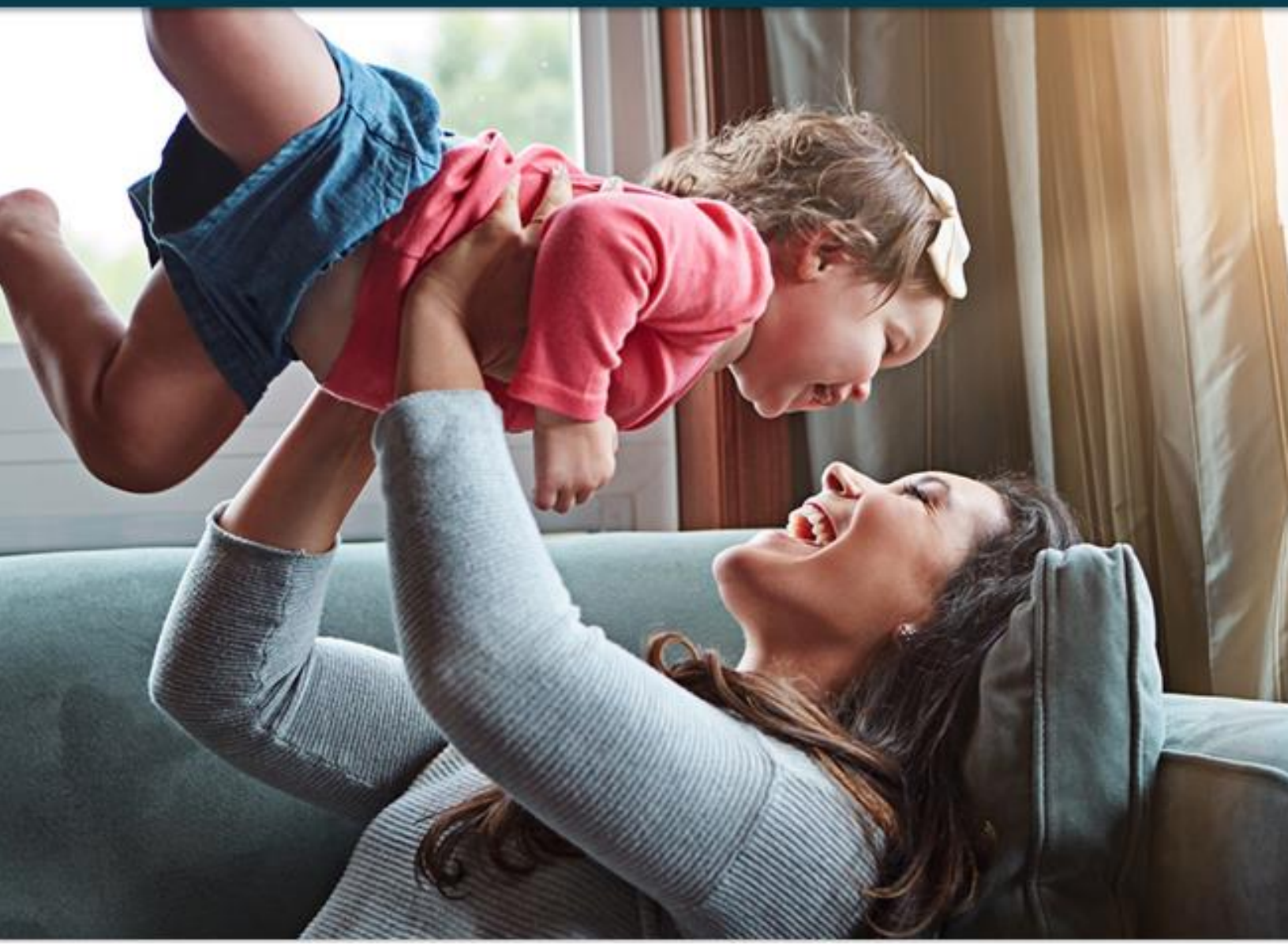
Marshfield Clinic Health System



2024-2026 Community Health Needs Assessment

Dickinson County Healthcare System d/b/a/ Marshfield Medical Center–Dickinson

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Welcome Letter

Dear Community Members,

Marshfield Clinic Health System's (MCHS) mission is to enrich lives and create healthy communities through accessible, affordable, compassionate health care. And that includes your community.

We know that health is driven by much more than what happens in the doctor's office. Wherever and whenever possible through programs, services, public policy or other means, emphasis needs to be on addressing health choices before medical needs arise.

That's why the MCHS Hospitals Board, Inc., authorized governing body, has adopted this needs assessment on December 6, 2023.

The Health System has collaborated with community partners to assess communities' health and needs. The process has included meetings, surveys, community conversations, key informant interviews and a variety of data sources.

This document summarizes these key findings. Electronic versions and companion documents can be found at https://marshfieldclinic.org/about-us/community-health-needs-assessment-reports.

Through these collaborative efforts, the top health priorities identified through the Community Health Needs Assessment process have been identified. MCHS will continue to support additional community health needs as they arise. The top health priorities for Dickinson County Healthcare System d/b/a Marshfield Medical Center-Dickinson (hereafter referred to as "MMC-Dickinson") are:

- Alcohol and Substance Abuse
- Behavioral Health
- Health Equity

We hope you find this document useful and welcome your comments and suggestions for improving the health of Dickinson County's citizens.

Yours in health,

Dr. Brian Hoerneman
CEO Interim
Marshfield Clinic Health System

Amanda Shelast
President
MMC-Dickinson

Jay Shrader
Vice President
Community Impact and Social Accountability

MMC-Dickinson, EIN # 38-2780429
1721 South Stephenson Avenue
Iron Mountain, MI 49801

Definition of Terms

- **Community Benefits Workgroup-Dickinson (CBW-Dickinson):** local and internal workgroup of MMC-Dickinson that contributes to the Health System's community benefits and community health initiatives. Essential functions are to monitor key policies, including financial assistance, billing, and collections, help to develop and sustain community relationships, participate in and develop the Community Health Needs Assessment and Implementation Strategy, and monitor and evaluate implementation of community benefits programs.

- **Community Health Assessment (CHA)/Community Health Needs Assessment (CHNA):** refers to a state, tribal, local, or territorial health assessment that identifies key health needs and issues through systematic, comprehensive data collection and analysis. (Centers for Disease Control and Prevention, 2019) Health Departments are required to participate in a CHA every five years. Non-profit (tax-exempt) hospitals are required by the Affordable Care Act to conduct a CHNA once every three years. Hospitals have the option to partner with local health departments to simultaneously conduct a CHA/CHNA. (Community Catalyst, 2013)

- **Community Health Improvement Plan (CHIP):** a long-term, systematic effort to address public health problems based on the results of community health assessment activities and the community health improvement process. A CHIP is typically updated every three to five years. (Centers for Disease Control and Prevention, 2019)

- **Health Equity**: everyone has a fair and just opportunity to be as healthy as possible. This requires removing obstacles to health such as poverty, discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care. (University of Wisconsin, Population Health Institute)

- **Health Priority(ies):** Health areas selected to be addressed by hospital based off of community input collected via survey, community conversations, and/or coalition meetings; and secondary data review.

- **Implementation Strategy (IS):** a written plan to address the community health needs identified through an assessment and approved by an authorized governing board. Hospitals must use the CHNA to develop and adopt an implementation strategy. (Community Catalyst, 2013)

- **Social Determinants of Health (SDOH):** the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks. Can be grouped into five domains: Economic Stability, Education Access and Quality, Health Care Access and Quality, Neighborhood and Built Environment, and Social and Community Context. (Healthy People 2030, U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion.)

- **United Way ALICE report:** ALICE is an acronym that stands for Asset Limited, Income Constrained, Employed. ALICE represents the households with income above the Federal Poverty Level but below the basic cost of living. United Way's ALICE Report provides current research-based data that quantifies who in Wisconsin is living on the edge of financial insecurity. (United Way ALICE Project, 2018)

- **University of Wisconsin's Population Health Institute's County Health Rankings:** a data source ranking nearly every county in the nation to identify the multiple health factors that determine a county's health status and indicate how it can be affected by where we live. (University of Wisconsin Population Health Institute, 2019)

Health System Overview

Marshfield Clinic was founded in 1916 by six physicians practicing in Marshfield, a rural central Wisconsin city. At its inception, Clinic founders saw research and education as critical to their practice of health care and that remains so today.

The Clinic became a 501(c)(3) nonprofit organization in 1992 and in 2014, Marshfield Clinic Health System, Inc., was formed. The Health System's mission is to enrich lives and create healthy communities through accessible, affordable, compassionate health care.

Marshfield Clinic Health System is an integrated health system whose mission is to enrich lives through accessible, affordable compassionate health care. The Health System serves Wisconsin and Michigan's Upper Peninsula with more than 1,600 providers comprising 170 specialties, health plan, and research and education programs. Primary operations include more than 60 Marshfield Clinic locations and 11 hospitals.

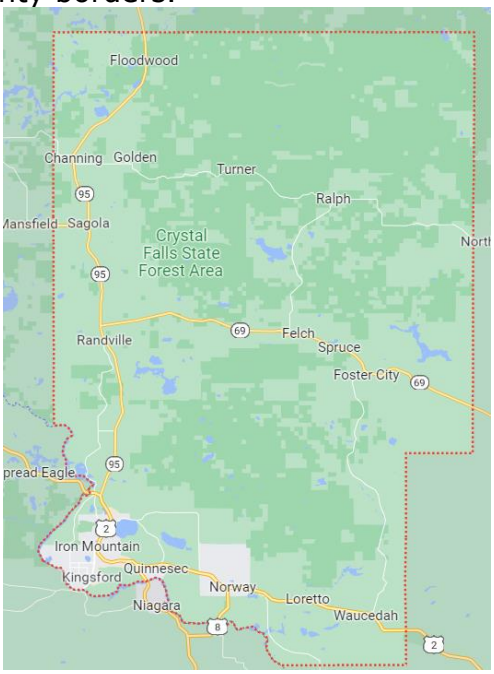
MCHS primary operations include Marshfield Clinic, Marshfield Medical Center hospitals in Marshfield, Eau Claire, Beaver Dam, Ladysmith, Minocqua, Neillsville, Rice Lake, Weston, Park Falls, Dickinson, and Marshfield Children's Hospital, Marshfield Clinic Research Institute, Security Health Plan, Division of Education and Marshfield Clinic Health System Foundation.

Hospital Overview

MMC-Dickinson has provided healthcare services to Northern Wisconsin and the Central Upper Peninsula of Michigan for over 70 years. Dickinson is a 49-bed general medical and surgical hospital in Iron Mountain, Michigan. It has over 70 providers on staff and more than 700 employees, providing a broad range of high-quality acute care, including inpatient, outpatient, diagnostic, home health, hospice, and specialty services. It also has primary care clinics in the Michigan towns of Iron Mountain, Norway, and Florence, Wisconsin.

Our Community

MMC-Dickinson strives to provide affordable and accessible health care for all. Many patients and community members reside in rural areas of Dickinson County and neighboring counties. The Health System focuses on serving those that are underserved and living in rural areas of the service area. MMC-Dickinson service area is not defined by county borders but serves those in high need areas with limited resources. However, for the purposes of this CHNA, the community served is defined by Dickinson County borders.



Geographic Area

Dickinson County is in the central Upper Peninsula of Michigan bordering Wisconsin. The county is comprised of three cities (Iron Mountain, Kingsford, and Norway) and seven townships (Breen, Breitung, Felch, Norway, Sagola, Waucedah, and West Branch) with a total population of 25,787 in 2021.

Demographics

	Dickinson County	Michigan	Wisconsin	United States
Total Population	25,787	10,050,811	5,895,908	331,893,745
Age				
Persons under 5 years	4.9%	5.5%	5.4%	5.7%
Persons under 18 years	19.8%	21.4%	21.6%	22.2%
Persons 65 years and over	24%	18.1%	17.9%	16.8%
Sex				
Female persons	49.3%	50.4%	49.9%	50.5%
Race				
White alone, not Hispanic or Latino	95.9%	79%	86.6%	75.8%
Hispanic or Latino	1.8%	5.6%	7.5%	18.9%
American Indian and Alaska Native alone	1.1%	0.7%	1.2%	1.3%
Black or African American alone	0.5%	14.1%	6.8%	13.6%
Asian alone	0.7%	3.4%	3.2%	6.1%
Native Hawaiian and other Pacific Islander alone	0.1%	Z	0.1%	0.3%
Two or More Races	1.7%	2.7%	2.2%	2.9%
Language other than English spoken at home	1.8%	9.7%	8.7%	21.5%
Education				
High school graduate or higher	94.7%	91.3%	92.6%	88.5%
Bachelor's degree or higher	24.4%	30%	30.8%	32.9%
Income				
Median household income, 2016-2020	$51,704	$59,234	$63,293	$64,994
Persons in poverty	9.7%	13.1%	10.8%	11.6%

Dickinson County Demographics, U.S. Census, 2021

Assessing the Needs of the Community

Overview
Community Benefits Workgroup (CBW)-Dickinson identified and prioritized community health priorities through a comprehensive process that included input from multi-sector community partners and organization leadership. Direct community input was gathered and focused on understanding the priorities of the underserved in the community. The CBW–Dickinson is committed to addressing health inequities and conducted the Community Health Needs Assessment (CHNA) using a health equity lens. The CBW-Dickinson seeks to address "types of unfair health differences closely linked with social, economic, or environmental disadvantages that adversely affect a group of people". (Attaining Health Equity. CDC. Retrieved from: https://www.cdc.gov/nccdphp/dch/programs/healthycommunitiesprogram/overview/healthequity.htm)

The Community Benefits workgroup (CBW)—Dickinson met in June 2023 to discuss the results of the Dickinson County prioritization processes. The hospital president of MMC-Dickinson convened the CBW-Dickinson, which included hospital leadership. All members are committed to guiding community benefits efforts and improving health in the community of Dickinson County. The CBW-Dickinson reviewed the Dickinson County CHA, secondary quantitative data to develop this report. The CHNA is used to develop an Implementation Strategy (IS) tailored to meet the identified health priorities.

See Appendix A for a list of those involved in the CBW-Dickinson.

Community Health Needs Assessment (CHNA) Timeline

August 2021	Upper Peninsula Community Health Issues and Priorities Survey Distributed to residents
September 2021	Deadline for Upper Peninsula Community Health Issues and Priorities Survey completion and return deadline.
May 2022	Survey data tabulation was completed by Michigan Technological University
July 2022	2021 Upper Peninsula Community Health Needs Assessment published
January 2023	Dickinson-Iron Community Health Improvement Planning Team started to meet regularly to discuss findings
March 2023	Dickinson-Iron Community health Improvement Planning Team established priorities
June 2023	CBW-Dickinson prioritized health priorities for MMC-Dickinson
December 2023	Completed, approved, and publicized the MMC-Dickinson CHNA

Process and Methods

The assessment process began with a thorough review of the 2018 Upper Peninsula Community Health Needs Assessment (CHNA) which was led completed by the Western Upper Peninsula Health Department with contributions from all other Upper Peninsula local health departments and 42 additional partners. The objective of the 2021 Upper Peninsula CHNA is to gather accurate, actionable, local information to advance our knowledge of our current health status, our future health needs, and identify our health-related priorities. With the input of community members, this information can be used to generate plans, develop policies, and allocate resources to improve the health of our local communities.

A complete list of partner organization representatives who participated in the health assessment process is included as Appendix A. The complete Upper Peninsula Wide CHNA is available here: https://www.wupdhd.org/2022/07/25/upchna/

Local partners include:

- Dickinson-Iron District Health Department
- BCBS Foundation of Michigan
- Bellin Health Hospital and Clinics
- Great Lakes Recovery Center
- Marshfield Medical Center- Dickinson
- Michigan Department of Health and Human Services
- Michigan Health Endowment Fund
- Michigan Technological University
- Northcare Network- Northpointe Behavioral Health System
- Northern Michigan Center for Rural Health
- Superior Health Foundation
- Upper Peninsula Health Care Solutions
- Upper Peninsula Health Group
- Upper Peninsula Health Plan

The partnership utilized the County Health Rankings and Roadmaps Take Action Model (Figure A) to guide the CHA process, which outlines the steps needed for the community health improvement process: assess needs and resources of the county, focus on the top health priorities, and develop action plans with effective programs.

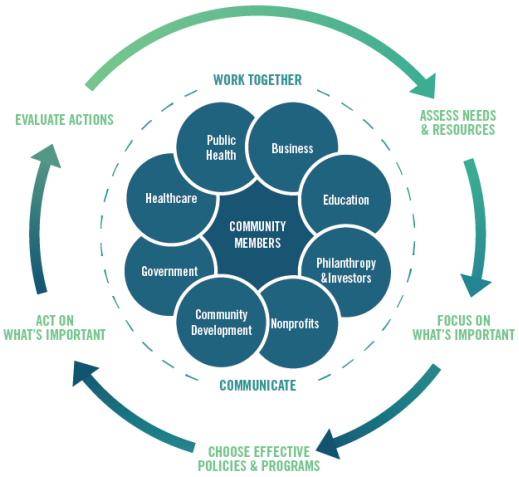


Figure A. County Health Rankings and Roadmaps Take Action Model

Identified Health Priorities Identified by Various Data Collection Methods	
Survey	Mental Health Substance Use Issues of Healthy Equity and Accessibility
Coalition Meeting	Mental Health Substance Use Health Equity and Accessibility
Secondary Data	Healthy Equity and Accessibility Preventative Care Mental Health Substance Use

Data Sources

The CHNA included primary and secondary data. Primary data included a county-wide survey and community conversations. Secondary data was compiled into a data packet, which included data from various sources.

Primary Data Collection

Community Health Assessment Survey

Primary data collection began with a community health survey in August 2021. The sample for the 2021 Community Health Survey of Upper Peninsula Adults was purchased from Marketing Systems Group. The sample was address-based and drawn from a database matched to the United States Postal Service's Delivery Sequence File. Within each Upper Peninsula County, 1,700 addresses were randomly selected.

Packets containing a cover letter, survey, and postage-paid pre-addressed return envelope were prepared and mailed to the entire sample of 23,800 addresses in August 2021. The packet included instructions for accessing an online version of the same survey, which was better utilized in 2021 than in 2017 Households that returned completed surveys early qualified for a prize drawing consisting of eight $50 grocery gift cards. No reminders were sent. Dickinson County had a survey response rate of 15% in 2021, which was down compared to the 2017 response rate of 20.7%.

Data analysis was conducted by Kelly Kamm, PhD from the Department of Kinesiology and Integrative Physiology, Michigan Technological University in Houghton, and Robert S. Van Howe, MD, MS, the provisional Medical Director for the Western U.P. Health Department and the Dickinson-Iron District Health Department. All analyses were completed in SAS, version 9.4 (Cary, North Carolina). Survey data were assessed for completeness and consistency.

The CBW-Dickinson recognizes that health is determined by more than health care. In an effort to further understand the conditions that affect a wide range of health, functioning, and quality-of-life outcomes and risks, a series of questions related to social determinants of health (SDOH) were included and further analyzed.

Coalition Meetings

The Dickinson-Iron Community Health Improvement Team met to discuss findings and have further dialogue. The first meeting was held in January 2023, to discuss preliminary CHA results. The goals of these meetings were 1) engage coalition members in discussion related to the top three health priorities identified by the community survey and community conversations, 2) review and highlight existing initiatives existing in the community, and 3) to encourage continued and ongoing commitment for local health improvement efforts through collaborative action plans. The Dickinson-Iron Community Health Improvement (CHIP) team meeting representing a broad cross-section of community members, leaders and organizations. CHIP team members participated in a facilitated small group discussion to refine the health priorities.

The coalition meeting resulted in following health priorities: **mental health, substance use and health equity**.

Secondary Data Collection

Local secondary quantitative health data was compiled from a variety of sources based on the Michigan Alliance for Local Public Health (MALPH) recommendations. Data sources included US Census, Centers for Disease Control and Prevention, Youth Risk Behavior Surveillance System, United Way reports, Healthy People, Michigan Vital and Health Statistics, and more.

This UPCHNA contains data and information from a wide range of indicators that either describe or impact the health of local residents. Although no single indicator tells a complete story, each contributes to an overall understanding of our community health needs. Data ranges from pollution levels to exercise practices, to how often vegetables are eaten, to household incomes, to how often residents see a healthcare provider, to how many adults have dental insurance, and hundreds of other indicators that impact health. Not surprisingly, many indicators identified in Upper Peninsula residents reflect state and national trends.

The University of Wisconsin's Population Health Institute's County Health Rankings identify multiple health factors that can significantly impact a county's health status such as, the environment, education, jobs, individual behaviors, access to services and health care quality. To determine the top health priorities for secondary data measures, national and state data measures were compared to Dickinson County data measures.

A Dickinson County Health Rankings report is included as Appendix C.

Prioritization Process

The prioritization process of the health needs is summarized below.

Step 1: Community Health Needs Survey in August – September 2021

A hard copy survey was randomly mailed out to Dickinson County households. Packets contained a cover letter, survey, and postage-paid pre-addressed return envelope were prepared and mailed to the entire sample of 1700 addresses in August 2021. The packet included instructions for accessing an online version of the same survey, which was better utilized in 2021 than in 2017. A total of 228 surveys were returned for analysis. Dickinson County had a survey response rate of 15% in 2021, which was down compared to the 2017 response rate of 20.7%. Survey results, which follow this introduction, provide county-level and regional data on physical and mental health status; access to primary care, dental care, mental health counseling and substance abuse treatment services; use of screening and preventive health care services; the prevalence of chronic diseases and disabilities; and certain behaviors linked to health status, morbidity, and mortality, including diet, exercise, and use of alcohol, tobacco, and other drugs. The survey was inspired by and modeled on the Centers for Disease Control and Prevention's (CDC) Behavioral Risk Factor Surveillance System (BRFS).

Step 2: Secondary Data Review: February 2023

After the UPCHNA was published, local secondary quantitative and qualitative health data were compiled with contribution of stakeholders within the community. The group heard from the Community That Cares Coalition Coordinator who presented youth risk and asset data sets from a survey from 2021.

Step 3: Coalition Meeting in March 2023
The Dickinson-Iron CHIP Team convened to review the Community Health Survey and secondary data results.
The following criteria was also considered in the prioritization process.

- Scope of problem (e.g., severity, number of people impacted)
- Health disparities (e.g., by income and/or race and ethnicity)
- Feasibility (e.g., are there known interventions, can we have an impact)
- Alignment with others (e.g., local health department priorities)

Step 4: CBW-Dickinson Meeting in June 2023
The CBW-Dickinson met in June 2023 to discuss the results of the Dickinson County prioritization processes. Additional consideration of alignment with the ABHE Community Health Focus Areas of Marshfield Clinic Health System were made. The National Association of County and City Health Officials (NACCHO) Prioritization Matrix was used to determine the health priorities, which included the following criteria:

- How is the county doing compared to the state and national goals?
- What health priorities have the largest community impact?
- What health priorities have the most serious impact?
- Is the community ready to change?
- Can these health priorities be changed over a reasonable period of time?
- Are there gaps in county efforts to address the health priority?
- Did the community and county data identify this as a health priority?

A full list of data sources and references is included in Appendix E.

Addressing the Needs of the Community

Overview
After completing extensive review of the UPCHNA, Dickinson County CHA, United Way data, County Health Rankings, and other quantitative and qualitative data, the top community health priorities identified by Marshfield Medical Center in Dickinson are:

- Alcohol and Substance Abuse
- Behavioral Health
- Health Equity

As these priorities are addressed, intentional efforts will be made to ensure appropriate resources are provided, and unfair and unjust obstacles are eliminated for all people and communities to reach their optimal health. Due to the interconnected nature of these health priorities, the CBW-Dickinson chose to combine a number of health priorities as shown in Table C.

Table C. Health Priority Crosswalk

Dickinson County Community Health Needs Assessment Survey Results	MMC-Dickinson CHNA
Alcohol Misuse	Alcohol and Substance Abuse
Substance Abuse	
Mental Health	Behavioral Health
Chronic Disease Prevention and Management	Health Equity
Tobacco and Vaping	
Accessibility and affordability to healthcare and service programs	

Health Priority: Alcohol and Substance Abuse
Substance use and alcohol misuse was identified as a top health priority in the Dickinson County CHA. Alcohol misuse is "more than 1 drink per day on average for women, and more than 2 drinks per day on average for men. Alcohol misuse is a pattern of drinking that result in harm to one's health, interpersonal relationships or ability to work." (Centers for Disease Control and Prevention, 2019) Substance abuse is "the harmful or hazardous use of psychoactive substances, including alcohol and illicit drugs" (i.e. marijuana, heroin, cocaine, and methamphetamine). (World Health Organization, 2019)

Consequences of alcohol or substance abuse is far reaching and includes motor vehicle and other injuries, fetal alcohol spectrum disorder and other childhood disorders, alcohol and/or drug dependence, liver, brain, heart, and other chronic diseases, infections, family problems, and both violent and nonviolent crimes.

MMC-Dickinson will complement local community efforts by focusing on reducing underage alcohol consumption and access, reducing excessive alcohol consumption and reducing opioid related deaths in addition to supporting community driven efforts through a variety of methods.

Data highlights
Data gathered from a Communities That Care Risk and Protective Factor Survey provided useful insight into the thoughts and beliefs of area students in grades 6, 8, 10, and 12 in 2021. More than 45% of students surveyed believe that laws and norms favor drug and alcohol use within the community. More than 33% of students felt that they could easily access drugs and alcohol of their choice. The top reported substances being used by students in grade 12 were alcohol (57.8%), vaping (33.8%), and marijuana (33.1%) trends were similar in other surveyed students. Between 20-25% of all students reported within the last 30 days they rode in a car with a driver who had been drinking alcohol. One in 10 students in grade 8 and 10 and 12% of seniors reported that they have been drunk or high at school within the last year.

The Dickinson County Adult Health Survey indicated that 13.4% of adults are heavy drinkers, which is more than Michigan's average of 6.8%. Furthermore, 13.5% admit to binge drinking regularly. Approximately 15% of adults also stated that they have used marijuana within the previous 30 days. Dickinson County ranked as the 8th highest rate of Operating Under the Influence of Liquor and Operation with Presence of Drugs out of 83 counties in Michigan.

Dickinson County Community Health Survey, Top Reasons this is a problem in the community:

- Drug Abuse (56%)
- Shortage of substance abuse treatment programs and services or lack of affordable care (40.5%).

Health Priority: Behavioral Health

Mental health was indicated as a top health priority in the Dickinson County CHA. Mental health is "an important part of overall health and well-being. Mental health includes our emotional, psychological, and social well-being. It affects how we think, feel, and act. It also helps determine how we handle stress, relate to others, and make healthy choices. Mental health is important at every stage of life, from childhood and adolescence through adulthood."
(Centers for Disease Control and Prevention, 2019)

Mental illness affects all ages and influences many areas of one's wellbeing. Mental health plays a role in the ability to maintain good physical health, while mental health issues are commonly associated with physical health issues and increased risk factors like substance abuse and obesity.

MMC-Dickinson will complement local community efforts by focusing on decreasing suicide rates in Dickinson County and improving social and emotional development of children and adolescents in addition to supporting community driven efforts through a variety of methods.

Data Highlights

Data gathered from a Communities That Care Risk and Protective Factor Survey provided useful insight into the thoughts and beliefs of area students in grades 6, 8, 10, and 12 in 2021. Nearly 55% of students reported experiencing depressive symptoms. Depressive symptoms in students of grade 12 were increased by more than 12% between 2019 and 2021.

The Dickinson County Adult Health Survey indicated that 27% of adults have been diagnosed with depressive disorder, which is more than Michigan's average of 19.5%. Approximately 28% of adults indicated that they have taken medication for mood within the last 12 months.

Dickinson County Community Health Survey, Top Reasons this is a problem in the community:

- Shortage of mental health programs and services or lack of affordable mental health care (53%).

Health Priority: Health Equity

Michiganders have long-experienced inequities (differences in health and opportunity that are systematic, avoidable, unnecessary, unfair, and unjust). Health Equity means that "everyone has a fair and just opportunity to be as healthy as possible" (Braveman et al., 2017). Achieving health equity in Michigan means that every Michigander has access to the conditions and resources they need in order to achieve their optimal health and wellbeing – regardless of where they are born, the level of resources their birth family had access to, the color of their skin, or cultural background (Governor's Health Equity Council Recommendations Executive Summary, 2022).

A strong and growing body of research shows that differences in health outcomes are the result of community conditions and policies and systems that shape health and opportunity. The neighborhoods we live in – along with past and present housing, education, and employment policies – create opportunities for some, but roadblocks for others (Wisconsin Population Health and Equity Report Card, 2021).

Social determinants of health are "the conditions in the environments where people are born, live, learn, work, play, worship and age that affect a wide range of health, functioning and quality-of-life outcomes and risks" (Healthy People 2030, 2021). It is critical to address social determinants of health in order to improve health and reduce health inequities as 80% of what impacts our health is affected by these areas.

MMC-Dickinson will focus on supporting access to basic needs, develop a work plan to address health equity gaps, both internally and within the community, and support partners in their work to address social determinants of health.

Data Highlight:
Information gathered from the Adult Health Survey portion of the Community Health Needs Assessment identified a socioeconomic health disparity that exists in Dickinson County.

Health Indicator By Household Income	Less Than $25,000	$50,000+
Health Fair or Poor	29.4%	7.6%
Uninsured (18-64)	3.9%	1.3%
Unable to Access Care Due to Cost	13%	3.9%
No Dental Care in Past Year	41.5%	20.9%
Current Smoker	17.8%	13.5%
No Physical Activity	18.1%	11.1%
Diabetes Diagnosis	16.9%	8.2%
Heart Disease	10.3%	6.3%
Chronic Lung Disease	13.3%	4.8%
Current Asthma	12.2%	9.8%
Limited By Arthritis	38.2%	24.3%
Depressive Disorder	32.4%	23.9%
Marijuana Past Month*	24.7%	15.4%
Prescription Abuse	10.1%	2.8%
*Survey completed before the legalization of marijuana		

In addition, the 2021 Regional Adult Health Survey indicates that some of the most important community issues include:

- Health Insurance is expensive or has high costs for co-pays and deductibles (56.2%)
- Unemployment, wage, and economic factors (50.6%)
- Lack of health insurance (42.8%)

An escalation has occurred in the health disparities around dental health. More dental offices are refusing to cover those without private insurance or they require out of pocket payment for treatment and care. Children on state funded dental insurance are being waitlisted or refused.

Potential Resources to Address Health Priorities

Potential resources and assets in the community that will help address the identified health priorities as well as help develop the implementation plans include the following:

Dickinson Area Community Foundation
Dickinson-Iron Community Health Improvement Planning Team
Dickinson-Iron Community That Cares Coalition
Dickinson-Iron District Health Department
Dickinson-Iron Intermediate School District
Great Lakes Recovery
Northern Lights YMCA
Northpointe Behavioral Health
Northwoods Coalition
Smiles On Wheels
Upper Peninsula Commission for Area Progress (UPCAP)
UP Food As Medicine

Next Steps

Having identified the health priorities that will be addressed, the next steps include collaboration with community partners through a variety of community coalitions, workgroups, and organizations. MMC-Dickinson will leverage existing partnerships and community resources to coordinate strategic efforts to address identified community health priorities that can be monitored, evaluated, and improved upon over time.

The CBW-Dickinson, a local and internal workgroup that contributes to the Health System's community benefits and community health initiatives, will oversee the three-year Implementation Strategy plan that will integrate these health priorities into the strategic plan for resource investments and allocations. The CBW-Dickinson will implement strategies that systematically focus on the social determinants of health, subsequently reduce health disparities and that demonstrate potential to have the most impact on improving selected health priorities.

CBW-Dickinson will evaluate implemented programs and activities and track key performance indicators during each year of the implementation plan. This analysis will be done in collaboration with respective partners with the intent to identify new and current resources that can be better integrated and deployed to maximize positive impact on population health.

This CHNA will be shared among all partners and made publicly available.

Approval and Community Input
This Community Health Needs Assessment (CHNA) report was adopted by the MCHS Hospitals Board Inc. on December 6, 2023.

If you would like to serve on a coalition that helps meet the aims of this report, or have a comment on this assessment, please contact the Marshfield Clinic Health System Center for Community Health Advancement at communityhealth@marshfieldclinic.org or (715) 221-8400.

Evaluation of the Impact of the Preceding Implementation Strategy

MMC-Dickinson was officially affiliated with the Marshfield Clinic Health System in February of 2022. Therefore, there is no preceding Implementation Strategy to evaluate.

Appendix A: Individuals Involved in the CHNA

2021 Upper Peninsula Community Health Needs Assessment Partnerships

- Aspirus Hospital- Iron River, Ironwood, Keweenaw, Ontonagon
- BCBS Foundation of Michigan
- Baraga County Memorial Hospital
- Belling Health Hospital and Clinics
- Chippewa County Health Department
- Copper County Community Mental Health
- Dickinson-Iron District Health Department
- Gogebic County Community Mental Health
- Great Lakes Recovery Center
- Helen Newberry Joy Hospital
- Keweenaw Bay Indian Community
- Luce-Mackinaw-Alger-Schoolcraft District Health Department
- Mackinac Straits Health System
- Marshfield Clinic Health System- Dickinson
- Marquette County Health Department
- Michigan Department of Health and Human Services
- Michigan Health Endowment Fund
- Michigan Technological University
- Munising Memorial Hospital/Baycare Medical Center
- MyMichigan Medical Center- Sault
- Northcare Network
- Northern Michigan Center for Rural Health
- Northpointe Behavior Health System
- OSF St. Francis Hospital
- Pathways Community Mental Health
- Portage Health Foundation
- Public Health of Delta and Menominee Counties
- Schoolcraft Memorial Hospital
- Superior Health Foundation
- Upper Great Lakes Family Health Center
- Upper Peninsula Health Care Solutions
- Upper Peninsula Health Group
- Upper Peninsula Health Plan
- UP Health Systems- Bell, Marquette, Portage
- War Memorial Hospital
- Western UP Health Department
- Western UP Planning and Development Region

Community Benefits Workgroup–Dickinson

- Amanda Shelast President, MMC-Dickinson
- President of Medical Affairs, MMC-Dickinson
- Trenton Rankin, Regional Chief Nursing Officer, MMC-Dickinson
- Jay Shrader, Vice President, Community Impact and Social Accountability
- Darcy Vanden Elzen, Director-Community Health
- Carolyn Hoy, Population Health and Quality Management Manager, MMC-Dickinson
- Ruth Manier, Community Benefits Coordinator, MMC-Dickinson

Appendix B: Community Health Survey

Instructions for Completing the Survey

These instructions will show you how to answer each type of question found in this survey. Each question should be answered only about the adult taking the survey, not anyone else in your household. Feel free to answer in pen or pencil, whichever you prefer.

- Some questions are answered by checking a choice from a list. You answer the question by checking a box, like this:

  ☑ Yes
  ☐ No

- Some questions are answered by entering numbers into one or more boxes. You answer the question by filling in one digit per box::

  [0][9] Number of days

- You will sometimes be instructed to skip one or more future questions based on how you answer the current question. In the example, if your choice is 'Yes', the next question you should answer is 6.2. If your choice is 'No', the next question you should answer is 7.1.

  ☐ Yes ➡ **Go to 6.2**
  ☐ No ➡ **Go to Section 7**

Please begin the survey now with Section 1: About Your Household.

Section 1: About Your Household

1.1 How many adults (age 18 or older) currently live in this household?

☐☐ Number of adults

1.2 What is YOUR gender?

☐ Male
☐ Female

1.3 What county do you live in?

☐ Alger County
☐ Baraga County
☐ Chippewa County
☐ Delta County
☐ Dickinson County
☐ Gogebic County
☐ Houghton County
☐ Iron County
☐ Keweenaw County
☐ Luce County
☐ Mackinac County
☐ Marquette County
☐ Menominee County
☐ Ontonagon County
☐ Schoolcraft County

Section 2: Health Status

2.1 Would you say that in general your health is ...

☐ Excellent
☐ Very good
☐ Good
☐ Fair
☐ Poor

Section 3: Healthy Days

3.1 Now thinking about your physical health, which includes physical illness and injury, for how many days during the past 30 days was your physical health only FAIR or POOR?

☐☐ Number of days (0 to 30)

3.2 Now thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental health only FAIR or POOR?

☐☐ Number of days (0 to 30)

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

☐☐ Number of days (0 to 30)

Section 4: Health Care Access

4.1 Do you have any type of health insurance coverage?

- ☐ I have health insurance
- ☐ I do NOT have health insurance

4.2 Do you have one person you think of as your personal doctor or health care provider?

- ☐ Yes – only one person
- ☐ Yes – more than one person
- ☐ No – no particular person or persons

4.3 Was there a time in the past 12 months when you needed to see a doctor but could not because of cost?

- ☐ Yes
- ☐ No

4.4 Was there a time in the past 12 months when you needed to see a doctor but could not because of a lack of transportation?

- ☐ Yes
- ☐ No

4.5 About how long has it been since you last visited a doctor for a routine checkup?
A routine checkup is a general physical exam, not an exam for a specific injury, illness, or condition.

- ☐ Within past year (anytime less than 12 months ago)
- ☐ More than one year ago
- ☐ Never
- ☐ Don't know/ Not sure

Section 5: Hypertension Awareness

5.1 Have you EVER been told by a doctor, nurse, or other health professional that you have high blood pressure? "Other health professional" could be a nurse practitioner, a physician's assistant, or some other licensed health professional.

- ☐ Yes ➡ **Go to 5.2**
- ☐ Yes, but only during pregnancy **(women only)** ➡ **Go to Section 6**
- ☐ No ➡ **Go to Section 6**
- ☐ Don't know/ Not sure ➡ **Go to Section 6**

5.2 Are you currently taking medicine for your high blood pressure?

- ☐ Yes
- ☐ No

Section 6: Cholesterol Awareness

6.1 Blood cholesterol is a fatty substance found in the blood. Have you EVER had your blood cholesterol checked?

- ☐ Yes ➡ **Go to 6.2**
- ☐ No ➡ **Go to Section 7**
- ☐ Don't know/ Not sure ➡ **Go to Section 7**

6.2 Have you EVER been told by a doctor, nurse or other health professional that your blood cholesterol is high?

- ☐ Yes
- ☐ No
- ☐ Don't know/ Not sure

Section 7: Oral Health

7.1 How long has it been since you last visited a dentist or dental clinic for any reason? Include visits to dental specialist, such as orthodontist.

- ☐ Within the past 12 months
- ☐ Between 1 and 2 years ago
- ☐ Between 2 and 5 years ago
- ☐ More than 5 years ago
- ☐ Never

7.2 Do you have any kind of dental insurance coverage?

- ☐ Yes
- ☐ No

7.3 Was there a time in the past 12 months when you needed to see a dentist but could not because of cost?

- ☐ Yes
- ☐ No

7.4 Was there a time in the past 12 months when you needed to see a dentist but could not because of transportation?

- ☐ Yes
- ☐ No

7.5 In the past 12 months, did you delay a dental visit because you could not find an available dental professional?

- ☐ Yes
- ☐ No

Section 8: Disability

8.1 Are you limited in any way in any activities because of physical, mental, or emotional problems?

- ☐ Yes
- ☐ No

8.2 Do you now have any health problem that requires you to use special equipment, such as a cane, a wheelchair, a special bed, or a special telephone? Please also include occasional use or use in certain circumstances.

- ☐ Yes
- ☐ No

Section 9: Chronic Health Conditions

9.1a Have you EVER been told by a doctor, nurse, or other health professional that you had asthma?

- ☐ Yes ➡ **Go to 9.1b**
- ☐ No ➡ **Go to 9.2**
- ☐ Don't know/ Not sure ➡ **Go to 9.2**

9.1b Do you still have asthma?

- ☐ Yes
- ☐ No
- ☐ Don't know/ Not sure

9.2 Has a doctor, nurse or other health professional EVER told you that you have diabetes?

- ☐ Yes
- ☐ Yes, but only during pregnancy **(women only)**
- ☐ No
- ☐ No, but I was told that I have pre-diabetes or borderline diabetes
- ☐ Don't know/ Not sure

9.3 Has a doctor, nurse, or other health professional EVER told you that you had any of the following?

	Check one box for each item		
	YES	NO	NOT SURE
a. A heart attack, also called a myocardial infarction?	☐	☐	☐
b. Heart disease?	☐	☐	☐
c. A stroke?	☐	☐	☐
d. Skin cancer?	☐	☐	☐
e. Other types of cancer?	☐	☐	☐
f. COPD (chronic obstructive pulmonary disease), CLRD (chronic lower respiratory disease), emphysema or chronic bronchitis?	☐	☐	☐

9.4 Arthritis can cause symptoms like pain, aching, or stiffness in or around a joint. Are you now limited in your usual activities because of arthritis or joint symptoms? Please answer the question based on your current experience, regardless of whether you are taking any medication or treatment.

☐ Yes
☐ No

9.5 Has a doctor, neurologist, psychiatrist, psychologist, or other health professional ever told you that you have Alzheimer's Disease or dementia?

☐ Yes
☐ No

9.6 Has a doctor, social worker, or other professional ever recommended that you move to a nursing home, long-term care facility, or other alternate living arrangement due to declining physical or mental capabilities?

☐ Yes
☐ No

Section 10: Tobacco Use

10.1 Have you smoked at least 100 cigarettes in your entire life?

5 packs = 100 cigarettes

☐ Yes ➡ **Go to 10.2**
☐ No ➡ **Go to 10.5**

10.2 If yes, at what age did you start smoking?

☐☐ Age in years

10.3 Do you now smoke cigarettes every day, some days, or not at all?

☐ Every day ➡ **Go to 10.4**
☐ Some days ➡ **Go to 10.4**
☐ Not at all ➡ **Go to 10.5**

10.4 During the past 12 months, have you stopped smoking for one day or longer because you were trying to quit smoking?

☐ Yes
☐ No

10.5 Do you currently use e-cigarettes or vaping products every day, some days, or not at all?

- ☐ Every day
- ☐ Some days
- ☐ Not at all

10.6 Do you currently use chewing tobacco, snuff, or snus every day, some days, or not at all?

- ☐ Every day
- ☐ Some days
- ☐ Not at all

Section 11: Fruits and Vegetables

These next questions are about the fruits and vegetables you ate or drank **during the past 7 days**. Please think about all forms of fruits and vegetables: cooked or raw, fresh, frozen or canned. Please think about all meals, snacks, and foods eaten at home and away from home.

11.1 During the past 7 days, how many times did you drink 100% PURE fruit juices? Do not include fruit-flavored drinks with added sugar or fruit juice you made at home and added sugar to. Only include 100% juice.

☐☐ Times in the past 7 days

(if never, enter 0)

11.2 During the past 7 days, not counting juice, how many times did you eat fruit? Count fresh, frozen, or canned fruit.

☐☐ Times in the past 7 days

(if never, enter 0)

11.3 During the past 7 days, how many times did you eat cooked or canned beans, such as refried, baked, black, garbanzo beans, beans in soup, soybeans, edamame, tofu or lentils? Do NOT include long green beans.

☐☐ Times in the past 7 days

(if never, enter 0)

11.4 During the past 7 days, how many times did you eat dark green vegetables, such as broccoli or dark leafy greens including romaine, chard, collard greens or spinach?

☐☐ Times in the past 7 days

(if never, enter 0)

11.5 During the past 7 days, how many times did you eat orange-colored vegetables such as sweet potatoes, pumpkin, winter squash, or carrots?

☐☐ Times in the past 7 days

(if never, enter 0)

11.6 Not counting the vegetables you already reported, during the past 7 days, how many times did you eat OTHER vegetables? Examples of other vegetables include tomatoes, tomato juice or vegetable juice, corn, eggplant, peas, long green beans, lettuce, cabbage, and white potatoes that are not fried, such as baked or mashed potatoes.

☐☐ Times in the past 7 days

(if never, enter 0)

Section 12: Leisure-Time Physical Activity

The next few questions are about exercise, recreation, or physical activities OTHER THAN your regular job duties.

12.1 Some examples of leisure-time physical activities are running, biking, golf, gardening, walking for exercise, basketball, and moderate to strenuous housework. During the past month, did you participate in any of these OR OTHER leisure time physical activities for ANY length of time?

- ☐ Yes ➡ **Go to 12.2**
- ☐ No ➡ **Go to 12.4**

20.4 How long has it been since you had your last Pap test?

- ☐ Within the past 12 months
- ☐ Between 1 year and 3 years ago
- ☐ Between 3 years and 5 years ago
- ☐ More than 5 years ago
- ☐ Never

20.5 Have you had a hysterectomy?

- ☐ Yes
- ☐ No

The next section is for MEN only.
WOMEN ➡ **Go to Section 22.**

Section 21: Prostate Cancer Screening (Men)

21.1 Have you and your health care provider ever discussed whether you should have a prostate cancer screening test?

- ☐ Yes
- ☐ No
- ☐ Don't know/ Not sure

21.2 A Prostate-Specific Antigen test, also called a PSA test, is a blood test used to check men for prostate cancer. Have you EVER HAD a PSA test?

- ☐ Yes
- ☐ No
- ☐ Don't know/ Not sure

Section 22: Colorectal Cancer Screenings

22.1 Have you had any of the following screening tests for colorectal cancer? Answer in the table below.

	YES	IF YES, INDICATE WHEN YOU LAST HAD THE TEST DONE.	NO	NOT SURE
a. Blood-stool (fecal-occult) test?	☐	☐ Less than 1 year ago ☐ 1 to 2 years ago ☐ More than 2 years ago	☐	☐
b. Sigmoidoscopy?	☐	☐ Less than 5 years ago ☐ 5 to 10 years ago ☐ More than 10 years ago	☐	☐
c. Colonoscopy?	☐	☐ Less than 10 years ago ☐ 10 to 15 years ago ☐ More than 15 years ago	☐	☐

17.2 Have you ever used prescription drugs not prescribed to you, for the purpose of getting high?

- ☐ Yes
- ☐ No

17.3 Have you ever injected or snorted drugs for the purpose of getting high?

- ☐ Yes
- ☐ No

17.4 During the last 30 days, on how many days did you use marijuana, hashish, marijuana wax, or marijuana-infused edibles?

☐☐ Times in the past 30 days

(if never, enter 0)

17.5 Do you have a prescription for medical marijuana?

- ☐ Yes
- ☐ No

Section 18: Access to Treatment Services

18.1 In the past 12 months, did you receive substance abuse treatment services for alcohol or drug addiction, or for problem behaviors associated with drug or alcohol use (either voluntary or court-ordered)?

- ☐ Yes, alcohol treatment or counseling ONLY
- ☐ Yes, drug treatment or counseling ONLY
- ☐ Yes, treatment for alcohol AND other drugs
- ☐ No

18.2 In the past 12 months, have you delayed or not received needed substance abuse treatment due to cost?

- ☐ Yes
- ☐ No

18.3 In the past 12 months, have you delayed or not received needed substance abuse treatment due to lack of transportation?

- ☐ Yes
- ☐ No

18.4 In the past 12 months, have you delayed or not received needed substance abuse treatment because you could not find an available program or professional addictions counselor?

- ☐ Yes
- ☐ No

Section 19: Hepatitis C

19.1 Have you ever been tested for Hepatitis C? Do not count tests you may have had as part of a blood donation.

- ☐ Yes
- ☐ No
- ☐ Don't know/ Not sure

The next section is for WOMEN only.
MEN ➡ **Go to Section 21.**

Section 20: Breast/Cervical Cancer Screening (Women)

20.1 A mammogram is an x-ray of each breast to look for breast cancer. Have you ever had a mammogram?

- ☐ Yes ➡ **Go to 20.2**
- ☐ No ➡ **Go to 20.3**

20.2 How long has it been since you had your last mammogram?

- ☐ Within the past 2 years
- ☐ Longer than 2 years

20.3 A Pap test is a test for cancer of the cervix. Have you ever had a Pap test?

- ☐ Yes ➡ **Go to 20.4**
- ☐ No ➡ **Go to 20.5**

15.4 In the last 12 months, have you taken any medication to help with mood, emotions, or mental health?

☐ Yes
☐ No

15.5 In the past 12 months, have you received counseling or other non-medication treatment from a mental health professional?

☐ Yes
☐ No

15.6 In the past 12 months, have you delayed or not received needed counseling due to cost?

☐ Yes
☐ No

15.7 In the past 12 months, have you delayed or not received needed counseling due to lack of transportation?

☐ Yes
☐ No

15.8 In the past 12 months, have you delayed or not received needed counseling because you could not find an available mental health professional?

☐ Yes
☐ No

Section 16: Alcohol Consumption

16.1 During the past 30 days, on how many days did you have at least one drink of any alcoholic beverage such as beer, wine, or liquor?

☐☐ Enter your best estimate for the number of days (0 to 30)
(if no drinks in the past 30 days, enter 0 and ➡ **Go to Section 17**)

16.2 One drink is equivalent to a 12-ounce beer, a 5-ounce glass of wine, or a drink with one shot of liquor. A 40-ounce beer would count as 3 drinks, or a cocktail drink with 2 shots would count as 2 drinks. During the past 30 days, *on the days when you drank*, about how many drinks did you drink per day?

☐☐ On the days when you drank, average number of drinks per day

16.3 During the past 30 days, how many times have you driven when you've had perhaps too much to drink?

☐☐ Times in the past 30 days
(if never, enter 0)

16.4a MEN ONLY: Considering all types of alcoholic beverages, about how many times during the past 30 days did you have 5 or more drinks within a 2 hour period?

☐☐ Times in the past 30 days
(if never, enter 0)

16.4b WOMEN ONLY: Considering all types of alcoholic beverages, about how many times during the past 30 days did you have 4 or more drinks within a 2 hour period?

☐☐ Times in the past 30 days
(if never, enter 0)

Section 17: Drug Use

*Remember while answering the following questions that this is an **anonymous survey.** We appreciate your honesty in answering all questions so we can get an accurate picture of regional health conditions.*

17.1 Have you ever used over-the-counter drugs, or synthetic or designer drugs such as K2/Spice, Salvia, Bath Salts, or synthetic cannabinoids, for the purpose of getting high?

☐ Yes
☐ No

12.2 **Vigorous-intensity aerobic activity** makes you breathe hard and fast, and your heart rate goes up quite a bit. If you're working at this level, you won't be able to say more than a few words without pausing for a breath. Some examples of vigorous-intensity aerobic activities are jogging or running, swimming laps, and playing basketball.

During a typical week in the past month, how many days did the time you spent doing vigorous-intensity aerobic activities add up to 20 minutes or more a day?

☐☐ Number of days (0 to 7)

12.3 **Moderate-intensity aerobic activity** makes you work hard enough to raise your heart rate and break a sweat. If you're working at this level, you should still be able to carry on a conversation with another person. Some examples of moderate-intensity aerobic activities are walking, biking, playing doubles tennis, dancing, and pushing a lawn mower.

During a typical week in the past month, how many days did the time you spent doing moderate-intensity aerobic activities add up to 30 minutes or more per day? Do not include time spent doing vigorous-intensity aerobic activities.

☐☐ Number of days (0 to 7)

12.4 **During a typical week in the past month, how many times did you do physical activities or exercises to STRENGTHEN your muscles?** Do NOT count aerobic activities. Count activities using your own body weight like yoga, sit-ups or push-ups and those using weight machines, free weights, or elastic bands.

☐☐ Times in a typical week

(if never, enter 0)

Section 13: Immunization

13.1 **During the past 12 months, did you get a seasonal flu shot?**

- ☐ Yes
- ☐ No

13.2 **A pneumonia shot or pneumococcal vaccine is usually given only once or twice in a person's lifetime and is different from the flu shot. Have you ever had a pneumonia shot?**

- ☐ Yes
- ☐ No
- ☐ Don't know/ Not sure

Section 14: Seatbelt Use

14.1 **How often do you use seat belts when you drive or ride in a car or truck?**

- ☐ Always
- ☐ Nearly always
- ☐ Sometimes
- ☐ Seldom
- ☐ Never
- ☐ Never drive or ride in a car or truck

Section 15: Mental Health

15.1 **Has a doctor, nurse, or other health care professional EVER told you that you have a depressive disorder (including depression, major depression, dysthymia, or minor depression)?**

- ☐ Yes
- ☐ No
- ☐ Don't know/Not sure

15.2 **Has a doctor or other mental health professional EVER told you that you have an anxiety disorder (including generalized anxiety disorder, panic disorder, social anxiety disorder, or a specific phobia)?**

- ☐ Yes
- ☐ No
- ☐ Don't know/Not sure

15.3 **In the last 12 months, did you call or text a crisis line such as the National Suicide Prevention Lifeline, Dial Help, 24-hour crisis lines at local mental health agencies, or other similar services?**

- ☐ 1 or 2 times in the past 12 months
- ☐ More than 3 times in the past 12 months
- ☐ No

Section 24: Community Health Issues and Priorities

You have almost completed the survey. To this point, you have answered questions about your own individual health. Now we will ask you for your opinion on community health issues. For each issue, please select the response that best reflects how important you think the issue is on a 4-point scale, from "No an issue..." to "Very important..." Answer based on your perception of overall community conditions, not necessarily the needs of your family.

24.1 In the table below, rate how important each issue is for people in your community—your neighborhood, city, township, county. How serious is each issue in your opinion, and how important is it for consideration in local or regional health improvement planning? ***(PLEASE CHECK ONE BOX IN EACH ROW)***

Community Health Issue	Not an issue, or of very little importance	Fairly unimportant	Fairly important	Very important—should be a priority
a. Unemployment, wages, and economic conditions	☐	☐	☐	☐
b. Lack of health insurance	☐	☐	☐	☐
c. Health insurance is expensive or has high costs for co-pays and deductibles	☐	☐	☐	☐
d. Shortage of mental health programs and services, or lack of affordable mental health care	☐	☐	☐	☐
e. Shortage of substance abuse treatment programs and services, or lack of affordable care	☐	☐	☐	☐
f. Shortage of dentists, or lack of affordable dental care	☐	☐	☐	☐
g. Transportation to non-emergency medical care	☐	☐	☐	☐
h. Tobacco use	☐	☐	☐	☐
i. Alcohol abuse	☐	☐	☐	☐
j. Drug abuse	☐	☐	☐	☐
k. Childhood obesity and overweight	☐	☐	☐	☐
l. Lack of affordable healthy foods, including year-round fresh fruits and vegetables	☐	☐	☐	☐
m. Lack of affordable facilities or programs for year-around physical activity or recreation	☐	☐	☐	☐
n. Lack of programs and services to help seniors maintain their health and independence	☐	☐	☐	☐
o. Shortage of long-term care (nursing home beds) or lack of affordable long-term care services	☐	☐	☐	☐
p. Lack of programs and housing for people with Alz-heimer's Disease or dementia.	☐	☐	☐	☐

Thank you for helping us better understand regional health needs!

Please return the completed survey promptly, using the enclosed postage-paid return envelope.

Section 23: About You

23.1 What is your age?

☐☐☐ Age in years

23.2 About how tall are you without shoes?

☐ *Feet and* ☐☐ *Inches*

23.3 About how much do you weigh without shoes?

☐☐☐ *Pounds*

23.4 What is the highest grade or year of school you completed?

- ☐ Less than grade 12
- ☐ Grade 12 or GED (High school graduate)
- ☐ College 1 year to 3 years (Associate's degree, or some college or technical school)
- ☐ Bachelor's degree or higher

Please indicate below in Question 23.5 which broad income category your household falls into. **REMEMBER, the survey is anonymous, no one will ever know your identity, and your individual responses will never be shared.** We use your answers from 1.1 (number of adults in household), 1.2 (gender), 1.3 (county of residence), 23.1 (age), 23.4 (educational attainment), and 23.5 (household income) **ONLY** for purposes of statistical weighting of the random household address sample so that local health data can be accurately compared with state and national data.

23.5 Please mark your annual household income from all sources:

- ☐ Less than $25,000
- ☐ $25,000 to less than $50,000
- ☐ $50,000 or more

You are almost finished! Please turn to page 12 and complete the FINAL section.

Appendix C: Community Health Survey Results

Community Health Issues	Not an issue, or of very little importance	Fairly unimportant	Fairly important	Very important — should be a priority
	% (95%CI) [2017 value]	% (95%CI) [2017 value]	% (95%CI) [2017 value]	% (95%CI) [2017 value]
Unemployment, wages, and economic conditions	7.4 (3.7, 11.0) [3.9]	6.2 (2.2, 10.2) [7.6]	35.8 (26.7, 45.0) [36.3]	50.6 (40.7, 60.5) [52.2]
Lack of health insurance	7.6 (2.6, 12.6) [5.7]	6.0 (2.4, 9.6) [4.5]	43.6 (33.5, 53.8) [33.9]	42.8 (33.3, 52.3) [55.8]
Health insurance is expensive or has high costs for co-pays and deductibles	1.9 (0.4, 3.5) [5.9]	4.9 (0.2, 9.6) [4.7]	37.0 (27.3, 46.6) [14.0]	56.2 (46.4, 66.1) [75.5]
Shortage of mental health programs and services, or lack of affordable mental health care	5.3 (2.3, 8.3) [6.7]	8.0 (2.8, 13.2) [17.7]	33.7 (24.5, 42.9) [38.8]	53.0 (43.2, 62.8) [36.8]
Shortage of substance abuse treatment programs and services/lack of affordable care	9.7 (4.3, 15.1) [9.3]	14.3 (7.5, 21.0) [16.4]	35.5 (25.3, 45.7) [36.8]	40.5 (31.2, 49.8) [37.4]
Shortage of dentists, or lack of affordable dental care	15.8 (9.6, 22.0) [11.8]	19.1 (11.0, 27.3) [20.1]	31.6 (22.6, 40.6) [36.5]	33.5 (23.7, 43.2) [31.6]
Transportation to non-emergency medical care	16.3 (9.0, 23.6) [15.8]	25.3 (16.6, 33.9) [22.1]	29.8 (21.3, 38.3) [41.9]	28.7 (19.0, 38.3) [20.1]
Tobacco use	17.6 (9.9, 25.3) [17.8]	24.6 (15.6, 33.6) [18.0]	41.8 (31.9, 51.7) [42.5]	16.0 (10.4, 21.6) [21.7]
Alcohol abuse	14.1 (6.8, 21.5) [11.0]	15.4 (7.7, 23.1) [11.2]	38.9 (29.1, 48.6) [43.5]	31.6 (23.2, 40.0) [34.4]
Drug abuse	8.6 (2.6, 14.6) [8.4]	8.5 (2.6, 14.4) [5.3]	26.9 (18.5, 35.2) [31.8]	56.0 (46.2, 65.8) [54.6]
Childhood obesity	8.1 (2.0, 14.2) [4.6]	12.4 (5.7, 19.2) [14.8]	41.0 (31.5, 50.6) [37.3]	38.5 (28.6, 48.3) [43.3]
Lack of affordable healthy foods, including year-round fresh fruits and vegetables	11.2 (4.3, 18.2) [13.3]	19.8 (12.1, 27.6) [20.8]	36.4 (27.2, 45.6) [36.8]	32.5 (22.9, 42.2) [29.1]
Lack of affordable facilities or programs for year-round physical activity or recreation	14.3 (7.4, 21.2) [13.3]	22.8 (15.4, 30.3) [25.0]	30.6 (22.0, 39.2) [33.8]	32.3 (22.2, 42.4) [28.0]
Lack of programs and services to help seniors maintain their health and independence	14.2 (6.7, 21.6) [5.9]	14.9 (7.8, 22.0) [21.8]	33.3 (24.5, 42.0) [36.5]	37.7 (27.8, 47.5) [35.7]
Shortage of long-term care (nursing home beds)/lack of affordable services	13.4 (5.6, 21.2) [11.8]	12.0 (5.8, 18.3) [17.8]	36.0 (27.0, 45.0) [33.6]	38.6 (28.7, 48.4) [36.7]
Lack of programs and housing for people with Alzheimer's Disease and dementia	11.3 (3.6, 19.1) [7.5]	9.2 (3.8, 14.5) [18.7]	37.8 (28.5, 47.1) [37.5]	41.7 (31.8, 51.7) [36.2]

Appendix D: References

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