Results of the Community Health Needs Assessment Survey and Focus Groups

A Report to Marlette Regional Hospital

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Executive Summary

This report is a primary data source that complements other primary and secondary data sources collected by Marlette Regional Hospital for its 2016 Community Health Needs Assessment. The primary data contains information from the Thumb CHNA Collaboration Community Health Survey developed and distributed by hospitals and public health departments in Huron, Sanilac, and Tuscola Counties. Marlette Regional Hospital distributed surveys in thirteen ZIP codes in its service area and posted the survey on-line. Marlette Regional Community also held a focus group of three men and six women, all of whom were senior citizens. They represented agriculture, faith community, schools, hospital, and the rotary club. Key stakeholder interviews were held with four individuals from three key county organizations: William (Bill) Weston, Director for Sanilac County, Michigan Dept. Of Health and Human Services; Jamie Reinke, Sanilac County Program Manager; Jim Johnson, Executive Director, Sanilac County Community Mental Health; and Duane Lange, Superintendent, Sanilac Intermediate School District.

The survey findings are based on the responses of 563 individuals, most of whom were female (78.8%). well educated (59.9% with some college degree), and about one-third (32.0%) with household incomes of $75,000 or more.

The survey covered five areas of concerns: community's health, quality of life, availability of health services, safety and environment, delivery of health services, and vulnerable populations (seniors, females, low education, and low income). It also asked about preventing access to care. Many of the concerns were about access to and availability of health care providers as well as the costs of health care. Youth obesity, drug use, and bullying were also of concern. Quality of life concerns were related to jobs and attracting young families.

Like the survey respondents, the focus group identified the cost of health insurance and cost of health care services as top concerns. In addition, alcohol and drug use and abuse by adults, drug use and abuse among youth, and obesity/overweight were top concerns.

The focus group thought the major challenges facing the community were better jobs, drug and substance abuse. They mentioned empty buildings and blight, which is usually associated with inner city urban areas. They considered the elderly and low income residents to be medically underserved and suggested providing transportation for them. They indicated that residents appear to choose hospitals outside of the area when specialties are not offered or due to concerns about privacy/confidentiality in small towns.

The stakeholders mentioned the loss of factory jobs, poor housing conditions, and a lack of public transportation. The community needed both mental health and dental service. They wanted a year round recreation/sports facility for adults and youth as well as child care facilities. Stakeholders urged providers to improve collaboration and communications, especially at the case management level.

These findings are consistent with Marlette Regional Hospital and other local hospitals being located in a rural, medically underserved community.

Background and Objectives

The Affordable Care Act (ACA) of 2010 requires hospitals to conduct a Community Health Needs Assessment (CHNA) to identify health issues encountered in a hospital's service area as well as to develop possible strategies to address these issues, adopt an implementation plan at least every three years, and be prepared to monitor and measure its progress.[1]

The first round of CHNAs was carried out in 2012-2013. A second round begins in 2016. In August 2015, the Michigan Center for Rural, Hospital Council of East Central Michigan, and Thumb Rural Health Network convened a discussion group around the CHNA process in Huron, Sanilac, and Tuscola Counties often referred to as the Thumb of Michigan. The eight hospitals and three public health departments in the Thumb were invited to this conversation. They agreed to develop and administer a common survey of community members and use the same set of questions for focus groups and key stakeholder interviews. Each hospital would receive the results for its service area based on the ZIP code of respondents to the survey. The individual hospital will include the findings from the survey, focus groups and key stakeholder interviews in identifying gaps, setting priorities, and then creating and implementing a plan to address the gaps. The use of a common survey instrument, focus group and interview schedules will permit aggregating the hospital data by county and by the three county Thumb region. This could enable cooperative initiatives within counties and the region.

The Thumb CHNA Collaboration included representatives from the hospitals and health departments and met several times to develop a survey instrument and questions/topics for the focus groups and stakeholder interviews. They consulted with Lynette Dickson and Karin L. Becker from the Center for Rural Health (CRH), University of North Dakota, School of Medicine & Health Sciences about conducting CHNAs in rural areas.[2] A training was provided in December 2015 regarding the CHNA process used in North Dakota in 2013. The CRH process included conducting a community survey, focus groups and interviews with key informants. The CRH conducted 21 CHNAs for hospitals in North Dakota utilizing the same CHNA methodology which generated a more consistent dataset that could be analyzed across hospitals. The aggregated data and findings most likely present a more representative view of the population than data from a single hospital.[3]

[1] Ackerman, B. Van Ochten, K.. (nd). The Patient Protection and Affordable Care Act: Newly Required Community Health Needs Assessments. *Health Planning Source*. Available at: *https://www.ncha.org/doc/385*
[2] Becker, K. L. (2015). Conducting Community Health Needs Assessments in Rural Communities *Health Promotion Practice*, 16:15-19
[3] Becker, K.L. (2013). *Emerging Health Trends in North Dakota: Community Health Needs Assessments Aggregate Data Report.* Grand Forks, ND: Center for Rural Health, University of North Dakota, School of Medicine & Health Sciences.

Survey Methods

Purpose

The purpose of the Community Health Survey is to:

- Learn about the good things in the community as well as concerns in the community.
- Understand perceptions and attitudes about the health of the community.
- Gather suggestions for improvement.
- Learn more about how local health services are used by community residents.

Sample/Target Population

The Thumb CHNA Collaboration members decided to use non probability sampling, combining convenience sampling with purposive (judgmental) sampling. In a convenience sample respondents can be anyone who happens to come into contact with the researcher or has access to the survey from people on a street corner or in a mall to those who come across the survey on line. In a purposive sample respondents are recruited based on some characteristic which will be useful for the study.[4] For example, a purposive CHNA survey would target members of block clubs and religious congregations in low income neighborhoods or seniors residing in independent living and assisted living facilities.

In addition, a mixed sampling design should gather a sufficient number of low income, low education and senior citizens to permit an analysis of their health concerns and views on health care services. Finally, since each hospital will be using the same survey methodology, the results can be analyzed and compared. Although the findings cannot be generalized, they can point out common needs and solutions.

Survey Instrument and Procedures

The survey instrument contained 34 questions covering Community Assets, Community Concerns, Delivery of Health Care and Demographic Information. The survey was printed and posted on line using SurveyMonkey. The survey instrument is in Appendix A.

Printed surveys were not mailed out. Each county developed a distribution list identifying public locations for envelopes and surveys. Marlette Regional Hospital is located in Marlette, Sanilac County, Michigan. Surveys were also distributed at meetings and at the end of focus groups. Printed surveys could be left in drop boxes or mailed in to the Institute for Public Policy and Social Research (IPPSR) at Michigan State University.

An on-line version of the survey was posted at SurveyMonkey. Survey links were included in press releases and regional promotion efforts through radio. Links were distributed by direct email and forwarded to hospitals and service providers who could forward it to their staff and their email patient base.

[4] Babbie, E. (2013). *The Practice of Social Research*: 13th Edition. Belmont, CA: Wadsworth Thomson p 190-91.

Surveys were entered and data sets prepared by IPPSR. Focus group and interview notes were recorded by the Michigan Center for Rural Health (MCRH) with summaries provided for analysis. Both IPPSR and MCRH are located at Michigan State University. Data were analyzed using the Statistical Package for the Social Sciences (SPSS) Version 20 multiple response sets frequencies and cross-tabulations.

Respondent Characteristics

The findings are based on the responses of 563 individuals who completed the survey by March 15, 2016 and live in the thirteen ZIP codes served by Marlette Regional Hospital and its five family healthcare offices: 48416 (Brown City, 48426 (Decker), 48453 (Marlette), 48454 (Melvin), 48466 (Peck), 48471(Sandusky), 48472 (Snover), 48435 (Fostoria), 48741 (Kingston), 48744 (Mayville), 48461 (South Branch), 48727 (Clifford) and 48760 (Silverwood). Of the 563 respondents, one-third (34.5%) lived in 48471 (Sandusky) and one-quarter (25.8%) lived in 48453 (Marlette) where the hospital is located.

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

The respondents were predominantly female (78.8%). Almost all (95.8%) self identified as White/Caucasian. Three quarters (78.8%) were currently married or remarried. Only 42.1% of households had children under 18. Three-fifths (59.1%) were employed full-time. About three-fifths (57.7%) had health insurance through their employer or union, 8.6% indicated they purchased health insurance from an insurance company or healthcare.gov, and only 1.5% reported not having any health insurance.

In terms of vulnerable populations, seniors 58 or older accounted for a little over one quarter (26.3%) of respondents; those with a high school education or less account for 20.6% of the respondents, and 21.0% of respondents reported annual household incomes $24,999 or less.

Table 1: Demographic highlights

Age	Respondents were asked their year of birth which was then recoded into quartiles. Of the valid cases, 25.7% were 37 or younger, 24.5% between 38 and 51, 23.5% between 52 and 60, and 26.3% were 61 or older.
Gender	Over three-fourths of the respondents were female (78.8%).
Marital Status	Over two-thirds (69,6%) were married
Children	Only 42.1% of households had children under 18
Education	One-fifth (20.6%) had a high school diploma or less, 19.2% some college, 17.4% a technical/jr college degree, 22.1% a bachelor's degree and 20.4% a graduate or professional degree.
Employment Status	Almost three-fifths (59.1%) worked full time, 15.3% worked part time and 3.3% held multiple jobs. Retirees accounted for 15.3%.
Health Sector	A little over one-quarter (27.7%) worked for hospital, clinic or public health dept.
Race	95.8% self identified as White/Caucasian
Household income	One--fifth (21.0%) had incomes $24,999 or less; about one-quarter (23.4%) between $25,000 and $49,999), another quarter (23.6%) between $50,000 and $74,999) and about one-third (32.0%) $75,000 or more.
Health Insurance	Almost three-fifths (57.7%) had health insurance through an employer or union, 8.6% were on Medicare, and 8.6% individually purchased a plan. Oonly 1.5% reported not having any health insurance
Hospitals used past 2 years	Over one-third (35.8%) used Marlette Regional Hospital and 23.8% used McKenzie Health Systems (Sandusky).
ZIP Codes	One-third (34.5%) lived in Sandusky, one-quarter (25.8%) in Marlette and 12.6% in Brown City.

Survey Findings

Survey results for community assets and concerns are in Appendix C. The main focus of this analysis is to identify problem areas that prevent access to health care and the concerns of vulnerable groups—seniors, low education and low income regarding health and health care.

Preventing Access to HealthCare

Table 2 contains responses to Q17. Please rate how much the following issues prevent you or other community residents from receiving health care. Responses were on a four point scale from 1 = not a problem to 4 = major problem. Means and standard deviations were calculated for each.

Table 2: Q17 Issues prevent receiving health care

In this table, a higher mean score indicates a higher perceived problem.	N	Mean	Std. Deviation
Q17. Not enough evening or weekend hours	533	2.44	1.30
Q17. Not enough specialists	528	2.38	1.30
Q17. Not able to get appointment/limited hours	532	2.16	1.14
Q17. Not enough doctors	520	2.15	1.24
Q17. Don't know about local services	528	1.96	1.13
Q17. Distance from health facility	530	1.94	1.10
Q17. Not able to see same provider over time	530	1.83	1.14
Q17. Can't get transportation services	533	1.80	1.15
Q17. Not accepting new patients	523	1.74	1.17
Q17. Poor quality of care	516	1.58	0.99
Q17. Barriers to accessing veterans services	517	1.50	1.31
Q17. Concerns about confidentiality	525	1.36	0.93
Q17. Lack of disability access	524	1.31	0.87
Q17. Limited access to telehealth technology	517	1.28	1.24
Q17. I am afraid or too uncomfortable to go	504	1.25	0.91
Q17. Don't speak language or understand culture	528	1.13	0.69
Q17. I have other more important things to do	503	1.06	0.85

The table reveals four items with means between 2.00 and 3.00— not enough evening or weekend hours (μ=2.44), not enough specialists (μ=2.38), not able to get appointment/limited hours (μ=2.16), and not enough doctors (μ=2.15). These are considered to be high minor or low major problems. All refer to the supply of physicians which is highly dependent on the ratio of physician per 100,000 population and is endemic in rural and semi-rural counties. Sanilac County, in which Marlette Regional Hospital is located, had a population of 43,114 in 2010.[5]

Table 3 contains responses to Q16: "What cost considerations prevent you or other community residents from receiving health services?" Respondents were encouraged to choose ALL that apply. Table 3 shows that the number one cost consideration preventing receiving health services was high deductable or co-pay with 38.2% of the responses. Over four-fifths (83.7%) of the respondents names this cost consideration. The second largest was not having insurance with 42.9% of all respondents followed by not affordable insurance.

[5] Population of Michigan Counties 2000 and 2010. Available at http://www.michigan.gov/cgi/0,1607,7-158-54534-252541--,00.html

Table 3. Q16 Cost considerations prevent receiving health services

		Times chosen	Percent times chosen	Percent of Respondents choosing
Q16[a]	Q16. High deductible or co-pays	410	38.2	83.7
	Q16. No insurance	210	19.6	42.9
	Q16. Not affordable Services	169	15.7	34.5
	Q16. Insurance denies services	161	15.0	32.9
	Q16. Providers do not take my insurance	124	11.5	25.3
Total		1074	100.0	219.2

a. Dichotomy group tabulated at value 1.

That respondents picked high deductibles and copays, is not surprising. In theory both deductibles and copays are cost sharing devices designed to prevent policy holders from making small nuisance claims or seeking health care unnecessarily. The charges have to be just large enough to influence people's decisions, and not so big as to keep people from getting the care they need. Consumers are asked to decide ahead of time between plans that have lower premiums but higher deductible which they would prefer if they are less likely to need health care and higher premiums but lower deductibles which they would prefer if they are more likely. Theoretically this balances risk with cost.[6] Unfortunately the costs of premiums, deductibles and copays have steadily increased, making cost a determining factor in obtaining health insurance.

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

Although only 1.5% of respondents answered that they had no health insurance, 42.9% thought that not having insurance prevent themselves or community residents from receiving health services. This is double the Census Bureau's 2014 estimate[7] of 15.1% to 20.0% uninsured in Sanilac County. The question may reflect a concern with the costs of purchasing health insurance through healthcare.gov rather than indirectly measuring the population not having any health insurance.

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

[6] Kunreuther, H. and Pauly, M. (2005). Insurance Decision-Making and Market Behavior. *Foundations and Trends*® in *Microeconomics*. 1:2 p 63-127.
[7] US Census Bureau 2014 Small Area Health Insurance Estimates (SAHIE) Insurance Coverage Estimates: Percent Uninsured: 2014 http://www.census.gov/did/www/sahie/data/files/F4_Map.jpg

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

- Awareness of local health resources and services
- Access to exercise and fitness activities
- Assistance for low-income families
- Access to healthy food

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

- Jobs with livable wages
- Attracting and retaining young families

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

- Availability of doctors and nurses
- Availability mental health services
- Ability to get appointments

Concerns about the community's safety and environment **Table 8. Q10**

- Water quality (i.e. well water, lakes, rivers)
- Public transportation
- Crime and safety

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

- Cost of health insurance
- Ability to retain doctors, nurses, and other healthcare professionals
- Cost of health care services
- Cost of prescription drugs

Concerns about Vulnerable Populations

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

Table 4 contains the top 3 concerns of all survey respondents to Q12b, the physical health for youth in your community. The top concern was youth obesity with approximately three-eighths (37.9%) of all respondents checking it. One fourth of all respondents mentioned youth hunger and poor nutrition (26.0%) and teen pregnancy (25.6%).

Table 4. Q12b Top 3 concerns physical health in your community (youth frequencies).

		Times chosen	Percent times chosen	Percent of Respondents choosing
Q12b[a]	Q12b. Youth obesity	105	29.5	37.9
	Q12b. Youth hunger and poor nutrition	72	20.2	26.0
	Q12b. Teen pregnancy	71	19.9	25.6
	Q12b. Wellness and disease prevention, including vaccine-preventable	63	17.7	22.7
	Q12b. Youth sexual health	45	12.6	16.2
	Total	356	100.0	128.5

a. Dichotomy group tabulated at value 1.

Table 5 shows responses to Q13b the top 3 concerns of all survey respondents about mental health for youth in your community. The top two concerns were youth drug use and abuse and youth bullying with 45.0% and 44.3% of all respondents checking these.

Table 5. Q13b Top 3 concerns mental health substance abuse in your community (youth frequencies)

		Times chosen	Percent times chosen	Percent of Respondents choosing
Q13b[a]	Q13b. Youth drug use and abuse	190	27.3	45.0
	Q13b. Youth bullying	187	26.8	44.3
	Q13b. Youth alcohol use and abuse	117	16.8	27.7
	Q13b. Youth mental health	96	13.8	22.7
	Q13b. Youth suicide	56	8.0	13.3
	Q13b. Youth tobacco use	51	7.3	12.1
	Total	697	100.0	165.2

a. Dichotomy group tabulated at value 1.

Table 6 contains responses to Q14 the top 3 concerns of all survey respondents about senior population in your community. Over half (56.6%) of all respondents indicated that cost of medications was their chief concern about the senior population. This was followed by availability of resources to help the elderly stay in their homes (41.6%) and assisted living options (40.3%).

Table 6. Q14 Top 3 concerns about senior population in your community

		Times chosen	Percent times chosen	Percent of Respondents choosing
Q14[a]	Q14. Cost of medications	312	19.3	56.6
	Q14. Availability of resources to help the elderly stay in their homes	229	14.2	41.6
	Q14. Assisted living options	222	13.7	40.3
	Q14. Availability of activities for seniors	175	10.8	31.8
	Q14. Transportation	147	9.1	26.7
	Q14. Availability of resources for family and friends caring for	130	8.0	23.6
	Q14. Dementia/ Alzheimer's	126	7.8	22.9
	Q14. Long-term/nursing home care	103	6.4	18.7
	Q14. Hunger and poor nutrition	86	5.3	15.6
	Q14. Cost of activities for seniors	46	2.8	8.3
	Q14. Elder abuse	41	2.5	7.4
	Total	1617	100.0	293.5

a. Dichotomy group tabulated at value 1.

An additional analysis examined the top concerns of respondents who were identified as members of vulnerable populations: seniors, females, low education and low income (see Appendix D).

Respondents 61 or older were concerned about youth obesity.

Respondents with incomes less than $25,000 were more concerned about access to higher education opportunities. Respondents with incomes under $25,000 and those with a high school diploma or less were concerned about teen pregnancy and assistance for low income families. Respondents with incomes less than $50,000 and those with a high school diploma or less were more concerned about affordable housing. Those with a high school diploma or less were concerned about crime and safety

Both females and those with incomes under $50,000 were concerned about youth hunger and poor nutrition and females were also concerned about access to healthy foods.

Focus Group Methods

Purpose
The purpose of the focus group is to:

- Learn about the good things in the community as well as concerns in the community.
- Understand perceptions and attitudes about the health of the community.
- Gather suggestions for improvement.
- Learn more about how local health services are used by you and other residents.

Participants and Procedures

A focus group was held at Marlette Regional Hospital on March 2, 2016 at 5-7pm. The group consisted of three men and six women, all of whom were senior citizens. They represented agriculture, faith community, schools, hospital, and the rotary club. They were invited to participate by the hospital staff. The group was facilitated by Crystal Barter and notes were taken by Sara Wright, both from the Michigan Center for Rural Health.

Participants were told (verbally) that their responses will be treated in a way that will not reveal their name and that their responses will be combined with others in any reports. They were told that due to the closeness of the community, complete confidentiality in reporting their responses cannot be ensured.

The facilitator followed a script (see Appendix E) and engaged the group in several procedures including asking participants to review and comment on a list of potential health concerns that may affect the community as a whole; using post it notes on an easel pad or wall; and group discussion/ brainstorming. A PowerPoint projector was used to show the question in the front of the room as well as verbally. A prioritization process was not conducted since that will happen in the follow up focus group after the survey and initial report is shared and reviewed. Participants were provided with a paper copy of the survey which they could fill out and turn in.

Data Analysis
Sara Wright reviewed her notes and coded the responses. She then produced a list of highest ranking issues.

Focus Group Results

The focus group schedule contained 19 questions/ topics and the complete results are in Appendix F.

The Focus Group was provided a list of potential health concerns that may affect the community as a whole. They were asked to review and comment on whether you think these are important concerns, and which is the most important?

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

Table 7 Top concerns of focus group by topic

- Physical, Mental health and substance abuse concerns (for adults)
  - Alcohol use and abuse (8)**
  - Drug use and abuse (including prescription drug abuse) (7)***
  - Obesity/overweight (7)***
  - Cancer (6) **
- Concerns about health services
  - Cost of health insurance (8)
  - Cost of health care services (7)**
  - Extra hours for appointments, such as evenings and weekends (6)***
  - Availability of mental health services (6)***
  - Availability of substance abuse/treatment services (6)***
- Concerns Specific to youth and children
  - Youth drug use and abuse (including prescription drug abuse) (7)*
  - Not enough activities for children/youth (5)*
  - Youth hunger and poor nutrition (5)
  - Youth obesity (4)*
  - Teen pregnancy (4)*
- Concerns about the aging population
  - Being able to meet needs of the older population (5)**
  - Assisted living options (4)**
  - Long-term/nursing home care options (4)**

The focus groups considered a number of other issues. They thought the major challenges facing the community were better jobs, drug and substance abuse. Another challenge was attracting and retaining young families. They mentioned the problem of empty buildings and blight, which is usually associated with inner city urban areas.

Regarding health services they thought people did not use services because they were unclear about coverage and thought that they did not need such services. They suggested that educating the general population about health related things and would help improve the health of the community. Specifically mentioned were healthy living and life skill training classes on cooking, parenting, drug abuse for children and parents.

The focus group thought that the elderly and low income people were medically underserved and suggested providing transportation for those with low incomes and seniors. People did not use preventive services because they were unclear about coverage or thought they didn't need them.

The focus group identified a need for psychiatric services and they suggested that the hospital consider offering such services. They believed that more sharing information, common communications and joint programs would provide better services and improve the overall health of the population.

People used local hospitals because it was close and convenient. People went elsewhere for health services for specialties which local hospitals did not offered and issues of privacy/confidentiality in small towns. The focus group differed on whether or not local hospitals had a good or bad reputation based on past experiences.

Stakeholder Interview Methods

Purpose

The purpose of the stakeholder interviews is to:

- Learn about the good things in the community as well as concerns in the community.
- Assess community awareness and use of health care services
- Assess availability of and need for health care services
- Estimate collaboration among health organizations and providers.
- Gather suggestions for improving health care and removing barriers.

Participants and Procedures

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

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

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

- William (Bill) Weston, Director
- Jamie Reinke, Sanilac County Program Manager (Sanilac County Only)

Sanilac County Community Mental Health

- Jim Johnson, Executive Director

Sanilac Intermediate School District

- Duane Lange, Superintendent

Stakeholder Interview Responses

Since only four stakeholders were interviewed, their responses are simply listed and not presented as percentages. Appendix H contains the Stakeholder's responses and suggestions.

The top concerns of the stakeholders were not enough jobs with livable wages and not enough public transportation options/cost of public transportation, alcohol use and abuse, suicide, drug use and abuse (including prescription drug use, not enough activities for children/youth, youth alcohol use and abuse, youth drug use and abuse (including prescription drug use). Also mentioned was the lack of a year round recreation/sports facility like a YMCA, services for seniors, and mental health, dental services and child care facilities.

The stakeholders saw a lack of resources because it was a rural community. Specifically mentioned were transportation, loss of factory jobs, and housing conditions. They noted that no dental providers accept Medicaid and recommended that health facilities add psychological screening and psychiatric services. Stakeholders pointed to cultural norms in rural areas, such as if there's nothing wrong, they don't want to abuse the system and waste both their time and the provider's, to explain why people did not to use preventive health services.

They suggested that the health related organizations should develop better integration and communication between providers, improve proactive primary care outreach and reduce unnecessary paperwork. Specifically, the stakeholders thought that law enforcement especially the sheriff's office, emergency services and hospitals were most collaborative, followed by the county health department. Least collaborative were other local health providers such as dentists and chiropractors. The Indian Health Service and Veterans Affairs were seen as self contained silos. The Intermediate School District was more collaborative than individual schools or school districts.

In order to facilitate the use of local health services by the community as a whole, the Stakeholders proposed better transportation, financial aid for high co-pays and deductibles, and more information on what their insurance covers including eligibility. Stakeholders said better communication at the case management level, better education/ marketing on services and resources, and opening elementary school gyms for general recreation and exercise could contribute to the overall health and well being of the community.

Discussion

The survey identified not enough evening or weekend hours, not enough specialists, not able to get appointment/limited hours and not enough doctors as high ranking problems. The survey and focus groups also noted a lack of mental health and substance abuse/treatment services. All refer to the supply of physicians which is highly dependent on the ratio of physician per 100,000 population and is endemic in rural and semi-rural counties. Sanilac County, in which Marlette Regional Hospital is located, had a population of 43,114 in 2010.

Focus groups were concerned about being able to meet needs of the older population. This was echoed by the stakeholder interviewees who thought that the elderly and low income people were medically underserved and suggested providing transportation for those with low incomes and seniors. People did not use preventive services because they were unclear about coverage or thought they didn't need them. The survey respondents were most concerned about the cost of medications for seniors.

The analysis was able to separate out and give voice to vulnerable populations: seniors (58 and older), females, those with a high school education or less and those with low incomes. Since almost all respondents self identified as White/Caucasian, no analysis was done by race/ethnicity.

Respondents with incomes less than $25,000 were more concerned about access to higher education opportunities. Respondents with incomes under $25,000 and those with a high school diploma or less were concerned about teen pregnancy and assistance for low income families. Respondents with incomes less than $50,000 and those with a high school diploma or less were more concerned about affordable housing. Those with a high school diploma or less were concerned about crime and safety

The stakeholders noted how cultural norms and resources in a rural county impact the community's health and well being including underutilization of preventive health services, a lack of year round exercise and recreational facilities open to the general population, and the need for transportation services. Also lacking were psychological screening and psychiatric services. They pointed out that no dental providers accept Medicaid.

Limitations

The survey employed a non probability sampling, combining convenience sampling with purposive (judgmental) sampling. Surveys were available on-line and paper surveys were distributed at a variety of locations. This resulted in some skewed demographics. Respondents were disproportionately female (78.8%), had some college degree (59.9%), and one-third (32.0% had household incomes of $75,000 or more. A little over one-quarter (27.7%) worked for a hospital, clinic, or public health department. Census information on gender, education and income are grouped by census tracts which are not always congruent with ZIP codes. It is not practicable to adjust the survey responses for gender, education and income for the Marlette Regional Hospital ZIP codes. However, this could be done at the county level.