Community Health Needs Assessment

2019

Cooperstown Service Area, North Dakota

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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 2018, the previous CHNA having been conducted in 2016. The Center for Rural Health (CRH) at the University of North Dakota School of Medicine & Health Sciences (UNDSMHS) facilitated the assessment process, which solicited input from area community members and healthcare professionals as well as analysis of community health-related data.

To gather feedback from the community, residents of the area were given the opportunity to participate in a survey. There were 80 CMC service area residents who completed the survey. Additional information was collected through seven 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 2010 to 2017 decreased 6.7%. The average of residents under age 18 (19.1%) for Griggs County is slightly lower than the North Dakota average (23.3%). The percentage of residents ages 65 and older is 14.7% higher for Griggs County (29.7%) than the North Dakota average (15.0%), and the rates of education are slightly lower for Griggs County (87.6%) than the North Dakota average (92.0%). The median household income in Griggs County ($50,272) is lower than the state average for North Dakota ($55,322).

Data compiled by County Health Rankings show Griggs County is doing better than North Dakota for health outcomes/factors in 15 categories.

Griggs County, according to County Health Rankings data, is performing poorly relative to the rest of the state in 11 outcome/factor categories.

Of the 82 potential community and health needs set forth in the survey, the 80 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
- Dementia/Alzheimer's Disease
- Drug use and abuse – Youth and Adult
- Jobs with livable wages
- Availability of resources to help the elderly stay in their homes
- Bullying/cyber-bullying
- Cancer – Adult
- Quality of elder care
- Youth depression/anxiety

The survey also revealed the biggest barriers to receiving healthcare (as perceived by community members). They included not being able to see same provider over time (N=45), not enough specialists (N=19), and not enough providers (MD, DO, NP, PA) (N=17).

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

- Active faith community
- Family-friendly
- Feeling connected to people who live here
- Local events and festivals
- People are friendly, helpful, and supportive
- Safe place to live, little/no crime

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:

- Ability to retain primary care providers (MD, DO, NP, PA) and nurses in the community
- Alcohol use and abuse
- Attracting and retaining young families
- Availability of primary care providers (MD, DO, NP, PA) and nurses
- Availability of resources to help the elderly stay in their homes

Overview and Community Resources

With assistance from the CRH at the UNDSMHS, the CMC completed a CHNA of their service area. The hospital identifies its service area as a 30-mile radius of Cooperstown. Communities within this radius include Binford, Cooperstown, Hannaford, Sutton, and Jessie. Many community members and stakeholders worked together on the assessment.

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.

Additional healthcare services provided in the community are; county social services, a pharmacy, county-wide EMT/first responder volunteer ambulance services; a 2-day per week clinic in Binford; massage therapy and a chiropractor. WIC 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 the CMC.

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

The community is dedicated to maintaining the charm and values of a rural American town while being progressive with technology and savvy business expansions. Agricultural related businesses abound in our 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, replacing the still-standing 100 year-old historical

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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 a Dollar General and Vintage Pink Boutique and in 2018, the Vintage Post salon and specialty store opened in Hannaford.
- A development plan to replace the existing Cooperstown Medical Center critical access hospital, clinic, and Griggs County Care Center skilled nursing care facility in a new location has been initiated.
- 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 on-line technology.

The community has a number of physical assets and features including 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.

Hospice Agencies:

- Altru Hospice
- Hospice of the Red River Valley

Nursing Homes:

- Griggs County Care Center

Public Health Services:

- Nelson-Griggs District Health Unit

County Social Service Agencies/Medicaid Providers:

- Cooperstown Medical Center
- Griggs County Care Services
- Griggs County Social Services
- Nelson Griggs District Health Unit

Food Assistance:

- Cooperstown Bread of Life Food Pantry
- South Central Adult Regional Services – providing meals to the elderly
- WIC

Help with Rides to Medical Appointments:

- South Central Adult Regional Services

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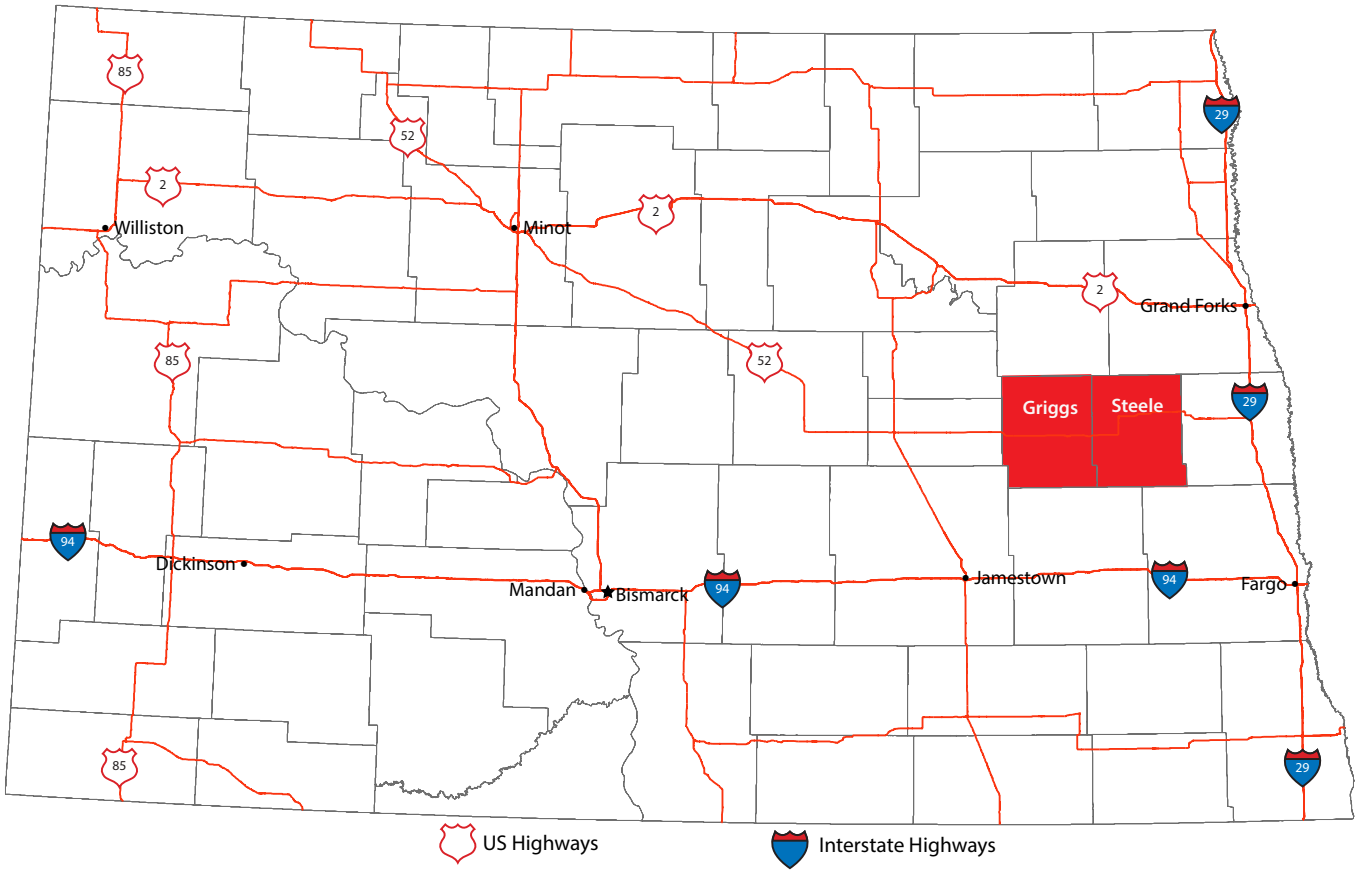
Figure 1: Griggs County, North Dakota



Cooperstown Medical Center

The Cooperstown Medical Center opened in 1951. It is a 501 c-3 non-profit community owned corporation located in Cooperstown, located within Griggs County, North Dakota. It comprises an 18-bed Critical Access Hospital; a level 5 designated trauma emergency department, a two-physician, two nurse-practitioner 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 44 skilled-bed nursing facility. Service emphasis is on primary and preventive healthcare services within a 30-mile radius of Cooperstown, North Dakota.

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

The 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 Sanford Health, ensuring that patients with the most critical needs receive immediate access to care. The local EMS volunteers deliver exemplary patient care service. The combined effort of these associations, along with the efforts of a well-qualified and dedicated staff of 123 employees, are key to meeting the mission of providing efficient, quality healthcare services.

Mission

The Cooperstown Medical Center is dedicated to providing high quality healthcare services in a personalized, compassionate, and professional manner.

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In February 2017, the CMC was recognized as one of the top 100 critical access hospitals in the U.S. by the National Rural Health Associations' Rural Health Policy Institute. Hospitals named to this list are top performers in managing risk, achieving higher quality, securing better outcomes, increasing patient satisfaction, and operating at a lower cost than their peers.

Services offered locally by CMC include:

General and Acute Services

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

Screening/Therapy Services

- 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

Radiology Services

- CT scan (mobile unit)
- Digital mammography (mobile unit)
- Echocardiograms
- EKG
- General x-ray
- Mammograms
- Nuclear medicine (mobile unit)
- Ultrasound (mobile unit)

Laboratory Services

- Blood types
- Chemistry
- Clot times
- Hematology
- Urine testing

Services offered by OTHER providers/organizations

- Ambulance
- Chiropractic services
- Hospice
- Massage therapy
- WIC program

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Nelson-Griggs District Health Unit

Nelson-Griggs District Health Unit provides public health services that include environmental health, nursing services, health screenings and education services. NGDHU utilizes evidence-based practices as public health transitions to population based services. This means 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
- Emergency preparedness and response program (work with community partners)
- Environmental health services (water, sewer, health hazard abatement)
- Flu shots
- Health education programs
- Home visits (in-home medication set-up, monitor health status)
- Immunizations (infants, youth, adults)
- Member of Child Protection Team
- Office visits (consultation and referrals)
- Preschool screenings
- School health (vision screening, health education, school immunizations)
- Substance abuse prevention (underage drinking, adult binge drinking, prescription drugs)
- Tobacco prevention and control program (signage, policies, cessation, newsletters)
- Tuberculosis case management
- West Nile disease program (education and surveillance)
- Worksite wellness
- Youth education programs (Progressive Ag Safety Day)

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Assessment Process

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

A CHNA benefits the community by:

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

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

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

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

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

This assessment examines health needs and concerns in Griggs County, the Cooperstown Medical Center service area.

The 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 the CRH and Cooperstown. A small steering committee (see Figure 2) was formed that was responsible for planning and implementing the process locally. Representatives from the CRH met and corresponded regularly by teleconference and/or via the eToolkit with the CHNA liaison. The community group (described in more detail below) provided in-depth information and informed the assessment process in terms of community perceptions, community resources, community needs, and ideas for improving the health of the population and healthcare services. Twelve 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

Nicole Johnson	CEO, Cooperstown Medical Center
Barbara Anderson	CFO, Cooperstown Medical Center
Julie Ferry	Administrator, Griggs-Nelson District Health Unit
Torry Reutter	Board Chairman, Cooperstown Medical Center
Brad Dewald	Loan Officer, Citizens State Bank
Melissa Myers	Director, Cooperstown Medical Center Foundation
Paulette Gronneberg	Survey Project Community Coordinator

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

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

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

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

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 12 community members was convened and first met on September 10, 2018. 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 December 6, 2018 with eight 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, and faith community. Not all members of the group were present at both meetings.

Interviews

One-on-one interviews with four key informants were conducted in person in Cooperstown on September 10, 2018. One additional key informant interview was conducted over the phone in September of 2018. A representative from the CRH conducted the interviews. Interviews were held with selected members of the community who could provide insights into the community's health needs. The informant interviews included public health professionals with several years of direct experience in the community, including working with medically underserved, low income, and minority populations, as well as 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.

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Survey

A survey was distributed to solicit feedback from the community and was not intended to be a scientific or statistically valid sampling of the population. It was designed to be an additional tool for collecting qualitative data from the community at large – specifically, information related to community-perceived health needs. A copy of the survey instrument is included in Appendix A.

The community member survey was distributed to various residents of Griggs County, which is 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; and
- 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; and
- Suggestions for capital improvements.

To promote awareness of the assessment process, press releases were published in the Griggs County Sentinel Courier and Steele County Press. Additionally, information was available on the CMC, CMC Foundation and Griggs County Care Center Facebook pages.

Approximately 200 community member surveys were available for distribution in Griggs County. The surveys were distributed by Community Group members and available at CMC, NGDHU, local banks, the courthouse, and area businesses.

To help ensure anonymity, included with each survey was a postage-paid return envelope to the CRH. In addition, to help make the survey as widely available as possible, residents also could request a survey by calling CMC or NGDHU. The survey period ran from September 6, 2018 to October 7, 2018. There were 34 completed paper surveys returned.

Area residents also were given the option of completing an online version of the survey, which was publicized in two community newspapers and on the websites and Facebook pages of both CMC and NGDHU. There were 46 online surveys completed. None of the online respondents used the QR code to complete the survey. In total, counting both paper and online surveys, 80 community member surveys were completed, equating to a 5.6% response rate. This response rate is below average for this type of unsolicited survey methodology and indicates lower than average community engagement.

Secondary Data

Secondary data was collected and analyzed to provide descriptions of: (1) population demographics, (2) general health issues (including any population groups with particular health issues), and (3) contributing causes of community health issues. Data was collected from a variety of sources, including the 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

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touches on multiple intersecting aspects of children's lives (www.childhealthdata.org/learn/NSCH); and North Dakota KIDS COUNT, which is a national and state-by-state effort to track the status of children, sponsored by the Annie E. Casey Foundation (www.ndkidscount.org).

Social Determinants of Health

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

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

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

Figure 3: Social Determinants of Health

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

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

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Figure 4: Social Determinants of Health

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

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.

TABLE 1: GRIGGS COUNTY: INFORMATION AND DEMOGRAPHICS

(From 2010 Census/2017 American Community Survey; more recent estimates used where available)

	Griggs County	North Dakota
Population (2017)	2,258	755,393
Population change (2010-2017)	-6.7%	12.3%
People per square mile (2010)	3.4	9.7
Persons 65 years or older (2016)	29.7%	15.0%
Persons under 18 years (2016)	19.1%	23.3%
Median age (2016 est.)	51.9	35.2
White persons (2016)	98.4%	87.5%
Non-English speaking (2016)	2.0%	5.6%
High school graduates (2016)	87.6%	92.0%
Bachelor's degree or higher (2016)	20.3%	28.2%
Live below poverty line (2016)	9.6%	10.7%
Persons without health insurance, under age 65 years (2016)	9.3%	8.1%

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

While the population of North Dakota has grown in recent years, Griggs County has seen a decrease in population since 2010. The U.S. Census Bureau estimates show that Griggs County's population decreased from 2,420 (2010) to 2,258 (2017).

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, Griggs 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 2017 County Health Rankings are pulled from more than 20 data sources and then are compiled to create county rankings. Counties in each of the 50 states are ranked according to summaries of a variety of health measures. Those having high ranks, such as 1 or 2, are considered to be the "healthiest." Counties are ranked on both health outcomes and health factors. Following is a breakdown of the variables that influence a county's rank.

A model of the 2017 County Health Rankings – a flow chart of how a county's rank is determined – may be found in Appendix B. For further information, visit the County Health Rankings website at www.countyhealthrankings.org.

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Table 2: County Health Rankings

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 and other surrounding counties in southwestern North Dakota. 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.

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.

For most of the measures included in the rankings, the County Health Rankings' authors have calculated the "Top U.S. Performers" for 2017. 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 4th out of 49 ranked counties in North Dakota on health outcomes and 12th 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 asterisk (*) indicates that the county is faring better than the North Dakota average but is not meeting the U.S. Top 10% rate on that measure. Measures that are not marked with a bullet or asterisk but are marked with a plus sign (+) indicate that the county is doing better than the U.S. Top 10%.

The data from County Health Rankings shows that Griggs County is doing better than many counties compared to the rest of the state on all of the outcomes, landing at or above rates for other North Dakota counties. The county is also doing well in many areas when it comes to the U.S. Top 10% ratings of outcomes.

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

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

- Premature deaths
- Poor or fair health
- Poor physical health days
- Poor mental health days

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- Adult smoking
- Adult obesity
- Food environment index
- Excessive drinking
- Unemployment
- Children in poverty
- Income inequality
- Children in single-parent households
- Violent crime
- Drinking water violations
- Severe housing problems

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

- Physical inactivity
- Access to exercise opportunities
- Alcohol-impaired driving deaths
- Uninsured
- Primary care physicians
- Dentists
- Preventable hospital stays
- Diabetic monitoring in Medicare enrollees
- Mammography screening in Medicare enrollees
- Injury deaths
- Air pollution – particulate matter

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Table 2: Selected Measures from County Health Rakings 2018 - Griggs County

+ Meeting or exceeding U.S. top 10% performers

***** Not meeting U.S. top 10% performers

• Not meeting North Dakota average

TABLE 2: SELECTED MEASURES FROM *COUNTY HEALTH RANKINGS* 2018 – GRIGGS COUNTY			
	Griggs County	**U.S. Top 10%**	**North Dakota**
Ranking: Outcomes	**4th**		**(of 49)**
Premature death	4,200 +	5,200	6,600
Poor or fair health	11% +	12%	13%
Poor physical health days (in past 30 days)	2.6 +	3.0	3.0
Poor mental health days (in past 30 days)	2.6 +	3.0	3.3
Low birth weight		6%	6%
Ranking: Factors	**12th**		**(of 49)**
Health Behaviors			
Adult smoking	14% +	14%	19%
Adult obesity	27% •	26%	31%
Food environment index (10=best)	9.1 +	8.4	8.4
Physical inactivity	31% *•	19%	23%
Access to exercise opportunities	45% *•	91%	66%
Excessive drinking	20% •	12%	25%
Alcohol-impaired driving deaths	67% *•	13%	47%
Sexually transmitted infections		145.5	477.1
Teen birth rate		17	27
Clinical Care			
Uninsured	12% *•	8%	9%
Primary care physicians	2,310:1*•	1,040:1	1,280:1
Dentists	2,280:1*•	1,320:1	1,630:1
Mental health providers		360:1	640:1
Preventable hospital stays	81 *•	36	46
Diabetic monitoring (% of diabetic Medicare enrollees ages 65-75 that receive HbA1c monitoring)	81% *•	91%	87%
Mammography screening (% of Medicare enrollees ages 67-69 receiving screening)	64% *•	71%	69%
Social and Economic Factors			
Unemployment	3.0% +	3.3%	2.7%
Children in poverty	12% +	12%	12%
Income inequality	4.2 •	3.7	4.4
Children in single-parent households	20% +	21%	27%
Violent crime	99 •	62	260
Injury deaths	112 *•	53	66
Physical Environment			
Air pollution – particulate matter	7.8 *•	6.7	7.5
Drinking water violations	No +	NA	
Severe housing problems	5% +	9%	11%

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

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Children's Health

The National Survey of Children's Health touches on multiple intersecting aspects of children's lives. Data are not available at the county level; listed below is information about children's health in North Dakota. The full survey includes physical and mental health status, access to quality healthcare, and information on the child's family, neighborhood, and social context. Data is from 2011-12. More information about the survey may be found at www.childhealthdata.org/learn/NSCH.

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

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

TABLE 3: SELECTED MEASURES REGARDING CHILDREN'S HEALTH (For children aged 0-17 unless noted otherwise)		
Health Status	**North Dakota**	**National**
Children born premature (3 or more weeks early)	10.8%	11.6%
Children 10-17 overweight or obese	**35.8%**	31.3%
Children 0-5 who were ever breastfed	79.4%	79.2%
Children 6-17 who missed 11 or more days of school	4.6%	6.2%
Healthcare		
Children currently insured	**93.5%**	94.5%
Children who had preventive medical visit in past year	**78.6%**	84.4%
Children who had preventive dental visit in past year	**74.6%**	77.2%
Young children (10 mos.-5 yrs.) receiving standardized screening for developmental or behavioral problems	**20.7%**	30.8%
Children aged 2-17 with problems requiring counseling who received needed mental healthcare	**86.3%**	61.0%
Family Life		
Children whose families eat meals together 4 or more times per week	83.0%	78.4%
Children who live in households where someone smokes	**29.8%**	24.1%
Neighborhood		
Children who live in neighborhood with a park, sidewalks, a library, and a community center	58.9%	54.1%
Children living in neighborhoods with poorly kept or rundown housing	12.7%	16.2%
Children living in neighborhood that's usually or always safe	94.0%	86.6%

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

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

- Obese or overweight children ages 10-17;
- Children with health insurance;
- Preventive primary care and dentist visits;
- Developmental/behavioral screening for children 10 months to 5 years of age;
- Children who have received needed mental healthcare; and
- Children living in smoking households.

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

The data show that Griggs County is performing more poorly than the North Dakota average on three of the examined measures. Griggs County is performing well on the percentage of children who are uninsured below 200% of poverty, children enrolled in Healthy Steps, the percentage of the population who are Supplemental Nutrition Assistance Program (SNAP) recipients, and the 4-year high school graduation rate. The most marked difference was on the measure of licensed child care capacity (almost 12% lower rate in Griggs County).

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

	Griggs County	North Dakota
Uninsured children (% of population age 0-18), 2016	10.6%	9.0%
Uninsured children below 200% of poverty (% of population), 2016	40.4%	41.9%
Medicaid recipient (% of population age 0-20), 2017	30.2%	28.3%
Children enrolled in Healthy Steps (% of population age 0-18), 2013	1.6%	2.5%
Supplemental Nutrition Assistance Program (SNAP) recipients (% of population age 0-18), 2017	11.4%	20.1%
Licensed childcare capacity (% of population age 0-13), 2018	30.2%	41.9%
4-Year High School Cohort Graduation Rate, 2017	100.0%	87.0%

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

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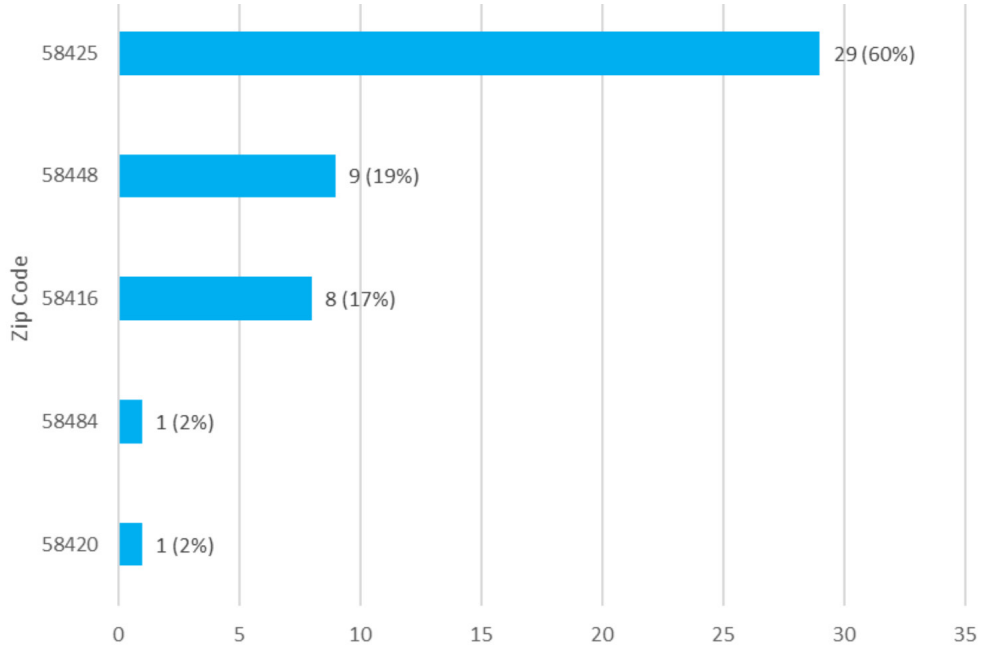
Survey Results

As noted previously, 80 community members completed the survey in communities throughout the counties in the CMC service area. The survey requested that respondents list their home zip code. While not all respondents provided a zip code, 48 did, revealing that the large majority of respondents (60%, N=29) lived in Cooperstown. These results are shown in Figure 5.

Figure 5: Survey Respondents' Home Zip Code
Total respondents: 48



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

Survey Demographics

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

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

- 70% (N=48) were age 55 or older.
- The majority (78%, N=52) were female.
- About one-third (29%, N=30) had bachelor's degrees or higher.
- The number of those working full time (38%, N=26) was even with those who were retired (38%, N=26).
- 99% (N=68) of those who reported their ethnicity/race were white/Caucasian.
- 43% of the population (N=26) had household incomes of less than $50,000.

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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 = 69

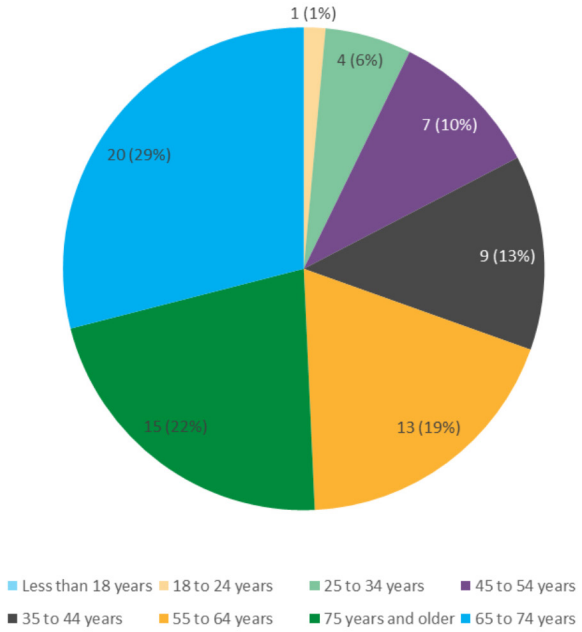

Figure 7: Gender Demographics of Survey Respondents
Total respondents = 67

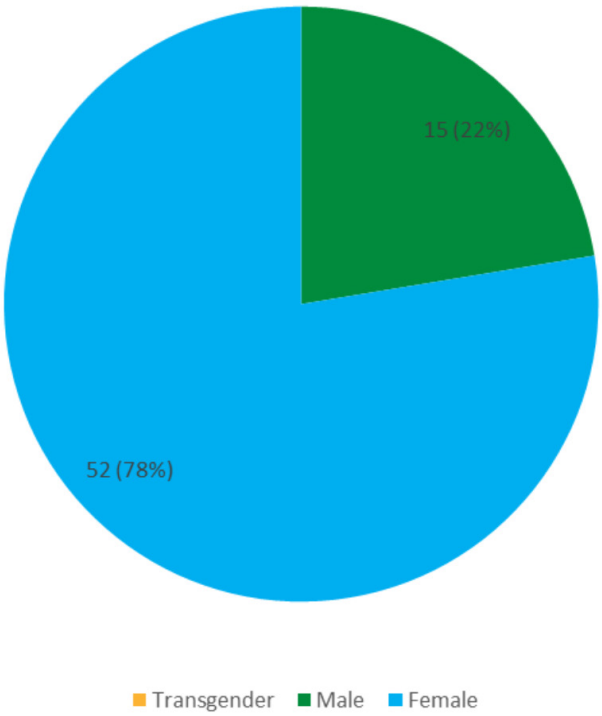

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Figure 8: Educational Level Demographics of Survey Respondents
Total respondents = 67

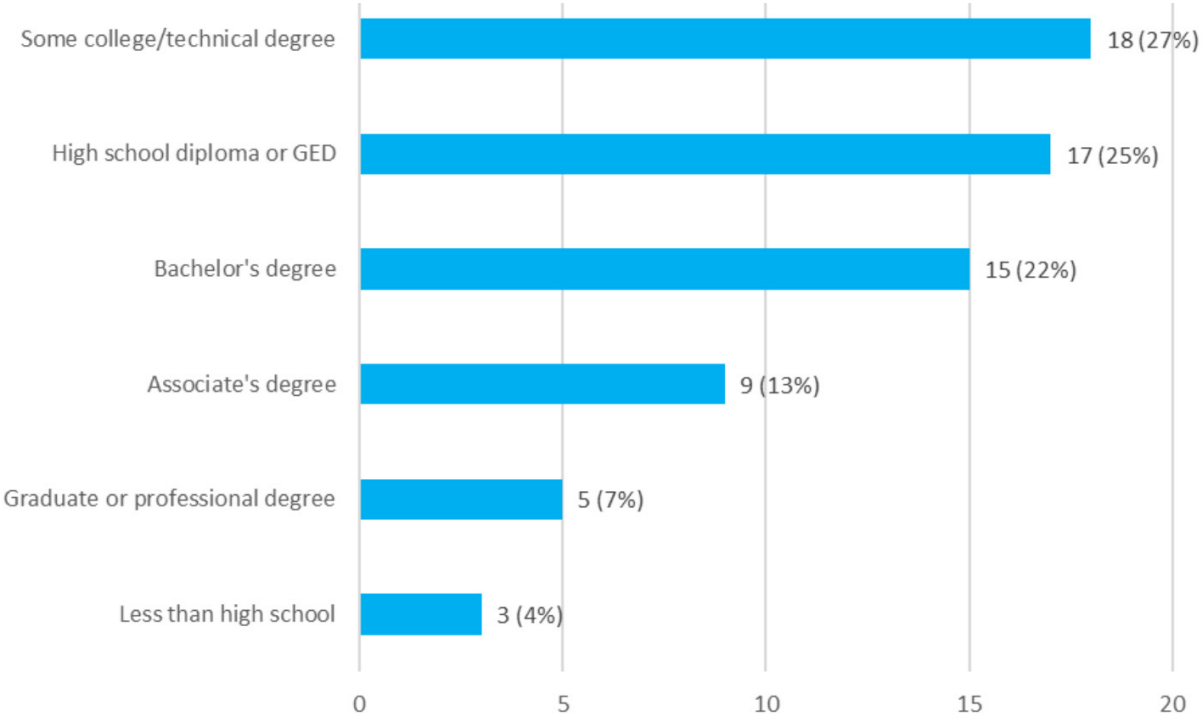
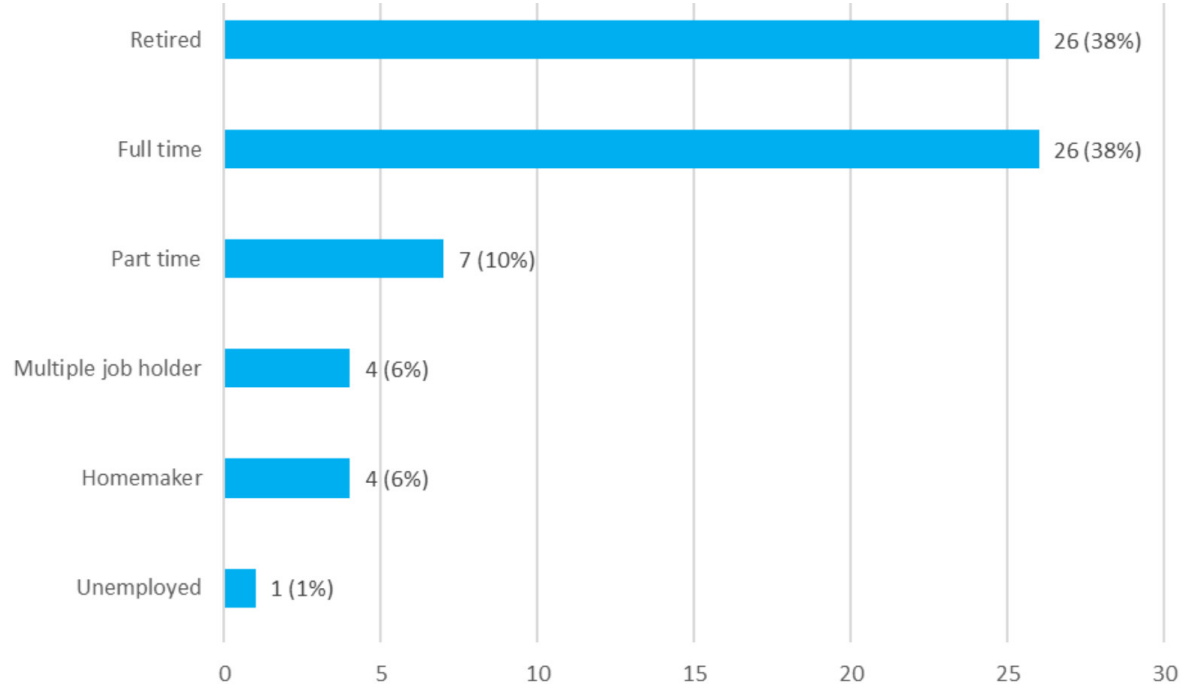


Figure 9: Employment Status Demographics of Survey Respondents
Total respondents = 68



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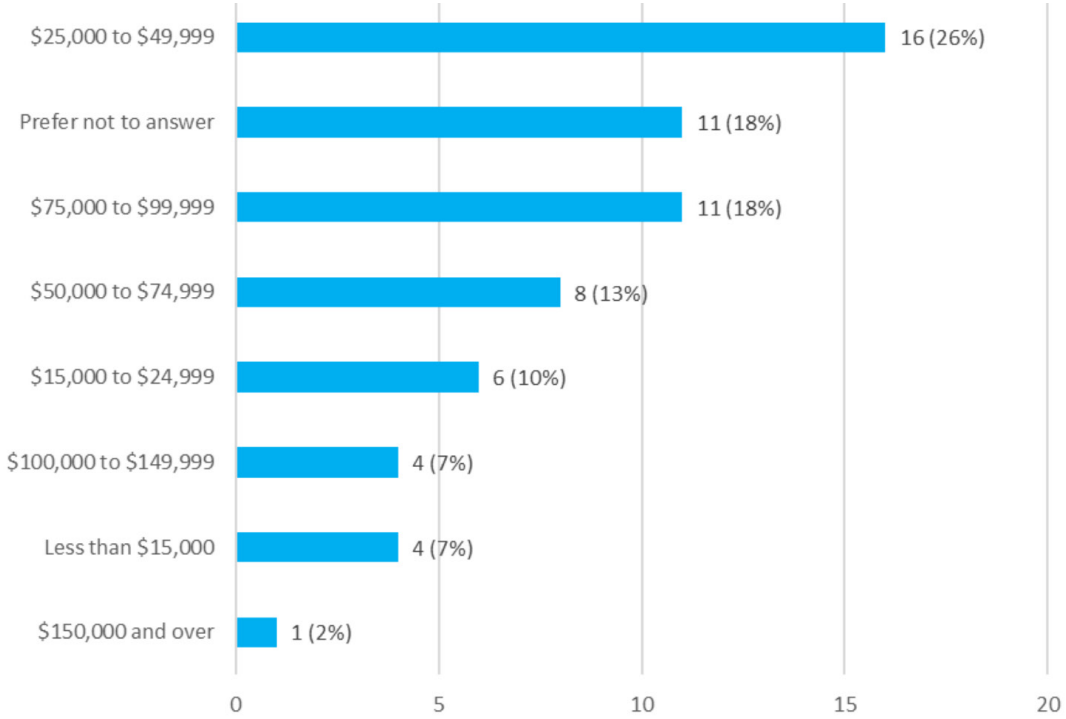
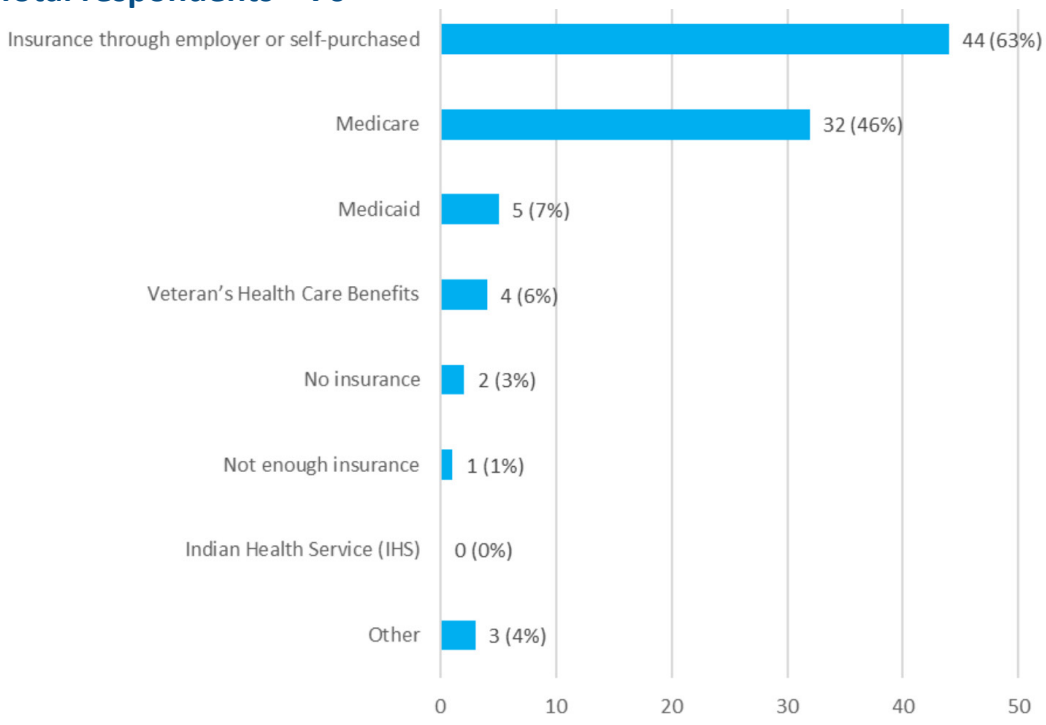
Of those who provided a household income, 17% (N=10) community members reported a household income of less than $25,000. Nine percent (N=5) indicated a household income of $100,000 or more. This information is show in Figure 10.

Figure 10: Household Income Demographics of Survey Respondents
Total respondents = 61



Community members were asked about their health insurance status, which is often associated with whether people have access to healthcare. 4% (N=3) of the respondents reported having no health insurance or being under-insured. The most common insurance types were insurance through one's employer or self-purchased (N=37), followed by Medicare (N=32) and Medicaid (N=5).

Figure 11: Health Insurance Coverage Status of Survey Respondents
Total respondents = 70



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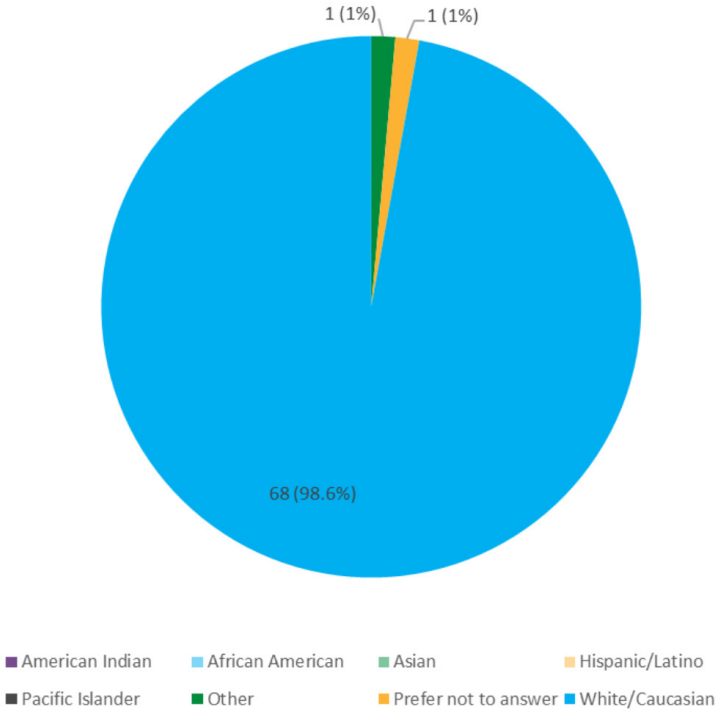
As shown in Figure 12, nearly all of the respondents were white/Caucasian (99%). This was in-line with the race/ethnicity of the overall population of Griggs County; the U.S. Census indicates that 98.4% of the population is white in Griggs County.

Figure 12: Race/Ethnicity Demographics of Survey Respondents
Total respondents = 69



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:

- Safe place to live, little/no crime (N=63);
- Family-friendly (N=52);
- Active faith community (N=51);
- People are friendly, helpful, supportive (N=51); and
- Feeling connected to people who live here (N=46).

Figures 13 to 16 illustrate the results of these questions.

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Figure 13: Best Things about the PEOPLE in Your Community
Total responses = 72

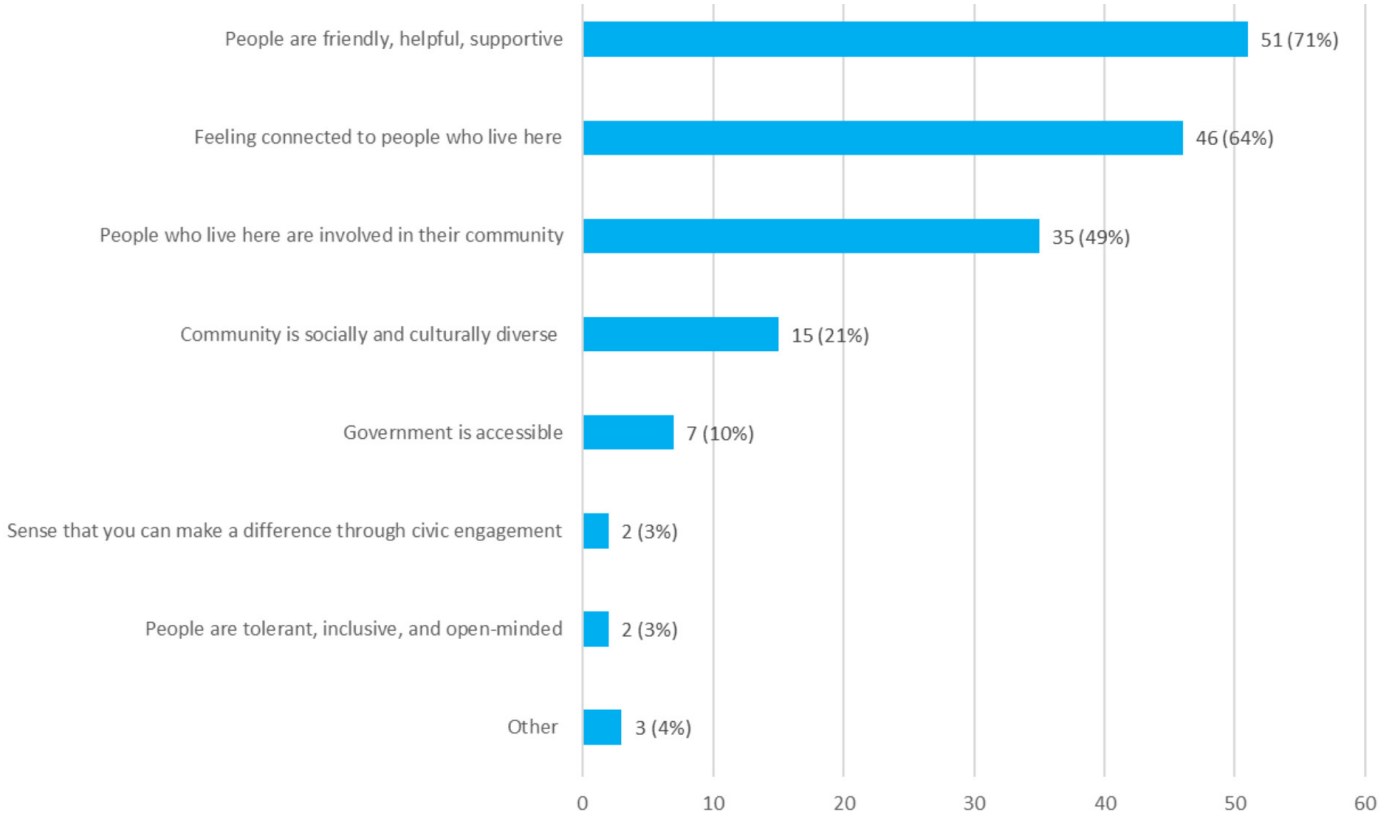

Figure 14: Best Things about the SERVICES AND RESOURCES in Your Community
Total responses = 73

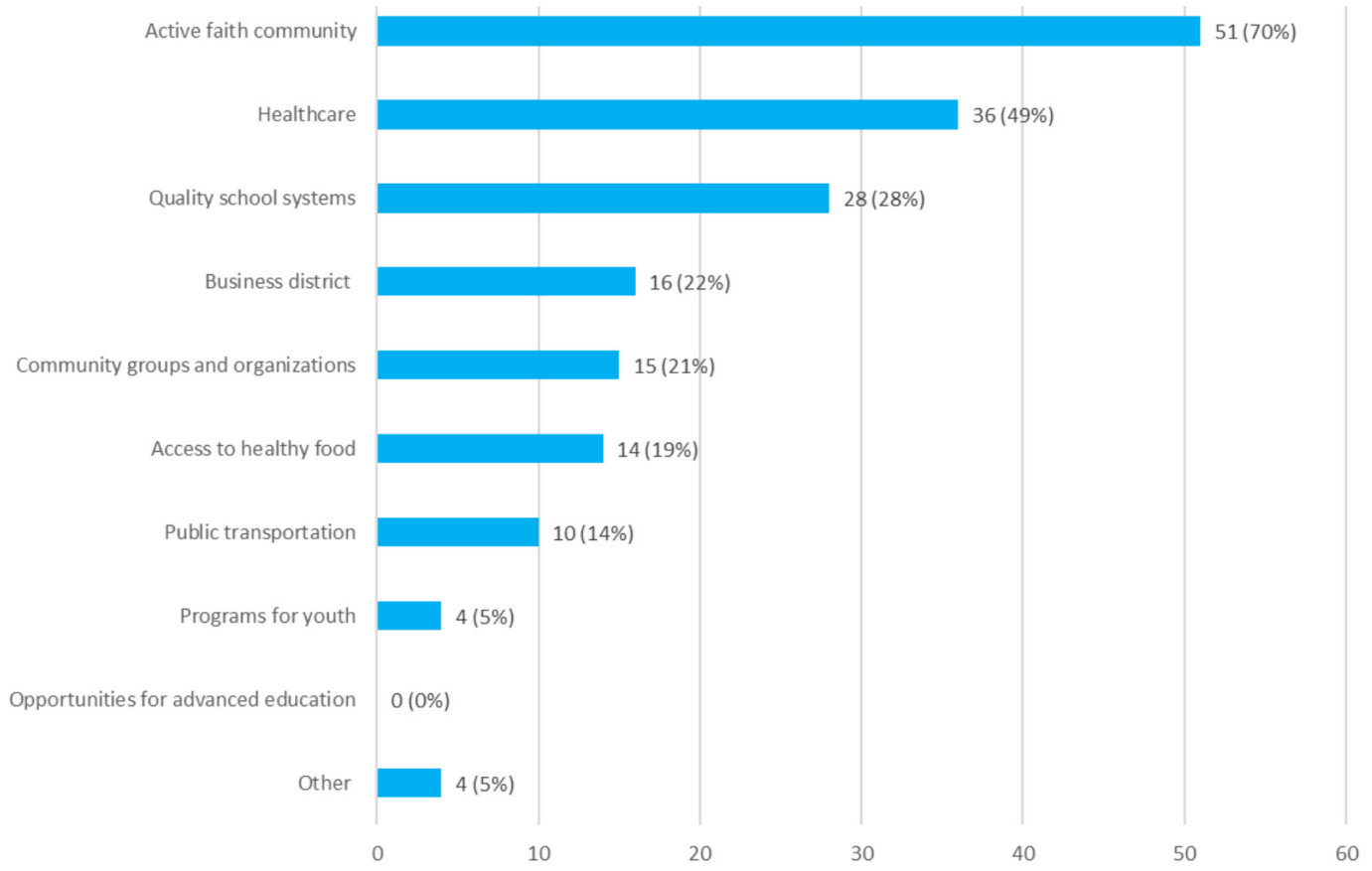

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Figure 15: Best Things about the QUALITY OF LIFE in Your Community
Total responses = 74

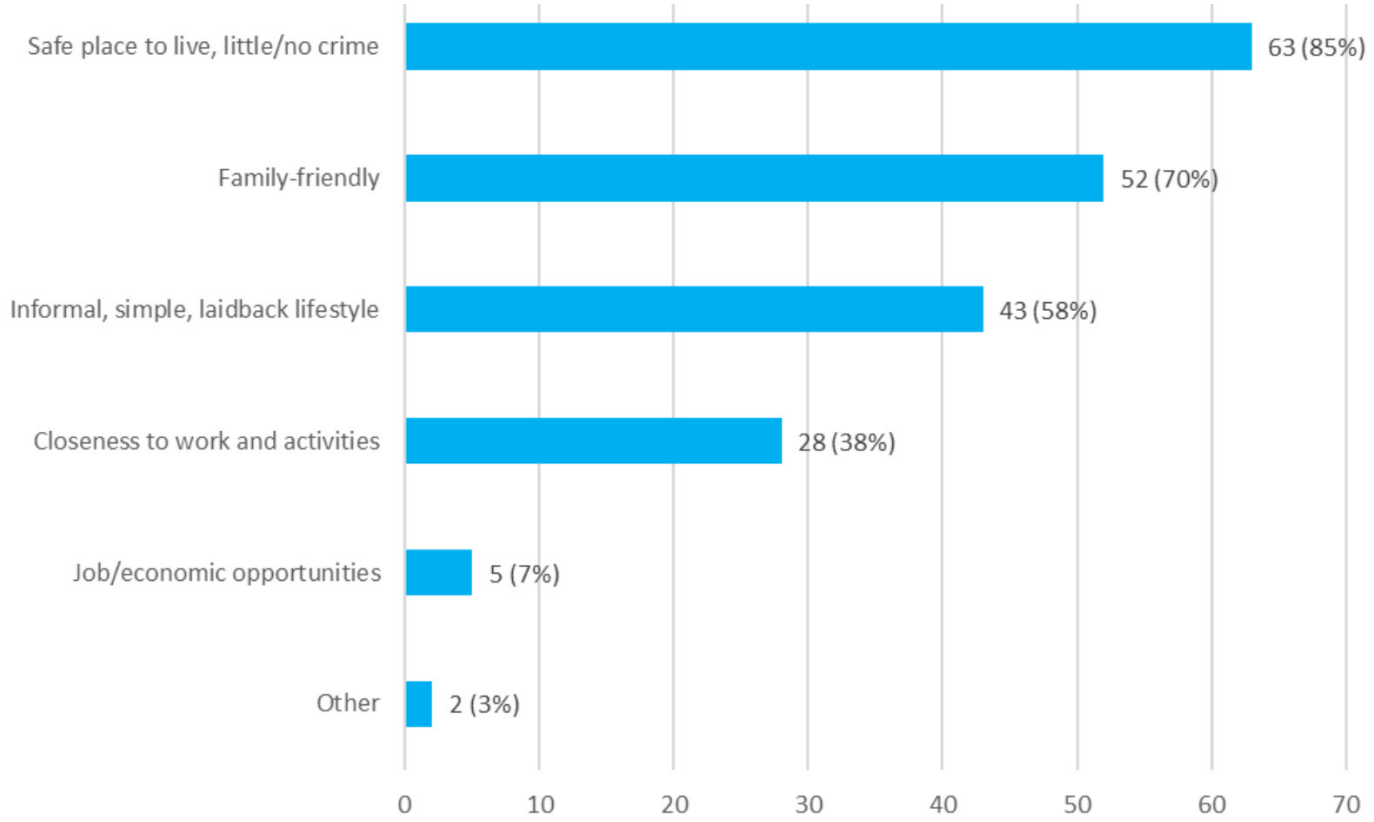
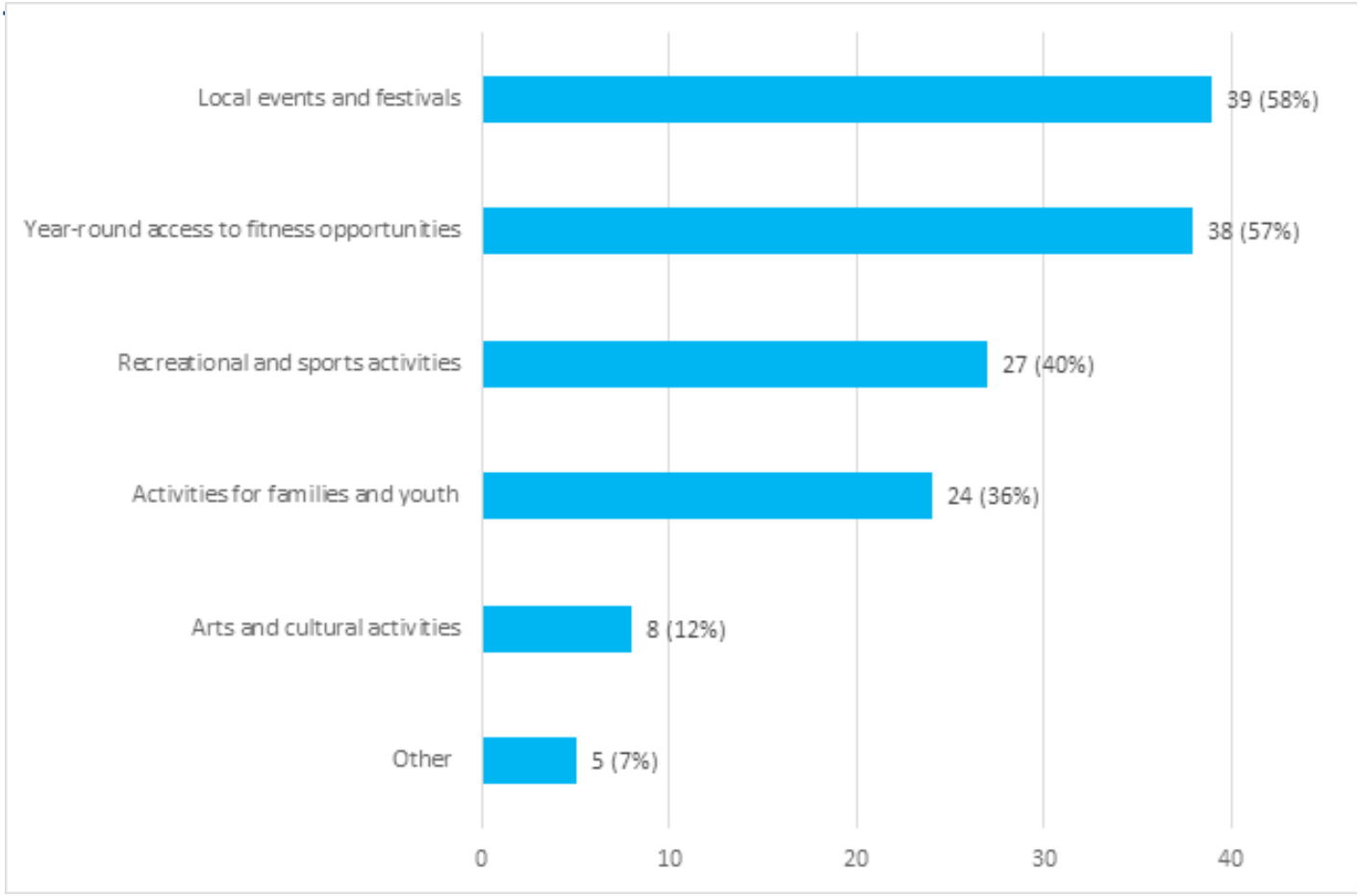


Figure 16: Best Thing about the ACTIVITIES in Your Community



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Community Concerns

At the heart of this community health assessment was a section on the survey asking survey respondents to review a wide array of potential community and health concerns in 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; and
- Violence.

With regard to responses about community challenges, the most highly voiced concerns (those having at least 25 respondents) were:

- Bullying/cyber-bullying (N= 40);
- Not enough jobs with livable wages (N=39);
- Drug use and abuse – Youth (N=36);
- Alcohol use and abuse – Youth (N=31);
- Attracting and retaining young families (N=31);
- Alcohol use and abuse – Adult (N=30);
- Cost of long-term/nursing home care (N=27); and
- Depression/anxiety - Youth (N=26).

The other issues that had at least 17 votes included:

- Cancer - Adult (N=24);
- Availability of resources to help the elderly stay in their homes (N=23);
- Dementia/Alzheimer's disease (N=19);
- Drug use and abuse – Adult (N=19);
- Child abuse/neglect (N=18);
- Emotional abuse (intimidation, isolation, withholding of funds) (N=18);
- Obesity/overweight - Adult (N=18);
- Assisted living options (N=17); and
- Not enough activities for children and youth (N=17);

Figures 17 through 22 illustrate these results.

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

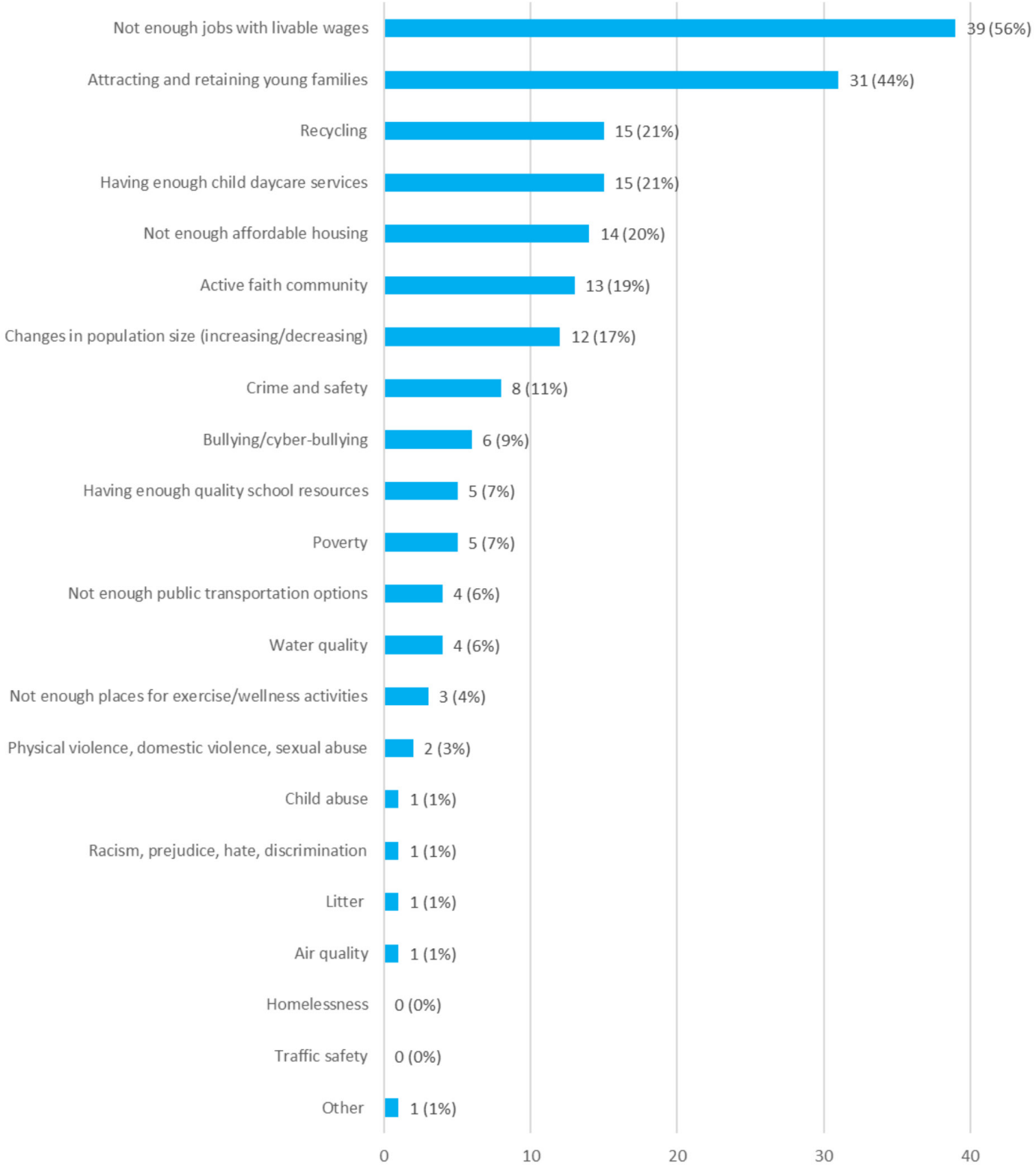

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Figure 18: Availability/Delivery of Health Services Concerns
Total responses = 70

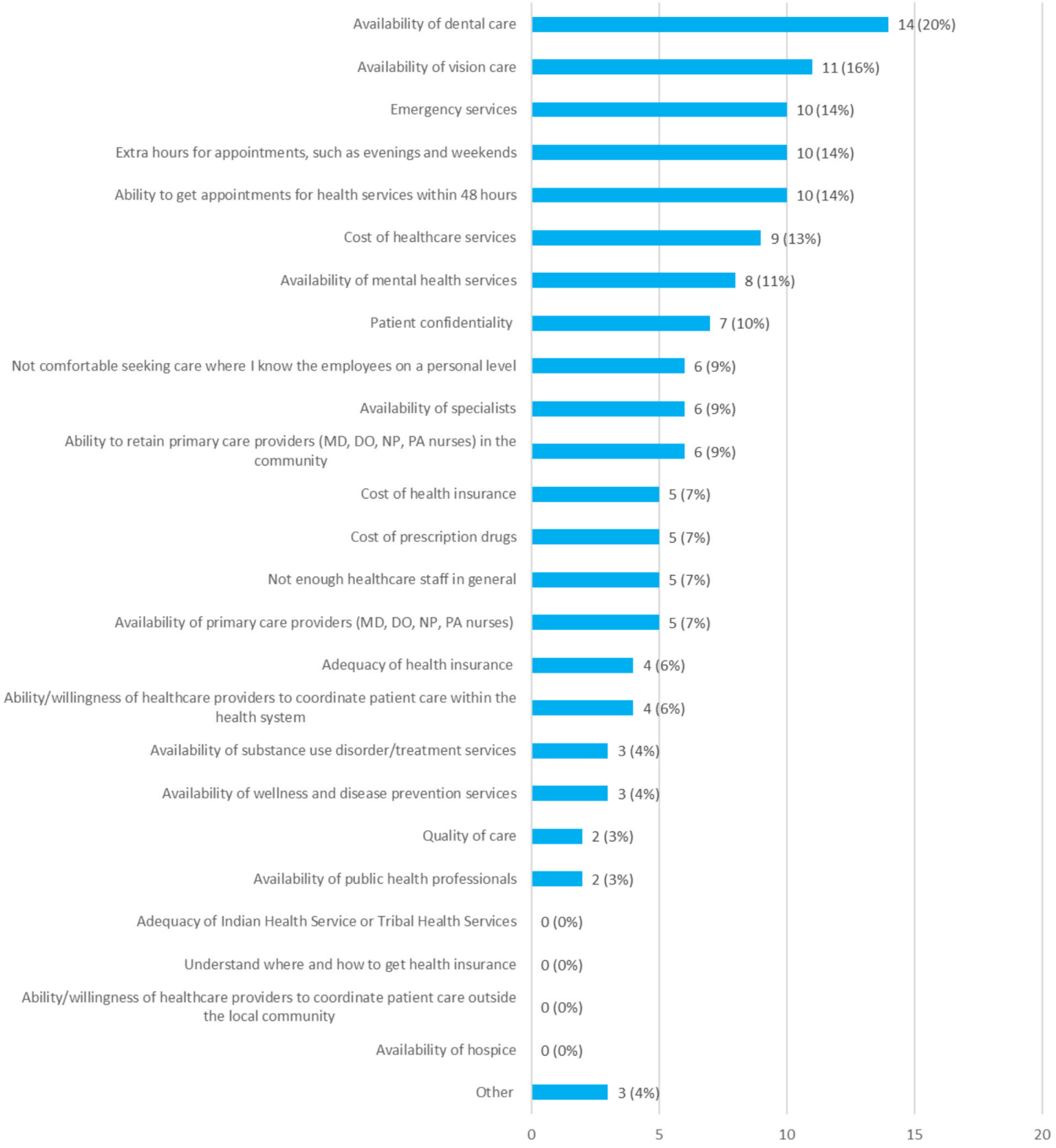

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Figure 19: Youth Population Health Concerns
Total responses = 65

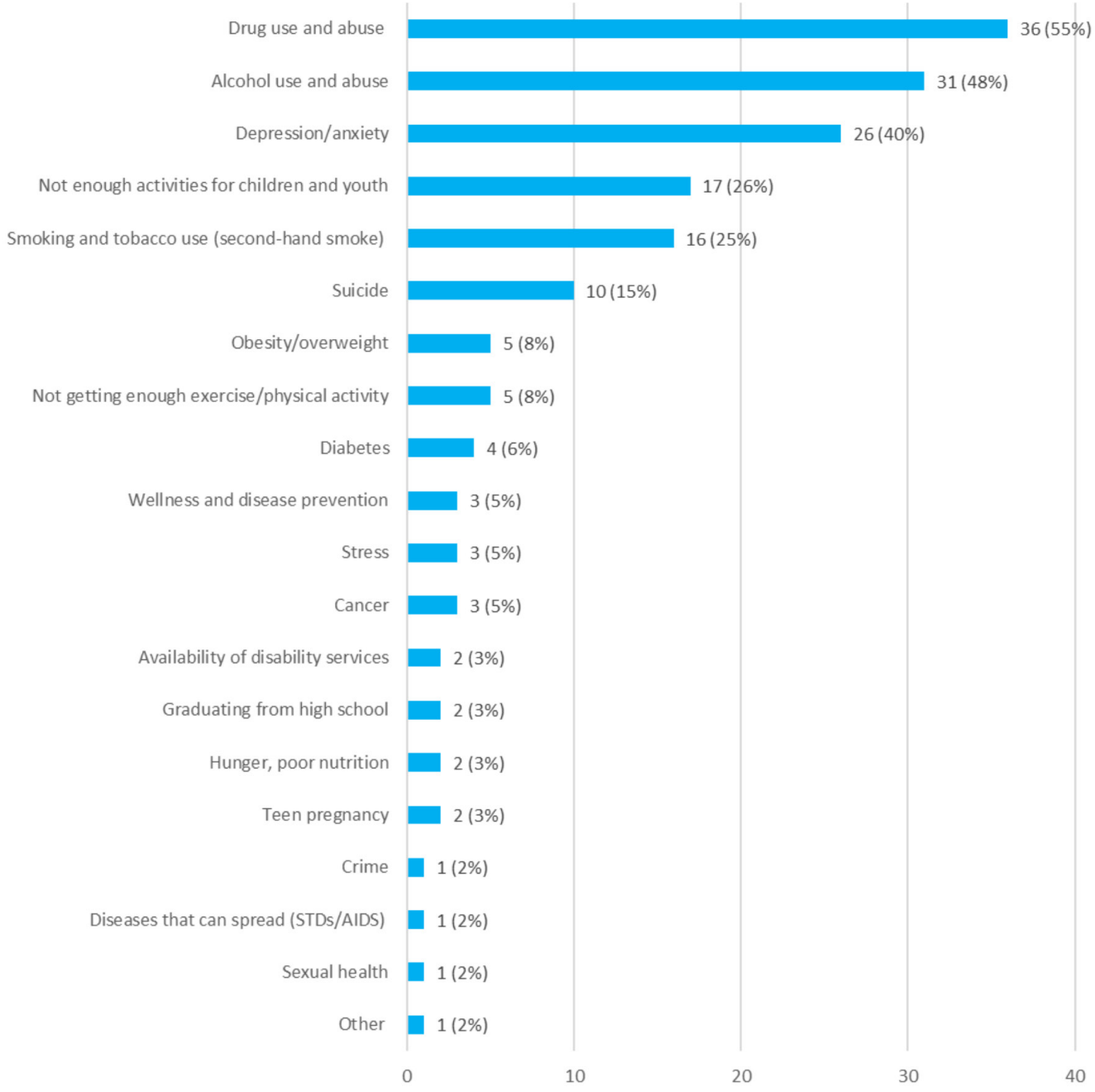

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Figure 20: Adult Population Concerns
Total responses = 68

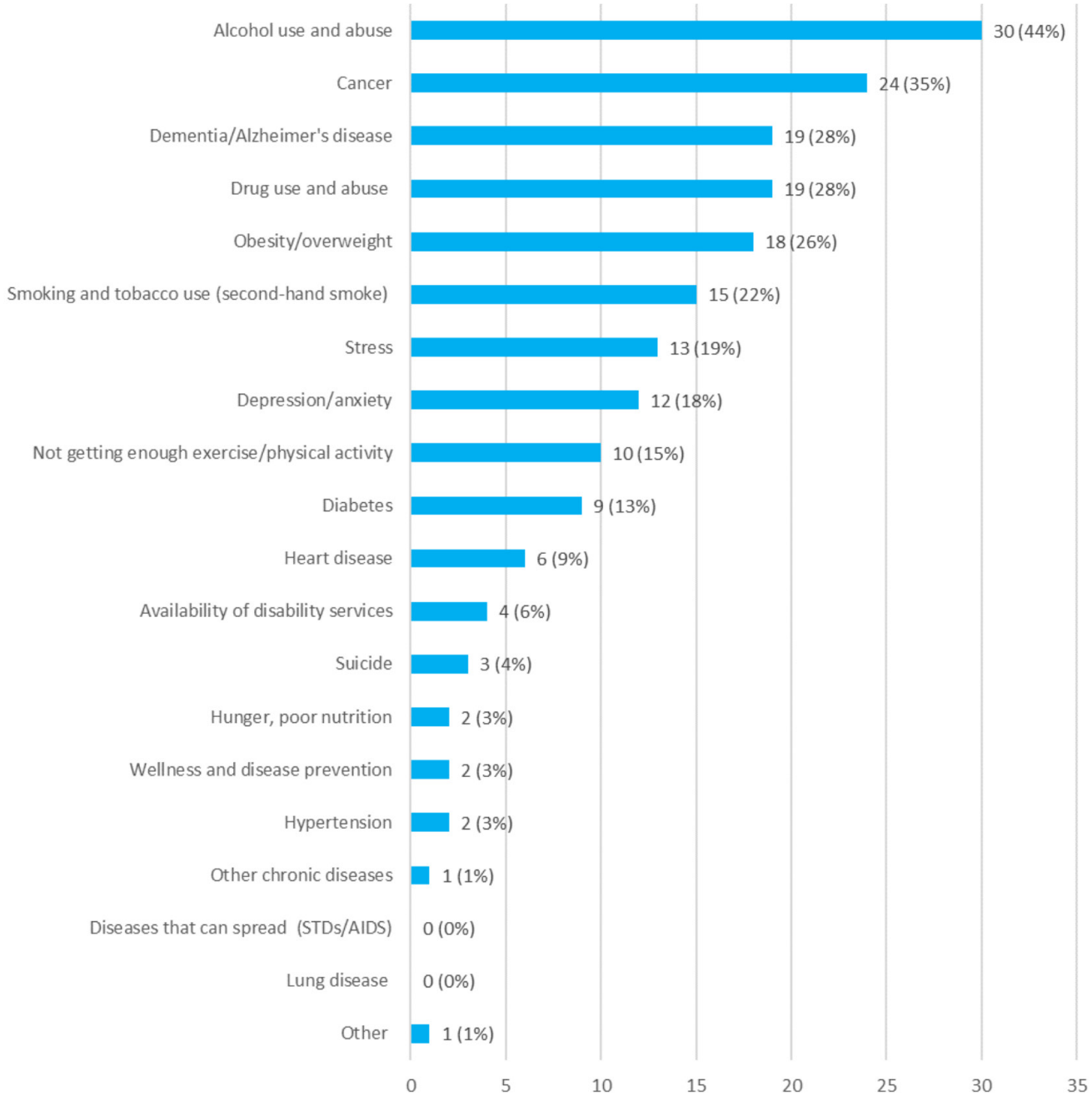

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Figure 21: Senior Population Concerns
Total responses = 68

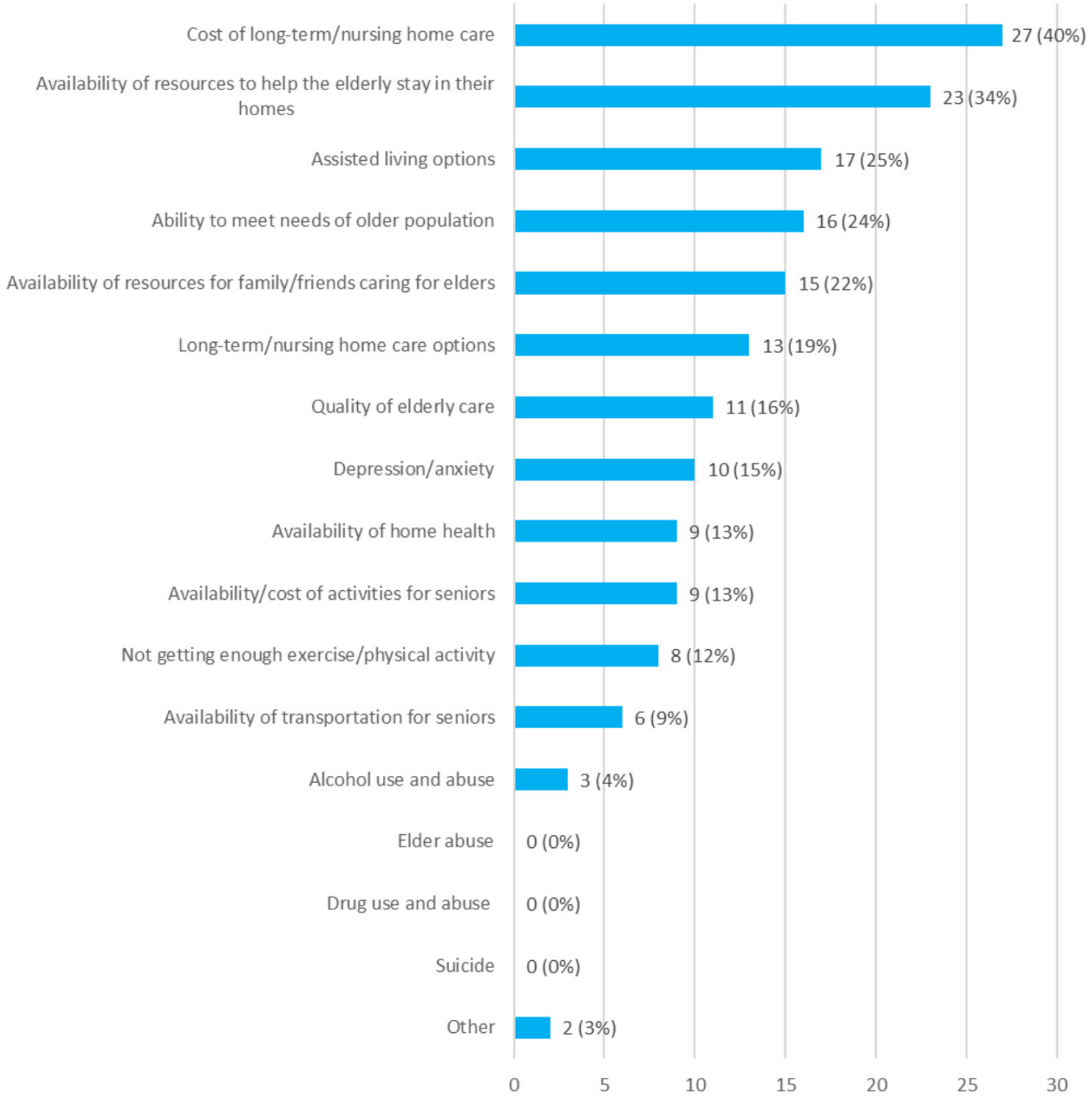

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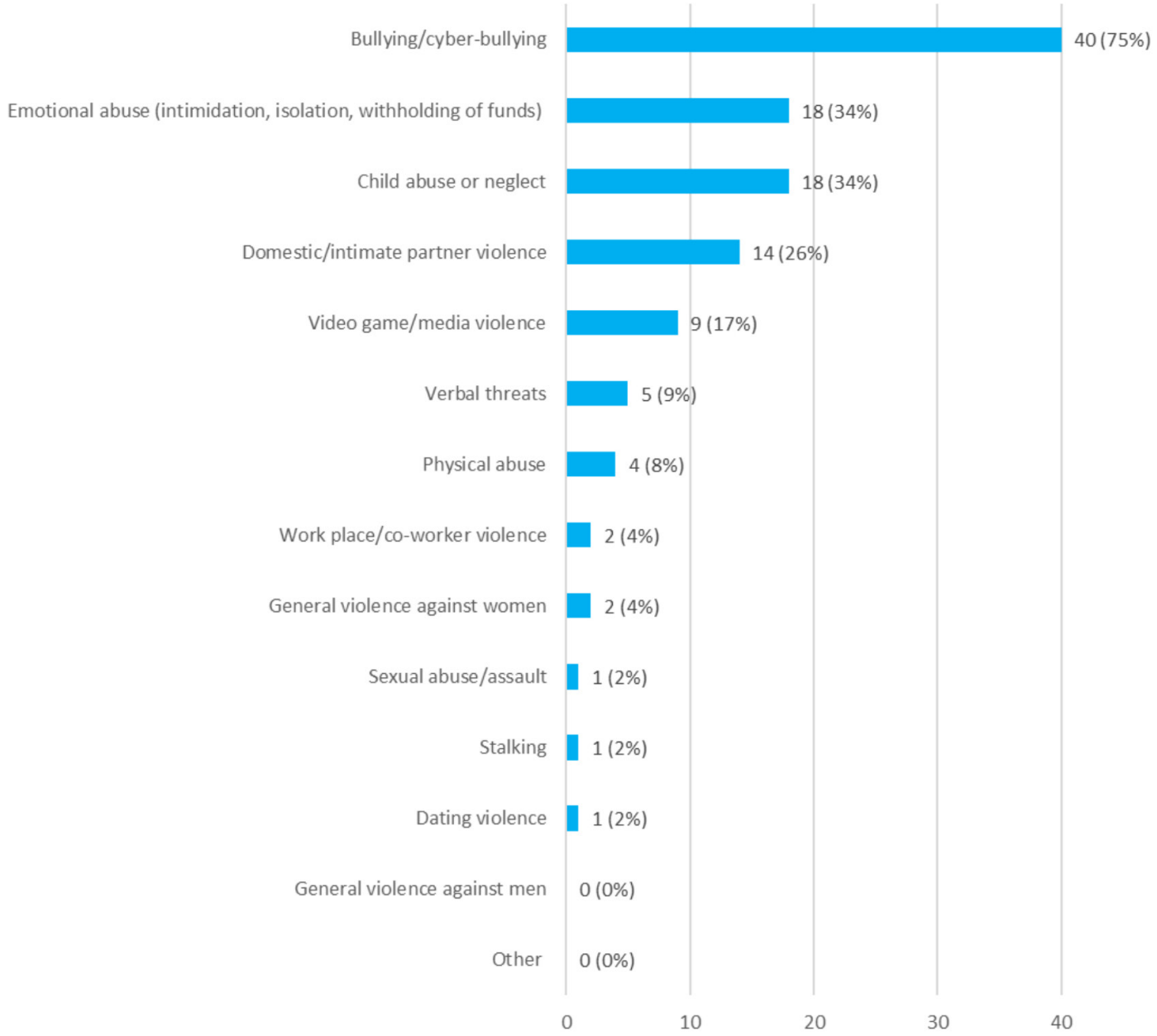
Figure 22: Violence Concerns
Total responses = 53



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. Retaining population

2. Lack of decent wages

Other biggest challenges that were identified were the lack of social services, retaining healthcare providers, retaining young people in the community, and keeping businesses open.

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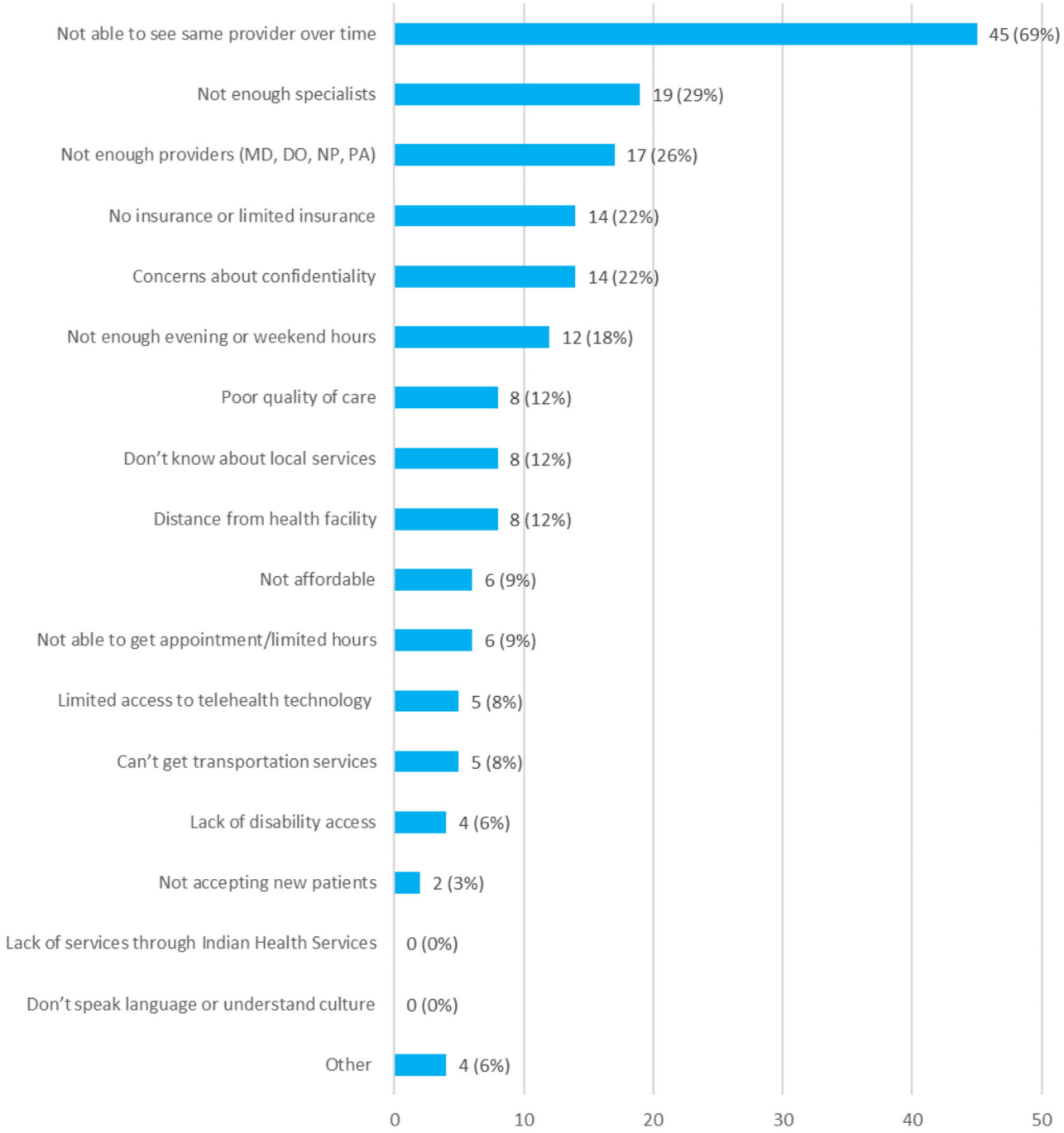
Delivery of Healthcare

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 not being able to see the same provider over time (N=45), with the next highest being not enough specialists (N=19). After these, the next most commonly identified barriers were not enough providers (MD, DO, NP, PA) (N=17), no insurance or limited insurance (N=14), and concerns about confidentiality (N=14).

Figure 23 illustrates these results.

Figure 23: Perceptions about Barriers to Care
Total responses = 65



Considering a variety of healthcare services offered, respondents were asked to indicate if they were aware that the healthcare service is offered though NGDHU or services they or a family member have used at NGDHU (See Figure 24).

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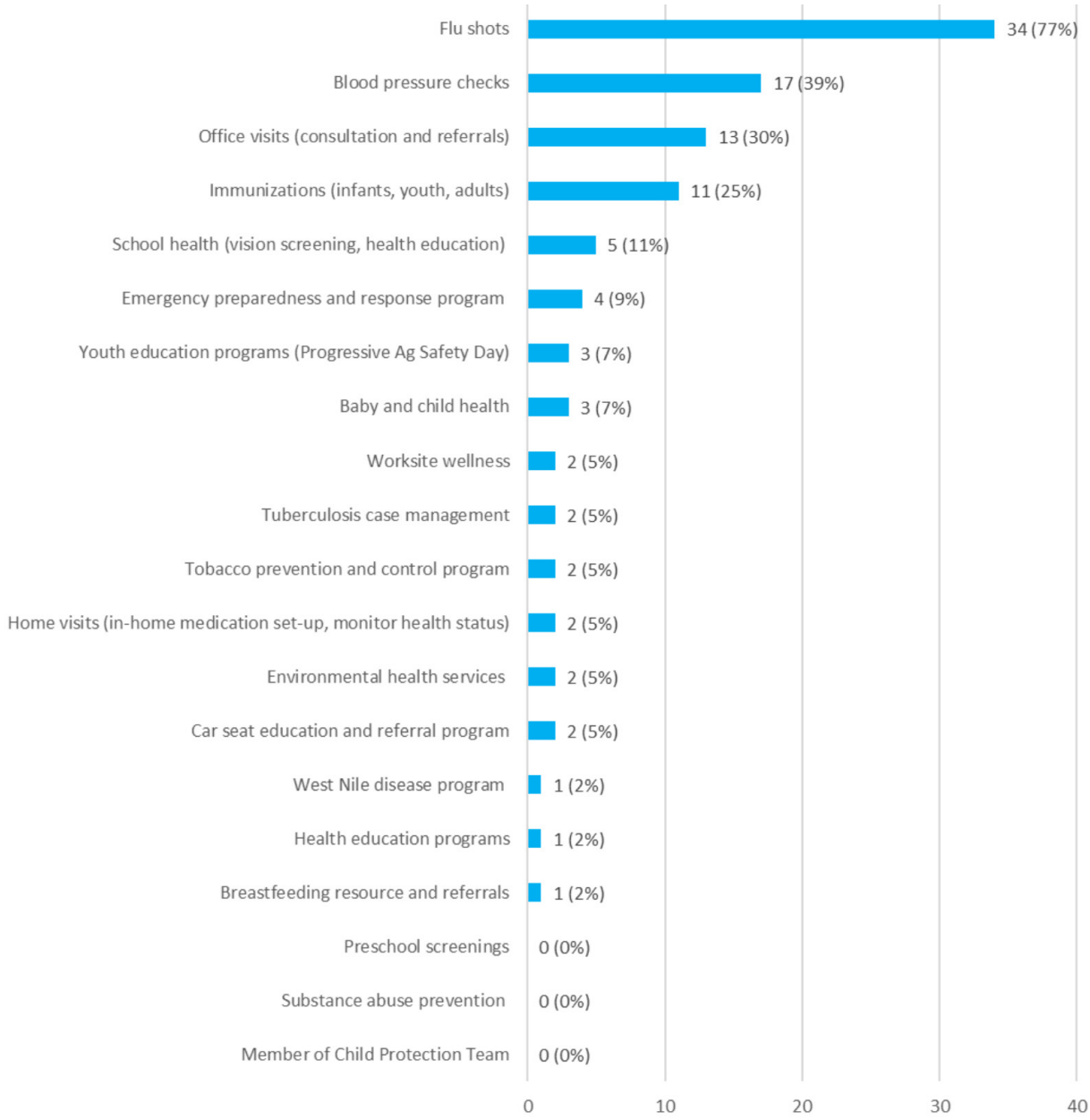
Figure 24: Awareness and Utilization of Public Health Services



In an open-ended question, respondents were asked what specific healthcare services, if any, they thing should be added locally. The most desired services to add locally were dental and vision services.

- Cardiology
- Chiropractic
- Chronic illness monitoring in home
- CT on site
- Dental
- Massage
- Podiatrist
- Pulmonologist
- Upgrades to ER
- Upgrades to nursing home/assisted living
- Urology
- Vision

While not a service, many respondents indicated that they would like physicians added. In regard to chiropractors being added locally, it was specifically noted that those professionals should be available on a daily basis.

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The key informant and focus group members felt that the community members were aware of the majority of the health system and public health services. There were a number of services where they felt the hospital should increase marketing efforts, these included prenatal and obstetrics, telehealth options, sleep studies, pediatrics, skin cancer preventative checks, minimal chiropractic services, and the clinic available on Wednesday evenings.

Respondents were asked to indicate which services at CMC they were aware of, regarding general and acute services, screening/therapy services, radiology services, and services offered by other providers/organizations. Figures 25-28 illustrate these results.

Figure 25: Awareness of General and Acute Services at Cooperstown Medical Center Total responses = 63

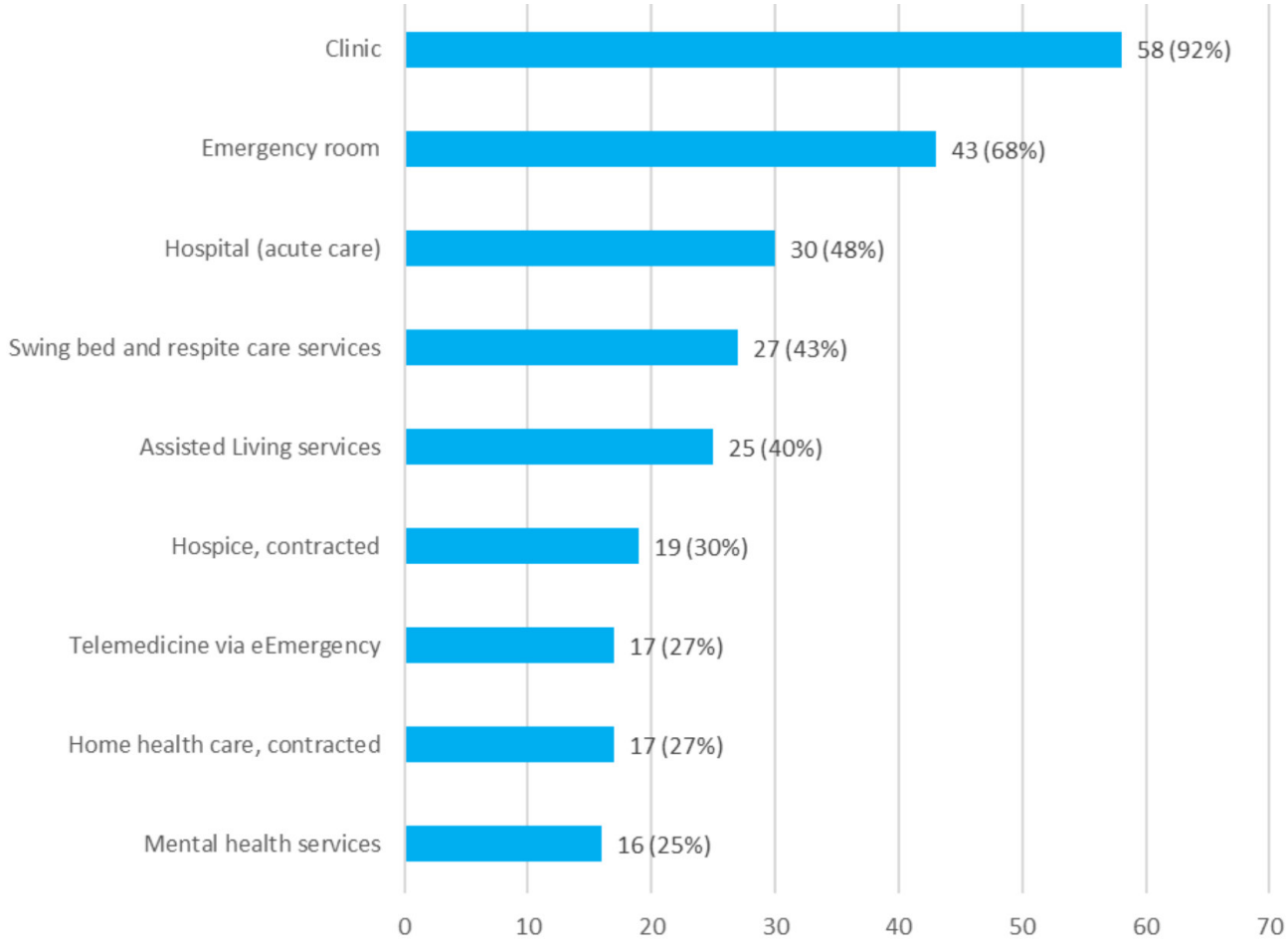

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Figure 26: Awareness of Screening/Therapy Services at Cooperstown Medical Center
Total responses = 62

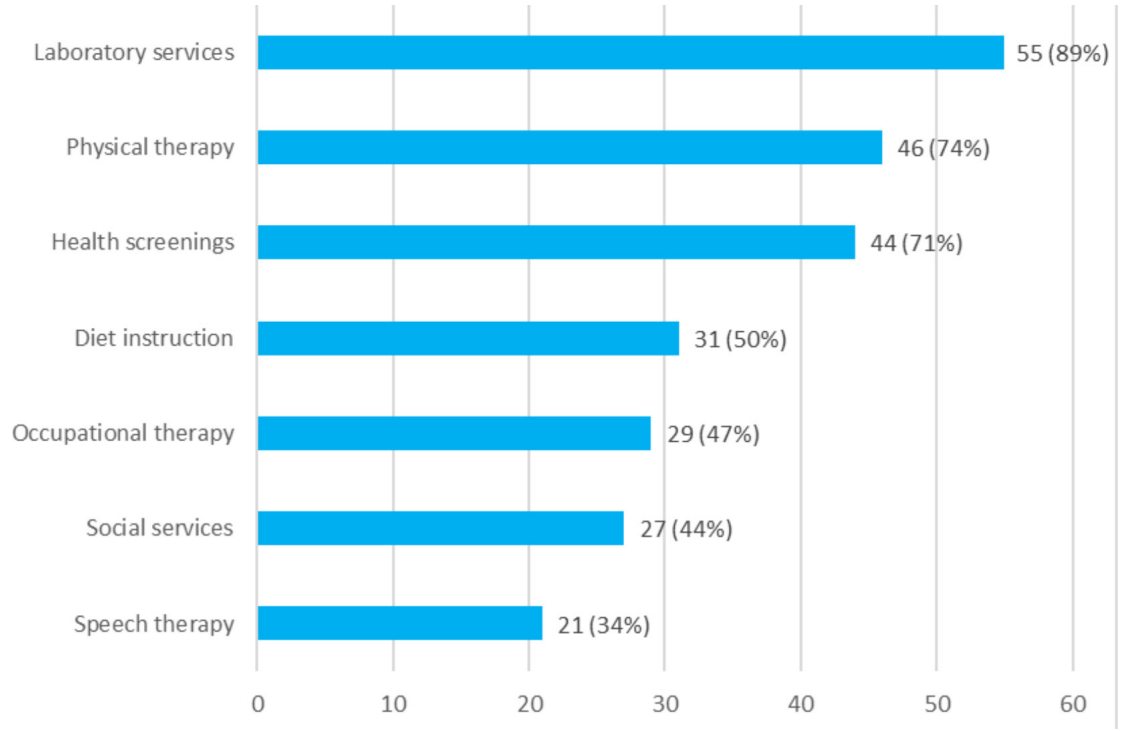

Figure 27: Awareness of Radiology Services at Cooperstown Medical Center
Total responses = 57

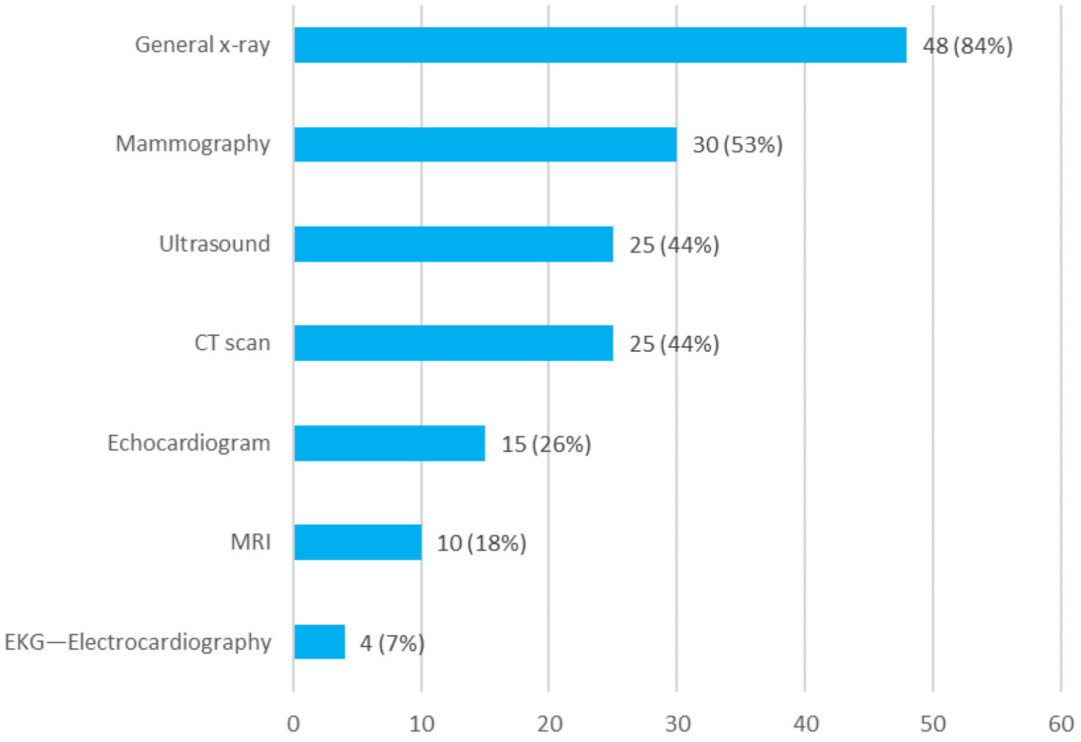

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Figure 28: Awareness of Services Offered by Other Providers/Organizations at Cooperstown Medical Center
Total responses = 54

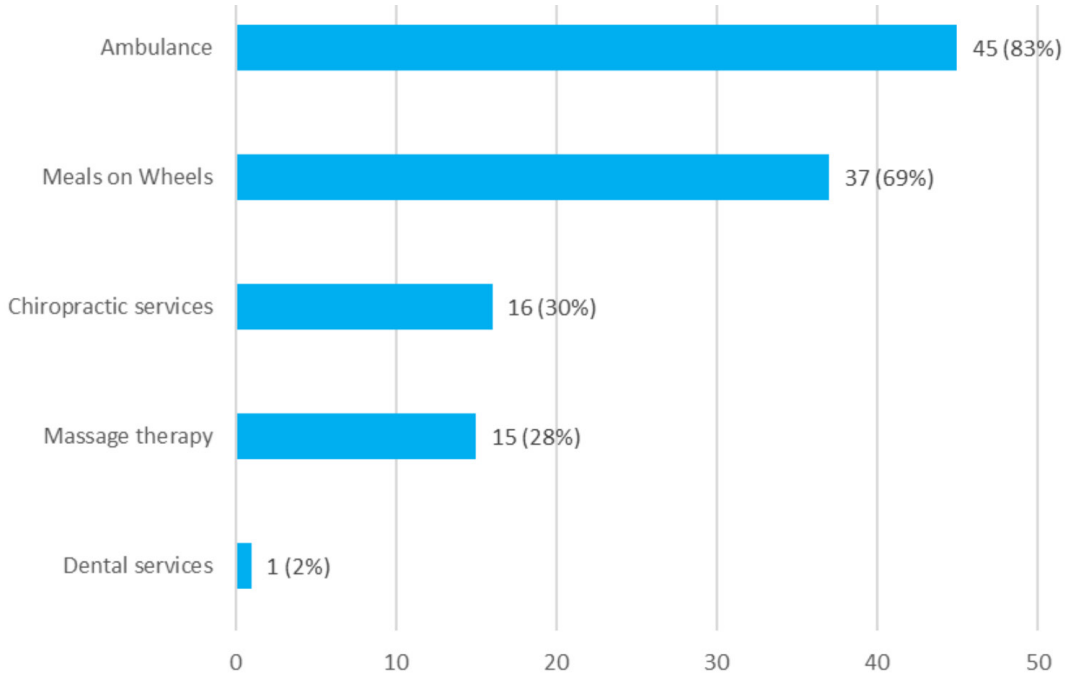
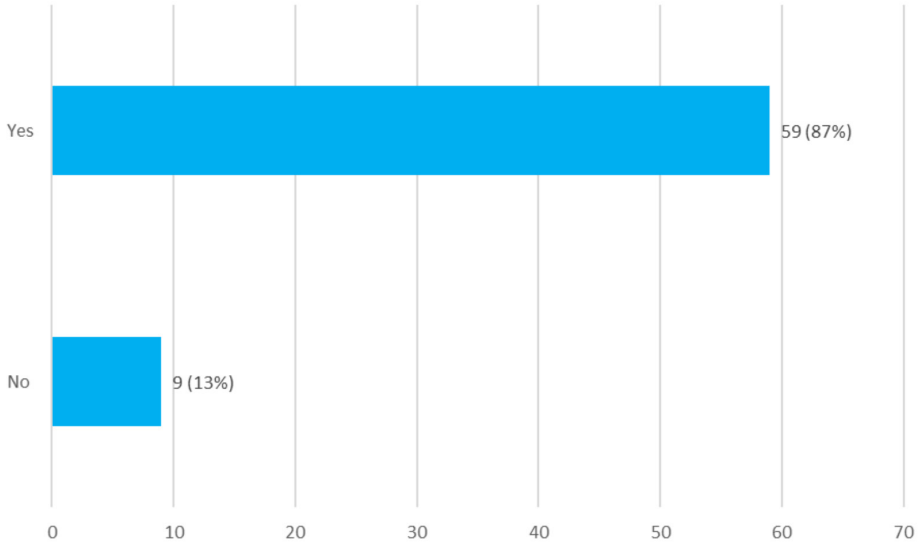


Figure 29: Awareness of Cooperstown Medical Center's Foundation
Total responses = 68



In an effort to gauge ways that community members' would be most likely to financially support the CMC Foundation, a question was included asking them to select ways they are most likely to support or have supported the CMC Foundation (see Figure 30).

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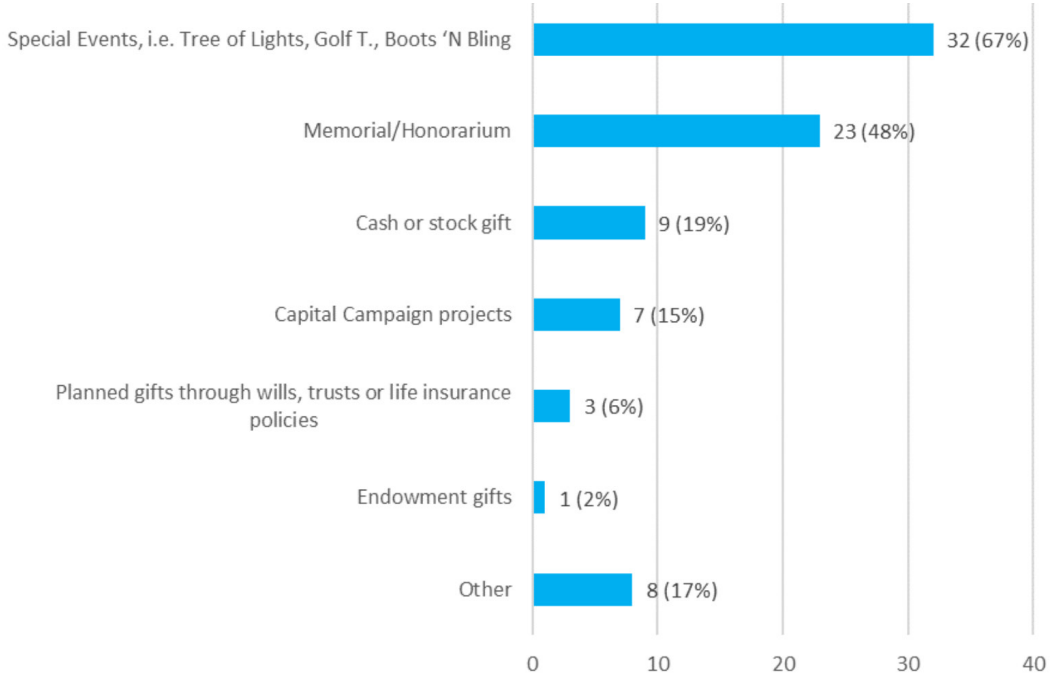
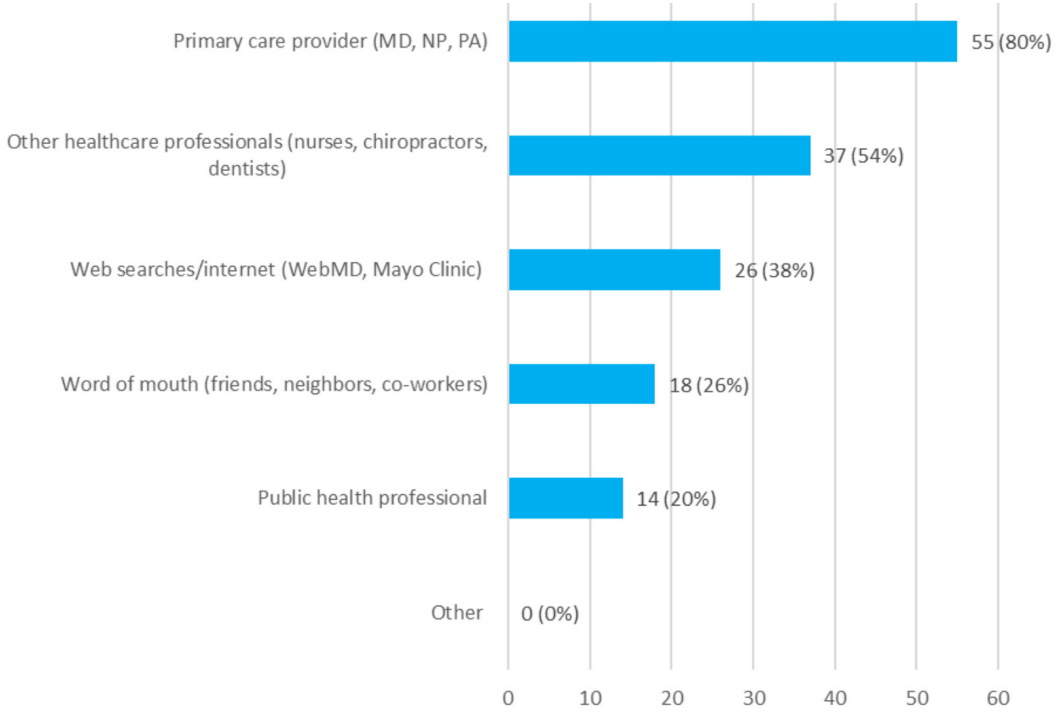
Figure 30: Means to Support the Cooperstown Medical Center Foundation
Total responses = 48



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=37), and then web/internet searches (N=26).

Results are shown in Figure 31.

Figure 31: Sources of Trusted Health Information
Total responses = 69



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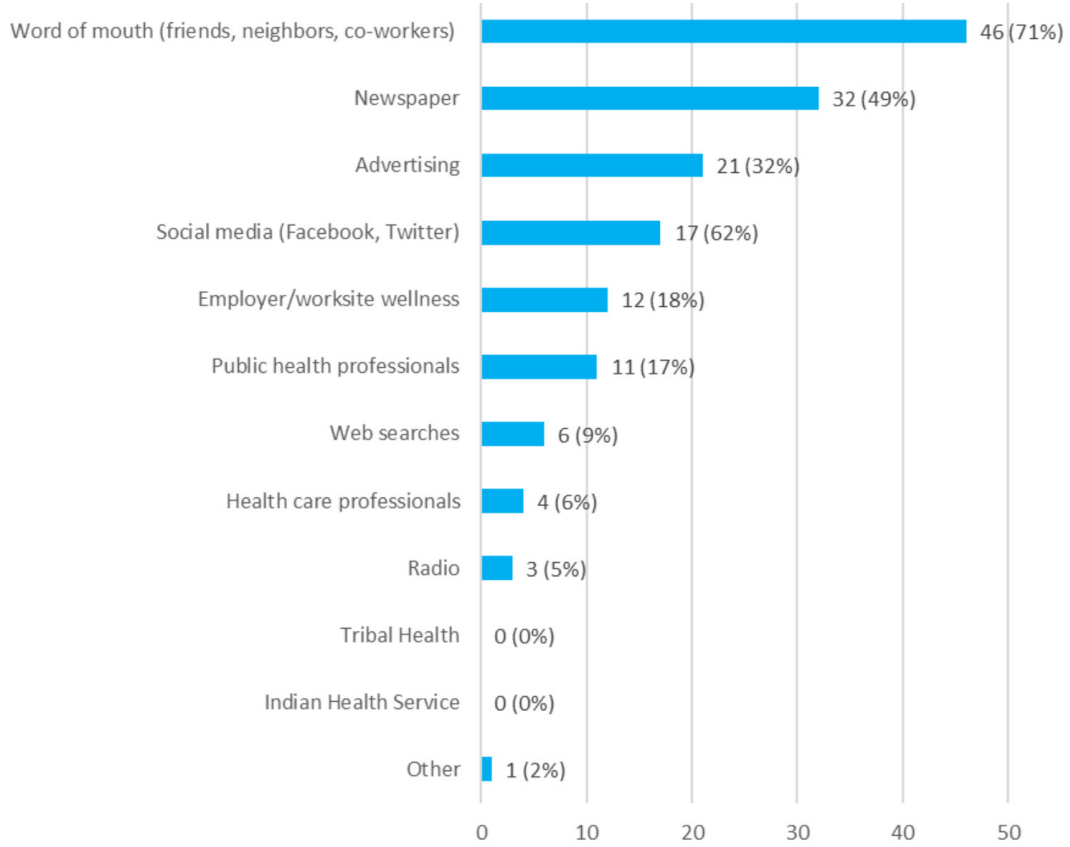
Respondents were also asked where they go to find out about local health services. Word of mouth (N=46) received the highest response rate, followed by the local newspaper (N=32). Figure 32 shows these results.

Figure 32: Sources Used to Find Out About Local Health Services
Total responses = 65



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, physicians leaving the community to practice elsewhere, and that nothing is being done to address this issue. A few respondents stated they don't use CMC for their healthcare needs and they would like to see more healthcare options available so they don't have to travel out of town so often. They said there needs to be more done to retain providers such as paying them fairly and not paying temporary help more than the people that already work there. They indicated there is a desire from community members for the hospital to recruit an MD who will live and stay in the community.

Some indicated expressed frustration with the administration related to transparency and provider retention.

Opinion was split on whether or not a building a new hospital would be beneficial to the community. Some feel the current facility is too old and outdated to be useful and the community needs to step up and get behind building a new facility. Others feel there is no need for a new building because if the proper services aren't set up and there aren't providers available, it won't change the quality of the healthcare provided.

It was suggested that there needs to be a focus on putting together an ambulance team that has the ability to provide top notch care. It was suggested that, since they are the first to see patients in a true emergency, they should be paid good wages and to provide them with the proper schooling.

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Findings from Key Informant Interviews & the Community Meeting

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

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

- Ability to retain primary care providers (MD, DO, NP, PA) and nurses in the community
- Alcohol use and abuse
- Attracting and retaining young families
- Availability of resources to help the elderly stay in their homes
- Drug use and abuse (including prescription drug abuse)

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

Ability to retain primary care providers (MD, DO, NP, PA) and nurses in the community

- Rotating door of providers makes it hard for community members to stick with one provider.
- High provider turnover in the past 2-5 years doesn't allow residents time to get comfortable with a provider before they leave, have to restart a new plan of care each time a provider leaves.
- No medical doctor on staff sends residents to other places they could see one.
- More specialists on staff at CMC are needed to cut down the inconsistency – people want to see a provider that is part of the community.
- Providers that used to work at CMC have left and taken their large following of patients with them.
- Need to host "meet and greet" with new providers so community members can get to know them.

Alcohol use and abuse

- Beer cans littered everywhere which shows how much drinking and driving is going on.
- Mental health services need to be increased to combat these issues.
- Bigger concern in youth.
- Alcohol addiction counseling needs to be added in to the community.

Attracting and retaining young families

- Child daycare services are limited.
- Large percent of the local population is elderly – no young families coming in.

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Availability of resources to help the elderly stay in their homes

- Availability of nursing home spots is limited.
- There needs to be an actual assisted living facility in the community with the appropriate level of service.
- Need more resources since a good percent of the population is elderly.
- Need more advocates for seniors – points of contact that would help seniors find services they need.
- Need more qualified service providers to help to provide home care to geriatric population.

Drug use and abuse (including prescription drug abuse)

- Larger concern for youth population.
- Mental health services need more attention to fight issues like this.
- Need more mental health programs and access.
- Would like to see addiction counseling offered in the community.
- Public Health and CMC are working to educate children in the community about the dangers of substance use.

Community Engagement and Collaboration

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

- Emergency services, including ambulance and fire (4.75)
- Long-term care, including nursing homes and assisted living (4.0)
- Hospital (healthcare system) (3.75)
- Public Health (3.75)
- Business and industry (3.5)
- Economic development organizations (3.5)
- Law enforcement (3.5)
- Pharmacy (3.5)
- Schools (3.5)
- Faith-based (3.25)
- Social Services (3.0)
- Human services agencies (2.5)
- Other local health providers, such as dentists and chiropractors (1.75)

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Priority of Health Needs

A Community Group met on December 6, 2018. There were eight community members who attended the meeting. Representatives from the CRH presented the group with a summary of this report's findings, including background and explanation about the secondary data, highlights from the survey results (including perceived community assets and concerns, and barriers to care), and findings from the key informant interviews.

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

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

- Availability of mental health services (5 votes)
- Depression/anxiety - Youth (4 votes)
- Having enough child daycare services (4 votes)
- Bullying/cyberbullying (3 votes)

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

1. Availability of mental health services (5 votes)
2. Depression/anxiety - Youth (1 vote)
3. Bullying/cyberbullying (1 vote)

Following the prioritization process during the second meeting of the Community Group and key informants, the number one identified need was the availability mental health services. A summary of this prioritization may be found in Appendix C.

Comparison of Needs Identified Previously

Top Needs Identified 2016 CHNA Process	Top Needs Identified 2019 CHNA Process
Ensure availability of emergency services	Availability of mental health services
Ability to recruit and retain primary care providers	Depression/anxiety – Youth
Jobs with livable wages	Having enough child daycare services
Adequate childcare services	Bullying/cyberbullying
Obesity/physical health	

The one common need that carried over from 2016 to 2018 was not having adequate childcare services.

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

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

Need 1: Ensure availability of emergency services – Since the last CHNA process, the quality of eEmergency services continues to strengthen with the implementation of the electronic health record, advanced equipment technologies, and with additional support services from tertiary centers like Altru, Sanford Health and Essentia.

Need 2: Ability to recruit and retain primary care providers – The community was concerned during the last CHNA process about the number of providers available and the turnover of providers. Since July 2016, the CMC has recruited one physician, a nurse practitioner, and a certified physician assistant. One nurse practitioner resigned but continues to provide locum services when needed.

Need 3: Jobs with livable wages –The steering committee decided not to address this need at this time.

Need 4: Adequate childcare services — The steering committee decided not to address this need at this time.

Need 5: Obesity/Physical health –The community was concerned with cancer, heart disease, diabetes, and wellness. In the past few years, CMC has increased emphasis on these areas through wellness clinics, diabetic education, and increased attention to preventative care and services.

The above implementation plan for Cooperstown Medical Center is posted on the Cooperstown Medical Center website at https://coopermc.homesteadcloud.com/community-health-needs-assessment

Next Steps – Strategic Implementation Plan

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

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

Community Benefit Report

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

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

- Free and discounted care to those unable to afford healthcare.
- Care to low-income beneficiaries of Medicaid and other indigent care programs.

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- Services designed to improve community health and increase access to healthcare.

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

What Are Community Benefits?

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

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

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

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

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

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Appendix A – CHNA Survey Instrument

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

Cooperstown Medical Center

Public Health
Prevent. Promote. Protect.
Nelson-Griggs
District Health Unit

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/Cooperstown18 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 Julie Reiten at 701-777-4173.

Surveys will be accepted through Oct. 7, 2018. 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) _____

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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) _____

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

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

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

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

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

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

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

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

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

_____

_____

Delivery of Healthcare

12. 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) _____

13. 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) _____

14. 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

15. 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

16. 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

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

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

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. Are you aware of Cooperstown Medical Center Convenience Clinic, open Monday – Friday from 5 – 7 pm and Saturdays 10 am – 12 pm?

☐ Yes ☐ No

20. Are you aware of Cooperstown Medical Center 's Foundation, which exists to financially support Cooperstown Medical Center?

☐ Yes ☐ No

21. Have you or would you support 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) _____

22. 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)

- ☐ Baby and child health (newborn visits, Cribs for Kids program)
- ☐ Blood pressure checks
- ☐ Breastfeeding resource and referrals
- ☐ Car seat education and referral program
- ☐ Emergency preparedness and response program (work with community partners)
- ☐ Flu shots
- ☐ 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)
- ☐ Member of Child Protection Team
- ☐ Office visits (consultation and referrals)
- ☐ School health (vision screening, health education, school immunizations)
- ☐ Substance abuse prevention (underage drinking, adult binge drinking, prescription drugs)
- ☐ Preschool screenings
- ☐ Tobacco prevention and control program (signage, policies, cessation, newsletters)

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- ☐ Tuberculosis case management
- ☐ West Nile disease program (education and surveillance)
- ☐ Worksite wellness
- ☐ Youth education programs (Progressive Ag Safety Day)

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

_____

_____

Demographic Information: Please tell us about yourself.

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

☐ Yes ☐ No

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

- ☐ Indian Health Service (IHS)
- ☐ Insurance through employer
- ☐ 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. Gender:

- ☐ Female
- ☐ Male
- ☐ Transgender

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: _____
- ☐ Prefer not to answer

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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
- ☐ Prefer not to answer

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

_____

_____

Thank you for assisting us with this important survey!

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Appendix B – County Health Rankings Explained

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

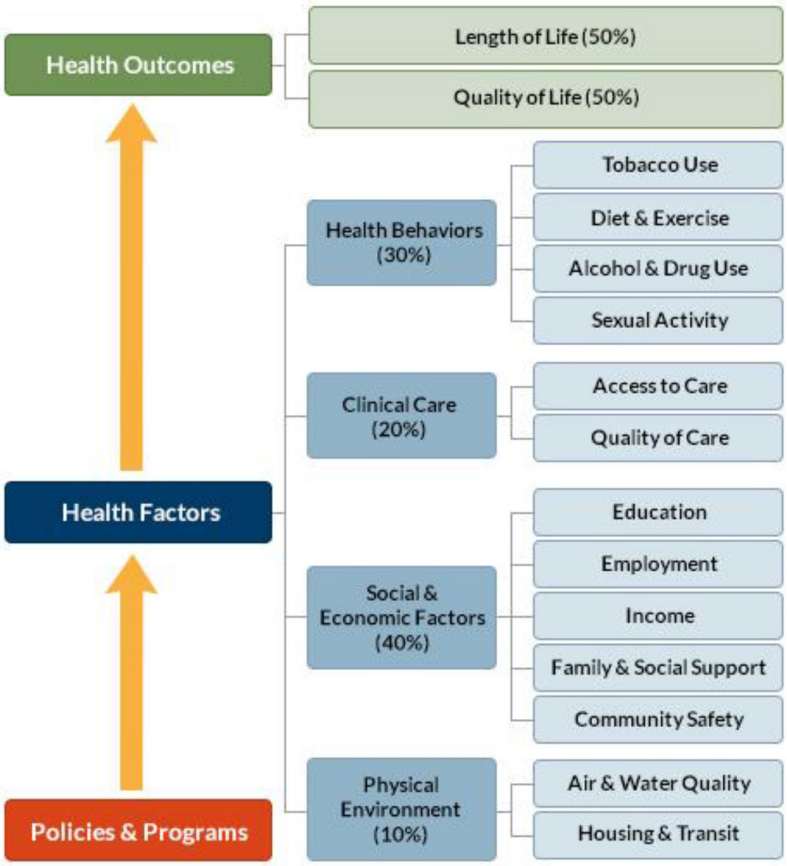
Methods

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

What is Ranked

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

Ranking System



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

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

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

Data Sources and Measures

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

Data Quality

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

Calculating Scores and Ranks

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

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Health Outcomes and Factors

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

Health Outcomes

Premature Death (YPLL)

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

Reason for Ranking

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

Poor or Fair Health

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

Reason for Ranking

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

Poor Physical Health Days

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

Reason for Ranking

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

Poor Mental Health Days

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

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

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

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

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

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

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

Health Factors

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

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

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

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

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Food Environment Index

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

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

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

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

Reason for Ranking

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

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

Physical Inactivity

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

Reason for Ranking

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

Access to Exercise Opportunities

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

Individuals who:

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

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

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

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

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

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

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

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

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

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

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

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

Uninsured

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

Reason for Ranking

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

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

Primary Care Physicians

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

Reason for Ranking

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

Dentists

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

Reason for Ranking

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

Mental Health Providers

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

Reason for Ranking

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Injury Deaths

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

Reason for Ranking

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

Air Pollution-Particulate matter

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

Reason for Ranking

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

Drinking Water Violations

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

Reason for Ranking

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

Severe Housing Problems

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

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

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

Reason for Ranking

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

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Appendix C – Prioritization of Community's Health Needs

Community Health Needs Assessment

Cooperstown, North Dakota

Ranking of Concerns

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

	Priorities	Most Important
COMMUNITY/ENVIRONMENTAL HEALTH CONCERNS		
Attracting & retaining young families	0	
Not enough jobs with livable wages, not enough to live on	0	
Changes in population size (increasing or decreasing)	0	
Having enough child daycare services	4	0
Recycling	0	
Crime and safety, adequate law enforcement personnel	1	
AVAILABILITY/DELIVERY OF HEALTH SERVICES CONCERNS		
Availability of dental care	2	
Availability of vision care	1	
Ability to get appointments within 48 hours	0	
Emergency services	0	
Extra hours for appointments, such as evenings and weekends	0	
Ability to retain primary care providers (MD, DO, NP, PA) and nurses	1	
Availability of mental health services	5	5
YOUTH POPULATION HEALTH CONCERNS		
Not getting enough exercise/physical activity	0	
Depression/anxiety	4	1
Alcohol use and abuse	1	
Drug use and abuse (including prescription drug abuse)	0	
ADULT POPULATION HEALTH CONCERNS		
Cancer	1	
Alcohol use and abuse	1	
Diabetes	0	
Dementia/Alzheimer's disease	1	
Drug use and abuse	0	
SENIOR POPULATION HEALTH CONCERNS		
Being able to meet needs of older population	0	
Assisted living options	0	
Cost of long-term/nursing home care	2	
Availability of resources to help elderly stay in their homes	0	
Ability to meet needs of older population	0	
VIOLENCE CONCERNS		
Bullying/cyberbullying	3	1
Child abuse/neglect	1	
Emotional abuse	0	
Domestic/intimate partner violence	0	

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Appendix D – Survey "Other" Responses

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

1. Considering the PEOPLE in your community, the best things are: "Other" responses:
    - I don't see this as a very open minded community
    - Safe
2. Considering the SERVICES AND RESOURCES in your community, the best things are: "Other" responses:
    - Nothing
    - Senior activities
    - There are none of these options in my community
3. Considering the QUALITY OF LIFE in your community, the best things are: "Other" responses:
    - Feel several of these do not apply anymore
4. Considering the ACTIVITIES in your community, the best things are: "Other" responses:
    - None of these
    - Not much available
    - Nothing
    - School activities

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:
    - Local government cutting out services
6. Considering the AVAILABILITY/DELIVERY OF HEALTH SERVICES in your community, concerns are: "Other" responses:
    - Local services are not used ever by employers of GCCC
    - Money spent by facility over the years on survey
    - Wonderful satellite clinic open 2-3 days in our little community.
8. Considering the YOUTH POPULATION in your community, concerns are: "Other" responses:
    - Chiropractic care
9. Considering the ADULT POPULATION in your community, concerns are: "Other" responses:
    - Insurance information at 1 on 1 levels
10. Considering the SENIOR POPULATION in your community, concerns are: "Other" responses:
    - Elder abuse in nursing home
    - Insurance info

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

- A decent wage per job
- A declining population and the need to maintain our local businesses and add businesses to attract people
- Affordable housing
- Availability of services to keep elderly/disabled in their home
- Awesome providers and nurses that have on because of the administrator!
- Big farming - losing the family life associated with small area farms and decreasing population in counties
- Controversy about new hospital building
- Decreasing population
- Getting an MD - full time
- Getting good, reliable, passionate medical doctors and providers to come here and stay here. It is concerning that the hospital board settles for sub-par providers because it is so hard to get good doctors for rural areas.
- Increasing elderly population with declining young population
- Lack of meals
- Letting more businesses in
- Loss of businesses; access to local services; retention of healthcare providers
- Not enough social resources
- Obesity
- Poor wages and lack of employable people
- Providing for all the needs of community- housing, road repair, jobs, services, school with limited funds
- Retaining population
- Retaining population to support the services we need.
- Spending dollars and not keeping things up. Do foresight and won't listen to common sense. Being able to work with large facilities. I know very few who use GCC as their primary medical anymore.
- The fool idea of building a multi-million dollar hospital that will never be viable!
- The loss of all of our young people.
- We have a healthcare facility that is old and failing. It is very difficult to provide the care required now and in prospectively, in the future as we do not have room to expand our current building in order to incorporate the necessary equipment for diagnostics in order to keep our facility relevant as new technology becomes available for healthcare. Our community is at least a 40 minute drive from any other healthcare facility. We must be able to care for our community members here in both emergent and non-emergent situations. A healthcare facility in this community is vital. Due to our inability to provide certain diagnostic services on a daily basis, is one reason why it is difficult to attract and retain healthcare practitioners.

Delivery of Healthcare

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

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

- A provider that does something for the reason why you came to the ER or Clinic
- Chiropractic
- CT on site
- Dental and vision
- Dental care
- Dental, vision, chiropractic, massage, podiatrist, heart specialist, pulmonologist, MDs- not just PAs or NPs

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- Dentist, vision care, CT in house
- Diagnostics daily, such as a CT scanner would be wonderful; it would be nice to have chiropractic services available on a daily basis. More specialists making visits to Cooperstown as we have found Telehealth to be difficult at times. More mental health training for healthcare personnel.
- I'd like to see them being able to do CT scans here rather than send people off for them.
- More in home services- light housekeeping, reviewing chronic illness/monitoring in home
- None with the current population
- Time, effort, and money upgrading nursing home/assisted living and kitchen heating and cooling system to those areas- Stop focusing on hospital
- Urology
- Vision
- Vision, dental, chiropractor
- Vision, dental, CT, better/more wellness offerings
- We have no chiropractic - dental - eye care in county
- Went to ER - did not seem equipped to help - could not transfer as Altru-Sanford-Essentia- wouldn't accept our ambulance. Had to drive to Jay to be hospitalized.

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

- Lack of continuity of care, not seeing a consistent provider
- My doctor is in Northwood
- No naturopathic provider
- Try to add services that are too expensive for our hospital i.e. colonoscopy

17. Where do you turn for trusted health information? "Other" responses:

- Pharmacist

18. Have you or would you support the Cooperstown Medical Center Foundation in any of the following ways? "Other" responses:

- Absolutely not!
- Bad experience in past donating - money poorly used
- No
- No
- No support
- No way
- None
- Use of hospital

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

- Better quality care in Nursing Home.
- Can't keep healthcare providers and nurses don't get paid fairly. Having too much temporary help that gets paid a lot more than our people already working there. Why wouldn't we pay our people more so they stay here?
- Close the hospital and maintain only a clinic on a part time basis
- CMC needs a full time MD
- Complete makeover
- Do not need new hospital!!
- Finding and retaining mid-level or higher healthcare providers that want to live in the community
- I am concerned we stay as an axillary hospital, but with no doctor, short staff - we do not need to

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expand. I can't believe we need a new facility (It feels as the courthouse we do not take care of our buildings) (Looking at neighboring cities - buildings are older and they are not being closed by the state)

- I believe the Cooperstown Medical Center and Griggs County Care Center is a joke and will never utilize their so called services.
- I don't use CMC for our family's healthcare. But we need a doctor at CMC very badly! And need to keep and retain our HCPs.
- I would like CT scan services in clinic to be available to physicians every day.
- Loss of population base - in rural farm community. It is a systemic problem in all of ND. How to support close in healthcare services with no population growth, you can't sustain healthcare providers in each and every small town. Average age keeps increasing as younger adults move out of area with their children.
- Need new building
- Not certain this survey will initiate any change. I think the sole purpose of this survey is related to question 21, to identify the level of financial support the community is able/willing to provide for the new hospital. A new building will not improve available healthcare if the services aren't set up properly or not available at all.
- Over the years, Griggs County has moved from one-room schools, to busing to small towns, to just one school with all 12 grades in one place. Each town in Griggs County, at one time had its own doctor and now we are unable to have a full time doctor in just one town. The writing is on the wall as the saying goes- time to move on and focus on elderly care as our population is older. Having a hospital, keeping it up to code is beyond the residents of Griggs ability to pay for regardless of the grants etc. to get one built- who can afford to keep it up? Better to spend money on a top notch EMT team that will get you to a hospital (Jamestown, Grand Forks, Fargo) without wasting time getting x-rays/test locally that just get repeated when they send you to a bigger hospital. Focus on top notch ambulance team that can get you where you need to be and has the services you need. Only those that live in Cooperstown have the plus of a local hospital. Those that are rural will have to drive to see family in a hospital setting and like many would rather go to a bigger town to do so where we know the facility has more up to date equipment and staff who have patients all the time with more variety of illness etc. than the knee, hip, cold, etc. care Cooperstown has to offer. Work on paying EMTs a good wage- providing schooling for them as they are the first you see in a true emergency.
- Provider consistency, follow-up (results etc.) Transparency from administration on what's happening with the facility - not just giving out lip-service to impress people.
- Staff retention, support from management, provider recruitment/retention
- The medical facility is rapidly falling apart. As a community we need to come together and work make a new facility happen. One that is more functional than beautiful and is supported by the community.
- To have medical providers here that know what they are doing and not be grabbing at straws in an emergency situation. To have more healthcare options here so there isn't so much traveling out of town.
- We must be aware that approximately 40 percent of the people in our community are using another healthcare facility within our county.
- We would appreciate having a family full time doctor of medicine living in community

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