SPECTRUM HEALTH

# Community Health Needs Assessment for:

## Newaygo County General Hospital Association d/b/a Spectrum Health Gerber Memorial

The “hospital facilities” listed above are part of Spectrum Health System. Spectrum Health is a not-for-profit health system in West Michigan offering a full continuum of care through the Spectrum Health Hospital Group, which is comprised of 11 hospitals; the Spectrum Health Medical Group which employs more than 1,200 physicians and advanced practice providers; and Priority Health, a health plan with 590,000 members. Spectrum Health System is West Michigan’s largest employer with more than 21,700 employees. The organization provided $294.6 million in community benefit during its 2014 fiscal year. Spectrum Health was named one of the nation’s Top Health Systems in 2014 by Truven Health Analytics.

***Community Health Needs Assessment – Exhibit A***

The focus of this Community Health Needs Assessment attached in Exhibit A is to identify the community needs as they exist during the assessment period (late 2014-early 2015), understanding fully that they will be continually changing in the months and years to come. For purposes of this assessment, “community” is defined as the county in which the hospital facility is located. This definition of community based upon county lines, is similar to the market definition of Primary Service Area (PSA). The target population of the assessment reflects an overall representation of the community served by this hospital facility. The information contained in this report is current as of the date of the CHNA, with updates to the assessment anticipated every three (3) years in accordance with the Patient Protection and Affordable Care Act and Internal Revenue Code 501(r). This CHNA report complies with the requirements of the Internal Revenue Code 501(r) regulations either implicitly or explicitly.

***Evaluation of Impact of Actions Taken to Address Health Needs in Previous CHNA – Exhibit B***

Attached in Exhibit B is an evaluation of the impact of any actions that were taken, since the hospital facility finished conducting its immediately preceding CHNA, to address the significant health needs identified in the hospital facility’s prior CHNA.

# Spectrum Health Gerber Memorial Hospital Community-Wide Health Needs Assessment

Research Results from the 2014-15 Community-Wide Health Needs Assessment

# A Research Project for

SPECTRUM HEALTH

Gerber Memorial

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VP RESEARCH AND EVALUATION
VISION · INSIGHT · PRAXIS

**May 1, 2015**

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# *INTRODUCTION*

# Background and Objectives

- VIP Research and Evaluation was contracted by Spectrum Health to conduct a Community Health Needs Assessment (CHNA), which included a Behavioral Risk Factor Survey (BRFS) for Spectrum Health Gerber Memorial Hospital (SHGMH).

- The Patient Protection and Affordable Care Act (PPACA) passed by Congress in March of 2010 set forth additional requirements that hospitals must meet in order to maintain their status as a 501(c)(3) Charitable Hospital Organization. One of the main requirements states that a hospital must conduct a Community Health Needs Assessment (CHNA) and must adopt an implementation strategy to meet the community health needs identified through the assessment. The law further states that the assessment must take into account input from persons who represent the broad interests of the community, including those with special knowledge of, or expertise in, public health.

- In response to the PPACA requirements, organizations serving both the health needs and broader needs of Spectrum Health Gerber Memorial Hospital communities began meeting to discuss how the community could collectively meet the requirement of a CHNA.

# Background and Objectives (Cont'd.)

- The objective of the BRFS is to obtain information from SHGMH area residents about a wide range of behaviors that affect their health. More specific objectives include measuring each of the following:
  - Health status indicators, such as perception of general health, satisfaction with life, weight (BMI), and levels of high blood pressure
  - Health risk behaviors, such as smoking, drinking, diet/nutrition, and physical activity
  - Clinical preventative measures, such as routine physical checkups, cancer screenings, oral health, and immunizations
  - Chronic conditions, such as diabetes, asthma, heart disease and cancer, and the management of chronic conditions

- The overall objectives of CHNA include:
  - Gauge the overall health climate or landscape of the regions primarily served by Spectrum Heath Gerber Memorial Hospital, including primarily, Lake, Newaygo, and Oceana counties
  - Determine positive and negative health indicators
  - Identify risk behaviors
  - Discover clinical preventive practices
  - Measure the prevalence of chronic conditions
  - Establish accessibility of health care
  - Ascertain barriers and obstacles to health care
  - Uncover gaps in health care services or programs
  - Identify health disparities

# Background and Objectives (Cont'd.)

- The information collected will be used to:
  - Prioritize health issues and develop strategic plans
  - Monitor the effectiveness of intervention measures
  - Examine the achievement of prevention program goals
  - Support appropriate public health policy
  - Educate the public about disease prevention through dissemination of information

# *EXECUTIVE SUMMARY*

# Executive Summary

In 2014, VIP Research and Evaluation was contracted by Spectrum Health to conduct a Community Health Needs Assessment (CHNA), which included a Behavioral Risk Factor Survey (BRFS), for Spectrum Health Gerber Memorial Hospital (SHGMH).

The primary goal of the study was to identify key health and health service issues in the SHGMH service area, which included primarily Lake, Oceana, and Newaygo counties. The results will be used to assist in planning, implementation of programs and services, evaluating results, allocation of resources, and achieving improved health outcomes, specifically related to identified needs.

Data was gathered from a variety of sources and using multiple methodologies. Resident feedback was obtained via a Behavioral Risk Factor Survey (BRFS) (n=980) of the broader adult population in the SHGMH area, as well as a self-administered survey (n=77) to more targeted subpopulations of underserved or vulnerable residents (e.g., single mothers with children, uninsured/underinsured/ Medicaid). Health care professionals and other community leaders, known as Key Stakeholders or Key Informants, provided input via in-depth interviews (n=5) and an online survey (n=90). Secondary data gathered from state and national databases was also used to supplement the overall findings.

# Executive Summary (Cont'd.)

Some of the characteristics that make the SHGMH area a great place to live and raise a family, such as being a small, close-knit rural community with farm fresh food/gardens, parks, and recreation areas, also contribute to problems of high unemployment and poverty rates and lead to transportation issues for many.

On the positive side, most adult residents in the SHGMH area report their general overall health status to be good to excellent. Most adults also report good physical health. That said, the proportion of adults in fair/poor general health and in poor physical health are greater than the state or the nation.

Residents are satisfied with their lives and most often receive the social and emotional support they need.

Area adults have lower life expectancy rates (both men and women) and higher age-adjusted mortality rates than adults across the nation. Death rates from Alzheimer's disease and chronic lower respiratory disease are higher than peer counties and death rates from cancer are higher than MI or the U.S.

Chronic conditions, such as cancer, diabetes, and stroke are more prevalent among adults in the area than in Michigan and the U.S. Further, approximately one in eight adults has diabetes, a rate higher than MI, the U.S., or peer counties.

On the other hand, chronic conditions such as angina/coronary heart disease, heart attacks, and skin cancer are less prevalent than in MI or the U.S.

# Executive Summary (Cont'd.)

Almost two-thirds of area adults are overweight or obese. Though obesity rates are lower than the state, three in ten adults are obese and this is a major area that is perceived to have an insufficient community response.

More than one-third of adults have high blood pressure and this rate is worse than the state or the nation. The rate for high cholesterol is lower than the state or the nation, however, adults do not have their cholesterol checked as often as they should.

In terms of risk behaviors, smoking is problematic, with one-fourth of area adults classified as smokers, a rate higher than MI or the U.S. Area health care workers, especially Key Informants, feel that the high incidence of smoking is not being adequately addressed in the community.

Rates for heavy drinking are higher than the state and nation, however, binge drinking rates are lower than MI or U.S.

Area adults and children also consume inadequate amounts of fruits and vegetables and do not engage in physical activity as much as they should.

# Executive Summary (Cont'd.)

There is a direct relationship, or at the very least a strong association, between positive health outcomes and both education and income; those with higher incomes and more education are more likely to report better health and greater satisfaction with life, and are more likely to have health coverage, visit a dentist, refrain from smoking, and exercise regularly. They are less likely to have chronic health conditions, high blood pressure, or high cholesterol.

Health care coverage has expanded in the last several years to where nine in ten area adults have health care coverage and have a PCP. Both of these proportions are much better than state and national levels.

Most adults engage in clinical preventive practices such as routine physical checkups and cancer screenings. Still, the proportion of women who get screened for cervical cancer and the proportion of men screened for prostate cancer lag behind state.

Dental care is an area that many neglect, with one-third of area residents reporting no dental cleanings in the past year.

Despite an increase in insured residents, almost one in ten adults has had to forego a needed doctor visit due to cost in the past year, as deductibles and co-pays can be prohibitive. A similarly widespread barrier exists with respect to dental care.

# Executive Summary (Cont'd.)

These barriers are particularly prominent among the vulnerable/underserved population, such as the uninsured, underinsured, those on Medicaid, those with low incomes, and residents facing language barriers.

Not only are high health care costs a barrier to these groups, but even those with Medicaid find it hard to see a provider because increasingly more physicians are refusing to accept Medicaid. This has created critical consequences for primary health care, mental health treatment, dental care, and substance abuse treatment.

Further, traditional health insurance often doesn't cover ancillary services such as prescription drugs, vision, or dental care. Thus, if consumers have to pay for these services, plus deductibles and co-pays, the cost burden can be great and residents will avoid seeking necessary treatment or any type of preventive service.

Additional barriers to care include a shortage of providers – both primary care and specialists – particularly those accepting Medicaid, and transportation issues pose enormous challenges for many area residents. The two greatest barriers to care in the SHGMH area are lack of primary care providers and transportation issues (rural, lack of public transportation).

In sum, having health care coverage does not necessarily translate into utilization of needed services.

# Executive Summary (Cont'd.)

Additional areas identified by Key Stakeholders, Key Informants, and residents as needing more services and programming are:

- Low cost eye care (Newaygo County)
- Mental health treatment and dental care for the underserved (uninsured, underinsured, Medicaid, low income)
- Mental health treatment, especially for mild to moderate, depression, anxiety
- Prevention and wellness
- Primary care
- Programs aimed at chronic disease/pain management
- Programs that target obesity
- Programs that teach people how to cook/cook healthy foods
- Specialist services/care (e.g., orthopedics, OBGYN, GI, orthodontics, neurology)
- Substance abuse treatment, especially in Lake County
- Transportation
- Urgent care

Since the last CHNA conducted in 2011, Key Stakeholders report an improvement in residents' health awareness and making better lifestyle choices, and this is most evident in area youth. There have also been a number of initiatives/programs implemented to address obesity, such as Fit Kids, the Live Well campaign, and the Prescription for Health program. Moreover, there has been strengthening of dialogue between public health and the hospital community.

# Executive Summary (Cont'd.)

Community members (both residents and health care professionals) suggest further strategies to improve the health care landscape. Priorities include:

- Increase collaboration among health care providers, social services agencies, and community programs that support health (United Way, True North, Love Inc., SHGMH)
- Further, continue coordination among program providers to avoid duplication of efforts for example, there are multiple organizations offering a program on obesity
- Develop a system where family health clinics, mental health agencies, and social service agencies can share patient data (e.g., centralized database)
- Move more toward client-centered services by having a centralized intake process to determine client needs and how to meet those needs, and move away from the existing system where clients bounce from agency to agency in hopes of getting their needs addressed
- Prioritize creative transportation ideas/services, investigate possible grant opportunities, and reallocating resources similar to what was done in Lake County
- Consider using volunteers or a mobile clinic to address transportation issues
- Put better effort into inviting consumers/citizens to be involved in health/health care planning and decision making (e.g., the strategic planning phase of this research)
- Make better use of services and programs that are currently in place – through increased access (e.g., transportation; flexible hours), increased awareness among residents about available services, and stronger partnerships among existing services/providers
- Find ways to offer more affordable health care (e.g., offering sliding scale fees)
- Offer more support and social services to families in need
- Increase efforts to address more primary care physicians/physician extenders
- Increase mental health services (particularly outpatient services) and substance abuse services (because of high co-morbidity)
- Create a culture of health mindset early on in the life cycle by working closely with families and schools

# Executive Summary (Cont'd.)

Next steps may include the creation of a steering committee to work on prioritizing and then developing a coordinated response to issues deemed most important to work on, within a specific time frame, such as 1 year, 3 year, and 5 year goals. Above all, next steps involve the establishment of careful priorities for action that once implemented, will benefit the community for the long haul.

# Executive Summary (Cont'd.) – **Strengths**

**Social Indicators**

- ✓*Lower violent crime and homicide rates than MI/US*
- ✓*Children in single parent households better than peer counties*
- ✓*Better access to healthy foods than peer counties*
- ✓*Safe, walkable, and family-friendly community*
- ✓*Recreational area, parks, trails for walking, hiking, biking*
- ✓*Freemont Area Community Foundation, Newaygo County Community Collaborative programming, and school-based adolescent health clinics contribute to community health*
- ✓*Strong volunteer force*

**Health Care Access**

- ✓*Excellent services such as emergency care, prenatal care, orthopedics, OBGYN, ambulatory/emergency transport, in-home care, and oncology*
- ✓*More adults have health insurance and medical home (PCP) than MI/US*
- ✓*Fewer have had to forego medical care due to cost than MI/US*
- ✓*Health partnerships are collaborative and cooperative (but could do better)*
- ✓*Most adults are confident they can navigate the health care system*
- ✓*Older adult preventable hospitalizations better than peer counties*

**Health Indicators**

- ✓*Almost all pregnant women receive timely prenatal care and the majority receive it in the first trimester*
- ✓*Proportion of low birth weight in Newaygo County lower than MI/US*
- ✓*Fewer adults with poor mental health than MI*
- ✓*High satisfaction with life, higher than MI*
- ✓*Strong social and emotional support networks*
- ✓*Lower prevalence of chronic disease such as angina/CHD, heart attack, and skin cancer than MI/US*

**Risk Behaviors**

- ✓*Binge drinking rates lower than MI/US*
- ✓*Fewer adults with high cholesterol than MI/US*
- ✓*Fewer Oceana and Newaygo youth having sex than US*
- ✓*Lower prevalence of youth risk behaviors such as smoking and binge drinking compared to MI/US*
- ✓*Lower prevalence of marijuana use by Oceana and Newaygo youths compared to MI/US*
- ✓*Area youth more active than MI/US*
- ✓*Most adults say they always have enough to eat*

**Preventive Practices**

- ✓*More adults have routine checkups than MI/US*
- ✓More than nine in ten women, 40+, have had mammograms and rate of having them timely (in past year) is better than MI
- ✓*Higher proportion of immunized children than US*
- ✓*Majority have routine checkups and health screenings/tests*
- ✓*Timely colon cancer screening higher than MI/US*
- ✓*Flu vaccine for adults 65+ higher than MI/US*

# Executive Summary (Cont'd.) – **Opportunities for Improvement**

**Health Care Access**

- ✓*Even though more insured, high deductibles and co-pays preventing many residents from utilizing coverage*
- ✓*Far fewer PCPs per capita in all three counties (especially Lake) than MI – this is a major issue*
- ✓*Shortage of physicians accepting Medicare/Medicaid, and a shortage of specialists*
- ✓*More residents receiving Medicaid in all three counties compared to MI*
- ✓*One in nine adults visited ER/ED two or more times in the past year and they are overrepresented by low education and low income groups*
- ✓*Transportation continues to be a barrier to access*
- ✓*Lack of dermatology, oral surgery, substance abuse, mental health treatment, and urgent care services*
- ✓*Lack of adequate mental health care/substance abuse services in general and those that accept multiple forms of insurance*
- ✓*Lack of affordable oral health care and available dentists for uninsured, low income, and Medicare/Medicaid residents*
- ✓*Lack of health care access for unemployed, uninsured, and Medicare/Medicaid residents*
- ✓*Need for more focus on prevention and wellness*
- ✓*Only three in ten Key Informants are satisfied with the overall health climate of the region*

**Health Indicators**

- ✓*Life expectancy rates lower than U.S.*
- ✓*Age adjusted mortality rates higher than the U.S.*
- ✓*Adults reporting general health status as fair or poor worse than MI/US*
- ✓*Adults with poor physical health greater than MI*
- ✓*Three in ten adults obese, higher rate than peer counties*
- ✓*Overweight rate higher/healthy weight rate lower than MI/US*
- ✓*More adults rarely/never receive social or emotional support than MI*
- ✓*More adults with HBP than MI/US*
- ✓*Prevalence of chronic conditions, such as cancer, diabetes, and stroke higher than MI/US*
- ✓*Proportion of low birth weight in Lake and Oceana counties higher than MI/US*
- ✓*Death rates from heart disease higher in Lake County vs. MI/US*
- ✓*Death rates from cancer higher in Lake and Newaygo counties vs. MI/US*
- ✓*Roughly one in three youths reporting depression*
- ✓*Rates for youth attempted suicide higher in Oceana and Newaygo counties vs. MI/US*
- ✓*One in five adults have mild to sever psychological distress*
- ✓*Only between two-thirds of adults with severe psychological distress and just over half of adults considered to have poor mental health are currently taking medication or receiving treatment for a mental condition/emotional problem*
- ✓*Obesity, depression, and anxiety viewed as highly prevalent but dissatisfaction with community response to them also great*

# Executive Summary (Cont'd.) – **Opportunities for Improvement (Cont'd.)**

**Social Indicators**

- ✓*Unemployment rate for all three counties higher than US and peer counties*
- ✓*Percentage of people (children, adults, families) in poverty higher than MI, U.S., and peer counties*
- ✓*More students eligible for free/reduced lunch, more children receiving WIC, more Medicaid paid births, compared to MI*
- ✓*Percent of single female families with children under five that are in poverty ranges from 58.6% in Newaygo County to 97.1% in Lake County*
- ✓*Area adults are less educated than adults across MI/US*
- ✓*Rates of child abuse/neglect are higher in all three counties vs. MI/US*
- ✓*Housing stress worse than peer counties*
- ✓*On time high school graduation worse than peer counties*

**Preventive Practices**

- ✓*Fewer adults get cholesterol checked vs. MI/US*
- ✓*Rates for cervical cancer screening and prostate cancer screening worse than MI*
- ✓*One in three have not visited dentist in past year for a cleaning, worse than MI/US*
- ✓*Proportion of adults 65+ vaccinated against pneumonia lower than MI/US*

**Risk Behavior Indicators**

- ✓*Almost nine in ten adults consume inadequate amounts of fruits and vegetables, worse than MI/US*
- ✓*More than four in ten adults physically inactive**
- ✓*One in four adults smoke cigarettes, worse than MI/US*
- ✓*Rate of heavy drinking higher than MI/US*
- ✓*More pregnant women smoke in all three counties vs. MI*
- ✓*More Lake County youth sexually active vs. MI/US*
- ✓*Higher proportion of teen births in all three counties compared to MI/US*
- ✓*Youth obesity rates higher than MI/US, especially Lake County*
- ✓*Lack of adequate fruits and vegetables in diets of both youth and adults, combined with a lack of affordable, healthy food*
- ✓*Smoking, alcohol abuse, illicit drug use, and licit substance abuse are viewed as highly prevalent but Key Informant dissatisfaction with community response to them also great*
- ✓*Lack of personal responsibility and motivation to engage in behavioral changes*

*Residents reported their level of activity during the 30 days prior to taking the survey, which was administered in the winter months (December-February), when fewer opportunities for outdoor activity are present.

# Key Findings

Health Care Access

+ Nine in ten adults in the SHGMH area have health insurance, and nearly nine in ten have a medical home. Health care coverage has expanded since 2011, largely due to the Affordable Care Act and the Healthy Michigan Plan.
- The SHGMH area suffers from a shortage of providers and services, and Key Stakeholders agree that existing programs and services are not adequately meeting the needs of community residents.
- The area has far fewer primary care physicians per capita than Michigan as a whole. Lake County faces a particularly stark shortage, with fewer than one-fourth the number of PCPs per capita compared to Michigan overall.
- In addition, the area lacks mental health and substance abuse services, as well as local access to medical specialists. In Lake County, dental care is also lacking.
- Further, even though more than one in five residents has Medicaid, provider options for this group are especially limited.
- Despite the increase in insured residents, several barriers prevent citizens from obtaining needed care, most notably cost barriers, which can include the high cost of co-pays and/or deductibles for insured residents. The cost barrier is particularly prominent among the underserved population.
- Transportation is another major barrier, particularly with Newaygo County having no public transportation system.

# Key Findings (Continued)

Health Care Access (Continued)

- In addition to barriers to medical care, more than one in ten face barriers to obtaining needed dental care, and these barriers are nearly always cost-related.
- Further barriers reported by Key Stakeholders/Key Informants are the absence of a "culture of health," personal irresponsibility, and lack of awareness of programs.
+ Key Informants find the SHGMH area strong in emergency care, prenatal care, orthopedics, OBGYN, ambulatory/emergency transport, in-home care, and oncology.
- Service gaps identified by health care workers as most critical include mental health treatment/services, programs targeting obesity reduction, dental care, programs that specifically serve the underserved population (uninsured, underinsured, low income), and prevention/wellness programs in general.
- Additionally, Key Informants see a need for more/better services in dermatology, non-emergency transport, oral surgery, and substance abuse treatment.
- While Key Stakeholders and Key Informants are cognizant of service gaps, they also stress that existing programs and services could be better utilized by: (1) increasing awareness of their existence, how they work, and who they serve; (2) making transportation available to all residents; (3) enhancing service hours to enable more residents to access services; and (4) increasing coordination among providers, agencies, and community programs that support health.

# Key Findings (Cont'd.)

Health Status

+ SHGMH area adults report higher levels of life satisfaction than those in Michigan overall and report strong social and emotional support networks.
- While fewer adults report poor mental health compared to Michigan overall, one in five report mild to severe psychological distress. In addition, youth mental health is a significant concern, with roughly one in three youths reporting depression.
- Life expectancy among area residents is lower than the national averages, and a higher proportion of adults report fair or poor overall health compared to the state and nation.
- Age adjusted mortality rates are also higher than the national rates.
- Three in ten adult residents are obese, and another third are overweight, putting healthy weight rates below the state and nation.
- Local adults are more likely to report activity limitation due to poor physical/mental health than adults statewide.
- Youth obesity rates are higher than state and national rates, especially in Lake County, where nearly one in four youth are obese.
- Health professionals are dissatisfied with the community response to anxiety, depression, and obesity.

# Key Findings (Cont'd.)

Chronic Disease

+ Area residents have lower prevalence of angina/CHD, heart attack, and skin cancer than those across the state and nation.
- However, rates of non-skin cancer, diabetes, and stroke are higher than Michigan and the U.S. Roughly one in eight area adults has diabetes.
- Further, deaths from cancer are more prevalent in Lake and Newaygo counties than in the state and nation, as are Lake County heart disease deaths.
- Nearly three in ten area adults have arthritis.

# Key Findings (Cont'd.)

Clinical Preventive Practices

+ More than eight in ten adults have visited a physician for a routine checkup within the past year, a far greater percentage than in the state or nation.
+ The majority of older adults recommended to receive cancer screening (breast, cervical, prostate, and colon) are doing so, and rates for appropriately timed mammograms and having a colon cancer screening in the past five years are better than the state and nation.
- However, fewer women are having appropriately timed (last three years) cervical cancer screening compared to the state as a whole.
+ Most adults age 65 or older have received a flu vaccine in the past year and the rates are higher than MI or the U.S. In addition, most have received a pneumonia vaccine at some time, although the rate is lower than MI or the U.S.
- Dental care lags behind the state and nation, with more than one-third of area adults having had no dental cleaning within the past year.

# Key Findings (Cont'd.)

Lifestyle Choices/Behaviors

+ Most people know what they need to do to live a healthier lifestyle, such as exercising, eating healthier foods, and getting plenty of sleep.
- Thus, advocating for more education about healthy lifestyle choices is probably not the best way to utilize resources.
+ Residents recognize that what prevents them from making positive changes is cost, as well as lack of time, energy, and willpower.
+ Therefore, if policies are to focus on ways to encourage residents to make lifestyle changes, then the following four approaches are worth investigating: (1) find ways to incentivize people to make changes, (2) increase access to affordable and healthy foods, (3) educate people on quick, easy ways to prepare delicious healthy meals, and (4) increase access (affordable, convenient location, ease of use) to gyms, recreation areas, and community exercise programs and activities, especially in the winter months.
+ Education delivered in person at easily-accessible community sites is likely to be more successful with underserved residents than education delivered online.

# Key Findings (Cont'd.)

Risk Behaviors

+ Fewer adults have high cholesterol compared to the state and nation.
- On the other hand, more area adults have high blood pressure compared to Michigan and the nation overall.
+ Area youth are more active that those across the state and nation.
- However, area adults are far less active compared to those statewide or nationwide.*
- One in four area adults are smokers, considerably higher than statewide and nationwide rates. Further, smoking during pregnancy is more prevalent in all three SHGMH area counties compared to Michigan in general.
+ Incidence of adult binge drinking is lower than in Michigan or the U.S.
+ Area youth exhibit fewer risk behaviors such as cigarette smoking and binge drinking compared to state and national peers, and youth in Newaygo and Oceana counties have less marijuana use than state and national youth.
- Nearly nine in ten area adults and more than two-thirds of area youth consume inadequate amounts of fruits and vegetables daily.

*Residents reported their level of activity during the 30 days prior to taking the survey, which was administered in the winter months (December-February), when fewer opportunities for outdoor activity are present.

# Key Findings (Cont'd.)

Disparities in Health

- There continue to be disparities in health, particularly with respect to education and income. There is a direct relationship between health outcomes and either education or income on a number of key measures. For example, those with lower incomes or levels of education are less likely to:
  - Report good/very good/excellent general health
  - Report good physical and mental health
  - Be free of psychological distress
  - Be satisfied with life
  - Receive adequate social and emotional support
  - Be at a healthy weight
  - Have health coverage and a personal health care provider
  - Avoid visiting the ER/ED
  - Exercise
  - Refrain from smoking cigarettes
  - Consume adequate amounts of fruits and vegetables
  - Be screened at appropriate intervals for breast, cervical, and colon cancer
  - Visit a dentist and have their teeth cleaned
  - Avoid chronic health conditions such as diabetes and cardiovascular disease
  - Avoid high cholesterol
- The link between both education and income and health outcomes goes beyond the direct relationship. Those in the very bottom groups, for example, having no high school education and/or earning less than $20K in household income, are most likely to experience the worst health outcomes.

# Summary Tables – **A Comparison of Newaygo County to Peer Counties**

**MORTALITY**

| Better (Most Favorable Quartile) | Moderate (Middle Two Quartiles) | Worse (Least Favorable Quartile) |
|---|---|---|
| Chronic kidney disease | Cancer deaths | Alzheimer's disease deaths |
| Stroke deaths | Coronary heart disease deaths | Chronic lower respiratory disease (CLRD) deaths |
| | Diabetes deaths | |
| | Female life expectancy | |
| | Male life expectancy | |
| | Motor vehicle deaths | |
| | Unintentional injury (including motor vehicle) | |

**MORBIDITY**

| Better (Most Favorable Quartile) | Moderate (Middle Two Quartiles) | Worse (Least Favorable Quartile) |
|---|---|---|
| Gonorrhea | Adult overall health status | Adult diabetes |
| HIV | Alzheimer's disease/dementia | Adult obesity |
| Older adult asthma | Cancer | |
| Preterm births | Older adult depression | |
| Syphilis | | |

The above Summary Comparison Report provides an "at a glance" summary of how Newaygo County compares with **peer counties** on the full set of **primary indicators**. Peer county values for each indicator were ranked and then divided into quartiles.

Source: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, Community Health Profile, Newaygo County.

# Summary Tables – **A Comparison of Newaygo County to Peer Counties (Cont'd.)**

**ACCESS**

| Better (Most Favorable Quartile) | Moderate (Middle Two Quartiles) | Worse (Least Favorable Quartile) |
|---|---|---|
| Older adult preventable hospitalizations | Cost barrier to care | |
| | Primary care provider access | |
| | Uninsured | |

**HEALTH BEHAVIORS**

| Better (Most Favorable Quartile) | Moderate (Middle Two Quartiles) | Worse (Least Favorable Quartile) |
|---|---|---|
| | Adult binge drinking | |
| | Adult female routine pap tests | |
| | Adult physical inactivity | |
| | Adult smoking | |
| | Teen births | |

Source: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, Community Health Profile, Newaygo County.

# Summary Tables – **A Comparison of Newaygo County to Peer Counties (Cont'd.)**

**SOCIAL FACTORS**

| Better (Most Favorable Quartile) | Moderate (Middle Two Quartiles) | Worse (Least Favorable Quartile) |
|---|---|---|
| Children in single parent households | High housing costs | Inadequate social support |
| | Violent crime | On time high school graduation |
| | | Poverty |
| | | Unemployment |
| | | |

**ENVIRONMENT**

| Better (Most Favorable Quartile) | Moderate (Middle Two Quartiles) | Worse (Least Favorable Quartile) |
|---|---|---|
| Drinking water violations | Access to parks | Housing stress |
| Limited access to healthy food | Annual average PM2.5 concentration | |
| Living near highways | | |
| | | |
| | | |

Source: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, Community Health Profile, Newaygo County.

# *DETAILED FINDINGS*

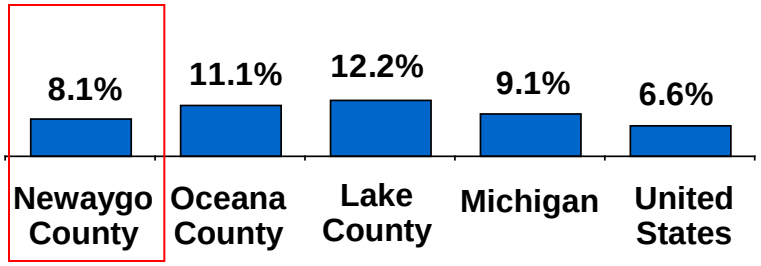
# *Secondary Data Sources*

# *Social Indicators*

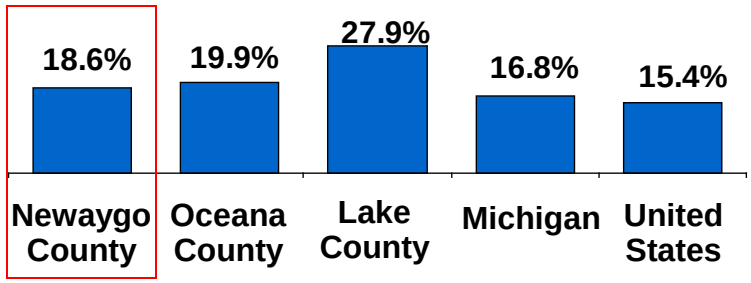
While the unemployment rate in Newaygo County is lower than MI, the rate is much higher in both Oceana and Lake counties compared to Michigan or the U.S. Moreover, one in four Lake County and one in five Oceana County residents live poverty. All three counties have poverty rates higher than the state or the nation.

## Unemployment and Poverty Rates

### Population Age 16+ Unemployed and Looking for Work




### Percentage of People in Poverty

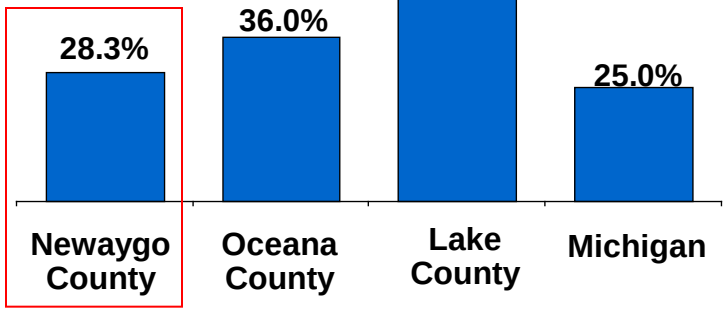



Source: Bureau of Labor Statistics, Local Area Unemployment Statistics, County Health Rankings. 2009-2013 American Community Survey 5-Year Estimates. Counties and MI and US 2014. Data compiled from various sources and dates.

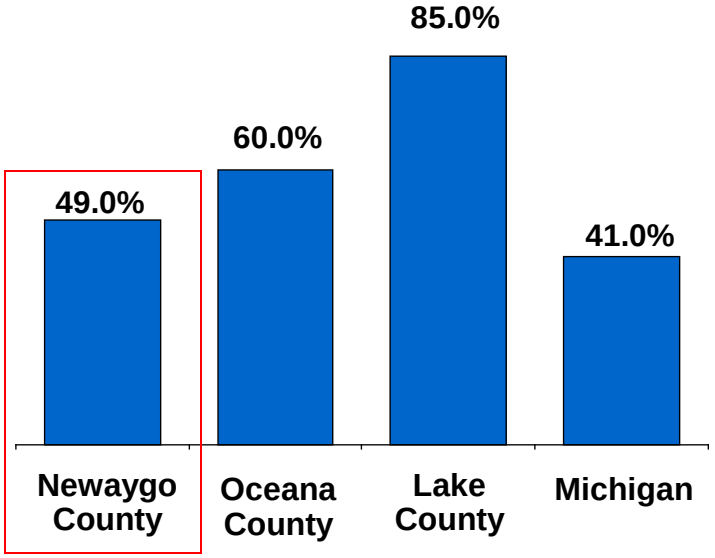
Compared to MI, the proportion of children living in poverty is greater in Oceana and Newaygo counties, and twice as high in Lake County. Similarly, the proportion of students eligible for free or reduced price school lunches is higher in Newaygo and Oceana counties compared to the state, while it is more than double in Lake County.

## Children Living in Poverty

### Percentage of Children (< Age 18) in Poverty




### Percentage of Students Eligible for Free/Reduced Price School Lunches

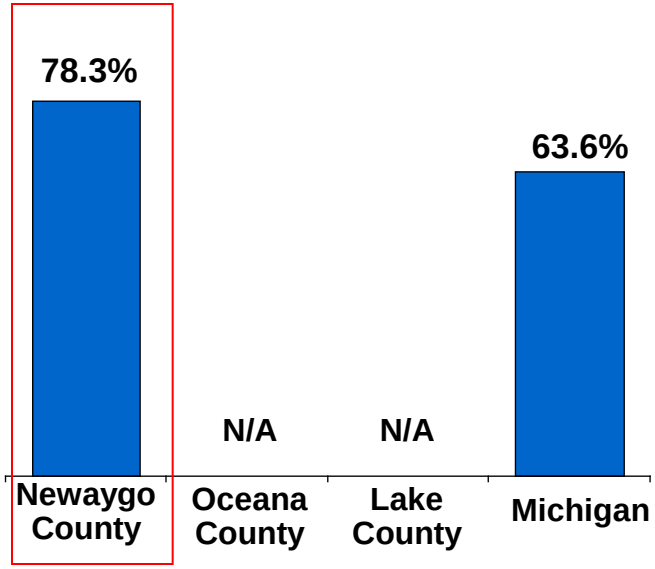



Source: 2014 County Health Rankings

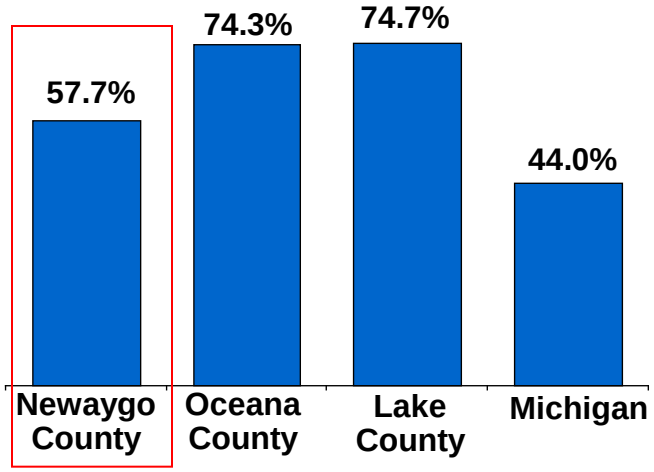
The proportion of children aged 1-4 receiving WIC is slightly higher in Newaygo County than throughout Michigan. The proportions of Medicaid paid births is also higher in Newaygo, Oceana, and Lake counties compared to Michigan.

## Children Born Into Poverty

### Children Ages 1-4 Receiving WIC (2013)




### Medicaid Paid Births (2012)

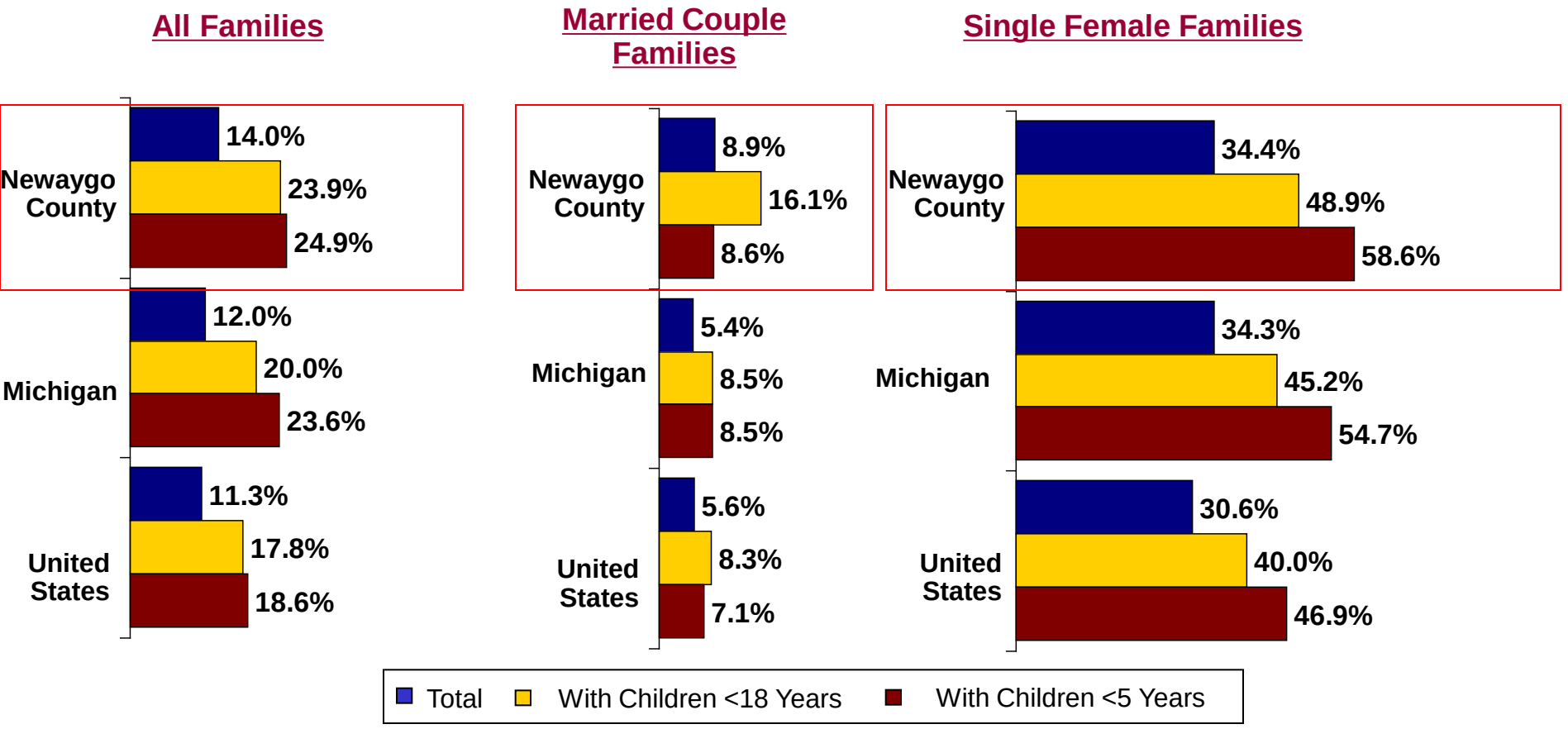



Source: Kids Count Data Book. Counties and MI 2013.

Note: The WIC percent is based on the population ages 1-4. Data for 2006-09 reflect the county of service, but subsequent data are based on the county of residence. Because of these changes, accurate data for some counties, including Oceana and Lake, are not available.

In general, more families with children under age eighteen live below the poverty line in Newaygo County compared to the state or nation. Further, poverty rates for single female families with children are higher in Newaygo County than MI or the U.S. For example, just under half (48.9%) of single female families with children under 18 live in poverty vs. 45.2% for MI and 40.0% for the U.S. Almost three in five single female families with children under age five in Newaygo County live in poverty.

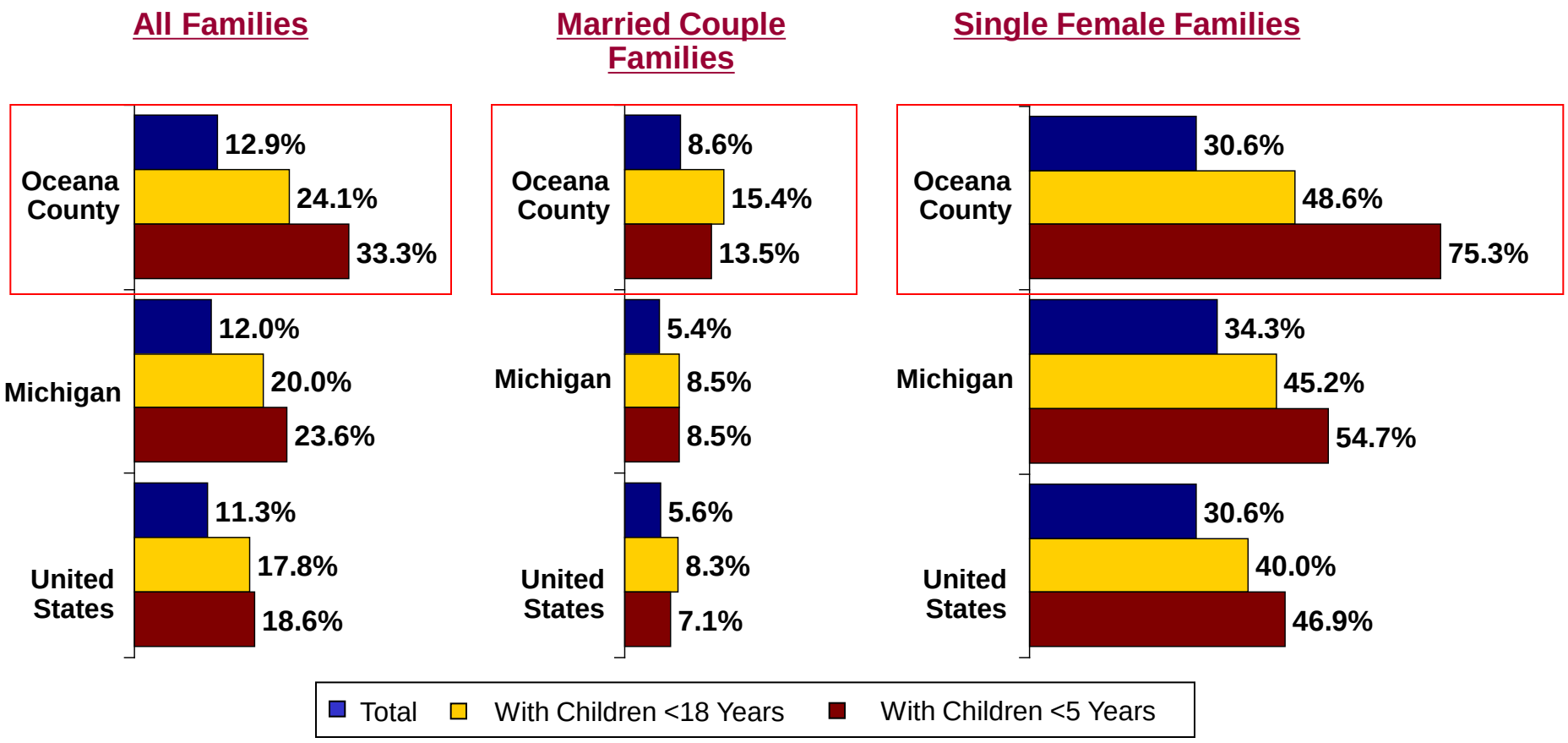
## Poverty Status of Families by Family Type in Newaygo County (% Below Poverty)




Source: US Census, 2009-2013 American Community Survey 5-Year Estimates, Data Profiles, Selected Economic Characteristics

The proportion of all families living in poverty in Oceana County is higher than in Michigan and the U.S. Poverty rates for Oceana County married couples, with or without children, are higher than in the state or nation. Rates for single female households in Oceana County are comparable to MI and the U.S. except for those with children. **Three-fourths (75.3%) of single-female families with children under age five live in poverty**.

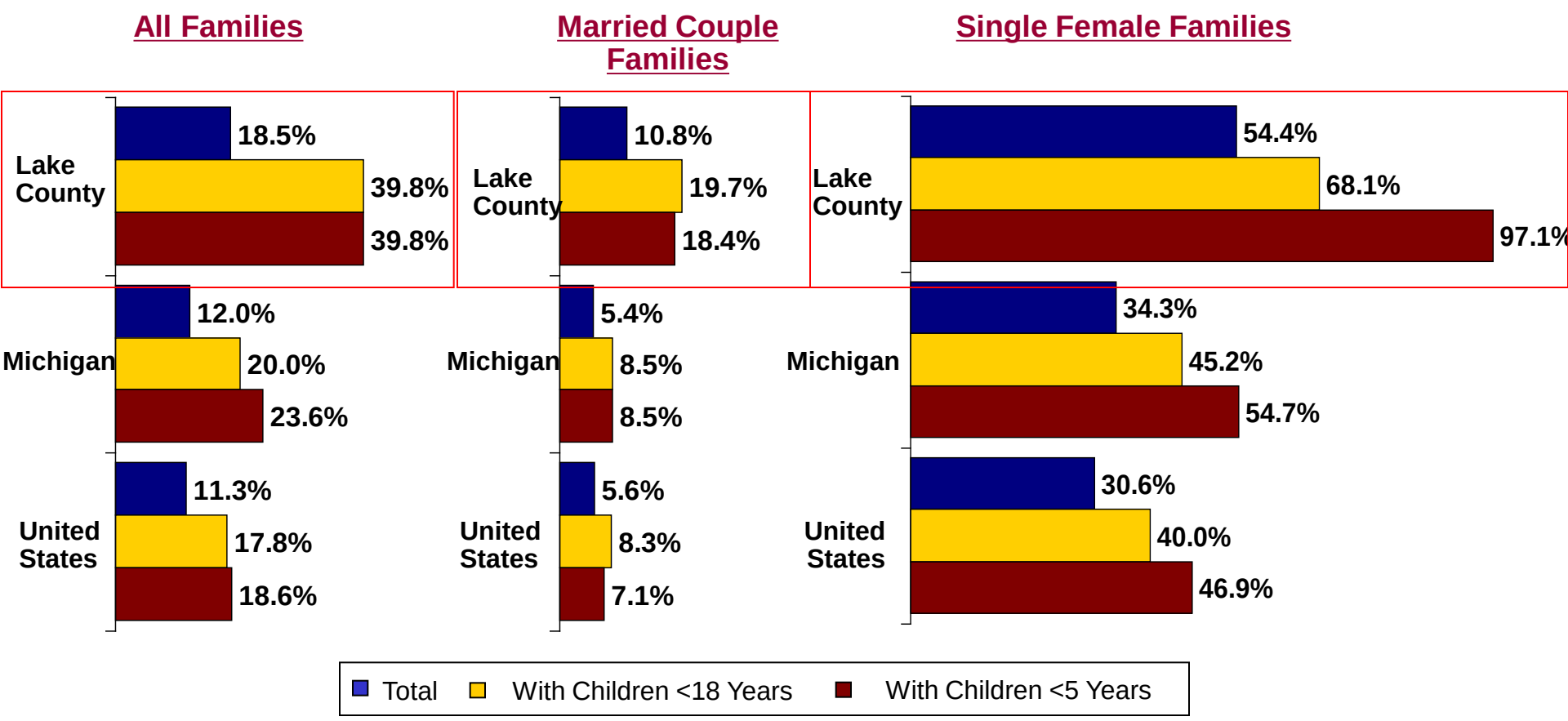
## Poverty Status of Families by Family Type in Oceana County (% Below Poverty)




Source: US Census, 2009-2013 American Community Survey 5-Year Estimates, Data Profiles, Selected Economic Characteristics

The proportion of families living in poverty in Lake County is higher than in Michigan and the U.S., especially for those with children. **Four in ten Lake County families with children lives in poverty**. The county exceeds both the state and nation in families living in poverty with children under eighteen years of age. In fact, what is extremely concerning is that **almost all (97.1%) single female families with children under five in Lake County live in poverty**.

## Poverty Status of Families by Family Type in Lake County (% Below Poverty)




Source: US Census, 2010 American Community Survey, Data Profiles, Selected Economic Characteristics

Greater proportions of men and women in the three county area have not graduated from high school in comparison to Michigan or the U.S. All three counties have lower proportions of residents with Bachelor's and higher degrees than the state or nation. The greatest disparity in Bachelor degrees is seen between Lake County residents and their state and national peers.

## Educational Level Age 25+

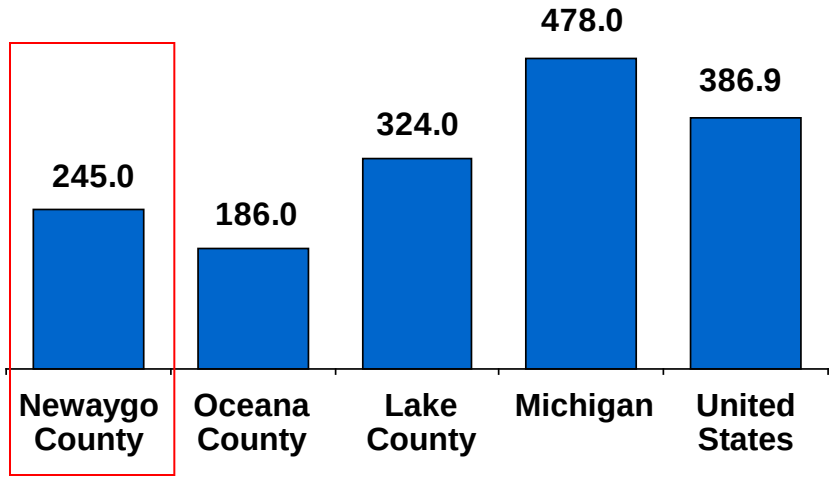
| | Men | | | | | Women | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Newaygo | Oceana | Lake | MI | U.S. | Newaygo | Oceana | Lake | MI | U.S. |
| No Schooling Completed | 1.4% | 1.6% | 1.2% | 3.6% | 1.4% | 0.9% | 1.5% | 1.3% | 1.0% | 1.4% |
| Did Not Graduate High School | 14.8% | 15.0% | 20.6% | 8.4% | 12.6% | 11.1% | 13.7% | 16.0% | 7.3% | 11.4% |
| High School Graduate, GED, or Alternative | 41.9% | 37.7% | 40.7% | 30.9% | 28.4% | 40.5% | 34.6% | 41.5% | 30.6% | 27.2% |
| Some College, No Degree | 22.6% | 23.5% | 24.3% | 23.8% | 20.8% | 24.9% | 22.7% | 25.5% | 24.2% | 21.4% |
| Associate's Degree | 6.4% | 7.6% | 4.6% | 7.2% | 7.2% | 9.7% | 12.1% | 7.4% | 9.5% | 8.9% |
| Bachelor's Degree | 8.5% | 8.3% | 5.6% | 15.8% | 18.3% | 8.3% | 10.0% | 4.7% | 15.7% | 18.6% |
| Master's Degree | 3.4% | 4.2% | 2.6% | 6.9% | 7.3% | 3.9% | 4.6% | 3.2% | 7.8% | 8.5% |
| Professional School Degree | 0.5% | 1.2% | 0.3% | 2.1% | 2.3% | 0.5% | 0.6% | 0.1% | 1.2% | 1.6% |
| Doctorate Degree | 0.5% | 0.9% | 0.0% | 1.4% | 1.7% | 0.1% | 0.3% | 0.1% | 0.7% | 1.0% |

Source: U.S. Census Bureau, American Community Survey, 2013 American Community Survey 1-Year Estimates

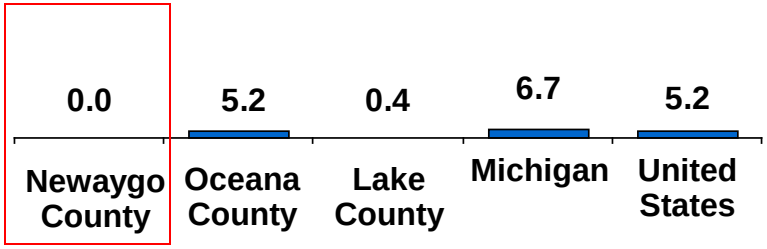
According to violent crime rates, the three counties are safer than MI or the U.S. Homicide rates are practically non-existent in Lake and Newaygo counties, however, the rate in Oceana is on par with the U.S.  Conversely, child abuse/neglect rates in Newaygo and Oceana counties are higher than the state and national averages, while the rate in Lake County is distressingly high.

## Crime Rates

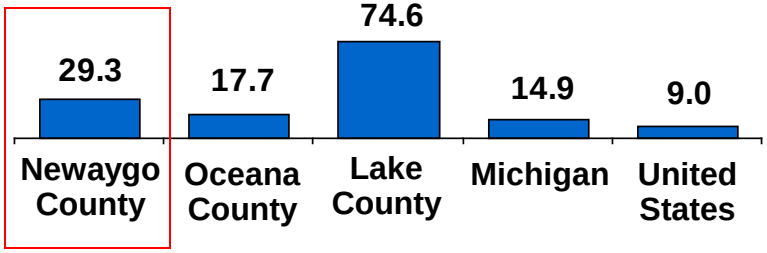
### Violent Crime Rate Per 100,000 Population




### Homicide Rate Per 100,000 Population




### Confirmed Victims of Child Abuse/Neglect Rate Per 1,000 Children <18

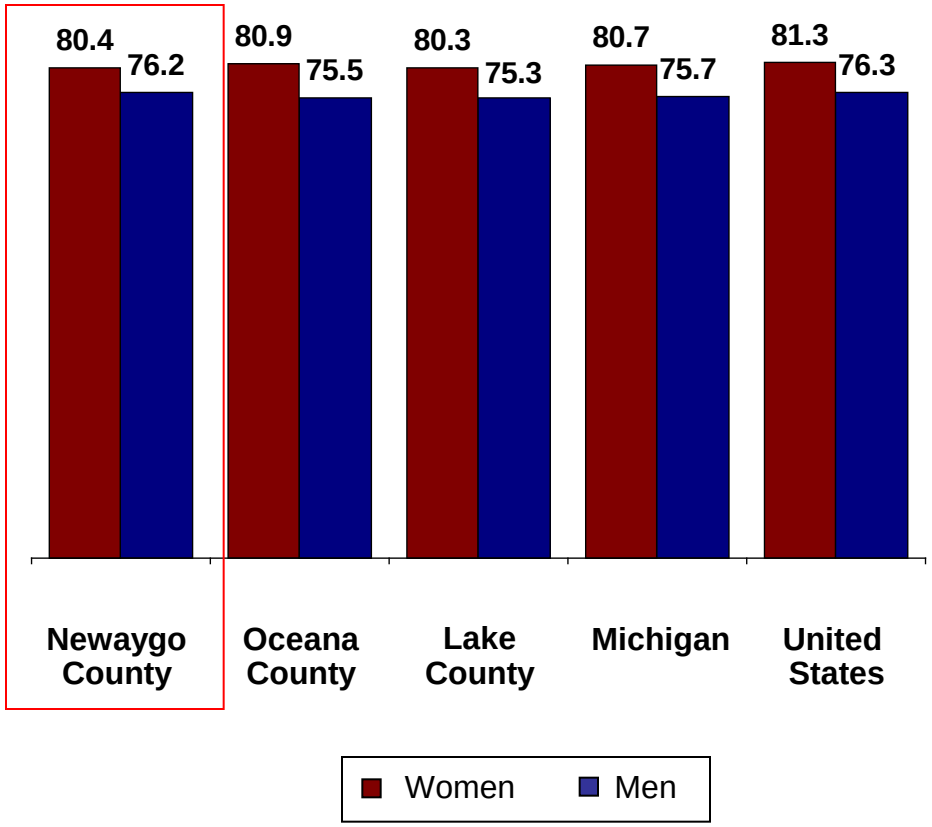



Source: County Health Rankings. Counties and MI 2013, US FBI Website 2012; MDCH, Division of Vital Records, Counties and MI 2012, United States Census Bureau 2012; Kids Count Data Book. 2012, 2013. Note: Data compiled from various sources and dates

# *Health Indicators*

The average life expectancy for both men and women in Newaygo, Oceana and Lake counties is on par with Michigan and slightly lower than the U.S.

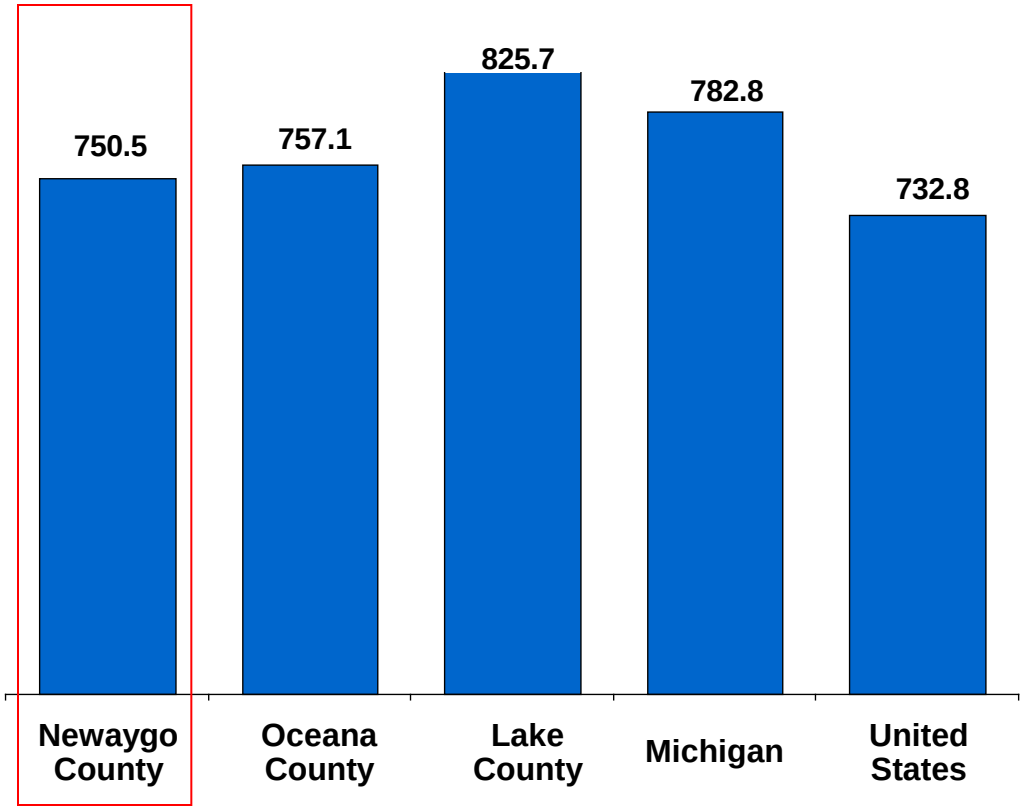
**Life Expectancy (Average Age)**




Source: Institute for Health Metrics and Evaluation at the University of Washington. Uses 2010 mortality data for counties, 2010 MI, 2010 US

Newaygo and Oceana counties have lower age adjusted mortality rates than the state but higher rates compared to the U.S.  Lake County has higher mortality rates than both the state and the nation.

## Mortality Rates, Age Adjusted Per 100,000 Population

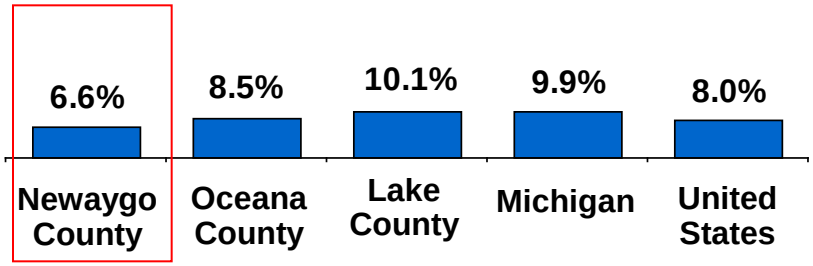



Source: Michigan Resident Death File, Vital Records & Health Statistics Section, Michigan Department of Community Health. Counties and MI 2013; US 2012;

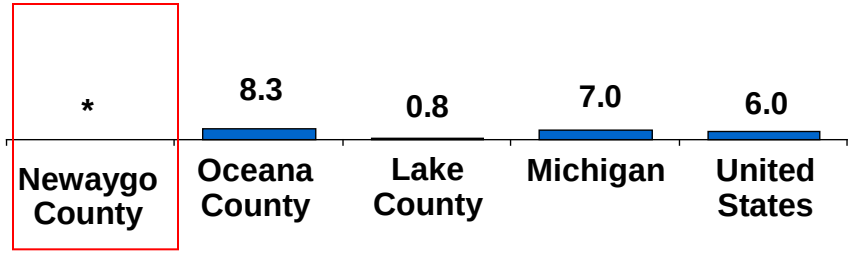
Newaygo County has fewer live births with low birth weight than Lake County, Oceana County, the state and nation, while Lake County has the most. Lake county's infant mortality rate is significantly lower than that of MI or U.S., while Oceana County's infant mortality rate is slightly higher than both MI and U.S.

## Low Birth Rates and Infant Mortality Rates

### Proportion of Live Births with Low Birth Weight




### Infant Mortality Rate Per 1,000 Live Births




Source: Kids Count Data Book/MDCH Vital Records Division, Resident Birth Files. Counties and MI 2013, and US 2012.

*A rate is not calculated where there are fewer than 6 events, because the width of the confidence interval would negate any usefulness for comparative purposes.

The top two leading causes of death – cancer and heart disease – are the same for all three counties, Michigan, and the U.S. However, the rate of death from cancer is highest in Lake County, followed by Newaygo County. The death rate from heart disease in Lake County is higher than MI/US. The rates of death from stroke, CLRD, and unintentional injuries are higher in Newaygo County compared to MI or the U.S.

## Top 5 Leading Causes of Death

| | Newaygo County | | Michigan | | United States | |
|---|---|---|---|---|---|---|
| | RANK | Rate | RANK | Rate | RANK | Rate |
| Cancer | 1 | 204.3 | 2 | 174.9 | 2 | 168.6 |
| Heart Disease | 2 | 158.7 | 1 | 197.7 | 1 | 173.7 |
| Stroke | 3 | 54.0 | 4 | 45.2 | 5 | 37.9 |
| Chronic Lower Respiratory Diseases | 4 | 50.3 | 3 | 37.2 | 3 | 42.7 |
| Unintentional Injuries | 5 | 48.1 | 5 | 36.6 | 4 | 38.0 |

| | Oceana County | | Michigan | | United States | |
|---|---|---|---|---|---|---|
| Heart Disease | 1 | 170.1 | 1 | 197.9 | 1 | 173.7 |
| Cancer | 2 | 135.3 | 2 | 174.9 | 2 | 168.6 |
| Unintentional Injuries | 3 | * | 5 | 36.6 | 4 | 38.0 |
| Chronic Lower Respiratory Diseases | 4 | * | 3 | 45.2 | 3 | 42.7 |
| Kidney Disease | 5 | * | 8 | 13.5 | 9 | 13.4 |

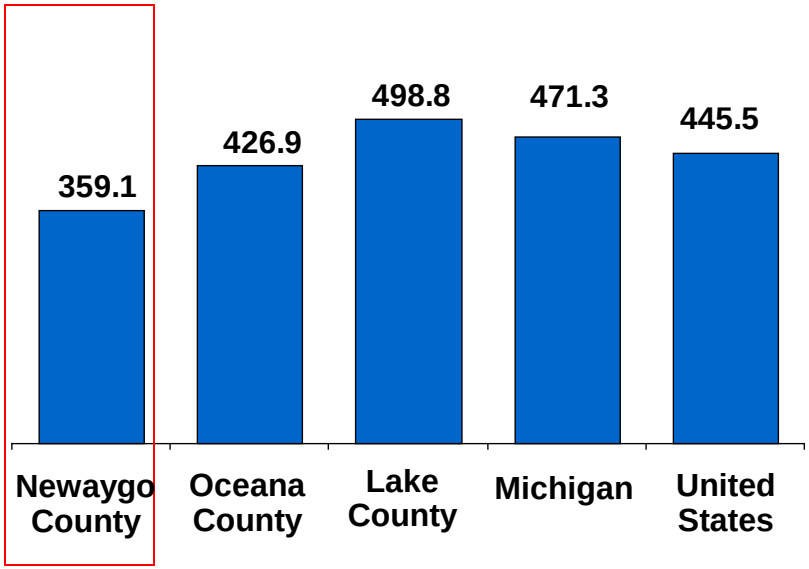
| | Lake County | | Michigan | | United States | |
|---|---|---|---|---|---|---|
| Cancer | 1 | 215.9 | 2 | 174.9 | 2 | 168.6 |
| Heart Disease | 2 | 198.1 | 1 | 197.9 | 1 | 173.7 |
| Stroke | 3 | * | 4 | 37.2 | 5 | 37.9 |
| Chronic Lower Respiratory Diseases | 4 | * | 3 | 345.2 | 3 | 42.7 |
| Unintentional Injuries | 5 | * | 5 | 36.6 | 4 | 38.0 |

Source: Michigan Department of Community Health, Counties and MI 2012; United States CDC, National Vital Statistics Report, 2012.

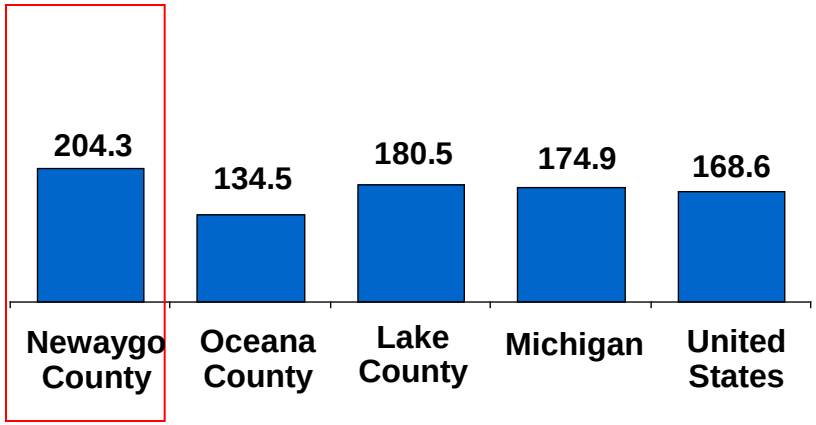
Compared to MI or the U.S., cancer diagnosis rates are lower in Newaygo and Oceana counties, while the rate is highest in Lake County. The cancer death rate is highest in Newaygo County, followed by Lake County. Since the cancer diagnosis rate is lowest in Newaygo County, but the cancer death rate is highest, these figures are key since it may be an indication that local residents are not diagnosed early enough to prevent a terminal outcome.

## Cancer Rates

### Cancer Diagnosis Rate (Age Adjusted) Per 100,000 Population




### Overall Cancer Death Rate Per 100,000 Population




Source: MDCH Cancer Incidence Files, Cases Diagnosed- Counties , MI, 2011. Death rates- Counties, MI 2012. US CDC Cancer Registry, 2010.

The top five leading causes for preventable hospitalizations are the same for Lake, Newaygo and Oceana counties, in slightly different order. **Bacterial pneumonia** is the leading cause of preventable hospitalization in Newaygo and Lake counties, whereas **congestive heart failure** is the number one cause in Oceana County and throughout MI. Rounding out the top five leading causes pf preventable hospitalizations are **COPD**, **cellulitis**, and **kidney/urinary infections**.

## Top 10 Leading Causes of Preventable Hospitalizations

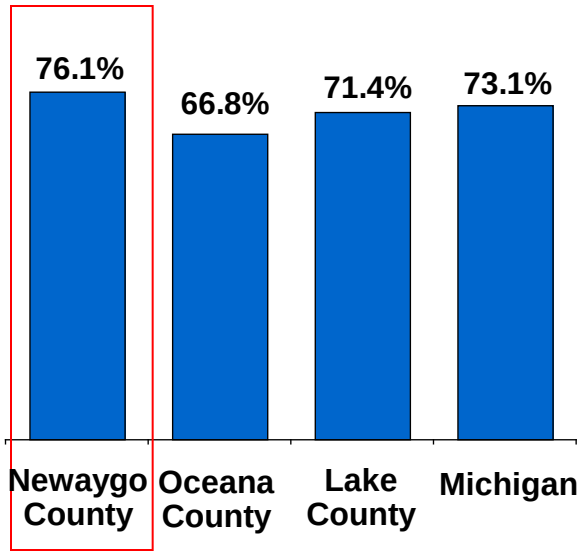
| | Newaygo County | | Oceana County | | Lake County | | Michigan | |
|---|---|---|---|---|---|---|---|---|
| | RANK | % of All Preventable Hospitalizations | RANK | % of All Preventable Hospitalizations | RANK | % of All Preventable Hospitalizations | RANK | % of All Preventable Hospitalizations |
| Bacterial Pneumonia | 1 | 15.9% | 2 | 10.7% | 1 | 15.6% | 2 | 10.7% |
| Congestive Heart Failure | 2 | 15.0% | 1 | 12.8% | 2 | 15.3% | 1 | 12.8% |
| Chronic Obstructive Pulmonary Disease (COPD) | 3 | 12.1% | 3 | 9.8% | 3 | 11.2% | 3 | 9.8% |
| Cellulitis | 4 | 8.3% | 5 | 6.5% | 4 | 6.1% | 5 | 6.5% |
| Kidney/Urinary Infections | 5 | 5.8% | 4 | 7.1% | 5 | 4.8% | 4 | 7.1% |
| Grand Mal and Other Epileptic Conditions | 6 | 5.3% | 8 | 3.2% | 8 | 3.2% | 8 | 3.2% |
| Diabetes | 7 | 4.5% | 6 | 5.6% | 6 | 4.1% | 6 | 5.6% |
| Asthma | 8 | 2.5% | 7 | 5.3% | 7 | 3.8% | 7 | 5.3% |
| Convulsions | 9 | 1.7% | 10 | 1.1% | 9 | 1.2% | -- | -- |
| Hypertensions | 10 | 1.4% | -- | -- | -- | -- | -- | -- |
| Dehydration | -- | -- | 9 | 2.2& | 10 | 1.6% | 9 | 2.2% |
| All Other Ambulatory Care Sensitive Conditions | | 27.6% | | 35.3% | | 31.5% | | 35.3% |
| Preventable Hospitalizations as a % of All Hospitalizations | | 20.2% | | 16.0% | | 20.9% | | 20.2% |

Source: MDCH Resident Inpatient Files, Division of Vital Records, Counties and MI 2012.

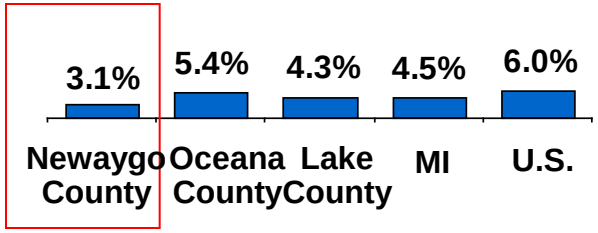
Newaygo County exceeds Michigan in the proportion of women receiving prenatal care in the first trimester, while Oceana and Lake counties lag slightly behind the state. More importantly, most women have timely prenatal care, and the proportion of women having late or no prenatal care in the three county area is better than the national average. Newaygo, Oceana and Lake counties fully immunize about the same proportion of children aged 19-35 months as the state and are slightly above the national average.

## Prenatal Care and Childhood Immunizations

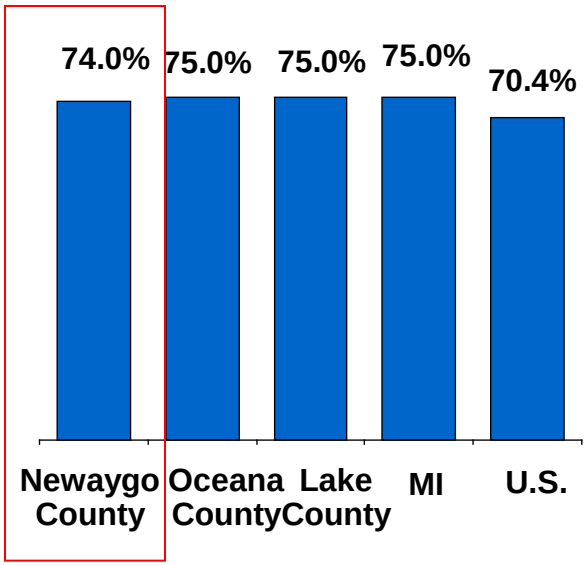
### Proportion of Women Who Begin Prenatal Care in First Trimester




### Proportion of Births to Women Who Receive Late or No Prenatal Care



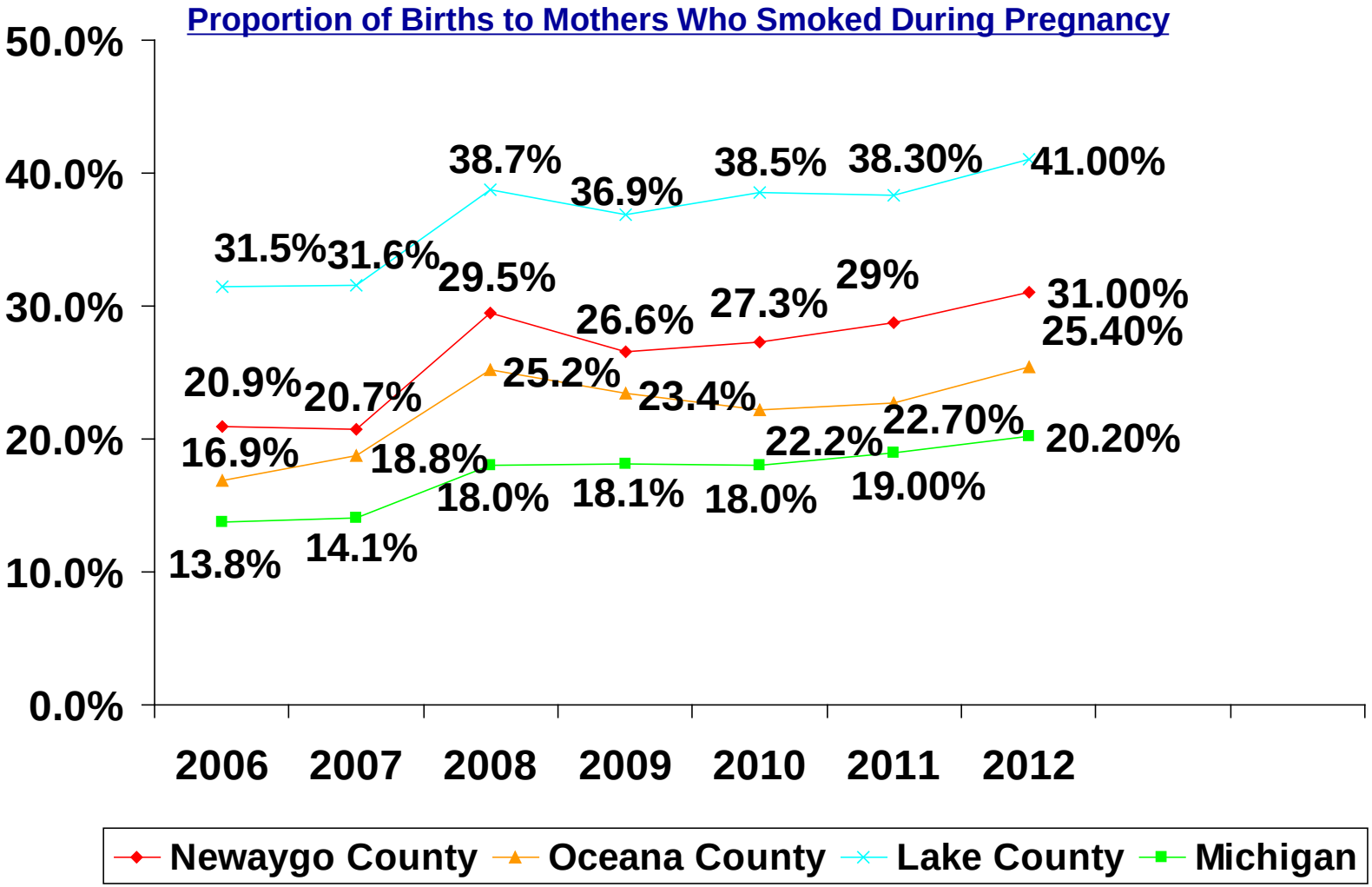

### Proportion of Children Aged 19-35 Months Fully Immunized




Source: MDCH Vital Records Counties and MI 2013; Kids Count Data Book/MDCH V. Immunization data: Counties and MI from MICR NOV 2014) National data: CDC National Immunization Survey- National, State, and Selected Local Area Vaccination Coverage Among Children Aged 19–35 Months —Counties and MI 2013 Published August 29, 2014

# *Adult Risk Behaviors*

The proportion of Lake County mothers who smoke during pregnancy is more than double the proportion across Michigan. The proportion of births in Newaygo and Oceana counties to mothers who smoke is also higher than for Michigan. The proportions of mothers smoking during pregnancy for all three counties and the state have been trending upward since 2011.



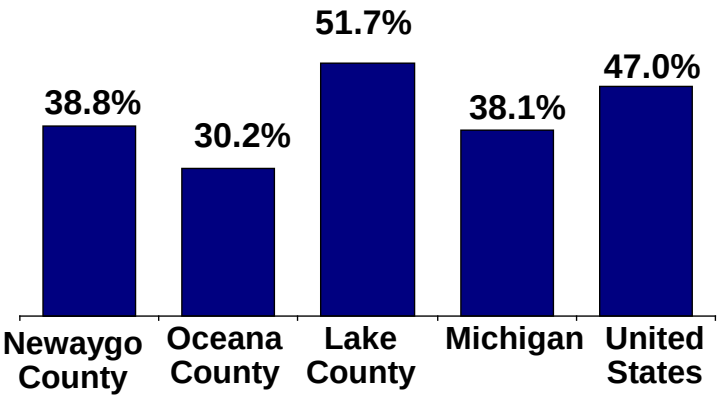

Source: Michigan League for Human Services; Oceana county Health Profile, District Health Department #10, 2011 (2005-2008). Kids Count Data, 2009-2012.

# *Youth Risk Behaviors*

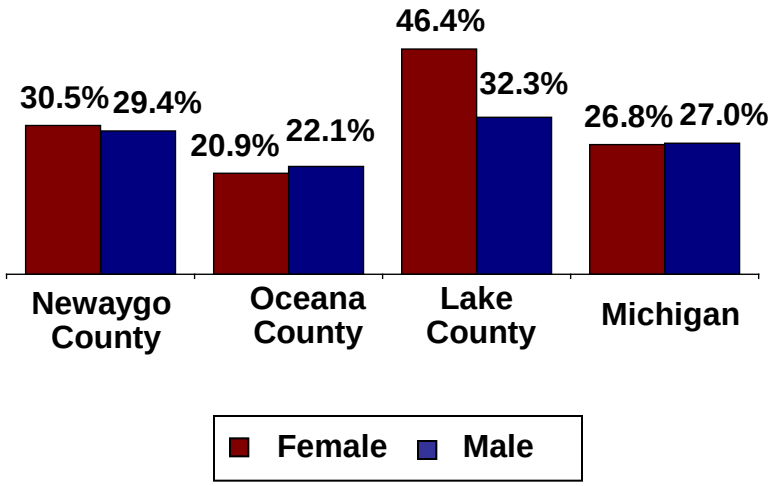
Newaygo County teens are less likely to engage in sexual intercourse than teens across the U.S. but equally likely as teens throughout Michigan, while teens in Lake County are most likely to be sexually active. Similarly, almost half of female, and one-third of male, youths in Lake County have had sexual intercourse in the past three months, compared to just over a quarter for both female and males across Michigan.

## Teenage Sexual Activity

### Youth Who Have Ever Had Sexual Intercourse




### Youth Who Have Had Intercourse in Past 3 Months

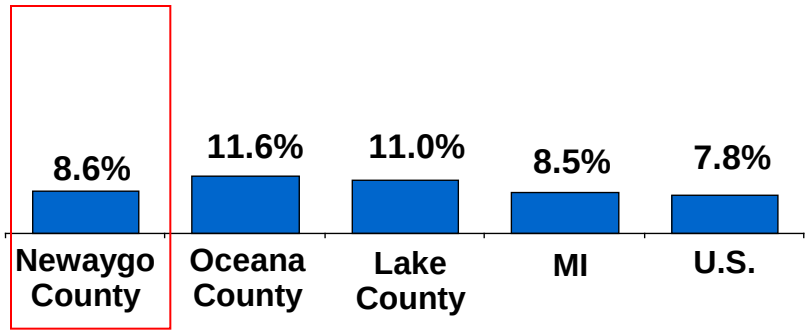



Source: Michigan YRBS; Newaygo, Oceana, and Lake: MiPhy 2013-2014- Sexual Behavior Note: Data groups Lake and Newaygo Co. information together. MiPhy; MI & US Data: YRBS 2013

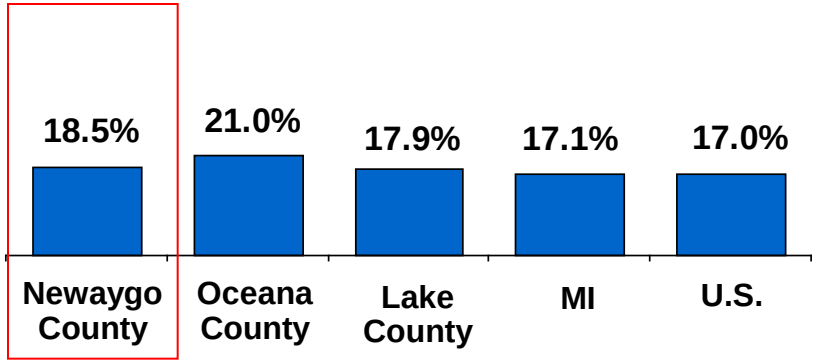
Teen births are slightly higher in Lake and Oceana counties compared to Michigan or the U.S., while the rate of teen births in Newaygo County is on par with the state. Repeat teen births in Lake, Newaygo, and Oceana counties are also slightly higher than both the state and national figures.

## Teenage Pregnancy

### Teen Births, Ages 15-19 (% Of All Births)




### Repeat Teen Births (% Of All Births to Mothers Aged 15-19)

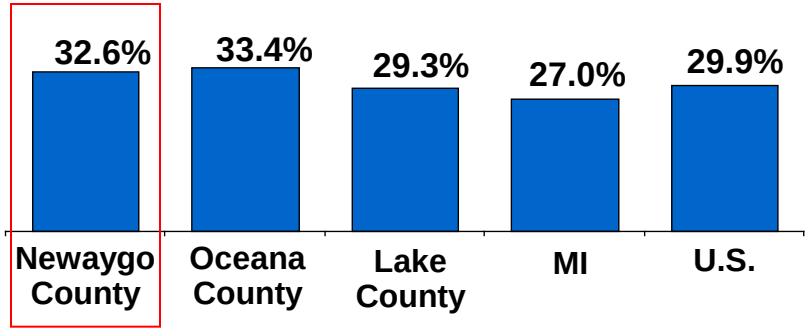



Source: MDCH Vital Records. Newaygo Co. and MI 2013. Kids Count Data Book. Counties, MI, and US 2012.

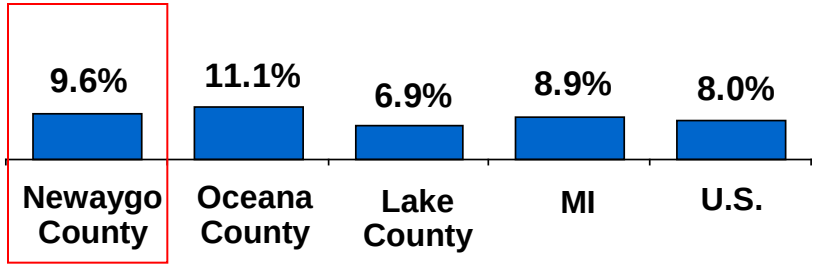
The prevalence of **depression among youth is higher in all three counties than in Michigan**, with approximately three in ten reporting depression. Youth suicide attempts are also more prevalent in Newaygo and Oceana counties vs. the state or nation. Suicide attempts in both these counties are distressingly high, with one in ten youths reporting an attempt in the past year.

## Mental Health Indicators Among Youth

### Proportion of Youth Reporting Depression in Past Year




### Proportion of Youth Reporting Suicide Attempt in Past Year

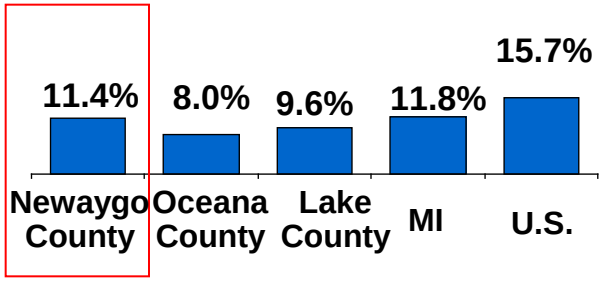



Source: MiPHY, 2013-2014, Lake Co. data figures includes data for Newaygo Co. National YRBS, 2013.

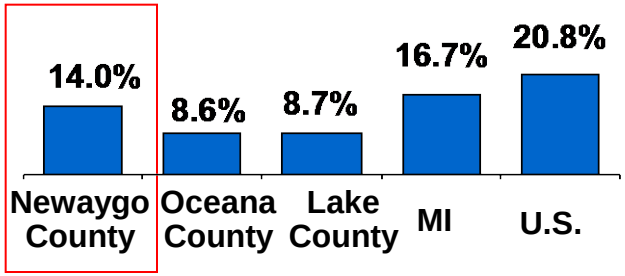
Fewer Newaygo, Oceana, and Lake County youth smoke cigarettes compared to youth across the state or the nation. Fewer youths in the three counties binge drink compared to MI or U.S. More youths from Lake County use marijuana than youths in Newaygo County, Oceana County, or across the state of Michigan. Newaygo County youths are more likely to smoke and binge drink compared to youths from Lake or Oceana counties.

## Tobacco, Alcohol and Marijuana Use Among Youth

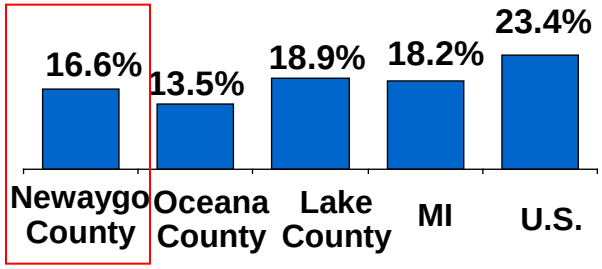
### Proportion of Youth Who Report Current Smoking (Past 30 Days)




### Proportion of Youth Reporting Binge Drinking (5+ Drinks, Past 30 Days)




### Proportion of Youth Reporting Current Marijuana Use (Past 30 Days)

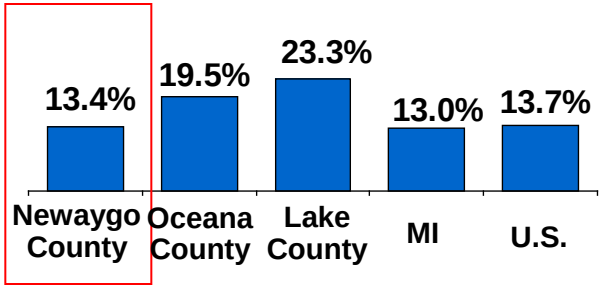



Source: MiPHY, Lake County data includes data for Newaygo Co. 2013-2014. Youth Risk Behavior Survey (YRBS), 2011.

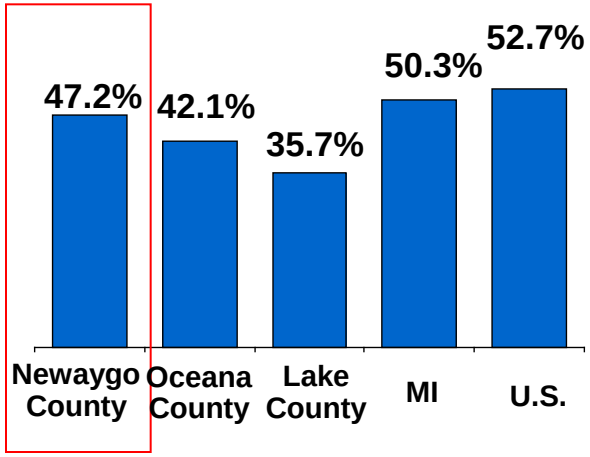
The proportion of obese youth in all three counties exceeds that of the state or the nation, particularly in Oceana and Lake counties. Fruit and vegetable consumption in all three counties is better than the state or nation, however, between two-thirds and three-fourths of area youth consume inadequate amounts of fruits and vegetables each day. On the positive side, youth in the three county region report lower levels of inactivity compared to MI or the U.S. peers.

## Obesity, Physical Activity and Diet Among 9th and 11th Grade Students

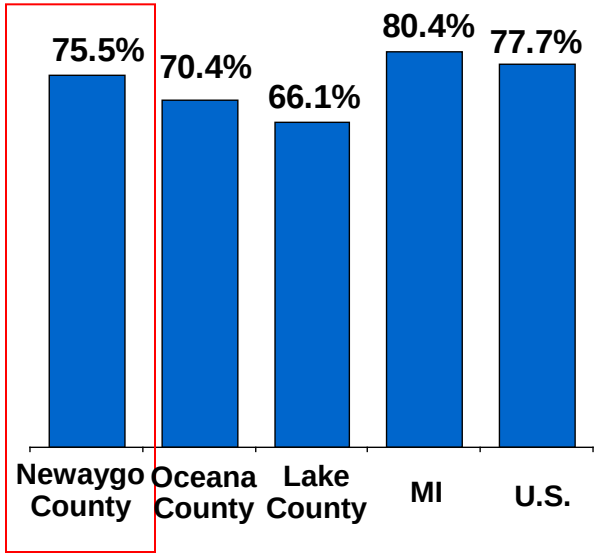
### Youth Who Are Obese (>95th Percentile BMI for Age and Sex)




### Youth Reporting Inadequate Physical Activity (<60+ Minutes, 5+ Days Per Week)




### Youth Reporting Less Than 5 Servings of Fruits/Vegetables Per Day (Past Week)



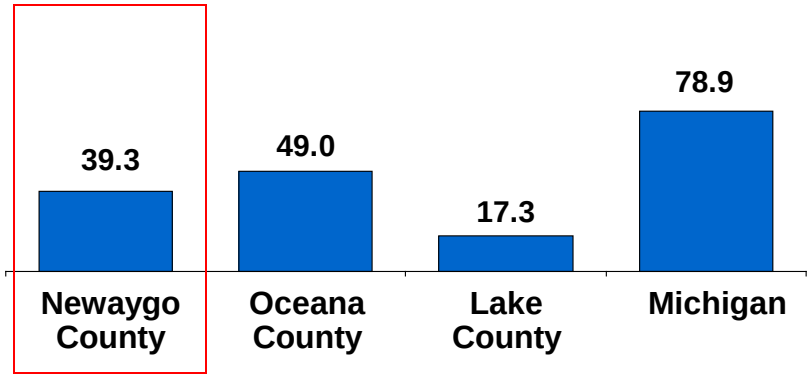

Source: Michigan Profile for Healthy Youth (MiPHY) 2013-2014 cycle. Lake county data grouped with that of Newaygo Co. MI and US from 2011 YBRS.

# *Health Care Access*

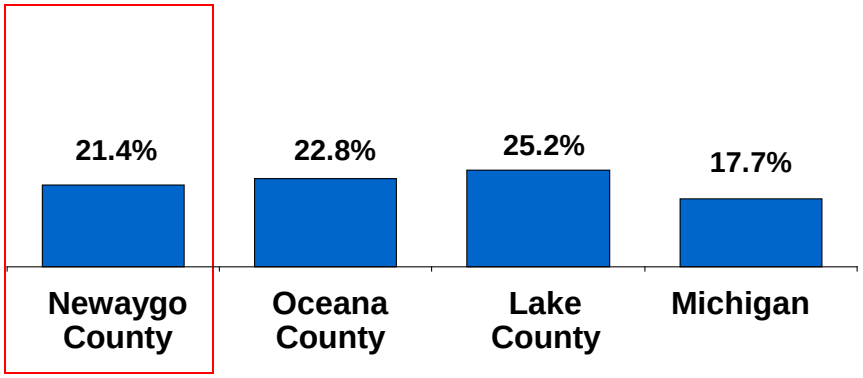
There are far more primary care physicians per capita throughout Michigan than in the three counties. The greatest discrepancy is between Lake County (17.3) compared to Michigan (78.9). All three counties have greater proportions of residents receiving Medicaid than across Michigan, where slightly more than one in five residents receives Medicaid in Newaygo and Oceana counties and one in four receives it in Lake County.

## Primary Care Physicians and Medicaid Patients

### Primary Care Physicians (MDs and DOs) Per 100,000 Population




### Proportion of Residents Receiving Medicaid



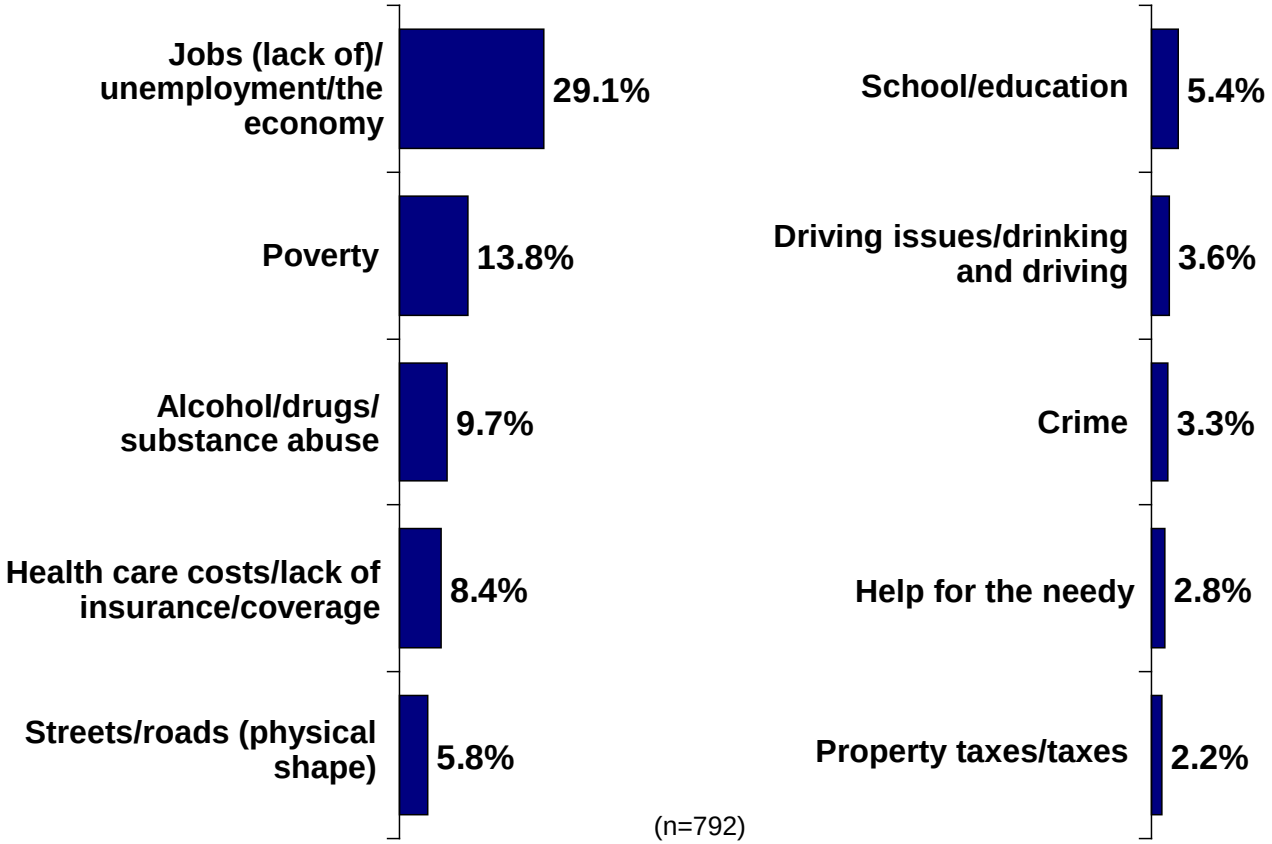

Source: PCP: County Health Rankings, 2013. Medicaid: US Census, Green Book (Dec 2014), 2014 estimate.

# *Behavioral Risk Factor Survey*

# *Perception of Community Problems*

When asked to give their top of mind response in addressing the community's most important problems, Spectrum Health Gerber Memorial Hospital (SHGMH) area adults report a wide range of issues, with **lack of jobs or the economy** leading the way. Other problems mentioned include **poverty**, **substance abuse**, **health care costs and lack of coverage**, and the **physical conditions of the roads/streets**.

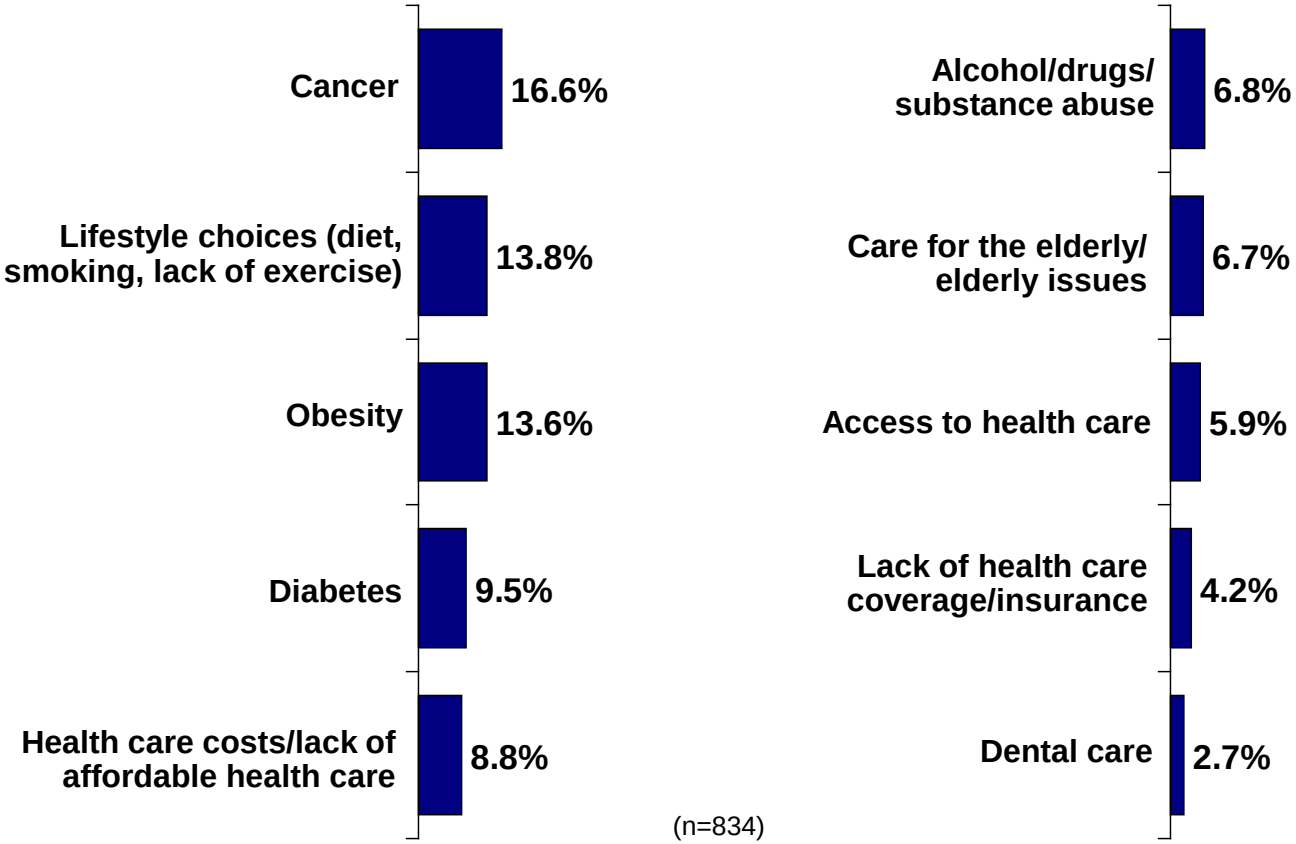
## Top 10 Most Important Problems in the Community Today




Q1.1: What do you feel is the most important problem in your community today?

Area adults perceive the top health problem to be **cancer**, followed by **lifestyle choices** that lead to health problems, **obesity**, and **diabetes**. **Health care access** is a pressing and prevalent problem, including the **cost** of care in general, as well as co-pays and deductibles, and the **lack of health care coverage/insurance**.

## Top 10 Most Important *Health* Problems in the Community Today



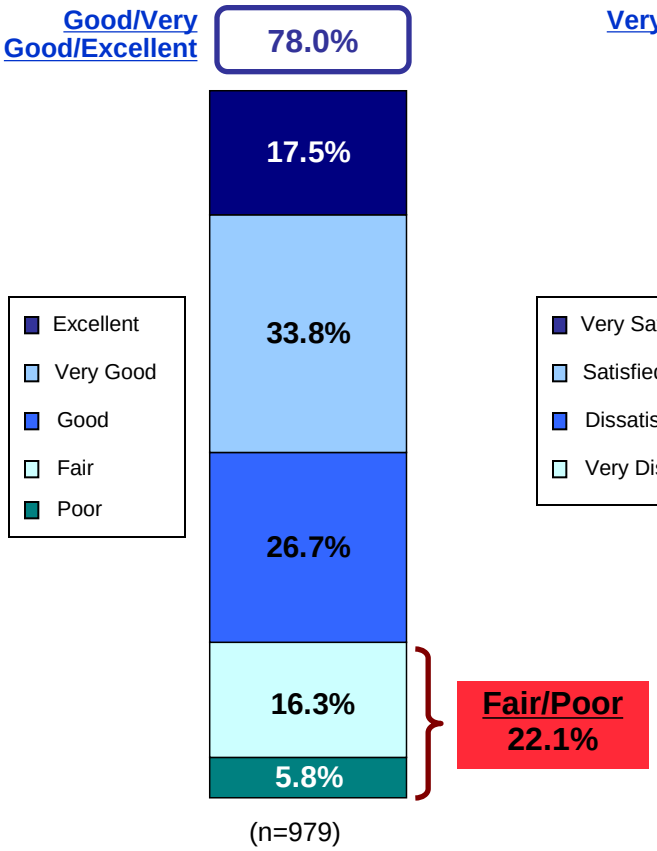

Q1.2: What do you feel is the most important health problem in your community today?

# *Health Status Indicators*

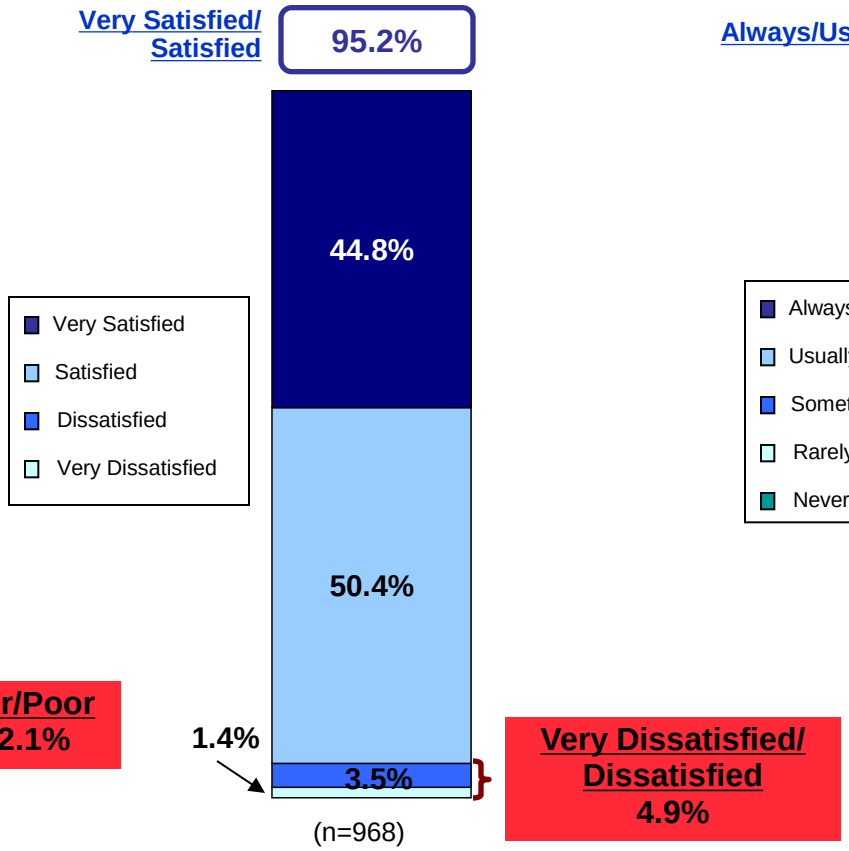
Almost eight in ten (78.0%) SHGMH area adults cite good or better general health and 95.2% say they are satisfied with their lives. Slightly more than eight in ten say they usually or always receive the emotional support they need. More than one in five report fair or poor health, 4.9% report dissatisfaction with life, and 7.0% rarely or never receive the emotional support they need.

## Perception of General Health, Life Satisfaction, and Social Support

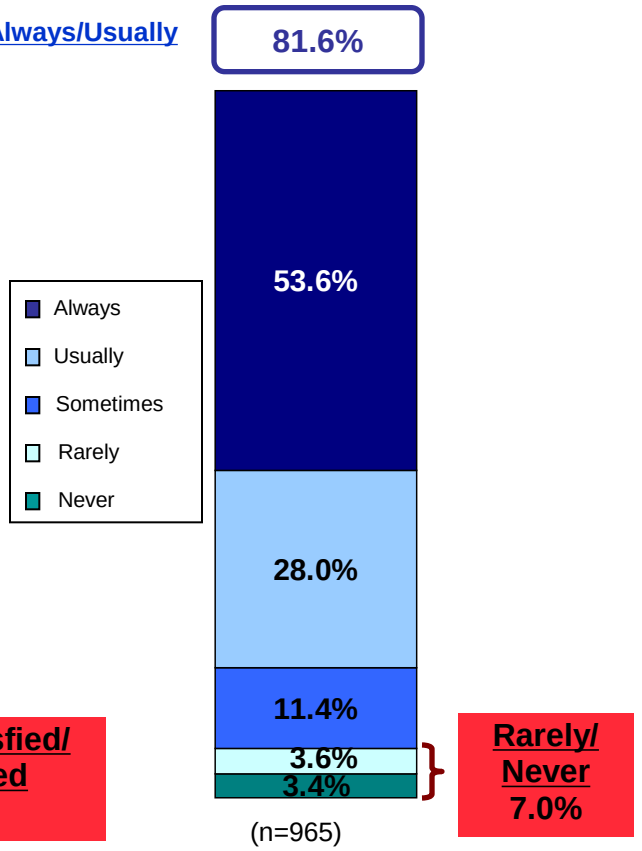
### Perception of General Health




### Overall Satisfaction with Life




### Frequency of Emotional Support

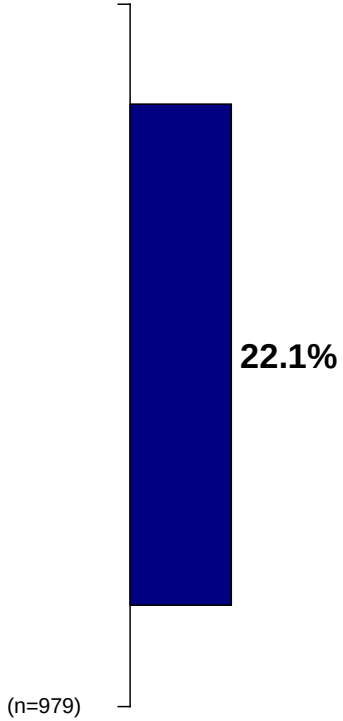



Q1.3: Would you say that in general your health is…
Q21.2: In general, how satisfied are you with your life?
Q21.1: How often do you get the social and emotional support you need?

The proportion of adults who perceive their health as fair or poor is inversely related to level of education and household income. For example, adults most likely to report fair or poor health have less than a high school education and/or live in households with annual incomes below $20K. People living below the poverty line are more likely than people living above the poverty to report fair or poor health. Significantly more non-White adults report fair or poor health than White adults.

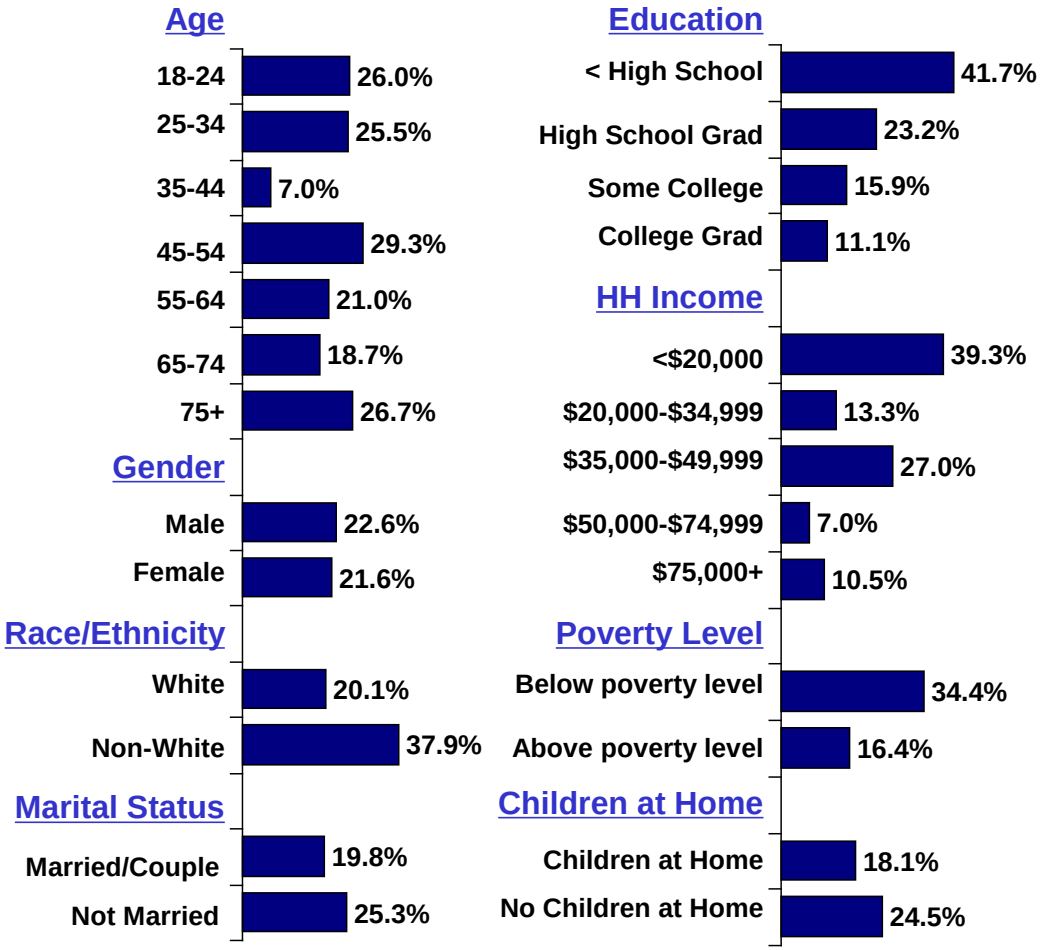
# General Health Status

## General Health Fair or Poor* (Total Sample)




*Among all adults, the proportion who reported that their health, in general, was either fair or poor.

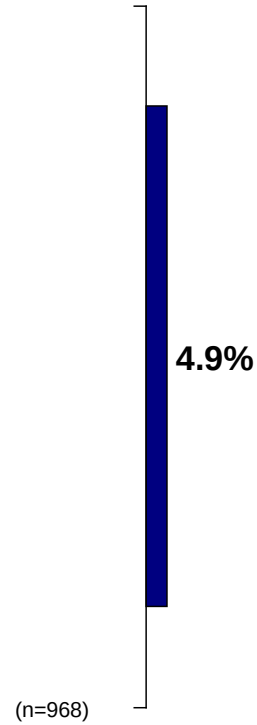
## Health Fair or Poor by Demographics



SHGMH area adults with incomes below $20,000 and those living below the poverty level are least satisfied with their lives. Conversely, adults most satisfied have college degrees and/or incomes of $75 or more.

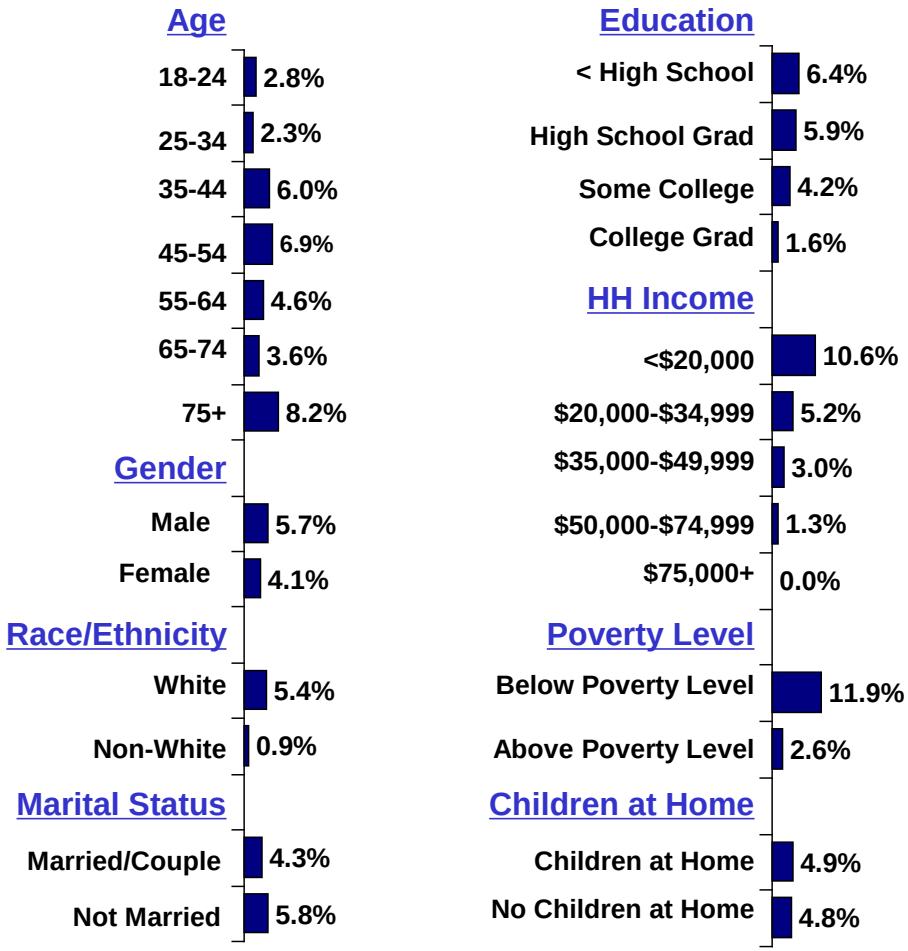
## Life Satisfaction

### Dissatisfied or Very Dissatisfied With Life* (Total Sample)




*Among all adults, the proportion who reported either "dissatisfied" or "very dissatisfied" to the following question: "In general, how satisfied are you with your life?

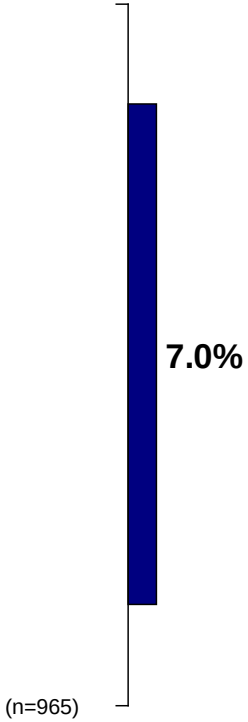
### Dissatisfied/Very Dissatisfied by Demographics



Adults who more often lack the social and emotional support they need come from groups that are non-White, have less than a college education, have household incomes less than $20,000, and are living below the poverty line.

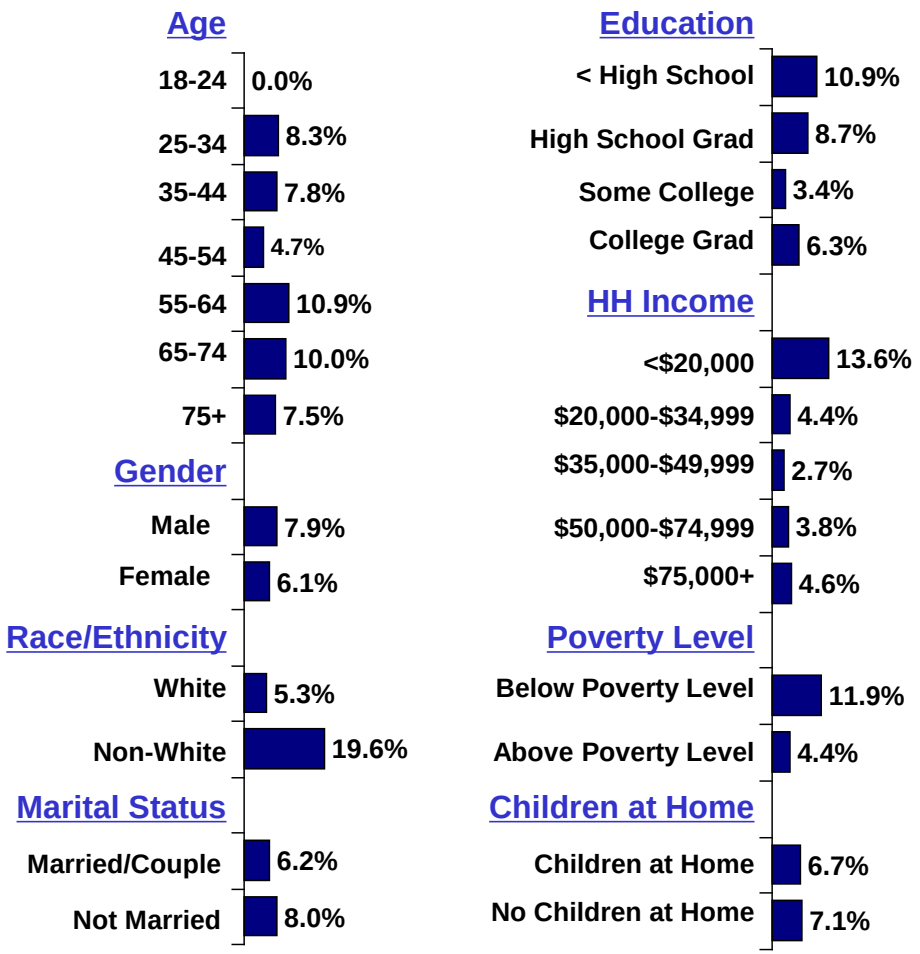
## Social and Emotional Support

### Rarely or Never Receive the Social and Emotional Support That is Needed* (Total Sample)




*Among all adults, the proportion who reported either "rarely" or "never" to the following question: "How often do you get the social and emotional support you need?

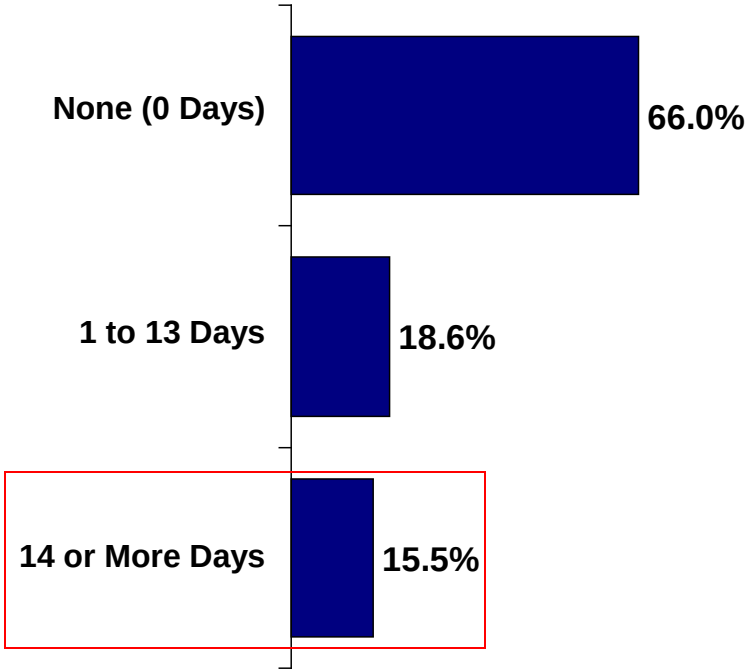
### Rarely/Never Receive Support by Demographics



Between one-fourth and one-third of SHGMH area adults have experienced at least one day in the past month where their physical or mental health was not good. Further, 15.5% and 8.3% are classified as having poor physical and mental health, respectively. Among all adults, they average 4.4 and 2.8 days where their physical or mental health is not good, respectively.

## Physical and Mental Health During Past 30 Days

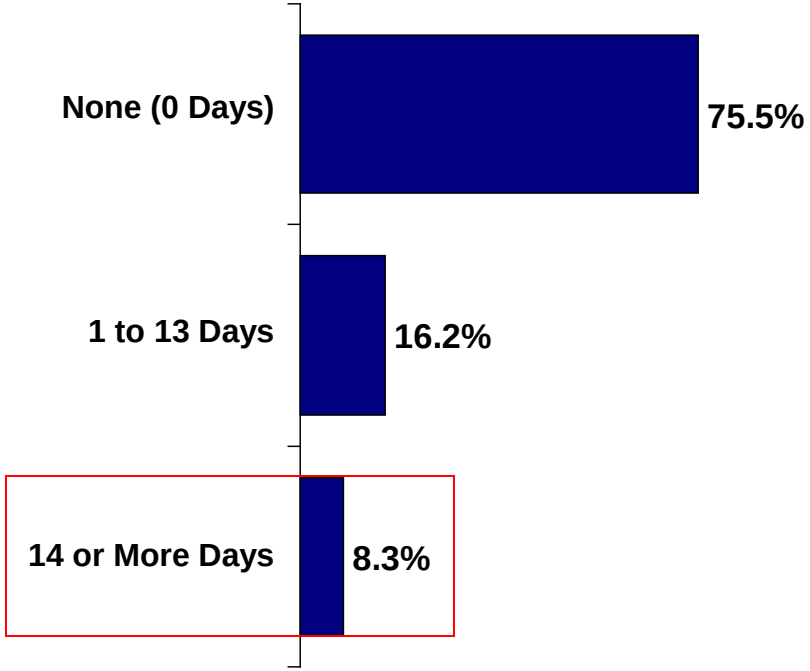
### Number of Days Physical Health Was Not Good in Past 30 Days




Mean Days (Including Zero) = 4.4
Mean Days (Without Zero) = 12.9

(n=972)

### Number of Days Mental Health Was Not Good in Past 30 Days




Mean Days (Including Zero) = 2.8
Mean Days (Without Zero) = 11.5

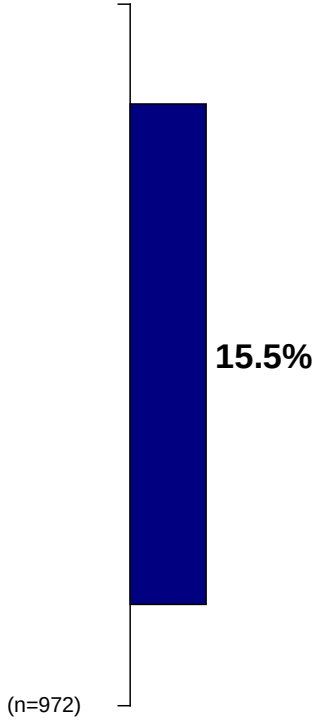
(n=975)

Q2.1: Now thinking about your physical health, which includes physical illness and injury. For how many days during the past 30 days was your physical health not good?
Q2.2: Now thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental health not good?

Prevalence of poor physical health is inversely related to education and income, where it is more common among adults with no high school diploma and those with annual incomes less than $20K. It is also slightly more common among non-White adults compared to White adults, and among more common among women than men. Adults least likely to report poor physical come from groups that are age 18-24 or 35-44, college graduates, and have incomes of $75K or more.

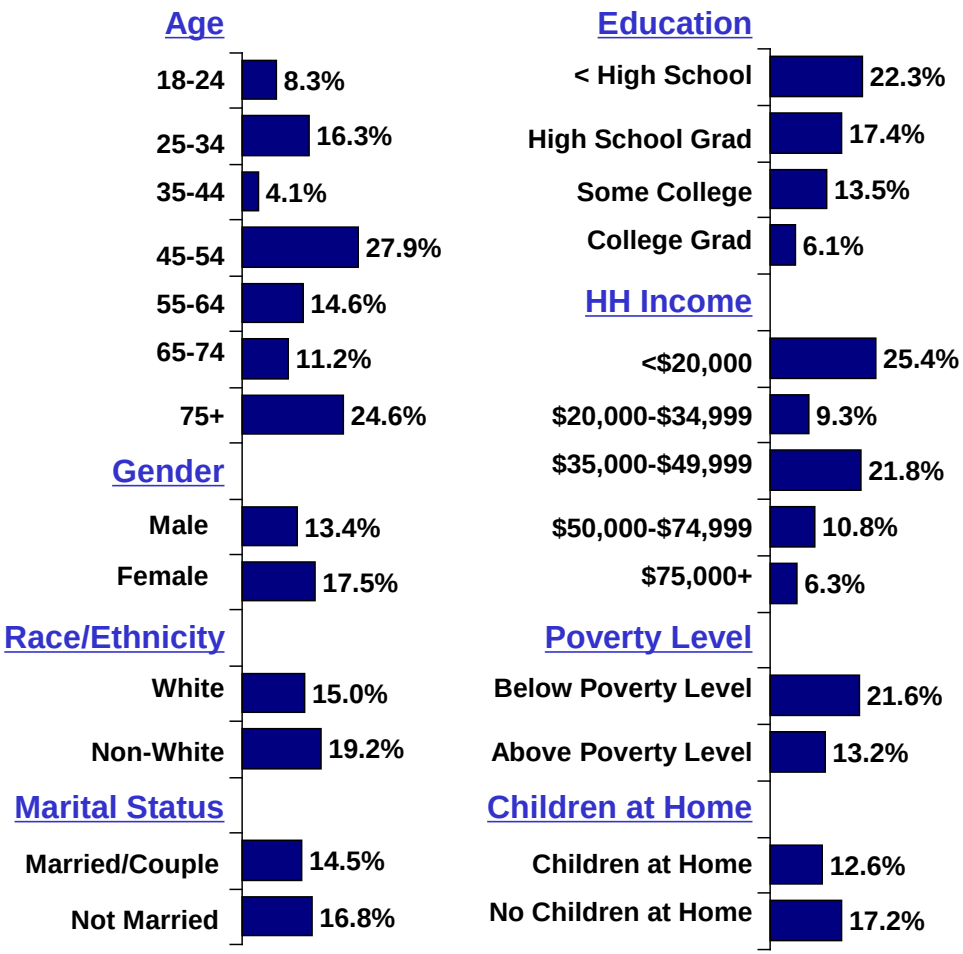
## Physical Health Status

### Poor Physical Health* (Total Sample)




*Among all adults, the proportion who reported 14 or more days of poor physical health, which includes physical illness and injury, during the past 30 days.

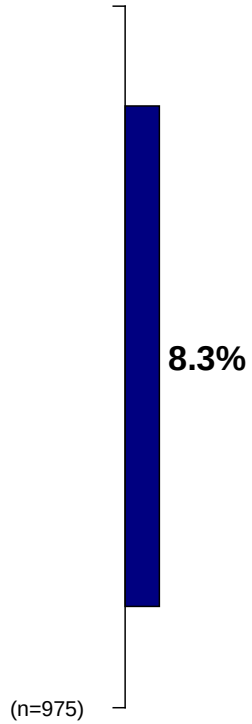
### Poor Physical Health by Demographics



The prevalence of poor mental health is inversely related to education, where those without a high school diploma are most likely to report poor mental health and those with a college degree are least likely. Also, non-White adults are more likely than White adults, and women more likely than men, to experience poor mental health.

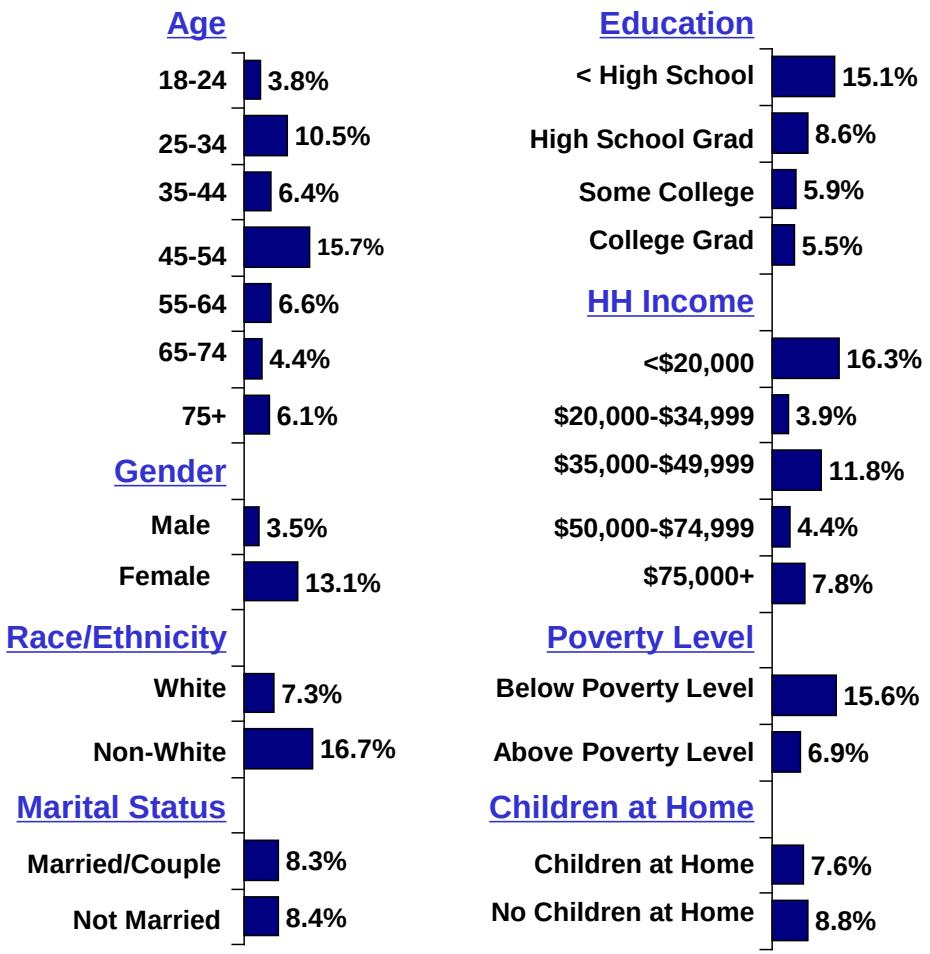
## Mental Health Status

### Poor Mental Health* (Total Sample)



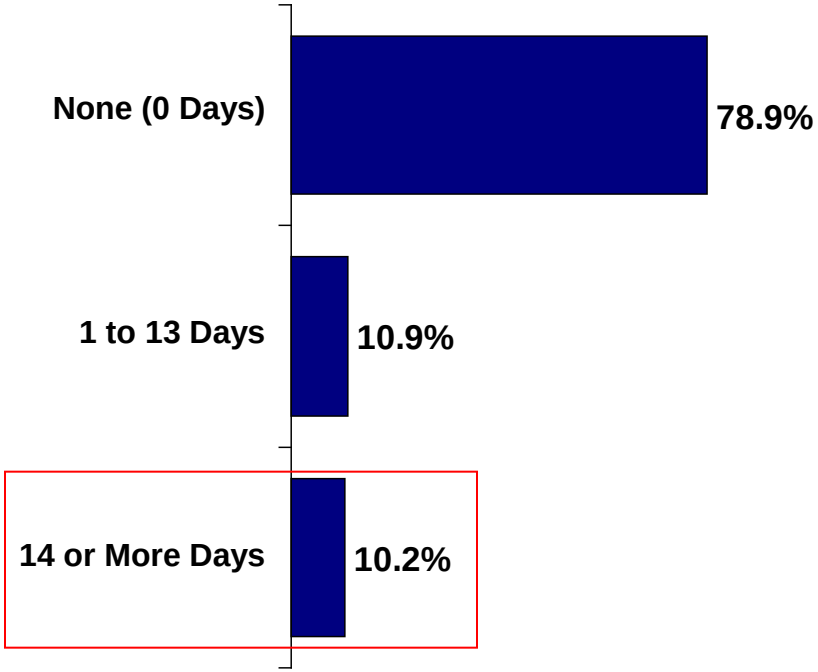

*Among all adults, the proportion who reported 14 or more days of poor mental health, which includes stress, depression, and problems with emotions, during the past 30 days.

### Poor Mental Health by Demographics



One in ten (10.2%) area adults experience limited activity due to poor physical or mental health. Those who experience this limitation average almost half the days per month (14.1 days) where they are prevented from doing their usual activities.

## Activity Limitation During Past 30 Days




**Mean Days (Including Zero) = 3.0**
**Mean Days (Without Zero) = 14.1**

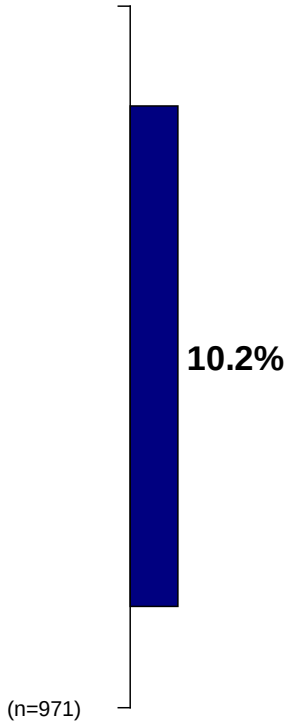
(n=971)

Q2.3: During the past 30 days, for about how many days did poor physical or mental health keep you from doing your usual activities, such as self-care, work, or recreation?

Activity limitation due to poor mental or physical health is most common among adults without a high school degree. Secondly, large proportions of adults who experience activity limitation are found among the poorest adults; those with the lowest incomes, for example, less than $20K (22.3%), and those living below the poverty line (15.8%).

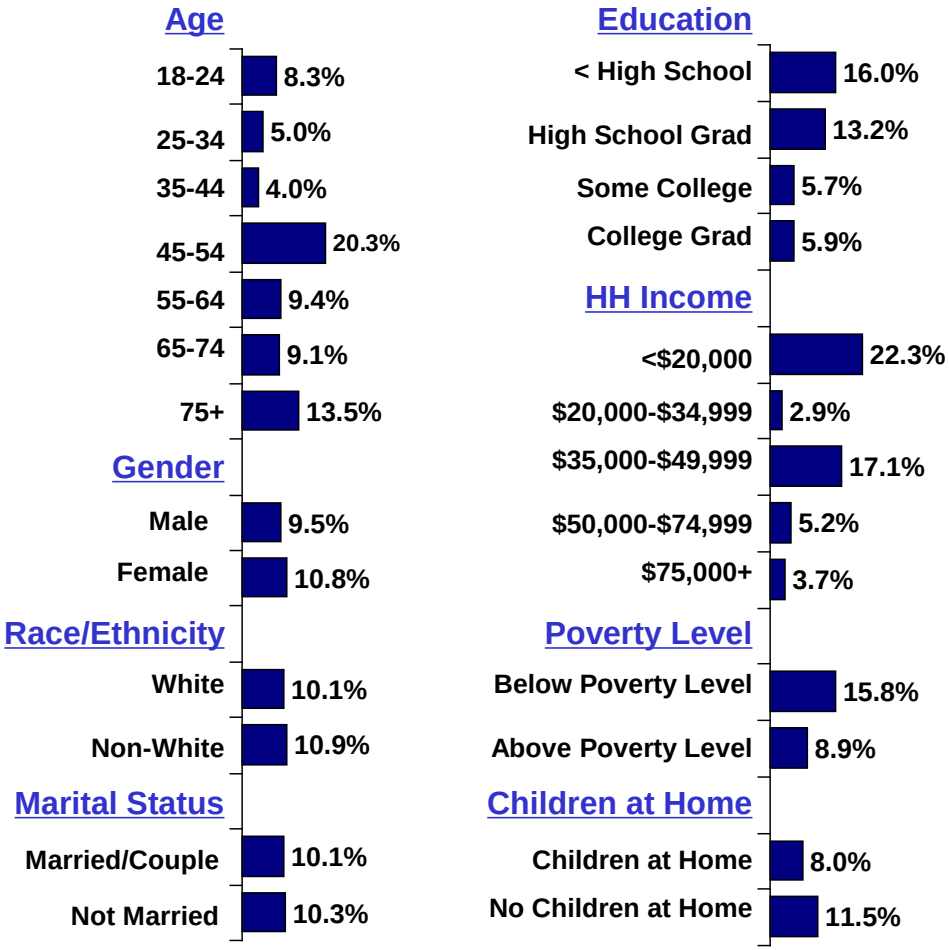
## Activity Limitation

### Activity Limitation* (Total Sample)




*Among all adults, the proportion who reported 14 or more days in the past 30 days in which either poor physical health or poor mental health kept respondents from doing their usual activities, such as self-care, work, and recreation.

### Activity Limitation by Demographics



Eight in ten (80.7%) area adults are considered to be mentally healthy according to the Kessler 6 Psychological Distress Questionnaire. Conversely, 16.5% experience mild to moderate psychological distress while 2.8% are severely distressed.

## Psychological Distress

| | *During the Past 30 Says, About How Often Did You….* | | | | | |
|---|---|---|---|---|---|---|
| ***Frequency of Feeling*** | **Feel Nervous (n=973)** | **Feel Hopeless (n=975)** | **Feel Restless or Fidgety (n=973)** | **Feel So Depressed That Nothing Could Cheer You Up (n=972)** | **Feel That Everything Is An Effort (n=969)** | **Feel Worthless (n=973)** |
| **None of the time** | **47.1%** | **78.1%** | **54.9%** | **85.7%** | **66.7%** | **87.0%** |
| **A Little** | **28.0%** | **11.4%** | **23.2%** | **8.0%** | **13.5%** | **6.3%** |
| **Some of the time** | **18.0%** | **6.1%** | **13.0%** | **4.9%** | **11.7%** | **3.9%** |
| **Most of the time** | **4.6%** | **2.1%** | **4.6%** | **0.9%** | **4.3%** | **1.5%** |
| **All of the time** | **2.4%** | **2.3%** | **4.4%** | **0.5%** | **3.8%** | **1.3%** |

**Mentally Healthy (Well) = 80.7%**

**Mild to Moderate Psychological Distress = 16.5%**

**Severe Psychological Distress = 2.8%**

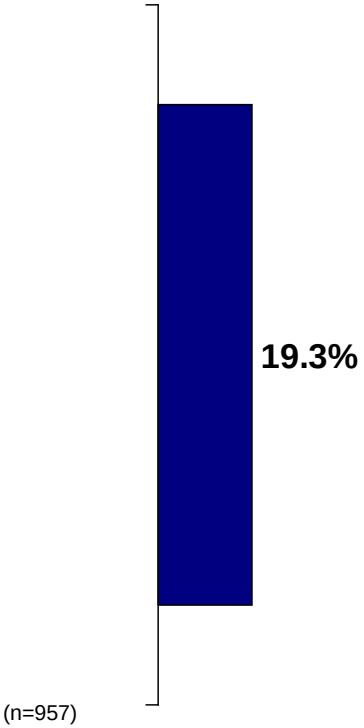
*Calculated from responses to Q. 22.1- 22.6, where none of the time =1, a little = 2, some of the time =3, most of the time =4, and all of the time =5. Responses were summed across all six questions with total scores representing the above categories: mentally well (6-11), mild to moderate psychological distress (12-19), and severe psychological distress (20+).

Q22.1-Q22.6 About how often over the past 30 days did you feel….

Among SHGMH area adults, the groups most likely to be diagnosed with mild to severe psychological distress include those who: have no college education, have household incomes less than $20K, and live below the poverty line. Conversely, those least likely to have psychological distress are found in groups that have a college degree and have incomes of $75K or more.

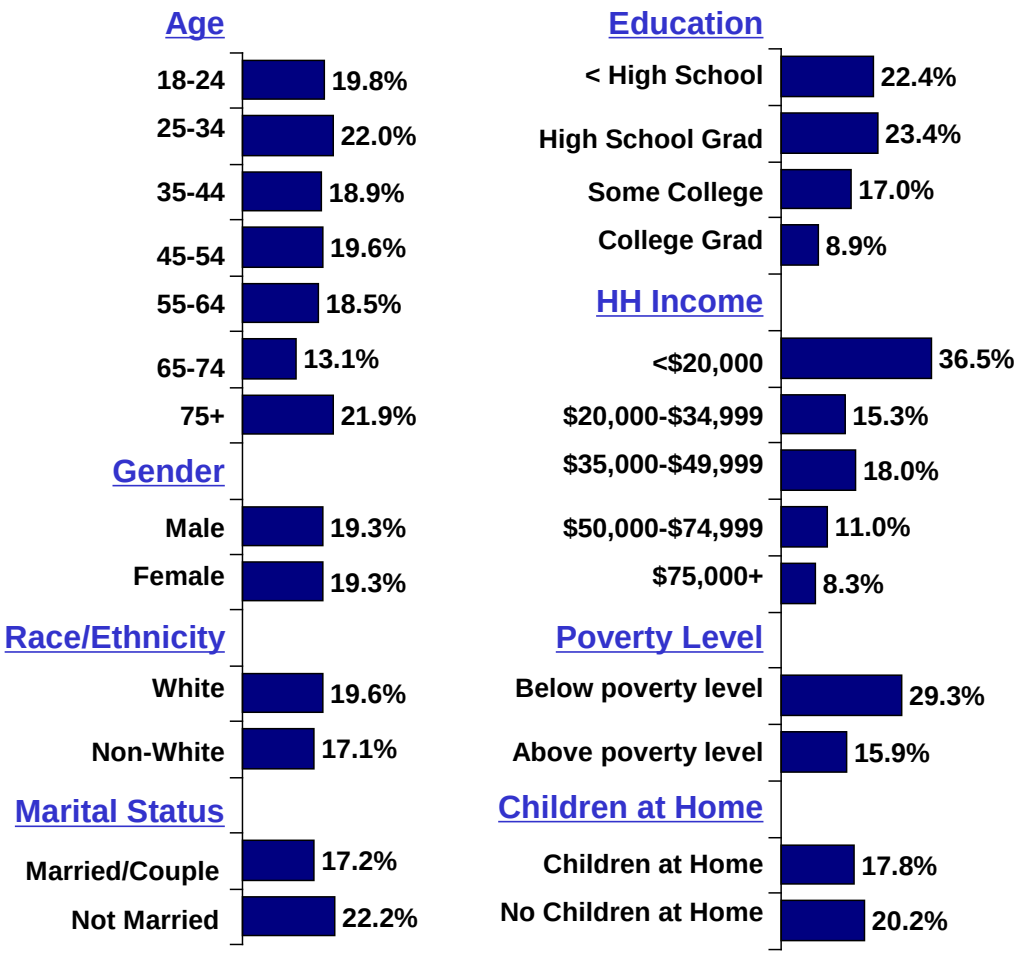
## Psychological Distress

### Mild to Severe Psychological Distress* (Total Sample)




*Calculated from responses to Q. 22.1- 22.6 where respondents scored 12 or more across the six items on the Kessler 6 scale.

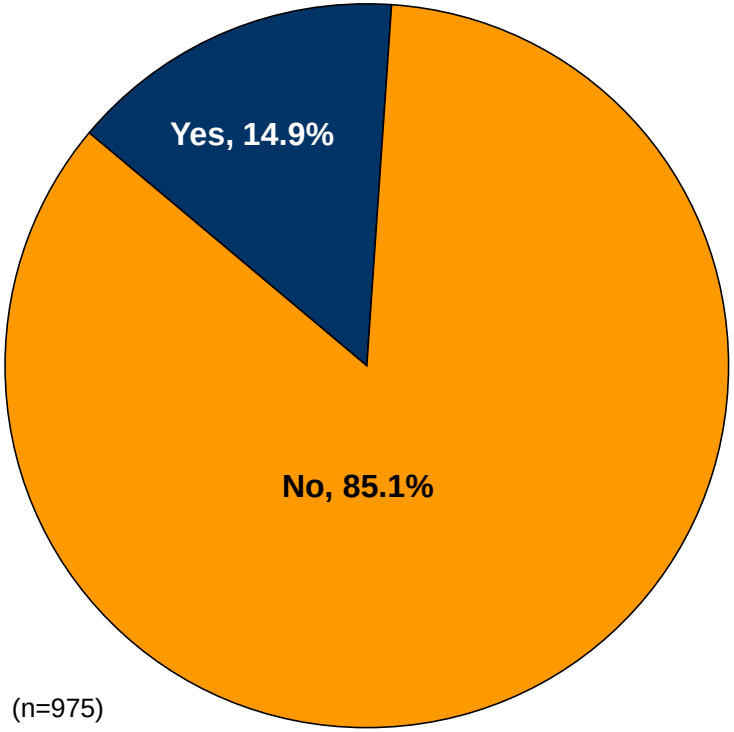
### Mild to Severe Psychological Distress by Demographics



Of all SHGMH area adults, 14.9% currently take medication or receive treatment for a mental health condition or emotional problem. However, those who could benefit the most from medication/treatment are not getting it as often as they should: roughly six in ten adults classified as having "severe psychological distress" and/or having "poor mental health" currently take medication or receive treatment for their mental health issues.

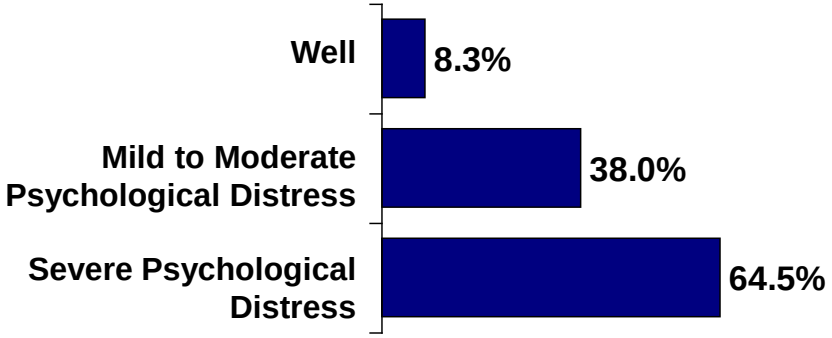
## Medication and Treatment for Psychological Distress

### Taking Medication or Receiving Treatment for Mental Health Condition or Emotional Problem




(n=975)

### Percent Taking Medication/Receiving Treatment by Psychological Distress Category




### Percent of Those Classified as "Poor Mental Health" That are Taking Medication/Receiving Treatment

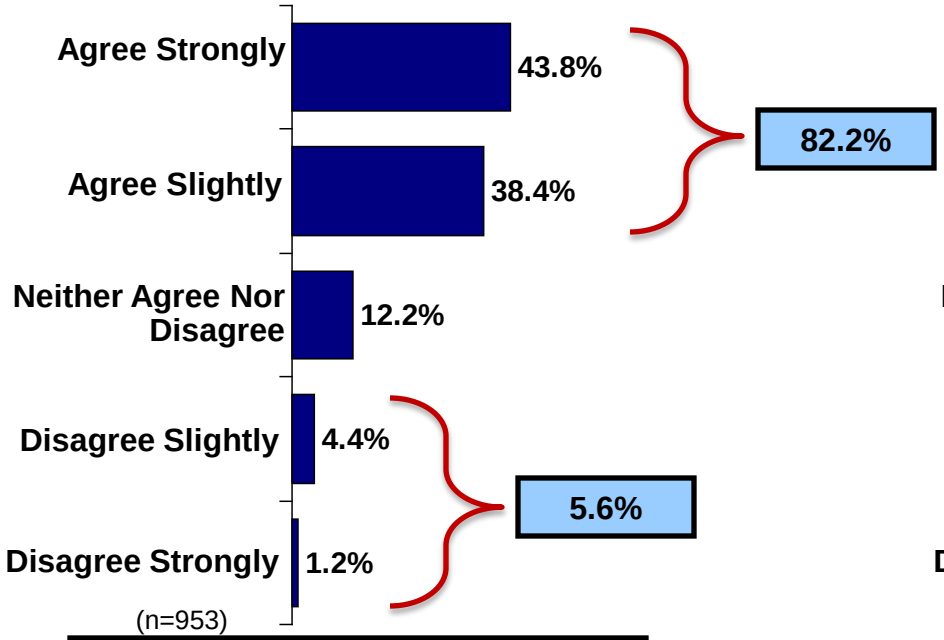
55.9%

Q22.7: Are you now taking medicine or receiving treatment from a doctor or other health care professional for any type of mental health condition or emotional problem.

The vast majority (82.2%) of area adults believe treatment can help people with mental illness lead normal lives. On the other hand, only four in ten (40.4%) think people are generally caring and sympathetic toward people with mental illness. This stigma could be a reason that, although the vast majority of people believe treatment works, far fewer seek it.

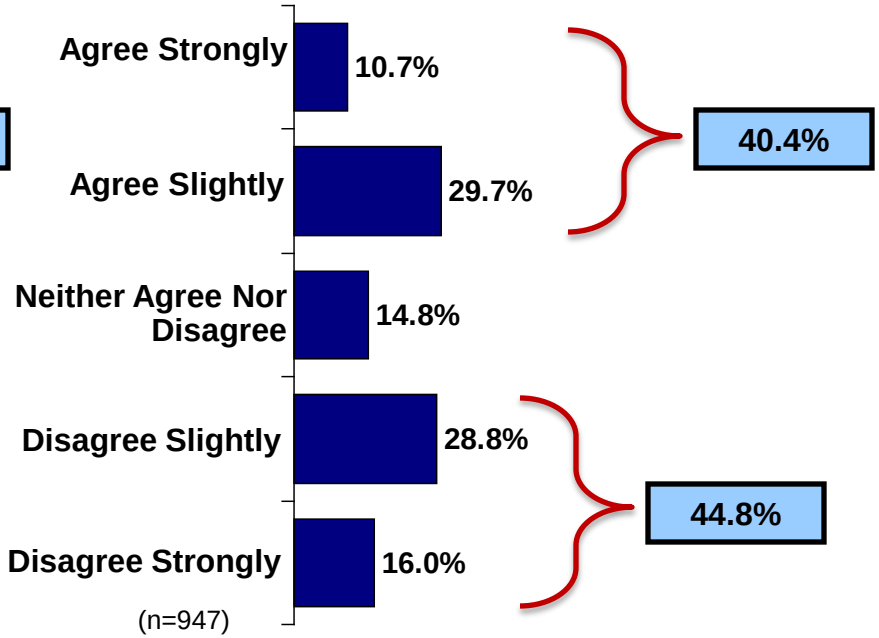
## Perceptions of Mental Health Treatment and Mental Illness

### "Treatment Can Help People With Mental Illness Lead Normal Lives"




**Agree by Psychological Distress**
- Well (82.6%)
- Mild to Moderate (78.7%)
- Severe (92.4%)

### "People Are Generally Caring and Sympathetic to People With Mental Illness"




**Agree by Psychological Distress**
- Well (40.2%)
- Mild to Moderate (35.7%)
- Severe (66.6%)

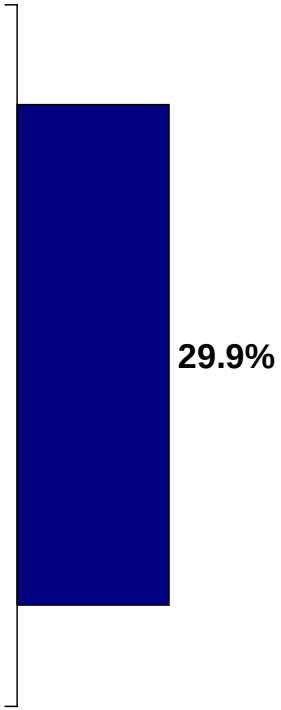
22.8 What is your level of agreement with the following statement? "Treatment can help people with mental illness lead normal lives." Do you – agree slightly or strongly, or disagree slightly or strongly?

22.9 What is your level of agreement with the following statement? "People are generally caring and sympathetic to people with mental illness." Do you – agree slightly or strongly, or disagree slightly or strongly?

Two-thirds (65.8%) of SHGMH area adults are considered to be either overweight or obese per their BMI. Three in ten (31.3%) are at a healthy weight.

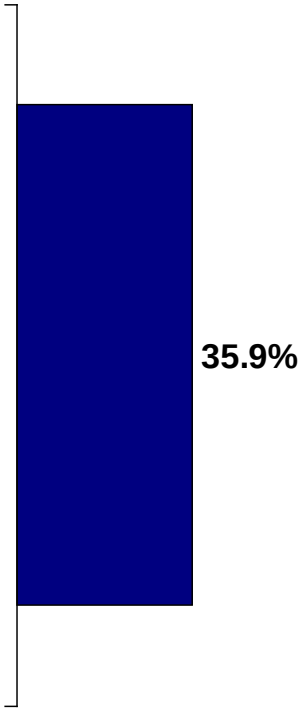
## Weight Status

### Obese* (Total Sample)



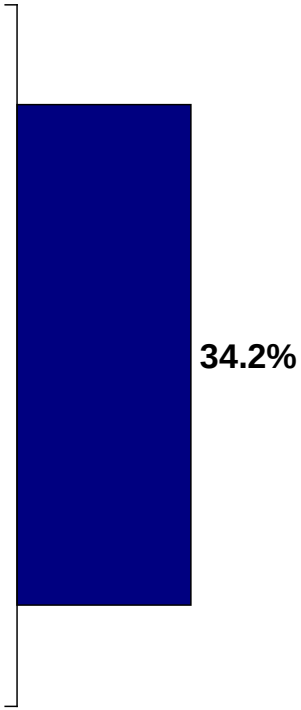

*Among all adults, the proportion of respondents whose BMI was greater than or equal to 30.0.

### Overweight* (Total Sample)




*Among all adults, the proportion of respondents whose BMI was greater than or equal to 25.0, but less than 30.0

### Not Overweight or Obese* (Total Sample)




**Healthy Weight = 31.3%**
**Underweight = 2.9%**

*Among all adults, the proportion of respondents whose BMI was less than 25.0.

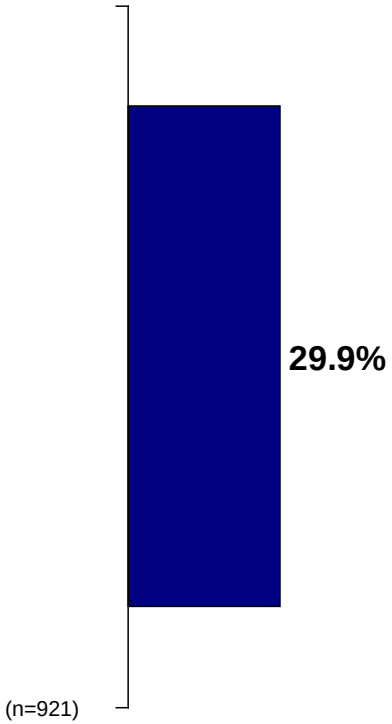
Q13.10: About how much do you weigh without shoes?
Q13.11: About how tall are you without shoes?

(n=921)

Obesity is a condition that affects adults regardless of socioeconomic or socio-demographic characteristics. That said, adults most likely to be obese come from groups that include those with less than a high school degree, non-White, and between the ages of 45-74. Those least likely to be obese are age 75+ and/or have incomes of $50K or greater.

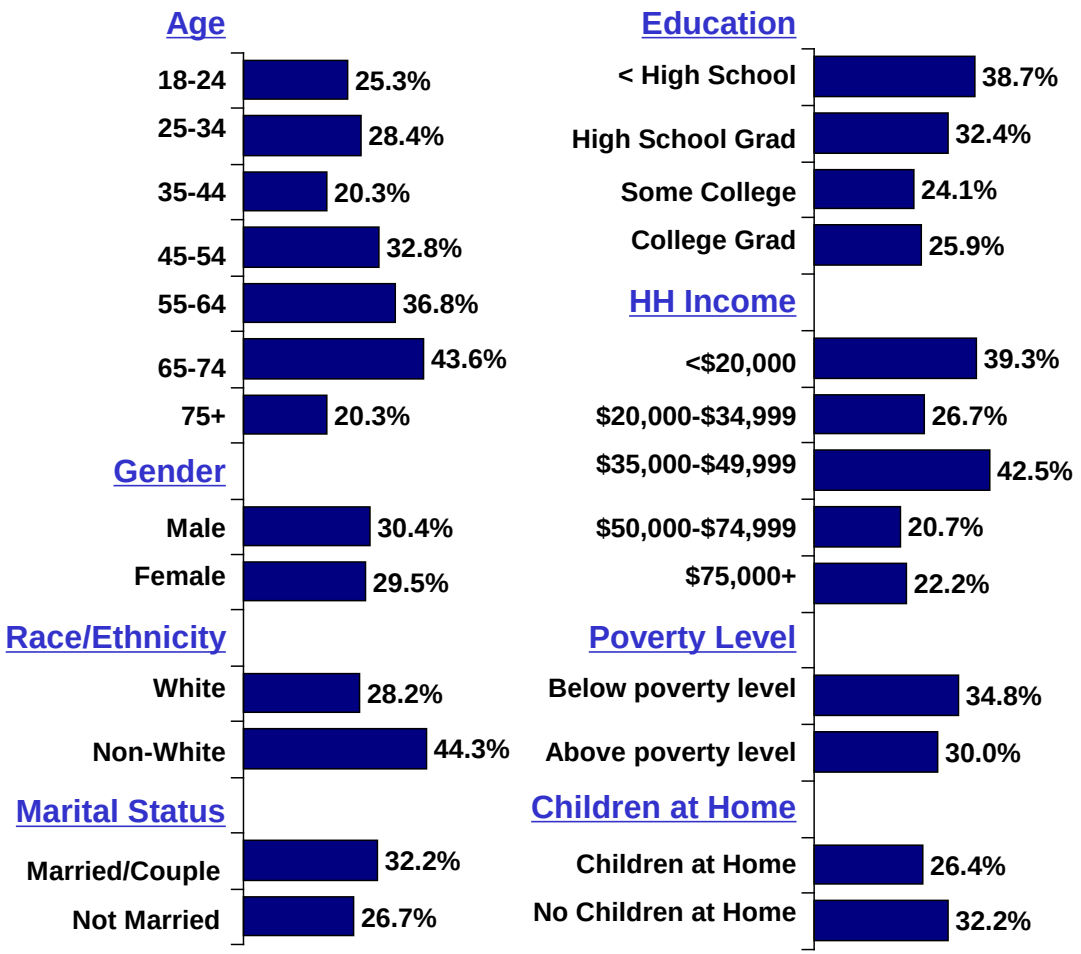
## Weight Status

### Obese* (Total Sample)




*Among all adults, the proportion of respondents whose BMI was greater than or equal to 30.0.

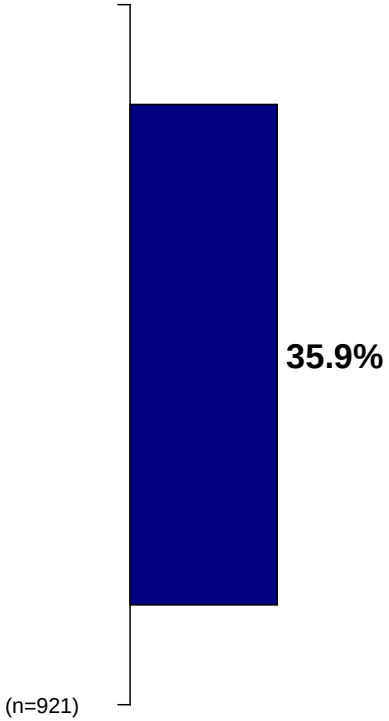
### Obese by Demographics



Men are far more likely to be considered overweight (but not obese) than women. Adult residents with the lowest incomes and/or lowest level of education are less likely to be overweight than others who are better off financially or have more education.

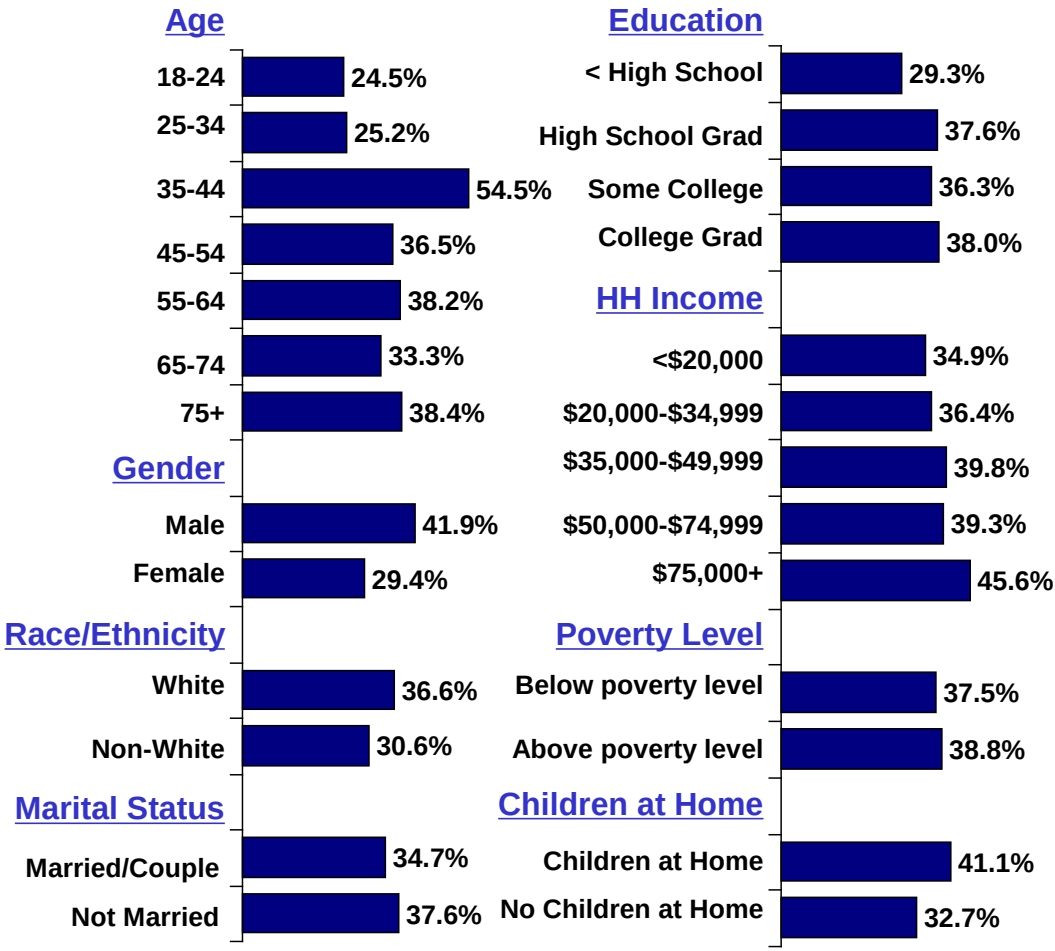
## Weight Status (Cont'd.)

### Overweight* (Total Sample)




*Among all adults, the proportion of respondents whose BMI was greater than or equal to 25.0, but less than 30.0.

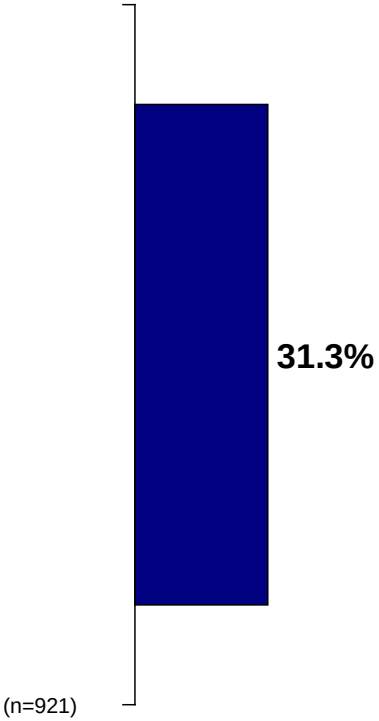
### Overweight by Demographics



Women and White adults are more likely to be at a healthy weight than men and non-White adults, respectively. Adults at both ends of the age continuum (18-34, 75+) are also most likely to be at a healthy weight. College educated adults are more likely to be at a healthy weight compared to adults with no college education.

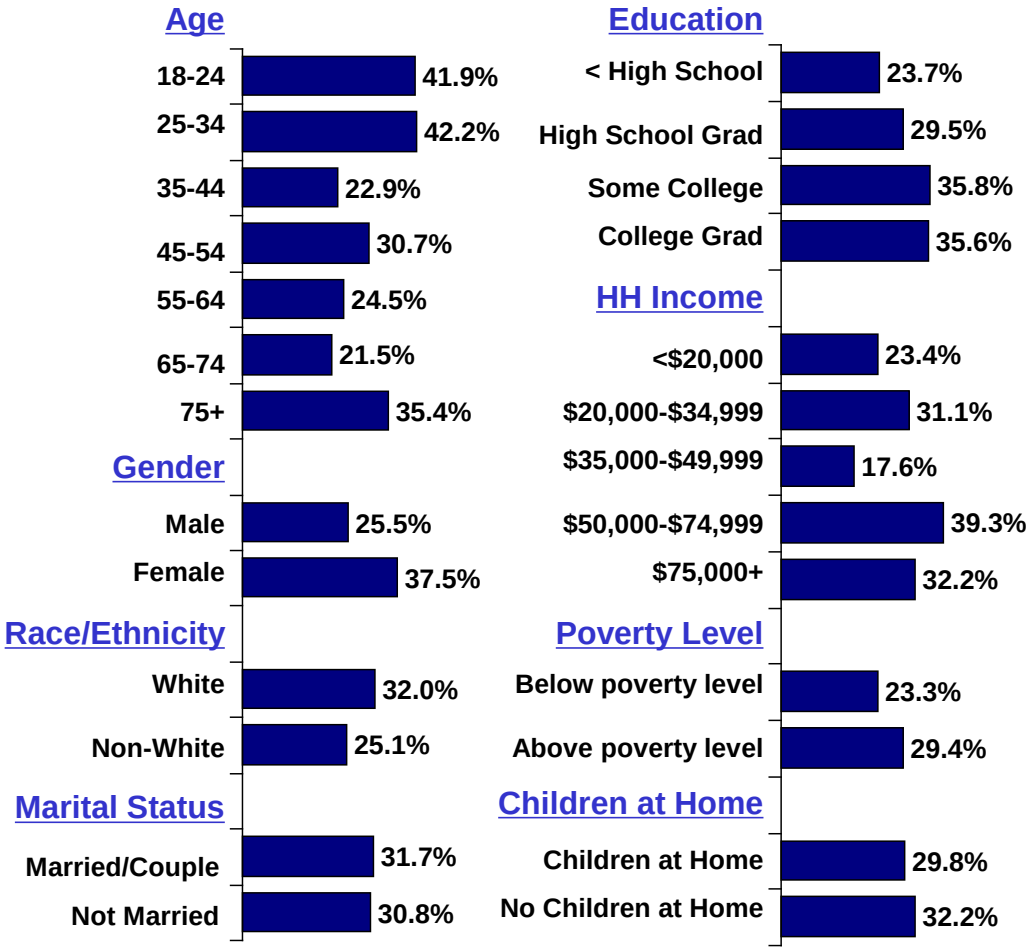
## Weight Status (Cont'd.)

### Healthy Weight* (Total Sample)




*Among all adults, the proportion of respondents whose BMI was greater than 18.5 but less than 25.0.

### Healthy Weight by Demographics

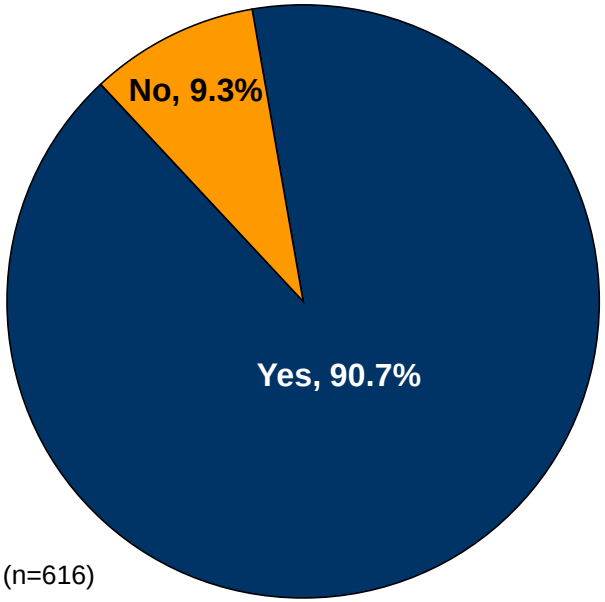


# *Health Care Access*

More than nine in ten (90.7%) adults under age 65 have health care coverage. The primary source of health coverage for all adults, by far, is a plan purchased through an employer or union. One in ten (10.0%) purchase health coverage on their own.

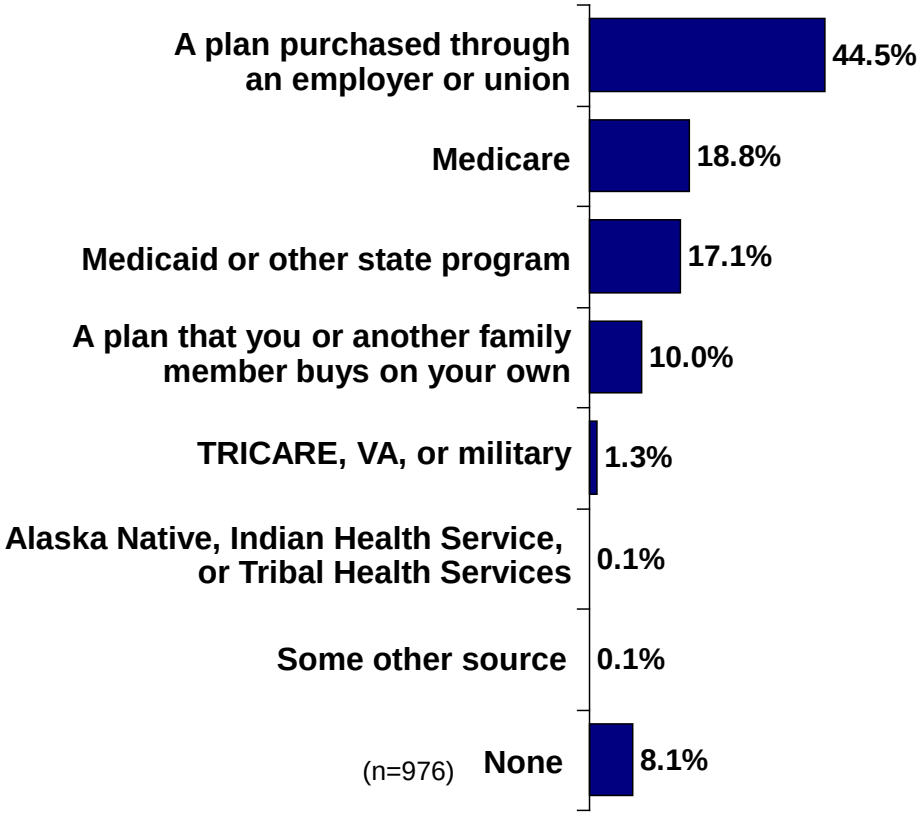
## Health Care Coverage

### Currently Have Health Coverage (Among Adults 18-64)




(n=616)

### Primary Source of Health Coverage (Total Sample)



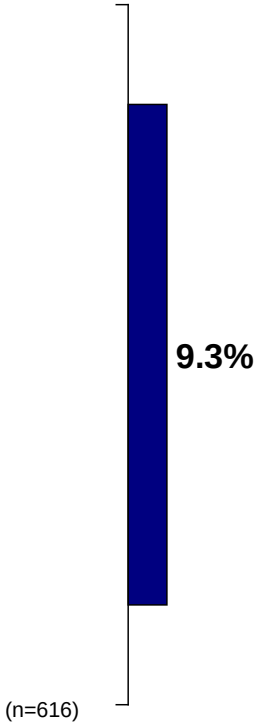

(n=976)

Q3.1: Do you have any kind of health care coverage, including health insurance, prepaid plans such as HMOs, or government plans such as Medicare or Indian Health Services?
Q3.2: What is the primary source of your health coverage? Is it….?

Having health care coverage is directly related to education and income. Additionally, non-White adults report lacking coverage more than White adults. Further, and perhaps more alarming, those with children at home are less likely to have coverage than those with no children at home.

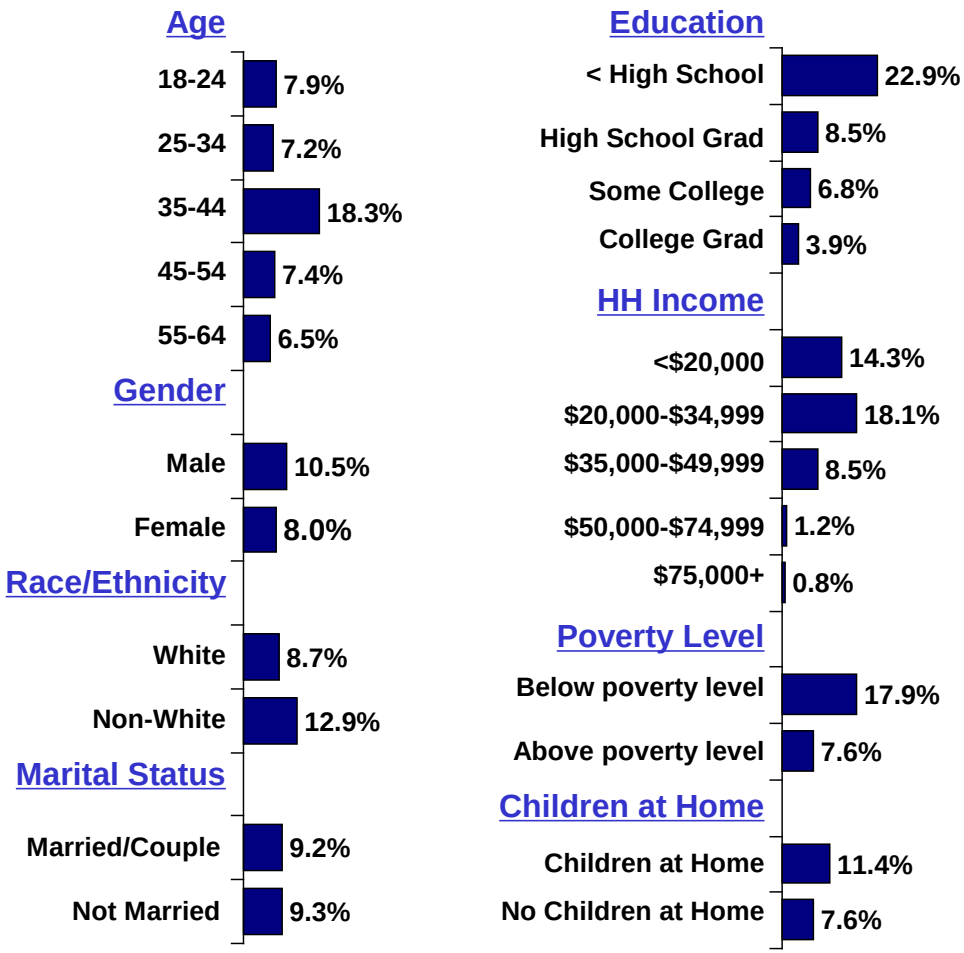
## Health Care Coverage Among Adults Aged 18-64 Years

### No Health Care Coverage* (Among Adults 18-64)




*Among adults aged 18-64, the proportion who reported having no health care coverage, including health insurance, prepaid plans such as HMOs, or government plans, such as Medicare.

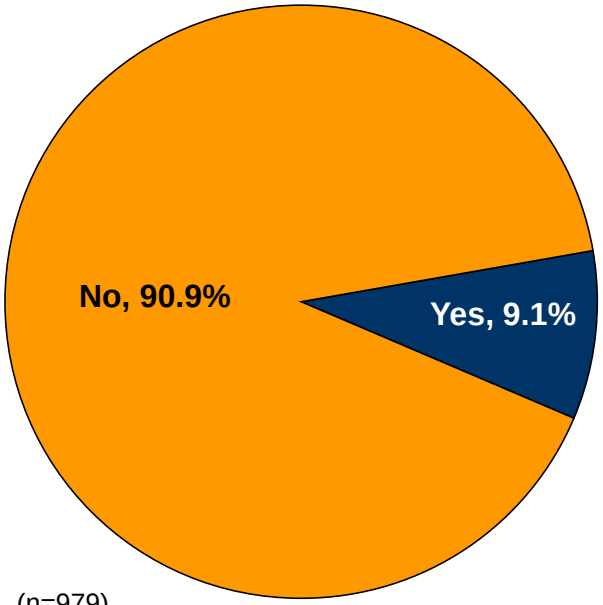
### No Coverage by Demographics



Slightly less than one in ten (9.1%) area adults have foregone health care in the past 12 months because of cost. For those who delayed needed medical care this past year, there are myriad reasons cited, however **cost**, either in general terms or for co-pays and deductibles, is the greatest factor. Further, 6.7% could not take prescribed medication due to cost.

## Problems Receiving Healthcare

### Could Not Receive Needed Medical Care in Past 12 Months Due to Cost

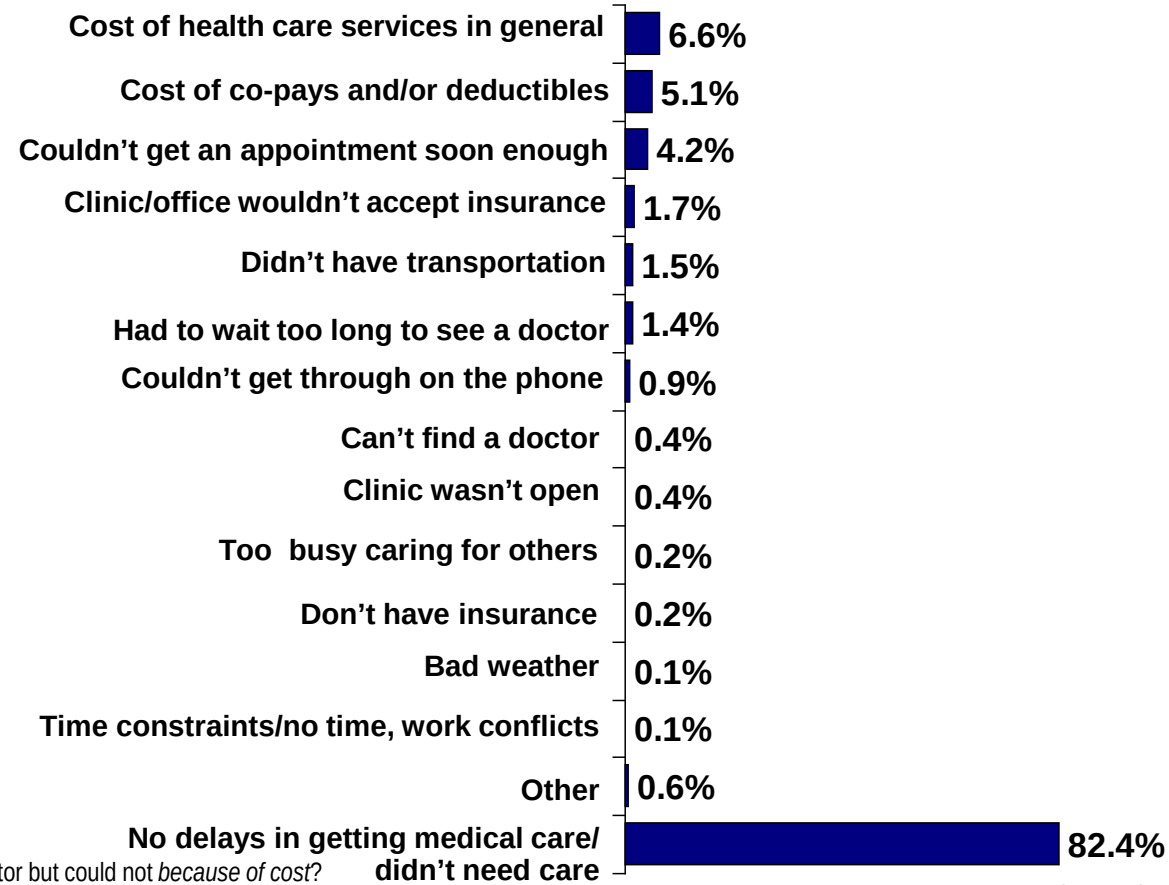



(n=979)

**Could Not Take Medication Due to Cost = 6.7%**

(n=980)

### Reasons for Delays in Getting Needed Medical Care



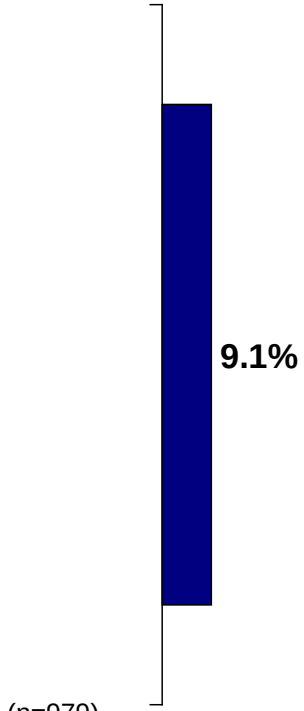

(n=979)

Q3.4: Was there a time in the past 12 months that you needed to see a doctor but could not *because of cost*?
Q3.5: There are many reasons people delay getting needed medical care. Have you delayed getting needed medical care for any of the following reasons in the past 12 months?
Q3.9: Was there a time in the past 12 months when you did not take your medication as prescribed because of cost? Do not include over the counter (OTC) medication.

Cost, as a barrier to health care, is inversely related to income; those who more often find it a barrier come from groups that have incomes below $20K and are below the poverty level. Additionally, costs are more likely to prevent non-White adults from receiving health care compared to White adults.

## Problems Receiving Health Care Due to Cost

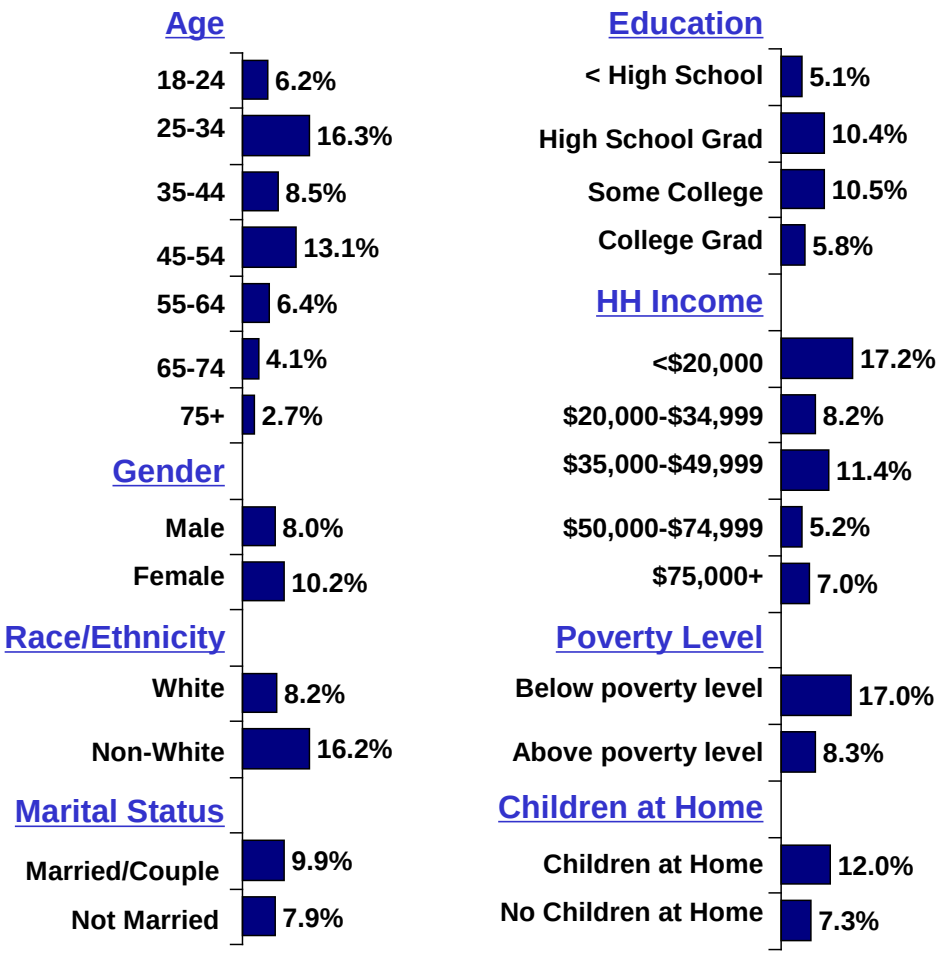
### No Health Care Access During Past 12 Months Due to Cost* (Total Sample)




(n=979)

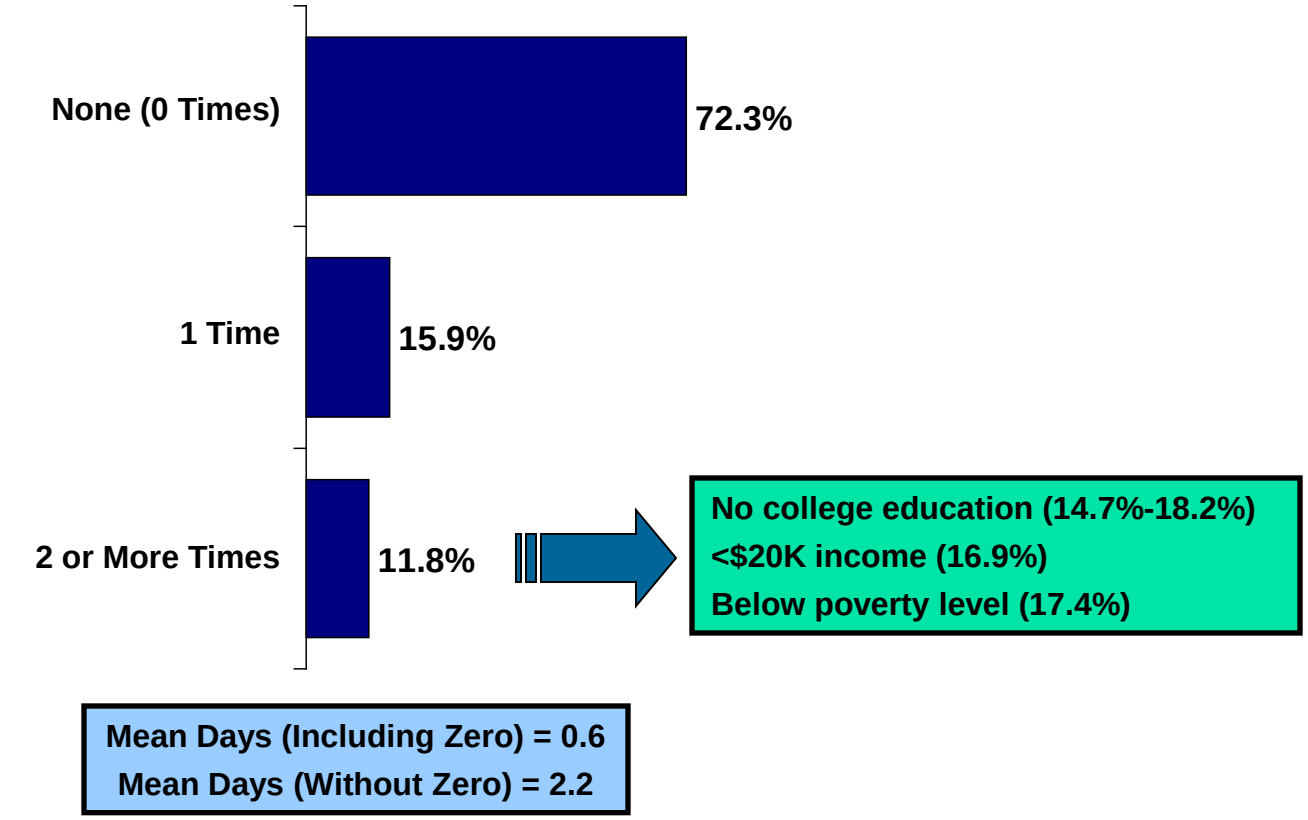
*Among all adults, the proportion who reported that in the past 12 months, they could not see a doctor when they needed to due to the cost.

### No Health Care Access Due to Cost by Demographics



Among SHGMH area adults, one-fourth (27.7%) visited an ER/ED at least once in the past 12 months. Those who used these facilities averaged more than two visits during the year. Those who use the ER the most come from groups that have no college education and are the poorest.

## Number of Times Visited ER/ED in Past 12 Months

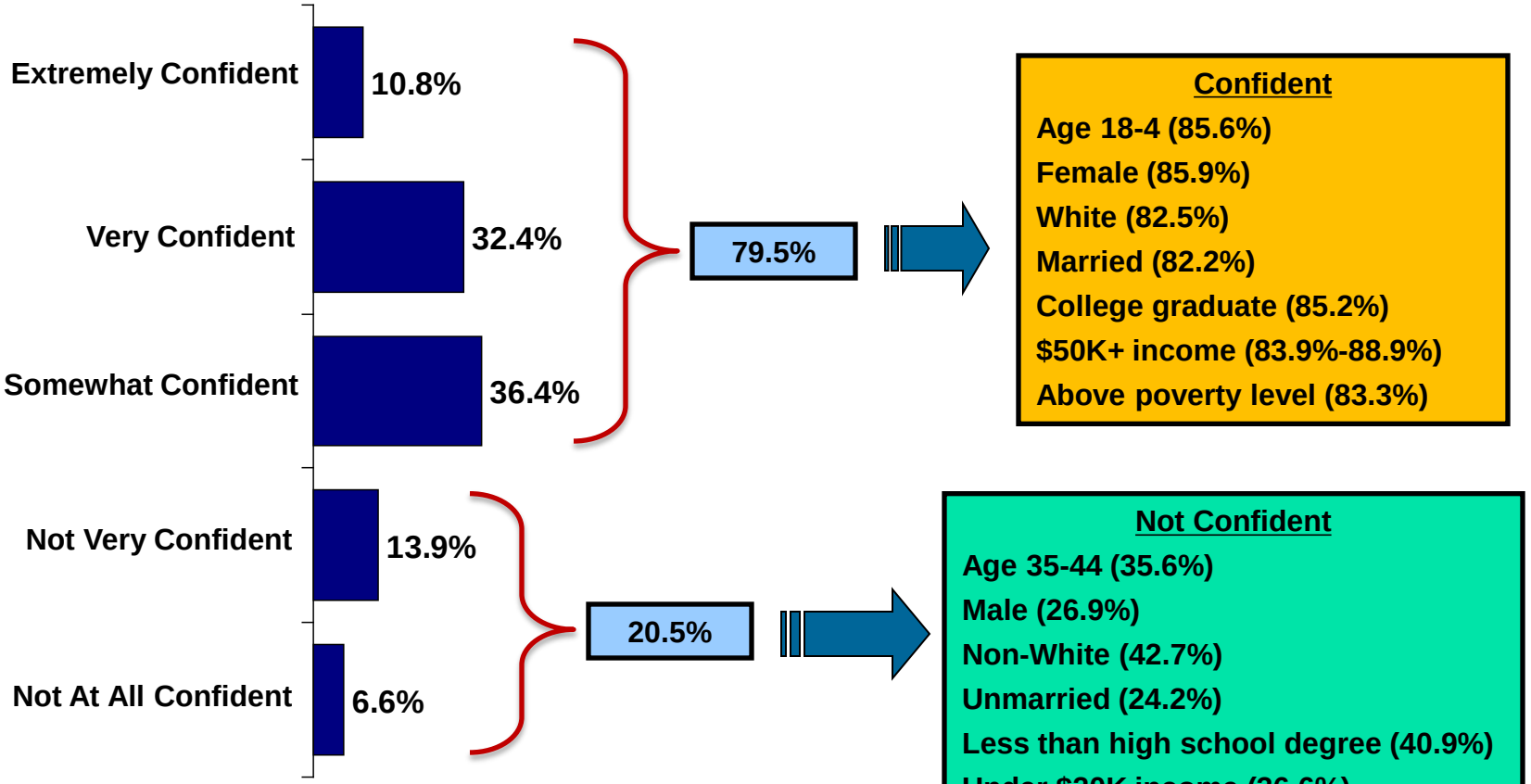



(n=979)

Q3.8: How many time have you been to an Emergency Department/Room in the past 12 months?

A large majority (79.5%) of adults are at least somewhat confident they can successfully navigate the health care system, however, 20.5% are not very or not at all confident. The most confident groups are the youngest, women, White, married, have incomes of $50K or more, and are college graduates. Conversely, those least confident groups are age 35-44, men, non-White, have incomes below $20K, live below the poverty line, and are without a high school diploma.

## Confidence in Navigating the Health Care System




(n=968)

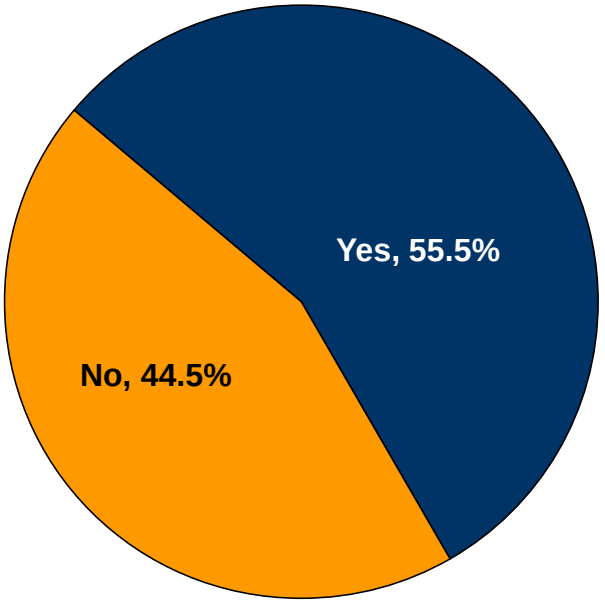
Q3.10: How confident are you that you can successfully navigate the health care system? Would you say….?

# *Risk Behavior Indicators*

Just over half (55.5%) of area adults participated in leisure time physical activity such as running, walking, or golf during the previous 30 days. Of those who did, three-fourths (77.3%) participated at least three times per week. Two-thirds (67.9%) participated for less than four hours per week, while 18.7% participated for six hours or more.

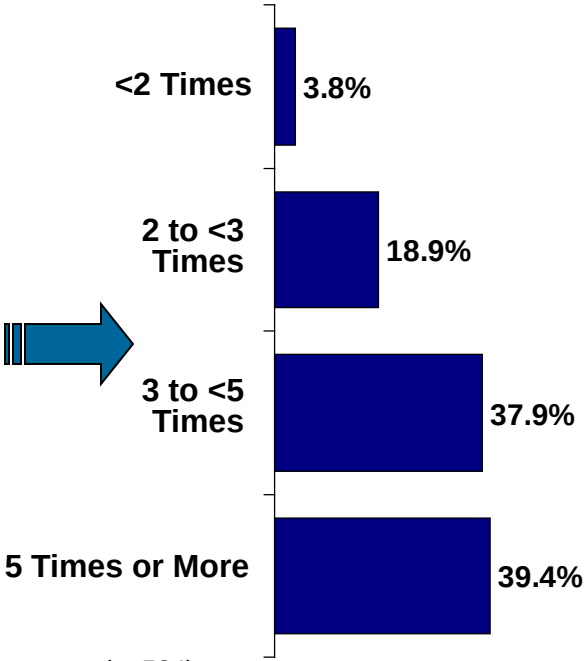
## Participation in Physical Activity

### Participation in Leisure Time Physical Activity/Exercise




(n=975)

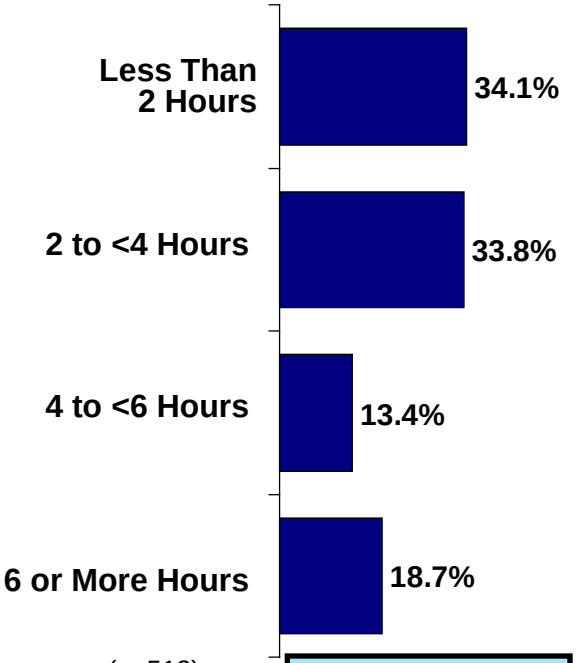
### Number of Times Performed Physical Activity Per Week (Among Those Who Participate)




(n=524)

Mean = 4.2
Median = 4.0

### Number of Hours Performed Physical Activity Per Week (Among Those Who Participate)




(n=512)

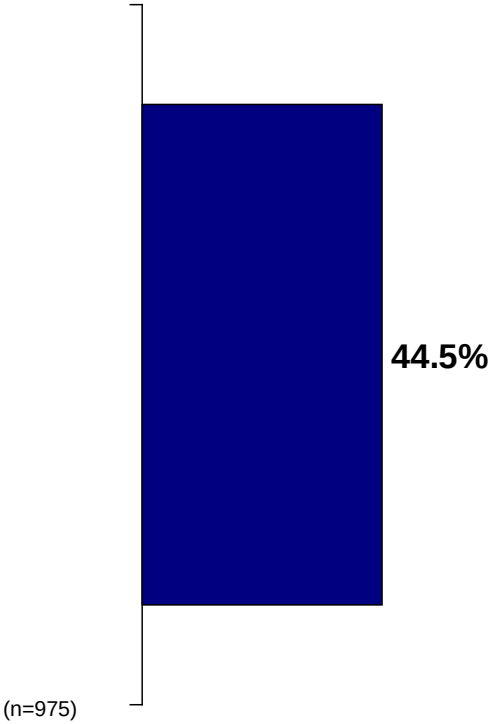
Mean = 4.2
Median = 2.5

Q18.1: During the past month, other than your regular job, did you participate in any physical activities or exercises such as running, calisthenics, golf, gardening, or walking for exercise?
Q18.2: (If yes) How many times per week or per month did you take part in physical activity during the past month?
Q18.3: And when you took part in physical activity, for how many minutes or hours did you usually keep at it?

The amount of leisure time physical activity area adults engage in is highly associated with education and income; those with the most education and highest incomes are most active. The least active groups include adults with no college education.

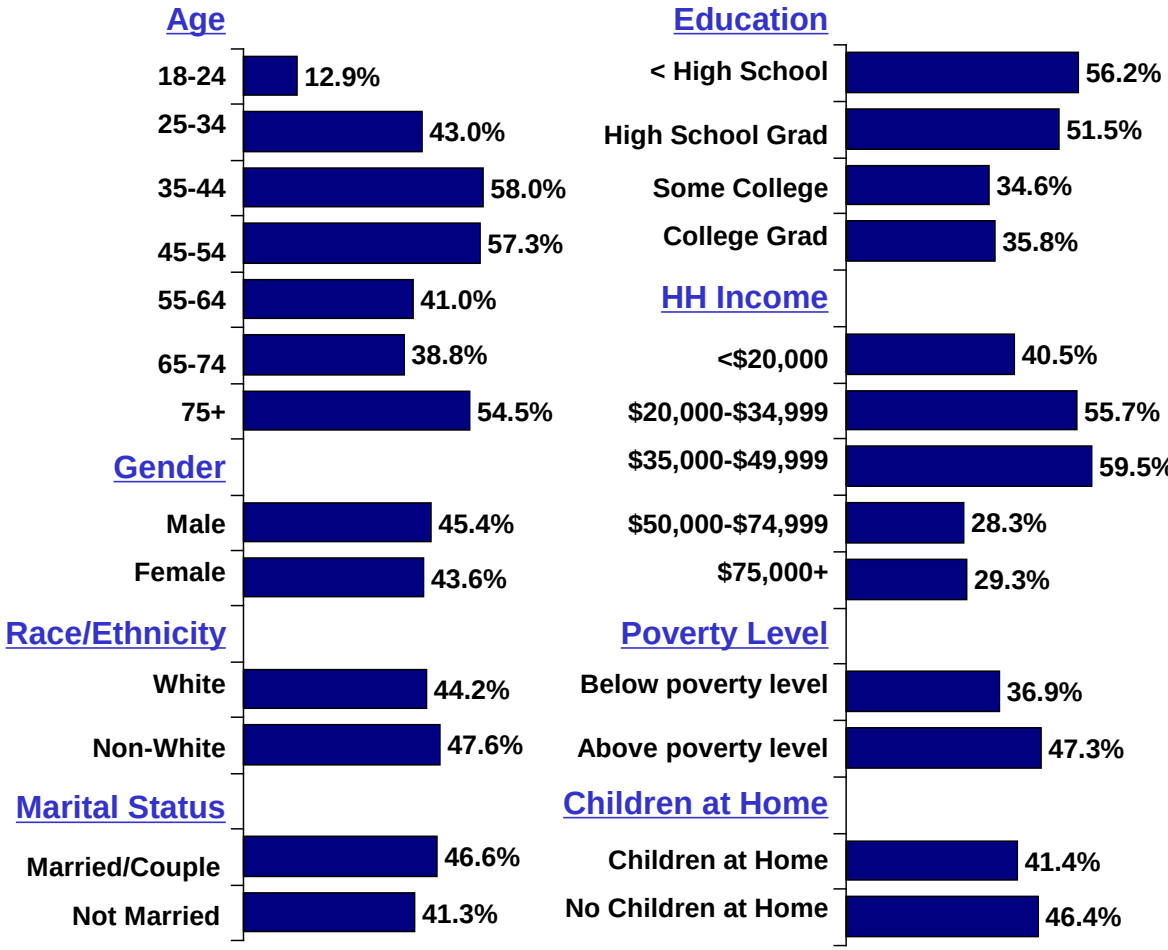
## Leisure Time Physical Activity

### No Leisure Time Physical Activity* (Total Sample)




*Among all adults, the proportion who reported not participating in any leisure-time physical activities or exercises, such as running, calisthenics, golf, gardening, or walking, during the past month.

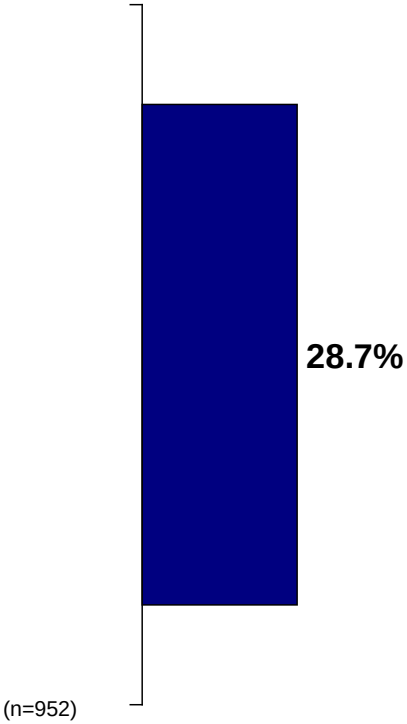
### No Leisure Time Activity by Demographics



Similarly, participating in adequate amounts of aerobic physical activity is directly related to education and greatly associated with income. Men and White adults are more likely to participate in adequate amounts compared to women and non-White adults, respectively. The youngest adults (18-24) are most likely to engage in aerobic activity.

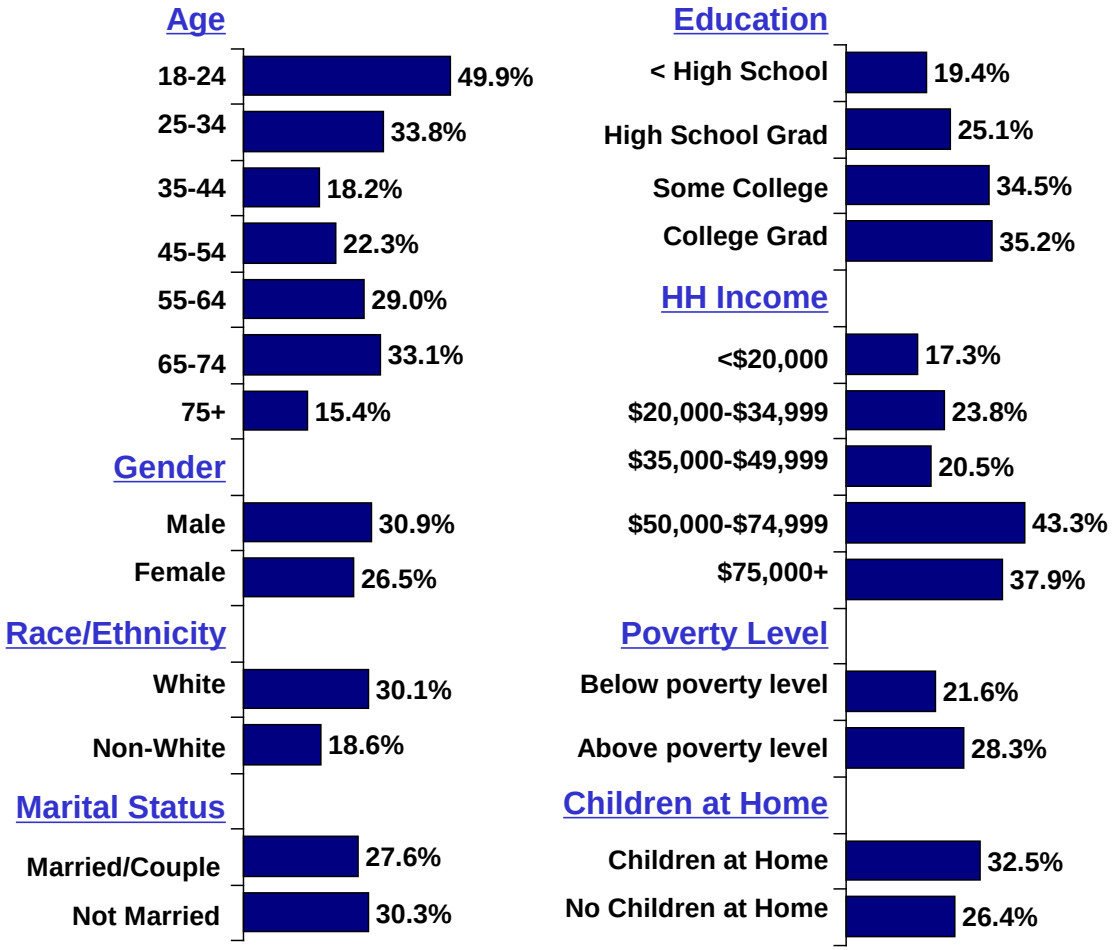
## Leisure Time Physical Activity (Cont'd.)

### Adequate Aerobic Physical Activity* (Total Sample)



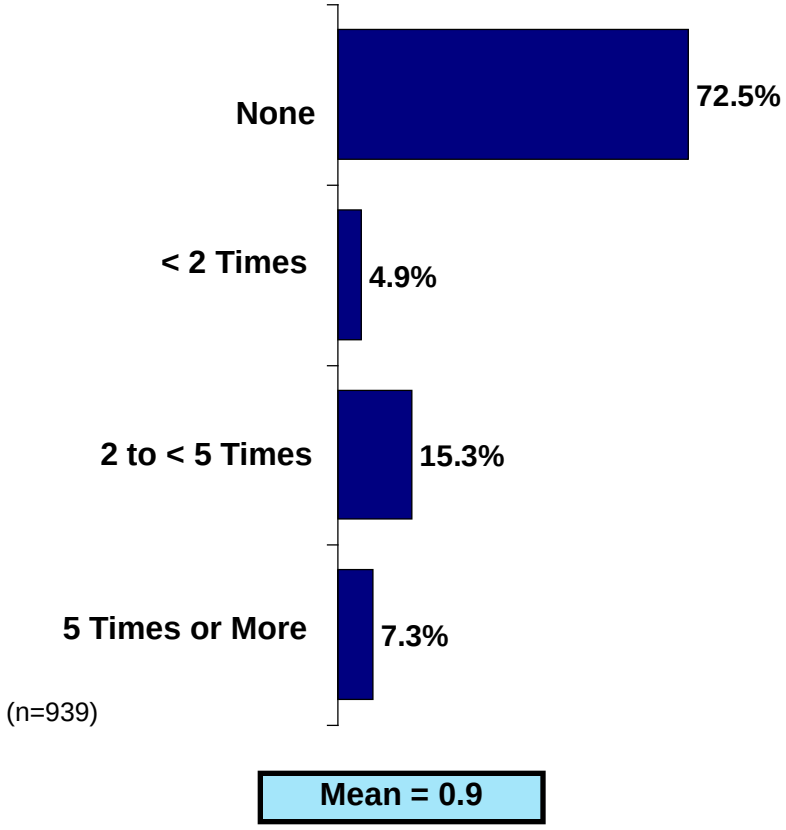

*Among all adults, the proportion who reported that they do either moderate physical activities for at least 150 minutes per week, vigorous physical activities for at least 75 minutes per week, or an equivalent combination of moderate and vigorous physical activities.

### Adequate Aerobic Physical Activity by Demographics



Among SHGMH area adults, seven in ten (72.5%) do not engage in any muscle-strengthening activities. On the other hand, more than one in five (22.6%) perform muscle-strengthening activities at least twice a week.

## Number of Times Performed Physical Activities to Strengthen Muscles Per Week in Past Month

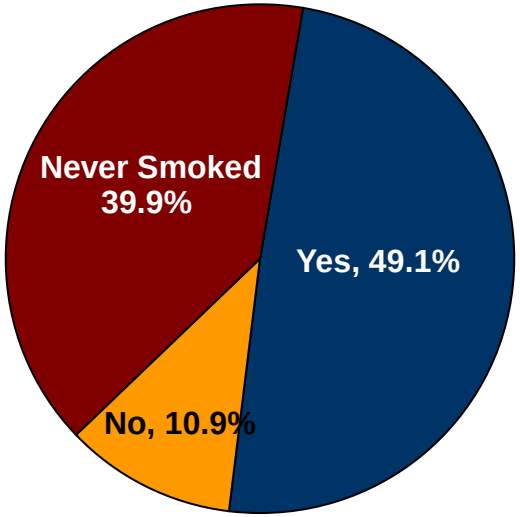



Q18.4: During the past month, how many times per week, or per month, did you do physical activities or exercises to STRENGTHEN your muscles? DO NOT count aerobic activities like walking, running, or bicycling. Count activities using your body weight like yoga, sit-ups or push-ups and those using weight machines, free weights, or elastic bands.

Almost half (49.1%) of area adults have smoked at least 100 cigarettes in their lifetime. Of these, 45.6% currently smoke every day and 4.6% smoke some days; these individuals are classified as smokers. Approximately one-fourth (24.7%) of area adults are smokers and 24.4% are considered former smokers (smoked at least 100 cigarettes in their life but currently do not smoke at all).

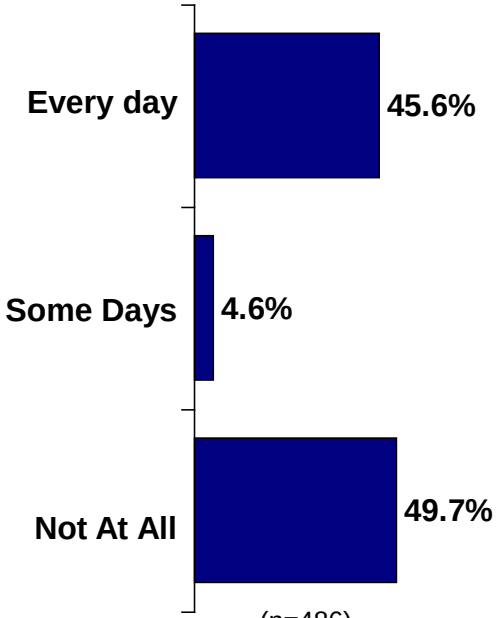
## Cigarette Smoking

### Smoked 100 Cigarettes in Lifetime



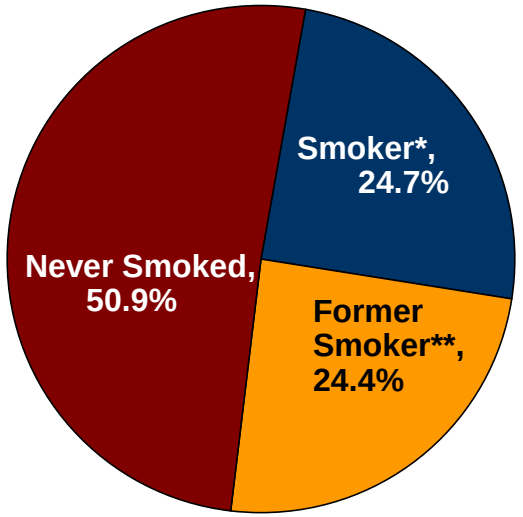

(n=979)

### Frequency of Current Use (Among Those Who Smoked at Least 100 Cigarettes in Their Lifetime)




(n=486)

### Smoking Status




(n=979)

Q12.1: Have you smoked at least 100 cigarettes in your entire life?
Q12.2: Do you now smoke cigarettes everyday, some days, or not at all?

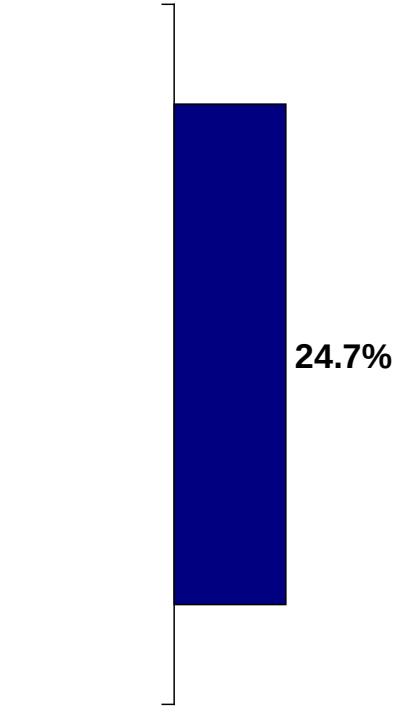
*Among all adults, the proportion who reported that they had ever smoked at least 100 cigarettes (5 packs) in their life and that they smoke cigarettes now, either every day or on some days.

**Among all adults, the proportion who reported that they had ever smoked at least 100 cigarettes (5 packs) in their life but they do not smoke now.

Cigarette smoking is strongly associated with education and income; adults with no high school degree are more likely to smoke than those with more education, and adults from households with incomes of $50K or more are far less likely to smoke compared to those who have lower incomes. Additionally, non-White adults are more likely to smoke compared to White adults.

## Cigarette Smoking (Cont'd.)

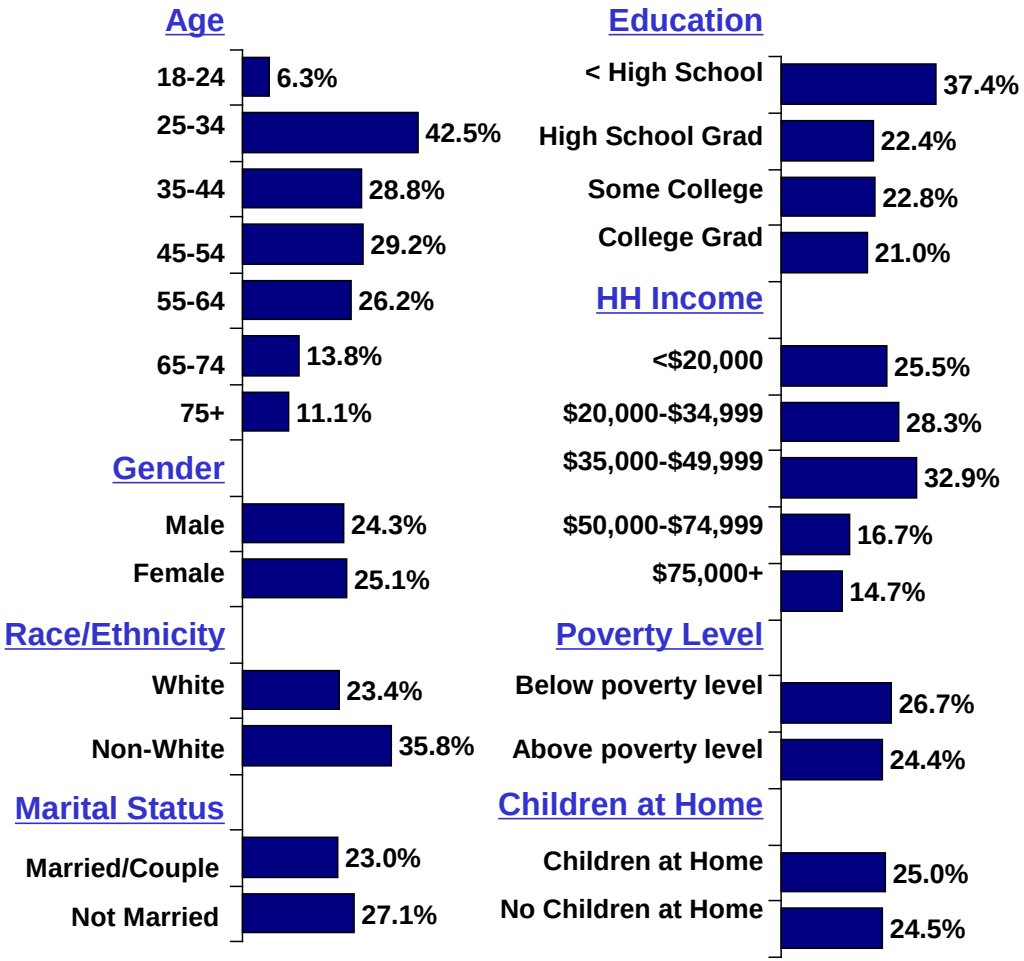
### Current Cigarette Smoking* (Total Sample)




(n=979)

*Among all adults, the proportion who reported that they had ever smoked at least 100 cigarettes (5 packs) in their life and that they smoke cigarettes now, either every day or on some days.

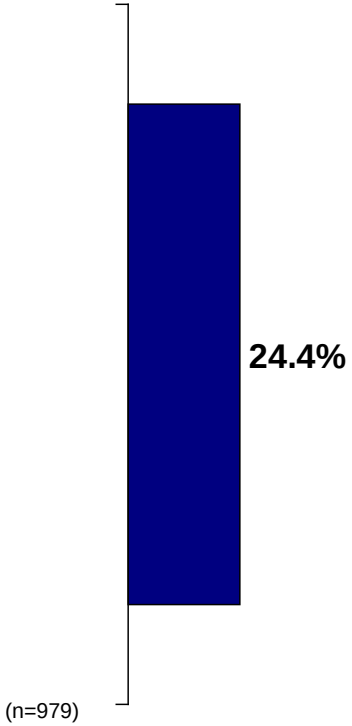
### Current Cigarette Smoking by Demographics



Area adults most likely to be former smokers come from groups that are male, White, married, and have no children at home. Being a former smoker is also directly related to age.

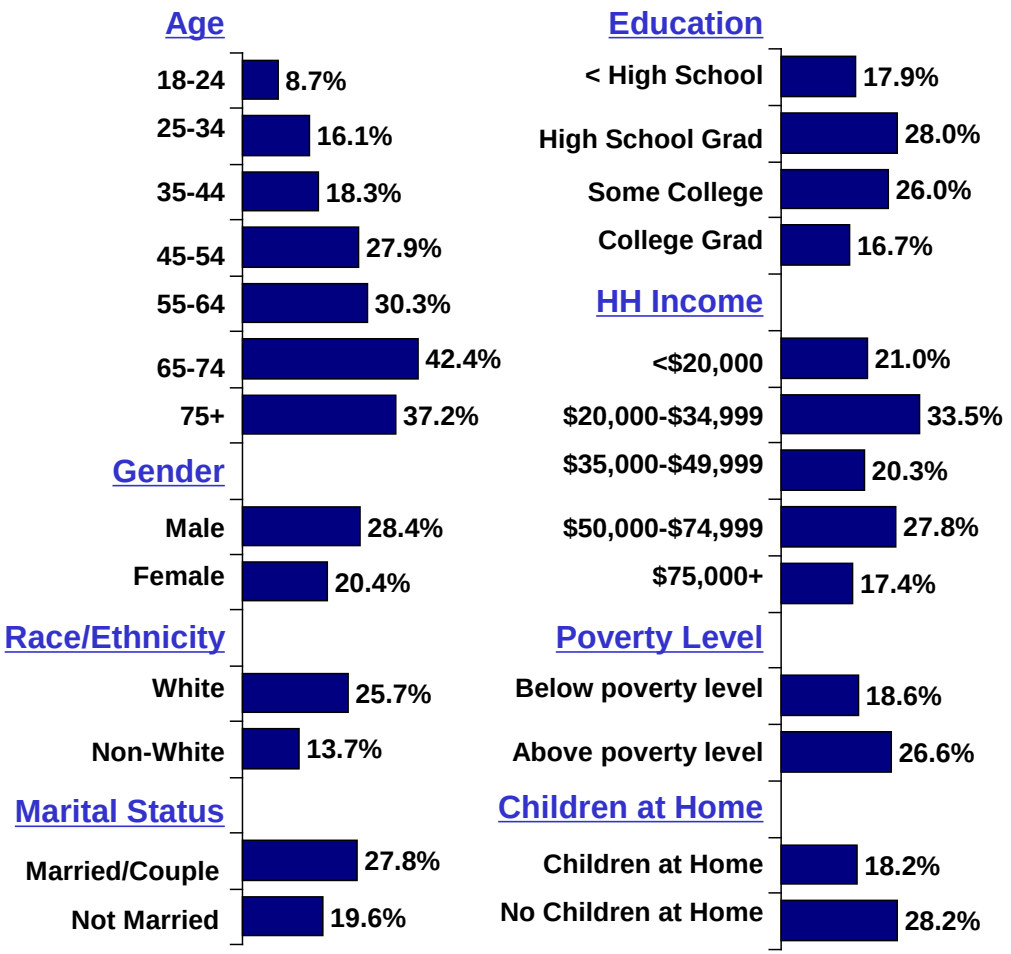
## Cigarette Smoking (Cont'd.)

### Former Cigarette Smoking* (Total Sample)




*Among all adults, the proportion who reported that they had ever smoked at least 100 cigarettes (5 packs) in their life but they do not smoke now.

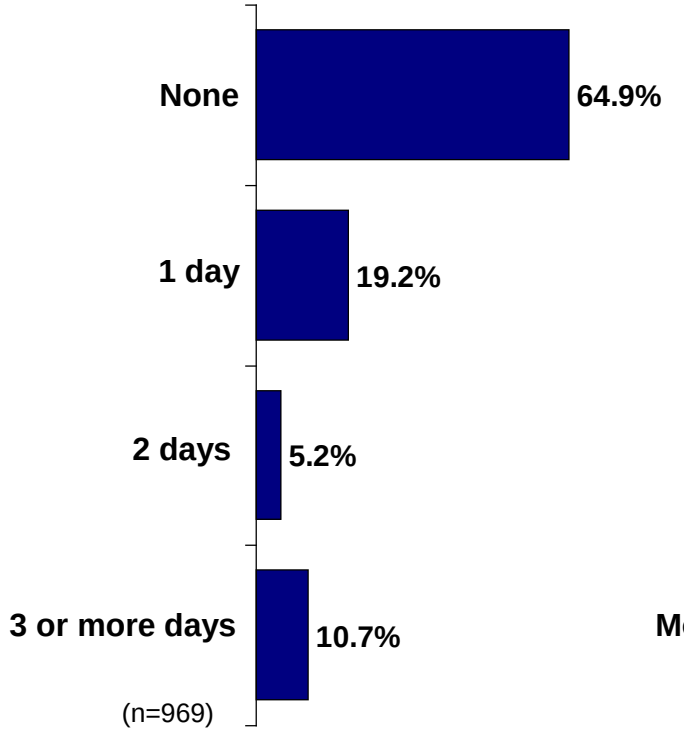
### Former Cigarette Smoking by Demographics



With regard to alcohol consumption, more than six in ten (64.9%) area adults are considered non-drinkers because they did not consume any alcohol during the past month. More than one-fourth (28.7%) are considered to be light to moderate drinkers. Heavy drinkers comprise 6.4% of area adults, meaning they consume an average of more than eight (if female) or fourteen drinks (if male) per week.

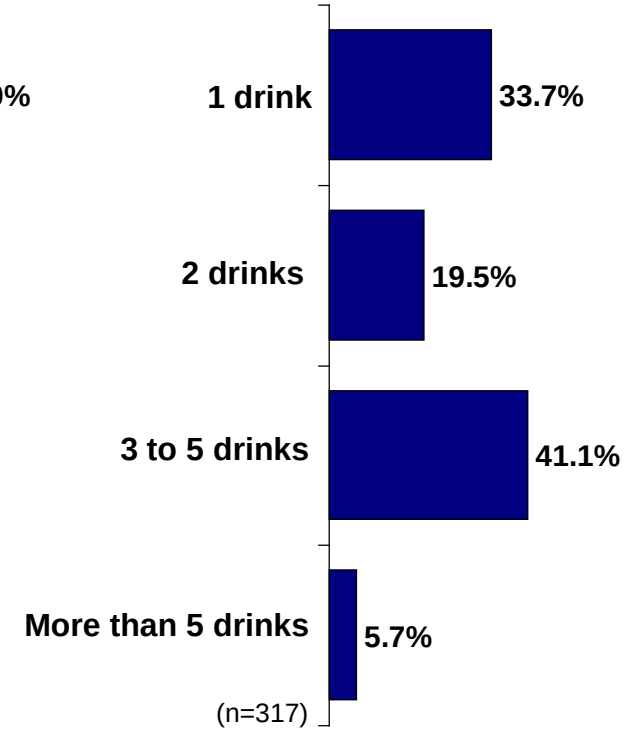
## Alcohol Consumption in Past 30 Days

### Number of Days Per Week Drank Alcohol in Past 30 Days




**Mean (All) = 0.8**
**Mean (Drinkers) = 2.2**

### Average Number of Drinks When Drinking




**Mean = 2.6**

### Drinking Status

| | |
|---|---|
| Non Drinker | 64.9% |
| Light/Moderate Drinker | 28.7% |
| Heavy Drinker | 6.4% |

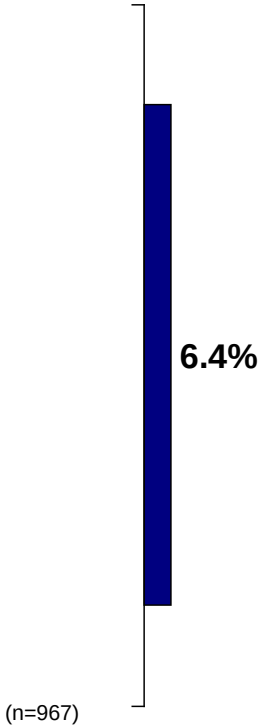
(n=967)

Q20.1: During the past 30 days, how many days per week, or per month did you have at least one drink of any alcoholic beverage such as beer, wine, a malt beverage, or liquor?
Q20.2: One drink is equivalent to a 12-ounce beer, a 5-ounce glass of wine, or a drink with one shot of liquor. During the past 30 days, on the days when you drank, about how many drinks did you drink on the average?

Men and non-White adults are more likely to drink heavily than women and White adults, respectively. Moreover, unmarried adults and those with no children at home are more likely to engage in heavy drinking than married adults or those with children at home, respectively.

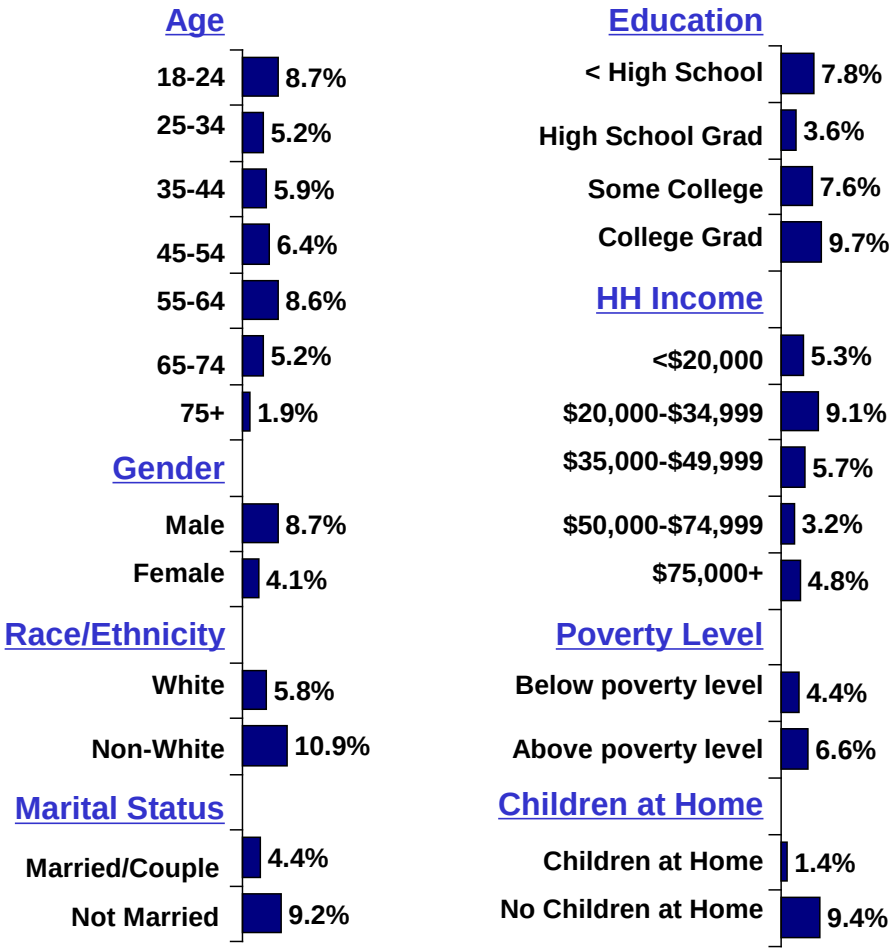
## Alcohol Consumption (Cont'd.)

### Heavy Drinking* (Total Sample)




*Among all adults, the proportion who reported consuming an average of more than two alcoholic drinks per day for men and one per day for women in the previous month.

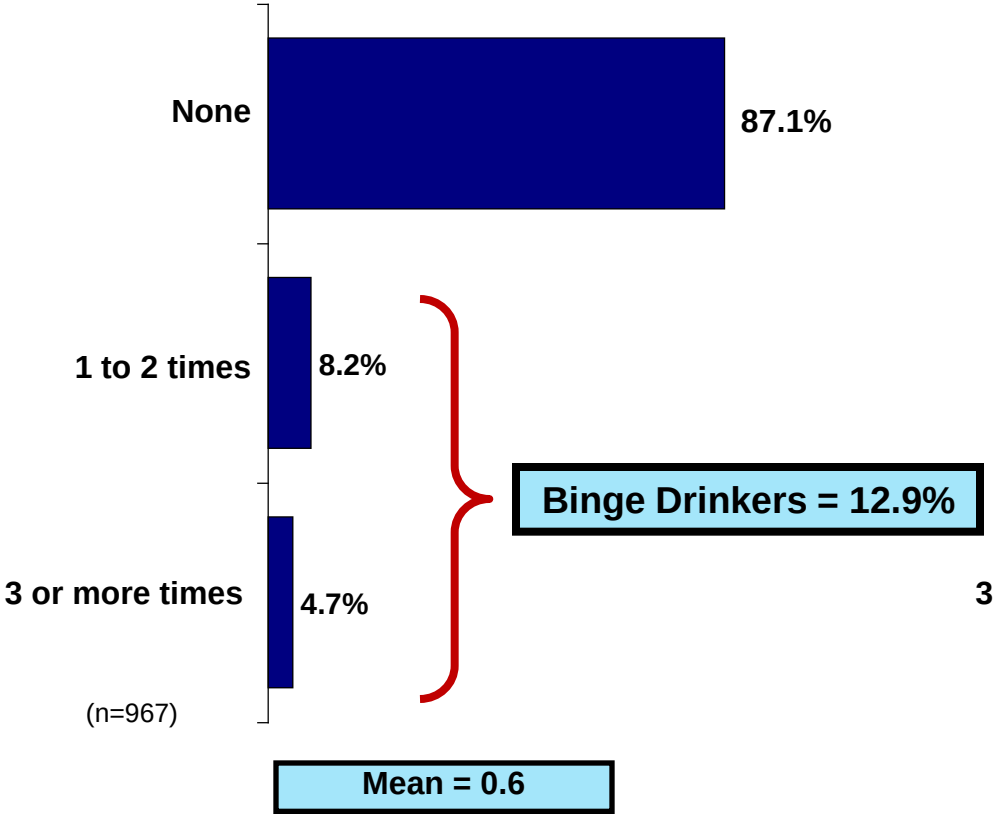
### Heavy Drinking by Demographics



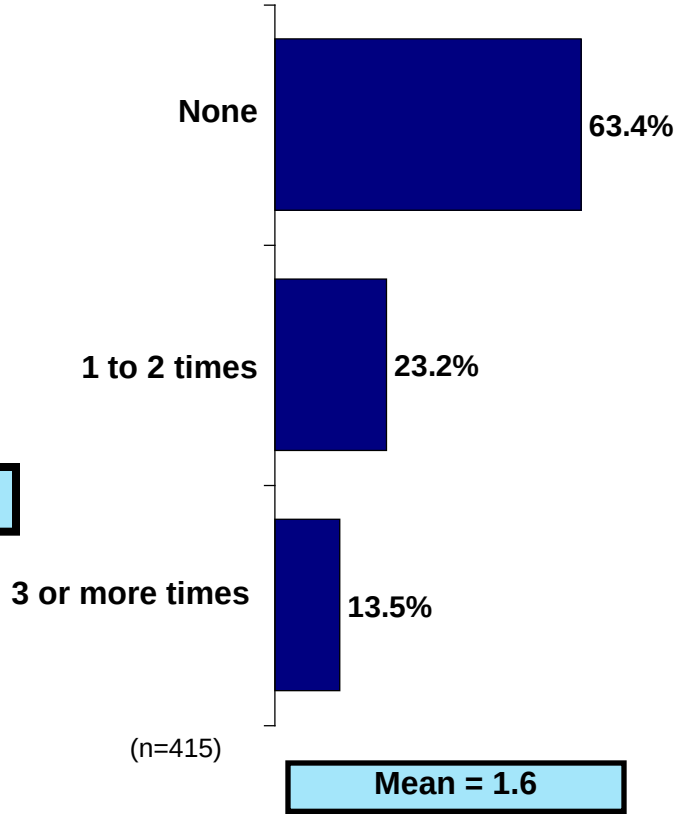
Among all adults, more than one in ten (12.9%) have engaged in binge drinking in the past 30 days. **Among those who drink, this proportion rises to 36.7%**.

## Binge Drinking

### Number of Times Consumed 5 or More (Men)/4 or More (Women) Drinks on an Occasion in Past 30 Days (All Adults)




### Number of Times Consumed 5 or More (Men)/4 or More (Women) Drinks on an Occasion in Past 30 Days (Drinkers)

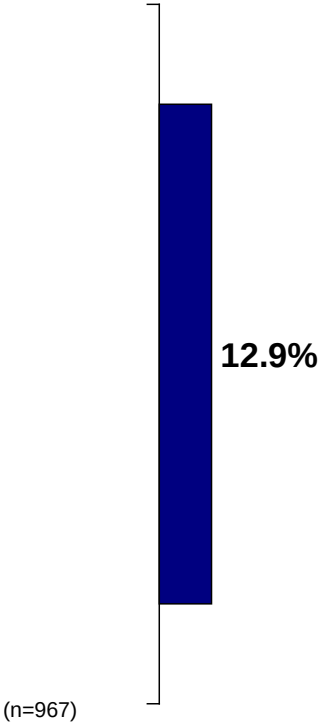



Q20.3: Considering all types of alcoholic beverages, how many times during the past 30 days did you have X (x=5 for men, x=4 for women) or more drinks on an occasion?

The prevalence of binge drinking is twice as high for men than it is for women and higher among adults younger than 35 years of age vs. older adults. Binge drinking is slightly more prevalent among adults with a college education compared to those with less education, and more prevalent among adults with the highest incomes, compared to those with lower incomes. Additionally, it is more prevalent among non-White adults compared to White adults.

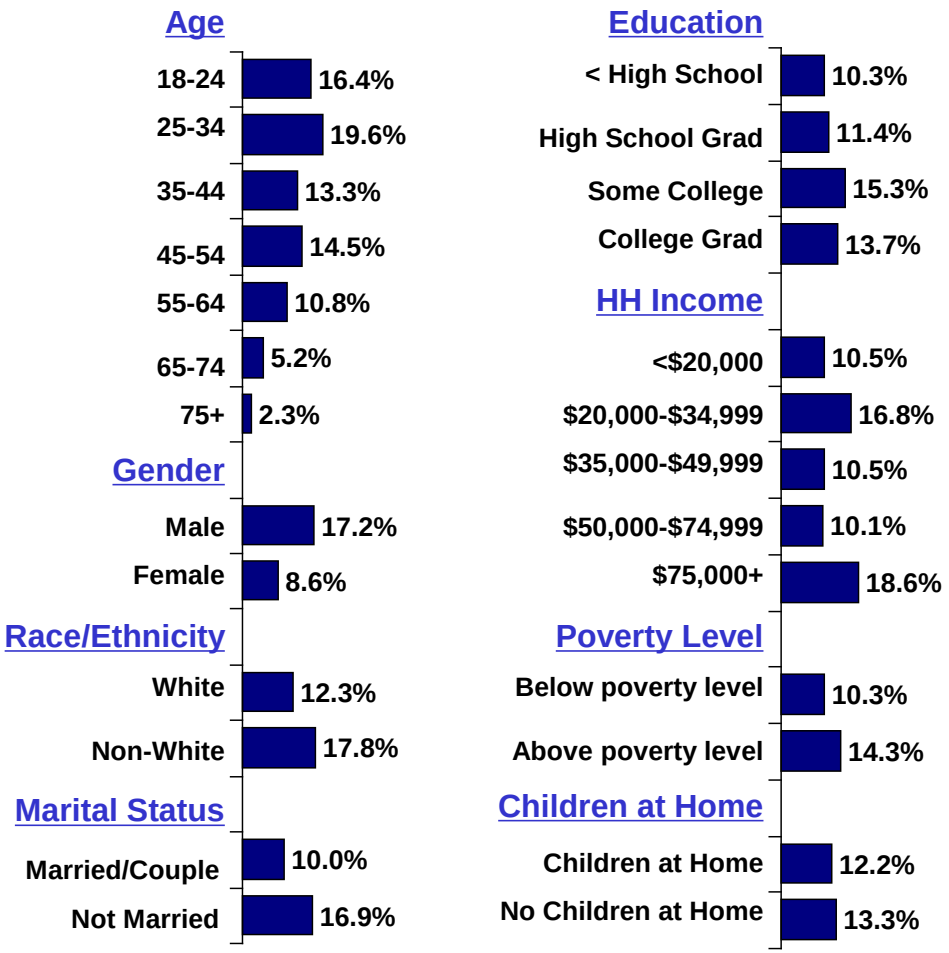
# Alcohol Consumption

## Binge Drinking* (Total Sample)



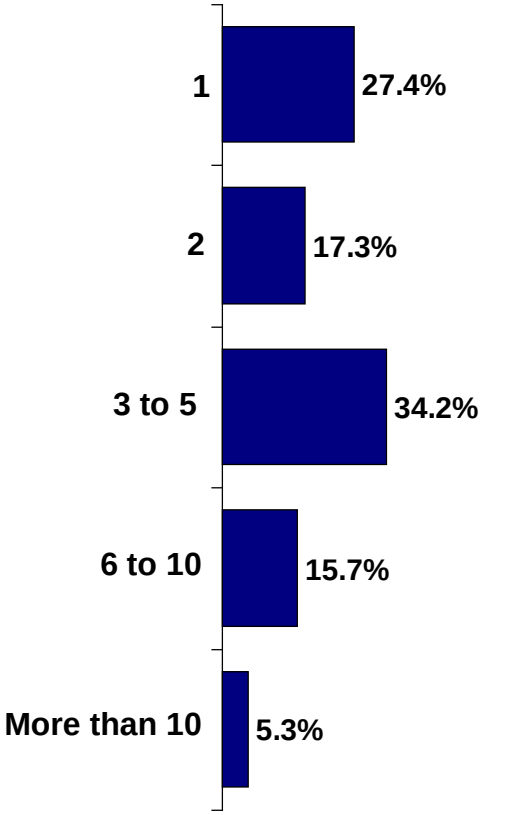

*Among all adults, the proportion who reported consuming five or more drinks per occasion (for men) or four or more drinks per occasion (for women) at least once in the previous month.

## Binge Drinking by Demographics



Among SHGMH area adults who drink alcohol, 44.7% have at most consumed one to two drinks on any occasion in the past 30 days, while 21.0% have consumed six or more drinks.

## Largest Number of Drinks Consumed on One Occasion in Past 30 Days (Among Drinkers)




(n=314)

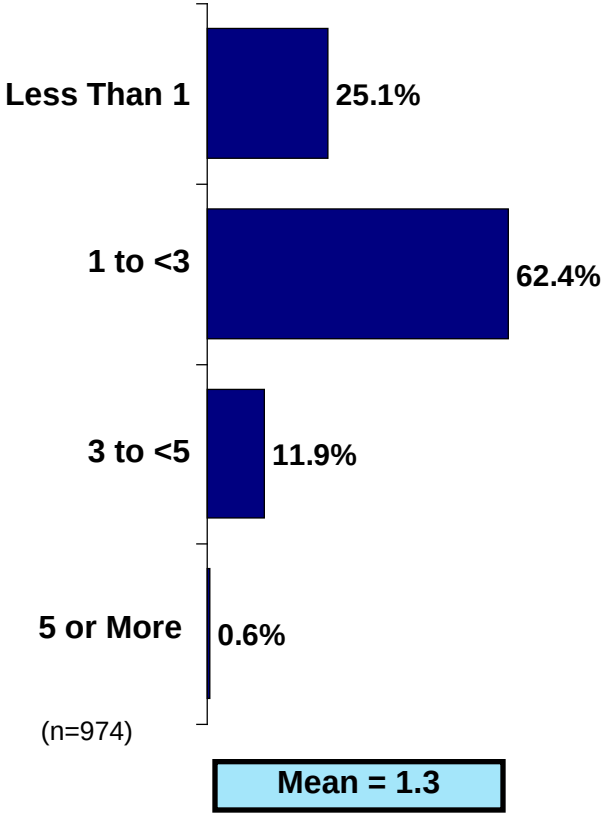
**Mean = 3.7**
**Median = 3.0**

Q20.4: During the past 30 days, what is the largest number of drinks you had on any occasion?

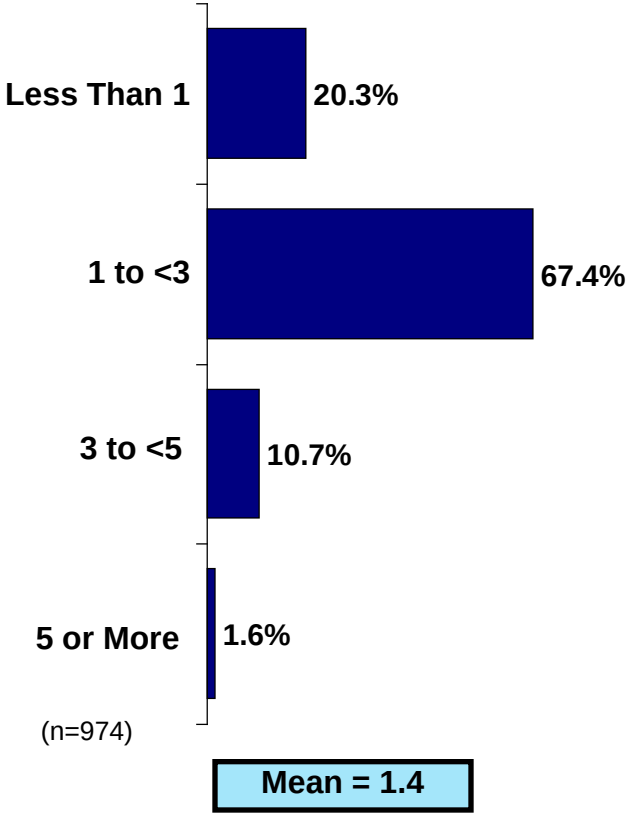
Area adults consume minor quantities of fruit (including 100% fruit juice) and vegetables per day, averaging less than two times a day for each. Taken together, fruits and vegetables are consumed on average just under three times per day. Still, only 13.5% of adults consume adequate amounts (five times) of fruits and vegetables per day.

## Consumption of Fruit and Vegetables

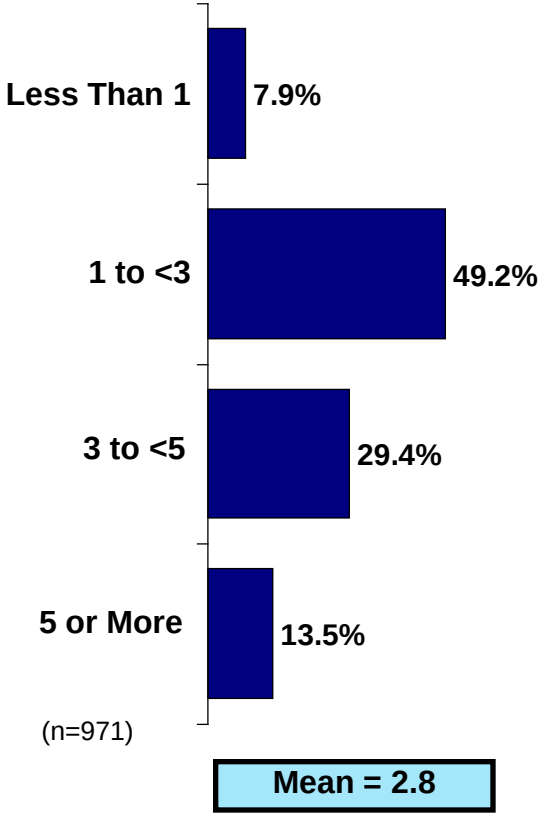
### Number of Times Consumed Fruit/Fruit Juice Per Day




### Number of Times Consumed Vegetables Per Day




### Number of Times Consumed Fruits or Vegetables Per Day



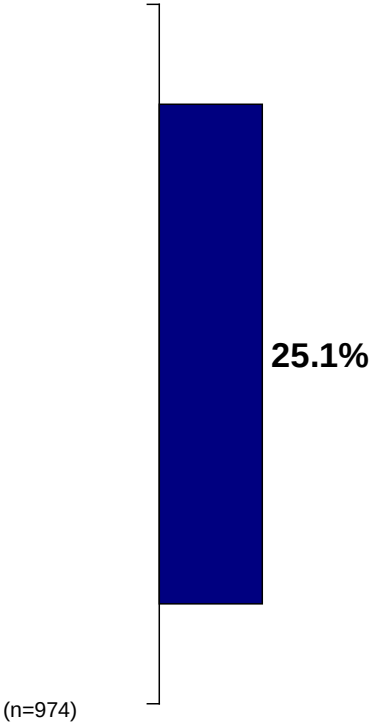

Q15.1: During the past month, how many times per day, week, or month did you eat fruit or drink 100% PURE fruit juices? Do not include fruit flavored drinks with added sugar or fruit juice you made at home and added sugar to. Only include 100% juice.

Q15.2: During the past month, how many times per day, week, or month did you eat vegetables, for example broccoli, sweet potatoes, carrots, tomatoes, V-8 juice, corn, cooked or fresh leafy greens including romaine, chard, collard greens, or spinach?

There are very few differences demographically when it comes to adults consuming fruit less than one time per day. Adults least likely to consume fruits less than one time per day come from groups that are age 18-24 or 35-44, non-White, have a college education, and have incomes of $75K or more.

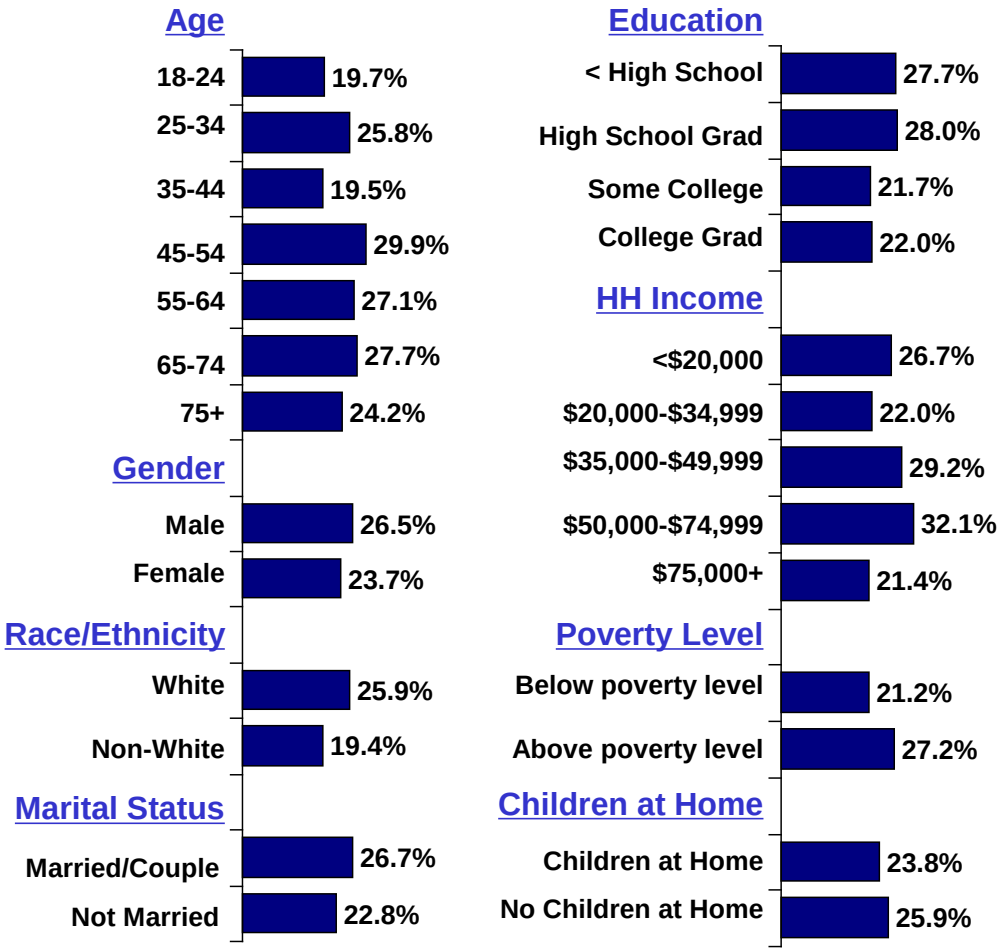
## Fruit Consumption

### Consumed Fruits <1 Time Per Day* (Total Sample)




*Among all adults, the proportion whose total reported consumption of fruits (including juice) was less than one time per day.

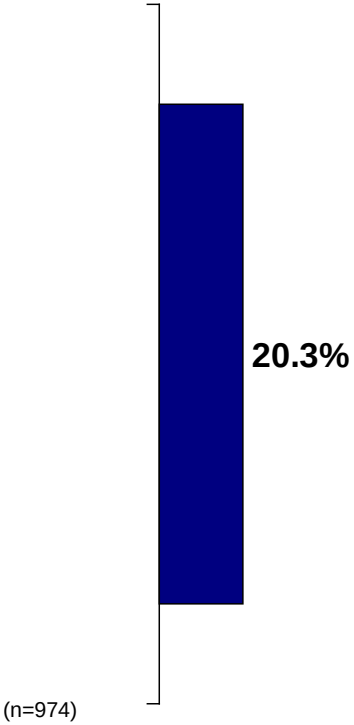
### Consumed Fruits <1 Time Per Day by Demographics



Consumption of vegetables less than once per day is inversely related to level of education; 23.4% of adults with no high school degree consume vegetables less than one time per day, compared to 9.9% of adults with a college degree. Adults under age 35 are more likely to consume vegetables less than once per day compared to older adults.

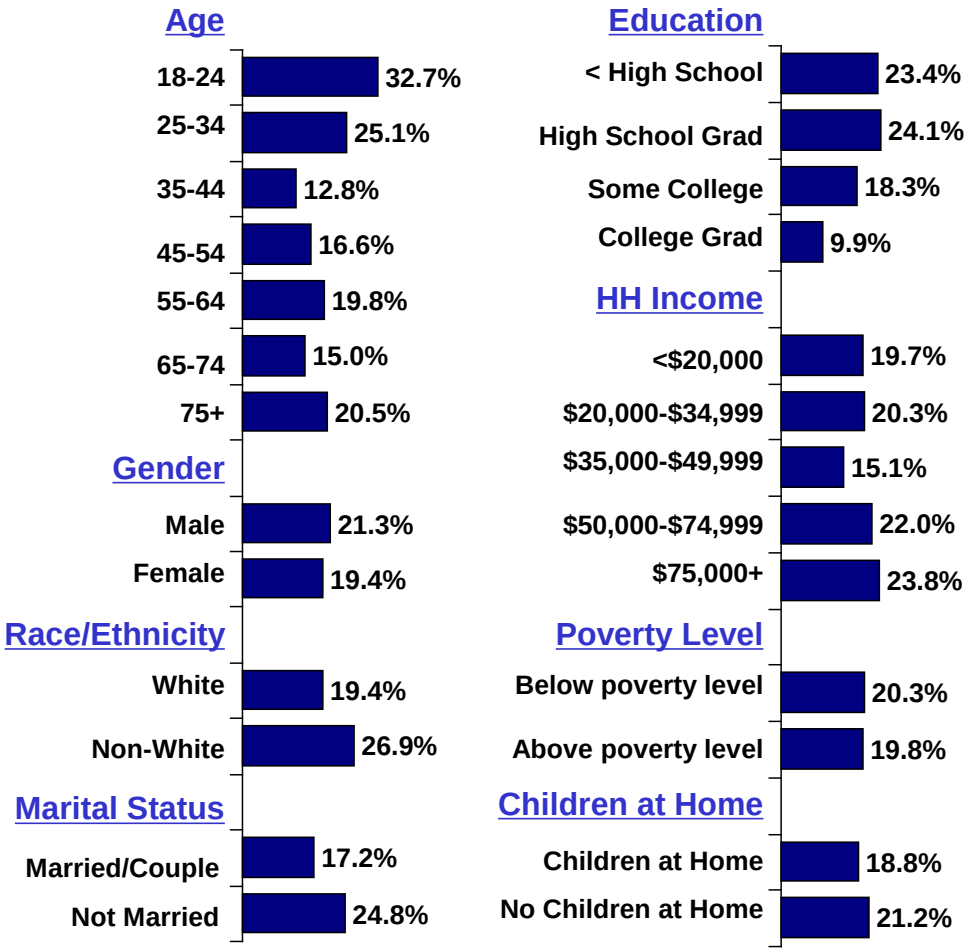
## Vegetable Consumption

### Consumed Vegetables <1 Time Per Day* (Total Sample)




*Among all adults, the proportion whose total reported consumption of fruits (including juice) was less than one time per day.

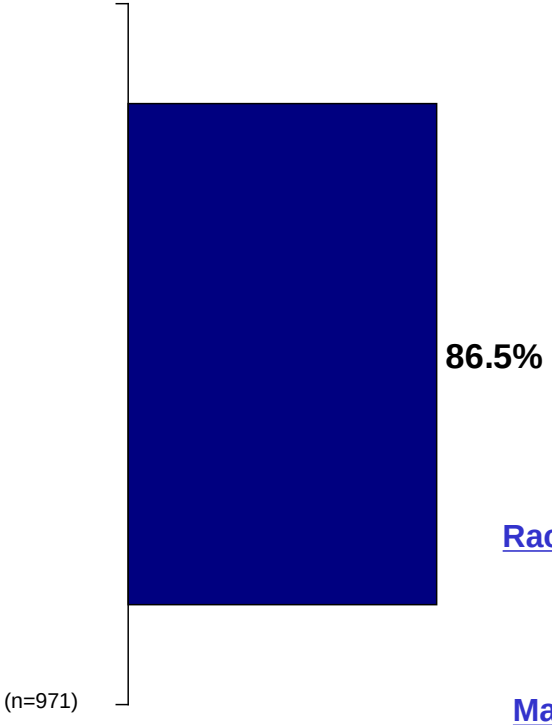
### Consumed Vegetables <1 Time Per Day by Demographics



Inadequate fruit and vegetable consumption is prevalent in the SHGMH area across demographics. Adequate fruit and vegetable consumption is directly related to education, and women and married adults tend to consume more fruits and vegetables than men and unmarried adults, respectively.

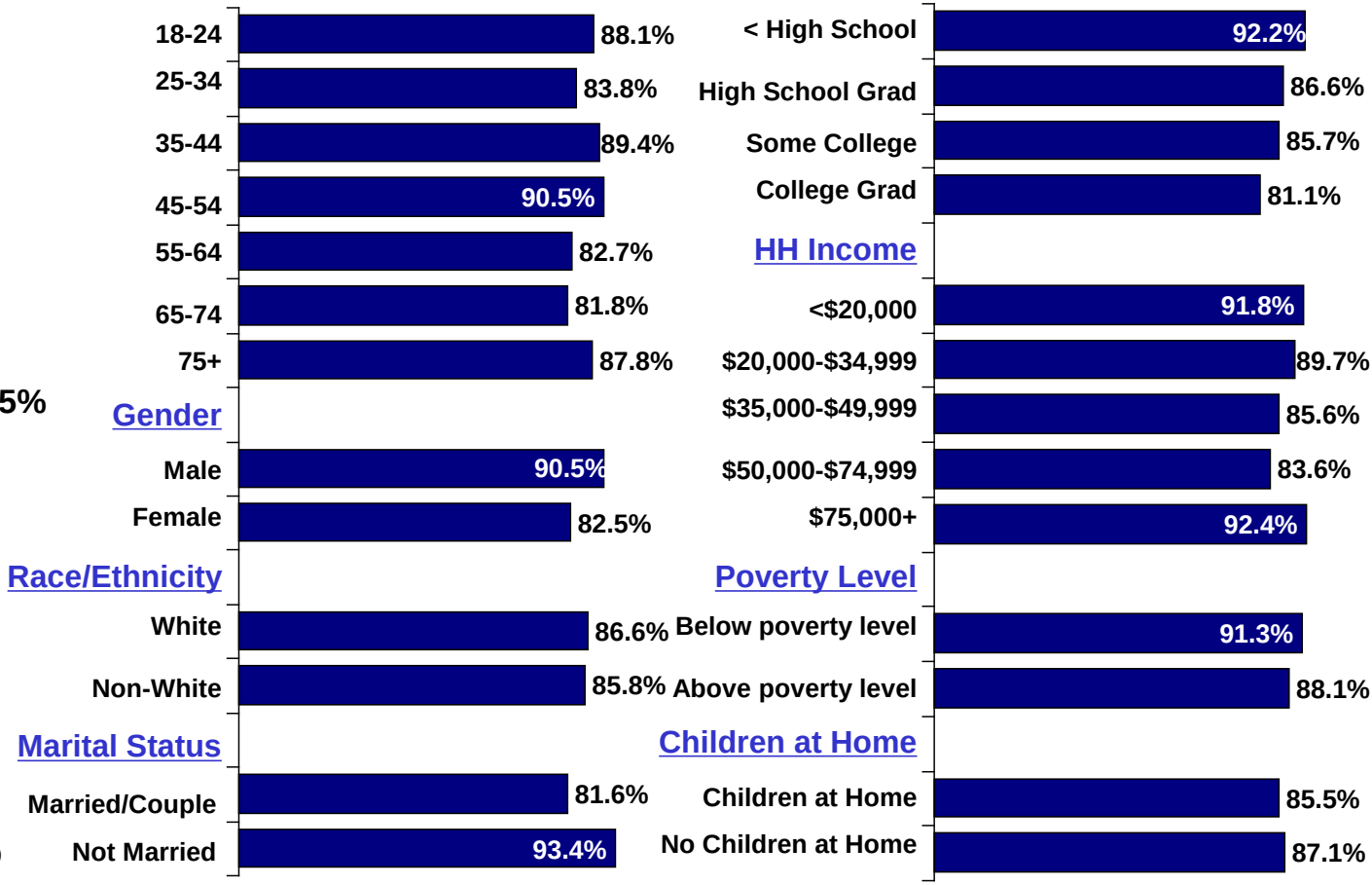
## Fruit and Vegetable Consumption

### Inadequate Fruit and Vegetable Consumption* (Total Sample)



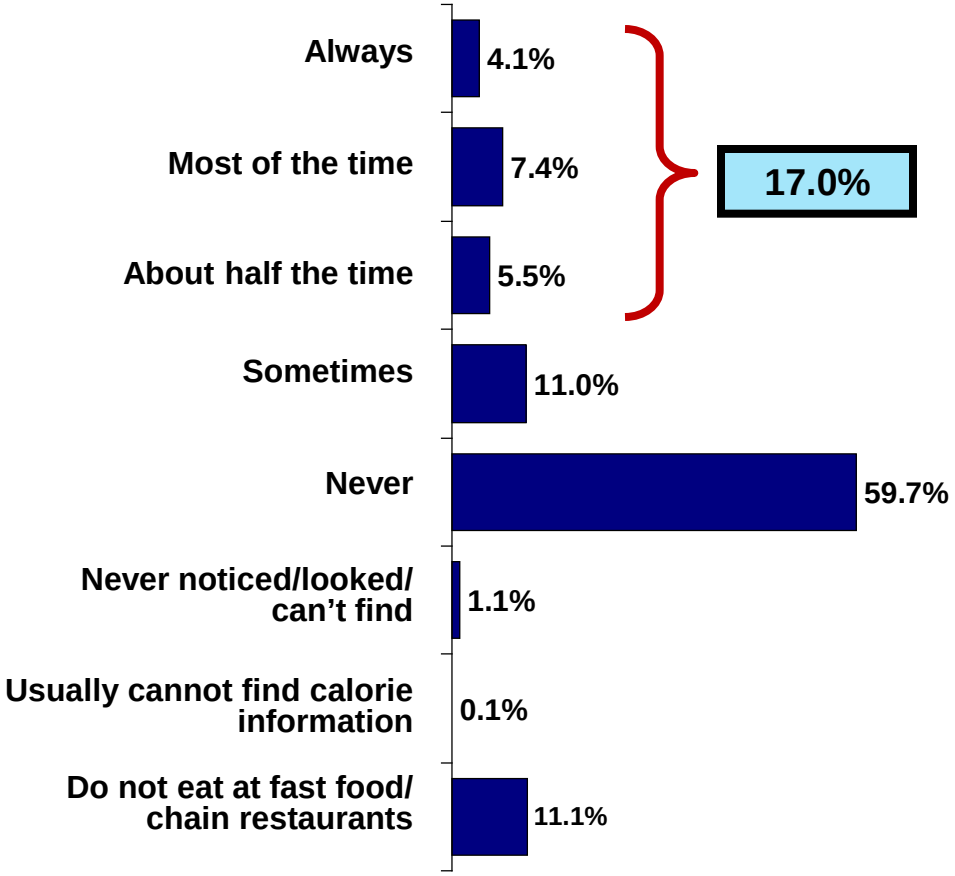

*Among all adults, the proportion whose total frequency of consumption of fruits (including juice) and vegetables was less than five times per day.

### Inadequate Consumption by Demographics



Fewer than one in five (17.0%) of adults report that when eating at fast food restaurants, listed calorie information impacts their decision on what to order at least half the time. However, six in ten (59.7%) say calorie information never impacts their decision.

## Frequency Calorie Information Helps in Deciding What to Order When Dining Out



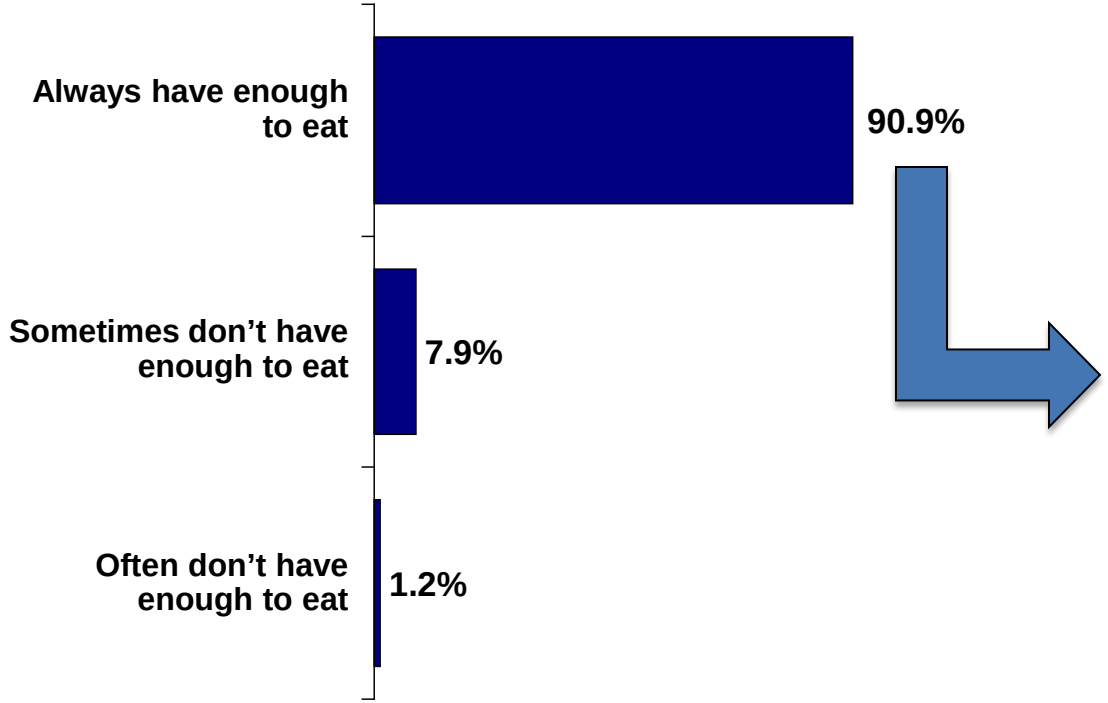

(n=977)

Q16.1: The next question is about eating out at fast food and chain restaurants. When calorie information is available in the restaurant, how often does this information help you decide what to order?

Nine in ten adults (90.9%) say they always have enough to eat, and of these, more than nine in ten are able to eat the foods they want (93.1%).

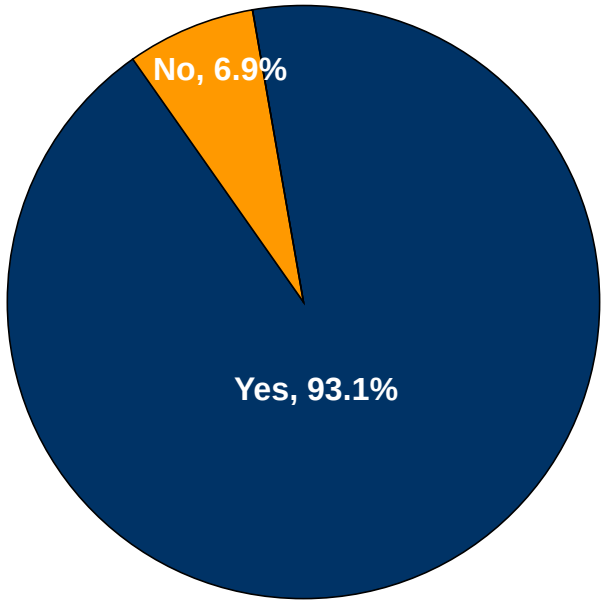
## Food Access and Sufficiency

### Food Sufficiency




(n=978)

### Access to Foods Wanted



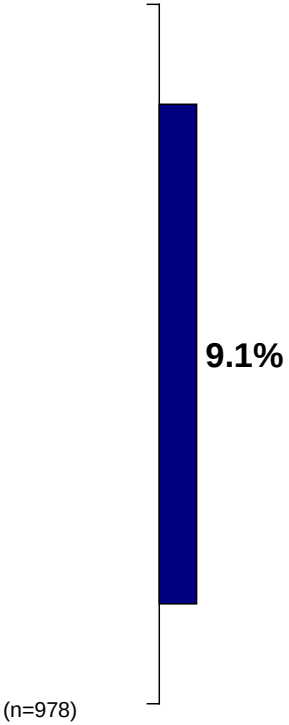

(n=902)

Q17.1: Which of the following statements best describes the food eaten in your household within the last 12 months? Would you say that…
Q17.2: Were these foods always the kinds of foods that you wanted to eat?

Among area adults, the groups most likely to experience food insufficiencies are: younger (25-34), have incomes below $20K, and live below the poverty line. Groups least likely to experience food insufficiency include college graduates and those with incomes of $75K or higher.

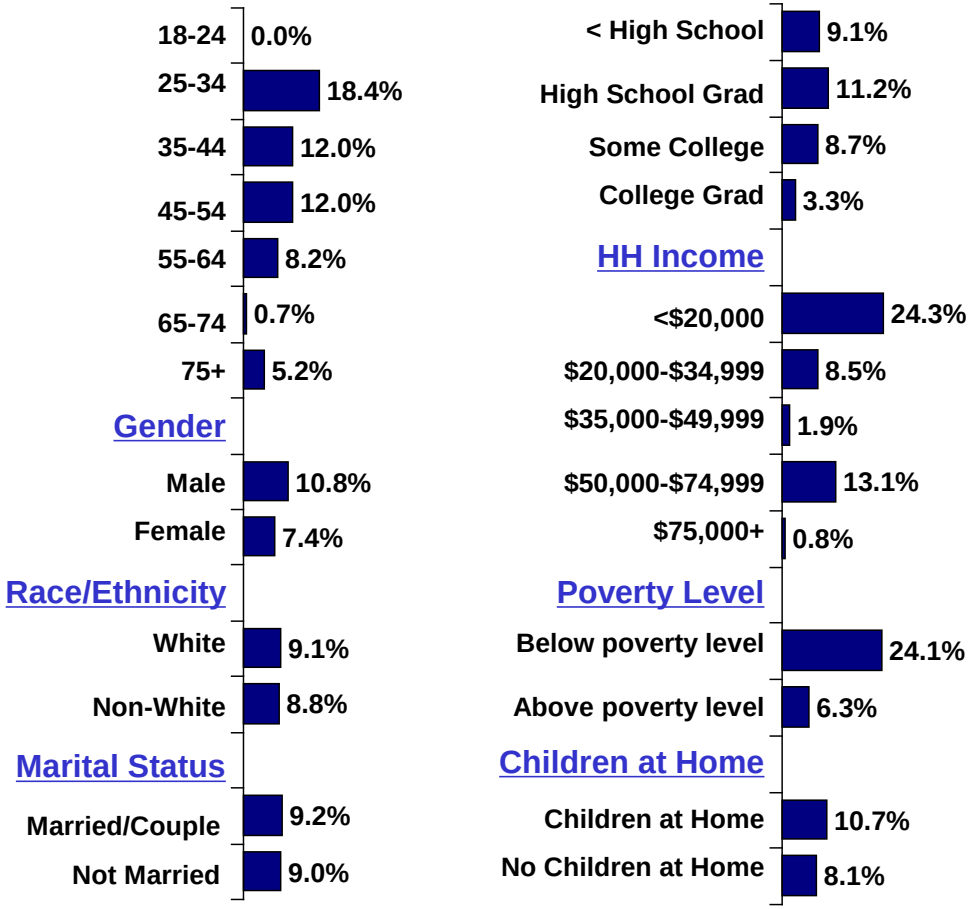
## Food Sufficiency

### Sometimes/Often Don't Have Enough to Eat* (Total Sample)




*Among all adults, the proportion who reported they sometimes or often do not have enough to eat.

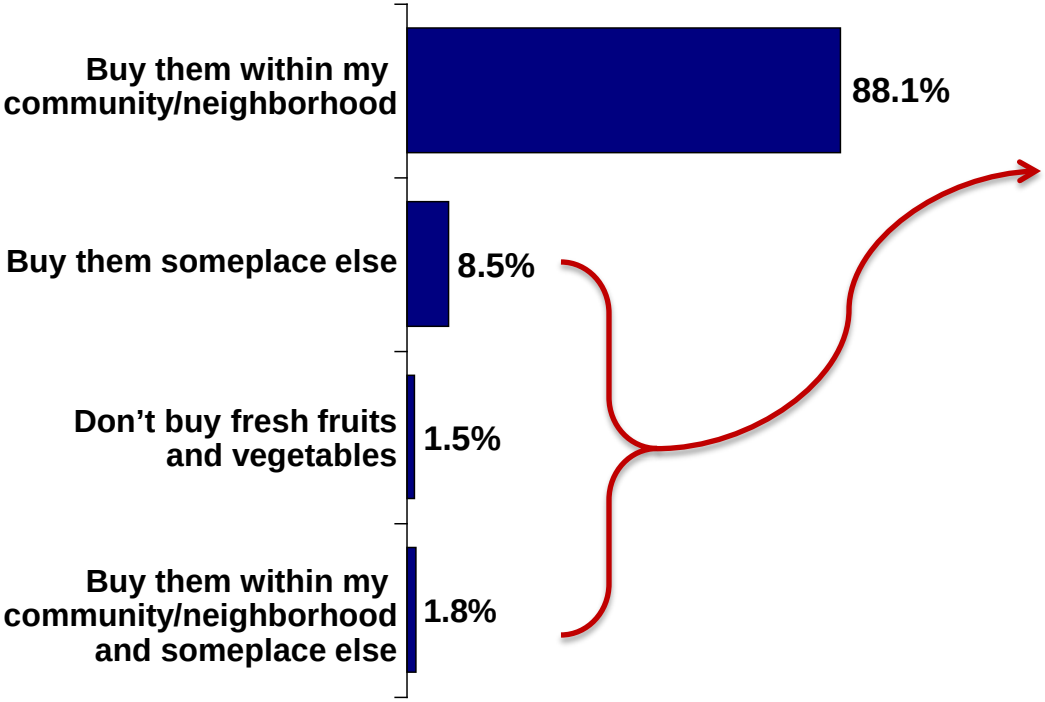
### Sometimes/Often Don't Have Enough to Eat by Demographics



Almost nine in ten adults (88.1%) say they purchase fresh fruits and vegetables within their community. Those who don't say the **stores in their community are too expensive** or that they have **poor quality produce**. Nearly one in five report there are **no stores in their community**.

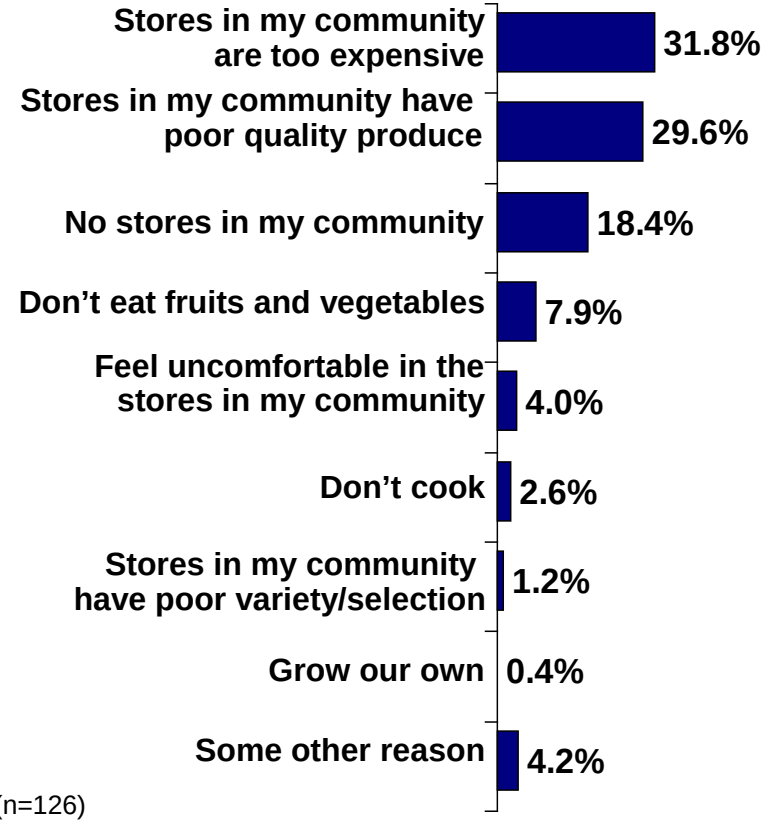
## Purchasing Fresh Fruits and Vegetables

### Location of Fresh Fruits/ Vegetables Purchased




(n=975)

### Reasons for Not Purchasing All Fresh Produce Locally



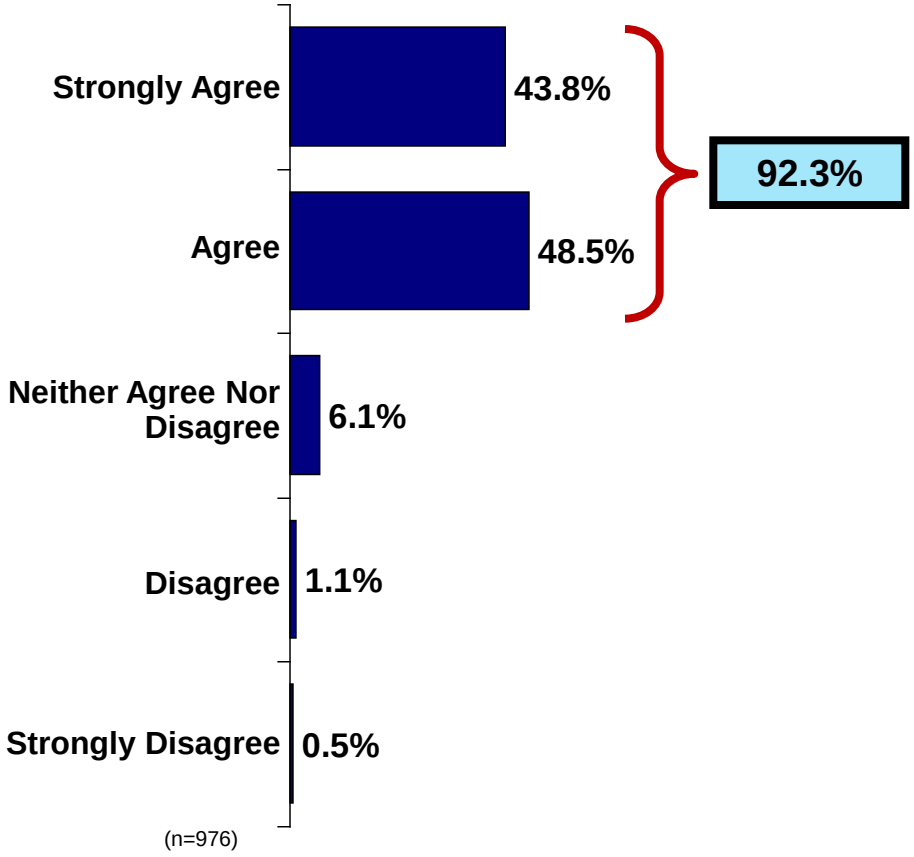

(n=126)

Q17.3: When you or someone in your household shops for fresh fruits and vegetables, would you say that…Which of the following statements best describes the food eaten in your household within the last 12 months? Would you say that…

Q17.4 What is the main reason you or someone in your household does not buy all your fresh fruits and vegetables within your community or neighborhood?

More than nine in ten (92.3%) report that fruits and vegetables are easy to find in their community or neighborhood.

## Availability of Fruits and Vegetables in the Community

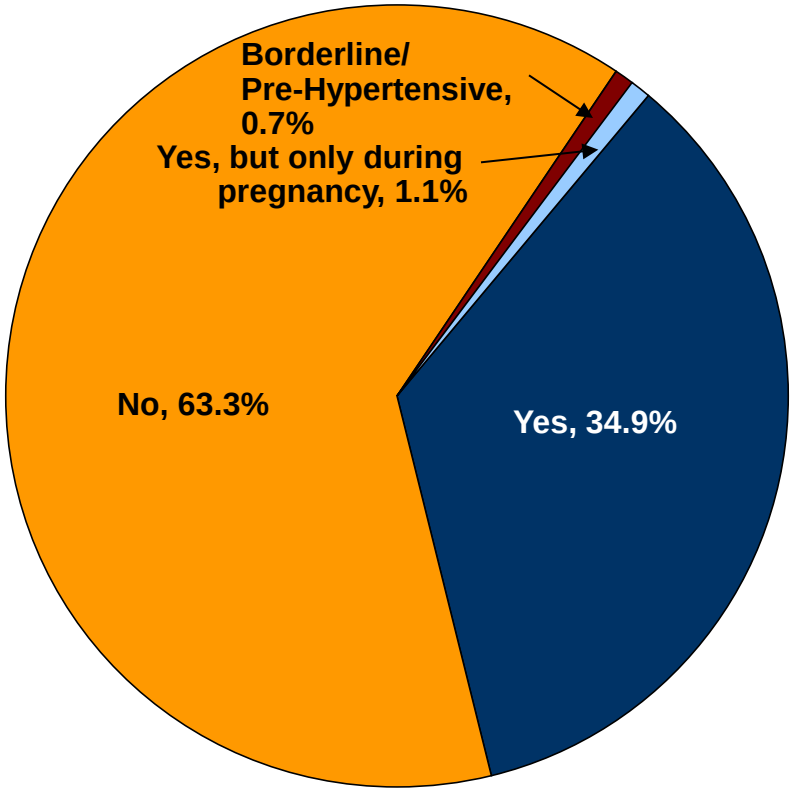



Q17.5: Please tell me how much you agree or disagree with the following statement. "It is easy to find fresh fruits and vegetables within your community or neighborhood." Would you say that you…

Just over one-third (34.9%) of area adults have been told by a health care professional they have high blood pressure (HBP). Among those who have HBP, **one-fourth (25.0%) are not currently taking medication for it**.

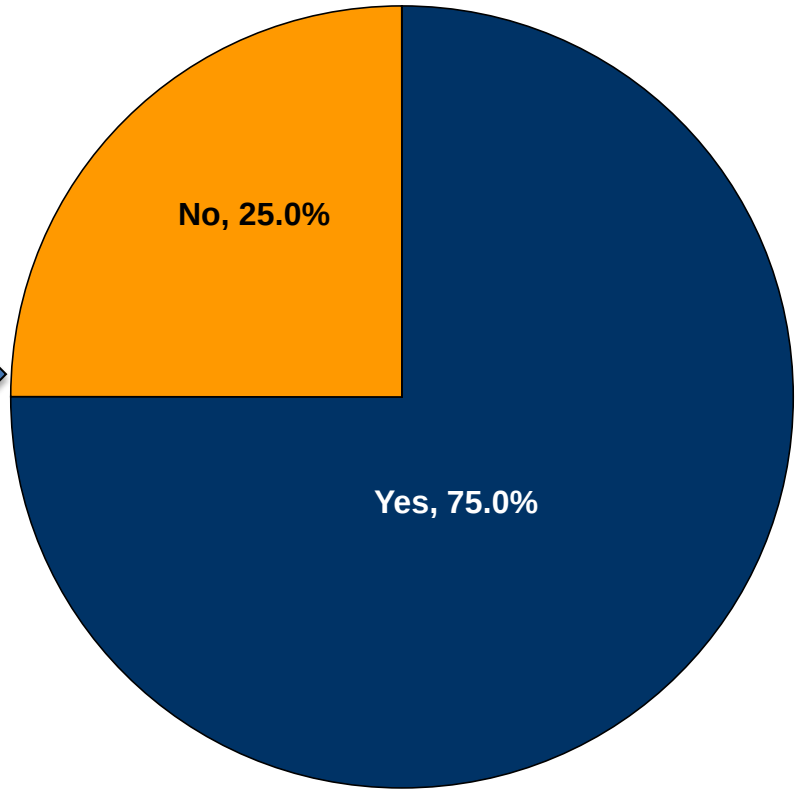
## Hypertension Awareness

### Ever Been Told You Have High Blood Pressure (Total Sample)




(n=978)

### Currently Taking Medication for HBP (Among Those Who Have Been Told They Have HBP)



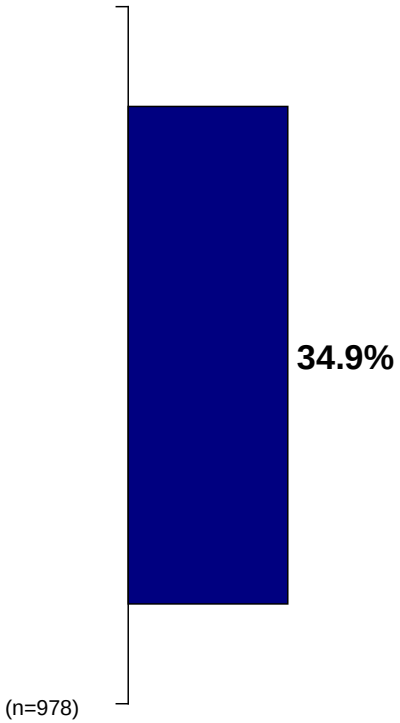

(n=439)

Q4.1: Have you EVER been told by a doctor, nurse, or other health professional that you have high blood pressure?
Q4.2: (IF YES) Are you currently taking medicine for your high blood pressure?

HBP is directly related to age. It is also significantly more common in adults with no high school degree vs. those with a college degree. It is also more common in adults from the following groups: White, married, and no children at home. It is least common in adults under age 45, college graduates, and those with incomes of $50K or more.

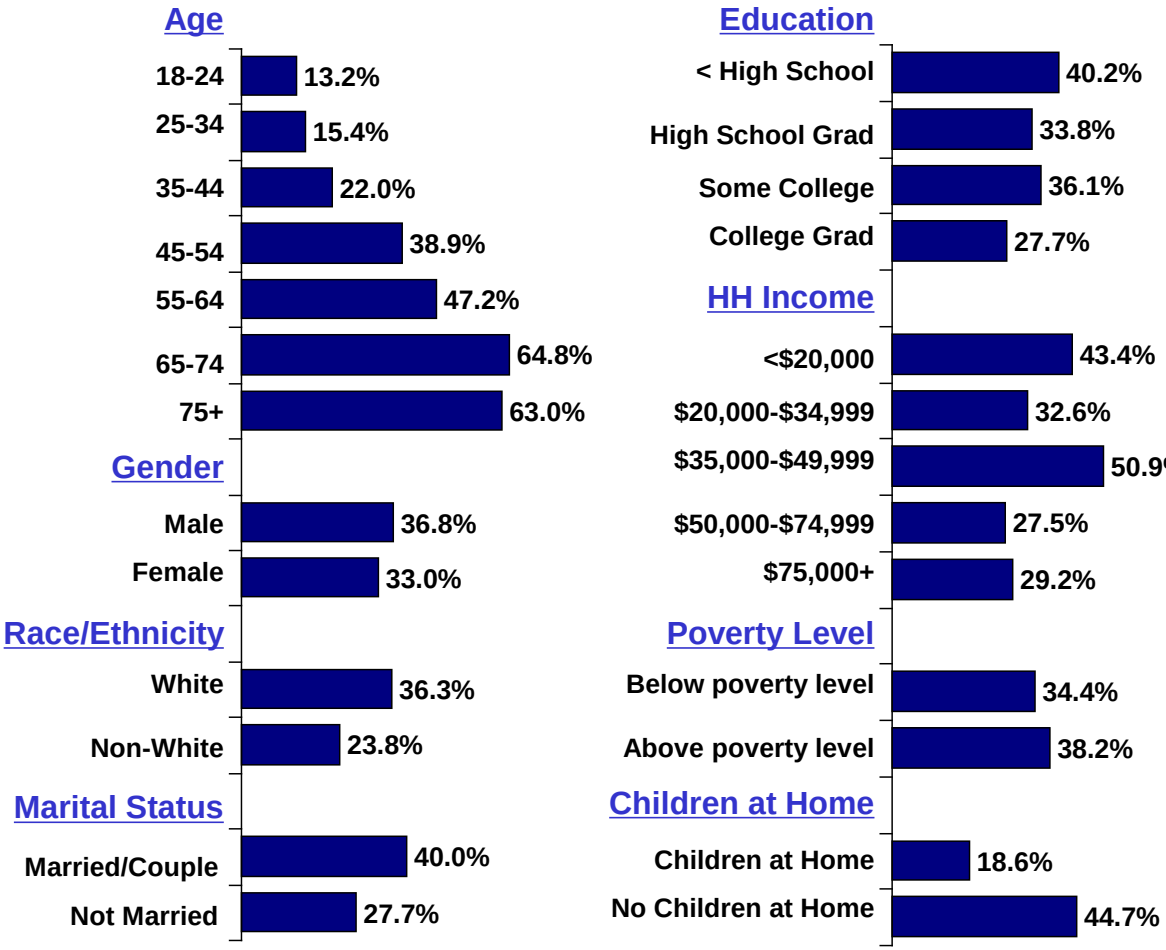
## Hypertension Awareness

### Ever Told Had High Blood Pressure (HBP)* (Total Sample)




*Among all adults, the proportion who reported that they were ever told by a health care professional that they have high blood pressure (HBP). Women who had high blood pressure only during pregnancy and adults who were borderline hypertensive were considered not to have been diagnosed.

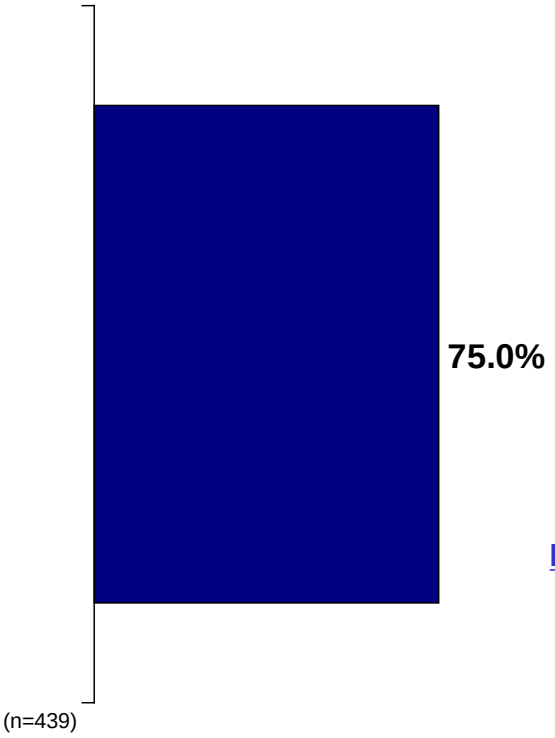
### Ever Told HBP by Demographics



Area adults most likely to take medication for their HBP include those who: are 45 years or older, female, non-White, and have no college education.

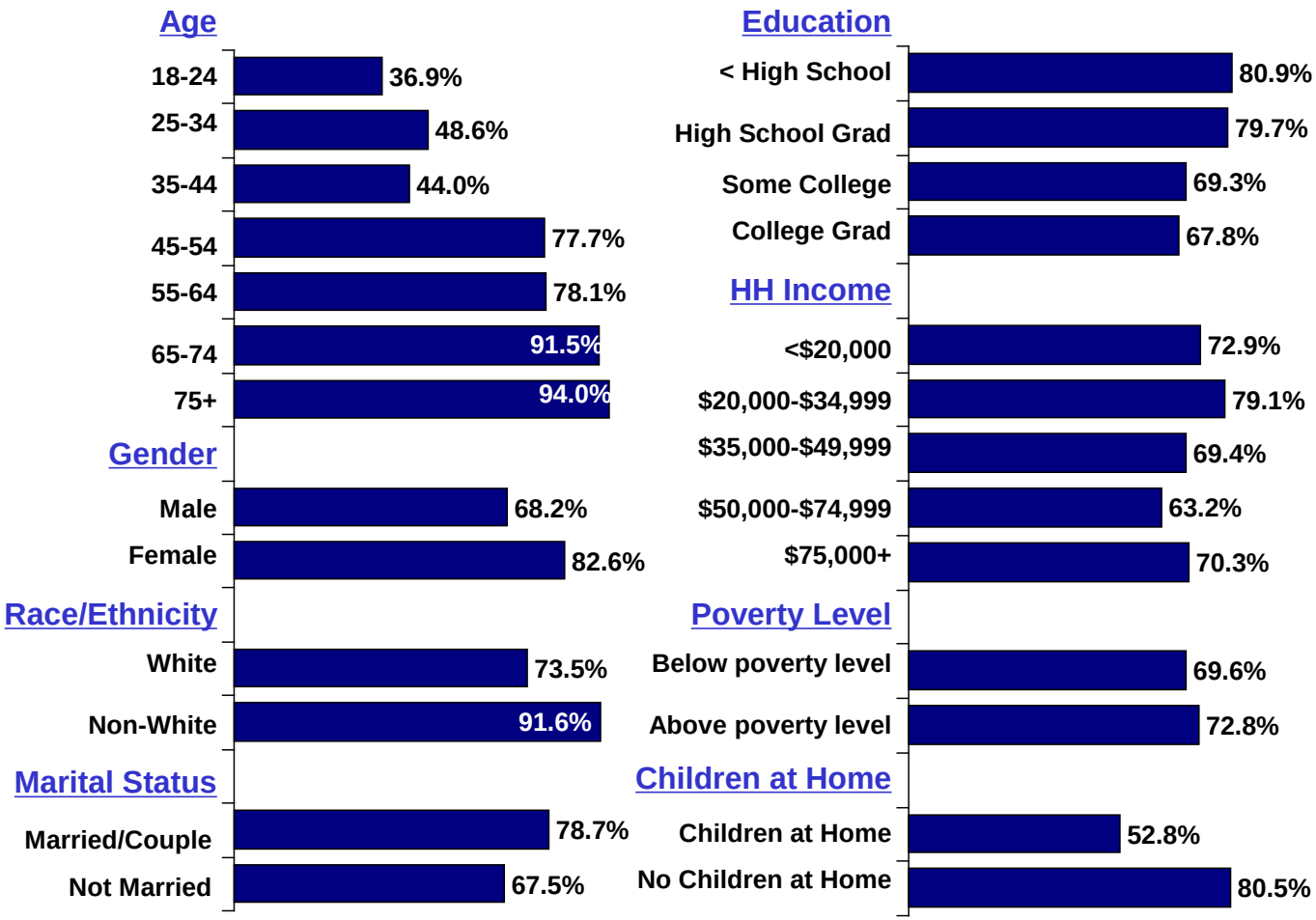
## Hypertension Awareness (Cont'd.)

### Currently Take Medication for High Blood Pressure (HBP)* (Total Sample)




*Among all adults who were ever told they had HBP, the proportion who reported they were currently taking blood pressure (BP) medicines for their HBP.

### Currently Take Medication for HBP by Demographics

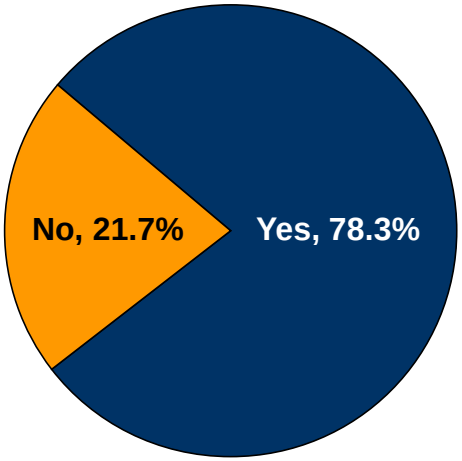


# *Clinical Preventative Practices*

Nearly eight in ten (78.3%) area adults have had their cholesterol checked, and the vast majority of them have had it done within the past year. One-third (32.6%) of them have been told by a health care professional that their cholesterol is high. Of these, almost two-thirds (65.4%) are currently taking medication to lower their cholesterol.

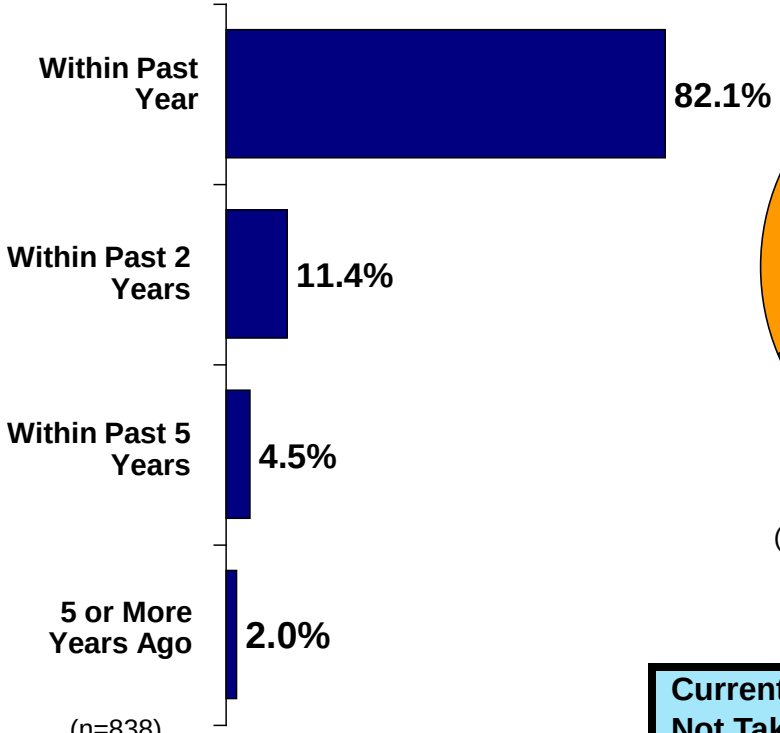
## Cholesterol Awareness

### Ever Had Blood Cholesterol Checked



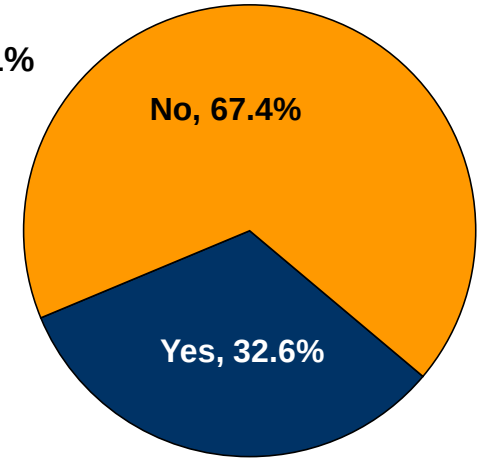

(n=964)

### Last Time Had Blood Cholesterol Checked




(n=838)

### Ever Told Blood Cholesterol is High




(n=839)

**Currently Taking Medication = 65.4%**
**Not Taking Medication = 34.6%**

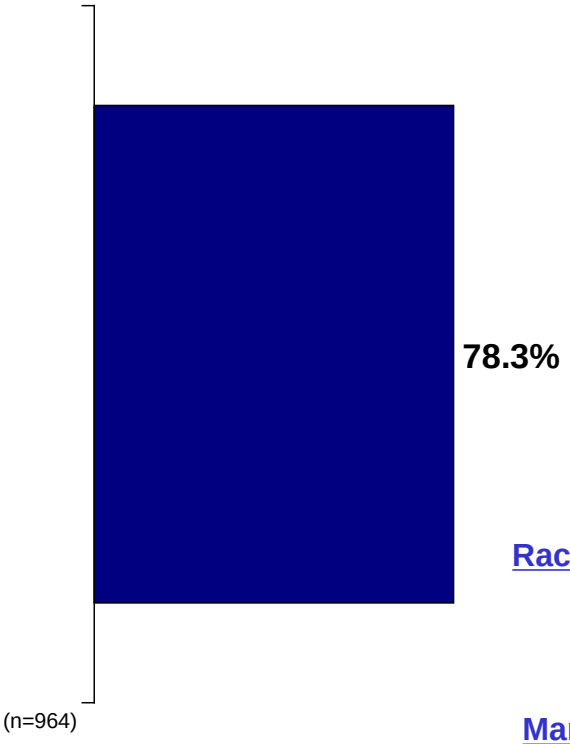
(n=320)

Q5.1: Blood cholesterol is a fatty substance found in the blood. Have you EVER had your blood cholesterol checked?
Q5.2: (If yes) About how long has it been since you last had your blood cholesterol checked?
Q5.3: (If yes) Have you EVER been told by a doctor, nurse or other health care professional that your blood cholesterol is high?
Q5.4: (If yes) Are you currently taking medicine for your high cholesterol?

Area adults most likely to have had their cholesterol checked are found among groups that are: age 45 or older, married, and college graduates.

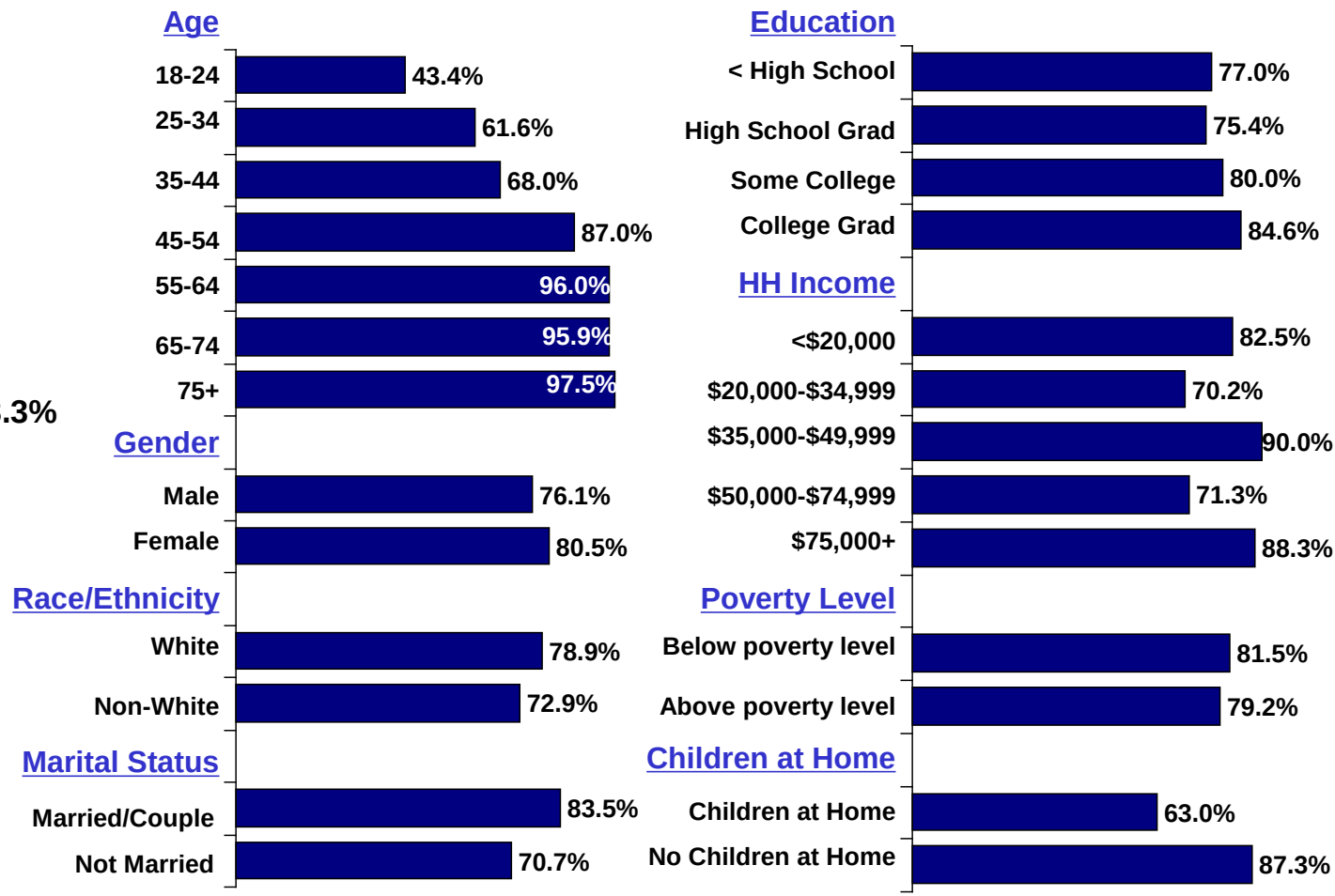
## Cholesterol Awareness (Cont'd.)

### Ever Had Blood Cholesterol Checked* (Total Sample)




*Among all adults, the proportion who reported having had their blood cholesterol checked.

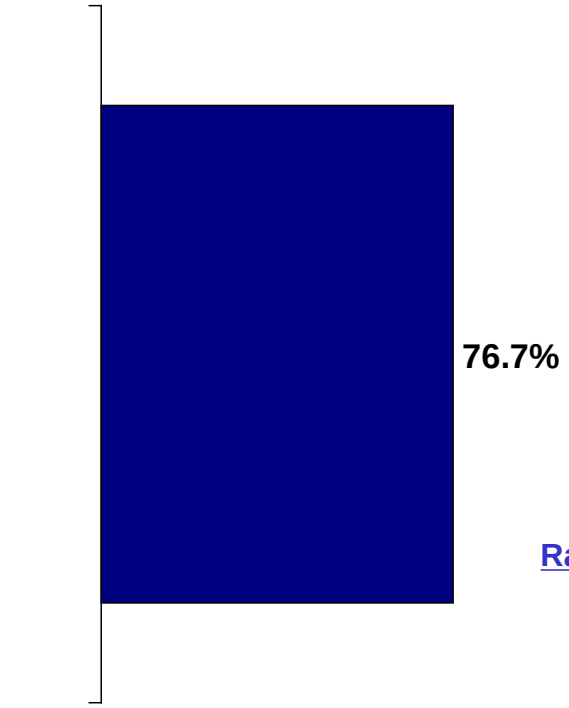
### Ever Had Blood Cholesterol Checked by Demographics



Similarly, adults most likely to have their cholesterol checked within the past five years are found in groups that include those age 45 or older, married, and college graduates.

## Cholesterol Awareness (Cont'd.)

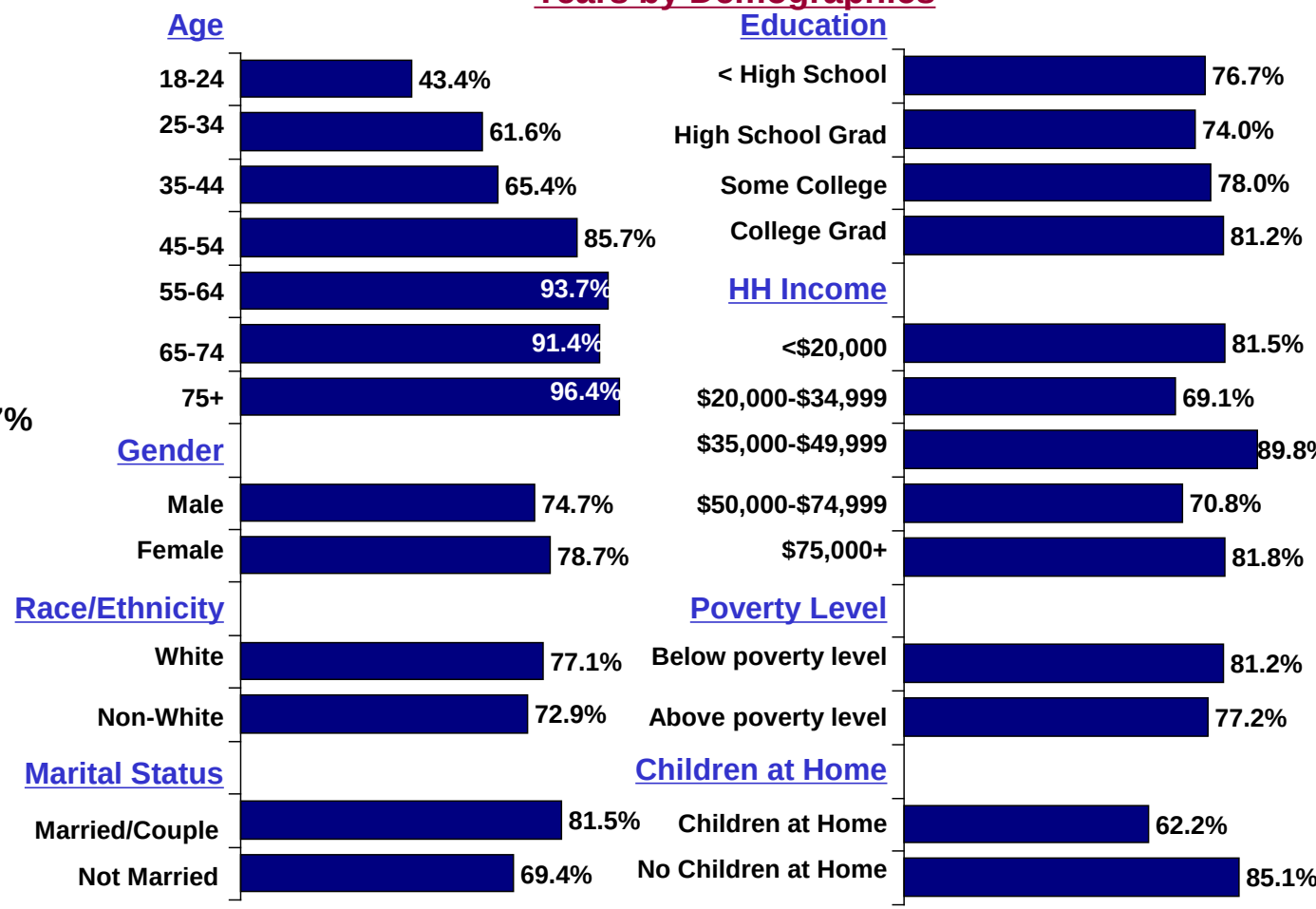
### Had Blood Cholesterol Checked Within Past Five years* (Total Sample)




(n=959)

*Among all adults, the proportion who reported they have had their blood cholesterol checked within the past five years.

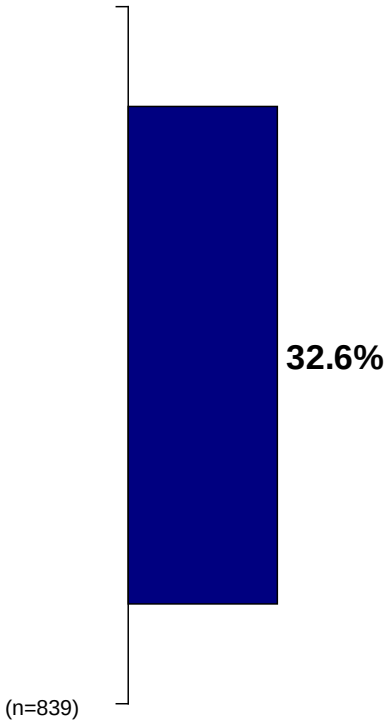
### Had Blood Cholesterol Checked Within Past Five Years by Demographics



Area adults most likely to have high cholesterol come from groups that are 45 years or older, White, have no high school degree, and have incomes below $20K.

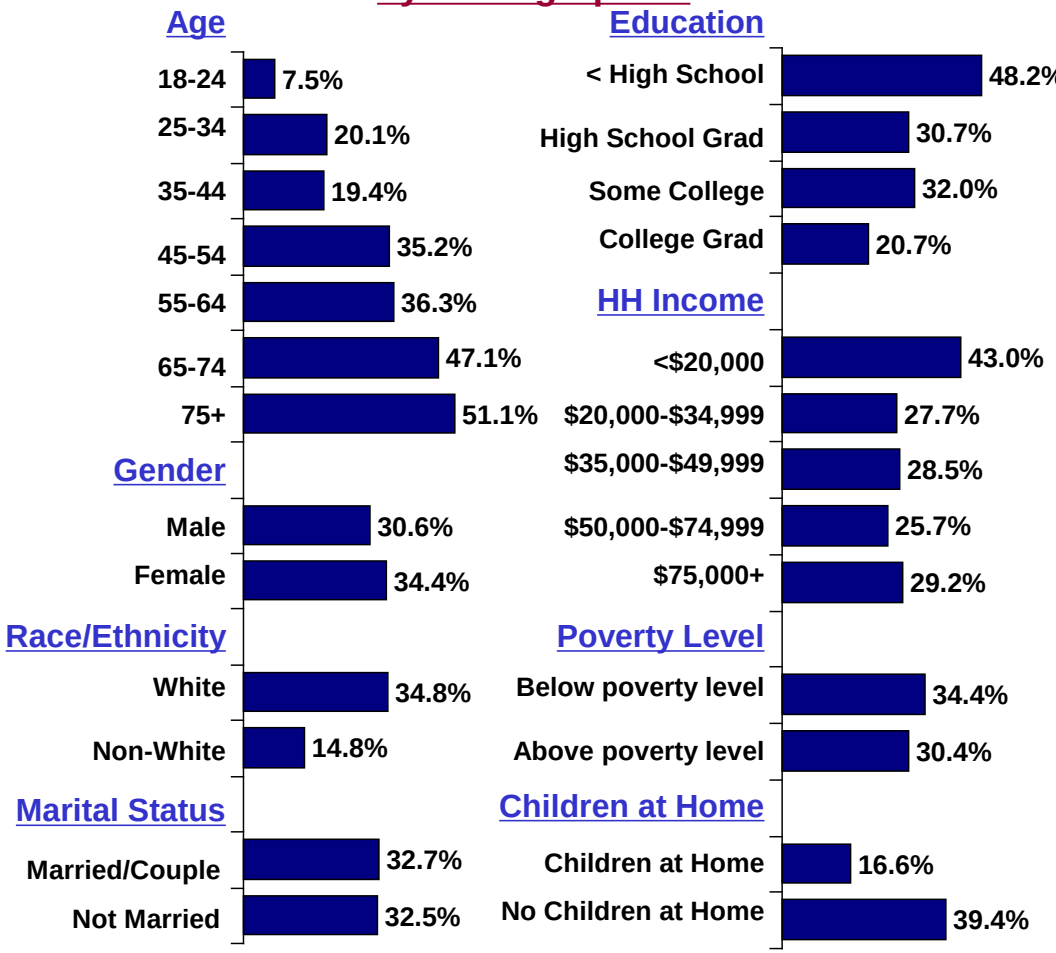
## Cholesterol Awareness (Cont'd.)

### Ever Told Blood Cholesterol High* (Total Sample)




*Among adults who ever had their blood cholesterol checked, the proportion who reported that a doctor, nurse, or other health professional has told them that their cholesterol was high.

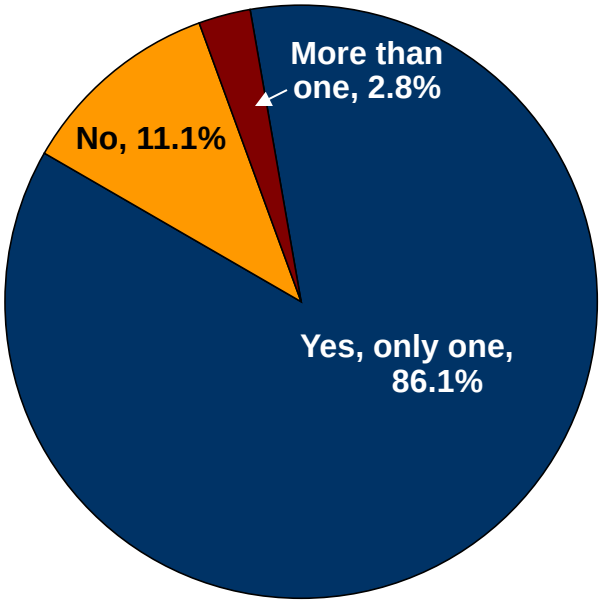
### Ever Told Blood Cholesterol High by Demographics



Nearly nine in ten adults (88.9%) have a medical home (personal physician) and eight in ten (83.0%) have visited a physician for a routine checkup within the past year.

## Personal Physician and Routine Checkups

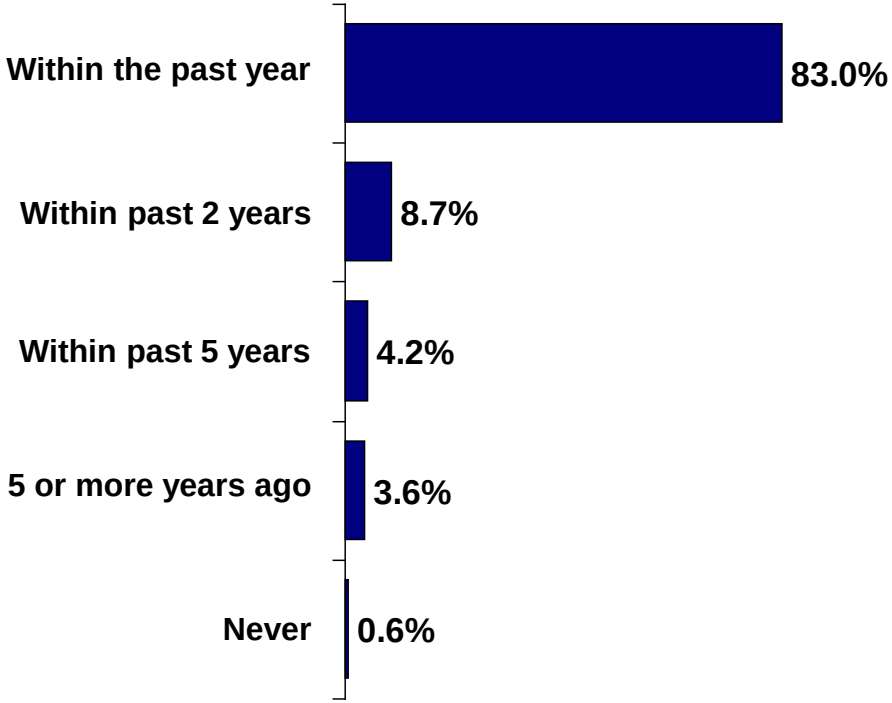
### Currently Have Personal Doctor/Health Care Provider




**88.9%** have medical home

(n=979)

### Last Time Visited Doctor for Routine Checkup



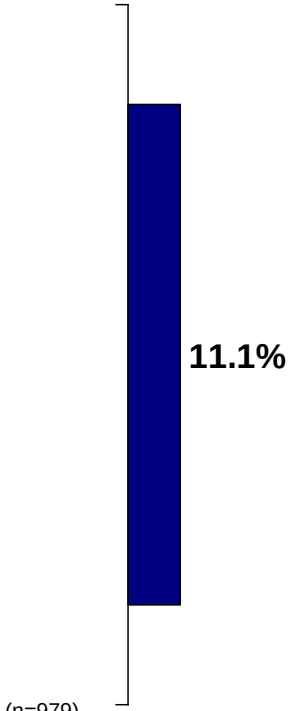

(n=974)

Q3.3: Do you have one person you think of as your personal doctor or health care provider?
Q3.6: About how long has it been since you last visited a doctor for a routine checkup? A routine checkup is a general physical exam, not an exam for a specific injury, illness, or condition.

More than one in ten (11.1%) area adults have no medical home (no personal health care provider). Those least likely to have a medical home are found in groups that are: men, non-White, unmarried, have not graduated from high school, and are the most impoverished (income below $20K, living below poverty line).The greatest discrepancy is seen in the difference between those below the poverty line (31.6% have no medical home) and those above the poverty line (7.0% have no medical home).

## Personal Health Care Provider

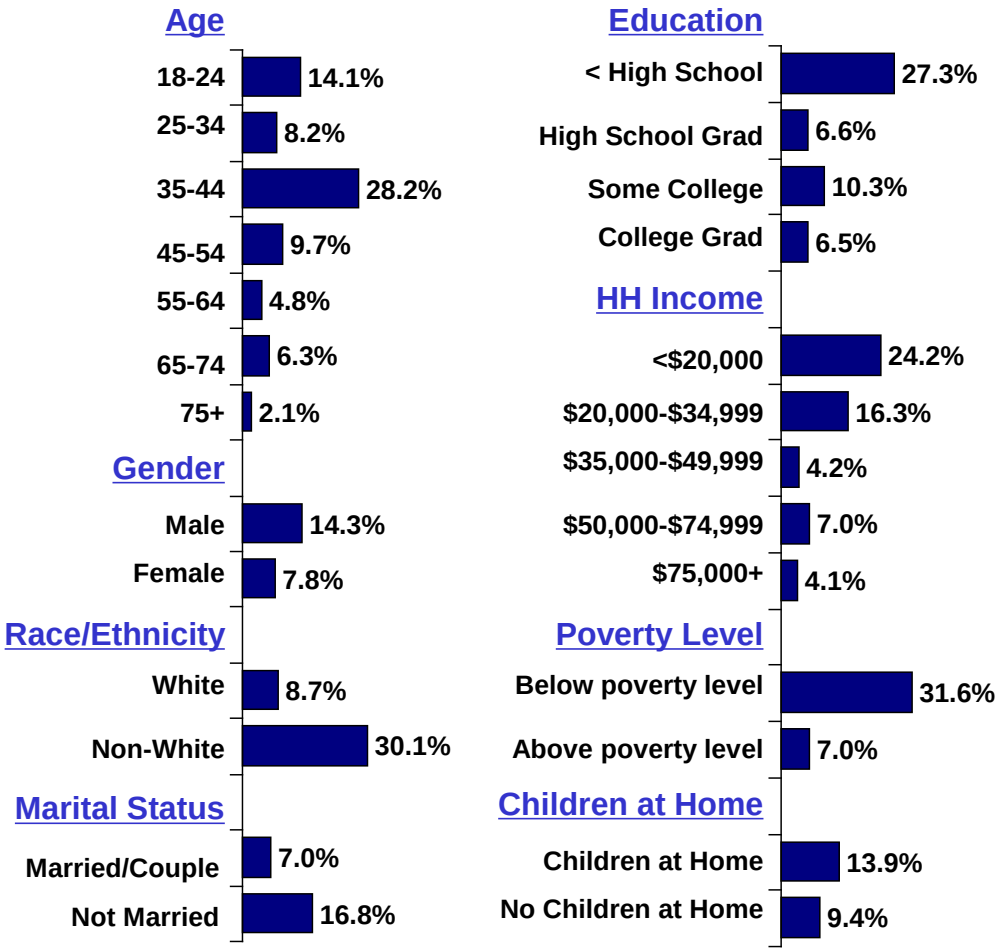
### No Personal Health Care Provider* (Total Sample)




(n=979)

*Among all adults, the proportion who reported that they did not have anyone that they thought of as their personal doctor or health care provider.

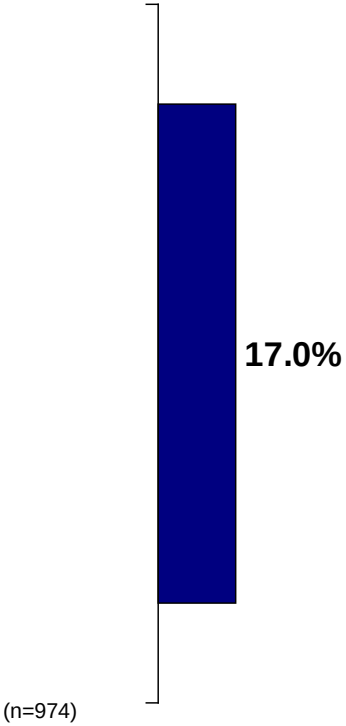
### No Provider by Demographics



Roughly one in six (17.0%) adults have not had a routine physical checkup in the past year. For the most part, having a timely routine physical checkup is directly related to age. Beyond that there are no notable differences across demographics.

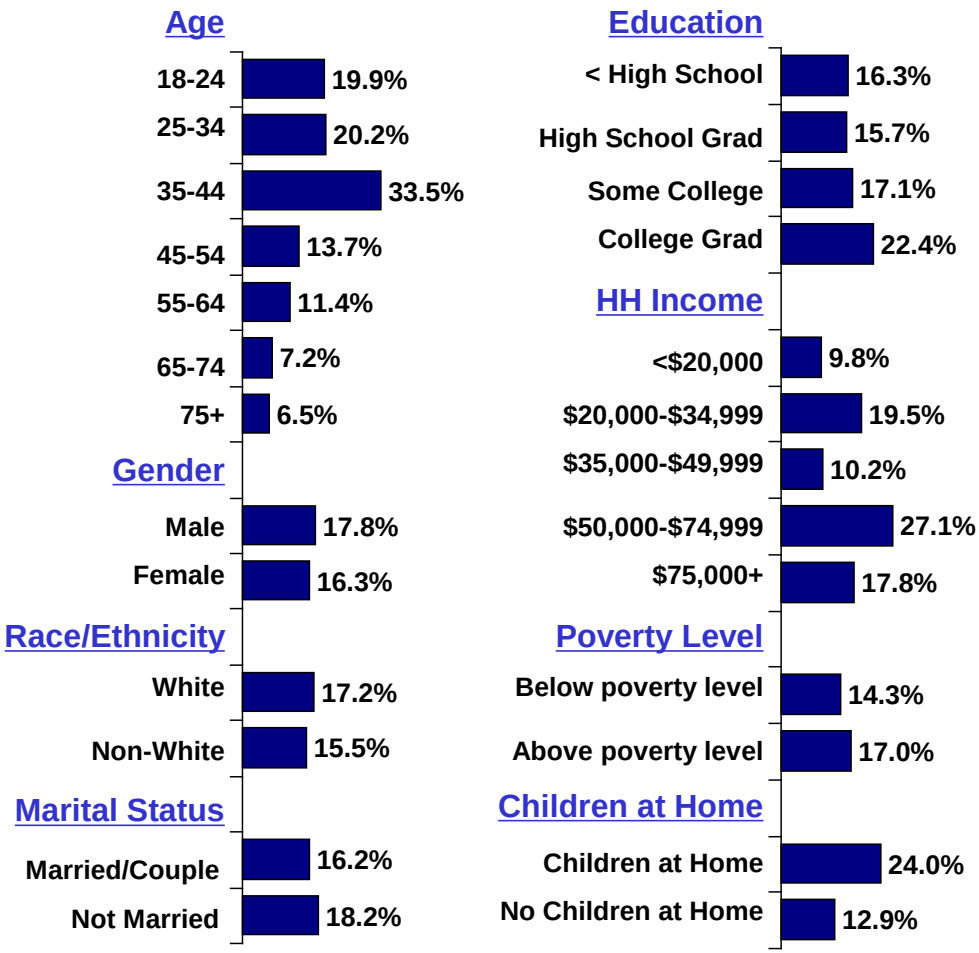
## Routine Physical Checkup in Past Year

### No Routine Physical Checkup in Past Year* (Total Sample)




*Among all adults, the proportion who reported that they did not have a routine checkup in the past year.

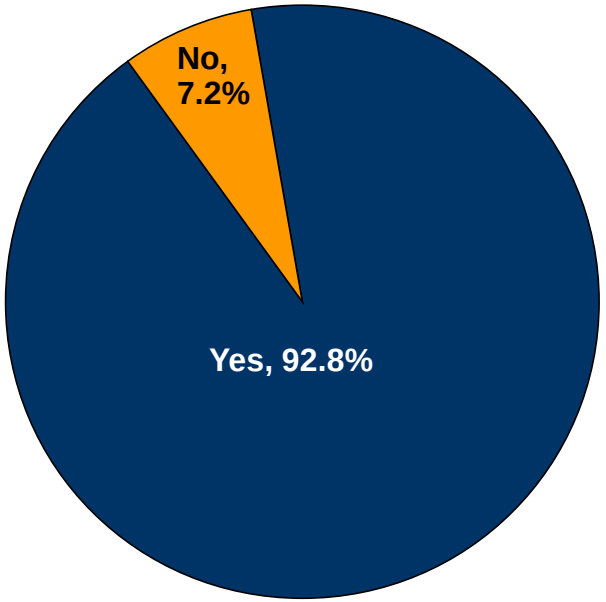
### No Checkup by Demographics



More than nine in ten (92.8%) SHGMH area women aged 40+ have had a mammogram to screen for breast cancer. Of those, the vast majority (71.9%) have had one within the past year. Of all women aged 40+, two-thirds (66.7%) have had a mammogram in the past year.

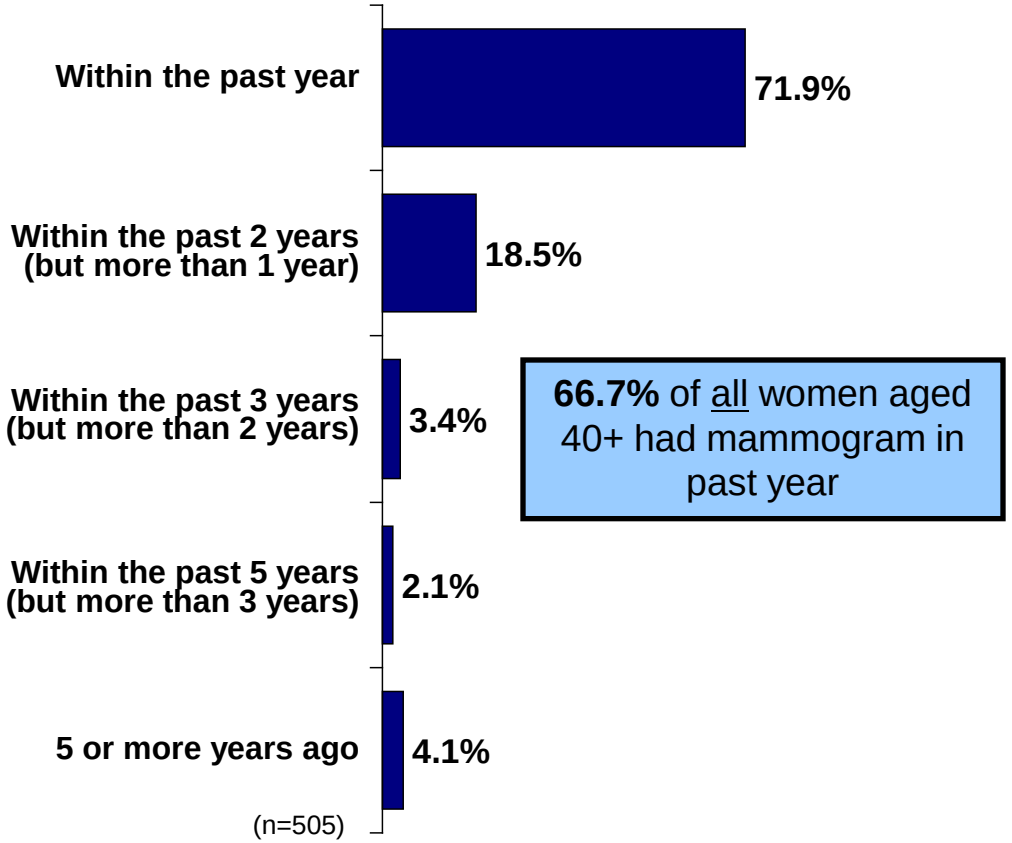
## Breast Cancer Screening Among Adult Females Aged 40+

### Have Had a Mammogram




(n=547)

### Last Time Had Mammogram



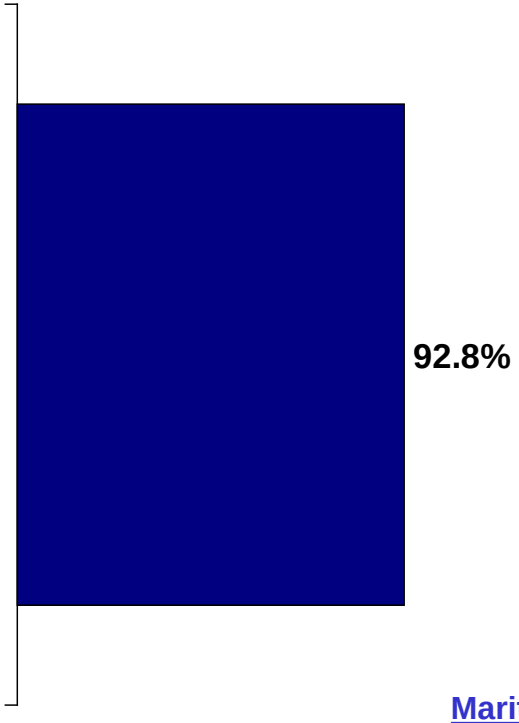

**66.7%** of all women aged 40+ had mammogram in past year

Q6.1: A mammogram is an x-ray of each breast to look for breast cancer. Have you ever had a mammogram?
Q6.2: (If yes) How long has it been since you had your last mammogram?

Since most women 40 years of age or older in the SHGMH area have had a mammogram at some point, there is very little difference across demographic groups.

## Mammography Indicators Among Women Aged 40 Years or Older

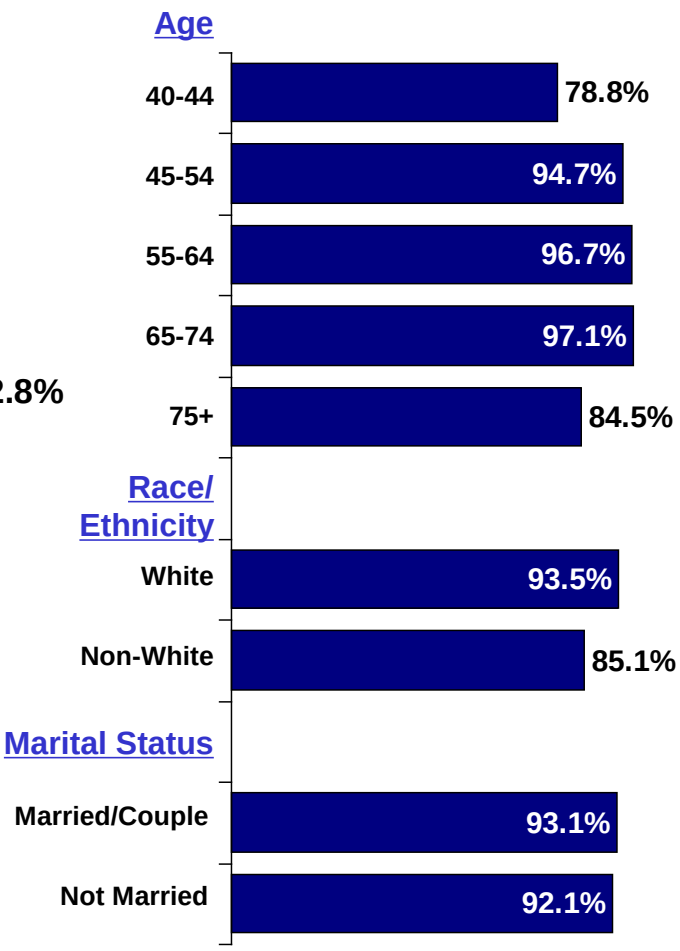
### Ever Had Mammogram* (Total Sample)

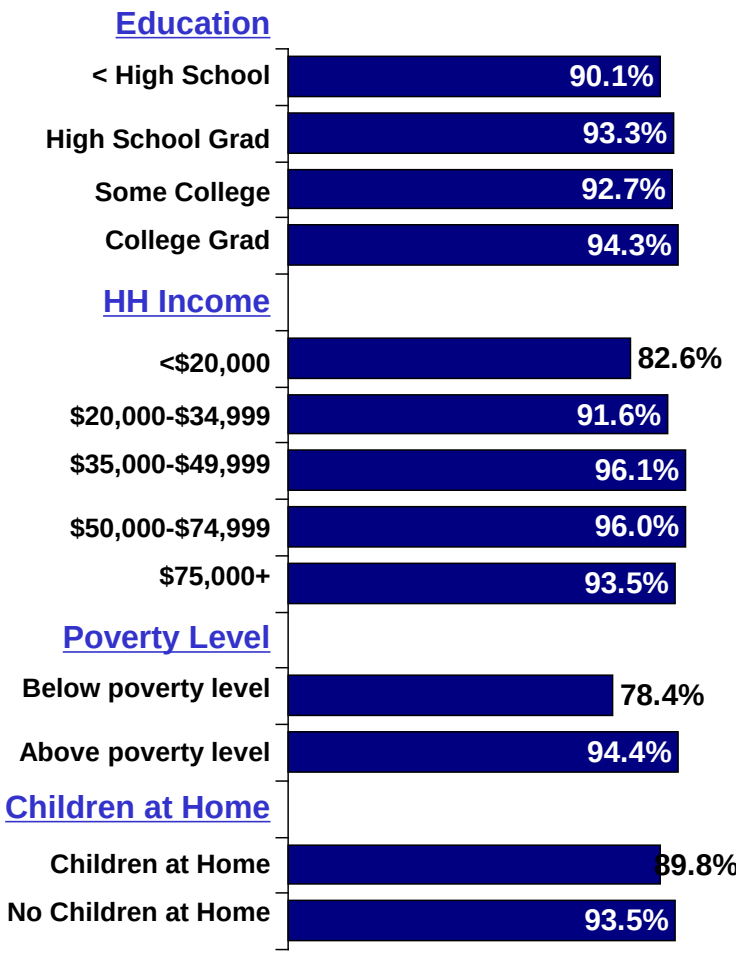



(n=543)

*Among women aged 40 years and older, the proportion who reported ever having a mammogram.

### Ever Had Mammogram by Demographics

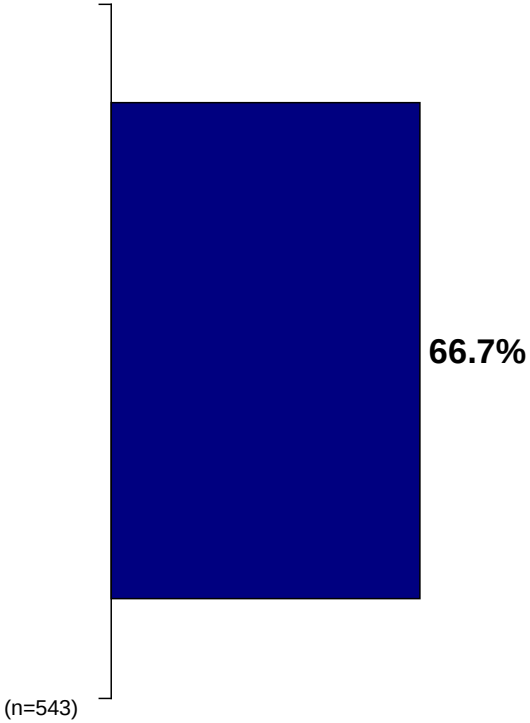


Having a timely mammogram is directly related to household income; 58.5% of women from households with incomes less than $20K have had a mammogram within the past year, compared to 74.3% of women from households with incomes $75K+. Women between 40-44 years of age are least likely to have timely mammograms. White women are less likely than non-White women to have a timely mammogram.

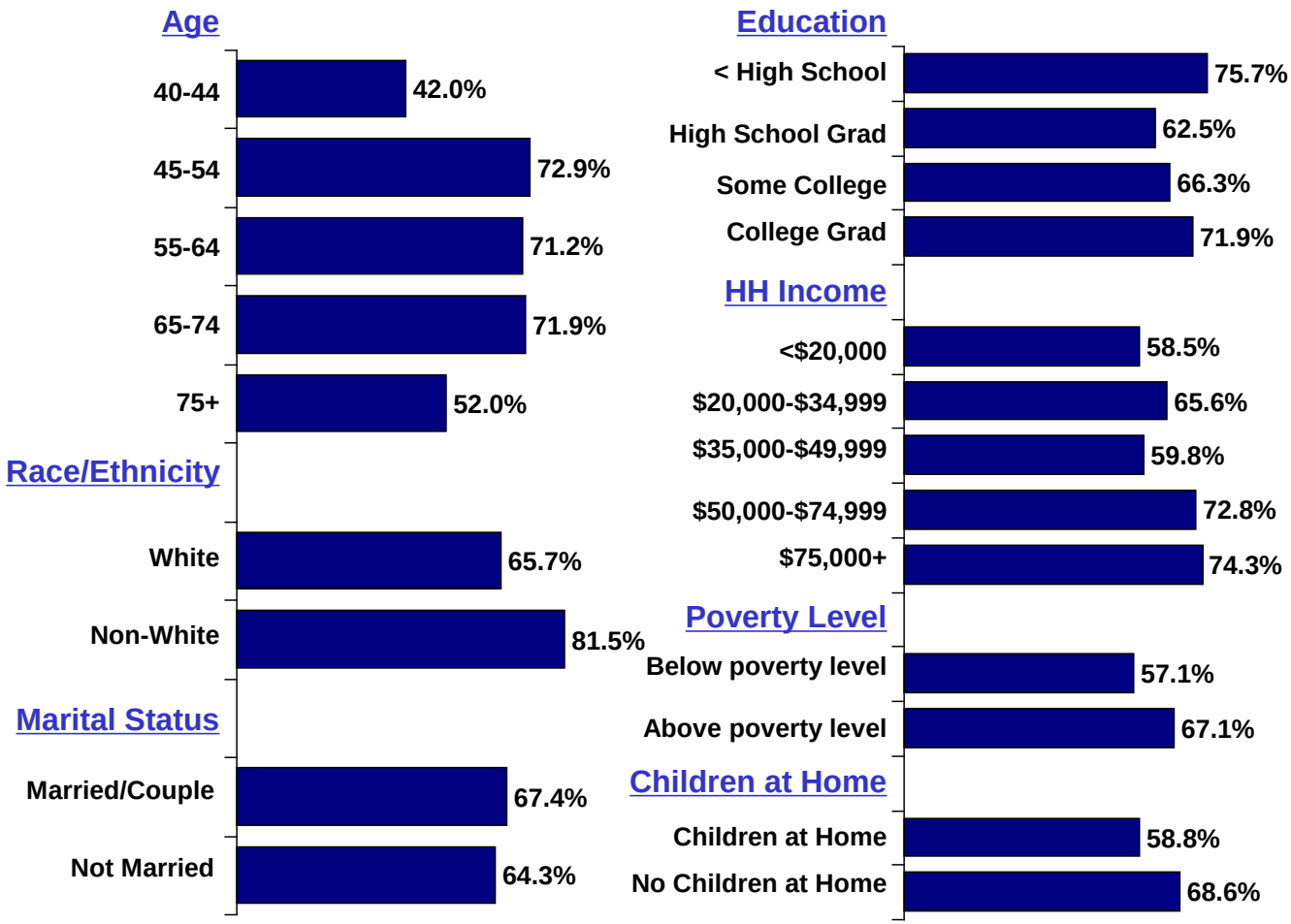
## Mammography Indicators Among Women Aged 40 Years or Older (Cont'd.)

### Had Mammogram in Past Year* (Total Sample)




*Among women aged 40 years and older, the proportion who reported having a mammogram in the past year.

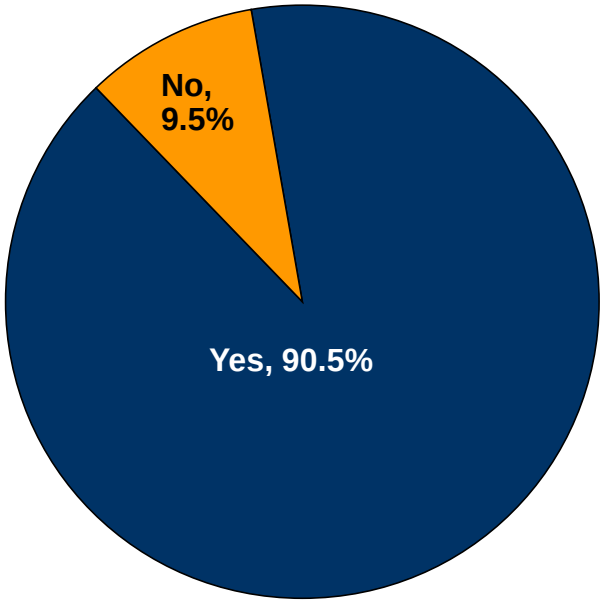
### Had Mammogram in Past Year by Demographics



Nine in ten (90.5%) area adult women have had a Pap test to screen for cervical cancer. Of those, roughly half have had one within the past year and 76.6% have had one in the past three years. Of all adult women, 69.3% have had a Pap test within the past three years.

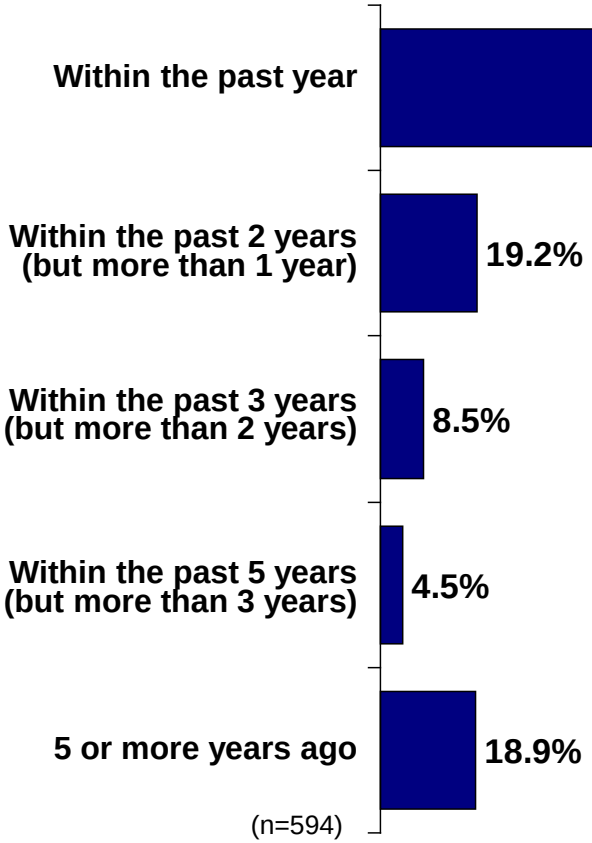
## Cervical Cancer Screening Among Adult Females

### Have Had a Pap Test




(n=645)

### Last Time Had Pap Test




(n=594)

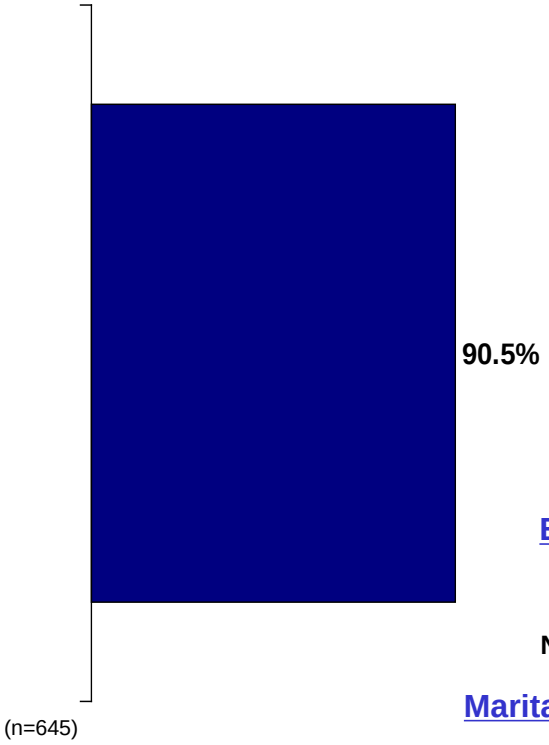
**69.3%** of all women had Pap test in past three years

Q6.3: A Pap test is a test for cancer of the cervix. Have you ever had a Pap test?
Q6.4:(If yes) How long has it been since you had your last Pap test?

Pap test rates are lowest among women aged 18-24, and lower among unmarried women compared to married women. Pap rates are highest among college graduates and those with incomes of $35K or more.

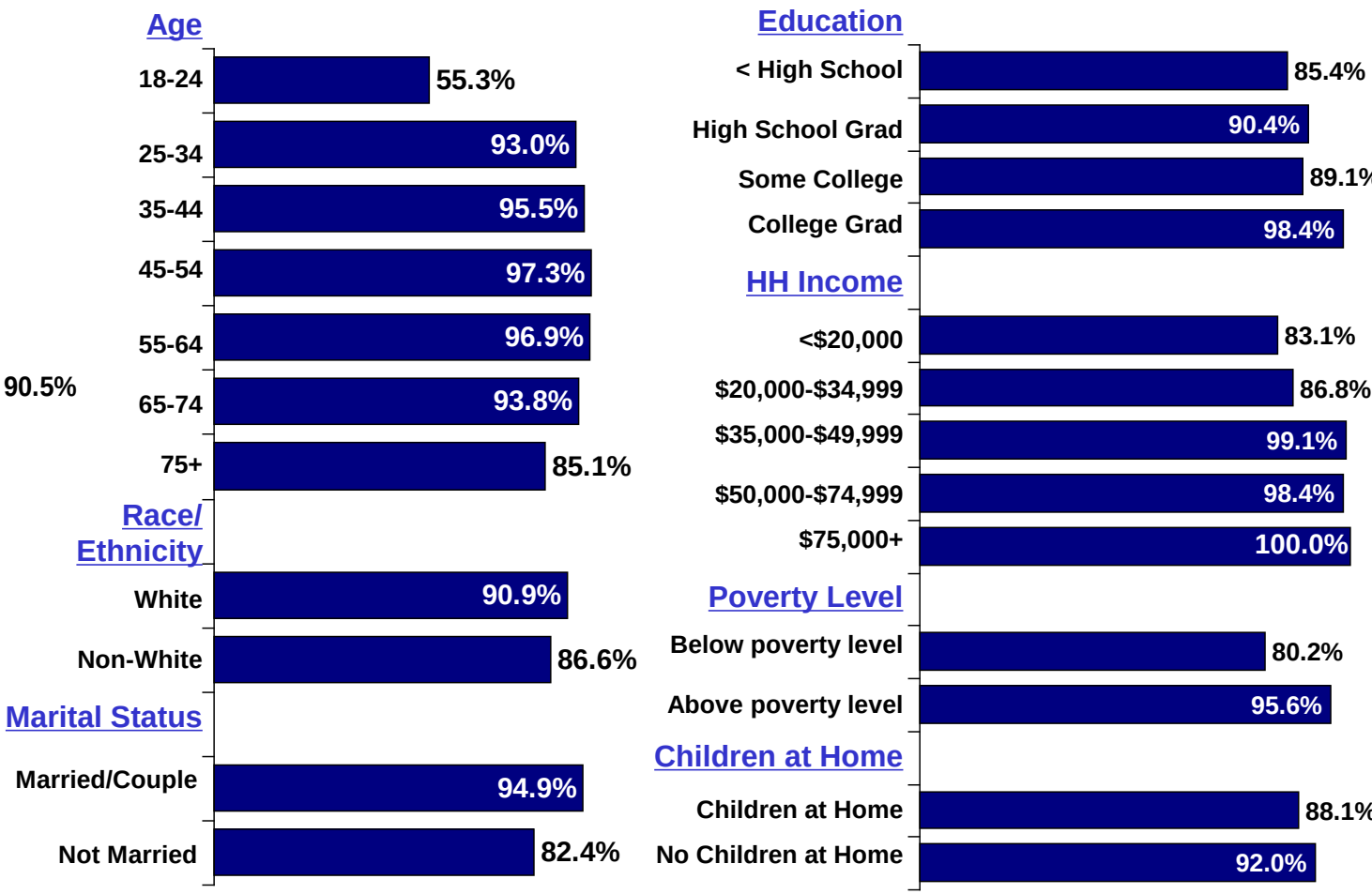
## Cervical Cancer Screening

### Ever Had Pap Test* (Total Sample)




*Among women aged 18 years and older, the proportion who reported ever having a Pap test.

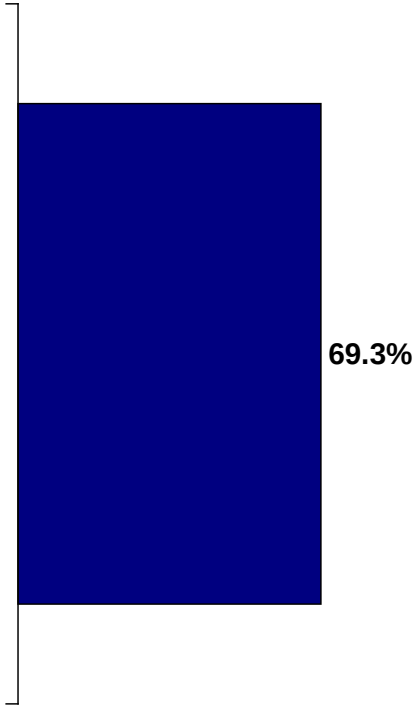
### Ever Had Pap Test by Demographics



Having an appropriately timed Pap test is directly related to income. Adult women least likely to have appropriately timed (within past three years) Pap tests are in the youngest (18-24) and oldest (65+) ages groups. Non-White women are more likely than White women to have had a Pap test in the past three years.

## Cervical Cancer Screening (Cont'd.)

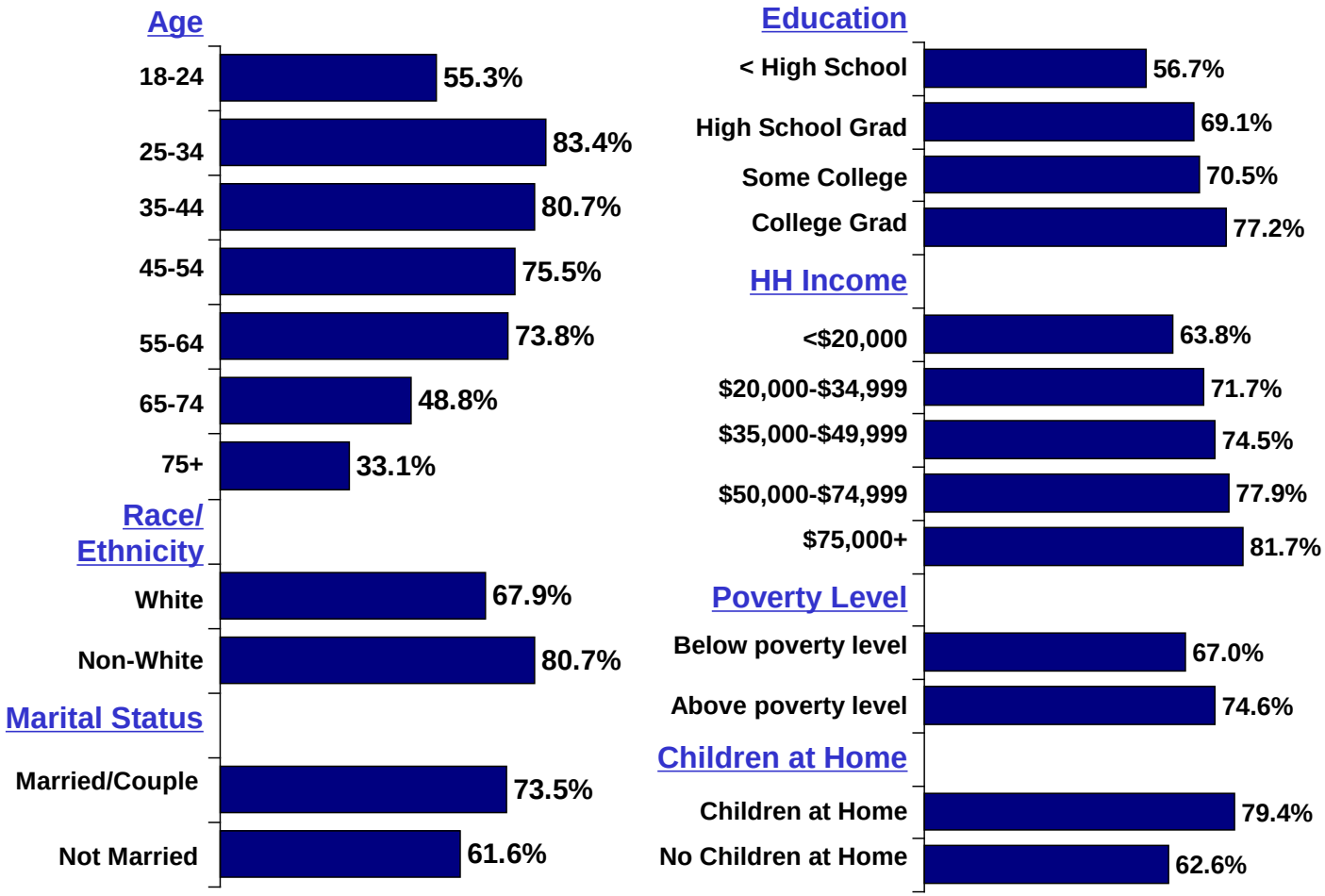
### Had Appropriately Timed Pap Test* (Total Sample)




(n=641)

*Among women aged 18 years and older, the proportion who reported having a Pap test within the previous three years.

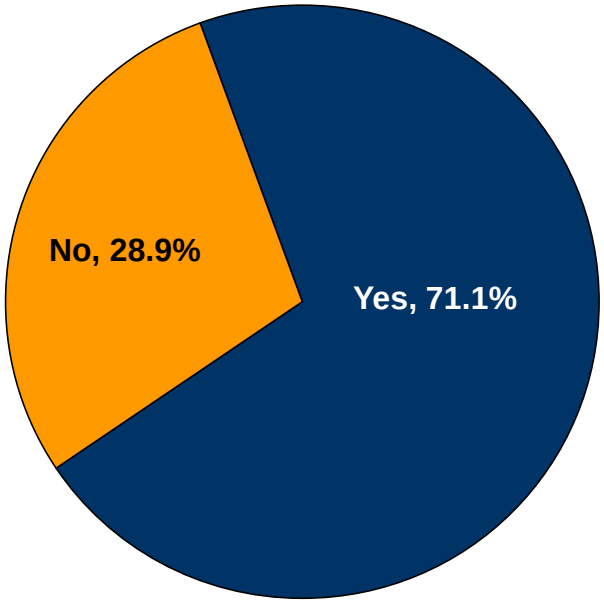
### Appropriately Timed Pap Test by Demographics



More than seven in ten (71.1%) area men aged 50 or older have had a doctor recommend a prostate screening test such as PSA and a comparable proportion (71.0%) have actually received the test.

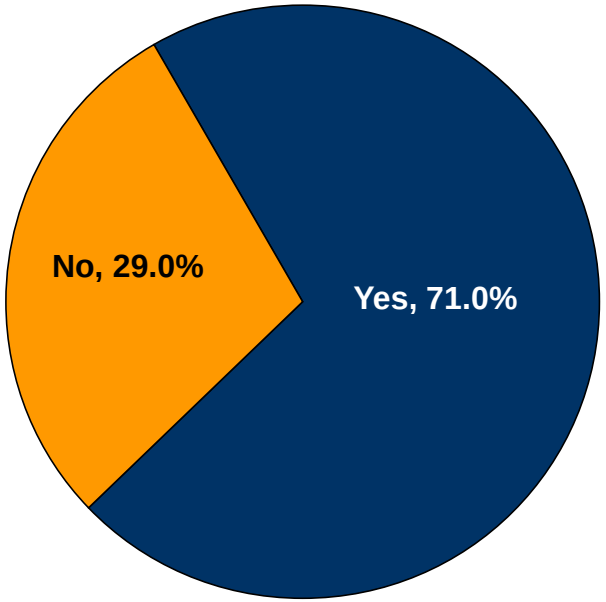
## Prostate Cancer Screening Among Adult Males Aged 50+

### PSA Test Ever Recommended




(n=215)

### Ever Had PSA Test



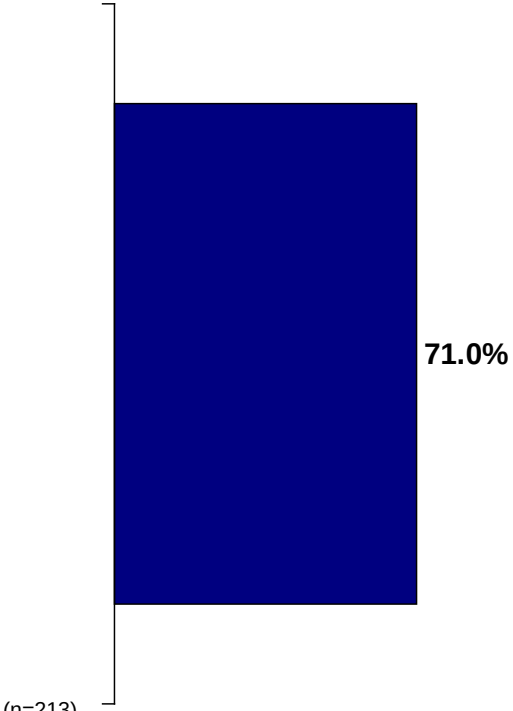

(n=213)

Q7.1: A prostate-specific antigen test, also called a PSA test, is a blood test used to check men for prostate cancer. Has a doctor EVER recommended that you have a PSA test?
Q7.2: Have you EVER had a PSA test?

Having a PSA test is directly related to age, where men least likely to have one are age 50-54. Men most likely to have a PSA test can be found among the following groups: non-White, married, and living below the poverty line.

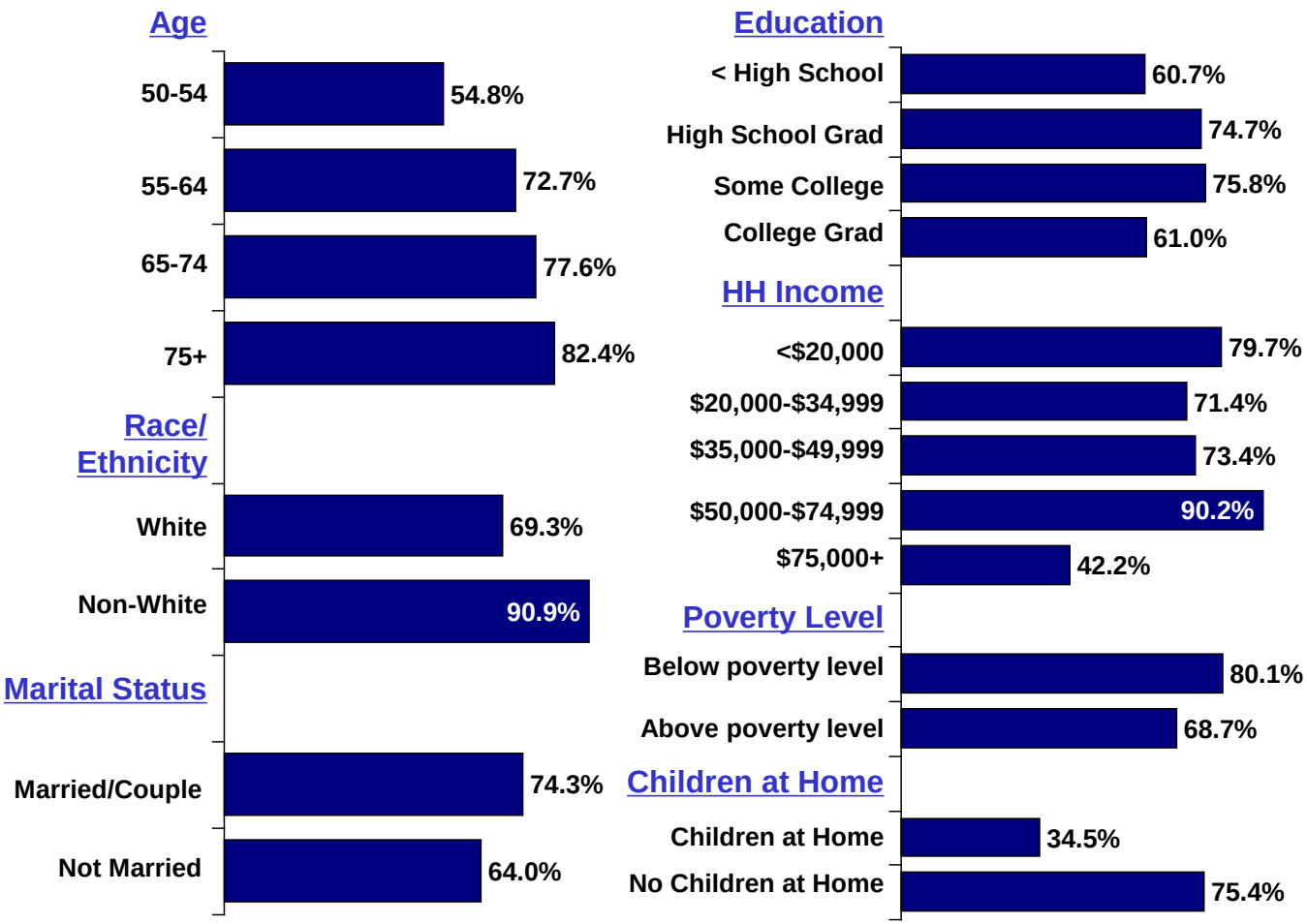
## Prostate Cancer Screening Among Men Aged 50 Years and Older

### Ever Had PSA Test* (Total Sample)




*Among men aged 50 years and older, the proportion who reported ever having a prostate-specific antigen (PSA) test.

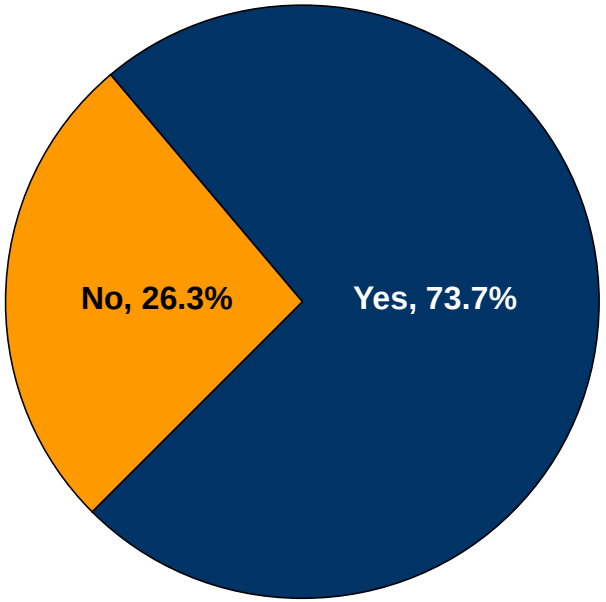
### Had PSA Test by Demographics



Three-fourths (73.7%) of area adults aged 50 or more have had an exam to screen for colon cancer. Two-thirds (66.7%) of those who have had an exam have had one in the past three years, while 84.6% have had one within the past five.

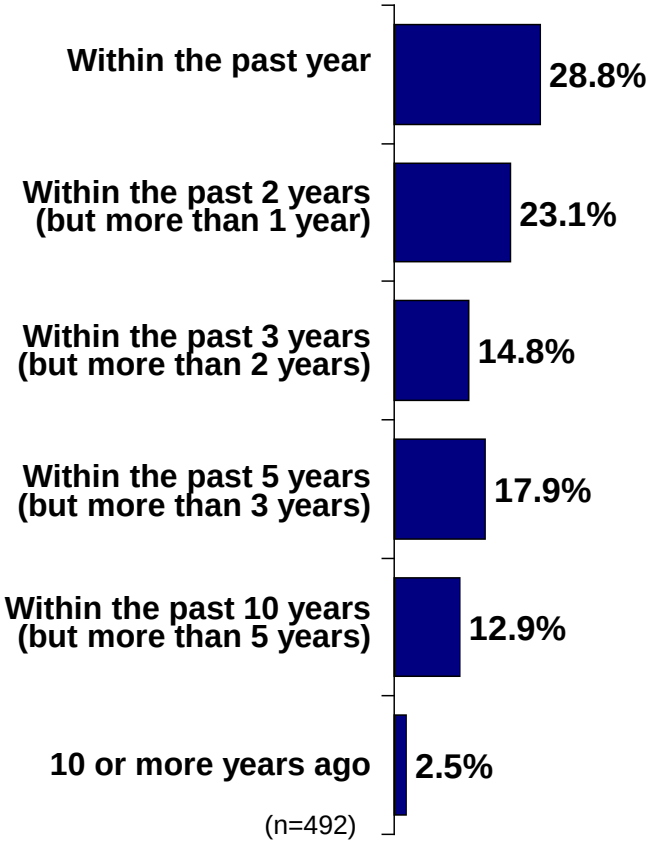
## Colorectal Cancer Screening Among Adults Aged 50+

### Have Had Sigmoidoscopy or Colonoscopy Exam




(n=670)

### Last Time Had Exam




(n=492)

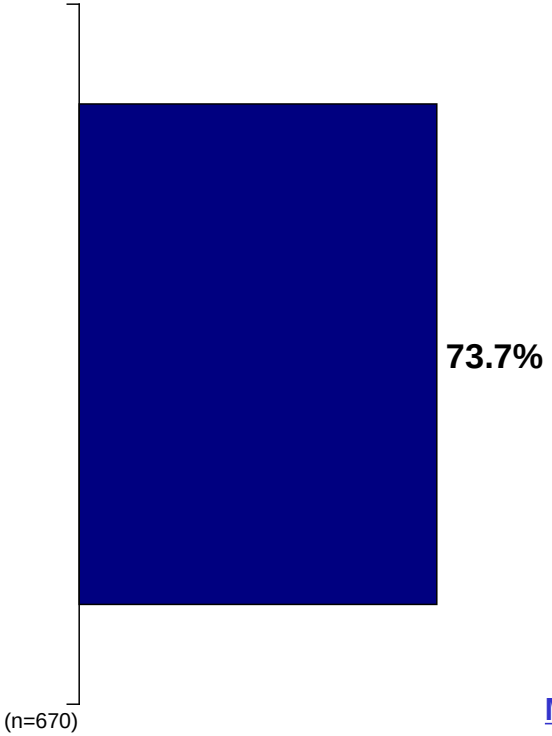
Q8.1: Sigmoidoscopy and colonoscopy are exams in which a tube is inserted in the rectum to view the colon for signs of cancer or other health problems. Have you ever had either of these exams?

Q8.2:How long has it been since you had your last sigmoidoscopy or colonoscopy?

Being screened for colorectal cancer is inversely related to education. Adults least likely to be screened can be found among the following groups: White, unmarried, college graduates, and those living below the poverty line.

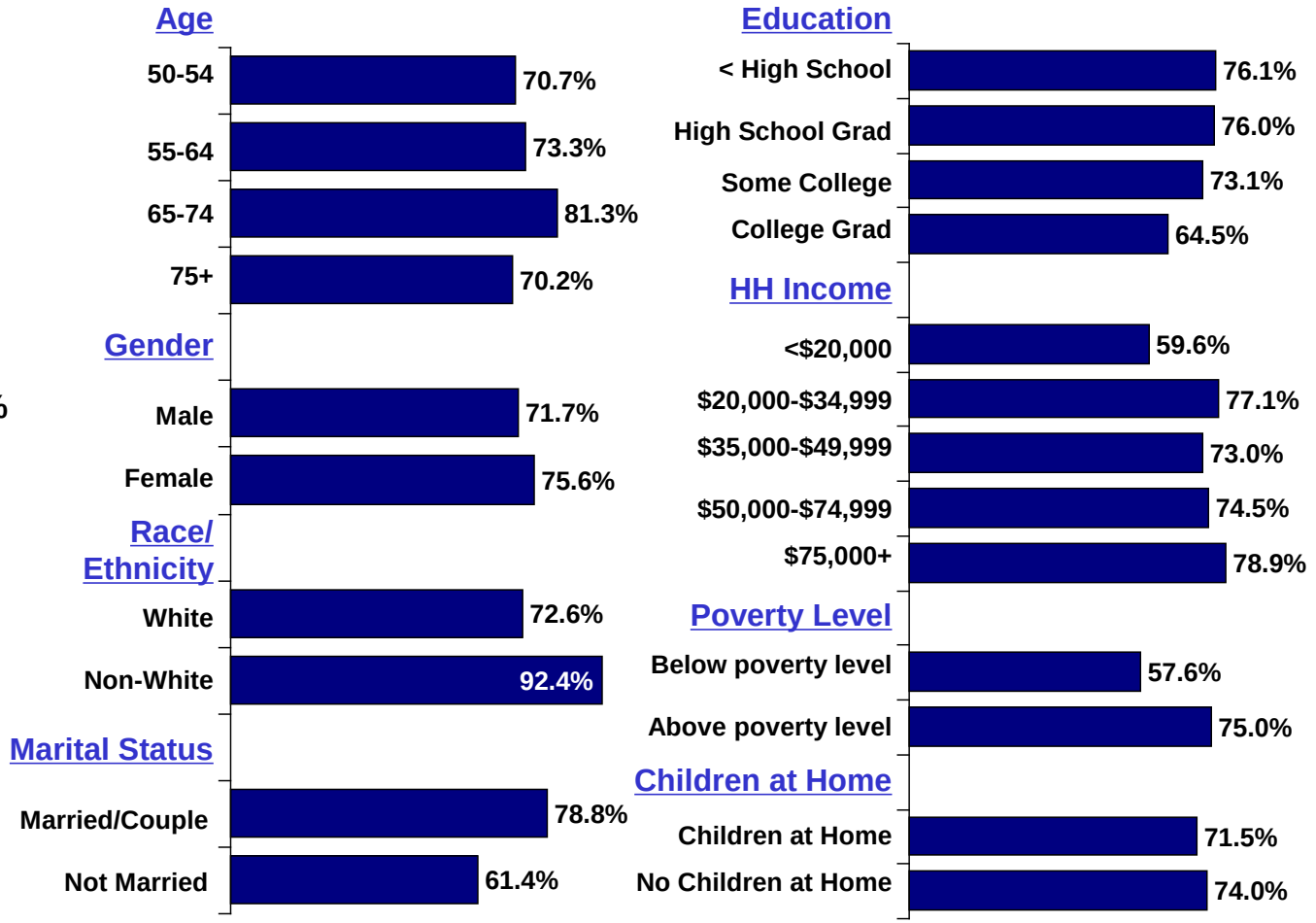
## Colorectal Cancer Screening (Sigmoidoscopy/Colonoscopy) Among Adults Aged 50 Years and Older

### Ever Had Sigmoidoscopy or Colonoscopy* (Total Sample)




*Among adults aged 50 years and older, the proportion who reported ever having a sigmoidoscopy or colonoscopy.

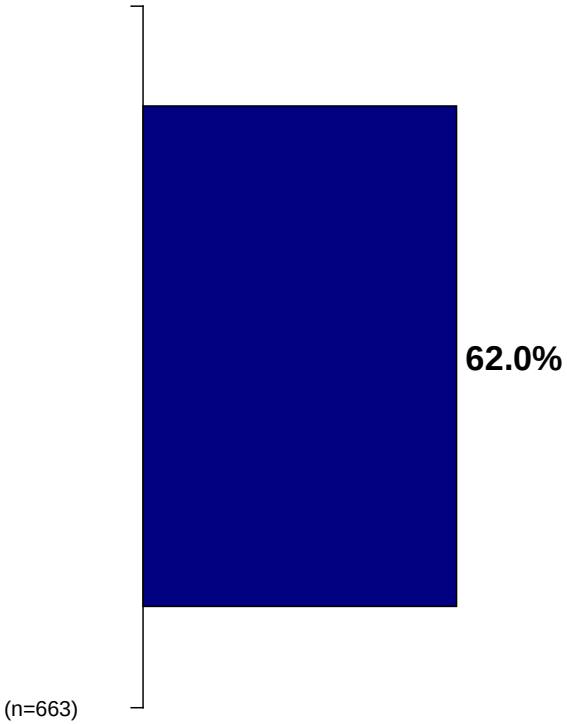
### Had Sigmoidoscopy/Colonoscopy by Demographics



When looking at all adults aged 50 or older, six in ten (62.0%) have been screened for colorectal cancer in the past five years. Non-Whites are more likely to screen for colorectal cancer than Whites. Adults above the poverty level are more likely to get screened compared to those living below the poverty level. Having a timely screening for colorectal cancer is inversely related to education.

## Colorectal Cancer Screening (Sigmoidoscopy/Colonoscopy) Among Adults Aged 50 Years and Older (Cont'd.)

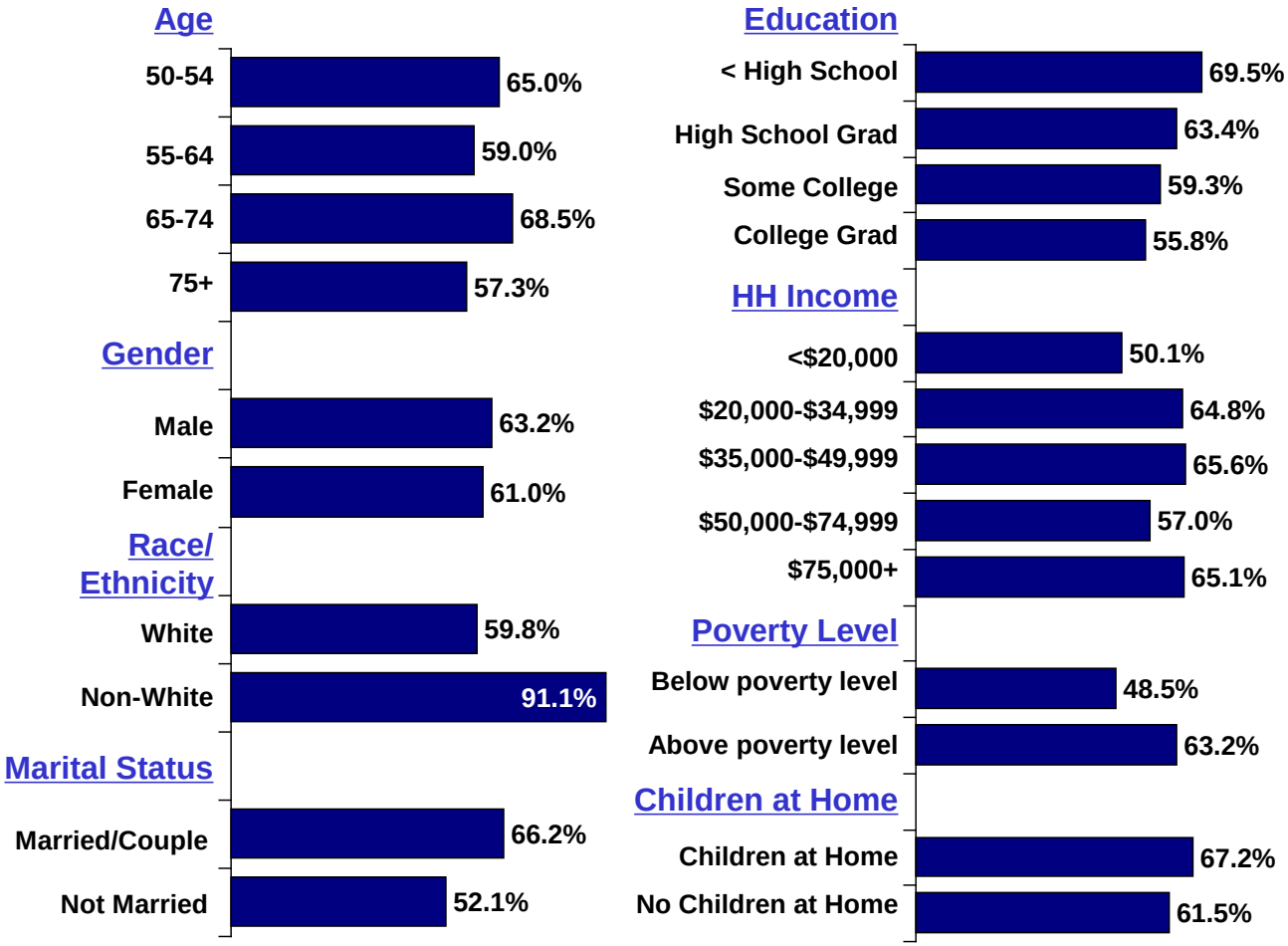
### Had A Sigmoidoscopy or Colonoscopy in Past Five Years* (Total Sample)




(n=663)

*Among adults aged 50 years and older, the proportion who reported ever having a sigmoidoscopy or colonoscopy in the past five years.

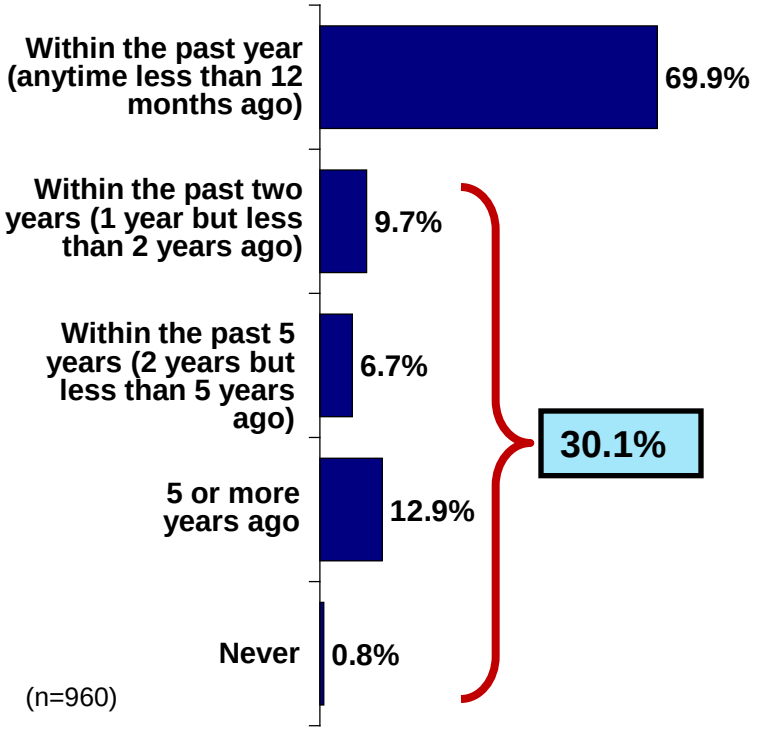
### Had Sigmoidoscopy/Colonoscopy in Past Five Years by Demographics



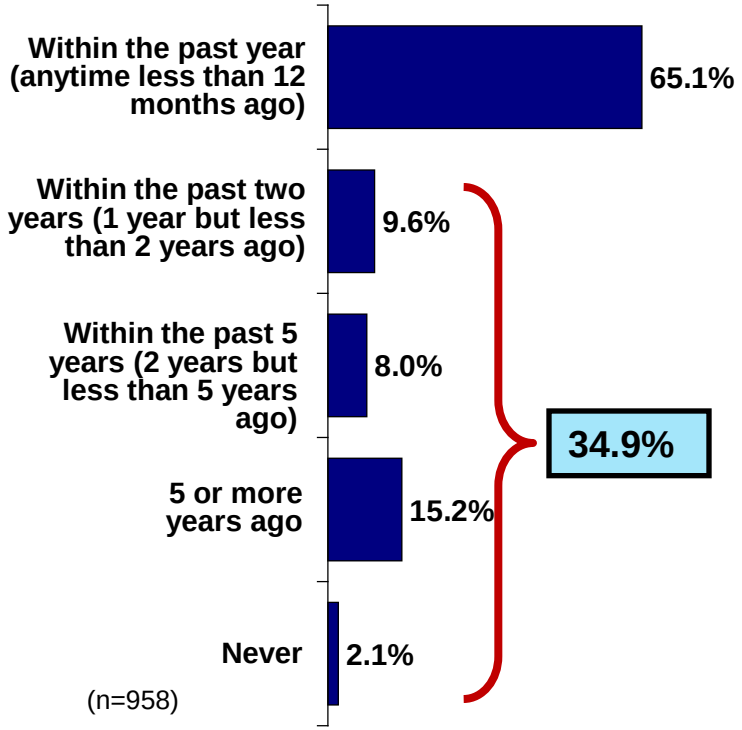
Seven in ten area adults have visited a dentist or dental specialist in the past year. However, more than one-third (34.9%) are not exercising preventive oral health care, in other words, have not visited the dentist in the past year for a teeth cleaning.

## Oral Health

### When Last Visited Dentist for Any Reason




### When Last Visited Dentist for Teeth *Cleaning*

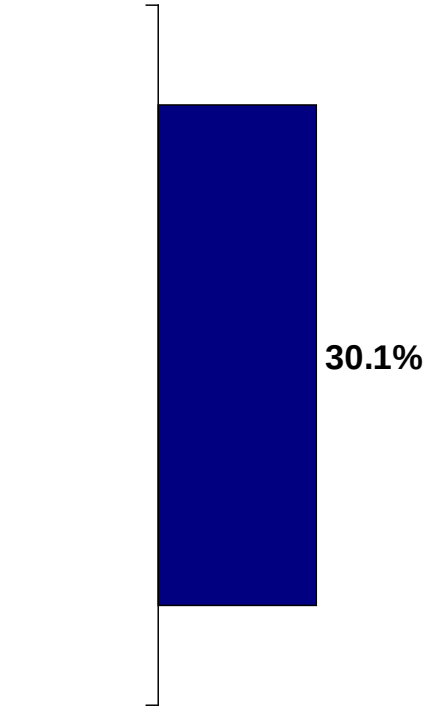



Q23.1: How long has it been since you last visited a dentist or dental clinic for any reason? Include visits to dental specialists, such as orthodontists.
Q23.2: How long has it been since you had your teeth cleaned by a dentist or dental hygienist?

Visiting a dentist in a timely manner is directly related to education and income. In fact, more than one-third (36.7%) of adults with less than a high school education and/or living in a household with income less than $20K (38.7%) have not visited a dentist in the past year. Additionally, 44.0% of adults living below the poverty line have not visited a dentist in the past year, compared to 24.7% for adults above the poverty line.

## Oral Health (Cont'd.)

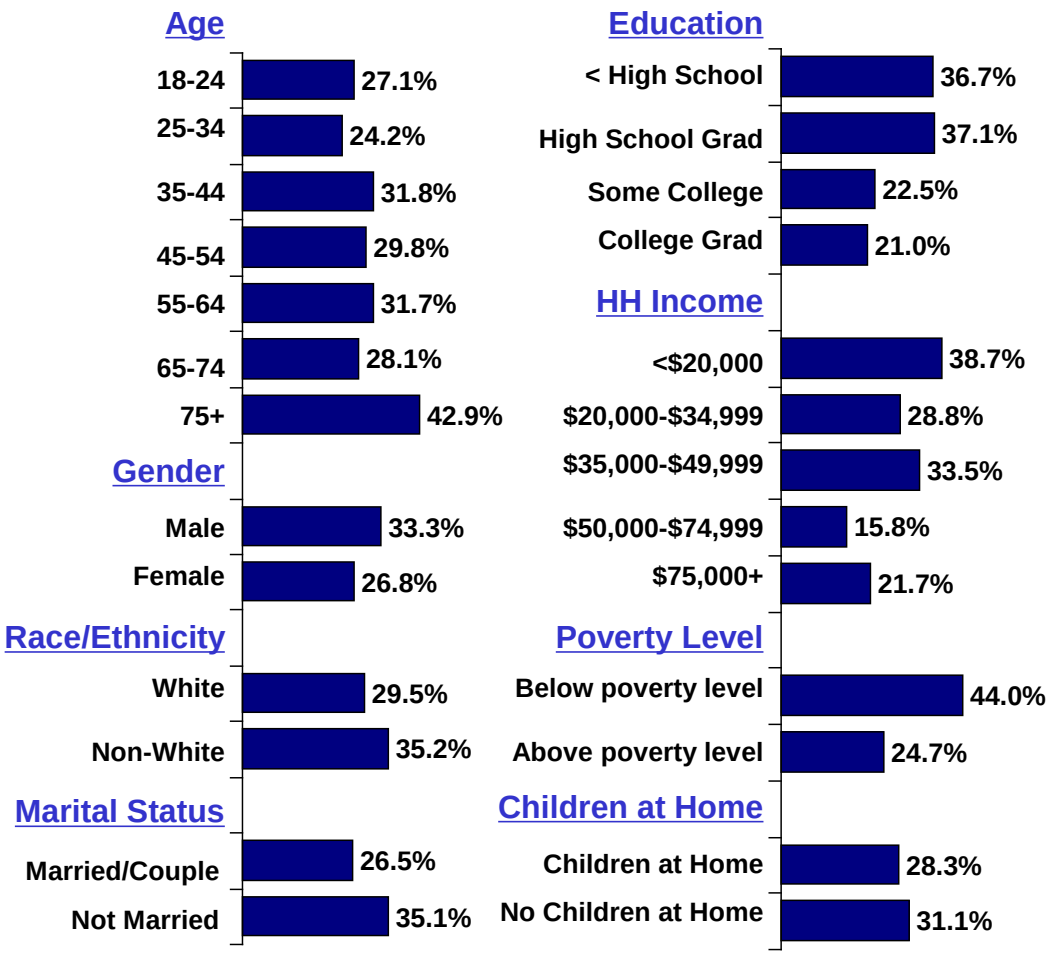
### No Dental Visit in Past Year* (Total Sample)




(n=960)

*Among adults, the proportion who reported that they had not visited a dentist or dental clinic for any reason in the previous year.

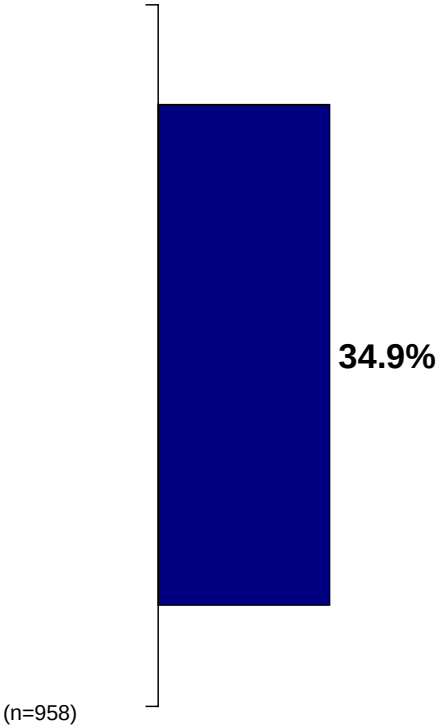
### No Dental Visit in Past Year by Demographics



Similarly, having a recent teeth cleaning is directly related to education and income. Least likely to have a timely cleaning are those from groups who have less than a high school education and those living in a household with income less than $20K. Also, non-White adults are less likely to have a timely cleaning compared to White adults, and men are less likely to have a cleaning than women.

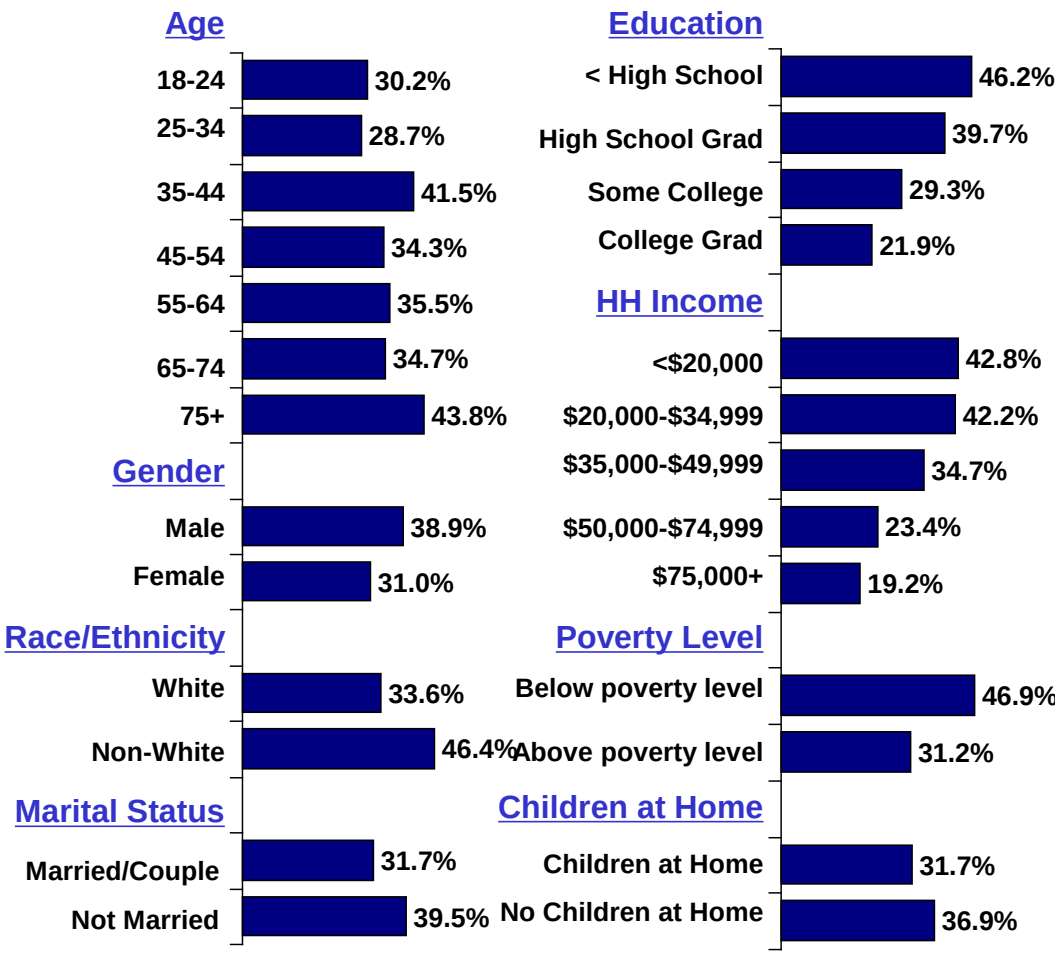
## Oral Health (Cont'd.)

### No Teeth Cleaning in Past Year* (Total Sample)




*Among adults, the proportion who reported that they did not have their teeth cleaned by a dentist or dental hygienist in the previous year.

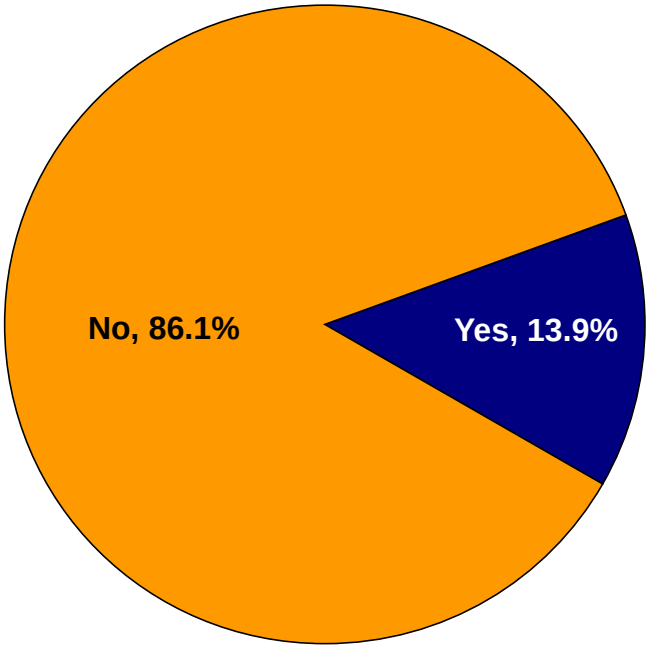
### No Teeth Cleaning in Past Year by Demographics



More than one in ten (13.9%) area adults have experienced problems receiving needed dental care. Those who have had problems cite an **lack of insurance** and an **inability to afford dental services** as the top barriers to receiving dental care. Other barriers include the **inability to pay out-of-pocket expenses such as co-pays and deductibles**, **providers not accepting a wider range of insurance plans**, and **insurance companies refusing to approve dental care**.

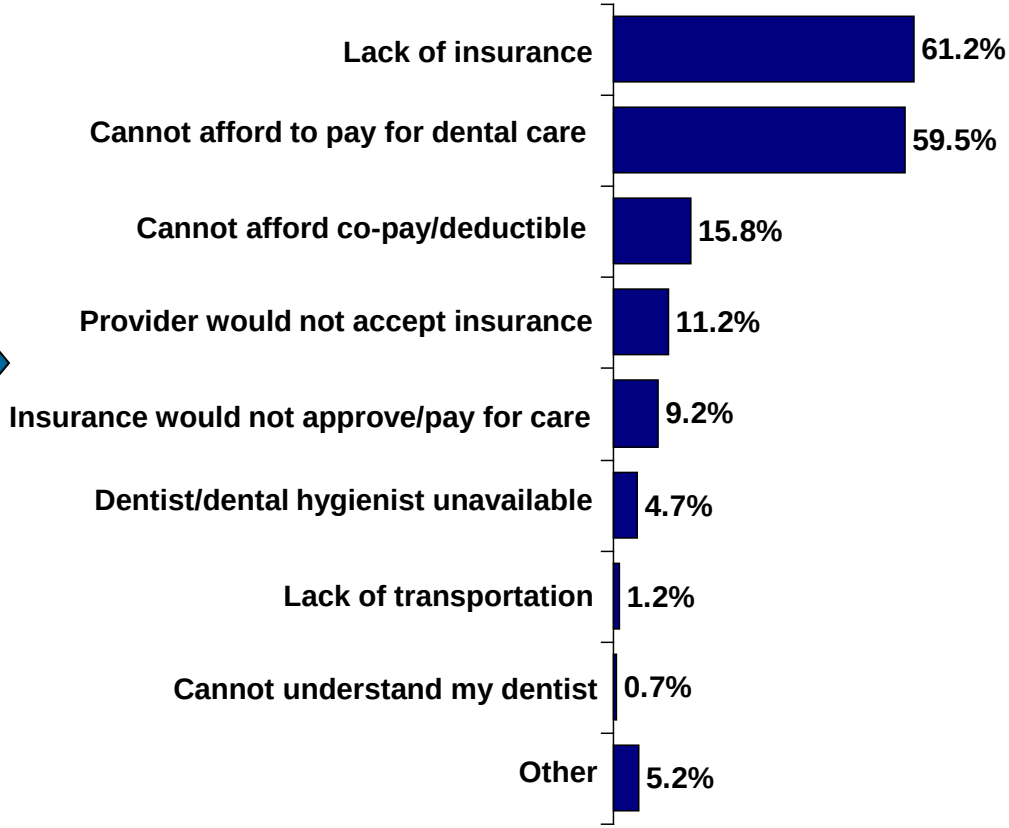
## Barriers to Dental Care

### Problems Getting Needed Dental Care




(n=971)

### Reasons for Difficulty in Getting Dental Care



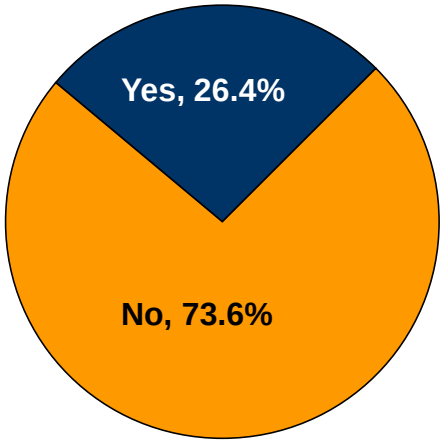

(n=121)
Base=had trouble getting needed dental care

Q23.3: In the past 12 months, have you had problems getting needed dental care?
Q23.4: Please provide the reason(s) for the difficulty in getting dental care. (Multiple responses allowed)

Among all SHGMH area adults, 26.4% have received a pneumonia shot at some point. More than four in ten (41.9%) have received a flu shot or vaccine in the past 12 months, and over half of them (55.1%) received it at a physician's office/HMO. Other common places to receive flu shots are at a store or at work.

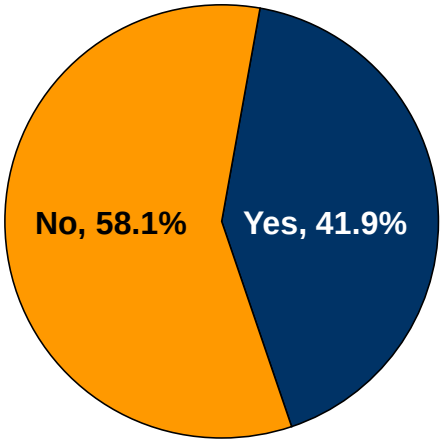
## Flu and Pneumonia Immunization

### Ever Had a Pneumonia Shot



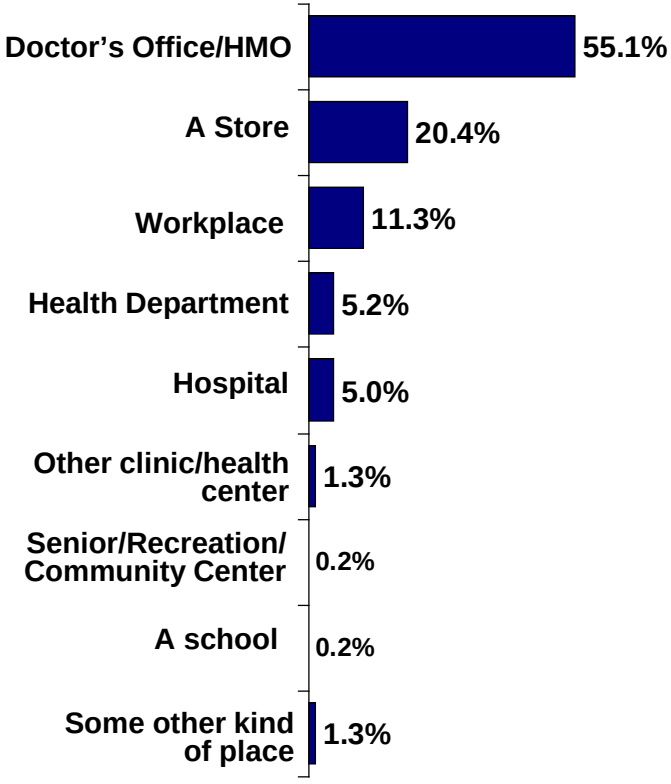

(n=962)

### Had Flu Shot/Vaccine in Past 12 Months




(n=976)

### Place Where Received Flu Shot/Vaccine



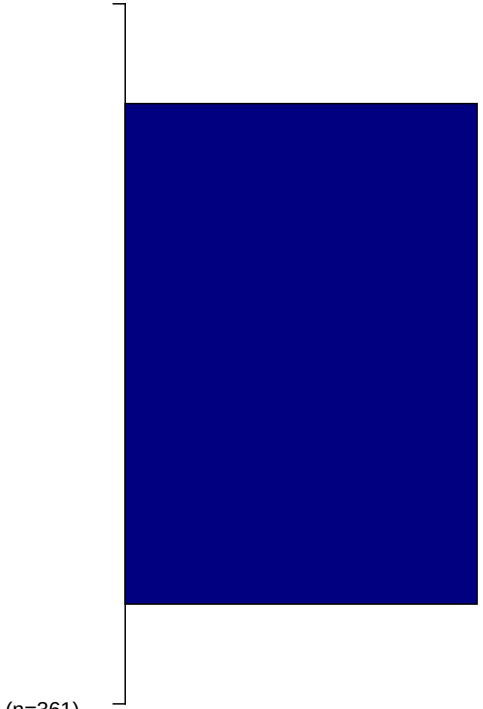

(n=494)

Q19.3: A pneumonia shot or pneumococcal vaccine is usually given only once or twice in a person's lifetime and is different from the flu shot. Have you ever had a pneumonia shot?
Q19.1: During the past 12 months, have you had either a seasonal flu shot or a seasonal flu vaccine that was sprayed in your nose?
Q19.2: At what kind of place did you get your last seasonal flu shot/vaccine?

Seven in ten (70.0%) adults aged 65 or older have received a flu vaccine in the past year. Senior non-White adults are more likely than White adults to have received a flu vaccine in the past year. Those living above the poverty line are more likely to have a flu vaccine than those living below it. Having a flu vaccine is inversely related to level of education.

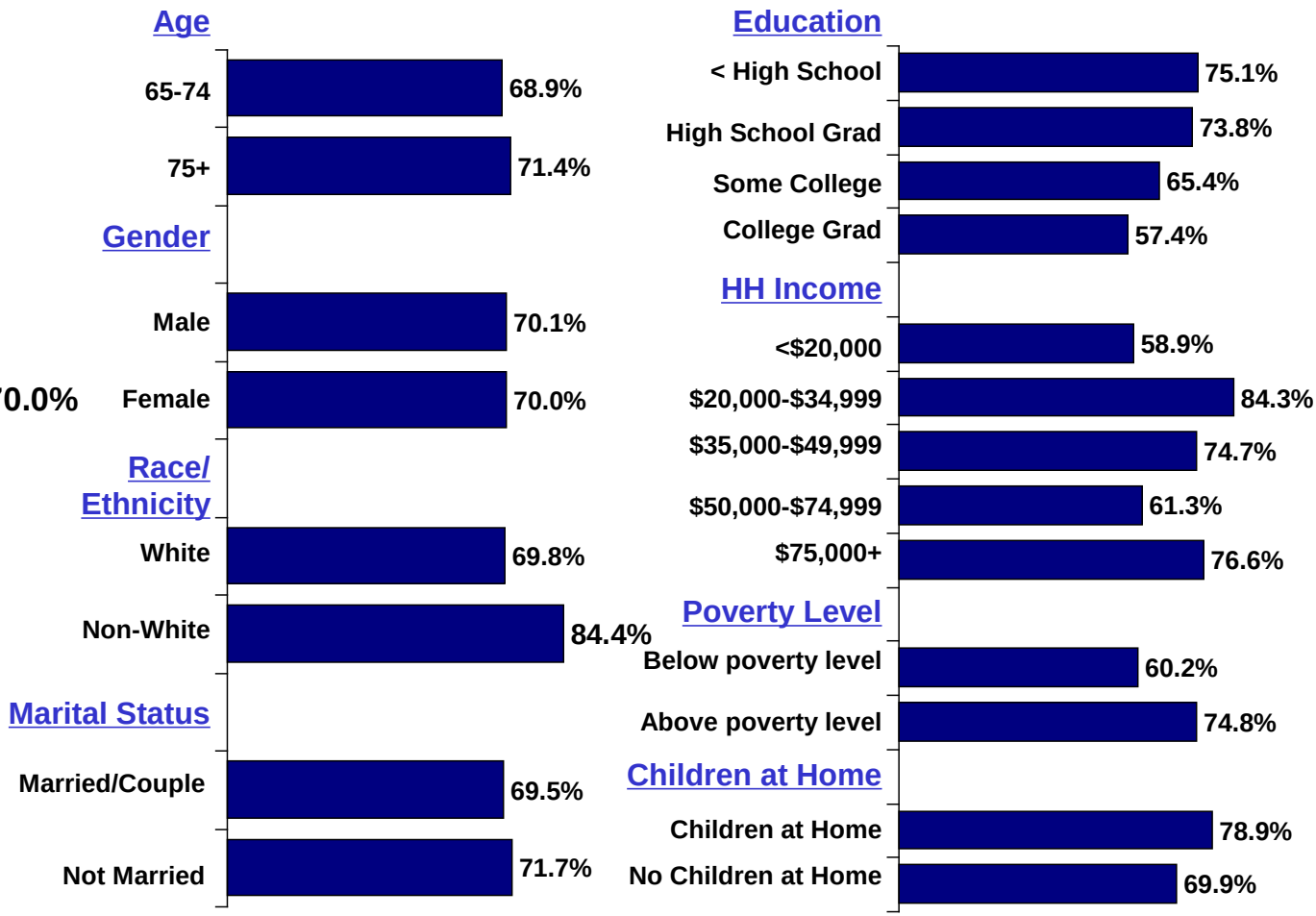
## Immunizations Among Adults 65 Years and Older

### Had Flu Vaccine in Past Year* (Total Sample)




*Among adults aged 65 years and older, the proportion who reported that they had a flu vaccine, either by an injection in the arm or sprayed in the nose during the past 12 months.

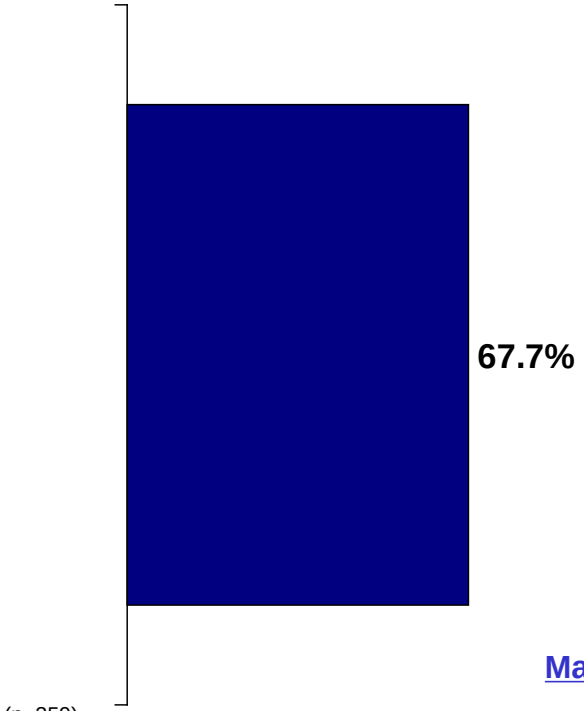
### Had Flu Vaccine by Demographics



Additionally, two-thirds (67.7%) of adults aged 65 or older received a pneumonia vaccine at some point and this rate is higher for those aged 75 or older. Non-White adults are more likely to have a pneumonia vaccine than White adults, and unmarried adults are more likely to have the vaccine compared to married adults. Senior adults living above the poverty level are more likely to have a flu vaccine than those living below the poverty line.

## Immunizations Among Adults 65 Years and Older (Cont'd.)

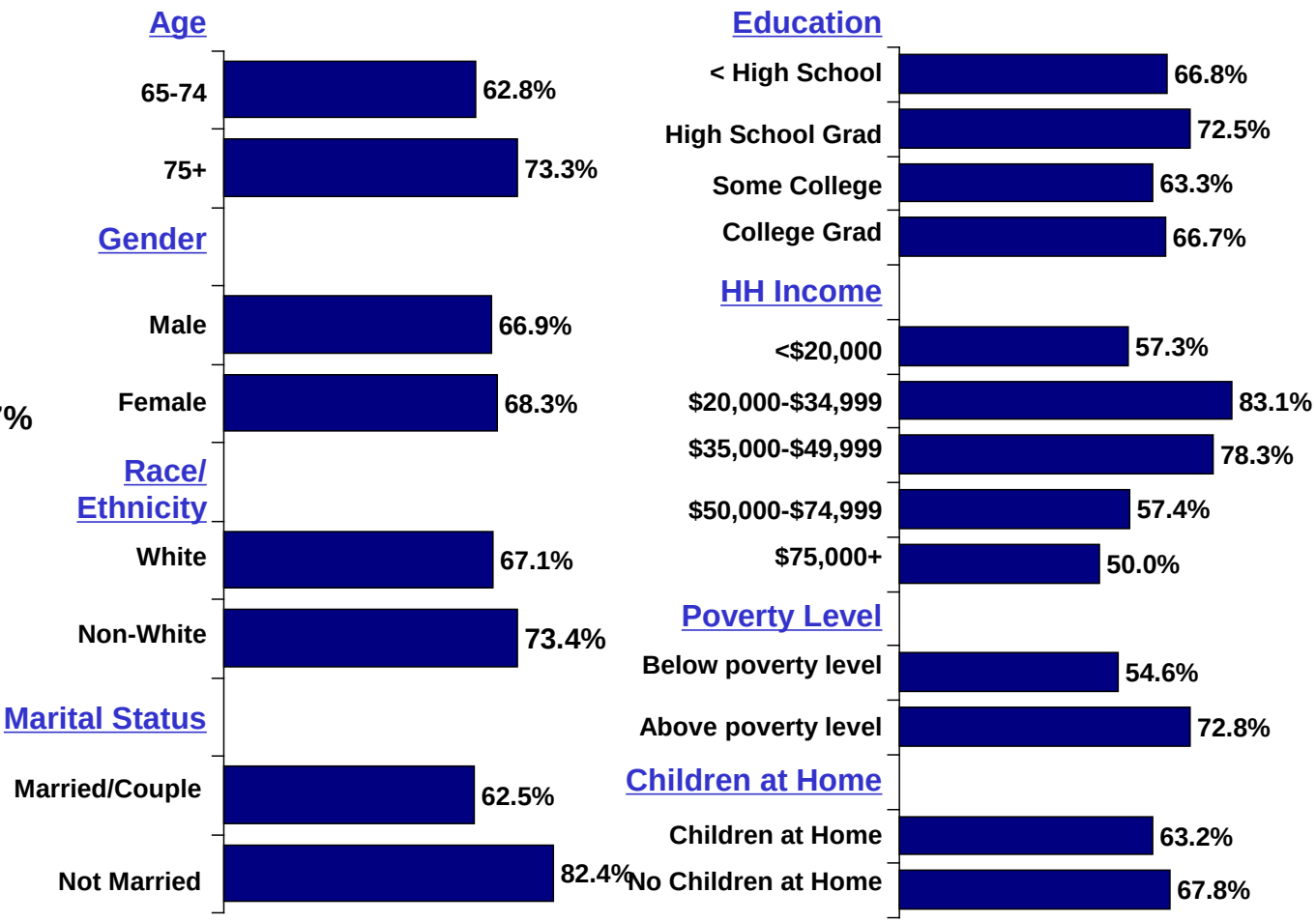
### Ever Had Pneumonia Vaccine* (Total Sample)




(n=359)

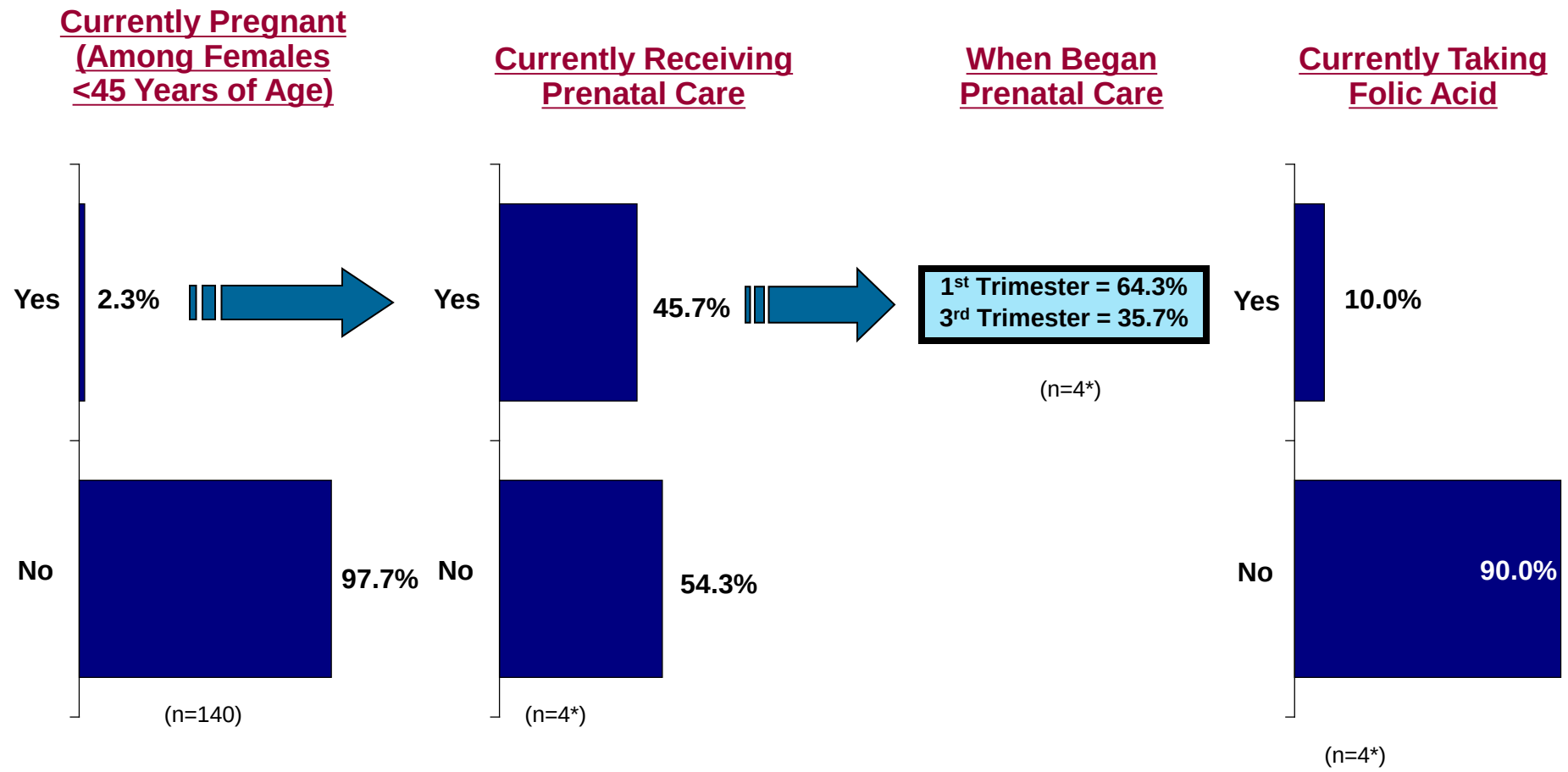
*Among adults aged 65 years and older, the proportion who reported that they ever had a pneumococcal vaccine.

### Had Pneumonia Vaccine by Demographics



Although the sample size is very small, the prenatal measures are somewhat alarming. For example, among pregnant females, less than half are currently receiving prenatal care and 64.3% began their care in the first trimester. Moreover, only one in ten are currently a vitamin or supplement that contains folic acid.

## Pregnancy and Prenatal Care



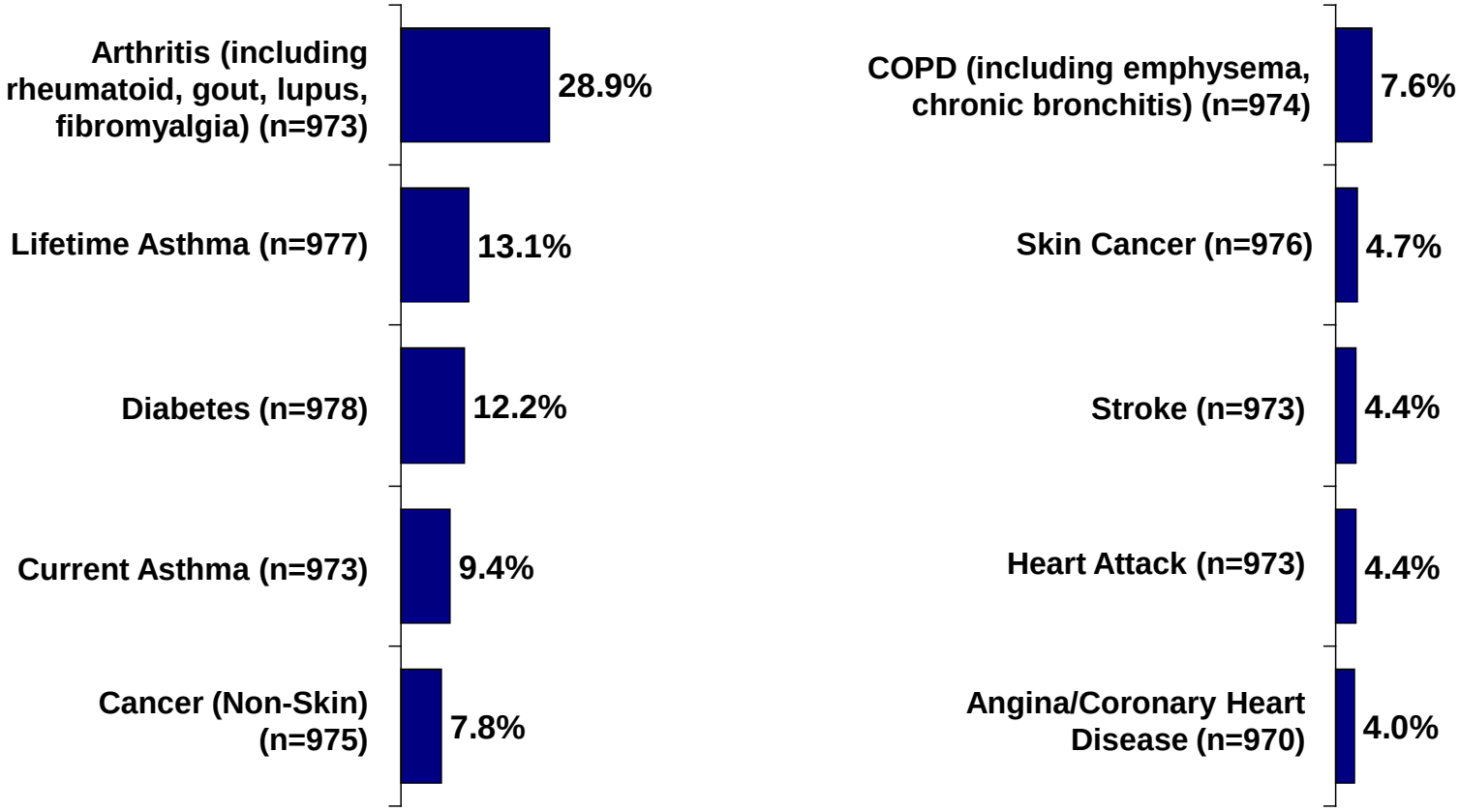

Q13.17: To your knowledge, are you now pregnant?
Q14.1 (If yes) Are you currently receiving prenatal care?
Q14.2: (If yes) When did you start receiving prenatal care?
Q14.3: (If yes) Are you currently taking a vitamin or supplement that contains folic acid?

*Caution: small n size

# *Chronic Conditions*

Arthritis-related conditions are the most prevalent chronic conditions among SHGMH area adults, by far, followed by diabetes and asthma. Prevalence is low for heart conditions and stroke.

## Prevalence of Chronic Health Conditions (% Have Been Told They Have)

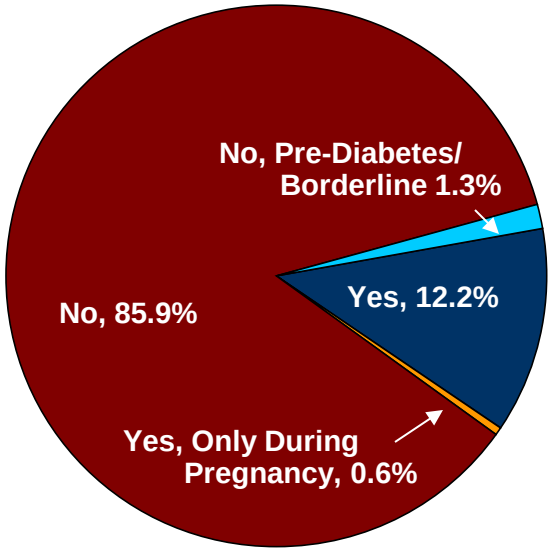



Q9.1-Q9.10: Has a doctor, nurse, or other health professional EVER told you that you had….
Q9.2: Do you still have asthma?

More than one in ten (12.2%) area adults has ever been told they have diabetes. On average, those with diabetes see a health professional and/or are checked for A1c between three and four times a year.

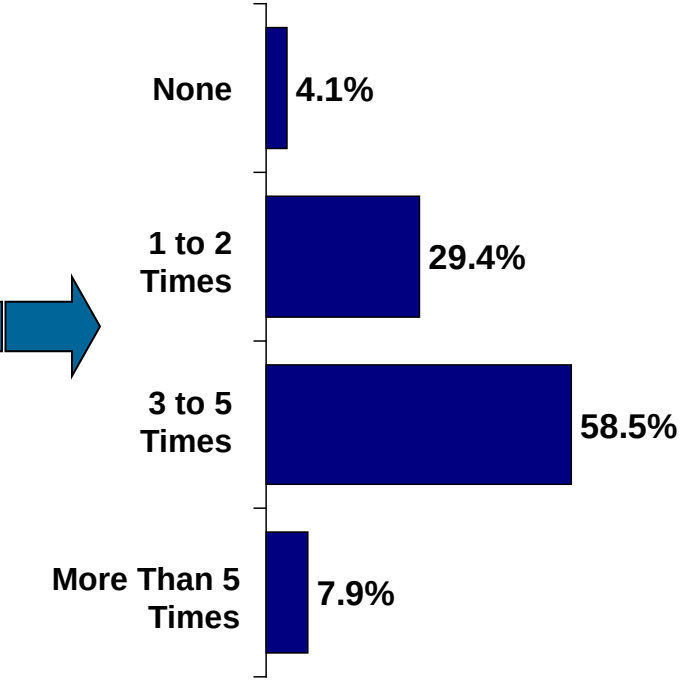
## Prevalence of Diabetes

### Ever Told Have Diabetes



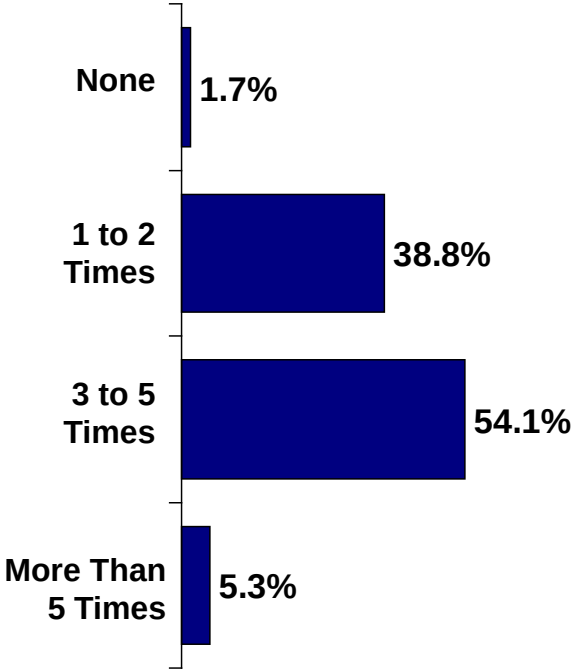

(n=978)

### Number of Times in Past 12 Months Seen Health Professional for Diabetes




(n=137) Mean = 3.6

### Number of Times in Past 12 Months Checked for A1c



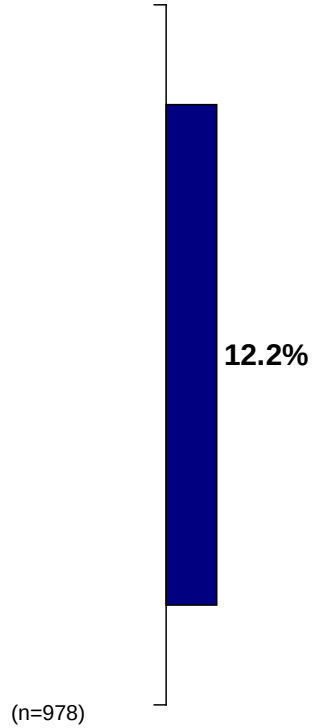

(n=134) Mean = 3.3

Q9.10: Has a doctor, nurse, or other health professional EVER told you that you had diabetes?
Q10.1: About how many times in the past 12 months have you seen a doctor, nurse, or other health professional for your diabetes?
Q10.2: A test for "A one C" measures the average level of blood sugar over the past three months. About how many times in the past 12 months have a doctor, nurse, or other health professional checked you for "A one C?"

The prevalence of diabetes is greater for older adults (55+), non-White adults, those with incomes less than $50K, and those with less than a high school diploma. The prevalence of diabetes is lowest among those under age 45 and among those with incomes of $50K or more.

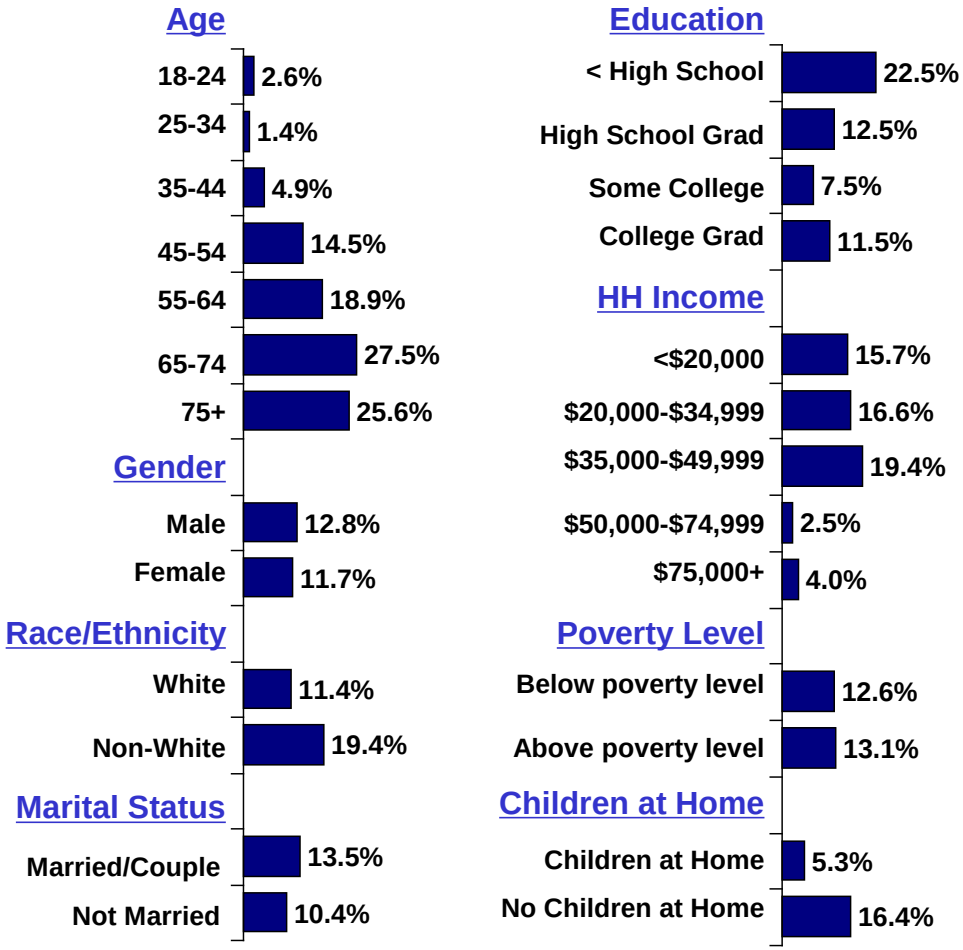
# Diabetes

## Ever Told Have Diabetes* (Total Sample)



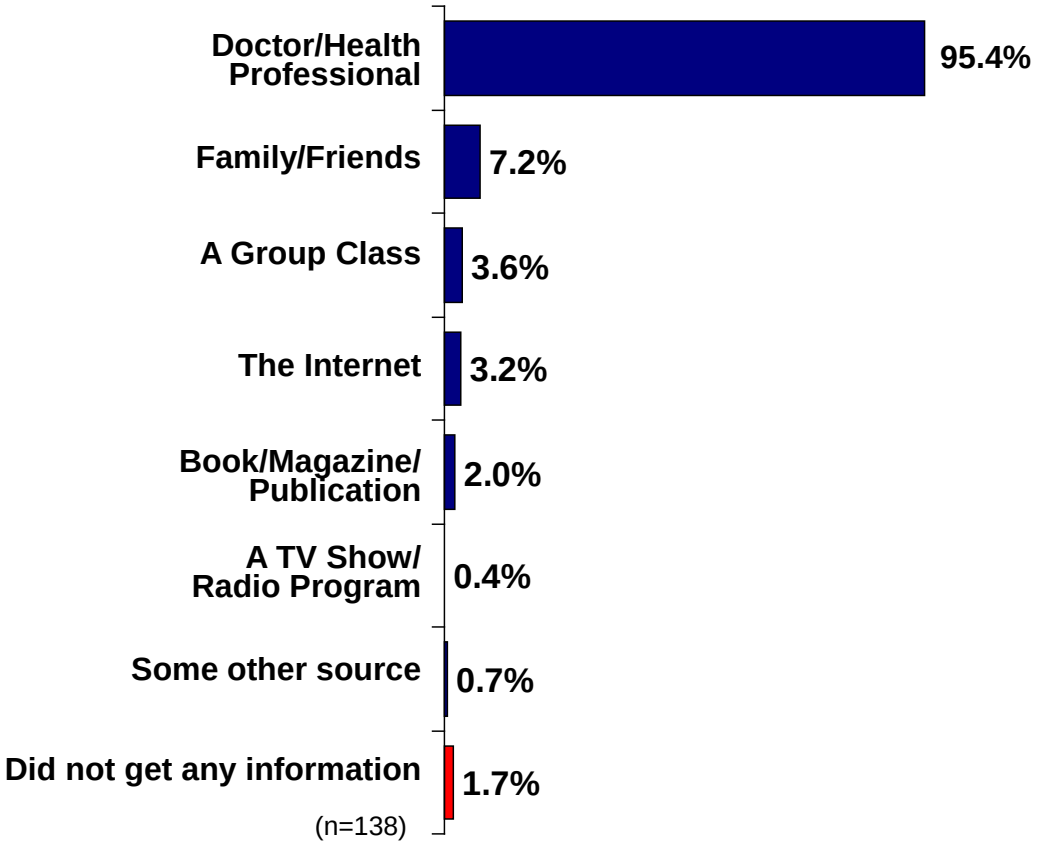

*Among all adults, the proportion who reported that they were ever told by a doctor that they have diabetes. Adults who had been told they have prediabetes and women who had diabetes only during pregnancy were classified as not having been diagnosed.

## Told Have Diabetes by Demographics



Almost all (98.3%) adults who have diabetes have received information in the past 12 months on how to care for the condition and most, by far, have received it from a doctor or health care professional. Other sources include family/friends, a group class, and the Internet.

## Information Sources for Management of Diabetes

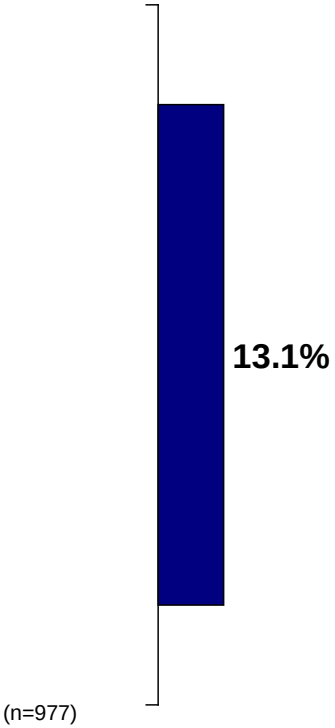



Q11.1: During the last 12 months, where did you get information about taking care of your [INSERT DISEASE]?

More than one in ten (13.1%) adults in the SHGMH area have been diagnosed with asthma in their lifetime. This rate is highest for adults aged 25-34 and lowest for those 75 years or older. Women are twice as likely as men to have been diagnosed with asthma in their lifetime. Least likely to have been diagnosed are college graduates and/or adults with incomes of $35K or more.

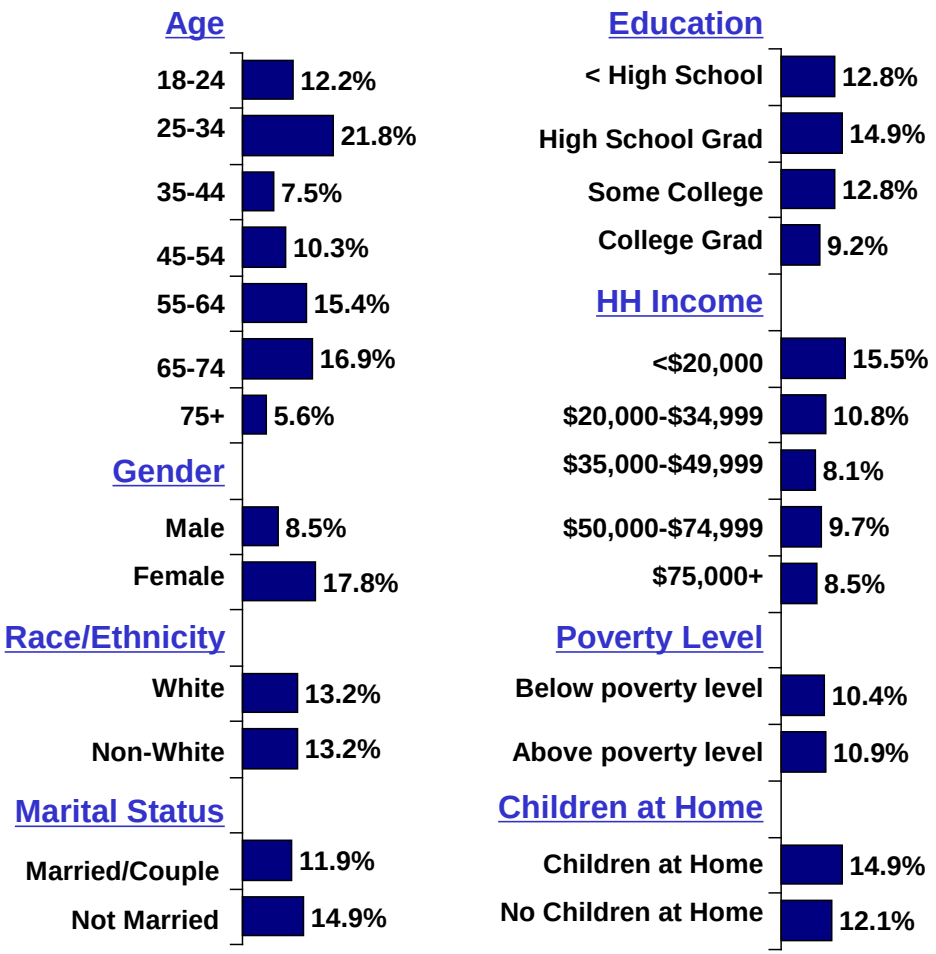
## Asthma Among Adults

### Lifetime Asthma Prevalence* (Total Sample)




*Among all adults, the proportion who reported that they were ever told by a doctor, nurse, or other health care professional that they had asthma.

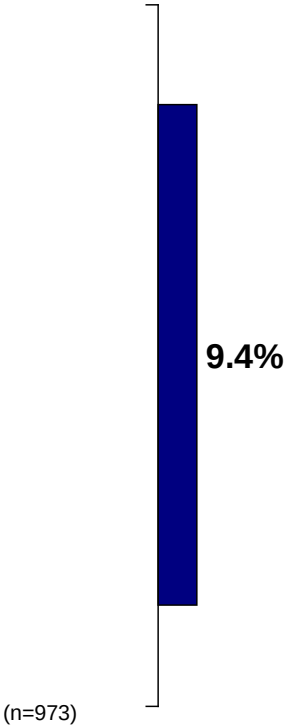
### Lifetime Asthma by Demographics



Fewer (9.4%) adults in the SHGMH area currently have asthma. Still, women are far more likely than men to currently have asthma. Having asthma is inversely related to education and income, where those without a college education are more likely to have the condition than those with a college education. Further, the prevalence of asthma for those with household incomes less than $20K is 11.2% vs. 3.1% for those with incomes of $75K or more.

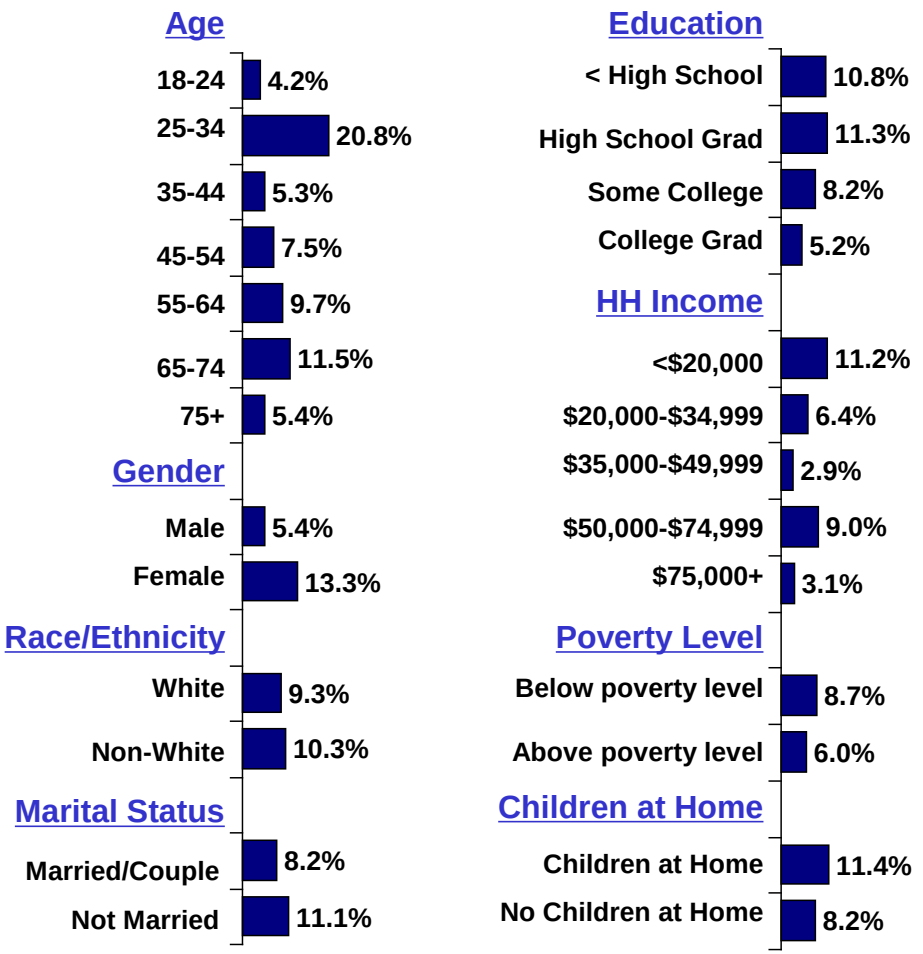
## Asthma Among Adults (Cont'd.)

### Current Asthma Prevalence* (Total Sample)



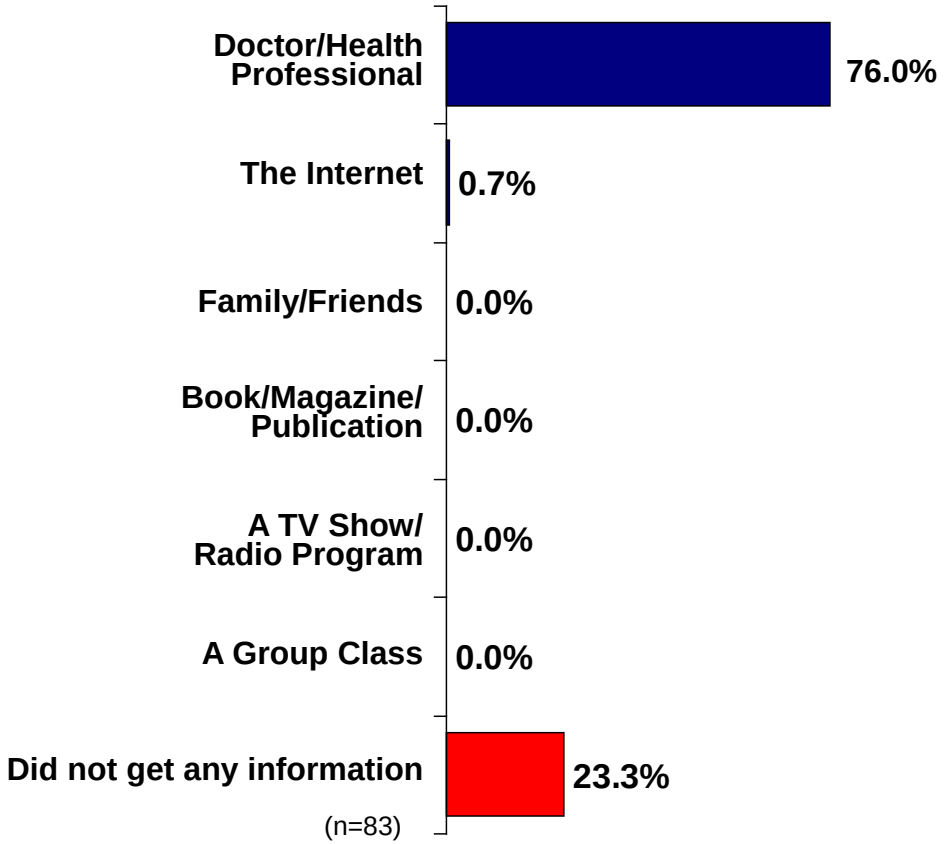

*Among all adults, the proportion who reported that they still had asthma.

### Current Asthma by Demographics



Three-fourths (76.7%) of adults who have asthma have received information in the past 12 months on how to care for the condition. However, this means nearly one-fourth (23.3%) have not received any information on ways to manage their asthma.

## Information Sources for Management of Asthma

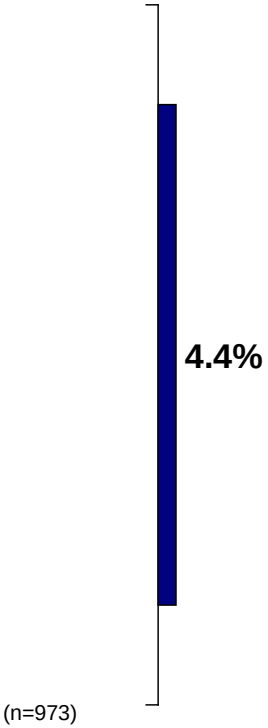



Q11.1: During the last 12 months, where did you get information about taking care of your [INSERT DISEASE]?

Very few area adults have had a heart attack and this is true regardless of demographics. That said, the prevalence of having a heart attack is directly related to age and inversely related to education and income. Further, it is a more common condition among men than women and more common among White adults compared to non-White adults.

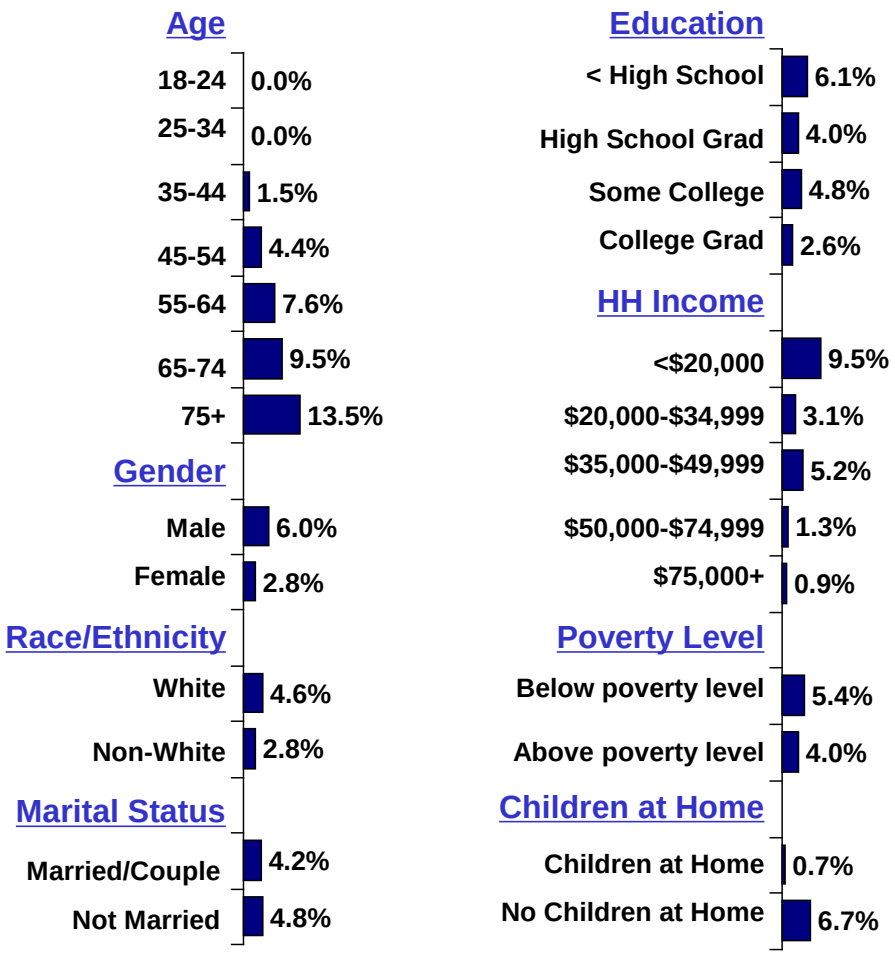
## Cardiovascular Disease

### Ever Told Had Heart Attack* (Total Sample)



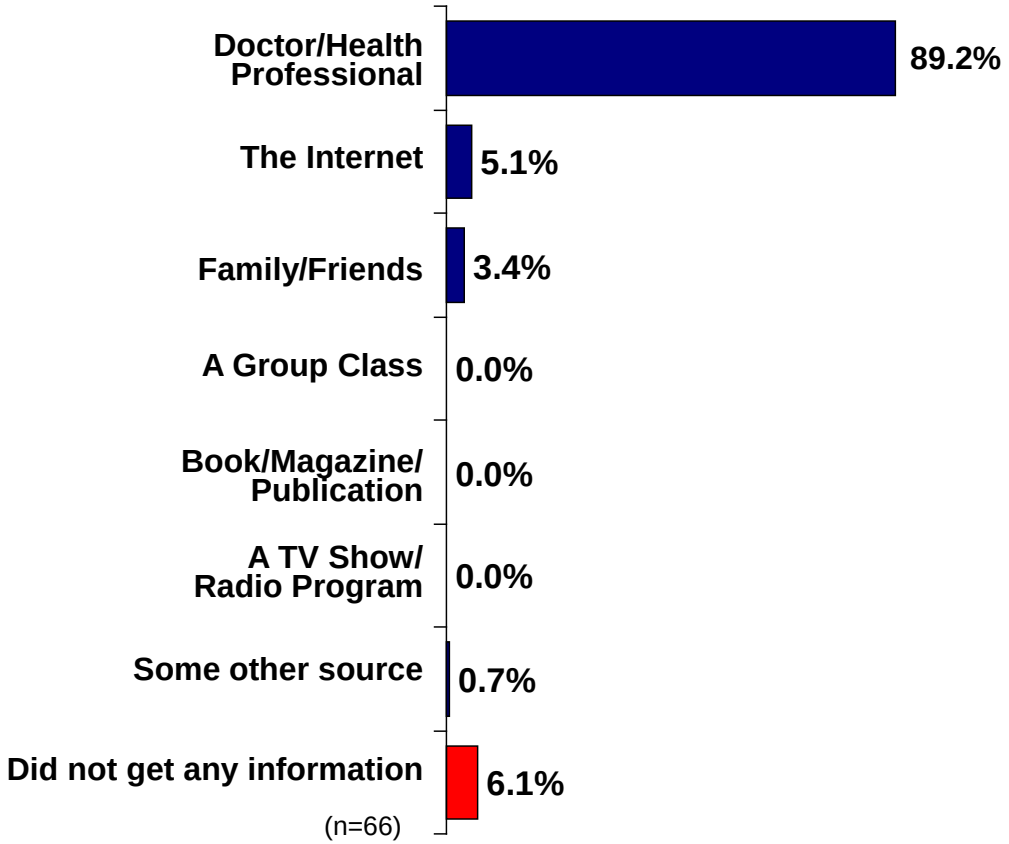

*Among all adults, the proportion who had ever been told by a doctor that they had a heart attack or myocardial infarction.

### Told Had Heart Attack by Demographics



More than nine in ten (93.9%) area adults who have had a heart attack have received information in the past 12 months on how to care for the condition. The greatest information source is the physician or health care professional. Other sources include the Internet, family, and friends.

## Information Sources for Management of Heart Attack/ Cardiovascular Disease

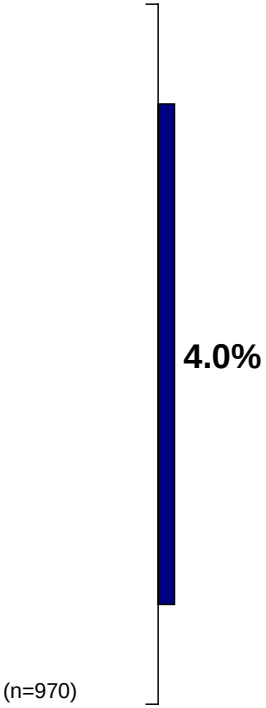



Q11.1: During the last 12 months, where did you get information about taking care of your [INSERT DISEASE]?

Very few area adults have ever been told they have angina or coronary heart disease. The rate is highest for adults aged 65+, those without a high school diploma, and those living in households with incomes less than $20K.

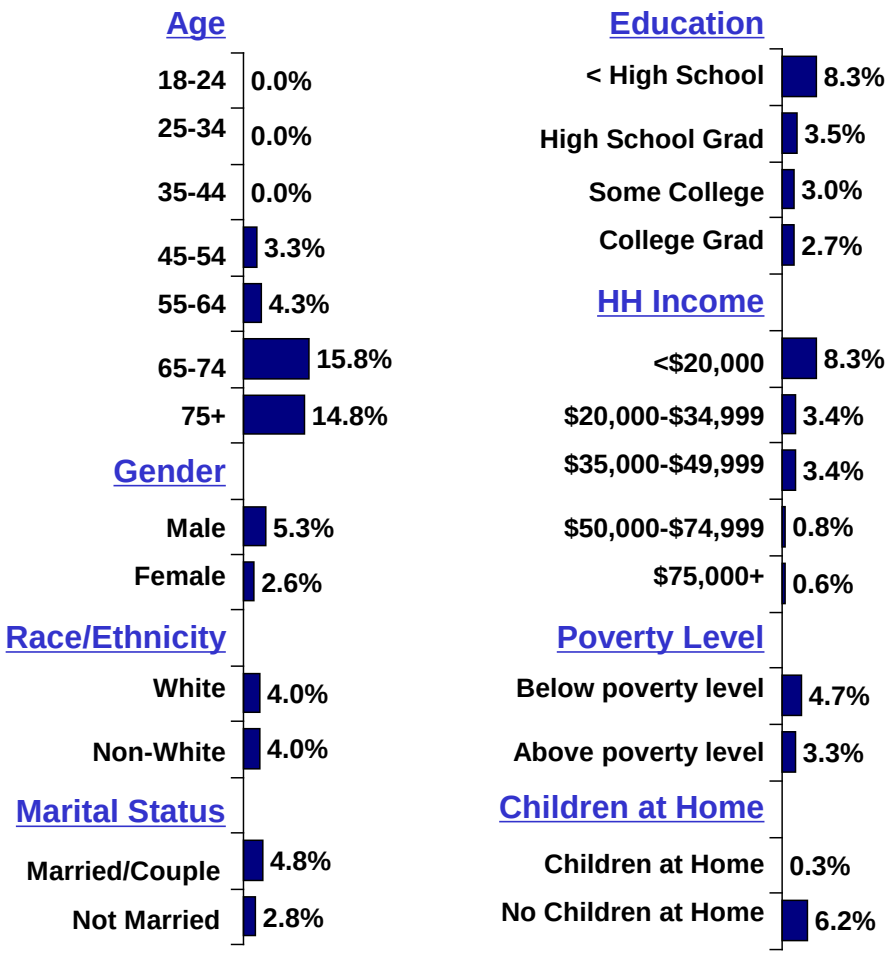
## Cardiovascular Disease (Cont'd.)

### Ever Told Have Angina/Coronary Heart Disease* (Total Sample)



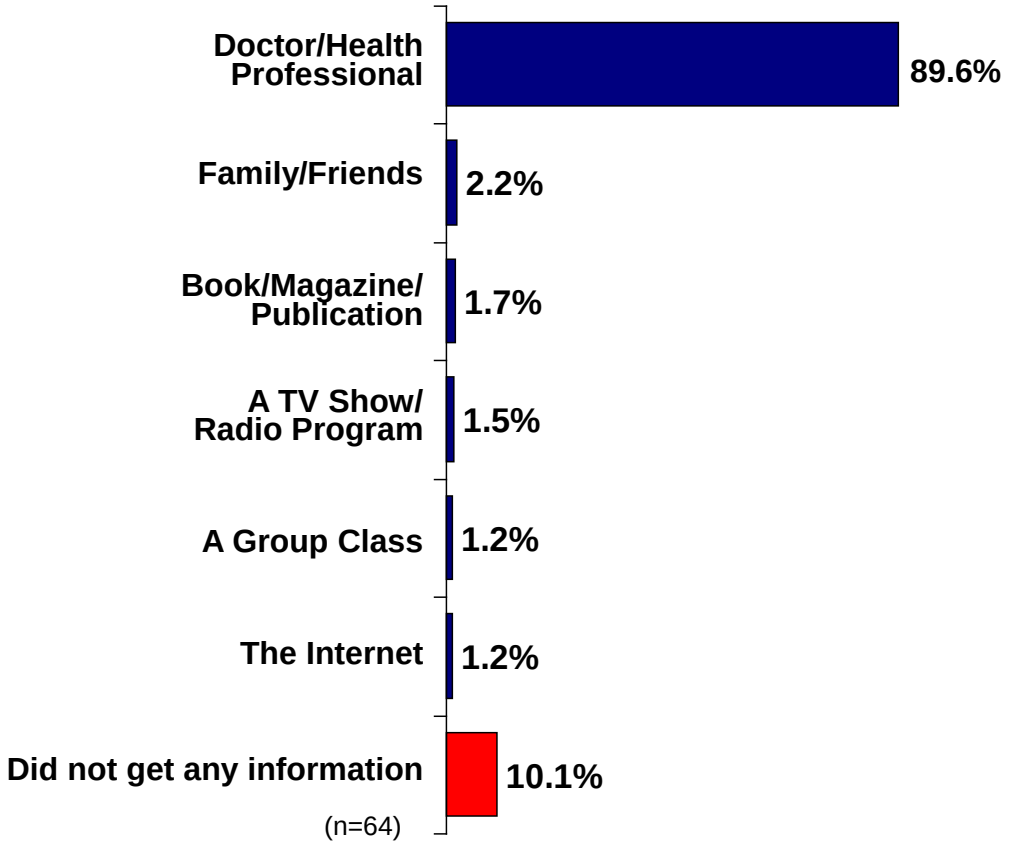

*Among all adults, the proportion who had ever been told by a doctor that they had angina or coronary heart disease.

### Told Have Angina/Coronary Heart Disease by Demographics



Nine in ten (89.9%) SHGMH area adults who have angina or coronary heart disease have received information in the past 12 months on how to care for these conditions. The greatest information source is the physician or health care professional. Too a far less degree, other sources include family/friends, books/periodicals, television, group classes, and the Internet.

## Information Sources for Management of Angina

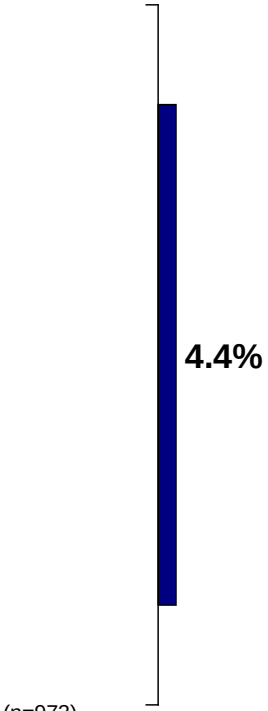



Q11.1: During the last 12 months, where did you get information about taking care of your [INSERT DISEASE]?

Few area adults have had a stroke. The highest prevalence of stroke can be found in the highest age, lowest education, and lowest income groups.

## Cardiovascular Disease (Cont'd.)

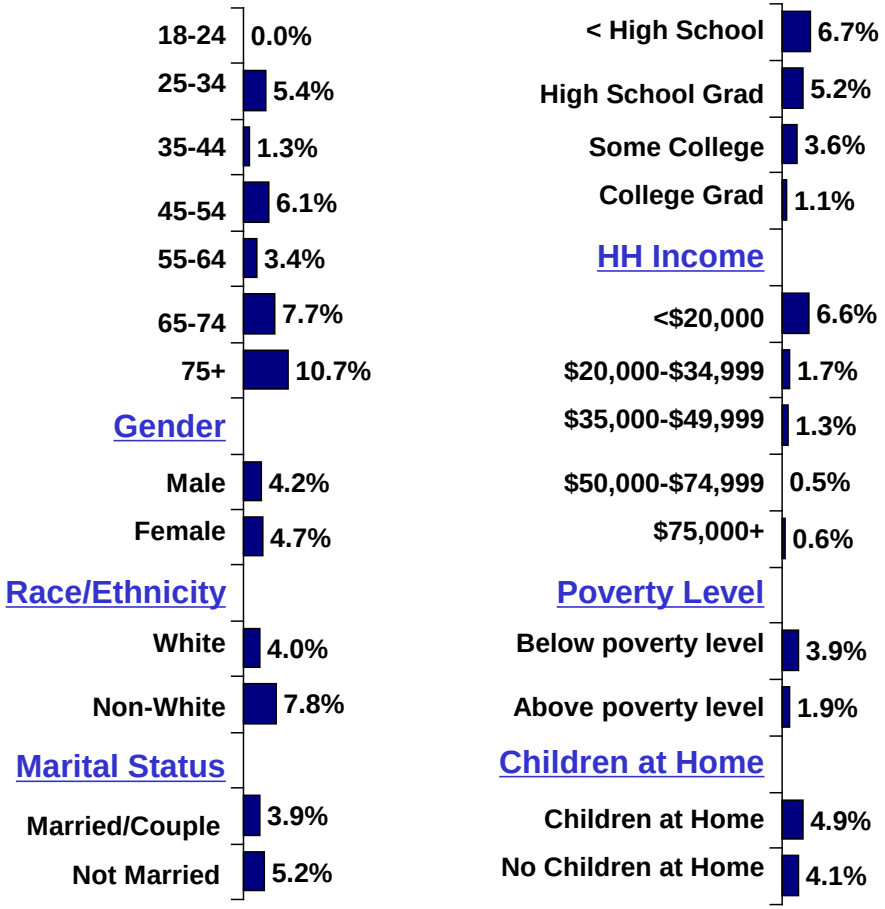
### Ever Told Had a Stroke* (Total Sample)




(n=973)

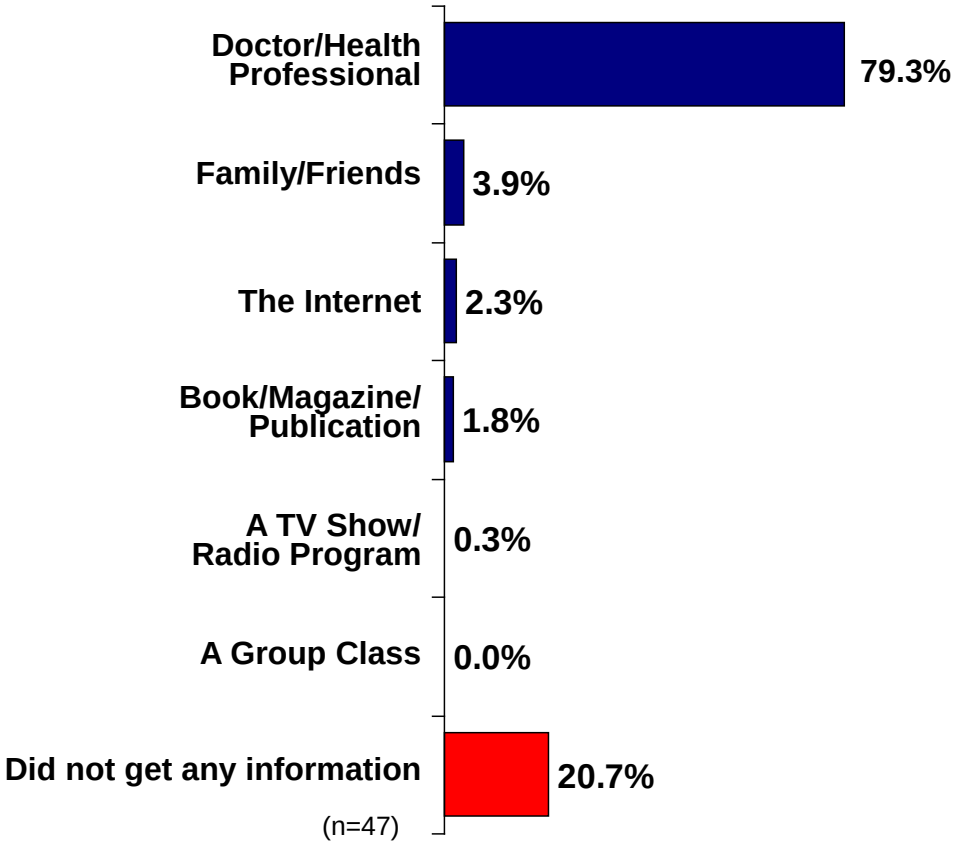
*Among all adults, the proportion who had ever been told by a doctor that they had a stroke.

### Told Had Stroke by Demographics



Eight in ten (79.3%) area adults who have had a stroke have received information in the past 12 months on how to care for the condition and they received their information first from health care professionals, then from family/friends, the Internet, or books and periodicals.

## Information Sources for Management of Stroke

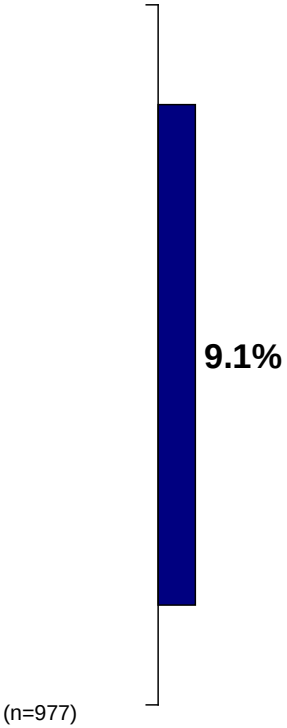



Q11.1: During the last 12 months, where did you get information about taking care of your [INSERT DISEASE]?

Having any form of cardiovascular disease (heart attack, angina, stroke) is directly related to age and inversely related to education and income. For example, 4.3% of college graduates have experienced heart disease in some form, compared to 13.5% of those with less than a high school diploma. Men are more likely than women to have some form of heart disease.

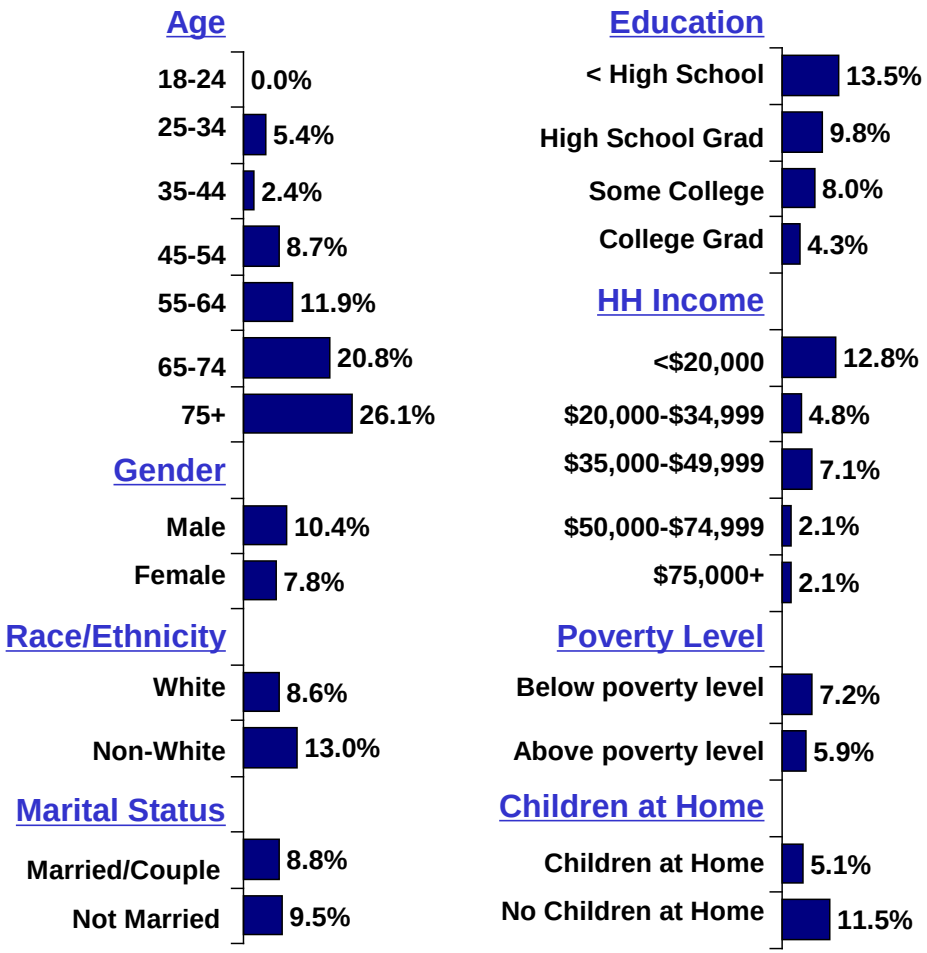
## Any Cardiovascular Disease

### Ever Told Had Heart Attack, Angina, or Stroke* (Total Sample)




*Among all adults, the proportion who had ever been told by a doctor that they had a heart attack, angina, or stroke.

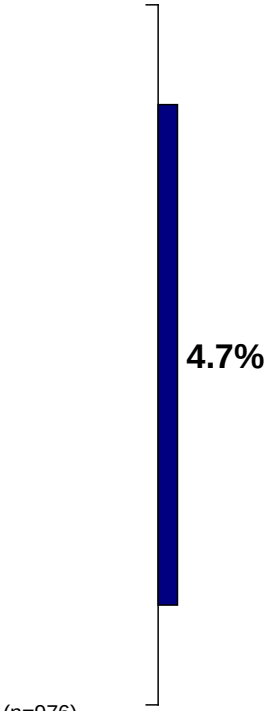
### Told Had Heart Attack, Angina, or Stroke by Demographics



Roughly one in twenty (4.7%) area adults have been told by a doctor they have skin cancer. Expectedly, this proportion rises dramatically with age; 17.3% of people aged 75 or older have been told they have skin cancer. The prevalence is also higher for adults with the highest incomes (6.6%) compared to those earning less than $20K annually (2.5%).

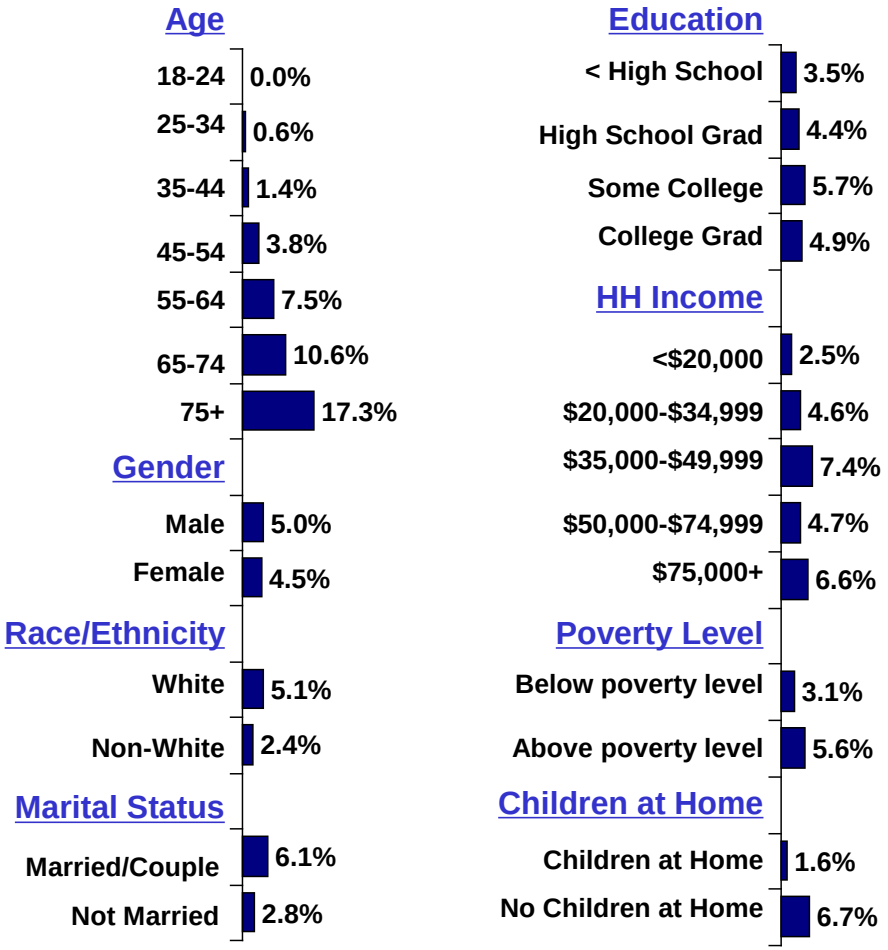
## Skin Cancer

### Ever Told Have Skin Cancer* (Total Sample)



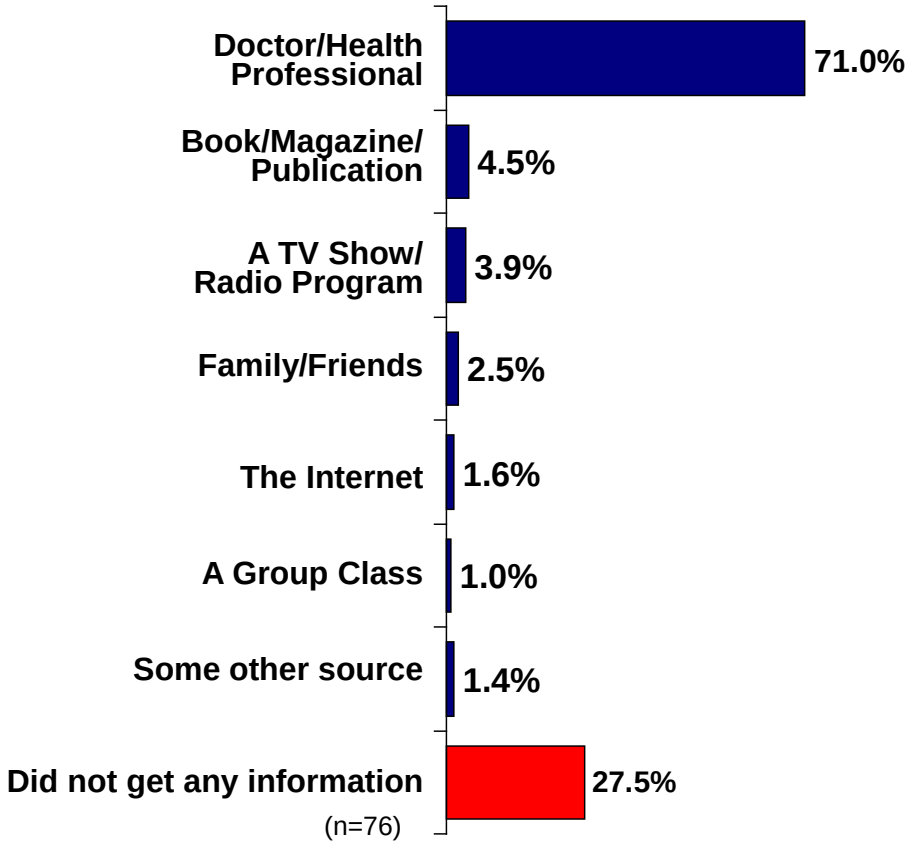

*Among all adults, the proportion who reported that they were ever told by a doctor that they have skin cancer.

### Told Have Skin Cancer by Demographics



Seven in ten (72.5%) area adults who have skin cancer have received information in the past 12 months on how to care for the condition and get the information primarily from physicians and health care professionals, but also from book and periodicals, television shows, family and friends, and the Internet.

## Information Sources for Management of Skin Cancer

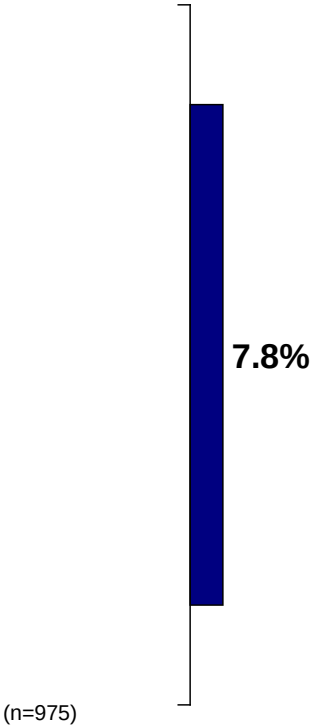



Q11.1: During the last 12 months, where did you get information about taking care of your [INSERT DISEASE]?

One in thirteen (7.8%) adults have been told by a doctor they have non-skin cancer. This proportion also rises dramatically with age; 24.0% of adults 65-74 years of age and 22.9% of those 75 or older, have been diagnosed with some form of non-skin cancer. Non-skin cancer is also twice as prevalent in White adults compared to non-White adults.

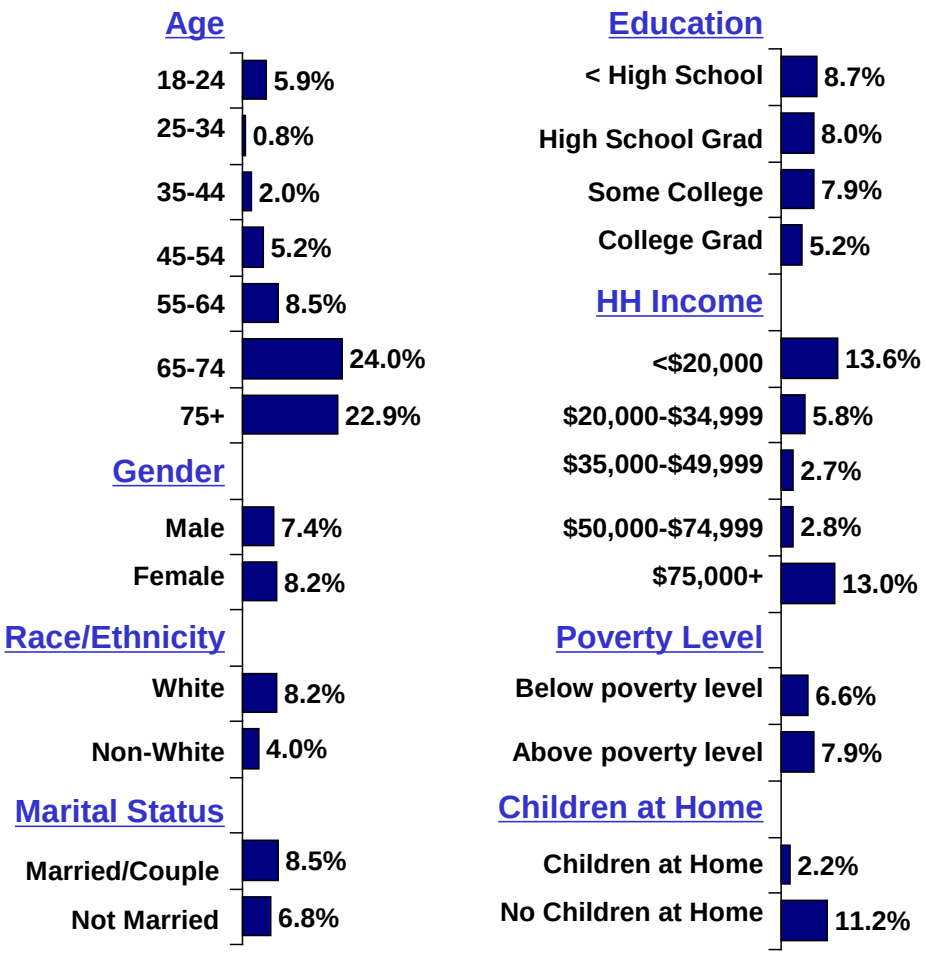
## Cancer (Other Than Skin)

### Ever Told Have Cancer (Other Than Skin)* (Total Sample)



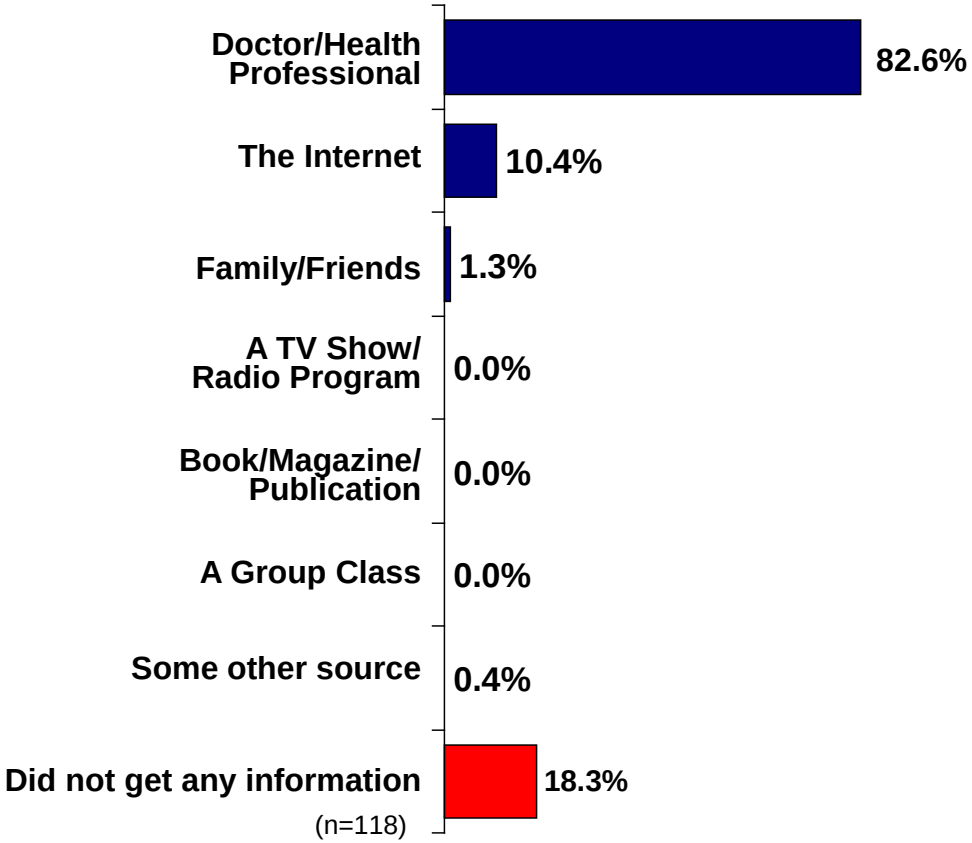

*Among all adults, the proportion who reported that they were ever told by a doctor that they have cancer (other than skin).

### Told Have Cancer by Demographics



More than eight in ten (81.7%) adults who have cancer (other than skin) have received information in the past 12 months on how to care for the condition. Physicians and health care professionals top the list of sources, however, one in ten (10.4%) receive information from the Internet.

## Information Sources for Management of Cancer (Other Than Skin)

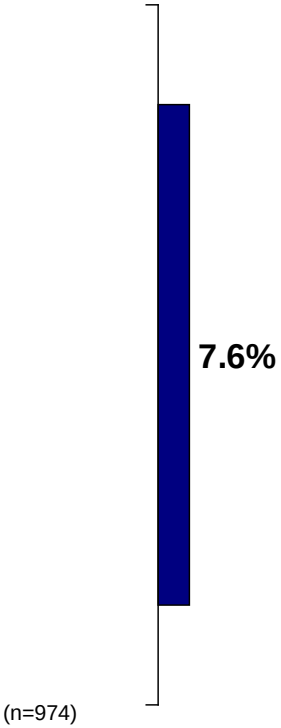



Q11.1: During the last 12 months, where did you get information about taking care of your [INSERT DISEASE]?

One in thirteen (7.6%) area adults have been told they have chronic obstructive pulmonary disease (COPD). The disease is more common among residents who are older (55+), have less education, and who have financial limitations. It is also more common among White adults than non-White adults.

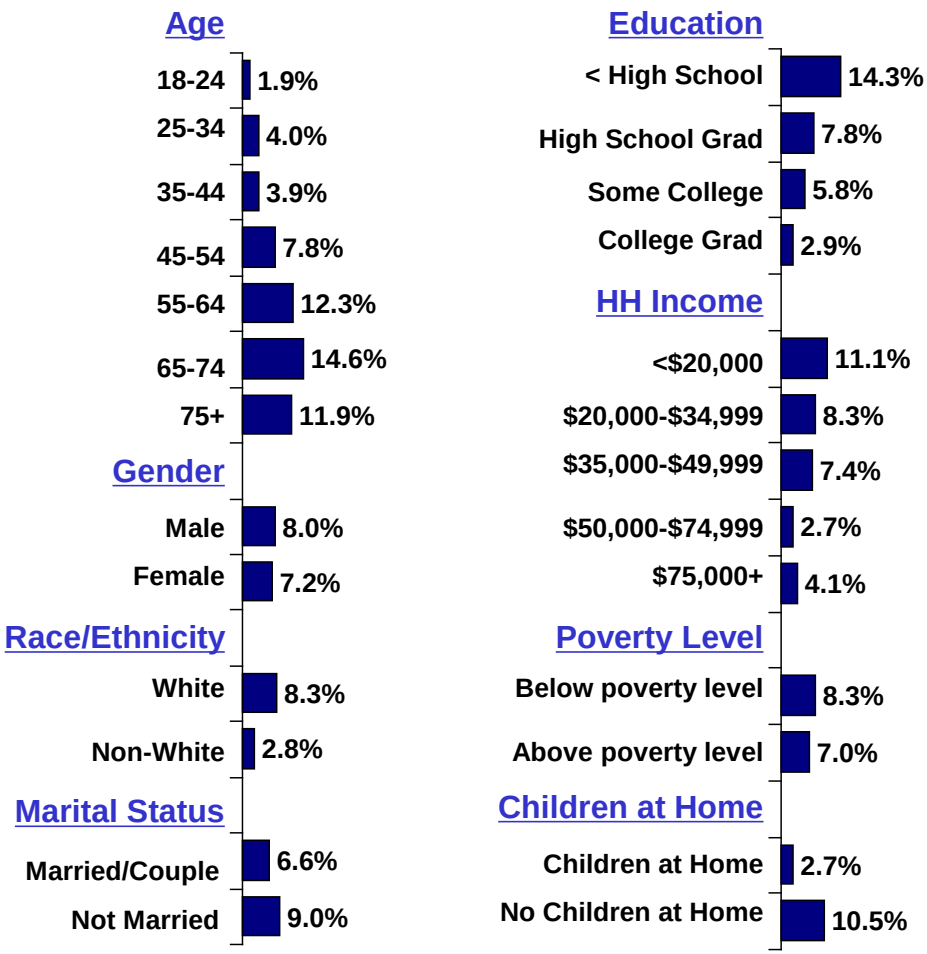
## COPD

### Ever Told Have COPD* (Total Sample)



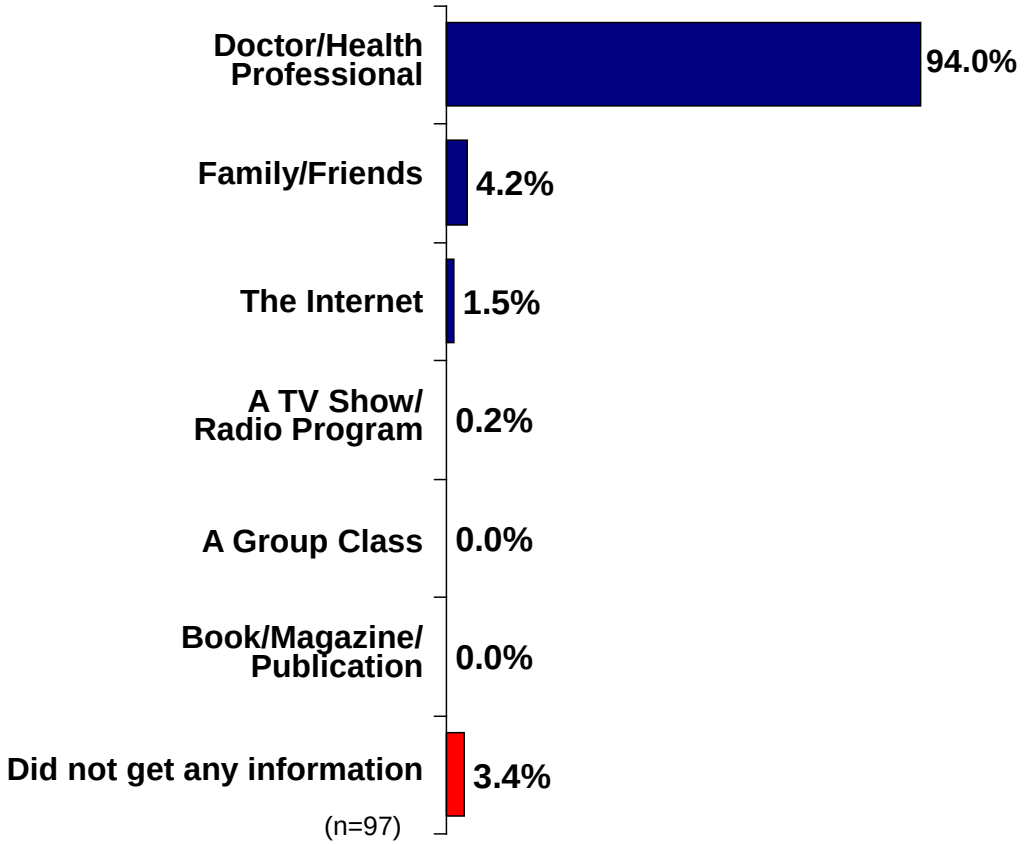

*Among all adults, the proportion who reported that they were ever told by a doctor that they have chronic obstructive pulmonary disease (COPD), emphysema, or chronic bronchitis.

### Told Have COPD by Demographics



Almost all (96.6%) adults who have COPD have received information in the past 12 months on how to care for the condition. The greatest information source for management of COPD, by far, is health care professionals.

## Information Sources for Management of COPD

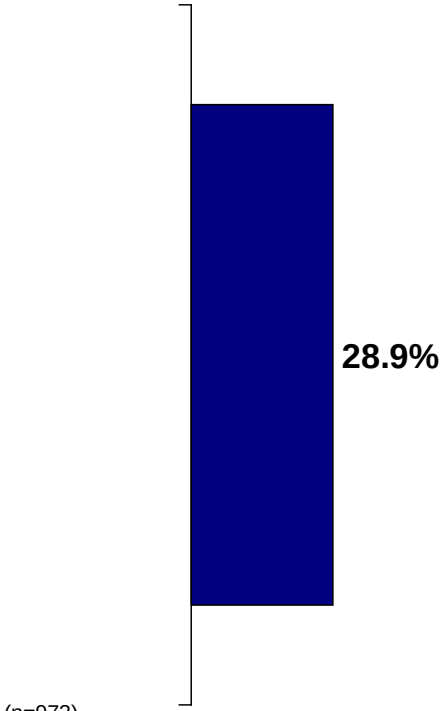



Q11.1: During the last 12 months, where did you get information about taking care of your [INSERT DISEASE]?

Nearly three in ten (28.9%) area adults have ever been told by a health care professional they have arthritis. This rate, not surprisingly, rises dramatically with age. Women are more likely to have arthritis than men. Having arthritis is less prevalent among adults with annual incomes of $50K or more.

# Arthritis

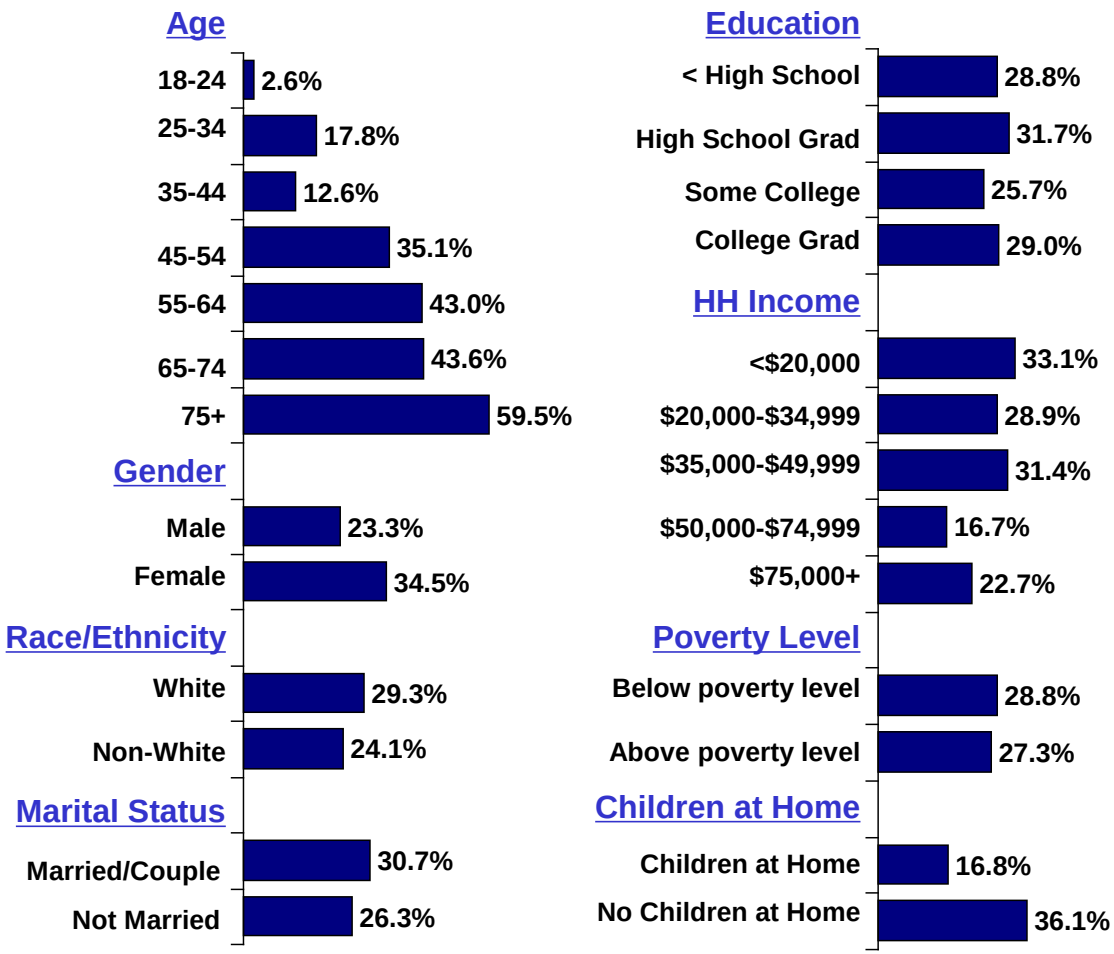
## Ever Told Have Arthritis* (Total Sample)




(n=973)

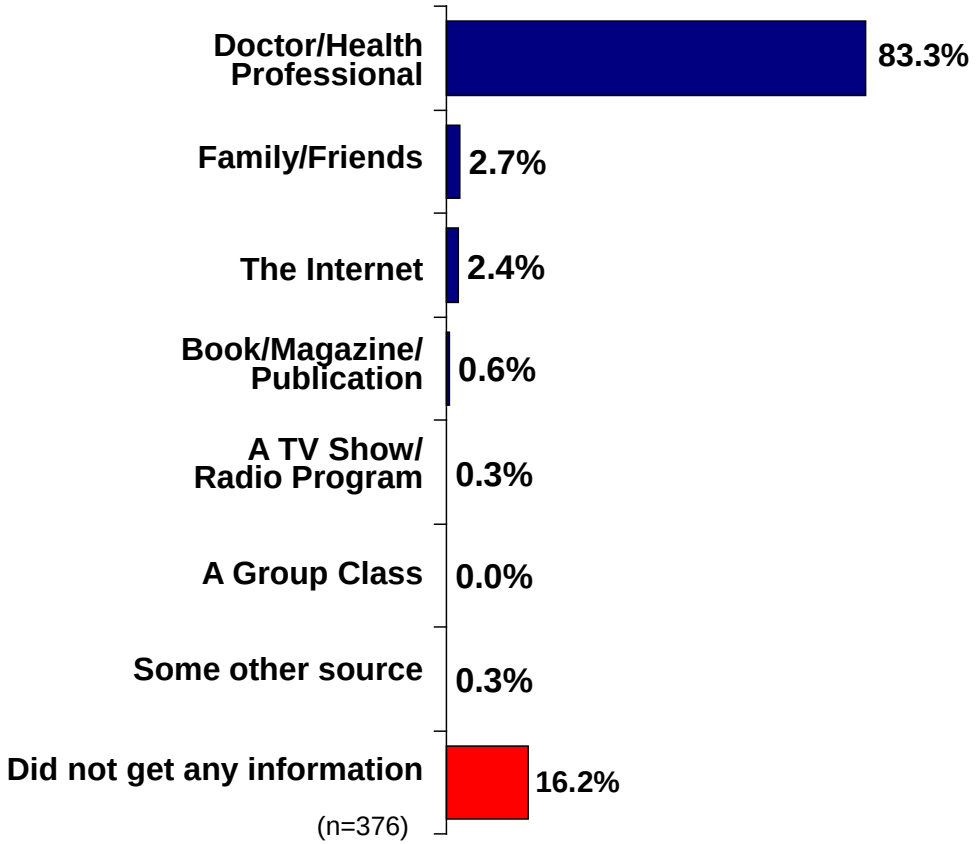
*Among all adults, the proportion who reported ever being told by a health care professional that they had some form of arthritis, rheumatoid arthritis, gout, lupus, or fibromyalgia.

## Told Have Arthritis by Demographics



More than eight in ten (83.8%) adults who have arthritis have received information in the past 12 months on how to care for the condition. In addition to physicians and health care professionals, others sources include family/friends and the Internet, although the latter are used far less often.

## Information Sources for Management of Arthritis




Q11.1: During the last 12 months, where did you get information about taking care of your [INSERT DISEASE]?

# Comparison of BRFS Measures Between Spectrum Health Gerber Memorial Hospital Service Area, Michigan, and the United States

## Health Status Indicators

| | SHGMH Service Area | Michigan | U.S. |
|---|---|---|---|
| General Health Fair/Poor | 22.1% | 17.7% | 16.9% (2013) |
| Poor Physical Health (14+ days) | 15.5% | 12.7% | -- |
| Poor Mental Health (14+ days) | 8.3% | 12.0% | -- |
| Activity Limitation (14+ days) | 10.2% | 8.8% | -- |
| Dissatisfied/Very Dissatisfied with Life | 4.9% | 6.1% (2010) | -- |
| Rarely/Never Receive Social and Emotional Support | 7.0% | 6.5% (2010) | -- |
| Obese | 29.9% | 31.5% | 28.9% (2013) |
| Overweight | 35.9% | 34.7% | 35.4% (2013) |
| Healthy Weight | 31.3% | 32.5% | 33.4% (2013) |
| No Health Care Coverage (18-64) | 9.3% | 17.4% | 20.0% (2013) |
| No Personal Health Care Provider | 11.1% | 17.0% | 22.9% (2013) |
| No Health Care Access Due to Cost | 9.1% | 15.5% | 15.3% (2013) |

= best measure among the comparable groups

= worst measure among the comparable groups

Sources: Preliminary Estimates for Risk Factor and Health Indicators, State of Michigan, Selected Tables, Michigan BRFS, 2013
Centers for Disease Control and Prevention (CDC). Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 2013

# Comparison of BRFS Measures Between Spectrum Health Gerber Memorial Hospital Service Area, Michigan, and the United States (Cont'd.)

## Risk Behavior Indicators

| | SHGMH Service Area | Michigan | U.S. |
|---|---|---|---|
| No Leisure Time Physical Activity | 44.5% | 24.4% | 25.5% (2013) |
| Inadequate Fruit and Vegetable Consumption (<5 Times Per Day) | 86.5% | 84.7% | 76.6% (2009) |
| Consume Fruits <1 Time Per Day | 25.1% | 37.5% | 39.2% |
| Consume Vegetables <1 Time Per Day | 20.3% | 23.9% | 22.9% |
| Current Cigarette Smoking | 24.7% | 21.4% | 19.0% (2013) |
| Former Cigarette Smoking | 24.4% | 27.0% | 25.2% (2013) |
| Binge Drinking | 12.9% | 18.9% | 16.8% (2013) |
| Heavy Drinking | 6.4% | 6.2% | 6.2% (2013) |
| Ever Told High Blood Pressure | 34.9% | 34.6% | 31.4% (2013) |
| Cholesterol Ever Checked | 78.3% | 83.2% | 80.1% (2013 |
| Ever Told High Cholesterol | 32.6% | 40.6% | 38.4% (2013) |

= best measure among the comparable groups

= worst measure among the comparable groups

Sources: Preliminary Estimates for Risk Factor and Health Indicators, State of Michigan, Selected Tables, Michigan BRFS, 2013
Centers for Disease Control and Prevention (CDC). Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 2013

# Comparison of BRFS Measures Between Spectrum Health Gerber Memorial Hospital Service Area, Michigan, and the United States (Cont'd.)

## Clinical Preventive Practices

| | SHGMH Service Area | Michigan | U.S. |
|---|---|---|---|
| No Routine Checkup in Past Year | 17.0% | 30.1% | 31.8% (2013) |
| Ever Had Mammogram (Females, 40+ only) | 92.8% | 94.5% (2012) | -- |
| Had Mammogram in Past Year (Females, 40+ only) | 66.7% | 59.2% (2012) | -- |
| Had Mammogram in Past 2 Years (Females, 40+ only) | 83.9% | 76.6% (2012) | 75.6% (2010) |
| Ever Had Pap Test | 90.5% | 92.1% (2012) | -- |
| Had Appropriately Timed Pap Test | 69.3% | 79.4% (2012) | -- |
| Ever Had PSA Test (Males, 50+ only) | 71.0% | 72.2% (2012) | -- |
| Ever Had Sigmoidoscopy or Colonoscopy (50+ only) | 73.7% | 74.0% | -- |
| Had Sigmoidoscopy /Colonoscopy in Past 5 Years (50+) | 62.0% | 56.4% | 52.8% (2010) |
| No Dental Visit in Past Year | 30.1% | 32.0% (2012) | 30.0% (2008) |
| No Teeth Cleaning in Past Year | 34.9% | 29.2% (2010) | 28.7% (2008) |
| Had Flu Vaccine in Past Year (65+ only) | 70.0% | 56.8% | 62.6% (2013) |
| Ever Had Pneumonia Vaccine (65+ only) | 67.7% | 68.6% | 69.4% (2013) |

= best measure among the comparable groups

= worst measure among the comparable groups

Sources: Preliminary Estimates for Risk Factor and Health Indicators, State of Michigan, Selected Tables, Michigan BRFS, 2013
Centers for Disease Control and Prevention (CDC). Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 2013

# Comparison of BRFS Measures Between Spectrum Health Gerber Memorial Hospital Service Area, Michigan, and the United States (Cont'd.)

## Chronic Conditions

| | SHGMH Service Area | Michigan | U.S. |
|---|---|---|---|
| Lifetime Asthma Prevalence | 13.1% | 15.2% | 14.1% (2013) |
| Current Asthma Prevalence | 9.4% | 10.9% | 9.0% (2013) |
| Ever Told Had Arthritis | 28.9% | 31.3% | 25.1% (2013) |
| Ever Told Had Heart Attack | 4.4% | 5.2% | 4.4% (2013) |
| Ever Told Had Angina/Coronary Heart Disease | 4.0% | 5.2% | 4.1% (2013 |
| Ever Told Had Stroke | 4.4% | 3.6% | 2.8% (2013) |
| Ever Told Had Diabetes | 12.2% | 10.4% | 9.8% (2013) |
| COPD | 7.6% | 8.8% | 6.3% (2013) |
| Skin Cancer | 4.7% | 5.4% | 6.0 (2013) |
| Other Cancer | 7.8% | 7.7% | 6.7 (2013) |

= best measure among the comparable groups

= worst measure among the comparable groups

Sources: Preliminary Estimates for Risk Factor and Health Indicators, State of Michigan, Selected Tables, Michigan BRFS, 2013
Centers for Disease Control and Prevention (CDC). Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 2013

# *Key Stakeholder Interviews*

# *Health Care Issues and Accessibility*

**Provider shortages** are a pressing health concern in Newaygo and Lake counties. Other concerns include **substance abuse**, **mental health**, and **social and economic issues**.

## Most Pressing Health Needs or Issues

- Insufficient access to needed care is a pressing community health issue.
  - Shortages of primary care, mental health care, and specialist services were all identified as top concerns.
- Less frequently mentioned needs or issues are:
  - Substance abuse
  - Absence of services for those with mild to moderate mental illness
  - Poverty and unemployment
  - Low value placed on education by area youth
  - Teen pregnancy
  - Poor health habits, e.g., smoking, lack of exercise
  - Chronic pain management

Q1: What do you feel are the most pressing health needs or issues in your community?

## Verbatim Comments on Most Pressing Health Needs or Issues

***"We need to look at how we can provide more access, convenient access, to our community. The other issue is access to behavioral medicine and mental health needs."***

***"Primary care provider access – there just aren't enough [physicians]. Secondary access to specialists within a decent distance – they are available, but people have to go long distances to Grand Rapids or Muskegon."***

***"The cycle of poverty is a huge issue. A lot of unemployment. There's not a lot for people to do. We're having difficulty with our young people, getting them to understand the value of education It's that cycle that's difficult to break, and it's unfortunate." [Lake County]***

***"How do we change the community norm that it's not acceptable to smoke during pregnancy, or what are the health risks of smoking, what are the risk factors related to not exercising?"***

Q1: What do you feel are the most pressing health needs or issues in your community?

# Key Stakeholders cite numerous programs and plans underway to address key issues, while stressing that more work remains to be done.

| Issue | Programs/Plans Aimed at Addressing Issue |
|---|---|
| **Shortage of providers** | • Attempting to recruit more physicians and APPs<br>• Extending office hours |
| **Substance abuse** | • Substance abuse task force created as part of the Newaygo County Community Collaborative |
| **Chronic pain management** | • Trying to devise systems to handle patients consistently across sites and providers; resources for pain clinics have dried up |
| **Mental health care access** | • Bringing in telepsychiatry services<br>• Family health clinic adding therapists and case managers for behavioral health services<br>• Implementation of school-based health center with therapist and social worker providing coordinated support to students<br>• Support groups addressing social issues, e.g., grandparents raising their grandchildren |
| **Health behaviors** | • Community gardens; efforts aimed at improving access to healthy foods |
| **Miscellaneous** | • Rotary Club programming for children |

Q1a. Is there anything currently being done to address these issues? Q1b. (If yes) How are these issues being addressed? Q1c. (If no) In your opinion, why aren't these issues being addressed? Q1d. (If no) In what ways have these issues been addressed in the past, if any?

## Verbatim Comments on How Issues are Being Addressed

***"We have been actively recruiting for both physicians and APPs. I think part of the solution is going to be to increase the number of APPs in our system and to extend office hours and Saturdays and things like that as well."***

***"We're trying to recruit. We're just having a terrible time. Anything that's being done is not being done on a system-wide basis or county-wide basis. It's being done as individual organizations. We're just not having much luck moving the needle as far as trying to get people who are interested in practicing in this environment: rural and/or underserved. The turnover is pretty high also for those that we get."***

***"We don't have a psychiatrist in Lake County. The problem is funding, of course, and sustaining such a program. I just received a grant for expansion of behavioral health services, so I'm putting in more therapists. My medical director is also developing a program that will help us bring in some telepsychiatry, especially for those with bipolar and post-traumatic stress disorder and some other anxiety diagnoses. The resources are pretty scarce. I'm trying to piece things together to try to bring resources in; it just doesn't cover the entire population, unfortunately."***

***"We've made some great strides. For the health department, we have been the recipient of the governor's four by four health and wellness grant. I think we've become a little more strategic in terms of looking at targeted activities."***

Q1a. Is there anything currently being done to address these issues? Q1b. (If yes) How are these issues being addressed? Q1c. (If no) In your opinion, why aren't these issues being addressed? Q1d. (If no) In what ways have these issues been addressed in the past, if any?

# Important outcome measures include chronic disease management, levels of preventative care, and rates of smoking and obesity.

## Important Health Outcomes

- Key Stakeholders identified the following *as important measures for health-related outcomes*:
  - Management of chronic disease, e.g., diabetes
  - Access to and use of preventative care – e.g., cancer screening, diabetic screening
  - Smoking rates
  - Obesity rates
  - Nutrition
  - Health behavior data from Behavioral Health Risk Assessment
  - Teen pregnancy rates
  - Immunization indicators
  - Cancer incidence
  - Infant mortality rates
  - Access to dental care
  - Graduation rates

***"Prevention is certainly a huge cost savings, so I think we would want to take a look at how well we are doing with warding off some of these chronic care issues with preventative means."***

***"I think smoking is one of the biggest priorities, but it can't be just the hospital. It has to be a whole community effort with that."***

***"We can't look just at health indicators and not look at education outcomes. We have to look at poverty rates and we have to look at education outcomes."***

Q2. What are the outcomes that should be evaluated?

The number of insured residents in Newaygo and Lake counties has risen dramatically with the introduction of the Healthy Michigan Plan and the Affordable Care Act. However, a shortage of providers, high deductibles and co-pays, and transportation challenges limit residents' access to needed care.

## The State of Health Care Access

- While many residents are newly insured under the Healthy Michigan Plan and the Affordable Care Act, a shortage of providers significantly impacts access.
  - Primary care physicians are in short supply regardless of patients' insurance status.
  - Patients must travel a long distance to see a specialist.
  - In Lake County, access to dental care and mental health care is limited as well.
- Key Stakeholders agree that the high deductibles and co-pays of today's health insurance plans present a significant challenge for the insured, causing some to forego needed care.
  - Some Stakeholders report inadequate insurance coverage for dental services and prescription medications.
- The absence of a public transportation system in Newaygo County presents another significant barrier to access.
- Plans to locate county mental health services directly next to the hospital are expected to improve access to and coordination of care for those with mental illness.

Q3. Describe the current state of health care access in your community. Q3a. Is there a wide variety/choice of primary health care providers? Q3b. (If yes) Is this variety/choice available to both insured and uninsured people? Q3c. (If no) In your opinion, why is there a lack of primary health care providers? Q3d. Is there a lack of insurance coverage for ancillary services, such as prescriptions or dental care? Q3e. Is there an inability to afford out-of-pocket expenses, such as co-pays and deductibles?

## Verbatim Comments on the State of Health Care Access

***"We have moved large numbers of what used to be our uninsured over into the Medicaid bucket. That would be one of the successes."***

***"The biggest issue for access is that I don't have enough providers. We are in a very severe medically underserved area. I can't recruit physicians."***

***"In the past, we've had many more providers. We are having trouble doing the wellness-related care that we should be doing, because we simply are too busy dealing with the acute issues. We don't have the capacity in our schedules to do the wellness things – to schedule somebody for a Pap smear or a routine physical. We can get new mid-level providers, physician assistants, or nurse practitioners; the problem is that it takes physician time to mentor them and get them up to date, and we don't have that physician time."***

***"Right now the state covers emergency dental under Medicaid, but there have been times when they've taken that away, and when they take that away it gets especially acute. We're big believers in providing dental services. Dental service are preventative in nature in that they prevent people from having other issues."***

***"At one point we were able to purchase [generic] medications fairly inexpensively and pass that savings along to our patients. [Now] we're seeing a huge increase in the cost of generic drugs, and it's a huge issue."***

***"We're anecdotally hearing that because of [high co-pays and deductibles], patients wait longer to come in."***

***"Transportation is a huge issue for our county. We don't have any kind of a public transportation system except for senior transportation and a little bit of transportation for people with disabilities."***

Q3. Describe the current state of health care access in your community. Q3a. Is there a wide variety/choice of primary health care providers? Q3b. (If yes) Is this variety/choice available to both insured and uninsured people? Q3c. (If no) In your opinion, why is there a lack of primary health care providers? Q3d. Is there a lack of insurance coverage for ancillary services, such as prescriptions or dental care? Q3e. Is there an inability to afford out-of-pocket expenses, such as co-pays and deductibles?

# *Existing Programs and Services*

# Key Stakeholders rate the community's existing programs and services as lacking in terms of meeting residents' needs. A transportation void and a shortage of care providers are critical gaps.

## Programs/Services Meeting Needs & Programs/Services Lacking

- Stakeholders generally agree that existing programs and services are not adequately meeting the needs of community residents.
- Services identified as lacking include:
  - Transportation
  - Primary care
  - Specialty care (orthopedics and obstetrics named in particular)
  - Mental health and substance abuse services [Lake County]
  - Mental health care for inmates
  - Low cost eye care [Newaygo County]
  - Pain management
  - Coordination of care
  - Reproductive education
- On the positive side, the Freemont Area Community Foundation, Newaygo County Community Collaborative programming, and school-based adolescent health clinics contribute to community health.

Q4. How well do existing programs and services meet the needs and demands of people in your community? Would you say they meet them exceptionally well, very well, somewhat well, not very well, or not at all well? Q4a. Why do you say (INSERT RESPONSE)? Q4b. What programs or services are lacking in the community?

## Verbatim Comments on Programs/Services Meeting Needs

***"We [have] a community collaborative called the Newaygo County Community Collaborative (NC3). It's composed of people from the schools, the foundation, the hospital, Council on Aging, True North services, and District Health. We're all there at the table talking about new programs that could improve the economic wellbeing and health and education of our community."***

***"I think we've seen some real successes with the work that's been done around adolescent health services, addressing a coordinated health and mental health component. I think that's one of the areas that has a lot of future potential."***

Q4. How well do existing programs and services meet the needs and demands of people in your community? Would you say they meet them exceptionally well, very well, somewhat well, not very well, or not at all well? Q4a. Why do you say (INSERT RESPONSE)?

## Verbatim Comments on Programs/Services Lacking in Community

***"We have over fifteen thousand people or so to serve, and we have three physicians and a couple mid-levels. Transportation is an issue – Lake County's a really big county. Finding affordable services, finding a doctor that accepts Medicaid. With the Medicaid expansion, people are on the search trying to find someone to take care of them."***

***"Transportation has always been the big one. I think the counties that surround us all have some type of transportation capability, but they all end at our county lines. We've just never been able to come to grips with a solution for that. There is a service for the elderly, but it's limited."***

***"I think we do a really good job with [young] kids. Sometimes once kids get into school we don't do such a good job."***

***"There is a tremendous demand for low cost eye care, and we've not been able to do anything in Newaygo County. We've addressed the need in Lake County through the Ferris Optometry Program, but we've not been able to do anything down here."***

***"There's a whole lot more that we could do for coordination of care."***

***"One of the downfalls of being in a very conservative and heavily Christian area is that people think that abstinence training is going to resolve the teen pregnancy problem, and it's probably not. It hasn't solved it yet. We have a very high rate of teen pregnancy, and it affects [young parents] the rest of their life. There's not a lot of openness to reproductive training and health, and too much focus on abstinence."***

Q4b. What programs or services are lacking in the community?

# Suggestions for service improvement focus overwhelmingly on the need for a collaborative approach among service providers.

## Recommendations for Service Improvement

- Recommendations for improved implementation of existing services focus heavily on the need for more collaboration among health care providers, social service agencies, and community programs that support health.
- Additional suggestions or needs include:
  - Continued coordination among program providers to avoid duplication of efforts, e.g., multiple organizations offering a program on obesity
  - Client-centered service – i.e., a centralized intake process to determine client's needs and how to meet them; current system requires client to go from agency to agency to try and get needs addressed
  - Increased funding

Q4c. In your opinion, how could any of the existing services/programs in your community be implemented better?

## Verbatim Comments on Recommendations for Service Improvement

***"If we had some easy way to communicate needs back and forth, such as social service referrals between Mental Health and True North, which is the major player for social programs for heat, food, etc. We don't have any way to track if people actually follow up. We're getting pushed from the patient-centered medical home perspective to both refer people when we become aware of the need and find out if they went. That's next to impossible. If I had all the resources in the world it would be easy, but there's not an automatic way to do that."***

***"Moving towards electronic medical records and how information is shared and 'How do we come together?' I know providers are tracking individuals with elevated cholesterol, elevated blood pressure, but how do we also roll in that community piece? I think there's some work being done, but I think that's an area where there is a need for more work."***

***"You don't want to just throw money at it. I think the best thing I've seen us all do here in our community is we used to duplicate a lot of things. Everybody had a program on obesity, everybody had a program on this, …, and one of the things we've been able to do is coordinate our efforts when we look at some of these areas, so that not everybody is doing the same thing and coming up with the same result – nothing."***

***"More client-centered services. Historically it would be that there is this program over here and this program over there, and you come in and we do the intakes here and if you don't qualify for what we have to offer then we tell you maybe there is something over there – go try the next agency. I think people are working to have a more client-centered intake process and to really be focused on what it is that the person needs and trying to broker the right level of services to them, as opposed to sending them running around all over the place, trying to put it together for themselves. They don't have the gas and the resources to run around and try to put it together for themselves."***

***"Everything hinges on funding. Spectrum Health has limited psychiatric beds. I hope they don't close. The reason Gerber closed theirs in Freemont is because of funding. They couldn't afford it. Our rural hospitals have really taken a big hit."***

Q4c. In your opinion, how could any of the existing services/programs in your community be implemented better?

# Stakeholders report strong partnerships in place in Newaygo and Lake counties.

## Recommendations for Partnerships

- The Newaygo County Community Collaborative (NC3) brings together a wide net of organizations with the goal of improving community health, education, and economic wellbeing.
  - Within NC3, the Live Well Newaygo group focuses specifically on community health.
- Other successful partnerships currently in place include:
  - School-based health clinics providing medical and dental services
  - Partnerships between the health department and area hospitals
    - A concern was raised that these partnerships may be compromised as a result of hospitals joining Spectrum.
  - In Lake County, support from a local foundation, Rotary Club, Lions Club, and concerned professionals in the community
- Ideas for partnerships include:
  - Data sharing between family health clinic, mental health agency, and social service agencies such as True North and Love Inc.
  - Increased involvement of United Way in Newaygo County

Q5. Are there any partnerships that could be developed to better meet a need? Q5a. (If yes) What are the partnerships? Q5b. (If yes) How could they be better developed?

## Verbatim Comments on Partnerships

***"We've really got some fabulous partnerships in Newaygo County. The Newaygo County Community Collaborative has several health care providers as part of its affiliates, so people are knowledgeable and informed. There is one that is specifically related to health – Live Well Newaygo county. That is an alliance of service providers that are collaborating and working together."***

***"Lake County has been very fortunate because we have a District Ten Health Department. We have support from the local foundation. We have the Rotaries and the Lions and we have people who are concerned and care. I think that the folks that are there really do work well together and try to improve the lives of the citizens. There are just not enough resources."***

***"I think people are really cognizant of the need to work together and try to improve that. Sometimes it's just that collaboration takes a lot of time and it's not just showing up at a meeting. It's truly collaborating and having some shared responsibilities."***

***"If we could share data better [family health clinic; mental health agency; True North; Love Inc.], we could maybe get a better picture of the average person in Newaygo County, or something that would tell us where we need to spend our time."***

***"I don't hear much about United Way in Newaygo County. I'm not even sure who serves us."***

Q5. Are there any partnerships that could be developed to better meet a need? Q5a. (If yes) What are the partnerships? Q5b. (If yes) How could they be better developed?

# *Barriers to Health Care Access*

Lack of transportation presents a significant barrier to care for area residents. Additional barriers include cost of care, cultural norms, and language differences.

## Barriers & How They Can Be Addressed

- Key Stakeholders identified the following barriers or obstacles to obtaining care:
  - Lack of transportation
  - Cost of care
  - Absence of a "culture of health"; fear of health care; lack of education about health care
  - Language barrier for Spanish-speaking residents and migrant workers
  - Cultural barrier for Native American residents
  - Technology barriers – Internet/working phone required to access services
- Solutions currently in place to alleviate barriers include:
  - Bilingual staff at health clinic
  - Farm workers fair to disseminate information on health-related services
  - City and town governments starting to incorporate health-promoting public spaces (e.g., biking and walking paths) into their plans
- Suggestions aimed at addressing the transportation barrier include:
  - Investigate possible grant opportunities
  - Reallocate resources similar to what was done in Lake County

Q6. Are there any barriers or obstacles to health care programs/services in your community? Q6a. (If yes) What are they? Q6b. Have any of these barriers been addressed? Q6c. Are there any effective solutions to these issues? Q6d. (If yes) What are they? Are they cost effective? Q6e. Have any solutions been tried in the past?

## Verbatim Comments on Barriers

***"Transportation is only available if you meet the guidelines of the vulnerable population – it's for people with disabilities and for the elderly."***

***"Everything has a cost, and [it's a question of] where do you spend your dollars first? Do you spend it addressing poverty issues? Where does transportation fit into the big picture?"***

***"People just don't have the resources. Even if there's a doctor to see them, they've got to figure out how they're going to get there. They have to figure out how they're going to pay their co-pay and deductible, how they get their meds, how they are going to get some place to get the diagnostics done – it's just endless."***

***"Trying to create the awareness that building healthy communities is not just public health, it's not just the hospitals, it's not just about having a doctor. It's creating that culture of health. Ann Arbor has a highly educated group of individuals living in the community that really have that sense of wanting a healthy community. They want places to ride their bike. They want to be able to walk. That culture of health is another [thing] that we don't have."***

***"There are always cultural barriers – a lot of fear of health care that has to be overcome; a lot of education that's required."***

***"You have temporary [farm] workers that come in that also have health needs. Generally there is a significant language barrier for the people that are only here on a part-time basis."***

***"Internet and cell phones – that's a huge barrier for people, because they don't have landlines, so they get these prepaid cards on their phones and when we're trying to keep in contact or follow up, the phone is disconnected. Communication is a huge issue in Lake County."***

Q6. Are there any barriers or obstacles to health care programs/services in your community? Q6a. (If yes) What are they?

## Verbatim Comments on Addressing Barriers

***"Lake County has far fewer resources and far better public transportation. What they've done is they don't have school busses – they went and put all of their resources into a bus service that also serves the school."***

***"About twenty-five percent of our patients are Spanish speaking in our Grant location, so we have a bilingual staff. Our Spanish-speaking provider is one of the ones that's booked the furthest out, so I think there probably is more demand than we are meeting."***

***"There is a farm workers fair that is held each year that helps to provide information on all of those services to the Latino population. They get a fairly good turnout of folks."***

***"Townships and cities are starting to realize that they need to think about creating a healthy environment in their recreation plans. I think some of that is gradually occurring."***

Q6b. Have any of these barriers been addressed? Q6c. Are there any effective solutions to these issues? Q6d. (If yes) What are they? Are they cost effective? Q6e. Have any solutions been tried in the past?

# While Key Stakeholders report some involvement of community residents in health care planning and decision making, several think more involvement would be beneficial.

## Involvement of Relevant Stakeholders/Community Residents

- Key Stakeholders report varying levels of involvement of local consumers in health care planning and decision making.
  - Several would like to see more involvement of the average citizen.

***"I have ten community members on my board. We try to get as diverse as we possibly can. I also have a Patient and Family Advisory Council, and we have a lot of really good people from the community on there, including Hispanic representation."***

***"The NC3 group is actually pretty well rounded."***

***"I would think that a lot of people would say they don't feel like they have a voice at the table. The leaders all collaborate together very well in this county, but what you don't see a lot of is citizen engagement. It happens sometimes through surveys, but that only goes so far. Our board is very diverse. We have some voices that are more grassroots leaders than community leaders. They're still leaders but they're more at a grassroots level."***

***"I think sometimes the community rep that we get to the table is the more articulate consumer. That is probably an area that we could strengthen is getting more input from the individuals who need the service."***

***"I don't see a lot of people from the actual community that needs to be at the table at the table. There are a lot of barriers for them to get there. It would be nice to have more people engaged and involved."***

Q8. With regard to health and health care issues, are relevant stakeholders or community residents involved in planning and decision making? Q8a. (If yes) Who is involved? Q8b. (If no) Should they be? Q8c. (If yes) Who should be?

# *Community Resources*

The Freemont Area Community Foundation is a highly valued community resource. Stakeholders identify numerous other resources, several of which are not utilized to their potential. Insufficient funding and manpower are resource limitations.

## Community Resources & Resource Limitations

- The Freemont Area Community Foundation is a major source of funding for services and programs aimed at improving the lives of Newaygo County residents.
- Other resources that support community health include:
  - True North
  - Live Well Newaygo County
  - District Ten Health Department
  - Community Health Needs Assessment team
  - Grants from a variety of sources
  - Area colleges – providing a volunteer base
  - Rotary Club
- Resources that are not being used to their full potential include:
  - Area churches
  - Retired residents who have time and willingness to volunteer
  - Local businesses/Chamber of Commerce
- Limited funding and manpower act as restraints on programs and services.

Q7. What resources currently exist in your community beyond programs/services just discussed? Q7a. What are any resource limitations, if any?

## Verbatim Comments on Community Resources

***"The Freemont Area Community Foundation is responsible for ninety percent of what exists. They are a very, very engaged foundation. They are sort of the force behind the Newaygo County Community Collaborative."***

***"There is a strong non-profit called True North. It does a fair amount of human service activities."***

***"We haven't talked about the Health Department. They are getting wellness messages and wellness programs into the workplace."***

***"We are having a great deal of luck with the various colleges around us – Grand Valley, Ferris, Baker, Central even. That's where a lot of our volunteer workforce has been coming from lately."***

***"There are a huge number of churches here – if we could somehow do something with them. The problem is that they are all small and they tend to want to work independently. I don't think we do a very good job of engaging businesses. There is one large Chamber of Commerce now, and I think there would be some potential there."***

***"I perceive us to have a slightly older community – it's not unusual for people to retire here. There are people who have the ability to volunteer. We just have to set up a system and then come up with something valuable for them to do."***

Q7. What resources currently exist in your community beyond programs/services just discussed?

## Verbatim Comments on Resource Limitations

***"I'm not aware of a whole lot of barriers other than the ability to pay for it. I think people are willing to do a lot of things if they could somehow be funded."***

***"There is never enough money. Agencies are stretched – they have to spend a lot of time raising funds as opposed to delivering services. There is never enough talent. Volunteerism isn't as prominent as it could be."***

***"We have a community health needs assessment group that is led by the Health Department. There is a core group of people but it's limited. We all work well together; it's just a lot of work for a few people."***

Q7a. What are any resource limitations, if any?

# *Impact of Health Care Reform*

# Federal Health Care Reform and the Healthy Michigan Plan have had a positive impact on access to health care.

## The Impact of Federal Health Care Reform and the Healthy Michigan Plan

- The Affordable Care Act and the Healthy Michigan Plan have resulted in more residents with health insurance and more residents seeking care.
- Other current or expected consequences of the reforms include the following:
  - \+ Adults who have been relying on Health Department services now eligible for coverage under Healthy Michigan Plan
  - \+ Less bad debt for hospitals
  - \- High out-of-pocket expenses discourage some insured residents from seeking care
  - \- Strain on providers as they try to accommodate new patients

Q9. What has been the impact of Federal Health Care Reform or the Healthy Michigan Plan in your community? Q9a. Has the implementation of HCR or Healthy MI positively impacted the access to health care? Q9b. In what ways have these changes impacted service delivery? Q9c. What impact has it had, if any, on health outcomes?

## Verbatim Comments on Impact of Federal Health Care Reform and the Healthy Michigan Plan

***"Healthy Michigan has been very positive for extending health care coverage. I don't know the impact of the ACA and the exchanges."***

***"It's been very positive because there are certainly fewer uninsured. For the people that are getting the care, it's costing them less. There are still [concerns] that people don't come in because they don't want to spend their high deductible, but for those that are eligible for Medicaid, they're moving from the uninsured to the insured role."***

***"It's been very positive from what I can see. I have multiple stories of people who are wanting to cry when they get their insurance. These are the working poor. They couldn't afford the marketplace. It's just been a huge boost for them. They're going to get their teeth fixed. They're going to get to come into the doctor and get whatever taken care of, get preventative care – they've never had that before. We're very busy, though – it's hard to get an appointment. With the limited number of primary care providers that I have, we do our best to meet the needs, but access is an issue."***

***"I'm guessing that if you looked at the hospital ER data, their visits may not be going down but maybe they have more people that are covered. One of the things that I'm hearing about hospitals is that their debt write-off is less than it's been in the past."***

Q9. What has been the impact of Federal Health Care Reform or the Healthy Michigan Plan in your community? Q9a. Has the implementation of HCR or Healthy MI positively impacted the access to health care? Q9b. In what ways have these changes impacted service delivery? Q9c. What impact has it had, if any, on health outcomes?

# *Impact of 2011 Community Health Needs Assessment*

# Stakeholders identify a number of programs and projects that have been implemented since the 2011 Community Health Needs Assessment.

## Impact of 2011 Community Health Needs Assessment

- The following initiatives and changes have occurred since the 2011 Community Health Needs Assessment:
  - Residents more health-aware and trying to make better choices; the importance of health starting to resonate with youth in the community
  - Live Well campaign
  - Efforts to address obesity
  - Fit Kids program
  - Trail development
  - Prescription for Health program
  - Strengthening of dialogue between public health and hospital community health assessment

***"I think there is a greater awareness of taking better care of yourself, addressing obesity issues and walking. We have more people who are trying to make better choices. I think it's resonated with our younger people."***

***"In Lake County, we received a grant for building healthy communities to work on a trail development project and also to work on implementing a Prescription for Health with our health care providers. The health department is working on a Live Well campaign in all of the counties. There is definitely work being done, but it's slow work."***

Q10. Since the Community Health Needs Assessment conducted three years ago in 2011, what has been done locally to address any issues relating to the health or health care of residents in your community?

# *Community Preparedness for a Communicable Disease Outbreak*

# Key Stakeholders in general feel the local health care community is fairly well prepared to handle an infectious disease outbreak.

## Community Preparedness for a Disease Outbreak

- Stakeholders feel fairly confident in the systems that are in place for managing an infectious disease outbreak.

***"We already have a system policy and approach to blood and airborne pathogens. It would have been a similar type of thing. We feel very comfortable that from a system standpoint we could have appropriate care and preventions taking place. I think everybody learned something from the Ebola issue, and that's probably improved our protocols even more."***

***"I think our health department and our local hospitals are prepared. We are certainly prepared. We train our staff and provide [for] all the needs our staff would have in meeting those kinds of emergencies."***

***"We train for this stuff, and [the health care providers] have the information; the problem is the applying of it. [Because] it's such a rare instance, often by the time somebody realizes that it's something, they've already been exposed."***

***"I honestly don't know. I'm sure that Gerber would rely heavily on procedures and policies that came out of Spectrum's system, so [I would] hope that a system that large is watching the trends."***

Q11. How well prepared are local health care professionals to deal with a communicable or infectious disease outbreak, such as Ebola? Would you say not at all well, not very well, somewhat well, very well, or extremely well? Why do you say that?

## Stakeholders' Closing Comments

***"All of our facilities are not yet part of Spectrum. Baldwin Family is our other family provider. I think sometimes we duplicate things by having two different systems. I know they both have a digital mammography machine now. I'm not even sure that the one at Spectrum is used to its full capacity. I think sometimes there might be a little more duplication than we really need."***

***"We will continue to try to move forward – it's just a slow process. Our governor thought he was going to reduce obesity in a year or whatever. It's taken forty years for tobacco uptake to come down. That type of behavior change takes time."***

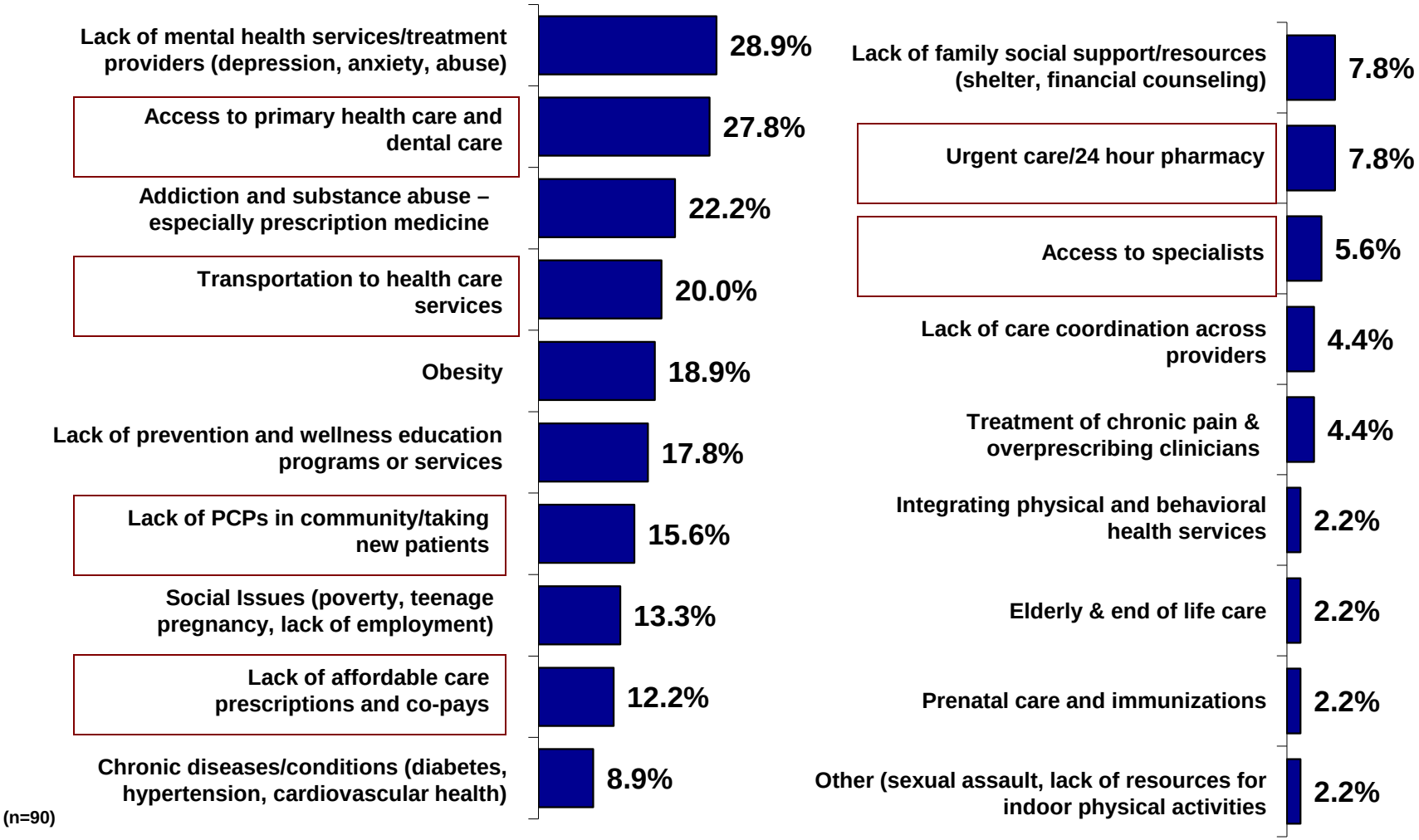
Q12. In concluding, do you have any additional comments on any issues regarding health or health care in your community that we haven't discussed so far?

# *Key Informant Survey*

# *Health Conditions*

When asked to cite, top of mind, the most pressing health issues or needs in the SHGMH Service Area, Key Informants identify many issues. Most often reported are issues revolving around **access to care**, **mental health and addiction services**, and a need for more **prevention education**. More specific areas of concern are **obesity** and **transportation**.

## Most Pressing Health Needs or Issues in SHGMH Service Area (Volunteered)



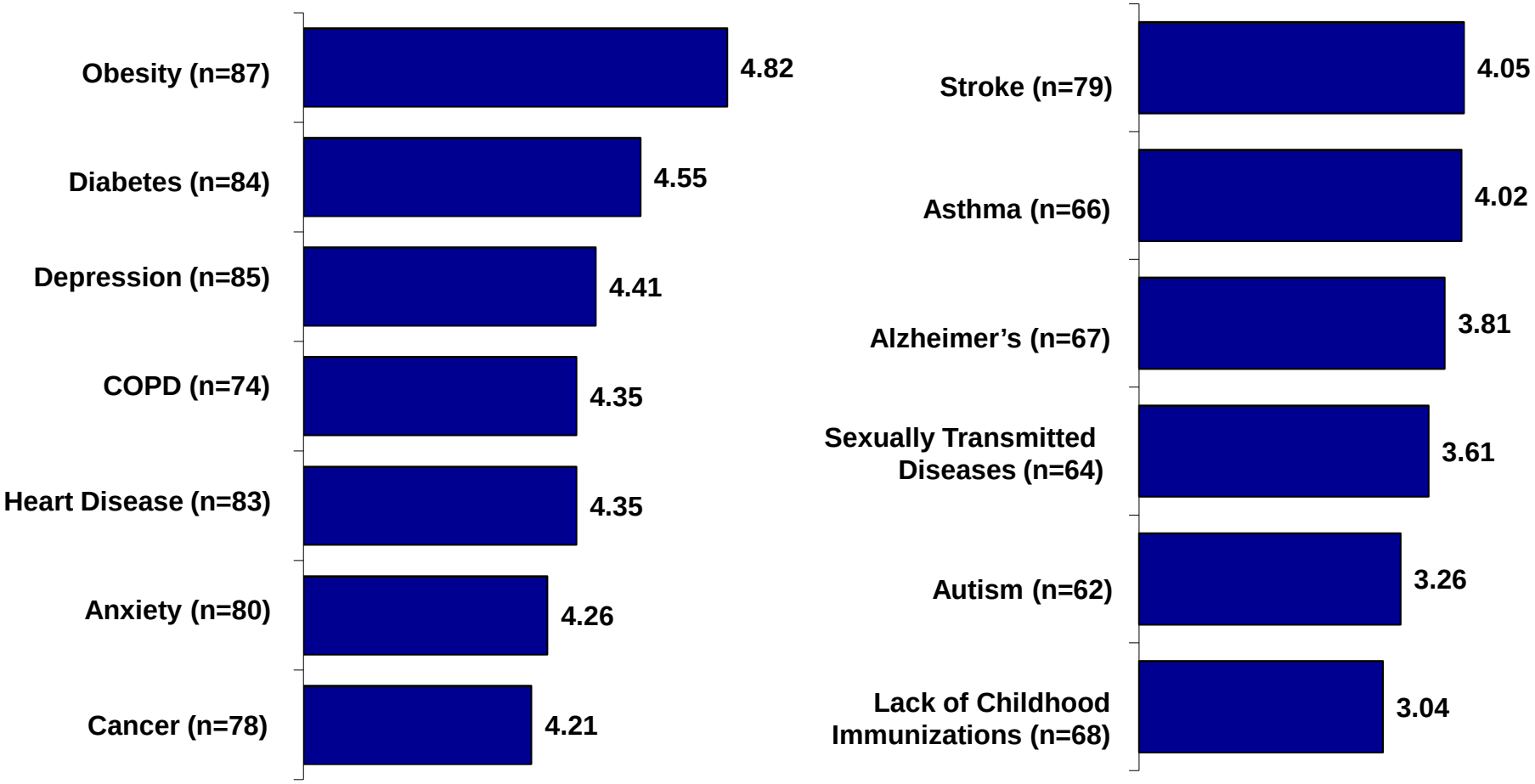

(n=90)

Q1: What do you feel are the most pressing health needs or issues in your community? Please be as detailed as possible.

= issues of health care access

Key Informants view **obesity** as the most prevalent health issue in the SHGMH service area, followed by **diabetes**, **depression**, **COPD**, and **heart disease**. Lack of childhood immunizations and cases of autism are perceived as less prevalent in the community.

## Perception of Prevalence of Health Issues in SHGMH Service Area

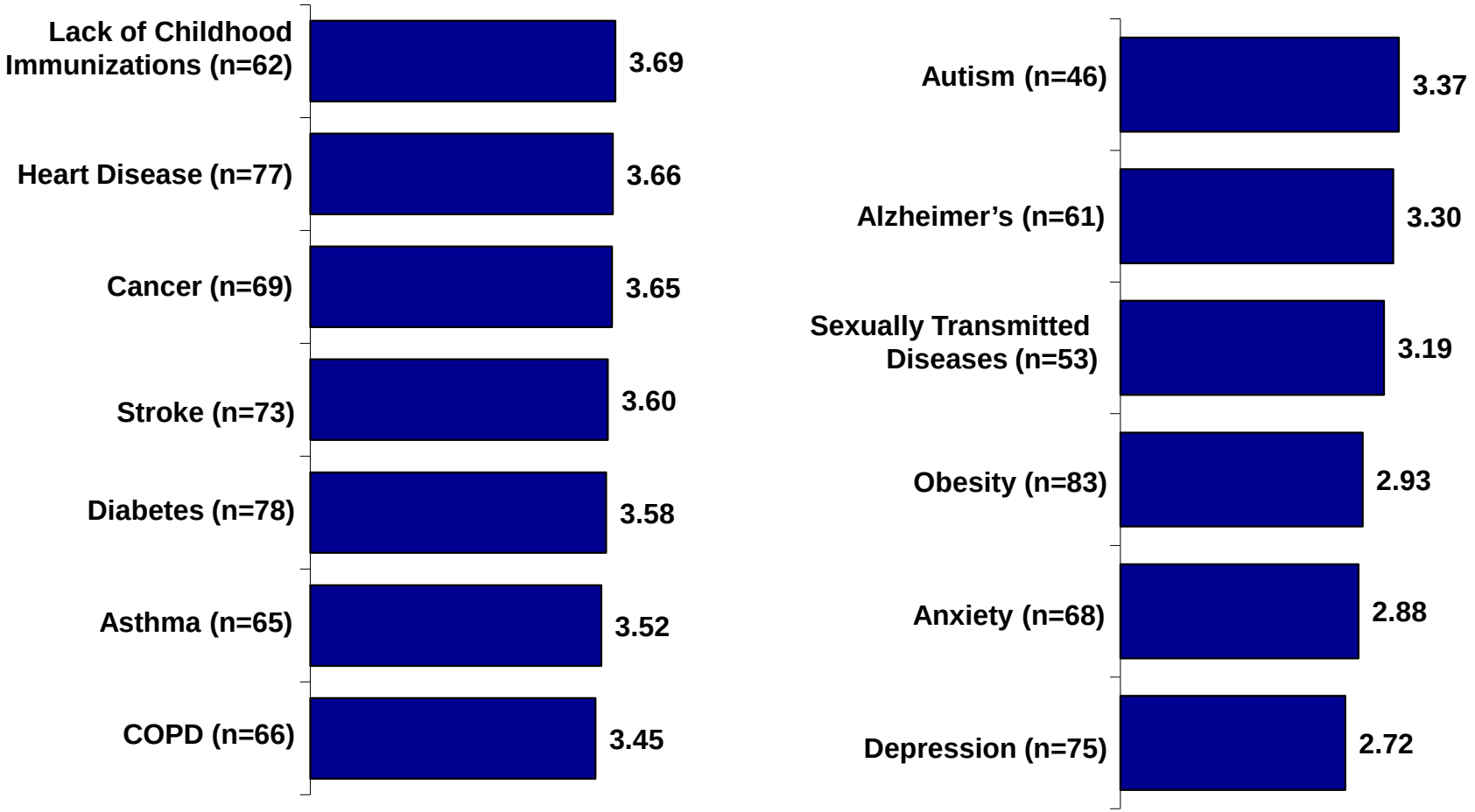



Note: all n's represent 2014 BRFS

Q2: Please tell us how prevalent the following health issues are in your community. (1=not at all prevalent, 2=not very prevalent, 3=slightly prevalent, 4=somewhat prevalent, 5=very prevalent)

Key Informants are most satisfied with the community's response to **childhood immunizations**, followed by **heart disease**, **cancer**, and **stroke**. They are least satisfied with the response to **depression**, **anxiety**, and **obesity**.

## Satisfaction with Community's Response to Health Issues in SHGMH Service Area

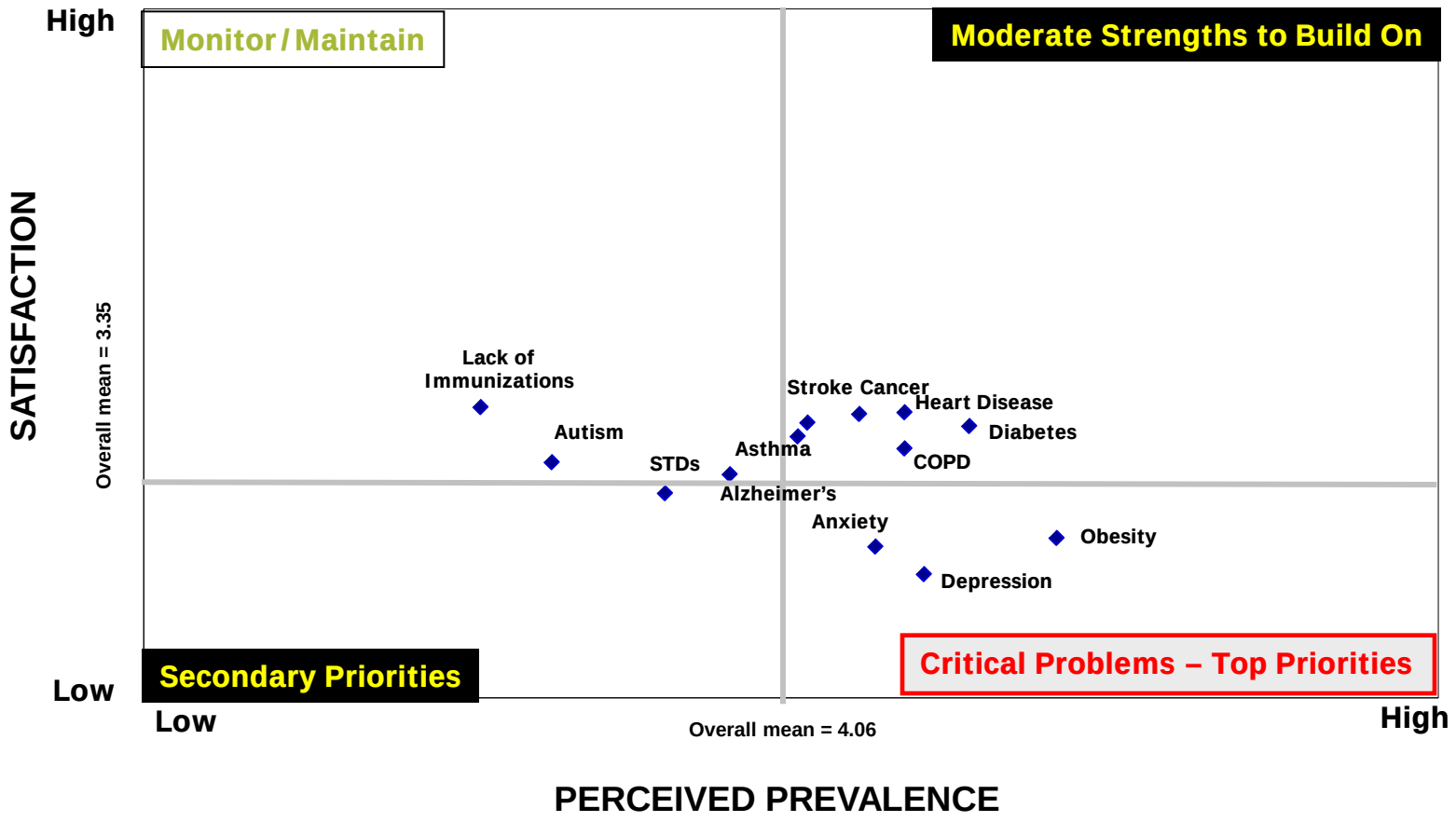



Note: all n's represent 2014 BRFS

Q2a: How satisfied are you with the community's response to these health issues? (1=not at all satisfied, 2=not very satisfied, 3=slightly satisfied, 4=somewhat satisfied, 5=very satisfied)

The quadrant chart below depicts both **problem areas and opportunities**. The community's response to stroke, cancer heart disease, diabetes, COPD, and asthma is strong because they are both perceived to be prevalent by Key Informants and they are also satisfied with the community's response to these issues. Conversely, **anxiety**, **depression**, and **obesity** are critical problem areas because they are not only perceived to be prevalent, but the perceived response to them is less than satisfactory.

## Performance of Community in Response to Health Issues in SHGMH Service Area




Q2: Please tell us how prevalent the following health issues are in your community. Q2a: How satisfied are you with the community's response to these health issues?

Additional health issues deemed prevalent in the SHGMH area are those involving **mental health** and **substance abuse**. More specifically, there is a **lack of mental health treatment** and those who report this shortcoming are dissatisfied with the community's response to the issue. Key Informants also view **obesity** as an important issue to address in their community.

## Additional Health Issues Prevalent in SHGMH Service Area

**Substance Abuse**

*"**Narcotic dependency is very prevalent**."*

*"Alcoholism is rampant."*

*"Illicit drug abuse and smoking."*

*"Drug/narcotic addiction and not all satisfied with response."*

**Mental Health**

*"Anxiety/depression. **We don't have enough counseling services in the area, let alone services that are covered for Medicaid patients.**"*

*"We have a huge problem with depression/suicide attempts in this community. We see many mental health patients in the ED here at Gerber."*

*"Mental Health - Newaygo County response is not good. Too many kids and adults with issues, and not enough people to serve them."*

**Obesity**

*"Obesity. Not satisfied with the community's response. **There are limited resources in the community for exercise during the winter for those on a limited income**."*

*"Obesity - particularly childhood. The only childhood obesity program is a 30 minute drive away and with transportation and food resources being a large issue these programs do not help our rural community."*

*"**Obesity - need more nutritional education for our patients**."*

Q2b: What additional health issues are prevalent in your community, if any? For each listed, tell us how satisfied you are with the community's response to the health issue.

Additionally, Key Informants see a **need for education** in **general health** and **on risk behaviors**, specifically concerning teen pregnancies. The need to **address chronic illnesses** or health conditions, and to **improve access to care** by removing cost or transportation barriers are also viewed as important to improving the community's overall health.

## Additional Health Issues Prevalent in SHGMH Service Area (Cont'd.)

**Education**

*"**Education and resources for the uninsured besides the ER**."*

*"Teen or single mother unable to provide for child pregnancies. Unsatisfied or unaware of program solutions."*

*"Good response when the correct people are informed."*

**Pain Management and Chronic Health Conditions**

*"Diabetes, COPD, obesity. For all I am not satisfied with the level of resources we provide nor the level of response by the patient to pre-education and post-education."*

*"Chronic pain management."*

*"**I think this community would benefit from better regulation of the narcotic medications through more stringent policies and also a pain clinic for management modalities**."*

**Access**

*"Low income population that does not regularly access routine health care. I am somewhat satisfied with community response to this issue."*

*"**Ability to get an appointment in a reasonable amount of time** - not very satisfied."*

*"Access to affordable medications. Not satisfied at all."*

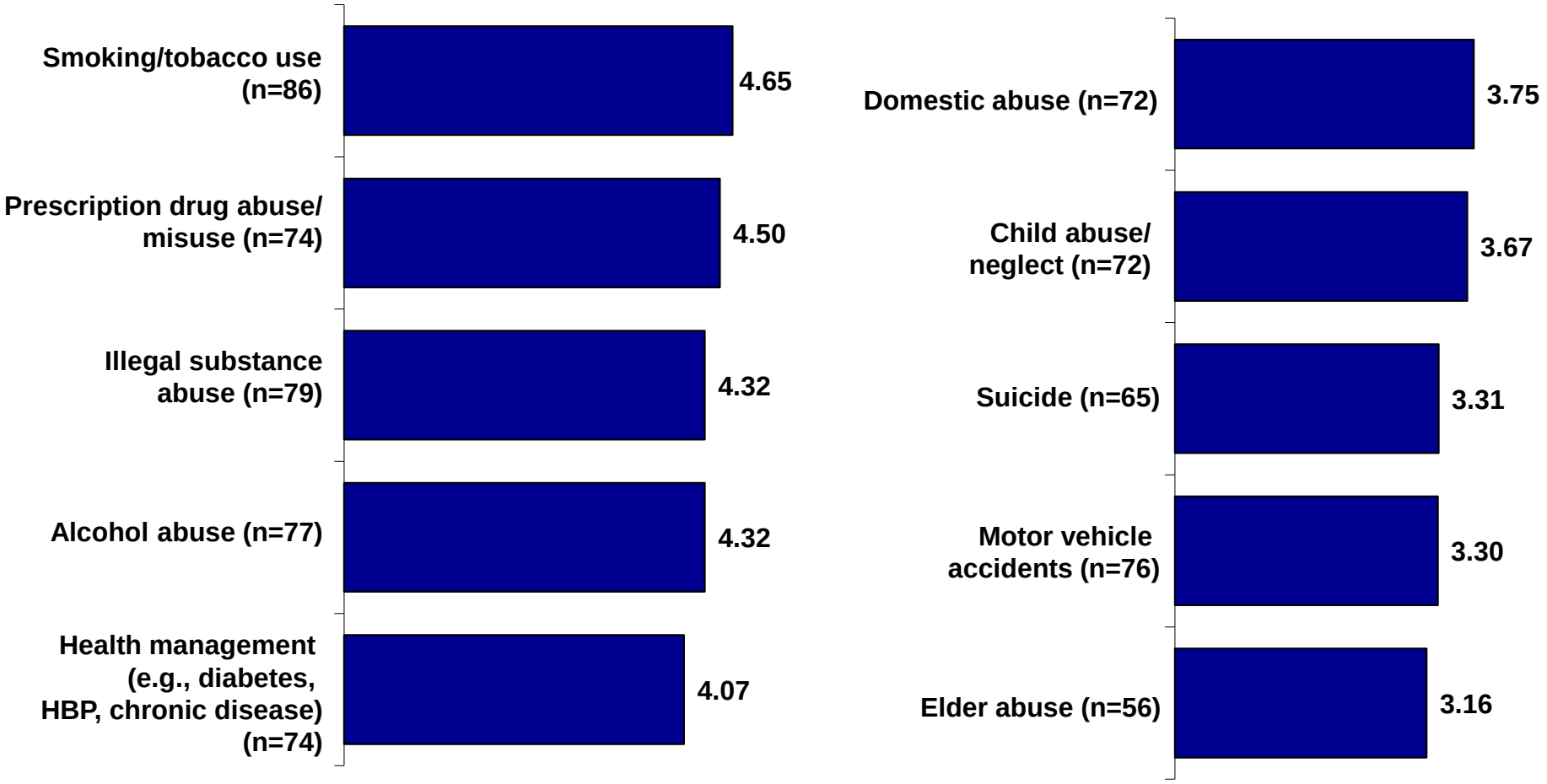
*"Lack of transportation - not at all. There are **no consistently available programs to address this and it limits access to care** more than the lack of insurance or money to pay for medications."*

Q2b: What additional health issues are prevalent in your community, if any? For each listed, tell us how satisfied you are with the community's response to the health issue.

# *Health Behaviors*

# Key Informants believe health behaviors involving the misuse/abuse of substances (tobacco, alcohol, illicit drugs, prescription drugs) and health management issues are most prevalent in the SHGMH Service Area.

## Perception of Prevalence of Health Behaviors in SHGMH Service Area

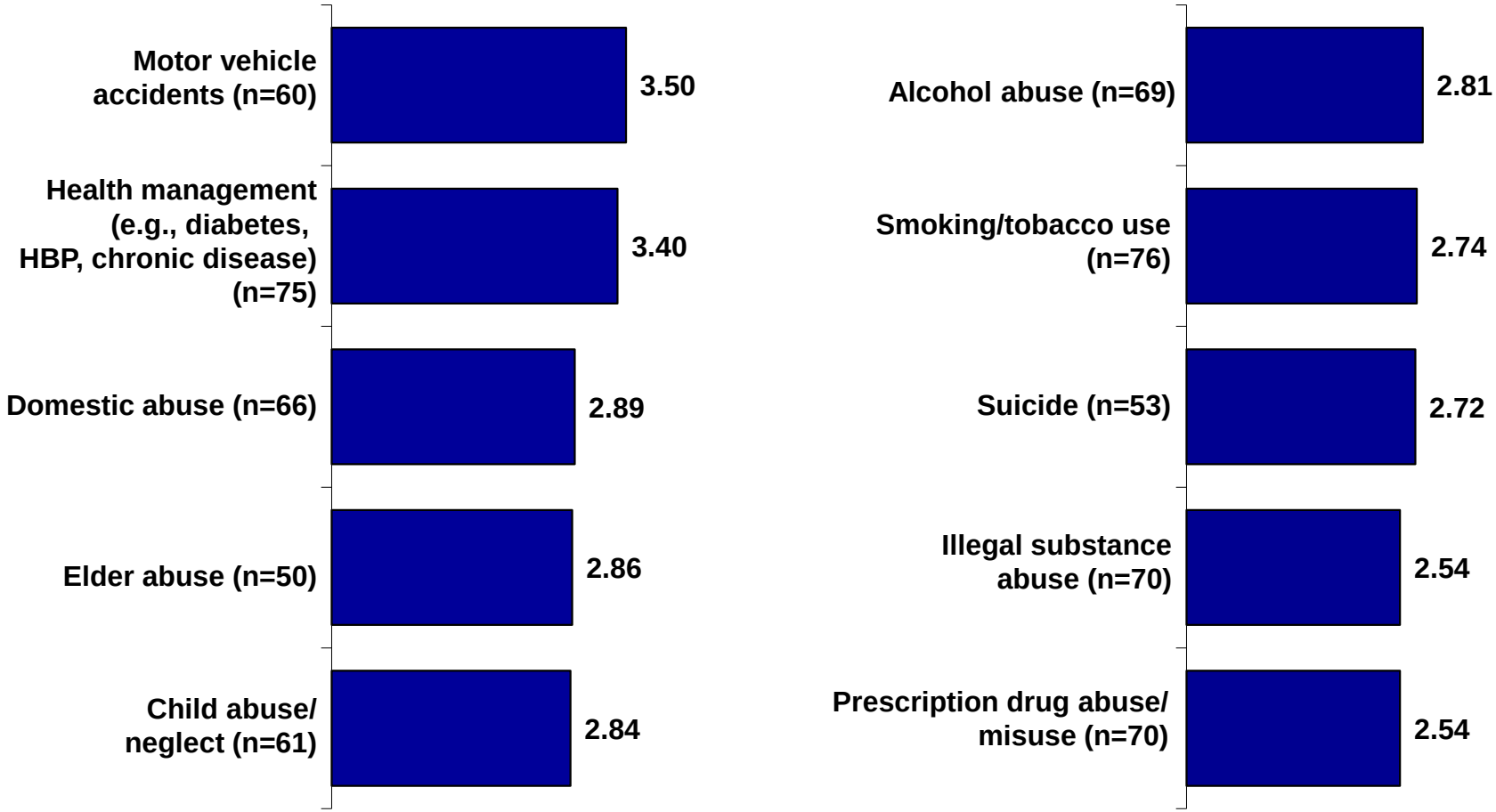



Note: all n's represent 2014 BRFS

Q3: Please tell us how prevalent the following health behaviors are in your community.

Key Informants are only moderately satisfied with the community's response to the health behaviors rated. Opportunities for improvement exist with behaviors they consider to be prevalent, such as **substance abuse (both licit and illicit)**.

## Satisfaction with Community's Response to Health Behaviors in SHGMH Service Area

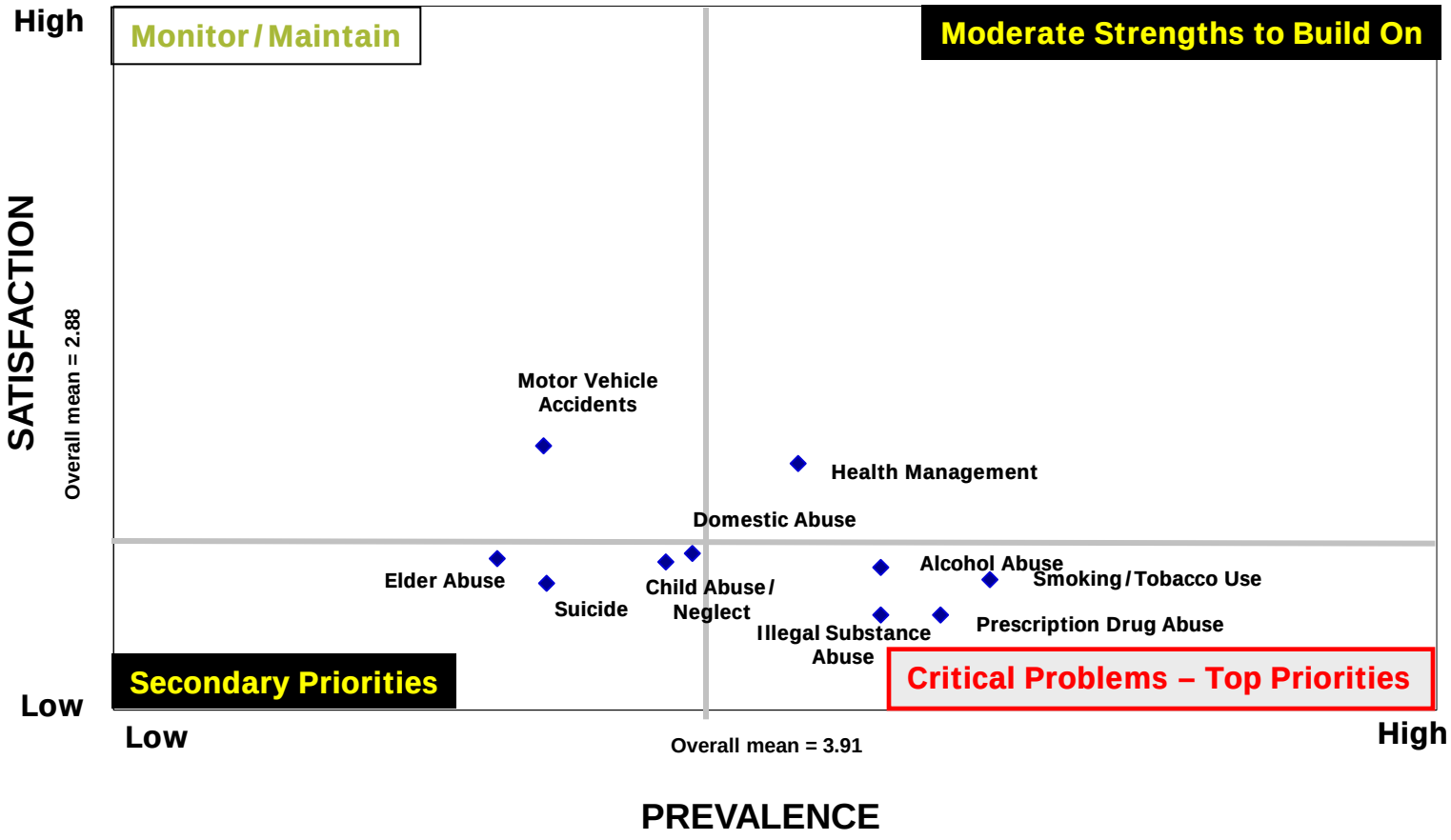



Note: all n's represent 2014 BRFS

Q3a: How satisfied are you with the community's response to these health behaviors?

The quadrant chart shows the most dissatisfaction and concern with responses to ***prescription drug abuse***, ***illegal substance abuse***, ***smoking/tobacco use***, and ***alcohol abuse***. Additionally, low satisfaction exists with the response to ***child abuse/neglect*** and ***domestic abuse*** - which represent important, secondary priorities.

## Performance of Community in Response to Health Behaviors in SHGMH Service Area




Q3: Please tell us how prevalent the following health behaviors are in your community. Q3a: How satisfied are you with the community's response to these health behaviors?

Key Informants believe **lifestyle choices**, **mental health** and **substance abuse and addiction** warrant further attention. Some also mention concern about financial abuse of the elderly.

## Additional Health Behaviors Prevalent in SHGMH Service Area

**Lifestyle Choices**

*"**General lack of healthy choices--in food, lifestyle, etc**. As for response, I think there are programs that are not being utilized as well as they could be. Transportation is often cited as a problem and poverty is a huge contributing factor."*

*"Poor nutrition knowledge, There is not a lot of access to nutritionist/dieticians in our area unless a patient is hospitalized. It would be nice to have more available to the community as open houses to discuss nutrition and health management."*

*"**Many people have a general lack of knowledge of how to select healthy foods and how to prepare them**. We have the resource for education in this area at Michigan State Extension office, but have not figured out how to make this practical to get the information to be people."*

*Poor nutrition habits - neutral satisfaction. Our community does offer multiple opportunities for nutrition education (including SNAP-ED) which is a great way to educate families about healthy eating habits.*

**Mental Health Issues**

*"Bullying which in turn leads to depression and suicide. Schools are just starting to address this. There appears to be nothing in place for adults and the elderly ."*

*"**Pediatric/adolescent psych. care**."*

*"Poor mental health and coping skills."*

**Substance Abuse/Addiction**

*"Alcoholism, psych issues, prescription drug abuse."*

*"**Drug use, especially prescription drug abuse among youth is problematic**. Marijuana use is widely accepted as common practice and social acceptable among youth. I am slightly satisfied with community response."*

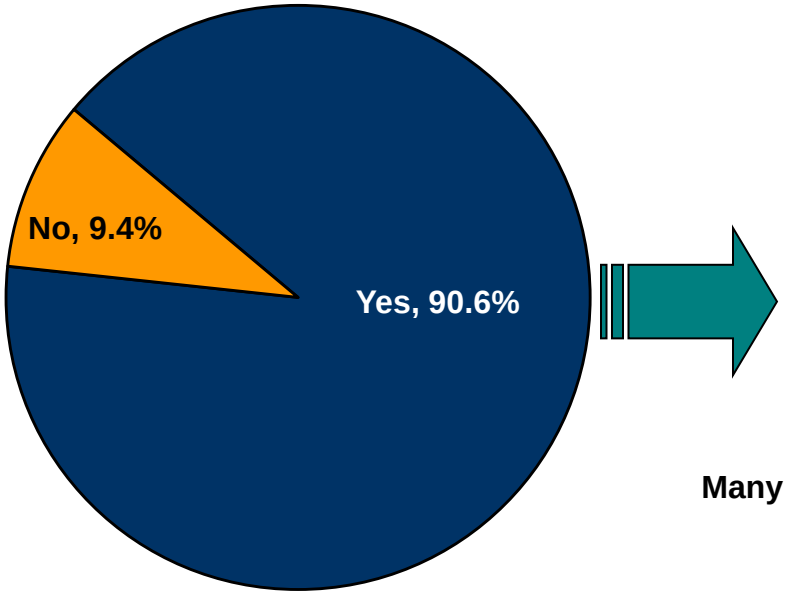
Q3b: What additional health behaviors are prevalent in your community, if any? For each listed, tell us how satisfied you are with the community's response to the health issue.

# *Access to Health Care*

Nine in ten (90.6%) Key Informants believe access to health care is a pressing and prevalent issue in the SHGMH Service area. The greatest barriers to health care access center on **transportation**, the **inability to afford out-of-pocket expenses such as co-pays/deductibles**, **lack of PCPs and other providers**, **lack of awareness of available options**, and **lack of community resources**.

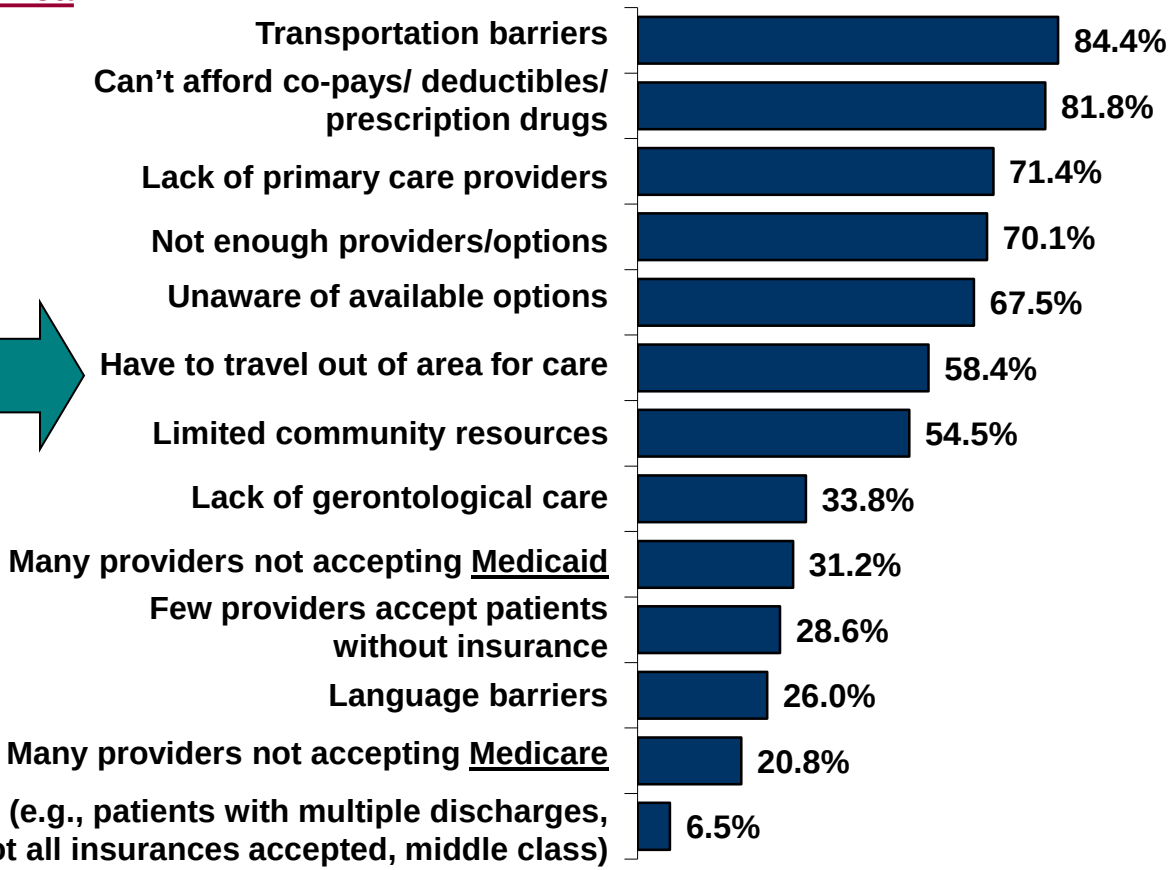
## Access to Health Care

### Is Access to Health Care a Pressing and Prevalent Issue in SHGMH Service Area




(n=85)

### Reasons Access to Health Care is an Issue



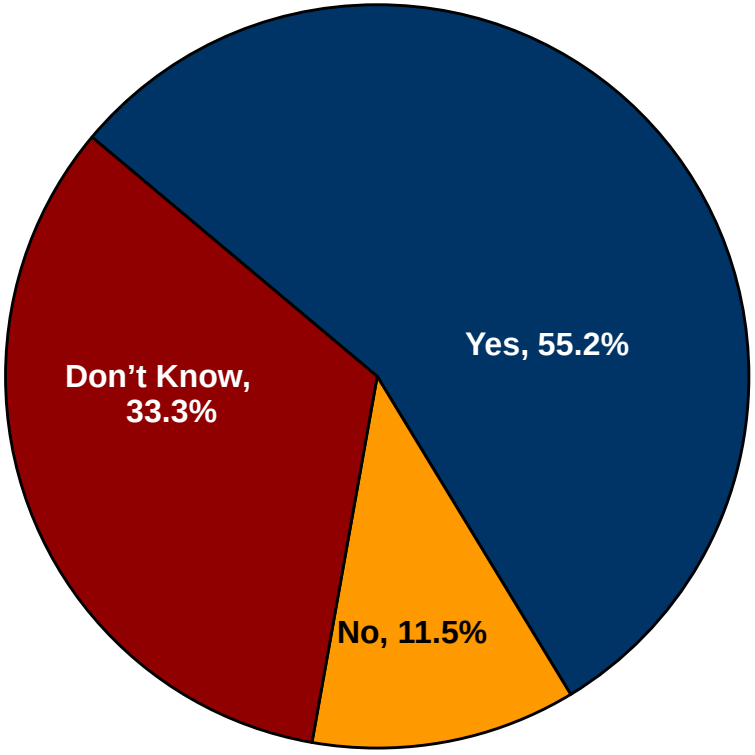

(n=77)

Q4: Do you believe that access to health care is a pressing and prevalent issue for some residents in your community?
Q4a: (If yes) In your opinion, why is access to health care an issues for some residents in your community? (Multiple responses allowed)

Roughly half (55.2%) of Key Informants recognize that certain subpopulations or groups in the SHGMH area are underserved with respect to health care, while a full third (33.3%) do not know what groups may be underserved. Those most at risk **lack insurance (completely or partially)**, are **undocumented immigrants**, **non-English speaking residents**, **senior adults**, **minorities**, or **children**.

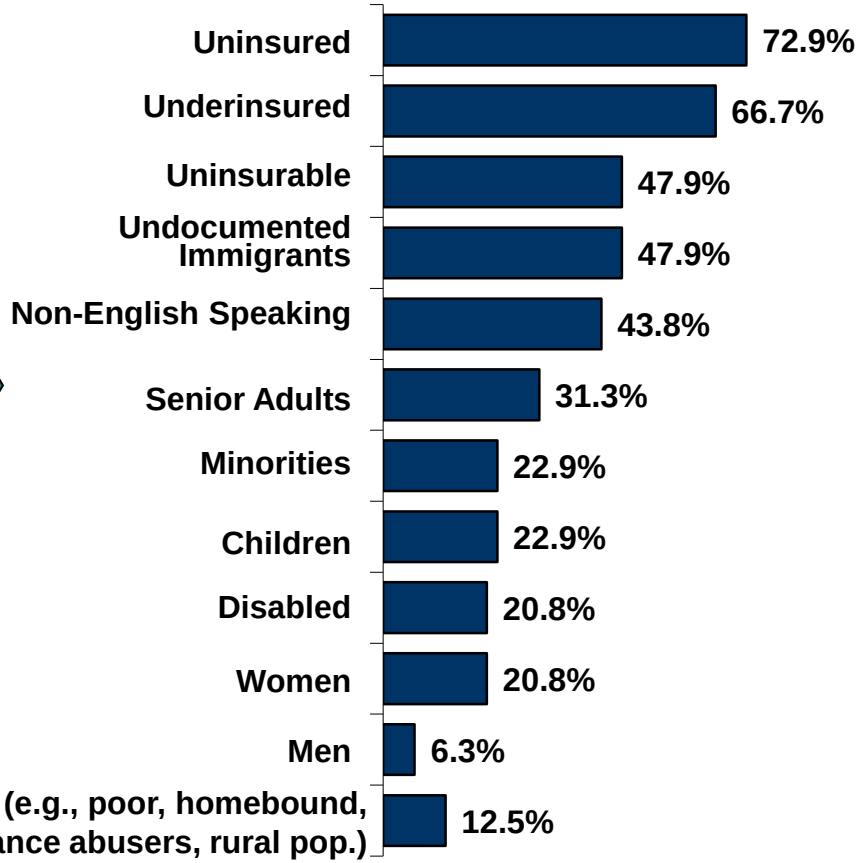
## Subpopulations Underserved with Regard to Health Care

### Are Specific Subpopulations or Groups Underserved?




(n=87)

### Subpopulations or Groups Underserved



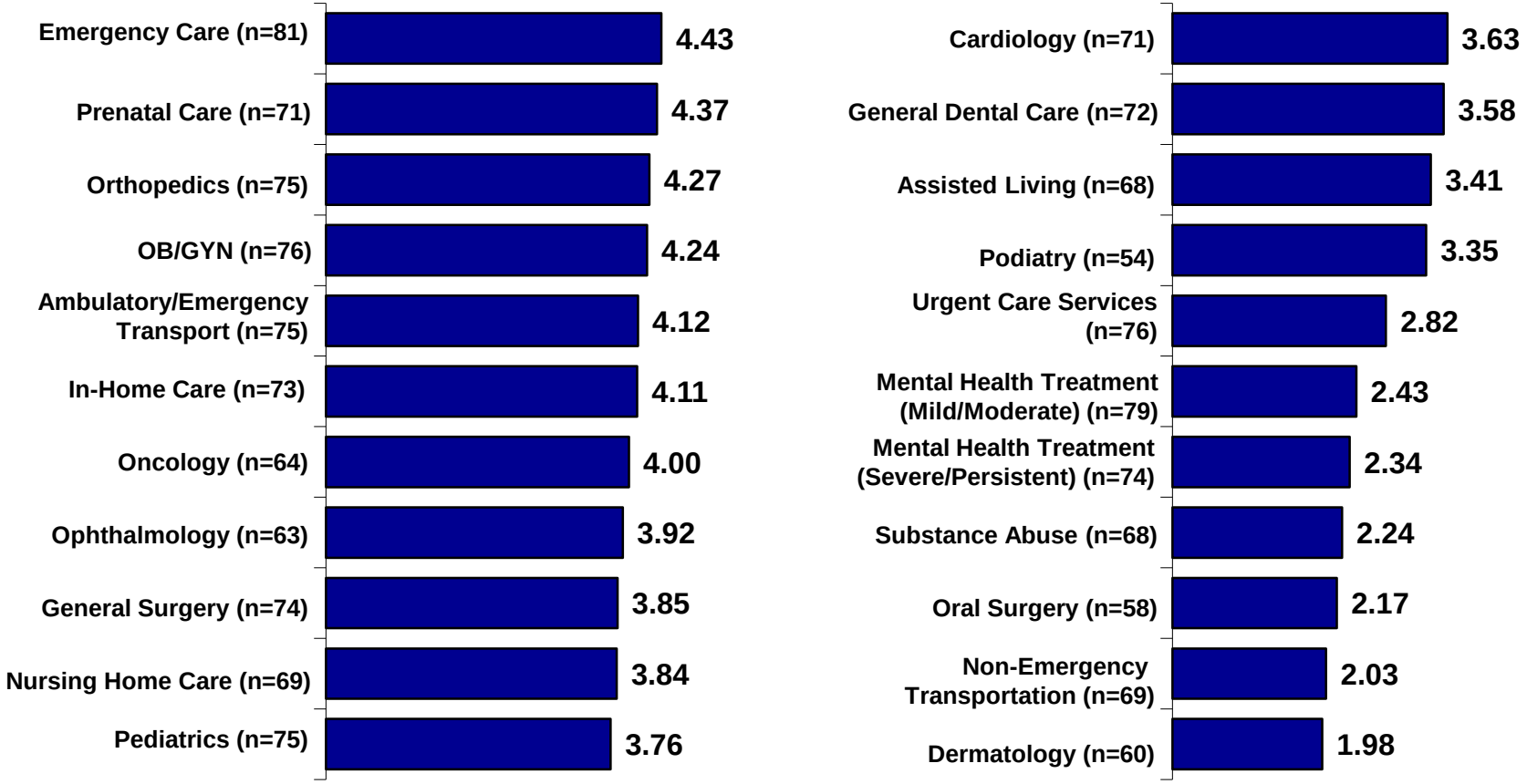

(n=48)

Q5: Are there specific subpopulations or groups of people in your community that are underserved with regard to health care?
Q5a: (If yes) Which of the following subpopulations are underserved? (Multiple responses allowed)

# *Gaps in Health Care*

SHGMH area programs and services perceived to meet the needs/demands of residents well are **emergency care**, **prenatal care**, **orthopedics**, and **OB/GYN**. Conversely, **dermatology**, **non-emergency transport**, **oral surgery**, **substance abuse**, and **mental health treatment (mild to severe)** are all perceived to be lacking.

## Degree to Which Programs/Services Meet the Needs/Demands of SHGMH Service Area Residents

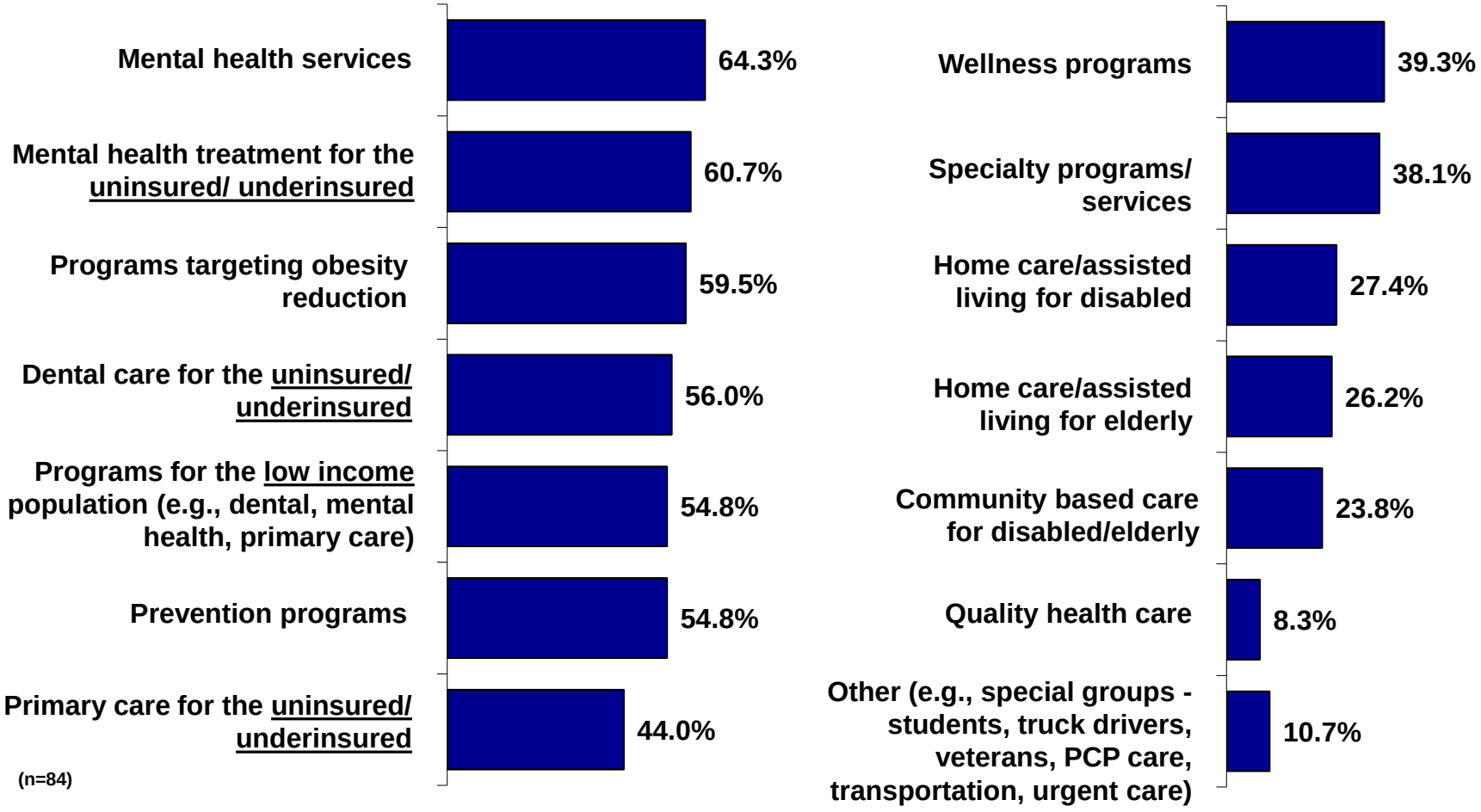



Q6: How well do the following programs and services meet the needs and demands of residents in your community?

Note: all n's represent 2014 BRFS

Key Informants report that the greatest void is found in **mental health treatment/services**, followed by **programs targeting obesity reduction**, **dental care**, and **programs** or care **targeting uninsured/underinsured** and **low income** residents. **Prevention** and **wellness** programs are also found to be lacking in the community.

## Programs/Services Lacking in SHGMH Service Area

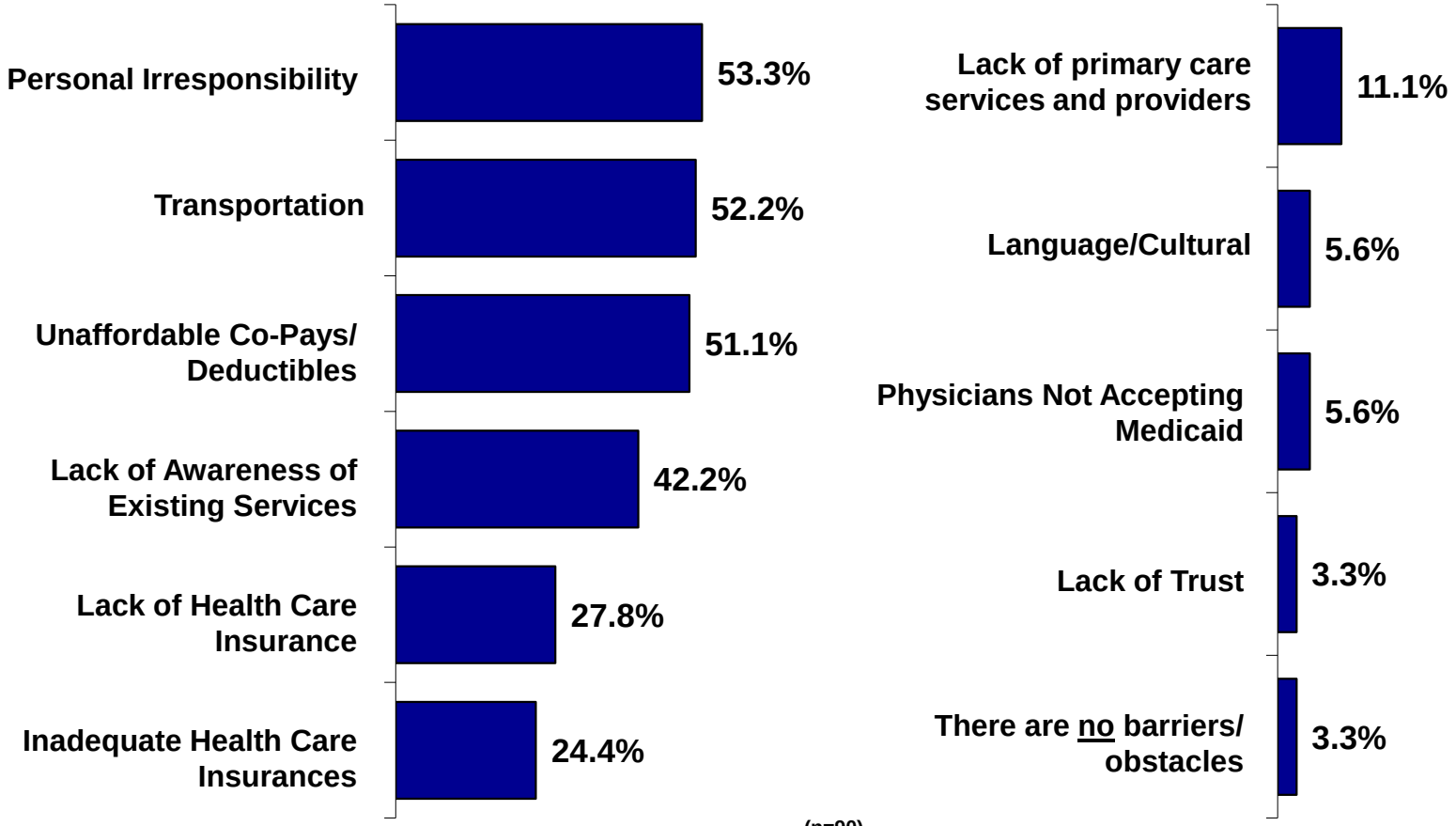



Q7: What programs or services are lacking in the community, if any? Please be as detailed as possible.

# *Barriers to Health Care*

According to Key Informants, **personal irresponsibility**, **transportation**, an **inability to afford out-of-pocket expenses such as co-pays and deductibles**, **lack of awareness of existing services**, and **inadequate health care insurance** are top barriers or obstacles to health care programs and services. A **lack of primary care providers** is considered an additional barrier to accessing health care in the community, while **lack of trust** or **language/cultural barriers** are not considered to be prevalent obstacles.

## Barriers and Obstacles to Health Care Programs/Services




(n=90)

Q8: What are the top three barriers or obstacles to health care programs and services? Please rank from 1 to 3, where 1 is the greatest barrier, 2 is the second greatest barrier, and 3 is the third greatest barrier.

Key Informants offer many ideas to effectively remove health care barriers. Solutions to the top barriers involve **using volunteers or a mobile clinic**, **increasing the number of prevention and wellness services**, **educating community members on healthy lifestyle decisions**, and **raising awareness of existing community resources**.

## Effective Solutions to Barriers and Obstacles to Health Care
## Verbatim Comments

**Personal Irresponsibility**

*"**Education on money management/budgeting and prevention of health problems**."*

*"Provide education possibly through partnership with public and private schools."*

*"If we can ever figure out the motivation to get people to adopt a healthier lifestyle and make healthier choices for themselves and their families, it could make a huge difference."*

*"Increase community health education and programs across the entire county."*

**Transportation**

*"**Volunteer drivers for elderly patients who need transportation to doctor appointments**."*

*"Need to go where the people are (church, senior centers, etc.) rather than forcing them to come to the treatments/services."*

*"Clinics to help the poor and elderly, **mobile clinics in the more rural areas** on a bi-weekly basis to take care of minor health care concerns."*

*"**A rural transit system would remove many barriers. However, after two recent transportation studies, the financial resources needed to remove this barrier are cost-prohibitive.**"*

*"County-wide shuttle service - lack of transportation."*

**Lack of Awareness of Existing Services**

*"Community education which is currently being addressed."*

*"More education and awareness, outreach to the community to make them aware of all health care and community resources available to them."*

*"More involvement in community events. **There are multiple festivals in the Grant/Newaygo/Fremont area which could be used as stepping grounds to reach the community**."*

Q8a: What, if any, are the effective solutions to these barriers? Please be as detailed as possible and identify which problems you are referring to when discussing solutions.

Key Informants also want to see: **care become more affordable** through the use of **sliding scale** fees or in lowering overall costs, an **increase in the number of mental health services** available to the community, more **support and social services available to families**, **increasing addiction counseling services**, and **improving community collaboration and care coordination**.

## Effective Solutions to Barriers and Obstacles to Health Care Verbatim Comments (Cont'd.)

**Affordable Health Care**

*"Having an urgent care with sliding fee would be a wonderful asset."*

*"403B pharmacy program to generate income to help with those who can't afford co-pays. I hear from a lot of elderly on fixed income asking for sample meds to help them with the co-pays."*

*"Offer free health screenings to draw in low income, senior, disabled, and uninsured and provide them with direct referrals for additional services (if needed) and/or materials."*

**Mental Health/Addiction Services**

*"**Mental health services - we have been told for three years now that we would have a counselor from CMH** or otherwise available in our office at least 3 days of the week and this has yet to happen."*

*"We need more mental health assistance at younger and younger ages. We have pre-school and kindergarten age students who come to school with severe mental health issues. More than I have ever seen in 30 years in education. The rates of mental illness and depression are growing amongst all school age kids K-12."*

*"**Provide training to local physicians on how to work with substance abusing or pain management problem patients** rather than discharging them; provide addictionology support (Dr. Cory Waller) to local PCPs to help them learn to prescribe pain meds in a responsible way that doesn't perpetuate the problem."*

*"**Accessible mental health care, substance abuse treatment programs especially after hours and on the weekends**. Patients often come to the ED with issues and no services available."*

**Care Coordination/Community Collaboration**

*"Through such venues as NC-3, community partners continue to try and develop/implement strategies to address the identified issues and problems."*

*"**Care Managers can be effective in working with patients in the area of creating self management goals** and increasing patient engagement. This service is not funded by most payers."*

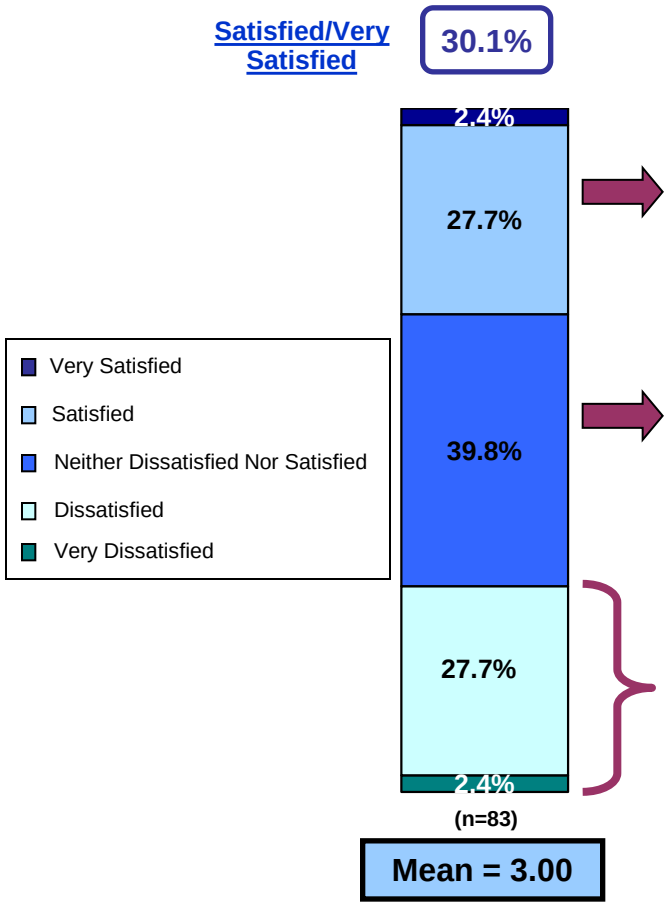
Q8a: What, if any, are the effective solutions to these barriers? Please be as detailed as possible and identify which problems you are referring to when discussing solutions.

# *Identifying and Addressing Needs*

About one third (30.1%) of Key Informants are satisfied overall with the health climate in the SHGMH area, while the same number are largely dissatisfied with the climate. Those who are satisfied cite **good care** but also the **need for more prevention care** and for **community members to make healthy lifestyle decisions**. Those who are dissatisfied view **lack of access to quality services**, **unmet mental health and addiction needs**, and an **overall unhealthy population** as priority concerns.

## Overall Satisfaction with Health Climate in SHGMH Service Area

### Level of Satisfaction



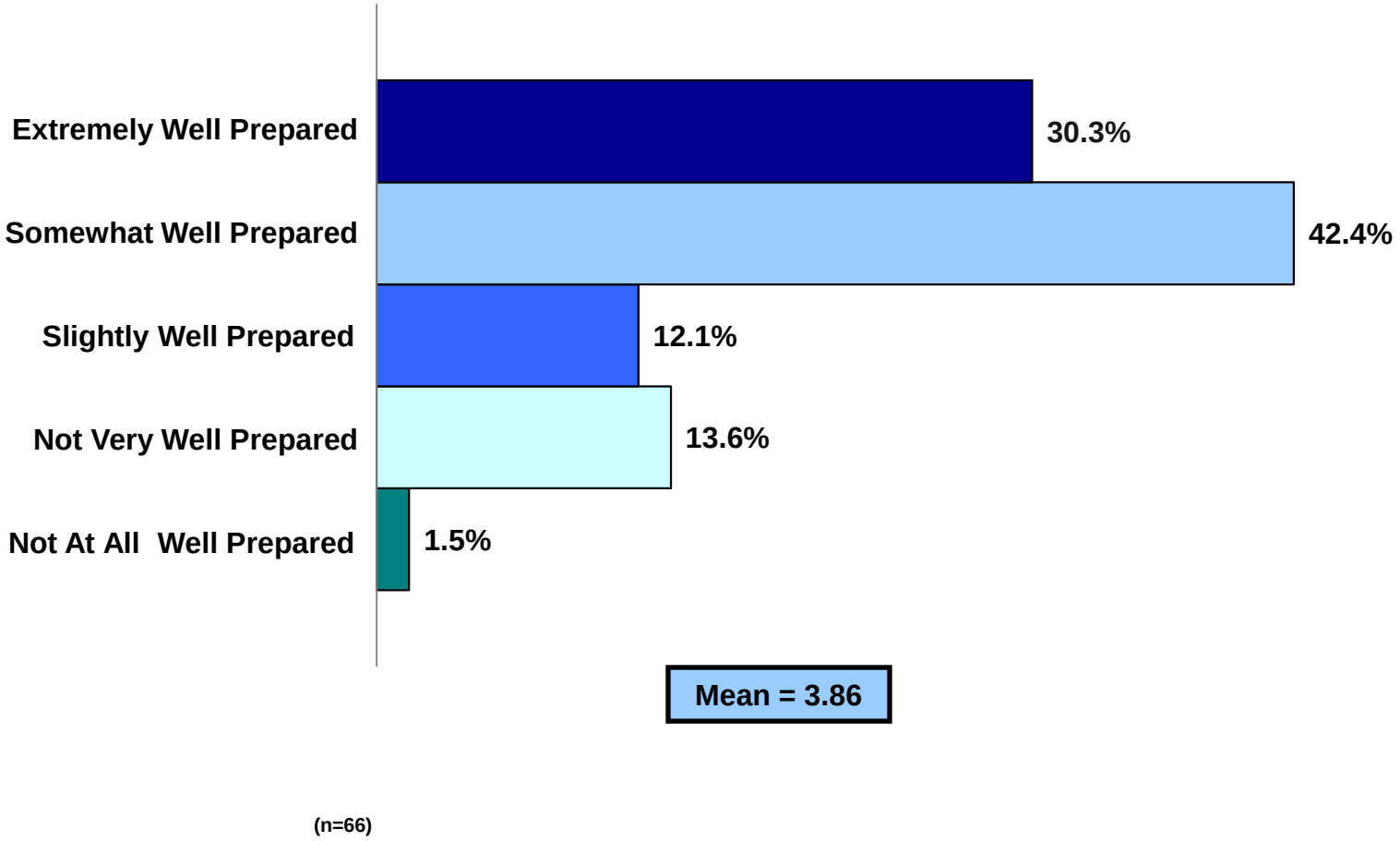

### Reasons for Rating

| | |
|---|---|
| ✓ What is in place is the best offered considering national political climate<br>✓ Needs are managed well within the broader hospital network<br>✓ Need more preventative care | ✓ People need to make better lifestyle choices<br>✓ Services continue to improve<br>✓ Striving to provide more resources and education |
| ✓ Access to specialty care is improving<br>✓ Have good base, need more collaboration<br>✓ Much more room for improvement<br>✓ Need more accessible PCPs and specialty services | ✓ Large deficits with mental health services<br>✓ Personal responsibility for healthy lifestyle choices should be a priority<br>✓ Uninsured need more support |
| ✓Access to services is difficult<br>✓Being rural is a challenge<br>✓Co-pay assistance needs<br>✓Counseling service needs<br>✓Geriatric needs<br>✓Lack of knowledge of available resources<br>✓Limited resources to help the poor | ✓Mental health/substance abuse not being addressed<br>✓Overuse of ER<br>✓Poor community mentality on lifestyle choices<br>✓System is too difficult to navigate for those in poverty<br>✓Too few providers overall to meet community needs |

Q9: Taking everything into account, including health conditions, health behaviors, health care availability, and health care access, how satisfied are you overall with the health climate in your community? Q9a: Why do you say that? Please be as detailed as possible.

More than seven in ten (72.7%) feel local health care professionals in the SHGMH area are at least "somewhat well" prepared to deal with a communicable or infectious disease outbreak such as Ebola. Three in ten believe health care professionals are "extremely well" prepared to handle such an outbreak.

## Preparedness to Address Communicable Disease Outbreak in SHGMH Service Area




(n=66)

Q12: How well prepared are local health care professionals to deal with a communicable or infectious disease outbreak such as Ebola?

When commenting on the impact of Federal Health Care Reform or the Healthy Michigan Plan, Key Informants are more likely to cite negative, mixed, or no observable results, compared to positive results. Those who view the legislation as positive point to a **greater access to health care for the uninsured or underinsured** and an expectation to see improved health outcomes in the future.

## Impact of Federal Health Care Reform/Healthy Michigan Plan in SHGMH Service Area
## *Positive* Results Verbatim Comments

*"At this point in time, **I see it has broadened access to health care**. It is too soon to evaluate if it has had any affect on the actual delivery of services or improved health outcomes."*

*"More people are able to establish care from a PCP, partake in preventative services, and begin to trust the health care team at the PCP office. Many people have been able to address health issues (such as dental care) that they have put off for years due to the inability to afford services."*

*"**Has helped as people have insurance and are seeing physicians, we have added providers to meet the need**. It is good to see the help people can finally get."*

*"I've been very, very happy with the improvement in access by my underinsured patients thus far. It needs to expand - many still aren't taking advantage of it, either because of misinformation or lack thereof. It has improved access to care. It has improved service delivery as a larger portion of the previously uninsured are now covered by Medicaid. Unclear on the effect of health outcomes."*

*"**I expect that the providers in our community will see an increase in demand for services. They are already addressing access and delivery by leveraging APPs and retail pharmacists. I expect it to have a positive impact on health outcomes**."*

*"Access to care - **more people can now go to the doctor. The hardest part is getting them all in**. Many patients of ours are accessing services that have been out of reach for them for years. When Spectrum took over Pine Medical, it was a blow to see urgent care go. Newaygo has had a lot of movement for healthcare on a more public health and population based focus. Having the NC3 coalition is a wonderful asset for the community to not only address health, but factors that affect health such as housing, mental health, domestic abuse."*

Q11: What has been the impact of Federal Health Care Reform od the Healthy Michigan Plan in your community? In other words, in what ways has it impacted the following: (1) access to health care, (2) service delivery, and (3) health outcomes? Please be as detailed as possible.

Those who view results as mixed say **more people are now covered, but that doesn't necessarily translate into access** for primarily three reasons: (1) many people still find insurance unaffordable or are purchasing insurance at an affordable premium yet this often comes with **high-deductibles and co-payments they cannot afford**, (2) **simply having coverage doesn't mean a provider will accept it** ,and (3) **quality of care** as well as **slower service delivery** still present important barriers to access.

## Impact of Federal Health Care Reform/Healthy Michigan Plan in SHGMH Service Area
## *Mixed* Results Verbatim Comments

*"Access to get into doctor is unchanged.* ***More people makes it harder to get in****. Service delivery is unchanged, health outcomes are improving for those who choose to seek care."*

*"At this point, I'm not sure. Some have had more access to care than in the past which is a definite benefit.* ***Others have not been able to afford insurance still, and thus do not receive adequate care****. At this time, I can't see that there has been much improvement in overall health outcomes unfortunately."*

*"It has complicated billing and tracking immensely. As a provider, every ACO, ICO, health plan etc. has different coverage, different co-pays, different rates, different forms. Need to add a full time case manager to get a handle on this. We can't admit someone until a prior auth. is received. This holds up transfers from other providers and causes stress for people."*

*"More demand on providers for patients to be seen limited access to see them. Lots of complaints about higher co-pays, less covered services. To early to see any changes in health outcomes."*

*"**More people have insurance and thus have access to care however they don't always understand how to use those benefits appropriate and how to navigate the system so they don't lose coverage. We have seen a lot of folks lose Healthy Michigan coverage.**"*

*"1. I have seen little change in the availability of health care. We continue to see patients and turn no one away. 2. Service delivery is improved in this community since we had the wisdom to build a new facility. 3. Health outcomes are impacted by education of the population and will not change until unhealthy lifestyles are changed at the family level."*

*1. The Affordable Care Act has not helped my patients.* ***In the second year of this they have all seen increases in the premium to such a level that it is not sustainable by them and when they do find a program that they can afford the co-pays and deductibles are so high that it prohibits them seeking care.*** *2. The Healthy Michigan Plan is starting to take off more in this area and has been helpful in getting people who did not previously have access to care access to care and medications as needed.*

Q11: What has been the impact of Federal Health Care Reform od the Healthy Michigan Plan in your community? In other words, in what ways has it impacted the following: (1) access to health care, (2) service delivery, and (3) health outcomes? Please be as detailed as possible.

In addition to higher deductibles and co-pays preventing people from using their health insurance, the **quality of those plans comes into question** and many Key Informants believe people have been **forced to purchase substandard or limited coverage (e.g., solely catastrophic coverage).** Some Key Informants also feel it has **worsened access issues**, **decreased individual attention to patients**, **increased use of the ER**, and that **businesses are now saddled with unnecessary cost** and have cut employee hours or benefits as a result.

## Impact of Federal Health Care Reform/Healthy Michigan Plan in SHGMH
## *Negative* Results Verbatim Comments

*"There is less physicians available to see patients. It is difficult to even get an appointment.* ***Find people use the ER more for what they used to go to a physicians office for*** *because they do not want to wait a month for an appointment.*

*"We had access to care issues prior to ACA; reimbursement models are not aligned. Has not positively impacted health outcomes."*

*"****Part time employees have lost hours*** *due to 30 hour requirement. Cost have risen thus prevent community members to be able to afford needs."*

*"A negative has been that there has* ***been a number of persons who have lost coverage and /or benefits in part related to the application processes.*** *Some of the latter was an unexpected outcome and is relative to a process beyond the control of the consumer applicants but seems to be an IS/Data retention and tracking issue."*

*"Access has been more difficult, due to the fact that* ***PCPs are not seeing patients with certain types of Medicaid****. Larger pharmacy chains, for example are no longer covering people with Etna Insurance."*

*"Nestle cancelled coverage for all Gerber retiree with Medicare. This was a shock for people at all ages. People age 85 to 95 were forced to shop for their own coverage thanks to the reform."*

*Health care is becoming generic in every sense of the word. The thing is,* ***we individually don't fit what is becoming a 'cookie cutter' approach****. Health care isn't an entity that can be molded to fit all."*

*"Limited access to health care, higher patient turn around from being discontinued from hospital to early or not being admitted when need to be."*

Q11: What has been the impact of Federal Health Care Reform od the Healthy Michigan Plan in your community? In other words, in what ways has it impacted the following: (1) access to health care, (2) service delivery, and (3) health outcomes? Please be as detailed as possible.

Key Informants offer a multitude of strategies for improving the overall health climate in the SHGMH service area. Addressing issues of **prevention education** and **raising awareness of existing services** top the list. Suggestions include: **targeting young families for intervention**, **community-wide exercise programs and events, financial planning education**, and **working with schools** to create an overall "culture of health" community mindset.

## Suggested Strategies to Improve the Overall Health Climate in SHGMH Service Area Verbatim Comments

*"A clear listing available to the public re: what is available and where. Avoidance of overlap and competition in services."*

*"**Add an Urgent Care. Add free classes for the community on disease specific topics and nutrition. The best treatment starts with prevention.**"*

*"Affordable programs for people to take advantage of in areas of combatting obesity, smoking cessation, and overall better care of themselves and their families."*

*"County-wide push by collaborative of all agencies in the county to build and implement a workable, effective wellness program including viable screening programs and education as to simple ways to improve people's health."*

*"**Free prevention programs for young mothers and dads** so they can avoid the stressors or life and bring their children up healthy. If it is offered to all - not just those at risk (poor, single, etc.) - there would be less of a stigma as well."*

*"**Partner with public and private schools** to provide health education early and often, starting in Kindergarten and continuing through high school graduation."*

*"Create a systemic, culture-changing initiative that **creates a prevention mindset**, which would go a long way to solving our childhood obesity problems."*

*"The addition of a low or minimal cost exercise or recreation center and community education classes on financial planning for health."*

Q10: What one or two things could be done in your community that would improve the overall health climate in your community? Please be as detailed as possible.

Additionally, Key Informants suggest that the community needs **increased mental health services** – more staff are needed to address **outpatient mental health** and **substance abuse problems**. **Transportation** is also considered a priority with Key Informants suggesting **increased coordination of resources across agencies**, **increasing home visits**, and **creating a volunteer network** to provide transportation services.

## Suggested Strategies to Improve the Overall Health Climate in SHGMH Service Area Verbatim Comments (Cont'd.)

*"**Create a transportation method for health care 24/7**. Increase home care visits to prevent ED and or hospitalizations."*

*"Businesses and churches offering health programs/services and transportation."*

*"More services for mental health. More awareness of mental health. More professional development about mental health."*

*"Development of local pain management / opioid abuse support for primary care."*

*"Finding an answer to the transportation issue. Additional providers with times that fit residents needs. Many work out of the county and when they return home, offices are closed."*

*"**Have social workers or mental health workers assigned to every clinic.**"*

*"More available transportation to and from healthcare appointments would ease the access issues. Commission on Aging does all that they can but their funding is limited. A network of retired volunteer drivers throughout the county is the answer but government oversight and regulatory burdens would have to be kept out of the picture."*

*"We need dental providers available & mental health/substance abuse inpatient services."*

*"**1. Transportation services 2. Access to mental health counselors in the doctors office.**"*

*"Community transportation. Even a taxi service would help."*

*"Establishment of a **sustainable infrastructure of public transportation** relative to consistent access to health care services and related resources."*

Q10: What one or two things could be done in your community that would improve the overall health climate in your community? Please be as detailed as possible.

Finally, bringing in and retaining **more PCPs and mid-level providers**, **increasing care coordination**, addressing the **social conditions faced by many families** (e.g., food security, poverty, lack of employment, low educational attainment), and **providing urgent care** as well as **health care services with non-traditional hours** are suggested strategies to improve the overall health climate of the community.

## Suggested Strategies to Improve the Overall Health Climate in SHGMH Service Area Verbatim Comments (Cont'd.)

*"Better coordination between the hospital and PCP offices. Mental health collaborators that would be able to see patients in a crisis."*

*"**Community wide recruitment of physicians**."*

*"A comprehensive approach to youth in engaging in a college education."*

*"Increase providers to decrease medically underserved areas."*

*"Having an urgent care available that requires lass of a co-pay/cost than having to go to the ED."*

*"**More wellness opportunities and financial education**."*

*"Raise the average IQ by 50 points. A better educated community is a healthier community on so many levels."*

*"Increase the number of providers/mid-level providers within the community. **Look for quality providers that are committed to making a difference & are part of our community; don't just fill a vacancy with someone that is looking for loan forgiveness or is not vested in our community.**"*

*"Urgent care center and services more readily available for mental health patients."*

Q10: What one or two things could be done in your community that would improve the overall health climate in your community? Please be as detailed as possible.

Since the last CHNA conducted in 2011, Key Informants report **increased agency collaborative efforts** to address health issues, followed by **increased programming to address weight loss and obesity** as well as **general health awareness**, **expansion of specialty services**, **more mental health services**, and **active recruitment of more PCPs to the area**.

## Activities Since CHNA Conducted in 2011
## Verbatim Comments

*"IHI workgroup out of the Live Well (NCHIC) group - this is a great opportunity for our community. Behavioral health has been integrated into two FQHC sites and one Spectrum PCP site. NCMH has been serving mild and moderately impaired persons with Medicaid to help meet that need."*

*"**Hospital has been recruiting additional providers which are hard to retain in a rural setting**. There have been free screening days, safety days, but not necessarily in the best locations."*

*Hospital has implemented dedicated Community Wellness initiatives and brought a new team on board to begin to address the issues. The revitalization of the Health Improvement Council to a viable organization with teeth and specific goals holds hope for the future."*

*"Our local Newaygo Council Health Improvement Council, recently renamed Live Well Newaygo County has been working to determine needs and impact in our community. **This group is a collaborative of multiple agencies and has developed a very complementary working relationship among those agencies. Plans moving forward are to continue with developing more effective impact on populations at risk in our community**."*

*"**Increased collaborative initiatives between the appropriate community partners towards the enhancement of community health and wellness** in a variety of venues such as community gardens, availability and more consistent access to fresh produce, increased public awareness of healthier living behaviors, improved depth of health care services with the partnership of Gerber Memorial and Spectrum Health."*

*"**Spectrum Health in Fremont has added a Community Health Director to the staff to work with the other stakeholders in the community. The hospital is also partnering with Community Mental Health to bring a CMH presence to Fremont**."*

*"The former Newaygo County Healthcare Improvement Council, now Live Well Newaygo County, has mobilized a strategic plan to address many concerns from the 2011 CHNA."*

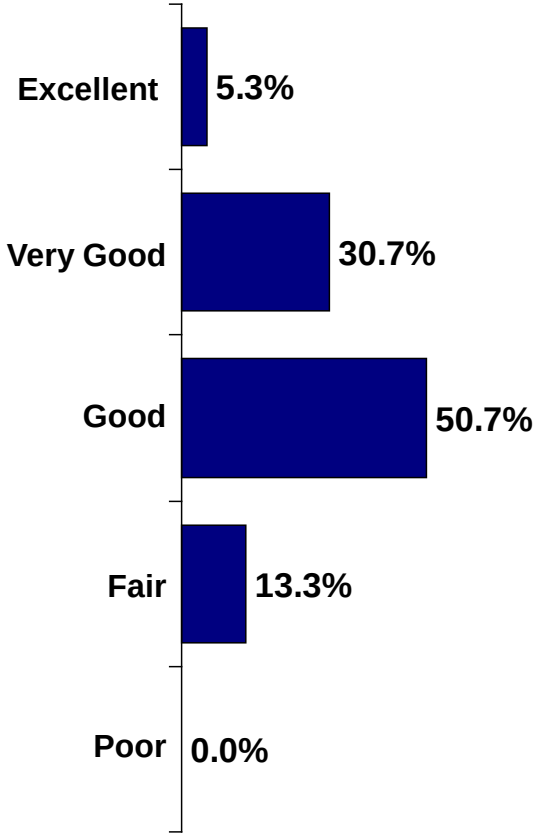
Q13: Since the Community Health Needs Assessment conducted three years ago in 2011, what has been done locally to address any issues relating to the health or health care of residents in your community? Please be as detailed as possible.

# *Underserved Resident Survey*

# *Health Status*

More than one in ten (13.3%) residents in the targeted subpopulations reports their general health as fair. Although nobody perceives their health as poor, only 36.0% report their general health as very good or excellent.

## Perception of General Health



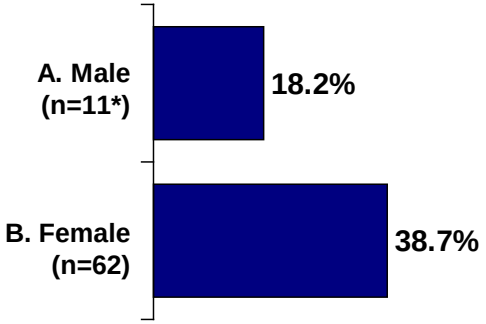

(n=75)

Q1: To begin, would you say your general health is….

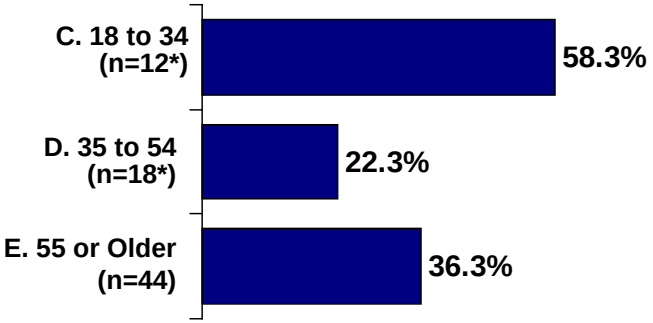
Among the underserved subpopulation, those most likely to report their general health as very good or excellent come from the following groups: women, age 18-34, have a college degree, have income of $50K or more, and have employer sponsored or private health insurance.

## Perception of General Health as Very Good/Excellent by Social Factors

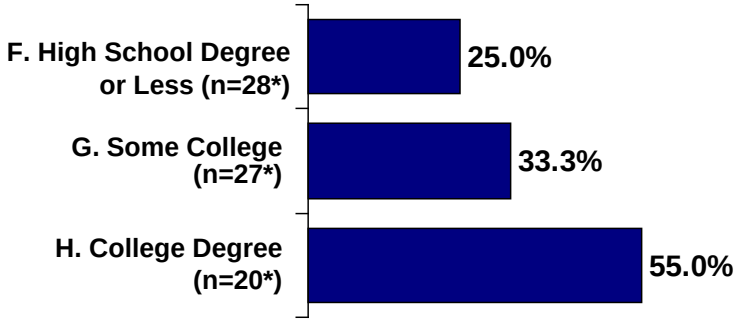
### Gender



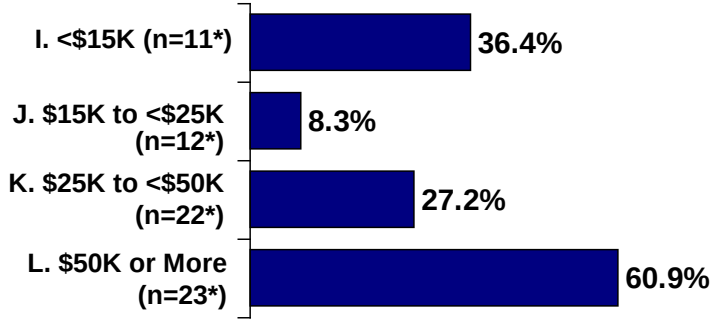

### Age



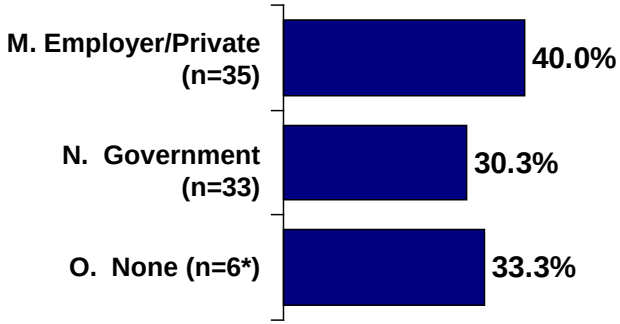

### Education




### Income




### Type of Insurance



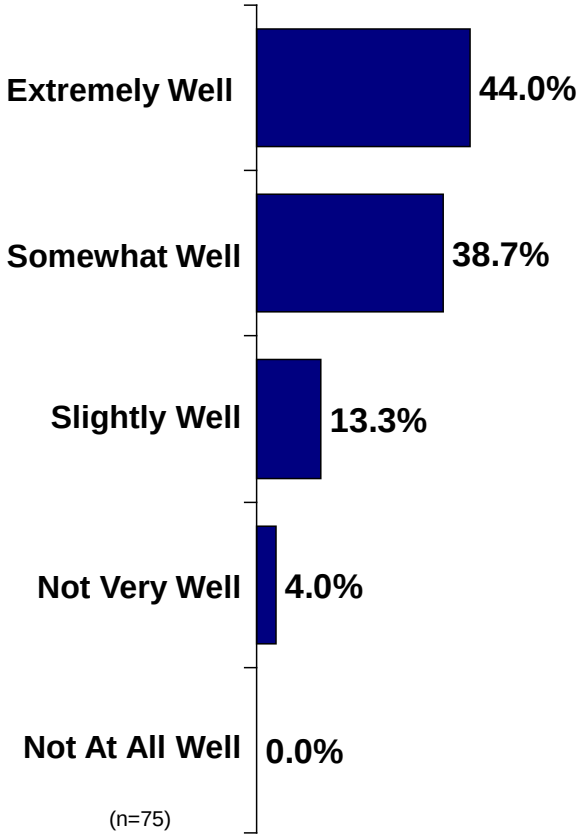

*Caution: small base size

Q1: To begin, would you say your general health is….

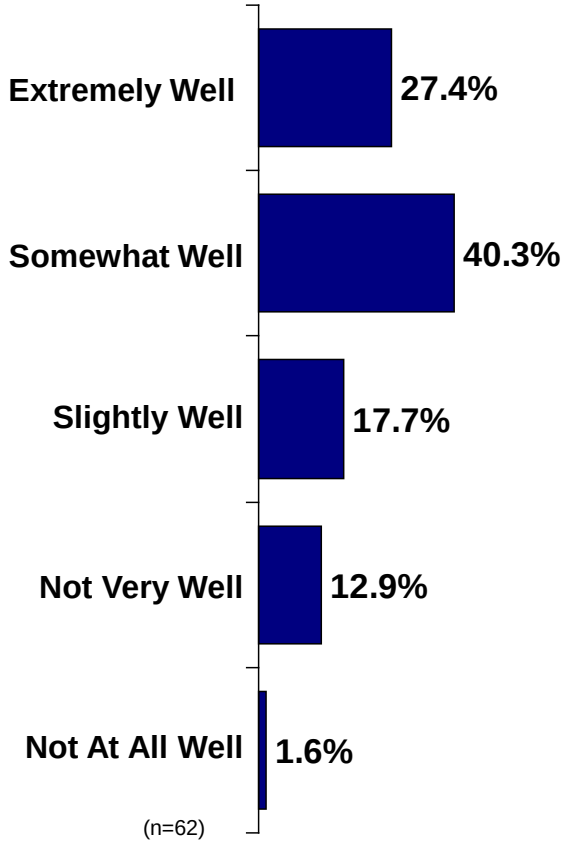
More than eight in ten (82.7%) underserved residents believe health care providers communicate somewhat or extremely well with them about their health, while two-thirds (67.7%) believe they communicate well with each other about patients' health.

## Quality of Communication Among Health Care providers

### Communication With *You* About Your Health



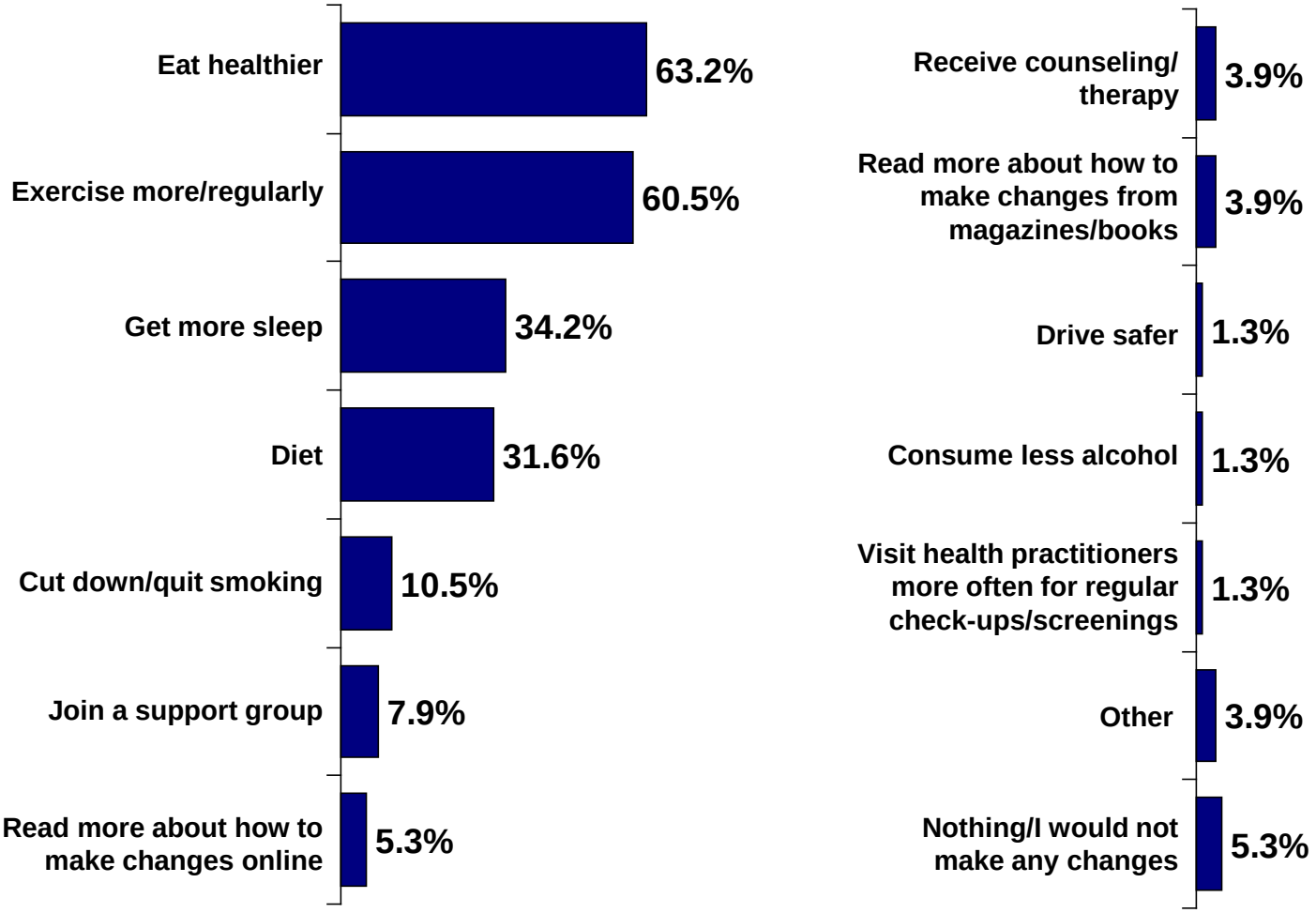

### Communication With *Each Other* About Your Health




Q6: How well do you feel health care providers communicate with you about your health?
Q7: How well do you feel health care providers communicate with each other about your health?

The vast majority of the underserved know what they need to do to improve their health: **eat healthier**, **exercise more regularly**, **get more sleep**, and **diet**. To a lesser degree, they are also willing to cut down or quit smoking and join support groups.

## Behavioral Changes Needed to Improve Health

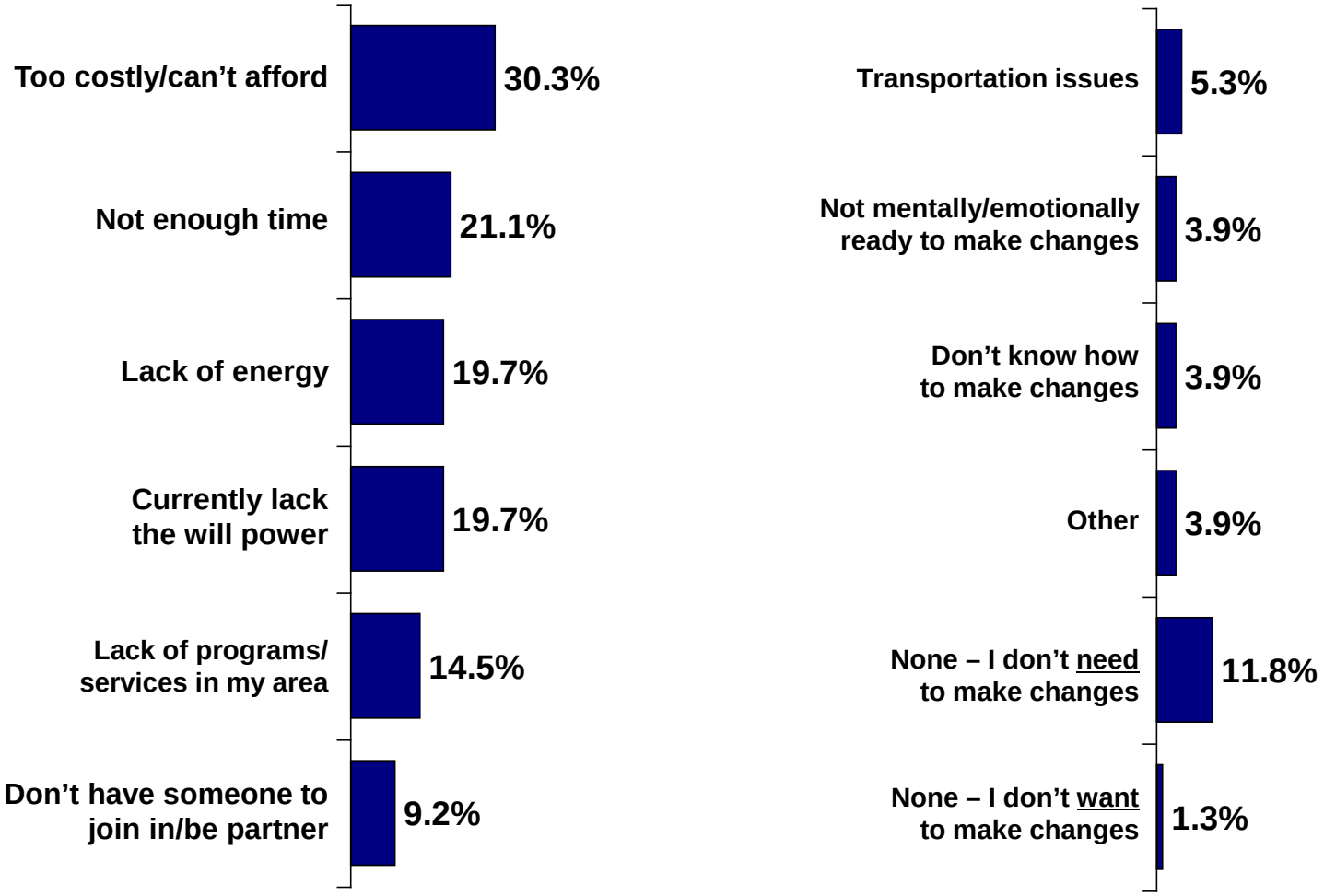



(n=75)

Q17: Which of the following behavioral changes do you believe you need to make to improve your health? (*Select all that apply*)

Although underserved residents know what they should do to improve their health, they face several barriers to living a healthy lifestyle, the greatest of which is **cost**. Further stumbling blocks include **lack of**: **time**, **energy** and **will power**. More than one in ten (11.8%) say they do not need to make any changes.

## Barriers Preventing Living a Healthier Lifestyle

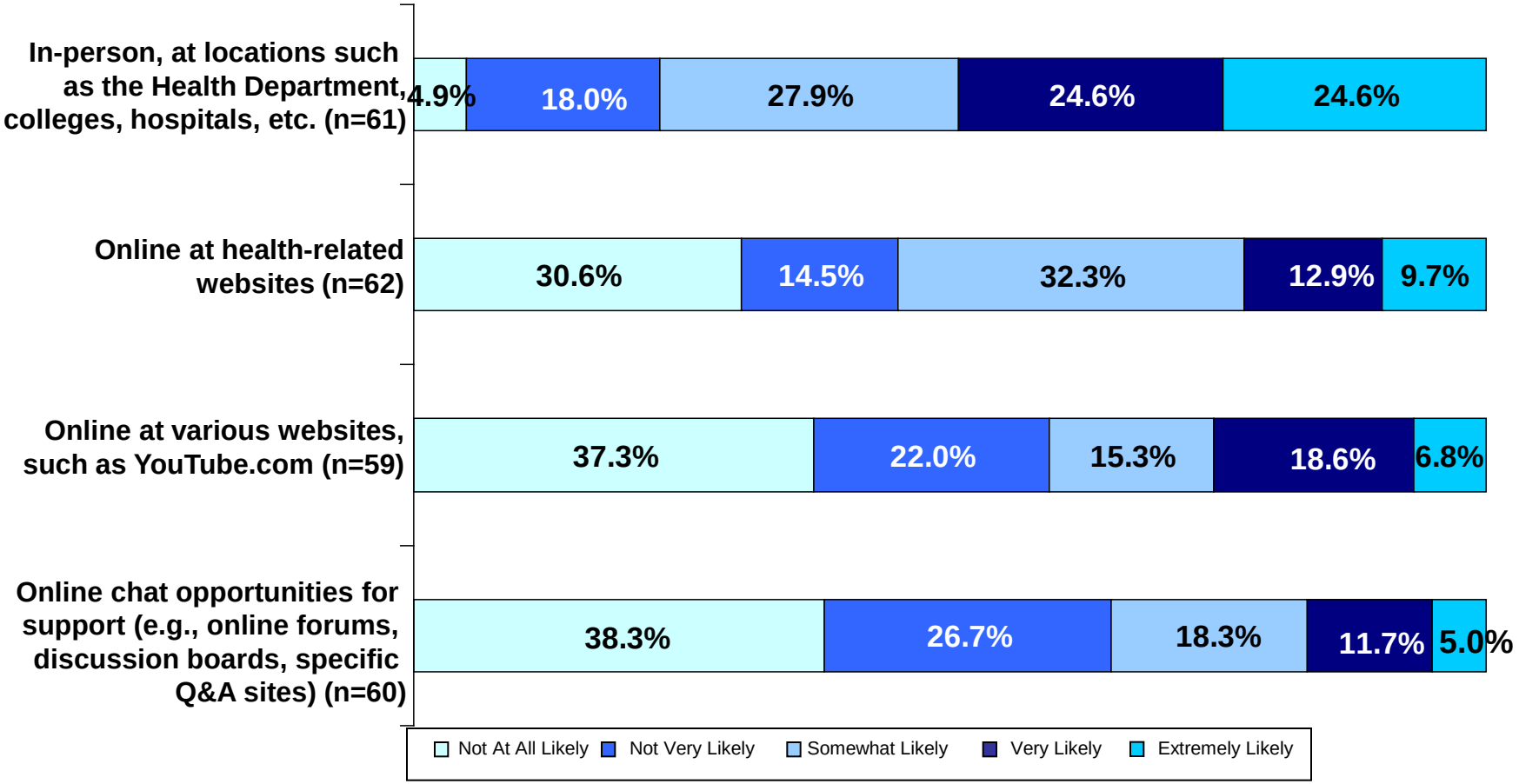



(n=76)

Q18: What are some of the barriers you face when trying to live a healthier lifestyle? (*Select all that apply*)

If education or instruction were provided on ways to live healthier lifestyles in various formats, underserved residents would most likely choose **in-person over online**. For those who prefer an online format, they are more likely to visit **health-related websites** than other websites (e.g., YouTube) or chat rooms.

## Likelihood to Participate in Education/Instruction on Leading Healthier Lifestyles

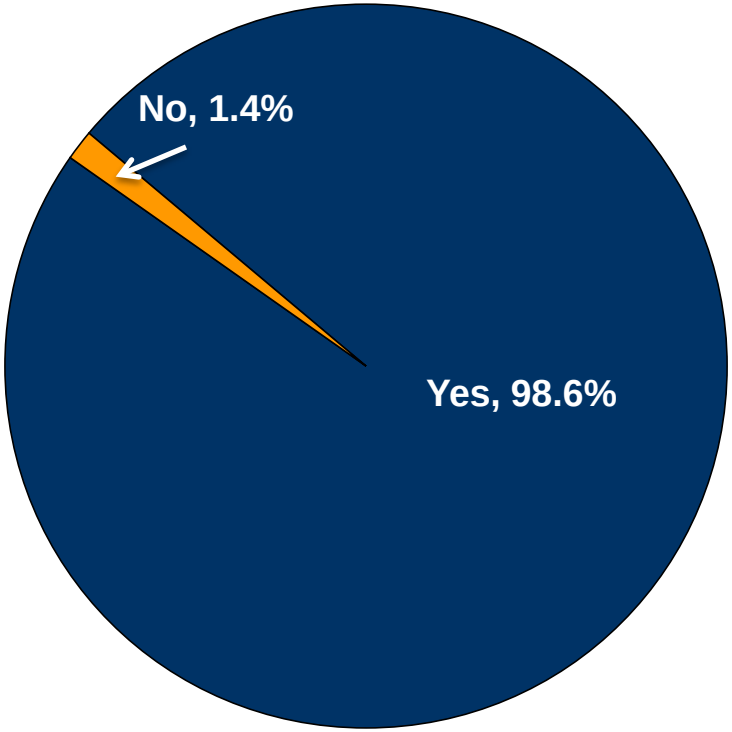



Q19: If education or instruction on how to lead a healthier lifestyle were available in different formats (below), please tell us how likely you would be to participate in these activities.

# *Health Care Access*

Almost all (98.6%) of underserved residents report having a primary care physician (medical home) that they can visit with any questions or concerns about their health.

## Have Primary Care Physician




(n=75)

Q2: Do you and your family members have a primary care physician that you can visit for questions or concerns about your health?

Underserved residents seek providers who are: **knowledgeable**, **good listeners**, **patient**, **caring**, **attentive**, **available** (can get an appointment within a reasonable time frame), **understanding**, **compassionate**, **honest**, **experienced**, and one who **treats them as a partner** (on the same team). Additionally, they should **show genuine concern**, be **relatable** (someone they can talk to), ask and **answer questions**, have **a good bedside manner**, take time to **visit with patients without making them feel rushed**.

## Most Important Qualities in a Health Care Provider

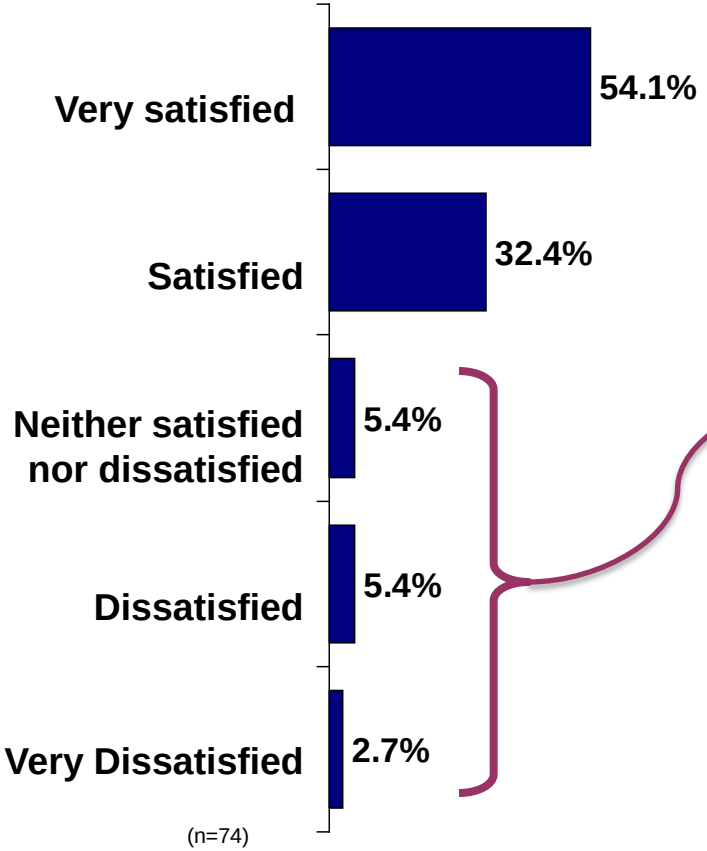

(n=76)

Q3: What is the most important quality you look for in a health care provider? (open end)

The vast majority (86.5%) of underserved residents are satisfied with their last visit for health care. However, those who are dissatisfied report the following issues: (1) rude or unprofessional staff, (2) lack of thorough diagnosis or misdiagnosis, (3) physicians unavailable so patients end up seeing mid-levels, (4) not listening to patients, and (5) costs.

## Satisfaction with Last Health Care Visit and Reason for Rating

### Satisfaction with Last Visit




### Reasons for Not Being Satisfied with Last Visit

*"Saw RN (or NP) and she was **unhelpful** and **rude**. Could have checked myself for cancerous moles but a skin care specialist told me to go in. **Waste of money**."*

*"Did **not do a very good check up** about my symptoms."*

*"Always **in a rush**, **rude**, and **overworked**."*

*"**Front desk** at….is **terrible**."*

*"Needs to **listen more**."*

*"My PCP is **rarely available**, usually see the NP."*

*"**Cost keeps increasing**. I should get discount for being healthy."*

*"Seems like **a lot of money for the office call**."*

Q4: How satisfied were you with your last visit for health care?
Q5: Why do you say that? Please be as detailed as possible.

Underserved consumers who are satisfied with their last health care visit appreciate providers (physicians, nurses) who **listen to them and take the time to formulate a plan** to address their ailments or concerns. They **do not like to feel rushed** and appreciate a health care provider who **places their focus on the patient**. They also like providers who **communicate well**, **show empathy/concern** (care), **answer as well as ask questions**, are **knowledgeable** and treat patients with **respect**.

## Reasons for Satisfaction with Last Health Care Visit
## Verbatim Comments

*"They **talked to me** about my problems."*

*"Person was **nice** and **helpful**."*

*"Well-child check, but baby was sick. **Advised not to do shots** (I preferred to wait). Went okay."*

*"**Explained** what I needed done and the results were given to me in a **timely fashion**."*

*"**Knowledge**, **communication**."*

*"My doctor **always listens to my concerns**, **helps** me be **proactive** about my health."*

*"I was seen for sinus infection and **asked questions** pertaining to medications and the impact when trying to get pregnant. Doctor was very **helpful**."*

*My OBGYN has really **taken the time** to meet all of my needs."*

*Because they **listened to me** and my doctor was very **concerned** about my health and he gave me money to pick up my medicine from Walgreens (headaches) and he gave me a diet coke."*

*"She **listened**."*

*"My PCP is **very focused on you** when he is with you."*

*"She is always willing to **give you the time you need**, she **never makes you feel rushed**."*

*"Been with provider for 12 years. Relationship is good."*

*"**Great all around service and attention**."*

*"I **got answers to all my questions** and they were **kind** and **understanding**."*

*"I have a doctor who is **knowledgeable**, **friendly**, **understanding**, and **patient**."*

*"**Doctor encourages me**. **Praises me** and helps me to continue to lose weight."*

*"Took time to **explain**, **ask questions**, **give answers**."*

*"He **listened** to me and **did not rush**."*

*"They do a very good job and they have a **wonderful pharmacy on site**."*

*"**Doctor knows our family**, **very knowledgeable**."*

*"Physician was **attentive to my needs**, did a **thorough** job."*

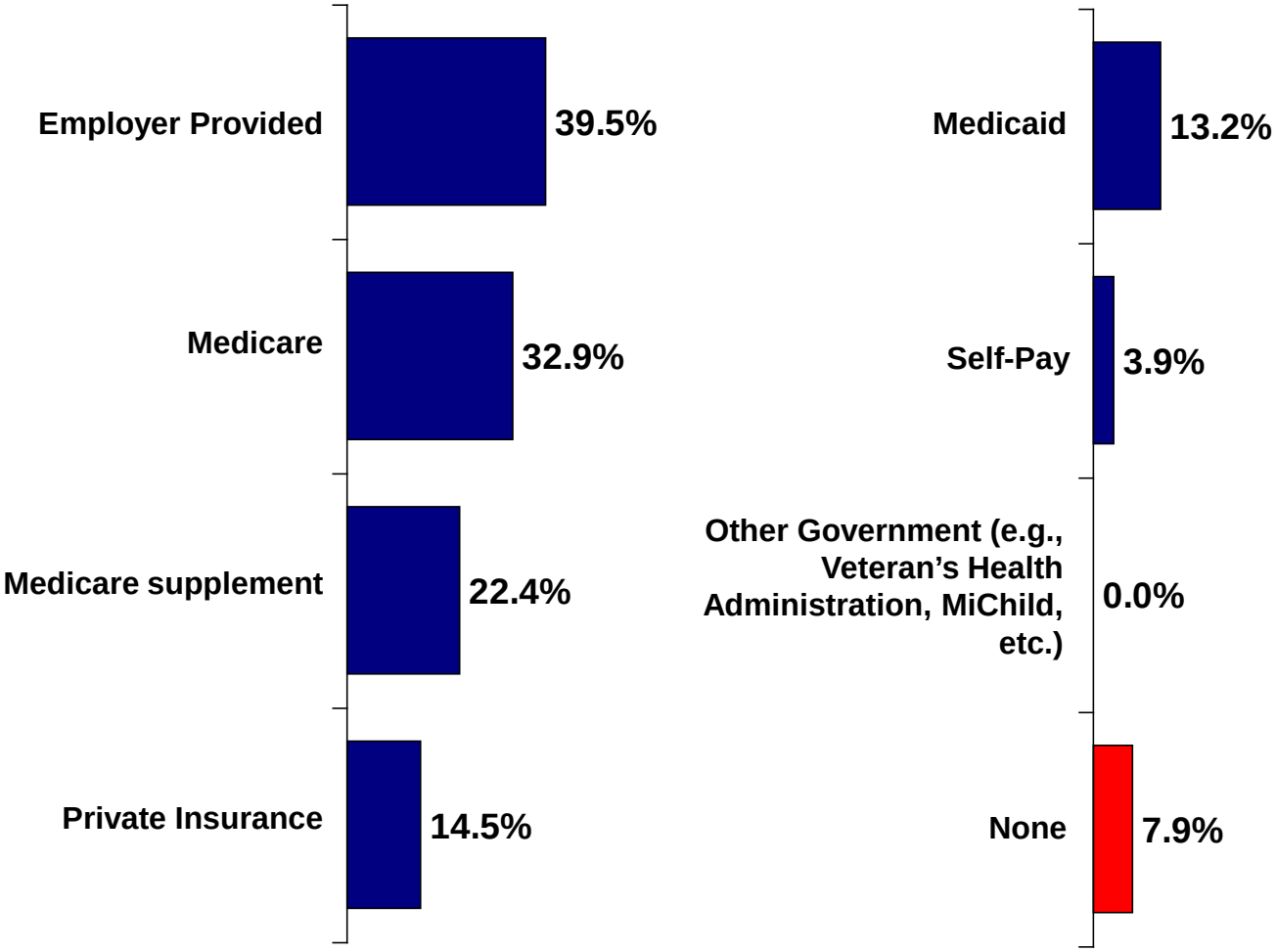
*"Doctor fully **addressed my concerns**, **knew my medical history**, **listened carefully**."*

*"Very **caring**, **thorough**."*

Q5: Why do you say that? Please be as detailed as possible.

Almost four in ten (39.5%) of the underserved residents have employer provided insurance, while 32.9% have Medicare and 13.2% have Medicaid. Nearly half (46.1%) have health insurance that is a government sponsored plan and 7.9% have no health coverage.

## Current Health Insurance



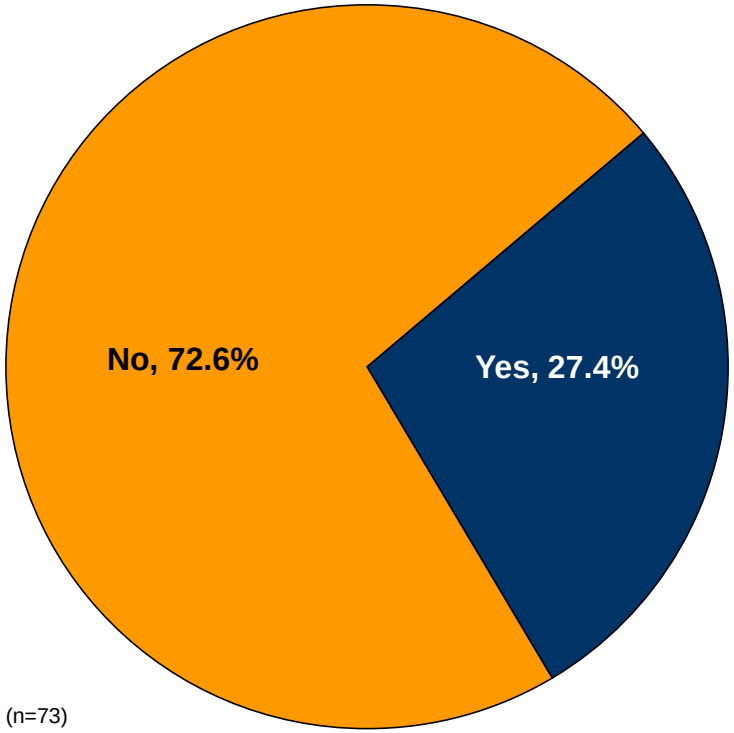

(n=76)

Q8: Which of these describes your health insurance situation? (*Select all that apply*)

More than one-fourth (27.4%) of the underserved have had trouble getting needed health care for either themselves or their family in the past two years. The most prominent reason for this is the **lack of health insurance**, followed by an **inability to afford out-of-pocket expenses such as co-pays and deductibles**. Other barriers to care include the **inability to get an appointment**, **lack of physician specialists in the area**, and **transportation issues**.

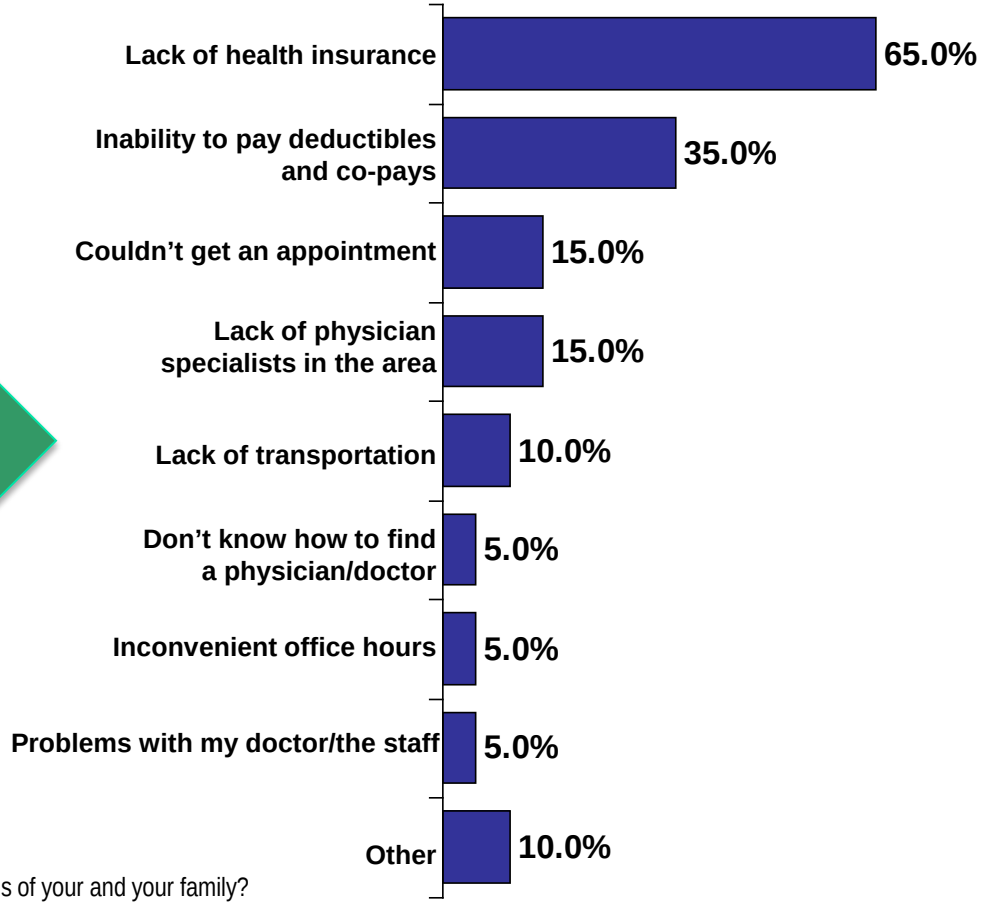
## Barriers to Meeting Health Care Needs

### Had Trouble Meeting Health Care Needs in the Past Two Years




(n=73)

### Reasons for Not Receiving Needed Health Care




(n=20)

Q9: In the past two years, was there a time when you had trouble meeting the health care needs of your and your family?
Q10: (If yes) What are some of the reasons you had trouble meeting the health care needs of you and your family? (Select all that apply)

Underserved residents see a **lack of physician specialists** in the area, specifically GI, oncology, orthopedics, and neurology. Additionally, there is a **lack of services for mental health**, **dental**, and **vision**. There are several issues for services and programs that do exist: (1) because of the rural nature of the area, **transportation** is a barrier, (2) some people are **unaware of existing programs and services**, and (3) the **limited office hours** prevent some residents from utilizing existing programs and services. Residents would like to see **more education (classes/workshops)** made available for teaching people how to cook, diet/nutrition, diabetes, weight management and senior adult issues.

## Health Care Programs, Services, and Classes That are Lacking in the Community

*"**Nutrition** for adults, **cooking demonstrations**."*

*"More **dental** and **vision** programs available for adults."*

*"**Urgent care**."*

*"**GI specialists**."*

*"**Dietary education** that is **affordable**."*

*"More local doctors' offices **closer to where I live**."*

*"Program that applies to **homeless** people."*

*"**Mental health**."*

*"More **gym** programs."*

*"**Teaching** young families **how to cook**."*

*"**Diabetic path**. It has been scheduled twice and cancelled twice. I want to teach it."*

*"**Gamblers' Anonymous**."*

*"**Transportation**."*

*"**Deductibles and co-pays** keep my clients from seeking care."*

*"Spectrum Health Gerber Memorial and Trillium have wonderful programs and services but the **hours need to vary more to accommodate all residents**."*

*"Unsure due to **lack of information about community programs**."*

*"**Weight loss**."*

*"**Affordable acupuncture**."*

*"**Teen counseling**."*

*"More about **seniors' needs**, **cooking classes**, **exercise** classes for knee pain/arthritis, in-depth questions and answers with **fun activities** and ways to learn."*

*"**Lack of physician specialists**, for example, **oncologists** only here two days a week."*

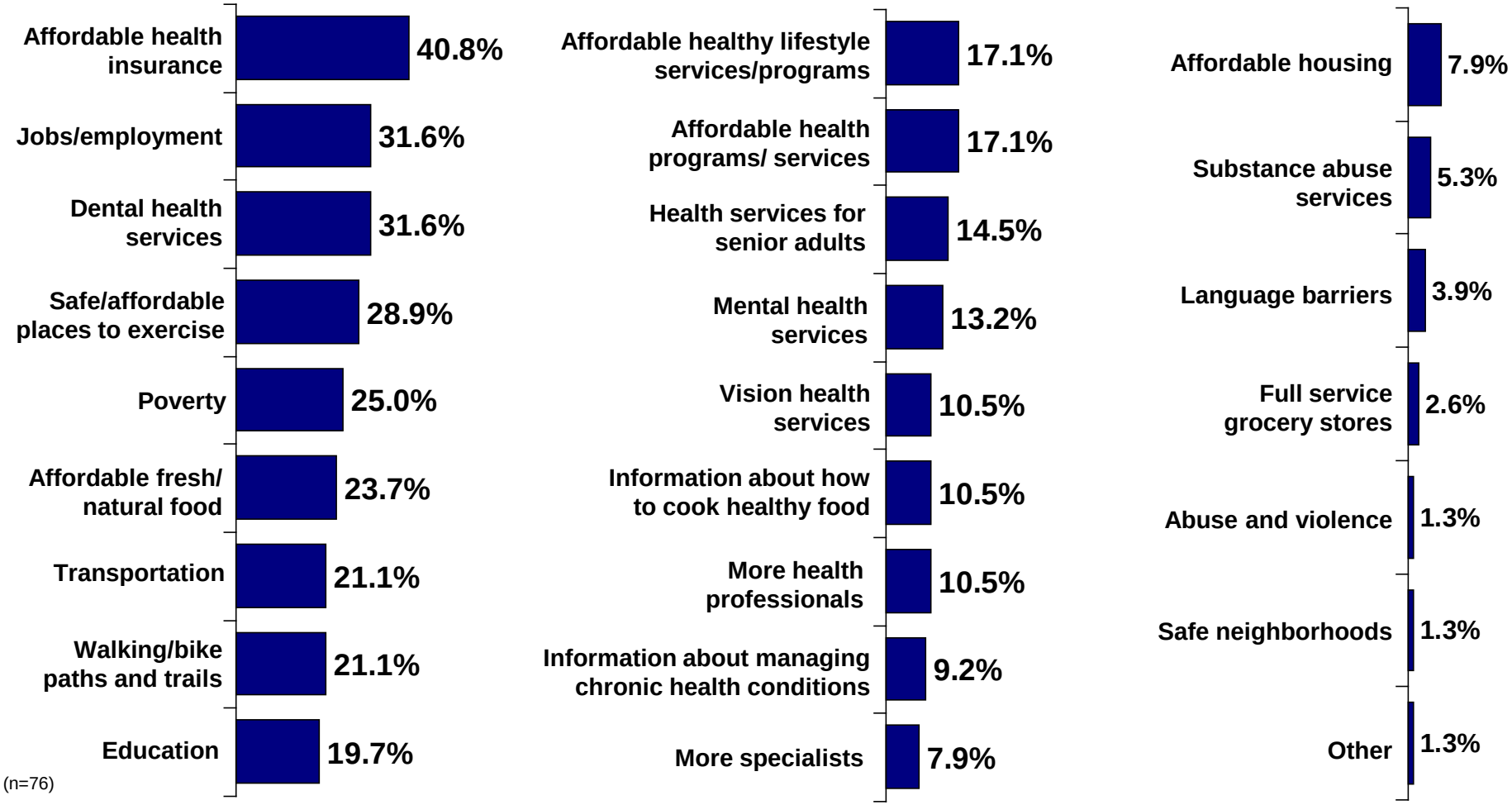
*"**Orthopedics**, **orthodontics**, **neurologist**."*

Q11: What health care related programs, services, or classes are lacking in your community? In other words, what programs, services, or classes do you want that are currently unavailable? Please be as detailed as possible.

# *Community Issues That Impact Health*

There are numerous issues that underserved residents believe impact health in their community. At the top is **affordable health insurance**, followed by **jobs/unemployment/the economy** and **dental services**. Other impactful issues include **safe/affordable places to exercise**, **poverty**, **affordable fresh/natural food**, **transportation**, **walking/bike paths and trails**, and **education**. Abuse and violence and safe neighborhoods are nonissues.

## Community Issues That Impact Health




Q12: What are the top five issues in your community that impact health?

Residents point to numerous community characteristics that make it easy for people to be healthy, such as **safe neighborhoods** that are walkable and **plenty of paths and trails** conducive to **walking**, **hiking**, **running**, and **biking**. The area is also **recreational**, there is access to **swimming** and **boating**. There is also an **abundance of clean air and water** and a **strong sense of community** because the small size/rural aspect. The rural nature of the area **allows people to garden and grow their own food** and provides **access to wonderful Farmer's Markets**. **Health care is accessible** via the local hospital and Tamarac Center for Health and Wellness and there are **gyms and health clubs available** as well.

## Community Characteristics That Make it *Easy* to be Healthy

*"**Walking paths**, **fresh air**, family."*

*"**Trails**, **walking paths**."*

*"Lots of **trails**."*

*"A resort area; **boating**, **swimming**, **biking**."*

*"**Small**, **rural**, **grown your own food**."*

*"**Walking/bike paths**, **trails**, enjoy **outdoor activities year around**."*

*"**Walking trails** and more being developed."*

*"We **can have garden**, raise own meat."*

*"**Bike trails**."*

*"**Walking/bike trails** and **community walks/runs for a fun** time."*

*"Plenty of **fresh air** and a **market for fresh foods** in season."*

*"**Rural**, lots of **places to be active**, **farms** with **fresh produce**."*

*"**Sidewalks for walking outdoors** in the summer."*

*"**Walking/bike paths/trails**."*

*"**Great exercise opportunities**, **Tamarac** [Center for Health and Wellness], **Senior Center**, **bike trails**, etc."*

*"**Outdoor recreation opportunities**."*

*"**Safe**, can **walk, run, bike, outdoors** and be generally safe, **Tamarac**, **Fremont rec center**."*

*"**Programs offered by local partners**."*

*"**Farmer's Market** in the summer, **walking paths**."*

*"We, and many others, **raise gardens** and it is a **farm community**."*

*"**Health care** is available."*

*"**Farmer's Market** for fresh foods, **walking/bike path**."*

*"**Gym** in town."*

*"We have a **food market**."*

*"**Good health services**."*

*"**Parks**."*

*"**Tamarac**."*

*"Having **Tamarac** available."*

*"Layers of science based messages through WIC and food pantries."*

*"Good, **clean air**."*

*"**Fresh water**, **air**, **healthcare is not far unless you have no vehicle**."*

*"**Local physicians**, **local hospital**, **Tamarac**, **Farmer's Market**, **CPR classes**, **dentists**, **pharmacies**."*

*"**Seasonal farm markets**, **work-out facilities**."*

Q13: What are the primary characteristics of your community that make it easy to be healthy? Please be as detailed as possible.

Conversely, community characteristics that some people think are great also make it hard for residents to lead healthy lifestyles. For example, the r**ural nature of the county is a barrier** to having an effective and efficient public transportation system, and **transportation is a major issue**. There are also an **abundance of fast food restaurants** or **stores that sell plenty of cheap, unhealthy food**. Other barriers to living healthy lives include: **lack of affordable and healthy food**, **cost of gym memberships**, and **inclement weather** (e.g., the entire winter season) preventing people from going outside to be active**.** The **local economy (lack of jobs)** exacerbates the problem of unaffordable services and an inability to make lifestyle changes such as eating healthier food. It also contributes to many residents being poor and impoverished.

## Community Characteristics That Make it *Hard* to be Healthy

*"**City water issues**, **fast food**."*

*"All **gyms are expensive** or **too far away**, **fruits and veggies are expensive**, **too expensive to get to a gym in our area**."*

*"**Bars**, **no Farmer's Market**."*

*"**Distance to travel** in order to exercise."*

*"**Access to healthy**, **fresh**, organic, non-GMO **foods** that are **affordable**."*

*"**Lack of good paying jobs**."*

*"**Lack of public transportation** and **cost of health facilities** (Tamarac)."*

*"**Expense** of the wellness center."*

*"**Too long to get an appointment** to see a doctor or a dentist."*

*"**Affordability**, and **jobs** that pay decent wages with **affordable health care coverage** for individuals and family."*

*"**Snow-covered roads in the winter** make it hard to walk."*

*"**No rural health or gyms**."*

*"Would be nice to have **indoor walking track in winter**."*

*"**Affordable places to exercise**."*

*"**Too many fast food places** to tempt me."*

*"**Food that is good for you is expensive**."*

*"**Transportation**, the **high prices for Tamarac**."*

*"**Farmers spraying fruit trees and crop fields**."*

*"People **may not have the money to pay for health care**."*

*"**Transportation**."*

*"**Affordable exercise places**."*

*"**Education**. People are not aware of their conditions, so therefore, do nothing to change to be healthier."*

*"**Fast food**."*

*"**Affordable health care**."*

*"**Poverty level**, **lack of education**."*

*"**Affordable**, **healthy food**, **affordable services/programs**."*

*"**Transportation**."*

*"**Fast food restaurants**, **price of gyms**, **slippery sidewalks**."*

*"**Lack of access to affordable fresh natural foods**."*

*"**Availability of affordable fresh**, **healthy foods** year round, **limited bike trails**, bicycle friendly employers."*

*"**Traveling distance** to any health programs."*

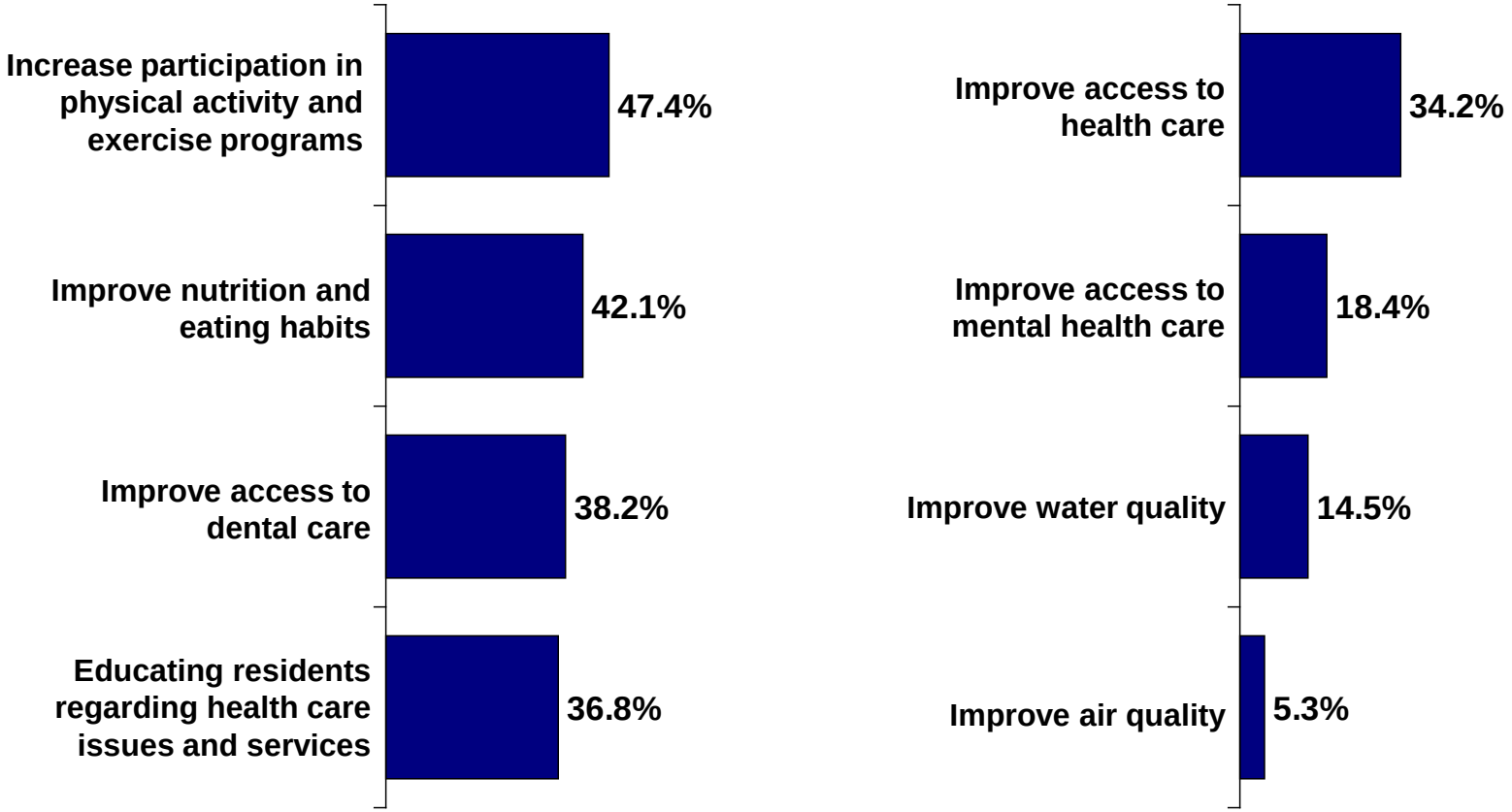
*"If you are not known to community, it's hard to get information."*

*"**Transportation** for people who do not have available transportation."*

Q14: On the other hand, what are the primary characteristics of your community that make it hard to be healthy? Please be as detailed as possible.

More than four in ten of the underserved think the most important changes that could make the local community healthier are to **increase participation in physical activity and exercise programs**, and **improve nutrition and eating habits.** Additionally, almost four in ten see a need for **improving access to dental care** and more than one-third would like to see **more education for residents in health care issues and services** and **improved access to health care**. Improving air quality is not considered necessary.

## Most Important Actions for Making Community Residents Healthier




(n=76)

Q15: From the following list, please rank the top three areas that are most important to making the people in your community healthier, For example, 1 would be your most important, 2 would be your second most important, and 3 would be your third most important.

Underserved residents offer suggestions for making the community healthier that focus on **education and teaching** residents about **healthy lifestyle choices**, **diet and nutrition** (e.g., proper portion size), **exercise**, and the **importance of health care**. There is also a need for better access to avenues of exercise such as gyms and biking/hiking trails. Others mention a need for better access to services for substance abuse/addiction.

## Suggestions for Making Community Residents Healthier

*"**Kids programs in school**."*

*"**Teach healthy living**, provide **resources for drug addiction**."*

*"**Teach proper portion size**."*

*"Have **accessible classes on healthier eating and exercise**."*

*"**Less stress**, flyers sent to homes on **community events** that are healthy."*

*"**More bike trails**, **hiking** and **public gyms**."*

*"**Difficult to convince other people**, they have to be motivated."*

*"**Better local gym**."*

*"**Educate people** regarding the **importance of health care**."*

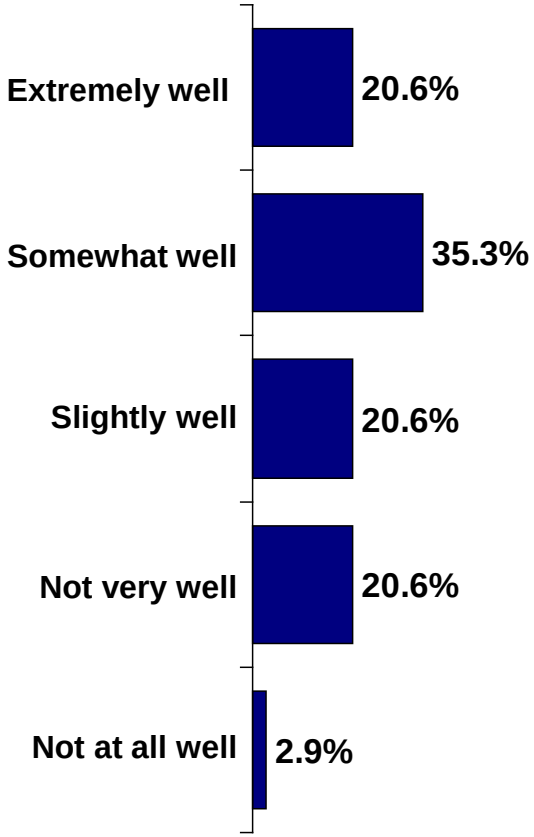
*"**Teach them**. Take classes, become certified, and teach."*

*"Somehow **provide transportation**."*

Q16: What other ideas do you have to make the people in your community healthier? Please be as detailed as possible.

When asked how well prepared they think local health professionals are when dealing with communicable or infectious disease outbreaks, many underserved residents are unable to answer. Of those who have an opinion, more than half (55.9%) think they are somewhat or very well prepared. Almost one-fourth (23.5%) feel they are not very or not at all well prepared.

## Preparedness for a Communicable or Infectious Disease Outbreak




(n=34)

Q20: How well prepared are local health care professionals to deal with a communicable or infectious disease outbreak, such as Ebola?

Underserved residents had a chance to provide concluding comments and those who took the opportunity to reiterate issues they have with **access to care** and **affordable care**. Residents also reiterated **transportation** issues as barriers to services and the need for more timely service.

## Concluding Verbatim Comments

*"Need **more affordable support groups for weight loss** for both children and adults."*

*"**Lack of safe walking areas**. Negative people. **Lack of closer gym** to exercise."*

*"Doctor's **office staff needs more education on how to provide safe care** and **follow safety guidelines**, like the hospital does."*

*"**Accessible and affordable** at the same time, that's what we need."*

*"Need **closer access to mental health**, especially when you are **without transportation**. White Cloud is 15 miles away from Fremont."*

*"Just **help for homeless** people getting health care coverage."*

*"I'm happy to **live in Fremont and have many opportunities**."*

*"It's nice to have the walking paths but we **need more park benches for people to rest** or take a break especially by Gerber plant on the right hand side of the street."*

*"**Time to exercise**. **I don't discipline myself to make time**. **The food I love to eat may not be the healthy choice**."*

*"People are afraid to go to the doctor because they fear there is nothing really wrong with them. **Need second opinions**."*

*"**Lack of transportation in outlying areas**. **Lack of money for co-pays**. Lack of doctors; **can't get an appointment quick enough** for the problem at hand. **Inconvenient office hours** for people that work. **No local radiation therapy**."*

*"Options. Availability. Local. Money. Friendly service."*

*"**Need to speed up ER**."*

*"**Need transportation**."*

*"I joined a group called **FA (Food Addiction)**. I have lost 81 1/2 pounds this year. The program works!!"*

Q21: In concluding, do you have anything else you would like to add about health or health care issues? Please be as detailed as possible.

# *APPENDIX*

# *Methodology*

# Methodology

- This research involved the collection of primary and secondary data. The table below shows the breakdown of primary data collected with the target audience, method of data collection, and number of completes:

| | Data Collection Methodology | Target Audience | Number Completed |
|---|---|---|---|
| Key Stakeholders | In-Depth Telephone Interviews | Hospital Directors, Clinic Executive Directors | 5 |
| Key Informants | Online Survey | Physicians, Nurses, Dentists, Pharmacists, Social Workers | 90 |
| Community Residents (Underserved) | Self-Administered (Paper) Survey | Vulnerable and underserved sub-populations | 77 |
| Community Residents | Telephone Survey (BRFS) | SHGMH Area Adults (18+) | 980 |

- Secondary data was derived from various government and health sources such as the U.S. Census, Michigan Department of Community Health, County Health Rankings, Youth Risk Behavior Survey, Youth Assessment Survey, Kids Count Data, and Bureau of Labor Statistics.

# Methodology (Cont'd.)

- A total of 5 *Key Stakeholders* completed an in-depth interview. *Key Stakeholders* were defined as executive-level community leaders who:
  - Have extensive knowledge and expertise on public health issues
  - Can provide a "50,000 foot perspective"
  - Are often involved in policy decision making
  - Examples include hospital administrators and clinic executive directors

- A total of 90 *Key Informants* completed an online survey. *Key Informants* are also community leaders who:
  - Have extensive knowledge and expertise on public health issues, or
  - Have experience with subpopulations impacted most by issues in health/health care
  - Examples include health care professionals or directors of non-profit organizations

- There were 77 self-administered surveys completed by *targeted sub-populations* of vulnerable or underserved residents, such as single mothers with children, senior adults, those who are uninsured/underinsured/have Medicaid, and minority populations, if any.

# Methodology (Cont'd.)

- A *Behavioral Risk Factor Survey* was conducted in the SHGMH catchment area via telephone with 980 adult (18+) residents. The response rate was 36%.

- Disproportionate stratified random sampling (DSS) was used to ensure results could be generalized to the population of each county from which the respondent resided. Characteristics of DSS are:
  - Landline telephone numbers are drawn from two strata (lists) that are based on the presumed density of known telephone household numbers
  - Numbers are classified into strata that are either high density (listed) or medium density (unlisted)
  - Telephone numbers in the high density strata are sampled at the highest rate, in this case the ratio was 1.5:1.0

- In addition to landline telephone numbers, the design also targeted cell phone users. Of the 980 completed surveys:
  - 303 are cell phone completes (30.9%), and 677 are landline phone completes (69.1%)
  - 178 are cell-phone-only households (18.2%)
  - 191 are landline phone-only completes (19.5%), and
  - 611 have both cell and landline numbers (62.3%)

# Methodology (Cont'd.)

- For landline numbers, households were selected to participate subsequent to determining that the number was that of an SHGMH area residence. Vacation homes, group homes, institutions, and businesses were excluded.

- Respondents were screened to ensure they were at least 18 years of age and resided in the SHGMH catchment area (determined by zip code). In households with more than one adult, interviewers randomly selected one adult to participate based on which adult had the nearest birthday. In these cases, every attempt was made to speak with the randomly chosen adult; interviewers were instructed to not simply interview the person who answered the phone or wanted to complete the interview.

- Spanish-speaking interviewers were used where Spanish translation/ interpretation was needed.

- Unless noted, as in the Michigan BRFS, respondents who refused to answer a question or did not know the answer to a specific question were normally excluded from analysis. Thus, the base sizes vary throughout the section regarding the BRFS.

# Methodology (Cont'd.)

- Data weighting is an important statistical process that was used to remove bias from the BRFS sample. The formula consists of both design and iterative proportional fitting. The purpose of weighting the data is to:
  - Correct for differences in the probability of selection due to non-response and non-coverage errors
  - Adjust variables of age, gender, race/ethnicity, marital status, education, and section to ensure the proportions in the sample match the proportions in the population of adults from Lake, Mecosta, Montcalm, Newaygo, or Oceana counties
  - Allow the generalization of findings to the adult population of the SHGMH catchment area

- The components of the design weighting formula are as follows:
  - STRWT – accounts for differences in the basic probability of selection among strata (subsets of area code/prefix combinations). STRWT = number of available phone numbers/number of phone numbers selected
  - IMPNPH – the number of residential telephone numbers in the respondent's house
  - NUMADULT – number of adults in the respondent's household

- The formula used for design weighting the BRFS data is:

**Design Weight = STRWT * 1/IMPNPH * NUMADULT**

# Methodology (Cont'd.)

- Raking weighting ensures the data are representative of the population of adults in Lake, Mecosta, Montcalm, Newaygo, and Oceana counties on a number of demographic characteristics, such as age, gender, race/ethnicity, marital status, and education. Raking weighting incorporates the known characteristics of the population into the sample. For example, if the sample is disproportionately female, raking will adjust the responses of females in the sample to accurately represent the proportion of females in the population. This is done in an iterative process, with each demographic characteristic introduced into the sequence. This process may require multiple iterations before the sample is found to accurately represent the population on all of the characteristics named above.

- The formula used for the final weight is: **Design Weight * Raking Adjustment**

# *Definitions of Commonly Used Terms*

# Definitions of Commonly Used Words/Acronyms

- ESL – means “English as a second language.” For this population/group, English is not their primary language. For purposes of this report, it most often refers to the Hispanic population that has Spanish as their primary language.

- PCP – refers to “primary care provider” or “primary care physician,” but the key terms are “primary care.” Examples of this are family physicians, internists, and pediatricians.

- Binge drinkers – those who consume five or more drinks per occasion (for men) or four or more drinks per occasion (for women) at least once in the previous month.

- Heavy drinkers – those who consume an average of more than fourteen alcoholic drinks per week for men and more than seven per week for women in the previous month.

# *Respondent Profiles*

# Behavioral Risk Factor Survey

| Gender | (n=980) |
|---|---|
| Male | 49.9% |
| Female | 50.1% |
| **Age** | **(n=980)** |
| 18 to 24 | 13.7% |
| 25 to 34 | 15.6% |
| 35 to 44 | 15.4% |
| 45 to 54 | 19.5% |
| 55 to 64 | 18.9% |
| 65 to 74 | 9.1% |
| 75 or Older | 7.8% |
| **Race/Ethnicity** | **(n=976)** |
| White, non-Hispanic | 88.6% |
| Non-White | 11.4% |
| **Marital Status** | **(n=979)** |
| Married | 57.6% |
| Divorced | 10.3% |
| Separated | 1.2% |
| Widowed | 5.0% |
| Never married | 24.9% |
| Member of an unmarried couple | 1.0% |

| Number of Children Less Than Age 18 At Home | (n=979) |
|---|---|
| None | 62.6% |
| One | 13.4% |
| Two | 11.2% |
| Three or more | 12.8% |
| **Number of Adults and Children in Household** | **(n=979)** |
| One | 13.7% |
| Two | 32.3% |
| Three | 19.4% |
| Four | 15.6% |
| Five | 7.8% |
| More than five | 11.2% |
| **Education** | **(n=977)** |
| Never attended school, or only Kindergarten | 0.0% |
| Grades 1-8 (Elementary) | 6.4% |
| Grades 9-11 (Some high school) | 9.3% |
| Grade 12 or GED (High school graduate) | 37.9% |
| College 1 year to 3 years (Some college) | 34.6% |
| College 4 years or more (College graduate) | 11.8% |

# Behavioral Risk Factor Survey (Cont'd.)

| Employment Status | (n=977) |
|---|---|
| Employed for wages | 43.0% |
| Self-employed | 5.5% |
| Out of work for more than a year | 2.8% |
| Out of work for less than a year | 2.1% |
| A homemaker | 6.7% |
| A student | 5.4% |
| Retired | 23.0% |
| Unable to work | 11.5% |
| **Household Income** | **(n=699)** |
| Less than $10,0000 | 6.0% |
| $10,000 to less than $15,000 | 7.1% |
| $15,000 to less than $20,000 | 8.8% |
| $20,000 to less than $25,000 | 12.9% |
| $25,000 to less than $35,000 | 15.7% |
| $35,000 to less than $50,000 | 19.8% |
| $50,000 to less than $75,000 | 14.5% |
| $75,000 or more | 15.0% |
| **Poverty Status** | **(n=699)** |
| Income under poverty line | 22.0% |
| Income over poverty line | 78.0% |

| Military Service | (n=980) |
|---|---|
| Served | 10.3% |
| Did not serve | 89.7% |
| **County** | **(n=980)** |
| Lake | 7.1% |
| Mecosta | 0.4% |
| Montcalm | 1.1% |
| Newaygo | 62.8% |
| Oceana | 28.7% |
| **Zip Code** | **(n=970)** |
| 49412 | 19.4% |
| 49337 | 15.4% |
| 49349 | 12.8% |
| 49455 | 12.4% |
| 49421 | 11.9% |
| 49327 | 9.5% |
| 49644 | 5.3% |
| 49446 | 3.4% |
| 49452 | 2.4% |
| 49656 | 1.6% |
| 49309 | 1.5% |
| 49329 | 1.1% |
| Other (49307, 49425, 49346, 49338, 49459, 49303, 49336, 49341, 49343) | 3.2% |

# Key Stakeholder Interviews

**Administrator, Baldwin Family Health Clinic**

**CEO, Fremont Community Foundation**

**Health Officer, District Health Department #10**

**President, Spectrum Health Gerber Memorial Hospital**

**Senior Project Development Lead, Baldwin Family Health Clinic**

# Key Informant Surveys

| | | |
|---|---|---|
| Nurse (RN, BSN, FNP) (18) | Executive Director (3) | Nurse Midwife |
| Administrator/CEO/VP/President (6) | Health Educator (3) | Orthopedic Surgeon |
| Clinical Supervisor/Nurse Manager/Supervisor/Director (6) | Director (2) | Patient Rights Advocate/Patient Relations |
| Hospital Program Director (6) | Educator (2) | PFAC Member |
| Physician/MD/Family Physician (5) | Community Leader | Practice Manager |
| Manager (4) | Coordinator of Health & Prevention Services | Retiree |
| RN Care Manager (4) | Human Resources | Social Worker |
| School Superintendent/Administrator (4) | Mayor | Women's Health Services Coordinator |
| Board Member (3) | Medical Social Worker | |

# Resident (Underserved) Survey

| | TOTAL |
|---|---|
| Gender | (n=74) |
| Male | 16.2% |
| Female | 83.8% |
| Age | (n=76) |
| 18 to 24 | 3.9% |
| 25 to 34 | 11.8% |
| 35 to 44 | 11.8% |
| 45 to 54 | 13.2% |
| 55 to 64 | 19.7% |
| 65 to 74 | 28.9% |
| 75 or Older | 10.5% |
| Race/Ethnicity | (n=75) |
| White/Caucasian | 94.7% |
| Black/African American | 1.3% |
| Hispanic/Latino | 1.3% |
| Other | 2.7% |
| Other | 2.7% |
| Adults in Household | (n=71) |
| 1 | 28.2% |
| 2 | 54.9% |
| 3 | 8.5% |
| 4 or More | 8.4% |

| | TOTAL |
|---|---|
| Marital Status | (n=76) |
| Married | 59.2% |
| Divorced | 11.8% |
| Widowed | 10.5% |
| Separated | 1.3% |
| Never married | 15.8% |
| Member of an unmarried couple | 1.3% |
| Children in Household < 18 | (n=72) |
| None | 70.8% |
| 1 | 11.1% |
| 2 | 9.7% |
| 3 or More | 8.4% |
| Education | (n=76) |
| Less than High School | 3.9% |
| Grades 12 or GED | 35.5% |
| College 1 to 3 Years | 34.2% |
| College Graduate | 26.3% |
| County | (n=68) |
| Newaygo | 95.6% |
| Oceana | 1.5% |
| Muskegon | 2.9% |

| | TOTAL |
|---|---|
| Children in Household <5 | (n=70) |
| None | 85.7% |
| 1 | 8.6% |
| 2 | 4.3% |
| 3 or more | 1.4% |
| Employment Status | (n=75) |
| Employed for wages | 40.0% |
| Self-employed | 4.0% |
| Out of work less than 1 year | 0.0% |
| Out of work 1 year or more | 0.0% |
| Homemaker | 8.0% |
| Student | 5.3% |
| Retired | 40.0% |
| Unable to work/disabled | 2.7% |
| Household Income | (n=69) |
| Less than $10K | 10.1% |
| $10K to less than $15K | 5.8% |
| $15K to less than $20K | 8.7% |
| $20K to less than $25K | 8.7% |
| $25K to less than $35K | 15.9% |
| $35K to less than $50K | 15.9% |
| $50K or more | 34.8% |

# Previous Implementation Plan Impact- Exhibit B

## Spectrum Health Gerber Memorial Hospital

This document serves as the tool to identify the impact of actions taken to address the significant health needs in the Implementation Plans created as a result from the previous 2011 CHNA.

| Specific Health Need Goal | Metric | Impact of Implementation Plan |
|---|---|---|
| **Access** | | |
| Develop and implement a staffing and recruitment plan for the primary care offices which takes into consideration the evolving needs and demographics of the community, the medical group and the hospital's strategic growth and market share plans. | Increase the number of new primary care providers | • Spectrum Health integrated the Pine Medical Group with 22 physicians including primary and specialty care. This creates improved communication and care coordination as these providers are now on the same electronic medical record with Gerber hospital and other Newaygo County providers.<br>• Gerber recruited 11 new providers to Newaygo County in 2011-2012.<br>• Medical home certification means that the practice is patient centered and has 30% of their schedule open for same day appointments that improves access. Four practices became medical home certified: Main St, Grant, Hesperia and Fremont (Pine Medical).<br>• To help patients with complex medical conditions, nurse care managers are being hired at all Newaygo County Spectrum Health provider offices. These nurses will help patients with complex needs improve their health outcomes.<br>• With provider's leaving the area, this goal remains partially met. Spectrum Health Gerber Memorial remains committed to continuing the recruitment process for additional primary care providers. |
| Collaborate with all primary care providers in Newaygo County to address improving access to behavioral and mental health | Increase the number of new access points or sites and create an integrated behavioral health/primary care model | • As of October 1, 2014, a fully integrated primary care/behavior health model was implemented at the Main St location. This model has a full time master's level social worker imbedded into the primary care |

## Previous Implementation Plan Impact- Exhibit B

## Spectrum Health Gerber Memorial Hospital

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| services through integration with primary care. | | practice at 3 levels: acute, urgent needs during primary care visit, problem focused follow up counseling appointments and improved real time communication between disciplines.<br>• In addition to general needs, focus was on 2 distinct groups to measure outcomes: patients with depression and new mothers with a history of trauma. The improvement and effectiveness of treatment in depression and health outcomes will be measured; a joint pilot with U of M for new moms focuses on mothers with a history of trauma and the development of their babies. Based on provider and patient feedback, the initial trial is a success, with the services expanding to the Obstetrics and Gynecology practice.<br>• The social worker has touched the lives of almost 300 patients between Oct 1, 2014 and Jan 31, 2015.<br>• To continue to expand local access to behavioral health services, Gerber donated an older school administration building next to the hospital to Newaygo County Mental Health. Newaygo County Mental Health (CMH) currently lacks a location in Fremont; this increases access for those with transportation issues and creates proximity for emergency management for CMH clientele. The building is currently being renovated by CMH. |
| Increase public and consumer awareness of primary care services through a marketing and communications plan which | Creation of new community wellness guide to highlight health and prevention. Effectiveness of the publication is measured through | • Awareness of our services was increased through the Community Wellness Guide, which was revamped and revised to a health promotion/primary care service focus. The publication's articles are written at a newspaper |

## Previous Implementation Plan Impact- Exhibit B

## Spectrum Health Gerber Memorial Hospital

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| includes maximizing current community based resources. | program/event attendance, return of call to action cards and program evaluation feedback. | reading level and focus on areas of preventative health including screenings, recipes, health tips, healthy community events and health information articles.<br>• Distribution of the Community Wellness Guide was changed from channel placement at various community sites to direct mail to homes; it is mailed to over 10,000 homes in Newaygo County every 3 months. Another 2,000 are sent to physician offices and other community partners.<br>• Community Education events showcasing physicians and services were completed both at Tamarac and in the community. These include Day of Dance, Women's Night Out, Turkey Trot Race, Run on the Edge, Safety Day, various Spirit of Women events, corporate lunch and learns, weight management classes and the Cancer Survivors lunch. Attendance is estimated at 2500-3000 people each year for all events combined. A listing of events and attendance can be found in the Community Benefit Event Summary from 2012, 2013 and 2014.<br>• Spirit of Women's events which highlight women's yearly preventative services were promoted and attended by over 500 women each year. |
| Implement a process for assisting patients in identifying, selecting and then accessing primary care when they've entered the hospital system without a usual primary care provider. Special emphasis will be placed on case finding within the emergency | Clearly identified pathways | • As we have chosen to focus on higher priority goals which will have greater impact on our community. |

## Previous Implementation Plan Impact- Exhibit B

## Spectrum Health Gerber Memorial Hospital

This document serves as the tool to identify the impact of actions taken to address the significant health needs in the Implementation Plans created as a result from the previous 2011 CHNA.

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| department, medical offices and at sponsored community events. | | |
| **Specific Health Need Goal** | **Metric** | **Impact of Implementation Plan** |
| **Health Literacy** | | |
| Increase the number of individuals receiving health information on lifestyle choices for the prevention or management of chronic disease by maximizing the SHGM health education platform and integrating throughout the community, within the medical offices and across community agencies. | 1. Create structure for future growth and add at least one new screening clinic<br><br>2. Train at least 2 staff members in well/health coaching<br><br>3. Improve access to Tamarac through scholarship programs | 1. A position of Director of Community Health was created to make sure our community health activities result in outcomes, to develop analytics, and expand public health and/or wellness activities further into the community including schools, churches, and workplaces; and to affect policy change.<br><br>2. Gerber Memorial supported and sent a member of the Michigan Health Department District #10 and a member of the Newaygo County Healthcare Improvement Council to the Community for Disease Control Worksite Wellness training in Chicago. This caused an increase in participating worksites to 12 in Newaygo County.<br><br>3. Changes were made at Tamarac to increase the participation in fitness to all irrespective of income levels: class passes were developed for non-members to take individual classes; low cost memberships are available with 363 members signed up to date.<br>• New Silver and Fit program was launched in August 2014 for seniors with Priority Health Medicare Advantage plans; this allows plan members a free membership. 412 members as of April 2015.<br>• Created new free blood pressure screening clinics |

## Previous Implementation Plan Impact- Exhibit B

## Spectrum Health Gerber Memorial Hospital

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| | | starting in October at SH Gerber Hospital. Over 50 people have been seen in the first 4 months with 9 cases of hypertension referred to primary care.<br>• One health coach and one social worker completed the gold standard Well Coaches training. This allows for one on one health coaching complementing Tamarac members, those in weight management, Diabetes Education and/or other health promotion programs. They are currently completing their post-training certification testing.<br>• Implemented the STAR program, designed to improve the quality of life and assist with side effects from various cancer treatments. Referrals have been lower than expected, with approximately 10 patients being seen. |
| Facilitate the Newaygo County Health Care Improvement Council (NCHIC) toward a strategy which aligns more community agencies with a common health promotion platform and plan. | • Determine best structure model and membership | • Newaygo County Health Care Improvement Council (NCHCIC) moved from a collaborative approach to a collective impact model. The NCHIC group created a structured approach for the future: operating guidelines were established and the name changed to LiveWell Newaygo County.<br>• Newaygo County Health Care Improvement Council is participating in the Institute for Healthcare Improvement's 12 month collaborative focused meeting the Triple Aim for patients with complex medical problems. The group includes Spectrum Health physicians, Gerber Memorial, Newaygo County Mental Health, Health District #10, Family Health Care, and the Newaygo County Community Collaborative. Partial |

## Previous Implementation Plan Impact- Exhibit B

## Spectrum Health Gerber Memorial Hospital

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| | | funding was obtained from the Fremont Foundation. The group has identified their governance structure, purpose statement, target population and metrics. Patient survey data is being compiled with a goal of creating a small pilot for 5 patients who fit the criteria guidelines. After the 5 initial patients, the care model will expand to 25, then 125, then to scale. |
| Develop and implement a hospital based health literacy strategy emphasizing discharge processes, medication reconciliation, teach back training and patient and family centered care as methodologies specifically targeted to increase health literacy for the intention of reduced avoidable readmissions. | • Develop and implement the health strategy | • Social worker completed education and certification in motivational interviewing and wellness coaching with the goal to increase effective communication with patients, improve motivation and compliance and move patients along the readiness to change continuum. An interdisciplinary group was formed to address care transitions from inpatient to primary care, readmissions, and the discharge process. Group members include administration, nursing, social work, discharge planning, and primary care.<br><br>A Value Stream Analysis (VSA) was completed with 18 months of Rapid Improvement Event's beginning March of 2013 to address processes and to create standard work. This includes improving our current medication reconciliation and patient education process. The VSA eliminated 4 steps in the process, created standard work around welcoming the patient and has helped to improve the likelihood to recommend score. |