Hills & Dales General Hospital

2016 Community Health Needs Assessment

A Report to the Community

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Executive Summary

This report is a primary data source that complements other primary and secondary data sources collected by Hills & Dales General Hospital for its 2016 Community Health Needs Assessment. The primary data contains information from the Thumb CHNA Collaboration Community Health Survey developed and distributed by hospitals and public health departments in Huron, Sanilac, and Tuscola Counties. Hills & Dales distributed surveys in nine ZIP codes in its service area. Hills & Dales also held a focus group of 9 women and 3 men. They represented community members, hospital board and auxiliary members, mental health care provider, school district, retired employee, and ministry/faith community. Ages ranged from mid/late 30s-to retired. Key stakeholder interviews were held with five individuals from five organizations.

The survey findings are based on the responses of 375 individuals, four-fifths (80.7%) of whom were female. well educated (59.7% with some college degree), and nearly one-third (30.7%) with household incomes of $75,000 or more.

The survey covered five areas of concerns: community's health, quality of life, availability of health services, safety and environment, delivery of health services, and vulnerable populations (seniors, females, low education, and low income). It also asked about preventing access to care. Many concerns were about access to and availability of health care providers and the costs of health care.

Survey respondents were also concerned about access to healthy food, jobs, attracting and retaining young families, public transportation, water quality, crime and safety. With respect to vulnerable populations, respondents were concerned about (a) youth obesity, drug and substance abuse, and bullying, and (b) the availability of support services and transportation for seniors. Low income respondents desired affordable housing and availability of dental and vision care.

Focus group members perceived a lack of affordable dental care and substance abuse counseling/education for both children and parents. They identified six groups as being medically underserved: the elderly, lower middle income, those with mental health issues, the Amish, preschool and kids, and young adults.

Focus group members thought most people use Hills & Dales because of its location and providers/staff, but used other providers because Hills & Dales lacked specialties and resources.

The stakeholder interviewees indicated that a lack of transportation, especially for health and medical needs as a major challenge. They were concerned about the availability of mental health services, youth obesity and youth substance use and abuse, and the availability of resources for caring for the elderly.

The stakeholders perceived a lack of trust in the local Tuscola county hospitals but held the county health department in high esteem. They wanted the providers to become more involved with the community and collaborate to get information out about services. It was not reported that these views pertained to Hills & Dales General Hospital specifically.

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Background and Overview

Background

Hills & Dales General Hospital is designated as a Critical Access Hospital (CAH). The Medicare Rural Hospital Flexibility Program (Flex Program), created by Congress in 1997, allows small hospitals to be licensed as Critical Access Hospitals and offers grants to States to help implement initiatives to strengthen the rural health care infrastructure.

Critical Access Hospital (CAH) Designation

A Medicare participating hospital must meet the following criteria to be designated as a CAH:

- Be located in a State that has established a State rural health plan for the State Flex Program;
- Be located in a rural area or be treated as rural under a special provision that allows qualified hospital providers in urban areas to be treated as rural for purposes of becoming a CAH;
- Demonstrate compliance with the Conditions of Participation (CoP) relevant to 42 CFR Part 485 Sub-part F at the time of application for CAH status;
- Furnish 24-hour emergency care services 7 days a week, using either on-site or on-call staff;
- Provide no more than 25 inpatient beds that can be used for either inpatient or swing bed services; however, it may also operate a distinct part rehabilitation or psychiatric unit, each with up to 10 beds;
- Have an average annual length of stay of 96 hours or less per patient for acute care (excluding swing bed services and beds that are within distinct part units); and
- Be located either more than a 35-mile drive from the nearest hospital or CAH or a 15-mile drive in areas with mountainous terrain or only secondary roads OR certified as a CAH prior to January 1, 2006, based on State designation as a "necessary provider" of health care services to residents in the area.

Hills & Dales General Hospital: Mission Vision, and Values

Mission

To be the provider of choice and the employer of choice in our primary market.

Vision

To be the premier critical access hospital in Michigan.

Our Commitment

At Hills & Dales, we are constantly striving to provide the highest quality of services for you– the patient.

Our Values

Customer Service

Our reputation is determined by the service we provide to our customers, physicians, and co-workers. We are committed to exceeding their expectations by going the extra mile. Our customer is defined as patients, their families or friends, co-workers, physicians, and vendors.

Respect

We will treat our customers with dignity and respect.

Teamwork

We are a team committed to excellence and helping each other be accountable to our mission and values. We practice team together and team apart and empower er people to make decisions that promote our success.

Attitude
We believe that each of us controls our own attitude and that what is important is not so much what happens to us, but how we choose to react to it. We believe we must recruit, retain, and reward people who make a positive difference in people's lives.

Continuous Improvement
We believe in continuous improvement and recognize that everything we do is a process that can be eliminated, simplified, or standardized. We must continue to grow and learn in order to provide better outcomes than our competition.

Fun

We believe we can and should have fun at work.

Services offered by Hills & Dales General Hospital:

- 24 hour Emergency Room Service
- After Hours Clinic
- 25 Inpatient Beds
- Swing Bed Program
- Lab Services
- X-Ray
- Ultrasound
- 128-slice CT Scanner
- Nuclear Medicine
- Bone Density Testing
- Digital State-of-the-Art Mammography
- Respiratory Therapy
- Pulmonary Rehabilitation
- Sleep Studies (both at Hills & Dales or in the comfort of your own home)
- Physical Therapy
- Occupational Therapy
- Speech Therapy
- Fitness Program
- Oncology Rehabilitation
- Community Education
- Speakers Bureau
- Occupational Health
- DOT Services
- Medical/Surgical Services
- Orthopedic and General Surgeon on staff
- Diabetes Education
- Certified Infusion Room
- State-of-the-Art Operating Rooms
- Support groups including Better Breathers, Cancer Support Group, and Diabetes Support Group
- Specialty Clinic
- Hospital Drive Pharmacy

What is a Community Health Needs Assessment?

The first step in meeting community needs is identifying the needs. Using an objective approach helps ensure that priorities are based on evidence and accurate information. The assessment process used by Hills & Dales General Hospital included a trifecta approach of reviewing three sources of primary data. In the trifecta approach, when there

are three sources of data that illustrate a need, there is a greater likelihood that addressing that need will produce a powerful impact.
Three methods were used to collect primary data:

- Surveys: Surveys were distributed to 9 ZIP codes in the hospital's service area. The survey was also posted online using www.surveymonkey.com.
- Focus Groups: The hospital held one focus group of 3 men and 9 women was held on May 11, 2016. They represented community members, hospital board and auxiliary members, mental health care provider, school administration, school health provider, retired employee, ministry/faith community. Ages ranged from mid/late 30s-to retired. They were invited to participate by the hospital staff (Kathy Dropeski and Danielle Blaine). . The facilitator followed a script (see Appendix E) and engaged the group in several procedures including asking participants to review and comment on a list of potential health concerns that may affect the community as a whole; using post it notes on an easel pad or wall; and group discussion/ brainstorming.
- Key Stakeholder Interviews: A county level committee selected key organizations and individuals for stakeholder interviews. Phone interviews were held with five individuals from chosen Tuscola County organizations: Tuscola County Government, Tuscola Behavioral Health Systems, Human Services Collaborative, Tuscola/Huron County DHS, and Huron Department of Health and Human Services.

In addition to the primary data, secondary data was reviewed for comparison to state rates and across counties located in the Thumb. This data was organized into a Thumb report card. Primary and Secondary data analysis was the first component of the CHNA process. The next step in the CHNA process was a prioritization process and an implementation meeting. Once priorities were selected, there was an assessment of existing services and programs. This assessment was used to identify gaps in services and develop strategies to address the priority needs. These strategies are then organized into an implementation plan and progress will be monitored.

This is the second cycle of Community Health Assessment and Planning. The first cycle was completed in 2012-2013. The process is intended to be completed on a three year cycle that aligns with Affordable Care Act requirements. The 2016 CHNA report includes a review of the 2013 implementation plan and progress toward targets.

Why is a Community Health Needs Assessment valuable?

Most experts agree that there are many challenges facing healthcare today. Rapidly changing technology, increased training needs, recruiting medical professionals, and responding to health needs of a growing senior citizen population are just a few of the most pressing challenges. These challenges occur at a time when resources for families and healthcare providers are stretched. These conditions make the Community Health Needs Assessment (CHNA) process even more critical. A CHNA helps to direct resources to issues that have the greatest potential for increasing life expectancy, improving quality of life, and producing savings to the healthcare system.

Background and Acknowledgments

In August 2015, the Michigan Center for Rural, Hospital Council of East Central Michigan, and Thumb Rural Health Network convened a discussion group around the CHNA process in Huron, Sanilac, and Tuscola Counties. This region, often referred to as the Thumb of Michigan, includes eight hospitals and three public health departments. In December 2015, area Hospitals and Health Departments invited representatives from the Center for Rural Health (CRH), University of North Dakota, School of Medicine & Health Sciences to present their method for conducting CHNAs in rural areas. At the end of this training all the hospitals and health departments decided to collaborate using a standardized process for a regional Community Health Needs Assessment. All organizations agreed to develop and administer a survey of community members and use the same set of questions and processes for focus groups and key stakeholder interviews.

Each hospital received results specific to their organization, utilizing data from their service area based on the ZIP code of survey respondents. Individual hospitals utilized findings from the survey, focus groups and key stakeholder interviews for their local CHNA. The use of a common survey instrument, focus group and interview schedules will permit aggregating the hospital data by county and by the three county Thumb region. This will enable cooperative initiatives within counties and the region.

Needs Assessment Process

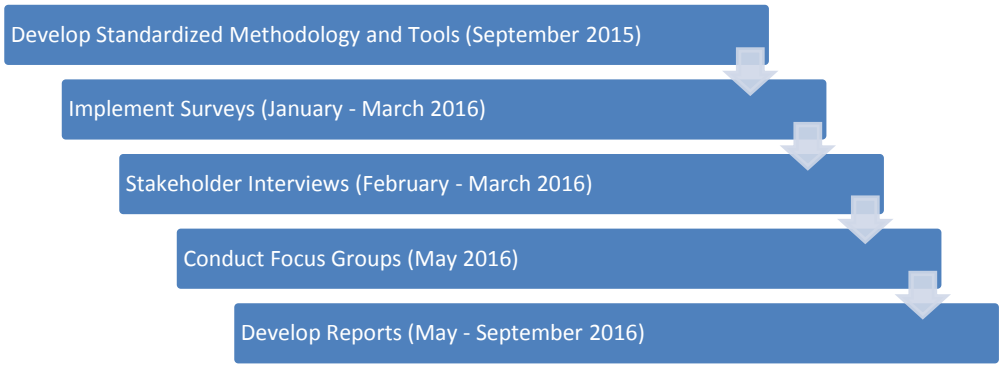
Process Overview

Steps in Process

In December 2015, the members of the Thumb CHNA Collaboration received training from the University of North Dakota on best practices in the field of Community Health Needs Assessment. Based on this training a process was developed for the Thumb Area that would allow for consistent data collection. This consistent data collection would allow for county and regional aggregation of data. In addition to the local hospital plans and activities, this process would allow for greater impact of countywide and regional projects and initiatives. The process was developed based review of the University of North Dakota Model[1]:

- Step 1: Establish a local and regional timeline
- Step 2: Convene county teams to manager logistics of assessment activities
- Step 3: Develop and administer Survey Instrument*
- Step 4: Design and implement Community Focus Groups in local hospital communities*
- Step 5: Design and implement Key Stakeholder Interviews or county agencies*
- Step 6: Produce localized hospital reports based on survey zip code data, local focus groups, and county interview data
- Step 7: Local hospitals hold Implementation Planning Meetings
- Step 8: Local hospitals prepare a written CHNA Report and Implementation Plan
- Step 9: Production of county and regional reports
- Step 10: Convene county and regional meetings to review reports
- Step 11: Monitor progress

Timeline



* In order to utilize the trifecta model, these three data collection methods were consistent in scope and question topics.

Representing the Community and Vulnerable Populations

Define the Community Served

Tuscola County is a rural county located in the Thumb of Michigan. A population of 54,000 resides in Sanilac County. The following charts showcase characteristics of the population.

Demographic Indicator	Michigan	Huron	Sanilac	Tuscola
Population	9,909,877	32,065	41,587	54,000
% below 18 years of age	22.40%	19.60%	22.20%	21.40%
% 65 and older	15.40%	23.40%	19.50%	18.30%
Non Hispanic African American	13.90%	0.50%	0.50%	1.20%
% American Indian and Alaskan Native	0.70%	0.40%	0.60%	0.60%
% Asian	2.90%	0.50%	0.40%	0.40%
% Native Hawaiian/Other Pacific Islander	0.00%	0.00%	0.00%	0.00%
% Hispanic	4.80%	2.10%	3.70%	3.30%
Non Hispanic White (below Hispanic	75.80%	95.70%	94.10%	93.70%
% Not Proficient In English (2014)	1%	0%	0%	0%
% Females	50.90%	50.50%	50.40%	49.90%
% Rural	25.40%	89.50%	90.20%	84.20%

Education Levels

Indicator	Michigan	Huron	Sanilac	Tuscola
High School Graduation**	78%	90%	87%	80%
Some College	66%	54%	52%	57%

Household Income.

Indicator	Michigan	Huron	Sanilac	Tuscola
Median Household Income	$49,800	$41,700	$42,100	$43,200

Poverty Rates

Indicator	Michigan	Huron	Sanilac	Tuscola
Children in Poverty: under age 18 living in poverty	23%	21%	23%	24%
ALICE level: household above poverty level, but less than the basic cost of living for county	NA	27%	27%	22%
Poverty Rate – US Census	16.9%	15.5%	15.6%	15.3%

Unemployment

Indicator	Michigan	Huron	Sanilac	Tuscola
Unemployment	7.30%	6.80%	8.40%	8.50%

Common Occupations and Industries

- Health care and social assistance
- Manufacturing
- Retail trade
- Education services
- construction

Uninsured rates

Indicator	Michigan	Huron	Sanilac	Tuscola
Uninsured	13%	15%	15%	14%
Uninsured adults	16%	18%	19%	18%
Uninsured children	4%	6%	6%	4%

Surveys and Focus Groups

Distribution of surveys was intentionally planned to include individuals from vulnerable population groups such as senior citizens, under-resourced families, veterans, youth and women. Data analysis included cross tabulation of results for vulnerable populations. Hospitals invited a variety of individuals that represented multiple sectors of industry, age, and health conditions for the focus group.

Vulnerable Populations Represented in Survey Findings	
Indicator	**Respondent Demographics**
Age	Respondents were asked their year of birth which was then recoded into quartiles. Of the valid cases, 24.4% were 36 or younger, 25% between 37 and 49, 24.4% between 50 and 58, and 26.2% were 59 or older.
Gender	Four-fifths (80.7%) of the respondents were female.
Children	Two-fifths (41.7%) of households had children under 18
Education	About one-fifth (18.8%) had a high school diploma or less, 21.5% some college, 17.4% a technical/jr college degree, 22.1% a bachelor's degree and 20.0% a graduate or professional degree.
Employment Status	Three-fifths (60.9%) worked full time, 10.0% worked part time and 3.1% held multiple jobs. Retirees accounted for 10.5%.
Household income	A little over one-fifth (22.7%) reported incomes $24,999 or less; about one-fifth (20.6%) between $25,000 and $49,999, one quarter (26.1%) between $50,000 and $74,999 and nearly one third (30.7%) $75,000 or more. About 15% preferred not to report their household income.
Health Insurance	Almost three-fifths (58.4%) had health insurance through an employer or union, 13.7% were on Medicare, 9.8% on Medicaid, and 7.8% individually purchased a plan. Only 1.2% reported not having any health insurance

Healthcare/Social Service Organizations Providing Input

Participants in stakeholder interviews were chosen based on their expertise in serving vulnerable populations and their experience with community issues. Organizations were chosen by each county level committee and varied slightly by county.

Five individuals were interviewed, four were from Tuscola County organizations and the fifth from Huron County Department of Health and Human Services who has worked closely with Tuscola County.,

The individuals interviewed agreed to participate and gave permission to use their name in a list of individuals participating in interviews but were assured that their responses would not be connected to their name.

Kay Balcer, of Balcer Consulting and Prevention Services conducted the interviews in person, and Sara Wright of Michigan Center for Rural Health took notes via phone. The interview followed a similar script as was used for the focus groups (see Appendix G). The interviewees, their titles and organizational affiliations are listed below.

Stakeholders Interviewed

Name	Title	Affiliation
Christine Trish	County Commissioner	Tuscola County Government
Sharon Beals	Chief Executive Officer	Tuscola Behavioral Health Systems
Susan Walker	Coordinator Past President	Human Services Community Collaborative Tuscola County Community Foundation
Karen Southgate	Program Manager	Tuscola/Huron County DHS
Julie Booms	Family Independence Manager	Huron Dept of Health and Human Services

Consultants

During the process various consultants were utilized to manage the workflow and ensure consistency including:

- → Balcer Consulting & Prevention Services, Kay Balcer: Overall project coordination and facilitation, stakeholder interviews, template development.
- → Michigan Center for Rural Health, Crystal Barter and Sara Wright: Notetaking, and coding of focus group and interview responses.
- → Institute for Public Policy and Social Research, Michigan State University: Paper survey processing, coding of survey data, and production of statistical data for analysis.
- → Independent Consultants, Harry Perlstadt, PhD, MPH and Travis Fojtasek, PHD: Data analysis and reports

Some hospitals also chose to contract with Balcer Consulting or Michigan Center for Rural Health for focus group facilitation, facilitation of implementation meetings, and preparation of the CHNA report and implementation plan. Questions about the CHNA project and requests for documents can be made by contacting Kay Balcer at 989-553-2927 or balcerconsulting@gmail.com .

2013 CHNA Progress

2013 CHNA Plan Progress

In 2013, the Community Health Needs assessment priorities identified by Hills & Dales General Hospital included:

- Heart disease
- Lack of Physicians
- Cancer
- Dental
- Access and affordability
- Obesity
- Diabetes
- Transportation
- Mental health

Implementation strategy:

- Comprehensive: Increase Lunch & Learns; intentionally target male population
  Update: Many males in target population work during the day, and are not able to attend a lunch-time meeting. Special effort is made to reach out to males with health screening events, such as PSA antigen blood tests offered during health fairs, and presents a display in the hospital lobby during Prostate Cancer Awareness month.
- Obesity Specific: Sponsor/support area run/walk events; work with city leaders to improve Cass City Walking Trail; work with Cass City officials to expand Farmers Market; investigate feasibility of including locally grown produce in system menu.
  Update: Hills & Dales General Hospital has hosted the annual Freedom Fest 5K/8K Run, 5k Walk and Toddler Trot for the last 20 years, with increasing attendance every year. The Cass City Walking Trail has been well-maintained by the village. The Farmer's Market continues to operate in the village successfully. The ability to offer locally-sourced produce in the system menu has not proven feasible at this time, but will be investigated as opportunities arise.
- Diabetes Specific: 11.2% responded that diabetes is one of the top three most serious health concerns; Hills & Dales will seek to expand Diabetes Support Group and Diabetes Education program.
  Update: The Diabetes Education Program referrals have grown by an average of 20% per year. The Diabetes Support Group has maintained strong attendance and continues to meet on a monthly basis.
- Cancer Specific: leading cause of Tuscola County deaths; Hills & Dales will seek to increase various cancer screenings; will investigate feasibility of tobacco-free campus; measure number of cancer diagnosed patients who cannot afford proper medications.
  Update: A member of the Rehabilitation Staff sits on the Board of Directors for the Michigan Cancer Consortium. The hospital provides all of the standard cancer screenings, i.e. colonoscopy, mammography, PSA blood tests, etc. and in 2016 added CT scan screening for lung cancer. Tobacco-free campus remains a possibility, although tobacco usage on campus is exceedingly low. There is currently no way to track inability of patients to afford cancer medications. The Social Work Department is available to assist patients with finding resources to pay for medications.

- Heart Disease Specific: 2nd leading cause of Tuscola County deaths; Hills & Dales will offer low-cost health screenings; evaluate purchase of mobile stress-test unit.
  Update: Low-cost community cholesterol screenings are offered twice a year. A mobile stress-test unit has not proven necessary at this point.
- Access & Affordability Specific: community respondents rated this number one most important item; Hills & Dales will continue to offer financial assistance and advice as appropriate; evaluate and adjust if necessary hours of operation; evaluate feasibility of office space redesign.
  Upate: Office spaces have been rearranged to offer maximum capacity, and the future building project will further expand space available. Hours of operation are carefully evaluated and adjusted as necessary, and the After Hours Clinic offers evening and weekend hours to meet urgent care needs outside of normal weekday hours. The hospital has a patient accounting representative available in the front desk area for patients to discuss financial assistance and payment plans. The Social Work Department assists patients and provides referrals for inpatients requiring resources.

CHNA Methodology

Surveys:

Sample/Target Population: The Thumb CHNA Collaboration members decided to use non probability sampling, combining convenience sampling with purposive (judgmental) sampling. In a convenience sample respondents can be anyone who happens to come into contact with the researcher or has access to the survey. This could range from people on a street corner or in a mall to those who come across the survey on- line. Since each hospital used the same survey methodology, the results can be analyzed and compared. Although the findings cannot be generalized, they can point out common needs and solutions.

Table 1: Demographic highlights of Survey Respondents	
Age	Respondents were asked their year of birth which was then recoded into quartiles. Of the valid cases, 24.4% were 36 or younger, 25.0% between 37 and 49, 24.4% between 50 and 58, and 26.2% were 59 or older.
Gender	Four-fifths (80.7%) of the respondents were female.
Marital Status	Two-thirds (66.2% were married or remarried
Children	Two-fifths (41.7%) of households had children under 18
Education	About one-fifth (18.8%) had a high school diploma or less, 21.5% some college, 17.4% a technical/jr college degree, 22.1 a bachelor's degree and 20.2% a graduate or professional degree.
Employment Status	Three-fifths (60.9%) worked full time, 10.0% worked part time and 3.1% held multiple jobs. Retirees accounted for 10.5%.
Health Sector	Three-eighths(37.2%) worked for hospital, clinic or public health dept.
Race	92.7% self identified as White/Caucasian
Household income	A little over one-fifth (22.7%) reported incomes $24,999 or less; about one-fifth (20.6%) between $25,000 and $49,999, one-quarter and between one between $50,000 and $74,999 (26.1%) and nearly one-third (30.7%) $75,000 or more. About 15% preferred not to report their household income.
Health Insurance	Almost three-fifths (58.4%) had health insurance through an employer or union, 13.7% were on Medicare, 9.8% on Medicaid and 7.8% individually purchased a plan. Only 1.2% reported not having any health insurance
Hospitals used past 2 years	Hills & Dales Hospital was the most frequently used hospital with 43.4% of the respondents reporting they used it in the past two years. This was followed by Huron Medical Center in Bad Axe (24.0%), Caro Community Hospital (21.7%) and Covenant Hospital in the Saginaw area (20.2%).
ZIP Codes	Of the 9 Zip codes, almost one-third (29.3%) of respondents lived in 48726 Cass City and a little over one-quarter (27.5%) lived in 48723 Caro.

Survey Instrument and Procedures: The survey instrument contained 34 questions covering Community Assets, Community Concerns, Delivery of Health Care and Demographic Information (Appendix A). The survey was printed and posted online. Each county developed a distribution list identifying public locations for envelopes and surveys. Surveys were also distributed at meetings and at the end of focus groups. Printed surveys could be left in drop boxes or mailed in to the Institute for Public Policy and Social Research (IPPSR) at Michigan State University. The on-line version of the survey was posted at www.surveymonkey.com. Survey links were included in press releases and regional promotion efforts. Links were distributed by direct email and forwarded to hospitals and service providers who could forward it to their staff and their email patient base. Surveys were entered and data sets prepared by IPPSR. Data were analyzed using the Statistical Package for the Social Sciences (SPSS) Version 20 multiple response sets frequencies and cross-tabulations.

Focus Groups:

Focus groups were conducted in a standard format across the three counties. The facilitator followed a script (see Appendix E) and engaged the group in several procedures including asking participants to review and comment on a list of potential health concerns that may affect the community as a whole; using post it notes on an easel pad or wall; and group discussion/ brainstorming. Focus group notes were recorded and coded by the Michigan Center for Rural Health (MCRH) with summaries provided for analysis.

A focus group was held on May 11, 2016 at Hills & Dales General Hospital. Twelve community members participated. They were invited to participate by the hospital staff.

Participants included 9 men and 3 women, representing community members, hospital board and auxiliary members, mental health care provider, school district, retired employee, and ministry/faith community.. Ages ranged from mid-thirties to retired.

Stakeholder Interviews:

The Tuscola county committee selected five organizations for input and suggested an individual at these organizations. The individuals interviewed agreed and provided consent to participate and have their name included in a list of interview participants. Individuals participating in interviews but were assured that their responses would not be connected to their name. Kay Balcer, of Balcer Consulting and Prevention Services conducted the interviews in person, and Sara Wright of Michigan Center for Rural Health took notes via phone.

The interview followed a similar script as was used for the focus groups (see Appendix G). The interviewees, their titles and organizational affiliations are listed below.

Name	Title	Affiliation
Christine Trish	County Commissioner	Tuscola County Government
Sharon Beals	Chief Executive Officer	Tuscola Behavioral Health Systems
Susan Walker	Coordinator Past President	Human Services Community Collaborative Tuscola County Community Foundation
Karen Southgate	Program Manager	Tuscola/Huron County DHS
Julie Booms	Family Independence Manager	Huron Dept of Health and Human Services

Secondary Data

Table 1: Major Data Sources for CHNA Secondary Data

Public Health Statistics			
Source/ Participants	**URL or Citation**	**Dates of Data**	**Additional Descriptors**
United States Census Bureau	http://quickfacts.census.gov	2010	Includes data from the American Community Survey (5-year averages), Census Demographic profiles from the 2010 Census, and subtopic data sets.
Michigan Labor Market	http://www.milmi.org	2016	Unemployment Data
Michigan Department of Community Health	http://milmi.org/cgi/dataanalysis/?PAGEID=94	2000 to 2014	Date ranges varied by health statistic. Some statistics represent one year of data as others are looking at 3 or 5 year averages.
Michigan Behavioral Risk Factor Survey	http://www.michigan.gov/mdch/0,1607,7-132-	2003-2015	Local data available for 2003 and 2008 only. County data that is more recent was pulled from County Health

	2945_5104_5279_39424---,00.html and www.trhn.org		Rankings
Health Resources & Services Administration (HRSA)	http://bhpr.hrsa.gov/shortage/	2016	Shortage designations are determined by HRSA.
Michigan Profile for Healthy Youth (MIPHY)	http://michigan.gov/mde/0,1607,7-140-28753_38684_29233_44681---,00.html	2014	Local data from surveys of 7th, 9th, and 11th grade students is compared to county data. State and national data using the MIPHY was not available. 9th-12th grade Youth Behavior Risk Factor survey data was used for state and national statistics.
County Health Rankings	www.countyhealthrankings.org	2005 to 2013	Includes a wide variety of statistics. Many statistics represent a combined score and reflect multiple years of data.
Kids Count	http://www.mlpp.org/kids-count/michigan-2/mi-data-book-2016	2016	Includes a variety of data from Michigan Department of Community Health, Department of Human Services, and Department of Education.
Healthcare Utilization Data			
Hospital Data CHNA	Local report in excel spreadsheet.	2007-2016	Data available on utilization of hospital services, payer/revenue sources, financial assistance programs, and transfers out of the community.
Local Ambulance Service	Local run report	2016	Includes information on reason for EMS call, demographic data, and transport location.
Individual Interviews and Focus Groups	2016 Focus group members and Key Stakeholders	2016	Results from interviews & meetings were included in survey report.

Findings...

Findings

Companion documents are available for the information included in this report. The following pages summarize the key information utilized by the committee. Information has been organized into three categories (survey, focus groups and stakeholder interviews); however most of the data is inter-related.

Survey

Purpose

The purpose of the Community Health Survey was to:

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

Survey results for community assets and concerns are in Appendix C. The main focus of this analysis is to identify problem areas that prevent access to health care and the concerns of vulnerable groups—seniors, low education and low income regarding health and health care.

Preventing Access to HealthCare

Table 2 contains responses to Q17. Please rate how much the following issues prevent you or other community residents from receiving health care. Responses were on a four point scale from 1 = not a problem to 4 = major problem. Means and standard deviations were calculated for each.

The table reveals that not enough specialties and not enough evening or weekend hours were considered to be between a minor and major problem with means of μ=2.48 and μ=2.40 respectively. Ranked below these were not able to get appointment/limited hours (μ=2.31) and not enough doctors (μ=2.29). These refer to the supply of physicians which is highly dependent on the ratio of physician per 100,000 population. This reflects the rural nature of Tuscola County, which had a population of 55,729 in 2010.[2]

[2] Population of Michigan Counties 2000 and 2010. Available at http://www.michigan.gov/cgi/0,1607,7-158-54534-252541--,00.html

Table 2: Q17 Issues prevent receiving health care

In this table, a higher mean score indicates a higher perceived problem.	N	Mean μ	Std. Deviation
Not enough specialists	360	2.48	1.30
Not enough evening or weekend hours	360	2.40	1.27
Not able to get appointment/limited hours	362	2.31	1.14
Not enough doctors	356	2.29	1.30
Can't get transportation services	363	2.10	1.23
Don't know about local services	354	2.07	1.14
Distance from health facility	357	2.05	1.12
Not able to see same provider over time	357	1.98	1.22
Not accepting new patients	357	1.94	1.18
Poor quality of care	353	1.73	1.10
Barriers to accessing veterans services	353	1.61	1.34
Concerns about confidentiality	360	1.45	0.92
Lack of disability access	353	1.41	0.93
I am afraid or too uncomfortable to go	346	1.37	0.98
Limited access to telehealth technology	354	1.30	1.24
I have other more important things to do	352	1.21	0.93
Don't speak language or understand culture	356	1.18	0.77

Table 3 contains responses to Q16: "What cost considerations prevent you or other community residents from receiving health services?" Respondents were encouraged to choose ALL that apply.

Table 3 shows that the number one cost consideration preventing receiving health services was high deductable or co-pay with 35.0% of the responses. Three-fourths (76.1%) of the respondents named this cost consideration. The second largest was not having insurance with 42.1% of all respondents followed by insurance denies serves and not affordable insurance.

TABLE 3 .Q16. Cost considerations prevent receiving health services

	Times chosen	Percent times chosen	Percent of Respondents choosing
High deductible or co-pays	251	35.0%	76.1%
No insurance	139	19.4%	42.1%
Not affordable Services	122	17.0%	37.0%
Insurance denies services	114	15.9%	34.5%
Providers do not take my insurance	91	12.7%	27.6%
Total	717	100.0%	217.3%

That a solid majority (76.1%) of respondents picked high deductibles and copays, is not surprising. In theory both deductibles and copays are cost sharing devices designed to prevent policy holders from making small nuisance claims or seeking health care unnecessarily. The charges have to be just large enough to influence people's decisions, and not so big as to keep people from getting the care they need. Consumers are asked to decide ahead of time between plans that have lower premiums but higher deductible which they would prefer if they are less likely to need health care and higher premiums but lower deductibles which they would prefer if they are more likely. Theoretically this balances risk with cost.[3] Unfortunately the costs of premiums, deductibles and copays have steadily increased, making cost a determining factor in obtaining health insurance.

In terms of CHNA implementation, although hospitals and health departments may adjust their own copays, they have almost no ability to change insurance deductibles

Although only 1.2% of respondents answered that they had no health insurance, 42.1% thought that not having insurance prevent themselves or community residents from receiving health services. This is more than double the Census Bureau's 2014 estimate[4] of 15.1% to 20.0% uninsured in Tuscola County. The question may reflect a concern with the costs of purchasing health insurance through healthcare.gov rather than indirectly measuring the population not having any health insurance.

Community Concerns

The concerns about the community's health included

- Access to healthy food
- Awareness of local health resources and services
- Assistance for low-income families
- Access to exercise and fitness activities
- Understanding/Navigating Healthcare Reform

Concerns about the quality of life in the community

- Jobs with livable wages
- Attracting and retaining young families

Concerns about availability of health services

- Availability of doctors and nurses
- Ability to get appointments
- Availability of mental health services
- Availability of substance abuse/treatment services
- Availability of specialists.
- Availability of wellness and disease prevention services

Concerns about the community's safety and environment

[3] Kunreuther, H. and Pauly, M. (2005). Insurance Decision-Making and Market Behavior. *Foundations and Trends*® in *Microeconomics*. 1:2 p 63-127.

[4] US Census Bureau 2014 Small Area Health Insurance Estimates (SAHIE) Insurance Coverage Estimates: Percent Uninsured: 2014 http://www.census.gov/did/www/sahie/data/files/F4_Map.jpg

- Public transportation (options and cost)
- Water quality (i.e. well water, lakes, rivers)
- Crime and safety

Concerns about the delivery of health services

- Cost of health insurance
- Ability to retain doctors, nurses, and other healthcare professionals
- Cost of health care services
- Cost of prescription drugs

Concerns related to Vulnerable Populations

One purpose of the Community Health Needs Assessment is to address perceptions and concerns of and about vulnerable populations. Vulnerable populations include youth, seniors, females, low education, low income and race/ethnicity. The survey instrument asked all respondents for their concerns about youth and seniors (see Appendix C).

Table 4 below shows that the largest concern about youth physical was youth obesity with 29.4% of the responses. It was selected by three-eighths (37.6% of the respondents. The second largest concern was wellness and disease prevention, including vaccine-preventable (21.7%) chosen by 27.7% of the respondents. The third largest concern was youth hunger and nutrition (19.0%). This was followed closely by teen pregnancy with 18.6% of the responses (41 of 221).

Table 4. Q12b Top 3 concerns physical health in your community (youth frequencies).

	Times chosen	Percent times chosen	Percent of Respondents choosing
Youth obesity	65	29.4%	37.6%
Wellness and disease prevention, including vaccine-preventable	48	21.7%	27.7%
Youth hunger and poor nutrition	42	19.0%	24.3%
Teen pregnancy	41	18.6%	23.7%
Youth sexual health (including sexually transmitted diseases	25	11.3%	14.5%
Total	221	100.0%	127.8%

a. Dichotomy group tabulated at value 1.

Table 5 shows that the largest concern with youth mental health and substance abuse with the largest concern with youth mental health and substance abuse with 28.4% of the responses was youth drug use and abuse (including prescription drug abuse). It was chosen by half (49.6%) of the respondents. The second largest concern with 23.7% of the responses (112 of 472) was youth bullying checked by 41.5% of the respondents. The third largest was youth alcohol use and abuse (17.4%).

Table 5. Q13b Top 3 concerns mental health substance abuse in your community (youth frequencies)

	Times chosen	Percent times chosen	Percent of Respondents choosing
Youth drug use and abuse (including prescription drug abuse)	134	28.4%	49.6%
Youth bullying	112	23.7%	41.5%
Youth alcohol use and abuse (including binge drinking)	82	17.4%	30.4%
Youth mental health	58	12.3%	21.5%
Youth suicide	46	9.7%	17.0%
Youth tobacco use (including exposure to second-hand smoke)	40	8.5%	14.8%
Total	472	100.0%	174.8%

As shown in Table 6, below, the top concern with the senior population in their community was the cost of medications (20.1% of the responses). It was chosen by nearly three-fifths (58.5%) of the respondents. The second largest at 14.7% of the responses and selected by 42.9% of the respondents was the availability of resources to help the elderly stay in their homes. The third largest concern was transportation (12.6%) chosen by a little more than one-third (36.8%) of the respondents.

Table 6. Q14 Top 3 concerns about senior population in your community

	Times chosen	Percent times chosen	Percent of Respondents choosing
Cost of medications	213	20.1%	58.5%
Availability of resources to help the elderly stay in their homes	156	14.7%	42.9%
Transportation	134	12.6%	36.8%
Availability of activities for seniors	102	9.6%	28.0%
Availability of resources for family and friends caring for	101	9.5%	27.7%
Assisted living options	88	8.3%	24.2%
Dementia/Alzheimer's disease	86	8.1%	23.6%
Hunger and poor nutrition	69	6.5%	19.0%
Long-term/nursing home care options	58	5.5%	15.9%
Elder abuse	30	2.8%	8.2%
Cost of activities for seniors	24	2.3%	6.6%
Total	1061	100.0%	291.4%

An additional analysis examined the top concerns of respondents who self identified as members of vulnerable populations: low income, low education, seniors and females (see Appendix D).

Income

Respondents with household incomes less than $25,000 were more likely than those with higher incomes to be concerned about

- affordable housing

- availability of dental care
- availability of vision care.
- availability of affordable dental services
- youth tobacco use.

Respondents with household incomes less than $25,000 were less likely than those with higher incomes to be concerned about

- understanding/navigating Healthcare Reform.
- the ability of the community to retain health providers and professionals.
- attracting and retaining young families
- youth drug use and abuse

Respondents with household incomes less than $25,000 were slightly less likely than those with higher incomes to be concerned about

- water quality than those with higher incomes.
- the costs of medications

Education

Respondents with a high school education or less were less likely than those with more education to be concerned about

- obesity/overweight.

Seniors

Respondents 59 years of age or older were more likely than younger respondents to be concerned about

- youth obesity
- wellness / disease prevention than younger respondents. The latter may be concerns about preventing flu and shingles.

Respondents 59 years of age or older were slightly more likely than younger respondents to be concerned about

- public transportation options and costs

Respondents 59 years of age or older were less likely than younger respondents to be concerned about

- obesity/overweight.
- youth hunger and poor nutrition
- youth sexual health
- adult mental health

Gender

Females were more likely than males to be concerned about

- adequate youth activities than males.
- public transportation options and costs
- youth sexual health and wellness and disease prevention.
- adult drug use and abuse

Males were more likely than females to be concerned about

- teen pregnancy
- youth obesity
- stress
- youth alcohol use and abuse than females.

Focus Group

Purpose

The purpose of the focus group is to:

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

Focus Group Results

The focus group schedule contained 19 questions/ topics and the complete results are in Appendix F.

Focus Group participants were provided a list of potential health concerns that may affect the community as a whole. They were asked to review and comment on whether they thought the concerns were important to their local community, and which of the concerns would be the most important to their community.

The participants initially went through and identified all health concerns they thought were relevant to their community (column 1). They were then asked to identify their top 5 concerns. The second column shows the number of people who noted it was of concern in the community. The third column shows the number of people who listed the concern in their top 5.

Table 7
Top Concerns of Focus Group by Topic

Community/Environmental Concerns

Concern	Times chosen	Times in top 5
Not enough jobs with liveable wages, not enough to live on	11	4
Attracting and retaining young families	10	7
Not enough public transportation options, cost of public transportation	9	1
Poverty	5	4
Changes in population size (increasing or decreasing)	5	2

Physical, mental health, and substance abuse concerns (adults)

Concern	Times chosen	Times in top 5
Drug use and abuse (including prescription drug abuse)	9	5
Alcohol use and abuse	8	5
Depression	6	1
Obesity/overweight	6	1

Concerns about health services

Concern	Times chosen	Times in top 5
Cost of health insurance	9	3
Cost of prescription drugs	8	1
Availability of substance abuse/treatment services	6	3
Availability of mental health services	6	2

Concerns about youth and children

Concern	Times chosen	Times in top 5
Youth drug use and abuse (including prescription drug abuse)	10	4
Youth alcohol use and abuse	4	1
Youth obesity	4	

Concerns about the aging population

Concern	Times chosen	Times in top 5
Availability of resources for family and friends caring for elderly/ availability of care for seniors without a family	3	
Availability of resources to help the elderly stay in their homes	2	1
Being able to meet needs of older population	2	
Assisted living options	2	

Focus group members identified affordable dental care as a service that was not on the list of potential health concerns that may affect the community as a whole. They thought the hospital needs to add substance abuse counseling/education for both children and parents.

The focus group identified six groups as being medically underserved. In addition to the elderly, lower middle income and those with mental health issues, they identified the Amish, preschool and kids, and young adults.

Focus group members thought most people use Hills & Dales because of its location and providers/staff, but used other providers because Hills & Dales lacked specialties and resources.

They thought that the health of community would be improved by having a health advocate help with insurance and access to resources.

Stakeholder Interview Methods

Purpose

The purpose of the stakeholder interviews is to:

- Learn about the good things in the community as well as concerns in the community.
- Assess community awareness and use of health care services
- Assess availability of and need for health care services
- Estimate collaboration among health organizations and providers.
- Gather suggestions for improving health care and removing barriers.

Stakeholder Interview Responses

Stakeholders identified a lack of transportation, especially for health and medical needs as a major challenge. They thought it is hard to get Medicaid eligible dental care for adults.

Their major concerns were the availability of mental health services and no inpatient programs, youth obesity and youth alcohol and drug use and abuse, and the availability of resources for family and friends caring for elderly and to help the elderly stay in their homes. They named veterans, mentally disabled adults, and people who can't afford health insurance, copays, etc. as medically underserved.

All five stakeholders mentioned a lack of knowledge about insurance and what is covered.

The stakeholders perceived a lack of trust in the local Tuscola county hospitals. They claimed that many people had been misdiagnosed. Also mentioned was the difficulty of understanding physicians whose English was not good. There being two hospitals in Tuscola County, it is not known if this was a generalization or if this pertained specifically to a hospital. On the positive side, the stakeholders held the Tuscola County Health Dept in high regard. They wanted the providers to become more involved with the community and collaborate to get information out about services. Hospital, health department, physician offices should rely on each other, as they cannot offer everything themselves, especially in a small community.

Secondary Data

The following Thumb Report Card illustrates how each county compares to data from the state.

Source	Indicator	Year	Michigan	Huron	Sanilac	Tuscola
CHR	Health Outcomes (county rank)			41	33	28
CHR	Length of Life (county rank)			41	51	36
CHR	Years of Potential Life Lost per 100,000	2011-2013	7,200	7,100	7,300	6,900
CHR	Age Adjusted Mortality per 100,000	2011-2013	360	350	360	350
MDCH	Heart Disease Deaths	2012-2014	199.3	203.3	233.2	196.9
MDCH	Cancer Related Deaths	2012-2014	173	176.9	164.5	176.4
MDCH	Diabetes Related Deaths	2012-2014	73.7	86.1	84.4	65.9
MDCH	Deaths due to Suicide	2010-2014	13.2	14.6	18.5	13.1
CHR	Child Mortality (under 18) per 100,000	2010-2013	50	50	40	50
CHR	Infant Mortality (under age 1) per 1000	2006-2012	7	NA	NA	NA
CHR	Quality of Life (county rank)			40	19	23
CHR	Poor Or Fair Health	2014	16%	14%	13%	13%
CHR	Average # of Poor physical health days (In past 30 days)	2014	3.9	3.5	3.4	3.5
CHR	Frequent physical distress (>14 days-past 30 when physical health was not good)	2014	12%	11%	10%	11%
Source	**Indicator**	**Year**	**Michigan**	**Huron**	**Sanilac**	**Tuscola**
CHR	Average # of Poor mental health days (In past 30 days)	2014	4.2	3.6	3.6	3.7
CHR	Frequent Mental Health distress (>14 days-past 30 when mental health was not good)	2014	13%	11%	11%	11%
PHY	7th grade students who felt so sad or hopeless almost every day for two weeks or more in a row that they stopped doing some usual activities-past 12 months	2014 H-T 2010 SC	NA	20.6%	NA	35.7%

PHY	9th grade students who felt so sad or hopeless almost every day for two weeks or more in a row that they stopped doing some usual activities-past 12 months	2014 H-T 2010 SC	NA	23.9%	45.0%	34.3%
PHY	11th grade students who felt so sad or hopeless almost every day for two weeks or more in a row that they stopped doing some usual activities-past 12 months	2014 H-T 2010 SC	NA	19.3%	34.0%	30.3%
CHR	Low Birthweight (<2500 grams; 5lbs,8 oz)	2007-2013	8%	8%	7%	7%
MDCH	Cancer Incidence (Age Adjusted Rate)	2010-2012	471.8	441.0	356.5	436.9
MDCH	Cardiovascular Discharges Incidence (Age Adjusted-Acute Myocardial Infarction)	2011-2013	200.3	225.2	275.8	251.6
MDCH	Cardiovascular Discharges Incidence (Age Adjusted Rate-Congestive Heart Failure)	2011-2013	284.8	245.2	260.2	288.1
MDCH	Cardiovascular Discharges (Stroke)	2011-2013	226.4	218.7	207.0	225.2
MDCH	Diabetes Discharges Incidence	2011-2013	183.0	122.7	176.2	138.8
CHR	Diabetes Prevalence** (age 20+ diagnosed with diabetes, 2012)	2012	10%	11%	11%	10%
CHR	HIV Prevalence 2012) per 100,000	2012	178	18	42	26
CHR	Health Factors (county rank)			17	49	43
CHR	Health Behaviors (county rank)			16	53	41
CHR	Adult Obesity** (BMI >30)	2012	31%	31%	34%	31%
PHY	7th Grade Obesity (>95th and 85th percentile)	2014 H-T 2010 SC	NA	12.9%/13.4%	16.3%/14.3%	13%/16.8%
PHY	9th Grade Obesity (>95th and 85th percentile)	2014 H-T 2010 SC	NA	13.6%/18.4%	18%/16.9%	20.3%/18.7%
PHY	11th Grade Obesity (>95th and 85th percentile)	2014 H-T 2010 SC	NA	15.3%/24.1%	17.1%/19%	19.3%/15.8%
0-8	Obesity among low income children	2014	13%	12%	11%	11%
CHR	Limited Access To Healthy Foods: % of low income who don't live close to grocery store	2010	6%	11%	2%	3%
CHR	Index of factors that contribute to a healthy food environment, 0 (worst) to 10 (best).	2013	7.1	6.9	7.7	7.6
Source	**Indicator**	**Year**	**Michigan**	**Huron**	**Sanilac**	**Tuscola**
CHR	Physical Inactivity: no leisure-time physical activity.	2012	23%	28%	22%	30%
PHY	7th Grade- 60 minutes of physical activity for at least 5 of 7 past days.	2014 H-T 2010 SC	NA	24.6%	58.0%	59.5%
PHY	9th Grade- 60 minutes of physical activity for at least 5 of 7 past days.	2014 H-T 2010 SC	NA	38.4%	62.7%	66.5%
PHY	11th Grade- 60 minutes of physical activity for at least 5 of 7 past days.	2014 H-T 2010 SC	NA	26.7%	36.4%	47.6%

CHR	% of individuals in a county who live reasonably close to a location for physical activity such as parks.	2010 & 2014	84%	53%	13%	43%
CHR	Adult Smoking (everyday or most days)	2014	21%	16%	18%	17%
PHY	7th Grade youth who smoked cigarettes during the past 30 days	2014 H-T 2010 SC	NA	0.9%	5.1%	2.4%
PHY	9th Grade youth who smoked cigarettes during the past 30 days	2014 H-T 2010 SC	NA	8.1%	15.7%	11.0%
PHY	11th Grade youth who smoked cigarettes during the past 30 days	2014 H-T 2010 SC	NA	21.5%	19.6%	18.7%
0-8	Live Births to Women Who Smoked During Pregnancy	2011-2013	21.6%	24.7%	26.3%	32.9%
CHR	Alcohol Impaired Driving Deaths (% of all driving deaths)	2010-2014	30%	27%	36%	39%
PHY	7th grade students who had at least one drink of alcohol during the past 30 days	2014 H-T 2010 SC	NA	4.8%	6.1%	9.3%
PHY	9th grade students who had at least one drink of alcohol during the past 30 days	2014 H-T 2010 SC	NA	24.4%	32.2%	21.2%
PHY	11th grade students who had at least one drink of alcohol during the past 30 days	2014 H-T 2010 SC	NA	48.2%	46.2%	38.6%
PHY	7th grade students who used marijuana during the past 30 days	2014 H-T 2010 SC	NA	1.4%	1.0%	3.5%
PHY	9th grade students who used marijuana during the past 30 days	2014 H-T 2010 SC	NA	6.2%	5.1%	11.3%
PHY	11th grade students who used marijuana during the past 30 days	2014 H-T 2010 SC	NA	17.8%	13.9%	21.0%
CHR	Drug Overdose Deaths: drug poisoning deaths per 100,000	2012-2014	16	NA	14	12
CHR	Drug Overdose Deaths Modeled: estimate of the number of deaths due to drug poisoning per 100,000	2014	18	6.1-8.0	12.0-14.0	12.0-14.0
CHR	Motor Vehicle Crash Deaths: traffic accidents involving a vehicle per 100,000	2007-2013	10	11	16	17
CHR	Sexually transmitted infections: diagnosed chlamydia cases per 100,000	2013	453.6	141.7	158.5	217.7
PHY	7th grade students who ever had sexual intercourse	2014 H-T 2010 SC	NA	4.5%	4.0%	9.7%
PHY	9th grade students who ever had sexual intercourse	2014 H-T 2010 SC	NA	14.4%	29.0%	17.5%
Source	**Indicator**	**Year**	**Michigan**	**Huron**	**Sanilac**	**Tuscola**
PHY	11th grade students who ever had sexual intercourse	2014 H-T 2010 SC	NA	41.3%	51.1%	43.9%
CHR	Teen Births (# of births per 1,000 female population, ages 15-19)	2007-2013	29	21	25	26
MDCH	Percent of Total Births to Mothers Age < 20	2011-2013	7.8	6.3	7.3	7.5

CHR	Insufficient Sleep: adults who report fewer than 7 hours of sleep on average	2014	38%	32%	30%	32%
CHR	Clinical Care (county rank)			48	75	71
CHR	Uninsured: <65 that has no health insurance coverage	2013	13%	15%	15%	14%
CHR	Uninsured Adults: 18 to 65 that has no health insurance coverage in a given county	2013	16%	18%	19%	18%
CHR	Uninsured Children: <19 that has no health insurance coverage	2013	4%	6%	6%	4%
CHR	Health care costs: price-adjusted Medicare reimbursements (Parts A and B) per enrollee	2013	$10,153	$10,391	$10,117	$10,808
CHR	Ratio of other Primary Care Providers: nurse practitioners (NPs), physician assistants (PAs), and clinical nurse specialists	2015	1,342:1	1,458:1	2,079:1	2,348:1
CHR	Dentists: ratio of the population to total dentists. Higher= less access	2014	1,450:1	2,290:1	3,470:1	2,840:1
CHR	Mental Health: ratio of the population to total mental health providers. Higher= less access	2015	450:01:00	1,280:1	670:01:00	430:01:00
HPSA	Provider Shortage Designations	Varies	NA	Primary Care Dental Mental Health	Primary Care Dental Mental Health	Primary Care Dental Mental Health
0-8	Live Births to Women With Less Than Adequate Prenatal Care	2011-2013	29.9%	16.0%	29.7%	24.3%
0-8	Toddlers Ages 19-35 Months Who Are Immunized 4:4:1:3:3:1:4	2014	73.8%	73.3%	75.0%	73.9%
CHR	Preventable Hospital Stays: discharge rate for ambulatory care-sensitive conditions per 1,000 Medicare enrollees	2013	59	52	72	72
CHR	Diabetic Monitoring: Medicare enrollees ages 65-75 that receive HbA1c monitoring	2013	86%	85%	87%	83%
CHR	Mammography Screening: female Medicare enrollees ages 67-69 that receive mammography screening	2013	65%	66%	64%	64%
CHR	Social & Economic Factors (county rank)			12	35	32
Source	**Indicator**	**Year**	**Michigan**	**Huron**	**Sanilac**	**Tuscola**
CHR	High School Graduation: % of students graduate high school in four years.	2012-2013	78%	90%	87%	80%
CHR	Some College: adults ages 25-44 with some post-secondary education; no degree	2010-2014	66%	54%	52%	57%
0-8	Births to Mothers Without a High School Diploma/GED	2011-2013	13.8%	10.3%	17.0%	10.9%
KC	Children age 3-4 enrolled in preschool.	2009-2013	47.5%	57.9%	48.0%	45.5%
0-8	Change in licensed childcare providers	From 2011-	NA	-2	-3	-13

		2015				
CHR	Unemployment: ages 16+ but seeking work	2014	7.30%	6.80%	8.40%	8.50%
CHR	Median Household Income: half the households earn more and half the households earn less than this income.	2014	$49,800	$41,700	$42,100	$43,200
CHR	Income inequality: Higher inequality ratio indicates greater division between the top and bottom ends of the income spectrum	2010-2014	4.7	4.1	3.9	3.7
CHR	Children In Single Parent Households	2010-14	34%	33%	26%	27%
CHR	Children in Poverty: under age 18 living in poverty	2014	23%	21%	23%	24%
Alice	ALICE level: households above poverty level, but less than the basic cost of living for county.	2014	NA	27%	27%	22%
census	Poverty rate- US Census	2014	16.9%	15.5%	15.6%	15.3%
0-8	Rate per 1,000 Children Ages 0-8 Who Are Substantiated Victims of Abuse or Neglect	2014	20.6	13.0	24.1	25.2
0-8	Change in rate per 1,000 Children Ages 0-8 Substantiated Victims of Abuse or Neglect	From 2010 to 2014	2.6	-6.6	4.6	6.9
0-8	Rate per 1,000 of Children Ages 0- 8 in Foster Care	2014	5.9	5.7	10.3	5.8
PHY	7th grade students who have seen students get pushed, hit, or punched one or more times during the past 12 months	2014 H-T 2010 SC	NA	62.1%	89.2%	71.6%
PHY	9th grade students who have seen students get pushed, hit, or punched one or more times during the past 12 months	2014 H-T 2010 SC	NA	57.7%	82.0%	60.9%
PHY	11th grade students who have seen students get pushed, hit, or punched one or more times during the past 12 months	2014 H-T 2010 SC	NA	51.9%	75.7%	52.0%
CHR	Violent Crime: offenses that involve face-to-face confrontation per 100,000.	2010-2012	464	123	196	177
CHR	Homicides: deaths per 100,000	2007-2013	7	NA	NA	NA
CHR	Injury Deaths: intentional and unintentional injuries per 100,000	2009-2013	61	60	70	56
CHR	Inadequate Social Support- adults	2005-10	20%	14%	20%	16%
Source	**Indicator**	**Year**	**Michigan**	**Huron**	**Sanilac**	**Tuscola**
CHR	Residential Segregation Black White: degree to which live separately in a geographic area (0 integration to 100 segregation)	2010-2014	74	NA	57	62
CHR	Residential Segregation nonwhite-white: degree to which live separately (0 integration to 100 segregation)	2010-2014	61	32	24	21
CHR	Physical Environment (county rank)			24	29	47

CHR	Air Pollution Particulate Matter: average daily density	2011	11.5	12	12.3	12
CHR	Drinking water violations: Yes=presence	FY2013-14		No	No	No
CHR	Severe Housing Problems: at least 1 of 4 problems- overcrowding, high housing costs, or lack of kitchen or plumbing	2008-2012	17%	13%	14%	14%
CHR	Driving Alone To Work: percentage of the workforce that usually drives alone to work.	2010-2014	83%	81%	77%	83%
CHR	Long Commute Driving Alone: Greater than 30 minutes	2010-2014	32%	22%	37%	42%

NOTE: The Thumb Rural Health Network Report may be beneficial in Regional conversations about need and also can shed some light as a region as to trends. This report is did not include county or Michigan comparisons and therefore did not lend well to inclusion in the report card table.

Source Key

CHR- County Health Ranking
PHY- Michigan Profile for Healthy Youth
MDCH- Michigan Department of Community Health
ALICE- Asset Limited Income Constrained Employed
0-8- Birth to 8 Indicators
HPSA- Health Provider Shortage Area
AR- Alice Report
KC- Kids Count

Discussion

Discussion and Limitations...

The survey, focus group, and stakeholders all identified the need for mental health services including substance abuse consoling for adults, parents, and youth. They also agreed about a shortage of physicians and specialties, as well as problems getting appointments and lack of afterhours care. All three noted that people were not aware of the local health resources and services and had problems understanding their insurance and what was covered. The focus group proposed having a health advocate help with insurance and access to resources.

Survey respondents and focus group members were concerned about the costs of health insurance, prescriptions, and medical services. Survey respondents, seniors, and stakeholders noted the need for better public transportation, especially for health and medical needs. Survey respondents who self identified as low income were concerned about access to dental and vision care and stakeholders also mentioned access to Medicaid eligible dental care.

The stakeholders perceived a lack of trust in the county hospitals based on reports of misdiagnoses, perhaps linked to practitioners who's did not speak English clearly. Stakeholder interview reports did not indicate that this finding specifically pertained to Hills & Dales General Hospital or it's physicians, or refer to specific instances or events.

Overall the findings appear consistent with a rural county in terms of provider shortages, lack of transportation, and little support for navigating the health care system and health insurance.

Limitations

The survey employed a non probability sampling, combining convenience sampling with purposive (judgmental) sampling. Surveys were available on-line and paper surveys were distributed at a variety of locations. This resulted in some skewed demographics. Respondents were disproportionately female (78.8%), had some college degree (59.9%), and one-third (32.0% had household incomes of $75,000 or more. A little over one-quarter (27.7%) worked for a hospital, clinic, or public health department. Census information on gender, education and income are grouped by census tracts which are not always congruent with ZIP codes. It is not practicable to adjust the survey responses for gender, education and income for the nine ZIP codes. However, this could be done at the county level.

Identified Needs & Priorities ...

Prioritization Process

A CHNA helps to direct resources to the issues that have the greatest potential for improving the health of the community. Successfully addressing priority issues increases life expectancy, improves quality of life, and results in a savings to the healthcare system.

Prioritization Meeting

Hills & Dales General Hospital began the prioritization process by reviewing the data described in the findings section of this report. The Prioritization meeting included 24 participants; with members from the first focus group and hospital employees (department managers and hospital leadership). The meeting participants also reviewed the following list of concerns revealed in focus groups.

Table 7 Top concerns of focus group by topic

Community/Environmental Concerns

Concern	Times chosen	Times in top 5
Not enough jobs with liveable wages, not enough to live on	11	4
Attracting and retaining young families	10	7
Not enough public transportation options, cost of public transportation	9	1
Poverty	5	4
Changes in population size (increasing or decreasing)	5	2

Physical, mental health, and substance abuse concerns (adults)

Concern	Times chosen	Times in top 5
Drug use and abuse (including prescription drug abuse)	9	5
Alcohol use and abuse	8	5
Depression	6	1
Obesity/overweight	6	1

Concerns about health services

Concern	Times chosen	Times in top 5
Cost of health insurance	9	3
Cost of prescription drugs	8	1
Availability of substance abuse/treatment services	6	3
Availability of mental health services	6	2

Concerns about youth and children

Concern	Times chosen	Times in top 5
Youth drug use and abuse (including prescription drug abuse)	10	4
Youth alcohol use and abuse	4	1
Youth obesity	4	

Concerns about the aging population

Concern	Times chosen	Times in top 5
Availability of resources for family and friends caring for elderly/ availability of care for seniors without a family	3	
Availability of resources to help the elderly stay in their homes	2	1
Being able to meet needs of older population	2	
Assisted living options	2	

Key information interview results were utilized to confirm concerns identified in other data and to identify other potential areas of concern. The meeting participants used a prioritization process that included analysis of issues located in multiple data sources. The ballot that was used during the meeting is available upon request. The final ballot results are below.

POTENTIAL NEEDS In Alphabetical order (Combined indicators from surveys, focus groups, and secondary data)	✓ = Not meeting state average	◊=County Need based on data	Δ=County Need based on interview	□ Focus group	❍= Survey	**VOTE for your top 5 (1 top choice, 5 lowest)**
1. Abuse and Violence including Bullying	✓	◊◊	Δ	□	○	8
2. Access to Dental Healthcare and Providers	✓		Δ	□		
3. Access to Emergency Care						
4. Access to in home healthcare and supports						
5. Access to long term healthcare services					○	
6. Access to Prenatal Care	✓		Δ			
7. Access to Primary Healthcare and Providers	✓✓	◊	Δ	□	○	9
8. Access to Public Health Services and Providers						
9. Access to specialized healthcare services			Δ		○	
10. Access to Vision Healthcare and Providers						10
11. Alcohol Use/Abuse	✓✓	◊◊	Δ	□	○	
12. Cancer	✓		Δ			
13. Diabetes						
14. Education		◊				
15. Environmental Health	✓		Δ		○	
16. Families Services and Supports		◊	Δ			
17. Health Education and Awareness			Δ	□	○	
18. Health Insurance and Healthcare Costs	✓✓		Δ	□	○	11

19. Healthcare Workforce	✓✓	◊	Δ	□	○	
20. Heart Disease	✓	◊◊◊				
21. Local Economic Conditions	✓✓	◊◊	Δ	□	○	
22. Lung Disease and Asthma						
23. Mental Health	✓	◊	Δ	□	○	8
24. Nutrition	✓			□	○	
25. Obesity		◊	Δ	□	○	11
26. Personal Attitudes to Health and Healthcare					○	
27. Physical Activity	✓✓	◊◊		□	○	
28. Quality of Healthcare			Δ	□	○	
29. Reproductive Health		◊				
30. Safety and Violence			Δ		○	
31. Senior Support Services			Δ	□	○	
32. Social Conditions	✓	◊	Δ	□	○	
33. Social Emotional Support						
34. Substance Abuse		◊	Δ	□	○	8
35. Teen Births		◊			○	
36. Tobacco Use	✓ (prenatal)	◊ (prenatal)				
37. Traffic Safety	✓✓	◊◊				
38. Transportation			Δ	□	○	8

Assess existing resources that are addressing priorities

Identified Needs & Available Resources

The next step in the resource assessment was to group needs into categories. The categories are listed on Table 4 along with the resources that are provided by the hospital and the community.

Table 4: Community Health Needs & Resources

Category	Need[5] and Related Data	Current Hills & Dales General Hospital Efforts	Current Community Efforts
Health Insurance and Healthcare Costs	**Need** Health insurance and healthcare costs **Related Data** • Secondary data sources • County-level stakeholder interview • Hospital focus group • Survey	1. Social Worker referrals for assistance with Medicaid application. 2. Charity Care Policy and Procedure. 3. Billing outreach personnel specifically assigned for customer assistance.	**County Programs** 1. Adult day services and Foster Care Homes 2. Human Development Commission 3. Subsidized Housing Assistance, Independent and Assisted Living, long term care homes 4. Region VII Area Agency on Aging and Huron County Council on Aging 5. Lakeshore Legal Aid 6. BWCIL is the Housing Assistance Resource Agency (HARA) for the Thumb Area Continuum of Care. Provides homeless prevention and rapid re-housing **Local Programs** 1. HDC-Home delivered meals
Obesity	**Need** Obesity **Related Data** • Secondary data sources • County-level stakeholder interview • Hospital focus group • Survey	1. Medical Nutrition Therapy offered as a clinical service. 2. Primary care services include obesity screening, diagnosis and treatment. 3. Fitness memberships at Center for Rehabilitation.	1. Village of Cass City walking trails. 2. Village actively worked to recruit grocery store to the village. Construction planned within the year. 3. Village Farmer's Market. 4. Area Weight Watchers and TOPS groups.
Access	**Need** • Access to specialized healthcare services • Access to Primary Healthcare and Providers **Related Data** • Secondary data sources • County-level stakeholder interview • Hospital focus group • Survey	1. Specialty clinic offering various specialty medical providers: neurosurgery, cardiology, gynecology, nephrology, orthopedics, pain management, physiatry and general surgery. 2. 7 primary care clinics in 3 towns. 3. After Hours Clinic with evening and weekend hours.	

[5] *indicates issue related to top community health priorities
** indicates issue related to top health system priorities

Abuse and Violence Including Bullying	**Need** Abuse and violence including bullying **Related Data** • Secondary data sources • County-level stakeholder interview • Hospital focus group • Survey	1. Domestic violence screening for emergency room patients. 2. Social Work referrals. 3. Employee education programs. 4. Mental health providers at Health Fairs.	1. Community Education Program through Human Services Collaborative. 2. Community Education efforts through county mental health. 3. School anti-bullying education.
Mental Health	**Need** Mental Health **Related Data** • Secondary data sources • County-level stakeholder interview • Hospital focus group • Survey	1. Referrals to local Mental Health providers through hospital and primary care. 2. Invite mental health providers to Health Fairs. 3. Invite Mental Health providers to host community training onsite.	1. Thumb Area Psychological Services based in Cass City. 2. Thumb Behavioral Health, List Psychological and other mental health providers.
Substance abuse	**Need** Substance Abuse **Related Data** • Secondary data sources • County-level stakeholder interview • Hospital focus group • Survey	1. Referrals for patients to substance abuse treatment and community support groups such as AA. 2. Substance Abuse screening and treatment referral in primary care clinics.	1. Thumb Area Unity Council: conglomeration of local Alcoholics Anonymous groups. 2. List Psychological, Thumb Area Psychological Services and Thumb Behavioral Health offer substance abuse counseling.
Transportation	**Need** Transportation **Related Data** • Secondary data sources • County-level stakeholder interview • Hospital focus group • Survey	1. Flexible scheduling to help patients with transportation needs. (For example, Radiology testing on same day as a clinic visit to save patient a trip.)	1. Thumbody Express services Caro area. 2. Thumb Area Transit serves Huron County. 3. Sanilac Transportation serves Sanilac County.

Written CHNA Report and Implementation Plan

- The CHNA report was completed in draft form in September 2016. The final report was reviewed and posted to the hospital website at www.hdghmi.org in September 2016.
- The Implementation Plan is currently in development and will also be posted to the www.hdghmi.org website with final approval by the Hospital Board of Directors in February, 2017.

Additional Documents (Available Upon Request)

- Survey Instrument
- Implementation Plan
- Focus Group Design
- Interview Outline
- Survey, Stakeholder, Focus Group Report
- Thumb Area Health Status Data Reports
- Prioritization Meeting Ballot