

Fiscal Years 2020 – 2022

Ascension Southeast Michigan Hospitals Community Health Implementation Strategy

Conducted: FY 2019 (July 1, 2018 – June 30, 2019)



Ascension

Ascension Southeast Michigan Hospitals Implementation Strategy

Implementation Strategy Narrative

Overview

Ascension St. John Providence hospitals, now rebranded as Ascension Southeast Michigan, is a non-profit Catholic health system comprised of five hospitals and over 125 medical facilities, located within southeast Michigan. We are required 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 Ascension St. John Providence 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. Ascension St. John Providence serves five counties in the southeast Michigan area which are Livingston, Macomb, Oakland, St. Clair, and Wayne County including the city of Detroit.

The CHNA process is an essential objective of Ascension Southeast Michigan. The CHNA aligns with the Ascension Mission statement that calls us to serve all persons with special attention to those who are poor and vulnerable. The Ascension St. John Providence CHNA assesses the communities of each of our hospital service areas to understand the health issues and needs of those residing there.

The FY 2019 CHNA will cover the hospitals in the Ascension Southeast Michigan area, which are:

1. Ascension Brighton Center for Recovery

*** Ascension Brighton Center for Recovery is a specialty hospital which focuses on mental health and substance abuse treatment.*

2. Ascension Macomb-Oakland Hospital, Warren Campus, Madison Heights Campus
3. Ascension Providence Hospital, Southfield Campus, Novi Campus
4. Ascension River District Hospital
5. Ascension St. John Hospital

Ascension SE MI Community Health is responsible for leading the CHNA process for all Ascension SE MI hospitals. The Center for Population Health, Southeastern Michigan Health Association (SEMHA) was contracted to provide extensive local, national, state, and regional hospital utilization data and statistics to assist the CHNA steering committee in prioritizing the needs of our service areas.

On April 1, 2019, a prioritization meeting of key stakeholders convened to provide guidance and oversight in the development of the CHNA priorities. The meeting attendees included 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. The secondary data, as well as primary data (community survey), enabled the meeting attendees to gain further insight into the needs and gaps in the hospital service area.

To select the top health priorities, we utilized the Hanlon Method approach. The Hanlon Method list those health needs to be viewed as priorities based on baseline data, numeric values, and feasibility factors.

After group discussion led by the Center for Population Health, SEMHA, our health issues were ranked from high to low.

Needs That Will Be Addressed

After completing the Hanlon Method prioritization with internal and external key stakeholders, the

CHNA steering committee conducted a final prioritization assessment based on the following relevant factors for each Hanlon Method priority:

1. Feasibility/ability to make a measurable impact
2. List of known/existing evidence-based programs and/or other interventions
3. Potential partners/partnership opportunities

The CHNA Steering committee finalized the top three priorities as the following:

- **Obesity Reduction and Diabetes Prevention** including high blood pressure, high cholesterol, diabetes, physical activity and fruit, and vegetable consumption
- **Mental Health/Substance Abuse Prevention**, including depression, suicide, stress and anxiety, and substance abuse intervention.
- **Improving Maternal/Infant Health**, including infant mortality prevention, adequate prenatal care, breastfeeding, safe sleep, and smoking cessation.

Needs That Will Not Be Addressed

The following needs will not be addressed in the FY 2019 CHNA report:

Access to care was identified as a need by the Hanlon Method prioritization. However, the CHNA steering committee confirmed through the final prioritization assessment that it is a low priority need. Due to MI Medicaid expansion, a large amount of the population in the SE MI area have health insurance and a primary care provider. Also, it would be challenging to make a measurable impact on health insurance cost. Also, the utilization of a primary care provider, and routine check-ups are behavioral activities that can be encouraged through education from the main three priorities.

A sub-category under Access to care is adequate prenatal care that will be addressed under the Improving Maternal/Infant Health priority.

Healthy behaviors priority included the sub-categories of smoking and safe sleep identified from the Hanlon Method prioritization. Based on the CHNA steering committee final prioritization assessment, this is a priority that coincides with the sub-categories of the main three priority areas. It would be more feasible to address healthy behaviors under the top three priority areas.

Other health issues identified by the Hanlon Method that were not selected as a top priority were **cancer, cardiovascular disease, arthritis, and asthma.**

These health issues were identified but not selected as a priority because of the following:

1. These health issues ranked lower on the Hanlon Method scoring than other health issues.
2. The CHNA steering committee evaluated each issue and concluded that there is an inability to measure impact for cancer, cardiovascular disease, and arthritis.
3. The health issue of Asthma continues to be addressed in our school-based health centers through our Asthma Camp and Deep Breathing programs.
 - An existing Michigan initiative titled AIM, Asthma Initiative of MI is addressing strategies for common issues in asthma.
4. The priority, Obesity reduction and Diabetes prevention will address the prevention of secondary/tertiary outcomes of cardiovascular disease.

Summary of Implementation Strategy

Prioritized Need #1: Obesity reduction and Diabetes Prevention

Goal 1: Increase access to weight reduction programs/services for individuals living with excess weight (overweight and obesity)

**Overweight and obesity definition: Weight that is higher than what is considered as a healthy weight for a given height is described as overweight or obese. Body Mass Index, or BMI, is used as a screening tool for overweight or obesity.¹*

Strategy: Utilize the Ascension SE MI Wellness centers to implement physical activities through exercise classes, creation of dedicated walk paths on hospital campuses for associates and the public, and partnerships with other fitness organizations to increase awareness, knowledge, and behaviors for preventing and reducing obesity.

Goal 2: To identify pre-diabetic adults (age 18 years and older) and provide education, programs and services to delay the onset of type 2 diabetes

Strategy: Implement the Centers for Disease Control and Prevention (CDC) Diabetes Prevention Program (DPP) 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.

Goal 3: Identify children living with obesity in the Tri-county area (Oakland, Macomb, and Wayne) through an Ascension SE MI school-based health centers

Strategy: 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.

Prioritized Need #2: Mental Health/Substance abuse prevention

Goal 1: Provide access to mental health programs/services for children, youth, and adults

Strategy 1: Increase access to mental health programs/services for children, youth, and adults, through the Ascension SE MI Community health school-based health centers and referrals to Eastwood clinics from the Ascension SE MI hospitals and physician offices.

Goal 2: 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.

Prioritized Need #3: Improving Maternal and Infant Health

Goal: Improve the health and well-being of women and infants

¹ Centers for Disease Control and Prevention (CDC). (n.d.). Retrieved from <https://www.cdc.gov/obesity/adult/defining.html>.

Strategy: Implement the Maternal Infant Health Program (MIHP), which provides evidence-based services to improve awareness, knowledge, and behaviors for preventing maternal mortality and infant mortality for communities, including vulnerable and at-risk populations.

An implementation plan follows for each priority area, including the resources, proposed actions, planned collaboration, and anticipated impact of the actions.

Prioritized Need #1: Obesity reduction and Diabetes prevention

GOAL 1: Increase access to weight reduction programs/services for individuals living with excess weight (overweight and obesity)

**Overweight and obesity definition: Weight that is higher than what is considered as a healthy weight for a given height is described as overweight or obese. Body Mass Index, or BMI, is used as a screening tool for overweight or obesity.²*

Action Plan

STRATEGY: Utilize the Ascension SE MI Wellness centers to implement physical activities through exercise classes, creation of dedicated walk paths on hospital campuses for associates and the public, and partnerships with other fitness organizations to increase awareness, knowledge, and behaviors for preventing and reducing obesity.

BACKGROUND INFORMATION:

- **Target Population:** Adults
- **How it Addresses Social Determinant of Health, Health Disparities, and Challenges of the Underserved:** The Ascension SE MI Wellness Centers in Macomb, Oakland, and Wayne County provide access to free and low cost physical activity classes to address the need of little to no physical activity. The locations are centrally located to provide physical activity access to populations with low socioeconomic status and diverse communities. Based on the secondary data from the Ascension SE MI hospital FY 2019 CHNA, 19.0% of Livingston county residents reported “no leisure time physical activity”, 25.2% of Macomb county residents, 21.0% of Oakland county residents, 26.9% of St. Clair county residents and 25.1% of Wayne county residents.³ By providing additional hours to the wellness centers and partnering with local parks and recreation centers and other fitness organizations, it will increase the number of physical activity access points for southeast Michigan residents. In addition, walkable paths on the hospital campuses is another avenue for increased physical activity for the community and Ascension SE MI employees.
- **Strategy Source:** The Community Preventive Services Task Force informs that access to parks, green space, and a built environment are essential for physical activity and it contributes to individual, social, economic and environmental benefits ⁴.

RESOURCES:

- Ascension SE MI Wellness Centers
- Ascension SE MI Community Health Department (ASEMICH)

COLLABORATION:

- Other identified fitness organizations

ACTIONS:

1. Beginning in July 2019, disseminate information to increase awareness of activities offered at each

² Centers for Disease Control and Prevention (CDC). (n.d.). Retrieved from <https://www.cdc.gov/obesity/adult/defining.html>.

³ Source: MDHHS BRFSS, 2014-2016 and 2013-2015*. Prepared By: Center for Population Health/Southeastern Michigan Health Association (SEMHA)

⁴ Stasi, S., Spengler, J., Maddock, J., McKyer, L., & Clark, H. (2019). Increasing access to physical activity within low income and diverse communities: A systematic review. *American Journal of Health Promotion*, 33(6), 933-940. doi:10.1177/0890117119832257

STRATEGY: Utilize the Ascension SE MI Wellness centers to implement physical activities through exercise classes, creation of dedicated walk paths on hospital campuses for associates and the public, and partnerships with other fitness organizations to increase awareness, knowledge, and behaviors for preventing and reducing obesity.

wellness center via publications and community and faith-based partnership sites.

2. Beginning in July 2019, continue Enhance Fitness classes at ASEMICH Wellness Centers.
3. Beginning in September 2019, explore opportunities to partner with service area counties parks and recreation departments.
4. Beginning in January 2020, plan discussion and coordination of mapped walking paths on (1) Ascension SE MI hospital campuses.

ANTICIPATED IMPACT:

- I. Beginning in July 2019, continue to implement Enhance Fitness in the current wellness centers (Southfield, Riverview, and Macomb) to increase health and physical performance of the participants.
- II. By June 30, 2020, Southfield Wellness center will offer an additional 2 hours per week in the evening.
- III. By June 30, 2020, Ascension SE MI Community Health Wellness Centers will increase new member participation rate from 2.65% to 5.0%.
- IV. By June 30, 2020, 80% of Enhance Fitness participants will self-report at least an 50% improvement in their physical activity.

Alignment with Local, State & National Priorities

OBJECTIVE:	LOCAL / COMMUNITY PLAN:	STATE PLAN:	"HEALTHY PEOPLE 2020" (or OTHER NATIONAL PLAN):
I, V	N/A	The goal of Michigan's Nutrition, Physical Activity, and Obesity (NPAO) Program is to prevent and control obesity and other chronic diseases through healthful eating and physical activity.	PA-2.1 Increase the proportion of adults who engage in aerobic physical activity of at least moderate intensity for at least 150 minutes/week, or 75 minutes/week of vigorous intensity, or an equivalent combination

GOAL 2: To identify pre-diabetic adults (age 18 years and older) and provide education, programs and services to delay the onset of type 2 diabetes.

Action Plan

STRATEGY: Implement the Center for Disease Control and Prevention 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 (age 18+)
- **How it Addresses Social Determinant of Health, Health Disparities, and Challenges of the Underserved:** The Center for Disease Control and Prevention 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. It is an evidence-based, affordable, and high-quality lifestyle change programs to reduce their risk of type 2 diabetes and improve their overall health.
- **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.

RESOURCES:

- Ascension SE MI Community Health Department (ASEMICH)
- Ascension SE MI hospitals
- Ascension Weight Loss Program
- Community Partners

COLLABORATION:

- Greater Detroit Area Health Council (GDAHC), Southeast Michigan Hospital Collaborative

ACTIONS:

1. Beginning in July 2019, disseminate information to increase awareness of DPP via the CareLink publication.
2. Beginning in July 2019, implement and refine process to receive referrals into DPP from one of the following: Emergency Department, SE MI Hospital, AMG Practice and/or community partners
3. Beginning in October 2019, explore pilot for referrals into DPP from the Ascension weight loss program.
4. Beginning in FY 2020, plan and initiate a 33.3% increase in DPP cohorts for the fiscal year.
5. Beginning in FY 2020, implement the revised CDC pre-diabetes screening tool ("Are you at risk?" document) at 4 Community events/per quarter that focus on healthy living/nutrition. (Document used to identify participants that need to follow up with PCP and possibly be eligible for DPP)
6. In FY 2020, retain 80% of participants after session #16 of the 16 weeks of the DPP cohorts.

ANTICIPATED IMPACT:

- I. Beginning in July 2019, implement DPP in community partnership sites with adults with

STRATEGY: Implement the Center for Disease Control and Prevention 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.

- prediabetes and reduce their diabetes risk.
- II. Beginning in FY 2020, increase number of DPP cohorts from 6 cohorts per fiscal year to 8 cohorts per fiscal year.
- III. By the end of June 30, 2020, 50% of the participants enrolled in a DPP cohort that began in FY 2019 will decrease weight by at least 5% or more.
- IV. By June 30, 2020, retain 80% of participants after session #16 of the 16 weeks of the DPP cohorts that began in FY 2019 and carried over into FY 2020.

Alignment with Local, State & National Priorities

OBJECTIVE:	LOCAL / COMMUNITY PLAN:	STATE PLAN:	“HEALTHY PEOPLE 2020” (or OTHER NATIONAL PLAN):
I, II	<p>The Southeast Michigan Hospital Collaborative (SEMI-HC) is an integrated, collaborative approach to reduce diabetes in the region. The SEMI-HC focuses on preventing diabetes through the CDC’s Diabetes Prevention Program (DPP). The work of the Collaborative will initially focus on six Detroit-area zip codes. These zip codes were identified as being areas of critical need due to the level of inequities in health outcomes and the high occurrence of chronic disease.</p>	<p>Increase clinical prediabetes screening and testing and referrals of high-risk patients to DPPs</p>	<p>D-16: Increase prevention behaviors in persons at high risk for diabetes with prediabetes D-16.2: Increase the proportion of persons at high risk for diabetes with prediabetes who report trying to lose weight D-16.3: Increase the proportion of persons at high risk for diabetes with prediabetes who report reducing the amount of fat or calories in their diet</p>

GOAL 3: Identify children living with obesity in the Tri-county area (Oakland, Macomb, and Wayne) through an Ascension SE MI school-based health centers.

Action Plan

STRATEGY: 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 in diverse and underserved communities.

BACKGROUND INFORMATION:

- **Target Population:** Students in school-based health centers ages 5-18 years
- **How it Addresses Social Determinant of Health, Health Disparities, and Challenges of the Underserved:** With 5-2-1-0, youth from low-income families have access to obesity prevention/reduction services.
- **Strategy Source:** An evaluation of the 5-2-1-0 program with the Maine Youth Overweight Collaborative (MYOC), found a decreasing trend in the rate of obesity prevalence among middle and high school students.⁵

RESOURCES:

- Ascension SE MI Community Health Department
- Ascension MI School-Based Health Centers (SBHC)

COLLABORATION: *(List partner organizations and/or community groups that will collaborate on strategy)*

- Partner schools (Elementary and middle schools with an Ascension MI School-Based Health Center)

ACTIONS:

1. Beginning September 2019, screen all students on their initial visit to the SBHC for obesity (BMIs > 85%).
2. Beginning September 2019, screen all high school students on their initial visit to the SBHC for diabetes (BMIs > 85%).
3. Beginning September 2019, enroll students that visit the SBHC with BMIs >85% into the 5-2-1-0 program.
4. Beginning September 2019, send informed notification of student enrollment into the 5-2-1-0 program to parents.
5. Beginning September 2019, implement the six-week 5-2-1-0 program within the partner schools.
6. Beginning September 2019, expand the 5-2-1-0 program to 3 additional schools outside of the Tri-County area.

ANTICIPATED IMPACT:

- I. Beginning in September 2019, continue to implement the 5-2-1-0 program, including education,

⁵ Gortmaker, S. L., Polacsek, M., Letourneau, L., Rogers, V. W., Holmberg, R., Lombard, K. A., ... Orr, J. (2015). Evaluation of a primary care intervention on Body Mass Index: The Maine Youth Overweight Collaborative. *Childhood Obesity*, 11(2), 187-193. doi:10.1089/chi.2014.0132

STRATEGY: 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 in diverse and underserved communities.

parental outreach, advanced clinical testing and weight monitoring in school-based clinics for youth with a BMI >85%, resulting in reduced BMI.

- II. By June 30, 2020 (End of FY 2020), increase 5-2-1-0 participant’s knowledge of healthy eating and physical activity by 96%.
- III. By June 30, 2020 (End of FY 2020), 5-2-1-0 participants will increase their healthy eating and exercise by 95%.

Alignment with Local, State & National Priorities

OBJECTIVE:	LOCAL / COMMUNITY PLAN:	STATE PLAN:	“HEALTHY PEOPLE 2020” (or OTHER NATIONAL PLAN):
I	Make changes that can be measured in childhood obesity rates. Changes will be measured against the county health rankings data.	The goal of Michigan's Nutrition, Physical Activity, and Obesity (NPAO) Program is to prevent and control obesity and other chronic diseases through healthful eating and physical activity.	NWS- 10: Reduce the proportion of children and adolescents who are considered obese ECBP-2.8: Increase the proportion of elementary, middle, and senior high schools that provide comprehensive school health education to prevent health problems in unhealthy dietary patterns ECBP-2.9: Increase the proportion of elementary, middle, and senior high schools that provide comprehensive school health education to prevent health problems in inadequate physical activity

Prioritized Need #2: Mental Health/Substance abuse prevention

GOAL 1: Increase access to mental health programs/services for children, youth, and adults.

Action Plan

STRATEGY: Increase access to mental health programs/services for children, youth, and adults, through the Ascension SE MI Community health school-based health centers and referrals to Eastwood clinics from the Ascension SE MI hospitals and physician offices.

BACKGROUND INFORMATION:

- **Target population:** Children, youth, and adults
- **How it Addresses Social Determinants of Health, Health Disparities and Challenges of the Underserved:** Access to quality mental health services is essential to the well-being of individuals overall health. Mental health plays a major role in people’s ability to maintain good physical health.⁶
- **Strategy source:** Supporting and continuing the work of Michigan’s Mental Health and Wellness Commission that dissolved in 2015. The goal of the commission was to make certain Michiganders living with mental health conditions could find a great quality of life, safety, and independence.⁷

RESOURCES:

- Ascension SE MI Community Health Department
- Ascension MI School-Based Health Centers
- Eastwood clinics
- Ascension SE MI hospitals

COLLABORATION:

- Partner schools (Elementary, middle, and high schools with an Ascension MI School-Based Health Center)

ACTIONS:

1. Beginning in September 2019, expand mental health services in 3 school-based health clinics.
2. Beginning in July 2019, continue implementation of auto-referrals from physician offices and hospitals to mental health services (Eastwood).
3. Beginning in July 2019, explore opportunity for substance abuse acute care facility.

ANTICIPATED IMPACT:

- I. By June 30, 2022, expansion of mental health services in 3 school-based health centers.
- II. By June 30, 2020, 40% of the auto-referrals received into the Eastwood clinics will be converted to scheduled appointments.

⁶ Healthy People 2020 [Internet]. Washington, DC: U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion [cited August 20, 2019].

⁷ Michigan Department of Health and Human Services (MDHHS). (n.d.). Retrieved from the Mental Health Commission website at <https://www.michigan.gov/mentalhealth/>

Alignment with Local, State & National Priorities

OBJECTIVE:	LOCAL / COMMUNITY PLAN:	STATE PLAN:	“HEALTHY PEOPLE 2020” (or OTHER NATIONAL PLAN):
I, II		Michiganders living with mental health conditions could find a great quality of life, safety, and independence.	

GOAL 2: Decrease youth risk factors for suicide and depression

Action Plan

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 to 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:** RAPPs is an evidence-based assessment. Validity and reliability of the RAAPS as a measure of adolescent risk behaviors is established.

RESOURCES:

- Ascension SE MI Community Health Department
- Ascension MI School-based health centers

COLLABORATION:

- Partner schools (Elementary, middle, and high schools with an Ascension MI School-Based Health Center)

ACTIONS:

1. Beginning September 2019, annually, administer RAAPS, either as paper copy or electronically through the RAAPS website, to every student age 9 and above who enters the School Based

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.

- Health Center for services and once per year on that respective students “anniversary” or annually.
2. Beginning in September 2019, make referral(s) for students to the appropriate referral source based on high risk responses related to suicide and symptoms of depression.
 3. Beginning in September 2019, provide counseling in the SBHCs to students age 9 and above that identify with signs of depression and/or suicidal thoughts.

ANTICIPATED IMPACT:

- I. Beginning in September 2019, continue annual RAAPS administration for youth 9-21 to determine risk factors and to plan effective counseling and interventions.

Alignment with Local, State & National Priorities

OBJECTIVE:	LOCAL / COMMUNITY PLAN:	STATE PLAN:	“HEALTHY PEOPLE 2020” (or OTHER NATIONAL PLAN):
I	N/A	N/A	MHMD-1: Reduce the suicide rate MHMD-2: Reduce suicide attempts by adolescents MHMD-6: Increase the proportion of children with mental health problems who receive treatment

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. Individuals living in poverty are at 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.

RESOURCES:

- Ascension SE MI Community Health Department
- Ascension MI School-based health centers

COLLABORATION:

- Partner schools (Elementary, middle, and high schools with an Ascension MI School-Based Health Center)

ACTIONS:

1. Beginning September 2019, implement the Red Flags program in the current 12 SBHCs with planning and implementation into 4 new SBHCs behavioral health sites.
2. Beginning September 2019, 400 – 500 students will be trained in the Red Flags mental health education.

ANTICIPATED IMPACT:

- I. Beginning in September 2019, continue to implement Red Flags training in partner schools to increase knowledge of mental health in youth.
- II. By June 30, 2020, students will increase their knowledge of signs, symptoms and information of mental health by 80%.

Alignment with Local, State & National Priorities

OBJECTIVE:	LOCAL / COMMUNITY PLAN:	STATE PLAN:	“HEALTHY PEOPLE 2020” (or OTHER NATIONAL PLAN):
I	N/A	N/A	ECBP 2.4: Increase the proportion of elementary, middle, and senior high

schools that provide comprehensive school health education to prevent health problems in suicide

ECBP 2.5: Increase the proportion of elementary, middle, and senior high schools that provide comprehensive school health education to prevent health problems in tobacco use and addiction

ECBP 2.6: Increase the proportion of elementary, middle, and senior high schools that provide comprehensive school health education to prevent health problems in alcohol and other drug use

Prioritized Need #3: Improving maternal and infant health

GOAL: Improve the health and well-being of pregnant women and infants

Action Plan

STRATEGY 1: Increase the utilization of the Maternal Infant Health Program (MIHP), which provides evidenced based services to improve awareness, knowledge and behaviors for preventing maternal mortality and infant mortality for communities, including vulnerable and at-risk communities.

BACKGROUND INFORMATION:

- **Target population:** Adults (pregnant women) and infants
- **How it Addresses Social Determinants of Health, Health Disparities and Challenges of the Underserved:** Home visiting providers (including social workers, community health workers, nurses, etc.) coach, educate, offer encouragement, and connect parents with community resources with the goal that all children grow and develop in a safe and stimulating environment. Home visiting focuses on the health of mother and baby, and the baby's subsequent growth and development through the child's entrance into kindergarten.
- **Strategy source:** Michigan's 2016-2019 Infant Mortality Reduction Plan has completed research with supported data that home visiting and supporting programs will assist in reducing infant mortality and promoting healthy mothers and babies.

RESOURCES:

- Ascension SE MI Community Health Department
- Maternal Infant Health Program
- Ascension SE MI Hospitals
- AMG Practices

ACTIONS: *(List main actions needed to implement strategy and achieve the SMART objectives above)*

1. Beginning in July 2019, increase referrals to the MIHP program from the Wayne county hospital (Ascension St. John), and expand outreach for referrals from the Macomb and Oakland hospitals.
2. Beginning in July 2019, explore opportunities to provide transportation to mothers for prenatal/postnatal visits.
3. Beginning in July 2019, explore opportunities for a pilot program that auto-refers pregnant women from one of the Ascension SE MI hospitals or an AMG practice to the MIHP.

ANTICIPATED IMPACT:

- I. Beginning in July 2019, continue to implement the Maternal Infant Health program (MIHP), with expansion in the Tri-county area (Macomb, Oakland, and Wayne counties).
- II. By June 30, 2020, 65% of women seen by Ascension physicians and enrolled in MIHP will achieve adequate prenatal care (7 to 13 prenatal care visits).
- III. By June 30, 2020, increase women's knowledge in breastfeeding benefits by 85%.
- IV. By June 30, 2020, increase women's knowledge in safe sleep practices by 85%.

Alignment with Local, State & National Priorities

OBJECTIVE:	LOCAL / COMMUNITY PLAN:	STATE PLAN:	“HEALTHY PEOPLE 2020” (or OTHER NATIONAL PLAN):
I	Southeast Michigan Perinatal Quality Improvement Coalition (SEMPQIC)- Create a coordinated network for delivery of home visiting services and other supports for high-risk babies and mothers, building on existing services and addressing the social determinants of health	Michigan 2016-2019 Infant Mortality Reduction Plan will engage a broad and diverse group of stakeholders committed to a collective effort to reduce infant mortality and promote healthy mothers, babies, and families.	MICH-10 Increase the proportion of pregnant women who receive early and adequate prenatal care MICH-10.1 Increase the proportion of pregnant women who receive prenatal care beginning in the first trimester MICH-10.2 Increase the proportion of pregnant women who receive early and adequate prenatal care

STRATEGY 2: Increase access and participation to parenting classes for pregnant women and mothers with infants less than a year.

BACKGROUND INFORMATION:

- **Target population:** Adults (parents), women, pregnant women.
- **How it Addresses Social Determinants of Health, Health Disparities and Challenges of the Underserved:** The parenting classes serve at-risk pregnant women and their families in an effort to produce healthy maternal outcomes, as well as reduce the number of infant deaths at birth and during the first year of life. The support groups emphasize peer support, availability of community services, parenting skills, adult and child safety, a safe sleep workshop, literacy and education, health screening and promotion, and domestic violence education.
- **Strategy source:** Previous research and evidence has shown that community-based care and interventions, such as parenting classes help improve the health outcomes of the mother and infant.⁸ In addition, this type of care and interventions provide access to quality care for at-risk populations that would otherwise have a lack of access due to the social determinants of health.

RESOURCES:

- Ascension SE MI Community Health Department
- Maternal Infant Health Program
- Ascension SE MI Hospitals

COLLABORATION:

- Community partners of Ascension SE MI Maternal Infant Health Program

ACTIONS:

1. Beginning in July 2019, offer the parenting classes to pregnant women and mothers with infants less than a year old.
2. Beginning in July 2019, plan and initiate the incorporation of an evidence-based curriculum to the current parenting classes program.
3. Beginning in July 2019, develop a transportation process coordinated for participants to attend parenting classes.

ANTICIPATED IMPACT:

- I. By June 30, 2020, increase participation in the parenting classes by 20%.
- II. By June 30, 2020, increase participants knowledge of infant/child health and safety education by 65%.

⁸ Lassi ZS, Kumar R, Bhutta ZA. Community-Based Care to Improve Maternal, Newborn, and Child Health. In: Black RE, Laxminarayan R, Temmerman M, et al., editors. Reproductive, Maternal, Newborn, and Child Health: Disease Control Priorities, Third Edition (Volume 2). Washington (DC): The International Bank for Reconstruction and Development / The World Bank; 2016 Apr 5. Chapter 14. Available from: <https://www.ncbi.nlm.nih.gov/books/NBK361898/> doi: 10.1596/978-1-4648-0348-2_ch14