Huron Medical Center
2016 Community Health Needs Assessment

A Report to the Community

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Executive Summary

Serving and Meeting Needs of the Community

Huron Medical Center (HMC), located in Huron County, Michigan, is a not-for-profit provider of integrated healthcare. Founded in 1906, it is a full service acute care hospital located in Bad Axe, Michigan. Huron Medical Center serves the residents of Huron, Sanilac, and Tuscola Counties and is committed to helping shape the future of health care. With a mission to provide excellence in healthcare to our communities in a caring, compassionate manner, Huron Medical Center is dedicated to improving the health of the community and providing quality care.

Services provided at Huron Medical Center include: Anti-Coagulation Clinic, Allergy Care, Cancer Care, Infusion Therapy, Cardiac Rehabilitation, Cardiology/Stress Testing, Pacemaker Insertion, Community Education, Dermatology, Digital Mammography, Ear, Nose & Throat, Endocrinology, Family Practice, Food & Nutrition, Intensive Care, Internal Medicine, Laboratory, Neurology, Obstetrics/Gynecology, Ophthalmology, Orthopedic Surgery, Pain Management, Pathology, Pediatrics, Physical, Occupational & Speech Therapy, Podiatry, Pulmonary Medicine, Radiology, Rheumatology, Sleep Studies, Surgical Services, Urology, Vascular Service and Wound/ Hyperbaric Center.

The leaders of Huron Medical Center 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 Huron Medical Center 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 Huron Medical Center 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 18 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 3 men and 5 women. They were an Attorney/HMC trustee, pharmacist, church secretary, RN, farmer, housewife, and a retired person. One preferred not to identify occupational status. Ages ranged from mid 20s to retired
- Key Stakeholder Interviews: A county level committee selected key organizations and individuals for stakeholder interviews. These interviews were held with four individuals from three key Huron county organizations that represented their clients.

- 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 Healh, 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, 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.

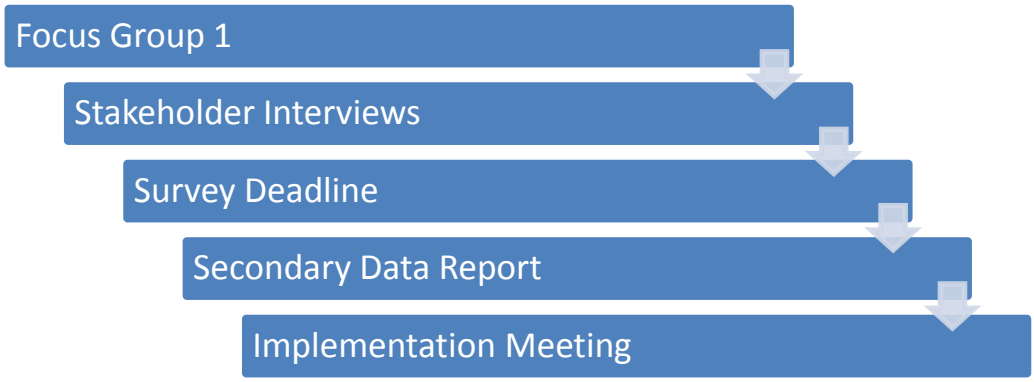
Process Overview

Steps in Process

In December 2016, 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:

- 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: 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

Huron Medical Center serves the residents of Huron, Sanilac, and Tuscola Counties.

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: One-fifth (19.7%) had a high school diploma or less, 20.0% some college, 19.4% a technical/Junior college degree, 23.0% a bachelor's degree and 17.9% a graduate or professional degree.
- Household Income: About one-fifth (19.0%) reported incomes $24,999 or less; about one-quarter (26.6%) between $25,000 and $49,999,and between one between $50,000 and $74,999 (26.1%) and a little over one quarter (28.9%) $75,000 or more. About 15% preferred not to report their household income.

- Employment: Three-fifths (60.0%) worked full time, 9.7% worked part time and 2.5% held multiple jobs. Retirees accounted for 15.8%.
- Insured Rates: Almost three-fifths (59.3%) had health insurance through an employer or union, 14.4% were on Medicare, and 9.9% individually purchased a plan. Only 1.0% reported not having any health insurance

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.

Table 1: Demographic highlights

Age	Respondents were asked their year of birth which was then recoded into quartiles. Of the valid cases, 23.8% were 37 or younger, 25.8% between 38 and 52, 25.2% between 53 and 60, and 25.2% were 61 or older.
Gender	Three-fourths (78.6%) of the respondents were female.
Marital Status	Over two-thirds (71.8%) were married or remarried
Children	Only 40.4% of households had children under 18
Education	One-fifth (19.7%) had a high school diploma or less, 20.0% some college, 19.4% a technical/jr college degree, 23.0% a bachelor's degree and 17.9% a graduate or professional degree.
Employment Status	Three-fifths (60.0%) worked full time, 9.7% worked part time and 2.5% held multiple jobs. Retirees accounted for 15.8%.
Health Sector	Over one-third (36.5%) worked for hospital, clinic or public health dept.
Race	94.4% self identified as White/Caucasian
Household income	About one-fifth (19.0%) reported incomes $24,999 or less; about one-quarter (26.6%) between $25,000 and $49,999,and between one between $50,000 and $74,999 (26.1%) and a little over one quarter (28.9%) $75,000 or more. About 15% preferred not to report their household income.
Health Insurance	Almost three-fifths (59.3%) had health insurance through an employer or union, 14.4% were on Medicare, and 9.9% individually purchased a plan. Only 1.0% reported not having any health insurance
Hospitals used past 2 years	Over one-quarter (28.3%) used Huron Medical Center in Bad Axe, 14.0% use Harbor Beach Community Hospital, 12.7% use Scheurer Hospital and 12.4% use Hills and Dales in Cass City.
ZIP Codes	Of the 18 Zip codes, three fifths (61.1%) of respondents lived in 48413 (Bad Axe), 48441 (Harbor Beach), 48726 (Cass City), and 48427 (Deckerville).

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.

Name	Title	Affiliation
Carl Osentoski	Executive Director	Huron County Economic Development Corporation
Kathie Harrison	Community Liaison	Huron Behavioral Health
Karen Southgate	Program Manager	Huron County Dept of Health and Human Services
Julie Booms	Family Independence Manager	Huron County 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 Plan

In 2013, the Community Health Needs assessment priorities identified by Huron Medical Center included:

1. Not having health insurance
2. People making unhealthy food choices/obesity
3. Heart disease
4. Diabetes
5. Cancer
6. Drug and substance abuse services
7. Confidentiality of health information
8. Treatment for mental health/depression
9. Dialysis services
10. Pain management services
11. Immunizations and vaccines
12. Lack of specialties and advanced care
13. OB/GYN and pediatric services

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 from people on a street corner or in a mall to those who come across the survey on line. 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

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Gender	Three-fourths (78.6%) of the respondents were female.
Marital Status	Over two-thirds (71.8%) were married or remarried
Children	Only 40.4% of households had children under 18
Education	One-fifth (19.7%) had a high school diploma or less, 20.0% some college, 19.4% a technical/jr college degree, 23.0% a bachelor's degree and 17.9% a graduate or professional degree.
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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 using a standard list of questions. Facilitators used a script and consistent processes for documenting data. Focus group notes were recorded and coded by the Michigan Center for Rural Health (MCRH) with summaries provided for analysis. A focus group of 3 men and 5 women was held on 04/12/2016 at Huron Medical Center. They were invited to participate by the hospital staff.

Stakeholder Interviews:

The Huron 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.
Community Survey			
Community Survey	<#> 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	3 men and 5 women	2016	Meeting included discussion of questions that were also utilized in individual interviews.
Individual Interviews and Focus Groups	Carl Osentoski, Kathie Harrison, Julie Booms and Karen Southgate	2016	Results from interviews & meetings were included in survey report.

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: Q17 Issues prevent receiving health care

In this table, a higher mean score indicates a higher perceived problem.	N	Mean	Std. Deviation
Q17. Not enough specialists	698	2.64	1.23
Q17. Not enough doctors	689	2.46	1.29
Q17. Not enough evening or weekend hours	691	2.44	1.23
Q17. Not able to get appointment/limited hours	690	2.32	1.14
Q17. Not able to see same provider over time	691	2.14	1.25
Q17. Don't know about local services	683	2.11	1.14
Q17. Distance from health facility	694	2.05	1.07
Q17. Not accepting new patients	684	1.92	1.15
Q17. Can't get transportation services	697	1.90	1.13
Q17. Poor quality of care	675	1.75	1.02
Q17. Concerns about confidentiality	691	1.52	0.94
Q17. Barriers to accessing veterans services	679	1.50	1.25
Q17. Limited access to telehealth technology	671	1.42	1.30
Q17. Lack of disability access	686	1.37	0.90
Q17. I am afraid or too uncomfortable to go	661	1.33	0.95
Q17. Don't speak language or understand culture	686	1.18	0.75
Q17. I have other more important things to do	665	1.11	0.84

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	500	36.2%	80.0%
	Q16. No insurance	257	18.6%	41.1%
	Q16. Insurance denies services	222	16.1%	35.5%
	Q16. Not affordable Services	220	15.9%	35.2%
	Q16. Providers do not take my insurance	183	13.2%	29.3%
Total		1382	100.0%	221.1%

Community Concerns

The concerns about the community's health included

- Access to healthy food
- Access to exercise and fitness activities
- Awareness of local health resources and services
-

Concerns about the quality of life in the community

- Jobs with livable wages
- Attracting and retaining young families
- Adequate youth activities

Concerns about availability of health services

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

Concerns about the community's safety and environment

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

Concerns about the delivery of health services

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

Concerns related to Vulnerable Populations

Concerns about 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.

Table 4 below (youth frequencies) shows that the largest concern about youth physical health was youth obesity with 32.6% of the responses, but chosen by two-fifths (41.1%) of the respondents. The second largest concern was wellness and disease prevention, including vaccine-preventable (21.7%). The third largest concern was teen pregnancy with 17.6% of the responses. This was followed closely by youth hunger and nutrition (15.8%).

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	143	32.6%	41.1%
	Q12b. Wellness and disease prevention, including vaccine-preventable	95	21.7%	27.3%
	Q12b. Teen pregnancy	77	17.6%	22.1%
	Q12b. Youth hunger and poor nutrition	69	15.8%	19.8%
	Q12b. Youth sexual health (including sexually transmitted diseases	54	12.3%	15.5%
	Total	438	100.0%	125.9%

a. Dichotomy group tabulated at value 1.

Table 5 shows that the largest concern with youth mental health and substance abuse with 30.6% of the responses was youth drug use and abuse, which was chosen by half (53.5%) of the respondents. The second largest concern with 22.2% of the responses was youth bullying, chosen by three-eighths (38.7%) of the respondents. The third largest was youth alcohol use and abuse at 17.5%.

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)	300	30.6%	53.5%
	Q13b. Youth bullying	217	22.2%	38.7%
	Q13b. Youth alcohol use and abuse (including binge drinking)	171	17.5%	30.5%
	Q13b. Youth mental health	108	11.0%	19.3%
	Q13b. Youth suicide	103	10.5%	18.4%
	Q13b. Youth tobacco use (including exposure to second-hand smoke,	80	8.2%	14.3%
	Total	979	100.0%	174.5%

a. Dichotomy group tabulated at value 1.

As shown in Table 6, the top concern with the senior population in their community was the cost of medications (18.8% of the responses) and chosen by half (53.7%) of the respondents. The second largest at 15.3% of the responses was the availability of resources to help the elderly stay in their homes. The third largest concern was assisted living options (10.9%) followed closely by the availability of activities for seniors (10.5%).

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	380	18.8%	53.7%
	Q14. Availability of resources to help the elderly stay in their	310	15.3%	43.8%
	Q14. Assisted living options	220	10.9%	31.1%
	Q14. Availability of activities for seniors	213	10.5%	30.1%
	Q14. Transportation	196	9.7%	27.7%
	Q14. Availability of resources for family and friends caring for	192	9.5%	27.1%
	Q14. Dementia/Alzheimer's disease	192	9.5%	27.1%
	Q14. Long-term/nursing home care options	127	6.3%	17.9%
	Q14. Hunger and poor nutrition	104	5.1%	14.7%
	Q14. Cost of activities for seniors	44	2.2%	6.2%
	Q14. Elder abuse	44	2.2%	6.2%
	Total	2022	100.0%	285.6%

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	**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 (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	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	1,280:01	670:01	430:01
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 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 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

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

Huron Medical Center began the prioritization process by reviewing the data described in the findings section of this report. The Implementation meeting included representatives from the Senior Management and Leadership Teams of Huron Medical Center. The participants also reviewed the list of concerns revealed in focus groups and individual stakeholder interviews.

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 team identified the following areas as priorities to address:

- Lack or perceived lack of available physicians, including specialists.
- Obesity, particularly among youth
- Cost of Healthcare

Implementation Plan and Strategies to fill gaps in resources

Table 5: Hospital Response to Needs

Category	Current Huron Medical Center Strategies	New or Expansion Strategies Under Consideration
Lack or Perceived Lack of Physicians including Specialists in the area	• Ongoing, active recruiting efforts of medical staff • Competitive wage/benefit packages • Ongoing relationship with CMU College of Medicine • Use of mid-level practitioners • Specialty Clinic for visiting physician specialists • Ongoing advertising of physicians to increase consumer awareness of providers availability	• Newly created position of "Administrative Medical Liaison" to assist with recruiting and retention efforts for physicians • Centralized scheduling of patients for physician services to allow patients quicker access to available physicians • Participation in collaboration with local hospitals to explore ways to effectively attract more specialist to the area • Increased marketing efforts to ensure that referral sources and the community are aware of Specialty Clinic offerings • New strategies to recruit providers are being developed such as different agencies and means of advertising for open positions
Obesity, particularly among youth	• School nurse program • Physician Counseling • Registered Dietician on staff • Pediatricians on staff	• Seek collaboration with schools in HMC's service area to educate about childhood obesity and strategies to combat it. • Identify resources for local doctors to refer families in need of assistance with obesity issues • Increase public and provider marketing related to the availability of Registered Dietician counseling at HMC for obesity related issues. • Work with local hospitals and health department to develop formal program to address childhood obesity.
Cost of Healthcare	• Charity Care Program • Financial Counselors/Payment Plans • Reduced Cost Mammograms offered twice yearly • Low-cost sports physicals at local school • School Nurse provided to Bad Axe and Ubly Schools • Free CPAP Clinic monthly • Free Bike Helmets given away at a Farmer's Market Event • Reduced cost flu shots provided at local businesses for employees • Health & Wellness Fairs • Free Health Screenings • Competitive bidding to keep customer costs down • 340B Drug Program	• Offer Blood Pressure and other Wellness Screenings at local senior centers • Offer exercise classes at local senior centers and schools • Online Bill Pay • Participation in the Huron County CHNA work group to explore future growth in this area

Written CHNA Report and Implementation Plan

- The CHNA report was completed in draft form in August 2016. The final report and implementation plan was reviewed and posted to the hospital website at www.huronmedicalcenter.org in September 2016.

Additional Documents (Available Upon Request)

- Survey Instrument
- Focus Group Design
- Interview Outline
- Survey, Stakeholder, Focus Group Report
- Thumb Area Health Status Data Reports