2012 COMMUNITY HEALTH NEEDS ASSESSMENT
ST. JOSEPH MERCY OAKLAND

Approved by the Board of Trustees:
June 27, 2012

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Michigan Department of Community Health
Catholic Social Services of Oakland County
Centro Multicultural La Familia, Inc.
Oakland Livingston Human Service Agency

Mission
We serve together in Trinity Health,
in the spirit of the Gospel,
to heal body, mind and spirit,
to improve the health of our
communities, and to steward the
resources entrusted to us.

Core Values
Respect
Social Justice
Compassion
Care of the Poor and Underserved
Excellence

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I. Introduction and Mission Review

St. Joseph Mercy Oakland (SJMO) is a 443-bed comprehensive community teaching hospital, and a long-time leader in health care in Oakland County. Founded in 1927 by the Sisters of Mercy, the hospital has won numerous local and national awards for patient safety, quality, and performance, and consistently ranks in the top 10% of hospitals nationwide. Recently, SJMO earned a "2011 Top Hospital" designation for patient safety and quality of care by The Leapfrog Group. A member of the Saint Joseph Mercy Health System, St. Joseph Mercy Oakland is a leader in technology, and a hospital that combines advanced medicine with personal care to assist patients on their path to wellness. With dedicated physicians, nurses, and hospital staff committed to providing quality care throughout the patient stay, St. Joseph Mercy Oakland truly personalizes the patient care experience—an experience that reflects our Trinity Health Values of Respect for the Dignity of the Human Person, Compassion, and Excellence.

Our other Values of Social Justice and Care for the Poor and Underserved require us to develop a Community Benefit Implementation Plan that fulfills our Mission, meet the needs of our community, and maximize good stewardship of the resources entrusted to us. To do so, it is necessary that we assess both our objective and subjective impact on the community: What impact do we actually have, and What do our neighbors perceive our impact to be? We must identify and nurture good working relationships with other persons, institutions, and agencies that are involved in providing services to support the health of our community. A rigorous Community Health Needs Assessment (CHNA), based on both quantitative and qualitative research, with contributions from residents of our community, physicians, business owners, and partners and potential partner agencies, is an integral part of such a full environmental assessment.

SJMO completed its last Community Needs Assessment in 2007. Inquiries grounding both that assessment and this 2012 CHNA involve questions about the needs of the entire community. In accord with the traditions of the Sisters of Mercy, who founded SJMO in 1927, and the Mission and Values of Trinity Health, the questions focus on the needs of the poor and underserved, recalling the biblical *anawim*—the lost and forgotten ones at the outskirts of society. In biblical times, they were the lepers, the lame, and the blind. Today we focus on the modern anawim, the underinsured and the uninsured, and all those who struggle to gain access to health care, including those who do not speak English or who feel threatened by their undocumented status in this country. For their sake, we ask three questions: “Who needs help?” “What help do they need?” and, “What help can St. Joseph Mercy Oakland provide?”

We cannot do everything alone, but neither can we ignore unmet needs. We thus ask two additional questions: “When We Cannot Help, Who Else in the Community Will?” and “How Can SJMO Facilitate Their Efforts?” With this in mind, we enthusiastically seek and accept opportunities to partner with others in our community, and this CHNA will serve as a guide in creating the subsequent Implementation, ensuring that the needs of the community are accurately assessed and appropriately addressed.

We ask the four questions above not merely out of a practical desire to contribute to our community, but from the mandate of our Mission and Values. These come to us from the example of the Sisters of Mercy, whose actions, in turn, were rooted in the healing ministry of Jesus himself. He called us to do unto others as we would have them do unto us: It is this message that grounds our outreach to the community and all our Community Benefit activities and expenditures.

II. A Retrospective Review of the 2007 SJMO Community Needs Assessment and Our Responses

"Health Care disparities" is clearly the overarching theme of Community Benefit services. As will be demonstrated in the following pages, the overwhelming disparities in all aspects of life between the Pontiac community and the other communities in our service area are stark, compelling, and perhaps even unique. For that reason, while we have Community Benefit outreach efforts throughout our service area, our Community Benefit dollars and programs are strongly focused on Pontiac.

What we learned from the 2007 Community Needs Assessment was that the Pontiac community needed continuing assistance in maintaining asthma care and in improving its high infant mortality rate, and that special focus throughout our service area was needed in fighting obesity, diabetes, and related cardiovascular disease. Comprehensive help needed to be provided to the community through education, screening, and affordable, ongoing care for all, from the unborn to the elderly, as well as through better transportation to medical services and provision for a better diet for many. Our community also identified a need for improved dental services and further outreach efforts to foreign-born persons—specifically, Hispanic and Hmong communities. From the 2007 focus groups, we learned that the perception of SJMO in the community was improving, but that we needed to be more "user-friendly" in access and accommodation. That is, we needed to help people with the logistics of accessing care, and we needed to diversify our signage and improve the foreign language skills of our associates and medical staff.

In response to the needs identified in 2007, and mindful of the Trinity Health system-wide commitment to focus on Diabetes and CHF, we have initiated, improved, or expanded the following services:

Diabetes:

- Diabetes Self-Management Training Program – We provide comprehensive education and support for diabetic patients and their families. This program was one of the first to be implemented in the area and is certified by the State of Michigan and by the American Association of Diabetes Educators. Registered nurses and dietitians, including certified diabetes educators, staff the program, which is held in locations both on and off the SJMO campus. The educational focus of these efforts includes nutrition, medication management, goal-setting, and stress reduction. SJMO also collaborates with other healthcare providers to raise awareness of diabetes in the community.

- Mercy Place Clinic – Our offsite clinic for the employed but uninsured population offers a wide-range of services, but has special focus on those with diabetes, providing them with comprehensive treatment, including eye and foot exams, at low or no cost through Mercy Support.

- In 2010, we began a community study to provide home-based telemonitoring systems for diabetic patients, to test for effectiveness and improved outcomes among the Community Benefit population. The goals have been to increase compliance in the measurement of blood glucose levels, and to reduce hospital admissions as a result of complications from diabetes.

Cardiovascular Disease:

- The Michigan Stroke Network – In October 2006, SJMO opened the Michigan Stroke Network in conjunction with Trinity Health. Through the Network, physicians from SJMO are able to consult not only on patients in our own service area, but from across Michigan and neighboring states, to provide immediate advice—via a system of remote robots—for the urgent treatment of suspected stroke victims. Those patients are often airlifted to SJMO (within the critical treatment window), and are eventually returned to their own local physicians and hospitals for follow-up care.

- In 2009, our onsite Henderson Medical Clinic initiated a study to make certain that uninsured patients with diabetes, a history of AMI, or CHF, receive the same treatment, and have similar measurable outcomes as the insured. We are developing creative methods to address discrepancies in outcomes that stem from patient behavior, such as noncompliance with diet or medication. We are also working with our pharmacy staff to provide patients with personalized, one-on-one education and assistance with medications.

Infant Mortality:

- Our Clìnica Santa Teresa, once located in Mercy Place, has grown its obstetrical and perinatal services to Hispanic mothers since 2007, and the clinic's patient load has increased as word of mouth and messaging from SJMO Community Outreach personnel increase. These services are now located in the SJMO Mercy Womens Clinic.

  In 2010, a group of young SJMO RNs carried out an educational effort tied to the "Back to Sleep" program of the American Academy of Pediatrics (AAP), to update Mother/Baby nurses on AAP recommendations for safe posture, bedding, and clothing for sleeping infants. These nurses in turn continue to educate new mothers about safe sleep practices for their newborns.

- Healthy Start/Healthy Families Oakland was an award winning fully-credentialed collaborative program, led by St. Joseph Mercy Oakland, which provided home visitation services for vulnerable families with infants and young children throughout Oakland County. Unfortunately, the program lost its federal funding in 2011, and the hospital could not shoulder the financial burden of sustaining it. We have thus worked with Oakland Livingston Human Service Agency, Catholic Social Services of Oakland County, and other similar agencies to support the families once served by Healthy Start. We continue to seek aggressively other grants and funding sources that will help us support this population.

- Since adopting the OB Keystone principles of the Michigan Health & Hospitals Association, along with the Trinity Health Perinatal Patient Safety Initiatives, we have made significant improvements in protecting the health and well-being of newborns:

    - The percentage of early elective inductions performed at less than 39 weeks gestation fell from 26.3 % in 2009 to 3.3% in 2010 to the current 0% (November 1, 2010 through June 2012).

    - Neonatal Intensive Care Unit (NICU) admissions at greater than 37 weeks have decreased from 12% to less than 2%.

- Teamwork and communication have improved with monthly high-fidelity simulation and team building, weekly multidisciplinary electronic fetal monitoring strip reviews, safety huddles, and executive rounding by the Chief Medical Officer and Chief Nursing Officer. We are initiating and basing protocols and policies on the best practices and standards of care from the American College of Obstetricians, the Association of Women's Health and Neonatal Nursing, the American Academy of Pediatrics, and the National Association of Neonatal Nursing.

- More than 106 nurses, resident physicians, and attending physicians have successfully completed the National Certification Corporation-Electronic Fetal Monitoring exam, which has improved collaborative communication, use of standardized terminology, and understanding of the interpretation of fetal monitoring strips.

Obesity: Since the last CHNA, SJMO has initiated or developed a number of initiatives to address obesity, and by extension, diabetes, stroke, and heart disease:

- Shapedown - A10-week program, based on a holistic approach to weight management for children and teens. The program supports a gradual adoption of a moderate and healthy food intake that provides essential nutrients and leads to weight loss. It also stresses overall fitness, including endurance, flexibility and strength. Family involvement and communication are key components of the program.

- Senior Fit - A free exercise program that combines weight management and other health benefits, such as cardiovascular fitness and avoidance of osteoporosis, with supportive social interaction. It encourages older adults to exercise their way to a healthier lifestyle, through body strengthening, floor and chair exercises, and strength and flexibility training.

- The Metabolic Nutrition & Weight Management Program –This program is an integrated, educational, medical program for those looking to control their metabolic issues related to insulin resistance and obesity through dedication to nutrition, physical activity, and overall lifestyle change. It teaches individuals how to manage metabolic issues including type 2 diabetes, obesity, cholesterol, and blood pressure, by incorporating nutritional information, physical activity, and other lifestyle changes into their weight management objectives.

- Comprehensive Surgical Weight Loss Plan – A new bariatric surgery program offering various surgical approaches to weight management, as well as integrated solutions for related issues, such as sleep apnea, rehabilitation services, and behavioral medicine interventions.

Community Dental Needs:

- Dental Clinic/General Dental Residency Program – This much needed program is designed to provide a full range of dental services to the community, regardless of ability to pay. Patients, including uninsured patients, who present at the Emergency Department with an infection or illness rooted in dental disease, can now be treated on site. A unique aspect of the program is service to the developmentally disabled population and those with other special medical needs. This is a critical component, as cognitively impaired children and adults have few places to receive dental treatment in

our service area. The hospital-based clinic is one of the only places in Michigan that provides dental care to people with medical, physical, or developmental special needs, in a safe and comfortable setting, often including the use of anesthesia. Furthermore, the General Practice Residency provides extensive practice and learning experiences with this population for dental school graduates.

Language Training, Signage, and Translation Services:

- At present, we have signage and printed materials in English and Spanish. Our Get Well Network in-room information and entertainment system includes messages in Arabic. As a major construction project goes forward, we intend to focus on converting foreign language signage to universal pictograms, and to adding Arabic printed materials.

- Standard forms are offered in English and Spanish.

- Translation of standard forms, as well as translation services for patients, families, staff and physicians, are available in a multitude of languages via personal interpreter, telephone, and Skype technology.

- For four years, in response to the sharp increase in the number of Spanish-speaking patients, the hospital subsidized "Medical Spanish" classes for all interested staff. [••]

Asthma:

- We are in conversation with other agencies across the service area to identify who might take on this issue as a focus of concern. At present, it is seen as a concern, but not a major health issue in our particular service area. We have on our medical staff, and at our urgent care centers, staff qualified to assist asthma patients with both chronic and acute needs.

III. Executive Summary of the 2012 Community Health Needs Assessment

Creating the 2012 CHNA was a comprehensive and time consuming task that both reinforced and expanded our knowledge of our community and its health needs. It gave us an opportunity to understand the severity of the challenges that affect the health of our community, and to assess our responsiveness to those challenges. It also assisted us in determining where we might make programmatic improvements, revisions, and changes.

The data collection and assessment process, formally conducted over nine months in 2011, revealed that while many respondents *appear* stable at a cursory level, most are barely making it—they are underemployed, underinsured, and spend well more on housing costs than is conventionally recommended. These phenomena set the stage for a perfect storm of ill health and lack of access to appropriate care. Our respondents continue to battle the chronic diseases that afflicted them in 2007: diabetes, hypertension, cardiovascular disease, and obesity. In reviewing the data, our team was curious as to whether the third of respondents reporting their health as "ok" or "not good" correlated with the 16 – 37% who reported suffering from a chronic disease.

[••] The Hmong population has for the most part moved away from our community, and no longer calls for special accommodations.

Set against a backdrop of a faltering state economy, with a newly elected governor, our assessment reminds us that gubernatorial budget cuts further exacerbate the two primary underlying problems that affect health—underinsurance and lack of funding—by reducing benefits and cash assistance to those who are most in need of this support. These cuts have further resulted in the juxtaposition of Medicaid caseload increases against decreases in the number of physicians who accept the state-backed insurance, thus rendering tens of thousands of state residents virtually uninsured, added to the thousands who are actually uninsured.

Through the multiple and varied methods of assessment, data collection, and review, we confirmed that in addition to multiple intransigent socioeconomic factors, the cost of healthcare services and health insurance, and the lack of coverage for specialty care services, remain the primary barriers to good community health in the greater Pontiac area. Poverty, depression and other mental health issues, and the chronic diseases discussed in this report, continue to be the chief complaints reported by our respondents. While we are heartened to note that SJMO is already working vigorously to break down the primary barriers to good community health, we remain challenged by the realities of their continued existence in the community, and continue to engage them, however and wherever necessary. For example, we address the problem of access by offering three free or reduced cost primary care clinics; by offering financial support for clinic visits, diagnostic, and pharmaceutical services through our Mercy Support program; and by educating and screening underserved community members for chronic diseases, through our Community Health Ambassador program and the Faith Community Nursing program. We respond to other barriers, such as cost and coverage, at both the local and federal level, through non-partisan, grass-roots, education and advocacy work with staff, hospital and board leadership, our community, and our elected officials.

The steering committee acknowledges that our next CHNA endeavor should include a more diverse pool of respondents, both geographically and in respect to their engagement in (or connection with) programs that are designed to provide service for socio-economically disadvantaged populations. Our method for engaging this population was directly tied to our relationships with community service organizations, resulting in respondents who were already part of the health and social service network in some way. Determining a method for reaching out to and engaging more effectively those “outside the system,” either because they fear the system or have given up on it, or because they are more affluent, insured, and regular recipients of health care services, would bring additional perspectives to the study of our community.

SJMO prides itself on its strong community partnerships, through which we are able to provide referrals for health and social services outside our scope. We recognize, however, that even more formal collaboration and program integration is needed—beyond limited projects and grant funding—to create a comprehensive safety net for a continuum of health and social services available to the most vulnerable members of our community.

IV. THE SJMO COMMUNITY

SJMO serves all of Oakland County north of Eight Mile Road, an area of urban, suburban and rural communities. In Pontiac, where SJMO is located, there are two other hospitals: Doctors Hospital of Michigan (formerly North Oakland Medical Center, which has downsized significantly since 2008 to a very small for-profit, doctor-owned facility with few patients), and the newly created McLaren Oakland Medical Center (formerly Pontiac Osteopathic Hospital), which as of June 2012 is seeking to move its beds out of Pontiac. Located within the remainder of our larger service area are the following not-for-profit hospitals: William Beaumont, Henry Ford Health-

West Bloomfield, Huron Valley-Sinai, Providence Park, Providence, and Crittenton. Henry Ford Macomb Hospital, in Macomb County, also draws patients from our service area, and Botsford Hospital in Farmington Hills, and McLaren Regional Medical Center in Flint, offer psychiatric units for senior citizens. SJMO provides to the community four Urgent Care Centers (two more will be added soon) and a network of medical offices and diagnostic centers. An off-site ambulatory surgery center, in which we partner with physicians, is located in Waterford.

Oakland County is part of the Detroit metropolitan area, though the actual city of Detroit is located in neighboring Wayne County, south of Eight Mile Road. Oakland County is home to 62 cities, villages, and townships, and these communities range from economically depressed to extremely wealthy. Several white-collar cities host a diverse mix of Fortune 500 companies, and the cities of Royal Oak and Ferndale attract many young people to their mature, bohemian downtowns. Oakland County is also home to Oakland University. The county's knowledge-based economic initiative, coined "Automation Alley," is one of the largest employment centers for engineering and related occupations in the United States. But Oakland County has shared in the recent economic hardships, especially those brought on by troubles at General Motors, Ford, and Chrysler, since all three automotive companies are major employers throughout southeast Michigan. Still, with the exception of Pontiac, the county as a whole has fared better than Detroit to the south and Flint to the north, as its economy is more diverse and less reliant on manufacturing jobs.[1]

Pontiac is unique within Oakland County. It is both the County Seat and by far the county's poorest city. The latter is reflected in its listing as the only Federally Designated Medically Underserved Area in Oakland County.[2] It is also a Dental Care Health Professional Shortage Area.[3] While the average Community Need Index (CNI) in the SJMO service area is 2.09, which is lower than the 3.27 national average, there is a significantly higher CNI in the Pontiac region.[4] Comparative demographics for Michigan, Oakland County, and three small cities in an area that immediately borders on Pontiac and extends only 10 miles to its south (Bloomfield Township, Bloomfield Hills, and Birmingham), highlight the significant relative poverty in Pontiac, and the obvious need to focus SJMO Community Benefit resources there. Those comparative statistics will be found in Section VI of this report.

Recent History of Pontiac

The current situation in Pontiac did not develop overnight. Its roots are deep and tenacious, leaving many to believe that there is little likelihood that Pontiac's downward spiral will be significantly remedied in the near future.[5]

Once a thriving center of the automotive industry, Pontiac began its decline in the early 1960s. In interviews for this CHNA, a number of adults who grew up in Pontiac, or worked for GM or the UAW there, attribute the city's downfall to its virtually sole reliance on General Motors, and to imprudent local government decision making.•• When times were good for GM, jobs were plentiful, and large numbers of workers came from outside Michigan in the 1950s to work at the numerous GM plants across the city. Subjective accounts are that many of those workers were not tied emotionally to the city as "home," and thus did not keep up their properties. Race riots in Pontiac in 1967 added to the tension, hastening out-migration to the suburbs, which was then exacerbated in the 1970s, not so much by integration, these sources remember, as by busing.[6]

•• A city official in June of 2009 remarked that it was because of GM that Pontiac could no longer even afford the $400,000 it had spent each year on the upkeep of cemeteries. On the other hand, in 2007, the city refused a bid of $20M for the purchase from the city of the Silverdome, former home of the Detroit Lions, only to see it sold at auction in November of 2009 for a mere $583K.

Auto industry troubles began in the late 70s, blamed in part on contentious UAW leadership of the Union Local #594 from the late 70s into the 1990s.[7] This caused GM to pull plants from the city in order to avoid working with the Local, and later concessions granted by the UAW in the 1980s, brought on by the international oil crisis, only made things worse. A steady erosion of auto jobs and plant shutdowns began in the 1980s and continued until September 2010, when the last GM assembly plant in Pontiac shuttered its doors.[8] Though GM maintains a limited presence in Pontiac in 2012 (e.g., a stamping plant and a powertrain facility), the combined losses of jobs and tax revenues that resulted when the major plants left town devastated both Pontiac and the household income of its residents. This is a particularly stark reality when one considers that because of the Big Three's generous wages and extensive benefits, autoworkers—who once formed the core of the Pontiac community—had from the late 1940s been among the best paid workers in the country.[9]

A thriving retail center in downtown Pontiac also began to crumble in the 1970s with the advent of large shopping centers outside the city's borders. A number of Pontiac's stores have been long abandoned. One that has continued throughout to do well is the Main Street Pawn Shop, with a steady stream of customers. "I've never seen anything like it," said owner George Bee in 2009. "Nobody has any money. Not just my normal customers. Nobody."[10] Just outside Pontiac's actual borders, the rapid-fire decline between 1995 and 2004 of the once hugely popular Summit Place Mall, and its ultimate closure in 2009, are emblematic of what has occurred in Pontiac over the last fifty years.

On February 20, 2009 the State of Michigan placed the city into receivership,[11] and in March of that year the Department of Treasury appointed Pontiac's first emergency financial manager (EM).[12] The Michigan Legislature created the position of EM to provide better management of cities deemed to be in the midst of a fiscal emergency. Pontiac's three EMs to date have had almost unilateral authority to run the city's government. Nevertheless, Pontiac's dire cash crunch continues, and it has been estimated that the city faces a deficit of about $8 million during fiscal year 2012. This is well above the $1 million-plus that is allowable for cities operating under an EM, and well beyond what was projected roughly four years ago, when it was hoped that such emergency management would at least permit the city to tread water while tackling larger problems. Nowhere in America do local officials have less control—and state appointees more—than in the financially distressed communities of Michigan with appointed EMs. It does appear, however, that at this point in time the current mayor and the current EM are working better together than was true in the past, and that while Pontiac faces a very slow climb out of a very deep hole, there are some signs of economic progress.[13]

University of Michigan economists predicted in April of 2011 that Michigan's economy would soon show some improvement,[14] and that has proven to be a correct prognosis. By May of 2012, the unemployment rate across Michigan dropped to 8.5%, improving from 5th worst in the nation to 13th worst.[15] Still, the national recession and loss of jobs have pushed many across Michigan into poverty, and while the state's outlook may be brightening, the journey back is predicted to be a long one.[16] Michigan has to make up for the more than 800,000 jobs lost during its one-state recession that started a decade ago, and one commentator suggested in 2011 that another 10 years might have to pass before all those jobs are regained.[17] Pontiac's future is even gloomier. While its unemployment rate has also dropped, there is little expectation that the city will experience significant recovery in the near future. Despite efforts to bring about a turn around, Pontiac has to recover not only from the effects of the ten-year one-state recession, but also from its own one-city descent into poverty that has been building for five decades. A recent article about Pontiac's plight sums it up well:

> "When we were affluent, we didn't diversify," says City Councilman Kermit Williams. "We married GM instead of dating around, and when the divorce happened, it was brutal." General Motors plants, which were once the economic driver of the city, are being demolished, and their rubble is carried away by freight trains. The process gives residents the unusual opportunity to watch their city disappear before their eyes.[18]

It is the Mission of St Joseph Mercy Oakland to work together with other healthcare providers, social service agencies, and community action agencies, to meet the healthcare needs of our community, which go hand in hand with such financial and emotional distress.

It is also our Mission to support our neighbors in seeking to forge a realistic path into a brighter future. Pontiac is not alone in the economic circumstances in which it finds itself today, and things will never return to circumstances of the past. "Nowhere [in the United States] is heavy manufacturing part of the solution," notes Richard Longworth, author and analyst at the Chicago Council on Global Affairs.[19] Yet powerful resources are now directing attention to the goal of helping such cities as Pontiac reinvigorate their faltering economies. The Chicago Federal Reserve Bank, for example, has been looking into the problems of Pontiac and similar cities across the country—cities that once flourished, thanks to strong manufacturing endeavors that have now all but disappeared. Federal Reserve researchers agreed with Longworth in a working paper published in February, and offered guidance to these cities in finding a way out. They advised these cities to focus on leadership, worker training, their ability to raise money for development, and their willingness to see themselves as players in regional and global economies, and SJMO will be here to do whatever we can to support the citizens of Pontiac as they take up this challenge.[20]

V. METHODOLOGY FOR DATA COLLECTION AND COMMUNITY INPUT APPROACHES

Data Collection Methodologies

To ensure the most comprehensive and useful community health needs data, SJMO used a number of methods to secure information on health status (both subjective and objective); service and programmatic needs; and gaps in service. These gaps included completely unmet needs; inadequately addressed needs; and the over- or under-utilization of facilities, services, and programs. We employed historical data review, literature review, meta-analysis, data mining, interpretive observation, content analysis, and questionnaires.

Historical Data Review –The CHNA work team reviewed data culled during previous collection periods, in order 1) to confirm that our current data collection was comprehensive and historically sound; and 2) to begin to prepare hypotheses about our current process outcomes.

Literature Review – SJMO's strongest collaborative relationship is with the Michigan Department of Community Health, which affords us access to a number of databases and reports, such as the "Michigan's Health Profile Chartbook," and the "Health Profile Chartbook: Region 2N." For the purposes of this process, we reviewed these and a number of other reports (e.g., the "2009-2010 Oakland County Community Assessment" of the Oakland Livingston Human Service Agency's Child and Family Services Division Head Start Program) to frame our conversations, and to further understand the health needs of our community against others throughout the state of Michigan.

In addition, data was collected from the U.S. Census Bureau; area Chambers of Commerce; the Michigan State Government; think tanks such as the Economic Policy Institute and Trust for America's Health; newspaper articles; and numerous databases, such as Behavioral Risk Factor Surveillance System, the USDA Food Consumption Atlas, and Health Related Quality of Life and Health Data Interactive, both from the U.S. Center for Disease Control. A complete list of databases is found in the Appendix of this document.

Meta-Analysis – In 2010, SJMO led a capacity-building effort among community health stakeholders in the Pontiac area. That effort included a survey of a small group (175 participants) on issues of healthcare and social service needs. We reviewed and considered the resultant data as we developed our CHNA survey tool, and as we analyzed the data from this assessment experience.

Data Mining – SJMO created a survey tool (the CHNA Questionnaire) to extract similar data, but from varying stakeholder perspectives. The Questionnaire was customized for individuals; business owners; physicians; and community service volunteers and employees. Its administration was a large part of our data collection effort. Rather lengthy, at 35 – 48 questions (depending on the stakeholder group surveyed), the questionnaires provided demographic data; a wealth of information on health status needs (both perceived and diagnosed); respondents' awareness of programs and services; and their personal hypotheses about what is needed to improve community health. The survey was administered either by a CHNA work team member or a trained representative of a community partner. Our mining task concluded with a summarization of these varying data points into useful information that we will use to assess current program design, costs, and outcomes, and to envision and implement new programs to better meet the needs identified by our various stakeholder groups.

Interpretive Observation – The CHNA work team had some unique opportunities to interact with members of our community in the places they frequent to receive various healthcare services—Mercy Place, the Baldwin Center, the Bowen Center, and New Mt. Moriah Church. While the data collected in this manner is by definition subjective, it did provide useful insight into the lives of our community members.

Content Analysis – As with any large data gathering process, both the quantitative and qualitative data collected through this process had to be reduced to a level that made sense, in order to attempt to identify core consistencies and meanings. This important step was included in our analysis process, the results of which are outlined in Section VII of this document.

Community Participation Strategies

As a result of our 2007 CHNA, SJMO developed aggressive strategies for assessing and responding to community needs. Because of this, we were able to identify several community partners who were eager to support, publicize, and assist in the administration and collection of the 2011 CHNA questionnaires.

We fully incorporated community partners in the planning process, from service on the Steering Committee to the collection and analysis of data. We will continue to include the community as we report our findings; assess our current programs; and envision new strategies for improving the health of our community.

Our Steering Committee included representation from:

- Trinity Health and SJMO personnel
- Oakland Livingston Human Service Agency, Pontiac's most prominent community action agency
- Catholic Social Services of Oakland County, the social services agency of the Archdiocese of Detroit
- The Oakland County Workforce Development Division
- Centro Multicultural La Familia, Inc.
- The Archdiocese of Detroit

The committee had input into the planning of our processes for collecting data, and gave guidance in revising the CHNA questionnaires. They then participated in final editing of the report and in suggesting future Community Benefit services at SJMO.

One particularly effective approach to community involvement was the method we used for administering the surveys to various constituent groups. Because of the strong ties to the community, and the well-established presence SJMO has developed in the past four years, we were able to present our CHNA "campaign" and administer surveys during the meeting agendas of several community organizations of which we are a part. This saved time in the data collection process, since we did not have to schedule and facilitate separate meetings, and allowed us to have maximum participation and exposure.

Similarly, our strong collaboration with another group—the Pontiac School District (PSD)—afforded us the rare opportunity to meet with community-level district representatives (i.e., parents) during the final days of the school year. We brought this geographically disparate group to SJMO, in order to discuss the CHNA, complete the surveys, and begin planning strategically for SJMO/PSD collaboration during the 2011-2012 school year. We regularly use this strategy of bringing community partners in house, in order to balance our community presence and to foster a lasting non-clinical relationship with the community as well.

VI. FINDINGS FROM COMMUNITY HEALTH AND HEALTH DATA - (See Exhibits)

Key Community Socioeconomic Factors

Exacerbating the plight of Pontiac are the following statewide socioeconomic factors, as outlined in a 2011 presentation by the Budget Director of the State of Michigan:

- Michigan lost 815,000 jobs from 2001 to 2010.
- 55,183 people left the state from 2000 through 2010 (-0.6%), when Michigan was the only state to lose population.
- 46% of Michigan college graduates left the state to seek employment elsewhere.
- In 1970, Michigan's personal income ranked 12th in the nation. It has now fallen to 36th.
- The Medicaid caseload has seen a rapid increase of 84% since 2000.
- Food assistance expenditures are four times the 2004 numbers; one out of every five people in Michigan receives food assistance.
- Corrections spending has risen from 5% to 24% of the state budget—almost 9 times as much as in 1982.[21]

Population Projections – Michigan was the only state in the nation to lose population between 2000 and 2010, but all the loss occurred among the state's child population, which dropped by 10%, while the statewide adult population rose by 3%.[22] The population of Oakland County actually rose by 0.7% during that same period,[23] but its population growth rates are slowing to a rate not seen in a century. For the three-decade period from 2000 through 2030, Oakland County is projected to gain only around 20,000 people more than it gained during the one decade from 1990 to 2000.[24]

As of the census of 2010, there were 59,515 people; 24,234 households; and 15,267 families residing in the city of Pontiac. The population is estimated to have fallen by 15.46% between 2000 and the end of 2010, added to a drop of 22.14% between 1990 and 2000, and the predicted drop of another 5.63% by 2014. Detroit, which is situated 35 miles south of Pontiac, and which shared a similar reliance on the auto industry, was the United States' 11th most populous city in 2004, with slightly over 900,000 residents, which was only half the population the city boasted at its peak in the 1950s.[25] Detroit's population decline has been one of the largest in the nation, and mirrors what is happening in Pontiac.

Age Predictions – As noted above, fewer babies are being born in Michigan. The number of births per year across the state decreased by 14% between 2000 and 2009, dropping from 136,000 births to 117,300 per year.[26] County officials predict that Oakland County will experience an unprecedented growth in the percentage of older adults in the population, and that by 2030 the number of seniors in the county will have doubled. Officials also predict that by 2020, almost half of Oakland County's 61 communities will have more residents over age 65 than school-age children. Some express concern that many seniors (some surveys say 59-60%) plan to relocate. This could be a devastating loss to local communities, Oakland County, southeast Michigan, and the State of Michigan. According to the Census Bureau, the median annual income for an Oakland County householder age 65 and older in 2007 was $40,598, from Social Security, pensions, and/or investment earnings. These dollars were imported into our local economy, and on average, seniors spent (rather than saved) 92% of this $5.5 billion.[27]

Having said that, it puts things in perspective to note that while virtually every part of the country will age dramatically over the next thirty years, this is more true in Southeast Michigan than in most other areas of the nation. "By 2040," a 2012 report from the University of Michigan notes, "the age gap between SE Michigan and the rest of the country, as measured by the share of the population 65 and older, will be about the same as it is today between Florida and the rest of the country."[28]

Race - Across Michigan, 78.88% of citizens are White, and 13.05% African American. The 2010 racial breakdown for Oakland County is: White not Hispanic 75.1%; African American 13.6%; American Indian and Alaskan Native 0.3%; Asian 5.6%; persons reporting two or more races 2.2%; and Hispanic or Latino 3.5%.[29] The estimates for the City of Pontiac were: White not Hispanic 37.1%; African American 47.4%; American Indian and Alaska Native 0.8%; Asian 2.4%; persons reporting two or more races 2.4%; Hispanic or Latino 16.5%.[30] There is no prediction for significant change in race demographics. This data on race is not just sociologically significant: Because Michigan's unemployment rates differ significantly by race, the data is economically significant as well, and that has noteworthy bearing on healthcare, as shown in the following paragraph.

Uninsured Adults in Oakland County – In 2009, an estimated 16.2% of Michigan adults aged 18-64 had no health care coverage. This represents a 70.5% increase from the 1999 estimate of 9.5%. The decrease in health care coverage is an indicator of the continuing economic hardship in Michigan. Further, the percentages of adults who have not had a routine checkup in the past year (1999: 27.9% vs. 2009: 30.9%) and who have not been able to receive proper health care due to cost (1999: 7.8% vs. 2009: 13.9%) are also cause for concern.[31] Despite the fact that Michigan as a whole has a lower percentage of uninsured residents than the majority of states, and that Oakland County's uninsured rate is even lower than the state's, it can be statistically deduced, as well as anecdotally noted, that residents of Pontiac do not enjoy the same rates of coverage as their neighbors. First, a 2010 study found that African American and Hispanic residents of Michigan are almost twice as likely as White residents to be uninsured, and Pontiac has a disproportionately African American population. Second, the report found that Michigan's poor and working poor are disproportionately uninsured, and that Pontiac's population is disproportionately made up of the poor and working poor. Finally, the study found that rates of uninsured decrease as the education level of the family head increases, and as shown next, Pontiac residents are generally less well-educated than others across the state and county.[32]

Education – Oakland is the best-educated county in Michigan. While 24.5% of all residents across the state over the age of 25 have earned a bachelor's degree or higher, this is true of 43.5% of that demographic in Oakland County, and a comparatively staggering 69.1%, 66.7%, and 67.1%, in the nearby cities of Bloomfield, Bloomfield Hills, and Birmingham respectively. It is significant, therefore, that only 11.5% of those over age 25 in Pontiac hold a bachelor's degree.[33]

Median Per Household Income – The estimated median household income for the State of Michigan is $49,450.[34] Across Oakland County, that figure is $68,500, and in Bloomfield Township, Bloomfield Hills, and Birmingham, the estimates are $122,279, $114,269, and $93,992.[35] The estimated 2010 median household income for Pontiac was only $36,095,[36] though up from $29,653 in 2009, when 51% of population of Pontiac was below 200% of the federal poverty level ($39,821 household income for family of four).[37]

Marital Status – The U.S. Census Bureau reports that in 2009, across the State of Michigan, 49.1% of residents over 15 years of age were married. That figure for Oakland County was 53.5%, but for the City of Pontiac was only 34.0%.

Social Security Disability – Approximately 4.8% of the more than six million residents living in the State of Michigan receive Social Security disability benefits. There are approximately 50,000 more Michigan residents backlogged in the Social Security system waiting for a decision on their disability claims. Approximately 65% of Michigan Social Security disability applications are denied during the initial stage of the application process, and of these, 70% who file a Request for Reconsideration are also denied.[38]

Medicare and Medicaid –
Medicare: In 2011, there were 1.7 million Michigan residents on Medicare.[39] The latest data on qualification shows that 82% qualified by age, and 18% by other qualifying factors, such as end-stage renal disease (ESRD).[40]

Medicaid: By 2009, roughly two of every five births in Michigan were covered by Medicaid—up by roughly 10 percentage points from 2003.[41] Thirty-eight percent of the Medicaid budget is now used for medical care for children and their mothers, who represent more than 75% of the Medicaid population. Seventy percent of the Michigan Medicaid budget goes toward coverage

for middle-class and low-income elderly and disabled, covering two-thirds of Michigan nursing home patients; much of the health care for Michigan residents with HIV and AIDS; and about 80% of Michigan's mental health costs. The state's Medicaid caseload has skyrocketed to a record high of approximately 1.8 million people. By 2010, nearly 20% of Michigan residents relied on Medicaid for their medical coverage. The growth in the Medicaid caseload is due, in large part, to hundreds of thousands of Michigan families losing health insurance once provided by their employers. Since 1999, more than 700,000 Michigan families have lost employer-provided health benefits.[42] Medicaid is the single largest health insurer for low-income children. It is also the primary source of health care for low-income parents and other non-elderly adults, the elderly, and persons with disabilities. Children make up 53% of Michigan's Medicaid population, but are of very low cost, accounting for only 21.1% of the state's Medicaid spending. In general, Michigan children who are in families of four with incomes below $41,348 (for infants) or $33,525 (for children ages 1-18) are eligible for Medicaid. (Recall that the estimated median household income for all Pontiac families is now only $36,095.) Medicaid faces serious financial threats that endanger the health of Michigan's children. An estimated 123,000 Michigan children (4.9%) are uninsured. Sixty-six percent of these uninsured Michigan children are eligible, but not enrolled in Medicaid or the Children's Health Insurance Program.[43] This data is only available at the state level, but we can deduce that the enrollment figures would be lower for Oakland County and higher in Pontiac.

Poverty – Oakland County ranks third highest in wealth among U.S. counties with populations over 1 million, yet numerous pockets of poverty exist within its borders; 8.5% of the total population of Oakland County live at or below poverty, but this is true of 31.3% of all Pontiac residents. While nearly 80% of those who live in poverty in Oakland County reside outside the City of Pontiac,[44] the concentration of poverty within Pontiac far exceeds the rates in any other locale in our service area. Across Michigan, 26.5% of children under the age of five live in poverty, while in Pontiac, a tragic 49.8% of such children do.[45] In the relatively affluent Oakland County as a whole, 15.4 % of all children find themselves in poverty, compared to a figure of 43% in Pontiac.[46] Putting the dire situation in Pontiac in even greater relief is the dissonant reality that in the city of Birmingham, just eight miles away, poverty affects only 1.6% of all children.[47] Even more worrisome for the long-term health of this community, is the fact that experts find that children who are born into poverty tend to stay in poverty.[48]

Homelessness – In an improvement from February 2012 numbers, March data shows that Michigan ranked eighth in the country for number of foreclosures, with one out of 489 households receiving filings. In Detroit, however, it was one in 300 households.[49] On any one night across Michigan, there are approximately 24,713 sheltered homeless individuals, with an additional 41,338 unsheltered, for a total of 66,051. These statistics include not just lone individuals, but 34,622 adults and children in homeless families. In Michigan, adults and children in families account for 52% of the total homeless population. Youth 17 years of age or younger, and not in families, account for an estimated 5% of the total homeless in Michigan. This means that in Michigan, there are at least 3,000 youth and children who are alone and homeless.[50] At the Baldwin Center in Pontiac, in May of 2011 alone, the kitchen served 4,486 homeless meals. The clothes closet had 1,238 "shoppers"; 69 people received showers; and 30 families cleaned 120 loads of laundry. Several tons of canned goods were collected as part of their annual post office food drive.[51]

Unemployment – The good news is that as of April 2012, Michigan's unemployment rate continues a recent downward trend, dropping to 8.3%. The seasonally adjusted rate has dropped to the lowest monthly mark since August 2008, and while the national unemployment rate was 8.3% in February 2012, the gap between the national rate and the state rate has narrowed significantly in recent months.[52]

Still, Michigan is one of only six states in which White populations experienced unemployment rates of 10% or higher since the start of the "Great Recession" (i.e., December 2007 through June 2009).[53] Michigan's White unemployment rate peaked at 12.7% in the last quarter of 2009, and declined to 9.5% in the last quarter of 2010. For all of 2010, however, Michigan's average White unemployment rate of 10.8% was significantly worse than the national White unemployment rate of 8.0%.

This pales in comparison to the African American unemployment rates in Michigan, which actually rivaled the top unemployment rates for all Americans during the Great *Depression* of the 1930s. At the peak of the recent Great *Recession*, around one in every four African Americans was unemployed. In fact, the unemployment trend for Michigan African Americans has been so bad that their lowest unemployment rate of 12.2% (2008 Q1) nearly matched the Recession's highest unemployment rate (12.7% in 2009 Q3 and Q4) for Whites. The peak unemployment rate for Michigan's African Americans was 26.4% in the third quarter of 2010, but edged down to 25.1% in the fourth quarter of 2010.[54] Michigan's African American unemployment rate in the third quarter of 2011 was 21.8%, and the predicted fourth quarter 2012 rate will be 22%.[55] Like White unemployment rates, Michigan's overall African American unemployment rate for 2010 (23.4%) was much higher than the average 2010 rate for African Americans across the country (15.9%). And while the White unemployment rate in Michigan was 34% higher than the national average for Whites in 2010, the average for Michigan African Americans was 47% higher than the national average for African Americans.[56] Factor in the rise in the unemployment rate of Hispanic Americans (11%) and African Americans (13.6%) across the nation in the May 31, 2012 jobs report, and one can extrapolate continuing bad news on this front in Pontiac.[57]

The city's unemployment rate, while down from a high of 31.1% in October of 2009, was still at a staggering 26.6% in June of 2011, 19.1% in April of 2012 and back up to 21.6% in May. These figures can be compared to the Michigan unemployment rates of 10.5% and 8.3%, and the Oakland County rates of 10.9% in April and the current 7.4%. While showing improvement, the recent data showed, at its worst, a significant rise in unemployment compared to the pre-recession year of 2007—Pontiac, up 60.9%; Michigan up 43.5%; and Oakland County up 72.1%. Despite the fact that the rise in unemployment for the entire United States has been much higher, at 89.6%,[58] it should be remembered that Michigan, and especially Pontiac, began their recessions between ten and thirty years ago, so recent increases add insult to greater existing injury, and thus appear less significant.

Employment Predictions – According to a comprehensive profile published in March of 2012 by the University of Michigan, the economic and demographic profile of southeast Michigan is brighter than only a year ago. U of M economists stated that the Southeast Michigan economy is now emerging from what they call, "the most catastrophic period in our lifetime," noting that during the first decade of the 2000s the region lost virtually all of the jobs it had garnered during the robust 1990s. They argue that there is evidence that the regional economy has now made a good start in returning to positive job growth, and their view is that "its competitive position has turned around and job growth will be sustained." According to their economic and demographic outlook through 2040, growth in Southeast Michigan will be much more subdued than what was seen prior to the extended downturn, and they now expect that by 2040, employment in the region will still remain slightly below its peak level achieved in 2000. They also note that one consequence of the poor performance of the local economy from 2000 to 2009 has been the permanent loss of population mentioned here earlier. This accelerating growth in the over-65 population, and the low in-migration rates for young adults, will limit the region's ability to expand, and though it is hard to imagine today, will lead to labor shortages down the road. This

will be especially true of workers with skills that mesh with the emerging knowledge- and information-based economy. [59]

Disabilities – There are an estimated 1,470,000 people in the state of Michigan over the age of five with one or more disabilities. Approximately 270,000 people, or 2.9% of the state's population, experience difficulties performing activities of daily living, such as bathing, dressing, or moving around inside of their homes. There are around 805,000 people in the state who have a form of work disability, and around 287,000 people with disabilities in Michigan are employed.[60] In Oakland County, 140,610 persons over the age of five (12.6% of the population) have at least one disability.[61]

A vehicle per Household – The median number of vehicles per household in Oakland County in 2010 was 2.3. There were no vehicles in 4.38% of households; one vehicle in 30.57%; two vehicles in 47.52%; three vehicles in 15.78%; and four or more vehicles in 5.76% of Oakland County households. As in Oakland County, the median number of vehicles per household in Pontiac was 2.3. However, there were no vehicles in 13.82% of households (a greater than threefold increase over Oakland County); one vehicle in 42.11%; two vehicles in 30.48%; three vehicles in 10.2%; and four or more vehicles in 3.56% of Pontiac households.[62]

Crime – Pontiac is located directly between the Greater Detroit Metropolitan Area (Detroit, Livonia, and Southfield), and the city of Flint. Though wealthy cities of Birmingham, West Bloomfield, Bloomfield Hills, and Bloomfield Township, lie between Greater Detroit and Pontiac, it unfortunately has been shown in this CHNA that Pontiac better reflects the facts of life in Detroit and Flint than of those affluent neighboring cities. Greater Detroit and Flint, which consistently rank among America's most crime-ridden cities, held first and fourth places on Forbes's list of "Most Dangerous Cities" for 2010,[63] with Flint now in first place and Detroit a close second according to FBI statistics published in June of 2012.[64] A precipitous drop in population and employment rates due to suburbanization and the struggles of the Big Three automakers is a big factor in both cities, as it is in Pontiac, leaving all strapped for funds to devote to basic services, such as education and public safety. "Year in, year out, and decade after decade, there's been a very large population loss," says Brian Stults, an assistant professor of criminology at Florida State University, writing about Detroit and Flint. "A large section of the population is gone, and they're not the people doing crime to begin with." "People don't have jobs, they don't have money for food, so they become a lot more desperate, and these trends take a long time to reverse," continues Megan Wolfram, an intelligence analyst at the risk assessment firm iJET.[65]

Priority 1 Health Indicators

***NB**: In determining prevalence of disease and negative behaviors (e.g., smoking, obesity, alcohol and other drug abuse) in Oakland County and Pontiac, it is often necessary to extrapolate from abundant state data. Much of the following data come from the last comprehensive state-wide report on risky behaviors in the State of Michigan, published in 2009 (see endnote #32). Factors that have a negative influence on health (and thus on disease) are lower in Oakland County, where the population is more affluent and better educated than the population across Michigan, and are especially more affluent and better educated than the population of Pontiac*.

Diabetes – Between 2008 and 2010, the average percentage of Michigan residents with diabetes was 9.5%, ranking the state 16th in the nation.[66] Between 2001 and 2009, the prevalence of doctor-diagnosed diabetes among Michigan adults increased significantly over

time (p<0.001). Comparing the 2001 and 2009 prevalence estimates for diabetes, the percent increase was 30.6% (2001: 7.2% vs. 2009: 9.4%),[67] with an increase of 15% over the past five years. An estimated 701,000 Michigan adults have been diagnosed with diabetes, and an additional 364,400 are estimated to have currently undiagnosed diabetes. In recent years, men have reported significantly higher rates than women— especially in African American and other non-White races. Compared to Whites, African Americans and Native Americans have twice the prevalence of diagnosed diabetes, Hispanics 75% more diagnosed diabetes, and Asians and Pacific Islanders 55% more diagnosed diabetes. "Other" races (which includes multiracial but excludes Arab ancestry) have double the prevalence.[68] The 2007 adult diabetes rate for Oakland County was 8.8%,[69] which indicates (with the 15% increase over five years, indicated above) that it now stands in 2011 at ~10.12%. Pontiac's diabetes rate is more than three times the county rate, and 64% of the population surveyed by Oakland Primary health Services reported that they had gone without medication because they couldn't afford them. Thirty-one percent reported that they had been hospitalized or had an emergency room visit within the last six months due to complications from diabetes.[70]

Sickle Cell Disease (SCD) – SCD affects 90,000 to 100,000 Americans; it occurs in about 1 out of every 500 African American births, and in about 1 out of every 36,000 Hispanic-American births. Though the number of cases is perhaps not alarming, the impact on the City of Pontiac, given its high percentage of African and Hispanic residents, and its low-income population, calls special attention to these disease. This health condition was flagged for this report by our own health care professionals, because these patients live with serious pain, and with an array of sociological problems, they often become "frequent flyers" in hospital emergency rooms. In addition, their persistent need for pain medication, including narcotics, leaves them at risk of being deemed "drug seekers" by ER and other healthcare professionals.[71]

Cardiovascular Disease (CVD) – A three-year Michigan average (2008 - 2010) shows 28.7% of the population of Michigan is hypertensive, ranking Michigan at 17th among the states.[72] Heart disease and stroke are the first and third leading causes of death, respectively, in both Michigan and the United States. In 2009, 4.5% of Michigan adults had ever been told they had a heart attack or myocardial infarction, 4.4% had ever been told angina or coronary heart disease, and 2.7% had ever been told they had suffered a stroke. All three indicators of cardiovascular disease decreased with education and household income, and increased with age. Eight-and-a-half percent (7.9-9.1) of Michigan adults reported ever being told that they had cardiovascular disease (i.e., ever been told of a heart attack, angina/coronary heart disease, or stroke). Men were more likely than women to have ever been diagnosed with a heart attack (5.5% vs. 3.5%). In addition, men (9.4% [8.5-10.4]) were also more likely than women (7.7% [7.0-8.4]) to have ever been diagnosed with any form of CVD. When comparing gender specific rates of heart attack, angina or coronary disease, and stroke among Michigan adults to the gender-specific U.S. median rates, it was found that cardiovascular disease rates among Michigan males were comparable to the U.S. median rates for males, while Michigan females reported slightly higher rates than the U.S. median rates for females. Black males have the highest hospitalization rate for four of the five diseases (cardiovascular disease, heart disease, heart failure and stroke). The highest CVD mortality rates occur in black males (499.4 per 100,000), more than twice the rate for white females (231.3 per 100,000), who have the lowest CVD mortality rate. Coronary heart disease hospitalization rates have been highest among white males.[73]

Asthma – In 2009, the estimated proportion of Michigan adults ever told by a health care professional that they had asthma was 15.6% and an estimated 9.9% of all Michigan adults currently had asthma. Women (12.2%) were more likely than men (7.3%) to have current asthma. In addition, individuals with household incomes of less than $20,000 (15.5%) were more likely to have current asthma when compared to individuals with household incomes of

greater than or equal to $75,000 (7.0%). Over the past ten years, the proportion of Michigan adults who ever reported having asthma has significantly increased from 9.8% (8.6-11.0) in 2000 to 15.6% (14.6-16.7) in 2009. Since asthma is often difficult to diagnose, this increase may be partially due to an increase in the misdiagnosis of this disorder. In addition, the prevalence of lifetime asthma among Michigan adults has been consistently higher than that of the U.S. median. Based on proxy information provided by the adult respondent, the estimated proportion of Michigan children aged 0-17 years who were ever told by a health care professional that they had asthma for 2009 was 11.7% and an estimated 8.4% of children currently had asthma. Boys and girls were similar in terms of both history (13.3% vs. 10.1%) and current asthma prevalence (8.9% vs. 7.9%). There were no significant differences between White boys and White girls (8.5% vs. 11.8%), as well as Black boys and Black girls (9.7% vs. 16.3%), in terms of having ever been told they had asthma.[74] According to Oakland Primary Health Services data, Pontiac's asthma rate is twice the state rate.[75]

Teen Pregnancy – Between 1990 and 2007, teen pregnancies in girls between the ages of 10 and 14 dropped 57%; between ages 15 and 17, 46.8%; between ages 18 and 19, 39%. In attempting to determine what the statistics are in Pontiac, compared to Oakland County or Michigan, consider that pregnancy rates are traditionally three times higher among African American teenagers as among White teenagers, and that the percentage of the population of Pontiac that is African American is far higher than that of Oakland County or the State of Michigan.[76]

Immunizations – In 2009, an estimated 69.1% of Michigan adults had a routine checkup in the past year, a decrease from 75.5% in 2000. This proportion was lowest among those less than 45 years old (56.8-65.1%), and then increased to 86.7% of those aged 75 and older. During the routine checkup, the health care professional can suggest appropriate screenings and immunizations. Those who received a routine checkup in the past year were more likely to have had their cholesterol checked within the past five years (87.5% vs. 63.2%), and among those aged 65 years and older to have had a flu vaccine in the past year (72.2% vs. 51.6%), and ever had a pneumonia vaccination (69.7% vs. 53.3%). In addition, individuals who received a routine checkup in the past year were more likely to have a regular health care provider (75.6% vs. 27.5%). Among those who had a routine checkup in the past year, the majority (91.2%) did currently have health care coverage.[77]

Smoking – 2009 data shows that 23.2% of the Michigan population; 12.4% of the Oakland County population; and 19% of the population of Pontiac were smokers. In 2009, an estimated 19.8% of Michigan adults were current smokers, and 25.8% (24.7-26.9) were estimated to be former smokers. Men were more likely than women to be current smokers (21.5% vs. 18.2%), and former smokers (28.6% [26.8-30.5] vs. 23.1% [21.8-24.5]), while women were more likely to have never smoked (58.7% [57.0-60.5] vs. 49.8% [47.5-52.1]). Smoking prevalence was similar among Blacks and Whites, and declined with increasing levels of education and household income. The proportion of Michigan adults who are current smokers has remained above the U.S. median during the past ten years. Those who reported fair to poor general health were more likely to be current smokers than those who reported good to excellent general health (30.0% [26.9-33.4] vs. 18.0% [16.8-19.3]).[78]

The good news is that Michigan has been selected as an "ActionTo Quit" grantee, to assist in efforts to provide equity to all its Medicaid recipients who smoke. At present, however, Michigan's fourteen Medicaid providers do not meet all the provisions of the Public Health Service (PHS) Guidelines for Tobacco Dependence Treatment.[79]

Priority 2 Health Indicators:

Incidence of AIDS/HIV –A study of health risk behaviors in Michigan estimates that 18,800 people are living with HIV/AIDS in the state, 4,200 of whom do not know that they are infected. An estimated 38.2% of Michigan adults aged 18-64 years of age have been tested for HIV, apart from blood donations. The prevalence of HIV testing decreases with age from 51.6% among those aged 35-44 years to 21.4% among those aged 55-64 years. Women are more likely than men (42.3% vs. 34.0%) to have ever been tested, and Blacks are more likely than Whites. Since 2000, the lifetime prevalence of HIV testing in Michigan among adults aged 18-64 years has decreased 21.7% (from 48.8% to 38.2%).[80] According to the January 2012 Quarterly HIV/AIDS Analysis of the Michigan Department of Community Health, across Michigan 59% of HIV infected persons without AIDS are African American, 34% are White, and 4% are Hispanic; and 58% of persons with AIDS are African American, 35% are White, and 4% are Hispanic.[81] In Oakland County, there was a slight decrease in HIV/AIDS cases between 2008 and 2009. There were 81 new HIV cases in Oakland County among teens in 2009 compared with 95 in 2008, and 30 new AIDS cases in 2009, compared to 55 in 2008. African Americans make up 14% of the state's population, but accounted for 60% of all cases of HIV/AIDS diagnosed in 2007, with a rate more than 10 times higher than that among whites, or 37.6 cases vs. 3.5 cases per 100,000. The number of teens living with HIV/AIDS in Oakland County was 1,575 in 2009.[82] There is no reason to assume that these numbers have improved since that year. Unfortunately, given the relative high percentage of African Americans in the Pontiac community, what we can assume is that a disproportionate number of Pontiac teens suffer from HIV/AIDS than across Oakland County.

Incidence of Cancer - More than 20,000 people in Michigan died of cancer in 2008. In 2009, an estimated 9.9% of Michigan adults reported that they had ever been told by a doctor, nurse, or other health professional that they had cancer. The proportion of Michigan adults with cancer increased with age from 0.9% of those aged 18-24 years to 32.5% of those aged 75 years and older. Females were more likely than males to have had cancer (11.0% vs. 8.7%), and the prevalence of cancer decreased with increasing education and household income levels. When examining cancer status by race and gender, it was found that White females reported the highest cancer prevalence rate at 11.8% (10.8-12.9). In addition, White females (11.8% [10.8-12.9]) reported a significantly higher cancer prevalence rate than that of either White males (8.9% [8.0-10.0]) or Black females (6.4% [4.7-8.7]). The high cancer prevalence rates among Whites, particularly White females, may be partially explained by the fact that Whites are more likely to participate in cancer screening activities than other racial/ ethnic groups.[83]

Infant Mortality - Oakland County's overall infant mortality rate continues to be lower than statewide averages. The county's infant mortality rate was 6.5 deaths per 1,000 births in 2009, up slightly from the 6.2 deaths in 2000, but below the state average of 7.2. Pontiac's 2009 infant mortality rate was 18.7%.[84] Pontiac may be an outlier because of its racial makeup; information shows that babies born to African American mothers in Oakland County are three times more likely to die in the first year of life than those born to White mothers. This disparity is most noticeable in the cities of Pontiac and Southfield, where African American infant death rates are the highest. The 2008 low birth weight rate (approximately 5 lb. 8 oz.) across Michigan, based on live birth weights, was 8.5%; for Oakland County it was 8.2%, but for Pontiac it was 11.3%. This is not encouraging, since the rate had steadily improved between 2001 and 2008. Not since 2001, when the figure was 11.5%, has Pontiac's low birth weight rate been worse,[85] and babies born to African American and Hispanic mothers in Michigan (a significant proportion of the Pontiac demographic), suffer from higher risk for almost all adverse circumstances than their white counterparts. Research has shown that these birth disparities often lead to poor early

development, delayed school readiness, poor academic achievement, and thus to diminished lifelong potential.[86]

Alcohol Use – In 2009, 16.9% of Michigan adults were estimated to have engaged in binge drinking, i.e., the consumption of five or more drinks per occasion (for men) or four or more drinks per occasion (for women) at least once in the previous month. The proportion for binge drinking decreased with age from 25.2% of those aged 18-24 years to 2.5% of those aged 75 years and older. Men were more likely than women (23.8% vs. 10.5%), and Whites were more likely than Blacks, to have engaged in binge drinking. When compared to the median for all participating states, Michigan has consistently had a slightly higher prevalence of binge drinking. In 2009, the proportion who engaged in heavy drinking, i.e., the consumption of more than two alcoholic beverages per day for men or more than one alcoholic beverage per day for women was 5.2% (4.5-5.9). Approximately one-sixth of Michigan underage adults, aged 18-20 years, reported binge drinking in the previous month (15.6% [10.5-22.7]). An estimated 6.1% (3.1-11.4) of underage adults reported heavy drinking in 2009.[87]

Illegal Drug Use - Drug abuse statistics for the state of Michigan indicate that drug addiction is highest between the ages of 36 and 40 years. This is not the case in Pontiac, where drug abuse is as prevalent among 18 year olds as among 36 year olds. The most popular drug in Pontiac is marijuana, closely followed by heroin and cocaine. As noted earlier, while 8.5% of the total population of Oakland County lives at or below poverty. This is true of approximately 31.3% of the population of Pontiac. Addictions are commonly found in areas where people are wealthy or extremely poor, and it is reasonable to link the use of drugs "for comfort or oblivion" to Pontiac's socio-economic conditions. Indeed, the city's drug abuse statistics have risen in inverse proportion to the decline of the city's economic and social well-being,[88] and a 2009 survey found that Pontiac has twice the state substance abuse rate.[89]

Obesity – Michigan is the 10th most obese state in the country (32.3% of the population), according to the 2011 report entitled "*F as in Fat: How Obesity Threatens America's Future 2011*." Over the past 15 years, the obesity rate in Michigan increased by 77%. Fifteen years ago, the state had a combined obesity and overweight rate of 53.6%. Ten years ago, it was 59.3%. Now, the combined rate is 65.7%.[90] In 2007, the obesity figure in Oakland County was 25.6%.[91] Between 2010 and 2012, it rose from 26% to 27%.[92] The proportion of Michigan adults who were obese in 2009 increased with age from 16.6% of those aged 18-24 years to 36.9% of those aged 55-64 years, and then decreased back to 21.9% of those aged 75 years and older. Blacks were more likely to be obese than Whites (41.6% vs. 28.7%).[93]

VII. FINDINGS FROM THE COMMUNITY INPUT PROCESS

St. Joseph Mercy Oakland was successful in securing input from nearly 400 individuals regarding health needs in our community, focusing (for reasons well illustrated here) on greater Pontiac. The 400 represent private citizens, business owners, physicians, and health and social services professionals. Collected through the administration of the written questionnaires discussed above, we were able both to validate our current knowledge and to garner new information to support our efforts to ensure proper alignment of SJMO programs and services with the needs expressed by our community.

In regard to the actual production of this report, we gained insight about focus groups. They need to last longer, as we felt rushed at the end of each, perhaps as participants "warmed up" to

the topics. This was especially so with the Spanish language groups, who for sociological as well as linguistic reasons took longer to become engaged. We are glad that we chose to use consultants to run the focus groups, as they were not emotionally vested in the discussion, and thus kept conversations on target.

We did decide that next time we set up a series of focus groups we want to go farther and deeper into the communities we serve. We want to ensure that we are not missing those most in need. We acknowledge that having identified participants through our partners, we were touching only those who are already "in the loop" to some degree. We will begin planning now to find and engage in conversation with the "anawim" at the farthest edges of our communities, the most isolated and most in need.

At the same time, we also want to reach out more extensively to the economically stable, the insured and well-educated citizens, who also may have valuable observations about what needs to be done and about what we can do together to make our communities healthier. We realize the odd reality that not reaching out to those who are most comfortable places them at the edges of our discourse along with those who are the most uncomfortable. We have to enhance our efforts to embrace all the voices in our communities in this discourse. We can achieve these goals by including not only such groups as Lighthouse, Common Ground (an organization that provides a lifeline for individuals and families in crisis, victims of crime, persons with mental illness, people trying to cope with critical situations, and runaway and homeless youths), and Haven (whose mission is "to eliminate domestic violence and sexual assault. . . through treatment and prevention services), but also to such groups as the Junior League and the Senior Men's Club of Birmingham.

To best present these findings, we return to the first of our foundational inquiries:

- Who needs help?
- What help do they need?

Answers to the questions "What help can SJMO provide?" and "When SJMO cannot provide help, what efforts can we make to ensure that someone else will?" will be addressed below in Section VIII.

Who Needs Our Help?

At a glance, the face of our typical respondent appears fairly stable. Most are employed (60%) and insured (55%), and many (41%) are homeowners. A deeper look, however, reveals that although employed, a full 80% have household incomes below $30,000 annually, with 40% earning less than $10,000 each year. Sixty percent of our respondents said their household income is "barely enough" or "not enough" to support their family. Eighty-two percent expend greater than 25% of their income on housing costs, with 40% spending more than half. (The financial "rule of thumb" is to spend no more than 30% of household income on housing.)

Of the 55% who are insured, the majority are insured through public programs (32% Medicaid; 27% Medicare) and 45% report having trouble getting healthcare services for themselves or their families. Forty-one percent have, in the past year, skipped needed medical care because of the cost.

A third of the mostly female (60%) and slightly more Hispanic than statistically indicated respondents (40%, compared to 35% Black and 20% White), were between 30 and 50 years of age, with the balance evenly spread across an age range from 18 to over 65.

We acknowledge that the partner-focused approach to our survey dissemination may have impacted our demographic snapshot in the following ways:

- Respondents were already connected to SJMO or one of our healthcare/social services agency partners. We expect that the health and socio-economic picture of those *not* connected is even more dismal.
- The general Pontiac population has a smaller incidence of Hispanic residents than does our respondent group. We attribute this to the collaborative partnership with, and high survey return rates from, local agencies Centro Multicultural La Familia and the Hispanic Outreach program of Catholic Social Services of Oakland County.

In addition, we learned anecdotally that some community members consider the SJMO Mercy Support charity program to be "healthcare insurance." Though it is not, we recognize that some respondents may have checked "yes, other" to the question of whether or not they have healthcare insurance.

What Help Do They Need?

Here, the actual question is, "What Help Do *They Believe* They Need," although their subjective self-reporting is remarkably in line with what the objective data in Section VI. The overwhelming majority of respondents reported that barriers to seeking and receiving adequate healthcare services are cost and coverage. From the overall cost of insurance to the cost of deductibles, co-pays, and prescriptions, paying for services is the largest challenge in our market. For those *with* insurance, a close second is the lack of (or limited coverage for) needed services, including office visits, emergency room visits, and prescription drug and diagnostic services. They indicate that dental services are by far the most omitted service from health insurance plans. A full 60% of those surveyed reported skipping necessary dental care because of the cost. (According to a 2009 survey by Oakland Primary Health Services, 18% of the adults in a surveyed population in Pontiac self-reported that they had lost 6 or more teeth due to decay, infection or gum disease.)

A third of our respondents reported their health as only "ok" or "not good." Interestingly, a third of our respondents also report that they do not engage in any moderate or vigorous exercise. While we cannot demonstrably correlate these two responses, we highlight it here as probably being worthy of note. Those who do not exercise cited reasons that included: not having exercise equipment (20%), inability to afford gym or fitness club membership (27%), and not receiving encouragement from others (13%).

Many respondents self-report having a diagnosed chronic disease: 37% reported hypertension, 26% obesity, 22% high cholesterol, and 16% diabetes. Seventeen percent of those surveyed reported being diagnosed with depression. (The Oakland Primary Health Services survey mentioned above notes that 36% of Pontiac's 10th graders reported being severely depressed and/or have considered or attempted suicide.)

When asked to identify the top three most important areas of focus to make the community healthier, 53% of respondents selected improved nutrition and eating habits; 54% chose increased access to healthcare services; and 43% included increased participation in physical

activity and exercise. The fourth most common answer was education about healthcare topics and available services.

As we delved into the data, we found that poverty, depression, and other mental health challenges, and the prevalence of chronic disease in the community, were three critical areas of need.

VIII. Reflections on the Community Health Needs Assessment: Lessons Learned and Recommendations for the Future

We now address the two remaining questions: "What help Can SJMO Provide?" and "When we cannot help, who else in the community will? How can SJMO facilitate their efforts?"

What Help Can SJMO Provide?

Cost/Coverage - The dual problems of the cost of healthcare services (and healthcare insurance) and the lack of coverage for necessary services even when a person is insured, reach far beyond SJMO and the Pontiac area. Current presidential election year wrangling makes clear that this is an issue of national proportion requiring national resolution. SJMO can, and does, however, have an impact on this issue through its advocacy initiatives. Throughout the year, SJMO partners with Trinity Health and the Michigan Health & Hospital Association to lead grassroots education and organizing activities to keep the two critical issues of cost and coverage in the forefront of our elected officials' minds. Through letter writing and e-mail, hospital tours and educational visits, and awareness campaigns, SJMO ensures that our associates, community members, and legislators clearly understand this dual challenge and potential solutions.

Access - SJMO addresses issues of access in several ways. The hospital has three clinics (Mercy Place, the Henderson Medical Clinic, and the Women's Center) dedicated to the primary care needs of the community's seriously underserved, uninsured, and underinsured members. In addition to expanded access, the Henderson Clinic and the Women's Center offer more social services support than do most private doctors' offices, through the use of a medical resident model (M.D. and D.O.). Our three clinics are supported by financial counseling services provided through our Mercy Support program, which has a two-fold design: 1) to ensure that applicants are taking advantage of any public assistance health care programs available; and 2) to assess the level of financial support necessary from SJMO to provide care to the applicant.

To enhance services to our community and free some of our limited resources to address other Community Benefit needs, we are currently considering an operational transition of these clinics over the next few years to the control of a Federally Qualified Health Center (FQHC). This relationship will expand access to needed social service support, and better position clinic patients to benefit from the unique programs and services available through this federally-funded initiative.

SJMO recognizes that in addition to primary care services, access to specialty care is a major challenge to uninsured and underinsured community residents. To that end, Mercy Place is taking part in a grant-funded pilot program to expand specialty care access across Trinity Health's Community Benefit clinics in southeast Michigan. This initiative is designed to ensure

specialty care access to patients who are enrolled as primary care patients in any Trinity supported clinic(s).

The SJMO Community Health Ambassador program will continue to offer free health screenings and disease risk assessments throughout the community, through trained lay-health educators who focus on the chronic diseases of hypercholesterolemia, diabetes, hypertension, and obesity. The Ambassadors offer or participate in numerous opportunities for community members to attend screenings and educational sessions, and to receive follow up intervention as necessary. SJMO realizes, both statistically and anecdotally, that these screenings are often the only form of healthcare access the participants enjoy.

Similarly, SJMO's Oncology department will continue to partner with Community Programs and Faith Community Nursing to offer free screenings for various cancers—breast, prostate, colon, and lung—that hit the Pontiac community particularly hard. Were it not for SJMO outreach efforts, many participants might find themselves receiving cancer diagnoses at a much further advanced stage.

Dental Care - In the summer of 2011, SJMO opened a dental residency program and clinic. As a testament to the dire need in our community, in its first six months, the Dental Clinic had more than 1,045 patient visits; more than 200 patients received oral cleanings; more than 100 patients received fillings or tooth extractions. Many of these patients had endured years of pain because they could not afford dental care. The current annual work plan is to provide preventative dental services to 400 patients; comprehensive dental care to 200 patients; and dental care to 40 patients with special needs. By the middle of FY'15, the program plans to have added at least one additional dental resident, and to have expanded its work plan to provide preventative dental services to 500 patients per year; comprehensive dental care to 240; and to provide dental care to 50 patients with special needs.

Nutrition/Healthy Eating - In addition to our nationally renowned Metabolic Nutrition and Weight Management Program, SJMO will continue to offer opportunities for community members to learn about the relationship between good nutrition and good health. Our standing programs that offer this education are: Shapedown, (a 10-week family-based weight management program for children and teens, which focuses on healthy eating, active lifestyles, and effective communication) and our semi-annual Healthy Living Workshops (six-week chronic disease prevention and management classes for adults who are at risk of developing a chronic disease). Both these programs offer easy-to-understand, user-friendly tips on how to "eat healthy" on a budget, how to make quick but nutritious meals and snacks, and how to find fresh produce in the community and advocate for more healthy food options. The Shapedown program focuses on getting children interested in healthy food and good nutrition, and on teaching them how to create their own healthy snacks; make quick assessment of meals and snacks that they may be offered outside the home; and counter with confidence any negative societal and peer pressure related to food and food choices.

Exercise - At the hospital, we offer yoga classes, a walking club, and ballroom dancing and Zumba classes, and we eagerly facilitate such activities as opportunities arise.
We also continue to offer and expand a number of exercise options to our associates and community members:

- Shapedown has "fun-based" physical activity as one of its three programmatic foci
- Senior Fit is a very popular program that leads adults over the age of 50 through endurance, strength, balance, and flexibility exercises three times each week in

locations throughout the SJMO service areas, in Auburn Hills, Pontiac, Troy, Ferndale, White Lake and Waterford

- Community Fitness Boot Camp, offered at Mercy Place for 36 weeks out of the year, designed for seasoned exercisers who are ready to take their routines beyond walking and stretching to a higher intensity workout.

Community Health Education - In addition to the Community Health Ambassador program and Healthy Living Workshops, Community Programs partners with multiple departments (e.g., Oncology, Women's Services, and the Michigan Stroke Network) to offer community health educational activities. These activities, conducted by both clinicians and lay-health educators, often include disease risk assessments as part of the experience. Educational sessions are offered throughout the year in a number of different venues in and around Pontiac and throughout our service area. The programs generally focus on chronic diseases—diabetes, hypertension, high cholesterol, obesity—and breast, prostate, colon, and lung cancer detection and prevention. We are now more and more often presenting educational sessions on stress, depression and other mental health topics.

Poverty - We have established that poverty is a huge challenge in the SJMO community, and we know that it plays a critical role as a social determinant in the overall health status of a person and of a community. While outside our core services—the prevention, diagnosis, and treatment of illness—SJMO is proud to play a role in addressing poverty in our community as a preventative health measure. Through our strong community collaborations, we are often able to connect "at risk" families and associates with organizations and agencies that offer a full spectrum of programs and services for individuals and families in need.

Mental Health - In addition to the hospital based services we offer through our behavioral health department, SJMO addresses community mental health needs through a grant-funded alliance with Centro Multicultural La Familia. The Integrated Care Program affords patients in our primary care clinics the opportunity to be screened for stress, depression, and/or mental illness, and referred to mental health counselors and psychiatrists, if necessary, for intervention and treatment. SJMO also maintains a strong relationship with Community Network Services (CNS), through which we bring both early detection and anti-stigma education to the community. We are enhancing our strategies for screening for and identifying mothers at risk for post-partum depression, since this affects not only the mother, but her newborn and other family members.

Chronic Disease Management - Our primary care clinics and Community Health Ambassadors screen for various chronic diseases, while our Healthy Living Workshops teach prevention techniques, and diabetes education sessions teach persons newly diagnosed with diabetes how to manage the disease. The Diabetes Case Management program is designed to ensure that persons with poorly controlled diabetes are treated aggressively and comprehensively, in order to bring their disease under control and to maintain that controlled state. We have a new focus on heart disease related conditions (obesity, hypertension, and hypercholesterolemia), and are developing new methods of controlling CHF admissions though a number of expanding strategies. We are also piloting a program to manage the pain and hospital admission rates of persons with Sickle Cell Disease, by addressing the disjoint that often occurs between primary care and emergency room physicians, in regard to pain thresholds and medication dosage.

When We Cannot Help, Who Else in the Community Will? How Can SJMO Facilitate Their Efforts?

SJMO's Department of Community Programs is very proud of its strong collaborative partnerships in and around Pontiac, with such agencies as Catholic Social Services of Oakland County, Oakland Livingston Human Service Agency, Lighthouse of Oakland County, El Centro de la Familia, etc. The department works tirelessly to maintain and nurture these relationships, and to leverage them to improve the health status and advance the health needs of the community. We work together through strategic planning meetings, joint educational sessions, standing project/initiative update meetings, and co-sponsored health activities etc. In addition, hospital executives serve on the boards of several of these and other agencies, universities, and important organizations throughout our community.

In 2010, SJMO facilitated a grant-funded capacity building project, which galvanized the community toward finding solutions to the healthcare problems it faces. We continue to work to keep the momentum going from that experience.

As we move forward to address the issues identified in this CHNA, SJMO will focus its collaborative efforts on encouraging our partners to use their unique skill sets to align themselves with us regarding cost and coverage advocacy. While we are committed to working closely with *all* our partners to involve them in our advocacy plan, partners with particular aptitude for such initiatives include: Committee of Fifty, Oak65, Downtown Business Development Association, Pontiac Regional Chamber, PNC Bank, and Genesys Credit Union. These entities (and their constituents) lend breadth to our ranks of community healthcare advocates who will fight with us for lower costs, increased coverage, and greater access throughout the community.

Partners with special interest in access issues include the Committee of Fifty, the Gary Burnstein Clinic, Oakland Primary Health Services, and Baker College (for access to dental care). Organizations focused on other critical community-identified issues include:

Nutrition/Healthy Eating: Lighthouse of Oakland County, Healthy Oakland Partnership, Bowen Center, La Amistad, Oakland County Health Department, Department of Human Services, Baldwin Center, Pontiac School District, Catholic Social Services of Oakland County, Oakland Livingston Human Service Agency, and Oakland Primary Health Services.

Exercise: Healthy Oakland Partnership, Bowen Center, La Amistad, Baldwin Center, Pontiac School District, Catholic Social Services of Oakland County, and Oak65

Community Health Education: Lighthouse, Baker College, Healthy Oakland Partnership, Bowen Center, La Amistad, the county health department, Pontiac Library, Baldwin Center, Centro Multicultural La Familia, Oak65, Gary Burnstein Clinic, Oakland Primary Health Services, and Committee of Fifty.

Poverty: Lighthouse, Department of Human Services, Baldwin Center, Catholic Social Services, Oakland Livingston Human Service Agency, Centro Multicultural La Familia, Oakland Family Services, PNC Bank, Genesys Credit Union, and Oakland Workforce Development.

Mental Health: Community Network Services, Common Ground, Oakland County Community Mental Health Authority, Oakland Family Services, Oakland Livingston Human Service Agency, Oak65, and The Haven.

Chronic Disease Management: Baker College, Bowen Center, La Amistad, Pontiac School District, Catholic Social Services, Centro Multicultural La Familia, Oak65, and Oakland Primary Health Services.

IX. Conclusion

While do not yet see on the horizon a robust return to good health of the economy of our community, and with it a return to good health of its citizens, the findings from this 2012 Community Health Needs Assessment are nevertheless both encouraging and inspiring. On the one hand, we see how far we have come since the 2007 CHNA, and on the other we appreciate the clear direction it gives us about where we need to go moving forward. Perhaps the single most interesting takeaway is that little new appeared from our investigations, surveys, focus groups, or community partner documents and studies. It is not surprising that Pontiac remains our community most in need of Community Benefit dollars. And while we are more informed today about the impact of economic realities on a whole new "in need" demographic in southeast Michigan, it is the scope of the problem, not the problem itself that we learned about in this process. The problems in 2007 remain the problems today, but we have a significantly better grasp on them than we did then. With the advent of the SJMO Department of Community Outreach and the new Community Health Ambassadors, we have better tools, and additional talented personnel, for reaching into and relating to our communities.

Throughout this CHNA, the reader has had an opportunity to learn what we have found, what we do, what more we can and intend to do, and what we will work with others to do, in answer to our community's needs.

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