Kalamazoo County

Community Health Needs Assessment for **Behavioral Health and Developmental Disabilities**

2021

What is a CHNA?

- A Community Health Needs Assessment (CHNA) is a learning process undertaken by providers of health-related services. There are many methods and approaches, but they all have the goal of gaining a better understanding of actual community needs at a point in time, so that the health service provider can better align their work to those needs.
- Many types of health care organizations are legally required to conduct a CHNA or similar process every few years.

The ISK CHNA — inspiration:

Ascension Borgess Hospital

ASCENSION BORGESS HOSPITAL COMMUNITY HEALTH NEEDS ASSESSMENT JUNE 2019

Kalamazoo County, Michigan

IDENTIFICATION AND PRIORITIZATION OF NEEDS

The CHNA process identified many needs within the community. During the collaborative process with stakeholders, they determined the priority area of Racism and Discrimination as an overarching issue that directly impacts all the other priority areas. The following needs were identified as the most pressing and are cited in order of priority.

1. Racism and Discrimination
2. Living Wage to Afford (Housing, Childcare, Transportation and Healthy Food)
3. Mental Health Assistance and Access
4. Access to Primary Care Providers

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Top 11 Topics (in no ranking order):

- Laws & Policies
- Personal Experiences of Racism
- Transportation
- Land Use, Parks & Recreation/Greenspace
- Proximity to Affordable, Healthy Food
- Mental Health & Substance Abuse
  - Access to Services
  - Experiences of Stress and Trauma
- Community Connectedness
- Quality Education
- Healthcare
- Social Services
- Career Pathways, Income, Poverty

Goals of the ISK CHNA:

- Compliance
- Learning
- Education
- Advocacy

- Michigan DHHS requires each CMHSP to conduct a nominal Needs Assessment at least every two years.
- Michigan also launched as a CCBHC Demonstration state in 2021, and Michigan DHHS will require all local CCBHC sites to have a Needs Assessment.

Goals of the ISK CHNA:

- Compliance
- Learning
- Education
- Advocacy

Internal learning, external education and advocacy are the reasons to go beyond minimum compliance requirements.

- Improving alignment within ISK on how we want to approach understanding community needs, and what kinds of responses from ISK should be highly prioritized
- Providing a resource for community members outside the behavioral health system to gain a basic foundational understanding of needs & barriers
- The CHNA report itself and community presentations on the CHNA will help reduce stigma in the community, as well as offering suggestions about how community members can help support the behavioral health system

Approach for the ISK CHNA:

- Community survey (open-ended questions; ~250 responses received)
- Compiling/analyzing data from secondary sources (Census, CDC, Medicaid data, ISK internal data, etc.)
- ISK staff focus groups, each concentrating on a specific theme (15 groups)
- Combining and connecting different themes, summarizing findings
- ISK Senior Leadership ranked and selected the highest prioritized "strategic directions" based on findings

Another important choice was to undergird the entire ISK CHNA with an equity framework. (Putting into action the ISK Board resolution declaring racism a public health crisis; approach inspired by Bronson's CHNA)

- Embedding equity into the CHNA process itself

- Emphasis on systems thinking, root-cause analysis, and acknowledging systemic oppression itself as an important "root cause"

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www.bronsonhealth.com/app/files/public/8108/chna-kalamazoo-county-2019-final.pdf

> *Understanding health disparities starts with **understanding the history** of discrimination and oppression that marginalized communities have faced.*

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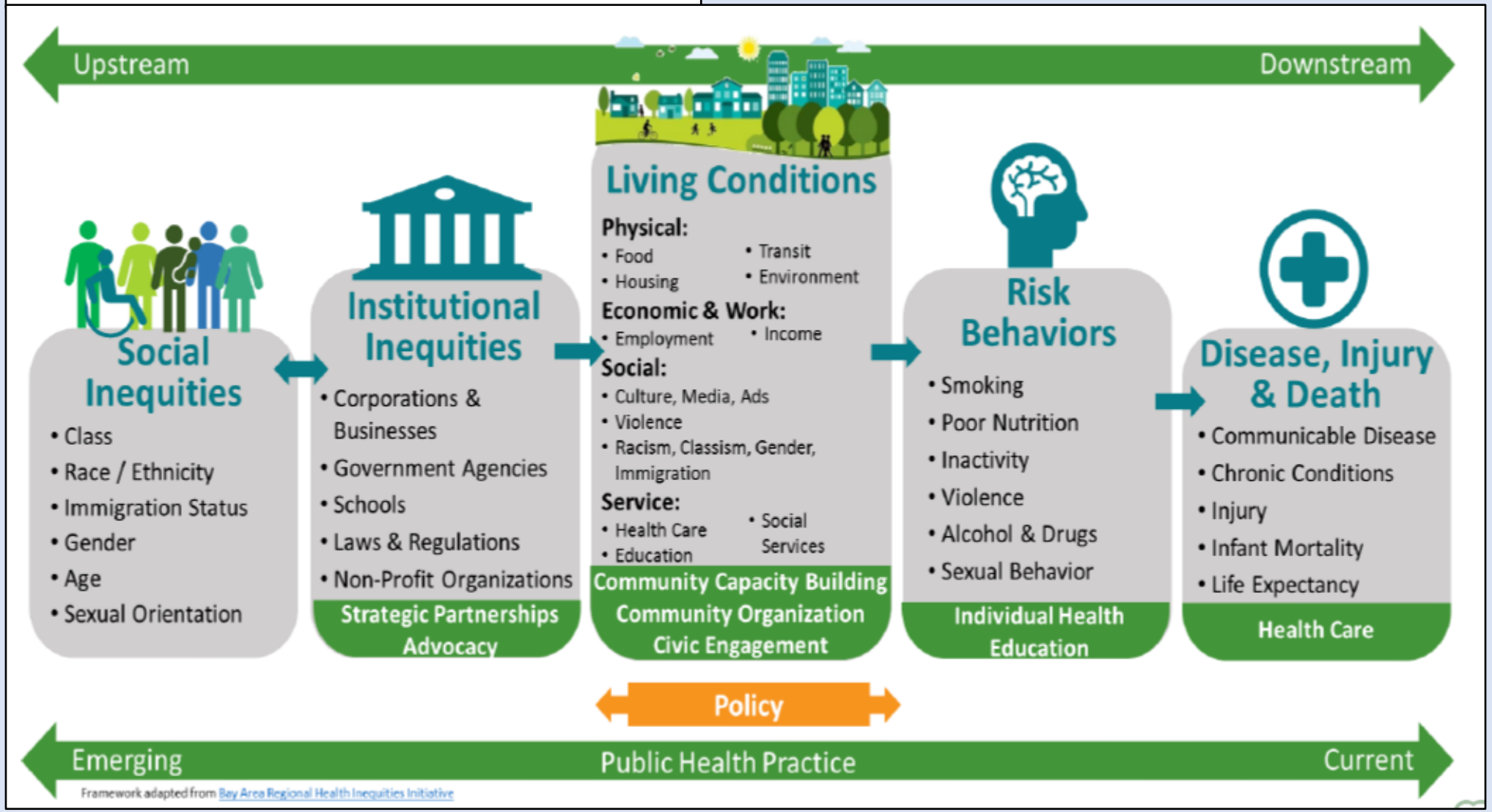
www.bronsonhealth.com/app/files/public/8108/chna-kalamazoo-county-2019-final.pdf



CHNA Findings

Estimated prevalences:

(Extrapolated from national/regional estimates)

- **40,000**+ adults in Kalamazoo County (about 21%) will experience *some* type of mental health issue in a year-long timeframe. Adults with serious mental illness (SMI) estimated about **10,000**.
- **10,000**+ youth in Kalamazoo County with one or more mental, emotional, developmental or behavioral problems.
- **16,000**+ adults & adolescents with a substance use disorder.
- Suicide: about 9500 adults and 1500 adolescents seriously consider suicide each year; about 1000 adults and 1000 youth actually make an attempt. Kalamazoo County numbers about 40-50 people die by suicide per year.
- Adults with I/DD: up to **2,000** individuals in the county.

https://www.samhsa.gov/data/report/2019-nsduh-annual-national-report
https://www.cdc.gov/healthyyouth/data/yrbs/2019_tables/pdf/2019_MMWR-SS_Tables.pdf
https://www.nichd.nih.gov/health/topics/idds/conditioninfo/default

Large amount of unmet need:

The BH/DD system is not adequately meeting the needs of all people who need these services. This is common across the country and not a Kalamazoo-specific problem.

National/regional estimates of the proportion of people that actually receive treatment they need – less than half (2017 or 2019):

- Only 46% of adults with MI
- Only 43% of youth with MI/SED
- Only 21% of people with SUD

Covid impacts include increasing depression, anxiety, deaths of despair – extra pressure on a system that was already strained.

NSDUH: https://www.samhsa.gov/data/report/2019-nsduh-annual-national-report , MI Behavioral Health Barometer: https://store.samhsa.gov/sites/default/files/d7/priv/michigan-bh-barometervolume5-sma19-baro-17-us.pdf

Because the system is overburdened…

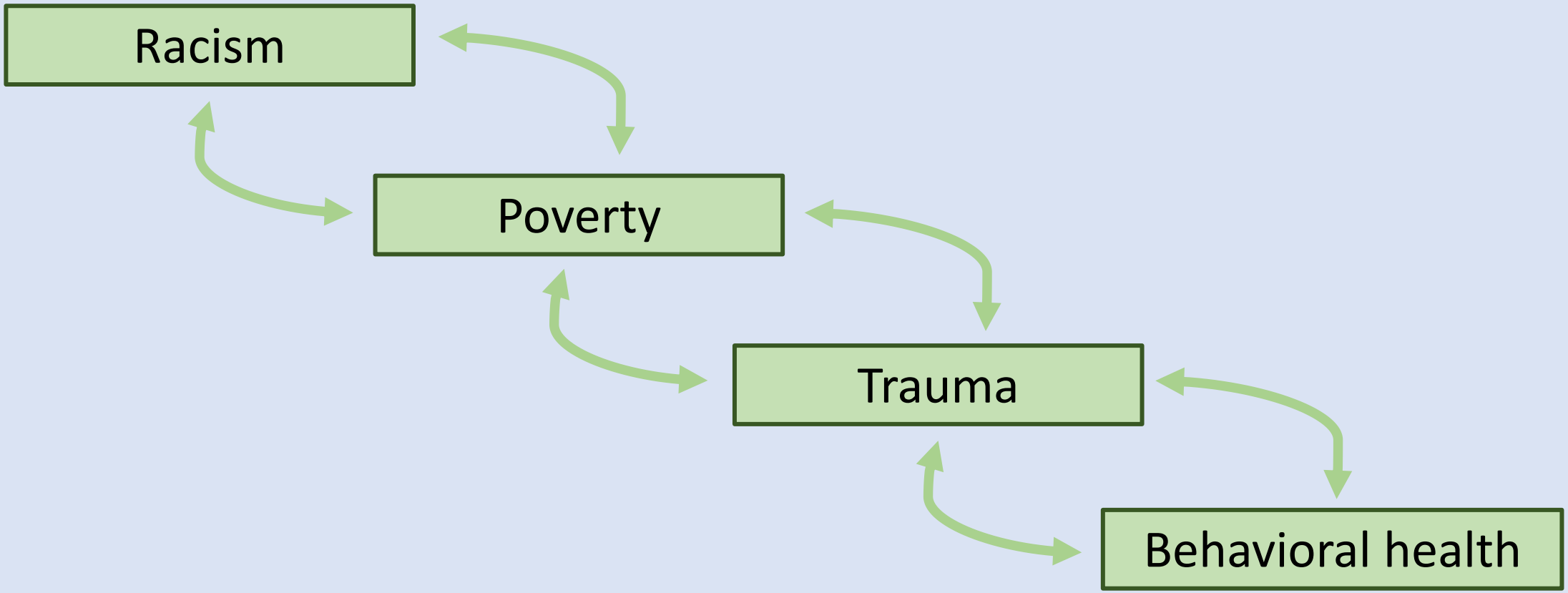
- People who would benefit from treatment simply not receiving any – increases the risk of behavioral health needs turning into crisis situations.
  - ISK handles about 200 crisis contacts every week
  - ~12,000 hospitalization days related to BH paid by Medicaid each year in the County
  - County Dispatch has estimated 15,000 calls to 911 each year where MI and/or SU is a contributing factor

> We have, what, eight hospitals in Michigan we can call for youth [in crisis]? And you have fifty counties calling those eight hospitals. We have some kids who are in some pretty serious crises, needing inpatient services, who will sit for two weeks. We have had a kid sit for six weeks in the ED waiting for a hospital bed. … When we need a bed, a place for this youth to be safe, there is no bed except the ED. And that is **heartbreaking** for families.
>
> —A crisis services professional

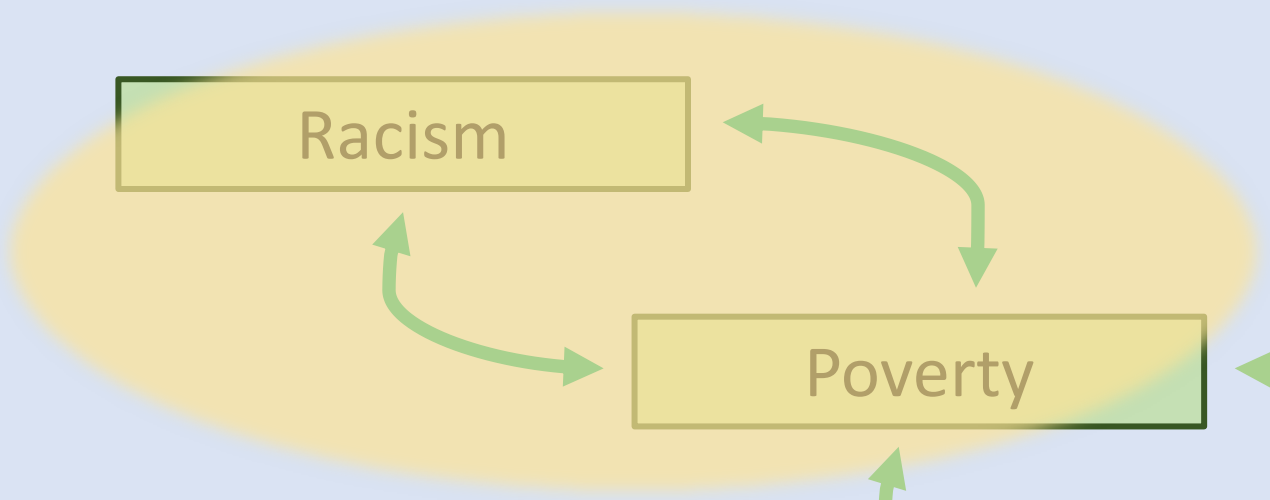
Because the system is overburdened…

- When the BH system is not able to meet routine needs or crisis needs, extra burden falls to other human service systems
  - Schools, homeless shelters / housing services, the criminal justice system
  - Estimated 54% of prison inmates having a past or current mental health problem; jails and prisons as “the new asylums”
  - Professionals in these other systems generally are not equipped to adequately handle emotional or psychiatric crises

Root causes: Racism and poverty



Root causes: Racism and poverty



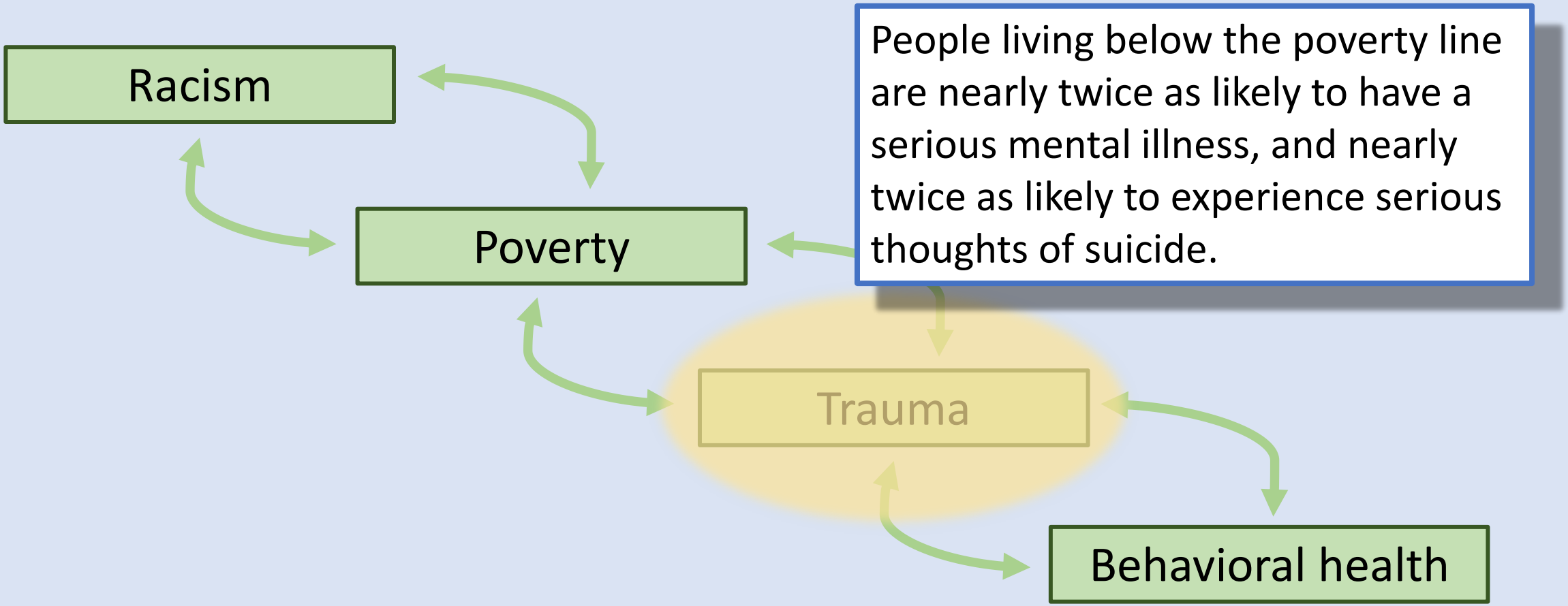
Kalamazoo County poverty rates:

- 11.8% for non-Hispanic white
- 20.8% for Hispanic/Latino
- 28.9% for Black/African-American

Trauma

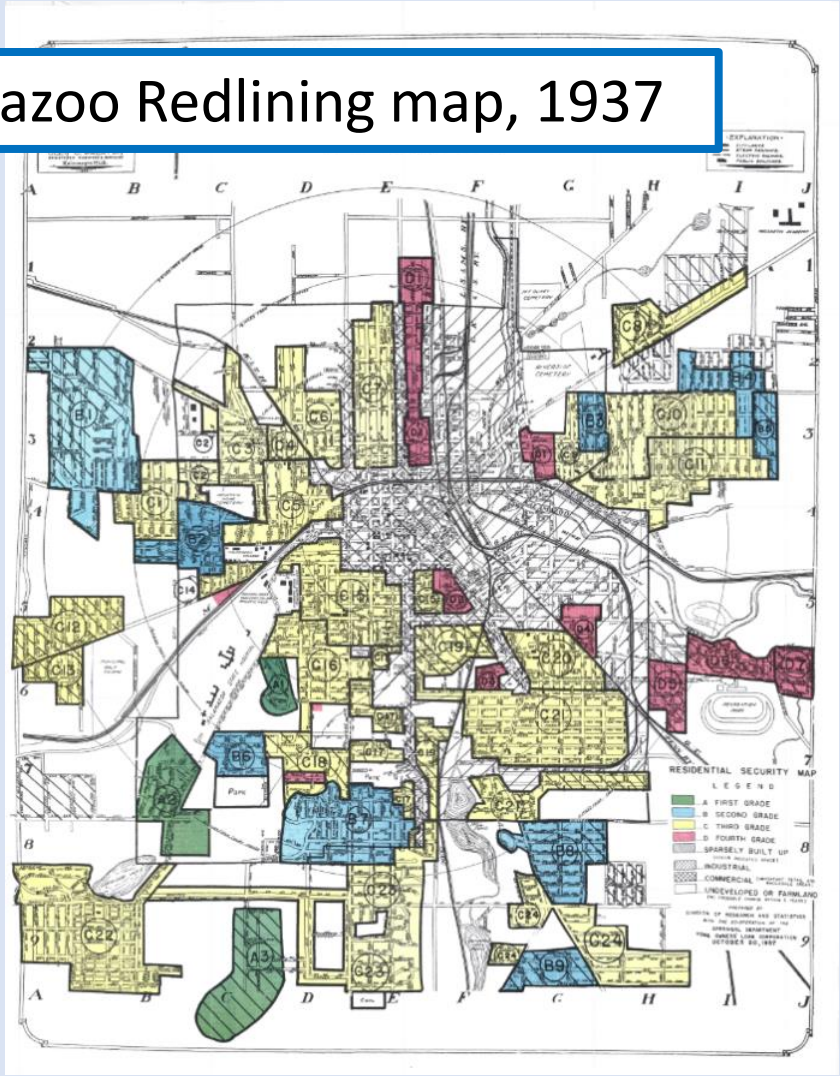
Behavioral health

Root causes: Racism and poverty



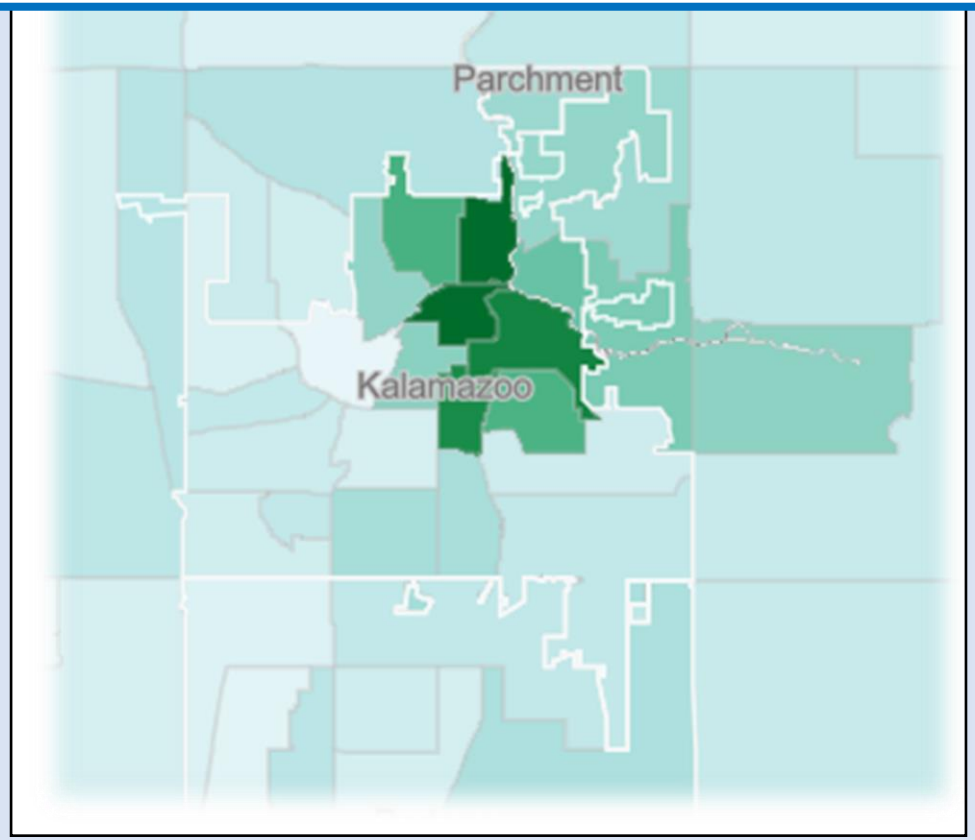
Geography clarifies these connections even more:

Kalamazoo Redlining map, 1937

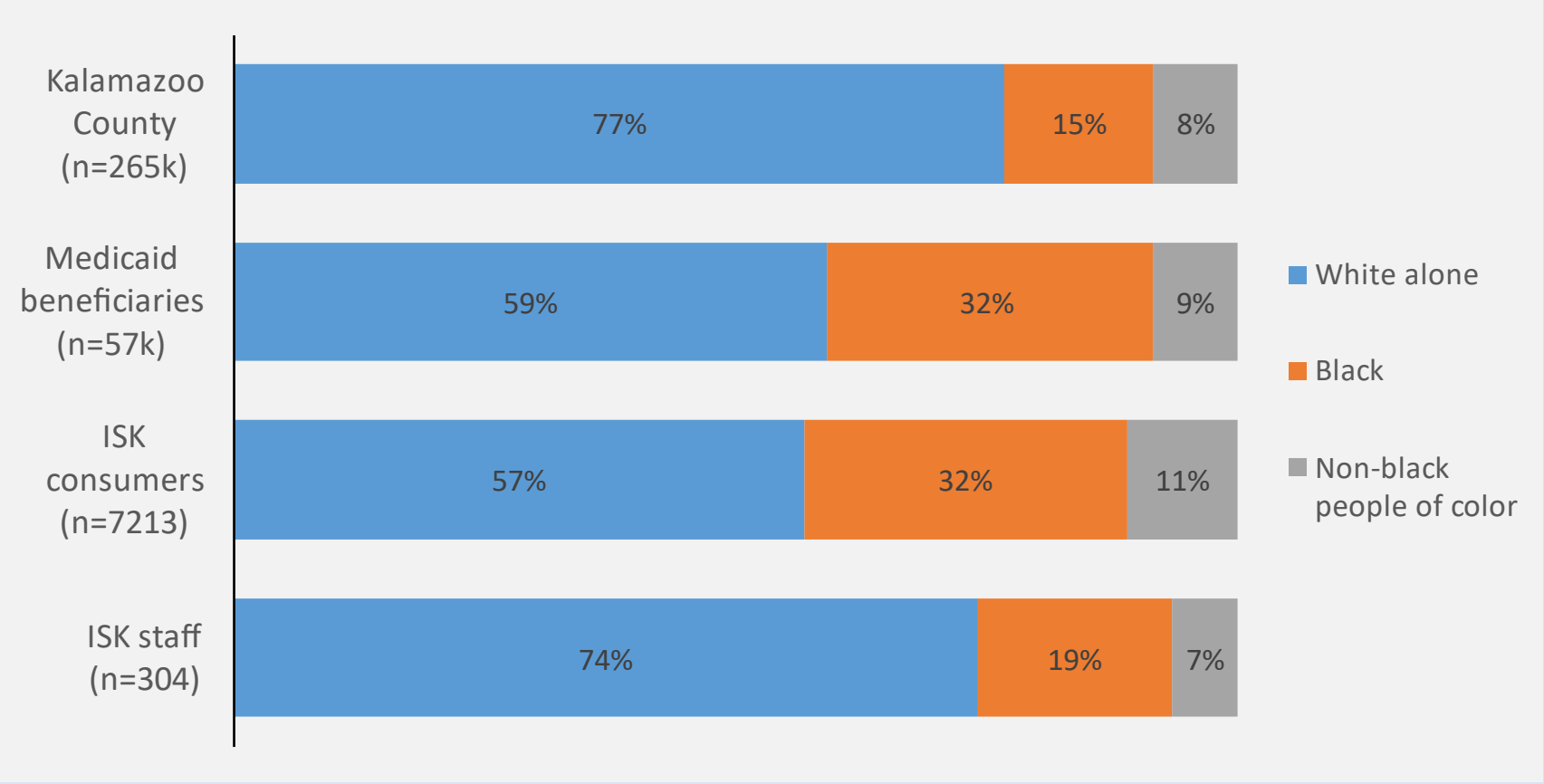


(Learn more: Matt Smith, KPL, How FDR Segregated Kalamazoo https://www.youtube.com/watch?v=YRnMMDXdneA)

% of Population receiving ISK services, 2020



One other direct consequence of the racialized nature of poverty is a dramatic **demographic mismatch,** the existence of which creates inequity in the system



"When working with providers who do not have a historically marginalized identity, I have found that I spent more time **explaining** my experience as a person of color than receiving actual care."

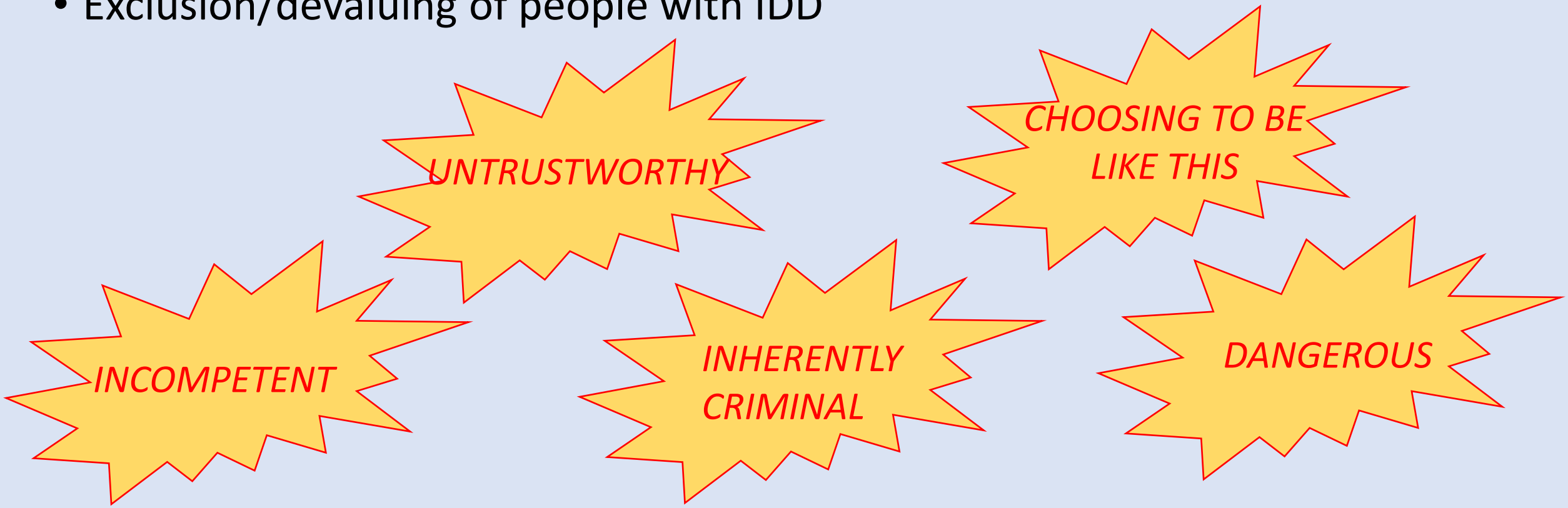
—A consumer of mental health services

Root causes: Ableism and stigma

- **Ableism**: A set of beliefs or practices that devalue and discriminate against people with physical, intellectual, or psychiatric disabilities. Ableism is rooted in assumptions that typical abilities are superior, that it is better to be non-disabled than to be disabled, or that disabled people are fundamentally defined by their disabilities.
- Disability is a normal part of the human experience and can be celebrated as a valuable dimension of human diversity, but societal ableism wrongly teaches us instead that disability is a problem to be fixed or eliminated.

Examples of ableist assumptions:

- Stigma against mental illnesses
- Criminalization of substance use disorders
- Exclusion/devaluing of people with IDD



These negative social judgments are **inaccurate** as well as harmful.

- People do not choose to develop mental illnesses or substance use disorders; caused by complex, interacting factors including traumatic experiences, genetic predisposition, and environmental stressors

- People with intellectual and developmental disabilities, people with behavioral health conditions, and people in recovery can and do maintain productive employment, volunteer commitments, family responsibilities, and other valuable contributions to the community.

- It is extremely rare for a mental illness, even a severe mental illness, to cause a person to behave violently, and in fact people with severe mental illness are at a greatly increased risk of being the *victim* of violence, not the perpetrator.

Different settings where ableism is expressed:

Internalized ableism
(Self-stigma)

Interpersonal ableism
(Public stigma)

Structural/systemic ableism
(Institutionalized stigma)

American Psychiatric Association:
https://www.psychiatry.org/patients-families/stigma-and-discrimination

Institutional ableism

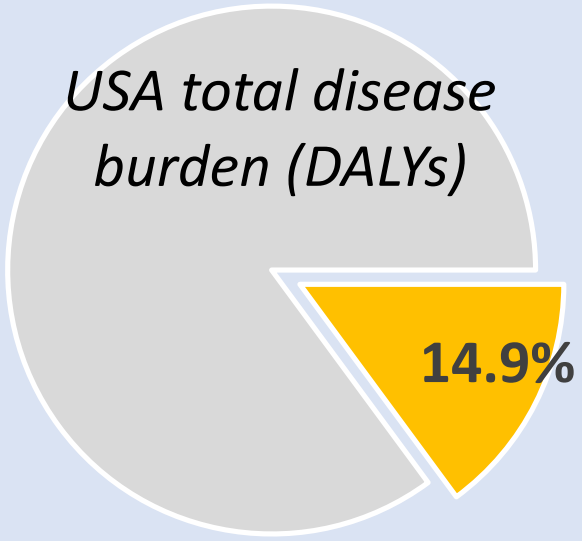
Funding structures are formed via law and policy, and many of these policies (past and current) were developed from a point of view that devalues people with disabilities, including mental illnesses or intellectual/developmental disabilities.

Funding choices have been based on an ableist attitude that equal resources do not need to be spent on disabled individuals and the treatment they need, because it is assumed that their lives have lesser value.

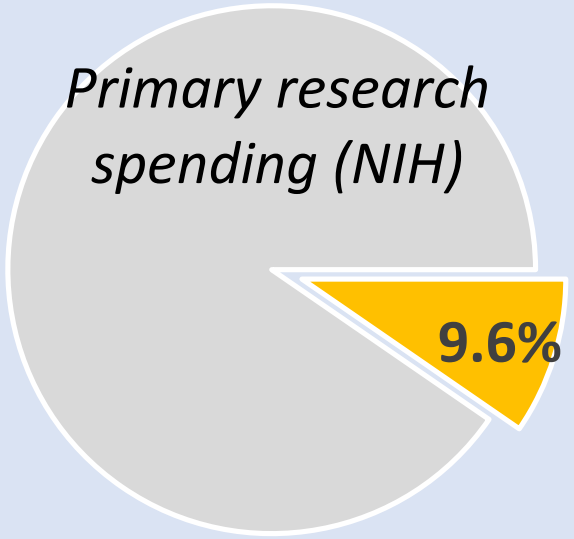
The underfunding of the system is thus a prime example of institutional ableism.

Systemic underfunding as an example of institutionalized stigma and ableism

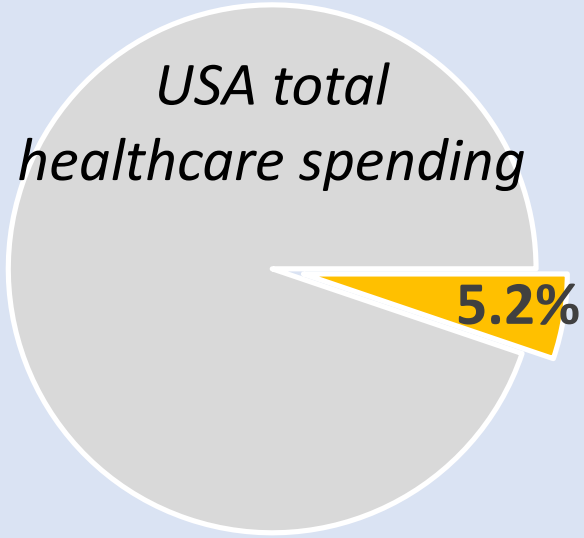
Approximate proportions attributable to behavioral health:



Global Burden of Disease project, IHME: http://ghdx.healthdata.org/GBD-results-tool
(mental disorders, substance use, self-harm)



NIH appropriations, 2020-2021: https://officeofbudget.od.nih.gov/approp_hist.html
(NIAAA, NIDA, NIMH)



Milliman 2019: https://www.milliman.com/en/insight/addiction-and-mental-health-vs-physical-health-widening-disparities-in-network-use-and-p

Impacts of systemic underfunding

- Lack of Evidence-based practices
- System is overly complex and constantly changing
- Careers are underfunded -> Salaries are low -> Not enough BH workers (exacerbated by Covid pressure)

- Having too few workers has major impacts
  - Creates access barriers
  - High caseloads – service quality, burnout

CHNA next steps and response

CHNA next steps and response:

- Full report available to the public on ISK website
- Ongoing presentations on our CHNA in the community
- The CHNA results and the two top prioritized strategies (selected by Senior Executive Team) will be emphasized in 2022 strategic planning and the 2022 quality improvement plan
  - Workforce development & hiring
  - Internal process improvement

Audience questions

Full report:
https://iskzoo.org/community-health-needs-assessment/

Contact agalick@iskzoo.org for feedback, questions, or to request a presentation