Central Michigan District Health Department

Promoting Healthy Families, Healthy Communities

mithrive

2021 COMMUNITY HEALTH NEEDS ASSESSMENT

Arenac, Clare, Gladwin, Isabella, Osceola, and Roscommon Counties

June 2023

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Promoting Healthy Families, Healthy Communities

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A MESSAGE FROM CMDHD'S HEALTH OFFICER

June 1, 2023

In 2021, Central Michigan District Health Department (CMDHD) participated in MiThrive - a 31-county regional approach to developing a Community Health Needs Assessment to better inform partnerships across our six-county service area and create greater impact and success in improving the health of the communities we serve. The CMDHD Community Health Needs Assessment report is a subset of the MiThrive full report and identifies the most pressing health issues in our communities and helps us determine what more can be done to improve the health of residents in the counties of Arenac, Clare, Gladwin, Isabella, Osceola, and Roscommon.

The purpose of this report is to serve as a foundation for community decision-making and improvement efforts. Key objectives include:

- Describe the current state of health and well-being in the six-county Central Michigan District Health Department jurisdiction.
- Describe the processes used to collect community perspectives.
- Describe the process for prioritizing Strategic Issues within the 31-county region of Northern Michigan, and specifically for each of the three sub-regions of the Community Health Innovation Regions of Northern Michigan: Northwest CHIR, Northeast CHIR and the North Central CHIR.
- Identify community strengths, resources, and service gaps.

CMDHD appreciates funding and/or resources for completing the regional MiThrive Community Health Needs Assessment from Spectrum Health, McLaren Northern Michigan, Munson Healthcare, District Health Department #4, District Health Department #2, District Health Department #10, Health Department of Northwest Michigan, Grand Traverse County Health Department, and Benzie-Leelanau District Health Department.

Should you have any questions on our efforts in completing this assessment, please feel free to contact me at (989)773-5921 ext. 1421 or by email at shall@cmdhd.org.

Again, I hope you find this a beneficial tool.

Sincerely,

Steve Hall, R.S., M.S.
Health Officer
Central Michigan District Health Department

Central Michigan District Health Department
Promoting Healthy Families, Healthy Communities

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 Health Needs 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

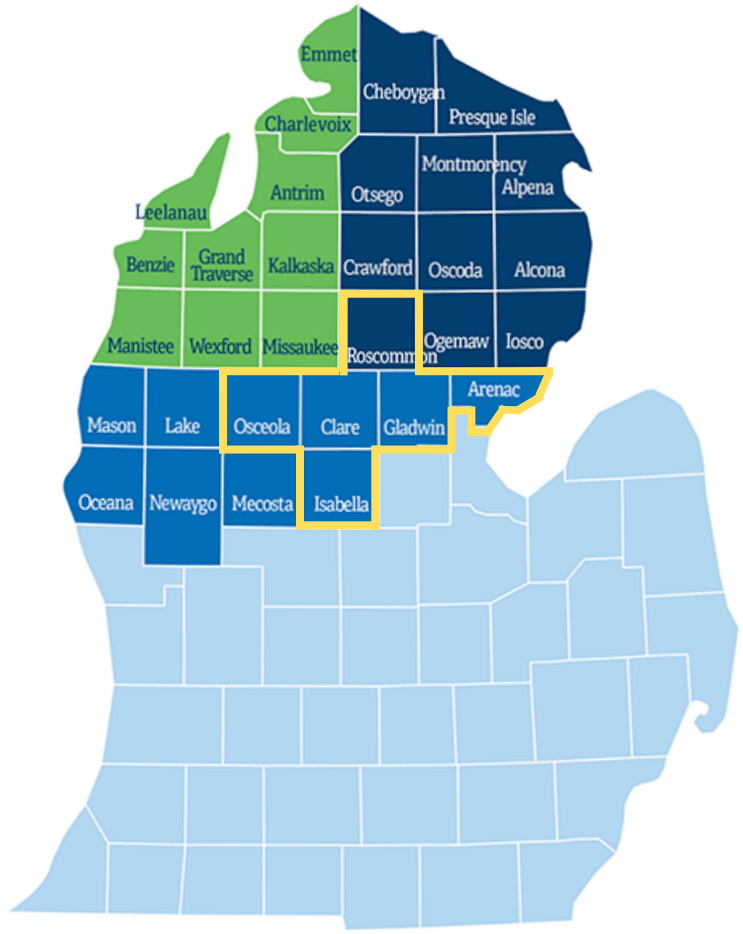
The purpose of this report is to serve as a foundation for community decision-making and improvement efforts. Key objectives include:

- Describe the current state of health and well-being in the Central Michigan District Health Department 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.

Central Michigan District Health Department jurisdiction includes Arenac, Clare, Gladwin, Isabella, Osceola, and Roscommon Counties, which are located in the Northeast and North Central CHIR Regions. Of the four MiThrive assessments, two were conducted at the county level and two were conducted within the MiThrive regions.



Central Michigan District Health Department Counties by MiThrive Region

Northeast Region	North Central Region	
Roscommon	Arenac Clare Gladwin	Isabella Osceola

Data Collection

The findings detailed throughout this report are based on data collected through a variety of primary data collection methods and existing statistics. From the beginning, it was our goal 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?" The purpose of this assessment is to collect quantitative secondary data about the health and well-being of residents and communities. We collected approximately 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 US Census Bureau.
- **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?" 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 community collaborative meetings 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?" and "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 to achieving health equity is to understand current health disparities, **diverse community partners were invited to join the MiThrive Steering Committee, Design Team, and Workgroups. The partners 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 & 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 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

Key Findings

Following analysis of primary and secondary data collected during the 2021 MiThrive Community Health Assessment, 12 significant health needs emerged in each of the MiThrive Regions (North Central and Northeast). 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.

The purpose of this ranking process was to prioritize Strategic Issues to collectively address in a collaborative Community Health Improvement Plan. Following the Data Walk and Priority Setting Events, MiThrive partners and participants refined the prioritized Strategic Issues to remove any jargon, clarify language, and wordsmith.

Significant Health Needs by Region (unranked)

Health Need	Northeast Region	North Central Region
Access to Healthcare & Chronic Disease Prevention	X	X
Economic Security	X	X
Equity	X	X
Housing Security	X	X
Mental Health	X	X
Safety and Well-Being	X	X
Substance Use	X	X
Transportation	X	X
Broadband Access		X
Food Security		X
Healthy Weight	X	X
COVID-19	X	

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

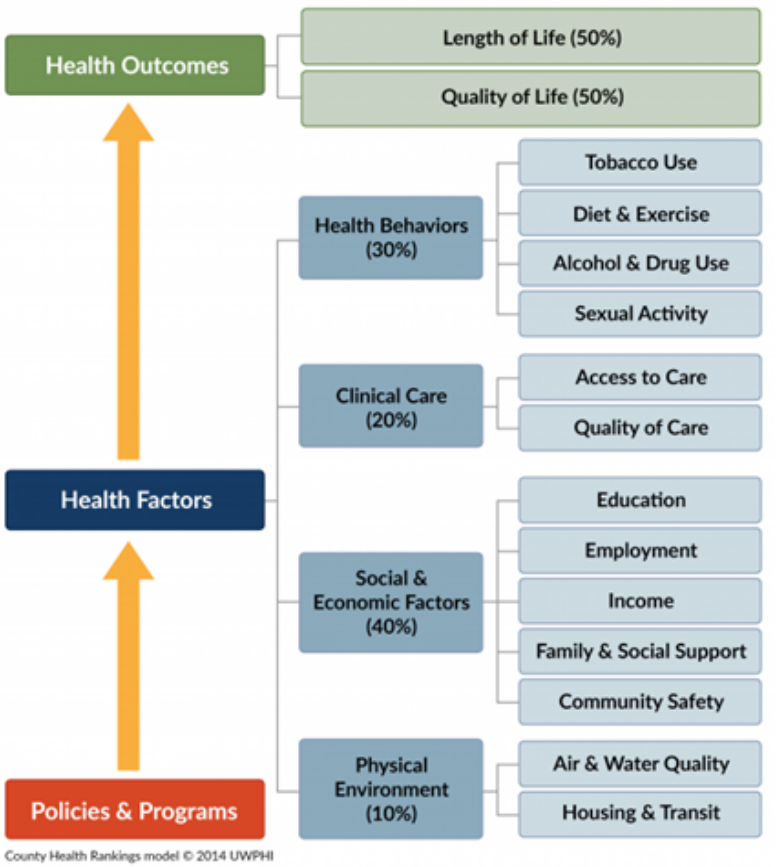
1. How do we increase access to quality mental health services while increasing resiliency and wellbeing for all?
2. How do we increase access to healthcare?
3. How do we reduce chronic disease rates in the region?
4. How do we foster a community where everyone feels economically secure?

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 wellbeing for all?
3. How do we increase access to healthcare?
4. How do we reduce chronic disease rates in the region?

Introduction

We all have a role to play in our community's health. Many factors combine to determine the health of a community. In addition to disease, health is influenced by education level, economic status, and many other 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.



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 of health. 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 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 Workgroups. 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 to 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, 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 the list of organizations that participated in MiThrive.)

Health Equity

There is more to good health than healthcare. **A number of factors affect people's health that people do not often think of as healthcare concerns, like where they live and work, the quality of their neighborhood, how rich or poor they are, their level of education, or their race or ethnicity.** These social factors contribute greatly to an individual's length of life and quality of 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 jobs with fair pay, quality education and housing, safe environments, and healthcare. All 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

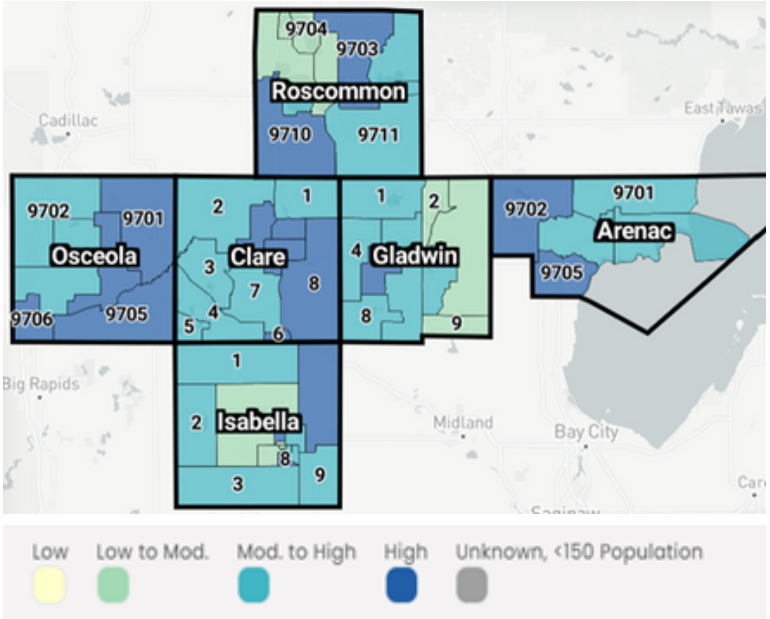
The Community Health Status Assessment identifies priority community health and quality of life issues. It answers the questions "How healthy are our residents?" and "What does the health status of our community look like?" The answers to these questions were measured by collecting 100 secondary indicators 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 below, census tracts in the CMDHD jurisdiction have Social Vulnerability Indices at "high" or "moderate to high" in most of the counties.

Social Vulnerability Index by Census Tract in the CMDHD 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 53 statistics scored above 1.5 across all counties in the CMDHD jurisdiction, indicating they were worse than the National overall or State rates:

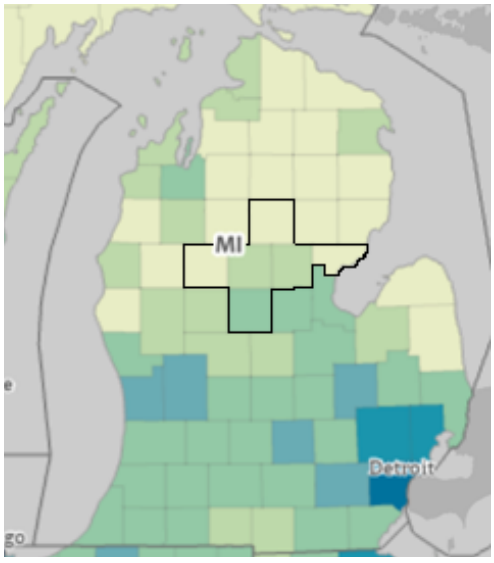
- Median household income (dollars)
- Median household income (dollars)
- ALICE Households (%)
- Households below federal poverty level (FPL) (%)
- Families living below poverty level (%)
- Population below the poverty level (%)
- Children below poverty level (%)
- Unemployment rate (%)
- Students Not Proficient in Grade 4 English (%)
- High school graduate or higher (%)
- Bachelor's Degree or higher (%)
- Uninsured (%)
- Average HSPA Score - Mental Health
- Adults: No personal health check up in the past year (%)
- Preventable Hospital Stays (per 100,000 Medicare enrollees)
- Fully immunized toddlers aged 19-35 mo (%)
- Homes with broadband internet (%)
- Severe quality problems with housing (%)
- Median value of owner-occupied homes
- Gross rent is >=35% of household income (%)
- Gross mortgage is >=35% of household income (%)
- Number of Evictions (rate)
- Child abuse/Neglect Rate (per 1,000)
- Teens with 2+ ACES (%)
- Child food insecurity (%)
- Population food insecurity (%)
- Teens with 5+ fruits/veg per day (%)
- No household vehicle(%)
- Political Participation, (2020 voter turnout as a proportion of pop >=18)
- All cancer incidence (per 100,000)
- Breast Cancer incidence (per 100,000)
- Colorectal Cancer incidence (per 100,000)
- Lung and bronchus cancer incidence (per 100,000)
- Ever told diabetes (adults)
- Ever told heart disease (adults)
- Self-reported health assessment fair or poor
- Pneumonia incidence (per 100,000)
- Poor mental health 14+ days (adults)
- Obesity (teens) (%)
- Obesity (adults) (%)
- Binge drinking (adults) (%)
- Used prescription drugs without prescription (teens) (%)
- Had a drink of alcohol in past 30 days (teens)(%)
- Vaped in past 30 days (teens) (%)
- All causes of death (per 100,000)
- All Cancer Mortality (per 100,000)
- Diabetes Mortality (per 100,000)
- Heart Disease Mortality (per 100,000)
- YPLL Pneumonia/Flu Mortality (per 100,000)
- Motor vehicle crash involving alcohol Mortality (per 100,000)
- Unintentional injury Mortality (per 100,000)
- Intentional self-harm Mortality (per 100,000)
- Chronic Lower Respiratory Disease Mortality (per 100,000)
- Kidney Disease Mortality (per 100,000)

Please see Appendix B for values for the top 25 indicators for each county within the CMDHD jurisdiction.

Geography and Population Rurality by County

Health Jurisdiction Demographics

CMDHD's jurisdiction is situated in a rural area of the lower peninsula of Michigan in the center and 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 188,583 individuals. Numerous social and economic factors impact the health of the residents and their communities. High numbers of individuals living in poverty and with disabilities are just two examples of some of the factors that negatively impact these communities.



Persons per square mile by county (or county equivalent)

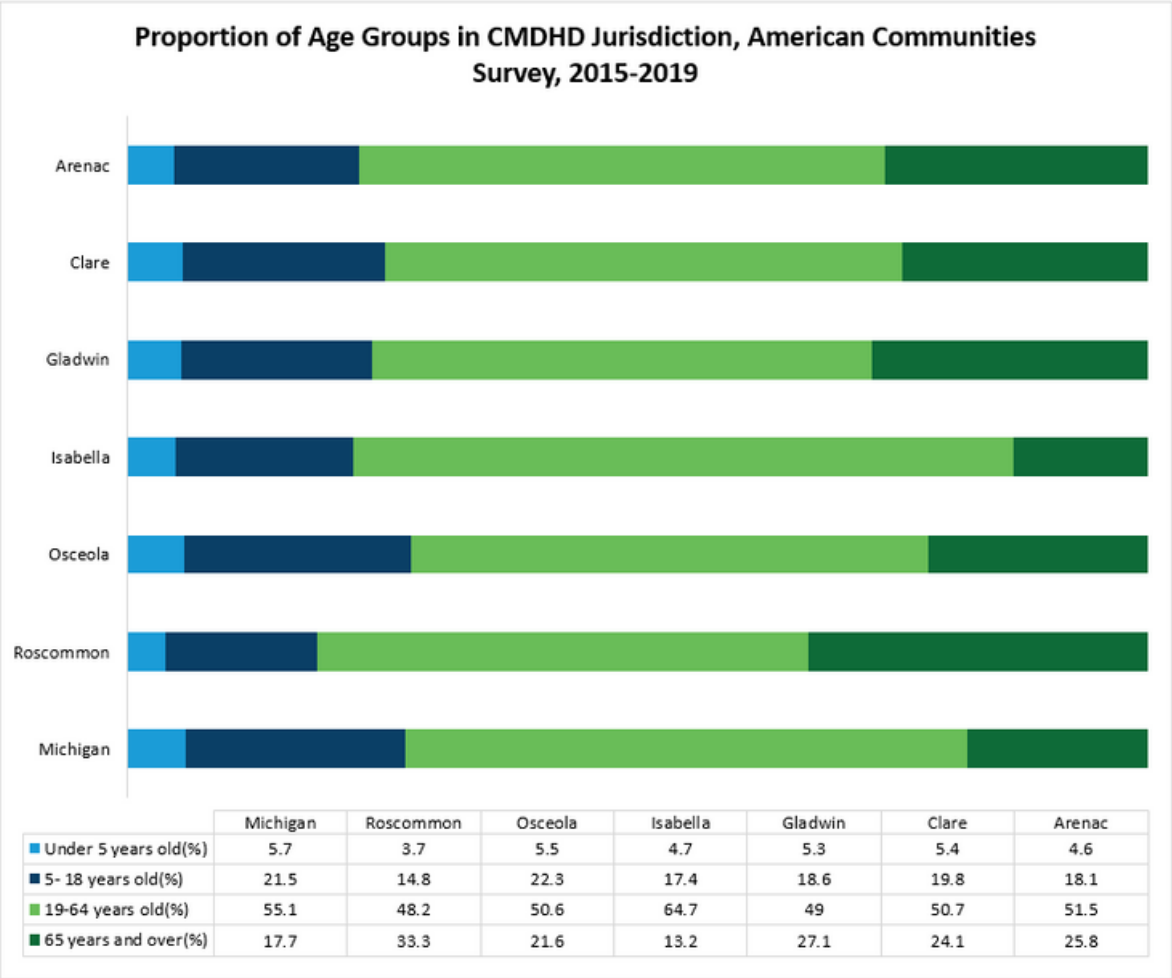
- 10,000 or more
- 5,000 to 9,999
- 2,000 to 4,999
- 1,000 to 1,999
- 500 to 999
- 100 to 499
- 50 to 99
- Less than 50

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

Population and age: Total population in 2019 for each county ranges from 14,833 in Arenac County to 69,872 in Isabella County. When broken down by age group, Roscommon County has the lowest percent of people under age 5 at 3.7% and Osceola has the highest at 5.5%. All six counties have a lower percent of residents under age 5 than Michigan. In the under 18 age group, Roscommon County has the lowest percent at 14.8% and Osceola has the highest at 22.3%. Five counties are under the Michigan percent of 21.5%. Five counties have higher percentages of individuals aged 65 and over compared to the Michigan rate of 17.7%. CMDHD's counties range from 13.2% in Isabella County to 33.3% in Roscommon County. Arenac, Clare, Gladwin, and Osceola are above 20% aged 65 and older.

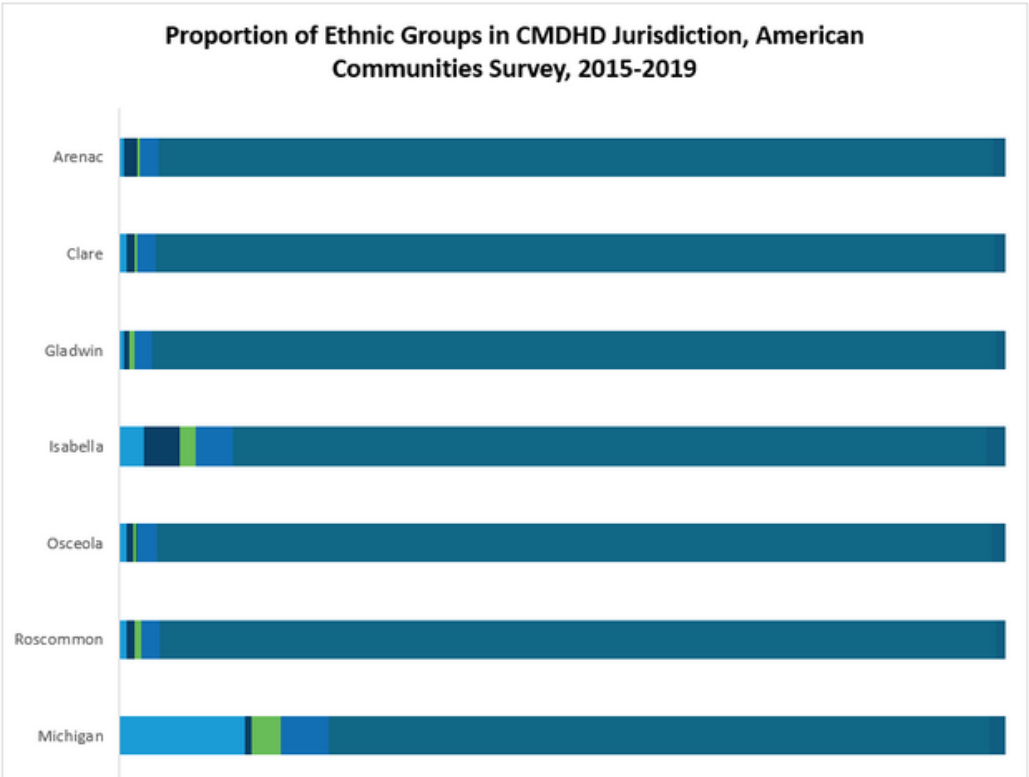
The composition of the population is also important, as health and social issues can impact groups in different ways, and different strategies may be more appropriate to support these diverse groups. All six counties in the CMDHD jurisdiction are predominately White, with the highest percentage in Gladwin and Clare Counties (95.3%, 94.6%). The highest percentage of Blacks is reported in Isabella County (2.7%). The highest percent of Hispanic population is found in Isabella County (4.1%). The highest percent of American Indian population is reported in Isabella County (4.1%), followed by Arenac County (1.4%).

Most of the CMDHD jurisdiction falls within the East Central Michigan region, in which the Saginaw Chippewa Indian Tribe is the largest federally-recognized indigenous tribe. (Indigenous Peoples of Michigan - Indigenous Resources - Research Guides at University of Michigan Library [umich.edu])



	Michigan	Roscommon	Osceola	Isabella	Gladwin	Clare	Arenac
Under 5 years old(%)	5.7	3.7	5.5	4.7	5.3	5.4	4.6
5- 18 years old(%)	21.5	14.8	22.3	17.4	18.6	19.8	18.1
19-64 years old(%)	55.1	48.2	50.6	64.7	49	50.7	51.5
65 years and over(%)	17.7	33.3	21.6	13.2	27.1	24.1	25.8

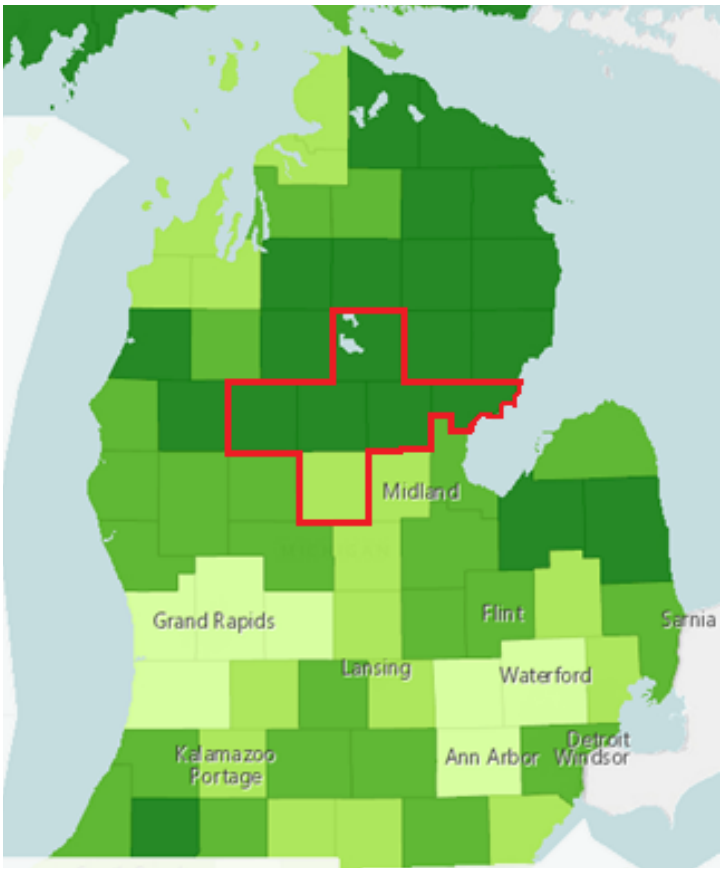
Arenac, Clare, Gladwin, Osceola, and Roscommon Counties have a higher proportion of adults over the age of 65 than Michigan overall.



	Michigan	Roscommon	Osceola	Isabella	Gladwin	Clare	Arenac
Black or African American (%)	14.1	0.7	0.8	2.7	0.5	0.8	0.5
American Indian and Alaska Native (%)	0.7	1	0.7	4.1	0.6	0.9	1.4
Asian (%)	3.4	0.7	0.3	1.8	0.5	0.3	0.3
Native Hawaiian/Other Pacific Islander (%)	0	0	0.1	0	0	0	0.1
Hispanic or Latino (%)	5.3	2.1	2.3	4.1	2	2.1	2
Non-Hispanic White (%)	74.7	94.4	94.2	85.2	95.3	94.6	94.3
Other (%)	1.8	1.1	1.6	2.1	1.1	1.3	1.4

Arenac, Clare, Isabella, and Roscommon Counties have a higher proportion of American Indian and Alaskan Native populations than Michigan overall.

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



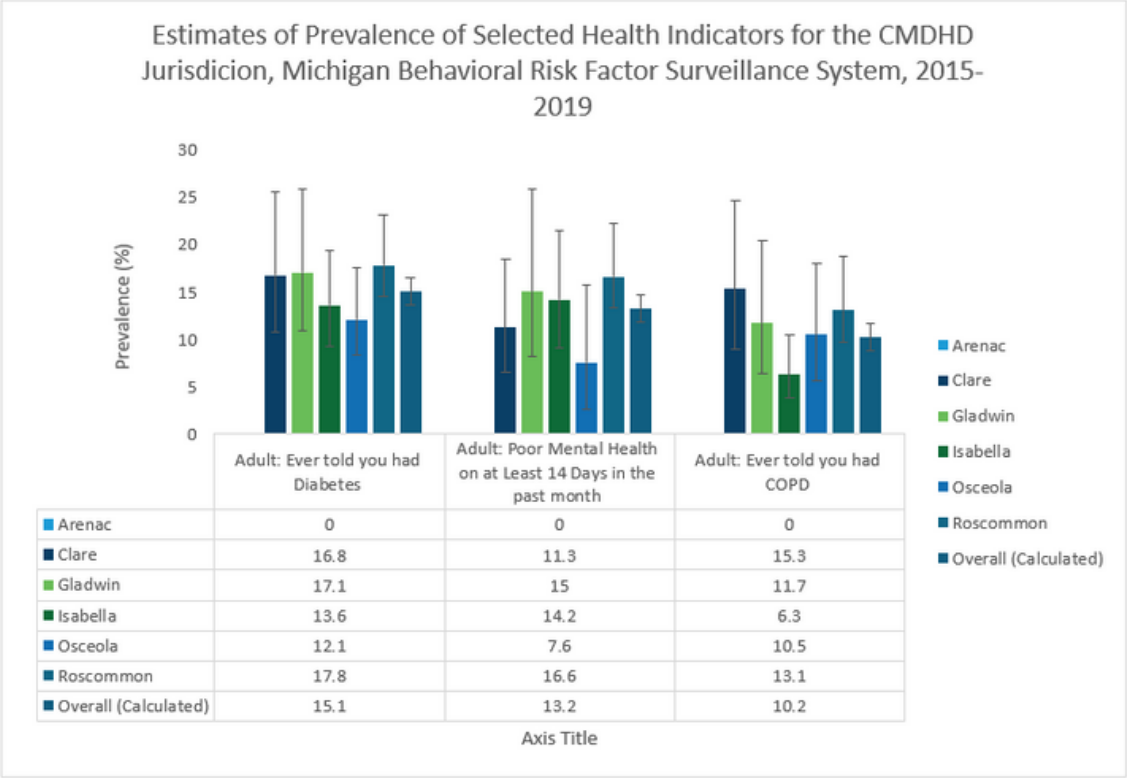
A greater proportion of people in the CMDHD jurisdiction – about 20.4% - have a disability compared to the state (14.2%).

Map Legend

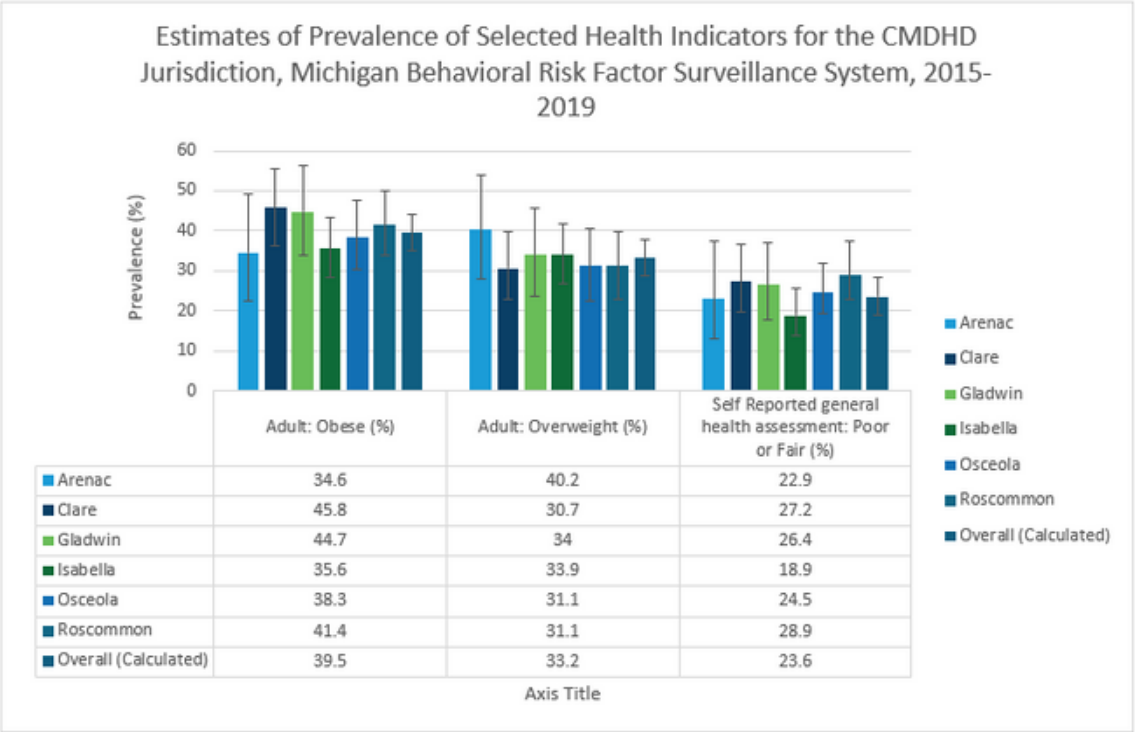
Disabled Population, Percent by County, ACS 2015-19

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

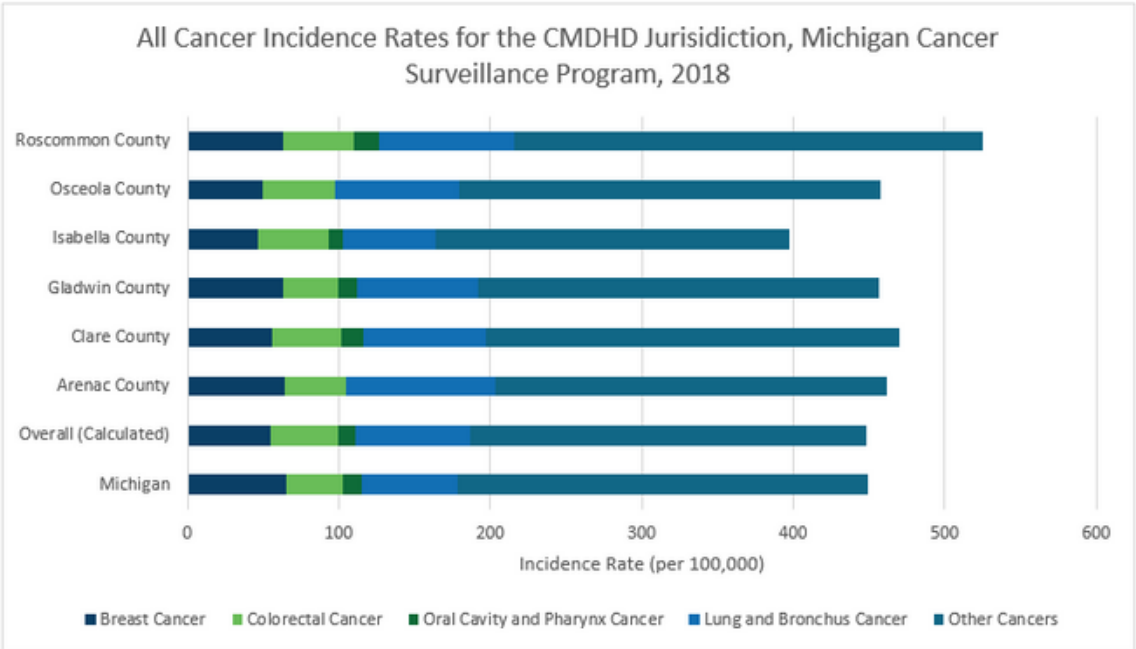
https://careshq.org/map-room/, 2/16/2022



The Michigan Behavioral Risk Factor Survey (BRFSS) asked adults within all CMDHD's counties if a medical professional has ever told them they had diabetes. CMDHD overall had 15.1% of its residents report being told they had diabetes. Roscommon (17.8%) and Gladwin (17.1%) have the highest prevalence, while Osceola (12.1%) had the lowest. For adults reporting at least 14 days having poor mental health, Roscommon County (16.6%) had the highest prevalence. Individuals ever being told they had chronic obstructive pulmonary disease (COPD) was highest in Clare County (15.3%). Arenac County was suppressed for all of these health indicators.



All the counties have a high prevalence of individuals who are overweight or obese. The BRFSS shows that Clare (45.8%) and Gladwin (44.7%) Counties have the highest prevalence of obesity, while Arenac (40.2%) and Gladwin (34.0%) Counties have the highest prevalence of individuals who are overweight. District-wide prevalence of individuals who are overweight and obese continues to increase year after year. This partially contributes to the next indicator, which is self-reported general health. For this indicator, 23.6% of CMDHD counties reported having poor or fair general health. Roscommon County had the highest prevalence of poor or fair general health at 28.9%.



In 2018, Isabella County had the lowest of all cancer incidence at 397.2, while Roscommon County had the highest incidence at 525.6. Michigan's incidence is 449.6, while CMDHD overall is slightly lower at 446.1. Within the CMDHD jurisdiction, five counties (Arenac, Clare, Gladwin, Osceola, and Roscommon) have cancer incidence rates higher than the state. CMDHD has lower breast, oral cavity, and pharynx cancer incidence rates compared to the state. For breast cancer, Arenac County's rate of 64.4 has the highest incidence; however, it is lower than Michigan's rate of 65.7. For oral cavity and pharynx cancer, two out of six counties are higher than Michigan's rate of 12.1: Clare at 13.9 and Roscommon at 16.5. Arenac and Osceola Counties have been suppressed for oral cavity and pharynx cancer. CMDHD has a higher incidence rate than the state at 75.9 to 62.9 for lung and bronchus cancer. Arenac County has the highest rate at 99.1, followed by Roscommon at 89.3. Overall, five out of six counties have lung and bronchus cancer incidence rates higher than the state. For colorectal cancer, CMDHD has a higher incidence rate than the state at 44.8 to 37.3. Five out of six counties have colorectal cancer incidence higher than the state. Osceola has the highest incidence at 46.9 followed by Isabella at 46.7.

CMDHD 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
Michigan	647.7	710.3	780.6	987.8
CMDHD	0.0	894.6	620.4	956.4
Arenac	0.0	0.0	421.3	862.9
Clare	0.0	0.0	675.4	998.5
Gladwin	0.0	0.0	463.4	766.0
Isabella	0.0	894.6	655.9	871.8
Osceola	0.0	0.0	553.1	764.1
Roscommon	0.0	0.0	482.6	650.7

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 CMDHD due to the low number of individuals who fall into the more affluent category. The highest mortality rate (836.3 deaths per 100,000) within the CMDHD 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. Clare is the only county to have a mortality rate over the state for the 20% to 100% poverty level.

Approximate Mortality Rates by Race and Sex for the CMDHD Jurisdiction Service Area, MDHHS Vital Statistics, 2021

	WHITE			BLACK			OTHER		
Mortality Rates (per 100,000)	Total	Male	Female	Total	Male	Female	Total	Male	Female
Michigan	1,190	1230	1140	1260	1410	1130	380	400	370
CMDHD	1,389	1481	1299	390	470	0	1000	1040	970
Arenac	1700	1760	1630	0	0	0	0	0	0
Clare	1680	1870	1480	*	0	*	*	*	*
Gladwin	1780	1870	1700	0	0	0	*	0	*
Isabella	920	920	920	390	470	*	1000	1040	970
Osceola	1190	1280	1100	0	0	0	*	*	*
Roscommon	1970	2220	1730	0	0	0	*	*	*

In Michigan, the crude mortality rate for black individuals is higher than white; however, in CMDHD, there is a higher mortality rate for white individuals than black. Residents of Isabella County that classify as Other have a higher mortality rate than individuals who classify as white. 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 CMDHD counties for white, black, and other races.

Mortality Rate (per 100,000)	Male	Female	Total
Michigan	1084.3	822.9	951.6
Overall (Calculated)	1088.1	880.0	983.2
Arenac	1112.0	907.3	1011.0
Clare	1239.7	905.6	1071.7
Gladwin	1140.5	911.7	1027.1
Isabella	1033.1	909.5	969.6
Osceola	915.3	706.9	812.5
Roscommon	1153.0	873.0	1012.5

Mortality Rates for Males by Age Group in CMDHD 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	55.1	134.8	285.9	435.1	890.0	1973.0	7518.1
CMDHD	68.9	90.4	418.9	486.0	926.1	2042.5	7176.9
Arenac	177.9	84.8	543.5	349.2	790.2	1688.1	7706.1
Clare	79.6	161.1	691.1	505.1	1105.9	2358.3	7740.2
Gladwin	48.1	260.9	474.7	630.4	1056.5	1585.8	7339.5
Isabella	98.4	54.4	270.2	449.8	779.9	2204.7	6989.0
Osceola	0.0	47.2	234.0	154.7	1095.7	1793.2	6447.2
Roscommon	0.0	127.8	681.0	883.4	778.2	2292.2	6899.4

Mortality Rates for Females by Age Group in CMDHD 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	50.1	58.4	145.6	425.9	521.0	1831.2	5664.5
CMDHD	50.2	48.8	146.2	378.7	764.7	1145.9	6507.9
Arenac	0.0	0.0	278.6	501.9	568.6	1291.8	6852.6
Clare	0.0	41.2	136.3	417.7	753.5	1209.1	6958.3
Gladwin	53.9	0.0	0.0	535.6	867.7	1276.9	6828.9
Isabella	39.2	42.9	173.9	304.6	807.1	1078.5	7069.5
Osceola	50.4	155.1	0.0	387.3	417.9	1148.0	5160.6
Roscommon	206.5	72.7	326.8	260.2	1038.8	994.1	5826.4

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

Of the counties with available data, three -- Arenac, Clare, and Isabella -- have a higher male mortality rate than Michigan for ages newborn to 14 years. Additionally, two counties -- Clare and Gladwin -- have a higher male mortality rate than Michigan for ages 15-29. Clare County has the highest mortality rate for males ages 30-39, and Roscommon County has the highest mortality rate for males ages 40-49.

Three counties -- Gladwin, Osceola, and Roscommon -- have a higher female mortality rate than Michigan for ages newborn to 14 years old. Additionally, two counties -- Osceola and Roscommon -- have a higher female mortality rate than Michigan for ages 15-29. Roscommon County has the highest mortality rate for males ages 30-39, and Gladwin has the highest mortality rate for males ages 40-49.

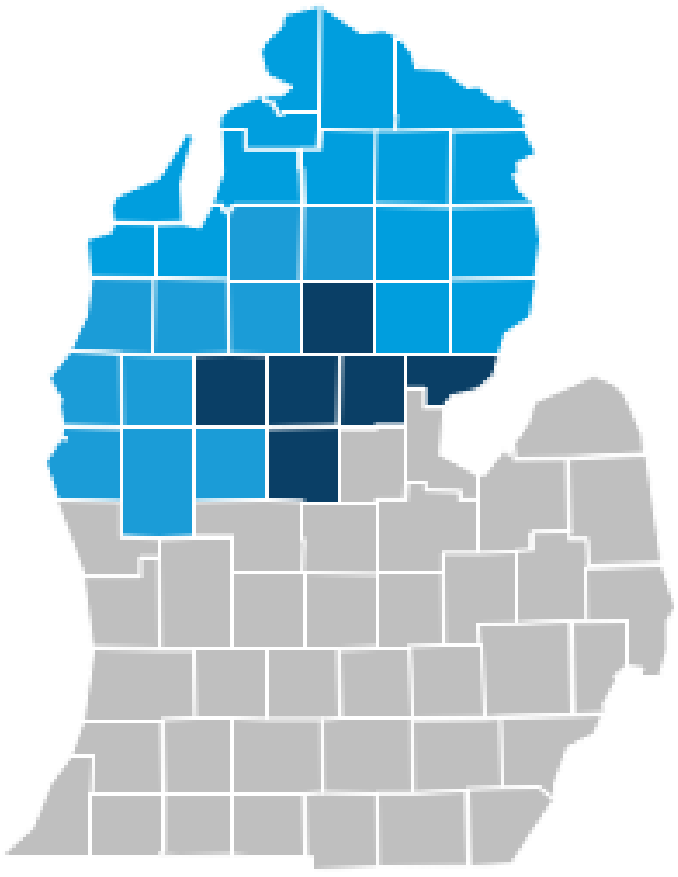
• Community Themes and Strengths Assessment

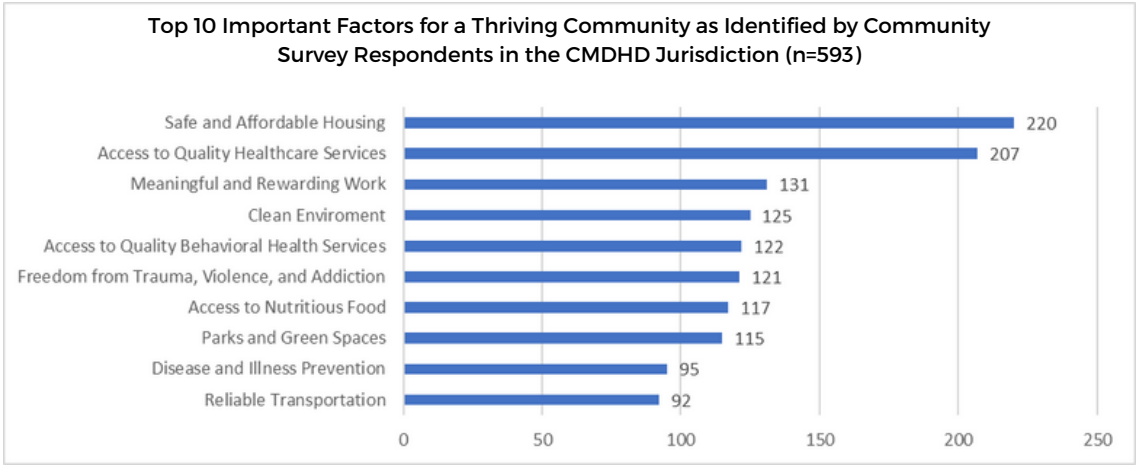
The Community Themes and Strengths Assessment provides a deep understanding of the issues that residents feel are significant by answering the questions "What is important to our community?" and "How is quality perceived in our community?" and "What assets does our community have that can be used to improve well-being?" For the Community Themes and Strengths Assessment, the MiThrive Design Team created 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 Appendixes C1, C2, and C3 for assets identified for the CMDHD service area.

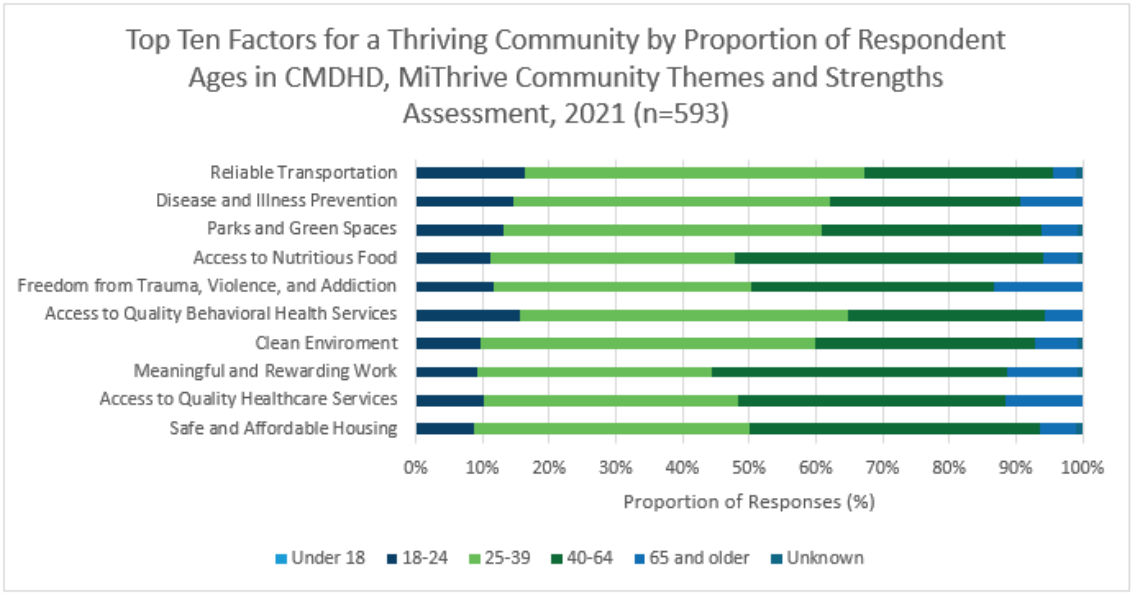
Community Surveys were administered electronically and via paper format in both English and Spanish. The electronic version of the survey was available through an electronic link and QR code. The survey was open from Monday, October 4, 2021, to Friday, November 5, 2021.

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. A total of 593 community survey responses were collected in the CMDHD jurisdiction of the following counties: Arenac (116), Clare (116), Gladwin (82), Isabella (148), Osceola (75), and Roscommon (56).

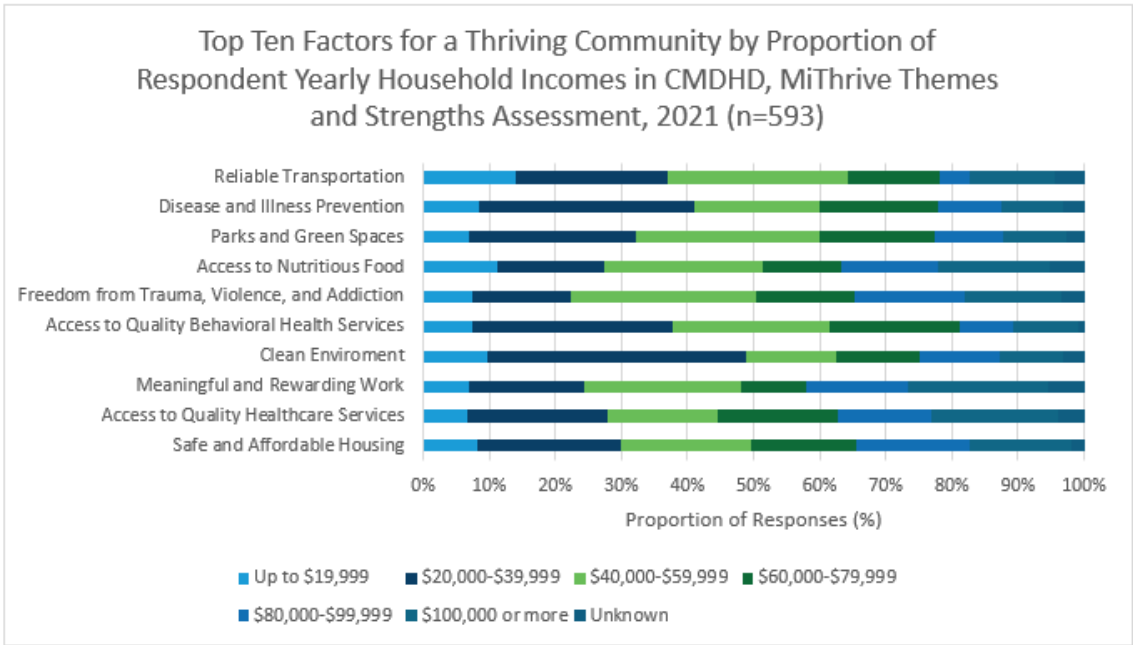




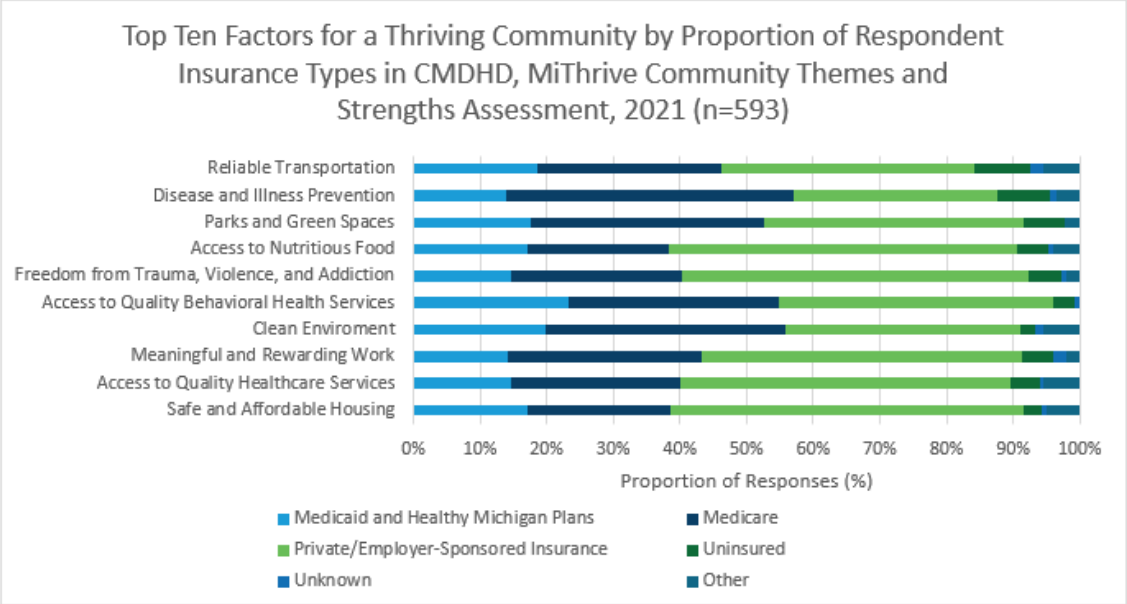
Note: Additional factors included Belonging & inclusion, Arts and cultural events, Lifelong learning, Civic engagement, Disability accessibility.



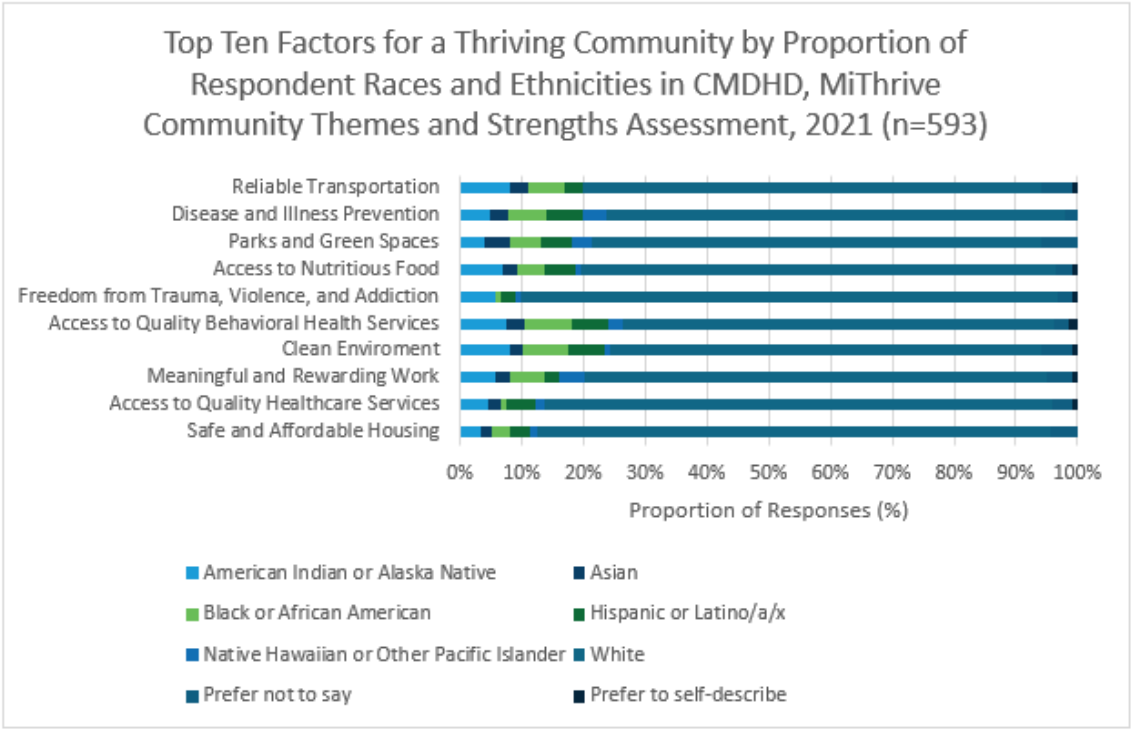
A larger proportion of individuals ***aged 18 to 24*** *responded that* ***access to quality healthcare services, access to quality behavioral healthcare services, and safe/affordable housing*** *were important factors for a thriving community. While a large portion of individuals* ***aged 25 to 64*** *responded that* ***safe and affordable housing*** *was an important factor for a thriving community.* ***For ages 65 and above****, respondents identified that* ***access to quality healthcare services*** *was an important factor for a thriving community, compared to the other nine factors.*



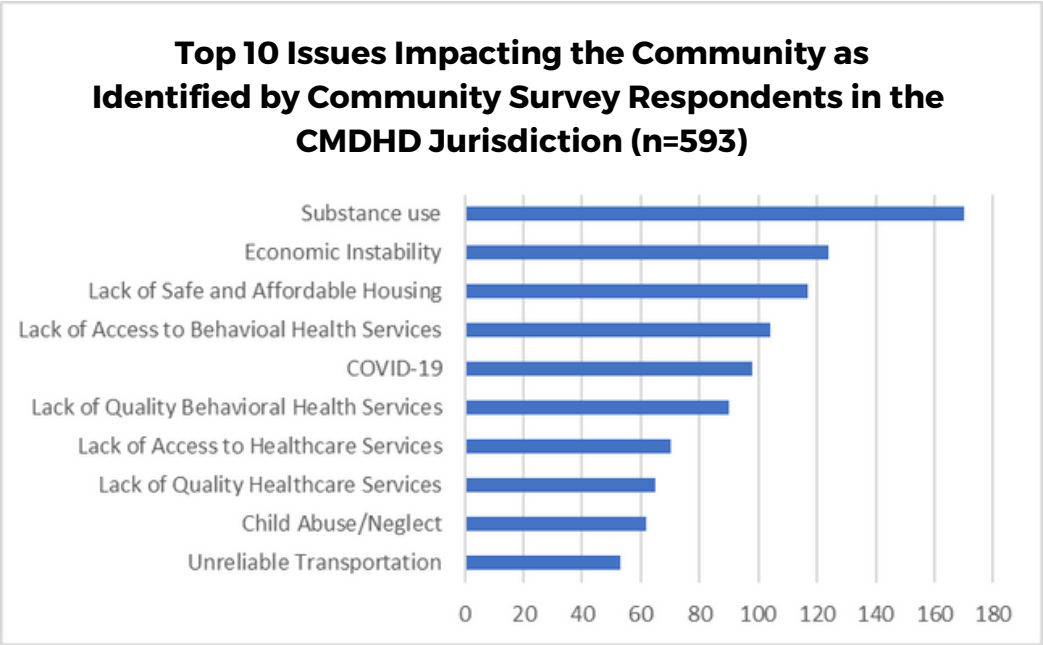
A larger proportion of individuals with a ***yearly household income of $20,000-39,999*** *responded that* ***clean environment*** *was an important factor for a thriving community when compared to the other top nine factors.*



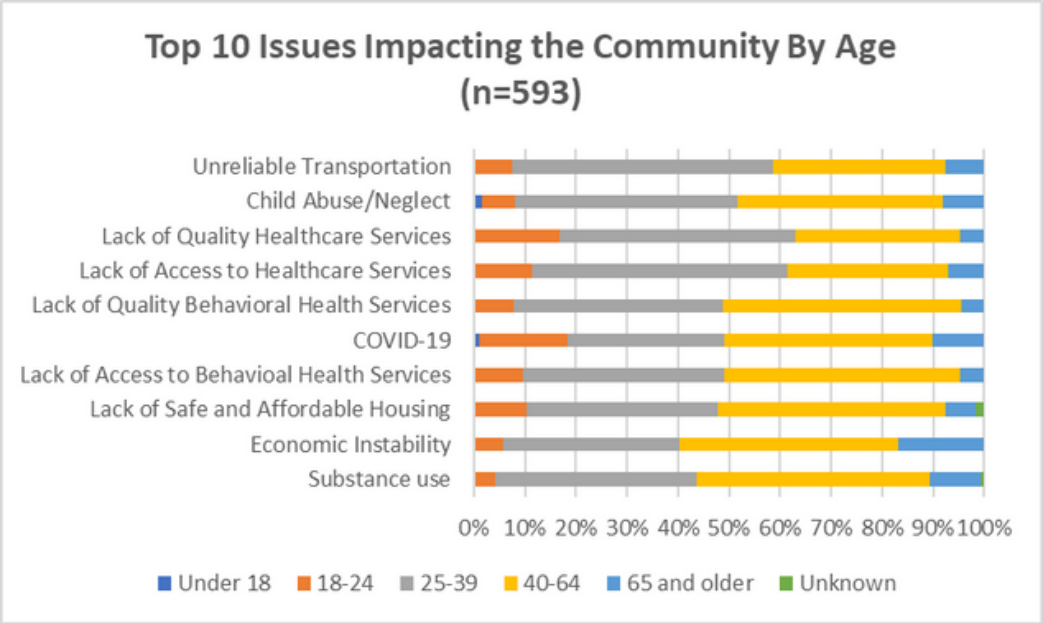
*A larger proportion of individuals with **Medicare or Uninsured** responded that **access to quality healthcare services** was an important factor for a thriving community when compared to the other top nine factors. Additionally, individuals with **Private/Employer-sponsored insurance** responded that **safe and affordable housing** was an important factor for thriving community.*



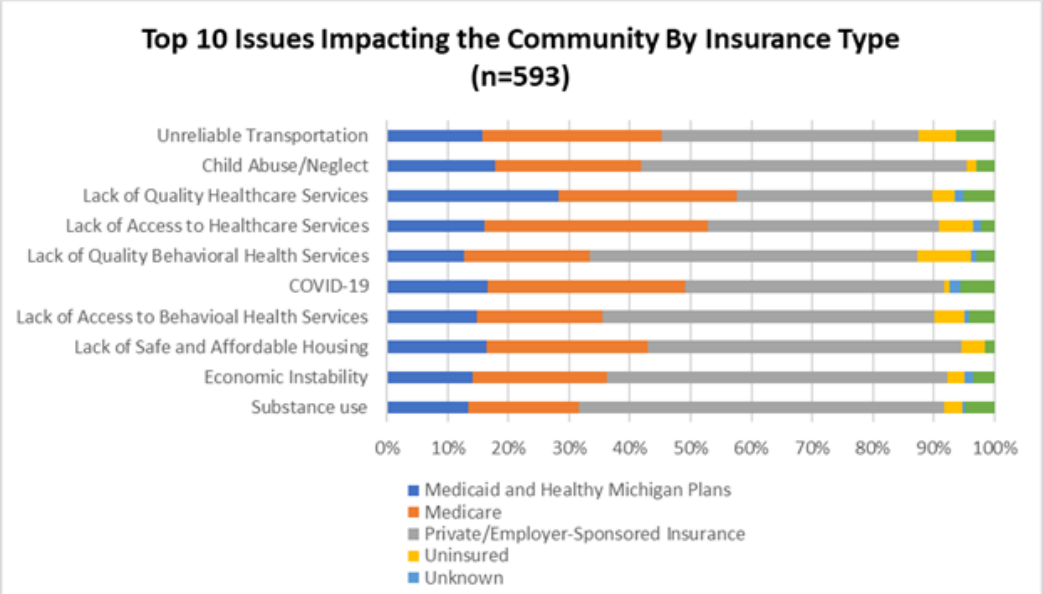
*A larger proportion of **Black or African American** individuals responded that a **clean environment** and **access to quality behavioral healthcare services** were important factors for a thriving community when compared to the other top eight factors. Additionally, **Hispanic or Latino/a/x** individuals responded that **access to quality healthcare services** was an important factor for a thriving community when compared to other top nine factors.*



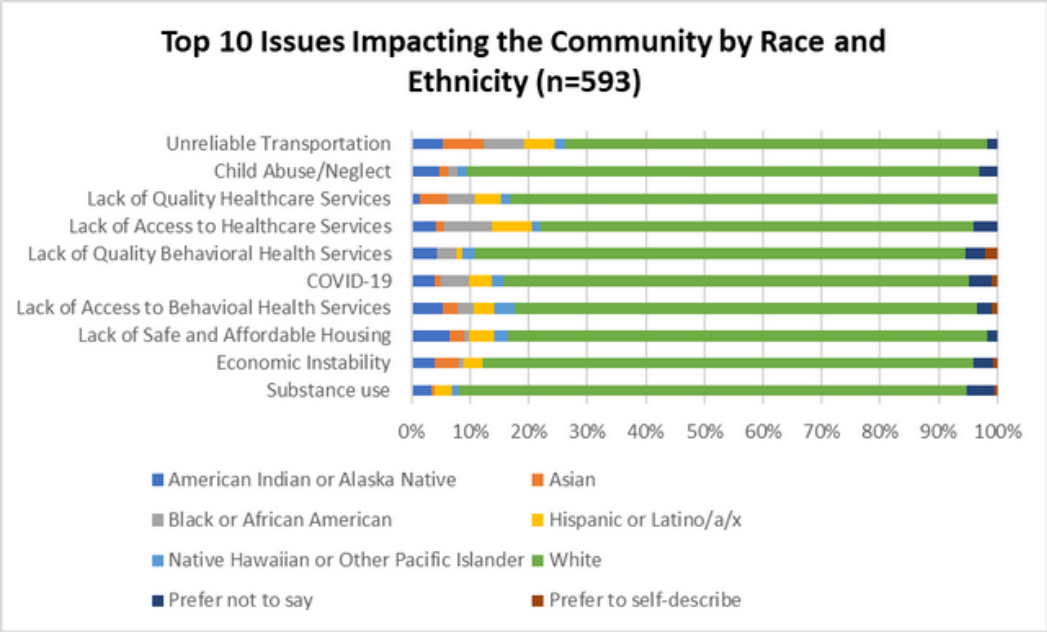
Note: Additional factors included Access to Child Care, Lack of Community Engagement, Obesity, Aging problems (e.g. arthritis, hearing/vision loss, etc.), Lack of access to nutritious foods, Motor vehicle crash injuries, Sexually transmitted infections, Cancer, Neighborhood and built environment, Civic 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.



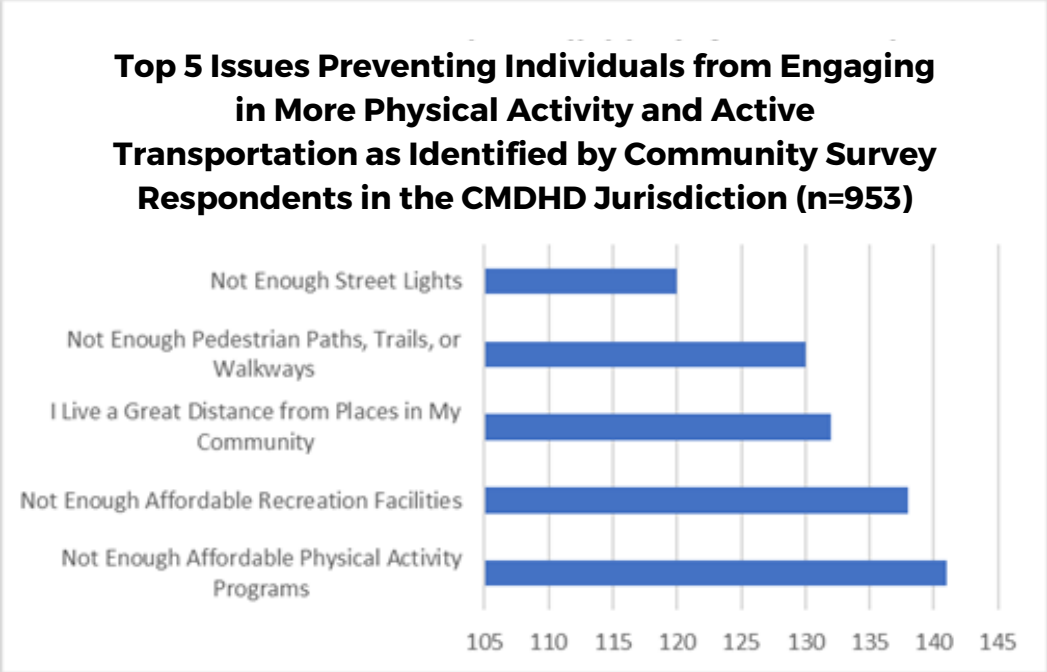
*A larger proportion of individuals aged **18-24** responded that **safe and affordable housing** was an important issue impacting the community when compared to the other top nine issues. While **25-64 aged** individuals responded that **substance use** was an important issue impacting the community when compared to the other top nine issues. Individuals **aged 65 and older** responded that **economic instability** was an important issue impacting the community when compared to the other issues.*



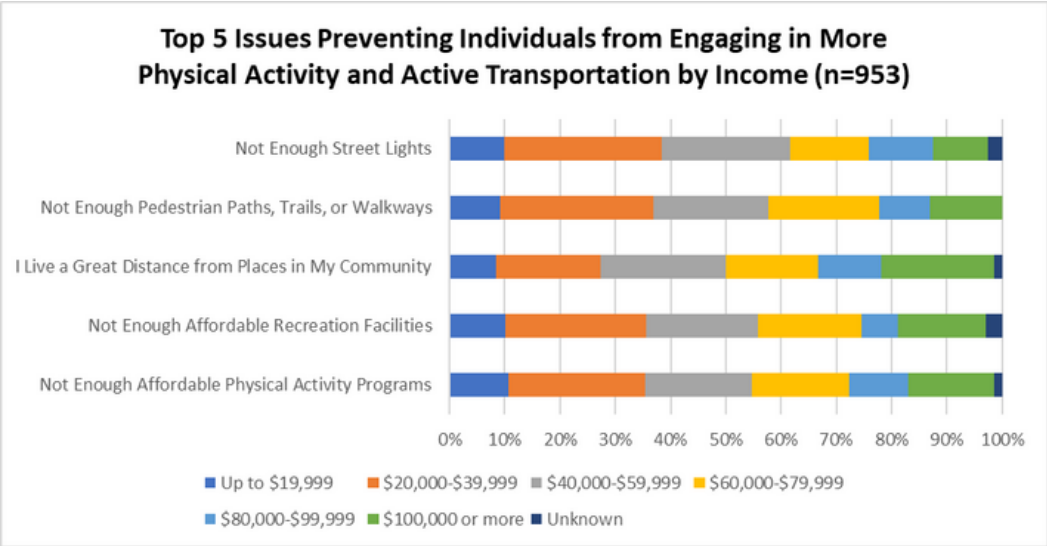
*A larger proportion of individuals with **Medicare** responded that **substance use, economic instability, and lack of quality healthcare services** were important issues affecting the community.*



*A larger proportion of **American Indian or Alaska Native** responded that a **lack of safe and affordable housing** was an important issue impacting the community in comparison to the other top nine issues.*

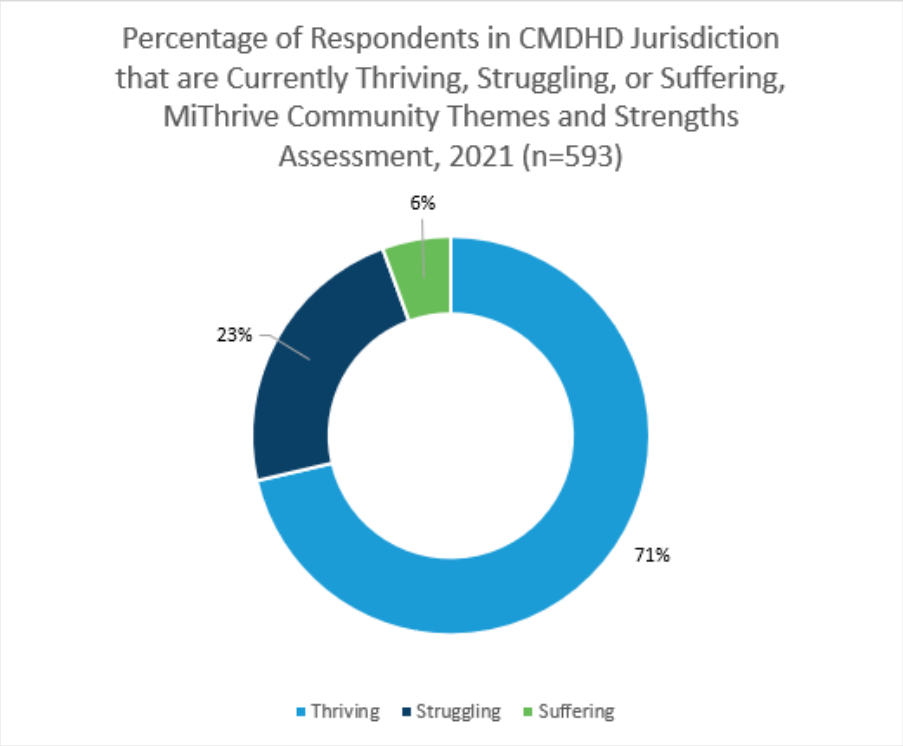


Note: Additional factors included Not Enough Sidewalks, Not Enough Bike Lanes, Not Enough Greenspaces, Not Enough Wayfinding Signage, I Feel Unsafe in my Community or Parks, Low Accessibility, Work and Parenting Time Conflicts, Lack of Child Care, Social Stigma and Lack of Community Acceptance, Under-maintained Exercise Areas, Minimal Offerings for a Variety of Exercises (e.g., Swimming Pools, etc.), Limited Parking Spaces.

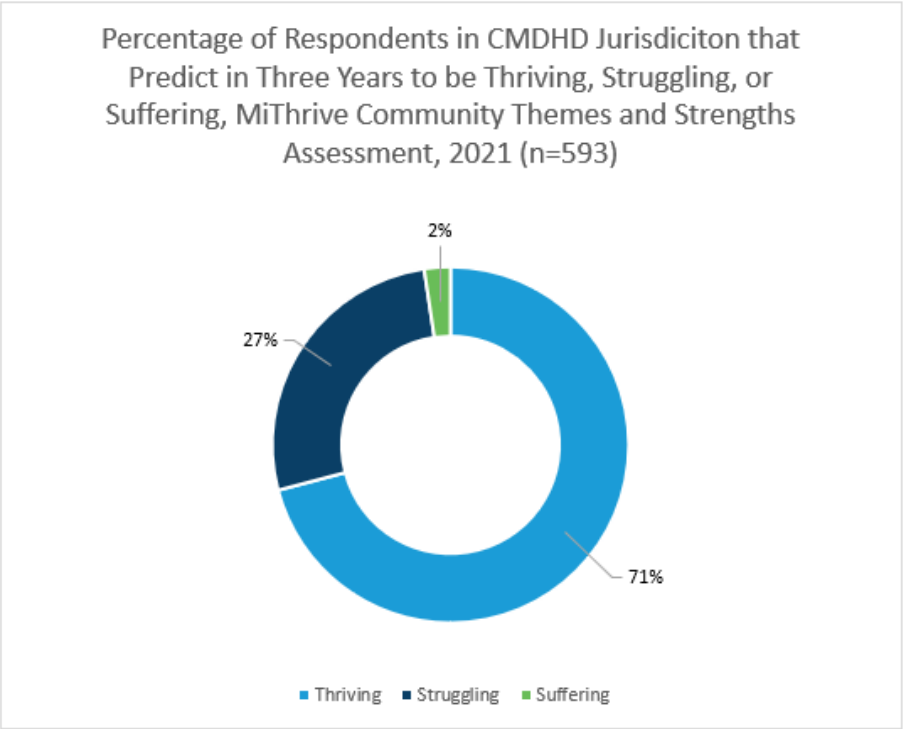


*Individuals with a yearly **household income of up to $19,999** make up a larger proportion of those who said **Not Enough Affordable Physical Activity Programs** prevented them from being more physically active in their community compared to the other top issues.*

Survey respondents were asked to imagine 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 and where they felt they would stand three years from now.



29% of Community Survey respondents in Arenac, Clare, Gladwin, Isabella, Osceola, and Roscommon Counties are currently either struggling or suffering compared to 71% who are thriving.



29% of Community Survey respondents in Arenac, Clare, Gladwin, Isabella, Osceola, and Roscommon Counties predict they will either be struggling or suffering compared to 71% who predict they will be thriving three years from now.

On average, Community Survey respondents in Arenac, Clare, Gladwin, Isabella, Osceola, and Roscommon Counties felt they would move **.87 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 well-being. 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.*

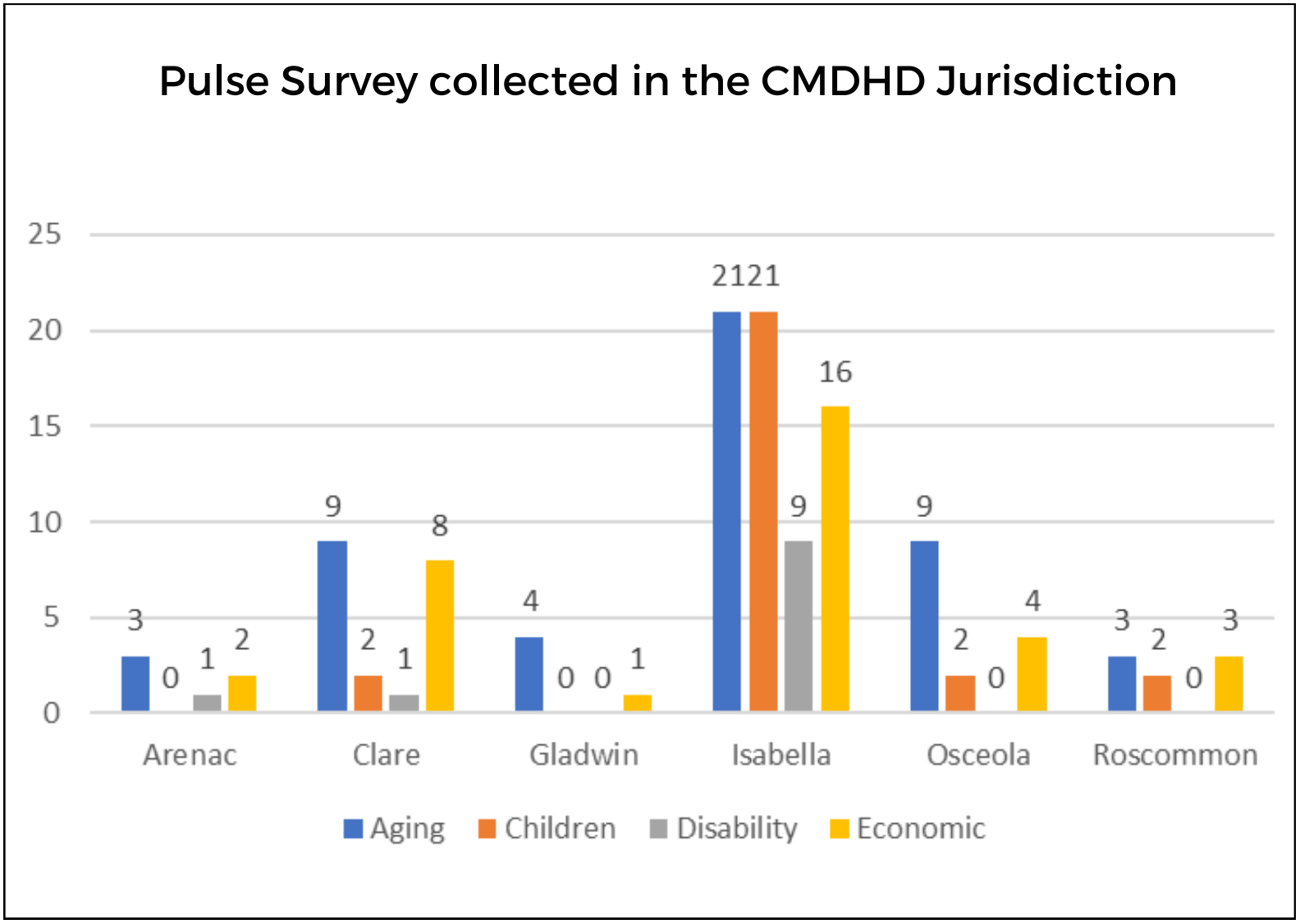
• **Pulse Survey**: The purpose of the Pulse Survey was to gather input from people and populations facing barriers and inequities in the 31-county MiThrive region. It was a four-part data collection series, where each topic-specific questionnaire was conducted over a two-week span, resulting in an eight-week 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.

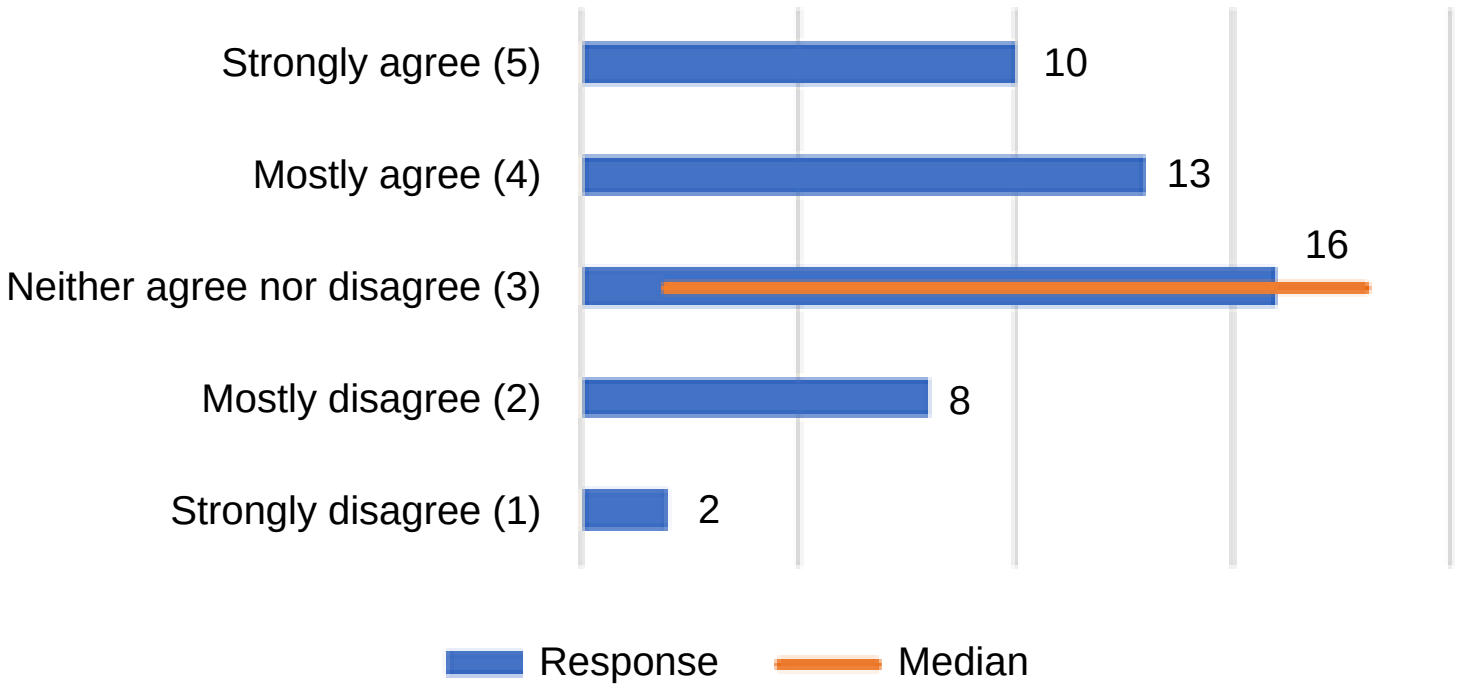
Within the CMDHD jurisdiction 49 aging, 27 children, 11 disability, and 34 economic responses were collected for a total of 121.

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.



A total of 121 pulse surveys were collected in the CMDHD jurisdiction.

Agreement with the Statement "My community is a good place to age" for Respondents from CMDHD, MiThrive Pulse Surveys, 2021 (n=49)



Overall, individuals agree with the statement "My community is a good place to age." The median response for this question is 3 or neither agree nor disagree.

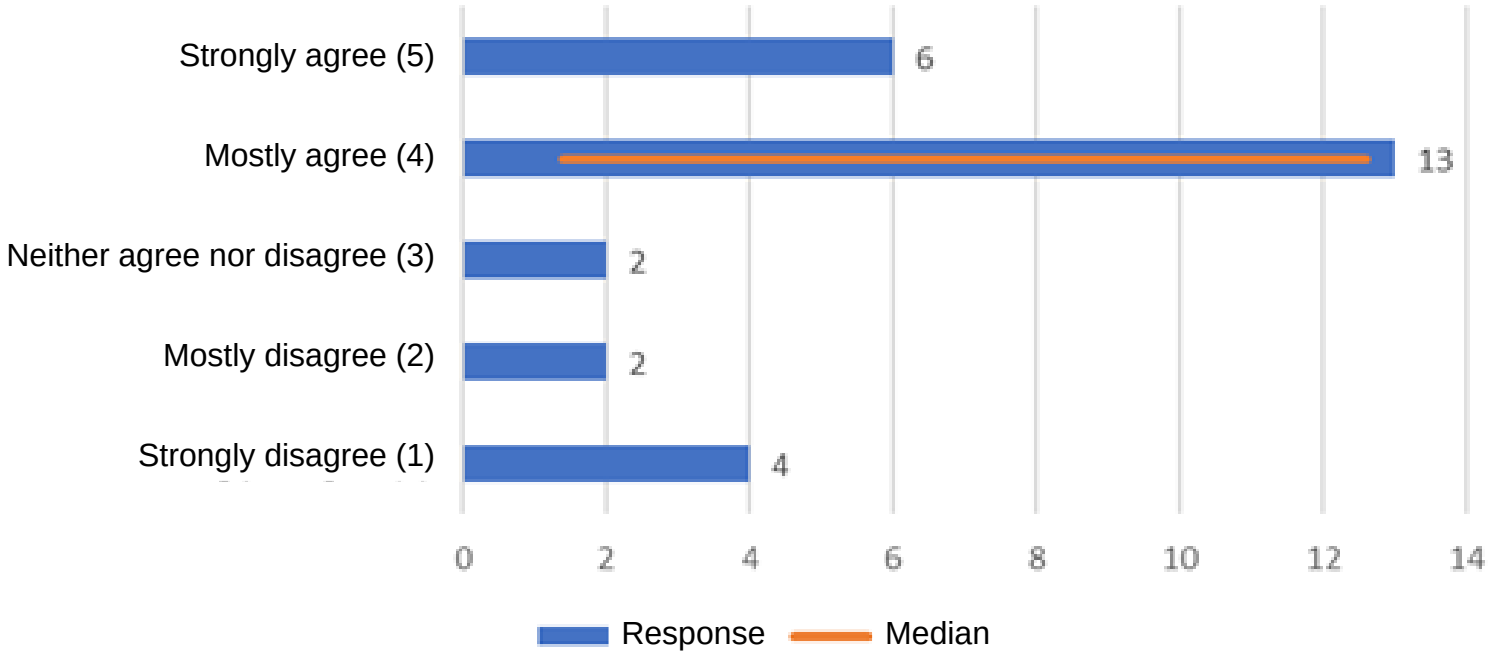
Theming of Concerns Related to Aging in the CMDHD Community

Themes	CMDHD	North Central	Northeast
Lack of Resources	○	○	○
Lack of Transportation	○	○	○
Poverty	○	○	○
Geographic Location/ Rurality	○	○	○
Lack of Housing	○	○	○
Safety Concerns	○	○	
Social Stigma and Discrimination			○
Lack of Healthcare	○		○
Community Engagement			

Theming of Strategies to Ensure Everyone has a Chance to Live a Healthy Life in the CMDHD Community

Themes	CMDHD	North Central	Northeast
Combat Food Insecurity	○	○	
Promote Community Engagement	○	○	○
Improve Outreach Efforts	○	○	○
Promote Nutrition and Physical Activity	○	○	○
Improve Transportation	○	○	○
Improve the Healthcare System	○	○	○
Increase Housing Options	○	○	○
Promote Social Justice	○	○	○
Improve Built Environment	○		○
Greater Focus on Mental Health	○		○
Greater Focus on Policies			

Agreement with the Statement "This community is a good place to raise children" for Respondents from CMDHD, MiThrive Pulse Surveys, 2021 (n=27)



Overall, individuals mostly agree with the statement "This community is a good place to raise children." The median response for this question was 4, or mostly agree.

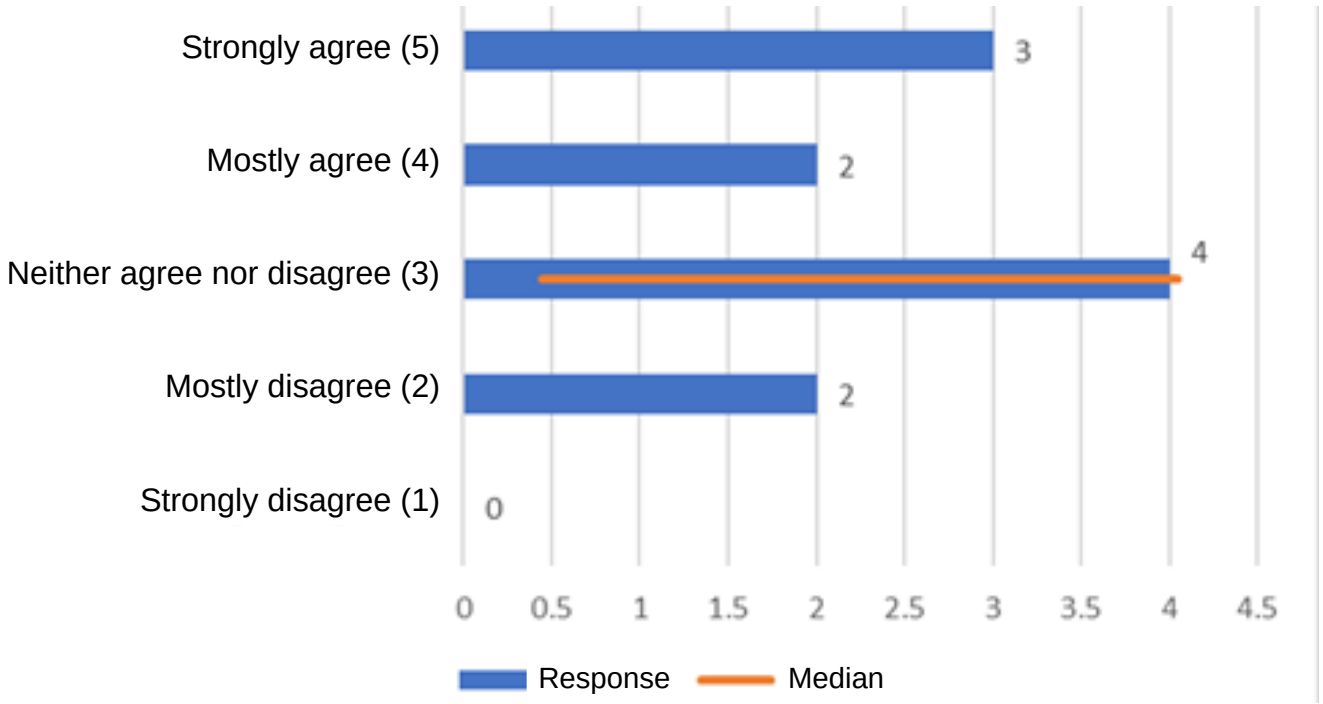
Theming of Concerns Related to Raising Children in the CMDHD Community

Themes	CMDHD	North Central	Northeast
Lack of Resources		○	○
Poverty	○	○	○
Safety Concerns	○	○	○
Low Quality Education	○	○	
Lack of Recreation Programming			

Theming of Strategies for Shared Community Wellbeing in the CMDHD Community

Themes	CMDHD	North Central	Northeast
Strengthen Community Connection	○	○	○
Affordable Recreation Opportunities	○	○	○
Improve Health Education and Awareness	○	○	
Increase Mental Health Supports	○	○	○
More Resources and Services	○	○	○
Strengthen Family Supports	○	○	○
Address Political Division	○		○
More COVID-19 Prevention Measures			

Agreement with the Statment "In this community, a person with a disability can live a full life" for Respondents from CMDHD, MiThrive Pulse Surveys, 2021 (n=11)



Overall, individuals agree with the statement "In this community, a person with a disability can live a full life." The median response for this question was 3, or neither agree nor disagree.

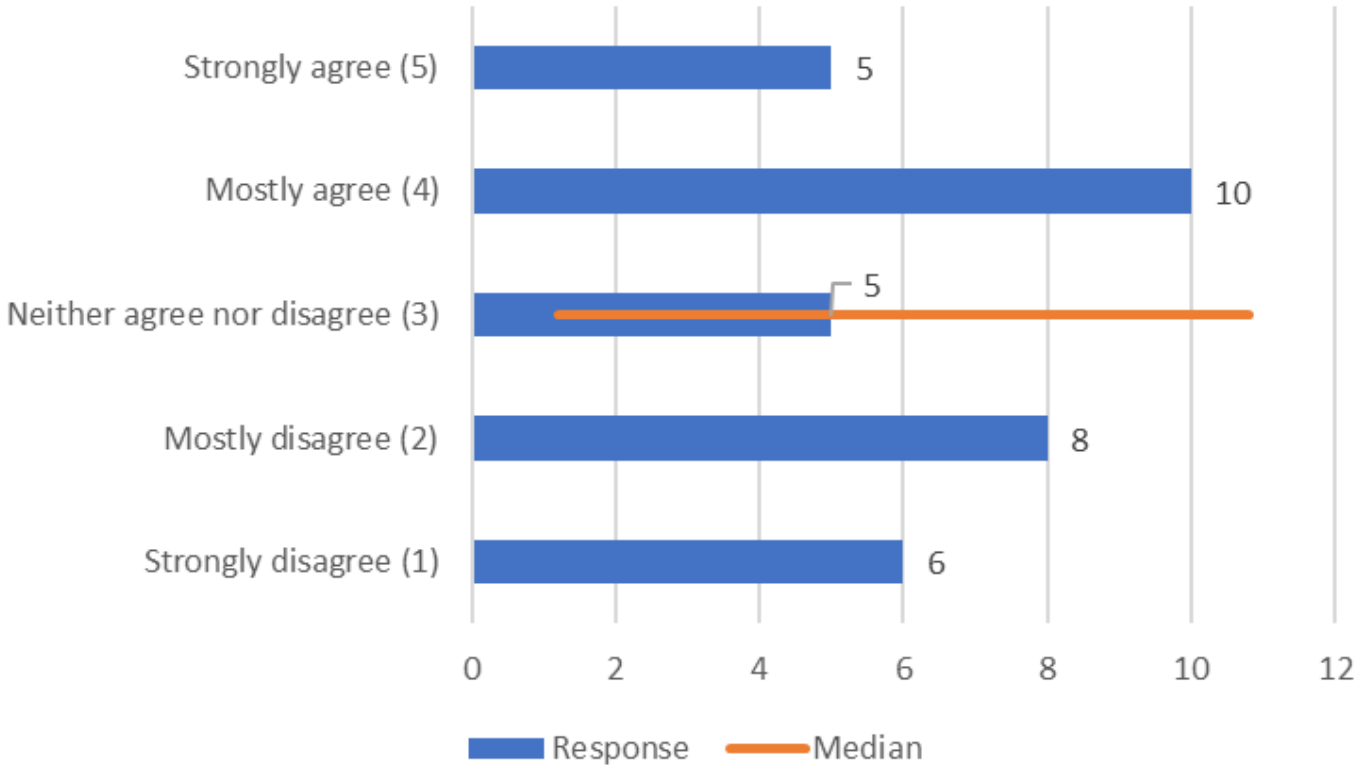
Theming of Concerns Related to Living a Full Life with Disability in the CMDHD Community

Themes	CMDHD	North Central	Northeast
Lack of Resources	◯	◯	◯
Lack of Accessible Infrastructure	◯	◯	◯
System Issues	◯	◯	◯
Geographic Location and Rurality	◯	◯	◯
Need for More Community Support	◯	◯	◯
Poverty	◯		◯

Theming of Factors that Contribute to Health Disparities in the CMDHD Community

Themes	CMDHD	North Central	Northeast
Lack of Healthcare	◯	◯	◯
Poverty	◯	◯	◯
System Navigation Issues	◯	◯	◯
Lack of Education	◯	◯	◯
Lack of Resources	◯	◯	◯
Lack of Insurance	◯	◯	◯
Geographic Location and Rurality		◯	
Increased Community Support	◯	◯	◯

Agreement with the Statement "There is economic opportunity in the community" for Respondents from CMDHD, MiThrive Pulse Surveys, 2021 (n=34)



Overall, individuals are neutral with the statement "There is economic opportunity in the community." The median response was 3, or neither agree nor disagree.

Theming of Concerns Related to Economic Opportunity in the CMDHD Community

Themes	CMDHD	North Central	Northeast
Job Availability	○	○	○
Lack of Housing	○	○	○
Poor Wages	○	○	○
Lack of Resources	○	○	○
Childcare	○	○	○
Transportation and Commute	○	○	○
Rurality and Geographic Location	○	○	○

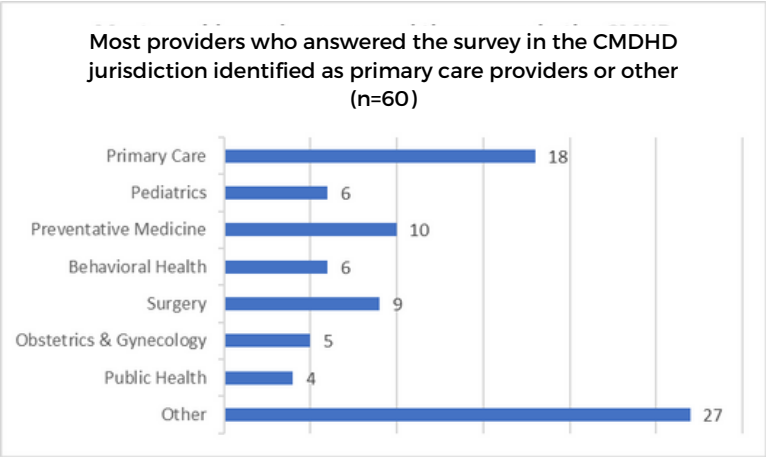
Theming of Strategies that Could Be Utilized to Promote Health in the Most Marginalized Groups in the CMDHD Community

Themes	CMDHD	North Central	Northeast
Change in Healthcare System	○	○	○
Financial and Government Assistance	○	○	○
More Resource Navigation	○	○	○
Increase Education and Job Availability	○	○	○
Increase Community Support	○	○	○
Affordable and Accessible Childcare	○		○
More COVID-19 Prevention Measures			○
Insurance	○		○
Improve Transportation	○	○	

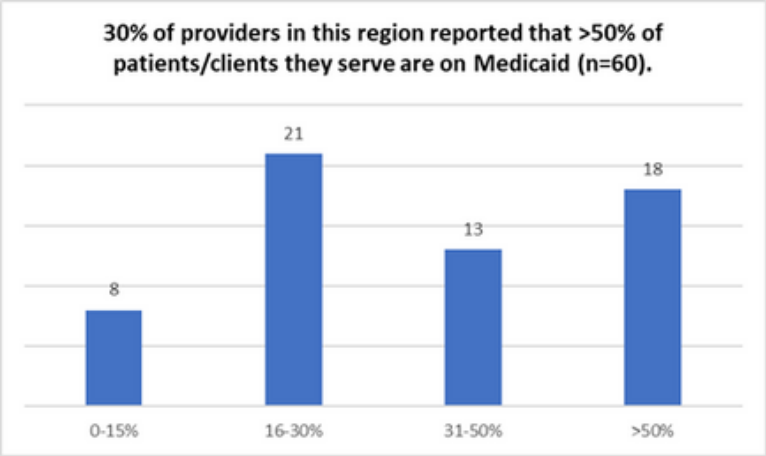
• **Healthcare Provider Survey**: Data collected for the Healthcare Provider Survey was gathered through a self-administered, electronic survey. It asked 10 questions about what is important to the community, what factors are impacting the community, quality of life, built environment, community assets,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

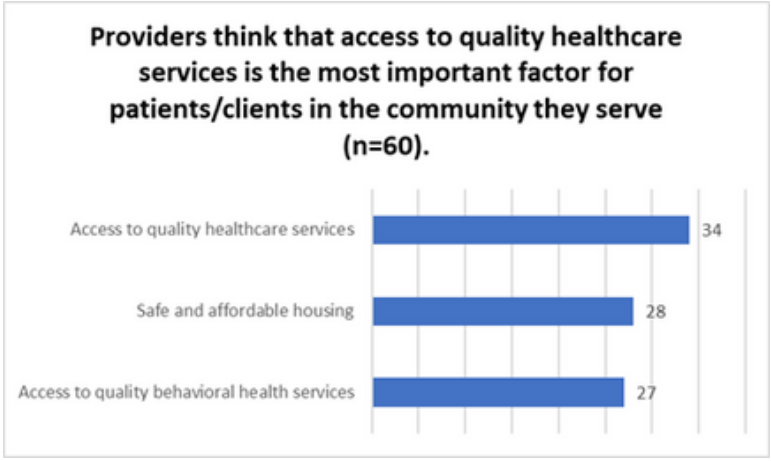
Healthcare partners such as hospitals, federally qualified health centers and local health departments, among others, sent the Healthcare Provider Survey via an electronic link to their physicians, nurses, and other clinicians. Additionally, partner organizations supported survey promotion by sharing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

Sixty providers completed the Healthcare Provider Survey in the CMDHD jurisdiction.

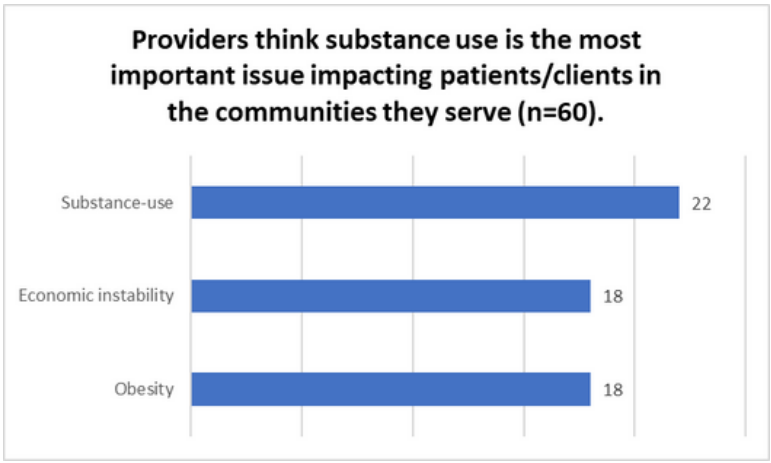


Most providers who answered the survey in the CMDHD jurisdiction identified as **a primary care provider or other**.

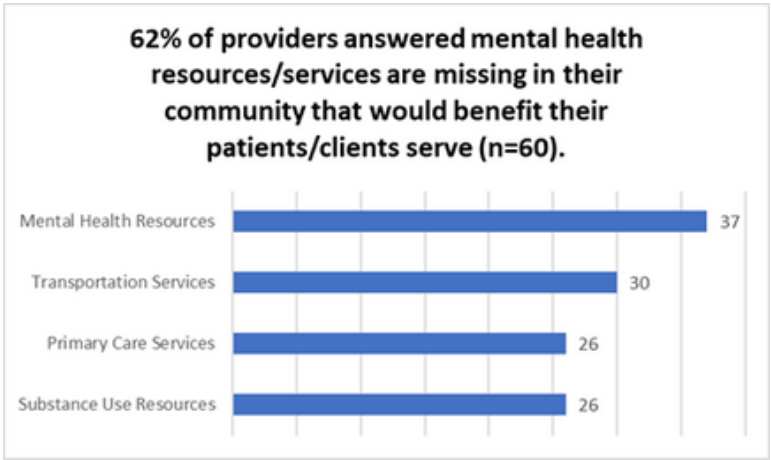




Providers think that **access to quality healthcare services** is the most important factor for patients/clients in the community they serve.



Providers think **substance use** is the most important issue impacting patients/clients in the communities they serve.



62% of providers answered **mental health resources/services** are missing in their community that would benefit their patients/clients.

• 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.

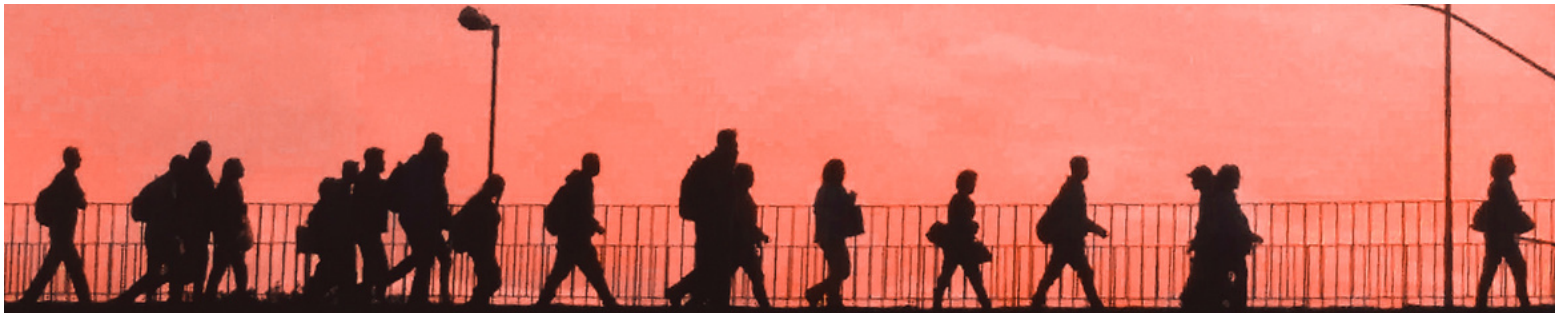
The Community System Assessment was composed of two components: Community System Assessment and subsequent focused discussions at 27 county-level community coordinating bodies. A total of 539 residents and partners, representing 199 organizations, participated in the Community System Events and/or Focused 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 North Central 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 Summary

Focus Area and Definition	System Strengths in the Northeast Region	System Strengths In the North Central 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.	• Organizations work together to connect people to the resources they need. • More than one organization is working together and sharing several resources
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	• None identified
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	• Hospitals and health departments conduct community health assessments, gather input from the community, and identify needs to address as a community
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	• The Community System is composed of strong collaborative groups
Workforce: The people engaged in or available for work in a particular area	• Michigan Works! Is a great asset to address workforce issues	• Individual organizations are knowledgeable about 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.	• The North Central Community Health Innovation Region is positioned to provide leadership in the region • Leadership is occurring at the county level.
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	• There is good work happening and the system is improving in creating awareness of public health issues and engaging the community.
Capacity for Health Equity: Assurance of the conditions for optimal health for all people	• Data is collected regarding needs of residents in the community	• No strengths were noted



Community System Assessment—System Opportunities for Improvement Summary

Focus Area and Definition	System Opportunities for Improvement in the Northeast Region	System Opportunities for Improvement in the North Central 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	• Create an asset map. • Need to connect to the community ("silent population") to link to resources that they need. • Increase broadband access
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	• Need to engage in activities that inform the policy development process, organizations in the system. Need to provide education to ensure informed decisions. • The system is currently reactive. Needs to be more proactive
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	• Need to present the data to the public in a more meaningful way. • Update the Community Health Assessment and monitor progress. • Improve data sharing
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	• To improve community health the system needs to develop action steps and increase accountability. • Virtual meetings are a challenge
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	• Identify priority areas of need and submit plans to address workforce issues to funders. • Need systemic collaboration to address workforce gaps
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	• There is not a broad community system vision. • Collaboration is difficult due to Covid. • There is value in collaboration. • Need to create an environment for collaboration.
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.	• Increase resident voice and engagement to inform decision-making. • There is need for improvement around diversity. • Need direct representation of vulnerable populations on boards and in leadership.
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	• Develop a common language around health disparities. • Advocate for a health in all policies framework so that all sectors understand how policies impact health.

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

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

Arenac County: Arenac County Human Service Coordinating Council

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

- Broadband access
- Enhanced coordinated intake system for all programs to use and make referrals from
- Streamline or create a universal link to resources
- Programs work together to share resources
- Have a strong transportation system
- Improve stigma

Clare County: Clare County Community Collaborative Body (CCCB)

Collaborative members chose "Community Alliances" as the most important focus area to work on in Clare County. In the discussion the following themes emerged:

- Improved Collaborations around social determinants of health
- Entities missing from the table.
- Data needs to be publicized and accessible for decision making.

Gladwin County: Gladwin County Human Service Coordinating Council

Roundtable members chose "Community Alliances" as the most important focus area to work on in Gladwin County. In the discussion the following themes emerged:

- Reduce inequities
- Partnerships and community connections
- Increase funding to back partnership work
- Common language

Isabella County: Isabella County Human Services Coordinating Council

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

- Universal link to resources across the entire community
- Broadband access to prevent isolation and lack of access to resources
- Increasing information around resources available
- Hubs to connect individuals to resources

Osceola County: Mecosta/Osceola Human Services Collaborative Body (M/OHSCB)

M/O HSCB members chose "Resources" as the most important focus area to work on in Mecosta and Osceola Counties. In the discussion the following themes emerged:

- There is a need for increased broadband access, unified access to assets, better transportation, and the creation of trust to better approach the populations in need
- Improve outreach and follow up services
- Staffing! Various agencies are struggling with hiring
- Partner with trusted messengers, identify more gaps, and fill them

Roscommon County: Roscommon County Human Service Coordinating Council CSA Meeting

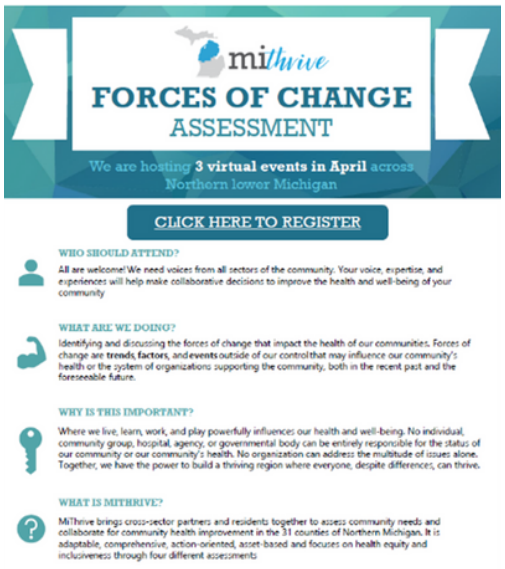
Roscommon County participants chose "Resources" as the most important focus area to work on in Roscommon County. In the discussion the following themes emerged:

- Education and resources surrounding substance use disorders, stigma, and access to healthcare for low income
- Reduce stigma for those in rural communities and for individuals who have had negative experiences and are afraid to return
- Transportation to resources
- Resident voice during planning
- Empowering residents
- Adding partners with leadership roles and strengthen collaboration
- Intentional information sharing

• 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.

141 residents and community partners participated in the Forces of Change Assessment in the Northwest, Northeast, and North Central Region in April 2021.



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

Top Forces of Change in the Northeast and North Central MiThrive Regions

Categories of Forces	Top Forces in Northeast Region	Top Forces in North Central Region
Government Leadership And Spending/Budget Priorities	• Political Agendas, Influences and Policies	• Trust in government • Inability to flex • Diversity and inclusion • Political agendas/influences • Regional demographics • COVID-19 Pandemic
Sufficient Healthcare Workforce	• Monies & Grants for Training • Minimum Wage Pending Legislation • Lack of Staff in Specific Industries (i.e., mental health & substance use disorders)	• Broadband and telehealth • Attracting healthcare professionals to rural areas • Severe shortage of mental health professionals
Access to health services	• Cost & Access of Insurance • Large Poverty & ALICE* population in our region • Provider shortages & Rurality	• Rurality • COVID-19 impact on substance use and poverty • Provider access and affordability of care
Economic environment	• Education and Income Levels • Affordable Housing • Broadband Internet	• Broadband access • Political administration changes • Behavioral health issues on employment
Access to social services	• Lack of housing (public/ affordable) • Isolation • Access to SUD services/ treatment facilities (alcohol, vaping, marijuana, prescription drugs)	• Insufficient number of providers • Affordable housing • Technology gap
Social context	• Environment and Climate Change • Access to accurate information / discernment of information • Affordable housing	• Broadband • ALICE population
Impacts related to COVID-19	• Vaccinations coming out, recent adverse events. • Overall decrease in mental health • Closing of businesses, loss of jobs	• Distrust in science and public health and political rhetoric • Economic impact • Family hardships

*ALICE refers to the population in our communities that are Asset Limited, Income Constrained, Employed. The ALICE population represents those among us who are working, but due to childcare costs, transportation challenges, 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.
- Data with small samples may be suppressed in order to protect participants identity or due to uncertain confidence intervals.
- 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 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 results of the assessment 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 addressed 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 & 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.

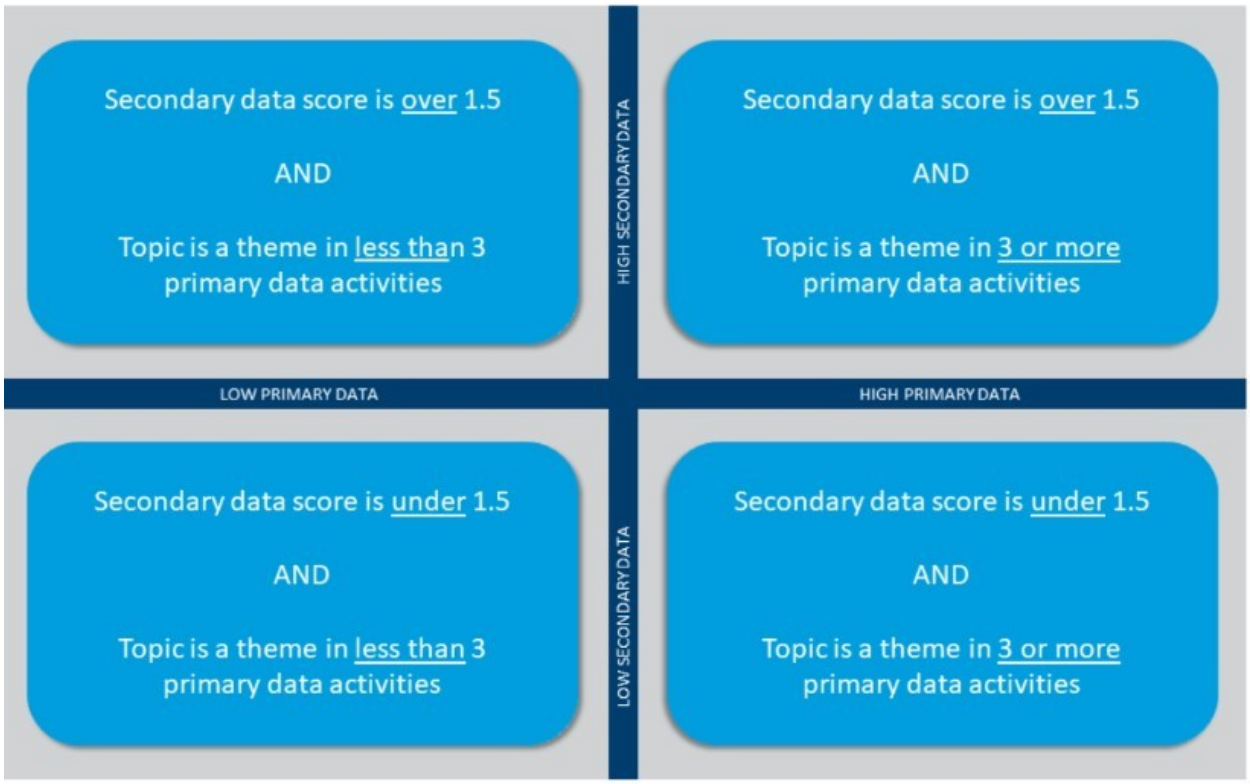
Indicators with a score above 1.5 were defined as "high secondary data" and indicators with scores below 1.5 were defined as "low secondary data." Primary data was collected from the Community System Assessment, Community Themes and Strengths Assessment (Community Survey, Pulse Survey, and Healthcare 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."

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



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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**) Community Survey
- Community Themes and Strengths Assessment (**CTSA**) Provider Survey

SECONDARY DATA:

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

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

Northeast Region	North Central Region
Broadband Access **Food Security** **Healthy Weight**	**COVID-19** **Healthy Weight**

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 community's overall 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 10-11 strategic issues developed for each MiThrive Region:

Northeast Region	Northwest Region	North Central Region
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 do we foster infrastructure and opportunities for residents to live healthy lives?**	**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?	**What policy, system and environmental changes do we need to ensure reliable access to healthy food?**	**How can we create an environment which provides access, opportunities, and support for individuals to reach and maintain a healthy weight?**
		What policy, system and environmental changes do we need to ensure reliable access to healthy food?

In **December 2021**, 166 residents and community partners participated in the MiThrive Data Walk and Priority Setting Events in each of 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 Appendixes G1, G2, and G3).

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:

CMDHD counties are green.

North Central Region: Arenac, Clare, Gladwin, Isabella, Lake, Mason, Mecosta, Newaygo, Oceana, and Osceola.

- How do we increase access to quality mental health services while increasing resiliency and wellbeing for all?
- How do we increase access to healthcare?
- How do we reduce chronic disease rates in the region?
- How do we foster a community where everyone feels economically secure?

Northeast Region: Alcona, Alpena, Cheboygan, Crawford, Iosco, Montmorency, Ogemaw, Oscoda, Otsego, Presque Isle, and Roscommon.

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

Priority Area Narratives

Key data points from the 2021 MiThrive Community Health Assessment for the 6-county CMDHD jurisdiction are briefly discussed below.

Access to Quality Mental Health and Substance Use Disorder Services

Mental health is important to well-being, healthy relationships and ability to live a full life. It also plays a major role in our ability to maintain good physical health, because mental illness increases risk for many chronic health conditions. According to the U.S. Centers for Disease Control and Prevention, mental illness is common in the United States: more than 50% will be diagnosed with a mental illness at some point in their lifetime, and one in five Americans will experience a mental illness in a given year, making access to mental health services essential.

Substance misuse impacts people's chances of living long, healthy, and productive lives. It can decrease quality of life, academic performance, and workplace productivity; it increases crime and motor vehicle crashes and fatalities and raises healthcare costs for acute and chronic conditions. According to the State of Michigan County Substance Use Vulnerability Index Results, Oscoda, Wayne, Clare, Schoolcraft, and Oceana Counties are Michigan's most vulnerable in terms of susceptibility to adverse outcomes linked with substance misuse.

Healthcare providers across all three MiThrive regions identified substance use as a top issue impacting their patients/clients. This ranked #1 out of 35 issues. Residents in the North Central and Northeast Regions identified substance use as a top issue impacting their community. This ranked #1 out of 35 issues.

A severe shortage of mental health and substance use disorder providers was also identified in the Community Health Status Assessment with the average Health Professional Shortage Area scores for mental health providers being higher than the State in all of the CMDHD Counties. The average HPSA Scores for Mental Health exceed the State rate (15), in Arenac County (17.7), Clare County (17.7), Gladwin County (18), Isabella County (17.8), Osceola County (18.4), and Roscommon County (17.3).

Across the CMDHD six-county region, stigma regarding mental illness and substance use disorders was noted as a barrier to care in the Forces of Change Assessment and the Community System Assessment. This stigma contributes to health disparities for populations experiencing mental illness and/or substance use disorders.

MiThrive Data Collection Activities

- **100+ secondary data indicators**
- **Community Survey**
- **Pulse Survey**
- **Healthcare Provider Survey**
- **Community System Assessment**
- **Forces of Change Assessment**

Access to Healthcare

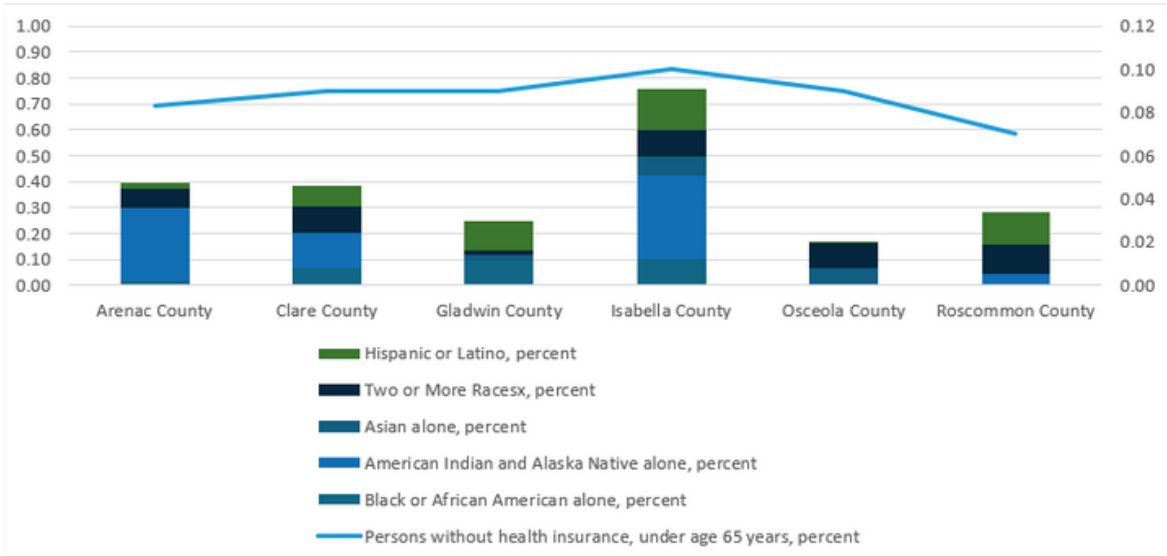
Access to healthcare services affects a person's health and well-being. Access can prevent disease and disability, detect and treat illness, reduce the likelihood of an early death, and increase life expectancy. Access to both physical and mental health services is important for all individuals, regardless of age, and includes factors like insurance status and the ability to cover the cost of care and time/transportation to travel to and from office visits.

Access to care was identified as a top theme in five of six data collection activities in the MiThrive North Central and Northeast Region. Access to quality healthcare services ranked number one among healthcare providers in the North Central regions and ranked number two among residents in the North Central region as a top factor for a thriving community. The average HPSA Scores for Primary Care exceed the State rate (14), in Arenac County (16.7), Clare County (16), Gladwin County (16), Isabella County (14), Osceola County (15.6), and Roscommon County (17). "Sufficient healthcare workforce" and "access to care" were also identified as powerful forces impacting health across all three regions in the Forces of Change Assessment, with participants citing rurality, provider access, and affordability of care as negative forces and the increasing use of telehealth as a positive force.

Some individuals and groups face more challenges getting healthcare than others. In rural areas like CMDHD counties, doctors and specialists may only be found in larger towns, so many residents must travel long distances to get healthcare. Low-income people and those living in rural areas face more challenges related to transportation, cost of care, difficulty navigating health insurance bureaucracy, inflexibility of work schedules, child-care, and other issues. Lack of cultural competency among healthcare providers can also become a barrier to care. If community residents who are ethnic minorities or identify as LGBTQ+ visit the doctor and perceive discrimination or inadequate understanding of issues that affect them, they may receive inadequate care or choose to delay seeking needed healthcare in the future. Furthermore, people experiencing mental illness or substance use disorders are wary of seeking help as a result of the stigma around mental illness and substance use disorders.

Another example of inequities in access to care are the significant differences in insurance coverage among people of different races/ethnicities. In our service area. This mostly impacts the American Indian and Alaska Native populations. According to the 2020 U.S. Census, CMDHD has an average American Indian and Alaska Native population of 1.4%, and an average of 13.5% of the population does not have health insurance. Isabella County has the largest Hispanic population at 4.0% and the largest amount of people without health insurance at 9.7% (U.S. Census, 2020).

Persons without Health Insurance and Minority Race/Ethnicity Population in CMDHD, U.S. Census Bureau, 2020



Chronic Disease

According to the US Centers for Disease Control and Prevention, chronic diseases such as heart disease, cancer, and diabetes are the leading causes of death and disability in the US. Leading causes of death in CMDHD counties, are, by far, heart disease and cancer (2020, Michigan Department of Health and Human Services). All cancer incidence rates in Arenac, Clare, Gladwin, Osceola, and Roscommon counties are higher than the State. Roscommon County has an all cancer incidence of 525.6 compared to 449.6 in the State. Diabetes rates are higher than the State in all counties except Arenac County, due to the value being suppressed. Roscommon County has a diabetes rate of 17.8%, compared to 11.7% in the State. Heart disease diagnosis rates are higher than the State in all counties except for Isabella County with Arenac County having the highest rate of 223.4/100,000 versus 104.9/100,000 in the State.

Many chronic diseases are caused by a short list of risk behaviors, such as tobacco use, poor nutrition, lack of physical activity, and excessive alcohol use. Within the six counties, the proportion of obese adults in the CMDHD jurisdiction (39.5%) exceeds the State (34.7%); however, the proportion of overweight adults in the jurisdiction (33.2%), does not exceed the State rate (34.5%). (Source: *2018-2020 Michigan BRFS Regional & Local Health Department Estimates*.) According to MiThrive data, Clare County has the highest proportion of adult obesity at 45.8%, and Arenac County has the highest proportion of overweight adults at 40.2%.

Social determinants of health, or the conditions where people live, work and play, include factors like access to care, neighborhood safety, transportation, and greenspaces for physical activity. Social determinants of health are contributing factors to health inequities. For example, people without access to a safe place for physical activity may be more likely to be obese, which raises the risk of other chronic diseases, like heart disease and diabetes.

Residents in the CMDHD jurisdiction noted many barriers to physical activity in the MiThrive Community Survey, including:

- Not enough affordable physical activity programs.
- Not enough affordable recreation facilities.
- Not enough pedestrian paths, trails, or walkways.
- Living a great distance from places in the community to engage in physical activity or active transportation.

Also, pulse survey respondents ranked “promote nutrition and physical activity” as one of the top ways everyone has a chance to live the healthiest life possible.

Food insecurity also emerged as a theme across the assessments. Child food insecurity in all counties in the CMDHD jurisdiction (except Isabella County) was identified as an indicator exceeding Michigan rates. CMDHD counties ranged from 24.4% in Roscommon County to 18.2% in Osceola County as compared to 14.2% statewide. Population food insecurity in all counties in the CMDHD jurisdiction exceeded Michigan rates. Clare County has 18.7% with food insecurity compared to the State at 13%.

Economic Security

Economic Security was identified as a priority strategic issue in the North Central Region, which includes Arenac, Clare, Gladwin, Isabella, and Osceola Counties.

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

In the CMDHD jurisdiction, many rural counties have populations experiencing economic disparities, such as low income, low levels of education, unaffordable housing, and food insecurity. The median household income in all counties in the CMDHD jurisdiction is below the median household income in the State of Michigan ($57,144). Median household income ranges from $39,565 in Clare County to $45,116 in Isabella County.

There is a greater percentage of ALICE households in all counties, compared to the State (25%). The percentage of ALICE households range from 33.3% in Clare County to 26% in Osceola County. All CMDHD counties have higher percentages of population living below the poverty level than the State (14.4%). The percentage of population below the poverty level ranges from 30% in Roscommon County to 16.9% in Gladwin County.

All CMDHD counties, except Isabella County, have a lower percentage of adults with at least a bachelor's degree than the State (29.10%). The percentage of uninsured is higher than the State (5.50%), ranging from 11.3% in Clare County to 6.0% in Arenac County.

The percentage of population whose gross rent is equal to or more than 35% of household income is higher than the State (40.0%) in Clare (47.2%) and Isabella (49.8%) Counties.

According to the Community Themes and Strengths Assessment, healthcare providers in CMDHD counties identified economic instability as one of the top 3 issues impacting their patients. In CMDHD counties, economic instability was identified by residents as one of the top ten issues impacting the community.

Health, education, and wealth are intrinsically linked. People with lower education levels typically work at low-wage jobs, limiting their choices in healthcare, proper nutrition, safe neighborhoods, transportation, and other social determinants of health.

People who live in socially vulnerable areas live shorter lives and experience reduced quality of life. Census tracts in the CMDHD jurisdiction have Social Vulnerability Indices at "high" or "moderate to high" in most of the district.

Data from the MiThrive Community Health Needs Assessment illustrates the theme of economic insecurity in the CMDHD jurisdiction. Healthcare providers noted economic instability as a top issue impacting patients and clients in the communities they serve.

On average, pulse survey respondents would neither agree nor disagree when asked if there is economic opportunity in their community. Those who ranked economic opportunity low cited concerns regarding barriers to job availability, lack of housing, poor wages, lack of resources, childcare, transportation, and rurality.

Next Steps

Now that the MiThrive Community Health Needs Assessment is complete, MiThrive Workgroups will be developing and overseeing the implementation of Community Health Improvement Plans for the top-ranked priorities in their region. The MiThrive Community Health Improvement Plan will serve as the foundation for the Central Michigan District Health Department Community Health Improvement Plan, with CMDHD 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 would like to join a MiThrive Workgroup, please email mithrive@northernmichiganchir.org.

Economic indicators for counties in the CMDHD jurisdiction

Indicator	Arenac	Clare	Gladwin	Isabella	Osceola	Roscommon	Michigan
ALICE Household	31%	33.3%	26.9%	26.9%	26%	29.1%	25%
Households below federal poverty level	15.6%	19.9%	17.2%	22.1%	16.8%	15.2%	13%
Children below the poverty level	26%	36.4%	23.9%	20.4%	27.1%	29%	20%
Median household income	$42,290	$39,565	$44,619	$45,116	$44,032	$42,054	$57,144

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.

Central Michigan District Health Department Implementation Strategy

The Implementation Strategy details which priorities identified in the Community Health Needs Assessment Central Michigan District Health Department 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 CMDHD intends to take, including programs and resources it plans to commit, anticipated impacts of these actions, and planned collaboration between CMDHD, the hospitals and community partners.

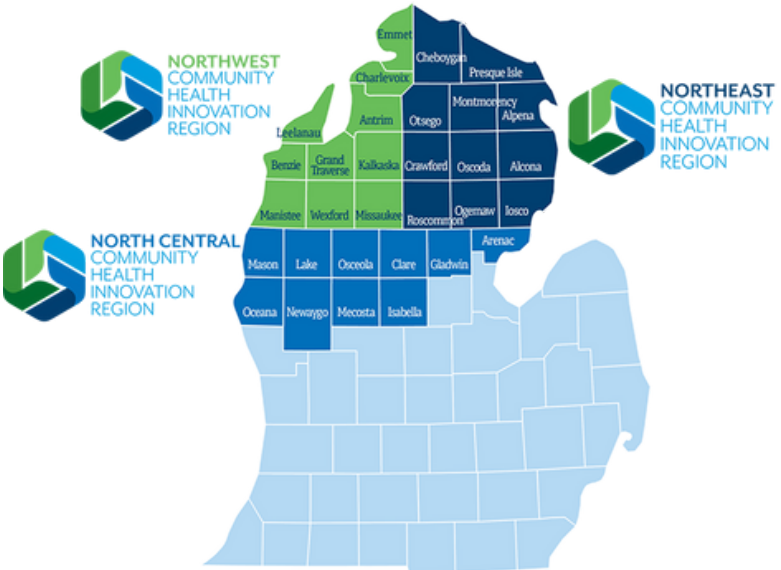
Acknowledgements

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.

COMMUNITY HEALTH INNOVATION REGIONS OF NORTHERN MICHIGAN

NORTHWEST | NORTH CENTRAL | NORTHEAST

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
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- Donna Norkoli, MCHES, Community System Assessment Team Lead and Northeast Region Lead, District Health Department #10
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- 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 Hirschenberger, 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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- Woody Smith, Avenue ISR
- 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
- Michigan Dept of Health and Human Services
- Municipalities
- Physicians and other healthcare providers
- Schools
- Substance use prevention, treatment and recovery services
- Tribal Nations

MiThrive North Central Workgroup

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- Gene Ford, Standard Process
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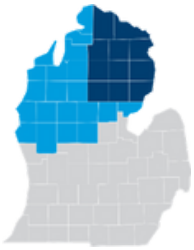
- Beth Pomranky-Brady, Ascension Health
- Abby Reeg, Newaygo County Community Collaborative
- Lynne Russell, Mason County United Way
- Annie Sanders, United Way of Gratiot & Isabella
- Monica Schuyler, Pennies from Heaven Foundation
- Meredith Sprince, Spectrum Health
- Julie Tatko, Family Healthcare
- Shawn Washington, Lake County Habitat for Humanity
- David Wingard, PhD, TrueNorth Community Services
- Jena Zeerip, Spectrum Health



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- Kathy Jacobsen, Munson Healthcare
- Mary Kushion, Ascension Health
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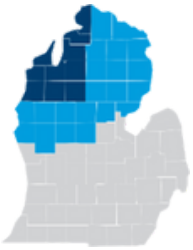
- Jordan Smith, Alcona Health Centers
- Alice Snyder, Crawford County Commission on Aging
- Nena Sork, Northeast Michigan CMH Authority
- Nancy Stevenson, Northern Lakes CMH Authority
- Patty Thomas, Alcona County Resident
- Teresa Tokarczyk, AuSable Valley CMH Authority
- Nancy Wright, AuSable Valley CMH Authority



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- Kim Chandler, Munson Healthcare
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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.