2019 Community Health Needs Assessment

MICHIGAN MEDICINE
UNIVERSITY OF MICHIGAN

ST. JOSEPH MERCY
ANN ARBOR
SAINT JOSEPH MERCY HEALTH SYSTEM

HEALTH
ST. JOSEPH MERCY
CHELSEA

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EXECUTIVE SUMMARY

Background

From 2015 – 2016 all nonprofit hospitals in Washtenaw County, Michigan collaborated to conduct a single Community Health Needs Assessment (CHNA) for the shared geographic region of greater Washtenaw County. The hospitals--Saint Joseph Mercy Ann Arbor (SJMAA), Saint Joseph Mercy Chelsea (SJMC), and Michigan Medicine (UMHS)—named their collaborative the Unified Needs Assessment Implementation Plan Team Engagement (UNITE) group. UNITE group members assembled and assessed data in partnership with the Washtenaw County Public Health Department and area health coalitions; the process was facilitated by the Washtenaw Health Initiative.

The UNITE group, which is continuing to work together to promote health and improve health equity in Washtenaw County, reassembled in 2018 to take this work further. UNITE group members are now collaborating on both a CHNA and Implementation Plan to guide hospital community benefit investments across Washtenaw County for the next three years. They are continuing to work with the Washtenaw Health Initiative (WHI)—a voluntary, county-wide collaboration focused on improving the health of low-income populations in Washtenaw County—as a facilitator.

Identification and Prioritization of Needs

- Members of the UNITE group analyzed data from multiple data sources, community focus groups, and key stakeholder/informant interviews to determine potential priority areas.
- The data show that the three priority areas identified in the group's 2016 CHNA--mental health and substance use disorders, Obesity and related illnesses, and Preconceptual and perinatal health--continue to be significant areas of need across the community.

The selected priorities—outlined in the pages that follow—were analyzed through the lens of social determinants of health (SDOH) and health equity, and presented for approval and adoption to each hospital's executive board and were approved by St. Joseph Mercy Ann Arbor April 24, 2019, by St. Joseph Mercy Chelsea May 17th 2019, and by Michigan Medicine June 6th, 2019.

I. INTRODUCTION

The Patient Protection and Affordable Care Act (PPACA) of 2010 mandated new IRS requirements for hospitals to: (i) conduct a Community Health Needs Assessment (CHNA) every three years and (ii) adopt an Implementation Plan to address community needs every three years. Both the assessment and plan must be reported in the hospital's Schedule H 990. The provisions took effect in a hospital's taxable year beginning after March 23, 2012. Failure to comply could lead to a $50,000 excise tax and possible loss of tax-exempt status.

Until 2016, each hospital in Washtenaw County published an individual Community Health Needs Assessment. While each CHNA's structure and format was unique to the specific hospital, the proximity of the three hospitals resulted in comparable community needs and populations served. Each hospital also utilized the same community level data and surveys to identify these needs. To improve service to the community and to increase the impact of the implementation plan, each hospital made a commitment to come together and publish a collaborative CHNA on behalf of all three hospitals in the area: Saint Joseph Mercy Ann Arbor, Saint Joseph Mercy Chelsea, and the University of Michigan Health System. Representatives from each hospital formed a group titled UNITE (Unified Needs Assessment Implementation Plan Team Engagement) to engage the community and collaborate to assess and address community needs together. The Washtenaw County Health Department also sits at the UNITE table as a critical partner in this work. The first joint plan was published in 2016, and the group re-convened for the 2019 cycle.

A. RETROSPECTIVE REVIEW - 2016 COMMUNITY HEALTH NEEDS ASSESSMENT

Identification and Prioritization of Needs

Members of the UNITE team analyzed data from multiple data sources, community focus groups, and key stakeholder and informant interviews to determine potential priority areas. Potential priority areas were evaluated based on the following agreed-upon criteria, taken from each hospital's previous criteria, and based on common public health frameworks:

1. Number of people impacted,
2. Severity of the problem,
3. UNITE members' ability to positively impact the potential priority,
4. UNITE members' ability to enhance existing resources or complement strategies
5. Alignment with institutional missions, and
6. Likely impact on health equity.

Potential priorities were ranked using a point system based on how well the potential priorities met criteria one through five; points were then summed for these criteria. To emphasize criterion six, the UNITE group agreed to separately rank each potential priority and then multiply by a factor reflecting impact on equity for each potential priority, thus allowing for health equity to have a bigger impact in the final selection of top health priorities. If there was a tie, it would be resolved by democratic vote, with one vote per UNITE voting entity (Saint Joseph Mercy Ann Arbor, Saint Joseph Mercy Chelsea, and the University of Michigan Health System).

Ranked potential priorities were then presented to the Washtenaw Health Initiative Steering Committee for review before being presented for approval and adoption to the hospital executive boards of Saint Joseph Mercy Ann Arbor, Saint Joseph Mercy Chelsea, and the University of Michigan Hospitals and Health Centers.

The following were presented as potential priority health needs:

Oral Health • Decay-related tooth loss • Dental care	Mental Health • Mood disorders • Psychoses • Anxiety disorders	Infant Mortality
Cardiovascular Diseases • High blood pressure • Stroke	Substance Use Disorder • Tobacco use • Binge drinking • Marijuana use • Opioid use	Unintended Pregnancy
Diabetes	Obesity	Vaccine-Preventable Diseases

From these, three top health priorities were adopted by the approval bodies at each institution:

B. RETROSPECTIVE REVIEW - 2016 IMPLEMENTATION STRATEGY

Below is a non-exhaustive summation of activities and outcomes achieved across health systems.

Saint Joseph Mercy – Ann Arbor

Priority 1: Mental Health and Substance Use Disorders

Goal #1: Improve the behavioral health status of at-risk populations in the community, including people who are homeless and have mental health and/or substance abuse conditions, older adults, and pregnant women and their fetuses.

Activity #1: Provide health safety net services to the uninsured and underinsured through health clinics, health fairs, and screenings in the community.
Outcome: Over $800,000 per year was allocated in outward outward-facing and SJMAA-run safety net clinics.

Activity #2: Work with Washtenaw County Sheriff's Department Street Outreach Team to develop a cohort of health-focused outreach workers.
Outcome: Conducted three didactic sessions for Emergency Department and Primary Care residents by those in long-term recovery around interactions with healthcare system. Pre- and post-survey results showed an increase in empathy and knowledge of existing resources to support behavioral health patients).

Activity #3: Expand presence and align existing resources around behavioral health services in primary care and community settings.
Outcome: In 2017, Developed Transition Clinic to serve Behavioral Health inpatients discharged through SJMAA. Funded two programs designed to increase the integration of behavioral health into primary care and community settings through partnership with Washtenaw County Coordinated Funders.

Goal #2: Reduce Substance Use Disorders to protect the health, safety, and quality of life for all, especially children.

Activity #1: Advocate for adoption of tobacco control policies; Enhance standard physician practice and clinic flow process improvement policies around tobacco cessation counseling and referral.
Outcome: Tobacco 21 legislation passed in Ann Arbor ensuring e-cigarettes were added to tobacco-free campus policies; established new clinical tobacco cessation programs for those who are ineligible/not compatible with state quit line resources.

Activity #2: Continue to provide substance use prevention education through the Health Exploration Station.
Outcome: Over 15,000 youth and adults participated per year in SUD related programming, and new programming was developed in 2018 to support community needs arising around vaping among youth.

Priority 2: Obesity and Related Illnesses

Goal #1: Promote healthy weight and reduce chronic disease risk among youth and adults.

Activity #1: Support, maintain, and explore programs that target nutrition education (i.e. Health Exploration Station, ShapeDown, The Farm).
Outcome: Over 1,000 students per year participated in youth education at The Farm at St. Joe's. Additionally, over 250 youth per year participated in ShapeDown weight management programming. As a result of the ShapeDown program in 2017, 55 percent of participants reported that their Body Mass Index (BMI) decreased or remained the same, and self-reported consumption of three or more servings of fruit and vegetables per day went from 37 percent to 70 percent of participants.

Activity #2: Through Washtenaw County Coordinated Funders Program Operations grants cycle, finance efforts to reduce food insecurity through local safety net food provision organizations.
Outcome: Over $50,000 per year was allocated through Coordinated Funding to support food security initiatives. Each year, SJMHS hospitals return over $500,000 back to local farmers through programming run or supported by hospital sites. Coordinated Funding efforts contributed to a decrease of those reporting food insecurity in the community within the Implementation Plan cycle.

Priority 3: Pre-conceptual and Perinatal Health

Goal #1: Increase positive outcomes for pre-conceptual and perinatal health. Improve the health and well-being of women, infants, children, and families.

Activity #1: Educate expectant mothers on the risks of smoking during pregnancy; continue Centering Pregnancy group pre-natal program.
Outcome: Centering Pregnancy 2017 results show the rate of premature babies decreased from 12 percent to 4 percent; low birth weight decreased from 7.8 percent to 4 percent; and 82 percent of mothers reported breastfeeding at hospital discharge.

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Saint Joseph Mercy – Chelsea

Priority 1: Mental Health and Substance Use Disorders

Goal #1: Improve health by increasing social support and access to behavioral health services.

Activity #1: Expand presence of behavioral health services staff in primary care and community settings.
Outcome #1: A Behavioral Health Navigator was deployed in the five communities that make up the SJMC primary service area, to help people access needed mental health services. The BHS Navigator works with safety net providers, schools, primary care physicians, and others who can refer individuals or families in need of support. In the first two years of this program, the Navigator assisted 251 people, and provided education and training for 2,467 people.
Outcome #2: SJMC secured grant funding from the Community Mental Health Partnership of Southeast Michigan to bring a Project SUCCESS Counselor to two local school districts. Project SUCCESS is a school-based youth substance abuse prevention program. The counselor conducts screening, facilitates small group work, provides brief individual interventions, and makes referrals to community mental health providers when needed. The counselor also coordinates positive social norm campaigns to promote the fact that most teens do not use drugs or alcohol. Finally, the counselor conducts educational sessions for students and parents on drugs and alcohol, including vaping, or e-cigarette use.

Activity #2: Participate in local youth mental health coalition and support related activities.
Outcome: Hospital representatives from the Community and Behavioral Health departments participated on school district wellness committees, as requested, to address mental health issues among youth.

Activity #3: Increase capacity to provide outpatient services to youth and adults.
Outcome: Measured by patient volume in outpatient BHS in Chelsea and Dexter.

Activity #4: Provide opportunities for mindfulness and wellness.
Outcome: In partnership with the Cancer Center, and Therapy Departments, SJMC provided free yoga classes designed specifically for cancer patients, survivors and families in the community.

Goal #2: Reduce Substance Use Disorders to protect the health, safety, and quality of life for all, especially children.

Activity #1: Support local community coalitions in addressing the risk and protective factors that lead to youth substance abuse.
Outcome: SJMC facilitated the SRSLY coalitions in Chelsea, Dexter, Manchester and Stockbridge, which work to prevent youth substance abuse. These communities have seen youth substance use rates drop in recent years, as measured by the Michigan Profile for Healthy Youth survey. Less than 15% of high school students reported regular marijuana use in these four communities, and this rate was lower than it was when SRSLY started; regular marijuana use has increased in other communities in Washtenaw County during the same time period. Lifetime and regular alcohol use and binge drinking were also down across these four towns during this time period; Binge drinking among Chelsea teens is down by 52% compared to 2007. (Source: MiPHY)

Activity #2: Reduce availability of opiate prescription medication in the community available for diversion to youth or adults
Outcome: Safe medication disposal sites maintained by local law enforcement in the five towns in the SJMC primary service area. SJMC Surgery department worked to change prescribing and patient education practices to reduce the number of unused medications following surgery.

Priority 2: Obesity and Related Illnesses

Goal #1: Promote health and reduce chronic disease risk by increasing the prevalence of healthy weight among youth and adults living and working in the SJMC service area.

Activity #1: Increase access to fruits and vegetables for the community.
Outcome #1: SJMC served as the fiscal agent and employed the Market Manager at the Chelsea Farmers Markets. The markets ran twice per week, May through October, and once per week in November and December. The total sales at these markets was more than $500,000 for the 2016-2018 market seasons. SJMC also made financial contributions to local farmers market food assistance programs through community food pantries. Total food assistance sales at the Chelsea, Dexter and Manchester farmers markets for 2016-2018 was $34,494.
Outcome #2: With support from the Hilton Fund, SJMC partnered with Washtenaw County Health Department and the Chelsea Senior Center to develop a low barrier food assistance program to benefit seniors and local farmers markets. Senior Market Bucks started in 2017, and was repeated in 2018. The program provided booklets of coupons redeemable only at the farmers markets in Chelsea, Dexter and Manchester. The Senior Market Bucks program served 218 seniors, and supported 32 local farmers in 2018, with total sales of $2,936.
Outcome #3: Starting in 2017, SJMC dedicated 10 hours per week for a Registered Dietitian to provide education and technical assistance on nutrition. The Community Nutritionist worked with local wellness coalitions, schools, churches, and businesses to increase healthy eating through system and policy changes, education, skill-building, and support.

Activity #2: Increase access to opportunities for physical activity.
Outcome #1: The Heart and Sole run/walk/bike event maintained low-cost entry fees for youth to promote participation in the race, and as a result more than 20% of runners and walkers were under the age of 18. More than 500 participants completed the race every year, including groups from local elementary schools, senior living facilities, and the St. Louis Center, which is a residential facility and school for youth and adults with intellectual and developmental disabilities.
Outcome #2: Increase and improve walking paths to encourage physical activity. SJMC created a master plan to connect and improve walking paths through the hospital campus, which were regularly utilized by community members walking for exercise, and children walking to and from school. SJMC also donated financial resources to the Huron Waterloo Pathways Initiative to continue their work developing paved paths for safe recreation in the region.
Outcome #3: Due to decreased demand, and duplicated resources in the community, SJMC no longer offered staff support for the Healthy Communities Walking Program. This program is now offered to businesses and churches through the Occupational Medicine and Faith Community Nursing programs. Participants in the program tracked their walking, and received peer support through group challenges and progress tracking on maps. Previous evaluations demonstrated that program completers lost an average of ten pounds in a year, and reported fewer poor mental health days once they started walking for exercise regularly.

Activity #3: Build skills and provide support to prevent the onset or complications of diabetes and other weight-related illnesses.
Outcome #1: SJMC began offering the Diabetes Prevention Program in 2016 through Faith Community Nursing, and expanded the program under Diabetes Education in 2017. Program participants have reported an average weight loss of 10 pounds, or 5.74% of starting body weight. The most recent cohort to complete the program in Chelsea enjoyed the peer support aspect of the program so much, they decided to form an ongoing monthly share group, so they could continue to meet after the initial 12-month program ended.
Outcome #2: The SJMC Diabetes Share Group met monthly to provide education and support to residents living with diabetes. The group heard presentations from medical professionals and community partners, including the local wellness center and farmers markets.
Outcome #3: Hungerwise is a mindfulness program to support healthy eating, created by SJMC in partnership with the Center for Eating Disorders in Ann Arbor. SJMC subsidized the program to make it more accessible to area residents. Hungerwise is not a weight loss or dieting program. Participant feedback has been very positive.

Activity #4: Participate in local wellness coalitions' and support activities related to social support as needed.
Outcome #1: 80% of wellness coalition meetings include a representative from SJMC, totaling more than 250 hours per year donated in-kind to support the coalitions.

Goal #2: Improve social determinants of health for the poor and vulnerable living in the SJMC service area.

Activity #1: Provide support to partner organizations working to address social determinants of health for poor and vulnerable populations living in the SJMC service area.
Outcome: From 2016 to 2018, SJMC donated $627,084 to non-profit organizations in the communities to address social determinants of health, including housing, food access, social isolation, education and transportation.

Activity #2: Increase rates of low-income residents with health insurance.
Outcome: Two SJMC staff members were trained to help people enroll in health insurance through the marketplace exchanges, or Medicaid expansion. More than 100 local residents were able to enroll in health insurance through Medicare, Medicaid, the Health Insurance Exchange, or McAuley Support with the help of these hospital staff.

Activity #3: Increase access to transportation for low-income residents.
Outcome: SJMC provided vouchers to patients who cannot afford transportation to and from healthcare appointments. The hospital also provided in-kind an financial assistance to the Washtenaw Area Value Express bus, which services Chelsea and the surrounding communities.

Michigan Medicine (UMHS)

Priority 1: Mental Health and Substance Use Disorders

Goal #1: Improve mental health through prevention and by ensuring access to appropriate quality mental health services and supports.

Activity #1: UMHS Depression Center has continued its depression and suicide awareness campaigns in numerous schools throughout Washtenaw County. Also, the Depression Center continued to build community awareness through its Bright Nights Forum at local libraries.
Outcome: Depression Center data available regarding awareness activities. Bright Nights Forum served approximately 125 persons per forum.

Activity #2: UMHS continued to provide a regularly occurring Speaker series for the Deaf, Deaf/Blind, and Hard of Hearing population using American Sign Language and providing free parking and food.
Outcome: Attendance data and topics can be obtained from UMHS Interpreter Services or from UMHS Deaf Health Clinic.

Activity #3: Michigan Medicine Population Health Office and Community Health Services worked collaboratively to develop a Social Determinants of Health screening to first pilot test and then implement across all Patient Centered Medical Homes within the system. This tool has helped screen and identify patient needs. The two departments are working on how to effectively enact change for all those who desire assistance.
Outcome: Patient Centered Medical Homes data report

Activity #4: Train providers to increase capability towards addressing needs of LGBTQ+ population, youth in schools, and Limited English Proficient (LEP) population through UMHS Interpreter Services.
Outcome: Michigan Medicine Adolescent Health Initiative has developed four Spark training modules to improve quality of care for LGBTQ+ youth.

Activity #5: Continued collaboration with Michigan Islamic Academy to coordinate the Health Sparks school based health program.
Outcome: Program serves approximately 160-200 students on a yearly basis and their school staff. Program has developed a peer to peer support network to help students learn how to identify depression in classmates and friends.

Activity #6: Provide health safety net services to uninsured and underinsured through health clinics, health fairs, and screenings in the community.
Outcome #1: Annually, Community Health Services provided free immunizations at local area churches and other community venues. Also, UMHS donated physician labor to the Hope Clinic from various departments.
Outcome #2: UMHS Emergency Department provided Emergency ride home services for patients who need transportation. This served approximately 1000-1100 patients each year.

Outcome #3: UMHS Ann Arbor Meals on Wheels (AAMOW) provided meals and support to fragile and homebound elderly in the community. AAMOW provides around 128,000 meals each year, to roughly 450 customers. MOW volunteers increase the well-being of a vulnerable homebound population by providing human contact that helps reduce isolation, depression and anxiety.
Outcome #4: UM School of Dentistry provides dental services to those eligible for Medicaid and a tiered payment for those who cannot afford services at the Community Dental Clinic.
Outcome #5: Continued to participate in efforts to address housing issues of vulnerable populations. Housing Bureau for Seniors (HBS) provides a variety of services that help keep seniors safely housed and provides support for taxes, etc. In FY 2018 alone, 152 clients remained in their rental housing through HBS' Eviction Prevention Program. HBS made 103 HomeShare placements to ensure the safety and wellbeing of older adults, allowing them to age in place, and 99 clients were able to keep their homes from being lost to foreclosure.

Goal #2: Reduce Substance Use Disorders to protect the health, safety, and quality of life for all, especially children

Activity: UMHS hosts Pain Medication take back events yearly in order to collect pills including opioids that might create harmful overdoses.
Outcome: Medication received at Take Back Events range from 96 to 587 pounds with an average of 238 pounds per event.

Goal #3: Reduce Substance Use Disorders to protect the health, safety, and quality of life for all, especially children

Activity: The Regional Alliance for Healthy Schools at Michigan Medicine continues to utilize Project S.U.C.C.E.S.S. in school-based health center programming in Washtenaw County.
Outcome: The Regional Alliance for Healthy Schools at Michigan Medicine has continually increased the number of adolescents receiving mental health visits between FY16 and FY18. For more specific information, please see: http://umhs-rahs.org/rahs-success/.

Priority 2: Obesity and Related Illnesses

Goal: Promote healthy weight and reduce chronic disease risk among youth and adults.

Activity #1: Project Healthy Schools continues to support programs in 13 Washtenaw County Schools.
Outcome: Data available upon request.

Activity #2: MHealthy continues to offer exercise and relaxation classes that are open to the community and also a database for healthy recipes.
Outcome: Data available upon request.

Activity #3: UMHS Ann Arbor Meals on Wheels continues to serve many seniors throughout Ann Arbor and to help them maintain proper nutrition and health.
Outcome: During following fiscal years (FY) this many customers received nutritionally balanced meals: FY16=406, FY17=440 and FY18=461.

Activity #4: Michigan Medicine's Regional Alliance for Healthy Schools (RAHS) served students and youth through visits with a Registered Dietitian.
Outcome: RAHS, in partnership with the Washtenaw County Health Department and Saint Joseph Mercy Health System, provides a Prescription of Health program to help support the increase of fresh vegetables and fruit by providing tokens to redeem at local farmer markets. In FY18 they enrolled a total of 63 patients. RAHS also partnered with Food Gatherers to distribute food boxes to students and families in need throughout their schools within Washtenaw County. They distributed between 5 to almost 50 boxes at each of the six schools they serve.

Activity #5: The Program for Multicultural Health in partnership with the UM-School of Public Health Dietetic Interns and School of Public Health Future Public Health Interns provide nutrition education to both youth and seniors.
Outcome: Data available upon request.

Activity #6: Participate and support local wellness activities, such as coalitions, walks, runs, and other wellness events.
Outcome: Data available on monies to support, volunteers, and number of participants.

Activity #7: UMHS Patient Food and Nutrition Services (PFANS) has partnered with Ypsilanti Meals on Wheels to provide tailored meals to fragile and homebound seniors that support their chronic disease conditions.
Outcome: UMHS-PFANS has become the supplier of balanced and nutritious meals to Ypsilanti Meals on Wheels (YMOW). This partnership has allowed YMOW to increase the number of meals from 5 to 6-7 meals per week per person.

Priority 3: Preconceptual and Perinatal Health

Goal: Increase positive outcomes for preconceptual and perinatal health. Improve the health and well-being of women, infants, children, and families.

Activity #1: U of M Psychiatry continues to provide a regular cycle of MOM Power programming out in the community for qualifying low-income residents.
Outcome: Data available in MiChart.

Activity #2: Provide positive parenting resources and empowerment workshops in public and low income housing communities.
Outcome #1: Michigan Medicine Program for Multicultural Health has developed a partnership with Family Empowerment Program and the Nursing sorority (Chi Eta Phi) to host health cafes that help with empowerment of families and individuals towards better health.
Outcome #2: Program for Multicultural Health staff devoted time to service to promote breastfeeding among Black Mothers through staff support of Black Mothers Breastfeeding Association (BMBFA), at the Ypsilanti Heritage Festival (YpsiFest) offering a safe, secure, and comfortable place for mothers to feed their infants. Also, providing trainings to groups within UMHS regarding supporting mothers when they go back to work.

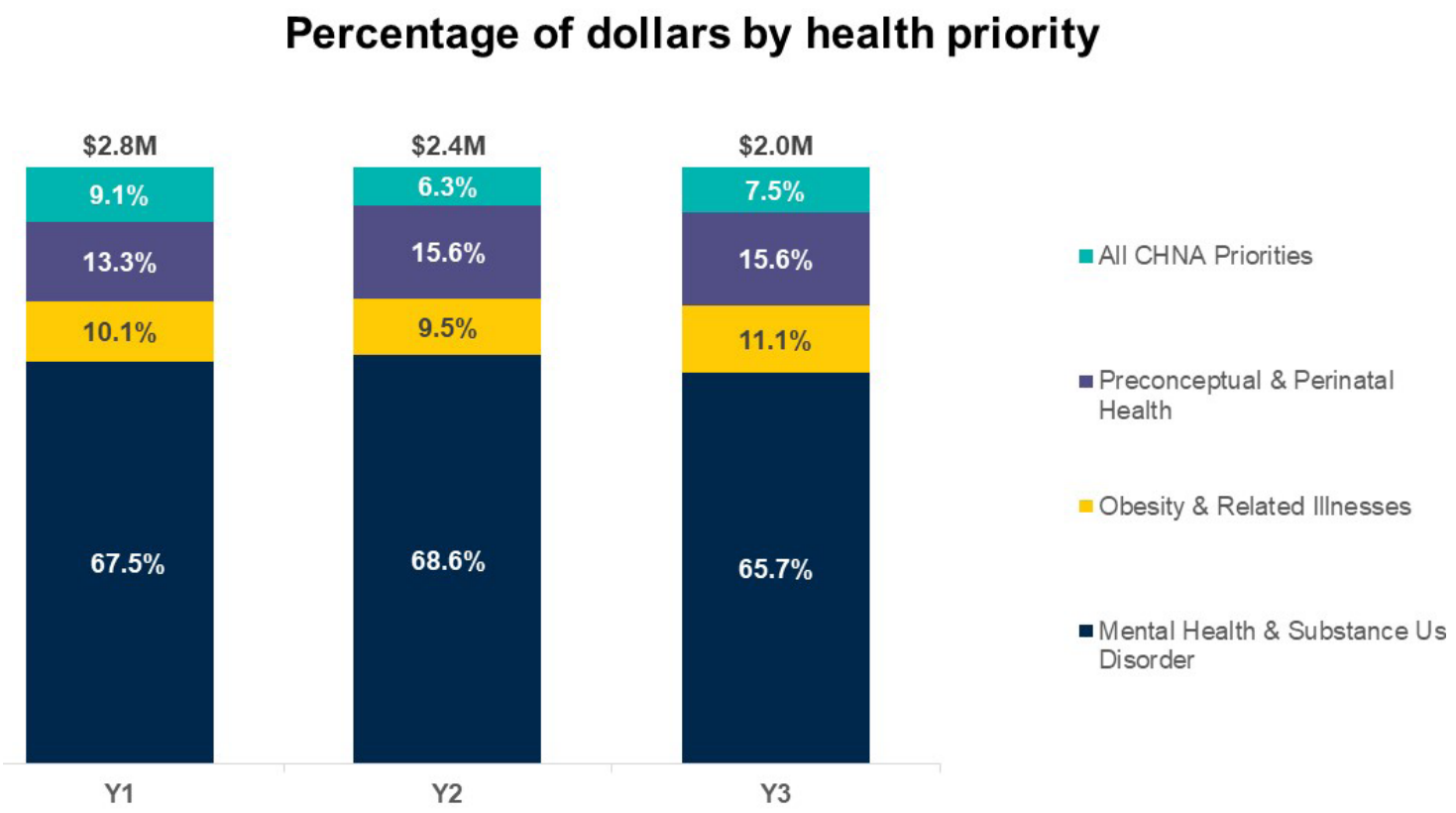
Activity #3: UMHS Maternal Infant Health Program has continued to serve Mothers and Infants within Washtenaw County.
Outcome: MIHP Has served 787 women between FY16 & FY17.

Activity #4: UMHS Women's Health Program provides a variety of classes to help educate women on birth, infant care, and other pre-conceptual and perinatal health topics.
Outcome: Women's Health Program has hosted a total of 42 events from FY16 - FY18.

Activity #5: Develop data collection strategy for use in community to identify supports and programming needed.
Outcome #1: Conducted a series five (5) focus groups (1 focus group in Spanish) with a total of 25 participants. Groups were hosted at community organizations, housing communities, and health centers in Ypsilanti, MI.
Outcome #2: One-on-one interviews were conducted with mothers within the Deaf/Hard-of-Hearing community.

Focus on Health Equity, the Social Determinants of Health and Community Accountability
Within each of the three priority areas described above, the University of Michigan Health System (UMHS) worked to address the social determinants of health and to improve health equity. With funding approved by UMHS executive leaders, Michigan Medicine Community Health Services conducted two RFP processes from 2018-19, requesting proposals from both community-based organizations and University of Michigan internal departments. Ultimately, UMHS funded a total of 26 community-based projects in the following categories.

Below is a breakout of dollars granted per CHNA health priority.



For more information on the funding opportunity please visit: http://www.uofmhealth.org/news/archive/201810/michigan-medicine-commits-72m-addressing-health-inequities or http://www.med.umich.edu/chs/.

II. COMMUNITY SERVED

Community Description

For the purposes of this needs assessment, the three health systems represented[1] serve all of greater Washtenaw County.

Washtenaw County is located in southeast Michigan and covers 720 square miles. Its cities, villages and townships are home to approximately 361,509 (census.gov) citizens in urban, suburban, and rural settings. The county consists of six cities, nineteen townships and two villages:

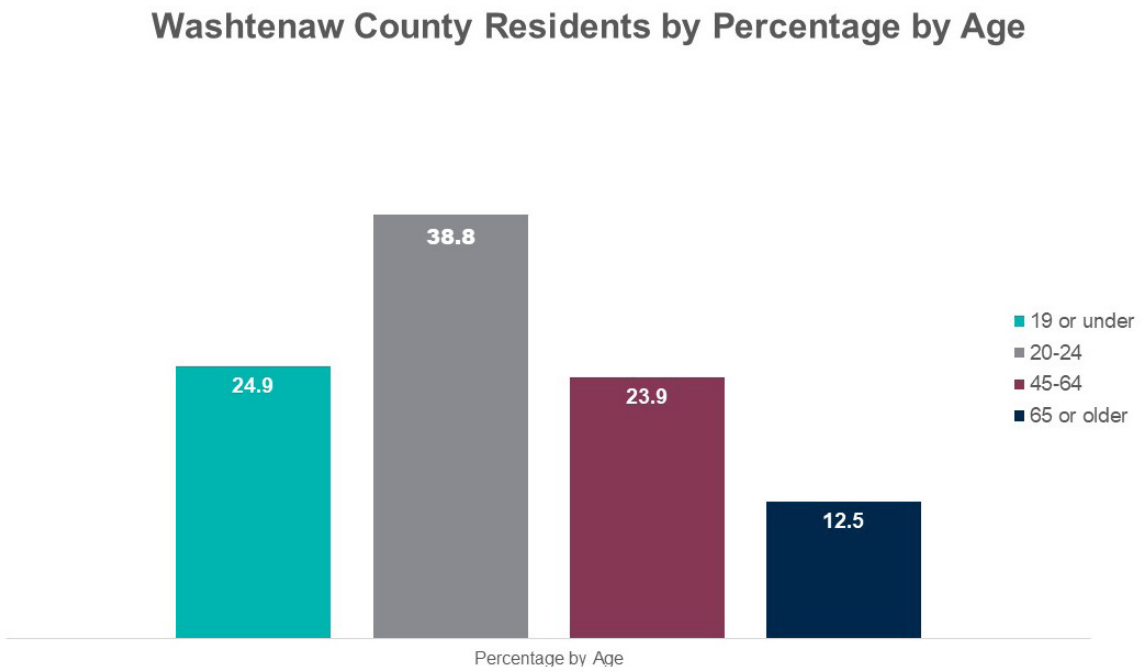
- Cities: Ann Arbor, Chelsea, Dexter, Milan, Saline, Ypsilanti
- Townships: Augusta, Bridgewater, Dexter, Freedom, Lima, Lodi, Lyndon, Manchester, Northfield, Pittsfield, Salem, Saline, Scio, Sharon, Superior, Sylvan, Webster, York, and Ypsilanti.
- Villages: Barton Hills, Manchester

Greater Washtenaw County includes two villages and four townships outside of Washtenaw County:

- Townships: Grass Lake, Henrietta, Stockbridge, Unadila
- Villages: Grass Lake, Stockbridge

Demographics

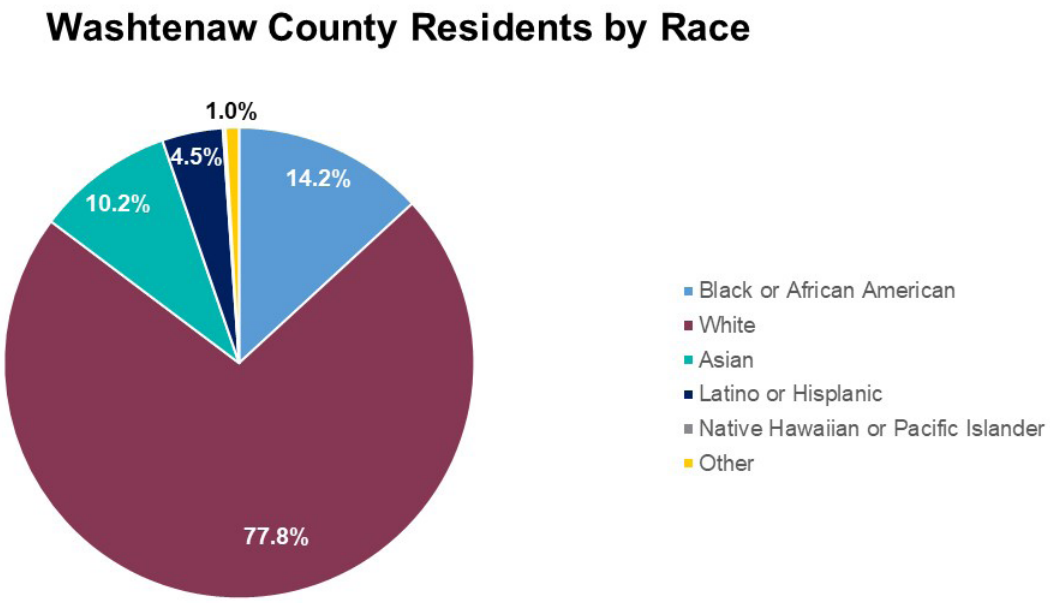
Of the County's 361,509 residents, 25 percent are age 19 or under, 39 percent are between the ages of 20 and 44, 24 percent are between the ages of 45 and 64, and 12.5 percent are 65 or older.[2]



Demographic information for Washtenaw County, Grass Lake Township, and Stockbridge Township are included below.

Washtenaw County Population (2013-2017 ACS 5-Year Estimates) https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?src=CF

Washtenaw County residents are 77.8 percent white, 14.2 percent Black or African American, 10.2 percent Asian, 4.5 percent Hispanic or Latino, and 0.2 percent Native Hawaiian or Pacific Islander. Percentages do not total because more than one race/ethnicity could be selected.



RACE	Percentage of County Population
White	77.8%
Black / African American	14.2%
Asian	10.2%
Native Hawaiian / other Pacific Islander	0.2%
Other	1.0%
Hispanic or Latino (of any race)	4.5%

The additional villages of Greater Washtenaw County served are more rural, and less racially diverse.

Of the 3,941 in Stockbridge Township, for example, 98.7 percent are white and the population is older, on average, with 22.1 percent age 19 or under, 28.1% age 20 to 44, 31.2 percent age 45 to 64, and 18.7 percent 65 or older.[3]

Stockbridge Township, Ingham Co. MI
https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?src=CF
Total Population: 3,941

GENDER	Percentage of Stockbridge Township Population	Percentage of Grass Lake Charter Township Population
Male	49.54%	53.4%
Female	50.6%	46.6%
Age		
19 years old & Under	22.1%	25.0%
20 - 44 years old	28.1%	27.6%
45 - 64 years old	31.2%	34.2%
65 & older	18.7%	13.2%
RACE		
White	98.7%	95.4%
Black / African American	0.2%	1.9%
Asian	1.4%	2.0%
Native Hawaiian / other Pacific Islander	1.6%	0.0%
Other	0.0%	0.9%
Hispanic or Latino (of any race)	4.2%	1.7%

3 Stockbridge Township, Ingham Co. MI
https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?src=CF
(Washtenaw County Population (2013-2017 ACS 5-Year Estimates) *race alone or in combination with other races)

Map of cities and townships in Washtenaw County, MI

Image source: https://gisappsecure.ewashtenaw.org/MapWashtenaw/

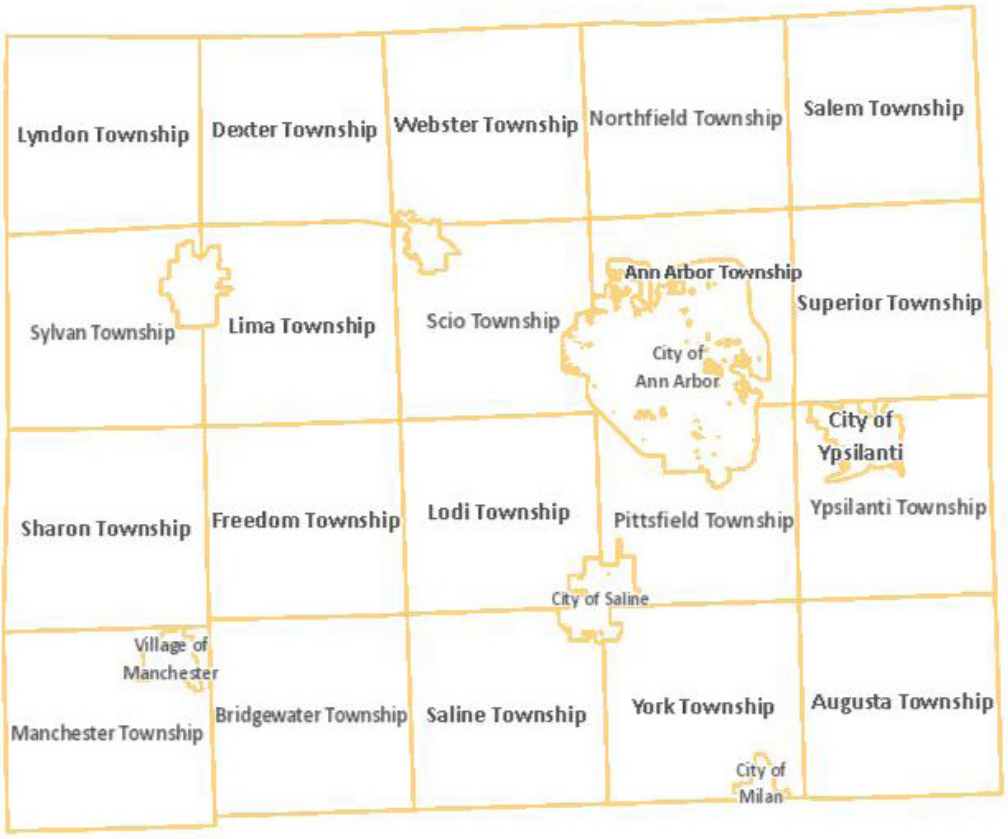


Figure 1: SJMC Service Area

III. 2019 CHNA PROCESS AND METHODS USED

Process and methods

The purpose of the 2019 CHNA was to:

- Evaluate current health needs of the community and discern whether previously identified needs continue to be priority areas
- Identify resources available to meet both the priorities as well as the opportunities identified through the CHNA
- Inform the development of an Implementation Plan to address the health priorities
- Build capacity to address the opportunities within the context of the existing health system programs, resources, priorities, and partnerships

Infrastructure

The infrastructure designed to successfully complete this CHNA required the full collaboration and participation of all three health systems and their partners.[4] Representatives from Saint Joseph Mercy Ann Arbor, Saint Joseph Mercy Chelsea, the University of Michigan Health System, the Washtenaw County Public Health Department and the Washtenaw Health Initiative (WHI) met regularly to develop the CHNA. Within each organization there was an internal structure for CHNA development. This infrastructure was based on existing partnerships within each health system, in addition to the establishment of new partnerships. No third parties were contracted to conduct this CHNA.

Saint Joseph Mercy Ann Arbor -- The CHNA and Implementation Strategy work at SJMAA was guided by the Community Benefit Ministry Council (CBMC), a leadership council comprised of SJMAA clinicians, department directors, and administrators with background, knowledge, and interest in health promotion and disease prevention. This group met monthly to review and analyze data, identify community partners, set priorities, and make decisions about the hospital's community health improvement initiatives. CBMC is responsible for conducting the Community Health Needs Assessment and developing the Implementation Strategy.

Saint Joseph Mercy Chelsea -- The CHNA and Implementation Strategy work at SJMC was guided by the Community Health Improvement Council (CHIC), a leadership council comprised of SJMC board members, clinicians, department directors, and administrators with background, knowledge, and interest in health promotion and disease prevention. This group met monthly to review and analyze data, identify community partners, set priorities and make decisions about the hospital's community health improvement initiatives. CHIC is responsible for conducting the Community Health Needs Assessment and developing the Implementation Strategy.

University of Michigan Health System -- The CHNA and Implementation Strategy work at UMHS was guided by the UMHS Community Health Coordinating Committee (CHCC). CHCC includes a wide range of leaders from the University of Michigan Medical School, the Office of Health Equity and Inclusion, the Department of Family Medicine, the Population Health Department, the Cardiovascular Center, the Children's and Women's Hospital, and the Obstetrics/Gynecology Department at UMHS, as well representatives from the Michigan Institute for Clinical and Health Research, the UM School of Public Health's Office of Public Health Practice, the UM Law School, the UM Ford School of Public Policy, and several community members.

The Washtenaw County Health Department (WCHD) actively participated in the UNITE process as a collaborator, a subject matter expert, and a connector to community resources and representatives. WCHD worked to align the Washtenaw County Community Health Improvement Plan (CHIP) priority health issues with those of UNITE.

The Washtenaw Health Initiative continued to support and assist the UNITE group in the 2018-2019 CHNA cycle. This support was given through the dedication of in-kind staffing (0.25 full-time equivalent in-kind staffing) for managing the project, securing logistics, gathering and analyzing data, and facilitating the group.

Data sources

Secondary data analysis

In order to build on the wealth of information and data analysis that had already been conducted by social service agencies, local government entities, county public health departments, and community-based organizations, the UNITE collaborative reviewed and analyzed 40 community assessments relating to health outcomes and the social determinants of health, including reports on housing and homelessness, food security, poverty, transportation, health literacy, and economic equity.

Each team member was allotted a certain number of reports to analyze and summarized key data points as they related to health inequities. These content and data summaries formed the basis for a deeper discussion at a UNITE data retreat that was convened in November 2018.

Primary data collection

In addition to the secondary data analyzed, UNITE members conducted primary data collection in areas where it was felt there were gaps in existing data. Specifically, Michigan Medicine conducted five focus groups to understand the needs of pregnant women and mothers of young children, as these groups were underrepresented in the secondary data. Four English and one Spanish focus group were facilitated in the community, with a focus on low-income and under-served groups. UNITE sought to better understand their specific needs, especially in light of the fact that pre-conceptual and perinatal health had previously emerged as one of the community's top health needs.

Another mode of primary data collection was through the Michigan State Innovation Model (SIM), which required hundreds of primary care providers across the state to screen their patients for social determinants of health needs. Michigan Medicine and Saint Joseph Mercy Health System clinical partners through IHA medical group deployed this SDOH survey across a variety of clinical service providers. Through December 2018, 72,430 patients were screened across three health systems and 5 percent reported at least one of the nine social needs on the screening tool.[5]

Community engagement and prioritization of needs

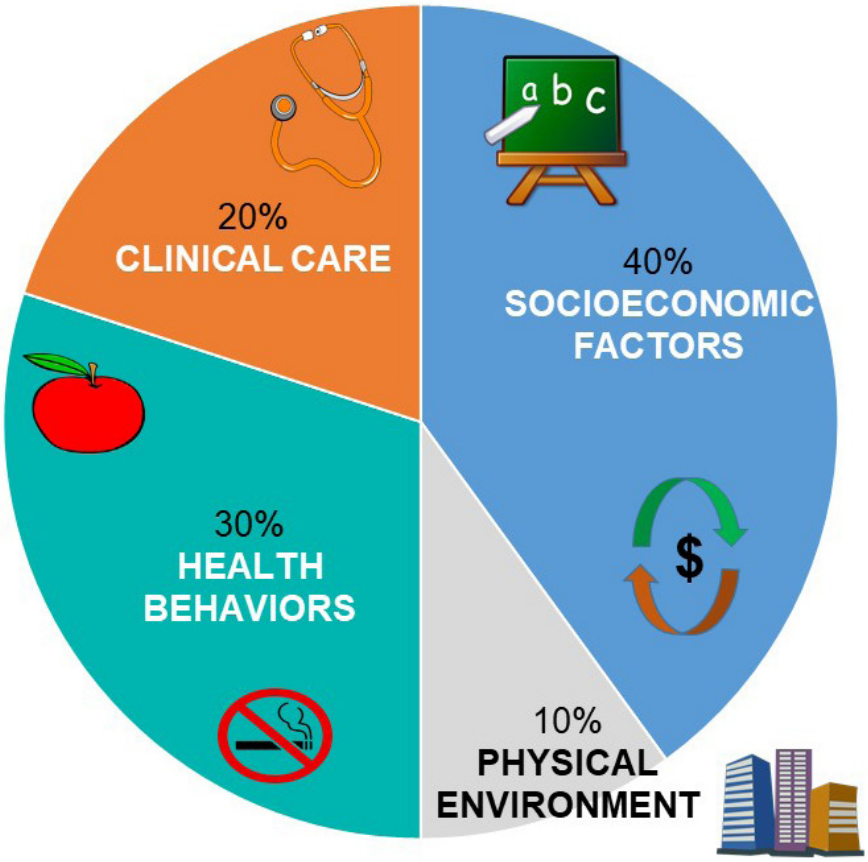
Throughout the months of September and October 2018, UNITE members sought qualitative input from community members and key stakeholders on what the top community health needs were, as well as broader community needs. UNITE members collected this data in person at meetings of wellness coalitions, safety-net organizations, food pantries, civic clubs, ministerial associations, and Washtenaw Health Initiative stakeholders. UNITE also collected this data electronically, via a survey link sent to community partners (including healthcare providers as well as social service providers and community-based organizations). Summaries of all of their input were discussed at the UNITE November 2018 retreat.

At the UNITE retreat, after reviewing all of the data and community input, the collaborative unanimously agreed that the information pointed to the persistence of the three community health priorities identified during the group's 2016 community health needs assessment:
1) Mental Health and Substance Use Disorders
2) Obesity and Related Illnesses
3) Pre-conceptual and Perinatal Health.

During the data retreat UNITE group members also conducted a root cause analysis (RCA) around local community conditions and contributing factors to the prioritized health needs. The RCA placed particular emphasis on the SDOH that are the major drivers of inequities in the prioritized health needs as a means of understanding which strategies would be most effective.

See Appendix D for the Root Cause Analysis.

Following these activities, the UNITE group renewed its commitment to addressing the three priorities and using the social determinants of health (SDOH) as both an analytical lens and a key strategy in addressing the root cause of these health inequities. UNITE group members agreed that focusing on upstream factors, and the conditions and environments where people live, work, and play, would have a greater impact on the identified community health needs than a downstream approach.



www.countyhealthrankings.org

Select data points and findings
According to County Health Rankings, Washtenaw County is ranked 4th out of 83 Michigan counties in health outcomes with premature death rates at 5,000 out of every 100,000 residents. Washtenaw County ranks 5th in the state on quality of life indicators. And only 8 percent of Washtenaw County pregnancies result in low birth weights, which is equivalent to the state rate.

However, there are areas of stark disparity in the county, as socio-economic opportunities and consequently health outcomes are inequitably distributed. For the racial segregation (white/non-white measures), Washtenaw is the 19th worst segregated county in the state.

As of 2015, the average age of death for White Washtenaw County residents was 76 years, compared to 66 years for Black residents and 60 years for Hispanic residents.[6]

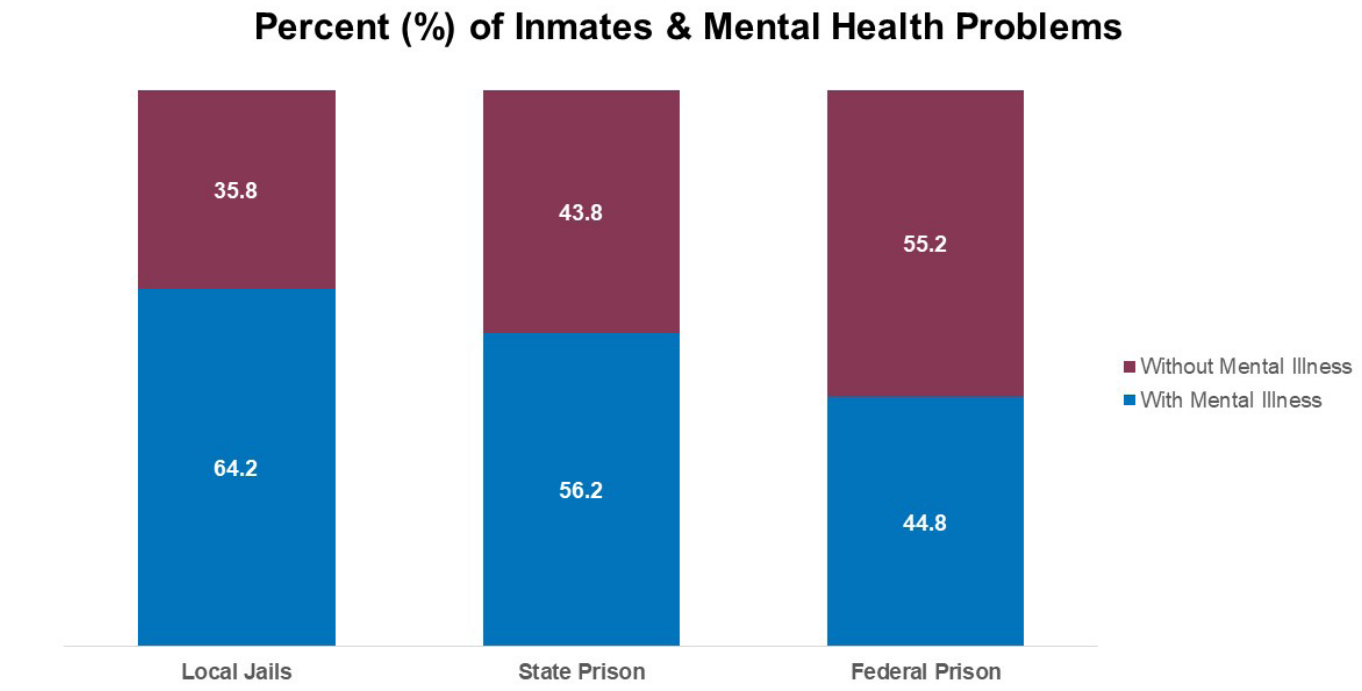
A. PRIORITIZING COMMUNITY HEALTH NEEDS

In the section that follows, we present compelling data on the three priority health needs and their underlying social determinants of health.[7]

Priority 1: Mental Health and Substance Use Disorders

Adult Mental Health
Adult Mental Health and Substance Abuse Disorders
- Overall in Washtenaw County, there has been an increase in opioid-related overdose deaths from 2011 (29 deaths) to 2018 (80 deaths).[8]
- In 2016, the average Washtenaw resident reported 3.8 mentally unhealthy days in the past 30 days.[9]
- In Washtenaw County, 25 percent of adults reported binge or heavy drinking, compared to 21 percent statewide.[10]

Adult Mental Health and Incarceration
- In 2017, the Washtenaw County Sheriff's office responded to 735 mental health calls (an increase of 20 percent from 2016).[11]
- 56.2 percent of state prison inmates, 44.8% of federal prison inmates, and 64.2% of local jail inmates have one or more mental health problems.[12]
- Nationally, 20 percent of incarcerated individuals with mental health issues in the state prison system have been in a fight resulting in an injury since their prison admission, compared to 10 percent of those without a mental health issue.[13]



https://www.bjs.gov/content/pub/pdf/mhppji.pdf

Youth Mental Health and Substance Use Disorders[14]

- While 18 percent of high school teens report regular use of e-cigarettes, this rate is higher in rural communities, ranging from 21 percent to as high as 35 percent.
- Regular alcohol use and binge drinking have diminished in Washtenaw County from 18 percent in 2010 to 12 percent today for alcohol use and from 9 percent in 2010 to 6 percent today for binge drinking.
- Although regular (past 30 day) marijuana use is down or unchanged in rural communities compared to 2010 (some communities have seen decreases of 25 to 44 percent), the rate of regular marijuana use among high school students across Washtenaw County as a whole increased during this same time period, from 11.7% in 2010 to 13.1% in 2018. This also marks the first time regular marijuana use was higher than regular alcohol use among high school students in Washtenaw County.
- 6.9 percent of Washtenaw County high school students reported having attempted suicide in the past year.
- 32 percent of Washtenaw County high school students reported experiencing depression in the past year.
- High school students in some rural communities reported an increase in intimate partner violence (with 19 percent of students in one district reporting having been hurt by a boyfriend or girlfriend in the past month, compared to the county-wide rate of 7.5 percent).
- While the county-wide rate of high school students reporting two or more Adverse Childhood Experiences (ACES) was 25 percent, some low-income communities had significantly higher rates, ranging from 35 to 45 percent.

Housing, Mental Health and Substance Use

- One in 9 adults in Washtenaw County who were experiencing homelessness reported having a alcohol and/or drug issue. And 60% with a substance or drug issue reported having a co-occurring mental illness.[15]

- Compared with housed children, homeless children suffer worse health, more developmental delays, more anxiety, depression, and behavioral problems, and lower academic achievement.[16]
- Cuts to mental health funding and more rigorous eligibility criteria have caused a ripple effect in the county's homeless response system. Agencies report an uptick in the impact of untreated mental health issues that cause homelessness and housing instability.[17]

Obesity and Related Illnesses

- Childhood obesity continues to be an issue in Washtenaw County with 25 percent of children being overweight or obese (2016).
- While most percentages of overweight and obesity rates held steady, the rate of overweight and obesity in 5 to 7 year olds decreased from 22 percent to 20 percent and the rate of overweight and obesity among Latino children increased from 31 percent to 35 percent between 2013 and 2016.[18]
- Food security and access to healthy foods, and safe opportunities for physical activity, continue to be reported as barriers in Ypsilanti.[19]
- There is a need to strengthen the capacity of pantries to offer fresh produce and to help connect eligible people to food assistance (SNAP).
- Food assistance program participation at local farmers markets is needed in Dexter, Grass Lake, Manchester and Stockbridge.[20]
- As reported via the Five Towns Survey, the zip codes, 49152 and 49285 (Manchester and Stockbridge) had the highest rates of youth and adult obesity, showed the biggest challenges with food access, and scored the worst on the Nutrition Environmental Assessment Tool survey. Manchester scored slightly higher on the Promoting Active Communities due to local government plans and policies.

Pre-conceptual and Perinatal Health

Birth outcome disparities continue to persist among racial and ethnic minorities, largely due to institutional and systemic issues that inequitably distribute resources and opportunities.

- Women in the Ypsilanti area identified a need for access to mental health treatment, quality and affordable child care, affordable healthy food, and safe, stable, and affordable housing.[21]
- Latina women have lower insurance coverage rates compared to the rest of Washtenaw County women.
- African-American women have a significantly higher infant mortality rate compared to all other counterparts in the county.[22]
- Locally, 40 percent of homeless youth seeking services are pregnant or parenting compared to 27 percent statewide.[23]
- There are gaps in dental care access for pregnant women, and during the first years of children's lives.
- Fear of ligation has been cited as why dental care is refused to pregnant women.[24]
- Diapers are not covered through public assistance programs, and the expense of diapers came up in the mothers' focus group feedback meeting. This reflects the national data of 1 in 3 American families reporting diaper need, and not being able to buy them being a leading cause of mental health problems among new moms. Studies show families in the lowest income quintile spend almost 14 percent of their pretax income on diapers.[25]

Impact of Incarceration on Maternal and Infant Health

The United States has the highest per capita rate of people in prison of any country in the world. As of December, 2016, the Bureau of Justice Statistics reported a total of 2,162,400 people in either prison or jail throughout the country. The number of women who are incarcerated has been increasing over the past several decades -- from 26,378 in 1980 to 222,061 in 2014. Incarceration among women is not distributed equally across racial groups -- Black women are incarcerated at over twice the rate of White women and incarceration rates of Hispanic women are also disproportionately high.

- In most cases, women who give birth while incarcerated are allowed just 24 hours with their newborn after delivery, causing negative impacts for both the mothers (psychological trauma and increased risk of recidivism) and their infants (more likely to experience self-esteem issues later in life, difficulty in peer relationships and with managing stress).[26]
- According to 2006 data from the Bureau for Justice Statistics (the most recent data available), approximately 5 percent of female inmates nationally report being pregnant at the time of detention into jail or prison.[27]
- As of 2004, 62 percent of women in state prisons and 56 percent of women in federal prison in the United States reported being a parent. Collectively, 25 percent of children of incarcerated individuals are below the age of 5.[28]
- Locally, at the Women's Huron Valley Correctional Facility, 70.4 percent of inmates (all female) are between the childbearing ages of 20 and 44.[29]
- Almost 60 percent of women in state prisons have experienced physical or sexual abuse in their lives.[30]

Inadequate Health Insurance and Coverage

The decimation of community-based mental health supports also continues to be a systemic issue, and not all insurance types cover needed mental health services.[31] Some policy factors impacting reproductive justice and perinatal health include administrative rules that may allow employers to stop paying for birth control[32]; and the fact that life and disability insurance providers have sometimes penalized women with mental illnesses, including postpartum depression, by charging them more money, excluding mental health coverage, or declining coverage.[33]

Lack of Child Care, Paid Parental Leave

The need for safe and affordable child care and paid parental leave is another issue that surfaced through analysis of secondary data and in the mothers' focus groups. Households with young children have the most expensive Household Survival Budget of all household types due to the additional expense of child care, preschool, and after-school care.[34] A study from the Michigan Department of Education and Public Sector Consultants shows how Michigan has lost thousands of child care providers from its licensed system in recent years, especially home-based providers.[35] Additionally, the cost of existing child care options is prohibitively expensive for working class families. This is borne out by Kids Count data, which showed the average cost of full-time childcare per month in 2017 to be $769, or 49.9 percent of full-time minimum wage.

Social Determinants of Health that disproportionately influence the top CHNA priorities

In the months following the November 2018 retreat, the UNITE collaborative continued to dig deeper into the root causes underlying three SDOH domains that they agreed had an outsized impact on the top CHNA priorities. These domains were (i) housing, (ii) poverty and (iii) social isolation. They used the Community Anti-Drug Coalition of America (CADCA) model to conduct a root cause analysis (RCA) around local community conditions and contributing factors to the prioritized health needs.

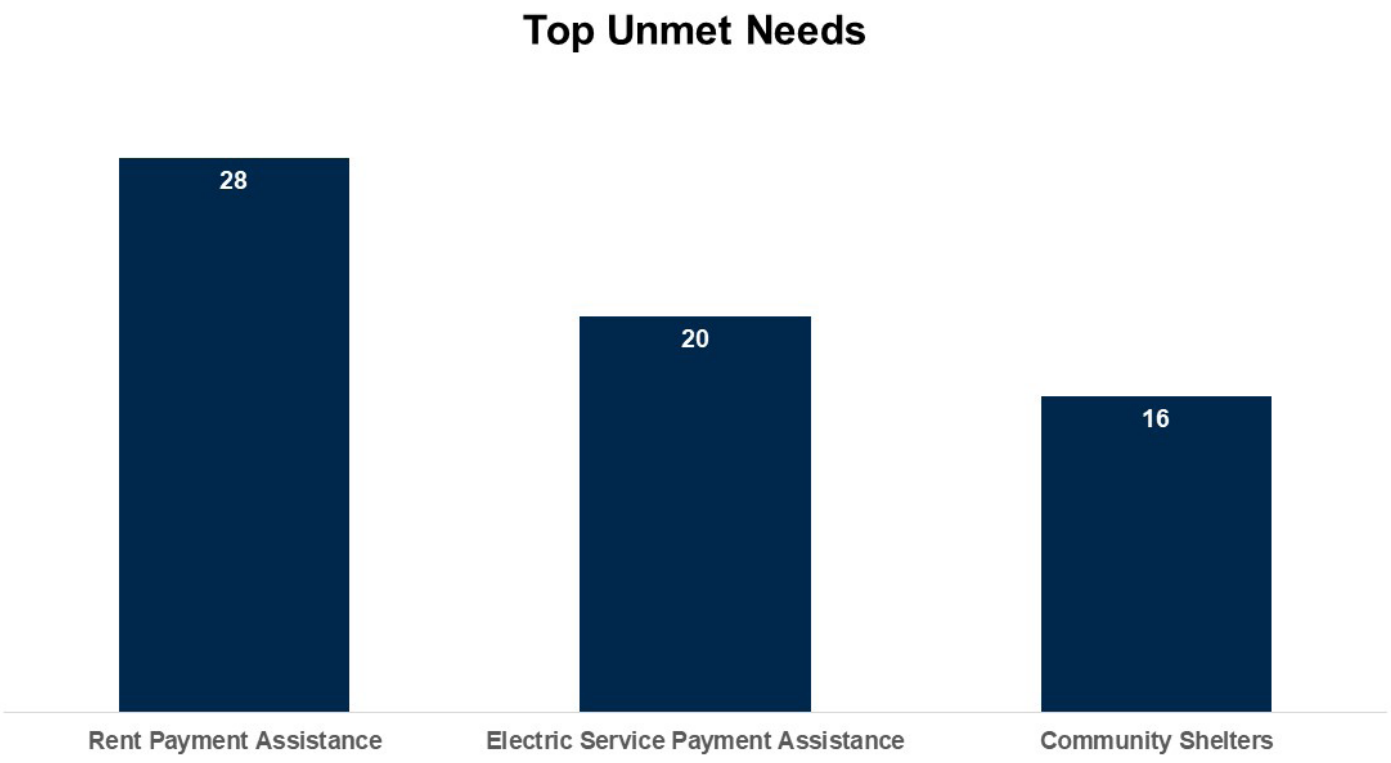
Housing/Homelessness

There is strong evidence that an individual's housing status impacts their health. Housing stability, quality, safety, and affordability all affect health outcomes, as do the physical and social characteristics of neighborhoods.[36]

- Over half of renters (56 percent) pay more than 30 percent of their income on housing; 32 percent of all renters pay more than 50 percent of their income on housing.[37]
- Nearly one in three Washtenaw County Jobs (31 percent of the county's workforce) pay too little to keep pace with housing costs.
- Washtenaw County lacks sufficient permanent housing resources to meet the level of need, with a particular need for more permanent supportive housing.
- 9 percent of students in the Ypsilanti school district are homeless. Children without stable housing are more likely to transfer schools, have long commutes, struggle with poor health, and be chronically absent than their permanently housed peers.

Poverty and Opportunity Gaps

Poverty has long been recognized as a contributor to death and disease. In recent decades, as income inequality in the United States has dramatically increased, life expectancy differences by income have grown too. The United States has among the largest income-based health disparities in the world. Poor adults are five times as likely as those with incomes above 400 percent of the federal poverty level to report being in poor or fair health.[38]

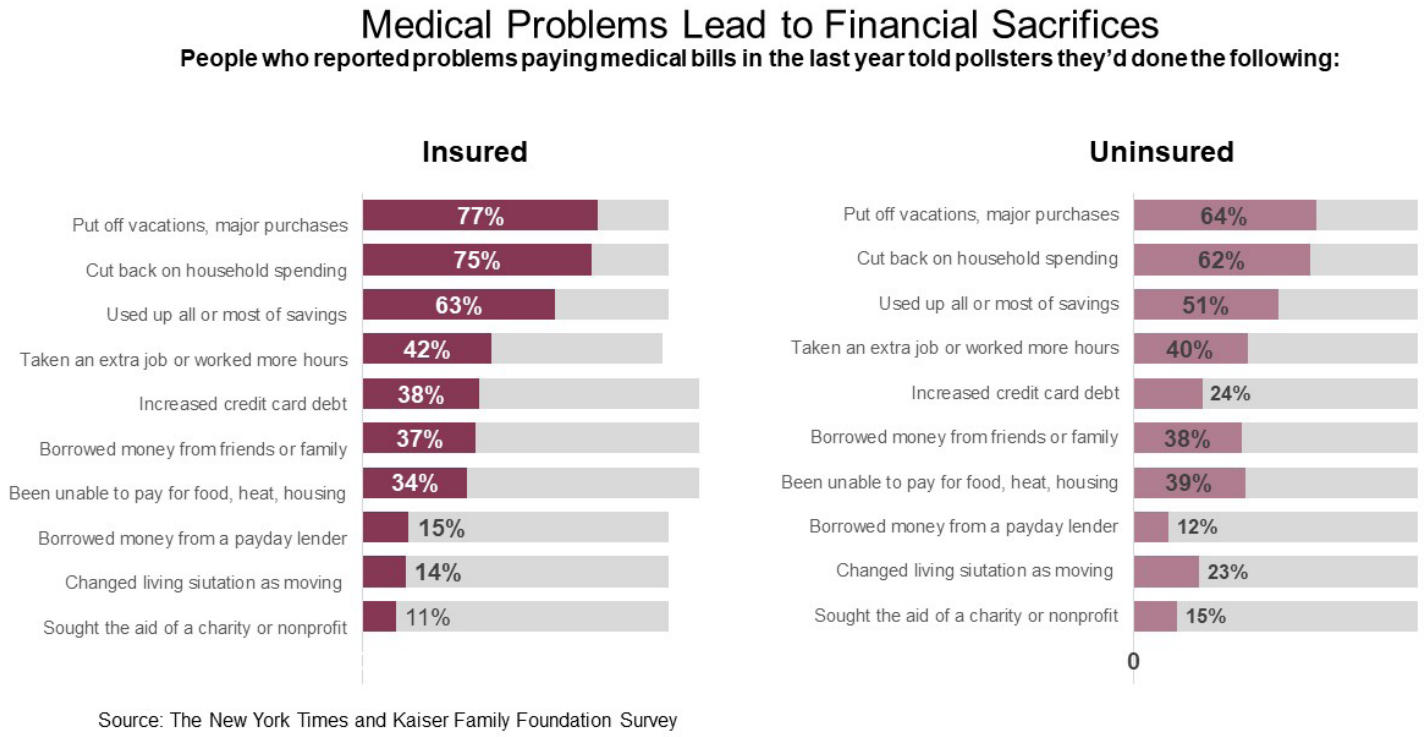


Source: United Way, 2-1-1 Quarterly Report, 2017 4th Quarter

- In Washtenaw county there are 138,099 households with 37 percent of these either poor or asset limited, income constrained employed (ALICE) households that earn more than the Federal Poverty Level (FPL), but less than the basic cost of living for the state.
- The basic cost of living has increased, but two-thirds of Michigan jobs fall short of a survival budget: The cost of basic household expenses increased steadily in every county in Michigan between 2007 and 2015. Low-wage jobs continued to dominate the landscape in Michigan, with 62 percent of all jobs in the state paying less than $20 per hour. And, more than two-thirds of these jobs pay less than $15 per hour. This falls far short of a family survival budget.[39]
- Nine of the ten largest job categories in Washtenaw County pay less than $32,000 per year.[40]
- In Washtenaw County, in the 4th quarter of 2017 alone, there were 224 requests for emergency shelter; 181 requests for electric service payment assistance and 179 requests for temporary financial assistance.[41]
- West Willow neighborhood (in Ypsilanti) has double the poverty rate (14 percent) than the county at large (7 percent) and almost double the unemployment rate than the county; 30 percent of the population there is under the age of 18.[61]
- Over 35 percent of the Ypsilanti, charter schools, and Lincoln schools student populations are economically disadvantaged.[42]

Medical debt, cost of hospital encounters, prescription drugs

The devastating health impact of being uninsured is well-documented. Studies also show that insurance often fails as a safety net, and even insured Americans struggle with medical bills, as health plans often require hundreds or thousands of dollars in out-of-pocket payments — sums that can create a cascade of financial troubles for the many households living paycheck to paycheck.[43] Going to the hospital has been shown to have the same income impact as working for a plant that closes.[44]



Source: The New York Times and Kaiser Family Foundation Survey

Loneliness and Social Isolation

Decades of research substantiate the devastating effects of social isolation and general lack of social support. Loneliness is equivalent to smoking 15 cigarettes a day and increases the risk of death by 26 to 45 percent, which is on par with risk factors such as high blood pressure, obesity, and lack of physical activity. It also has drastic implications for mental health and well-being.[45]

- A youth collaborative based in Ypsilanti evaluated health and safety concerns of young people (age 12 to 25) and found that two out of every three young people surveyed wished there were more opportunities to get to know their neighbors.[46]
- Within Washtenaw County the most positive SDOH screens within primary care sites was the domain of Loneliness (as an equivalent to social isolation). [47]
- Focus groups of pregnant women and mothers of young children in Washtenaw County revealed that a lack of social support and social isolation affected the ability to go back to work and had effects on mental health during the postpartum period.[48]

Other Barriers to Access and Health: Transportation, Language, Immigrant Status

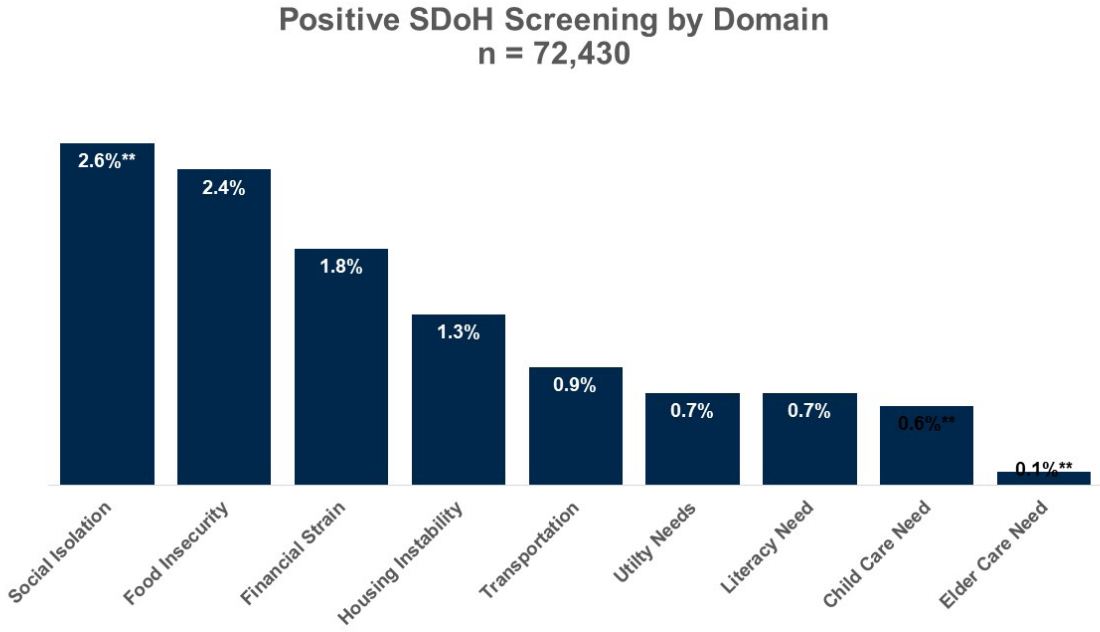
- Within Ypsilanti, the frequency of bus service is an impediment to reaching medical appointments and pharmacies. Specifically, mental health treatment locations are difficult to access.[49]
- Among Ypsilanti residents, inadequate transportation, and lack of full-service grocery stores within a reasonable walking distance are issues of great concern.
- Transportation services need to be expanded for older adults who cannot drive, especially older adults who live in rural areas.[13]
- Language and literacy classes can be difficult to access, both due to services being unknown and due to conflicting work schedules.
- Public benefits can be difficult to access for immigrants, especially for immigrants with a language barrier.
- Community Mental Health services are limited to immigrants who are eligible[50] for full Medicaid regardless of the need or severity of their mental health challenges.[51] Note: Emergency mental health services are limited to a small subset of the population leaving a significant gap for others in need.
- When the Limited English Proficiency (LEP) population seeks dental care, the dentists do not have access to interpreter services, therefore limiting the LEP population's ability to receive care. Further, the LEP population is afraid of jeopardizing their immigrant status and fear repercussions and therefore will not seek dental care when needed.[5]
- Anti-immigrant rhetoric, policies and fear of Immigration and Customs Enforcement is showing a frightening impact on all the community health priorities, and leading to increased mental health problems in the community, and an increase in preterm birth rates for immigrant mothers.[52]

Social determinants are increasingly recognized as playing an important role in health outcomes. Social, behavioral, and environmental factors account for 50 to 60 percent of health outcomes, while clinical care accounts for only 10 to 20 percent of health outcomes.[53]

Local Needs Assessment: Social Determinants of Health Screening

In 2017, Washtenaw and neighboring Livingston counties came together to form the Livingston - Washtenaw Community Health Innovation Region (LWCHIR) as part of the Michigan State Innovation Model (SIM). Together, they began to implement a two-pronged approach to integrate social services with medical care: A community care coordination intervention run by the Washtenaw Health Initiative and a social determinants of health screening and referral process run by primary care providers across the county. As a part of the primary care-based work, Patient Centered Medical Homes (PCMHs) and

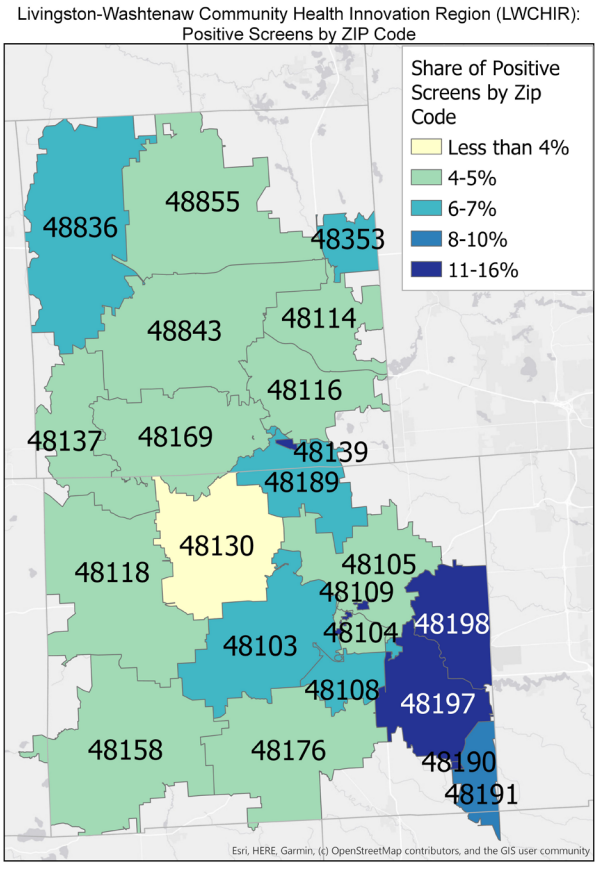
other community partners, including all three hospitals participating in this needs assessment, worked together to develop a way to screen and assist those in the community experiencing social determinants of health needs. Michigan Medicine and Saint Joseph Mercy Health System clinical partners, through the IHA medical group, deployed this survey across a variety of clinical service providers. Through December 2018, 72,430 patients were screened across the three health systems and 5 percent reported at least one of the nine social needs being screened for. Positive screens by domain are shown below.



** Michigan Medicine and HVPA did not ask Social Isolation, Elder Care, or Child Care questions – Michigan Medicine added questions in October 2018.

Needs by Location

Using data from the social determinants of health screenings, it was also possible to determine needs by location. The map below shows both Washtenaw and neighboring Livingston counties and the percentage of positive screens (i.e. at least one social need identified) by zip code. This information aligns with data we reviewed from other sources in the community.



Health and Climate

In addition to various needs emerging locally, there are certain global impacts that will be felt in our county which will have serious implications for community health. With the 2018 publication of the landmark report by the Intergovernmental Panel on Climate Change (IPCC) representing 91 authors from 44 citizenships and 40 countries of residence, there is resounding scientific consensus on the need for immediate action at a global and local level, in order to mitigate the of risks of drought, floods, extreme heat and poverty for hundreds of millions of people.[54]

Climate change is an issue of increasing concern among public health professionals. A 2016 American Public Health Association report declared climate change as "the greatest threat to public health today."[55] Climate change is widely accepted by the scientific community as the result of the high levels of greenhouse gas emissions that have resulted from human activity such as electricity generation, transportation, livestock farming, and the mining and use of natural gas.[56]

According to the Natural Resources Defense Council, if unchecked, climate change will increase the number of dangerously hot summer days, as well as the average number of excess heat-related deaths. From 1975 to 2010, the Detroit metropolitan area had an average of nine dangerously hot summer days per year, with an average of 65 excess deaths per year related to these hot weather days. If no action is taken on climate change, scientists predict an average of 50 dangerously hot summer days per year from 2046-2055, with 760 excess deaths per year related to this heat.[57]

The health impacts of climate change will disproportionately impact communities of color, people living in poverty, individuals with pre-existing health conditions, and those living in social isolation.[58] For example, analysis of heat waves and hospitalizations in three Michigan counties (Ingham, Washtenaw, and Wayne) revealed that "heat wave days increased the odds of hospitalization for kidney disease by 37 percent among people of color from 2000 to 2009. In contrast, there was no increase in hospitalization odds among white people."[59] Additionally, the temperature increases associated with climate change increase the prevalence of hospitable habitats within Michigan for ticks that transmit Lyme's disease and mosquitos that cause West Nile virus and yellow fever.[60]

This CHNA therefore recognizes the need for mitigation strategies (i.e. reducing the human impact on the climate), as well as adaptation and resilience-building strategies (i.e. weatherizing homes of low-income individuals, increasing urban area green spaces, and increasing the capacity of community organizations to respond to climate-related needs).

Non-Prioritized Community Needs

Two needs were identified during the UNITE data retreat that are not being addressed:

Dental Health

Dental Health was identified as a need within the UNITE data retreat, but the health systems decided that this would not be a target of their current CHNA, as there are other agencies taking the lead in this area, as well as several resources within the community whose focus is addressing dental health. The University of Michigan School of Dentistry, for example, supports the Community Dental Center that provides services for individuals with special needs, those with Medicaid, or those that are uninsured and sees patients at the University's dental clinics. Further, the Regional Alliance for Healthy Schools has a mobile van that is addressing dental health by providing it to students from the affiliated schools. Finally, Saint Joseph Ann Arbor provides space for Washtenaw County Public Health to offer dental services to adults and children who are low-income or enrolled in Medicaid, MI Child, or Healthy Kids.

And the Hope Dental Clinic provides free or low-cost dental services to those without insurance or the ability to pay for dental care.

Education and Educational Achievement

Education and educational achievement was also identified as a key social determinant of health within Washtenaw County. However, because education cannot be easily influenced by the county's health systems, it was not chosen as a health priority. Further, there are various school districts within Washtenaw County that are working diligently to decrease the educational achievement gap.

IV. DOCUMENTING AND COMMUNICATING RESULTS

The CHNA report will be available on the websites of all partners (Saint Joseph Mercy Ann Arbor, Saint Joseph Mercy Chelsea, and Michigan Medicine (UMHS)), as well as on the website of the Washtenaw Health Initiative. A paper copy will be made available at all hospital facilities. Results have been communicated to numerous community groups and agencies, and plans to share results through a series of community conversations in the summer of 2019 are in development.

For comment or questions, contact Washtenaw Health Initiative Project Manager, Carrie Rheingans, at crheinga@umich.edu or 734-998-7567.

V. CONCLUSION

Members of the community, community-based organizations, social service providers and a wide range of partners were integral to the UNITE group's ability to identify community-driven CHNA health priorities.

Appendices

Appendix A- Community Description- Hospitals

The **Saint Joseph Mercy Hospital - Chelsea (SJMC)** is a 113-bed community hospital located on 115 wooded acres in Chelsea, Michigan. For information on hospital services, please call (734) 593-6000, or visit the website, www.stjoeschelsea.org, and click on the Services tab. The SJMC service area is defined as the geographic area encompassing the zip codes of Chelsea, Dexter, Grass Lake, Gregory, Manchester and Stockbridge, Michigan. This includes sections of four counties (western Washtenaw, southeastern Ingham, southwestern Livingston and eastern Jackson) and all or part of the following cities, villages, and townships: Bridgewater Township, City of Chelsea, Dexter Township, Freedom Township, Grass Lake Township, Lima Township, Lyndon Township, Manchester Township, Scio Township, Sharon Township, Stockbridge Township, Sylvan Township, Unadilla Township, Webster Township, City of Dexter, Village of Grass Lake, Village of Manchester, and Village of Stockbridge. The SJMC service area was determined by the proximity of these communities to the hospital, which is located at 775 S. Main St, Chelsea, Michigan.

The **Saint Joseph Mercy Hospital - Ann Arbor (SJMAA)** service area for purposes of this need assessment is defined as the population of Washtenaw County. St. Joseph Mercy Ann Arbor is a 537-bed teaching hospital located on a 340-acre campus in Ann Arbor, Michigan. The SJMAA Hospital is located at 5301 McAuley Dr, Ypsilanti, MI 48197.

The mission of the St. Joseph Mercy hospitals states that "We, Trinity Health, serve together in the spirit of the Gospel as a compassionate and transforming healing presence within our communities."

Michigan Medicine (UMHS) is home to one of the largest health care complexes in the world. The University Hospital is the UMHS hospital for adult patients. The 11-story, 550-bed hospital first opened its doors in 1986. Today, 70 percent of University Hospital's patients are admitted from communities or regional hospitals outside the Ann Arbor area. In its 1,796,262 square feet, the hospital houses diagnostic equipment, clinical laboratories, operating rooms and inpatient and intensive care units. The UMHS Hospital is located at 1500 E. Medical Center Dr. Ann Arbor, MI 48109. UMHS's main campus is also comprised of the Alfred Taubman Health Care Center, C.S. Mott Children's Hospital, Frankel Cardiovascular Center, Med Inn, Rogel Cancer Center, University Hospital South, and Von Voigtlander Women's Hospital. UMHS has numerous primary care sites within Washtenaw County as well as several satellite locations in the surrounding area. Specialty Care Centers are primarily located in Ann Arbor but with satellite locations throughout Southeast Michigan.

The mission of Michigan Medicine is that, "We advance health to serve Michigan and the world."

Community Health Needs Assessment Partners

- Saint Joseph Mercy – Ann Arbor
- UM School of Public Health
- Saint Joseph Mercy – Chelsea
- Office of Public Health Practice
- 5 Healthy Towns Foundation Wellness Coalition
- Washtenaw Health Initiative
- Future Public Health Leaders Program
- University of Michigan Health System (UMHS)
- Washtenaw County Public Health Plan
- Community Programs and Services
- Health Improvement Plan of Washtenaw Co.
- Program for Multicultural Health

Appendices

Appendix B- Washtenaw County Community Reports Summary (Fall 2018)

In Fall 2018, members of the UNITE group examined local reports on a variety of topics that relate to health outcomes. Where available, reports that had been published since the previous 2016 CHNA were utilized. Report themes and data were summarized and contributed to the CHNA.

Local Report Name	Description	Year
Blueprint for Aging- Washtenaw County Older Adult Data Book	The BFA Older Adult Data Book, created in 2009, provides a holistic framework to highlight indicators of older adult well-being and to emphasize existing challenges. Updates to the Data Book made in 2012 track changes of older adults in Washtenaw County and present new information.	2012
City of Ypsilanti Planning & Development Department - South of Michigan Avenue (SOMA) Community Needs Assessment	The South of Michigan Avenue Community Needs Assessment (SOMA) is intended as a public planning effort to engage residents who live in neighborhoods south of Michigan Avenue.	2011
City of Ypsilanti Planning & Development Department - An Integrated Assessment of Transportation to Healthy Food in Eastern Washtenaw County	This research project investigated the degree to which residents of eastern Washtenaw County experience difficulty in accessing healthy food, with a focus on finding suggestions for overcoming transportation barriers.	2012
Food Gatherers - Food Gatherers Food Security Plan	Identifies both near and long-term strategies to enhance individual and community food security.	2015
SIM (CHRT)- SIM PCMH Social Determinants of Health Screening Aggregate	Data aggregate report of three provider organizations' social determinants of health screening at PCMH primary care well visits.	2018
United Way - ALICE report-Michigan	Asset Limited, Income Constrained, Employed - ALICE represents those in our communities who are working yet still struggling to make ends meet. The ALICE Report is the most comprehensive depiction of need in Michigan to date.	2017
WACY (Washtenaw Alliance for Children and Youth)- WACY Report Card	Every year, WACY compiles and reports on local data to help our community better understand the strengths and needs of our children and youth	2017

Appendices

Appendix B (cont) - Washtenaw County Community Reports Summary (Fall 2018)

Local Report Name	Description	Year
Washtenaw County OCED- Housing Affordability and Economic Equity Analysis	The goal of this analysis is to provide a snapshot of housing market conditions and corresponding goals to improve affordability across a wide spectrum of households in Washtenaw County's urban core communities.	2015
Washtenaw County OCED- Washtenaw Urban County Action Plan	5-Year Consolidated Plans are carried out through Annual Action Plans, which provide a concise summary of the actions, activities, and resources that will be used each year to address the priority needs and goals identified by the Consolidated Plan.	2017
Washtenaw County OCED- Washtenaw Urban County Consolidated Plan	5-Year Consolidated Plans describe a jurisdiction's community development priorities and multiyear goals based on an assessment of housing and community development needs, an analysis of housing and economic market conditions and available resources.	2018
Washtenaw County OCED- Washtenaw Urban County Consolidated Annual Performance and Evaluation Report (CAPER)	CAPERs show accomplishments and progress toward Consolidated Plan goals from each year.	2017
Washtenaw County OCED- The 25% Shift: The Economic Benefits of Food Localization for Washtenaw County and Ypsilanti & The Capital Required to Realize Them	This paper evaluates the economic benefits that Washtenaw County and the Ypsilanti area (zip codes 48197 and 48198, within the County) could enjoy through a 25% shift toward local food.	2013
Washtenaw County OCED- The 25% Shift: The Economic Benefits of Food Localization for Washtenaw County and Ypsilanti & The Capital Required to Realize Them	This paper evaluates the economic benefits that Washtenaw County and the Ypsilanti area (zip codes 48197 and 48198, within the County) could enjoy through a 25% shift toward local food.	2013
Washtenaw Health Plan- Coordinated Health and Safety Net Funding: Needs Assessment, Vision, Strategies, and Outcomes	The Coordinated Health Funding Needs Assessment examines six subtopics within the Safety Net Health and Nutrition priority area. Within each subtopic, we summarize existing services, identify key population groups, and analyze areas representing ongoing challenges.	2017

Appendices

Appendix B (cont) - Washtenaw County Community Reports Summary (Fall 2018)

Local Report Name	Description	Year
Washtenaw Housing Alliance- A Home for Everyone: A Blueprint to End Homelessness in Washtenaw County (2014)	Goal to map out the way we could end homelessness in our community in ten years. This plan was released with four primary goals: prevention; housing with support services; reforming our systems of care and engaging the community.	2014
Washtenaw Housing Alliance- Blueprint Progress Report 2004-2011	Provides a look at the community's collective achievements in seven years.	2014
Washtenaw Literacy White Paper 2014: The Impact of Adult Illiteracy in Washtenaw County	The Impact of Adult Illiteracy in Washtenaw County.	2014
Washtenaw Health Plan-Needs Assessment for Immigrants and Mental Health in Washtenaw County	The intent of this project is to provide a picture of immigrants in Washtenaw County, their mental health needs, and how they are—or are not—being met.	2015
Washtenaw Health Initiative/Community Coordination and Dental Services- Environmental Assessment of Access to Oral Health Care in Washtenaw County	The Washtenaw Health Initiative (WHI) Oral Health work-group first completed a dental assessment in the spring of 2011. Since 2011, three major changes have altered the dental environment in Washtenaw County and beyond: the Healthy Kids Dental Program, the Healthy Michigan Plan and the newly opened Washtenaw County Dental Clinic. This report has been updated and provides an overview of the dental state in Washtenaw County.	2015
Washtenaw County OCED-West Willow	Housing and neighborhood focus group.	2017
Washtenaw overweight Childhood Obesity and Overweight	Describes obesity rates among children in Washtenaw County.	2016
5 Healthy Towns Foundation- Promoting Active Communities Survey	The mission of the 5HF is to cultivate improvements in personal and community wellness.	2017 (est.)
5 Healthy Towns Foundation- Nutritional Environment Assessment Tool	The mission of the 5HF is to cultivate improvements in personal and community wellness.	2018
SRSLY Needs Assessment – Youth Substance Abuse	Based on data from the needs assessments, the coalitions determine the top youth substance abuse problems their communities	2018

Appendices

Appendix B (cont) - Washtenaw County Community Reports Summary (Fall 2018)

Local Report Name	Description	Year
Dexter Community Foundation - Community Needs Assessment	The Dexter Community Fund (DCF) is a source of community capital that is available to invest in a wide range of initiatives, projects, and organizations that enrich the quality of life in Dexter.	2018
Washtenaw County Opioid Reports	Washtenaw County Health Department's Opioid Reports provide timely information on opioid-related overdoses, deaths and trends occurring among Washtenaw County residents.	2018
U-M Taubman School of Architecture and Urban Planning & New West Willow Neighborhood Association- From Needs to Opportunities: Strategies for the West Willow Neighborhood	The goal of this report is to help West Willow residents productively address change by clearly describing existing conditions and needs, and identifying opportunities for enhancement.	2014
Washtenaw County Health Department - Whitmore Lake Community Conversation Summary	Community perspectives and ideas for action.	2017-2018
Washtenaw County Health Department - West Willow Community Conversation Summary	Community perspectives and ideas for action.	2018
Washtenaw County Health Department Health Equity and Community Voice Report	The purpose of this report is to demonstrate the importance of community voice in addressing health inequities.	2017
MiPHY Michigan Profile for Healthy Youth - Washtenaw County	A comprehensive, needs assessment survey that assesses students' risk behaviors at 7th, 9th, and 11th grades.	2016
Washtenaw County Health Department Maternal and Child Health Needs Assessment Update	Increase understanding of MCH status & disparities in MCH outcomes.	2017
Food Gatherers Healthy Food Access: Local Data and Federal Policy	Food insecurity overview with local and national data.	2017

Appendices

Appendix B (cont) - Washtenaw County Community Reports Summary (Fall 2018)

Local Report Name	Description	Year
Washtenaw County Health Department Immunization Rates by Zip Code	Vaccine coverage rates by populations.	2016
Washtenaw County Health Department Perinatal Health - Women of Childbearing Age, Washtenaw County	Key findings of preconceptual health including health behaviors.	2015
Washtenaw County Health Department Health Improvement Plan - Survey Database	Survey results identify health trends, disparities that exist between groups, and where additional resources could improve community health.	2015
Ypsilanti Youth Creating Change (Y2C2) Findings: A youth-led research project	Evaluation of health and safety concerns of young people ages 12-25 in Ypsilanti by conducting focus groups and collecting surveys during 2015.	2015
UM Poverty Solutions-Poverty in Michigan map	This map combines publicly available data from the U.S. Census, United Way, CDC Community Health Indicators, and Robert Wood Johnson Foundation.	2016
UM Poverty Solutions-Child Homelessness in Michigan	This map seeks to fill that gap so that policymakers and local stakeholders can begin to think about the impact of homelessness in their area and to identify resources to support some of the State's most vulnerable children.	2016
Michigan League for Public Policy Michigan Kids Count Data	Kids Count in Michigan is part of a broad national effort to measure the well-being of children at the state and local levels, and use that information to shape efforts to improve the lives of children.	2017
Michigan Medicine Mothers Focus Group Data (Four English and one Spanish Speaking Focus Group)	Focus group conducted to understand challenges of mothers of young children to maintain or improve their health.	2017-2018

Appendices

Appendix C - Mothers Focus Group Data Summary

2016 Health Priority #3-Preconceptual and Perinatal Focus Group Findings
Michigan Medicine (UMHS) Community Health Services in partnership with Corner Health Center, Destiny and Purpose Community Outreach (DAPCO), Eastern Michigan University, Family Empowerment Program, Ypsilanti Health Center, and the UM School of Public Health Future Public Health Leadership Program conducted a series of focus groups that included 22 mothers with at least one child 2 years of age or younger. These mothers reside in primarily urban areas of Washtenaw County. The purpose of these focus groups is to help inform Health priority #3: Preconceptual and Perinatal health.

Informed by qualitative research methods, best practices, and the social ecological perspective, a focus group guide was developed to collect information about health, social support, and other factors that would improve the lives of mothers. IRB exemption was obtained as a Quality Improvement project.

Key findings from focus groups were:

- Mothers revealed relatively poor physical health, for young women (mothers average age was 27 years old).
- Mothers reported mental health issues.
- Mothers described that social support at home, work, and in networks was variable. Often they felt unsupported in one or more of these three areas.
- Mothers expressed that they want access to healthy food but they found healthy food unaffordable.
- Mothers shared that, while they know physical activity is important, they often felt too overwhelmed, had too little time, or too little energy to be physically active.
- Finally, mothers said they found safe housing and trusted childcare is unaffordable.

These findings will be utilized in the 2019-2021 CHNA-Implementation Plan to improve current services and supports or to tailor future programming to help improve the overall health and well-being of mothers.

Appendices

Appendix D - Root Cause Analysis of Three (3) Social Determinants of Health

HOUSING			
What is the problem?	Why is it a problem?	Why is it a problem here?	Strategies

• Housing is segregated in Washtenaw County
 	
• Housing cost is quite high and therefore precludes many from being able to live near job and resources.
	• Unaffordable housing causes individuals and families to forgo healthcare and food.
	• Stable affordable housing reduces stress, toxins, and infectious disease.
	• Contributes to the vitality of the community
	• Affordable housing contributes to supporting a local workforce
	• Affordable housing supports less traffic congestion and less air pollution
	• Helps to improve individual and families' economic situation in life
	• Can stimulate economic growth
		• Not enough affordable units
		• Definitions of affordable are poor
		• Lack of a livable wage (Right to work state)
		• Segregation
		• Not enough quality apartment units
		• Local zoning not supportive of low- income and multi-family housing
		• Lack of housing for youth transitioning out of foster care
		• Rural areas lack affordable housing
		• Landlords (not maintaining properties, not providing affordable units)
		• Lack of enforcement:
		  • Building code
		  • HUD
		  • Accessible housing for disabled individuals
			• Help landlords get information that might help them mitigate tenant issues (e.g. landlord mitigation fund to alleviate concerns of tenants who cannot afford a deposit).
			• Collaborate with county VA departments (VCATS model and housing is a component of it).
			• Build skills and modify policy on diversity and inclusion
			• Provide tenants with skills to resolve landlord issues
			• Advocacy to ensure greater enforcement of landlords (e.g. sycamore meadows)
			• Advocacy for greater enforcement of building codes

Appendices

Appendix D (cont.) - Root Cause Analysis of Three (3) Social Determinants of Health

POVERTY			
What is the problem?	Why is it a problem?	Why is it a problem here?	Strategies

• Poverty	• Poverty affects everyone poor and rich
	• Health outcomes are worse
	  • Low birth weight
	  • Asthma
	  • Heart disease
	  • Diabetes
	  • Greater years of life loss
		• Living wage is lacking
		• Lack of jobs
		• Segregation
		• Washtenaw County has a high cost of living (including childcare, housing medication)
		• Inequity (Economic and racial)
		• Inequitable distribution of resources through the county (geographically)
		• Lack of broadband in rural areas
		• Employers choosing inequitable distribution of where to locate jobs
		• Medical debt
		• Student loans
		• Generational poverty
		• Geographical variation in opportunities and resources
		• Federal and State benefits cliff
		• Aging out of the foster care system
		• Policies that exclude formerly incarcerated people and trans people
			• Review health system policies on wages, identify improvements and hire from disadvantaged groups
			• Build job seeking skills
			• Build skills and modify policies on diversity, equity and inclusion.
			• Diapers
			• Medical debt conversion to charity care
			• Monies for aging in place programs
			• Medicaid work requirement
			• Money for programs for youth aging out of foster care
			• Provide support to County Mental Health (CMH) in jail diversion efforts

Appendices

Appendix D (cont.) - Root Cause Analysis of Three (3) Social Determinants of Health

SOCIAL ISOLATION			
What is the problem?	Why is it a problem?	Why is it a problem here?	Strategies

• Social Isolation	• Mental Health Issues (Depression, Anxiety)
	• USA Cultural Norms
	  • Independent vs. collective
	  • Increase prevalence and use of technology and social media
		• Fractured kinship due to incarceration
		• Fractured sense of community because of lack of options for affordable and acceptable housing
		• Fear of deportation
		• Neighborhood safety
		• Policies restricting mobility/transportation
		• Lack of transportation especially in rural areas and among seniors
		• Lack of affordable/ quality childcare and respite care (for caregivers)
		• Inaccessible infrastructure at both residences and public spaces
		• High cost of living/ resource strain (contributes to longer working hours and lack of free time to socialize)
		• Gentrification and community shifts
		• Gaps in available support groups
		• Mental health and physical health issues/ poor access to treatment
			• Accessibility policy/ support enforcement
			• Support groups/ peer support/homevisiting
			• Family care—intergenerational
			• Investment in supportive housing
			• Policy advocacy-wages
			• Anchor institution
			• CHW
			• Mentorship programs
			• Success by 6 Trusted advisors group

Appendices

Appendix E - Community Engagement Online Survey

Community Engagement Survey (Online) Results (Fall 2018)
An online survey was open to individuals representing health serving organizations and was either directly emailed to them or a link to the survey was shared in community health meetings. The surveys asked respondents about how well the three priority areas of Mental Health and Substance Use, Obesity and Related Illnesses, and Preconceptual and Perinatal Health, were being addressed, and what else might be a gap in the community. The results are summarized below:
Respondents Demographics (N=85):

City of Respondents			
Ann Arbor (32)	Dexter (16)	Ypsilanti (11)	Chelsea (9)
Grass Lake (4)	Manchester (3)	Other (8)	

Respondents were spilt 57% in non-healthcare industry and 43% within the healthcare industry. Organizations Represented as Respondents:	
Ann Arbor Center for Independent Living	NAR-ANON
Catholic Social Services of Washtenaw County	Neighborhood Family Health Center
Chelsea First UMC	Ozone House
Community Resource Center	Packard Health
Dawn Farm	Q3
Dexter Rotary	St. Joseph Mercy Chelsea, Inc.
Dexter Wellness Coalition	St. Joseph Mercy Health System
Faith in Action	SafeHouse Center
Jewish Family Services	Shelter Association of Washtenaw County
Livingston County Health Department	Success by 6 Great Start Collaborative
Manchester Community Schools	The Women's Center of Southeastern Michigan
MDHHS	United Way of Washtenaw County
Michigan Advocacy Program	WCCMH
Michigan Medicine	Washtenaw County Health Department
NAMI Washtenaw	Webster United Church of Christ
Washtenaw Health Initiative (WHI)	Ypsilanti Senior Center

Appendices

Appendix E (cont.) - Community Engagement Online Survey

What have you seen work well to address these needs?

Mental Health and Substance Use Disorder(s)	
Work to address opioid epidemic • opioid summit • opioid project • harm reduction/needle exchanges • fewer opioid deaths	Behavioral and mental health • behavioral health made it on a priority list • seems to be an increase in mental health providers • behavioral health navigator • increased MH outreach and education • improvement in patient care for those with MH/SUD need • CMH outreach and programs
Community Support	
Better collaboration in the community • better communication • collaboration with providers • collaboration in community • partnering with providers and community organizations • health plan enrollment efforts • improved collaboration with Community Mental Health	Community education • engagement and education of consumers • community education • increased community education • EVERFI courses
Obesity and Related Illnesses	
Food Assistance	Nutrition/weight loss
• Farmers market improvements • Project Success and SRSLY • Food assistance program expansion	• Group sessions for mindfulness, weight loss, etc. with the use of teams or a buddy system to create a sense of belonging and peer pressure work well. • More nutrition support

Appendices

Appendix E (cont.) - Community Engagement Online Survey

What could we do better about these needs?

<table>
<tr>
<td>Treatment Access
Mental Health/ Substance Use Disorder(s)
• More behavioral health providers who take Medicaid
• Treatment on demand for SUD
• Mild to moderate behavioral health for those without commercial insurance
• Access to engage individuals
• Funding
• Continue to address MH and SUD stigma
• MH access
• Stress relief for all age groups</td>
<td>Services Offered
Mental Health/Substance Use Disorder
• Better coordination peer to peer network for severe mental illness
• Older adult needs for MH and SUD services
• Better MH and SUD services
• Additional MH services for all ages
Seniors
• Continuing increasing focus on seniors
• Lower prices for wellness center for seniors</td>
</tr>
<tr>
<td>Community Partnerships
Schools
• Connecting to schools
• Involve schools, churches, small groups
• Substance use education in schools</td>
<td>Communication/Education
• Publicize more broadly
• Spread the word even more i.e. educational events
• Make sure organizations know what WHI is doing
• Educational information to organizations serving folks so that orgs can education clients
• More free support groups, and resources, health fairs</td>
</tr>
<tr>
<td colspan="2">Other
• Misuse of funds for administrative purposes instead of care
• More action oriented outcomes
• Make hospital campus more walkable</td>
</tr>
</table>

Appendices

Appendix E (cont.) - Community Engagement Online Survey

What other needs in the community do you see?

Housing • Safe and affordable housing • Services for those experiencing homelessness • Housing • (identified by Dexter Community Fund (DCF)) • Permanent supportive housing	**Older Adults** • (identified by DCF) • Senior transportation • Older adult outreach
Mental Health and Substance Use Disorder • Opioid epidemic • Non-traditional hours for treatment • Resources for families who experience trauma • Mental health support • (Identified by DCF) • Behavior concerns among kindergarteners • Mental health support staff • More providers or increased capacity for SUD • Outpatient detox and primary care treatment of SUD	**Transportation** • Transportation in western Washtenaw • (Identified by DCF)
Other • Domestic violence services for perpetrator • Dexter Community Fund needs identified: Dexter senior center funding, MH services for youth and adults, affordable housing, homebound senior support, B2B trail, need for teen center, public transit, one stop social service support for seniors, vets, mental health, and disabilities • Healthy diet and exercise • Frontline and primary care education about vulnerable populations • Wellness center • Collaborations to reduce community gaps	

Appendices

Appendix E (cont.) - Community Engagement Online Survey

What can be done to address those needs?

Money • Public will and financing • Fundraising and grants • Need more funds!	**Housing** • Emergency shelters for families • Shelter association is working to implement medical recuperative care shelter program to house those post-discharge • Increase affordable, emergency housing stock
Primary Care • Train primary care groups how to offer outpatient detox and MAT options • Searchable database for providers to get their patients a referral for assistance (SDoH)	**Older Adults** • Recovery agencies in the county work closer with aging services • In cold weather opportunity for seniors to exercise inside. • Community needs assessment for older adults- survey them directly
Mental Health and Substance Use Disorders • More options for evidence based treatment similar to Packard's MAT • More funding and access to non-traditional hours • Destigmatize mental health problems • More mental health providers • More local providers or increase capacity for current providers SUD • Harm reduction model rather than abstinence	**Transportation** • Transportation to outside services • Explore partnership with AATA, WAVE to broaden transportation opportunities
Other • Partnering with school districts • Bring community leaders together to develop short and longer term plans • Opportunities for all ages to learn and have access to healthy food and exercise. • Dexter community government stop wasting tax payer dollars suing the wellness center. • Outreach for young, new mothers	

Appendices

Appendix F - St. Joseph Mercy - Chelsea Community Engagement Meetings

Summary of Community Engagement Meetings facilitated by St. Joseph Mercy Chelsea.
In September and October 2018, UNITE members sought qualitative input from community members and key stakeholders. UNITE members collected this data in person at wellness coalitions, safety-net organizations, food pantries, civic clubs, ministerial associations, and the WHI Stakeholders meetings. Also, data was collected electronically, via an electronic survey sent to community partners. Here are the summarized themes:

What's working well, want more of:

• Diabetes Prevention Program • Farmers Markets and Food Assistance programs • Behavioral Health Services Navigator • Youth Substance Abuse Prevention Coalition (SRSLY) • Red Barrel for safe medication disposal • Community nutrition classes • Senior Center programs	• Walk to School Wednesdays in Manchester • Project SUCCESS in Manchester and Chelsea (school-based substance abuse prevention for at-risk youth • Built environment improvements - trails and playgrounds • Group activities for physical activity and mental health support

What needs to be addressed: (listed in ranked order of frequency mentioned at community engagement sessions):

Social Determinants of Health
1. Transportation
2. Food Access – grocery & convenience stores, fresh food at pantries
3. Affordable Housing
4. Support services for seniors - respite care, housing
5. Support services for single parents and new moms, day care
6. Job Training

Mental Health - Youth and Adults
1. Stress, Anxiety, Depression, Social Isolation
2. Reduce Stigma
3. Access to Services

Nutrition
1. Access to healthy foods in stores, restaurants, food pantries
2. Education on healthy eating
3. Marketing healthy food options

Substance Abuse
1. Vaping
2. Marijuana
3. Opiates – alternatives for pain management
4. Education, Prevention, Support Groups, Treatment

Physical Activity
1. Access to programs and resources – location, cost, child care
2. Walkability

Appendices

Appendix F (cont.) - St. Joseph Mercy - Chelsea Community Engagement Meetings

General:

1. More collaboration, eliminate silos, work across organizations and towns
2. More communication about all the resources available
3. Make resources available in each town, so they are accessible

Summary

- Seventeen (17) meetings attended in Chelsea, Dexter, Grass Lake, Manchester, and Stockbridge
- Wellness Coalitions (5) and 5H Board, Safety Net Organizations (4), Ministerial Associations (2), Rotary Clubs (2), Senior Centers (3), SJMC Patient Experience Team
- More than 150 community members from the SJMC service area participated in person or via online survey

Date	Group	Attendees
3-Oct	Dexter Senior Center Board	
4-Oct	Chelsea Wellness Coalition	16
9-Oct	Chelsea and Dexter Ministerial Associations	
9-Oct	Dexter Wellness Coalition	16
11-Oct	Chelsea Senior Center Board	12
15-Oct	Grass Lake Wellness Coalition	11
15-Oct	Stockbridge Community Outreach Board	
16-Oct	CSD Wellness Committee Meeting	24
17-Oct	Manchester Community Resource Board	11
18-Oct	Dexter Rotary	
18-Oct	Stockbridge Wellness Coalition	14
22-Oct	5H Board of Directors	
22-Oct	Copper Nail Board	
23-Oct	Manchester Wellness Coalition	9
23-Oct	Patient Experience Team	5
6-Nov	Chelsea Rotary	15
20-Nov	Faith in Action Board	11

Appendices

Appendix G - Grantee Kickoff Meeting Feedback

As part of the University of Michigan Health System's efforts to address community needs as identified by the 2016 CHNA, Michigan Medicine's Department of Community Health Services (CHS) awarded $7.2 million for 26, 1-3 year projects (2018 – 2020). These projects address health inequities and social determinants of health specifically impacting the three identified health priorities: (1) mental health and substance use disorders, (2) obesity and related illnesses, and (3) preconceptual and perinatal health. In September 2018, CHS gathered the recipients for a project kick-off meeting, in which participants were divided into 5 groups, and each group was asked several questions designed to reveal organizational representative's perspectives on Community Health needs. The questions and the responses provided by these representatives are recorded below.

<table>
<tr><th colspan="2">What system/policy changes should we advocate for to have an impact on SDOH and equity?</th></tr>
<tr><td>Group 1
Universal basic income
Universal health care
Cure digital divide – access to information about resources
Better transportation
Better communication/collaboration among agencies
Better referrals among agencies – warm hand-offs</td><td>Group 2
Collaboration between organizations and projects
Reduce barriers to access
Increase communication between hospitals and community services and/or communities
Greater impact from people impacted by SDOH who need services
Advocacy at state level
Increase program funding</td></tr>
<tr><td>Group 3
System – Train to serve people, not problems
Policy – Crisis in Mentorship
Policy – Continuity of care with staff (new)
Policy – Onboarding process – passing on experience value</td><td>Group 4
All-the-level mental health funding from the government
Changes in homelessness categorization (to qualify for services)
Awareness and integration of services
Reform for equity issues around education funding
Expanding insurance access
Intervening on predatory financial practices</td></tr>
<tr><td colspan="2">Group 5
Standard Living Wage (Group 5)
Universal Access to resources (Group 5)
Educational equity and access to jobs/work (Group 5)
Ease of access to ID / license (Group 5)</td></tr>
</table>

Appendices

Appendix G (cont.) - Grantee Kickoff Meeting Feedback

<table>
<tr><td colspan="2">How do we measure the collective impact of this work?</td></tr>
<tr><td>Group 1
Need baseline data
Publicize baseline data, and subsequent measures – to demonstrate value to community and policy makers
Need long term data
Positive outcomes rather than negative outcomes Create county advisory boards</td><td>Group 2
Qualitative data collection
Output rather than outcome</td></tr>
<tr><td>Group 3
Number of Encounters
Measure satisfaction (one question change it up)</td><td>Group 4
Fund evaluation
Shared outcomes
Evaluation consultation services
Capturing stories / voices of those impacted</td></tr>
<tr><td colspan="2">Group 5
Decrease in incarceration
Decrease in evictions/homelessness
Increase in workplace diversity
Increase in employment</td></tr>
</table>

ENDNOTES

1 See Appendix A for a description of the three hospitals.

2 U.S. Census Bureau (2019, April 15). 2013-2017 ACS 5-Year Estimates (race alone or in combination with other races), Fact Finder. Washtenaw Co. MI. Retrieved from https://factfinder.census.gov/faces/nav/jsf/pages/index.xhtml

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4 See Appendix A for CHNA partners

5 See Appendices B & C for a summary of quantitative and qualitative data sources

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