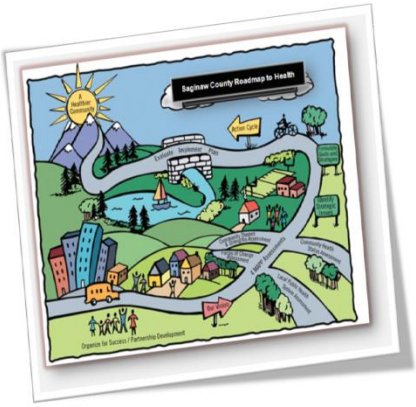
SAGINAW COUNTY COMMUNITY MENTAL HEALTH AUTHORITY
COMMUNITY NEEDS ASSESSMENT
2019

The Saginaw County Roadmap to Health is the Community Health Needs Assessment and Community Health Improvement Plan (CHNA/CHIP) for Saginaw County is for the three year period of 2017-2020. The annual report for 2019 will be published by the Michigan Health Improvement Alliance. The MiHIA Team working on the report has a vision statement which describes a vision of success:



- Alignment of priorities
- Efficient deployment of resources
- Culture of cooperation and systems thinking
- Improved health of Saginaw residents
- Action plan to address identified priorities which is evidence based, data driven and has stated timeliness
- Necessary persons engaged to inform the process
- Improved service delivery and awareness of available services
- Consumers who are co-producers and partners in the transformation of their health
- Unified promotion of improved public policy to support health improvement

The document is published by the Saginaw County Department of Public Health in response to their duty under Public Act 368, the Michigan Public Health Code. The process and the publication are collaborative and also meet the public obligations of both of Saginaw's hospital systems--Covenant and St. Mary's of Michigan—to prepare a Community Benefit Plan. Saginaw County Community Mental Health has similar legislatively defined obligation in Public Act 258, the Michigan Mental Health Code, to conduct a community needs assessment and plan on an annual basis. As the various public and private agencies with health assessment and planning duties came together, Alignment Saginaw became the perfect venue for pooling resources to cover the cost of this activity, for sharing data and more importantly for developing and implementing a plan for implementation of activities to address the plan. SCCMHA is a CHNA/CHIP partner and steering committee member of Alignment Saginaw. This model of collaborative population health addresses our MDHHS contractual guideline for community needs assessment which states that ***"the greatest values in conducting a needs assessment is its application to a local planning process, requiring the inclusion of key community partners and stakeholders."***

The Community Needs Assessment guideline goes on to state that ***"the needs assessment process must take into account significant system changes related to the integration of primary healthcare and***

behavioral healthcare." This expected integration of physical health and behavioral health is bi-directional. This year's annual report is being prepared on the eve of the MDHHS 298 Pilot and so in this year's report we would like to demonstrate our capacity provide both vertical and horizontal health care system interface, bringing locally selected population health goals into state level dialog, informing the selection of key performance indicators and guiding the development of the SCCMHA Health System.

The Roadmap to Health is both a local and a collaborative population health planning process which brings our community resources and objectives into alignment. SCCMHA is deeply involved in these discussions and activities with our Roadmap to Health collaborators. The report and plan is available on our website at: https://www.sccmha.org/healthcare-partnerships/healthcare-partnerships/saginaw-county-roadmap-to-health.html

Methods and Results: The CHNA/CHIP process uses the **Mobilizing for Action through Planning and Partnerships (MAPP)** model which includes four scopes of assessment : 1) community health status, 2) community themes and strengths, 3) local public health system and 4) forces of change. The MAPP model includes community resident and stakeholder participation. Out of this process the following priority health needs were identified. SCCMHA will use this integrated set of needs as our priorities in 2018 with a goal of aligning our population health activities with the broader community under this single County Health Improvement Plan.

Saginaw County Priority Health Needs	
Health Conditions	**Determinants of Health**
Physical Health • Obesity • Chronic Illness:; Diabetes, Cancer, Heart Disease, Asthma • Dental Health • Maternal, Infant and Child Health a. Infant Mortality b. Childhood lead poisoning **Behavioral Health** • Substance Abuse/Misuse • Mental Health	**Environmental (Social & Physical)** • Equal Access to Healthy Choices and Opportunities • Eliminating race, place, poverty access inequities • Access to affordable and reliable transportation **Health Care** • Access to Health Care and Utilization of Services • Affordability • Navigation: Coordination, Outreach/Awareness, Health Literacy • Service Delivery: Location, Hours, Effective Provider/Patient Communication

Integrated Data Driven Community Health Needs Assessment: SCCMHA has not been able to successfully replicate the web links in the MDHHS Community Data Set but we are following the department's guidance to continue pursuit of health data trending as a basis for the annual needs assessment. Dr. Pamela Pugh, the author of the Saginaw County Roadmap to Health, provides an excellent summary and critique of the data sources both primary and secondary in the introduction to the analysis.

The Saginaw Roadmap to health uses these secondary data health data sources in addition to primary source data collected from the Community Themes and Strengths Health Status Assessment:

- Michigan Behavioral Risk Factor Surveillance System
- Michigan Profile for Healthy Youth
- Michigan Department of Health and Human Services prevalence and utilization data
- Kids Count
- County Health Rankings
- 2-1-1 Northeast Michigan Unmet Need Count
- US Census

Our expectation is that in the coming publications of the Community Health Needs Assessment that SCCMHA will be able to offer data from our experience with Key Performance Indicators and National Quality Measures which have been adopted by MDHHS and incorporated into value-based performance measures for our Managed Health Plans. We believe that state level population health initiatives require local responses which are not competing but are in alignment. Thus our community mental health needs assessment is equally as interested in obesity as in poor mental health days and infant mortality as it is in suicide risk.

Current Actions: Health Conditions

Physical Health: In this category of health needs, SCCMHA examines both the prevalence of the concern among those we serve as well as our capacity to provide primary and secondary levels of prevention and interventions which are selected to reduce the occurrence or impact of the chronic condition. Research shows that adults with Serious Mental Illness die 25 years younger than the general population so our goal is to identify as early as possible those at risk and to incorporate routine health care and coordination of care to improve overall health and wellness and to reduce mortality. SCCMHA has developed the ability to assess metrics in each of the five priority physical health conditions identified in the CHIP and is contributing directly or indirectly in each area to community initiatives impacting these health priorities.

Obesity: Obesity is a preventable health condition which SCCMHA has been monitoring among the consumers who participate in the Health Home. Our biometric monitoring includes Body Mass Index (BMI) and waist circumference. SCCMHA also reports on two Clinical Quality Measures to the Centers for Medicare and Medicaid Services (CMS.) The ***CMS69*** Preventive Care and Screening Body Mass Index (BMI) and ***CMS155*** Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents. These measures are incorporated in the Sentri electronic health record and are a part

of our evolving integrated health service delivery design. With the addition of Certified Medical Assistants in the Health Home these measures are recorded with every consumer visit and become a part of the overall health conversation with consumers who come in for psychiatry services.

Chronic Illness - Diabetes, Cancer, Heart Disease, Asthma: SCCMHA monitors the occurrence of single and multiple chronic conditions. CC360 compiles Medicaid encounter data and makes it available to CMH as a part of the state wide effort to address the integration of behavioral and physical health. SCCMHA uses a health data analytics tool from Zenith Technology Solutions to identify persons who are at high risk. The Zenith Integrated Care Data Platform uses the Johns Hopkins Adjusted Clinical Groups (ACGs) and Resource Utilization Bands (RUBs) to analyze Medicaid encounter data in order to identify active consumers who are at high risk of readmission. Multiple health conditions contribute to a higher risk score. The numbers are staggering with some consumers having as many as 6-10 chronic conditions. We conduct diabetes screening and cardiovascular screening as a part of our routine assessments and treat these key performance indicators as care alerts in our electronic health record.

Dental Health: At this time SCCMHA uses the Personal Health Questionnaire for inquiring about the dental health of new consumers. This questionnaire asks about the last dental visit and the name of the dentist. The MDHHS CareConnect 360 data shows that 1862 of the 8577 persons served in the past 18 months, about 22%, had used their Medicaid Dental benefit for some type of preventative or dental treatment services. Our ability to include dental health as a preventative health indicator is an important component of integrated behavioral and physical health care. Consumers might not be aware of the dental insurance benefit, they might not know what providers are accessible or they might avoid dental care due to anxiety or other reason related to their mental health diagnosis or other for reasons such as lack of transportation. Oral health education can be incorporated in overall health literacy programming. Colleen Sproul, MSW, Director of Health Home and Integrated Health is a member of the Saginaw Bay Health Plan Oral Health Coalition.

Maternal, Infant and Child Health: Infant Mortality: SCCMHA has been a member of the Infant Mortality Coalition and the Child Death Review board in Saginaw County for many years. We have worked collaboratively on a number of projects including the Home Visiting Hub and similar supports for Home Visiting. At this time SCCMHA supports the use of PA2 Substance Abuse prevention funds for the expansion of Parents as Teachers which is an evidence-based home visiting model. SCCMHA is a member of the Local Leadership Group for Home Visiting and works to provide collaborative training for home visitors in topics ranging from Trauma to Motivational Interviewing.

Maternal, Infant and Child Health: Childhood lead poisoning: This population health topic is not one that SCCMHA is closely involved with except tangentially though our participation with other initiatives such as the Home Visitation Partners Local Leadership Group. Screening for lead exposure is incorporated in a number of the tools used by the various home visiting programs. Another point of awareness regarding the risk of lead in the environment is through the Housing Resource Center which manages our HUD Tenant Based Rental Assistance for the homeless. Housing quality inspections conducted by the HRC staff evaluate the presence of lead in the prospective rental property. Lead

exposure initiatives in our community are implemented largely through the Public Health Department and the Fields Neuroscience Institute.

Behavioral Health

Substance Abuse/Misuse: SCCMHA touches the SUD community services in a number of ways. As one of the MSHN delegated points of access for SUD services, SCCMHA provides 24/7 access to the full range of SUD services which are managed by Mid-State Health Network. We are able to provide the community with SUD service utilization information as well as provide leadership in the evidence based models of care such as Integrated Dual Disorder Treatment, Motivational Interviewing and Stages of Change. In FY 2017 SCCMHA was presented with the opportunity to facilitate a Michigan Endowment Fund Neonatal Abstinence grant with MPHI. This is a community assessment of services to prevent and or treat Neonatal Abstinence. SCCMHA has also led a community wide distribution of Narcan the opiod antagonist to community partners include law enforcement and other first responder to address deaths due to opioid overdose.

Mental Health: The need for access to mental health services is identified by the community at large. The Roadmap to Health cites the Michigan Behavioral Risk Factor Surveillance System. The monthly phone survey reported that Saginaw respondents experienced Poor Mental Health Days at a rate of 15.4% exceeding the state average of 12.2% in 2015 survey data. A follow up question of whether the respondent had ever been told by a doctor that they had a depressive disorder also exceed the state average with Saginaw at 24.4% and the state at 20.5%. The CHNA also notes that SUD and Behavioral Health were ranked as priority health needs at rates greater than any physical health concern in the Community Themes segment of their assessment. SCCMHA chairs the Behavioral Health workgroup of the CHIP work plan and in that role is directly informed of unmet needs as defined by our collaborative partners. The needs of the uninsured and those whose mental health conditions can be described as mild or moderate are continuously topics which the community attempts to grapple with. The SCCMHA Entitlements Office is a Referral Partner with the new MiBridges portal and we are accepting referrals directly over the internet from persons who use the MiBridges app to apply for Medicaid and self-refer to a range of community social and health services.

Current Actions: Determinants of Health

Environmental (Social & Physical)

Equal Access to Healthy Choices and Opportunities: eliminating race, place, poverty access inequities and improving access to affordable and reliable transportation. SCCMHA has also identified transportation as perhaps the single greatest barrier to accessing health care. Working with the Medicaid Health Plans, local public and private transportation providers has been a priority of the SCCMHA Customer Services department, as well as including benefit education regarding transportation in all consumer contacts. SCCMHA has also taken leadership in training to address race based bias throughout the health, public service and law enforcement professionals and institutions through implementation of community wide training in the California Brief Multi-Cultural Competence Scale. Co-

location of services in schools and health care settings is another way that SCCMHA has moved to address place based barriers to health access.

Health Care

Access to Health Care and Utilization of Services: Improving Affordability, Navigation, Coordination, Outreach/Awareness, Health Literacy, and Service Delivery (Location, Hours, Effective Provider/Patient Communication.) These dimensions of health care access are included as Key Performance Indicators in the SCCMHA analytics. We monitor SCCMHA consumer access for adults and children separately to primary care. Throughout our system we are introducing supports for consumers to access health care including the co-located services provide by Great Lakes Health Care at 500 Hancock.

SCCMHA Planned Actions

We have identified the following planned actions for FY 2018 which will promote our ability to impact population health priorities for Saginaw County:

1. Develop a Data Cube and Metric Report: - Health Conditions Morbidity and Mortality: SCCMHA will create a Data Cube and Metric Report in FY2018 which will assist in trending Biometrics Screening Data, Morbidity and Mortality data.
2. Develop an Individual Health Report Card: This report card would be printed and used for individual follow up at regular appointments to facilitate consumer health education and health literacy.
3. Expand Preventive Dental Screening and Oral Health Education and Referrals
4. Apply for Community Mental Health Entity Status: This MDHHS status will be required in order to manage the SUD Medicaid, Block Grant and Prevention PA2 funding under the 298 Pilot.
5. Implement: MiBridges Referral Partner and Renewal of Saginaw County Enrollment Advocacy Network (SCEAN) workgroup under Saginaw Health Plan Leadership
6. Develop a Plan for Expanding Personal Health Record Education: Use of the CHER Portal to the SCCMHA Sentri electronic health record is a meaningful use performance measure and a plan to increase use and improve consumer satisfaction with the tool will be required.
7. Continued use and expansion of web based/mobile based apps to assist in self-management of depression, anxiety, sleep disorders, physical health goals and other quality of life measures for families, adolescents and adults.