2016 Community Health Needs Assessment

A Report to the Community

Table of Contents

Contents

Background and Overview

Executive Summary

Serving and Meeting Needs of the Community

Deckerville Community Hospital is a Critical Access Hospital. The Medicare Rural Flexibility Program, created by Congress in 1997, allows small hospitals to be licensed as a critical access hospital (CAH), and offers grants to States to help implement initiatives to strengthen the rural healthcare infrastructure. 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) found at 42 CFR Part 485 Sub-part F at the time of application for CAH status
- Furnish 24-hour emergency care services seven days a week, using either onsite or on-call staff
- Provide no more than twenty-five 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 ten 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)
- 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 “necessary provider” of health care services to residents in the area.

Deckerville Community Hospital Mission, Vision and Values

The mission of Deckerville Community Hospital and Clinics, in partnership with its Medical Staff, other health providers, and the East-Central Thumb Community, is to provide quality, cost-effective primary care close to home in a patient-centered environment, provide coordination of specialty and tertiary care, and provide systems of care that assist patients as they transition through various care continuums.

Deckerville Community Hospital, through the efforts of the Board of Directors, the Medical Staff, and employees will be recognized by the East-Central Community for its support and efforts in informing the community on public health needs, implementing progressive changes to meet these needs, and visionary efforts to continually plan for the expanding residential, recreational, and Industrial populations.

Deckerville Community Hospital and its Medical Staff are committed to:

- Excelling in customer service by consistently meeting or exceeding patient needs and expectations while concurrently being responsive to their personal values and apprehension.
- Continuously improving the quality and selection of services delivered by the hospital.
- Collaborating with other care givers to coordinate services such that the patients receive the patients receive the appropriate care in the proper location at the right time.

Deckerville Community Hospital Services

General and Acute Services

1. Cardiology (Dr. Suresh Tumma)
2. Clinic (Walk-in)
3. Emergency Room (24/7)
4. Gastroenterology (Dr. Kavita Tumma)
5. Hospice
6. Hospital (Acute Care)
7. Neurology (Dr. Steven Beall)
8. Neurosurgery (Dr. Gerald Schell)
9. Nephrology (Dr. Abida Zafar)
10. Nutrition Counseling (Kari Pangborn, RD)
11. Orthopedics (Dr. Gerald Jerry)
12. Pharmacy (Scott Rayl PharmD/ Harbor Drug)
13. Podiatry (Dr. Robert Patrus)
14. Pulmonary Disease (Dr. Basha/ Dr. Haidar)
15. Respite Care
16. Surgical Services (Dr. Erina Kansakar)

Screening/ Therapy Services

1. Chronic Disease Management
2. Holter Monitoring
3. Laboratory Services
4. Lower Extremity Circulatory Assessment
5. Occupational Physicals
6. Pediatric Services
7. Physical Therapy

Radiology Services

1. Computed Tomography
2. Digital Mammography
3. Ultrasound
4. X-ray (IVP and Fluoroscopy)

The leaders of Deckerville 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 Deckerville 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 Deckerville 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 to the 48419, 48427, 48434, 48456, 48465, and 48469 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 two members of the board, the Superintendent of Deckerville Community Schools, the Head Librarian of Deckerville Community Library, and a Businessman from Deckerville.

Focus Group Findings

The responses of the focus group were coded independent of the survey. Therefore, some do not have the exact same wording as reported in the survey findings.

Question #1 - What are the best things about your community?

Q1	Frequencies	Proportion
Supportive Community	4	30.8%
Close community	3	23.1%
Hospital	2	15.4%
Lack of Traffic	1	7.7%
Library	1	7.7%
Schools	1	7.7%
Work ethic of community	1	7.7%
	13	100.0%

Focus group members thought the major challenge facing the community was jobs and employment.

Question #2 - What are the major challenges facing your community?

Q2	Frequencies	Proportion
Jobs/Better jobs	6	100.0%

Focus groups identified seven services they did not know Deckerville Hospital provided.

#3 please review the list of services provided by Deckerville Hospital. Highlight the services you did not know about.

Explanation: each Focus Group participant was handed a list of services provided by the hospital. They highlighted the services they did not know about. The handouts were collected, and the items on the following lists were the services participants did not know about. If there is a number next to the service, the number represents the number of participants who did not know about the service.

- General and acute services
  - Hospice (1)

- Podiatry (1)
- Pulmonary Disease (1)
- Respite Care (1)

o Screening/ Therapy Services

- Holter Monitoring—heart rhythm (2)
- Lower extremity circulatory assessment (1)

o Radiology Services

- Computed tomography (2)

Focus group members thought the hospital should facilitate transportation and access to specialty services.

Question #4 What specific services, if any, do you think local Hospitals needs to add? Why?

Q4	**Frequencies**	**Proportions**
Transportation	3	33.3%
Access to Specialty services	2	22.2%
OB/GYN	2	22.2%
Sharing of services	1	11.1%
Access to Primary care services	1	11.1%
	9	100.0%

Focus groups identified nine services provided by the Sanilac County Health Department that they did not know about.

#5 please review the list of services provided by the Sanilac County Health Department. Highlight the services you did not know about.

> Explanation: Each Focus Group participant was handed a list of services provided by the Health Department. They highlighted the services they did not know about. The handouts were collected, and the items on the following lists were the services participants did not know about. If there is a number next to the service, the number represents the number of participants who did not know about the service.

Deckerville (Sanilac County Health Department):

- Dental Health Programs (2)
- Hearing and vision programs (2)
- Vision Program (2)

- Baby Pantry (1)
- Children's special health care services (1)
- MI Child & Healthy Kids (1)
- Safe Kids (1)
- EH Clerk (1)
- Septic (1)

Focus group members suggested more collaboration would provide better services and improve overall health of the population.

Question #6 What suggestions do you have for health-related organizations to work together to provide better services and improve the overall health of the area population?

Q6	Frequencies	Proportions
Collaboration	4	36.4%
Access	3	27.3%
Community awareness of services	2	18.2%
Billing improvements	1	9.1%
Healthy lifestyle education	1	9.1%
	11	100.0%

Focus group members thought that people found out about available health services from the hospital/health care provider and the library.

Question #7: Where do people find out what health services are available in the area?

[* items show the items that were also used for trusted health information (question 8)]

Q7	Frequencies	Proportions
Hospital/Service Provider	2	22.2%
Library	2	22.2%
Online	1	11.1%
School	1	11.1%
Social Media	1	11.1%
Word of Mouth	1	11.1%

Community	1	11.1%
	9	100.0%

Focus group members identified four trusted sources for health information

Question #8: Where do people turn for trusted health information?

These responses are in addition to the * responses above

Q8	Frequencies	Proportions
Hospital/Service Provider	1	25.0%
Library	1	25.0%
Online	1	25.0%
Community	1	25.0%
	4	100.0%

#9 Please review the list of potential health concerns that may affect the community as a whole. Please highlight the items you feel are important concerns for your community. Of those items highlighted, please star five items you think are the most important.

> Each Focus Group participant was handed a list of "potential community concerns". They were asked to highlight ANY item that they felt was a concern in their community. They were then asked to look at their highlighted items and place a star next to the five they thought were of the largest concern.

The following lists represent the items participants highlighted (felt were of concern in their community). If there is a number following the item, it shows the number of people who highlighted it. The number following the star (*) represents the number of people who felt it was one of their top five concerns (for example, *** means 3 people placed it in their top five concerns.)

Deckerville:

- Physical, mental health and substance abuse concerns (adults)
  - Cancer (5) ****
  - Diabetes (4) *
  - Depression (4)
    - Stigma- especially with men
  - Drug use and abuse (including prescription drug abuse) (3) **
  - Heart disease (3)
  - Wellness and disease prevention, including vaccine-preventable disease (2) *
    - 1 highlighted vaccine preventable disease

  - Stress (2)
  - Not getting enough exercise (2)
  - Obesity/overweight (2)
  - Alcohol use and abuse (1) *
  - Dementia/Alzheimer's disease (1)
  - Poor nutrition, poor eating habits (1)

- Concerns about Health Services
  - Cost of health insurance (4) ***
  - Adequacy of health insurance (concerns about out-of-pocket costs) (3) **
  - Ability to retain doctors and nurses in the community (3) **
  - Ability to get appointments for health services (3) **
  - Cost of health care services (2) **
  - Extra hours for appointments, such as evenings and weekends (2) *
  - Availability of doctors and nurses (2) *
  - Availability of specialists (2) *
  - Availability of public health professionals (2)
  - Availability of substance abuse/treatment services (2)
  - Availability of providers that speak my language and/or have translators (1)
  - Availability of wellness and disease prevention services (1)
  - Availability of dental care (1)
  - Different health care providers having access to health care information and working together to coordinate care (1)
  - Patient confidentiality (1)
  - Quality of care (1)
  - Emergency services (ambulance & 911) available 24/7 (1)
  - Cost of prescription drugs (1)

- Concerns specific to youth and children
  - Youth drug use and abuse (including prescription drug abuse) (4) **
  - Youth alcohol use and abuse (2)
  - Youth obesity (1)
  - Youth hunger and poor nutrition (1)
  - Youth mental health (1)
  - Youth sexual health (1)
  - Youth graduating from school (1)

- Concerns about the aging population
  - Long-term/nursing home care options (2) **
  - Availability of resources to help the elderly stay in their homes (2)
  - Availability of resources for family and friends caring for elderly (2)

- Availability/cost of activities for seniors (1) *
- Assisted living options (1) *
- Being able to meet needs of older population (1)

Focus group members were concerned about difficulty and delay in getting appointments.

Question #10: What other community concerns do you perceive that are not listed

Q10	Frequencies	Proportions
Access –difficult delay in getting appointment	3	37.5%
Insurance education and management	1	12.5%
Perception that it is not needed	1	12.5%
Insurance education and management	1	12.5%
Billing issues	1	12.5%
Not enough preventative care for adults	1	12.5%
	8	100.0%

Again, availability and delay in making appointments was a barrier to accessing preventive services.

Question #11: Even though most insurance now cover basic preventative services like wellness visits, many people do not use these services. Why do you think that may be?

Q11	Frequencies	Proportions
Availability/delay making appointments	5	45.5%
Care about kids or parents not selves	3	27.3%
Problems with billing	2	18.2%
New system- insurance may not cover as much as old	1	9.1%
	11	100.0%

Focus group members mentioned more hours and online portals and hotlines as way to remove barriers to use of health services.

Question #12: What would help to remove barriers that may be affecting the use of local health by the community as a whole?

Q12	Frequencies	Proportion
expand walk-in clinic hours	1	50.0%
online portals, nurse hotlines	1	50.0%
	2	100.0%

Focus group members thought peopled used Deckerville Healthcare because of its location, trust and knowledge of providers, and positive experiences.

Q 13 What are the reasons that community members use Deckerville Healthcare rather than other providers for health care needs?

Q13	Frequencies	Proportions
Location	5	38.5%
Trust the Service/ know providers	3	23.1%
Positive experience	2	15.4%
Quality of the service (blood draws)	1	7.7%
Easy	1	7.7%
Convenience	1	7.7%
	13	100.1%

Focus group members thought that people went to other healthcare providers because specialties were not offered at Deckerville and issues of privacy/confidentiality.

Question #14: What are the reasons that community members use other providers for their healthcare needs?

Q14	Frequencies	Proportions
Specialties not offered	3	33.3%
Privacy/confidentiality	2	22.2%
Bad Experience	1	11.1%
Debt to Hospital	1	11.1%
Insurance not taken	1	11.1%
access hours/availability	1	11.1%

	9	100.0%

Focus group members thought that middle income families and those without savings to pay out of pocket were medically underserved.

Question #15: Are you aware of particular populations or groups in the area that are medically underserved?

Q15	**Frequencies**	**Proportions**
Middle Income families	1	50.0%
No savings pay out of pocket	1	50.0%
Total	2	100.0%

Focus group members suggested that more education and marketing of services would help improve the health of the community.

Question #16: If you were to give one piece of advice to improve the health of the community, what would it be? Is there other advice you would offer?

Q16	**Frequencies**	**Proportions**
Education/ awareness of services offered/available	2	50%
Education of wellness services eg PT	1	25%
What else hospital could add	1	25%
	4	100%

Question #17 What are the reasons that community members use other health care providers rather than use their local Hospital?

Question skipped

Question #18 Are you aware of particular populations or groups in the area that are medically underserved?

a. If so, are there any particular health concerns of those groups?
b. Are there certain resources or assets currently available that could help meet these particular needs?

Question skipped

Question #19 How are low-income and/or minority populations in the community impacted differently by these potential needs?

Question skipped

Question #20 If you were to give one piece of advice to improve the health of the community, what would it be? Is there other advice you would offer?

- Key Stakeholder Interviews: A county level committee selected key organizations and individuals for stakeholder interviews. These interviews were held with William Weston, Director of the Michigan Department of Health and Human Services for Saint Clair and Sanilac Counties; Jamie Reinke, Sanilac County Program Manager, also from the Michigan Department of Health and Human Services; Jim Johnson, Director of the Sanilac County Community Mental Health; and Duane Lange, Superintendent for the Sanilac Intermediate School District.

Stakeholder Interview Responses

When asked what the best things about their community, interviewees mentioned supportive community and close/tight knit community.

Question #1 - What are the best things about your community?

Q1	Frequencies	Proportion
Supportive Community	4	30.8%
Close community	3	23.1%
Hospital	2	15.4%
Lack of Traffic	1	7.7%
Library	1	7.7%
Schools	1	7.7%
Work ethic of community	1	7.7%
	13	100.0%

Interviewees thought the major challenge facing the community was jobs and employment.

Question #2 - What are the major challenges facing your community?

Q2	Frequencies	Proportion
Jobs/Better jobs	6	100.0%

Follow-up to Q3 which gave individual as list of hospital services asking individuals which services they did not know about. The number of interviewees who did not know about the service is in parentheses.

Q3

- General and acute services
  - Hospice (1)
  - Podiatry (1)

- Pulmonary Disease (1)
- Respite Care (1)

- Screening/ Therapy Services
  - Holter Monitoring—heart rhythm (2)
  - Lower extremity circulatory assessment (1)
- Radiology Services
  - Computed tomography (2)

Interviewees thought the hospital should facilitate transportation and access to specialty services.

Question #4 What specific services, if any, do you think local Hospitals needs to add? Why?

Q4	Frequencies	Proportions
Transportation	3	33.3%
Access to Specialty services	2	22.2%
Ob/Gyn	2	22.2%
Sharing of services	1	11.1%
Access to Primary care services	1	11.1%
	9	100.0%

Question #5 I'm handing you a list of services provided by the Sanilac County Health Department. Please review and comment on whether you think the community as a whole is aware of these locally available services.

Q5	Frequencies	Proportions
Dental	1	16.7%
Hearing	1	16.7%
Vision	1	16.7%
Community not aware of all services	1	16.7%
Include HD services in packet new students,	1	16.7%
Include HD services in library welcome	1	16.7%
	6	100.0%

Interviewees suggested more collaboration would provide better services and improve overall health of the population.

Question #6 What suggestions do you have for health-related organizations to work together to provide better services and improve the overall health of the area population?

Q6	Frequencies	Proportions
Collaboration	4	36.4%
Access	3	27.3%
Community awareness of services	2	18.2%
Billing improvements	1	9.1%
Healthy lifestyle education	1	9.1%
	11	100.0%

Interviewees thought that people found out about available health services from the hospital/health care provider and the library.

Question #7: Where do people find out what health services are available in the area?

[* items show the items that were also used for trusted health information (question 8)]

Q7	Frequencies	Proportions
Hospital/Service Provider	2	22.2%
Library	2	22.2%
Online	1	11.1%
School	1	11.1%
Social Media	1	11.1%
Word of Mouth	1	11.1%
Community	1	11.1%
	9	100.0%

Question #8: Where do people turn for trusted health information?

These responses are in addition to the * responses above

Q8	Frequencies	Proportions
Hospital/Service Provider	1	25.0%

Library	1	25.0%
Online	1	25.0%
Community	1	25.0%
	4	100.0%

Question #9: Please review the list of potential health concerns that may affect the community as a whole, and highlight those you feel are important concerns for your community. Of the highlighted, please star five which you think are the most important

Not asked of stakeholders

Interviewees were concerned about difficulty and delay in getting appointments.

Question #10: What other community concerns do you perceive that are not listed

Q10	**Frequencies**	**Proportions**
Access –difficult delay in getting appointment	3	37.5%
Insurance education and management	1	12.5%
Perception that it is not needed	1	12.5%
Insurance education and management	1	12.5%
Billing issues	1	12.5%
Not enough preventative care for adults	1	12.5%
	8	100.0%

Again, availability and delay in making appointments was a barrier to accessing preventive services.

Question #11: Even though most insurances now cover basic preventative services like wellness visits, many people do not use these services. Why do you think that may be?

Q11	**Frequencies**	**Proportions**
Availability/delay making appointments	5	45.5%
Care about kids or parents not selves	3	27.3%
Problems with billing	2	18.2%
New system- insurance may not cover as much as old	1	9.1%

	11	100.0%

Interviewees mentioned more hours and online portals and hotlines as way to remove barriers to use of health services.

Question #12: What would help to remove barriers that may be affecting the use of local health by the community as a whole?

Q12	Frequencies	Proportion
expand walk-in clinic hours	1	50.0%
online portals, nurse hotlines	1	50.0%
	2	100.0%

Interviewees used Deckerville Healthcare because of its location, trust and knowledge of providers, and positive experiences.

Q 13 What are the reasons that community members use Deckerville Healthcare rather than other providers for health care needs?

Q13	Frequencies	Proportions
Location	5	38.5%
Trust the Service/ know providers	3	23.1%
Positive experience	2	15.4%
Quality of the service (blood draws)	1	7.7%
Easy	1	7.7%
Convenience	1	7.7%
	13	100.1%

Interviewees thought that people went to other healthcare providers because specialties were not offered and issues of privacy/confidentiality.

Question #14: What are the reasons that community members use other providers for their healthcare needs?

Q14	Frequencies	Proportions
Specialties not offered	3	33.3%
Privacy/confidentiality	2	22.2%

Bad Experience	1	11.1%
Debt to Hospital	1	11.1%
Insurance not taken	1	11.1%
access hours/availability	1	11.1%
	9	100.0%

Interviewees thought that middle income families and those without savings to pay out of pocket were medically underserved.

Question #15: Are you aware of particular populations or groups in the area that are medically underserved?

Q15	**Frequencies**	**Proportions**
Middle Income families	1	50.0%
No savings pay out of pocket	1	50.0%
Total	2	100.0%

Interviewees suggested that more education and marketing of services would help improve the health of the community.

Question #16: If you were to give one piece of advice to improve the health of the community, what would it be? Is there other advice you would offer?

Q16	**Frequencies**	**Proportions**
Education/ awareness of services offered/available	2	50%
Education of wellness services eg PT	1	25%
What else hospital could add	1	25%
	4	100%

Question #17 What are the reasons that community members use other health care providers rather than use their local Hospital?

Question #18 Are you aware of particular populations or groups in the area that are medically underserved?

c. If so, are there any particular health concerns of those groups?
d. Are there certain resources or assets currently available that could help meet these particular needs?

Question #19 How are low-income and/or minority populations in the community impacted differently by these potential needs?

Question skipped

Question #20 If you were to give one piece of advice to improve the health of the community, what would it be? Is there other advice you would offer?

Question skipped

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, 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

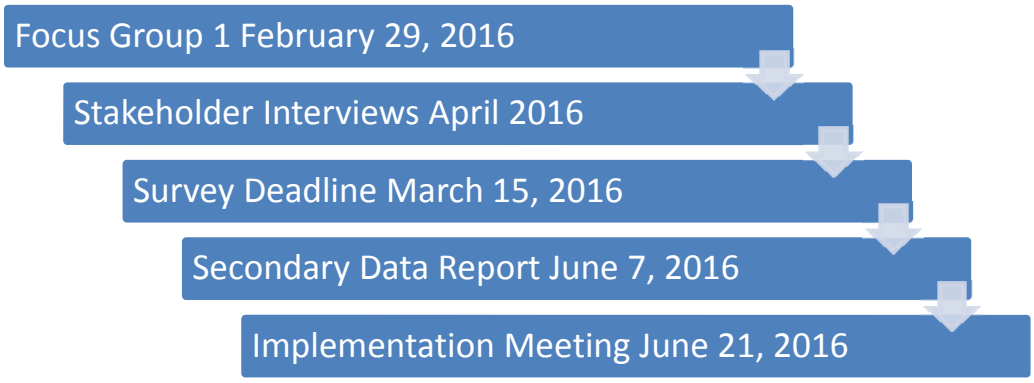
Process Overview

Steps in Process

In December 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[1]:

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

The findings are based on the responses of 163 individuals living in the five ZIP codes served by Deckerville Community Hospital who completed the survey by March 15, 2016. Deckerville Community hospital's ZIP codes are: 48419 (Carsonville); 48427 (Deckerville); 48434 (Forestville); 48456 (Minden City), and 48465 (Palms). Of the 163 respondents 57.1% lived in 48427 (Deckerville) where the hospital is located and 22.7% in 48419 (Carsonville).

Table 1 contains the demographics for age, gender, marital status, children under 18 in home, educational attainment, employment status, health sector employment, race, annual household income, source of health insurance and respondent's ZIP code. Complete demographic frequency tables can be found in Appendix B.

Table 1: Demographic highlights

Age	Respondents year of birth which was then recoded into quartiles..20.2% were 33 or less, 25.2% between 34-48, 21.5% between 49-58, and 24.5% were 59 or older.
Gender	86.4% were female and only 13.6% male
Marital Status	69.9% were married or remarried; the remainder were currently unmarried
Children	55.2% of the respondents had no children under the age of 18 living at home
Education	19.0% had a high school diploma or less; 20.9% some college; 21.6% technical or junior college degree;, 21.6% a BA/BS; 17.0% a graduate/ professional degree.
Employment Status	67.3% worked full-time; 7.5% part-time; 0.6% held multiple jobs; 12.6% were retired
Health Sector	33.8 % worked for a hospital, clinic, or public health dept; 66.2% did not
Race	95.1% self-identified as White/Caucasian
Household income	Respondents were asked their household income in 7 brackets which were then divided into 4 groups: 16.9% reported $24,999 or less; 35.3% $25,000 to $49,999; 27.9% $50,000 to $74,999; and 19.9% $75,000 or more.
Health Insurance	60.0% reported that their employer or union provided health insurance; 11.2% individually purchased a plan from an insurance company or healthcare.gov; 11.2% reported Medicare; 3.5% Medicaid. Only 3.5% claimed to be uninsured.
Hospitals used past 2 years	55.3% of respondents reported using Deckerville Community Hospital and 38.6% used McKenzie Health Systems (Sandusky).
ZIP Codes	57.1% lived in 48427 (Deckerville) where the hospital is located, 22.7% in 48419 (Carsonville) and 14.7% in 48456 (Minden City).

The respondents were predominantly female (86.4%). Almost all (95.1%) self-identified as White/Caucasian. Approximately 70% were currently married or remarried. Less than half (44.7%) had children under 18 living in the household. About two thirds (67.3% were employed full-time. Approximately one-fifth (19.9%) had incomes $75,000 or more. Three-fifths (60.0%) had health insurance through their employer or union, 11.2% indicated they purchased health insurance from an insurance company or healthcare.gov, and only 3.5% reported not having any health insurance.

In terms of vulnerable populations, seniors 59 or older accounted for approximate one-quarter (24.5%) of respondents; respondents with a high school education or less accounted for 19.0%, and 14.2% of respondents reported annual household incomes $24,999 or less.

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%

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.

Deckerville Community survey was designed to capture demographic information about the respondents. Tables Q21 through Q33 summarize these findings.

As shown in Table Q21 below, most of the respondents (66.2%) stated that they did not work for a hospital, clinic, or public health department.

Table Q21. Work for a hospital, clinic, or public health department

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	52	31.9	33.8	33.8
	No	102	62.6	66.2	100.0
	Total	154	94.5	100.0	
Missing	System	9	5.5		
Total		163	100.0		

Table Q22 below shows that the number one provider of health insurance for these respondents was employer or union provided with three-fifths (60.0%) The second and third largest providers with 11.2% of respondents were MEDICARE and individually purchased plan.

TABLE Q22. Primary health insurance.

		Frequency	Percent	Cumulative Percent
Valid	Q22. Employer or union provided insurance	102	60.0%	60.0%
	Q22. MEDICARE	19	11.2%	71.2%
	Q22. Individually purchased plan (from company or healthcare.gov)	19	11.2%	82.4%
	Q22. MEDICAID	6	3.5%	85.9%
	Q22. Uninsured (no health insurance)	6	3.5%	89.4%
	Q22. MEDICARE/MEDICAID combined with supplemental/other insurance	5	2.9%	92.4%
	Q22. Healthy Michigan	3	1.8%	94.1%
	Q22. Both MEDICARE and MEDICAID (dual eligible)	2	1.2%	95.3%
	Q22. MiChild	2	1.2%	96.5%
	Q22. Another government insurance (CHAMPUS, Military, Veteran)	1	0.6%	97.1%
	Q22. Other	5	2.9%	100.0%
	Total	170	100.0%	

As seen in Table Q23 below, the age quartiles of the respondents were fairly evenly divided with the age group 34-48 being the largest the age group 49-58 being the smallest.

Table Q23. Age

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	33 or younger	33	20.2	22.1	22.1
	34-48	41	25.2	27.5	49.7
	49-58	35	21.5	23.5	73.2
	59 or older	40	24.5	26.8	100.0
	Total	149	91.4	100.0	
Missing	System	14	8.6		
Total		163	100.0		

Table Q24 below shows that a majority of the respondents, almost 70%, were either married or remarried. The smallest group of respondents (3.3%) was a member of an unmarried couple.

Table Q24. Marital Status

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Married, Remarried	107	65.6	69.9	69.9
	Divorced	15	9.2	9.8	79.7
	Widowed	11	6.7	7.2	86.9
	Member of an unmarried couple	5	3.1	3.3	90.2
	Single, never been married	15	9.2	9.8	100.0
	Total	153	93.9	100.0	
Missing	System	10	6.1		
Total		163	100.0		

Table Q25 below shows that over 55% of the respondents had no children under 18 living at home. The smallest group of respondents with children under 18 living at home was those with four children.

Table Q25. Children (under 18) living in your house.

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	None	85	52.1	55.2	55.2
	1.00	25	15.3	16.2	71.4
	2.00	33	20.2	21.4	92.9
	3.00	8	4.9	5.2	98.1
	4.00	3	1.8	1.9	100.0
	Total	154	94.5	100.0	
Missing	System	9	5.5		
Total		163	100.0		

As seen in Table Q26 below the largest group of respondents with individuals 18 year of age or older living in their household was those with two people, or 54.5% of those who answered this question. The smallest group had five individuals (1.3%).

Table Q26. individuals 18 or over live in your household.

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	35	21.5	22.7	22.7
	2	84	51.5	54.5	77.3
	3	25	15.3	16.2	93.5
	4	8	4.9	5.2	98.7
	5	2	1.2	1.3	100.0
	Total	154	94.5	100.0	
Missing	System	9	5.5		
Total		163	100.0		

Table Q27 below shows that the largest group of respondents had a technical or junior college degree and those with bachelor's degree each representing 21.6% of the respondents, or a total of 43% of the respondents. The third largest group had some college (20.9%) and 17.0% had a graduate or professional degree.

Table Q27. Highest level of education completed.

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Less than high school	1	.6	.7	.7
	High school diploma/GED	28	17.2	18.3	19.0
	Some college (no degree)	32	19.6	20.9	39.9
	Technical or junior college degree	33	20.2	21.6	61.4
	Bachelor's degree	33	20.2	21.6	83.0
	Graduate or professional degree	26	16.0	17.0	100.0
	Total	153	93.9	100.0	
Missing	System	10	6.1		
Total		163	100.0		

As shown in Table Q28 below, a large majority of the respondents (86.4%) were female.

Table Q28. Gender

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Female	133	81.6	86.4	86.4
	Male	21	12.9	13.6	100.0
	Total	154	94.5	100.0	
Missing	System	9	5.5		
Total		163	100.0		

Table Q29 below shows that two-thirds (67.3.9%) of the respondents had a full time job. The next largest group at 12.6% was retired.

TABLE Q29. Employment status.

		Frequency	Percent	Cumulative Percent
Valid	Q29 Full time	107	67.3%	67.3%
	Q29 Retired	20	12.6%	79.9%
	Q29 Part time	12	7.5%	87.4%
	Q29 Disabled	7	4.4%	91.8%
	Q29. Other coded	4	2.5%	94.3%
	Q29 Homemaker	3	1.9%	96.2%
	Q29 Student full time	2	1.3%	97.5%
	Q29 Unemployed and seeking a job	2	1.3%	98.7%
	Q29 Work + go to school	1	0.6%	99.4%
	Q29 Multiple job holder	1	0.6%	100.0%
	Total	159	100.0%	

Table Q30 below shows that the largest group of respondents lived in the Deckerville zip code area (57.7%). The second largest group lived in the Carsonville zip code area (22.7%) and the third largest lived in the Minden City zip code area

Table Q30. ZIP code.

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	48427 Deckerville	94	57.7	57.7	57.7
	48419 Carsonville	37	22.7	22.7	80.4
	48456 Minden City	24	14.7	14.7	95.1
	48465 Palms	7	4.3	4.3	99.4
	48434 Forestville	1	0.6	0.6	100
	Total	163	100	100	

Table Q31 below shows that a vast majority of the respondents owned their home (81.1%). Seventeen respondents (10.4%) were renting a home or apartment, and 6.1% lived in someone else's home.

TABLE Q31. Housing situation.

		Frequency	Percent	Cumulative Percent
Valid	Q31. Own a home	133	81.1%	81.1%
	Q31. Rent a home or apartment	17	10.4%	91.5%
	Q31. Live in someone else's home (family/friends)	10	6.1%	97.6%
	Q31. Do not have home, but have a place to sleep	3	1.8%	99.4%
	Q31. Homeless	1	0.6%	100.0%
	Total	164		

As seen in Table Q32 below, almost all of the respondents (95.1%) described themselves as White/Caucasian.

TABLE Q32. Race

		Frequency	Percent	Cumulative Percent
Valid	Q32. White/Caucasian	156	95.1%	95.1%
	Q32. Race Prefer not to answer	5	3.0%	98.2%
	Q32. Hispanic	2	1.2%	99.4%
	Q32. Native American	1	0.6%	100.0%
	Total	164	100.0%	

Table Q33 below shows that a little more than half (52.2%) had household incomes under $50,000. Approximately one-fifth (19.9%) had incomes $75,000 or more.

Table 33. Annual household income before taxes (quartiles)

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	$24,999 or less	23	14.1	16.9	16.9
	$25,000 to $49,999	48	29.4	35.3	52.2
	$50,000 to $74,999	38	23.3	27.9	80.1
	$75,000 or more	27	16.6	19.9	100.0
	Total	136	83.4	100.0	
Missing	System	27	16.6		
Total		163	100.0		

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.

The Sanilac county committee selected three organizations for input and suggested an individual at these organizations. The individuals interviewed agreed and the Department of Human Services in Huron County opted to have an additional person. They provided via email permission to use their name in a list of individuals participating in interviews but were assured that their responses would not be connected to their name.

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

Michigan Deptartment Of Health and Human Services- St. Clair/Sanilac County

- William (Bill) Weston, Director
- Jamie Reinke, Sanilac County Program Manager (Sanilac County Only), Sanilac County Community Mental Health
- Jim Johnson, Executive Director, Sanilac Intermediate School District
- Duane Lange, Superintendent

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 Deckerville Community Hospital included:

- The three most serious health concerns of the community were obesity, cancer, and heart disease.
- Lack of coordination of local resources in terms of health education services and social services.
- Education on how to utilize healthcare services [insurance coverage, ER, Primary Care, Community Clinic (urgent care)]

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

Objective	Strategy
Greater community education using news media, social media, community and school programs.	Education provided at the annual Funtastic Family Fair. Programs include Weight Watchers, Go Red Campaign, Smoking Cessation Counseling, Nutrition Counseling, 5K Boo Run, Fitness Equipment offered to the public at Physical Therapy, Screening including mammograms, pap smears, prostate checks, and low dosage lung cancer screens.
Strengthen primary care base through recruitment, retention, continued education and training, and IT support.	Since 2013, DHS has hired two physicians and two nurse practitioners. Lindsey Bulgrien NP-C was able to take training in Women's Health. A TeleMedicine contract exists between DCH and St. Joseph Mercy Hospital for stroke care utilizing a robot.
Continued exploration and development of procedures and opportunities to improve the efficiency and effectiveness of the health care system for the community, especially those with the greatest need.	DCH partners with and refers patients to specialty physicians in such areas as Cardiology, Gastroenterology, Nephrology, Neurology, Neurosurgery, Orthopedics, Podiatry, Pulmonology, and General Surgery. DHS has extended their hours to include weekend office hours and Walk-in-Clinic hours on holidays and weekends. Community resources such as Community Mental Health and the Sanilac Health Department are utilized to provide services not available at DCH. Coordination of Services with Autumnwood of Deckerville and most home health/ hospice agencies is also available.
Training and education of Certified Health Insurance Advisors to council and educate the community on the Affordable Care Act and the Health Insurance Marketplace.	DCH currently has four staff members who are certified to council the public on their insurance claims. DCH also partners with Insurance Specialist, Scott Salowitz. He is able to find affordable policies for patients in need of insurance.
Build on greater community education using news media, social media, and community and school programs.	All forms of media have been utilized to make the public aware of programs such as Respite Care, Walk-in-Clinic hours, weekend office hours, Funtastic Family Fair, and reduced cost Sports Physicals for Deckerville Community School students at both of the clinics. DCH has its own web page, Facebook page, and a written Community Link News Letter.

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

Age	Respondents year of birth which was then recoded into quartiles..20.2% were 33 or less, 25.2% between 34-48, 21.5% between 49-58, and 24.5% were 59 or older.
Gender	86.4% were female and only 13.6% male
Marital Status	69.9% were married or remarried; the remainder were currently unmarried
Children	55.2% of the respondents had no children under the age of 18 living at home
Education	19.0% had a high school diploma or less; 20.9% some college; 21.6% technical or junior college degree;, 21.6% a BA/BS; 17.0% a graduate/ professional degree.
Employment Status	67.3% worked full-time; 7.5% part-time; 0.6% held multiple jobs; 12.6% were retired
Health Sector	33.8 % worked for a hospital, clinic, or public health dept; 66.2% did not
Race	95.1% self-identified as White/Caucasian
Household income	Respondents were asked their household income in 7 brackets which were then divided into 4 groups: 16.9% reported $24,999 or less; 35.3% $25,000 to $49,999; 27.9% $50,000 to $74,999; and 19.9% $75,000 or more.
Health Insurance	60.0% reported that their employer or union provided health insurance; 11.2% individually purchased a plan from an insurance company or healthcare.gov; 11.2% reported Medicare; 3.5% Medicaid. Only 3.5% claimed to be uninsured.
Hospitals used past 2 years	55.3% of respondents reported using Deckerville Community Hospital and 38.6% used McKenzie Health Systems (Sandusky).
ZIP Codes	57.1% lived in 48427 (Deckerville) where the hospital is located, 22.7% in 48419 (Carsonville) and 14.7% in 48456 (Minden City).

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. The focus group was held at Deckerville Community Hospital on February 29, 2016 at 5pm in the hospital conference room. Flyers advertising the event, were posted at local grocery stores, laundry mats, clinic offices, gas stations, and restaurants. Personal letters of invitation were sent to the hospital Board Members; businesses; Deckerville School Superintendent, Tricia Pawloski; and Deckerville Public Library librarian, Jill Brown.

Stakeholder Interviews:

The Sanilac 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			
Hospital Data CHNA	http://www.deckervillehosp.org/Documents/CHNA-2013.pdf	2007-2016	Data available on utilization of hospital services, payer/revenue sources, financial assistance programs, and transfers out of the community.
Local Ambulance Service	http://www.mckenziehealth.org/services/sanilac-ambulance/	2016	Includes information on reason for EMS call, demographic data, and transport location.
Community Survey			
Community Survey	One hundred sixty-three 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	Five community members including: two board members, a local businessman, the librarian, and school superintendent.	2016	Meeting included discussion of questions that were also utilized in individual interviews.
Individual Interviews and Focus Groups	William Weston, Jamie Reinke, Jim Johnson, and Duane Lange	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 (86.4%), held a college degree (60.20%), and one-fifth (19.9%) had household incomes $75,000 or above. 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 Deckerville Community ZIP codes. However, this could be done at the county level.

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

	N	Mean	Std. Deviation
Q17. Not enough specialists	153	2.61	1.17
Q17. Not enough evening or weekend hours	154	2.49	1.16
Q17. Not enough doctors	154	2.47	1.17
Q17. Not able to get appointment/limited hours	153	2.20	1.14
Q17. Don't know about local services	153	2.16	1.19
Q17. Not able to see same provider over time	155	2.10	1.13
Q17. Distance from health facility	155	2.08	1.08
Q17. Can't get transportation services	155	1.86	1.08
Q17. Not accepting new patients	153	1.80	1.04
Q17. Poor quality of care	151	1.76	1.06
Q17. Barriers to accessing veterans services	152	1.71	1.31
Q17. Concerns about confidentiality	152	1.45	0.89
Q17. Limited access to telehealth	153	1.38	1.29
Q17. Lack of disability access	155	1.36	0.95
Q17. I am afraid or too uncomfortable to go	149	1.24	0.96
Q17. Don't speak language or understand culture	153	1.20	0.81
Q17. I have other more important things to do	149	1.10	0.94

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 reveals seven items with means between 2.00 and 3.00—not enough specialists (μ=2.61), not enough evening or weekend hours (μ=2.49), not enough doctors (μ=2.47), not able to get appointment/limited hours (μ=2.20), don't know about local services (μ=2.16), not able to see same provider over time (μ=2.10), and distance from health facility (μ=2.08). These are considered to be high minor or low major problems. Many of these refer to the supply of physicians which is highly dependent on the ratio of physician per 100,000 population and is endemic in rural and semi-rural counties. Sanilac County, in which Deckerville Community is located, had a population of 43,114 in 2010.[2]

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	125	38.7%	88.7%
	Q16. No insurance	57	17.6%	40.4%
	Q16. Insurance denies services	51	15.8%	36.2%
	Q16. Not affordable services	50	15.5%	35.5%
	Q16. Providers do not take my insurance	40	12.4%	28.4%
	Total	323	100.0%	229.1%

a. Dichotomy group tabulated at value 1.

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

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

[2] Population of Michigan Counties 2000 and 2010. Available at http://www.michigan.gov/cgi/0,1607,7-158-54534-252541--,00.html
[3] Kunreuther, H. and Pauly, M. (2005). Insurance Decision-Making and Market Behavior. *Foundations and Trends*® in *Microeconomics*. 1:2 p 63-127.

Two-fifths (40.4%) of survey respondents thought that not having insurance prevent themselves or community residents from receiving health services. But only 3.5% of respondents answered that they had no insurance (see Table 1 above). This misperception could be corrected through better communications and information on actual uninsurance rates.

Community Concerns

The survey asked questions about five areas of concerns. The top concerns are summarized from the listed tables in Appendix C.

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

- Awareness of local health resources and services
- Access to exercise and fitness activities
- Understanding/navigating Healthcare Reform
- Access to healthy food

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

- Jobs with livable wages
- Attracting and retaining young families

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

- Availability of doctors and nurses
- 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

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

- Cost of health insurance
- Cost of health care services
- Cost of prescription drugs

Concerns related to Vulnerable Populations

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

Table 4 contains responses to Q12b, the top 3 concerns about physical health for youth in your community. Youth obesity was chosen two-fifths of the time (39.3%) by almost half (48.9%) of all respondents. Teen pregnancy was chosen 17.9% of the time by 22.3% of all respondents and wellness disease prevention was chosen 16.2% of the time by one fifth (20.2%) of all 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	46	39.3%	48.9%
	Q12.b Teen pregnancy	21	17.9%	22.3%
	Q12b. Wellness and disease prevention, including vaccine-preventable	19	16.2%	20.2%
	Q12b. Youth sexual health (including sexually transmitted diseases	16	13.7%	17.0%
	Q12b. Youth hunger and poor nutrition	14	12.0%	14.9%
	Q12b. Other	1	0.9%	1.1%
	Total	117	100.0%	124.5%

a. Dichotomy group tabulated at value 1.

Table 5 shows responses to Q13b the top 3 concerns about mental health for youth in your community. Youth drug use and abuse was chosen 29.3% of the time by about half (53.8%) of all respondents. Second was youth bullying chosen 26.4% of the time by a little less than half (48.54%) of all respondents. Youth alcohol use and abuse and youth suicide were closely ranked third and fourth, each chosen by about one-fifth (21.5% and 20.8%) of all 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)	70	29.3%	53.8%
	Q13b. Youth bullying	63	26.4%	48.5%
	Q13b. Youth alcohol use and abuse (including binge drinking)	28	11.7%	21.5%
	Q13b. Youth suicide	27	11.3%	20.8%
	Q13b. Youth tobacco use (including exposure to second-hand smoke,	26	10.9%	20.0%
	Q13b. Youth mental health	25	10.5%	19.2%
	Total	239	100.0%	183.8%

a. Dichotomy group tabulated at value 1.

Table 6 contains responses to Q14 the top 3 concerns about senior population in your community. The top two concerns about the senior population were the cost of medication and the availability of resources to help the elderly stay in their homes. They were chosen 18.8% and 17.7% of the time respectively by a little over half of all respondents (54.1% and 51.0% respectively).

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	85	18.8%	54.1%
	Q14. Availability of resources to help the elderly stay in their homes	80	17.7%	51.0%
	Q14. Assisted living options	64	14.2%	40.8%
	Q14. Availability of resources for family and friends caring for seniors	40	8.9%	25.5%
	Q14. Availability of activities for seniors	35	7.8%	22.3%
	Q14. Long-term/nursing home care options	35	7.8%	22.3%
	Q14. Transportation	34	7.5%	21.7%
	Q14. Dementia/Alzheimer's disease	34	7.5%	21.7%
	Q14. Hunger and poor nutrition	23	5.1%	14.6%
	Q14. Elder abuse	14	3.1%	8.9%
	Q14. Cost of activities for seniors	7	1.6%	4.5%
	Total	451	100.0%	287.3%

a. Dichotomy group tabulated at value 1.

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%
CHR	HIV Prevalence 2012) per 100,000	2012	178	18	42	26

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	450:01:00	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 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

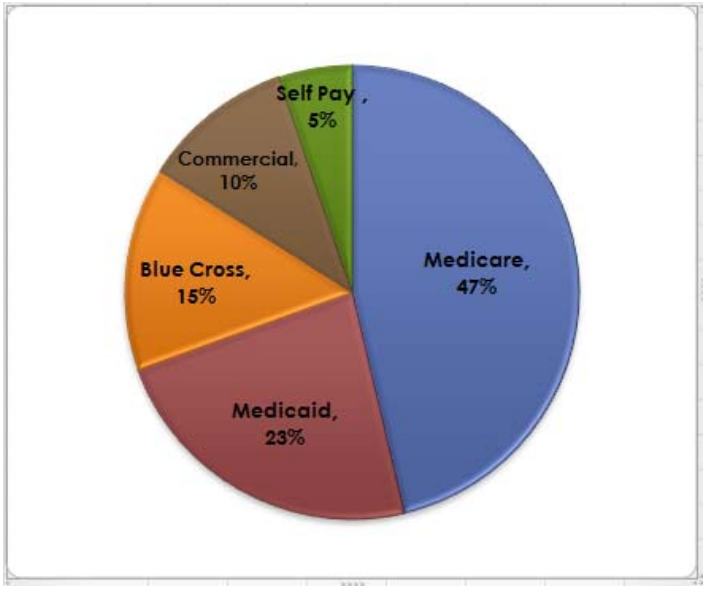
Healthcare System Data

A number of factors can impact whether a community has adequate access to quality clinical care services. Access may be related to the number of providers and shortage designations OR may be linked to barriers to access such as transportation or cost. Studying utilization of services is one step to identifying conditions that may be limiting access to care.

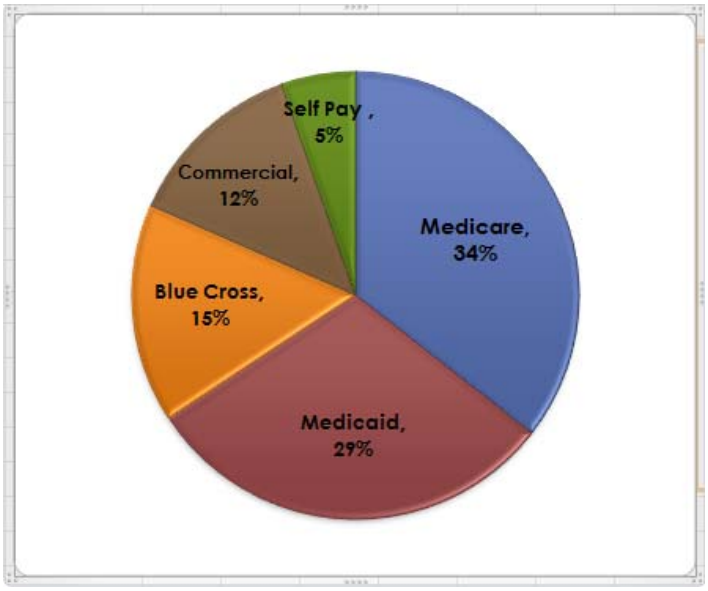
Cost and Insurance Coverage are major factors that can limit access to care.

- The pie charts below demonstrate the insurance companies that patients in the community currently utilize.
- Deckerville Community Hospital has a financial liaison who is available to create a payment plan for any uncovered health care costs. Our hope is that ability to pay is not a deterrence to seeking care.

2015 Hospital Payer Mix for Deckerville Community Hospital



2015 Black River Street Clinc Payer Mix



Deckerville Community Hospital in partnership with Harbor Drug of Deckerville, participates the 340(b) drug program. What this means for our patients is that any prescription written by a Deckerville Community Hospital provider and filled at the Harbor Drug Pharmacy in Deckerville, can be purchased at a reduced rate. The Harbor Drug Pharmacists can answer any questions. This is another way Deckerville Community Hospital makes healthcare more assessable for the community it serves.

Utilization Decreased
- Inpatient Admissions
- Walk-in-Clinic Patients
- Specialty Clinic Patients
- Inpatient Surgeries
- Outpatient Surgeries

Utilization Increased
- CT Scans
- Ultrasounds
- Physical Therapy
- # of Patient Observations
- Emergency Visits

Utilization Fluctuated
- Laboratory
- Mammography Screenings
- Blood Utilization

Hospital Utilization 2013-2015	2013	2014	2015		
Inpatient Admissions	117	104	58		
Short Stay Admissions	188	224	232		
Emergency Department Admissions	1443	1535	1592		
Inpatient Surgical Admissions	43	41	35		
Outpatient Surgical Admissions	173	164	161		
Specialty Clinic Admissions	1288	1181	1149		
Physical Therapy Admissions	N/A	1699	1949	1	
Black River Street Clinic Admissions	N/A	4089	6219	2	
Walk-in-Clinic Admissions	6679	5351	1529		
Mammography Screenings	311	245	270		
Outpatient CT scans	290	627	665		
Outpatient Ultrasounds	408	502	645		
Blood Utilization (total units transfused)	123	73	124		
Laboratory Utilization	9332	9950	8257		

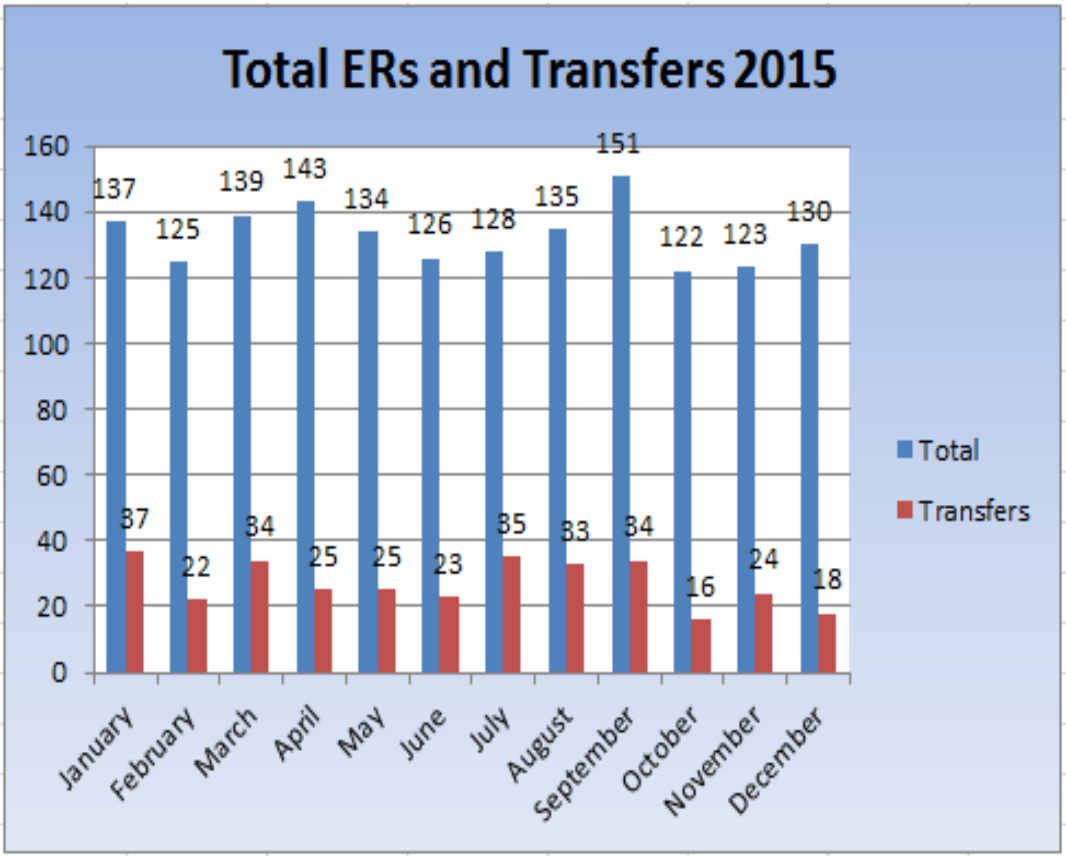
1. Data not available for 2013 admissions to Physical Therapy
2. Black River Street Clinic opened to the public on May 27, 2014

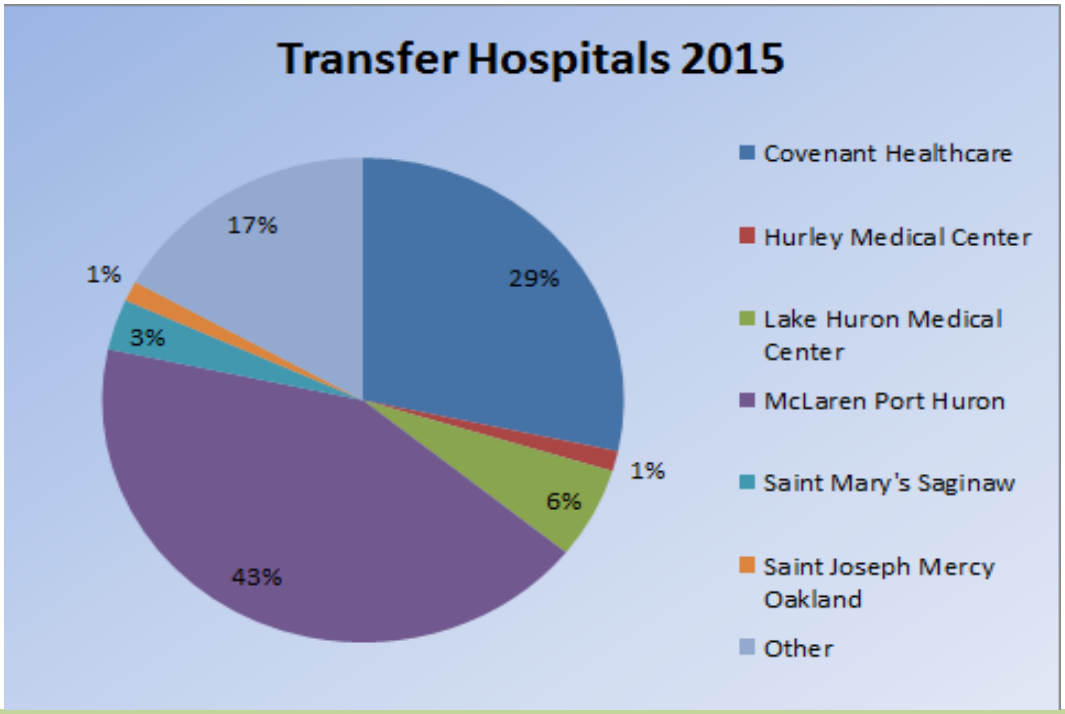
Primary Reason for Transfer

Critical Access Hospitals serve a very important role in Emergency situations. With the low volume found in rural communities, it is impossible for each rural hospital to house the equipment and medical staff necessary to provide every medical procedure for every condition. That is why the role of stabilizing, assessing, and if needed, transferring patients is critical. Many conditions have steps that if taken early can reduce injury and long term damage for the patient.

2015 Diagnoses of transfers

- Cardiac 84
- Respiratory 72
- Gastrointestinal 66
- Trauma 38
- Infections 22
- Neurological 22
- Overdose 2
- Other 16





Emergency Response: Sanilac County Ambulance Services Utilized

Monitoring Hospital Quality Data

Deckerville Community Hospital conducts ongoing quality studies and improvement processes.

- Medicare/Medicaid assigns certain items to monitor
- DCH meets or exceeds expectations for markers
- This process identifies items where improvement can be made and a team develops system or operational changes to improve the indicator.

Why is ongoing quality improvement important?

- Giving aspirin in the Emergency Department and performing an EKG within 10 minutes for chest pain have both been proven to limit the damage to your heart that may be caused if the chest pain is caused by a heart attack.
- Research has shown that patients with pneumonia that receive the first dose of the antibiotic in six hours or less have fewer complications and recover faster from their illness.
- Ongoing chart reviews for diagnosis of Abdominal Pain, Pediatric Fever, Headache, Pain Assessment to be sure standards of care are met.

Quality Goal Examples

Nursing

1) Implementation of Hourly Rounding on Observation and Inpatient stays 100% of the time.
2) Maintain zero pressure ulcers acquired during hospital stays.
3) Maintain 100% compliance for completion of an individualized care plan for inpatients.

Operating Room

1) Ensuring understanding of Preoperative Preparation during patient education through teach back.
2) Implement optimal perioperative management of the geriatric patient by developing a pre-op assessment based on the new best practice guidelines for a patient greater than 65 years-old.
3) Ensure that 100% of surgical patients have designated patient advocate named.

Infection Control

1) Monitor/track hygiene compliance to ensure 95% compliance throughout the hospital staff.
2) Educate surgical staff about best practices to reduce Surgical Sight Infection to less than 1%.
3) Monitor/Track patients tested for Clostridium Difficile to ensure nursing is implementing proper contact precautions, and documenting their actions 100% of the time.

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

Deckerville Community Hospital began the prioritization process by reviewing the data described in the findings section of this report. The Implementation meeting included members of Administration, Risk Management and Marketing. The meeting participants also reviewed the follow list of concerns revealed in focus groups.

The participants initially went through and highlighted all of their concerns (the number represents the number of people who thought it was a concern). They then went through and starred their top concerns of the ones they highlighted. The number following the star (*) represents the number of people who indicated it was one of their top five concerns (for example, (3) *** means 3 people placed it in their top five concerns.). The complete results are in Appendix F.

Table 7 Top concerns of focus group by topic

- Physical, mental health and substance abuse concerns (adults)
  - Cancer (5) ****
  - Diabetes (4) *
  - Drug use and abuse (including prescription drug abuse) (3) **
- Concerns about Health Services
  - Cost of health insurance (4) ***
  - Adequacy of health insurance (concerns about out-of-pocket costs) (3) **
  - Ability to retain doctors and nurses in the community (3) **
  - Ability to get appointments for health services (3) **
- Concerns specific to youth and children
  - Youth drug use and abuse (including prescription drug abuse) (4) **
- Concerns about the aging population
  - Long-term/nursing home care options (2) **

Key information interview results were utilized to confirm concerns identified in other data and to identify other potential areas of concern. The top concerns of the stakeholders were not enough jobs with livable wages and not enough public transportation options/cost of public transportation, alcohol use and abuse, suicide, drug use and abuse (including prescription drug use, not enough activities for children/youth, youth alcohol use and abuse, youth drug use and abuse (including prescription drug use). Also mentioned was the lack of a year round recreation/sports facility like a YMCA, services for seniors, and mental health, dental services and child care facilities. The meeting participants used a prioritization process that included analysis of issues located in multiple data sources.

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.

Category of Need	Current Deckerville Community Hospital Efforts
Copay & Deductible	-Availability to pay your bill online -Insurance Specialist, Scott Salowitz, came to the hospital during open enrollment times to counsel and help community purchase health insurance policies. -Four Certified Health Insurance Advisors employed by the hospital to counsel patients on claims
Access to Care	-Weekend appointments available at the Main Street Clinic. -Walk-In-Clinic hours available weekdays, weekends, and holidays. -Two physicians have been hired with five year contracts. -Provider, Lindsey Bulgrien NP-C, took training in Women's Health. -Transportation available via Sanilac Transportation Buses or Sandusky Taxi Service. -TeleMedicine contract available with St. Joseph Mercy Hospital for Stroke Care utilizing a robot.
Cancer	-Screenings including mammograms, pap smears, and prostrate checks available. -Smoking cessation treatment and counseling available at the Clinics. -Nutrition counseling available once a month with Registered Dietitian, Keri Pangborn. -Exercise Equipment available to the public at Physical Therapy for $25/month charge. -Boo Run 5K run/walk to raise money for Breast Cancer research every October.
Heart Disease	-Blood Pressure screening at Funtastic Family Fun Fair. -Weight Watchers classes available weekly on Thursday evenings. -Exercise Equipment available to the public at Physical Therapy for $25/month charge. -A Go Red Campaign was implemented to raise awareness of heart disease in women.
Care Coordination	-Care Coordinator hired to develop health promotion programing and develop education for the public. -Care Coordinator also to promote establishing with a Deckerville Health Services Provider.
Drug Use and Abuse	-Patients presenting to the hospital with a drug use crisis, are treated for medical needs, are assessed by Community Mental Health, and have a Security Plan in place before discharge. -Partner with Deckerville Community Schools in the DARE and SADD programs.
Senior Services	-Respite Care program available. -Coordination of Services with all local Home Health and Hospice Agencies -Dr. Keeling M.D. and Keith Davison NP-C available to see patients at Autumnwood of Deckerville -Dr. Keeling M.D. has a special interest in Dementia. -Keith Davison NP-C is a Geriatric Specialist.
Youth Services	-Influenza vaccination offered to Deckerville Community School Staff. -BLS CPR/ First Aid training offered to the staff of Deckerville Community Schools. -Class tours of the hospital facility provided to preschool and second grade classes during the school year. - Sports Physicals offered at the Black River Street and Main Street Clinics for $5 to Deckerville Community School Students. - Offer our medical facilities as needed to the Bialowieza Polish Camp.

Implementation Strategy

Develop Strategies to fill gaps in resources

A resource assessment and potential strategies was distributed to hospital leadership for input and to ensure accuracy. It was then distributed to other hospital staff, medical providers, and members of the community. The strategies under consideration were also posted to the hospital website for public comment and feedback.

Category	New or Expansion Strategies Under Consideration	Lead Person/Group	Status of Resources to Complete Strategy
Copay & Deductible	-Prompt Pay Discount: Develop a program to reward patients who pay their bill early with a discount -Financial Liaison: Develop education for community to work with this person to create a payment plan for medical bills. -FAQ Claims Management: Develop a page on the hospital website to explain how medical insurance claims work. -Patients will receive a letter of explanation when a claim is denied.	Financial Liaison, IT Dept. Marketing	Financial Liaison will work with Marketing to make the public aware of the Prompt Pay Discount. It will also be a documented on the patient's bill. The patient will receive a letter from the Financial Liaison explaining the reason a claim was denied, and referral to a more appropriate form of care. IT will work with the Financial Liaison to develop a Frequently Asked Question page on the hospital's website to explain how a claim works.
Access to Care	-Expanded hours for certain providers available later during the week. -Medication Costs: Educate the public about the 340(b) program at Harbor Drug in Deckerville. -Elderly Services: Collaborations with Autumnwood of Deckerville to provide Dementia/Alzheimers Care	Marketing Administration Providers	We currently provide late hours and weekend hours. Providers and Administration will continue to monitor for greater need. Providers, nursing, and MA staff will educate patients on the 340(b) program with Harbor Drug of Deckerville. Administration and Providers will continue to collaborate with Autumnwood of Deckerville to provide long term care needs for seniors. Marketing will educate the public on hours and services as they become available and at the Fun Fair.
Cancer	-Promote low dose radiation lung screenings -Patient Care Coordinator to develop Preventative Screening Program and educate the public on its availability.	Patient Care Coordinator Marketing	Marketing will educate the public on the availability of low dose radiation. Patient Care Coordinator will work with Marketing to educate the public about screening services as they become available. Education will also be presented at the Fun Fair.
Heart Disease	-Educate the public on services available including: screenings, smoking cessation treatment, nutrition counseling, physical fitness equipment availability, use of the track at the school for walking/running.	Marketing Providers Patient Care Coordinator	Marketing will work with providers and the patient care coordinator to make the community aware of services such as screenings, smoking cessation treatment, nutrition counseling, and the availability of fitness equipment.

Category	New or Expansion Strategies Under Consideration	Lead Person/Group	Status of Resources to Complete Strategy
Care Coordinator	-Patient Care Coordinator will look into available training options to become a Diabetic Educator and work with other facilities in the area that offer this program until it is available at DCH	Patient Care Coordinator Marketing	The patient care coordinator will refer patients to area diabetic education as needed. She will work with Marketing to make the community aware of this program when it becomes available at DCH.
Drug Use and Abuse	-Develop a program using our robot to provide virtual conferencing for Community Mental Health -Refer patients to the Sanilac Community Health Department until Mental Health Services are available at DCH	Providers Administration	Administration will look into the availability of virtual Mental Health Services. Providers will refer patients to Community Mental Health for their needs until such services become available at DCH.
Senior Services	-Care Coordinator is developing a Medicare Program to utilize preventive care measures. -Promote low dosage radiation screenings for lung cancer. -Promote Respite Program. -Refer patients to the Region VII Area Agency on Aging. -Funtastic Family Fair	Patient Care Coordinator Providers Marketing	The Care Coordinator will work with Marketing to make the community aware of the Medicare Program as it becomes available. Marketing will work with providers to make the community aware of low dosage radiation screening for lung cancer. Patients will be referred to the Region VII Area Agency on Aging because it provides information on resources available including transportation to appointments and programs that support seniors in staying in their homes.
Youth Services	-Develop a Safe Sitter Program -Sponsor sports teams -Encourage further collaborations with Deckerville Community School to teach healthy lifestyle habits and drug avoidance to students. -Funtastic Family Fair	Administration CPR Instructor Marketing Nursing	CPR Instructor will look into the requirements for teaching a Safe Sitter Program for area youth. Administration will look at the health needs of area youth to develop educational programs at Deckerville Community School to be taught by nursing staff. Marketing will reach out to area resources to encourage them to showcase their programs at the annual Funtastic Family Fair.

Written CHNA Report and Implementation Plan

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