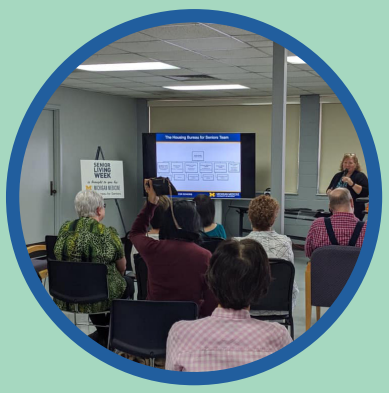
2021 Community Health Needs Asessment







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I. EXECUTIVE SUMMARY

Background

In 2021, as in 2016 and 2019, St. Joseph Mercy Ann Arbor (SJMAA), St. Joseph Mercy Chelsea (SJMC), and Michigan Medicine (MM) convened for the third time to conduct a single Community Health Needs Assessment (CHNA) for the shared geographic region of greater Washtenaw County. With facilitation support from the Washtenaw Health Initiative (WHI), the collaborative, known as the Unified Needs Assessment Implementation Plan Team Engagement (UNITE), assembled and assessed data in partnership with Washtenaw County Public Health Department and area health coalitions. The CHNA was completed in 2021 (a year ahead of schedule) in order to align with the timeline of all Trinity hospitals across the state of Michigan and align priorities in the midst of the ongoing COVID-19 pandemic.

Identification and Prioritization of Needs

- Members of the UNITE group analyzed data from multiple data sources, community focus groups, and stakeholder surveys to determine potential priority areas.

- The data shows that the three priority areas identified in the 2016 and 2019 CHNAs continue to be significant areas of need across the community. Therefore, the UNITE group agreed to keep the same priority areas for the 2021 CHNA. These priorities are:

    - Mental Health and Substance Use Disorders
    - Obesity and Related Illnesses
    - Pre-conceptual and Perinatal Health

- In 2021, updated sources were analyzed to determine the impact of COVID-19 on the previously identified priority areas. Additionally, throughout the year, community engagement through town halls, individual hospital engagements with community stakeholders, listening sessions and surveys through affiliated partners, and a final survey were conducted to understand the landscape of community need. It was determined that the issues prioritized in the prior needs assessment are, indeed, still a priority and the social determinants of health that influence the priority areas have been further exacerbated by COVID-19.

- The selected priorities—outlined in the pages that follow—were analyzed through the lens of social determinants of health (SDOH) and health equity, reflecting the hospitals' commitment to addressing upstream factors that contribute to poor health, and presented for approval and adoption to each hospital's executive board and were approved by St. Joseph Mercy Ann Arbor June 23, 2021, by St. Joseph Mercy Chelsea June 24, 2021, and by Michigan Medicine June 3, 2021.

II. INTRODUCTION

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

In 2021, for the third time, the group titled UNITE (Unified Needs Assessment Implementation Plan Team Engagement) composed of the three hospitals in Washtenaw County; St. Joseph Mercy Ann Arbor, St. Joseph Mercy Chelsea and Michigan Medicine engaged the community and collaborated to assess and address community needs together. Each hospital also utilized the same community level data and surveys to identify these needs. To improve service to the community and to increase the impact of the implementation plan, each hospital made a commitment to come together and publish a collaborative CHNA. The Washtenaw County Health Department also sits at the UNITE table as a critical partner in this work.

In 2020, the global COVID-19 pandemic caused immediate priorities to shift amongst health systems across the country and in our immediate area to address the influx of patients impacted by COVID-19. Although social isolation was identified as focus areas for UNITE group in Washtenaw County, plans for collaborative work on this issue was paused in order to focus efforts on combating COVID-19. The COVID-19 pandemic has further exacerbated the previously existing health disparities and reaffirmed the focus of UNITE on these health priorities and the social determinants of health that shape deep health inequities. In 2021, UNITE reconvened to evaluate the impact of COVID-19 on local communities in the areas of the previously identified health priorities. Another benefit of revisiting the CHNA at this time is that Michigan Medicine, St. Joseph Mercy Ann Arbor, and St. Joseph Chelsea will now be aligned with the assessment cycle of all Trinity Health System hospitals in the state of Michigan, allowing for a broader picture of Michigan's needs to be expressed through the CHNA process.

The agreement between Michigan Medicine and their Trinity Health partners of St. Joe's Ann Arbor and St. Joe's Chelsea to revisit the CHNA in 2021 is representative of the shared spirit of collaboration and the evident value added to the community when health systems collectively work to be better stewards in their respective communities. This is particularly clear in addressing racial injustice and health inequities as racism is a public health crisis magnified further by the COVID-19 pandemic. The health systems participating in UNITE are committed to confronting racism and this CHNA provides an opportunity to analyze the landscape within each health system and in the shared community to identify areas for improvement and remain accountable to this established commitment, as well as mutual health priorities.

A. RETROSPECTIVE REVIEW - 2019 Community Health Needs Assessment

In 2019, the UNITE group reviewed all of the secondary and primary data sources for the greater Washtenaw County area and community input, the collaborative unanimously agreed that the information pointed to the persistence of the three community health priorities identified during the group's 2016 community health needs assessment: 1) Mental Health and Substance Use Disorders, 2) Obesity and Related Illnesses, and 3) Pre-conceptual and Perinatal Health.

The UNITE group members conducted a root cause analysis (RCA) around local community conditions and contributing factors to the prioritized health needs. The RCA placed particular emphasis on the social determinants of Health (SDOH) that are the major drivers of inequities in the prioritized health needs as a means of understanding which strategies would be most effective. The three RCAs conducted were on: 1) Poverty, 2) Housing/Homelessness and 3) Loneliness/Social Isolation.

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

B. RETROSPECTIVE REVIEW - 2019 IMPLEMENTATION STRATEGY

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

St. Joseph Mercy Chelsea

Priority #1: Mental Health and Substance Use Disorders

Goal: Improve mental health and reduce the negative impacts of substance use among youth and adults in Washtenaw County.

Activity #1: Support SRSLY coalitions to prevent youth substance abuse.

Outcome: SRSLY coalitions operate in Chelsea, Dexter, Manchester and Stockbridge, with youth leaders and involvement from 12 key community sectors in each town. SRSLY Chelsea is now also addressing youth mental health. SJMC employs SRSLY staff and provides significant in-kind support to the coalitions, including grant-writing support. These communities have seen youth substance use rates drop over the past decade, as measured by the Michigan Profile for Healthy Youth survey.

Outcome: Safe medication disposal sites maintained by local law enforcement in the five towns in the SJMC primary service area, and inside the main entrance at SJMC.

Activity #2: Implement the Project SUCCESS program in local middle and high schools

Outcome: Project SUCCESS is a school-based youth substance abuse prevention program. The counselor conducts screening, facilitates small group work, provides brief individual interventions, and makes referrals to community mental health providers when needed. The counselor also conducts educational sessions for students and parents on drugs and alcohol, including vaping, or e-cigarette use. SJMC secured grant funding from the Community Mental Health Partnership of Southeast Michigan to bring a Project SUCCESS Counselor to three local school districts. Two of the three sites have since ended the program due to the pandemic, and challenges implementing Project SUCCESS in a virtual environment.

Activity #3: Continue and expand support groups in the service area.
Outcome: In partnership with the Cancer Center, and Therapy Departments, SJMC provided free yoga classes designed specifically for cancer patients, survivors and families in the community. This program was paused due to the pandemic.

Outcome: The Behavioral Health Navigators facilitate support groups for multiple mental health and substance use issues, and partner with the National Alliance for Mental Illness of Washtenaw County to bring mental health support groups to the area.

Outcome: The SJMC Diabetes Share Group met monthly to provide education and support to residents living with diabetes. The group heard presentations from medical professionals and community partners, including the local wellness center and farmers markets.

Outcome: The SJMC Behavioral Health Services department hosted AA, NA and Al-anon meetings prior to the pandemic. Those had to move off-site due to COVID.

Activity #4: Collaborate with schools and other community partners to address mental health needs of youth.

Outcome: Hospital representatives from the Community and Behavioral Health departments participated on school district wellness committees, as requested, to address mental health issues among youth.

Outcome: SRSLY staff assisted one district in designing a survey to measure the impact of the pandemic on youth mental health and substance use.

Activity #5: Expand presence of behavioral health services staff in primary care and community settings, and facilitate access to care through the Behavioral health Navigator.

Outcome: The Behavioral Health Navigator role was expanded to two people (1.2 FTE total). They are deployed in the five communities that make up the SJMC primary service area, to help people access needed mental health services. The BHS Navigators work with safety net providers, schools, primary care physicians, and others who can refer individuals or families in need of support. In the first four years of this program, the Navigators have assisted more than 700 people, and provided education and training for more than 3,000 people.

Activity #6: Participate in local coalitions and activities related to increasing social support.

Outcome: SJMC colleagues participate in the five local wellness coalitions. Each coalition is tasked with developing a comprehensive wellness plan to encourage residents to move more, eat better, avoid unhealthy substances, and connect with others in healthy ways. 80% of wellness coalition meetings include a representative from SJMC, totaling more than 250 hours per year donated in-kind to support the coalitions.

Priority #2: Obesity and Related Illnesses

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

Activity #1: Continue to promote walking and running for all ages through activities and events.

Outcome: The Heart and Sole run/walk/bike event maintained low-cost entry fees for youth to promote participation in the race, and as a result more than 20% of runners and walkers were under the age of 18. More than 500 participants completed the race every year, including groups from local elementary schools, senior living facilities, and the St. Louis Center, which is a residential facility and school for youth and adults with intellectual and developmental disabilities. This event was paused in 2020 due to the pandemic.

Activity #2: Increase availability and connectivity of walking paths on the hospital campus.

Outcome: SJMC created a master plan to connect and improve walking paths through the hospital campus, which were regularly utilized by community members walking for exercise, and children walking to and from school. Work began in 2020 on the highest priority section of the paths along the southern end of the SJMC campus. That paved and lighted section of trail was completed in October 2020.

Activity #3: Support the Chelsea Farmers Market and Farmers Market Food Assistance programs throughout the service area.

Outcome: SJMC serves as the fiscal agent and employs the Market Manager at the Chelsea Farmers Markets. The markets run twice per week, May through October, and once per week in November and December. The total sales at these markets was more than $450,000 for the 2019 and 2020 market seasons. SJMC also made financial contributions to local farmers market food assistance programs through community food pantries. Total food assistance sales at the Chelsea, Dexter and Manchester farmers markets for 2019 and 2020 was $29,229.

Outcome: With support from the Hilton Fund, SJMC partnered with Washtenaw County Health Department and the Chelsea Senior Center to develop a low barrier food assistance program to benefit seniors and local farmers markets. Senior Market Bucks started in 2017, and has continued since then. The program provided booklets of coupons redeemable only at the farmers markets in Chelsea, Dexter and Manchester.

Activity #4: Provide nutrition education and technical assistance to individuals and organizations in the service area.

Outcome: Starting in 2017, SJMC has dedicated 10 hours per week for a Registered Dietitian to provide education and technical assistance on nutrition. The Community Nutritionist worked with local wellness coalitions, schools, churches, and businesses to increase healthy eating through system and policy changes, education, skill-building, and support.

Outcome: SJMC began offering the Diabetes Prevention Program in 2016 through Faith Community Nursing, and expanded the program under Diabetes Education in 2017. The hospital now has three facilitators and offers the program virtually in coordination with other hospitals in Saint Joseph Mercy Health System. Program participants have reported an average weight loss of 10 pounds, or 5.74% of starting body weight.

Activity #5: Support the development and expansion of area trail networks.
Outcome: SJMC participates in the Huron Waterloo Pathways Initiative, and supports expansion of the Border-to-Border trail in Washtenaw County.

Priority #3: Preconceptual and Perinatal Health

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

Activity #1: Collect data on local needs related to prenatal care and education among expectant mothers in the service area.

Outcome: SJMC is exploring offering breastfeeding classes for expectant and new mothers in our primary service area.

Other Relevant Activities

Goal: Address Social Determinants of Health

Activity #1: In January 2020, SJMC and SJMAA went live with a new electronic medical record, EPIC. The tool assesses social needs through 10 questions, and if a positive screen occurs, the patient is referred to community resources through a community resource directory embedded in the EMR.

Outcome: As of April 2021, 111,785 patients were screened for social needs through a tool in the EMR (across SJMC and SJMAA).

Activity #2: Provide support to partner organizations working to address social determinants of health for poor and vulnerable populations living in the SJMC service area.

Outcome: From 2019 to 2020, SJMC donated $387,652 to non-profit organizations in the communities to address social determinants of health, including housing, food access, social isolation, education and transportation.

Activity #3: Increase rates of low-income residents with health insurance.

Outcome: Two SJMC staff members were trained to help people enroll in health insurance through the marketplace exchanges, or Medicaid expansion. The hospital helped 142 local residents enroll in health insurance through Medicare, Medicaid, the Health Insurance Exchange, or McAuley Support with the help of these hospital staff.

Activity #4: Increase access to transportation for low-income residents

Outcome: SJMC provided vouchers to patients who cannot afford transportation to and from health care appointments. The hospital also provided in-kind and financial assistance to the Washtenaw Area Value Express bus, which services Chelsea and the surrounding communities. This led to the creation of a new free shuttle between Manchester, Stockbridge and Chelsea. This shuttle increases access to food, health care, education and employment opportunities for residents of these communities.

St. Joseph Mercy Ann Arbor

Priority #1: Mental Health and Substance Use Disorders

Goal: Improve mental health and reduce the negative impacts of substance use among youth and adults in Washtenaw County.

Activity #1: Expand the presence and align existing resources around behavioral health services in primary care and community settings.

Outcome: Grow Transition Clinic for community members as an opportunity to connect to long-term behavioral health care. The Transition Clinic team works with patients to identify and connect them with long-term community providers, or connect them back to their primary care providers with an optimized treatment regimen to ensure they have the support they need to continue towards wellness.

Activity #2: Through Washtenaw County Coordinated Funders Programs Operations grants, finance behavioral health efforts through local safety net providers.

Outcome: Funded multiple programs through a coordinated funding partnership, totaling over $700,000 per year in partnered investments in behavioral health specific or aligned programming in safety net health, housing and homelessness, senior services, and early childhood and school-aged youth.

Activity #3: Maintain SOAR coordination support to improve access to SSI/SSDI benefits for eligible community members.

Outcome: Led southeast Michigan region of SOAR providers in total number of approved cases for SSI/SSDI benefits in 2019, with 86 cases documented (the programming was ceased due to the pandemic for the year 2020).

Activity #4: Provide educational opportunities around substance use disorder to schools through Health Exploration Station activities (Vaping curriculum, Drugs, 101).

Outcome: These programs served thousands of students through early 2020; due to the pandemic, these programs are paused as of print of this report.

Activity #5: Continue expansion of health system tobacco cessation programming to other Trinity Health Michigan sites.

Outcome: Expansion of this program is paused as of print of this report due to the pandemic. However, the program continues to operate in support of lung cancer screening and general oncology referral patients at St. Joseph Mercy Ann Arbor, St. Joseph Mercy Chelsea, and St. Joseph Mercy Livingston. Prior to the pause of the pandemic, the program had served 600 patients and had a quit rate far exceeding the Michigan Quitline.

Priority #2: Obesity and Related Illnesses

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

Activity # 1: Continue to provide food security support and nutrition education through The Farm at St. Joe's initiatives (i.e. Subsidized CSA, Youth Farm Field Trips, Youth Summer Camp, Residency Garden, Nutrition Buddies, Hospital Farmers Markets, Produce to Patients, etc.).

Outcome: Subsidized CSA has expanded and while field trips, summer camp programming, and farmers markets were paused due to the pandemic, additional delivery food programming for those in need was started. Over 7,000 boxes of produce went to community members, and 82 community members received free memberships to the CSA. Additionally, in partnership with other community agencies, an online farmers market was established to support community members.

Activity #2: Through Washtenaw County Coordinated Funders Program Operations grants, finance efforts to reduce food insecurity through local safety net food provision organizations.

Outcome: Funded multiple programs through a coordinated funding partnership, totaling over $400,000 per year in partnered investments in nutrition focused programming.

Activity #3: Continue to advocate for policy change on food systems infrastructure through participation in Washtenaw Food Policy Council and other emerging policy efforts.

Outcome: Continued expansion of 10 cents per meal, and advocated for enhanced food programming support during the pandemic at the state level.

Activity #4: Continue to enhance the local economy through return of dollars back into small local farms participating in The Farm at St. Joe's CSA programming.

Outcome: Through CSA programming and new delivery programming and market support, in 2020 $140,000 was put back into the community to local farms through the CSA, and almost $20,000 through the COVID food assistance program. This was particularly beneficial during the pandemic due to the economic landscape.

Priority #3: Preconceptual and Perinatal Health

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

Activity #1: Educate expectant mothers on the risks of smoking during pregnancy and provide cessation services.

Outcome: Continue to educate women during prenatal visits on risks of smoking, offer cessation services through quitline.

Activity #2: Work with Michigan Prison Doula Initiative to provide financial support for doulas assisting incarcerated mothers through the perinatal period.

Outcome: Provided services to over a dozen incarcerated mothers through doula support in 2019. The program was paused in 2020 due to the pandemic.

Activity #3: Continue Centering Pregnancy group prenatal support programming.

Outcome: Decreased infant mortality, low birth weight, and increased breastfeeding uptake in babies delivered to Centering Pregnancy mothers.

Activity #4: Maintenance of Baby Friendly Designation status at SJMAA.

Outcome: Continued maintenance.

Other Relevant Activities

Goal: Address Social Determinants of Health

Activity #1: In January 2020, SJMC and SJMAA went live with a new electronic medical record, EPIC. The tool assesses social needs through 10 questions, and if a positive screen occurs, the patient is referred to community resources through a community resource directory embedded in the EMR.

Outcome: As of April 2021, 111,785 patients were screened for social needs through a tool in the EMR (across SJMC and SJMAA).

Activity #2: Provide support to partner organizations working to address social determinants of health for poor and vulnerable populations living in the SJMAA service area through collaborative funding partnership

Outcome: support initiatives across education, senior support, healthcare access, and housing to a total of $4M per year collaboratively.

Activity #3: Advance equitable access to leadership education opportunities through funding leaders of color fellowship workshops.

Outcome: support three-year contract of two fellowship cohorts per year.

Activity #4: Support advocacy efforts at the state and local level to advance social determinants of health

Outcome: supported passage of Racism as a Public Health Crisis in Washtenaw County, encouraged voting on Affordable Housing Millage in City of Ann Arbor, engaged in decision-making strategies to deploy public safety and mental health dollars, in part going to social determinant agencies offering wrap-around support.

Michigan Medicine

Priority #1: Mental Health & Substance Use Disorders

Goal: Improve mental health and reduce the negative impacts of substance use among youth and adults in Washtenaw County

Activity #1: Provide screenings and interventions in the community to youth experiencing mental illnesses or suicidal ideation

Outcome: RAHS continued care during the pandemic for mental health visits through providing secure virtual visits. RAHS provided 560 In-person visits and 1853 virtual visits within Washtenaw County. For a total of 2413 visits.

Activity # 2: Provide mental health support sessions for families in the community that have a child with mental illness

Outcome: Regional Alliance for Healthy Schools (RAHS) continued mental health services through secure virtual visits. For exact numbers please contact us at Michigan Medicine.

Activity # 3: Provide translated materials to social service agencies and provide mental health screenings in ASL through UMHS Interpreter Services and Family Medicine

Outcomes: Talks were hosted during both FY20 and FY21 including the following time frames: July 2020, November 2020, January – April 2021

Activity # 4: Provide two (2) 4- or 6-weeks workshops “Addiction in Older Adults” to social service agencies, and providers.

Outcome: A social worker trained in addiction provided 5 one-day workshops for a total 10 over the course of 2 years.

Activity # 5: CHS older adult services (Housing Bureau for Seniors and Ann Arbor Meals on Wheels) will screen all new clients for depression using the PHQ-9 tool during the intake assessment.

Activity #6: CHS older adult services (Housing Bureau for Seniors and Ann Arbor Meals on Wheels) will screen all new clients for substance use during the intake assessment.

Outcome for Activity #5 and #6: Greater than 750 clients were screened for both of these assessments.

Activity #7: CHS Grants Program: Michigan Medicine fulfilled the commitment of support for CHS grantees, totaling over $2.2 Million since the publication of the 2019 CHNA report. This is a summary of the outcomes that came from the supported projects

Activity 7a. Ozone House in their expansion of Community Engagement, Outreach activities, and community partnerships in order to ensure successful service linkages for youth in crisis.

Outcome: Between July 2018 and December 2021, Ozone House and its partners screened 410 youth to ensure that needs are met by the appropriate organization. 131 youth participated in a Brief Intervention or Linkage to Services.

Activity 7b. Packard Health's Medication-Assisted Treatment program to reduce overdose deaths, lower risk of relapse, and decrease incarceration among individuals with opioid addiction.

Outcome: Packard Health provided Medication Assisted Treatment for 580 individuals, 462 specifically for opioid addiction.

Activity 7c. Eastern Michigan University to expand the resident support services offered by its Family Empowerment Program.

Outcome: EMU provided mental health screenings to 40 individuals, and health screenings to 12 individuals. Residents participated in stress reduction workshops and activities, including Mood Lifters programming.

Activity 7d. Women's Center of Southeastern Michigan so that it may build administrative capacity and pilot Dialectical Behavioral Therapy.

Outcome: Piloted two iterations of a Dialectical Behavioral Therapy group, and piloted a Single-Session therapy model titled "Jumpstart" to reduce waitlist.

Activity 7e. Our House to provide supportive housing services, mentoring, and financial support to youth aging out of foster care.

Outcome: Our House hired staff, rented a house for the LaunchPad Program from which 5 Youth "launched" into their own apartments, began the Guest House Program (from which 1 moved into their own housing). Additionally, our House provided Housing Scholarships, mentors, and Mental Health subsidies to participants.

Activity 7f. Student Advocacy Center's Check and Connect program to provide social support and mentorship to students who are court-involved, have a disability, and homeless, or lack supportive adults at home.

Outcome: On average over the three years of funding, Student Advocacy Center provided 68 students with mentorship services per year.

Activity 7g. Corner Health Center's youth behavioral health services program.

Outcome: During the first year of grant funding, the Corner provided 71 unduplicated patients with 531 visits. Year 2: 68 unduplicated patients received 659 visits. In the first 6 months of Year 3, 83 unique patients received 493 therapy visits.

Activity 7h. MSU 4H Extension in order to engage youth in activities to support mental health. Outcome: Trained 22 youth in the Natural Helpers model to enable them to support their classmates and friends.

Activity 7i. Michigan Organization for Adolescent Sexual Health in their efforts to improve mental health outcomes among LGBTQ+ youth.

Outcome: Trained facilitators 13 who facilitated 8 Community workshops about mental health needs of LGBTQ youth in 8 of 9 Washtenaw County school districts.

Activity 7j.a mental health pilot program at Hope Clinic, aimed to remove barriers to care for low-income and uninsured families and individuals.

Outcome: Provided 205 intake assessments, 17 crisis counseling sessions and 209 counseling sessions, and 118 psychiatric visits.

Activity 7k. A pilot program offering supportive services for caregivers (Jewish Family Services).

Outcome: Provided 29 caregivers with respite care and 9 with in-person therapy services.

Activity 7l. The University of Michigan School of Public Health in improving access to mental health and substance use services for sexual and gender minority adolescents and emerging adults.

Outcome: By the end of Year 2,175 people completed CHAI trainings.

Activity 7m. UMHS Regional Alliance for Healthy Schools' expansion of school-based and community-integrated mental health services for at-risk adolescents and young adults.

Outcome: Provided outreach to 1,000 individuals, provided Mom Power and CBT Groups, provided 168 teletherapy visits.

Activity 7n. The expansion of UMHS Housing Bureau for Seniors' efforts to expand their reach throughout Washtenaw County in order to support seniors in achieving housing stability.

Outcome: HBS supported 1390 seniors throughout Washtenaw County.

Activity 7o. the UMHS Program for Multicultural Health's pilot project titled EmpowerU2, which increases the ability of adolescents in managing adversity.

Outcome: Completed 63 workshops with youth from Parkridge Community Center, Pathways High School, and the Community Family Life Center.

Priority #2: Obesity and Related Illness

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

Activity #1: Support programs and policies that help to eliminate food insecurity:

Outcome: UMHS Ann Arbor Meals on Wheels continued to support their recipients of services and keep them safe by keeping the numbers of meals the same but only doing drop-offs 3 times instead of five times. In FY20-FY21 they served 241,384 (as of 5/7/2021) meals for a total of 785 unduplicated clients.

Activity #2: Support, maintain and explore programs that target nutrition education

Outcomes: MHealthy has continued to provide services in Tobacco cessation, healthy eating and exercise and alcohol management. Project Healthy Schools—MHealthy tobacco cessation partnered with Project Healthy Schools to provide lessons on vaping and the consequences of consumption. Regional Alliance for Healthy Schools (RAHS) had to modify their programming because of the pandemic and therefore closure of schools. RAHS deployed their dietitian to assist clients at Ann Arbor Meals on Wheels (AAMOW). As things transitioned, RAHS began to offer secure virtual visits with the registered dietitian.

Activity #3: Continue to support program and policies that encourage more physical activity

Outcomes: MHealthy has continued to offer programs and support to faculty, staff and clients virtually to help them maintain their physical activity levels and other health goals. RAHS was unable to support programming and policies for physical activity because of the changes in the schools. But they re-deployed their staff to help with COVID screening and clinics. See SDOH related activities below for more details.

Activity #4: Provide health information to the Deaf, Deaf/Blind, and Hard of Hearing through Speakers series using American Sign language in the community

Outcome: Provided two deaf talks during 2020 (July and November) and are providing monthly talks (January-April) in 2021. Topics include: Maternal and Child Health during COVID-19, When to go to the Emergency Department, Physical Fitness for All, COVID-19 Vaccine Q & A, Mental Health During a Pandemic, and COVID-19, What is known and What is Next. Talks are on Facebook and free to the public.

Activity #5: Continue collaboration with Michigan Islamic Academy to address their ongoing needs

Outcome: The Program for Multicultural Health has continued to support the collaboration between Health Education for Young Adults (HEPYA) a UM student run organization and the Michigan Islamic Academy. Staff served as a senior advisor, presenter, and operations coordinator for the program in FY20. Included multiple consults and meetings. Specific data available upon request.

Activity #6: Michigan Medicine fulfilled the commitment of support for CHS grantees, totaling nearly $700,000 since the publication of the 2019 CHNA report. This is a summary of the outcomes that came from the supported projects:

Activity 6a. A project of Food Gatherers which aims to reduce food insecurity through partnerships with primary care providers, social service providers, and community organizations.

Outcome: Supported 27 agencies throughout Washtenaw County in utilizing the Link2Feed software to improve tracking of food pantry usage. Between July 1 and Dec 31, 2020, Link2Feed Software demonstrated that 7270 unique households were served by Washtenaw County food pantries.

Activity 6b. Ann Arbor Meals on Wheels to pilot a hand dexterity program with their clients in order to help them improve or maintain the ability to complete activities of daily living.

Outcome: 13 Ann Arbor Meals on Wheels clients participated in Hands and Health at Home programming with the goal of improving nondominant hand pinch strength.

Activity 6c. Michigan Medicine's Patient Food and Nutrition Services so that it may provide meals to Ypsilanti Meals on Wheels and improve food security among aging and ill Ypsilanti residents.

Outcome: Provided resources to improve service parity between Ann Arbor and Ypsilanti Meals on Wheels clients. In 2019, Ypsilanti Meals on Wheels provided 47,131 hot meals and 40,919 cold meals to 298 unique individuals. In 2020, Ypsilanti Meals on Wheels provided 51,930 hot meals and 48,331 cold meals to 330 unduplicated clients. Between January 1, 2021 and May 20th, 2021, they provided 21,790 hot meals and 20,176 cold meals to 301 unduplicated clients.

Priority #3: Pre-conceptual and Perinatal Health

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

Activity #1: Train and educate providers, staff, and parents on safe sleep practices

Outcome: UM C.S. Mott Children's Hospital's Injury prevention team offered Baby Safe classes to parents prenatally. Pre-pandemic, these classes took place twice monthly in the Family Center. During the pandemic, the class has shifted to virtual. The materials are available to families via a recorded PowerPoint presentation. Additionally, all families receive safe sleep training in the NewBorn nursery prior to discharge.

Activity #2: Provide positive parenting resources and empowerment workshops in public and low-income housing communities

Outcome: Community Health Services Program for Multicultural Health work completed a series of workshops called Health Cafe at one of the low-income housing complexes in Ypsilanti, MI. This series was hosted by PMCH and a nurses association. They presented various topics such as controlling diabetes, healthy eating, and other health related topics. PMCH also hosted the Empower U program at Pathways high school in FY20. This included job fairs and various workshops. There were nutrition workshops conducted at Community Family Life Center and Parkridge. Additionally, there has been continued support and empowerment down through virtual presentations and scientific writings to present community-based findings.

Activity #3: Continue the Maternal and Infant Health Program (MIHP) for pregnant women and infants up to one year of age

Outcome: The maternal infant health program has continued to see clients for FY20; over the course of the year, they have served 192 moms and 197 infants. They had a 87% breastfeeding initiation rate and a duration of greater than one month was 46%.

Activity #4: CHS Grants Program: Fulfill previous commitment of support for CHS grantees related to Preconceptual and Perinatal Health, totaling over $365,000 since the publication of the 2019 CHNA report as well as projects that addressed Preconceptual and Perinatal Health as well as the other priorities (over $250,000). This is a summary of the outcomes that came from the supported projects:

Activity 4a. The University of Michigan Medical School Department of Psychiatry to provide the evidence-based Mom Power intervention to at-risk families with young children.

Outcome: Trained 35 providers in Mom Power Facilitation, and provided Mom Power programming to 29 families after two years of the grant.

Activity 4b. The University of Michigan Medical School Department of Obstetrics and Gynecology to provide expedited partner therapy for sexual transmitted infections to patients of community clinics.

Outcome: Provided expedited partner therapy to 59 individuals.

Activity 4c. The Michigan Advocacy Program to implement a Medical-Legal partnership, increasing access to legal services and advocacy for low-income individuals and families in Washtenaw County. (This activity also impacts Priority 1 & 2.)

Outcome: Opened 276 cases impacting 500+ low-income Washtenaw residents on issues such as public benefits, housing and family law.

Activity 4d. The United Way of Washtenaw County's Mobile Financial Resource team in order to provide free personal financial coaching sessions with the goal of clients achieving financial security. (This activity also impacts Priority 1 & 2.)

Outcome: Provided 60 clients with coaching services, and 388 individuals with financial education workshops.

Activity 4e. The UMHS Interpreter Services' Community Interpreter Initiative in order to increase the quantity of qualified interpreters in Washtenaw County. (This activity also impacts Priority 1 & 2.)

Outcome: Trained 58 individuals in medical and/or community interpreting, and provided 101.75 hours of pro bono interpretation.

Other Relevant Activities

Goal: Address Social Determinants of Health

Activity #1: Reduce climate impact of Michigan Medicine.
Outcome: The Regents of the University of Michigan voted to divest from investments in fossil fuels.

Activity #2: Understand Medical Debt as related to Michigan Medicine patients and service area residents.

Outcome: The CB/CHNA team met with the Michigan Medicine financial team that is in charge of handling Medical Debt. Michigan Medicine offers financial support through the MSupport program, which is available to patients meeting income/asset requirements, medical necessity, and Michigan residency requirements.

Activity #3: Address Racism as a Social Determinant of Health

Outcome: In response to the Racial Discrimination and Social Unrest Survey, and concerns presented by the Black Medical Student Association and White Coats for Black Lives, Michigan Medicine instituted an Anti-Racism Oversight Committee. The committee is chaired by Phyllis M. Blackman, director of the Office of Health Equity and Inclusion, and Dr. David C. Miller, chief clinical officer of the University Hospital and CVC and professor of the Department of Urology, and comprised of leadership, faculty, staff and medical students with the charge to implement sustainable measures that address the committee's priority areas.

The AROC charge is to develop and recommend a plan around contributions to eliminate racism and inequities that may exist today at Michigan Medicine, identify practices that contribute to racism and discrimination and recommend changes for Michigan Medicine, and identify an approach that achieves an anti-racist culture and utilize an internal dashboard to track the progress and outcomes.

For more information regarding AROC visit: https://ohei.med.umich.edu/anti-racism-oversight-committee

Activity #4: Join the Healthcare Anchor Network

Outcome: Michigan Medicine joined the Healthcare Anchor Network of over 60 health systems across the nation, collaborating to improve community well-being by proactively addressing economic and racial inequities in community conditions that create poor health. HAN members do this by leveraging all their assets, including *hiring, purchasing, and investment practices*. As part of this network Michigan Medicine has collected baseline data in these areas which will inform the strategic focus of the institution over the next few years.

UNITE Group Collaborative Efforts

Priority #4: Social Isolation

Goal: Increase social support and reduce the negative impacts of social isolation among youth and adults in greater Washtenaw County.

Activity #1: Data Collection and Project Planning

Outcome: The UNITE group partnered with the University of Michigan School of Public Health Office of Public Health Practice to collaboratively work with the PHSAT (Public Health Student Action Team), a volunteer group of graduate students continue the work through key stakeholder interviews based upon the literature review and asset scan a deeper data dive of the problem of social isolation in 5 specific populations: 1) seniors, 2) mothers/caregivers of children 5 and under, 3) rural communities, 4) individuals with disabilities/caregivers of those with disabilities, and 5) adolescents. In January 2020, when key stakeholder interviews were completed and coding had been finalized the UNITE team members met with School of Public Health collaborators to review findings. Then a plan of regular meeting and a tentative budget by each hospital was agreed upon for the FY21 fiscal year. After the retreat, the number of COVID-19 cases increased in Michigan to the point where the Stay-at-Home order was put in place and hospitals had to mobilize to treat cases. UNITE members had to place the Social Isolation project on hold as the pandemic made it urgent to isolate for the sake of safety. Once UNITE members were able to begin meeting regularly, they decided that social isolation was still an issue but that the hospitals did not have the capacity to address the issue with the current recommendations for isolating. This issue would be re-evaluated when life returned to a more normal cadence.

Other Joint Efforts

Activity: COVID-19 Food Security

UNITE convened a group to discuss emergent issues arising during COVID-19. During the height of the pandemic, there was an emerging issue of food security within Washtenaw County. The UNITE group scanned food resources and invited community stakeholders to a meeting to discuss the landscape of food security (see Appendix F).

Written Comments

No written comments were received on the prior CHNA and Implementation Plan.

III. COMMUNITY SERVED

Community Description

For the purposes of this needs assessment, the three health systems represented[1] serve all of great- er Washtenaw County. Service areas are defined by the communities' proximity to the hospitals.

Washtenaw County is located in southeast Michigan and covers 720 square miles. Its cities, villages and townships are home to approximately 367,601 (census.gov) citizens in urban, suburban, and rural settings. The county consists of six cities, nineteen townships and two villages:

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

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

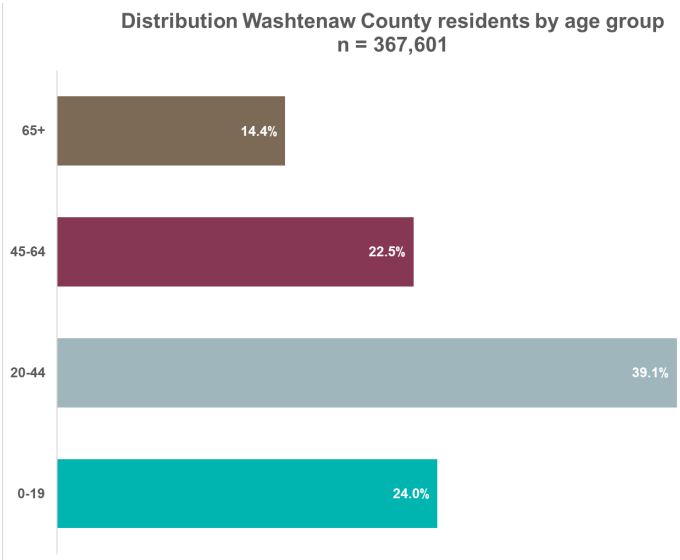
- Townships: Grass Lake, Henrietta, Stockbridge, Unadilla
- Villages: Grass Lake, Stockbridge

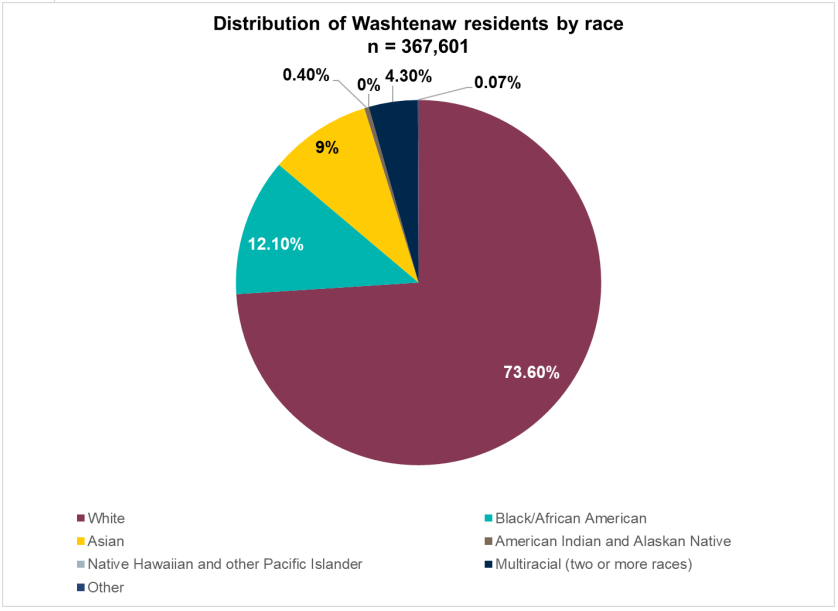
Demographics

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

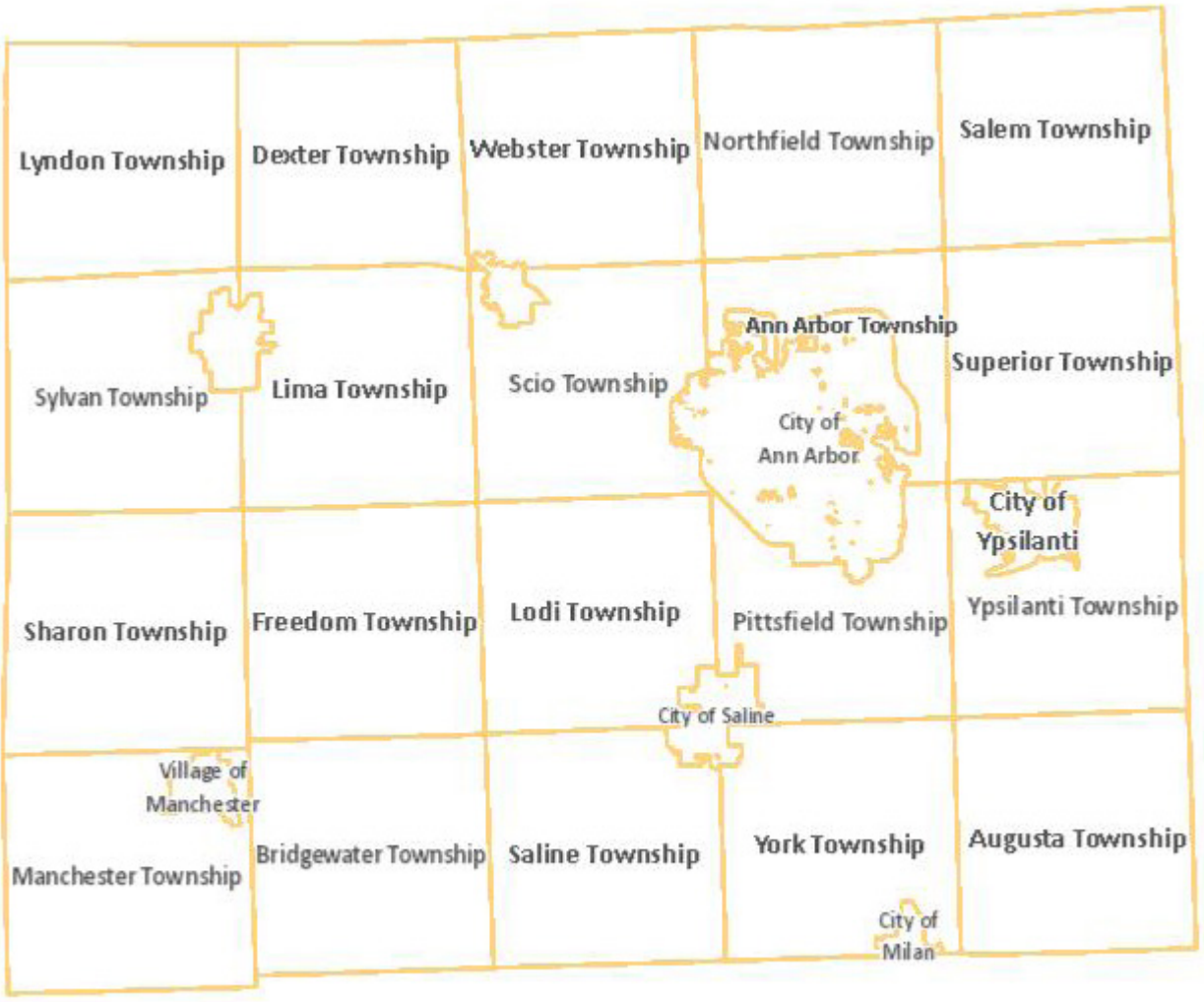
	Washtenaw County[1]	**Grass Lake Charter Township[2]**	**Stockbridge Township[3]**
Total Population	367,601	5,983	3,978
Race			
White	73.6%	97%	96.2%
Black/African American	12.1%	0.2%	0.8%
Asian	9%	1.8%	1.2%
American Indian and Alaskan Native	0.4%	0.4%	0.1%
Native Hawaiian and other Pacific Islander	0%	0%	0%
Multiracial (Two or more races)	4.3%	0.4%	1.7%
Other	.07%	0.2%	0%

	Washtenaw County[4]	Grass Lake Charter Township[5]	Stockbridge Township[6]
Hispanic or Latino (of all Races)			
Hispanic or Latino			
Not Hispanic of Latino			
Age Range	**Washtenaw County[7]**	**Grass Lake Charter Township[8]**	**Stockbridge Township[9]**
0-19	24%	23.7%	20.7%
20-44	39.1%	27%	31.3%
45-64	22.5%	32.5%	29.5%
65+	14.4%	16.8%	18.4%





Map of cities and townships in Washtenaw County, MI[10]



St. Joseph Mercy Chelsea Service Area

IV. 2021 CHNA PROCESS AND METHODS USED

Infrastructure

The infrastructure designed to successfully complete this CHNA required the full collaboration and participation of all three health systems and their partners[11]. Representatives from St. Joseph Mercy Ann Arbor (SJMAA), St. Joseph Mercy Chelsea (SJMC), Michigan Medicine (MM), and the Washtenaw Health Initiative (WHI) met regularly to develop the CHNA. Washtenaw County Health Department was kept in the loop through email communication but was unable to attend regular meetings due to their commitment to various COVID-19 related needs. Within each organization there was an internal structure for CHNA development. This infrastructure was based on existing partnerships within each health system, in addition to the establishment of new partnerships. No third parties were contracted to conduct this CHNA. Within each institution there is an internal structure to guide Community Health Work, via. the Community Benefit Ministry Council (SJMAA), Community Health Improvement Council (SJMC) and the Community Health Coordinating Committee (MM).

The Washtenaw Health Initiative continued to support and assist the UNITE group in this CHNA cycle. This support was given through the dedication of in-kind staffing (0.22 full-time equivalent in-kind staffing) for managing the project, securing logistics, assisting with data, and facilitating the group.

Process and methods

The purpose of the 2021 CHNA was to utilize new and pre-existing data and engage community to discern whether previously identified needs continue to be priority areas and to explore how COVID-19 has impacted these priorities. To do so, the UNITE group completed the following steps:

- Reviewed the data list for the 2019 CHNA and updated the list with more recent data sources, which were also reviewed
- Solicited community feedback, which affirmed that the community continued to identify Mental Health & Substance Use Disorders, Obesity & Related Illnesses, and Preconceptual & Perinatal Health as key issues of concern

    - Formal feedback sessions took place with the Wellness Coalitions of Dexter, Manchester, Grass Lake, and Stockbridge. Surveys were sent to the Washtenaw Health Initiative, Washtenaw County Health Department's Health for All Steering Committee, the Chelsea Wellness Coalition, and Michigan Medicine's Community Health Coordinating Committee.

    - Additional community-based sessions were conducted throughout the year and not as a formal part of the needs assessment process, there is no formal compendium of results from session feedback.

The CHNA will be utilized to inform the development of an Implementation Plan to address the health priorities and the complexities created by the COVID-19 pandemic. This will include the identification of resources available to address the priority health needs and an examination of opportunities available to the health systems to address these needs.

Data sources

Secondary data analysis

Since this CHNA is being conducted a year early, and many existing data sources and reports have not yet had an opportunity to publish updates as many organizations have shifted gears to address the COVID-19 pandemic, UNITE reviewed three new community assessments analyzing the impact of COVID-19 on the community. The UNITE collaborative reviewed each report and pulled out the key findings for group discussion and further analysis.

These community assessments were related to the impact of COVID-19 on poverty, housing and utilities, food insecurity, education, economic stability, as well as racial and health equity[12]. (See Appendix D for more information about the sources used.)

Community engagement and prioritization of needs

During 2020 and early 2021, community engagement occurred through town halls, individual hospital engagements with community stakeholders, listening sessions and surveys through affiliated partners. These engagements sought to better understand the needs of the community in a para-COVID world, and questions around what the hospital needed to focus on to meet the needs of the community were addressed. Some of these sessions additionally focused on equitable access to testing, vaccination, and care in general, and how the hospitals could use the pandemic as a learning opportunity to change how care was made available to those most in need. This level of engagement with the community went above and beyond any prior year, and provided a rich narrative for the partners to lead them in prioritizing needs. Included in these sessions were members from community areas recognized as medically underserved and socially vulnerable, community members at large gathered virtually based on interest in providing input to the health systems, and community partners from organizations representing the interests of those who are experiencing food insecurity, housing and homelessness, mental health and substance use, the elderly, and other areas.

The partners agreed that, because there were multiple engagements in community to assess needs and gain feedback throughout the year outside of the formal CHNA process, and expressions of fatigue around these types of engagements going into 2021 were being heard, the group decided against holding more sessions under the auspices of formal feedback sessions to respect community member time and engagement in prior sessions. As such, a culminating survey with a small representative subset of community members was conducted to affirm the data gathered throughout the year and through secondary sources. Throughout the months of March and April 2021, UNITE members sought feedback from community members and key stakeholders on what the top community health needs were as identified in the above engagements mentioned as well as secondary data sources gathered, and to confirm the identified priority areas were aligned with residents' experiences and observations. UNITE members collected this data by participating in virtual meetings of five local wellness coalitions, and a patient experience team. The wellness coalitions included representatives from key community sectors including (but not limited to) local government, senior centers, food pantries, businesses, libraries, faith communities, schools, farmers markets and parents. The patient experience team includes service area residents with chronic diseases. UNITE also collected this data electronically, via a survey link sent to community members and key stakeholders through the Washtenaw Health Initiative, the Washtenaw County Health Department's Health for All Steering Committee, and the Community Health Coordinating Committee. Summaries of survey results are included in Appendix E.

Select data points and findings

COVID-19 has had a profound impact on our community since the last CHNA was conducted two years earlier. Financial instability, particularly due to job loss during the pandemic, has exacerbated many of the challenge's families across the county and the state have faced.

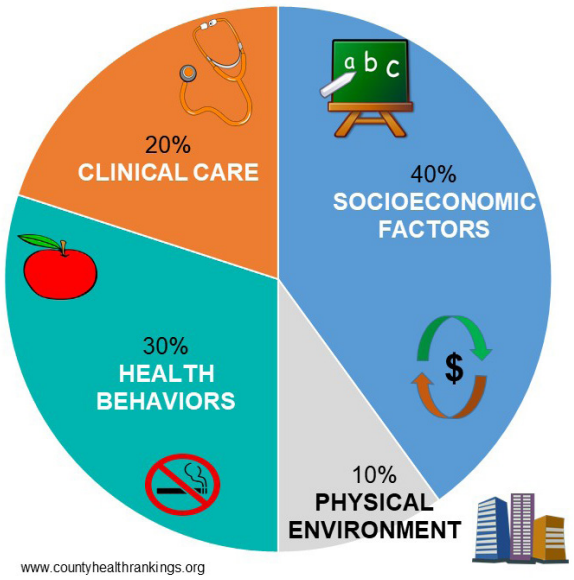
- Food insecurity has increased across all areas of Washtenaw County, including in Ann Arbor, Chelsea, and Ypsilanti.[13]

- A survey conducted in Ypsilanti, MI during the summer of 2020 demonstrated that COVID-19 has disproportionately impacted minority communities, with 41% of Black respondents, and 36% of Latinx respondents reporting being late with utility payments, compared to 15% of white respondents.
- Furthermore, 35% of Black respondents report having friends and family members die from COVID-19, versus 9% of white and 15% of Latinx respondents. Virtual learning during the pandemic has placed an additional burden on many families, particularly in minority communities of Ypsilanti and in rural parts of the county without sufficient access to high speed internet.[14]

Although many of these areas were previously identified needs, COVID-19 has compounded many of these challenges and intensified the need to review our health priorities, as well as the resources and approaches we are taking to address these needs in our shared community.

V. SDOH, Health Equity, and COVID-19

In 2021, the UNITE group renewed its commitment to addressing 1) Mental Health and Substance Use Disorders, 2) Obesity and Related Illnesses, and 3) Pre-conceptual and Perinatal Health and used the social determinants of health (SDOH) and health equity as both an analytical lens and a key strategy in addressing the root cause of these health inequities. UNITE group members agreed that focusing on upstream factors, and the conditions and environments where people live, work, and play, would have a greater impact on the identified community health needs than a downstream approach. The COVID pandemic highlighted the importance of SDOH.



While there are many Social Determinants of Health that impact health outcomes in our community, the UNITE group has identified three key SDOH to focus on due to their relevance and magnitude in our community, and our ability as health systems to have an impact. These SDOH are:

- Housing and Homelessness
- Poverty
- Social Isolation

We have also identified three additional emerging SDOH impacting our community. While our primary focus is on the above key SDOH, these emerging SDOH are also critical and may represent areas of future work for our collaborative:

- Climate Change (Emerging)
- Incarceration (Emerging)
- Medical Debt (Emerging)

At a UNITE data retreat in March of 2021, the group completed a Root Cause Analysis using the Community Anti-Drug Coalition of America (CADCA) model to understand why each of the priority Social Determinants of Health are impacting our community, and how COVID has created additional challenges in each identified priority SDOH. The Root Cause Analyses for Housing and Homelessness, Poverty and Social Isolation can be located in Appendix C.

More information about each of the SDOH can be found below.

Housing and Homelessness

Access to safe and affordable housing is a key social determinant of health. According to the American Community Survey, there are approximately 44,033 households in Washtenaw County who are paying more than 30% of their income toward their housing costs. Approximately 37% of these households have annual incomes of less than $20,000.[15]

Providing housing to people who are homeless or providing affordable housing to people who are housing unstable has been demonstrated to reduce Medicaid expenditures, increase use of primary care facilities and reduce emergency department use. In addition to being affordable, housing must also be safe. Substandard housing with issues such as mold and pests are associated with poor health outcomes, as is exposure to high or low temperatures in housing.[16]

The health issues associated with homelessness were highlighted as a result of the COVID 19 pandemic. The CDC notes that people who are homeless may be at increased risk of contracting COVID because they often reside in congregate settings, making physical distancing difficult or impossible.[17]

Poverty

Poverty is a huge public health issue. Not only because it deals with limitations in fulfilling basic needs for living but because of the mental health toll. Additionally, the strain of growing up in poverty continues to have mental and physical implications into and throughout adulthood.[18] The gap in life expectancy between the richest and poorest Americans is almost 15 years for men and 10.1 years for women.[19]

As of 2019, 34 million people in the US were living in poverty. In Washtenaw County, 31% of families could barely afford a monthly budget for housing, food and other basic necessities.[20] Black families disproportionately experience difficulty paying their bills - 54% of Black families fall below the ALICE threshold (Asset Limited, Income Constrained, Employed).[21]

Although poverty was on the decline for the first time in 2019 the COVID-19 pandemic plunged many households into severe economic distress due to being laid-off from jobs. 31% percent of adults and 42% of adults with families who lost work reported not being able to pay their monthly bills and going without food or medical care in the past month.[22]

There are many individual and policy strategies that can be supported by the UNITE group in alleviating the effects of poverty and therefore increasing the overall health of Washtenaw County residents. Therefore, the UNITE group recognizes that poverty is a SDOH that they would like to target.

Social Isolation

Social isolation and loneliness have become indicators of increased morbidity and mortality as well as shortened lifespan. Loneliness has been shown to affect at least 1 out of every 5 adults based on national surveys. It has also been seen that social isolation is increasing in the adult population as many adults are living alone, not getting married, not having children, and are participating less in religious and volunteer activities.[23] Social isolation and loneliness have been shown to increase the risk for heart disease and stroke. It has also been shown that you can be more at risk for early death[24]. In Washtenaw County we have had multiple assessments over the years that have shown that moms, patients and youth were all suffering from lack of social support, social isolation or loneliness[25,26,27,28]. During COVID-19 there was at least an acute increase in social isolation and loneliness after the months of having to stay-at-home[29].

UNITE recognizes that although there are unique challenges to launching efforts to decrease loneliness and social isolation during a pandemic, we continue to want to focus on decreasing social isolation once it is safe for individuals and families to begin interacting

Emerging Social Determinants of Health

Climate Change

Climate change is an issue of increasing concern among public health professionals. A 2016 American Public Health Association report declared climate change as "the greatest threat to public health today."[30] Climate change is widely accepted by the scientific community as the result of the high levels of greenhouse gas emissions that have resulted from human activity such as electricity generation, transportation, livestock farming, and the mining and use of natural gas.[31]

According to the Natural Resources Defense Council, if unchecked, climate change will increase the number of dangerously hot summer days, as well as the average number of excess heat-related deaths. From 1975 to 2010, the Detroit metropolitan area had an average of nine dangerously hot summer days per year, with an average of 65 excess deaths per year related to these hot weather days. If no action is taken on climate change, scientists predict an average of 50 dangerously hot summer days per year from 2046-2055, with 760 excess deaths per year related to this heat.[32]

The health impacts of climate change will disproportionately impact communities of color, people living in poverty, individuals with pre-existing health conditions, and those living in social isolation.[33] For example, analysis of heat waves and hospitalizations in three Michigan counties (Ingham, Washtenaw, and Wayne) revealed that "heat wave days increased the odds of hospitalization for kidney disease by 37 percent among people of color from 2000 to 2009. In contrast, there was no increase in hospitalization odds among white people." Additionally, the temperature increases associated with climate change increase the prevalence of hospitable habitats within Michigan for ticks that transmit Lyme's disease and mosquitoes that cause West Nile virus and yellow fever.[34]

The COVID-19 outbreak presents a powerful reminder of the potential impact of climate change and environmental change on human health. The World Health Organization (WHO) states that while there may not be a "direct connection between climate change and the emergence or transmission of COVID-19, there is evidence that increasing human pressure on the natural environment may drive disease emergence. Strengthening health systems, improved surveillance of infectious disease in wildlife, livestock and humans, and greater protection of biodiversity and the natural environment, should reduce the risks of future outbreaks of other new diseases."[35]

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

Incarceration
The US houses almost 2.2 million youth and adults in jails, prisons, and juvenile detention centers. That is one of the highest in the world. Many of the individuals who are incarcerated suffer disproportionately from chronic health conditions and mental health issues. The healthcare that those who are incarcerated receive before, during and after their incarceration often is inadequate for their conditions and the life expectancy is significantly lowered.[36]

Additionally, incarceration tends to affect low-income communities and communities of color disproportionately.[37] Mass incarceration tends not to change crime rates in communities but does disrupt the family social network and income and has significant repercussions for the children of those incarcerated.[38] The experience of incarceration itself (including solitary confinement or living in small spaces without privacy) may exacerbate mental illness. Among the formerly incarcerated population, recidivism rates are at least 50% higher among people with mental health diagnoses than for people without such diagnoses.[39]

During COVID-19, jails, prisons, and detention centers have been hotspots because it is impossible to physically distance in these carceral facilities, the rate was 5.5 times higher than the U.S. Population rate.[40] The spread cannot be contained to these facilities and therefore poses public health dangers for the whole community. These uniquely susceptible environments place incarcerated individuals at increased risk of not only contracting COVID-19, but developing severe infections that require hospitalization or result in death, given their older age and disproportionately high burden of underlying conditions. UNITE affirms the American Public Health Association's Governing Council statement on addressing the harms of the carceral system and now, as ever, intervention necessitates prioritizing health and prevention, by centering public health strategies.

The UNITE group recognizes that both those incarcerated and formerly incarcerated individuals need advocacy for services, programs, and better healthcare to make sure that they have a chance at a healthy life. Therefore, we need to advocate for better community mental health services, better access to mental health care for all regardless of insurance status, and also more ways for folks to get acute mental health treatment before the criminal legal system becomes involved.

Medical Debt
Over 125 million people in the US experience financial hardship because of medical costs. High healthcare bills are the number one reason people raid their retirement or file for bankruptcy.[41] Often individuals forgo getting critical medical care because of fear of acquiring medical debt.[42] It has been seen that one in three Black Americans is past due on medical bills. Also, 31% of individuals face problems getting the medical care they need because of unpaid medical debt. Medical debt has a huge impact on savings and the number of jobs that someone has to work. These problems are faced by people with insurance as well as those without.[43]

COVID-19 and the effects on the economy caused over 14 million Americans to lose employee sponsored insurance.[44] This is a significant amount of the population that cannot seek primary care services or services for chronic conditions.

Although all partners in the UNITE group have strategies within their agencies to help mitigate large amounts of debt, it remains important to make sure that patients and community members are able to access the care they need.

A Statement on Racial Equity
In addition to the SDOH identified above, the hospitals represented by the UNITE Group recognize the critical importance of naming and addressing racial injustice and the impact it has on the communities we serve. In 2020, following the murder of George Floyd by a police officer in Minnesota, Michigan Medicine leadership created an Anti-Racism Oversight Committee, in response to concerns presented by the Black Medical Student Association and White Coats for Black Lives. This committee is seeking to

- "Develop and recommend a plan around contributions [Michigan Medicine] can, and must make to eliminate racism and inequities that may exist today at Michigan Medicine
- Identify practices that contribute to racism and discrimination and recommend chances for Michigan Medicine, if needed.
- Identify and approach that achieves an anti-racist culture and utilize the dashboard to track the progress and outcomes." [45]

In alignment with the AROC, the Priority Health needs identified within this report represent areas of health inequities that are critical to address in order to advance racial justice in our community.

Additionally, in 2020 Michigan Medicine joined the Healthcare Anchor Network of over 60 health systems across the nation, collaborating to improve community well-being by proactively addressing economic and racial inequities in community conditions that create poor health. HAN members do this by leveraging all their assets, including hiring, purchasing, and investment practices.

St. Joseph Mercy Chelsea and St. Joseph Mercy Ann Arbor have each established a Diversity and Inclusion (D & I) Council. These groups develop and implement local strategies while providing feedback and guidance on goals, priorities, strategic opportunities, and operational challenges pertaining to D & I. The councils include hospital administrators, department leaders, clinicians, and board members.

VI: Priority Health Needs and Methodology

At the UNITE retreat, after reviewing all of the data and community input, the collaborative unanimously agreed that the information pointed to the persistence of the three community health priorities identified during the previous cycle's needs assessment. A robust discussion was had around the feasibility of action for the partners around these needs, the scope of impact the partners felt they could have, and the ability to have a meaningful impact as measured through agreed upon evaluation strategies. The three priority health needs that will be focused on by the UNITE group during the 2021-2023 CHNA cycle are:

- Mental Health and Substance Use Disorders
- Obesity and Related Illnesses
- Preconceptual and Perinatal Health

Each of these priority health needs are strongly impacted by Social Determinants of Health, such as Poverty, Housing/Homelessness, Social Isolation, Climate Change, Incarceration, and Medical Debt, and represent areas in which racial inequities present in our community.

In the below section, we will begin by presenting data about how each of the priority health issues present in the UNITE group's service area. Then, there will be a brief discussion of how Social Determinants of Health impact each of these health needs.

Priority 1: Mental Health and Substance Use Disorders in the UNITE Group Service Area

Mental Health and Substance Use Disorders: Key Data Points

- Overall in Washtenaw County, there has been an increase in opioid-related overdose deaths from 2011 (29 deaths) to 2018 (80 deaths).[46]
- In 2018, the average Washtenaw county resident reported 4.6 mentally unhealthy days in the past 30 days.[47]
- In Washtenaw County, 21 percent of adults reported binge or heavy drinking (2019).[48]
- The percentage of high school students reporting recent use of an e-cigarette or vaping device decreased from 18 percent in 2018 to 15.5 peent in 2020.[49]
- Regular alcohol use has diminished in Washtenaw County from 18 percent in 2010 to 14.9 percent in 2020 for alcohol use. Recent binge drinking among high school students rose from 6 percent in 2018 to 9.6 percent in 2020. The average age of first use for marijuana by high school students in Washtenaw County is 14.3-years-old. 22.6 percent of HS students reported ever having used marijuana, and 14 percent report using marijuana recently.[50]
- While the county-wide rate of high school students reporting two or more Adverse Childhood Experiences (ACES) was 26.2 percent, some low-income communities had significantly higher rates, ranging from 33.6 to 39.6 percent.[51]
- The percentage of high school students who seriously considered attempting suicide during the past 12 months was 17.1 percent in Washtenaw County in 2020. Nearly one-third (31.5 percent) of high school students in Washtenaw County reported having felt so sad or hopeless almost every day for two weeks or more in a row that they stopped doing some usual activities during the past 12 months.[52]

Mental Health and Substance Use Disorders: COVID-19

In June of 2020, the CDC surveyed 5,412 adults. Overall, 40.9% of respondents reported at least one adverse mental or behavioral health condition, including symptoms of anxiety disorder or depressive disorder (30.9%), symptoms of a trauma- and stressor-related disorder (TSRD) related to the pandemic (26.3%), and having started or increased substance use to cope with stress or emotions related to COVID-19 (13.3%). The percentage of respondents who reported having seriously considered suicide in the 30 days before completing the survey (10.7%) was significantly higher among respondents aged 18–24 years (25.5%), minority racial/ethnic groups (Hispanic respondents [18.6%], Black respondents [15.1%]), self-reported unpaid caregivers for adults (30.7%), and essential workers (21.7%). Symptoms of anxiety disorder and depressive disorder increased considerably in the United States during April–June of 2020, compared with the same period in 2019.[53]

An April survey of 24,155 Michigan residents found 79% of respondents reported concern about stress, loneliness, anxiety, and/or depression, with 29% indicating that they were “very” or “extremely” concerned about these mental health symptoms. The concerns were validated, as 32% of Michigan adults reported symptoms of an anxiety or depressive disorder in a June 2020 study.[54] These mental health symptoms exacerbate risk of suicide, and reaffirm the prioritization of mental health and substance use disorders, as COVID-19 has amplified the need to focus resources and efforts on this community health need.

Mental Health and Substance Use Disorders: Social Determinants of Health

Mental Health and Substance Use Disorders are impacted by all six of the SDOH highlighted previously in this report. The below represents just a few key statistics to demonstrate the relationships between SDOH and the health needs in our community.

Homelessness:

- According to the director of the Washtenaw Housing Alliance in 2021, about 70 percent of those served by the Delonis Center, a site that provides temporary shelter and services to individuals experiencing homelessness, have a chronic physical or mental health issue.[55]
- Compared with housed children, homeless children suffer worse health, more developmental delays, more anxiety, depression, and behavioral problems, and lower academic achievement.[56]
- According to the 2019 Annual Report, Ending Homelessness in Michigan, in the state, 44 percent of individuals experiencing homelessness have a disability. Of those individuals with a disability, 26 percent of those individuals have a substance use disorder, and 66 percent have a significant mental health condition.
- Homelessness in Michigan is a racial equity issue. Black individuals are overrepresented in homelessness, as Black individuals account for 52 percent of Michigan's homeless population, yet only represent 14 percent of the state's overall population.[57]

Incarceration:

- Approximately 10-25 percent of the U.S. prison population has a serious mental health issue, compared to about 5% of the U.S. population overall. Incarceration also can exacerbate mental health issues.[58]
- Locally, the Washtenaw County Sheriff's office responded to 735 mental health calls in 2017 (an increase of 20 percent from 2016).[59]

Priority 2: Obesity and Related Illnesses in the UNITE Group Service Area

Note: UNITE recognizes there are complications and considerations when discussing obesity in the context of illness, health status, and medical conditions. The medicalization of obesity can inadvertently label all overweight individuals as "sick" without considering their overall health status or their satisfaction with their body and health status. This medicalization can have a stigmatizing effect, and can be physically and mentally damaging to individuals whose other health concerns are downplayed or ignored because of the focus on obesity as the primary frame. Additionally, it can obscure the many causes of obesity outside of an individual's control, including access to affordable, nutritious and fresh food options, walkable communities, access to public transportation and built environments. UNITE acknowledges that both the language and intention must be carefully considered when discussing obesity and associated illnesses, and the nuance of this is an ongoing discussion in the UNITE meetings.

Obesity and Related Illnesses: Key Data Points

- Childhood obesity continues to be an issue in Washtenaw County with 25 percent of children being overweight or obese (2016).
- While most percentages of overweight and obesity rates held steady, the rate of overweight and obesity in 5- to 7-year-olds decreased from 22 percent to 20 percent and the rate of overweight and obesity among Latino children increased from 31 percent to 35 percent between 2013 and 2016.[60]
- Food security and access to healthy foods, and safe opportunities for physical activity, continue to be reported as barriers in Ypsilanti.[61]
- There is a need to strengthen the capacity of pantries to offer fresh produce and to help connect eligible people to food assistance (SNAP)
- Food assistance program participation at local farmers markets is needed in Dexter, Grass Lake, Manchester and Stockbridge.

- As reported via the Five Towns Survey, the zip codes, 49152 and 49285 (Manchester and Stock- bridge) had the highest rates of youth and adult obesity, showed the biggest challenges with food access, and scored the worst on the Nutrition Environmental Assessment Tool survey. Manchester scored slightly higher on the Promoting Active Communities due to local government plans and policies.[62]

Obesity and Related Illnesses: COVID-19

In addition to being a risk factor for other chronic illnesses, such as diabetes and heart disease, obesity is also a recognized risk factor for severe COVID-19. In a CDC study of 148,494 adults diagnosed with COVID-19 who sought either emergency department or inpatient care, obesity was found to be a risk factor for invasive mechanical ventilation, as well as hospitalization, and death from COVID-19, particularly among adults above the age of 65. In this analysis, 50.8 percent of adult COVID-19 patients had obesity, compared with the national average of 42.4 percent. [63]

Additionally, the social and economic conditions created by COVID-19 have contributed to weight gain for many individuals during the pandemic. Gyms and fitness facilities were closed, people working from home struggled to balance their new schedules, and for many, emotional eating and drinking to cope with stress and anxiety contributed to increased weight gain. A study of 269 participants by the University of California, San Francisco found that on average, after shelter-in-place orders, participants experienced steady weight gain at a rate of .27kgs or about 0.6lbs every 10 days, regardless of comorbidities or geographic location.[64] According to MDHHS, Michigan has consistently ranked in the top 10 to 15 states for highest obesity rates, and this overall increase in obesity and changes to relevant social and economic conditions will certainly impact our state and community here in Washtenaw County. [65]

Obesity and Related Illnesses: Social Determinants of Health

Poverty

- Access to healthy food is essential for preventing and managing diabetes and other chronic illnesses related to obesity. Low-income communities often do not have places where residents can purchase healthy, affordable foods.[66]
- People who are homeless face particular barriers to managing diabetes and other chronic illness due to housing and food insecurity.[67]

Incarceration:

- According to the Bureau of Justice Statistics, 74% of those in prison and 64% of jail inmates are overweight, obese, or morbidly obese. [68]

Priority 3: Pre-conceptual and Perinatal Health in the UNITE Group Service Area

Pre-conceptual and Perinatal Health: Key Data Points

- Birth outcome disparities continue to persist among racial and ethnic minorities, largely due to institutional and systemic issues that inequitably distribute resources and opportunities. According to an April 27, 2021 press release from the Michigan's Department of Health and Human Services, the 2019 Infant Mortality Rate in Michigan was 6.4 per 1000 live births, and the 2019 Black and White Infant Mortality Ratio was 2.9 in 2019 (a reduction from 3.2 in 2018).[69]
- Women in the Ypsilanti area identified a need for access to mental health treatment, quality and affordable child care, affordable healthy food, and safe, stable, and affordable housing.[70]
- Latina women have lower insurance coverage rates compared to the rest of Washtenaw County women. As of 2015, just 83% of Hispanic or Latina women in Washtenaw County had health insurance coverage compared to 92% of Washtenaw County adults overall.[71]
- 43% of women in Michigan with dental problems during pregnancy do not receive treatment. Fear of litigation has been cited as why dental care is refused to pregnant women.[72]
- 14.3% of Black babies in Washtenaw County have a low birth weight as compared to 7.5% overall (2018).[73]

Pre-conceptual and Perinatal Health: COVID 19

By June 30, 2020, because of concerns about COVID-19, an estimated 41 percent of U.S. adults had delayed or avoided medical care including urgent or emergency care (12%) and routine care (32%). Avoidance of urgent or emergency care was more prevalent among unpaid caregivers for adults, persons with underlying medical conditions, Black adults, Hispanic adults, young adults, and persons with disabilities. It is understood that delaying or avoiding medical care could increase morbidity and mortality associated with both chronic and acute health conditions.[74] This avoidance of care has implications for pre-conceptual health and routine examinations for women of reproductive age, while the outcomes of this are yet to be seen.

Although pregnant women are not more at risk for contracting COVID-19 than non-pregnant women, they are more likely to be admitted to the intensive care unit or needing invasive ventilation than non-pregnant women. In a systematic review of 192 studies, pre-existing comorbidities, non-white ethnicity, chronic hypertension, pre-existing diabetes, high maternal age, and high body mass index are risk factors for severe covid-19 in pregnancy. Pregnant women with covid-19 versus without covid-19 are more likely to deliver preterm and could have an increased risk of maternal death, and their babies are more likely to be admitted to the neonatal unit.[75]

In a scoping review of 95 studies, a severe spike was observed in maternal mental health issues, such as clinically relevant anxiety and depression during the pandemic. This review also pointed to access to care as a concern for pregnant women during the COVID-19 pandemic. The number of prenatal and postnatal visits were significantly reduced as many hospitals needed to postpone "non-essential" or non-urgent visits on-site and many outpatient clinics temporarily closed during shelter-in-place orders, leaving many women with limited access to reproductive and maternal health care.[76] All of these circumstances have reaffirmed the focus on preconceptual and perinatal health as a priority health need area for UNITE.

Pre-conceptual and Perinatal Health: Social Determinants of Health

Incarceration:

- Locally, at the Women's Huron Valley Correctional Facility, 70.4 percent of inmates (all female) are between the childbearing ages of 20 and 44.[77]
- Almost 60 percent of women in state prisons have experienced physical or sexual abuse in their lives.[78]
- According to 2006 data from the Bureau for Justice Statistics (the most recent data available), approximately 5 percent of female inmates nationally report being pregnant at the time of detention into jail or prison.[79]

Housing/Homelessness:

- Locally, 40 percent of homeless youth seeking services are pregnant or parenting compared to 27 percent statewide.[80]

Poverty

- A study from the Michigan Department of Education and Public Sector Consultants shows how Michigan has lost thousands of child care providers from its licensed system in recent years, especially home-based providers.[81] Additionally, the cost of existing child care options is prohibitively expensive for working class families. As of 2014, families with incomes less than 200% of the federal poverty spent over ⅓ of their income on childcare.[82]
- Diapers are not covered through public assistance programs, and the expense of diapers came up in the mothers' focus group feedback meeting. This reflects the national data of 1 in 3 American families reporting diaper need, and not being able to buy them being a leading cause of mental health problems among new moms. Studies show families in the lowest income quintile spend almost 14 percent of their pretax income on diapers.[83]

VII. DOCUMENTING AND COMMUNICATING RESULTS

The CHNA report will be available on the websites of all partners (St. Joseph Mercy Ann Arbor, St. Joseph Mercy Chelsea, and Michigan Medicine (UMHS)), as well as on the website of the Washtenaw Health Initiative. A paper copy will be made available at all hospital facilities. Results have been communicated to numerous community groups and agencies, and plans to share results through a series of community conversations in the summer of 2021 are in development.

For comment or questions, contact Washtenaw Health Initiative Project Manager, Deana Smith, at dgrabel@med.umich.edu or 734-998-6517.

VIII. CONCLUSION

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

Appendices

Appendix A - Community Description - Hospitals

St. Joseph Mercy Hospital - Chelsea (SJMC) is a 133-bed community hospital located on 115 wooded acres in Chelsea, Michigan. It is a joint venture hospital between Saint Joseph Mercy Health System and Michigan Medicine. For information on hospital services, please call (734) 593-6000, or visit the website,www.stjoeschelsea.org. The SJMC primary service area is defined as the geographic area encompassing the zip codes of Chelsea, Dexter, Grass Lake, , Manchester and Stockbridge, Michigan. This includes sections of four counties (western Washtenaw, southeastern Ingham, southwestern Livingston and eastern Jackson) and all or part of the following cities, villages, and townships: Bridgewater Township, City of Chelsea, Dexter Township, Freedom Township, Grass Lake Township, Lima Township, Lyndon Township, Manchester Township, Scio Township, Sharon Township, Stockbridge Township, Sylvan Township, Unadilla Township, Webster Township, City of Dexter, Village of Grass Lake, Village of Manchester, and Village of Stockbridge. The SJMC service area was determined by the proximity of these communities to the hospital, which is located at 775 S. Main St, Chelsea, Michigan.

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

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

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

Appendix A - Community Description – Hospitals (Continued)

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

Community Health Needs Assessment Partners

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

Appendix B- Washtenaw County Community Reports Summary

In early 2021, members of the UNITE group examined local reports on a variety of topics that relate to health outcomes. Where available, reports that had been published since the previous 2019 CHNA were utilized. Report themes and data were summarized and contributed to the CHNA. Some sources were not updated due to the pandemic but the group felt were valuable sources of information, the reports that were still valid without updates remained as resources. All new reports compiled were completed in the year of the pandemic, and are summarized in Appendix D: COVID-19 Appendix.

COVID-19 and Washtenaw County Reports		
Local Report Name	Description	Year
Michigan LEO Poverty Task Force Report	This document details the assessment at the State level of Poverty and what potential policy solutions are being proposed to help alleviate some of the stresses of poverty.	2021
Family Empowerment, School Social Work-Impact of COVID in Ypsilanti	This report shows the data from a survey completed in Ypsilanti regarding what effect COVID-19 has had on them.	2020
Food Gatherers Food insecurity data map	To show food insecurity across and around Washtenaw County area	2020

2019 CHNA Data Sources (Utilized for 2021 CHNA)		
Local Report Name	Description	Year
5 Healthy Towns Foundation- Nutritional Environment Assessment Tool	The mission of the 5HF is to cultivate improvements in personal and community wellness.	2018
Dexter Community Foundation - Community Needs Assessment	The Dexter Community Fund (DCF) is a source of community capital that is available to invest in a wide range of initiatives, projects, and organizations that enrich the quality of life in Dexter.	2018
SIM (CHRT)- SIM PCMH-Social Determinants of Health Screening Aggregate	Data aggregate report of three provider organizations' social determinants of health screening at PCMH primary care well visits.	2018
Local Report Name	Description	Year
SRSLY Needs Assessment-Youth Substance Abuse	Based on data from the needs assessments, the coalitions determine the top youth substance abuse problems their communities	2018
Washtenaw County Health Department - West Willow Community Conversation Summary	Community perspectives and ideas for action.	2018

Local Report Name	Description	Year
Washtenaw County OCED- Washtenaw Urban County Consolidated Plan	5-Year Consolidated Plans describe a jurisdiction's community development priorities and multiyear goals based on an assessment of housing and community development needs, an analysis of housing and economic market conditions and available resources.	2018
Washtenaw County Opioid Reports	Washtenaw County Health Department's Opioid Reports provide timely information on opioid-related overdoses, deaths and trends occurring among Washtenaw County residents.	2018
Michigan Medicine Mothers Focus Group Data (Four English and one Spanish Speaking Focus Group)	Focus group conducted to understand challenges of mothers of young children to maintain or improve their health.	2017-2018
Washtenaw County Health Department - Whitmore Lake Community Conversation Summary	Community perspectives and ideas for action.	2017-2018
5 Healthy Towns Foundation- Promoting Active Communities Survey	The mission of the 5HF is to cultivate improvements in personal and community wellness.	2017 (est.)
Food Gatherers Healthy Food Access: Local Data and Federal Policy	Food insecurity overview with local and national data.	2017
Michigan League for Public Policy Michigan Kids Count Data	Kids Count in Michigan is part of a broad national effort to measure the well-being of children at the state and local levels, and use that information to shape efforts to improve the lives of children.	2017
United Way - ALICE report- Michigan	Asset Limited, Income Constrained, Employed - ALICE represents those in our communities who are working yet still struggling to make ends meet. The ALICE Report is the most comprehensive depiction of need in Michigan to date.	2017

Local Report Name	Description	Year
WACY (Washtenaw Alliance for Children and Youth)- WACY Report Card	Every year, WACY compiles and reports on local data to help our community better understand the strengths and needs of our children and youth	2017
Washtenaw County Health Department Health-Equity and Community Voice Report	The purpose of this report is to demonstrate the importance of community voice in addressing health inequities.	2017
Washtenaw County OCED-West Willow	Housing and neighborhood focus group.	2017
Washtenaw Health Plan-Coordinated Health and Safety Net Funding: Needs Assessment, Vision, Strategies, and Outcomes	The Coordinated Health Funding Needs Assessment examines six subtopics within the Safety Net Health and Nutrition priority area. Within each subtopic, we summarize existing services, identify key population groups, and analyze areas representing ongoing challenges.	2017
MiPHY Michigan Profile for Healthy Youth - Washtenaw County	A comprehensive, needs assessment survey that assesses students' risk behaviors at 7th, 9th, and 11th grades.	2016
UM Poverty Solutions-Child Homelessness in Michigan	This map seeks to fill that gap so that policymakers and local stakeholders can begin to think about the impact of homelessness in their area and to identify resources to support some of the State's most vulnerable children.	2016
UM Poverty Solutions-Poverty in Michigan map	This map combines publicly available data from the U.S. Census, United Way, CDC Community Health Indicators, and Robert Wood Johnson Foundation.	2016
Washtenaw County Health Department Immunization Rates by Zip Code	Vaccine coverage rates by populations.	2016
Washtenaw overweight Childhood Obesity and Overweight	Describes obesity rates among children in Washtenaw County.	2016

Local Report Name	Description	Year
Food Gatherers - Food Gatherers Food Security Plan	Identifies both near and long-term strategies to enhance individual and community food security.	2015
Washtenaw County Health Department Health Improvement Plan - Survey Database	Survey results identify health trends, disparities that exist between groups, and where additional resources could improve community health.	2015
Washtenaw County Health Department Perinatal Health - Women of Childbearing Age, Washtenaw County	Key findings of preconceptual health including health behaviors.	2015
Washtenaw County OCED-Housing Affordability and Economic Equity Analysis	The goal of this analysis is to provide a snapshot of housing market conditions and corresponding goals to improve affordability across a wide spectrum of households in Washtenaw County's urban core communities.	2015
Washtenaw Health Initiative/Community Coordination and Dental Services- Environmental Assessment of Access to Oral Health Care in Washtenaw County	The Washtenaw Health Initiative (WHI) Oral Health work- group first completed a dental assessment in the spring of 2011. Since 2011, three major changes have altered the dental environment in Washtenaw County and beyond: the Healthy Kids Dental Program, the Healthy Michigan Plan and the newly opened Washtenaw County Dental Clinic. This report has been updated and provides an overview of the dental state in Washtenaw County.	2015
Washtenaw Health Plan-Needs Assessment for Immigrants and Mental Health in Washtenaw County	The intent of this project is to provide a picture of immigrants in Washtenaw County, their mental health needs, and how they are-or are not-being met.	2015
Ypsilanti Youth Creating Change (Y2C2) Findings: A youth-led research project	Evaluation of health and safety concerns of young people ages 12-25 in Ypsilanti by conducting focus groups and collecting surveys during 2015.	2015

Local Report Name	Description	Year
U-M Taubman School of Architecture and Urban Planning & New West Willow Neighborhood Association- From Needs to Opportunities: Strategies for the West Willow Neighborhood	The goal of this report is to help West Willow residents productively address change by clearly describing existing conditions and needs, and identifying opportunities for enhancement.	2014
Washtenaw Housing Alliance- Blueprint Progress Report 2004-2011	Provides a look at the community's collective achievements in seven years.	2014
Washtenaw Housing Alliance- A Home for Everyone: A Blueprint to End Homelessness in Washtenaw County (2014)	Goal to map out the way we could end homelessness in our community in ten years. This plan was released with four primary goals: prevention; housing with support services; reforming our systems of care and engaging the community.	2014
Washtenaw Literacy White Paper 2014: The Impact of Adult Illiteracy in Washtenaw County	The Impact of Adult Illiteracy in Washtenaw County.	2014
Washtenaw County OCED- The 25% Shift: The Economic Benefits of Food Localization for Washtenaw County and Ypsilanti & The Capital Required to Realize Them	This paper evaluates the economic benefits that Washtenaw County and the Ypsilanti area (zip codes 48197 and 48198, within the County) could enjoy through a 25% shift toward local food.	2013
Washtenaw County OCED- The 25% Shift: The Economic Benefits of Food Localization for Washtenaw County and Ypsilanti & The Capital Required to Realize Them	This paper evaluates the economic benefits that Washtenaw County and the Ypsilanti area (zip codes 48197 and 48198, within the County) could enjoy through a 25% shift toward local food.	2013

Local Report Name	Description	Year
Blueprint for Aging-Washtenaw County Older Adult Data Book	The BFA Older Adult Data Book, created in 2009, provides a holistic framework to highlight indicators of older adult well-being and to emphasize existing challenges. Updates to the Data Book made in 2012 track changes of older adults in Washtenaw County and present new information.	2012
City of Ypsilanti Planning & Development Department - An Integrated Assessment of Transportation to Healthy Food in Eastern Washtenaw County	This research project investigated the degree to which residents of eastern Washtenaw County experience difficulty in accessing healthy food, with a focus on finding suggestions for overcoming transportation barriers.	2012
City of Ypsilanti Planning & Development Department - South of Michigan Avenue (SOMA) Community Needs Assessment	The South of Michigan Avenue Community Needs Assessment (SOMA) is intended as a public planning effort to engage residents who live in neighborhoods south of Michigan Avenue.	2011

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

HOUSING			
What is the problem?	Why is it a problem?	Why is it a problem here?	Strategies
• Housing is segregated in Washtenaw County • Housing cost is quite high and therefore precludes many from being able to live near job and resources.	• Unaffordable housing causes individuals and families to forgo healthcare and food. • Stable affordable housing reduces stress, toxins, and infectious disease. • Contributes to the vitality of the community • Affordable housing contributes to supporting a local workforce • Affordable housing supports less traffic congestion and less air pollution • Helps to improve individual and families' economic situation in life • Can stimulate economic growth?	• Not enough affordable units • Definitions of affordable are poor • Lack of a livable wage (Right to work state) • Segregation • Not enough quality apartment units • Local zoning not supportive of low-income and multi-family housing • Lack of housing for youth transitioning out of foster care • Rural areas lack affordable housing • Landlords • (not maintaining properties, no providing affordable units) • Lack of enforcement: • Building code • HUD • Accessible housing for disabled individuals	• Help landlords get information that might help them mitigate tenant issues (e.g. landlord mitigation fund to alleviate concerns of tenants who cannot afford a deposit). • Collaborate with county VA departments (VCATS model and housing is a component of it). • Build skills and modify policy on diversity and inclusion • Provide tenants with skills to resolve landlord issues • Advocacy to ensure greater enforcement of landlords (e.g. sycamore meadows) • Advocacy for greater enforcement of building codes

HOUSING FY21 CHNA and COVID-19 Updates			
What is the problem?	Why is it a problem?	Why is it a problem here?	Strategies
	• Helps to improve individual and families' economic situation in life • Even with eviction moratoriums, the question remains are people going to need to pay back rent? • Housing shortages: Housing supply is low during COVID-19. The market for housing is currently very competitive and affordable housing is becoming even more difficult • Segregation of Housing: there is an inequitable distribution of housing and histories of redlining and structural racism really play a role • Housing is not considered a human right	• Housing cost is quite high and therefore precludes many from being able to live near job and resources. • Tenant rights are often not upheld • Gentrification becomes a concern, particularly in areas like Ypsilanti • Landlords not renting to individuals with criminal records	• Utilization of millage dollars to support the shift in housing needs during COVID-19 • Are these rules within housing leaving certain populations out - can we tap into grassroots groups that serve these populations to help fill in the gaps •Are there lessons related to housing (putting people up at hotels) from COVID-19 that could carry over post-pandemic? • How can we be better partners at identifying resources/ opportunities and bridging connections between partners who could assist one another? • Solutions should be more county-based rather than hospital-based

What is the problem?	Why is it a problem?	Why is it a problem here?	Strategies
	• Shelters do not have the capacity to house folks with mental illness, particularly if they are currently struggling to manage their mental health and the county does not have other housing options for them • Homelessness exacerbates mental health issues; it can be difficult to pinpoint the origin of the issue • Foster care; individuals age out of stable housing in this system • Homelessness is criminalized and contributes to folks ending up in jail due to laws that target these populations • Folks who do not fall into specific systems or do not follow the “rules” within these systems are left out and do not have access to resources; transgender individuals may experience discriminatory “rules” in sheltered housing, folks with mental illness and SUD also experience lack of access		

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

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

POVERTY FY21 CHNA and COVID-19 Updates			
What is the problem?	Why is it a problem?	Why is it a problem here?	Strategies
	• Increased unemployment • Job loss (particularly women of color) • Business closure (particularly small business) • Privilege of working from home (stratification by race, class, gender) • Accessibility of benefits (populations left out) • People forced into early retirement as companies downsize (future impacts on seniors)	• living wage vs. minimum wage depending on your location; in Washtenaw County, $15 would still be below a living wage (also taking into account ability to build personal savings) • lack of broadband access; people's ability to pivot and work from home was rarely dependent on internet access • local policies on cash bail	• decarceration of Washtenaw County Jail due to spread of COVID-19

Appendix C (cont.) – Root Cause Analysis of Three (3) Social Determinants of Health

SOCIAL ISOLATION			
What is the problem?	Why is it a problem?	Why is it a problem here?	Strategies
Social Isolation	Mental Health Issues (Depression, Anxiety) USA Cultural Norms • Independent vs. collective • Increase prevalence and use of technology and social media	• Fractured kinship due to incarceration • Fractured kinship due to incarceration • Fractured sense of community because of lack of options for affordable and acceptable housing • Fear of deportation • Neighborhood safety • Policies restricting mobility/transportation • Lack of transportation especially in rural areas and among seniors • Lack of affordable/quality childcare and respite care (for caregivers) • Inaccessible infrastructure at both residences and public spaces • High cost of living/ resource strain (contributes to longer working hours and lack of free time to socialize) • Gentrification and community shifts • Gaps in available support groups • Mental health and physical health issues/ poor access to treatment	• Accessibility policy/supports enforcement • Support groups/ peer support/ homevisiting • Family care—integenerational • Investment in supportive housing • Policy advocacy-wages • Anchor institution • CHW • Mentorship programs • Success by 6 Trusted advisors group
SOCIAL ISOLATION FY21 CHNA and COVID-19 Updates			
No updates were recorded for this area.			

Appendix D - COVID-19 Appendix: Summary of Assessment Summaries Community Health Needs Assessment 2021

COVID-19

Needs:
- 33% of Black respondents disagree or strongly disagree that an eventual COVID-19 vaccine will be safe and effective, versus 14% of white and 11% of Latinx respondents.
- 62% of Black respondents said they would not be willing to take an eventual COVID-19 vaccine, compared to 17% of white respondents, and 19% of Latinx respondents.
- 35% of Black respondents report having friends and family members die from COVID-19 versus 9% of white and 15% of Latinx respondents.
- 58% of Black respondents feel COVID-19 is very serious for themselves personally versus 40% of white and 34% of Latinx respondents.
- There is mistrust between the COVID response and how protected these survey respondents feel in the Ypsilanti survey[84].

Opportunities:
- Collaborate with the WCHD to reach out to these individuals so that they feel like they have a voice in government and how they are advocating.
- Help these areas to have information from the health systems (St. Joe's Ann and Chelsea, Michigan Medicine, Washtenaw County Health Department) regarding COVID testing and vaccination. Updating them on what programs are available to help them cope financially.
- Helping them with support of their children during the remainder of COVID testing.
- Support some of the policy recommendations listed through advocacy or dissemination of information to Washtenaw County residents.

Actions:
- The governor kept a stay on water shut-offs in the state until Spring 2021. UNITE partners need to be aware of how the end of this policy will affect residents after the stay has been removed. This affects residents who are in lower income areas.

Social Determinants of Health (commonly mentioned)

Financial Stability and Employment

Needs:
- 42% of Black and 34% of Latinx respondents report being late with utility payments
- 36% of Black and 34% of Latinx respondents report being late with phone, internet or cable payments
- 47% of Latinx respondents report being late with credit card payments versus 25% Black and 17% of white respondents.
- 16% of Black and 18% of Latinx report having lost their job as a result of COVID-19 versus 8% of white respondents.
- 48% of Black respondents think they are not eligible for expanded unemployment insurance benefits versus 29% of white and 25% of Latinx respondents.
- 57% of Black respondents report not being able to meet a $400 unexpected expense versus 36% of white and 30% of Latinx respondents[85].

Appendix D (cont.) - COVID-19 Appendix

Opportunities:
- Helping these individuals with assisting in increasing economic stability could help them navigate the strains of job loss and/or restricted movements.
- Partnering with United Way to help with financial coaching and other coaching to increase household economic stability.

Public Assistance/Benefits

Needs:
- 25% of Latinx and 20% of Black respondents report their use of public assistance has increased a great deal as a result of COVID-19 vs. 14% of white respondents[86].
- 53% of Black and Latinx respondents report receiving SNAP benefits versus 26% of white respondents.
- Families who are kicked off of benefits because of their secure income.
- Families not qualifying for benefits because of having too many assets in their accounts.
- Challenges that formerly incarcerated individuals face because of housing, lack of identification, and lack of insurance.
- ALICE families who are working but are struggling to pay for everyday costs because of the inability to access assistance but the lack of economic opportunities.
- TANF scholarship dollars going to students who have high test scores without any qualifying income requirements.[87]

Actions:
- Changed the amount of assets that families could have and still received assistance. (LEO)
- Allowed scholarships for frontline workers to pursue different and better career opportunities. (Also relates to “Education” and “COVID-19”, LEO)

Food Security

Needs:
- 48197 (Ypsilanti) had an almost 30% increase in food insecurity reaching a total of 12,100 of residents that are food insecure
- 48198 (Ypsilanti) had a 21% increase in food insecurity compared to 2018
- There was an ~50% increase in food insecurity (47%) in Chelsea (48188), over 1600 residents report food issues.
- In 48104, 48105, 48103 (Ann Arbor, MI) there was an increase in food insecurity. Anyways from 30-40% increase[88].

Opportunities:
- Strategize to help families impacted by food insecurity - This has been directly impacted by COVID as many have lost their employment because of the inability and/or lack of certain jobs to be maintained during the COVID safety protocols.

Actions:
- Pandemic EBT was expanded in collaboration with the USDA to help children who were staying in place during the pandemic. (LEO)

Appendix D (cont.) - COVID-19 Appendix

Education

Needs:
- Virtual Learning is presenting more challenges to the minority communities within Ypsilanti
- 47% of Latinx and 37% of Black respondents report a lack of structure is a barrier to the transition.
- 34% of Latinx respondents report lack of support from their school district transition to virtual learning
- 19% of Black and 15% of Latinx respondents report not having privacy at home to do virtual learning
- 25% of Latinx respondents report a lack of communication with teachers during the transition into virtual learning
- 12% of Black and 9% of Latinx respondents report not having a computer at home to do virtual learning

Opportunities:
- Help make sure that families have resources that they need for virtual learning opportunities.

Vulnerable Populations/Locations
- (Re: Food insecurity) Although the percentage of populations in the 48197/48198 did not increase as much as other areas they had a larger number of food insecure individuals to begin with and therefore have more folks overall who are food insecure.
- Financial stability and income are a struggle for many in the 48197/48198 zip codes that responded to the survey.
- Education: Virtual learning responsiveness and access is an issue in the 48197/48198
- Ypsilanti survey response noted Black and Latinx populations in the 48197/48198 zip codes were particularly impacted by:
    - Lack of finances to meet all of the basic needs of life
    - Stress from feeling threatened by COVID without support from government leadership
    - Lack of resources for virtual learning
- LEO/Poverty Task Force noted that Vulnerable populations include children in low-income families, formerly incarcerated individuals, and families who are on TANF.

Appendix E: Community Engagement

Community Engagement Online Survey

Community Engagement Survey (Online) Results (Spring 2021)

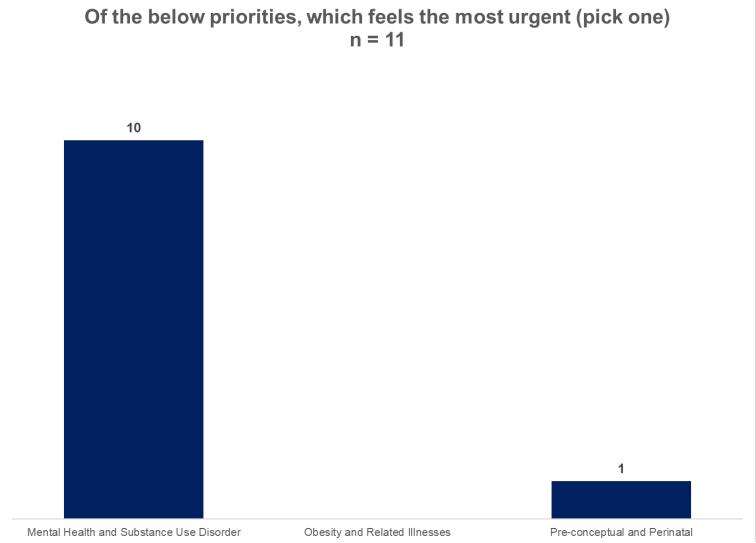
An online survey was open to individuals representing health serving organizations, community members aligned with the Health Department's Health For All steering committee, which represents community members in socially vulnerable areas, Michigan Medicine's Community Health Coordinating Committee, and the Chelsea Wellness Coalition. It was either directly emailed to them or a link to the survey was shared in community meetings. The surveys asked respondents about how well the three priority areas of Mental Health and Substance Use, Obesity and Related Illnesses, and Preconceptual and Perinatal Health, were being addressed, and what other health issues might be a gap in the community. A total of 11 individuals responded to the survey. The results are summarized below:

Do the identified needs (Mental Health and Substance Use Disorders, Obesity and Related Illnesses, and Preconceptual and Perinatal Health) align with the needs you are seeing in your community? If not, please share what you feel we are missing.

Responses show that these needs should be prioritized in community and are aligned with community need. Input expressed concern that these issues, especially behavioral health and obesity related issues, will have been exacerbated due the pandemic. Other issues expressed where related to housing and access to care.
One respondent shared: "These identified needs are aligned with needs that I see in our community, particularly through an equity lens. COVID-19 has not only highlighted these inequities, but has shown in the case of obesity, direct correlation to greater likelihood of serious illness, hospitalization and death from COVID-19. We also have seen growing impact on mental health and increased overdoses."

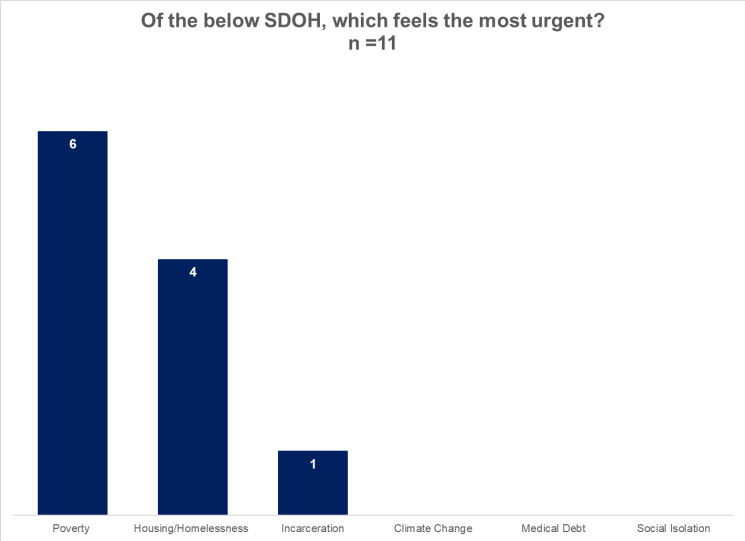
Of these issues (Mental Health and Substance Use Disorders, Obesity and Related Illnesses, and Preconceptual and Perinatal Health), which feels most urgent?

The majority of respondents (10 of 11) indicated that Mental Health & Substance Use Disorders was the most urgent priority to address. 1 respondent selected Pre-conceptual and Perinatal Health. No respondents selected Obesity & Related Illnesses.



Of the Social Determinants of Health listed (poverty, housing/homelessness, social isolation, climate change, incarceration, and medical debt), which feels the most urgent?

Poverty, housing and homelessness, and incarceration were highlighted as the most urgent Social Determinants of Health to address.



Where are our greatest opportunities for impact?

Respondents highlighted both a need for support to address immediate basic needs as well as efforts that address root causes of health inequities in our community. A sampling of responses is included below:

Immediate Needs:
- "Cash assistance to people experiencing poverty, increased access/reduced wait for primary and specialty physicians."
- "Making investments in organizations that support MH and SUD...and maybe with a focus on school-aged children and teens, in collaboration with the local school districts. Additionally, MH, SUD, and social isolation supports for populations most in need."
- "Providing fresh food"
- "Helping families with back rent and utilities bills"

Root Causes:
- "Simplifying mental health accessibility for all populations regardless of age, economic status, educational level, race, etc. The current system is hard to maneuver which results in many people giving up before getting assistance."
- "Integration of behavioral health and physical health services and interventions, reducing stigma (particularly among healthcare providers), increasing evidence of benefit of harm reduction approaches."
- "Making investments in the community that help alleviate poverty (i.e., SDOH). Advocating for increases in minimum wage within health systems and other employers. Advocating for other supportive employment policies, e.g., hiring from or training/pipeline programs for disadvantaged communities."

- “Build housing affordable for people who are truly low income/low wage (not simply “workforce housing” due to how it is defined) and provide supportive housing services. Also, build efforts to address health hazards in current housing stock (especially things like mold.)”
- “Use your vast resources to invest dollars in the community, through grant programs and supporting ongoing grassroots work.”
- “Use a social determinants of health frame to invest in addressing the root causes of health inequities.”

As we move into implementation planning this summer, what programs, activities, and partners do we need to know about?

Respondents consistently cited the importance of cross-sectoral partnerships in their responses.

Additionally, familiarizing ourselves with housing policy and its contributions to the impact on those experiencing housing instabilities was a priority.

Appendix E - Community Engagement (continued)

St. Joseph Mercy Chelsea (SJMC) Community Engagement Meetings

To encourage community participation in the CHNA process, SJMC attended six meetings of stakeholder groups to present data and prioritized needs, and ask for input. The five wellness coalitions include representatives from local municipalities, food pantries, senior centers, libraries, schools, community education, rotary and kiwanis clubs, business owners, farmers markets, and faith community leaders. After presenting an overview of key data points related to the prioritized needs, groups were asked the following questions:

1. Does this information align with the needs you are seeing in your community?
2. Are we missing something?
3. What feels the most urgent?
4. Where are our greatest opportunities for impact?
5. As we move into implementation planning this summer, what programs, activities and partners do we need to know about?

General Feedback:

1. Social Isolation is a major concern in all communities, for all populations. Community leaders want to know more about local conditions and risk and protective factors that impact social isolation, and how it is experienced differently across the lifespan.
2. Youth mental health is also a major concern in all communities, as 2020 MiPHY data showed worsening indicators prior to schools shutting down.
3. Farmers markets saw positive growth in 2020. This is attributed to people's desire to be closer to their food sources, and the fact that the markets provided a safe and positive way to interact with people during the pandemic.

Date	Group	Attendees
March 23, 2021	Manchester Wellness Coalition	8
April 13, 2021	Dexter Wellness Coalition	16
April 19, 2021	Grass Lake Wellness Coalition	11
April 21, 2021	Stockbridge Wellness Coalition	9
May 24, 2021	Patient Advisory Council	5

Appendix E - Community Engagement (continued)

Michigan Medicine Stakeholder Engagement Meeting: Technical Assistance

On Thursday, November 19th 2020, Michigan Medicine convened a meeting with key stakeholders to discuss Technical Assistance needs and resources available to Washtenaw County organizations. Representatives from the Community Health Coordinating Committee, Ypsilanti District Library, Michigan Institute for Clinical & Health Research, Ginsberg Center, Program Evaluation Group, NEW, St. Joseph Mercy Chelsea and Ann Arbor and Program for Multicultural Health attended.

The purpose of the convening was to discuss several questions. These questions and the key learnings are included below:

For organizations who are already engaging in technical assistance: What are you doing?

- NEW Center: NEW takes an ecosystem approach. Currently offering direct services to nonprofits such as board development, leadership development, Champions for Change, DEI training, back office support (IT, finance support, physical building), and Centering Justice series.

- Ginsberg Center: Offers data analysis, data collection, logic models, and evaluation (matching community organizations to university resources).
    - Track patterns for what people are coming for. Recently seeing requests for technical support during pandemic, emergency fundraising, benchmarking, adaptive finance models, website design and development (hard to find university partners for this). Grant writing, but capacity tied to student capacity.
    - Offers small amounts of grant funding for research seed funding.

- Program Evaluation Group at School of Social Work: Currently offering a 6 part webinar series on program evaluation for community organizations (using excel was a recent topic). Additionally, help community orgs complete and submit the evaluation component of their grant applications. Program Evaluation Group helps with survey design, how to write an evaluation, and including evaluation in program budgets and program design.
    - Small staff of professional evaluators and also work with grad students.
    - Frequently has organizations ask about the cost of utilizing their services.

- Program for Multicultural Health (PMCH): Develops culturally responsive and community based programming with/for community partners. Providers training for students, faculty, providers. Connects community partners to other resources and UM organizations (like Ginsberg). Also does onsite health education programming for community partners.

- Michigan Institute for Community Health Research (MICHR): Offers grant writing, evaluation, and support. Working on translating research into community. With COVID there has been an increased focus on DEI and Social Determinants of Healthy (SDOH). MICHR partnered with School of Pharmacy to manufacture and distribute hand sanitizer. Also has hosted community forums in Flint and elsewhere.

- St Joseph Mercy Chelsea & Ann Arbor: Offers grant writing support and/or help with data for school districts. Provides fiscal sponsorship and cash/in kind donations to Community Based Organizations (donated to purchase a bus serving as a free shuttle for Manchester and Stockbridge, which recently both lost grocery stores). Offer in-kind staff support (enrollment in health insurance, food assistance, unemployment benefits). Helps orgs create nutrition policies.

Community Organizations: What services would you like that you haven't been able to access/use? What have been the barriers?

- Ypsilanti District Library: Organizations don't have staff with expertise in grant writing, grant writing support would be helpful. Ann Arbor Area Community Foundation offered a simple RFP and then matched community organizations with similar interests. Organizations found this helpful.

TA providers and funders: What have you heard from your service-users about gaps/ other needs? What services do you see a need for have you wanted to offer but haven't been able to? Why not? Are there groups that you have found harder to reach/access?

- MICHR: We fund community engaged research projects, but community partners are rarely involved in budget conversations and decision making about how research budgets will be spent/money will be allocated. (points to a structural and power issue). Sometimes faculty and community orgs don't know who to contact/who to get in contact with. Faculty don't know how to describe their work to community partners, which can make match-making hard, and make it difficult for community partners and faculty to have shared expectations.

- PMCH: Sees that there is a need for grant writing support, strategic planning, and board development. Additionally, with COVID many organizations that relied on volunteers had to shut down because the majority of volunteers were older and cannot volunteer during COVID. Some for-profit organizations also need help but are not able to apply for grants. For example, Senior Living Facilities.

- NEW Center: Many grant applications/reporting requirements are too onerous to make it worth it for organizations to apply.

How do we best collaborate in capacity building for our community?

- MICHR: Start conversations with MICHR leadership (Julie Lumeng, Erica Marsch, and Tricia Piechowski).

- St Joe's: Bring multiple partners together. For example, a funder brought in trainers for 4-8 hour training that gathered together local government, non-profit organizations, senior centers, and schools. This offered opportunities for networking and facilitating connections. Many of the rural organizations have just 1-2 paid staff plus volunteers, so it can be hard/ intimidating to connect with other local leaders.

- Program Evaluation Group: Offer four convenings a year on technical topics (organizations determine the focus). It could be board development or other topics. Would allow for multiple organizations to learn at once. The convenings could bring together organizations in similar domains/affinity areas - housing, youth-serving organizations, etc.

● Ginsberg: Organizations are strapped for time and capacity. There is a need for implementation support, not just consultation. Organization has to all do the follow-up--is there a series that is complementary to what we offer through the students. Multiple organizations from this call could co-sponsor events together and invite people widely.

● MICHR: Offer support for faculty who are committed to dedicating their career to community-based work. If we don't invest in and support these faculty, they will take their relationships and research dollars with them to different institutions. Develop strategies to sustain relationships with these faculty so they can have the impact in the community that they want to have.

What do you see as MM's role in this? What could/should MM offer?

Possible Ideas: survey, scholarships for folks to participate in trainings/workshops, etc).

● Ask the Community Foundation of SE Michigan if they have any information on what the community needs. They may have done a survey in the past. They helped provide the training in Chelsea, they might have data on it. Still might be helpful to do a survey, especially since needs have changed so much.

● Ginsberg: So many units are doing so many things and trying to figure out how we work across the units. Ginsberg is exploring a model in which community partners create the RFP and campus partners apply to the community. This is the opposite of the current model. Proposes a shared funding model/grant application across multiple campus partners (i.e., Common App, a process for applying to college and universities that centralizes the process for wide application).

● MICHR: Proposes a system that would help people know about resources available from different entities. "A sequenced constellation" that takes partners through the steps to determine what resources are the right fit for them and how to apply, in order to help partners, extend and sustain their work (a warm handoff model).

● A community representative noted that when funding bodies come together it can reinforce the hegemonic non-profit funding model. For example, with Coordinated Funders, small organizations didn't fit into any of the priority areas so fell through the cracks. It is important to make grant making efficient without losing the agile nature of direct interactions. Perhaps discretionary funds outside of the priority areas could help create agility.

Closing Summary

● There are discrete needs in the community, such as web support, grant writing, emergency fundraising, adaptive finance models, pandemic tech support, and implementation support.
● There are structural and power dynamics at play. Funders/TA providers can commit to making RFPs and TA convenings community-driven and shaped, and accessible (streamline processes, without compromising responsiveness to unique needs)
● There are many opportunities if we align our asks, and mutually reinforce our messaging to leadership.
● There is a need to trust community partners and ensure we don't force our partners through a machine that doesn't suit them. Emergent strategy and adaptiveness are critical.

Appendix E - Community Engagement (continued)

Michigan Medicine Listening Session

February 2021, Michigan Medicine (MM) Leadership met with trusted and influential faith leaders, county officials, community activists, and community program directors to garner their feedback on MM's efforts to address racism as a public health crisis and improve the culture. A follow-up debrief session was held in May. This discussion generated themes of racism and discrimination, health equity and social needs. The social needs specifically pertained to housing, transportation, education and navigating health care. Recommendations:

Strategically plan and implement a way to have a continued presence in distressed areas or areas with the most need.

- Be open to the expertise that [community] brings to the table – lived experiences
- Create a culture where people are heard and seen (no longer invisible) or suspect
- Create pipeline programs (e.g., high school to nursing school) but also for employment
- Community investments (e.g., Birthing Center in Ypsilanti)
- Value community members by compensating them for their time and expertise

Appendix E - Community Engagement (continued)

UNITE Group Stakeholder Engagement Meeting: Food Security during COVID

On August 31, 2020, the UNITE group convened a group of stakeholders to discuss Food Security within Washtenaw County. This group identified possible strategies for increasing Food Security in the UNITE service areas:

Policy and Advocacy
Advocacy for continuation of funds that have emerged from CARES Act and FEMA Funds. Advocacy on issues such as SNAP, USDA commodities. Increase accessibility of purchasing with SNAP. Reducing frequency people have to recertify for benefits, especially seniors.

Scaling Up Programs that Work to Fill Gaps
Support for school meals, increasing screenings for SDOH in health care settings, increasing access to Double Up Food Bucks. Addressing transportation barriers impacting students' ability to access meals during COVID. Support for new food pantries that are emerging. Need to make sure people are safe and warm when picking up groceries from food pantries during winter. Filling gaps for organizations that haven't been able to utilize volunteers during COVID, especially because the majority of volunteers are older adults. Increasing access to COVID tests so volunteers can get tested more. Possible engagement with Catchafire to expand support for organizations through partnership with volunteers with specialized skills.

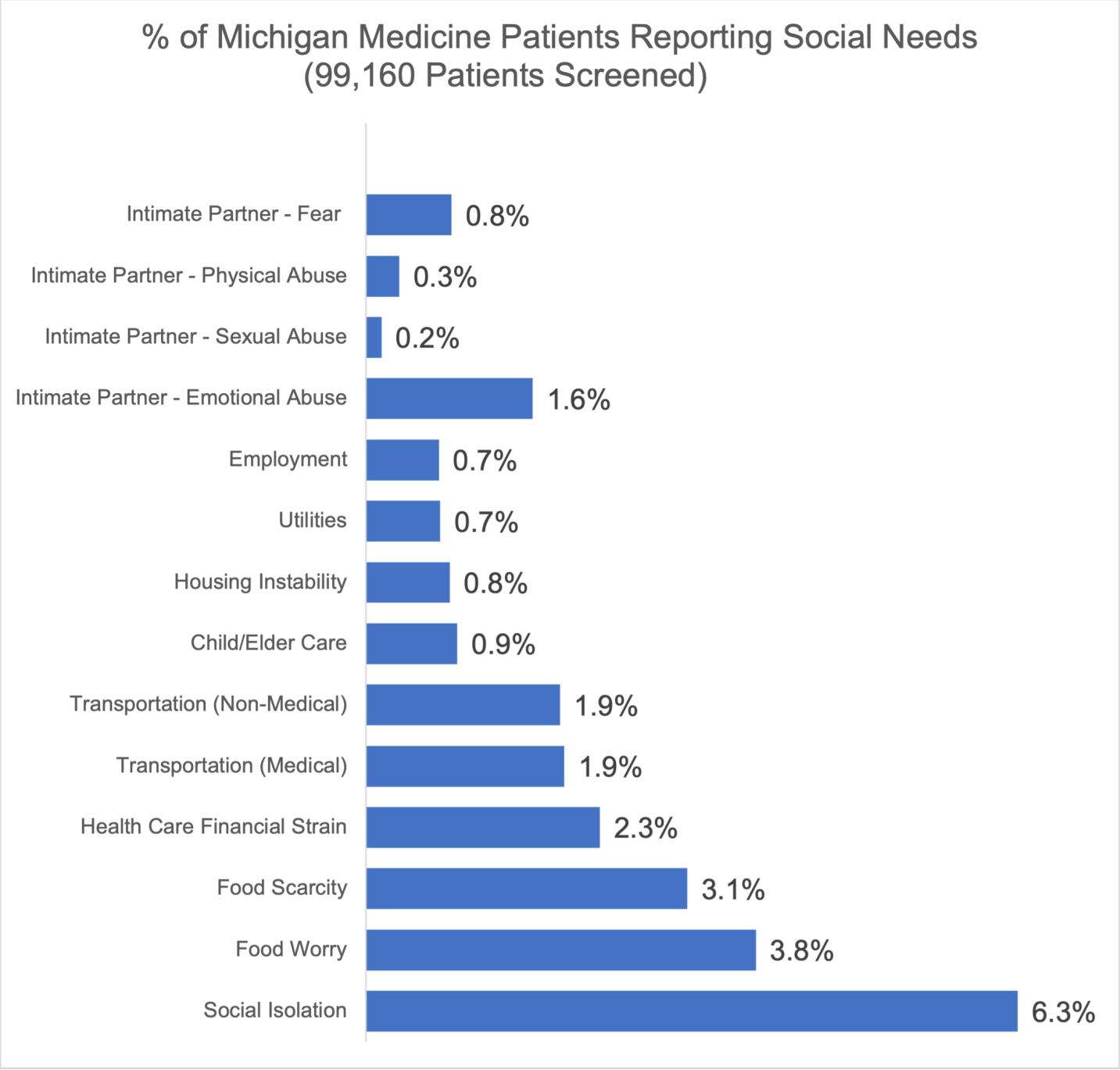
Iterative Community Feedback Loop
Offer support to ensure a strong, formal collaborative network on food security in Washtenaw County. There could be opportunities to collaborate with the Local Food Summit to incorporate more of a public health and hunger relief lens.

Community-Driven Investment Strategies/Sustainable Funding Streams for Collaborative Work
Consider how to bring in dollars to support community health and wellbeing through development and reimbursement strategies.

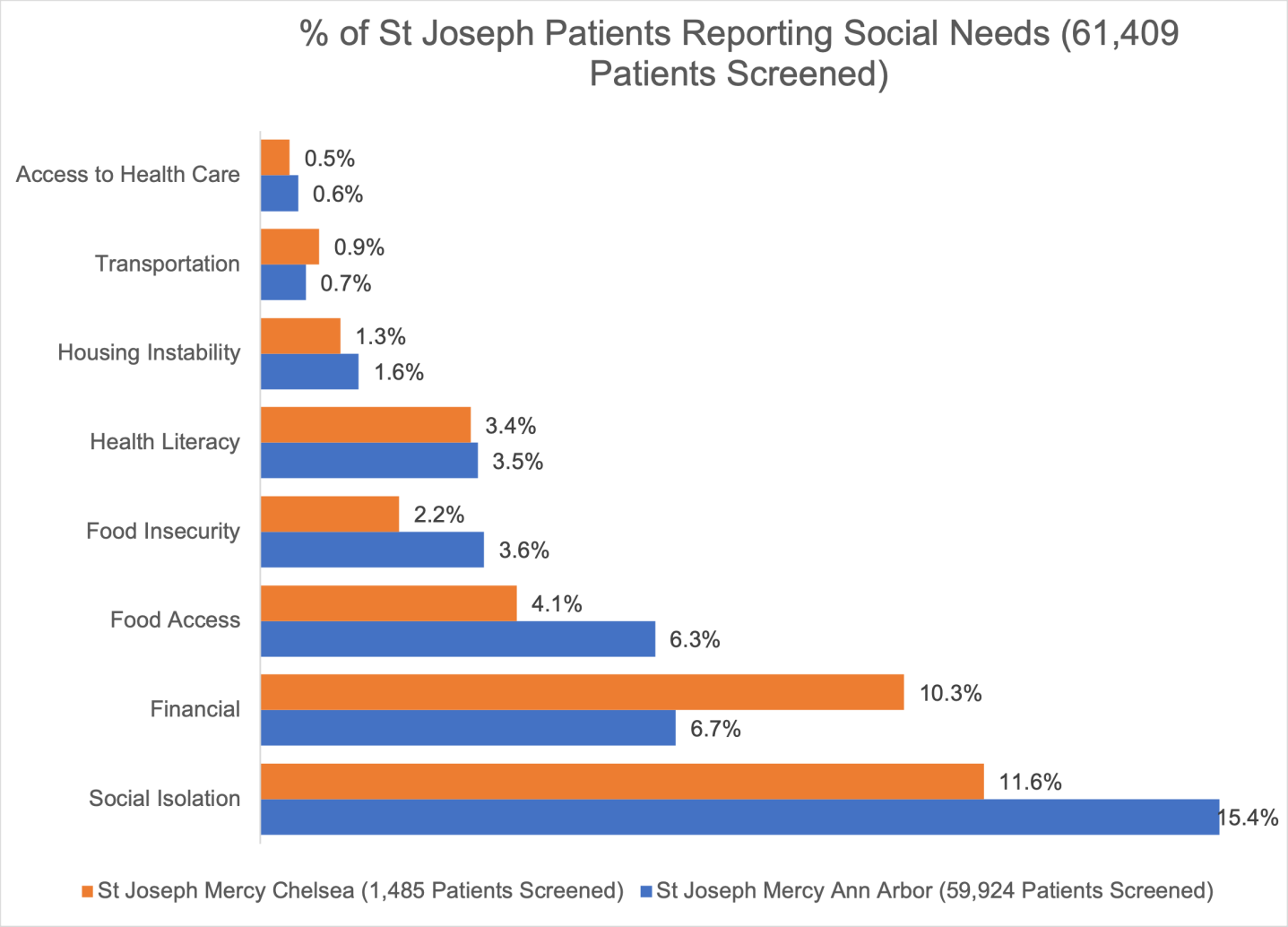
Appendix F: Patient Social Need Screenings

Michigan Medicine and St Joseph Chelsea and Ann Arbor have implemented Social Needs Screenings in primary care settings in order to better understand the needs of their patients and facilitate connection to resources.

During Fiscal Year 2020 (July 1, 2019 – June 30, 2020), Michigan Medicine Screened 99,160 patients for Social Needs. 12,190 unique patients answered "yes" to one or more of the Social Need Screener questions. The most common issues identified by Michigan Medicine patients were Social Isolation, Food Worry, Food Scarcity, and Health Care Financial Strain.



During Calendar Year 2020 (January 1 – December 31, 2020), St. Joseph Mercy Ann Arbor and St. Joseph Mercy Chelsea screened 61,409 patients for Social Needs. As with Michigan Medicine patients, the most common issues identified by patients were Social Isolation, Food Access and Insecurity, and Financial Strain.



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