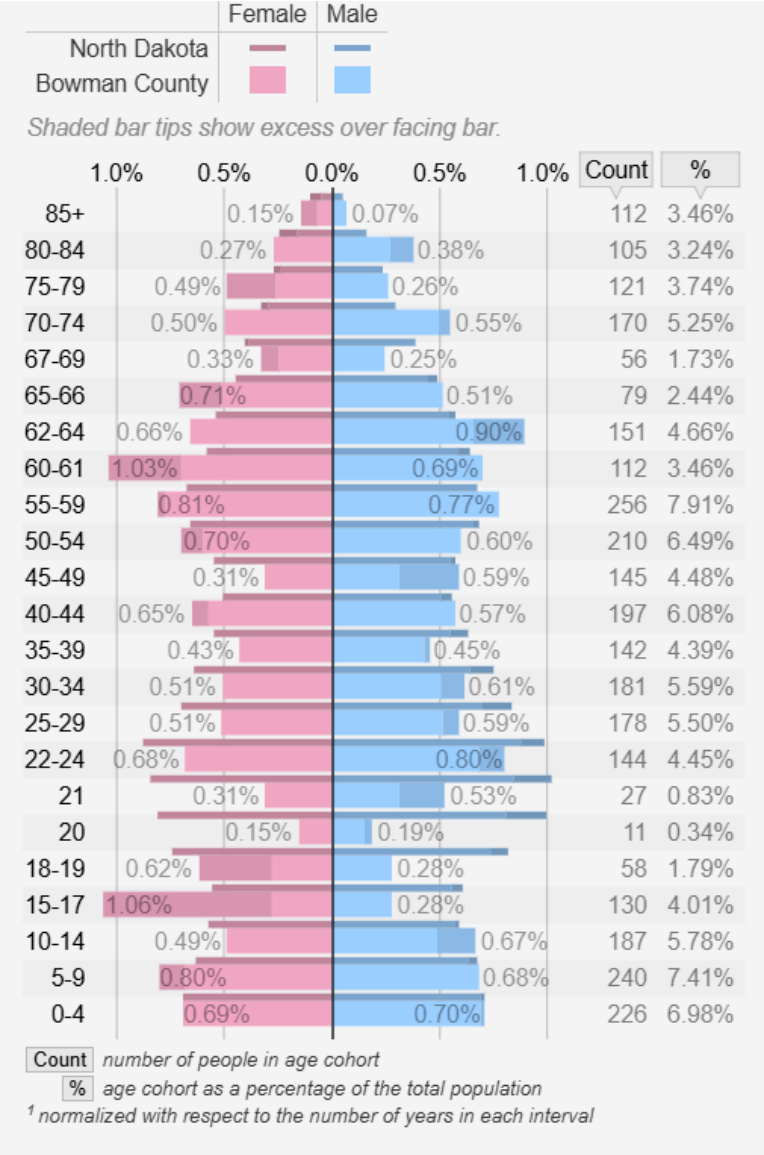
In 2024, 7.17% of the population was living with severe housing problems in Bowman County. From 2014 to 2024, the indicator grew 1.47%.

Race and Ethnicity (% of total population)

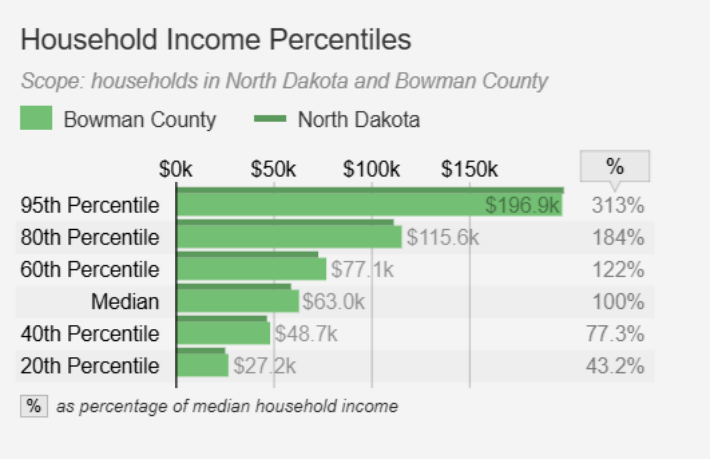


Source: https://statisticalatlas.com/county/North-Dakota/Bowman-County/Race-and-Ethnicity#figure/race-and-ethnicity

Population Pyramid: Population by Age and Sex



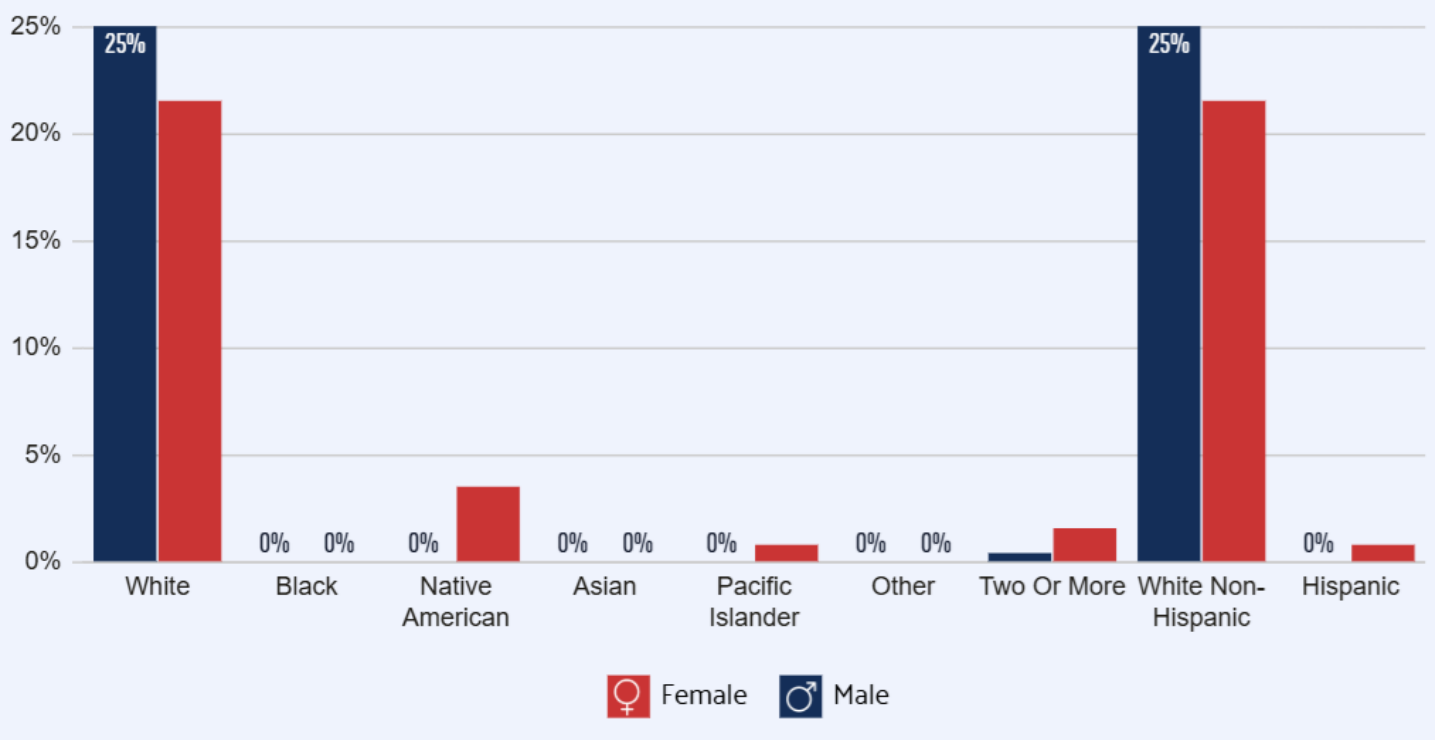
Household Income



Source: https://statisticalatlas.com/county/North-Dakota/Bowman-County/Race-and-Ethnicity#figure/race-and-ethnicity

Poverty

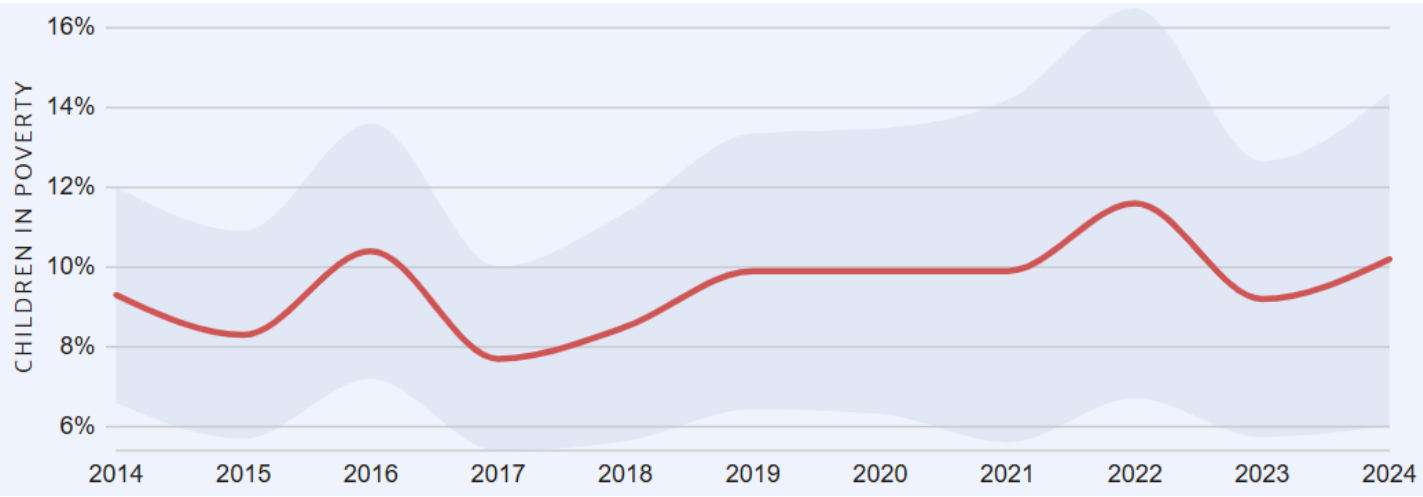
9.5% of the population for whom poverty status is determined in Bowman County, ND (272 out of 2.86k people) live below the poverty line, a number that is lower than the national average of 12.4%. The largest demographic living in poverty are Males 18 - 24, followed by Males 65 - 74 and then Females < 5.



Source: Data from the Census Bureau ACS 5-year Estimate.

Children in Poverty

In 2024, 10.2% of the children was living in poverty in Bowman County, ND. From 2014 to 2024, the indicator grew 0.9%. The graph shows the trend of the percentage of the children living in poverty.

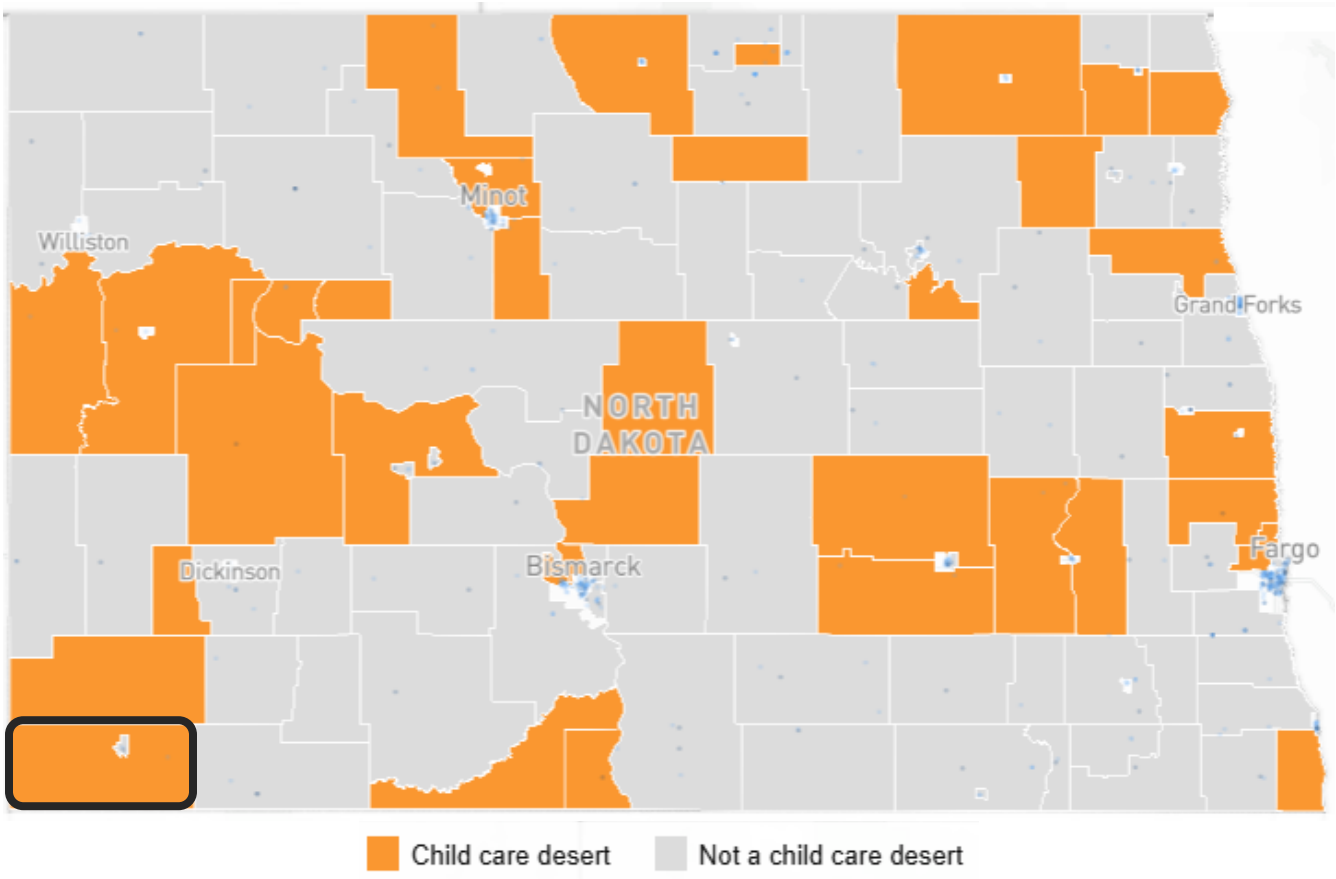


Source: Data from the County Health Rankings & Roadmaps County Health Rankings.

Childcare

Daycare plays a role in many communities, including those in SWHS's service area. As shown below in Figure 3, according to the Center for American Progress Childcare Deserts website (https://childcaredeserts.org/), Bowman County is a childcare desert. A childcare desert means that the shortage of licensed childcare slots (as compared to the number who are likely to need childcare based on parental workforce participation) is at least 3 to 1. Meaning there are three children who are likely to need care for every one care slot available in the community. Appendix C provides the 2024 ND Health & Human Services Child Care Profile for Bowman County.

Figure 3. ND Child Care Deserts



Southwest Healthcare Services (SWHS)

SWHS is a multi-unit health system, comprised of seven entities. Encompassed within the system is a rural medical clinic, a 35-bed acute care hospital, 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. The Critical Access Hospital Profile for SWHS includes a summary of hospital-specific information and is available in Appendix A.

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

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 as the long-term care facility. In May of 2017, the new facility opened its doors. SWHS serves multiple counties and multiple communities in the tri-state area of southwest North Dakota, northwest South Dakota, and southeast Montana.

Mission

"Guided by faith, we provide excellent care for 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.

We will show:

WE CARE

- Welcoming
- Ethical
- Communication
- Accountability
- Respectful
- Empowerment

SWHS includes a 35-bed Critical Access Hospital (CAH) with various outpatient therapies and services located in Bowman, North Dakota. As a hospital, clinic, and designated Level 4 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

1. Acne treatment
2. Allergy testing
3. Spirometry testing
4. Allergy, flu, and pneumonia shots
5. Ambulance and Emergency services
6. Assisted living

7. Blood pressure checks
8. Cardiac rehab
9. Pulmonary rehab
10. Clinic
11. Emergency room
12. Gynecology (visiting physician)
13. Hospital (acute care)
14. Independent senior housing
15. Mole/wart/skin lesion removal
16. EKG
17. Obstetrics (visiting physician)
18. Pharmacy
19. Prenatal care up to 32 weeks
20. Physicals: annuals, D.O.T., sports, and insurance
21. Sports medicine
22. Surgical services – biopsies
23. Surgical services – outpatient
24. Surgical services – upper and lower endoscopy
25. Skilled & Non-skilled Swing bed services
26. Telemedicine
27. Telepsych services
28. Visiting nurse services
29. Home oxygen
30. Nebulizer services
31. Non-opioid pain management

Screening/Therapy Services

1. Chronic disease management
2. Holter monitoring
3. Laboratory services
4. Lower extremity circulatory assessment
5. DOT physicals
6. Pediatric services
7. Physical therapy
8. Occupational therapy
9. Speech therapy
10. Respiratory care
11. Sleep studies
12. Social services
13. Senior mental health services

Radiology Services

1. CT scans
2. Digital mammography
3. Echocardiograms (visiting service)
4. General x-ray
5. Mammograms
6. MRI (mobile unit)
7. Ultrasound

Laboratory Services

1. Blood bank
2. Blood gasses
3. Coagulation
4. Chemistry
5. D.O.T and Non-D.O.T. drug and breath alcohol testing
6. Hematology
7. Urinalysis
8. Quick kits

Services offered by OTHER providers/organizations

1. Chiropractic services
2. Dental services
3. Massage therapy
4. Optometric/vision services

Southwestern District Health Unit (SDHU)

Southwestern District Health Unit (SWDHU) provides public health services that include health, nursing services, the WIC (Women, Infants, & 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 SWDHU is to "Prevent, Promote and Protect for optimal community health." To fulfill this mission, 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

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 provided by SWDHU include:

- Flu shots
- Health Tracks - child health screening (Medicaid eligible)
- Immunizations (includes in school immunizations and travel vaccines
- Medication setup – home visits
- Newborn home visits
- Nutrition education
- School health – vision, health education, and resource to the schools
- Preschool education programs and screening
- Tobacco Prevention and Control and cessation
- Tuberculosis testing and management
- West Nile program – education
- WIC (Women, Infants, & Children) Program
- Health Maintenance Program
- Dental health education

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.

Social determinants of health (SDOH) are the conditions in which people are born, grow, live, work, and age that affect a wide range of health, functioning, and quality-of-life outcomes (economic stability, education access and quality, social and community context, health care access and quality, neighborhood and built environment). SDOH are fundamental factors that influence health outcomes and disparities. Addressing these determinants is necessary for creating healthier communities, achieving health equity, and ensuring that all individuals have the opportunity to lead healthy lives. By focusing on SDOH, we can develop more effective and comprehensive public health strategies that go beyond medical care to address the broader factors affecting health. County Health Rankings help depict where each county sits in regards to the SDOH of their population.

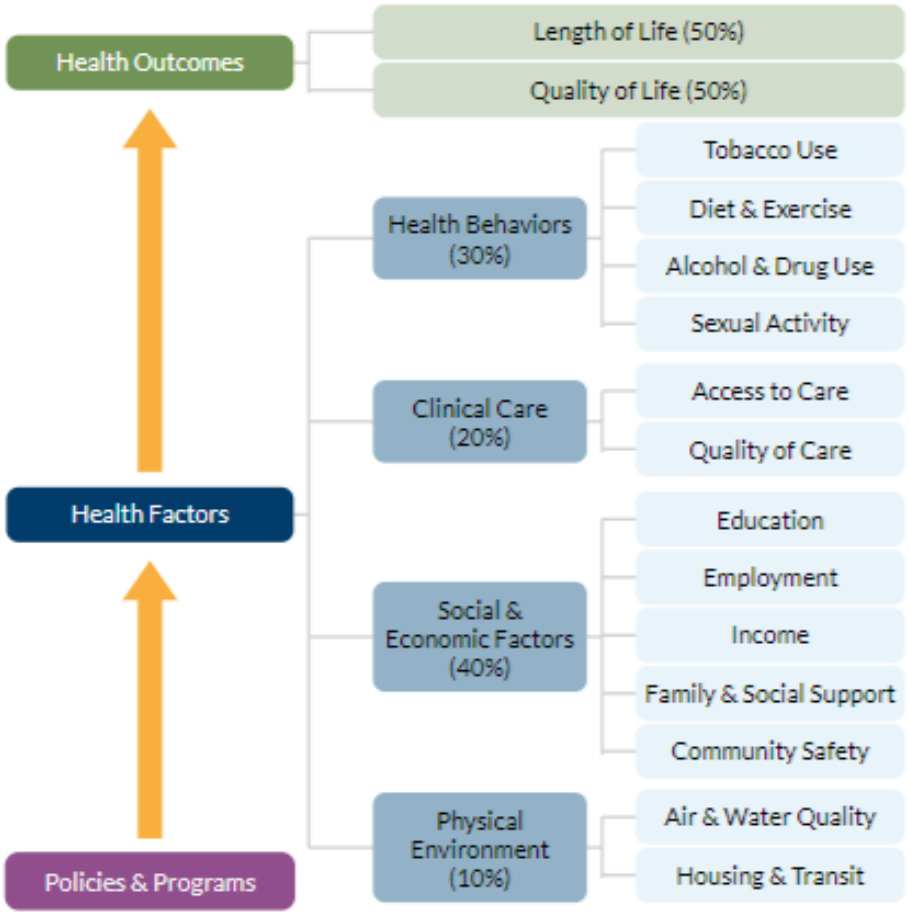
The data used in the 2024 County Health Rankings are pulled from more than 30 data sources and then are compiled to create county rankings. Counties in each of the 50 states are ranked according to summaries of a variety of health measures. Those having high ranks, such as 1 or 2, are considered to be the "healthiest." Counties are ranked on both health outcomes and health factors. The data reflected is from 2022 – there is a two-year lag in the data.

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

Health Outcomes tell us how long people live on average within a community, and how much physical and mental health people experience in a community while they are alive. They are influenced by many factors, such as clean water, affordable housing, the quality of medical care and the availability of good jobs. Programs and policies at the local, state and federal levels influence these factors. Many things influence how well and how long we live. Health Factors represent those things we can improve to live longer and healthier lives. They are indicators of the future health of our communities. Figure 1 shows the County Health Rankings Model.

Figure 4. County Health Rankings Model

Source: https://www.countyhealthrankings.org/what-impacts-health/county-health-rankings-model



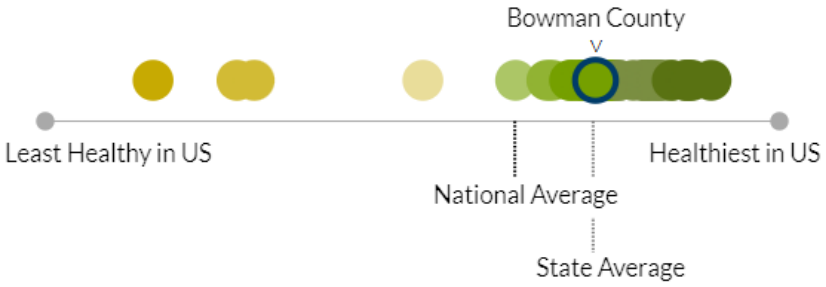
Bowman County is faring about the same as the average county in North Dakota for Health Outcomes and Health Factors, and better than the average county in the nation. Figure 2 depicts where Bowman County falls in regard to health outcomes and health factors compared to the least healthy in the US, the healthiest in the U.S., the state average, and the national average.

Figure 5. Bowman County Health Outcomes and Factors

Source: www.countyhealthrankings.org

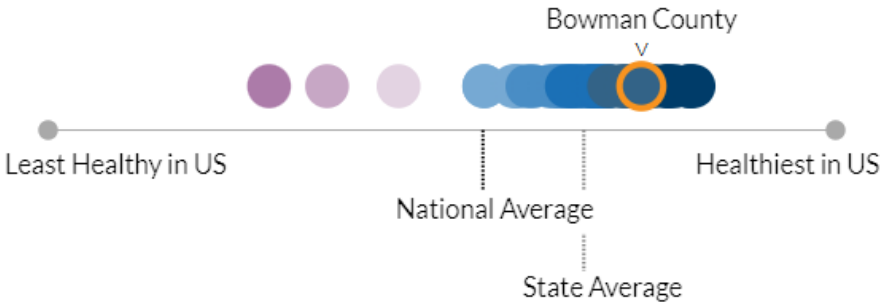
Health Outcomes:

- Length of life
- Quality of life



Health Factors:

- Health behavior
- Clinical care
- Social & Economic Factors
- Physical Environment



Children's Health

The National Survey of Children's Health (NSCH) provides rich data on multiple, intersecting aspects of children's lives - including physical and mental health, access to and quality of health care, and the child's family, neighborhood, school, and social context. The NSCH is funded and directed by the Health Resources and Services Administration (HRSA) Maternal and Child Health Bureau. A revised version of the survey was conducted as a mail and web-based survey by the Census Bureau in 2016, 2017, 2018, 2019, 2020, 2021 and 2022. Data reported in Table 3 is from 2021-2022. Items noted in red show where North Dakota is fairing more poorly than the national average.

Table 2. Data Resource Center for Child & Adolescent Health
2021-2022 National Survey of Children's Health
Source: https://www.childhealthdata.org/

Health Status	North Dakota	National
Children born premature (3 or more weeks early)	11.0%	11.4%
Children 10-17 overweight or obese	28.0%	33.7%
Children 0-5 who were ever breastfed	77.6%	81.5%
Community and School Activities		
Children 6-17 who missed 11 or more days of school	**5.9%**	5.7%
Children 12-17 who work for pay	53.4%	35.6%

Health Care		
Children currently insured	94.3%	93.1%
Children that had one or more preventative visits in the past year	**73.6%**	76.8%
Children who spent less than 10 minutes with the provider at a preventive medical visit	16.1%	18.8%
Children (1-17 years) who had a preventive dental visit in the past year	77.7%	77.0%
Children (0-17 years) who have seen an eye doctor in the past 2 years	51.7%	39.4%
Children (3-17 years) received mental health care	13.4%	11.6%
Children (3-17 years) who had difficulties getting the mental health treatment/counseling needed and did not obtain care	5.0%	5.5%
Young children (9-35 mos.) receiving standardized screening for developmental problems in the past year	46.1%	33.7%
Children who have received coordinated, ongoing, comprehensive care within a medical home	52.3%	46.1%
Family Life		
On most weekdays, children who usually spend 4 or more hours in front of a TV, computer, cellphone or other electronic device watching programs, playing games, accessing the internet or using social media, not including schoolwork	18.4%	22.9%
Children who live in households where someone smokes	**17.1%**	12.7%
Children who have, during the past year, not afford to eat	3.1%	4.5%
Neighborhood		
Children who live in neighborhoods with parks, recreation centers, sidewalks, and a library	**33.6%**	36.1%
Children living in neighborhoods with poorly kept or rundown housing	19.5%	24.7%
Children living in a safe neighborhood	76.3%	66.2%

North Dakota KIDS COUNT is dedicated to providing current, relevant, and reliable data to shape the issues affecting North Dakota children and families. North Dakota KIDS COUNT also regularly updates the KIDS COUNT Data Center to include the most recent statistics for children and families. The KIDS COUNT Data Center is a project of the Annie E. Casey Foundation, and KIDS COUNT is a comprehensive source for data on child and family well-being in the United States (https://ndkidscount.org/county-data). See Appendix B. In addition to the population demographics of children in Bowman County and North Dakota, Figure 3 shows the 2021-2022 results versus the 2020-2021 results when available.

Figure 6. Bowman County KIDS COUNT Data Report

Source: https://ndkidscount.org/county-data

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North Dakota County Profiles

Bowman County

Select a county on the map below:

ight blue shading shows the five American Indian reservations within North Dakota.

Population Estimates for: 2023	Bowman	North Dakota
Child Population (under 18):	702	184,734
American Indian/Alaska Native:	6.0%	7.8%
Black:	0.9%	5.2%
White:	90.9%	79.6%
2+ Races or Other:	2.3%	7.4%

Health & Wellness

Children Without Health Insurance	Children Enrolled in Medicaid or CHIP	Women Who Receive Early Prenatal Care
8.6%	213	86.7%
2022	2023	2023
14.2% 2021	213 2022	85.0% 2022

Early Childhood

Children Under Age 6	Child Care Providers	Child Care Capacity
199	7	153
2023	2024	2024
203 2022	7 2023	153 2023

Education

Free or Reduced-Price Lunch Participation	Four-Year Cohort Graduation Rate	3rd Grade Students Proficient in Reading
19.4%	88.2%	41.3%
2023/24	2022/23	2022/23
19.7% 2022/23	>= 95% 2021/22	39.2% 2021/22

Family Economic Security

Children Living in Poverty	Child Food Insecurity	Children with All Parents Working
10.8%	13.1%	86.4%
2023	2022	2019-2023
10.2% 2022	6.7% 2021	82.2% 2018-2022

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

Table 3 depicts some of the YRBS data that has been collected in 2017, 2019, and 2021(most recent published data). 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 2019 to 2021, and "↓" for a decreased trend in the data changes from 2019 to 2021. The final column shows the 2021 national average percentage. For a more complete listing of the YRBS data, see Appendix H.

Table 3. Youth Behavioral Risk Survey Results
North Dakota High School Survey
Rate Increase ↑, rate decrease ↓, or no statistical change **=** in rate from 2019-2021.

	ND 2019	ND 2021	ND Trend ↑, ↓, =	Rural ND Town Average	Urban ND Town Average	National Average 2021
% of students who rarely or never wore a seat belt (when riding in a car driven by someone else)	46	49.6	↑	9.2	5.5	39.9
% 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)	14.2	13.1	=	18.2	13.7	14.1
% of students who texted or e-mailed while driving a car or other vehicle (on at least one day during the 30 days before the survey)	53.0	55.4	=	59.9	55.9	36.1
% of students who were in a physical fight on school property (one or more times during the 12 months before the survey)~2017/2019~ *in 2021 replaced by* % of students who carried a weapon on school property (such as a gun, knife, or club, on at least 1 day during the 30 days before the survey)	7.1	-		6.2	4.4	3.0
% of students who experienced sexual violence (being forced by anyone to do sexual things [counting such things as kissing, touching, or being physically forced to have sexual intercourse] that they did not want to, one or more times during the 12 months before the survey)	9.2	9.4	=	9.7	11.6	11
% of students who were bullied on school property (during the 12 months before the survey)	19.9	15.8	↓	19.8	15.0	15.0
% of students who were electronically bullied (includes texting, Instagram, Facebook, or other social media ever during the 12 months before the survey)	14.7	13.6	↓	16.2	14.5	15.9
% of students who made a plan about how they would attempt suicide (during the 12 months before the survey)	15.3	14.8	=	15.1	17.2	17.6
% of students who currently use an electronic vapor product (e-cigarettes, vape e-cigars, e-pipes, vape pipes, vaping pens, e-hookahs, and hookah pens at least one day during the 30 days before the survey)	33.1	21.2	↓	24.2	23.6	18.0

% of students who currently used cigarettes, cigars, or smokeless tobacco (on at least one day during the 30 days before the survey)	12.2	5.9	↓	8.0	6.1	3.8
% of students who currently were binge drinking (four or more drinks for female students, five or more for male students within a couple of hours on at least one day during the 30 days before the survey)	15.6	14.0	=	17.8	14.6	10.5
% of students who currently used marijuana (one or more times during the 30 days before the survey)	12.5	10.7	=	10.2	12.9	15.8
% of students who ever took prescription pain medicine without a doctor's prescription or differently than how a doctor told them to use it (counting drugs such as codeine, Vicodin, OxyContin, Hydrocodone, and Percocet, one or more times during their life)	14.5	10.2	↓	9.7	11.0	12.2
% of students who were overweight (>= 85th percentile but <95th percentile for body mass index)	16.5	15.6	=	15.5	14.2	16.0
% of students who had obesity (>= 95th percentile for body mass index)	14.0	16.3	=	17.4	15.0	16.3
% of students who did not eat fruit or drink 100% fruit juices (during the seven days before the survey)	6.1	5.0	=	5.7	4.6	7.7
% of students who did not eat vegetables (green salad, potatoes [excluding French fries, fried potatoes, or potato chips], carrots, or other vegetables, during the seven days before the survey)	6.6	5.9	=	5.3	6.2	9.3
% of students who drank a can, bottle, or glass of soda or pop one or more times per day (not including diet soda or diet pop, during the seven days before the survey)	15.9	16.6	=	17.5	13.8	14.7
% of students who did not eat breakfast (during the seven days before the survey)	14.4	15.1	=	14.5	17.3	22.0
% of students who were not 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 seven days before the survey)	50.1	43.5	↑	58.0	55.3	NA
% of students who ever had sexual intercourse	38.3	36.6	=	36.5	37.0	30
% of students who had eight or more hours of sleep (on an average school night)	29.5	24.5	↓	28.3	23.2	22.7

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

Low Income

The 2023 Needs Assessment Study of Low-Income North Dakota Individuals and Families, was a collaborative effort between the Community Action Agencies (CAAs) and North Dakota State University (NDSU). It was carried out through the utilization of surveys and focus groups, followed by statistical analysis. Specifically, the assessment involved a variety of survey methods, including both online and

paper surveys, chosen based on their appropriateness for different respondent groups, targeting low-income individuals and families across the state of North Dakota.

Findings from the study found that "Rental Assistance" remained the top priority need among people experiencing poverty throughout the state under the category of "Housing". Inconsistencies between the responses from low-income or non-low-income respondents were found, which reflect distinct needs within these two groups. For example, the top priority need for the non-low-income respondents is "Mental Health Service", while "Rental Assistance" stands as the top need for the low-income people, as well as the broader community, including both low-income and non-low-income people. Individuals and families with higher incomes tend to prioritize Civic Engagement and Community Involvement, including aspects like "Recreational Activities" and "Safe Neighborhoods, Sidewalks, Parks". Conversely, those with lower incomes are more inclined to place greater emphasis on fundamental necessities such as "Rental Assistance", "Food", and "Dental Insurance/Affordable Dental". This divergence in priorities reflects varying needs and concerns across income levels.

Increased living costs and inflation have emerged as significant contributing factors to the causes of poverty across the state, and they could also be the key drivers behind the top priority need for "Rental Assistance". The frequently mentioned causes of poverty, derived from analysis of the qualitative data collected across the state, are listed below in order of frequency (with the most frequently mentioned causes listed first).

1. Increasing living costs/Inflation
2. Disability, Mental Illness, Severe Anxiety/Depression, etc.
3. Childcare Issue for Working Parents
4. Family Instability
5. Less/No Skills for Jobs (with better pay and benefits)
6. Lack of Affordable Transportation (to and from work)
7. Generational Poverty
8. Lack of Education
9. Bad Record/Background

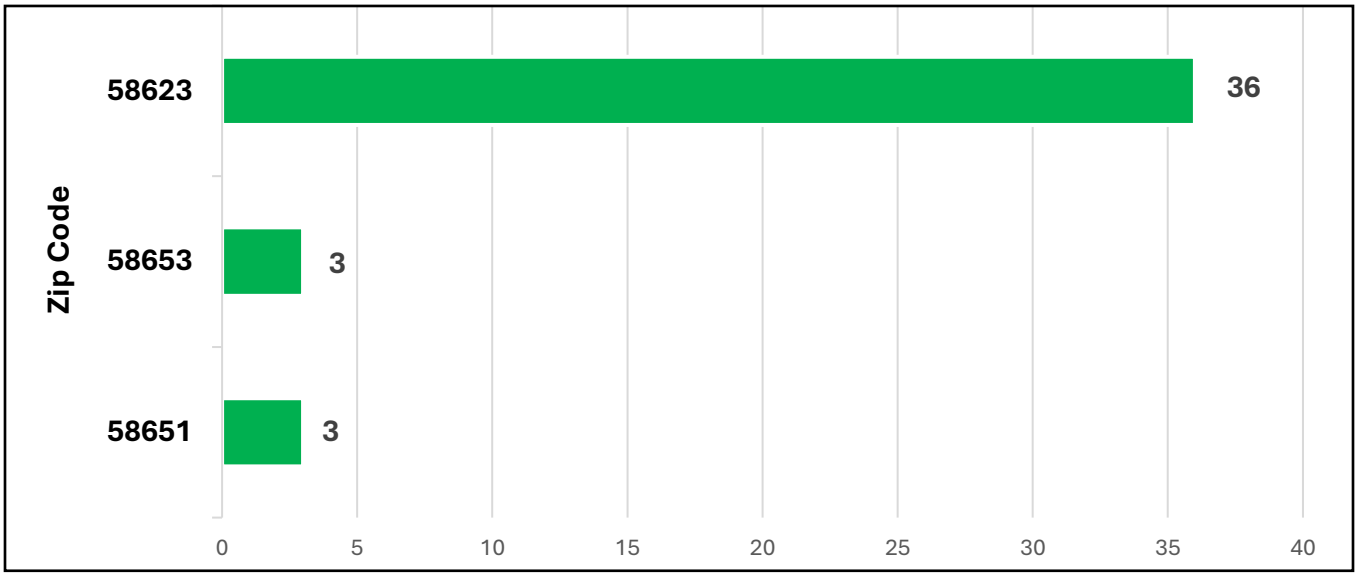
Survey Results

A total of 45 community members completed the survey in communities throughout the counties in the Southwest Healthcare Services service area. For all questions that contained an "Other" response, all of those direct responses may be found in Appendix B. In some cases, a summary of those comments is additionally included in the report narrative. The "Total respondents" number under each heading indicates the number of people who responded to that particular question and the "Total responses" number under the heading depicts the number of responses selected for that question (some questions allow for selection of more than one response). An asterisk (*) indicates that survey respondents were able to select more than one answer response.

The survey requested that respondents list their home zip code. While not all respondents provided a zip code, 42 did, revealing that a large majority of respondents (N=36) had a Bowman zip code followed by (N=3) in Scranton, and (N=3) in Rhame. There were no other zip codes provided.

Figure 7: Survey Respondents' Home Zip Code

Total respondents: 42



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

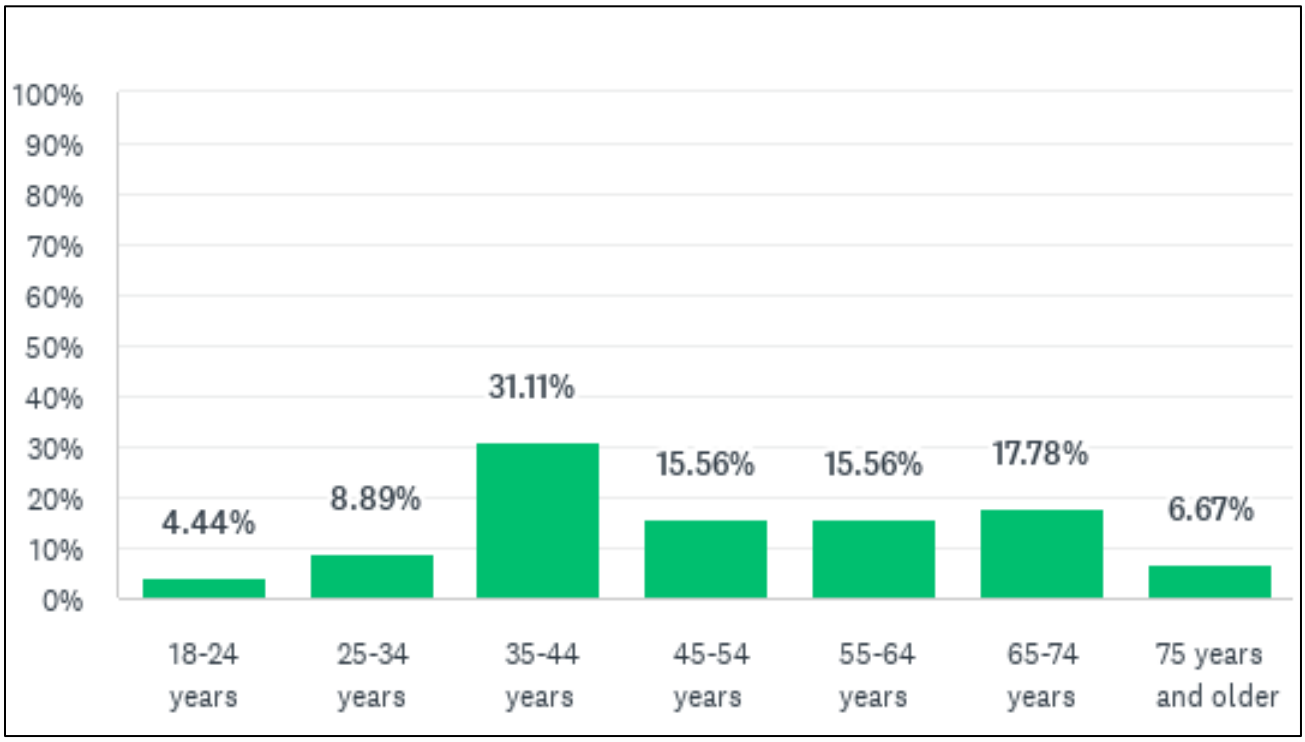
To better understand the perspectives being offered by survey respondents, survey-takers were asked a few demographic questions. Throughout this report, numbers (N) instead of just percentages (%) are reported because percentages can be misleading with smaller numbers. Survey respondents were not required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

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

- The largest group of respondents (27.5%, n = 15) were between 35 and 44 years old.
- The majority (82.5%, n = 33) were female.
- Over half of the respondents (56%, n = 22) had bachelor's degrees or higher.
- The number of those working full time (62.5%, n = 25) was more than three times higher than those who were retired (20%, N=8).
- 100% (N=40) of those who reported their ethnicity/race were white/Caucasian.
- 58% of the population (N=22) had household incomes of $100,000 or above.

Figures 8 through 14 show these demographic characteristics. It illustrates the range of community members' household incomes and indicates how this assessment took into account input from parties who represent the varied interests of the community served, including a balance of age ranges, those in diverse work situations, and community members with lower incomes.

Figure 8: Age Demographics of Survey Respondents
Total respondents = 45



People under age 18 are not questioned using this survey method.

Figure 9: Gender Demographics of Survey Respondents
Total respondents = 43

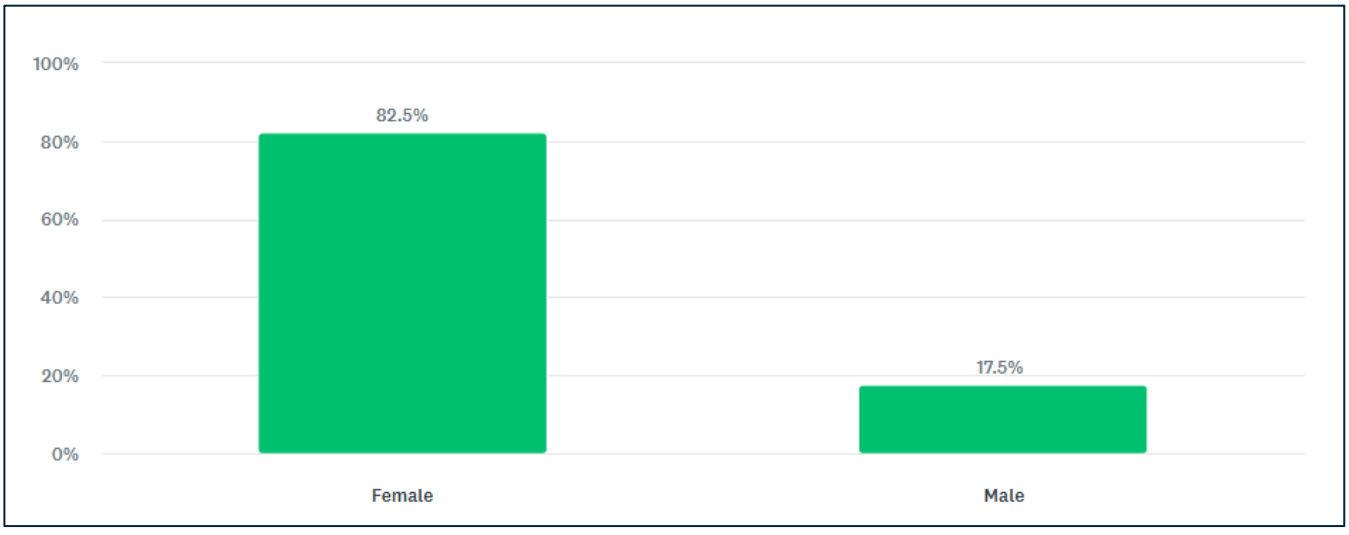


Figure 10: Educational Level Demographics of Survey Respondents
Total respondents = 44

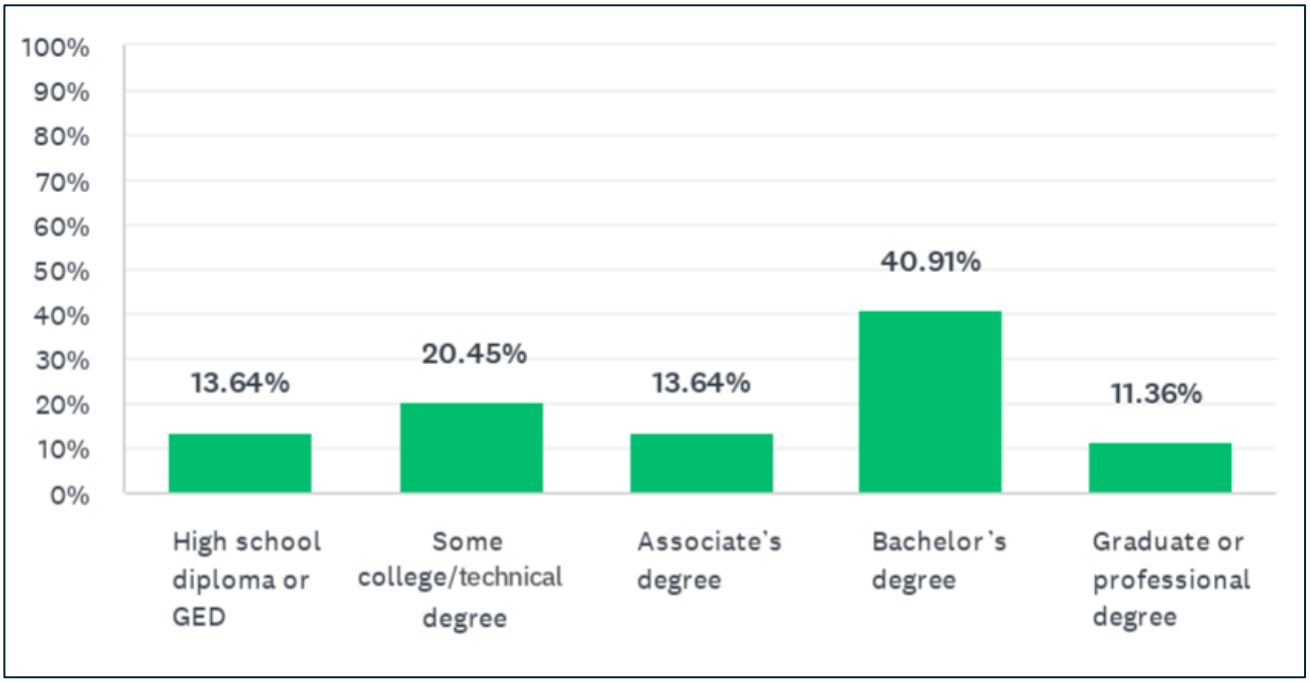
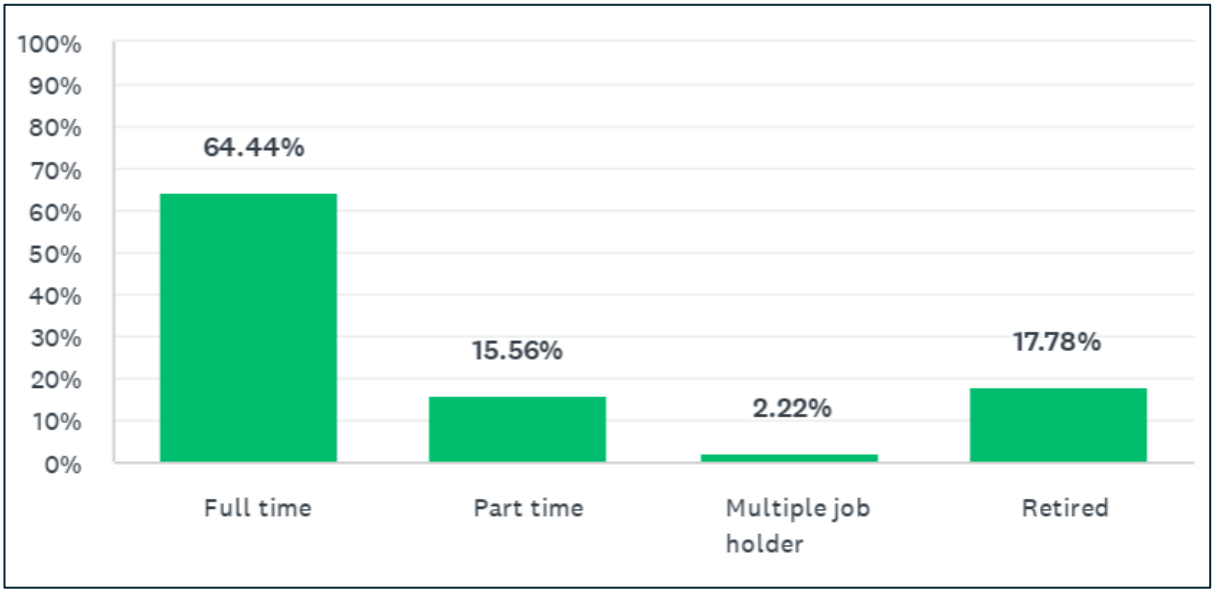
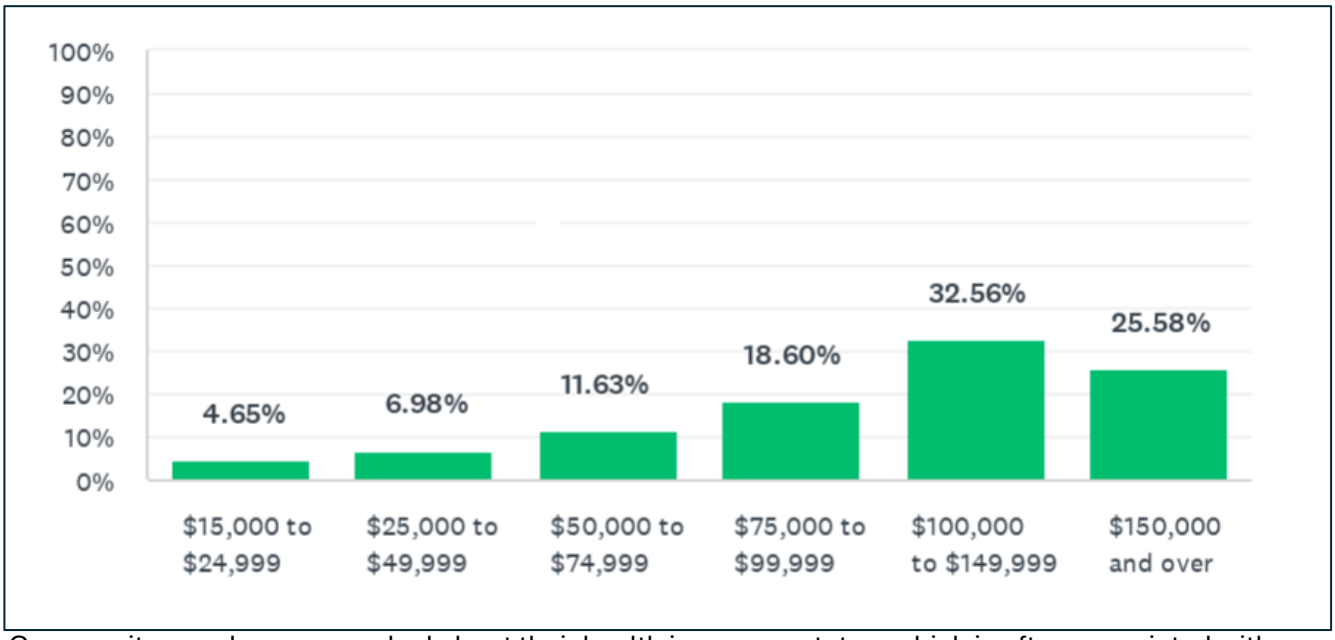


Figure 11: Employment Status Demographics of Survey Respondents
Total respondents = 45



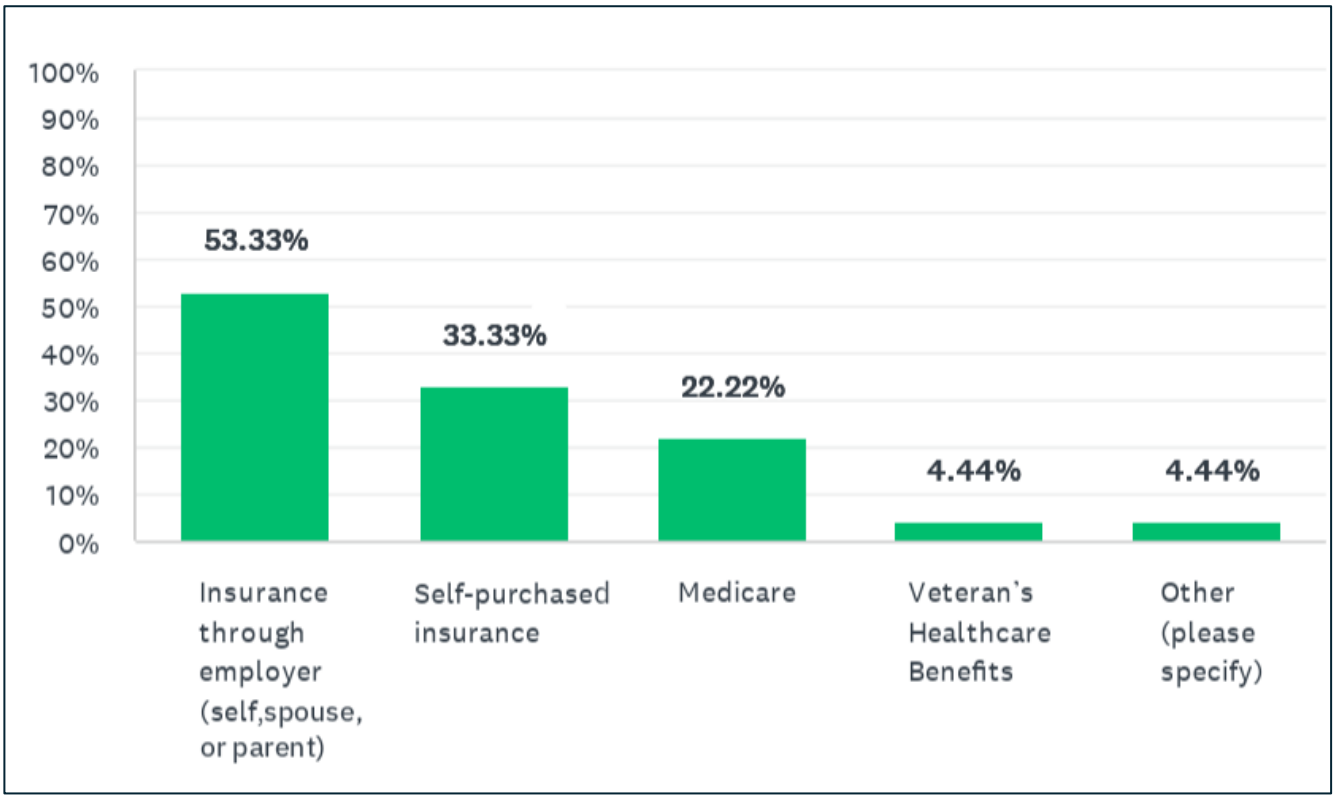
Of those who provided a household income, 5% (N=2) community members reported a household income of less than $25,000. Fifty-eight percent (N=13) indicated a household income of $100,000 or more. This information is shown in Figure 12.

Figure 12: Household Income Demographics of Survey Respondents
Total respondents = 43



Community members were asked about their health insurance status, which is often associated with whether people have access to healthcare. None of the respondents reported having no health insurance. The most common insurance types were insurance through one's employer (N=24), followed by self-purchased (N=15) and Medicare (N=10). The "Other" responses were Medigap insurance and through another state.

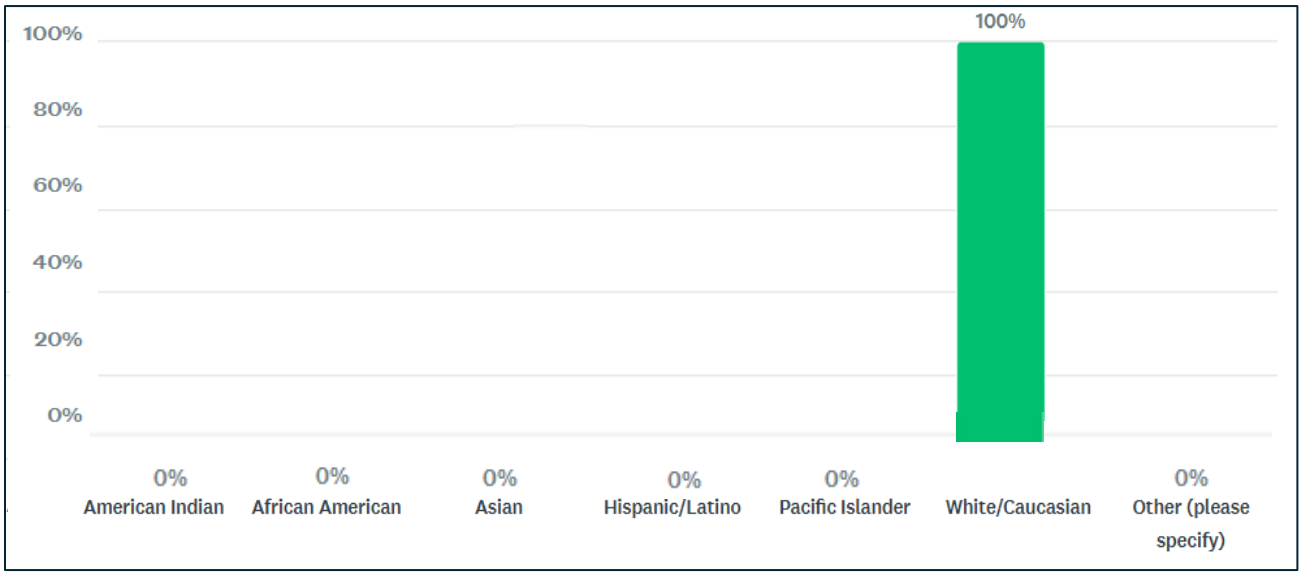
Figure 13: Health Insurance Coverage Status of Survey Respondents
Total respondents = 45



As shown in Figure 12, all of the respondents were white/Caucasian (100%). This was not far off from the race/ethnicity of the overall population of Bowman County; the US Census indicates that 92.2% of the population is white in Bowman County.

Figure 14: Race/Ethnicity Demographics of Survey Respondents

Total respondents = 45



Community Assets and Challenges

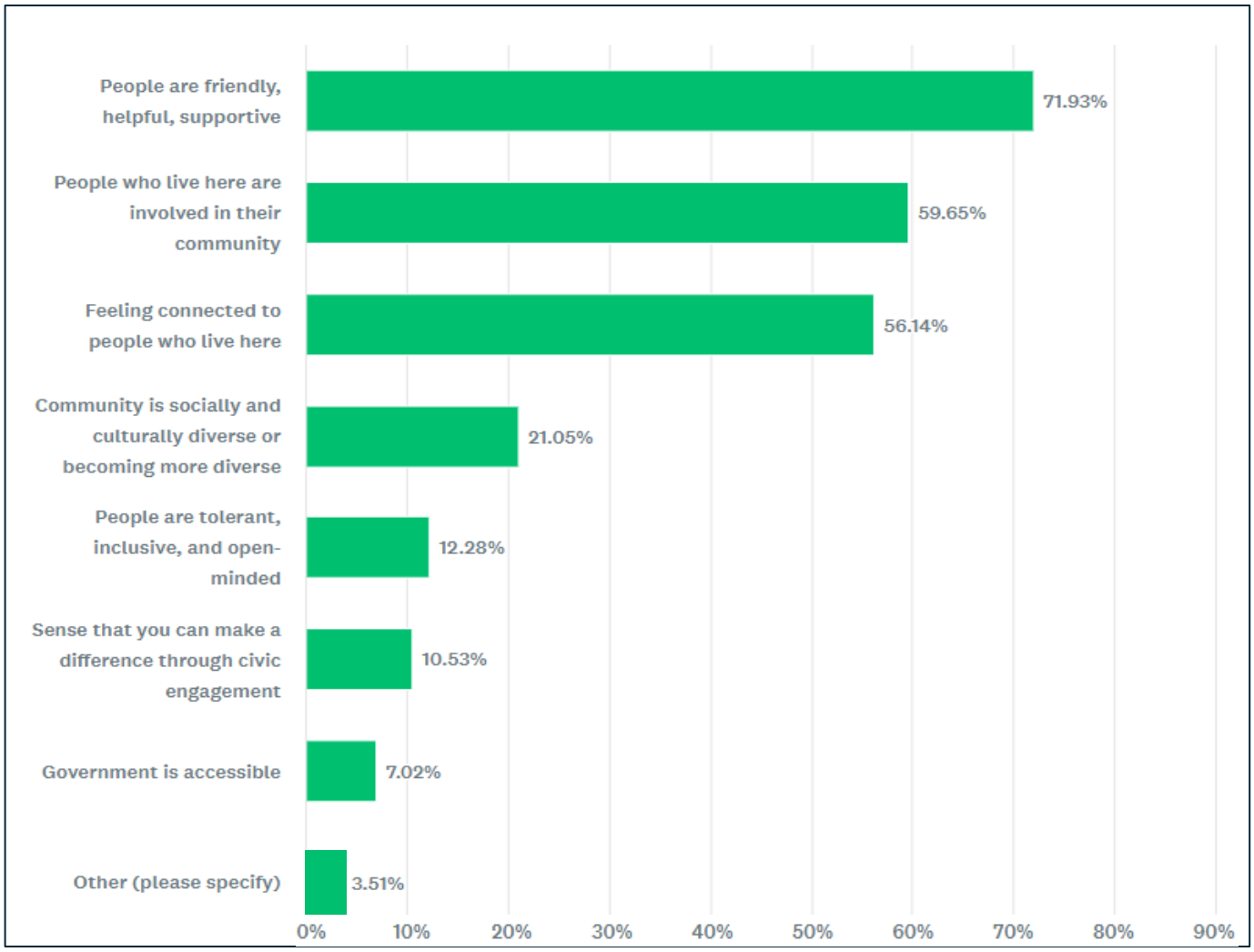
Survey-respondents were asked what they perceived as the best things about their community in four categories: people, services and resources, quality of life, and activities. In each category, respondents were given a list of choices and asked to pick the three best things. Respondents occasionally 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 30 respondents agreeing) that community assets include:

- People are friendly, helpful, supportive (n=41);
- People who live here are involved in their community n=34);
- Feeling connected to people who live here (n=32);
- Healthcare (n=36);
- Quality school systems (n=36);
- Active faith community (n=33);
- Family-friendly, good place to raise kids (n=46); and
- Safe place to live, little/no crime (n=40).

Figures 15 to 18 illustrate the results of these questions.

Figure 15: Best Things about the PEOPLE in Your Community

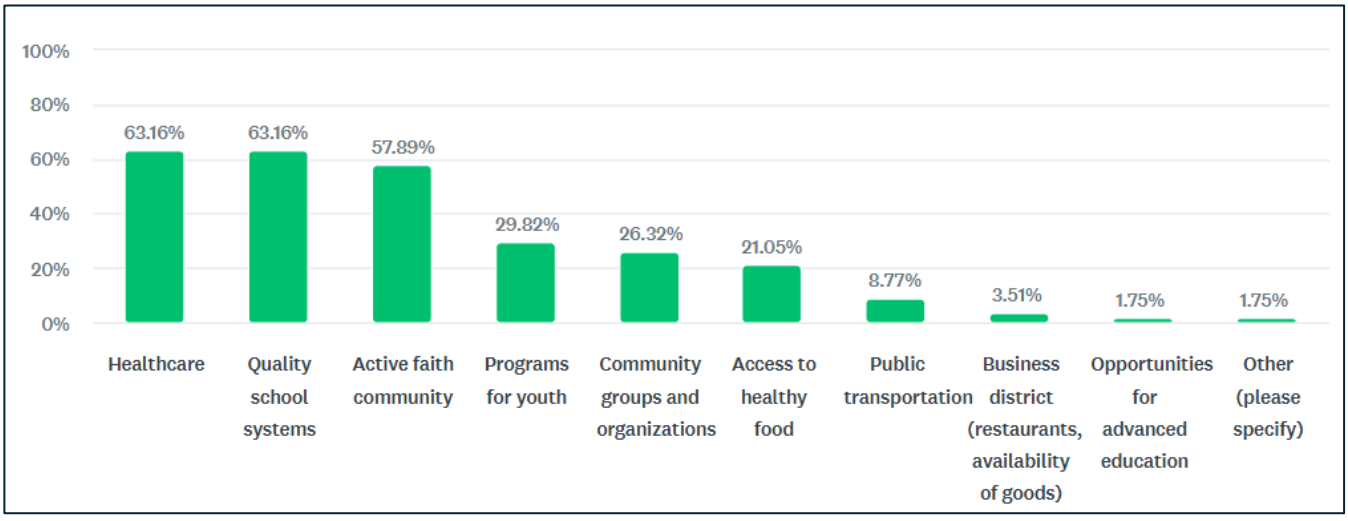
Total responses = 59



The "Other" response addressed community members reluctance to accept newcomers.

Figure 16: Best Things about the SERVICES AND RESOURCES in Your Community

Total responses = 59



The other response was “Small town living.”

Figure 17: Best Things about the QUALITY OF LIFE in Your Community
Total responses = 59

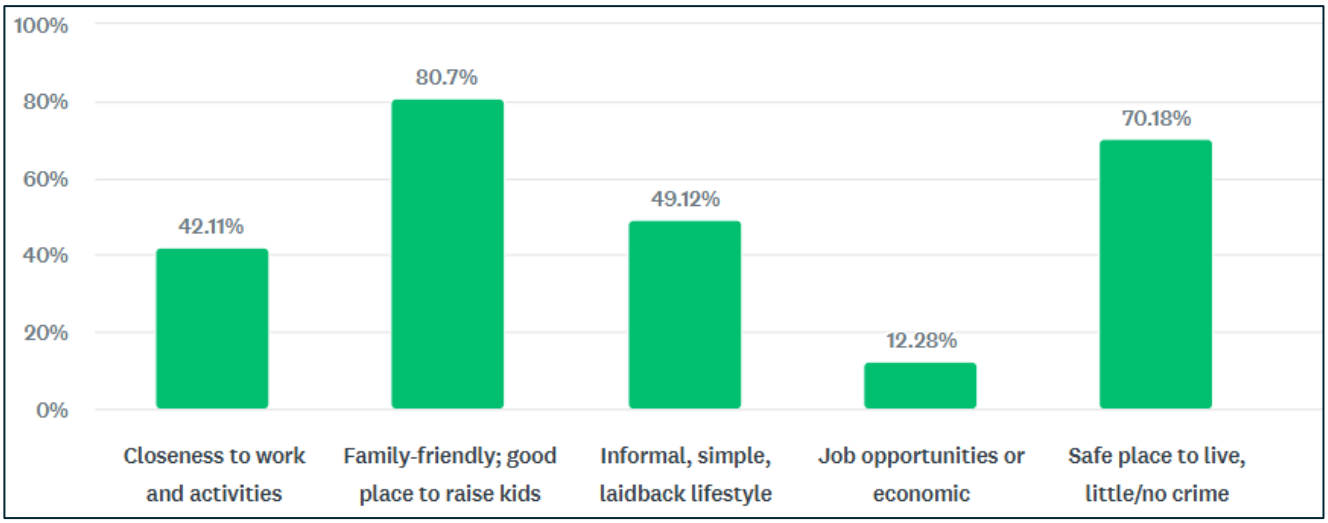
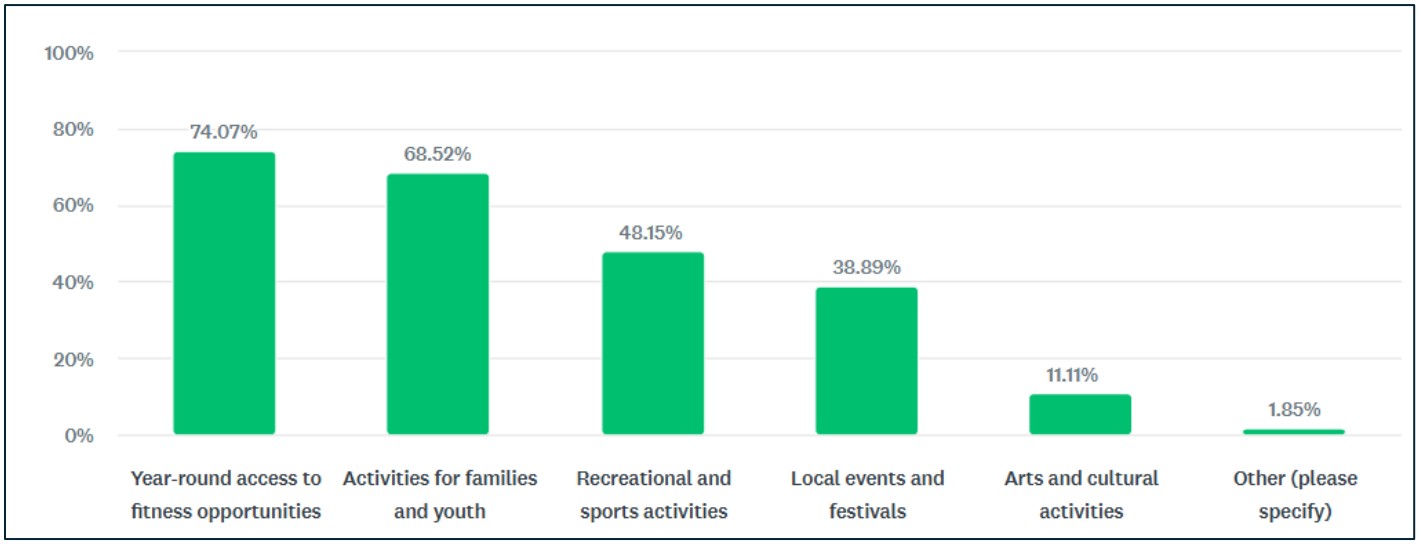


Figure 18: Best Things about the ACTIVITIES in Your Community
Total responses: 55



The Other response for this question was: **“**Unless you have small children or they are in sports not much activities for adults or anywhere to go except for bars, entertainment only a couple times a year except for bars . The only sit down restaurant that is family oriented other then a bar /or has a bar in the restaurant is in Rhame which still can get alcohol and there is no transportation other then southwest transportation.**”**

Community Concerns

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

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

With regard to responses about community challenges, the most highly voiced concerns (those having at least 20 respondents) were:

- Attracting and retaining young families (n=33)
- Alcohol use and abuse – Adult (n=25);
- Cost of long-term/nursing home care (n=25);
- Depression/anxiety – Youth (n=24);
- Smoking and tobacco use, exposure to second-hand smoke or vaping (juuling) – Youth (n=23);
- Not enough places for exercise and wellness activities (n=23);
- Assisted living options (n=20).

The other issues that had at least 19 votes included:

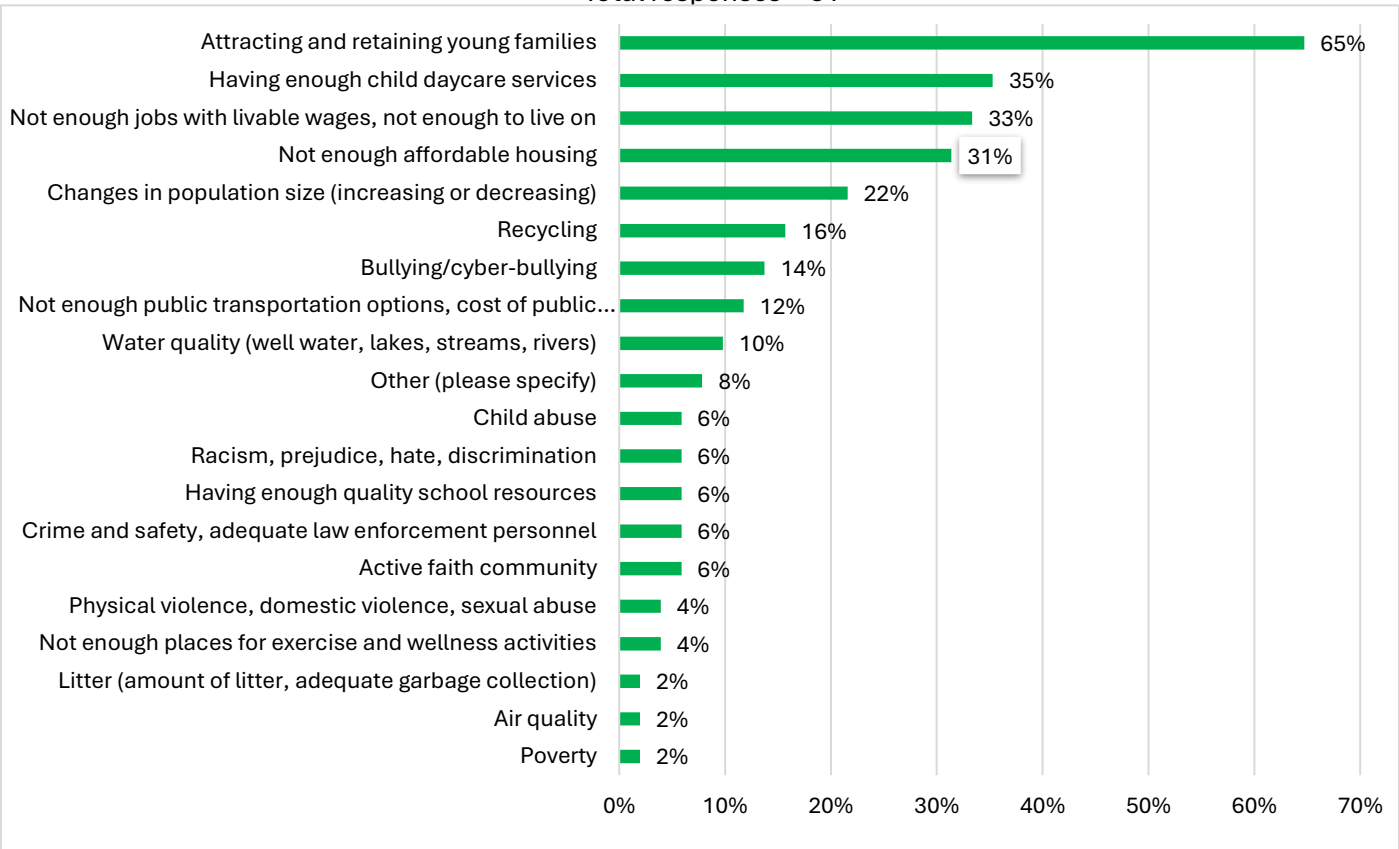
- Ability to retain primary care providers (ND, DO, NP, PA) and nurses in the community (n=19)

For questions that had long responses that are truncated in the charts, the full text is in italics below each chart.

Figures 19 through 24 illustrate these results.

Figure 19: Community/Environmental Health Concerns

Total responses = 51



Cut-off chart text:

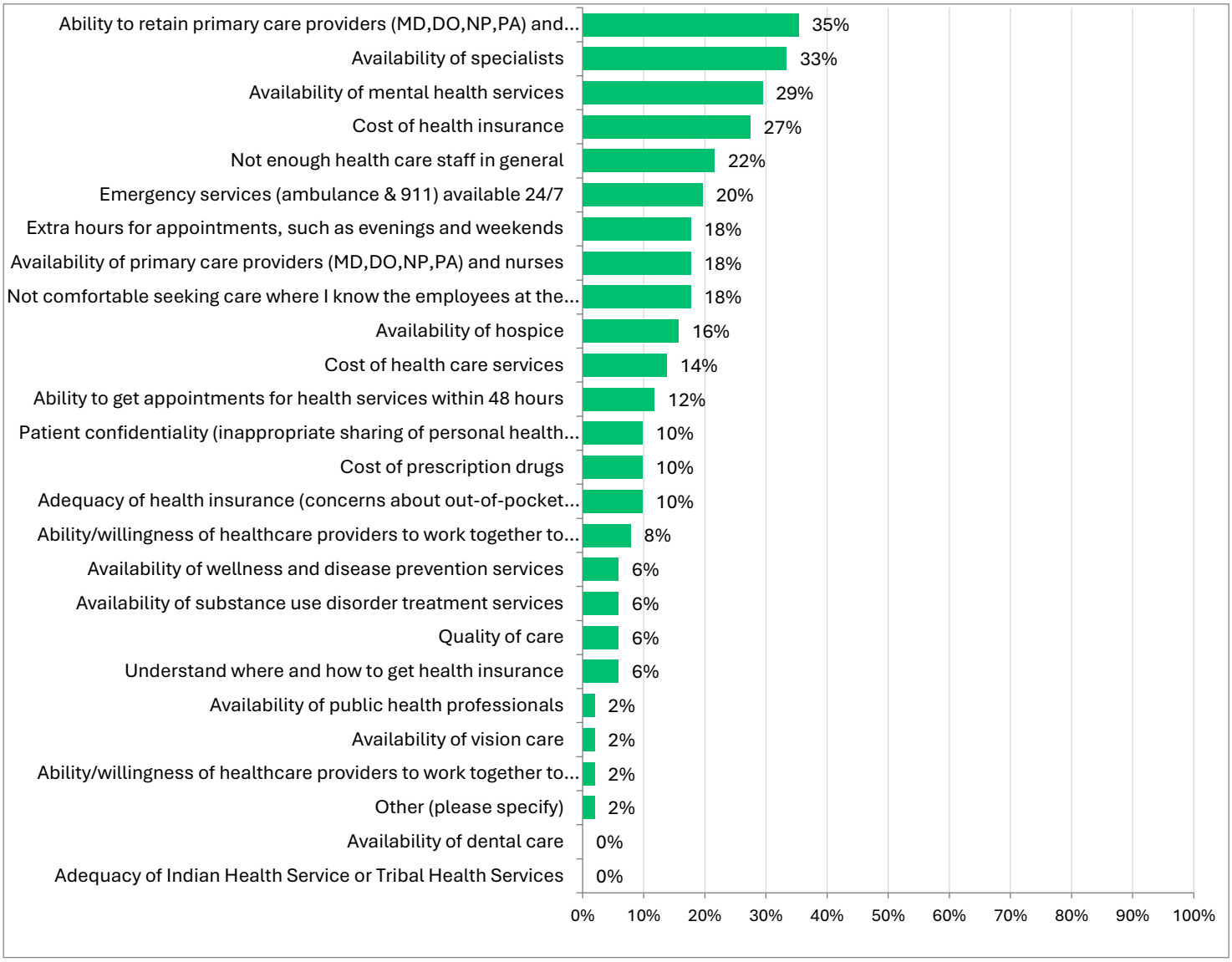
- *Not enough jobs with livable wages, not enough to live on*
- *Not enough public transportation options, cost of public transportation*
- *Crime and safety, adequate law enforcement personnel*
- *Not enough places for exercise and wellness activities*

In the "Other" category for community and environmental health concerns, the "Other" responses were

- Cliquishness in Schools and other work environments.
- Having access to functional doctors: Dr Vincent Pedre, regenerative medicine physicians such as Dr. Ian White, neuroscientist: Dr Robert Melillo, one of the \pioneers of biohacking: Dave Asprey and many more. For SWHC to set up zoom appointments for those of us you cannot travel all over the United States for cutting edge health.
- Drug dealers and people not dealt with.
- Not enough workers for businesses to keep open.

Figure 20: Availability/Delivery of Health Services Concerns

Total responses = 51



Cut-off chart text:

- *Ability to recruit and retain primary care providers (MD,DO,NP,PA) and nurses in the community*
- *Adequacy of health insurance (concerns about out-of-pocket costs)*
- *Patient confidentiality (inappropriate sharing of personal health information)*
- *Not comfortable seeking care where I know the employees at the facility on a personal level*
- *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*

In the "Other" category for Availability/Delivery of Health Services Concerns there was an expressed need for urgent care where no appointments is necessary without going to the ER.

Figure 21: Youth Population Health Concerns
Total responses = 48

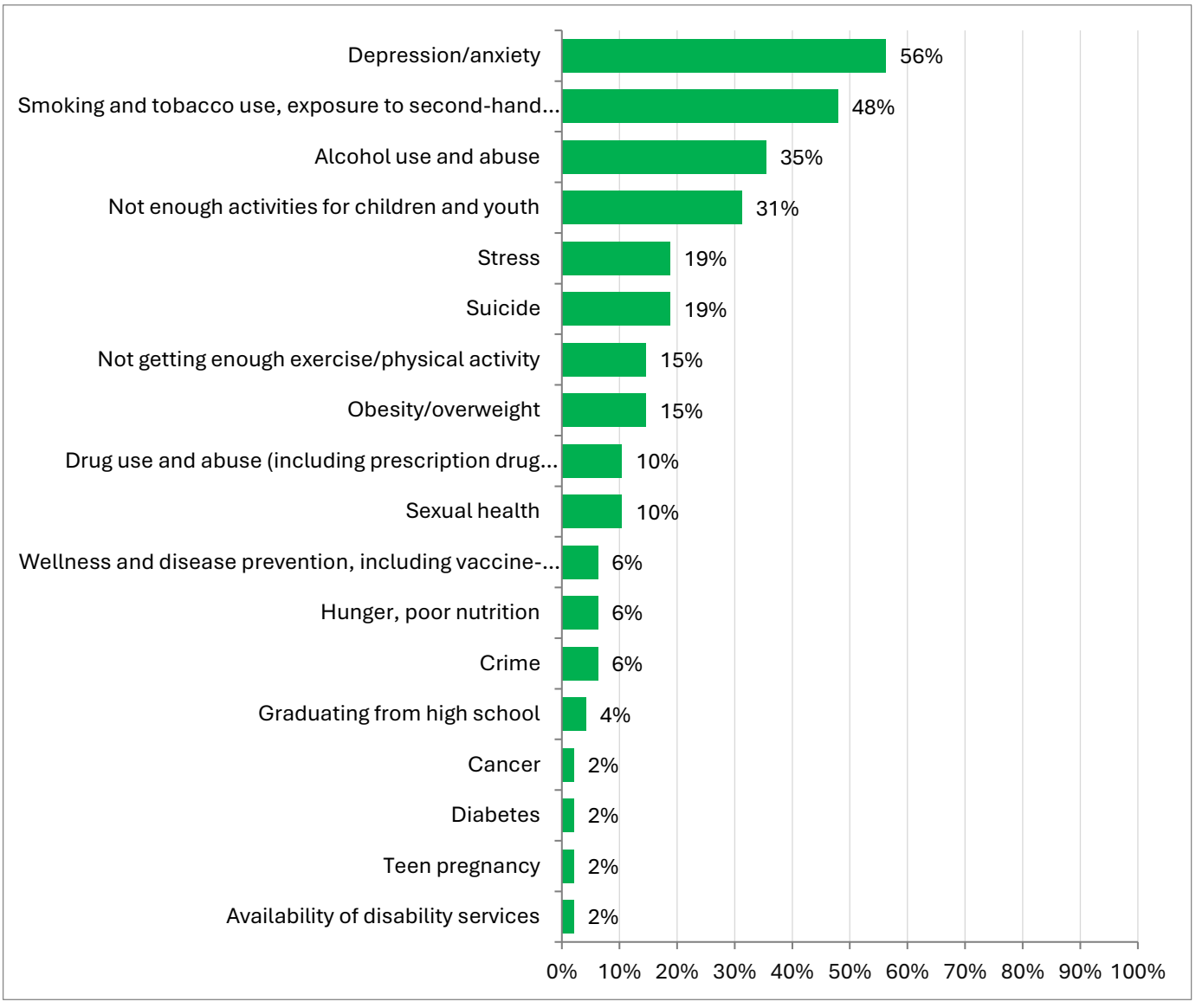
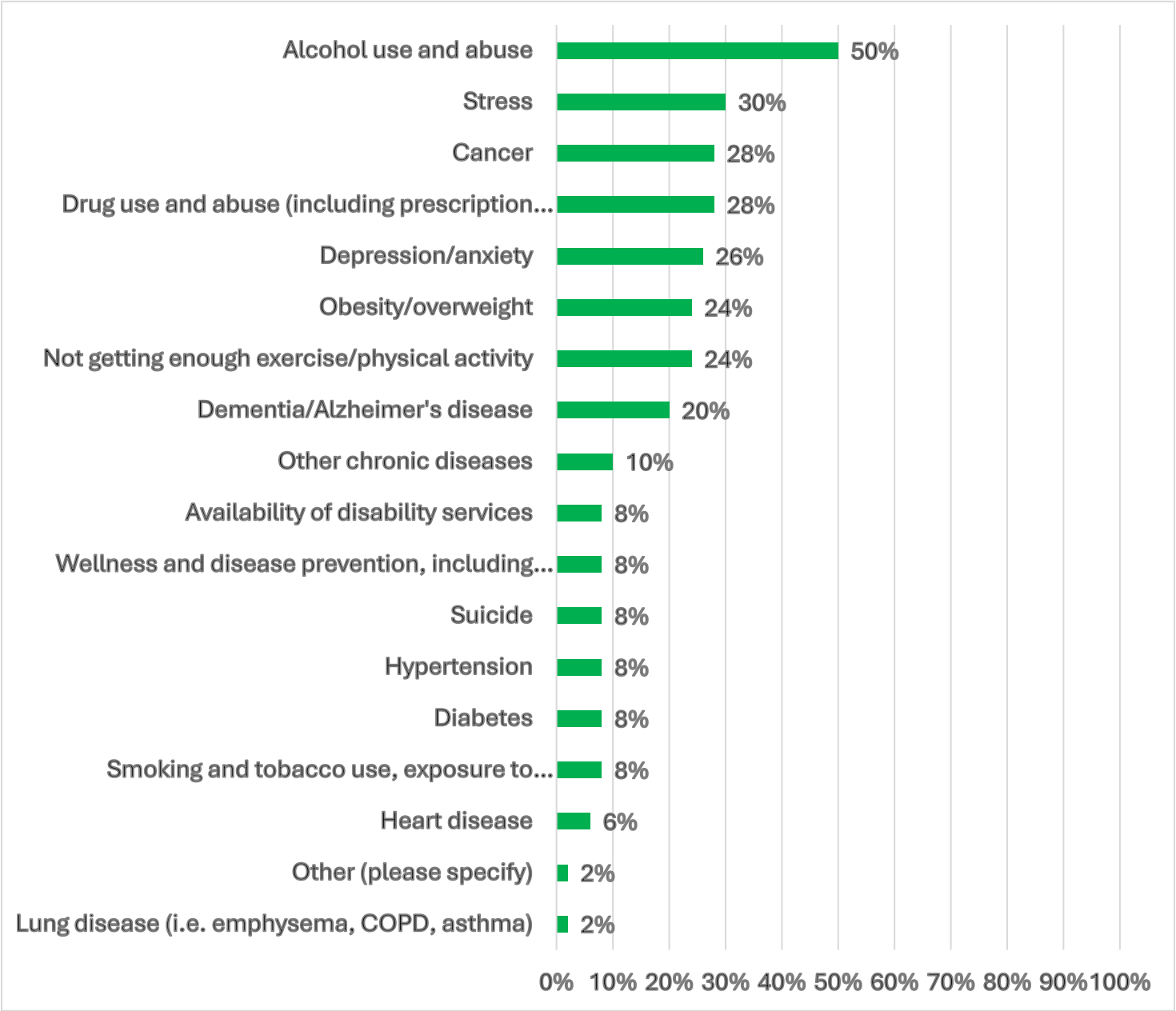


Figure 22: Adult Population Concerns
Total responses = 50

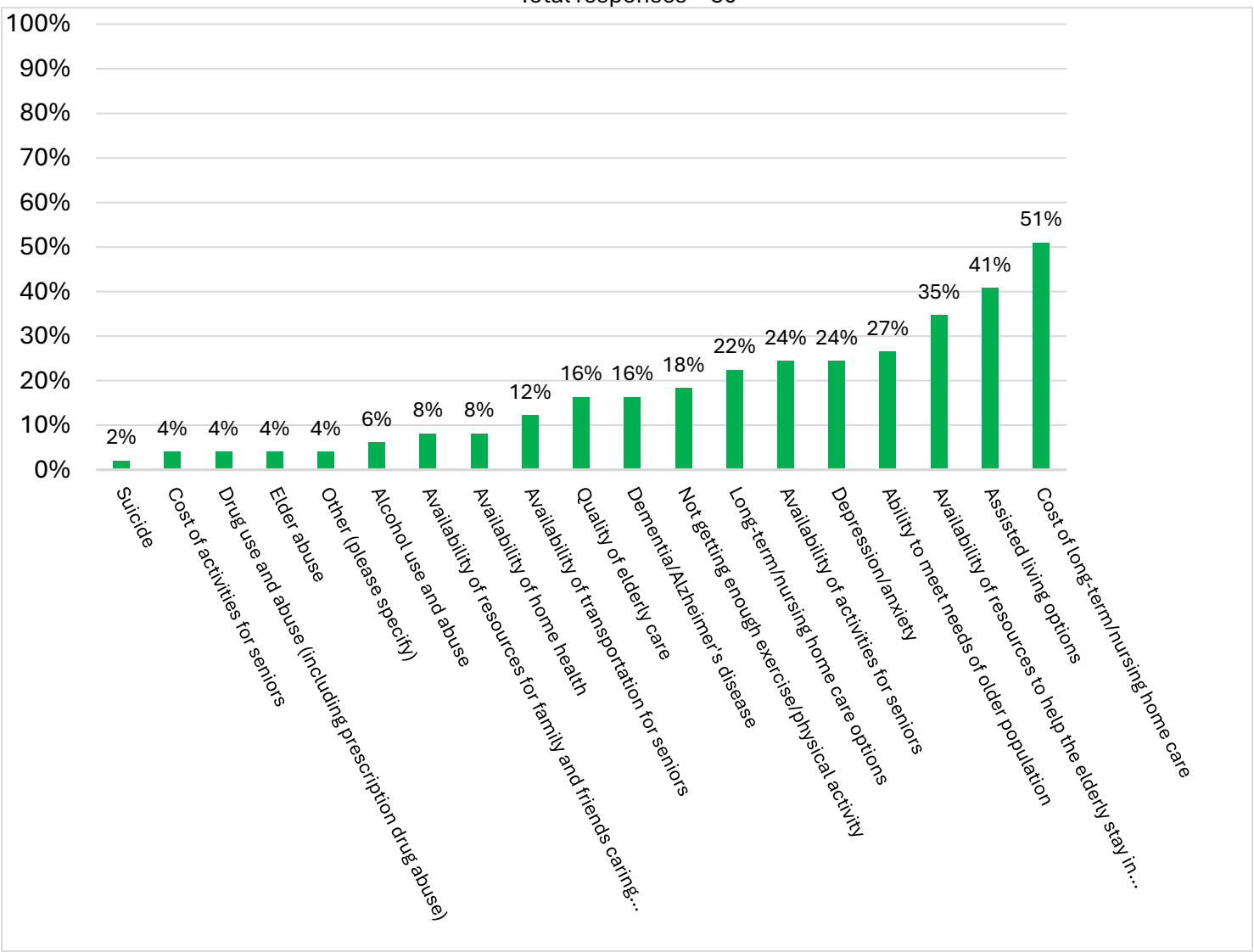


Cut-off chart text:

- *Smoking and tobacco use, exposure to second-hand smoke or vaping*
- *Wellness and disease prevention, including vaccine-preventable diseases*
- *Diseases that can spread, such as sexually transmitted diseases or AIDS*

Comments included in the "Other" category for the Adult Population Concerns were vulnerable adults and scammer.

Figure 23: Senior Population Concerns



Cut-off chart text:

- *Availability of resources to help the elderly stay in their homes*

In the "Other" category, the two concerns mentioned were the availability of Public/disable transportation later than 3:00 p.m., and adequate meals on wheels.

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 restaurants and food options.
2. Having enough workforce at all places of work.

Other biggest challenges that were identified were lack of healthcare staffing, limited access to affordable/available housing, low wage levels, and lack of community engagement.

Delivery of Healthcare

The survey asked about the health and health care of the survey respondents. They were asked to rate their overall health from poor to excellent. In another question they were asked to indicate any chronic conditions that applied to them. Finally, they were asked if they had a primary care physician. A primary care provider manages chronic diseases, promotes comfort and transparency of medical history, lower overall healthcare costs, ensures routine screenings for early detection before minor issues become big concerns, and refers to specialty care when necessary.

Figure 24-26 illustrates the results of each.

Figure 24: How would you rate your overall health?

Total responses = 45

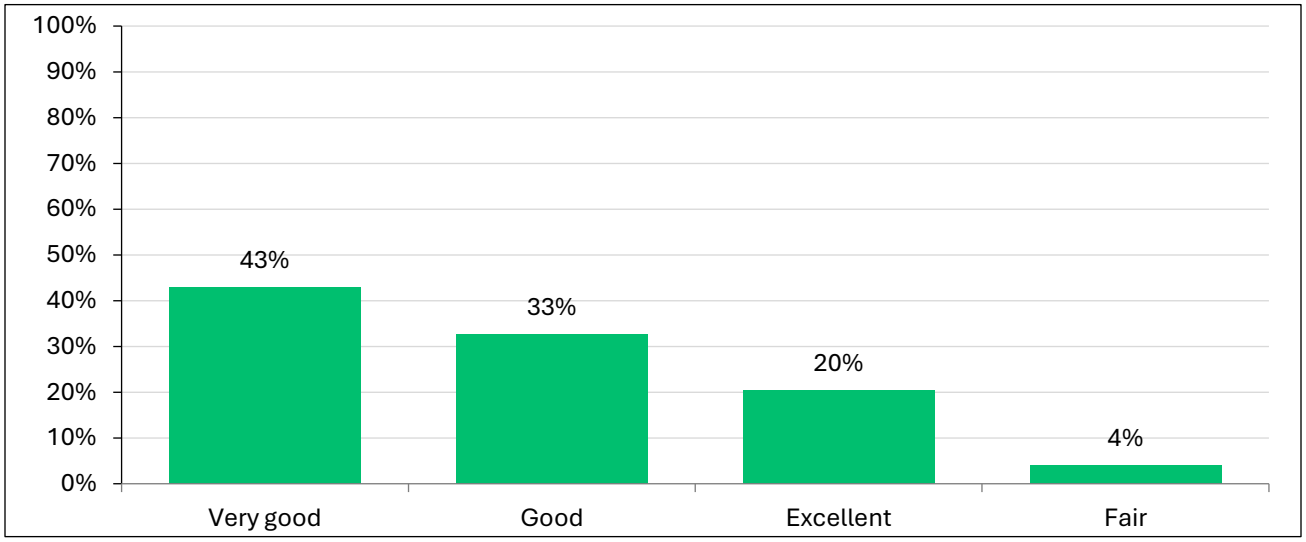
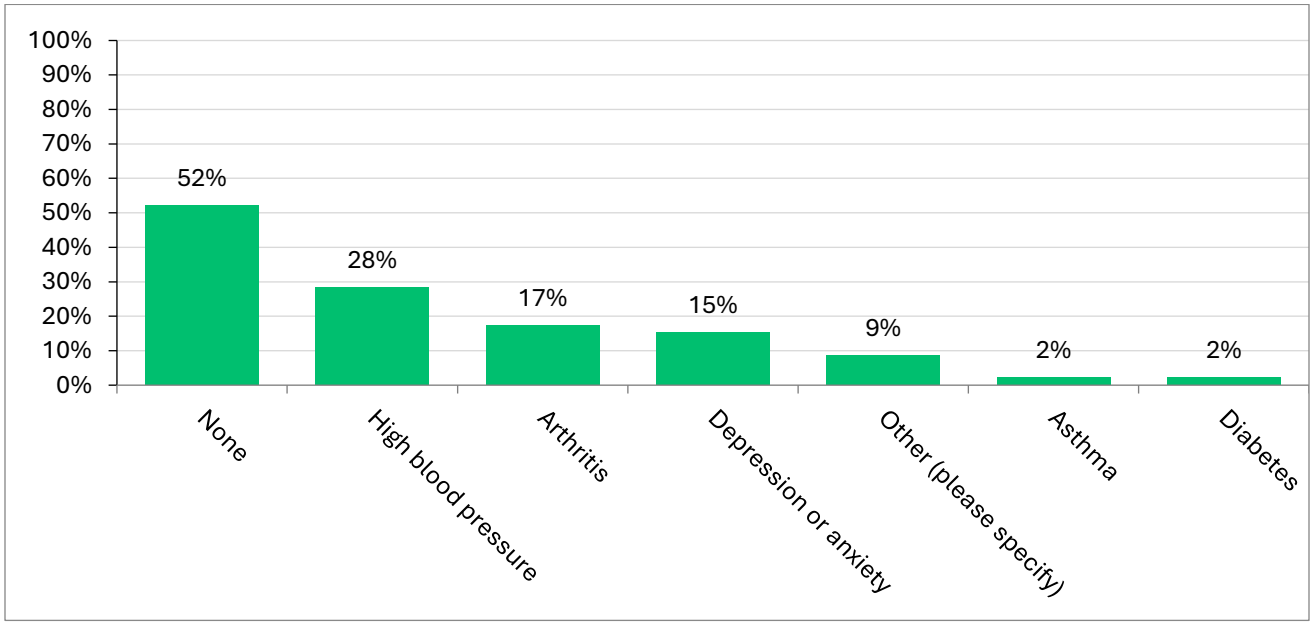


Figure 25: Do you have any chronic conditions (check all that apply)

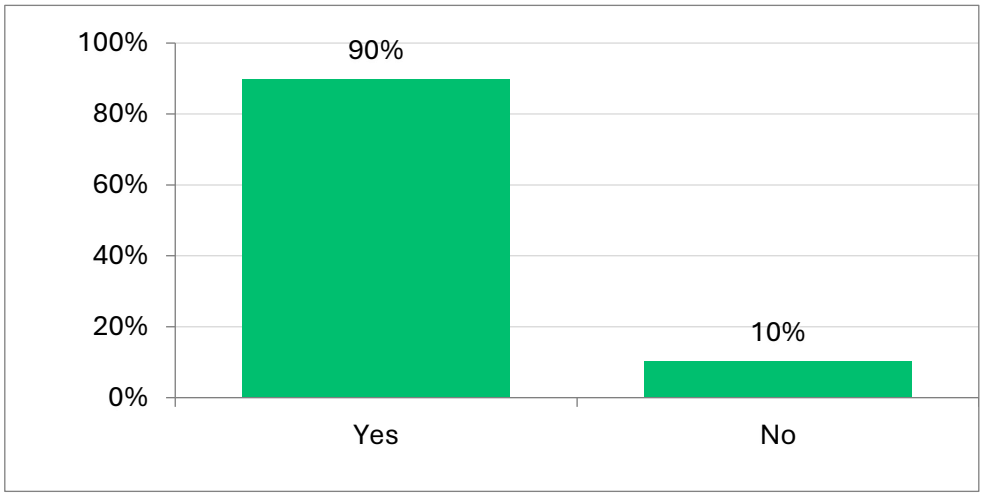
Total responses = 46



Other responses included but weren't limited to: frequent headaches and cholesterol issues.

Figure 26: Do you have a primary care physician?

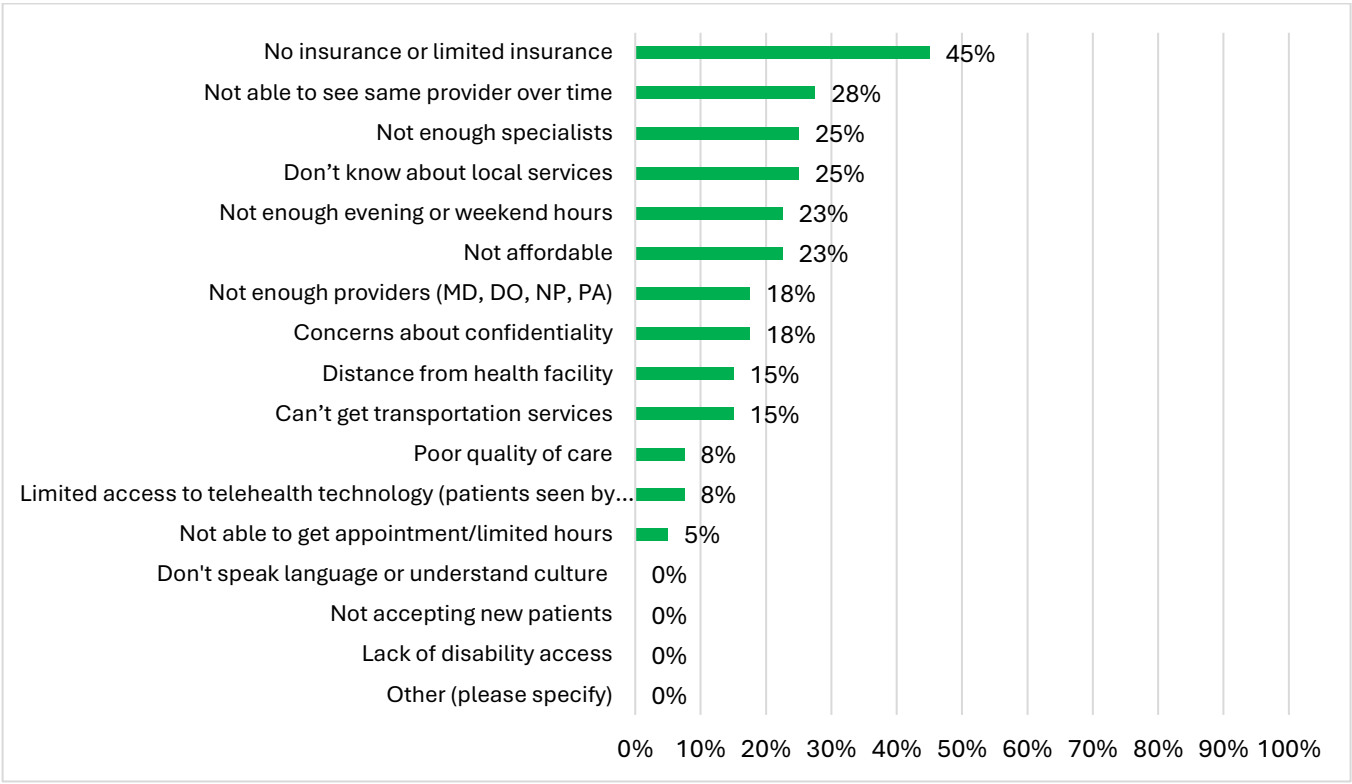
Total responses = 45



As seen in figure 27, the survey asked residents what they see as barriers that prevent them, or other community residents, from receiving healthcare. The most prevalent barriers perceived by residents were no insurance or limited insurance (N=18) and not able to see same provider over time (N=11). After these two responses, the next most identified barrier was not enough specialists and lack of awareness in local services.

Figure 27: Perceptions about Barriers to Care

Total responses = 40



Cut-off chart text:

- *Limited access to telehealth technology (patients seen by providers at another facility through a monitor/TV screen)*

In an open-ended question, respondents were asked what specific healthcare services, if any, they think should be added locally. The top desired services to be locally added was and specialists. Other requested services included:

- Cardiology Services
- Mental Health Services
- Orthopedic services
- Senior care housing
- Healthcare facility expansion
- Rehabilitation services
- Alternative medicine services

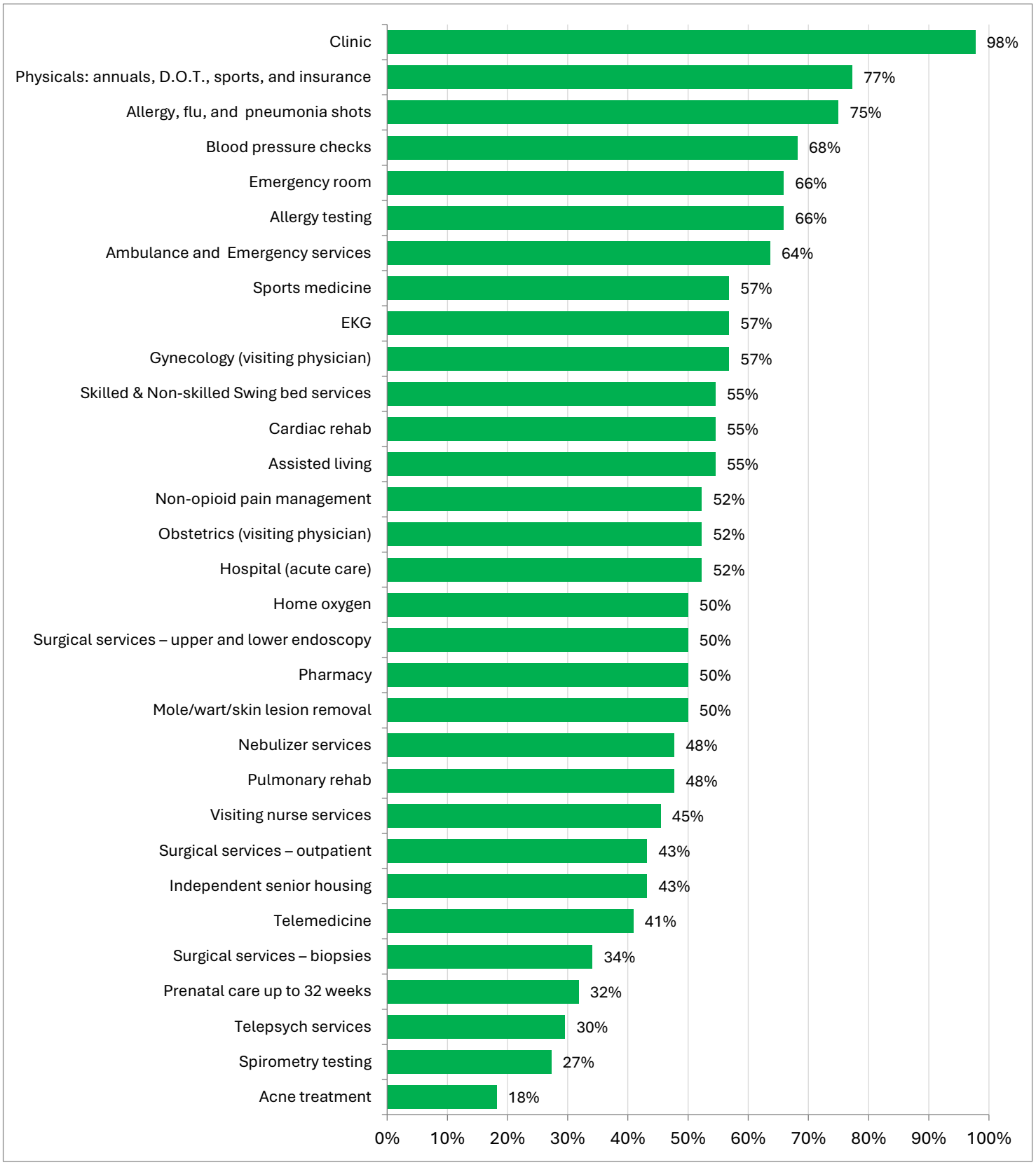
A full list of survey responses is provided in Appendix B.

The survey asked residents which Southwest Healthcare services they used in the past year. The most commonly used were clinic visits, routine physicals (annuals/DOT/sports/insurance), and immunizations, followed by blood-pressure checks and emergency room care. Many also reported allergy testing; ambulance/emergency services; and sports medicine, EKG, and gynecology. Far fewer used extended or specialty services such as telemedicine, prenatal care up to 32 weeks, and telepsych, with acne treatment used least.

Figure 28 illustrates these responses.

Figure 28: Services Provided by Southwest Healthcare That Were Used Within the Past Year

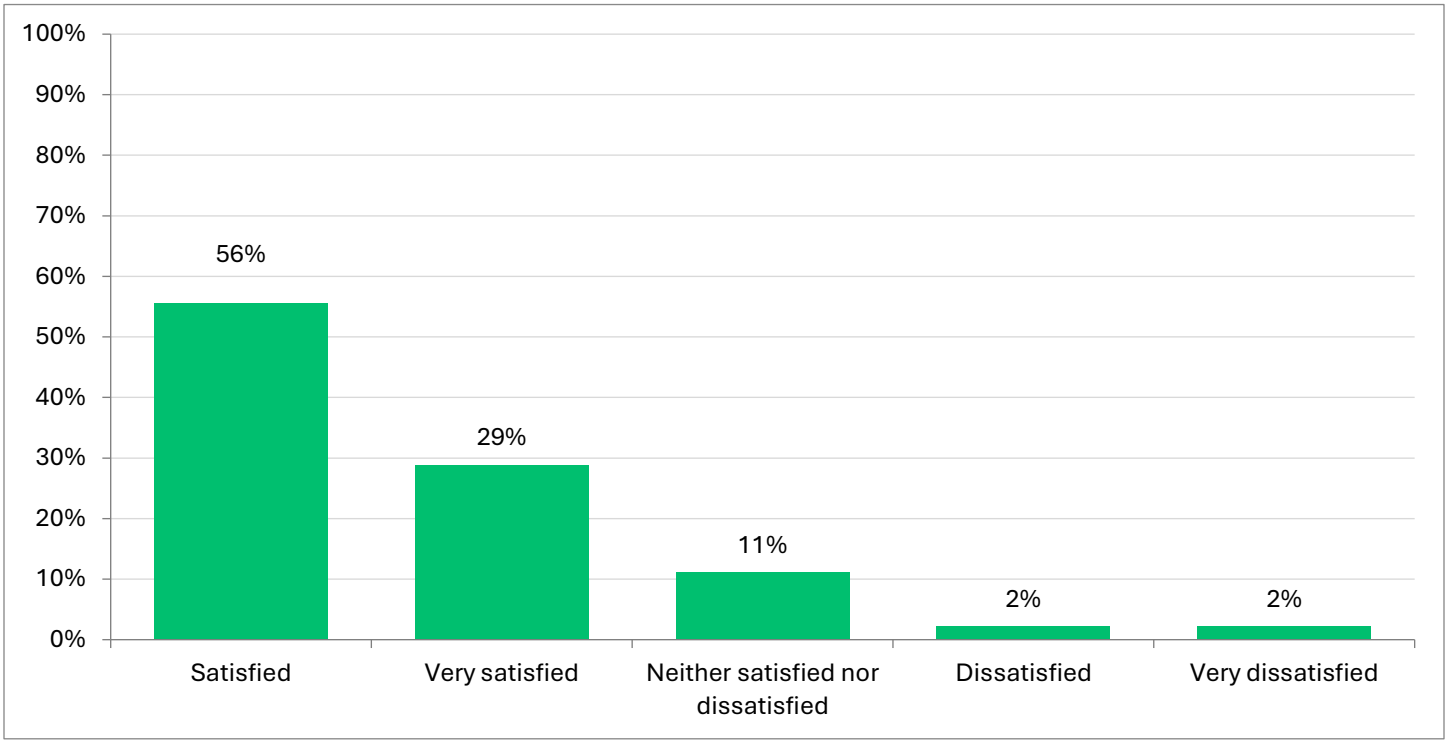
Total responses = 44



Survey respondents rated how satisfied they are with the healthcare services in their community from very satisfied to very dissatisfied. The majority (85%) of respondents were satisfied or very satisfied.

Figure 29: Satisfaction with the Community's Healthcare Services

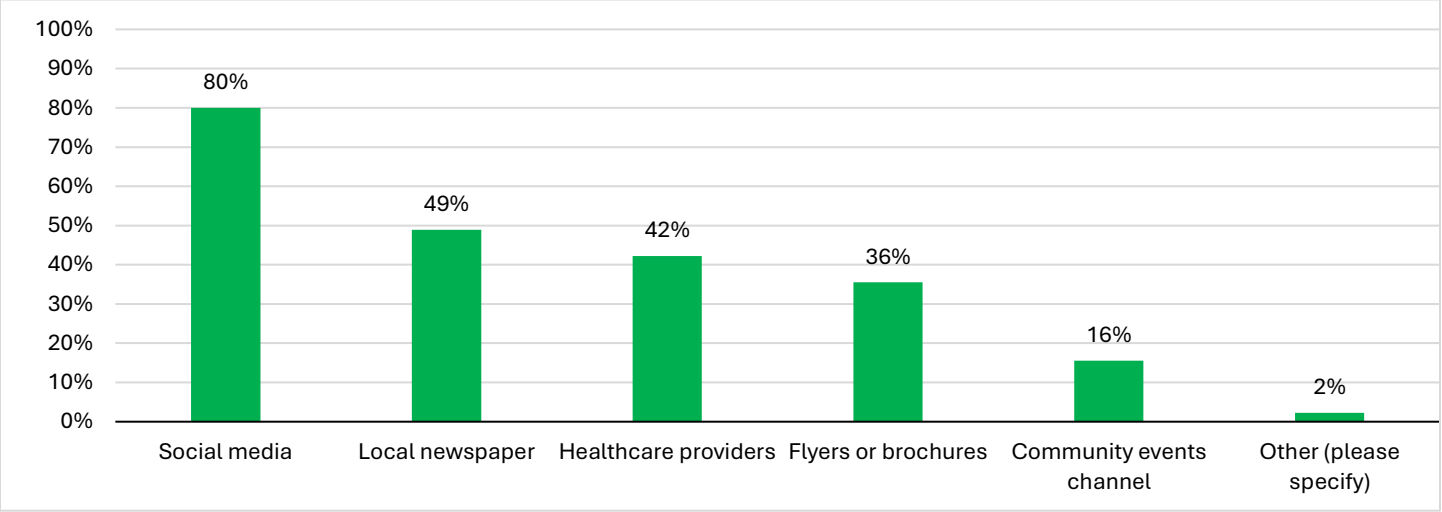
Total responses = 45



To understand how residents prefer to learn about available local health services, respondents were asked to select their primary sources of information. The majority reported using social media, followed by the local newspaper and healthcare providers. Flyers or brochures were also common at 36%, while fewer respondents identified community events or other sources These results, shown in Figure 30, highlight the importance of maintaining a strong online presence while continuing to use traditional channels to reach a broader audience.

Figure 30: Best Way to Receive Information about Health Services and Resources

Total responses =45



The Other response indicated the website, and emails were the best way to receive information on services and resources.

The final question of the survey asked respondents to share additional comments or suggestions for improving healthcare services in the community. 16 responses were received.

Several comments emphasized the importance of expanding healthcare services and facilities. Respondents expressed a desire for an urgent care clinic within the Southwest Healthcare System and suggested expanding the local village or facility to reduce waitlists.

Staffing concerns were also noted. Participants encouraged recruiting more permanent physicians, nurses, and local staff rather than relying heavily on traveling providers. They emphasized the value of provider consistency, continuity of care, and long-term physician retention to help patients build stronger relationships with their providers.
A few respondents commented positively, stating that Southwest Healthcare provides very good services and that they are happy with their care.

Additionally, one respondent highlighted the need for improved public transportation, noting that Southwest Transit should extend hours past 4:00 p.m. and add more vans and drivers, particularly to accommodate after-school demand and residents with disabilities.

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 specialists
- Cost of long-term/nursing home options
- Depression/anxiety
- Having enough child daycare services

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

Alcohol Use and Abuse

Alcohol use and abuse remain persistent concerns across all age groups. Community members noted that limited access to treatment and accountability programs makes it difficult for those struggling with addiction to get help. Seasonal isolation, particularly during the winter months, was also cited as contributing to increased alcohol use.

Availability of Specialists

Access to healthcare specialists continues to be a challenge, with residents often needing to travel long distances for specialty care. Participants expressed a desire for more visiting specialists or expanded telemedicine options to reduce barriers to timely care.

Cost of Long-Term/Nursing Home Options

The cost of long-term and nursing home care was identified as a major concern, particularly as the local population ages. Many residents worry about how to afford care while still maintaining quality of life and access to needed services.

Depression and Anxiety

Mental health issues such as depression and anxiety were frequently mentioned. Respondents described increased stress across all age groups and a shortage of local mental health and addiction services. Limited inpatient options and the lack of local treatment facilities were also noted as ongoing challenges.

Having Enough Child Daycare Services

Access to affordable childcare was identified as a key factor in supporting working families and attracting young families to the community. Limited daycare availability was seen as a barrier to both family stability and local workforce growth.

Limitations

The Community Survey results are meant to represent the opinions and needs of the general population in Bowman County and service area. This survey used a convenience sampling method as it was distributed and made broadly available throughout the service area. It should be noted that when looking at survey demographics, most respondents were white females reporting to have at least a bachelor's degree. Most respondents were also fully employed. As a convenience sampling method was employed, data findings may not necessarily represent the entire community.

Prioritization of Health Needs

A community group composed of those that attended the first community meeting as well as the key informants met on October 14, 2025. 11 community members attended the meeting. A facilitator from Cibolo Health presented the group with a summary of this report's findings, including background and explanation about the secondary data, highlights from the survey results (including perceived community assets and concerns, and barriers to care), and findings from the key informant interviews.

Following the presentation of the assessment findings, and after considering and discussing the findings, all members of the group were asked to identify what they perceived as the top community health needs. All of the potential needs were listed and attendees noted their items of biggest concern.

From there, each attendee voted on the one item they felt was the most important to address in the next three years. The rankings were:

- Availability of mental health services (4 votes)
- Attracting and retaining young families (4 votes)
- Not enough jobs with livable wages, not enough to live on (2 votes)

Upon completion of the prioritization process, the number one identified need, as voted on by those attending the second community meeting, was the availability of mental health services. A summary of this prioritization may be found in Appendix I.

Comparison of Needs Identified Previously

Top Needs Identified 2022 CHNA Process	Top Needs Identified 2025 CHNA Process
• Availability of mental health services	• Availability of mental health services
• Attracting and retaining young families	• Attracting and retaining young families
• Not enough healthcare staff in general	• Not enough jobs with livable wages
• Depression and anxiety (all ages)	

The current process did identify two identical common needs from the previous cycle, the availability of mental health services, and attracting and retaining young families were both identified in the 2022 CHNA process. Not enough jobs with livable wages was a new common need that was identified.

Southwest Healthcare Services invited written comments on the 2022 CHNA report and implementation strategy both in the documents and on the website where they are widely available to the public. No written comments have been received.

Upon adoption of this CHNA Report by the Southwest Healthcare Services Board vote, a notation will be documented in the board minutes reflecting the approval and then the report will be widely available to the public on the hospital's website, and a paper copy will be available for inspection upon request at the hospital. Written comments on this report can be submitted to Southwestern District Health Unit.

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

In response to the needs identified in the 2022 CHNA process, the following actions were taken:

Need 1: Availability of mental health services – Since the last CHNA process, SWHS teamed up with a group called Senior Life Solutions. Senior Life Solutions (SLS) is a Medicare pay only mental health service that assists the community's older, retired generation with mental health difficulties that may come with aging. The service offers one-on-one counseling and group therapy sessions.

Although not affiliated with SWHS, Bowman saw the opening of Phoenix Therapy Center that offers a wide range of therapeutic services.

Need 2: Attracting and retaining young families – SWHS continues to offer a robust recruitment program that includes, among other things, generous sign-on bonuses. The bonuses are not exclusive to clinic staff. Recently SWHS offered a sign-on bonus to any candidate that could fill a need that was with the maintenance staff. When recruiting a candidate that is not from the area, the administration collaborates with the economic development office and a town tour is given, along with resources that includes permanent and temporary housing options. As this is also a need with the economic development offices, they have continued to build assets for the community to improve the quality of life. The Parks and Recreations of Bowman also has helped in this regard. Since the last CHNA, Bowman Parks and Recreation was able to secure a one percent city sales tax allocation which has helped support the construction of a new recreation center, that includes the areas first trampoline park. The department was also a part of a team that revitalized an older park and added a small slash pad with a giant, jumping balloon.

Need 3: Not enough healthcare staff in general – Since the last CHNA in 2022, they've not only been able to staff two, consistent doctors, but have also brought on another advanced practice provider, a Certified Nurse Practitioner! In total they have two doctors and three advanced practice providers who see patients. They have also have added an occupational therapist since 2022.

The above implementation plan for Southwest Healthcare Services is posted on their website at https://swhealthcare.net/get-involved/community-health-needs-assessment.html

Recommendations and Action Plan

Within five months and 15 days, an implementation plan mapping out how the community will address the findings of the CHNA has to be approved by the Southwest Healthcare Services board of directors. Although a CHNA and strategic implementation plan are required by hospitals and accredited local public health units, 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 next step is to convene the steering committee, or other community group that includes those that will be valuable in enacting changes, to outline the path that will be taken to implement change to improve the health of the community. A 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.

All activities proposed in the implementation plan will need to be monitored and evaluated to see if the plan is working or if modifications need to be made. The implementation plan is a starting place, it will need to be refined as you travel through the three years of application.

Appendix A – Community Survey Instrument

Southwest Healthcare Services Area Health Survey

Community Health Needs Assessment

Southwest Healthcare Services is interested in hearing from you regarding the community health needs in your area. A Community Health Needs Assessment (CHNA) survey is designed to gather information about the health needs and priorities of a community. It is important that we have the thoughts of those within the community providing their opinions. These questions help identify the health needs of the community, the barriers to accessing healthcare, and the resources that are most needed. The survey results are then used to inform community health improvement plans and strategies.

Surveys will be tabulated by Cibolo Health (https://cibolohealth.com/). Your responses are completely 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 aggregate. If you have questions about the survey or the process, please contact Kylie Nissen at kylie.nissen@cibolohealth.com or 701.330.0464.

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
- [ ] Other (please specify)
- [ ] Opportunities for advanced education
- [ ] Public transportation
- [ ] Programs for youth
- [ ] Quality school systems

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
- [ ] Other (please specify)
- [ ] Job opportunities or economic opportunities
- [ ] Safe place to live, little/no crime

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
- [ ] Other (please specify)
- [ ] Recreational and sports activities
- [ ] Year-round access to fitness opportunities

Southwest Healthcare Services Area Health Survey

Community Concerns

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
- ☐ Other (please specify)

_____

- ☐ 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

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

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

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

- [ ] Alcohol use and abuse
- [ ] Drug use and abuse (including prescription drug abuse)
- [ ] Smoking and tobacco use, exposure to second-hand smoke or vaping (juuling)
- [ ] Cancer
- [ ] Diabetes
- [ ] Depression/anxiety
- [ ] Stress
- [ ] Suicide
- [ ] Not enough activities for children and youth
- [ ] Teen pregnancy
- [ ] Other (please specify)

_____

- [ ] 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

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

- [ ] Alcohol use and abuse
- [ ] Drug use and abuse (including prescription drug abuse)
- [ ] Smoking and tobacco use, exposure to second-hand smoke or vaping (juuling)
- [ ] Cancer
- [ ] Lung disease (i.e. emphysema, COPD, asthma)
- [ ] Diabetes
- [ ] Heart disease
- [ ] Hypertension
- [ ] Dementia/Alzheimer's disease
- [ ] Other chronic diseases
- [ ] Other (please specify)

- [ ] 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

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

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

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

Health Status and Behaviors

11. How would you rate your overall health?

- ◯ Excellent
- ◯ Very good
- ◯ Good
- ◯ Fair
- ◯ Poor

12. Do you have any chronic conditions (check all that apply)

- ☐ Diabetes
- ☐ Heart disease
- ☐ Asthma
- ☐ Arthritis
- ☐ Other (please specify)
- ☐ High blood pressure
- ☐ Depression or anxiety
- ☐ None

13. Do you have a primary care physician?

- ◯ Yes
- ◯ No

Delivery of Healthcare

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

- [ ] Can't get transportation services
- [ ] Concerns about confidentiality
- [ ] Distance from health facility
- [ ] Don't know about local services
- [ ] Don't speak language or understand culture
- [ ] Lack of disability access
- [ ] Lack of services through Indian Health Services
- [ ] Limited access to telehealth technology (patients seen by providers at another facility through a monitor/TV screen)
- [ ] No insurance or limited insurance
- [ ] Other (please specify)

- [ ] 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

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

- [ ] Acne treatment
- [ ] Allergy testing
- [ ] Spirometry testing
- [ ] Allergy, flu, and pneumonia shots
- [ ] Ambulance and Emergency services
- [ ] Assisted living
- [ ] Blood pressure checks
- [ ] Cardiac rehab
- [ ] Pulmonary rehab
- [ ] Clinic
- [ ] Emergency room
- [ ] Gynecology (visiting physician)
- [ ] Hospital (acute care)
- [ ] Independent senior housing
- [ ] Mole/wart/skin lesion removal
- [ ] EKG
- [ ] Obstetrics (visiting physician)
- [ ] Pharmacy
- [ ] Prenatal care up to 32 weeks
- [ ] Physicals: annuals, D.O.T., sports, and insurance
- [ ] Sports medicine
- [ ] Surgical services – biopsies
- [ ] Surgical services – outpatient
- [ ] Surgical services – upper and lower endoscopy
- [ ] Skilled & Non-skilled Swing bed services
- [ ] Telemedicine
- [ ] Telepsych services
- [ ] Visiting nurse services
- [ ] Home oxygen
- [ ] Nebulizer services
- [ ] Non-opioid pain management

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

17. How satisfied are you with the healthcare services in your community?

- ◯ Very satisfied
- ◯ Satisfied
- ◯ Neither satisfied nor dissatisfied
- ◯ Dissatisfied
- ◯ Very dissatisfied

18. What is the best way for you to receive information about health services and resources? (check all that apply)

- ☐ Local newspaper
- ☐ Social media
- ☐ Community events channel
- ☐ Other (please specify)
- ☐ Healthcare providers
- ☐ Flyers or brochures

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

- ☐ Indian Health Service (IHS)
- ☐ Insurance through employer (self, spouse, or parent)
- ☐ Self-purchased insurance
- ☐ Medicaid
- ☐ Other (please specify)
- ☐ Medicare
- ☐ No insurance
- ☐ Veteran's Healthcare Benefits

20. Age:

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

21. 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

22. Gender:

- ◯ Female
- ◯ Male
- ◯ Non-binary
- ◯ Other (please specify)

23. Employment status:

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

24. Your zip code:

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

- [ ] American Indian
- [ ] African American
- [ ] Asian
- [ ] Other (please specify)
- [ ] Hispanic/Latino
- [ ] Pacific Islander
- [ ] White/Caucasian

26. 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

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

Thank you for assisting us with this important survey!

Appendix B – Open-Ended Survey Question Responses

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):

- I feel most of the people in this community are closed minded and do not readily accept newcomers to the area.
- Nothing comes to my mind.

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

- Small town living

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

- Nothing

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

- Unless you have small children or they are in sports not many activities for adults or anywhere to go except for bars, entertainment only a couple times a year except for bars. The only sit-down restaurant that is family oriented other than a bar /or has a bar in the restaurant is in Rhame which still can get alcohol and there is no transportation other than southwest transportation

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):

- Cliquishness in Schools and other work environments.
- Having access to functional doctors: Dr Vincent Pedre, regenerative medicine physicians such as Dr. Ian White, neuroscientist: Dr Robert Melillo, one of the \pioneers of biohacking: Dave Asprey and many more. For SWHC to set up zoom appointments for those of us you cannot travel all over the United States for cutting edge health.
- Drug dealers and people not dealt with.
- Not enough workers for businesses to keep them open

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

- There is a need for urgent care where no appointments are necessary without going to the ER

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

- No concerns

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

- Vulnerable adults and scammers

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

- Availability of public/disabled transportation later than 3:00 pm and evening hours.
- Adequate meals on wheels

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

- Atmosphere It is like a ghost town on weekends and evenings So many elderly don't receive the care especially for the ones suffering from dementia and Alzheimer's. They used to have a wing dedicated to them but guess they thought that was not profitable Crime as in more domestic, vandalism, theft, abuse seems to be going up.
- Failing Businesses, inability to get new businesses started, and concentration of business services available: i.e. only one grocery store, a shortage of restaurants, and a shortage of qualified workers generally.
- The rate of inflation is outpacing the elderly's ability to care for themselves properly.
- The amount of contract staff working at our hospital
- Corrupt leaders
- ADA accessible living for elderly so they can stay in the area
- Taking care of the elderly and long term and assisted living
- All small rural communities are facing affordable healthcare staff shortages
- labor pool is low.
- Getting people to work
- Lack of labor force
- With the increase of population, it would be housing and meeting needs within our community.
- Not having the connection at our SWHC with cutting edge health: of naturopathic/holistic physicians, functional physicians, nutritionists, regenerative physicians etc. A person ends up having to find these types of physicians on our own, where as a referral from our physicians and assistant physicians would be a tremendous plus in our community for the youth and adults.
- Retention of staffing at all places of work.
- The community pulling together, working as one to overcome the challenges. We have intelligent people with great ideas, but the leaders of government, organizations and businesses refuse to listen.
- Attracting and retaining young workforce
- NEED MORE RESTAURANTS AND FOOD OPTIONS
- WAGES
- Affordable housing, short term and long term. Keeping businesses open
- The lack of restaurants and staff to work at eating establishments.
- I don't think that there are enough things to do for our youth. I feel like the community is not as tight as other small towns I have lived in. Bowling only open parts of the year, movies not offering better selection, the one "hang out" restaurant available is never open. No where to get breakfast on a weekend morning. Only 2 restaurants to count on for dinner and one is a bar that I would rather not go to. The only option is Grazers. The business in this community is not built to serve the community, the only place I can count on is the coffee shop.
- Not enough help to fill the lower wage jobs.

Delivery of Healthcare

12. Do you have any chronic conditions (check all that apply)

- Headaches
- Migraines
- Periodically loose stools
- Cholesterol issues

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

- Just a walk in and be seen option

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

- SWHS already did the community a great service by building in a rehabilitation center into their facility with the combination of the Nursing Home and Hospital. In the past the hospital or clinic had to request a rehab person from a facility out of town or send them there. It has saved several people thousands or miles to receive rehab here rather than in Bismarck etc. I want to see this supported and continued.
- Orthopedic consultation, Dermatology consultation,
- Mental health counseling
- Orthopedics
- Mental health counseling
- I don't know
- Dermatology, ortho, urology
- More assisted living housing
- None
- telemarketing for regenerative medicine physicians, bio hackers, holistic nutritionist, naturopathic practitioners, etc.....
- Cardiologist
- Full time in town. MD with Emergency background
- Mental health for youth and young adults
- Doctors that live here
- visiting specialist: cardiology ortho dermatology
- NONE ALL GOOD
- cardiology
- NA
- Orthopedic, Dermatology, Cardiology
- cardiology

20. What is the best way for you to receive information about health services and resources? (check all that apply)

- website, through emails

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

- Medigap insurance
- Thru another state

24. Gender:

- Na

27. Race/Ethnicity:

- Na

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

- As already mentioned, we need Southwest Transit to run later than 4:00 p.m. with more vans and drivers available during the after-school rush for the sake of the disabled. Also, we need an urgent care facility available within SWHS's system.
- Add on to the village so there aren't so many on the waiting list.
- I feel SWHC provides very good health services.
- SWHC does an excellent job; we are very happy with our care from them.
- More permanent providers and nurses and less dependence on traveling healthcare providers.
- Already mentioned concerns in this survey. My physician assistant at SWHC is excellent and open to holistic health.
- I feel there is too much contract staff at the local hospital and not a familiar face. Used to have local faces.
- It is important to retain a MD long term (more than 10 years) so patients can build a relationship and keep healthcare costs reasonable.
- Being able to see the same doctor when needed.
- NOTHING ALL IS GOOD.
- Recruit local nurses. Travelers aren't as good as someone local.

Appendix C – NDDHHS 2024 Child Care Profile

NORTH Dakota | Health & Human Services
Be Legendary.

Child Care Profile
2024
BOWMAN County

Children Potentially Needing Child Care

	0-2 yrs	3 yrs	4-5 yrs	6-12 yrs	Total
Children in County by Age[1]	110	30	86	308	504
% of Children Ages 0 to 5 with All Parents in the Labor Force[1]					90.0%
% of Children Ages 6 to 13 with All Parents in the Labor Force[1]					83.9%
Children Ages 0 to 5 potentially needing child care due to parents in workforce					226
Children Ages 6 to 12 potentially needing child care due to parents in workforce					283
Capacity of state-licensed child care programs (family, group, center, school-age[3])					159
Current Child Care Assistance Program Recipients Age 0-13					
Percent to which supply meets potential demand					31%

State-Licensed Early Childhood Program Type and Capacity[2] (2024)

	Family	Group in a home	Group in a facility	Center	Total
Number of Programs	0	4	2	1	7
Licensed Capacity	0	70	23	66	159
Reported Vacancies[4]	0	7	0	10	17
Programs open before 7:00 a.m.	0	2	0	1	3
Programs open after 6:00 p.m.	0	0	0	0	0
Programs open on Weekends	0	0	0	0	0
Reported Size of Workforce	0	11	4	11	26
State-licensed school-age programs[3]	0	with a licensed capacity of			0

Annual Cost of State-Licensed Child Care[2] (Due to the limited number of programs, rates reflect a regional average)

	Home-based Programs		Centers and Group Facilities	
Age of Child	**Average**	**Highest Rate**	**Average**	**Highest Rate**
Ages 0 to 17 months	$7,488	$8,320	$8,788	$10,400
18 to 35 months	$7,072	$7,800	$8,528	$10,400
Ages 3 to 5	$7,072	$7,800	$8,424	$10,400
Ages 6 to 12 (Annual costs for school-age children vary greatly based on hours needed.)				

1. 2022 ND Kids Count Fact Book
2. ChildCare Aware® of North Dakota WorkLife Systems Database
3. School-age care numbers reflect programs licensed exclusively as before and after school programs under Early Childhood Services rules. Not all school-age programs are required to be licensed. In addition, many school-age children are enrolled in family/group programs and child carecenters.
4. Vacancies change daily and may not match the location or program characteristics desired by families needing care. A 10% vacancy rate allows families some choice among programs.

Appendix D – SWHS CAH Profile

Critical Access Hospital Profile

Spotlight on: Bowman, North Dakota

Southwest Healthcare Services

Quick Facts

Administrator: Dennis Goebel

Chief of Medical Staff:
Dr. Tim Adams

Board Chair: Jordan Anderson

City Population:
1,430 (2021 estimate)[1]

County Population:
2,903 (2021 estimate)[1]

County Median Household Income:
$70,521 (2021 estimate)[1]

County Median Age:
41.1 years (2020 estimate)[1]

Service Area Population:
3,280 miles

Owned by: Non-Pro it

Hospital Beds: 35

Independent Living Apts: 12

Assisted Living Apts: 12

Trauma Level: IV

Critical Access Hospital Designation: 2001

Economic Impact on the County*

Employment:

Primary – 148
Secondary – 98
Total – 294

Financial Impact:
Primary – $6.4 million
Secondary – $3.2 million
Total – $9.6 million

** The impact of jobs and expenditures generated by the hospital within the community was estimated using payroll information and an economic multiplier of 1.5.*

Mission

Guided by faith, we provide excellent care for those we are priveleged to serve.

County: Bowman
Address: 802 2nd Street NW
Bowman, ND 58623
Phone: (701) 523-3226
Fax: (701) 523-4139
Web: www.swhealthcare.net

Southwest Healthcare Services is a non-profit organization dedicated to providing quality healthcare for the residents of southwest North Dakota and the northwest corner of South Dakota. Located in Bowman, North Dakota, Southwest Healthcare Services is comprised of six facilities in separate locations which include: a 23-bed Critical Access Hospital, a 40-bed long-term care facility, 12 independent living apartments, a 12-unit assisted living facility, a Rural Health Clinic, and emergency ambulance services.

Services

Southwest Healthcare Services provides the following services directly:

- 24-hour Emergency Room
- Level IV Trauma
- Radiology
- Physical and occupational therapy
- Acute care
- Swing bed
- Pharmacy
- Respiratory therapy
- Dietetic service
- Laboratory
- Swingbed activities
- Pulmonary rehabilitation
- Cardiac rehabilitation
- Sleep studies
- Social services

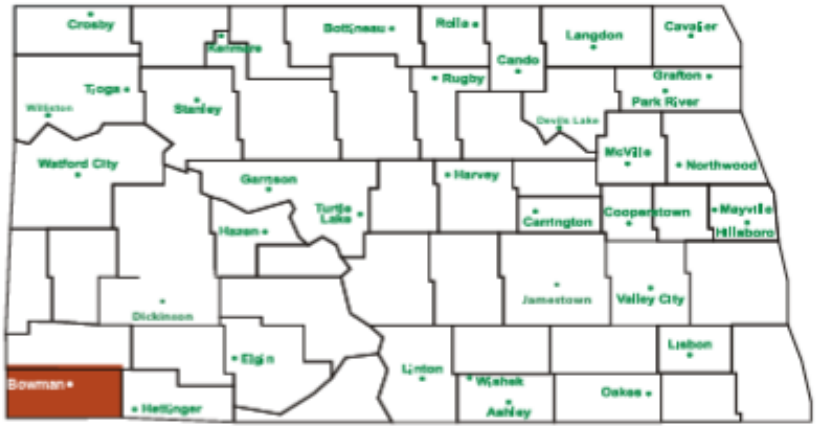
Staffing

Physicians: 2
Nurse Practitioners: 1
PAs: 1
RNs & LPNs 27
Total Employees: 140

Local Sponsors and Grant Funding Sources

- Blue Cross Blue Shield of North Dakota
- Burlington Resources
- Burlington Northern Santa Fe Foundation
- City of Bowman
- Center for Rural Health
  - SHIP Grant (Small Hospital Improvement Program)
  - Flex Grant (Medicare Rural Hospital Flexibility Grant Program)
- County of Bowman
- Dakota West RC & D
- March of Dimes
- Midcontinent Media Foundation
- Nellie J. Svee Grant
- North Dakota Community Foundation
- North Dakota Department of Emergency Services
- North Dakota Department of Health
- North Dakota Department of Human Services
- North Dakota Emergency Management
- North Dakota Oil & Gas Impact Grants
- North Dakota Workforce Safety
- Southwest Regional Grant Program
- State Homeland Security Grant
- Sunrise Foundation North Dakota Chapter

North Dakota Critical Access Hospitals



History

In 1945, the communities in Bowman and Slope Counties realized there was a need for organized health services. In July 1946, a city block in the west side of Bowman was donated for the location of a hospital. Area residents rallied together, coming up with innovative fundraising methods to pay for the construction of the hospital and necessary medical equipment.

Through the efforts of many, the dedication ceremony for the opening of the hospital was held on May 12, 1951, with Governor Norman Brunsdale cutting the ribbon and opening the doors for their first patients.

Over the next 55 years, local healthcare has grown from a hospital to an entire healthcare system. Dedicated staff, administration and volunteers have worked diligently to ensure that quality healthcare remains a vital part in Bowman and surrounding communities.

Recreation

Bowman, located in southwestern North Dakota, is just 80 miles from an urban shopping center. The Bowman school system provides an excellent education for students K-12, offering a comprehensive program for all students including foreign languages, advanced science, math electives, computer education and special education programs. The Black Hills of South Dakota, a popular tourist attraction, is just 100 miles south. This area is not only a popular summer recreation spot, but also provides skiing in the wintertime. Theodore Roosevelt National Park is about an hour and a half to the north. Picnicking, hiking, and several freshwater dams and lakes are within a short distance. Recreational facilities also include a 9-hole grass-greens golf course, Olympic size swimming pool, tennis courts, farming, ranching, rodeos, paleontology, and hunting.

Updated 11/2022

Appendix E – Bowman County Brief Economic Impact

December 2020

SOUTHWEST HEALTHCARE SERVICES
Complete Healthcare Today, For a Better Tomorrow

Healthcare, especially a hospital, plays a vital role in local economies.

Economic Impact

Southwest Healthcare Service is composed of a Critical Access Hospital (CAH), a Rural Health Clinic, a long-term care facility, an assisted living facility, an ambulance service, and a visiting nurse service located in Bowman, North Dakota.

Southwest Healthcare Service directly employs **114.45 FTE employees** with an annual payroll of over **$7.5 million** (including benefits).

- After application of the employment multiplier of 1.45, these employees created an additional **52** jobs.
- The same methodology is applied to derive the income impact. The income multiplier of 1.25 is applied to create over **$1.9 million** in income as they interact with other sectors of the local economy.
- **Total impacts = 166 jobs and more than $9.43 million in income.**

Healthcare and Your Local Economy

The health sector in a rural community, anchored by a CAH, is responsible for a number of full- and part-time jobs and the resulting wages, salaries, and benefits. Research findings from the National Center for Rural Health Works indicate that rural hospitals typically are one of the top employers in the rural community. The employment and the resulting wages, salaries, and benefits from a CAH are critical to the rural community economy. Figure 1 depicts the interaction between an industry like a healthcare institution and the community, containing other industries and households.

Key contributions of the health system include

- Attracts retirees and families
- Appeals to businesses looking to establish and/or relocate
- High quality healthcare services and infrastructure foster community development
- Positive impact on retail sales of local economy
- Provides higher-skilled and higher-wage employment
- Increases the local tax base used by local government

Data analysis was completed by the Center for Rural Health at the Oklahoma State University Center for Health Sciences utilizing IMPLAN data.

Fact Sheet Author: Kylie Nissen, BBA

For additional information, please contact:
Kylie Nissen, Program Director, Center for Rural Health
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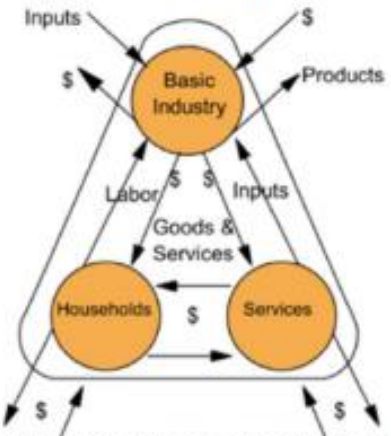
CENTER FOR RURAL HEALTH
OSU Center for Health Sciences

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

Figure 1. An overview of the community economic system.



Source: Doeksen, G.A., T. Johnson, and C. Willoughby. 1997. Measuring the Economic Importance of the Health Sector on a Local Economy: A Brief Literature Review and Procedures to Measure Local Impacts

This project is/was supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) through the Medicare Rural Hospital Flexibility Grant Program and the State Office of Rural Health Grant.

Appendix F - County Health Rankings Explained

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

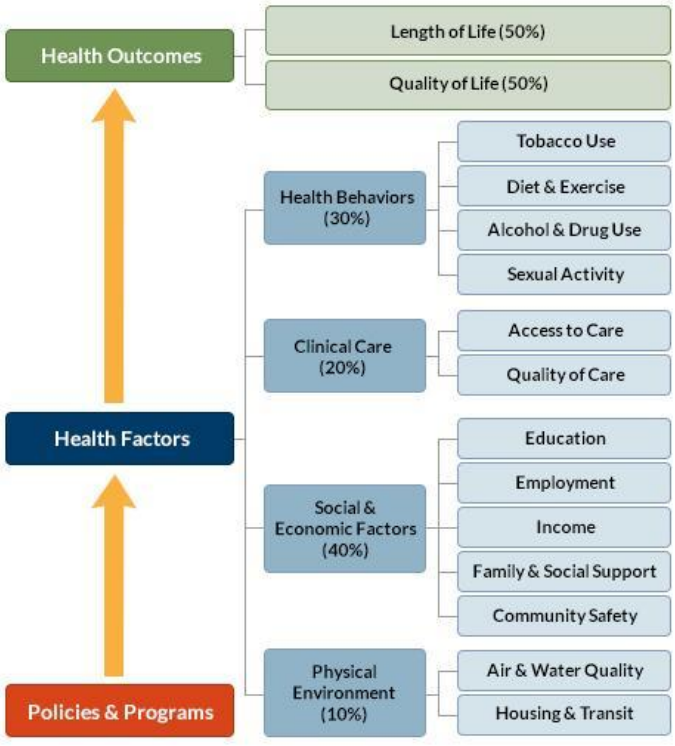
Methods

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



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.

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 U.S. population.

Reason for Ranking

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

Poor or Fair Health

Self-reported health status is a general measure of health-related quality of life (HRQoL) in a population. This measure is based on survey responses to the question: "In general, would you say that your health is excellent, very good, good, fair, or poor?" The value reported in the County Health Rankings is the percentage of adult respondents who rate their health "fair" or "poor." The measure is modeled and age-adjusted to the 2000 U.S. population. 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" are based on survey responses to the question: "Thinking about your physical health, which includes physical illness and injury, for how many days during the past 30 days was your physical health not good?" The value reported in the County Health Rankings is the average number of days a county's adult respondents report that their physical health was not good. The measure is age-adjusted to the 2000 U.S. population. 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" are based on survey responses to the question: "Thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental health not good?" The value reported in the County Health Rankings is the average number of days a county's adult respondents report that their mental health was not good. The measure is age-adjusted to the 2000 U.S. population. Note that the methods for calculating this measure changed in the 2016 rankings.

Reason for Ranking

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

Low Birth Weight

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

Reason for Ranking

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

In terms of the infant's health outcomes, LBW serves as a predictor of premature mortality and/or morbidity during the life course. 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.

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.

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. 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."

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.

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% of the federal poverty threshold for the family size.

2) Food insecurity estimates the percentage of the population that 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. Supermarkets traditionally provide healthier options than convenience stores or smaller grocery stores.

Additionally, access in regard 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. 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 ages 20 and older 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 U.S. and caused more than 5.3 million of the 57 million deaths that occurred worldwide in 2008. In addition, physical inactivity at the county level is related to healthcare expenditures for circulatory system diseases.

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 are comprised of 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; in urban census blocks: reside within one mile of a recreational facility; and 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.

Excessive Drinking

Excessive drinking is the percentage of adults that report either binge drinking, defined as consuming more than four (women) or five (men) alcoholic beverages on a single occasion in the past 30 days, or heavy drinking, defined as drinking more than one (women) or two (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. Approximately 80,000 deaths are attributed annually to excessive drinking. Excessive drinking is the third leading lifestyle-related cause of death in the U.S.

Alcohol-Impaired Driving Deaths

Alcohol-impaired driving deaths are 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.

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. STIs are associated with a significantly increased risk of morbidity and mortality, including increased risk of cervical cancer, infertility, and premature death. STIs also have a high economic burden on society. The direct medical costs of managing STIs and their complications in the U.S., for example, was approximately $15.6 billion in 2008.

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. 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. Preterm delivery and low birthweight babies have increased risk of child developmental delay, illness, and mortality. Additionally, there are strong ties between teen birth and poor socioeconomic, behavioral, and mental outcomes. A teenage woman who bears a child is much less likely to achieve an education level at or beyond high school, much more likely to be overweight/obese in adulthood, and more likely to experience depression and psychological distress.

Uninsured

Uninsured is the percentage of the population younger than 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? 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."

Primary Care Physicians

Primary care physicians is the ratio of the population to total primary care physicians. Primary care physicians include nonfederal, practicing physicians (MDs and DOs) younger than age 75 specializing in general practice medicine, family medicine, internal medicine, and pediatrics. 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.

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.

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 who treat alcohol and other drug abuse, and advanced practice nurses specializing in mental healthcare. In 2015, marriage and family therapists and mental health providers who treat alcohol and other drug abuse were added to this measure.

Reason for Ranking

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

Preventable Hospital Stays

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

Reason for Ranking

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

Mammography Screening

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

Reason for Ranking

Evidence suggests that mammography screening reduces breast cancer mortality, especially among older women. 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.

Flu Vaccinations

Flu vaccinations are Percentage of fee-for-service (FFS) Medicare enrollees that had an annual flu vaccination.

Reason for Ranking

Influenza is a potentially serious disease that can lead to hospitalization and even death. Every year there are millions of influenza infections, hundreds of thousands of flu-related hospitalizations, and thousands of flu-related deaths. An annual flu vaccine is the best way to help protect against influenza and may reduce the risk of flu illness, flu-related hospitalizations, and even flu-related death. It is recommended that everyone 6 months and older get a seasonal flu vaccine each year, and those over 65 are especially encouraged because they are at higher risk of developing serious complications from the flu.

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. 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. 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 younger than 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 younger than age 18, and whether the primary householder is older than age 65. Family income is then compared to the poverty threshold; if that family's income is below that threshold, the family is in poverty. For more information, please see Poverty Definition and/or Poverty.

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

Reason for Ranking

Poverty can result in an increased risk of mortality, morbidity, depression, and poor health behaviors. A 2011 study found that poverty and other social factors contribute a number of deaths comparable to leading causes of death in the U.S., such as heart attacks, strokes, and lung cancer. 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.

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 such as ADHD, behavior disorders, and anxiety, which can limit learning opportunities and social competence, leading to academic deficits that may persist into adulthood. 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. Note that the methods for calculating this measure changed in the 2015 rankings.

Reason for Ranking

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

Children in Single-Parent Households

Children in single-parent households is the percentage of children in families where the household is headed by a single parent (male or female head of household with no spouse present). 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). 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. Children in single-parent households are at greater risk of severe morbidity and all-cause mortality than their peers in two-parent households.

Violent Crime Rate

Violent crime rate 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. 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. Exposure to chronic stress also contributes to the increased prevalence of certain illnesses, such as upper respiratory illness and asthma in neighborhoods with high levels of violence.

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 U.S. mortality in 2014. 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. Injuries account for 17% of all emergency department visits and falls account for more than 1/3 of those visits.

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. Negative consequences of ambient air pollution include decreased lung function, chronic bronchitis, asthma, and other adverse pulmonary effects. 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.

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. 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, and kidney, liver, and nervous system damage.

Severe Housing Problems

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

- Housing unit lacks complete kitchen facilities;
- Housing unit lacks complete plumbing facilities;
- Household is severely overcrowded; or
- Household is severely cost burdened.

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

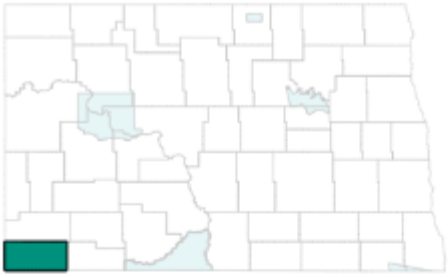
Reason for Ranking

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

Appendix G – North Dakota KIDS COUNT

View State Profile

Select a county on the map below:



Light blue shading shows the five American Indian reservations within North Dakota.

North Dakota County Profiles

Bowman County

Population Estimates for: 2023	Bowman	North Dakota
Child Population (under 18):	702	184,734
American Indian/Alaska Native:	6.0%	7.8%
Black:	0.9%	5.2%
White:	90.9%	79.6%
2+ Races or Other:	2.3%	7.4%

Health & Wellness

Children Without Health Insurance	Children Enrolled in Medicaid or CHIP	Women Who Receive Early Prenatal Care
8.6%	213	86.7%
2022	2023	2023
14.2% 2021	213 2022	85.0% 2022

Early Childhood

Children Under Age 6	Child Care Providers	Child Care Capacity
199	7	153
2023	2024	2024
203 2022	7 2023	153 2023

Education

Free or Reduced-Price Lunch Participation	Four-Year Cohort Graduation Rate	3rd Grade Students Proficient in Reading
19.4%	88.2%	41.3%
2023/24	2022/23	2022/23
19.7% 2022/23	>= 95% 2021/22	39.2% 2021/22

Family Economic Security

Children Living in Poverty	Child Food Insecurity	Children with All Parents Working
10.8%	13.1%	86.4%
2023	2022	2019-2023
10.2% 2022	6.7% 2021	82.2% 2018-2022

KIDS COUNT NORTH DAKOTA

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For more information on this data or North Dakota KIDS COUNT, contact ndkidscount@gmail.com or visit ndkidscount.org

Appendix H – Youth Behavioral Risk Survey Results

Youth Behavioral Risk Survey Results

North Dakota High School Survey

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

	ND 2015	ND 2017	ND 2019	ND Trend ↑, ↓, =	Rural ND Town Average	Urban ND Town Average	National Average 2019
Injury and Violence							
Percentage of students who rarely or never wore a seat belt (when riding in a car driven by someone else)	8.5	8.1	5.9	=	8.8	5.4	6.5
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)	17.7	16.5	14.2	=	17.7	12.7	16.7
Percentage of students who talked on a cell phone while driving (on at least one day during the 30 days before the survey, among students who drove a car or other vehicle)	NA	56.2	59.6	=	60.7	60.7	NA
Percentage of students who texted or e-mailed while driving a car or other vehicle (on at least one day during the 30 days before the survey, among students who had driven a car or other vehicle during the 30 days before the survey)	57.6	52.6	53.0	=	56.5	51.8	39.0
Percentage of students who never or rarely wore a helmet (during the 12 months before the survey, among students who rode a motorcycle)	NA	20.6	NA	**NA**	NA	NA	NA
Percentage of students who carried a weapon on school property (such as a gun, knife, or club on at least one day during the 30 days before the survey)	5.2	5.9	4.9	=	6.2	4.2	2.8
Percentage of students who were in a physical fight on school property (one or more times during the 12 months before the survey)	5.4	7.2	7.1	=	7.4	6.4	8.0
Percentage of students who experienced sexual violence (being forced by anyone to do sexual things [counting such things as kissing, touching, or being physically forced to have sexual intercourse] that they did not want to, one or more times during the 12 months before the survey)	NA	8.7	9.2	=	7.1	8.0	10.8
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)	7.6	NA	NA	**NA**	NA	NA	8.2
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)	NA	11.4	11.6	=	12.6	11.4	NA
Percentage of students who were bullied on school property (during the 12 months before the survey)	24.0	24.3	19.9	↓	24.6	19.1	19.5
Percentage of students who were electronically bullied (including being bullied through texting, Instagram, Facebook, or other social media during the 12 months before the survey)	15.9	18.8	14.7	↓	16.0	15.3	15.7

Percentage of students who felt sad or hopeless (almost every day for two or more weeks in a row so that they stopped doing some usual activities during the 12 months before the survey)	27.2	28.9	30.5	=	31.8	33.1	36.7
Percentage of students who seriously considered attempting suicide (during the 12 months before the survey)	16.2	16.7	18.8	=	18.6	19.7	18.8
	ND 2015	ND 2017	ND 2019	ND Trend ↑, ↓, =	Rural ND Town Average	Urban ND Town Average	National Average 2019
Percentage of students who made a plan about how they would attempt suicide (during the 12 months before the survey)	13.5	14.5	15.3	=	16.3	16.0	15.7
Percentage of students who attempted suicide (one or more times during the 12 months before the survey)	9.4	13.5	13.0	=	12.5	11.7	8.9
Tobacco Use							
Percentage of students who ever tried cigarette smoking (even one or two puffs)	35.1	30.5	29.3	=	32.4	23.8	24.1
Percentage of students who smoked a whole cigarette before age 13 years (even one or two puffs)	NA	11.2	NA	**NA**	NA	NA	NA
Percentage of students who currently smoked cigarettes (on at least one day during the 30 days before the survey)	11.7	12.6	8.3	↓	10.9	7.3	6.0
Percentage of students who currently frequently smoked cigarettes (on 20 or more days during the 30 days before the survey)	4.3	3.8	2.1	↓	2.3	1.7	1.3
Percentage of students who currently smoked cigarettes daily (on all 30 days during the 30 days before the survey)	3.2	3.0	1.4	↓	1.6	1.2	1.1
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)	NA	7.5	13.2	=	9.4	10.1	8.1
Percentage of students who tried to quit smoking cigarettes (among students who currently smoked cigarettes during the 12 months before the survey)	NA	50.3	54.0	=	52.8	51.4	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 one day during the 30 days before the survey)	22.3	20.6	33.1	↑	32.2	31.9	32.7
Percentage of students who currently used smokeless tobacco (chewing tobacco, snuff, or dip on at least one day during the 30 days before the survey)	NA	8.0	4.5	↓	5.7	3.8	3.8
Percentage of students who currently smoked cigars (cigars, cigarillos, or little cigars on at least one day during the 30 days before the survey)	9.2	8.2	5.2	↓	6.3	4.3	5.7
Percentage of students who currently used cigarettes, cigars, or smokeless tobacco (on at least 1 day during the 30 days before the survey)	NA	18.1	12.2	NA	15.1	10.9	10.5
Alcohol and Other Drug Use							
Percentage of students who ever drank alcohol (at least one drink of alcohol on at least one day during their life)	62.1	59.2	56.6	=	60.6	54.0	NA
Percentage of students who drank alcohol before age 13 years (for the first time other than a few sips)	12.4	14.5	12.9	=	16.4	13.2	15.0
Percentage of students who currently drank alcohol (at least one drink of alcohol on at least one day during the 30 days before the survey)	30.8	29.1	27.6	=	29.4	25.4	29.2
Percentage of students who currently were binge drinking (four or more drinks of alcohol in a row for female students, five or more for male students within a couple of hours on at least one day during the 30 days before the survey)	NA	16.4	15.6	=	17.2	14.0	13.7

	ND 2013	ND 2017	ND 2019	ND Trend ↑, ↓, =	Rural ND Town Average	Urban ND Town Average	National Average 2019
Percentage of students who usually obtained the alcohol they drank by someone giving it to them (among students who currently drank alcohol)	41.3	37.7	NA	**NA**	NA	NA	40.5
Percentage of students who tried marijuana before age 13 years (for the first time)	5.3	5.6	5.0	=	5.5	5.1	5.6
Percentage of students who currently used marijuana (one or more times during the 30 days before the survey)	15.2	15.5	12.5	=	11.4	14.1	21.7
Percentage of students who ever took prescription pain medicine without a doctor's prescription or differently than how a doctor told them to use it (counting drugs such as codeine, Vicodin, OxyContin, Hydrocodone, and Percocet, one or more times during their life)	NA	14.4	14.5	=	12.8	13.3	14.3
Percentage of students who were offered, sold, or given an illegal drug on school property (during the 12 months before the survey)	18.2	12.1	NA	NA	NA	NA	21.8
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)	NA	NA	NA	NA	NA	NA	NA
Sexual Behaviors							
Percentage of students who ever had sexual intercourse	38.9	36.6	38.3	=	35.4	36.1	38.4
Percentage of students who had sexual intercourse before age 13 years (for the first time)	2.6	2.8	NA	NA	NA	NA	3.0
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)	14.7	16.1	16.5	=	16.6	15.6	16.1
Percentage of students who had obesity (>= 95th percentile for body mass index, based on sex- and age-specific reference data from the 2000 CDC growth chart)	13.9	14.9	14.0	=	17.4	14.0	15.5
Percentage of students who described themselves as slightly or very overweight	32.2	31.4	32.6	=	35.7	33.0	32.4
Percentage of students who were trying to lose weight	NA	44.5	44.7	=	46.8	45.5	NA
Percentage of students who did not eat fruit or drink 100% fruit juices (during the seven days before the survey)	3.9	4.9	6.1	=	5.8	5.3	6.3
Percentage of students who ate fruit or drank 100% fruit juices one or more times per day (during the seven days before the survey)	NA	61.2	54.1	↓	54.1	57.2	NA
Percentage of students who did not eat vegetables (green salad, potatoes [excluding French fries, fried potatoes, or potato chips], carrots, or other vegetables, during the seven days before the survey)	4.7	5.1	6.6	=	5.3	6.6	7.9
Percentage of students who ate vegetables one or more times per day (green salad, potatoes [excluding French fries, fried potatoes, or potato chips], carrots, or other vegetables, during the seven days before the survey)	NA	60.9	57.1	↓	58.2	59.1	NA
Percentage of students who did not drink a can, bottle, or glass of soda or pop (such as Coke, Pepsi, or Sprite, not including diet soda or diet pop, during the seven days before the survey)	NA	28.8	28.1	=	26.4	30.5	NA
Percentage of students who drank a can, bottle, or glass of soda or pop one or more times per day (not including diet soda or diet pop, during the seven days before the survey)	18.7	16.3	15.9	=	17.4	15.1	15.1
Percentage of students who did not drink milk (during the seven days before the survey)	13.9	14.9	20.5	↑	14.8	20.3	30.6
Percentage of students who drank two or more glasses per day of milk (during the seven days before the survey)	NA	33.9	NA	NA	NA	NA	NA

Percentage of students who did not eat breakfast (during the 7 days before the survey)	11.9	13.5	14.4	=	13.3	14.1	16.7
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)	NA	2.7	2.8	=	2.1	2.9	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)	NA	51.5	49.0	=	55.0	22.6	55.9
	ND 2015	ND 2017	ND 2019	ND Trend ↑, ↓, =	Rural ND Town Average	Urban ND Town Average	National Average 2019
Percentage of students who watched television three or more hours per day (on an average school day)	18.9	18.8	18.8	=	18.3	18.2	19.8
Percentage of students who played video or computer games or used a computer three or more hours per day (counting time spent on things such as Xbox, PlayStation, an iPad or other tablet, a smartphone, texting, YouTube, Instagram, Facebook, or other social media, for something that was not school work on an average school day)	38.6	43.9	45.3	=	48.3	45.9	46.1
Other							
Percentage of students who had eight or more hours of sleep (on an average school night)	NA	31.8	29.5	=	31.8	33.1	NA
Percentage of students who brushed their teeth on seven days (during the 7 days before the survey)	NA	69.1	66.8	=	63.0	68.2	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)	NA	12.8	NA	NA	NA	NA	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)	NA	8.3	7.0	=	6.0	5.9	4.5

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

Appendix I – Southwest Healthcare Services Prioritization

Ranking of Concerns

The top concerns for each of the five topic areas, based on the community survey results, were discussed during the second community meeting. Since the meeting was held virtually via Zoom, participants were not given physical dots to vote. Instead, they were provided with QR codes for each category and asked to select their top three biggest concerns within each area. After the first round of voting, results were tallied to identify the highest-ranked priorities. Participants were then asked to complete a second round of voting, this time choosing the single topic they felt was the most important overall priority among the top-ranked issues.

COMMUNITY/ENVIRONMENTAL HEALTH CONCERNS	PRIORITIES	MOST IMPORTANT
Attracting and retaining young families	8	**4**
Not enough jobs with livable wages, not enough to live on	4	**4**
Not enough affordable housing	9	
Changes in population size (increasing or decreasing)	4	
Having enough child daycare services	10	
AVAILABILITY/DELIVERY OF HEALTH SERVICES CONCERNS	**PRIORITIES**	**MOST IMPORTANT**
Ability to retain primary care providers (MD,DO,NP,PA) and nurses	5	
Availability of specialists	10	
Not enough health care staff in general	5	
Availability of mental health services	4	**6**
Availability of substance use disorder treatment services	4	
Availability of hospice	4	
Cost of health insurance	6	
YOUTH POPULATION HEALTH CONCERNS	**PRIORITIES**	**MOST IMPORTANT**
Alcohol use and abuse	7	
Smoking and tobacco use, exposure to second-hand smoke	5	
Depression/anxiety	11	
ADULT POPULATION HEALTH CONCERNS	**PRIORITIES**	**MOST IMPORTANT**
Alcohol use and abuse	9	
Drug use and abuse (including prescription drug abuse)	4	
Depression/anxiety	9	
Stress	4	
SENIOR POPULATION HEALTH CONCERNS	**PRIORITIES**	**MOST IMPORTANT**
Being able to meet needs of older population	7	
Cost of long-term/nursing home care	10	
Availability of resources to help the elderly stay in their homes	4	
Availability of activities for seniors	5	
Dementia/Alzheimer's disease	5	
Depression/anxiety	6	