CALHOUN COUNTY

COMMUNITY HEALTH IMPROVEMENT PLAN

2023 REPORT

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Message from the Co-chairs

On behalf of the Calhoun County Community Health Improvement Plan (CHIP) Steering Committee, we are pleased to present the 2023 Calhoun County CHIP. The plan describes how the Calhoun County Public Health Department (CCPHD), Summit Pointe, and community partners can work together to improve the health of the county.

Calhoun County Public Health Department and Summit Pointe have worked together on numerous community programs to measure and better understand community health in Calhoun County. The CHIP is an extension of the work and represents the ongoing work of Calhoun County community partners to create and implement a shared vision for providing and maintaining quality health for all Calhoun County communities.

We want to thank the residents and community partners who contributed their time and ideas in developing this plan.

Sean Field, Ph.D., BCBA-D, LLP, LBA Clinical Director
Summit Pointe
CHIP Co-chair

Mission Statement

Summit Pointe provides the highest quality behavioral health services to help individuals maximize their potential.

Vision Statement

Summit Pointe pioneers Community Mental Health Services by developing innovative ideas and community partnerships that lead to high-quality care and a healthy community.

Summit Pointe

Erika Larsen, CHES
Health Educator II
Calhoun County Public Health Department
CHIP Co-chair

Mission Statement

Calhoun County Public Health Department works together to enhance our community's total well-being by promoting healthy lifestyles, protecting health, and preventing disease.

Vision Statement

The healthiest community for life and living

Acknowledgments

A work of this magnitude can be done only through a collaborative effort involving groups and individuals that are committed to the health and well-being of the community. We recognize many of Calhoun County's key leaders, supporters, and contributors that are part of the CHIP workgroups, and we also want to thank the many others whose participation and assistance enriched the process and made this CHIP possible.

Calhoun County CHIP Steering Committee:

- *Eric Pessell, Health Officer, Calhoun County Public Health Department*
- *Erika Larsen, Health Educator II, Calhoun County Public Health Department*
- *Irene Johnston, Director of Quality, Safety, and Risk, Oaklawn Hospital*
- *Joel Murr, Director of Community Health Advancement, Bronson Hospital*
- *Rod Auton, Administrator, Albion Health Care Alliance*
- *Rosalind Johnson, Health and Human Services Director, Pine Creek Indian Reservation*
- *Sean Field, Clinical Director, Summit Pointe*
- *Stacy Duncan-Jackson, Clinical Analytics Manager, Integrated Health Partners*
- *Thamary Correa, Director of Quality Improvement, Grace Health*

Calhoun County CHIP Work groups, and other contributing organizations:

- *Albion College*
- *Albion Health Care Alliance*
- *Population Health Alliance*
- *Athens Public Schools*
- *Battle Creek Community Foundation*
- *Bronson Battle Creek Hospital*
- *Calhoun County Drug Court*
- *Calhoun County Public Health Department*
- *Grace Health*
- *Integrated Health Partners*
- *Nottawaseppi Huron Band of the Potawatomi (NHBP) Health and Human Services Department*
- *Oaklawn Hospital*
- *STARR Commonwealth*
- *Substance Abuse Prevention Services*
- *Summit Pointe*

Consultants

Calhoun County Public Health Department and Summit Pointe commissioned Conduent Healthy Communities Institute (HCI) to support the report development of Calhoun County's 2023 CHIP. Conduent HCI collaborates with clients across the nation to drive community health outcomes by assessing needs, developing focused strategies, identifying appropriate intervention programs, establishing monitoring systems, and implementing performance evaluation processes. To learn more about Conduent Healthy Communities Institute, please visit https://www.conduent.com/community- health/.

Background

Introduction

Calhoun County Public Health Department (CCPHD) and Summit Pointe are pleased to share the first joint Community Health Improvement Plan (CHIP) for Calhoun County. A CHIP is a three-to- five-year community-driven, long-term, systematic effort to address health issues identified in a Community Health Needs Assessment (CHNA).[1] The CHIP is an action-oriented work plan that includes developing strategies, objectives, and activities to address predetermined health challenges. Calhoun County's CHIP is only the beginning of a commitment to removing barriers to health equity and closing the gap in accessing quality health services in Behavioral Health and Maternal, Fetal, and Infant Health throughout the county.

The CHIP is more comprehensive than the roles and responsibilities of health organizations alone. A CHIP is intended to address the range of strengths, weaknesses, challenges, and opportunities that exist within a community. [1] It is designed to set priorities, direct the use of resources, and develop projects, programs, and policies through multi-sector collaboration to improve the health status of that locality.

Calhoun County's CHIP was achieved through the efforts of a shared coalition of diverse community partners. It is informed by the CHNA and builds on the data gathered since 2019. The priorities were selected based on the CHNA data, including engagement from Calhoun County CHIP Co-chairs, Calhoun County Steering Committee, and input from diverse organizations involved in the CHIP. It is important to recognize the work of the partners across the community to help build upon the work of past years and reflect the needs and assets of our county today.

Calhoun County's CHIP describes the planned response developed by CCPHD, Summit Pointe, the CHIP Steering Committee, and work groups. Listed below are needs found in the 2022 CHNA and selected for this CHIP process. This report details the process and includes the strategies, objectives, activities, and resources to help improve health in the areas of Behavioral Health and Maternal, Fetal, and Infant Health in Calhoun County over the next three years.

The foundational goals will be the overarching themes of the priority areas. CCPHD, Summit Pointe, and the CHIP Steering Committee hope that organizations and collaboratives serving Calhoun County can use the CHIP to assist in aligning organizational and community plans.

[1] Community Health Assessments & Health Improvement Plans. Centers for Disease Control and Prevention. 2022. www.cdc.gov/publichealthgateway/cha/plan.html.

Calhoun County CHIP Purpose

The CHIP aims to identify strategies, objectives, and activities for prioritized health areas identified in the most recent CHNA: Behavioral Health (BH) and Maternal, Fetal, and Infant Health (MFIH). In addition, this CHIP includes policies and programmatic strategies in work plan format designed to affect both short-term and long- term measures.

The work plans were developed to leverage current community resources, while also working collaboratively across multiple sectors to engage new community partners. A series of virtual workshops were conducted by Conduent HCI using a virtual platform to gather consensus on strategies, objectives, and activities from professional and leaders in those fields of work.

The CHIP reflects the importance of collaboration and uses diverse approaches to tackle these complex issues by addressing access to quality health and services and health equity within the two prioritized areas. The CHIP fosters strong partnerships and highlights the critical role of community partners to improve outcomes in Calhoun County.

Alignment with National Initiative

Alignment with Healthy People 2030

Priorities and strategies identified in the 2023 Calhoun County CHIP align with Healthy People 2030. Healthy People 2030 sets data-driven national objectives to improve health and well-being over a decade. [2] As Healthy People has evolved, it has strengthened its focus on health equity. Its focus on health equity and access to quality health services is a shared value and reflects the foundational goals of the 2023 Calhoun County CHIP. Table 1 shows the alignment between Calhoun County CHIP foundational goals and priorities, and Healthy People 2030 goals.

TABLE 1: ALIGNMENT WITH HEALTHY PEOPLE 2030

CHIP Foundational Goals and Priorities	Healthy People 2030 Goals
Health Equity	• Eliminate health disparities, achieve health equity, and attain health literacy to improve the health and well-being of all.
Access to Quality Health Services	• Increase access to comprehensive, high-quality, health services.
Behavioral Health	• Improve mental health.
Maternal, Fetal, and Infant Health	• Prevent pregnancy complications and maternal deaths and improve women's health before, during, and after pregnancy.

[2] **Leading Health Indicators. Healthy People 2030. 2023.**

Summary of CHNA Findings

Definition of Community Served

The community for the CHNA and CHIP has been defined as Calhoun County, Michigan. According to the U.S. Census Bureau in 2021, the estimated population of Calhoun County was 133,878.[3] This is a decrease of 2% compared to the 2010 United States Census of 136,146. The county seat is Marshall. The county has a total area of approximately 718 square miles. It comprises the Battle Creek Metropolitan Statistical Area and includes the Kalamazoo-Battle Creek-Portage Combined Statistical Area.

Figure 1 shows the population by ZIP code within Calhoun County. The darkest blues represent ZIP codes with the largest populations. The Calhoun County population by age group is 23% infants, children, and adolescents (17 or younger), 58% adults (18-64 years), and 18% 65 years and older.[4] Calhoun County population by sex is comprised of 49% males and 51% females. Population by race and ethnicity is 79% White, 11% Black/African American, 3% Asian, and 6% identify as Hispanic or Latino. The median household income for Calhoun County is $51,190 which is below the state average of $62,426. There are race/ethnicity disparities when compared to the overall median income for Calhoun County. Black/African American populations earn a median income of $30,686 and Hispanic/Latino populations earn $44,210[5] compared to an overall county value of $51,190. In looking at the community population served by the CHIP community partners, it was clear that all the organizations involved in CHIP planning define the community as the same. Defining the community allows the community partners to collaborate with public health agencies more readily for future assessments and CHIP planning.

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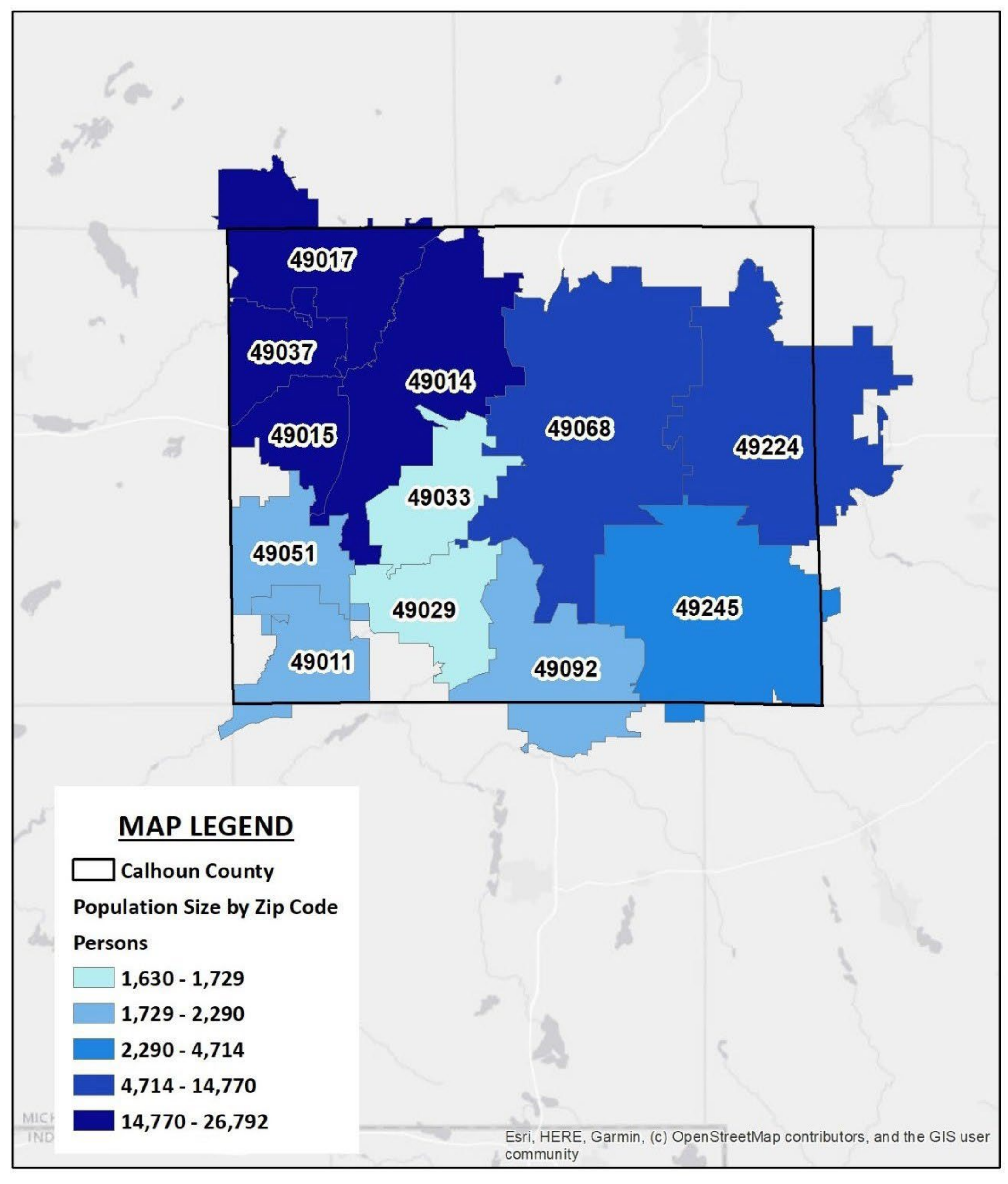
[3] U.S Census Bureau, 2022, https://www.census.gov/quickfacts/fact/table/calhouncountymichigan/PST045222
[4] Healthy Communities Institute QuickFacts, Population by Age Group, 2022
[5] Healthy Communities Institute QuickFacts, Median Household Income, 2022

FIGURE 1: CALHOUN COUNTY POPULATION



Identifying and Prioritizing Needs

To better target activities to address the most pressing health needs in the community, CCPHD convened a group of community leaders to participate in a presentation of data on significant health needs facilitated by Conduent HCI. During the presentation and discussion session, participants were given access to an online link to complete a scoring exercise to rank the significant health needs based on a set of criteria. The process was conducted virtually to maintain social distancing and safety guidelines related to the COVID-19 pandemic. Calhoun County's CHNA planning committee reviewed the scoring results of the significant community needs and determined prioritized health needs based on the same set of criteria used in the scoring exercise.

Prioritization Process

The CHNA prioritization process included meetings held on September 29 and 30, 2021, community partners reviewed and discussed the results of community input and secondary data analysis. This led to the preliminary significant health needs discussed in detail in the data synthesis portion of this report. During the meetings, participants accessed an online scoring tool and had an opportunity to score each of the significant health needs by how well they met the criteria set forth by CCPHD.

Completion of the online exercise resulted in a numerical score for each health need that correlated with how well that need met the criteria for prioritization. Conduent HCI downloaded the online results, calculated the scores, and then ranked the significant health needs according to their topic scores, with the highest-scoring health need receiving the highest priority ranking.

Prioritized Significant Health Needs

The eight priority health needs of the CHNA are listed in Table 2. They were considered for subsequent improvement planning. A deeper dive into the primary and secondary data indicators for each of these eight priority health topic areas are provided in the Calhoun County CHNA report. See Appendix A for a full summary of key findings of the CHIP priorities collected in the 2022 CHNA process.

TABLE 2: HEALTH NEEDS-AGGREGATE RANKING LIST

CHNA Prioritized Health Needs
1. Behavioral Health (Mental Health & Mental Health Orders, and Alcohol & Drug Use)
2. Access to Health Services
3. Health Equity (discrimination or inequity based on race/ethnicity, gender, age, sex, and disability)
4. Weight Status, Nutrition & Healthy Eating, and Diabetes
5. Children's Health
6. Older Adults
7. Maternal, Fetal, and Infant Health
8. Crime and Crime Prevention

CHIP Structure

The first stage of the CHIP planning process included a series of meetings with the CHIP co-chairs to identify the steering committee members. Once the steering committee members were identified, they were asked to attend monthly meetings. Members participated in meetings and were asked to help recruit participants for the focus groups, the work groups, or a community partner in one or more phases of the CHIP process. These individuals are part of the overall CHIP structure. Figure 2 shows an overview of the CHIP structure.

FIGURE 2: CALHOUN COUNTY CHIP STRUCTURE

Steering Committee
Leadership

Focus Groups
Help inform decision making

Workgroups
Lead and Implement CHIP work

Community Partnerships
Collaborative community partners

Calhoun County Public Health Department &
Summit Pointe
Co-Chairs

Steering Committee

The CHIP steering committee provides oversight to the CHIP. The steering committee is responsible for overseeing the CHIP planning process and ensuring that it reflects the community's needs. The steering committee members participate in the planning, marketing, and implementation of the CHIP with support from CHIP Co-chairs. Meeting objectives included establishing values, structure, roles, responsibilities, and purpose for the committee. Additional meeting objectives included a review of the CHNA priorities, an introduction to the CHIP process, work group recruitment efforts, and developing plans to determine the CHIP goals.

Recruitment efforts included Co-chairs coordinating with The Coordinating Council to identify the individual community partners who showed interest in participating in the CHIP initiative. Those individuals were provided an overview of the CHIP, expected roles and responsibilities, and time commitments.

Nine individuals accepted the role, including the two Co-chairs and meetings began on September 7, 2022. Steering Committee members developed shared values for meetings and for the overall CHIP. These statements will help provide focus, purpose, and direction to the process so that the steering committee and partners can collectively make decisions, implement strategies, and achieve a shared vision for the future. For implementation, the estimated yearly time commitment for the Steering Committee member will be 12-15 hours.

Roles and Responsibilities:

- Attend monthly meetings
- Provide input and assist CHIP structure, goals, objectives, and action plans
- Provide recommendations for gaining broad community participation
- Identify resources to meet the needs of the CHIP
- Help monitor the achievement of goals, objectives, activities, and programs
- Champion the vision and serve as an advocate for the CHIP

Goals:

- To identify and respond to current and emerging Calhoun County health priorities.
- To set a vision for collaborative community action by formulating the framework for the CHIP.
- To develop strategies to ensure the success of program and service implementation by using the latest evidence in community health planning.

CHIP Values:

- Equity
- Community Engagement and Participation
- Collaboration
- Commitment to Health

Focus Groups

The CHIP Co-chairs conducted focus groups to gain deeper insight into perceptions, attitudes, experiences, or beliefs held by community members about their health. It is important to note that the information collected in an individual focus group was exclusive to that group and was not representative of other groups. Focus groups were scheduled during January and February 2023. They were led in person and included participants from Battle Creek, Albion, Marshall, and other parts of Calhoun County. Individuals recruited for focus groups included those who were community leaders living in and/or working in Calhoun County. The in-person focus group sessions lasted 60 minutes. Results from the focus groups will be shared with the CHIP work groups at monthly meetings and incorporated into the CHIP plans as appropriate. The CHIP Co-chairs will continue to conduct focus groups and analyze the results throughout the CHIP cycle to gain insight into the changing health concerns and issues within the county.

Work Groups

The CHIP work groups were formed to develop and implement the CHIP work. Work group participants discussed each strategic issue in-depth and identified goals, strategies, and an action plan related to the issues. The result of the work group sessions is the development of strategic statements and a detailed plan of action including activities, time frames, potential responsible parties, and potential collaborative partners.

Recruitment efforts included asking steering committee members and community leaders for recommendations and referrals. Email invites were set by the Co-chairs. Participants included individuals from organizations who worked in and had relevant experience, skills, and knowledge in the health priority area.

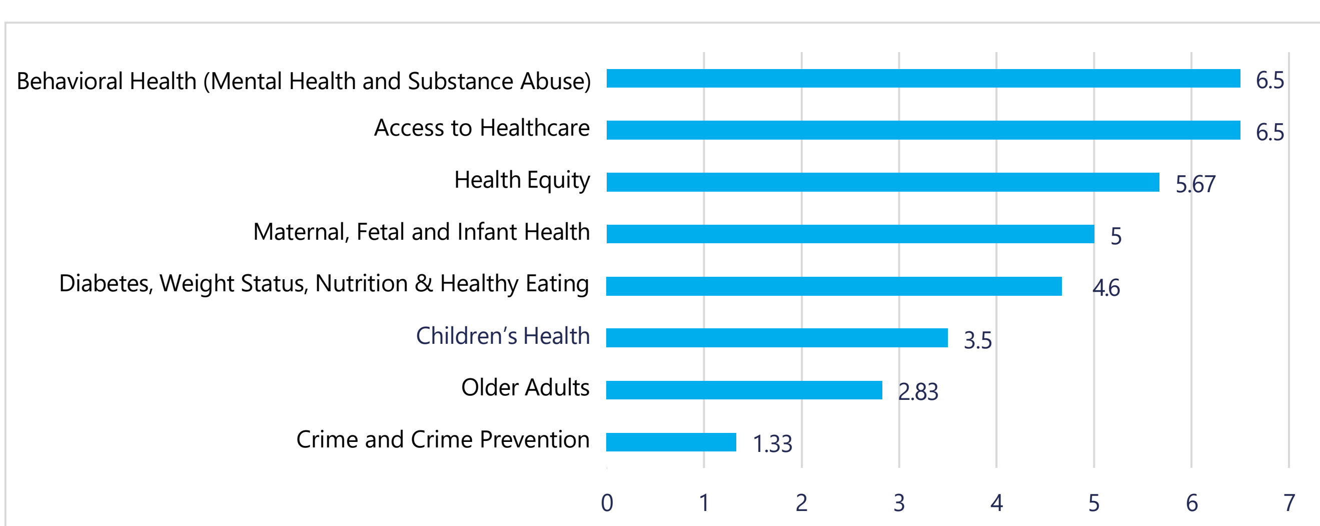
Work groups will continue to meet throughout the CHIP to review plans, evaluation measures, and progress.

CHIP Planning Process

Narrowing Down Priorities and Determining CHIP Priorities

Based on the CHNA health priority findings, the Calhoun County Steering Committee completed a one-question survey to rank the CHIP health priorities. Figure 3 shows the survey result. Behavioral Health (Mental Health and Substance Abuse) and Access to Healthcare scored highest, followed by Health Equity (discrimination or inequity based on race/ethnicity, gender, age, and sex), Maternal, Fetal, and Infant Health, Diabetes, Weight Status, Nutrition & Healthy Eating, Children's Health, Older Adults, and Crime and Crime Prevention.

FIGURE 3: HEALTH PRIORITY RANKINGS



The survey results showed Behavioral Health (Mental Health and Substance Abuse), Access to Healthcare, Health Equity (discrimination or inequity based on race/ethnicity, gender, age, and sex), and Maternal, Fetal, and Infant Health as the top four priorities. The co-chairs discussed the top four priorities and determined that these four categories can fall into two groupings: health priorities and social determinants of health.

Behavioral Health and Maternal, Fetal, and Infant Health fall under health priorities. Access to Healthcare and Health Equity fall under social determinants of health, which represent factors that influence individual and community health status. While addressing Behavioral Health and Maternal, Fetal, and Infant Health, the CHIP work will subsequently need to address access to health services and health equity. Therefore, the co-chairs and the steering committee came up with the idea to narrow the scope of our CHIP into two health priority areas and have the social determinants of health as foundational goals. Figure 4 shows how the foundational goals and priorities are represented.

This proposal was agreed upon by the steering committee via email and at the November 16, 2022, meeting.

FIGURE 4: FOUNDATION GOALS AND PRIORITIES

Foundational Goals:	Improve health equity Improve access to quality health services
Priority 1:	Improve access to and quality of behavioral health services for all of Calhoun County.
Priority 2:	Prevent pregnancy complications and maternal deaths and improve women's health before, during, and after pregnancy.

CHIP Kickoff and Workshop Meetings

Following initial planning meetings with the Calhoun County Steering Committee, Conduent HCI hosted a series of virtual meetings and workshops with workgroup participants to create individual work plans for each prioritized health area. An overview of the CHIP meetings is shown in Figure 5.

Kickoff Meetings

The Calhoun County Steering Committee and workgroup members participated in separate kickoff meetings. The steering committee kickoff meeting was on September 7, 2022, the Behavioral Health on January 19, 2023, and Maternal, Fetal, and Infant Health, on January 23, 2023. The Behavioral Health and Maternal, Fetal, and Infant Health kickoff meetings were incorporated into the first workshops. During the kickoff portion of the meetings, the findings from the CHNA were presented, and the CHIP planning process was introduced which included logic models, process measures, and outcome measures. During the meeting, participants were asked to provide feedback on a draft framework that was proposed for developing the implementation plan and were asked to review existing community programs and plans and explore evidence-based literature to help with the development of the priority area framework.

FIGURE 5: OVERVIEW OF CHIP MEETINGS

Kickoff Webinar

- Review of the CHNA results
- Introduction to CHIP development
- Review suggested CHIP framework

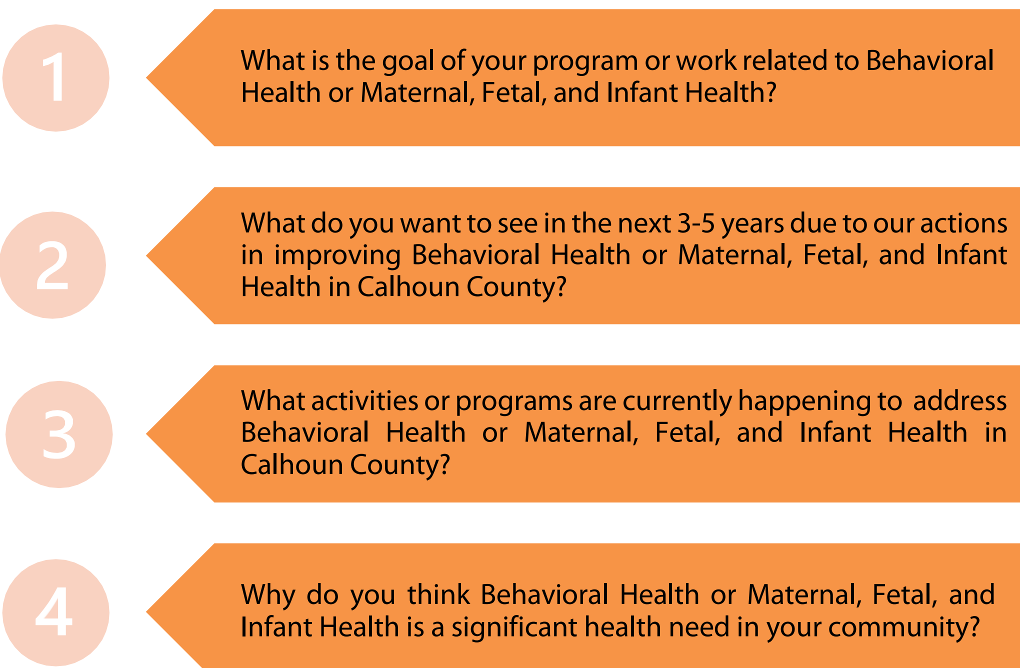
Prioritized Health Area Workshops

- Three virtual workshops for each priority
- Goal development
- Identify strategies
- Identify objectives and activities

Pre-Workshop Survey

Conduent HCI developed a *Pre-Workshop survey,* shown in Figure 6, to prepare workgroup participants for group discussion in the upcoming workshops. Participants were asked about the goal of their program or work related to the health priority, what they would like to see in the next three to five years to improve the health priority, to review existing programs or interventions that address the relevant priority health area, and to consider the root causes for each of the priority health issues. A link to the worksheet was emailed to participants several days before the respective workshop.

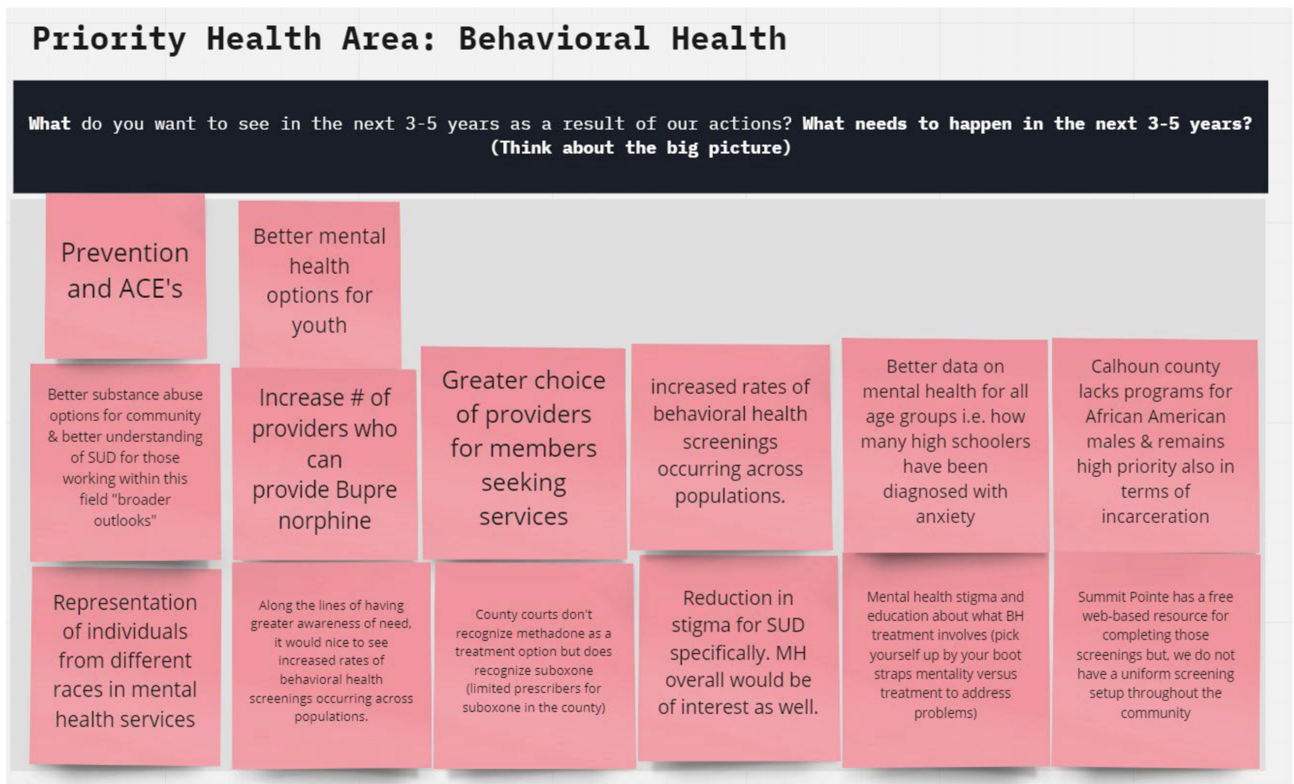
FIGURE 6: PRE-WORKSHOP SURVEY QUESTIONS



CHIP Workshops

The CHIP Co-chairs invited community partners to attend workshops on each prioritized area. Participants included providers and subject matter experts knowledgeable about community needs and services for the topic. The first virtual workshop took place over a two-hour meeting. Before the first workshop, the project team encouraged participants to review relevant initiatives within their organizations as well as best practices outlined in the pre-workshop survey. During the workshop, Conduent HCI facilitated a group discussion session using a collaborative digital board, Miro, to begin building an implementation framework for each health need. Figure 7 provides an example of the Miro board from the first behavioral health workshop. The group discussed findings from the CHNA specific to the prioritized health area, identified root causes of health needs and disparities, current activities, and potential activities that could be part of the CHIP. In the second workshop, participants discussed strategies and categorized them by policy, programmatic or educational approaches. The approaches included increasing general knowledge or changing attitudes and practices within each health need. In addition to capturing information on the Miro board, Conduent HCI captured the feedback and categorized it by themes (see Appendices E and F for themes).

FIGURE 7: EXAMPLE MIRO BOARD FROM WORKSHOP ONE BRAINSTORMING ACTIVITY



After conducting the virtual workshops, Conduent HCI utilized the information gathered during the group brainstorming activity and created an implementation framework that was shared with the same group in workshops two and three. During the subsequent workshops, participants refined goals, strategies, objectives, and resources within the context of the CHIP framework. To ensure accountability of the plans, work plans also included lead agencies for activities and measures to monitor the progress of the CHIP. Figure 8 provides an overview of the CHIP timeline.

FIGURE 8: CHIP PROCESS TIMELINE

Addressing Health Equity and Access to Health through Community Partnerships

Community partnerships are the core of Calhoun County CHIP Co-chairs, Steering Committee, and Work group efforts to improve health equity and access to health in the areas of behavioral health and maternal, fetal, and infant health. Many community partners have strong relationships and a deep understanding of the strengths and needs of the communities they serve. Calhoun County CHIP representatives will work alongside those organizations that serve to improve health equity and access to quality health services in the community through collaborative efforts, such as grant writing, programming, committees, and response efforts.

In addition, current CHIP work to improve health equity and access to health across both areas was identified and plans to collaborate were finalized. Some examples of this model include:

- Increase behavioral health community screenings and programming among under-served populations.
- Provide community outreach and education for new and existing MFIH-related programs to reduce social, cultural, environmental, and economic barriers.
- Collaborate with multi-sector partners to influence social determinants of health impacting Calhoun County.
- Recruit a diverse workforce in the behavioral health and maternal, fetal, and infant health fields.

CHIP Work Plans

The CHIP work plan puts into action the selected and developed strategies to address the prioritized health needs. The following components are outlined in the framework below: 1) broad goals and community-level indicators to track long-term progress; 2) strategies with measurable shorter-term objectives; 3) organize activities, timelines, and potential lead organizations; 4) identify community partners and opportunities for collaboration; and 5) opportunities to address policy, equity, or access.

Prioritized Health Area 1: Behavioral Health

Behavioral Health, including the subtopics of *Mental Health & Mental Health Orders, and Alcohol & Drug Use,* was identified as a top concern in the 2022 Calhoun County CHNA. Key concerns discussed during the Behavioral Health CHIP workshops included: lack of funding, lack of trust in the system, stigma around behavioral health concerns, and workforce shortages. Some current services in Calhoun County include behavioral health programs for seniors, Question Persuade Refer (QPR) monthly training, therapy services/counseling for Intermediate School District (ISD) educators and students, and other outreach, education, and treatment services to increase awareness about mental health and services. The Behavioral Health Work Plan includes strategies and activities that build off existing and new programs to improve access to and quality of services and improve behavioral health outcomes for all of Calhoun County. The work plan will be reviewed and revised annually to reflect evolving community needs, assets, and activities.

Goal: Improve access to and quality of behavioral health services for all Calhoun County
Community Level Indicators
• Depression: Medicare Population • Mental Health Needs for Youth • Rates of Suicide for Youth • Age-Adjusted Death Rate due to Suicide • Programming Increases • Medicare Population

Strategy 1: Increase community screening and programming among under-served populations			
Objective: By December 31, 2025, increase the percentage of individuals receiving behavioral health screenings and programming in schools by 30%.			
Activities:	**Year 1**	**Year 2**	**Year 3**
Generate a listserv of Behavioral Health community resources to distribute to Calhoun Intermediate School District (ISDs)	X		
Conduct an environmental scan or analysis of all ISDs to understand the capacity of Behavioral Health resources within and outside of the school and the disparities between/within districts	Planning YR	X	X
Increase the awareness of the Blue Envelope Program	X	X	X
Provide QPR training for school systems, staff, and families/community members	X	X	X
Provide Mental Health First Aid training to educators/school district training	X	X	X
Expand STARR Commonwealth pilot program "Student Resilience and Empoment Center" to area schools		X	X
Baseline measure: Baseline data developed in Year 1 will be used here			
Anticipated measurable outcome(s) based on current trends: Increase knowledge about behavioral health screenings and programs			
Indicator(s) used to measure outcomes and data source: TBD in Year 1			
Potential lead organization: Summit Pointe, The Coordinating Council, STARR Commonwealth, Grace Health, Calhoun County Public Health Department, Calhoun Intermediate School Districts			
Identified community partners/opportunities for collaboration: Calhoun Intermediate School District nurses, Calhoun Intermediate School District			
Specific opportunities to address policy, equity, and/or access: Access to behavioral health support services			
Target population(s): Youth, older adults, school staff, parents, caregivers, Calhoun County residents			

Strategy 2: Support the coordination of services and service delivery across multisector partners (schools, healthcare organizations, coalitions, grassroots organizations, nonprofits, and county partners)			
Objective: By December 31, 2025, increase community and organizational knowledge regarding the existence and activities of behavioral health collaboratives among behavioral health providers.			
Activities:	**Year 1**	**Year 2**	**Year 3**
Conduct an inclusive environmental scan of the existing coalitions, partnerships, and grassroots organizations in Calhoun County	Planning YR	X	X
Establish a BH Network to expand community outreach efforts	Planning YR	X	X
Establish a memorandum of understanding outlining shared goals/objectives to facilitate collaboration for sustainability	Planning YR	X	X
Baseline measure: Baseline data developed in Year 1 will be used here			
Anticipated measurable outcome(s) based on current trends: Increase knowledge of existing behavioral health collaboratives.			
Indicator(s) used to measure outcomes and data source: Reporting tools per program			
Potential lead organizations: Summit Pointe, CCPHD, Oaklawn Hospital, Bronson Battle Creek, Grace Health			
Identified community partners/opportunities for collaboration: Opioid Coalition, Mental Health and Substance Abuse Task Force, Suicide Prevention Coalition, Quarterly Faith Leader Forum (a comprehensive list of resources for individuals to turn to, exists through coordination council, but needs to be expanded/updated)			
Specific opportunities to address policy, equity, and/or access: Access to behavioral health support services			
Target population(s): Calhoun County residents			

Strategy 3: Expand the use of promising practices (i.e., evidence-based or adaptive-based practices) to improve treatment outcomes			
Objective: By December 31, 2025, increase the incidence in which evidence-based practice is employed in conjunction with the initiation of SUD services at a rate of 20% over three years.			
Activities:	**Year 1**	**Year 2**	**Year 3**
a. Refer SUD patients to peers/recovery coaches within 48 hrs. of presenting in ED or First Step Psychiatric Urgent Care Recovery Services Unlimited b. Refer SUD patients who do not connect with peers or recovery coaches to Project ASSERT or Harm Reduction program	Planning YR	X	X
Recruit a diverse workforce/peer recovery coaches/peer support specialist	Planning YR	X	X
Expand the network of Mental Health ambassadors to expand the network of support for youth by working with colleges/ universities for internship approaches	Planning YR	X	X
Expand Smart Recovery services/EBP service approach jail/ prison program	Planning YR	X	X
Baseline measure: Baseline data developed in Year 1 will be used here			
Anticipated measurable outcome(s) based on current trends: Increase in incidence of EB practice with SUD services per program reports			
Indicator(s) used to measure outcomes and data source: Reporting tools per program			
Potential lead organizations: Summit Pointe, Oaklawn Hospital, Bronson Battle Creek Hospital, Calhoun County Public Health Department, Recovery Services Unlimited			
Identified community partners/opportunities for collaboration: Battle Creek Community Foundation, Project Access, Summit Pointe, Bronson Battle Creek Hospital			
Specific opportunities to address policy, equity and/or access: Access to behavioral health support services			
Target population(s): SUD patients, African American populations, People/persons who are incarcerated, Partner/child of an incarcerated person, college students, Calhoun County residents			

Prioritized Health Area 2: Maternal, Fetal, and Infant Health

Maternal, Fetal, and Infant Health (MFIH) was identified in the 2022 CHNA as a top concern in Calhoun County. Key concerns discussed during the MFIH CHIP workshops included: lack of cultural competency, discrimination/implicit bias in care settings, lack of transportation, language barriers, lack of awareness, lack of funding, providers being emotionally and mentally strained during the pandemic, fragmented referral system, and a lack of unity among providers regarding MFIH resources and staff shortages. Current programs and services include outreach, education, and visitation programs to increase awareness of pre- and post-partum care. The MFIH Work Plan includes strategies and activities that build off existing and new programs to prevent pregnancy complications and maternal deaths and improve women's health outcomes before, during, and after pregnancy. The work plan will be reviewed by the project team and collaborative partners and revised at least annually to reflect evolving community needs, assets, and activities.

Goal: Prevent pregnancy complications and maternal deaths and improve women's health
Community Level Indicators
• Mothers who Received Early Prenatal Care • Babies with Low Birth Weight • Preterm Births • Teen Birth Rate: Ages 15-19 • Teen Pregnancy Rate

Strategy 1: Coordinate policy-level interventions that facilitate access to pre-and post-partum care to reduce preterm births, low birth weight, and infant mortality			
Objective: By December 31, 2025, develop procedures/guidelines/practices/standards to improve pre- and post-partum care.			
Activities:	**Year 1**	**Year 2**	**Year 3**
Initiating conversations with feedback from MFIH-focused organizations to increase participation in county-wide transportation planning	Planning YR	X	
Conduct an environmental scan of countywide organizations' procedures and practices for pre- and post-partum care intervention and education relating to: a. Nutrition and healthy eating education b. Chronic disease management c. Access to clinical services d. Access behavioral health services e. Environmental safety and emergency preparedness		X	X
Conduct an environmental scan of data collection practices for evaluating pre- and post-partum care intervention	Planning YR	Planning YR	X
Evaluate agency systems for language inclusivity to decrease language barrier for pre- and post-partum care education	X		
Baseline measure: Baseline data developed in Year 1 will be used here			
Anticipated measurable outcome(s) based on current trends: Increase in knowledge per program measured through survey and report evaluations			
Indicator(s) used to measure outcomes and data source: Reporting tools per program			
Potential lead organizations: Calhoun County Public Health Department, Bronson Battle Creek Hospital, Grace Health			
Identified community partners/opportunities for collaboration: Grace Health, Calhoun County Public Health Department, Maternal, Fetal, and Infant Health Commission			
Specific opportunities to address policy, equity, and/or access: Access to pre- and post-partum care			
Target population(s): Calhoun County residents			

Strategy 2: Expand the use of promising practices (i.e., evidence-based or adaptive-based practices) to improve maternal, fetal, and infant health			
Objective: By December 31, 2025, increase knowledge of new and existing MFIH programs through data collection, education, and outreach.			
Activities:	**Year 1**	**Year 2**	**Year 3**
Provide community outreach and education for new and existing MFIH-related programs to reduce social, cultural, environmental, and economic barriers.	X	X	X
Create a survey to gather input on MFIH concerns from the parent ambassador programs	X	X	X
Develop frontline medical care training for post-partum depression signs and symptoms		X	X
Baseline measure: Baseline data developed in Year 1 will be used here			
Anticipated measurable outcome(s) based on current trends: Increase in knowledge through reporting tools and evaluation reports			
Indicator(s) used to measure outcomes and data source: Reporting tools per program			
Potential lead organizations: Calhoun County Public Health Department, The Coordinating Council, Nurse-Family Partnership®, Perinatal Health Equity Collaborative, Great Start Collaborative, Maternal Infant Health Commission, Population Health Alliance			
Identified community partners/opportunities for collaboration: Parent advisory group (home visitation program to gather input)			
Specific opportunities to address policy, equity, and/or access: Access to MFIH programs and services			
Target population(s): Calhoun County residents			

Strategy 3: Support the coordination of services and service delivery across multi-sector partners (including schools, healthcare organizations, coalitions, grassroots organizations, nonprofits, and county partners)

Objective: By December 31, 2025, increase coordination of MFIH-related educational materials, activities, and events in Calhoun County.

Activities:	**Year 1**	**Year 2**	**Year 3**
Research, track, and update community platforms with the public-facing platform (i.e., MiCalhoun, Born to Be)	Planning YR	X	X
Conduct an inclusive environmental scan of the existing coalitions, partnerships, and grassroots organizations in Calhoun County (sub-activity of the BH Network)	Planning YR	X	X
Expand central hub (provider level) outreach efforts		X	X
Explore creating a backbone resources network focused on the MFIH population for providers and community		X	X
Establish a Memorandum of Understanding outlining shared goals and objectives to facilitate collaboration for sustainability amongst key partners	Planning YR	X	X

Baseline measure: Baseline data developed in Year 1 will be used here

Anticipated measurable outcome(s) based on current trends: Increase in programs, events, and activities in the community

Indicator(s) used to measure outcomes and data source: Reporting tools per program

Potential lead organizations: Calhoun County Public Health Department, Bronson Battle Creek Hospital, Maternal Infant Health Commission, Oaklawn Hospital

Identified community partners/opportunities for collaboration: Grace Health, Calhoun County Public Health Department, Maternal Infant Health Commission

Specific opportunities to address policy, equity, and/or access: Access to services and service delivery

Target population(s): Calhoun County residents, MFIH-focused organizations, and professionals

Appendix

This Appendix provides a summary of key findings for prioritized health areas and themes in the 2023 Calhoun County CHIP. An overview is provided for each health area, followed by a table highlighting the poorest-performing indicators and a description of key themes that emerged from community feedback. The two prioritized health areas are presented in alphabetical order. A full overview of findings is available in the 2022 CHNA Report located on the MiCalhoun platform.

Conduent HCI's Data Scoring Tool® was used to systematically summarize multiple comparisons across the Community Dashboard to rank indicators based on the highest need. For each indicator, the Calhoun County value was compared to a distribution of Michigan and U.S. counties, state and national values, Healthy People 2030, and significant trends. Each indicator was then given a score based on the available comparisons. These scores range from 0 to 3, where 0 indicates the best outcomes and 3 the worst. A 1.50 threshold was determined for Calhoun County and anything scoring 1.50 or higher indicates areas of concern. The availability of each type of comparison varies by indicator and is dependent upon the data source, comparability with data collected from other communities, and changes in methodology over time. These indicators were grouped into topic areas for a higher-level ranking of community health needs.

Key themes from community input and secondary data warning indicators are included for each prioritized health area. The warning indicators shown for certain health topics are above the 1.50 threshold. See the legend below for how to interpret the distribution gauges and trend icons used within the data-scoring results tables.

	Indicates the county fell in the bottom 10% of all counties in the distribution. The county fares worse than 90% of all counties in the distribution.
	Indicates the county is in the top 30% of all counties in the distribution. The county fares better than 70% of all counties in the distribution.
	The indicator is trending up, significantly, and this is not the ideal direction.
	The indicator is trending up and this is not the ideal direction.
	The indicator is trending down, signifcantly, and this is the ideal direction.
	The indicator is trending down and this is the ideal direction.
	The indicator is trending up, significantly, and this is the ideal direction.
	The indicator is trending up and this is the ideal direction.

Appendix A

Prioritized Health Topic #1: Behavioral Health

Based on the CHNA secondary data scoring results, Behavioral Health was identified as a top health need in Calhoun County. This health topic includes mental health, mental health orders, and alcohol and drug use. Using Conduent HCI's Secondary Data scoring technique, mental health and mental disorder had the fourth highest data score and alcohol and drug use ranked eighth. The overall topic scores were 1.95 and 1.82, respectively. Further analysis was done to identify specific indicators of concern across the county. Individual indicators with high data scores within a topic area were categorized as indicators of concern and are listed below.

Behavioral Health: Mental Health & Mental Disorders

Secondary Data Score: **1.95**

Key Themes from Community Input

- One of the top health needs to be addressed from survey; impacts everyone (44.95%)
- Mental health care, resources, and available providers are disproportionate to community need

Warning Indicators

- Depression: Medicare Population
- Age-Adjusted Death Rate due to Alzheimer's Disease
- Age-Adjusted Death Rate due to Suicide
- Alzheimer's Disease or Dementia: Medicare Population

Behavioral Health: Alcohol and Drug Use

Secondary Data Score: **1.82**

Key Themes from Community Input

- Drug abuse and alcohol abuse were two of the top risky behaviors that impact community health from the survey (56.55%)

Warning Indicators

- Liquor Store Density
- Alcohol-Impaired Driving Deaths
- Age-Adjusted Drug and Opioid-Involved Overdose Death Rate

DATA SCORING RESULTS FOR MENTAL HEALTH & MENTAL ORDERS

SCORE	MENTAL HEALTH & MENTAL ORDERS	Calhoun County	Michigan	U.S.	Michigan Counties	U.S. Counties	Trend
2.82	Depression: Medicare Population (2018) *percent*	22.1	20.9	18.4			
2.74	Age-Adjusted Death Rate due to Alzheimer's Disease (2015-2019) *deaths/100,000 population*	44	33.3	30.2		–	
2.74	Age-Adjusted Death Rate due to Suicide (2015-2019) *deaths/100,000 population*	20.6	14	13.8 **HP2030*** 12.8		–	
2.00	Alzheimer's Disease or Dementia: Medicare Population (2018) *percent*	10.9	11.7	10.8			
1.85	Frequent Mental Distress (2018) *percent*	15.5	14.8	13			–

*HP2030 - Healthy People provides science-based, 10-year national objectives for improving the health of all Americans. HP2030 represents a Healthy People target to be met by 2030.

DATA SCORING RESULTS FOR ALCOHOL & DRUG USE

SCORE	ALCOHOL & DRUG USE	Calhoun County	Michigan	U.S.	Michigan Counties	U.S. Counties	Trend
3.00	Liquor Store Density (2019) *stores/100,000 population*	19.4	16.5	10.5			
2.71	Alcohol-Impaired Driving Deaths (2015-2019) *percent of driving deaths with alcohol involvement*	41.7	29.3	27 **HP2030*** 28.3			
2.29	Age-Adjusted Drug and Opioid-Involved Overdose Death Rate (2017-2019) *deaths/100,000 population*	38.2	27.1	22.8		—	—
1.79	Mothers who Smoked During Pregnancy (2019) *percent*	20.6	13.6	5.9 **HP2030*** 4.3		—	
1.76	Death Rate due to Opioid-Related Drug Poisoning (2019) *deaths/100,000 population*	23.1	17.7	—	—	—	
1.65	Emergency Department Opioid Visits (July 2020) *visits*	28	—	—	—	—	
1.65	Teens who Use Marijuana: 9th, 11th Graders (2020) *percent*	17.1	—	—	—	—	
1.62	Death Rate due to Drug Poisoning (2019) *deaths/100,000 population*	27.6	23.6	—		—	

SCORE	ALCOHOL & DRUG USE	Calhoun County	Michigan	U.S.	Michigan Counties	U.S. Counties	Trend
1.59	Health Behaviors Ranking (2021)	61	—	—		—	—

*HP2030 - Healthy People provides science-based, 10-year national objectives for improving the health of all Americans. HP2030 represents a Healthy People target to be met by 2030.

Appendix B

Prioritized Health Topic #2: Maternal, Fetal, and Infant Health

From the CHNA secondary data scoring results, Maternal, Fetal, and Infant Health was identified to be a significant health need in Calhoun County. It had the seventh-highest data score of all health topic areas using the data scoring technique, with a score of 1.85. Further analysis was done to identify specific indicators of concern across the county. Individual indicators with high data scores within a topic area were categorized as indicators of concern and are listed below.

Maternal, Fetal and Infant Health

Secondary Data Score: 1.85

- Mothers who Received Early Prenatal Care
- Babies with Low Birth Weight
- Preterm Births
- Teen Birth Rate: 15-19
- Teen Pregnancy Rate

DATA SCORING RESULTS FOR MATERNAL, FETAL, AND INFANT HEALTH

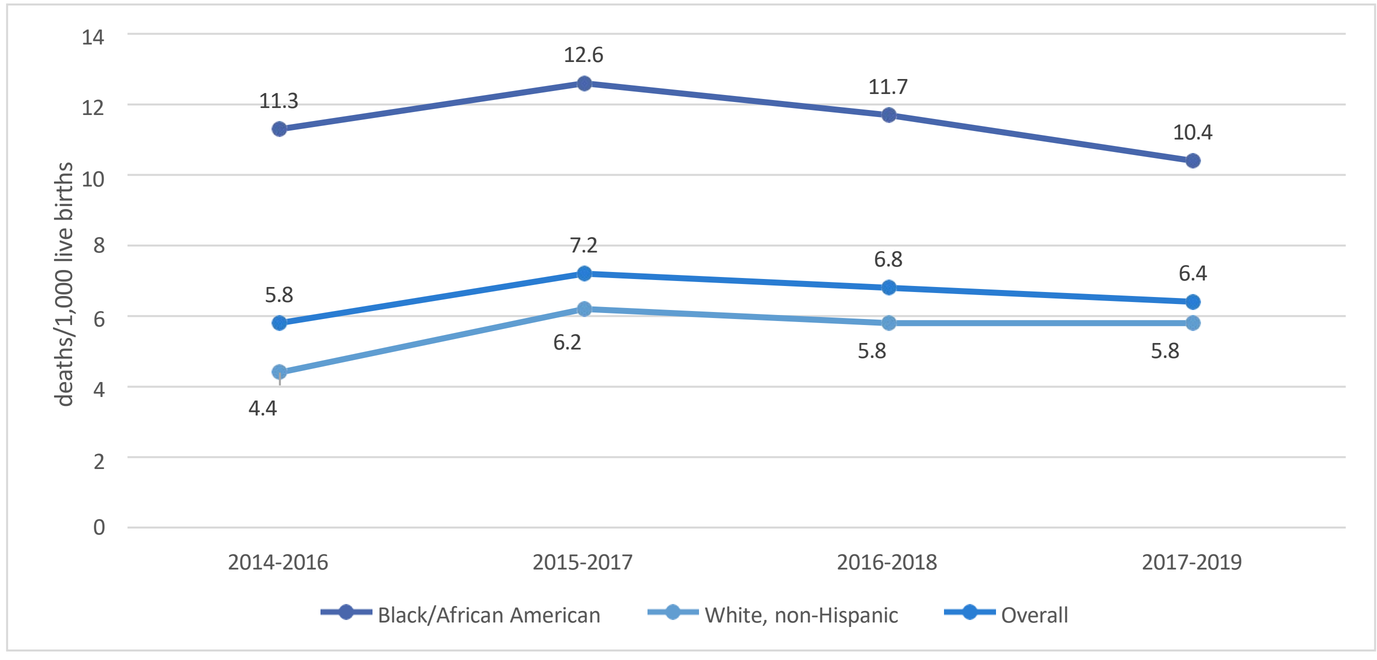
SCORE	MATERNAL, FETAL, AND INFANT HEALTH	Calhoun County	Michigan	U.S.	Michigan Counties	U.S. Counties	Trend
2.74	Mothers who Received Early Prenatal Care (2019) *percent*	57.5	74.2	75.8		—	
2.12	Babies with Low Birth Weight (2019) *percent*	9.6	8.8	8.3		—	
1.94	Preterm Births (2019) *percent*	10.7	10.3	10		—	
1.88	Teen Birth Rate: 15-19 (2019) *live births/1,000 females aged 15-19*	22.5	15.1	16.7		—	
1.88	Teen Pregnancy Rate (2019) *pregnancies/1,000 females aged 15-19*	37.2	25.8	—		—	
1.79	Mothers who Smoked During Pregnancy (2019) *percent*	20.6	13.6	5.9		—	
1.65	Infant Mortality Rate: 5 year rate (2015-2019) *deaths/1,000 live births*	6.2	6.6	—		—	
1.56	Mothers with Gestational Diabetes (2019) *percent*	6	6.1	—	—	—	
1.56	Mothers with Hypertension (2019) *percent*	10	11	—	—	—	

*HP2030 - Healthy People provides science-based, 10-year national objectives for improving the health of all Americans. HP2030 represents a Healthy People target to be met by 2030.

CHNA secondary data results revealed that the rate of Mothers who Received Early Prenatal Care is lower in Calhoun County when compared to Michigan and the U.S. However, this indicator is performing better in Calhoun County compared to other Michigan counties over a period of time. Babies with low birth weight and preterm babies are two warning indicators that have comparatively worse rates in Calhoun County than in Michigan and the U.S. and the trend data shows that the rates are getting worse over a period of time in Calhoun County.

The graph below shows that Infant Mortality continues to be a concern for Calhoun County, the infant death rates have remained relativity steady over a 5-year period (2014-2019). Furthermore, there are apparent disparities between infant deaths among Black/African American populations as compared to White, non-Hispanic populations.

FIGURE 7: INFANT MORTALITY RATE IN CALHOUN COUNTY



Appendix C

Foundational Goal: Access to Quality Health Services

Access to health services was voted as a top priority for Calhoun County. Cost of care was a common barrier mentioned across primary data sources in the CHNA. This included the general cost to access care, lack of funds for purchasing needed medication as well as being uninsured or underinsured. Mental health care, mental health resources, and the availability of mental health providers were also cited as disproportionate to community needs. Survey respondents in Calhoun County reported not being able to access needed mental health services in the past 12 months. Because access to healthcare services has a significant impact on overall health it will be an area focus in the 2023 Calhoun County CHIP.

Access to Health Services

Key Themes from Community Input

- Top priority from community survey (36.87%)
- Cost of healthcare is a barrier
- Additional impact of Covid-19
- Long wait times to see a provider or specialist
- Lack of trust in healthcare services and/or providers

Warning Indicators

- Percentage of women receiving prenatal care in the first trimester
- Children with health insurance
- Adults with health insurance

FIGURE 8: CALHOUN COUNTY COMMUNITY SURVEY RESPONDENTS REPORTING INABILITY TO ACCESS HEALTH SERVICES IN THE LAST 12 MONTHS

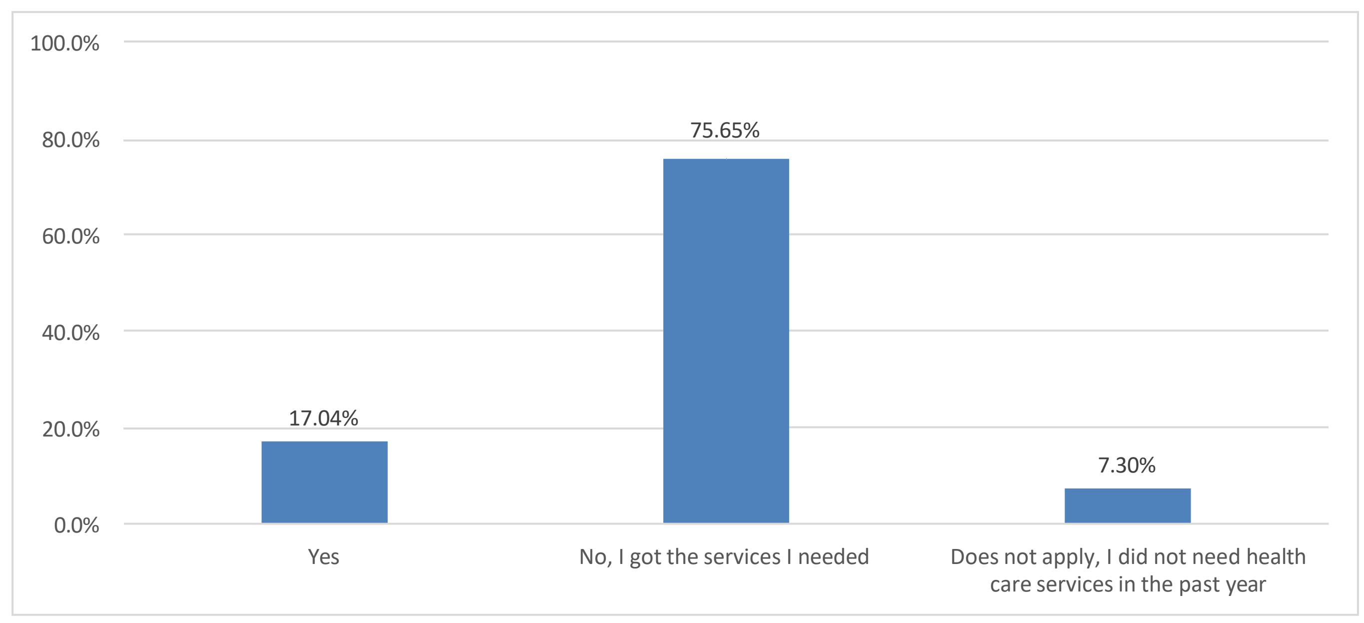
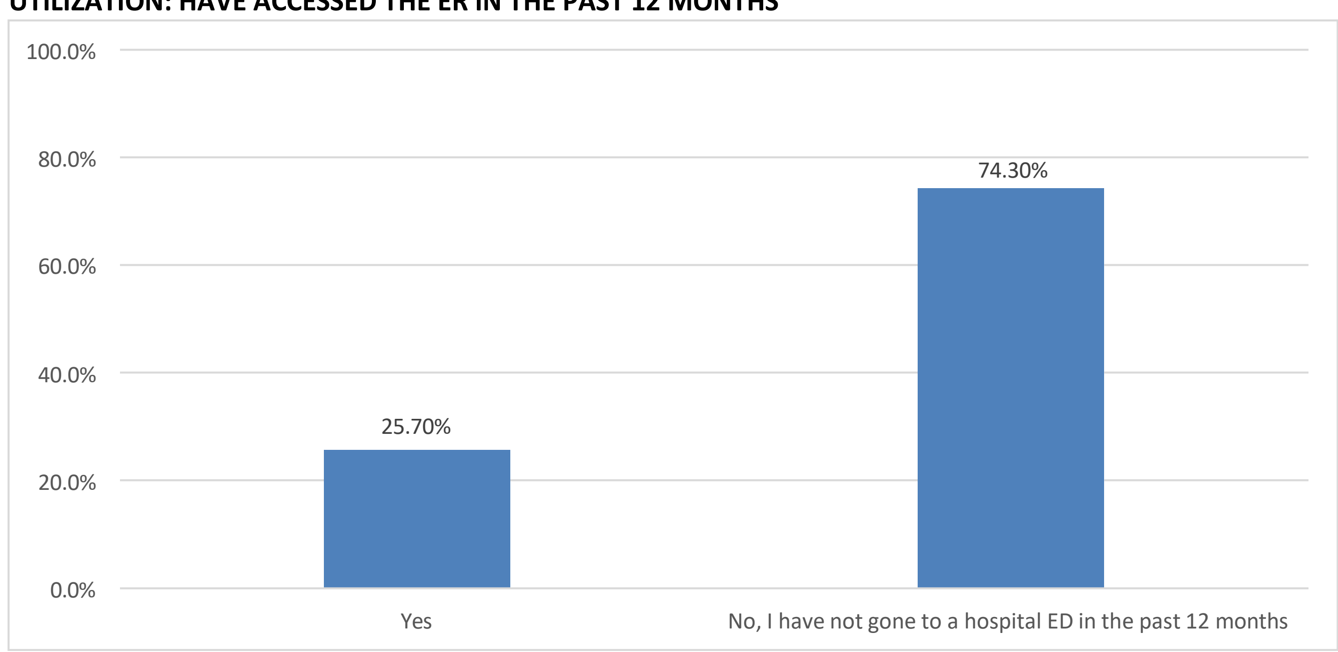


FIGURE 9: CALHOUN COUNTY COMMUNITY SURVEY RESPONDENTS SELF-REPORTED EMERGENCY ROOM UTILIZATION: HAVE ACCESSED THE ER IN THE PAST 12 MONTHS



Appendix D
Foundational Goal: Health Equity

Health Equity was also voted as a top priority for Calhoun County. Health Equity focuses on the fair distribution of health determinants, outcomes, and resources across communities. [6] National trends have shown that systemic racism, poverty, and gender discrimination have led to poorer health outcomes for groups such as Black/African American persons, Hispanic/Latino persons, Indigenous persons, people with incomes below the federal poverty level, and LGBTQ+ communities.

In Calhoun County, Health Equity was a top concern of people who were at higher risk for discrimination or inequity. A total of 21% of community survey respondents thought that discrimination or inequity on race/ethnicity, gender, age, sex, and disability needed to be addressed in Calhoun County. A significant barrier to the improvement of health outcomes is inequity experienced by communities that have historically experienced racism, isolation, and segregation. There was a concern about inequities associated with infant mortality, specifically between Black/African American and White populations. The Calhoun County Steering Committee and partners will focus on the area of health equity in the 2023 Calhoun County CHIP.

Health Equity

Key Themes from Community Input

- Top concern of people who are at higher risk for discrimination or inequity (N= 313)
- 21.09% of survey respondents think discrimination or inequity based on race/ethnicity, gender, age, sex needs to be addressed

> Language barriers are sometimes addressed by online and phone interpretation services and some in-person translators, but a barrier still exists. Having more interpreters in-person was a recommended solution, specifically having someone from the community served act as the translator.
>
> - 2019 Qualitative Data

[6] **Klein R, Huang D. Defining and measuring disparities, inequities, and inequalities in the Healthy People initiative. National Center for Health Statistics (2022). Center for Disease Control and Prevention. https://www.cdc.gov/nchs/ppt/nchs2010/41_klein.pdf**

Appendix E: Work Session 1: Themes-Behavioral Health

Goals/Vision
Access & Quality of Services • Greater choice of providers for members seeking services • Better mental health options for youth • Better substance abuse options for the community • Increase # of providers who can provide Buprenorphine • County courts do not recognize methadone as a treatment option but do recognize suboxone, limited prescribers for suboxone in the county Representation/Equity • Individuals from different races in mental health services • Calhoun County lacks programs for African American males & remains a high priority in terms of incarceration Prevention • Greater focus on ACEs • Better data on mental health for all age groups i.e., how many high schoolers have been diagnosed with anxiety • Increased rates of BH screenings across populations • Uniform screening practice community-wide (Summit Pointe has a free web-based resource for completing these screenings) Stigma/Community Education • Greater understanding of SUD for those working within the field • More education about what BH treatment involves • Reduction in stigma for SUD / MH overall

Barriers/Challenges
Funding/sustainability challenges • Policy dictates funding/determines what services can be provided • Availability of crisis beds • Many initiatives funded by the state & foundations lose funding Staffing challenges • Provider limitations (Medicaid/commercial coverage have different provider eligibility. Medicare has a very limited pool of providers meeting eligibility) • Difficulties filling open positions/finding providers at Oaklawn Psychological Services • Lack of early intervention providers/opportunities • Criteria for who can provide care are difficult to meet • Lack of options to refer people to after stabilization, screening, and evaluation (lack of qualified personnel) Trust • Stigma ("therapy is very expensive", "mental health providers are mean", viewing SUD as a failure rather than an external issue/disease) • Lack of trust in the system • Lack of relationships leads to mistrust • More funding in schools to build trust • Working in silos • No central model for how to work together

Looking forward…

Better collaboration

- Between larger organizations/grassroots organizations to deliver services
- Health leaders of large enterprises need to meet to discuss challenges within their system and with the core leadership group to roll out CHIP framework
- Better connect two sides of the county with transportation
- Expansion of existing programs
- SSP Project Access Program: having enough supplies to meet increased needs with growth. Peer recovery coaches/peer support specialists as we are expanding/looking at additional people who can distribute supplies and work with us who understand/engage with the population & focus on outreach/innovative ideas
- Community Health Workers (CHW): training paraprofessionals to be a community resource with expansion into school
- Summit Pointe & Project Access Grant: targeting SUD presenting at ED, targeting AA males to increase engagement with peers/recovery coaches within 48 hours of ED identification. Look to expand to different points of outreach beyond ED visits
- Update/expand the listing of resources maintained by the Quarterly Faith Leader Forum and The Coordination Council (ensuring referrals are appropriately finding the right care for people)

Increase focus on prevention

- Early education for substance use orders & mental health through the school system: bring in health educators/navigators after school to circumvent policies
- Positive Behavioral Interventions and Supports Model: continue/expand prevention work within ISD. *Unified mental health prevention education program adopted at ISD level*
- Ensure we have an effective continuum of care (i.e., appropriate levels of care once services are done, "maintenance/prevention")
- Increase screenings/rates of screenings across populations with a focus on addressing disparities
- Will we have enough staff to address issues that come about with those screenings?
- Do have a limitation in terms of providers in the grandest scheme. But when we look at individuals that have the lowest level of severity of presentation, we do not have the resource challenge there as much. So, individuals that are presenting with a mild to moderate level of behavioral health needs, have a greater array of choices in service providers and access points and tend to have insurance opportunities that extend beyond that of Medicaid
- While I do think we do have a service provider capacity challenge in particular with SUD, I do not know that that is a universal challenge, especially in the early intervention, early engagement, and outpatient realm. We have the greatest availability and resource in that area.

Appendix F: Work Session 1: Themes-Maternal, Fetal, and Infant Health

Goals/Vision

Access & Quality of Services

- Lack of support in the community for postpartum depression
- Increase availability of hospital-provided breast pumps/equipment to prevent delays
- Increase in nurse home visiting (teen mothers especially)
- Increase usage of doulas (during pregnancy, labor/delivery)
- Increase participation in prenatal education groups
- Improve transportation prioritized for moms with children

Representation/Equity

- Better representation of marginalized families
- Improve health indicators (i.e., morbidity/mortality)
- Teen pregnancy rates, maternal smoking during pregnancy, low birth weight, preterm births, breastfeeding rates, maternal/infant mortality rates (infant mortality due to unsafe sleep)

Barriers/Challenges

Staffing/funding challenges

- Staffing resources, moral injury with current staff
- Emotional/mental strain during the pandemic in addition to the physical strain of being under-resourced/having difficulty staffing, and significant staff turnovers all affect engagement
- Vacancies within Nurse-Family Partnership
- Funding

Discrimination/implicit bias/racism

- Lack of cultural competence
- Systemic problems: transportation, poverty, trust/mistrust, discrimination/implicit bias in care settings
- Groups we are not more competent to serve: BIPOC communities, and LGBTQIA+ communities. We have a lack of understanding/lack of leaning into that curiosity and more of those set implicit biases that exist, lack of inter-cultural competence coupled with implicit bias
- Language barriers: understanding how different families tend to discuss things, or how they respond to things, and that is where we tend to see that lack of that inner cultural competence and where that implicit bias and discrimination play a role,
- Staff that do not speak common languages in our community, having translators/language lines is still a barrier
- Lack of trust in CCPHD/Systems/Facilities (Stemming back from COVID) Patchwork/fragmented system
- No centralized referral system for home visiting
- Lack of unity in resources, all on one page to share available resources
- Lack of awareness of services

Looking forward…

Policy Level

- Transportation: Many Medicaid families seeking transportation face barriers i.e., no drivers available (incorporating recommendations to the state)
- Paid Family Leave: policy opportunity
- Breastfeeding policy in the workplace- many parents returning to work do not have adequate support/right infrastructure
- Childcare that is high quality (getting good support to informal caregivers/expanding access to formal settings)
- Someone from this group to have seat at the table for countywide transportation planning
- Increasing prenatal visits- OB offices have their own policies to get expedited appt. set up, so catching people that didn't know they were pregnant/concerns about initiating prenatal care in the county, pre-pregnancy education comes into play (prior work in the ER looked at every + pregnancy test having a referral to connect them to prenatal care immediately, so systems-level intervention for early/frequent referrals to prenatal care could address this—Bronson might do this and Oaklawn Hosptial?)
- Six-week post-partum visits: our system has atrocious rates for them to show up for that 1 post-partum visit. (Prior work with an OB office doing three- and six-week follow-ups. Three weeks was intentional to catch mood disorders and could be tied to reimbursement/policy level recommendation)
- Policies within our agencies to promote hiring practices that reflect the community being served (driver's license on the job requirement as a barrier)
- Include MIH CHIP in the organization policy review during the second half of maternal mental
- health programming
- Postnatal care policy/intervention (one 6-week post-delivery visit is not enough to support for postpartum mom) Funding
- Financial support for groups doing the work (Milk Like Mine)
- If we're thinking to fund, MHEF's MIH grant that PHA got for the PMAD training is open again now https://mihealthfund.org/grantmaking/maternal-infant-health

Health promotion/Connecting people to resources

- Increasing referral/enrollment to evidence-based programs i.e., nurse home visiting programs to, in turn, improve Infant mortality rates/breastfeeding rates
- Increase referrals to safe sleep education, Grace Health Centering Program (so families can have additional education/follow-up)
- "Cradle Kalamazoo" to target infant mortality rates, specifically, racial disparities. They saw a huge increase in referrals to their home visiting programs and had wait lists. Based on the LA County model. "Community-wide systems level approach" with the intention of streamlining things so patient has one place they call and directs them to where they need to go. Central Home Visiting Hub for the county (agreed upon way for referrals to go out). Kalamazoo County has a dedicated centralized referral process- how is that going?
- Development of flow sheet of "if you have insurance if you don't have insurance..."
- A large social media presence in encouraging healthy education and sharing local hub information
- ISD partnership to provide education for the teen population on teenage health parenting/caregiver education
- Building relationships with trusted leaders in the community (BC Pride, Burma Center, New Level Sports Ministries)
- Engagement and alignment with other groups in the community and tapping into trusted leaders partnerships/awareness of resources to support our patients' "provider level hub" and "central hub" to remove silos