# 2026-2029 COMMUNITY HEALTH IMPROVEMENT PLAN

## TABLE OF CONTENTS



McLaren BAY REGION

UNITED WAY Bay County

BAY COUNTY MICHIGAN 1857 HEALTH DEPARTMENT Prevent. Promote. Protect.

# Bay County Human Services Collaborative Partners

| | | |
|---|---|---|
| Mid-Michigan Community Action Agency | United Way of Bay County | Historic Second Baptist Church |
| MyMichigan Health | Do-All Inc. | McLaren Bay Region |
| Recovery Pathways LLC. | Wellspring Lutheran Services | Great Lakes Bay Health Centers |
| MDHHS | Sacred Heart Rehabilitation | Bay Area Chamber of Commerce |
| Sacred Heart Rehabilitation | Helen M. Nickless Volunteer Clinic | Disability Network of Mid-Michigan |
| The Arc of Bay County | Legal Services of Eastern Michigan | Department of Veteran Affairs |
| City of Bay City | Bay County Probate Court | Bay County Prevention Network |
| Bay Arenac Suicide Prevention Coalition | Bay Arenac ISD | Bay Arenac Behavioral Health |
| Bay County Dept on Aging | Bay Area Community Foundation | Bay Area Chamber of Commerce |

## BACKGROUND

The Bay County Health Department, in collaboration with its many partners, is proud to present the 2025-2027 Community Health Improvement Plan (CHIP). This document is the result of decades of routine Community Health Assessments (CHAs) and is a result of dedication and support by the Bay Human Services Collaborative Coalition (Bay HSCC) and core leaders from the Bay County Health Department, McLaren Bay Region, and the United Way of Bay County. This continuous, community-driven process brings together a wide range of entities—including local businesses, schools, human service agencies, healthcare providers, and faith-based organizations—to create a data-informed plan dedicated to improving the health and well-being of all Bay County residents.

This document begins by describing the background and vision for our work, followed by a new, modernized, web-based community health profile for improved accessibility, and concludes by detailing the CHIP process, which identifies health priorities with supporting data and clear objectives so that we can reach our desired outcomes.

Our guiding vision is: “To sail Bay County to better health and grow a vibrant and diverse community in which regional collaboration allows all people the ability to achieve optimum health.”

## COMMUNITY HEALTH PROFILE

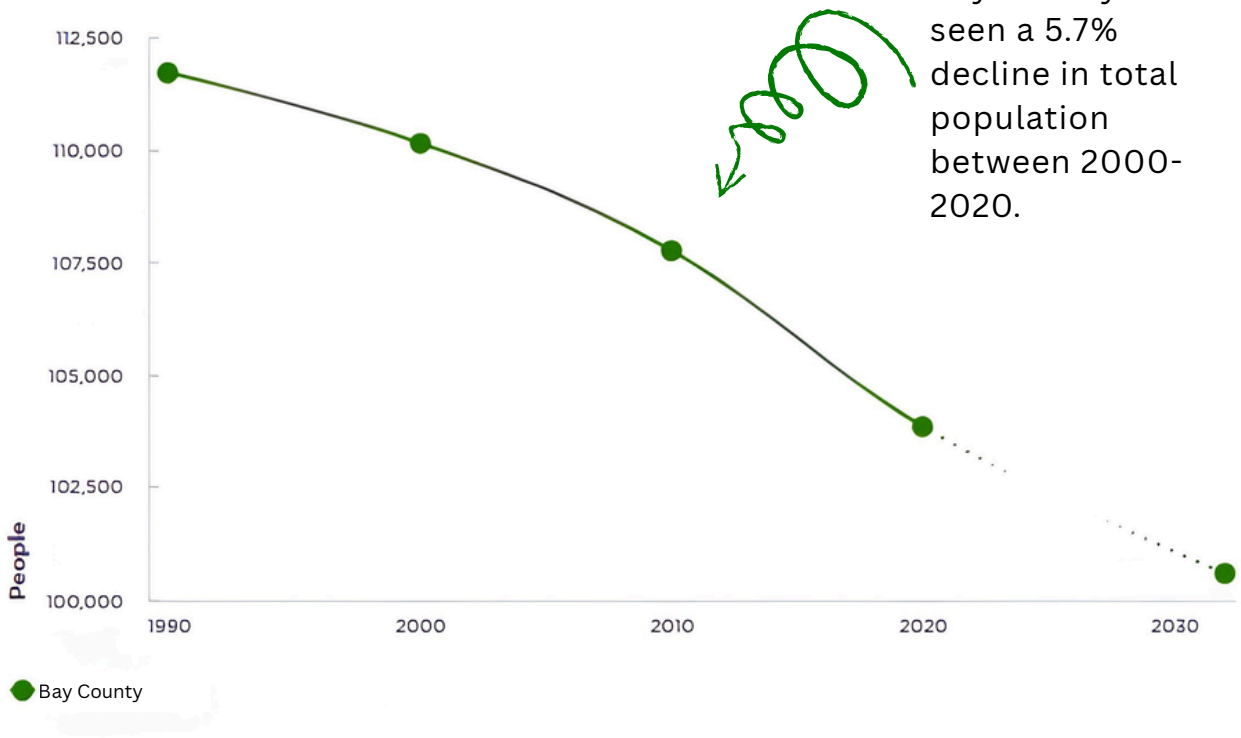
The focus of the Community Health Needs Assessment (CHNA) is to identify the community needs as they exist during the assessment period. Completed in August 2025, the project revolved around one central question: How do we improve health and quality of life in our communities? For the purpose of this assessment, the community is defined as the McLaren Bay Region’s service area’s. The target population of the assessment reflects an overall representation of the communities served by the hospital and all health and human services providers in Bay County.

The results of this assessment are crucial for guiding strategic planning and resource allocation by the hospital and its community partners to address the most significant health priorities.

You can view the 2025 Bay County Community Health Assessment at this link: https://dashboards.mysidewalk.com/bay-county-cha/our-health-tells-a-story

# Total Population

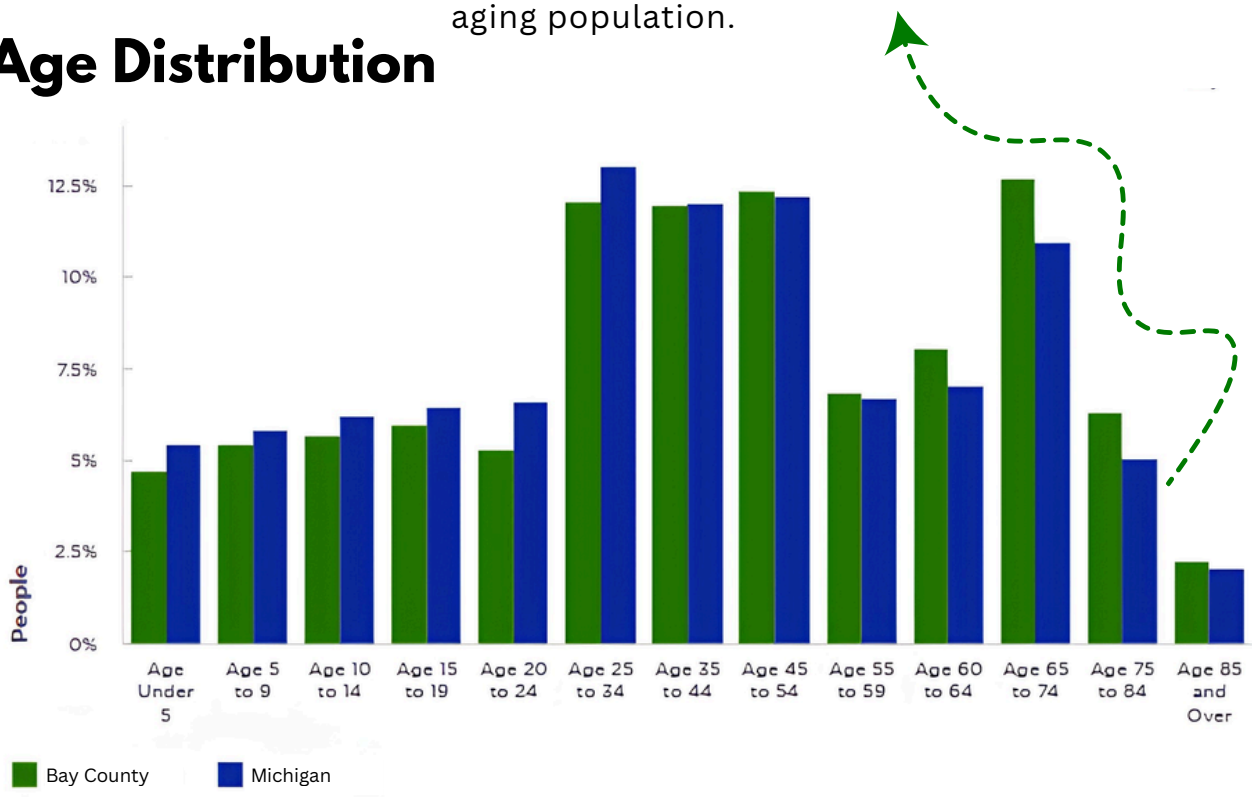
Bay County has seen a 5.7% decline in total population between 2000-2020.




*Sources: US Census Bureau; US Census Bureau ACS 5-year*

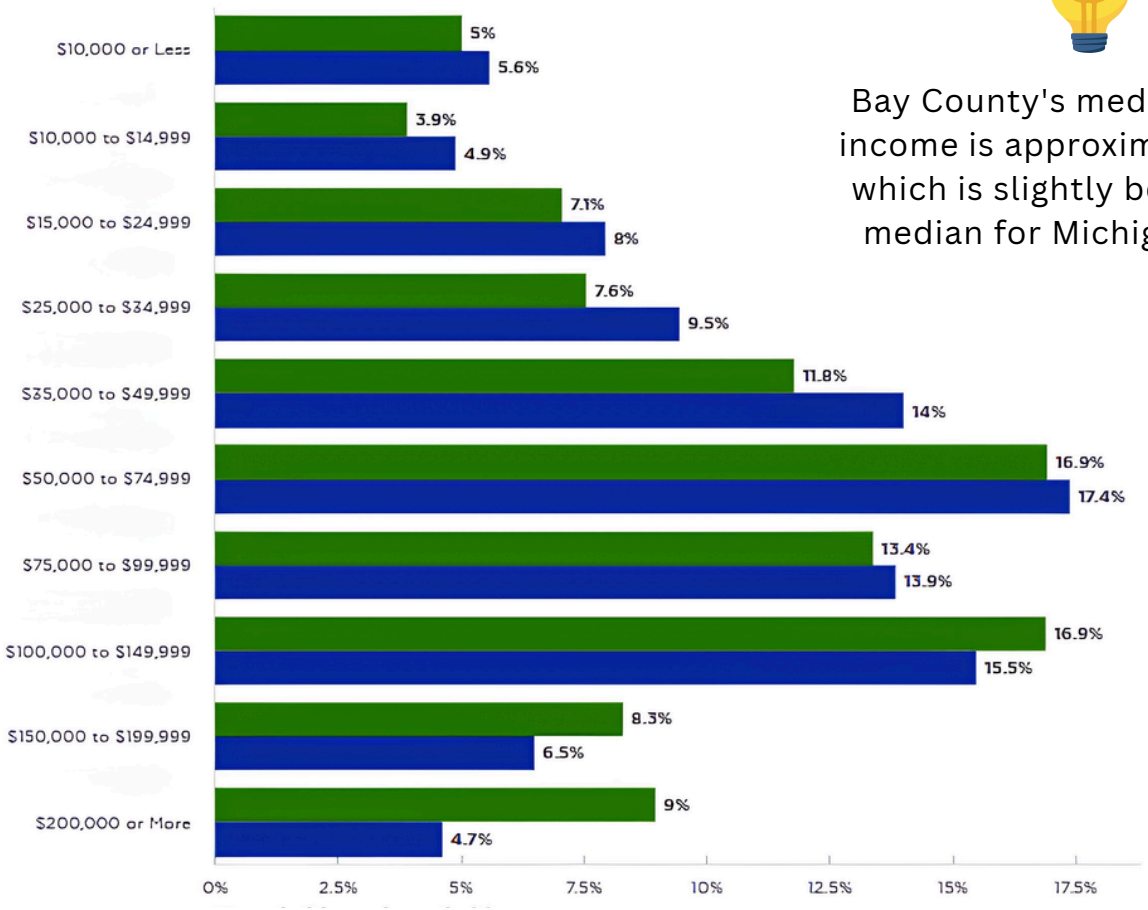
# Age Distribution

With a median age consistently higher than the state average (around 43.8 years compared to Michigan's 40.5), Bay County's demographic profile points to an aging population.




*Sources: US Census Bureau ACS 5-year 2019-2023*

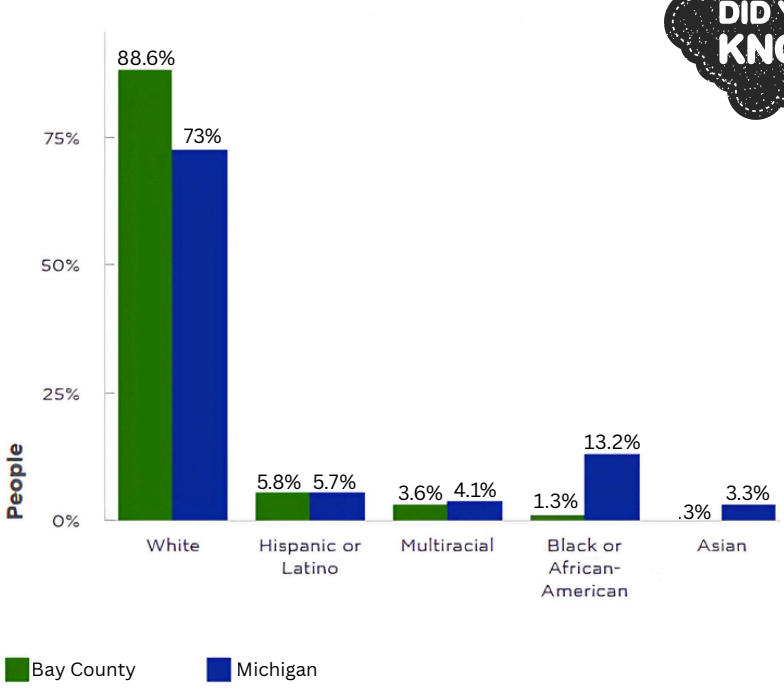
## Household Income for Michigan, Bay County, MI

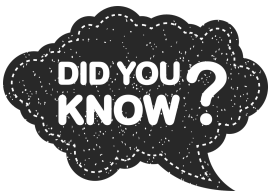



Sources: US Census Bureau ACS 5-year 2019-2023

Bay County's median household income is approximately $60,523, which is slightly below the state median for Michigan ($71,149).

## Race Distribution in Bay County, MI




All of this information and more can be found in our **NEW** interactive Community Health Assessment Dashboard!

https://dashboards.mysidewalk.com/bay-county-cha

*Sources: US Census Bureau ACS 5-year 2019-2023*

*Note: Hispanic or Latino includes any race. All other races in this chart are not Hispanic or Latino.*

# County Health Rankings

The County Health Rankings & Roadmaps program is a collaboration between the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute. The County Health Rankings show the rank of the health of nearly every county in the nation and illustrate that much of what affects health occurs outside of the doctor's office. The Rankings help counties understand what influences the health of residents and how long they will live. The Rankings are based on a model of population health that emphasizes the many factors that, if improved, can help make communities healthier places to live, learn, work and play.

# Health Outcomes

Health outcomes represent how healthy a county is right now, in terms of length of life but quality of life as well.

Bay County is faring about the same as the average county in Michigan for population health and well-being, and slightly better than the average county in the nation.

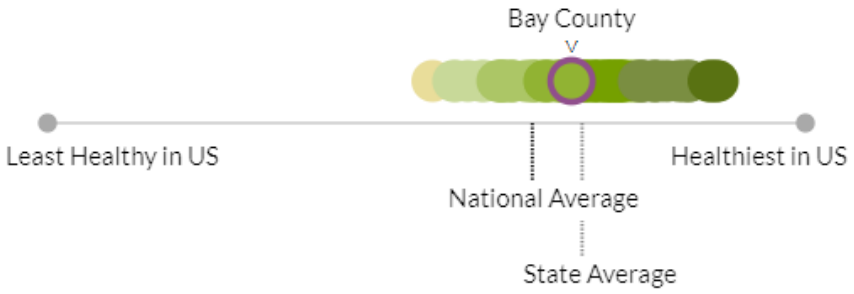



Diagram summarizes data released on 03/19/2025

# Health Factors

Bay County is faring about the same as the average county in Michigan for Community Conditions, and slightly better than the average county in the nation.

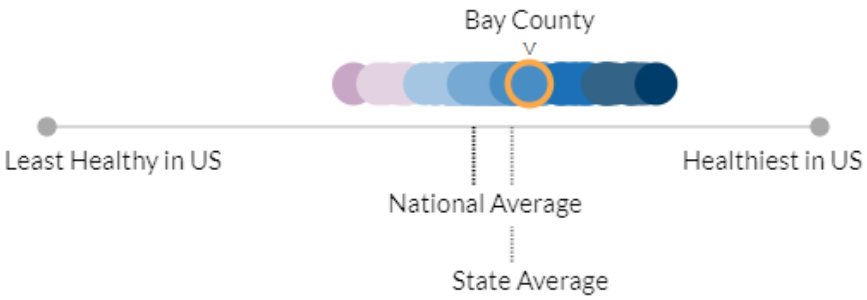
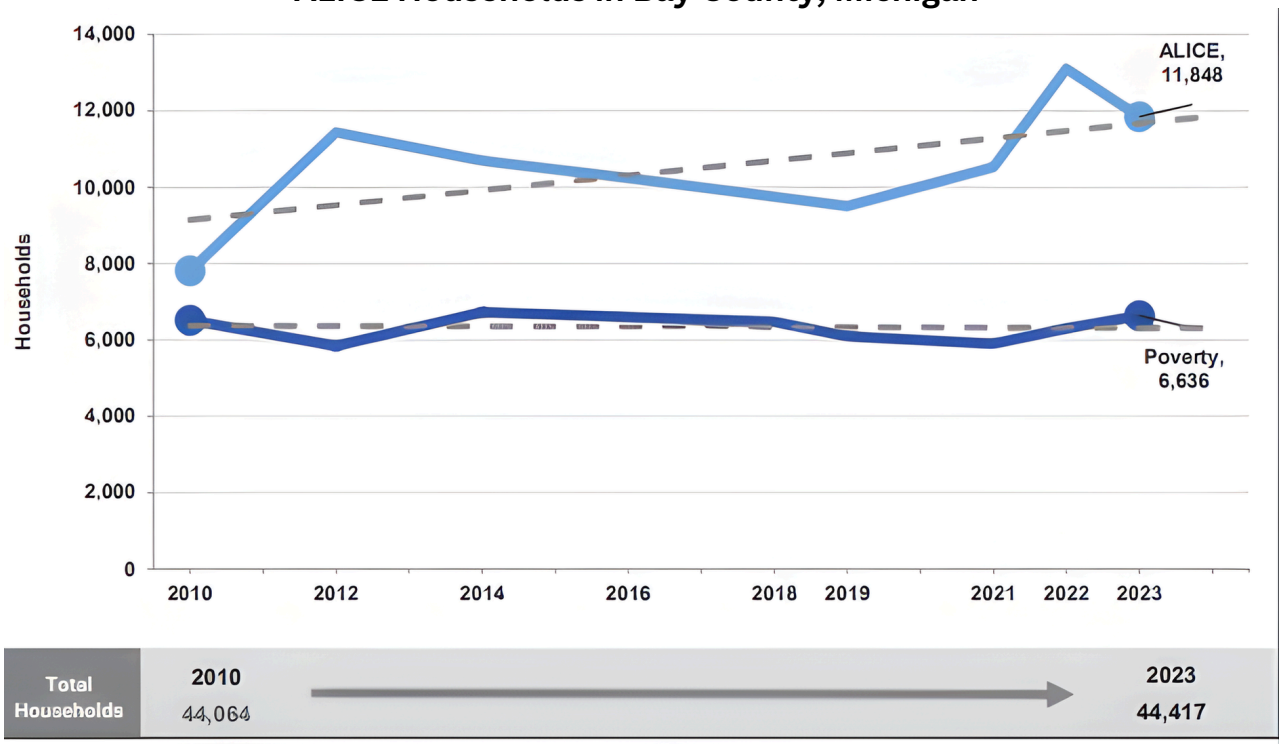



Diagram summarizes data released on 03/19/2025

## ALICE Households in Bay County, Michigan



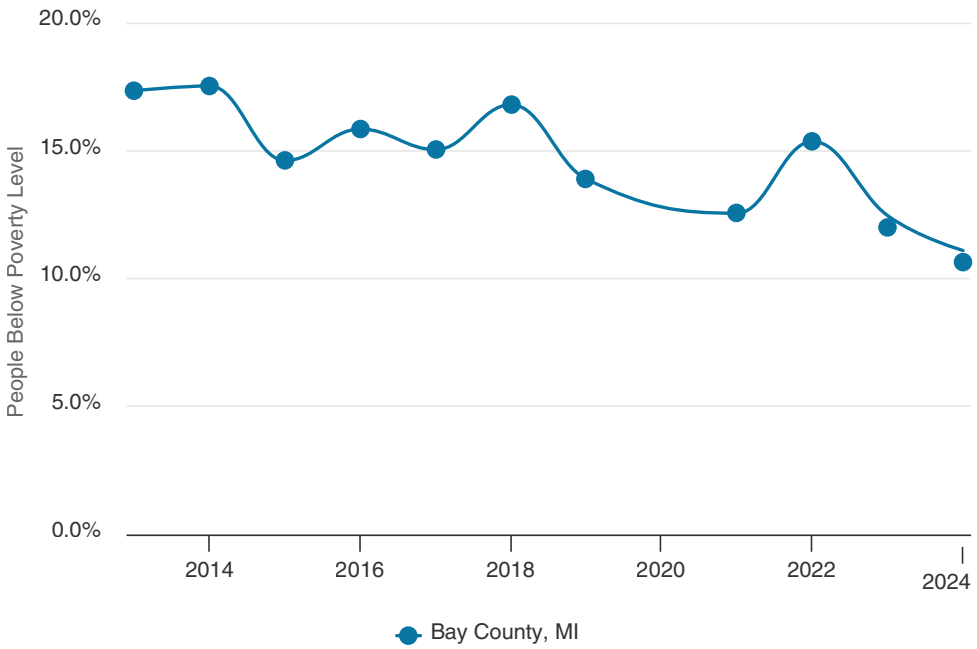

**Note: See an interactive version of this data at UnitedALICE.org/Michigan**
**Source: ALICE Threshold, 2010-2025, American Community Survey, 2010-2023**

## WHAT IS ALICE?

An ALICE family is a household that earns more than the Federal Poverty Level (FPL) but less than the basic cost of living in their specific county.

These households may struggle to cover necessities like housing, child care, food, transportation, healthcare, and are vulnerable to financial emergencies like a car repair or a medical bill.

### People Below Poverty Level




| Household Size | Annual Gross Income (100% Federal Poverty Limit) |
|---|---|
| 1 Person | $15,960 |
| 2 Person | $21,640 |
| 3 Person | $27,320 |

U.S. Census Bureau. American Community Survey (ACS) 1-Year Estimates, Table B17021 ("Poverty Status of Individuals in the Past 12 Months by Living Arrangement"), People Below Poverty Level as a share of the Population for Whom Poverty Status is Determined, Bay County, Michigan; years 2013–2019, 2021–2024.

## Community Themes and Strengths Assessment

The community values and assets review, was designed to answer three vital questions:

- What is important to the Bay County community?
- How is the quality of life perceived by residents?
- What existing assets and resources can be used to improve overall community health?

The answers gathered from this review guided the direction of the entire assessment process.

## Community Survey

We collaborated to create an accessible resident survey, offered online and in paper, in both English and Spanish. This critical tool gathered hard data on demographics, physical and mental health, substance use, the impact of COVID-19, and social factors like housing and transportation, alongside identifying valuable community strengths. This feedback is essential, giving us a clear, evidence-based picture of Bay's greatest needs and assets. The resulting quantitative data informs the priorities laid out in the Community Health Improvement Plan.

## Community Conversations

To gather more qualitative insights, we hosted public discussion groups. Think of these less as a relaxed chat around your kitchen table, intentionally designed to encourage open, honest dialogue. We engaged residents with questions about the perceived strengths and areas needing improvement right in their own neighborhoods and across the wider Bay County area. These valuable sessions also allowed participants to share their personal vision for an ideal future community.

## Local Public Health Systems Assessment (LPHSA)

The public health system capabilities assessment was a formal review designed to evaluate the local public health infrastructure. This assessment aimed to answer: 1) What are the activities, competencies, and capacities of the local public health system? 2) How effectively are the 10 Essential Public Health Services being provided to the community? The BCHD collected this vital systems-level data in two ways: first, through a survey completed by local community organizations, and second, through a collaborative workshop where organizations identified their collective strengths and weaknesses in delivering the 10 Essential Services.

## Forces of Change Assessment (FOC)

The Analysis of External Changes and Trends was conducted to ensure the assessment was forward-looking and adaptable. This process sought to answer two key questions: 1) What is occurring or might occur externally that affects the health of the community or the local public health system? 2) What specific threats or opportunities are generated by these external occurrences? The FOC was finalized through a structured, facilitated discussion involving identified key community leaders and stakeholders.

## METHOD

The evaluation began with a comprehensive, multi-method approach to data collection, combining primary (newly gathered) and secondary (existing) information. We obtained primary data from key sources such as community and provider surveys, client interviews, and public meetings. The secondary data provided essential context on current health trends and metrics. After all data was synthesized, we entered the Prioritization and Planning phase, where we prioritized the identified health issues using the Hanlon Method. This prioritization then guided the creation of specific goals, strategies, and a detailed Community Health Improvement Plan.

- Regional meetings were conducted along with strategic community-focused conversations.
- Over 100 local, state, and national indicators were collected for the Community Health Status Assessment.
- Meetings were attended by a broad, multi-sector coalition (hospitals, health departments, community organizations) to co-own the entire process and work collaboratively to gather information about the community.

## REGIONAL STRATEGIC PRIORITIES

The identification and implementation plan was developed based on key findings in the Community Health Needs Assessment, aligned with the hospital's strategic plan, and a review of the hospital's existing community benefit activities.

- Access to Care/Chronic Disease Prevention
- Affordable Housing
- Mental Health
- Substance Use
- Equity
- Economic Security
- Transportation
- Safety and Well-being

## CERTIAN STRATIGIES WERE NOT TARGETED AND WHY

The Bay County Health Department, United Way of Bay County, and McLaren Bay Region acknowledge the wide range of issues identified in the Community Health Needs Assessment (CHNA). Given the broad nature of these findings, the committee determined that we could achieve the greatest impact by focusing strictly on direct health-related issues. While critical community needs like Affordable Housing, Economic Security, and Broadband Access were reviewed, the committee felt these fell outside our primary health focus where we could drive immediate, viable change.

## IMPLEMENTATION PLAN

# Maternal and Child Health

### STRATEGIC ISSUE:

Ensure a community has the capability to provide preventative and accessible maternal and infant health services.

### GOAL:

Improve Maternal and Child health by ensuring access to appropriate, quality services and support.

### STRATEGIES:

- Promote and expand doula services in Bay County.
- Promote diabetes education services to mothers.
- Expand publicity in health fairs and expos distributing free information and education on reducing health risks.
- Participate in national health observances (Great American Smoke Out, Nutrition Month, Breastfeeding month, etc.).
- Increase the availability and reimbursement of doulas and Community Health Workers (CHWs).
- Address social determinants of health.
- Improve access to care/home visits.
- Improve the location of and number of health services offered to residents of the Bay region.

# Behavioral Health (Mental Health & Substance Use)

### STRATEGIC ISSUE:

Ensure a community has preventative and accessible substance abuse services.

### GOAL:

Improve substance use through prevention and by ensuring access to appropriate, quality services and support.

### STRATEGIES:

- Broaden access to Naloxone (Narcan) training and distribution through pharmacies, first responders, and community health centers to prevent opioid overdose deaths.
- Strengthen local youth substance use prevention coalitions and improve awareness/integration.
- Promote proscription drug collection drives and community take-back initiatives.
- Participate in substance use prevention and awareness efforts in collaboration with local providers.
- Promote the integration of behavioral health services within non-traditional settings like primary care clinics and local law enforcement centers.

## Chronic Disease

### STRATEGIC ISSUE:

Ensure the community has the capability to address the root causes of chronic disease by overcoming systemic barriers to healthy lifestyles and proactive self-management.

### GOAL:

Reduce the burden of chronic disease by ensuring access to and utilization of appropriate prevention and self-management programs.

### STRATEGIES:

- Promote Diabetes Prevention Program (DPP) to help residents manage their symptoms, pain, stress, and develop action plans for better health.
- Partner with local clinics, pharmacies, and community centers to offer free or low-cost screenings for conditions like high blood pressure, high cholesterol, and pre-diabetes, and ensure a clear pathway for participants to be referred to a primary care provider or specialist.
- Support initiatives that increase access to affordable, healthy food in all parts of the county, especially in food deserts.
- Employ Community Health Workers to work specifically with patients who have frequent Emergency Room visits for manageable chronic conditions like diabetes or COPD.
- Promote senior evidence-based fall prevention and arthritis management programs at local senior centers, faith organizations or local gyms.

## Reporting Requirements

Both Michigan hospitals and local health departments have mandatory public reporting duties regarding community health.

Non-Profit Hospitals (IRS Mandates): Tax-exempt hospitals must comply with IRS Section 501(r). This requires them to:

- Conduct a Community Health Needs Assessment (CHNA) every three years.
- Formally adopt an Implementation Strategy (CHIP) outlining how they will meet the identified needs.
- Make both the CHNA and CHIP publicly available on their website for transparency.
- Report their CHNA/CHIP activities annually on IRS Form 990, Schedule H.

Local Health Departments (Public Health Code): Health departments are responsible for public health surveillance and improvement:

- Lead or collaborate on the Community Health Assessment (CHA) and development of the long-term CHIP.
- Required to receive and report data on communicable diseases, infections, and outbreaks from healthcare providers and other entities to the state (MDHHS) for purposes of control and prevention.