

**Borgess Health
Borgess-Lee Memorial Hospital
Dowagiac MI**

**2015 Community Health
Needs Assessment
And Implementation Plan**

Borgess Health
Community Benefit Department
1521 Gull Rd
Kalamazoo, MI 49048

Our Mission, Vision and Values

Mission

Borgess Health, as a Catholic health ministry rooted in the values of Ascension Health and its sponsors, is committed to providing holistic, spiritually centered care, which strives to improve the health of individuals in communities we serve with special attention to the poor and vulnerable.

Vision

By putting safety and quality at the core of all we do, Borgess Health will provide health care that is coordinated across the continuum based on meeting the needs and expectations of the patients we serve.

Values

We are called to:

- Service of the Poor - generosity of spirit, especially for persons most in need
- Reverence - respect and compassion for the dignity and diversity of life
- Integrity - inspiring trust through personal leadership
- Wisdom - integrating excellence and stewardship
- Creativity - courageous innovation
- Dedication - affirming the hope and joy of our ministry

Guiding Principles

- Your care will be safe.
- We know who you are and are ready for you.
- We will see you when you want to be seen.
- You will know what to expect
- We will be your trusted partner in health.
- We will exceed your expectations
- We will coordinate your care.

SUMMARY OF 2013 CHNA

The 2013 CHNA identified several needs encompassing all regions of the community service areas. While a good deal of conversation and planning occurred, some of the implementation did not begin seeing any outcomes until fiscal year 2016. Because of staffing shortages and the lack of a trained educator as the “right fit” to provide the Diabetes Self-Management classes, this initiative did not take off until March of 2016. However, the needs identified in the 2013 CHNA were categorized into four general areas of concern:

1. Access to Primary Care
2. Access to Mental Health Providers
3. Diabetes
4. Community Wellness/Health Education

Over the past three years, Borgess Lee Memorial Hospital has implemented action plans designed to fulfill these significant community needs. To address the Access to Primary Care goal, there was a net increase of one full-time family practice physician (three hires, two departures). There is a current complement of 4 (four) physicians and 4 (four) Nurse Practitioners and Physician Assistants. Also, there was a net decrease of one full-time pediatrician (one hire, two departures). It is unfortunate that in this rural community physicians seem to find employment in more populated areas after a time. The current complement in that area is 3 (three) Nurse Practitioners and 3 (three) Physician Assistants. There is active recruitment and evaluation of alternative staffing and scheduling models that continue in Family Practice and Pediatrics.

To address the Access to Mental Health Providers, telepsychology/psychiatry services were established (with the assistance of grant funding) at Borgess-Lee Medical Group (BLMG) clinic. The clinic provides one half day per week with a physician assistant with training specific to mental health. Additionally, a part-time psychiatrist provides on-site service at BLMG two days per week. There is also a full-time MSW who also provides counseling services at BLMG. Additionally, a seminar was held in 2014 in conjunction with Woodlands Behavioral Health. The Woodlands Event was entitled “Mental Health Summit” and was held at Southwestern Michigan College on November 13, 2013. Topics presented were: Recovery Testimonial; Anxiety and Depressive Disorders Diagnosis and Treatment Options; Vendor Fair; Impact of Traumatic Stress and Prenatal Drug/Alcohol Exposure on Brain Development and Challenging Behavior in Children and Adolescents; and included a panel discussion.

To address the Diabetes Education need, BLMH brought in a full time registered nurse care coordinator that was established at BLMG in 2015 to coordinate care for patients with chronic conditions, including diabetes. Preparations and coordination to re-establish the Diabetes Self-Management Education (DSME) program were initiated; however implementation did not occur in this reporting period. In spring of 2016, the DSME program began once again and will be reported in the next reporting period.

The Community Wellness and Health Education area of need did not gain traction unfortunately. There was some cooperation between the local agencies, but no formal activity in this area. The group did meet and provide updates respective to their particular agency, but they did not identify a community need to work on collaboratively. It is the hope that this will be accomplished with the 2015 goals set in the second iteration of the CHNA.

Although it may appear that the goals of the 2013 Implementation were not reached, it is important to point out that a Health Resources and Services Administration (HRSA) Grant Project was initiated in November, 2014, to create a Rural Health Planning Network. Much thought and deliberation were put into this grant and the goals, as described below, align with the CHNA goals. Collaborative partners in the Rural Health Planning Network include; Borgess-Lee Memorial, the Council on Aging, the Cass Family Clinic, the Van Buren/Cass County Health Department, the Woodlands Behavioral Health and the Pokagon Band of Potawatomi. The purpose of the proposed Cass County Rural Health Planning Network Planning project is to create an effective health planning network of the health care providers of Cass County, Michigan in order to creatively address the community's greatest health needs; improve the coordination of health care services; and ensure local access to a full continuum of care locally, particularly to underserved residents.

The target area for the proposed Network Planning project is Cass County in southern Michigan, along the Indiana border. The goals of the project as stated were:

- 1) Jointly develop and formalize the Network's organization, operations, and effectiveness through the development of business, strategic and sustainability plans for the Cass County Rural Planning Network.
- 2) Use the 2013 regional Community Health Needs Assessment to prioritize needs and develop joint solutions that will better meet the health needs of region, particularly of underserved residents of Cass County.
- 3) To specifically explore and implement diabetes outreach program by Network partners to meet the needs of the diabetic population in Cass County.

It is a goal of all of these community partners that utilization of this grant and the CHNA will improve health care and collaboration in this very rural and expansive community and will expand services to many areas of the community.

**Borgess Health
Borgess-Lee Memorial Hospital**

**2015 Community Health Needs Assessment
& Implementation Strategy**

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Executive Summary

Background

The Patient Protection and Affordable Care Act (PPACA) of 2010 mandated new IRS requirements for hospitals: (1) to conduct a Community Health Needs Assessment (CHNA) and (2) adopt an Implementation Strategy Plan, both of them to be reported in the schedule H 990. These provisions take place in a hospital's taxable year beginning after March 23, 2012. Failure to comply could lead to a \$50,000 excise tax and possible loss of tax exempt status.

In compliance with these requirements, Borgess Health conducted a community health data collection and assessment process. Upon completion of the data collection Borgess Lee Memorial Hospital (BLMH) developed an Implementation Plan. The population assessed was Cass County. The first CHNA developed by BLMH was published in June, 2013. This original CHNA provided information for problem solving and asset identification as well as for policy and program development, implementation and evaluation and was an effort to be compliant with the Affordable Care Act (ACA) of 2010.

The second iteration of the 2015 CHNA encompasses data collection and community input. The quantitative data was also supplemented with a community asset review and qualitative data was gathered from key informant interviews and focus groups. The information in the CHNA will help identify health problems in the community based on the collection of this data. This health information drives decisions and setting priorities and strategies addressing community health issues.

Identification and Prioritization of Needs

Following the data collection processes, the draft CHNA was presented to the Community Health Needs Assessment Committee as well as the Community Benefit and Health Needs and Assessment Committee (CB&HNA), both committees are comprised with external partners along with some internal leadership members. As with the first iteration of the CHNA, both groups were consulted to provide oversight and guidance in the compilation of data, the process involved as well as in decision making. Both of these groups were tasked to review the data collected and identify health needs based on the size and the severity of the issues and the direction the data were trending. The group was tasked with prioritizing the needs based on:

- Borgess Lee Memorial Hospital's ability to make an impact
- Alignment with other health systems and agencies serving the same population, the Governors' statewide priorities, and local public health departments priorities
- Current BLMH priorities and programs
- Effectiveness of existing programs
- Duplication of services within the local community

The resulting top tier of prioritized needs comprises Access to Care, Diabetes, Mental Health and Community Health Education.

Implementation Plan Development

BLMH is fortunate to have the two community groups listed above very engaged in the health of their community. Leaders from these groups have volunteered to collaborate and help develop, coordinate and deliver the goals for each priority area. They will attend regularly scheduled meetings, provide staffing for health education classes and screenings, and will be actively involved in the high-level Implementation Plan which will be fluid in nature over the next several years as BLMH continues to build on existing community partnerships and programs.

2015 Community Health Needs Assessment

Borgess Health

Borgess-Lee Memorial Hospital

BACKGROUND

The Federal Affordable Care Act (ACA) requires all Not for Profit hospitals in the country to conduct an assessment of the health of the community. This intent of this assessment will provide an overall view of the health of the community it serves. This Assessment, called the Community Health Needs Assessment (CHNA) provides necessary data and information to hospitals that is invaluable when gaining in depth knowledge of the community, the residents and their patients. This assessment not only takes into consideration local, state and federal data but also assesses the social determinants of health which play a direct role in the health of the community, families and individuals. With the knowledge gained from the CHNA, the hospital is better equipped to fully understand major health needs that extend outside the walls of the hospital.

The CHNA

- Must take into account input from persons who represent the broad interests of the community served by the hospital facility including those with special knowledge of or expertise in public health
- Must be made widely available to the public
- Will be based on current information collected by a public health agency or non-profit organizations and may be conducted with one or more organizations including related organizations.

The Internal Revenue Code Section 6033(b) (15) (A) requires hospital organizations to include in their annual information return (i.e. Form 990) a description of how the organization is addressing the needs identified in each CHNA conducted under Section 501(r) and a description of any needs that are not being addressed along with the reasons why those needs are not being addressed.

Introduction

In 1918, Lee Memorial Hospital was founded in a mansion in Dowagiac as a gift from Mr. and Mrs. Fred Lee. The Sisters of Mercy agreed to sponsor the hospital as part of their healing ministry at that point in time. It was later assumed by the Sisters of St. Joseph as part of their healing ministry. In 1999, The Daughters of Charity National Health System and the Sisters of Saint Joseph Health System joined together to form Ascension Health.

Lee Memorial joined with Borgess Health and the new name, Borgess Lee Memorial Hospital, was given to reflect the unity of the two hospitals. In recent years, the hospital board sought

and acquired the designation of Critical Access Hospital for Borgess-Lee, a status given to 24/7 emergency care providers that contain 25 or less in-patient beds.

Borgess Health now offers a complete continuum of services to nearly 1 million people living in 10 counties in Southwest Michigan. Borgess Health is a member of Ascension, the nations' largest Catholic Health System.

THE COMMUNITY SERVED BY THE HOSPITAL

Borgess Health Primary, Secondary and Tertiary Service Areas



Borgess Health Continuum of Care Facilities

Borgess Medical Center – a 422-bed tertiary care hospital and flagship of Borgess Health with a continuum of health services from a Level II Trauma Center to primary and specialty care practices throughout southwest Michigan. The majority of Borgess Health inpatient and outpatient services are provided at Borgess Medical Center.

Borgess-Pipp Hospital – a 43-bed long-term acute care hospital with an emergency department, diagnostics, rehabilitation services and an affiliated primary care practice.

Borgess-Lee Memorial Hospital – a critical care access hospital with 25 swing beds, an emergency department, rehabilitation services, diagnostics, outpatient surgery, and owned primary care practices.

Borgess at Woodbridge Hills – a large ambulatory care facility with an immediate medical care center, an endoscopy and outpatient surgery center, diagnostics, rehabilitation services, pharmacy and two large primary care practices.

Borgess Gardens – a 101-bed skilled nursing and short-stay rehabilitation facility.

Borgess Medical Group – a multidisciplinary group consisting of:

- 97.5 Primary Care Providers (38.6%) & 155 Specialty Care Providers (61.4%)
- 19 Primary Care Practices
- 14 Patient Centered Medical Homes
- 69 Specialty Care Practices
- 36 Locations across a 10 County Area in Southwest Michigan

Southwest Michigan Population Demographics and Trends

The Borgess-Lee Memorial Hospital is located in Southwest Michigan and is comprised of a nine-county region that borders Indiana. Cass County is located in southwest Michigan and borders the State of Indiana. It covers about 491 square miles with a total population of 51,910. The area was originally inhabited by three bands of Potawatomi Indians. During the Civil War, Cass County played a major role in the Underground Railroad which resulted in the settling of many black families in the area.

Three characteristics combine to make Cass County somewhat unique, especially as it relates to serving health needs. The first is the county's rather large, rural/agriculture base. About 60% of Cass County is farm land, ranking it 15th out of Michigan's 83 counties. Much of the farm land is used for growing seasonal fruits and vegetables which require migrant farm laborers to harvest. This results in a heavy influx of mostly Hispanic families which in turn impacts the need and delivery of health care services.

The second characteristic relates to the significant recreational opportunities that abound in Cass County. It has over 250 lakes and the county's close proximity to major population centers in Indiana and Illinois makes a regional recreational "mecca". During the summer, the population around the lakes grows significantly. Both the summer and full-time lake residents tend to be very affluent. While most of the health care needs of the summer residents are served by out-of-state providers, these people do impact the area's health care service delivery, especially emergency room and fast track primary care services.

The third characteristic is the large blue-collar population in the county’s two largest population centers-Dowagiac and Cassopolis. The City of Dowagiac is the county’s largest city. It has about 2,400 households with a total population of 5,879. Median household income is \$31,329 and per capita income is \$17,739. Both are well below the county and state averages. The Village of Cassopolis, the County Seat, ranks even lower. It has about 700 households with a total population of 1,774. Median household income is \$24,781 and per capita income is \$15,114. Almost 30% of the Cassopolis residents fall below the poverty level. All of these factors contribute to the unique cultural diversity of the county.

The county consists of cities, townships and villages as described below:

Cities	Villages	Townships	Townships
Dowagiac	Cassopolis	Calvin	Newberg
Niles	Edwardsburg	Howard	Ontwa
	Marcellus	Jefferson	Penn
	Vandalia	LaGrange	Pokagon
		Marcellus	Porter
		Mason	Silver Creek
		Milton	Volinia
			Wayne

There are 19 public schools in Cass County serving over 6,500 students. The most diverse school district is Dowagiac Union School District. Minority enrollment is 21%; the majority of the minorities are black and Hispanic.

2013 Demographics Cass County

Population Age	% Rate
65+	17.08
55 – 64	15.08
45 – 54	15.57
35 – 44	12.13
25 – 34	9.69
18 – 24	7.66
5 – 17	17.44
0 – 4	5.36
Household Types	
Families with Children	28.39
Race	
Non-Hispanic	
White	88.67

Race	% Rate
Black	5.14
Asian	0.78
Multi-racial	3.23
Hispanic	3.06
Other	1.52
Highest Level of Education	
Associate degree or higher	25.62
No high school diploma	12.76
Income/Poverty	
Families with income over \$75,000	34.65
Children below 100% Federal Poverty Level	14.52
Children below 200% FPL	44.93
Population below 50% FPL	6.28
Population below 100% FPL	15.52
Unemployment	
October 2015 US Dept. of Labor Statistics	5.2
Crime	
2013 arrests	660
2014 arrests	625
2014 offenses	2513
2014 CSC offenses	62
2014 murders	1
Access to Healthy Food	
46 grocery establishments	15.30 per 100,000 population
Low income low food access	3.69
Population with low food or no healthy food access	26.69
Access to Recreation and Fitness	
1 establishment	1.91 per 1000,000 population
Parks	6 county parks
Health Care Specific Data	
Access to Primary Care	
7 Primary Care Physicians	13.4 per 100,000 population
Access to Dentists	
10	19.3 per 100,000 population
Federally Qualified Health Centers (FQHC)	
1	Cassopolis Family Clinic Network

EXISTING HEALTH CARE FACILITIES AND RESOURCES

While Borgess-Lee Memorial Hospital is the only hospital in Cass County, there are three Michigan based health systems and three large Indiana hospitals that serve the Cass county population:

Borgess Health (BLMH and Borgess Medical Center-Kalamazoo)

Lakeland Health (Lakeland Hospital-Niles and Lakeland Medical Center-St. Joseph)

Bronson Healthcare (Bronson Lakeview Hospital-Paw Paw and Bronson Methodist Hospital-Kalamazoo)

Elkhart General Hospital-Elkhart, Indiana

Memorial Hospital-South Bend, Indiana

St. Joseph Regional Medical Center-South Bend, Indiana

Community Health Needs Assessment

Establishing the CHNA Infrastructure and Partnerships

Internal

After the initial CHNA, Borgess Health (BH) developed a defined process to continue the ongoing process of CHNA and Implementation strategy reporting processes. No third parties were contracted to conduct the 2015 CHNA. Several infrastructure building activities were completed:

- Dedicating 1 Full Time equivalent employee to developing the CHNA, the Implementation Plan and the community benefit process.
- Internal community benefit reporting was implemented that provides a formal process and internal policy for reporting all community benefit provided by BLMH.
- Attending ongoing training that is provided to all Ascension Ministries to complete CHNA and the Implementation Strategies.

External

In an effort to ensure that the hospital continues to have a relationship with the community that it has called home for nearly a century, Borgess-Lee created an informal committee to ensure the connection between leadership and the residents they serve remains strong. The group's name is the Community Benefit and Health Needs Committee (CB&HNA) of Borgess-Lee Memorial Hospital. It is important to note that this group is comprised of the past Board of Trustees of BLMH, now defunct due to the merger with Ascension. The following list represents the Community Benefit and Health Needs Committee participating members and their organization:

Name	Organization
Terry Harris	CFO – Coloma Foods (retired)
Charles Burling, DDS	Dentist
James Eckman, DC	Chiropractor
Sue McCormick	Borgess-Lee (retired)
John Ryder	Chief Operating Officer, BLMH
Jan Troeger	Chief Nursing Officer, BLMH
Beth Cripe	Director of Foundation, BLMH

Defining Purpose and Scope

The purpose of the CHNA was to 1) Evaluate the current health needs of the community and prioritize them 2) identify resources available to meet both the priorities as well as opportunities identified through the CHNA process 3) create an Implementation Plan to systematically address health priorities 4) build capacity to address opportunities within the health system's existing programs, resources, partnerships and 5) develop a reporting tool for means of providing information to Borgess Health System senior leadership as well as the IRS 990 report.

Data Collection and Analysis

Description of process and methods used

The framework used to guide BLMH through the process was based on two different models, Best Practices for Community Health Needs Assessment and Implementation Strategy Development: A Review of Scientific Methods, Current Practices and Future Potential Report of Proceedings from a Public Forum and Interviews of Experts submitted by Kevin Barnett, DrPH, MCP, The Public Health Institute, February 2012. Also considered in the development of the 2015 BLMH Community Health Needs Assessment was the Community Health Needs Assessment Template developed by the Catholic Health Association of the United States.

Types of data collected for the assessment include, but are not limited to the following:

- Disease incidence and/or prevalence
- Inpatient, emergency room, and/or outpatient utilization
- Household income, unemployment
- Home ownership/rental properties
- Arrests and criminal activity
- Proximity of healthy food sources
- Proximity of basic and social services
- Parks, recreational facilities, open space
- Access to public transportation

The framework used to guide BLMH through the CHNA process was based on the model provided by The Association for Community Health Improvement's six step model:

1. Identify the Team and Resources
2. Define the Purpose and Scope
3. Collect and Analyze data
4. Determine Priorities
5. Document and Communicate Results
6. Plan for Action and Monitor Progress

Description of Data Sources

Quantitative Data

A wide variety of sources were reviewed as part of the data collection process. Those data sources are described in the table below:

Quantitative Community Health Data Sources

Source	Description
Borgess-Lee Memorial Hospital	Internal data from inpatient, emergency room and out-patient utilization years 2013 - 2015
Michigan Incident Crime Reporting, (MICR)	Michigan State Police Criminal justice Information Center, county arrests and county offenses 2013, 2014
County Health Rankings	Annual public report available through a grant from the Robert Wood Johnson Foundation using most recent data to rank the health of each county in each state
US Census Bureau	The 2009 – 2013 American Community Survey, County Business Patterns, 2013
National Center for Education Statistics (NCES)	Common Core of Data, 2013 - 2014
US Department of Education	EDFacts via DATA.gov Data analysis by CARES, 2011 - 2012
US Census Bureau	Small Area Health Insurance Estimates, 2013
Centers for Disease Control and Prevention	Behavioral Risk Factor Surveillance System, Health Indicators Warehouse, US Department of Health and Human Services, 2006 - 2012
Center for Disease Control and Prevention	Division of Nutrition, Physical Activity and Obesity, 2011 Program Evaluation Guide
US Department of Agriculture	Economic Research Service, USDA – Food Access Research Atlas, 2010
US Department of Health and Human Services	Health Resources and Services Administration, Area Health Resource File, 2012.
Michigan Department of Health and Human Services (MDCH)	2014 Behavioral Risk Factor Survey (MiBRFS)

Description of data limitations and gaps

Limitations and gaps exist that impact the ability to create a more robust and accurate assessment. Much of the data used is considered outdated but is the most recent data available. For example, demographics used in this assessment were derived from the US Census 2000 – 2010. Additionally, the Michigan Department of Community Health MiBRFS is an annual, statewide telephone survey adults aged 18 years and older participate in. The data is collected via a telephone survey from both landline and cell phone respondents. Since the information is self-reported, the information may not be 100% accurate. However it provides a good snapshot of what Michigan residents think their health is. Additionally, due to limited resources and time constraints, data was not collected on every vulnerable population desired.

Qualitative Data

While data tells an indisputable story of the health of the community, oftentimes the untold yet equally important part of the picture is how the members of the community feel about their health and the health of the community. With regard to the IRS Treasury Notice 2011 – 52, data derived from key informant interviews and focus groups was sought to represent the broad interest of the community as well as members of the community considered to be the most vulnerable population; the low-income, medically under-served, homeless, minorities and those with chronic health conditions. Permission to use the data gleaned from the groups was granted by each individual or the group lead contact.

Focus Groups

Three (3) focus groups were conducted within the Cass County area. Those focus groups were the Community Benefit and Health Needs Assessment (CB&HNA) listed above, the Community Benefit Advisory Committee (members listed below), and the Area Council on Aging, a local agency that provides a wide variety of services for the aging population, ages 55 and older. The Area Council on Aging focus group was consisted of nine (9) senior citizens, (names withheld by request) who volunteered their time to lend their voices and concerns at a focus group.

The Community Benefit Advisory Council is a group of Cass County community leaders, whose expertise involves public health, not-for-profit agencies, school/educational programs, elderly support services, family health centers, chronic disease specialty clinics, BLMH representatives involved in community work, and local government officials. These committee members also represent the poor and the vulnerable in this area and understand the needs of this socio-economic population. The committee consists of twelve (12) community leaders throughout Cass County and is intended to represent a wide range of expertise and services that impact our community's health status. They are:

Name	Agency/Role
Father Kevin Covert	Sacred Heart, Holy Maternity of Mary Catholic Church
Bob Cochrane	Cass County Council on Aging
Kathy Emans	The Woodlands
Priscilla Gatties	Pokagon Band of Potawatomi
Steve Grinnewald	Dowagiac Police and Fire

Name	Agency/Role
Linda Iwan	Borgess Lee Medical Center
Mary Middleton	Cass Family Clinic
John Ryder	Borgess-Lee
Karen Schalte	The Timbers of Cass County
Jan Troeger	Borgess-Lee
Kathy Valdes	Cass County Department of Health and Human Services
Mary Van Arsdall	RN, community member

Some of the combined key points learned in these meetings were:

1. What are the biggest health issues in your community?

- | | |
|---|--|
| Diabetes | Cancer |
| Obesity | Environment |
| Heart disease, CHF | Kidney disease |
| Stroke | Hearing problems |
| Vision problems | Depression |
| Mental health | Alzheimer's/Dementia |
| Aging Population | Drugs and addiction, meth, opiates, heroin |
| COPD | Parents not parenting |
| Childhood wellness | Domestic violence |
| Alcoholism | End stage renal disease |
| Elder abuse | Food Insecurity/lack of fresh food |
| Lack of compassionate doctors | Multiple sclerosis |
| You can get any drug you want in the high school or middle school | |

2. What is causing these issues?

- | | |
|---|------------------------------------|
| Environmental exposures | Diet/nutrition |
| Lack of exercise | No transportation |
| Lack of social support | Finances – cost of care is so high |
| Poverty/generational poverty | The drinking water |
| Lack of education | Lack of family structure |
| Can't get ahead past government support, make a little more money, and get a little more support taken away, no such thing as getting ahead | |

No school nurses
Parents take their kids to school when they are sick because of no child care, can't afford it
Generational drug abuse and addiction
Social determinants of health
Can't get past basic survival skills (Maslow's Hierarchy of Needs)
Some insurances aren't accepted, it's confusing, "out of network"
Hard to get answers, little access to doctors and communication with physicians
No organized or structured spiritual development
Chronic pain is not managed well

3. What changes have you seen in the health issues of the community in the last few years?

Increase in wait times to get in to doctor
Have to see more than the same provider in the office, no consistency
Can't talk to a real person on the phone
Lack of good doctors in the rural communities
"Let the doctors do the doctoring, not the insurance company"
Borgess Lee is doing a great job with treatment of cancer, increased access for those needing treatment
Increase of drug use across all socio-economic levels, heroin and opioid use has increased
More awareness of the substance abuse in county
Coping mechanisms
Improvement in Access – Healthy Michigan
Some make too much money for Healthy Mi and fall between the cracks, can't afford insurances
High deductibles

4. Who struggles most with the issues you've identified?

Elderly – everything is computerized and most seniors don't use them
Those who live in poverty or borderline poverty
75% of children receive free or reduced lunch
The unemployed
Those without healthcare
Poor black families
Those who make too much money to qualify for Medicaid yet not enough to pay for premiums of Marketplace insurance
Children
Teachers independently seek help for children in school who have needs

The homeless – no homeless shelters “it’s easier to be homeless in an urban setting than in rural”

5. How does this impact their lives?

In every area of life

People wait too long before going into the doctor and their situation gets worse.

If you do not have a computer and live in the country, you have no access to your MyBorgess Health

Not seeking health care until the disease process is critical or it becomes an emergency

6. What are some challenges and barriers that your community faces to maintain health?

Money and economy

Lack of transportation

Lack of education

Don’t understand what the doctor says when they are talking, need to talk in simpler language

Access to quality health care – have to travel pretty far for a specialist

Learning how to eat well

Need patient navigators to help figure out the system, what to do

Reimbursement benchmarks

Consistent primary care access

Socio-economic

The mindset to care for one’s own health is not a priority

Fear of finding out what may be wrong

Fear of hospitals or health care providers

Availability of local services i.e. no local dialysis center

Docs won’t take Medicaid and those who will have huge wait times to get in

Reimbursement has been cut

Patient no show rates

No schools nurses, kids are sick at school

Pregnant girls in schools

No health education anywhere

7. Where are opportunities for your community to improve and maintain health?

Council on Aging is great, inexpensive, offers a lot for seniors

A “clearing house” to help direct needs and learn about resources and advocate for patients

Hospital needs to do more community outreach

Develop a partnership with the Pokagon Tribe (6,000 patients)

Flu shot clinics

Local runs and walks i.e. Steve’s Run, Relay for Life, United Way

Prostate cancer screens

Community health workers
 Need more primary care physicians
 Integrative behavioral health along with primary care
 An updated list of resources with local services and agencies and keep it updated
 Health information exchange
 Need to educate consumers on health portals
 Need more health education, especially in schools
 We don't even know our doctors anymore, they come and go
 Can't understand what the doctor says, speaks at too high of a level

8. What are the resources available in the community that might address some of these health issues?

Council on Aging	Churches
Helping Hands	Cass Family Clinic - FQHC
ACTION	Schools
Food Pantries	
Department of Health (Cass/Van Buren counties) – dental health	

Key Informant Interviews

Key informant interviews are typically conducted with local community members who have historical knowledge of the community, are engaged with the community and understand local areas of concern. The leaders of these organizations have a great deal of hands on experience and are well versed with the health needs in the community. They represented health care providers, public health officials, those from rural populations and those from urban populations. There were participants who represented the underserved, minority populations and businesses.

Those involved in the interviews and their agencies include:

Quantitative Data Sources

Name	Agency
Names withheld by request	A group of women of various ages and socio-economic levels at a local lunch spot in Dowagiac
Priscilla Gatties, Business Manager Matt Clay, Director	Pokagon Health Center, Pokagon Tribe
Mary Middleton	CEO, Cass Family Clinic, FQHC

Summary of Key Informant Interviews

There were common themes in every interview and it was fairly easy to glean from the conversations the pressing issues in the community. Key informants were asked specific questions regarding, in their opinions, what the health issues are in the community, what is working and what is not working. Some comments made during the interviews that were different than those found in the focus groups are listed below:

1. Tell me about your organization, the area and populations it serves.

Federally recognized tribe, population 5,000 members nationwide, has own government, police, tribal court, health center, social services offices

The local FQHC - their Mission in Cass County is to serve all the underserved

2. What is causing these issues?

Childhood trauma

Social determinants of health

3. What changes have you seen in the health issues of the community in the last few years?

Low socio economic status, increased rates of diabetes, substance abuse

4. Who struggles most with the issues you've identified?

Families

Children

5. What are some challenges and barriers that your community faces to maintain health?

Trust issues are huge with this group. They do not trust outside providers with their healthcare

Don't see what is happening in the future – no visibility of Borgess Lee in the community (meaning community health education or outreach)

6. Where are opportunities for your community to improve and maintain health?

The tribe is a small enough group to be able to make a difference, they are on track to get more people educated and involved with behavioral health assistance.

Ask the community what it needs

7. What are the resources available in the community that might address some of these health issues?

This population is totally independent of outside health care unless it is a serious issue. Their model is working very well. Physician visits are 30 – 60 minutes long. They use a circuit healing approach including nutrition, massage and acupuncture. Every citizen has access to optical, dental, behavioral health, pharmacy, education funding, traditional healing physical therapy, a gym, outdoor space. The tribe economy is strong (casinos, gas stations, other businesses) and as a result the clinic is growing and adding services.

Cass has wonderful resources; there is no clear leadership, no community health network, no clear work being done there. There is not a common issue that is being tackled by a group of community leaders.

We are using a model where there is a therapist on staff along with 7 providers, (MD's and DO's and mid-levels) use a team approach to their model. While very effective, the need is "overwhelming" for behavioral therapists

Identification and Process for Prioritization of Needs

The results of the key informant interviews and the focus groups were presented to the Borgess Lee Community Benefit and Health Needs Assessment Committee and to the Community Health Needs Assessment Group. A copy of the health issues data was provided to each member of the committees. The committee members were then asked to provide feedback on the results as well as engage in conversation with the rest of the committee members. Criteria considered when making decisions were:

- The ability of Borgess-Lee Memorial Hospital to make an impact based on current resources
- The effectiveness of current BLMH programs and services
- Avoiding duplication and/or enhancing community initiatives already established
- The Michigan Department of Community Health statewide health priorities and local health department priorities
- Healthy People 2020 goals

The nominal group planning process method of identifying and determining needs was used. Nominal group planning can be used to:

- determine what community issues are of greatest concern;
- decide on a strategy for dealing with the identified issues; and

- design improved community services or programs.

This method is based on group discussion and information exchange. Group members generate a list of ideas or concerns surrounding the topic being discussed. This list becomes decision-making criteria and the prioritization is the ultimate result of consensus and a vote to rank order the criteria.

Based on the process and criteria listed above, BLMH identified the following priorities for the Implementation Plan:

- Access to Care
- Diabetes
- Mental Health
- Community Health Education

Description of Community Health Needs Identified

Goal 1: Access to Care

Access to care is an ongoing health issue and is listed in the Healthy People 2020 report as one of the leading twelve indicators for the nation to focus on. Healthy People 2020 provides science-based, 10-year national objectives for improving the health of all Americans. As we move into 2016 and the next phase of implementation of the Affordable Care Act, more and more individuals will become insured with Medicaid expansion. Through the Health Insurance Marketplaces (Exchanges) there will still remain the need to support those unfamiliar with the system in navigating the health system, locating a primary care physician, and obtaining support for other non-medical needs that, if not addressed, may present a barrier to access to care. The need to address and strengthen Access to Care is an ongoing system-wide initiative through the Ascension Health's Call to Action policy "Healthcare That Leaves No One Behind". The policy represents Ascension Health's commitment to 100% access and coverage for all Americans. Ascension Health has evolved its 2020 destination for "Healthcare That Leaves No One Behind" to describe that all people, particularly those who are poor and vulnerable, can access environments and healthcare that (1) create and support the best journey to improved health status for individuals and communities, and (2) are financed in an adequate and sustainable fashion. The vulnerable people we are focused on serving includes individuals who remain uninsured in a post-reform era, but also includes people who are vulnerable due to factors other than insurance coverage, including their economic situation, citizenship status, geographic location, health status, age, education level or decision-making ability.

Strategy 1:

Borgess Lee Memorial Hospital will expand the tele-health program. Tele-health was a strategy in the 2013 Implementation Plan. It was completed and the end result was the ability to provide tele-psychiatry to senior citizens. Another half-day will be added which will bring the available service days to two full days per week. To meet that need, a physician's assistant who has specialized training in behavioral health will also be added to tele-health part-time.

Goal 2: Diabetes Prevention

In Michigan, in 2014, an estimated 10.4% of Michigan adults 18 years and older were diagnosed with diabetes. According to the Centers for Disease Control and Prevention (CDC), 27.8% of people of all ages with diabetes are undiagnosed. Also the CDC reported about 37% of adults age 20 years and older were estimated to have pre-diabetes, putting them at high risk for developing type 2 diabetes. However, in 2014, only an estimated 8.2% of Michigan adults reported ever being told that they had pre-diabetes. Michigan ranked 22nd out of 50 states in highest diabetes prevalence among adults 18 years and older in 2013. Diabetes was the seventh leading cause of death in Michigan in 2013 (*Michigan Department of Community Health*). Although reducing incidence of diabetes was a priority area for the 2013 BHS CHNA, hospitalizations it remains one of the top causes of death and hospitalizations in Cass County and at BLMH from 2013 – 2015.

Strategy 1:

Provide diabetes screenings and education through community groups and local churches. Due to the fact that there remains a large percentage of the population undiagnosed, it is important to reach out to those community members who are at high risk and undiagnosed. Developing a relationship with our local churches and community groups will allow access to community members who may not have a primary care physician and may be undiagnosed or are considered pre-diabetic. Identifying those who are pre-diabetic will allow an intervention and education to prevent further progression of the disease.

Strategy 2:

Design, develop and distribute web based pre-diabetes programs. Working in tandem with Borgess Diabetes and Marketing departments, an online pre-diabetes program will be developed and distributed. This will be done in a culturally appropriate manner and will be distributed widely throughout the community. This strategy greatly improves access to much

needed health education where it can be delivered through computer or electronic device at any time at any place. It provides 365/24/7 access to life changing health education.

Goal 3: Community Health Education

Through the community engagement process, it was mentioned often that there is very little community health education, both in the school system and in the community. Children in the school system do not receive basic health education as there are limited resources to provide that education. Community members do not have access to health education either and prevention of chronic disease such as diabetes, obesity, COPD and heart disease can be thwarted through free community health classes.

Strategy 1:

Working with BLMH and other community health providers, a school based health program will be developed and delivered to the Cass County Schools. This includes such areas as mental health, nutrition, and physical activity. A menu of classes will be developed to provide to area schools utilizing health educators from BLMH and other local health agencies will be scheduled and delivered. Along with that, having health educators present at local community functions will be established as well. This will include events such as local races, back to school events and local festivals.

Strategy 2:

At the community level, it was apparent that tobacco cessation programs were non-existent in the community while tobacco use is very high in this area. Re-admission rates at BLMH for Chronic Obstructive Pulmonary Disease are the number one cause of preventable hospitalizations at BLMH. A series of tobacco cessation classes will be developed and delivered at a variety of locations.

Goal 4: Exploration of an Integrated Primary Care and Behavioral Health Clinic

This goal is a combined goal to address both Access to Care and Mental Health. Mental Health was the number one need identified in the community engagement interviews. Due to the rural nature of this area, access to mental health services is a significant need. Many of the other needs mentioned: drug use and addiction, domestic violence, and alcoholism for example, are a by-product of mental health. Expanding access through a primary care setting will aid in identifying and treating community members with mental health needs.

Strategy 1: A model of integrated primary care and behavioral health already exists in Cass County at the Family Health Clinic, the local FQHC. The model has proven to be highly effective by providing access to mental health providers at the point of care, their primary care

provider. What has been discovered is that oftentimes a person comes to their primary care provider and that primary care provider identifies at risk patients and can direct them to a mental health provider during that patient's visit. This helps create a continuum of care and maintains connectivity with the patients by keeping them in their primary care location. By working collaboratively with the Family Health Clinic and other local health care providers, the concept of adding another community based clinic will be explored.

Community Needs Not Addressed

Identified needs that will not be addressed were determined by availability of services in the community. Chronic diseases with substantial support in the community such as cancer, lung disease and heart disease are supported by strong Borgess Health programs with a variety of available resources in addition to the support of the American Cancer Society, American Lung Association and the American Heart Association. The Cass /Van Buren District Health Department provide a number of community services. There is a mental health provider in Cass County, The Woodlands Behavioral Health Care. They provide services to those with mental health needs but there are far more needs in the community than they can provide. Because the demographics of the Cass County is rural coupled with high amount of poverty, there are significant community needs. However, resources are limited as well in this area. BLMH has chosen areas to address where they think they will make the most impact with the resources allotted.

Next Steps

The BLMH team and community team members will collaborate on appropriate areas of identified need and guide the development of implementation strategies and individual action plans for each area of opportunity. Measureable outcome indicators will also be established. The team will appropriately communicate the CHNA results and the Implementation Plan Strategy to the community using a variety of methods.