COMMUNITY SYSTEM ASSESSMENT EVENT REPORT

NORTHEAST REGION - AUGUST 16, 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?	3.3 Moderate+
1.2 Help people access resources and services in a way that considers the unique needs of different populations?	3 Moderate
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?	3 Moderate
1.4 Understand the reasons that people do not get the services they need?	2.8 Minimal+

Strengths:	**Improvement Opportunities:**
-Organizations in the system know resources and what is available, -In some communities, transportation ideas have improved -In some programs in organizations staff are getting more time with the clients to talk them about all the programs they offer	-Need to increase getting information out to the public, County HSCC or HSBC monthly meeting attendance has been down -Helping people with unique needs -Virtual access, always spinning our heads on ways to improve -Self-mindset, staff changes, where can we share our information for people to see -Why people aren't receiving resources: stigma is a big issue, need to reduce stigma, people who have been turned away don't feel comfortable coming back again, how will we really know why people aren't requesting services when they don't show up in the first place?

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?	• HSCC/ HSCB monthly meetings are so helpful. • Organizations have changed from meeting in person to virtually. Things have changed since COVID. • Working with 2-1-1 and MDDHS, 2-1-1 is sometimes easy to use, but there are some resources that are missing
2. How do we link populations to needed resources?	• Work together with other organizations for referrals • Staff are having an issue finding resources for COVID 19 issues, • Community resources cards are available in Alcona and Iosco County from the HSCC and also Great Start Collaborative has some resource cards for Alpena-Montmorency- Alcona
3.How do we provide assistance to vulnerable populations in accessing needed resources?	• Word of mouth • Families need to have good experiences to encourage them to come back • Hand holding for a lot of the clients • Some clients need more assistance than others
4.How do we identify populations that may experience barriers to services?	• Community Events • Being out in the community and spreading the word • County fairs, project connects, talking to people

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?	2.8 Moderate
2.2 Alert policymakers and the community of the possible public health effects (both intended and unintended) from current and/or proposed policies?	3 Moderate
2.3 Review existing policies periodically?	2.5 Minimal/ Moderate

Strengths:	**Improvement Opportunities:**
• HSCBs, Great Start Collaboratives, Community Foundations contribute to policy development. • Health Coalition members work together: Example Tobacco free outdoor recreation areas. Coalition members can plan and attend local government meetings to educate about the benefits of health policies.	• Get the right people around the table. • Write letters to the editor. • Organizations in the system need staffing, manpower.

Discussion Questions & Notes:

1. How does the Community System work together to see that public health considerations become a part of all policies?	• Some organizations that adopt health policies are Medicaid Health Plans and Community Connections. • DHD#10 works to educate about policies that impact health and works with member organizations in local health coalitions. • Many community organizations have health policies for staff. • There are policies in the community to create inclusiveness for people with physical disabilities**.**
2. How does the Community System alert policymakers and the general public of public health impacts from current and/or proposed policies?	• Radio, newspaper, websites • Attend local government meetings
3. How does the Community System contribute to the development of public health policies?	• Community-based groups come together on an issue. Example: In the DHD#2 jurisdiction people in Oscoda came together over PFAS issues. • It sometimes takes a crisis. • Everyone has their own agenda.
4. How does the Community System engage constituents in identifying and analyzing issues?	• It is difficult to gather resident voice

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?	2.3 Minimal+
3.2 Update the community assessment with current information continuously?	1.8 Low Minimal
3.3 Promote the use of the community assessment findings among community members and partners?	2.5 Minimal/ Moderate
3.4 Analyze health data, including geographic information, to see where health problems exist?	2.5 Minimal/ Moderate

Improvement Opportunities:

- Limitation of not enough resources or manpower.
- Assessment is a lengthy endeavor it has been hard to update, COVID was an issue.
- Getting access to the right data/entity to share information. Issues with privacy and demographic data with larger entities.
- The focus of health improvement issues has shifted to Covid.
- Getting the information to the public is difficult. It is a struggle to engage the media.
- Work at keeping data presentation short, use infographics, one page result sheet. This may allow for more interest in the information being provided.

- Getting the right people to the meetings, such as a trusted member of the community is essential. Businesses or organizations that can identify the issues provide first-hand experience and knowledge of the need.
- We need to present the data to target populations and tailor the data for them.
  Organizations are seeking vulnerable population, once we have the information what do we do with it?
- Use Community Commons website to search data information for census tracts.
- Use Census and Michigan.gov/LMI
- Use data on SDOH (Social Determinants of Health) gathered by community outreach workers.
- Focus on assets first. Don't present as negative.

Discussion Questions & Notes:

1. Does everyone have access to community assessment findings?	• Access via websites and via email with partners. • Idea of sharing information: Chamber of Commerce. • In Presque Isle an intensive assessment was completed and an effort was made to get the results to the public. • Booklet forms - effort to give to community members that connect via meetings
2. How is the community assessment used to inform health policy and planning decisions?	• Organizations are using assessment information as a way to improve process and inform others on the need and resources. • One community completed an assessment on poverty and access to fruits and vegetables. This spurred plans to create a Farmers Market.

	• Organizations gather data and make it easily understandable, but the follow up is where there is a potential lacking. There are not enough people to assist with the effort.
3. What else is occurring in our community to monitor needs that has not been mentioned?	• There is follow up twice a year but also there is lack of manpower to assist with monitoring and follow up.

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?	2.8 Low Moderate
4.2 Do we have community improvement committees or coalitions for improving health in the community?	2.8 Low Moderate
4.3 Feel that community partnerships and strategic alliances are working to improve community health?	2.6 Minimal/ Moderate
4.4 Identify and encourage key stakeholders to participate in activities to improve community health?	2.8 Low Moderate

Strengths:

- There are Community Collaboratives, coalitions, and health fairs.
- Virtual meetings have helped in attendance. Participants can attend any meeting anywhere.
- There is a strong Great Start Parent Coalition.

Improvement Opportunities:

- Need to get community members involved
- Meetings are better in person – harder on zoom.
- Barriers within different regions need to be addressed.
- Need a MiThrive Workgroup for all northern counties.
- Need a hub of organizations with resources i.e. 211
- Need a better way to search organizations who do the same thing.
- Connect regions better. Need a designated person for regional meetings.

Discussion Questions & Notes:

1. What is our process for identifying key constituents or stakeholders for improving community wellness?	• Need a more stable foundation. • No wrong door approach • Include behavioral and mental health.

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?	3 Moderate
5.2 Use the knowledge from the workforce assessment to develop plans to address workforce gaps?	3.4 Moderate+
5.3 Develop and implement plans for addressing gaps and shortfalls in the workforce?	3.2 Low Moderate

Strengths:

- There are social determinant screenings being conducted that look at many different areas of need. If a person needs a job or further education, then they are referred to the resources they need
- Organizations make many referrals to Michigan Works for resumes and job referrals
- As a system, organizations share resources and share staff.
- MI Works helps with mock interviews and job searches. In our rural area there is a lack of access to computers and internet. MiWorks helps people in rural areas to access the internet and use computers
- MI Works educates legislators about the successes that they have in training the work force.
- Mi Works also works with legislators at a Federal level. There are Federal training dollars for working directly with employers.

Improvement Opportunities:

- Who is talking to the high school students and the schools? There is a need for career counselors and there is such a disconnect. We need more short-term programs to fill jobs that previously required 4-year degrees.
- The wages that employers can pay is not appealing to people that have the skills sets they may be looking for. There is a need to bring wages up to where they need to be.
- There is opportunity overall to educate agencies within the community system if we want to have a healthy economy.
- The Community System needs to develop unmet needs reports to better understand what people are looking for and report to every community that they serve
- Need to use the knowledge from work force assessments to give people more education or help them get in touch with Michigan Works for resume writing and job searching or to help them print off resumes.
- Need to get people the answers they are looking for

Discussion Questions & Notes:

1. What types of Workforce Assessments are done in the community?	• LMI Data is referenced quite often, labor data. • Data can be slightly skewed because it can go by region and is heavier in southern counties than northern counties • 211 conducts assessments on everyone that calls. • Workforce assessments were conducted in last MITHRIVE. • It is hard to find people to work during a pandemic
2. How is this assessment information used to develop plans for workforce development?	• Organizations utilize labor market data to find out skill gaps, employment expectations in the next few years. They look at projections and discuss with workforce development board and employers • Assessments in the health department to get data for grants and requirements.

	• Used for addressing needs of the community as they develop and for being ready to pivot when the need changes
3. How have the organizations within the community implemented plans for addressing these shortfalls or gaps?	• MI works has classroom training opportunities. With the knowledge of MITHRIVE assessments they can look at what programs need more assistance • There are programs that pay for tuition, books, fees, short term trainings that the state and federal programs can't cover. NE MI can help pay for additional things and support services such as mileage, scrubs, other support services • Organizations are working with Michigan State Rural Community Health Program so that students can go to rural Michigan for their residency and hopefully retain them to stay on staff. MAT- substance use assessment is being conducted with funds going to this. Recruiting is very important to get the right people in place. • My reach, my leap, (grants) opioid grants are available and it is all to get people trained in positions in healthcare. • Communities are starting to see value in community health workers to address those gaps that other organizations can't take up or that don't have time.

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?	2.6 High Minimal
6.2 Collaborate for participatory decision-making regarding health improvement initiatives?	2.6 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 Minimal

Strengths:	**Improvement Opportunities:**
• We have people who want to help!!!	• Increase facilitation of leadership opportunities. • Help people with strengths find opportunities for leadership. • We tend to stay in our own silos and don't reach out • Many of the service providers are multi county and based elsewhere. • The decision makers who impact the community aren't at the table. • There is a disconnect between the input and the ability to make things happen. • We need more staff to be able to make good change. • There are too many meetings for "collaboration" • Unless you know people, you don't know about opportunities. You have to be a go getter to find the leadership opportunities. • It is difficult if you are younger or are new to the community. • "Let's try it" is a terrifying concept for a lot of people. It is especially bad in small towns. • There is a need for childcare for meetings.

Discussion Questions & Notes:	
1. Have leaders within the Community System collaborated to create a shared vision for the community? And How?	• Multiple small groups are having conversations, however, there is no overarching goal that has been developed. • People want a main theme and goal, however, there doesn't appear to be an overarching theme at this time. • The conversation is there, but it hasn't gone anywhere yet.
2. How have leaders in the community collaborated for participatory decision-making regarding health improvement initiatives?	• The Mayor of Rogers City is collaborating with other partners in the community. • Sometimes community leaders need a reminder or encouragement on who potential partners could be. They need to think more broadly. There has not been enough practice yet. • Organizations feel like they need to reinvent the wheel sometimes due to being a small area. Community leaders need to understand that they can reach out to other counties.

	• One agency was contacted throughout covid and they ended up getting a training through law enforcement for suicide prevention as they were receiving multiple calls for help. • The MIThrive Forces of Change event brought leaders together for collaboration.
3 How does the Community System recruit and retain leaders who represent the diversity of the community?	• The community system needs more youth leaders to increase diversity. Many leaders are older individuals. • The System needs diversity of political ideals/religion. • Many organizations (local government) are ingrained in their ways and it can be very intimidating to approach them. • The System needs more informal meet and greets to help recruit leadership members. • Organizations need a collaborative approach for increasing leadership opportunities - where do interests and skills lie? Help people find where they can thrive.
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 System is not performing well on this measure. • There are people with multiple skills to offer but can't find their space. • Opportunities are increasing in the community.

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?	2.3 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?	2.9 Low Moderate

Strengths:

- There is connection and collaboration in the Community System
- Surveys and work groups gather input
- Presence on social media is a strength
- Michigan Works does a good job of sharing information from other agencies and making sure clients know resources available to them.
- Michigan Works staff develop plans with participants regarding programs related to helping them overcome specific barriers to employment. This includes: educating about steps to take in order to accomplish goals, assigning activities to help with becoming self-sufficient, and referring clients to other agencies that may be of assistance.

Improvement Opportunities:

- There is always somewhere to improve, but it is important to have communication in place. Communication is something that you must stay on top of because of how many changes take place within so many organizations
- Agencies could do a better job of communicating what is going on within their agencies, especially regarding special projects or programs.
- The barrier for people that are looking for resources is the problem of knowing where to find the resources first, and then where to go from there.
- Not being able to meet face to face and having to be online is a huge barrier
- Planning that goes through supervisors and includes employees that work daily with clients might be helpful
- Coverage being provided is great, but with overall health issues there is not enough support
- Not sure that any community system does a good job of this, need to find ways to engage people.
- There are people that don't have access to the internet or do not want the internet
- We need to find several different ways to get people invested in things
- It is hard to engage people, people want to say what is and isn't provided but then don't want to take part in making a change
- People believe that they don't have a voice or that their voice is not going to be heard
- Organizations need to have open-ended discussions and written input. Need to have not only electronic surveys

	but paper surveys and sections for comments or questions. • Organizations need to hold meetings where issues are discussed, and a plan is implemented • Special programs have been obliterated before COVID and people didn't have those services that they do now • With covid media has been great, needs to improve for other issues of importance in the community
Discussion Questions & Notes:	
1.How many of your organizations have developed communication plans?	• There are coalitions and committees in the area that organizations can contact to make connections with. • There are opportunities to attend health and human services meetings, community agencies, churches. They have a large presence on Facebook and agencies share other peoples' post if they have something special coming up especially with covid. • The Health Department does a great job communicating with the public and other agencies in the area. • There used to be agency fairs in the fall and organizations would come and connect. It was not open to the public.
2. How do your organizations work collaboratively to link the communication plans to one another?	• There are weekly or monthly meetings to talk about specific clients, people, or programs and where it has been tried to help this person to overcome a certain barrier. That way we can connect the dots. • Organization staff might have a discussion with the participant and get their input as well • Seagull County United Way has a human services newsletter that goes out weekly that discusses what goes on in the community and other agencies
3. How many of you provide information on community health issues to the general public, policymakers, and public and private stakeholders?	• MI Works doesn't have health related services but when they get health information, they share it. • Organizations are always willing to share on social media, their newsletter, or emailing to all staff • Any information that is given is shared whether it be a new resource or health issue. • We provide information to any caller we have if we have the information to share
4. How are community members encouraged to participate in improving community health?	• Community members are crucial to getting help to the community by providing transportation to doctors' appointments and getting other information to the public.

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?	3.2 Moderate
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?	2.8 Low Moderate
8.3 Develop structures and processes that support equity?	2.8 High Minimal

Strengths:

- Community health needs assessments are conducted. We collect data and act on focus areas. Focus areas include chronic disease prevention, behavioral health, access to care, pre and peri-natal care.
- The needs assessment covers many counties.
- Sterling Area Health offers substance use disorder treatment. behavioral health, Medical Assisted Treatment, pediatric care.
- There is tuition assistance for those working in low-income places. This is designed to increase the number of providers in these areas.

Improvement Opportunities:

- Include resident voice in planning solutions.
- Fill in the gaps.
- Substance use disorder stigma causes discrimination against certain populations. There is bias against transgender population, obesity, and substance use disorders.
- Educate health care workers.
- There is a lack of resources and barriers to access. Need to improve access to care for low-income individuals. There is a need for a list of doctors who accept Medicaid.

Discussion Questions & Notes:

Discussion question notes were not captured.

Organizations Represented

A total of 31 people participated in this event.

- Central Michigan District Health Department
- MidMichigan Health
- Alpena Montmorency Alcona Educational Service District
- Sterling Area Health Center
- MI Works Northeast Consortium
- Health Department of Northwest Michigan, Otsego County
- District Health Department #4
- Partners in Prevention
- Department of Health and Human Services Alcona/Iosco
- Department of Health and Human Services Oscoda/Otsego/Crawford
- 211 NE Michigan
- Ogemaw County EMS and Rescue
- Alpena Montmorency Alcona Great Start Collaborative
- Catholic Human Services
- District Health Department #10, Crawford County

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.