COMMUNITY SYSTEM ASSESSMENT EVENT REPORT

NORTHCENTRAL REGION – AUGUST 12, 2021

The Community System: Our System of Local Community Services

All of us are part of the Community System. Community Systems are networks of diverse agencies and groups with differing roles, relationships, and interactions whose activities combined contribute to the health and well-being of the community.

The Community System Assessment:

- Improves organizational and community communication and collaboration by bringing a broad spectrum of partners to the same table.
- Helps participants learn about community health and how activities are interconnected.
- Identifies system strengths and weaknesses may then be used to improve and better coordinate activities at the community level

Process:

One Community System Assessment event was held in each CHIR region. We partnered with local Community Collaborative leaders to engage key stakeholders and residents to participate in the assessment.

Participants discussed the 8 Focus Areas of the Community System in Team Discussions led by a trained facilitator. Participants were able to discuss two Focus Areas of their choice in two Team Discussion sessions.

Facilitators led the groups through a set of specific discussion questions and then participants scored the performance of the Community System based on three or four performance measures. (The Scoring grid is included in Appendix 1 of this document.) Participants then brainstormed Strengths and Opportunities for Improvement regarding their Focus Area.

Discussion may focus on specific counties as representation may not include all counties in the Northeast CHIR Region. This report highlights discussion for each Focus Area, Performance Measure Scores, and discussion of Strengths and Opportunities for Improvement.

Focus Area 1 Resources

Resources: A community asset (or a community resource) is anything that can be used to improve the quality of community life.

Performance Measures & Scoring:

At what level do we, as a system of community services,

1.1 Connect or link people to organizations that can provide the resources they may need?	Voting scores were not able to be captured
1.2 Help people access resources and services in a way that considers the unique needs of different populations?	
1.3 Coordinate the delivery of health and social services so that everyone in the community has access to the services and resources they need?	
1.4 Understand the reasons that people do not get the services they need?	

Strengths:

- There are programs that connect people to resources, family links, etc.
- More than one program is working together and sharing several resources
- Many programs are centered in one location.
- Community Connections is a one stop shop model

Improvement Opportunities:

- Streamline or create a universal link to resources
- How can we dig deeper to refer people to resources?
- Create an asset map
- Dial-a-ride: Make it available for all our counties
- Having availability and breaking down the issue of transportation deeper
- Making it so people do not have to drive to the services (expansion)
- How do we connect to our community to let them know about different events and resources
- Try to figure out broadband access and access to internet

Discussion Questions & Notes:

1.How do we coordinate the delivery of health and social services to optimize access to services and resources for populations who may encounter barriers to services?	• There is information overload when there are multiple services being promoted, it may help to work together as agencies to promote each other's services • Need a one stop shop for resources to help break down barriers. Having different agencies housed in one location is a benefit to those utilizing the services
2. How do we link populations to needed resources?	• Participating in assessments like this Community Health System assessment helps us to learn more about what is available in the community. • There is a large silent population out there that does not know how to connect to services. We don't know how to connect with the "silent population" • Populations that need these resources aren't coming to us – we need to go to them to connect

3.How do we provide assistance to vulnerable populations in accessing needed resources?	• We need boots on the ground outreach to get resources out to those that need them • There are several organizations that perform outreach and are going to the clients. Different organizations are partnering to provide resources • We need better coordination from organizations to have collective impact so we can better get these services out to the community as a unit
4.How do we identify populations that may experience barriers to services?	• Talking to law enforcement may help. Law enforcement can make referrals to different agencies depending on what is needed • Hands on direct relational contacts are so critical to linking people to resources (home visits, intakes, etc.)

Focus Area 2 Policy

Policies are the written or unwritten guidelines that governments, organizations and institutions, communities, or individuals use when responding to issues and situations.

Performance Measures & Scoring:

At what level do we, as a system of community services,

2.1 Contribute to public health policies by engaging in activities that inform the policy development process?	2 Minimal
2.2 Alert policymakers and the community of the possible public health effects (both intended and unintended) from current and/or proposed policies?	3.3 Moderate
2.3 Review existing policies periodically?	2.8 High Minimal

Strengths:	**Improvement Opportunities:**
No notes recorded documented regarding strengths	• Encourage more people to speak up and voice opinions • Break down the topics so they don't seem so big and complex • Provide education to ensure well informed decisions • Create better access to data

Discussion Questions & Notes:

1. How does the Community System work together to see that public health considerations become a part of all policies?	• It doesn't seem like community system is working together to see public health considerations become part of all policies • There are multiple layers and complexity of the system both internally and externally that can be affected by policy • It is unclear at times how to have a voice • Help to create a "line of sight" to show the impacts of policies
2. How does the Community System alert policymakers and the general public of public health impacts from current and/or proposed policies?	• There is not enough staff at an organizational level • Important to be proactive rather than reactive • Many organizations engage when they know there is an issue to engage on. However, it is easy to miss an opportunity to give feedback
3. How does the Community System contribute to the development of public health policies?	• Help identify barriers that are created and could be prevented by adopting Public Health policies • Lack of understanding in layers and complexities. Examples are: Federal policies, State policies, Local policies, Organization policies, Grant policies, Land Use policies, etc. • Identify how a policy can affect communities Urban vs. Rural
4. How does the Community System engage constituents in identifying and analyzing issues?	• Constituents don't always have "line of sight" • It is hard to determine the right questions to get the best answers • The system is currently being reactive and needs to be more proactive. • Often there is only a narrow time for input before a decision on policy is made.

Focus Area 3 Data Access/Capacity

A community with data capacity is one where people can access and use data to understand and improve health outcomes where they live.

Performance Measures & Scoring:

At what level do we, as a system of community services,

3.1 Conduct regular collaborative community assessments?	2.7 High Minimal
3.2 Update the community assessment with current information continuously?	2.4 Minimal
3.3 Promote the use of the community assessment findings among community members and partners?	2.6 High Minimal
3.4 Analyze health data, including geographic information, to see where health problems exist?	2.6 High Minimal

Strengths:

- Hospitals are required to conduct community needs assessments every three years
- Organizations solicit input from the community
- Identify needs to address as a community
- Midland Co. presented their community health improvement plan publicly, which gave members an opportunity to provide input
- Some organizations are good at getting data and analyzing it
- Providing 1-page infographics has been helpful for people to understand the data

Improvement Opportunities:

- Make data interesting to the public
- Present more infographics
- Schools could mandate participation in MIPHY
    - If all schools in a district participated, then data can be made public
- Data is not shared well between organizations
- Need to see progress reports on how the data is being used so that changes can be made
- Data can be shared in a more appealing way
- Some organizations conduct the assessment and create an action plan but do not monitor progress after it is completed

Discussion Questions & Notes:

1. Does everyone have access to community assessment findings?	• Data is available on Hospital and Health Department websites, but general community members do not have access. • It is difficult for rural areas to get good county level data. • Organizations often don't share data
2. How is the community assessment used to inform health policy and planning decisions?	• A lot of time and effort goes into planning, but nothing is done with the plan
3. What else is occurring in our community to monitor needs that has not been mentioned?	• There is a lot of room for improvement • Data is available at the State level • It is difficult for rural counties to get good county level data and census tract data

Focus Area 4 Community Alliances

Diverse partnerships which collaborate in the community to maximize health improvement activities and are beneficial to all partners involved.

Performance Measures & Scoring:

At what level do we, as a system of community services,

4.1 Establish community partnerships and strategic alliances to provide a comprehensive approach to improving health in the community?	3.2 Moderate
4.2 Do we have community improvement committees or coalitions for improving health in the community?	3.3 Moderate
4.3 Feel that community partnerships and strategic alliances are working to improve community health?	2.9 High Minimal
4.4 Identify and encourage key stakeholders to participate in activities to improve community health?	3.1 Low Moderate

Strengths:

- Being virtual has allowed the opportunity to collaborate more easily to those who couldn't meet in person and bring in more people
- There are strong collaborative groups in the community
- Connections are there and groups tend to grow organically with participants identifying gaps and pulling new people into those groups

Improvement Opportunities:

- Know who to reach out to
- The System needs to develop more reasonable action steps
- Increase accountability at follow up meetings

Discussion Questions & Notes:

1. What types of partnerships exist in the community to maximize health improvement activities?	• There are many coalitions in our North Central counties, including HSCBs and other coalitions/committees that cover specific areas like substance abuse, suicide prevention, etc. Sometimes we are aware of how many coalitions/groups there are, but we don't necessarily know how to reach out to them or connect with them.
2. How do organizations within these partnerships interact?	• Each group hopefully continually expands – those at the table think of others who could be there and are not there, and they get invited, and we continually grow. • It was noted that we sometimes forget about our local government organizations, like Parks & Rec, that can participate. • 211 expressed that they would like to attend our various collaborative meetings (John Mitchell – jmitchell@hwmuw.org).

	• Some of our counties are so rural that it's challenging to get people at the table for these meetings, or to even know who to reach out to. • Virtual meetings have become the norm, but connections are sometimes missed via zoom versus being in-person. • Engaging people via virtual formats can be challenging, but it can also allow more people to attend who may otherwise not be able to be physically present.
3. If there is a Community Health committee or coalition, what do they do? Any constituents involved?	• Case managers at various agencies talk to clients about how they feel about the services being provided and how involved they feel etc. • A suggestion was made to have a Resident Advisory Committee, but that can be challenging because sometimes you just spend a lot of time bringing residents up to speed on previous conversations • Provide some type of stipend to residents in hopes of getting some participation in meetings regularly.

Focus Area 5 Workforce

The people engaged in or available for work in a particular area, company, or industry.

Performance Measures & Scoring:

At what level do we, as a system of community services,

5.1 Conduct workforce assessments to determine gaps and shortfalls in providing needed services for community residents?	2.4 Minimal
5.2 Use the knowledge from the workforce assessment to develop plans to address workforce gaps?	2.4 Minimal
5.3 Develop and implement plans for addressing gaps and shortfalls in the workforce?	2.6 High Minimal

Strengths:	**Improvement Opportunities:**
• Internally organizations are using knowledge from the workforce, but not using the information out in the community as much	• Identify priority areas of need, and submit plans to funders such as MDHHS • There is a need for systemic collaboration on workforce gaps

Discussion Questions & Notes:

1. What types of Workforce Assessments are done in the community?	• Business needs survey, business resource network to collect employee needs. (MI-Works), Community Listens, Mental Health First Aid (MI-Works) • Northern Michigan Opioid Consortium • Community Health Workers Alliance survey • West MI Regional Prosperity Alliance has a workforce area of focus • Needs assessment through Annual Submission Process
2. How is this assessment information used to develop plans for workforce development?	• To drive whatever supportive services we may need • Recruitment/Retention strategies • Identify types of trainings employers may need
3. How have the organizations within the community implemented plans for addressing these shortfalls or gaps?	• No notes captured for Question 3.

Focus Area 6 Leadership

Leadership within the community is demonstrated by organizations and individuals that are committed to improving the health of the community.

Performance Measures & Scoring:

At what level do we, as a system of community services,

6.1 Collaborate to create a shared vision for the community?	2.9 High Minimal
6.2 Collaborate for participatory decision-making regarding health improvement initiatives?	2.9 High Minimal
6.3 Provide leadership opportunities for individuals and/or organizations in areas where their expertise or experience can provide insight, direction, or resources	2.9 High Minimal

Performance Measure Scoring Notes:

- Leadership opportunities within the community (Is the demand higher than the availability?)
- What types of barriers are there to professional development? Ex: Opportunities, time, funding, location?
- Building future leaders
- Having a flexible work environment is important
- Making time for training; learn by practice and giving more opportunities
- Cross fertilization may be limited due to job limitations

Strengths:

- The NCCHIR Steering committee has created a vision for the region, but it is not widely shared with other organizations**.**
- There is opportunity for this NCCHIR Steering Committee to provide leadership.
- Hospitals have individuals responsible for needs assessments.
- Hospitals and health departments have taken the lead on collaboration for community health improvement plans.
- Mid-Michigan Community Health has an RN educator that attends meeting and works on community collaborations.
- The Leadership training program in Mason County, led by the Chamber of Commerce, is an opportunity for developing leaders.

Improvement Opportunities:

- Individual groups have a vision but there is not a broad community vision. Some discussion has occurred but not a lot of action.
- Groups get together, but do not move forward
- We are not aware of the collaboration
- It is difficult to generate consensus or prioritization of which projects to move forward on. It would be nice to prioritize and vote on which projects we will focus on.
- Collaboration is hard during COVID and it is difficult to find the correct stakeholders in community meetings.
- Participants agreed that there is value in collaboration. Everyone is busy. How do we create that environment for collaboration?

Discussion Questions & Notes:

1. Have leaders within the Community System collaborated to create a shared vision for the community? And How?	• If so, not aware of it • Multiple Community Foundations meet once a month to discuss a community assessment

	• Mason County has good collaboration. A good group, with heart, exists and is focused on how to make the community better.
	• Groups are still working on how we get services to people in a pandemic.
	  ○ Example: In Mason County telehealth and broadband connectivity has limited access. The leaders asked how we could bring broadband to all residents. This morphed into a whole program as to how to start a municipal broadband service.
	  ○ The Community Foundation then partnered with the local Chamber and secured some funds and discussed how to look at opportunities to partner on large scale projects. Broadband was on everyone's list.
	  ○ It is an opportunity to bring county together for collaboration/partnership.
	  ○ The same thing occurred in Oceana County. A group coordinated and helped fund a "tower" for an access point.
	  ○ They don't have enough funding to complete the project so we don't know if they will use the money for the tower. They will need federal dollars to complete.
	• There is an intentional effort to find ways to collaborate on a community vision. There are opportunities for collaboration and multiple areas where agencies collaborate.

2. How have leaders in the community collaborated for participatory decision-making regarding health improvement initiatives?	• In avenues where it is reasonable and aligned the group believes that collaboration happens in a mutually beneficial way, but not in a broad way. • Many agencies are conducting community health needs assessment. • Different entities do their own assessments and develop their own strategic responses. Not aware of interactions that cross groups.
3. How does the Community System recruit and retain leaders who represent the diversity of the community?	• Within the community board for the hospital there is an effort to turn over leadership and look at trying to ensure

	both geographical area we serve as well as different elements within the geographical area. • In Mason County, efforts are being made to increase collaboration but not sure all areas are aware. There is not a comprehensive group. They are addressing ways to pull in partners that may have greater impact. • There are efforts to recruit non-traditional partners
4. How does the Community System provide leadership opportunities for individuals and/or organizations in areas where their expertise or experience can provide insight, direction, or resources?	• The Community Foundation partnered with that effort. There was a diverse group with discussions. • We have leaders out there that do not think of themselves as leaders. They have an area of expertise, and they really are leaders, and we need to bring them together. This could facilitate good discussions. • Clare has created a Clare Leadership Lunch where leaders from various community providers meet to discuss gaps, issues, and areas of collaboration. • The Ludington Chamber conducts a leadership training. The Community Foundation provides some funding to attend. Gladwin county also does this.

Focus Area 7 Community Power/Engagement

Power is the ability to control the processes of agenda setting, resource distribution, and decision-making, as well as to determine who is included and excluded from these processes.

Performance Measures & Scoring:

At what level do we, as a system of community services,

7.1 Create awareness regarding the importance of public health issues developed with the community-at-large and organizations within the system of community services?	3 Moderate
7.2 Engage the community residents in the process of setting priorities, developing plans, and implementing community programs and activities?	2.6 High Minimal
7.3 Use resident voice and engagement to inform decision-making?	2.8 High Minimal
7.4 Use relationships with different media providers (e.g., print, radio, television, the Internet) to share health, matching the message with the target audience?	3 Low Moderate

Strengths:

- Organizations are getting creative to get the message out.
- The community system and organizations within do a relatively good job of trying to use different media relationships and platforms.
- There is good work happening and the system is getting creative in how to create awareness and engage the community, but there is room for improvement.

Improvement Opportunities:

- Increase resident voice to inform decision-making.
- Youth voice is often missing.
- There is a need for improvement around diversity.
- There is often a "representative" of vulnerable populations serving on boards and in leadership but not with direct connection to the clients or common voice. It is often a person to speak on behalf of, and not direct representation.
- There is a need for racial and ethnic diversity to support community power/engagement opportunities at all levels (client through leadership). What are community partners doing to ensure this? How are we ensuring efforts/activities are culturally competent?

Discussion Questions & Notes:

1.How many of your organizations have developed communication plans?	• Many organizations, especially the larger ones, expressed that they had developed communications plans. • Where they felt they struggled was collaborative plans or adapting to deficiencies in the plans.
2. How do your organizations work collaboratively to link the communication plans to one another?	• Each entity works hard on their own plan and struggles with improving the plan. To also work across sectors is another layer. • Consensus is that there is value in cross-sector collaboration, but it is difficult to accomplish. • COVID in some ways helped bring common language around health to the forefront and is a priority in communications.
3. How many of you provide information on community health issues to the general public, policymakers, and public and private stakeholders?	• There is a need to co-craft messaging and thank partners for input and time. • Organizations feel that the Community System tries to provide information to the general public, policymakers, and public and private stakeholders.

Focus Area 8 Capacity for Health Equity

. Health Equity is the assurance of the conditions for optimal health for all people.

Performance Measures & Scoring:

At what level do we, as a system of community services,

8.1 Identify health disparities?	2.9 High Minimal
8.2 Identify, develop, and/or implement policies, laws, systems, environments, and practices to reduce inequities in the opportunities and resources needed for community members to be as healthy as possible?	2.3 Minimal
8.3 Develop structures and processes that support equity?	2.7 High Minimal

Strengths:	**Improvement Opportunities:**
No notes were documented in this section	• There are opportunities locally and regionally to establish a common language around health disparities. • Develop common language identifying those in distant populations that are experiencing health inequities • Better advocate for health in all policies framework so that other sectors see how they impact health

Discussion Questions & Notes:

1. Does the Community System Identify health disparities?	• There is limited accessibility to no accessibility. People can find information on disparities nationally or regionally, but not locally. • Some agencies identify health disparities, but we may not know where to find them. • There is no broad system for identifying disparities. • Only a small group focuses on health disparities within the Community System.
2. Does the Community System identify, develop, and/or implement policies, laws, systems, environments, and practices to reduce inequities in the opportunities and resources needed for community members to be as healthy as possible?	• The Community System partners attempt to … but we are not as successful as we would want to be. • Our rural areas do not have the level of accessibility to broadband to break down barriers. • It is difficult for the medical community to do this on their own. Different sectors oversee some barriers (broadband). • There needs to be greater level of engagement with other sectors to help them realize how their decisions impact health.
3. Does the Community System actively engage those most affected by disparities in the identification, design, implementation, and evaluation of promising solutions?	• We know some of the gaps and the barriers, but we are not taking the steps forward to do something about it.

	• We are invested because we are in healthcare, but we need to get other agencies that impact barriers involved and educated on why their representation matters. • We need to Include resident voice – convincing others outside of programs. • The system is not set up well to have those that need to be engaged, involved. • There are people without lived experience making decisions for people receiving services.

Organizations Represented

A total of 69 people participated in this event.

Board of Spectrum Health Big Rapids and Reed City

Big Rapids Rotary

211 West Michigan

Gladwin Department of Health and Human Services

Central Michigan District Health Department, Gladwin

District Health Department #10

GIRESD

Clare, Isabella Department of Health and Human Services

True North Services

Northern Michigan Regional Entity

Newaygo County Community Collaborative

Michigan Department of Health and Human Services

Ferris State University

Spectrum Health Ludington

Community Foundation of Mason County

Bay Arenac ISD

Community Mental Health for Central Michigan

MidMichigan Health

Walkerville Thrives

Appendix 1: Scoring Grid

Optimal Activity (76–100%)	Greater than 75% of the activity described within the question is met.
Significant Activity (51–75%)	Greater than 50% but no more than 75% of the activity described within the question is met.
Moderate Activity (26–50%)	Greater than 25% but no more than 50% of the activity described within the question is met.
Minimal Activity (1–25%)	Greater than zero but no more than 25% of the activity described within the question is met.
No Activity (0%)	0% or absolutely no activity.