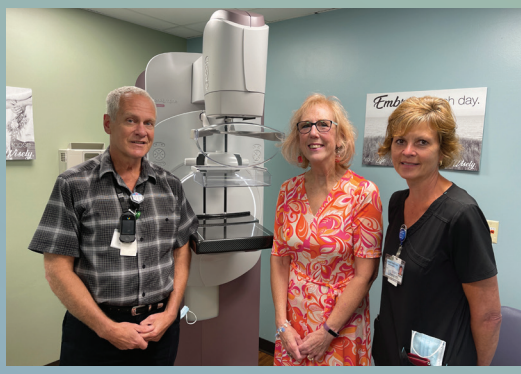
McKenzie Health System

2022 Community Health Needs Assessment





2022

A REPORT TO THE COMMUNITY

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EXECUTIVE SUMMARY

Background

McKenzie Health System is pleased to present the 2022 Community Health Needs Assessment (CHNA). The goal of this CHNA report is to identify the most pressing health issues in our community, determine if there are steps we can take to address those issues, and detail steps to take in the next three years to improve the health of the people we serve. Going through this process each year assures we are gauging our effectiveness and correcting course based on what we learn with each CHNA.

In 2021, the Michigan Thumb Public Health Alliance completed a comprehensive health assessment. The Alliance is a partnership between local public health departments in Huron, Lapeer, Sanilac, and Tuscola Counties. To prevent duplication of effort and to align work with public efforts, McKenzie Health System used the data provided in the four-county assessment completed by the Alliance as the first step in the CHNA process. McKenzie Health System also completed a survey of community stakeholders to further verify that the correct priorities were being considered.

This report contains background information and statistics that were used to create a clearer picture of our current situation, set priorities to address needs, and determine the best plan to address those needs. Extensive information can also be found in the 2021 Thumb Community Health Assessment available at www.mithumbpha.org/documents.

Identified Priorities

McKenzie Health System determined the following priorities for the 2022 - 2024 CHNA: Behavioral Health (Mental Health, Substance/Opioid Use Disorders); Chronic Disease (Management, Prevention); Social Determinants of Health; Access to Specialists; Tele-Health Services; Access to In-Home Medical Care; Transportation Barriers; Financial Assistance Programs and Health Insurance; Awareness of Services; and Prenatal Care.

Making a Difference

McKenzie Health System has implemented a number of programs and strategies already to address some of the health needs that were identified. Those strategies and programs will be maintained and strengthened as appropriate. We will continue to create awareness of those services and programs, remove barriers to accessing services when possible, and will continue to provide support and connect patients to community resources. In addition, we will continue to expand services and outreach when possible as we become aware of needs and opportunities. The implementation plan included in this report provides a more extensive list of strategies specific to each priority identified.

HISTORY

In 1959, with a bequest from Kenneth H. McKenzie, a local banker and merchant, wheels were set in motion for the planning, development, and construction of a local hospital in Sandusky. In June of 1967, McKenzie Memorial Hospital held their ribbon cutting ceremony. The hospital saw many phases of growth over the next five decades.

- In May of 1973, a new wing was added, which included semi-private rooms and an intensive care unit.
- In 1980, an outpatient clinic with four suites was built to house specialty physicians visiting Sandusky.
- In 1998, another addition was added that included a new radiology center, a dining room addition, remodeling in the inpatient area, air-conditioning, energy-efficient windows, and a new medical office building housing Physical Therapy and Rehabilitation.
- In October of 2002, the hospital sought and received Critical Access Hospital (CAH) certification.
- In 2003, some of the beds were approved for short-term rehabilitation services known as Swing Beds.
- Once again there was a need for additional space to house Physical Therapy and associated rehabilitation services. This resulted in the McKenzie Health and Wellness Center being built in July of 2005.
- Following the passage of the Affordable Care Act in March of 2010, McKenzie changed its name to better reflect the broader range of services offered to the community: McKenzie Health System.
- In 2014, McKenzie Health System became a founding member of a newly formed group called the National Rural Accountable Care Organization, which is a Center for Medicare & Medicaid Services approved by Accountable Care Organization. This program, along with our Patient Centered Medical Home certifications, provided for the change in how we deliver care. The change in delivery of care is one whereby McKenzie is transitioning away from sickness and volume to wellness and value. McKenzie was the only critical access hospital in Michigan that began pursuing this transformation in 2014, and still is considered a leader in changing how to deliver care.
- Over the past five years, McKenzie Health System has led in the way care is delivered in our rural area by building “systems of care.” These systems assure we are delivering the highest quality of care in the most efficient way possible using strategies and technology designed for care in rural settings.

What has become clear over years of healthcare service, is that McKenzie Health System is progressive and embraces the changes required to manage local community health needs. We are proud of the leadership role we are playing in the healthcare community within Michigan and nationally. We hope you are equally proud in what your local hospital is accomplishing as well.

McKenzie Health System: Mission, Vision, and Values

As McKenzie Health System leads in transforming how healthcare is designed and delivered, we emphasize clinical and service excellence and promote access to affordable care. We accomplish this through the combined efforts of our healthcare team and partnerships with the community and other healthcare systems.

McKenzie Health System will improve the quality of life in our community through an integrated healthcare delivery system that is characterized by collaboration, innovation, technology, and value.

The values of McKenzie Health System are:

- Respect: We treat each individual we serve and those with whom we work with professionalism and dignity.
- Integrity: We communicate openly and honestly, build trust, and conduct ourselves according to the highest ethical standards.
- Accountability: We take ownership for our actions and responsibility for their outcomes.
- Compassion: We deliver extraordinary care with empathy and kindness for those we serve and to all members of the healthcare team.
- Excellence: We are continuously improving the quality of our service through a commitment to education and prudent stewardship of assets and resources.
- Teamwork: We build system effectiveness on the collective strength of everyone through open communication and mutual respect.
- Innovation: We embrace change and actively pursue progress in a fiscally responsible manner.
- Wellness: We inspire our community to achieve a healthy lifestyle.

The leaders of McKenzie Health System understand that operating a COMMUNITY hospital means striving to understand and respond to the needs of the community. With this community mindset, in 2013, the hospital conducted its first Community Health Needs Assessment (CHNA). This is the fourth cycle of Community Health Assessment and Planning. The process is intended to be completed on a three-year cycle. Therefore, this 2022 report includes a review of the 2019 implementation plan and progress toward plan targets.

What Is a Community Health Needs Assessment (CHNA)?

The first step in meeting community needs is identifying the needs. Using an objective approach helps ensure that priorities are based on evidence and accurate information. Under the Affordable Care Act, a process and guidelines for developing the CHNA are provided. A CHNA helps to direct resources to issues that have the greatest potential for increasing life expectancy, improving quality of life, and producing savings to the healthcare system.

Specific steps outlined by the Internal Revenue Service include:

1. Define the community.
2. Assess the health needs of the defined community.
3. In assessing the community's health needs, solicit and take into account input received from persons who represent the broad interests of the community, including those with special knowledge and expertise in public health.
4. Document the CHNA in a written report that is adopted by an authorized body of the hospital facility.
5. Make the CHNA report widely available to the public.

PROCESS OVERVIEW

McKenzie Health System works in partnership with a wide variety of health and community organizations to meet the needs of the community. The CHNA process was conducted in collaboration with the Thumb Community Health Partnership (TCHP). As a partner of TCHP, McKenzie Health System participated in the regional collection of adequate health indicators and collection of input from stakeholders and vulnerable populations through a community survey. As part of a Network Development Grant received by the Partnership, McKenzie Health System received assistance with the CHNA from Kay Balcer, Director, and other Partnership staff. Support included guidance to the CHNA Team, providing consultation in designing a process for the CHNA, obtaining community health data and information, facilitation of CHNA Team meetings, analysis of gaps in information and areas of need, design of a community survey, survey analysis for the service area, consultation during development of the implementation plan, and developing written reports. Kay Balcer has been involved in numerous needs assessments, surveys, and program evaluations over the past 25 years. She has worked with the various organizations and collaborative groups in the Thumb region to complete various needs assessments. She has also been involved in needs assessment and strategic planning for Great Start Collaborative organizations across the state.

McKenzie Health System also considered a 2021 update of the Thumb Area Community Health Improvement Plan created by the Michigan Thumb Public Health Alliance. The Alliance is a partnership between local public health departments in Huron, Lapeer, Sanilac, and Tuscola Counties. The full Alliance report and plan can be accessed at https://www.mithumbpha.org/documents. The hospital's Community Health Needs Assessment (CHNA), as outlined by the Internal Revenue Service, is slightly different than the assessments produced by the Alliance. The Alliance assessment is designed to inform the public about the health needs of a county or region. A hospital Community Health Needs Assessment informs the public but is also used as a guide to focus efforts of the hospital on prioritized areas of a need.

After reviewing the data compiled by TCHP and the Alliance, the leaders of McKenzie Health System identified priorities and assessed existing services and programs related to those priorities. Gaps were identified and strategies developed to form an implementation plan.

CHNA Team

McKenzie Health System formed an internal team to lead the CHNA process. A consultant provided technical assistance and objectivity. The team met and communicated frequently from March to September 2022. The team consisted of a diverse set of members:

Steve Barnett
President/CEO

Amy Ruedisueli
Chief Financial Officer

Billi Jo Hennika
Chief Operating Officer

Heather Chambers
Director of Healthcare Practices

Rebecca Stoliker
Director of Nursing Services

Louise Blasius
Director of Human Services

Nina Barnett
Public Relations and Foundation Coordinator

Gloria Jerome
Marketing, Communications, and Foundation Director

Timeline

Regional Community Health Survey	October 2021
Review of Health Indicator Data	March 2022
Review of Progress on 2019 Priorities	May 2022
Development of 2022 Priorities	May 2022
Strategy Development	June 2022
Community Input Survey	July 2022
Creation of Implementation Plan	July 2022
Written CHNA Report	August/September 2022

REPRESENTING THE COMMUNITY AND VULNERABLE POPULATIONS

The 2021 Community Health Survey, which was used by McKenzie Health System as part of the CHNA process, included input from the community and vulnerable populations.

Table 1: Community Needs Surveys and Input

Thumb Community Health Partnership		
Behavioral Health Survey (March 2021)	- Distributed across Huron, Lapeer, Sanilac, and Tuscola Counties - 780 people participated in the community survey - 68 medical providers participated - 98 mental health providers participated	Behavioral Health was identified as a priority for the region in 2019. To gain a better understanding of needs related to behavioral health in the region, three surveys were distributed: Medical Provider, Mental Health Provider, and Community. Questions were designed for each target population including multiple choice, rating scale, multiple option checklists, and open ended questions. Assessment topics fell into four main categories: 1) Prevalence of Mental Health Needs, 2) Availability of Services, 3) Barriers to Accessing Services, and 4) Impact of Stigma. As part of the community survey, participants were asked about personal experience with behavioral health. Of the 750 that answered the question, many represented a vulnerable population: 37% of respondents had a mental health condition, 23% cared for someone with a mental health condition, and 61% had a close family member or friend with a condition. These individuals were asked additional questions about their experiences with local services.

Community Survey (October 2021)	- Distributed across Huron, Lapeer, Sanilac, and Tuscola Counties - 1171 participants - Report produced for Service area by zip codes - 387 participants	A public survey was distributed online and on paper. The survey had four sections: 1) community strengths and weaknesses, 2) health priorities, 3) health system strengths and weaknesses, and 4) barriers to healthcare and wellness. The purpose of the survey was to gain a deeper understanding of contributing factors and community perceptions across a wide array of health issues. Vulnerable populations were widely represented in the MHS Service Area Report: - Senior Citizen, 41% or 82 people - Someone that experiences a mental health condition or disability or special education needs, 31% or 63 people - Low Income, 21% or 42 people - Healthcare or Human Service Provider that can speak for a wide variety of patients/people, 13% or 26 people - Veterans, 13% or 26 people - The Physically Disabled, 13% or 26 people - Someone with a Substance Use Disorder or Alcoholism or in recovery from substance use, 9% or 19 people - Victim of Domestic Abuse or Child Abuse, 6% or 13 people - People of a minority race or ethnic background, 4% or 8 people - Seasonal or part time resident, 3% or 7 people - People who are homeless, 2% or 5 people
McKenzie Health System		
Presentation and Survey of Hospital Foundation, Auxiliary, and Committees (July 2022)	Fifteen participants representing the hospital service area	The purpose of the survey was to obtain feedback from community leaders on the draft priorities and strategies. On a scale of 1 to 4 with 4 indicating highest need, there was support for all six draft priorities. Table on next page. The group also answered a question on reasons for choosing a provider with the top three reasons being: convenience, trust for the organization, and like the doctor. When asked about COVID-19, 40% of participants felt that worry or stress related to COVID-19 did NOT have a negative impact on their mental health, 47% felt that the pandemic had a minor impact on their mental health, and none reported a major impact. 13% were unsure. The group perceived that COVID-19 was handled well by the hospital: 57% - Very Good and 43% - Good.

	Weighted average
Awareness of Services	3.6
Access to Specialists	3.53
Access to In-Home Medical Care	3.47
Financial Assistance Programs and Health Insurance	3.4
Tele-Health Services	3.33
Prenatal Care	3.27
Behavioral Health	3
Chronic Disease	3
Access to Transportation	2.93
Social Determinants of Health	2.8

DEFINE THE COMMUNITY SERVED

Sanilac County is a rural county located in the Thumb of Michigan. A population of 40,747 resides in Sanilac County. Nearby counties with similar demographics include Huron and Tuscola County. The following chart showcases characteristics of the population. Source: www.countyhealthrankings.org

Demographics	Michigan	Huron	Sanilac	Tuscola
Population	9,966,555	30,653	40,747	52,289
% below 18 years of age	21.30%	19.00%	20.90%	20.20%
% 65 and older	18.20%	26.70%	22.80%	21.50%
% Non-Hispanic African American	13.70%	0.60%	0.50%	1.30%
% American Indian and Alaskan Native	0.70%	0.40%	0.70%	0.70%
% Asian	3.40%	0.70%	0.40%	0.40%
% Native Hawaiian/Other Pacific Islander	0.00%	0.00%	0.00%	0.00%
% Hispanic	5.40%	2.70%	4.10%	3.70%
% Non-Hispanic White	74.50%	94.80%	93.50%	92.90%
% not proficient in English	1%	0%	0%	0%
% Females	50.80%	50.30%	50.00%	49.70%
% Rural	25.40%	89.50%	90.20%	84.20%

In Sanilac County, the following data provides insight into quality of life for residents:

- Median income in 2020 was $51,200 in Sanilac County and $61,400 in Michigan.
- 2015 - 2019 poverty rate for Sanilac County was 15.1% and in Michigan was 14.4%.
- Percent of children under age 6 living in a household with income below poverty in Sanilac County was 26% and for Michigan was 22%.
- In 2021, Sanilac County had a 6% unemployment rate similar to Michigan.
- The 2015 - 2019 rate of people with a bachelor's degree or higher in Sanilac County was 14% and in Michigan it was 29% (2016 - 2020).
- In Sanilac County, 11% of adults are uninsured, and in Michigan, 8% of adults are uninsured.

Common Occupations and Industries include:

Manufacturing	22%
Educational services, and health care and social assistance	19%
Retail trade	11%
Construction	9%
Agriculture, forestry, fishing and hunting, and mining	7%
Arts, entertainment, and recreation, and accommodation and food services	7%
Professional, scientific, and management, and administrative and waste management services	5%
Public administration	5%
Finance and insurance, and real estate and rental and leasing	4%

ASSESSMENT FINDINGS

Data Sources: Three types of data sources were utilized during the Community Health Needs Assessment (CHNA): public health statistics, U.S. Census Data, and community survey results. The Team obtained the most recent data available. Whenever possible, data comparing county, regional, state, or national statistics was used. Major data sources for the 2022 report included:

- Michigan Department of Health and Human Services
  https://vitalstats.michigan.gov/osr/chi/IndexVer2.asp
- Michigan Behavioral Risk Factor Survey (BRFS)
  http://www.michigan.gov/mdhhs/0,5885,7-339-71550_5104_5279_39424-134707--,00.html
- Michigan Profile for Healthy Youth
  https://mdoe.state.mi.us/schoolhealthsurveys/ExternalReports/CountyReportGeneration.aspx
- County Health Rankings
  www.countyhealthrankings.org
- United States Census
  https://data.census.gov/cedsci/
- Great Start Data Set
  Great Start Collaborative compiled by the Michigan League for Public Policy

Priorities for the Thumb Region

In order to address complex health challenges more effectively, the Thumb Community Health Partnership facilitates a regional data workgroup. The workgroup reviews health indicator data quarterly and provides reports to partners. In 2021, the workgroup developed a regional process to support the needs assessment requirements of member organizations which include Public Health Departments, Mental Health Agencies, and hospitals. The TCHP Data workgroup identified regional data collection activities that provided local hospitals support for their organizational assessment. Partner assessments will be utilized for regional prioritization and planning.

The four health departments of the region, under the Michigan Thumb Public Health Alliance, developed a regional Community Health Improvement Plan. Seven regional goals were selected by the Alliance. The full document which includes county level priorities for all four counties can be found at www.thumbhealth.org/healthdata.

Goal 1: Improve Perinatal Health
Thumb Objective 1:1 - Reduce smoking during pregnancy
Thumb Objective 1:2 - Increase planned and initiated breastfeeding
Additional Sanilac County Objective: Objective 1:3 - Increase access to prenatal care

Goal 2: Reduce Adolescent Health Risks
Thumb Objective 2:1 - Decrease the use of tobacco and nicotine delivery devices by adolescents
Additional Sanilac County Objective: Objective 2:2 - Decrease marijuana use by adolescents

Goal 3: Reduce Chronic Disease Deaths
Thumb Objective 3:1 - Decrease deaths from cardiovascular disease
Thumb Objective 3:2 - Decrease use of tobacco and nicotine delivery devices by adults
Thumb Objective 3:3 - Decrease obesity
Additional Sanilac County Objective: Objective 3:6 - Increase participation in physical activity

Goal 4: Reduce Infectious Disease
Objective 4:1 - Increase adult immunization

Goal 5: Reduce the Impact of Substance Use Disorders
Objective 5:1 - Reduce substance use disorders

Goal 6: Reduce Injuries among Adults
Objective 6:1 - Reduce alcohol impaired accidents
Objective 6:2 - Decrease incidence of senior injuries

Goal 7: Increase Access to Safe Food, Water, Soil, and Air

Additional Sanilac County Goals & Objectives:

Goal 8: Reduce Childhood Illness & Injury
Objective 8:1 - Increase children receiving immunizations
Objective 8:2 - Increase lead testing for eligible children

Goal 9: Improve Mental Health
Objective 9:1 - Increase access to mental health services

Goal 10: Increase Oral Health
Objective 10:1 - Increase access to oral health services

IDENTIFIED PRIORITIES

The McKenzie Health System CHNA Team analyzed the results from the 2021 Community Health Survey and compared it to priorities from 2019.

2021 Community Input Survey - McKenzie Health System Service Area

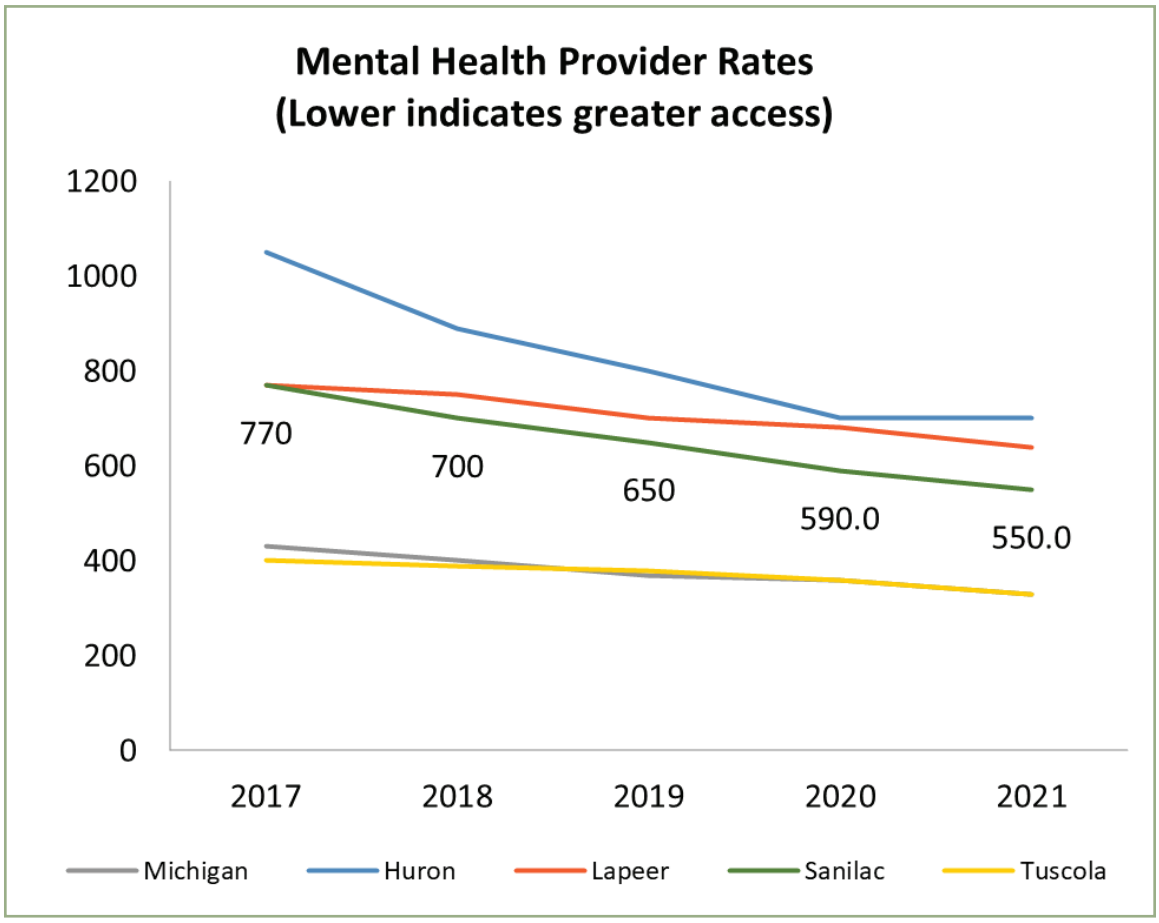
Items identified as Strengths in the Community Survey	Items rated in the middle of the Weakness - Strength Scale	Items rated as Weakness and ADDRESSED in 2019 McKenzie CHNA	Items rated as Weakness and NOT addressed in 2019 McKenzie CHNA
Non-Intentional Injuries	Prenatal and Infant Health	Mental Health & Services	Tobacco Use and Vaping
Violence	Homelessness	Substance Use Disorders and Treatment	Cancer
Infectious Disease	Food/Hunger	Chronic Disease	Prenatal Care
Dental Health	Poverty	Specialist Services	COVID-19
Safety/Crime	Vision Services	Use of Tele-Health	Affordable Quality Housing
Environmental Health	Convenient Services	Financial Assistance Programs	In-Home Medical Care
Primary Care Services	Having enough healthcare staff to meet needs	Access to Health Insurance	Assisted Living Facilities
Emergency Medical Services		Awareness of Services	Long-Term Inpatient Nursing Homes
COVID-19 vaccinations and testing		Transportation	Access to Childcare and Preschool
Other child and adult immunizations			Veterans Services
Privacy and Confidentiality			Internet Connectivity
Personal Care Staff			Electronic Medical Records
			Coordination of Services between Providers

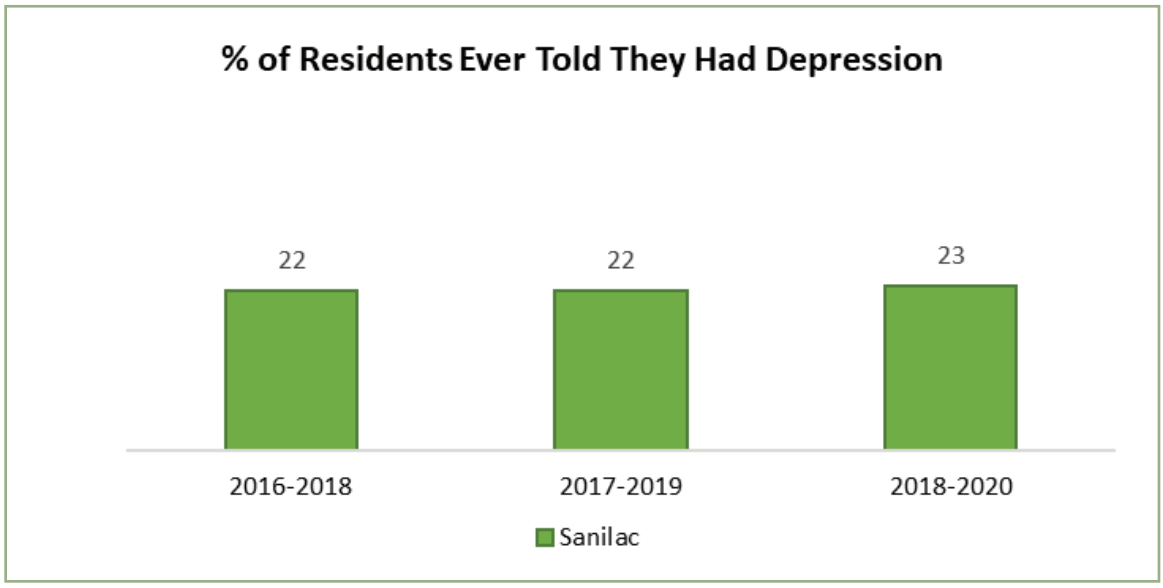
Health indicator data was also reviewed. Based on this analysis, the following priorities were identified.

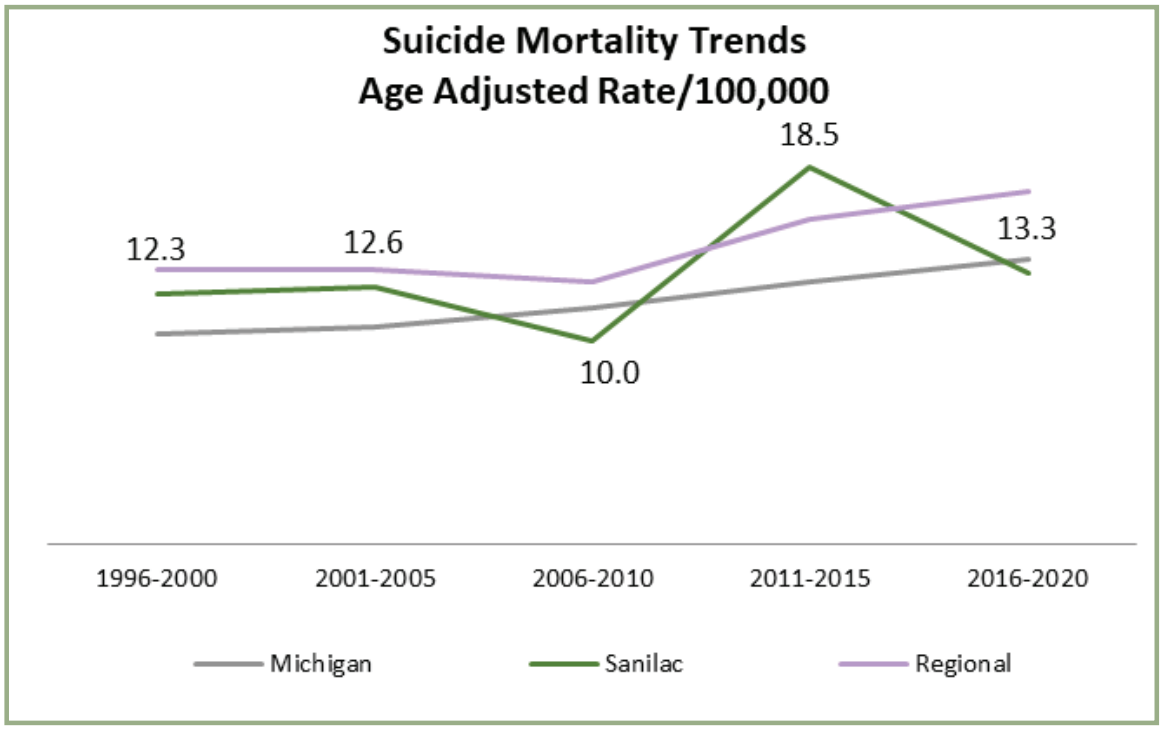
1. Behavioral Health	Behavioral health is a broader term that includes both Mental Health Conditions and Substance Use Disorders. Patients often experience conditions in both categories which requires a comprehensive approach to treatment.
2. Chronic Disease	Chronic disease includes illnesses that persist over time, can progress over time, do not resolve on their own, and may not be cured. Emphasis for the CHNA include Heart Disease and Diabetes.
3. Social Determinants of Health	There are often conditions in a community that affect a wide range of health risks and outcomes. The CDC groups these into five categories - Healthcare Access and Quality, Education Access and Quality, Social and Community Conditions, Economic Stability, and the Community Environment.
4. Awareness of Services	Despite active marketing of services, it is difficult to ensure that the public is aware of available services. Messages may be overlooked or forgotten due to lack of a current need. It is only later when a need is identified that people try to learn about services.
5. Access to Specialists	Healthcare Access and Quality can be divided into two subcategories. Are the services available? What barriers prevent members of the community from accessing the available services?
6. Tele-Health Services	Tele-Health is a strategy that can make additional services available in the local community and increase access for people who are homebound or have transportation barriers.

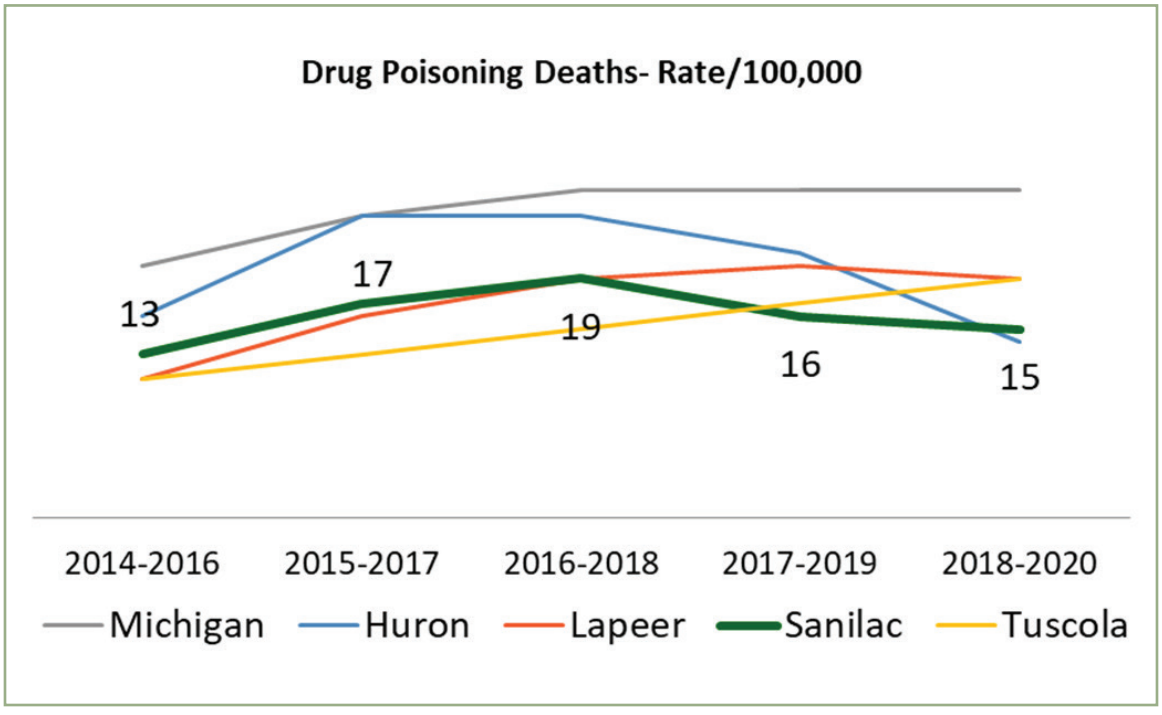
7. Access to In-Home Medical Care	Providing services in the home can increase access for people who have health conditions that limit mobility or have transportation barriers. Well-timed In-Home services can identify health symptoms, increase understanding of discharge instructions, and reduce the need for higher levels of medical care which can be costly and result in more serious health outcomes.
8. Transportation Barriers	Transportation in a rural community can present unique challenges including lack of a private vehicle, fuel costs, few public transportation options, and limited hours or locations of public transportation services.
9. Financial Assistance Programs and Health Insurance	It is a challenge for many to obtain affordable health insurance. While supports may be available, understanding the enrollment process and options offered for various plans or public assistance programs can be confusing. Some individuals may opt for low-cost plans without understanding the plan benefits, deductible, and co-pays. Reluctance to share financial information or accept help may be barriers for some people who would be eligible for public or hospital programs.
10. Prenatal Care	Two counties in the Thumb, Sanilac and Tuscola, do not have local obstetrics and birthing facilities. Access to prenatal services and prenatal health is critical to a healthy birth and early child development.

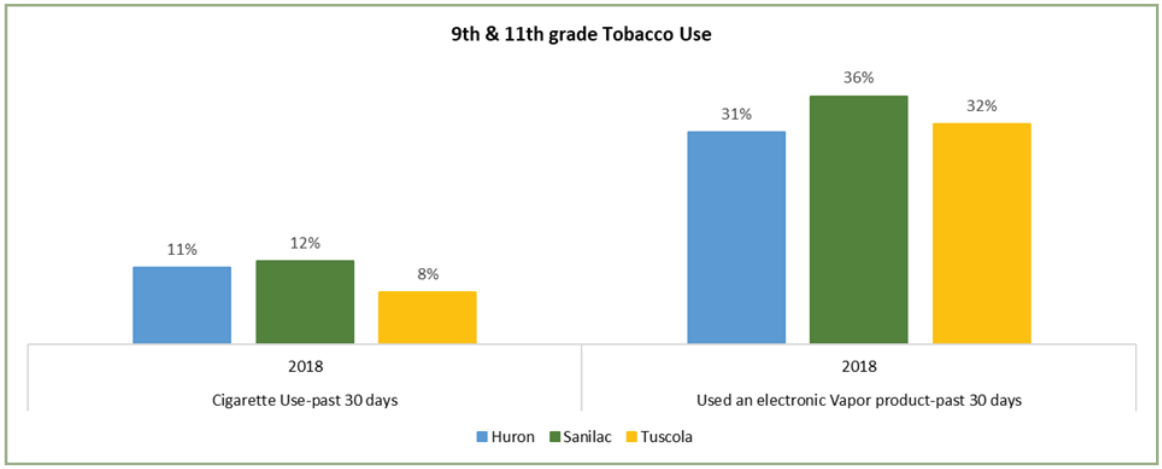
1. BEHAVIORAL HEALTH

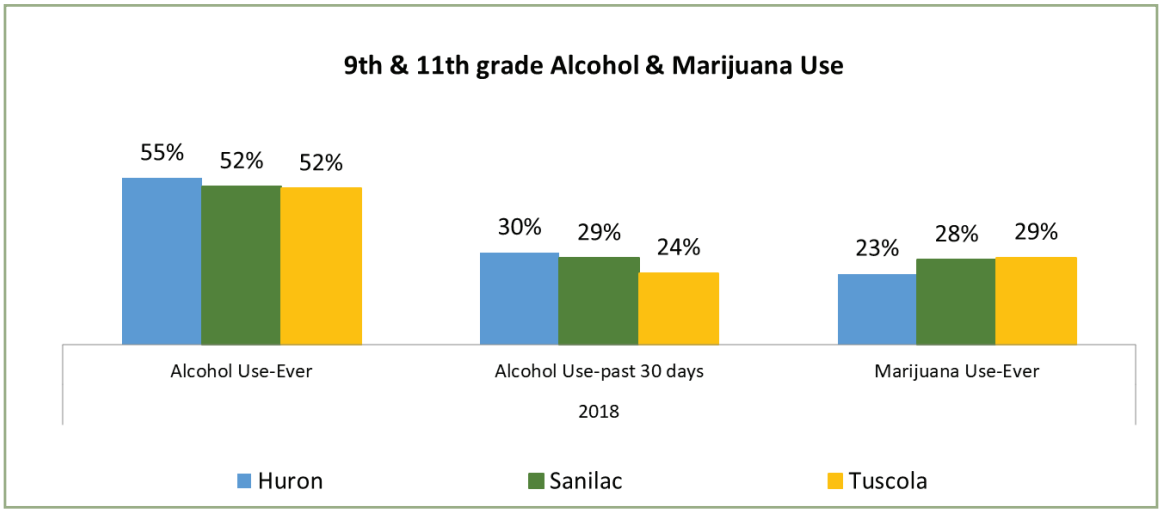




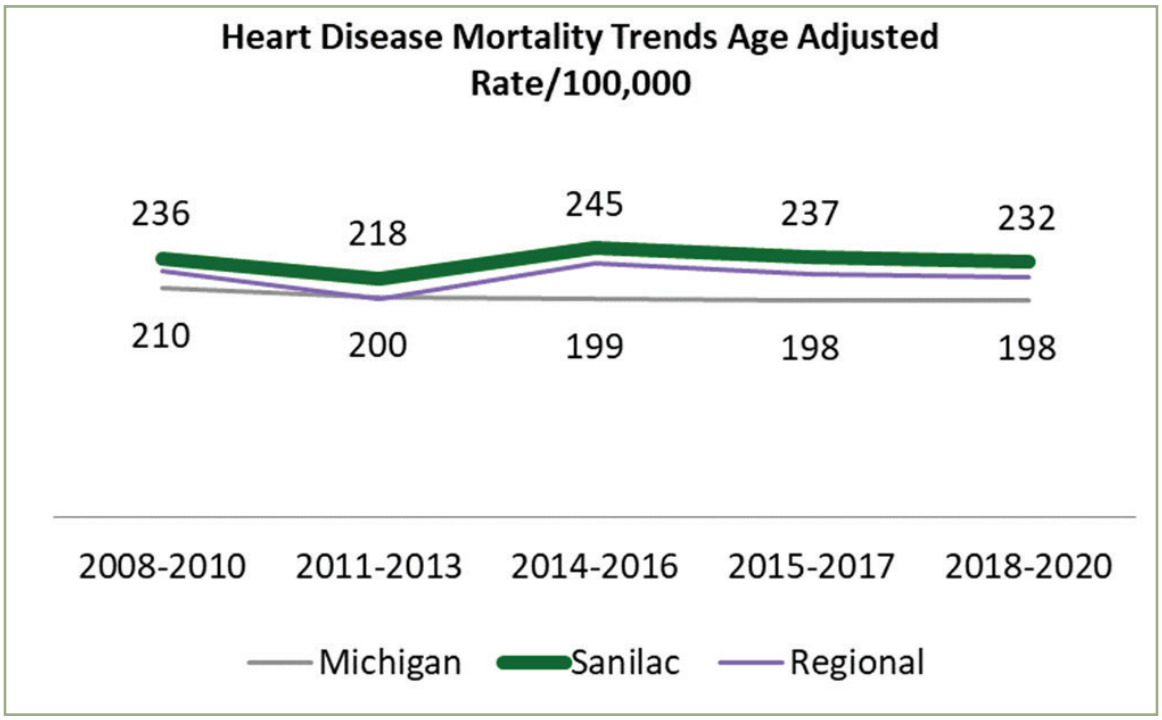

Suicide Mortality Trends
Age Adjusted Rate/100,000
18.5
12.3
12.6
13.3
10.0
1996-2000
2001-2005
2006-2010
2011-2015
2016-2020
Michigan
Sanilac
Regional

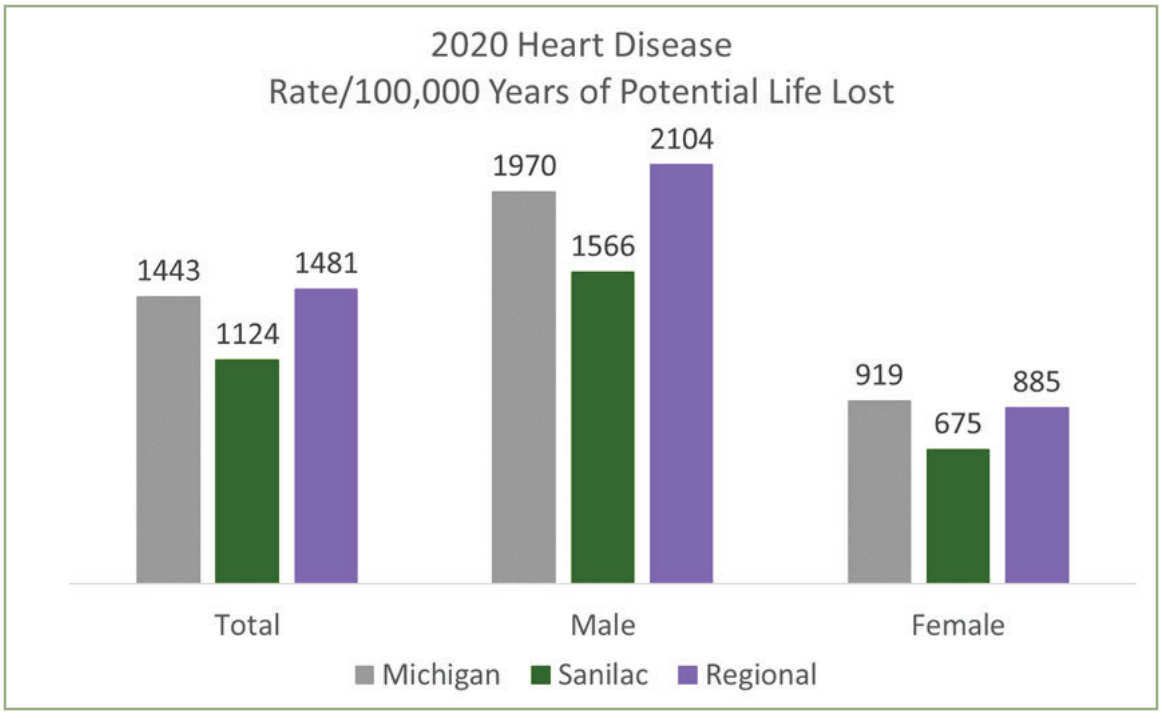

Drug Poisoning Deaths- Rate/100,000
17
13
19
16
15
2014-2016
2015-2017
2016-2018
2017-2019
2018-2020
Michigan
Huron
Lapeer
Sanilac
Tuscola

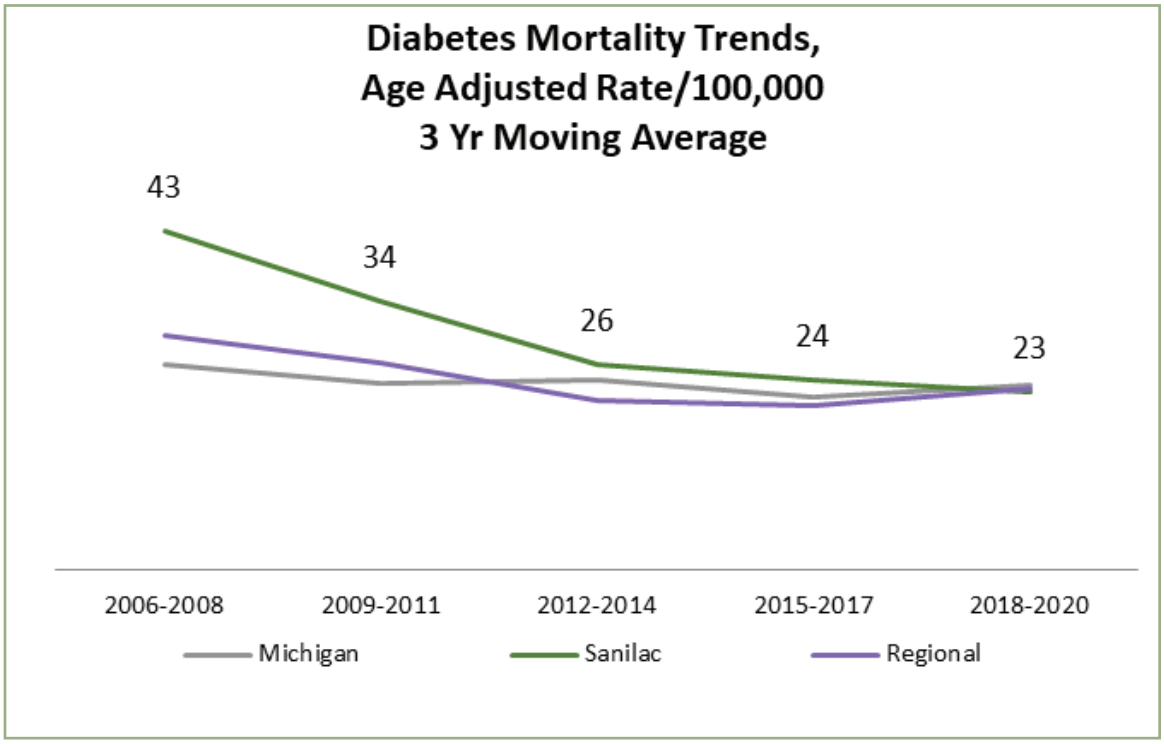

9th & 11th grade Tobacco Use
11%
12%
8%
31%
36%
32%
2018
Cigarette Use-past 30 days
2018
Used an electronic Vapor product-past 30 days
Huron
Sanilac
Tuscola

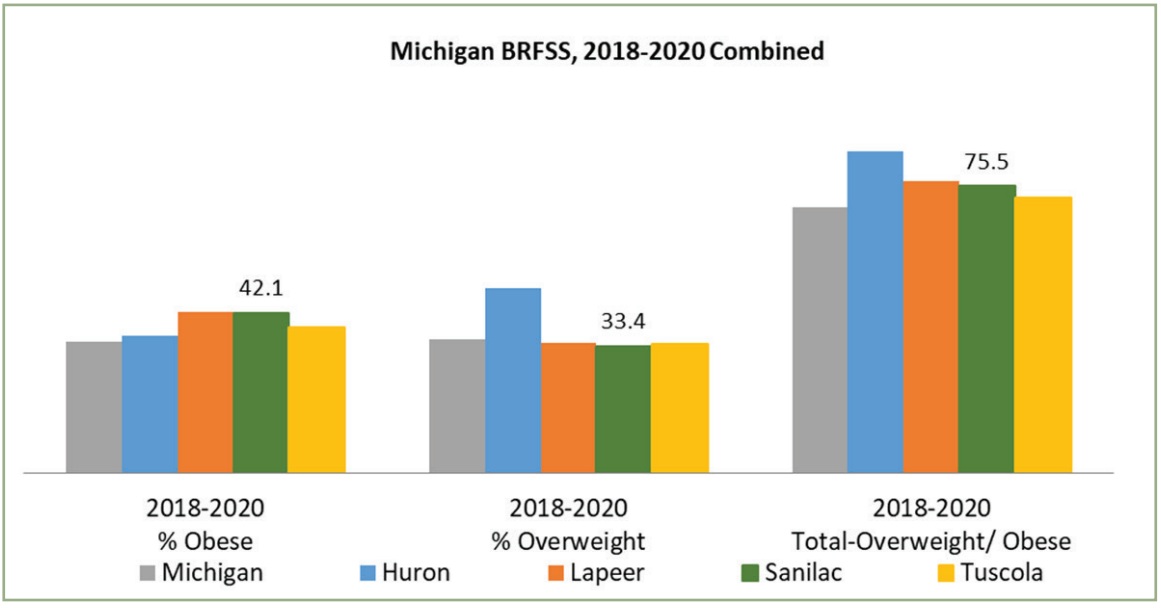

9th & 11th grade Alcohol & Marijuana Use
55%
52%
52%
30%
29%
24%
23%
28%
29%
Alcohol Use-Ever
Alcohol Use-past 30 days
Marijuana Use-Ever
2018
Huron
Sanilac
Tuscola

2. CHRONIC DISEASE

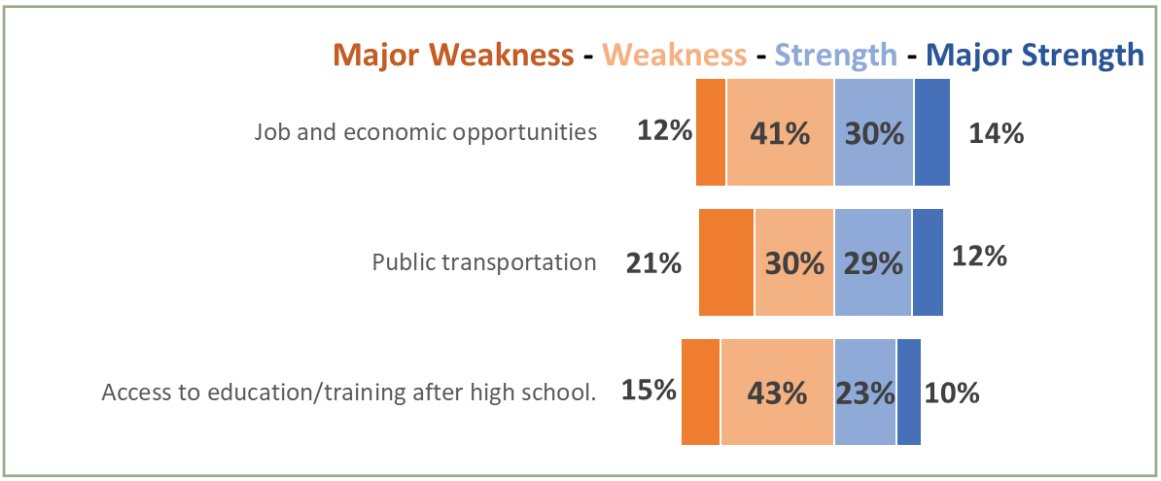





Diabetes Mortality Trends,
Age Adjusted Rate/100,000
3 Yr Moving Average
43
34
26
24
23
2006-2008
2009-2011
2012-2014
2015-2017
2018-2020
Michigan
Sanilac
Regional


Michigan BRFSS, 2018-2020 Combined
42.1
33.4
75.5
2018-2020
% Obese
2018-2020
% Overweight
2018-2020
Total-Overweight/ Obese
Michigan
Huron
Lapeer
Sanilac
Tuscola

3. SOCIAL DETERMINATES OF HEALTH



ACCESS TO SERVICES

4. Awareness of Services - 49% of Community Health Survey Respondents indicated that awareness of services is a weakness.

5. Access to Specialists - 59% of Community Health Survey Respondents indicated that specialist services were a weakness.

6. Tele-Health Services - 45% of Community Health Survey Respondents indicated that internet connectivity is a barrier to tele-health services.

7. Access to In-Home Medical Care - 36% of Community Health Survey Respondents indicated that In-Home medical services were a weakness.

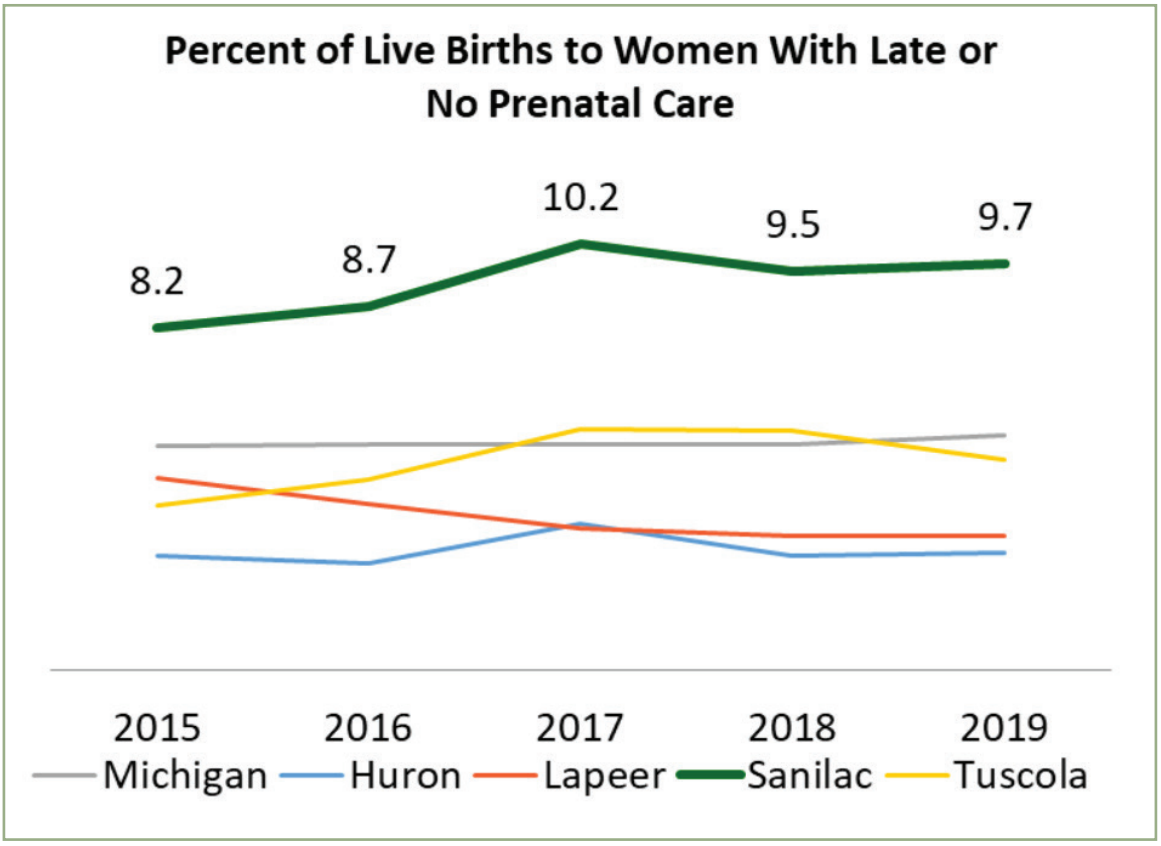
8. Transportation Barriers - 52% of Community Health Survey Respondents indicated that transportation is a community weakness.

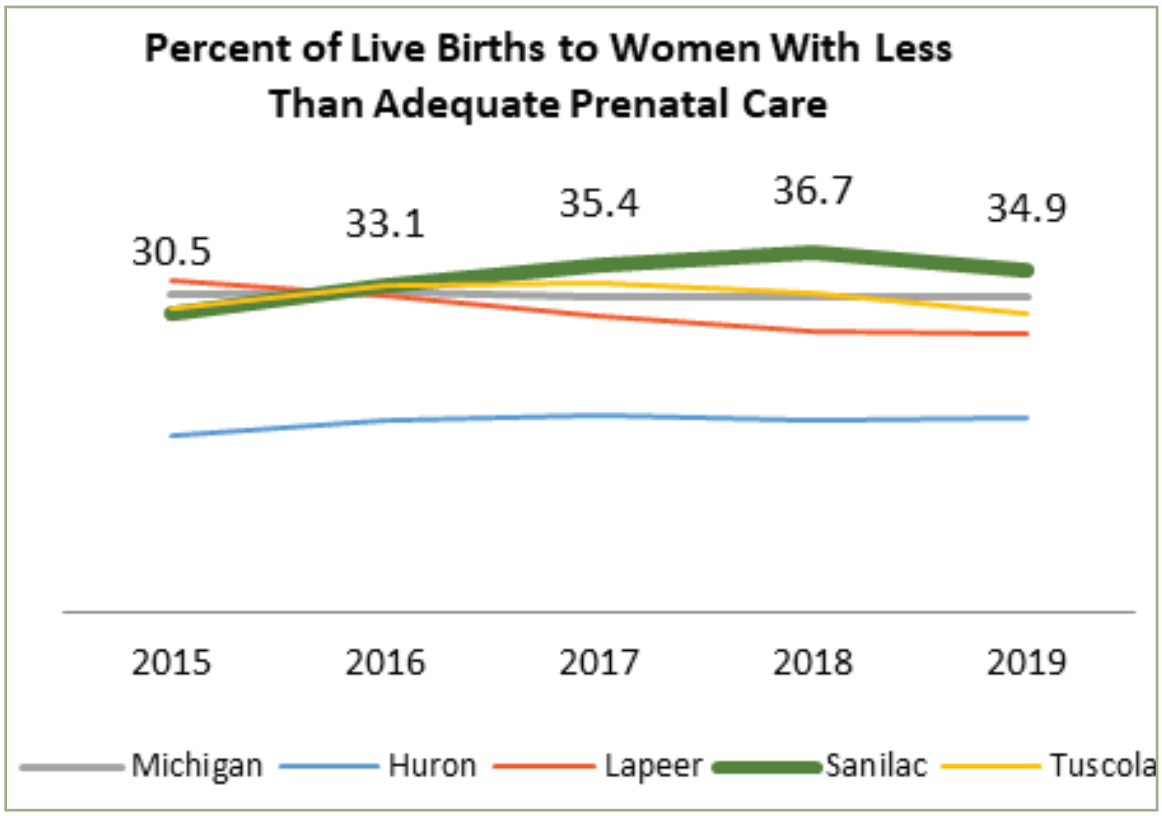
9. FINANCIAL ASSISTANCE PROGRAMS AND HEALTH INSURANCE

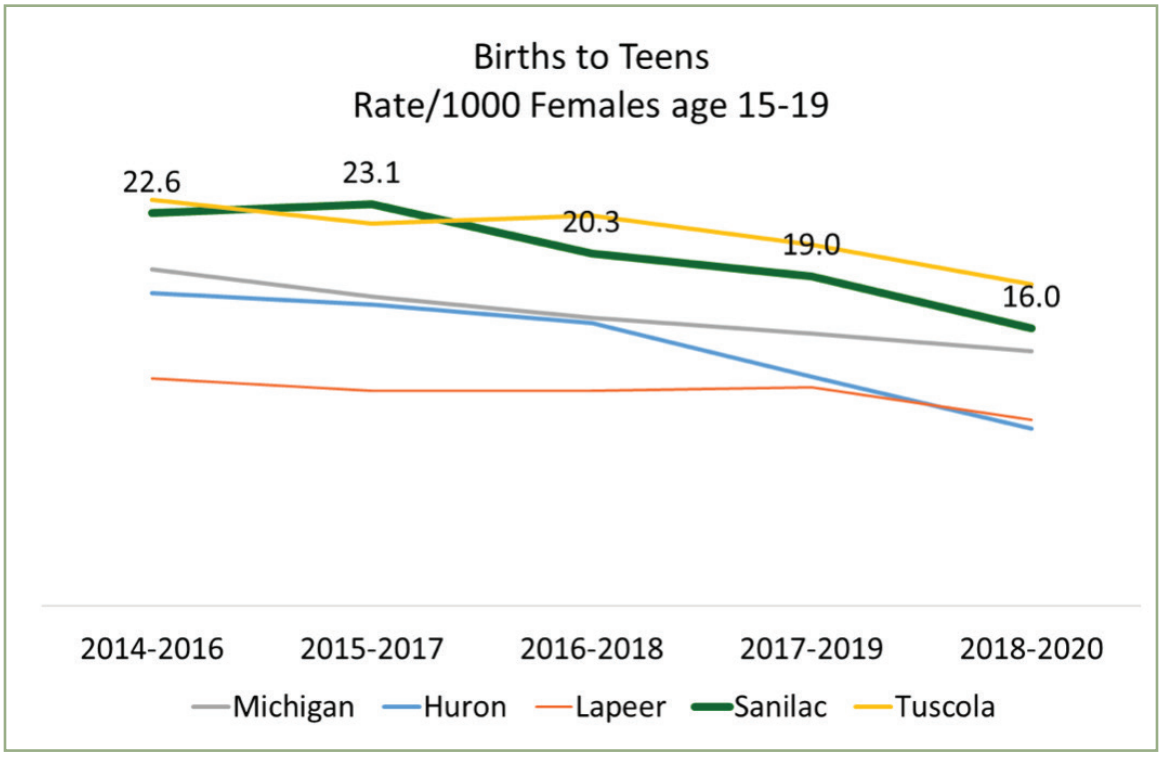
37% of Community Health Survey Respondents indicated that financial assistance programs offered by providers were the largest weakness.

	Michigan	Huron	Sanilac	Tuscola
Uninsured adults	8%	10%	11%	9%
Uninsured children	3%	4%	6%	3%

10. PRENATAL CARE




Percent of Live Births to Women With Less Than Adequate Prenatal Care
30.5
33.1
35.4
36.7
34.9
2015
2016
2017
2018
2019
Michigan
Huron
Lapeer
Sanilac
Tuscola


Births to Teens
Rate/1000 Females age 15-19
22.6
23.1
20.3
19.0
16.0
2014-2016
2015-2017
2016-2018
2017-2019
2018-2020
Michigan
Huron
Lapeer
Sanilac
Tuscola

2019 CHNA IMPLEMENTATION PLAN AND PROGRESS

Chronic Diseases: Strategies/Activities	Status Update
1. Continue to grow Chronic Care Management (CCM) and transitional care programs 2. Integrated dietician visits at primary care offices 3. Explore community paramedicine to address chronic diseases 4. Acute Heart Attack Ready 5. Cardiac outpatient rehab 6. Continue to focus on and promote annual wellness visits and screenings 7. Continue to monitor and promote community and hospital programs	1. Added another Chronic Care Manager and CCM have been moved out into the physician offices. 2. Implemented dietician visits at primary care office. However, providers can refer to our new dietitian. 3. Started a community paramedic program in 2021. 4. Recertified for another three years. 5. Cardiac and pulmonary rehabilitation is in place. 6. CCM do majority of AWV. Implemented new software that alerts providers in live time of this need. 7. Programs are promoted through Town Halls and the new website.
Access to Care: Strategies/Activities	**Status Update**
1. Continue community presentations 2. Continue partnerships with schools and other organizations 3. Continue to use a variety of methods to reach audiences of all ages and vulnerable populations 4. Continue to assist individuals in reducing cost barriers to accessing care. 5. Explore use of community paramedicine to increase access to care 6. Partnering with new PACE programs will reduce transportation and other access barriers 7. Continue to monitor needs and opportunities for additional specialist services (i.e. pulmonology, neurology)	1. COVID-19 stopped some of this. Town hall meetings were held and recorded. Go Red Ladies Night, Healthy Living lunch and learn have continued. Both are currently virtual and are recorded and placed on Facebook and YouTube. People can call into these events if they don't have internet access. 2. Ongoing communication to remain aware of opportunities for participation and engagement. 3. Nothing specific to vulnerable population. See #1 above. 4. Staff member certified for Medicaid and Medicare and will now be certified as a navigator for Healthcare Market Place. 5. Community Paramedic (CP) Program was implemented in 2021. CPs will help patients connect to tele-health visits using our iPad. 6. None. 7. Added a GI specialist, lipedema treatment, MAT, and acupuncture.

Behavioral Health: Strategies/Activities	Status Update
1. Partner in Intercept Program 2. Emergency department consultations with social work and tele-psychiatry 3. Explore behavioral health integration with primary care 4. Partner on a Rural Communities Opioid Response Program planning grant 5. Explore Medication Assisted Treatment (MAT) in primary care clinics; Implement MAT expansion grant received from the Office of Rural Health Policy	1. Still involved in the Intercept Program, but due to COVID-19 there have been delays. 2. Social work and tele-psychiatry in place for O/P. 3. Working on this. 4. MAT program 5. MAT Program

ADDITIONAL DOCUMENTS

(Available Upon Request)

The following documents support the findings and the work completed during the Community Health Needs Assessment Process.
They are available upon request by contacting Amy Ruedisueli, Chief Financial Officer at aruedisueli@mckenziehealth.org or 810-648-6162.

- Planning Timeline
- Thumb Community Health Partnership Data Dashboard and County Health Indicator Recordings
  https://www.thumbhealth.org/healthdata
- 2021 Behavioral Health Needs Assessment Report
  https://www.thumbhealth.org/_files/ugddc955f_1d4d3f2b8660477886bb0e6c0f64ee71.pdf
- 2022-2026 Thumb Community Health Improvement Plan
  https://www.thumbhealth.org/_files/ugd/dc955f_dc87a73fdacc4bbd8bdabf9afb45130e.pdf
- 2021 Community Survey Instrument
- 2021 MHS Service Area Community Survey Report
- Prioritization Analysis
- 2022 Implementation Plan

MCKENZIE HEALTH SYSTEM RESPONSE
2022 COMMUNITY HEALTH NEEDS ASSESSMENT IMPLEMENTATION PLAN

This document outlines McKenzie Health System's (MHS) response to the priority health needs identified in the hospital's 2022 Community Health Needs Assessment (CHNA). The assessment process used by McKenzie Health System expanded on a regional assessment process led by the Thumb Community Health Partnership. Once MHS priorities were selected, the CHNA Team discussed work already completed as part of the 2019 CHNA Implementation Plan and existing services and programs. Gaps in services were identified and strategies were developed. This plan will be used to guide activities over the next three years. An annual report will be prepared and provided to meet CHNA requirements.

McKenzie Health System has many programs and strategies in place to address identified health needs. Existing strategies and programs will be maintained and strengthened as opportunities arise.

Priority	Strategy	Lead Person
1. Behavioral Health	a. Explore behavioral health integration with primary care.	Billi Jo Hennika
	b. Emergency department consultations with social work and tele-psychiatry.	Rebecca Stoliker
	c. Implement the Collaborative Care Model.	Billi Jo Hennika & Heather Chambers
	d. Change MAT focus to identify mental health and SUD DX, identify risk factors, and provide intervention at PCP.	Billi Jo Hennika
	e. Collaborate with various community partners to address emerging substance use.	Rebecca Stoliker
2. Chronic Disease	a. Continue to grow Chronic Care Management (CCM) and transitional care programs.	Heather Chambers
	b. Increase access to dietitian services and education services (i.e. integration at primary care offices, certified diabetic educator).	Billi Jo Hennika & Heather Chambers
3. Social Determinates of Health	See 8 and 9 below.	

Priority	Strategy	Lead Person
4. Awareness of Services	a. Continue to work with community partners to educate the public and raise awareness about health needs and services.	Nina Barnett and Gloria Jerome
5. Access to Specialists	a. Continue to monitor needs and opportunities for additional specialist services (i.e. pulmonology, neurology) .	Billi Jo Hennika
6. Tele-Health Services	a. Continue to explore and educate people on tele-health (i.e. community education and health services).	Billi Jo Hennika
7. Access to In-Home Medical Care	a. Continue the use of community paramedicine to increase access to care (i.e. chronic disease management, ER follow up, reducing barriers to care).	Rebecca Stoliker
8. Transportation Barriers	a. Evaluate and make improvements as needed related to screening and referral practices for Social Determinants of Health needs. b. Investigate how local transportation services are accessible especially related to wheelchair accessible transportation in and out of county. c. Utilize best practices to meet individuals where they are thereby reducing transportation barriers.	Heather Chambers Louise Blasius Billi Jo Hennika, Heather Chambers, and Rebecca Stoliker
9. Financial Assistance Programs and Health Insurance	a. Continue to assist individuals in reducing cost barriers to accessing care. b. Navigator Grant Program	Louise Blasius & Amy Ruedisueli Louise Blasius
10. Prenatal Care	a. Work with community partners to identify strategies to improve access to timely prenatal care and ensure perinatal health.	Steve Barnett

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