District Health Department No. 2
www.dhd2.org

mithrive

2021 COMMUNITY HEALTH NEEDS ASSESMENT

Alcona, Iosco, Ogemaw, and Oscoda Counties

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A MESSAGE FROM DHD2'S HEALTH OFFICER

"Healthy families create healthy communities."

As a Chief Health Strategist, District Health Department No. 2 (DHD2) is a proud leader in the Northeast for the Northern Michigan Community Health Innovation Region (CHIR), a network comprised of health departments, health systems, mental health agencies, and community-based organizations across 31-counties working together for the greatest collective impact. Every three years, the CHIR convenes a diverse team of partners to conduct a regional Community Health Needs Assessment (CHNA), MiThrive.

Outlined on the following pages is the extensive, phased MiThrive assessment process as well as a breakdown of the top three (3) priority needs identified for the DHD2 jurisdiction, covering Alcona, Iosco, Ogemaw and Oscoda Counties. There is a tremendous amount of pride in our communities recognizing how caring and connected we are in northeast Michigan. During the 2021 assessment process, 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.

We know that simply promoting healthy choices won't close gaps in access to mental and physical healthcare or eliminate health disparities that exacerbate chronic conditions and inequities in our communities. Instead, public health organizations and their partners in sectors like healthcare, education, transportation, and housing can collectively take actions to improve environmental conditions and increase social support that allow people to thrive. Given the findings in this report, DHD2 is committed to implementing the 2023 Northeast Community Health Improvement Plan to address the priority areas identified.

We are thankful for the MiThrive Steering Committee, Design and Core Teams, as well as the Northeast Workgroup and all the partners across various sectors of the community who made the 2021 MiThrive cycle a success.

Denise M. Bryan, MPA
Administrate Health Officer
District Health Department No. 2

District Health Department No. 2

Executive Summary

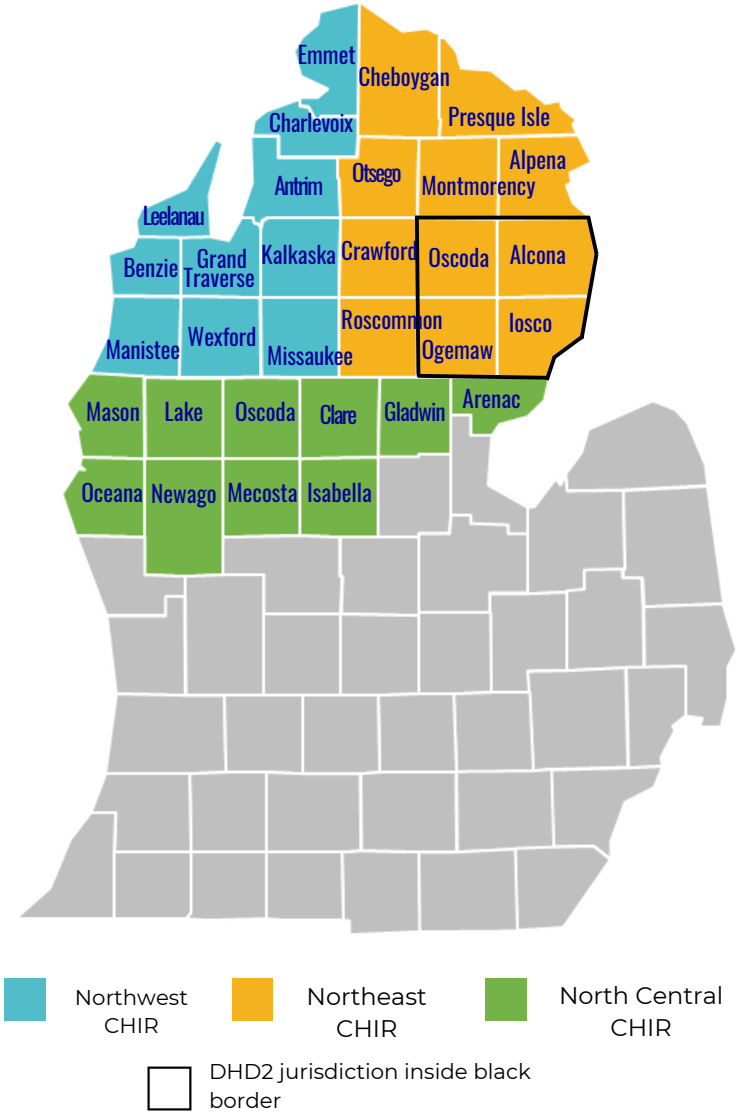
In a remarkable partnership, hospitals, health departments, and other community partners in Northern Michigan join together every three years to take a comprehensive look at the health and well-being of residents and communities. Through community engagement and participation across a 31-county region, the MiThrive Community HealthNeeds Assessment collects and analyzes data from a broad range of social, economic, environmental, and behavioral factors that influence health and well-being and identifies and ranks key strategic issues. In 2021, together, we conducted a comprehensive, community-driven assessment of health and quality of life on an unprecedented scale. MiThrive gathered data from existing statistics, listened to residents, and learned from community partners, including healthcare providers. Our findings show our communities face complex interconnected issues, and these issues harm some groups more than others.

Report Goals and Objectives

- Describe the current state of health and well-being in the District Health Department No. 2 jurisdiction.
- Describe the processes used to collect community perspectives
- Describe the process for prioritizing Strategic Issues within the Northwest, Northeast, and North Central CHIR regions
- Identify community strengths, resources, and service gaps

Regional Approach

MiThrive was implemented across a 31-county region through a partnership of hospital systems, local health departments, and other community partners. Our aim is to leverage resources while still addressing unique local needs for high-quality, comparable county-level data. The 2021 MiThrive Community Health Needs Assessment utilized three regions: Northwest, Northeast, and North Central. We've found there are several advantages to a regional approach, including strengthened partnerships, alignment of priorities, reduced duplication of effort, comparable data, and maximized resources.



District Health Department No. 2 jurisdiction includes Alcona, Iosco, Ogemaw, and Oscoda Counties, which are located in the Northeast CHIR Region. Of the four MiThrive assessments, two were conducted at the county level, and two were conducted within the MiThrive regions.

Data Collection

The findings detailed throughout this report are based on data collected through various primary data collection methods and existing statistics. From the beginning, our goal was to engage residents and many diverse community partners in data collection methods.

To accurately identify, understand, and prioritize strategic issues, MiThrive combines quantitative data, such as the number of people affected, changes over time, and differences over time, and qualitative data, such as community input, perspectives, and experiences. This approach is best practice, providing a complete view of health and quality of life while assuring results are driven by the community.

MiThrive utilizes the Mobilizing for Action through Planning and Partnerships community health needs assessment framework. Considered the "gold standard," it consists of four different assessments for a 360-degree view of the community. Each assessment is designed to answer key questions:

- Community Health Status Assessment: The Community Health Status Assessment identifies priority community health and quality of life issues. It answers the questions, "How healthy are our residents?" and "What does the health status of our community look like?". This assessment aims to collect quantitative secondary data about the health and well-being of residents and communities. We collected about 100 statistics by county for the 31-county region from reliable sources such as County Health Rankings, Michigan Department of Health and Human Services, and the US Census Bureau.
- Community System Assessment: The Community System Assessment focuses on organizations contributing to well-being. It answers the questions "What are the components, activities, competencies, and capacities in the regional system?" and "How are services being provided to our residents?" The Community System Assessment was completed in two parts. First, community-wide virtual meetings were convened in the Northwest, Northeast, and North Central MiThrive regions, where participants discussed various attributes of the community system. These were followed by related discussions at the county or two-county level.

Community Themes & Strengths Assessment: The Community Themes and Strengths Assessment provides a deep understanding of the issues that residents feel are significant by answering the questions "What is important to our community?", "How is quality perceived in our community?" and "What assets do we have that can be used to improve well-being?" The Community Themes and Strengths Assessment consisted of three surveys: Community Survey, Healthcare Provider Survey, and Pulse Survey. Results from each were analyzed by county, hospital service area, and the three MiThrive Regions.

Forces of Change Assessment: The Forces of Change Assessment identifies forces such as legislation, technology, and other factors that affect the community context. It answers the questions "What is occurring or might occur that affects the health of our community or the local system?" and "What specific threats or opportunities are generated by these occurrences?" Like the Community System Assessment, the Forces of Change Assessment was composed of community meetings convened virtually in the Northwest, Northeast, and North Central MiThrive Regions.

Each assessment provides important information, but the value of the four assessments is maximized by considering the findings as a whole.

MiThrive Data Collection in 31-County Region

100	Local, state, and national indicators collected by county for the Community Health Status Assessment
152	Participants in three Community System Assessment regional events
396	Participants in focused conversations for the Community System Assessment at 27 community collaborative meetings
3,465	Residents completed the Community Surveys for the Community Themes and Strengths Assessment
840	Residents facing barriers to social determinants of health participated in Pulse Surveys conducted by community partners for the Community Themes and Strengths Assessment
354	Physicians, nurses, and other clinicians completed Healthcare Provider Survey for the Community Themes and Strengths Assessment
199	Participants in three Forces of Change Assessment regional events

Health Equity

The Robert Wood Johnson Foundation says health equity is achieved when everyone can attain their full health potential, and no one is disadvantaged from achieving this potential because of social position or any other socially-defined circumstance. Without health equity, there are endless social, health, and economic consequences that negatively impact patients/clients, communities, and organizations. Health equity can be viewed using different lenses, such as race, culture, geographic location, available resources, and job availability to name a few -- all of which can be significant contributors to increased mortality, lower life expectancy, and higher incidence of disease and disability, according to the Rural Health Information Hub.

The MiThrive Vision, a vibrant, diverse, and caring region where collaboration affords all people equitable opportunities to achieve optimum health and well-being, is grounded in the value of health equity. As one of the first steps of achieving health equity is to understand current health disparities, diverse community partners were invited to join the MiThrive Steering Committee, Design Team, and Workgroups and gathered primary and secondary data from medically underserved, minority and low-income populations in each of the four MiThrive assessments, including—

- Cross-tabulating demographic indicators, such as age, race, and sex, for the Community Themes and Strengths Assessment
- Engaging residents experiencing barriers to social determinants of health and organizations that serve them in the Community System Assessment, Community Themes and strengths Assessment, and Forces of Change Assessment
- Reaching out to medically underserved and low-income populations through Pulse Surveys administered by organizations that serve them
- Increasing inclusion of people with disabilities in the community health needs assessment through a partnership with the Disability Network of Northern Michigan.
- ·Surveying providers who care for patients/clients enrolled in Medicaid Health Plans
- Recruiting residents experiencing barriers and diverse organizations that serve them to MiThrive Data Walks and Priority-Setting Events.

Following analysis of primary and secondary data collected during the 2021 MiThrive Community Health Assessment, 10-11 significant health needs emerged in each of the MiThrive Regions (North Central, Northeast, and Northwest). Members of the MiThrive Steering Committee, Design Team, and three Workgroups framed these significant health needs as Strategic Issues, as recommended by the Mobilizing for Action through Planning and Partnerships Framework.

In December 2021, residents and community partners participated in one of three regional MiThrive Data Walk and Priority Setting events. Using a criteria-based process, participants ranked the Strategic Issues as listed below. Severity, magnitude, impact, health equity, and sustainability were the criteria used for this ranking process.

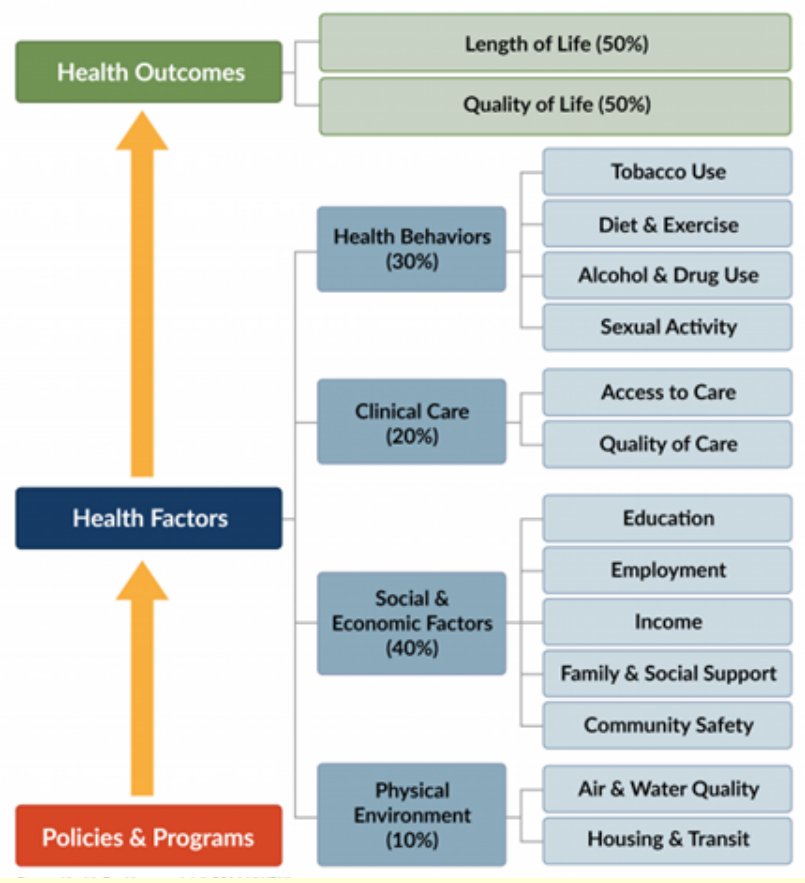
Significant Health Needs for Northeast Region	
Access to Healthcare & Chronic Disease Prevention	X
Economic Security	X
Equity	X
Housing Security	X
Mental Health	X
Safety and Well-Being	X
Substance Use	X
Transportation	X
Broadband Access	
Food Security	
Healthy Weight	X
COVID-19	X
Built Environment	

The final top-ranked Strategic Issues in the Northeast Region are as follows:

1. How do we increase access to quality substance use disorder services?
2. How do we increase access to quality mental health services while increasing resiliency and well-being for all?
3. How do we increase access to health care?
4. How do we reduce chronic disease rates in the region?

Introduction

We all have a role to play in our communities' health. Many factors combine to determine the health of a community. In addition to disease, health is influenced by education level, economic status, and issues. No one individual, community group, hospital, agency, or governmental body can be responsible for the health of the community. No one organization can address complex community issues alone. However, working together, we can understand the issues, and create plans to address them.



The County Health Rankings Model of How Health Happens provides a broad understanding of health, describing the importance of social determinants of health, organized in the categories of health behaviors, clinical care, social and economic factors, and the physical environment. It illustrates how community policies and programs influence health factors and in turn, health outcomes.

Purpose of Community Health Needs Assessment

The foundation of the MiThrive community health needs assessment is the County Health Rankings Model and its focus on social determinants. The purpose of the community health needs assessment is to:

1. Engage residents and community partners to better understand the current state of health and well-being in the community
2. Identify key problems and assets to address them. Findings are used to develop collaborative community health improvement plans and implementation strategies and to inform decision-making, strategic planning, grant development, and policy-maker advocacy.

Role of MiThrive Steering Committee, Design Team, and Work Groups

The MiThrive Design Team is responsible for developing data collection plans for the four assessments and proposing recommendations to the Steering Committee. In addition to approving the Data Collection Plans, the Steering Committee updated the MiThrive Vision and Core Values and provided oversight to the community health needs assessment. The regional Workgroups (Northwest, Northeast, and North Central) assisted in the local implementation of primary data collections, participated in assessments and Data Walk and Priority-Setting Events. They will develop a collaborative Community Health Improvement Plan for the top-ranked priorities in their regions and oversee their implementation. (Please see Appendix A for list of organizations engaged in MiThrive in the North Central, Northwest, and Northeast Regions).

Impact of COVID-19 on MiThrive

There were challenges in conducting a regional and collaborative community health needs assessment in 2021 during the peak of the COVID-19 pandemic. Despite their roles in pandemic response, leaders from hospitals, health departments, and other community partners prioritized their involvement in planning and executing the MiThrive Community Health Needs Assessment through their active participation in the Steering Committee, Design Team, and/or one or more regional Work Groups. In all, 53 individuals representing 40 organizations participated in the MiThrive organization.

In previous cycles of community health needs assessment, MiThrive convened in-person events for the Community System Assessment and Forces of Change Assessment. During the pandemic, they were convened virtually using Zoom and participatory engagement tools like breakout rooms, MURAL and RetroBoards, among others. Because residents and partners did not have to spend time and travel, their participation at the community assessment events was increased. Overall, 5,406 people participated in MiThrive primary data collection activities.

Mobilizing for Action through Planning and Partnerships

MiThrive utilizes the Mobilizing for Action through Planning and Partnership (MAPP) community health needs assessment framework. It is a nationally recognized, best practice framework that was developed by the National Association of City and County Health Officials (NACCHO) and the U.S. Centers for Disease Control and Prevention (CDC).

Organizing and Engaging Partners

Phase 1 of the MAPP Framework involves two critical and interrelated activities: organizing the planning process and developing the planning process. The purpose of this phase is to structure a planning process that builds commitment, encourages participants as active partners, uses participants' time well and results in a Community Health Needs Assessment that identifies key issues in a region to inform collaborative decision making to improve population health and health equity, while at the same time, meeting organizations' requirements for community health needs assessment. During this phase, funding agreements with local health departments and hospitals were executed, the MiThrive Steering Committee, Design Team, and Workgroups were organized, and the Core Support Team was assembled.

Conducting the Four Assessments

The MAPP framework consists of four different assessments, each providing unique insights into the health of the community. For the 2021 community health needs assessment the MiThrive gathered more health equity data than ever before, and engaged more diverse stakeholders, including many residents, in the assessments (Please see Appendix A for list of organizations that participated in MiThrive).

Health Equity

There is more to good health than health care. A number of factors affect people's health that people do not often think of as health care concerns, like where they live and work, the quality of their neighborhoods, how rich or poor they are, their level of education, or their race or ethnicity. These social factors contribute greatly to individuals' length of life and quality life, according to the County Health Rankings Model.

A key finding of the 2021 MiThrive community health needs assessment mirrors a persistent reality across the country and the world: health risks do not impact everyone in the same way. We consistently find that groups who are more disadvantaged in society also bear the brunt of illness, disability, and death. This pattern is not a coincidence. Health, quality of life, and length of life are all fundamentally impacted by the conditions in which we live, learn, work, and play. Obstacles like poverty and discrimination lead to consequences like powerlessness and lack of access to good Social Vulnerability Index by Census Tract jobs with fair pay, quality education and housing, safe environments, and healthcare. All of these community conditions combine to limit the opportunities and chances for people to be healthy. The resulting differences in health outcomes (like risk of disease or early death) are known as “health inequities”.

The health equity data collected in the four MiThrive assessments is discussed below.

> Health equity is the realization of all people of the highest attainable level of health. Achieving health equity requires valuing all individuals and populations equally, and entails focused and ongoing societal efforts to address avoidable inequities by ensuring the conditions for optimal health for all groups.
>
> --Adewale Troutman
>
> *Health equity, Human Rights and Social Justice: Social Determinants as the Direction for Global Health*

MiThrive Assessment Results

- **Community Health Status Assessment**

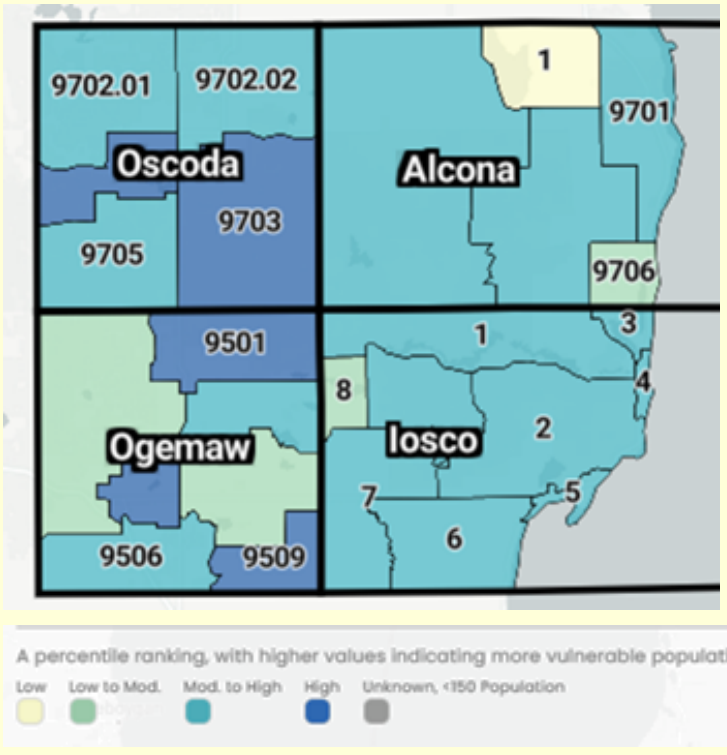
The Community Health Status Assessment identifies priority community health and quality of life issues. It answers the questions, “How healthy are our residents?” and “What does the health status of our community look like?”. The answers to these questions were measured by collecting 100 secondary indicators from different sources including the Michigan Department of Health and Human Services, US Census Bureau, and US Centers for Disease Control and Prevention.

The Design Team assured secondary data included measures of social and economic inequity, including: Asset-Limited, Income-Constrained, Employed (ALICE) households; children living below the Federal Poverty Level; families living below the Federal Poverty Level, households living below Federal Poverty Level; population living below Federal Poverty Level; gross rent equal to or above 35% of household income; high school graduation rate; income inequality; median household income; median value of owner-occupied homes, political participation; renters (percent of all occupied homes); and unemployment rate.

The Social Vulnerability Index illustrates how where we live influences health and well-being. It ranks 15 social factors: income below Federal Poverty Level; unemployment rate; income; no high school diploma; aged 65 or older; aged 17 or younger; older than five with a disability; single parent households; minority status; speaks English “less than well”; multi-unit housing structures; mobile homes; crowded group quarters; and no vehicle.

As illustrated in the map at right, census tracts in the DHD2 jurisdiction have Social Vulnerability Indices at “moderate to high” in majority of the district.

Social Vulnerability Index by Census Tract in the DHD2 Jurisdiction, 2022



Source: Michigan Lighthouse 2022, Centers for Disease Control and Prevention/ Agency for Toxic Substances and Disease Registry/ Geospatial Research, Analysis, and Services Program. CDC Social Vulnerability Index 2018 Database - Michigan..

Community Health Status Assessment indicators were collected and analyzed by county for MiThrive's 31-county region from the following sources:

- County Health Rankings
- Feeding America
- Kids Count
- Michigan Behavioral Risk Factor Surveillance Survey
- Michigan Cancer Surveillance Program
- Michigan Care Improvement Registry Michigan Health Statistics
- Michigan Profile for Healthy Youth
- Michigan School Data
- Michigan Secretary of State
- Michigan Substance Use Disorder Data Repository
- Michigan Vital Records
- Princeton Eviction Lab
- United for ALICE
- U.S. Census Bureau
- U.S. Health Resources & Services Administration
- U.S. Department of Agriculture

Each indicator was scored on a scale of one to four by sorting the data into quartiles based on the 31-county regional level, comparing to the mean value of the MiThrive Region, and comparing to the State, national, and Healthy People 2030 target when available. Indicators with a score above 1.5 were defined as "high secondary data" and indicators with scores below 1.5 were defined as "low secondary data".

The following 19 statistics scored above 1.5 across all counties in the DHD2 jurisdiction, indicating they were worse than the National overall or State rates:

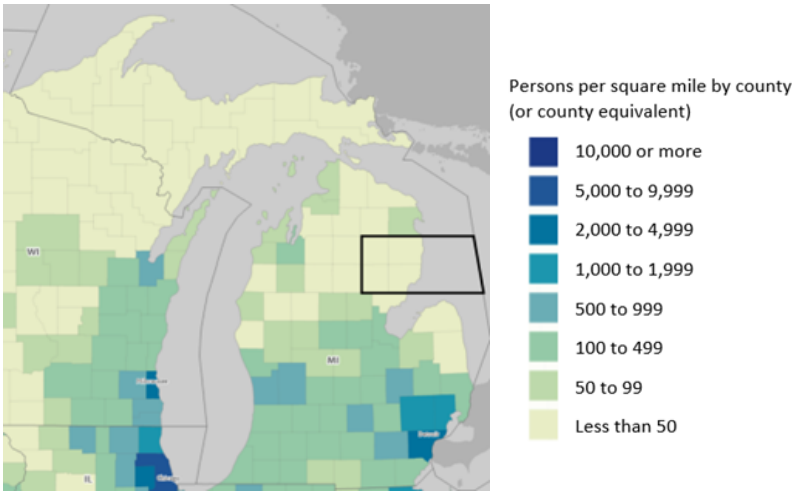
- Median household income (dollars)
- Special Education – Child Find (%)
- High School graduation rate (%)
- Bachelor's Degree or higher (%)
- Adults with no personal health check up in the past year (%)Median value of owner-occupied homes (dollars)
- Vacant housing units (%)
- Child food insecurity (%)
- Population food insecurity (%)
- Oral Cavity and pharynx cancer (per 100,000)
- Adult with heart disease (per 10,000)
- Adults who have ever been told COPD (%)

Please see Appendix B for values for these indicators for each county within the DHD2 jurisdiction.

Geography and Population Rurality by County

Health Jurisdiction Demographics

DHD2's jurisdiction is situated in a rural area of the lower peninsula of Michigan on the northeast side of the state. This is one of its most important characteristics as rurality influences health and well-being. Within the health jurisdiction, there are 64,351 individuals. Numerous social and economic factors impact the health of the residents and their communities. High numbers of individuals living in poverty and elevated jobless rates are just two examples of some of the factors that negatively impact the communities.



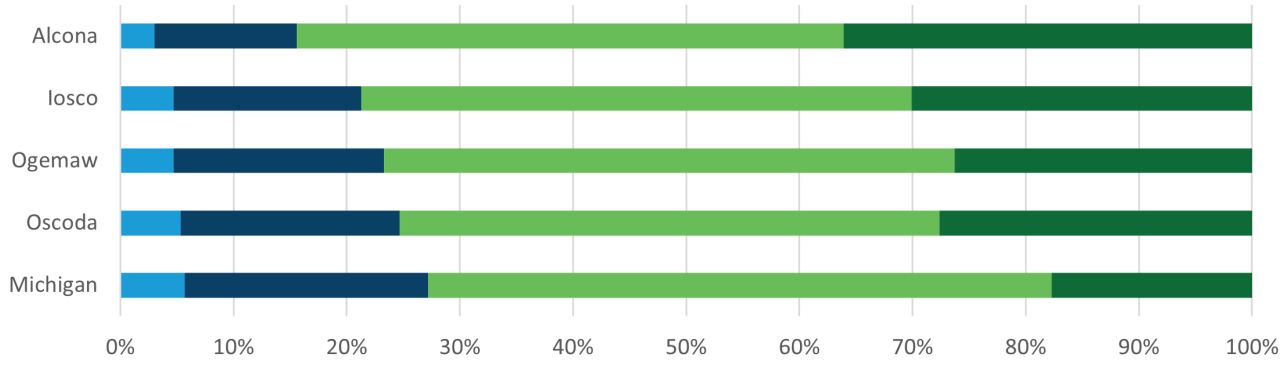
Source: U.S. Census Bureau, 2020 Census Demographic Data Map Viewer

Population and age: Total population in 2019 for each county ranges from 8,241 in Oscoda County to 25,127 in Iosco County. When broken down by age group, Alcona County has the lowest percent of people under age 5 (3.0%) and Oscoda has the highest at 5.3%. All four counties in the DHD2 district have a lower percent of residents under age 5 than Michigan. In the under 18 age group, all four counties have a lower percentage compared to Michigan (21.5%) with Oscoda having the highest in the region (19.4%). All four counties have higher percentages of individuals aged 65 and over compared to the Michigan rate of 17.7% ranging from 36.1% in Alcona County to 26.3% in Ogemaw County.

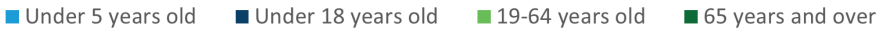
The composition of the population is also important, as health and social issues can impact groups in different ways, and different strategies may be more appropriate to support these diverse groups. All four counties in the DHD2 jurisdiction are predominately White, with the highest percentage in Alcona County (95.1%). The highest percentage of black people are reported in Iosco

(0.8%). The highest percent of Hispanic population is found in Iosco County (2.6%). The highest percent of American Indian population are reported in Iosco, Ogemaw, and Oscoda Counties (1.0%).

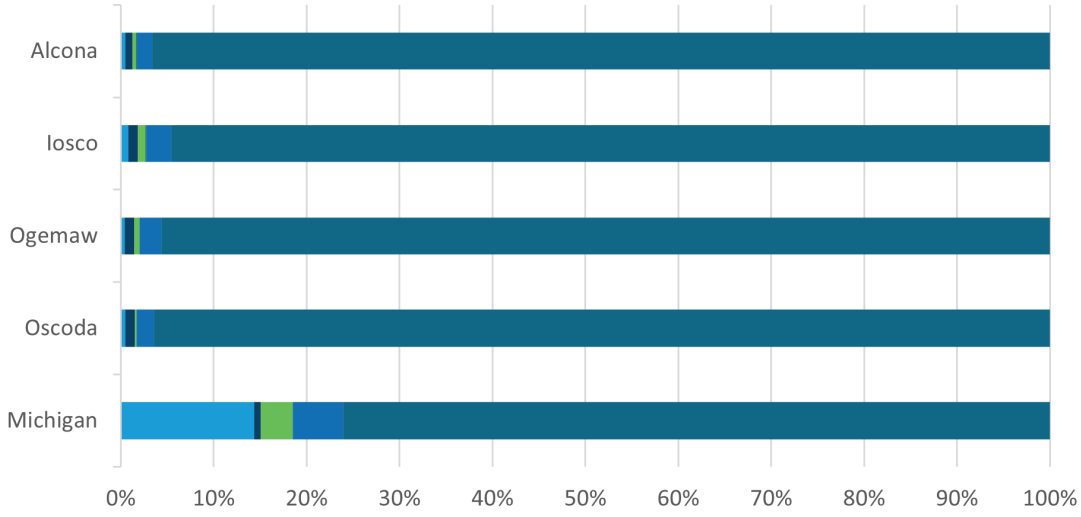
Proportion of Age Groups in DHD2 Jurisidiction, American Communities Survey, 2015-2019



	Michigan	Oscoda	Ogemaw	Iosco	Alcona
Under 5 years old	5.7	5.3	4.7	4.7	3
Under 18 years old	21.5	19.4	18.6	16.6	12.6
19-64 years old	55.1	47.7	50.4	48.6	48.3
65 years and over	17.7	27.6	26.3	30.1	36.1

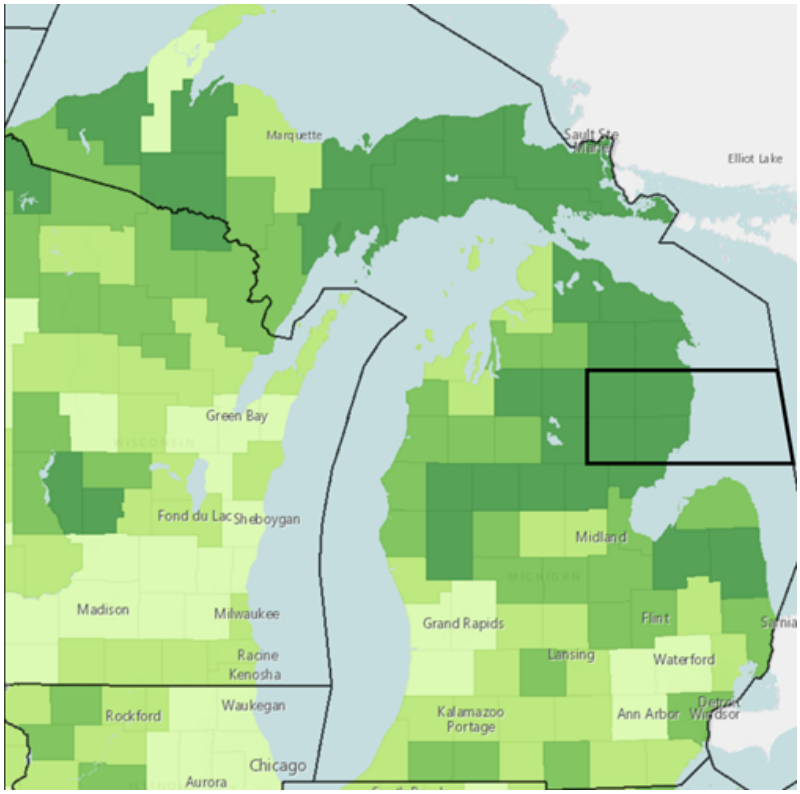


Proportion of Ethnic Groups in the DHD2 Jurisdicition, American Communities Survey, 2015-2019



	Michigan	Oscoda	Ogemaw	Iosco	Alcona
Black or African American	14.1	0.5	0.4	0.8	0.5
American Indian and Alaska Native	0.7	1	1	1	0.7
Asian	3.4	0.2	0.6	0.8	0.4
Native Hawaiian/Other Pacific Islander	0	0	0	0.1	0.1
Hispanic or Latino	5.3	1.8	2.3	2.6	1.6
Non-Hispanic White	74.7	95.1	94.3	93.2	95.3

Proportion of Disabled Population in DHD2 Jurisdiction, American Communities Survey, 2015-2019



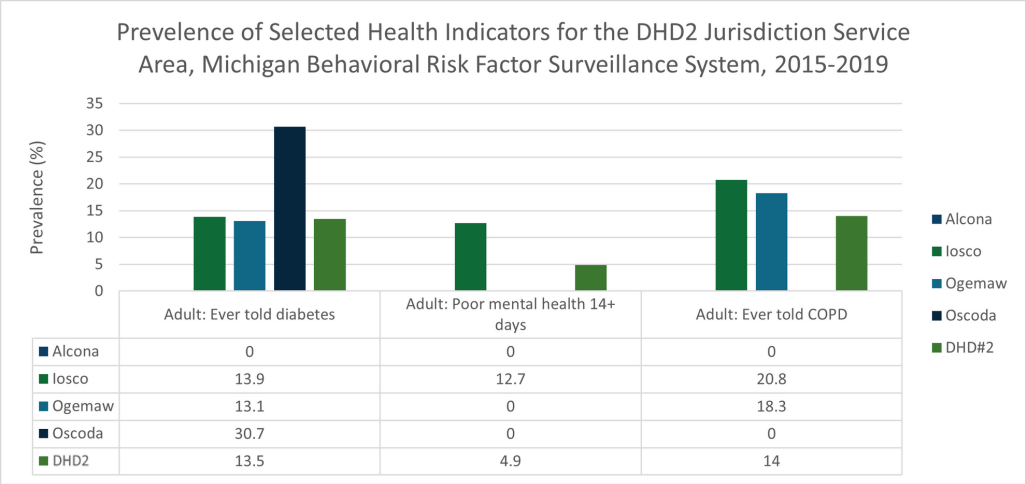
Map Legend

Disabled Population, Percent by County, ACS 2015-19

- Over 18.0%
- 15.1 - 18.0%
- 12.1 - 15.0%
- Under 12.1%
- No Data or Data Suppressed

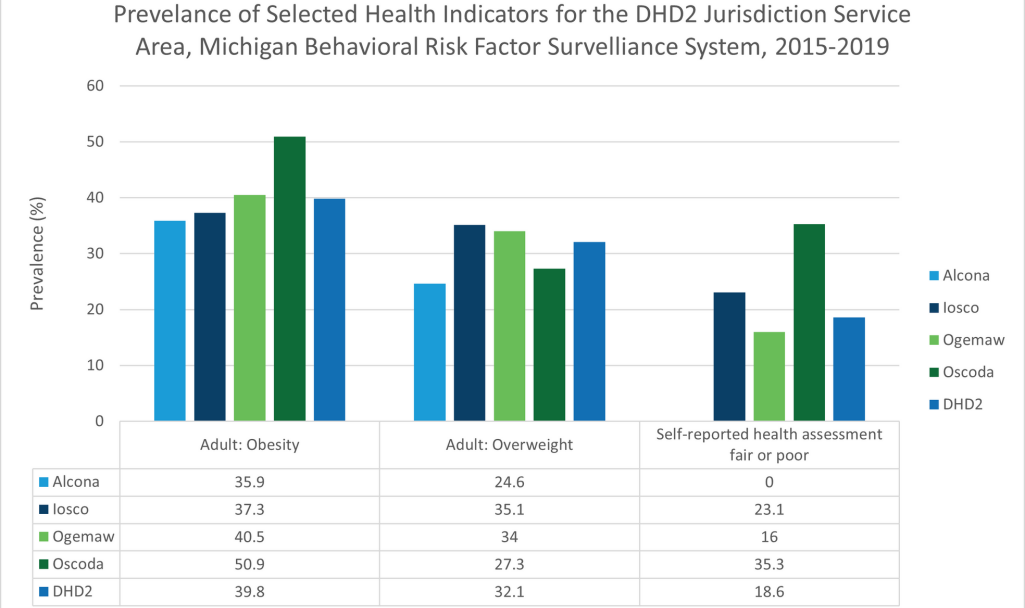
https://careshq.org/map-room/, 2/16/2022

A greater proportion of people--about 22.0%-- of the people in the DHD2 jurisdiction have a disability compared to the State (14.1%).



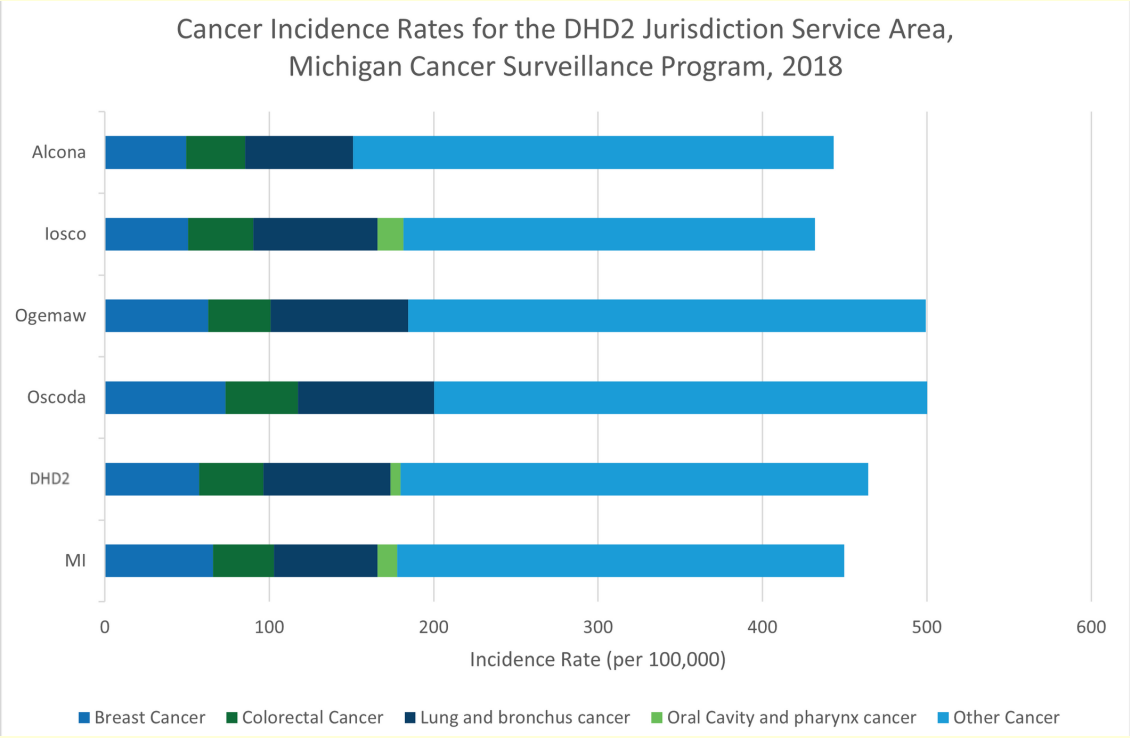
	Adult: Ever told diabetes	Adult: Poor mental health 14+ days	Adult: Ever told COPD
Alcona	0	0	0
Iosco	13.9	12.7	20.8
Ogemaw	13.1	0	18.3
Oscoda	30.7	0	0
DHD2	13.5	4.9	14

The Michigan Behavioral Risk Factor Survey (BRFSS) asked adults within all DHD2 counties if a medical professional has ever told them they had diabetes. DHD2 overall had 13.5% of its resident's report being told they had diabetes. Oscoda County (30.7%) has the highest prevalence while Ogemaw County (13.1%) had the lowest. For adults reporting at least 14 days having poor mental health, Iosco County (12.7%) had the highest prevalence. Alcona, Ogemaw, and Oscoda Counties were suppressed for this health indicator. Individuals ever being told they had chronic obstructive pulmonary disease (COPD) was highest in Iosco County (20.8%).



	Adult: Obesity	Adult: Overweight	Self-reported health assessment fair or poor
Alcona	35.9	24.6	0
Iosco	37.3	35.1	23.1
Ogemaw	40.5	34	16
Oscoda	50.9	27.3	35.3
DHD2	39.8	32.1	18.6

All the counties have a high prevalence of individuals who are overweight or obese. The BRFSS shows that Oscoda (50.7%) and Ogemaw (40.5%) Counties have the highest prevalence of obesity. While Iosco (35.1%) and Ogemaw (34.0%) Counties have the highest prevalence of individuals who are overweight. This partially contributes to the next indicator which is self-reported general health. For this indicator, 18.6% of DHD2 reported having poor or fair general health. Oscoda County had the highest prevalence of poor or fair general health at 35.3%.



In 2018, Iosco County had the lowest of all cancer incidence at 431.3 while Oscoda County had the highest incidence at 500.3. Michigan's incidence is 449.6 while DHD2 overall is slightly higher at 464.2. Within the DHD2 jurisdiction, two counties ((Ogemaw and Oscoda) have cancer incidence rates higher than the state. DHD2 has lower breast, oral cavity and pharynx cancer incidence rates compared to the state. For breast cancer, Oscoda County's rate of 73.3 is the only county higher than Michigan's rate of 65.7. For colorectal cancer, three out of four counties are higher than Michigan's rate of 37.3: Iosco at 39.8, Ogemaw at 37.7, and Oscoda at 44.2. The DHD2 jurisdiction has a higher incidence rate than the state at 77.7to 63.0 for lung and bronchus cancer. Ogemaw County has the highest rate at 83.7 followed by Oscoda at 82.9. Overall, all four counties have lung and bronchus cancer incidence rates higher than the state. For oral cavity and pharynx cancer, DHD2 has a lower incidence rate than the state at 6.2 to 12.0. Alcona has the highest incidence at 15.8.

DHD2 Jurisdiction Mortality Rates by Census Tract Poverty Level, MDHHS Vital Statistics, 2019

		Poverty Level by Census Tract			
		0.0% - 4.9% of Population in Poverty	5.0% - 9.9% of Population in Poverty	10.0% - 19.9% of Population in Poverty	20.0% - 100% of Population in Poverty
Age-Adjusted Mortality Rates (per 100,000)	Michigan	647.7	710.3	780.6	987.8
	DHD2	0.0	465.5	884.6	957.6
	Alcona	0.0	996.1	693.2	1190.6
	Iosco	0.0	0.0	916.6	900.3
	Ogemaw	0.0	*	1003.9	1029.9
	Oscoda	0.0	0.0	770.9	843.5

This table displays mortality rates per 100,000 population, separated by poverty level. Poverty level groups show the percentage of census tract population that falls under the poverty line. The most affluent track has the least amount of people living below the poverty line (0.0% - 4.9%) and the less affluent tracts have the highest percent of people living below the poverty line (20.0% to 100%), where at least 1/5 of the population falls under the poverty line. From this table, the mortality for the 0% to 4.9% poverty group is suppressed for DHD2 due to the low number of individuals who fall into the more affluent category. The highest mortality rate (957.6 deaths per 100,000) within the DHD2 jurisdiction is in the lowest poverty category of 20% to 100%, which demonstrates a higher rate of death as the amount of people living in poverty increases. Alcona and Ogemaw have mortality rates over 1,000 for the 20% to 100% poverty level.

Approximate Mortality Rates by Race and Sex for the DHD2 Jurisdiction Service Area, MDHHS Vital Statistics, 2020

Mortality Rate (per 100,000)	Black			White			Other		
	Total	Male	Female	Total	Male	Female	Total	Male	Female
Michigan	1260.0	1410.0	1130.0	1190.0	1230.0	1140.0	380.0	400.0	370.0
Overall (Calculated)	*	*	*	1860.0	2030.0	1690.0	520.0	*	*
Alcona	*	*	*	1910.0	2070.0	1750.0	*	*	*
Iosco	*	*	*	1920.0	2090.0	1750.0	*	*	-
Ogemaw	-	-	-	1680.0	1830.0	1540.0	*	*	-
Oscoda	-	-	-	2100.0	2330.0	1850.0	-	-	-

**Suppressed due to low mortality counts*

Mortality Rate (per 100,000)	Male	Female	Total
Michigan	1000.8	782.5	890.6
Overall (Calculated)	1137.9	869.5	1005.2
Alcona	1064.6	773.7	920.8
Iosco	1174.8	861.2	1018.6
Ogemaw	1052.2	888.7	971.5
Oscoda	1329.4	967.0	1153.3

In Michigan, the crude mortality rate for black individuals is higher than white; however, in DHD2, there is a higher mortality rate for white individuals than black. Much of the data on individuals who fall into the other category is suppressed due to low numbers. Males have a higher mortality rate than females in DHD2 for white races.

Mortality Rates for Males by Age Group in DHD2 and Michigan, MDHHS Vital Statistics, 2020

Males Only Mortality Rate (per 100,000)	<1-14	15-29	30-39	40-49	50-59	60-69	70=<
Michigan	55.7	139.4	267.5	442.3	915.7	1830.3	6700.0
Overall (Calculated)	86.9	151.7	298.2	591.7	1188.5	1671.4	7453.9
Alcona	0.0	341.9	257.1	551.0	982.0	2130.2	9470.8
Iosco	123.1	127.3	97.8	373.8	1157.6	2101.5	7013.4
Ogemaw	57.6	161.0	491.4	500.8	1405.5	1331.7	7876.1
Oscoda	186.9	0.0	259.7	1459.9	882.7	1329.8	6167.1

Mortality Rates for Females by Age Group in DHD2 and Michigan, MDHHS Vital Statistics, 2020

Females Only Mortality Rate (per 100,000)	<1-14	15-29	30-39	40-49	50-59	60-69	70=<
Michigan	50.8	60.1	138.6	438.6	566.3	1701.8	5259.6
Overall (Calculated)	45.7	49.2	207.3	664.0	667.1	1459.0	5766.1
Alcona	0.0	0.0	0.0	489.0	1757.5	1726.3	6201.6
Iosco	67.02	69.3	436.7	704.2	480.4	1519.9	5673.4
Ogemaw	57.7	63.4	0	890.2	536.5	1406.0	5844.4
Oscoda	0.0	0.0	561.8	219.3	528.4	12667.0	5468.8

Out of all counties, Oscoda has the highest mortality rate followed by Iosco. All counties have a higher male mortality rate than female.

Of the counties with available data, three; Alcona, Iosco, and Ogemaw have a higher male mortality rate than Michigan for ages less than 1 to 14 years. Additionally, two counties; Iosco and Oscoda have a higher male mortality rate than Michigan for ages 15-29. Iosco has the highest mortality rate for males ages 30-39 and Iosco has the highest mortality rate for males ages 40-49.

Two counties; Iosco and Ogemaw have a higher female mortality rate than Michigan for ages less than 1 to 14 years old. Additionally, two counties; Iosco and Ogemaw have a higher female mortality rate than Michigan for ages 15-29. Alcona has the highest mortality rate for females ages 30-39 and Iosco has the highest mortality rate for females ages 40-49.

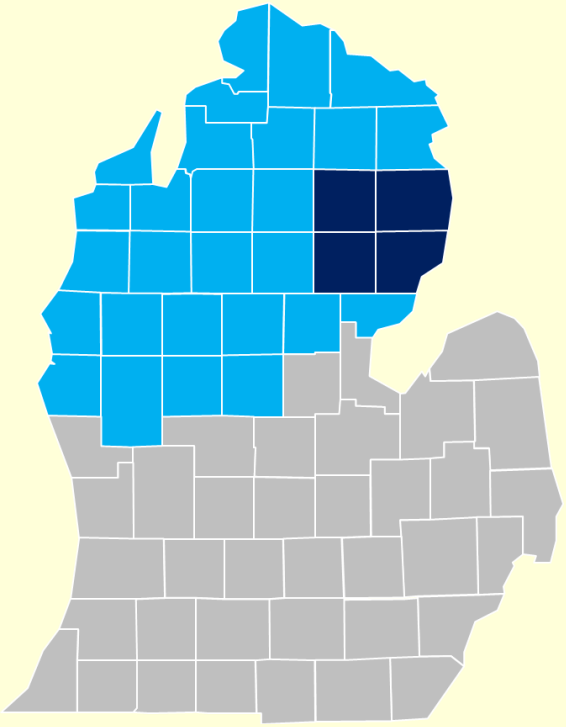
- ## Community Themes and Strengths Assessment

The Community Themes and Strengths Assessment provides a deep understanding of the issues that residents feel are significant by answering the questions, "What is important to our community?", "How is quality perceived in our community?", and "What assets does our community have that can be used to improve well-being?" For the Community Themes and Strengths Assessment, the MiThrive Design Team designed three types of surveys: Community Survey, Healthcare Provider Survey, and Pulse Survey.
(Please see Appendix D for survey instruments).

Community Survey: The Community Survey asked 18 questions about what is important to the community, what factors are impacting the community, quality of life, built environment, and demographic questions. The Community Survey also asked respondents to identify assets in their communities. Please see Appendix C for assets identified for the District Health Department No. 2 jurisdiction service area.

Community Surveys were administered electronically and via paper format in both English and Spanish. The electronic version of the survey was available through an electronic link and QR code. The survey was open from Monday, October 4, 2021, to Friday, November 5, 2021.

Five $50 gift cards were used as an incentive for completing the survey. Partner organizations supported survey promotion through social media and community outreach. Promotional materials developed for Community Survey include a flyer, social media content, and press release. Three hundred and ten surveys were collected from Alcona, Iosco, Ogemaw, and Oscoda Counties

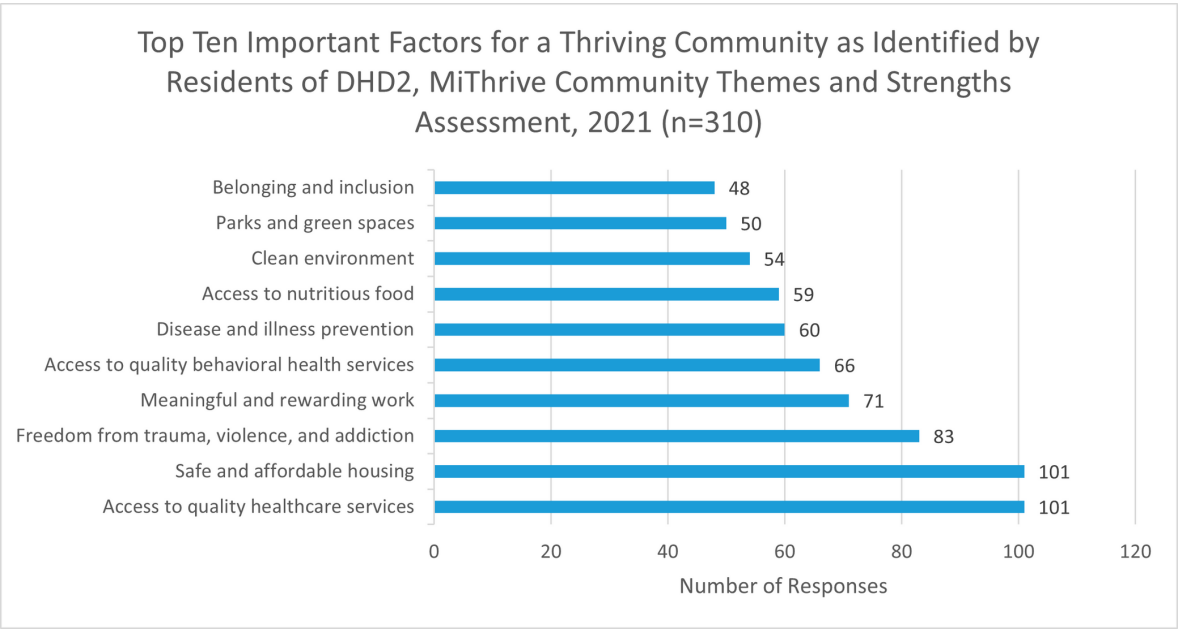


A total of **310 community survey** responses were collected in **the DHD2 jurisdiction.**

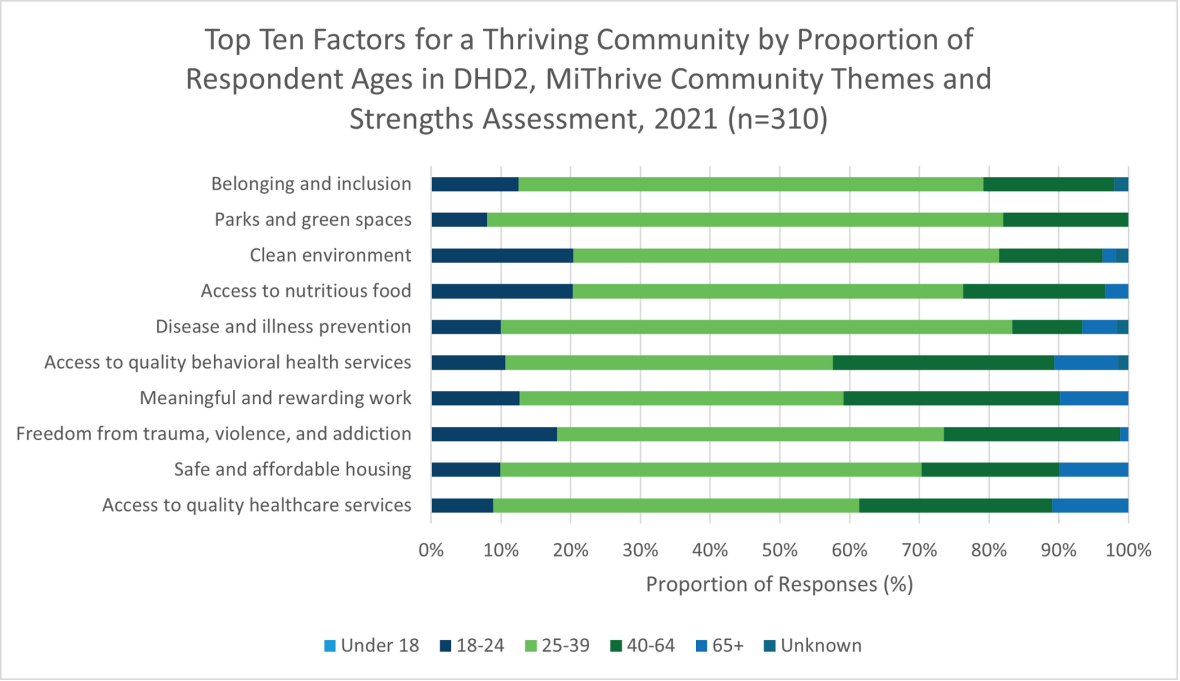
Alcona County = 149 Responses

Iosco County = 87 Responses

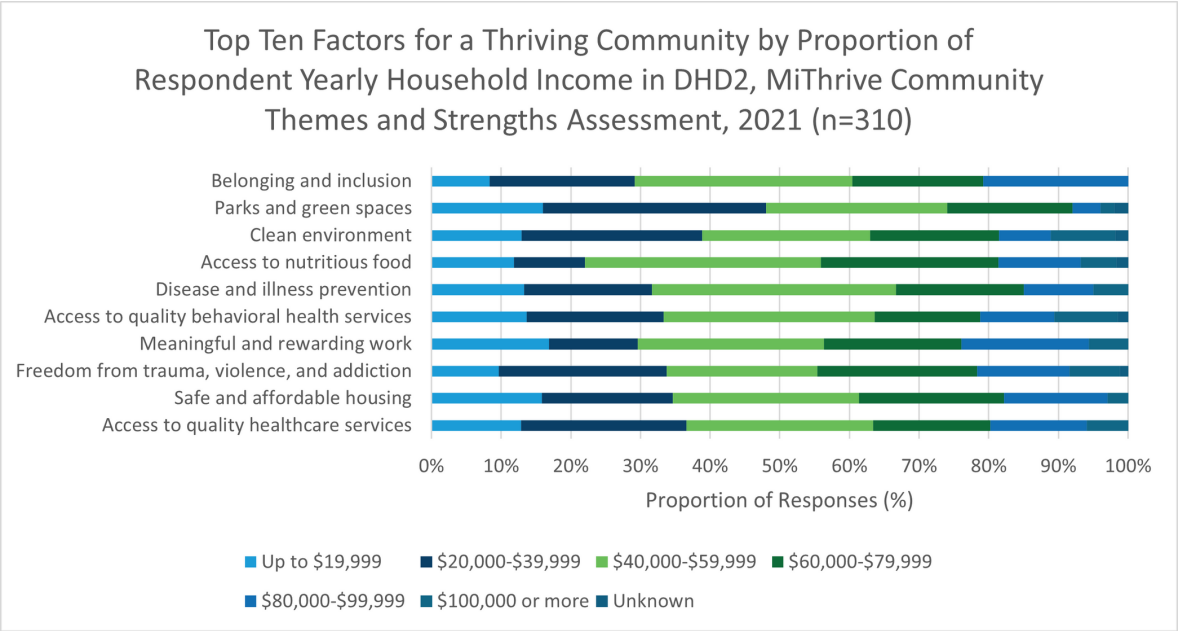
Ogemaw County = 50 Responses



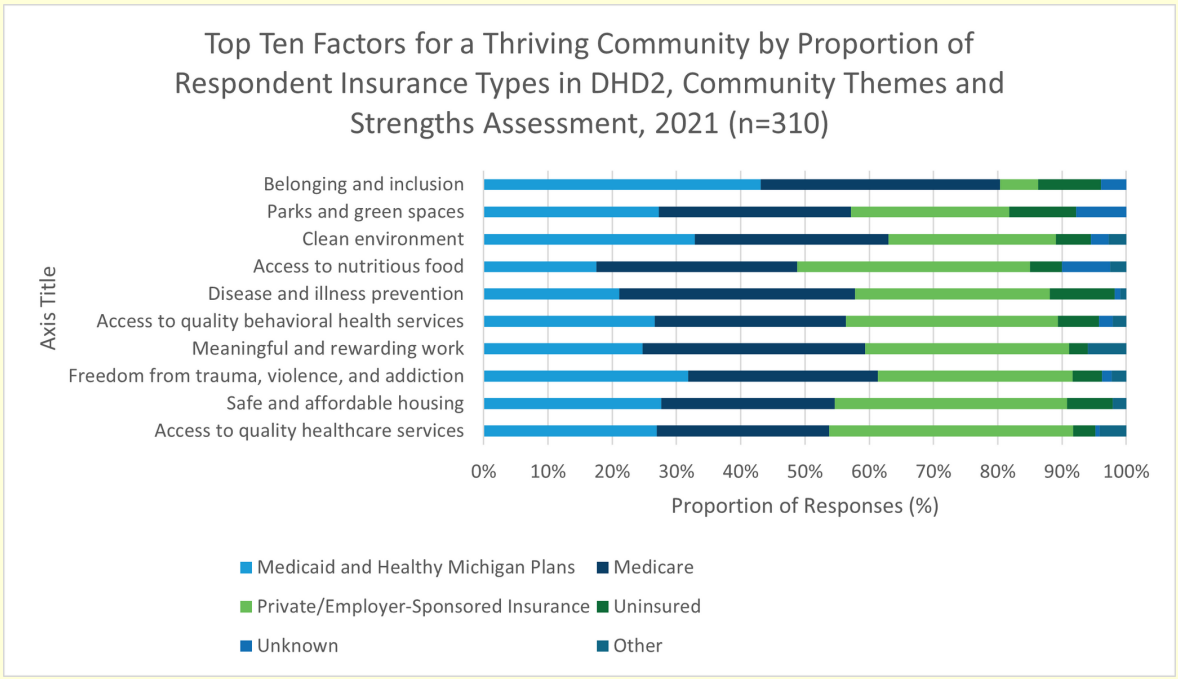
Note: Additional factors included Belonging & inclusion, Arts and cultural events, Lifelong learning, Civic engagement, Disability accessibility.



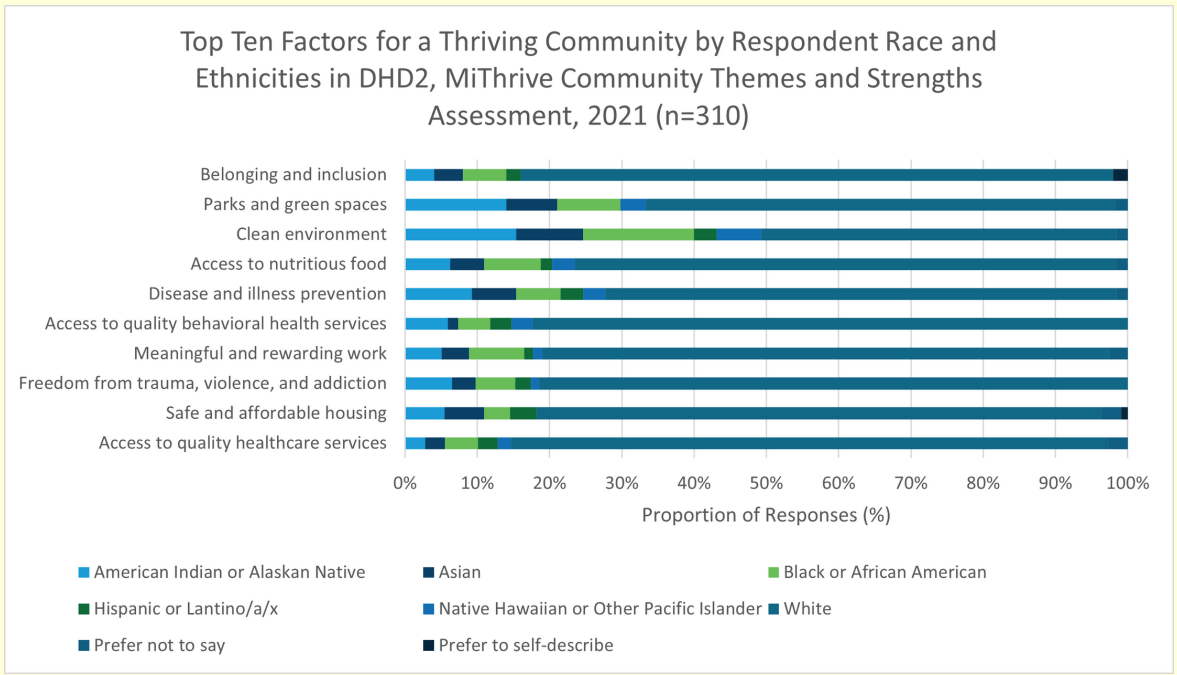
A larger proportion of individuals aged 25-39 responded that parks and green spaces was an important factor for a thriving community when compared to the other top nine factors. Belonging and inclusion, as well as safe and affordable housing, was also important to this age group.



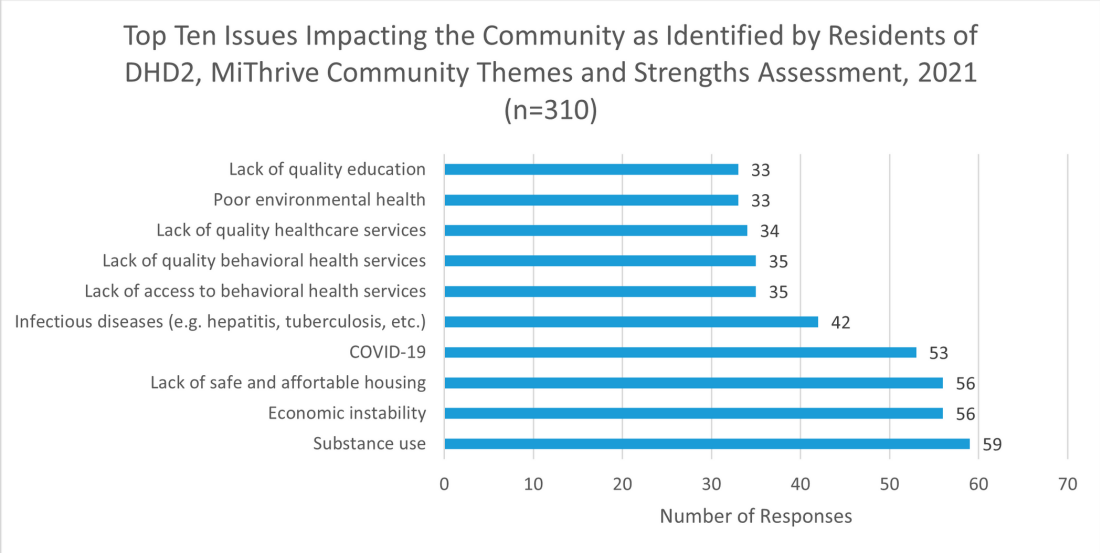
A larger proportion of individuals with a yearly household income of $40,000-59,999 responded that access to nutritious foods was an important factor for a thriving community when compared to the other top nine factors.



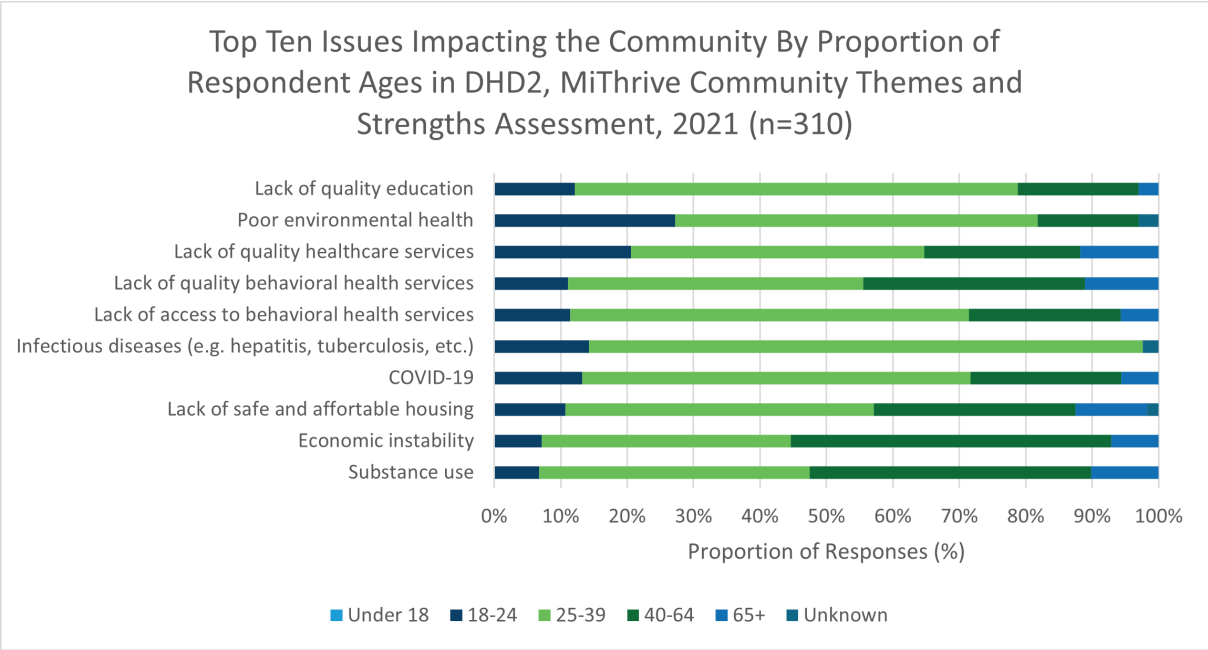
A larger proportion of individuals with Medicaid and Healthy Michigan Plans responded that belonging and inclusion was an important factor for a thriving community when compared to the other top nine factors.



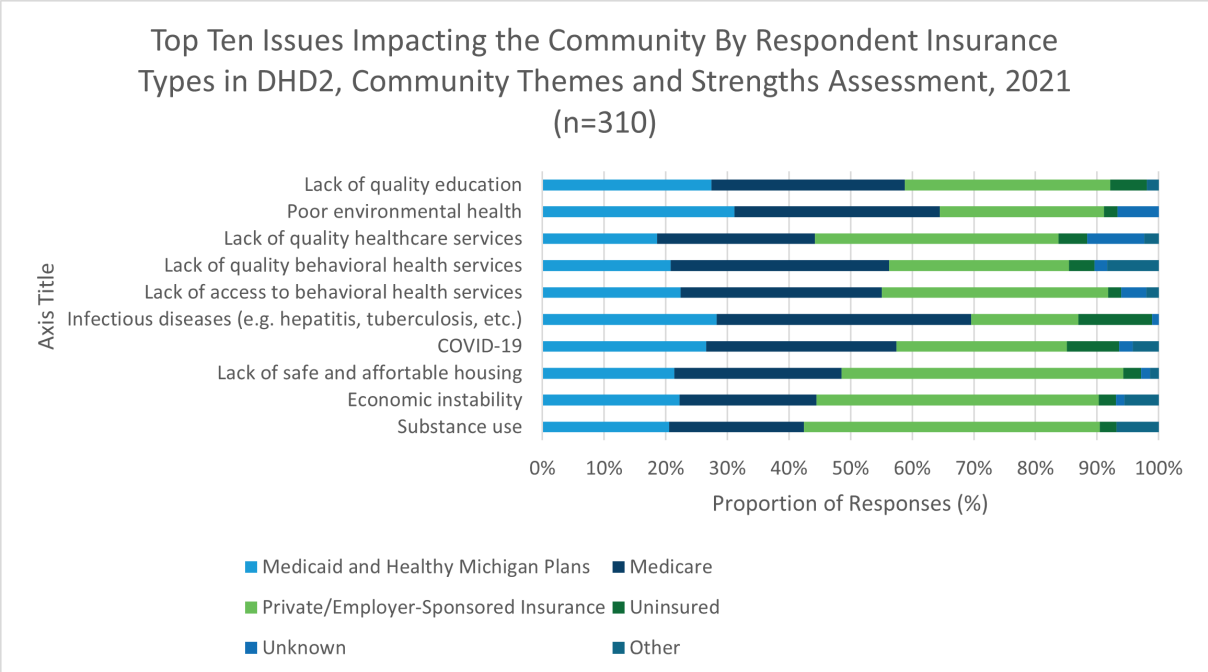
A larger proportion of American Indian or Alaskan Native and Black or African American individuals responded that clean environment was an important factor for a thriving community when compared to the other top nine factors.



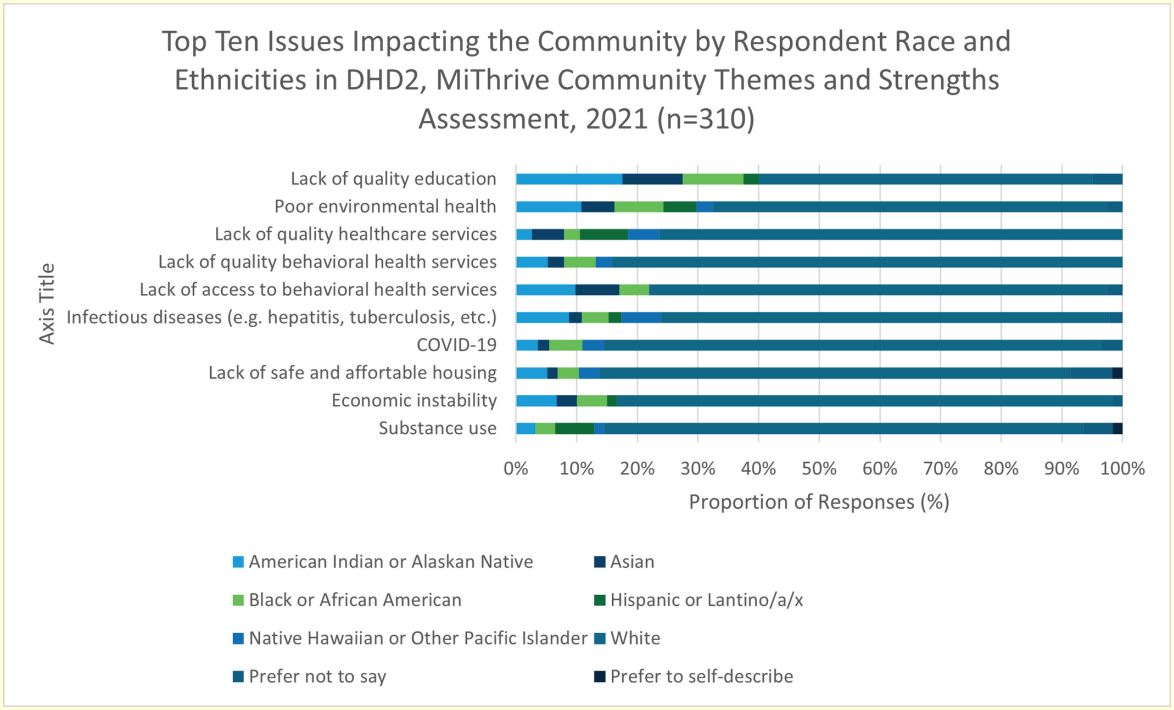
Note: Additional factors included Access to Child Care, Lack of Community Engagement, Obesity, Aging problems (e.g. arthritis, hearing/vision loss, etc.), Lack of access to nutritious foods, Motor vehicle crash injuries, Sexually transmitted infections, Cancer, Neighborhood and built environment, Civic engagement, Dental problems, Diabetes, Disability accessibility, Domestic violence, Heart disease and stroke, High blood pressure, HIV/AIDS, Homicide, Infant death, Infectious diseases (e.g., hepatitis, tuberculosis, etc.), Racism and discrimination, Rape/sexual assault, Respiratory/lung disease, Lack of quality education, Suicide, Teenage pregnancy, Poor environmental health, Lack of access to education, Firearm-related injuries. Factors are not listed in order.



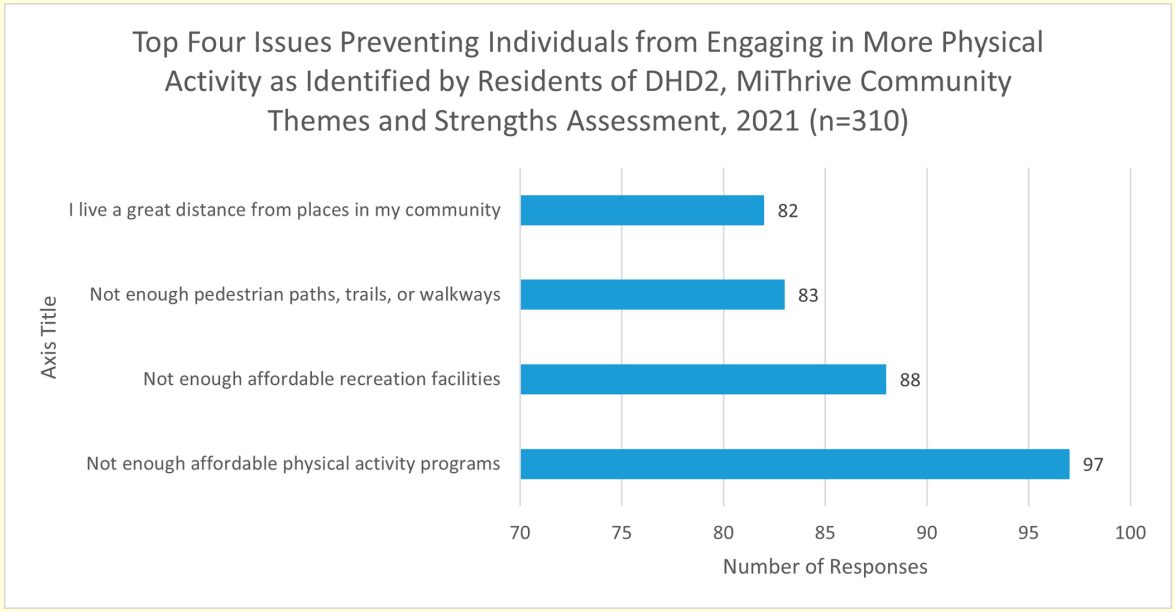
A larger proportion of individuals aged 25-39 responded that infection diseases was an important issue impacting the community when compared to the other top nine issues.



A larger proportion of individuals with Private/Employer-Sponsored Insurance responded that substance use was an important issue affecting the community when compared to the other top nine issues.



A larger proportion of American Indian or Alaskan Native individuals responded that lack of quality education was an important issue impacting the community in comparison to the other top nine issues.



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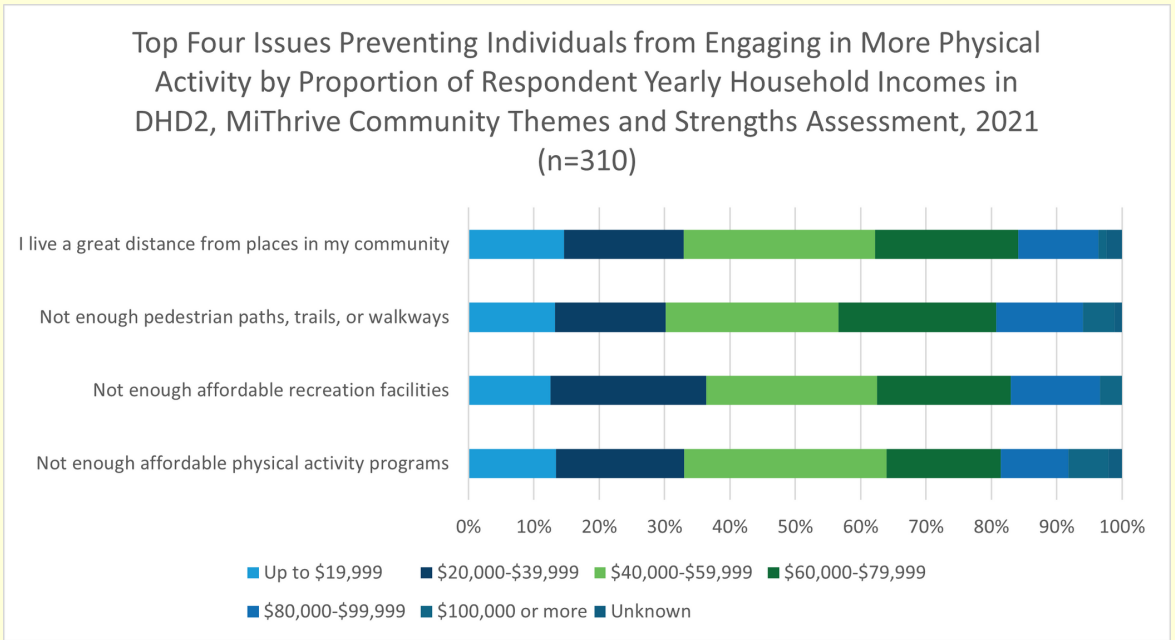
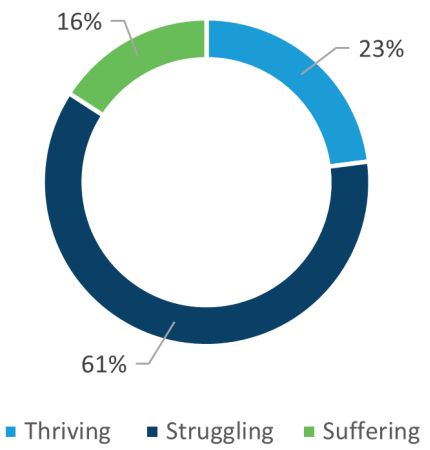


Individuals with a yearly household income of $40,000 – 59,999 make up a larger proportion of those who said not enough affordable physical activity programs prevented them from being more physically active in their community compared to the other top issues.

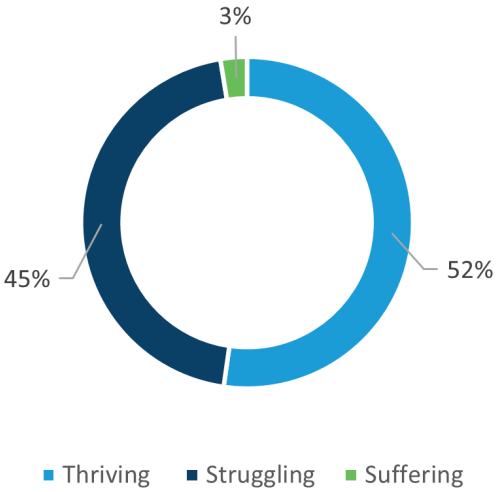
Survey respondents were asked to image a ladder with steps numbered from zero at the bottom to ten at the top. The top of the ladder represented the best possible life (10), and the bottom of the ladder represented the worst possible life (0). Survey respondents identified where they felt they stood on the ladder at the time of completing the survey (top figure) and where they felt they would stand three years from now (bottom figure).

Percentage of Respondents in DHD2 Jurisdiction that are Currently Thriving, Struggling, or Suffering, MiThrive Community Themes and Strengths Assessment, 2021 (n=309)



77.02% of Community Survey respondents in Alcona, Iosco, Ogemaw, and Oscoda counties are currently either studdling or suffering compared to 22.98% who are thriving (n=309).

Percentage of Respondents in DHD2 Jurisdiciton that Predict in Three Years to be Thriving, Struggling, or Suffering, MiThrive Community Themes and Strengths Assessment, 2021 (n=310)



47.74% of Community Survey respondents in Alcona, Iosco, Ogemaw, and Oscoda Counties predict they will either be struggling or suffering compared to 52.26% who predict they will be thriving three years from now (n=310).

On average, Community Survey respondents in Alcona, Iosco, Ogemaw, and Oscoda Counties felt they would move one and a half of a step higher on the ladder three years from how they scored themselves presently.

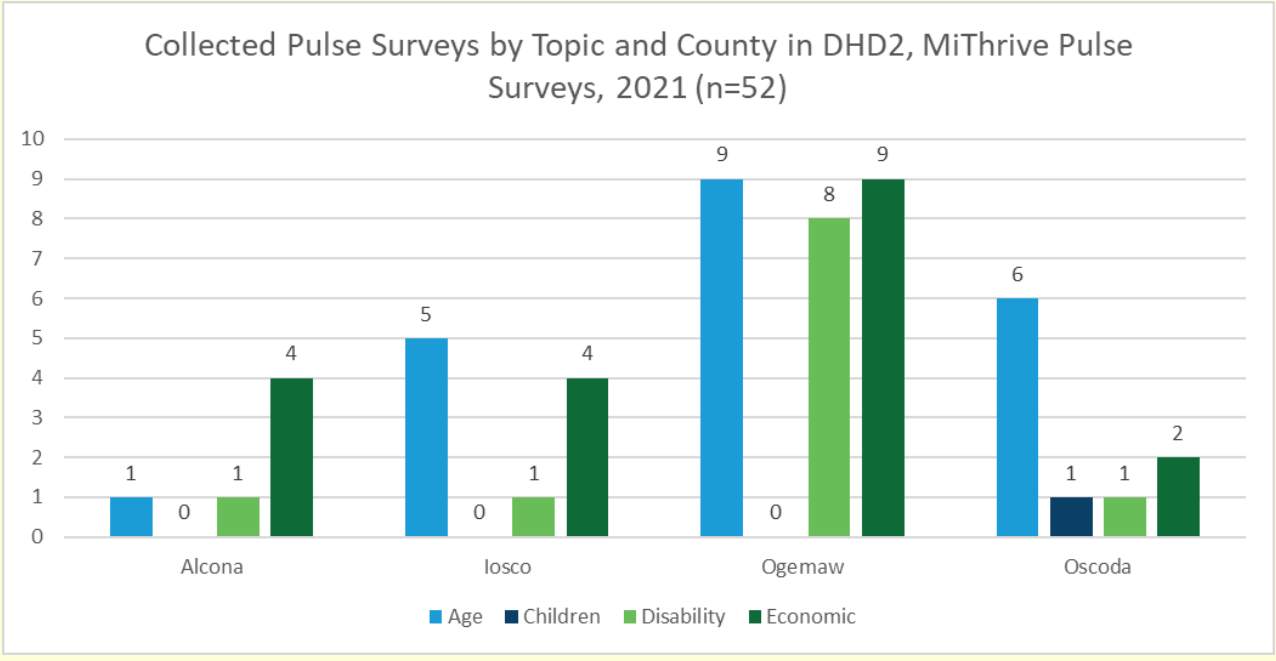
**The Cantril-Ladder self-anchoring scale is used to measure subjective wellbeing. Scores can be grouped into three categories- thriving, struggling, and suffering. Cantril's Ladder data was analyzed separately for the purpose of the 2021 MiThrive Community Health Needs Assessment.*

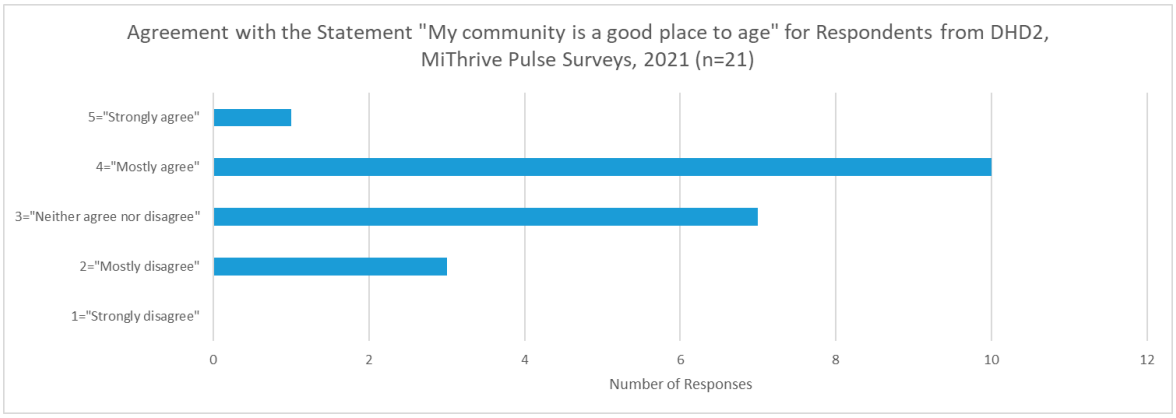
Pulse Survey: The purpose of the Pulse Survey was to gather input from people and populations facing barriers and inequities in the 31-county MiThrive region. It was a four-part data collection series, where each topic-specific questionnaire was conducted over two weeks resulting in an eight-week data collection period. This data collection series included four three-question surveys targeting key topic areas to be conducted with clients and patients.

The Pulse Surveys were designed to be weaved into existing intake and appointment processes of participating agencies/organizations. Community partners administered the Pulse Survey series between July 26, 2021, and September 17, 2021, using a variety of delivery methods, including in-person interviews, phone interviews, in-person paper surveys, and through client text services. Pulse Survey questionnaires were provided in English and Spanish.

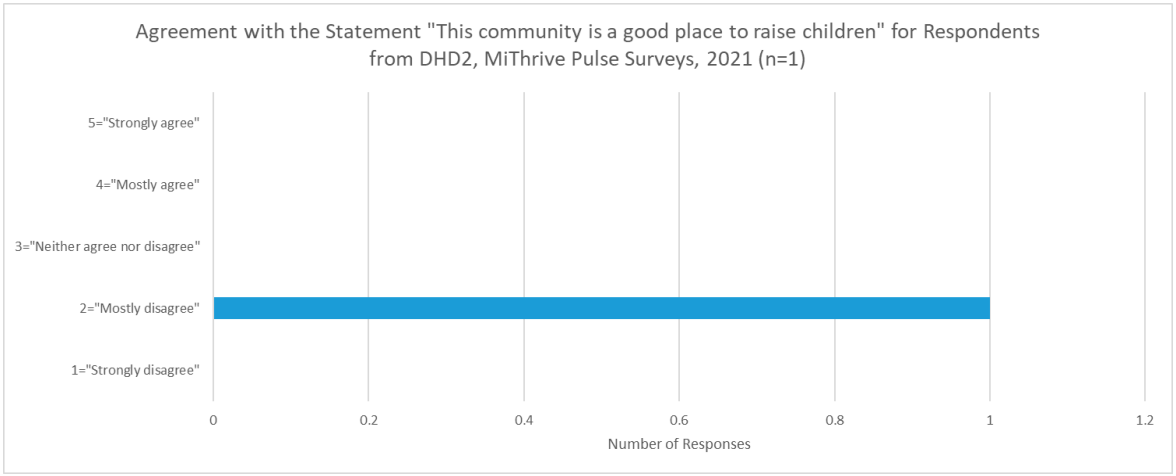
Each Pulse Survey focused on a different quality of life topic area (aging, economic security, children, and disability) using a Likert-scale question and open-ended topic-specific question. Additionally, each survey included an open-ended equity question. Within the DHD2 jurisdiction, there were 21 aging, 1 child, 11 disability, and 19 economic surveys collected for a total of 52 responses.

The target population for the pulse survey series included those historically excluded, economically disadvantaged, older adults, racial and ethnic minorities, those unemployed, uninsured and under-insured, Medicaid eligible, children of low-income families, LGBTQ+ and gender non-conforming, people with HIV, people with severe mental and behavioral health disorders, people experiencing homelessness, refugees, people with a disability, and many others.

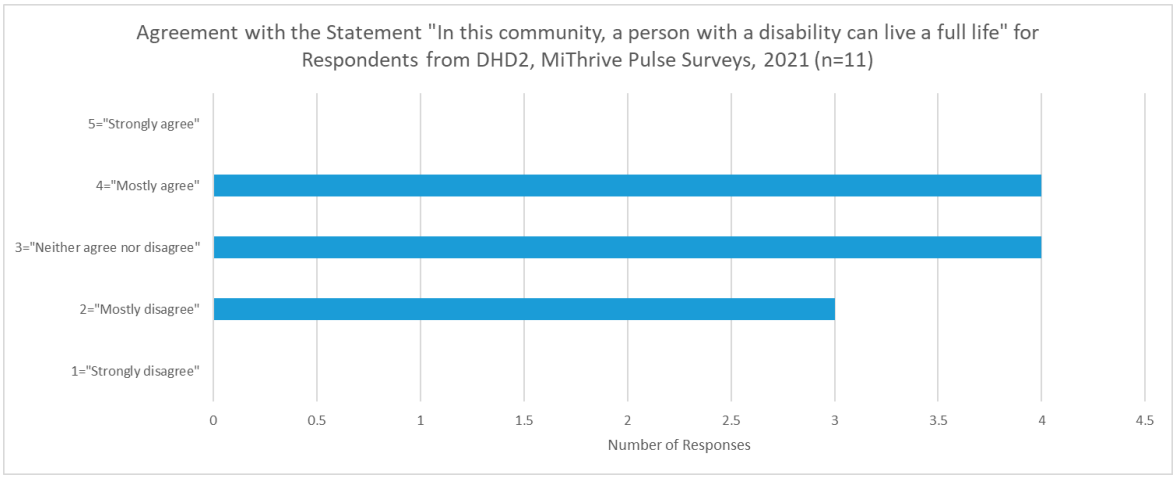




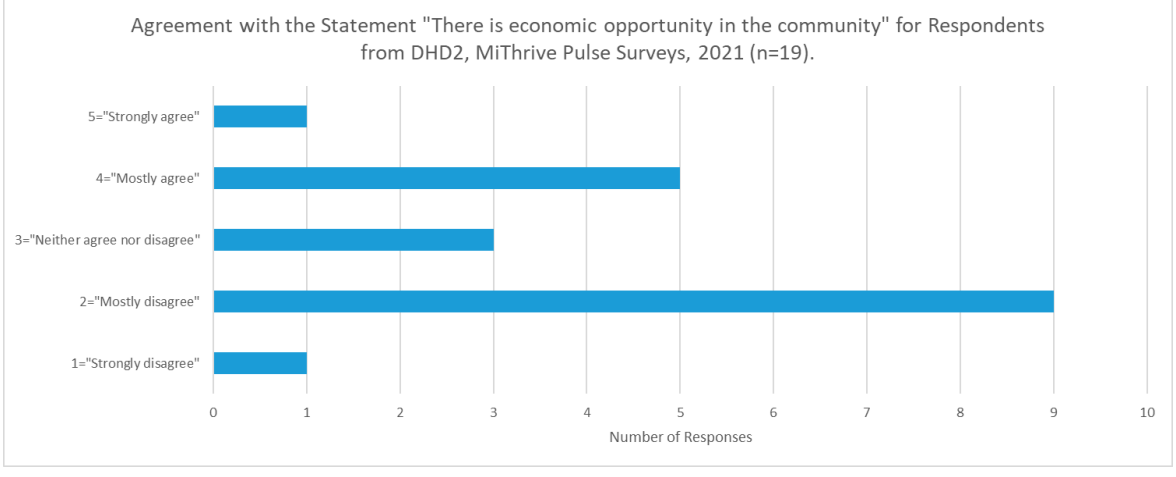
Key themes that emerged from pulse survey response to the following statement, "My community is a good place to age".



Key themes that emerged from pulse survey response to the following statement, "This community is a good place to raise children."



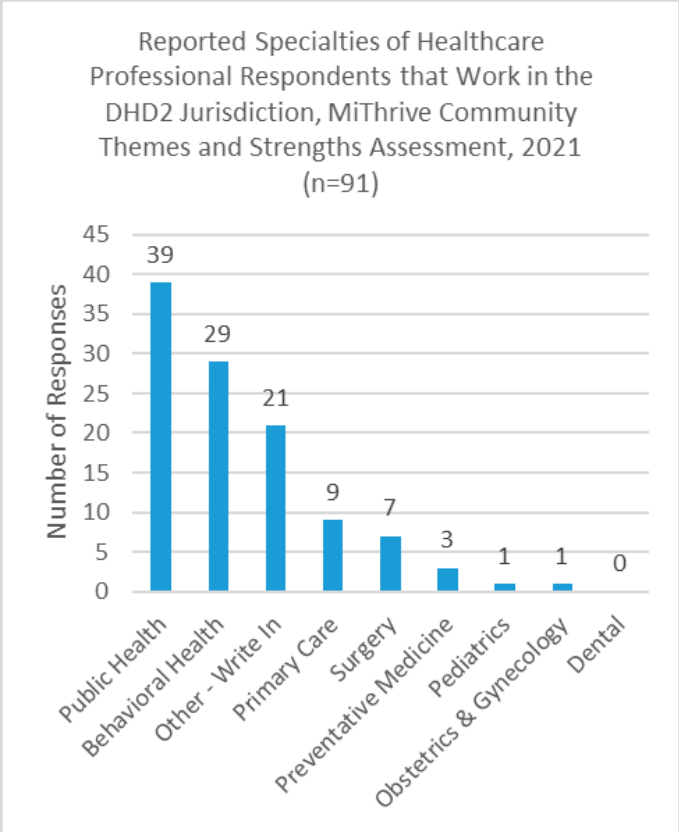
Key themes that emerged from pulse survey response to the following statement, "In this community, a person with a disability can live a full life."

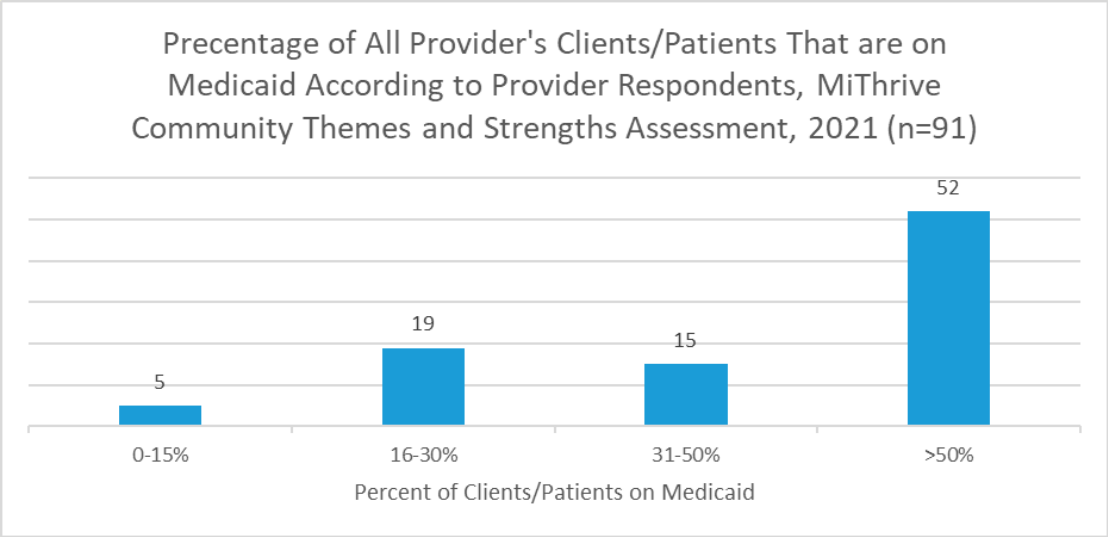


Key themes that emerged from pulse survey response that rated to the following statement, "There is economic opportunity in the community."

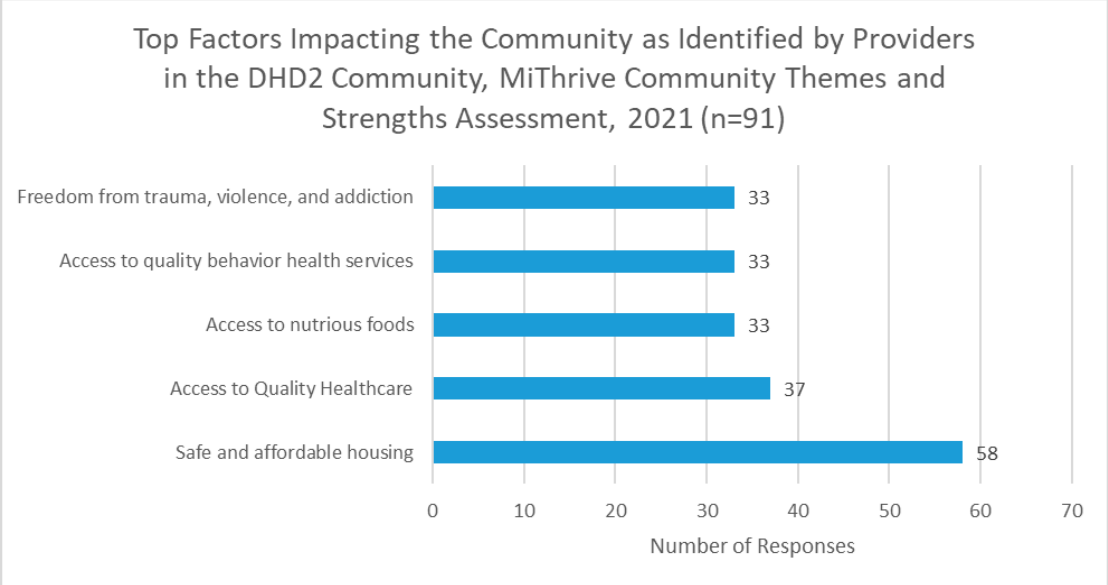
Healthcare Provider Survey:
Data collected for the Healthcare Provider Survey was gathered through a self-administered, electronic survey. It asked 10 questions about what is important to the community, what factors are impacting the community, quality of life, built environment, community assets, and demographic questions. The survey was open from October 18, 2021, to November 7, 2021.

Healthcare partners such as hospitals, federally qualified health centers and local health departments, among others, sent the Healthcare Provider Survey via an electronic link to their physicians, nurses, and other clinicians. Additionally, partner organizations supported survey promotion by sharing the survey link with external community partners. Ninety-one providers completed the Healthcare Provider Survey in the DHD2 jurisdiction.

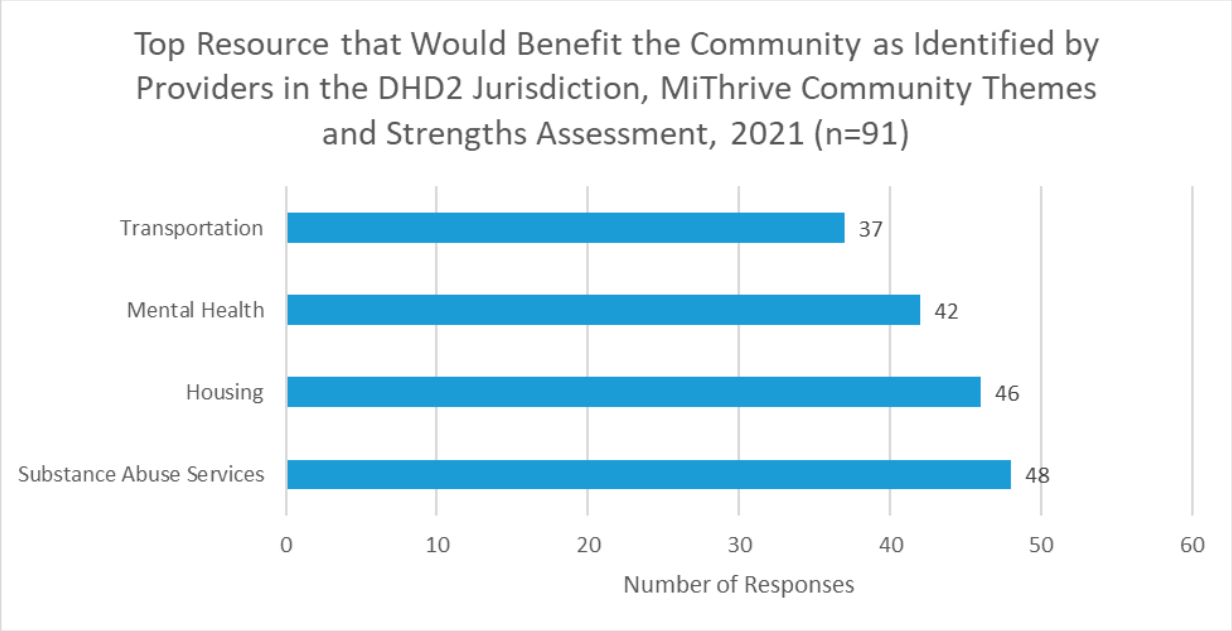




57.1% of providers in this region reported that >50% of patients/clients they serve are on Medicaid.



Providers think that safe and affordable housing is the most important factor for patients/clients in the community they serve.



53% of providers answered substance abuse services are missing in their community that would benefit their patients/clients they serve.

- **Community System Assessment**

The Community System Assessment focuses on organizations that contribute to wellbeing. It answers the questions, "What are the components, activities, competencies and capacities in the regional system?" and "How are services being provided to our residents?" It was designed to improve organizational and community communication by bringing a broad spectrum of partners to the same table; explore interconnections in the community system; and identify system strengths and opportunities for improvement. The Community System Assessment was composed of two components: Community System Assessment and subsequent focused discussions at 27 county level community coordinating bodies. A total of 539 residents and partners, representing 199 organizations participated in the Community System Events and/or Focused Discussions in the Northeast, Northwest and North Central Regions.

Community System Assessment Event: In August, residents and community partners assessed the system's capacity in the MiThrive Northwest, Northeast, and Northwest Regions. Through a facilitated discussion, they identified system strengths and opportunities for improvement among eight domains. (Please see Appendix E for Community System Assessment Meeting Agenda/Design).

Community System Assessment - System Strengths Survey

Focus Area and Definition	System Strengths in the Northeast Region
Resources: A community asset or resource is anything that can be used to improve the quality of life for residents in the community	• Organizations in the system know what resources are available. • Organizations work together to connect people to the resources they need.
Policy: A rule or plan of action, especially an official one adopted and followed by a group, organization, or government	• Many organizations in the system work together to alert policymakers and the community of possible public health effects from current or proposed policies
Data Access/Capacity: A community with data capacity is one where people can access and use data to understand and improve health outcomes	• None identified
Community Alliances: Diverse partnerships which collaborate in the community to maximize health improvement initiatives and are beneficial to all partners	• The Community System is composed of many diverse partners
Workforce: The people engaged in or available for work in a particular area	• Michigan Works! Is a great asset to address workforce issues
Leadership: Leadership is demonstrated by organizations and individuals that are committed to improving the health of the community.	• There are Individuals and organizations in the System that want to help.
Community Power/Engagement: Power is the ability to control the processes of agenda setting, resource distribution, and decision-making, as well as determining who is included and excluded from these processes	• There is connection and collaboration in the Community System
Capacity for Health Equity: Assurance of the conditions for optimal health for all people	• Data is collected regarding needs of residents in the community

Community System Assessment - System Opportunities for Improvement Summary

Focus Area and Definition	System Opportunities for Improvement in the Northeast Region
Resources: A community asset or resource is anything that can be used to improve the quality of life for residents in the community.	• Organizations need to increase understanding of the reasons that people do not get the services they need. • The system needs to reduce stigma that may be a barrier to people accessing resources
Policy: a rule or plan of action, especially an official one adopted and followed by a group, organization, or government	• Need to engage in activities that inform the policy development process, organizations in the system need more staff and funding. • Need to get the decision-makers to the table
Data Access/Capacity: A community with data capacity is one where people can access and use data to understand and improve health outcomes	• There are limited resources and manpower • Need to present the data to the identified target population and tailor the data so it is meaningful to them. • Update the Community Health Assessment with current information continuously
Community Alliances: Diverse partnerships which collaborate in the community to maximize health improvement initiatives and are beneficial to all partners	• There is a need to get community members engaged in partnerships • The partnerships could improve upon work to improve community health
Workforce: The people engaged in or available for work in a particular area	• The Community System needs to develop an unmet needs report to better understand workforce gaps. • Use the knowledge from the assessment to develop plans to address workforce gaps and shortfalls. • Increase wages to create livable wages
Leadership: Leadership is demonstrated by organizations and individuals that are committed to improving the health of the community.	• More staff are needed to make significant changes. • Need to help people and organizations with strengths find opportunities for leadership • The community system needs more diversity in leadership
Community Power/Engagement: Power is the ability to control the processes of agenda setting, resource distribution, and decision-making, as well as determining who is included and excluded from these processes	• Increase resident voice and engagement to inform decision-making • Access to broadband is a barrier • Work collaboratively to link communications plans between organizations.
Capacity for Health Equity: Assurance of the conditions for optimal health for all people	• Include resident voice to identify health disparities and plan ways to reduce inequities • Reduce stigma which leads to bias and discrimination against certain populations

Follow-up conversations at the local Community Collaboratives and other county-level groups.

Subsequently, focused conversations were held at county-level collaboratives and other cross-sector groups in the DHD2 jurisdiction.

Alcona County: Alcona County Collaborative Body (ACCB)

ACCB members chose "Resources" as the most important focus area to work on in Alcona County. In the discussion, the following themes emerged:

- Navigating staff turnover and redistributing responsibilities
- Improving communication amongst local agencies to help reduce duplicated efforts
- Expanding capacity and making resources from each specialty widely accessible
- Reducing stigma and educating the community regarding stigma and the effects of stigma

Iosco County: Iosco County Human Services Collaborative Council (HSCC)

Collaborative members chose "Resources" as the most important focus area to work on in Iosco County. In the discussion, the following themes emerged:

- Coordination of shared data
- Understanding what resources are needed and how to get them to the people in need
- Utilizing the voice of the residents to fully understand the needs and struggles they are facing
- Reducing stigma and educating the community regarding stigma and the effects of stigma

Ogemaw County: Ogemaw County Roundtable

Roundtable members chose "Getting the right people at the meeting/table" as the most important focus area to work on in Ogemaw County. In the discussion, the following themes emerged:

- Empowering individuals with making personal health goals
- Increase education on ways to seek needed resources
- Making resources available and bringing them to the groups that have the capacity to make a difference
- Reducing stigma and educating the community regarding stigma and the effects of stigma

Oscoda County: Oscoda County Human Services Collaborative Council (HSCC)

Oscoda County participants chose "Resources" as the most important focus area to work on in Oscoda County. In the discussion the following themes emerged:

- Adapting to the increased need for the Internet
- Increased education on available resources
- Improving involvement of the younger generation
- Increased collaboration of established groups and organizations

Forces of Change Assessment

The Forces of Change Assessment aims to answer the following questions: "What is occurring or might occur that affects the health of our community or the local system?", and "What specific threats or opportunities are generated by these occurrences? Like the Community System Assessment, the Forces of Change Assessment was composed of community meetings convened virtually in the Northwest, Northeast, and North Central MiThrive Regions. It focused on trends, factors, and events outside our control within several dimensions, such as government leadership, government budgets/ spending priorities, healthcare workforce, access to health services, economic environment, access to social services, social context, and impact of COVID-19.

(Please see Appendix F for Forces of Change Assessment Event Agenda/Design)

One hundred and forty-one residents and community partners participated in the Forces of Change Assessment in the Northwest, Northeast, and North Central Region in April, 2021.

Top Forces of Changes in the Northeast MiThrive Region

Categories of Forces	Top Forces in Northeast Region
Government Leadership And Spending/Budget Priorities	• Political Agendas, Influences and Policies
Sufficient Healthcare Workforce	• Monies & Grants for Training • Minimum Wage Pending Legislation • Lack of Staff in Specific Industries (i.e., mental health & substance use disorders)
Access to health services	• Cost & Access of Insurance • Large Poverty & ALICE* population in our region • Provider shortages & Rurality
Economic environment	• Education and Income Levels • Affordable Housing • Broadband Internet
Access to social services	• Lack of housing (public/ affordable) • Isolation • Access to SUD services/ treatment facilities (alcohol, vaping, marijuana, prescription drugs)
Social context	• Environment and Climate Change • Access to accurate information / discernment of information • Affordable housing
Impacts related to COVID-19	• Vaccinations coming out, recent adverse events • Overall decrease in mental health • Closing of businesses, loss of jobs

**ALICE refers to the population in our communities that are Asset Limited, Income Constrained, Employed. This population represents those among us who are working, but due to high cost of living and so much more are living paycheck to paycheck.*

Data Limitations

Community Health Status Assessment

- Since scores are based on comparisons, low scores can result even from very serious issues, if there are similarly high rates across the state and/or US.
- We can only work with the data we have, which can be limited to the local level in Northern Michigan. Much of the data we have has wide confidence intervals, making many of these data points inexact.
- Some data is missing for some counties - as a result, the "regional average" may not include all counties in the region. Additionally, some counties share data points, for example, in the Michigan Profile for Healthy Youth, data from Crawford Ogemaw, Oscoda, and Roscommon counties is aggregated and therefore each of these counties will have the same value in the MiThrive dataset.
- Secondary data tells only part of the story. Viewing all the assessments holistically is therefore necessary.
- Some data sources have not updated data since the past MiThrive cycle therefore values for some indicators may not have changed and therefore cannot be used to show trends from the last cycle to this cycle.

Community System Assessment

- Completing the Community System Assessment is a means to an end rather than an end in itself. The assessment results should inform and result in action to improve the Community System's infrastructure and capability to address health improvement issues.

- Each respondent self-reports with their different experiences and perspectives. Based on these perspectives, gathering responses for each question includes some subjectivity.
- When completing the assessment at the regional events or at the county level, there were time constraints for discussion and some key stakeholders were missing from the table.
- Some participants tended to focus on how well their organization adressed the focus areas for health improvement rather than assessing the system of organizations as a whole.

Community Themes and Strengths Assessment

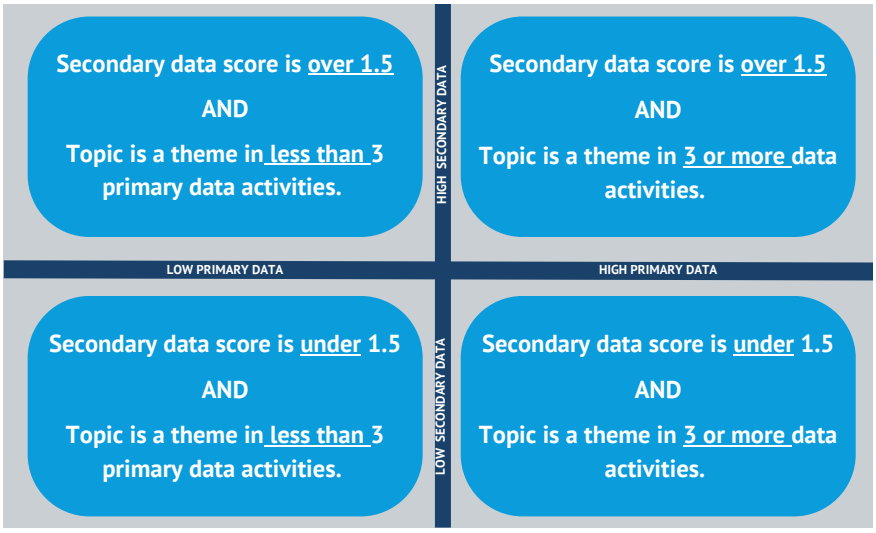
- A unique target number of completed CTSA Community Surveys was set for each county based on county population size. Survey responses were not weighted for counties who exceeded this target number.
- While the CTSA Community Survey was offered online and in-person, most surveys were collected digitally.
- Partial responses were removed from the CTSA Community Survey.
- Outreach and promotion for the CTSA Provider Survey was driven by existing MiThrive partners which influenced the distribution of survey responses across provider entities.
- The CTSA Pulse Surveys were conducted across a wide variety of agencies and organizations. Additionally, survey delivery varied including in-person interview, over the phone interview, text survey, and paper format.

Forces of Change Assessment

- Participants self-selected into one of eight Forces of Change Assessment topic areas during the events and discussed forces, trends and events using a standardized Facilitation Guide although facilitators and notetakers differed for the topic areas and events.
- These virtual events removed some barriers for participants although internet accessibility was a requirement to participate.
- When completing the assessment there were time constraints for discussion and some key stakeholders were missing from the table.
- MiThrive staff selected the eight topic areas using the MAPP's guidance in addition to insights from the MiThrive Core Team members.
- COVID-19 was included as a standalone topic area and all participants were advised of the topic areas and were instructed to focus on their topic area with minimal discussion on COVID-19 unless it was their specific topic area.

Identifying and Prioritizing Strategic Issues

To launch Phase 4, the MiThrive Core Support Team developed the MiThrive Prioritization Matrix (pictured below) to engage in data sensemaking. The Team sorted the data by categorizing the primary and secondary data as either high or low. Secondary data was collected in the Community Health Status Assessment (CHSA) and each indicator was scored on a scale of zero to three. This scoring was informed by sorting the data into quartiles based on the 31-county regional level, comparing to the mean value of the MiThrive Region, and comparing to the state, national, and Healthy People 2030 target when available. Indicators with a score above 1.5 were defined as "high secondary data" and indicators with scores below 1.5 were defined as "low secondary data." Primary data was collected from the Community System Assessment, Community Themes and Strengths Assessment (Community Survey, Pulse Survey, and Healthcare Provider Survey), and the Forces of Change Assessment. If a topic emerged in three or more primary data activities, it was classified as "high primary data" where topics that emerged in less than three primary data activities were classified as "low primary data."



mithrive

Prioritization Matrix

PRIMARY DATA

- Community System Assessment **(CSA)**
- Forces of Change Assessment **(FOCA)**
- Community Themes and Strengths Assessment **(CTSA)** Pulse Survey
- Community Themes and Strengths Assessment **(CTSA)** Pulse Survey Community Survey
- Community Themes and Strengths Assessment **(CTSA)** Provider Survey

SECONDARY DATA

- Community Health Status Assessment **(CHSA)**

On **November 16, 2021**, MiThrive Design Team members met to sort the data for the Northwest, Northeast, and North Central Regions using the MiThrive Prioritization Matrix. The Team identified where the primary and secondary data converged by clustering data points based on topic, theme, and interconnectedness. Given the interconnectedness of the social determinants of health and health outcomes, some data points were duplicated and represented in numerous clusters. Data clusters that fell into the High Secondary Data/High Primary Data quadrant of the MiThrive Prioritization Matrix were classified as significant health needs.

All of the assessments provide valuable information, but the health needs that occur in multiple data collection methods are the most significant.

There was considerable agreement across the 31-county region, with the following cross-cutting significant health needs sorted into the High Secondary Data/High Primary Data (upper right quadrant) in all three MiThrive Regions:

- Behavioral Health
- Substance Misuse
- Safety and Well-Being
- Housing
- Economic Security
- Transportation
- Diversity, Equity, and Inclusion
- Access to Healthcare

In addition, themes emerged that were unique to each Region:

North Central Region	Northeast Region	Northwest Region
Broadband Access	COVID-19	COVID-19
Food Security	Healthy weight	Food Security
Healthy Weight		Built Environment

In **November 2021**, members of the MiThrive Steering Committee, Design Team, and Workgroups framed the significant health needs identified in each region as Strategic Issues, as recommended by the Mobilizing for Action through Planning and Partnerships Framework. Strategic Issues are fundamental policy choices or critical challenges that must be addressed for a community system to achieve its vision. Strategic Issues should be broad, which allows for the development of innovative, strategic activities as opposed to relying on the status quo, familiar, or easy activities. The broad strategic issues help align the overall community's strategic plan with the missions and interests of individual community system partners. This facilitated process included MiThrive Partners to review the data clusters as a whole and the individual data points that made up the significant health need.

The 11 strategic issues developed for the MiThrive Region is reflected in the table to the right (listed in alphabetical order):

Northeast Region Strategic issues
How do we ensure that everyone has **safe, affordable, and accessible housing**?
How can we increase comprehensive **substance misuse prevention and treatment services** that are accessible, patient-centered, and stigma free?
How do we increase access and reduce barriers to **quality behavioral health services** while increasing resiliency and wellbeing?
How can we nurture a **community and health-oriented transportation environment** which provides safe and reliable transportation access, opportunities, and encouragement to live a healthy life?
How do we foster a community where everyone feels **economically secure**?
How do we cultivate a community whose policies, systems, and practices are rooted in **equity and belonging**?
How do we increase access to integrated **systems of care** as well as increase engagement, knowledge, awareness with existing systems to better **promote health, and prevent and treat chronic disease**?
How do we ensure all community members are aware of and can access **safety and wellbeing supports**?
How do we reduce the impact of **Covid-19** on our communities?
How can we create an **environment which provides access, opportunities, and support** for individuals to reach and maintain a **healthy weight**?

In **December 2021**, 166 residents and community partners participated in the MiThrive Data Walk and Priority Setting Events in the three regions: Northeast, Northwest, and North Central. During these live events, participants engaged in a facilitated data walk and participated in a criteria-based ranking process to prioritize 2-3 Strategic Issues to collectively address in a collaborative Community Health Improvement Plan. For each Strategic Issue, a MiThrive Data Brief was prepared that summarized, by MiThrive Region, the results of the four assessments (See Appendix G).

After engaging in the MiThrive Data Walk, participants were asked to complete a prioritization survey to individually rank the Strategic Issues. The ranking process used five criteria to assess each Strategic Issue including severity, magnitude, impact, health equity, and sustainability. Participant votes were calculated in real-time during the event revealing the top scoring Strategic Issues **(example scoring grid provided below)**.

This transparent process elicited robust conversation around the top scoring Strategic Issues and participants identified alignment between the healthy weight Strategic Issue and chronic disease element in the access to healthcare Strategic Issue. Participants opted to combine these two Strategic Issues and wordsmith post event.

Prioritizaiton Total Scoring Grid						
Strategic Issue	Severity	Magnitude	Impact	Health Equity	Sustainability	Total Score
How can we nurture a community and health-oriented transportation environment which provides safe and reliable transportation access, opportunities, and encouragement to live a healthy life?						
How do we ensure all community members are aware of and can access safety and well-being supports?						
How can we advocate for increased broadband access and affordability?						
How can we create an environment which provides access, opportunities, and support for individuals to reach and maintain a healthy weight?						
How do we increase access and reduce barriers to quality behavioral health services while increasing resiliency and wellbeing?						
What policy, system and environmental changes do we need to ensure reliable access to healthy food?						
How do we increase access to integrated systems of care as well as increase engagement, knowledge, awareness with existing systems to better promote health and prevent, treat chronic disease?						
systems, and practices are rooted in equity and belonging?						
How do we ensure that everyone has safe , affordable, and accessible housing?						
How can we increase comprehensive substance misuse prevention and treatment that are accessible, patient centered and stigma free?						
How do we foster a community where everyone feels economically secure?						

Following the Data Walk and Priority Setting Events, MiThrive partners and participants refined the prioritized Strategic Issues by wordsmithing the combined strategic issues, clarifying the language, and removing any jargon. This process included gathering feedback via a feedback and revision document sent out to MiThrive partners on **January 5, 2022**. Comments, feedback, and suggestions were collected over the course of a week and half, and the MiThrive Core Support Team updated the top-ranked Strategic Issues based on this feedback.

Key changes, based on revisions, are as follows:

- All three MiThrive Regions separated access to healthcare from chronic disease/healthy weight given the two distinct buckets of work. This change is reflected in the final top-ranked strategic issues below.
- The North Central and Northeast MiThrive Regions updated the term behavioral health to mental health.

The final top-ranked strategic issues in the MiThrive Regions are as follows:

Northeast Region: **Alcona**, Alpena, Cheboygan, Crawford, **Iosco**, Montmorency, **Ogemaw**, **Oscoda**, Otsego, Presque Isle, and Roscommon **(DHD2 counties shown in bold)**.

- How do we increase **access to health care**?
- How do we reduce **chronic disease** rates in the region?
- How do we increase access to quality **mental health** services while increasing resiliency and wellbeing for all?
- How do we increase access to quality **substance use disorder** services?

Priority Area Narratives

Access to Healthcare

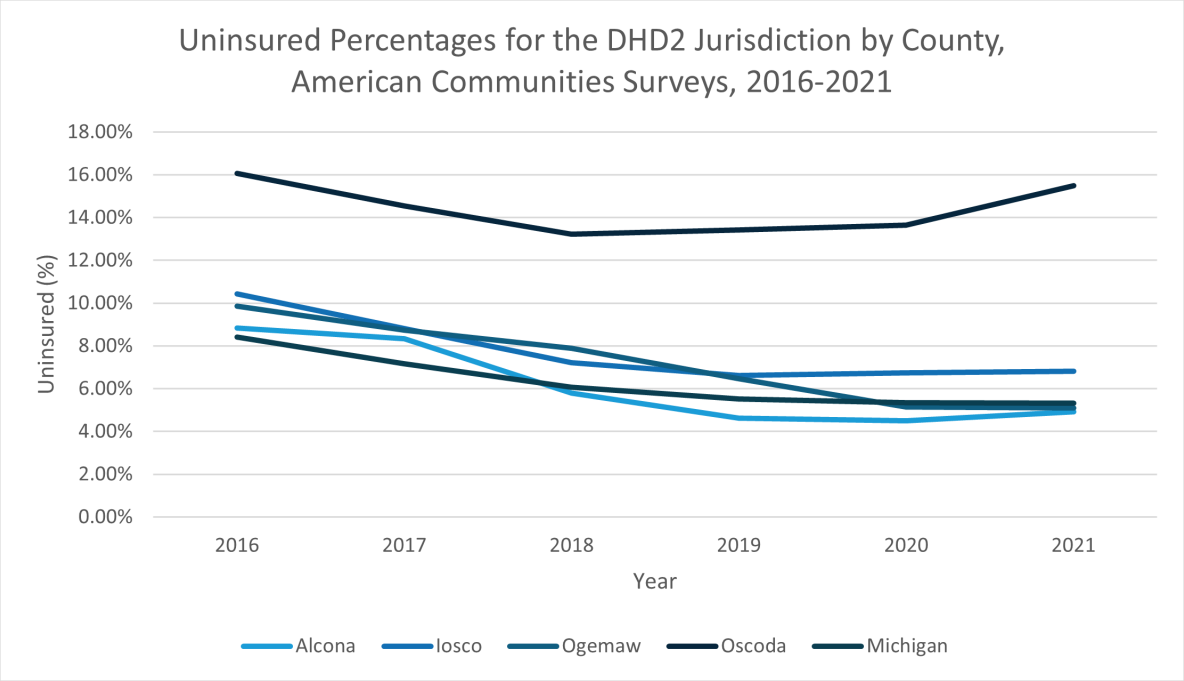
Access to healthcare refers to the ability of individuals and communities to obtain timely, affordable, and appropriate medical services and resources when needed. It encompasses physical, financial, geographical, and cultural barriers that can either facilitate or hinder a person's ability to receive necessary healthcare services. Access to healthcare is a fundamental aspect of public health and healthcare systems, aiming to ensure equitable and inclusive health outcomes for all members of a community.

For the District Health Department No. 2 (DHD2) jurisdiction, several data indicators were used to determine that access to healthcare should be a priority area. Local organizations highlighted a lack of manpower and resources as important impediments to providing services. Additionally, the Community System Assessment (CSA) showed that many local organizations need to increase their understanding of the reasons why residents are not able to get the services they need. Community members responding to the MiThrive surveys highlighted access to quality healthcare services as the number one most important factor for a thriving community with even distribution among household incomes. Local area providers similarly reported access to quality healthcare as the second most important factor. This feeling was especially prevalent for younger adults aged 25-39 years old and those who relied on Medicaid or private insurance. Other surveys showed that 57.1% of responding providers reported that more than half of the population they served relied on Medicaid, which may indicate the need for more services for individuals who obtain health insurance though this governmental program.

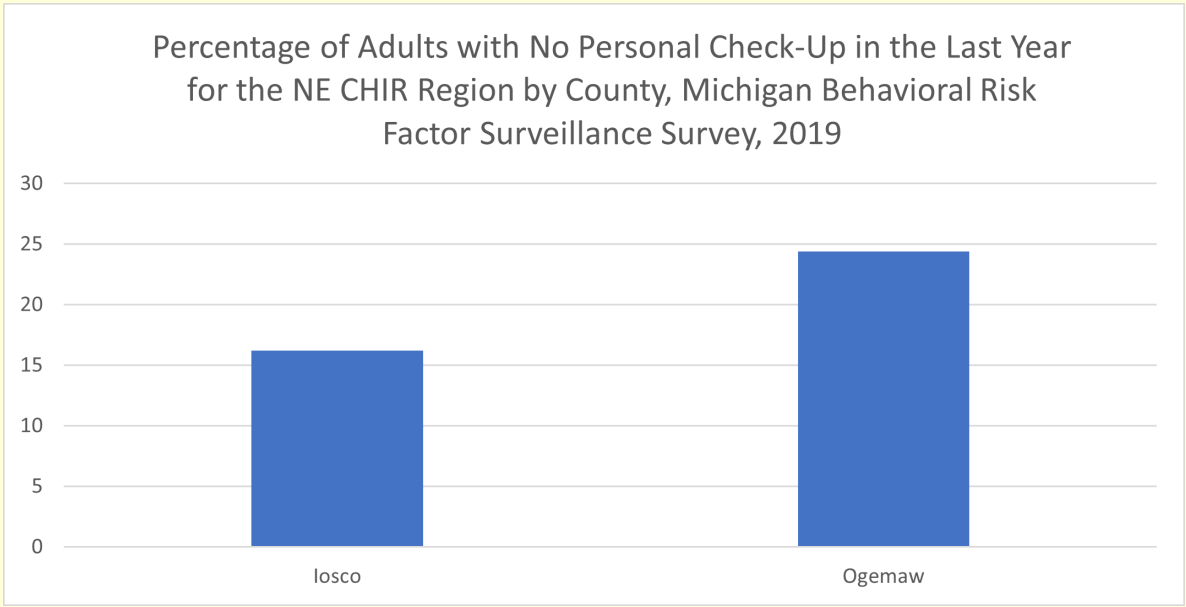
Residents of the DHD2 area may have issues securing access to healthcare for a variety of reasons. Poverty is a prevalent issue within the DHD2 area and is likely a primary diver of lack of access for many individuals and families. In these communities, there are no census tracts with less than five percent of individuals who are below the poverty line. Data shows increasing mortality rates for those tracts with more poverty. Additionally, the median household income in the jurisdiction is below the state average. This is likely related to overall

lower levels of educational attainment, which is often also linked to decreased healthcare usage and lower health literacy. DHD2 also exhibits higher levels of child food insecurity and has a higher proportion of individuals with a disability when compared to state averages.

The rate of uninsured individuals in the DHD2 area can be illustrative of these healthcare access issues. When looking at the trends in uninsured rates for the community over the last several years, we can identify several key points (see the graph below). While Alcona, Iosco, and Ogemaw counties closely follow the state value, Oscoda County has a substantially higher proportion of residents who are uninsured, which is a trend that is consistent over the years for which data was collected. This is likely due in part to higher levels of poverty in this county as well as the presence of communities that do not interact with the healthcare system in a traditional manner (such as the Amish-Mennonite population).



While the other counties are nearer the state average for uninsured rates, this is still an issue with Ogemaw and Iosco counties both showing high levels of adults who are not receiving an annual healthcare checkup (see the graph below). Similar data was not available for Oscoda and Alcona counties due to low response rates and small base populations, highlighting the importance of increased efforts for gathering this data from rural communities.



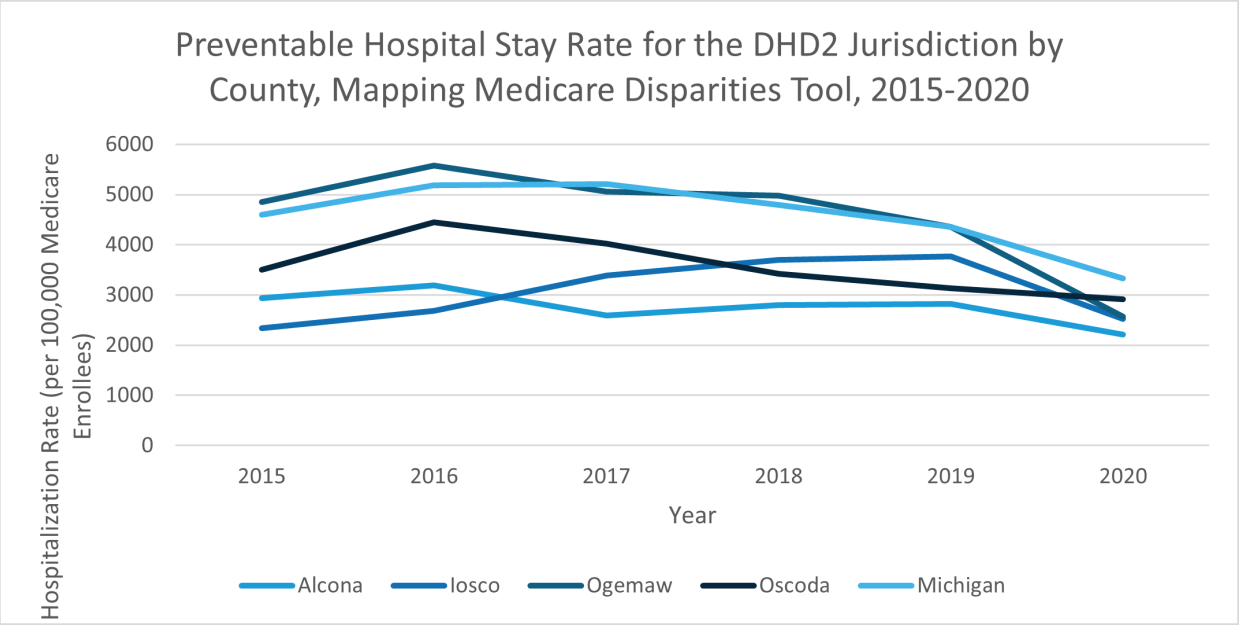
Chronic Disease

Chronic diseases are those that either develop over a long period of time or have effects that are persistent over months or years. This includes diseases such as heart disease, cancer, diabetes, and many others and are often the leading causes of death in the United States. Many of these chronic conditions are often associated with aging or prolonged/repeated environmental exposure, but some conditions can occur in younger populations or have etiological or random associations with an individual's environment. A large amount of healthcare spending is devoted to managing and preventing chronic diseases and associated effects.

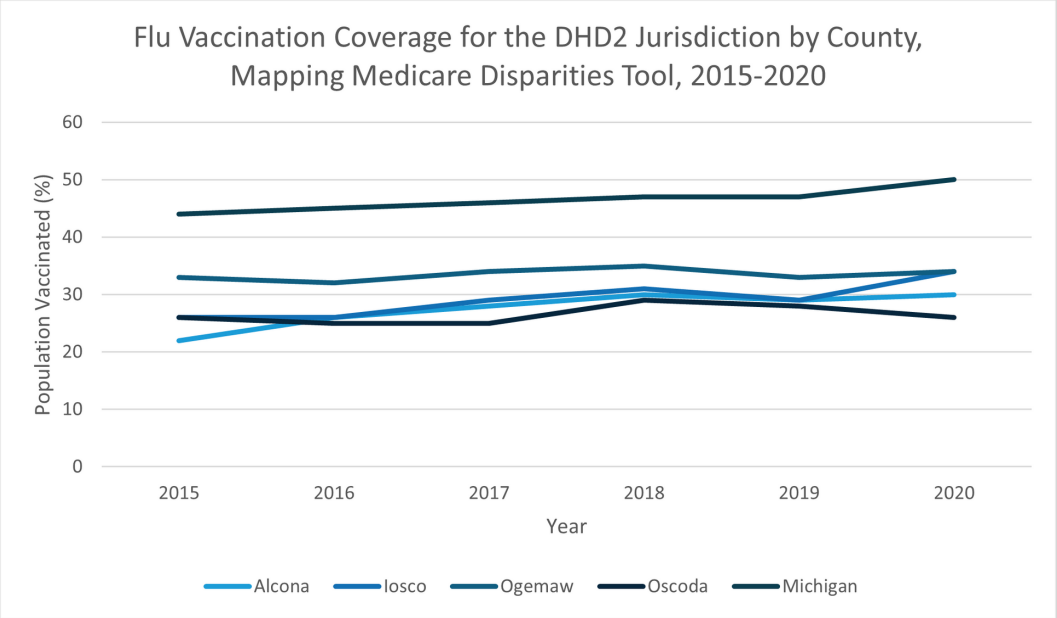
Chronic disease was determined to be a priority area for the NECHIR region due to data gathered from the assessments. The entire region, but the DHD2 jurisdiction in particular, has higher average ages for residents and a higher proportion of individuals who are over the age of 65 years when compared to other regions in the state. This means that a higher proportion of residents are likely at risk for having or developing some of these chronic diseases. The CSA found that there was a need for local organizations to engage in activities that inform policy development processes for local jurisdictions, ensuring that the health of the community is always considered when important policy decisions are being made. Community members who responded to the CTSA listed disease and illness prevention as an important community issue that needed to be addressed.

Collected secondary indicators showed that the DHD2 area has higher rates of many chronic diseases when compared with state averages (this includes heart disease prevalence and mortality, cancer incidence, COPD and lower respiratory disease mortality, and kidney disease mortality). Overall, the four-county area has a higher prevalence of obese adults (39.8%) and overweight adults (32.1%) when compared to state averages. These numbers mean that more than two-thirds of DHD2 adults are above what would be considered their healthy weight. High levels of mortality in poorer census tracts are also likely linked to chronic disease in these areas.

Preventable hospital stays are defined as those admissions which are due to certain acute illnesses and worsening chronic illnesses that could have been prevented if managed sooner and successfully in other settings. Among the resident Medicare population, DHD2 has higher rates of these preventable stays when compared to the state, although recent data does seem to suggest this disparity is closing (see the graph below). This is important to acknowledge, as health promotion and prevention of these hospital stays can be critical to improving quality of life and preventing untimely mortality.



Although influenza infections are not considered a chronic disease, vaccination against the yearly flu can be important in preventing complications in individuals who have underlying conditions. This is important for jurisdictions such as DHD2, where more of the population is likely to be elderly and have chronic respiratory diseases. Trend data shows that the percent of the population that receives the yearly flu vaccination is consistently lower for the counties of DHD2 compared with the state average (see the graph below).



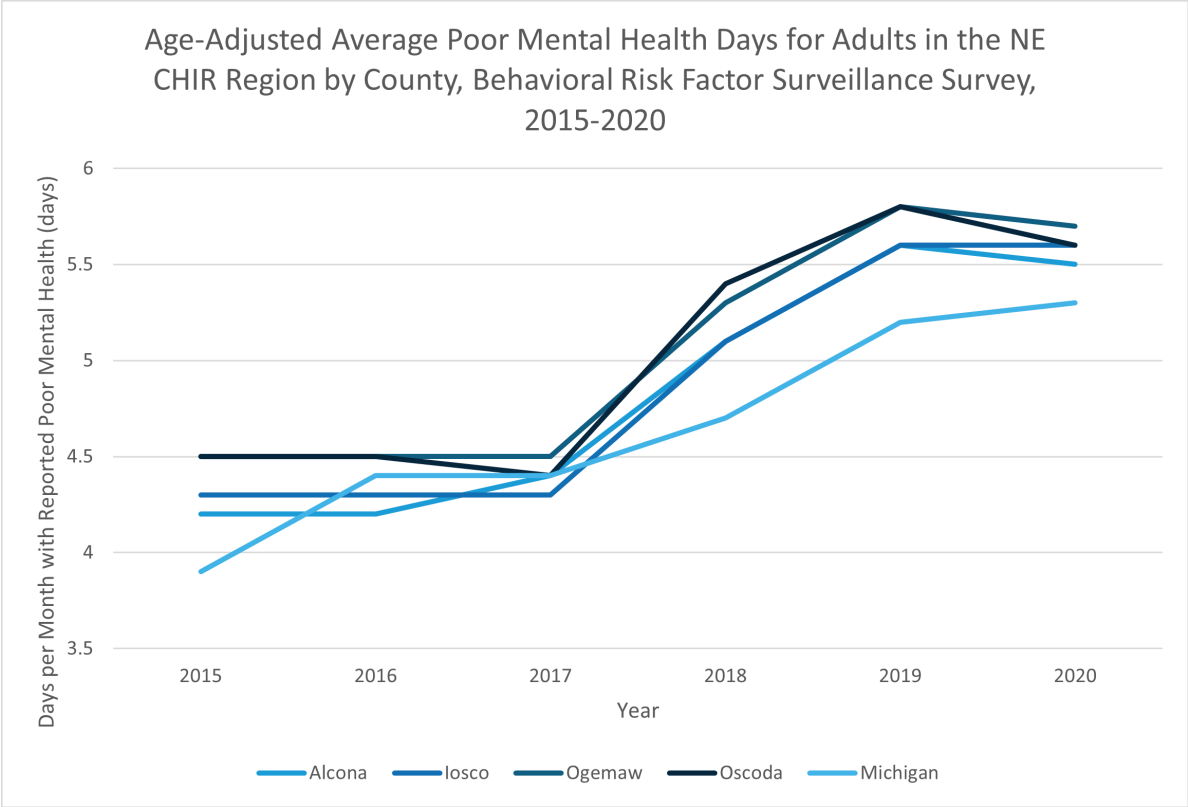
Mental Health

Access to mental healthcare is the ability for individuals to obtain timely, affordable, and appropriate mental health services and support when needed. Mental healthcare is often distinguished from general access to healthcare due to the differences in qualifications for providers and facilities. It involves overcoming barriers such as stigma, availability of mental health professionals, financial constraints, and geographical factors to ensure that people can access the necessary care for their mental wellbeing. Access to mental health services is essential for addressing mental health conditions, promoting psychological resilience, and improving overall quality of life. It is a critical component of a comprehensive healthcare system that prioritizes both physical and mental health.

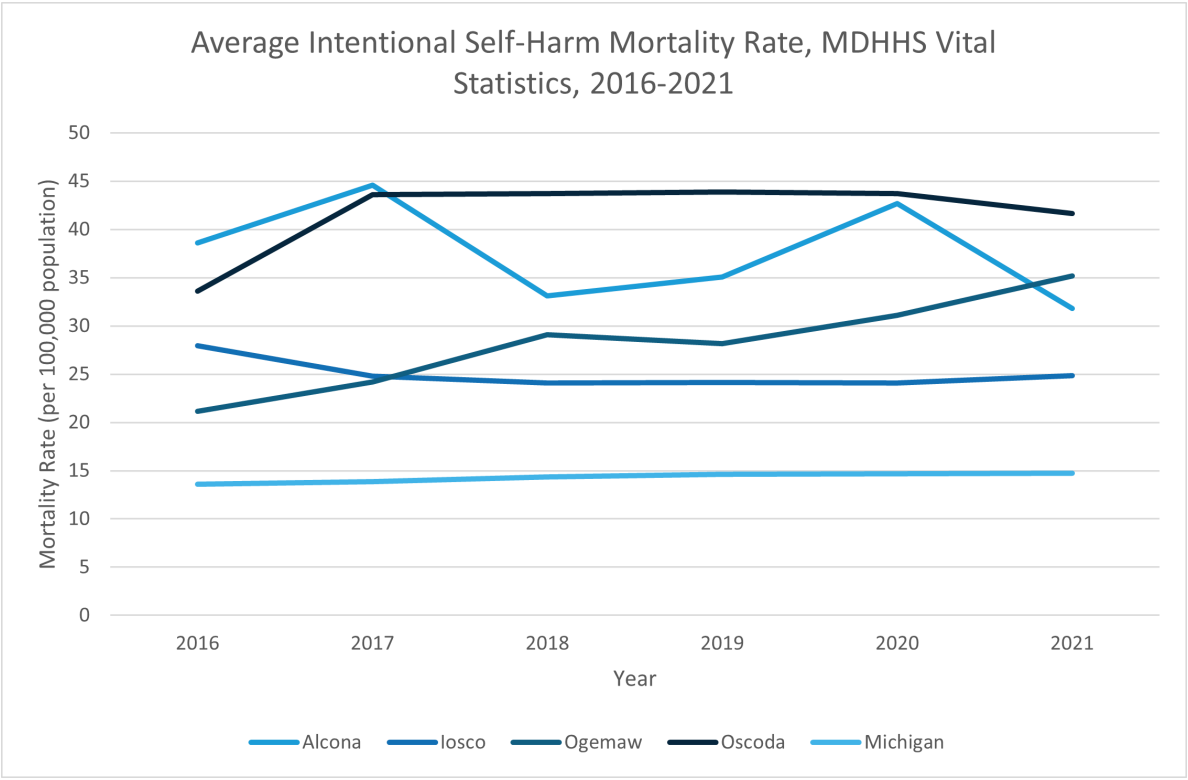
The inclusion of mental health as a priority area for the Northeast Community Health Innovation Region (NECHIR) and DHD2 came from the results of the MiThrive assessments. The importance of reducing stigma towards mental health conditions and seeking treatment was an important takeaway from the CSA. Access to quality behavioral health services was one of the top ten most important factors for a thriving community according to community members, and local providers not only listed behavioral health services as the third most important factor, but also the third most important need for resources.

Much like access to healthcare, ensuring access to mental healthcare is impacted largely by excess poverty throughout the region, meaning that many of the same factors that impact access to healthcare are also an issue when accessing mental healthcare. Currently, most of the community identifies themselves as “Struggling” according to the Community Themes and Strengths Assessment (CTSA) survey (61% of respondents). Nearly 1 in 6 respondents additionally counted themselves in the “Suffering” category of the same question.

Several data sets clearly show that mental health is an important priority for the healthcare system in the DHD2 jurisdiction. Although the reported average of poor mental health days among adults in the four counties trend similarly to the Michigan average of poor mental health days, the trend is also consistently above that average figure (see the graph below). These numbers appear to have been on the rise since 2017, and although data was only available through 2020 it seems appropriate to assume that this trend has only trended towards an increase in poor mental health days though 2022 and 2023 due to the COVID-19 pandemic (isolation, loss of social cohesion, loss of schooling or jobs, etc.).



Poor mental health is linked to an increased risk for intentional self-harm and self-harm mortality. Vital statistics from the state of Michigan show that all four counties for the DHD2 jurisdiction have substantially higher levels of self-harm mortality when compared to the state average (see the graph below). This is a trend that has been in place for several years and suggests that there are systemic or community-wide issues that are impacting the rates of self-harm for this local health department. Wide swings in data points between years, such as is observed for Alcona County between 2017 and 2019, are due to a low base population in the county leading to individual cases of self-harm mortality to have larger impacts on the calculated mortality rate.

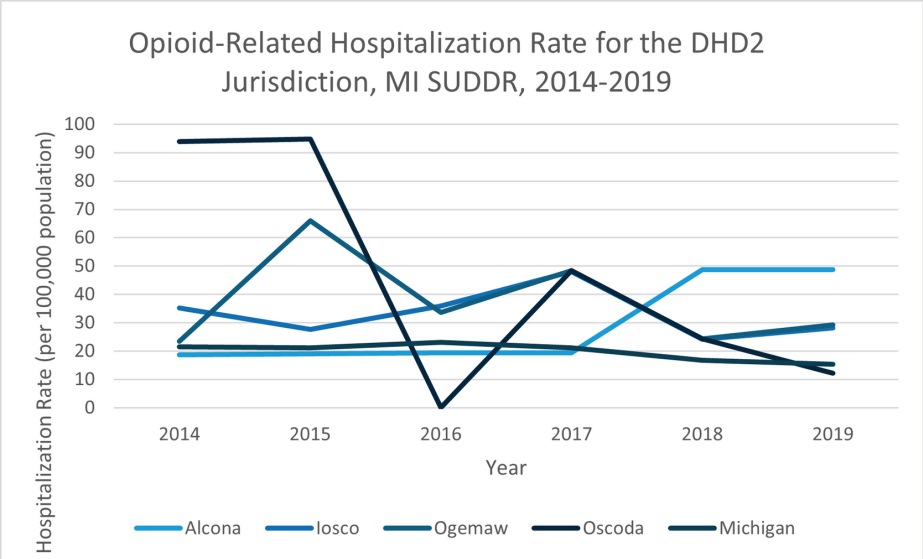


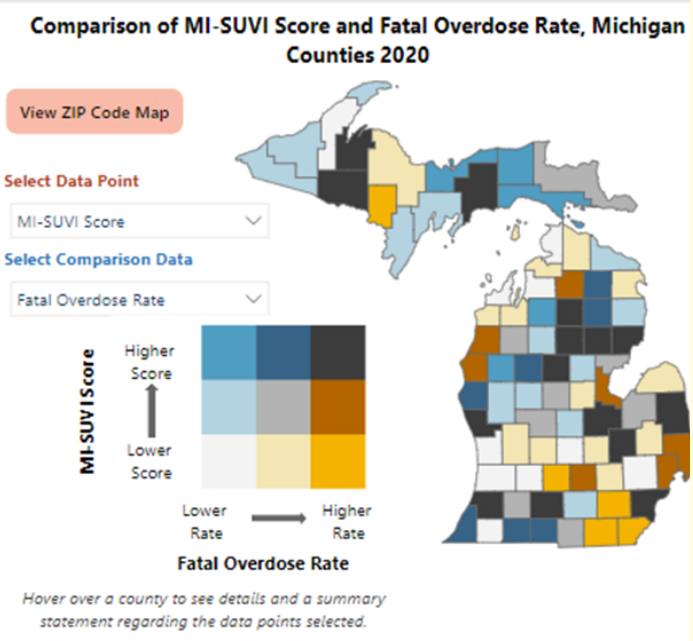
Substance Use Disorder

Substance use disorder (SUD) is a medical condition characterized by a pattern of harmful or hazardous use of one or more psychoactive substances, such as drugs or alcohol. SUDs can encompass a range of symptoms and behaviors and can vary in severity or significantly impact an individual's overall health or relationships. It is typically diagnosed and treated by specialized healthcare professionals with a variety of interventions.

There were many data points reviewed by the NECHIR workgroup that contributed to SUD becoming a priority area. Much like the mental health priority area, reducing stigma was an important theme to emerge from the CSA. The DHD2 community members who responded to the CTSA survey found that freedom from addiction was the third most important community factor and that substance use overall was the number one issue affecting their communities. Similarly, providers who work in the region and responded to the CTSA agreed that freedom from addiction was the third most important community factor. Providers also reported that the top resource that would benefit the community was an increase in substance abuse services.

Secondary data indicators collected for the Community Health Status Assessment (CHSA) showed that the DHD2 jurisdiction has a higher than state average rate of adult binge drinking. There was also higher than average injury mortality, which can be related to SUD but is not specific. Data from the state of Michigan shows that the counties of DHD2 have higher rates on average for opioid-related hospitalizations when compared to the state, although this is not consistently the case (see the graph below). These changes could also indicate that the risk of these hospitalizations is impacted by an unconsidered secondary factor.





Data for the Michigan Substance Use Vulnerability Index (MI-SUVI) was released in 2021 and compiled information on several SUD factors into a single value for each Michigan county. This data was not originally included in the CHSA but is indicative of the substantial need in the DHD2 communities. Among the 83 counties, Oscoda County had the highest SUVI value due to substance use rates that were relatively high compared to the base population and the lack of support facilities and resources within the county. Additionally, when compared against the fatal overdose rate, the MI-SUVI data shows that Iosco and Ogemaw counties are also at higher risk of vulnerability among residents (see the graph to the left; Source: MI-SUVI Dashboard, 2023).

Next Steps

Now that the MiThrive Community Health Needs Assessment is complete, MiThrive Workgroups will be developing Community Health Improvement Plans for the top-ranked priorities in their region and overseeing the implementation. The MiThrive Community Health Improvement Plan will serve as the foundation for the DHD2 Community Health Improvement Plan, with DHD2 incorporating strategies specific to essential local public health services.

It is important to note that the strategies identified by MiThrive represent only one component of the complete plan. No one individual, community group, hospital, agency, or governmental body can be responsible for the health of the community. No one organization can address complex community issues alone. However, working together, we can understand the issues and create plans to address them. It will be through this combined approach that we will achieve the greatest impact in improving and maintaining the health of our communities and residents.

If you are interested in joining a MiThrive Workgroup, please email mithrive@northernmichiganchir.org.

Definitions

Community Health Improvement Process

The Community Health Improvement Process is a comprehensive approach to assessing community health, including social determinants of health, and developing action plans to improve community health through substantive involvement from residents and community organizations. The community health needs assessment process yields two distinct yet connected deliverables: community health needs assessment report and community health improvement plan/implementation strategy.

Community Health Needs Assessment

Community Health Needs Assessment is a process that engages community members and partners to systematically collect and analyze qualitative and quantitative data from a variety of resources from a certain geographic region. The assessment includes information on health status, quality of life, social determinants of health, mortality and morbidity. The findings of the community health assessment include data collected from both primary and secondary sources, identification of key issues based on analysis of data, and prioritization of key issues.

Community Health Improvement Plan

The Community Health Improvement Plan includes an Outcomes Framework that details metrics, goals and strategies and the community partners committed to implementing strategies for the top priorities identified in Community Health Needs Assessment. It is a long-term, systematic effort to collaboratively address complex community issues, set priorities, and coordinate and target resources.

District Health Department No. 2 Implementation Strategy

The Implementation Strategy details which priorities identified in the Community Health Needs Assessment District Health Department No. 2 plans to address and how it will build on previous efforts and existing initiatives while also considering new strategies to improve health. The Implementation Strategy describes actions DHD2 intends to take, including programs and resources it plans to commit, anticipated impacts of these actions, and planned collaboration between DHD2, the hospitals and community partners.

Acknowledgements

The 2021 MiThrive Community Health Needs Assessment is a regional, collaborative initiative led by the Northern Michigan Community Health Innovation Region (CHIR). It is designed to bring together hospitals, local health departments, community-based organizations, coalitions, agencies, and residents across 31 counties in Northern Michigan to collect data, identify strategic issues, and develop plans for collaboratively addressing them.

The MiThrive Core Team

The Northern Michigan Community Health Innovation Region (CHIR) leads the MiThrive community health needs assessment every three years in partnership with hospitals, local health departments and other community partners. The CHIR's backbone organization is the Northern Michigan Public Health Alliance, a partnership of seven local health departments that together serve a 31-county area. This area was organized into three regions—Northwest, Northeast, and North Central—for the 2021 MiThrive community health needs assessment.

Administrators, communication specialists, epidemiologists, health educators, and nurses from the Northern Michigan Public Health Alliance formed the MiThrive Core Team:

- Jane Sundmacher, MEd, Northern Michigan Community Health Innovation Region and MiThrive Lead
- Erin Barrett, MPH, MCHES, Community Themes and Strengths Assessment Team Lead and North Central Region Lead, District Health Department #10
- Emily Llore, MPH, Forces of Change Assessment Lead and Northwest Region Lead, Health Department of Northwest Michigan
- Donna Norkoli, MCHES, Community System Assessment Team Lead and Northeast Region Lead, District Health Department #10
- Jordan Powell, MPH, Community Health Status Assessment Lead, District Health Department #10
- Scott Izzo, MPH, MA, Community Health Status Assessment Team Member, District Health Department #2
- Amy Horstman, MPH, CHES, Community Health Status Assessment Team Member, Health Department of Northwest Michigan
- Laura Laisure, RN, Grand Traverse County Health Department
- Sarah Oleniczak, MPH, MCHES, District Health Department #10
- Rachel Pomeroy, MPH, CHES, Benzie Leelanau District Health Department
- Anna Reetz, Central Michigan District Health Department
- Devin Spivey, MPH, District Health Department #4

Thank you to all who shared their time and expertise in the MiThrive initiative, especially local residents. Thousands of residents and organizations participated in planning the assessments, participating in community events and surveys, collecting data, analyzing data and ranking strategic issues We are especially grateful to members of the MiThrive Steering Committee and Design Team, as well as the Northwest, Northeast, and North Central Workgroups.

MiThrive Steering Committee

- Kerry Baughman, Northwest Michigan Community Action Agency
- Rachel Blizzard, McLaren Central Michigan
- Arlene Brennan, Traverse Health Center
- Ashley Brenner, MidMichigan Health
- Denise Bryan, District Health Department #2 and District Health Department #4
- Dan Buron, Goodwill Northern Michigan
- Amy Christie, North County CMH Authority
- Sarah Eichberger, Michigan State University Extension
- Danielle Gritters, Spectrum Health
- Steve Hall, Central Michigan District Health Department
- Wendy Hirshenberger, Grand Traverse County Health Department
- Kevin Hughes, District Health Department #10
- Beth Jabin, Spectrum Health (Chair)
- Tanya Janes, McLaren Northern MIchigan
- Natalie Kasiborski, PhD, Northern MIchigan Health Consortium
- Michelle Klein, Benzie Leelanau District Health Department
- Shannon Lijewski, Everyday Life Consulting (Vice-Chair)
- Jim Moore, Disability Network of Northern Michigan
- Christi Nowak, Munson Healthcare
- Lisa Peacock, Benzie Leelanau District Health Department and Health Department of Northwest Michigan
- Erica Phillips, MyMichigan Health
- Abby Reeg, Newaygo County Community Collaborative
- Lori Schultz, Michigan Department of Health and Human Services
- Nicole Smith, Northeast Michigan Community Service Agency
- Woody Smith, Avenue ISR

MiThrive Design Team

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- Danielle Gritters, Spectrum Health
- Tanya Janes, McLaren Northern Michigan
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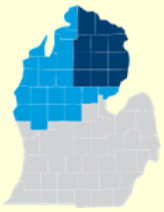
- Teresa Tokarczyk, AuSable Valley CMH Authority
- Jessica Wimmer, Mecosta Osceola Intermediate School District
- David Wingard, PhD, TrueNorth Community Services

MiThrive partners represent many sectors of the community, including:

- Residents
- Businesses
- Collaborative bodies and coalitions
- Community-based organizations
- Community mental health agencies
- Federally qualified health centers
- Grant-making organizations
- Hospitals
- Local health departments
- Municipalities
- Michigan Dept of Health and Human Services
- Physicians and other healthcare providers
- Schools
- Substance use prevention, treatment and recovery services
- Tribal Nations



MiThrive Northeast Workgroup

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- Angie Bruning, Alpena, Montmorency, and Alcona Great Start Collaborative
- Denise Bryan, District Health Department #2 and District Health Department #4
- Dan Connors, Alcona Community Schools
- Dawn Fenstermaker, Great Start Collaborative Cheboygan, Otsego, and Presque Isle Counties
- Heather Gagnon, Alpena, Montmorency, and Alcona Great Start Collaborative
- Steve Hall, Central Michigan District Health Department
- Amy Hepburn, Thunder Bay Community Health Services
- Kevin Hughes, District Health Department #10
- Tanya Janes, McLaren Northern Michigan
- Kathy Jacobsen, Munson Healthcare
- Mary Kushion, Ascension Health
- Laura Marentette, AuSable Valley CMH Authority
- Lisa Peacock, Health Department of Northwest Michigan
- Erica Phillips, MyMichigan Health
- Beth Pomranky-Brady, Ascension Health
- Tara Rybicki, Munson Healthcare
- Jacquelyn Schwanz, Alpena-Montmorency-Alcona ESD
- Jordan Smith, Alcona Health Centers
- Alice Snyder, Crawford County Commission on Aging
- Nena Sork, Northeast Michigan CMH Authority
- Nancy Stevenson, Northern Lakes CMH Authority
- Patty Thomas, Alcona County Resident
- Teresa Tokarczyk, AuSable Valley CMH Authority
- Nancy Wright, AuSable Valley CMH Authority

MiThrive North Central Workgroup

- Ashley Brenner, MyMichigan Health
- Julie Burrell, The Right Place
- Beverly Cassidy, TrueNorth Community Services
- Gene Ford, Standard Process
- Danielle Gritters, Spectrum Health
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- Kevin Hughes, District Health Department #10
- Naomi Hyso, Michigan State University Extension
- Kelsey Killinger, MyMichigan Health
- Cassandre Larrieux, Spectrum Health
- Andrea Leslie, Spectrum Health
- Scott Lombard, Spectrum Health
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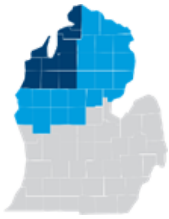
- Kaley Petersen, Spectrum Health
- Mark Petz, Fremont Area Community Foundation
- Beth Pomranky-Brady, Ascension Health
- Abby Reeg, Newaygo County Community Collaborative
- Lynne Russell, Mason County United Way
- Annie Sanders, United Way of Gratiot & Isabella
- Monica Schuyler, Pennies from Heaven Foundation
- Meredith Sprince, Spectrum Health
- Julie Tatko, Family Healthcare
- Shawn Washington, Lake County Habitat for Humanity
- David Wingard, PhD, TrueNorth Community Services
- Jena Zeerip, Spectrum Health



MiThrive Northwest Workgroup

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- Kathleen Jakinovich, Health Department of Northwest Michigan
- Tanya Janes, McLaren Northern Michigan
- Seth Johnson, United Way of Northwest Michigan
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- Jim Moore, Disability Network of Northern Michigan
- Gerry Morris, Project Unity 4 Life
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- Madison Smith, Northwest Michigan Health Services
- Joshua Stoltz, GrowBenzie
- Mindy Taylor, Little Traverse Bay Band of Odawa Indians
- Stephanie Williams, Munson Healthcare
- Lauren Wolf, Benzie-Leelanau District Health Department

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- Cross Jurisdictional Sharing Mini-Grant from the Center for Sharing Public Health Services to implement the Mobilizing for Action through Planning and Partnerships (MAPP) Process' Health Equity Supplement
- Increasing Disability Inclusion in the MAPP Process Grant from the National Association of City and County Health Officials.

END OF REPORT