Caro Community Hospital
2016 Community Health Needs Assessment

A Report to the Community

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Executive Summary

Executive Summary

This report is a primary data source that complements other primary and secondary data sources collected by Caro Community 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. Caro Community Hospital distributed surveys in eight ZIP codes in its service area. They also held a focus group of 8 women and 5 men with age ranges from mid/late 30s to 60s. The attendees represented hospital employees, other health professionals, schools, ISD, County Commission, law enforcement, and community members. Key stakeholder interviews were held with five individuals from five organizations.

The survey findings are based on the responses of 207 individuals, three-quarters (78.3%) of whom were female. Respondents were well educated with three-fifths (61.2%) earning some college degree, and a little over one-quarter (27.7%) reporting 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 concerned about jobs with livable wages, supply of doctors and nurses, and a lack of substance abuse, mental health and dental services. They noted the costs of health insurance, health care services and prescription drugs.

Focus group members identified poverty as a major issue which included not enough jobs with livable wages. They were also concerned about the costs of health insurance, health care services and prescription drugs. They perceived a lack of mental health services and thought the community had difficulty retaining doctors and nurses.

Focus group members thought most people use Caro Community Hospital because of its staff, location/convenience, quality and being safe, but used other providers because they preferred the staff or doctors at other hospitals and a lack of privacy at CCH. They suggested that the health of the community would be improved by having better leadership, integrating the staff into the community, a new clinic, and a focus on responding to trauma.

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.

Background and Overview

Background

Caro Community Hospital is a Critical Access Hospital. The Medicare Rural Hospital Flexibility Program (Flex Program), created by Congress in 1997, allows small hospitals to be licensed as Critical Access Hospital 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 healthcare services to residents in the area.

Caro Community Hospital: Mission

Caro Community Hospital, a community-minded healthcare system, is dedicated to providing compassionate care and services to enhance the health of all people we serve.

Services:

<u>General and Acute Services</u>

24/7 Emergency Department	OB/GYN (evaluation & surgical services)
Cardiology	Ophthalmology (evaluation and surgical services)
Dermatology	Oral/Maxillofacial Surgery
Endocrinology	Orthopedics (evaluation & surgical services)
ENT & Facial Plastic Surgery	Pathology
Family Practice Clinics	Pharmacy
Hematology/Oncology	Podiatry (evaluation & surgical services)
Hospital (acute care, including hospitalist)	Pulmonology
Nephrology	Rheumatology
Neurology	Stroke Robot
Neurosurgery	Surgical Services
Nutrition Counseling	Urology

Screening/Therapy Services

Chronic Disease Management	Pediatric services
DOT Physicals	Physical therapy
Holter Monitoring	Respiratory care
Laboratory Services	Sleep Studies
Lower extremity circulatory assessment	Social Services
Occupational physicals	Total body fat analysis

Radiology Services

CT Scan	MRI (Thumb MRI)
Digital Mammography	Teleradiology (After hours)
General x-ray	Ultrasound
Nuclear medicine	Bone Density Testing

The leaders of Caro Community Hospital understand that operating a ***COMMUNITY*** hospital means striving to understand and respond to the needs of the community- you, your families, and your friends. It was with this community mindset, in 2016, that Caro Community Hospital launched a Community Health Needs Assessment (CHNA).

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 Caro Community 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 in eight 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. Participants included a focus group of 8 women and 5 men. They represented Caro Community Hospital employees, other health professionals, schools, ISD, County Commission, law enforcement, and community members, Ages ranged from mid/late 30s-to-60s
- Key Stakeholder Interviews: A county level committee selected key organizations and individuals for stakeholder interviews. These interviews were held with five individuals from five different organizations.

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. The

CHNA process was followed by a prioritization process and 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. Hospitals and health departments invited representatives from the Center for Rural Health (CRH), University of North Dakota, and 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 common process for Community Health Needs Assessment. They 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 for its 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: Have local hospitals hold Implementation Planning Meetings
- Step 8: Have local hospitals prepare a written CHNA Report and Implementation Plan
- Step 9: Produce 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 55,729 resides in the county. The following charts showcase characteristics of the population.

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
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%

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, 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. Seniors 58 or older accounted for one quarter (26.7%) of respondents; those with a high school education or less account for 19.9% of the respondents, and about one-third (30.7%) reported household incomes $24,999 or less.

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.

Stakeholders Interviewed

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

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: Note taking, 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 Plan Progress

In 2013, the Community Health Needs assessment priorities identified by Caro Community Hospital (CCH) included:

1. After Hours Clinic
2. Transportation Needs
3. Cooperation between neighboring hospitals
4. Community support of available services
5. Publicize 211

The following table includes an update on the progress toward activities in the 2013 Implementation Plan:

Priority	Progress/Update
After Hours Clinic	CCH has worked diligently to find an appropriate location for an after hours clinic. They have recently secured a building in downtown Caro for an urgent care/after hours clinic that is scheduled to open 7 days a week in Spring 2017.
Transportation Needs	CCH has worked with the Tuscola County Transit Authority as well as TRHN to help market the services to the public. They have also discussed routes and availability of transportation to Thumb MRI.
Cooperation Between Neighboring Hospitals	They have worked extensively with TRHN to provide health and wellness services to the entire thumb and collaborated on potential grants. CCH has also worked with other hospitals (Thumb as well as Saginaw) on community education – specifically PATH for Diabetes.
Community Support for Available Services	CCH continues to provide extensive coverage in multiple media areas including social media, billboards, direct mailings, newspaper ads (Tuscola County Advertiser, Reese Reporter, Frankenmuth News, Cass City Chronicle, Vassar Pioneer Times, Huron Daily Tribune, Thumb Area Senior News and Varsity

	Monthly). In the last 2 years, they have completely updated all marketing materials to better promote hospital and clinic services. CCH has provided public education at local Exchange Club and Rotary meetings as well as the Caro Senior Commons. They also host annual community health fairs as well as a Mamm Party to educate the public about early detection and breast health.
Publicize 211	CCH invites 211 to their annual health fair, there is a link on the hospital website, they PR the service regularly on social media, there is information throughout the hospital and clinics and they have invited 211 to speak at Caro Rotary.

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 comes in contact with the researcher or has access to the survey - from people on a street corner or in a mall to those who come across the survey online. In a purposive sample, respondents are recruited based on some characteristic which will be useful for the study. For example, a purposive CHNA survey would target members of clubs and religious congregations in low income neighborhoods or seniors residing in independent living and assisted living facilities. In addition, a mixed sampling design intended to gather a sufficient number of low income, low education and senior citizens to permit an analysis of their health concerns and views on health care services. Finally, 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

Age	Respondents were asked their year of birth which was then recoded into quartiles. Of the valid cases, 23.0% were 35 or younger, 26.2% between 36 and 48, 24.1% between 49 and 57, and 26.7% were 58 or older.
Gender	Three-quarters (78.3%) of the respondents were female and 21.7% male.
Marital Status	A little over half (56.7%) were married or remarried.
Children	A little over two-fifths (43.8%) of households had children under 18.
Education	About one-fifth (19.9%) had a high school diploma or less, 18.9% some college, 18.9% a technical/Jr college degree, one-fifth (20.9%) a bachelor's degree and 21.4% a graduate or professional degree.
Employment Status	A little over half (56.4%) worked full time, 10.9% worked part time and 2.5% held multiple jobs. Retirees accounted for 10.3%.
Health Sector	A little less than one-third (31.2%) worked for a hospital, clinic or public health dept.
Race	90.3% self-identified as White/Caucasian.
Household income	About one-third (30.7%) reported household incomes $24,999 or less; one-fifth (20.0%) between $25,000 and $49,999, 15.1% between one between $50,000 and $74,999 (26.1%) and a little over one-quarter (27.7%) $75,000 or more.
Health Insurance	Almost three-fifths (57.4%) had health insurance through an employer or union, 16.8% were on Medicare, one-fifth (20.3%) on Medicaid and 9.4% individually purchased a plan. Only 1.0% reported not having any health insurance.
Hospitals used in past 2 years	Caro Community Hospital was the most frequently used hospital with half (52.2%) of the respondents reporting they used it in the past two years. This was followed by Hills & Dales in Cass City with one-third (34.1%), and Covenant Hospital in Saginaw (28.3%).
ZIP Codes	Of the 8 Zip codes, half (49.8%) 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. 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 was analyzed using the Statistical Package for the Social Sciences (SPSS) Version 20 multiple response sets frequencies and cross-tabulations.

Focus Groups:

A focus group of 5 men and 8 women was held on September 27, 2016 from 6:00-7:30pm at Caro Community Hospital. The group represented hospital employees, other health professionals, schools, ISD, County Commission, law enforcement, and community members. Ages ranged from mid/late 30s-to 60s. The group was facilitated by Sara Wright, notes by Victoria Lantzy, both from the Michigan Center for Rural Health.

Participants were told (verbally) that their responses will be treated in a way that will not reveal their name and that their responses will be combined with others in any reports. They were told that due to the closeness of the community, complete confidentiality in reporting their responses cannot be ensured.

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; and group discussion/brainstorming. A PowerPoint presentation via a projector was used to show the question in the front of the room as well as verbally. A prioritization process was not conducted since that will happen in the follow up focus group after the survey and initial report is shared and reviewed.

Stakeholder Interviews:

The Tuscola county committee selected three 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.

Secondary Data

Table 1: Major Data Sources for CHNA			
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/0,1607,7-132-2945_5104_5279_39424---,00.html and www.trhn.org	2003-2015	Local data available for 2003 and 2008 only. County data that is more recent was pulled from County Health 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			
Community Survey			
Community Survey	207 community members participated in survey.	2016	Questions included rating draft priorities, open ended questions, and input on the current healthcare services provided in the community.
Focus Group/Stakeholder Interviews			
Focus Group	13 community members participated in focus group	2016	Meeting included discussion of questions that were also utilized in individual interviews.
Individual Interviews and Focus Groups	2016 Focus Group Participants and Key stakeholders	2016	Results from interviews & meetings were included in survey report.

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 (78.3%), had some college

degree (61.2%), and 27.7% had household incomes of $75,000 or more. A little less than one-third (31.2%) 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.

Surveys were available online and paper surveys were distributed at a variety of locations. This resulted in some skewed demographics. Respondents were disproportionately female (78.3%), had some college degree (61.2%), and one 27.7% had household incomes of $75,000 or more. A little less than one-third (31.2%) worked for a hospital, clinic, or public health department.

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; however most of the data is inter-related.

Access to Care

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.

Table 2: Q17 Issues that prevent receiving health care

In this table, a higher mean score indicates a higher perceived problem.	N	Mean μ	Std. Deviation
Q17. Not enough specialists	193	2.55	1.35
Q17. Not enough evening or weekend hours	197	2.51	1.28
Q17. Not enough doctors	191	2.42	1.31
Q17. Not able to get appointment/limited hours	198	2.29	1.14
Q17. Don't know about local services	193	2.27	1.20
Q17. Can't get transportation services	198	2.26	1.25
Q17. Distance from health facility	195	2.21	1.15
Q17. Not accepting new patients	195	2.08	1.20
Q17. Not able to see same provider over time	194	1.99	1.20

Q17. Poor quality of care	192	1.85	1.13
Q17. Barriers to accessing veterans services	196	1.76	1.39
Q17. Lack of disability access	194	1.55	1.07
Q17. I am afraid or too uncomfortable to go	189	1.52	1.11
Q17. Limited access to telehealth technology	196	1.48	1.33
Q17. Concerns about confidentiality	197	1.48	0.96
Q17. I have other, more important things to do	193	1.33	1.08
Q17. Don't speak language or understand culture	194	1.18	0.76

The table reveals that the top three issues that prevent receiving health care were not enough specialists (mean of μ=2.55), not enough evening or weekend hours (μ=2.51), and not enough doctors (μ=2.42). These were considered to be between a minor and major problem. Minor problems were not able to get appointment/limited hours (μ=2.29), don't know about local services (μ=2.27), can't get transportation services (μ=2.26), and distance from health facility (μ=2.21).

The top three refer to the supply of physicians which is highly dependent on the ratio of physician per 100,000 population. This, combined with issues of transportation and distance from health facility, reflects the rural nature of Tuscola County, which had a population of 55,729 in 2010.[2]

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 deductible or co-pay with one-third (33.9%) of the responses and chosen by three-quarters (74.2%) of the respondents. The second largest was not having insurance with 18.9% of the responses and chosen by two-fifth (41.4%) of the respondents.

TABLE 3 Q16. Cost considerations prevent receiving health services

		Times chosen	Percent times chosen	Percent of Respondents choosing
Q16[a]	Q16. High deductible or co-pays	138	33.9%	74.2%
	Q16. No insurance	77	18.9%	41.4%

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

Q16. Insurance denies services	67	16.5%	36.0%
Q16. Not affordable Services	64	15.7%	34.4%
Q16. Providers do not take my insurance	61	15.0%	32.8%
Total	407	100.0%	218.8%

a. Dichotomy group tabulated at value 1.

It is not surprising that a solid majority (74.2%) of respondents picked high deductibles and copays. 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) vs higher premiums but lower deductibles (which they would prefer if they are more likely to need health care). 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 1.0% of respondents answered that they had no health insurance, 41.4% thought that not having insurance prevents 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 survey asked questions about five areas of concerns. The top concerns are summarized from the listed tables in Appendix C.

[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

The concerns about the community's health included: **Table 5. Q7**

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

Concerns about the quality of life in the community: **Table 6. Q8**

- Jobs with livable wages
- Attracting and retaining young families
- Affordable housing
- Adequate school resources

Concerns about availability of health services: **Table 7. Q9**

- Availability of doctors and nurses
- Ability to get appointments
- Availability of substance abuse/treatment services
- Availability of dental care
- Availability of mental health services

Concerns about the community's safety and environment: **Table 8. Q10**

- Public transportation (options and cost)
- Water quality (i.e. well water, lakes, rivers)
- Crime and safety
- Emergency services available 24/7
-

Concerns about the delivery of health services: **Table 9. Q11**

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

Concerns related to Vulnerable Populations

One purpose of the CHNA 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 health was youth obesity, which accounted for one-quarter (26.1%) of the responses. It was selected by a little over one-third (35.7%) of the respondents. The second largest concern was youth hunger and poor nutrition, chosen 22.4% of the time and selected by 30.6% of the respondents.

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

		Times chosen	Percent times chosen	Percent of Respondents choosing
Q12b[a]	Q12b. Youth obesity	35	26.1%	35.7%
	Q12b. Youth hunger and poor nutrition	30	22.4%	30.6%
	Q12b. Wellness and disease prevention, including vaccine-preventable	25	18.7%	25.5%
	Q12b. Teen pregnancy	23	17.2%	23.5%
	Q12b. Youth sexual health (including sexually transmitted diseases)	21	15.7%	21.4%
	Total	134	100.1%	136.7%

a. Dichotomy group tabulated at value 1.

Table 5 shows that the largest concern with youth mental health and substance abuse with 26.1% of the responses was youth drug use and abuse (including prescription drug abuse). It was chosen by almost half (47.3%) of the respondents. The second largest concern (25.6% of the responses) was youth bullying checked by 46.6% of the respondents.

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

		Times chosen	Percent times chosen	Percent of Respondents choosing
Q13b[a]	Q13b. Youth drug use and abuse (including prescription drug abuse)	62	26.1%	47.3%
	Q13b. Youth bullying	61	25.6%	46.6%
	Q13b. Youth alcohol use and abuse (including binge drinking)	36	15.1%	27.5%
	Q13b. Youth mental health	35	14.7%	26.7%
	Q13b. Youth suicide	22	9.2%	16.8%
	Q13b. Youth tobacco use (including exposure to second-hand smoke)	22	9.2%	16.8%
	Total	238	99.9%	181.7%

a. Dichotomy group tabulated at value 1

As shown in Table 6, below, the top concern with the senior population in their community was the cost of medications with 17.5% of the response). It was chosen by half (52.7%) of the respondents. The second largest at 15.7% of the responses and selected by 47.3% of the respondents was the availability of resources to help the elderly stay in their homes. The third largest concern was transportation (12.1%) chosen by a little more than one-third (36.5%) of the respondents.

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

		Times chosen	Percent times chosen	Percent of Respondents choosing
Q14[a]	Q14. Cost of medications	107	17.5%	52.7%
	Q14. Availability of resources to help the elderly stay in their homes	96	15.7%	47.3%
	Q14. Transportation	74	12.1%	36.5%
	Q14. Availability of resources for family and friends caring for	61	10.0%	30.0%
	Q14. Assisted living options	55	9.0%	27.1%
	Q14. Dementia/Alzheimer's disease	55	9.0%	27.1%
	Q14. Availability of activities for seniors	50	8.2%	24.6%
	Q14. Hunger and poor nutrition	39	6.4%	19.2%

	Q14. Long-term/nursing home care options	38	6.2%	18.7%
	Q14. Elder abuse	21	3.4%	10.3%
	Q14. Cost of activities for seniors	15	2.5%	7.4%
	Total	611	100.0%	300.9%

a. Dichotomy group tabulated at value 1

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:

- Assistance for low income families
- Affordable housing
- Availability of dental care
- Crime and safety
- Availability of affordable dental care
- Wellness and disease prevention

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

- Understanding and navigating Healthcare Reform
- Availability of substance abuse and treatment services
- Public transportation and water quality
- Retaining doctors and health care professionals
- Youth drug use and abuse

Education

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

- Affordable housing
- Cost of health care services
- Youth hunger and poor nutrition and with wellness and disease prevention

Respondents with high school education or less were less likely than those with more educations be concerned about:

- Adult drug use and abuse

Seniors

Respondents 58 years of age or older are more likely than younger respondents to concerned about:

- Change in population size
- Wellness and disease prevention, including vaccine preventable conditions
- Youth mental health

Respondents 58 years of age or older were less likely than younger respondents to be concerned about:

- Youth sexual health
- Youth alcohol use and abuse

Gender

Females were more likely than males to be concerned about:

- Youth sexual health
- Adult drug use and abuse

Females are slightly more likely than males to be concerned about:

- Access to exercise and fitness activities

Males were more likely than females to be concerned about:

- Prejudice and discrimination
- Diabetes
- Wellness and disease prevention
- Youth drug use and abuse
- Dementia/Alzheimer's disease

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%
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%

Source	Indicator	Year	Michigan	Huron	Sanilac	Tuscola
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
CHR	Food Insecurity (did not have access to reliable source of food in the past year)	2013	16%	14%	15%	15%
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 (every day 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	Excessive Drinking (Binge- 5+ drinks or daily drinking)	2014	20%	19%	20%	21%
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%
Source	**Indicator**	**Year**	**Michigan**	**Huron**	**Sanilac**	**Tuscola**
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%
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	Primary Care: ratio of the population to total primary care physicians. Higher= less access	2013	1,240:1	1,530:1	3,490:1	3,190:1
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

Source	Indicator	Year	Michigan	Huron	Sanilac	Tuscola
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**
CHR	High School Graduation: % of students who 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 2011-2015	NA	-2	-3	-13
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	2010-2014	34%	33%	26%	27%
CHR	Children Eligible For Free Lunch: % enrolled in public schools eligible for free lunch	2012-2013	42%	39%	44%	49%
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%
Source	**Indicator**	**Year**	**Michigan**	**Huron**	**Sanilac**	**Tuscola**
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	2005-2010	20%	14%	20%	16%
CHR	Social associations: number of associations per 10,000 population	2013	10.2	23.3	13.2	14.6
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 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

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.

Implementation Meeting

Caro Community Hospital began the prioritization process by reviewing the data described in the findings section of this report. The Implementation meeting included 8 men and 6 women; from both Caro Community Hospital's Board of Directors and internal hospital leadership. The meeting participants also reviewed the follow list of concerns revealed in focus groups:

Table 7 Top concerns of focus group by topic

Caro Community Hospital:

- Community/Environmental Concerns
  - Poverty (9) (*6)
  - Not enough jobs with livable wages, not enough to live on (7) (*5)
  - Attracting and retaining young families (6) (*4)
  - Not enough public transportation, cost of public transportation (5) (*3)
  - Child abuse (5)
  - Physical violence, domestic violence, sexual abuse (4)

- Physical, mental health, and substance abuse concerns (adults)
  - Drug use and abuse (including prescription drug abuse) (9) (*5)
  - Obesity/overweight (9) (*4)
  - Poor nutrition, poor eating habits (8) (*1)
  - Alcohol use and abuse (7) (*1)
  - Cancer (6) (*2)
  - Diabetes (3) (*2)
  - Stress (3) (*2)
  - Suicide (3)
  - Smoking and tobacco use/exposure to second-hand smoke (3)

- Concerns about health services
  - Cost of health insurance (10) (*3)
  - Cost of prescription drugs (7) (*1)
  - Ability to retain doctors and nurses in the community (5) (*2)
  - Availability of mental health services (5) (*2)
  - Cost of health care services (5) (*1)
  - Adequacy of health insurance (concerns about out-of-pocket costs) (5) (*1)
  - Availability of specialists (5)
  - Extra hours for appointments, such as evenings and weekends (4) (*2)
  - Quality of care (3)

- Concerns about youth and children
  - Youth obesity (5) (*1)
  - Youth mental health (5) (*1)
  - Youth drug use and abuse (including prescription drug abuse) (3) (*1)
  - Not enough activities for children/youth (3)
  - Youth hunger and poor nutrition (2) (*2)

- Concerns about the aging population
  - Availability of resources to help the elderly stay in their homes (5)
  - Being able to meet needs of older population (4)
  - Assisted living options (4)

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.

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

18. Health Insurance and Healthcare Costs	✓✓			▪	o	4
19. Healthcare Workforce	✓✓	◊	➢	▪	o	4
20. Heart Disease	✓	◊◊◊		▪		
21. Local Economic Conditions	✓✓	◊◊	➢	▪	o	
22. Lung Disease and Asthma					o	
23. Mental Health	✓	◊	➢	▪	o	8
24. Nutrition	✓		➢	▪	o	
25. Obesity		◊	➢	▪	o	
26. Personal Attitudes to Health and Healthcare			➢	▪	o	
27. Physical Activity	✓✓	◊◊		▪	o	
28. Quality of Healthcare			➢	▪	o	
29. Reproductive Health		◊	➢	▪	o	
30. Safety and Violence			➢	▪	o	
31. Senior Support Services			➢	▪	o	
32. Social Conditions	✓	◊	➢	▪	o	
33. Social Emotional Support			➢	▪	o	
34. Substance Abuse		◊	➢	▪	o	
35. Teen Births		◊			o	
36. Tobacco Use	✓ (prenatal)	◊ (prenatal)		▪	o	
37. Traffic Safety	✓✓	◊◊		▪	o	
38. Transportation			➢	▪	o	

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 Caro Community Hospital Efforts	Current Community Efforts
Access to Care	**Need** • Access to primary healthcare and providers • Access to dental health **Related Data** • Not meeting state average • County need based on data • County need based on stakeholder interviews • Hospital need based on focus group • Hospital need based on survey	1. Specialty clinic offering various specialty medical providers: a. Dermatology b. Nephrology c. Cardiology d. Pulmonology e. Orthopedics f. Neurology g. Gynecology h. Endocrinology i. Oncology j. Neurosurgery k. And more 2. Primary care clinic in Caro. 3. After Hours Clinic with evening and weekend hours opening soon 4. Students from CMU College of Medicine 5. Use of mid-level practitioners 6. Ongoing advertising of physicians to increase consumer awareness	**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. Legal services for seniors- Port Huron Office 6. A&D Home Care and BWCIL provides Nursing Home Transition services 7. BWCIL is the Housing Assistance Resource Agency (HARA) for the Thumb Area Continuum of Care. Provides homeless prevention and rapid re-housing 8. Homeless Coalition- Emergency Shelter, security deposits rental arrearages 9. Lakeshore Legal Aid **Local Programs** 1. HDC-Home delivered meals
Specialty Services	**Need** • Mental Health • Alcohol use/abuse **Related Data** • Not meeting state average • County need based on data • County need based on stakeholder interviews • Hospital need based on focus group	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 4. Referrals for patients to substance abuse treatment and community support groups such as AA	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. 3. Thumb Area Psychological Services based in Cass City. 4. Thumb Behavioral Health, List Psychological and other mental health providers.

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

	Hospital need based on survey	5. Substance Abuse screening and treatment referral in primary care clinics	
Health Insurance & Healthcare Costs .	**Need** • Health insurance and healthcare costs **Related Data** • Not meeting state average • County need based on data • County need based on stakeholder interviews • Hospital need based on focus group	1. Financial Assistance Program 2. Working with new insurance companies to be in their network 3. Financial Counselor 4. Payment Plans 5. Online Bill Pay 6. Annual Community Health Fair 7. Low-cost sports physicals for local students 8. Program for uninsured or those with high deductibles to get cost-effective lab work	**County Programs** 10. Adult day services and Foster Care Homes 11. Human Development Commission 12. Subsidized Housing Assistance, Independent and Assisted Living, long term care homes 13. Region VII Area Agency on Aging and Huron County Council on Aging 14. Legal services for seniors- Port Huron Office 15. A&D Home Care and BWCIL provides Nursing Home Transition services 16. BWCIL is the Housing Assistance Resource Agency (HARA) for the Thumb Area Continuum of Care. Provides homeless prevention and rapid re-housing 17. Homeless Coalition- Emergency Shelter, security deposits rental arrearages 18. Lakeshore Legal Aid **Local Programs** HDC-Home delivered meals
Recruitment and Retention	**Need** • Healthcare Workforce **Related Data** • Not meeting state average • County need based on data • County need based on stakeholder interviews • Hospital need based on focus group	1. Ongoing, active recruiting efforts of medical staff 2. Competitive wage/benefit packages 3. Continually updating employee benefits package 4. Internationals 5. Medical Opportunities of MI (MCRH)	

Written CHNA Report and Implementation Plan

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

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