COMMUNITY SYSTEM ASSESSMENT EVENT REPORT

NORTHWEST REGION – AUGUST 17, 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 Northwest 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

A community asset (resource) anything that can be used to improve the quality of community life

Performance Measures & Scoring:

At what level do we, as a system, score in the following community services:

1.1 Connect or link people to organizations that can provide the resources they may need	4.1 Significant
1.2 Help people access resources and services in a way that considers the unique needs of different populations	3.4 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	3.6 Moderate
1.4 Understand the reasons people do not get the services that they need	3.2 Moderate

Strengths:

- Community Connections: SDOH navigation
- Collaboration is good at helping identify needs and gaps
- Able to provide home visits for multiple family services
- Able to work as a team within the Health Department and the community
- Linking populations one at a time
- No wrong door approach- multiple ways to access different resources

Improvement Opportunities:

- There is more need than availability of resources
- Marketing balancing (Balancing the act of how much can be provided vs not leaving people out)
- No dental benefits for seniors, limited dental benefits for Medicaid patients, not enough workforce needs
- Transportation barriers
- Better communication strategies needed so 'Boots on the Ground' folks know what is available in the community
- Possibility for some type of community platform?
- Automatic systems often are difficult for people! (They do not want phone trees, they just want a live person)
- It is hard to know why some people didn't get the services they needed because you can't connect with them to follow up sometimes.

Discussion Questions & Notes:

Discussion Question notes were not captured.

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, score in the following community services:

2.1 Contribute to public health policies by engaging in activities that inform the policy development process	3.5 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	3.5 Moderate

Strengths:	**Improvement Opportunities:**
• Covid has created new partnerships to develop policies • There has been an increase in awareness of how policies impact health • More collaboration is occurring • The CHIR has gathered agencies to work together	• Find out how the system can influence policy • Be more transparent. Review policies and don't wait until there is a policy-related issue. • Review communication avenues and work to repair • Develop a "toolkit" on how to make an impact in the community. • Reduce agency silos. Get rid of the "not my job" attitude. • Smaller centers work more closely together. As the geographic area gets larger there is less collaboration.

Discussion Questions & Notes:	
1. How does the Community System work together to see that public health considerations become a part of all policies?	• The health department has developed policies regarding covid • New policies have been created at worksites to keep employees healthier • Memorandums of Understanding allow agencies to work together • The Child Advocacy Team is a working group to create policies • The health department helps agencies with their policies on Covid but some agencies make their own policies based on CDC recommendations
2. How does the Community System alert policymakers and the general public of public health impacts from current and/or proposed policies?	• Emails and calls to legislators to educate about policy impacts • Through a call to action for the general public • The Covid pandemic has increased demand for information and increased awareness of the need for policies
3. How does the Community System contribute to the development of public health policies?	• The Board of Health develops policies.
4. How does the Community System engage constituents in identifying and analyzing issues?	• Assessment leads to identification of issues • Organizations take data collected to focus groups

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 score in the following community services:

3.1 Conduct regular collaborative community assessments	3.5 Moderate
3.2 Update the community assessment with current information continuously	3.5 Moderate
3.3 Promote the use of the community assessment findings among community members and partners	3.5 Moderate
3.4 Analyze health data, including geographic information to see where health problems exist	3.8 Moderate

Strengths

- Assessment tools are gathering more information and breaking it down better geographically
- Organizations are reaching out to a wider variety of people (Farmers Markets, Senior Centers, HSCB'S).
- 211 is doing a lot of data collection

Improvement Opportunities

- Some agencies are participating more than others
- Sometimes you are not aware of the amount of information that you know that you don't think would be useful, or vice versa the amount of information that you don't know that would be beneficial to know
- Technology can be a barrier to reach the results. The strength is that it is web based but that can also be a challenge. Print copies are not usually used.

Discussion Questions & Notes:

1. Does everyone have access to community assessment findings?	• Most people have access • If you are part of the process, you get the information but if you are the general public may only hear about it once. People often don't realize what data is available or have barriers to accessing it electronically.
2. How is the community assessment used to inform health policy and planning decisions?	• It is used to gain financial support • Stepping One initiatives/Jails, organizations working together • Getting information out in the community Ex. (Covid-19 information from Health Departments) • It was used to start the transit in Emmet County
3. How are the data helping identify health inequities?	• Community Connections data is available on the website and is a way to share data • Organizations are using the data collected to learn about gaps and needs in the community, such as food • East Jordan Health Center conducts a survey to determine patient needs
4. At what level within the community are the data available?	• It is available if you know where and how to look. • Some find it challenging to find. • Organizations need to do a better job about getting the information out there regarding what data an agency has and can share.

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, score in the following community services:

4.1 Establish Community partnerships and strategic alliances to provide a comprehensive approach to improving health in the community?	3.9 High Moderate
4.2 Do we have community improvement committees or coalitions for improving health?	3.8 High Moderate
4.3 Feel that community partnerships and strategic alliances are working to improve community health?	3.8 High Moderate
4.4 Identify and encourage key stakeholders to participate in activities to improve community health?	3.2 Moderate

Strengths:

- Organizations are seeing the same people in the groups
- Hundreds of people are engaged in health improvement across the region
- Motivation and spark in the community (leadership) shifts over time depending on resources

Improvement Opportunities:

- Health is dependent on economic health. That captures the attention of local leaders and is a way to connect
- Community Partnerships vary from county to county. Counties don't have the same resources available. There are pockets of engagement. The Challenge is getting people involved.
- It is hard for individual health providers who are not part of a larger organization to find their role, understand the jargon, and navigate the process; it is sometimes difficult for direct care providers to get involved.
    - What is in it for them? Do they want to be connected? It is possible but will require some new strategies.
- How do we improve alliances within the whole system? The CHIRS work to empower the local community to build capacity. Communities depend on strong the local units of government.

Discussion Questions & Notes:

1. What types of partnerships exist in the community to maximize health improvement activities?	• Benzie Area Youth Initiative • Benzie Care for Kids • Northwest Food Coalition • Child and Adolescent Health Program (Health Dept NW: DHHS) work closely schools/ISD/CMH/local providers • Early Childhood Collaboratives • Munson Shape Up North: Diabetes Initiative • Northern Michigan Health Alliance (legislative advocacy) • CHIR Behavioral Health planning initiative • Human Services Collaborating Bodies (Senior, ACES)
2. How do organizations within these partnerships interact?	• Monthly Meetings • Newsletters • Grant Applications (Collaborative Funding)

3. If there is a Community Health committee or coalition, what do they do? Any constituents involved?	• MIThrive Work Group (community health assessment, priorities based on data, create and implement community improvement plan) • Learning Community: Health Equity and resident voice • Grand Traverse Community Foundation and the Northwest CHIR coordinated the Outcome Framework

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, score in the following community services:

5.1 Conduct workforce assessments to determine gaps and shortfalls in providing needed services for community residents?	2.3 Minimal
5.2 Use the knowledge from the workforce assessment to develop plans to address workforce gaps?	2.1 Minimal
5.3 Develop and implement plans for addressing gaps and shortfalls in the workforce?	2.1 Minimal

Improvement Opportunities:

Gaps and shortfalls:

- There are not enough mental health providers, especially for youth
- There is a decrease in the ability to recruit nurses and therapists
- Everyone is short-staffed
- The pay scale is contributing to the shortfall
- Some professional positions are based on grant funding.

- Start with a workforce assessment and identify the issues
    - Childcare issues
    - Housing issues
    - Pay gaps – low pay compared to statewide pay
    - Drug testing/marijuana use
    - Cultures/ generational

Discussion Questions & Notes:

1. What type of workforce assessments have been conducted within the community?	• There is a lack of knowledge about which agencies conduct workforce assessments. • No knowledge of assessments that look at regional data.
2. How is the knowledge from the workforce assessment used to develop plans to address workforce gaps?	• Michigan Works! Looks at trending jobs and employment rates (Hot 100/1000)
3. How have the organizations within the community implemented plans for addressing workforce shortfalls or gaps?	• Some organizations have created positions to fill gaps in professional positions. Example: Peer support specialists • Some organizations and worksites are offering bonuses and pay increases. • Organizations are partnering with schools to prepare and recruit professional workers. • A video series was created with return to Michigan Career Mapping

4. Is there a formal process to evaluate the effectiveness of plans to address workforce gaps?	• No, possibly at the Federal level.
5. How are results from formal or informal workforce assessments and/or gap analyses shared with community organizations for use in strategic or operational plans?	• Public health conducts workforce assessments. • The Northern Michigan Public Health Alliance share information. • There is collaboration regarding training opportunities.

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, score in the following community services:

6.1 Collaborate to create a shared vision for the community?	3.4 Moderate
6.2 Collaborate for participatory decision-making regarding health improvement initiatives?	2.8 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	3.3 Low Moderate

Strengths:	**Improvement Opportunities:**
• None noted	• 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 • May not have as much cross fertilization due to limited job opportunities • Broadband limitations • Improve managerial skills with individuals who are technical experts • Put an emphasis on leadership/management skills as a specific skill set • Innovation: leadership acquisition/attract leaders to the region

Discussion Questions & Notes:	
1. Have leaders within the Community System collaborated to create a shared vision for the community? And How?	• MiThrive and CHIR; Hospital/Health systems to look at and prioritize (happens every three years) • Community Collaboration
2. How have leaders in the community collaborated for participatory decision-making regarding health improvement initiatives?	• YMCA reaches out to the medical community • Food coalition: Working through governance to ensure broader participation • Medical health: Physician/hospital integration of physical/behavioral health
3. How does the Community System recruit and retain leaders who represent the diversity of the community?	• What is the community system? In each area, there are different community systems • Leaders bubble up and emerge to grab the mantle • Intentional outreach to migrant community: Ensure bilingual outreach workers • There are 12 different sectors to be represented on the coalition

	• Work on client leaders to ensure they have a voice at the table (including parents) • Diversity is also the type of organizations represented • Traverse Connect on DEI: Boomerang; efforts to have diversity of experience/opportunity on board to ensure the full community is represented
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?	• Young professionals/ Traverse Connect • Little Traverse Leadership • Rotary Charities consultations and training

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, score in the following 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?	3.5 Moderate
7.2 Engage the community residents in the process of setting priorities, developing plans, and implementing community programs and activities?	2.8 High Minimal
7.3 Use resident voice and engagement to inform decision-making?	2.5 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?	3.3 Low Moderate

Strengths:

- There is significant activity creating awareness in the region with minimal and moderate votes: Informed by the reach of CHIR and learning networks
- Organizations are In tune with getting resident voice
- Community Connections provides that authentic voice from clients in need - its a great resource of real live data in the moment.

Improvement Opportunities:

- Get people to engage without fear of threat to societal status
- More authentic voices in some of the Northern counties
- The gap or opportunity might be seen within different populations. In prevention there is overlap with treatment and recovery so folks engaging are speaking out but active users hide and are not willing to be reached. This could be related to legal issues with engagement.
- Some of the younger people want to connect online versus connecting directly with the organization that might have access to the information directly

Discussion Questions & Notes:

1.How many of your organizations have developed communication plans?	• Paula M: Groundwork, Sarah Oleniczak: Health Department
	• Lisa Anderson: Prevention Specialist
	• Ranae MaCauley: Antrim County Collaborative
	  ○ Wondering about feedback loops, when communication goes out, and how feedback can get shared internally
	  ○ We are not sure how we know if we are reaching the target audiences needed. How are we matching the message with the projects we are working on, and increase collaborations between organizations. Regional SOP standardized communication plans might be a good thing to have.
	• Dawn Strehl: Health Department of Northwest Michigan
	  ○ Public health information phone lines are good ways to reach people and then gather in-coming feedback.

	• Grow Benzie ○ Working on a communication plan and meeting face to face about communications for all internal partners in addition to community users of the organizations. Learning the way constituents want to be reached: Text, Social, Newspaper, Blog, Phone calls
2. How many of you provide information on community health issues to the general public, policymakers, and public and private stakeholders?	• There is "a lot" of general public and target health information that goes out • Information is for both policy makers and community members. Policy makers are a challenging area • LCB needs information, and with that LCB can give information back • Grow Benzie provides information on community health issues to the general public, policy makers, and public and private stakeholders. • Groundworks has similar communication as Grow Benzie and has expanding policy maker communications with people in the community and policy makers. They have employees in Lansing to help with communication with policy makers on food, farming and nutrition, food access, school food services, SNAP and other food programs.

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, score in the following community services:

8.1 Identify health disparities?	3.8 High 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?	3 Moderate
8.3 Develop structures and processes that support equity?	3 Moderate

Strengths:

- Identifying and discussing (Ex. More referrals, making resources known, available, and accessible)
- Examples of system efforts to support equity:
  - Great start Collaborative and Head Start- their steering committees are parent leaders
  - This allows them to get community perspective, but it is hard to sustain
- Poverty reduction initiative
  - Brought community members in and offered incentives and daycare
  - Professionals followed up with community members after the in-person meeting, which led to some action

Improvement Opportunities:

- Need to improve development and implementation of equity policies and structures
- Need more input from people experiencing disparities: Hard to be effective without their voice
- Organizations can't develop policies from just data and be effective
- Go to residents when they are available and in a comfortable environment
- Do not expect residents to be available from 9am-5pm
- Meetings held separate from professional meetings
  - It's a challenge to blend professional and resident voices when in the same room.

Discussion Questions & Notes:

1. Does the Community System identify health disparities?	• Federally Qualified Health Centers identify health disparities federally and down to local level • Munson has MOUs with other organizations for referrals • These partnerships help to identify red flags and health disparities
2. Does the Community System identify, develop, and/or implement policies, laws, systems, environments, and practices to reduce inequities in	• No- There is a lot of silo work. Only occasional collaboration • Policies are not implemented on a large spectrum • There is a disconnect between policies and what needs to be happening/ what the actual needs are

the opportunities and resources needed for community members to be as healthy as possible?	• There is a need for people to learn how to work within the system • Residents and professionals are working on the policy rather than meeting needs • Organizations need to find loopholes in the system/policies to meet the needs of clients
3. Does the Community System actively engage those most affected by disparities in the identification, design, implementation, and evaluation of promising solutions?	• The System is lacking resident voice • The System is trying to check boxes and follow policies as organizations and as a system • Residents have to work hard to find help (Ex. They wait for way too long to speak to someone on the phone) • MiThrive is doing better compared to previous assessments
4. Does the Community System develop structures and processes that support equity?	• The system is beginning to look at the bigger picture and realize the impact on disparities • There is still a need for data and resident voice to construct procedures and structures
5. Does the Community System take specific actions that address the social determinants of health**?**	• This is in motion (Ex. Collaborative groups and some funding) • Goals are in in place as a system, but little to no action
6. Does the Community System evaluate and monitor efforts using short- and long-term measures as it may take decades or generations to reduce some health disparities?	• No robust evaluation tools are in place across the system • Better measures need to be put in place • The focus changes too often for a long-term measurement (grants/funding changes, organization focus changes)

Organizations Represented

A total of 52 people from the following organizations participated in the NW CSA Event:

Health Department of Northwest Michigan
District Health Department #10
Central Michigan District Health Department
Benzie/Leelanau District Health Department
East Jordan Family Health Center
Antrim/Kalkaska Collaboratives
Bay Bluffs
Grandvue
Groundwork Center
Grow Benzie
CRS Mediation
Munson Healthcare
Catholic Human Services
North Country Community Mental Health
Grand Traverse County Health Department
Northwest Michigan Hospice
Community Connections
Benzie Area Christian Neighbors
211 Call Center
Michigan Department of Health and Human Services
Munson Community Health
Goodwill Northern Michigan
Hospice Volunteer
Grand Traverse Bay YMCA
Northern Michigan Health Services
Thomas Judd Care Center (Munson HIV Center)
Antrim County Economic Development

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.