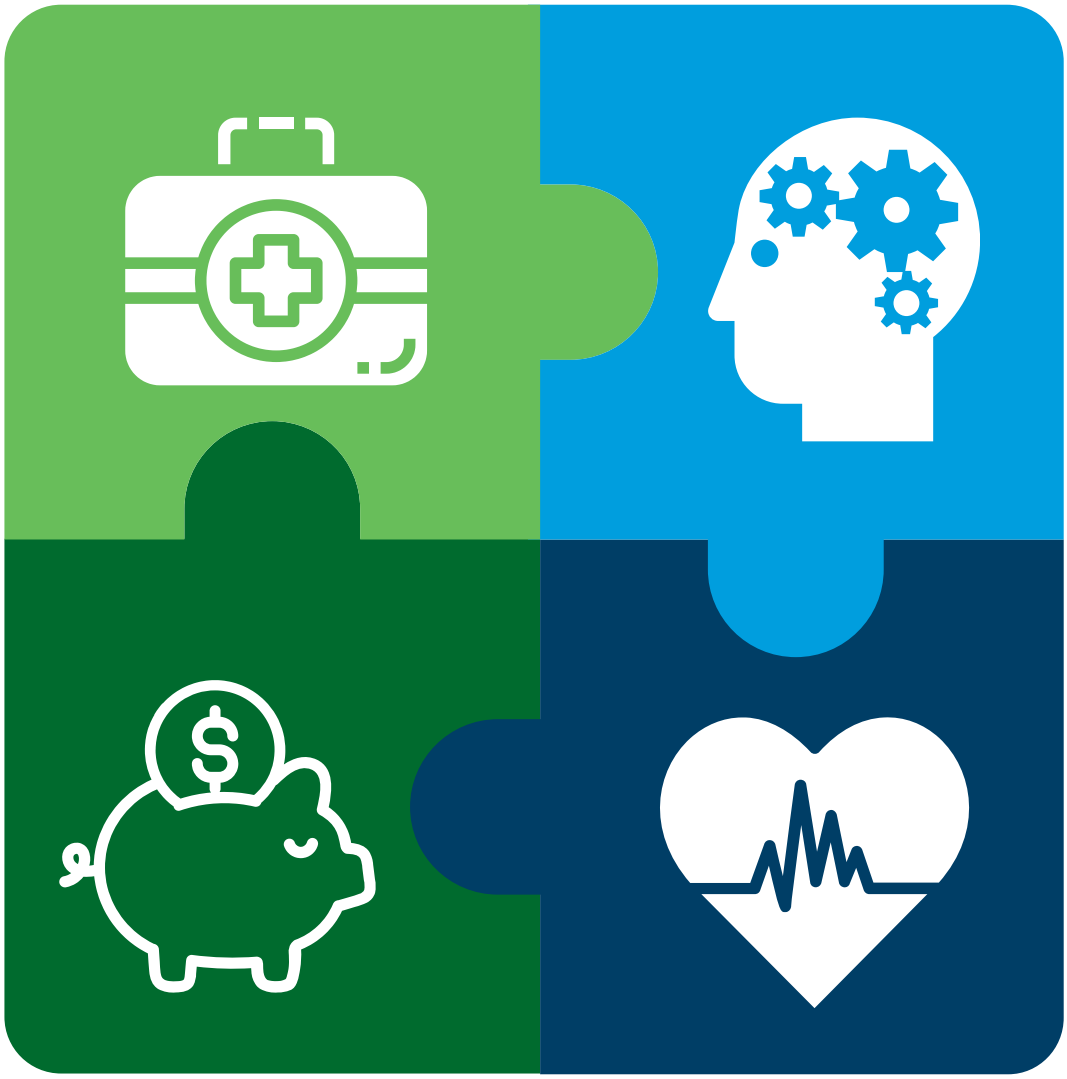
Community Health Improvement Plan

2023



Arenac, Clare, Gladwin, Isabella, Lake, Mason, Mecosta, Newaygo, Oceana, and Osceola Counties

mithrive | NORTH CENTRAL COMMUNITY HEALTH INNOVATION REGION

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Contact

Questions about this report can be emailed to mithrive@northernmichiganchir.org.

Description of the Process

Overview of MAPP

The 2021-2023 MiThrive Community Health Assessment and Improvement Initiative is an extensive collaborative effort, led by the Northern Michigan Community Health Innovation Region (NMCHIR). The assessment and improvement process involves collecting data, identifying strategic issues, and developing comprehensive plans to address them. To ensure the highest quality results, MiThrive utilizes the nationally recognized Mobilizing for Action through Planning and Partnership (MAPP) framework. Developed by the National Association of City and County Health Officials and the U.S. Centers for Disease Control, the MAPP framework consists of four different assessments, each offering a unique perspective on the community's health. For the 2021 assessment, MiThrive made a concerted effort to gather more health equity data than ever before and engage a diverse range of stakeholders, including many residents, in the assessments. This inclusive approach ensures that the results are truly representative of the community's needs and priorities.

Community Vision Statement

MiThrive, as part of the Northern Michigan Community Health Innovation Region, envisions a community where all individuals have the opportunity to live healthy lives in equitable and supportive environments. Our mission is to enhance the well-being of our population by improving population health, increasing health equity, and reducing unnecessary medical expenses through collaborative partnerships and transformative systems change. Our efforts focus on addressing the root causes of health disparities by breaking down barriers to social determinants of health at the individual, sector and systemic levels. Together, we strive to create a future where everyone has the resources and opportunities needed to achieve optimal health and well-being.

View the NMCHIR vision video here

Individuals and Organizations Involved

This regional initiative unites hospitals, local health departments, community-based organizations, coalitions, businesses, and residents, across 31 counties in Northern Michigan every three years. A diverse team of administrators, communication specialists, epidemiologists, health educators, and nurses lead this comprehensive assessment. We are thankful for the MiThrive Steering Committee, Design and Core Teams, as well as the Northwest, Northeast, and North Central Workgroups, and all the partners who represent numerous sectors of the community including; residents, businesses, collaborative bodies and coalitions, Federally Qualified Health Centers, grant-making organizations, health systems, municipalities, Michigan Department of Health and Human Services, healthcare providers, schools, substance use prevention, treatment and recovery services and Tribal Nations. This unprecedented collaboration provides us with a complete picture of our communities.

Click here for a complete list of the contributors and partners.

HEALTHY PEOPLE *in Equitable Communities*

The Assessments Conducted

The goal from the outset was to engage as many residents and diverse community partners as possible in the data collect process, in order to ensure that the findings truly reflect the community's needs and priorities. MiThrive employs both quantitative and qualitative data to provide a complete and accurate picture of the health and quality of life in Northern Michigan. Quantitative data, such as the number of people affected, changes over time, and differences between different groups, are combined with qualitative data, such as community input, perspectives, and experiences. This approach is considered best practice, as it provides a more comprehensive and nuanced understanding of community health needs.

To guide this process, MiThrive follows the MAPP framework, which is widely recognized as the gold standard for community health needs assessment and improvement planning. The MAPP framework consists of four different assessments, which together provide a 360-degree view of the community. These assessments cover a range of areas and include the Community Health Status Assessment, Community Themes and Strengths Assessment, Community System Assessment, and Forces of Change Assessment.

By following this rigorous and inclusive process, MiThrive is able to provide valuable insights and recommendations that can help to guide local decision-making and resource allocation. The input and expertise of the community members and partners is essential to this process, and we are grateful for the many individuals and organizations that contributed this important effort.

- Click here for additional details on the MiThrive Assessment.
- Find the complete data sets by visiting the MiThrive webpage.

Click here to view the MiThrive Community Health Assessment Explainer Video.

MiThrive Data Collection

100 Local, state, and national indicators collected by county for the Community Health Status Assessment.

152 Participants in 3 Community System Assessment regional events.

396 Participants in focused conversations for the Community System Assessment at 28 collaborative meetings.

3,465 Residents completed the surveys for the Community Themes and Strengths Assessment.

840 Residents facing barriers to social determinants of health participated in Pulse Surveys.

354 Physicians, nurses, and other clinicians completed the Healthcare Provider Survey.

199 Participants in 3 Forces of Change Assessment regional events.

Description of how priority issues, goals, strategies, and ojectives were selected and prioritized

The MiThrive Community Health Assessment uncovered 10-11 significant health needs in each of the MiThrive Regions. After analyzing primary and secondary data, members of the MiThrive Steering Committee, Design Team, and three workgroups, framed these needs as Strategic Issues. To prioritize these issues for collective action, residents and community partners participated in regional MiThrive Data Walk and Priority Setting events, using a criteria-based process to rank the Strategic Issues based on severity, magnitude, impact, health equity, and sustainability. Following the ranking process, MiThrive Workgroup members refined and prioritized the Strategic Issues by removing jargon, clarifying language, conducting a root cause analysis and environmental scan, and developing consensus on goals, strategies, and metrics for a collaborative Community Health Improvement Initiative.

Visit the MiThrive webpage to access the MiThrive Data Briefs. MiThrive Data Briefs provide regional-level data for the 10-11 Strategic Issues identified per region.

Click here for additional details on the prioritization process.

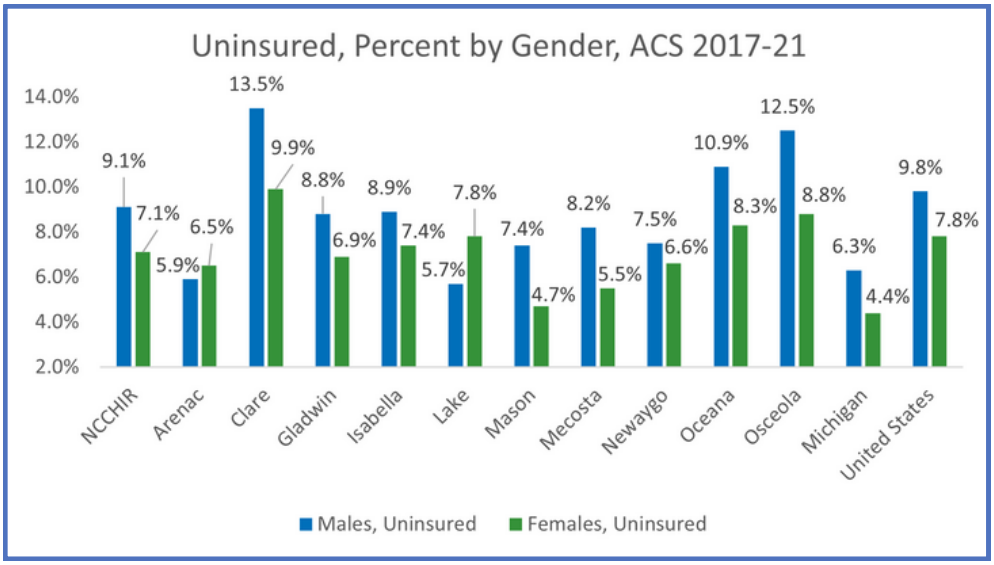
Access to Health Care

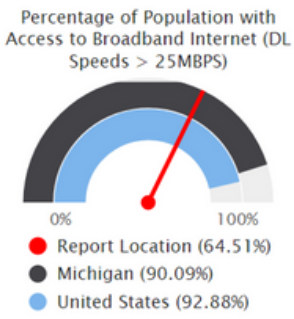
Access to health care affects a person's health and wellbeing. It can prevent disease and disability, detect, and treat illness and conditions; and reduce the likelihood of early death and increase life expectancy.

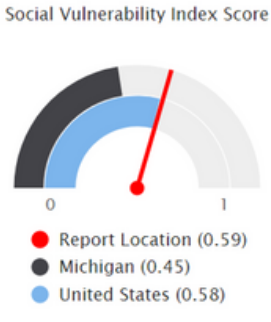
What Does Access to Health Care Look Like in the Region?

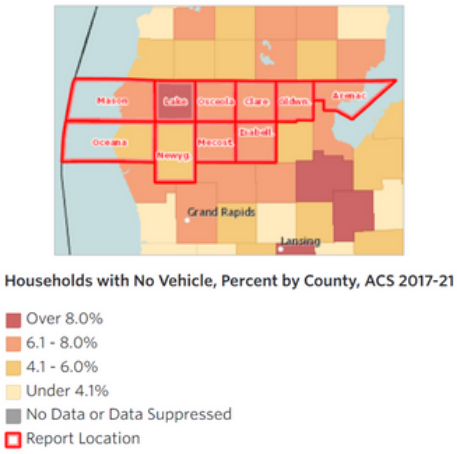
Access to health care includes access to broadband; only 64.5% of the NCCHIR has access to broadband internet with DL speeds greater than 25MBPS. With higher scores expressing greater need and 25 being the highest score for primary healthcare, the NCCHIR has a Health Provider Shortage Area (HPSA) score of 16.1. Mecosta County has the highest HPSA score for primary healthcare at 17.2. The highest HPSA score for dental health is 26, the NCCHIR has a score of 19.1. Lake County has the highest HPSA score for dental health at 23.0. Also, the NCCHIR has a high percentage of individuals that are uninsured. Males in Clare and Osceola Counties have the highest percentage uninsured rates (13.5%, 12.5%).

Lake County has over 8% of households with no vehicle, the most out of all NCCHIR counties. 48.3% of Arenac County has a 30 minute drive or less to a substance-use disorder treatment center and 0.1% of Mason County has a 15 minute drive or less to a syringe service program. Additionally, in 2022, Community Connections has had a total of 3620 referrals. A majority of the referrals aided individuals 20-39 years of age. Lastly the NCCHIR has a Social Vulnerability Index of 0.59. The higher the score, the greater vulnerability the area suffers.

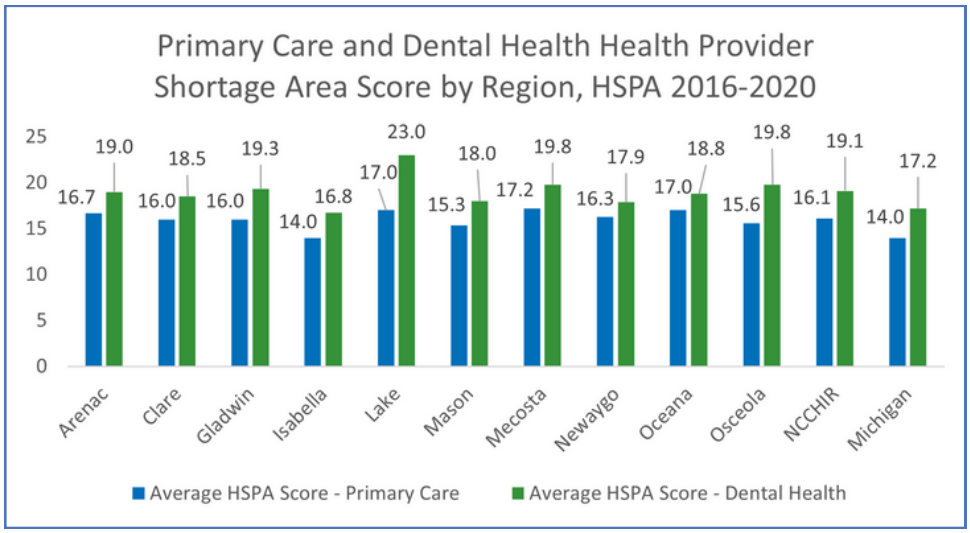


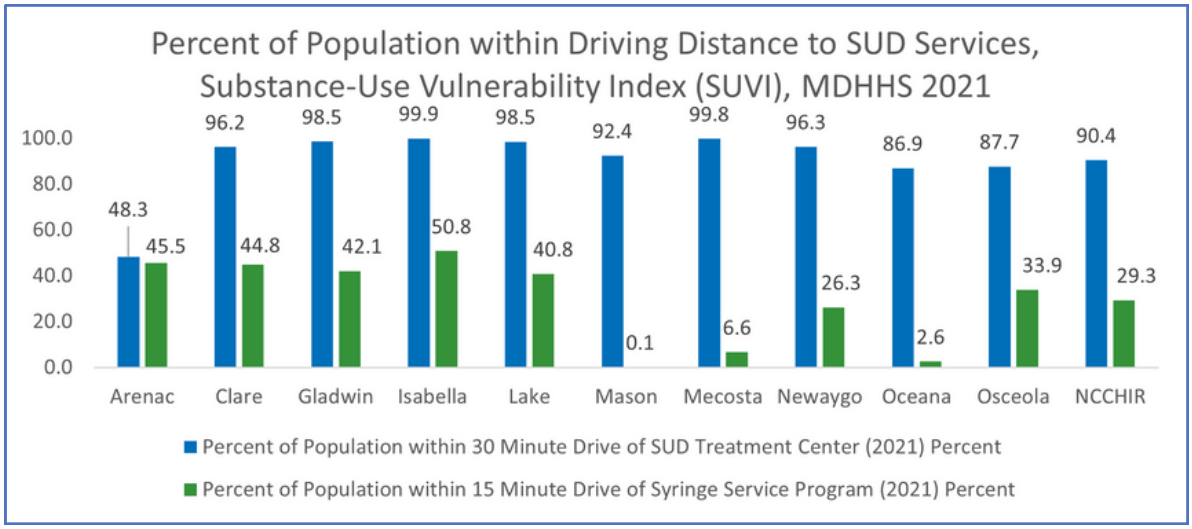






Access to Health Care





In addition to the Community Health Assessment, three discovery channels were explored to develop the following Community Health Improvement Plan:

Root Cause Analysis

Environmental Scan

Strategy Guide

Access to Health Care, Goal 1

Prioritized Root Cause: Health Literacy

Goal 1	Improve Health Literacy
Metrics	Percentage of residents in the community who report having a regular source of primary care. • 11.6% of residents do not have a primary care provider (BRFSS, 2015-2019) Percentage of residents that are uninsured. • In the NCCHIR, 8.1% are uninsured (ACS, 2017-2021) Rate of Preventable Hospitalizations, per 100,000 • 2,594 per 100,000 NCCHIR residents on Medicare had preventable hospitalizations (Medicare, 2020) Percentage of residents that have access to broadband. • 64.5% of NCCHIR residents have access to broadband internet (DL speeds > 25mbps) (FCC, 2022) Percentage of residents that have slow or no internet. • 21.3% of NCCHIR residents reported having slow or no internet (ACS, 2017-2021) Percentage of residents that have no household computer. • 10.7% of NCCHIR residents have no household computer (ACS, 2017-2021) Social Vulnerability Index Score • The NCCHIR has a SVI score of 0.59 (CDC, 2020)
Aligned Partner Data	Does your organization collect aligned data that can support this collective work? Let's connect | Click here. This data might look like: Number of patients visits by service they utilized, number of health service appointment cancelations, percentage of treatment or medication adherence, average health literacy comprehension level, average health literacy word recognition level, percentage of avoidable hospitalizations, rate of hospital readmissions, rate of pre-mature deaths, number of emergency room visits.

Strategy 1.1	Develop and disseminate health and safety information that is accurate, accessible, and actionable.			
Objectives	By December 2024, conduct landscape analysis on existing health literacy efforts in the region.	By December 2024, host 3 health literacy training courses for cross-sector partners in the region.	By December 2024, 10 cross-sector partner training attendees will implement improved health literacy methods at the organizational level.	By December 2024, develop a regional health resident advisory board to review, test, and make recommendations on consumer health information.
Metrics	• Number of organizations participating in landscape analysis • Number of participants completed landscape analysis	• Number of health literacy trainings completed. • Number of organizations participating in health literacy training. • Number of participants in health literacy training.	• Number of partnering organizations implementing health literacy methods. • Number of qualitative success stories given by partnering organizations that implemented health literacy knowledge.	• Number of residents on advisory board. • Number of regional health resident advisory board meetings. • Number of reviewed materials at regional health resident advisory board meetings.

Metrics Continued		• Number of evaluations completed after health literacy training. • % change in knowledge of health literacy after training. • % change in skills of utilizing health literacy after training. • % change in attitudes surrounding health literacy after training.		• Number of recommendations on consumer health information. • Funds paid to residents.

Strategy 1.2	Engage in collective advocacy to increase access to and affordability of broadband.
Objectives	By December 2024, conduct collective advocacy campaign (regional focus) to support increased access to and affordability of broadband.
Metrics	• Number of partnering organizations sharing campaign. • Number of advocacy messaging outputs (calls, emails, letters, meetings). • Number of legislators reached via messaging.

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MiThrive values an asset-based approach to community health improvement efforts and will prioritize existing assets and efforts in the community.

Access to Health Care, Goal 2

Prioritized Root Cause: Transportation

Goal 2	Strengthen transportation options to healthcare services.
Metrics	Number of community connections referrals. • Community Connections had 3620 referrals in 2022 (Community Connections, 2022) Percentage of households with no motor vehicle. • In the NCCHIR, 6.6% of households have no motor vehicle (ACS, 2017-2021) Ratio of providers to residents, Health Provider Shortage Area • The NCCHIR has an HPSA score of 16.1 for primary care (HRSA, 2016-2020) • The NCCHIR has an HPSA score of 19.1 for dental healthcare (HRSA, 2016-2020) Percentage of population within 30-minute drive of Substance-use Disorder Treatment Center. • 90.4% of NCCHIR residents are within a 30-minute drive of an SUD treatment center (MDHHS Opioid Dashboard, 2021) Percentage of population within 15-minute drive of Syringe Service Program. • 29.3% of NCCHIR residents are within a 15-minute drive of an SSP (MDHHS Opioid Dashboard, 2021)
Aligned Partner Data	Does your organization collect aligned data that can support this collective work? Let's connect | Click here. This data might look like: Number of participants utilizing ride share, number of referrals for transportation with community connections/ 2-1-1, number of available transportation service programs to healthcare services, number of appointment cancellations, reasons for cancellations (specifically transportation related cancelations).

Strategy 2.1	Develop a regional coordinated transportation service model.	
Objectives	By December 2024, conduct a regional landscape analysis to identify existing transportation assets and gaps related to access to healthcare in the region to inform additional objectives.	By December 2024, conduct a healthcare transportation resident voice survey to inform additional objectives.
Metrics	• Number of organizations partnering to complete the landscape analysis. • Number of participants completed landscape analysis.	• Number of participants taking resident voice survey. • Number of key findings from resident voice survey. • Number of deliverables (presentations/reports) distributed to community partners, stakeholders, or residents.

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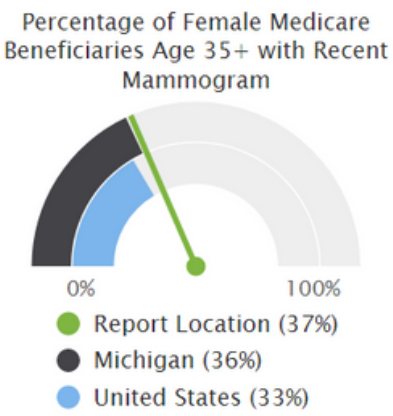
Chronic Disease

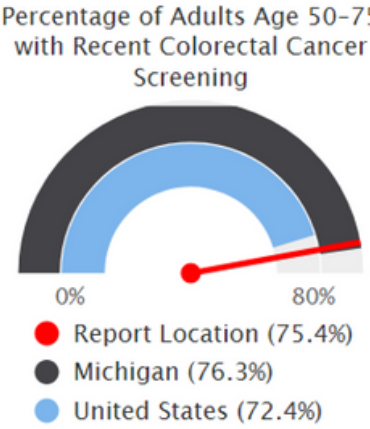
Chronic diseases can significantly impact an individual's quality of life, as well as put a strain on healthcare resources. Chronic diseases are defined broadly as conditions that last 1 year or more and require ongoing medical attention or limit activities of daily living or both. Heart disease, stroke, cancer, and diabetes are considered the major chronic diseases where tobacco use, poor nutrition, physical inactivity are considered the major risk factors.

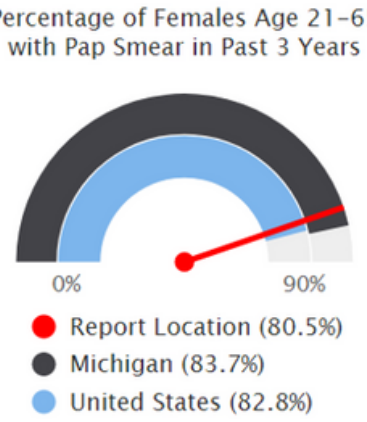
What does chronic disease look like in the region?

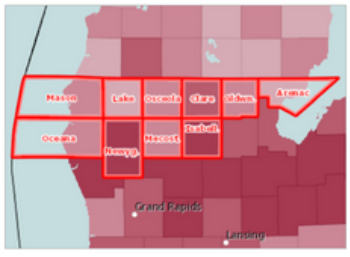
75.4% of NCCHIR adults have had a recent colorectal cancer screening and 80.5% of females have had a pap smear in the past three years. In Isabella and Newaygo Counties, over 34.0% of the population older than 20 is obese or has a BMI equal or higher than 30. Eight out of 10 counties in the NCCHIR have 26.1% of the population classified as obese. Additionally, 89.5% of Medicare enrolled with diabetes receive annual A1C testing. In Newaygo and Osceola, between 23.1% to 26.0% of the residents have no leisure time to participate in physical activity. 17.7% of NCCHIR residents have poor or fair general health. All of these indicators track preventative factors against chronic disease.

8.8% of residents in the NCCHIR that are 20 and older have been diagnosed with diabetes. As for chronic disease incidence and mortality, Clare County has a cancer incidence over 480 per 100,000 residents, the highest cancer incidence in the NCCHIR. In the CHIR, 175.6 per 100,000 for cancer mortality, 116.0 for coronary heart disease.



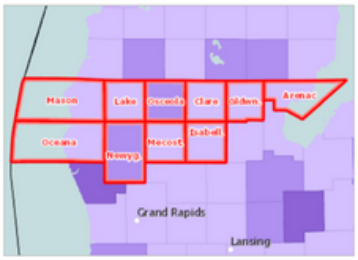






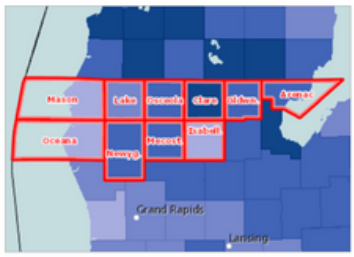
Obese (BMI >= 30), Adults Age 20+, Percent by County, CDC NCCDPHP 2019

- Over 34.0%
- 30.1 - 34.0%
- 26.1 - 30.0%
- Under 26.1%
- No Data or Data Suppressed
- Report Location



No Leisure-Time Physical Activity, Adults Age 20+, Percent by County, CDC NCCDPHP 2019

- Over 29.0%
- 26.1 - 29.0%
- 23.1 - 26.0%
- Under 23.1%
- No Data or Data Suppressed
- Report Location

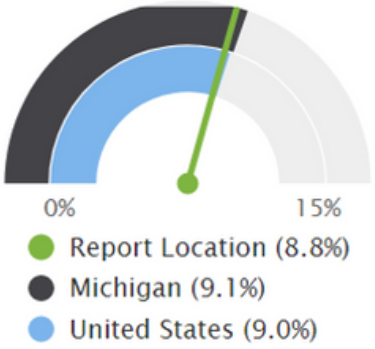


Cancer (All Sites), Incidence Rate (Per 100,000 Pop.) by County, State Cancer Profiles 2015-19

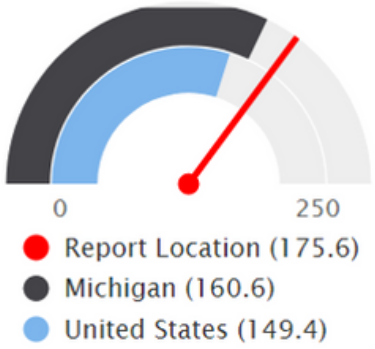
- Over 480.0
- 440.1 - 480.0
- 400.1 - 440.0
- 0.1 - 400.0
- Data Suppressed (<16 Cases)
- No Data
- Report Location

Chronic Disease

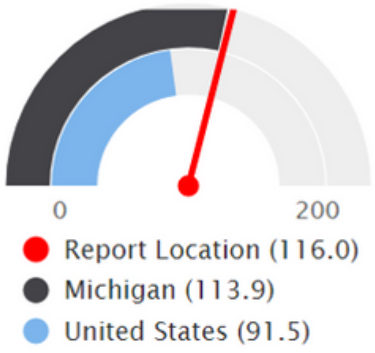
Percentage of Adults Age 20+ with Diagnosed Diabetes (Age-Adjusted), 2019



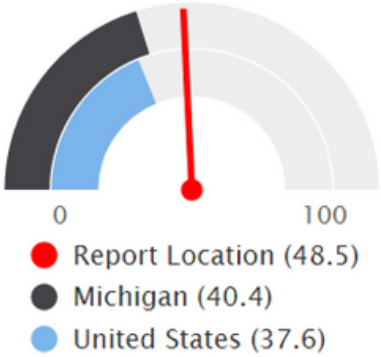
Cancer Mortality, Age-Adjusted Death Rate (Per 100,000 Pop.)



Coronary Heart Disease Mortality, Age-Adjusted Death Rate (Per 100,000 Pop.)



Stroke Mortality, Age-Adjusted Death Rate (Per 100,000 Pop.)



In addition to the Community Health Assessment, three discovery channels were explored to develop the following Community Health Improvement Plan:

Root Cause Analysis

Environmental Scan

Strategy Guide

Chronic Disease, Goal 1

Prioritized Root Cause: Lack of Health in All Policies

Goal 1	Increase preventive health in the community.
Metrics	Decrease percent of residents with diabetes and cancer (incidence & prevalence). • Cancer incidence in the NCCHIR is 436.8 per 100,000 (MDHHS, 2015-2019) • Diabetes prevalence in the NCCHIR is 8.8% for adults 20 years and older (age-adjusted) (CDC NCCDPHP, 2019) Decrease percentage of stroke, heart disease, and cancer mortality. • Cancer mortality in the NCCHIR is 175.6 per 100,000 (age-adjusted) (MDHHS Vital Statistics, 2016-2020) • Coronary Heart Disease mortality is 116.0 per 100,000 (age-adjusted) (MDHHS Vital Statistics, 2016-2020) • Stroke mortality is 48.5 per 100,000 (age-adjusted) (MDHHS Vital Statistics, 2016-2020) Percent of adults with 14 or more poor general health days per month • 17.7% of NCCHIR residents reported having 14 or more days per month of poor or fair general health (BRFSS, 2020) Percent of adults reporting no leisure time physical • In the NCCHIR, 21.9% of adults reported having no leisure time for physical activity (CDC NCCDPHP, 2019)
Aligned Partner Data	Does your organization collect aligned data that can support this collective work? Let's connect | Click here. This data might look like: Number of patient visits that utilized preventative health services or number of health promoting policies at your agency.

Strategy 1	Integrate Health in All Policies across sectors.	
Objectives	By December 2024, host one Health in All Policies training in the region.	By December 2024, 5 cross-sector organizations will adopt a Health in All Policies approach.
Metrics	• Number of Health in All Policies trainings. • Number of organizations that participate in Health in All Policies trainings. • Number of Health in All Policies training participants. • Number of Health in All Policies training evaluations completed. • Percent change in knowledge of Health in All Policies. • Percent change in skills utilizing Health in All Policies. • Percent change in attitudes of importance of Health in All Policies.	• Number of organizations that have adopted Health in All Policies. • Number of qualitative success stories/bright spots found when policy change enacted.

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Chronic Disease, Goal 2

Prioritized Root Cause: Access Barriers

Goal 2	Increase use of preventive health services & programs in the region.
Metrics	Percent of cancer screening (Colorectal, Breast, and Cervical Cancer). • 37% of NCCHIR female residents on Medicare age 35+ have had a mammogram in the past year (Medicare, 2019) • 80.5% of NCCHIR female residents aged 21 to 65 have had a pap smear in the past 3 years (BRFSS, 2020) • 75.4% of NCCHIR residents age 50-75 have had a colorectal cancer screening in past 3 years for sigmoidoscopy and in past 10 years for colonoscopy (BRFSS, 2020) Percent of residents utilizing diabetes management. • In the NCCHIR, 89.5% of residents with Diabetes on Medicare have had annual A1C testing (Medicare, 2019) Percent of adults that are obese. • Of adults 20 years and older, 31.5% have a BMI over 30 (Obese) in the NCCHIR (CDC NCCDPHP, 2019)
Aligned Partner Data	Does your organization collect aligned data that can support this collective work? Let's connect | Click here. This data might look like: Number of patient visits that utilized preventative health services.

Strategy 1	Increase use of community health workers, patient navigators, and other allied health professionals to help people get the recommended preventive healthcare services.		
Objectives	By September 2023, develop a SDOH accelerator plan to address issues of access to and utilization of chronic disease prevention and management services and increase social connectedness.	By December 2024, develop a regional coordinated approach to CHW efforts, across agencies, in the region.	By December 2024, develop a collaborative monitoring system to track multi-disciplinary referrals.
Metrics	• Completed SDOH Accelerator Plan. • Number of strategies developed in the SDOH Accelerator Plan. • Number of partnering organizations listed on the SDOH Accelerator Plan.	• Completed Regional Coordinated Approach plan. • Number of strategies developed for the Regional Coordinated Approach. • Number of partnering organizations involved in the Regional Coordinated Approach. • Number of qualitative success stories/bright spots.	• Developed Multi-disciplinary Referral Monitoring System. • Number of individuals data incorporated into the Multi-disciplinary Referral Monitoring System. • Number of partnering organizations involved in the Multi-disciplinary Referral Monitoring System. • Percentage of referrals • Increase in types of referrals offered.

Let's Collaborate | Click Here

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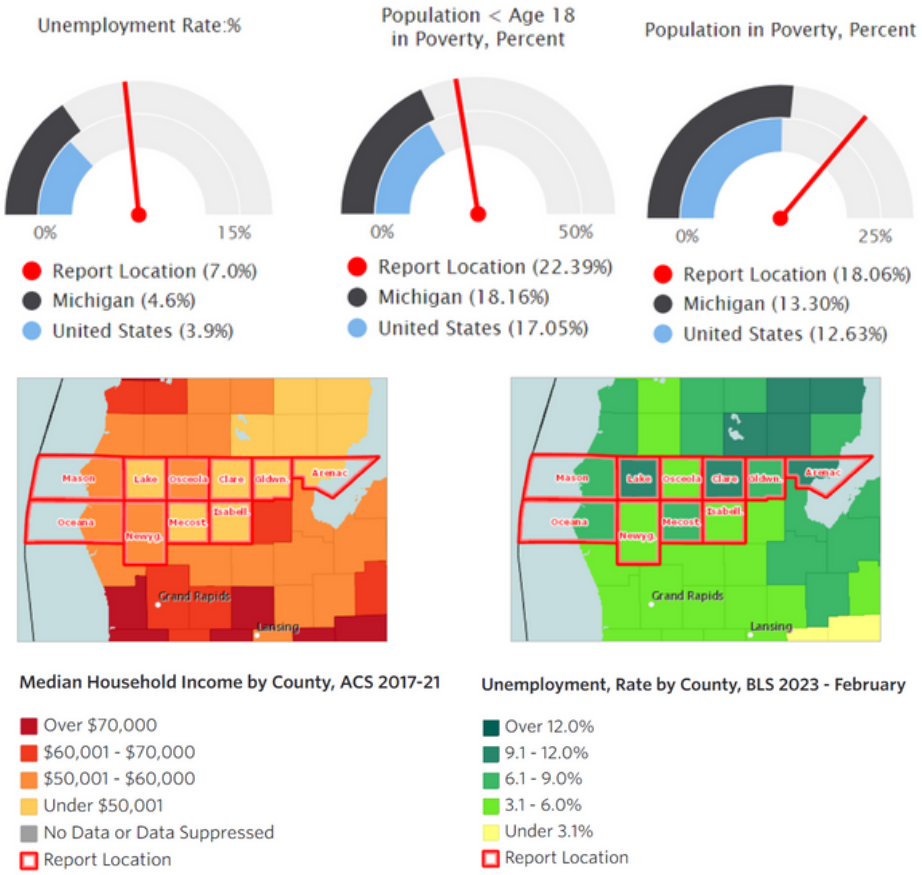
Economic Security

Health and wealth are closely linked. Economic disadvantage affects health by limiting choice and access to proper nutrition, safe neighborhoods, transportation, and other elements that define standard of living. People who live in socially vulnerable areas live shorter lives and experience reduced quality of life.

What does economic security look like in the region?

7.0% of the NCCHIR is unemployed which is almost double the percent of unemployment in Michigan and the United States. Unemployment is highest in Lake, Clare, and Arenac Counties. Over 22.4% of the NCCHIR under the age of 18 is in poverty, 18% of the whole NCCHIR population is in poverty, and 6 of the 10 NCCIR Counties have a median income below $50, 001. Additionally, 60% of NCCHIR students receive free or reduced-price school lunch compared to 51% of Michigan and United States residents.



In addition to the Community Health Assessment, three discovery channels were explored to develop the following Community Health Improvement Plan:

Root Cause Analysis

Environmental Scan

Strategy Guide

Economic Security, Goal 1

Prioritized Root Cause: Lack of Awareness of Available Resources

Goal 1	**Increase essential need resource utilization (food, housing, childcare, education, employment programs etc.) among individuals living at or below the ALICE level.**
Metrics	Percentage of unemployment • 7.0% of residents in the NCCHIR are unemployed (BLS, 2023) Percentage of total population in poverty • 18.1% of NCCHIR residents are in poverty (ACS, 2017-2021) Percentage of population under the age of 18 in poverty • 22.4% of residents under the age of 18 in the NCCHIR are in poverty (ACS, 2017-2021) Percentage of students eligible for free or reduce priced lunch • 60.6% of students are eligible for free or reduced priced lunch in the NCCHIR (NCES CCD, 2020-21) Median household income • The average median household income of all NCCHIR counties is $49,344 (ACS, 2017-2021) Per capita income • NCCHIR's per capita income is $26,374 (ACS, 2017-2021)
Aligned Partner Data	Does your organization collect aligned data that can support this collective work? Let's connect | Click here. This data might look like: Number of individuals unable to afford services, number of individuals utilizing food stamps, number of individuals on Medicaid, percentage of individuals that end use of resources due to cost service or cost of transportation.

Let's Collaborate | Click Here

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Mental Health

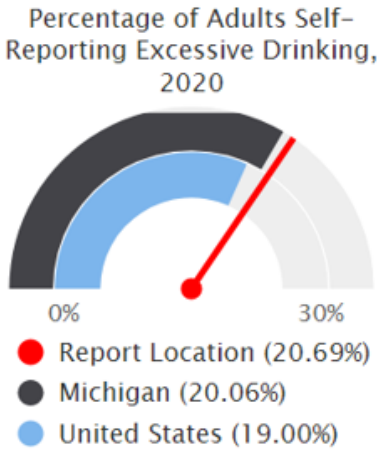
Addressing mental health is critical for our community. Mental health disorders are prevalent in our community, and they can have profound impact on individuals, families, and the community as a whole. Our goal is to implement evidence-based interventions that promote mental health, reduce stigma, and reduce barriers/improve access to mental health services.

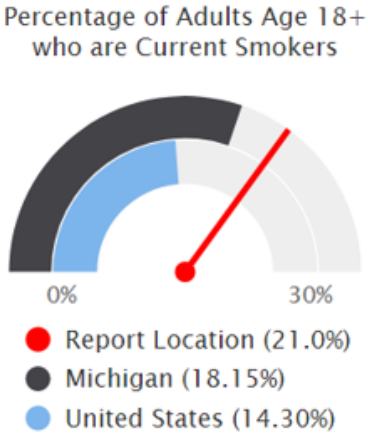
What does mental health look like in the region?

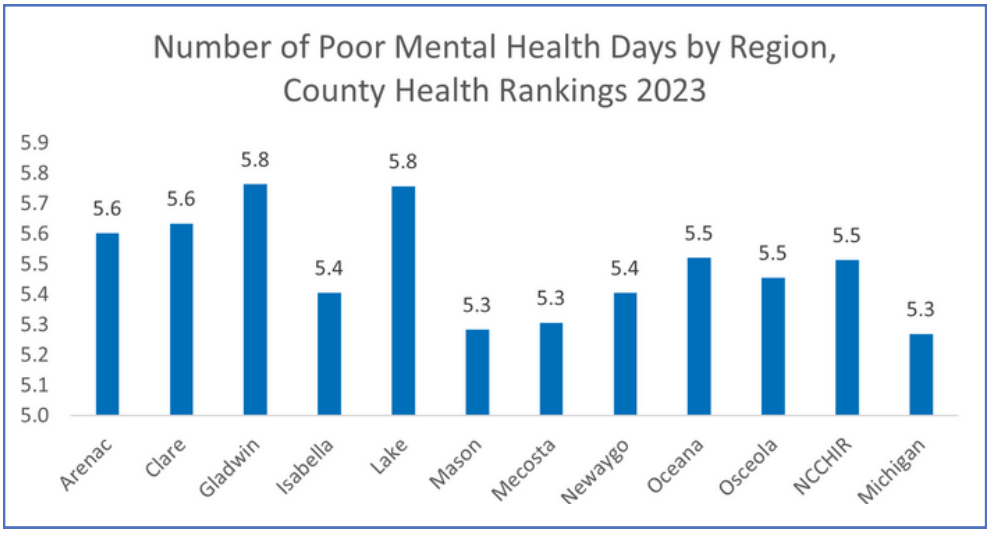
In the NCCHIR, Clare County has a suicide mortality over 20 per 100,000 residents. Followed by Gladwin, Mason, Newaygo, and Osceola that have a mortality between 16.1 to 20.0 per 100,000. Out of the counties that report, Oceana County has the highest percentage of high school students have attempted suicide in the past year (11.2%). The average NCCHIR resident has approximately 5.5 poor mental health days per month. In all NCCHIR counties that report, the number of high school students that have experienced major depression in the past year increased from 2018 to 2022.

In the NCCHIR, 20.7% of residents reported excessive drinking and 21.0% reported that they currently smoke cigarettes. Arenac, Lake, and Mason have the highest percentage of students that have had alcohol in the past 30 days out of the counties that report student alcohol use.

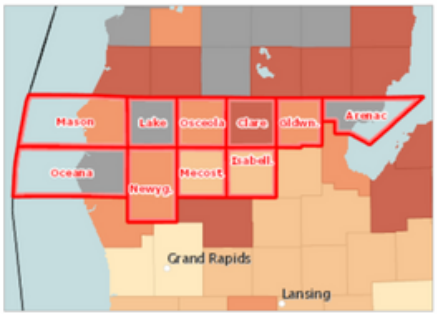
With higher score expressing greater need and 25 being the highest score for mental health, the NCCHIR has a Health Provider Shortage Area (HPSA) score of 17.8. Lake County has the highest HPSA score at 20.5. Also, the NCCHIR has a high percentage of individuals that are uninsured. The males in Clare and Osceola Counties have the highest percentage uninsured (13.5%, 12.5%).





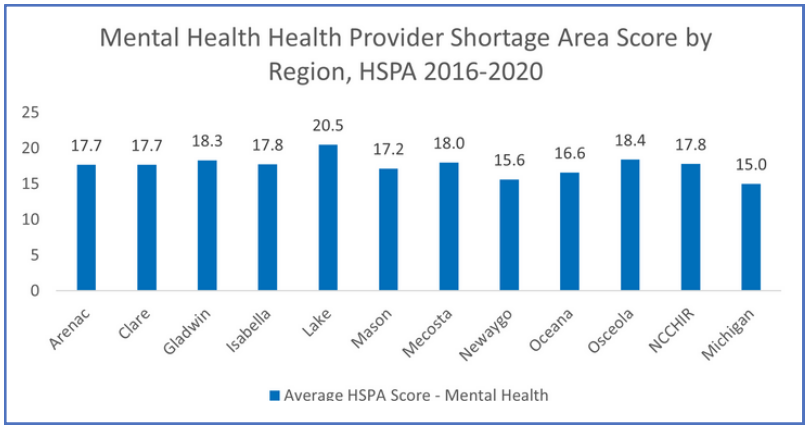


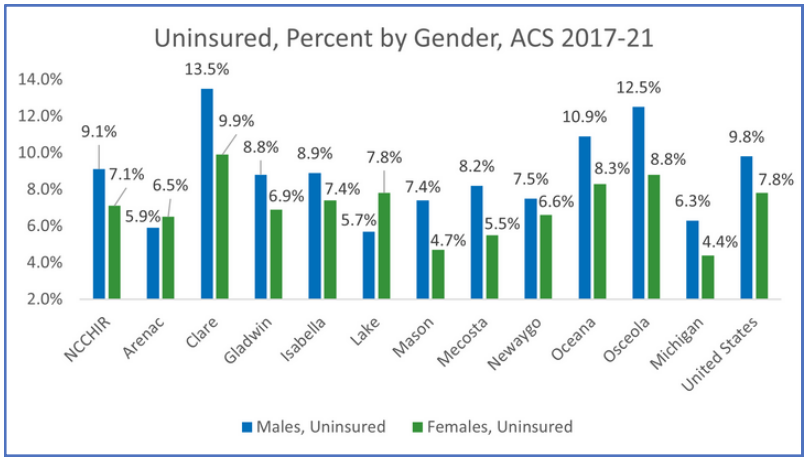
Mental Health



Suicide Mortality, Age Adj. Rate (Per 100,000 Pop.) by County, CDC NVSS 2016-20

- Over 20.0
- 16.1 - 20.0
- 12.1 - 16.0
- Under 12.1
- Data Suppressed (<20 Deaths)
- Report Location



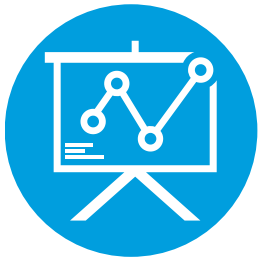


In addition to the Community Health Assessment, three discovery channels were explored to develop the following Community Health Improvement Plan:

Root Cause Analysis

Environmental Scan

Strategy Guide



Mental Health, Goal 1

Prioritized Root Cause: Adult Mental Health Stigma

Goal 1	Improve adult mental health.
Metrics	Decrease number of poor mental health days (14+ days per month) • The average number of mentally unhealthy days for a resident in the NCCHIR is 5.5 per month (County Health Rankings, 2023) Decrease percentage of intentional self-harm (suicide) mortality • In the NCCHIR, there is a rate of 17.3 per 100,000 for suicide mortality (age-adjusted) (MDHHS Vital Statistics, 2016-2020) Decrease percentage of substance use- heavy alcohol consumptions, current tobacco use. • 20.7% of NCCHR residents age 18+ participate in excessive drinking (BRFSS, 2020) • 21.0% of NCCHIR residents age 18+ currently participate in smoking (BRFSS, 2020)
Aligned Partner Data	Does your organization collect aligned data that can support this collective work? Let's connect | Click here. This data might look like: Coordination with hospitals; number of mental health crisis in the emergency room, number of adults utilizing mental health services, percentage of adults that have access to mental health insurance, percentage of adults that feel it is easy to access mental health services, number of mental health services in the community, number of referrals for mental health services, percent of change in stigmatizing views around mental illness.

Strategy 1	Raise critical consciousness within the public and across all systems that adults living with mental health challenges have the capacities for recovery, resilience, and wellness.			
Objectives	By December 2024, partner with mental health providers and those who have/are experienced/ing a mental health episode to co-create a language guide to reduce stigmatizing language.	By December 2024, create a campaign highlighting professionals sharing their mental health experience.	By December 2024, partner with the Great Lakes Bay Region's iMatter Anti-Stigma & the NWCHIR Behavioral Health Initiative to highlight residents sharing their mental health experience.	By December 2024, host (or co-host) 1 Adult Mental Health First Aid Training in each county.
Metrics	• Completed stigma reducing language guide. • Number of organizations working on the language guide. • Number of the language guides shared. • Percent change in knowledge regarding stigmatizing mental health language.	• Number of social media posts created. • Number of views, shares, likes. • Number of partnering organizations sharing the campaign. • Percent change of attitudes related to mental health stigma.	• Number of social media posts created. • Number of views, shares, likes. • Number of partnering organizations sharing the campaign. • Percent change of attitudes related to mental health stigma.	• Number of Adult Mental Health First Aid Trainings. • Number of organizations participating in the Adult Mental Health First Aid Trainings. • Number of participants at the Adult Mental Health First Aid Trainings.

Metrics Continued				• Number of evaluations completed after the Adult Mental Health First Aid Trainings. • Percent change in knowledge of Adult Mental Health First Aid. • Percent change in skills related to Adult Mental Health First Aid. • Percent change in attitudes related to Adult Mental Health First Aid.

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MiThrive values an asset-based approach to community health improvement efforts and will prioritize existing assets and efforts in the community.

Mental Health, Goal 2

Prioritized Root Cause: Youth Mental Health Stigma

Goal 2	Improve youth mental health.
Metrics	Percent of substance use (alcohol, tobacco, marijuana) in the past 30 days. • 15.9% of high school students in the NCCHIR have had alcohol in the past 30 days (MiPHY, 2022) * • 2.0% of high school students in the NCCHIR have smoked cigarettes in the past 30 days (MiPHY, 2022) * • 3.0% of high school students in the NCCHIR have used prescription drugs illegally in the past 30 days (MiPHY, 2022) * Percent who experienced major depressive episode in past year. • 42.7% of high school students in the NCCHIR have experienced a major depressive episode in the past year (MiPHY, 2022) * Percent of students who have attempted suicide in the past year. • 9.9% of high school students in the NCCHIR have attempted suicide in the past year (MiPHY, 2022) * *Percentage only includes schools that participate in MiPHY and has data that is not suppressed.
Aligned Partner Data	Does your organization collect aligned data that can support this collective work? Let's connect | Click here. This data might look like: Coordinate with hospitals & schools; coordinate with community mental health services & adolescent health centers; number of mental health crisis in the emergency room, number of youth utilizing mental health services, percentage of youth that have access to mental health insurance, percentage of youth that feel it is easy to access mental health services, number of youth mental health services in the community, number of referrals for youth mental health services, percent of change in stigmatizing views around mental illness, percentage of students with anxiety or depression, percentage of school counselors seeing students with mental health conditions.

Strategy 2.1	Raise critical consciousness within the public and across all systems that youth living with mental health challenges have the capacities for recovery, resilience, and wellness.	
Objectives	By December 2024, partner with mental health providers, youth serving organizations, and youth groups to co-create a youth mental health campaign.	By December 2024, identify youth mental health care coordination network.
Metrics	• Number of social media posts created. • Number of views, shares, likes. • Number of partnering organizations sharing the campaign. • Percent change in attitudes regarding mental health stigma. • Percent change in knowledge regarding mental health.	• Youth Mental Health Care Coordination Network established shared goal. • Number of partners identified to participate in the Youth Mental Health Care Coordination Network.

Strategy 2.2	Advocate for age-appropriate mental illness prevention, recovery, and wellness programs, services, and systems of care.	
Objectives	By December 2024, host 1 Youth Mental Health First Aid Training in each county.	By December 2024, conduct a regional landscape analysis to identify Social and Emotional (SEL) efforts across the region and develop a plan to support and promote existing efforts.

Mental Health, Goal 2

Metrics	• Number of Youth Mental Health First Aid Trainings. • Number of organizations participating in the Youth Mental Health First Aid Trainings. • Number of participants at the Youth Mental Health First Aid Trainings. • Number of evaluations completed after the Youth Mental Health First Aid Trainings. • Percent change in knowledge of Youth Mental Health First Aid. • Percent change in skills related to Youth Mental Health First Aid. • Percent change in attitudes related to Youth Mental Health First Aid.	• Number of participating organizations. • Number of participants completing the landscape analysis.

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Mental Health, Goal 3

Prioritized Root Cause: Mental Health Access Barriers and Missing Services

Goal 3	Increase access to mental health services unique to the community.
Metrics	Percent of substance use (alcohol, tobacco, marijuana) in the past 30 days. • 15.9% of high school students in the NCCHIR have had alcohol in the past 30 days (MiPHY, 2022) * • 2.0% of high school students in the NCCHIR have smoked cigarettes in the past 30 days (MiPHY, 2022) * • 3.0% of high school students in the NCCHIR have used prescription drugs illegally in the past 30 days (MiPHY, 2022) * Percent who experienced major depressive episode in past year. • 42.7% of high school students in the NCCHIR have experienced a major depressive episode in the past year (MiPHY, 2022) * Percent of students who have attempted suicide in the past year. • 9.9% of high school students in the NCCHIR have attempted suicide in the past year (MiPHY, 2022) * Percentage of residents that are uninsured. • In the NCCHIR, 8.1% are uninsured (ACS, 2017-2021) Ratio of mental health providers to residents. • The NCCHIR has an HPSA score of 17.8 for mental healthcare (HRSA, 2016-2020) *Percentage only includes schools that participate in MiPHY and has data that is not suppressed.
Aligned Partner Data	Does your organization collect aligned data that can support this collective work? Let's connect | Click here. This data might look like: Coordinate with hospitals, courts, police, & schools; coordinate with community mental health services, department of education; percentage of individuals aware of tele-mental health services, percentage of individuals utilizing tele-mental health services, percentage of individuals that are able to afford mental health services, length of wait time for individuals beginning/new to mental health services, number of youth utilizing mental health services, percentage of youth that have access to mental health insurance, percentage of youth that feel it is easy to access mental health services, number of mental health services that do not require parental approval, number of referrals for youth mental health services

Strategy 3.1	Engage in collective advocacy for mental health services being integrated into local public-school systems.		
Objectives	By December 2024, host 4 of PBIS (Positive Behavioral Interventions and Supports) and ISF (Interconnected Systems Framework) informational sessions for schools to learn more about each program and how to implement them into their school system.	By December 2024, develop local case study of PBIS and ISF impact, including data comparisons for youth outcomes between PBIS and ISF.	By December 2024, create a list of funding sources that support integration of PBIS or ISF in school systems.
Metrics	• Number of PBIS (Positive Behavioral Interventions and Supports) and ISF (Interconnected Systems Framework) information sessions. • Number of schools participating in PBIS (Positive Behavioral Interventions and Supports) and ISF	• Completed PBIS and ISF case study. • Number of data comparisons found from the PBIS and ISF case study.	• Number of funding sources identified to support integration of PBIS or ISF in school systems. • Number of funding sources applied to or reached out to that could support integration of PBIS or ISF in school systems.

Metrics Continued	(Interconnected Systems Framework) information sessions. • Number of participants attending PBIS (Positive Behavioral Interventions and Supports) and ISF (Interconnected Systems Framework) information sessions. • Number of recommendations/feedbacks from participants attending PBIS (Positive Behavioral Interventions and Supports) and ISF (Interconnected Systems Framework) information sessions. • Number of bright spots.		

Strategy 3.2	Build awareness around mental health parity.
Objectives	By December 2024, conduct collective advocacy campaign to build system awareness around what mental health parity is and why it's important.
Metrics	• Number of mental health parity social media posts created. • Number of views, likes, shares. • Number of partnering organizations sharing the mental health parity campaign. • Percent change in knowledge of mental health partity.

Strategy 3.3	Increase access to mental health services unique to the community.		
Objectives	By December 2024, convene a biannual roundtable of mental health service providers and conduct a share-out of available services.	By December 2024, develop a recommendation guide for cross-organizational referral system.	By December 2024, conduct a regional landscape analysis to identify gaps and assets in mental health services in the community and compare mental health needs in the region.
Metrics	• Number of roundtable meetings. • Number of participants that attend the biannual roundtable meeting.	• Completed recommendations guide for cross-organizational referral system. • Number of recommendations within the guide. • Bright spots	• Number of participating organizations. • Number of participants completing the mental health services landscape analysis

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