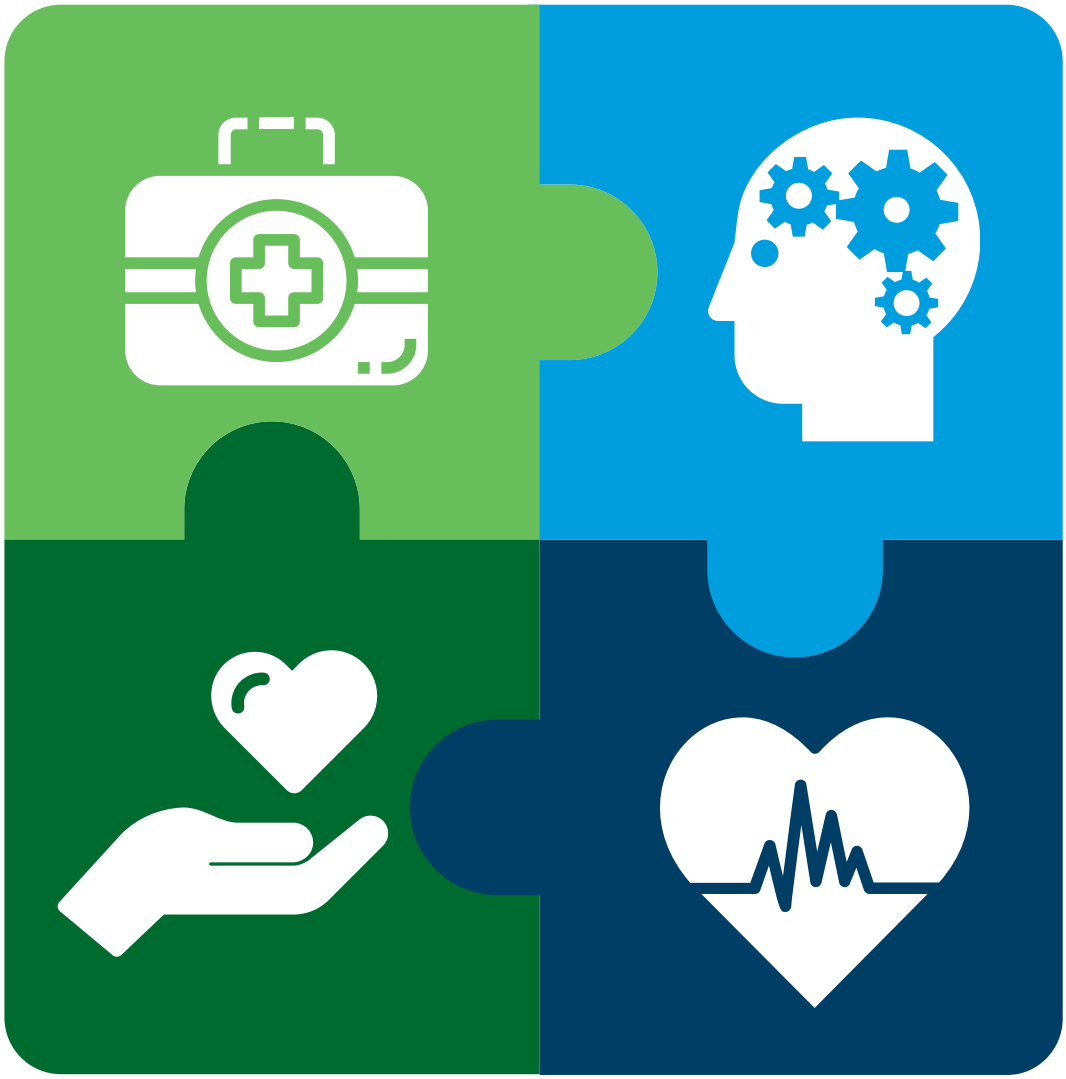
Community Health Improvement Plan

2023



Alcona, Alpena, Cheboygan, Crawford, Iosco, Montmorency, Ogemaw, Oscoda, Otsego, Presque Isle, and Roscommon Counties

NORTHEAST COMMUNITY HEALTH INNOVATION REGION | mithrive

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Contact

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Description of the Process

Overview of MAPP

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

Community Vision Statement

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

View the NMCHIR vision video here

Individuals and Organizations Involved

The Northeast CHIR is composed of **Alcona**, **Alpena**, **Cheboygan**, **Crawford**, **Iosco**, **Montmorency**, **Ogemaw**, **Oscoda**, **Otsego**, **Roscommon**, and **Presque Isle** counties.

These counties are served by several local health departments, including **Central Michigan Health Department**, **Health Department of Northwest Michigan**, **District Health Department No. 2**, **District Health Department No. 4**, and **District Health Department No. 10**.

This regional initiative unites hospitals, local health departments, community organizations, coalitions, businesses, and residents across 31 counties in Northern Michigan every three years. A diverse team of professionals lead this comprehensive assessment. We are thankful for the MiThrive Steering Committee, Design and Core Teams, as well as the Northeast Workgroup and all the partners who represent numerous sectors of the community. This unprecedented collaboration provides us with a complete picture of our communities.

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

HEALTHY PEOPLE *in Equitable Communities*

The Assessments Conducted

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

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

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

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

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

MiThrive Data Collection

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

152 Participants in 3 Community System Assessment regional events.

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

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

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

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

199 Participants in 3 Forces of Change Assessment regional events.

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

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

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

Click here for additional details on the prioritization process.

Access to Health Care

Access to health care affects a person's health and wellbeing. It can prevent disease and disability, detect and treat illness and conditions; and reduce the likelihood of early death and increase life expectancy. We are committed to collaboratively working together to redesign community conditions for improved access to health care.

Goal Metrics

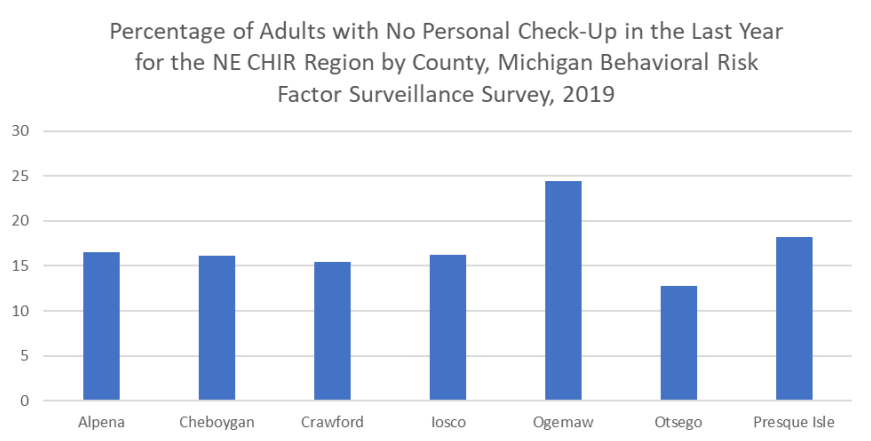
- Process:
  - Number of health literacy trainings
- Intermediate:
  - Increase usage of urgent health care services with decrease in emergency health care services,
  - increased rate of residents who track at least one personal health metric,
  - Track health literacy strategies utilized in the region
- Outcome:
  - Increase proportion of adolescents with a preventative health care visit within the last year,
  - Increase proportion of people with health insurance, Health literacy assessment

CHIP Goal #1

By December 2024, host **three (3)** health literacy training courses for cross-sector partners in the region.

Targeted Root Causes

Staff Shortages, Barriers to Healthcare, and Lack of adequate health literacy.



This data illustrates that there are a significant portion of adults within the Northeast CHIR communities that do not receive annual personal check-ups with a health professional. Increasing support for health literacy within the community would reduce barriers to healthcare and help ensure that the care received is more effective. Data for Alcona, Montmorency, Oscoda, and Roscommon was either suppressed or otherwise not included.

Next Steps for NE MiThrive Workgroup

- Identify health literacy training model(s).
  - Likely that training for staff might look different than training for community.
- Identify health literacy assessment.
- Identify target areas/hosting organizations.
- Identify any special community needs regarding health literacy.
- Identification of partners who will take lead on this goal.

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Goal Metrics

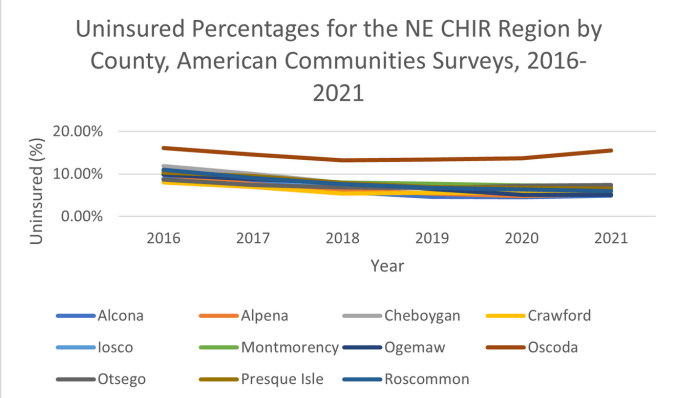
- Process:
  - Number of Community Connections presentations hosted.
  - Percent increase in Community Connections Memorandums of Understandings for the region.
- Intermediate:
  - Increase in referrals for Community Connections
- Outcome:
  - Increase in residents who can find services they need,
  - Increase proportion of people with health insurance

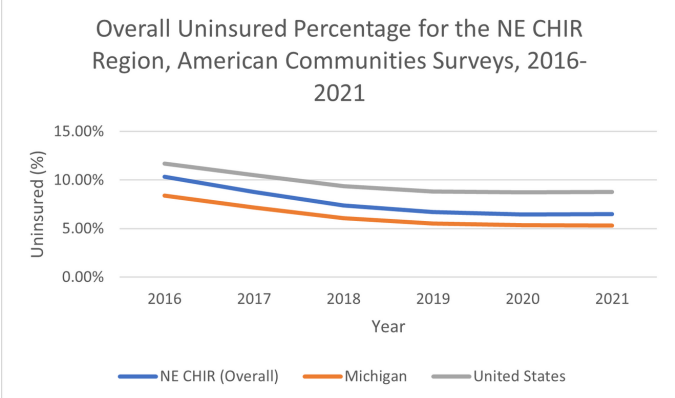
CHIP Goal #2

By December 2024, develop a regional coordinated approach to community health workers and Community Connections efforts across agencies in the region by hosting four (4) Community Connections presentations and increasing the Community Connections Memorandums of Understanding (MOUS) in the regional system by 25%.

Targeted Root Causes

- Staff Shortages,
- Barriers to Healthcare
- Lack of adequate health literacy.





Data gathered from the American Communities Survey show that the Northeast CHIR counties have higher rates of uninsured individuals when compared to Michigan but also have an overall lower rate of uninsured individuals when compared with the United States at large. When comparing amongst the Northeast CHIR counties, it can be observed that Oscoda County has a rate of uninsurance that is generally 1.5 times to 2 times greater than the next highest value (for example, Oscoda County had 15.48% of it's adult population uninsured in 2021, compared to 7.45% for Otsego County in the same year).

Next Steps for NE MiThrive Workgroup

- Work with Community Connections and organizations with Community Health Workers to determine the best time for meetings.
- Work with Community Connections to identify process data streams.
- Work with MDHHS to identify intermediate data stream.
- Work with Community Connections to identify outcome data stream.
- Identification of partners that will take lead on this goal.

Chronic Disease

Chronic diseases can significantly impact an individual's quality of life, as well as put a strain on healthcare resources. We are committed to collaboratively implementing evidence-based interventions to prevent, manage and control chronic diseases in our community. Our goal is to empower individuals and families to adopt healthy behaviors, create an environment that supports and sustains healthy lifestyle choices by working together to redesign community conditions for improved chronic disease rates in our region.

Goal Metrics

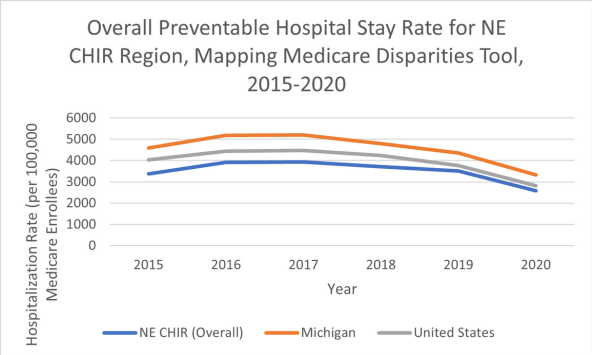
- Process:
  - Identification of partners or local organizations that are interested in Health inAll Policies (HiAP), Presentations to partners or local organizations that are interested in HiAP.
  - 4 (four) cross-sector partners will adopt HiAP approach through their internal leadership structures.
- Intermediate:
  - Nutritional, Physical Activity, and Weight Status,
  - Obesity/overweight,
  - Increase in target population tracking at least one personal health metric
- Outcome:
  - Preventable hospitalization rates,
  - Obesity rates

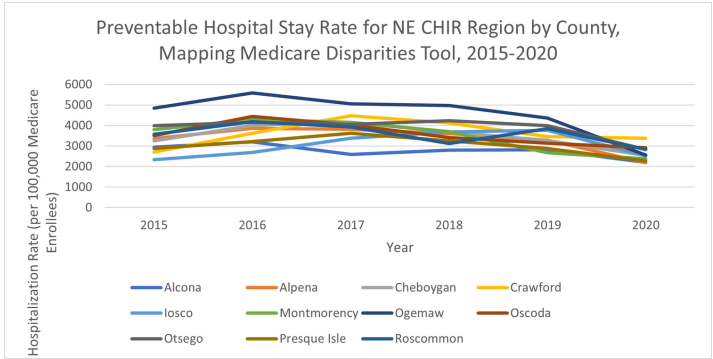
CHIP Goal #3

By December 2024, four (4) cross-sector organizations in the CHIR region with adopt a Health in All Policies Approach through their internal leadership structure.

Targeted Root Causes

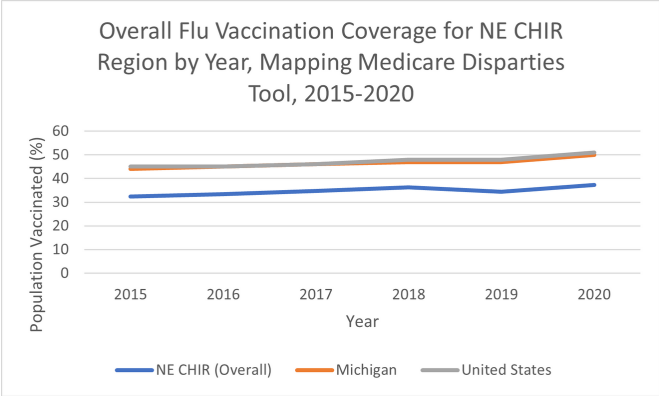
- Healthy Food Access
- Rural Geography
- Social Determinants of Health (SDoH)





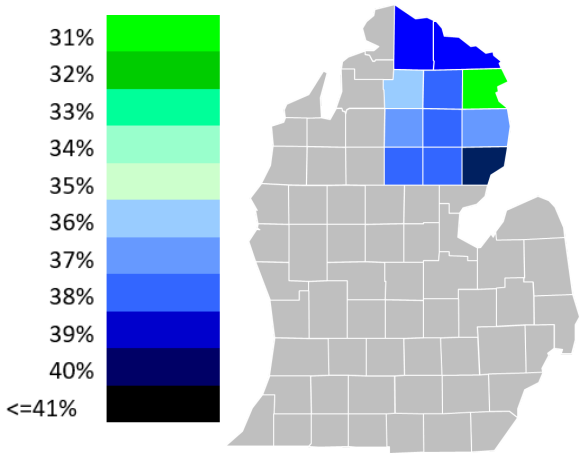
While overall the Northeast CHIR has a lower rate of preventable hospital stays in Medicare patients compared to Michigan and the United States, disaggregating the CHIR data shows that there is wide variation in preventable hospital utilization around the region. Ogemaw County displays a consistently higher rate across time compared to the other counties, although that does appear to be trending towards the average. Across all Northeast CHIR counties, preventable hospitalizations appear to be trending down, a pattern which appears to continue through the first year of the COVID-19 pandemic. Preventable hospital stays are more likely in those that poorly managed chronic conditions.

Chronic Disease



Data from the Mapping Medicare Disparities Tool shows that the Northeast CHIR has an overall vaccination rate that is consistently about 10 percentage points behind the yearly flu vaccination rates for Michigan and the United States. This information was gathered before the COVID-19 mass vaccination campaign in 2021, which was a global event that could have impacted public sentiment regarding vaccinations in ways not shown in this figure. Influenza, or flu, vaccinations are important tools to prevent communicable disease in special populations including the elderly and those with chronic health conditions.

Obesity Rates for NE CHIR Region by County, Behavioral Risk Factor Surveillance System, 2020



Obesity is not only a risk factor for many chronic health conditions, but it is also a potential outcome from chronic conditions and side effect from long-term medication use. Due to this, obesity can be an important leading indicator to illustrate the long-term health of a community. On average, a resident of the Northeast CHIR region would be more likely to be obese when compared to the average Michigan resident. In 2020, the proportion of the population in the counties that were considered obese (possessing a Body Mass Index greater than or equal to 30) ranged from just about 31% of the population in Alpena County to 40% in Iosco County. Although not displayed here, obesity is on the rise for children living in the region as well and points towards systemic causes of obesity and chronic disease in the community that must be addressed.

Next Steps for NE MiThrive Workgroup

- Create a Health in All Policies Action Team
- Identify potential community organization or governments that would be good candidates for HiAP (can be existing partners or others)
- Create presentations to recruit organization leadership,
- Create or identify work plans and templates that can help.
- Perhaps we want to search for a subject matter expert on this topic?
- Create a process or toolkit to help organizations through steps to set up HiAP
- Identification of partners that can take the lead on this goal.

Health in All Places (HiaP)

Health in All Policies (HiAP) is a collaborative approach that integrates and articulates health considerations into policymaking across sectors to improve the health of all communities and people. HiAP recognizes that health is created by a multitude of factors beyond healthcare and, in many cases, beyond the scope of traditional public health activities. The HiAP approach provides one way to achieve the National Prevention Strategy and Healthy People goals and enhance the potential for state, territorial, and local health departments to improve health outcomes. The HiAP approach may also be effective in identifying gaps in evidence and achieving health equity.

Mental Health

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

Goal Metrics

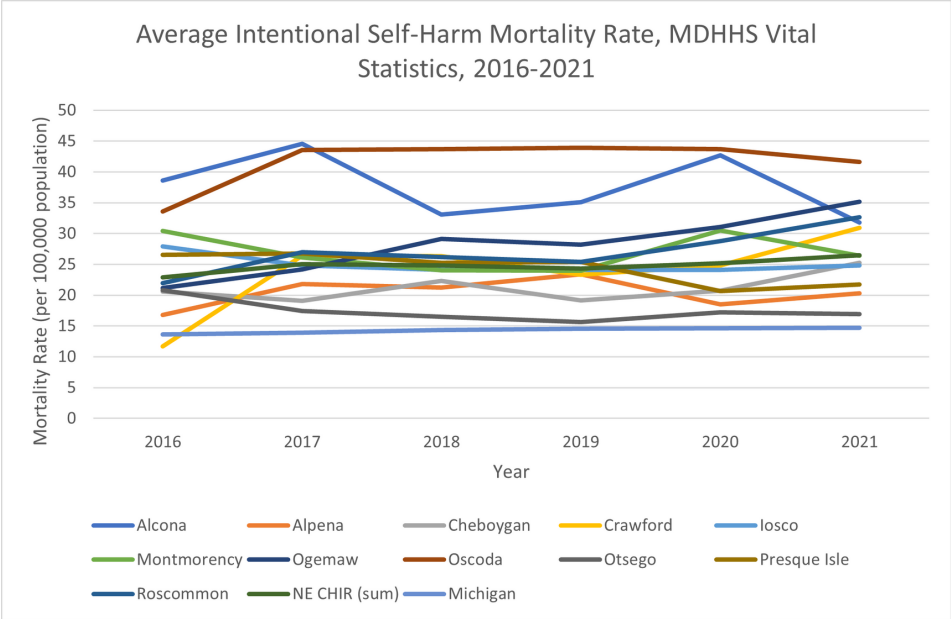
- Process:
  - 10 trainings will be hosted by cross-sector organizations within the CHIR.
- Intermediate:
  - Increase in related skill set for attendees (pre- and post- test comparisons),
  - Increased community knowledge of mental health first aid
  - Increase community knowledge for the need for Michigan Profile for Healthy Youth data from more jurisdictions
- Outcome:
  - Suicide mortality,
  - Attempted or planned suicide,
  - Poor mental health days 14+,
  - Rural health mapping of suicide trends

CHIP Goal #4

By December 2024, ten (10) mental health first aid trainings will be hosted by cross-sector organizations within the CHIR for their staff, clients, or residents.

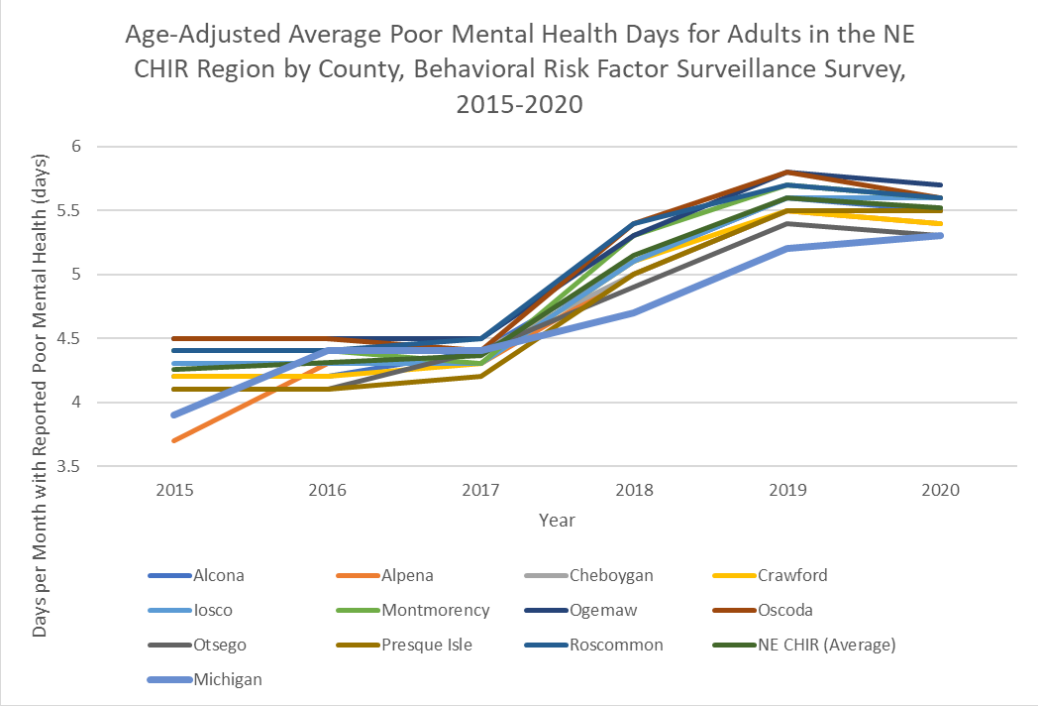
Targeted Root Causes

- Personal Barriers
- Availability of Services
- Community Education and Awareness



The Michigan Department of Health and Human Services Vital Statistics tracks, among other indicators, all fatalities in the state of Michigan and records the associated cause of death. This graph shows that while local figures are more sporadic than what is seen at the state level, it can be concluded that the Northeast CHIR region has a disproportionate number of intentional self-harm deaths in the state over the years 2016 to 2021. This is an important observation, as self-harm is often associated with poor mental health conditions or suicidal ideation. All associated counties display intentional self-harm rates higher than the state average, but mortality rates in Alcona and Oscoda counties appear to be of particular concern.

Mental Health



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Next Steps for NE MiThrive Workgroup

- Work with Community Mental Health Authorities (CMHAs) to determine the best time for meetings.
- Work with current work group partners to begin meeting logistics
- Recruit additional partners from populations of interest (e.g., schools, area agencies on aging, etc.)
- Work with CMHAs to determine best data streams for process and intermediate metrics.
- Identification of partners that can take lead on this goal.

Substance Use Disorder

Substance use disorder (SUD), sometimes referred to as substance misuse disorder, is a chronic condition that affects the brains of individuals who use alcohol, drugs, or other substance have the possibility of creating addiction or other changes in brain chemistry. Treatment for SUD can vary based on the substance in question and personal factors but can often include community support or changes to the built environment. The goal for this group is to provide additional opportunities for support or education surrounding SUDs and to increase the visibility of existing resources within our communities.

Goal Metrics

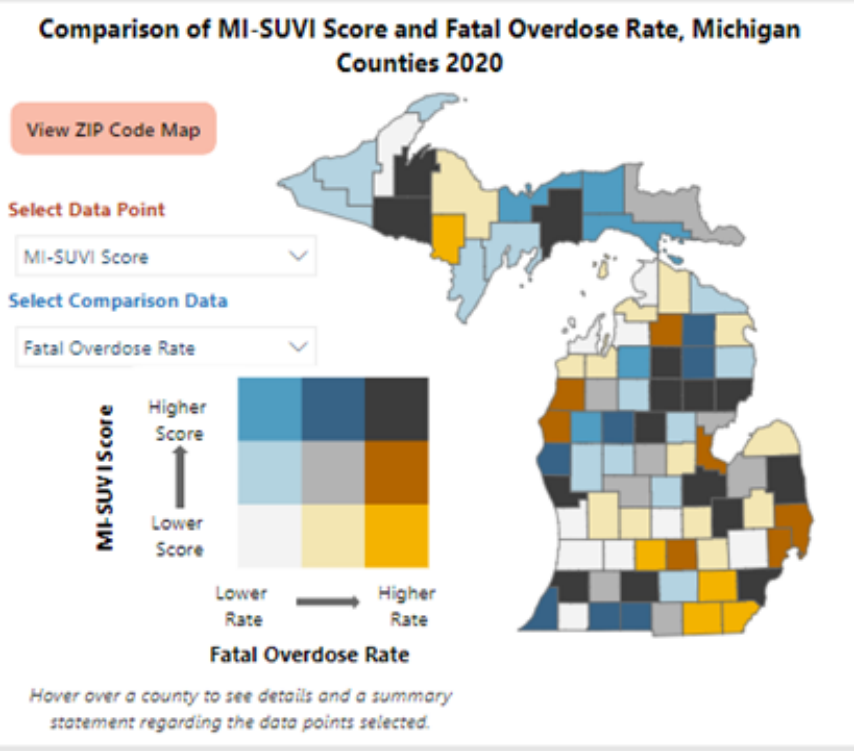
- Process:
  - Eleven naloxone training sessions held,
  - At least one training session held in each county of the NE CHIR region
- Intermediate:
  - Increase in number of naloxone kits distributed,
  - Increase community knowledge for the need for Michigan Profile for Healthy Youth data from more jurisdictions
- Outcome:
  - Overdose death rate,
  - Nonfatal overdose ED visit rate,
  - Opioid related hospitalizations

CHIP Goal #5

By December 2024, partner organizations will have collaborated, organized, and held at least one naloxone training session for the public in every NECHIR county (at least eleven (11) trainings sessions).

Targeted Root Causes

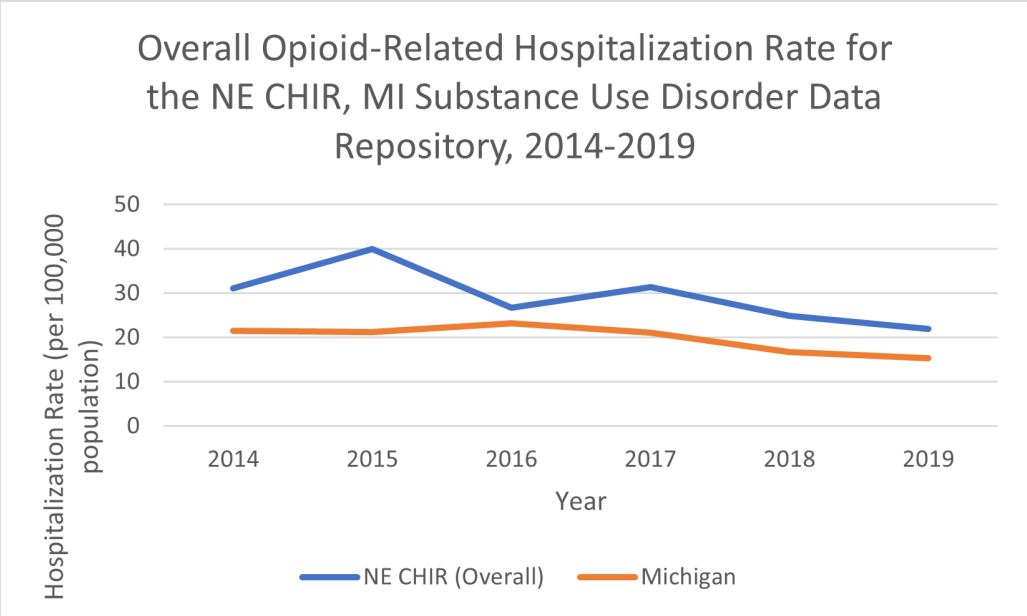
- Stigma,
- Availability of services

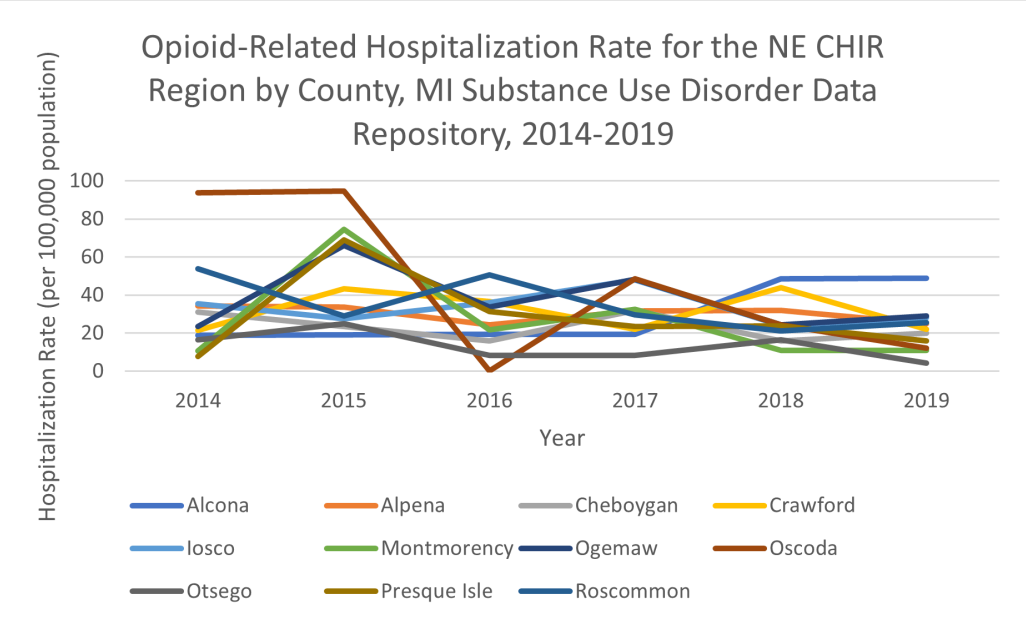


In 2021, the Michigan Department of Health and Human Services released the Michigan Substance Use Vulnerability Index (SUVI), a tool designed to incorporate several substance use-related indicators into a single value that would represent the relative risk or vulnerability that a community experiences from substance use, particularly opioids. This data showed that Northern lower Michigan and the Upper Peninsula are more vulnerable, and exploring the SUVI shows that this is largely due to a lack of resources for individuals with substance use disorders. When comparing the SUVI data to data on overdose fatalities from 2020, there is a high burden of SUVI meeting a high burden of overdose fatalities across the Southern and Western portions of the Northeast CHIR (this includes Crawford, Roscommon, Ogemaw, and Iosco Counties).

The Rural Health Mapping Tool interactive map, which is built and maintained by NORC. The base map is the Prosperity Index at the county level. This index measures the prosperity of each county by standardizing 16 indicators across four social and economic components that are associated with prosperity. A complete picture is created by utilizing both social and economic factors, allowing users to target initiatives to improve quality of life. This index results in a numerical measure depicting the prosperity of a county, with 1 being the most prosperous and 5 being the least.

Substance Use Disorder





Opioid-related hospitalizations are another metric that can be used to better understand the burden of substance use on the community. For the years 2014 to 2019, the Northeast CHIR region had a consistently higher rate of hospitalization when compared with the rest of the state. Wide swings in data, such as is exhibited by the Oscoda County data from 2015 to 2017, are likely due to small base populations that cause any individual opioid-related hospitalization to have a more outsized effect on the overall data.

Next Steps for NE MiThrive Workgroup

- Identify high-quality naloxone training program, or the components of a high-quality training.
- Identify host organizations for each county.
- Determine regional outreach program and materials.
- Identify staff (possibly from multiple organizations or from an organization that already provides naloxone training) that can lead these trainings.
- Record that trainings are taking place, link to comms.
- Identification of partners that will take the lead on this goal.

Substance Use Disorder

Goal Metrics

- Process:
  - 15 CPR trainings supplemented with naloxone training due to partner efforts
- Intermediate:
  - Number of naloxone kits distributed (MDHHS),
  - Increase community knowledge for the need for Michigan Profile for Healthy Youth data from more jurisdictions
- Outcome:
  - Overdose death rate,
  - Nonfatal overdose ED visit rate,
  - Opioid related hospitalizations

CHIP Goal #6

By December 2024, partner organizations will have identified those organizations providing CPR instruction in the community and cause fifteen (15) CPR training session to be supplemented with additional naloxone overdose training.

Targeted Root Causes

- Stigma
- Availability of services

Highlighted Data

- Substance Use Vulnerability Index data (MDHHS, 2020) (see page 10)
- Fatal Overdose Rates (MDHHS, 2020) (see page 10)

Next Steps for NE MiThrive Workgroup

- Identify those organizations that provide CPR training.
- Determine if they are currently providing naloxone training or have an approved naloxone training program.
- Reach out to those groups to partner with MiThrive, determine if they have.
- Identify high-quality naloxone training program, or the components of a high-quality training.
- Share high-quality naloxone training program with CPR training organizations.
- Record that trainings are taking place as expected.
- Identify partners that will take the lead on this goal.