Community Health Needs Assessment 2015

March 10, 2015

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I. Introduction and Mission

St. Joseph Mercy Oakland (SJMO) is one of six hospitals comprising Saint Joseph Mercy Health System. Saint Joseph Mercy Health System, itself a member of Trinity Health, is a health care organization serving six counties in southeast Michigan including Livingston, Macomb, Oakland, St. Clair, Washtenaw and Wayne. St. Joseph Mercy Oakland is a 443-bed hospital located in the City of Pontiac and primarily serving Oakland County in partnership with its many physicians and community services.

As part of Trinity Health, SJMO's mission is to serve together in the spirit of the Gospel to be a compassionate and transforming healing presence within our communities. SJMO embraces the core values of Reverence, Commitment to Those Who are Poor, Justice, Stewardship, and Integrity. We are faithful to who we say we are.

Our mission guides everything we do. As Saint Joseph Mercy Health System continues our healing ministry into the 21st century, we are called to both serve others and transform care delivery. We reinvest our resources back into the community through new technologies, vital health services and access for everyone regardless of their circumstances.

We are compelled to care for our community. As a faith-based health care organization in the Catholic Christian tradition, SJMO's work of providing services that benefit the community is core to our identity. While governed by laws and regulations for non-profit tax-exempt hospitals to provide services to those in need, we are ultimately compelled by a desire to extend the healing ministry of Jesus Christ (cf. John 13:14-17, Matthew 25:35-36). Our mission and core values call us to improve the health of our community with a particular concern for the poor and underserved. We call our commitment our "*Community Benefit Ministry*." Our Community Benefit Ministry is an organized and measured approach to meeting community health needs. It implies collaboration with a community to benefit its residents by improving health status and quality of life.

II. A Retrospective Review of the 2012 Community Health Needs Assessment (CHNA)

In 2012, St. Joseph Mercy Oakland participated in a Community Health Needs Assessment (CHNA) for the Oakland County area to identify community perceptions of health concerns, barriers to access, gaps in service, health education, prevention services, vulnerable populations and social concerns. At that time, a plan was developed for addressing needs within the community. The full report can be viewed at http://www.stjoeshealth.org/cbm. In that 2012 Needs Assessment, the health and social needs priorities listed in the table below were identified and plans were implemented to address each priority need.

As part of the 2015 Community Health Needs Assessment process, a retrospective review of the 2012 CHNA and Implementation plan was conducted. This review included collecting information on each of the Community Benefits programs supported in FY2014, including the following metrics:

- Number of individuals served
- Alignment of the initiative with an identified need in the CHNA
- Included in the 2012 CHNA Implementation Plan
- Metrics for program impact
- Total expenditures on the program

The complete inventory of community benefits is available on request and is provided annually to the IRS in compliance with the IRS' requirements for charitable hospitals.

As part of the 2015 CHNA, SJMO also evaluated progress in impacting the needs it had prioritized in its 2012 CHNA. SJMO had selected nine (9) health and social needs as priorities and identified many initiatives to address those needs in its 2012 Plan. The assessment of the change, if any, in the metrics related to those priorities is included in the table below. As can be seen, the data were mixed regarding the trend for most priorities. In some cases, this was because relevant, timely data of community-wide impact were not available at the community level, regardless of SJMO's collection of measurable results for its specific initiatives.

2012 PRIORITIES	TREND	DETAILS behind TREND
Cost/Coverage	Unclear	Data regarding the impact of expanded access to insurance are not yet available so the trend is unclear. However, community interviews point toward ongoing financial issues for low income and undocumented people, and Medicaid recipients requiring specific services. Cultural and language barriers to care also exist, as do transportation-related barriers.
Access to Primary and Specialty Care	Unclear	Data regarding access to care predate Medicaid expansion so the trend is unclear. Community interviews and surveys indicate adequate access to primary care and pregnancy care, but inadequate hours of service for working poor. Community interviews and surveys revealed some specialties for which access continues to be a problem for Medicaid recipients.
Dental Care	Unclear	Data were not found regarding dental access. However, community interviews point toward financial access issues for underinsured and low income. Dental access was not one of the Top 5 Access concerns revealed through the community survey process.

2012 PRIORITIES	TREND	DETAILS behind TREND
Exercise	Unclear	Data were not found regarding exercise. However, the community survey indicated exercise is a high priority for health determinants and one interviewee indicated a need for safe exercise locations.
Community Health Education	Unclear	Data were not found regarding community health education. However, community interviews point toward need for community health education in a wide variety of areas on a wide range of topics.
Poverty	Good	Poverty is declining in Pontiac and Oakland County on nearly every measure. Pontiac's poverty continues to be substantially greater than in Oakland County.
Nutrition/Healthy Eating	Poor	The only metric of healthy eating, percent of adults eating adequate fruits and vegetables, had an unclear trend for Oakland County and was lower overall for Oakland County compared to Michigan. Community interviews and surveys indicated this is a continued need, both in terms of access and education regarding healthy eating.
Mental Health	Mixed	Data regarding mental health are mixed; the suicide rate in Pontiac has improved but Oakland County's suicide rate rose most recently and the percent of people reporting mental health days grew most recently. Community interviews and surveys indicated a high need for increased access and capacity for mental health and behavioral health services for many sub-populations.
Chronic Disease Management	Mixed	Data regarding incidence, hospitalization and mortality rates from chronic diseases were mixed, with some improvement in overall mortality but no clear trend. Interviews and surveys showed interest in community-based chronic disease management education.

III. Summary Observations from the Current CHNA

Service Area

Saint Joseph Mercy Oakland's service area is defined as all of Oakland County. The total population of Oakland County was estimated to be 1,231,640 in 2013, with small increases annually for the past several years. While the total population is growing, the population is aging. Oakland County's population continues to be racially diverse and is gradually becoming more diverse.

Assessing Community Health Care Needs

SJMO engaged in a robust Community Health Needs Assessment (CHNA) process. The CHNA process included an in-depth review of national, state and local data, key stakeholder interviews, community agency surveys and reviews of local level surveys and studies. The Community Benefit Team (CBT) for SJMO reviewed information from each of these sources over a period of several meetings during the last quarter of 2014 and first quarter of 2015. The purpose of these meetings was to evaluate trends, needs, special populations, and hospital and community capabilities.

The 2015 Community Health Needs Assessment identified twenty potential areas of need. A "need" was evidenced by a wide variance between local and regional metrics, an unfavorable trend, issues identified by a majority of survey respondents, issues identified by multiple, key stakeholders or issues identified by local, third-party studies. In total, the following issues were identified as potential needs to be addressed.

2015 POTENTIAL NEEDS NEED	
HEALTH CONDITIONS	Cancer
	Chronic Diseases e.g. heart disease, diabetes
	Obesity
	Suicide
HEALTH BEHAVIORS	Alcohol abuse
	Healthful eating
	Immunizations
	Exercise
ACCESS ISSUES	Hospital-based care
	Behavioral and Mental Health
	Dental care
	Specialist physicians
	End of life care
	Pharmaceuticals
	Primary care
SOCIAL DETERMINANTS	Health insurance enrollment
	Maternal health education
	Transportation
	Health literacy (understanding health info)
	Navigation of healthcare resources

Health Care Priorities and Contributing Risk Factors
Using the data, findings and feedback from its fact-finding process, the CBT and SJMO leadership prioritized the community's potential needs according to the four criterion of:

- The degree to which the need was essential to the overall health of the community
- The urgency of the need
- SJMO's ability as a hospital to address the need
- The likelihood SJMO's efforts would impact the need.

These four criteria balance considerations of the depth and urgency of the needs, and the hospital's relative ability to affect the need based on its expertise, programs and partner relationships. As a result of this discernment process, SJMO prioritized the following four health needs in its service area:

- Obesity
- Dental Care
- Behavioral Health, which includes Mental Health and Substance Abuse
- Financial Access to Care

Our Response
To address the needs identified in the 2015 CHNA, SJMO will engage key internal and community partners in identifying and implementing evidence-based strategies. These strategies will guide SJMO's existing community benefit programs and efforts, as well as new tactics and partnerships that can be integrated into its Community Benefit Ministry.

IV. Community Description

The St. Joseph Mercy Oakland (SJMO) service area for purposes of this needs assessment is defined as the entire population of Oakland County. Oakland County is estimated to have a population of 1,231,640 as of 2013 (MDCH). The population of Oakland County is growing at a steady rate. This estimate indicates population growth of nearly 2.4% between 2010 and 2013 and 4.4% between 2000 and 2013.

MAP: Oakland County Commission Districts, 2013-2021

The population of Oakland County is gradually aging. The population under age 18 has consistently declined over the past four years while the over-65 population has grown as a percentage of the whole. Oakland County's population is racially diverse with 77.9% White, 15.0% Black, 6.6% Asian, and 0.4% Native American in 2013. The chart below shows how this mix of races has changed over time, and is becoming more diverse.

DEMOGRAPHICS - AGE	2010	2011	2012	2013
TOTAL POPULATION	1,202,829	1,211,026	1,220,643	1,231,640
% Under Age 18	23.4	23.1	22.8	22.5
% 18-44 years	33.6	33.5	33.5	33.5
% 45-64 years	29.7	29.9	29.6	29.4
% 65+ years	13.3	13.6	14.2	14.6

SOURCE: National Center for Health Statistics (NCHS) as prepared for Michigan Department of Community Health

DEMOGRAPHICS - RACE	2010	2011	2012	2013
% White	79.1	78.6	78.3	77.9
% Black	14.4	14.7	14.9	15.0
% Native American	0.4	0.4	0.4	0.4
% Asian/Pacific Islander	6.1	6.2	6.4	6.6

SOURCE: National Center for Health Statistics (NCHS) as prepared for Michigan Department of Community Health

Oakland County's poverty rate has consistently been lower than that of all Michigan. In 2013, approximately 7.3% of Oakland County households lived in poverty. This percentage has declined since 2011 but is not as low as it was 2010.

INCOME INDICATORS		2010	2011	2012	2013
PONTIAC	% Children age <18 living in poverty	48.0	53.9	53.3	53.1
	% HH Below Poverty Level	29.5	32.4	32.0	33.3
OAKLAND	% Children age <18 living in poverty	13.4	14.9	14.4	13.0
	% HH Below Poverty Level	7.2	8.1	7.9	7.3
	% HH Lead by Single Woman below Poverty	21.6	23.1	25.8	24.5
MICHIGAN	% Children age <18 living in poverty	23.5	24.8	24.9	23.8
	% HH Below Poverty Level	12.1	12.5	12.6	12.3
	% HH Lead by Single Woman below Poverty	33.8	34.7	35.9	34.6

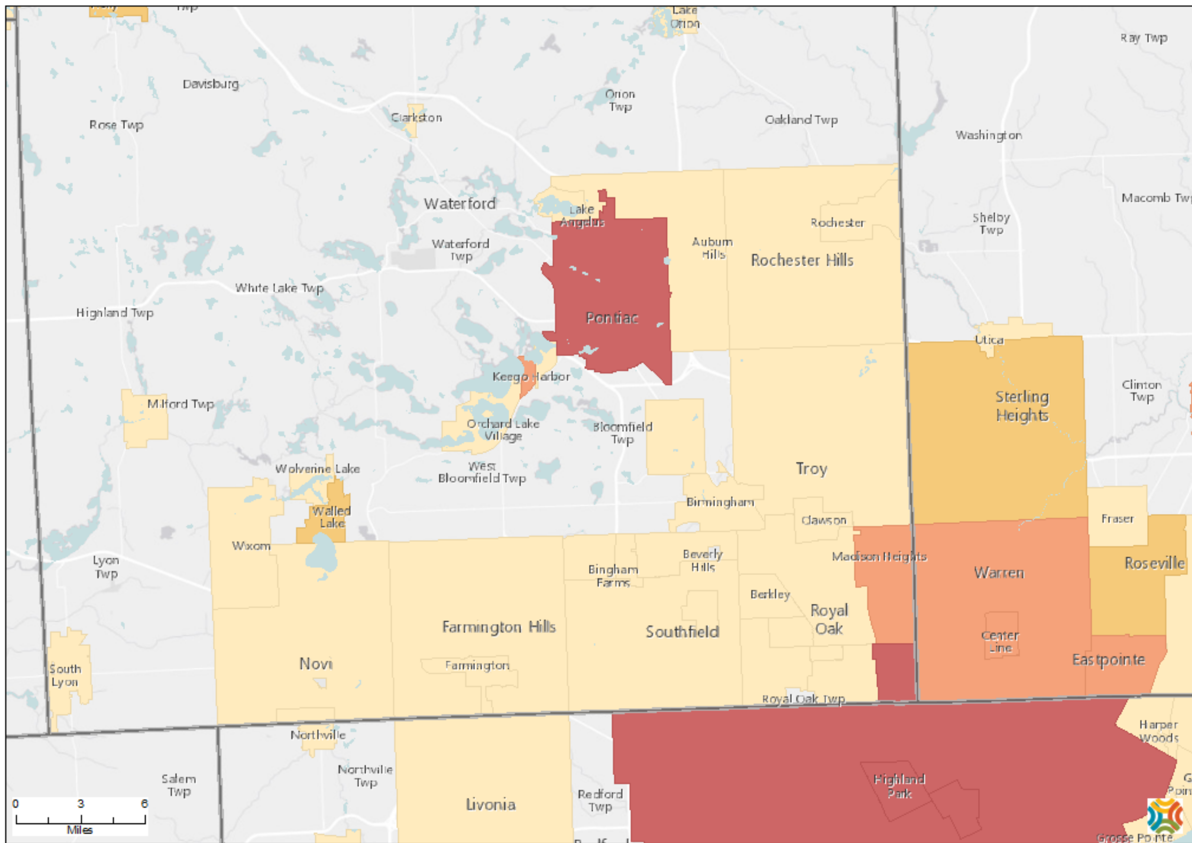
SOURCE: American Community Survey 1-year estimates.

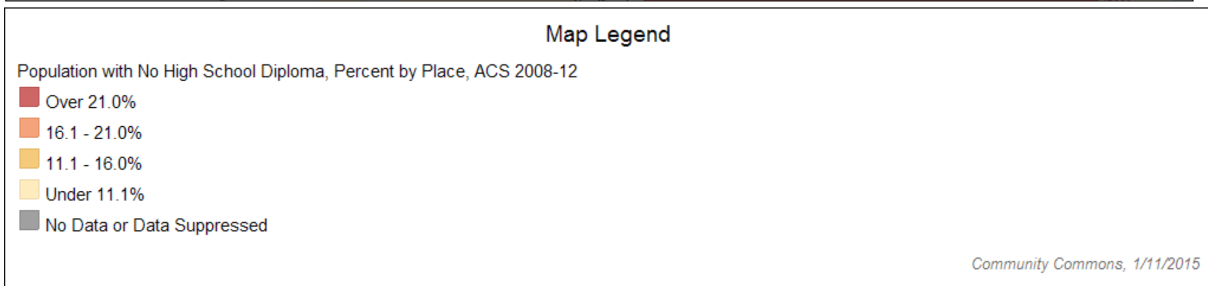
Oakland County has a high proportion of people with a 4-year degree or higher. However, it also has geographic pockets where more than 20% of the population has less than a high school diploma as shown in the map below.

EDUCATION INDICATORS	2009	2010	2011	2012	2013
% High School Graduates Graduating On Time	78.6	79.6	78.3	79.7	81.2
% Pop age 25+ with 4-Year degree or higher	N/A	N/A	42.9	43.6	43.8

SOURCE: American Community Survey and Michigan League for Public Policy-Kids Count survey.

Percent Population with No High School Diploma





Oakland County is home to twelve (12) acute care hospitals with comprehensive medical and surgical care programs available to the general public. Each facility accepts patients of all races, genders, ethnicities and a variety of insurance plans, including Medicaid and Medicare. Oakland County also has two specialty hospitals, four (4) Long Term Acute Care Hospitals and 53 nursing homes.

OAKLAND COUNTY HOSPITALS		CITY	BEDS
Acute Care Hospital	Botsford Hospital	Farmington Hills	305
	St. John Macomb Oakland Hospital	Madison Heights	133
	Providence Hospital and Medical Center	Southfield	391
	Huron Valley Sinai Hospital	Commerce Twp.	158
	Beaumont Hospital, Royal Oak	Royal Oak	1040
	Crittenton Hospital	Rochester	270
	Doctor's Hospital of Michigan	Pontiac	306

OAKLAND COUNTY HOSPITALS		CITY	BEDS
	McLaren Oakland	Pontiac	278
	St. Joseph Mercy Oakland	Pontiac	443
	Henry Ford West Bloomfield Hospital	West Bloomfield	191
	Providence Medical Center	Novi	212
	Beaumont Hospital	Troy	458
Specialty Hospital	Oakland Regional Hospital	Southfield	45
	DMC Surgery Hospital	Madison Heights	36
Long Term Acute Care Hospital	Providence Long Term Acute Care Hospital	Southfield	30
	Straith Hospital for Special Surgery	Southfield	34
	Pioneer Specialty Hospital	Pontiac	30
	Select Specialty Hospital	Pontiac	30

V. Information Sources & Data Collection Approaches

SJMO engaged a market research company, Arbor Advisors, to lead the process of gathering both primary and secondary data. The process involved actively reaching out to community experts through surveys and interviews, delving already-conducted local studies that used focus groups, community forums and surveys, and gathering of local, regional and nationally available data sources.

A. Primary Data Sources - Surveys

Arbor Advisors generated primary data through a survey of essential community agencies. A web-based community health needs survey was created in November 2014 to evaluate the health and social needs in the SJMO service area. The survey was composed of eight questions regarding the top health concerns, barriers to health care services, gaps in health care services, vulnerable populations, and the impact of various social determinants of health. Survey participants were asked to identify organizations that are already being successful in addressing some of the needs. Survey participants were also given an opportunity to suggest ways they thought SJMO could address some of the needs they had identified. Participant demographic information was collected, but on a voluntary basis with many participants opting to remain anonymous. The survey also allowed respondents to recommend other people to contact for information, and surveys or interview invitations were extended accordingly.

The web-based survey was available to the public from November 2014 through January 2015. The survey was distributed to hand-selected individuals within community agencies and programs, as well as to SJMO's key community outreach staff and staff working with vulnerable populations. The open survey was available for direct re-distribution by respondents and invitees; this was encouraged. Email invitations to complete the survey were sent two and three times during this period. Within the survey was a section that allowed respondents to recommend other participants, and surveys or interview invitations were extended accordingly.

B. Primary Data Sources – Key Stakeholder Interviews

During this same period of November 2014 through January 2015, interviews were conducted with key stakeholders. These stakeholders were identified as local subject matter experts, community leaders or experts within key populations such as the Latino population and the elderly. The focus of these interviews closely aligned with the questioning on the survey regarding health care service needs and barriers, vulnerable populations, and social determinants of health. These intensive interviews offered great opportunity to delve into issues of service coordination and partnering, and detailed assessment of specific population needs.

C. Secondary Data Sources - Local studies

Where available, local studies were used to inform the CHNA. These studies were made available by people who participated in this CHNA's interviews and surveys, or were suggested by these participants as resources for additional information. In each key stakeholder interview, the participant was asked whether his or her agency had conducted any studies that would be useful for this CHNA. The survey also gathered suggested information resources.

Some studies were regional in nature, such as those conducted by the Area Agency on Aging and Oakland Livingston Human Services Agency. Regional studies provided insights into potential health needs and social determinants of health and were used to inform the direction of additional, local data research. Other studies were specific to Oakland County and did not exclusively measure health needs or determinants of health but did provide some data pertinent to this CHNA process. These latter

studies typically focused on at-risk populations, such as the elderly and minorities. This CHNA used the following studies:

- Oakland Livingston Human Services Agency Community Forums – 2014 http://www.olhsa.org/files/cna2015.pdf
- Area Agency on Aging Community Forums – 2013 http://www.aaa1b.org/news-events/publications/2013-community-forums/

D. Publically Available National, State and Local data

Local, state and national data on demographics, socio-economic factors, health behaviors, health status, access, and mortality were gathered from a wide range of sources. Some data were limited by the frequency by which it was collected and by the geographic level of detail. The most recent data were reviewed. Where possible, data were broken down to the lowest level of city or township with comparisons conducted between increasingly larger geographies. For example, where City of Pontiac data were available, they were compared with Oakland and Michigan overall. In many cases, local level (city) data were not available from these sources in a timely and meaningful (statistically relevant) manner; most data compared Oakland with Michigan overall. The interviews and local surveys were relied upon for the most local-level information.

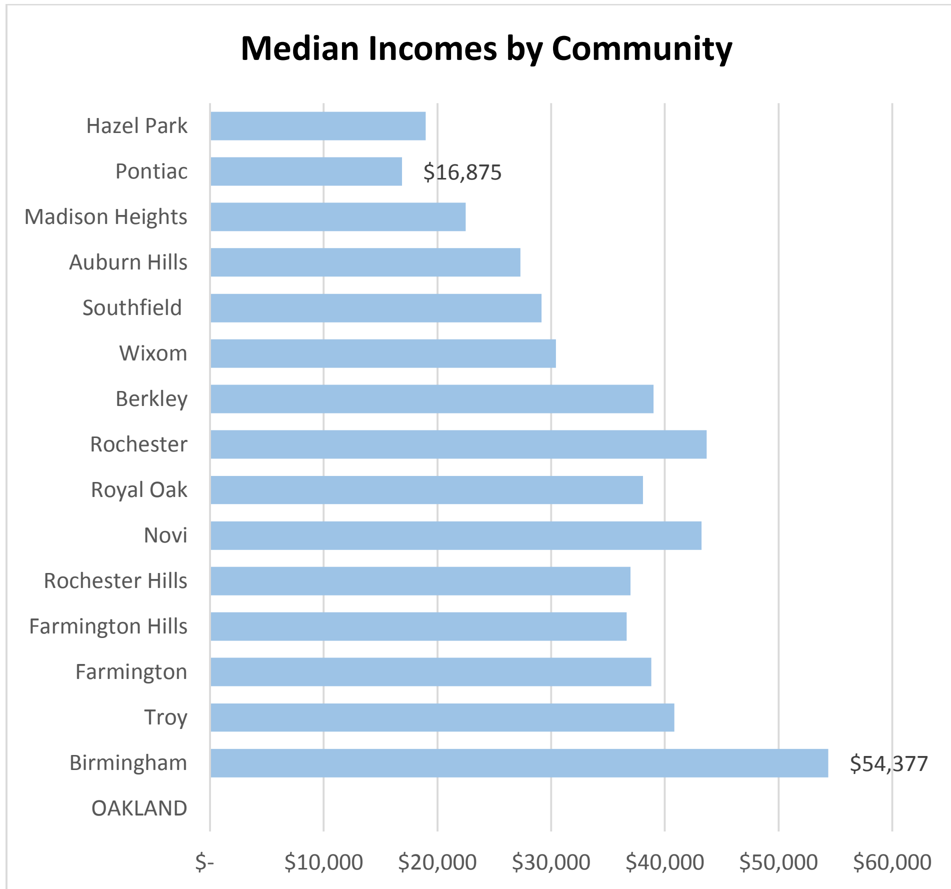
Some of the following resources served as the basis for the National, State and Local data analysis:

- Michigan Office of Highway Safety Planning http://www.michigantrafficcrashfacts.org/
- Michigan Profile for Healthy Youth (MIPHY) http://www.michigan.gov/mde/0,4615,7-140-28753_64839_38684_29233_44681---,00.html
- Michigan Behavioral Risk Factors Surveillance System (MI-BRFSS) https://www.michigan.gov/mdch/0,1607,7-132-2945_5104_5279_39424---,00.html
- American Community Survey http://www.census.gov/acs/www/
- Michigan League for Public Policy- Kids Count http://www.mlpp.org/kids-count
- Bureau of Labor Statistics http://www.bls.gov/data/
- Oakland County Health Department Dashboard http://oakland.mi.networkofcare.org/ph/
- Southeastern Michigan Council of Governments http://semcog.org/Data-and-Maps
- Michigan Department of Community Health, Vital Statistics http://www.michigan.gov/mdch/0,4612,7-132-2944_4669---,00.html
- Pediatric Nutrition Surveillance Study http://www.cdc.gov/pednss/pednss_tables/index.htm
- United Way for Southeastern Michigan http://www.liveunitedsem.org/
- Michigan Department of Education https://www.mischooldata.org/districtschoolprofiles/studentinformation/graduationdropoutrate.aspx

VI. Findings from Health and Community Data

Socio-Economic Indicators: INCOME

"Researchers have identified that educational attainment and poverty are two factors that can have significant influence when it comes to health." (Community Commons, CHNA.org). According to the Small Area Income & Poverty Estimates of 2013, Oakland County had the 2nd highest median income of all Michigan Counties, at $67,281 per household. A closer review of the data shows wide variation in median household income for many communities within Oakland County. Pontiac had the lowest median income while Birmingham had the highest median income at three times that of Pontiac.



SOURCE: Community Commons, 2015.

Socio-Economic Indicators: EDUCATION

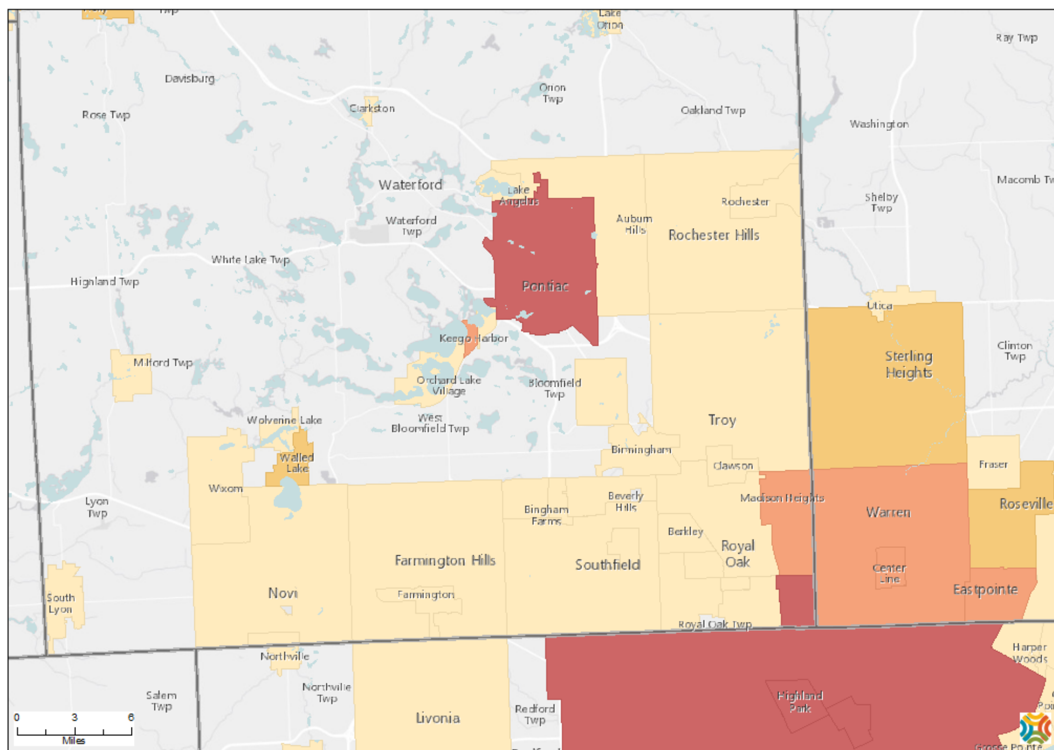
On the whole, Oakland County has a favorable educational profile when compared with Michigan. Oakland has a much higher percentage of residents with a 4-year degree or higher (43.8%) than Michigan (26.2%). Oakland County also has an overall higher percentage of its high school students who graduate on time than Michigan. There is wide variation among the communities that comprise Oakland County on each of these metrics. For example, only about one in ten residents has a 4-year degree higher in the City of Pontiac. And only about half of Pontiac's public high school students ever graduate from high school. The percentage of high school students graduating in Pontiac fell to a 5-year low in 2013.

EDUCATION		2009	2010	2011	2012	2013
PONTIAC	% Graduation Rate *	58.6	58.4	57.9	56.5	51.0
	% Pop age 25+ with 4-Year degree or higher	N/A	N/A	12.7	12.6	10.9
OAKLAND	% High School Graduates On Time	78.6	79.6	78.3	79.7	81.2
	% Pop age 25+ with 4-Year degree or higher	N/A	N/A	42.9	43.6	43.8
MICHIGAN	% High School Graduates On Time	75.2	76.0	74.3	76.2	78.8
	% Pop age 25+ with 4-Year degree or higher	N/A	N/A	25.3	25.7	26.2

SOURCE: American Community Survey and Michigan League for Public Policy-Kids Count survey and Michigan Department of Education. NOTE*: Pontiac uses different metric than County/State

The map below shows the percentage of population that has less than a high school diploma in Oakland County. In Pontiac, for example, more than 21% of residents have no high school diploma.

Percent Population with No High School Diploma



Map Legend

Population with No High School Diploma, Percent by Place, ACS 2008-12

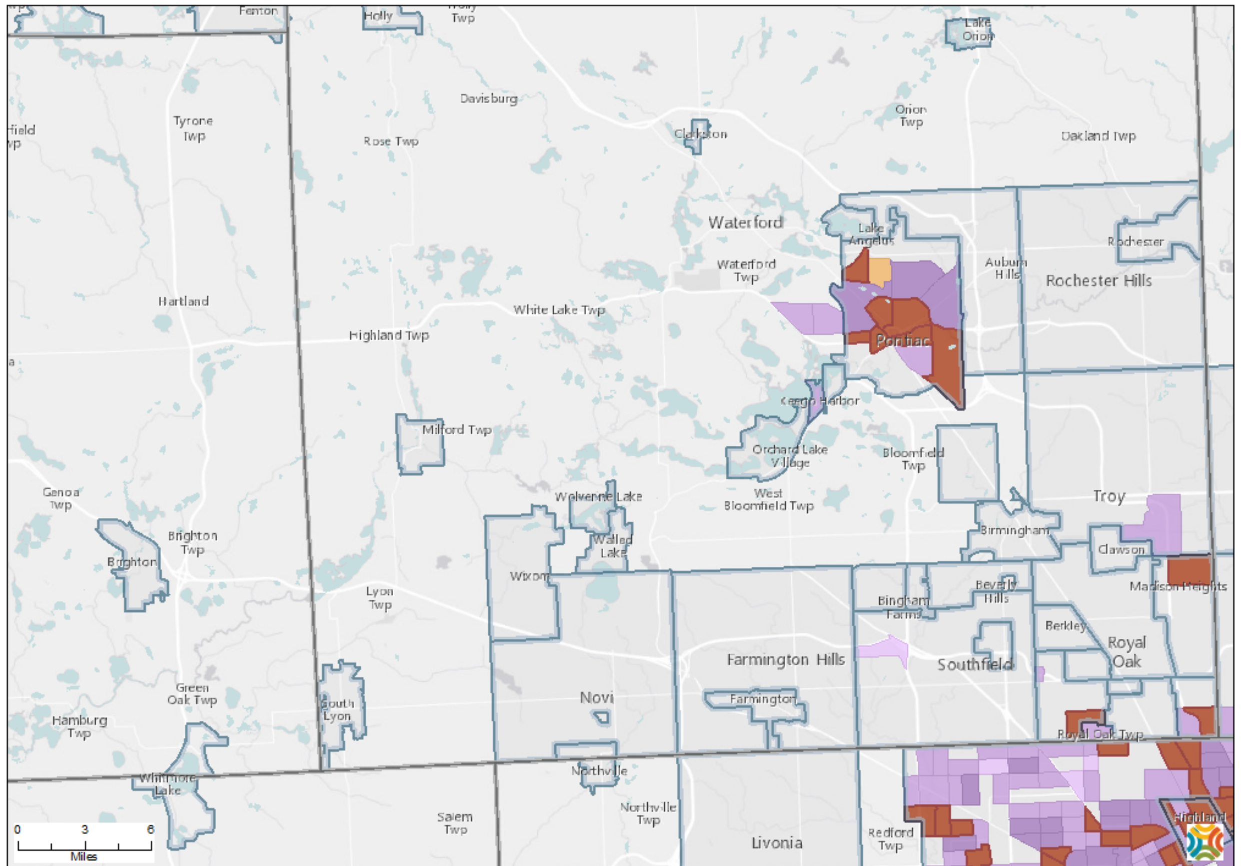
- Over 21.0%
- 16.1 - 21.0%
- 11.1 - 16.0%
- Under 11.1%
- No Data or Data Suppressed

Community Commons, 1/11/2015

Populations with both low income and low educational attainment are considered to be highly vulnerable to unfavorable health outcomes. The map below shows populations that are most vulnerable according to the metrics of 30% Poverty and 15% with less than a high school diploma. The color legend is:

- Brown: 30% or more persons are in poverty AND 15% have less than a high school diploma.
- Orange: 30% or more persons are in poverty.
- Purple 15% have less than a high school diploma.

Vulnerable Population - Based on Income and Education



Map Legend

Vulnerable Populations Footprint

Community Commons, 1/11/2015

Socio-Economic Indicators: EMPLOYMENT

Oakland County's unemployment rate has closely mimicked Michigan's overall unemployment rate. For the period October 2014, Oakland County ranked 64th of Michigan's 82 counties for unemployment, and was a half percentage more favorable than the state average. The City of Pontiac has chronically had a much higher unemployment rate than Oakland County. Because employment is closely associated with health insurance, it is an important metric in understanding health. In general, the percentage of residents ages 0-64 with insurance in Oakland County has been similar to Michigan's population overall. Data on insurance coverage were not available at the community level.

EMPLOYMENT and INSURANCE COVERAGE		2010	2011	2012	2013	2014
PONTIAC	% Population age 16+ unemployed, looking for work	28.4	24.7	21.9	20.3	17.9
OAKLAND	% Population age 16+ unemployed, looking for work	11.5	9.4	8.6	7.8	6.9
	% Uninsured Ages 0-64*	N/A	12.0	12.0	11.0	N/A
MICHIGAN	% Population age 16+ unemployed, looking for work	11.2	9.3	8.3	8.2	6.4
	% Uninsured Ages 0-64*	N/A	12.5	10.9	11.0	N/A

SOURCES: Unemployed: Bureau of Labor Statistics (October metric).
Uninsured: County Health Rankings (Oakland), Current Population Survey (Michigan).

Socio-Economic Indicators: ACCESS TO NUTRITIOUS FOODS

Oakland County has a lower percentage of food-insecure residents than does Michigan overall and its total number of food-insecure people in 2013 had fallen substantially from 2009 even though the total population in Oakland County had grown. Similarly, the percentage of children eligible for free or reduced lunches is lower in Oakland County than in Michigan. About one-third (1/3) of Oakland County school students are eligible for free or reduced lunches. In comparison, nearly three-quarters (3/4) of City of Pontiac schools children are eligible for free or reduced lunches, and the number of people receiving cash assistance and SNAP benefits has grown in Pontiac.

FOOD SECURITY		2009	2010	2011	2012	2013
PONTIAC	# Receiving Cash Assistance or Food Stamps/ SNAP	7,135	7,682	9,081	9,044	9,115
	% Children Eligible to Receive Free or Reduced Lunch	84.0	74.6	75.6	73.7	73.6
OAKLAND	# Receiving Cash Assistance or Food Stamps/ SNAP	33,378	52,235	58,780	55,349	52,240
	% Children Eligible to Receive Free or Reduced Lunch	30.7	31.6	33.7	33.3	33.2
	# Food Insecure People	183,660	173,700	163,710	164,830	N/A
	% Food Insecure People	15.3	14.5	13.6	13.7	N/A
MICHIGAN	# Receiving Cash Assistance or Food Stamps/ SNAP	586,083	673,301	712,577	707,080	670,570
	% Children Eligible to Receive Free or Reduced Lunch	45.8	46.5	48.1	48.2	48.6
	# Food Insecure People	1,828,060	1,872,780	1,769,790	1,660,050	N/A
	% Food Insecure People	18.2	19.0	17.9	16.8	N/A

SOURCES: USDA. American Community Survey. Michigan League for Public Policy – Kids Count Survey.
Pontiac # receiving assistance are 3-year estimates.

Socio-Economic Indicators: HOUSING and ECONOMIC SECURITY

The United Way ALICE report shows the number of households whose average income is insufficient to afford the basics of the housing, child care, food, health care, and transportation. Oakland County had

489,897 households, or 34%, falling below the ALICE threshold for their communities. The cost of housing was the most significant condition leading to household struggle; Housing Affordability was rated "Poor" in Oakland while Job Opportunities and Community Support were rated "Good." The following Oakland County communities had the most unfavorable ALICE scores:

INCOME INDICATORS		2012
OAKLAND	% Households Below ALICE	34.0
MICHIGAN	% Households Below ALICE	40.0

COMMUNITY	% Households in Poverty or Below ALICE Threshold
Pleasant Ridge City	67
Lyon Charter Township	55
Oakland Charter Township	48
Royal Oak City	68
Groveland Township	60
Fenton City	48
Independence Charter Township	58
Royal Oak Charter Township	47
Village of Clarkston	48
White Lake Charter Township	48

SOURCE: United Way Study of Financial Hardship. 2013.

These high burdens of housing costs contribute, among other things, to the number of homeless individuals in Oakland County. In Oakland County, the number of homeless individuals rose between 2012 and 2013, with a larger portion of that increase attributed to children. Approximately 40% of homeless people had a disability and 17% were chronically homeless.

Homeless in Oakland County	2012	2013
Total number of homeless	3,370	3,503
Number of children in families	522	721
Individuals with disabilities	1,413	1,434
Chronically homeless individuals	477	597
First time homeless families	231	263

SOURCE: Alliance for Housing-Oakland County's Continuum of Care 2013 Annual State of Homelessness Report

Health Indicators: OVERALL

Overall, Oakland County residents enjoy a favorable health status; Oakland County is twenty-second (22nd) among Michigan's counties in overall health outcomes according to the County Health Rankings by Robert Wood Johnson Foundation. On each of the key self-reported health status factors, Oakland County compared favorably to Michigan. More than one in five Oakland County adults reported experiencing limitations due to a physical, mental or emotional problem in the most recent survey.

HEALTH STATUS	PERCENT – SELF REPORTED	2006-2008	2008-2010	2011-2013
OAKLAND	Current Health Status as Fair or Poor	12.7	11.0	12.0
	With at least 14 Days of Fair or Poor Physical Health in Past Month	10.5	9.0	9.3
	With at least 14 Days of Fair or Poor Mental Health in Past Month	9.7	9.4	10.6
	Limitations because of a Physical, Mental or Emotional Problem	22.7	21.5	22.6
MICHIGAN	Current Health Status as Fair or Poor	14.8	14.6	17.3
	With at least 14 Days of Fair or Poor Physical Health in Past Month	10.9	10.8	13.1
	With at least 14 Days of Fair or Poor Mental Health in Past Month	10.8	10.8	12.7
	Limitations because of a Physical, Mental or Emotional Problem	23.8	23.7	26.1

SOURCE: BRFSS Surveys.

Health Indicators: PREVENTIVE BEHAVIORS

Preventive behaviors include a wide range of actions residents can take to keep themselves healthy. Most data on health behaviors are collected through self-reporting on surveys. Overall, Oakland County's adults are slightly more likely to receive the influenza vaccination. During the most recent period, Oakland County's adults were also more likely to receive a pneumonia shot; in past periods Oakland County's adult pneumonia vaccination rate had lagged Michigan. In contrast, Oakland County's children are less likely to be fully vaccinated. One in ten (1:10) Oakland County students have received vaccine waivers compared with Michigan's rate of one in seventeen (1:17). Oakland County adults were more likely to have a screening colonoscopy or sigmoidoscopy than Michigan adults. The percentage of Oakland County adults who eat less than five (5) fruits and vegetables daily has been consistently favorable to that of all Michigan adults since 2006.

PREVENTION		2006-2008	2008-2010	2011-2013
OAKLAND	% Influenza (Flu) Shot in Past Year (65+ Years)	73.8	71.1	57.8
	% Ever Had Pneumonia Shot	65.4	66.6	68.5
	% Colonoscopy, Sigmoidoscopy (50 + Years, Appropriately Timed)	N/A	66.1	69.8
	% Adults Eating <5 Fruits or Vegetables Daily	74.9	75.0	74.2
	% Students with Vaccine Waivers	N/A	N/A	10.6
MICHIGAN	% Influenza (Flu) Shot in Past Year (65+ Years)	70.7	68.9	56.7
	% Ever Had Pneumonia Shot	65.7	67.1	67.5
	% Colonoscopy, Sigmoidoscopy (50 + Years, Appropriately Timed)	N/A	64.5	67.8
	% Adults Eating <5 Fruits or Vegetables Daily	78.5	N/A	78.3
	% Students with Vaccine Waivers	N/A	N/A	5.9

SOURCE: BRFSS Surveys. Fruits and Vegetables: 2005, 2007, 2009. MDCH School Status Reports.

Health Indicators: AMBULATORY-SENSITIVE CONDITIONS

Oakland County generally has lower hospitalization rates for ambulatory care sensitive conditions than Michigan as a whole. This implies Oakland County residents are receiving necessary preventive and disease-management services in an outpatient setting to appropriately avoid hospitalization. Oakland County had three ambulatory care sensitive conditions that were less favorable than Michigan in 2012: Asthma, Kidney/Urinary Tract Infections and Cellulitis. This may be attributed in part to normal variation. Only the rate for Kidney/Urinary Tract Infections was higher on average that Michigan for the entire period of 2007-2011.

Ambulatory Care Sensitive Hospitalization Rates per 10,000		2007-2011 Avg.	2012
OAKLAND	Asthma Hospitalizations - Ages <18	11.8	10.7
	Asthma Hospitalizations – All Ages	14.4	13.8
	Congestive Heart Failure - All Ages	34.3	31.7
	Bacterial Pneumonia - All Ages	24.5	22.6
	Chronic Obstructive Pulmonary - All Ages	19.9	20.6
	Kidney/Urinary Infections - All Ages	18.5	21.4
	Cellulitis - All Ages	15.4	17.1
	Diabetes - All Ages	11.2	13.0
	All Ambulatory Sensitive Conditions - All Ages	249.2	255.0
MICHIGAN	Asthma Hospitalizations - Ages <18	16.0	11.8
	Asthma Hospitalizations – All Ages	15.8	13.7
	Congestive Heart Failure - All Ages	37.7	33.1
	Bacterial Pneumonia - All Ages	31.9	27.6
	Chronic Obstructive Pulmonary - All Ages	25.9	25.4
	Kidney/Urinary Infections - All Ages	17.3	18.3
	Cellulitis - All Ages	15.9	16.8
	Diabetes - All Ages	13.3	14.6
	All Ambulatory Sensitive Conditions - All Ages	268.6	259.1

SOURCE: MDCH Hospitalization Rates: Oakland County Health Department 2007-2011 average

Health Indicators: OBESITY

Obesity and being overweight affects approximately of 60% of Oakland County's adult population, 25% of its high school population and 27% of its children ages 2 to 5. These combined rates are slightly lower than Michigan overall (note: Michigan does not publish a high school metric at the state level). However, the percent of Oakland County's adults reporting themselves to be overweight has consistently exceeded Michigan's average across all time periods. Obesity and overweight rates in children ages 2-5, which are based on in-office measurements and not on self-reporting, fell during the most recent measurement period.

OBESITY		2006-2008	2008-2010	2011-2013
OAKLAND	% Adults Overweight (BMI 25.0-29.9)	36.7	35.7	35.0
	% Adults Obese (BMI 30.0 or Greater)	23.8	25.9	25.7
	% HS students who are overweight (between 85th and 95th percentile for BMI by age and sex)	N/A	N/A	11.4
	% students who are obese (> 95th percentile for BMI by age and sex)	N/A	N/A	14.0
	% Children ages 2 to 5 Overweight	N/A	15.3	15.0
	% Children ages 2 to 5 Obese	N/A	12.8	12.2
MICHIGAN	% Adults Overweight (BMI 25.0-29.9)	35.7	35.3	34.5
	% Adults Obese (BMI 30.0 or Greater)	29.2	30.9	31.3
	% HS students who are overweight (between 85th and 95th percentile for BMI by age and sex)	N/A	N/A	N/A
	% students who are obese (> 95th percentile for BMI by age and sex)	N/A	N/A	N/A
	% Children ages 2 to 5 Overweight	N/A	16.5	16.8
	% Children ages 2 to 5 Obese	N/A	13.4	14.1

SOURCES: BRFSS, Pediatric Nutrition Surveillance Survey and Michigan Profiles for Health Youth Surveys.
Student Data: 2012—2013, 2013-2014. Child Data: 2009-2011, 2011-2013

Health Indicators: SUBSTANCE USES

The percentage of Oakland County adults and students who smoke tobacco is lower than Michigan overall. Despite this, the percentage of adults who smoke tobacco increased to a 3-period high in 2011-2013. These data do not reflect changes related to the increased use of e-cigarettes. The percentage of Oakland County high school students who reported smoking marijuana in the past 30 days (16.6%) is twice as high as those smoking tobacco (7.8%). The percentage of Oakland County adults consuming alcohol rose across every time period. The percentage of heavy drinkers (6.4%) in Oakland County has risen and now equals that of Michigan. The 5.4% of Oakland County high school students using heroin or pain killers without a physician prescription is higher than each of nearby Washtenaw (3.9%) and Livingston Counties (5.1%).

OAKLAND SUBSTANCE USE		2006-2008	2008-2010	2011-2013
TOBACCO	% Adults Smoke Cigarettes Now, Every Day or Some Days	16.8	13.7	19.0
	% Adults Never Smoked	55.8	60.7	52.1
	% HS students who smoked cigarettes during the past 30 days	N/A	N/A	7.8
ALCOHOL	% Adults Consuming >2/1 drinks per day (Heavy)	4.8	5.2	6.4
	% Adults Consuming 5+ drinks per occasion in previous month	N/A	15.4	18.4
	% HS students who had at least one drink of alcohol during the past 30 days	N/A	N/A	22.1
DRUGS	% HS students who used marijuana past 30 days	N/A	N/A	16.6
	% HS students who used heroin one or more times during the past 30 days	N/A	N/A	0.7
	% HS students who took painkillers such as OxyContin, Codeine, Vicodin, or Percocet without a doctor's prescription during the past 30 days	N/A	N/A	5.4

SOURCES: BRFSS and Michigan Profiles for Health Youth. Student Data: 2011, 2013. Drug Use data: 2012-13, 2013-2014.

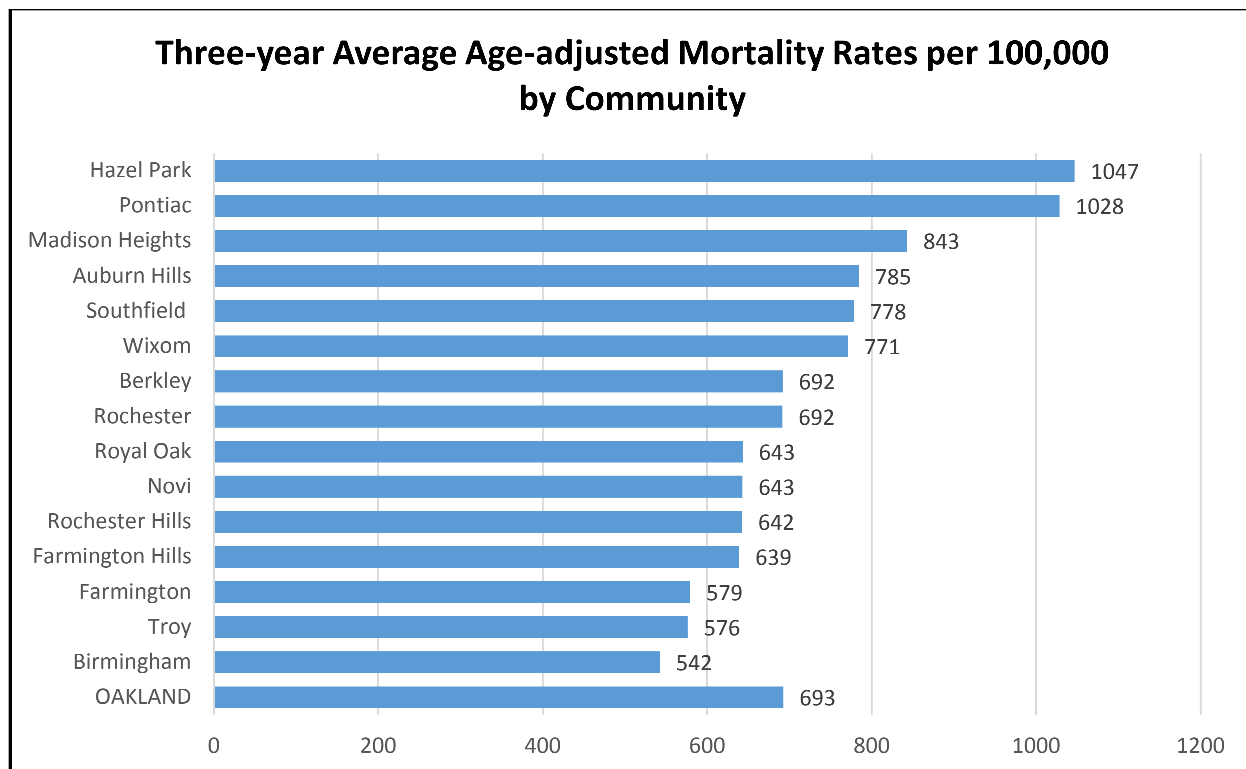
Health Indicators: MORTALITY

Measures of mortality are used to identify specific needs that might not otherwise be reflected in other data. Overall, Oakland County enjoys favorable mortality rates compared with Michigan in every top cause-of-death category except Intentional Self-Harm; Oakland County's age-adjusted death rate for Intentional Self-Harm (suicide) most recently surpassed Michigan's rate. Many of Oakland County's age-adjusted death rates are declining over time for its top causes of death. In particular, Oakland's age-adjusted death rate for cancer and chronic lower respiratory diseases such as COPD have improved substantially since 2010.

MORTALITY	Deaths / 100000 (age-adjusted)	2008	2009	2010	2011	2012
OAKLAND	Cancer	167.5	165.8	169.8	159.3	155.1
	Chronic Lower Resp. Diseases	37.5	34.7	39.5	37.8	35.2
	Diabetes	21.5	19.0	21.4	19.0	18.9
	Heart Disease	200.9	188.5	183.5	184.2	184.3
	Pneumonia & Flu	14.1	12.3	11.8	13.0	10.3
	Stroke	35.6	37.5	33.7	35.7	34.4
	Intentional Self-Harm	9.3	10.9	10.0	12.1	13.9
MICHIGAN	Cancer	183.9	181.5	182.4	177.2	174.9
	Chronic Lower Resp. Diseases	47.6	44.8	45.5	46.0	45.2
	Diabetes	25.2	24.2	23.9	24.2	23.0
	Heart Disease	220.2	205.0	203.5	201.6	197.9
	Pneumonia & Flu	17.0	14.2	13.6	15.0	13.3
	Stroke	42.2	39.6	39.4	38.7	37.2
	Intentional Self-Harm	11.6	11.4	12.5	12.2	12.4

SOURCE: MDCH Vital Statistics.

Although Oakland County's mortality rates are generally favorable compared to Michigan, there is wide variation in the age-adjusted mortality rates among Oakland County's individual communities. For example, the age-adjusted mortality rate in Hazel Park is nearly two-times the rate in Birmingham. For the most part, communities with a lower median income had a higher age-adjusted mortality rate. In this example, Hazel Park has the second lowest median income of the data shown while Birmingham has the highest median income.



SOURCE: MDCH Vital Statistics.

A closer look at the mortality disparity shows the City of Pontiac has nearly a two-fold death rate for chronic liver disease than Oakland County. The only metric for which Pontiac's age-adjusted death rate is more favorable than Oakland County is Intentional Self-Harm (suicide) in 2012. Pontiac's suicide rate has fallen for the past three years and is now less than Oakland County's rate.

MORTALITY	Deaths / 100,000 (age-adjusted)	2008	2009	2010	2011	2012
PONTIAC	Cancer	247.0	209.3	237.8	221.6	217.6
	Chronic Liver Disease	17.3	13.6	16.1	16.3	15.8
	Chronic Lower Resp. Diseases	65.9	42.9	71.9	86.5	54.5
	Diabetes	53.2	N/A	62.7	47.9	N/A
	Heart Disease	356.8	333.8	338.1	242.4	288.2
	Pneumonia & Flu	14.0	15.0	N/A	17.8	17.2
	Stroke	42.4	45.6	58.7	47.6	52.3
	Intentional Self-Harm	12.4	14.2	15.0	14.1	13.2
OAKLAND	Cancer	167.5	165.8	169.8	159.3	155.1
	Chronic Liver Disease	8.9	8.6	8.7	8.3	8.3
	Chronic Lower Resp. Diseases	37.5	34.7	39.5	37.8	35.2
	Diabetes	21.5	19.0	21.4	19.0	18.9
	Heart Disease	200.9	188.5	183.5	184.2	184.3
	Pneumonia & Flu	14.1	12.3	11.8	13.0	10.3
	Stroke	35.6	37.5	33.7	35.7	34.4
	Intentional Self-Harm	9.3	10.9	10.0	12.1	13.9

SOURCE: MDCH Vital Statistics.

Priority I and Priority II Tables

Based on the findings of the community and health data, the following priorities were tentatively identified. These priorities are further refined based on the community input described in the following section, and the final prioritization of all these needs is discussed in Section VIII of this report.

	PRIORITY I Health Indicators	PRIORITY II Health Indicators
HEALTH CONDITIONS	Cancer	Asthma
	Chronic Diseases	Preventable Hospitalizations
	Obesity	
	Suicide	
HEALTH BEHAVIORS	Alcohol abuse	Cancer Screening
	Healthful eating	
	Immunizations	
	Exercise	
ACCESS ISSUES	Hospital-based care	Nursing Home Care
	Behavioral and Mental Health	In-Home Care
	Dental care	
	Specialist physicians	
	End of life care	
	Pharmaceuticals	
	Primary care	

VII. Findings from the Community Input Process

A. Health Needs

The key stakeholder interviews and community surveys created opportunities for community members to identify the determinants of health and health needs of the residents they serve. Where sample sizes were sufficiently large, the survey data was quantified by counting the frequency with which a metric was mentioned, or rankings of those metrics. Insights into the connectivity of needs, the specifics of needs and the significance of different needs often became most apparent in the qualitative portion of the data collection: open-ended responses and free-flowing interviews.

While each participant identified needs specific to the residents his/her agency served, several common needs arose.

Highest priority health issues *chosen by 50% of more of respondents*

- Obesity and Overweight
- Mental Health
- Substance Abuse, including prescription drugs
- Alcohol Abuse
- Dental Health
- Diabetes
- Poor Nutrition

Nearly every interviewee noted the issue of obesity and overweight conditions, as well as the impact weight problems have on other issues such as chronic diseases and mental illness. Obesity continues to be a priority for the Oakland County Health Department, and while it impacts some sub-populations more than others, obesity is considered to be non-discriminatory in that it is pervasive regardless of socio-economic, education or access-to-care factors.

Mental Health also was mentioned by a majority of interviewees and survey respondents. Interviewees noted that access to mental health services was needed for specific populations, including homeless individuals, the Spanish-speaking population, and people with mild and moderate mental health issues. It was generally felt that access to crisis mental health services was available, but that people with chronic disease or other barriers to care (language, housing, etc.) were at greatest risk for bouncing between crisis, care, and unmanaged care. Several participants suggested that the close connection between mental health and substance abuse should be considered a single issue of Behavioral Health. While it has not yet completed its own community health needs assessment process, the Oakland County Health Department indicated that suicide is likely to be one of its top priorities for the coming term.

Dental health was highly rated as a potential health issue on the surveys and was also mentioned by a few interview participants. The primary concern voiced was lack of access for residents with Medicaid and access to dental care that must be completed prior to being eligible for medical care, such as chemotherapy.

Diabetes care and poor nutrition appeared in the top listing of potential health issues by survey participants but were rarely mentioned by interviewees. Lowest rated on the list of potential health

issues were the health issues of: Chronic diseases, including lung and kidney disease and arthritis, and memory care.

B. Health Determinants

The community was asked to indicate the level of priority SJMO should place on addressing several determinants of health. In the survey, they were provided a list of 13 options, whereas they were prompted with examples during the interviews. The interviews and surveys revealed the following as the community's highest priority determinants of health for SJMO to address:

Highest priority determinants of health *in order by highest frequency of participants*

- Income/ Ability to Pay
- Preventive Health Behaviors such as breast feeding and exercise
- Education / Understanding of personal health needs
- Availability of Healthy Foods
- Social Norms and Attitudes

While many interviewees acknowledged improvements in financial access related to the expansion of Medicaid, the inability to pay continues to negatively impact the community. High deductibles and co-pays continue to make the inability to pay a large barrier to seeking care. Additionally, the Medicaid expansion did not benefit undocumented individuals; several interviewees noted that the undocumented community is growing and is having increasing difficulties accessing all types of care. The ability to pay also impacts the working-poor who cannot afford to take time off work for health issues. It was noted that many of the free and low-cost clinics in Oakland County are closed in the evenings, after the work hours of many working-poor individuals.

Preventive health behaviors and education/understanding of personal health needs were also highly rated as areas for SJMO to address. These two determinants are closely linked, as it requires some understanding about what good health requires before recognizing the need to engage in healthy behaviors such as exercise. Several interviewees and survey participants commented that people need to better understand how to navigate the health system and receive support for healthy behaviors. For example, many low income residents lack awareness of low-cost or covered services that are available to them, such as mammograms. Many respondents believed that interagency communication to increase awareness of available services would greatly benefit the community.

The community's concern with the availability of healthy foods was compatible with the earlier concern regarding poor nutrition and healthy behaviors. While there are some good resources for healthy foods, and many agencies are focused on this issue, there were concerns that low income households have difficulty accessing healthy food options on a regular basis. For example, there are about a dozen income census tracts in Oakland County in which a significant share of residents are more than one mile from a supermarket and this creates a barrier to fresh fruits and vegetables.

A few interviewees discussed the importance of being culturally sensitive when encouraging people to embrace healthy behaviors. For example, it was noted that Hispanic men are highly reluctant to engage in prostate screening. One interviewee noted that some cultures have not historically valued or prioritized physical activity.

The interviews revealed transportation to be another barrier to accessing care and engaging in healthy behaviors. Interview participants noted that transportation is particularly difficult for the poor and for persons who require multiple visits for care, such as for chemotherapy or chronic disease management. Transportation was also noted to be a problem for the mentally ill and homeless populations.

Finally, one interview participant greatly emphasized the specific need for continued, culturally-sensitive prenatal education. This participant believed there was adequate access to pregnancy care, but felt SJMO could assist women in learning about pregnancy health prior to becoming pregnant, and that these efforts ultimately would improve compliance with prenatal care.

SOCIO-ECONOMIC FACTORS	SPECIFIC NEED
Health insurance enrollment	Low income, uninsured undocumented people
Maternal health education	Prenatal education – before pregnancy education on starting early and continuing prenatal care
Transportation	→ Low income and uninsured → People with complex, chronic diseases that must be managed through regular visits/treatments → People with physical disabilities
Health literacy (understanding health information)	Support for Low Income, non-English speaking, and persons with low educational attainment
Navigation of healthcare resources	Increased information on programs and services that are already available

C. Access Issues

Survey respondents and interview participants were asked about specific concerns they had regarding access to care. In the survey, they were provided a list of 12 types of care, whereas they were prompted with examples during the interviews.

Top access concerns *in order by percent of respondents who favored*

- Hospital Care
- Immunizations
- End-of-Life
- Nursing Home
- Specialty Care

Unfortunately, the community survey did not prompt for details when a respondent marked an access issue except for when a respondent marked “Specialty care” or “in-Home care.” Therefore, the particular difficulties in accessing hospital care could only be derived from interviews. The survey and interview participants who noted a need for specialty care indicated particular needs for access to neurologists and orthopedic surgeons who accept Medicaid and self-paying patients, as well as for access to cancer screening for the elderly. Dental care was also mentioned at this time. A few interview participants indicated that people who lack insurance or are underinsured or low income also have difficulty accessing hospital-based services such as imaging, lab tests and outpatient surgery. End-of-life care concerns related to supports that enable seniors to remain in home for care, especially for families who lack adequate financial resources. Anecdotally, it was noted that some seniors are unnecessarily

placed in nursing homes under Medicaid because their families cannot afford what are often minimal in-home support services.

D. Special Populations

Survey and interview participants were asked whether there are specific populations who do not have access to care. Because the respondents represented a broad range of agencies serving different populations, the responses varied widely. The list of underserved populations and their specific needs appears in the table below.

POPULATION	NEED
Latinos	Insurance, Mental Health, prenatal education
African Americans	Mental Health, Healthy eating
Homeless	Access to medication, Mental health care, medical care, substance abuse services, continuity of care
School Age Children	Nutrition Advice, Hunger Issues, Mental Health access, Sex and Drugs
Seniors	Education on Self-care, How to find government help, Dementia
Undocumented persons	All health care, Access to Imaging, Assistance with enrollment and documentation
Underinsured or Low Income persons	Access to health care, Access to Imaging, Dental care, Management of conditions and medications (e.g. warfarin, asthma management, thyroid conditions), Access to inexpensive labs
Disabled	Transportation
Pregnant women	Pre-conception health care, prenatal care, prenatal education
Persons with Neurological impairment	Access to neurologists
Mild to Moderately Mentally Ill	Mental Health coordination
Persons with fractures and bone problems	Access to Orthopedic doctors
Young adults	Wellness care to prevent chronic conditions

E. Top Actions SJMO Can Take to Impact Need

The community was asked for suggestions regarding how SJMO can best help to address the needs and determinants of health. While the suggestions were wide-ranging with some very specific and many generalized, the interviewees and survey participants' suggestions generally fell into the following categories:

INCREASE EDUCATION/AWARENESS

Many community participants believed SJMO can be a leader in providing health education in Oakland County. Several were complimentary of SJMO's community classes and training, as well as its work in churches. The suggestions for education included promoting healthy eating, physical activity and healthy lifestyles. Other suggestions were more focused on awareness; several participants noted that a lack of awareness created many of the barriers to access, and contributed to duplication of efforts by agencies, as well as gaps in utilization of available services. There was keen interest in helping people become more aware of resources that are available in the

community. Similarly, nearly every participant highly valued SJMO's collaboration with community partners to address community needs. Several participants noted past partnerships with SJMO on initiatives they believed to be successful; the participants believed collaboration improves communication and coordination, and they welcomed the opportunity to continue or renew these initiatives.

IMPROVE CARE ACCESS

Because it is a healthcare provider, many respondents looked to SJMO to play an active role in addressing the lack of capacity for some health services. This was particularly true for mental health where the community is struggling to address the ongoing management needs of the mentally ill. Participants made specific suggestions related to access to low cost imaging, lab services, podiatry, dental care and eye surgery. Participants also called out the need to address access for the homeless, disabled, and undocumented populations. For additional, specific suggestions, please refer to the appendix.

TRANSPORTATION

As noted earlier in this report, lack of transportation was noted as a social health determinant the community believed important to address. While no specific suggestions were made, several participants believed SJMO could play a role in addressing this need.

VIII. Prioritization and Description of Needs Identified

The body of community health needs data was refined to twenty (20) health needs and social determinants of importance. These twenty needs were chosen based on the presence of an unfavorable trend, a wide degree of variance from comparison geographies and/or if it was considered a high priority to survey and interview participants. These twenty potential areas of focus and the particular targets of the need for each are listed in the table below.

NEED		SPECIFIC TARGET
HEALTH CONDITIONS	Cancer	→ Earlier identification tied with access to low cost treatment → Especially in lower income, lower education communities such as Pontiac
	Chronic Diseases e.g. heart disease, diabetes	→ Chronic disease self-management education → Nutrition education as part of medical management → Access to low cost medical management → Especially in lower income, lower education communities such as Pontiac
	Obesity	→ Adults - prevention, education and treatment → Children/Teens - prevention, education and treatment
	Suicide	Prevention
HEALTH BEHAVIORS	Alcohol abuse	→ Teen prevention and education → Adult Heavy Drinking and Binge Drinking Education and prevention
	Healthful eating	→ Access to healthy foods, particularly for elderly, children, low income and people with health issues → Education regarding good nutrition and food preparation options
	Immunizations	Adults and Children
	Exercise	Places to exercise for parents with children, particularly those living in high-crime areas and for African American and Hispanic communities.
ACCESS ISSUES	Hospital-based care	→ Access to hospital services such as OP surgery, imaging and lab for low income and uninsured → Care coordination and continuity with community partners to assure follow up
	Behavioral and Mental Health	Increased capacity and access for all populations, particularly outpatient services for: → Low income/underinsured/ poorly insured, Homeless, Non-English speakers, Ex-offenders → People with mild/moderate mental illness → People needing substance use treatment
	Dental care	Access for low income, uninsured and underinsured
	Specialist physicians	→ Access for low income, uninsured and non-English speaking populations. → Includes Ophthalmology, Podiatry, Neurology, Orthopedics
	End of life care	→ Pain Management → Support for elderly to remain in home for care, especially those without family support
	Pharmaceuticals	→ Access for homeless, disabled, low income → Assistance with enrollment in subsidized meds programs → Assistance with medication management for elderly, mentally ill, homeless
	Primary care	Access for working poor – Specifically Hours open after work, over lunch

SOCIAL DETERMINANTS	Health insurance enrollment	Low income, uninsured undocumented people
	Maternal health education	Prenatal education – before pregnancy education on starting early and continuing prenatal care
	Transportation	→ Low income and uninsured → People with complex, chronic diseases that must be managed through regular visits/treatments → People with physical disabilities
	Health literacy	Support for Low Income, non-English speaking, and persons with low educational attainment
	Navigation of resources	Increased information on healthcare programs and services that are already available

Members of the SJMO Community Benefit Team and SJMO Executive Leadership team reviewed data related to these twenty needs. They were asked to rate each need independently in consideration of the following factors:

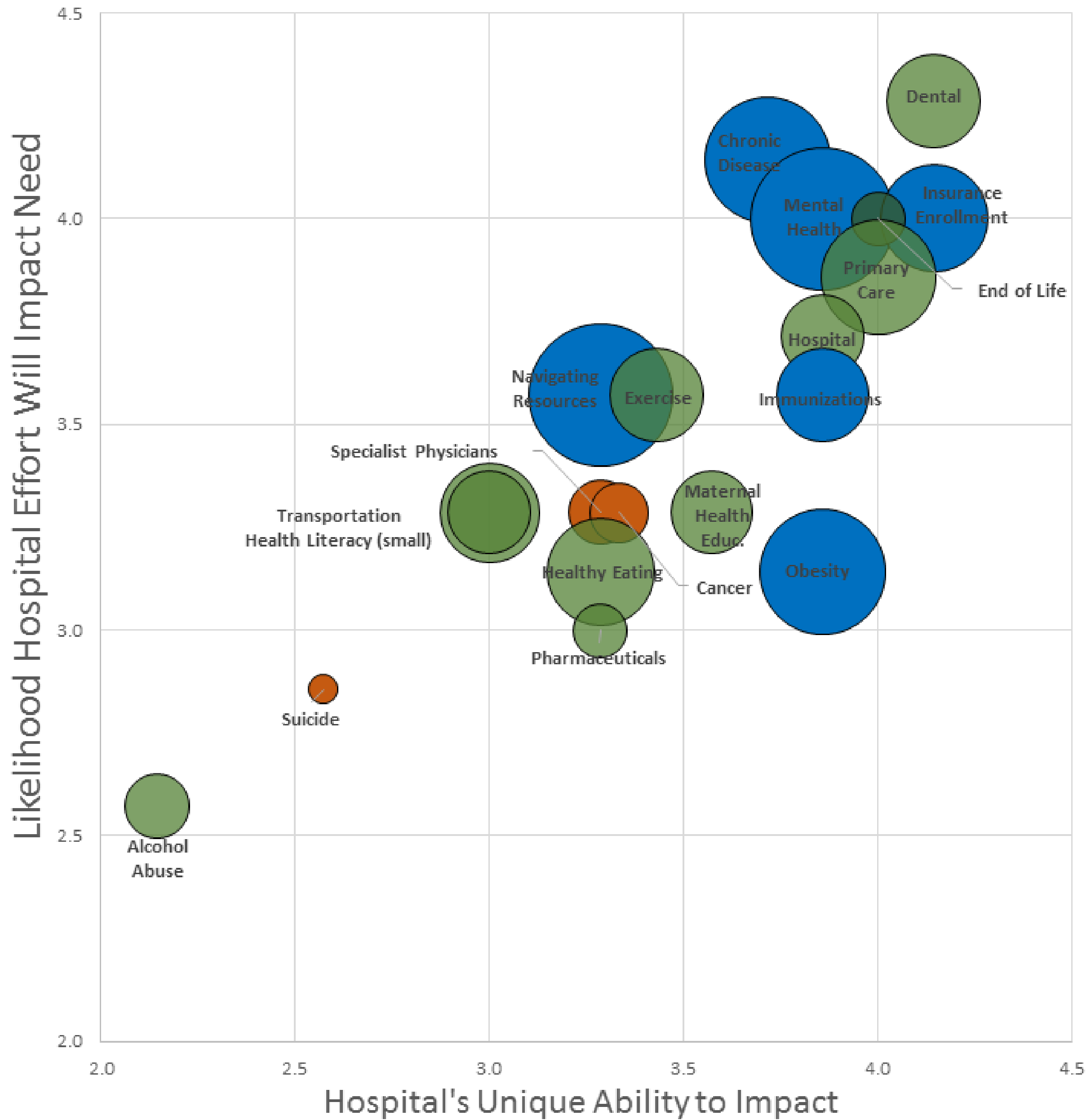
- Degree to which the need is essential to the community's overall health
- Urgency in addressing the need
- Hospital's unique ability to address the need
- Likelihood that the hospital's effort will make an impact on the need

The chart on the follow page shows the relative ratings of each need based on the feedback of the CBT and the SJMO Executive Leadership Teams. Bubbles that appear closer to the top-right were those for which the team felt SJMO was uniquely positioned to address the need and that the hospital's efforts would have an impact. The larger circles reflect needs that were considered to be more essential to the community's overall health. A blue circle represents a more-urgent need, while an orange circle represents a need that was rated to be less urgent.

The CBT spent a session reviewing this chart and its information to discern the needs that would be given highest priority. This discussion included careful consideration of the symbiotic relationships of many of the needs and the ability to potentially impact more than one need by focusing on specific populations and/or needs. As a result of this discernment process, SJMO prioritized the following four health needs in its service area:

1. Obesity
2. Dental Care
3. Behavioral Health, which includes Mental Health and Substance Abuse
4. Financial Access to Care

These needs were selected based on the relative urgency of the need (blue bubble), the essential nature of the need to the overall health of the community (size of bubble), and that in addressing these particular issues, SJMO might positively impact related needs. For example, in addressing financial access, SJMO may positively impact primary care and hospital access. Likewise, in addressing obesity, SJMO might improve the percent of people eating healthfully and reduce the prevalence of some chronic diseases such as diabetes.



Increasing bubble size indicates increasing degree of importance to community's overall health; larger bubbles are more essential to the community's overall health.

Blue – Urgent Need
Green – Moderately Urgent Need
Orange – Less Urgent Need

IX. Reflections on the Health Needs Assessment

A. The Process: Lessons Learned & Recommendations for Future CHNA

SJMO is continuously improving its processes and this CHNA is no exception. There is boundless information and sources of information available to inform the CHNA process. Unfortunately, these data are often too dated to be of value, especially when measuring impact of programs. For example, the data regarding health insurance coverage had not yet caught up with the impact of the Affordable Care Act and Michigan's Medicaid expansion. It was difficult to ascertain the actual shift, if any, in health insurance coverage. Likewise, SJMO knows that there are wide and important variations in health access, prevention and literacy in Oakland County. This is clearly evidenced by mortality rates within communities such as Pontiac and Hazel Park. However, data regarding the precursors to those deaths are less available, leaving SJMO to rely on anecdotal information and its own internal, yet-incomplete data about these communities. A more thorough process that engages multiple community partners to share efforts and costs to collect shared, community-specific data would be invaluable. These same agencies all require similar data for purposes of their own community assessments. The synergies and need to coordinate are clearly evident.

In part because the data is boundless, and because health needs and the social determinants for health are similarly boundless, time becomes a rate limiting factor in sifting through to find meaningful sources of data and information. The entire CHNA process, to be comprehensive, requires a substantial amount of time and effort. Due to timing and other issues, a survey of community residents was not created, and hence the community voice was only heard through the agencies who serve them. Similar to the suggestion above, more time and a coordinated effort between multiple community agencies to collect data directly from residents would substantially improve the process.

B. Strategic Next Steps

By identifying Obesity, Behavioral Health, Dental Care and Financial Access as its top priorities above many possible needs, SJMO has created a clear call-to-action to focus the future work of its Community Benefit Ministry programs. SJMO's implementation plan will identify the strategies and tactics it believes best suited to address these four priorities. Equally important, the Implementation plan will include carefully considered metrics for evaluating the effectiveness of its Community Benefits programs in addressing these important priorities.

As a first step in its implementation planning process, SJMO has begun working with its experts to determine high level strategies for the four priorities. These experts have identified the following strategies to address these needs:

Obesity:

- Improve the coordination of and collaboration with existing community resources in addressing this need
- Increase community access to nutritious foods
- Increase community opportunities for physical activity
- Increase education regarding healthy behaviors such as physical activity and healthy eating

Financial Access to Care:

- Improve enrollment levels in insurance plans and alternative payment sources
- Increase awareness regarding the benefits covered by insurance

Dental Care:

- Expand access to dental care for low income and medically complex individuals
- Improve coordination of and access to necessary follow up care after dental treatment
- Improve dental hygiene education in the community

Behavioral Health:

- Improve the coordination of and collaboration with existing community resources in addressing this need; identify further gaps
- Improve education of and awareness by existing medical staff regarding available services and patient management strategies
- Improve access to services

Specific implementation plans with tactics aligned to these strategies will be developed, implemented and measured for effectiveness in collaboration with appropriate internal and external partners. SJMO eagerly anticipates working in collaboration with community partners to expand the efforts of this CHNA and join around common efforts and strategies.

APPENDIX A
COMMUNITY DATA

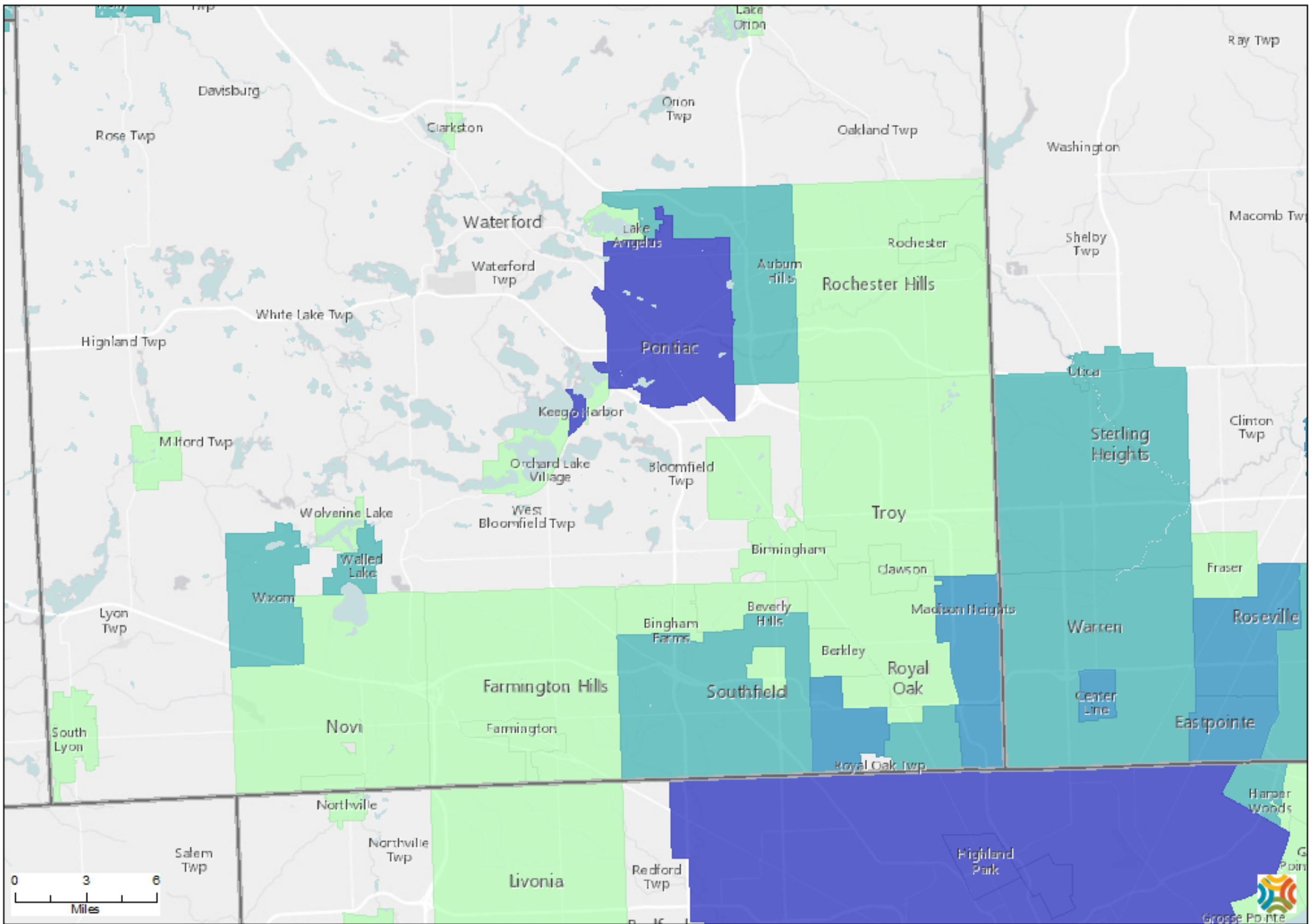
For all appendices tables, red color is used to indicate a metric that is worse than the Michigan average. Blank cells indicate metrics for which data were not available. A trend indication is only provided when the most recent three years show a consistent trend; trends are not available if a metric only had two measurement periods.

INCOME		2010	2011	2012	2013	2014	TREND
PONTIAC	% Population age 16+ unemployed, looking for work	28.4	24.7	21.9	20.3	17.9	GOOD
	% Children age <18 living in poverty	48.0	53.9	53.3	53.1		GOOD
	% HH Below Poverty Level	29.5	32.4	32.0	33.3		
	% HH Lead by Single Woman below Poverty	48.5	58.4	59.7	58.9		
OAKLAND	% Population age 16+ unemployed, looking for work	11.5	9.4	8.6	7.8	6.9	GOOD
	% Children age <18 living in poverty	13.4	14.9	14.4	13.0		GOOD
	% HH Below Poverty Level	7.2	8.1	7.9	7.3		
	% HH Lead by Single Woman below Poverty	21.6	23.1	25.8	24.5		
	% Households Below ALICE			34.0			
MICHIGAN	% Population age 16+ unemployed, looking for work	11.2	9.3	8.3	8.2	6.4	GOOD
	% Children age <18 living in poverty	23.5	24.8	24.9	23.8		
	% HH Below Poverty Level	12.1	12.5	12.6	12.3		
	% HH Lead by Single Woman below Poverty	33.8	34.7	35.9	34.6		
	% Households Below ALICE			40.0			

ALICE: Asset Limited, Income Constrained, Employed (United Way)

APPENDIX A
COMMUNITY DATA

Percent Population Below 200% Poverty



Map Legend

Population Below 200% Poverty Level, Percent by Place, ACS 2008-12

- Over 50.0%
- 38.1 - 50.0%
- 26.1 - 38.0%
- Under 26.1%
- No Data or Data Suppressed

Community Commons, 1/11/2015

APPENDIX A
COMMUNITY DATA

EDUCATION		2009	2010	2011	2012	2013	TREND
PONTIAC	% Graduation Rate *	58.6	58.4	57.9	56.5	51.0	POOR
	% Pop age 25+ with 4-Year degree or higher			12.7	12.6	10.9	POOR
OAKLAND	% High School Graduates On Time	78.6	79.6	78.3	79.7	81.2	GOOD
	% Pop age 25+ with 4-Year degree or higher			42.9	43.6	43.8	GOOD
MICHIGAN	% High School Graduates On Time	75.2	76.0	74.3	76.2	78.8	GOOD
	% Pop age 25+ with 4-Year degree or higher			25.3	25.7	26.2	GOOD

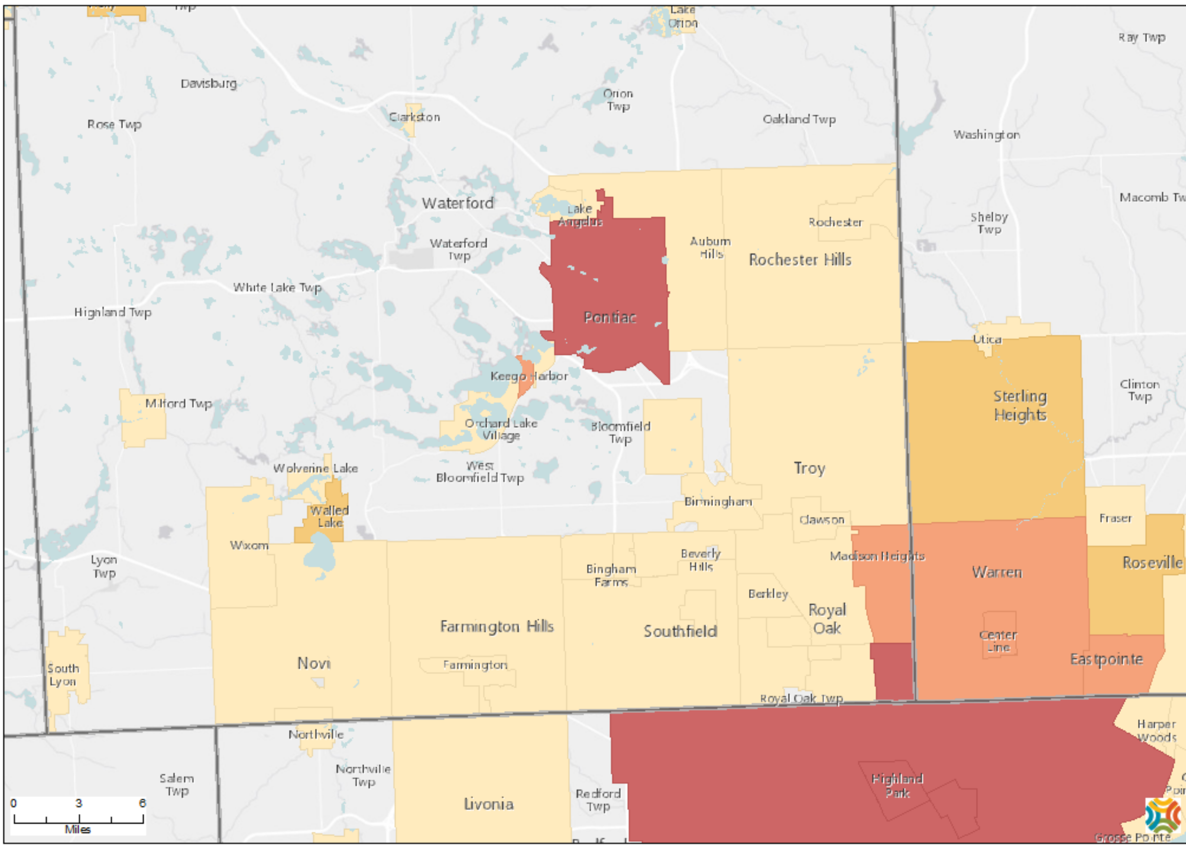
SOURCE: American Community Survey and Michigan League for Public Policy-Kids Count survey and Michigan Department of Education.
* NOTE: Pontiac uses different metric than County/State

FOOD SECURITY		2009	2010	2011	2012	2013
PONTIAC	# Receiving Cash Assistance or Food Stamps/ SNAP	7,135	7,682	9,081	9,044	9,115
	% Children Eligible to Receive Free or Reduced Lunch	84.0	74.6	75.6	73.7	73.6
OAKLAND	# Receiving Cash Assistance or Food Stamps/ SNAP	33,378	52,235	58,780	55,349	52,240
	% Children Eligible to Receive Free or Reduced Lunch	30.7	31.6	33.7	33.3	33.2
	# Food Insecure People	183,660	173,700	163,710	164,830	N/A
	% Food Insecure People	15.3	14.5	13.6	13.7	N/A
MICHIGAN	# Receiving Cash Assistance or Food Stamps/ SNAP	586,083	673,301	712,577	707,080	670,570
	% Children Eligible to Receive Free or Reduced Lunch	45.8	46.5	48.1	48.2	48.6
	# Food Insecure People	1,828,060	1,872,780	1,769,790	1,660,050	N/A
	% Food Insecure People	18.2	19.0	17.9	16.8	N/A

SOURCES: USDA. Gleaners. American Community Survey. Michigan League for Public Policy – Kids Count Survey.
Food Insecurity years: 2000-2002, 2007-2009, and 2010-2012. Pontiac # receiving assistance are 3-year estimates.

APPENDIX A
COMMUNITY DATA

Percent Population with No High School Diploma



Map Legend

Population with No High School Diploma, Percent by Place, ACS 2008-12

- Over 21.0%
- 16.1 - 21.0%
- 11.1 - 16.0%
- Under 11.1%
- No Data or Data Suppressed

Community Commons, 1/11/2015

APPENDIX B
HEALTH DATA

ACCESS AND HEALTH COVERAGE		2006-2008	2008-2010	2011-2013	TREND
OAKLAND	% No Personal Health Care Provider	11.0	9.6	15.0	
	% No Routine Checkup (in Past Year)	28.4	29.4	30.5	POOR
	No Health Coverage (Ages 18-64)	8.7	9.9	15.6	POOR
	Foregoing Care because of Cost	9.3	10.9	14.1	POOR
MICHIGAN	% No Personal Health Care Provider	13.3	12.5	16.1	
	% No Routine Checkup (in Past Year)	31.4	32.3	32.4	POOR
	No Health Coverage (Ages 18-64)	14.2	15.1	17.4	POOR
	Foregoing Care because of Cost	12.0	13.4	15.7	POOR

PREVENTION		2006-2008	2008-2010	2011-2013	TREND
OAKLAND	% Influenza (Flu) Shot in Past Year (65+ Years)	73.8	71.1	57.8	POOR
	% Ever Had Pneumonia Shot	65.4	66.6	68.5	GOOD
	% Colonoscopy, Sigmoidoscopy (50 + Years, Appropriately Timed)		66.1	69.8	
	% Adults Eating <5 Fruits or Vegetables Daily	74.9	75.0	74.2	
	% Students with Vaccine Waivers			10.6	
MICHIGAN	% Influenza (Flu) Shot in Past Year (65+ Years)	70.7	68.9	56.7	POOR
	% Ever Had Pneumonia Shot	65.7	67.1	67.5	GOOD
	% Colonoscopy, Sigmoidoscopy (50 + Years, Appropriately Timed)		64.5	67.8	
	% Adults Eating <5 Fruits or Vegetables Daily	78.5		78.3	
	% Students with Vaccine Waivers			5.9	

SOURCE: BRFSS Surveys. Fruits and Vegetables: 2005, 2007, 2009

APPENDIX B
HEALTH DATA

OVERALL HEALTH STATUS	PERCENT – SELF REPORTED	2006-2008	2008-2010	2011-2013	TREND
OAKLAND	Current Health Status as Fair or Poor	12.7	11.0	12.0	
	With at least 14 Days of Fair or Poor Physical Health in Past Month	10.5	9.0	9.3	
	With at least 14 Days of Fair or Poor Mental Health in Past Month	9.7	9.4	10.6	
	Limitations because of a Physical, Mental or Emotional Problem	22.7	21.5	22.6	
MICHIGAN	Current Health Status as Fair or Poor	14.8	14.6	17.3	
	With at least 14 Days of Fair or Poor Physical Health in Past Month	10.9	10.8	13.1	
	With at least 14 Days of Fair or Poor Mental Health in Past Month	10.8	10.8	12.7	POOR
	Limitations because of a Physical, Mental or Emotional Problem	23.8	23.7	26.1	POOR

SOURCE: BRFSS Surveys.

DISEASE STATUS	PERCENT – SELF REPORTED	2006-2008	2008-2010	2011-2013	TREND
OAKLAND	Ever Told Have Asthma	13.8	13.1	15.4	
	Have Asthma Now	8.8	8.6	10.0	
	Ever Told Have Diabetes	7.8	8.7	8.9	POOR
	Ever Told Have High Blood Pressure			31.6	
	Ever Told Have High Blood Cholesterol			40.8	
	Ever Told Had a Heart Attack	4.3	4.2	4.2	
	Ever Told Had Angina or Coronary Heart Disease	4.9	4.4	4.7	
	Ever Told Had a Stroke	2.6	1.9	3.0	
MICHIGAN	Ever Told Have Asthma	14.8	15.6	15.6	POOR
	Have Asthma Now	9.7	10.1	10.6	POOR
	Ever Told Have Diabetes	9.0	9.5	10.3	POOR
	Ever Told Have High Blood Pressure			34.4	
	Ever Told Have High Blood Cholesterol			41.2	
	Ever Told Had a Heart Attack	4.7	4.6	5.2	
	Ever Told Had Angina or Coronary Heart Disease	4.9	4.8	5.1	
	Ever Told Had a Stroke	2.9	2.8	3.4	

SOURCE: BRFSS Surveys.

APPENDIX B
HEALTH DATA

Ambulatory Care Sensitive Hospitalization Rates per 10,000		2007-2011 Avg.	2012	TREND
OAKLAND	Asthma Hospitalizations - Ages <18	11.8	10.7	
	Asthma Hospitalizations – All Ages	14.4	13.8	
	Congestive Heart Failure - All Ages	34.3	31.7	
	Bacterial Pneumonia - All Ages	24.5	22.6	
	Chronic Obstructive Pulmonary - All Ages	19.9	20.6	
	Kidney/Urinary Infections - All Ages	18.5	21.4	
	Cellulitis - All Ages	15.4	17.1	
	Diabetes - All Ages	11.2	13.0	
	All Ambulatory Sensitive Conditions - All Ages	249.2	255.0	
MICHIGAN	Asthma Hospitalizations - Ages <18	16.0	11.8	
	Asthma Hospitalizations – All Ages	15.8	13.7	
	Congestive Heart Failure - All Ages	37.7	33.1	
	Bacterial Pneumonia - All Ages	31.9	27.6	
	Chronic Obstructive Pulmonary - All Ages	25.9	25.4	
	Kidney/Urinary Infections - All Ages	17.3	18.3	
	Cellulitis - All Ages	15.9	16.8	
	Diabetes - All Ages	13.3	14.6	
	All Ambulatory Sensitive Conditions - All Ages	268.6	259.1	

SOURCE: MDCH Hospitalization Rates: Oakland County Health Department 2007-2011 average

APPENDIX B
HEALTH DATA

OBESITY		2006-2008	2008-2010	2011-2013	TREND
OAKLAND	% Overweight (BMI 25.0-29.9)	36.7	35.7	35.0	GOOD
	% Obese (BMI 30.0 or Greater)	23.8	25.9	25.7	
	% HS students who are overweight (between 85th and 95th percentile for BMI by age and sex)			11.4	
	% students who are obese (> 95th percentile for BMI by age and sex)			14.0	
	% Children ages 2 to 5 Overweight		15.3	15.0	
	% Children ages 2 to 5 Obese		12.8	12.2	
	% Ever Breastfed		55.4	56.3	
	% Breastfed at least 6 months		19.0	18.7	
MICHIGAN	% Overweight (BMI 25.0-29.9)	35.7	35.3	34.5	GOOD
	% Obese (BMI 30.0 or Greater)	29.2	30.9	31.3	POOR
	% HS students who are overweight (between 85th and 95th percentile for BMI by age and sex)		20.4	13.7	
	% students who are obese (> 95th percentile for BMI by age and sex)		19.5	9.4	
	% Children ages 2 to 5 Overweight		16.5	16.8	
	% Children ages 2 to 5 Obese		13.4	14.1	
	% Ever Breastfed		57.3	62.3	
	% Breastfed at least 6 months		17.7	17.7	

SOURCES: Pediatric Nutrition Surveillance Survey and Michigan Profiles for Health Youth Surveys.
Student Data: 2012—2013, 2013-2014. Child Data: 2009-2011, 2011-2013

APPENDIX B
HEALTH DATA

ALCOHOL USE		2006-2008	2008-2010	2011-2013	TREND
OAKLAND	% Consuming >2/1 drinks per day (Heavy)	4.8	5.2	6.4	POOR
	% Consuming 5+ drinks per occasion previous month (Binge)		15.4	18.4	
	% HS students who had at least one drink of alcohol during the past 30 days			22.1	
MICHIGAN	% Consuming >2/1 drinks per day (Heavy)	5.6	5.4	6.4	
	% Consuming 5+ drinks per occasion previous month (Binge)		16.6	19.2	
	% HS students who had at least one drink of alcohol during the past 30 days	30.5		28.3	

SOURCES: BRFSS surveys and Michigan Profiles for Health Youth Surveys.
Student Data: 2012—2013, 2013-2014. Michigan Student Data: 2011, 2013

TOBACCO USE		2006-2008	2008-2010	2011-2013	TREND
OAKLAND	% Smoke Cigarettes Now, Every day or Some Days	16.8	13.7	19.0	
	% Ever Smoked, But Do Not Now	27.4	25.7	28.9	
	% Never Smoked	55.8	60.7	52.1	
	% HS students who smoked cigarettes during the past 30 days			7.8	
MICHIGAN	% Smoke Cigarettes Now, Every day or Some Days	21.0	19.7	22.7	
	% Ever Smoked, But Do Not Now	25.4	25.6	26.2	GOOD
	% Never Smoked	53.6	54.8	51.2	
	% HS students who smoked cigarettes during the past 30 days	14.0		11.8	

SOURCES: BRFSS Survey and Michigan Profiles for Health Youth Surveys.
Student Data: 2012—2013, 2013-2014. Michigan Student Data: 2011, 2013

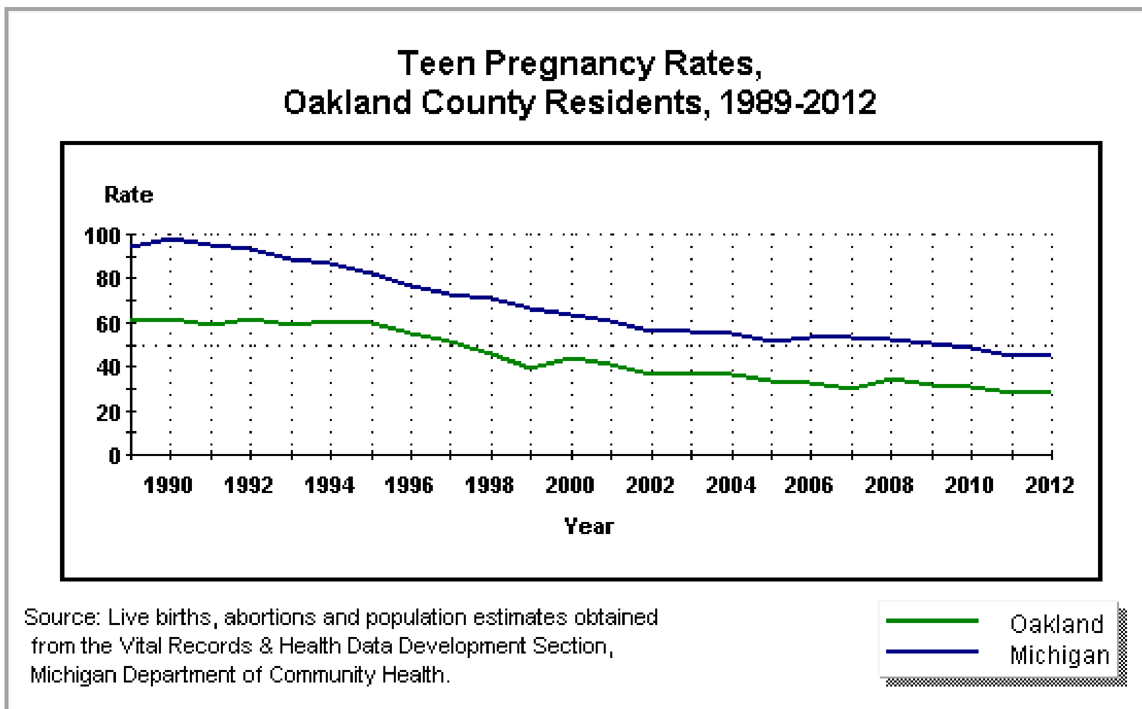
DRUG USE		2012-2013	2013-2014	TREND
OAKLAND	% HS students who used marijuana during the past 30 days		16.6	
	% HS students who used heroin one or more times during the past 30 days		0.7	
	% HS students who took painkillers such as OxyContin, Codeine, Vicodin, or Percocet without a doctor's prescription during the past 30 days		5.4	
MICHIGAN	HS students who used marijuana during the past 30 days	18.6	18.2	
	HS students who ever* used heroin (*different metric*)	2.5	2.8	
	HS students who took painkillers such as OxyContin, Codeine, Vicodin, or Percocet without a doctor's prescription during the past 30 days			

SOURCES: Michigan Profiles for Health Youth Surveys. Michigan Student Data: 2011, 2013

APPENDIX B
HEALTH DATA

INFANT HEALTH		2006-2008	2007-2009	2008-2010	2009-2011	2010-2012	TREND
PONTIAC	% Births with adequate prenatal care					70.6	
	% Low weight births	11.4	12.3	12.4	12.1	12.1	GOOD
	Infant Mortality Rate / 1000	12..5	14.4	13.8	11.9	8.5	GOOD
	Births /1000 Teens						
OAKLAND	% Births with adequate prenatal care	83.2	80.7	79.0	78.4	78.4	POOR
	% Low weight births	8.2	8.2	8.1	8.1	8.1	
	Infant Mortality Rate / 1000	6.4	6.2	6.2	5.8	6.2	
	Births /1000 Teens	34.5	31.8	30.4	28.4	28.3	GOOD
MICHIGAN	% Births with adequate prenatal care	73.4	70.2	67.8	68.3	68.6	GOOD
	% Low weight births	8.5	8.5	8.5	8.4	8.4	GOOD
	Infant Mortality Rate / 1000	7.6	7.6	7.3	7.1	6.9	GOOD
	Births /1000 Teens	52.7	50.3	48.2	44.5	45.5	

SOURCE: MDCH. PONTIAC INFANT MORTALITY RATE for each of 2008, 2009, 2010, 2011, 2012



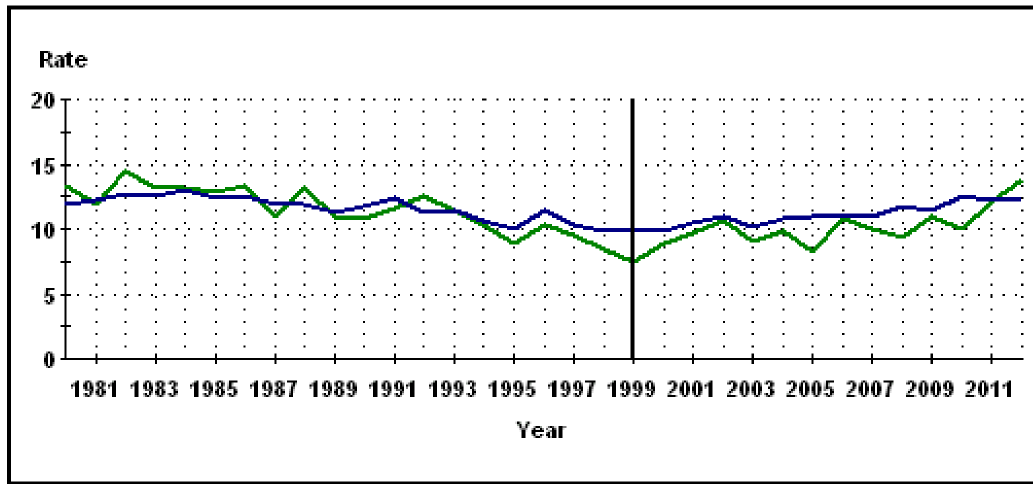
APPENDIX B
HEALTH DATA

MORTALITY	Deaths / 100000 (age-adjusted)	2008	2009	2010	2011	2012	TREND
PONTIAC	Cancer	247.0	209.3	237.8	221.6	217.6	GOOD
	Chronic Liver Disease	17.3	13.6	16.1	16.3	15.8	
	Chronic Lower Resp. Diseases	65.9	42.9	71.9	86.5	54.5	
	Diabetes	53.2		62.7	47.9		
	Heart Disease	356.8	333.8	338.1	242.4	288.2	
	Pneumonia & Flu	14.0	15.0		17.8	17.2	
	Stroke	42.4	45.6	58.7	47.6	52.3	
	Intentional Self-Harm	12.4	14.2	15.0	14.1	13.2	GOOD
OAKLAND	Cancer	167.5	165.8	169.8	159.3	155.1	GOOD
	Chronic Liver Disease	8.9	8.6	8.7	8.3	8.3	GOOD
	Chronic Lower Resp. Diseases	37.5	34.7	39.5	37.8	35.2	GOOD
	Diabetes	21.5	19.0	21.4	19.0	18.9	GOOD
	Heart Disease	200.9	188.5	183.5	184.2	184.3	
	Pneumonia & Flu	14.1	12.3	11.8	13.0	10.3	
	Stroke	35.6	37.5	33.7	35.7	34.4	
	Intentional Self-Harm	9.3	10.9	10.0	12.1	13.9	POOR
MICHIGAN	Cancer	183.9	181.5	182.4	177.2	174.9	GOOD
	Chronic Liver Disease	9.3	9.4	9.5	9.6	9.8	POOR
	Chronic Lower Resp. Diseases	47.6	44.8	45.5	46.0	45.2	
	Diabetes	25.2	24.2	23.9	24.2	23.0	
	Heart Disease	220.2	205.0	203.5	201.6	197.9	GOOD
	Pneumonia & Flu	17.0	14.2	13.6	15.0	13.3	
	Stroke	42.2	39.6	39.4	38.7	37.2	GOOD
	Intentional Self-Harm	11.6	11.4	12.5	12.2	12.4	

SOURCE: MDCH. Chronic Liver Disease: 2004-2008, 2005-2009, 2006-2010, 2007-2011, 2008-2012.
Pontiac Pneumonia: 2006-2008, 2007-2009, 2008-2010, 2009-2011, 2010-2012.

APPENDIX B
HEALTH DATA

Suicide Age-adjusted Death Rates,
Oakland County Health Department
District Residents, 1980-2012



Source: 1980 - 2012 Michigan Resident Death Files,
Division for Vital Records & Health Statistics,
Michigan Department of Community Health

YEARS OF POTENTIAL LIFE LOST		2008	2009	2010	2011	2012	TREND
PONTIAC	YPLL/100,000	8,162	8,566	7,349	7,148	6,702	GOOD
	Drug-Induced Death YPLL/100,000	1,095	1,000	945	820	695	GOOD
	Alcohol-Induced Death YPLL/100,000	155	160	275	245	140	GOOD
OAKLAND	YPLL/100,000	5,972	6,002	6,103	6,038	6,273	
	Drug-Induced Death YPLL/100,000	529	612	531	565	650	POOR
	Alcohol-Induced Death YPLL/100,000	126	143	164	148	172	
MICHIGAN	YPLL/100,000	7,419	7,445	7,485	7,519	7,482	
	Drug-Induced Death YPLL/100,000	539	595	589	594	564	
	Alcohol-Induced Death YPLL/100,000	173	198	207	205	190	GOOD

SOURCE: MDCH. YPLL: estimate of the average years a person would have lived if he or she had not died prematurely.

APPENDIX C
COMMUNITY SURVEY

St. Joseph Mercy Health Community Health Needs Survey

Every three years, St. Joseph Mercy Health conducts a Community Health Needs Assessment to evaluate the changing health needs in the communities it serves. Your input allows us to understand the community's perception of needs and how these needs are or are not being met. Once completed, the Community Health Needs Assessment will be shared publicly on our website. We appreciate your willingness to participate in this brief survey. You may skip any questions you do not wish to answer and you may exit the survey at any time. Your responses will be anonymous unless you volunteer to provide your name. If you would like to speak with someone directly regarding this survey – or speak with someone instead of completing this survey - you may contact Arlene Elliott of Arbor Advisors who we have engaged for this work. Arlene's contact information is arlene@arbor-advisors.com or 734-426-3196. Her contact information will also appear on the last page of the survey. We greatly appreciate your time and input. Thank you!

GREATEST HEALTH NEEDS IN THE COMMUNITY

1. What do you see as the most pressing health needs in your community? Needs you might consider include the following. If you don't see a need listed, you may write it at the bottom. Use the column to the right to add details. Feel free to indicate any health needs you feel should be the greatest priority. Please choose all that apply and provide a comment:

GREATEST HEALTH NEEDS	PRESSING NEED?	COMMENT
Alcohol Abuse		
Arthritis		
Asthma		
Cancer		
Cholesterol		
Chronic Diseases (specify)		
Dementia		
Dental Health problems		
Diabetes		
End-of-Life Care		
Heart Disease		
Infant Health		
Infectious Diseases/Immunizations (specify)		
Kidney Disease		
Lung Disease / COPD		
Mental Health problems		
Obesity/Overweight		
Poor Nutrition		
Stroke / High Blood Pressure		
Substance Abuse including prescription drugs		
Other		
Other:		

APPENDIX C
COMMUNITY SURVEY

2. What efforts or initiatives have been successful in helping meet these community health needs? Which specific organizations have taken a lead role in these efforts? Please write your answer here:

____
____
____

3. What do you think are the challenges or barriers to addressing the health care needs in the community? In other words, why aren't the things you mentioned being done more successfully already? What could be done to better to address these unmet needs? Please write your answer here:

____
____
____

SPECIFIC POPULATIONS WITH HEALTH NEEDS

4. Are there specific populations you haven't already mentioned that do not have access to care? If so, please elaborate regarding this population and its unmet needs. Please write your answer(s) here:

Population Group: ____
Health Need: ____
Population Group: ____
Heath Need: ____
Population Group: ____
Health Need: ____

DETERMINANTS OF HEALTH - TOP PRIORITIES

5. Please indicate the level of priority St. Joseph Mercy Health should place on addressing the following determinants of health. Please choose the appropriate response for each item:

DETERMINANTS OF HEALTH	High Priority	Moderate Priority	Not a Priority / Unsure
Income/ Lack of insurance/ Ability to pay/ Employment			
Education/ Understanding of personal health needs and treatment			
Language and Literacy			
Health Behaviors such as tobacco, drug or substance use			
Health Behaviors such as breastfeeding, exercise and preventive care			
Housing security			
Transportation options			
Social supports including access to child care and time from work/ responsibilities to seek care			
Social Norms and Attitudes including cultural, racial, age, or gender barriers to accessing care Exposure to Crime, Violence and Social Disorder			
Availability of healthy foods			
Availability of community resources for recreational and leisure-time activities			
Availability of care options in the community			
Access to Care Providers			

APPENDIX C
COMMUNITY SURVEY

6. Do you believe there is sufficient access to the following types of care in the community? Please choose the appropriate response for each item:

Access to Care	Yes	Sometimes	No	Don't Know / Uncertain	Specify Type/ For whom
Dental Care					
Immunizations					
In-Home Care					
Elderly Care					
Pregnancy Care					
Primary Care					
Specialty Care					
Hospital Care					
Mental Health Care					
Memory Care					
Nursing Home Care					
End-of-Life Care					

ST. JOSEPH MERCY HEALTH'S INVOLVEMENT

7. What are the top three things St. Joseph Mercy can do to help address the needs you have identified in this survey? Please write your answer(s) here:

1. ____
2. ____
3. ____

YOU CAN HELP

8. Has your organization recently conducted any health-related surveys or focus groups that you would be willing to share? Please choose *only one* of the following:

o Yes
o No

9. Are there other people in your organization you believe should be contacted with these questions? If so, please provide their name(s) and contact information. Please write your answer(s) here:

Name: ______________________________
Contact Information: ______________________________
Name: ______________________________
Contact Information: ______________________________

10. Would you be willing to respond to another survey in a few months that asks for your input into the priorities or initiatives St. Joseph Mercy Health considers? Please choose *only one* of the following:

o Yes
o No

11. Tell us about you. Please write your answer(s) here:

Your Name: ____________________
Your Role: ____________________
Your Organization: ____________________
Best Way to Contact You: ____________________

Thank you for sharing your thoughts with St. Joseph Mercy Health! If you have additional thoughts or questions regarding this Community Health Needs Assessment, please call Arlene Elliott at 734-426-3196 or send a message to arlene@arbor-advisors.com . Thank you for completing this survey

APPENDIX D
INTERVIEW FACILITATOR GUIDE

INTERVIEW FACILITATOR GUIDE

Please describe a little about your organization and the population it serves.
What is your role specifically within your organization?

1. What do you see as the most pressing physical health issues in your community? Issues you might consider include (list):
2. What efforts or initiatives have been successful in helping meet these community health needs? Which specific organizations have taken a lead role in these efforts?
3. What do you think are the challenges or barriers to addressing the health care needs in the community? In other words, why aren't the things you mentioned being done more successfully already? What could be done to better to address these unmet needs?
4. Are there specific populations you haven't already mentioned that do not have access to care? If so, please elaborate regarding this population and its unmet needs.
5. Do you believe there is sufficient access to the following types of care in the community? (list)
6. How could St. Joe's Health help address these needs?
7. Which of the following would be your top three priorities for determinants of health to address (list):
8. Has your organization recently conducted any health-related surveys or focus groups that you would be willing to share with me?
9. Are there other people in your organization you believe I should contact with these similar questions? If so, please provide their name(s) and contact information.

APPENDIX E
COMMUNITY SURVEY AND INTERVIEW FINDINGS

COMMUNITY SURVEY AND INTERVIEW FINDINGS

1. Highest priority health issue *chosen by 50% of more of respondents*

- Obesity and Overweight *
- Mental Health
- Poor Nutrition
- Substance Abuse, including prescription drugs
- Diabetes
- Alcohol Abuse
- Dental Health

2. Highest priority determinants of health *in order by highest frequency of survey respondents*

- Income/ Ability to Pay
- Preventive Health Behaviors such as breast feeding and exercise
- Education / Understanding of personal health needs
- Availability of Healthy Foods
- Social Norms and Attitudes

3. Top access concerns *in order by percent of survey respondents who favored*

- Hospital Care
- Immunizations
- End-of-Life
- Nursing Home
- Specialty Care (e.g. cancer screening in elderly)

SPECIFIC POPULATIONS	SPECIFIC NEED
Latinos	Insurance, Mental Health
African Americans	Mental Health, Healthy eating
Homeless	Access to medication, Mental health care, medical care, substance abuse services, continuity of care
School Age Children	Nutrition Advice, Hunger Issues, Mental Health access, Sex and Drugs
Seniors	Education on Self-care, How to find government help, Dementia
Undocumented persons	All health care, Access to Imaging, Assistance with enrollment and documentation
Underinsured or Low Income persons	Access to health care, Access to Imaging, Dental care, Management of conditions and medications (e.g. warfarin, asthma management, thyroid conditions), Access to inexpensive labs
Disabled	Transportation
Pregnant women	Pre-conception health care, prenatal care, prenatal education
Persons with Neurological impairment	Access to neurologists
Persons with fractures and bone problems	Access to Orthopedic doctors
Young adults	Wellness care to prevent chronic conditions
Ex-Offenders	Varied, but focus on mental health

APPENDIX E
COMMUNITY SURVEY AND INTERVIEW FINDINGS

TOP THINGS ST. JOSEPH MERCY CAN DO TO HELP ADDRESS NEEDS

COMMUNICATE SERVICES AVAILABLE

- Advertising the service; Help to educate people about health care options.
- Attend events and speak about the services you offer
- Get more information out to the community in a timely manner.

ACCESS

- Access to mental health without adequate health insurance.
- Availability of Clinical treatment
- Access to dental care; Provide dental services-more community education
- Immediate access to medical care without an appointment
- Make pediatric health care more accessible for those uninsured or underinsured
- Address ping pong of mentally ill individuals, not discharging them without care resources and ensuring continuity and tracking of care. We also need more programs that focus on substance abuse/rehab services
- Support mothers pre conception, pre natal and postnatal care
- Provide better access to mental health and dementia care.
- Provide medications directly to the patient instead of giving them a prescription
- Mental Health Screening
- Offer a variety of FREE programming at convenient times in community based settings
- Work with non-profits to partner on programming and enrolling individuals into health care programs
- Access to imaging at low cost
- Access to routine labs
- Access to podiatry for low income people
- Access to eye surgery services for low income people
- Bring services into the community beyond one time screening opportunities
- Address affordable home care for the disabled

EDUCATION

- Educate the people on health issues and care
- Continue to offer the excellent classes and training to the public possibly doing more in community settings, faith-based, community centers, schools, etc.
- Promote healthy eatings, physical activity and healthy lifestyles as a prevention for multiple health concerns

FUNDING

- Fund programs to address the issues
- Homeless. Veterans. Lack of understanding and adequate funding

TRANSPORTATION

- Utilize Medicaid and other resources to facilitate transportation to health care appts.
- Work on transportation issues

APPENDIX F
COMMUNITY SURVEY PARTICIPANTS

PARTICIPANT	ORGANIZATION	METHOD
Malkia Newman	Oakland Community Mental Health	Survey
August LaRuffa	No one dies alone	Survey
Jennifer Lucarelli	Healthy Pontiac, We Can; Oakland University	Survey
Michael Ennis	The Salvation Army	Survey
Lynn Crotty	Oakland Livingston Human Service Agency	Interview
Pam Donovan Haratsis	Gary Burnstein Community Health Clinic	Interview
Jim McGuire	Area Agency on Aging 1-B Oakland Co. Central Office	Interview
Ronald L Dunlap	Lay Pastor	Survey
Yohannes Bolds	Takeone Community Program	Survey
Margaret L. Hall	Southfield Domestic Violence Group	Survey
Mary Ann Ryan	Hope Hospitality and Warming Center	Survey
Lisa McKay-Chiasson	Oakland County Department of Health	Interview
Carrie Hribar	Oakland County Department of Health	Interview
Kathy Forzley	Oakland County Department of Health	Introduction
Lynn McDaniels	Oakland County Department of Health	Survey
Rachelle Bonelli	Gleaners - VP of Programs	Interview
Sonia Acosta, PhD	Centro Multicultural La Familia Inc.	Interview
Jim LeBlanc	Unknown	Survey
Oakland.gov	Anonymous	Survey
Anonymous	12 participants	Survey

APPENDIX G
LOCAL STUDIES DATA FINDINGS

Oakland Livingston Human Services Agency
Community Forums and Focus Group Findings 2014

1. Needs, if addressed, would increase family's independence:
   - More accessible and comprehensive list of available services;
   - Dental care.
2. Greatest challenges in "navigating" through the community services system:
   - Transportation program (wait list)
3. Improve the community services system:
   - Make programs more known (community flyers, local community hot-line);
   - 211 could be improved – service not available in some areas.
4. Most important characteristics of a healthy community:
   - More community involvement;
   - Preventive care;
   - Care for disabled/emotionally challenged – support systems.
5. Most important issues that must be addressed to improve the health and quality of life in the community:
   - Better public transportation – dependable and reliable (especially for elderly, SMART is limited);
   - Better communication with law enforcement.
6. Most Critical Aspects of Poverty Impacting Self-Sufficiency:
   - Adequate nutrition for seniors due to lack of transportation.
   - Nutrition education.
   - Substance abuse – need for assistance and address cycles of substance abuse.
   - Lack of public transportation (affects all areas of life).

Area Agency on Aging
Survey and Focus Group Highlights 2014

Ranked as top priority AAA service by those older adults who participated in Oakland County
- Information and Assistance
- Public Education
- Home Delivered Meals
- Wellness/Disease Prevention Programs
- Elder Abuse Prevention and Awareness

Ranked as medium-high priority AAA service:
- Care Management
- Resource Advocacy
- Health Benefits Education
- Chore Services
- In-Home Respite, Personal Care
- Medication Management
- Adult Day Service
- Out-of-Home Respite
- Volunteer Caregivers/Respite and Legal Services.