Spectrum Health
Big Rapids and Reed City Hospitals

2021-22 Community Health Needs Assessment

Spectrum Health

Community Health Needs Assessment for:

Mecosta County Medical Center d/b/a

Reed City Hospital Corporation d/b/a

Spectrum Health Big Rapids and Reed City Hospitals

Spectrum Health is a not-for-profit health system that provides care and coverage, comprising 31,000+ team members, 14 hospitals (including Helen DeVos Children's Hospital), a robust network of care facilities, teams of nationally recognized doctors and providers, and the nation's third-largest provider-sponsored health plan, Priority Health, currently serving over 1 million members across the state of Michigan.

People are at the heart of everything we do. Locally governed and headquartered in Grand Rapids, Michigan, we are focused on our mission: to Improve health, instill humanity and inspire hope. Spectrum Health has a legacy of strong community partnerships, philanthropy and transparency. Through experience, innovation and collaboration, we are reimagining a better, more equitable model of health and wellness.

Community Health Needs Assessment

The focus of this Community Health Needs Assessment (CHNA) is to identify the community needs as they exist during the assessment period (2021-2022), understanding fully that they will be continually changing in the months and years to come. The present assessment is a joint Community Health Needs Assessment between Spectrum Health Big Rapids Hospital and Spectrum Health Reed City Hospital. For this Community Health Needs Assessment, "community" is defined by the counties the Spectrum Health Big Rapids and Reed City hospitals' primary service area covers: Lake, Mecosta and Osceola counties. The target population of the assessment reflects an overall representation of the community served by these hospital facilities. The information contained in this report is current as of the date of the CHNA, with updates to the assessment anticipated every three years in accordance with the Patient Protection and Affordable Care Act and Internal Revenue Code 501(r). This CHNA complies with the requirements of the Internal Revenue Code 501(r) regulations either implicitly or explicitly.

Acknowledgments

The 2021 MiThrive Community Health Needs Assessment is a regional, collaborative initiative led by the Northern Michigan Community Health Innovation Region (CHIR). It is designed to bring together hospitals, local health departments, community-based organizations, coalitions, agencies and residents across 31 counties in northern Michigan to collect data, identify strategic issues and develop plans for collaboratively addressing them. The following partners contributed funding and leadership to the 2022 MiThrive Community Health Needs Assessment. We are grateful for their support.

In addition, the Northern Michigan CHIR was awarded two national grants to enhance a health equity focus in the MiThrive assessments:

- 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 County and City Health Officials

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 and participated 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.

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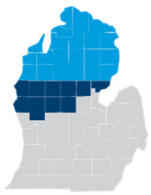
David Wingard, PhD, TrueNorth Community Services

MiThrive partners represent many sectors of the community, including:

- 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 health care providers
- Residents
- Schools
- Substance use prevention, treatment and recovery services
- Tribal nations

MiThrive North Central Workgroup



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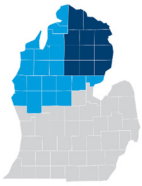

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Teresa Tokarczyk, AuSable Valley CMH Authority
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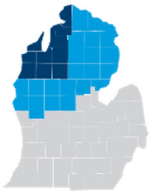
MiThrive Northwest Workgroup



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The MiThrive Core Support Team

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

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

- Jane Sundmacher, MEd, Northern Michigan Community Health Innovation Region and MiThrive Lead
- Erin Barrett, MPH, MCHES, Community Themes and Strengths Assessment Team Lead and North Central Region Lead, District Health Department #10
- Emily Llore, MPH, Forces of Change Assessment Lead and Northwest Region Lead, Health Department of Northwest Michigan
- Donna Norkoli, MCHES, Community System Assessment Team Lead and Northeast Region Lead, District Health Department #10
- Jordan Powell, MPH, Community Health Status Assessment Lead, District Health Department #10
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- Anna Reetz, Central Michigan District Health Department
- Devin Spivey, MPH, District Health Department #4

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: the community health needs assessment report and community health improvement plan and an implementation strategy. .

Community Health Needs Assessment

The 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 the Community Health Needs Assessment. It is a long-term, systematic effort to collaboratively address complex community issues, set priorities, and coordinate and target resources.

Hospital Implementation Strategy

The implementation strategy details which priorities identified in the Community Health Needs Assessment the hospital 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 the hospital intends to take, including programs and resources it plans to commit, anticipated impacts of these actions, and planned collaboration between the hospital and community partners.

Contents

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. It then 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 health care providers. Our findings show that our communities face complex, interconnected issues, and these issues harm some groups more than others.

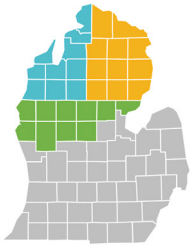
Report Goals and Objectives

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

- Describe the current state of health and well-being in northern Lower Michigan.
- Describe the processes used to collect community perspectives.
- Describe the process for prioritizing strategic issues within the North Central CHIR region.
- Identify community strengths, resources and service gaps.

Regional Approach

MiThrive was implemented across a 31-county region through a remarkable partnership of hospital systems, local health departments and other community partners. Our aim is to leverage resources and reduce duplication while still addressing unique local needs for high-quality, comparable county-level data. The 2021 MiThrive Community Health Needs Assessment covered 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.



MiThrive Regions

For this Community Health Needs Assessment, "community" is defined by the counties the Spectrum Health Big Rapids and Reed City hospitals' primary service areas covers: Lake, Mecosta and Osceola counties. This three-county area is included in the MiThrive North Central region. As discussed below, of the four MiThrive assessments, two were conducted at the county level and two were conducted within the MiThrive regions.

Data Collection

The findings detailed throughout this report are based on data collected through 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 ensuring results are driven by the community.

MiThrive utilizes the Mobilizing for Action through Planning and Partnerships (MAPP) 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 about 100 statistics by county for the 31-county region from reliable sources such as County Health Rankings, the Michigan Department of Health and Human Services, and the U.S. Census Bureau.

Community Themes and Strengths Assessment
The Community Themes and Strengths Assessment provides a deep understanding of the issues that residents feel are significant by answering the questions "What is important to our community?," "How is quality perceived in our community?" and "What assets 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.

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 28 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 the Healthcare Provider Survey for the Community Themes and Strengths Assessment
199	Participants in three Forces of Change Assessment regional events

Community System Assessment
The Community System Assessment focuses on organizations that contribute to well-being. It answers the questions "What are the components, activities, competencies and capacities in the regional system?" and "How are services being provided to our residents?" The Community System Assessment was completed in two parts. First, communitywide 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.

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 conducted through community meetings that convened virtually in the Northwest, Northeast and North Central MiThrive regions.

The assessments all provide important information, but the value of the four assessments is multiplied by considering the findings as a whole.

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. Although health equity is often framed in terms of race or culture, in rural areas, like Lake, Mecosta and Osceola counties, social isolation, higher rates of health risk behaviors, limited access to medical care and few opportunities for good jobs contribute to increased mortality rates, lower life expectancies, and higher incidence of disease and disability, according to the Rural Health Information Hub.

The MiThrive vision, a vibrant, diverse and caring region where collaboration affords all people equitable opportunities to achieve optimum health and well-being, is grounded in the value of health equity. As one of the first steps of achieving health equity is to understand current health disparities, we invited diverse community partners to join the MiThrive steering committee, design team and workgroups and we gathered primary and secondary data from medically underserved, minority and low-income populations in each of the four MiThrive assessments, including:

- Cross-tabulating demographic indicators such as age, race and sex for the Community Themes and Strengths Assessment
- Engaging residents experiencing barriers to social determinants of health and organizations that serve them in the Community System Assessment, Community Themes and Strengths Assessment, and Forces of Change Assessment
- Reaching out to the 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 the MiThrive Data Walks and Priority-Setting Events

Key Findings

Following analysis of primary and secondary data collected during the 2021 MiThrive Community Health Assessment, 11 health needs emerged in the North Central region. Members of the MiThrive steering committee, design team and workgroups framed these health needs as strategic issues, as recommended by the Mobilizing for Action through Planning and Partnerships Framework. On Dec. 8, 2021, 77 residents and community partners participated in the MiThrive North Central region's Data Walk and Priority-Setting Event. 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.

1. **Behavioral Health:** How do we increase access and reduce barriers to quality behavioral health services while increasing resiliency and well-being?
2. **Access to Health Care:** How do we increase access to integrated systems of care, as well as increase engagement, knowledge and awareness of existing systems to better promote health and prevent and treat chronic disease?
3. **Healthy Weight:** How can we create an environment that provides access, opportunities and support for individuals to reach and maintain a healthy weight?
4. **Economic Security:** How do we foster a community where everyone feels economically secure?
5. **Substance Misuse:** How can we develop increased comprehensive substance misuse prevention and treatment services that are accessible, patient centered and stigma free?
6. **Housing Security:** How do we ensure that everyone has safe, affordable and accessible housing?
7. **Transportation Options:** How can we nurture a community- and health-oriented transportation environment that provides safe and reliable transportation access, opportunities and encouragement to live a healthy life?
8. **Food Security:** What policy, system and environmental changes do we need to ensure reliable access to healthy food?
9. **Broadband Access:** How can we advocate for increased broadband access and affordability?
10. **Safety:** How do we ensure all community members are aware of and can access safety and well-being supports?
11. **Equity:** How do we cultivate a community whose policies, systems and practices are rooted in equity and belonging?

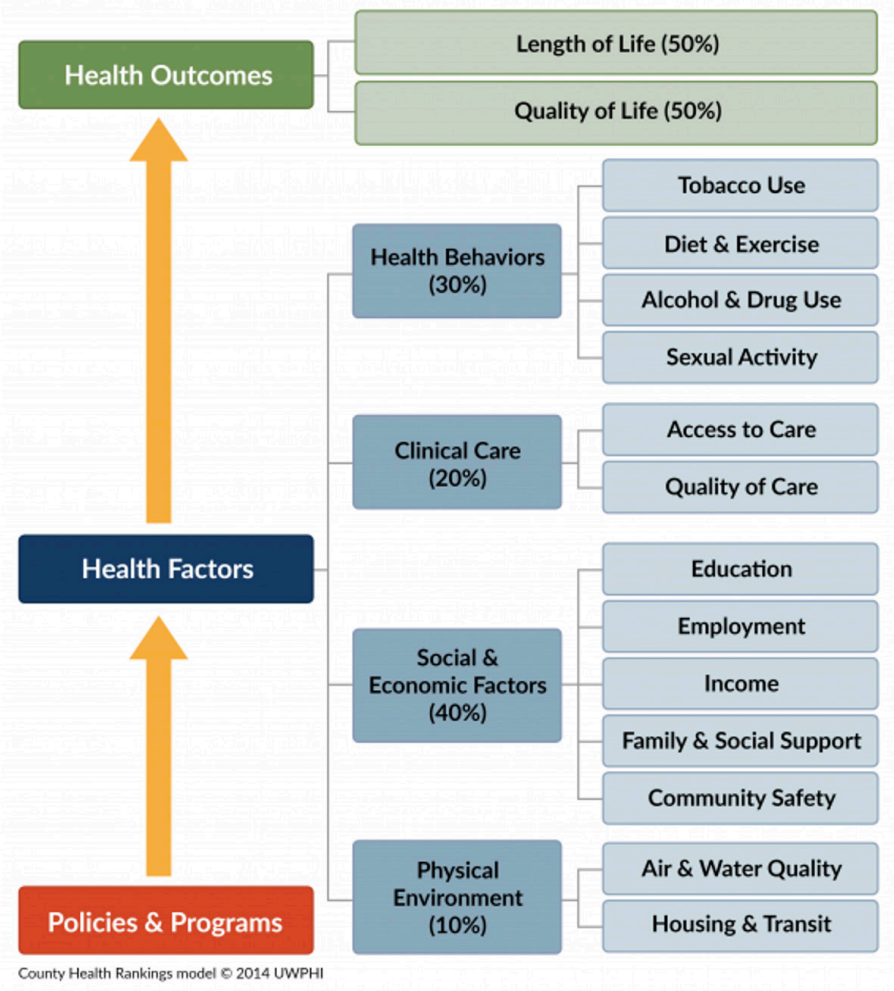
The purpose of this ranking process was to prioritize the significant health needs to collectively address in a collaborative Community Health Improvement Plan. Following the Data Walk and Priority-Setting Events, MiThrive partners and participants refined the prioritized strategic issues to remove any jargon, clarify language and wordsmith. The final significant health needs identified for the Spectrum Health Big Rapids and Reed City hospitals community are as follows:

1. Behavioral health
2. Access to health care
3. Chronic disease
4. Economic security

Introduction

We all have a role to play in the health of our community. In addition to disease, health is influenced by education level, economic status and 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.

Figure 1: County Health Rankings Model



Source: Remington, Patrick L, Bridget B Catlin, and Keith P Gennuso. 2015. "The County Health Rankings: Rationale and Methods." Population Health Metrics 13 (11): 1-12.

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

Purpose of the Community Health Needs Assessment

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

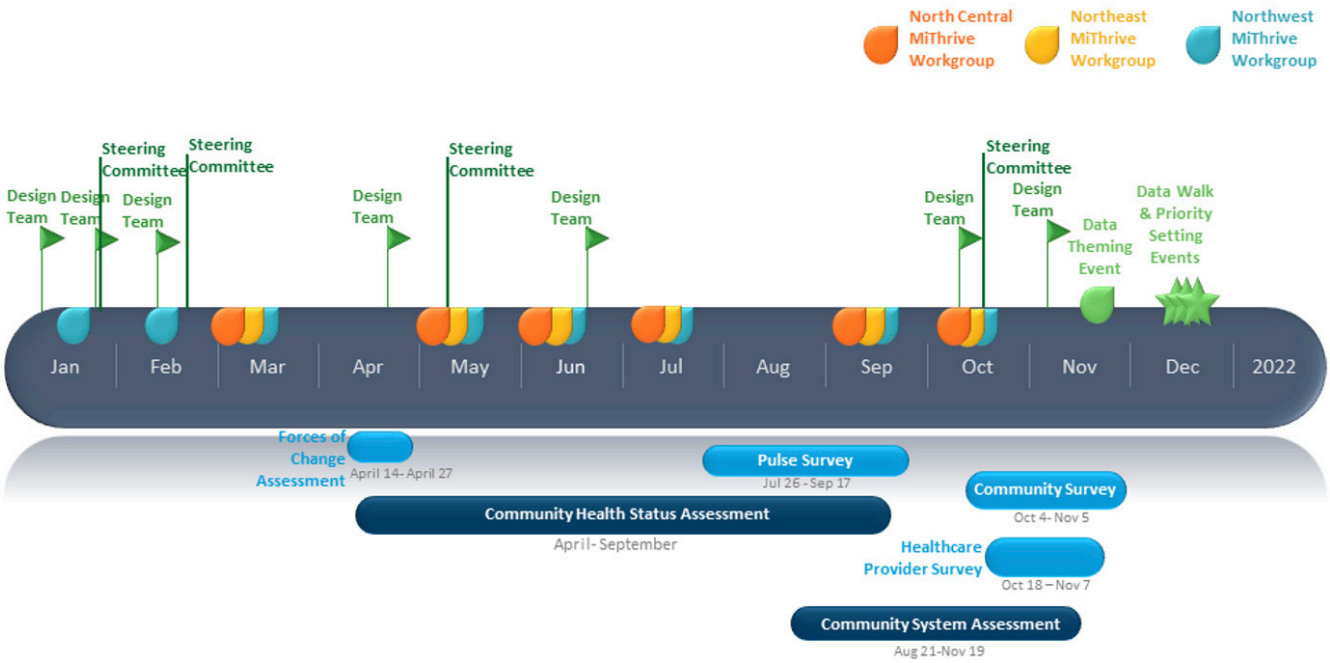
1. Engage residents and community partners to better understand the current state of health and well-being in the community.

2. Identify key problems and assets to address them. Findings are used to develop collaborative community health improvement plans and implementation strategies and to inform decision-making, strategic planning, grant development and policymaker advocacy.

Role of MiThrive Steering Committee, Design Team and Workgroups

The MiThrive design team is responsible for developing Data Collection Plans for the four assessments and providing 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 and 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 a list of organizations engaged in MiThrive in the North Central region.)

Figure 2: MiThrive Infrastructure Meetings and Assessment Timeline



Impact of COVID-19 on MiThrive

There were challenges in conducting a regional, 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 the community health needs assessment, MiThrive convened in-person events for the Community System Assessment and Forces of Change Assessment. During the pandemic, meetings 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 allocate resources and time for travel, overall participation at the community assessment events increased. Overall, more than 2,000 people participated in MiThrive assessments in the North Central region:

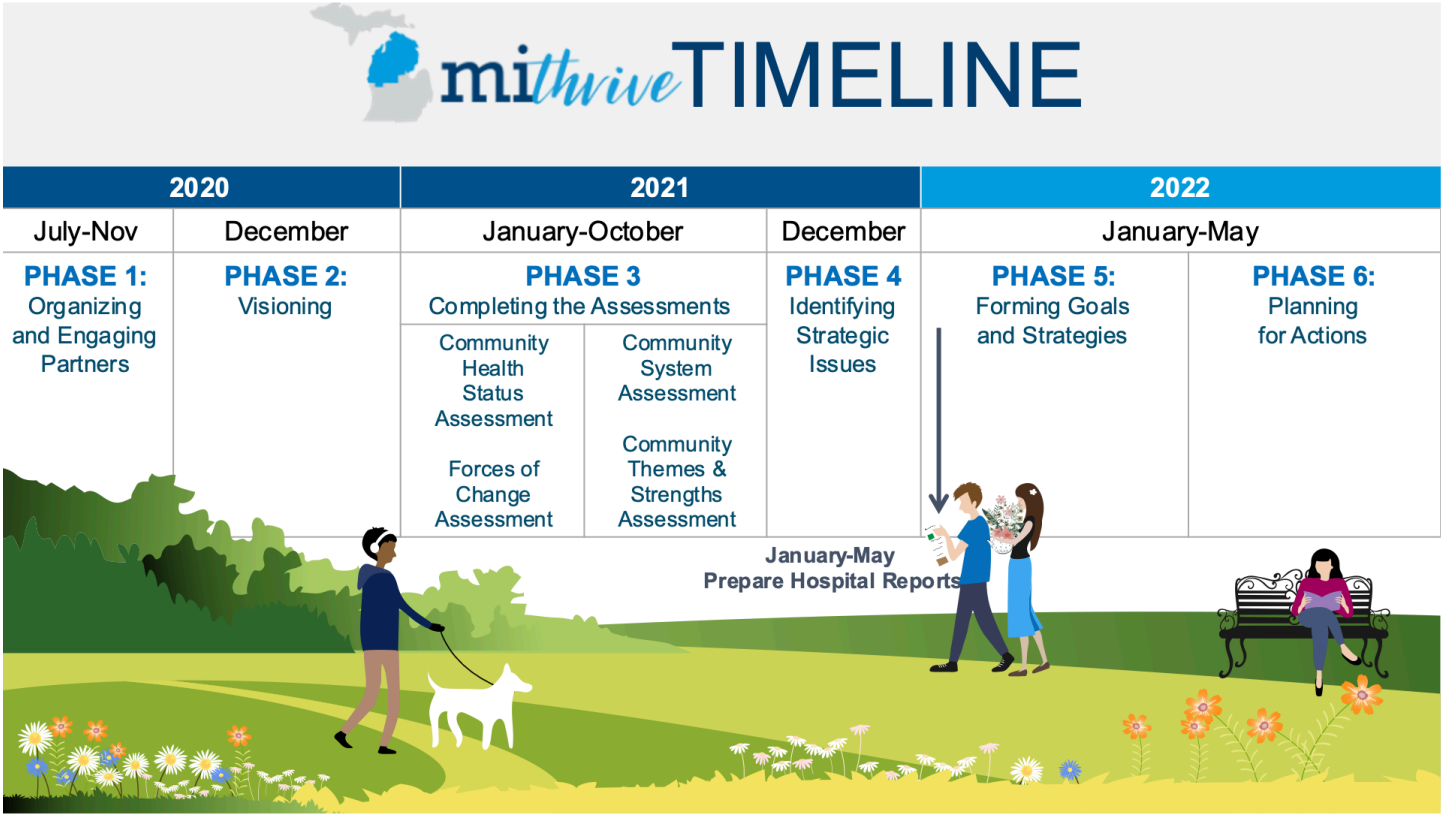
Table 1: Primary Data Collection Activities

MiThrive Assessments—Primary Data Collection North Central Region Only		**Participants or Respondents**
Community System Assessment	Community system assessment event on Aug. 12, 2021, via Zoom	69
	Focused conversations at nine collaborative body meetings via Zoom	128
Community Themes and Strengths Assessment	Community surveys collected (distributed widely by community	1,456
	Pulse surveys collected	378
	Provider surveys collected	104
Forces of Change Assessment	Forces of change assessment event on April 20, 2021, via Zoom	67
Total		**2,202**

Mobilizing for Action through Planning and Partnerships Community Health Needs Assessment Framework

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

Figure 3: MiThrive MAPP Timeline



Phase 1: Organizing and Engaging Partners

Phase 1 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 to be 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 the 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.

Phase 2: Visioning

Vision statements provide focus, purpose and direction to the community health needs assessment. They provide a useful mechanism for convening the community, building enthusiasm for the process and setting the stage for planning. Following thoughtful discussion, steering committee members updated the MiThrive vision in January 2021 to: A vibrant, diverse, caring region where collaboration affords all people equitable opportunities to achieve optimal health and well-being.

Phase 3: 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 a list of organizations that participated in MiThrive.).

Health Equity

There is more to good health than health care. A number of factors affect people's health that people do not often think of as health care concerns, such as where they live and work, the quality of their neighborhoods, how rich or poor they are, their level of education, and their race or ethnicity. These social factors influence about 80% of length of life and quality life, according to the County Health Rankings Model.

A key finding of the 2021 MiThrive community health needs assessment mirrors a persistent reality across the country and the world: Health risks do not impact everyone 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.

> 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

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 health care. All of these community conditions combine to limit the opportunities and chances for people to be healthy. The resulting differences in health outcomes (like risk of disease or early death) are known as "health inequities."

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

MiThrive Assessment Results

Community Health Status Assessment

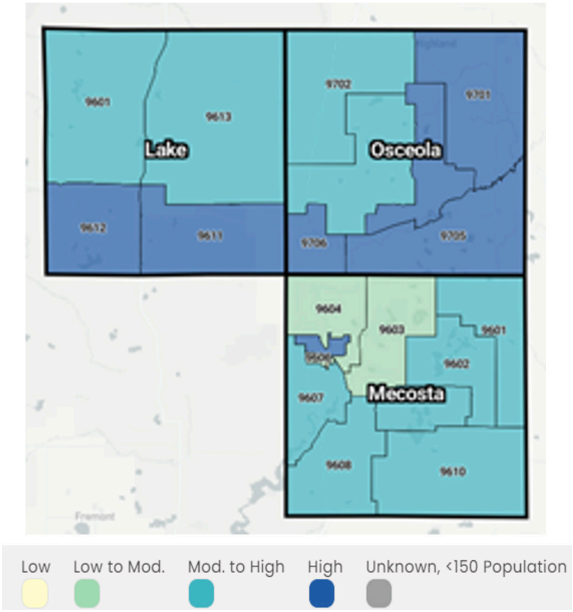
The Community Health Status Assessment identifies priority community health and quality of life issues. It answers the questions “How healthy are our residents?” and “What does the health status of our community look like?” The answers to these questions were measured by collecting 100 secondary indicators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

The design team ensured that 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 the federal poverty level; population living below the 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 (percentage of all occupied homes); and unemployment rate.

The Social Vulnerability Index illustrates how where we live influences health and well-being. It ranks social factors such as income below federal poverty level; unemployment rate; income; no high school diploma; age 65 or older; aged 17 or younger; older than 5 with a disability; single-parent households; minority status; speaks English “less than well”; multi-unit housing structures; mobile homes; crowded group quarters; and no vehicle.

As illustrated in the map at right, census tracts in Lake, Mecosta and Osceola counties have social vulnerability indices at “high” or “moderate to high,” with the exception of two census tracts in northeast Mecosta County.

Figure 4: Social Vulnerability Index by Census Tract in Lake, Mecosta and Osceola Counties



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. Department of Agriculture
- U.S. Health Resources & Services Administration

Each indicator was scored on a scale of 0 to 3 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."

There were 38 indicators in Lake, Mecosta and Osceola counties that scored above 1.5, indicating they were worse than the North Central region overall or state rates:

- All cancer mortality
- Alzheimer's disease/dementia mortality
- Asset Limited, Income Constrained, Employed (ALICE) households
- Average Health Professionals Shortage Area Score – Dental Health
- Average Health Professionals Shortage Area Score – Mental Health
- Average Health Professionals Shortage Area Score – Primary Care
- Bachelor's degree or higher
- Child abuse and neglect
- Child food insecurity
- Children below poverty level
- Colorectal cancer
- Families living below federal poverty level
- Fully immunized toddlers age 19-35 months
- Gross mortgage is ≥ 35% of household income
- Gross rent is ≥ 35% of household income
- High school graduate or higher
- High school graduation rate
- Homes with broadband internet
- Households below federal poverty level
- Liver disease mortality
- Lung and bronchus cancer
- Median household income
- Median value of owner-occupied homes
- Motor vehicle crash involving alcohol mortality
- Motor vehicle crash mortality
- No household vehicle
- Overweight (adults)
- Political participation
- Population below federal poverty level
- Population food insecurity
- Renters (percentage of all occupied homes)
- Self-reported health assessment as fair or poor
- Severe quality problems with housing
- Special education percent Child Find
- Students not proficient in Grade 4 English
- Unemployment rate
- Vacant housing units

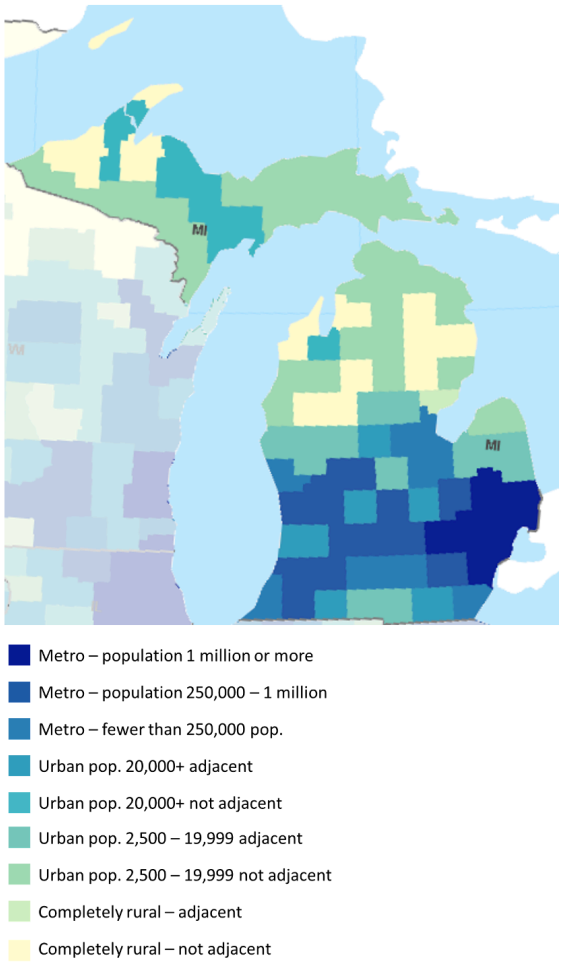
Please see Appendix B for values for these indicators and their scores for the three-county area.

Geography and Population

The joint service area for Spectrum Health Big Rapids Hospital and Spectrum Health Reed City Hospital is composed of Lake, Mecosta and Osceola counties. The three-county area is known for its clean environment and abundant resources for outdoor recreation. Covering 1,688 square miles of land, most of the region is designated as "rural" by the U.S. Census Bureau. This is one of its most important characteristics, as rurality influences health and well-being.

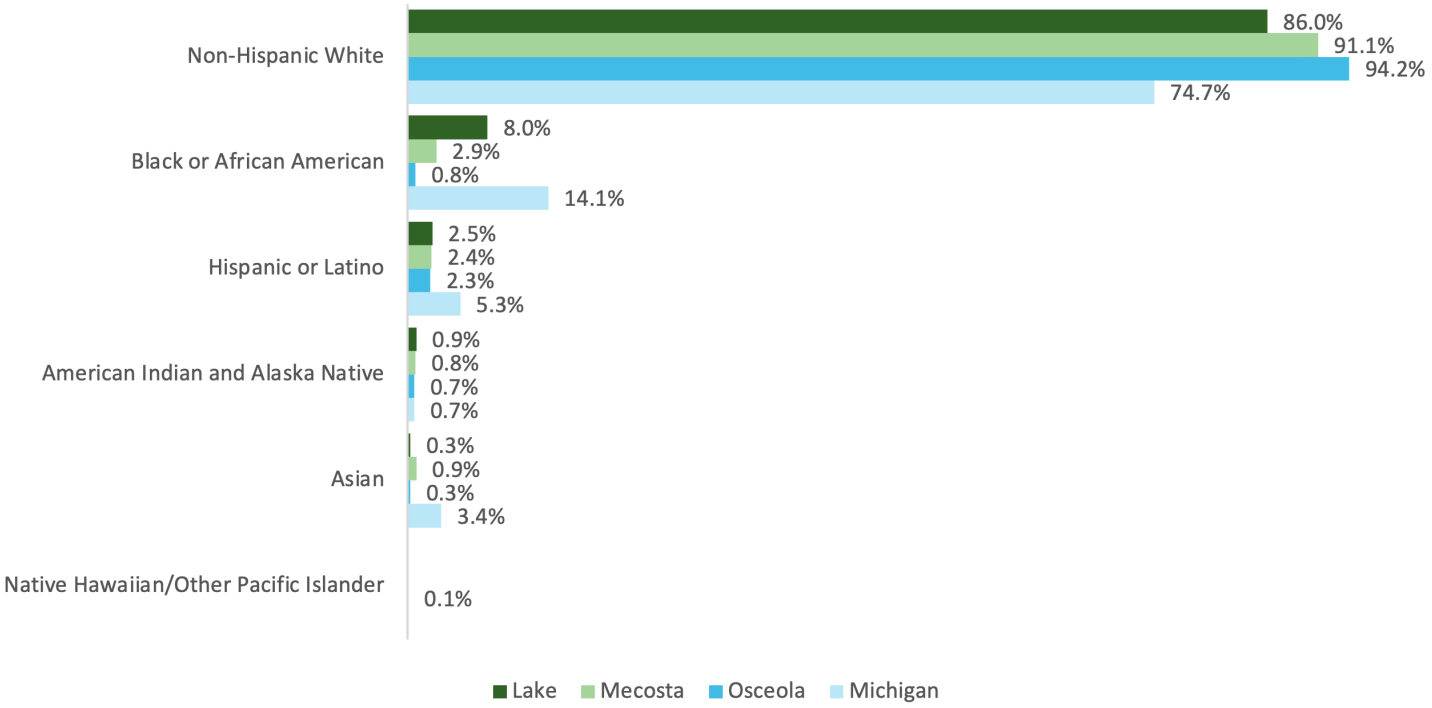
The composition of the population is also important, as health and social issues can impact disparate groups in different ways, and a strategy that works to support one group may not be the best choice for another. Of the 78,766 people who live in the three-county region, 90.4% are white. The largest racial or ethnic minority groups are Black or African American (3.9%), Hispanic or Latino (2.4%), and American Indian and Alaska Native (0.8%).

Figure 5: Rurality by County



Source: 2013, Rural-urban Continuum Code, Economic Research Service U.S. Department of Agriculture

Figure 6: Race and Ethnicity Distribution of Lake, Mecosta and Osceola counties and Michigan



Source: United States Census Bureau, 2019

Figure 7: Age Distribution of Lake, Mecosta, and Osceola counties and Michigan

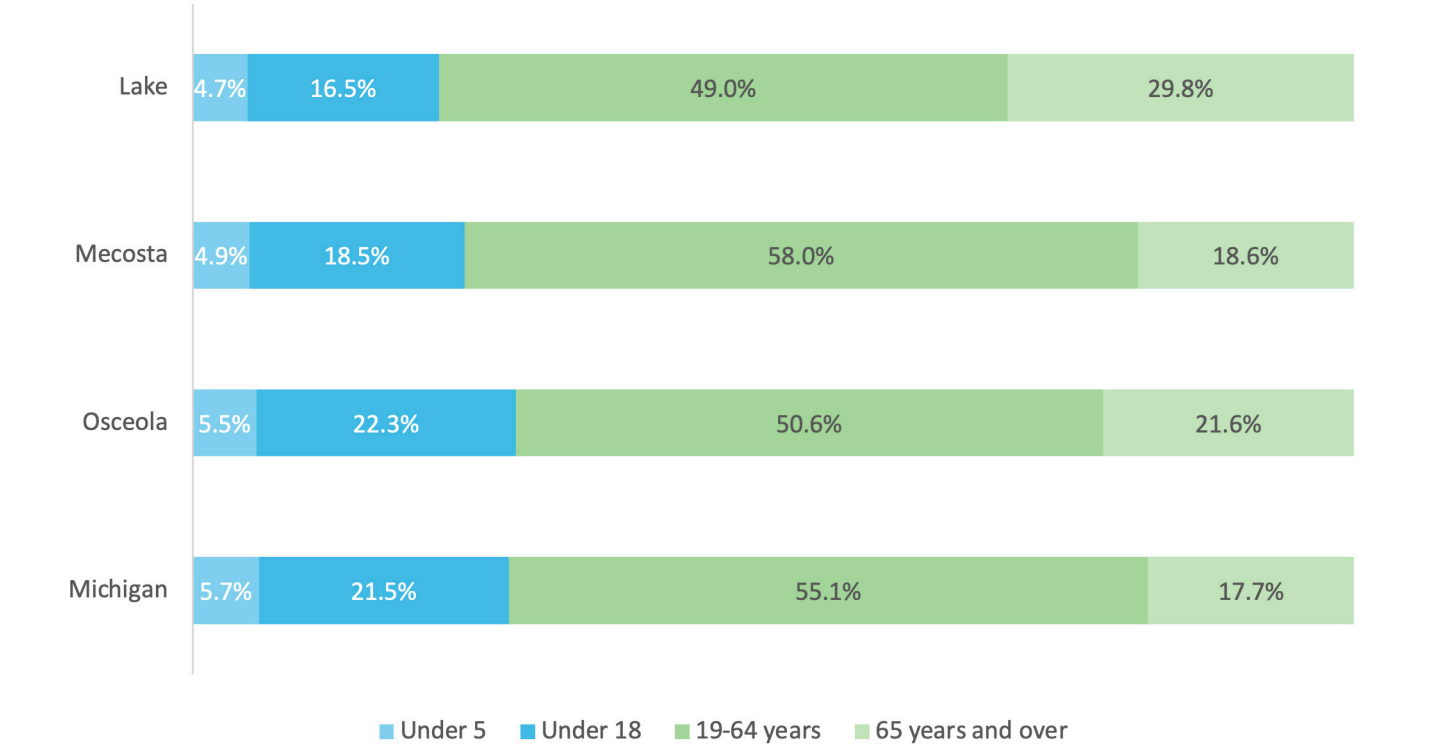
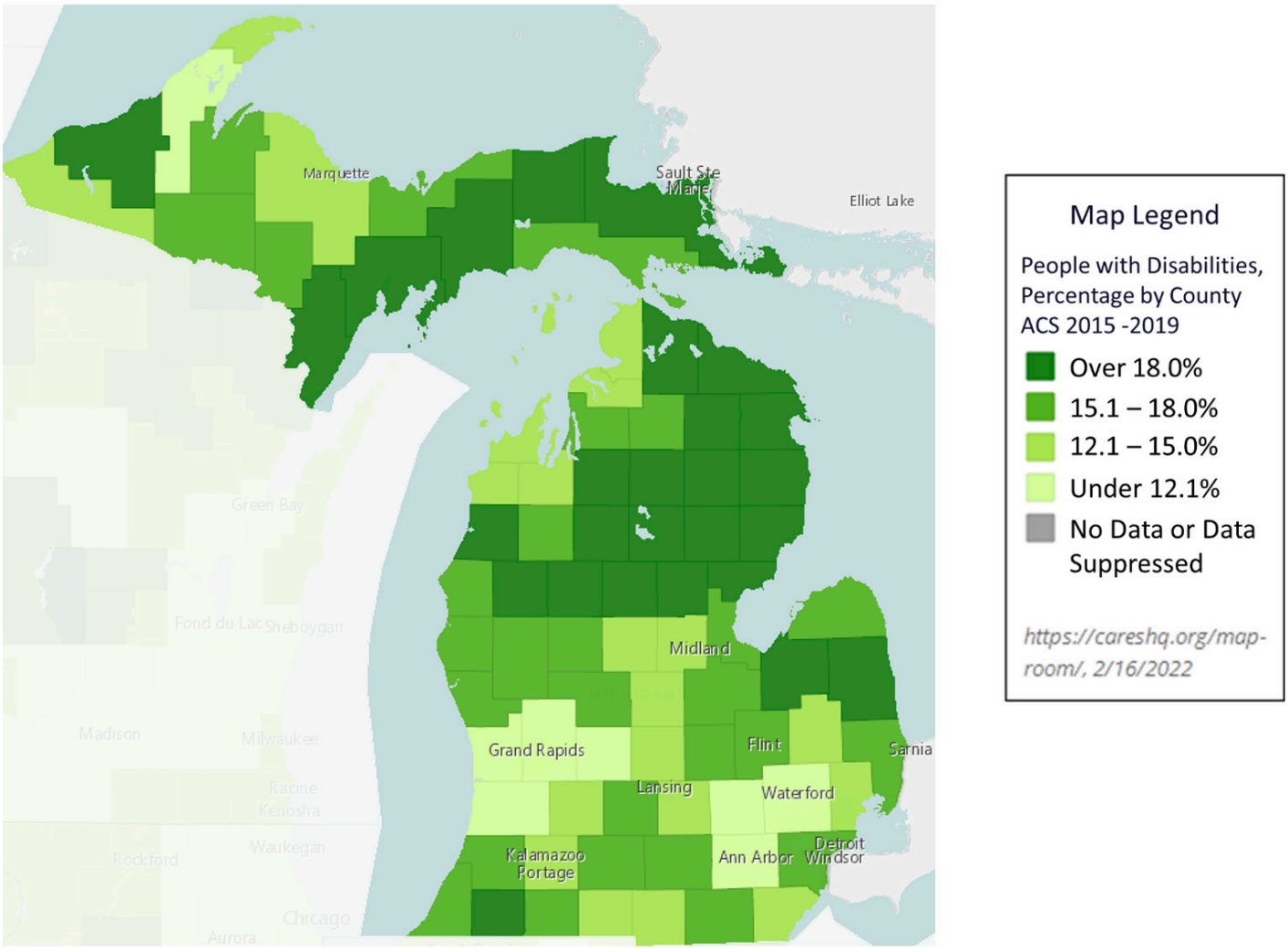
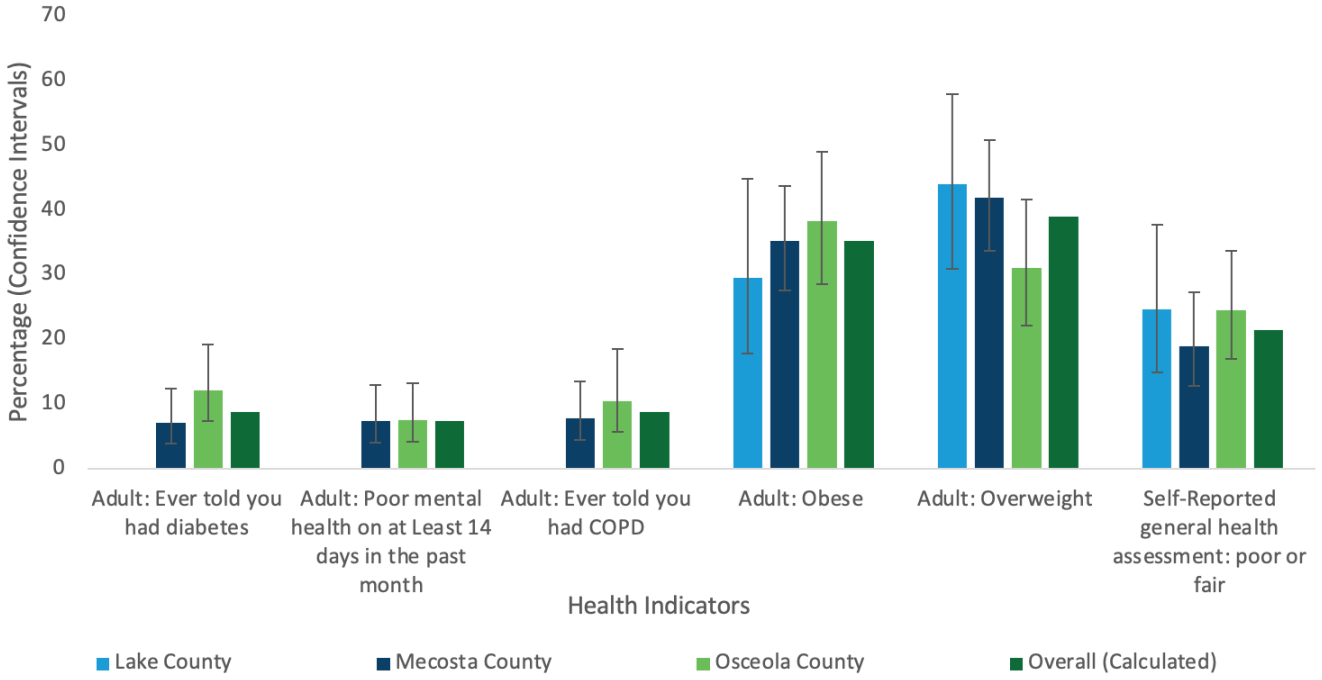


Figure 8: State of Michigan – Prevalence of People with Disabilities



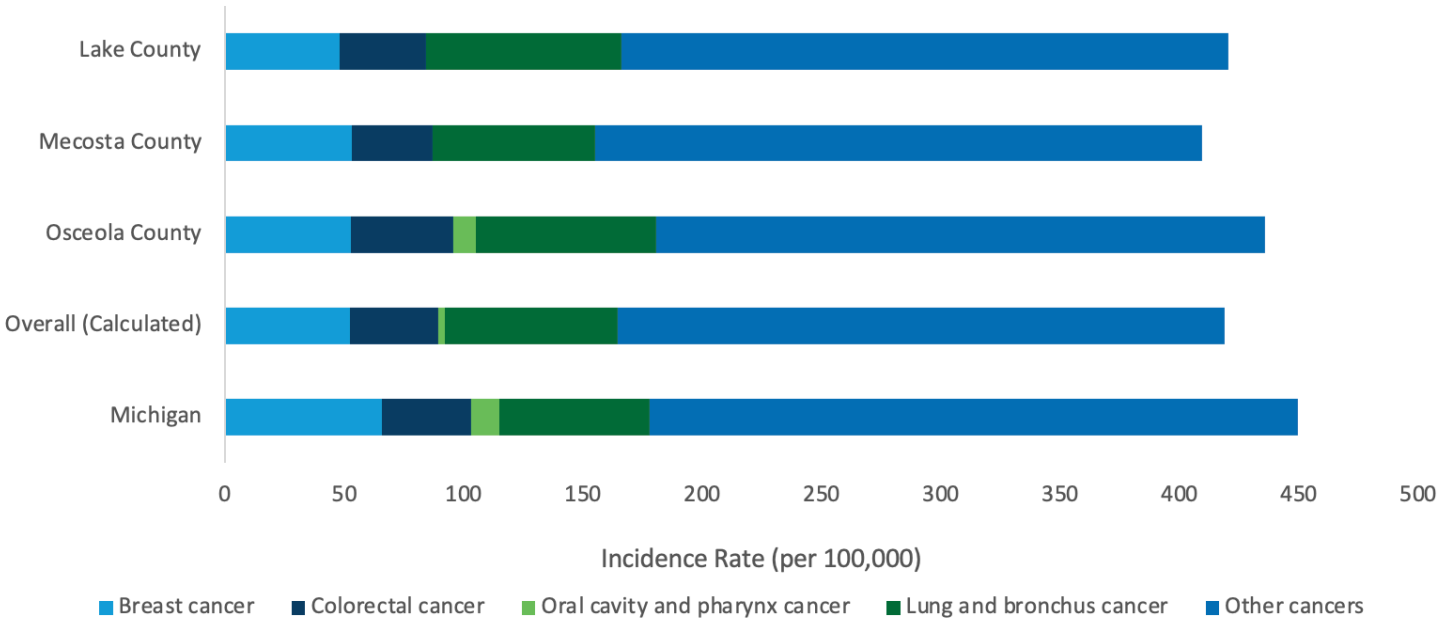
A greater percentage of people in the region (20.5%) have a disability compared to the state (14.2%).

Figure 9: Selected Health Indicators for the Big Rapids Hospital/Reed City Hospital Service Area



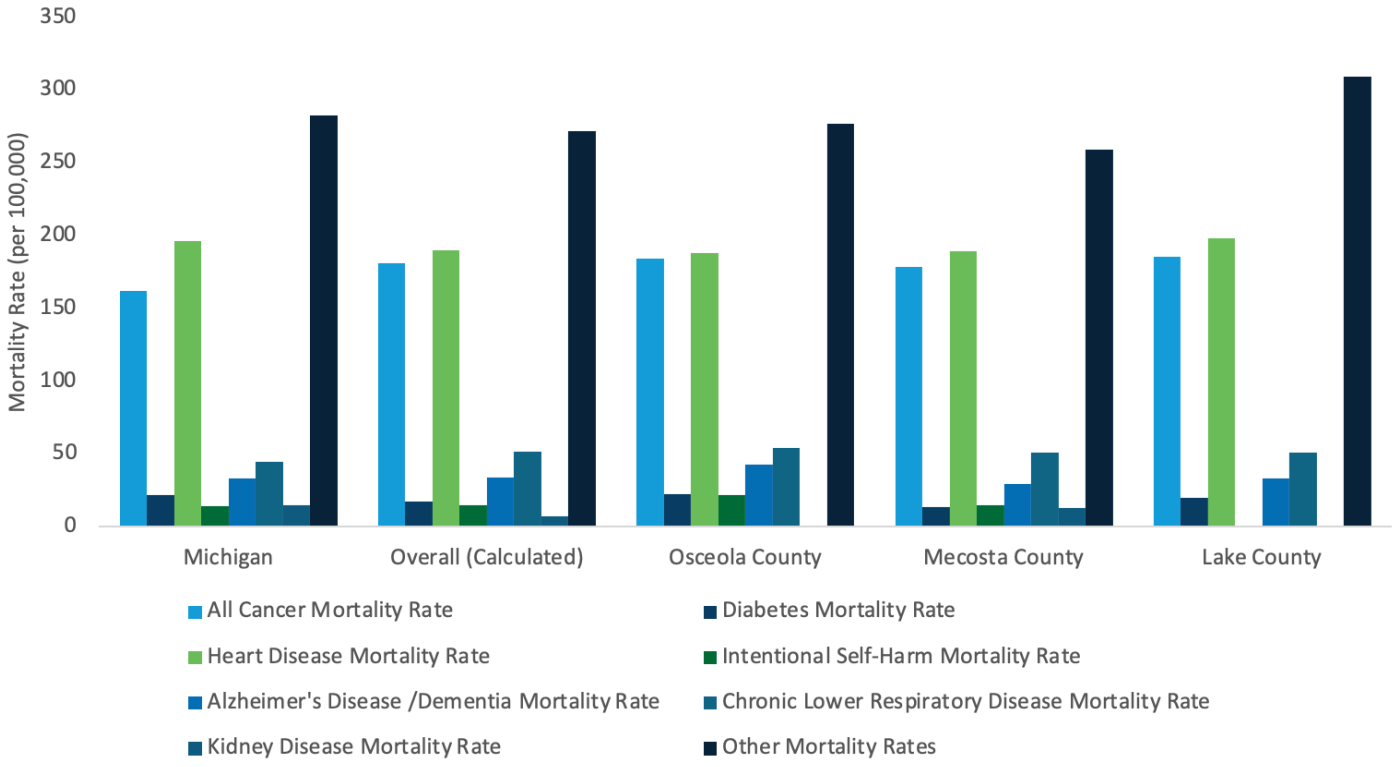
Note: Prevalence figures for Lake County in the "Adult: Ever told you had diabetes," "Adult: Poor mental health on at least 14 Days in the past month" and "Adult: Ever told you had COPD" health indicator categories were suppressed due to low availability of data. In the case of those health indicators, the calculated overall prevalence figures were based on data from Mecosta County and Osceola County alone.

Figure 10: Cancer Incidence Rates for Big Rapids Hospital/Reed City Hospital Service Area



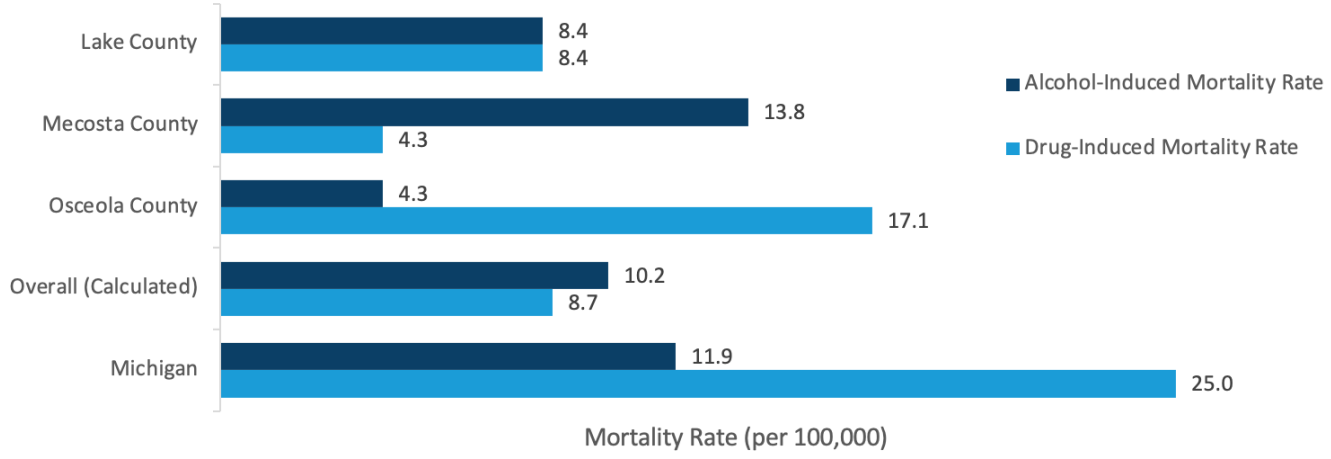
Source: Michigan Behavioral Risk Factor Surveillance System, 2015-2019

Figure 11: Selected Mortality Rates as a Proportion of Total Mortality Rate



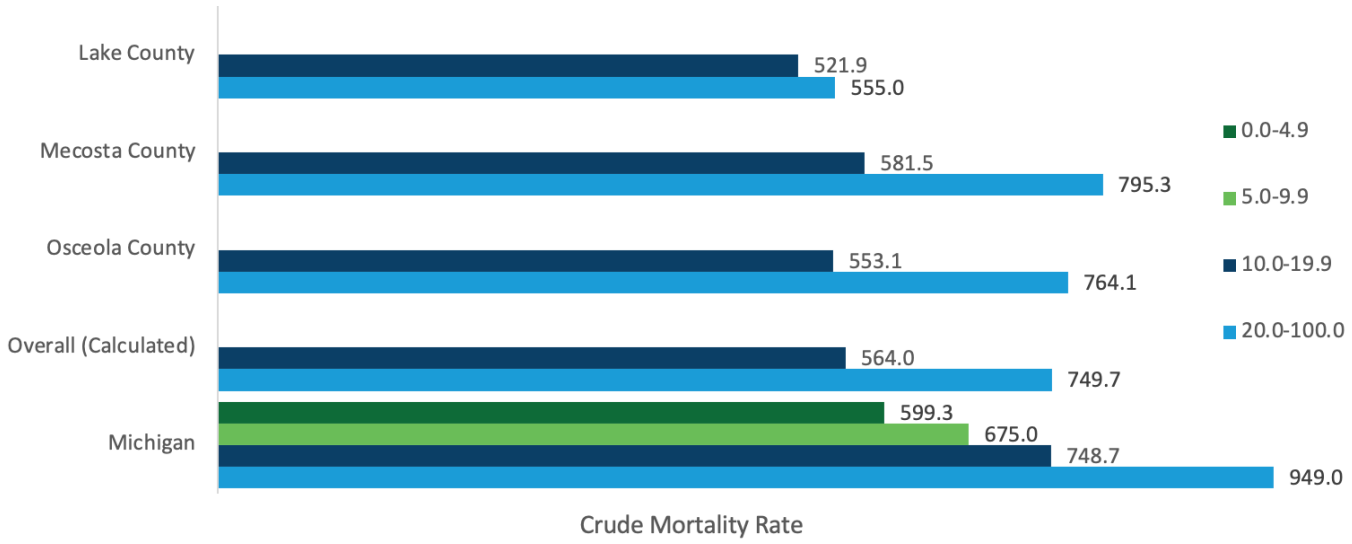
Source: Michigan Department of Health and Human Services Vital Statistics, 2015-2019

Figure 12: Substance-Use-Associated Mortality Rates



Source: Michigan Department of Health and Human Services Vital Statistics, 2015-2019

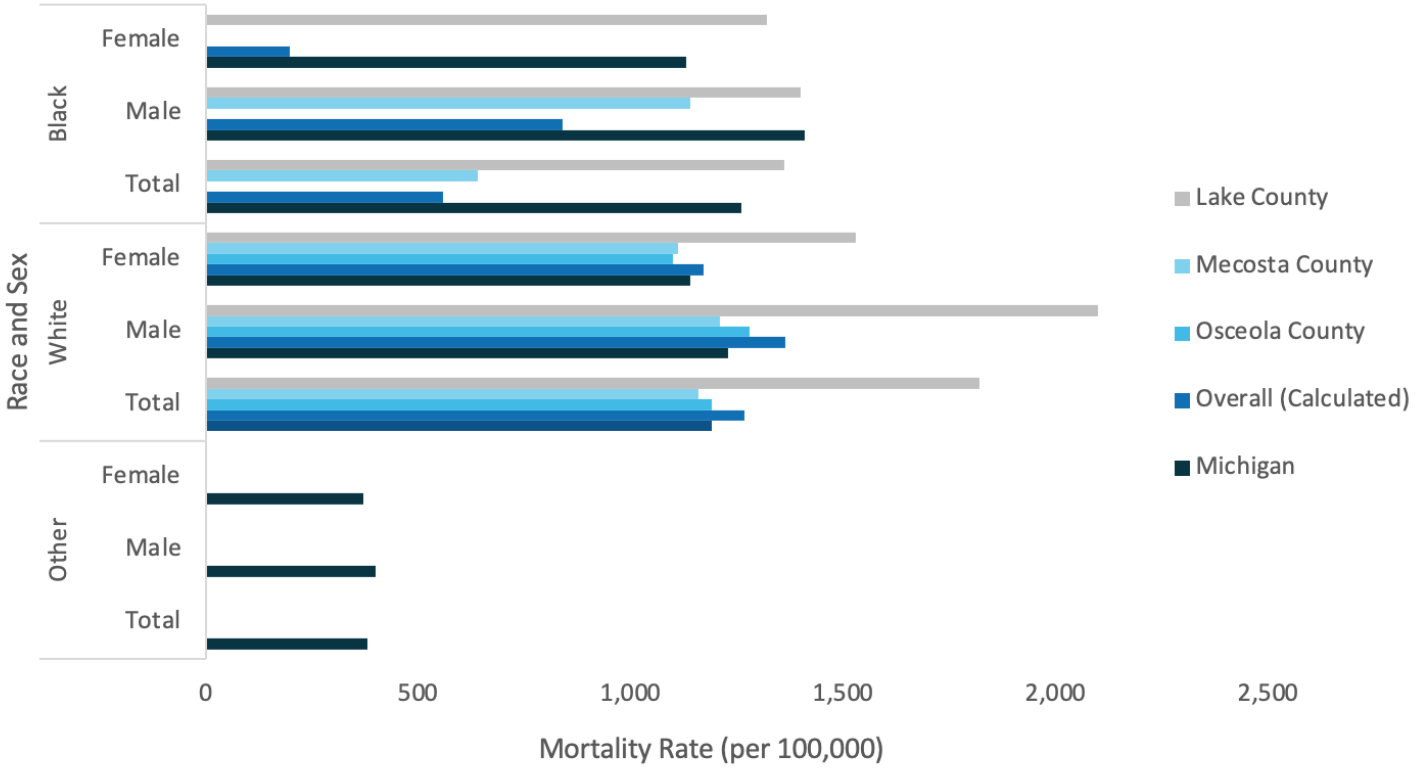
Figure 13: Age-Adjusted Mortality Rates by Poverty Level



Source: Michigan Department of Health and Human Services Mortality and Poverty Statistics, 2019

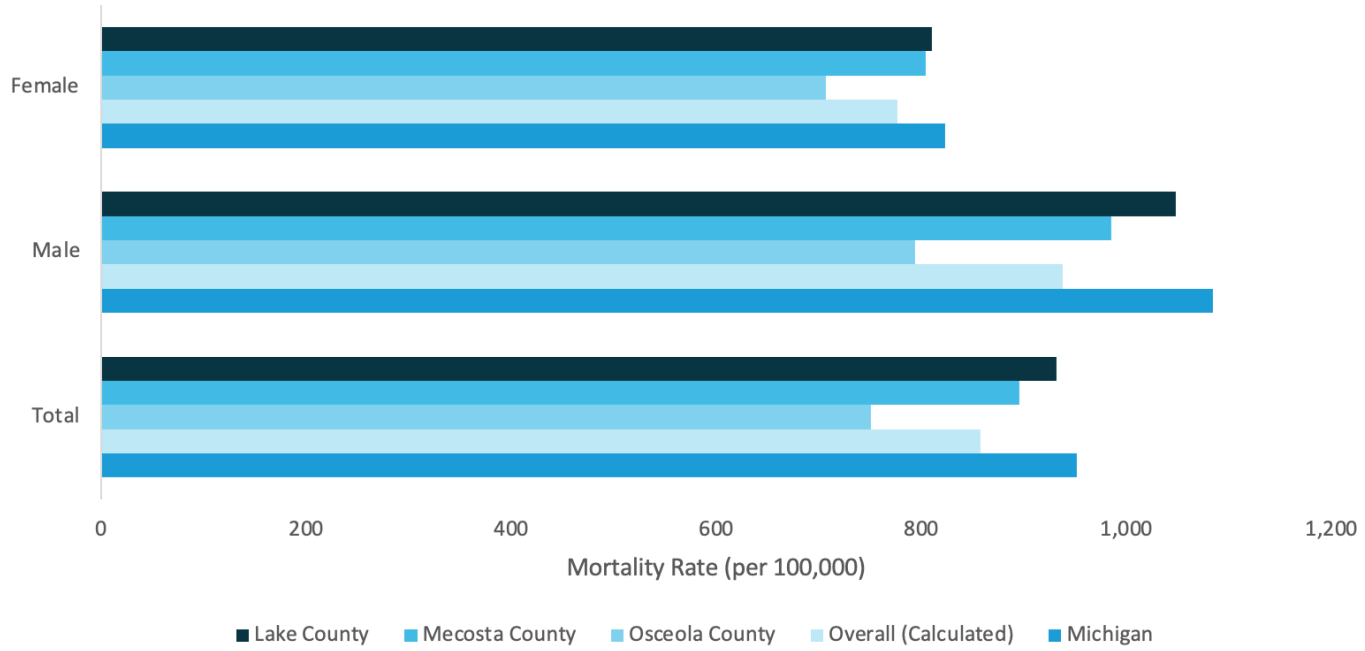
Note: The poverty categories here refer to the percentage of residents in each census tract that live below the poverty line. Deaths have been organized by these categorizations. Any area with 20% or more of the population living below the poverty line is considered a poverty area by U.S. census reports. Age adjustment was performed using the standardized population from the 2000 U.S. census.

Figure 14: Mortality Rates by Race and Sex



Source: Michigan Department of Health and Human Services Vital Statistics, 2020

Figure 15: Age-Adjusted Death Rates by Sex for the Big Rapids Hospital/Reed City Hospital Service Area



Source: Michigan Department of Health and Human Services Vital Statistics, 2020

Note: Age adjustment was performed using the standardized population from the 2000 U.S. Decennial Census.

Community Themes and Strengths Assessment

The Community Themes and Strengths Assessment provides a deep understanding of the issues that residents feel are significant by answering the questions “What is important to our community?,” “How is quality perceived in our community?” and “What assets do we have that can be used to improve well-being?” For the Community Themes and Strengths Assessment, the MiThrive design team designed three types of surveys: Community Survey, Healthcare Provider Survey and Pulse Survey. (Please see Appendix C 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 demographics. The Community Survey also asked respondents to identify assets in their communities. Please see Appendix D for assets from Lake, Mecosta and Oceana counties.

Community Surveys were administered electronically and on paper 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, Oct. 4, 2021, to Friday, Nov. 5, 2021. Five $50 gift cards were offered to incentivize people to complete the survey. Partner organizations promoted the survey through social media and community outreach. Promotional materials developed for the Community Survey include a flyer, social media content, and a press release. Of the 1,456 surveys collected in the North Central MiThrive region, 293 surveys were collected from Lake, Mecosta and Osceola counties.

Figure 16: Community Survey Response Count

A total of 293 Community Survey responses were collected in Lake, Mecosta and Osceola counties.

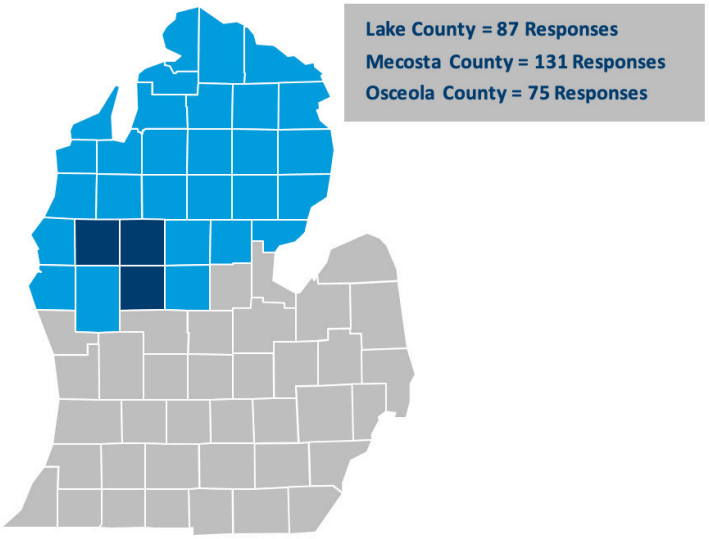


Figure 17: Top 10 Factors for a Thriving Community as Identified by Lake, Mecosta and Osceola County Community Survey Respondents (n=290)

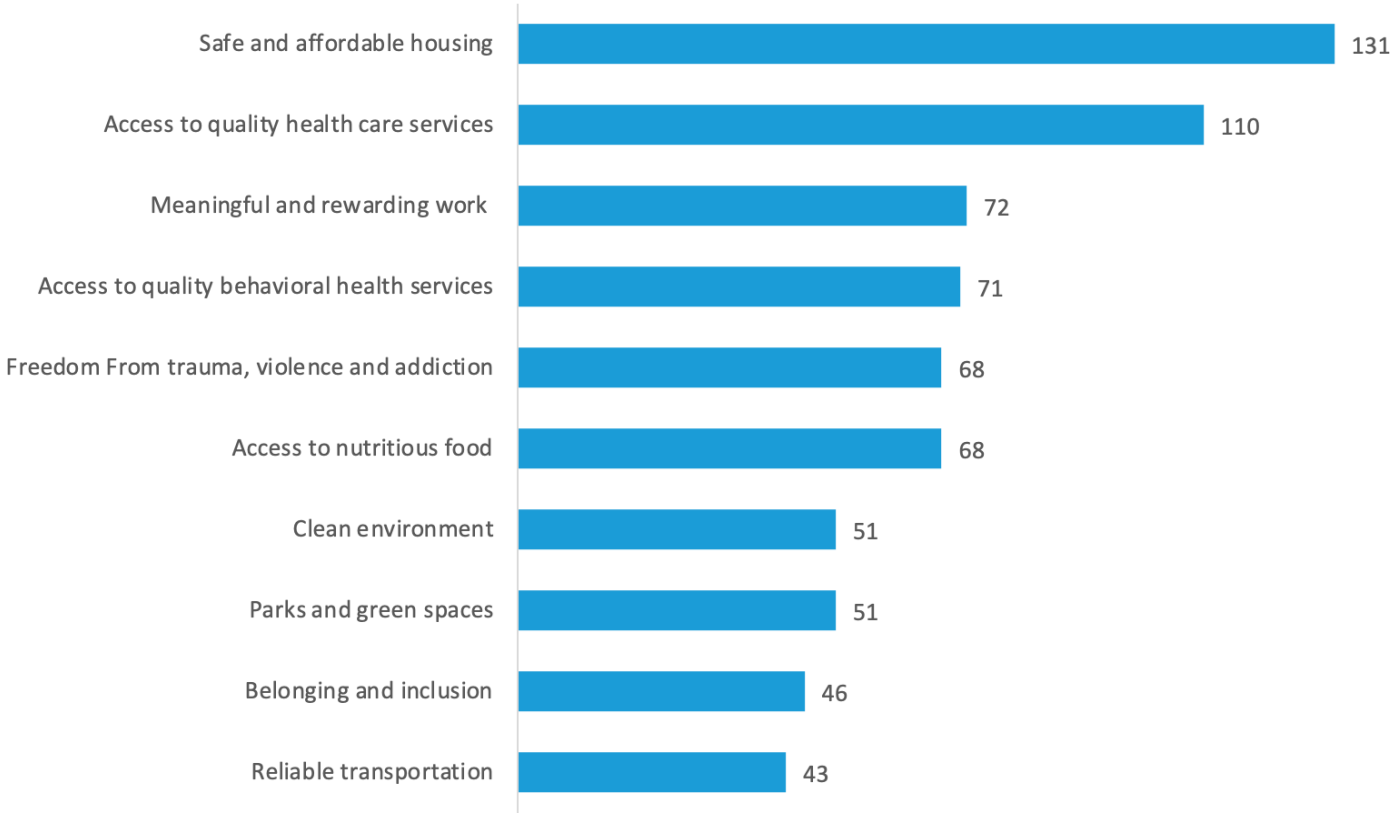
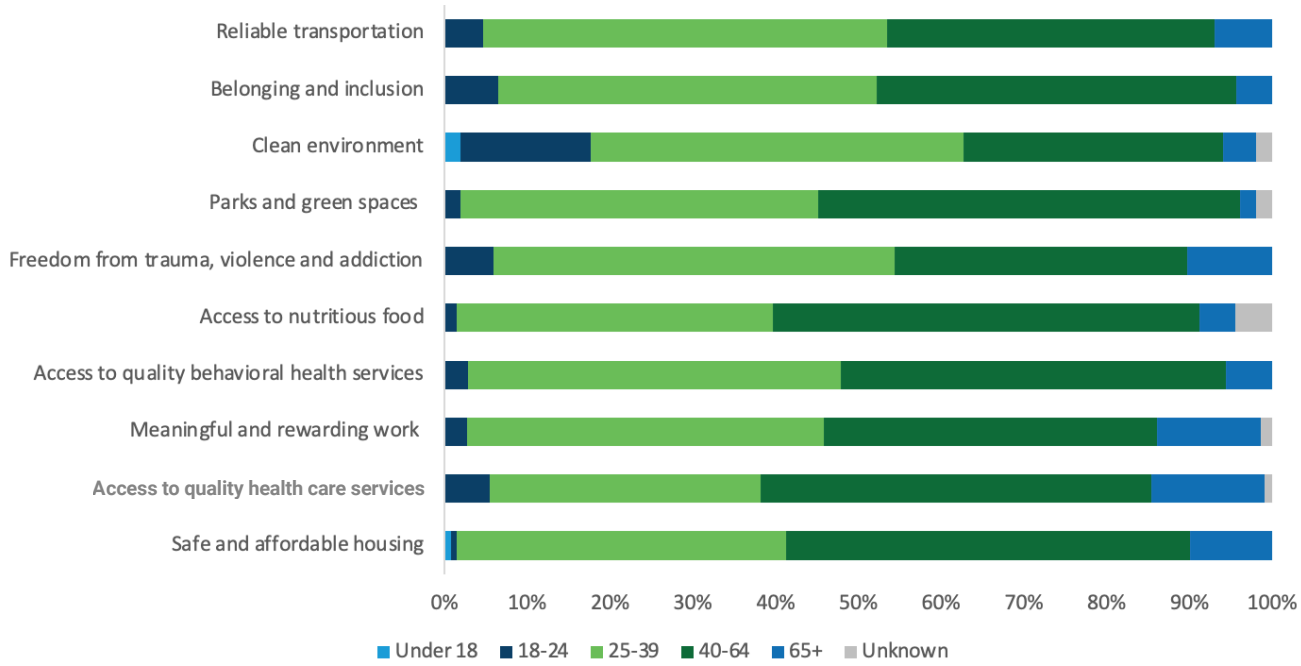
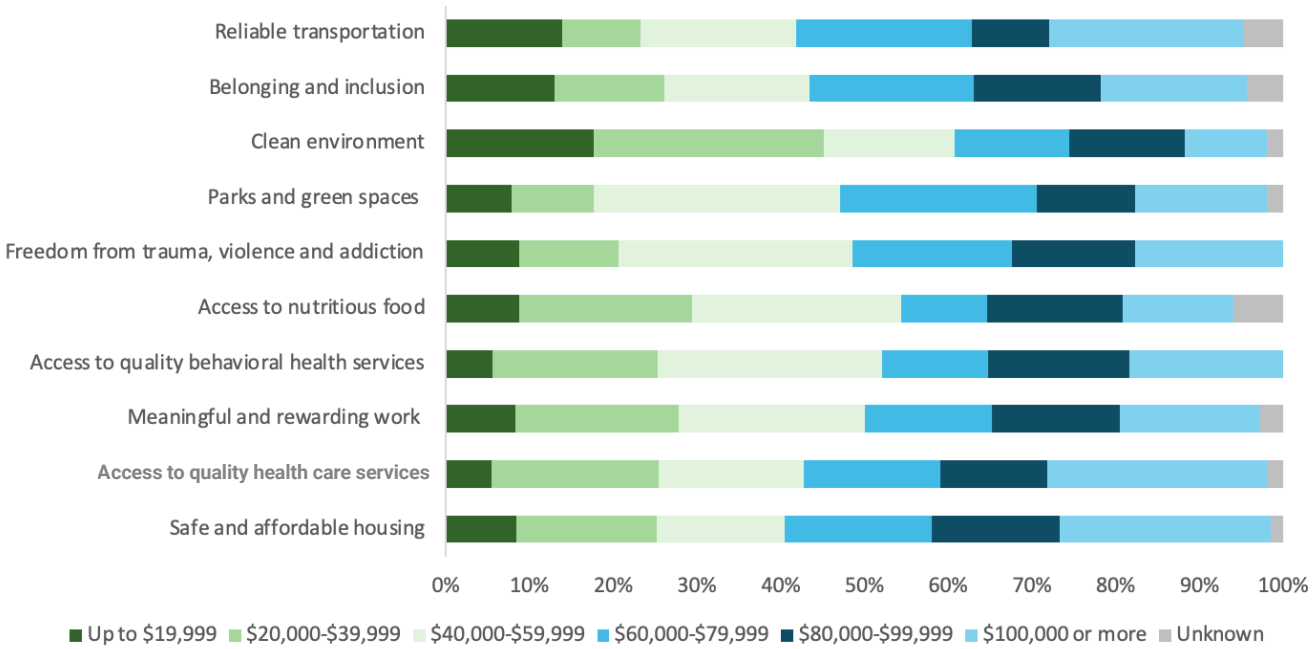


Figure 18: Top 10 Factors for a Thriving Community by Age (n=290)



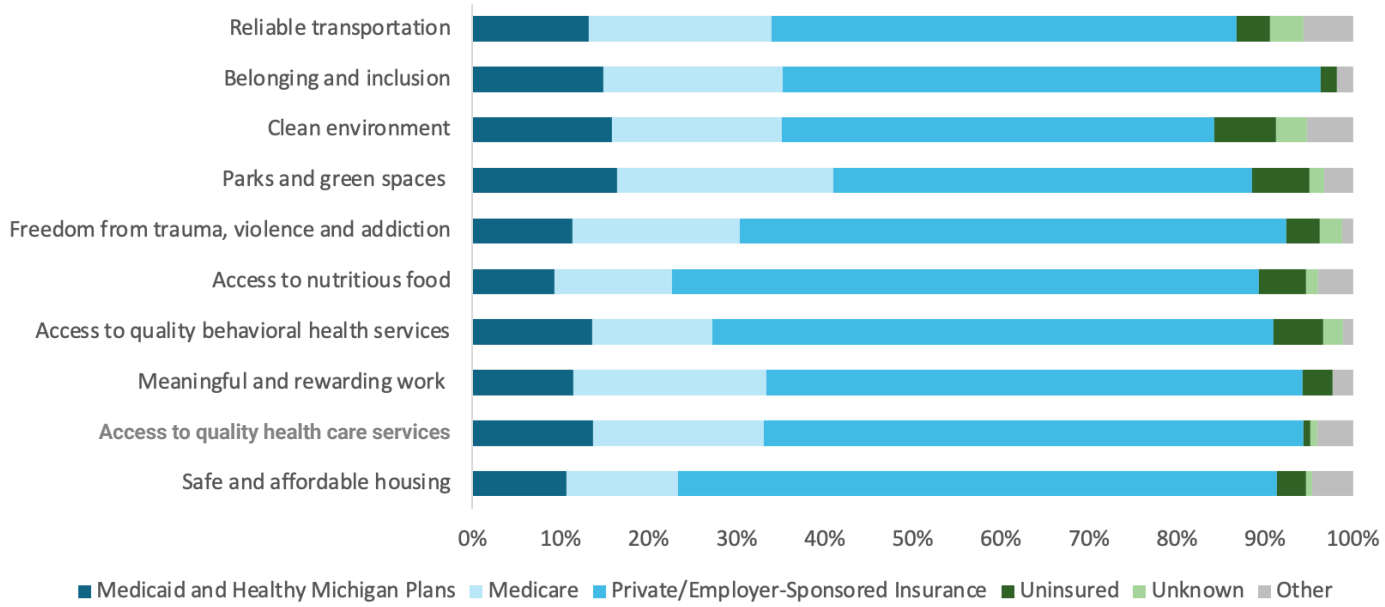
Among individuals age 18-24, more people identified a clean environment as an important factor for a thriving community than identified the other nine top factors.

Figure 19: Top 10 Factors for a Thriving Community by Yearly Household Income (n=290)



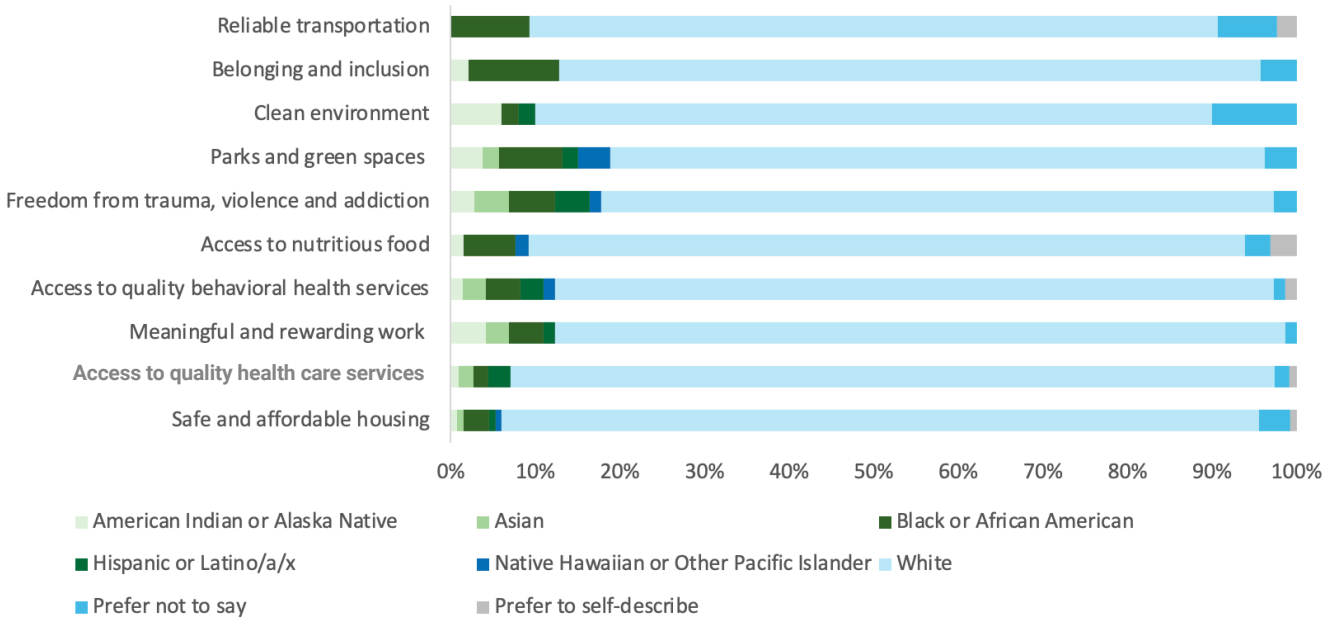
Among individuals with a yearly household income up to $39,999, more people identified clean energy as an important factor for a thriving community than identified the other nine top factors.

Figure 20: Top 10 Factors for a Thriving Community by Insurance Type (n=290)



Among individuals with Medicare, more people identified parks and greenspaces as an important factor for a thriving community than identified the other nine top factors.

Figure 21: Top 10 Factors for a Thriving Community by Race and Ethnicity (n=290)



Among racial and ethnic minority groups, more people identified parks and greenspaces as an important factor for a thriving community than identified the other nine top factors.

Figure 22: Top 10 Issues Impacting the Community as Identified by Lake, Mecosta, and Osceola County Community Survey

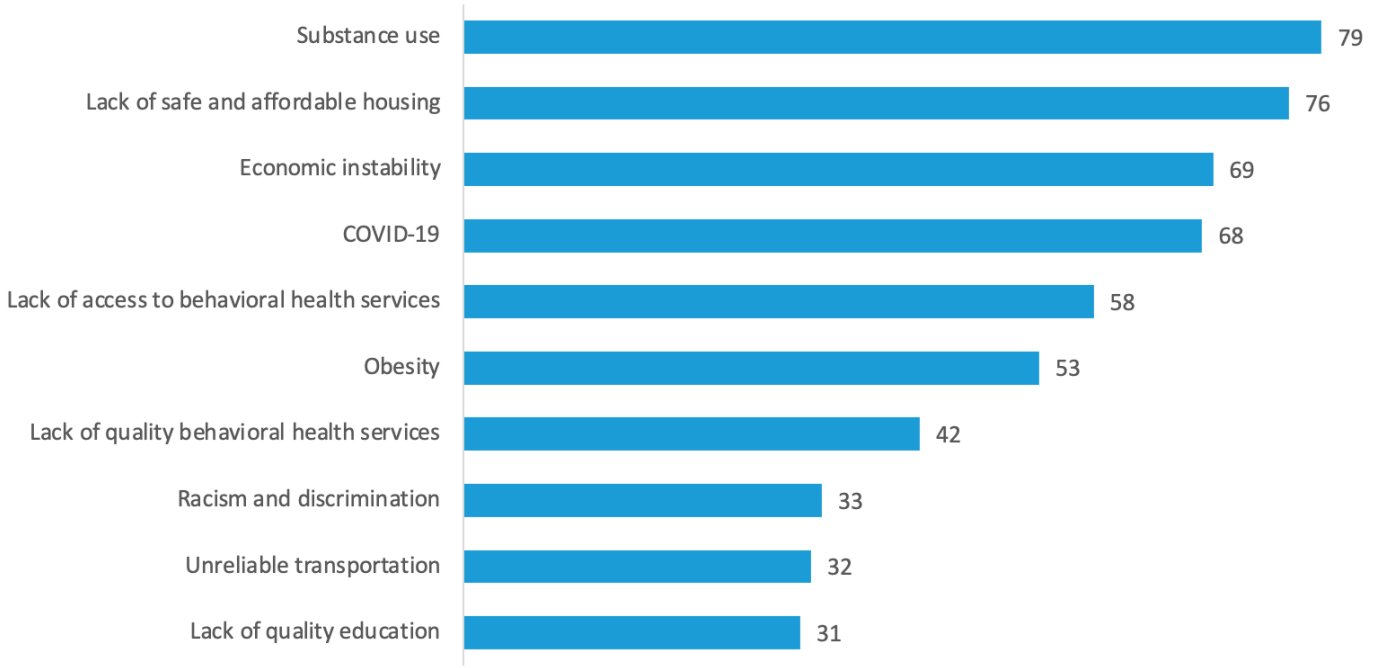
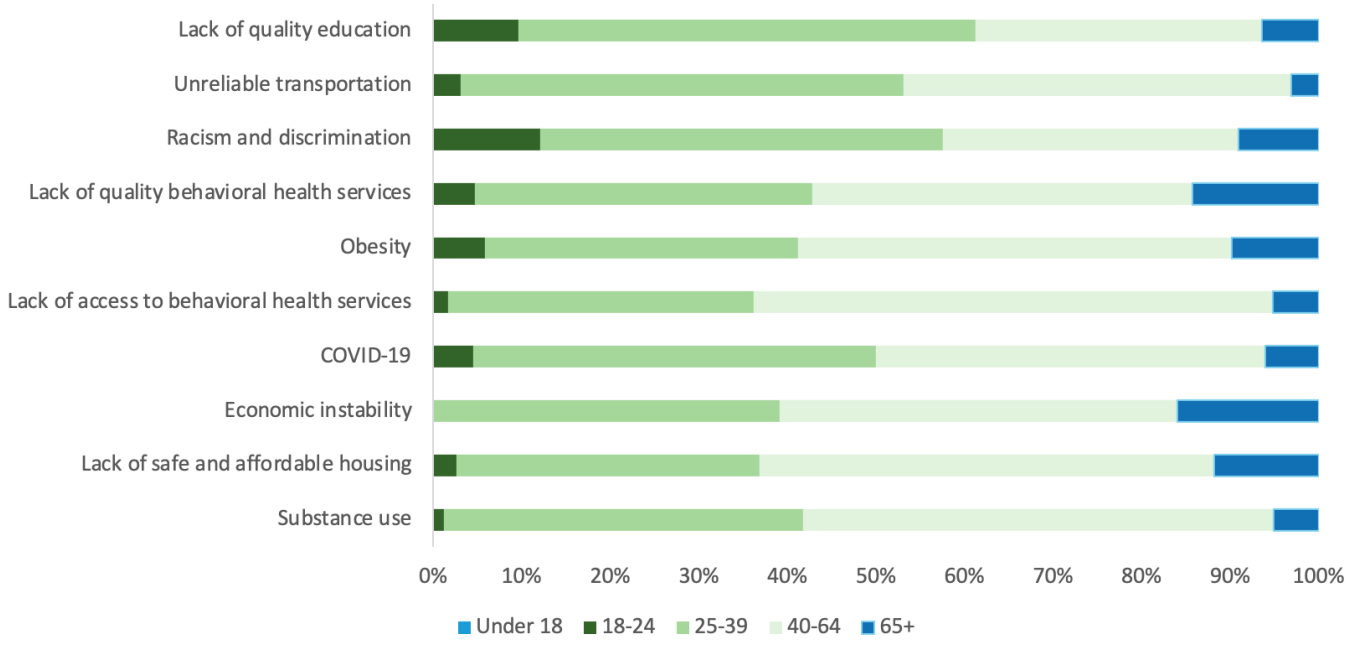
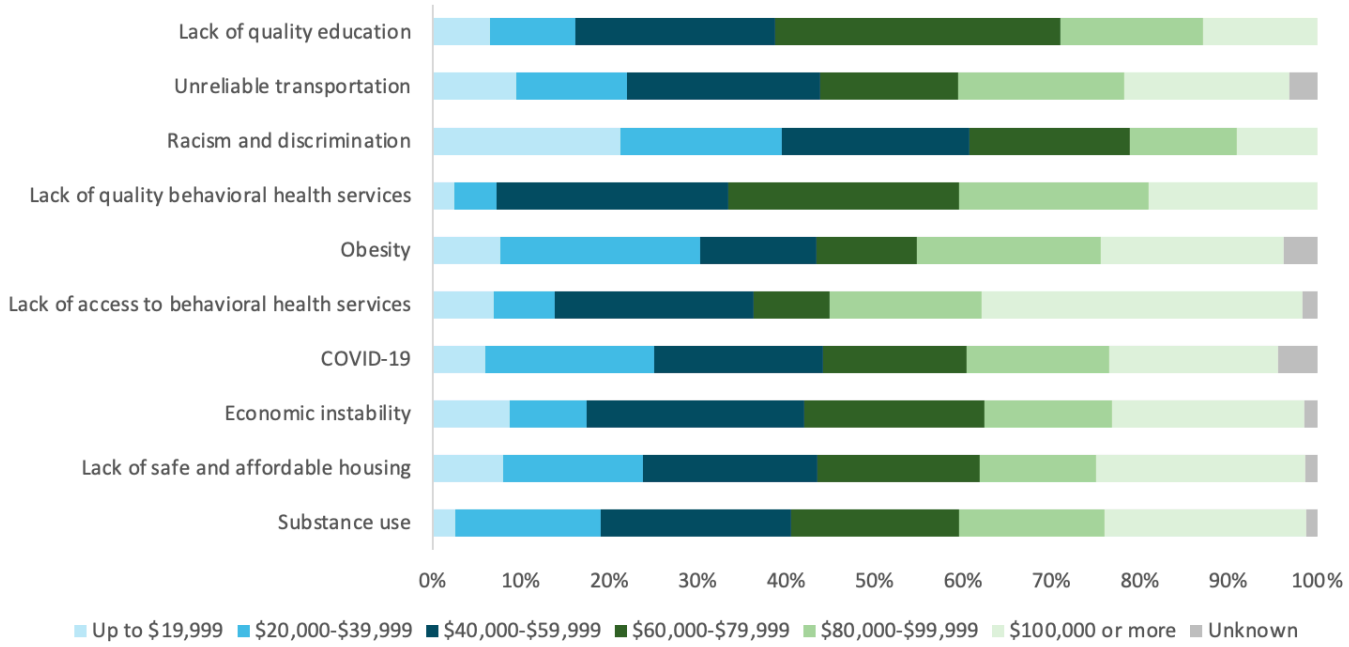


Figure 23: Top 10 Issues Impacting the Community by Age (n=292)



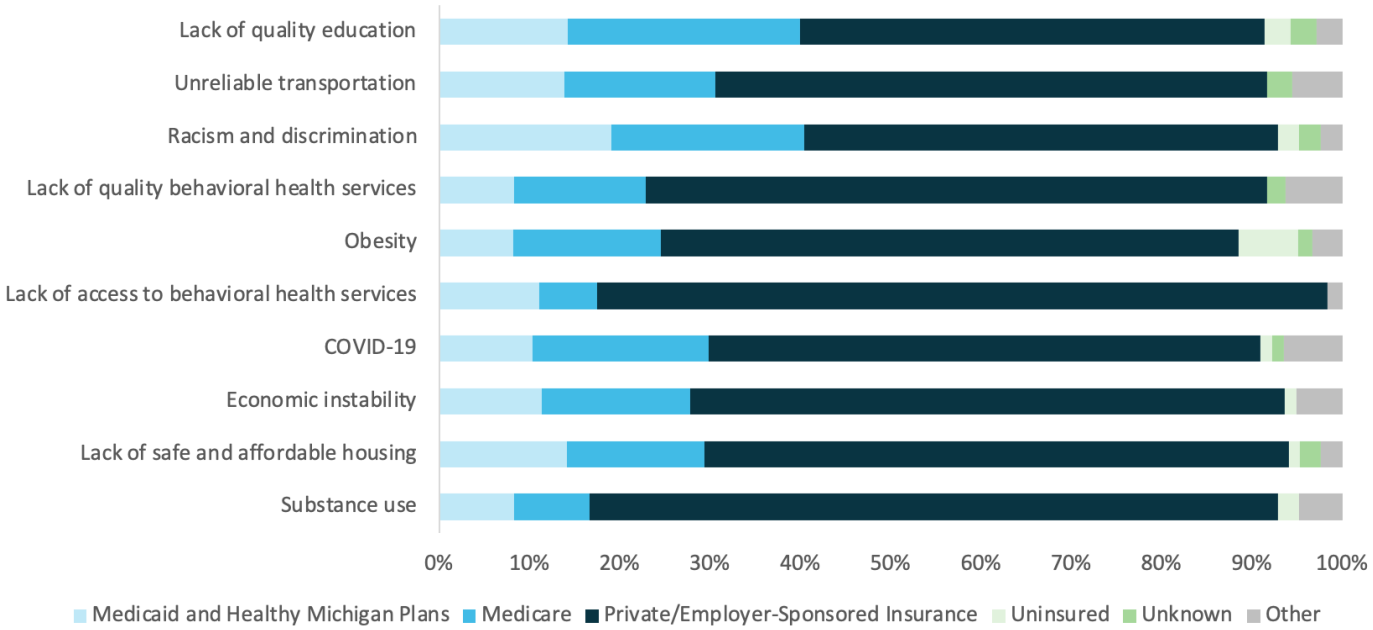
Among individuals age 65 and over, more people identified economic instability as an important issue impacting the community than identified the other nine top factors.

Figure 24: Top 10 Issues Impacting the Community by Yearly Household Income (n=292)



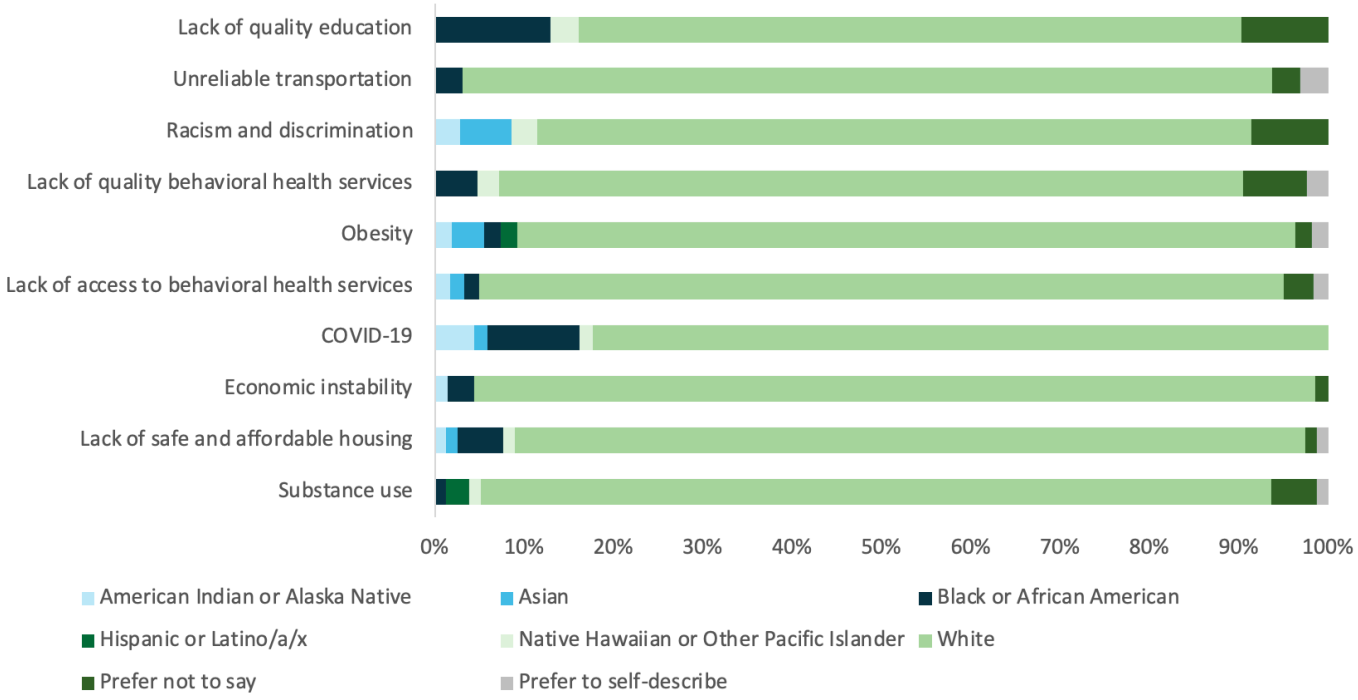
Among individuals with a yearly household income up to $59,999, more people identified racism and discrimination as an important issue impacting the community than identified the other nine top factors.

Figure 25: Top 10 Issues Impacting the Community by Insurance Type (n=292)



Among individuals with private/employer sponsored insurance, more people identified substance abuse as an important issue impacting the community than identified the other nine top factors.

Figure 26: Top 10 Issues Impacting the Community by Race and Ethnicity (n=292)



Among racial and ethnic and minority groups, more people identified COVID-19 as an important issue impacting the community than identified the other nine top factors.

Figure 27: Top Issues Preventing Individuals From Engaging in More Physical Activity as Identified by Lake, Mecosta and Osceola County Community Survey Respondents (n=290)

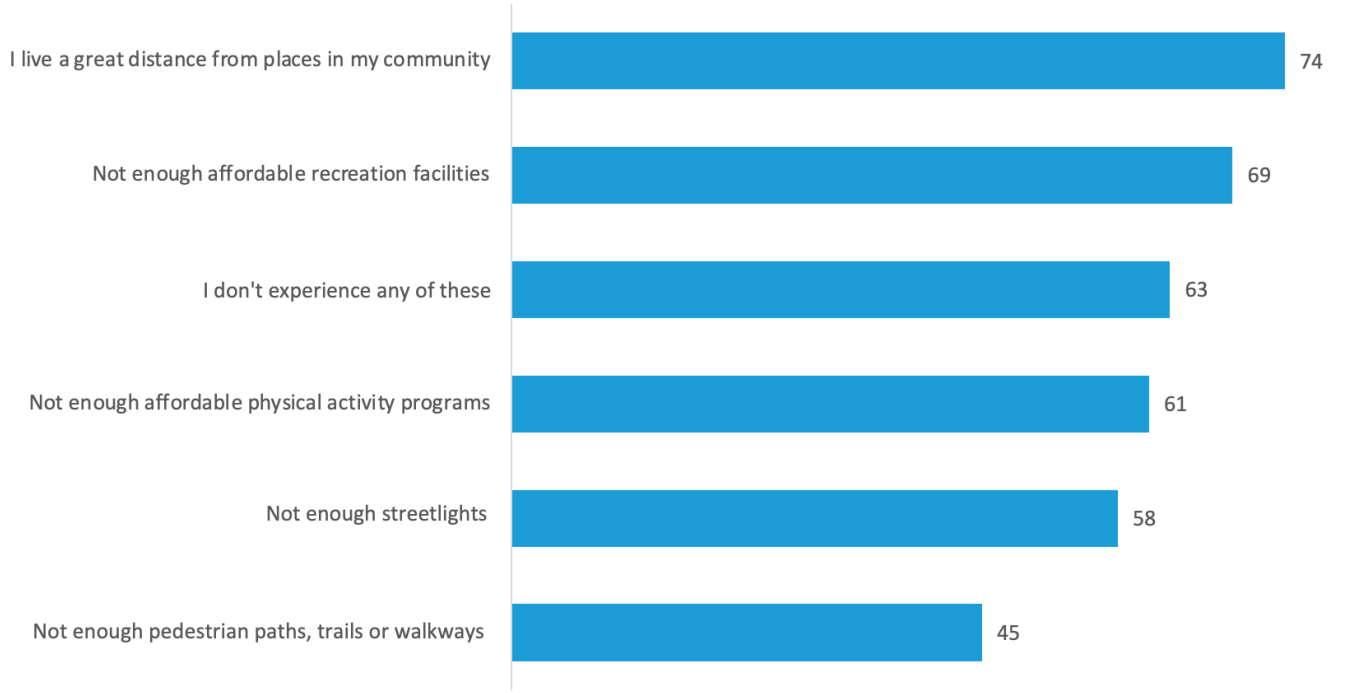
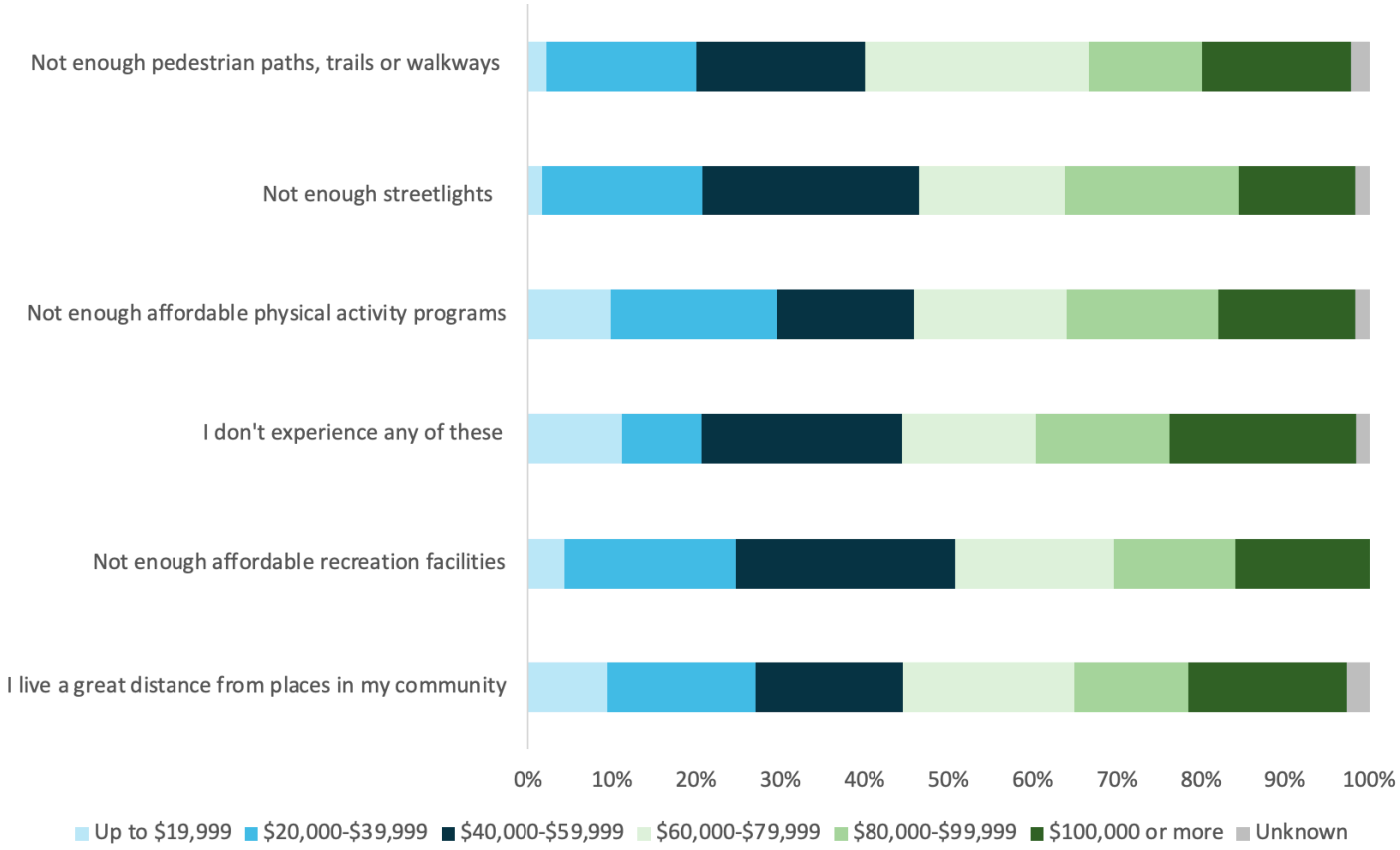


Figure 28: Top Issues Preventing Individuals From Engaging in More Physical Activity by Yearly Household Income (n=290)



Among individuals with a yearly household income of $40,000-$59,999, more people identified not enough affordable recreation facilities as an issue preventing them from being more physically active than identified the other nine top factors.

Survey respondents were asked to imagine a ladder with steps numbered from 0 at the bottom to 10 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 (Figure29) and where they felt they would stand three years from now (Figure 30).

Figure 29: 36.33% of individuals in Lake, Mecosta and Osceola Counties are currently either struggling or suffering compared to 63.67% who are thriving.

Figure 30: 28.03% of individuals in Lake, Mecosta, and Osceola Counties predict they will either be struggling or suffering compared to 71.97% who predict they will be thriving three years from now.

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

On average, individuals in Lake, Mecosta and Osceola counties felt they would move **one step higher** on the ladder three years from how they scored themselves presently (n=289)

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 in which 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 woven into existing intake and appointment processes of participating agencies/organizations. Community partners administered the Pulse Survey series between July 26, 2021, and Sept. 17, 2021, using a variety of delivery methods, including in-person interviews, phone interviews, in-person written surveys, and 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 an open-ended topic-specific question. Additionally, each survey included an open-ended equity question. Within the Lake, Mecosta and Osceola service region, 41 aging, 19 children, 8 disability and 25 economic security responses were collected. The target population for the Pulse Survey series included people from historically excluded groups, economically disadvantaged individuals, older adults, racial and ethnic minorities, unemployed individuals, uninsured and underinsured individuals, Medicaid-eligible individuals, children from low-income families, LGBTQ+ and gender-nonconforming individuals, people with HIV, people with severe mental and behavioral health disorders, people experiencing homelessness, refugees, people with a disability and many others.

Figure 31: Total Count of Pulse Surveys Collected in Lake, Mecosta and Osceola Counties (n=93)

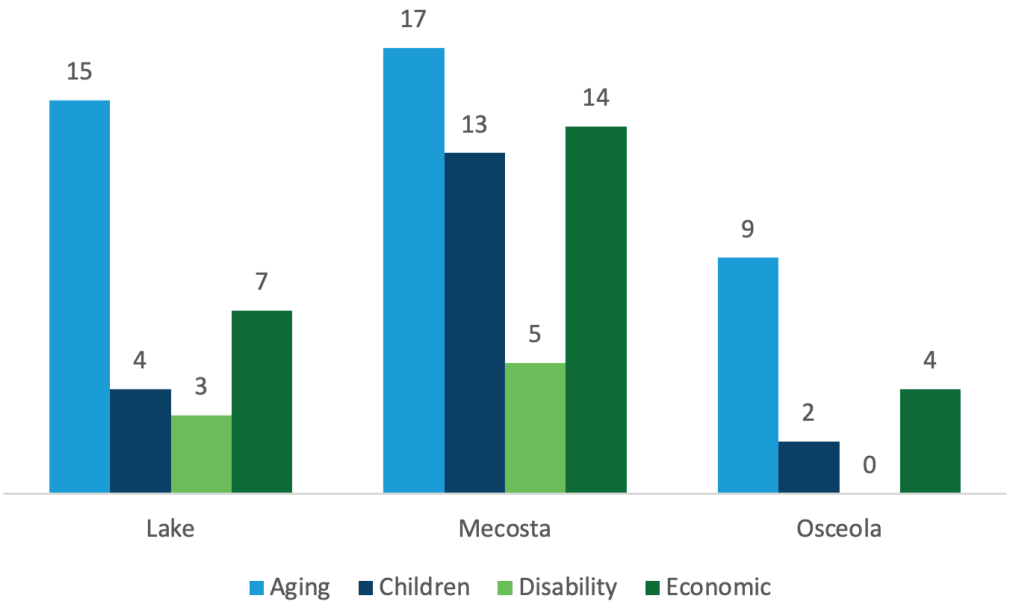
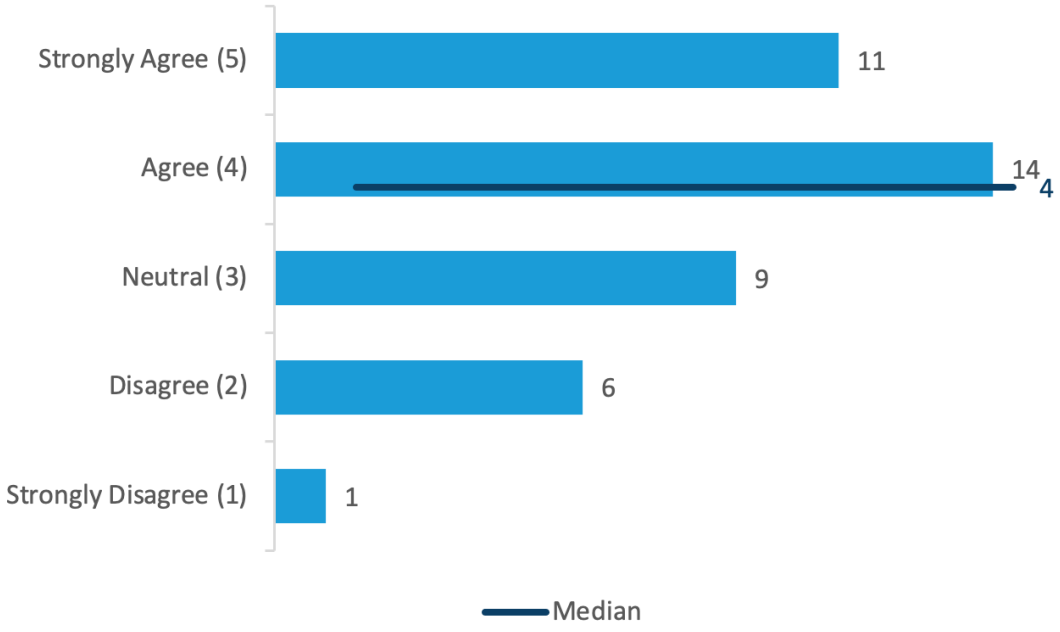


Figure 32: Agreement Breakdown of the Statement "My community is a good place to age" (n=41)



Key themes that emerged among Pulse Survey respondents who gave a low rating to the statement "My community is a good place to age."

1	Lack of Resources
2	Lack of Transportation
3	Poverty
4	Geographic Location/Rurality
5	Lack of Housing
6	Safety Concerns

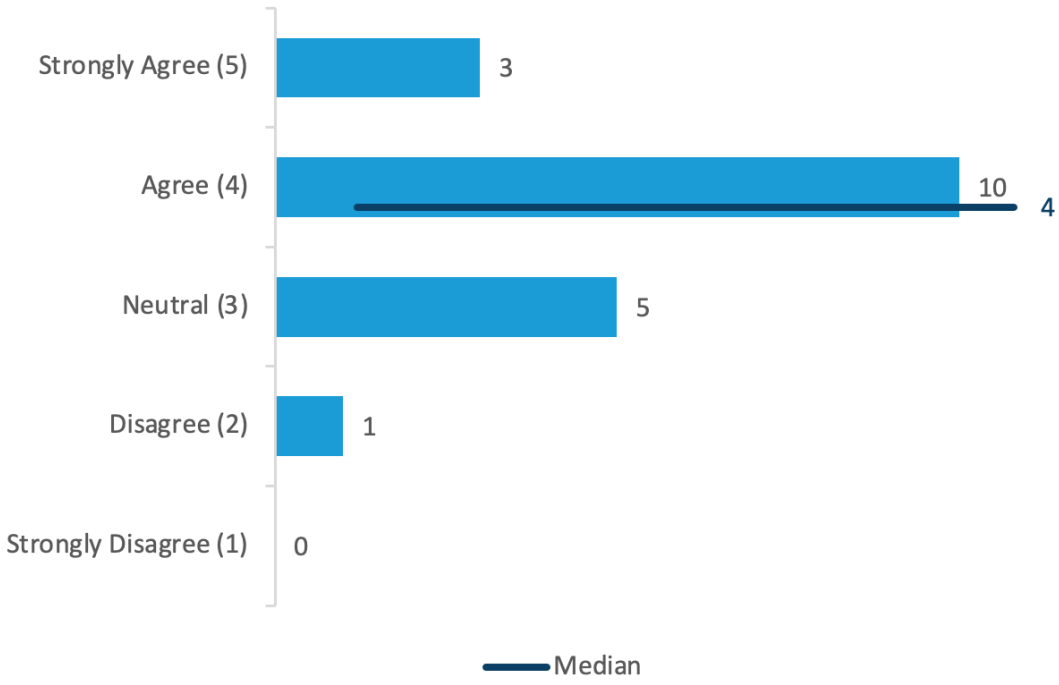
**Themes emerged from the 10-county MiThrive North Central region data.*

Thinking more broadly, how would you ensure that people in tough life circumstances come to have as good a chance as other do in achieving good health and well-being over time?

1	Change in Health Care System
2	Increase Financial Assistance/Government Assistance
3	More Resource Navigation
4	Increase Education and Job Availability
5	Increase Community Support/Support Systems
6	Improved Transportation

**Themes emerged from the 10-county MiThrive North Central region data.*

Figure 33: Agreement Breakdown of the Statement "This community is a good place to raise children" (n=19)



Key themes that emerged among Pulse Survey respondents who gave a low rating to the statement "This community is a good place to raise children."

1	Lack of Resources
2	Poverty
3	Safety Concerns
4	Low-Quality Education

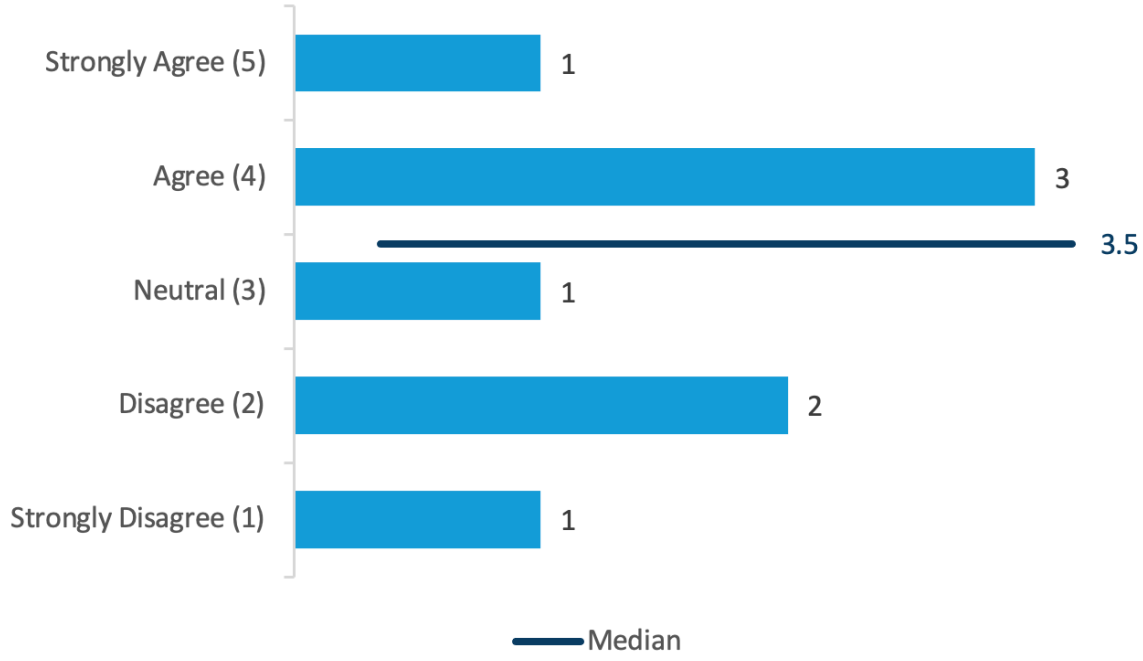
**Themes emerged from the 10-county MiThrive North Central region data.*

Thinking more broadly, what are some ways in which your community could ensure everyone has a chance at living the healthiest life possible?

1	Combat Food Insecurity
2	Promote Community Engagement
3	Improve Outreach Efforts
4	Promote Nutrition and Physical Activity
5	Improve Transportation
6	Improve the Health Care System
7	Increase Housing Options
8	Promote Social Justice

**Themes emerged from the 10-county MiThrive North Central region data.*

Figure 34: Agreement Breakdown of the Statement, “In this community, a person with a disability can live a full life” (n=8)



Key themes that emerged among Pulse Survey respondents who gave a low rating to the statement “In this community, a person with a disability can live a full life”

1	Lack of Resources
2	Lack of Accessible Infrastructure
3	System Issues
4	Geographic Location/Rurality
5	Need for More Community Support

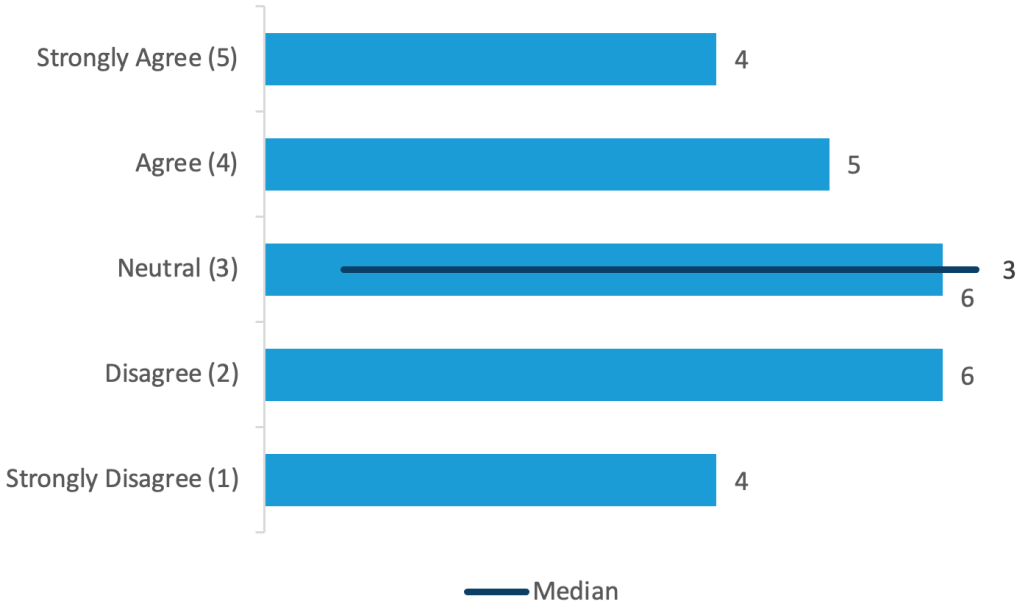
**Themes emerged from the 10-county MiThrive North Central region data.*

Thinking more broadly, how can we come together so that people promote each other’s well-being and not just their own?

1	Strengthen Community Connection and Support
2	Provide Affordable Recreation Opportunities
3	Improve Health Education and Awareness
4	Increase Mental Health Supports
5	Offer More Resources and Services
6	Strengthen Family Support

**Themes emerged from the 10-county MiThrive North Central region data.*

Figure 35: Agreement Breakdown of the statement "There is economic opportunity in the community" (n=25)



Key themes that emerged among Pulse Survey respondents who gave a low rating to the statement "There is economic opportunity in the community."

1	Job Availability
2	Housing
3	Wages
4	Lack of Resources
5	Child Care
6	Transportation/Commute
7	Rurality/Geographic Location

**Themes emerged from the 10-county MiThrive North Central region data.*

Think more broadly about groups that experience relatively good health and those that experience poor health. Why do you think there is a difference?

1	Change in Health Care System
2	Increased Financial Assistance/Government Assistance
3	More Resource Navigation
4	Increased Education and Job Availability
5	Increased Community Support/Support Systems
6	Improved Transportation
7	Need for Increased Community Support
8	Geographic Location/Rurality

**Themes emerged from the 10-county MiThrive North Central region data.*

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 demographics. The survey was open from Oct. 18, 2021, to Nov. 7, 2021.

Health care 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. Forty-nine providers completed the Healthcare Provider Survey in Lake, Mecosta and Osceola counties.

Figure 36: Provider Survey Response Breakdown (n=49)

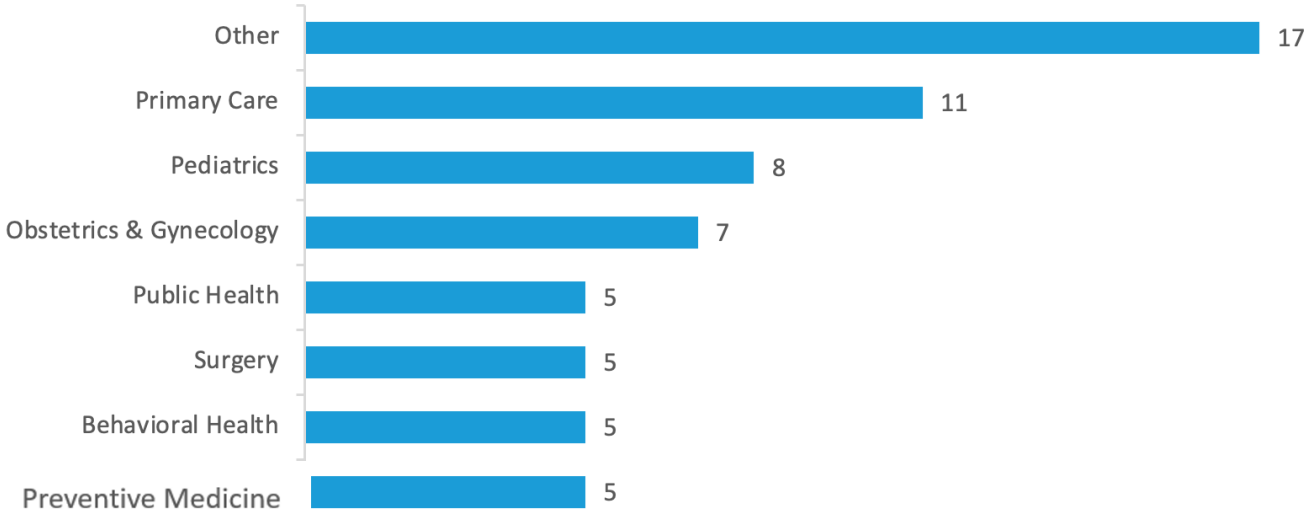


Figure 37: Count of Providers Reporting the Percentage of Patients/Clients Who Are On Medicaid (n=49)

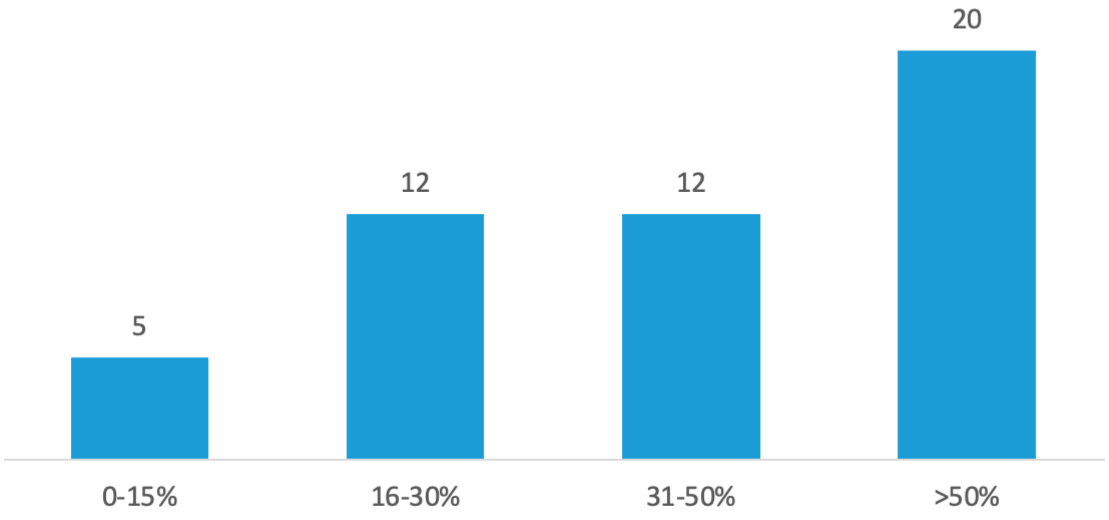


Figure 38: Provider Survey Responses on Most Important Factors For a Thriving Community (n=49)

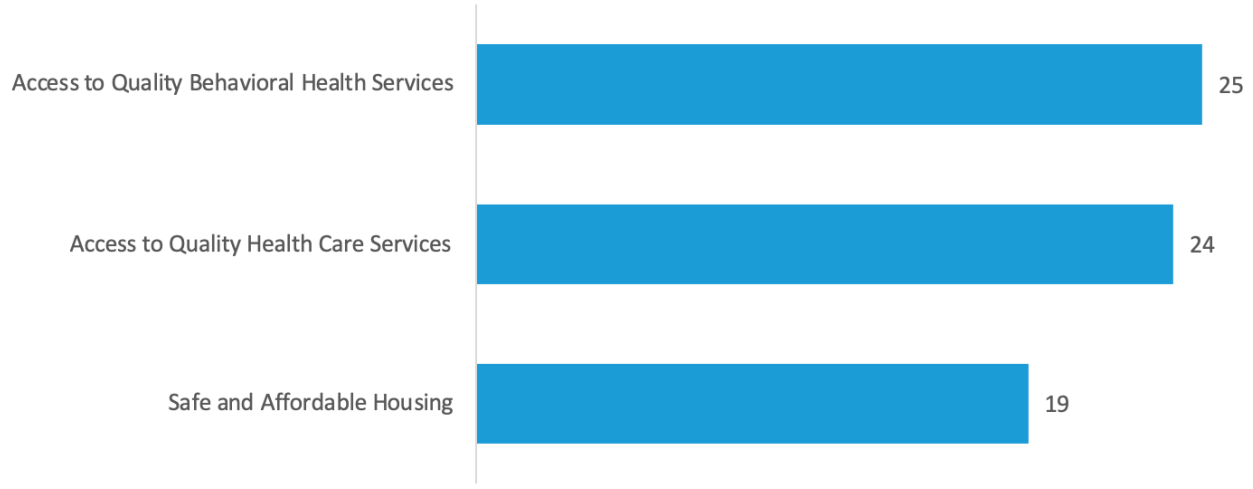


Figure 39: Provider Survey Responses on Resources Missing From Their Community (n=49)

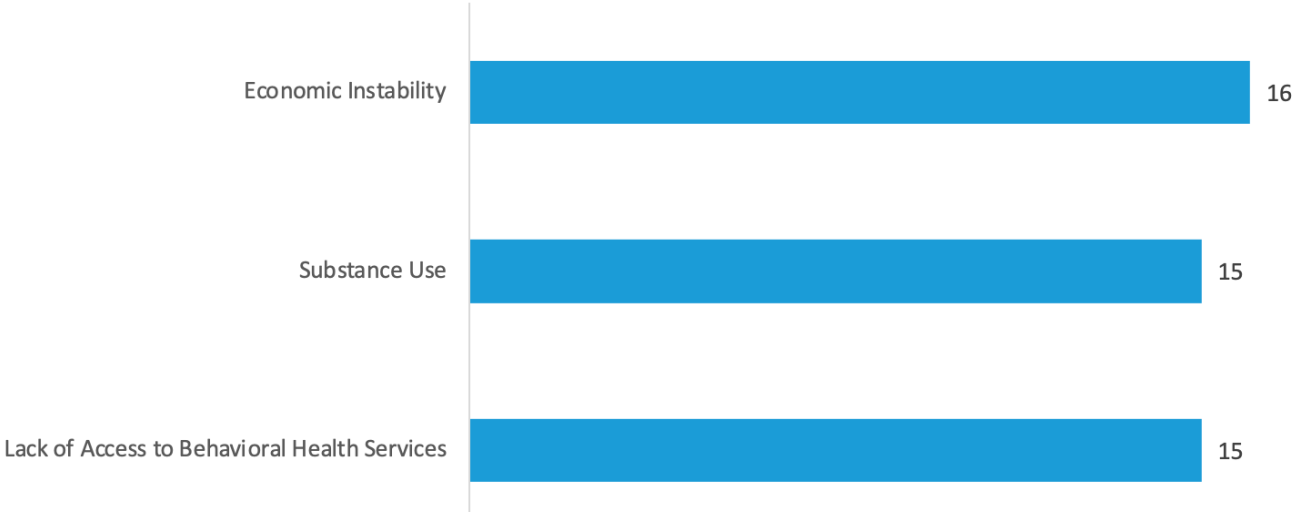
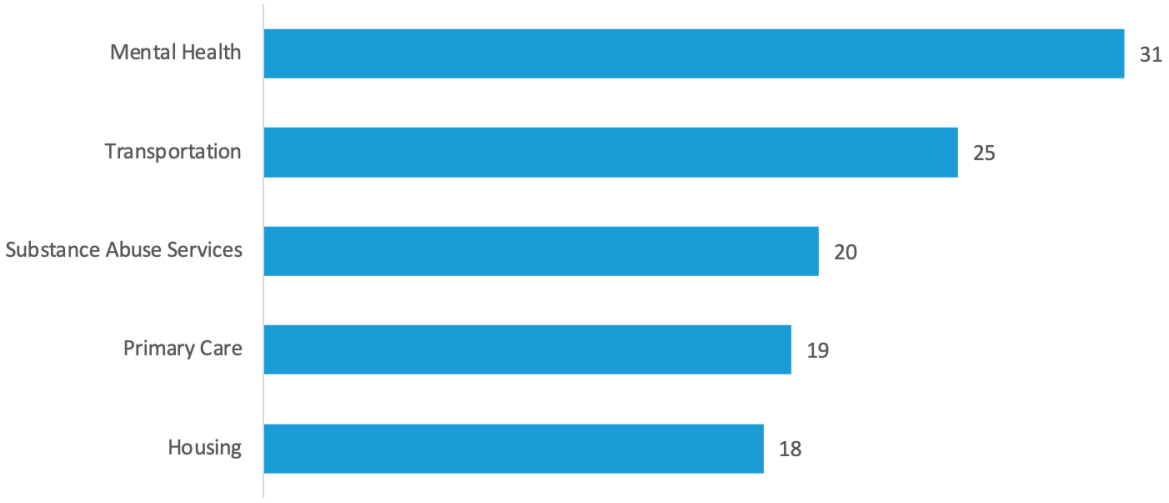


Figure 40: Provider Survey Responses on Issues Impacting Patients/Clients in their Community (n=49)



Community System Assessment

The Community System Assessment focuses on organizations that contribute to well-being. It answers the questions "What are the components, activities, competencies and capacities in the regional system?" and "How are services being provided to our residents?" It was designed to improve organizational and community communication by bringing a broad spectrum of partners to the same table; to explore interconnections in the community system; and to identify system strengths and opportunities for improvement. The Community System Assessment had two components:

Community System Assessment Event

On Aug. 12, 2021, 69 residents and community partners representing 27 organizations and agencies in the MiThrive North Central region assessed the system's capacity. Through a facilitated discussion, they identified system strengths and opportunities for improvement.

(Please see Appendix E for the Community System Assessment meeting agenda/design.)

MiThrive North Central Region Community System Assessment Results

Table 2. MiThrive North Central Region Community System Assessment Results

Focus Area	System Strengths	Opportunities for Improvement of the System
Resources A community asset or resource is anything that can be used to improve the quality of life for residents in the community	• Organizations work together to connect people to the resources they need • More than one organization is working with others and sharing several resources	• Create an asset map • 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		• Engage in activities that inform the policy development process; organizations in the system need to provide education to ensure informed decisions • Transition from a reactive to proactive system
Data Access/Capacity A community with data capacity is one where people can access and use data to understand and improve health outcomes	• Hospitals and health departments conduct community health assessments, gather input from the community and identify needs to address as a community	• 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 that collaborate in the community to maximize health improvement initiatives and are beneficial to all partners	• The Community System is composed of strong collaborative groups	• Develop action steps and increase accountability • Design engaging virtual meetings
Workforce The people engaged in or available for work in a particular area	• Individual organizations are knowledgeable about workforce issues	• Identify priority areas of need and submit plans to address workforce issues to funders • Collaborate systematically to address workforce gaps
Leadership Demonstrated by organizations and individuals that are committed to improving the health of the community	• The North Central Community Health Innovation Region (CHIR) is positioned to provide leadership in the region • Leadership is occurring at the county level	• Develop a broad community system vision • Create an environment for collaboration

Community Power and Engagement The ability to control the processes of agenda setting, resource distribution and decision-making, as well as to determine who is included and excluded from these processes	• There is good work happening, and the system is improving in creating awareness of public health issues and engaging the community	• Increase resident voice and engagement to inform decision-making • Increase diversity • Increase direct representation of vulnerable populations on boards and in leadership
Capacity for Health Equity Assurance of the conditions for optimal health for all people		• 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 facilitated conversations at county community collaborative bodies

Subsequently, focused conversations were held during county collaborative body meetings, including the Mecosta/Osceola Human Services Coordinating Body and the Lake County Roundtable. Both county collaboratives chose "Resources" as the most important focus area to work on in their counties. In addition, the following opportunities for improvement emerged at collaborative body meetings:

- There is a need to improve access to broadband to get resources to community members experiencing disparities.
- There is a need for increased collaborative work to improve transportation options.
- There is a need for a universal link to services to improve access to resources.
- There is a need for sustainable funding sources to provide staffing and resources.
- There is a need to increase community member involvement to identify ways to increase access to resources.

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, health care workforce, access to health services, economic environment, access to social services and social context.

(Please see Appendix F for the Forces of Change Assessment event agenda/design.)

Sixty-seven residents and community partners participated in the Forces of Change Assessment in the North Central region on April 20, 2021. The most powerful forces they identified were:

- Broadband internet
- Mental health and substance misuse
- Affordable housing
- Health care provider shortage
- Telehealth
- Rurality
- Diversity and inclusion
- Misinformation and mistrust
- Asset Limited, Income Constrained, Employed (ALICE) population

MiThrive North Central Region Forces of Change Assessment Results

Table 3. MiThrive North Central Region Forces of Change Assessment Results

Topic Area	Top Forces of Change	Threats	Opportunities
Government Leadership	Trust in Government	Pervasive polarization hinders improvements, misinformation is spread and integrity is lost in leaders. Therefore, people don't follow guidance; no middle ground equals no progress	
	Inability to Flex	Rural communities are left out at all levels—including financial and programmatic; flexible, unique problem solving is taken away; people are unable to improve their situations where there are multiple layers of policy/ bureaucracy; one size does not fit all; government policy interferes with multi-sector systems work—e.g., Health Insurance Portability and Accountability Act of 1996/ Family Educational Rights and Privacy Act are barriers to cross-sector collaboration	Boots on the ground/hands-on approach can be an opportunity to target interventions locally; local leaders know their population and what they need, so the ability to flex funding or policy could lead to improvements; cross-sector alignment of priorities and work will eliminate duplication, streamline efforts and result in increased services
	Diversity and Inclusion	When everyone in leadership looks the same, there is no representation of age, gender, race, experience and socioeconomic status; lack of diversity limits progress of new ideas, and we lose the voice of unique communities/culture/history	Having more voices at the table expands opportunities for the underserved communities and those with limited power to influence change; improved quality of life and health for those at greatest risk; resident voice would provide real solutions to barriers the rest of us don't see

Government Budgets and Spending Priorities	Political Agendas and Influences	Lack of funding; changes in policies; reduction in affordable services; changes in leadership at the national and state level; term limits for legislators; barriers to engagement and need for education; some are not interested in pursuing our goals and needs	Grant opportunities like Healthy Heart or Fit for You; changes in policies; restructuring platforms like when MDHHS merged with Community Mental Health; changes in leadership at the national and state level
	Demographics of the Region: Rural Nature, Aging Population, Low Income	Lack of funding; lack of services; resource reduction; education on health and well-being; preparing for wave of older adults and their increased needs for housing and in-home help; smaller voice for new policies	Collaboration of community partners; innovative programs like Ever Promise Plus (two-year degree)
	COVID-19 Pandemic	Lack of funding and financial strain; priority overall-everything else goes by the wayside; patients are reluctant to visit doctors' offices	Planning for the future (if there is a similar event, preparations are more current); relief to working families (day care)
Sufficient Health Care Workforce	Broadband and Telehealth	Limits access to health care; limits the ability to work from home; limits the ability to participate in online schooling; financial strain of cost of broadband	Create the possibility of being able to work from home; provide opportunities to increase access to health care; allow some students to participate in school virtually; increase opportunities for communication
	Attracting Health Care Professionals in Rural Areas	Creates access issues; people may have to travel great distances to access health care	People may want to move to northern Michigan vs. homegrown talent—keep our residents from moving out of the area; grants available to train local residents; MI-LEAP program funding available; Department of Labor and Economic Opportunity trainings available

	Severe Shortage of Mental Health Providers	People must travel to access mental health care; not a lot of private providers for people who don't qualify for Community Mental Health (CMH) increase in suicides and overall decline in mental health; increase in substance use disorders; shortage of inpatient beds; people with mental illness end up in the jail system; privatization of mental health system	Grant from the state to expand services; jail diversion grant—training for law enforcement; tuition assistance and student loan forgiveness opportunities
Access to Health Services	Rurality	Continues to widen access gap; difficulty with transportation; difficulty with broadband; increased need for telehealth	More discussion on policy related to broadband; services needed throughout the region—opportunity for continued partnership and investment
	COVID-19 Impact on Substance Use and Poverty	Misinformation creating division; restrictions have widened gap for those who need it the most	Engaging conversations surrounding improvement in language, inclusion, equity
	Provider Access and Affordability of Care	Poor health outcomes due to limited preventive care; increased difficulty with transportation; insurances changing—difficulty of high-deductible plans; difficulty in recruiting providers to rural areas	Some providers may want to move to more rural areas due to COVID-19; need to develop more "Grow Your Own" programs (foster local talent); opportunity for more discussion surrounding reimbursement

Economic Environment	Broadband Access	Lack of access to resources; Department of Health and Human Services has different online apps; lack of information, when and where would you get information other than online; telehealth increase; unreliable broadband can limit access to telehealth opportunities; expensive, unreliable, unavailable	If available—faster access to information; access to patients; access to support resources; businesses would be able to expand; would be on the map more for attraction projects
	Political Administration Changes	Racial issues—safety of various communities; uncertainty within people; mistrust of official information—e.g., COVID-19 vaccine and information from the political divide; access to affordable health care; current administration focus; mistrust; financial support; racial tensions; affordable health care; access to broadband; current administration priorities	Government funding—the amount of dollars coming to local municipalities could lead to lasting impactful changes if used wisely; current administration focus
	Behavioral Health Issues on Employment	Mental health and substance use disorder impact employees' ability to get to work and cost of health care to employees; utilization cost can go up for employees and employers; negative impact on labor force participation rate; low unemployment and talent retention; Mental health and substance use disorder barriers; unintended consequences of unemployment benefits; student well-being; long-term impacts	Easier to talk about behavioral health—not as "taboo" to talk about it; increase focus on employees' mental health as well as if they are physically sick; easier to find self-care resources and mental health diagnosis information online; additional funding for schools (31N funding) for increased school counseling

Access to Social Services	Insufficient Number of Providers	People continue to fall behind with their health care	Remote providers
	Affordable Housing	Affects your overall well-being	Building trades
Social Context	Broadband	Many seniors and others lack the education and capability to utilize technology resources; language barriers for non-English-speaking population; geographic size and space—rural areas	Opportunities for collaboration with community organizations and resources
	ALICE Population	Often fall through the cracks because they aren't eligible for many social services but have need for social services; employment challenges because people can make more money from public benefits; cost of day care continues to be an issue	Emerging and ongoing advocacy efforts for the needs of this population; opportunities for policy change at the state level; informing workplaces to be ALICE-friendly with their policies; benefits to case management

Impacts Related to COVID-19	Distrust in Science and Public Health and Political Rhetoric	Johnson & Johnson pause on vaccine manufacturing caused a shift in mistrust; anti-vaxxers; social media—rapid miscommunication; lack of understanding of evidence-based science; spikes in COVID-19 cases	Power of local leaders to spread evidence-based information; benefit of consistent messaging; strengthened communication across community partners
	Economic Impact	Fear of going back to work (especially in health care); disproportionate impact on low-income communities; businesses having to close; capitalism vs. individual health; trying to find employees: stimulus checks (factor)—unintended consequences; internet access isn't in all places	Encourage use of less expensive health services, telehealth services, virtual mental health services; encourage businesses to expand services; encourage grocery stores to provide home deliveries, curbside services; stimulus checks were helpful
	Family Hardship and the Impact on Low-Income Individuals and Families	Lack of child care is a continuing issue for those looking for work; women exiting the workforce—lack of child care and support; hardship on families (especially with school-age children); youth isolation; financial impact	Encourage new and/or more social connections

Data Limitations

Community Health Status Assessment

- Since secondary indicator scores are based on comparisons, low scores can result even for very serious issues if there are similarly high rates across the state and/or U.S.
- We can only work with the data we have, which can be limited at the local level in northern Michigan. Much of the data we have has wide confidence intervals, making many of these data points inexact.
- Some data is missing for some counties—as a result, the "regional average" may not include all counties in the region. Additionally, some counties share data points—for example, in the Michigan Profile for Healthy Youth, data from Crawford, Ogemaw, Oscoda and Roscommon counties is aggregated; 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 been updated since the previous MiThrive cycle; therefore, values for some indicators may not have changed and thus cannot be used to show trends from the previous 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-reported with their different experiences and perspectives. Based on these perspectives, gathering responses for each question includes some subjectivity.
- When completing the assessment at the regional events or at the county level, there were time constraints for discussion, and some key stakeholders were missing from the table.
- Some participants tended to focus on how well their organization adressed the focus areas for health improvement rather than assessing the system of organizations as a whole.
- Community Themes and Strengths Assessment
- A unique target number of completed Community Themes and Strength Assessment (CTSA) Community Surveys was set for each county based on county population size. Survey responses were not weighted for counties that 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 interviews, phone interviews, text surveys and paper surveys.

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 note takers 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, participants had 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 stand-alone topic area, and all participants were advised of the topic areas and were instructed to focus on their topic area with minimal discussion of COVID-19 unless it was part of their specific topic area.

Phase 4: Identifying and Prioritizing Strategic Issues

To launch Phase 4, the MiThrive core support team developed the MiThrive Prioritization Matrix (pictured below) to engage in data sensemaking. The team sorted the data by categorizing the primary and secondary data as either high or low. Secondary data was collected in the Community Health Status Assessment (CHSA), and each indicator was scored on a scale of 0 to 3. 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, the 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"; topics that emerged in less than three primary data activities were classified as "low primary data."

On Nov. 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.

There was considerable agreement across the 31-county region, with the following cross-cutting strategic issues or top 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 health care

In addition, three strategic issues or top health needs emerged unique to the North Central region:

- Broadband access
- Obesity
- Food security

On Nov. 22, 2021, members of the MiThrive steering committee, design team and workgroups framed the 11 strategic issues, as recommended by the Mobilizing for Action through Planning and Partnerships (MAPP) 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 to allow for the development of innovative, strategic activities as opposed to relying on the status quo or on 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 strategic issues or top health needs

The 11 strategic issues developed in the North Central region are reflected below in alphabetical order:

- **Access to Health Care:** How do we increase access to integrated systems of care, as well as increase engagement, knowledge and awareness of existing systems to better promote health and prevent and treat chronic disease?
- **Behavioral Health:** How do we increase access and reduce barriers to quality behavioral health services while increasing resiliency and well-being?
- **Broadband Access:** How can we advocate for increased broadband access and affordability?
- **Economic Security:** How do we foster a community where everyone feels economically secure?
- **Equity:** How do we cultivate a community whose policies, systems and practices are rooted in equity and belonging?
- **Food Security:** What policy, system and environmental changes do we need to ensure reliable access to healthy food?
- **Healthy Weight:** How can we create an environment that provides access, opportunities and support for individuals to reach and maintain a healthy weight?
- **Housing Security:** How do we ensure that everyone has safe, affordable and accessible housing?
- **Safety:** How do we ensure all community members are aware of and can access safety and well-being supports?
- **Substance Misuse:** How can we develop increased comprehensive substance misuse prevention and treatment services that are accessible, patient centered and stigma free?
- **Transportation Options:** 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?

On Dec. 8, 2021, 77 residents and community partners participated in the MiThrive North Central region's Data Walk and Priority-Setting Event. During this live event, participants engaged in a facilitated Data Walk and participated in a criteria-based ranking process to prioritize two to three 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. (Please see Appendix G.)

After engaging in the MiThrive Data Walk, participants were asked to complete a prioritization survey to individually rank the 11 strategic issues. The ranking process used five criteria to assess each strategic issue: severity, magnitude, impact, health equity and sustainability. Participant votes were calculated in real time during the event, and the top-scoring strategic issues are reflected in green in the scoring grid below. This transparent process elicited robust conversation around the top-scoring strategic issues, and participants identified alignment between the healthy weight strategic issue and the chronic disease element in the access to health care strategic issue. Participants opted to combine these two strategic issues and adjust the wording to reflect this after the event.

Table 4. North Central Region Prioritization Total Scoring Grid

Prioritization Total Scoring Grid						
Strategic Issue	**Severity**	**Magnitude**	**Impact**	**Health Equity**	**Sustainability**	**Total Score**
How can we nurture a community- and health-oriented transportation environment that provides safe and reliable transportation access, opportunities and encouragement to live a healthy life.	158	149	172	174	143	**796**
How do we ensure all community members are aware of and can access safety and well-being supports?	156	140	152	158	135	**741**
How can we advocate for increased broadband access and affordability?	143	160	160	164	148	**775**
How can we create an environment that provides access, opportunities and support for individuals to reach and maintain a healthy weight?	173	167	176	167	155	**838**
How do we increase access and reduce barriers to quality behavioral health services while increasing resiliency and well-being?	196	180	192	175	162	**905**
What policy, system and environmental changes do we need to ensure reliable access to healthy food?	161	150	165	163	151	**790**
How do we increase access to integrated systems of care, as well as increase engagement, knowledge and awareness of existing systems to better promote health and prevent and treat chronic disease?	175	174	180	168	168	**865**
How do we cultivate a community whose policies, systems and practices are rooted in equity and belonging?	143	146	153	157	138	**737**
How do we ensure that everyone has safe, affordable and accessible housing?	171	156	173	162	144	**806**
How can we develop increased comprehensive substance misuse prevention and treatment services that are accessible, patient centered and stigma free?	178	153	175	169	151	**826**
How do we foster a community where everyone feels economically secure?	176	166	179	178	139	**838**

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 Jan. 5, 2022. Comments, feedback and suggestions were collected over the course of a week and a half, and the MiThrive core support team updated the top-ranked strategic issues based on this feedback. A key change, based on revisions, was to separate access to health care from chronic disease/healthy weight given the two distinct buckets of work. This change is reflected in the final top-ranked strategic issues, or significant health needs, below.

The final top-ranked strategic issues, or significant health needs, identified for the Spectrum Health Big Rapids and Reed City hospitals' communities are as follows:

1. Behavioral health

2. Access to health care

3. Chronic disease

4. Economic security

Key data points from the 2021 MiThrive Community Health Assessment for the 10-county North Central region and the hospitals' three-county service area are briefly discussed below.

#1: Behavioral Health

MiThrive Data Collection Activities

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

Mental health is important to well-being, healthy relationships and the ability to live a full life. It also plays a major role in our ability to maintain good physical health, because mental illness increases the 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% of Americans 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.

Lake, Mecosta and Osceola counties are included in the 10-county MiThrive North Central region, where mental health emerged as the top theme in all six data collection activities. Geographic disparities exist at the census tract level, with high percentages of poor mental health in the western part of the North Central region.

Over half (51%) of the respondents of the MiThrive Healthcare Provider Survey from the three-county area stated that access to quality behavioral health services is important for a thriving community (compared to 43.3% in the 10-county region). When asked what resources and services are missing in their communities that would benefit their patients/clients, nearly two-thirds (63.2%) from Lake, Mecosta and Osceola counties answered, "mental health services." Similarly, Pulse Survey respondents (vulnerable residents) from the three-county region ranked "increasing mental health supports" fourth among actions they could take to promote each other's well-being and not just their own.

The average Health Professional Shortage Area (HPSA) scores for mental health in the three-county area are high when compared to the North Central region and the state. Scored by the U.S. Health Resources and Services Administration on a scale of 0-25, with higher scores indicating greater need, the HPSA scores for mental health are 20.5 in Lake County, 18 in Mecosta County and 18.4 in Osceola County. A severe shortage of mental health providers was also identified as one of the strongest forces in the North Central region's Forces of Change Assessment, with participants noting barriers such as a shortage of inpatient psychiatric beds and the dearth of outpatient providers outside of the community mental health system, as well as the impact behavioral health issues have on workforce and employee productivity.

#2: Access to Health Care

Access to health services affects a person's health and well-being. It can prevent disease and disability, detect and treat illness, and 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 and 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 region. Access to quality health care services ranked No. 1 among health care providers and ranked No. 2 among residents as a top factor for a thriving community. Nineteen percent of health care providers identified that primary care services are a missing resource in their communities. The average HPSA scores for primary care exceed the MiThrive North Central region rate (16.1) in both Lake County (17) and Mecosta County (17.2). (The Osceola County HPSA score for primary care is 15.6.) The health care provider shortage was also identified as one of the most powerful forces in the Forces of Change Assessment in the North Central region, 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 health care than others. In rural areas like Lake, Mecosta and Osceola counties, doctors and specialists may only be found in larger towns, so many residents must travel long distances to get health care. Low-income individuals and people 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 health care providers can also become a barrier to care. If community residents who are ethnic minorities or who identify as LGBTQ+ visit the doctor and perceive discrimination or inadequate understanding of issues that affect them, they may receive inadequate care or delay seeking needed health care 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 Native American and Hispanic populations.

Lack of access to health care contributes to statistics in the MiThrive North Central Community Health Status Assessment that exceed state rates, such as all causes of death (814.9 per 100,000 population), heart disease mortality (199.2 per 100,000), all cancer mortality (178.2 per 100,000), injury mortality (81.4 per 100,000), diabetes mortality (22.9 per 100,000), uninsured rate (7.9%), fully immunized toddlers age 19-35 months (67.7%), and self-reported health as "fair" or "poor" (22.6%).

#3: Chronic Disease

According to the U.S. 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 U.S. As of 2020, the leading causes of death in Lake, Mecosta and Osceola counties, by far, were heart disease and cancer (Michigan Department of Health and Human Services). As noted above, rates in the MiThrive North Central region for heart disease, cancer and diabetes exceed state rates.

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. In the hospitals' three-county service area, the proportion of overweight adults, at 44% in Lake County, 42% in Mecosta County and 31.1% in Osceola County, exceeds both the MiThrive North Central region and state rates.

Social determinants of health, or the conditions where people live, work and play, include factors like access to care, neighborhood safety, transportation and green spaces 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 of Lake, Mecosta and Osceola counties noted many barriers to physical activity in the MiThrive Community Survey, including:

- Living a great distance from community resources
- Not enough affordable recreation activities
- Not enough affordable physical activity programs

Also, vulnerable residents 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 Lake County (24%), Mecosta County (16.70%) and Osceola County (18.20%), was identified as an indicator exceeding overall MiThrive North Central region and Michigan rates. In addition, vulnerable residents reported in the MiThrive Pulse Survey that the No. 1 way their community could ensure everyone has a chance at living the healthiest life possible is to combat food insecurity.

#4: Economic Security

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

People who live in socially vulnerably areas live shorter lives and experience reduced quality of life. With the exception of two census tracts in northeast Mecosta County, residents of Lake, Mecosta and Osceola counties live in census tracts with social vulnerability indices at "high" or "moderate to high."

Data from the MiThrive Community Health Needs Assessment illustrate the theme of economic insecurity in the MiThrive North Central region and the three-county area. Health care providers noted that economic stability is the most important issue impacting their patients. In addition, there are several secondary data indicators for Lake, Mecosta and Osceola counties that exceed the North Central region and state rates, such as ALICE households and children, families, households and population living below the federal poverty level. On average, 20.3% of the population lives below the federal poverty level.

On average, vulnerable residents who completed the MiThrive Pulse Survey were neutral when asked if there is economic opportunity in their community. Those who ranked economic opportunity low cited concerns regarding barriers to job availability, affordable housing, resources, child care and transportation.

Next Steps

Now that the MiThrive Community Health Needs Assessment is complete, MiThrive workgroups will be developing Community Health Improvement Plans for the top-ranked priorities in their region and overseeing their implementation. If you are interested in joining the North Central MiThrive workgroup, please email mithrive@northernmichiganchir.org.

APPENDIX A

Participating Organizations in the North Central MiThrive Region

Arenac, Clare, Gladwin, Isabella, Lake, Mason, Mecosta, Oceana, and Osecola Counties

Sector	Participating Organization 31-County	31-County MiThrive		North Central MiThrive Work Group	Community Themes and		Community System Assessment	Forces of Change Assessment	Data Walk and Priority Setting
		Steering Committee	Design Team		Pulse Survey	Provider Survey			
Hospital Systems	Ascension Michigan • St. Joseph Hospital • Standish Hospital			X		X			X
	McLaren • McLaren Central Michigan • McLaren Northern Michigan	X	X		X	X			
	MyMichigan Health • Alpena Medical Center • Clare Medical Center • Gladwin Medical Center • Mt. Pleasant Medical Center • West Branch Medical Center	X	X	X		X	X		
	Munson Healthcare • Charlevoix Hospital • Grayling Hospital • Manistee Hospital • Munson Medical Center • Otsego Memorial Hospital • Paul Oliver Hospital	X	X			X			
	Spectrum Health • Big Rapids Hospital • Gerber Memorial • Ludington Hospital • Reed City Hospital	X	X	X		X	X	X	X

Local Health Depts.	Benzie Leelanau District Health Department	X	X						
	Central Michigan District Health Department	X	X	X	X	X	X	X	X
	District Health Department #2	X	X		X				
	District Health Department #4	X	X						
	District Health Department #10	X	X	X	X	X	X	X	X
	Grand Traverse County Health Department	X	X						
	Health Department of Northwest Michigan	X	X						
Community Based Orgs	211 West Michigan						X		
	Central Michigan Recovery & Education Network							X	
	Children's Advocacy Center						X		
	Disability Network of Northern Michigan	X							
	EightCAP							X	
	Food Bank of Eastern Michigan							X	
	Goodwill Northern Michigan	X							
	Habitat for Humanity of Lake County			X					
	Habitat for Humanity of Mason County							X	
	Hope Network							X	
	Isabella Community Soup Kitchen				X				
	Isabella County Restoration House				X				
	Lakeshore Food Club							X	
	Ludington Area Senior Center								
	Mason County United Way			X			X		
	MDHHS County Offices		X		X		X	X	
	MSU Extension Health and Nutrition Institute	X							
	Michigan WORKS!							X	

	Mid-Michigan Big Brothers and Big Sisters								
	Mid-Michigan Community Action								X
	Muskegon Health Project							X	
	Northeast Michigan Community Service Agency							X	
	Northern Michigan Regional Entity							X	
	Northwest Michigan Community Action Agency	X	X				X		
	Our Brother's Keeper—Big Rapids							X	
	Staircase Youth Services						X	X	
	Sunrise Side Senior Services					X		X	
	Ten16 Recovery Network								
	The Red Project							X	
	The Right Place, Inc.			X				X	
	True North Community Services		X	X	X		X	X	X
	United Way of Gratiot and Isabella Counties			X					
	United Way of the Lakeshore							X	
	Wellspring Adult Day Services							X	
	Women's Information Services (WISE) Big Rapids							X	
Community Mental Health Agencies	Arbor Circle					X			
	AuSable Valley CMH Authority		X						X
	CMH for Central Michigan						X	X	
	Newaygo County CMH Authority								X
	North Country CMH Authority	X							
	West Michigan CMH Authority						X	X	
Primary Care	Alpine Cardiology								
	Cadillac Family Physicians							X	
	Family Health Care				X			X	
	Isabella Citizens for Health					X		X	
	MSU College of Human Medicine							X	
	Northwest Michigan Health Services						X		

	Sterling Area Health Center							X	
	Traverse Health Clinic	X							
	Northern Michigan Neurology								
Native Nations	Little Traverse Band of Odawa Indians								
Coalitions and Service Clubs	Arenac Co. Human Services Coordinating Body						X		
	Big Rapids Rotary Club						X		
	Clare Community Leaders						X		
	General Federation of Women's Clubs							X	
	Gladwin Co. Human Services Coordinating Body						X		
	Isabella Co. Human Services Coordinating Body						X		
	Lake County Roundtable						X		
	Meceola Human Trafficking Task Force							X	
	Mecosta Osceola Human Services Coor Body						X		
	Newaygo County Community Collaborative (NC3)	X		X			X	X	
	Oceana Health Bound Coalition						X		
	Rotary Charities								
	Walkerville Thrives						X		
Educational Institutions	Bay-Arenac Intermediate School District						X	X	
	Ferris State University						X	X	
	Gratiot-Isabella Education Service District						X	X	
	Great Lakes Bay Regional Alliance								
	Ludington Area Schools						X		
	Mason County Central School District						X		
	Mason County Eastern Schools						X		

	Mason County Promise						X		
	Mecosta Osceola Intermediate School District		X					X	
	MSU College of Human Medicine								
	Pentwater Public Schools				X				
	West Shore Educational Service District								
Grant-Making Organizations	Catholic Charities West Michigan						X		
	Community Foundation of Mason County						X		
	Fremont Area Community Foundation							X	
	Pennies From Heaven Foundation			X			X		X
Government	City of Big Rapids							X	
	City of Fremont							X	
	City of Ludington							X	X
	Ludington Area Senior Center						X		
	Mason County Emergency Management						X		
	Mason County Library						X	X	
	Newaygo County Commission on Aging							X	
Businesses	CBD Store of Michigan							X	
	Everyday Life Consulting	X							
	Harmonized Healing Counseling Services							X	
	Inspire Counseling and Consulting							X	
	Standard Process Inc			X					

APPENDIX B

Indicators and Scores

	Average Comparison Score	Lake	Mecosta	Osceola
Population below poverty level	2.9	21.00%	21.20%	17.90%
Households below federal poverty level	2.8	20.30%	20.10%	16.80%
Families living below poverty level	2.8	12.70%	13.00%	12.90%
Children below poverty level	2.7	31.50%	23.90%	27.10%
Average HPSA score - Mental Health	2.7	20.5	18	18.4
Median value of owner-occupied homes	2.7	$88,000	$121,400	$98,500
Median Household Income	2.6	$37,320	$45,018	$44,032
Average HPSA score - Dental Health	2.6	23	19.8	19.8
Bachelor's degree or higher	2.5	11.90%	22.70%	14.20%
Population food insecurity	2.5	18.10%	15.40%	15.50%
Child abuse/neglect rate (per 1,000)	2.4	245.4	142.2	195.2
Lung and bronchus cancer	2.4	81.71	75.88	82.16
All cancer mortality	2.4	185.9	178.4	184.1
Average HPSA score - Primary Care	2.3	17	17.2	15.6
Renters (% of all occupied homes)	2.2	15.80%	26.70%	19.30%
Vacant housing units	2.2	69.80%	26.60%	33.40%
Child food insecurity	2.2	24.00%	16.70%	18.20%
Political participation	2.2	64.60%	59.80%	68.00%
Motor vehicle crash involving alcohol mortality	2.2	30.00%	40.00%	50.00%
Students not proficient in Grade 4 English	2.1	67.70%	50.40%	58.40%
High school graduation rate	2	76.20%	75.90%	87.40%
Adults: No personal health checkup in the past year	2	*	18.9	*
Gross mortgage is >= 35% of household income	2	29.80%	20.90%	22.20%
Overweight (adults)	2	44.00%	42.00%	32.10%
Special Education % Child Find	1.9	99.10%	100.00%	100.00%
Homes with broadband internet	1.9	69.80%	80.80%	74.00%
Severe quality problems with housing	1.9	17.00%	16.00%	13.00%
Gross rent is >= 35% of household income	1.9	42.40%	45.60%	36.20%
Alzheimer's/Dementia mortality	1.9	33.3	29.8	42.8
ALICE Households	1.8	36.30%	27.90%	26.00%
No household vehicle	1.8	8.20%	6.40%	8.20%
Self-reported health assessment fair or poor	1.8	24.70%	19.00%	24.50%
Motor vehicle crash mortality	1.8	*	11	18

High school graduate or higher	1.7	82.40%	90.20%	88.70%
Fully immunized toddlers aged 19-35 months	1.7	58.50%	72.10%	70.60%
Colorectal cancer	1.7	36.46	42.91	46.94
Unemployment rate	1.6	3.70%	3.80%	3.50%
Liver disease mortality	1.6	22.6	10.6	*

APPENDIX C1

MiThrive Community Survey

MiThrive Community Survey

Informed Consent

2

What is important to the community? What resources and strengths does the community have that can be used to improve community health?

This survey is a chance for you to tell us what is most important to you. MiThrive isworking to improve the health of communities in Northern Michigan by collecting data, identifying key issues, and bringing people together for change.

This survey will take about 10 minutes to complete. Your participation in this survey is completely voluntary. Your answers are confidential. The survey data will be managed by MiThrive staff. Your answers will not be used to identify who you are. You are free to skip any question and stop taking the survey at any time. The information you provide will not be used for a discriminatory purpose and there is minimal risk to you for taking the survey.

At the end of the survey, you can choose to be entered into a drawing for a chance to win a $50 gift card. Five (5) winners will be chosen - must be 18 or older.

If you have any questions about this survey, please email mithrive@northernmichiganchir.org.

VALIDATION Max. answers = 3 *(if answered)*

ID 13

1. In the following list, what do you think are the**three most important factors for a thriving community?**

Check only three:

- ☐ Reliable transportation
- ☐ Parks and green spaces
- ☐ Meaningful and rewarding work
- ☐ Civic engagement
- ☐ Access to quality behavioral health services
- ☐ Freedom from trauma, violence, and addiction
- ☐ Access to quality healthcare services
- ☐ Disease and illness prevention
- ☐ Safe and affordable housing
- ☐ Belonging & inclusion
- ☐ Lifelong learning: cradle to career
- ☐ Disability Accessibility
- ☐ Clean environment
- ☐ Access to nutritious food
- ☐ Arts and cultural events
- ☐ Other - Write In

VALIDATION Max. answers = 3 *(if answered)*

ID 16

2. In the following list, what do you think are the**three most important issues impacting your community**?

Check only three:

- ☐ Racism and discrimination
- ☐ Infectious diseases (e.g., hepatitis, tuberculosis, etc.)
- ☐ Child abuse/neglect
- ☐ Rape/sexual assault
- ☐ Diabetes
- ☐ Sexually transmitted infections (STIs)
- ☐ COVID-19
- ☐ Dental problems
- ☐ Domestic violence
- ☐ Poor environmental health
- ☐ Homicide
- ☐ Economic instability
- ☐ Suicide
- ☐ Infant death
- ☐ Substance use
- ☐ HIV/AIDS
- ☐ Lack of access to nutritious foods
- ☐ Lack of access to behavioral health services
- ☐ Teenage pregnancy
- ☐ Neighborhood and built environment
- ☐ Lack of quality education
- ☐ Cancer
- ☐ Lack of access to education
- ☐ Motor vehicle crash injuries
- ☐ Lack of access to healthcare services
- ☐ Unreliable transportation
- ☐ Obesity
- ☐ Lack of quality behavioral health services
- ☐ Heart disease and stroke
- ☐ High blood pressure
- ☐ Aging problems (e.g., arthritis, hearing/vision loss, etc.)
- ☐ Respiratory/lung disease
- ☐ Lack of safe and affordable housing
- ☐ Lack of quality healthcare services
- ☐ Firearm-related injuries
- ☐ Other - Write In

18

Imagine a ladder with steps numbered from zero at the bottom to 10 at the top. The top of the ladder represents the best possible life for you and the bottom of the ladder represents the worst possible life for you.

19

3. On which step of the ladder would you say you personally feel you stand at this time?

- 10
- 9
- 8
- 7
- 6
- 5
- 4
- 3
- 2
- 1
- 0

20

4. On which step of the ladder do you think you will stand about three years from now?

- 10
- 9
- 8
- 7
- 6
- 5
- 4
- 3
- 2
- 1
- 0

21

5. Think about your level of physical activity and ability to bike, walk, or roll from one place to another. Do any of the following issues prevent you from being more active in your community? (select all that apply)

- [ ] Not enough bike lanes
- [ ] Not enough affordable recreation facilities
- [ ] I live a great distance from places in my community
- [ ] Not enough street lights
- [ ] Not enough sidewalks
- [ ] Low accessibility
- [ ] Not enough pedestrian paths, trails, or walkways
- [ ] Not enough wayfinding signage
- [ ] Not enough affordable physical activity programs
- [ ] I feel unsafe in my community
- [ ] Not enough greenspaces
- [ ] Other - Write In

- [ ] I don't experience any of these

28

A community is defined, not only by its problems, but by its assets. Assets are resources that bring value to a community such as people, groups, and organizations. We want to know what assets make your community unique and special. Below is a list of community assets. Check the box by each asset that exists in your community. On the following page you will be asked to identify the name of the person, group, or organization and if that asset is primarily focused on a particular population.

26

6. Check the box next to each asset you know is in your community (feel free to check as many or as few options as you want):

Social Service

- [ ] Community Center
- [ ] Housing Organizations
- [ ] Food Pantry / Kitchens
- [ ] Emergency Housing Shelters
- [ ] Halfway Houses
- [ ] Domestic Violence Shelters

Social/Grassroot Organizations

- [ ] Seniors' Group
- [ ] Special Interest Group
- [ ] Advocacy Groups/Coalitions
- [ ] Cultural Organizations
- [ ] Hunting/Sportsman Leagues
- [ ] Amateur Sports Leagues

Education

- [ ] Colleges or Universities
- [ ] Community College
- [ ] Before-/After-School Program
- [ ] Vocational/Technical Education Programs

Health Institutions

- [ ] Hospital
- [ ] Healthcare Clinic
- [ ] Health Department
- [ ] Behavioral Health Services

Public Service

- [ ] Library
- [ ] Police Department
- [ ] Fire Department
- [ ] Emergency Medical Services

Community-Based Organizations

- [ ] Religious Organizations
- [ ] United Way
- [ ] Community or Philanthropic Foundation
- [ ] Political Organizations

Infrastructure

- [ ] Parks
- [ ] Public Pools
- [ ] Vacant Private Building or Lot
- [ ] Public Lake or Coastline
- [ ] Community Gardens
- [ ] Farmers' Markets

Noteworthy Person/Group

- [ ] Local Artists/Musicians
- [ ] Community Leader
- [ ] Celebrity or Influential Figure

Other

- [ ] Other - Write In (Required)

*

(untitled)

ID 29

PIPING Piped From Question 6. (Check the box next to each asset you know is in your community (feel free to check as many or as few options as you want):)

Can you tell us the names of the organization you selected?

[question("piped value")]

ID 30

PIPING Piped From Question 6. (Check the box next to each asset you know is in your community (feel free to check as many or as few options as you want):)

7. Some of the assets you selected may be geared to a special population. Can you tell us the target population for the assets you identified?

Demographic Questions

33

7. What county do you live in?*

- Alcona
- Alpena
- Antrim
- Arenac
- Benzie
- Charlevoix
- Cheboygan
- Clare
- Crawford
- Emmet
- Gladwin
- Grand Traverse
- Iosco
- Isabella
- Kalkaska
- Lake
- Leelanau
- Manistee
- Mason
- Mecosta
- Missaukee
- Montmorency
- Newaygo
- Oceana
- Ogemaw
- Osceola
- Oscoda
- Otsego
- Presque Isle
- Roscommon
- Wexford

4

8. What is your zip code?

5

9. How old are you?

- ○ Under 18
- ○ 18-24
- ○ 25-39
- ○ 40-64
- ○ 65 and older

6

10. What kind of health insurance do you have? (select all that apply)

- ☐ Medicaid and Healthy Michigan Plans
- ☐ Medicare
- ☐ Private/Employer-Sponsored Insurance
- ☐ Uninsured
- ☐ Unknown
- ☐ Other - Write In

7

11. Which of the following best describes you? (select all that apply)

- [ ] American Indian or Alaska Native
- [ ] Asian
- [ ] Black or African American
- [ ] Hispanic or Latino/a/x
- [ ] Native Hawaiian or Other Pacific Islander
- [ ] White
- [ ] Prefer not to say
- [ ] Prefer to self-describe

8

12. What is your yearly household income?

- ○ Less than $10,000
- ○ $10,000 to $19,999
- ○ $20,000 to $29,999
- ○ $30,000 to $39,999
- ○ $40,000 to $49,999
- ○ $50,000 to $59,999
- ○ $60,000 to $69,999
- ○ $70,000 to $79,999
- ○ $80,000 to $89,999
- ○ $90,000 to $99,999
- ○ Over $100,000

ID 9

13. Including yourself, how many people live in your household?

- 1
- 2
- 3
- 4
- 5
- 6
- >7

LOGIC Show/hide trigger exists.

ID 10

14. Do you identify as having a disability?

- Yes
- No

LOGIC Hidden unless: #14 Question "Do you identify as having a disability?" is one of the following answers ("Yes")

ID 11

15. Select all that apply

- [ ] Physical Disability
- [ ] Mental Disability
- [ ] Emotional Disability
- [ ] Prefer not to say
- [ ] Prefer to self-describe

12

16. How do you identify your gender? (select all that apply)

- [ ] Female
- [ ] Male
- [ ] Non-binary
- [ ] Transgender
- [ ] Prefer to self-describe:
- [ ] Prefer to not answer

34

IMPORTANT: After you submit this survey, click the link on the thank you page to be entered into the gift card drawing.

Thank You!

1

Thank you for your time and energy to complete this survey.

Click here for a chance to win a $50 gift card. Your personal information will not be connected to your survey responses. The same link will also allow you to indicate if you are interested in additional opportunities to provide feedback or participate in opportunities to support health improvement in your community.

APPENDIX C2
Four Pulse Survey

Pulse Survey: Older Adults

mithrive

MiThrive is conducting a **Community Themes & Strengths Assessment (CTSA) Pulse Survey** and would like to gather feedback from you as a member of one of our communities!

Informational Purposes ONLY - Do not read to client.

What is MiThrive?
MiThrive is a collaboration of diverse community organizations, local health departments, and hospital systems with a shared goal to assess and collaboratively improve community health within the 31 counties of Northern lower Michigan.

What is the purpose of the CTSA Pulse Survey?
The purpose of the MiThrive CTSA Pulse Survey is to gather input from people and populations facing barriers and inequities in the 31-county MiThrive region. These populations can include 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 mental and behavioral health disorders, people without housing, refugees, people with a disability, and many others.

How does the CTSA Pulse Survey work?
The CTSA Pulse Survey is a four-part data collection series. Each survey will be distributed in a two-week cycle beginning July 26th and ending September 19th.

Thank you so much for your time and consideration! If you have any questions regarding this survey please feel free to reach out to us at mithrive@northernmichiganchir.org

Informed Consent

We are collecting information about client experiences to improve health within your community. This will take about four minutes. Your answers will be anonymous – we will not record your name or personal information.

If you are willing to answer a few questions, please fill out the following:

1. Please write the name of the organization/agency you are filling this out at

   _____

2. What county do you live in? _____

3. What is your zip code? _____

Pulse Survey Series 2021

4. Thinking about resources for older adults such as housing, transportation to medical services, churches, shopping, adult day care, social support for older adults living alone, meals on wheels, rate your level of agreement on a scale from 1 to 5 where 1= “strongly disagree” and 5= “strongly agree” with the following statement:

My community is a good place to age

1="Strongly disagree"	2="Mostly disagree"	3="Neither agree nor disagree"	4="Mostly agree"	5="Strongly agree"
○	○	○	○	○

5. What about your community made you think that?

6. Thinking more broadly, what are some ways in which your community could ensure everyone has a chance at living the healthiest life possible?

mithrive

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If you are willing to answer a few questions, please fill out the following:

1. Please write the name of the organization/agency you are filling this out at

   _____

2. What county do you live in? _____

3. What is your zip code? _____

Pulse Survey Series 2021

mithrive

4. Thinking about school quality, day care, after school programs, recreation, rate your level of agreement on a scale from 1 to 5 where 1= “strongly disagree” and 5= “strongly agree” with the following statement:

This community is a good place to raise children

1="Strongly disagree"	2="Mostly disagree"	3="Neither agree nor disagree"	4="Mostly agree"	5="Strongly agree"
○	○	○	○	○

5. What about your community made you think that?

6. Thinking more broadly, how can we come together so that people promote each other’s well-being and not just their own?

MiThrive is conducting a **Community Themes & Strengths Assessment (CTSA) Pulse Survey** and would like to gather feedback from you as a member of one of our communities!

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The purpose of the MiThrive CTSA Pulse Survey is to gather input from people and populations facing barriers and inequities in the 31-county MiThrive region. These populations can include 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 mental and behavioral health disorders, people without housing, refugees, people with a disability, and many others.

How does the CTSA Pulse Survey work?
The CTSA Pulse Survey is a four-part data collection series. Each survey will be distributed in a two-week cycle beginning July 26th and ending September 19th.

Thank you so much for your time and consideration! If you have any questions regarding this survey please feel free to reach out to us at mithrive@northernmichiganchir.org

Informed Consent

We are collecting information about client experiences to improve health within your community. This will take about four minutes. Your answers will be anonymous – we will not record your name or personal information.

If you are willing to answer a few questions, please fill out the following:

1. Please write the name of the organization/agency you are filling this out at

   _____

2. What county do you live in? _____

3. What is your zip code? _____

mithrive

4. Thinking about individuals that have a disability (such as physical, mental, emotional), rate your level of agreement on a scale from 1 to 5 where 1 = “Strongly disagree” and 5 = “strongly agree” with the following statement:

In this community, a person with a disability can live a full life

1="Strongly disagree"	2="Mostly disagree"	3="Neither agree nor disagree"	4="Mostly agree"	5="Strongly agree"
○	○	○	○	○

5. What about your community made you think that?

6. Thinking more broadly, think about groups that experience relatively good health and those that experience poor health. Why do you think there is a difference?

MiThrive is conducting a **Community Themes & Strengths Assessment (CTSA) Pulse Survey** and would like to gather feedback from you as a member of one of our communities!

Informational Purposes ONLY - Do not read to client.

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mithrive

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○	○	○	○	○

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Pulse Survey Series 2021

Informed Consent

We are collecting information about client experiences to improve health within your community. This will take about four minutes. Your answers will be anonymous – we will not record your name or personal information.

If you are willing to answer a few questions, please fill out the following:

1. Please write the name of the organization/agency you are filling this out at

   _____

2. What county do you live in? _____

3. What is your zip code? _____

4. Thinking about basic needs contributing to quality of life such as being able to support yourself, having a job that allows you to pay bills on time, having a safe home, a reasonable commute, being able to get what you need in the community, rate your level of agreement on a scale from 1 to 5 where 1 = “strongly disagree” and 5 = “strongly agree” with the following statement:

There is economic opportunity in the community

1="Strongly disagree"	2="Mostly disagree"	3="Neither agree nor disagree"	4="Mostly agree"	5="Strongly agree"
○	○	○	○	○

5. What about your community made you think that?

6. Thinking more broadly, how would you ensure that people in tough life circumstances come to have as good a change as others do in achieving good health and well being over time?

APPENDIX C3

Four Provider Survey

2021 MiThrive Provider Survey

Informed Consent

2

This survey seeks providers perspectives on how various issues impact the health and wellbeing of their patients/clients within the 31 counties of Northern Lower Michigan. MiThrive is working to improve the health of communities in Northern Michigan by collecting data, identifying key issues, and bringing people together for change.

This survey will take approximately 10 minutes to complete. Your participation in this survey is completely voluntary. Your answers are confidential. The survey data will be managed and analyzed by MiThrive staff. You will not be identifiable by your answers. You are free to skip any question and stop taking the survey at any time. There is minimal risk to you for taking the survey, including an imposition of time and questions which may be sensitive in nature. If you have any questions about this survey, please email mithrive@northernmichiganchir.org.

(untitled)

Page exit logic: Skip / Disqualify Logic
IF: #1 Question "Do you provide direct care or services for clients or patients?" is one of the following answers ("No") **THEN:** Disqualify and display:
Thank you for your interest in this survey; however, you do not meet the requirement for this survey.

3

1. Do you provide direct care or services for clients or patients?*

- Yes
- No

(untitled)

18

2. What health system, organization, or entity do you work for? (Please avoid using abbreviations) *

16

3. What is your primary role? *

- Clinical Social Worker
- Doctor of Medicine or Osteopathy
- Pharmacist
- Physician's Assistant
- Dental Hygenist
- Public Health Educator
- Community Health Worker
- Nurse Practitioner
- Chiropractor
- Nurse
- Clinical Psychologist
- Podiatrist
- Dentist
- Optometrist
- Nurse-Midwife
- Other - Write In

7

4. Please check the boxes that define your specialty or that of your practice. (Check all that apply) *

- [ ] Primary Care
- [ ] Pediatrics
- [ ] Dental
- [ ] Preventative Medicine
- [ ] Behavioral Health
- [ ] Surgery
- [ ] Obstetrics & Gynecology
- [ ] Public Health
- [ ] Other - Write In

8

5. Which county(ies) do you provide direct care or services in? (Check all that apply) *

- [ ] Alcona
- [ ] Alpena
- [ ] Antrim
- [ ] Arenac
- [ ] Benzie
- [ ] Charlevoix
- [ ] Cheboygan
- [ ] Clare
- [ ] Crawford
- [ ] Emmet

- [ ] Gladwin
- [ ] Grand Traverse
- [ ] Iosco
- [ ] Isabella
- [ ] Kalkaska
- [ ] Lake
- [ ] Leelanau
- [ ] Manistee
- [ ] Mason
- [ ] Mecosta
- [ ] Missaukee
- [ ] Montmorency
- [ ] Newaygo
- [ ] Oceana
- [ ] Ogemaw
- [ ] Osceola
- [ ] Oscoda
- [ ] Otsego
- [ ] Presque Isle
- [ ] Roscommon
- [ ] Wexford

9

6. Approximately what percentage of the patients you serve are on Medicaid? *

- ○ 0-15%
- ○ 16-30%
- ○ 31-50%
- ○ >50%

VALIDATION Max. answers = 3 *(if answered)*

10

7. Thinking about the population you serve, what do you think are the three most important factors for a thriving community?

Check only three: *

- ☐ Disease and illness prevention
- ☐ Clean environment
- ☐ Reliable transportation
- ☐ Safe and affordable housing
- ☐ Parks and green spaces
- ☐ Access to quality healthcare srvices
- ☐ Civic engagement
- ☐ Access to nutritious food
- ☐ Lifelong learning: cradle to career
- ☐ Access to quality behavioral health services
- ☐ Belonging & inclusion
- ☐ Meaningful and rewarding work
- ☐ Disability Accessibility
- ☐ Arts and cultural events
- ☐ Freedom from trauma, violence, and addiction
- ☐ Other - Write In

VALIDATION Max. answers = 3 *(if answered)*

ID 12

8. What do you think are the three most important issues impacting patients/clients in the community(ies) you serve?

Check only three: *

- [ ] Motor vehicle crash injuries
- [ ] Lack of access to healthcare services
- [ ] Aging problems (e.g., arthritis, hearing/vision loss, etc.)
- [ ] Homicide
- [ ] Cancer
- [ ] Lack of safe and affordable housing
- [ ] Lack of quality behavioral health services
- [ ] Unreliable transportation
- [ ] Infant death
- [ ] High blood pressure
- [ ] Heart disease and stroke
- [ ] Lack of quality healthcare services
- [ ] Lack of quality education
- [ ] Firearm-related injuries
- [ ] Poor environmental health
- [ ] Rape/sexual assault
- [ ] Economic instability
- [ ] Obesity
- [ ] Lack of access to behavioral health services
- [ ] Neighborhood and built environment
- [ ] Lack of access to education
- [ ] COVID-19
- [ ] Racism and discrimination
- [ ] Sexually transmitted infections (STIs)
- [ ] Dental problems
- [ ] Teenage pregnancy
- [ ] Substance use
- [ ] Suicide
- [ ] Respiratory/lung disease
- [ ] Infectious diseases (e.g., hepatitis, tuberculosis, etc.)
- [ ] Domestic violence
- [ ] Child abuse/neglect
- [ ] Lack of access to nutritious foods
- [ ] Diabetes
- [ ] HIV/AIDS
- [ ] Other - Write In

14

9. From the list below which resources or services are missing in your community that would benefit your patients/clients? (Check all that apply) *

- [ ] Employment Navigation
- [ ] Domestic Violence Services
- [ ] Mental Health
- [ ] Housing
- [ ] Food
- [ ] Substance Abuse Services
- [ ] Translation
- [ ] Financial Support
- [ ] Transportation
- [ ] Education
- [ ] Childcare
- [ ] Dental Health
- [ ] Primary Care
- [ ] Other - Write In

- [ ] I feel there are enough services and resources to refer my patients/clients to.

LOGIC Show/hide trigger exists.

ID 15

10. Are you interested in additional opportunities to provide feedback or participate in opportunities to support health improvement efforts in your community?

*

- Yes
- No

LOGIC Hidden unless: #10 Question "Are you interested in additional opportunities to provide feedback or participate in opportunities to support health improvement efforts in your community?
" is one of the following answers ("Yes")

ID 17

IMPORTANT: In an effort to keep your survey responses confidential, click the link on the thank you page which will take you to a separate form where you can enter your contact information if you are interested in further feedback or engagement opportunities.

Thank You!

ID 5

Thank you for your time and energy to complete this survey.
If you selected yes to the last question, please provide your contact information by clicking this link.

APPENDIX D
Community Assets

Spectrum Health Big Rapids Hospital and Reed City Hospital Assets

Identified by Community Survey Respondents from Lake, Mecosta, and Osceola Counties

Social Service

Community Center
- Mecosta County Commission on Aging
- Lakeview Community Center
- Baldwin Community Center
- Ferris Rec Center
- Morley Community Center

Housing Organizations
- Big Rapids Housing Commission
- Evart Housing Commission
- MI State Housing Development Authority
- Mid Michigan Community Action
- Red City Housing Commission
- True North
- MDHHS
- Baldwin Housing Commission
- Wexford-Osceola Habitat for Humanity
- Northwest Michigan Community Action Agency

Food Pantry/Kitchens
- Manna Pantry
- Project Starburst
- Angels of Action
- God's Helping Hands
- St Philip Neri Church
- Church of the First Born
- Bread of Life Food Pantry
- Sears Food Pantry
- Feeding America Food Trucks
- Uplift Pine River Area Kids
- Chippewa Lake Community Church
- Reed City Area Ministerial Association Food Pantry
- United Methodist Church Reed City

Emergency Housing Shelters
- Our Brother's Keeper Shelter
- WISE
- Youth Attention Center

Halfway Houses
- Our Brother's Keeper
- Hersey House of Hope
- Sisters of Sobriety

Domestic Violence Shelters
- WISE
- Oasis
- Hersey House of Hope

Social/Grassroot Organizations

Seniors' Group
- Mecosta County Commission on Aging
- Reed City Senior Center
- Hollister Senior Center
- Northwest Lake County Senior Center
- St. Ann's Senior Center
- Canadian Lakes Association
- Osceola County Commission on Aging

Special Interest Group
- Big Rapids Social Justice and Equality
- Garden Club
- American Legion
- Veterans of Foreign Wars (VFW)
- Mecosta County Reads
- Relay for Life of Wexford-Missaukee-Osceola-Mecosta

Advocacy Groups/Coalitions
- Mecosta County Reads
- Mecosta Osceola Human Services Collaborative Body
- Big Rapids Social Equity Initiative
- Animal Rescue Coalition
- Pregnancy Resource Center
- Central Michigan Recovery and Education Network
- Lake County Collaborative/Round Table
- Lake County Communities That Care
- Mecosta Osceola Substance Awareness Coalition
- Mecosta Children's Council

- Mecosta County Angels of Action
- Big Rapids New Journey Club

Cultural Organizations
- CrossRoads Theatre Guild
- Artworks – Big Rapids
- Old Rugged Cross Historical Society Museum
- Festival of the Arts
- Wheatland Music Festival
- Ferris Hispanic Student Committee

Hunting/Sportsman Leagues
- Mecosta Gun & Rod Club
- Reed City Sportsman's Club
- Tustin Sportsman Club
- Barryton Rod & Gun Club
- Rodney Rod & Gun Club
- Haymarsh Chapter Ducks Unlimited – Big Rapids Area
- Whitetails Unlimited – Mecosta County

Amateur Sports Leagues
- Reed City Little League
- Reed City Softball League
- Big Rapids Little League
- Northland United Soccer Club
- Canadian Lakes Pickle Ball
- West Winds Gymnastics
- Reed City Men's Softball League
- Northern Rockets Football League
- Cadillac Area Hockey Association

Education

Colleges or Universities
- Ferris State University
- Baker College of Cadillac

Community College
- Mid Michigan College
- West Shore Community College
- Montcalm Community College

Before-/After-School Program
- Kiddie Klubhouse – Reed City
- Mecosta Elementary After School Programs
- St. Peter's Lutheran Church & School – Big Rapids
- Latchkey Program – Crossroads Charter Academy
- Newbees Day Care Center – Reed City
- Big Rapids Public Schools
- Reed City Public Schools

Vocational/Technical Education Programs
- Mecosta-Osceola Career Center

Health Institutions

Hospital
- Spectrum Health Big Rapids and Reed City Hospitals

Health Care Clinics
- Spectrum Health Family Medicine
- Reed City Family Practice
- Spectrum Health Walk-in Clinic – Big Rapids and Reed City
- Family Health Care – Big Rapids
- Hope House Free Medical Clinic
- Spectrum Health Evart Family Practice
- Birkam Healthcare – Ferris State University
- West Michigan Pain Clinic
- Premier Primary Health
- Baldwin Family Healthcare
- Williams Family Medical

Health Department
- District Health Department#10
- Central Michigan District Health Department

Behavioral Health Services
- Community Mental Health for Central MI
- West Michigan Community Mental Health
- Ten16 Recovery Network

Public Service

Library
- Reed City Area District Library
- Big Rapids Community Library
- Evart Public Library
- Morton Township Library
- Leroy Community Library
- Chase Public Library
- Luther Area Public Library
- Walton Erickson Public Library
- Tustin Library
- Pathfinder Community Library

Police Department
- Reed City Police Department
- Osceola County Sheriff's Department
- Mecosta County Sheriff's Department
- Big Rapids Department of Public Safety
- Michigan State Police
- Evart Police Department
- Barryton Police Department
- Lake County Sheriff's Department
- Ferris State University Department of Public Safety

Fire Department
- Reed City Fire Department
- Big Rapids Fire Department
- Morton Township Fire Department
- Austin Township Fire Department
- Webber Township Fire Department
- Sauble Elk Eden Townships Fire Station
- Lake County Fire Department
- Evart Fire and Rescue
- LeRoy-Rose Lake Fire Department
- Big Rapids Township Fire Department
- Mecosta Fire Department
- Luther Fire Department District 1
- Morley Area Fire Department
- Hersey Township Fire Department
- Tustin Area Fire Department
- Wheatland Township Fire Department

Emergency Medical Services
- Osceola County EMS
- Life EMS
- Mecosta County EMS

Community-Based Organizations

Religious Organizations
- Reed City Trinity Lutheran Church
- Resurrection Life Church
- Reed City United Methodist Church
- St. Peter's Lutheran Church
- Evart Free Methodist Church
- Sylvester Community Church
- St. Mary's Catholic Church
- St. Paul Lutheran Church
- St. Philip Neri Catholic Church
- Church of the Nazarene
- First Baptist Church
- Crossroads Community Church
- Calvary Baptist
- Chippewa Hills Baptist Church
- Chase Fellowship Church
- St. Michael's Catholic Church
- The Church of the First Born and Revival Center
- Liberty Baptist Church
- SpringHill

United Way
- Mecosta-Osceola United Way

Community or Philanthropic Foundation
- Osceola County Community Foundation
- Rotary Club
- Mecosta County Community Foundation
- Spectrum Health Foundation Big Rapids Reed City Hospital
- Lake County Community Foundation
- Moose Lodge #705
- Angels of Action
- Artworks
- Ferris Foundation
- Friends of the Big Rapids Library
- Salvation Army

Political Organizations
- Osceola County Republicans
- Osceola County Democrats
- Lake County Democrats
- Lake County Republicans
- Mecosta County Republicans
- Mecosta County Democrats

Infrastructure

Parks
- Rambadt Park – Reed City
- Westerburg Park – Reed City
- Hemlock
- North End
- Buffalo
- Pere Marquette Park
- Linear Park
- Hollister Park
- Hemlock Park
- Mitchell Creek Park

- Browers Park
- Crittenden Park
- Paris Park
- School Section Lake Veterans Park
- Brutus Dog Park
- Highbanks Park
- Hersey Park
- Reed City Park
- Riverside Park

Public Pools
- Charles E. Fairman Community Pool
- Ferris State University Rec Center
- Canadian Lakes Outdoor Pool

Vacant Private Building or Lot
- Train Depot
- JCPenny Building

Public Lake or Coastline
- School Section Lake
- Chippewa Lake
- Youngs Lake
- Horsehead Lake
- Wolf Lake
- Muskegon River
- Big Bass Lake
- Townline Lake
- Canadian Lakes
- Clear Lake
- Hungerford Lake
- Hardy Dam
- Idlewild Lake
- Rose Lake
- Mill Pond
- Martiny Chain of Lakes

Community Gardens
- Big Rapids Community Garden
- Lakeview Community Garden

Farmer's Markets
- Big Rapids Farmer's Market
- Evart Farmer's Market
- Reed City Farmer's Market
- Hersey Farmer's Market
- Morley Farmer's Market
- Barryton Farmer's Market

Noteworthy Person/Group

Local Artists/Musicians
- Aaron Rhode
- Artworks
- Tuba Bach
- Stage M
- Voca Lyrica
- Idlewild Music Festival
- Kasey Thren
- Kym Nichols
- John Mallett
- Quinn's Music
- Ann and Eldon Whitford
- Roosevelt Digs
- Wheatland Music Festival
- May Elerwine
- Damned by Dawn

Community Leader
- Mayor Tom Hogenson
- Chief Danielle Haynes
- Jane from Baldwin Lumber
- Rex Schuberg
- City Manager – Rich Saladin
- Mayor of Evart
- Sheriff Miller
- Kris Arnold – Relay for Life of Wexford, Missaukee, Osceola, and Mecosta Counties
- Mark Gifford - City Manager of Big Rapids
- Marilynn Bradstrom – Mecosta County Commissioner
- Larry Emig – Reed City

Celebrity or Influential Figure

Other

APPENDIX E
CSA Agenda

Northeast Community System Event | Monday, August 16, 2021 | 1:30 p.m. to 3:30 p.m.

Northeast Community System Assessment Agenda

1:15 p.m. Virtual Event Opens
1:30 p.m. Welcome and Introductions
1:40 p.m. Community System Assessment Unpacked
1:50 p.m. Team Discussion #1
2:40 p.m. Large Group Check In (Break)
2:45 p.m. Team Discussion #2
3:25 p.m. Large Group Celebration (Wrap Up)
3:30 p.m. (optional) Happy Half Hour – Questions and Networking

Introduction to the Community System Assessment

Activity Purpose:

- Improve organizational and community communication and collaboration by bringing a broad spectrum of partners to the same table.
- Learn about community health and how activities are interconnected.
- Identify system strengths and weaknesses which may then be used to improve and better coordinate activities at the community level

What is a Community System?

All of us are part of the Community System. Community Systems are networks of diverse agencies and groups with differing roles, relationships, and interactions whose activities combined contribute to the health and well-being of the community.

What topic areas will we be talking about today?

- **Resources:** A community asset (or community resource) is anything that can be used to improve the quality of community life.
- **Policy:** Policies are the written or unwritten guidelines that governments, organizations and institutions, communities, or individuals use when responding to issues and situations.
- **Data Access/Capacity:** A community with data capacity is one where people can access and use data to understand and improve health outcomes where they live.
- **Community Alliances:** Diverse partnerships which collaborate in the community to maximize health improvement activities and are beneficial to all partners involved.
- **Workforce:** The people engaged in or available for work in a particular area, company, or industry.
- **Leadership:** Leadership within the community is demonstrated by organizations and individuals that are committed to improving the health of the community.
- **Community Power/Engagement:** Power is the ability to control the processes of agenda setting, resource distribution, and decision-making, as well as to determine who is included and excluded from these processes.
- **Health Equity Capacity:** Health Equity is the assurance of the conditions for optimal health for all people.

Team Discussion #1: Community System Assessment

Detailed Instructions:

Team Introductions: [10 minutes]

- Designate your Note Taker. This person will take notes on the CSA Notes Form.
- Get to know your team! Introduce yourself.
- Review your Focus Area

Introduction Inclusion Tips:

- Learn how to pronounce people's names: It is helpful to phonetically spell names in the chat box [Why is this important?]
- Share pronouns: One best practice is to include preferred pronouns with one's name [Why is this important?]
- Put Names with Faces: Show your face with your preferred name if you can, also realize that not everyone can see you. Introductions that include descriptors of what people would see are helpful to those who can't see you.

Overview of Discussion and Performance Measure Scoring: [5 minutes]

- Review as a group the questions to think about in the regarding your Focus Area (See Participant Packet)
- Introduce the Performance Measure questions and scoring grid

Discussion: [15 minutes]

Using discussion questions in your Participant Packet for your Focus Are discuss how the community organizations participate in these focus area activities, and how the system as a whole performs.

Scoring of Performance Measures (8 Minutes)

Vote on the specific measures for your Focus Area using the scoring grid.

Optimal Activity (76-100%)	Greater than 75% of the activity described within the question is met.
Significant Activity (51-75%)	Greater than 50% but no more than 75% of the activity described within the question is met.
Moderate Activity (26-50%)	Greater than 25% but no more than 50% of the activity described in the question is met.
Minimal Activity (1-25%)	Greater than 0% but no more than 25% of the activity described in the question is met.
No Activity (0%)	0% or absolutely no activity relating to the activity described in the question.

Discussion to determine strengths and opportunities to improve Performance Meaasures (12 miniutes)

Choose one of the measures with the most disagreement for more discussion to dig deeper into strengths, weaknesses and opportunities.

Team Discussion #2 Community System Assessment

Repeat Steps for Team Discussion #1

Omit grounding question

TEAM FACILITATORS: PLEASE SEND US YOUR NOTES IMMEDIATELY FOLLOWING THE EVENT THANK YOU!

MiThrive@northernmichiganCHIR.org

APPENDIX F
FOCA Agenda

Agenda

9:45 a.m. Virtual Event Opens

10 a.m. Welcome & Introductions

10:10 a.m. Introduction to MiThrive and the Forces of Change Assessment

10:30 a.m. Forces of Change Small Group Brainstorming Session

10:45 a.m. Small Group Spotlight

11:05 a.m. Forces of Change Small Group Threats and Opportunities Session

11:25 a.m. Small Group Spotlight

11:45 a.m. Wrap Up & Next Steps

Noon Adjourn

Event Access Link

https://zoom.us/j/96917348003?pwd=ZHhiTCtUM0Q5L3BOL3dwb0JzbHk1UT09 Meeting ID: 969 1734 8003

Passcode: 484284

One tap mobile

+13126266799,,96917348003#,,,,*484284# US (Chicago)

+19292056099,,96917348003#,,,,*484284# US (New York)

Dial by your location

+1 312 626 6799 US (Chicago)

+1 929 205 6099 US (New York)

+1 301 715 8592 US (Washington DC)

+1 346 248 7799 US (Houston)

+1 669 900 6833 US (San Jose)

+1 253 215 8782 US (Tacoma)

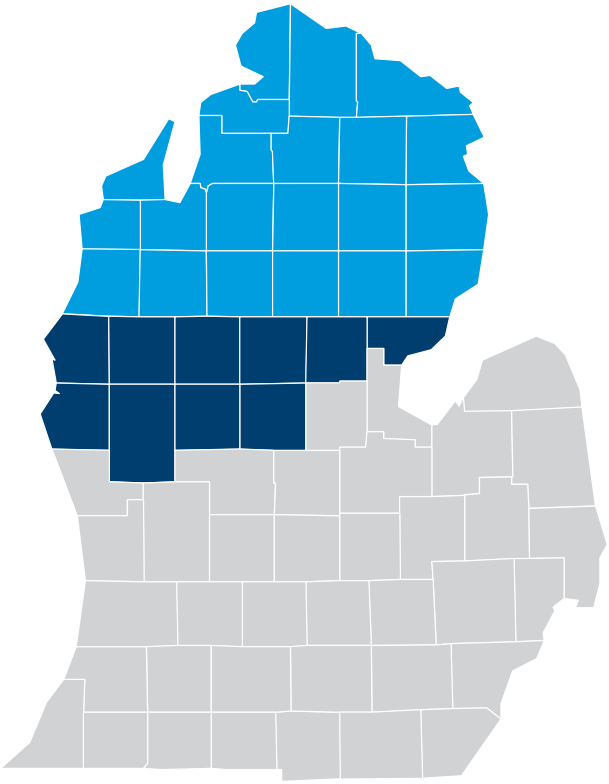
Meeting ID: 969 1734 8003

Passcode: 484284

Find your local number: https://zoom.us/u/aeCTgzoACl

APPENDIX G

North Central MiThrive Data Briefs



2021 North Central MiThrive Data Briefs

Published: January 2022

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

Assessment Snapshot

The **Forces of Change Assessment (FOCA)** aims to answer the following questions:

- What is occurring or might occur that affects the health and wellbeing of our community?
- What specific threats or opportunities are generated by these occurrences?

Forces of change are trends, factors, and events *outside of our control* that may influence the health of our community or the system of organizations supporting the community, both in the recent past and the foreseeable future.

The FOCA Topic Areas:

1. Government Leadership & Budgets, Spending Priorities
2. Sufficient Health Care Workforce
3. Access to Health Services
4. Population Demographics
5. Economic Environment
6. Access to Social Services
7. Social Context
8. COVID-19 Pandemic

The **Community Health Status Assessment (CHSA)** aims to answer the following questions:

- How healthy are our residents?
- What does the health status of our community look like?

The answers to these questions were measured by collecting 100 secondary indicators from 20 different sources including the US Census Bureau, Centers for Disease Control, and Michigan Department of Health and Human Services. The table in green shows select indicators relevant to the strategic issue.

For each strategic issue, a map related to one of the indicators in the table is visualized at either the census-tract or county level. A brief statement highlighting the geographical disparities is located near the map.

The **Community System Assessment (CSA)** aims to answer the following question:

- What are the components, activities, competencies, and capacities in our local systems?

The CSA assessed performance measures for 8 topic areas:

1. Resources
2. Policies
3. Data Access & Capacity
4. Community Alliances
5. Workforce
6. Leadership
7. Community Power/Engagement
8. Capacity for Health Equity

The CSA was conducted at the regional level. Additional data was then collected at the county-level through facilitated conversations at community collaboratives.

The **Community Themes and Strengths Assessment (CTSA)** aims to answer the following questions:

- What is important to the community?
- How is quality of life perceived in the community?
- What assets does the community have that can be used to improve community health?

The CTSA collected data using 3 different methods:

1. **Pulse Survey Series:** Four, three question mini client interviews conducted by community partners with clients and patients. Topics included education, aging, disability, and economic security.
2. **Community Survey:** This survey was conducted through an online and paper format and asked questions about what makes a thriving community, current issues impacting the health of the community, and quality of life questions.
3. **Provider Survey:** This survey was conducted through an online format and targeted individuals providing direct care and services.

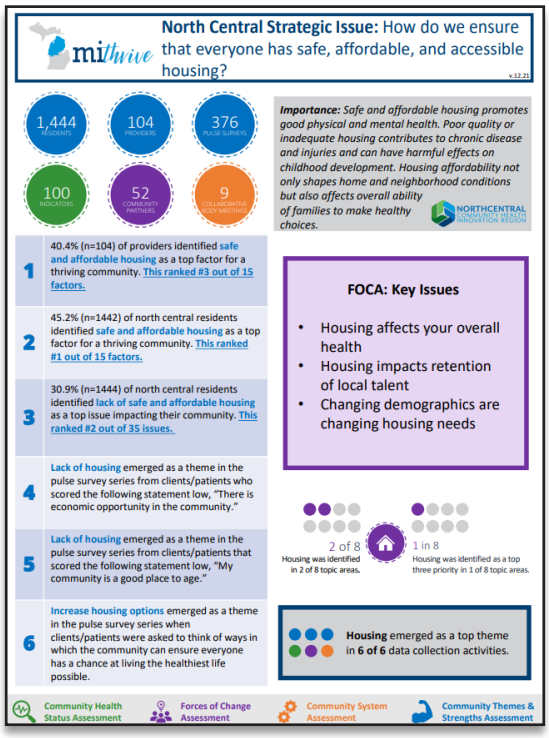
Data Brief Navigation Guide

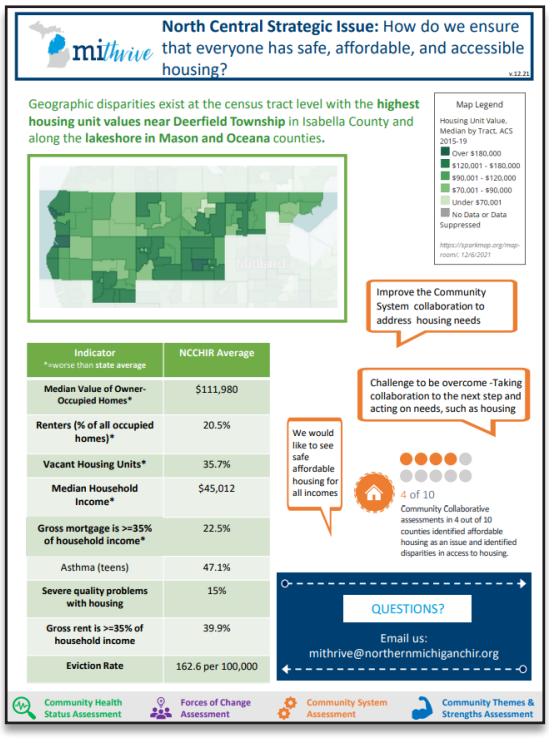
Data was collected 6 different ways. Each circle represents a different data collection method.

Data collected in the Community Themes and Strengths Assessment is shown in blue. Data was collected through a community survey, provider survey, and pulse surveys as reflected by the 3 blue circles.

Strategic issue

Data collected in the Community Health Status Assessment is shown in green. Indicators in bold had a state value available to compare to. If the regional value was worse than the state value (meaning of worse depends on what the indicator is measuring) an asterisk is placed next to the indicator title.





Indicator *=worse than state average	NCCHIR Average
Median Value of Owner-Occupied Homes*	$111,980
Renters (% of all occupied homes)*	20.5%
Vacant Housing Units*	35.7%
Median Household Income*	$45,012
Gross mortgage is >=35% of household income*	22.5%
Asthma (teens)	47.1%
Severe quality problems with housing	15%
Gross rent is >=35% of household income	39.9%
Eviction Rate	162.6 per 100,000

Importance Statement

Data collected in the Forces of Change Assessment is shown in purple. The dot illustration represents how often the strategic issue was identified in one of the 8 topic areas (left) and as a top priority within a topic area (right)

This graphic illustrates where a topic or theme emerged in the different data collection methods.

Data collected in the Community System Assessment is shown in orange. The dot illustration represents the number of community collaboratives in which a topic or theme emerged. The comment boxes indicate comments from participants regarding recurring themes.

Color coded key illustrating the 4 MiThrive assessments

Data Brief Acronyms

Acronym	What does it stand for?	What does it mean?
YPLL	Years Potential Life Lost	The difference between a predetermined end point (usually age 75 and the age at death for death(s) that occurred prior to that end point age
ALICE	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.
FPL	Federal Poverty Level	A measure of income issued every year by the Department of Health and Human Services used to determine eligibility for certain programs and benefits.
ACE(s)	Adverse Childhood Experience(s)	Potentially traumatic events that occur in childhood (0-17 years)
HPSA	Health Professional Shortage Area	Geographic areas, populations, or facilities with a shortage of primary, dental or mental health care providers.
WIC	Women Infants Children	Aims to safeguard the health of low-income women, infants, and children up to age 5 who are at nutrition risk by providing nutritious foods to supplement diets, information on healthy eating, and referrals to care
COPD	Chronic Obstructive Pulmonary Disorder	Chronic inflammatory lung disease that causes obstructed airflow from the lungs.
Description of per 100,000		Rates take into account the number of cases/deaths/etc. and the population size. Rate per 100,000 is calculated by taking the total number of cases divided by the total population and multiplied by 100,000.
Description of Gini index		measure of income inequality.; It ranges from 0, indicating perfect equality (everyone receives an equal share), to 1, perfect inequality (only one recipient or group of recipients receives all the income)

North Central Strategic Issue: How do we ensure that everyone has safe, affordable, and accessible housing?

v.12.21

1,444 RESIDENTS

104 PROVIDERS

376 PULSE SURVEYS

100 INDICATORS

52 COMMUNITY PARTNERS

9 COLLABORATIVE BODY MEETINGS

Importance: *Safe and affordable housing promotes good physical and mental health. Poor quality or inadequate housing contributes to chronic disease and injuries and can have harmful effects on childhood development. Housing affordability not only shapes home and neighborhood conditions but also affects overall ability of families to make healthy choices.*

NORTHCENTRAL COMMUNITY HEALTH INNOVATION REGION

1	40.4% (n=104) of providers identified **safe and affordable housing** as a top factor for a thriving community. **This ranked #3 out of 15 factors.**
2	45.2% (n=1442) of north central residents identified **safe and affordable housing** as a top factor for a thriving community. **This ranked #1 out of 15 factors.**
3	30.9% (n=1444) of north central residents identified **lack of safe and affordable housing** as a top issue impacting their community. **This ranked #2 out of 35 issues.**
4	**Lack of housing** emerged as a theme in the pulse survey series from clients/patients who scored the following statement low, "There is economic opportunity in the community."
5	**Lack of housing** emerged as a theme in the pulse survey series from clients/patients that scored the following statement low, "My community is a good place to age."
6	**Increase housing options** emerged as a theme in the pulse survey series when clients/patients were asked to think of ways in which the community can ensure everyone has a chance at living the healthiest life possible.

FOCA: Key Issues

- Housing affects your overall health
- Housing impacts retention of local talent
- Changing demographics are changing housing needs

2 of 8
Housing was identified in 2 of 8 topic areas.

1 in 8
Housing was identified as a top three priority in 1 of 8 topic areas.

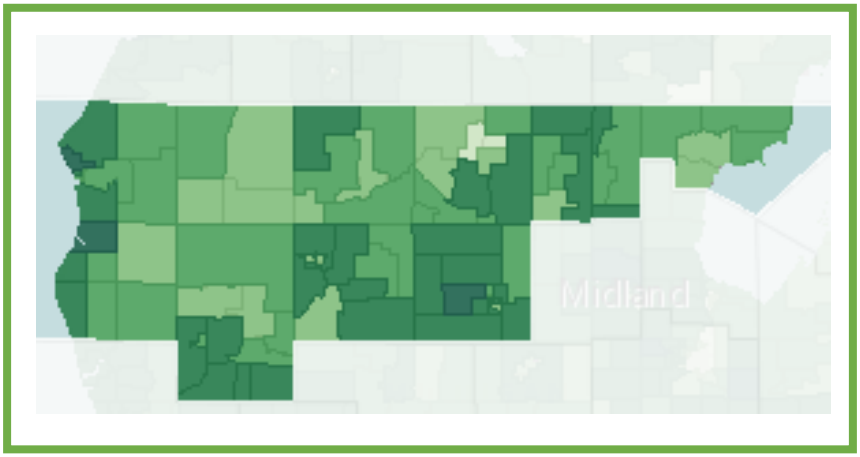
Housing emerged as a top theme in **6 of 6** data collection activities.

Community Health Status Assessment | Forces of Change Assessment | Community System Assessment | Community Themes & Strengths Assessment

North Central Strategic Issue: How do we ensure that everyone has safe, affordable, and accessible housing?

v.12.21

Geographic disparities exist at the census tract level with the **highest housing unit values near Deerfield Township** in Isabella County and along the **lakeshore in Mason and Oceana** counties.



Map Legend

Housing Unit Value, Median by Tract, ACS 2015-19

- Over $180,000
- $120,001 - $180,000
- $90,001 - $120,000
- $70,001 - $90,000
- Under $70,001
- No Data or Data Suppressed

https://sparkmap.org/map-room/, 12/6/2021

Indicator *=worse than **state average**	NCCHIR Average
Median Value of Owner-Occupied Homes*	$111,980
Renters (% of all occupied homes)*	20.5%
Vacant Housing Units*	35.7%
Median Household Income*	$45,012
Gross mortgage is >=35% of household income*	22.5%
Asthma (teens)	47.1%
Severe quality problems with housing	15%
Gross rent is >=35% of household income	39.9%
Eviction Rate	162.6 per 100,000

Improve the Community System collaboration to address housing needs

Challenge to be overcome -Taking collaboration to the next step and acting on needs, such as housing

We would like to see safe affordable housing for all incomes

4 of 10

Community Collaborative assessments in 4 out of 10 counties identified affordable housing as an issue and identified disparities in access to housing.

QUESTIONS?

Email us:
mithrive@northernmichiganchir.org

Community Health Status Assessment | Forces of Change Assessment | Community System Assessment | Community Themes & Strengths Assessment

North Central Strategic Issue: How can we increase comprehensive substance misuse prevention and treatment services that are accessible, patient-centered and stigma free?

v.12.21

1,444 RESIDENTS

104 PROVIDERS

376 PULSE SURVEYS

100 INDICATORS

52 COMMUNITY PARTNERS

9 COLLABORATIVE BODY MEETINGS

Importance: *Substance misuse impact people's chances of living long, healthy, and productive lives. It can decrease quality of life, academic performance, and workplace productivity; increases crime and motor vehicle crashes and fatalities; and raises health care costs for acute and chronic conditions.*

NORTHCENTRAL COMMUNITY HEALTH INNOVATION REGION

Encourage people to engage without fear of threat to societal status – reduce stigma

More opportunities for counseling for families and children

Need additional resources for substance misuse prevention and treatment

1	18.3% (n=104) of providers identified **freedom from trauma, violence, and addiction** as a top factor for a thriving community. **This ranked #7 out of 15 factors.**
2	34.6% (n=104) of providers identified **substance use** as a top issue impacting their patients/clients. **This ranked #1 out of 35 issues.**
3	44.2% (n=104) of providers said **substance abuse services** for patients/clients are missing in the community they serve. **This ranked #3 out of 13 resources/services.**
4	23% (n=1442) of north central residents identified **freedom from trauma, violence, and addiction** as a top factor for a thriving community. **This ranked #4 out of 15 factors.**
5	31.9% (n=1444) of north central residents identified **substance use** as a top issue impacting their community. **This ranked #1 out of 35 issues.**

What improvements would you like to see in your community in the next three years?

We need programs working in unison to develop a universal intake so that families can be supported, and resources known

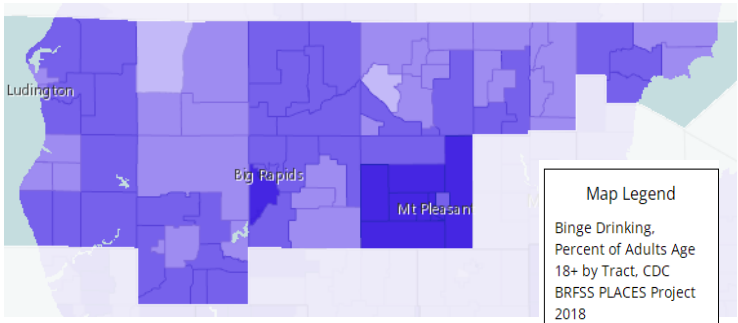
Substance misuse emerged as a top theme in **4 of 6** data collection activities.

Community Health Status Assessment | Forces of Change Assessment | Community System Assessment | Community Themes & Strengths Assessment

North Central Strategic Issue: How can we increase comprehensive substance misuse prevention and treatment services that are accessible, patient-centered and stigma free?

v.12.21

Geographic disparities exist at the census tract level with the **highest percentages** of **binge drinking** in **Isabella** and **Mecosta** county **near Ferris State University**



Indicator *=worse than **state average**	NCCHIR Average
Liver Disease Mortality*	15.1 per 100,000
Heart Disease Mortality*	199.1 per 100,000
Smoked cigarettes in past 30 days (teens)	3.9%
Teens with 2+ ACES	36.3%
Oral Cavity and Pharynx Cancer*	12.8 per 100,000
Lung and Bronchus Cancer*	76.1 per 100,000
Asthma (teens)	47.1%
Ever told COPD (adults)*	10.5 per 100,000
Binge drinking (adults)	16.8%
Used prescription drugs w/o prescription (teens)	3.5%
Used marijuana in past 30 days (teens)	10.1%
Had a drink of alcohol in past 30 days (teens)	12.8%
Smoked cigarettes in past 30 days (teens)	5.1%
Used chew tobacco in past 30 days (teens)	2.7%
Vaped in past 30 days (teens)	14.4%
Opioid related hospitalizations*	15.4 per 100,000
Motor vehicle crash involving alcohol mortality	35%
Drug-Induced Mortality	13.1 per 100,000
Alcohol-Induced Mortality*	12.3 per 100,000

COVID-19 has increased the substance misuse in our communities and impacted other systems-like workforce

There has historically been a shortage of providers and now it has worsened.

3 of 8

Substance misuse was identified in 3 of 8 topic areas.

3 in 8

Substance misuse was identified as a top three priority in 3 of 8 topic areas.

QUESTIONS?

Email us:
mithrive@northernmichiganchir.org

Community Health Status Assessment | Forces of Change Assessment | Community System Assessment | Community Themes & Strengths Assessment

North Central Strategic Issue: How do we increase access and reduce barriers to quality behavioral health services while increasing resiliency and wellbeing?

v.12.21

1,444 RESIDENTS

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376 PULSE SURVEYS

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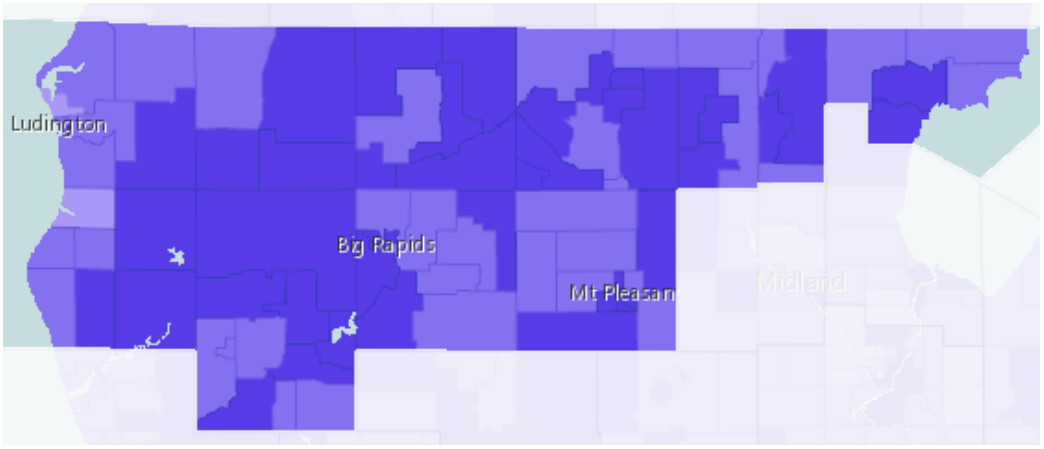
9 COLLABORATIVE BODY MEETINGS

Importance: *Mental health is essential to a person's well-being, healthy relationships, and ability to live a full life. It also plays a major role in people's ability to maintain good physical health because mental illness increases risk for many chronic health conditions.*

NORTHCENTRAL COMMUNITY HEALTH INNOVATION REGION



Map Legend

Poor Mental Health, Prevalence Among Adults Age 18+ by Tract, CDC BRFSS PLACES Project 2018

- Over 16.0%
- 13.1% - 16.0%
- 10.1% - 13.0%
- Under 10.1%
- No Data or Data Suppressed

https://sparkmap.org/map-room/, 12/3/2021

Indicator *=worse than **state average**	NCCHIR Average
Teens with 2+ ACES	36.3%
Alzheimer's/Dementia Mortality*	31.9 per 100,000
Poor mental health 14+ days (adult)	11.4%
Major depressive episode (teen)	40.0%
Average HPSA Score – Mental Health*	17.8
Intentional Self-Harm*	17.8 per 100,000

Geographic disparities exist at the census tract level with a large portion of **high percentages** of **poor mental health** in the **western** part of the region.

Mental health emerged as a top theme in **6 of 6** data collection activities.

Community Health Status Assessment | Forces of Change Assessment | Community System Assessment | Community Themes & Strengths Assessment

North Central Strategic Issue: How do we increase access and reduce barriers to quality behavioral health services while increasing resiliency and wellbeing?

v.12.21

1	43.3% (n=104) of providers identified **access to behavioral health services** as a top factor for a thriving community. **This ranked #2 out of 15 factors.**
2	18.3% (n=104) of providers identified **freedom from trauma, violence, and addiction** as a top factor for a thriving community. **This ranked #7 out of 15 factors.**
3	31.7% (n=104) of providers identified **lack of access to behavioral health services** as a top issue impacting their patients/clients. **This ranked #3 out of 35 issues.**
4	19.2% (n=104) of providers identified **lack of quality behavioral health services** as a top issue impacting their patients/clients. **This ranked #7 out of 35 issues.**
5	62.5% (n=104) of providers said **mental health resources/services** for patients/clients are missing in the community they serve. **This ranked #1 out of 13 resources/services.**
6	21.2% (n=1442) of north central residents identified **access to quality behavioral health services** as a top factor for a thriving community. **This ranked #5 out of 15 factors.**
7	23% (n=1442) of north central residents identified **freedom from trauma, violence, and addiction** as a top factor for a thriving community. **This ranked #4 out of 15 factors.**
8	19.5% (n=1444) of north central residents identified **lack of access to behavioral health services** as a top issue impacting their community. **This ranked #4 out of 35 issues.**
9	14.7% (n=1444) of north central residents identified **lack of quality behavioral health services** as a top issue impacting their community. **This ranked #6 out of 35 issues.**
10	**Increase mental health supports and resources** emerged as theme in the pulse survey series when clients/patients were asked to identify ways in which to promote each other's wellbeing and not just their own.

Taking collaboration to the next step and acting on needs, such as mental health

Need to decrease stigma

Build trust. Create easy access to services

8 of 10

Community Collaborative assessments in 8 out of 10 counties identified. Access to mental health services as an issue

Behavioral health is easier to talk about- it is less taboo

One opportunity that resulted from COVID-19 is the increase in availability of virtual mental health services

There is a severe shortage of mental health providers.

5 of 8

Behavioral health services was identified in 5 of 8 topic areas.

2 in 8

Behavioral health services was identified as a top three priority in 2 of 8 topic areas.

QUESTIONS?

Email us:
mithrive@northernmichiganchir.org

Community Health Status Assessment | Forces of Change Assessment | Community System Assessment | Community Themes & Strengths Assessment

North Central Strategic Issue: 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?

v.12.21

1,444 RESIDENTS

104 PROVIDERS

376 PULSE SURVEYS

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52 COMMUNITY PARTNERS

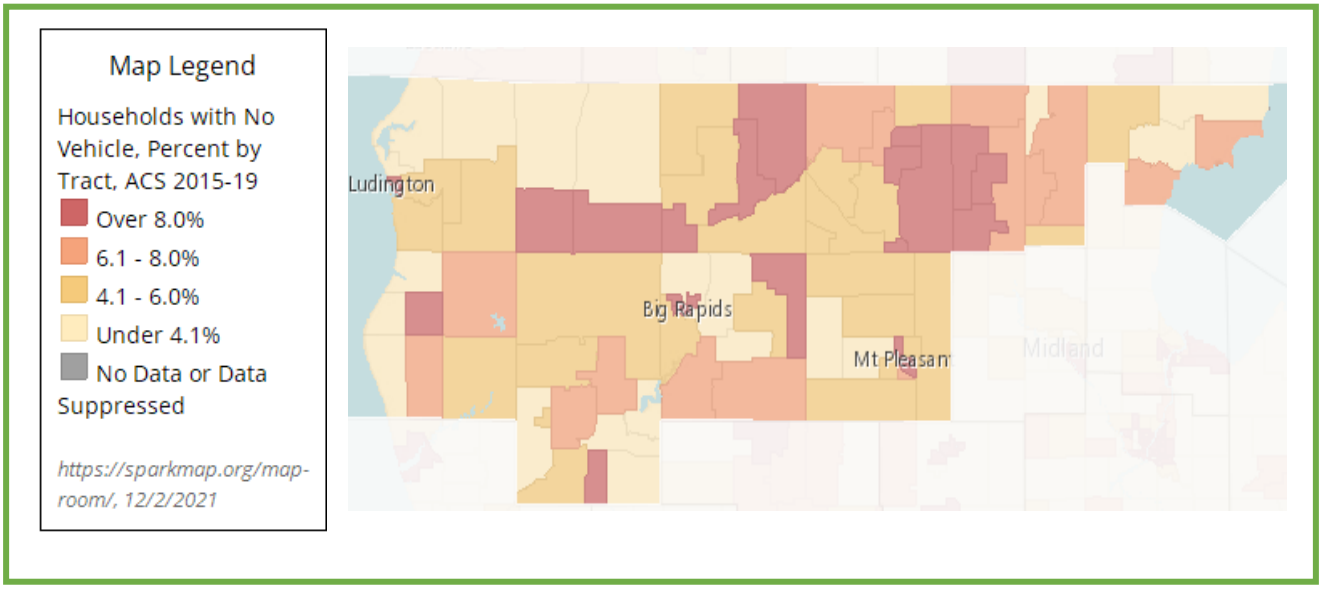
9 COLLABORATIVE BODY MEETINGS

Importance: *Transportation is a critical factor that influences people's health and the health of a community. Barriers to transportation options may result in missed or delayed health care visits, increased health expenditures and overall poorer health outcomes.*

NORTHCENTRAL COMMUNITY HEALTH INNOVATION REGION

Geographic disparities exist at the census tract level with a large portion of the **highest percentages** of **households with no vehicle** around the shared border of **Clare** and **Gladwin**.

Indicator *=worse than **state average**	**NWCHIR Average**
Motor vehicle crash mortality	16.1 per 100,000
No household vehicle	6.7%



Transportation emerged as a top theme in **4 of 6** data collection activities.

Community Health Status Assessment | Forces of Change Assessment | Community System Assessment | Community Themes & Strengths Assessment

North Central Strategic Issue: 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?

v.12.21

3 of 8
Transportation was identified in 3 of 8 topic areas.

1 in 8
Transportation was identified as a top three priority in 1 of 8 topic areas.

1	30.8% (n=104) of providers identified **reliable transportation** as a top factor for a thriving community. **This ranked #5 out of 15 factors.**
2	21.2% (n=104) of providers identified **unreliable transportation** as a top issue impacting their patients/clients. **This ranked #5 out of 35 issues.**
3	45.2% (n=104) of providers said **transportation resources/services** for patients/clients are missing in the community they serve. **This ranked #2 out of 13 resources/services.**
4	**Transportation and long commute** emerged as themes in the pulse survey series for clients/patients that scored the following statement low, "There is economic opportunity in the community."
5	**Addressing transportation needs** emerged as a theme in the pulse survey series when clients/patients were asked to identify ways in which to ensure people in tough life circumstances come to have as good a chance as others do in achieving good health and wellbeing over time.
6	**Lack of transportation** emerged as a theme in the pulse survey series for clients/patients that scored the following statement low, "My community is a good place to age."
7	**Improve transportation options** emerged as a theme in the pulse survey series when clients/patients were asked to think of ways in which the community can ensure everyone has a chance at living the healthiest life possible.

FOCA: Key Issues

- COVID-19 & working from home has reduced some transportation needs
- Limited access to healthcare & providers in rural areas has increased the need for non-emergency medical transportation and widened the access gap

Communities need Increased transportation options at a reasonable cost and easily accessible

Improvements to public transportation and access for individuals without driver's license/ vehicle/money for gas/insurance

Have a strong transportation system that is growing

4 of 10
Community Collaborative assessments in 4 out of 10 counties identified transportation barriers as impacting the health of their community.

QUESTIONS?

Email us:
mithrive@northernmichiganchir.org

Community Health Status Assessment | Forces of Change Assessment | Community System Assessment | Community Themes & Strengths Assessment

North Central Strategic Issue: How do we foster a community where everyone feels economically secure?

v.12.21

1,444 RESIDENTS

104 PROVIDERS

376 PULSE SURVEYS

100 INDICATORS

52 COMMUNITY PARTNERS

9 COLLABORATIVE BODY MEETINGS

Importance: *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.*

NORTHCENTRAL COMMUNITY HEALTH INNOVATION REGION

1	18.3% (n=104) of providers identified **meaningful and rewarding work** as a top factor for a thriving community. **This ranked #7 out of 15 factors.**
2	28.8% (n=104) of providers identified **economic instability** as a top issue impacting their patients/clients. **This ranked #4 out of 35 issues.**
3	26.7% (n=1442) of north central residents identified **meaningful and rewarding work** as a top factor for a thriving community. **This ranked #3 out of 15 factors.**
4	24.1% (n=1444) of north central residents identified **economic instability** as a top issue impacting their community. **This ranked #3 out of 35 issues.**
5	**Lack of job availability and wages** emerged as themes in the pulse survey series for clients/patients that scored the following statement low, "There is economic opportunity in the community."
6	**Poverty** emerged as a theme in the pulse survey series when clients/patients were asked to think about groups that experience relatively good health and those that experience poor health and identify why there might be a difference.

Family hardship with lack of affordable childcare- women tend to exit workforce as result.

FOCA Bright Spot: innovative programs **like Evart Promise Plus**

There was fear going back to work and it disproportionately impacted low-income workers.

The ALICE population often falls through the cracks .

Emerging and ongoing advocacy efforts for the policy changes needed for the ALICE population.

4 of 8

Economic security was identified in 4 of 8 topic areas.

$

3 in 8

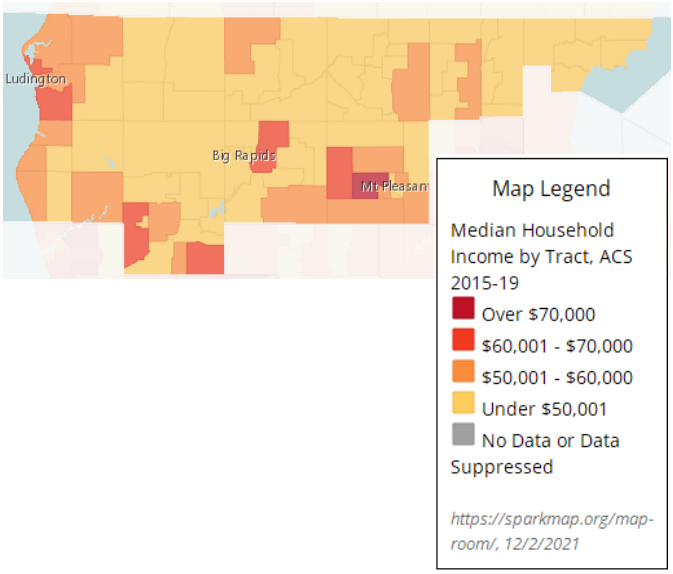
Economic security was identified as a top three priority in 3 of 8 topic areas.

Economic security emerged as a top theme in **5 of 6** data collection activities.

Community Health Status Assessment | Forces of Change Assessment | Community System Assessment | Community Themes & Strengths Assessment

North Central Strategic Issue: How do we foster a community where everyone feels economically secure?

v.12.21



Geographic disparities exist at the census tract level with **highest household income** in **Isabella County near Deerfield Township**.

Keep track of the needs that are not met in our community. Discuss the needs not met and how the community can assist.

Provide opportunity for community growth- housing, childcare, employment, school. Families need to know they can THRIVE not just survive

Childcare is needed for working families

Indicator *=worse than **state average**	NCCHIR Average
Median Household Income*	$45,012
Gross mortgage is >=35% of household income*	22.5%
High school graduation rate	82.6%
High school graduate or higher*	88.0%
Children 0-5 in Special Education	4.2%
Special Education % Child Find	99.6%
Children enrolled in early education	28.7%
Students not proficient in Grade 4 English*	59.1%
ALICE Households*	29.0%
Households below federal poverty level (FPL)*	17.4%
Families living below the poverty level (%)*	12.2%
Population below poverty level*	18.9%
Children below poverty level*	26.0%
Unemployment	3.5%
Income inequality (Gini index)	0.44

4 of 10

Community Collaborative assessments in 4 out of 10 counties identified. access to affordable childcare as an issue for economic stability.

QUESTIONS?

Email us:
mithrive@northernmichiganchir.org

Community Health Status Assessment | **Forces of Change Assessment** | **Community System Assessment** | **Community Themes & Strengths Assessment**

North Central Strategic Issue: How do we cultivate a community whose policies, systems, and practices are rooted in equity and belonging?

v.12.21

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9 COLLABORATIVE BODY MEETINGS

Importance: *Health inequities are systematic and unjust differences in opportunities to achieve optimum health and wellbeing. These inequities lead to preventable differences in health status or outcome (health disparities). The dimensions in which health disparities exist can include geographic location, race, ethnicity, disability, age, sexual identity, and socioeconomic status.*

NORTHCENTRAL COMMUNITY HEALTH INNOVATION REGION

1	**Strengthening community engagement and promoting social justice** emerged as themes in the pulse survey series when clients/patients were asked to identify ways in which their community could ensure everyone has a chance at living the healthiest life possible.
2	**Strengthen community connection and support** emerged as theme in the pulse survey series when clients/patients were asked to identify ways in which we can come together so that people promote each other's wellbeing and not just their own.
3	**A lack of community support/connectedness** and **system navigation issues** emerged as themes in the pulse survey series when clients/patients were asked to think about groups that experience relatively good health and those that experience poor health and to identify why that difference may exist.
4	14.9% (n=1442) of north central residents identified **belonging and inclusion** as a top factor a thriving community.
5	8.9% (n=1444) of north central residents identified **racism and discrimination** as a top issue impacting their community.

FOCA: Key Issues

- Lack of diversity limits progress of new ideas and we lose the voice of unique communities, culture, and history
- Leadership looks the same. There is no representation of age, gender, race, experiences and socioeconomic status
- Expanding the table and resident voices could provide real solutions to barriers that may otherwise go unnoticed.
- Our communities would benefit from being a diverse, thriving, safe, and inclusive community.
- Current culture brings all these issues up to the surface and now we can start system change; seeing and recognition of inequity allows us to begin reducing them

4 of 8

Diversity, equity, and inclusion was identified in 4 of 8 topic areas.

1 in 8

Diversity, equity, and inclusion was identified as a top three priority in 1 of 8 topic areas.

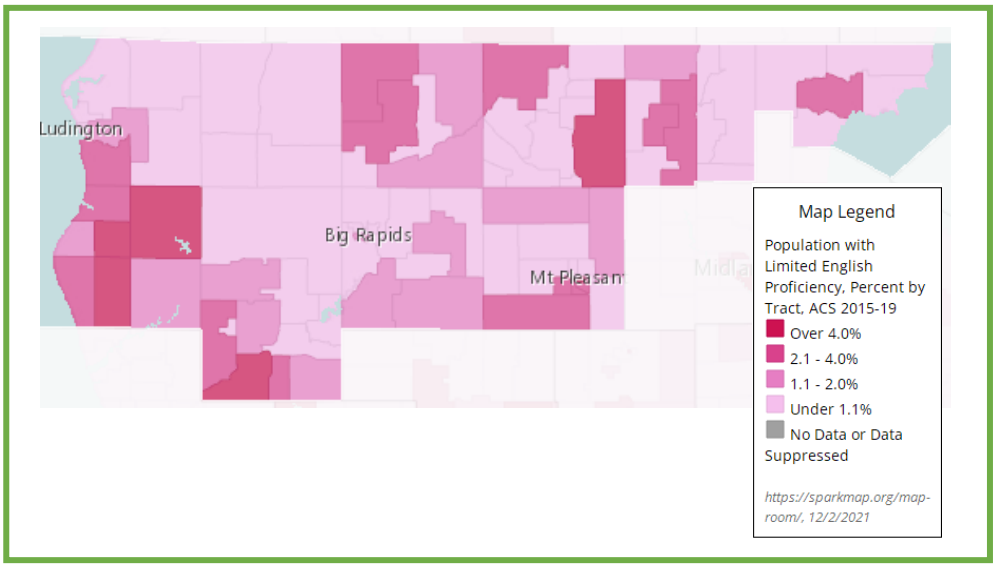
Diversity, equity, and inclusion emerged as a top theme in **4 of 6** data collection activities.

Community Health Status Assessment | Forces of Change Assessment | Community System Assessment | Community Themes & Strengths Assessment

North Central Strategic Issue: How do we cultivate a community whose policies, systems, and practices are rooted in equity and belonging?

v.12.21

Geographic disparities exist at the census tract level with the **highest percentages of limited English proficiency** in **Clare, Newaygo**, and **Oceana**



Create a broad system for identifying disparities.

Increase resident voice and engagement to inform decision-making

There are opportunities locally and regionally to establish a common language around health disparities.

Indicator *=worse than state average	NCCHIR Average
Children 0-5 in Special Education	4.2%
Special Education % Child Find	99.6%
Children enrolled in early education	28.7%
Students not proficient in Grade 4 English*	59.1%
High school graduation	82.6%
High school graduate or higher*	88.0%
Bachelor's degree or higher*	17.6%
Families living below federal poverty level (FPL)*	12.2%
ALICE Households*	29.0%

9 of 10

Community Collaborative assessments in 9 out of 10 counties **identified a need for increased diversity and inclusion**

QUESTIONS?

Email us:
mithrive@northernmichiganchir.org

Community Health Status Assessment | Forces of Change Assessment | Community System Assessment | Community Themes & Strengths Assessment

North Central Strategic Issue: 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?

v.12.21

1,444 RESIDENTS

104 PROVIDERS

376 PULSE SURVEYS

100 INDICATORS

52 COMMUNITY PARTNERS

9 COLLABORATIVE BODY MEETINGS

Importance: *Access to health services affects a person's health and well-being. It can prevent disease and disability, detect and treat illness and conditions; and reduce the likelihood of early death and increase life expectancy.*

NORTHCENTRAL COMMUNITY HEALTH INNOVATION REGION

1	53.8% (n=104) of providers identified **access to quality health care services** as a top factor for a thriving community. **This ranked #1 out of 15 factors.**
2	34.6% (n=104) of providers identified **disease and illness prevention** as a top factor for a thriving community. **This ranked #4 out of 15 factors.**
3	19.2 (n=104) of providers identified **lack of access to health care services** as a top issue impacting the community they serve. **This ranked #6 out of 35 issues.**
4	35.6% (n=104) of providers said **primary care services for patients/clients** are missing in the community they serve. **This ranked #4 out of 13 resources/services.**
5	42.6% (n=1442) of north central residents identified **access to quality health care services** as a top factor for a thriving community. **This ranked #2 out of 15 factors.**
6	**Improve the health care system** emerged as a theme in the pulse survey series when clients/patients were asked to identify ways we can ensure people in tough life circumstance come to have as good a chance as others do in achieving good health and wellbeing over time.
7	**Health care and insurance** emerged as themes in the pulse survey series when clients/patients were asked to identify why some groups of people experience relatively good health as compared to those that experience poor health.

FOCA: Key Issues

- The health care workforce isn't sufficient.
- COVID-19 and health care access issues have led to less preventative care and poor health outcomes.
- Accessing health care through telehealth has been helpful to some but broadband access is limited for others.
- Funding for health services and recruiting providers in rural areas is an ongoing challenge.
- Health insurance & insurance changes result in health inequities.

5 of 8

Health care was identified in 5 of 8 topic areas.

3 in 8

Health care was identified as a top three priority in 3 of 8 topic areas.

Health care emerged as a top theme in **5 of 6** data collection activities.

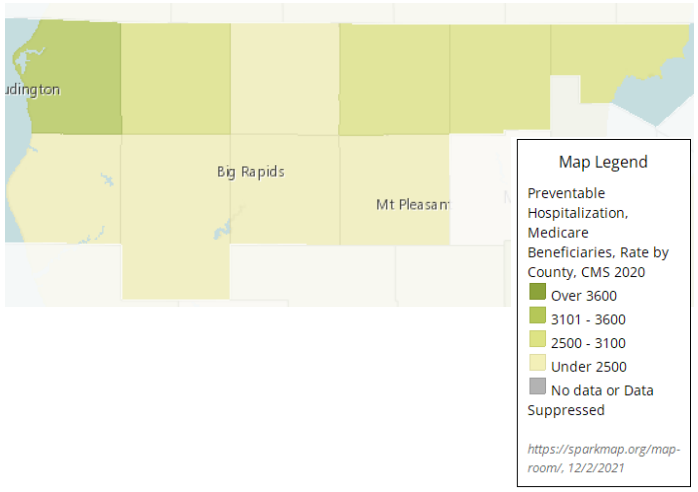
Community Health Status Assessment | Forces of Change Assessment | Community System Assessment | Community Themes & Strengths Assessment

North Central Strategic Issue: 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?

v.12.21

Indicator *=worse than state average	NCCHIR Average
Breast cancer incidence	54.7 per 100,000
Self-reported health fair or poor*	22.6%
All Cancer Incidence	432.4 per 100,000
Average HPSA Score- Dental Health*	19.1
Liver disease mortality*	15.1 per 100,000
Injury mortality*	81.4 per 100,000
Uninsured*	7.9%
No personal health checkup in the past year	16.8%
Preventable hospital stays (Medicare enrollees)	3,968 per 100,000
Average HPSA Score – Primary Care*	16.1
Fully immunized toddlers (aged 19-35 months)*	67.6%
Colorectal cancer incidence*	37.8 per 100,000
All cancer mortality*	178.2 per 100,000
Diabetes mortality*	22.9 per 100,000
Heart disease mortality*	199.2 per 100,000
YPLL Pneumonia/Flu	88.0 per 100,000
Chronic lower respiratory disease mortality*	57.1 per 100,000
Kidney disease mortality*	17.1 per 100,000
Oral cavity and pharynx cancer incidence*	12.8 per 100,000
Lung and bronchus cancer incidence*	76.2 per 100,000
Ever told diabetes (adults)	13.3%
Ever told COPD (adults)	10.5%
All causes of death*	814.9 per 100,000

Geographic disparities exist at the county level with the **highest preventable hospitalization rate** in **Mason County**.



Would like to see greater access to all healthcare and healthier living styles and standards

When transporting across county lines, drop off for medical appointments

Need for more home visits or case managers to help support individuals

3 of 10

Community Collaborative assessments in 3 out of 10 counties identified access to healthcare issues

QUESTIONS?

Email us:
mithrive@northernmichiganchir.org

Community Health Status Assessment | Forces of Change Assessment | Community System Assessment | Community Themes & Strengths Assessment

North Central Strategic Issue: How do we ensure all community members are aware of and can access safety and well-being supports?

v.12.21

1,444 RESIDENTS

104 PROVIDERS

376 PULSE SURVEYS

100 INDICATORS

52 COMMUNITY PARTNERS

9 COLLABORATIVE BODY MEETINGS

Importance: *Witnessing or being a victim of child maltreatment, youth violence, intimate partner, violence, bullying, or elder abuse are linked to lifelong physical, emotional, and social consequences.*

NORTHCENTRAL COMMUNITY HEALTH INNOVATION REGION

1	18.3% (n=104) of providers identified **freedom from trauma, violence, and addiction** as a top factor for a thriving community. **This ranked #7 out of 15 factors.**
2	23% (n=1442) of north central residents identified **freedom from trauma, violence, and addiction** as a top factor for a thriving community. **This ranked #4 out of 15 factors.**
3	**Safety concerns** emerged as a theme in the pulse survey series for clients/patients that scored the following statement low, "My community is a good place to age."
4	**Safety concerns** emerged as a theme in the pulse survey series for clients/patients that scored the following statement low, "My community is a good place to raise children."
5	14.9% (n=1442) of north central residents identified **belonging and inclusion** as a top factor for a thriving community.
6	8.9% (n=1444) of north central residents identified **racism and discrimination** as a top issue impacting their community.

The Community System needs to work together to see public health considerations become part of all policies

Childcare is needed for working families

Programs working in unison to develop a universal intake so that families can be supported, and resources known

7 of 10

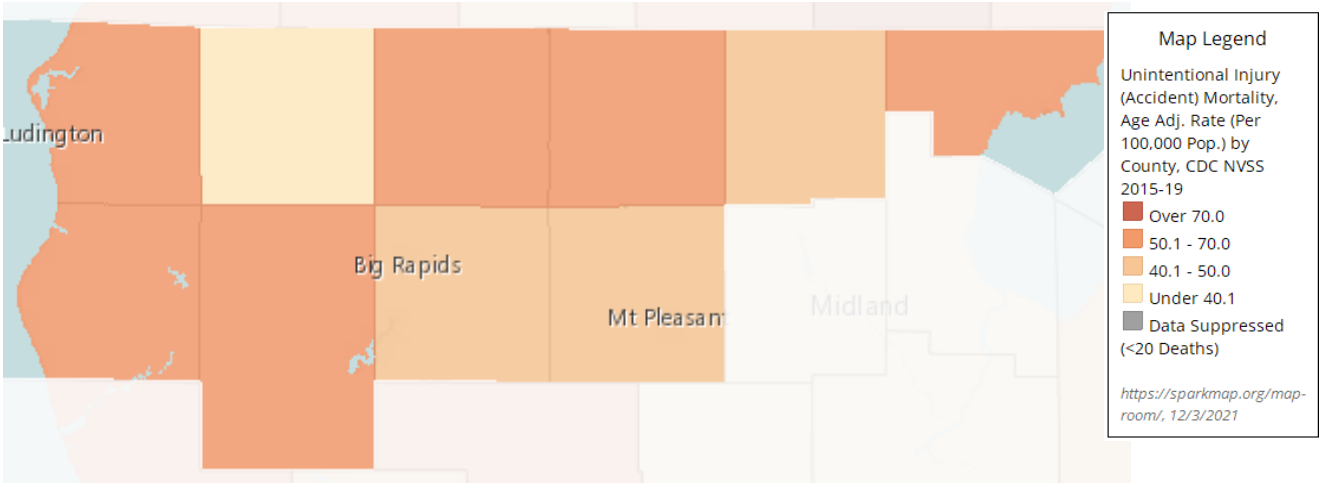
Community Collaborative assessments in 7 out of 10 counties identified. Issues to improve the safety and well-being of community members.

Safety and wellbeing emerged as a top theme in **4 of 6** data collection activities.

Community Health Status Assessment | Forces of Change Assessment | Community System Assessment | Community Themes & Strengths Assessment

North Central Strategic Issue: How do we ensure all community members are aware of and can access safety and well-being supports?

v.12.21



Geographic disparities exist at the county level with **higher age-adjusted rates** of **unintentional injury in Arenac, Clare, Mason, Oceana, Osceola,** and **Newaygo**

Racial issues were identified, and the safety of various communities is in question with political climate

Indicator *=worse than state average	NCCHIR Average
Teens with 2+ ACES	36.3%
Child abuse/neglect rate*	169.2 per 1,000
Injury mortality*	81.4 per 100,000
Unintentional injuries	40.0 per 100,000
Motor vehicle crash mortality	16.1 per 100,000

1 of 8
Safety & well-being was identified in 1 of 8 topic areas.

0 in 8
Safety & well-being was identified as a top three priority in 0 of 8 topic areas.

QUESTIONS?

Email us:
mithrive@northernmichiganchir.org

Community Health Status Assessment | Forces of Change Assessment | Community System Assessment | Community Themes & Strengths Assessment

North Central Strategic Issue: How can we advocate for increased broadband access and affordability?

v.12.21

1,444 RESIDENTS

104 PROVIDERS

376 PULSE SURVEYS

100 INDICATORS

52 COMMUNITY PARTNERS

9 COLLABORATIVE BODY MEETINGS

Importance: *High-speed internet is necessary for many aspects of modern life such as remote work and schooling, telemedicine, online banking and connecting with family and friends. Attaining broadband access is associated with improved health outcomes. by increasing access to health care via telemedicine, improving economic stability through opportunities for telework and job search opportunities, and increasing food access with online grocery shopping.*

NORTHCENTRAL COMMUNITY HEALTH INNOVATION REGION

1 **Geographic location and rurality** emerged as themes in the pulse survey series when clients/patients were asked to identify why some groups of people experience relatively good health where others don't.

> Lack of broadband access limits access to healthcare, ability to work from home, and participate in school.

> We need to have the ability to have affordable broadband access

> For many broadband is unreliable, unaffordable or unavailable

> Infrastructure related to broadband widens rural communities access gap.

> Our rural areas do not have the level of accessibility to broadband to break down barriers

> There is a need for broadband internet access in rural areas

5 of 8

Environment/infrastructure was identified in 5 of 8 topic areas.

3 in 8

Environment/infrastructure was identified as a top three priority in 3 of 8 topic areas.

7 of 10

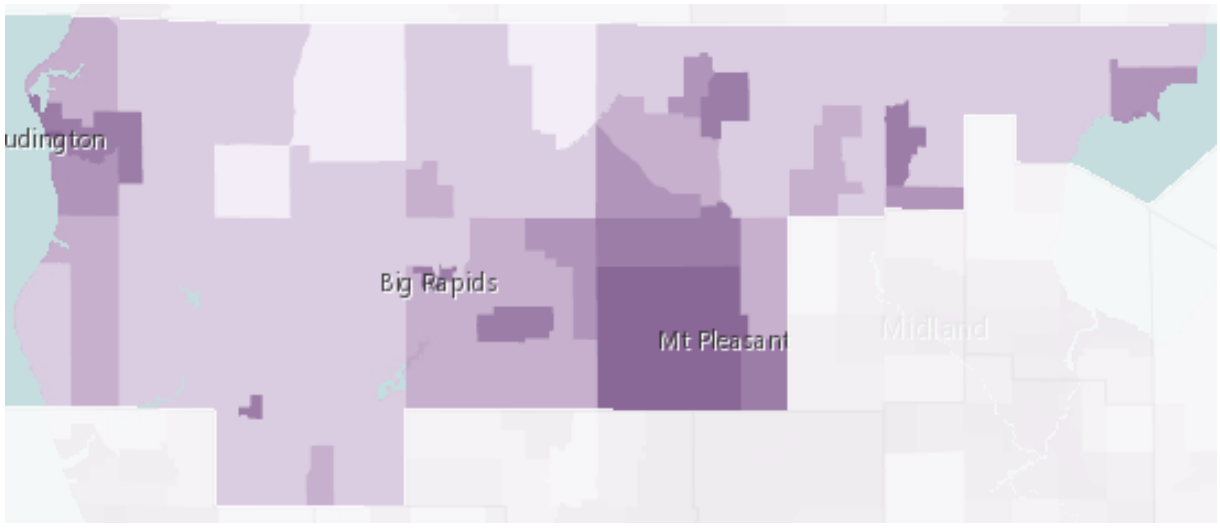
Community Collaborative assessments covering 7 out of 10 counties identified broadband access and affordability as an issue

Broadband emerged as a top theme in **4 of 6** data collection activities.

Community Health Status Assessment | Forces of Change Assessment | Community System Assessment | Community Themes & Strengths Assessment

North Central Strategic Issue: How can we advocate for increased broadband access and affordability?

v.12.21



Geographic disparities exist at the census tract level with **majority of the region** having **less than 70.1% of the population** located in **a high-speed internet service area.**

Indicator *=worse than state average	NCCHIR Average
Homes with broadband internet*	76.6%

Map Legend

Broadband Access, Pct. Population in a High-Speed Internet Service Area by Tract, FCC June 2017

- 100.0%
- 95.1 - 99.9%
- 90.1 - 95.0%
- 70.1 - 90.0%
- 0.01% - 70.0
- No Coverage or No Data

https://sparkmap.org/map-room/, 12/2/2021

QUESTIONS?

Email us:
mithrive@northernmichiganchir.org

Community Health Status Assessment | Forces of Change Assessment | Community System Assessment | Community Themes & Strengths Assessment

Appendix H

Spectrum Health Big Rapids Hospital

2021-22 Implementation Strategy Impact Report

Spectrum Health

Spectrum Health Big Rapids Hospital

Previous Implementation Strategy Impact

This report identifies the impact of actions to address the significant health needs addressed in the 2021-2022 Spectrum Health Big Rapids Hospital Implementation Strategy created from results of the 2020 Community Health Needs Assessment. The Implementation Strategy was shortened from the traditional three-year coverage to two-year, beginning Jan. 1, 2021 and ending Dec. 31, 2022. This change was necessary because a change in year-end by the organization, from a fiscal year to a calendar year, would have caused a gap in compliance if no action was taken until the organization resumed assessment activities with other community partners in a collaborative community health needs assessment the following year.

The two-year implementation strategy reporting period was narrowed further for this document and only covers Jan. 1, 2021 to Mar. 31, 2022. This is to ensure the governing board approved at the needed time to stay in compliance with IRS regulations. Regardless of the shortened reporting period, all goals set for Dec. 31, 2022 are expected to be met. Monitoring of all the 2021-2022 Spectrum Health Big Rapids Hospital's Implementation Strategies will continue in accordance with the identified action date and the organization will use all resources committed towards these goals to accomplish the desired impacts.

Health Care Access

Maternal Infant Health Program

Action

By Dec. 31, 2022, Spectrum Health Big Rapids will increase referrals to the Maternal Infant Health Program by 25 to 100 per year. External partners include District Health Department #10 and Central Michigan District Health Department (CMDHD).

Measurable Impact

At least 100 referrals per year into the Maternal Infant Health Program by Dec. 31, 2022.

Impact of Strategy

As of Mar. 31, 2022, Spectrum Health Big Rapids made 407 referrals to the Maternal Infant Health Program. In calendar year 2021, the referrals increased from a baseline of 25 to 365.

Action

By Dec. 31, 2022, as a result of referral from Spectrum Health Big Rapids providers, Maternal Infant Health Program enrollment rates will increase by 5% to 25% per year.

Measurable Impact

Increase the Maternal Infant Health Program enrollment rate to 25% annually by Dec. 31, 2022.

Impact of Strategy

As of Mar. 31, 2022, Spectrum Health Big Rapids increased the Maternal Infant Health Program enrollment rates from a baseline of 5% to 26.9% (54/201). In calendar year 2021, the enrollment rate increased from 23% to 27%.

Advocacy Efforts

Action

By Dec. 31, 2022, Spectrum Health will increase community ability to access information and services via virtual technology. This will be accomplished by successfully advocating for public policy and resource allocation to provide individuals and families living in the Spectrum Health Big Rapids service area with reliable, affordable access to information and services delivered via virtual technology. Partners include local decisionmakers and regional decision-makers.

Measurable Impact

Involvement in advocacy efforts at the regional hospital level by Dec. 31, 2022.

Impact of Strategy

As of Mar. 31, 2022, Spectrum Health has supported the nearly $1 billion Build Back Better Act effort by Congress to expand broadband affordability and accessibility, which includes funding for committees and awareness efforts. Spectrum Health also supported the Biden Administration's Internet for All initiative, which is a $45 billion initiative to provide affordable high-speed broadband access to all Americans by 2029. Spectrum Health has supported Governor Whitmer's announcement of a project to utilize $5.2 million in CARES Act funding to identify gaps in broadband coverage across the state. Lastly, Spectrum Health supported Congressman Moolenaar's efforts to support two acts: The BOOST Act, which is a rural broadband legislation that allows rural homeowners and primary lessees to receive tax credits for purchasing mobile hotspot, and the Gigabit Opportunity Act, which creates opportunity zone in low-income rural and urban areas that lack the federal minimum broadband service.

COVID-19

Action

By Dec. 31, 2022, Spectrum Health will contribute to reducing the number of COVID-19 infections within the community by providing employers, school administrators, and general community with accurate and timely information on preventing the spread of COVID-19.

Measurable Impact

Spectrum Health releases timely and accurate information about COVID-19 and its prevention, targeted to a variety of sectors and population by Dec. 31, 2022. This is measured by community emails sent, the number of community virtual conversations and number of website/social media updates.

Impact of Strategy

As of Mar. 31, 2022, Spectrum Health Big Rapids released 42 community emails about COVID-19 and prevention, had 17 community virtual conversations, and 142 website and or social media updates.

Action

By Dec. 31, 2022, Spectrum Health will contribute to reducing COVID-19 infections within the community by providing community-based screening and appropriate testing.

Measurable Impact

Spectrum Health provides opportunities for COVID-19 testing that is convenient and meets the needs of the community by Dec. 31, 2022.

Impact of Strategy

As of Mar. 31, 2022, Spectrum Health Big Rapids had one COVID-19 testing site, defined as the location in which the COVID-19 sample is tested (i.e., lab site). At this site, there have been 9,079 COVID-19 tests administered during the coverage period.

Mental Health

School-Based Behavioral Health Clinics

Action

By Dec. 31, 2022, Spectrum Health Big Rapids will serve a minimum of 16 Evart and 16 Big Rapids high schools' students per week via a virtual school-based behavioral health clinic. Partners include Spectrum Health Virtual Health, Spectrum Health Behavioral Health, Evart public Schools and Big Rapids Public schools. Spectrum Health Big Rapids Foundation is providing funding in the amount of $30,000.

Measurable Impact

Serve 16 Evart high schools' students per week by Dec. 31, 2022.

Measurable Impact

Serve 16 Big Rapids high schools' students per week by Dec. 31, 2022.

Impact of Strategy

As of Mar.31, 2022, an average of 1.6 Evart high school and 12.5 Big Rapids High school students were served each week by the virtual school-based behavioral health clinic. The original measurable impact goal of 16 students was developed based on having a full-time behavioral health program; however, due to school student population and demand, the programming was adjusted. For example, Evart schools have staffing one day per week. The intent to ingrate mental health services within the selected public schools was achieved.

Action

By Dec. 31, 2022, 50% of Evart and Big Rapids high schools' students served by the virtual school-based behavioral health clinic will successfully have completed their therapy programs. Partners include Spectrum Health Virtual Health, Spectrum Health Behavioral Health, Evart public Schools and Big Rapids Public schools. Spectrum

Health Big Rapids Foundation is providing funding in the amount of $30,000.

Measurable Impact

Individual completion of school-based behavioral health clinic therapy programs by 50% of Evart high schools' students by Dec. 31, 2022.

Measurable Impact

Individual completion of school-based behavioral health clinic therapy programs by 50% of Big Rapids high schools' students by Dec. 31, 2022.

Impact of Strategy

The identified action and associated measurable impact were not achievable as originally anticipated. The team had challenges in tracking this data. However, a new software program has been implemented that allow for tracking of this data starting in quarter two of 2022.

24/7 Inpatient Consultations

Action

By Dec. 31, 2022, expand psychiatry consultative services for adult patients within Spectrum Health Big Rapids through utilization of 24/7 inpatient consultative services.

Measurable Impact

Successfully expand psychiatry consultative services for adult patients within Spectrum Health Big Rapids by Dec. 31, 2022.

Impact of Strategy

As of Mar. 31, 2022, expansion of psychiatry consultative services for adult patients within Spectrum Health Big Rapids through utilization of 24/7 inpatient consultative services was complete. The implementation of this services was effective on Mar. 1, 2022.

Substance Use Disorder

National Take Back Event

Action

By Dec. 31, 2022, in collaboration with local law enforcement and Ten16 Recovery Network, Spectrum Health Big Rapids will participate in 12 local Medication and Needle Take Back events.

Measurable Impact

Participation in 12 local Medication and Needle Take Back events by Dec. 31, 2022.

Impact of Strategy

As of Mar. 31, 2022, 13 local Medication and Needle Take Back events occurred, with nine more events planned by the end of Dec. 2022. In addition, a community sharps exchange program was started which takes in filled sharps containers and distributes replacement sharps containers.

Action

By Dec. 31, 2022, in collaboration with local law enforcement and Ten16 Recovery Network, Spectrum Health Big Rapids Community Health will participate in the annual National Take Back Event.

Measurable Impact

Participation in two annual National Take Back events by Dec. 31, 2022.

Impact of Strategy

As of Mar. 31, 2022, Spectrum Health Big Rapids participated in four annual National Take Back events, with four more events planned throughout 2022.

Project Assert

Action

By Dec. 31, 2022, Spectrum Health Big Rapids will expand Project Assert to the Spectrum Health OB/GYN provider resulting in 175 screenings for substance misuse over 2020 baseline. External partners include Ten16 Recovery Network.

Measurable Impact

Increase substance misuse screenings by a minimum of 175 by Dec. 31, 2022.

Impact of Strategy

As of Mar. 31, 2022, Spectrum Health Big Rapids expanded Project Assert to the Spectrum Health OB/GYN provider resulting in 236 substance misuse screenings. The Project Assert program partnership with Ten16 Recovery Network completed this objective by expanding screening for substance misuse to the Spectrum Health OB/GYN provider practice. The objective was surpassed by 35%.

Action

By Dec. 31, 2022, Project Assert staff at Spectrum Health Big Rapids will increase referrals made for substance misuse treatment from 568 to 650 annually. External partners include Ten16 Recovery Network.

Measurable Impact

Increase referrals made for substance misuse treatment to 650 annually by Dec. 31, 2022.

Impact of Strategy

As of Mar. 31, 2022, Project Assert staff at Spectrum Health Big Rapids made 1309 referrals for substance misuse treatment.

Tobacco/Nicotine Cessation Program

Action

By Dec. 31, 2022, as a result of referral by a Spectrum Health Big Rapids provider, 20 women will enroll in the Smoking Cessation and Reduction in Pregnancy Treatment (SCRIPT) program.

Measurable Impact

Referrals by Spectrum Health Big Rapids providers resulting in 20 pregnant women enrolling in the SCRIPT program by Dec. 31, 2022.

Impact of Strategy

As of Mar. 31, 2022, referrals by Spectrum Health providers resulted in 25 pregnant women enrolling in the Smoking Cessation and Reduction in Pregnancy Treatment (SCRIPT) program. This objective was surpassed through staff education and process improvement activities such as tobacco and nicotine screening for all patients.

Action

By Dec. 31, 2022, 5 women participating in the SCRIPT program will report a reduction in use of tobacco and/or nicotine products during their pregnancy.

Measurable Impact

Reduction of reported tobacco and/or nicotine products among 5 pregnant women participating in the SCRIPT program by Dec. 31, 2022.

Impact of Strategy

As of Mar. 31, 2022, 13 women participating in the Smoking Cessation and Reduction in Pregnancy Treatment (SCRIPT) program reporting a reduction in the use of tobacco and/or nicotine products.

Action

By Dec. 31, 2022, as a result of referral from Spectrum Health Big Rapids providers, 20 individuals will enroll in a

tobacco/nicotine cessation program and 5 individuals will report being tobacco and/or nicotine free at the end of the program.

Measurable Impact

Referrals by Spectrum Health Big Rapids providers resulting in 20 individuals enrolling in a tobacco nicotine cessation program by Dec. 31, 2022.

Measurable Impact

Reduction of reported tobacco and/or nicotine products among 5 individuals participating in the tobacco/nicotine cessation program by Dec. 31, 2022.

Impact of Strategy

As of Mar. 31, 2022, as a result of referrals from Spectrum Health Big Rapids providers, three individuals enrolled in a tobacco/nicotine cessation program. To date, the program has not been successful in receiving referrals from Spectrum Health Big Rapids providers. New tactics have been developed to increase community referrals. These tactics consist of social media posts and program flier distribution to community agencies, local employers and local Spectrum Health providers, all of which will be implemented in 2022 quarter two.

As of Mar. 31, 2022, one out of three enrolled tobacco/nicotine cessation program participants have reported a reduction of tobacco and/or nicotine products.

Policy Change

Action

By Dec. 31, 2022, Spectrum Health Big Rapids will provide technical assistance to a minimum of two schools to implement at least one anti-vaping policy.

Measurable Impact

Technical assistance provided by Spectrum Health Big Rapids to at least two schools to implement at least one anti vaping policy by Dec. 31, 2022.

Impact of Strategy

As of Mar. 31, 2022, there have not been any schools within the Spectrum Health Big Rapids community that have implemented an anti-vaping policy. However, three schools will receive a draft copy of the policy in quarter two of 2022 and will provide feedback and updates on school adoption of the policies.

Opioid Prescribing Guidelines

Action

By Dec. 31, 2022, Spectrum Health Medical Group will implement opioid prescribing guidelines that are procedurally/conditionally based.

Measurable Impact

Implementation of opioid prescribing guidelines by Dec. 31, 2022.

Impact of Strategy

As of Mar. 31, 2022, Spectrum Health Medical Group has completed Safe Opioid Prescribing (SOP) education to all offices and are now monitoring every quarter to ensure that high risk patients are individually handled. Continuation of provision of supportive measures and resources for all prescribing providers.

Action

By Dec.31, 2022, Spectrum Health Medical Group will monitor provider scorecards related to prescribing guidelines for opioids on a monthly basis and report findings/recommendations to the appropriate leadership.

Measurable Impact

Continuously monitor opioid prescribing provider scorecards by Dec. 31, 2022.

Impact of Strategy

As of Mar. 31, 2022, an opioid dashboard is live in Epic, the system electronic medical records. The next steps are to educate system providers regarding its availability through the Safe Opiate Prescribing project.

Go Team

Action

By Dec. 31, 2022, the "Go team" will be activated and provide coaching and mentoring to requested Spectrum Health locations 90% of the time.

Measurable Impact

The "Go team" will provide coaching and mentoring to requested Spectrum Health locations 90% of the time by Dec. 31, 2022.

Impact of Strategy

As of Mar. 31, 2022, the "Go team" is support and in-place. During the reporting period, there were zero requests for the "Go team" by Spectrum Health Big Rapids.

Substance Use Disorder Screening

Action

By Dec. 31, 2022, Spectrum Health Medical Group Obstetrics and Gynecology will utilize substance use disorders screening to screen 100% of pregnant patients for substance use disorders and refer them to treatment.

Measurable Impact

100% of Spectrum Health Medical Group Obstetrics and Gynecology pregnant patients screened for substance use disorder by Dec. 31, 2022.

Measurable Impact

100% of Spectrum Health Medical Group Obstetrics and Gynecology pregnancy patients with substance use disorder referred for treatment by Dec. 31, 2022.

Impact of Strategy

As of Mar. 31, 2022, progress in meeting the identified target is unknown due to challenges in report development.

Obesity

Weight Management Program

Action

By Dec. 31, 2022, Spectrum Health Big Rapids Community Health will add 50 new participants in a Weight Management Program.

Measurable Impact

50 new participants in the Spectrum Health Big Rapids Community Health weight management program by Dec. 31, 2022.

Impact of Strategy

As of Mar. 31, 2022, there were 49 new participants in the Weight Management Program. Additional classes are planned throughout 2022 that will result in meeting the goal of 50.

Action

By Dec. 31, 2022, 50% of participants in the Weight Management Program will report achieving their predetermined weight or healthy lifestyle goals.

Measurable Impact

50% of participants in the weight management program reporting their goal was achieved (e.g., weight, lifestyle goals) by Dec. 31, 2022.

Impact of Strategy

As of Mar. 31, 2022, 78.3% of participants in the Weight Management Program reported their goal was achieved. The program has been impactful for individuals meeting their goals. Participants have decreased their blood pressure, waist circumference, body fat percentage and weight. Participants also reported increases in their physical activity, fruits and vegetables intake.

Coordinated Approach to Child Health (CATCH)

Action

By Dec. 31, 2022, Spectrum Health Big Rapids Community Health will implement the CATCH program in two area public schools. Funding is available to support a health educator, material and supplies.

Measurable Impact

Implement the CATCH program in two area public schools by Dec. 31, 2022.

Impact of Strategy

As of Mar. 31, 2022, zero public schools in the Spectrum Health Big Rapids community implemented. Funding was not able to be secured, and as a result, CATCH could not be implemented.

Action

By Dec. 31,2022, 70% of teachers in schools participating in CATCH will report observing positive changes in student behavior related to nutrition and physical activity. Funding is available to support a health educator, material and supplies.

Measurable Impact

Of schools participating in CATCH, 70% of teachers reported positive change in student behavior related to nutrition and physical activity by Dec. 31, 2022.

Impact of Strategy

As of Mar. 31, 2022, zero public schools in the Spectrum Health Big Rapids community implemented. As a result, this action and measurable impact was not achievable.

Action

By Dec. 31, 2022, 90% of teachers in participating schools will report that by utilizing CATCH materials they feel that they are making a positive contribution to the overall culture of health within the school. Funding is available to support a health educator, material, and supplies.

Measurable Impact

Of schools participating in CATCH, 90% of teachers reporting perception of positive contribution to the overall culture of health within the school by Dec. 31, 2022.

Impact of Strategy

As of Mar. 31, 2022, zero public schools in the Spectrum Health Big Rapids community implemented. As a result, this action and measurable impact was not achievable.

Action

By Dec. 31, 2022, 90% of teachers in participating schools will utilize a virtual CATCH option to further supplement health education for students in grades K-5th. Funding is available to support a health educator, material and supplies.

Measurable Impact

Of schools participating in CATCH, 90% of teachers will utilize a virtual CATCH option by Dec. 31, 2022.

Impact of Strategy

As of Mar. 31, 2022, zero public schools in the Spectrum Health Big Rapids community implemented. As a result, this action and measurable impact was not achievable.

Action

By Dec. 31, 2022, each participating school will implement at least one policy or environmental support designed to improve student nutrition and/or increase physical activity during the school day. Funding is available to support a health educator, material and supplies.

Measurable Impact

Of schools participating in CATCH, implementation of at least one policy or environmental support by Dec. 31, 2022.

Impact of Strategy

As of Mar. 31, 2022, zero public schools in the Spectrum Health Big Rapids community implemented. As a result, this action and measurable impact was not achievable.

Prescription for Health Program

Action

By Dec. 31, 2022, Spectrum Health Big Rapids Community Health will provide nutrition education to 1,000 community members through District Health Department #10 grant and 500 community members will redeem Prescription for Health vouchers for fruits and vegetables.

Measurable Impact

Nutrition education to 1,000 community members by Dec. 31, 2022.

Measurable Impact

Prescription for Health vouchers utilized by 500 community members by Dec. 31, 2022.

Impact of Strategy

As of Mar. 31, 2022, Prescription for Health vouchers for fruits and vegetables were utilized by 789 community members. Partnerships with District Health Department #10, Angels of Action, Bread of Life Food Pantry, City of Big Rapids and other human service agencies has allowed to surpass the goal of this objective.

Nutrition Education

Action

By Dec. 31, 2022, Spectrum Health Big Rapids will provide nutrition education and/or recipe sampling to 1400 community members in a farmer's market setting.

Measurable Impact

Nutrition education and/ or recipe sampling to 1400 community members by Dec. 31, 2022.

Impact of Strategy

As of Mar. 31, 2022, nutrition education and/or recipe sampling was provided to 522 community members. This objective is unachievable as originally anticipated as a result of the COVID-19 pandemic significantly reducing the volume of people attending the farmer's market.

Action

By Dec. 31, 2022, Spectrum Health Big Rapids Community Health will provide virtual nutrition education to 2,000 community members.

Measurable Impact

Virtual nutrition education provided to 2,000 community members by Dec. 31, 2022.

Impact of Strategy

As of Mar. 31, 2022, virtual nutrition education was provided to 5474 community members. The virtual education offerings were made available through social media.

YMCA Veggie Van

Action

By Dec. 31, 2022, Spectrum Health Big Rapids Community Health will provide 1,500 community members with access to fresh produce via the YMCA mobile Veggie Van.

Measurable Impact

Fresh produce provided to 1,500 community members via the YMCA mobile Veggie Van by Dec. 31, 2022.

Impact of Strategy

As of Mar. 31, 2022, 1450 community members received fresh produce via the YMCA Veggie Van. Additional food distribution events are planned for the remainder of 2022.

Policy Change

Action

By Dec. 31, 2022, Spectrum Health Big Rapids Community Health will provide technical assistance to at least one municipality to implement a policy related to increasing opportunities for residents to be more physically active.

Measurable Impact

Implementation of one policy by one municipality that

aims to increase opportunities for residents to be more physically active by Dec. 31, 2022.

Impact of Strategy

As of Mar. 31, 2022, implementation of one policy by one municipality aiming to increase opportunities for residents to be more physically active did not occur. Suggestions for policy/environmental change were brought forward to a local municipality and were not supported. Discussions are planned to continue.

Appendix I

Spectrum Health Reed City Hospital

2021-22 Implementation Strategy Impact Report

Spectrum Health

Spectrum Health Reed City Hospital

Previous Implementation Strategy Impact

This report identifies the impact of actions to address the significant health needs addressed in the 2021-2022 Spectrum Health Reed City Hospital Implementation Strategy created from results of the 2020 Community Health Needs Assessment. The Implementation Strategy was shortened from the traditional three-year coverage to two-year, beginning Jan. 1, 2021 and ending Dec. 31, 2022. This change was necessary because a change in year-end by the organization, from a fiscal year to a calendar year, would have caused a gap in compliance if no action was taken until the organization resumed assessment activities with other community partners in a collaborative community health needs assessment the following year.

The two-year implementation strategy reporting period was narrowed further for this document and only covers Jan. 1, 2021 to Mar. 31, 2022. This is to ensure the governing board approved at the needed time to stay in compliance with IRS regulations. Regardless of the shortened reporting period, all goals set for Dec. 31, 2022 are expected to be met. Monitoring of all the 2021-2022 Spectrum Health Reed City Hospital's Implementation Strategies will continue in accordance with the identified action date and the organization will use all resources committed towards these goals to accomplish the desired impacts.

Health Care Access

Maternal Infant Health Program

Action

By Dec. 31, 2022, Spectrum Health Reed City will increase referrals to the Maternal Infant Health Program by 25 to 100 per year. External partners include District Health Department #10 and Central Michigan District Health Department (CMDHD).

Measurable Impact

At least 100 referrals per year into the Maternal Infant Health Program by Dec. 31, 2022.

Impact of Strategy

As of Mar. 31, 2022, Spectrum Health Reed City made 407 referrals to the Maternal Infant Health Program. In calendar year 2021, the referrals increased from a baseline of 25 to 365.

Action

By Dec. 31, 2022, as a result of referral from Spectrum Health Reed City providers, Maternal Infant Health Program enrollment rates will increase by 5% to 25% per year.

Measurable Impact

Increase the Maternal Infant Health Program enrollment rate to 25% annually by Dec. 31, 2022.

Impact of Strategy

As of Mar. 31, 2022, Spectrum Health Reed City increased the Maternal Infant Health Program enrollment rates from a baseline of 5% to 26.9% (54/201). In calendar year 2021, the enrollment rate increased from 23% to 27%.

Advocacy Efforts

Action

By Dec. 31, 2022, Spectrum Health will increase community ability to access information and services via virtual technology. This will be accomplished by successfully advocating for public policy and resource allocation to provide individuals and families living in the Spectrum Health Reed City service area with reliable, affordable access to information and services delivered via virtual technology. Partners include local decisionmakers, and regional decision-makers.

Measurable Impact

Involvement in advocacy efforts at the regional hospital level by Dec. 31, 2022.

Impact of Strategy

As of Mar. 31, 2022, Spectrum Health has supported the nearly $1 billion Build Back Better Act effort by Congress to expand broadband affordability and accessibility, which includes funding for committees and awareness efforts. Spectrum Health also supported the Biden Administration's Internet for All initiative, which is a $45 billion initiative to provide affordable high-speed broadband access to all Americans by 2029. Spectrum Health has supported Governor Whitmer's announcement of a project to utilize $5.2 million in CARES Act funding to identify gaps in broadband coverage across the state. Lastly, Spectrum Health supported Congressman Moolenaar's efforts to support two acts: The BOOST Act, which is a rural broadband legislation that allows rural homeowners and primary lessees to receive tax credits for purchasing mobile hotspot, and the Gigabit Opportunity Act, which creates opportunity zone in low-income rural and urban areas that lack the federal minimum broadband service.

COVID-19

Action

By Dec. 31, 2022, Spectrum Health will contribute to reducing the number of COVID-19 infections within the community by providing employers, school administrators, and general community with accurate and timely information on preventing the spread of COVID-19.

Measurable Impact

Spectrum Health releases timely and accurate information about COVID-19 and its prevention, targeted to a variety of sectors and population by Dec. 31, 2022. This is measured by community emails sent, the number of community virtual conversations and number of website/social media updates.

Impact of Strategy

As of Mar. 31, 2022, Spectrum Health Big Rapids released 42 community emails about COVID-19 and prevention, had 17 community virtual conversations, and 142 website and or social media updates.

Action

By Dec. 31, 2022, Spectrum Health will contribute to reducing COVID-19 infections within the community by providing community-based screening and appropriate testing.

Measurable Impact

Spectrum Health provides opportunities for COVID-19 testing that is convenient and meets the needs of the community by Dec. 31, 2022.

Impact of Strategy

As of Mar. 31, 2022, Spectrum Health Reed City had one COVID-19 testing site, defined as the location in which the COVID-19 sample is tested (i.e., lab site). At this site, there have been 4,265 COVID-19 tests administered during the coverage period.

Mental Health

School-Based Behavioral Health Clinics

Action

By Dec. 31, 2022, Spectrum Health Reed City will serve a minimum of 16 Evart and 16 Big Rapids high schools' students per week via a virtual school-based behavioral health clinic. Partners include Spectrum Health Virtual Health, Spectrum Health Behavioral Health, Evart public Schools and Big Rapids Public schools. Spectrum Health Big Rapids Foundation is providing funding in the amount of $30,000.

Measurable Impact

Serve 16 Evart high schools' students per week by Dec. 31, 2022.

Measurable Impact

Serve 16 Big Rapids high schools' students per week by Dec. 31, 2022.

Impact of Strategy

As of Mar. 31, 2022, an average of 1.6 Evart high school and 12.5 Big Rapids High school students were served each week by the virtual school-based behavioral health clinic. The original measurable impact goal of 16 students was developed based on having a full-time behavioral health program; however, due to school student population and demand, the programming was adjusted. For example, Evart schools have staffing one day per week. The intent to ingrate mental health services within the selected public schools was achieved.

Action

By Dec. 31, 2022, 50% of Evart and Big Rapids high schools' students served by the virtual school-based behavioral health clinic will successfully have completed their therapy programs. Partners include Spectrum Health Virtual Health, Spectrum Health Behavioral Health, Evart public Schools and Big Rapids Public schools. Spectrum

Health Big Rapids Foundation is providing funding in the amount of $30,000.

Measurable Impact

Individual completion of school-based behavioral health clinic therapy programs by 50% of Evart high schools' students by Dec. 31, 2022.

Measurable Impact

Individual completion of school-based behavioral health clinic therapy programs by 50% of Big Rapids high schools' students by Dec. 31, 2022.

Impact of Strategy

The identified action and associated measurable impact were not achievable as originally anticipated. The team had challenges in tracking this data. However, a new software program has been implemented that allow for tracking of this data starting in quarter two of 2022.

24/7 Inpatient Consultations

Action

By Dec. 31, 2022, expand psychiatry consultative services for adult patients within Spectrum Health Reed City through utilization of 24/7 inpatient consultative services.

Measurable Impact

Successfully expand psychiatry consultative services for adult patients within Spectrum Health Reed City by Dec. 31, 2022.

Impact of Strategy

As of Mar. 31, 2022, expansion of psychiatry consultative services for adult patients within Spectrum Health Reed City through utilization of 24/7 inpatient consultative services was complete. The implementation of this services was effective on Mar. 1, 2022.

Substance Use Disorder

National Take Back Event

Action

By Dec. 31, 2022, in collaboration with local law enforcement and Ten16 Recovery Network, Spectrum Health Reed City will participate in 12 local Medication and Needle Take Back events.

Measurable Impact

Participation in 12 local Medication and Needle Take Back events by Dec. 31, 2022.

Impact of Strategy

As of Mar. 31, 2022, 13 local Medication and Needle Take Back events occurred, with nine more events planned by the end of Dec. 2022. In addition, a community sharps exchange program was started which takes in filled sharps containers and distributes replacement sharps containers.

Action

By Dec. 31, 2022, in collaboration with local law enforcement and Ten16 Recovery Network, Spectrum Health Reed City Community Health will participate in the annual National Take Back Event.

Measurable Impact

Participation in 2 annual National Take Back events by Dec. 31, 2022.

Impact of Strategy

As of Mar. 31, 2022, Spectrum Health Reed City participated in four annual National Take Back events, with four more events planned throughout 2022.

Project Assert

Action

By Dec. 31, 2022, Spectrum Health Reed City will expand Project Assert to the Spectrum Health OB/ GYN provider resulting in 175 screenings for substance misuse over 2020 baseline. External partners include Ten16 Recovery Network.

Measurable Impact

Increase substance misuse screenings by a minimum of 175 by Dec. 31, 2022.

Impact of Strategy

As of Mar. 31, 2022, Spectrum Health Reed City expanded Project Assert to the Spectrum Health OB/GYN provider resulting in 236 substance misuse screenings. The Project Assert program partnership with Ten16 Recovery Network completed this objective by expanding screening for substance misuse to the Spectrum Health OB/GYN provider practice. The objective was surpassed by 35%.

Action

By Dec. 31, 2022, Project Assert staff at Spectrum Health Reed City will increase referrals made for substance misuse treatment from 568 to 650 annually. External partners include Ten16 Recovery Network.

Measurable Impact

Increase referrals made for substance misuse treatment to 650 annually by Dec. 31, 2022.

Impact of Strategy

As of Mar. 31, 2022, Project Assert staff at Spectrum Health Reed City made 1309 referrals for substance misuse treatment.

Tobacco/Nicotine Cessation Program

Action

By Dec. 31, 2022, as a result of referral by a Spectrum Health Reed City provider, 20 women will enroll in the Smoking Cessation and Reduction in Pregnancy Treatment (SCRIPT) program.

Measurable Impact

Referrals by Spectrum Health Reed City providers resulting in 20 pregnant women enrolling in the SCRIPT program by Dec. 31, 2022.

Impact of Strategy

As of Mar. 31, 2022, referrals by Spectrum Health Reed City providers resulted in 25 pregnant women enrolling in the Smoking Cessation and Reduction in Pregnancy Treatment (SCRIPT) program. This objective was surpassed through staff education and process improvement activities such as tobacco and nicotine screening for all patients.

Action

By Dec. 31, 2022, five women participating in the SCRIPT program will report a reduction in use of tobacco and/or nicotine products during their pregnancy.

Measurable Impact

Reduction of reported tobacco and/or nicotine products among five pregnant women participating in the SCRIPT program by Dec. 31, 2022.

Impact of Strategy

As of Mar. 31, 2022, 13 women participating in the Smoking Cessation and Reduction in Pregnancy Treatment (SCRIPT) program reporting a reduction in the use of tobacco and/or nicotine products.

Action

By Dec. 31, 2022, as a result of referral from Spectrum Health Reed City providers, 20 individuals will enroll in a

tobacco/nicotine cessation program and 5 individuals will report being tobacco and/or nicotine free at the end of the program.

Measurable Impact

Referrals by Spectrum Health Reed City providers resulting in 20 individuals enrolling in a tobacco nicotine cessation program by Dec. 31, 2022.

Measurable Impact

Reduction of reported tobacco and/or nicotine products among five individuals participating in the tobacco/nicotine cessation program by Dec. 31, 2022.

Impact of Strategy

As of Mar. 31, 2022, as a result of referrals from Spectrum Health Reed City providers, three individuals enrolled in a tobacco/nicotine cessation program. To date, the program has not been successful in receiving referrals from Spectrum Health Reed City providers. New tactics have been developed to increase community referrals. These tactics consist of social media posts and program flier distribution to community agencies, local employers, and local Spectrum Health providers, all of which will be implemented in 2022 quarter 2.

As of Mar. 31, 2022, one out of three of tobacco/nicotine cessation program participants have reported a reduction of tobacco and/or nicotine products.

Policy Change

Action

By Dec. 31, 2022, Spectrum Health Reed City will provide technical assistance to a minimum of two schools to implement at least one anti-vaping policy.

Measurable Impact

Technical assistance provided by Spectrum Health Reed City to at least two schools to implement at least one anti vaping policy by Dec. 31, 2022.

Impact of Strategy

As of Mar. 31, 2022, there have not been any schools within the Spectrum Health Reed City community that have implemented an anti-vaping policy. However, three schools will receive a draft copy of the policy in quarter two of 2022 and will provide feedback and updates on school adoption of the policies.

Opioid Prescribing Guidelines

Action

By Dec. 31, 2022, Spectrum Health Medical Group will implement opioid prescribing guidelines that are procedurally/conditionally based.

Measurable Impact

Implementation of opioid prescribing guidelines by Dec. 31, 2022.

Impact of Strategy

As of Mar. 31, 2022, Spectrum Health Medical Group has completed Safe Opioid Prescribing (SOP) education to all offices and are now monitoring every quarter to ensure that high risk patients are individually handled. Continuation of provision of supportive measures and resources for all prescribing providers.

Action

By Dec. 31, 2022, Spectrum Health Medical Group will monitor provider scorecards related to prescribing guidelines for opioids on a monthly basis and report findings/recommendations to the appropriate leadership.

Measurable Impact

Continuously monitor opioid prescribing provider scorecards by Dec. 31, 2022.

Impact of Strategy

As of Mar. 31, 2022, an opioid dashboard is live in Epic, the system electronic medical records. The next steps are to educate system providers regarding its availability through the Safe Opiate Prescribing project.

Go Team

Action

By Dec. 31, 2022, the "Go team" will be activated and provide coaching and mentoring to requested Spectrum Health locations 90% of the time.

Measurable Impact

The "Go team" will provide coaching and mentoring to requested Spectrum Health locations 90% of the time by Dec.31, 2022.

Impact of Strategy

As of Mar. 31, 2022, the "Go team" is support and in-place. During the reporting period, there were zero requests for the "Go team" by Spectrum Health Reed City.

Substance Use Disorder Screening

Action

By Dec. 31, 2022, Spectrum Health Medical Group Obstetrics and Gynecology will utilize substance use disorders screening to screen 100% of pregnant patients for substance use disorders and refer them to treatment.

Measurable Impact

100% of Spectrum Health Medical Group Obstetrics and Gynecology pregnant patients screened for substance use disorder by Dec. 31, 2022.

Measurable Impact

100% of Spectrum Health Medical Group Obstetrics and Gynecology pregnancy patients with substance use disorder referred for treatment by Dec. 31, 2022.

Impact of Strategy

As of Mar. 31, 2022, progress in meeting the identified target is unknown due to challenges in report development.

Obesity

Weight Management Program

Action

By Dec. 31, 2022, Spectrum Health Reed City Community Health will add 50 new participants in a Weight Management Program.

Measurable Impact

50 new participants in the Spectrum Health Reed City Community Health weight management program by Dec. 31, 2022.

Impact of Strategy

As of Mar. 31, 2022, there were 49 new participants in the Weight Management Program. Additional classes are planned throughout 2022 that will result in meeting the goal of 50.

Action

By Dec. 31, 2022, 50% of participants in the Weight Management Program will report achieving their predetermined weight or healthy lifestyle goals.

Measurable Impact

50% of participants in the weight management program reporting their goal was achieved (e.g., weight, lifestyle goals) by Dec. 31, 2022.

Impact of Strategy

As of Mar. 31, 2022, 78.3% of participants in the Weight Management Program reported their goal was achieved. The program has been impactful for individuals meeting their goals. Participants have decreased their blood pressure, waist circumference, body fat percentage and weight. Participants also reported increases in their physical activity, fruit and vegetables intake.

Coordinated Approach to Child Health (CATCH)

Action

By Dec. 31, 2022, Spectrum Reed City Community Health will implement the CATCH program in two area public schools. Funding is available to support a health educator, material and supplies.

Measurable Impact

Implement the CATCH program in two area public schools by Dec. 31, 2022.

Impact of Strategy

As of Mar. 31, 2022, zero public schools in the Spectrum Health Reed City community implemented. Funding was not able to be secured, and as a result, CATCH could not be implemented.

Action

By Dec. 31,2022, 70% of teachers in schools participating in CATCH will report observing positive changes in student behavior related to nutrition and physical activity. Funding is available to support a health educator, material and supplies.

Measurable Impact

Of schools participating in CATCH, 70% teacher reported positive change in student behavior related to nutrition and physical activity by Dec. 31, 2022.

Impact of Strategy

As of Mar. 31, 2022, zero public schools in the Spectrum Health Reed City community implemented. As a result, this action and measurable impact was not achievable.

Action

By Dec. 31, 2022, 90% of teachers in participating schools will report that by utilizing CATCH materials they feel that they are making a positive contribution to the overall culture of health within the school. Funding is available to support a health educator, material, and supplies.

Measurable Impact

Of schools participating in CATCH, 90% of teachers reporting perception of positive contribution to the overall culture of health within the school by Dec. 31, 2022.

Impact of Strategy

As of Mar. 31, 2022, zero public schools in the Spectrum Health Reed City community implemented. As a result, this action and measurable impact was not achievable.

Action

By Dec. 31, 2022, 90% of teachers in participating schools will utilize a virtual CATCH option to further supplement health education for students in grades K-5th. Funding is available to support a health educator, material and supplies.

Measurable Impact

Of schools participating in CATCH, 90% of teachers will utilize a virtual CATCH option by Dec.r 31, 2022.

Impact of Strategy

As of Mar. 31, 2022, zero public schools in the Spectrum Health Reed City community implemented. As a result, this action and measurable impact was not achievable.

Action

By Dec. 31, 2022, each participating school will implement at least one policy or environmental support designed to improve student nutrition and/or increase physical activity during the school day. Funding is available to support a health educator, material and supplies.

Measurable Impact

Of schools participating in CATCH, implementation of at least one policy or environmental support by Dec. 31, 2022.

Impact of Strategy

As of Mar. 31, 2022, zero public schools in the Spectrum Health Reed City community implemented. As a result, this action and measurable impact was not achievable.

Prescription for Health Program

Action

By Dec. 31, 2022, Spectrum Health Reed City Community Health will provide nutrition education to 1,000 community members through District Health Department #10 grant and 500 community members will redeem Prescription for Health vouchers for fruits and vegetables.

Measurable Impact

Nutrition education to 1,000 community members by Dec. 31, 2022.

Measurable Impact

Prescription for Health vouchers utilized by 500 community members by Dec. 31, 2022.

Impact of Strategy

As of Mar. 31, 2022, Prescription for Health vouchers for fruits and vegetables were utilized by 789 community members. Partnerships with District Health Department #10, Angels of Action, Bread of Life Food Pantry, City of Big Rapids, and other human service agencies has allowed to surpass the goal of this objective.

Nutrition Education

Action

By Dec. 31, 2022, Spectrum Health Reed City will provide nutrition education and/or recipe sampling to 1400 community members in a farmer's market setting.

Measurable Impact

Nutrition education and/ or recipe sampling to 1400 community members by Dec. 31, 2022.

Impact of Strategy

As of Mar. 31, 2022, nutrition education and/or recipe sampling was provided to 522 community members. This objective is unachievable as originally anticipated as a result of the COVID-19 pandemic significantly reducing the volume of people attending the farmer's market.

Action

By Dec. 31, 2022, Spectrum Health Reed City Community Health will provide virtual nutrition education to 2,000 community members.

Measurable Impact

Virtual nutrition education provided to 2,000 community members by Dec. 31, 2022.

Impact of Strategy

As of Mar. 31, 2022, virtual nutrition education was provided to 5474 community members. The virtual education offerings were made available through social media.

YMCA Veggie Van

Action

By Dec. 31, 2022, Spectrum Health Reed City Community Health will provide 1,500 community members with access to fresh produce via the YMCA mobile Veggie Van.

Measurable Impact

Fresh produce provided to 1,500 community members via the YMCA mobile Veggie Van by Dec. 31, 2022.

Impact of Strategy

As of Mar. 31, 2022, 1450 community members received fresh produce via the YMCA Veggie Van. Additional food distribution events are planned for the remainder of 2022.

Policy Change

Action

By Dec. 31, 2022, Spectrum Health Reed City Community Health will provide technical assistance to at least one municipality to implement a policy related to increasing opportunities for residents to be more physically active.

Measurable Impact

Implementation of one policy by one municipality that

aims to increase opportunities for residents to be more physically active by December 31, 2022.

Impact of Strategy

As of Mar. 31, 2022, implementation of one policy by one municipality aiming to increase opportunities for residents to be more physically active did not occur. Suggestions for policy/environmental change were brought forward to a local municipality and were not supported. Discussions are planned to continue.

Spectrum Health

Spectrum Health complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.
[81 FR 31465, May 16, 2016; 81 FR 46613, July 18, 2016]

ATENCIÓN: Si usted habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1.844.359.1607 (TTY: 711).

إذا كنت تتحدث اللغة العربية، فبإمكانك الحصول على المساعدة اللغوية المتاحة مجانًا. اتصل على الرقم 1.844.359.1607 (TTY: 771).