



**Fiscal Year 2016
St. John Providence
Community Health Needs
Assessment and
Implementation Strategies**

Conducted: FY2016 (July 1, 2015 – June 30, 2016)

2016 Community Health Needs Assessment (CHNA)

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I. Executive Summary

St. John Providence (SJP), member of Ascension, is a non-profit Catholic health system comprised of five hospitals and over 125 medical facilities. We are mandated by the Internal Revenue Service (IRS) to conduct a Community Health Needs Assessment (CHNA) every three years. This assessment was completed jointly for each of the five SJP operating hospitals, as allowed by current guidelines. The focus is the geographic service area for each facility which is determined to be the counties where 80 percent of its patients reside.

Evaluation covering CHNAs FY2013 - FY2015

The CHNA Advisory Group met and discussed the strategies related to the prior CHNAs (approved and posted to the SJP website in FY2013) before completing its prioritization for the new/current CHNA. The discussion around the three previous priorities of **Access to Care**, **Infant Mortality Reduction** and **Diabetes/Obesity Reduction** is summarized below.

Access to Care was greatly improved in SEM due to two factors: 1) Medicaid Expansion and SJP active advocacy for its passage and participation in outreach and enrollment of newly eligible uninsured individuals and 2) Expansion of community health centers and SJP support and partnership with Covenant and Advantage Federally Qualified Health Centers. The need going forward will be in the area of health literacy.

Infant Mortality Reduction activities continued and were improved with the focus on breast feeding reduction, establishment of Baby Friendly Hospitals and SJP outreach, home visits and participation in community related education events such as SEM Perinatal Task Force. Further the work of other organizations in this area such as the Nurse Family Partnership and Healthy Start was recognized. Going forward this was concluded to remain a need and placed fourth in the prioritization process for the next CHNA.

Diabetes/Obesity reduction was discussed as an ongoing need. SJP established two wellness centers in the service area offering exercise, PATH Diabetes education, enhanced fitness and other classes. Further the schools health centers offered Kids Mile program physical activities for school children. It was recognized that more needed to be done in this area as Diabetes and Obesity are the precursors of many significant and life threatening causes of disability and death. It was acknowledged that all SEM health systems offer classes for Diabetics but there continues to be a need for community based education and a new focus on Diabetes Prevention using evidence based models such as the one offered through CDC. This area remains a priority area going forward for this CHNA.

Framework and Approach for FY2017 - FY2019

A Steering Committee was convened to provide guidance and oversight in the development of the CHNA. The committee included all of the directors from the local health departments, as well as individuals from a variety of health professions such as public health, physicians, nurses, finance, health planning, communications, behavioral health and faith-based leaders. Extensive local, national, state and hospital utilization data and statistics were obtained from internal as well as external sources to identify health specific trends. These sources as well as information collected through a survey of 465 community members and 86 key informants groups enabled the Steering Committee to gain further insight into the needs and gaps in the hospital service area. The result of their analysis was consistent with the published 2016 County Health Rankings provided by the University of Wisconsin in partnership with Robert Wood Johnson Foundation, indicating that of the 83 ranked Michigan counties; Wayne County was 83rd, Oakland County, 15th, Macomb County 58th, Livingston County 3rd and St. Clair County 51st in Health Outcomes.

To select health priorities for focus, we utilized a common form of prioritization called Multi-Voting Technique, as outline by the National Association of County and City Health Officials (NACCHO). Multi-voting outcomes are appealing because it allows a health problem which may not be a top priority of any individual but is favored by all, to rise to the top. The selected priorities are **Obesity and Diabetes Prevention, Access to Care** and **Mental Health and Substance Abuse**. Although other health needs were identified, it was determined that the health system will work with other organizations as needed to address health needs not selected. For each selected priority, strategies have been developed that focus on outreach and education, evidence-based interventions or advocacy.

SJP's CHNA aligns with guidelines established by the Affordable Care Act and complies with IRS requirements.

Summary of Implementation Strategies

Prioritized Need: Obesity and Diabetes Prevention

Goal 1: Prevent and reduce obesity in children, youth and adults (across the lifespan).

Strategy 1: Implement evidence-based, breast-feeding interventions, including Mother Nurture, to improve awareness, knowledge and behaviors for preventing and reducing obesity, for communities, including those that are diverse and underserved.

Strategy 2: Implement 5-2-1-0 as an age-appropriate community-wide education and evidence-based intervention that improves awareness, knowledge and behaviors for preventing and reducing obesity in communities, including those that are diverse and underserved.

Strategy 3: Implement Enhance Fitness as an age-appropriate community wide education and evidence-based intervention to improve awareness, knowledge and behaviors for preventing and reducing obesity in communities, including those that are diverse and underserved.

Goal 2: Prevent and reduce risk factors for diabetes in adults.

Strategy 1: Implement Diabetes Prevention Program as a community-wide education and evidence-based intervention that prevents and reduces the complications of diabetes in communities, including those that are diverse and underserved.

Strategy 2: Implement the Diabetes Self-Management Program as a community-wide education and evidence-based intervention that prevents and reduces the complications of diabetes in communities, including those that are diverse and underserved.

Prioritized Need: Access to Care

Goal 1: Reduce the social determinants of health barriers that impact health equity and access to healthcare.

Strategy 1: Implement Mobile Mammography to improve patient access to care.

Strategy 2: Implement Asthma Camp and Deep Breath to improve patient access to care.

Strategy 3: Convene a transportation workgroup to develop strategies and interventions leading to improved options for transportation to obtain needed care.

Strategy 4: Implement a Health Literacy Information and Education Series for physicians, staff and patients to improve knowledge about universal health literacy precautions and strategies for reducing health illiteracy.

Prioritized Need: Mental Health & Substance Abuse

Goal 1: Decrease youth risk factors for suicide, depression and substance abuse.

Strategy 1: : Implement the Rapid Assessment for Adolescent Preventive Services (RAAPS) as a suicide risk screening and provide mental health education, counseling and referral for youth in partner schools.

Strategy 2: Implement Red Flags mental health education, counseling and referral for youth in partner schools.

Goal 2: Decrease youth and adult risk factors for suicide, depression and substance abuse.

Strategy 1: Implement Mental Health First Aid to focus on changing the community/culture and perception of persons with less than optimal mental health.

Goal 3: Decrease youth risk factors for post-traumatic stress disorder

Strategy 1: Utilize the Trauma Symptoms Checklist for Children to screen for posttraumatic stress and related psychological symptomatology and provide appropriate counseling and referrals.

Goal 4: Prevent and reduce addiction / mental illness in children, youth and adults (across the lifespan).

Strategy 1: Utilize the Screening, Brief Intervention, and Referral to Treatment (SBIRT).

Strategy 2: Provide family education to families involved with and at risk for substance use disorders.

Evaluation

Over the next three years, SJP's hospitals will execute the implementation strategies. We will evaluate strategies on an annual basis and make changes where appropriate. We have contracted with an evaluator to help us develop systematic measurement and tracking of program effectiveness, as well as reporting progress and outcomes.

II. Systemwide Approach to the CHNA

About St. John Providence

St. John Providence (SJP), member of Ascension, is a non-profit Catholic health system comprised of five hospitals and over 125 medical facilities. SJP has 2,012 licensed beds and 15,947 associates. In 2015 SJP had over 95,000 patient discharges, over 372,000 emergency department visits and more than 8,100 births at its facilities. The hospitals serve a five county region that makes up southeastern Michigan and includes: Macomb, Oakland, Livingston, St. Clair and Wayne County (which includes the city of Detroit). SJP’s mission drives the community benefit work by its focus on improving the health of the community with special attention to the poor and vulnerable.

Community Health at St. John Providence

SJP is one of very few health systems in the country that has an entire department devoted to serving the community. St. John Providence Community Health dedicates 74 full-time employees for holistic health improvement, which resulted in approximately 150,000 encounters, annually, with the most vulnerable people in the communities that we serve. In addition to our hospitals and community health staff, the SJP family includes thousands of volunteers and donors who support our healthcare mission in the community with their generosity.

Service Area Demographics

County	Population	Median Household Income	Percent White	Percent Black	Percent Hispanic or Latin	Percent Asian	Percent Multi-racial	Percent of persons below poverty	County Health Ranking
Macomb	864,840	\$54,059	82.9	11.0	2.5	3.6	2.2	12.3	58 th
Oakland	1,242,304	\$66,436	76.5	14.5	3.8	6.5	2.1	10.0	15 th
Wayne	1,759,335	\$41,421	54.8	39.3	5.7	3.0	2.3	24.1	83 rd
St. Clair	159,875	\$48,703	94.3	2.6	3.2	0.6	2.0	13.8	50 th
Livingston	187,316	\$73,694	96.7	0.6	2.2	0.9	1.3	6.1	3 rd

Source: United States Census Bureau, Quick Facts, retrieved: <http://www.census.gov/quickfacts/table/PST045215/00>

CHNA Guiding Principles and Framework

SJP used the Centers for Disease Controls *Invest in Your Community Model* for understanding of what contributes to a healthy community.



INVEST IN YOUR COMMUNITY 4 Considerations to Improve Health & Well-Being *for All*

WHAT Know What Affects Health

40% SOCIOECONOMIC FACTORS
20% CLINICAL CARE
30% HEALTH BEHAVIORS
10% PHYSICAL ENVIRONMENT

WHERE Focus on Areas of Greatest Need

Your zip code can be more important than your genetic code. Profound health disparities exist depending on where you live.

WHO Collaborate with Others to Maximize Efforts

HEALTH INSURANCE, PUBLIC HEALTH, HEALTH CARE PROVIDERS, NONPROFITS, PEOPLE, COMMUNITY DEVELOPERS, BUSINESSES, EDUCATION, GOVERNMENT, FAITH-BASED ORGANIZATIONS, PHILANTHROPISTS & INVESTORS

HOW Use a Balanced Portfolio of Interventions for Greatest Impact

- Action in one area may produce positive outcomes in another.
- Start by using interventions that work across all four action areas.
- Over time, increase investment in socioeconomic factors for the greatest impact on health and well-being for all.

Four ACTION Areas: SOCIOECONOMIC FACTORS, PHYSICAL ENVIRONMENT, HEALTH BEHAVIORS, CLINICAL CARE

VISIT www.cdc.gov/CHInav FOR TOOLS AND RESOURCES TO IMPROVE YOUR COMMUNITY'S HEALTH AND WELL-BEING

CDC NATIONAL PREVENTION STRATEGY Robert Wood Johnson Foundation

CHNA Approach and Timeline

SJP began working on the CHNA on July 1, 2015. At the onset of our work, we met with each director of the local health departments in our service area to gauge the health of the community and discover opportunities for collaboration. Next we gathered data using state and national resources. We worked with our Ascension Michigan team to develop a framework for implementation strategies that focused on evidence-based approaches with a strong evaluation component. The CHNA Steering Committee was convened with members in disciplines such as public health, physicians, nurses, finance, health planning and behavioral health. The committee had three extensive face-to-face meetings to review the collected data, select preliminary priority areas for focus, look at the feasibility of implementing strategies in the preliminary priority areas, and formally voting on priority areas. The Implementation Strategy Steering Committee was convened and had three intensive face-to-face meetings and four conference calls. This committee conducted both an internal and external inventory of what was already being done in and out of the health system to address our selected priorities. The group went through a logic model process to develop evidence based strategies.



III. Summary of Systemwide CHNA

Key CHNA Contributors and Participant Groups

St. John Community Health led the CHNA process for all St. John Providence hospitals. Macomb, Oakland, Wayne, St. Clair and Livingston County, and Detroit Health Departments provided public health expertise about current health issues and trends. Healthy Communities Institute offered us a model for the CHNA and Implementation Strategies as well as a frame work for developing implementation strategies using logic models.

Ongoing Process/Collaboration



CHNA Steering Committee reviewed secondary public health data, selected prioritization methodology, recommended community partners and selected the priorities. The CHNA Steering Committee included all of the directors from the local health departments as well as individuals from a variety of health professions in disciplines such as public health, physicians, nurses, finance, health planning, communications, behavioral health and faith-based leaders.

SJP conducted two surveys, one for the general community and another for key informants, which included leaders of programs and community organizations. More than 550 people completed the CHNA survey. It was important to SJP to gauge community members’ greatest concerns from our entire service area to ensure that there was community input from diverse groups.

Data and Input Sources

The data input sources that SJP used included both quantitative and qualitative data from sources such as:

Secondary Data

- Michigan Department of Health and Human Services
- Centers for Disease Control
- County Data (for all 5 counties and City of Detroit)
- Behavioral Risk Factor Surveys from both local, state and national sources
- Hospital Data

CHNA Community Survey

- Survey was distributed widely throughout the SJP service area via SJP associates
 - Both paper and online surveys were sent to community members as well as key informants.

Prioritization Process and Criteria

The CHNA Steering Committee agreed to utilize a common form of prioritization called Multi-Voting Technique, as outline by National Association of County and City Health Officials (NACCO). Multi-voting outcomes are appealing because it allows a health problem which may not be a top priority of any individual but is favored by all, to rise to the top. In contrast, a straight voting technique would mask the popularity of this type of health problem making it more difficult to reach a consensus.

IV. Summary of Systemwide Priorities and Implementation Strategies

Disease and Health Condition

Although the CHNA's are specific to each hospital, Obesity and Diabetes Prevention emerged as a key health priority for four of our hospitals and Mental and Substance Abuse emerged as key health priority for all five of our hospitals. A CDC study finds that Obesity is the second leading cause of preventable deaths in the United Statesⁱ and Diabetes is the seventh leading cause of death in Michiganⁱⁱ.

Social Determinants Priorities

SJP is committed to not only improving clinical outcomes for the people that we serve, but to reducing the social determinants of health barriers that impact health equity and access to healthcare. SJP will focus our priority of Access to Care on the following:

- Access to mammography and asthma care
- Transportation advocacy
- Cultural competence and health literacy

Identified Community Health Needs

Priorities*	Collaboration **	Supportive***
Obesity and Diabetes Prevention	Infant Mortality	Child Abuse Prevention
Access to Care	Immunization	HIV/AIDS Reduction
Mental Health and Substance Abuse	Chronic Disease	Food Insecurity
	Asthma	Education

*The most common priority areas identified through our surveys, feedback from partners and data from secondary data sources was Obesity and Diabetes , Mental Health and Substance Abuse and issues relating to Access to Care.

**Through surveys and conversations with key informants and secondary data sources, infant mortality, immunization, chronic disease and asthma came up as identified needs. SJP will continue working on the reduction of Infant Mortality through our Infant Mortality Program, Mother Nurture, Outpatient breastfeeding clinics, and through collaborations with Women-Inspired Neighborhood Network (WIN network) and local health departments and sponsorship for March of Dimes. SJP works diligently on immunization efforts through our School-Based Health centers, Community Outreach, Faith Community Partnerships. In FY15 our community health programs immunized more than 2,000 adults and children. SJP partners with community organizations by providing immunizations at health fairs. Asthma will be addressed through our Access To Care priority. School Based Health Centers to educate and treat children with asthma. We have an annual Asthma camp in the fall that provides children with a fun-filled opportunity to leave their urban center and experience nature, under the supervision of licensed clinicians. SJP will continue addressing chronic disease through our Personal Action Toward Health (PATH) program and fitness classes. We also provide sponsorship and grants through our Mission Fund to organizations that target specific chronic disease like the National Kidney Foundation, Arthritis Foundation, American Diabetes Foundation, and Lupus Detroit.

*** Through surveys and conversations with key informants, child abuse, HIV/AIDS Reduction, Food Insecurity and Education came up as identified needs. Although SJP will not directly focus on Child Abuse, all of the SJP licensed clinicians are mandated to report and have protocols in place for reporting any suspected/reported child abuse. We also provide Sponsorship to CareHouse and Alternatives for girls. SJP works on HIV/AIDS Reduction through our Ryan White program, we host events at several sites for World AIDS Day, and we support an annual AIDS Walk. Food Insecurity is an issue in our service area and SJP supports Gleaners Community Food Bank, Focus Hope, Forgotten Harvest as well as facilitating several community food drives and food distribution at our sites. SJP has strong partnerships with the school districts in our service area. We have School-Based Health Centers that offer comprehensive care in three counties in our service area. We provide support to organizations like Communities in Schools Michigan, Literacy Through Letters and Mercy Education Project,

Implementation Strategies

Recommendations for selected priorities were presented to the SJP board of directors for approval. Once the selected priorities were approved an Implementation Strategy Steering Committee was convened. This group conducted an internal and external scan of programs and resources in the SJP service area. The group worked to identify evidence-based strategies to address the selected priorities by going through the process of developing a logic model. This process helped the committee to select the goals, strategies and outcomes for each selected priority.

Evaluation

Over the next three years, SJP's hospitals will execute the implementation strategies. We will evaluate strategies on an annual basis and make changes where appropriate. We have contracted with an evaluator to help us develop systematic measurement and tracking of program effectiveness, as well as reporting progress and outcomes. Annual evaluations will support continuous improvement for program effectiveness. Outcome evaluations will assess changes in knowledge, behavior or health outcomes among the program participants. The CHNA and Implementation Committees will convene annually to review and make any updates to the implementation strategies and recommend appropriate partnerships.

V. Community Health Needs Assessments and Implementation Strategies

St. John Hospital and Medical Center

22101 MOROSS
DETROIT, MI 48236

St. John Hospital and Medical Center Service Area: Wayne, Macomb and St. Clair Counties

As a member of St. John Providence and Ascension, St. John Hospital and Medical Center is part of the nation's largest Catholic and non-profit health system, and the only hospital in Detroit, Michigan with the Baby Friendly designation. St. John Hospital and Medical Center is a teaching hospital with a Level II Trauma Center with 761 licensed beds, 1300 medical staff and more than 50 medical surgical specialties. More than 80% of our patient population resides in Wayne, Macomb, and St. Clair County. This geographic area also includes the following major healthcare facilities: Henry Ford Health System, Detroit Medical Center, Beaumont Health and John D. Dingell VA Medical Center.

Community Health Priorities

- Obesity
- Access to Care
- Mental Health and Substance Abuse

St. John Macomb Oakland Hospital

MACOMB CENTER
11800 E. 12 MILE RD
WARREN, MI 48093

OAKLAND CENTER
27351 DEQUINDRE RD
MADISON HEIGHTS, MI 48071

St. John Macomb Oakland Service Area: Macomb and Oakland Counties

As a member of St. John Providence and Ascension, St. John Macomb-Oakland Hospital is part of the nation's largest Catholic and non-profit health system, and the only medical-surgical hospital in Warren, Michigan, the state's third largest city. St. John Macomb Hospital, located in Warren, Michigan and St. John Oakland Hospital located in Madison Heights, Michigan merged in 2007. Today, we are St. John Macomb-Oakland Hospital (SJMOH)—one hospital, two campuses, 535 licensed beds, 3,400 nurses and associates, 600 volunteers, 195 residents and more than 1,200 physicians in over 45 specialties. More than 80% of our patient population resides in Wayne, Oakland and Macomb County. This geographic area also includes the following major healthcare facilities: Henry Ford Health System and Beaumont Health.

Community Health Priorities

- Obesity
- Access to Care
- Mental Health and Substance Abuse

Providence-Providence Park Hospital

SOUTHFIELD CAMPUS
16001 W. NINE MILE RD
SOUTHFIELD, MI 48075

NOVI CAMPUS
47601 GRAND RIVER
NOVI, MI 48374

Providence-Providence Park Service Area: Oakland and Wayne Counties

As a member of St. John Providence and Ascension, Providence-Providence Park Hospital is part of the nation's largest Catholic and non-profit health system. For 100 years, Providence-Providence Park Hospital has been a premier provider of compassionate and leading-edge health care. Since 2008 Providence-Providence Park has operated on two campuses. Our 659-bed hospital facility is the largest employer in Southfield, Michigan and is building a strong presence in Novi. Providence-Providence Park Hospital has more than 4,600 nurses and associates, 1,400 physicians, 180 medical residents and approximately 900 volunteers dedicated to healing the bodies and touching the souls of thousands each year. More than 80 percent of patients served by Providence-Providence Park Hospital reside in Wayne and Oakland counties, including the city of Detroit. This geographic area also includes the following major healthcare facilities: Henry Ford Hospital, Harper University Hospital, Detroit Receiving Hospital, and Beaumont Health.

Community Health Priorities

- Obesity
- Access to Care
- Mental Health and Substance Abuse



St. John River District Hospital

4100 RIVER ROAD

EAST CHINA TOWNSHIP, MI 48054

St. John River District Hospital Service Area: St. Clair County

As a member of St. John Providence and Ascension, St. John River District Hospital is part of the nation's largest Catholic and non-profit health system. St. John River District has 68 licensed beds and medical staff of 180. More than 80% of our patient population resides in from St. Clair County. This geographic area also includes the following major healthcare facilities: Port Huron Hospital and St. Joseph Mercy, Port Huron.

Community Health Priorities

- Obesity
- Access to Care
- Mental Health and Substance Abuse

Brighton Center for Recovery

12851 Grand River Ave.
Brighton, MI 48116

Brighton Center for Recovery: Wayne, Oakland and Livingston Counties

As a member of St. John Providence and Ascension, Brighton Center for Recovery, a 41 bed hospital, is part of the nation's largest Catholic and non-profit health system. Brighton Center for Recovery is the first addiction treatment center to be licensed in Michigan, the second oldest alcohol and drug treatment facility in the United States and is accredited by The Joint Commission. Brighton offers inpatient and outpatient treatment, art therapy, transitional housing, a 12-step program and support to help children and family members of patients who are struggling with addiction. More than 80 percent of patients served by Brighton Center for Recovery reside in Wayne, Oakland and Livingston counties, including the city of Detroit. This geographic area also includes the following major healthcare facilities: Henry Ford Hospital, Harper University Hospital, Detroit Receiving Hospital, and Beaumont Health, and St. Joseph Mercy Livingston.

Community Health Priorities

- Mental Health and Substance Abuse

I. Obesity and Diabetes Prevention

Objective:

Prevent and reduce obesity in children and adults across the lifespan and prevent and reduce risk factors for diabetes in adults. Efforts include risk assessment, screening, education, healthy eating, physical activity and lifestyle modification.

Secondary Data: Framing the Issue

- 34 percent of adults in Wayne County, 26 percent in Oakland County, 33 percent in Macomb County, 29 percent in Livingston County and 32 percent in St. Clair County are obese with a body mass index (BMI) over 30 or more.ⁱⁱⁱ
- 20 percent of adults in Oakland County, 26 percent in Wayne County, 23 percent in Macomb County, 19 percent in Livingston County and 24 percent in St. Clair County reported they were physically inactive.^{iv}
- Diabetes is the seventh leading cause of death in Michigan as of 2014 at a rate of 23.6 per 100,000 compared to the national rate of 20.9.^v
- Diabetes was the sixth leading cause of ambulatory care sensitive conditions in Michigan as of 2014 with 14, 592 hospitalizations.^{vi}
- In 2011, 13.2 percent of children ages 2-4 years from low income households in Michigan were obese with a BMI in the 85 percentile or higher, 14.8 percent of children ages 10-17 years and 13.0 percent of high school students are obese.^{vii}

GOAL 1: Prevent and reduce obesity in children, youth and adults (across the lifespan).

Strategy 1: Implement evidence-based, breast-feeding interventions, including Mother Nurture, to improve awareness, knowledge and behaviors for preventing and reducing obesity, for communities, including those that are diverse and underserved.

Background Information:

- **Target Population:** Birth to weaning
- **How it Addresses Social Determinant of Health, Health Disparities, and Challenges of the Underserved:** The Mother Nurture Project is particularly focused on addressing the “huge cultural and ethnic disparity” in breastfeeding rates through education and community outreach. Mother Nurture ensures that all women and babies, regardless of race or address can experience the enduring benefits of breastfeeding. Research has shown that black mothers are less likely to breastfeed their babies than Hispanic or white women (U.S. News & World Report, 2013). These findings suggest that black mothers may face unique challenges and require additional targeted support to breastfeed...” (para 8). In the Detroit area, the breastfeeding rate is below the national average. Among African Americans, the rate is under 40 percent, compared to 70 percent for non-white, non-Hispanic mothers in metro Detroit, according to St. John’s statistics.
- **Strategy Source:** In 1981, Kramer reported a significantly reduced risk for being overweight among children who were breastfed. For each month of breastfeeding up to age 9 months, the odds of

being overweight decreased by 4%. This decline resulted in more than a 30% decrease in the odds of being overweight for a child breastfed for 9 months when the comparison was with a child never breastfed. (Centers for Disease Control, 2004). Mother Nurture is an existing program of St. John Providence and may require revisions to metric plans and processes for determining outcomes.

Actions:

1. Provide breastfeeding education during the prenatal and intrapartum periods taught by trained lactation specialists.
2. Support the written policy/protocol on breastfeeding in all health facilities.
3. Promote the benefits of breastfeeding with staff.
4. Encourage early breastfeeding initiation, supporting cue-based feeding, restricting supplements and pacifiers for breastfed infants, and provide for post-discharge follow-up.
5. Make education and information about the benefits of breastfeeding available to all staff.
6. Replicate the Baby Friendly Hospital Initiative as designated by the World Health Organization, across the health system.
7. Determine and implement process and outcome evaluation.
8. Provide regularly scheduled report of evaluation data.
9. Utilize evaluation findings for continuous program improvement.

Anticipated Impact:

Beginning in September, 2016, continue to provide breast-feeding interventions, such as Mother Nurture, to mothers at the Providence, Moross and Macomb campuses so that there are increased numbers of women who initiate breast-feeding, breast feed exclusively at 3 months and breast feed exclusively at 6 months.

Strategy 2: Implement 5-2-1-0 as an age-appropriate community wide education and evidence-based intervention that improves awareness, knowledge and behaviors for preventing and reducing obesity in communities, including those that are diverse and underserved.

Background Information:

- **Target Population:** Students in school-based health centers ages 5-18 years
- **How it Addresses Social Determinants of Health, Health Disparities and Challenges of the Underserved:** 5-2-1-0 is a multi-setting initiative designed to reach families where they live, learn, work and play to reinforce the importance of healthy eating and physical activity. Continued implementation of 5-2-1-0 will occur in the school health centers. Through that venue, youth from low-income families have access to obesity prevention/ reduction services. Without this program, these types of services might not be available to the communities where the school health centers are located.
- **Strategy Source:** 5-2-1-0 is an evidence-based strategy. In a study conducted in Maine in 2013, surveillance data gathered through the Maine Integrated Youth Health Survey was used to track healthy eating and active living behaviors and clinical outcomes resulting from 5-2-1-0, formerly called Let’s Go. Results of the study revealed a greater percentage of Maine’s youth, though not across all grades, met recommendations for each of the 5-2-1-0 healthy behaviors, compared to

2011. Furthermore, the prevalence of obesity and overweight status for students in Maine remained unchanged or had decreased from 2011 levels. (Rogers, V., Vine, J., (2014) 5-2-1-0 Let's Go Evaluation Report. Barbara Bush Children's Hospital at Maine Medical Center). 5-2-1-0 is an existing initiative of St. John Providence and requires consistent messaging within the school setting. It is currently in 12 school-based health centers. Therefore, other evidence-based interventions will be investigated for implementation in the remaining school sites. 5-2-1-0 may also require revisions to metric plans and processes for determining outcomes.

Actions:

1. Screen youth visitors for obesity (BMIs > 85%).
2. Recruit youth health center visitors with BMIs >85% for 5-2-1-0.
3. Send informed notification to parents.
4. Implement six weekly 5-2-1-0 sessions with 2 cohorts of students annually.
5. Continue to provide health promotion class presentations that encourage physical fitness and better nutrition.
6. Evaluate 12 week sessions and health promotion presentations and report findings.
7. Utilize evaluation findings for continuous program improvement.
8. Explore collaboration with local health departments in Livingston and St. Clair counties for 5-2-1-0 or other evidence-based programs to reduce obesity targeting youth.

Anticipated Impact:

Beginning in September, 2016, continue to implement six weeks of the 5-2-1-0 intervention, including education, parental outreach, advanced clinical testing and weight monitoring in school-based clinics for youth with a BMI >85%, resulting in reduced BMI.

Strategy 3: Implement Enhance Fitness as an age-appropriate community wide education and evidence-based intervention to improve awareness, knowledge and behaviors for preventing and reducing obesity in communities, including those that are diverse and underserved.

Background Information

- **Target Population:** Adults
- **How it Addresses Social Determinants of Health, Health Disparities and Challenges of the Underserved:** Enhance Fitness is a low-cost, evidence-based group exercise program that helps older adults at all levels of fitness become more active, energized, and empowered to sustain independent lives. Continued implementation of Enhance Fitness will occur in St. John community settings. Through that venue, older adults from low-income families have access to obesity prevention/ reduction services. Without this program, these types of services might not be available to this community.
- **Strategy Source:** Enhance Fitness is an evidence-based strategy. Belza, B., Shumway-Cook, A., Phelan, E., Williams, B., Snyder, S., LoGerfor, J. (2006) in *The Effects of a Community-Based Exercise Program on Function and Health in Older Adults: The Enhance Fitness Program*. The Journal of

Applied Gerontology, Vol. 25 No. 4, August 2006 291-306, examined the effectiveness of participation in Enhance Fitness (EF) (formerly the Lifetime Fitness Program). EF incorporated performance and health status measure testing in year 2000. Initial performance was compared to age and gender-based norms to classify participants as within or at or above normal limits (WNL) or below (BNL). In 2,889 participants who participated in outcomes testing, improvements were observed at 4 and 8 months on performance tests for both subgroups. Participants' self-rating of health improved at 8 months. All participants improved on performance tests. Enhance Fitness is an existing initiative of St. John Providence. However, it may require revisions to metric plans and processes for assessing outcomes.

Actions:

1. Provide marketing support through CareLink program, regional mailings.
2. Cross market with other community programs.
3. Implement ongoing Enhance Fitness classes in the Southfield and Riverview sites.
4. Provide program through SJP faith community partnerships
5. Explore expansion to another community site to launch in 2017.
6. Evaluate participant outcomes for health and physical performance semi-annually and annually.
7. Continue health promotion efforts in communities.

Anticipated Impact:

- I. Beginning in September, 2016, continue to implement Enhance Fitness in the current community settings to increase health and physical performance of the participants.
- II. Increase implementation of Enhance Fitness from 2 to 3 sites in FY 17.

GOAL 2: Prevent and reduce risk factors for diabetes in adults.

Strategy 1: Implement Diabetes Prevention Program as a community wide education and evidence-based intervention that prevents and reduces the complications of diabetes in communities, including those that are diverse and underserved.

Background Information

- **Target Population:** Adults
- **How it Addresses Social Determinants of Health, Health Disparities and Challenges of the Underserved:** National Diabetes Prevention Program—or National DPP—is a partnership of public and private organizations working to reduce the growing problem of pre-diabetes and type 2 diabetes. The partners work to make it easier for people with pre-diabetes to participate in evidence-based, affordable, and high-quality lifestyle change programs to reduce their risk of type 2 diabetes and improve their overall health. DPP will be implemented in St. John community settings and provide services to populations that may not have access to these services.

- **Strategy Source:** DPP is an evidence based strategy. DPP researchers found that participants who lost a modest amount of weight through dietary changes and increased physical activity sharply reduced their chances of developing diabetes. DPP is a new initiative of St. John Providence, and thus will require presentation of information/awareness sessions to the community and physicians. It may also require adaptations to metric plans and processes to determine outcomes.

Actions:

1. Develop recruitment tools including informative letters and mailings to physicians, ambulatory sites, community partners and through the CareLink newsbrief.
2. Screen and identify participants using an evidence-based pre diabetes risk questionnaire and through physician referrals.
3. Recruit adults with prediabetes or metabolic syndrome.
4. Initiate implementation of DPP in two sites.
5. Conduct weekly, DPP classes including nutrition education, life-style support, and goal setting for six months then monthly for the remaining six months.
6. Conduct program evaluation, including reporting and utilization of data for continuous quality improvement.

Anticipated Impact:

Beginning in September, 2016, implement DPP in community partnership sites with adults with prediabetes and/or metabolic syndrome and reduce their diabetes risk.

Strategy 2: Implement the Diabetes Self-Management Program as a community wide education and evidence-based intervention that prevents and reduces the complications of diabetes in communities, including those that are diverse and underserved.

Background Information

- **Target Population:** Adults
- **How it Addresses Social Determinants of Health, Health Disparities and Challenges of the Underserved:** Developed at Stanford University, the Diabetes Self-Management Program (called Diabetes PATH in Michigan) is designed specifically to enhance patient confidence in their ability to manage their diabetes and to work more effectively with their health care providers. Diabetes PATH will be implemented in St. John community settings and provide services to populations that may not have access to these services.
- **Strategy Source:** Diabetes Self-Management Program is an evidence based strategy. Results from PATH with Spanish speaking individuals showed that the program participants, as compared to usual care control subjects demonstrated improved health status, health behavior, and self-efficacy as well as fewer emergency room visits at four months. At one year, the improvements were maintained and remained significantly different from baseline condition. Diabetes PATH is an existing initiative of St. John Providence. It may also require adaptations to metric plans and processes to determine outcomes.

ACTIONS:

1. Disseminate education information to increase awareness of the Diabetes Path training via publications and partnership sites.
2. Register self-identified and referred diabetics.
3. Assess readiness to change and knowledge of diabetes management.
4. Conduct weekly classes for six weeks which includes nutrition education, lifestyle support and goal setting.
5. Conduct 4 Healthy Habits sessions as part of health promotion efforts.
6. Conduct evaluation of Diabetes Path and Healthy Habits to determine outcomes and effectiveness.

Anticipated Impact:

Beginning in September, 2016, continue partnering across community partnership sites to provide the Diabetes Self-Management Program and increase patients’ knowledge and skills for managing their diabetes.

II. Access to Care

Objective:

Reduce the social determinants of health barriers that impact health equity and access to healthcare.

Secondary Data: Framing the Issue

- The 2015 Community Health Status Indicator by U.S. Department of Health and Human Services and Centers for Disease Control and Prevention provides a rating of social factors among peer counties. Wayne County was worse off than peer counties in poverty and unemployment, Oakland and Macomb counties were worse off in unemployment, Livingston County was worse off in on-time graduation rates and unemployment and St. Clair was worse off in high housing costs, on-time graduation rates, poverty and unemployment.
- Primary Care Provider to Patient Ratio in Wayne County was 1515:1, Macomb County 1698:1, St. Clair County 1983:1, Livingston County 2151:1 and Oakland County 665:1. The ratio in Michigan is 1246:1 and top performing counties in the nation are 1,040. Mental Health Provider to Patient Ratios are: Wayne County 418:1, Oakland 328:1, 632:1, Livingston 658:1 and St. Clair 426:1. Michigan’s ratio is 450:1 and top performing counties in the nation are 370:1.^{viii}

Goal 1: Reduce the social determinants of health barriers that impact health equity and access to healthcare.

Strategy 1: Implement Mobile Mammography to improve patient access to care.

Background Information

- **Target Population:** Adult women
- **How it Addresses Social Determinants of Health, Health Disparities and Challenges of the Underserved:** The “Anthony L. Soave Family Mobile Mammography & Health Screening Center” is a self-contained screening center on wheels featuring advanced 3D\Tomosynthesis imaging in a clean and comfortable environment. For many women who are un-insured and underinsured, a screening mammogram is not a priority, not affordable, or easily accessible. The Anthony L. Soave Family Mobile Mammography and Health Screening Center is designed to ensure all women have easy access to high-quality breast health services regardless of their ability to pay.
- **Strategy Source:** Current evidence supporting mammograms is even stronger than in the past. In particular, recent evidence has confirmed that mammograms offer substantial benefit for women in their 40s. Mobile Mammography is an existing initiative of St. John Providence. However, it may require revisions to metric plans and processes to determine outcomes.

Actions:

1. Conduct speaking engagements to churches and community groups about the importance of Breast Health.
2. Register patients and obtain insurance authorization for insured patients.
3. Complete mammography insight in mobile unit.
4. Submit reimbursement for uninsured patients through Susan Komen grant.

Anticipated Impact:

Beginning in September, 2016, continue Mobile Mammography in underserved neighborhoods to increase breast cancer screening.

Strategy 2: Implement Asthma Camp and Deep Breath to improve patient access to care.

Background Information

- **Target Population:** Children and Youth 9-18 years of age
- **How it Addresses Social Determinants of Health, Health Disparities and Challenges of the Underserved:** Asthma Camp is an annual camp that provides camping opportunities for youth with asthma. Deep Breath helps youth with asthma gain self-management knowledge and skills. The asthma burden in Detroit was found to be greater than the overall asthma burden in Michigan. The prevalence of current asthma among Detroit adults was 29% higher than in Michigan as a whole. The rate of hospitalizations for asthma was more than three times greater for Detroit residents than for Michigan residents as a whole. The rate of asthma hospitalizations for white persons in Detroit was about 35% less than the rate among black persons in Detroit. The rate of emergency department visits among children covered by Michigan Medicaid was twice as high in Detroit as the rate for the state as a whole (DeGuire, Cao, Wisnieski, Strane, Wahl, Lyon-Callo and Garcia, 2016).
- **Strategy Source:** Asthma Camp and Deep Breath are existing initiatives of St. John Providence. However, they may require revisions to metric plans and processes to assess outcomes.

Actions:

1. Follow participant attendance qualifications (Note: To attend Asthma Camp participants must have Asthma and participate in the Asthma program).
2. Implement selection process to include youth participants.
3. Ensure that each student has the required physical and recorded peak flow readings.
4. Implement camp and Deep Breath initiatives.
5. Evaluate outcomes and use data for continuous quality improvement.

ANTICIPATED IMPACT:

Beginning in September, 2016, continue to implement Asthma Camp and Death Breath to improve asthma self-management.

Strategy 3: Convene a transportation workgroup to develop strategies and interventions leading to improved options for transportation to obtain needed care.

Background Information

- **Target Population:** Patients/clients
- **How it Addresses Social Determinants of Health, Health Disparities and Challenges of the Underserved:** Access to affordable and reliable transportation widens opportunities and is essential to addressing poverty, unemployment, and other equal opportunity goals such as access to good schools and health care services. Nearly 20% of African-American households, 14% of Latino households, and 13% of Asian households live without a car.
- **Strategy source:** The Transportation Workgroup is a new initiative of St. John and will require policy and system changes which are to be determined. It will also require development and implementation of metrics to determine process and outcome components.

Actions:

1. Hire facilitator or consultant.
2. Develop a statement or issue brief on the problem including listing of identified current sources of transportation.
3. Convene the workgroup.
4. Complete work in no more than 6 meetings.
5. Communicate recommendations and obtain any newly identified resources for implementation.
6. Evaluate at 3, 6, and 12 months.
7. Utilize evaluation findings for continuous quality improvement.

Anticipated Impact:

Beginning in January, 2018, convene a Transportation Workgroup (TW) to plan effective strategies designed to eliminate transportation as a barrier to healthcare.

Strategy 4: Implement a Health Literacy Information and Education Series for physicians, staff and patients to improve knowledge about universal health literacy precautions and strategies for reducing health illiteracy.

Background Information

- **Target Population:** Physicians, staff and patients
- **How it Addresses Social Determinants of Health, Health Disparities and Challenges of the Underserved:** Inadequate health literacy can result in difficulty accessing health care, following instructions from a physician, and taking medication properly. Patients with inadequate health literacy are more likely to be hospitalized than patients with adequate skills (Keenan, 2005). Patients with lower health literacy have poorer medication knowledge (Mosher, Lund, Kripalani and Kaboli, 2012).
- **Strategy Source:** After participating in a health literacy training course, pharmacists' average test scores on knowledge-based questions increased (from 69.89% to 83.75%. $p < .001$). Also their comfort and confidence levels in working with patients with low health literacy increased in 5 specific areas (Mihalopoulous, Powers, Lengel and Mangal, 2013). In another study, mean knowledge scores increased significantly from 60.3% to 77.6%, $p < 0.001$, for internal medicine residents (Green, Gonzaga, Cohen and Spagnoletti, 2014).

Actions:

1. Review results from the IM-WEL2 pilot
2. Design new tools and/or revise surveys and evaluation processes for patients, physicians and staff from IM-WEL2 pilot.
3. Obtain IRB approval to conduct patient assessment and project evaluation
4. Conduct interviews with waiting patients in private area.
5. Give participants an incentive for completing survey interview.
6. Analyze survey results.
7. Utilize data for continuous quality improvement.

Anticipated Impact:

- I. Beginning in June, 2017, implement health literacy education and information sessions in all sites targeted at the patient/clients to increase their health literacy.
- II. Beginning in June, 2017, implement health literacy education and information sessions in all sites targeted at multiple staff roles to increase their knowledge and skills about health literacy

III. Mental Health and Substance Abuse

Objective: Decrease youth risk factors for suicide, depression and substance abuse.

Secondary Data: Framing the Issue

- In 2013, 27% of Michigan youth reported having depressive feelings and nearly one out of ten (8.9%) students reported having attempted suicide one or more times.^{ix}
- In 2014, suicide was the second leading cause of death for people ages 15-34 years and third leading cause of death for those ages 5-14 years, in Michigan.^x

- Rate of suicide per 100,000 was 12.0 in Wayne County and 12.7 in Oakland County. The national suicide rate is 12.6.^{xi}
- Rate of opioid related hospitalizations increased from 136%, 2000-2013.^{xii}
- Number of deaths in Michigan caused by unintentional prescription opioid overdose grew from 31 in 1999 to 384 in 2013.^{xiii}
- According to data from the National Survey on Drug Use and Health (NSDUH) from 2010-2011, 10.7% of Michigan residents aged 12 years and older reported using illicit drugs in the past month. When marijuana was excluded, the estimated dropped to 3.6%.

Goal 1: Decrease youth risk factors for suicide, depression and substance abuse.

Strategy 1: Implement the Rapid Assessment for Adolescent Preventive Services (RAAPS) as a suicide risk screening and provide mental health education, counseling and referral for youth in partner schools.

Background Information

- **Target Population:** Youth and young adults 9 –21 years of age
- **How it Addresses Social Determinants of Health, Health Disparities and Challenges of the Underserved:** The Rapid Assessment for Adolescent Preventive Services (RAAPS) is a risk screening system developed especially for the needs of young people. Communities of color tend to experience greater burden of mental and substance use disorders often due to poorer access to care; inappropriate care; and higher social, environmental, and economic risk factors. According the 2015 Michigan Epidemiological Report, in 2013, 27.0% of Michigan youth reported having depressive feelings, and nearly one out of ten (8.9%) students reported having attempted suicide one or more times. Youth with depressive feelings are at higher risk for substance abuse problems. When youth have both substance abuse problems and mental health illnesses such as depression, they are at increased risk for problems with peer and familial relationships, academics, suicide, and homelessness.

Strategy Source: RAAPS is an evidence-based assessment. Validity and reliability of the RAAPS as a measure of adolescent risk behaviors is established. Face validity was established by consensus of focus groups. Cohen kappa ranged from 0.44 to 0.99; percent inter-rater reliability agreement ranged from 0.71 to .99; Fisher exact test resulted in all $p > 0.05$ establishing criterion-related validity and equivalence. Results indicate RAAPS is an acceptable screening tool in identifying adolescent risk behaviors, contributing most to morbidity, mortality, and social problems (Salerno, Marshall, and Picken, 2012). RAAPS is an existing strategy in the partner schools.

Actions:

1. Administer RAAPS, either as paper copy or electronically through the RAAPS website, to every student age 9 and above who enters the Health Center for services and once per year on that respective students “anniversary” or annually.
2. Tally results and calculate student’s rating.

3. Have BHC review all responses to all questions and counsel as needed.
4. Make referral(s) to the appropriate referral source based on high risk responses such as recent thoughts of suicide, symptom of depression, abuse/neglect, etc. – if completed by Nurse Practitioner referral made to BHC – if completed by BHC – counseling and if needed referral or crisis response is provided).
5. Ensure crisis response, referral, and hand off as found appropriate to other agencies/hospital, etc.
6. If needed, clinician follows clinic protocol for ongoing counseling.

Anticipated Impact:

Beginning in September, 2016, continue annual RAAPS administration for youth 9-21 to determine risk factors and to plan effective counseling and interventions.

STRATEGY 2: Implement Red Flags Mental Health Education, Counseling And Referral For Youth In Partner Schools.

Background Information

- **Target Population:** Grades 5-12
- **How it Addresses Social Determinants of Health, Health Disparities and Challenges of the Underserved:** Red Flags is a framework and toolkit for school-based mental health education. The framework promotes sound mental health as an essential component of overall health. Individuals living in poverty are at particular risk for mental health illness due to an overrepresentation in homeless populations, people who are incarcerated, children in foster care and child welfare systems, and victims of serious violent crime. [Surgeon General’s Report: Mental Health, Cultural, Race, Ethnicity, 2001]
- **Strategy Source:** Red Flags is an evidence-based intervention. Pre-and post-tests showed significant increase in participants’ understanding of clinical depression after the training.

Actions:

1. BHC offers program to designated (grade appropriate) teachers in respective schools
2. BHC coordinates dates/times/sessions with teacher(s)
3. Educational sessions are implemented
4. Review of program
5. Post-test is administered
6. Each student given Red Flags in Children’s Behavior Booklets for safe keeping with signs, symptoms, prevention, intervention, treatment and resource information
7. As students identify selves or peers as needing counseling services BHC schedules individual or groups of students for assessment and counseling as appropriate.

Anticipated Impact:

Beginning in September, 2016, continue to implement Red Flags training in partner schools to increase knowledge of mental health in youth and school personnel.

Goal 2: Decrease youth and adult risk factors for suicide, depression and substance abuse.

Strategy 1: Implement Mental Health First Aid to focus on changing the community/culture and perception of persons with less than optimal mental health.

Background Information

- **Target Population:** Adults
- **How it Addresses Social Determinants of Health, Health Disparities and Challenges of the Underserved:** Mental Health First Aid is an 8-hour course that teaches one how to identify, understand and respond to signs of mental illnesses and substance use disorders. The training gives participants the skills needed to reach out and provide initial help and support to someone who may be developing a mental health or substance use problem or experiencing a crisis. Individuals living in poverty are at particular risk for mental health illness due to an overrepresentation in homeless populations, people who are incarcerated, children in foster care and child welfare systems, and victims of serious violent crime. [Surgeon General’s Report: Mental Health, Cultural, Race, Ethnicity, 2001]
- **Strategy Source:** Mental Health First Aid USA is listed in the Substance Abuse and Mental Health Services Administration’s National Registry of Evidence-based Programs and Practices. Mental Health First Aid is an international program proven to be effective. Peer-reviewed studies published in Australia, where the program originated, showed that individuals trained in the program:
 - Experienced increased knowledge of signs, symptoms and risk factors of mental illnesses and addictions.
 - Could identify multiple types of professional and self-help resources for individuals with a mental illness or addiction.
 - Increased their confidence in and likelihood to help an individual in distress.
 - Showed increased mental wellness themselves.

Evaluations in randomized controlled trials and a quantitative study have proven that the program is effective in improving trainees’ knowledge of mental disorders, reducing stigma and increasing the amount of help provided to others. Mental Health First Aid training will require a staff member to facilitate implementation of the sessions for SJP.

Actions:

1. Contact with local mental health agencies to determine current resources and schedule of training.
2. Collaborate to offer training at additional sites that serve the target population.
3. Identify and facilitate training of other individuals serving the target population.
4. Collect information on pre and post test scores.
5. Maintain a list of sites served and geographic locations....
6. Prepare reports on reach and impact of the training.

Anticipated Impact:

Beginning in January 2017, partner with St. John and community mental health partners to provide Mental Health First Aid training to staff and youth to increase their ability to detect and respond to

mental health issues in school aged children and to connect them to appropriate services.

GOAL 3: Decrease youth risk factors for post-traumatic stress disorder

Strategy 1: Utilize the Trauma Symptoms Checklist for Children to screen for posttraumatic stress and related psychological symptomatology and provide appropriate counseling and referrals.

Background Information

- **Target Population:** Youth 8-16 years of age
- **How it Addresses Social Determinants of Health, Health Disparities and Challenges of the Underserved:** Child traumatic stress occurs when children and adolescents are exposed to traumatic events or traumatic situations that overwhelm their ability to cope. The Trauma Symptom Checklist for Children (TSCC- A) is a risk screening system used to measure posttraumatic stress and related psychological symptomatology in children who have experienced traumatic events, such as physical or sexual abuse, major loss, or natural disasters, or who have been a witness to violence. Because of poverty and discrimination, racial and ethnic minority youth and families are more likely to be subjected to traumatic events, and immigrant youth and families may be particularly at risk. Cultural context and background, as well as membership in a minority group, will affect how individuals perceive a traumatic event and its impact and how the community can assist in recovery. <http://www.apa.org/pi/families/resources/children-trauma-update.aspx>. Among 536 elementary and middle school children surveyed in an inner city community, 30 percent had witnessed a stabbing and 26 percent had witnessed a shooting. Bell, C.C. & Jenkins E.J. (1993) *Community Violence and Children on Chicago's Southside*, *Psychiatry*, 56 (1): 46-54. Among middle and junior high school students (n=2248) in an urban school system, 41 percent reported witnessing a stabbing or shooting in the past year. Schwab-Stone, M.E., Ayers, T.S., Kasrow, W. & Voyce, C. (1995) *No Safe Haven: A Study of Violence Exposure in an Urban Community*, *Journal of the American Academy of Child and Adolescent Psychiatry*, 34: 1343-1352.
- **Strategy Source:** The 44-item TSCC includes two validity scales (Underresponse and Hyperresponse), six clinical scales (Anxiety, depression, Anger, Posttraumatic Stress, Dissociation, and Sexual Concerns), and eight critical items. Profile forms allow for conversion of raw scores to age and sex appropriate T scores and enable you to graph the results. The TSCC scales are internally consistent (alpha coefficients for clinical scales range from .77 to .89 in the standardization sample) and exhibit reasonable convergent, discriminant, and predictive validity in normative and clinical samples. The use of the TSCC is an existing strategy in the partner schools to help to identify suicide ideation in youth.

Actions:

1. Contact school social worker to identify students in need of peer grief support.
2. Administer TSCC to students ages 8-16.
3. Students scoring high on suicide ideation will be assessed on the same day to determine if they need hospitalization or individual counseling.
4. Have school social worker contact parent.

5. Meet with the child to discuss safety plan.
6. Schedule follow-up counseling sessions with Open Arms or another mental health agency.
7. Re-administer TSCC at the last group session.

Anticipated Impact:

Beginning in September, 2016, continue to administer the Trauma Symptoms Checklist for children and youth participating in grief support groups in partnership with local schools to determine risk factors and to plan effective counseling and interventions.

GOAL #4: Prevent and reduce addiction / mental illness in children, youth and adults (across the lifespan).

Strategy 1: Utilize the Screening, Brief Intervention, and Referral to Treatment (SBIRT)

Background Information

- **Target Population:** Individuals seeking care in Ascension Michigan emergency departments
- **How it Addresses Social Determinant of Health, Health Disparities, and Challenges of the Underserved:** SBIRT is an approach to the delivery of early intervention and treatment to people with substance use disorders and those at risk of developing these disorders. This effort reaches patients in underserved rural and urban areas through tele-health; providing SBIRT screening via trained health professionals to patients that otherwise would not have access to a behavioral health professional or whose access is generally limited to (and ends at) an emergency department visit.
- **Strategy Source:** Brief interventions are evidence-based practices design to motivate individuals at risk of substance abuse and related health problems to change their behavior by helping them understand how their substance use puts them at risk and to reduce or give up their substance use. Healthcare providers can also use brief interventions to encourage those with more serious dependence to accept more intensive treatment within the primary care setting or a referral to a specialized alcohol and drug treatment agency, Department of Health and Human Services, Centers for Medicare & Medicaid Services: Screening, Brief Intervention, and Referral to Treatment (SBIRT) Services, October, 2015. Also referencing “Fleming MF, Barry KL, Manwell LB, Johnson K, Jondon R. Brief physician advice for problem alcohol drinkers. A randomized controlled trail in community-based primary care practices. Journal of the American Medical Association. 1997; 277(13):103-1045.”

Actions:

1. Provide SBIRT to emergency department patients.
2. Educate patients on risks associated with alcohol and other stimulants.
3. Refer patients for follow-on care where appropriate.
4. Provide treatment services at Brighton Center for Recovery to patients as required.
5. Determine and implement process and outcome evaluation.
6. Provide regularly scheduled report of evaluation data.
7. Utilize evaluation findings for continuous program improvement.

Anticipated Impact:

Beginning in October, 2016 screen 15 – 25 patients per day in Ascension Michigan emergency departments based upon referral, with a focus on learning risk factors related to addiction.

Strategy 2: Provide family education to families involved with and at risk for substance use disorders.

Background Information

- **Target Population:** Individuals seeking family education services at Brighton Center for Recovery.
- **How it Addresses Social Determinant of Health, Health Disparities, and Challenges of the Underserved:** Family education on addiction is a key public health goal due to the stigma associated with the disease. Providing channels for addiction and mental health education to families and minors is thus an important contribution to the health of underserved communities that generally lack access to these type of interventions.
- **Strategy Source:** Arria AM, Mericle AA, Rallo D, Moe J, White WL, Winters KC, O'Connor G. *Integration of Parenting Skills Education and Interventions in Addiction Treatment*. Journal of Addiction Medicine. 2013;Jan-Feb;7(1):1-7. Moe J, Johnson JL, Wade W. *Resilience in Children of Substance Users: in their Own Words*. Substance Use & Misuse Journal. 2007;42(2-3):381-98

Actions:

1. Provide family education sessions twice weekly (Wednesday / Saturday) year round.
2. Educate families on prevention of addiction and how to support a family member who is in recovery.
3. Hold monthly 4-day prevention and education programs for minors who have parents in recovery.
4. Determine and implement process and outcome evaluation.
5. Provide regularly scheduled report of evaluation data.
6. Utilize evaluation findings for continuous program improvement.

Anticipated Impact:

Beginning July, 2016 educate a minimum of 75 individuals every Wednesday and Saturday on ways to prevent addiction and on how to support family members who are in recovery. Also, provide monthly prevention / education sessions to minors related to addiction.

VI. Appendix

CHNA Steering Committee 2015-2016			
Ron Beford	Executive Director, Interfaith Health and Hope Coalition	Daphne Marbury	Lead, St. John Community Health
Karen Beger	Director, St. John Community Health	Dr. Annette Mercatante	Health Officer/Medical Director, St. Clair County Health Department
Steve Candela	Director, Eastwood Clinics	George Miller	Director at Oakland County Health Department
Michele Ciokajlo	Director, Strategic Planning	Chelsea Moxlow	Health Promotion and Accreditation Coordinator, Livingston County Health Department
Ken Coleman	Director, St. John Community Health	Dr. Beena Nagappala	St. John Community Health Medical Director
Laura Dailey-Pelle	Director, Radiation Therapy	Mary O'Brien	Community Outreach Coordinator
Dr. Abdul El-Sayed	Executive Director and Health Officer, Detroit Health Department	Bill Ridella	Director and Health Officer, Macomb County Health Department
Kristin Finton	Lead, St. John Community Health	David Rupprecht	Lead, St. John Community Health
Karen Gray Sheffield	Director, St. John Community Health	Madiha Tariq	Public Health Manager, ACCESS
Jonnie Hamilton	Manager, School-Based Health Centers	Cynthia Taueg	Vice President, St. John Providence
Sharonlyn Harrison	President/CEO Public Research and Evaluation Services	Dr. Jamila Taylor	Family Medicine Physician, St. John Providence
Carrie Hribar	Planning and Evaluation Supervisor, Oakland County Health Department	Erica Thrash-Sall	Lead, St. John Community Health
Cassandra Jackson	Lead, St. John Community Health	Raymond Waller	Director, Brighton Center for Recovery
Sandra King	Lead, St. John Community Health	Thomas Wehner	Consultant, St. John Providence-Communications
Bianca Lawrence	Special Projects Liaison, Detroit Health Department	Dr. Michael Wiemann	President, Providence Hospital

Major Partners

ACCESS
Advantage Health Care
Arab-Chaldean Council
CARE
Clintondale Community Schools
Covenant Community Care
Crime Stoppers
Detroit Health Department
Detroit Public Schools
Detroit Wayne County Mental Health
Eastside Community Network
Education Achievement Authority
GDHAC
Macomb County Community Mental Health
Macomb County Health Department
Macomb County office of Substance Abuse and Community Mental Health
Mercy Primary Care
Northeast Guidance Center
Oak Park Schools
Oakland County Community Mental Health
Oakland County Health Department
Oakland County Health Department
Susan G. Komen Foundation
Warren Consolidated Schools
WIC

Implementation Strategies Steering Committee 2015-2016

Karen Beger	Director, St. John Community Health
Ken Coleman	Director, St. John Community Health
Kristin Finton	Lead, St. John Community Health
Karen Gray Sheffield	Director, St. John Community Health
Jonnie Hamilton	Manager, School-Based Health Centers
Sharonlyn Harrison	President/CEO Public Research and Evaluation Services
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Sandra King	Lead, St. John Community Health
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David Rupprecht	Lead, St. John Community Health
Cynthia Taueg	Vice President, St. John Providence
Erica Thrash-Sall	Lead, St. John Community Health

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ⁱⁱⁱ County Health Rankings Road Map, retrieved <http://www.countyhealthrankings.org/>

^{iv} County Health Rankings Road Map, retrieved <http://www.countyhealthrankings.org/>

^v Michigan Department of Health and Human Services, retrieved <http://www.mdch.state.mi.us/PHA/OSR/deaths/causrankcnty.asp>

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^{viii} County Health Rankings Road Map, retrieved <http://www.countyhealthrankings.org/app/michigan/2016/measure/factors/4/map>

^{ix} Michigan Epidemiological Profile, April 2015, Behavioral Health and Developmental Disabilities Administration: Office of Recovery Oriented Systems of Care, Michigan Department of Health and Human Services

^x Michigan Department of Health and Human Services, retrieved <http://www.mdch.state.mi.us/pha/osr/deaths/LeadingAgeSpecificCauseTotal2014.asp>

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^{xii} Michigan Inpatient Database, Division for Vital Records and Health Statistics, Michigan Department of Health and Human Services (MDHHS). *Drug-related inpatient discharges by category, type of drug and year, Michigan, 2000-2013.*

^{xiii} Centers for Disease Control and Prevention, National Center for Health Statistics. Multiple Cause of Death 1999-2013 on CDC WONDER Online Database, released 2015. Data are from the Multiple Cause of Death Files, 1999-2013. Accessed at <http://wonder.cdc.gov/mcd-icd10.htm>