Community Health Needs Assessment

Cooperstown Medical Center Service Area
Cooperstown, North Dakota

2022

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Executive Summary

To help inform future decisions and strategic planning, Cooperstown Medical Center (CMC) conducted a Community Health Needs Assessment (CHNA) in 2022, the previous CHNA having been conducted in 2019. The Center for Rural Health (CRH) at the University of North Dakota (UND) School of Medicine & Health Sciences (SMHS) facilitated the assessment process, which solicited input from area community members and healthcare professionals as well as analysis of community health-related data.

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

With regard to demographics, Griggs County's population from 2020 to 2021 decreased by 1.1%. The average number of residents younger than age 18 (21.1%) for Griggs County comes in 2.5 percentage points lower than the North Dakota average (23.6%). The percentage of residents, ages 65 and older, is almost 15% higher for Griggs County (30.3%) than the North Dakota average (15.7%), and the rate of education is slightly lower for Griggs County (91.0%) than the North Dakota average (93.1%). The median household income in Griggs County ($53,917) is much lower than the state average for North Dakota ($65,315).

Data compiled by County Health Rankings show Griggs County is doing better than North Dakota in health outcomes/factors for 12 categories.

Griggs County, according to County Health Rankings data, is performing poorly relative to the rest of the state in 14 outcome/factor categories.

Of 106 potential community and health needs set forth in the survey, the 75 CMC service area residents who completed the survey indicated the following 10 needs as the most important:

- Alcohol use and abuse – youth and adult
- Attracting and retaining young families
- Availability of resources to help the elderly stay in their homes
- Availability of dental care
- Not enough healthcare staff in general
- Child abuse/neglect
- Depression/anxiety – youth and adult
- Having enough child daycare services
- Not enough jobs with livable wages
- Bullying/cyberbullying

The survey also revealed the biggest barriers to receiving healthcare (as perceived by community members). They included concerns about confidentiality (N=16), don't know about local services (N=15), and no insurance/limited insurance (N=14).

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

- Safe place to live
- Healthcare
- People are friendly, helpful, and supportive
- Family-friendly
- People who live here are involved in their community
- 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:

- Attracting and retaining young families
- Availability of vision care
- Alcohol use and abuse – youth and adults
- Depression/anxiety – youth and adults
- Cost of long-term/nursing home care

Overview and Community Resources

With assistance from the CRH at the UNDSMHS, the Cooperstown Medical Center completed a CHNA of the CMC service area. The hospital identifies its service area as Griggs County and Steele County in their entirety, plus portions of Foster and Nelson Counties – the last two have a medical center in their county. Many community members and stakeholders worked together on the assessment.

CMC is located in a rural area and is licensed as a Critical Access Hospital (CAH) with two provider-based rural health clinics. One clinic is attached to the CMC hospital and the other is located 52 miles to the north in Lakota, North Dakota. Cooperstown is the county seat of Griggs County, located in east central North Dakota near the scenic Sheyenne River Valley. It is less than a 90-minute drive to either Fargo or Grand Forks, two of North Dakota's largest cities.

Additional healthcare services provided in the community are county social services, a pharmacy, county-wide EMT/first responder volunteer ambulance services, a two-day per week clinic in Binford, massage therapy, and a chiropractor. WIC (Women, Infants, and Children) and Hospice provide services county-wide. The Nelson-Griggs District Health Unit (NGDHU) serves Nelson and Griggs Counties with offices located in Lakota. Mobile mammography and diagnostic services are routinely provided through CMC.

Cooperstown is home to the Bread of Life Food Pantry; for senior citizens, meal and transportation services are provided by South Central Adult Regional Services.

According to the U.S. Census Bureau's estimated census for 2011, the three major counties that utilize CMC services, Foster, Eddy, and Wells, have a total area of 2,536 square miles and approximately 9,958 people, a slight increase from 2010 census of 9,935. The racial makeup of the counties was 97.6% White. The number of households decreased from 4,806 to 4,601 households.

The community is dedicated to maintaining the charm and values of a rural American town while being progressive with technology and savvy business expansions. Agriculturally related businesses abound in the rural area. The community is proud of these accomplishments:

- Ashtabula II Wind Farm, consisting of 113 wind turbines in southern Griggs and Steele counties

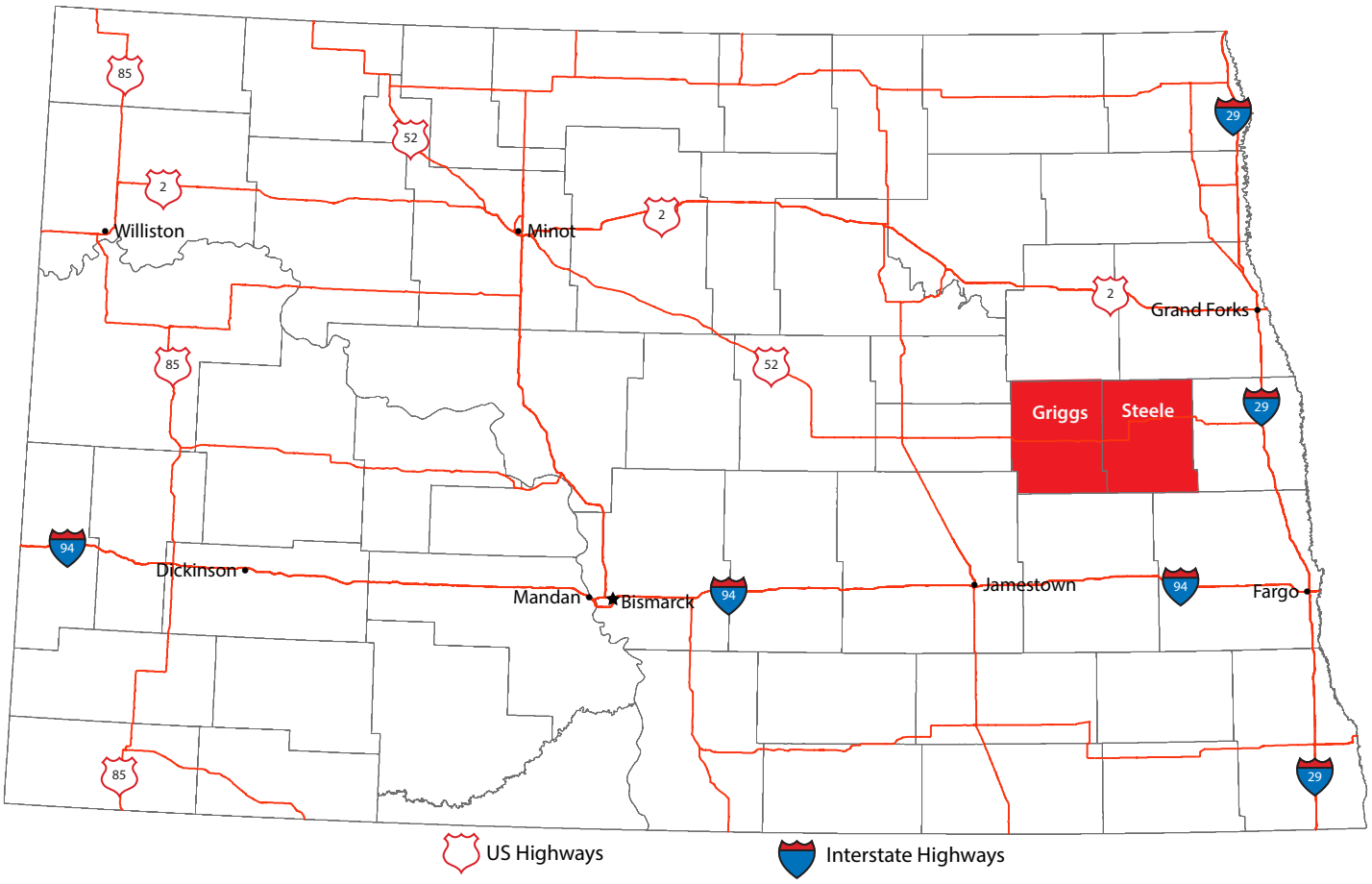
- The Central Plains Grain terminal in Hannaford, situated on the Burlington Northern rail line
- A new Griggs County Courthouse, built in 2017, is replacing the still-standing 100-year-old historical building. The new courthouse is also the home for Griggs County Social Services, the Emergency Management Center, and the Griggs County Sheriff's Department
- New businesses in Cooperstown include Christian Motors, Zaun Roll Off, Main Addictions, Nana's Café and Coffee Shop, TNT Eatery, Nodak Hydro LLC, Bloom Café, and Mindful Nutrition. In Hannaford, new businesses include the Hannaford Mercantile Co. and Grover's Timeless Gifts
- A building project has been initiated to replace the existing CMC CAH, clinic, and Griggs County Care Center skilled nursing care facility in a new location. The planned completion date is December 28, 2022. New services will include a 24/7 CT scanner as well as coloscopies and endoscopies
- Up-to-date and recently renovated school systems in Cooperstown (Griggs County Central Schools) and in Binford/Glenfield (Midkota Schools) offer comprehensive programs for Pre-K through high school. Both schools offer several college-level courses via online technology
- CMC has recently added additional mental health services via Inspired Health

In terms of physical assets and features, the community includes a fitness center, bike path, swimming pool, city park, tennis courts, 18-hole golf course, a baseball complex, skating rink, and movie theatre. The Sheyenne River Valley area offers multi-use trails for biking, hiking, cross-country skiing, canoeing, boating, fishing, and ATV riding. Additional valuable assets include local realtors, several churches, local attorneys, grocery, hardware, floral and variety stores, manufacturing businesses, and the Griggs County Library.

An Area Rich in History and Culture

The Griggs County Museum contains a wealth of historical information and artifacts to peruse, thanks to the dedication of the Griggs County Historical Society. A visual history of Cooperstown is depicted through the Compass on the Prairies site, located on the east side of Cooperstown. The Ronald Reagan Minuteman Missile site, located just north of Cooperstown, tells the story of the cold war years. Tours are given year-round. Fossils can be found at the Pierre Shale rock formation site, located along the Sheyenne River southeast of Cooperstown in a place referred to locally as the "Indian mounds."

Figure 1: Griggs and Steele County



Cooperstown Medical Center, CMC

CMC opened in 1951. It is a 501(c)(3) nonprofit community-owned corporation, located in Cooperstown, Griggs County, North Dakota. It comprises an 18-bed CAH, a level V designated trauma emergency department, a one physician, two nurse-practitioners, and a physician assistant certified rural health clinic, designated as a Qualified Health Service Corps location; Park Place, an attached 12-unit assisted living housing complex; and the affiliated Griggs County Care Center, a 41-bed skilled nursing facility. Service emphasis is on primary and preventive healthcare services within a 30-mile radius of Cooperstown, North Dakota. The CAH Profile for Cooperstown Medical Center includes a summary of hospital-specific information and is available in Appendix A.

In an effort to meet the mission of the organization, the CMC has tertiary affiliations with Altru telehealth, Sanford Health, and Essentia to ensure that patients have access to specialists and advanced medical technology. The Cooperstown Medical Center ER is equipped with an eEmergency system, linked to Avera-McKennan Hospital in Sioux Falls, South Dakota. This system gives CMC 24-hour immediate access to emergency trained physicians, nurses, and specialists, such as cardiologists, neurologists, and obstetrics.

CMC is fortunate to work with a group of dedicated area ambulance and first responder units in Cooperstown, Binford, and Hannaford. Life flight is available through several organizations, ensuring that patients with the most critical needs receive immediate access to care. Local EMS volunteers are to be credited for their first response efforts in the delivery of exemplary patient care service.

The combined effort of these associations, along with the efforts of a well-qualified and dedicated staff of 119 employees, are key to meeting CMC's mission of providing efficient, quality healthcare services.

Cooperstown Medical Center has a significant economic impact on the region. They directly employ 93.97 FTE employees with an annual payroll of over $7.76 million (including benefits). These employees create an additional 28 jobs and nearly $1.26 million in income, as they interact with other sectors of the local economy. This employment results in a total impact of 122 jobs and more than $9 million in income. Additional information is provided in Appendix B.

Mission
CMC is dedicated to providing high quality healthcare services in a personalized, compassionate, and professional manner.

Vision
CMC will be the preferred healthcare provider for the people of this area. Patient care and satisfaction will be our highest priority. CMC will be responsive, innovative, and effective at meeting and exceeding the expectations of those CMC serve.

CMC is the choice employer for quality employees. The team strives to be knowledgeable, flexible, and accountable in their performance. We value those we serve and treat customers and each other with respect, empathy, courtesy, and compassion.

Services, offered locally by CMC include:

General and Acute Services

- Acne treatment
- Hospital (acute care)
- Allergy, COVID-19, influenza, and pneumonia shots
- Blood pressure checks
- Clinic
- Emergency room
- Independent senior housing
- Mole/wart/skin lesion removal
- Nutrition counseling
- Pharmacy
- Prenatal care up to 32 weeks
- Physicals: annuals, D.O.T., sports, and insurance
- Respite care services
- Sports medicine
- Surgical services – biopsies
- Swing bed services

Screening/Therapy Service

- Chronic disease management
- Holter monitoring
- Infusion therapy
- Laboratory services
- Lower Extremity Circulatory Assessment
- Occupational therapy
- Pediatric services
- Physical therapy
- Respiratory care
- Sleep studies
- Social services
- Speech therapy

Radiology Services

- CT scan (mobile unit)
- Digital mammography (mobile unit)
- Echocardiograms
- EKG
- General X-ray
- MRI (mobile unit)
- Ultrasound (mobile unit)
- Arterial blood gases
- Blood types
- Clot times
- Chemistry
- Hematology
- Immunology
- Urine testing

Services Offered by OTHER Providers/Organizations

- Ambulance
- Chiropractic services
- Massage therapy

Nelson-Griggs District Health Unit (NGDHU)

NGDHU provides public health services that include environmental health, nursing services, health screenings, and educational services. NGDHU utilizes evidence-based practices as public health transitions to population-based services. These services mean there is a shift to changing systems and the environment by implementing good public health policies. There is still a wide variety of services to accomplish the mission of public health, which is to assure that North Dakota is a healthy place to live, and each person has an equal opportunity to enjoy good health. To accomplish this mission, NGDHU is committed to the promotion of healthy lifestyles, protection and enhancement of the environment, and provision of quality healthcare services for the people of North Dakota.

Specific services that NGDHU provides are:

- Baby and child health (newborn visits, Cribs for Kids program)
- Blood pressure checks
- Breastfeeding resource and referrals
- Car seat education and referral program
- Community influenza clinics
- Emergency preparedness and response program (work with community partners)
- Environmental health services (water, sewer, health hazard abatement)
- Health education programs
- Home visits (in-home medication set-up, monitor health status)
- Immunizations (infants, youth, adults)
- Office visits (consultation and referrals)
- School health (vision screening, health education, school immunizations)
- Strategic Planning and Community Engagement: Health Equity and Immunizations
- Substance abuse prevention (prescription drugs)
- Pandemic response, including education, case investigation, contact tracing, and vaccinations
- Preschool screenings
- Tobacco prevention and control program (signage, policies, youth activities, newsletters)
- Tobacco treatment specialist (cessation services)
- Tuberculosis case management
- West Nile disease program (education)
- Worksite wellness
- Youth education programs (Progressive Ag Safety Day)

Assessment Process

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

A CHNA benefits the community by:

1. Collecting timely input from the local community members, providers, and staff.
2. Providing an analysis of secondary data, related to health-related behaviors, conditions, risks, and outcomes.
3. Compiling and organizing information to guide decision making, education, and marketing efforts, and to facilitate the development of a strategic plan.
4. Engaging community members about the future of healthcare.
5. Allowing the community hospital to meet the federal regulatory requirements of the Affordable Care Act, which requires not-for-profit hospitals to complete a CHNA at least every three years as well as helping the local public health unit meet accreditation requirements.

This assessment examines health needs and concerns in Griggs County and Steele County as well as Foster and Nelson Counties, which are all included in the CMC service area. In addition to Cooperstown, located in the service area are the communities of Binford, Hannaford, Sutton, Jessie, Glenfield, Finley, Hope, and Lakota.

CRH, in partnership with CMC and NGDHU, facilitated the CHNA process. Community representatives met regularly in-person, by telephone conference, and email. A CHNA liaison was selected locally, who served as the main point of contact between CRH and CMC. A small steering committee (see Figure 2) was formed that was responsible for planning and implementing the process locally. Representatives from CRH met and corresponded regularly by videoconference and/or via the eToolkit with the CHNA liaison. The community group (described in more detail below) provided in-depth information and informed the assessment process in terms of community perceptions, community resources, community needs, and ideas for improving the health of the population and healthcare services. Eighteen people, representing a cross section demographically, attended the focus group meeting. The meeting was highly interactive with good participation. CMC staff and board members were in attendance as well but largely played a role of listening and learning.

Figure 2: Steering Committee

Nikki Johnson	CEO, CMC
Barbara Anderson	CFO, CMC
Julie Ferry	Administrator, NGDHU
Torry Reutter	Board Chairman, CMC
Brad Bewald	Loan Officer, Citizens State Bank
Melissa Myers	Foundation Director, CMC
Kelley Shawn	Survey Project Community Coordinator, CMC

The original survey tool was developed and used by CRH. In order to revise the original survey tool to ensure the data gathered met the needs of hospitals and public health, 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 (NDSU).

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

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

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

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

Community Group

A community group, consisting of eighteen community members, was convened and first met on January 20, 2022. During this first community group meeting, group members were introduced to the needs assessment process, reviewed basic demographic information about the community, and served as a focus group. Focus group topics included community assets and challenges, the general health needs of the community, community concerns, and suggestions for improving the community's health.

The community group met again on March 28, 2022, with 12 community members in attendance. At this second meeting, the community group was presented with survey results, findings from key informant interviews and the focus group, and a wide range of secondary data, relating to the general health of the population in Griggs County. The group was then tasked with identifying and prioritizing the community's health needs.

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

Interviews

One-on-one interviews with five key informants were conducted via virtual meeting in January and February 2022. A representative from CRH conducted the interviews. Interviews were held with selected members of the community who could provide insights into the community's health needs. Included among the informants were public health professionals with special knowledge in public health acquired through several years of direct experience in the community, including working with medically underserved, low income, and minority

populations as well as with populations with chronic diseases.

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

Survey

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

The community member survey was distributed to various residents of Griggs and Steele Counties, which are all included in the CMC service area. The survey tool was designed to:

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

Specifically, the survey covered the following topics:

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

To promote awareness of the assessment process, advertisements were placed in the Griggs County Sentinel Courier and Steele County, and posters were distributed throughout the service area. Additionally, information was available on the CMC, CMC Foundation, and Griggs County Care Center Facebook pages.

Approximately 50 community member surveys were available for distribution in Griggs County. The surveys were distributed by community group members and at CMC, NGDHU, and local businesses.

To help ensure anonymity, included with each survey was a postage-paid return envelope to CRH. In addition, to help make the survey as widely available as possible, residents also could request a survey by calling CMC or NGDHU. The survey period ran from January 7, 2022 to February 11, 2022. Five completed paper surveys were returned.

Area residents were also given the option of completing an online version of the survey, which was publicized in two community newspapers, distributed posters, emailed to community groups, and on the websites and Facebook pages of both CMC and NGDHU. Seventy online surveys were completed. Two of those online respondents used the QR code to complete the survey. In total, counting both paper and online surveys, the 75 community member surveys were completed, equating to a 10% response rate. This response rate is low for this type of unsolicited survey methodology and indicates an unengaged community.

Secondary Data

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

Social Determinants of Health

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

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

There are numerous models that depict the social determinants of health. While the models may vary slightly in the exact percentages that they attribute to various areas, the discrepancies are often because some models have combined factors when other models have kept them as separate factors.

For Figure 3, data has been derived from the County Health Rankings model (https://www.countyhealthrankings.org/resources/county-health-rankings-model) and it illustrates that healthcare, while vitally important, plays only one small role (approximately 20%) in the overall health of individuals and ultimately of a community. Physical environment, social and economic factors, and health behaviors play a much larger part (80%) in impacting health outcomes. Therefore, as needs or concerns were raised through this Community Health Needs Assessment process, it was imperative to keep in mind how they impact the health of the community and what solutions can be implemented.

Figure 3: Social Determinants of Health

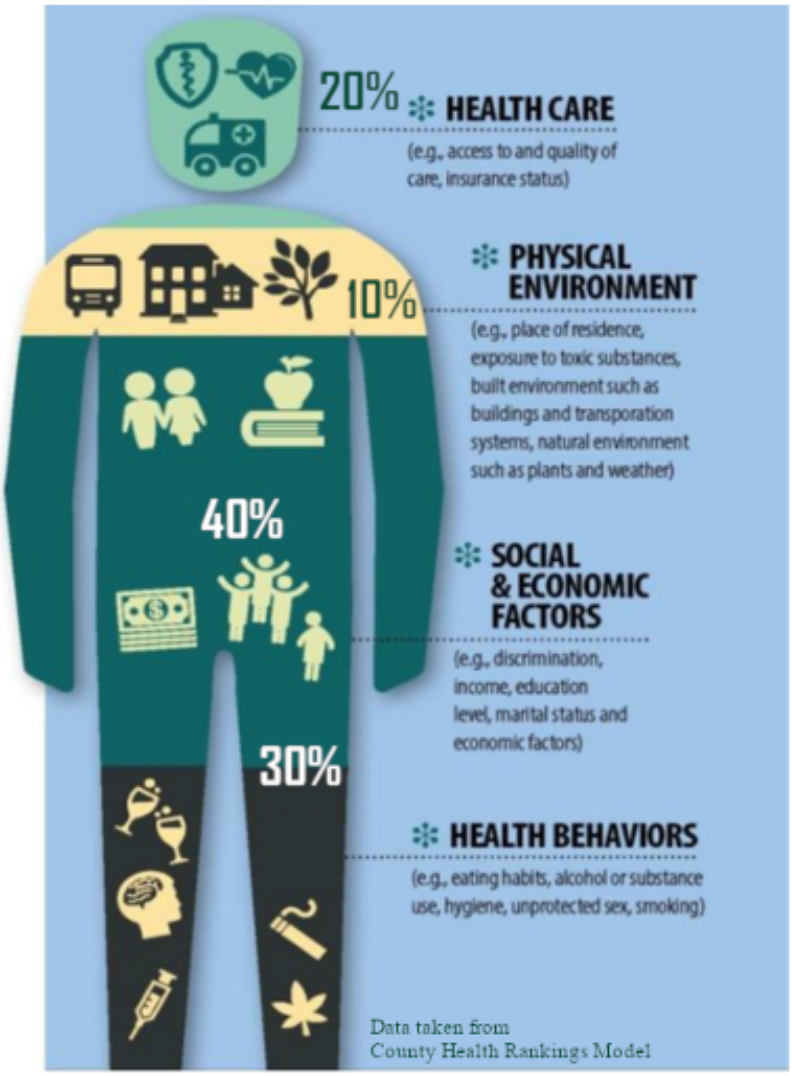


Figure 4 (Henry J. Kaiser Family Foundation, https://www.kff.org/disparities-policy/issue-brief/beyond-health-care-the-role-of-social-determinants-in-promoting-health-and-health-equity/), provides examples of factors that are included in each of the social determinants of health categories that lead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

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

Figure 4: Social Determinants of Health

Economic Stability	Neighborhood and Physical Environment	Education	Food	Community and Social Context	Health Care System
Employment	Housing	Literacy	Hunger	Social integration	Health coverage
Income	Transportation	Language	Access to healthy options	Support systems	Provider availability
Expenses	Safety	Early childhood education		Community engagement	Provider linguistic and cultural competency
Debt	Parks	Vocational training		Discrimination	Quality of care
Medical bills	Playgrounds	Higher education		Stress	
Support	Walkability				
	Zip code / geography				

Health Outcomes
Mortality, Morbidity, Life Expectancy, Health Care Expenditures, Health Status, Functional Limitations

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Demographic Information

Table 1 summarizes general demographic and geographic data about Griggs County

	Griggs County	North Dakota
Population (2021)	2,281	774,948
Population change (2020-2021)	-1.1%	-0.5%
People per square mile (2010)	3.4	9.7
Persons 65 years or older (2020)	30.3%	15.7%
Persons younger than 18 years (2020)	21.1%	23.6%
White persons (2020)	98.3%	86.9%
High school graduates (2020)	91.0%	93.1%
Bachelor's degree or higher (2020)	27.5%	30.7%
Live below poverty line (2020)	9.6%	10.2%
Persons without health insurance, younger than age 65 (2019)	7.7%	8.1%
Households with a broadband internet subscription (2020)	83.1%	83.1%

Source: https://www.census.gov/quickfacts/fact/table/ND,US/INC910216#viewtop and https://data.census.gov/cedsci/profile?g=0400000US38&q=North%20Dakota

While the population of North Dakota has grown in recent years, Griggs County has seen a decrease in population since 2020. The U.S. Census Bureau estimates show that Griggs County's population decreased from 2,306 (2020) to 2,281 (2021).

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, Walsh County is compared to North Dakota rates and national benchmarks on various topics, ranging from individual health behaviors to the quality of healthcare.

The data, used in the 2021 County Health Rankings, are pulled from more than 20 data sources and then are compiled to create county rankings. Counties in each of the 50 states are ranked, according to summaries of a variety of health measures. Those items having high ranks, such as 1 or 2, are considered to be the "healthiest." Counties are ranked on both health outcomes and health factors. Following is a breakdown of the variables that influence a county's rank.

A model of the 2021 County Health Rankings – a flow chart of how a county's rank is determined – may be found in Appendix D. For further information, visit the County Health Rankings website at www.countyhealthrankings.org.

Health Outcomes

- Length of life
- Quality of life

Health Factors

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

Health Factors (continued)

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

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

For most of the measures included in the rankings, the County Health Rankings' authors have calculated the "Top U.S. Performers" for 2022. The Top Performer number marks the point at which only 10% of counties in the nation do better, i.e., the 90th percentile or 10th percentile, depending on whether the measure is framed positively (such as high school graduation) or negatively (such as adult smoking).

Griggs County rankings within the state are included in the summary following. For example, Griggs County ranks 27th out of 48 ranked counties in North Dakota on health outcomes and 23rd on health factors. The measures, marked with a bullet point (•), are those where a county is not measuring up to the state rate/percentage; a square (■) indicates that the county is not meeting the U.S. Top 10% rate on that measure. Measures that are not marked with a colored shape but are marked with a plus sign (+) indicate that the county is doing better than the U.S. Top 10%.

The data from County Health Rankings show that Griggs County is doing better than many counties, compared to the rest of the state on all but two of the outcomes, which do not have enough data for the area to rank. Griggs County is also doing better in many areas, when it comes to the U.S. Top 10% ratings on all but two outcomes, which do not have enough data for the area to rank.

On health factors, Griggs County performs below the North Dakota average for counties in several areas.

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

- Poor or fair health
- Poor mental health days
- Adult obesity
- Food index environment
- Excessive drinking
- Mammography screening
- Unemployment
- Sexually transmitted infections
- Income inequality
- Social associations
- Violent crime
- Drinking water violations
- Severe housing problems
- Air pollution – particulate matter

Outcomes and factors in which Griggs County were performing poorly, relative to the rest of the state, include:

- Poor physical health days
- Adult smoking
- Physical inactivity
- Access to exercise opportunities
- Uninsured
- Children in poverty
- Children in single-parent households
- Alcohol-impaired driving deaths
- Primary care physicians
- Dentists
- Preventable hospital stays
- Flu vaccinations
- Injury deaths

TABLE 2: SELECTED MEASURES FROM COUNTY HEALTH RANKINGS 2021– WALSH COUNTY

● = Not meeting North Dakota average

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

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

Blank values reflect unreliable or missing data

TABLE 2: SELECTED MEASURES FROM *COUNTY HEALTH RANKINGS* 2022 – GRIGGS COUNTY			
	Griggs County	**U.S. Top 10%**	**North Dakota**
Ranking: Outcomes	**27th**		**(of 47)**
Premature death		5,600	7,100
Poor or fair health	14% ●+	15%	13%
Poor physical health days (in past 30 days)	3.3 ●+	3.4	3.1
Poor mental health days (in past 30 days)	3.7 +	4.0	3.7
Low birth weight		6%	7%
Ranking: Factors	**23rd**		**(of 48)**
Health Behaviors			
Adult smoking	20% ●■	15%	17%
Adult obesity	35% ■	30%	36%
Food environment index (10=best)	8.9 +	8.8	8.9
Physical inactivity	22%●■	23%	28%
Access to exercise opportunities	44% ●■	86%	64%
Excessive drinking	23% ■	15%	24%
Alcohol-impaired driving deaths	67% ●■	10%	41%
Sexually transmitted infections	310.0 ■	161.8	509.1
Teen birth rate		11	18
Clinical Care			
Uninsured	8% ●■	6%	7%
Primary care physicians	2,230:1●■	1,010:1	1,290:1
Dentists	2,230:1●■	1,210:1	1,480:1
Mental health providers		250:1	470:1
Preventable hospital stays	7,267●■	2,233	3,553
Mammography screening (% of Medicare enrollees ages 65-74 receiving screening)	54% +	52%	53%
Flu vaccinations (% of fee-for-service Medicare enrollees receiving vaccination)	34%●■	55%	50%
Social and Economic Factors			
Unemployment	2.5% +	4.0%	5.1%
Children in poverty	12%●■	9%	11%
Income inequality	4.2 ■	3.7	4.4
Children in single-parent households	23% ●■	14%	19%
Social associations	49.3 +	18.1	15.9
Violent crime	44 +	63	258
Injury deaths	115 ●■	61	72
Physical Environment			
Air pollution – particulate matter	5.0 +	5.9	6.4
Drinking water violations	No +		
Severe housing problems	6% +	9%	12%

Source: http://www.countyhealthrankings.org/app/north-dakota/2021/rankings/outcomes/overall

Children's Health

The National Survey of Children's Health touches on multiple intersecting aspects of children's lives. Data are not available at the county level; listed below is information about children's health in North Dakota. The full survey includes physical and mental health status, access to quality healthcare, and information on the child's family, neighborhood, and social context. Data are from 2019-20. More information about the survey may be found at www.childhealthdata.org/learn/NSCH.

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

TABLE 3: SELECTED MEASURES REGARDING CHILDREN'S HEALTH (For children ages 0-17 unless noted otherwise), 2020

Health Status	North Dakota	National
Children born premature (3 or more weeks early)	9.9%	11.2%
Children 10-17 overweight or obese	26.9%	32.1%
Children 0-5 who were ever breastfed	86.1%	80.8%
Children 6-17 who missed 11 or more days of school	2.9%	3.9%
Healthcare		
Children currently insured	93.6%	93.1%
Children who spent less than 10 minutes with the provider at a preventive medical visit	16.0%	18.1%
Children (1-17 years) who had preventive a dental visit in the past year	73.7%	77.5%
Children (3-17 years) received mental healthcare	10.5%	11.0%
Children (3-17 years) with problems requiring treatment did not receive mental healthcare	2.3%	2.5%
Young children (9-35 mos.) receiving standardized screening for developmental problems	31.1%	36.9%
Family Life		
Children whose families eat meals together 4 or more times per week	79.2%	75.2%
Children who live in households where someone smokes	16.1%	14.0%
Neighborhood		
Children who live in neighborhood with a park, sidewalks, a library, and a community center	81.1%	74.9%
Children living in neighborhoods with poorly kept or rundown housing	9.1%	13.3%

Source: https://www.childhealthdata.org/browse/survey

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

- Children (1-17 years) who had a preventative dental visit in the past year
- Young children (9-35 mos.) receiving standardized screening for developmental problems
- Children who live in households where someone smokes

Table 4 includes selected county-level measures regarding children's health in North Dakota. The data come from North Dakota KIDS COUNT, a national and state-by-state effort to track the status of children, sponsored

by the Annie E. Casey Foundation. KIDS COUNT data focuses on the main components of children's well-being; more information about KIDS COUNT is available at www.ndkidscount.org. The measures highlighted in blue in the table are those in which the counties are doing worse than the state average. The year of the most recent data is noted.

The data show Griggs County is performing more poorly than the North Dakota average on all of the examined measures except the percentage of the four-year high school graduation rate. The most marked difference was on the measure of Medicaid recipients (over 3.5% higher rate in Eddy County).

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

	Griggs County	North Dakota
Child food insecurity, 2019	**11.2%**	9.3%
Medicaid recipient (% of population age 0-20), 2020	**29.6%**	26.0%
Children enrolled in Healthy Steps (% of population age 0-18), 2020	**2.5%**	1.7%
Supplemental Nutrition Assistance Program (SNAP) recipients (% of population age 0-18), 2020	**17.0%**	17.0%
Licensed childcare capacity (# of children), 2020	91	36,701
Four-year high school cohort graduation rate, 2020/2021	89.7%	87.0%
Victims of child abuse and neglect requiring services (rate per 1,000 children ages 0-17), 2020	**NA**	8.89

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

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

North Dakota has two survey groups, selected and voluntary. The selected school survey population is chosen, using a scientific sampling procedure, 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 5 depicts some of the YRBS data that have been collected in 2015, 2017, and 2019. They are further broken down by rural and urban percentages. The trend column shows an "=" for statistically insignificant change (no change), "↑" for an increased trend in the data changes from 2017 to 2019, and "↓" for a decreased trend in the data changes from 2017 to 2019. The final column shows the 2019 national average percentage. For a more complete listing of the YRBS data, see Appendix E.

TABLE 5: Youth Risk Behavior 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							
% 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
% 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
% of students who talked on a cell phone while driving (on at least one day during the 30 days before the survey)	NA	56.2	59.6	=	60.7	60.7	NA
% 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)	57.6	52.6	53.0	=	56.5	51.8	39.0
% 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
% 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
% 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
% of students who were electronically bullied (includes texting, Instagram, Facebook, or other social media ever during the 12 months before the survey)	15.9	18.8	14.7	↓	16.0	15.3	15.7
% 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
Tobacco, Alcohol, and Other Drug Use							
% of students who currently use an electronic vapor product (e-cigarettes, vape e-cigars, e-pipes, vape pipes, vaping pens, e-hookahs, and hookah pens at least one day during the 30 days before the survey)	22.3	20.6	33.1	↑	32.2	31.9	32.7
% of students who currently used cigarettes, cigars, or smokeless tobacco (on at least one day during the 30 days before the survey)	NA	18.1	12.2	**NA**	15.1	10.9	10.5
% 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)	NA	16.4	15.6	=	17.2	14.0	13.7
% 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
% 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
Weight Management, Dietary Behaviors, and Physical Activity							
% of students who were overweight (>= 85th percentile but <95th percentile for body mass index)	14.7	16.1	16.5	=	16.6	15.6	16.1
% of students who had obesity (>= 95th percentile for body mass index)	13.9	14.9	14.0	=	17.4	14.0	15.5
% 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
% 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

% 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
% 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
% of students who did not eat breakfast (during the seven days before the survey)	11.9	13.5	14.4	=	13.3	14.1	16.seven
% 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.seven	2.8	=	2.1	2.9	NA
% of students who were physically active at least 60 minutes per day on 5 or more days (doing any kind of physical activity that increased their heart rate and made them breathe hard some of the time during the seven days before the survey)	NA	51.5	49.0	=	55.0	22.6	55.9
% of students who watched television 3 or more hours per day (on an average school day)	18.9	18.8	18.8	=	18.3	18.2	19.8
% of students who played video or computer games or used a computer three or more hours per day (for something that was not schoolwork on an average school day)	38.6	43.9	45.3	=	48.3	45.9	46.1
Other							
% of students who ever had sexual intercourse	38.9	36.6	38.3	=	35.4	36.1	38.4
% 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
% of students who brushed their teeth on seven days (during the seven days before the survey)	NA	69.1	66.8	=	63.0	68.2	NA

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

Low Income Needs

The North Dakota Community Action Agencies (CAAs), as nonprofit organizations, were originally established under the Economic Opportunity Act of 1964 to fight America's war on poverty. CAAs are required to conduct statewide needs assessments of people experiencing poverty. The most recent statewide needs assessment study of low-income people in North Dakota, sponsored by the CAAs, was performed in 2020. The needs assessment study was accomplished through the collaboration of the CAAs and North Dakota State University (NDSU) by means of several kinds of surveys (such as online or paper surveys, etc., depending on the suitability of these survey methods to different respondent groups) to low-income individuals and families across the state of North Dakota. In the study, the survey data were organized and analyzed in a statistical way to find out the priority needs of these people. The survey responses from low-income respondents were separated from the responses from non-low-income participants, which allows the research team to compare them and then identify the similarity, difference, and uniqueness of them in order to ensure the validity and accuracy of the survey study and avoid bias. Additionally, two comparison methods were used in the study, including cross-sectional and longitudinal comparisons. These methods allow the research team not only to identify the top specific needs under the seven need categories, including Employment, Income and Asset-Building, Education, Housing, Health and Social/Behavior Development, Civic Engagement, and Other Supports, through the cross-sectional comparison but also to be able to find out the top specific needs, regardless to which categories these needs belong through the longitudinal comparison.

Top Needs Identified by People Experiencing Poverty Across North Dakota

Category	Need
Housing	Rental Assistance
Income	Financial Issues
Employment	Finding a job
Health	Dental Insurance/Affordable Dental Care
Education	Cost

2020 North Dakota LOW INCOME COMMUNITY NEEDS

Helping People. Changing Lives. Community Action Partnership — America's Poverty Fighting Network

NDSU North Dakota State University

Assessed by CAPND and NDSU, November 2020

KEY FINDINGS

1st Priority Need

Rental Assistance

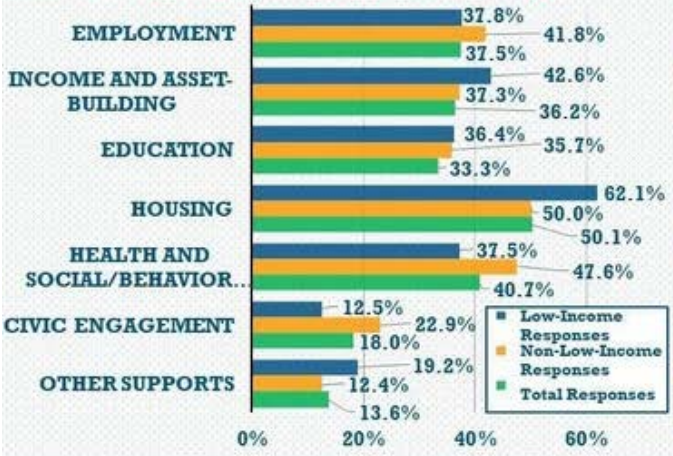
3,458 Total Survey Responses

- **1,086** Low-Incomes
- **2,084** Non- Low-Incomes
- **288** Others (roles cannot be identified)

"***Rental Assistance***" becomes the 1st priority need of people experiencing poverty across the state under the category of "***Housing***". This need, however, would represent their immediate (short-term) need, which could be partially or significantly affected by the pandemic of COVID-19.

- The 1st priority need for the non-low-income respondents is "***Mental Health Service***".
- For the community (including both low-income and non-low-income people), the 1st priority need is "***Dental Issuance/Affordable Dental***".

STATEWIDE OVERALL NEEDS



TOP STATEWIDE SPECIFIC NEEDS

Low-Incomes

- **Housing** - Rental Assistance
- **Health and Social/Behavior Development** - Dental Insurance/Affordable Dental
- **Other Needs** - Food

Non-Low-Incomes

- **Health and Social/Behavior Development** - Mental Health Service
- **Health and Social/Behavior Development** - Health Insurance/Affordable Health Care
- **Income and Asset-Building** - Budget/Credit/Debit Counseling

Community (Low-Income & Non-Low-Income)

- **Health and Social/Behavior Development** - Dental Insurance/Affordable Dental
- **Health and Social/Behavior Development** - Health Insurance/Affordable Health Care
- **Health and Social/Behavior Development** - Mental Health Service

TOP REGIONAL OVERALL NEEDS FOR LOW-INCOMES

ACKNOWLEDGMENTS

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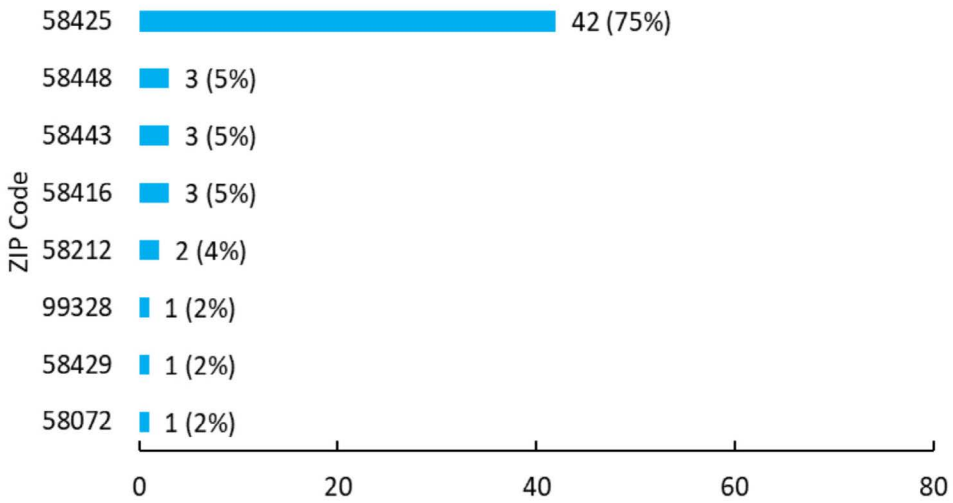
Survey Results

As noted previously, 75 community members completed the survey in communities throughout the counties in the Cooperstown Medical Center service area. For all questions that contained an "Other" response, all of those direct responses may be found in Appendix G. 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).

The survey requested that respondents list their home ZIP code. While not all respondents provided a ZIP code, 56 persons did, revealing that a large majority of respondents (75%, N=42) lived in Cooperstown. These results are shown in Figure 5.

Figure 5: Survey Respondents' Home ZIP Code
Total respondents: 56



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

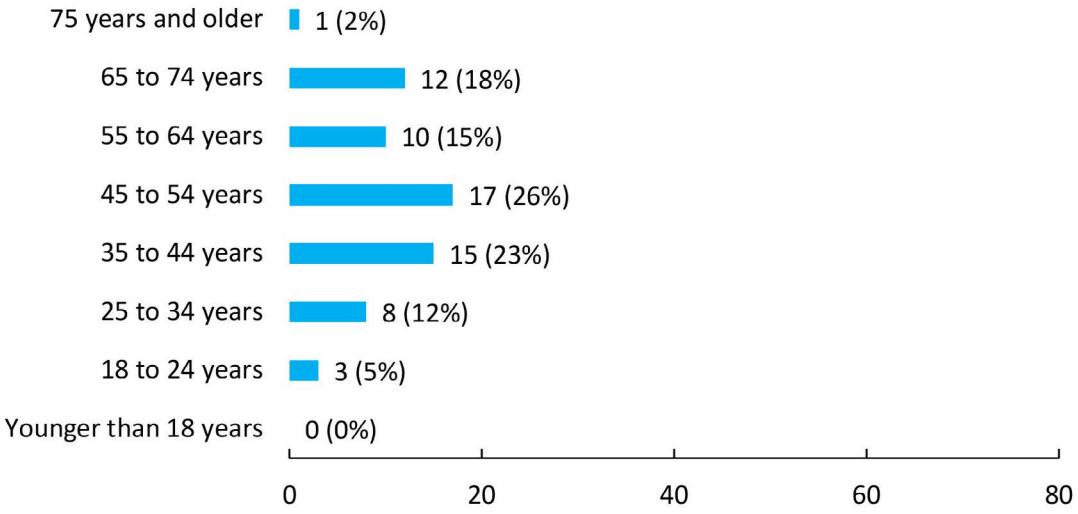
To better understand the perspectives, offered by survey respondents, survey-takers were asked a few demographic questions. Throughout this report, numbers (N) instead of just percentages (%) are reported because percentages can be misleading with smaller numbers. Survey respondents were not required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

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

- 35% (N=23) were age 55 or older
- The majority (84%, N=54) were female
- More than half of the respondents (55%, N=35) had bachelor's degrees or higher
- The number of those working full time (71%, N=46) was just less than five times higher than those who were retired (15%, N=10)
- 92% (N=58) of those who reported their ethnicity/race were White/Caucasian
- 19% of the population (N=11) had household incomes of less than $50,000

Figures 6 through 12 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 6: Age Demographics of Survey Respondents
Total respondents = 66



People younger than age 18 are not questioned, using this survey method.

Figure 7: Gender Demographics of Survey Respondents
Total respondents = 64

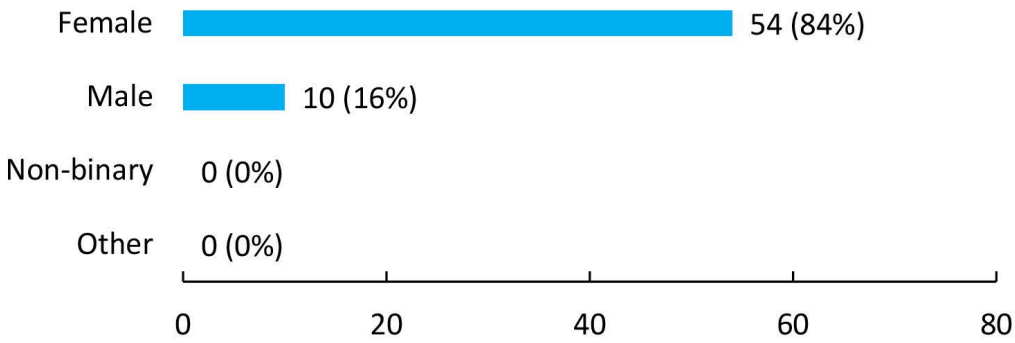


Figure 8: Educational Level Demographics of Survey Respondents
Total respondents = 64

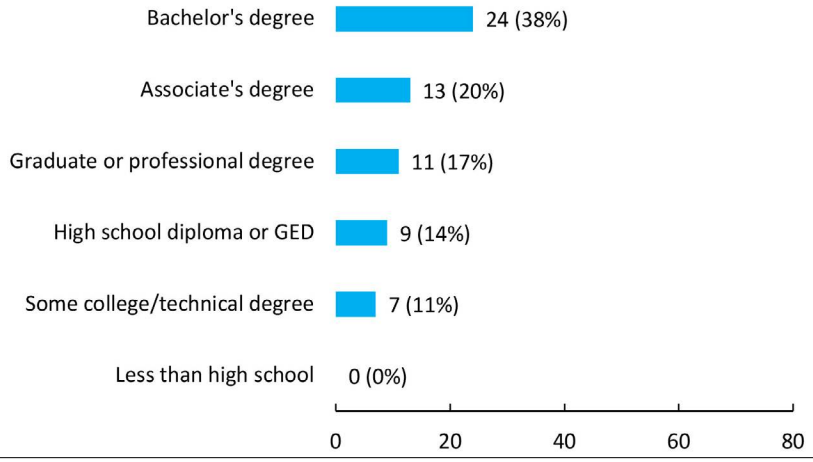
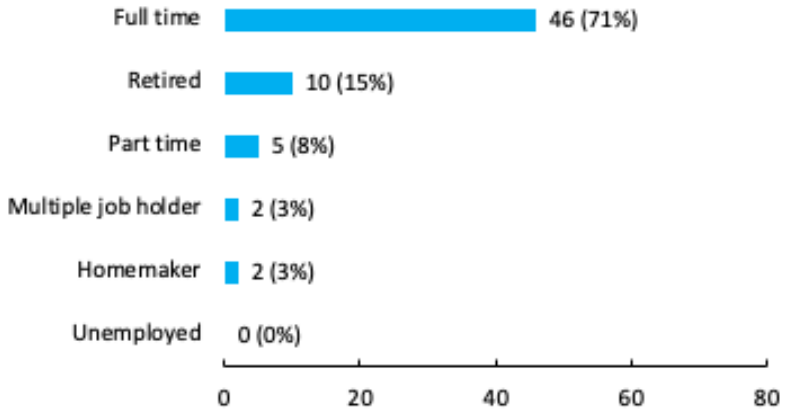
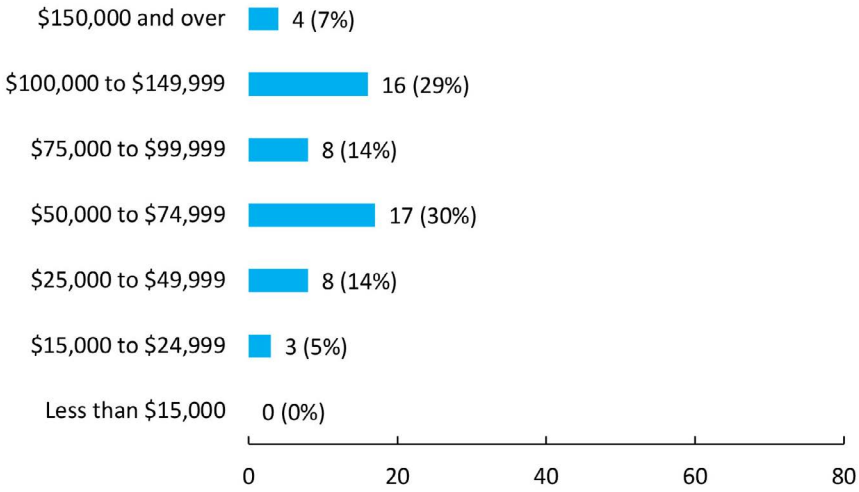


Figure 9: Employment Status Demographics of Survey Respondents
Total respondents = 65



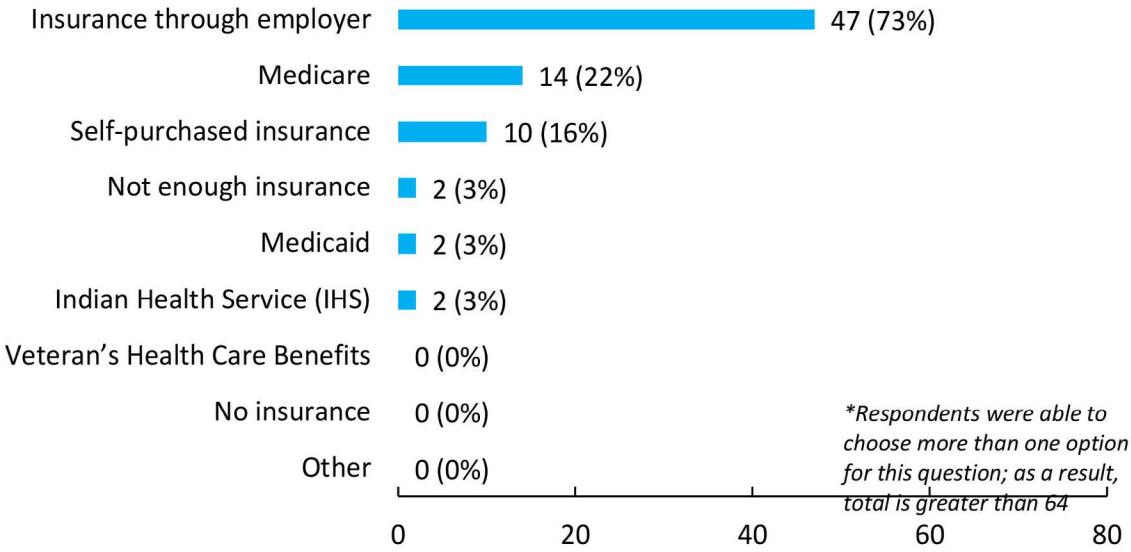
Of those who provided a household income, 19% (N=11) community members reported a household income of less than $25,000. Thirty-six percent (N=20) indicated a household income of $100,000 or more. This information is shown in Figure 10.

Figure 10: Household Income Demographics of Survey Respondents
Total respondents = 56



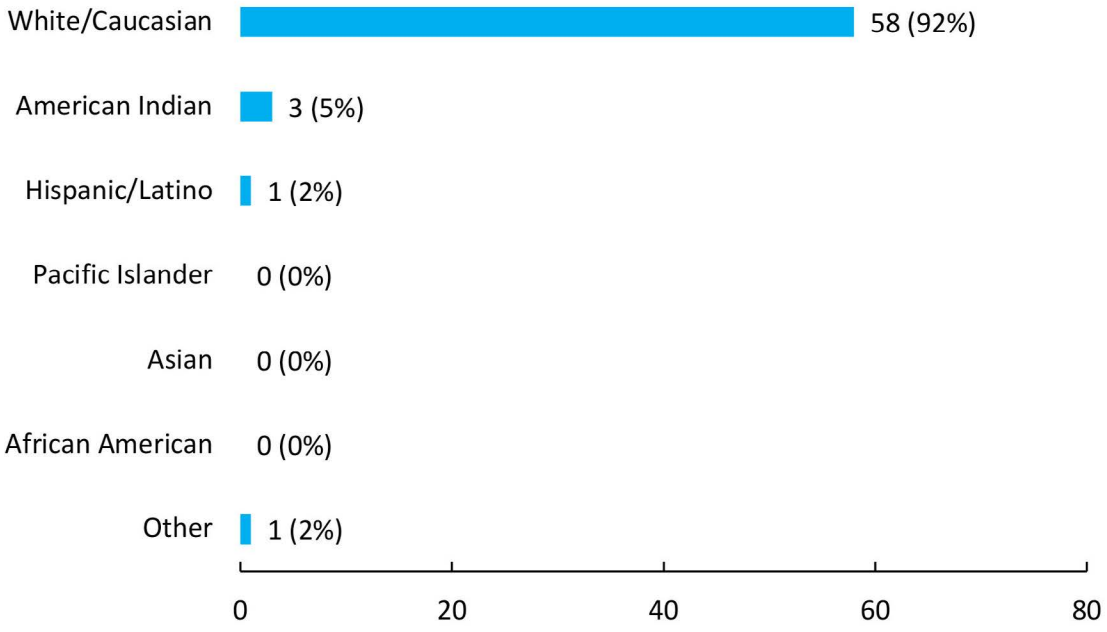
Community members were asked about their health insurance status, which is often associated with whether people have access to healthcare. Three percent (N=2) of the respondents reported having no health insurance or being under-insured. The most common insurance types were insurance through one's employer (N=47), followed by Medicare (N=14), and self-purchased insurance (N=10).

Figure 11: Health Insurance Coverage Status of Survey Respondents
Total respondents = 64*



As shown in Figure 12, nearly all of the respondents were White/Caucasian (92%). This statistic was in-line with the race/ethnicity of the overall population of Griggs County; the U.S. Census indicates that 98.3% of the population is White in Griggs County.

Figure 12: Race/Ethnicity Demographics of Survey Respondents
Total respondents = 63



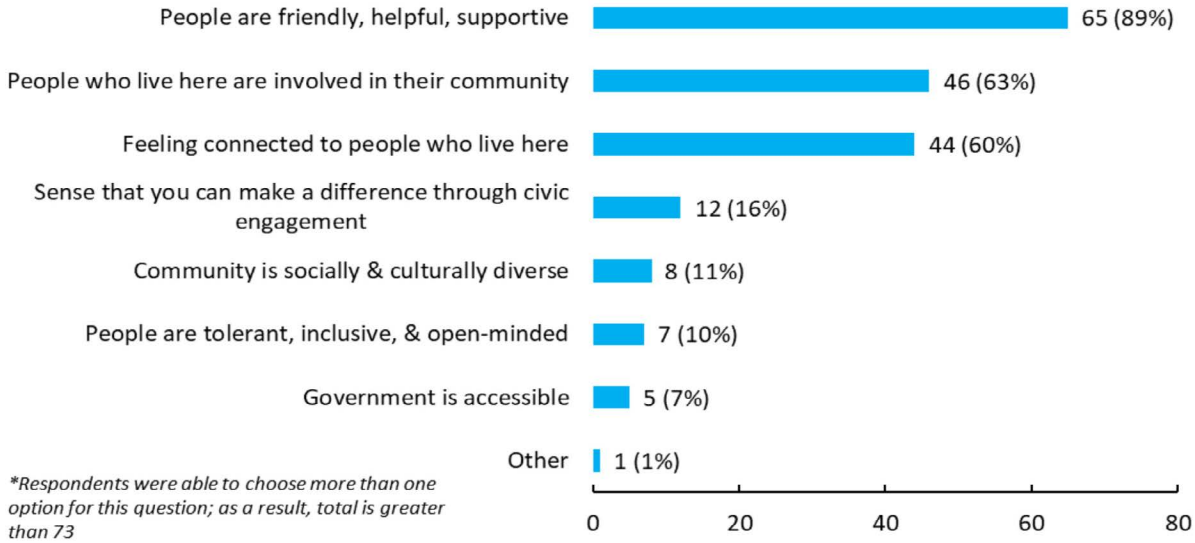
Community Assets and Challenges

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 45 respondents agreeing) that community assets include:

- People are friendly, helpful, supportive (N=65)
- Safe place to live (N=59)
- Family-friendly (N=58)
- Healthcare (N=56)
- People who live here are involved in their community (N=46)

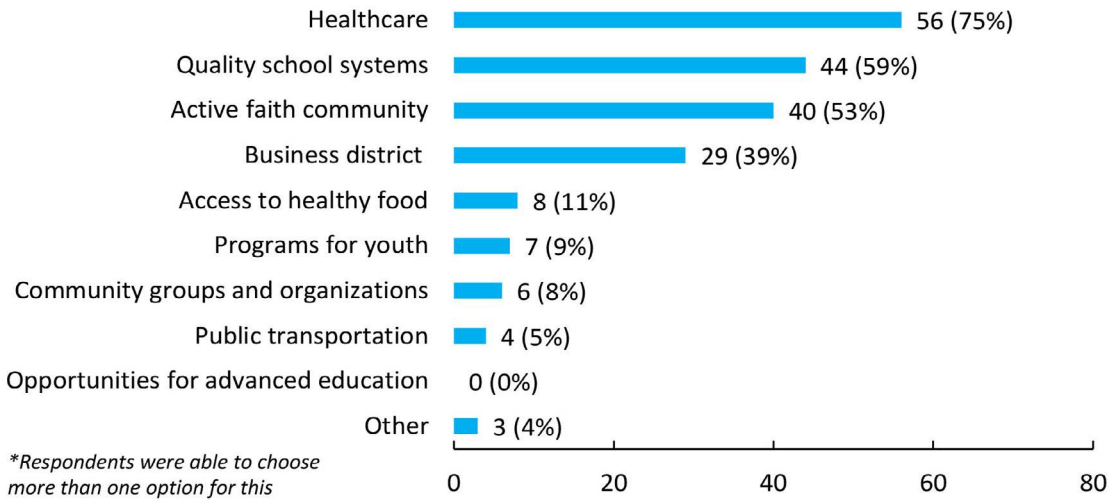
Figures 13 to 16 illustrate the results of these questions.

Figure 13: Best Things About the PEOPLE in Your Community
Total responses = 73*



Included in the "Other" category of the best things about the people was people are becoming more accepting of new families in the area.

Figure 14: Best Things About the SERVICES AND RESOURCES in Your Community
Total responses = 75



Respondents who selected "Other" specified the grocery store and having a great medical center.

Figure 15: Best Things About the QUALITY OF LIFE in Your Community
Total responses = 74*

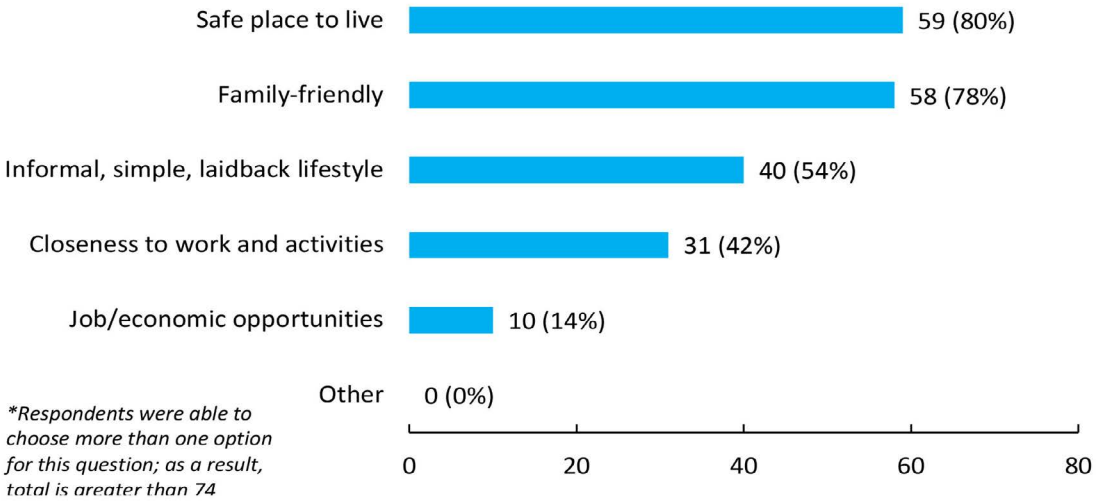
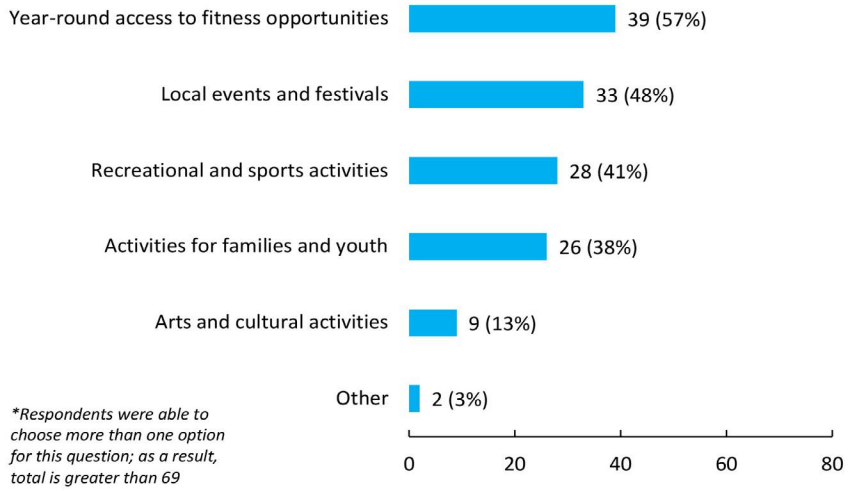


Figure 16: Best Thing About the ACTIVITIES in Your Community
Total responses = 69*



Community Concerns

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

- Community/environmental health
- Availability/delivery of health services
- Youth population
- Adult population
- Senior population
- Violence

With regard to responses about community challenges, the most highly voiced concerns (those having at least 26 respondents) were:

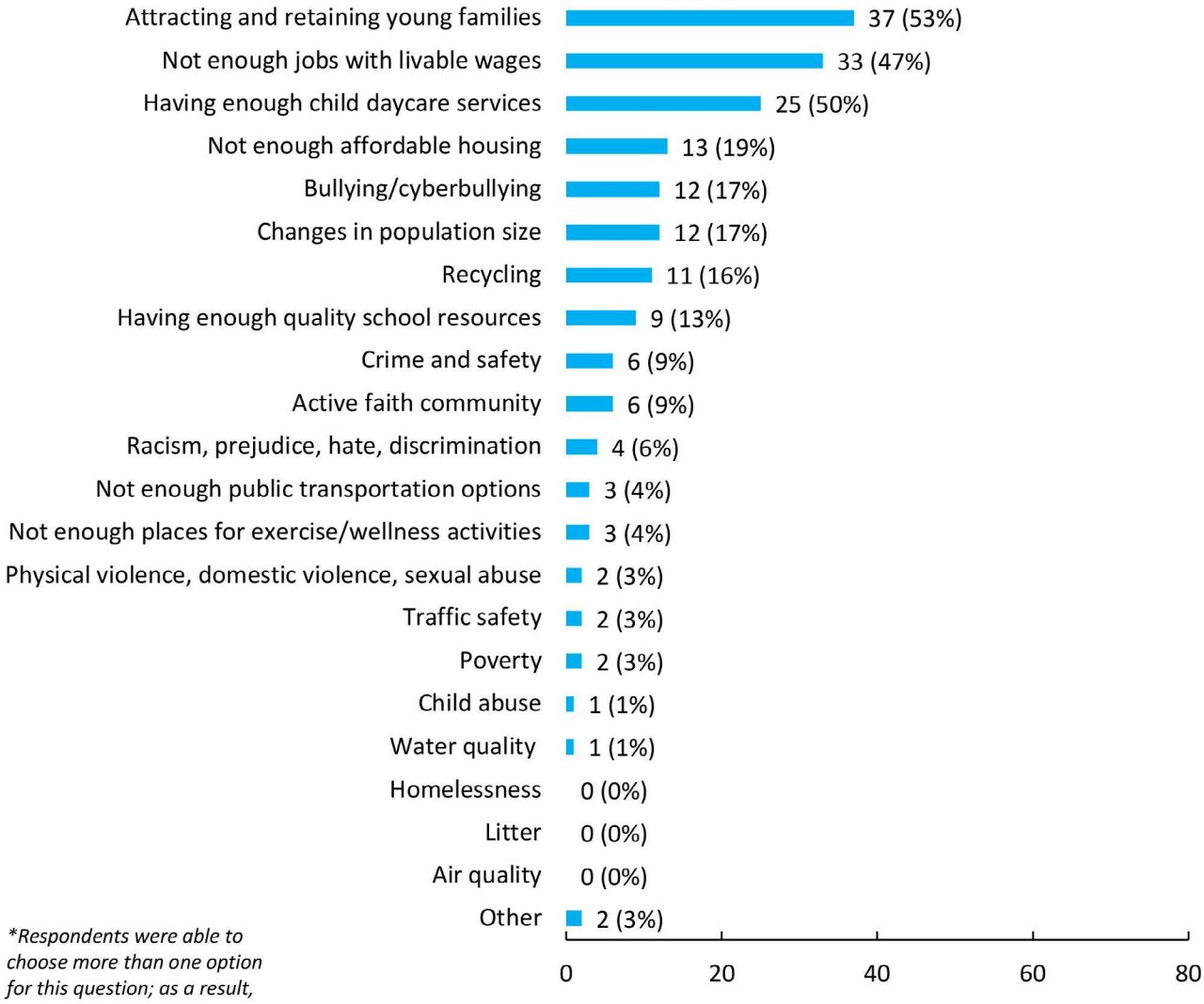
- Bullying/cyberbullying – violence (N=44)
- Attracting and retaining young families (N=37)
- Depression/anxiety – youth (N= 37)
- Not enough jobs with livable wages (N=33)
- Depression/anxiety – adult (N=32)
- Availability of resources to help the elderly stay in their homes (N=29)
- Alcohol use and abuse – youth (N=26)

The other issues that had at least 20 votes included:

- Alcohol use and abuse – adults (N=25)
- Ability to retain primary care providers in the community (N=25)
- Having enough child daycare services (N=25)
- Child abuse/neglect (N=25)
- Availability of dental care (N=24)
- Not enough healthcare staff in general (N=24)
- Drug use and abuse – youth (N=23)
- Cost of long-term/nursing homing care (N=22)

Figures 17 through 22 illustrate these results.

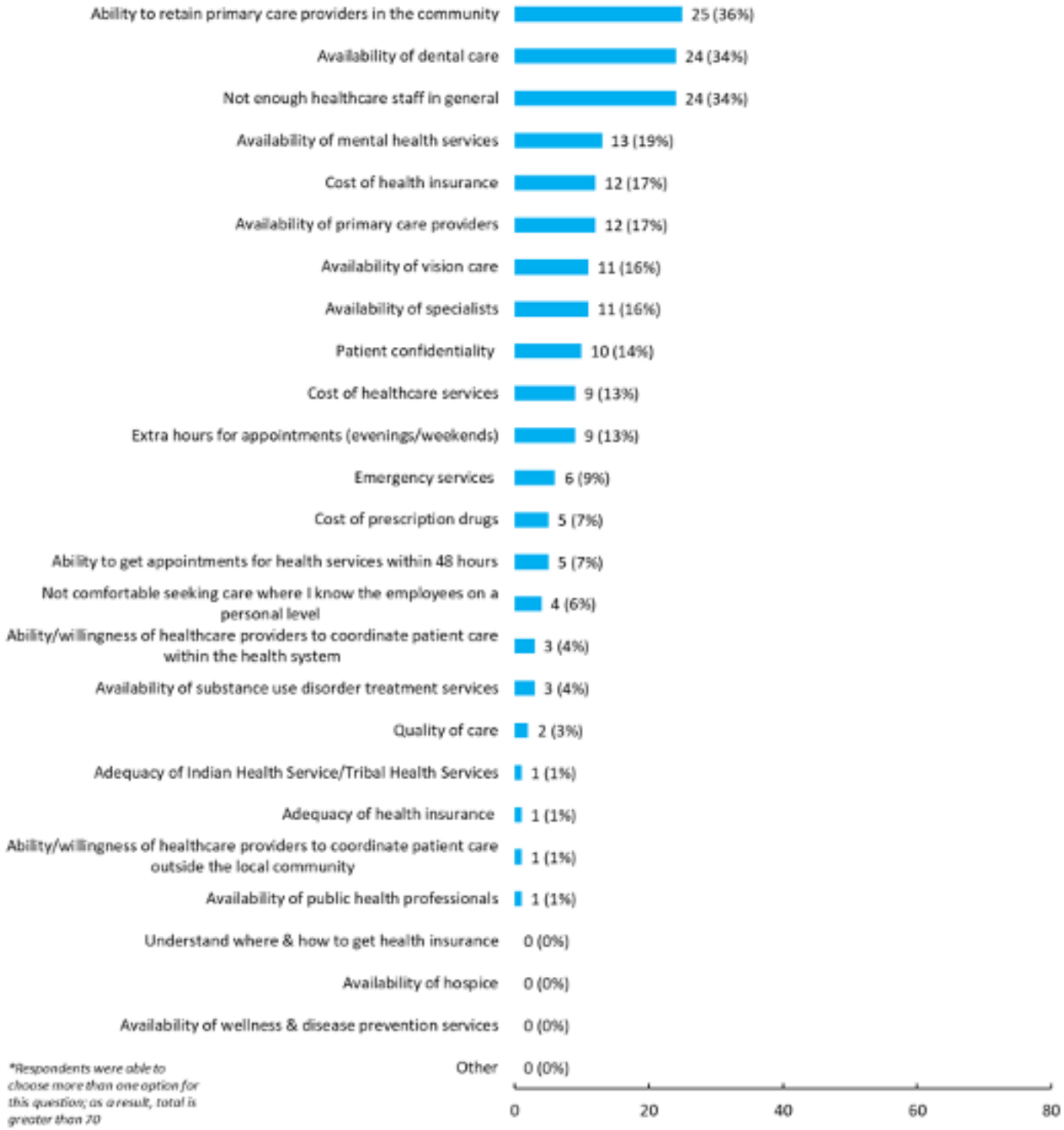
Figure 17: Community/Environmental Health Concerns
Total responses = 70*



**Respondents were able to choose more than one option for this question; as a result,*

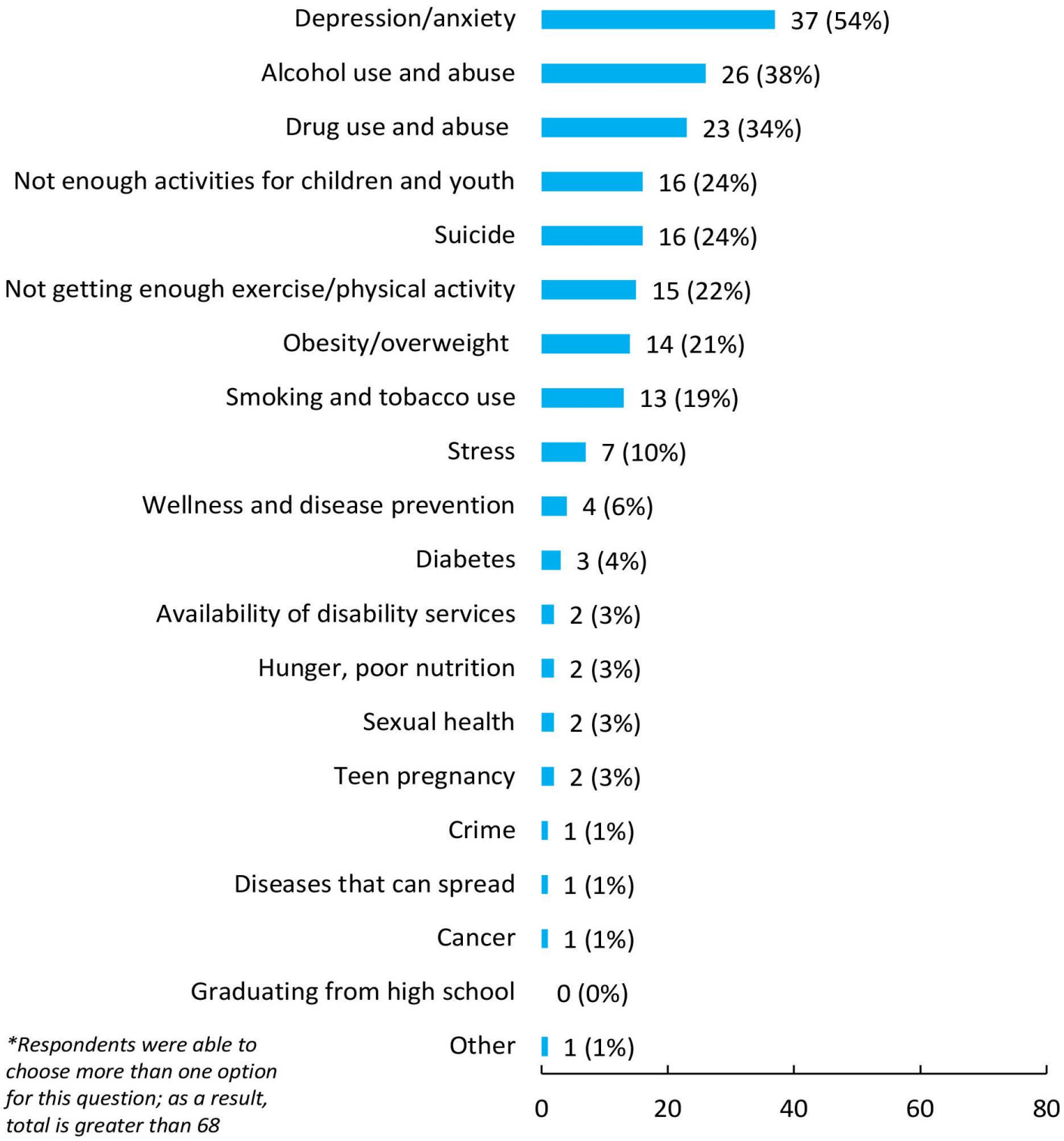
In the "Other" category for community and environmental health concerns, the following were listed: decent daycare center and drugs.

Figure 18: Availability/Delivery of Health Services Concerns
Total responses = 70*



Respondents were able to choose more than one option for this question; as a result, total is greater than 70

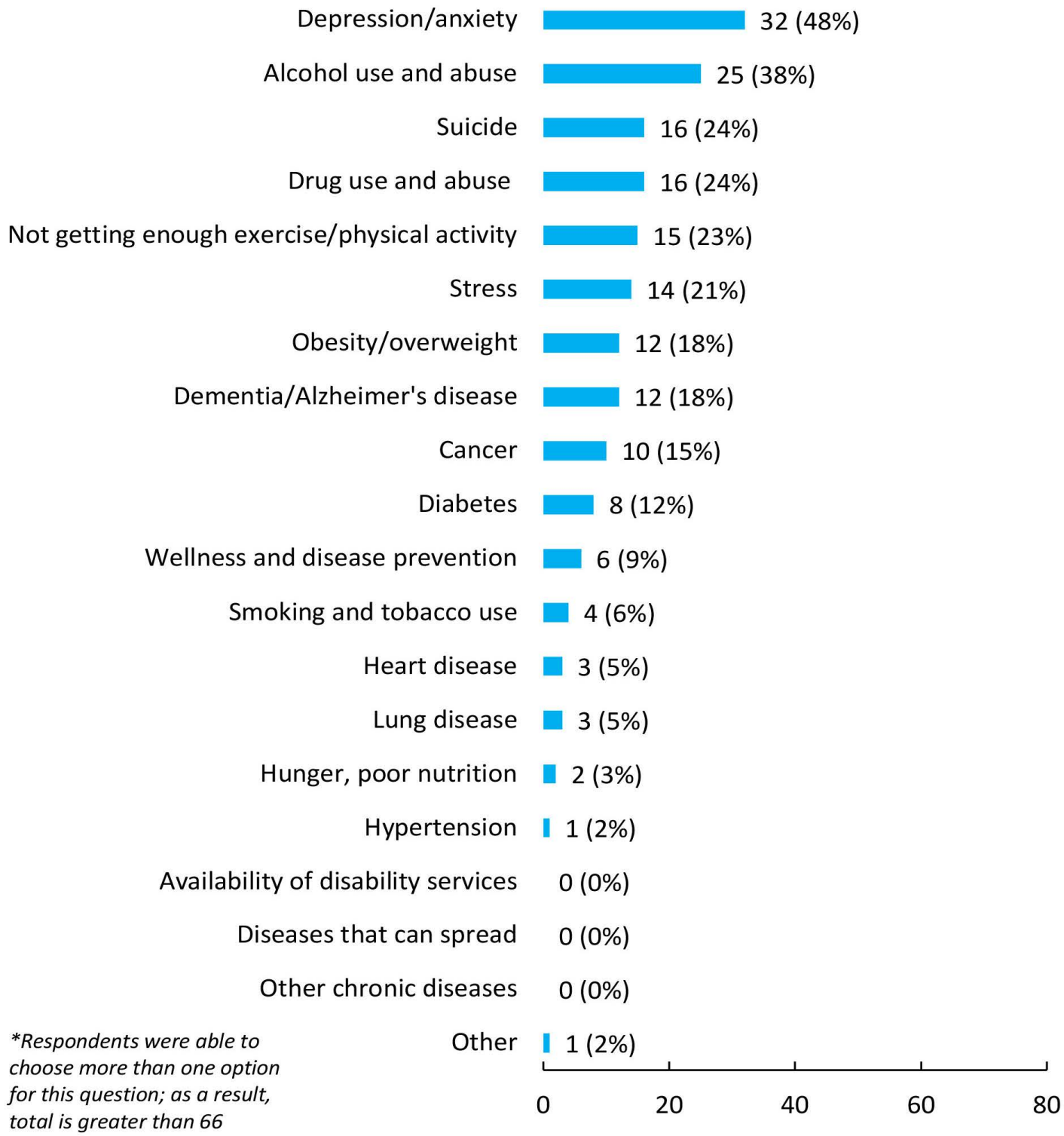
Figure 19: Youth Population Health Concerns
Total responses = 68*



**Respondents were able to choose more than one option for this question; as a result, total is greater than 68*

Listed in the "Other" category for youth population concerns was not enough daycare options.

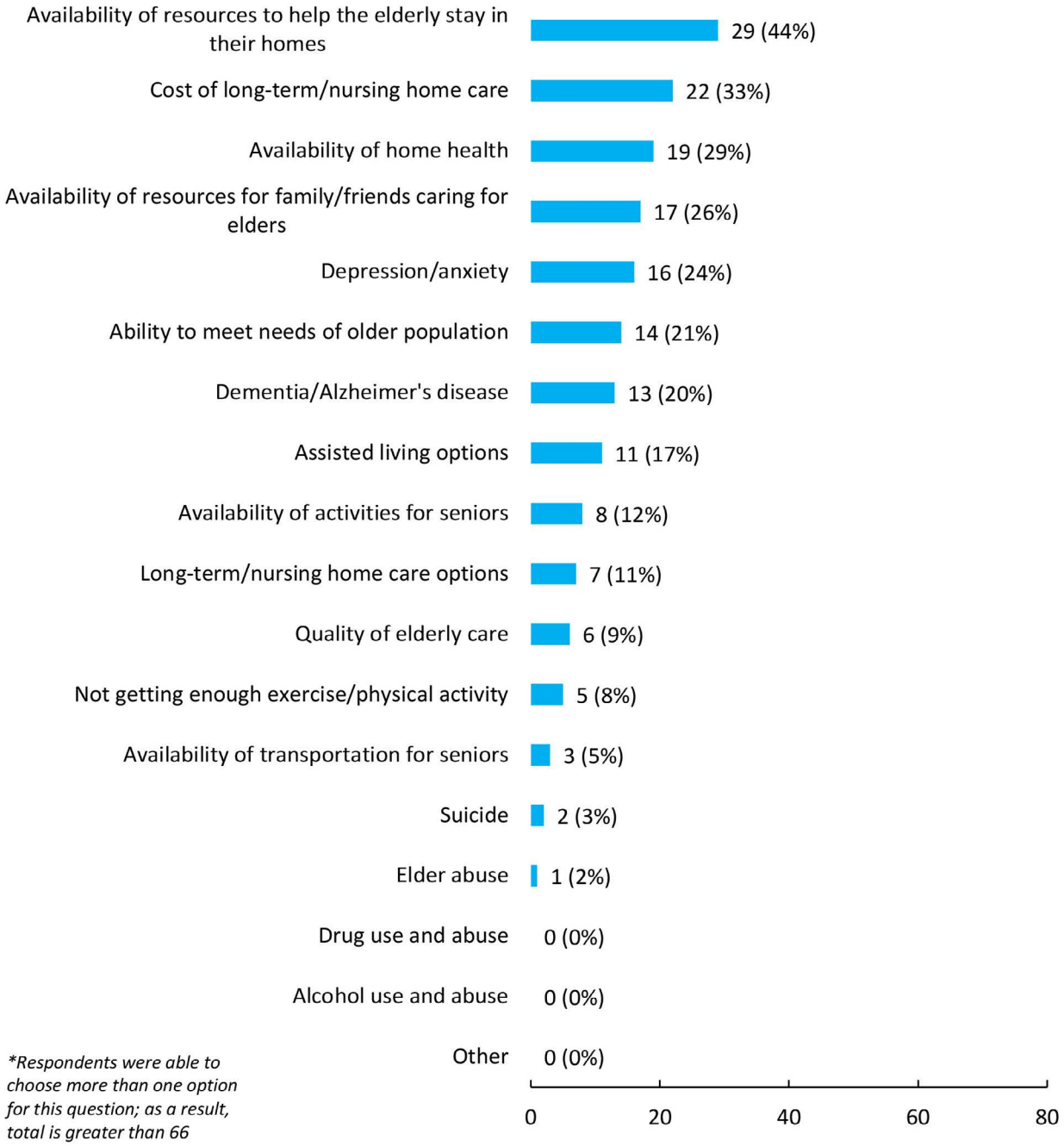
Figure 20: Adult Population Concerns
Total responses = 66*



**Respondents were able to choose more than one option for this question; as a result, total is greater than 66*

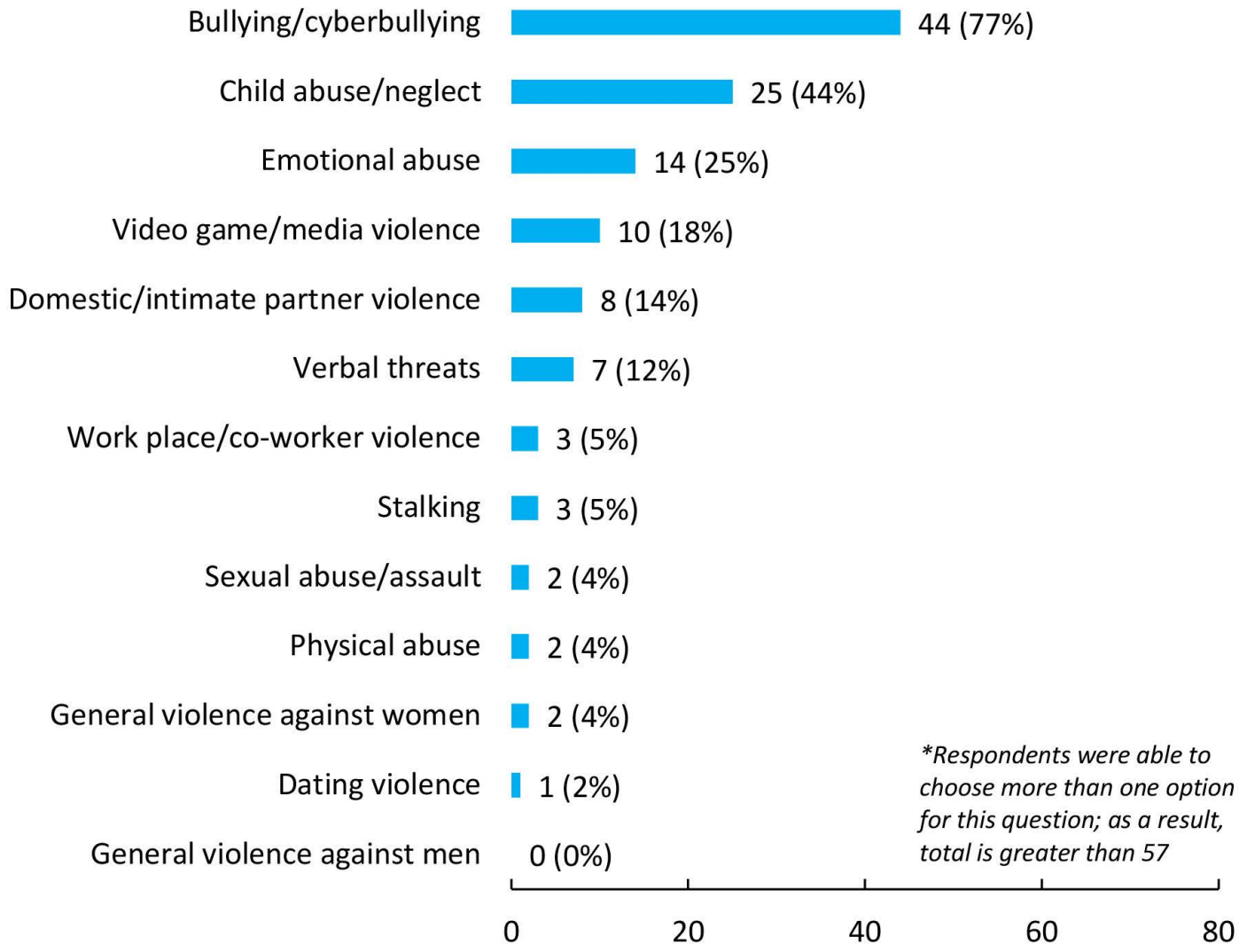
Theft was indicated in the "Other" category for adult population concerns.

Figure 21: Senior Population Concerns
Total responses = 66*



**Respondents were able to choose more than one option for this question; as a result, total is greater than 66*

Figure 22: Violence Concerns
Total responses = 57*



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. Population declining
2. Low wages and lack of jobs

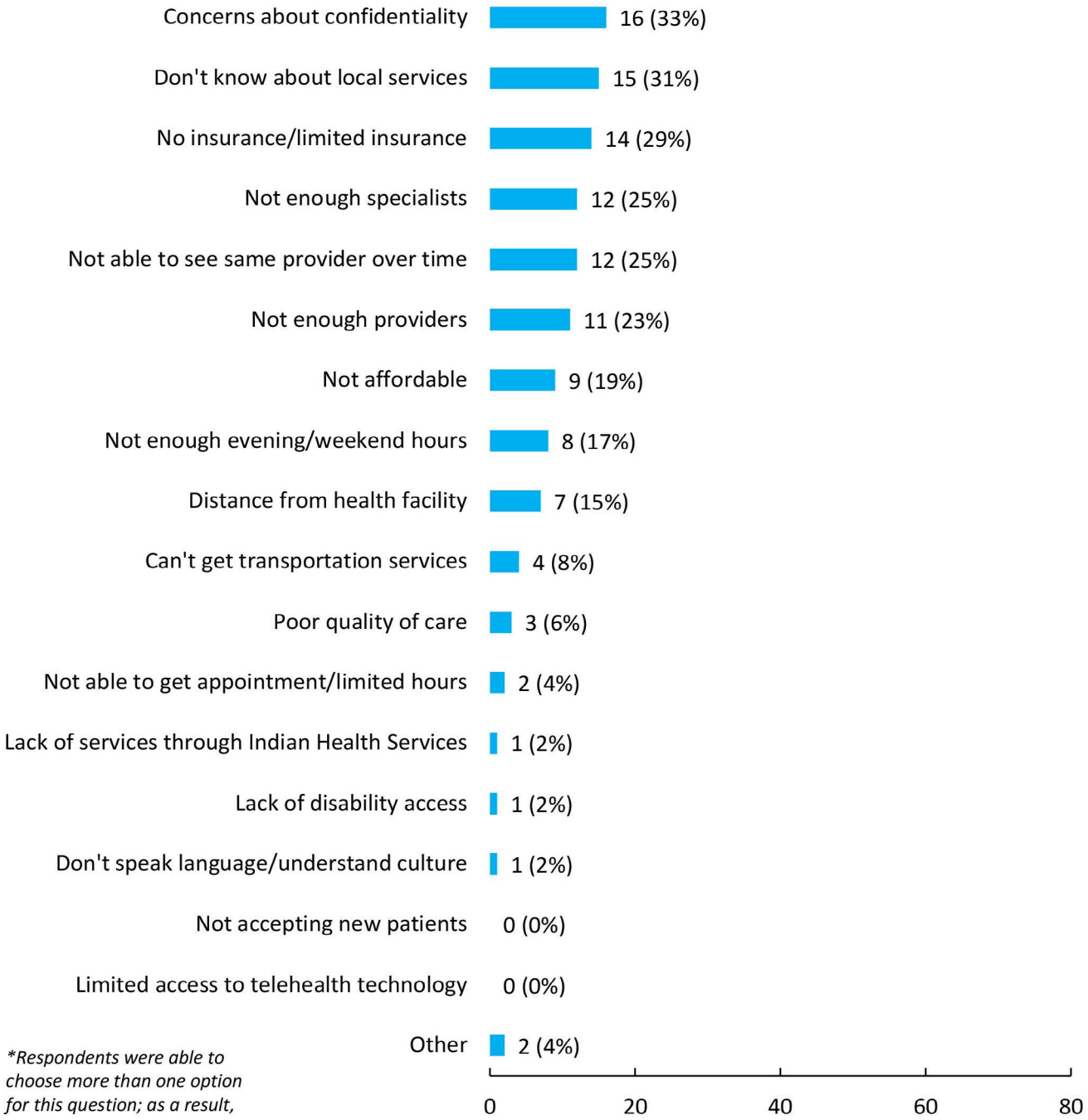
Other biggest challenges that were identified were housing shortages, lack of leadership from city officials, lack of interest in developing and growing the community, affordable daycare options, retaining medical doctors, misinformation regarding vaccinations, and lack of therapy options within the community. One respondent stated parents have to drive over an hour just to bring their child to speech therapy.

Delivery of Healthcare

The survey asked residents what they see as barriers that prevent them or other community residents from receiving healthcare. The most prevalent barrier perceived by residents was concerns about confidentiality (N=16) with the next highest being don't know about local services (N=15). After these items, the next most commonly identified barriers were no insurance or limited insurance (N=14), not enough specialists (N=12), and not able to see the same provider over time (N=12). In the "Other" category was going out of town.

Figure 23 illustrates these results.

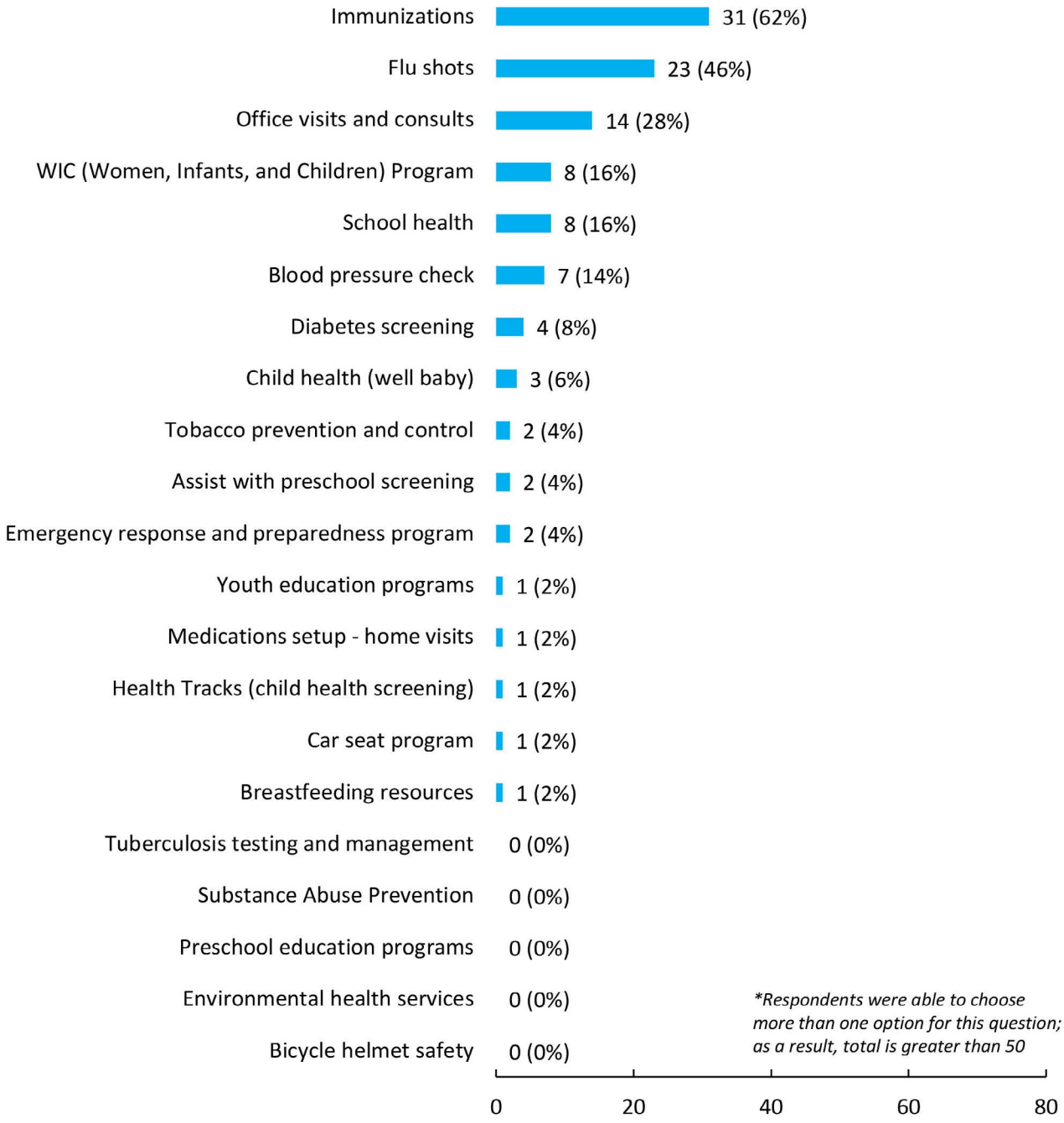
Figure 23: Perceptions About Barriers to Care
Total responses = 48*



**Respondents were able to choose more than one option for this question; as a result, total is greater than 48*

Considering a variety of healthcare services offered by Nelson-Griggs District Health Unit (NGDHU), respondents were asked to indicate what, if any, services they or a family member have used at NGDHU in the past year (See Figure 24).

Figure 24: Awareness and Utilization of Public Health Services
Total responses = 50*



In an open-ended question, respondents were asked what specific healthcare services, if any, they think should be added locally. The number one desired service to add locally was dental services. Other requested services included:

- Chiropractor
- Cardiac rehab
- Car seat program
- Eye/vision care
- Medical doctors (MDs)
- Dialysis
- Transportation for all
- Home health
- MRI
- Mental health services
- Preschool education

The key informant and focus group members felt that the community members were aware of the majority of the health system and public health services. There were a few services, where they felt the hospital should increase marketing efforts, such as sleep studies.

One person indicated that NGDHU should add the car seat checks. They stated police do not have the staff or training to provide this service to the community. Another person stated they would like to see the NGDHU nurse in the Griggs community more, as they currently do not see her there. When asked about CMC services, people stated they would like to see a 24/7 MRI/CT scan service available to the community. This service would keep patients in the community and would not have to be referred out.

Respondents were asked where they go to for trusted health information. Primary care providers (N=55) received the highest response rate, followed by other healthcare professionals (N=39), and then web/Internet searches (N=24).

Results are shown in Figure 25.

Figure 25: Sources of Trusted Health Information
Total responses = 66*

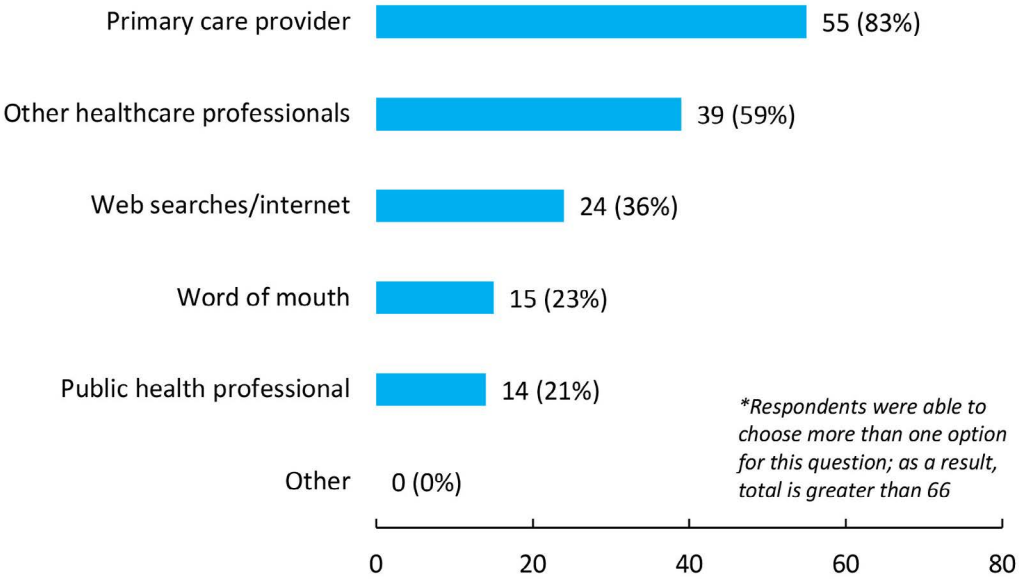
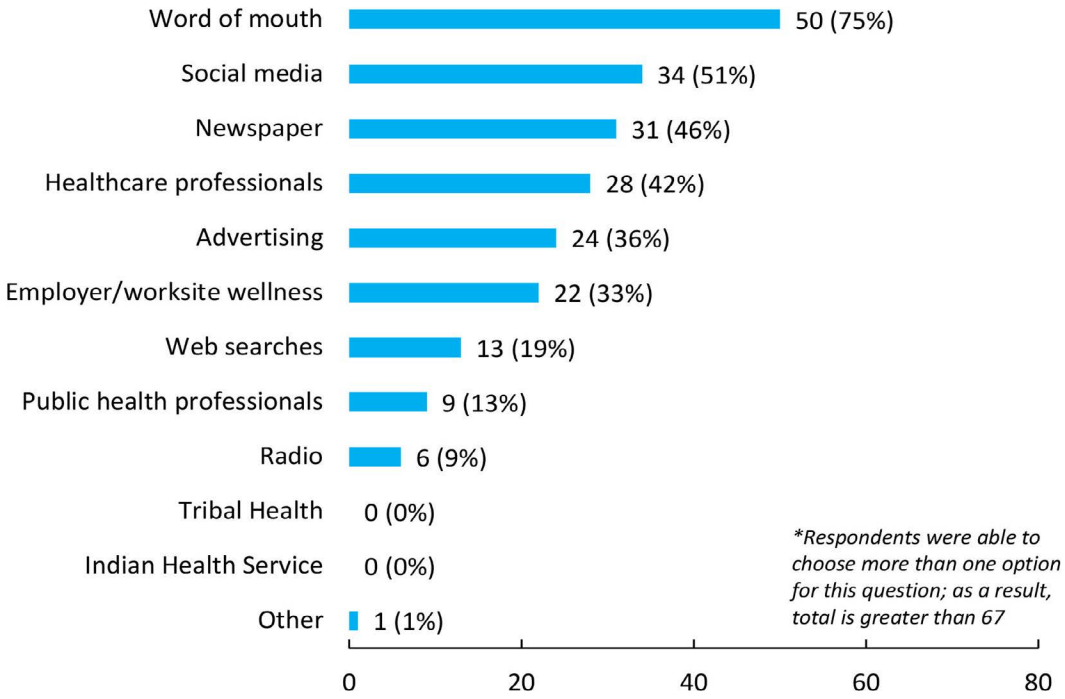


Figure 26: Sources of Information about Local Health Services
Total responses = 67*



In the "Other" category, look up insurance providers was listed as a source of trusted information.

Figure 27: Awareness or Use of General and Acute Services
Total responses = 68*

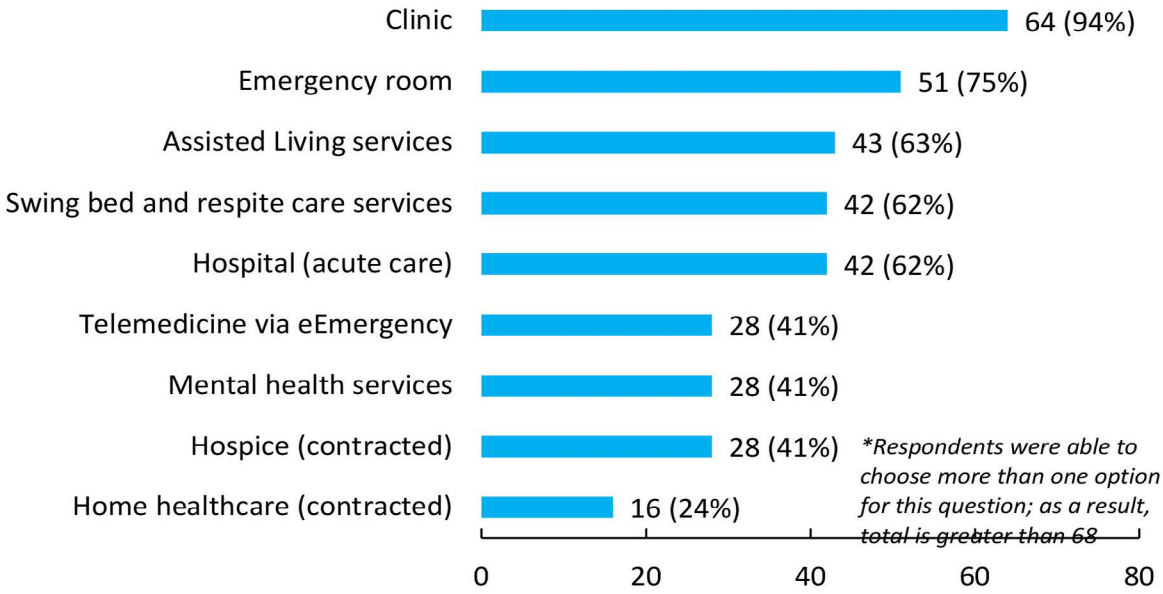


Figure 28: Awareness or Use of Screening and Therapy Services
Total responses = 61*

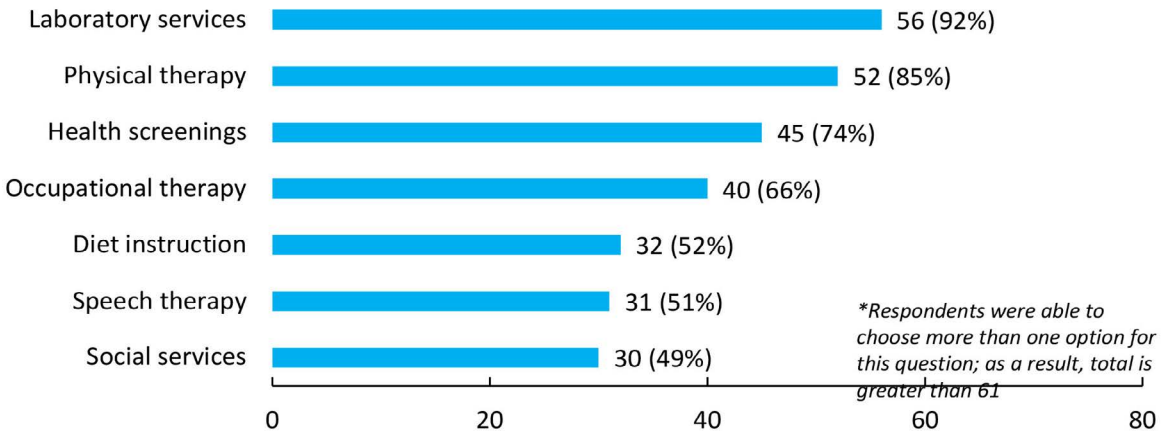


Figure 29: Awareness or Use of Radiology Services
Total responses = 60*

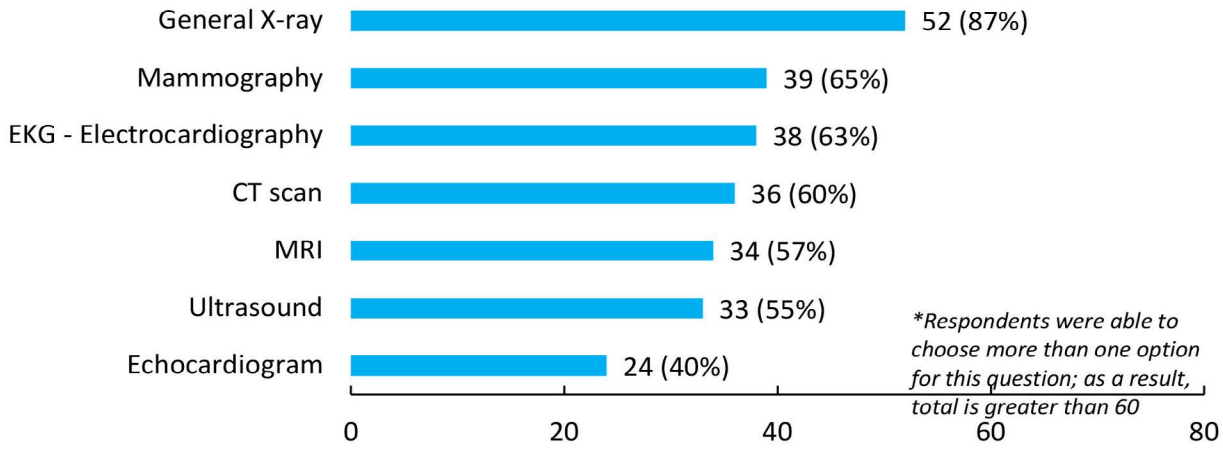
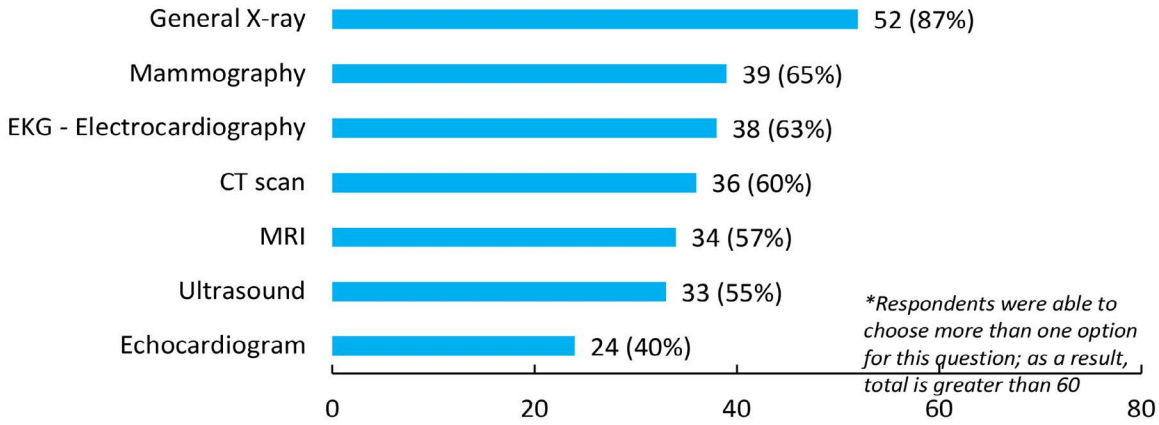
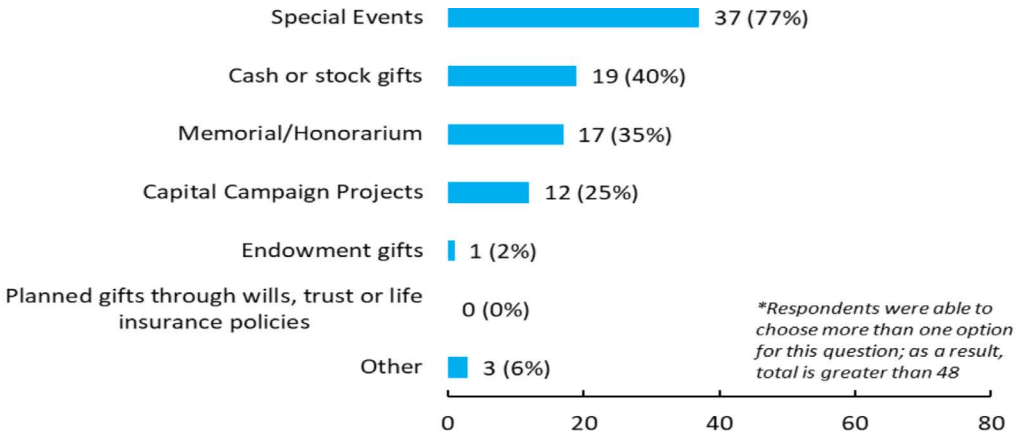


Figure 30: Awareness of Cooperstown Medical Center's Foundation
Total responses = 67



In an effort to gauge ways that community members would be most likely to support the foundation, a question was included, asking them to select ways they are most likely to support the foundation at CMC (see Figure 31). Recommendations in the "Other" category included giving hearts day and pledges.

Figure 31: Forms to Support for the Foundation
Total responses = 48*



The final question on the survey asked respondents to share concerns and suggestions to improve the delivery of local healthcare. The majority of responses focused on concern with the lack of physicians, staffing shortages, and the cost for an office visit. Local providers are healthcare drivers in the community. The community needs to do all they can to retain existing providers and continue to recruit new ones, even when there is no shortage. It will always draw new patients and help the whole community by providing an increased level of care and a business climate in Cooperstown and the surrounding towns.

There is a concern regarding the poverty level in the area. Respondents stated the lack of jobs and insurance make general visits to the clinic difficult. People are having a hard time paying for office visits as well as medication, if needed. Transportation is another burden mentioned by a respondent, especially if they have to travel out of town to see a specialist or specific therapies. Another respondent stated they have not been to the doctor in over two years due to the cost.

A respondent mentioned the hospital, clinic, and ambulance service should be more involved in the community's health as a whole. They would like these entities to do a better job of teaching the community about healthy living. They would like more classes on healthy living to be offered to the community free of charge.

Others believe that CMC does a great job of identifying and delivering healthcare within its means and offers a wide variety of healthcare services.

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, health professionals, and 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 six categories (listed in alphabetical order):

- Alcohol use and abuse – all ages
- Attracting and retaining young families
- Depression/anxiety – all ages
- Having enough child daycare services
- Not enough jobs with livable wages

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

Alcohol use and abuse

- Top concern is addressing alcohol abuse in both adults and youth
- Always been concern in the youth population
- Not enough to do in the community, so people drink and do drugs

Attracting and retaining young families

- The population in the community is declining, and the average age is going up
- This is most important because that is the future of Cooperstown. The community is older; if we are going to continue, us old folks need to be replaced. The future and viability of the community depends on it. Other things listed can be fixed with programs.

Depression/anxiety

- Top concern is addressing depression/anxiety
- Not enough mental health resources locally

Having enough child daycare services

- People are not able to work because they can't find childcare for their children
- Cost of childcare is hard for low-income families, may not be an option to work

Not enough jobs with livable wages

- People are having a hard time staying in the community due to the lack of jobs paying livable wages, housing shortages, and lack daycare services

- Housing for low-income families is still very expensive

Community Engagement and Collaboration

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

- Emergency services, including ambulance and fire (4.25)
- Hospital (healthcare system) (4.25)
- Long-term care, including nursing homes and assisted living (4.0)
- Pharmacy (4.0)
- Law enforcement (3.75)
- Public health (3.75)
- Schools (3.75)
- Business and industry (3.5)
- Faith-based (3.5)
- Human/social services (3.0)
- Economic development organizations (2.75)
- Other local health providers, such as dentists and chiropractors (2.25)
- Tribal Health/Indian Health Service (1.0)

Priority of Health Needs

A community group met on March 28, 2022. Twelve community members attended the meeting. Representatives from the Center for Rural Health (CRH) presented the group with a summary of this report's findings, including background and explanation about the secondary data, highlights from the survey results (including perceived community assets and concerns, and barriers to care), and findings from the key informant interviews.

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

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

- Attracting and retaining young families (6 votes)
- Having enough child daycare services (6 votes)
- Not enough affordable housing (4 votes)

- Availability of mental health services (4 votes)
- Depression and anxiety for all ages (4 votes)

From those top five priorities, each person voted on the one concern they felt was the most important. The rankings were:

1. Attracting and retaining young families (3 votes)
2. Having enough child daycare services (2 votes)
3. Availability of mental health services (2 votes)
4. Depression and anxiety for all ages (2 votes)

Following the prioritization process during the second meeting of the community group and key informants, the number one identified need was attracting and retaining young families. A summary of this prioritization may be found in Appendix E.

Comparison of Needs Identified Previously

Top Needs Identified 2019 CHNA Process	Top Needs Identified 2022 CHNA Process
Availability of mental health services	Attracting and retaining young families
Depression/anxiety – youth	Having enough child daycare services
Having enough child daycare services	Availability of mental health services
Bullying/cyberbullying	Depression/anxiety – all ages

The current process did identify some identical common needs from 2019. Similar to 2019, three needs that were identified in the 2022 assessment are having enough child daycare services, availability of mental health services, and depression and anxiety for all age groups. A new need identified in the 2022 assessment was attracting and retaining young families.

Cooperstown Medical Center (CMC) invited written comments on the most recent 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 CMC Board vote, a notation will be documented in the board minutes, reflecting the approval; 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 CMC.

Hospital and Community Projects and Programs Implemented to Address Needs Identified in 2019

In response to the needs identified in the 2019 community health needs assessment process, the following actions were taken:

Ensure all community members, including the uninsured and working poor have access to mental health services: Since the 2019 Survey, CMC has advertised its current mental health services via Billboards and portable signs. CMC has also added two more days per month of mental health services, provided by Inspired Healthcare providers, Becky Kuss, APRN, CNP, PMHNP and Roxanne Johnson, APRN, CNP, FNP.

Depression and anxiety in the youth: Since the 2019 Survey, CMC providers, Steven Barlow, FNP-C and Larissa Haug, PA-C, held a lyceum at Griggs County Central School on November, 28, 2019, for students on the topics of anxiety, depression, and bullying/cyberbullying.

Bullying/cyberbullying: Since the 2019 Survey, CMC providers, Steven Barlow, FNP-C and Larissa Haug, PA-C, held a lyceum at Griggs County Central School on November, 28, 2019, for students on the topics of anxiety, depression, and bullying/cyberbullying.

The above implementation plan for Cooperstown Medical Center is posted on the CMC's website at https://coopermc.com/about/patient-resources/#community-health.

Next Steps – Strategic Implementation Plan

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

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

Community Benefit Report

While not required, the Center for Rural Health (CRH) strongly encourages a review of the most recent Community Benefit Report to determine how/if it aligns with the needs identified, through the CHNA, as well as the implementation plan.

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

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

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

What Are Community Benefits?

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

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

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

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

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

Appendix A – Critical Access Hospital Profile

Critical Access Hospital Profile

Spotlight on: Cooperstown, North Dakota

Cooperstown Medical Center

Administrator/CEO:
Nikki Johnson

Chief of Medical Staff:
Jon Berg, MD

Board Chair:
Jayne Ott

City Population:
1,047 (2014 Estimate)[1]

County Population:
2,370 (2013 Estimate)[1]

County Median Household Income:
$45,542 (2013 Estimate)[1]

County Median Age:
54.3 (2013 Estimate)[1]

Service Area Population:
2,620 (30 mile radius)

Owned by: Nonprofit

Hospital Beds: 18

Critical Access Hospital Designation: 2000

Employment:
Primary – 54
Secondary – 27
Total – 81

Financial:
Primary – $2 million
Secondary – $1 million
Total – $3 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

The Cooperstown Medical Center (CMC) is dedicated to providing high quality health care services in a personalized, compassionate, and professional manner.

County: Griggs
Address: 1200 Roberts Avenue, NE
Cooperstown, ND 58425
Phone: (701) 797-2221
Fax: (701) 797-2421
Web: www.coopermc.com

Our **18-bed Critical Access Hospital** is privately located on the second floor of our facility. Twenty-four hour emergency medical services are available. Helping to relieve the added stress of extended travel, CMC is happy to provide many of the services found in large hospitals right here locally. Through strong affiliations with major medical organizations we are proud to provide the services below.

Cooperstown Medical Center's Rural Health Clinic has one part-time Physician and 3 full-time FNP-C's. Our Family Practitioners specialize in all major medical areas ranging from pediatrics to gerontology; including gynecology, prenatal and baby care.

Cooperstown Medical Center includes 'Park Place', a 12 unit assisted living complex. Each apartment is a spacious, two bedroom unit. CMC services are accessible to Park Place residents through a rear entrance and enclosed walk-way. Also attached to CMC property is Griggs County Care Center. Nursing home care is available for: long-term care stays, convalescent care and short-term stays. Residents are allowed to retain their independence and dignity with assistance to succeed in daily tasks.

Services

Cooperstown Medical Center provides the following services directly:

- Hospital Services: Outpatient/ Observation, Acute Care, 24-hour Emergency Care, X-Ray/ Laboratory, Cardiac Monitoring/ Telemetry, Electrocardiography, Physical Therapy, Speech Therapy/ Occupational Therapy, Cardiac Rehabilitation, Swing Bed
- Other Available Services: Respite Care, Lifeline, Meals on Wheels, Hospice Care, Medical Library, Community Education
- Clinic Services: General Medical Services, Pulmonary Function Testing, Holter Monitor, Stress Testing, Flexible Sigmoidoscopy, Endometrial Biopsy Procedure, Minor Surgery Procedures, Muscle stimulation/Ultrasound, Immunizations, Injections, Nutrition Counseling
- Visiting Consultants: Urology, Podiatry, Psychology

Staffing

Physicians: 1
Nurse Practitioners: 3
RNs: 12
LPNs: 4
Total Employees: 54

Local Sponsors and Grant Funding Sources

- American Heart Association
- ATOD Mini-grant
- Cardinal Health Foundation Challenge Grant
- Center for Rural Health
  - SHIP Grant (Small Hospital Improvement Program)
  - Flex Grant (Medicare Rural Hospital Flexibility Grant Program)
- Dakota Medical Foundation
- Griggs Steele Empowerment Zone
- Nodak Electric Cooperative
- North Dakota Department of Emergency Services Homeland Security SHSP
- North Dakota Department of Human Services
- Workforce Safety & Insurance
- USAC/Rural Health Care Div.

Sources

[1] US Census Bureau; American Factfinder; Community Facts

Center *for* Rural Health

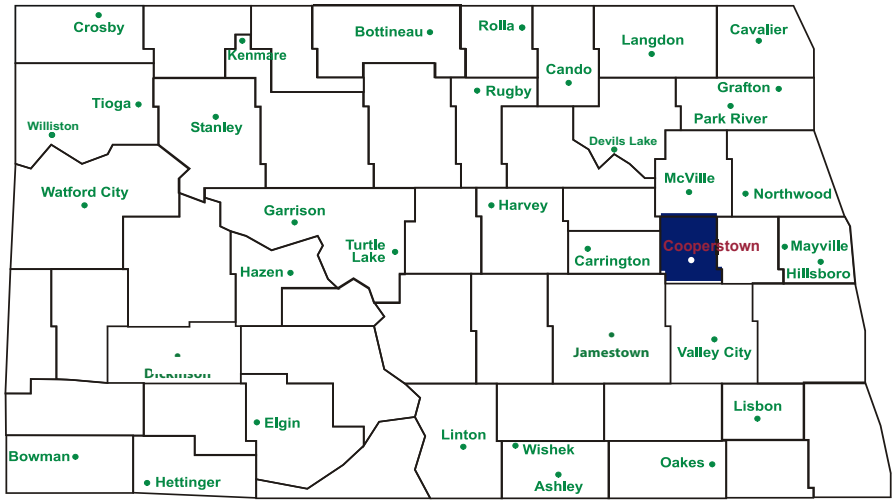
This project is supported by the Medicare Rural Hospital Flexibility Grant Program at the Center for Rural Health, University of North Dakota School of Medicine & Health Sciences located in Grand Forks, North Dakota.

ruralhealth.und.edu

Cooperstown Medical Center provides the following services through contract or agreement:

- WIC Program
- Dr. Arlo Neumiller, Dentist
- Family Vision Center
- The Hearing Aid Company
- Mobile Diagnostic Services: CT Scan, Ultrasound, Echocardiogram, Mammography, Bone Densitometry
- Griggs County Nursing Home Care Center

North Dakota Critical Access Hospitals



History

For the past 126 years health care has been a crucial component to the vitality of Griggs County and its people. We have come a long way from Dr. T. F. Kerr, the first doctor in Griggs County in 1881, to the first hospital opening in 1903, to the building of the current hospital building in 1951, through remodeling and additions in the 80's and 90's and finally to relocating the hospital in 2006.

The one constant that has remained throughout the years is the collaboration between the facility and the people it serves. It was the community members who first had a vision for health care in Griggs County. In a public meeting held March 22, 1947 Dr. Rose, the dentist, commented, "I'm interested in not a Cooperstown Hospital but a Griggs County Hospital. We should have had it 20 years ago. We won't get much use from it, but the next generation will and I hope I live to see a hospital here." Little did Dr. Rose know that only five short years later he would suffer a disabling stroke and spend the last seven years of his life as a permanent patient of the hospital. It was only through the generous support of the community nearly 60 years ago that the hospital came to be.

Today, the same is true: change is inevitable, but it is the community who sustains Cooperstown Medical Center. Initially health care was simple, however, due to the amazing strides in medical knowledge, technology, and insurance things have changed. Gone are the days of running a health facility like any other business, a service is completed and payment is made. We still strive to provide affordable high quality health care to the community regardless of their ability to pay or the rate of reimbursement by insurance, but the costs to provide these services continue to rise.

Recreation

Cooperstown is located in east central North Dakota, within 100 miles of North Dakota's two largest cities, Fargo and Grand Forks. Both communities have excellent medical facilities and state universities. The University of North Dakota at Grand Forks is the site of the state's medical school. Cooperstown's education system provides basic curriculum and several enrichment programs for its students. The Sheyenne River Valley offers a beautiful recreation area for water sports, camping and hiking. Nearby lakes provide good fishing and boating opportunities. A tree-lined challenging 9-hole grass green golf course is located on the northwest edge of town. The Ronald Reagan Minuteman Missile State Historic Site is located just north of Cooperstown.

Updated 12/2015

Appendix B – Economic Impact Analysis

December 2020

Cooperstown Medical Center

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

Cooperstown Medical Center

Economic Impact

Cooperstown Medical Center is composed of a Critical Access Hospital (CAH) in Cooperstown, assisted living facility, and a nursing home.

Cooperstown Medical Center **directly** employs **93.97 FTE** employees with an annual payroll of over **$7.76 million** (including benefits).

- After application of the employment multiplier of 1.30, these employees created an additional **28** jobs.
- The same methodology is applied to derive the income impact. The income multiplier of 1.16 is applied to create over **$1.26 million** in income as they interact with other sectors of the local economy.
- **Total impacts = 122 jobs and more than $9 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:
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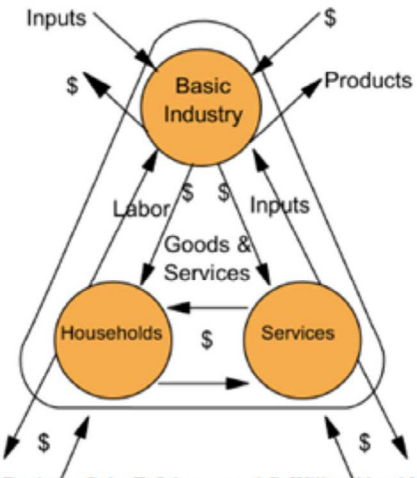
Figure 1. An overview of the community economic system.



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

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Appendix C – CHNA Survey Instrument

Griggs County Health Survey

Cooperstown Medical Center and Nelson-Griggs District Health Unit are interested in hearing from you about community health concerns.

The focus of this effort is to:

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

If you prefer, you may take the survey online at http://tinyurl.com/Cooperstown2021 or by scanning on the QR Code at the right.

Surveys will be tabulated by the Center for Rural Health at the University of North Dakota School of Medicine and Health Sciences. Your responses are anonymous, and you may skip any question you do not want to answer. Your answers will be combined with other responses and reported only in total. If you have questions about the survey, you may contact Kylie Nissen at 701.777.5380.

Surveys will be accepted through January 21, 2022. Your opinion matters – thank you in advance!

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

9. Considering the **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
- ☐ 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)
- ☐ Availability of activities for seniors
- ☐ Elder abuse
- ☐ Other (please specify): _____

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

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

Delivery of Healthcare

12. Considering **GENERAL and ACUTE SERVICES** at Cooperstown Medical Center, which services are you aware of (or have you used in the past year)? (Choose ALL that apply)

- ☐ Clinic
- ☐ Emergency room
- ☐ Home health care, contracted
- ☐ Hospice, contracted
- ☐ Hospital (acute care)
- ☐ Mental Health services
- ☐ Assisted Living services
- ☐ Swing bed and respite care services
- ☐ Telemedicine via eEmergency

13. Considering **SCREENING/THERAPY SERVICES** at Cooperstown Medical Center, which services are you aware of (or have you used in the past year? (Choose ALL that apply)

- ☐ Diet instruction
- ☐ Health screenings
- ☐ Laboratory services
- ☐ Occupational therapy
- ☐ Physical therapy
- ☐ Social services
- ☐ Speech therapy

14. Considering **RADIOLOGY SERVICES** at Cooperstown Medical Center, which services are you aware of (or have you used in the past year)? (Choose ALL that apply)

- ☐ EKG—Electrocardiography
- ☐ CT scan
- ☐ Echocardiogram
- ☐ General x-ray
- ☐ Mammography
- ☐ MRI
- ☐ Ultrasound

15. Which of the following **SERVICES** provided by your local **PUBLIC HEALTH** unit have you or a family member used in the past year? (Choose ALL that apply)

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

16. Considering services offered locally by **OTHER PROVIDERS/ORGANIZATIONS** in your community, which services are you aware of (or have you used in the past year)? (Choose ALL that apply)

- ☐ Ambulance
- ☐ Chiropractic services
- ☐ Massage therapy
- ☐ Meals on Wheels

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

_____

_____

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

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

19. 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
- ☐ Not able to get appointment/limited hours
- ☐ Not able to see same provider over time
- ☐ Not accepting new patients
- ☐ Not affordable
- ☐ Not enough providers (MD, DO, NP, PA)
- ☐ Not enough evening or weekend hours
- ☐ Not enough specialists
- ☐ Poor quality of care
- ☐ Other (please specify): _____

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

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

21. Are you aware of Cooperstown Medical Center Foundation, which exists to financially support the Coopestown Medical Center?

☐ Yes ☐ No

22. Have you supported the Cooperstown Medical Center Foundation in any of the following ways? (Choose ALL that apply)

- ☐ Cash or stock gift
- ☐ Endowment gifts
- ☐ Memorial/Honorarium
- ☐ Planned gifts through wills, trusts or life insurance policies
- ☐ Capital Campaign Projects
- ☐ Special Events, i.e., Tree of Lights, Golf T., Boots 'N Bling
- ☐ Other (please specify): _____

Demographic Information: Please tell us about yourself.

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

☐ Yes ☐ No

24. How did you acquire the survey (or survey link) that you are completing?

☐ Hospital or public health website
☐ Hospital or public health social media page
☐ Hospital or public health employee
☐ Hospital or public health facility
☐ Economic development website or social media
☐ Other website or social media page (please specify): _____
☐ Newspaper advertisement
☐ Newsletter (if so, what one):_____
☐ Church bulletin
☐ Flyer sent home from school
☐ Flyer at local business
☐ Flyer in the mail
☐ Word of Mouth
☐ Direct email (if so, from what organization):_____
☐ Other (please specify): _____

25. 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
☐ Medicare
☐ No insurance
☐ Veteran's Healthcare Benefits
☐ Other (please specify): _____

26. Age:

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

27. 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

28. Sex:

☐ Female
☐ Male
☐ Non-binary
☐ Other (please specify): _____

29. Employment status:

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

30. Your zip code: _____

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

☐ American Indian
☐ African American
☐ Asian
☐ Hispanic/Latino
☐ Pacific Islander
☐ White/Caucasian
☐ Other: _____

32. 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

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

_____

_____

Thank you for assisting us with this important survey!

Appendix D – County Health Rankings Explained

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

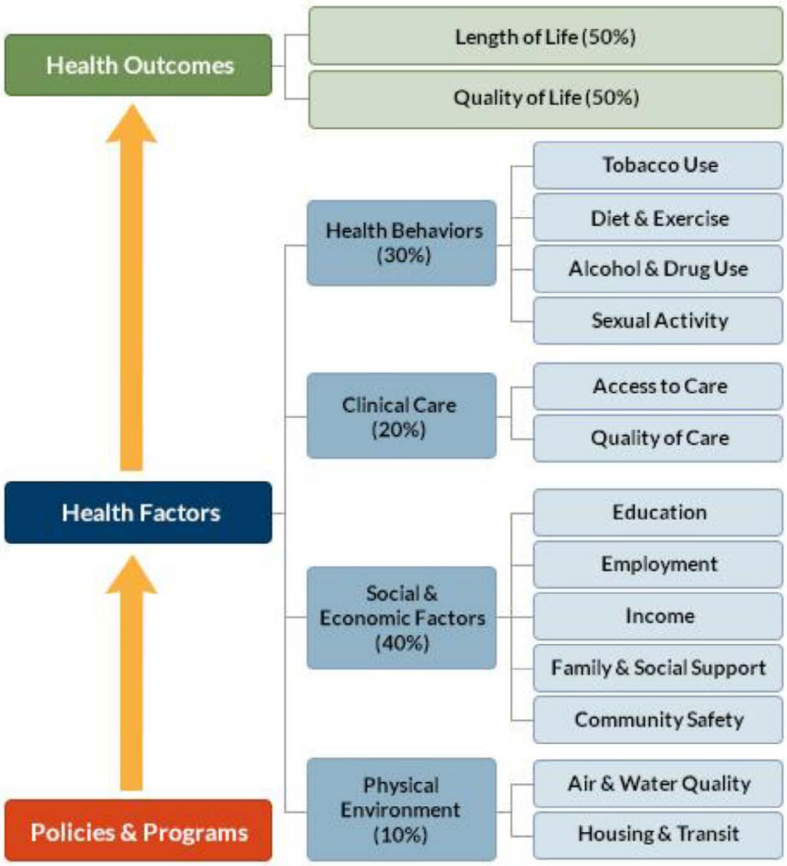
Methods

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 E – Youth Risk Behavior Survey

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
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

	ND 2013	ND 2017	ND 2019	ND Trend ↑, ↓, =	Rural ND Town Average	Urban ND Town Average	National Average 2019
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 F – Prioritization of Community's Health Needs

Community Health Needs Assessment
Cooperstown, North Dakota
Ranking of Concerns

The top concerns for each of the six topic areas, based on the community survey results, were presented at the second community meeting. The numbers below indicate the total number of votes by the people in attendance. The "Priorities" column lists the number of votes for the concerns indicating which areas are felt to be priorities. Each person was given four votes for the items they felt were priorities. The "Most Important" column lists the number of votes for the most important concern. After the first round of voting, the top five priorities were selected based on the highest number of votes. Each person was given one vote for the item they felt was the most important priority of the top five highest ranked priorities.

	Priorities	Most Important
COMMUNITY/ENVIRONMENTAL HEALTH CONCERNS		
Attracting & retaining young families	6	3
Having enough child daycare services	6	2
Not enough affordable housing	4	0
Not enough jobs with livable wages	2	
AVAILABILITY/DELIVERY OF HEALTH SERVICES CONCERNS		
Availability of mental health services	4	2
Availability of dental care	1	
Not enough healthcare staff in general	2	
Availability of vision care	0	
Ability to retain primary care providers (MD, DO, NP, PA, nurses)	1	
YOUTH POPULATION HEALTH CONCERNS		
Smoking and tobacco use, exposure to second-hand smoke, juuling/vaping	1	
Not enough activities for children	2	
ADULT POPULATION HEALTH CONCERNS		
Alcohol use and abuse- All Ages	1	
Drug use and abuse (including prescription drugs)- All Ages	0	
Depression/Anxiety – All Ages	4	2
Suicide – All Ages	0	
SENIOR POPULATION HEALTH CONCERNS		
Cost of long-term/nursing home care	0	
Long-term/nursing home care options	0	
Availability of resources to help elderly stay in their homes	1	
Ability to meet needs of older population	2	
Availability of activities for seniors	0	
Availability of home health	0	
VIOLENCE CONCERNS		
Bullying/cyber-bullying	2	
Child abuse/neglect	1	
Video game/media violence	0	
Emotional abuse (isolation, verbal threats, withholding of funds)	0	

Appendix G – Survey "Other" Responses

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

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

1. Considering the PEOPLE in your community, the best things are: "Other" responses:
    - People are becoming more accepting of new families in the area
2. Considering the SERVICES AND RESOURCES in your community, the best things are: "Other" responses:
    - Awesome grocery store
    - Great medical center
    - Grocery store
4. Considering the ACTIVITIES in your community, the best things are: "Other" responses:
    - Not much for activities
    - Nothing, this community needs development

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: "Other" responses:
    - Decent daycare center
    - Drugs
8. Considering the YOUTH POPULATION in your community, concerns are: "Other" responses:
    - Not enough daycare options
9. Considering the ADULT POPULATION in your community, concerns are: "Other" responses:
    - Theft
11. What single issue do you feel is the biggest challenge facing your community?
    - Lack of financial education, poor financial choices
    - Mental health
    - Social media addiction
9. Considering the SENIOR POPULATION in your community, concerns are: "Other" responses:
    - Accessibility
11. What single issue do you feel is the biggest challenge facing your community?
    - activities for children/teens
    - aging population lack of quality jobs for college grads.
    - Being paid a living wage
    - Community involvement
    - Correct information regarding vaccines, as well as the community's willingness to learn correct

information about vaccines (mostly COVID related ones). Increasing COVID positives in the community as well.

- decline of population
- Declining population due to wages being paid in this community. Followed up with housing availability
- Drugs
- Drugs
- Finding and retaining qualified worker in different departments of the Hospital
- Good paying jobs
- Housing
- I feel child abuse and child neglect are the biggest issues.
- Isolation of elderly population during cold winter months
- It's a horrible place to live. No one would leave here unless they had to. We don't use the doctors here they aren't even real doctors
- Lack of jobs.
- Lack of attention by City officials in developing a community that will attract young/new families or retain the ones we have. They are too satisfied with the status quo and don't seem to want to make things better! When people try to improve the area, they push back and tend to not support development.
- Lack of leadership from city officials. Lack of interest in developing and growing the community, which will bring more families to the area.
- Not enough activities in general for adults or older kids. Community club often has activities for younger kids, but teenagers are left to their own devices. No feeling of inclusivity. Community is "cliquey" Difficult to make friends if you aren't into the bar scene.
- Not sure
- People not wanting to make the community a better place
- Population
- population decline
- Raising children with 2 parents working and low wages, trying to pay health insurance and medical experts
- the ability to get healthcare providers to stay in the community long term and child care options
- The breakdown of strong family structures
- The lack of childcare available in our community. The waiting list is long for the daycare facilities that we do have so many parents must find alternate daycare far from our community.
- The severe lack of rehab and therapy. As in therapists for speech therapy in toddlers and kids. The amount of parents having to drive an hour plus just for speech therapy is ridiculous. If Northwood can have different kinds of rehab and occupational therapy there's absolutely no reason Cooperstown cannot. Come on CMC, get it together!!
- Wages vs increase cost of living don't match. Employees pay newbies and the dedicated staff get left in the dust.

Delivery of Healthcare

13. Where do you find out about LOCAL HEALTH SERVICES available in your area? "Other" responses:

    - Look up my insurance providers

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

    - A decent chiropractor! Again, many having to drive 45+ miles for a decent chiropractor
    - Car seat program!!!!!
    - Car seat Program!
    - cardiac rehab

- chiropractic
- Chiropractor on a regular basis
- Chiropractic, vision, dental.
- Dental
- dental
- Dental
- Dental and Vision
- Dental and vision
- Dental, optical, chiropractic
- Dentist, vision, chiropractor
- Dialysis
- Eye and dental care
- Home Health
- More access to mental health services.
- More mental health services.
- MRI
- preschool education
- Real doctors
- transportation for all
- vision and dental

16. What PREVENTS community residents from receiving healthcare? "Other" responses:

- Going out of town
- Nothing has prevented me

17. Have you supported the Cooperstown Medical Center Foundation in any of the following ways? "Other" responses:

- Giving hearts day
- Pledge

18. How did you acquire the survey (or survey link) that you are completing? "Other" responses:

- Cooperstown Medical Center (3)
- dwvigesaa@mlgc.com
- Email to employees
- Facebook (6)
- IT Coordinator
- Kelley
- n/a

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

- Care center facility is having structural issue.
- "encourage Fargo/Grand Forks hospitals to refer patients to local facilities after discharge esp. hip/knee surgery, long-term care, not facility in their big city.
- encourage medical students to practice family medicine in small rural hospital/clinics. "
- Healthcare worker shortages from housing to lab to nurses to MD. All areas need more staff.
- I am so thankful for all the services offered in our community. Would like to NOT have to go out of town as much as possible.
- I think the ambulance service and the hospital/clinic could do a better job of trying to get community involved in healthy living. Should pursue cardiac ready community status. Should offer more classes for free to community.

- Listen to what's needed in this community
- N/A
- Nobody should invest in this shithole
- Poverty level individuals living in rural communities have a difficult time with insurance, transportation, and affording medical visits. Assistance, like case managers, would help to arrange these programs and encourage these programs to strengthen that gap
- Too expensive. $270.00 for an office visit for sinus infection and prescription, both of which I already know what I have and what I need. I have to be really desperate to go in at that price. And it's been two years since I've been to the clinic for ANY reason because of the expense, so it's probably WAY more than that by now.