Community Health Needs Assessment

November 30, 2012

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District Health Department #10

Community Health Needs Assessment

Prepared by:

Kevin Hughes, MA, Deputy Health Officer
Jan Wiltse, PhD, Health Educator
Nancy Thome, BS, University of Michigan MPH Candidate in Epidemiology

Community Health Needs Assessment and Community Health Improvement Plan

Steering Committee Members:

Donn Lemmer, MBA
West Shore Medical Center

Lorelei King, RN, MS
Mercy Hospital Grayling

Patricia Ezdebski
Memorial Medical Center West Michigan

Jay Bryan, FACHE
Mercy Health Partners Lakeshore Campus

Diane Butler, BSN, RN-BC
Munson Medical Center

Jenny Babcock, MS, OTR, EMBA
Spectrum Health Gerber Memorial Hospital

Linda VanGills, MA
District Health Department #10

Dorthy Batzer, RN, BSN, MSA
West Shore Medical Center

Tom Hogenson, RN
Mecosta County Medical Center

Peter Sartorius, MA, MS
Muskegon Health Project

Dawn Ewald, BSN
Mercy Hospital Cadillac

Laura Laisure, RN, MS
Munson Medical Center

Sarah Oleniczak, MPH, MCHES
District Health Department #10

For additional information:
District Health Department #10
3986 North Oceana Drive
Hart, MI 49420
(231) 873-2193
(231) 873-4248 (fax)
www.dhd10.org

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District Health Department #10

Strong Communities Through Healthy People

Serving Crawford, Kalkaska, Lake, Manistee, Mason, Mecosta, Missaukee, Newaygo, Oceana, and Wexford

November 30, 2012

Message from the Health Officer

District Health Department #10 is completing this Community Health Needs Assessment in an effort to better prepare for building and maintaining healthier communities within its ten county health jurisdiction. The purpose of the assessment is to assist in the agency's program development, monitoring, and evaluation process. The information contained within this report represents the most current primary and secondary data available at the time this process began. As part of this assessment, District Health Department #10 has utilized a steering committee made up of representatives from its partner hospitals. This steering committee will oversee the completion of this assessment as well as the accompanying Community Health Improvement Plan. Recognizing that achieving healthier communities will require collaboration, planning, and participation on the part of all partners, District Health Department #10 commits to maintaining these efforts now and in future years.

Linda VanGills, MA
Health Officer
District Health Department #10

Community Health Needs Assessment
District Health Department #10

1. Introduction

In an effort to better learn about and understand the health status of its jurisdiction, District Health Department #10 (DHD#10) completed this Community Health Needs Assessment (CHNA) process.

Purpose

CHNA is a collaborative process of collecting, reviewing, and analyzing health related data focused on the health jurisdiction. Development of a CHNA requires the collection of data, both primary and secondary, and the analysis of the data and other pertinent community information. This will enable the health department and its collaborative partners to make informed decisions and plan for action. Data included in the CHNA consist of both local and statewide demographics, health indicators, health behaviors, and local resources.

Uses

DHD#10 will utilize data obtained through the CHNA process to educate and mobilize the community, identify areas of focus at the community level, identify available local resources for target issues, and create a community plan spelling out priorities to be addressed. The data contained within the CHNA identify current, emerging, or future issues that may have a negative impact on the community. The CHNA can also be used as an evaluation tool to measure change from previous interventions and/or actions. Data gathered in the CHNA will form the foundation for the development of a DHD#10 Community Health Improvement Plan and will provide direction for the health department's strategic plan.

2. Agency Description

Agency History

DHD#10 was formed in 1997 through the consolidation of District Health Department #1, District Health Department #5, the Manistee-Mason District Health Department, and the Mecosta County Health Department. The health jurisdiction covered by the agency includes the counties of: Crawford, Kalkaska, Lake, Manistee, Mason, Mecosta, Missaukee, Newaygo, Oceana and Wexford. An office is located in each county to facilitate easy access to services for clients. DHD#10 serves the largest geographical area of any health department in the state of Michigan and serves the 10th largest population in the state. The geographical service area of the agency is larger than the states of Delaware, Rhode Island, and Connecticut. The six

divisions that make up DHD#10 are: Environmental Health; Personal Health; Women, Infants and Children (WIC); Health Promotion; Administrative Services; and Human Resources. Each Division Director reports to the Health Officer, who is responsible for the daily operation of the agency. A full-time Medical Director is also employed by the agency. DHD#10 is governed by a Board of Health, responsible for reviewing agency efforts and setting agency policy. The Board of Health is comprised of two county commissioners from each of the 10 counties making up the health jurisdiction.

As an organization, DHD#10 has developed a Vision, Mission, Core Values, and Agency Goals.

Vision: *Strong Communities through Healthy People*

Mission: *To promote and enhance the health of all individuals through education, prevention, intervention, and protection of the environment*

Core Values: *Responsibility and Accountability, Customer Service, Integrity, Positive Attitude, Communications*

Agency Goals:

Maintain excellence as a public health agency

Improve the health of our communities

Communicate with community partners and leaders to increase awareness of public health services

Maintain a working environment that is driven by the agency's Core Values

Health Jurisdiction Demographics

DHD#10's health jurisdiction is situated in a rural area of the lower peninsula of Michigan on the northwest side of the state. Within the health jurisdiction, there are 261,616 individuals. Numerous social and economic factors impact the health of the residents and their communities. High numbers of individuals living in poverty and elevated jobless rates are just two examples of some of the factors that negatively impact the communities.

The following provides a narrative snapshot of the demographics of the DHD#10 health jurisdiction. A chart of these data is included as *Appendix A*.

Population: Total population for each county ranges from 11,539 in Lake County to 48,460 in Newaygo County (US Census Bureau, 2010). When broken down by age group, Lake County has the lowest percent of people under age 18 (18.4%) and Oceana has the highest at 25.6%. In the 18-44 year old age group, Mecosta has the highest percent at 40.4%, which is similar to Michigan at 39.3%. In the 18-44 year old age group, all other counties are lower than

Michigan, ranging from 27.5% to 31.9%. In the 45-64 year old age group, only Mecosta (24.1%) has a rate lower than Michigan (27.6%). All ten counties have percentages of individuals age 65 and over higher than the Michigan rate of 13.6% (Michigan Department of Community Health, 2009).

Education: The percent of those with a high school education are all the same or lower than the Michigan rate of 87.4% for all ten counties in the health jurisdiction. The percentage of high school graduates in Mason County is highest at 87.4% and Lake County is lowest at 78.8%. The percentage of those with a college degree is lower in all ten counties than the 24.5% in Michigan. The highest is Mecosta County (19.5%) and lowest is Lake County (8.3%) (US Census Bureau, 2005-2009).

Income: Median household income ranges from $29,373 in Lake County to $41,067 in Manistee County. In Michigan, the median household income is $45,254 (US Census Bureau, 2009).

Race: All ten counties in the DHD#10 jurisdiction are predominately White, with the highest percent in Crawford County (97.5%). The highest percent of Blacks are reported in Lake County (9.2%). The highest percent of Hispanic population is found in Oceana County (13.7%). Within the DHD#10 health jurisdiction, Manistee County is the base for the governing council and offices of the federally recognized tribe of the Little River Band of Ottawa Indians (US Census Bureau, 2010).

Poverty: Manistee County has the lowest percent of persons in poverty (13.9%) and the highest percent is found in Lake County (23.4%). Eight of the ten counties have a higher percent of persons in poverty than in Michigan at 16.1% (US Census Bureau, 2009). The percentages of children in poverty, both the 0-17 and 5-17 age groups, are higher in all ten counties than compared to Michigan overall. The highest percentages of those in poverty by age group are in Lake County with 36% of the 0-17 age group and 33.9% of the 5-17 age group (US Census Bureau data provided by the Michigan League for Human Services, 2008).

Jobless Rate: The lowest jobless rate is in Mecosta County (12.1) and the highest is in Wexford County (15.7). The jobless rate in Michigan is 12.5 (Michigan Department of Technology, Management and Budget, 2010).

Free/Reduced Price Lunch: The percentage of children eligible for free and reduced price lunch in all ten counties is higher than the Michigan percent of 45.8%. The lowest percent is in Mason County (52.3%) and the highest percent is 89.0% in Lake County (Michigan Department of Community Health data provided by the Michigan League for Human Services, 2009).

Medicaid Covered Births: The percent of births in Michigan covered by Medicaid is 42.8%. All ten counties have a percentage higher than Michigan, with the lowest in Mecosta County (50.8%) and the highest (66.3%) in Kalkaska County (Michigan Department of Community Health data provided by the Michigan League for Human Services, 2009).

DHD#10 Service Area Map

As stated previously, the health jurisdiction of DHD#10 is the largest geographical service area of any local health department in the state of Michigan and the tenth largest based upon population. DHD#10 covers 261,616 residents within the health jurisdiction. A map of the DHD#10 service area is included as *Appendix B.*

DHD#10 Programs and Services

Funding comes from a mix of local, state, and federal dollars for programs and services provided by DHD#10. This mix of funding is used to provide the following core and mandated services as outlined in the Public Health Code:

- Immunizations
- Infectious/Communicable Disease Control
- Sexually Transmitted Disease Control
- Hearing Screening
- Vision Screening
- Public/Private Wastewater
- Food Protection
- Public/Private Water Supply
- Family Planning

Other screening and prevention-related services, designed to maintain and promote the health of residents and the community, are also provided by DHD#10. Examples include:

- Women-Infants-Children Program (WIC)
- Maternal and Infant Health Services
- Emergency Preparedness
- Health Education/Promotion
- Breast and Cervical Cancer Control Program/WISEWOMAN
- Colorectal Cancer Early Detection Program

3. Community Health Needs Assessment Process

DHD#10 CHNA Efforts

DHD#10's experience with the CHNA includes: 1) a required process stipulated by funding from the Michigan Department of Community Health (MDCH), and 2) a secondary project supported by agency funds and limited to current available data. From 1995 through 2004, DHD#10 received funding from the MDCH to conduct and facilitate an annual CHNA process within each county in the health jurisdiction. These processes involved the gathering of both primary and secondary data. Hospital partners and other community organizations collaborated. In 2004, funding from MDCH ceased and so did these efforts.

From 2005 to 2009, county level data were gathered and reviewed for grants and reports, as well as when requested by partner organizations. In 2010, DHD#10 began producing county level data books for the health jurisdiction. This process was supported by agency dollars. These data books were placed on the agency's website for community-wide access and contained a variety of community health and census related data.

In 2011, the data books were reconfigured to model the MDCH Chart Books (*Appendix C*), updated with current data, and again placed on the agency's website. Individual one-page county summaries (*Appendix D*) were also produced and placed on the website. At this point, a commitment was given by the agency to its partners that these Chart Books and one page summaries would be updated annually and kept available on the DHD#10 website. These Chart Books and Summaries are also intended to serve as the foundation for the agency's CHNA. A copy of the DHD#10 CHNA Plan is included in *Appendix E.* In addition to the chart books and their secondary data sources, DHD#10 gathered and compiled primary data from its health department clientele. Primary data were collected in June 2012 through surveys and focus groups. The process will be reported in-depth in the proceeding pages. Copies of the survey and focus group questions are included as *Appendix F.*

Collaborative Partnerships

The process of completing a CHNA is generally not undertaken by a single entity but rather by a group. In June 2011, DHD#10 facilitated a meeting of its hospital partners to discuss how the organizations could collaborate to complete this process. As part of the Patient Protection and Affordable Care Act, every three years non-profit hospitals are required to complete a CHNA and Community Health Improvement Plan (CHIP). Serving the DHD#10 health jurisdiction are nine hospitals, eight within and one outside of the jurisdiction. The hospitals within the jurisdiction are: Mercy Grayling, Kalkaska Memorial Health Center, Mercy Cadillac, West Shore Medical Center, Memorial Medical Center of West Michigan, Mecosta County Medical Center, Mercy Health Partners Lakeshore Campus Shelby, and Spectrum Health Gerber Memorial. The hospital outside the health jurisdiction is Spectrum Health Reed City, which provides services to

Lake County. Of these hospitals, Mecosta County Medical Center and West Shore Medical Center did not meet the IRS definition of being required to complete the CHNA process, but they both chose to proceed because "it was the right thing to do."

In an attempt to avoid duplication of efforts, DHD#10 and its hospital partners agreed to assist each other in the completion of each organization's CHNA and CHIP. As outlined in the hospital requirements, DHD#10 would serve as a member of each organization's steering committee, provide county level chart book data and community health related input, and participate in the prioritization and strategy identification process. In return, the hospital partners agreed to serve as the steering committee for the DHD#10 CHNA and CHIP development process, as well as participate in the DHD#10 public health focused prioritization and strategy identification process. Copies of the groups' meeting agendas and meeting minutes are included as *Appendix G*. The steering committee did agree that while collaboration in this process was required and essential to its success, it was recognized that each individual organization needed to determine its own specific process for completing its CHNA and CHIP. Links to hospital partners' CHNA are included in *Appendix H.*

Community Resources

Within the DHD#10 health jurisdiction, collaboration among the community members and organizations is essential for success. Limited resources, both personnel and financial, have created huge issues in trying to adequately address all community health needs. While it is true that some counties and communities have fewer resources than others, all have equal commitment to working together to address issues. Existing community health coalitions and collaboratives (led by the health department and/or led by partners) have come together to explore and secure resources needed to create and maintain healthier communities. These resources have come from a variety of sources including local community foundations, state agencies, local service organizations, national funding organizations and foundations, local governmental agencies, and community members.

In the DHD#10 health jurisdiction there are presently six community health coalitions serving seven counties and one eleven county Cancer Awareness and Prevention Coalition working to improve the health of the community. Four of these coalitions are chaired by health department staff. In addition, each county is served by a community collaborative of which three of the health coalitions are considered subgroups. All of the health coalitions focus on a philosophy of utilizing policy, environmental changes, and systems changes in addressing health issues in the community. Coalitions do differ in regards to whether they address single or multiple issues. Membership in these groups is comprised of: health department staff, hospital and provider staff, school and college personnel, city and county governmental representatives,

county extension staff, chambers of commerce, worksite and business members, and community members.

The following are examples of some of the resources available within each county, including existing community health coalitions:

Crawford County

- Crawford County Collaborative Body
- Northwest Michigan Cancer Awareness and Prevention Coalition
- Local Service Organizations
- Mercy Hospital Grayling

Kalkaska County

- Kalkaska County Community Collaborative
- United Way of Northwest Michigan
- Traverse City Rotary Charities
- Three Women's Giving Circle
- Northwest Michigan Cancer Awareness and Prevention Coalition
- Local Service Organizations
- Kalkaska Memorial Health Center
- Rapid City School and Community Garden

Lake County

- Lake County Community Foundation
- Northwest Michigan Cancer Awareness and Prevention Coalition
- Local Service Organizations
- Spectrum Health Reed City Hospital
- Baldwin Family Health Care
- Lake County Roundtable

Manistee County

- Healthy Manistee County Coalition (chaired by West Shore Medical Center)
- Manistee County Human Services Collaborative Body
- Manistee County Community Foundation
- Manistee County United Way
- Northwest Michigan Cancer Awareness and Prevention Coalition
- City of Manistee Non-motorized Transportation Committee
- Local Service Organizations
- West Shore Medical Center
- Manistee Community Kitchen
- Manistee Community Garden – Sophia Street
- City of Manistee Farmers Market – Double Up Food Bucks

Mason County

- Health Improvement Project (HIP) Mason County (chaired by the Health Department)
- Mason County Community Foundation
- Mason County United Way
- Northwest Michigan Cancer Awareness and Prevention Coalition
- Local Service Organizations
- Memorial Medical Center of West Michigan

Mecosta County

- Healthy Big Rapids Group (chaired by the City of Big Rapids)
- Ferris State University
- Mecosta County Community Foundation
- Mecosta/Osceola United Way
- Norwest Michigan Cancer Awareness and Prevention Coalition
- Local Service Organizations
- Mecosta County Medical Center

Missaukee County

- Cadillac Area Health Coalition (co-chaired by Mercy Hospital and the Health Department)
- Missaukee County Community Foundation
- Wexford/Missaukee United Way
- Northwest Michigan Cancer Awareness and Prevention Coalition
- Local Service Organizations
- Mercy Hospital Cadillac
- Great Lakes Family Care
- Friends Ministry Community Garden

Newaygo County

- Newaygo County Health Care Improvement Council (chaired by Spectrum Health Gerber Memorial Hospital)
- Fremont Area Community Foundation
- Gerber Foundation
- Newaygo County Community Collaborative
- Northwest Michigan Cancer Awareness and Prevention Coalition
- Local Service Organizations
- Spectrum Health Gerber Memorial Hospital
- Family Health Care
- Fremont Community Garden
- Tamarac Wellness Center
- White Cloud Community Garden

Oceana County

- Oceana Healthy Lifestyles Group (chaired by the Health Department)
- Oceana County Community Foundation
- United Way of the Lake Shore
- Northwest Michigan Cancer Awareness and Prevention Coalition
- Local Service Organizations
- Mercy Health Partners Lakeshore Campus

Wexford County

- Human Services Leadership Council
- Cadillac Area Health Coalition(co-chaired by Mercy Hospital and the Health Department)
- Mercy Hospital Community Benefit Program
- Cadillac Area Community Foundation
- Local Service Organizations
- Northwest Michigan Cancer Awareness and Prevention Coalition
- Pioneering Healthy Communities Group
- Mercy Hospital Cadillac
- Cornerstone Community Garden

Community Level Coalitions

Recognizing that no single organization or group can adequately or effectively address all community issues, collaboration is a priority. Within the DHD#10 health jurisdiction, community level health coalitions do exist in seven of the ten counties. Some of the coalitions may be stronger than others. Efforts to energize and engage weaker coalitions must be combined with maintaining the stronger coalitions; these efforts are essential to achieving success. Only through these collaborative groups can healthier communities be built and maintained. Data on issues related to the coalitions are not identified in the chart books or the one page summaries, but they are recognized as being paramount to the successful creation and maintenance of healthy communities.

4. Findings from Community Health Needs Assessment Data

Risk/Issue Areas from County Summaries

The proceeding health risk/issue areas identified represent consistencies across the DHD#10 health jurisdiction. Secondary data on the health risk/issue areas were included in both the individual county level chart books and one page summaries complied by DHD#10. Data for these measures were gathered from the Michigan Department of Community Health (MDCH) Behavioral Risk Factor Survey (BRFS); US Census Bureau; County Health Rankings; Michigan

Department of Technology, Management and Budget; Michigan League for Human Services; and the Michigan Care Improvement Registry.

High School Education: In Michigan, the percent of those with a high school education is 87.4%. The percent of those with a high school education in the DHD#10 health jurisdiction ranges from 87.4% in Mason to 78.8% in Lake. All of the counties except Mason are below the state percentage rate (US Census Bureau, 2005-2009).

College Degree: The percentage of Michigan residents who attained a college degree is 24.5%. Within the health jurisdiction, Mecosta has the highest percentage at 19.5% and Lake has the lowest at 8.3% (US Census Bureau, 2005-2009).

Jobless Rate: The current jobless rate in Michigan is 12.5. In the health jurisdiction, the range is from a high of 15.7 in Wexford to a low of 12.1 in Mecosta. All but Mason and Mecosta are above the state rate (Michigan Department of Technology, Management, and Budget, 2010).

Persons Living Below Poverty: In Michigan, the percentage of those living below poverty is 16.1% compared to a high of 23.4% in Lake and a low of 13.9% in Manistee. All but Manistee and Missaukee have percentages above the state percentage (US Census Bureau, 2009).

Free and Reduced Lunch: The percentage of students eligible for free and reduced lunch is higher than the state percentage in all counties within the DHD#10 health jurisdiction. DHD#10 counties range from a high of 89.0% in Lake to a low of 52.3% in Mason compared to 45.8% in Michigan (Michigan League for Human Services, 2009).

Medicaid Paid Births: Michigan births covered by Medicaid are 42.8%. In the DHD#10 health jurisdiction, the percentages range from a high of 66.3% in Kalkaska to a low of 50.8% in Mecosta, with all the counties being above the state rate (Michigan League for Human Services, 2009).

Number of People per Primary Care Physician: For the state, the number of individuals per primary care physician is identified at 874. In the DHD#10 jurisdiction, all counties except Wexford (n=660) are above the state rate (County Health Rankings, 2012).

No Access to Care in Past Year Due to Cost: In Michigan, the percent of individuals reporting no access to care in the past year due to cost is 12.9%. All counties in the DHD#10 jurisdiction, except for Crawford (5.5%), Mason (12.4%), and Oceana (9.4%), are above the state percent (MDCH-BRFS, 2006-10).

No Health Insurance: The percent of individuals reporting having no health insurance in Michigan is 15.1%. All counties in the DHD#10 jurisdiction are above this percent, ranging from a high of 31.6% in Missaukee to a low of 16.3% in Kalkaska (MDCH-BRFS, 2006-10).

No Dental Visit in the Past Year: The percent of individuals in Michigan reporting that they had not had a dental visit in the past year is 26%. In the DHD#10 jurisdiction, six of the counties, Manistee (47.9%), Mason (35.8%), Mecosta (28.1%), Missaukee (38.3%), Oceana (26.8%), and Wexford (30.6%), are above the state while Newaygo (25.1%) is below. Crawford, Kalkaska, and Lake do not have data available (MDCH-BRFS, 2006-10).

Poor Mental Health Days: In Michigan, 10.9% of individuals report poor mental health, which includes stress, depression, and problems with emotions, during the past 30 days. In the health jurisdiction, six of the ten counties are above the state rate: Crawford (11.1%), Oceana (12.7%), Manistee (13.7%), Newaygo (14.5%), Lake (15.9%), and Kalkaska (20.5%) (MDCH-BRFS, 2006-10).

Cancer Mortality Rate: The cancer mortality rate for Michigan is 184.8. The counties of Crawford (199.1), Kalkaska (223.6), Lake (233.1), Manistee (198.1) and Newaygo (196.6) are above the state rate while Mason (168) Mecosta (157.3), Missaukee (182.1), Oceana (164.3) and Wexford (168.9) are below (MDCH, 2007-9).

Cancer Incidence: Michigan's cancer incidence rate is 494.3. The counties of Crawford (499.2), Lake (591.4), Manistee (495.6), Mecosta (498), Newaygo (652.5) and Wexford (566.6) are all above the state rate while Kalkaska (408.4), Mason (456.1), Missaukee (452.3) and Oceana (401.4) are below (MDCH, 2005-7).

Infant Mortality: The Michigan rate for infant mortality is 7.6 per 1000 live births. Four of the ten counties have higher rates: Crawford (17.9), Mecosta (8.2), Newaygo (8.1), and Wexford (7.7) (MDCH, 2009).

Overweight: The percent of individuals in Michigan classified as overweight is 30.1%. All of the counties in the DHD#10 jurisdiction are above the state percentage and range from a high of 53% in Mason to a low of 31.7% in Newaygo (MDCH-BRFS, 2006-10).

No Leisure Time Physical Activity: In Michigan, the percent of individuals who report getting no leisure time physical activity is 23.4%. Counties in the DHD#10 jurisdiction above this percent include Lake (26%), Manistee (32.9%), Mecosta (25.7%), Missaukee (34.4%), Newaygo (24.3%), Oceana (26.8%), and Wexford (26.7%) (MDCH-BRFS, 2006-10).

Binge Drinking: Over 17% of Michigan residents report engaging in binge drinking. In the DHD#10 jurisdiction, all counties except for Kalkaska (14.4%), Lake (11.6%), and Wexford (12.6%) were above this percentage (MDCH-BRFS, 2006-10).

Smoking: The percentage of smokers in Michigan is 20.3%. All the counties in the DHD#10 jurisdiction except Oceana (18.8%) are above the state percentage. These percentages range from a high of 35.2% in Crawford to a low of 21.6% in Wexford (MDCH-BRFS, 2006-10).

Smoking during Pregnancy: In Michigan, the percent of mothers who report smoking during pregnancy is 18.2%. Within the DHD#10 jurisdiction, all counties exceed this percentage and range from a high of 45.5% in Crawford to a low of 20.1% in Oceana (MDCH – BRFS, 2006-10).

Teen Pregnancy: The teen pregnancy rate in Michigan is identified as 53.6. All of the DHD#10 counties except for Mecosta (32.4) are above the state rate. Rates above the Michigan rate range from a high of 75.2 in Oceana to a low of 54.4 in Manistee (MDCH, 2007-09).

Diabetes: The percent of individuals in Michigan reporting to have diabetes is 9.3%. Except for the counties of Manistee (5.8%) and Mason (7.6%), all other counties within the DHD#10 jurisdiction are above the state percentage (MDCH – BRFS, 2006-10).

County Health Rankings

In addition to the county chart books and summary page data, DHD#10 has included County Health Rankings findings for consideration and review as part of this assessment. The County Health Rankings have been available since 2010 and provide a mechanism by which counties can see the areas in which they are doing well and areas where improvement is needed. In Michigan, 82 counties are ranked, with "1" being the best score.

County Health Rankings are broken down into two main categories: Health Outcomes and Health Factors. Health Outcomes illustrate the current health of the community while Health Factors focus on the future health of a community. Within each of these categories are subgroups. The Health Outcomes subgroup contains mortality and morbidity data and the Health Factors subgroup contains health behaviors, clinical care, social and economic factors, and physical environment. The following chart illustrates the Health Outcomes and Health Factors rankings comparing 2010 and 2011. Improvement was seen in Health Outcomes rankings for seven counties and in the Health Factors rankings for four counties. A summary of the County Health Rankings for the health jurisdiction is included in *Appendix I.*

	Health Outcomes 2010	Health Outcomes 2011	Improved	Health Factors 2010	Health Factors 2011	Improved
Crawford	53	65		49	52	
Kalkaska	66	74		34	54	
Lake	80	78	↑	80	80	
Manistee	62	56	↑	29	45	
Mason	44	42	↑	32	37	
Mecosta	36	31	↑	43	42	↑
Missaukee	20	19	↑	44	35	↑
Newaygo	39	59		51	72	
Oceana	61	44	↑	68	61	↑
Wexford	68	61	↑	46	44	↑

Tencon Health Plan Data

A third piece of data included in the assessment is from the Tencon Health Plan participants. Tencon Health Plan is one of the county health plans that operate in the state of Michigan. The Tencon Health Plan was formed in 2002 through the collaboration of DHD#10, hospitals operating within the health jurisdiction, and local county governmental units. Components of the Health Plan include Plan A (Adult Benefit Wavier participants), Plan B (Limited medical and formulary services), and Plan D (Limited formulary services only).

The focus of the Tencon health plan is to provide basic primary care services including the establishment of a medical home, basic lab and radiology services, and limited prescription coverage. Participants in the plan must meet certain eligibility requirements including: income at or below 150% of federal poverty level, between the ages of 19 and 64, a resident of the health jurisdiction, and not eligible for other health insurance including Medicare and Medicaid. Enrollment into Plan B and Plan D is done at each local DHD#10 office. As part of the enrollment process, participants receive a health screening and complete a health risk appraisal. Results from the FY 2011 (10/10 – 9/11) enrollment screening process showed that of the 747 individuals completing the screening, 28% are overweight, 44% are obese, 52% are smokers, 9% are diabetic, and 62% have not had a dental visit within the past year. Data from this population are consistent with the other health risk/issue areas identified within the health jurisdiction. The Tencon data also follow other national data that illustrate low income,

uninsured individuals tend to have increased health risks. A chart of the Tencon cumulative screening data from FY 2011 is included as *Appendix J.*

Michigan Profile for Healthy Youth (MiPHY) Data

The final piece of data contained within the DHD#10 CHNA is from the 2010 Michigan Profile for Healthy Youth (MiPHY) survey. This survey is made available to students in the 7th, 9th and 11th grades statewide every other year. Participation in the online survey is voluntary and prior registration with the MDCH is required. MiPHY provides student results on health risk behaviors, including substance use, violence, physical activity, nutrition, sexual behavior, and emotional health. The survey also measures risk and protective factors most predictive of alcohol, tobacco, other drug use, and violence. Individual school results are made available to each respective school. County-wide results, providing at least two schools in each county complete the survey, are available online for community partners and stakeholders to view.

For the 2010 school year, counties with schools completing the MiPHY survey included: Crawford, Lake, Mason, Missaukee, Newaygo, Oceana and Wexford. Efforts were undertaken by DHD#10 during the FY 2012 school year to encourage all schools in the health jurisdiction to complete the MiPHY survey. Included in *Appendix K* is a summary of MiPHY data from the 2010 survey. Mason and Lake county schools are grouped together. Crawford county data is included with Ogemaw, Oscoda, and Roscommon counties. Below are some highlights from the 2010 survey data.

- 24.3% of the 7th graders (Newaygo) and 71.0% of the 11th graders (Missaukee) reported ever drinking alcohol; 15.3% of the 7th graders (Mason/Lake) and 59.0% of the 11th graders (Crawford) reported ever being drunk
- 43.9% of the 7th graders (Newaygo) reported riding in a car driven by someone who had been drinking alcohol; 14.0% of the 11th graders (Crawford) reported that in the past 30 days they had driven when they had been drinking alcohol
- 13.6% of the 7th graders (Crawford) and 48.8% of the 11th graders (Crawford) reported ever smoking a whole cigarette; 26% have smoked in the past 30 days; 44.3% have ever tried marijuana
- 14.9% of the 7th graders (Missaukee) reported ever trying to kill themselves and 17.4% of the 11th graders reported attempting suicide during the past 12 months (Mason/Lake)
- 10.0% of the 7th graders (Mason/Lake) and 61.9% of the 11th graders (Crawford) reported ever having sexual intercourse
- 29.8% of the 7th graders (Mason/Lake) and 20.6% of the 11th graders (Missaukee) are obese; 26.6% of the 7th graders (Oceana) and 19.8% of the 11th graders (Missaukee) are

overweight; 57.4% of the 7th graders (Oceana) and 51.9% of the 11th graders (Crawford) are trying to lose weight

Community Survey Findings

In addition to the secondary data sources used in completing the CHNA, DHD#10 also undertook a process to gather primary data from its health department clientele. Through a combination of client surveys and population specific focus groups, DHD#10 attempted to identify individual and community health needs and barriers related to addressing them. With assistance from a University of Michigan Epidemiology graduate student intern, a survey tool focused on individual and community health needs and barriers was developed. This tool was utilized with health department clientele during June 2012. During a four week period, DHD#10 conducted a community needs assessment using both quantitative and qualitative methods. Over 1000 surveys were administered; 989 were fully completed by clients in the DHD#10 health jurisdiction. As part of the surveying process, participants were asked if they would be interested in participating in a focus group. Data gathered from the completed surveys were used to develop specific focus group questions. Focus groups were completed during July 2012 and targeted Breast and Cervical Cancer Control/WISEWOMAN, WIC, Family Planning and County Health Plan (Tencon) participants. All data gathered through this process were reviewed, compiled, and analyzed by the graduate student intern and health department staff. Copies of the survey and focus group questions can be found in *Appendix F*.

Survey Demographics: There were 989 completed surveys, and over 93% of the respondents were female. A large percent of participants (40%) were between 20-29 years of age. Other age groups included: 0-19 (9%), 30-39 (19%), 40-49 (13%), 50-59 (13%), 60-69 (5%), and 70+ (1%). The participants were asked to rate their health condition on a scale of "Excellent, Good, Fair, Poor." The majority of individuals rated their physical, dental, and mental health as "Good." For physical and mental health, 84% and 87%, respectively, rated their health as "Excellent" or "Good." However, only 65% of individuals rated their dental health as "Excellent" or "Good." Twelve percent of individuals (n=121) rated their dental health as poor.

Information Sources: When asked from whom or where do they receive information about their health, 77% reported they received information from their doctor, 42% from relatives, and 35% from friends and coworkers. For media sources, 30% reported they received information on their health via the internet. Television provided 22% of individuals with their health information. Magazines informed 19%, while newspapers advised 12%, and flyers educated 7% of the individuals surveyed.

Community Services: In an effort to assess the effectiveness of community services, clients were asked a few questions on a variety of identified services: "Was this service needed in the community," "Have you used this service," and "If used, was the service helpful?" District-wide, 40% of individuals reported a need for affordable dental care, 30% for eye care, and 29% for affordable health care in their community. A high percentage of individuals reported a need for economic services such as housing, job searching, and job training and education (24%, 27%, and 26%, respectively). Other health services needed in communities included alcoholism treatment (18%), drug abuse treatment (19%) and mental health counseling (17%). Childcare and clothing were also needs for21% and 17% of individuals, respectively. The most used source was food assistance (15% of individuals). A comprehensive list of the findings from the survey and the focus groups can be found in *Appendix L.*

Health Care Access: To assess issues related to health care access, individuals were asked to identify the specific barriers to receiving health care. When asked if there have ever been times they didn't understand what their doctor or health care provider was explaining to them, 21% reported "yes." Forty-eight percent of individuals indicated there have been times they were not able to get health care for themselves or their family. The primary reasons why they were not able to receive care were because it was too expensive (70%) and they did not have medical insurance (61%). Other high-ranking reasons that prevented them from accessing health care included high prescription costs (29%) and their medication not being covered by insurance (25%). Additional reported barriers to receiving health care are included in *Appendix L.* Fifty-five percent of individuals indicated there have been times they were not able to get dental care for themselves or their family. The primary reasons why they were not able to receive dental care matched those for health care: too expensive (78%) and lacked dental insurance (77%). Another reason that prevented dental care was the dentist not accepting Medicaid (19%). Other barriers to receiving dental care are reported in *Appendix L.*

Healthy Lifestyles: Individuals were then asked about their physical activity and eating habits. Over 32% reported that they were physically active seven days a week. In comparison, 26% of individuals were physically active only 3 days or less per week. The primary reasons for lack of physical activity were lack of time and lack of motivation. A fair number of individuals (greater than 100) reported they were not physically active because they didn't have an exercise partner or did not live near a recreation center. When assessing eating habits, the bulk of individuals (97%) completing the survey obtained the majority of their food at the grocery store. Other sources for accessing food included the farmer's market (44%), restaurants (38%) and fast-food restaurants (28%). In an effort to increase fruit and vegetable intake through improving accessibility, we asked individuals if they would purchase fresh fruits and vegetables at a convenience store if they were available. Seventy-eight percent said "yes." Also, individuals were asked what factors would encourage them to purchase fruit and vegetables at

a convenience store. The biggest factors were affordability, availability of fresh produce, and quality of produce. Other factors considered were locally grown produce, variety of produce, easy to get to store, and availability of frozen or canned produce.

Health Issues: To better gauge the perspective of DHD#10's clients, we asked for the identification of personal health issues as well as community health issues. Twenty health issues were presented, the results of which can be found in *Appendix L.* Four health conditions were ranked high among individuals as well as community: dental health problems, mental health issues, overweight, and smoking. Three issues had high rankings among individuals, but lower perceptions about the community having those issues: arthritis, asthma, and vision problems. Lastly, four issues had relatively low rankings among individuals, but alarmingly high rankings as community health issues: alcoholism, drug abuse, lack of physical activity, and teen pregnancy. The top five community health issues, chosen by the participants were: smoking, overweight, drug abuse, alcoholism, and lack of physical activity.

Future Programs: Lastly, we asked participants to identify which community programs would most help them and the community. Obtaining health insurance, having an exercise/healthy eating partner, and exercise classes offered by DHD#10 were the top three programs that would benefit individuals in the district the most. Having DHD#10 offer cooking/healthy lifestyle classes and a smoking cessation program in addition to providing health insurance (or at least a means to obtaining it) would help the community at-large. Other programs highly ranked included appointment reminders via text message, offering healthy eating classes, having a farmers' market nearby, and the improvement of recreation areas.

Community Focus Group Findings: Following the survey process, focus groups were intended to be convened in all 10 counties of the health jurisdiction. Unfortunately, due to a lack of participants, only six counties were able to schedule a focus group. These included: Manistee, Mecosta, Missaukee, Wexford, Oceana, and Newaygo. Each focus group began by asking participants what it meant to be healthy, and what a healthy *community* looked like. Some of the responses were surprising, and most seemed to fall out of the jurisdiction of the health department's work. They are summarized here to support the community health improvement plan and District Health Department #10's global efforts to overcome poverty and strengthen communities through better health.

Participants felt that being healthy meant having a good quality of life (no symptoms or pain, no dependence on prescription medication, feeling good, and having time for "me"). This included the need and ability to eat healthy, be physically active regularly, and be mentally fit. Environmental factors were also included: clients associated "healthy" with having safe and affordable housing, access to proper and affordable health care, knowledge of community

resources (including cooking classes), access to senior centers and services, and attendance at community functions.

A healthy community, an idea many participants had never given much thought, supported the ideas for an individual's health. Much of the conversation focused on having friendly interactions with community members across age groups, which then funneled into community projects (e.g., clean-up days), recreational activities, and community sports (especially for children). Focus group participants thought that a community would be healthier if the following existed: affordable health/dental insurance and care, available employment, active and growing businesses, education on self-sustainability, and encourage high school graduation. All of these required an infrastructure to bolster the ideas of a healthy community, so the conversation turned toward the built environment. Participants felt that creation of a healthy community would include a central recreation area; clean parks and walking paths with easy access; churches; farmers' markets; public transportation with handicap accessibility; health centers well connected to the community that provide resources, services and programs for all; good schools with concerned teachers; and a clean, active downtown with industry.

Each of the six focus groups had a different tone and focus based upon the concerns of those in attendance. A variety of health and community concerns carried the conversation. A few concepts and ideas brought up in the groups were included in the categories presented previously, but are also included here and in *Appendix L* for depth. The topics of conversation are summarized in the following six categories:

Health Care Access: Focus group attendees expressed the need for a free health and dental clinic (or at least one with a sliding scale fee) to provide care for them and their families. If that wasn't possible, expansion of the participating physicians for the Tencon and Medicaid insurance was necessary. Additionally, it was suggested that the Health Department provide classes to teach clients how to prepare for doctor's appointments, how to understand physician orders, and what natural remedies are effective.

Knowledge of Resources: Many clients who attended the focus group did not know about the resources the health department offered and other resources available in the community. Outreach ideas from participants included: bulk mailings, emails, more frequent health fairs, linking other websites to the health department's website and vice versa, more flyers, text messaging, a health department newsletter (that could be sent home with kids through school), and recruiting client volunteers to promote health department services.

New Programs: Program suggestions were brought up at multiple focus groups: stress management groups, parenting groups, a "WISEWOMAN" program for men, free exercise

classes at the health department, free mental health services, and a multitude of classes (healthy eating/cooking, couponing and budgeting, preventive care, diabetes prevention, technology, smoking cessation, prescription drug abuse and natural remedies). One specification made at almost all six focus groups was the need for childcare to be provided during all of the classes and programs. One conclusion about the programs was how important sharing success stories and communication of a program's value would be to client involvement. Even if the health department could not provide these classes, expressing the need to other agencies and even collaborating with other agencies, would further help strengthen the communities it serves.

Community Involvement: One continual concern brought up in focus groups was the lack of interaction among people in the community and lack of involvement within the community. The need for a central recreation area that provided many activities and hosted events for people of all ages to participate in was expressed. Also mentioned was the need for a venue for physical activity including free fitness activities, low-cost community sports, and clean, accessible parks.

Geriatric Care and Senior Services: At one of the focus groups, geriatric care was brought up, primarily because of the lack of geriatric specialists in the area despite a high elderly population. Clients stressed the need for advocacy at hospitals and doctor's offices for medical care and medications for elderly individuals. Educational programs like "healthy cooking for one" classes, how to understand physician orders and medications, and how to approach the doctor at a visit were also mentioned.

Youth and the Community: The need for a boys and girls club in some counties for physical activities and community sports (who can't afford to participate in school sports) was mentioned in one of the counties. Most of the counties mentioned how essential youth involvement, be it high school or college, with the community was – whether through tutoring, community clean-up, childcare, or technology education for older adults. Suggestions for better health education within the schools included healthy eating, gardening, and exercise classes after school.

Strengths in the Health Jurisdiction

While numerous health risks/issues exist within the health jurisdiction, many strengths are also present. Eight counties are below the state percentage of individuals reporting they do not have a primary health care provider. Eight counties have cardiovascular disease mortality rates and diabetes mortality rates below state rates. Seven counties report lower than state percent of low-birth rates. Childhood immunization percentages for all ten counties are above the state percentage rate while chlamydia rates for all ten counties are below the state rate. Infant

mortality rates in six of the ten counties (Kalkaska, Lake, Manistee, Mason, Missaukee, and Oceana) are below the state rate. Within the health jurisdiction, DHD#10 is the only provider of the Maternal and Infant Health Program, a statewide Medicaid program for pregnant women and new babies. Finally, DHD#10 has a strong history of collaborative efforts both on a local level as well as statewide. Staff holds leadership positions and participates in local collaborative bodies, community coalitions, and professional organizations and groups. All of these strengths illustrate the commitment and efforts of the agency, and its partners, to create and maintain healthy communities.

While all the data collected and analyzed illustrate a multitude of issues facing the health jurisdiction of DHD#10, the struggle will be focusing limited agency resources towards the health risks/issue areas that will provide the greatest public health impact. These identified health risk/issue areas will serve as the foundation on which DHD#10 will build its CHIP. They will be used to identify and determine the agency's public health focus areas for which strategies will be developed and implemented by DHD#10. These focus areas as well as strategies will be shared with our hospital partners so that they can be included in their plans to ensure that a public health approach is part of each hospitals process and plan.

5. DHD#10 CHNA Recommendations

DHD#10, as part of a collaborative effort, completed this CHNA process in an attempt to gather and analyze community level health data. These findings will in turn be used to develop a plan to improve and maintain the health of the jurisdiction. Included below are the public health focus areas DHD#10 identified from its own CHNA process and upon which it will develop and implement its CHIP. Specific strategies for each focus area will be identified by DHD#10 and presented to the steering committee for approval prior to the development of the CHIP. In addition to these public health focus areas, DHD#10 will also direct its efforts to those areas identified as priorities by its hospital partners. *Appendix M* includes a listing of the hospital partners focus areas. Through the following collaborative efforts, it is anticipated that the partners can build and maintain both healthier communities and residents, as well as create a more successful health jurisdiction.

Poverty

The level of poverty in a community is both a measure for its potential success and risk for future decline. Within the DHD#10 health jurisdiction, eight of the ten counties (excluding Manistee and Missaukee) have poverty rates above that of the state of Michigan. Research has shown that higher poverty levels correlate with unhealthy lifestyle habits, increased engagement in risky health behaviors, and poorer health status. Higher poverty levels have also been shown to decrease the overall health status of a community thus making it less

attractive to business and industry, resulting in decreased employment opportunities. Within the DHD#10 health jurisdiction, numerous communities and collaboratives have begun poverty reduction initiatives, focusing on a multitude of directions, in an attempt to address this issue. *Appendix N* provides trend data for a sampling of poverty measures.

Access to Preventive Care

Communities, in which residents have access to medical and dental care, as well as other preventive services, are generally considered to be healthier communities. Within the DHD#10 health jurisdiction, eight of the ten counties for which data are available reported the number of individuals without health insurance is above the state rate. The percent of individuals without a dental visit in the past year is above the state rate in six of the ten counties for which data are available. Compared to the state average, seven of the ten counties report a greater percentage of individuals with no access to care due to cost. Providing access to and increased availability of preventive services, e.g. Breast and Cervical Cancer Control Program, Colorectal Cancer Screening Program, WIC, Family Planning, Immunizations, is essential to creating and maintaining healthy residents and communities.

Promotion of Healthy Lifestyles and Behaviors

The recognition of individual responsibility for health is essential to improving the health status of a community and of the health jurisdiction. For this to occur, individuals need knowledge on how to make successful changes, as well as the access and opportunity to live and sustain the changes they have made. In Michigan, the strategies contained in the release of "The Michigan Health and Wellness 4 x 4 Plan" document, as well as other best practices, need to be incorporated into family, home, work, and faith to help facilitate this process.

Creation and Maintenance of Healthy Communities

Preventing and managing chronic disease are two of the biggest challenges facing communities and health organizations today. Incidence of heart disease, cancer, stroke, and diabetes, and their associated risk factors have contributed to the decline of the health status of both individuals and communities. As a result, communities with lower health status and increased health risks may not be viewed as attractive by businesses, worksites, and organizations looking to invest. It is imperative that community groups and community health coalitions look to best practices and recommendations, including the "Michigan Health and Wellness 4 x 4 Plan," the Michigan Infant Mortality Reduction Plan, and the National Association of County and City Health Officials (NACCHO) Roadmap for Chronic Disease Prevention, as evidence of direction to take to address these issues. Public health agencies, with their understanding of policy, environmental, and systems change approaches, can serve as leaders to facilitate these efforts.

6. Next Steps

The DHD#10 focus areas identified will serve as the foundation upon which the agency's Community Health Improvement Plan will be developed. To set the course for the development of the CHIP, DHD#10 will proceed as follows:

- Present the identified focus areas to the steering committee for approval
- Identify specific public health focused objectives and strategies for each focus area
- Create a DHD#10 health jurisdiction CHIP
- Share and disseminate the CHIP
- Update the DHD#10 strategic plan to include CHIP activities
- Monitor and evaluate CHIP progress

It is important to note that the strategies identified by DHD#10 represent only one component of the complete plan. The other pieces that will make up the plan will be provided by our partners. It will be through this combined approach that we will achieve the greatest impact in improving and maintaining the health of our communities and residents.

** Click on the blue rectangles around the appendices to download and view that particular appendix.

Appendices

A. Demographic Data Chart

B. DHD#10 Service Area Map

C. DHD#10 County Chart Books

D. County One-Page Summaries

E. DHD#10 Community Health Assessment Plan

F. DHD#10 Community Needs Survey and Focus Group Questions

G. Hospital Partner Meeting Agendas and Meeting Minutes

H. Links to Hospital Partners CHNA Plans

I. 2012 County Health Ranking Summary

J. 2011 Tencon Screening Data

K. 2010 MiPHY Data

L. Findings from the Community Survey and Focus Group

M. Hospital Partners Focus Areas

N. Poverty Trend Data