THE SCHOOLCRAFT MEMORIAL HOSPITAL
PRIMARY SERVICE AREA

COMMUNITY HEALTH NEEDS ASSESSMENT REPORT
and
SCHOOLCRAFT HEALTH IMPROVEMENT IMPLEMENTATION STRATEGY
(Meeting Our Community's Priority Health Needs)

2013 - 2016

SCHOOLCRAFT MEMORIAL HOSPITAL'S
PRIMARY SERVICE AREA

Manistique	49854
Garden	49835
Gulliver	49840
Germfask	49836
Cooks	49817

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BACKGROUND

For many years, hospitals that provide a significant amount of free and low-cost benefits and services to their communities have not been required to pay Federal taxes. These hospitals must be not-for-profit, and must meet certain requirements set by the Internal Revenue Service. Schoolcraft Memorial has always been a non-profit organization, but in 2007 the hospital applied for and was granted a specific non-profit status as a charitable care organization under Section 501(c)(3) of the Internal Revenue Code (IRC).

On March 23, 2010, President Barack Obama signed into law the Patient Protection and Affordable Care Act (PPACA). One of its many requirements is that hospitals under IRC Section 501(r), in addition to the community benefits and services they have always provided, are now required to conduct a Community Health Needs Assessment (CHNA) once every three years. In completing the CHNA, the hospital must consult with persons who represent the community's interests, determine the priority health needs of the community, and develop an implementation strategy to meet those needs.

Schoolcraft Memorial took this responsibility very seriously. The hospital's coordinator for the first three years is Susan Phillips, a SMH social worker, and someone who has worked extensively in the community. Susan immediately partnered with Kerry Ott of the Sault Ste. Marie Tribe of Chippewa Indians. Kerry is the coordinator of the Strategic Alliance for Health, and has been instrumental in bringing grant funding into the community for health improvements, leading to successes such as the Farmers Market, Complete Streets, Safe Routes to School, and several school-based grants for improving the health of our schoolchildren.

Susan and Kerry began educating themselves about various methods for conducting a community health needs assessment and developed ideas for what they believed would work best for the SMH service area. Their first step was to send out letters of invitation to a number of people – community members and persons representing community organizations that are actively involved in health and human services for people of all age groups – in order to form an Assessment Advisory Committee. Please refer to **Appendix A** for a listing of the organizations and individual community members that were invited to be a part of the AAC and the titles of those who represented those organizations. **Appendix B** provides examples of the letters of invitation.

The first Assessment Advisory Committee meeting took place at the Comfort Inn in Manistique on April 11, 2012. There were 31 hospital and community representatives present. SMH had contracted with the Great Lakes Center for Youth Development to provide an outside facilitator for the meeting, as the GLCYD has a significant amount of experience in this area. At the first meeting, the purpose of the Community Health Needs Assessment was introduced. In addition, a community profile was presented. **Appendix C** provides a copy of the SMH Service Area Community Profile.

Following the first AAC meeting, there were four focus groups held. It was requested that some of the health and human service organizations that were a part of the AAC ask their clients to participate in the focus groups so that we could get as much representation as possible from the community's vulnerable populations. Attendance was very light at each focus group meeting, but we were able to get some very helpful comments that guided our decisions going forward. The four focus groups were held for the Cooks/Garden area at Big Bay de Noc School; in Manistique at the Manistique Senior Center; in Germfask at the Germfask Community Center; and at the Sault Tribe Community Center in Manistique. Each focus group was led by the GLCYD facilitator, who is from the Marquette area and unknown locally, so that people would feel comfortable in speaking freely about local health issues. There was no one from the hospital present, and there were no names recorded for the people who participated. To this day, we have no idea who made up the individual focus groups, or which person made any specific comment. We appreciate their honesty and their willingness to participate.

Following the four focus groups, the Assessment Advisory Committee met again on June 25, 2012. GLCYD had "aggregated" the comments; that is, all comments were grouped together to further protect the identity of the participants, and the facilitator presented some general themes for the AAC to consider. **Appendix D** provides a summary of the results of the focus groups. Taking into consideration the focus group findings, there was a great deal of discussion among the AAC members about what should be chosen as the priority health needs for the first three-year assessment period, from July 2013 – June 2016. The facilitator led the discussion and recorded ideas to assist the group in choosing the priorities. The priorities for the first three years can be found in **Appendix E**.

The next step was to form a workgroup of Assessment Advisory Committee members – a smaller group of people who were interested and willing to work out an implementation strategy to address the priority health needs chosen for the first three years. **Appendix F** is a listing of the members of the Schoolcraft Health Improvement Implementation Strategy workgroup.

The workgroup met several times and stayed busy in between meetings as well, brainstorming and sharing ideas about possible strategies that might help us make progress with the priority health needs. There have been many versions of the implementation strategy since the second AAC meeting at the end of June 2012 and our intent is to keep it very flexible. The goals will remain essentially the same throughout the 3-year period, but the action steps we take to meet the goals may change continually. If we find that something doesn't work, we will throw it out and try something else. We will not be able to be completely successful with all of the goals – our community has many serious health needs that are complicated by our other serious problems – poverty, unemployment, lack of health insurance, and living in an area that is so rural it is almost frontier. We hope to see improvement by the end of the three-year period, but we realize that many of the goals may carry over to the next three-year period, depending on the results of the next Community Health Needs Assessment in 2016. The most current version of the Schoolcraft Health Improvement Implementation Strategy is attached as **Appendix G.** The IRS requires that the Implementation Strategy include a listing of the health needs named by the community, and that it indicate for each health need whether it is addressed in the implementation strategy, whether it is being addressed by other community resources, or whether the need is not being met, and if it is not being met, why it is not being met.

The implementation strategy that has been developed to meet these first priority health needs must, under IRS regulations, be adopted by the hospital's governing body – the SMH Board of Trustees. The Board adopted the implementation strategy found in **Appendix G** on September 23, 2013. The Community Health Needs Assessment report (this document) is to be widely publicized – it will be available at the hospital's website at www.scmh.org, and there will be a printed copy available at the hospital. An individual copy of the complete CHNA report will be made for anyone upon request. Please contact Susan Phillips at 906.341.3238.

The implementation strategy will also be provided to the IRS in the annual report the hospital files – the Form 990 – which is required of all 501(c)(3) organizations. The section of the Form 990 that specifically addresses the CHNA is called "Schedule H". The IRS asks for detailed information about what was included in the CHNA and in doing so is providing a guideline for what they expect to see in the CHNA. On the following pages, we have highlighted (bold print) the information requested by the IRS and our answers to those questions as an additional way of providing this information to the community we serve.

From: IRS Form 990, Schedule H
Part V – Facility Information

Indicate What the Community Health Needs Assessment Describes

A. A definition of the community served by the hospital facility

Schoolcraft Memorial Hospital (SMH) is a 12-bed Critical Access Hospital located in Manistique, a small town of approximately 3,100 people in Michigan's Upper Peninsula. Manistique is situated on the southern border of Schoolcraft County, and at the northern tip of Lake Michigan. The hospital's service area covers all of Schoolcraft County, and parts of several additional counties because the distance between hospitals is so great. To the east, the service area extends into Mackinac County. Mackinac County is so broad that Mackinac Straits Hospital in St. Ignace is 65 miles from the western border of the county, but only 25 miles from SMH. To the west, the service area extends into Delta County, and in particular into Garden and Fairbanks Townships. The Village of Garden is 24 miles from Manistique, but 46 miles from OSF St. Francis Hospital in Escanaba.

Ninety-five percent of SMH's inpatient and outpatient discharges in 2012 came from five zip codes: Manistique (49854), Garden (49835), Gulliver (49840), Germfask (49836), and Cooks (49817). All of these communities are located within Schoolcraft County with the exception of Garden. In 2010, the population estimate for the Garden zip code (49835) was 740 (www.citydata.com/zips/49835.html).

During the initial CHNA Advisory Committee meeting, the following groups were named as being among the more vulnerable populations in the SMH service area. Unless otherwise indicated, please refer to **Appendix C**, the Schoolcraft Memorial Hospital Community Profile, for related data:
http://www.safe3c.com/Info_History.html
Uninsured persons
Persons in poverty
Minority groups (primarily American Indian)
Persons with chronic illnesses/diseases
Adults & children who are victims of abuse, neglect, sexual assault

> **Tri-County Safe Harbor, Inc., a shelter for persons who are experiencing domestic violence and/or sexual assault, and which serves Delta, Schoolcraft & Menominee Counties, provides annually over 2,600 bed nights, and serves over 500 families** (http://www.safe3c.com/Info_History.html)

Vulnerable elderly (frail, victims of abuse & neglect, chronic illness, undernourished, inadequate resources, inadequate health care)
Vulnerable youth and young children (victims of abuse & neglect, inadequate resources, inadequate health care)
Adults receiving inadequate health care (including dental, vision, pharmaceuticals, mental health)
Inadequate housing/homelessness/near-homelessness (facing eviction or utility shut-offs)
Inadequate nutrition
Substance abusers (street drugs, prescription drugs, alcohol)
Suicide & survivors of suicide
Veterans, especially returning military

B. Demographics of the community

Please refer to **Appendix C**, the Schoolcraft Memorial Hospital Community Profile for Schoolcraft County, Michigan QuickFacts.

C. Existing health care facilities & resources within the community that are available to respond to the health needs of the community

Please refer to **Appendix H** for a partial listing of existing health and human service resources available to the residents of Schoolcraft County. Many of these resources are available across county lines.

D. How data was obtained

A broad cross-section of health and human service professionals was called together as an Assessment Advisory Committee (**Appendix A**). At the first meeting, the purpose of the community health needs assessment was explained and there was a great deal of discussion about the health needs of the community. In the two months following this meeting, there were four focus groups held in four locations in the hospital's service area: Manistique, Cooks/Garden, Germfask, and the Sault Tribal Community Center. While we requested the Assessment Advisory Committee members to provide participants for the focus groups from the vulnerable populations they serve, we were not able to get a large number of participants. The hospital has no knowledge of who attended the focus groups; only that there were @ 16 participants total across the four sites. We had contracted with an outside organization, the Great Lakes Center for Youth Development from Marquette, Michigan because their staff is not known in our community and our community residents would not be known to them. We would therefore be able to ensure some level of anonymity/confidentiality in the hopes that people would feel more comfortable in speaking freely. Participants were assured by the outside facilitator that no individual's identity would be revealed to the hospital and that all comments would be grouped together so that no individual comment could be attributed to any particular person. We feel we succeeded very well in protecting the participants' confidentiality, because we received a good number of very frank and open comments. After a listing of the comments was completed by the GLCYD facilitator, they were summarized by the CHNA co-coordinator (**Appendix D**) and were presented at a second meeting of the Assessment Advisory Committee (see below).

E. The health needs of the community

Please refer to **Appendix D** for a summary of the focus group findings, and to **Appendix E** for a listing of the community health priorities chosen for the first three years by the Assessment Advisory Committee.

F. Primary & chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups

Please refer to **Appendix D** for a summary of the focus group findings. We specifically asked that participants in the focus groups not be community professionals, to further protect confidentiality, and we were specifically seeking representatives of vulnerable populations. Members of the Assessment Advisory Committee were asked not to participate.

Please refer to **Appendix E** for a listing of the community health priorities ultimately selected for the first three years by the Assessment Advisory Committee. The AAC was made up of health, human service, and community representatives of many of our underserved and most vulnerable populations.

G. The process for identifying & prioritizing community health needs and services to meet the community health needs

Following a great deal of discussion, brainstorming, and prioritizing, the Assessment Advisory Committee (**Appendix A**), at its second meeting, agreed upon the following list of community health needs to be addressed during the first three years:

1. Primary Prevention & Wellness
   Health care professionals, insurance companies, and the Federal and State governments are encouraging people to become more health conscious, and to become more personally responsible for maintaining

their own good health, partly in order to try and control the staggering costs of health care these days. We believe that primary prevention is very important; that is, living in a healthy manner and preventing chronic illness instead of seeking treatment only when a person is sick. The Sault Ste. Marie Tribe of Chippewa Indians received a Federal grant through the U.S. Centers for Disease Control (CDC) and formed the Strategic Alliance for Health (SAH) which places an emphasis on increasing physical activity and offering improved nutritional choices in the communities located in the seven counties of the Upper Peninsula that have a formal Sault Tribe presence. In Manistique, this has resulted in a first-time Farmers Market with fresh, locally grown produce available during the summer months. The Manistique SAH has a collaborative relationship with the City of Manistique in working to improve sidewalks and street crossings (Complete Streets), as well as increase the quality and number of walking and biking paths for people of all ages and abilities. The SAH also has a close relationship with Emerald Elementary School and St. Francis School. The Strategic Alliance for Health Community Coordinator is a member of both Coordinated School Health Teams and there has been a great deal of effort toward increasing physical activity opportunities for children, as well as teaching them about healthy nutritional choices. The hospital participates with the SAH's prevention and wellness efforts, and the SAH Community Coordinator is a member of the hospital's Wellness Committee. SMH Wellness Committee health professionals are frequently educating in the schools on health-related topics. There are several diabetic educators in the community, both at the hospital and at the Sault Tribe Health Clinic. These educators believe that teaching people self-responsibility, and to take personal control of their own health is very important. The Upper Peninsula Commission for Area Progress (UPCAP) strongly supports this view, and offers a course called "Personal Action Toward Health" (PATH), which teaches people to self-manage their chronic diseases.

Some of the focus group comments reflected an understanding of the need for people to take personal responsibility for their own health; others commented on the poor nutritional value of local institutional food (schools, senior center, hospital, medical care facility), the number of people who choose fast food restaurants, the lack of walking paths in some of the smaller communities outside Manistique, the level of obesity in this geographic area, the lack of activities that would provide exercise, the level of poverty which leads to poor nutrition, the poor nutritional habits being instilled in children by their parents, and people being just plain "lazy". It was considered a priority by the Assessment Advisory Committee to continue, and to expand, wellness and prevention programs, to educate community members on their availability, and to encourage increased community participation.

2. Communication & Education Through Community Collaboration

A number of focus group comments revealed that there are health-related services available in the community that people remain unaware of. Other comments reflected a lack of confidence in the local physicians, and/or the quality of care delivered at the hospital. There appears to be a belief among some community members that "bigger is better" – the medical care in a larger town or city has to be superior to what is available here. As with anything else, any perception of a negative experience spreads throughout the community like wildfire and positive experiences are often barely mentioned. Some community residents feel negatively toward us over services we are no longer able to offer, such as Obstetrics. In addition, there were some who expressed dissatisfaction with the Monday through Friday hours the local Tribal Health Center offers. There were comments about some non-hospital community services that have been discontinued. And, some people admitted that they are not at all familiar with the resources available here; there is a lack of information, and a belief that collaboration among groups would improve care.

Clearly we have a good deal of communicating, educating, and self-improvement to be accomplished. Despite the amount that we advertise, people are not getting the word about the services that we have available to them. There is a need to educate the community on the credentials of our physicians. They attended the same medical schools and received the same education as doctors in Marquette, in Green

Bay, or in Milwaukee. Most of our Family Practice physicians, who people refer to as "general practitioners", made a deliberate choice to become family practitioners, and are in fact Board Certified in the field of Family Medicine; that is, they have completed a 3-year residency program to become "specialists" in this field of practice. And, they are in Manistique because they choose to be here. They prefer rural areas in which to live and raise their children in a smog-free and relatively crime-free area. Any physician practicing in Michigan must have a Michigan license, which means passing the same exam as any other physician in any other area of Michigan. In order to maintain their licenses, they must obtain a certain number of continuing medical education credits per year, just as any other physician. In order to earn their CME credits, they attend the same medical conferences as physicians in Chicago, Los Angeles, or Boston.

There is a need to educate on the purpose of a Critical Access Hospital, which is not intended to be the same thing as a large regional specialty center such as Marquette General Hospital. It takes skill for a physician to recognize his or her limitations and to know when to refer a patient to a specialist. The key phrase is "critical access". Small rural hospitals are "critically" necessary for stabilizing people who have been injured or have had heart attacks or strokes. If it were not for the skill, knowledge, and experience of our SMH Emergency Room physicians, these gravely injured or critically ill people would never make it alive to Marquette General Hospital. It is the collaborative partnership between the hospital and our excellent City of Manistique Emergency Medical Services that save countless numbers of lives every year. There are many people who have received their care here for years and are very pleased with the quality of our service and the competence of our physicians. We receive very high marks on our satisfaction surveys through Arbor and Associates, an independent survey company. Many people have expressed pride and satisfaction with our new hospital facility.

We plan to do more to let people know of the services we offer in this community, whether through a website, newspaper advertising, the radio, or hard copy resource directories that will be distributed throughout the hospital's service area. We intend to teach people how to access 2-1-1, the "resource hotline" that is provided in the Upper Peninsula by UPCAP. The focus group comments revealed a need for such an educational and informational commitment because some of the services they would like to receive here we do, in fact, already offer! For some examples, please refer to **Appendix I.**

According to some of the comments made by focus group participants, the hospital and community <u>do</u> have strengths on which to build:

1. The Clinic and Veterans Outpatient Clinic give excellent care.
2. There is an eye surgeon who will come to Manistique.
3. The new orthopedic doctor is good.
4. There were two comments about the excellent diabetes education programs in Manistique.
5. There is a Tribal eye doctor and any veteran is now able to receive vision services at the Tribal Health Center.
6. We have telemedicine "and that's a good thing."
7. At least two participants recognize the importance of having a yearly physical, and a third gets checkups every three months.
8. Another participant believes in maintaining good dental care.
9. One participant commented that s/he has the desire to work toward good health.
10. Parents stated they must set good examples for their children, and that they want their children to get preventative care.
11. A participant commented that s/he believes our community does great things, if people would only take advantage of them.

3. Mental Health and the Treatment of Mental Illness

A number of focus group participants and a majority of Assessment Advisory Committee members believe there is a significant need for mental health services, particularly for persons with less than serious mental illness who can no longer receive ongoing services through the local behavioral health authority. The AAC chose mental health and treatment of mental illness as their third priority to address during this first three-year assessment period. The community has been very vocal with examples of vulnerable people falling through the cracks due to not meeting the criteria to receive ongoing services. Because of the economic depression, high rate of poverty, high rate of unemployment, and high number of uninsured in this area, most people cannot afford the cost of a private psychotherapist, and most do not have health insurance that will cover the cost. Few, if any, private therapists will accept Medicaid, and Medicare has a very low reimbursement rate that some psychotherapists consider "not worth it". It leaves the client with a high co-pay that s/he often cannot afford. Furthermore, the only practitioner in Schoolcraft County is 35 miles outside of Manistique and the next nearest are in Munising at 45 miles or in Escanaba at 55 miles distance.

The Schoolcraft Memorial Hospital Rural Health Clinic was able to help fill this gap to a certain extent, for a time. The RHC had leased space to a Psychiatric Nurse Practitioner with Blue Water Mental Health Services in Sault Ste. Marie. The nurse practitioner was able to work with patients on their psychiatric medications; however, she was not a psychotherapist, so did not have the credentials to provide talking therapy. She worked in collaboration with the RHC for 14 months, and then had to return to the Sault area due to a shortage of staff there. Despite our RHC Director's best efforts, she has not been able to make the arrangements necessary to bring the nurse practitioner back to this area because of continued budget cuts and staff shortages. At the time of the first Assessment Advisory Committee meeting, the audience was very pleased to hear that the Rural Health Clinic was working with the local Hiawatha Behavioral Health Authority to again staff a psychiatric nurse practitioner at the RHC to be able to assist less than seriously mentally ill people. As we were creating our implementation strategy, we added hiring a nurse practitioner for the RHC as one step toward our goal of bringing mental health services to the hospital's service area. Hiawatha Behavioral Health was in the process of hiring a psychiatric nurse practitioner and we believed we would be able to contract for her services to also serve some of our patient population. There was a problem with that, however. A "Rural Health Clinic" is a Federal designation, and is under Federal rules and regulations. The only mental health professionals a Rural Health Clinic is allowed to hire under Federal regulations are psychiatrists (physicians) or clinical psychologists. In order for the psychiatric nurse practitioner from HBHA to be able to work at the RHC, HBHA would have to lease space from the RHC and do its own billing for the services, as Blue Water had. With their own level of budget cuts, HBHA did not feel they were able to provide this service.

H. The process for consulting with persons representing the community's interests

The hospital's CHNA coordinator teamed with the community health educator of the Sault Tribe of Chippewa Indians. The co-coordinators met together numerous times and created a list of every health and human service organization in the community and region that would have an interest in the health of the local community. They additionally chose people active in the community who represented youth, the senior population, and young families with children. Please refer to **Appendix A** for the organizations and represented populations asked to be a part of the Community Health Needs Assessment process. Letters of invitation were sent out, and as we recognized other people who should be at the table, we sent emails or made phone calls to request their participation. **Appendix B** provides templates of the letters of invitation that were sent to community members and community and regional professional organizations.

I. Information gaps that limit the hospital facility's ability to assess the community's health needs

Our primary information gap was caused by a lack of participation in the focus groups. We must work to find ways to persuade people, particularly people representing vulnerable populations, to participate. This effort –

reaching the necessary people with our message(s) – has actually been made a part of the implementation strategy. In a rural area, other than community professionals who serve vulnerable populations, there are no specific community leaders representing these groups. People do not tend to organize around a cause. People who are concerned with basic survival – food, shelter, clothing – do NOT have community participation as a priority.

Indicate How the Hospital Facility is Making Its Community Health Needs Assessment Report Widely Available to the Public

A. At the hospital facility's website – (www.scmh.org)
B. Available upon request from the hospital facility (one copy per individual will be provided at no cost)
C. Other – Hard copy available at the Rural Health Clinic; copy provided to the public library; press release about the availability of the CHNA report with contact information; links from other community organization websites to the SMH website.

How the Hospital Facility Plans to Address the Needs Identified In Its Most Recently Conducted Community Health Needs Assessment

A. Adopting (approving) an implementation strategy to address the health needs of the community **(Appendix G)**
B. Working to complete the implementation strategy
C. Participation in the development of a community-wide community benefit plan (The hospital's implementation strategy IS a community-wide community benefit plan, in addition to other community benefits provided by the hospital. The implementation strategy was created in collaboration with community partners.)
D. Participating in working on the community-wide community benefit plan
E. Including a community benefit section in the hospital's operational plan
F. Adoption of a budget for provision of services that address the needs identified in the Community Health Needs Assessment: The hospital is able to contribute limited funds toward the activities of the implementation strategy.
G. Prioritizing the health needs in the community
H. Prioritizing the services that the hospital facility will undertake to meet the health needs in its community
I. Other – As above in (C), the hospital intends to collaborate closely with other community stakeholders in carrying through on the implementation strategy, which was created by these same community partners.

Needs the Hospital Facility Has Not Addressed and the Reasons Why It Has Not Addressed Such Needs

Please refer to the table at the end of **Appendix G (Implementation Strategy)** for a listing of the health needs named by the community focus groups. Per IRS regulations, we have indicated for each health need whether it is addressed in the implementation strategy, whether it is being addressed by other community resources, or whether the need is not being met, and if it is not being met, why it is not being met.

Schoolcraft Memorial Hospital is a 12-bed Critical Access Hospital in an area so rural that by population density, it is close to the designation of "frontier". The number of uninsured, the number living in poverty, and the number of unemployed persons overwhelms the local resources. The hospital provides a great deal of service to the community; one example has been the donation of up to $70,000 per year in primary care, labs, and radiology to the low-income uninsured clients of the Medical Care Access Coalition. The MCAC donation is completely separate from the hospital's Community Cares (charity care) program which in 2012 provided $446,205 in free care. In addition, the hospital in 2012 wrote off $960,449 in uncollectible debt.

The hospital could not afford to cover the costs of meeting all of the health care needs named by the focus group participants. Some of these problems will take many decades to even notice an effect; some will never be resolved. The hospital, in collaboration with other health and human service professionals in the community, can and will work toward putting programs into place that will address as many of these needs as possible. Over time, we will strive to make measurable improvements in the lives of our community members. We will be committed to the CHNA process and subsequent implementation strategies for many years to come. The implementation strategy that is included as **Appendix G** is merely our first three-year effort – a place to start. We believe it is very important to start with education about wellness and prevention, and teach people what they can do to help themselves by maintaining good health habits and preventing the start of chronic diseases. We can help those who already have chronic disease to improve their health habits and to take responsibility for managing their conditions. No single entity can successfully address the many health needs in this community. By working together, however, with our patients and community members as partners, we can make a significant difference.

APPENDICES

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APPENDIX A

PEOPLE INVITED TO PARTICIPATE IN THE CHNA ASSESSMENT ADVISORY COMMITTEE PROCESS

APPENDIX A – ORGANIZATIONS INVITED TO PARTICIPATE ON THE CHNA ASSESSMENT ADVISORY COMMITTEE

(1) Attended meeting #1 – Introduction to the CHNA – 4/11/12
(2) Attended meeting #2 – Determining the community health priorities – 6/25/12
(3) Attended meeting #3 – Approval of the Schoolcraft Health Improvement Implementation Strategy – 4/16/13

<u>Attended all three meetings</u>
Senior Community Representative, Manistique Senior Center (issues of the senior population) (1) (2) (3)
Director, Manistique Senior Center (support for senior needs and services) (1) (2) (3)
Clinical Social Worker, Manistique Veterans Outreach Clinic, Department of Veteran Affairs (mental health services for local veterans) (1) (2) (3)
Program Director, Medical Care Access Coalition of Marquette/Alger/Schoolcraft Counties (facilitates donated medical services for the low-income uninsured) (1) (2) (3)
Community Health Education Specialist, Sault Tribe Strategic Alliance for Health (co-coordinated throughout the CHNA process; Sault Tribal representative) (1) (2) (3)
Regional Director, Great Lakes Recovery Centers (substance abuse treatment) (1) (2) (3)
Medical social worker & community liaison; CHNA Coordinator, Schoolcraft Memorial Hospital (1) (2) (3)
Community Health Nurse, Sault Tribal Health (largest minority population) (1) (2) (3)

<u>Attended two of three meetings</u>
Local pastor representing the Manistique Ministerial Association and the SMH Board of Trustees (MMA assists in the community with the needs of vulnerable populations) (1) (3)
Parent Liaison, Delta-Schoolcraft Great Start Collaborative (Great Start/Great Start Readiness Program for children 0 – 5 years) (1) (3)
Chief Financial Officer, Schoolcraft Memorial Hospital (1) (2)
Administrator, Schoolcraft County Medical Care Facility (county home for the aged and rehab facility) (1) (2)
Director, Schoolcraft Memorial Hospital Rural Health Clinic (1) (2)
Emergency Preparedness Coordinator, Luce-Mackinac-Alger-Schoolcraft District Health Department (1) (2)
Senior Community Representative (1) (2)
Chief Executive Officer, Schoolcraft Memorial Hospital (1) (2)
Chief Nursing Officer, Schoolcraft Memorial Hospital (1) (2)
Great Lakes Center for Youth Development (experienced at non-profit development, group facilitation; contracted to facilitate the first two Assessment Advisory Meetings and the focus group sessions) (1) (2)

<u>Attended one of three meetings</u>
Long Term Care Program Director, Upper Peninsula Commission for Area Progress (UPCAP) (1)
Manistique Area Schools high school senior (youth issues) (1)
Health/Disabilities Manager, Menominee-Delta-Schoolcraft Early Childhood Programs (Head Start, Early Head Start, Early On) (1)
Chair, Schoolcraft County Board of Commissioners (1)
Retired School Psychologist, Delta-Schoolcraft Intermediate School District (3)
Chief Executive Officer, Hiawatha Behavioral Health Authority (seriously mentally ill, developmental disabilities) (1)
Director, Schoolcraft County Economic Development Corporation (1)
School Nurse, Manistique Area Schools (3)
Service Supervisor, Marquette/Alger/Schoolcraft Department of Human Services (1)
Trustee, Doyle Township Board (Gulliver) (1)
Cardiac Rehabilitation Coordinator, Schoolcraft Memorial Hospital (1)
Certified Diabetic Educator, Schoolcraft Memorial Hospital (2)
Diabetic Educator, Schoolcraft Memorial Hospital (3)

Administrative Manager, Upper Peninsula Commission for Area Progress/ Area Agency on Aging/2-1-1 resource hotline (3)
Former Director, Good Neighbor Services (reaching out to assist vulnerable populations with food, clothing, shelter, medication needs) (1)
Owner/practitioner, Acupuncture & Therapeutic Massage Clinic (alternative medical therapy) (1)

Did not attend meetings – declined, sent representative, or unable to attend
City Manager, City of Manistique
Optometrist, The Vision & Learning Center
Local Coordinator of Lutheran Social Services Youth Services & Marquette/Alger/Schoolcraft County Department of Human Services (youth age 11 – 21/foster care services)
Manistique Area Schools high school senior (youth issues)
Chief Financial Officer, Schoolcraft Memorial Hospital (new – participated in implementation strategy development)
Supervisor, Cardiopulmonary Services, Schoolcraft Memorial Hospital
Medical social worker, Schoolcraft Memorial Hospital (assists with many resource needs in the hospital and community – frail elderly, Medicare/Medicaid Assistance Program, child passenger safety seats; assisted with implementation strategy development)
Coordinator, Schoolcraft County Coalition for Safe & Stable Housing (homeless and near-homeless populations; assisted with implementation strategy development)
Health Officer, Luce-Mackinac-Alger-Schoolcraft District Health Department
Township Supervisor, Germfask Township
Program Manager, Manistique Tribal Health Center (Largest minority population – Chippewa Tribe; sent Community Health Nurse as representative)
Senior Community Representative
Pastor/Community Representative, Cooks/Garden area (very active in local improvement efforts)
Local dentist, Gentle Family Dentistry
Regional Manager, Goodwill Industries (services for persons with disabilities)
Retired Director, Marquette/Alger Department of Human Services
District 2 Coordinator, Michigan State University Extension
Superintendent, Manistique Area Schools (sent school nurse as representative)
Nursing Services Coordinator, Schoolcraft Memorial Hospital
Doyle Township Supervisor (chose a township trustee to represent the Gulliver area)
Local dentist, Emerald City Dentistry
Recreation Director, City of Manistique/Schoolcraft Memorial Hospital Fitness Center (participated in implementation strategy development)
Director, Schoolcraft Memorial HomeCare & Hospice
Director, Schoolcraft County Public Transit Authority (through the transit drivers, is made aware of many issues with vulnerable populations that community resources may not be aware of; participated in implementation strategy development)
Director, Schoolcraft County Veterans Council
Schoolcraft County Coordinator, Community Action Agency (serves a variety of vulnerable populations & needs)
Director, St. Vincent de Paul Services (local Catholic charity)
Director, Marquette/Alger/Schoolcraft Department of Human Services (sent the Service Supervisor as representative)

APPENDIX B

LETTERS OF INVITATION

Letter of Invitation for Community Members

March 7, 2012

[Community Member]
[Address]
Manistique, MI 49854

Dear [Community Member]:

Schoolcraft Memorial Hospital will be conducting a Community Health Needs Assessment in 2012, in compliance with the Patient Protection & Affordable Care Act. Our objectives are to identify the health strengths and needs of the hospital and our community, and to develop a three-year implementation plan that will begin to address identified health care gaps. Working together with local agencies, area residents, and other community partners, we are committed to the health and well-being of all who live in our hospital service area.

In order for the CHNA to be comprehensive, it is vital that other community stakeholders join us in planning the assessment, in developing an implementation plan, and in accomplishing long term health care goals for the benefit of the community. As a leading representative of senior adults in the Manistique community, we are asking you to consider being part of an Assessment Advisory Committee (AAC) that will be facilitated by Susan Phillips of SMH and Kerry Ott of the Sault Tribe Strategic Alliance for Health project. Susan and Kerry will be assisted by Amy Quinn and Paul Olson of the Great Lakes Center for Youth Development, both of whom are experienced meeting facilitators. The time commitment for the AAC will be two meetings of approximately 90 minutes in length; one during the second week of April, and the second during the last week of June. A tentative agenda for the April meeting is enclosed.

Please contact Susan Phillips by March 20, 2012 if you are able to assist with this project:

906.341.3238 or sphillips@scmh.org. We will follow-up with a meeting planner to select the most optimum date and time for the majority of participants during the second week of April.

Thank you in advance for your interest and assistance.

Sincerely,

Susan Phillips, LMSW

Letter of Invitation for Community Professionals

March 7, 2012

[Community Professional]
[Address]
Manistique, MI 49854

Dear [Community Professional]:

Schoolcraft Memorial Hospital will be conducting a Community Health Needs Assessment in 2012, and every three years thereafter, in compliance with the Patient Protection & Affordable Care Act. Our objectives are to identify the health strengths and needs of the hospital and our community, and to develop a three-year implementation plan that will begin to address identified health care gaps. Working together with local agencies, area residents, and other community partners, we are committed to the health and well-being of all who live in our hospital service area.

In order for the CHNA to be comprehensive, it is vital that other community stakeholders join us in planning the assessment, in developing an implementation plan, and in accomplishing long term health care goals for the benefit of the community. We are asking you to consider being part of an Assessment Advisory Committee (AAC) that will be facilitated by Susan Phillips of SMH and Kerry Ott of the Sault Tribe Strategic Alliance for Health project. Susan and Kerry will be assisted by Amy Quinn and Paul Olson of the Great Lakes Center for Youth Development, both of whom are experienced meeting facilitators. If you are unable to attend, we would appreciate your selection of another person who is knowledgeable about the health needs and gaps in the communities within Schoolcraft County and the Garden Peninsula.

The time commitment for the AAC will be two meetings of approximately 90 minutes in length; one during the first week of April, and the second during the last week of June. A tentative agenda for the April meeting is enclosed.

Please contact Susan Phillips by **March 15, 2012** if you are able to assist with this project: 906.341.3238 or sphillips@scmh.org. We will follow-up with a meeting planner to select the most optimum date and time for the majority of participants during the first week of April.

Thank you in advance for your interest and assistance.

Sincerely,

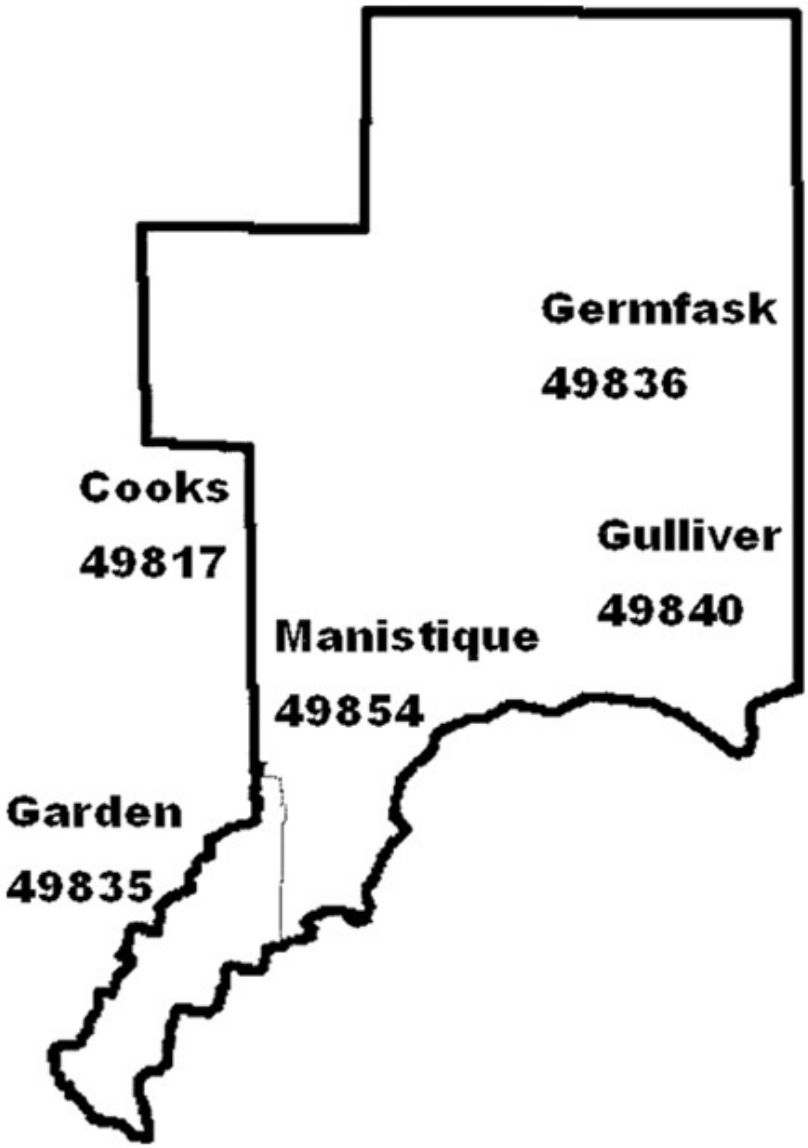
Susan Phillips, LMSW

APPENDIX C

SCHOOLCRAFT MEMORIAL HOSPITAL SERVICE AREA COMMUNITY PROFILE

SCHOOLCRAFT
MEMORIAL HOSPITAL

Primary Service Area
Demographic and Health Data



Schoolcraft County, Michigan

People QuickFacts	Schoolcraft County	Michigan
Population, 2013 estimate	NA	9,895,622
Population, 2012 estimate	8,343	9,882,519
Population, 2010 (April 1) estimates base	8,485	9,883,701
Population, percent change, April 1, 2010 to July 1, 2013	NA	0.1%
Population, percent change, April 1, 2010 to July 1, 2012	-1.7%	Z
Population, 2010	8,485	9,883,640
Persons under 5 years, percent, 2012	4.3%	5.8%
Persons under 18 years, percent, 2012	19.0%	22.9%
Persons 65 years and over, percent, 2012	22.6%	14.6%
Female persons, percent, 2012	50.5%	50.9%
White alone, percent, 2012 (a)	87.0%	80.1%
Black or African American alone, percent, 2012 (a)	0.2%	14.3%
American Indian and Alaska Native alone, percent, 2012 (a)	9.1%	0.7%
Asian alone, percent, 2012 (a)	0.2%	2.6%
Native Hawaiian and Other Pacific Islander alone, percent, 2012 (a)	0.0%	Z
Two or More Races, percent, 2012	3.5%	2.2%
Hispanic or Latino, percent, 2012 (b)	0.8%	4.6%
White alone, not Hispanic or Latino, percent, 2012	86.4%	76.2%
Living in same house 1 year & over, percent, 2008-2012	89.1%	85.4%
Foreign born persons, percent, 2008-2012	1.3%	6.0%
Language other than English spoken at home, pct age 5+, 2008-2012	2.0%	9.0%
High school graduate or higher, percent of persons age 25+, 2008-2012	89.0%	88.7%
Bachelor's degree or higher, percent of persons age 25+, 2008-2012	12.3%	25.5%
Veterans, 2008-2012	859	692,582
Mean travel time to work (minutes), workers age 16+, 2008 -2012	17.5	23.9
Housing units, 2012	6,315	4,525,004
Homeownership rate, 2008-2012	85.6%	72.8%
Housing units in multi-unit structures, percent, 2008-2012	4.7%	18.0%
Median value of owner-occupied housing units, 2008-2012	$86,300	$128,600
Households, 2008-2012	3,651	3,818,931
Persons per household, 2008-2012	2.27	2.53
Per capita money income in past 12 months (2012 dollars), 2008-2012	$20,962	$25,547
Median household income, 2008-2012	$37,468	$48,471
Persons below poverty level, percent, 2008-2012	18.3%	16.3%

Business QuickFacts	Schoolcraft County	Michigan
Private nonfarm establishments, 2011	226	217,344[2]
Private nonfarm employment, 2011	1,925	3,379,035[2]
Private nonfarm employment, percent change, 2010-2011	2.0%	2.8%[2]
Nonemployer establishments, 2011	405	687,228
Total number of firms, 2007	S	816,972
Black-owned firms, percent, 2007	S	8.9%
American Indian- and Alaska Native-owned firms, percent, 2007	S	0.7%
Asian-owned firms, percent, 2007	S	2.6%

Native Hawaiian and Other Pacific Islander-owned firms, percent, 2007	S	0.1%
Hispanic-owned firms, percent, 2007	S	1.3%
Women-owned firms, percent, 2007	S	30.4%
Manufacturers shipments, 2007 ($1000)	0[1]	234,455,768
Merchant wholesaler sales, 2007 ($1000)	D	107,109,349
Retail sales, 2007 ($1000)	110,816	109,102,594
Retail sales per capita, 2007	$13,097	$10,855
Accommodation and food services sales, 2007 ($1000)	10,158	14,536,648
Building permits, 2012	24	11,692[2]

Geography QuickFacts	**Schoolcraft County**	**Michigan**
Land area in square miles, 2010	1,171.36	56,538.90
Persons per square mile, 2010	7.2	174.8
FIPS Code	153	26
Metropolitan or Micropolitan Statistical Area	None	

1: Counties with 500 employees or less are excluded.
2: Includes data not distributed by county.

(a) Includes persons reporting only one race.
(b) Hispanics may be of any race, so also are included in applicable race categories.

D: Suppressed to avoid disclosure of confidential information
F: Fewer than 25 firms
FN: Footnote on this item for this area in place of data
NA: Not available
S: Suppressed; does not meet publication standards
X: Not applicable
Z: Value greater than zero but less than half unit of measure shown

Source U.S. Census Bureau: State and County QuickFacts. Data derived from Population Estimates, American Community Survey, Census of Population and Housing, State and County Housing Unit Estimates, County Business Patterns, Nonemployer Statistics, Economic Census, Survey of Business Owners, Building Permits
Last Revised: Monday, 06-Jan-2014 17:33:04 EST

Schoolcraft (SH)

	Schoolcraft County	Error Margin	Michigan	National Benchmark*	Rank (of 82)
Health Outcomes					57
Mortality					55
Premature death	7,568	5,230-9,905	7,254	5,317	
Morbidity					56
Poor or fair health	14%	8-24%	14%	10%	
Poor physical health days	3.9	1.3-6.5	3.5	2.6	
Poor mental health days	3.3	1.3-5.3	3.7	2.3	
Low birthweight	8.1%	5.8-10.5%	8.4%	6.0%	
Health Factors					35
Health Behaviors					20
Adult smoking			20%	13%	
Adult obesity	30%	23-37%	32%	25%	
Physical inactivity	26%	19-34%	25%	21%	
Excessive drinking	11%	6-21%	19%	7%	
Motor vehicle crash death rate	20	10-34	11	10	
Sexually transmitted infections	71		500	92	
Teen birth rate	31	24-40	32	21	
Clinical Care					37
Uninsured	18%	16-20%	14%	11%	
Primary care physicians**	1,697:1		1,271:1	1,067:1	
Dentists**	2,157:1		1,626:1	1,516:1	
Preventable hospital stays	56	45-67	70	47	
Diabetic screening	85%	72-97%	86%	90%	
Mammography screening	76%	58-94%	67%	73%	
Social & Economic Factors					45
High school graduation**	86%		74%		
Some college	50%	39-61%	64%	70%	
Unemployment	12.9%		10.3%	5.0%	
Children in poverty	25%	18-32%	25%	14%	
Inadequate social support			20%	14%	
Children in single-parent households	26%	16-35%	33%	20%	
Violent crime rate	264		497	66	
Physical Environment					57
Daily fine particulate matter	8.7	8.5-8.8	9.9	8.8	
Drinking water safety	0%		1%	0%	
Access to recreational facilities	0		9	16	
Limited access to healthy foods**	10%		6%	1%	
Fast food restaurants	40%		49%	27%	

* 90th percentile, i.e., only 10% are better.
** Data should not be compared with prior years due to changes in definition.
Note: Blank values reflect unreliable or missing data

Selected Comparisons Among UP Counties in the RWJF/UW County Health Rankings
Rank Out Of 82 Michigan Counties

Health Outcome	Schoolcraft 2010	Schoolcraft 2011	Schoolcraft 2012	Alger 2012	Baraga 2012	Luce 2012	Ontonagon 2012
Overall Ranking on Health Outcomes	60	70	60	8	6	71	82
Mortality Ranking Measure of the numbers of deaths	66	75	62	14	7	77	82
Premature death: Years of potential life lost before age 75 per 100,000 population (age-adjusted)	8,517	9,345	8,316	5,980	5,172	9,447	11,422
Morbidity Ranking Number of individuals in poor health over a given time period	33	58	45	6	19	46	81
Health Behaviors Ranking Obesity, physical inactivity, excessive drinking, STDs, teen birth rate	56	48	20	21	35	58	40
Clinical Care Ranking Uninsured adults, primary care provider rate, preventable hospital stays, diabetic screening, hospice use	28	17	32	43	82	81	71
Social & Economic Factors Ranking High school graduation, college degrees, unemployment, children in poverty, income inequality	65	63	47	40	77	70	48
Physical Environment Air pollution particulate matter days (2010 – 2012) Air pollution ozone days (2010 – 2012) Access to healthy foods (healthy food outlets including grocery stores & produce stands/farmers' markets) 2010 – 2012 Liquor store density (number per 10,000 population) 2010 only Access to recreational facilities (added for 2011 – 2012) Fast food restaurants (added for 2012)	79	81	76	54	59	40	21

Definition of "recreational facility": "Establishments primarily engaged in operating fitness and recreational sports facilities, featuring exercise and other active physical fitness conditioning or recreational sports activities such as swimming, skating, or racquet sports. **Where it comes from:** This measure is based on a measure from United States Department of Agriculture (USDA) Food Environment Atlas, and is calculated using the most current County Business Patterns data set. Recreational facilities are identified by North American Industrial Classification System (NAICS) code 713940.

Data Source: http://www.countyhealthrankings.org

SCHOOLCRAFT

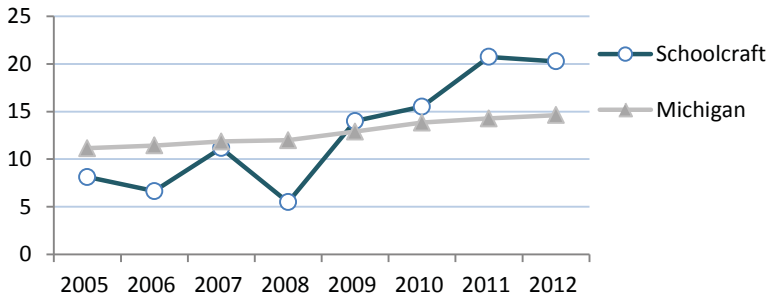
BACKGROUND INFORMATION (ALL DATA ARE FOR 2012 UNLESS OTHERWISE NOTED.)

POPULATION	2005	2011	% CHANGE
Total population	8,819	8,489	-3.7%
Child population 0–17	1,807	1,678	-7.1%
• Ages 0-4	388	394	1.5%
• Ages 5-9	495	431	-12.9%
• Ages 10-14	568	507	-10.7%
• Ages 15-19	529	522	-1.3%

ECONOMIC CLIMATE	COUNTY	MICHIGAN
Unemployment	12.5%	9.1%
Median household income (2011)	$38,366	$45,931
Average cost of full-time child care-month (2013)	$528	$532
Percent of full-time minimum wage (2013)	42.5%	42.8%

FAMILY SUPPORT PROGRAMS	NUMBER	PERCENT	MI RATE
Children receiving...			
• Subsidized child care, ages 0–12[1]	23	2.1%	3.3%
• FIP cash assistance[1,2]	46	2.6%	4.5%
• Food Assistance Program[1,3]	454	25.6%	29.1%
Children with support owed	487	26.3%	20.7%
• Receiving none (% of those owed)	127	26.1%	30.0%
• Receiving less than 70% of amount	270	55.4%	61.6%
• Average amount received (month)	$183	—	$228

Confirmed Child Abuse Neglect Victims, Ages 0-17 (rate per 1,000)



Source: Michigan Department of Community Health, Vital Records and Health Data Development Section.

kids count in Michigan

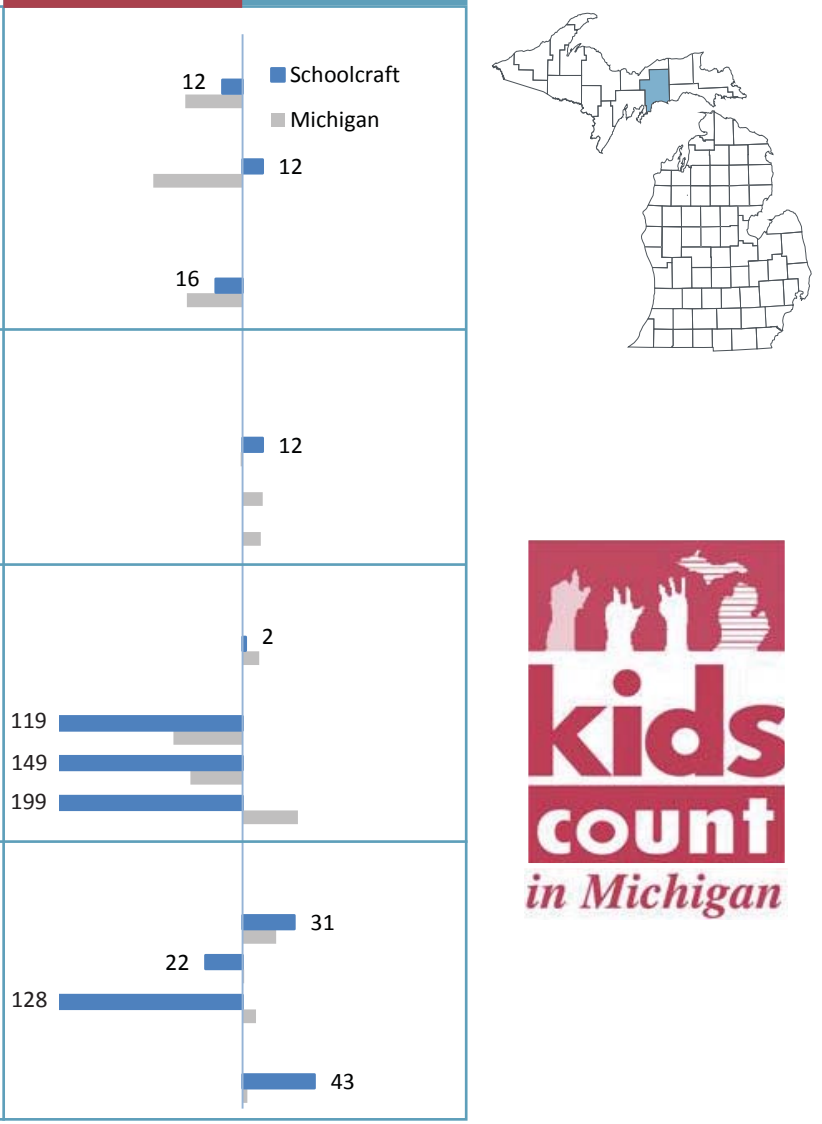
ACCESS TO HEALTH CARE			
Children with health insurance	1,653	93.8%	95.6%
Children, ages 0–18, insured by...			
• Medicaid[1]	801	45.2%	41.0%
• MIChild	52	3.0%	1.5%
Fully immunized toddlers, ages 19–35 months (for the series 4:3:1:3:3:1)[1]	62	68.1%	74.6%
Lead poisoning in children, ages 1–2			
• Tested	76	47.2%	38.2%
• Poisoned (% of tested)	2	*	4.8%
Children, ages 1–14, hospitalized for asthma (rate per 10,000)[4]	*	*	17.2
Children with special needs			
Babies with a birth defect**	5	7.3%	6.6%
Students in Special Education[1]	102	11.9%	13.8%
Children receiving Supplemental Security Income (rate per 1,000)[1]	26	15.5	20.3

[1] As of December 2012.
[2] Family Independence Program.
[3] State name for the federal Supplemental Nutrition Assistance Program, formerly called "food stamps."
[4] Annual rate and number are based on the three-year period 2009–2011 and only for counties with a total number over 20.

Note: Percentages reflect percent of population unless otherwise noted.
* Sometimes a rate could not be calculated because of low incidence of events or unavailable data.
** Based on three year period 2009-2011.
N/A not available.
See Data Notes and Sources for details.

TRENDS IN CHILD WELL-BEING

	BASE YEAR NUMBER	BASE YEAR RATE	CURRENT YEAR NUMBER	CURRENT YEAR RATE	RANK[1]	MI RATE
Economic Security	**2005**		**2011**			
Children in poverty, ages 0–17	400	22.6%	413	25.2%	42	24.6%
			2012			
Children, ages 0–5, eligible for SNAP[2]	174	37.7%	161	33.1%	29	36.7%
	2006					
Students eligible for free/reduced price school lunches[3]	505	47.5%	473	55.2%	44	48.2%
Health	**2003–05 (avg)**		**2009–11 (avg)**			
Less than adequate prenatal care	N/A	N/A	27	39.8%	75	29.4%
Low-birthweight babies	7	8.8%	5	7.8%	50 of 81	8.4%
Infant mortality (per 1,000)	1	*	0	*	* of 47	7.1
Child/Teen deaths, ages 1–19 (per 100,000)	0	*	0	*	* of 52	27.6
Family and Community (per 1,000)						
Births to teens, ages 15–19	10	37.8	9	37.1	59	30.2
	2005		**2012**			
Children in investigated families	102	55.3	203	121.0	49	90.1
Confirmed victims	15	8.1	34	20.3	50	14.6
Children in out-of-home care	7	3.8	19	11.3	76 of 78	4.5
Education (not proficient)	**2008**					
Fourth-graders (MEAP reading)	29	36.7%	15	25.4%	19	31.9%
Eighth-graders (MEAP math)	54	68.4%	70	83.3%	79	67.5%
High school students (MME reading)	17	23.6%	48	53.9%	78	44.1%
	Class of 2007		**Class of 2012**			
Students not graduating on time	32	31.7%	15	18.1%	29	23.8%



kids count in Michigan

[1] A ranking of 1 means a county has the "best" rate compared with other counties in the state. Unless noted, the ranking is based on 82–83 counties.
[2] Supplemental Nutrition Assistance Program.
[3] Family income is below 130 percent poverty level.
* Sometimes a rate could not be calculated because of low incidence of events or unavailable data.
MME - Michigan Merit Exam
N/A not available.

Missing bars indicate no change or a rate could not be calculated; a "0" reflects no change. Percentage change is calculated with unrounded rates.

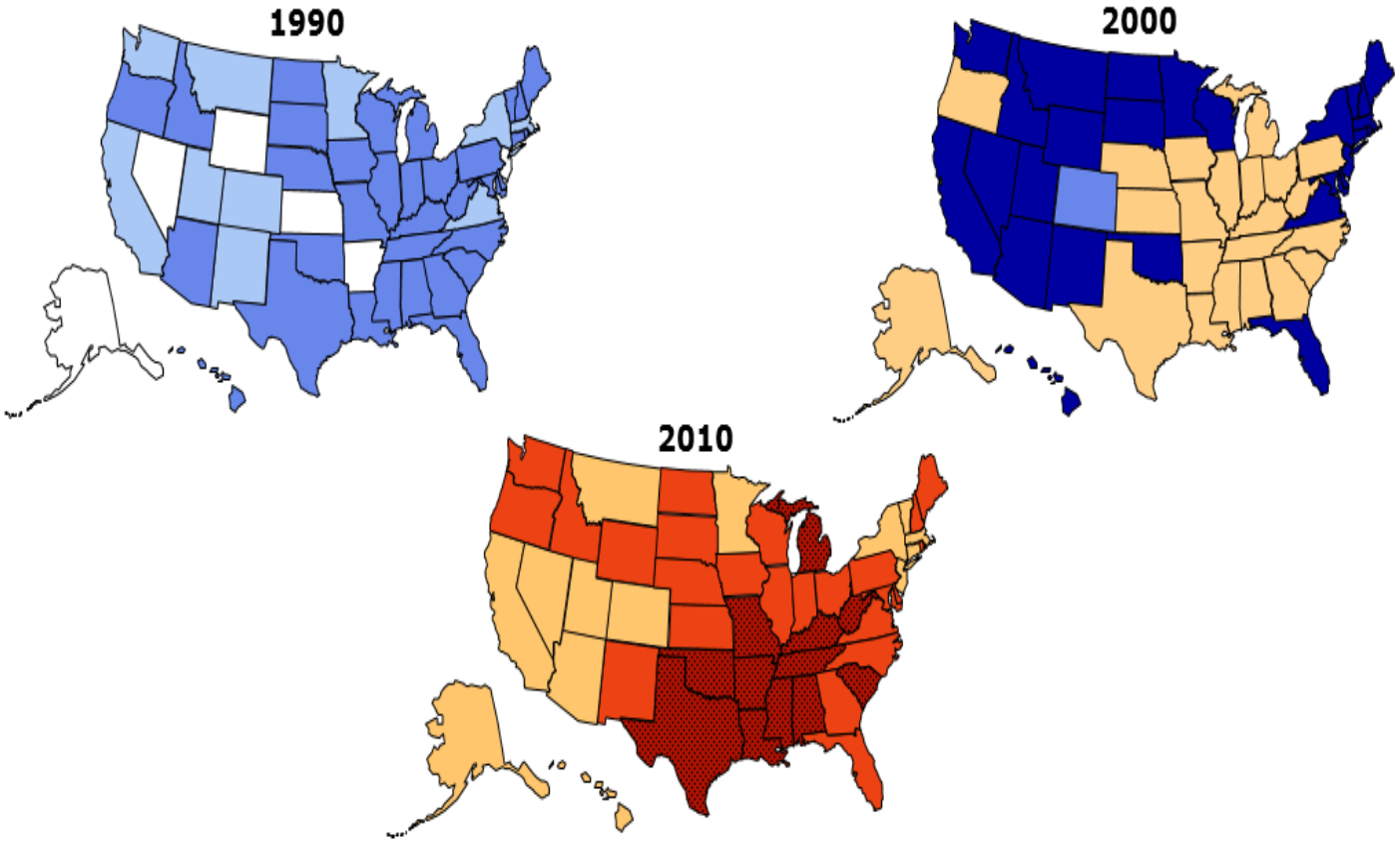
Luce-Mackinac-Alger-Schoolcraft (LMAS) District Health Department
Selected Results From The Michigan Behavioral Risk Factor Survey
2008 – 2010 Combined

Behavioral Risk Measure	LMAS DHD Weighted % Estimates	State of Michigan Weighted % Estimates
Proportion of adults who reported that they:		
"Rarely" or "never" have the social/emotional support they need	7.8	7.1
Are limited in activities d/t physical, mental, or emotional problems; or, that they require the use of special equipment (cane, wheelchair, special bed, or special telephone) d/t a health problem	27.9	23.7
Did not have anyone they thought of as their personal doctor or health care provider	12.4	12.5
In the past 12 months there was a time they needed a doctor but could not go due to cost	17.3	13.4
Had not participated in any leisure-time physical activities or exercise such as running, calisthenics, golf, gardening, or walking during the past month	29.3	24.3
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	22.6	19.7
Had ever smoked at least 100 cigarettes (5 packs) in their life, but they do not smoke cigarettes now	31.7	25.6
Had never smoked	45.6	54.8
Consumed on average more than two alcoholic beverages per day for men or more than one alcoholic beverage per day for women (defined as "heavy drinking")	5.5	5.4
Consumed five or more drinks per occasion at least once in the previous month (defined as "binge drinking")	17.3	16.6
Drove when they'd had too much to drink at least once in the previous month	3.0	2.7
Always use a seatbelt when driving or riding in a car	86.0	88.3
Did not have a routine checkup in the past year	45.8	32.3
[Women aged 40 years and older] Had both a clinical breast exam and mammogram in the previous year	46.7	54.6
[Women aged 18 years and older] Had a PAP test within the previous three years	67.9	79.3
[Men aged 50 years and older; men who had been diagnosed with prostate cancer were excluded] Had a PSA in the past year [Sample size was <50 respondents; a UP prevalence estimate is given]	51.8	59.0
[Adults aged 50 and older] Had a sigmoidoscopy within the past five years or a colonoscopy within the past ten years	58.1	64.5
Had visited a dentist or dental clinic for any reason in the previous year	68.1	73.8
Were missing 6+ teeth d/t tooth decay/gum disease, excluding teeth lost for other reasons such as injury/orthodontics	16.4	13.8
[Adults aged 65 years and older] Had a flu vaccine (injection or spray) during the past 12 months	62.9	68.9
[Adults aged 65 years and older] Have ever had a pneumococcal vaccine	50.5	67.1
Were ever told by a doctor, nurse, or other health care professional that they had asthma	20.7	15.6
Still have asthma	12.7	10.1
Were ever told by a health care professional that they have some form of arthritis, rheumatoid arthritis, gout, lupus, or fibromyalgia	30.4	31.5
Have ever been told by a doctor that they had a heart attack or myocardial infarction	3.7	4.6
Have ever been told by a doctor that they have angina or coronary heart disease	4.0	4.8
Have ever been told by a doctor that they have had a stroke	4.4	2.8
Were ever told by a doctor that they have diabetes (only during pregnancy and pre-diabetes not counted)	4.0	9.5

Obesity Trends* Among U.S. Adults

BRFSS, 1990, 2000, 2010

(*BMI ≥30, or about 30 lbs. overweight for 5'4" person)



Source: Behavioral Risk Factor Surveillance System, CDC.

Schoolcraft County

Crash and Injuries by Month

Month	Crashes				Persons	
	Total	Fatal	Injury	Property Damage Only	Fatality	Injury
January	47	0	5	42	0	6
February	20	0	1	19	0	1
March	23	0	1	22	0	2
April	13	0	3	10	0	3
May	16	0	2	14	0	3
June	25	0	4	21	0	5
July	24	0	8	16	0	9
August	35	0	9	26	0	11
September	24	0	1	23	0	4
October	35	0	2	33	0	2
November	44	0	4	40	0	4
December	38	0	1	37	0	1
TOTAL	**344**	**0**	**41**	**303**	**0**	**51**

In Schoolcraft County in 2012 there were:

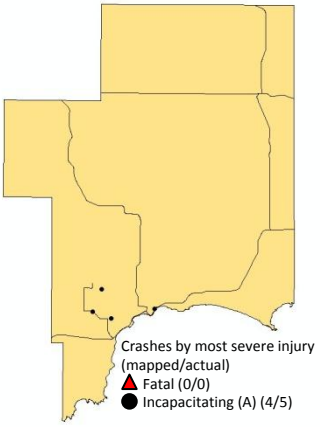
344 crashes

Involving:

467 people

466 motor vehicle drivers and passengers

1 train engineer



Driver Statistics

Age Group	2011* Population	Licensed Drivers	Drivers in Crashes	Drivers in Crashes	
				Per 10K Population	Per 10K Licensed
0 - 15	1,440	65	3	20.8	461.5
16 - 20	491	423	41	835.0	969.3
21 - 64	4,731	4,341	289	610.9	665.7
65 +	1,828	1,699	51	279.0	300.2
Other/Unknown	--	--	18	--	--
TOTAL	**8,490**	**6,528**	**402**	**473.5**	**615.8**

*2012 Population of Michigan Counties (by single-year of age) not yet available from U.S. Census Bureau

Vehicles in Crashes

Vehicle Type	Motor Vehicles		Fatal Crash		Injury Crash	PDO Crash
	Number of Vehicles	% of Total	Number of Vehicles	% of Total		
Passenger car & station wagon	255	63.4	0	0.0	26	229
Van, motorhome	21	5.2	0	0.0	2	19
Pickup truck	88	21.9	0	0.0	11	77
Small truck under 10,000 lbs. GVWR	5	1.2	0	0.0	0	5
Cycle	9	2.2	0	0.0	7	2
Moped	0	0.0	0	0.0	0	0
Go Cart	0	0.0	0	0.0	0	0
Snowmobile	4	1.0	0	0.0	4	0
Off-Road Vehicle (ORV) / All-Terrain Vehicle (ATV)	5	1.2	0	0.0	4	1
Other	0	0.0	0	0.0	0	0
Truck/bus over 10,000 lbs.	12	3.0	0	0.0	0	12
Unknown	3	0.7	0	0.0	0	3
TOTAL	**402**	**100.0**	**0**	**0.0**	**54**	**348**

Schoolcraft County Experience

Schoolcraft County did not experience a fatal crash.

Schoolcraft County driver statistics indicate 6.5 percent of licensed drivers were age 16-20, and 10.2 percent of drivers in that age group were involved in crashes.

Leading Causes of Death By Age, Schoolcraft County, Michigan 2011

Cause of Death	All Ages	Under 20 Years	20-44 Years	45-74 Years	75+ Years
All Causes of Death	104	1	5	34	64
1. Heart Disease	18	-	-	7	11
2. Cancer	28	-	1	14	13
3. Chronic Lower Respiratory Diseases	9	-	-	5	4
4. Stroke	3	-	-	-	3
5. Unintentional Injuries	8	1	3	2	2
6. Alzheimer's Disease	3	-	-	1	2
7. Diabetes Mellitus	1	-	-	-	1
8. Pneumonia/Influenza	4	-	-	1	3
9. Kidney Disease	6	-	-	-	6
10. Intentional Self-harm (Suicide)	-	-	-	-	-
All Other Causes	24	-	1	4	19

Note: The causes of death are listed in order of the 10 leading causes of death for Michigan residents in 2011.

Data displayed are by the underlying cause of death which is the condition giving rise to the chain of events leading to death. Causes of death are classified in accordance with the Tenth Revision of the International Classifications of Diseases (ICD-10), a coding structure developed by the World Health Organization. This revision has been used to classify deaths occurring on or after January 1, 1999. The ICD-10 codes are grouped into broader categories for the causes listed in this table in order to classify these selected causes of death (e.g., ICD-10 codes C00-C97 are used to indicate deaths due to cancer).

All Ages column includes deaths with age not stated.

-: A dash indicates a zero value.

Source: 2011 Geocoded Michigan Death Certificate Registry. Division for Vital Records & Health Statistics, Michigan Department of Community Health

Last Updated: 9/27/2013

By Gender: By Age Group:

Twenty Leading Diagnoses for Hospitalizations
Schoolcraft County Residents, Michigan 2011

(View Number of Days of Care and Average Length of Stay)

PRINCIPAL DIAGNOSIS (View ICD-9-CM Codes)	HOSPITALIZATIONS		
	Number	Percent	Rate Per 10,000 Population
All Hospitalizations	970	100.0	1,142.5
Heart Diseases	99	10.2	116.6
Newborns and Neonates (Less than 7 days)	72	7.4	84.8
Females with Deliveries	69	7.1	81.3
Injury and Poisoning	64	6.6	75.4
Osteoarthrosis and Allied Disorders	51	5.3	60.1
Pneumonia	49	5.1	57.7
Cancer (Malignant Neoplasms)	41	4.2	48.3
Psychoses	39	4.0	45.9
Cerebrovascular Diseases	31	3.2	36.5
Care Involving Use of Rehabilitation Procedures	31	3.2	36.5
Diseases of Arteries, Arterioles & Capillaries	19	2.0	22.4
Diseases of the Blood & Blood-Forming Organs	18	1.9	21.2
Kidney/Urinary Infections	18	1.9	21.2
Intervertebral Disc Disorders	16	1.7	18.9
Chronic bronchitis	15	1.6	17.7
Septicemia	10	1.0	11.8
Diseases of the Skin and Subcutaneous Tissue	10	1.0	11.8
Chest Pain	9	0.9	10.6
Diverticula of Intestine	8	0.8	9.4
All Infectious & Parasitic Diseases Except Septicemia	8	0.8	9.4
All Other Hospitalization Conditions	293	30.2	345.1

Notes:

Hospitalizations are inpatient hospital stays as measured by stays that were completed during the specified year. The number of hospitalizations is often greater than the number of persons hospitalized since some persons are hospitalized more than once during a year.

Percent of all hospitalizations for the specified year.

Hospitalization Rates are the number of hospitalizations per 10,000 population for the year.

****** Indicates the number of hospitalizations is too small (less the 6) to calculate statistically reliable rate.

Source: Michigan Resident Inpatient Files,
Division for Vital Records and Health Statistics, Michigan Department of Community Health.

Last Updated: 04/10/2013

HEALTH TOPIC AREAS FROM HEALTHY PEOPLE 2020
THAT REFLECT SIGNIFICANT HEALTH ISSUES
FOR THE SCHOOLCRAFT MEMORIAL HOSPITAL SERVICE AREA

Access to health services
Adolescent health
Arthritis, osteoporosis, and chronic back conditions
Cancer
Chronic kidney disease
Dementias, including Alzheimer's Disease
Diabetes
Disability & health
Early & middle childhood issues
Educational and community-based programs
Health-related quality of life & well-being
Heart disease & stroke
Immunization & infectious diseases
Mental health & mental disorders
Nutrition & weight status
Older adult issues
Oral health
Physical activity
Respiratory diseases
Sexually transmitted diseases
Sleep health
Social determinants of health
Substance abuse
Tobacco use
Vision

APPENDIX D

SUMMARY OF FOCUS GROUP RESULTS

APPENDIX D – SUMMARY OF FOCUS GROUP RESULTS

In 2012, Schoolcraft Memorial Hospital conducted four community focus groups in Manistique, Cooks/Garden, Germfask, and for Tribal members at the Sault Tribe Community Center in Manistique. Each focus group was asked the following five questions:

1. How do you perceive your health?
2. What are barriers to care? To healthy behaviors?
3. When you seek care, what motivates you to do so?
4. If there was a service that Schoolcraft Memorial Hospital wanted you to know about, what would be the best way to get that information to you?
5. What do you feel are the major health issues in the community?

**Note that percentages may not add to 100% under each item, due to some comments containing multiple answers.*

1. Perception of own health

57% - lack of access to and/or quality of local care
35% - responded about their own health; 50% of these perceived their health as poor
8% - institutional meal quality is poor or there is no place to walk in their community

2. Barriers to care/healthy behaviors

40% - medical providers (lack of and or quality of; specific need for OB/GYN, Pediatrician, Medicaid Dentist)
16% - financial
14% - poor quality of care at Schoolcraft Memorial Hospital
14% - environment (specifically food and physical activity environments; and UP culture)
12% - perceptions of other community members (old; bad parenting; obese; lazy kids)
7% - lack of knowledge (health information)
7% - transportation

3. Motivation to seek care

46% - last resort; desperate (acute symptoms)
33% - try to seek regular preventive care
13% - there are no local doctors they would seek care from
8% - prefer alternative or home remedies

4. Ways for Schoolcraft Memorial Hospital to communicate about available services

33% - local newspapers
29% - local radio
33% - other (word of mouth; Senior Center; township halls and newsletters; schools; physician)
5% - will not reach the people who need it, because people don't care

5. Major community health issues:

10% - cardiovascular disease/stroke/high blood pressure
8% - transportation
8% - money/poverty/lack of insurance
8% - lack of specialists
7% - aging issues
7% - mental illness
7% - drugs/alcohol
5% - lack of physical activity (cost of fitness center)
5% - diabetes
5% - tobacco
3% - obesity
28% - other (from SMH image to personal behaviors to lack of information

APPENDIX E

COMMUNITY HEALTH PRIORITIES 2013 – 2016

APPENDIX E – COMMUNITY HEALTH PRIORITIES 2013 – 2016

1. Primary Prevention (Wellness) – Teaching people the importance of taking care of themselves through healthy living

2. Community organizations working together on communication, education, and consistent messages throughout the community

3. Need treatment for mental illness as well as a focus on mental health and wellness

APPENDIX F

MEMBERS OF THE SCHOOLCRAFT HEALTH IMPROVEMENT PLAN IMPLEMENTATION STRATEGY WORKGROUP

APPENDIX F – SCHOOLCRAFT HEALTH IMPROVEMENT IMPLEMENTATION STRATEGY WORKGROUP

[An asterisk (*) indicates the number of strategy development meetings in which the representative/ organization was able to participate.]

Senior Community Representative, Manistique Senior Center **
Pastor, Manistique Ministerial Association & SMH Board of Trustees**
Chief Financial Office (new), Schoolcraft Memorial Hospital***
Medical social worker, Schoolcraft Memorial Hospital*
Coordinator, Schoolcraft County Coalition for Safe & Stable Housing*
Parent Liaison, Delta-Schoolcraft Great Start Collaborative & Parent Coalition*
Director, Manistique Senior Center***
Retired School Psychologist, Delta/Schoolcraft Intermediate School District*
Chief Executive Officer, Hiawatha Behavioral Health Authority*
School Nurse, Manistique Area Schools*****
Emergency Preparedness Coordinator, Luce-Mackinac-Alger-Schoolcraft District Health Department****
Clinical Social Worker, Manistique Veterans Outreach Clinic, Department of Veteran Affairs**
Senior Community Representative*
Program Director, Medical Care Access Coalition****
Chief Executive Officer, Schoolcraft Memorial Hospital**
Chief Nursing Officer, Schoolcraft Memorial Hospital***
Community Health Education Specialist, Sault Tribe Strategic Alliance for Health****
Medical social worker/community liaison, CHNA coordinator, Schoolcraft Memorial Hospital*****
Recreation Director, City of Manistique/Schoolcraft Memorial Hospital Fitness Center*
Community Health Nurse, Sault Ste. Marie Tribe of Chippewa Indians***
Diabetic Educator, Schoolcraft Memorial Hospital*
Executive Director, Habitat for Humanity Hiawathaland*
Director, Schoolcraft County Public Transit**
2-1-1 Director/Administrative Manager, Upper Peninsula Commission for Area Progress/Area Agency on Aging*
Retired City of Manistique/Community Volunteer*

Dates of Meetings:
November 6, 2012
November 30, 2012
January 25, 2013
March 1, 2013
March 22, 2013

APPENDIX G

WORKING DRAFT OF THE SCHOOLCRAFT HEALTH IMPROVEMENT IMPLEMENTATION STRATEGY

Community Health Needs Assessment → Schoolcraft Health Improvement Implementation Strategy
Year 1 (July 2013 – June 2014)
PLANNING & DEVELOPMENT
(Revision of 09/05/13) – Adopted by Schoolcraft Memorial Hospital Board of Trustees on September 23, 2013

Year 1 – Goal #1	Strategies	Resource Commitment	Anticipated Outcome
Widely publicize the CHNA & the implementation strategy	Make the complete report available at the hospital's website – www.scmh.org. Post a hard copy within the hospital that is available for inspection; make one copy per individual request at no charge. SMH website link for the CHNA & IS at collaborative partner websites. Announce availability of the CHNA & IS through various media outlets – two hospital newsletters, local newspapers, etc. Advertise availability through hospital's Facebook account	Schoolcraft Memorial Hospital (SMH) will commit staff time & collaborate with community partners	The public will be made aware of the community health priorities that were chosen & how SMH & the collaborative partners plan to address the needs

Year 1 – Goal #2	Strategies	Resource Commitment	Anticipated Outcome
Inventory all available community resources & determine optimal public information/education format(s); develop a plan for educating the public about resources already available here. **Year 1 – begin inventory/planning; complete in Year 2**	Comprehensively inventory & compile available community resources; encourage community organizations with resources/programs available to list in the 2-1-1 database; offer to assist with completing application for the 2-1-1 directory (complete in Year 1) [2-1-1 is "the 9-1-1" for community resources – a hotline that people can dial to find the community resources they need.]	SMH & Implementation Committee partners will commit staff time (see attached roster of IC members)	Community members throughout the SMH service area will be educated about health & human services resources available to them in this area

Year 1 – Goal #3	Strategies	Resource Commitment	Anticipated Outcome
Begin education program for community professionals – series of speakers/presentations	Utilize the Community Collaborative meetings as a forum; advertise the speakers more widely to reach more health & human service professionals and increase attendance beyond CC membership. [The Schoolcraft County Community Collaborative is the primary gathering point for all health & human service agencies in the community.]	SMH will commit staff time to planning the presentations in coordination with the CC chair and other IC members	Community professionals will increase their knowledge base of community resources available in order to better assist their clients.

Year 1 – Goal #4	Strategies	Resource Commitment	Anticipated Outcome
Improve SMH's community image through personal & customer-friendly service.	Continue the Capstone Leadership Solutions program. [Capstone is an employee and customer satisfaction program with a focus on service recovery.]	All SMH employees are involved including physicians; contracted services through Capstone Leadership Solutions	Successful internal marketing & education; successful internal motivational campaign leading to customers who are more willing to recommend hospital's services to others, leading to service recovery & increased market share

Year 1 – Goal #5	Strategies	Resource Commitment	Anticipated Outcome
Begin planning expansion of evidence-based wellness/fitness/ prevention community health activities. **Year 1 = planning year; implement in Year 2**	Locations for activities/events/classes will include the new hospital, the Farmers Market, the Senior Center, in order to improve/increase attendance. Also, go "where the people are" at community organizations/agencies & community worksites. Utilize the Great Start Parent Coalition meeting as a forum to present available options for young families. [The Great Start Collaborative focuses on the health & wellbeing of young families with children ages 0 – 5 years.] Annual Community Health Fair is used as a setting to provide many different types of testing & services at no or low cost. Look at ways of expanding testing/education offered.	SMH will commit staff time; in particular, members of the SMH Wellness Committee, in collaboration with community partners & IC members, to research & plan the activities/clinics. SMH will commit staff time to work with the GSC parent liaison and the parent coalition.	Encourage people to have an investment in & responsibility for their personal health. Community residents will view the hospital as a community center rather than a place to visit only when ill. Increase attendance at the Farmers Market to introduce community residents to the benefits of fresh, locally grown produce.

Year 1 – Goal #6	Strategies	Resource Commitment	Anticipated Outcome
Expand schools-based, evidence-based programs for youth, such as health & wellness, developing good health habits, improved nutritional choices, benefits of physical exercise, personal responsibility for self, building self-esteem, anti-bullying **Year 1 = planning year; implement in Year 2**	Consult & collaborate with the Coordinated School Health Teams of Manistique Area Schools & St. Francis School to plan these educational sessions/programs.	SMH will commit staff time; in particular, members of the SMH Wellness Committee, in collaboration with community partners & IC members, to research & plan the educational sessions/programs	Youth will have the benefit of health-related wellness/ fitness/prevention education appropriate for their ages & stages of development.

Year 1 – Goal #7	Strategies	Resource Commitment	Anticipated Outcome
Provide affordable local non-emergency medical transportation for hospital appointments.	SMH & Schoolcraft County Public Transit will develop a plan to provide partial coverage of transportation costs for patients coming to the hospital for appointments. Public Transit will extend their lowest fare rate out to the new hospital site, which is outside the city limits.	Patients will pay the cost to the hospital and SMH will cover the cost of their transportation back home.	Patients will benefit from a reduced cost of traveling to the hospital via public transportation.

Year 1 – Goal #8	Strategies	Resource Commitment	Anticipated Outcome
Determine creative, low-cost ideas for incentives to draw community members to health-related activities (target the audience). **Year 1 = planning year; Year 2 for implementing along with the events, activities, presentations, education sessions listed throughout the implementation strategy document.**	Build on the list of ideas already started by the Implementation Committee.	SMH will commit staff time to planning in coordination with other IC members. SMH will commit some funding from within their marketing/development budget, but will also seek donations and use other measures to control costs.	Find creative ways to draw people out and get them interested and involved in health-related community activities/events.

Year 1 – Goal #9	Strategies	Resource Commitment	Anticipated Outcome
Explore/research ways to bring community mental health services to Manistique for the "less than seriously mentally ill" population.	The SMH Senior Leadership Team (SLT) will explore options for leasing/renting space in the Rural Health Clinic for a mid-level practitioner to provide psychiatric services. An alternative option would be leasing/renting space to a private therapist. Schoolcraft County will be listed with the Health Resources & Services Administration (Federal) as a Mental Health Professional Shortage Area. Online research for creative models being used in other rural areas to meet mental health needs.	SMH has made exploring options for provision of psychiatric services a part of the hospital's strategic plan. SMH will commit staff time to working with other IC members to achieve a MHPSA designation with the Federal government.	The less than SMI population will have access to mental health services. Schoolcraft County will have opportunities for mental health professionals to locate here to meet their loan obligations to the Federal government.

Year 1 – Goal #10	Strategies	Resource Commitment	Anticipated Outcome
Develop a project/program evaluation plan. **Year 1 = short-term outcomes**	Determine measures to be used. Consult with Kerry Ott (LMAS DHD) if available Utilize www.resultsonline2.net. Contract with Great Lakes Center for Youth Development, if necessary	SMH will commit staff time to researching optimal methods for evaluation that will be cost-efficient & feasible.	The short-term outcomes of the planning/development year will be measured.

Community Health Needs Assessment → Schoolcraft Health Improvement Implementation Strategy
Year 2 (July 2014 – June 2015)
IMPLEMENTATION & DEVELOPMENT

Year 2 – Goal #1	Strategies	Resource Commitment	Anticipated Outcome
Continue the activities started in Year 1	Continue to widely publicize the CHNA & keep the public informed on progress made on the implementation strategy. Continue the education program for community professionals (speakers/presentations) utilizing the Community Collaborative as a forum. Continue Capstone Leadership Solutions program at SMH (increased employee & customer satisfaction & service recovery). Continue to explore methods for providing community mental health services in Manistique for the less than seriously mentally ill population. Continue the collaboration with Public Transit to provide affordable transportation for hospital customers.	Same as Year 1	Same as Year 1

Year 2 – Goal #2	Strategies	Resource Commitment	Anticipated Outcome
Continue the plan to educate the public about resources/ services <u>already</u> <u>available</u> in Schoolcraft County.	Complete the inventory/planning phase; distribute the informational materials created to community organizations/ agencies throughout Schoolcraft County & the Garden area. Utilize the professional & community listservs that were created in Year 1 to keep the community updated on new programs/ services/resources available. SMH will continue to facilitate a community presentation series & offer speakers for community groups.	SMH will commit staff time to accomplishing these strategies.	Community members throughout the SMH service area will be educated about health & human services resources available to them in this area

Year 2 – Goal #3	Strategies	Resource Commitment	Anticipated Outcome
Expand number/types of evidence-based wellness/fitness/prevention community health activities that were planned in Year 1	Locations to include the new hospital, the Farmers Market, the Senior Center, in order to improve/increase attendance. Also, go "where the people are" at community organizations/agencies & community worksites.	SMH will commit staff time; in particular, members of the SMH Wellness Committee, in collaboration with community partners & IC members, to research & plan the activities/clinics.	Encourage people to have an investment in & responsibility for their personal health. Community residents will view the hospital as a community center rather than a place to visit only when ill. Increase attendance at the Farmers Market to introduce community residents to the benefits of fresh, locally grown produce.

Year 2 – Goal #4	Strategies	Resource Commitment	Anticipated Outcome
Expand schools-based, evidence-based programs for youth that were developed in Year 1 such as health & wellness, developing good health habits, improved nutrition, physical exercise, taking personal responsibility for self, building self-esteem, anti-bullying	Consult & collaborate with the Coordinated School Health Teams of Manistique Area Schools & St. Francis School to implement these educational sessions/programs.	SMH will commit staff time; in particular, members of the SMH Wellness Committee, in collaboration with community partners & IC members, to research & plan the educational sessions/programs	Youth will have the benefit of health-related wellness/ fitness/prevention education appropriate for their ages & stages of development.

Year 2 – Goal #5	Strategies	Resource Commitment	Anticipated Outcomes
Develop a comprehensive community-based education, public relations, and marketing/ development plan with the goals of improving health, encouraging wellness, motivating people toward self & community improvement, incorporating incentives from Year 1. Address perceptions that the quality of health care services in Schoolcraft County are poor. **Year 2 = Planning year; implement in Year 3**	The Implementation Committee has developed a list of creative ideas to meet this goal. IC will work in collaboration with the SMH Strategic Planning Committee to share ideas and plan a community improvement/community relations campaign. (Many of the ideas the community group developed are also a part of the SMH Senior Leadership Team's strategic plan for the hospital.)	SMH has, & will continue, to commit a great deal of staff time to planning & offering community education, working to improve community relations, developing & carrying out a marketing plan, including staff time toward working with the Implementation Committee, which is community-based The hospital is developing a budget toward carrying out the CHNA implementation strategy.	Community health education will be increased & knowledge base of the public improved. Community will better understand the services available to them in the hospital & the community. Confidence & trust in the quality of health care in Schoolcraft County will improve.

Year 2 – Goal #6	Strategies	Resource Commitment	Anticipated Outcome
Develop & begin organizing a plan for health-promoting community activities; incorporate incentive ideas from Year 1. Year 2 = planning year	The Implementation Committee has developed a list of creative ideas to meet this goal.	SMH will commit staff time to planning & facilitating these events	The community will become more physically active

Year 2 – Goal #7	Strategies	Resource Commitment	Anticipated Outcome
Explore feasibility of a Gatekeeper model to use in the SMH service area **Year 2 = planning year; year 3 for implementation**	Resource to be researched: http://spokane.wsu.edu/researchoutreach/wimhrt/documents/A7.pdf [The Gatekeeper model utilizes community service persons – postal workers, delivery people, Meals on Wheels staff, transit drivers, etc., to be alert for community residents living in unsafe situations, or in need of community resources, who might not otherwise come to the attention of agencies that can assist.]	SMH will commit staff time to research & reporting back to work group	Research whether a Gatekeeper program could be developed in this geographic area to assist vulnerable populations.

Year 2 – Goal #8	Strategies	Resource Commitment	Anticipated Outcome
Begin process evaluation **Year 2 = Mid-term outcomes – evaluating & measuring the strategies after implementation & determining/demonstrating their benefits**	Determine measures to be used. Consult with Kerry Ott (LMAS DHD) if available Utilize www.resultsonline2.net. Contract with Great Lakes Center for Youth Development, if necessary	SMH will commit staff time to researching optimal methods for evaluation that will be cost-efficient & feasible.	The mid-term outcomes of the implementation/ development year will be measured.

Community Health Needs Assessment → Schoolcraft Health Improvement Implementation Strategy
Year 3 (July 2015 – June 2016)
IMPLEMENTATION & EVALUATION

Year 3 – Goal #1	Strategies	Resource Commitment	Anticipated Outcome
Continue with Year 1 & 2 activities.	Widely publicize the CHNA & keep the public informed on implementation strategy progress. Continue the education program for community professionals (speakers/presentations) utilizing the Community Collaborative as a forum. Continue the Capstone Leadership Solutions program at SMH (increased employee/customer satisfaction & service recovery. Continue to explore methods for providing community mental health services in Manistique for the less than seriously mentally ill population. Continue information/education efforts about resources currently available to community residents in Schoolcraft County. Continue evidence-based wellness/fitness/prevention community health activities. Continue schools-based, evidence-based programs for youth. Continue the collaborative transportation program for hospital customers between SMH & Public Transit.	See Years 1 & 2	See Years 1 & 2

Year 3 – Goal #2	Strategies	Resource Commitment	Anticipated Outcome
Implement the comprehensive community-based education, public relations, & marketing/development plan that was developed in Year 2	The Implementation Committee has developed a list of creative ideas to meet this goal. IC will work in collaboration with the SMH Strategic Planning Committee to share ideas and plan a community improvement/community relations campaign. (Many of the ideas the community group developed are also a part of the SMH Senior Leadership Team's strategic plan for the hospital.)	See Year 2	See Year 2

Year 3 – Goal #3	Strategies	Resource Commitment	Anticipated Outcome
Implement the plan for health-promoting community activities from Year 2	Incorporate incentive ideas from Year 1	See Year 2	See Year 2

Year 3 – Goal #4	Strategies	Resource Commitment	Anticipated Outcome
If research has demonstrated that a Gatekeeper program (community-based) is feasible & affordable, begin training/implementation of volunteers	Dependent upon the program model & whether it is replicable in this rural geographic area.	See Year 2	See Year 2

Year 3 – Goal #5	Strategies	Resource Commitment	Anticipated Outcome
Begin outcome evaluation	Determine measures to be used. Consult with Kerry Ott (LMAS DHD) if available Utilize www.resultsonline2.net. Contract with Great Lakes Center for Youth Development, if necessary	SMH will commit staff time to researching optimal methods for evaluation that will be cost-efficient & feasible.	The mid-term outcomes of the implementation/ development year will be measured.

Repeat the Assessment & Implementation Strategy Development Process
January 2016 – December 2019

	Strategies	**Resource Commitment**	**Anticipated Outcome**
Repeat the CHNA & analyze results; create a new implementation strategy & facilitate its completion.		SMH will take the lead; a SMH staff person will head the CHNA process & will facilitate the IS workgroup.	SMH will have knowledge of the community's health priorities as determined by residents of the hospital's service area, & will take the lead in developing an implementation strategy to meet the priority health needs of the community.

HEALTH ISSUES NAMED BY THE FOCUS GROUP PARTICIPANTS

Question asked of the focus group participants: "What do you feel are the major health issues in the community?"

Health Issue	**Being addressed in implementation strategy**
Personal attitudes toward health – the community offers great things if only people would take advantage of them	Primary prevention & wellness; communication & education through community collaboration
Cardiovascular disease – heart attacks, heart disease, strokes, high blood pressure	Community education on services in the community already available: Cardiologist comes here from Marquette; SMH operates a cardiac rehab program, a fitness center, produces a wellness newsletter that often addresses conditions such as hypertension; hospital professionals offer blood pressure clinics and community education in this topic area
Need for collaboration among groups, which would improve care	There is a great deal of collaboration already in place among health & human service organization in the communities, but the implementation strategy will strengthen these bonds.
Gastroenteritis ("stomach flu"); Hepatitis, especially C; Influenza ("flu"); scabies	This is a part of the implementation strategy through community education. The hospital and the Sault Tribe and the LMAS DHD (for Hepatitis C) all provide education to the community, offer flu shots, encourage people to get flu shots annually, etc. These efforts will be expanded to try and reach more people and especially those of the vulnerable populations.
Hospital/Rural Health Clinic/Fitness Center – negative perception, no prenatal services, services that aren't covered by insurance, need for specialists to come to Manistique, need for chemotherapy, lack of communication with doctors	The hospital has instituted an employee and customer satisfaction program & has an outside company – Arbor & Associates – completing its satisfaction surveys. We are attempting to change the negative perceptions that exist in the community; however, we know we will not be able to change everyone's mind. The implementation strategy addresses the negative perceptions. The educational aspect will address prenatal services (they are offered here), services that aren't covered by insurance (the hospital has a Community Cares program, which does have eligibility requirements, and in accordance with PPACA, our financial policies are transparent to the community); there is a listing of the specialists who come to our hospital on our website, as well as being advertised through the local media on a regular basis); need for chemotherapy (it is provided here); lack of communication with doctors (the intent of this is not completely clear, but as above, we are working to improve our relationship with the community.

Health Issue	Being addressed in implementation strategy – Page 2
Need for information, knowledge, education	The mainstay of our implementation strategy
Mental illness – mental health issues, stigma, self-medication, need for information about services offered	Hiawatha Behavioral Health Authority A priority of the implementation strategy The Sault Tribe offers mental health services to its Tribal members
Obesity – lack of physical activity, starts in kindergarten, need a place to walk in the wintertime (outside Manistique area)	A significant portion of the implementation strategy addresses increasing physical activity and nutritional choices for all age groups. The City of Manistique is developing walking, biking, and skateboard paths. In the winter, the high school is often open for people who want to walk indoors.
Suicide/suicide prevention – need for information about what's available for prevention	Will be addressed through the implementation strategy via education and development of support groups. We have a Friends Helping Friends Suicide and Bullying Prevention group active among high school students. We have a yearly vigil for those who have lost loved ones to suicide. We are members of the Upper Peninsula Suicide Prevention Coalition. A number of people in the community have been trained in the QPR (Question, Persuade, Refer) method. Hiawatha Behavioral Health Authority is a resource.
Transportation – long distance (would like a van that transports to Marquette every day), for cancer treatment to Marquette	Exploring expansion of long distance transportation services in this vast rural area is a part of the implementation strategy. At this time, public transit buses do not go much beyond county lines, and the counties are so large that there is not convenient transportation to all parts of the county on a regular basis. A van to Marquette every day would have to cross two county lines. The Senior Center offers volunteer drivers for persons 60 and older. The Schoolcraft County Coalition for Safe & Stable Housing has recently received an award to develop a program for people under 60. People do not HAVE to go to Marquette for chemotherapy, but may need to if that is where their doctors of choice are located, or if they are receiving radiation treatment.
Veterans – need counseling for young veterans	The Manistique Veterans Outreach Clinic provides such services. The implementation strategy will address this issue also through the development of support groups.

	Not chosen as priority health issue during this 3-year assessment period Being addressed by hospital and/or community resources
Advanced life support needed for emergency medical services	SMH will support the efforts of all Basic & Specialist level ambulance agencies in our service area to achieve paramedic level service via the leadership of our Medical Control Authority.
Aging issues Need for respite care when a caregiver needs to be out of the home	There are a number of organizations that serve the needs of the elderly: Schoolcraft Memorial Hospital is very involved in arranging for resources for patients and community members upon request; we have a social worker certified as a Medicare/Medicaid Assistance Program counselor who assists with Medicare/Medicaid questions, as well as assisting people during the open enrollment period for Medicare Part D. We offer assistance with the Durable Power of Attorney for Health Care; we offer diabetic education programs and other services. The Manistique Senior Center and the Community Action Agency have programs/services to offer the elderly, among others. Schoolcraft Memorial Hospital offers a Private Pay Guest Services program for caregivers to be able to provide a loved one 24-hour care when needed. The community has a volunteer program for providing respite for hospice caregivers. Until recently Schoolcraft Memorial HomeCare & Hospice provided private duty aide services that could be used for respite; however, for cost containment purposes, this program has recently been closed. Northwoods Home Nursing & Hospice has a private duty aide service.
Alcoholism – addiction, drugs, prescription drugs, meth, young people & families ripped apart	Great Lakes Recovery Centers offer inpatient and outpatient services. There are a number of AA groups and a Narcotics Anonymous group in the community. There is a community collaborative (multi-agency) task force to address prescription drug abuse, as well as other substance abuse. There is a Michigan Coalition Against Underage Drinking (MCRUD) group active in the community. The hospital would be involved with treating meth addicts on an acute care basis, but as a Critical Access Hospital has no facilities for inpatient drug rehab, and it is beyond our scope of service to try to directly eliminate the use of the drug in the community.

Being addressed by hospital & community resources – Page 2	It is beyond the scope of the hospital's service to address youth and family issues caused by the use/abuse of harmful substances, although we participate with the above mentioned task forces/workgroups (Rx drug abuse/MCRUD) The Sault Tribe offers addiction counseling & services to Tribal members
Contagious diseases	Luce-Mackinac-Alger-Schoolcraft District Health Department Schoolcraft Memorial Hospital Infection Control Department Sault Tribal Health Infection Control
Diabetes	Both the hospital and the Sault Tribe provide excellent diabetes education programs
Domestic issues – children being pulled out of homes, child neglect, physical abuse	The hospital is a mandated reporter and cooperates fully with law enforcement and protective services with the Michigan Department of Human Services. The Sault Tribe has its own investigative unit. The community has the services of Tri-County Safe Harbor, a domestic abuse and sexual assault prevention organization that provides services in the community and operates a shelter in Escanaba (55 miles). The Michigan Department of Human Services investigates claims of abuse/neglect and licenses foster care homes.
Early Childhood – the "Special Beginnings" program was discontinued	This is a part of the education piece within the implementation strategy – educating community residents on services already available to them. The Special Beginnings, or Welcome Newborn program is alive and well.
Homelessness	The Schoolcraft County Coalition for Safe & Stable Housing exists to address the issues of homelessness and near-homelessness in the community. On an annual basis, the county has the benefit of the Emergency Solutions Grant through the Michigan State Housing Development Authority. The SCCSSH coordinator has collaborated with other community organizations that provide food, shelter, clothing (Good Neighbor Services, St. Vincent de Paul, Manistique Ministerial Association) for case management so there is a collaborative effort among these helping groups when a person or family is in need.
Medicaid abuse	This is a Department of Human Services investigative issue and is outside the hospital's scope of services.
Poverty – aging people before their time, don't have the means to provide for themselves	This is a societal problem. There are organizations in the community that assist with poverty-related issues, including the hospital, and these

Being addressed by hospital & community resources – Page 3	organizations are mentioned throughout this document. The implementation strategy will help with poverty-related issues also.
Prescription medications – cost is awful; hospice should remove Rx drugs from the home when people pass away	There are several organizations in town that can help on an individual basis for prescription drug needs – Good Neighbor Services/St. Vincent de Paul. The Medical Care Access Coalition provides a community service in applying on behalf of community members to the pharmaceutical company prescription assistance programs for brand name medications. The Rural Health Clinic is able to help with some sample medications. Medical Care Access Coalition clients can go through a formulary to receive their generic drugs for a low co-pay. Putvin's Health Mart has a prescription drug card with a low member rate and then formulary drugs at a significantly reduced cost. The hospital has a certified Medicare/Medicaid Assistance Program counselor who assists people with Medicare D plan choices. There are other prescription drug plans available in the community for which an annual fee is paid and formulary drugs are provided at reduced cost. Hospice agencies remove the narcotic drugs from a patient's home whenever they have the family's permission to do so, but do not have the authority to remove the drugs if the family declines their offer.
Respiratory illness – lung cancer, smoking, tobacco abuse	Schoolcraft Memorial Hospital has a recently developed Cardiopulmonary Department that assesses and assists with these illnesses. The Sault Tribe offers smoking cessation classes. The hospital does not offer smoking cessation classes, but this will be looked at for the future.

	Not chosen as priority health issue during this 3-year assessment period + Reason for not being addressed
Aging issues – quality of senior meals, number of people homebound & having to receive Meals on Wheels	The hospital cannot address the quality of the meals being served at the Senior Center; we cannot address the number of people who are home-bound, but are thankful we HAVE a Meals on Wheels program that can assist them. The Sault Tribe provides meals for its Tribal elders
Dental Health – poverty related	The community has one dentist who will accept children on Medicaid (Delta Dental Healthy Kids), age 20 and under, without limit. No adults covered by Medicaid are accepted. The nearest services are through the FQHC in Engadine (40 miles) or in Spalding/Powers (75 miles) and then transportation becomes an issue. The hospital will collaborate in the community in trying to find resolution to these issues, but is not in a position to address the issues alone.
Dialysis	It is beyond the financial ability of the hospital to offer a dialysis program at this time.
Gambling – need for Gamblers Anonymous	There is a hotline for persons for whom gambling has become an addiction & it is posted throughout the community. The Sault Tribe casino has it posted; the State of Michigan has it posted wherever they sell lottery tickets; this is not an issue the hospital feels capable of addressing at this time.
Hospital/Rural Health Clinic/Fitness Center – no OB services; Fitness Center is too expensive & needs a sliding fee scale; doctors won't do a behavioral contract for prescription drugs	Schoolcraft County does has not had enough deliveries for years to attract an OB physician to set up practice here. We used to have two Family Practice physicians who delivered babies, but opted to discontinue to do so. The hospital is not in a financial position to be able to reopen an OB wing, and at this time does not have the space to do so even if we wanted to. With regard to modification of the Fitness Center's pay scale and the physicians doing behavioral contracts for prescription drugs, these were not chosen as priorities for this 3-year assessment period, but can be revisited in the future. The Sault Tribal Health Clinic does do a behavioral contract for prescription drugs.
Community outside Manistique needs a place to walk in the wintertime	This is not something the hospital would address by itself, but might in the future be part of this community's effort to formulate a plan to address this

APPENDIX H

PARTIAL LISTING OF HEALTH & HUMAN SERVICES RESOURCES AVAILABLE TO THE RESIDENTS OF SCHOOLCRAFT COUNTY

APPENDIX H – PARTIAL LISTING OF AVAILABLE HEALTH & HUMAN SERVICES RESOURCES AVAILABLE TO THE RESIDENTS OF SCHOOLCRAFT COUNTY

[NOTE: Many of these services are available across county lines.]

Schoolcraft Memorial Hospital/SMH Rural Health Clinic/Schoolcraft Memorial HomeCare & Hospice (Please refer to website for names of providers and services offered – www.scmh.org)
Sault Tribe of Chippewa Indians Community Center
- Tribal Health Center
- Community & Family Services (including substance abuse services)

Luce-Mackinac-Alger-Schoolcraft District Health Department
Medical Care Access Coalition-Schoolcraft Office (serving the low-income uninsured)
North Woods Home Nursing & Hospice
Department of Human Services – Marquette/Alger/Schoolcraft Counties
Upper Peninsula Health Plan (Medicaid HMO) (Marquette)
Upper Peninsula Commission for Area Progress (UPCAP)/Area Agency on Aging
Hiawatha Behavioral Health (mental health services for persons with serious mental illness; case management and community homes for persons with developmental disabilities)
Community Home Medical (durable medical equipment, respiratory therapy services)
Schoolcraft County Medical Care Facility (skilled nursing care & rehabilitation services)
Upper Peninsula Long-Term Care Facility Directory (adult foster care, nursing homes, homes for the aged, assisted living facilities)
- http://www.upcap.org/programs_services/long_term_care/facilities_directory.html
- 2013 printed copies available; to request a copy, contact Deb Trombly @ 906.217.3037 or (Upper Peninsula residents only) dial 2-1-1. Email requests to webtech@upcap.org

Putvin Health Mart Drug Store
Shopko Pharmacy
Tri-County Safe Harbor, Inc. (Domestic Violence/Sexual Assault) (Serves Schoolcraft, Delta, & Menominee Counties; shelter located in Escanaba)
Emergency Services:
- Manistique Public Safety – Police, Fire, Emergency Medical Services
- Tri-Star Community Ambulance (Delta County – Garden, MI)
- Inwood Township EMS (Cooks, MI)
- American Red Cross

American Cancer Society, Schoolcraft County Branch
Menominee-Delta-Schoolcraft (MDS) Community Action Agency
Manistique Senior Center (loan closet offering durable medical equipment, long-distance transportation for medically-related services, and other services for senior adults)
Schoolcraft County Public Transit (has partnered with Schoolcraft Memorial Hospital to provide cost-sharing transportation for medical appointments at the new hospital & Rural Health Clinic site)
Manistique Ministerial Association (assistance for persons who are homeless or near-homeless; assistance with utility shut-offs; works closely with the Schoolcraft County Coalition for Safe & Stable Housing)
Grief/Loss Support Group
Schoolcraft County Coalition for Safe & Stable Housing – assistance for persons who are homeless or near-homeless; coordinates/networks with many of the other resources in the community to prevent utility shut-offs, provide food, clothing, shelter and other emergency basic needs

Good Neighbor Services – Food, clothing, medication purchasing assistance through the Medication and Patient Assistance Program; furniture for free in cases that a family is burned out of their home; GNS runs a thrift store with low-cost clothing, furniture, appliances, and other items
St. Vincent de Paul – Emergency food, clothing, lodging, medication purchasing assistance, and furniture in cases that a family is burned out of their home; SVDP runs a thrift store with low-cost clothing, furniture, appliances, and other items
Habitat for Humanity Hiawathaland – Builds and rehabilitates homes; runs a ReStore that sells low-cost furniture, appliances, and other household & building items
Dental Services:
- Manistique Dental Center – Gregory LaFayette, DDS
- Gentle Family Dentistry – Peter J. Jacobs, DDS
- Emerald City Dental Center – Frank E. Pink, DDS

Vision Services:
- The Vision & Learning Center – Shelly D. Baker, OD
- Michael L. Wilson, OD

Chiropractic Physicians:
- Edward H. Klumpp, DC
- Schone's Chiropractic

Acupuncture:
- Georganne R. Verigan, PhD, Dipl. Ac.

Massage Therapy:
- Patricia Hazel, LMT
- Kimberly Haug, LMT
- Kathy Jerde (Mustard Seed)

Health Foods & Supplements:
- Aunt Sandy's Health & Gourmet Food

Veterans Services:
- Veterans Council
- Veterans Outpatient Clinic

Salvation Army – shelter and basic needs assistance (Escanaba)
Economic Development Council
Visiting Specialty Physicians (Schoolcraft Memorial Hospital Rural Health Clinic)
http://www.scmh.org/specialist-schedule
- Kendall Tabor, DPM (feet)
- John Michael Garrett, MD, Ophthalmologist (eyes)
- Megan Haas, Escanaba Hearing Services
- Cardiology – Cardiology Associates
- John A. Klim, DO, Ear, Nose, & Throat
- Obstetrics – Marquette General Hospital's Family Practice Residency Program
- Oncology – Santosh Gowda, MD (cancer & chemotherapy)
- Urology – Shahar Madjar, MD, MBA

Self-Help Groups:
- Alcoholics Anonymous
- Al Anon
- Narcotics Anonymous
- Grief/Loss Support Group

Children/Youth Services:

- Early Childhood Center – Head Start, Early Head Start, Early On, Welcome Newborns
- Great Start Collaborative (0-5)
- Great Start Parent Coalition (0-5)
- Delta-Schoolcraft Intermediate School District
- Manistique Area Schools
  - K-12
  - Alternative Education Program
  - 4-year-old program
- St. Francis de Sales School
- Bethel Baptist Christian School
- Big Bay de Noc Schools (Delta County)
- Hiawatha Behavioral Health – Services for children with emotional & behavioral issues
- Youth Programs:
  - TATU (Teens Against Tobacco Use)
  - YETI (Youth Entertaining Teen Interests)
  - MCRUD (Michigan Coalition to Reduce Underage Drinking)
  - FHF (Friends Helping Friends – Suicide & Bullying Prevention)

Great Lakes Recovery Centers

- Substance Abuse/Prescription Drug Abuse Prevention Coalition

If you are unsure of how to contact any of these organizations, please call the Medical Social Services Department at Schoolcraft Memorial Hospital – we will be happy to assist you!

Jeani – 906.341.1863
Susan – 906.341.3238

APPENDIX I

A PARTIAL LISTING OF SERVICES & PROGRAMS AVAILABLE TO THE RESIDENTS OF SCHOOLCRAFT COUNTY

APPENDIX I – A PARTIAL LISTING OF SOME OF THE SERVICES & PROGRAMS AVAILABLE TO THE RESIDENTS OF SCHOOLCRAFT COUNTY

[NOTE: Many of these services are available across county lines.]

1. Schoolcraft Memorial Hospital and the SMH Rural Health Clinic offer the following specialties; schedules for these physicians can be found at our website, www.scmh.org.
    a. General Surgery
    b. Orthopedic Surgery
    c. Pre-natal care through the Family Practice Residency Program at Marquette General Hospital
    d. Eye surgery (Ophthalmologist)
    e. Foot surgery (Podiatrist)
    f. Cancer treatment (Oncologist and chemotherapy)
    g. Cardiology
    h.
2. The Sault Tribal Health Center offers the following:
    a. Family Practice
    b. Dental Care
    c. Vision Care
    d. Pharmacy
    e. Tribal Healer
    f. Diabetic Education
    g. Tobacco cessation
3. The hospital offers the following services:
    a. Diabetic education
    b. Medicare/Medicaid Assistance Program counseling
    c. Child safety seat education and installation
    d. Durable Power of Attorney for Health Care
    e. Fitness Center
    f. Cardiopulmonary services including cardiac rehabilitation
    g. Exercise classes – Body Recall
    h. Telemedicine services
    i. Swing Bed (skilled care/rehab therapy services)
    j. Transportation program for medical appointments in collaboration with Public Transit
    k. Home health and hospice programs
4. Other health, wellness, and prevention services being offered in the community:
    a. The Sault Tribe Strategic Alliance for Health, along with community partners, has established a first-ever Farmers Market; is working toward Complete Streets that will be safe and inviting for people of all ages and physical abilities; is working to increase physical activity and improve the nutritional choices of our school children; facilitates the Blue Cross/Blue Shield Michigan Community Challenge, a community-based exercise competition that Manistique has just won for the third year in a row; and is working with the City of Manistique to complete a walking/biking/ jogging path that will complete a loop through the City that incorporates the length of our boardwalk. The idea behind these projects is to make it easy and attractive for people to take responsibility for their own health and fitness.

b. Alternative Medicine: Acupuncture, massage therapy
c. Chiropractic medicine
d. Great Lakes Recovery Centers (outpatient substance abuse treatment)
e. Mental health services for those with serious mental illness and developmental disabilities
f. Dental care
g. Vision care
h. Veterans services – Manistique Veterans Outpatient Clinic, including counseling services
i. Annual community health fair
j. Annual community resource fair
k. Schoolcraft County Coalition for Safe & Stable Housing (prevention of homelessness and near- homelessness
l. Early childhood programs including dental screenings, "Special Beginnings"
m. "Friends Helping Friends" a high school-based suicide and bullying prevention group
n. MCRUD – the Michigan Coalition to Prevent Underage Drinking
o. Senior Center Services
p. Department of Human Services

If you are unsure of how to connect with any of these programs or services, please call the Medical Social Services Department at Schoolcraft Memorial Hospital – we will be happy to assist you!

Jeani – 906.341.1863
Susan – 906.341.3238