Saint Joseph Mercy Livingston
Community Health Needs Assessment Implementation Strategy
Fiscal Years 2019-2021

Saint Joseph Mercy Livingston (SJML) completed a comprehensive Community Health Needs Assessment (CHNA) that was adopted by the Board of Directors in June, 2018. SJML performed the CHNA in adherence with certain federal requirements for not-for-profit hospitals set forth in the Affordable Care Act and by the Internal Revenue Service. The assessment took into account input from representatives of the community, community members, and various community organizations.

The complete CHNA report is available electronically at http://www.stjoeshealth.org/cbm. This page also includes an opportunity for community members to provide comment and request a hard copy of the documents. Printed copies are available at Saint Joseph Mercy Livingston.

Hospital Information and Mission Statement
Saint Joseph Mercy Livingston (SJML) is one of 10 hospitals comprising Trinity Health Michigan/Saint Joseph Mercy Health System/Mercy Health. These 10 hospitals span across western and southeast Michigan. Saint Joseph Mercy Livingston is a 136-bed hospital located in Howell and serving Livingston County. Additional services in the community are provided in part through Saint Joseph Mercy Brighton, an outpatient health center housing primary care and specialty physicians, comprehensive diagnostic and testing services, emergency services, outpatient surgery and cancer care.

The service area for Saint Joseph Mercy Livingston's CHNA is defined as Livingston County, as the majority of patients served by the hospital are from this county. Livingston County is located on the southeast side of Michigan, bordered by Washtenaw, Genesee, Shiawassee, Oakland, Ingham and Jackson counties. The Census Bureau 2017 population estimates are at 189,651, an increase from the last cycle’s CHNA. The population seeing the largest increase is 65 and over, with a 66% increase recorded in the 2000-2010 Census, and a
projected increase through 2040 identified by Southeast Michigan Council of Governments. White individuals make up 96.7% of the population.

The American Community Survey 2012-2016 reports that 61% of Livingston County families have an income over $75,000; this is much higher than the state rate (42%) and the national rate (45%). According to the GINI index on Community Commons, which measures income inequality, it is evident that while local Federal Poverty Level rates, children living in poverty, and unemployment are lower than state rates, some residents are experiencing grave inequities. GINI index values range between zero and one; a value of zero indicates perfect equality, where all households have equal income. Michigan and the United States have similar GINI Index rates of 0.46 and 0.48, respectively; Livingston County reports a GINI Index value of 0.4.

Mission
We, Trinity Health, serve together in the spirit of the Gospel to be a compassionate and transforming healing presence within our communities.

Health Needs of the Community

The CHNA conducted in 2018 identified three significant health needs within the Saint Joseph Mercy Livingston community. To identify these needs, a larger group of health needs were identified based on a review of data from multiple data sources, community focus groups and key stakeholder/informant interviews to determine potential priority areas. Potential priority areas were evaluated based on the following agreed-upon criteria, taken from each hospital’s previous criteria, and based on common public health frameworks:

1. The number of people impacted
2. Severity of the problem
3. SJML’s ability to positively impact the potential priority
4. SJML’s ability to enhance existing resources and/or complement strategies
5. Alignment with institutional missions
6. Impact on health equity

Potential priorities were ranked using a point system based on how well the potential priorities met the criteria listed above. To emphasize criterion 6, a subgroup of Community Benefit Ministry Council members and community stakeholders separately ranked each potential priority. The rank was then multiplied by a factor reflecting impact on equity for each potential priority, allowing for health equity to have a distinct impact on the final selection of top health priorities.

Ranked potential priorities were presented to the CBMC for review before being presented for approval and adoption to the hospital board.

Behavioral Health  •  Behavioral health was one of the most prevalent issues discussed in both key stakeholder interviews and focus groups. Feedback from the community
showed difficulty in accessing the limited number of providers for substance use issues and mental health in the community, coupled with stigmatization around acknowledging the need to seek support.

- The suicide rate in Livingston is 14.3, which is above both the state and Healthy People 2020 rates (12.7 and 10.2, respectively)
- The drug overdose rate in the county is 17 per 100,000, which is above the state rate of 15, and the Health People 2020 goal of 10.2
- Community feedback shows concern about overdose rates, and a desire to enhance and build on upstream and downstream strategies including naloxone intervention and increased training among law enforcement and access to treatment.
- 23% of adults in Livingston report as binge drinkers (12% in top US performers, 20% at state level), and the alcohol-impaired driving death percentage (36%) is much higher than the state percentage (29%)

**Obesity and Cardiovascular Disease**

- Community members identified obesity, food access, and cardiovascular disease as concerns in the community.
- The Coronary Heart Disease mortality rate in Livingston County is 134.2 out of 100,000, which is higher than the state rate of 131, and much higher than the Healthy People 2020 goal of 103.4
- Data shows a 9.95 grocery store rate per 100,000 residents across the county; this is much lower than the state rate of 18.77; WIC and SNAP authorized stores show much lower rates than the state at 4.53 and 12.7 (state rates at 10.11 and 21.7, respectively).

**Access to Care**

- Community members consistently expressed concerns about shortages of physicians, creating a barrier to accessing care in Livingston County.
- The rate of community members to primary care providers is 2,020 to 1, significantly higher than the state rate of 1,240 to 1
- The rate of community members to mental health providers is 680 to 1, significantly higher than the state rate of 460 to 1

**Transportation**

- Consistently described by community members and stakeholders interviewed as a barrier to accessing care and social determinants of health (housing, education, employment, etc)
- 53% of community members commute 30+
Food Insecurity

- Community members identified food access as main concerns
- Grocery store rates across the county are at 9.95 per 100,000 residents, much lower than the state rate of 18.77
- WIC and SNAP authorized stores show much lower rates than the state at 4.53 and 12.7 (state rates 10.11 and 21.7 respectively)
- 29.9% of community members report experiencing low food access

Affordable Housing

- Consistently mentioned as a barrier to improving health outcomes by community members
- Severe housing problems percentage as reported is at 12%

Hospital Implementation Strategy

Saint Joseph Mercy Livingston resources and overall alignment with the hospital’s mission, goals and strategic priorities were considered when identifying the significant health needs through the most recent CHNA process.

**Significant health needs to be addressed**

Saint Joseph Mercy Livingston will focus on developing and/or supporting initiatives and measure their effectiveness, to improve the following health needs:

- Behavioral Health – Detailed need specific Implementation Strategy on page 5
- Obesity and Cardiovascular Disease – Detailed need specific Implementation Strategy on page 8
- Access to Care – Detailed need specific Implementation Strategy on page 10

**Significant health needs that will not be addressed**

Saint Joseph Mercy Livingston acknowledges the wide range of priority health issues that emerged from the CHNA process, and determined that it could effectively focus on only those health needs which it deemed most pressing, under-addressed, and within its ability to influence. Saint Joseph Mercy Livingston will therefore not take formal action on the following health needs:

- **Transportation:** This will not be a priority health issue, but SJML will continue to advocate for and work with community partners on mitigating transportation barriers for community members, especially as it relates to access to care and behavioral health, as these were two areas in which transportation was identified as a main concern.
o **Food Insecurity:** Although this social determinant of health will not be addressed, it will be highlighted within the Obesity and Cardiovascular Disease strategies.

o **Affordable Housing:** Although this social determinant of health will not be a priority health issue, but SJML will continue to advocate for and work with community partners, especially through SOAR Coordination work and housing workgroups in which SJML staff have a presence, to improve housing conditions for those in the community.

This implementation strategy specifies community health needs that the Hospital has determined to meet in whole or in part and that are consistent with its mission. The Hospital reserves the right to amend this implementation strategy as circumstances warrant. For example, certain needs may become more pronounced and require enhancements to the described strategic initiatives. Likewise, during the three years ending in 2021, other organizations in the community may decide to address certain needs, indicating that the Hospital then should refocus its limited resources to best serve the community.
## CHNA Implementation Strategy
### Fiscal Years 2019-2021

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<th>Hospital Facility:</th>
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<td>Behavioral Health</td>
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### Brief Description of Need:
- Behavioral health was one of the most prevalent issues discussed in both key stakeholder interviews and focus groups. Feedback from the community revealed difficulty in accessing the limited number of providers for substance use issues and mental health in the community, coupled with stigmatization around acknowledging the need to seek support.
- The suicide rate in Livingston is 14.3, above the state rate and the Healthy People 2020 rates (12.7 and 10.2, respectively)
- The drug overdose rate in the county is 17 per 100,000, which is above the state rate of 15, and the Health People 2020 goal of 10.2
- Community feedback shows concern about overdose rates, and a desire to enhance and build on upstream and downstream strategies including naloxone intervention and increased training among law enforcement and access to treatment.
- 23% of adults in Livingston report as binge drinkers (12% in top US performers, 20% at state level), and the alcohol-impaired driving death percentage (36%) is much higher than the state percentage (29%)

### Goal:
- Improve mental health through prevention and by ensuring access to appropriate, quality mental health services and supports
- Reduce Substance Use Disorders to protect the health, safety, and quality of life for all Livingston County residents

### Objective:
- Increase the proportion of individuals with access to mental health services and Supports (metric under development)
- Reduce the number of opioid overdoses/deaths as reported by Livingston County Health Department (metric under development)
- Reduce tobacco use among high school aged adolescents by 2% as reported through the Michigan Profile for Healthy Youth (based on tobacco use in last 30 days)
- Reduce the number of alcohol-related driving deaths in Livingston County by 2% over a three year trend as reported through County Health Rankings
- Improvement in tobacco control policies through advocacy
- Improvement of driving while impaired policies through advocacy
## ACTIONS THE HOSPITAL FACILITY INTENDS TO TAKE TO ADDRESS THE HEALTH NEED:

1. Advocate for the improvement of driving while impaired policies county and state-wide
2. Work with physician network to improve communications around alcohol use among adult patients
3. Expand presence and align existing resources around behavioral health services in primary care and community settings
4. Continue to collaborate with CMH around Peer Support models for SUD.
5. Continue to participate in efforts to address housing issues of vulnerable populations and improving access to SSI/SSDI benefits for eligible community members through SOAR coordination
6. Continue to improve referral processes internally to community supports around behavioral health community services
7. Explore the provision of safe medication disposal method on hospital campus and through physician network
8. Financially support the LCCA’s Drug Free Community’s ongoing work through $20,000 annual match funds, which includes the following areas: opioids, youth alcohol use, and youth marijuana use
9. Enhance standard physician practice and clinic flow process improvement policies around tobacco cessation counseling and referral
10. Advocate for expansion of tobacco control policies in the community
11. Coordinate Health Exploration Station youth presentations with LCCA’s local awareness campaigns around e-cigarette use

## ANTICIPATED IMPACT (see above for overarching measurable objectives):

1. Increase in right time, right place utilization of mental health services
2. Reduction in readmission rates in those receiving SSI/SSDI benefits through SOAR coordination assistance
3. Community opioid use reduced
4. Naloxone opioid overdose reversals
5. Youth use of tobacco reduced
6. Alcohol-related traffic deaths reduced
7. Increase in access to care for opioid use treatment
8. Improvement of tobacco cessation referral process and follow-through

## PLAN TO EVALUATE THE IMPACT:

1. Readmission rate reports assessed at a minimum each year
2. Perception of ease of access to right time, right place utilization of mental health services through patient experience reports assessed at a minimum each year
3. Number of self-report opioid use reduced through BRFSS survey results with most readily accessible data year available and through other collection means being developed within the community
4. Implementation of safe medication disposal method (under development)
5. Pounds of medications collected through safe medication disposal method (measurement method not currently developed)
6. Naloxone opioid overdose reversals through data collection means being developed within the community
7. Number of self-report tobacco use among youth reduced through Michigan Profile for Healthy Youth in upcoming two-year survey cycle
8. Number of alcohol-related traffic deaths reduced through County Health Rankings trend
reporting (resulting from three year trend of yearly CHR reports if available), or from law enforcement reporting entities.

9. Tobacco related policies impacted (under development)
10. Driving while impaired policies impacted (under development)
11. Number of individuals who are accessing opioid use treatment through BRFSS with most readily accessible data year available and internal patient reports assessed at a minimum each year
12. Number of tobacco cessation referrals as captured through Electronic Medical Record assessed at a minimum each year
13. Quit rates among referred individuals as reported through internal tobacco cessation programming support assessed at a minimum each year

PROGRAMS AND RESOURCES THE HOSPITAL PLANS TO COMMIT:
1. Staff time needed for programming, participation in collaborative workgroups, boards and to support policy and environmental changes.
2. Funding for programs, community collaborations, and organizations who have demonstrated a need for assistance in addressing the priority health needs
3. Programs already in existence that address priority health needs

COLLABORATIVE PARTNERS (not exhaustive):
1. Community Mental Health
2. Livingston County Community Alliance
3. Human Services Collaborative Body partners
# CHNA Implementation Strategy

**Fiscal Years 2019-2021**

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## Brief Description of Need:
- Community members identified obesity, food access, and cardiovascular disease as concerns in the community.
- The Coronary Heart Disease mortality rate in Livingston County is 134.2 out of 100,000, which is higher than the state rate of 131, and much higher than the Healthy People 2020 goal of 103.4
- Data shows a 9.95 grocery store rate per 100,000 across the county; this is much lower than the state rate of 18.77; WIC and SNAP authorized stores show much lower rates than the state at 4.53 and 12.7 (state rates at 10.11 and 21.7, respectively).

## Goals:
- Promote healthy weight and reduce chronic disease risk, incidence and prevalence among youth and adults
- Improve food systems infrastructure in the community through collaboration to increase equitable access to healthy food

## Objective:
- Decrease the percent of obese or overweight individuals by 3% as reported in the BRFSS
- Decrease the number of individuals who report food insecurity through SJML supported programming by 80%
- Decrease the Coronary Heart Disease mortality rate in Livingston County by 2%
- Increase the number of WIC and SNAP authorized stores in Livingston County through advocacy

## Actions the Hospital Facility Intends to Take to Address the Health Need:
1. Continue to support and enhance Prescription for Health programming in partnership with Livingston County Health Department and physician partners
2. Support policies, systems, and environmental changes that work to eliminate food insecurity
3. Support, maintain, and explore programs that target nutrition education including: Health Exploration Station and ShapeDown program
### CHNA Implementation Strategy

**FISCAL YEARS 2016-2019**

4. Continue to provide comprehensive weight loss clinical support through the Michigan Bariatric Institute
5. Expand intensive cardiac rehabilitation services into Livingston County
6. Continue to operate and expand Diabetes Prevention Programming in Livingston County

### ANTICIPATED IMPACT (see above for overarching measurable objectives):

1. Decrease in food insecurity among vulnerable populations
2. Increase in consumption of fruits and vegetables
3. Increase in self-reported positive health behavior change around eating habits
4. Decrease in BMI among specific program participants
5. Decrease in those experiencing high blood pressure, high cholesterol

### PLAN TO EVALUATE THE IMPACT:

1. Self-reported health metrics and produce consumption through SJML sponsored program yearly reporting
2. BMI screening and referral rates through Electronic Health Records assessed at a minimum yearly
3. Annual sales, utilization rates, and monies supporting farmers markets through SJML sponsored program yearly reporting
4. Number of eligible people in publicly funded programs (Medicaid, SNAP benefits, WIC, etc) reporting accessible utilization of programs as reported through collaborating community programs (WIC, farmers market support programs, etc) (reporting structure in development)
5. Number of individuals achieving weight loss goals through clinical support services offered by SJML as reported through Electronic Health Records assessed at a minimum yearly
6. Decrease in admission rates due to cardiovascular events after expansion of intensive cardiac rehabilitation services as reported through Electronic Health Records assessed at a minimum yearly

### PROGRAMS AND RESOURCES THE HOSPITAL PLANS TO COMMIT:

1. Staff time needed for programming, participation in collaborative workgroups, boards and to support policy and environmental changes.
2. Funding for programs, community collaborations, and organizations who have demonstrated a need for assistance in addressing the priority health needs
3. Programs already in existence that address priority health needs

### COLLABORATIVE PARTNERS (not exhaustive):

1. Livingston County Health Department
2. Human Services Collaborative Body partners
3. Gleaners Food Bank
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**BRIEF DESCRIPTION OF NEED:**
- Community members consistently expressed concerns about shortages of physicians, creating a barrier to accessing care in Livingston County.
- The rate of community members to primary care physicians is 2,020 to 1, significantly higher than the state rate of 1,240 to 1.
- The rate of community members to mental health providers is 680 to 1, significantly higher than the state rate of 460 to 1.

**GOAL:** Improve healthcare access for community members

**OBJECTIVE:**
- Increase the number of community members utilizing right time, right place healthcare as reported through patient experience, readmission rates, and BRFSS reports.

**ACTIONS THE HOSPITAL FACILITY INTENDS TO TAKE TO ADDRESS THE HEALTH NEED:**
1. Increase the number of primary care physicians in the community by growing the number physicians in existing practices and opening four new primary care sites in Howell, Brighton, Pinckney, and South Lyon.
2. Continue to improve access to specialty care as indicated by market share analysis indicators, including but not limited to surgical services.
3. Enhance age-friendly health system strategies to improve the healthcare experience and navigation of the aging population.
4. Continue to participate in community efforts to improve transportation opportunities and infrastructure.
5. Implement social determinants of health screenings among patients and through partner community agencies to assess and refer or connect when possible individuals with necessary support services.

**ANTICIPATED IMPACT (see above for overarching measurable objectives):**
1. Improved access to healthcare for community members.
2. Improved transportation opportunities and infrastructure.

**PLAN TO EVALUATE THE IMPACT:**
1. Number of physicians in the community as reported through internal expansion efforts consistent with strategic plan timelines and data reporting.
2. Emergency Department visits for non-acute issues as reported through Electronic Health...
2. Emergency Department visits for non-acute issues as reported through Electronic Health Records assessed at a minimum each year
3. Number of physician offices given resource support around the aging population as reported through number of offices engaged through Senior Services Committee reporting (timeframe of reporting in development)
4. Number of senior centers and churches given resource support around the aging population as reported through number of community entities engaged through Senior Services Committee reporting (timeframe of reporting in development)
5. Hospital readmission rates as reported through Electronic Health Record assessed at a minimum yearly
6. Consumer perception of access through patient experience surveys assessed at a minimum yearly and BRFSS surveys with most readily accessible data year available
7. Transportation policies, infrastructure improvement through Transportation Coalition reporting (strategic plan and timeline in development)

PROGRAMS AND RESOURCES THE HOSPITAL PLANS TO COMMIT:

1. Staff time needed for programming, participation in collaborative workgroups, boards and to support policy and environmental changes.

2. Funding for programs, community collaborations, and organizations who have demonstrated a need for assistance in addressing the priority health needs

3. Programs already in existence that address priority health needs

COLLABORATIVE PARTNERS (not exhaustive):

1. Human Service Collaborative Body partners

Adoption of Implementation Strategy

On October 24, 2018 the joint Board of Directors for Saint Joseph Mercy Ann Arbor and Saint Joseph Mercy Livingston met to discuss the 2019-2021 Implementation Strategy for addressing the community health needs identified in the June 2018 Community Health Needs Assessment. Upon review, the Board approved this Implementation Strategy and the related budget.

Name & Title

Ani Turner
SJMHs Ann Arbor-Livingston Board Chair

10/25/18 Date