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September 9, 2013

To the Citizens of Washtenaw County:

On behalf of the Washtenaw County Public Health Department staff, it is our pleasure to release the Washtenaw County Public Health's **Community Health Assessment and Community Health Improvement Plan – Building a Healthier Washtenaw.**

The Community Health Assessment and Community Health Improvement Plan are roadmaps that help define the health of the community, identify strategic priorities for community health improvement, and highlight assets and resources that are in place to help make those improvements.

The public health department, in collaboration with many partners including community-based organizations, academia, business, labor, health services providers, and others, strives to improve the health of the community by identifying and investigating community health problems and hazards; educating and empowering people about health concerns; developing policies and regulations to protect health and ensure safety; linking people to health services; finding innovative solutions to health problems; and evaluating the effectiveness and accessibility of health services.

The task of maintaining and improving the health of a community is neither easy nor one that can be done alone. Rather, a healthy community is the result of collaboration among all its residents. Please join us in **Building a Healthier Washtenaw!**

Sincerely,

Richard Fleece, RS
Health Officer

Alice Penrose, MD, MPH
Medical Director

INTRODUCTION

What is a Community Health Assessment?

A community health assessment is a process that uses quantitative and qualitative methods to systematically collect and analyze health data within a specific community. Health data include information on risk factors, quality of life, social determinants of health, determinants of inequity, mortality, morbidity, community assets, forces of change, and information on how well the public health system provides essential services. (National Association of City and County Health Officials)

What is a Community Health Improvement Plan?

A community health improvement plan is a long-term, systematic effort to address public health problems on the basis of the results of the community health assessment. Government agencies, including health, education, and human services, use the plan to set priorities and coordinate and target resources in collaboration with other community partners. (National Association of City and County Health Officials)

What is “HIP,” or the Health Improvement Plan of Washtenaw County?

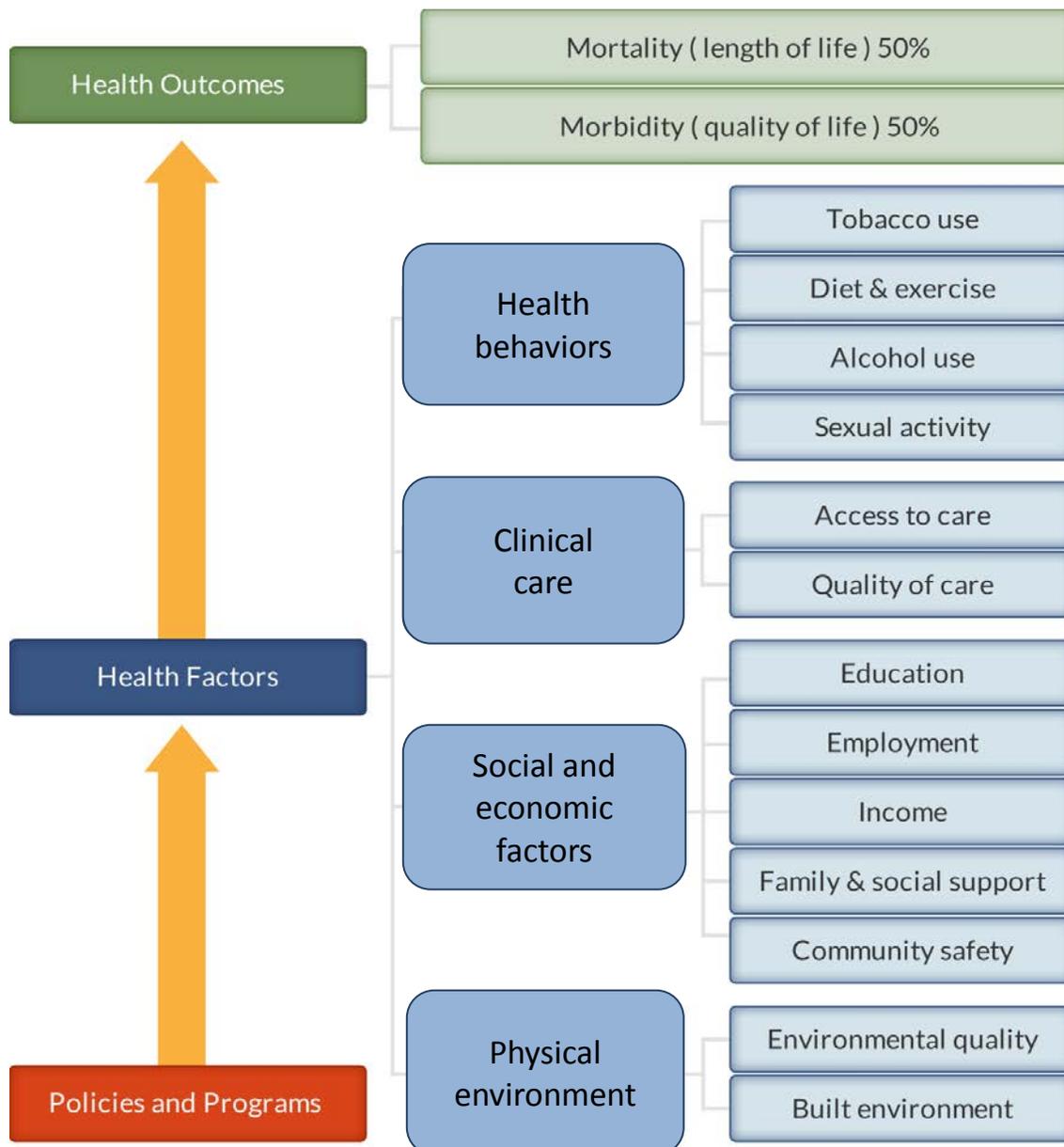
Washtenaw County Public Health’s community assessment program – the Health Improvement Plan of Washtenaw County (HIP) – has provided the organizational leadership for completing Washtenaw County’s own Community Health Assessment and Improvement Plan. Above all, HIP is a **coalition** with committed partners from across the county. The HIP program structure and assessment process are described below.



A Model of How Health Happens

The following model has been developed by the County Health Rankings through the University of Wisconsin Public Health Institute. This model describes the influences on health outcomes. It shows the importance of health factors such as health behaviors, clinical care, social and economic factors, and the physical environment. In addition, community policies and programs influence health factors and outcomes.

This Community Health Assessment was structured with this outline in mind. Each section of the Assessment begins with an overview of related Health Outcomes. Then Health Factors are discussed. Related policies and programs are listed in the Assets and Resources section of the Assessment and were considered when drafting the Community Health Improvement Plan.



County Health Rankings model ©2012 UWPHI

The Health Improvement Plan of Washtenaw County

The **Health Improvement Plan of Washtenaw County (HIP)** framework was established in 1995 by Washtenaw County Public Health in partnership with University of Michigan Health System, Chelsea Community Hospital, and St. Joseph Mercy Health System. The HIP partnership was based on a community health assessment process called Assessment Protocol for Excellence in Public Health (APEX/PH) and the US Department of Health and Human Services Healthy People 2000 goals for the nation.

The 3-pillar framework developed – **“Partnerships, Data, and Evidence-Based Strategies”** – helps ensure that population health data are collected and analyzed, needs prioritized, and issues addressed in a cost-effective and collaborative manner.

HIP has the following **strategic goals**:

Partnerships

- ➔ **Grow partnerships across sectors and disciplines.**

Data

- ➔ **Collect, analyze, and disseminate data on health factors, outcomes, and disparities in Washtenaw County.**
- ➔ **Establish long term health objectives and monitor progress.**

Evidence-Based Strategies

- ➔ **Increase understanding of evidence-based strategies.**
- ➔ **Increase understanding of policy and environmental approaches.**
- ➔ **Further address social determinants of health, social justice, and health equity.**
- ➔ **Develop, implement, and monitor shared countywide health improvement plan.**

The HIP program has the responsibility to assess the health of the population in Washtenaw County. HIP does this by guiding partners through a collaborative community health assessment process. Representatives from a wide variety of sectors in the community participate in regular meetings to identify key health issues and resources, and then agree on how to tackle prioritized needs.

The following section describes the HIP program and how this structure has resulted in: **“Building a Healthy Washtenaw: Community Health Assessment and Community Health Improvement Plan (2013).”**

Partnerships

HIP Goal:

- ➔ **Grow partnerships across sectors and disciplines.**

HIP's partnership now includes many different community sectors, over 25 organizations, and 350 individuals all working together to help build communities that make the healthy choice the easy choice. Any interested individual or organization can join the process.

HIP is supported by the following partner agencies who contribute funding and leadership to HIP:



In addition, numerous agencies, community volunteers, and funding organizations contribute to HIP by participating in key partnerships, including our Community Health Committee and Implementation and Coordinating Teams.

Community Health Committee

The Community Health Committee is HIP's community coalition. Meetings are open to the public and held five times per year. The Committee has an elected Chair and Co-Chair who volunteer their time and are from partner organizations. Attendance averages 40-60 individuals per meeting. Attendees include community members and representatives from a broad range of sectors including:

- Community Based Organizations
- Faith Based Communities
- Government Agencies
- Health Systems
- Hospitals
- Media Outlets
- Universities
- School Districts
- Downtown Development Authorities
- Area Transportation Authorities
- Foundations

Community Health Committee Meetings cover a variety of topics. Since 2010, agenda titles have included:

- Literacy Powers Health
- Health Equity: Community Conversations
- Health Disparities in Washtenaw County: Opening the Window of Opportunity of Health for All
- More than Care: Health Care Reform is Community Transformation
- Washtenaw Health Initiative's Oral Health Strategies
- Health and Academics: Linked for Success
- Childhood Obesity - Healthy Kids, Healthy Michigan, and Breastfeeding
- HIP 2010: More than a Survey - It's the Story of What We Know Matters Here
- HIP 2020: Objectives Progress Michigan's Political Landscape: Health at the Cross Roads
- A Community Lens on the Substance Abuse Scene
- Prescription Drug Abuse
- Transportation: At the Intersection of Health

Coordinating Team

The Coordinating Team functions as the HIP steering committee and is responsible for tracking overall progress, setting agendas for the Community Health Committee meetings and activities, and assuring that the Implementation Team's workplan remains consistent with HIP's broader goals. Members include leaders from Chelsea Community Hospital, St. Joseph Mercy Health System, University of Michigan Health System, Washtenaw County Public Health, Washtenaw Intermediate School District, and the community.

Implementation Team

The Implementation Team is responsible for ensuring the HIP's work is carried out. This includes maintaining quality assurance, monitoring health outcomes, interpreting data, and sharing information. Members include representatives from Chelsea Community Hospital, St. Joseph Mercy Health System, University of Michigan Health System, Ann Arbor Center for Independent Living, Washtenaw Health Plan, Ann Arbor YMCA, and Michigan Institute for Clinical and Health Research. This team meets six times per year; members volunteer their time.

At the same time, HIP staff members are active participants on other community coalitions and initiatives, including the Washtenaw Food Policy Council, the Food System Economic Partnership, the Washtenaw County Breastfeeding Coalition, Healthy Kids Healthy Michigan, and the Washtenaw Health Initiative – among others.

See the appendix for a list of partner organizations and members of all HIP teams and committees.

HIP Goals:

- **Collect, analyze, and disseminate data on health factors, outcomes, and disparities in Washtenaw County.**
- **Establish long term health objectives and monitor progress.**

How does HIP measure health in Washtenaw County?

The HIP program is responsible for assessing the health of the Washtenaw County population. HIP staff, with guidance from partners described above, collects primary data and multiple sources of secondary data in order to examine causes and rates of death and disease, birth outcomes, access to care, health behaviors, policy, and social and environmental factors. The Health Improvement Plan Survey, or HIP Survey, provides a key primary source of data regarding Washtenaw County residents. After careful consideration of these sources of data, HIP Objectives are written through a collaborative process. These objectives reflect the prioritized health needs and aims for the county.

The HIP Survey

Since 1995, the HIP Survey is conducted every five years in our community. In both 2005 and 2010, over 2,000 adults in Washtenaw County were interviewed by phone about their health status and health behaviors. In addition, over 600 of the adults reported on the health status of one child in the household. Survey responses are weighted to reflect the demographic characteristics of Washtenaw County. The data are available by region of the county and on the HIP web pages. Most of the questions are based on the Behavioral Risk Factor Survey (BRFS), so local data can be directly compared to state and national data. Many of the survey questions have been asked since 1995, allowing for trends to emerge.

Critical Health Issues

The HIP Community Health Committee and Implementation and Coordinating Teams provide oversight for the entire survey process. To facilitate broader community participation, HIP created Critical Health Issue Workgroups. Local content experts (academics, clinicians, policy makers, and community leaders) are able to participate in the survey process as it relates to specific content areas, including:

- Injury
- Mental Health
- Substance Abuse
- Chronic Disease
- Perinatal Health
- Healthy Communities
- Infectious Disease
- Access to Care

Survey Administration

The most recent HIP Survey was conducted from January 2010 through January 2011. The survey sample was designed to be a stratified random sample of 1,712 English-speaking, non-institutionalized adults in Washtenaw County. Additionally, we oversampled African Americans, Asian Americans, and the Western region of the county. The completion rate was 41%; the refusal rate was 7%.

Dissemination

Washtenaw County Public Health oversees the contractor and the details of the methodology, instrument, weighting, and data dissemination. Presentations of 2010 HIP Survey data were provided to the full Community Health Committee and all of the HIP funding partners. These presentations began in the spring of 2011 and continued through winter 2012.

Limitations

The telephone samples for the HIP Survey are based on landline numbers only. HIP uses the same survey methodology as the state Behavioral Risk Factor Survey (BRFS). Cell phone numbers are not sampled. Many individuals may acquire cell phone coverage from local providers and subsequently move out of the county. And many residents of Washtenaw County may have cell phone numbers from other areas of the country. Although this limitation impacts the state and national BRFS, the limitation in Washtenaw County may be even greater because of the large proportion of students and other populations likely to relocate frequently.

Other Sources of Data

In addition to the HIP Survey, HIP collects other primary data and regularly draws on secondary sources of data. Primary data development includes the SAFE and SOUND Survey and the *Encuesta Buenos Vecinos* or Good Neighbors Survey. SAFE and SOUND is a 1,000 household sample of 12-17 year olds and their parents, which identifies risk and protective factors regarding substance abuse. *Encuesta Buenos Vecinos* is a local Latino Health Survey, currently in progress.

Secondary data sources include:

- Community Commons, Community Health Needs Assessment
- County Health Rankings
- Annie E. Casey Foundation Kids Count Report
- Michigan Department of Community Health - birth, death, hospitalization and infectious disease data
- Michigan State Police – arrest, offense, and traffic incidence data
- Michigan Department of Agriculture – data on grocery stores, restaurants, and food vendors
- Michigan Care Improvement Registry – immunization data
- University of Michigan and St. Joseph Mercy Hospital – ICD-9 External Code data (admissions for injuries and poisonings)
- US Environmental Protection Agency – air, water, and land pollutant information
- Washtenaw County Public Health – local infectious disease data
- US Census – Decennial Census and American Community Surveys – sociodemographic data

Health Objectives

In 1995 and 2005, our HIP staff and partners developed health objectives that reflect health needs evident in the HIP Survey results and other data sources. HIP's objective-setting process uses the same structure as the survey-development process, and the same Critical Health Issue Workgroups are used. To set objectives, local experts and community leaders examined trends, risk groups, related evidence-based interventions, and emerging data. For the year 2020, HIP identified 52 health objectives related to the critical health issues listed above.

Between 2009-2013, HIP staff and partners gave 65 presentations to community groups, organizational leadership, and the community at large related to the HIP Objectives.

Progress Reports

Every five years, HIP publishes a Progress Report on the health objectives. The HIP Implementation Team reviews these reports and makes recommendations. In 2012, our HIP Implementation Team recommended numerous changes resulting from obsolete data sources, new national guidelines on clinical interventions, and programmatic changes. See the appendix for our latest Progress Report.

Strategies

HIP Goals:

- ➔ **Increase understanding of evidence-based strategies.**
- ➔ **Increase understanding of policy and environmental approaches.**
- ➔ **Further address social determinants of health, social justice, and health equity.**
- ➔ **Develop, implement, and monitor shared countywide health improvement plan.**

HIP has focused on educating partners across the county about evidence-based strategies, especially strategies that are focused on policy and environmental approaches. HIP has done this through presentations and trainings at Community Health Committee meetings, by disseminating resources on our listserv, and through our participation in other community coalitions and initiatives. Evidence-based strategies or interventions are those that have been proven effective, at least to some degree, through outcome evaluation. In other words, such interventions are likely to be effective at changing behavior (or other specific outcomes) if implemented as recommended for a given population. Using such interventions is a more cost effective way of allocating resources and achieving desired outcomes.

Evidence-based interventions that use policy and environmental approaches are prioritized within HIP because of their potential to impact the health more broadly. For example, a policy or environmental change in a school building or district sets the stage for changes that impact all students, staff, and administrators in that building or district.

HIP's focus on addressing social determinants of health, social justice, and health equity is rooted in the knowledge that the social conditions in which people are born, live, and work impact their health tremendously. Individual choices are important, but factors in the social environment influence lifestyle choices and access to health services. By emphasizing the social determinants of health through the HIP partnership, we are better able to identify health disparities, target geographic areas and/or vulnerable populations, and intervene to improve social and economic conditions that will ultimately improve health status.

Over the years, multiple initiatives, programs, coalitions, and surveillance systems have evolved. Some have been sustained, while others filled a specific need more temporarily.

- Washtenaw Asthma Coalition
- Pick up the Pace, Saline! Coalition
- Healthy Communities Steering Committee – Chelsea, Manchester, and Dexter
- Coalition for Infant Mortality Reduction
- Building Healthy Communities
- Substance Use Monitoring and Recommendation Team

HIP's latest strategic goal, "Develop, implement, and monitor shared countywide health improvement plan," was formally adopted in 2013. Our first shared countywide plan is presented in the second major section of this document, the Community Health Improvement Plan. Notably, the three hospital partners developed their initial community health assessment and community health improvement plans in 2011 and 2012. Together, the HIP partnership has worked to identify a set of six strategic priority health issues that are shared among hospitals and Washtenaw County Public Health. These six areas and associated action plans form a solid foundation for the Washtenaw County Community Health Improvement Plan:

- Access to Care
- Obesity
- Mental Health
- Substance Abuse
- Perinatal Health
- Vaccine Preventable Diseases

Emphasis on Health Disparities

HIP Health Objectives

The HIP objectives highlight health issues where inequalities exist between groups. For example, infant mortality is a measure that consistently affects some income, racial, ethnic, and educational groups more than others. HIP identifies the subgroup that has the best rate and uses that as the target for the group experiencing the worst rate.

HIP Survey Data Collection and Analysis

The HIP Survey items are, in part, selected based on the likelihood that the health issue is unequally distributed across different subgroups or communities. In order to analyze HIP Survey data by subgroups, HIP oversamples residents of Ypsilanti, African Americans, Western Washtenaw (rural), and Asian residents. Significantly, all HIP Survey data can be viewed and presented graphically on the HIP website. Charts and graphs are available for all Survey questions; maps and trends over time are available for some questions. Partners and stakeholders have consistently praised HIP for providing user-friendly information about how health may vary across the county and where there may be room for health interventions.

Sharing Information with the Community

HIP presents HIP Survey data through numerous presentations. These presentations include time for group input, enabling a greater understanding of the data itself as well as related programming and policy concerns.

We have developed a number of tools that we use to assess, identify, and share findings regarding health disparities. These tools include our “Health Disparities Matrix” and “Health Equity Index and Report Card.” (See the appendix.) The Disparities Matrix summarizes key health issues by income, racial, geographic, and educational subgroups. The Health Equity Index and Report Card is based on the PBS Series *Unnatural Causes: “Ten Things to Know about Health Equity.”*

