2025 Community Health Needs Assessment

McLaren
CENTRAL MICHIGAN

Acknowledgements

McLaren Central Michigan's 2025 Community Health Needs Assessment was developed in conjunction with MiThrive, collaborative initiative led by the Northern Michigan Community Health Innovation Region (CHIR). This initiative brought together hospital systems, local health departments, community-based organizations, coalitions, agencies, and residents across 31 counties in northern Michigan to collect data, identify and prioritize key issues, and work collaboratively to address them which began in 2024 and the implementation in 2026.

Funding partners contributed leadership as well as funding to the MiThrive Community Health Needs Assessment. Thanks to their ongoing financial commitment to Community Health Needs Assessment and Improvement, MiThrive was able to provide a new region-wide, barrier-free access to all MiThrive data and mapping tools to support collaboration, moving to action, benchmarking, and storytelling.

The MiThrive Team extends its gratitude to the many organizations and residents who contributed their time, expertise, and insights to the MiThrive Community Health Needs Assessment. Dedication and collaboration were essential in making this initiative possible. Thousands of individuals and organizations played a vital role in planning assessments, engaging in community events and surveys, collecting and analyzing data, and prioritizing key issues. We are particularly grateful to the members of the MiThrive Steering Committee and the Northwest, Northeast, and North Central Workgroups, Round Tables, for their leadership and commitment.

MiThrive Steering Committee:

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Dan Thorell, Benzie-Leelanau District Health Dept.
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MiThrive North Central Round Table:

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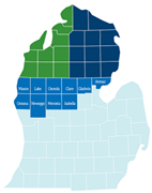

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Tara Herald, Isabella Citizens for Health

MiThrive Core Team

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

The MiThrive Core Team consists of a diverse group of public health professionals from across northern lower Michigan. Each member is an expert in their field and brings master-level experience in areas such as epidemiology, health disparities, health policy, project management, facilitation, communications, and systems change.

- Emily Llore, MPH, MiThrive Director, Health Department of Northwest Michigan MiThrive Director
- Scott Izzo, MPH, MA, Epi Team & Community Status Assessment Lead, District Health Department #2
- Erin Barrett, MPH, MCHES, Community Context Assessment Lead & Communications Team, District Health Department #10
- Jen Vollmer, MA, LPC, Community Partner Assessment Co-Lead, Health Department of Northwest Michigan
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- Donna Norkoli, MPH, North Central Community Engagement Lead, District Health Department #10
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- Emily Pokorski, MPH, Epi Team, District Health Department #10
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- Chloe Capaldi, MPH, Reports Copy Editor, Health Department of Northwest Michigan

Executive Summary

Every three years, hospital systems, health departments, community partners and residents across northern Michigan come together in a powerful collaboration to assess the health and wellbeing of residents and communities. Through extensive community engagement across a 31-county region, the MiThrive Community Health Needs Assessment gathers and analyzes data on the social, economic, environmental, and behavioral factors that shape health outcomes. This process helps identify and prioritize key issues that impact the region.

In 2024, MiThrive began a comprehensive, community-driven and community-owned assessment using the National Association of City and County Health Officials' (NACCHO) framework called, Mobilizing Action Through Panning and Partnership (MAPP). MiThrive combines existing data with insights from residents, community organizations, and healthcare providers to develop a deeper understanding of local and regional health challenges and opportunities.

The findings in this report highlight the complex and interconnected nature of these issues, with some populations experiencing a greater burden of health disparities than others. Addressing these challenges requires a collaborative, data-driven approach to create lasting improvements in health and quality of life for all.

The goal of MAPP is to achieve health equity by identifying urgent health issues in a community and aligning community resources.

The Report Goals and Objectives:

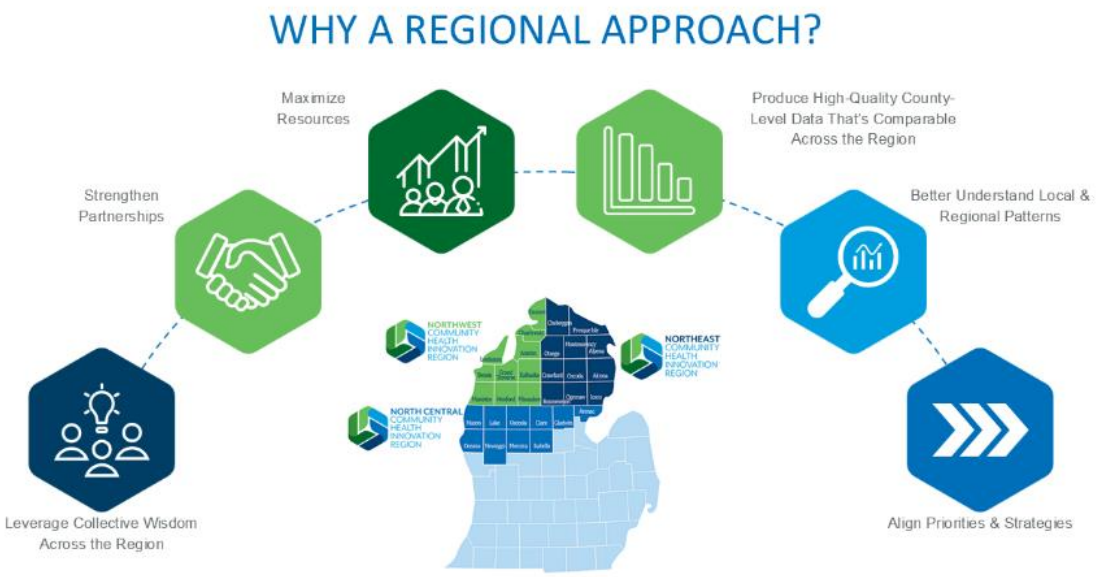
This report aims to provide a foundation for informed community decision-making and drive improvement efforts. Key objectives include:

- Describe the current state of health and wellbeing in northern lower Michigan, specifically within the McLaren Central Michigan's service area, including Clare and Isabella counties
- Describe the processes used to collect community perspectives
- Describe the process for prioritizing key issues
- 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. The aim is to leverage resources and reduce duplication while still addressing unique local needs for high quality, comparable county-level data. The MiThrive Community Health Needs Assessment utilized three regions: Northwest, Northeast, and North Central, shown in detail in map below. There are several advantages to a regional approach, including leveraging collective wisdom across the region, strengthening partnerships, maximizing

resources, producing high-quality county level data that is comparable across the region, better understanding local and regional patterns and aligning of priorities, while reducing duplication of effort.



The service area for **McLaren Central Michigan includes Clare and Isabella Counties**. Clare and Isabella counties are included in the MiThrive North Central Region. The North Central Region also consists of Arenac, Clare, Gladwin, Isabella, Lake, Mason, Mecosta, Newaygo, Oceana, Osceola counties.

Data Collection

The findings detailed throughout this report are based on data collected through a variety of primary and secondary data collection methods. Throughout the data collection process the focus was on engaging residents and diverse community partners. To accurately identify, understand, and prioritize issues, MiThrive combined quantitative data, such as the number of people affected and differences over time, and qualitative data, such as community input, perspectives, and experiences. This approach is best practice, providing a complete view of health and quality of life while assuring results are driven by the community.

MiThrive utilizes the MAPP Community Health Needs Assessment framework. Considered the "gold standard", it consists of three phases and includes three multi-faceted assessments for a 360-degree view of the community.

Community Status Assessment (CSA): Collects and analyzes quantitative data from trusted sources to assess the status of communities, particularly focusing on populations experiencing inequities. The MiThrive CSA consists of secondary indicators collected in addition to a community survey.

Community Context Assessment (CCA): Utilizes qualitative methods to explore community strengths, lived experiences, and external factors influencing change. It gathers non-numerical data, such as audio, photos, and text, to provide deeper insights into the unique aspects of the community. The CCA helps fill data gaps and contextualizes issues through the perspectives of those with lived experience, ensuring a more comprehensive understanding of community dynamics. The MiThrive CCA consisted of photovoice, asset maps, and quotes collected from residents.

Community Partner Assessment (CPA): Provides a framework for community partners to critically examine their individual systems, processes, and capacities, as well as their collective ability to address health inequities. It helps organizations identify both current efforts and future strategies to drive systemic and structural change. By fostering collaboration, the CPA strengthens the network of community partners working toward health equity. The MiThrive CPA consisted of a community partner

Each assessment offers valuable insights, but their overall impact is significantly enhanced when the findings are analyzed together.

MiThrive Data Snapshot

63 Residents submitted 140 Photos Captured to Photovoice

3,496 Residents Completed the Community Survey

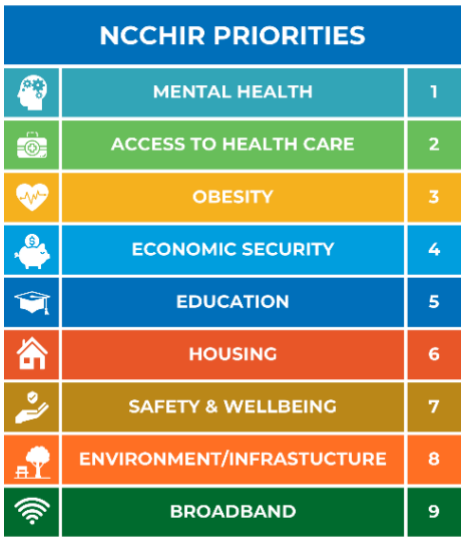
210 Secondary indicators collected for each of the 31-counties

75 Community partners participated

55 Asset Map Revisions Made

Key Findings

Analysis of primary and secondary data collected during the community health needs assessment revealed nine priorities issues in the North Central Region. In December 2024, 60 residents and community partners participated in the MiThrive North Central Data Walk and Priority Setting Event. Using a criteria-based process that included severity, magnitude, impact, sustainability, achievability and health equity, participants ranked the priorities by region. The region decided to concentrate efforts on the top three priorities while acknowledging the importance of the others.



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

- **Mental Health**
- **Access to Healthcare**
- **Obesity**

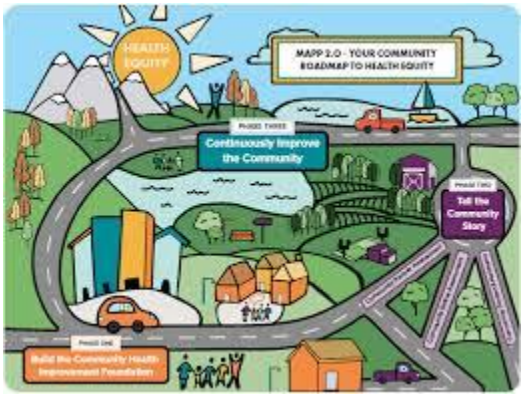
Introduction

Purpose of a Community Health Needs Assessment:

According to the National Association of City and County Health Officials, Community Health Needs Assessments (CHNAs) provide information for problem and asset identification as well as policy formulation, implementation, and evaluation. CHNAs should be part of an ongoing broader community health improvement process. A community health improvement process uses CHNA data to identify priority issues, develop and implement strategies for action, and establish accountability to ensure measurable health improvement. A community health improvement process looks outside of the performance of an individual organization serving a specific segment of a community to the way in which the activities of many organizations contribute to the overall health and wellbeing of the community residents and community health improvement.

Mobilizing for Action through Planning and Partnerships (MAPP)

MiThrive utilizes the Mobilizing for Action through Planning and Partnership community health needs assessment framework. It is a nationally recognized, best practice framework that was developed by the National Association of City and County Health Officials and the U.S. Centers for Disease Control. The goal of MAPP is to achieve health equity by identifying urgent health issues in a community and aligning community resources. MAPP defines **health equity** as the assurance of the conditions to achieve optimal health for all people. The MAPP framework provides an opportunity to strategically work toward a community-owned vision through collective action organized under one umbrella.



MAPP PHASE 1: Build the Community Health Improvement Foundation includes activities that build commitment, encourages participants as active partners, uses participants' time well, and results in a CHNA 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 a CHNA.

MAPP PHASE 2: Tell the Community Story emphasizes the need for a complete, accurate, and timely understanding of community health and wellbeing across all sub-populations within the community. This phase gathers data from the community for the CHNA by conducting three different assessments.

Community Status Assessment (CSA): Collects quantitative data on the status of communities from trusted local, state, and national sources (secondary data). The CSA explores data about populations experiencing inequities and describes complex issues that impact the community. It uses numerical data to identify patterns and averages, test hypotheses, and generalize results to wider populations. The

CSA helps a community move upstream and identify inequities beyond health behaviors & outcomes, including their association with social determinants of health and root causes.

The MiThrive CSA consisted of a community survey with a provider survey and open-ended questions as well as the secondary data collected and released in fall 2024 through the virtual MiThrive Data Platform and a Data Blob.

Community Context Assessment (CCA): Is a qualitative data tool to assess and collect data through three domains: community strengths and assets, built environment, and forces of change. The CCA explores the strengths, lived experience, and forces of change in the community using qualitative methods. It provides a process of collecting and analyzing non-numerical data (such as audio, video, or text) to understand experiences, concepts, or opinions. It is conducted to fill gaps in the data and explore the context of the community through the lens of people with lived experience.

The MiThrive CCA consisted of photovoice, asset maps and quotes collected from residents.

Community Partner Assessment (CPA): Provides a structure for community partners to look critically at their individual systems, processes, and capacities; and collective capacity as a network of community partners to address health inequities. The CPA identifies current and future actions to address health inequity at individual, systemic, and structural levels.

The MiThrive CPA consisted of a Community Partner Survey and two live virtual events.

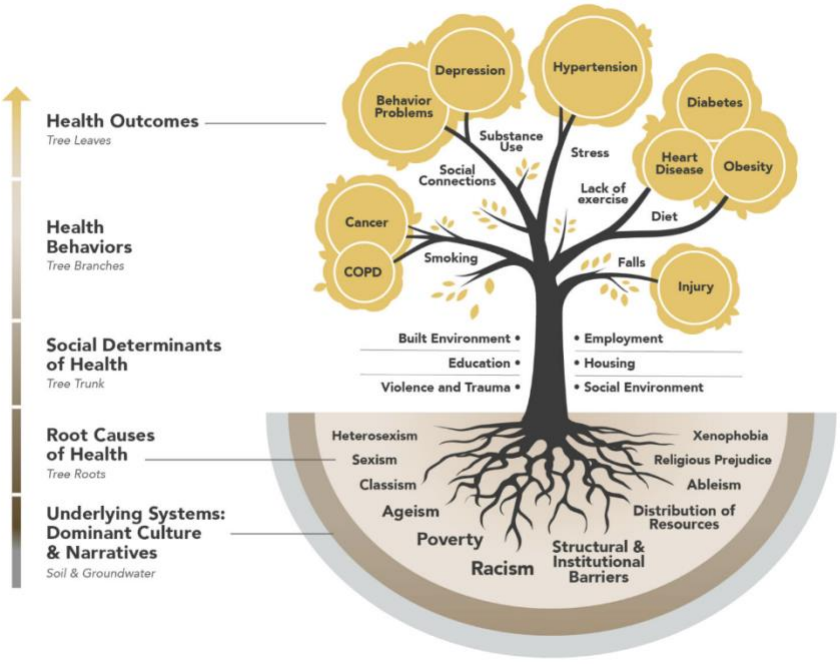
MAPP PHASE 3: Continuously Improve the Community involves prioritizing issues using CHNA results, creating issue briefs, and collaboratively prioritizing key issues to be targeted in a Community Health Improvement Plan or Implementation Strategy. MiThrive is committed to strengthening regional data capacity to drive community improvement efforts and enhance accountability. With generous support from the funding partners, MiThrive has secured a contract with Conduent Healthy Communities Institute to provide a data management and visualization platform for MiThrive data. The MiThrive Data Platform provides a one-stop resource for online access to community health indicators and related resources that impact the health of northern lower Michigan. Users can explore up-to-date demographic, health, and social determinants data, along with hundreds of maps, tables, figures, and capacity-building resources. This powerful tool is available to everyone on the MiThrive website without account, membership, or paywall requirement barriers. Whether using data for grant proposals, workplans, advocacy materials, business plans, or data storytelling, this platform provides valuable insights. Questions regarding the MiThrive Data Platform can be directed to: mithrive@northernmichiganchir.org

Health Equity

According to MAPP, Health Equity is the assurance of conditions to achieve optimal health for all people. Optimal health includes physical, mental and social, cultural, and spiritual wellbeing, beyond the lack of disease or infirmity. Optimal health is essential for people to reach their full capacity. In addition to disease, health is influenced by education level, economic status, and other complex issues. No one individual, community group, hospital, organization, or governmental agency can be responsible for the health of the community. No one organization can address complex community issues alone. However, collaborative action allows communities to identify assets and barriers, develop strategies, and implement solutions. In the pursuit of equitable health outcomes, new tools and approaches continue to emerge to support effective community-driven change.

The **Health EquiTREE**—developed by Health Resources in Action for the Massachusetts Community Health and Healthy Aging Funds—illustrates the relationships between health outcomes, social determinants of health and root causes. The **visible parts of the tree** represent observable health factors:

- **Leaves** symbolize **health outcomes**,
- **Branches** represent **individual and community behaviors**,
- **The trunk** signifies **social determinants of health** like housing, education, and income.



However, the **critical forces shaping health lie beneath the surface**:

- **The roots** reflect **deep-seated causes** of health disparities, such as systemic inequities and historical injustices,
- **The soil** represents **underlying systems, dominant narratives, and cultural frameworks** that either sustain or hinder health progress.

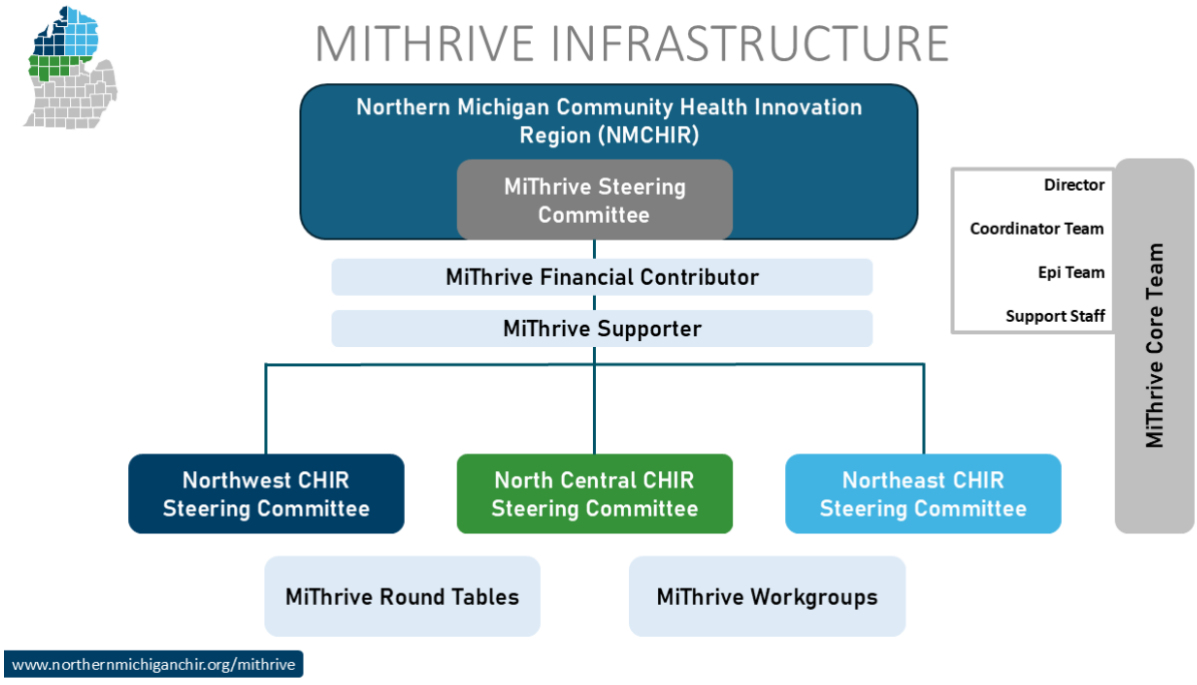
Phase 1: Building the Community Health Improvement Foundation

MiThrive is conducted on a three-year cycle; hospital systems, local health departments, community-based organizations, residents, coalitions and collaboratives, businesses, academic institutions, and elected officials come together to collaborate on a shared Community Health Needs Assessment (CHNA) and collaborate for community health improvement.

During phase 1, funding agreements with local health departments and hospitals were executed, the MiThrive Steering Committee, MiThrive Workgroups/Round Tables were organized, and the Core Team was assembled. Strategic partnerships were cultivated with both new and existing collaborators, with a particular focus on including community members and organizations that represent or serve populations facing health inequities. As the infrastructure and partnerships took shape, guided by clear expectations and timelines, the shared Vision was affirmed, Healthy People in Equity Communities.

Shared Vision Video

MiThrive takes a regional approach to leverage collective wisdom, strengthen partnerships, maximize resources, produce high-quality data that is comparable, understand local and regional patterns and align priorities and strategies. The MiThrive infrastructure supports effective and efficient collaboration.



Group	Description	Activities & Time Commitment	Expertise & Skills
MiThrive Supporter	Community members and organizations are invited to participate, provides input throughout MAPP, stay informed about status	Stays informed, subscribes to newsletter, share and participate in assessments, host event(s)	Invite community widely to participate, prioritizes creating opportunities for communities experiencing inequalities to contribute, has/values trusted partnerships
Region MiThrive WG/Round table	Provides local context and connection to MiThrive	Co-developed by group based on local assets, opportunities, needs, challenges	Amplifies communication, connections and alignment with local efforts
MiThrive Steering Committee Member	Gives MAPP process direction, represents communities' population and organizations, includes people with resources, community members, people from various parts of the local public health system	Provides input and feedback on major steps on MAPP, meets regularly (monthly), one voting member per organization	Maintains positive relationships with community members, represents local public health system and community, understands community needs and strengths
MiThrive Financial Contributor	Financially supports MiThrive CHNA, data platform, accessibility and engagement efforts	Provides funds for an element of MiThrive or the broad initiative	Funder, connections with funders, fundraising, grant writing
MiThrive Core Team	Project staff	Develops and implements assessments, CHNA, writes reports, facilitates groups and support prioritization	Diverse public health professional skills: epidemiology, communication, facilitation and project management
Northern Michigan Public Health Alliance	Serves as the Backbone Orgnaiztioan to the NMCHIR and MiThrive	Provides staffing	Local public health perspective, public health 3.0, experiences
Northern Michigan Health Consortium	Serves as the NMCHIR and MiThrive fiduciary	Financial oversight, conflicts of interest management, legal compliance, transparency and accountability	Financial management, legal, compliance, leadership skills, communication and transparency

The goal of MiThrive CHNA is to improve health outcomes by using data and collaboration to:

- **Inform Decision-Making**: More data means better insights, enabling informed decisions that address community health needs effectively.
- **Create Targeted Interventions**: More data allows for a focused approach around specific health issues and developing targeted interventions that make a real difference.
- **Allocate Resources**: Increased data allows for informed resource allocation, ensuring that funding and services are directed where they're needed most. Comprehensive data sets make initiatives more attractive to funders, opening doors for new resources.
- **Address Inequities**: More data helps us uncover and address health inequities, ensuring that all community members receive the support they need.
- **Empower Advocacy**: With robust data, we can advocate more effectively for policies and resources that benefit our community.
- **Benchmark Progress**: Data allows for a benchmark progress over time, celebrating successes and identifying areas for improvement.

MiThrive Explainer Video

Phase 2: Telling the Community Story

During Phase 2, each of the assessments were conducted with support from all MiThrive partners and residents. The MiThrive Core Team instituted a schedule that would have all the individual portions of the CHNA completed during the 2024 calendar year. This was done using MAPP 2.0 as a framework for all planned assessments, and with input and decisions from the MiThrive Steering Committee. Care was taken to ensure that each assessment was crafted with engagement opportunities for partner organizations and community members. Each of the assessments collected different types of data for the community: primary and secondary, qualitative data of health indicators and community sentiments, quantitative data reflecting resident viewpoints, and data regarding the capacity and shared goals of community partner organizations.

Community Status Assessment (CSA)

The Community Status Assessment identifies priority community health and quality of life issues. It answers the following questions:

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

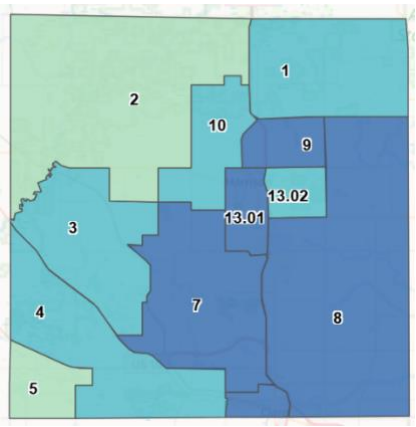
The answers to these questions were measured by collecting more than 200 indicators from a variety of secondary sources onto the MiThrive Data Platform, as well as primary data collected through the 2024 community survey and provider survey.

The MiThrive Core Team assured secondary data included measures of social and economic inequity, including: Asset-Limited, Income-Constrained, Employed (ALICE) households; children living below the Federal Poverty Level; families living below the Federal Poverty Level; households living below Federal Poverty Level; population living below Federal Poverty Level; gross rent equal to or above 35 percent of household income; high school graduation rate; income inequality; median household income; median value of owner-occupied homes, political participation; renters (percent of all occupied homes); and unemployment rate.

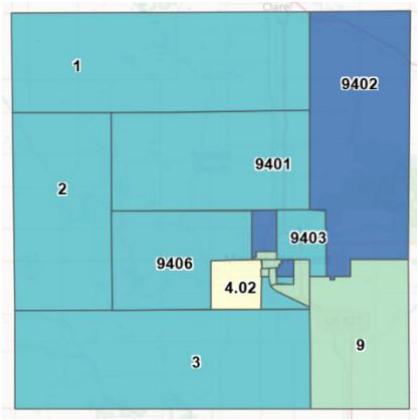
The Social Vulnerability Index illustrates how where we live influences health and well-being. It ranks social factors such as income below Federal Poverty Level; unemployment rate; income; no high school diploma; aged 65 or older; aged 17 or younger; older than five with a disability; single parent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

As illustrated in the map on the next page, Census Tracts in the Clare and Isabella counties have Social Vulnerability Indices at “high” or “moderate to high”, with the exception of the northwest corner of Clare County and south side of Isabella County.

Social Vulnerability Index by Census Tract in Clare and Isabella Counties.



Clare County



Isabella

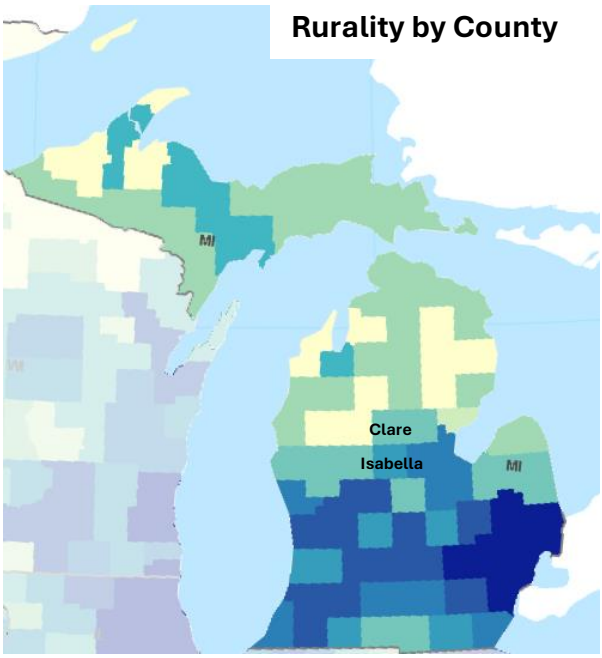
Source: Michigan Lighthouse 2022, Centers for Disease Control and Prevention/ Agency for Toxic Substances and Disease Registry/ Geospatial Research, Analysis, and Services Program. CDC Social Vulnerability Index 2018 Database - Michigan..

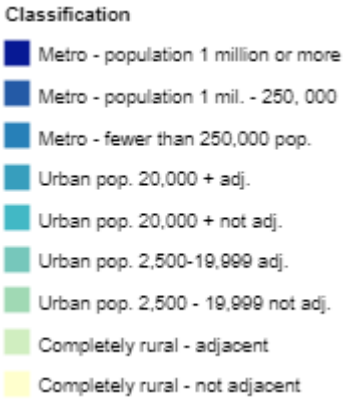
Geography and Demographics

The service area for McLaren Central Michigan is Clare and Isabella Counties. The county is known for its clean environment and abundant resources for outdoor recreation. Covering 1,136.07 square miles of land altogether, 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 groups in different ways, and different strategies may be more appropriate to support these diverse groups. Of the 95,584 people who live in these counties, 93.2 percent are white. The largest racial minority groups are Black or African American (3.1%), American Indian and Alaska Native (4.3%) and Some Other Race (2.9%). Additionally, the largest ethnic minority group is Hispanic and Latino; Clare (2.4%), and Isabella (5.2%).

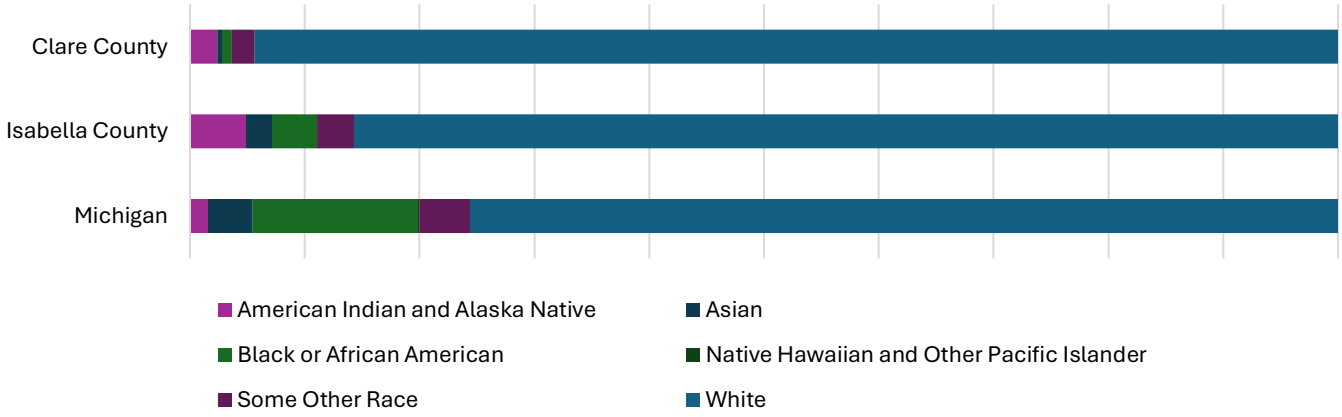
Rurality by County





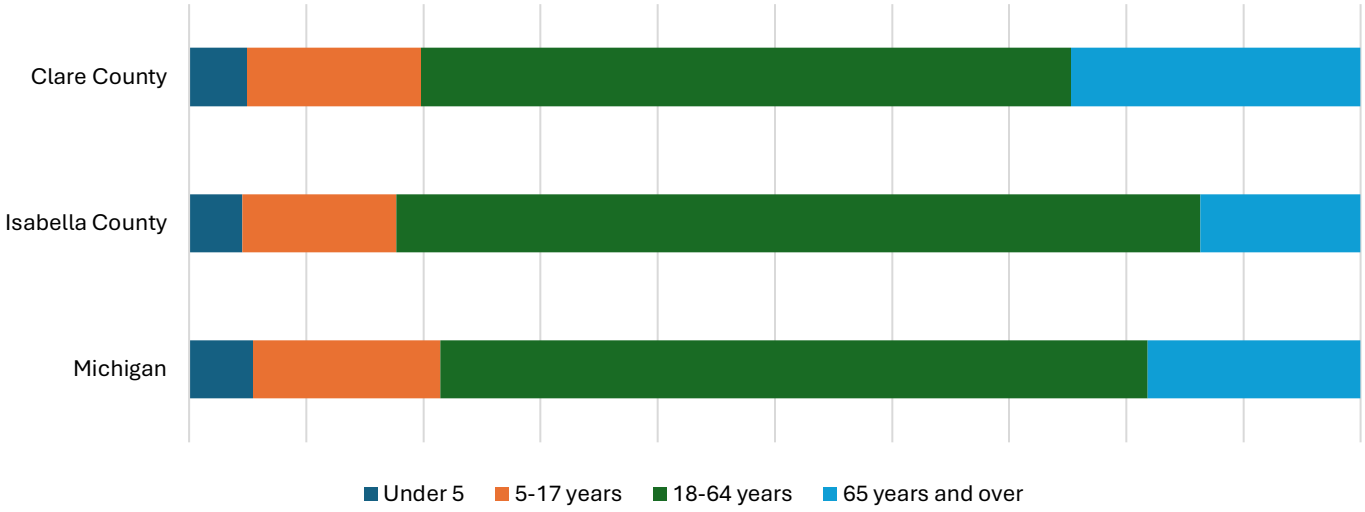
Source: 2013, Rural-urban Continuum Code, Economic Research Service U.S. Department of Agriculture

Population by Race for the McLaren Central Michigan Service Area, United States Census Bureau, 2019-2023



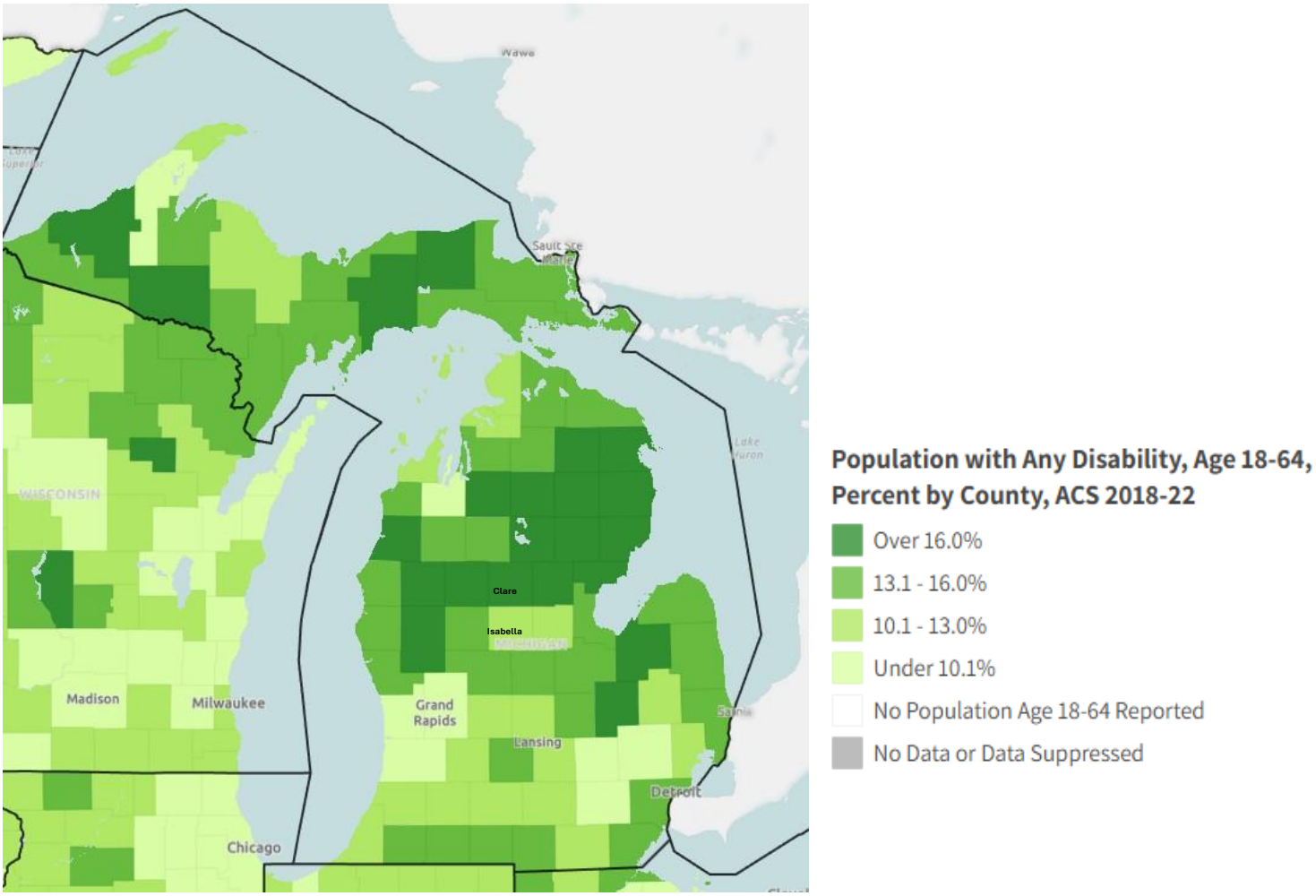
Clare and Isabella Counties have a lower proportion of racial minority groups (12.1%) than Michigan (26%).

Percentage of Population by Age Group for the McLaren Central Michigan Service Area, United States Census Bureau, 2019-2023



Clare County (24.7%) have higher proportions of adults over the age of 65 than Michigan overall (19.2%). Isabella County has 13.7% of adults over the age of 65.

Percentage of Population with Any Disability, Age 18-64
United States Census Bureau, 2018-2022

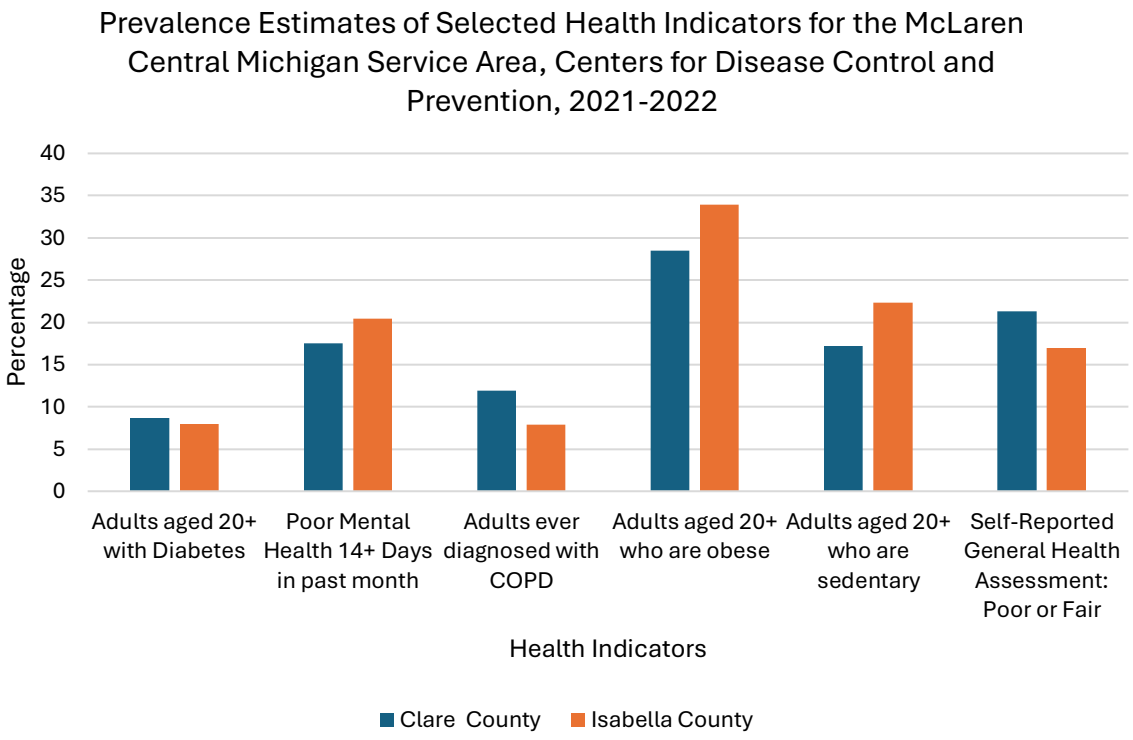


Source: United States Census Bureau, 2018-2022

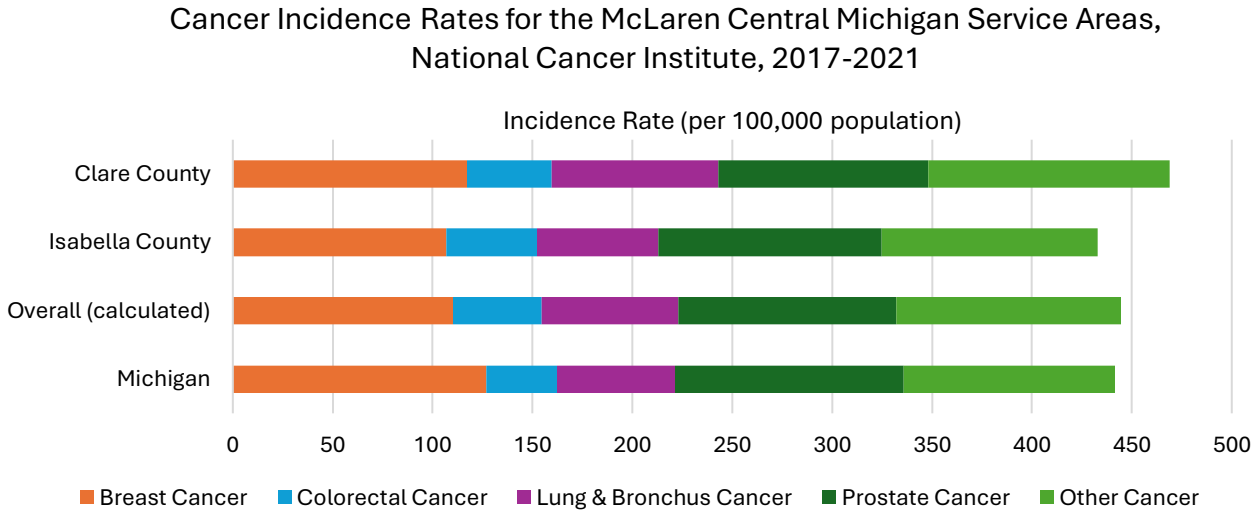
Notes: The U.S. Census Bureau has updated the data for individuals with disabilities to 2019-2023 estimates. However, the visualization data is only available for 2018-2022 data.

A greater proportion of people, 14.0%, of the people in the region have a disability compared to the State (10.3%).

Selected Morbidity and Mortality Indicators for the McLaren Central Michigan Service Area

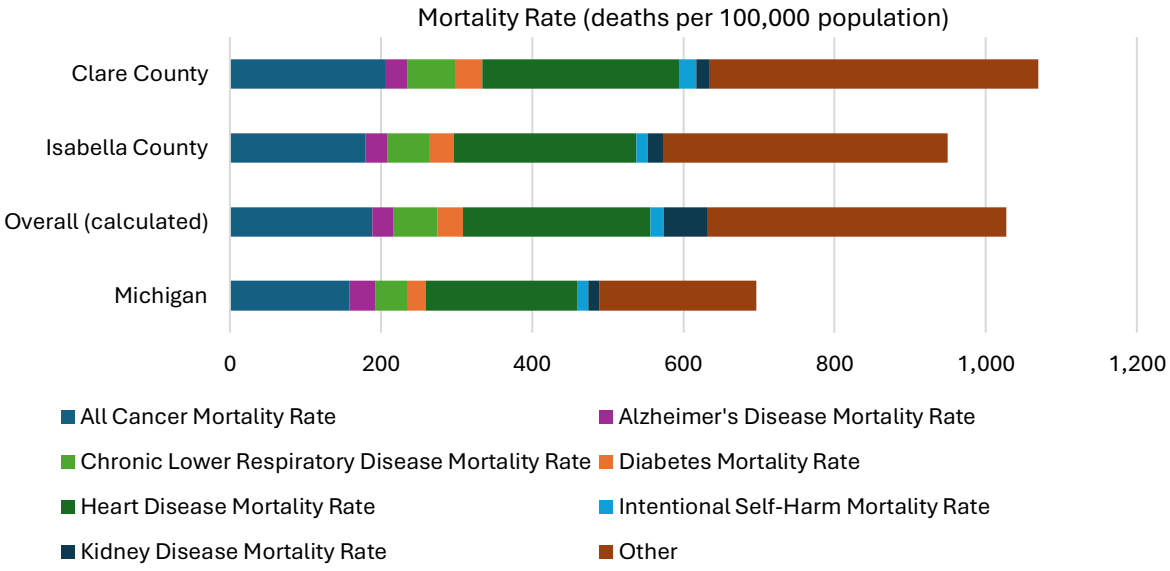


Notes: 'Poor Mental Health 14+ Days in past month' indicates the percentage of adults who stated that their mental health was not good 14 or more days in the past month, 2022.
'Adults ever diagnosed with COPD' shows the percentage of adults who have ever been diagnosed with Chronic Obstructive Pulmonary Disease (COPD), emphysema, or chronic bronchitis, 2022.
'Adults aged 20+ who are obese' shows the percentage of adults 20 and older who are obese using the Body Mass Index (BMI) value >=30, 2021.
'Adults aged 20+ who are sedentary' shows the percentage of adults who did not participate in any leisure-time activities (physical activities other than their regular job) during the past month, 2021. 'Self-Reported General Health Assessment: Poor or Fair' shows the percentage of adults who answered poor or fair to : "How is your general health?", 2022.

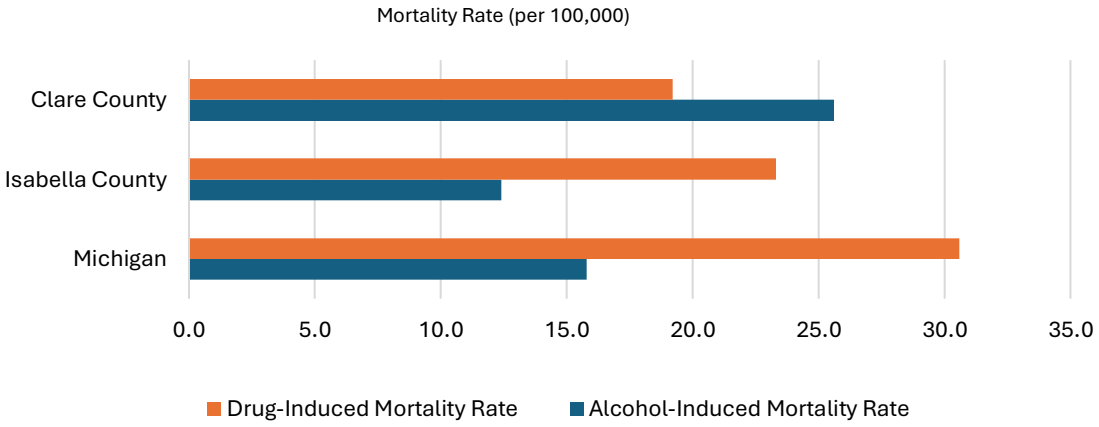


Note: Incidence rates (cases per 100,000 population per year) are age-adjusted to the 2000 US standard population (19 age groups: <1, 1-4, 5-9, ..., 80-84, 85+). Rates are for invasive cancer only (except for bladder cancer which is invasive and in situ) or unless otherwise specified. Rates calculated using SEER*Stat. Population counts for denominators are based on Census populations as modified by NCI. The US population Data File is used for SEER and NPCR incidence rates.
Data not available for some combinations of geography, cancer site, age, and race/ethnicity.
Suppression is used to avoid misinterpretation when rates are unstable.

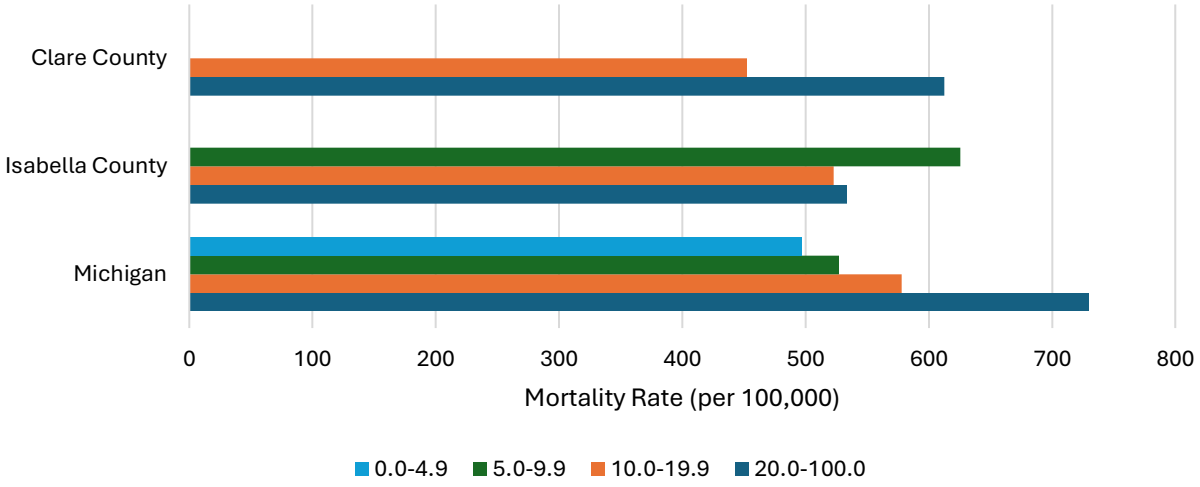
Selected Mortality Rates as a Proportion of Total Mortality Rate for the the McLaren Central Michigan Service Area, MDHHS Vital Statistics, 2018 -2022



Substance Use Associated Mortality Rates for the McLaren Central Michigan Service Area, MDHHS Mortality Statistics, 2022

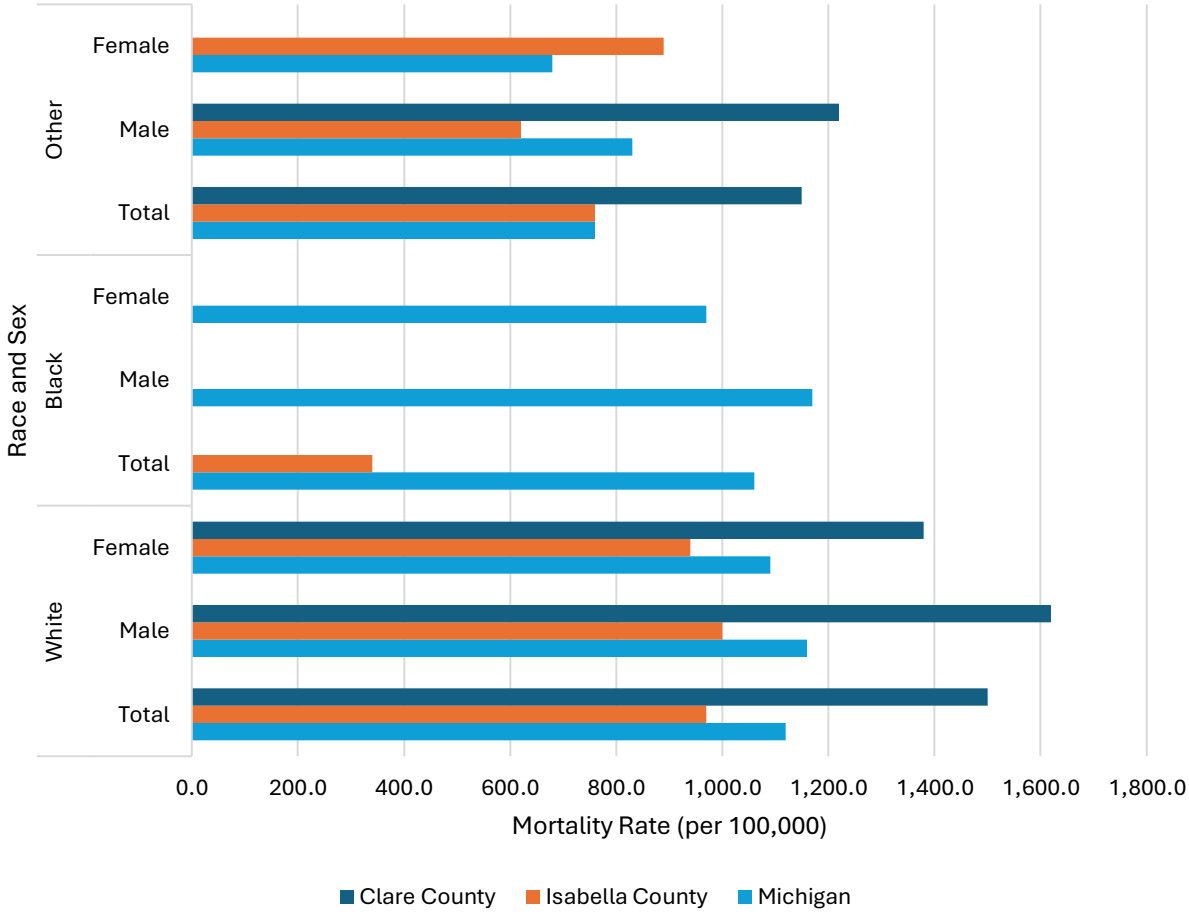


Age-Adjusted Mortality Rates by Poverty Level for the McLaren Central Michigan Service Area, MDHHS Mortality and Poverty Statistics, 2020



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 US Census reports. Age-adjustment was performed using the standardized population from the United States Census, 2000.

Mortality Rates by Race and Sex for the McLaren Central Michigan Service Area, MDHHS Vital Statistics, 2023



Community Survey

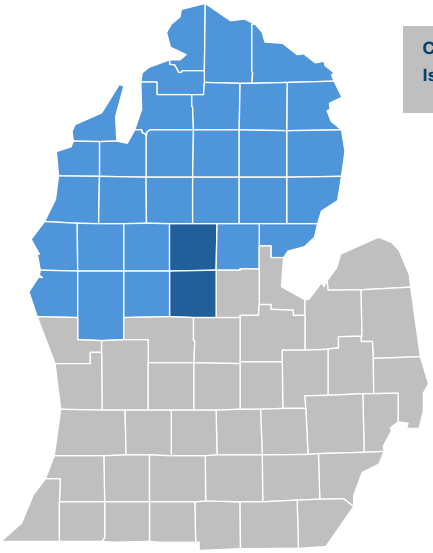
The 2024 Northern Michigan Community Health Survey asked 26 questions, including those geared towards determining what is important to the community, what factors are impacting the community, quality of life, built environment, as well as demographic questions. The survey questions intentionally look to provide a deep understanding of the issues that residents feel are significant by answering the following questions:

- What is important to our community?
- How is quality perceived in our community?
- What assets are in the community that can be used to improve well-being?

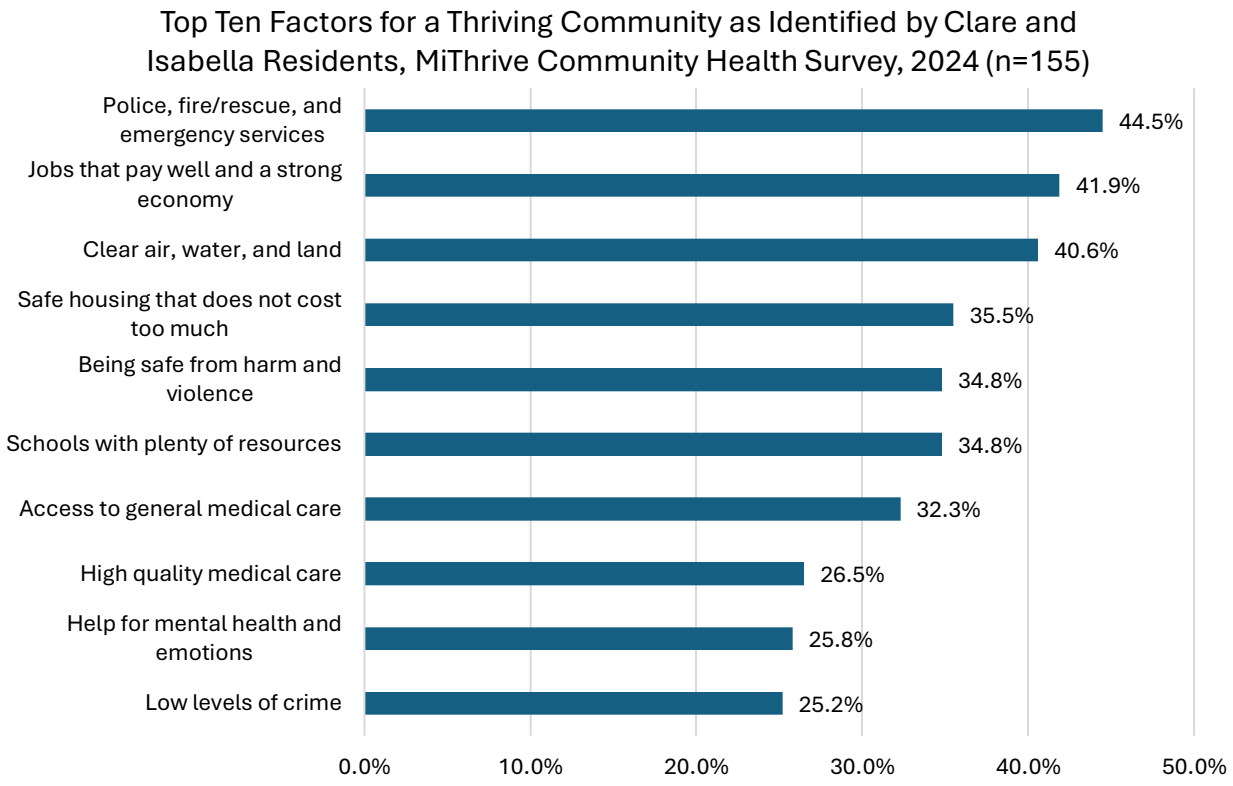
Community surveys were conducted both electronically and in paper format, available in English and Spanish. The electronic survey could be accessed via a direct link or QR code. The survey remained open from August 12, 2024 to October 6, 2024. To encourage participation, respondents who completed the survey had the opportunity to enter a drawing for a $50 gift card, with one winner selected from each of the 31 counties.

Partner organizations played a key role in promoting the survey through social media and community outreach. Promotional materials included flyers, social media content, and press releases. A total of 3,496 surveys were collected across the MiThrive Region, with 155 responses coming from Clare and Isabella Counties.

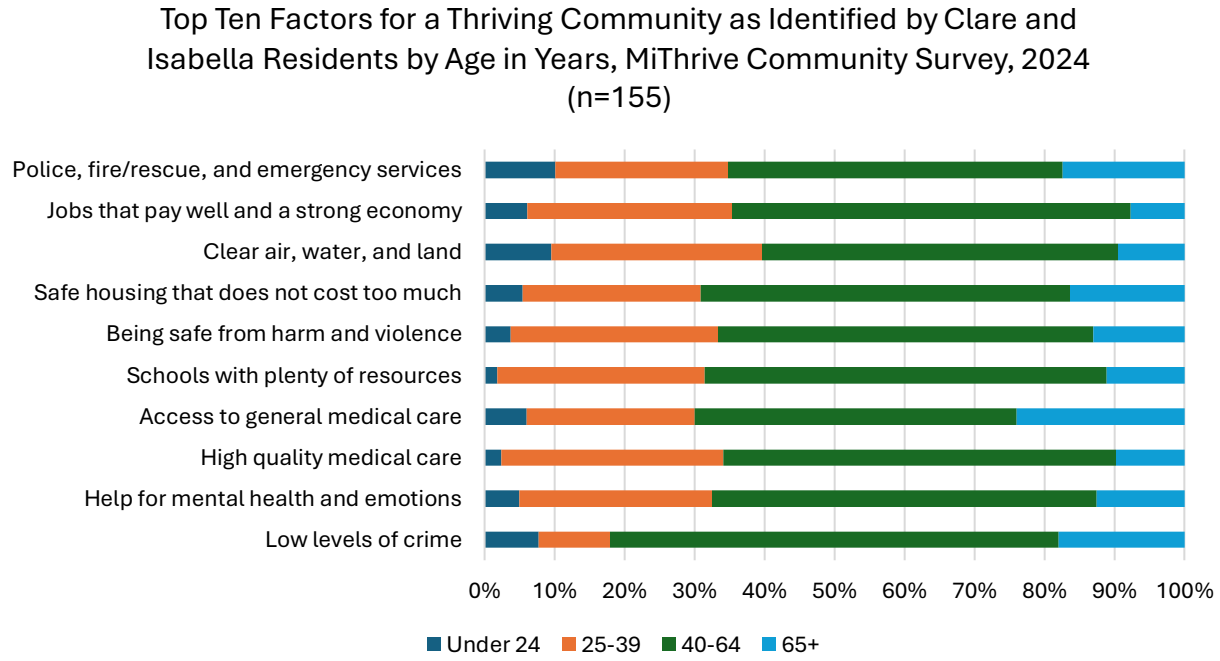
A total of **155 Community Survey** responses were collected in Clare and Isabella Counties.



Clare County = 61 Responses
Isabella County = 94 Responses

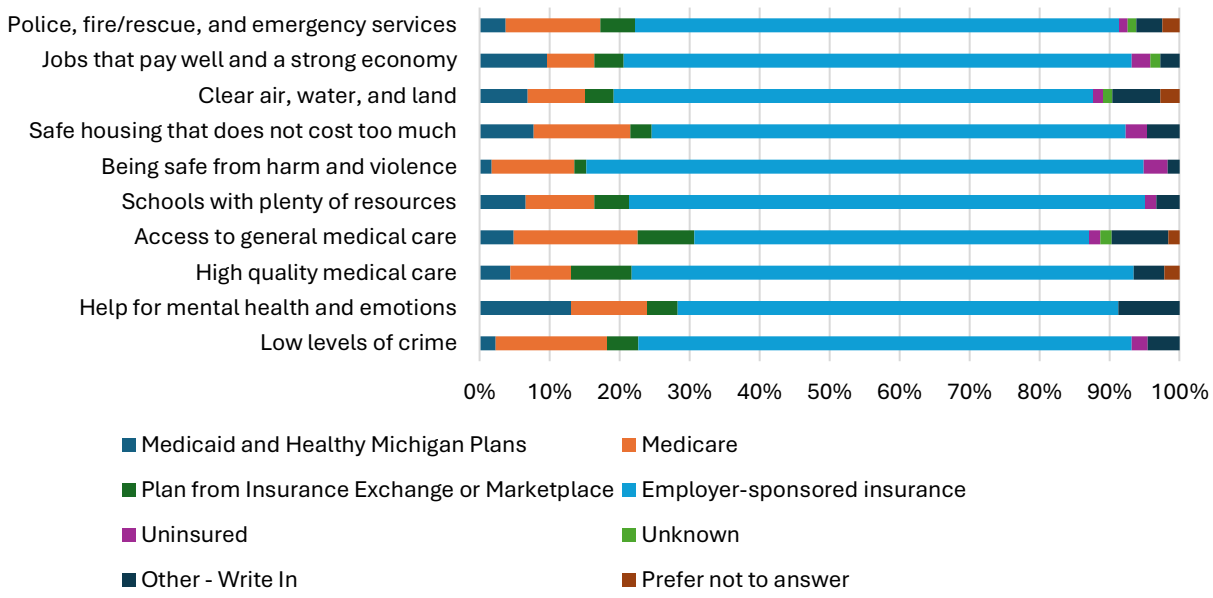


Note: This figure, "Top Ten Factors for a Thriving Community", is connected to the following four figures, each of which displays the proportionate demographic breakdown of the data above. This can help readers better understand how these groups in the community feel that they are connected to these factors.



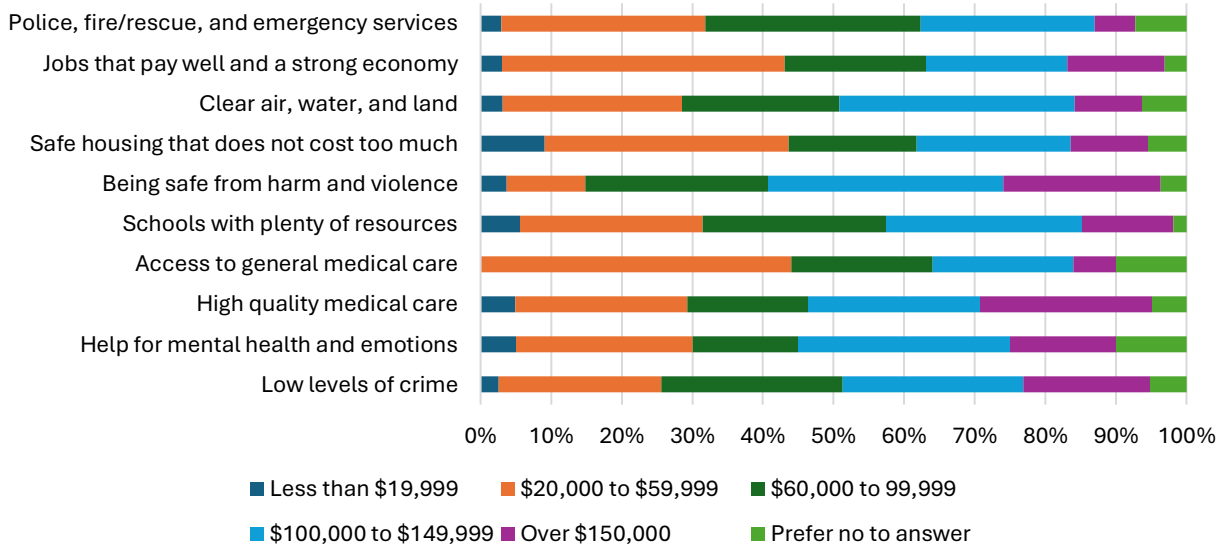
*A greater proportion of individuals between **40 and 64 years of age** responded that **jobs that pay well and a strong economy** was an important factor for a thriving community.*

Top Ten Factors for a Thriving Community as Identified by Clare and Isabella Residents by Insurance Type, MiThrive Community Survey, 2024 (n=155)



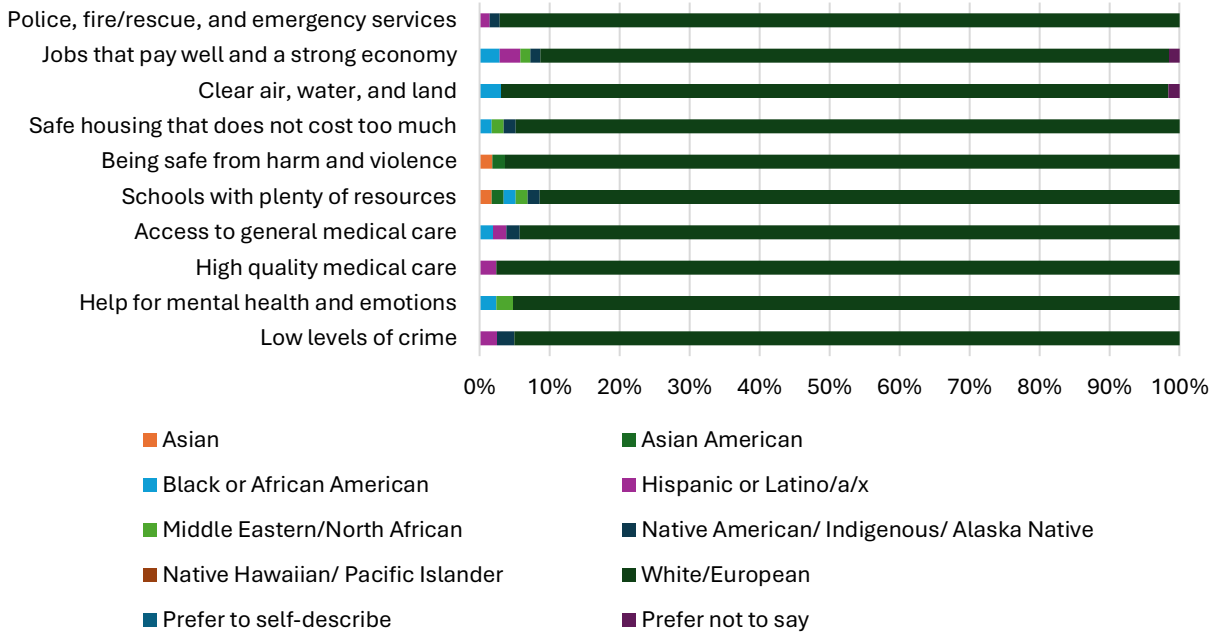
Safe housing that does not cost too much *was a more important factor for individuals making* ***under $60,000 a year****. This was also the case for the factor* ***access to general medical care****.*

Top Ten Factors for a Thriving Community as Identified by Clare and Isabella Residents by Yearly Household Income, MiThrive Community Survey, 2024 (n=155)



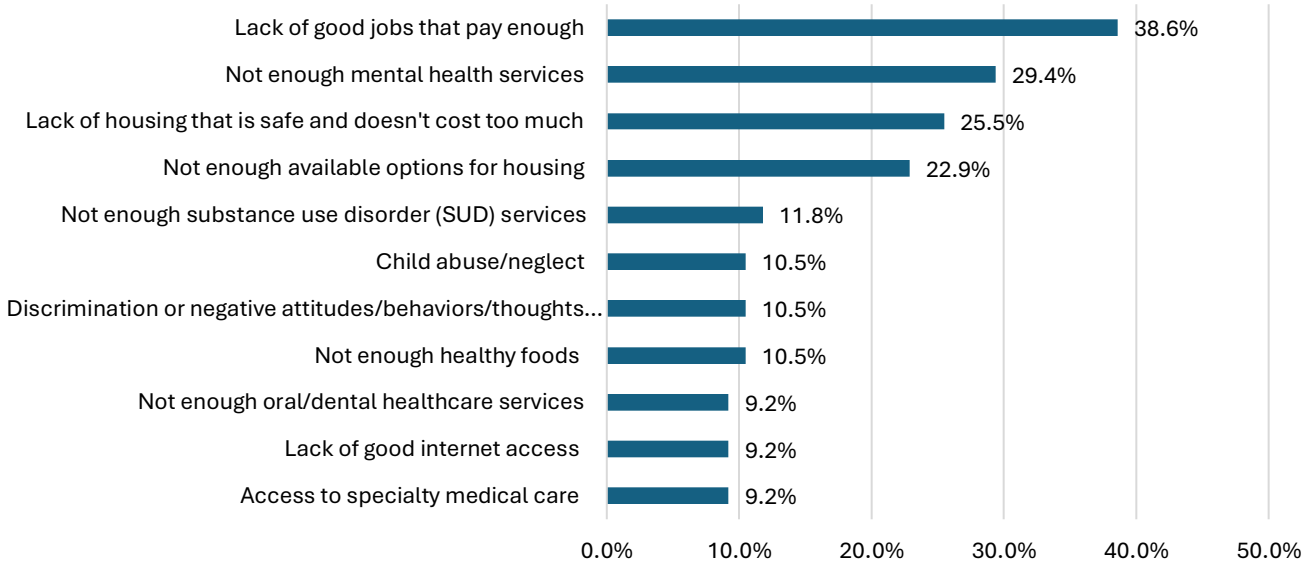
Access to general medical care *as a factor for a thriving community had a larger proportion of individuals who* ***Medicaid, Medicare,*** *or* ***insurance exchange/marketplace*** *plans compared to other factors.*

Top Ten Factors for a Thriving Community as Identified by Clare and Isabella Residents by Race and Ethnicity, MiThrive Community Survey, 2024 (n=155)



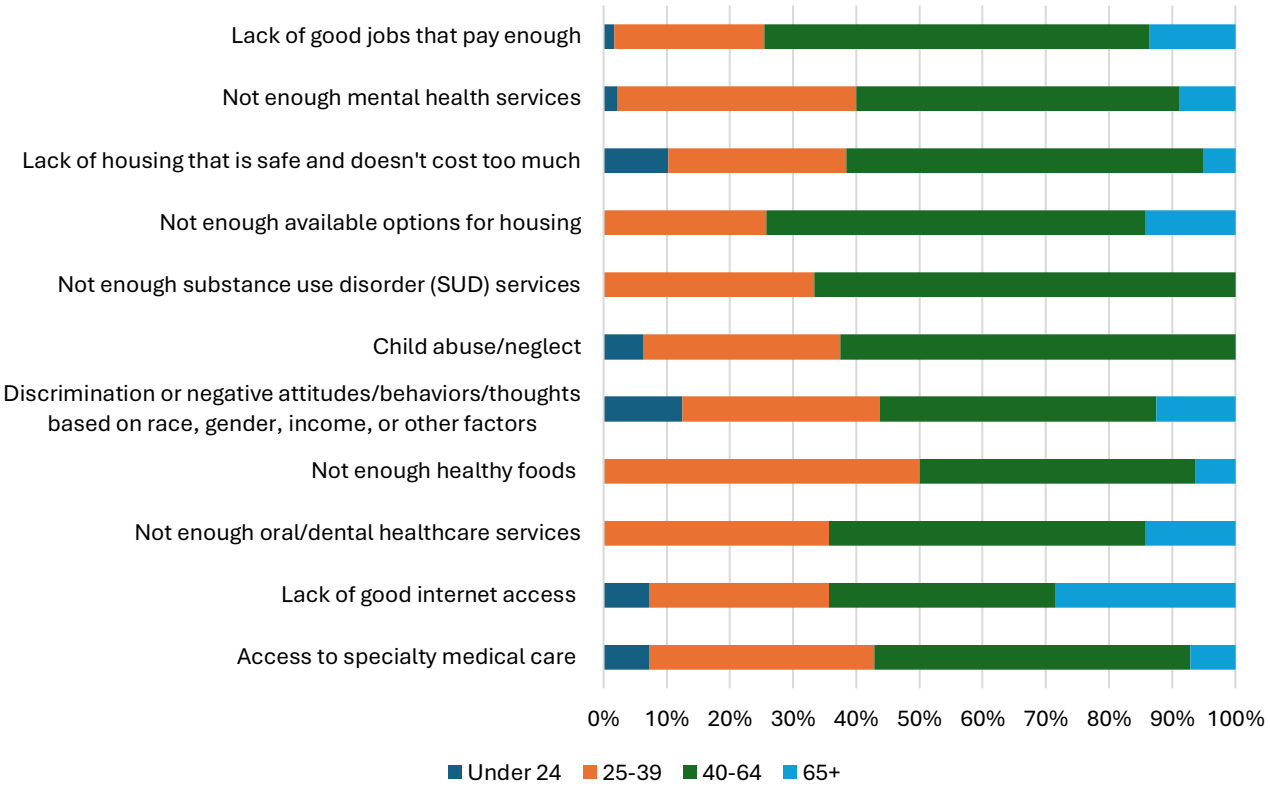
Jobs that pay well and a strong economy *was identified as an important factor for respondents who identified as part of a* ***racial or ethnic minority****. This is also true for the factor of* ***schools with plenty of resources****.*

Top Ten Issues Impacting the Community as Identified by Clare and Isabella Residents, MiThrive Community Health Survey, 2024 (n=155)



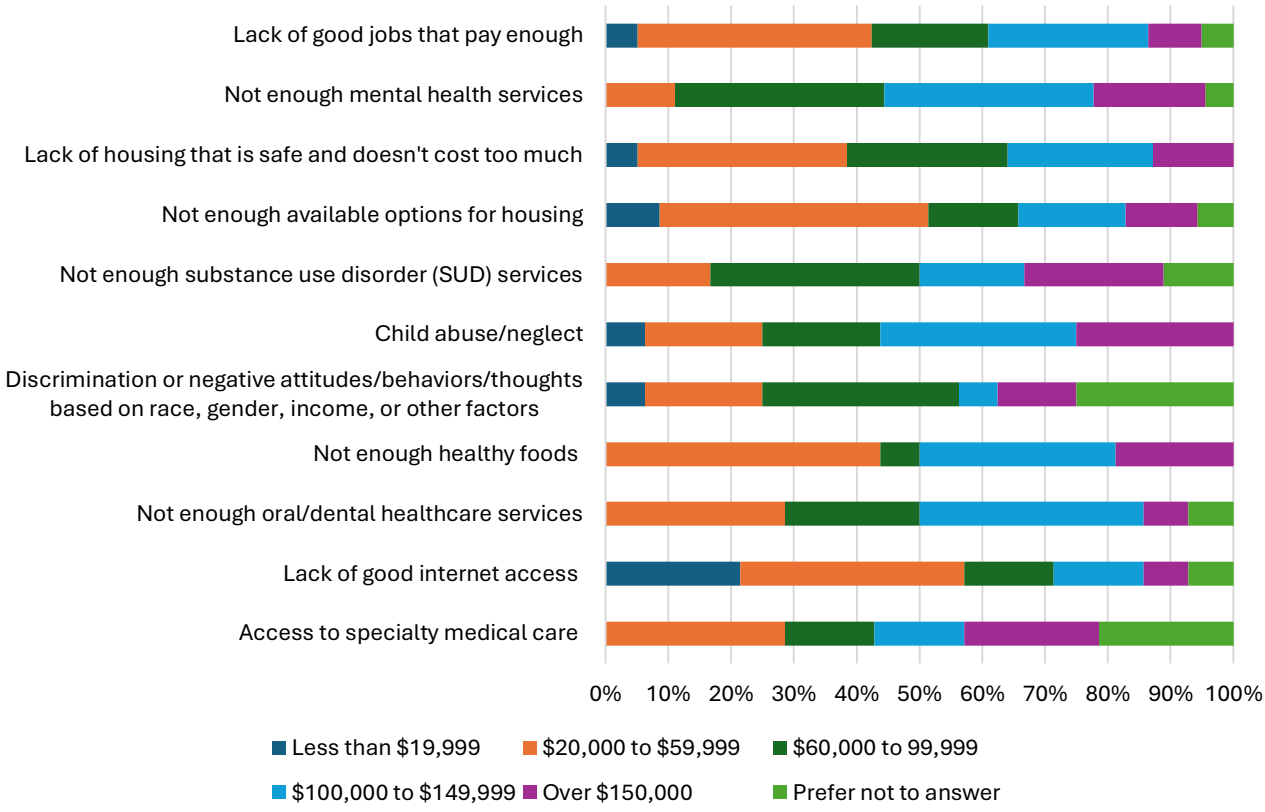
This figure, "Top Ten Issues Impacting the Community", is connected to the following four figures, each of which displays the proportionate demographic breakdown of the data above. This can help readers better understand how these groups in the community feel that they are connected to these issues.

Top Ten Issues Impacting the Thriving Community as Identified by Clare and Isabella Residents by Age in Years, MiThrive Community Survey, 2024 (n=155)



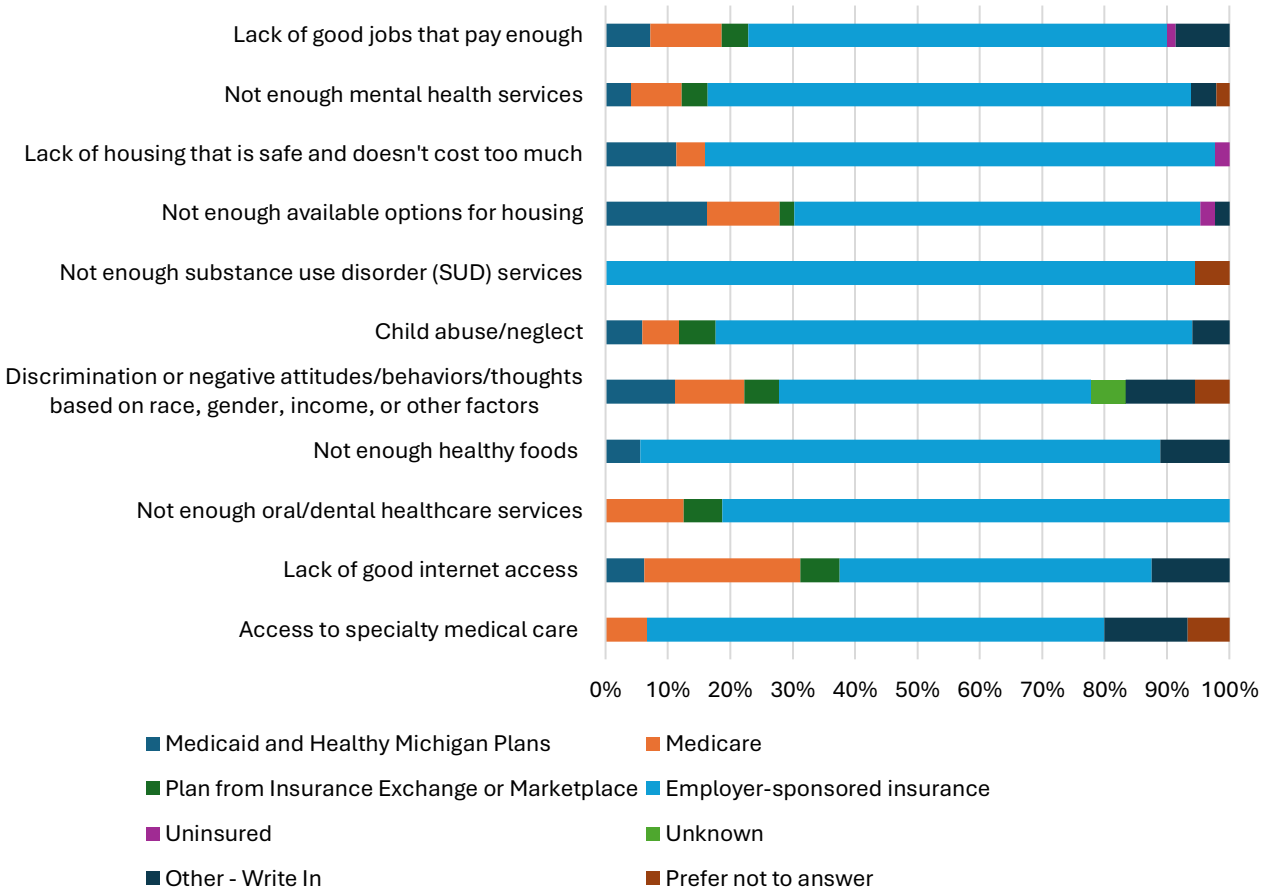
*Residents **under the age of 40** disproportionately identified lack of access or **not enough healthy foods** as a major issue in their community.*

Top Ten Issues Impacting the Community as Identified by Clare and Isabella Residents by Yearly Household Income, MiThrive Community Survey, 2024 (n=155)



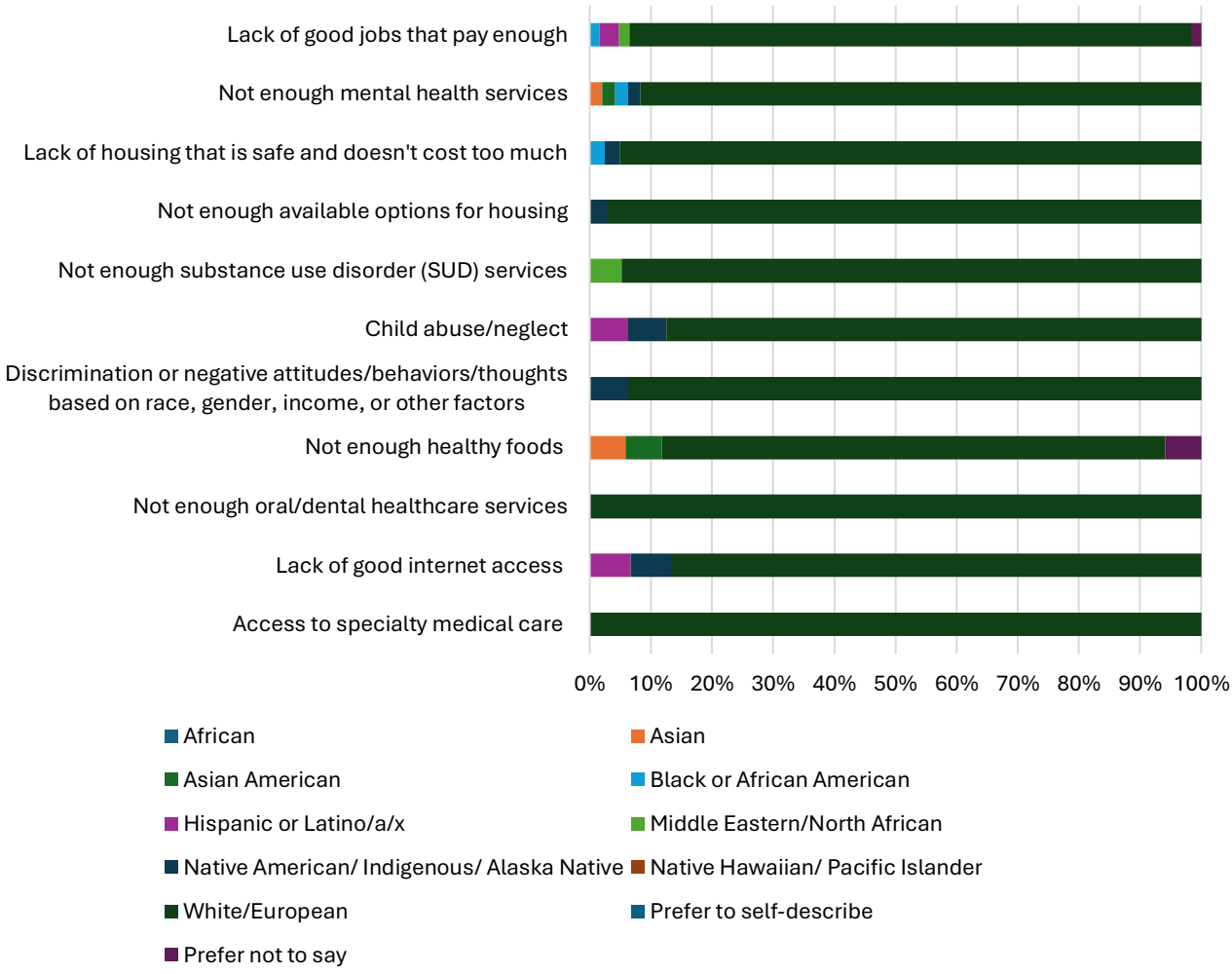
*Issues with **not enough available options for housing** and **lack of good internet access** were important issues for respondents making **less than $60,000 a year** in their household.*

Top Ten Issues Impacting the Community as Identified by Clare and Isabella Residents by Insurance Type, MiThrive Community Survey, 2024 (n=155)



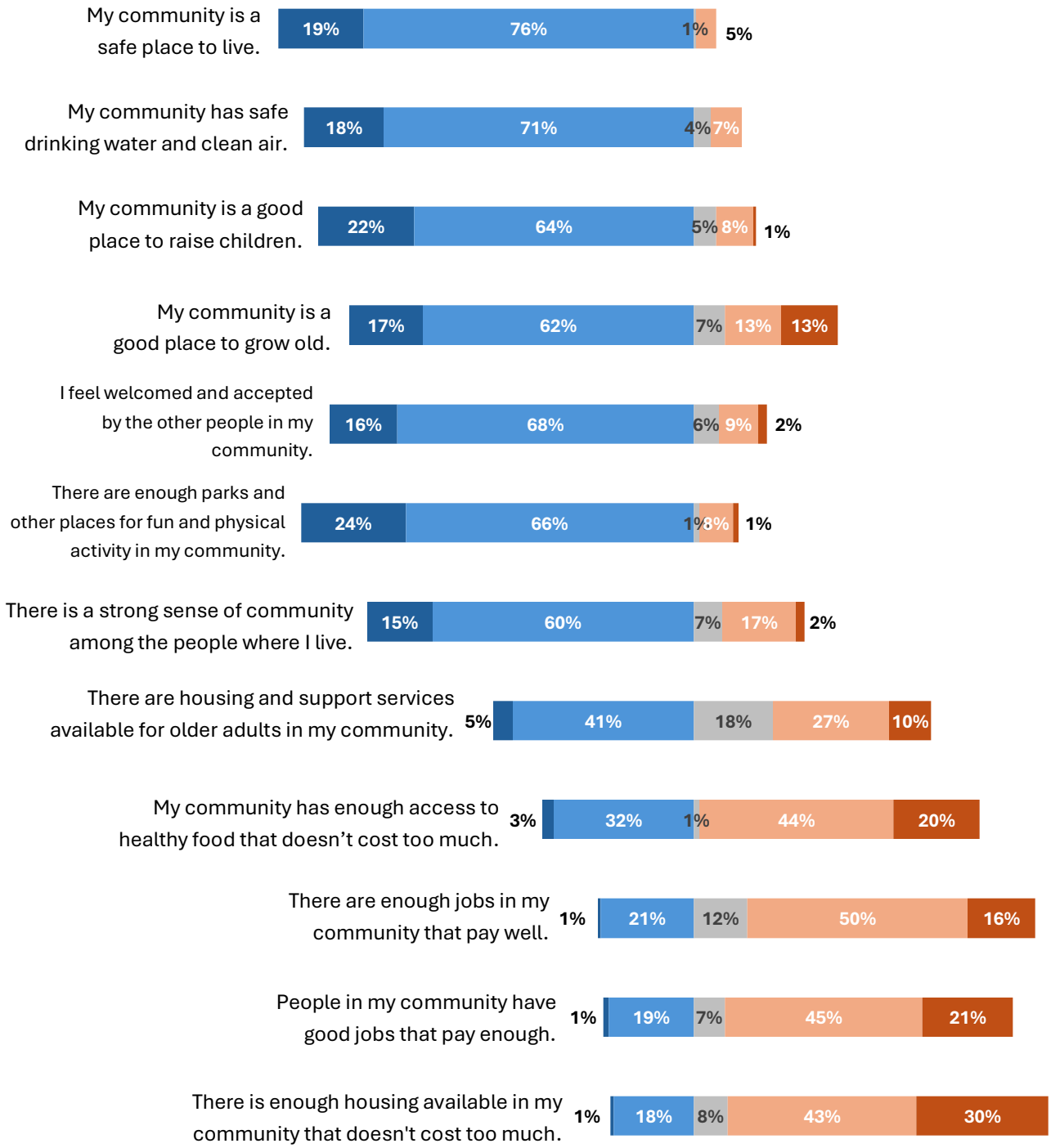
*Residents with **Medicaid, Medicare,** or **insurance plans from the exchange or marketplace** felt that a major issue in the community involved there being **not enough available options for housing**.*

Top Ten Issues Impacting the Community as Identified by Clare and Isabella Residents by Race and Ethnicity, MiThrive Community Survey, 2024 (n=155)



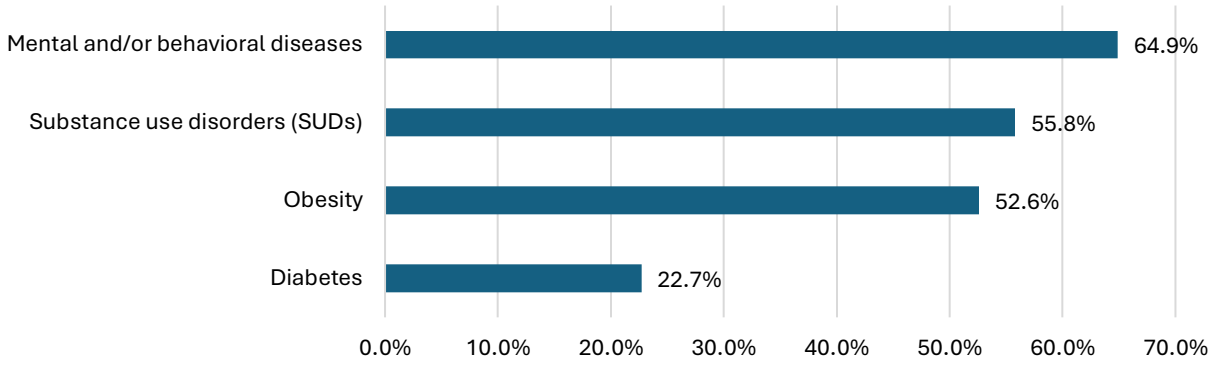
Lack of good jobs that pay enough *and* ***not enough mental health services*** *were both important issues for respondents who identified as members of a* ***racial or ethnic minority group***.

Responses to Likert Scale Questions as Identified by Clare and Isabella Residents, MiThrive Community Survey, 2024 (n=155)

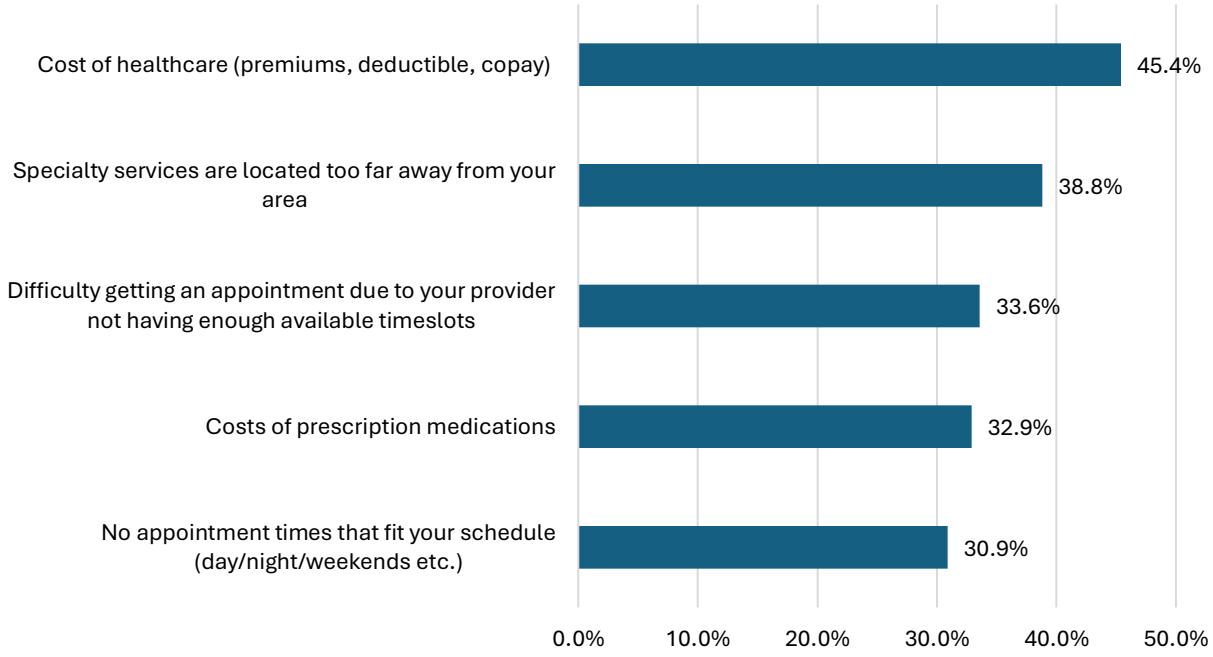


Dark blue indicates "Strongly agree" responses, light blue indicates "Agree" responses, grey represents the undecided or "I don't know" responses, light red indicates "Disagree" responses, and dark red indicates "Strongly disagree" responses. Data shows that respondents felt that their community was a safe place to live, but most also expressed that there were not enough jobs, access to healthy foods, or enough affordable housing available in the community.

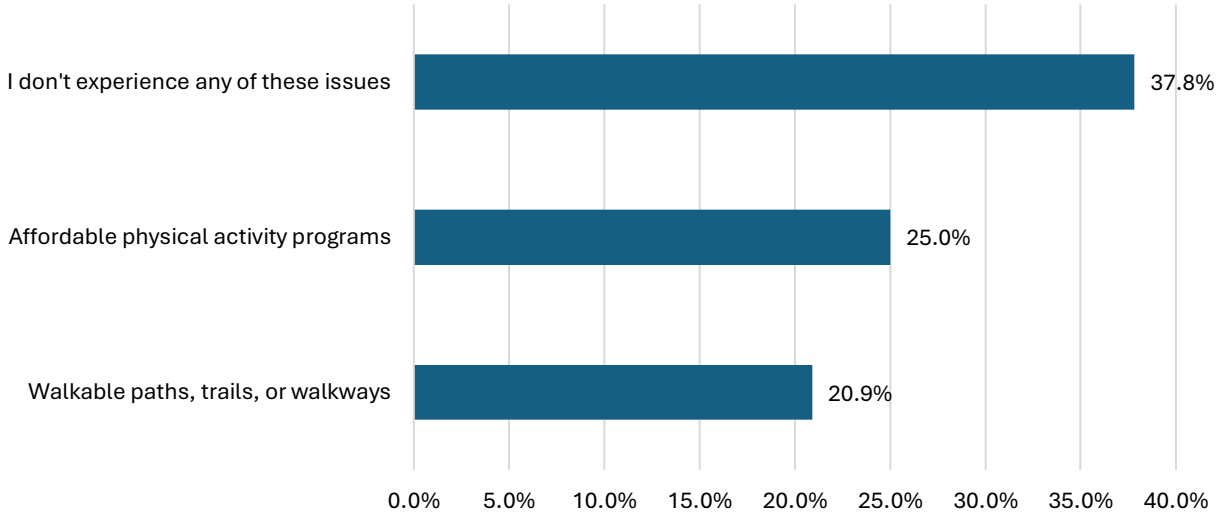
Most Concerning Medical Conditions in the Community According to Clare and Isabella Residents, MiThrive Community Survey, 2024 (n=155)



Top Identified Barriers to Healthcare Service According to Clare and Isabella Residents, MiThrive Community Survey, 2024 (n=155)



Top Issues Preventing Increased Physical Activity as Identified by Clare and Isabella Residents, MiThrive Community Survey, 2024 (n=155)

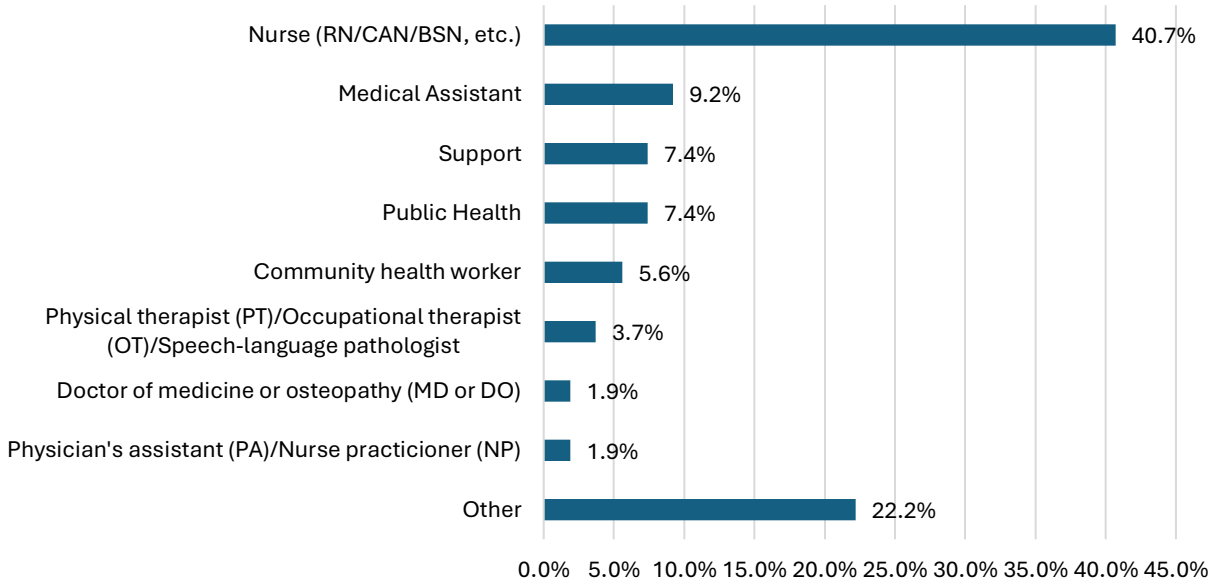


Healthcare Provider Survey

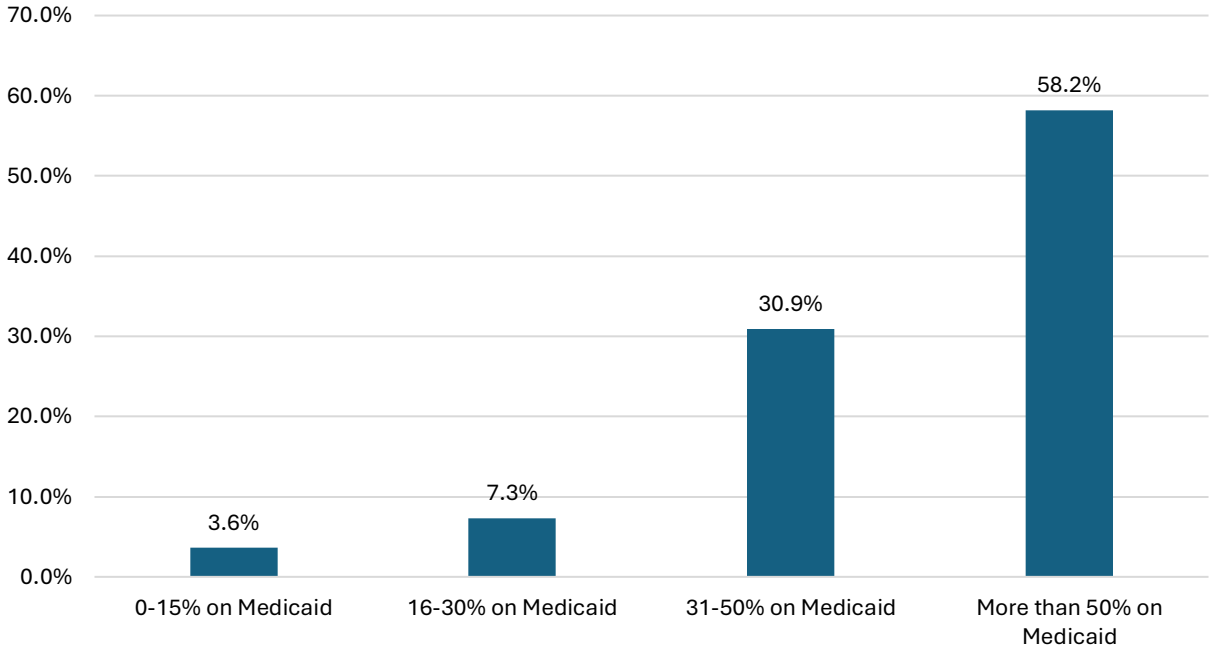
Data for the Healthcare Provider Survey was collected through additional questions included at the end of the Community Survey. Respondents who identified themselves as healthcare providers or healthcare staff were presented with six extra questions to capture their specialized perspective on the community's overall health and needs. The survey remained open from August 12, 2024, to October 6, 2024.

Healthcare partners, including hospitals, federally qualified health centers, and local health departments, distributed the survey electronically to physicians, nurses, and other clinicians. Partner organizations further supported outreach by sharing the survey link with external community partners. A total of 57 providers completed the healthcare provider section of the community survey in Clare and Isabella Counties.

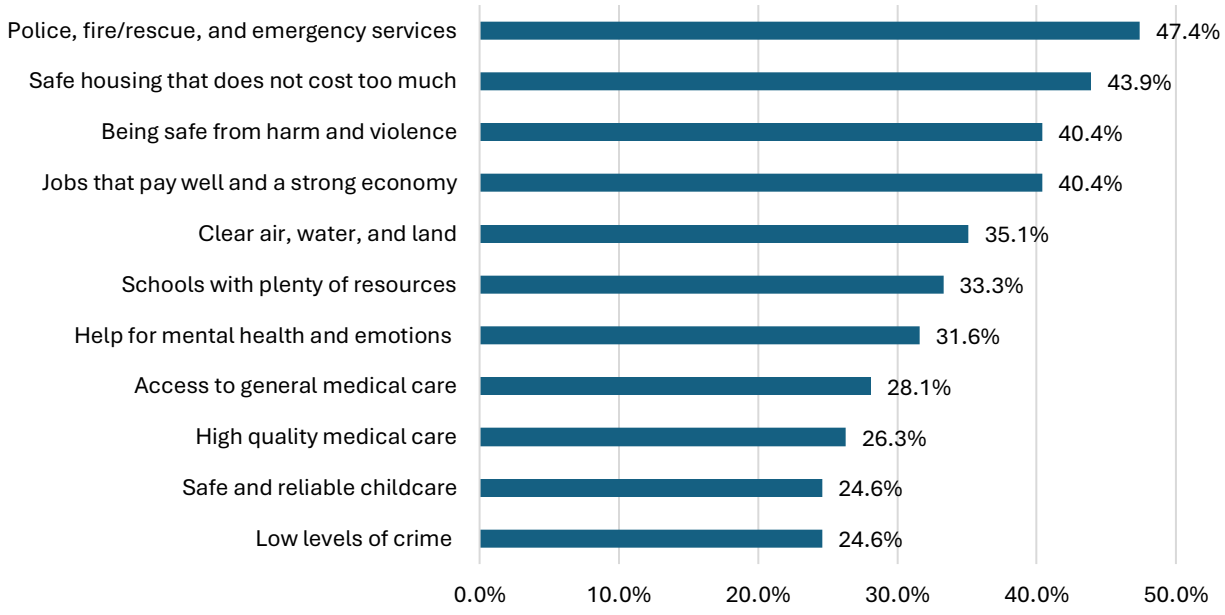
Top Roles of Survey Respondents that Identfied as Provider/Healthcare Staff in Clare and Isabella County, MiThrive Community Survey, 2024 (n=57)



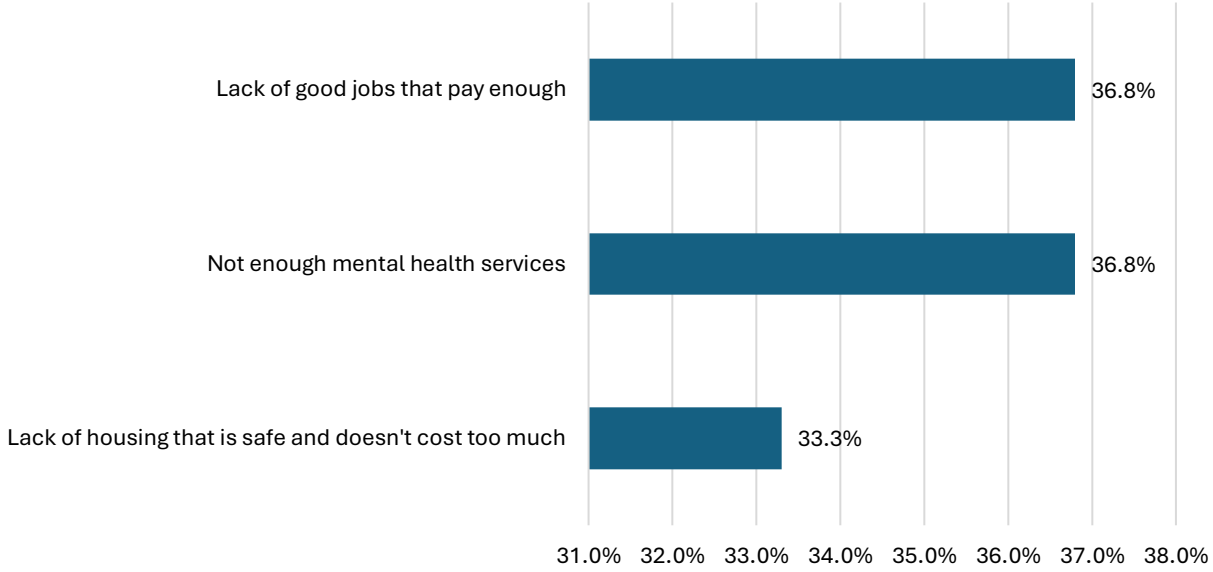
Proportion of Patient Population on Medicaid According to Survey Respondents that Identfied as Provider/Healthcare Staff in Clare and Isabella County, MiThrive Community Survey, 2024 (n=57)



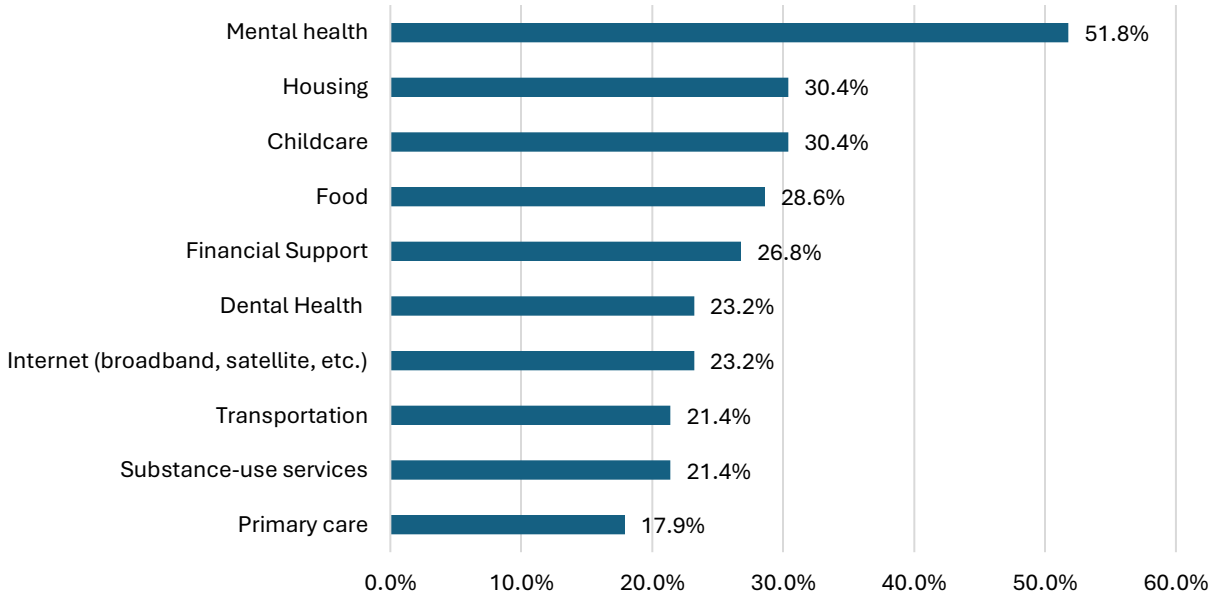
Top Factors for a Thriving Community According to Survey Respondents that Identfied as Provider/Healthcare Staff in Clare and Isabella County, MiThrive Community Survey, 2024 (n=57)



Top Issues Impacting the Community According to Survey Respondents that Identfied as Provider/Healthcare Staff in Clare and Isabella County, MiThrive Community Survey, 2024 (n=57)



Resources/Services Missing From the Community According to Survey Respondents that Identfied as Provider/Healthcare Staff in Clare and Isabella County, MiThrive Community Survey, 2024 (n=57)



Community Partner Assessment (CPA)

The Community Partner Assessment focuses on organizations that contribute to well-being. The CPA answers the following questions:

- What are the components, activities, competencies, and capacities in the regional system?
- How are services being provided to residents?

The assessment was designed to enhance communication between organizations and the community by bringing together a diverse range of partners. It aimed to explore connections within the community system, highlight strengths, and identify opportunities for improvement. The Community Partner Assessment included two key components: the Community Partner Assessment Survey and two virtual Community Partner Assessment Discussions events.

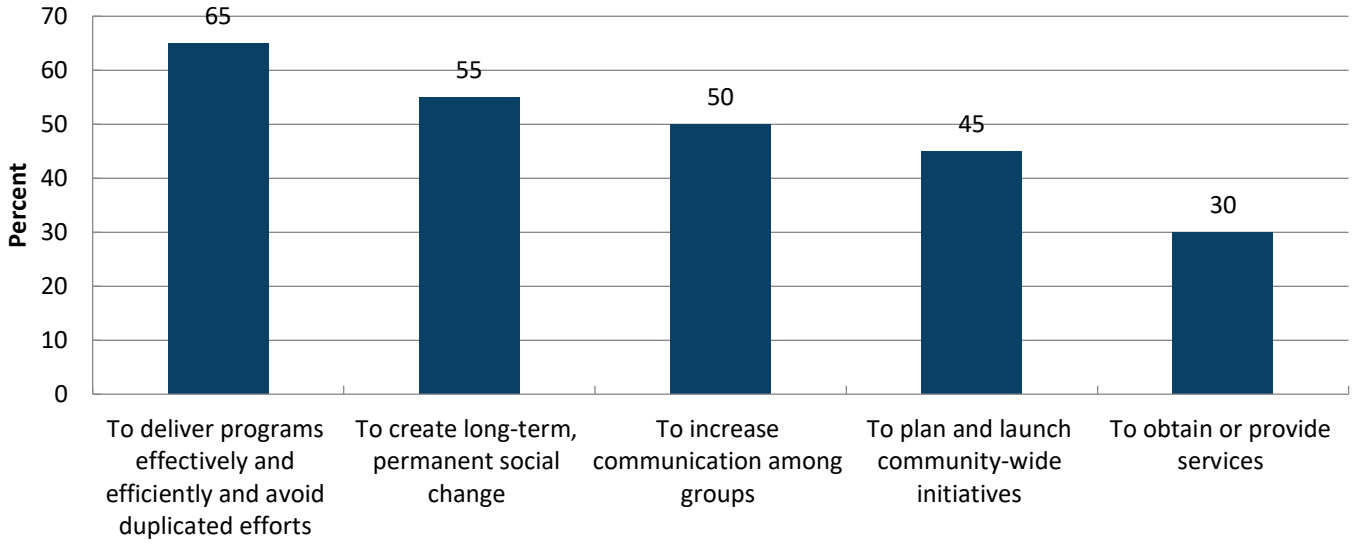
Community Partner Survey

From May 6, 2024, to June 3, 2024, 75 community partners from various organizations and sectors across the 31-county MiThrive Region participated in a community partner survey to assess the system's capacity. A total of 20 responses came from partners covering Clare and Isabella counties. See Appendix D for the Community Partner Assessment Survey instrument.

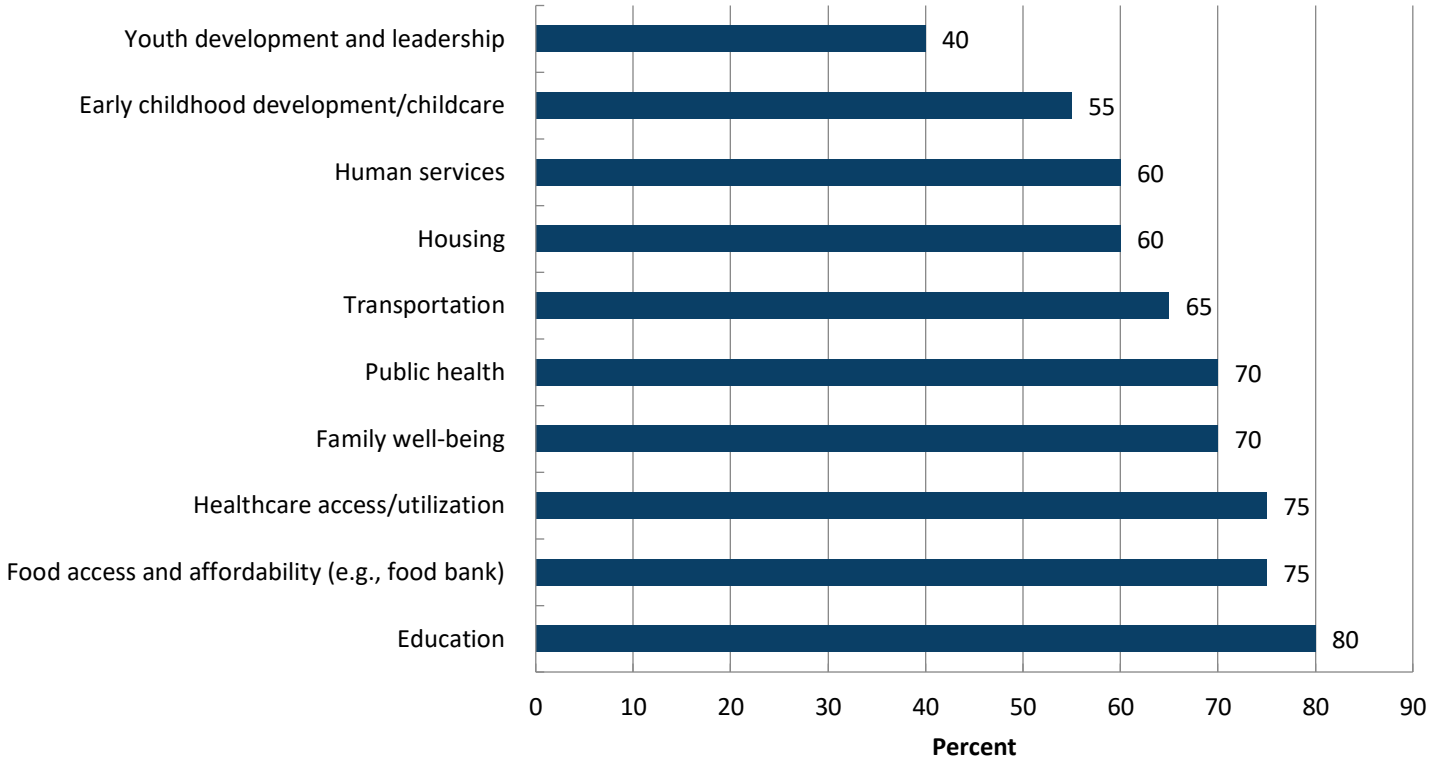
Additionally, survey participants were then invited to attend one of two virtual facilitated discussions, held on June 27, 2024, and July 10, 2024, allowing community partners to identify system strengths and areas for improvement collectively.

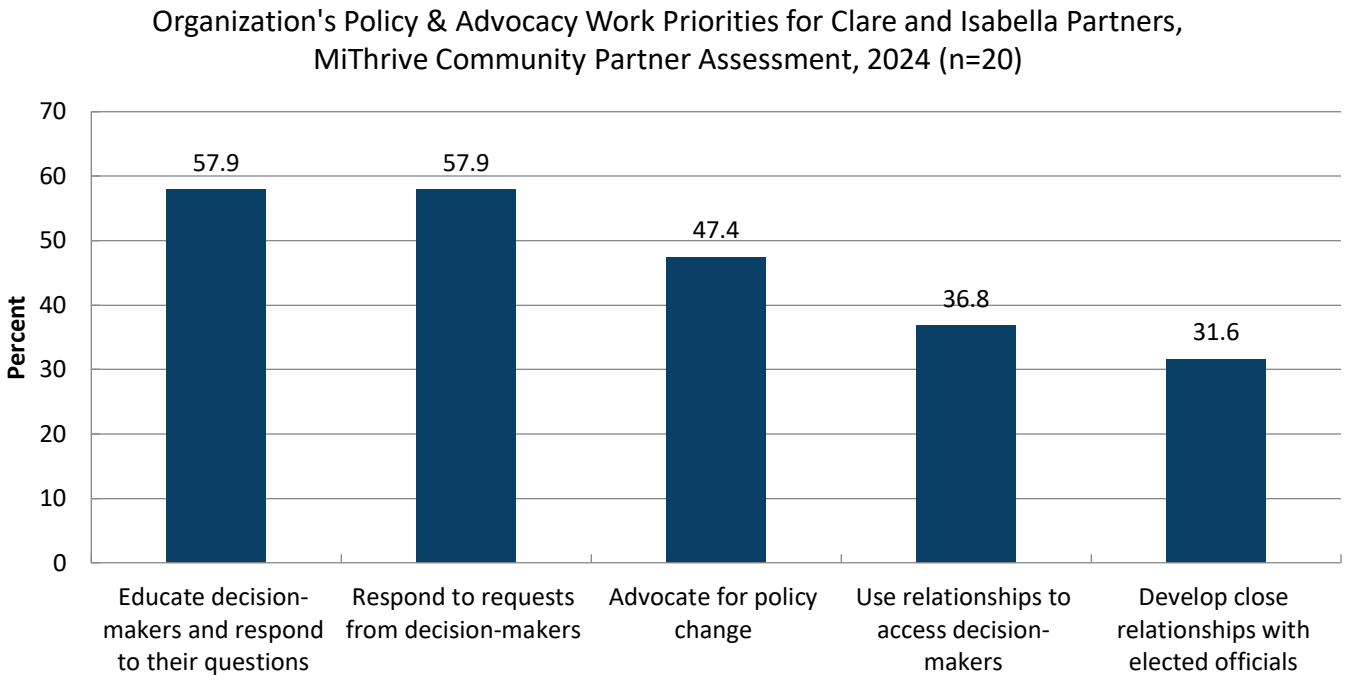
Community Partner Assessment Results

Clare and Isabella Partner's Top Interests in Joining a Community Health Improvement Partnership, MiThrive Community Partner Assessment, 2024 (n=20)



Clare and Isabella Partners Sector Engagement At Least Once within the Last Year, MiThrive Community Partner Assessment, 2024 (n=20)





Organization's Priorities for Clare and Isabella Partners, MiThrive Community Partner Assessment, 2024 (n=20)	A Lot	A Little	Not At All	Unsure
i. Economic Stability: The connection between people's financial resources, income, cost of living, and socioeconomic status—and their health. This includes issues such as poverty, employment, food security, and housing stability.	63.2%	31.6%	5.3%	0%
ii. Education Access and Services: The connection of education to health and well-being. This includes issues such as graduating from high school, educational attainment in general, language and literacy, and early childhood education and development.	60.0%	30.0%	10.0%	0%
iii. Healthcare Access and Quality: The connection between people's access to and understanding of health services and their own health. This includes issues such as access to healthcare, access to primary care, health insurance coverage, and health literacy.	65.0%	30.0%	5.0%	0%

iv. Neighborhood and Built Environment: The connection between where a person lives, housing, neighborhood, and environment—and their health and well-being. This includes topics like quality of housing, access to transportation, availability of healthy foods, air and water quality, and public safety.	36.8%	57.9%	0%	5.3%
v. Social and Community Context: The connection between characteristics of the contexts within which people live, learn, work, and play, and their health and well-being. This includes topics like cohesion within a community, civic participation, discrimination, conditions in the workplace, violence, and incarceration.	47.4%	47.4%	5.3%	0%

Virtual Facilitated Discussion Events:

Survey participants were invited to attend one of two virtual, facilitated discussion events. During these sessions, attendees reviewed the results of the Community Partner Assessment Survey and engaged in small group discussions to explore the findings and share their reflections. Through these conversations, the following opportunities for improvement emerged:

- **Cross-Agency Collaboration:** partners expressed a need for more collaboration, including network sharing, communication between partners regarding knowledge of other agencies programs and services. Partners emphasized capitalizing on collective wisdom, sharing lessons learned and expertise across organizations.
- **Storytelling:** partners expressed an opportunity to incorporate storytelling to amplify resident voice.
- **Social Determinants of Health:** partners expressed a desire to continue incorporating social determinants of health to their work, such as residents need for transportation, housing, food, etc.
- **Health Policy:** partners expressed a need for building capacity around policy work. Partners stated it was important to bring awareness of advocacy vs lobbying due to their funding structures being impacted by policy.
- **Minority Representation:** partners expressed a need to develop trust and working relationships with Native Nations and other minority groups to enhance representation.
- **Nonprofit and Grassroot Collaboration:** partners expressed an opportunity to improve collaboration with grassroots initiatives and community power building organizations.
- **Data Sharing:** partners expressed an opportunity to advocate for data sharing across organizations. Partners discussed the need to share social determinants of health data, such as housing, food, transportation, etc.

- **Thinking Outside the Box:** Partners expressed the need to expand services in nontraditional spaces. By bringing services to the target populations, it would increase accessibility to residents.

Community Context Assessment (CCA)

The Community Context Assessment aims to answer the four following questions:

- What strengths and resources does the community have that support health and well-being?
- What current and historical forces of change locally, regionally, and globally shape political, economic, and social conditions for community members?
- What physical and cultural assets are in the built environment? How do those vary by neighborhood?
- What is the community doing to improve health outcomes?
- What solutions has the community identified to improve community health?

The goal of this assessment is to explore the strengths, assets, lived experiences, and forces of change in the community using qualitative methods.

The MiThrive CCA consists of three parts: asset maps, quotes from residents, and photovoice project. As previously stated, 3,496 residents and partners completed the community survey, with 3,412 submitting quotes. These quotes are responses to the open-ended question within the Community Context Assessment section of the community survey. For Photovoice, 63 residents and community partners participated, submitting a total of 140 photos. A total of 17 photos came from residents within Clare and Isabella counties. In the Asset Maps, 55 revisions were made.

Community Context Assessment Results

Asset Mapping is a process to systematically identify and document all the positive resources, services and strengths present within the community that can be leveraged to address community health needs. During 2024, the asset maps completed in past CHNAs were compiled by county and shared with MiThrive Steering Committee members, partner organizations and Community Health Workers (CHW) to review and update. A full library of the 31-county MiThrive Asset Maps are available on the MiThrive website; see Appendix E for the Asset Maps for Clare and Isabella counties.

> A **community health worker (CHW)** is a trusted frontline public health worker with a strong understanding of the community they serve. This connection allows them to bridge health and social services, improving access to care and ensuring culturally competent service delivery. CHWs are well-versed in local resources and play a vital role in empowering individuals and communities by providing outreach, education, informal counseling, social support, and advocacy to enhance health knowledge and self-sufficiency.

Resident Voice Quotes

Residents were given space to answer one open-ended question nested within the community survey. The question was:

> "Thinking broadly, what changes are happening or might happen in your area that you believe will affect the health of your community? These changes can include weather, technology, money, laws, diseases, community resources, and other things."

Below are the selected resident voice quotes:

Clare County

*"**Primary care** doctors - mid mich area used as training ground for young doctors. **Appointments** are difficult to make - it feels I will be dead before I am seen for my illness sometimes."*

*"Mumps outbreak in Amish community, and a decrease in normal **childhood vaccination** rates due to distrust."*

*"Lack of reliable emergency **ambulance services**."*

*"Lack of people getting **immunized**."*

Isabella County

*"Aging population will put a strain on the already **understaffed** health care system. Hospital frequently using travel nurses."*

*"Lack of specialized providers including **mental health**. cost of living being way high right now and jobs not paying to reflect that, or even seeing benefits from MDDHS nor reflecting the cost of living."*

*"Less and less availability of medical providers. Long **wait time** to get an initial appointment to be established with a provider (six or more months) and no availability to get in for minor incidence i.e. sore throats, colds, etc. except for **urgent care**."*

Photovoice

Photovoice is a community-based research method that uses photography and quotes to document and discuss strengths, assets and experiences that affect the community. The MiThrive Photovoice Survey consisted of three questions for residents to answer by submitting photographs and captions electronically or requesting a disposable camera to take and submit photographs and captions through mail or drop off locations. To encourage participation, respondents who completed a photovoice submission had the opportunity to enter a drawing for a $50 gift card, with one winner selected from each of the 31 counties. As with the other community engagement opportunities, partner organizations were essential to sharing this opportunity with community residents. Promotional materials included flyers, social media content, and press releases.

MiThrive staff developed three photovoice prompts:

- Take a picture of something in your community that helps you, your family, or others live well. This can be places, jobs, services, cultural and faith-based groups, programs, nature, people, and more.
- Take a picture of something that makes your community a good place to live in, like parks, grocery stores, sidewalks, walking places, schools, housing, crosswalks, safety, and accessibility.
- Take a picture of something that needs improvement in your community.

The following are photographs and captions submitted from Clare and Isabella counties.

County: **Clare**

Caption: *"Clare Public Schools - Drama Club that offers youth the ability to learn and experience art and culture."*

Related Themes: **Education**

County: **Isabella**

Caption: *"GreenTree is our local grocery store, where customers can become owners and get food at discounted rates. They offer a wide selection and mostly healthy/vegan food and also offer a hot bar which I personally can say is amazing. This is a huge staple and definitely a must visit when in Mount Pleasant."*

Related Themes: **Obesity and Economic Security**

County: **Isabella**

Caption: *"The repainting and coloring of signs."*

Related Themes: **Environment/Infrastructure and Safety & Wellbeing**

County: **Isabella**

Caption: *"The McLaren hospital provides emergency access to those who need it quickly and attentively."*

Related Themes: **Healthcare Access and Quality**

Data Limitations

Community Status Assessment

Secondary Data

- Secondary indicator scores were used to condense secondary data into single scores that give data on the severity of the indicator value and allow for easier comparisons between jurisdictions. Since secondary indicator scores are based on these comparisons, low scores can result even for very serious issues, if there are similarly high rates across the state and/or US.
- Some data is missing for some counties - as a result, the "regional average", when included, 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.
- Data points pulled from secondary datasets from organizations across the country does present an issue, as data is being updated and released constantly throughout the year. As such, some data presented may not be the most up to date at the time of publication, although it was the most recent data available at the time of writing. Updated secondary data can be viewed on the online MiThrive data platform, if necessary.
- Secondary data tells only part of the story. Viewing all the assessments holistically is therefore necessary.

Community Survey and Provider Survey

- A target number of completed Community Survey responses was set for each county based on the county population size. While some counties reached this target, many did not. This results in data that, while indicative of the community, may not be representative of the entire community or may underrepresent some sub-populations. Survey responses are presented as gathered and were not weighted.
- While the Community Survey was offered online and in-person, most surveys were collected digitally. This may skew data around points involving access to care or broadband concerns.
- Partial or Incomplete responses were removed from the Northern Michigan Community Health Survey. Responses were also reviewed to remove suspect or fraudulent responses from the overall data set.
- Outreach and promotion for the Community Health Survey was driven by existing MiThrive partners which influenced the distribution of survey responses across provider entities.
- Provider/Healthcare staff responses are skewed towards nursing and support service professionals, and physicians are underrepresented. Additionally, Provider/Healthcare staff responses are included in overall community responses, so they may be overrepresented in the overall community data.

- The community survey was conducted during the 2024 Presidential Election cycle. As such, the survey was made to compete with many other surveys being conducted at the time, likely leading to resident survey burn-out.

Community Partner Assessment

- Data for the Community Partner Assessment was self-reported by representatives from partner agencies, each with different experiences and perspectives. Based on these differences, it can be assumed that there is some subjectivity inherent in these responses. Even with this subjective bias, data from this assessment should be considered representative of these organizations.
- Facilitated discussions during regional events yielded worthwhile insights but were limited by time constraints for conversation. Additionally, some key stakeholders were missing from these discussions due to scheduling conflicts or other competing responsibilities.
- Community Partner Assessment data reveals insights into the capacities and goals of local community organizations but should not be removed from the context of the other assessments which share information about the health of residents and their perspectives.

Community Context Assessment

Asset Map

- While much effort was taken to update the asset map, there are likely still gaps in identified services for some communities. This is often due to issues such as the asset having a low profile in the community, or just the inherent difficultly of completing an exhaustive list of services from a patchwork of service providers over a variety of jurisdictions.
- Data for the asset map may change in the future and throughout the year. As such, some information on organizations and services offered may become out of date unpredictably after publication.

Photovoice

- Some residents with limited digital literacy may find participation in the Photovoice challenging.
- Photovoice is a realatively new method of data collection. This means that some residents may new to the process of photovoice or may not understand the benefit of this type of data collection.
- The photovoice process has a lot of steps; reading the prompt questions, taking photos of the community, and coming back to the digital form to upload photos. Participation in photovoice can be a large time commitment for participants compared to a survey.
- Although we did offer diposable cameras for residents to use to submit photos, no one requested one.
- The photovoice assessment was conducted during the 2024 Presidential Election. As such, the survey was held with other surveys being conducted at the time, likely leading to survey burn-out.

Phase 3: Continuously Improving the Community

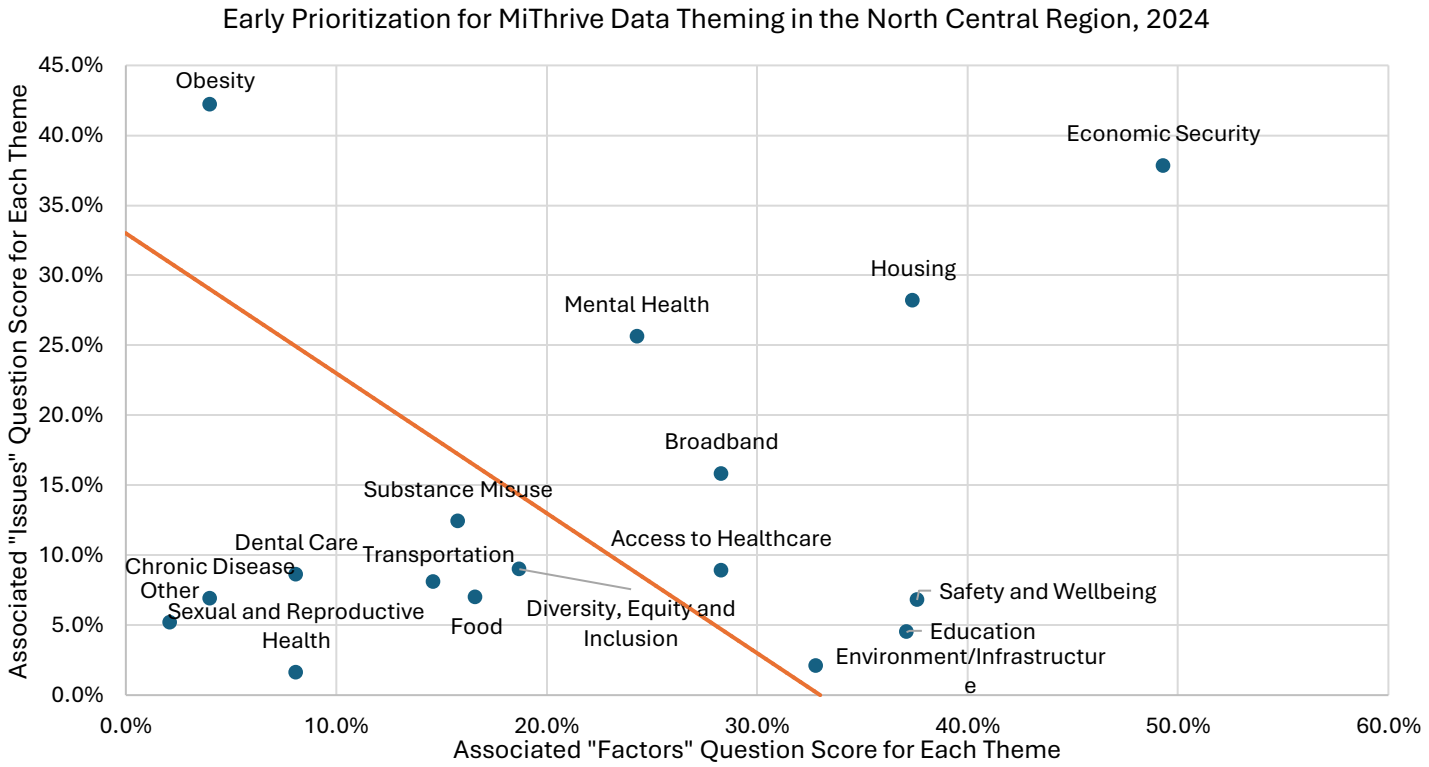
In Phase 3, community partners and organizations were invited to engage in the prioritization process. By analyzing the data collected from each assessment and incorporating community perspectives, key issues are able to be identified and then prioritized.

Identifying Key Issues

For the first step, the focus was placed on primary data from the community survey, as it contains data helpful for identifying the thoughts and opinions of residents. This data was then organized into themes. Categories for themes were initially pulled from MAPP 2.0 materials, then more themes were added as needed to describe the data collected. This was centered around two of the MiThrive Community Survey questions:

1. What is needed for a community to be thriving?
2. What needs to be fixed in your community?

For each theme, only the top response associated with each theme in each question was used as a reference point. These reference points were then used to graph each theme onto a plane, with the "factors" response used as the "x" variable and the "issues" response used as the "y" variable. Themes on this graph were determined to be key issues if they had at least a 33 percent response rate for either the "x" or "y" variable, or if they had a combined response rate above 33 percent. These identified key issues were then presented to MiThrive partner organizations for prioritization.



This graph Illustrates all the themes considered for prioritization. Each data point is comprised of the top associated response to the question asking residents to identify the “top factors for a thriving community” (the “x” variable) and “top issues impacting the community” (the “y” variable). The orange line indicates the cutoff for inclusion in priority setting events. All themes to the right of the line were included.

The nine key issues for consideration in the North Central Region included:

- Economic Security
- Obesity
- Housing
- Mental Health
- Broadband
- Access to Healthcare
- Safety and Wellbeing
- Education
- Environment/Infrastructure

Creating Regional Issue Brief

Once the key issues were identified through the prioritization of data on community opinions, the MiThrive Core Team gathered pertinent information on each of these topics. This was done by reviewing data that had been gathered from the MiThrive assessments and separating this data into themed topics. This included the Community Partner Assessment, the Community Status Assessment (including secondary data collected as well as primary data from the community and provider surveys), and the Community Context Assessment. Data that aligned topics that had been identified as key issues were compiled into a document called a Regional Issue Brief.

Each MiThrive Regional Issue Brief was comprised of curated information on each key issue specific to the region. The purpose of each Regional Issue Brief was to summarize the most pertinent data collected for representatives from MiThrive partner organizations and residents, before setting the priorities for each region. See Appendix H for the North Central Regional Issue Brief.

Collaboratively Priority Setting

In December 2024, residents and community partners participated in regional data walk and priority setting events. A Regional Issue Brief was created for each subregion for review during the Data Walk, highlighting data from each of the assessments that were most important to consider for the prioritization of key issues. Individuals who were not able to attend a Data Walk and Priority Setting Event

were also able to participate by attending one of several scheduled office hours event during the preceding or following weeks, to help gain insight into the data from the MiThrive Core Team.

After engaging in the MiThrive Data Walk, participants were asked to complete a prioritization survey to individually rank the nine key issues. The ranking process used six criteria to assess each key issue including severity, magnitude, impact, sustainability, achievability, and health equity. Individuals were given a link to the prioritization survey if they participated in one of the data walk events and were asked to complete the survey afterwards. The top prioritized key issues are reflected in green in the scoring grids below. This transparent process elicited robust conversation around the top scoring key issues.

For each score given by each individual, the highest prioritized key issue was given one point and the least prioritized key issue received nine points (reverse scoring where the lowest score is the highest prioritized). The scoring grid below shows the aggregate scores for each key issue across each of the six criteria in each region. In the rightmost column, green highlighted cells indicate which key issues were ultimately prioritized for the region.

North Central Region Prioritization Survey Scoring Grid							
Key Issues	**Severity**	**Magnitude**	**Impact**	**Sustainability**	**Achievability**	**Health Equity**	**Total**
Economic Security	78	56	72	142	149	73	570
Obesity	84	82	79	85	84	109	523
Housing	95	89	98	117	119	94	612
Mental Health	52	75	71	60	69	81	408
Safety and Wellbeing	95	113	101	96	96	97	598
Broadband	161	156	151	117	108	150	843
Education	125	108	95	69	73	85	555
Access to Health Care	69	87	92	83	79	60	470
Environment/Infrastructure	141	134	141	131	123	151	821

The final top-ranked Priority Issues for the MiThrive North Central Region area are as follows:

- **Mental Health**
- **Access to Healthcare**
- **Obesity**

Key data points from the MiThrive Community Health Needs Assessment for **McLaren Central Michigan** service area aligned with the regional top-ranked priority issues are discussed on the following pages.

Mental Health

Mental health is essential to overall wellbeing, influencing relationships, daily functioning, and ability to lead fulfilling lives. It is deeply connected to physical health, as mental illness can increase the risk of chronic conditions such as heart disease, diabetes, and weakened immune function. Despite its critical role in overall health, many individuals face significant barriers to accessing mental health services, including cost, stigma, and provider shortages. Ensuring that everyone has access to timely, quality mental health care is key to fostering healthier individuals and communities.

Across the state of Michigan, there are approximately 336 mental health providers for every 100,000 residents (County Health Rankings, 2023). In comparison, Clare County (128 mental health providers per 100,000 residents) has significantly lower rates of providers and Isabella County (374 mental health providers per 100,000 residents) has higher rates of providers available to treat mental health disorders. As the data shows, mental health conditions such as depression are being diagnosed more often within the region. CDC PLACES data from 2022 shows that 26.2 percent of adults in Clare County and 27.5 percent of adults in Isabella County were currently or had previously been diagnosed with depression. According to MDHHS data from 2018 to 2022, the age-adjusted death rate for suicide mortality is relatively high within the region. Overall, the state of Michigan has 14.4 suicide deaths per 100,000 residents. During the same timeframe, Clare County exhibited 22.7 suicide deaths per 100,000 residents and Isabella County had 15.0 suicide deaths per 100,000 residents.

25.8 percent of respondents to the community survey from Clare and Isabella Counties identified that help for mental health and emotions was an important factor for a community to be considered thriving. Additionally, 29.4 percent of respondents identified that one of the top issues in their community was a lack of mental health services. This was largely driven by responses from individuals who were over the age of 40 or who relied on employer-sponsored insurance. 36.8 percent of providers indicated that lack of mental health services was a serious issue for their area. 51.8 percent of providers thought that some form of mental health service was missing from their community.

Barriers to mental health services can lead to untreated conditions, exacerbating issues such as anxiety, depression, and substance use disorders. Limited availability of mental health professionals, high costs of therapy and medications, and a lack of awareness about available resources prevent many from seeking the help they need. Addressing these barriers by expanding affordable services, increasing provider availability, and integrating mental health into primary care can improve mental health outcomes and enhance overall wellbeing.

Access to mental health care goes beyond treatment—it encompasses early intervention, crisis support, and long-term management of mental health conditions. When individuals receive the mental health services they need, they are better able to manage stress, maintain healthy relationships, and contribute positively to their communities.

Access to Healthcare

Access to healthcare is a fundamental determinant of overall wellbeing, directly impacting disease prevention, early detection, and effective treatment. Limited access to healthcare services, whether due to cost, geographic barriers, timely appointment availability, logistical obstacles, or lack of insurance can lead to delayed diagnoses, unmanaged chronic conditions, and preventable health complications. Ensuring equitable access to both physical and mental health services is critical in improving quality of life and life expectancy across all communities.

In the state of Michigan, there are approximately 78 primary care providers per 100,000 residents (County Health Rankings, 2021), which is higher than the rate that is seen in Clare County (29 primary care providers per 100,000 residents) and Isabella County (49 primary care providers per 100,000 residents). This makes it harder for residents to seek care for acute or chronic diseases. Similarly, data also shows that only 79.8 percent of residents in Clare County and 75.0 percent of residents in Isabella County had received a routine health checkup within the last year (CDC PLACES, 2002). CDC PLACES data from 2022 also shows that 5.2 percent of adults in Clare County and 5.1 percent of adults in Isabella County do not have health insurance. Lack of access to healthcare (such as not having health insurance) contributes disproportionately to age-adjusted death rates across the state. For example, the age-adjusted death rate due to heart disease was 260.0 deaths per 100,000 residents in Clare County and 241.6 deaths per 100,000 residents in Isabella County. This is compared to the value across the entire state of Michigan, at 205.9 deaths per 100,000 residents (MDHHS, 2020-2022). Furthermore, age-adjusted death rate due to all cancer mortality from 2018 to 2022 shows Clare at 205.1 deaths per 100,000 residents and Isabella County at 180.0 deaths per 100,000 residents, compared to the Michigan state-wide value at 158.3 deaths per 100,000 residents (MDHHS).

32.3 percent of respondents to the Community Survey from Clare and Isabella Counties identified access to general medical care as one of the top factors for a thriving community. Additionally, 9.2 percent implicated the lack of specialty care as a major issue in the community. In terms of what needs to be improved with access to care, 45.6 percent of respondents identified the cost of healthcare as one of their top issues with access; 38.8 percent of respondents implicated specialty services being too far away from their area. Healthcare providers for the area generally agreed; 17.9 percent indicated that primary care services were missing in their community.

Barriers to healthcare access can create significant disparities in health outcomes. Individuals facing financial hardships, living in rural areas, or struggling with complex healthcare systems often experience gaps in care, leading to worsened health conditions and increased medical costs over time. Expanding healthcare access through affordable services, improved transportation, and enhanced health system navigation can reduce these disparities and improve population health.

Healthcare access is more than just the availability of medical services, it is about ensuring that individuals receive timely, high-quality care regardless of their socioeconomic status or geographic location. When people can access preventative care, manage chronic illnesses, and receive necessary treatments without

financial or logistical obstacles, they are more likely to experience better health outcomes, improved well-being, and a higher quality of life.

Obesity

Obesity is a complex health issue influenced by a combination of genetic, behavioral, environmental, and socioeconomic factors. Where and how people live significantly impacts their ability to maintain a healthy weight, as access to nutritious food, opportunities for physical activity, and overall lifestyle habits play a crucial role. Excess weight gain in both adults and youth increases the risk of numerous chronic conditions, including type 2 diabetes, high blood pressure, heart disease, and certain cancers. Addressing obesity requires a comprehensive approach that considers both individual behaviors and broader social determinants of health.

According to the US Centers for Disease Control and Prevention, chronic diseases such as heart disease, cancer, and diabetes are the leading causes of death and disability in the US. Leading causes of death in Clare and Isabella County are, by far, heart disease and cancer (MDHHS, 2020). Many chronic diseases are caused by a short list of unhealthy behaviors, such as tobacco use, poor nutrition, lack of physical activity, and excessive alcohol use. In Clare County, the percentage of obese adults 20 years and older is 28.5 percent (CDC, 2021). In comparison, the percentage of obese adults 20 years and older is 33.9 percent in Isabella County. Additionally, the percentage of adults 20 years and older who are considered sedentary (i.e. those that do not participate in physical activities outside of their employment) is 17.2 percent in Clare and 22.3 percent in Isabella (CDC, 2021). Child food insecurity in Clare County is at 25.4 percent and Isabella County is at 17.9 percent. These rates exceeded the rate across the state overall (17.9 percent) (Feeding America, 2022).

According to information gathered from residents of Clare and Isabella Counties, 44 percent of respondents disagreed, and 20 percent strongly disagreed with the statement “My community has enough access to healthy food that doesn’t cost too much.” 66 percent of respondents agreed that there were enough parks and green spaces for physical activity, and only 6 percent of respondents disagreed. Instead, individuals in these counties indicated that their physical activity levels were adversely affected by a lack of affordable physical activity programs and lack of walkable paths, trails, or walkways. 28.6 percent of providers surveyed agreed that access to healthy foods was lacking in the area.

Barriers to maintaining a healthy weight include limited access to affordable, nutritious food, a lack of safe spaces for physical activity, and the prevalence of sedentary lifestyles. Economic challenges and food insecurity can make it difficult for individuals to prioritize healthy eating, while demanding work schedules and urban design can limit opportunities for regular exercise. Expanding access to community resources, promoting nutrition education, and encouraging policies that support healthier lifestyles can help reduce obesity rates and improve long-term health outcomes.

Preventing and managing obesity goes beyond personal choice — it requires systemic changes that promote healthier environments and lifestyles. When individuals have access to nutritious foods, safe

recreational spaces, and healthcare providers who support weight management and overall well-being, they are more likely to achieve and maintain a healthy weight. Addressing obesity is essential for reducing the burden of chronic diseases, enhancing quality of life, and fostering healthier communities.

Next Steps

With the completion of the 2025 Community Health Needs Assessment, McLaren Central Michigan will create an implementation plan for 2026 – 2028 on ways to impact the final top-ranked priorities in our region.

For more information and access to the MiThrive Data Platform, visit their website at https://northernmichiganchir.org/mithrive/

MiThrive Webpage

MiThrive Data Platform

McLaren
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2025 Community Health Needs Assessment