FROM RUINS TO RESILIENCE

ADDRESSING TOXIC STRESS IN THE HEALTH CARE SAFETY NET

Community Report 2017
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Message from the President

Our primary strategic action in 2017 was the realignment of our resources around population health. This has been a significant area of program emphasis since a Kellogg Foundation commitment helped establish our Population Health Council. Under the leadership of John Powell, executive director of the Haas Center for a Fair and Inclusive Society, and Dr. Mouhanad Hammami, director of the Wayne County Health, Veterans, and Community Wellness Department, we feel we advanced this field in Southeast Michigan.

I was privileged to present on population health to the John Griffith Leadership Center at the University of Michigan School of Public Health. While there are growing academic centers of interest in population health, and many health systems are practicing it as patient management systems or through their community health needs action plans, there are few community organizations actually doing it. In fact, after decades as a health care administrator, it has occurred to me that the time has come for a new mode of health professional — a population health executive — one who melds the body of knowledge and experience of health care administration with the discipline of public health. In a way, this is similar to the new breed of primary care physician coming out of our teaching health center program — one who employs a community-centered approach to caring for individual patients. This is true for community health nursing, as evidenced by the holistic approach of our nurse home visitation model, the Detroit Nurse-Family Partnership. This is also true with our commitment to integrated wellness care.

This is an exciting time in the health and wellness field. While our political leadership acts to minimize the initiatives embodied by the Patient Protection and Affordable Care Act, and efforts to erode health equity, we are finding young professionals who look for opportunities to do the right thing.

Under the leadership of Josie Llaneza, vice president of Operations, and Dr. Meghan Dwaihy, manager of Health Equity and Collaboration, we have reorganized our convening structure to make better use of staff resources and community collaborations. We have organized virtually everything we do within the population health lens.

That approach is reflected in this community report. For the past several years, we have called it a population health report, with emphasis on our growing data analytics work and our community initiatives. We are reporting our work within the total context of population health.

We hope you find value in our accomplishments as we continue our work in concert with public health agencies, health systems, and human service agencies to meet the challenge of improving health and wellness status within the safety net, and ultimately our entire region.

Chris Allen
President and CEO, Authority Health
The InterLocal Agreement that established the Detroit Wayne County Health Authority (d.b.a. Authority Health) in 2004 stipulates several powers and responsibilities, intended to improve the health status of county residents.

Authority Health, with the resources available, has aggressively pursued health enrollment and navigation, support for capacity expansion, and workforce development.

After nearly 15 years of service, the organization has made tremendous strides to building coalitions and improving population health. This has been remarkable because of the absence of dedicated government investment in its mission and the limited philanthropic funds available.

Authority Health is an example of the kind of social entrepreneurship needed in this era of reduced government support for public health and the need to create alternative revenue streams to meet public accountability.

From a fiscal integrity perspective, Authority Health has maintained perfect audits since its inception and has weathered difficult financial periods with reasonable enterprise risk and innovation.

On behalf of the Board of Directors, I applaud Chris Allen and his staff for their effort and the realignment of resources around population health. We are confident that Authority Health will meet the challenges of this uncertain time.
Perspective on Population Health

People struggling to get by in America’s impoverished communities, and those in pockets of more affluent communities, suffer from a disproportionate share of many diseases, diabetes, heart disease, asthma and cancer. In population health, we need to look at another disease, even more insidious, toxic stress.

Stress is a normal part of a healthy life. When stress is continuous and cumulative without adequate release, it can become toxic. All the diseases mentioned above and more can be caused or exacerbated by chronic or toxic stress. Toxic stress is increasing particularly among individuals adversely affected by the social determinants of health. Unlike privileged population, communities impacted by social determinants can become overwhelmed by the breath and intensity of stress associated with 1) fiscal stress from lack of employment, 2) the duress of working multiple jobs, 3) disproportionate foreclosures, 4) neighborhood blight and crime, 5) poorly financed and unsafe educational environments, 6) inadequate maternal care and adverse childhood experiences, 7) unaffordable water and heat, 8) inadequate transportation, 9) food insecurity, and 10) unhealthy natural environments where impoverished people are forced to live.

Populations subjected to racism and other forms of social inequality suffer the primary and secondary effects of pervasive toxic stress. Hopelessness can literally break your heart. We are just beginning to address this in an integrated population health model.

In the years I have co-chaired the Authority Health Population Health Council, I have stressed that this health indicator should become a priority in our efforts to address the persistent poor health status of the people in the safety net. I am pleased that this has become more prominent in the work of Authority Health and its collaborators.

We are facing daunting pressures on the social infrastructure from our elected officials and those who administer government at all levels. It is evident through the absence of urban policy regarding the critical need for low income housing, or a municipal policy of assigning responsibility for resources needed to live, such as water and heat. They not only can’t pay their water or heat bill, they struggle to pay their rent, their car payment, and food.

As this report suggests, resilience is the means through which vulnerable populations thrive. And it is through the collective impact of those who advocate for systemic change that we will begin to lessen the toxicity that poisons the psyche and physiology of those who are trying to become healthy.

Resilient communities can be built, and should be considered in the same context as “healthy” community design. The social infrastructure is every bit as important to community design as the built infrastructure. We must become better at tracking and ameliorating toxic stress.

I am pleased with the direction of Authority Health to integrate population health into its strategic operations and that health equity including targeted universalism is the guiding principle that does not waver in trying time.
A half-century ago, there was a disruption of great magnitude in Detroit. Some called it a riot. Others called it a rebellion. Much of the city, as it was known at the time, was destroyed, its social system left in disarray. Psychological trauma affected not only those directly involved in the conflict, but the entire population. Generations would feel the after-effects directly, or indirectly.

There followed flight, blight, escalating personal and property crime, and desolation. There was a new political order but disinvestment. Much of the city that didn’t burn in 1967 was abandoned. Neighborhoods, once dense with working class homes and well-maintained parks, became desolated. The Great Recession dealt a catastrophic blow to the manufacturing community throughout Southeast Michigan, leaving thousands without employment, years later only to find employment at considerably lower wage levels and benefits – if at all. The foreclosure crisis created even more residential vacancies, as the numbers of homeless people increased. The core city of Detroit was bankrupt, crime ridden, and drug-infested. Its public schools were failing and its public transportation woefully inadequate.
Strangely, Detroit never lost its spirit. “Detroit vs Everybody,” became an ironic slogan. “Detroit Hustles Harder,” found its way on a line of T-shirts. While many people left, many also stayed as the city emerged from bankruptcy. By any measure, it is a “trauma-affected community”; yet it survives.

It survives in neighborhoods coming together through block clubs and community gardens, through church congregations, and through struggling schools. Despite high rates of injury and illness, it survives.

Like other vulnerable communities across the country, it is a community striving for resilience. In some sectors, it has achieved it. But despite the economic renaissance of the core city, in order for Detroit to thrive, it must become resilient.

**THE RESILIENCE MOVEMENT**

The Rockefeller Foundation, in its report *Cities Taking Action*, defines urban resilience as “the capacity of individuals, communities, institutions, businesses, and systems within a city to survive, adapt, and grow no matter what kinds of chronic stresses and acute shocks they experience.” Chronic stress weakens “the fabric of a city over time and exacerbates shocks when they inevitably occur.” It’s the cumulative effect, the interconnectedness of the stress — “toxic stress” as some have called it — that erodes the sense of wellbeing, the will and confidence to achieve, and often results in rage, sometimes against someone or oneself.

In 1987, the sociologist Julius Wilson noted that “historical trauma, due to a legacy of racism, residential segregation, and oppression erodes one’s emotional and physical well-being.”

“Pervasive current and historical trauma demands a community building approach that takes into account residents emotional needs and avoids re-traumatization triggers, which traditional community organizing may miss,” according to *Trauma Informed Community Building: A Model for Strengthening Community in Trauma Affected Neighborhoods*, published by Bridge Housing and the Health Equity Institute. Although psychotherapists help individuals cope, it’s a community health challenge of great magnitude in cities like Detroit, which require partnerships with congregations, schools, and community groups.

The report notes that traditional community building is achieved by establishing social networks, engaging residents in planning and vision setting, leveraging community capacity to solve collective problems, and collaborations with systems and organizations to improve social and community outcomes. In trauma affected communities like Detroit, there is a lack of trust and social cohesion, a lack of stability, reliability and consistency. There is also an inability to vision the future, a disempowerment and a lack of a sense of community ownership.

Social cohesion is a critical component of the resilient community. That can be found in pockets of the community, but with vast tracts of empty land and blighted neighborhoods, the challenge for the public and private health sectors is to align resources and integrate medical and mental health resources.

**DETROIT, COMMUNITY RESILIENCE, AND THE AMERICAN DREAM**

Those who have experienced Detroit during the past 50 years may be too close to devastation, too impacted by the trauma, to realize the good news. Millicent Johnson, a journalist from New York, knew immediately that she was in an important place, a place with history, and a place with a future. “Detroit, in a lot of ways, parallels the track we are on as a nation,” she wrote in an article published in *Grist*. “Unresolved racial tensions and the abandonment of cities are facts of life here in the states. Let’s be clear, Detroit is not alone in this. It may be pronounced here, but if we stay on the current track of trying to house ourselves in single-family homes, consuming without regard for practicality or sustainability, and looking at a single source for our well-being — in our cast straight-up consumer-driven capitalism — there is no need to look into a crystal ball. The snapshot of our future is staring at us in the face in the stereotypical shots of Detroit.”

"Building resilient and trauma-informed communities is essential to improving public health and well-being. Communities can be places where traumatic events occur, but they can also help keep us safe. They can be a source of trauma, or buffer us against the negative effects of adversity. Communities can collectively experience trauma much like individuals do, and they can be a resource for healing."

Substance Abuse and Mental Health Services Administration

"It's a community health challenge of great magnitude in cities like Detroit, requiring partnerships with congregations, schools, and community groups."

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That future, she adds, is not necessarily bleak. “It’s like what happens to a forest after a great fire. At first glance, it looks like everything is dead. But if you look closer you’ll find that the soil is fertile and ready for planting.”

The Christian Community Development Association, holding its 2017 conference in Detroit, stated that “Detroit’s journey has been one that puts a premium on resilience. Experiencing wave after wave of struggles like urban unrest, economic disinvestment, housing market collapse, and bankruptcy, has brought the city to its knees.”

**IT DIDN’T HAPPEN OVERNIGHT...**

“Catalyzing a movement takes time, and our vision for change is multi-generational,” notes the Rockefeller Foundation. Resilience involves a holistic approach, building on the assets while pushing back at the deficits. “The current approach to urban development is a soloed one, with one team designing disaster recovery plans, another team exploring sustainability issues, and another focused on livelihoods and well being, and yet another on land-use planning.” Cities, the report says, are “systems, not silos.”

The health “system” is no different. Detroit and Wayne County remain at the bottom of the County Health Rankings, as analyzed by the Robert Wood Johnson Foundation. Despite the efforts of several health care systems, primary and secondary physician practices, community health centers and public health agencies, the population continues to have a lower health status than other counties.

Resilience requires a culture of health, one built on social resilience, a holistic built infrastructure, and a clean environment. Evidence of both exists.

**A CULTURE OF HEALTH EMERGING**

In 2008, photographer Andrew Moore published a book and curated a traveling exhibit of photographs on the ruins of Detroit, called *Detroit Disassembled*. Many viewed this photographer’s work and the legions of international photographers who descended on the abandoned manufacturing and residential infrastructure of the city as exploitative. Where others saw ruins and vacant land, many Detroitzers began to develop small farms on empty lots, eventually becoming the national leader in urban farming, noting the nation’s first 100 percent “organic, self-sustainable neighborhood.” This back to nature was an indication of the city’s resilience: it began to bond at the community garden, the group bike ride, and other community events. Yet the affects of trauma linger.

**TRAUMA AS A CHALLENGE TO COMMUNITY BUILDING**

As the Downtown and Midtown areas of Detroit experience extensive real estate growth, the redevelopment of the rest of the community remains in question. While many are focused on how the city will redevelop its neighborhoods – and which ones – the question remaining is how to overcome the trauma that is endemic in the area.

The Health Equity Institute notes in *Trauma Informed Community Building*, “traditional community development formulas don’t apply to psychologically and physically devastated areas like Detroit.” Trauma informed community building de-escalates chaos and stress, builds social cohesion, and fosters community resiliency over time. This is an essential foundation for overcoming the social determinants of health – the basis of concern in population health.

In 2017, Authority Health focused its attention on the challenge of creating resilience, networking with mental health agencies, and its population health stakeholders. Kelly Herron, the 2017–18 Population Health Fellow, developed the curriculum for the spring Population Health Forum on community resilience, led a research project on adverse childhood experiences, coordinated a screening of the film *Resilience* and organized a training program for physicians and community health advocates on the impact of toxic stress on health and well-being.

We realize there are many aspects that need to be addressed to effectively improve population health. Most important, perhaps, is to create resilience, from which a culture of health can emerge.
Enhancing the Community Medicine Training Experience of Primary Care Medical Residents Through Engagement

It can be hard for a single, working parent to find time to take their child to see their pediatrician. Issues such as lack of transportation, financial restrictions, or health literacy problems can lead to a disconnect of services between children in the community and their health care provider. Many of these families receive services at a variety of community organizations in Detroit, including Head Start and Early Head Start programs. Family Medicine and Pediatric residents at the Authority Health Teaching Health Center have begun to bridge the primary care access by providing Head Start and physical health screenings to children at Focus:HOPE, Black Family Development, and other community organizations.

These clinical services are part of the expansion of the month-long Community Medicine rotation, funded by the Children’s Hospital of Michigan Foundation. The goals of the rotation include exposing residents to the community infrastructure and resources that could support their patients. Authority Health residents gain first-hand exposure to many of the social, community, family, and psychological/emotional factors that impact health. The community rotation is designed to enhance the resident’s understanding of the broader health care system. The rotation is also important to promote community-based care.

Residents provide Head Start and physical health screenings regularly at each partner site. In addition to the health exam, they teach families about the benefits of routine primary pediatric care, stressing the importance of health promotion and preventative care. Residents counsel parents on the recommendations of the American Academy of Pediatrics “Bright Future” program, which covers topics such as “Feeding Your Baby,” “Safety,” and “Healthy Teeth,” among others.

“We’re able to help parents when they are in a time or access bind,” explains Allison Tripi, D.O., who completed the Authority Health Pediatric residency program last year. She supervises residents at the site, teaching them to be “warm, educational, and trustworthy,” to make sure the child is well and their parents understand the importance of regular follow-up visits to their pediatrician. A majority of families have access to a pediatrician through their Medicaid-managed care plan and receive other services through these agencies.

The Children’s Hospital of Michigan Foundation grant emphasizes health promotion and education, explains Carolyn Custer, D.O., project administrator. “The opportunity to teach these families the importance of healthy habits and preventative measures has been amazing. The interaction with the medical residents and Dr. Tripi has empowered these parents to take an active part in their children’s health. At the same time, this rotation helps the residents build empathy skills so they will be prepared to provide holistic, unbiased care.”

The rotation’s clinical services are also provided at Loyola High School for sports physicals and the Development Centers for Head Start physicals. In addition, health education and promotion lectures are given at the Samaritas House (Heartline) and the Detroit Recovery Project (DRP). One feature at DRP is the “Ask a Doc” Q & A sessions on general health topics. Residents also spend a week providing services at The Children’s Center, a day on the Salvation Army food truck, working at the Coalition on Temporary Shelter and at the Wyandotte Clinic for the Working Uninsured in Brownstown Township. Residents have to complete required readings on population health; American Medical Association modules on Medicare, Medicaid, cultural competency, and unconscious bias; an advocacy project on health policy that impacts their specialty; a community health-related topic paper that reflects the experience of underserved and vulnerable populations with a focus on Detroit. Residents are also required to record a daily reflective journal, and complete a community resource list of four local programs that are not connected with the rotation.

The clinical component to the community medicine rotation, through the funding from the Children’s Hospital of Michigan Foundation is an important piece of the community medicine training medical residents receive at Authority Health. This experiences serves as an additional access point to care for children and families living in Detroit with hopes of continued growth and outreach in a way that serves the whole community.
GME Overview

The Authority Health GME Consortium is the second largest teaching health center in the nation. Yet in traditional graduate medical education, it is relatively small compared to programs sponsored by teaching hospitals and universities. This is an example of “small giants,” a term for highly effective, small businesses that manage their growth in ways that allow it to expand qualitatively, rather than size.

Authority Health has consistently refined its training experience for residents, offering opportunities in community health centers and private physician offices, as well as mental health centers and integrated sites. Together with the University of Michigan School of Public Health, it presents an innovative population health certification program for residents, giving them scope and depth of understanding that few residencies offer. Additionally, its community medicine rotation, which recently added a clinical component, further engages residents in the communities where they train.

Bo Burlingham, author of Small Giants, notes, “In business, after all, it’s easy to confuse size with greatness, and getting bigger with getting better. When you stop and think about it, the connections between the two are tenuous at best, but – with all the attention paid to getting big and growing fast – it’s easy to understand why most of us tend to equate them. But deciding to go for greatness rather than bigness, the small giants remind us that the two are not the same, thereby posing a compelling question: What exactly is it that makes a company great?... I figured that we could all benefit by considering the possibilities, by asking ourselves what we really want out of work, and out of life?”

Arguably, the Authority Health GME Consortium is demonstrating its role as a small giant by focusing on training the next generation of primary care physicians in a way that will prepare them to provide high quality, community centered practice in medically underserved areas.

We are pleased that funding for the national teaching health center program has been renewed by Congress. The Michigan Congressional Delegation provided bi-partisan support of this effort.

2017 STATISTICS

Of the 2017 Authority Health graduates who have decided on their post graduation practice plans, 70 percent chose to work or continue training in a medically underserved area or with a medically underserved population and 65 percent of graduates have accepted positions in ambulatory practice settings.

**Family Medicine:**
- Macomb County private practice
- Mid-Michigan federally qualified health center

**Geriatrics:**
- ConcertoHealth, Detroit

**Internal Medicine:**
- Dearborn health plan practice and telehealth provider for the Indian Health Service
- Infectious disease fellowship at Wayne State University
- Commitment to ambulatory practice opportunities in Southeast Michigan

**Psychiatry:**
- Child adolescent fellowship in Flint, an extension of the Michigan State University program

**Pediatrics:**
- Brighton private practice
- Western Wayne Family Health Center, Lincoln Park
- Authority Health Faculty Practice, Community Medicine
Impact: A Series of Small Steps Forward

Dr. Danny Kalash, a pediatric dentist who completed the New Orleans Albert Schweitzer Fellowship (ASF), told the inaugural group of Detroit ASF fellows that there are broad, seemingly insurmountable systemic problems in our health and social system. But humanitarians need to focus on helping one person at a time. It really does add up. That’s a difficult lesson for those whose education is focused on health issues and infrastructure problems facing populations. After all, caring for individuals is the business of traditional medical care and social service.

A few days earlier, Oday Salim, director and managing attorney of the Great Lakes Environmental Law Center, told a politically-charged group in Dearborn that resistance to seemingly overwhelming political challenges is a noble ambition, but success often comes in small procedural victories, like causing the withdrawal of a permit to increase industrial emissions. Creating a clean atmosphere will take a seismic change in industrial practices and social policy, but incremental checks and balances can create synergy over time.

That’s the best way to understand the impact of the Albert Schweitzer Fellowship, which over nearly 30 years has helped prepare over 3,500

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Authority Health Launches Detroit Chapter of Albert Schweitzer Fellowship

Authority Health became the 14th chapter of the national Albert Schweitzer Fellowship in 2016 and launched its first cohort in spring 2017. The program offers graduate students an opportunity to actualize their passion for humanitarian service and improve the health and well-being of the underserved population of our community. Fellows dedicate a minimum of 200 hours providing service, attend monthly presentations on topics such as cultural humility and trauma-informed service, as well as skills-building topics like the basics of social entrepreneurship, grassroots fundraising, and advocacy. It’s our hope that through service learning, we will create new humanitarians, in the spirit of Dr. Schweitzer, one of the 20th centuries great humanitarians, as well as contribute to the health and human service infrastructure of our community.

We sincerely appreciate the support of Michigan State University College of Osteopathic Medicine as a sponsor of the Schweitzer Fellowship.

2017–18 ALBERT SCHWEITZER FELLOWS

Jonathan Chan, Oakland University William Beaumont Medical School

“Incorporate mindfulness training in the middle school environment for both teachers and students.”

This project addresses the stressful environment within the educational environment for both students and teachers. Mr. Chan will incorporate the principles and practice of mindfulness to enhance the educational process and improve job satisfaction for educators. The project will measure the ability of mindfulness in increasing the physical, mental, and social health and well-being of teachers and students, thereby enhancing awareness of themselves and their health, as well as the ability to contribute to a positive school environment. Mr. Chan has selected two middle schools and will work in concert with the Michigan Collaborative for Mindfulness Education.

Brianne Feldpausch, Michigan State University College of Osteopathic Medicine

“Create the Spartan Street Medicine program to serve homeless people in East Lansing.”

This project builds on the experience of street medicine providers in Pittsburgh and Detroit, assessing the physical and psychological needs of homeless people and providing appropriate referrals. Through consistent and direct outreach, Spartan Street Medicine cultivates relationships built on dignity and respect to bridge the gap in health care for homeless people. Through holistic, multidisciplinary outreach...
teams, Ms. Feldpausch’s project treats medical issues, arranges follow-up care, and integrates health literacy and social services into the care plan. Each client of the program receives a full history and physical by a medical student. The student discusses each case with a supervising physician before offering any medical advice or needed medication. Spartan Street Medicine will be sustained as a model of street medicine in East Lansing and will instill the qualities of trust, empathy, and humility in the next generation of health care providers.

**Maliha Ahmed, Wayne State University School of Medicine, Department of Family Medicine and Public Health Sciences**

“Create an educational program on sexual health literacy in the Muslim community”

This program provides accurate information on a variety of health topics, ranging from the human papillomavirus vaccine to sexual assault awareness. The information will be presented in a culturally-competent way that considers the unique set of barriers that Muslim women face. It will be catered to all ages, providing resources and workshops to women over 18 years old. Ms. Ahmed’s program will incorporate in-person seminars, followed by group and one-to-one discussions. The site partner for this program is ACCESS, which is a humanitarian program located in Dearborn, Michigan. The overall goal is to foster a community of women and girls that is better informed and confident about their health, reflecting the goals of Healthy People 2020 in creating “social and physical environments that promote good health for all.”

**Lindsay Toman, Wayne State University Sociology**

“Improve the relationship between medical professionals and the lesbian, gay, bisexual, transgender, and queer community (LGBTQ).”

This project will help prepare medical professionals and medical students with the understanding and skills to care for LGBTQ patients, and help the LGBTQ population in the Detroit area better understand the best way to care for themselves and live healthy lives. Ms. Toman will employ educational seminars and training programs for medical professionals – physicians as well as other health professionals – including discussion of health disparities in this population. The seminars will include relevant topics such as how to appropriately identify transgender patients or address different kinds of gender identity. The program also plans to develop a panel discussion consisting of LGBTQ people who will share their experiences with a live audience. Medical professionals will not only learn about LGBTQ health topics, but how to be more culturally sensitive to the community. A second aspect of the program will involve outreach to the LGBTQ community through health fairs, including health navigation advice and health information.

We are pleased to offer this program under the guidance of our Advisory Board:

**Alice Thompson, Chair**

**Steve Gold**

**Dr. Gary Willyerd**

**Chris Allen**

**Dr. Geneva Williams**

 student humanitarians in many professional disciplines in the legacy of its 20th century namesake. Their success is evaluated for initial impact, and many of their programs have been sustained. Arguably, the world is a better place because of what their projects accomplished and the role the fellows serve professionally. But the world is a big place and the problems that plague humanity are seemingly overwhelming.

In Detroit, four graduate students set out to make a difference as 2017-18 Albert Schweitzer Fellows. They focused on specific opportunities to improve health and well-being among vulnerable populations. They overcame barriers, raised funds, recruited volunteers, pursued continuing education, and met their goals. Three-quarters of the way through the program, all of the fellows exceeded the requirements for hours of service.

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**Chris Allen**

**Dr. Geneva Williams**

2017–2018 Albert Schweitzer Fellows. From left to right: Maliha Ahmed, Lindsay Toman, Jonathan Chan and Brianne Feldpausch. Also pictured is Dennis Archambault, Vice President of Public Affairs.
A mother and a nurse, Kimberly Bracey, RN, was aware of the effect the environment has on health. When she applied for the Ecology Center’s Health Fellowship, she saw an opportunity for continued learning and improving her nursing practice. Bracey, who works with the Detroit Nurse-Family Partnership at Authority Health, was accepted as one of the Ecology Center’s 2017 Health Leaders Fellows.

The fellowship is offered to health professionals of all types, at any stage of their career. As trusted spokespeople for institutional and policy change, health professionals are uniquely positioned to tackle some of the most pressing environmental health challenges – which helps explain why the Ecology Center would offer this program. The Ecology Center has, for many years, linked environmental quality with health and is an advocate for the Fresh Prescription program and other aspects of improving health through environmental quality.

The Nurse-Family Partnership is an evidence-based community health program that helps transform the lives of vulnerable first-time moms and their babies through ongoing home visits from registered nurses. Low-income, first-time moms receive the care and support they need to have a healthy pregnancy, provide responsible and competent care for their children, and become more economically self-sufficient.

From pregnancy until the child turns two years old, NFP nurse home visitors form a much-needed, trusting relationship with the first-time moms, instilling confidence and empowering them to achieve a better life for their children – and themselves.

The Fellowship requires Bracey to complete eight modules featuring one in-person introductory training session, five webinars, four interactive in the field experiences, and a final practicum project.

“Discussions around environmental quality and its effect on maternal and child health, both in the home and outside, are part of the NFP process,” Bracey says. The Ecology Center Fellowship offers her greater depth in the subject matter.

“I am already incorporating the information in my regular visits with the mothers,” she says. She explained that the topic is something she has long been interested in, especially as it pertains to the health of her son who has an emerging disease known as EoE and other congenital GI disorders. The disease is triggered by environmental factors and allergic food responses.
One of the fellowship topics — healthy food options — has been helpful to Bracey. “I’ve already made changes in my food consumption. I’m buying more organic foods. I’m a lot more conscious about where food comes from and the whole process of getting food from the garden to the table.” Are her clients in a position to be more selective about the foods they eat, given the economic and social challenges impacting their daily lives? “Although access to healthier options may be limited, given these challenges, clients should absolutely be educated on these options and ways to incorporate small, gradual changes into the choices they make,” Bracey says.

“They’re in a unique position, just being pregnant and a first-time mom. They’re more interested in making healthy choices — more open than they otherwise would be. They’re thinking about being a mother, in a protective mode. They’re at a better point in their life and open to hearing about these options to improve it,” she says.

Detroit Nurse-Family Partnership Improves Maternal Health

The Detroit Nurse-Family Partnership continues to positively impact the infant mortality and maternal health portion of population health. Despite the challenge of recruiting nurses, Detroit NFP served 197 women in 2017. 100 percent take their infants for follow-up appointments and receive immunizations, while 77 percent initiate breastfeeding, compared to only 40 percent of all Michigan mothers giving birth. Detroit NFP ended 2017 with seven nurse home visitors, with the goal of filling its staffing complement at 10. Each nurse cares for 25 to 30 clients.

The return on investment speaks for itself:

- State and federal cost savings due to NFP will average $25,861 per family served, or 2.9 times the cost of the program.
- NFP’s total benefits to society equal $57,148 per family served.
- The social benefit yields a 6.4–1 benefit-to-cost ratio for every dollar invested in NFP.

Tezra is one of our clients who completed the NFP program in July 2017 without ever securing housing. She was “couch homeless” the entire time, never had a vehicle. She met with her nurse wherever she could, most frequently at her medical appointments for herself or the baby, but Taco Bell, McDonald’s, and the library were their regular meeting spots. “It’s really heartbreaking, but common to see clients complete the program and never accomplish housing,” says Kim Bracey, RN, NFP nurse. “However, she was very ambitious and followed up with every resource, without any real support system outside of NFP. She connected with much-needed mental health resources, consistently during her last six months with us. I believe they would definitely be an agency that would be able to get her into housing eventually, but that process and discussion started after she was finished with NFP.” At the end of 2017, Tezra was still “couch homeless,” but hopeful.

Another client experienced a house fire during the 2017 Christmas holiday. She lost everything but her car. She is now employed with a good job, but has been unable to find safe, suitable and affordable housing. It’s been especially hard because she hasn’t been on the job for long and can’t get away from work long enough to handle business. She is currently sleeping in an overcrowded home on the living room couch with her daughter. She’s very fearful of things she’s been told and due to her work schedule, she won’t go into a shelter situation because she’s “afraid it may put her daughter at risk of being exposed to germs, bedbugs and inappropriate people.”

This is an area where housing insecurity, one of the critical social determinants of health, severely complicates efforts to reduce infant mortality and promote maternal health. Housing insecurity creates a situation that impacts everything in the lives of NFP clients, and there’s no sure way out. Between finding a job, finding child care, and securing stable housing, there’s always just enough instability to collapse the whole process if any one thing goes wrong or is lacking.
Exploring Adverse Childhood Experiences and Toxic Stress in Detroit

Understanding the impact of adverse childhood experiences on the health and well-being of people has grown in recent years. In exploring aspects of toxic stress and its impact on health, Kelly Herron, population health fellow, chose to conduct a study of people seeking care in primary care and community mental health settings. Adverse Childhood Experiences (ACEs) are stressful or traumatic events, including a wide range of abuse, neglect, and household dysfunction. Individuals who experience ACEs during childhood are more likely to have poor mental and physical health in adulthood.

Herron’s survey will identify the most common ACEs and sources of toxic stress among people in urban Detroit. The project explores how stressors such as ACEs and growing up in an urban community like Detroit may impact health behaviors and health outcomes. Data was collected on 11 health outcomes thought to be associated with ACEs and toxic stress: obesity, tobacco use, depression, heart disease, substance abuse, stroke, chronic obstructive pulmonary disease, emphysema, lung cancer, chlamydia, and gonorrhea.

Over 100 people completed the 44 question Exploring Adverse Childhood Experiences & Toxic Stress in an Urban Community survey. The survey inquired about exposure to childhood adversities such as emotional and sexual abuse, as well as stressors that may be common in urban environments such as witnessing violence and experiencing discrimination based on race or ethnicity. In addition to questions about ACEs and stressors, patients were asked information on specific health outcomes. To compare self-reported information to actual outcomes, patient medical records were reviewed by Authority Health residents to verify the 11 health outcomes.

Collected Data

To collect the data for this analysis, we created categorical lists using Microsoft Excel to summarize information. We included the following categories for analysis: catchment area, preparer of the CHNA (internal versus external group), number of hospitals in health system, overall health priorities identified, and data collection/methodological approaches including surveys, focus groups, and secondary data sources.

Communities Defined

HCOs, which ranged from 1 to 8 hospitals, defined their communities according to their specific catchment areas and through demographic information. Geographically, HCO catchment areas differed according to county, city, and zip code reach. The most common were Wayne, Macomb, and Oakland Counties; St. Joseph Mercy restricted its CHNA to Oakland, St. John Providence expanded its catchment area to Livingston and St. Clair, and St. Mary Mercy Livonia Hospital restricted its catchment area to communities within a 5 mile radius of its facility within Wayne and Oakland. The demographic range included information such as gender, age, race, and ethnicity, as well as populations defined by education, access to insurance, health behaviors, income, homelessness, and more.

Data Sources Used

To measure health status of specific catchment areas, HCOs used a wealth of quantitative and qualitative data available by both federal and state health and human services, nonprofit organizations, and community knowledge from surveys and focus groups. The number of data sources used range from 5 to 23, and HCOs’ CHNAs differ regarding how central quantitative or qualitative data lead the development of the report.
Two of the HCOs used an external consulting company to compile data and conduct surveys and focus groups. Examples of secondary sources of data accessed for the assessment are: Michigan Department of Health & Human Services, Michigan Behavioral Risk Factor Survey, US Census data, the Michigan Inpatient Database and the Centers for Disease Control and Prevention.

Health Status and Conditions

To describe the health status of different catchment areas, HCOs differed according to their methods and thought processes. While some HCOs used more epidemiological data, such as prevalence, mortality, and leading causes of hospitalization, others used an approach using the social determinants of health, using information such as health behaviors, education, emotional and social support, and crime rates. Furthermore, some HCOs used established measures of health status including the 2011 Community Needs Index and 2012 County Health Rankings. Health conditions analyzed often led directly to the priorities taken on by HCOs, and included conditions ranging from heart disease and cancer to substance abuse and mental health.

Societal Risk Factors

While some HCOs used societal risk factors according to health behaviors, many also included the use of some to describe socioeconomic status (SES). Importantly, many HCOs used systemic issues such as lack of information about health programs available to support the use of their priority areas and programming. Although the use of systemic issues such as low levels of education and income described health status, HCOs did not indicate particular programs outside of healthcare to remedy their collective impact on health. This indicates the perceived scope and limits of specific institutions to execute change in regard to the social determinants of health.

Health Priorities and Areas of Importance

HCOs differed regarding how they determined their areas of importance, as well as their health priorities. For the purpose of this analysis, we defined “areas of importance” as points of interest raised as significant in CHNAs, and “health priorities” as the specific issues that HCOs would choose to focus on in their community efforts and programming. Health priorities were defined through geographic problem areas according to quantitative data analyses, surveys, focus groups, and defined their health priorities largely according to health conditions. HCO areas of importance often included long lists (up to 100 indicators), and priorities often culminated in lists of 5 or less.

*Number of times priority area mentioned collectively by Henry Ford Health System, St. Mary Mercy Livonia Hospital, St. John’s Hospital & Medical Center, St. Joseph Mercy Health System, and Beaumont Health System.

Dr. Carolyn Custer, Director of Scholarly Activity and Quality Improvement for the Authority Health Graduate Medical Education Teaching Health Center, is working with Herron, and Dr. Bill Corser, Director of Research and Chief Editor of Spartan Medical Research Journal at Michigan State University College of Osteopathic Medicine, to analyze the survey data.

Psychiatry residents Drs. Mark Balino, Bill Conway, and Albert Nguyen and Family Medicine resident Dr. Jason Phillips will complete an academic poster on the study. In collaboration with the residents, Herron and Dr. Custer are currently preparing a journal article for publication.

Findings from this small scale study will help to identify toxic stress related issues, which will in turn assist in understanding the types of interventions and policy changes that can help reduce the negative impacts of toxic stress. •

## Breakdown of Healthcare Organizations Analyzed

<table>
<thead>
<tr>
<th>System</th>
<th>Year</th>
<th>Address</th>
<th>Prepared By</th>
<th>Catchment Area</th>
<th># of Hospitals</th>
<th>Priorities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Beaumont Health (Beaumont, Oakwood, Botsford Hospitals/Health System)</td>
<td>2016</td>
<td>3601 W. 13 Mile Rd. Royal Oak, MI 48073-6769</td>
<td>Truven Health Analytics</td>
<td>Macomb, Oakland, and Wayne Counties</td>
<td>8</td>
<td>Obesity, Cardiovascular Disease, Diabetes</td>
</tr>
<tr>
<td>Henry Ford Health System</td>
<td>2016</td>
<td>One Ford Place Detroit, MI 48202-3450</td>
<td>HFHS Business Integrity Services and Corporate Strategic Planning departments, along with the Office of Community Health, Equity and Wellness</td>
<td>Macomb, Oakland, and Wayne counties</td>
<td>4</td>
<td>Obesity and Diabetes Prevention; Access to Care; Mental Health &amp; Substance Abuse</td>
</tr>
<tr>
<td>St. John Providence Hospital and Medical Center</td>
<td>2016</td>
<td>22101 Moross Rd. Detroit, MI 48236-2172</td>
<td>Community Health Needs Assessments (CHNA) Steering Committee / St. John Community Health</td>
<td>Macomb, Oakland, Livingston, St. Clair and Wayne County (which includes the city of Detroit)</td>
<td>5</td>
<td>Access to Care, Diabetes/Obesity Reduction; Asthma, Mental Health &amp; Substance Abuse</td>
</tr>
</tbody>
</table>

### Data Collection

More than 100 public health indicators were evaluated for the quantitative analysis. Community needs were identified by comparing each community's value for each health indicator to that of the state and nation. Where the community value was worse than the state, the indicator was identified as a community health need. After initial community needs were identified, an index of magnitude analysis was conducted to determine relative severity.

### Data Collection

Primary data was generated through surveys of essential community agencies and persons representing the broad interests of the communities we serve in each of the three counties. The Oakland County survey ECHO (Energizing Connections for Healthier Oakland) was conducted by the Oakland County Health Department in 2015, and its data was utilized for this community health needs assessment (CHNA). HFHS also collaborated with the Macomb County Health Department in their community survey process in 2016, and data has been incorporated in this CHNA. Finally, HFHS conducted the survey for Wayne County/Detroit in 2016. Secondary data sources utilized in this CHNA include publicly available local, state and national data on demographics, socio-economic factors, health behaviors, access and mortality from a wide range of sources. The most recent data available were reviewed using the Michigan Department of Health & Human Services,* Michigan Behavioral Risk Factor Survey, US Census data, Crimson Market Reports and the Michigan Inpatient Database (Data Koala).

### Data Collection

A Steering Committee was convened to provide guidance and oversight in the development of the community health needs assessments (CHNA). The committee included all of the directors from the local health departments, as well as individuals from a variety of health professions such as public health, physicians, nurses, finance, health planning, communications, behavioral health and faith-based leaders. Extensive local, national, state and hospital utilization data and statistics were obtained from internal as well as external sources to identify health specific trends. These sources as well as information collected through a survey of 465 community members and 86 key informants groups enabled the Steering Committee to gain further insight into the needs and gaps in the hospital service area. The data input sources that St. John Providence (SJP) used included both quantitative and qualitative data from sources such as:

- **Secondary Data**
  - Michigan Department of Health and Human Services
  - Centers for Disease Control
  - County Data (for all 5 counties and City of Detroit)
  - Behavioral Risk Factor Surveys from both local, state and national sources

- **Hospital Data**
  - CHNA Community Survey
  - Survey was distributed widely throughout the SJP service area via SJP associates
  - Both paper and online surveys were sent to community members as well as key informants.
### Data Collection

The process involved actively reaching out to community experts through surveys and interviews, delving already-conducted local studies that used focus groups, community forums and surveys, and gathering of local, regional and nationally available data sources.

- A. Primary Data Sources – Surveys
- B. Primary Data Sources – Key Stakeholder Interviews
- C. Secondary Data Sources – Local studies
- D. Publicly Available National, State and Local data

### Data Collection

Ensuring the most accurate demographic information and community health concerns, data was gathered from numerous sources. Primary data was obtained through the survey, Community Forum and information gathered from the community partners represented on the Community Health Needs Assessments (CHNA) Steering Committee. Secondary data analysis was conducted utilizing national, state and local demographic and community health databases.

*Not to be directly addressed*

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### SE MI Health System* Identified Health Priorities 2015-2016

![SE MI Health System* Identified Health Priorities 2015-2016](image-url)
Assuring Medicaid Redeterminations

Each year, recipients of the Medicaid program must provide updated information to their Michigan Department of Health and Human Services (MDHHS) caseworker to demonstrate that they are still eligible for benefits. Authority Health has been selected by several health plans to provide assistance in contacting and interviewing their Medicaid clients. These health plans refer clients 45-to-60 days before the month the redetermination is due. With the help of Rep. Sylvia Santana, Authority Health representatives met with the leadership in the MDHHS and as an extension of the state health department, were able to have the state’s human service worker, based at Authority Health, assist with the redetermination process without having to contact each Medicaid member.


Continued on next page >
well-being at the top of her priorities. For example, she is a member of the House CARES (Community Access, Resources, Education and Safety) Task Force, which was formed to develop policy solutions to the opioid crisis, mental health resources, and jail diversion. Detroit and Wayne County need community advocates like Rep. Santana.”

Michelle Adams-Calloway, Social and Community Service Manager, also works with the redetermination process. •
Management’s Discussion and Analysis for the Fiscal Year Ended September 30, 2017

Using this Annual Report

This annual report consists of three parts – management’s discussion and analysis (this section), the basic financial statements and required supplemental information. The basic financial statements include information that presents two different views of the Detroit Wayne County Health Authority (d/b/a Authority Health).

The General Fund is presented on a modified accrual basis of accounting; a short-term view to tell how the resources were spent during the year, as well as how much is available for future spending. This information is then adjusted to the full accrual basis to present a long-term view of Authority Health as a whole. The long-term view uses the accrual accounting basis, which measures the cost of providing services during the current year and whether the full cost of providing government services has been funded.

The General Fund modified accrual basis financial statements provide detailed information about the current financial resources. This is important as it demonstrates compliance with various state laws and shows the stewardship of Authority Health’s revenue.

Authority Health’s full accrual statements present information about the organization’s total economic resources, including long-lived assets and any long-term obligations. This information is important as it recognizes the long-term ramifications of decisions made by Authority Health on an ongoing basis.

The financial statements also include notes that explain some of the information in the statements with more detailed data. The statements are followed by a section of required supplemental information that further explain and support the information in the financial statements.

<table>
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<tr>
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<tbody>
<tr>
<td>Current Assets</td>
<td>$ 2,079,035</td>
<td>$ 2,062,682</td>
</tr>
<tr>
<td>Capital Assets</td>
<td>83,832</td>
<td>104,502</td>
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<tr>
<td>Total Assets</td>
<td>2,162,867</td>
<td>2,167,184</td>
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<tr>
<td>Total Liabilities</td>
<td>1,991,273</td>
<td>1,442,592</td>
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<tr>
<td>Net Assets</td>
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<td></td>
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<tr>
<td>Invested in Capital Assets</td>
<td>69,856</td>
<td>87,281</td>
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<tr>
<td>Restricted</td>
<td>184,613</td>
<td>490,649</td>
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<tr>
<td>Unrestricted</td>
<td>(82,875)</td>
<td>146,662</td>
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<tr>
<td>Total Net Position</td>
<td>$ 171,594</td>
<td>$ 724,592</td>
</tr>
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<tbody>
<tr>
<td>Revenue</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Contractual and operating grants</td>
<td>$ 10,557,761</td>
<td>$ 10,730,551</td>
</tr>
<tr>
<td>Contributions and foundation grants</td>
<td>446,908</td>
<td>530,837</td>
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<tr>
<td>Total revenue</td>
<td>11,004,669</td>
<td>11,261,388</td>
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<tr>
<td>Expenses - operations/other</td>
<td>11,557,667</td>
<td>11,454,713</td>
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<tr>
<td>Change in net position</td>
<td>(552,998)</td>
<td>(193,325)</td>
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<tr>
<td>Net position, beginning of year</td>
<td>724,592</td>
<td>917,917</td>
</tr>
<tr>
<td>Net position, end of year</td>
<td>$ 171,594</td>
<td>$ 724,592</td>
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</table>
Authority Health As a Whole

Authority Health had a decrease in fund balance of $496,383. This decrease is mainly the result of expending prior year foundation dollars for their intended purpose of the Detroit Nurse-Family Partnership (NFP) program. Authority Health’s primary source of revenue is from federal grants, specifically the U.S. Department of Health and Human Services (HRSA) and through the MDCH Interdepartmental Agreement-Medicaid Outreach Services, and contributions and donations. Salaries and fringe benefits are a significant expense representing 57 percent and 12 percent, respectively, of Authority Health’s total expenses. There was a two percent increase from the prior year which reflects the Authority Health GME Teaching Health Center program running at full capacity and modest adjustments.

The Authority Health General Fund

Authority Health’s Board of Directors has the ability to create separate funds to help manage money for specific purposes, and maintain accountability for certain activities. The organization’s major fund consists solely of the general fund.

Consistent with the decrease in net assets and the use of foundation funds for their intended purpose, the net position decreased by $552,998, which is $56,615 more than the change in fund balance. This difference is the result of how governmental accounting recognizes depreciation and capital outlays, how compensated absences and other long term items are reported, and the availability of revenues based on current financial resources are presented.

Authority Health’s Operational and Budgetary Highlights

Authority Health was created to “coordinate efforts to meet the health needs of the uninsured and underinsured residents in the City of Detroit and Wayne County by assuring access and improving the health status of all people.” The original goals of Authority Health are as follows:

- Expand the number and location of primary care access points throughout Detroit and Wayne County.
- Assign each enrolled client a primary care medical home.
- Coordinate the delivery of health care between and among health providers to eliminate fragmentation and reduce costs.
- Provide care management and referral services as a core component of the delivery system.
- Facilitate access to a full range of culturally competent, preventive, medical and non-medical services.
- Design a delivery system that is able to enhance federal and other funding and reduce duplication.
- Significantly expand preventive health services for at-risk populations.
- Increase provider-base workforce in the health care safety net.
To help accomplish these goals, Authority Health has developed advisory committees, councils, and collaborations, as well as programs to fill gaps in service delivery. Authority Health underwent a realignment of staff resources and functions that is anticipated to provide greater resource efficiency and effectiveness. All of the convening bodies will be integrated into the population health process.

**Population Health Council:** Established five years ago as a method of defining population health as an element of the Authority Health mission. Co-chaired by John Powell, Director of the Haas Institute for a Fair and Inclusive Society, and Dr. Mouhanad Hammami, Director of the Wayne County Health, Veterans Affairs, and Community Wellness Department, the council represented the interests of several stakeholder groups that influence the social determinants of health. The role of population health has grown in prominence within the Authority Health mission. As a result, it was determined that population health needed to be integrated in all aspects of the organization’s mission: graduate medical education, maternal health, wellness, and community engagement.

**Community Advisory Committee:** Chaired by Wayne County Commissioner Tim Killeen, a member of the Board of Directors, this committee is comprised of representatives from community-based health and human service organizations throughout Wayne County. Its charge has been to advise the organization on health issues from their perspective, respond to initiatives proposed by the organization, help communicate Authority Health objectives, and serve as a liaison to population health initiatives. In the realignment, the committee will broaden its scope to include issues pertaining to population health and include greater regional representation.

**Provider Advisory Committee:** Health system executives and public health officers in this committee have advised Authority Health on issues pertaining to the health care safety net and are engaged in strategies that leverage hospital community health impact. Rob Casalou, President and CEO of Trinity Health, and Kevin Barnett, Senior Investigator with the Public Health Institute, led a community benefit initiative as part of the work of the Provider Advisory Committee. This resulted in important discussion regarding the potential role of health systems in influencing the social determinants of health. This committee will also be expanded in scope to include primary care organizations and physicians, as well as other community health and human service leaders.

**Primary Care Network Council:** This Council was developed to coordinate and promote the expansion of primary care community resources in response to the need for such services, as well as promoting inter-organizational communication. It has functioned for most of the early history of Authority Health as a convening body for community health centers, free clinics and others in the primary care community with an interest in information sharing and potential collaboration. This council will be dissolved, with its members invited to join the Community Advisory Committee and Provider Advisory Committee.
Detroit Regional Health Collaborative: The realignment process underscored the importance of health data analytics, which was initially presented in the form of the Detroit Regional Health Collaborative. This resulted in an analysis of community health needs assessments, as reported by area hospitals, as well as other data sources. This process will continue, with increasing staffing and technological capabilities. The backbone team, comprised of health data analysis and community engagement staff, will be positioned to conduct spot data studies as well as more elaborate work. Regional academic institutions will be invited to create affiliations allowing for student internships and practicum experiences. This capability will enhance the ability of community health and human service organizations to achieve their missions through effective data analysis.

MOTION Coalition (Michigan Organizations to Impact Obesity & Nutrition): Emerged from Authority Health’s Childhood Obesity Task Force which was convened to address the urgent issue of childhood obesity. This coalition has benefitted from the leadership of Dr. William Dietz, a national pediatric obesity expert from George Washington University, and Diane Valade, health policy and legislative analyst with Henry Ford Hospital. Childhood obesity is viewed by the Coalition as not just a medical problem but a population health issue requiring a collaborative solution, requiring attention given not only to children but to their parents as well. Reflecting this dynamic, the coalition is comprised of stakeholders representing a multitude of sectors from youth organizations and community organizations, to health care providers and educators. The coalition meets quarterly and as with other convening functions has assumed a population health orientation. Its work will feed into the newly aligned population health process, influencing school health policy, as well as state and logical legislation and promoting concepts leading to improved nutrition and more active living.

Major programmatic accomplishments during the period of this audit include, but are not limited to, the following:

Authority Health, a longtime proponent of integrated health care delivery, announced an innovative partnership with Behavioral Health Professionals, Inc. and Development Centers, Inc., to create an integrated wellness model in Northwest Detroit. This model will feature an integrated training experience for Authority Health psychiatry and medical residents. The goals of the project, known as the Wellness Community Center, include:

- Assure timely access to the full range of integrated quality behavioral and physical health care services;
- Promote prevention and chronic disease management;
- Utilize innovative technology and community health navigators to facilitate person-centered integration across the continuum of care and community, and
- Incorporate and pilot a comprehensive screening process to address social determinants of health.
Nurse-Family Partnership (NFP) is funded by the Jewish Fund with matching funds from Michigan Department of Community Health to implement a program around first time pregnant moms. NFP is an evidence-based community health nursing program primarily staffed with bachelors prepared nurses. Its three main goals include: improved pregnancy outcomes, improved child health and development, and improved economic self-sufficiency. This program is especially unique because there were multiple randomized controlled trials showing positive outcomes in multiple populations nationwide. The program utilizes nurses who carry a caseload of 25–30 clients each, providing 1–2 hours of home visits weekly for the first month in the program, every other week throughout pregnancy, weekly from birth until six weeks postpartum, every other week until the child reaches 21 months, and then monthly when the mother and child graduate at two years of age. During these visits, time is spent teaching, providing support and setting goals that the clients themselves determine. The teaching includes many areas such as how to manage one’s care during a pregnancy, how to bond with a baby, how to build a support network and much more. There are three eligibility criteria: first time mother, low-income, and moms less than 28 weeks pregnant. Since the first graduating class in 2014, Detroit NFP has graduated a total of 100 clients. The graduation ceremonies were held at the Detroit Public Library Main for the first two years until the graduating clients outgrew the library. Currently 51 percent of the clients are either working full or part-time jobs. Several client centered events were held throughout the year. A very special event is the craft/tea party for Mother’s Day. Summer walking group is held on the Detroit River Walk, a tribute to fathers for Father’s Day and a successful holiday gathering entitled “Winter Wonderland” for all clients and their families.

Detroit NFP is on a journey with like organizations hoping to make the City of Detroit “baby friendly” and thereby increase breastfeeding rates. All staff will complete educational modules and once completed pass an exam taking the team closer to the “baby friendly” status. NFP Detroit can range from 96 percent initiation of breastfeeding to 79.5 percent initiation rate. These statistics are in tandem with the state of Michigan. The Detroit team completes three CQI projects yearly for MIECHV and continues their involvement with the Local Leadership Group for collaboration and support. Nurse Home Visitors are also trained in DANCE a tool to assist with identifying strengths and weaknesses in client infant attachment. Authority Health is a healthcare innovator and this year Nurse Family Partnership was nominated for the Crain’s Award for Healthcare. Several donations were received during the year, including gifts for moms, dads, and their infants. These donations are well-received and allow the staff to present the clients with gifts throughout the year. NFP has partnered with the Detroit Diaper Bank and this helps to supply the clients with diapers for their babies. Currently the team consists of a Director, Supervisor, 8 Nurse Home Visitors, and 2 Data Administrators. The goal is to have 10 Nurse Home Visitors, and we are sure to reach that goal.
The DWCHA (Authority Health) GME Consortium is a community-based graduate medical education consortium in partnership with Michigan State University, College of Osteopathic Medicine and five local federally-qualified community health centers. The consortium developed a Teaching Health Center (THC) funded by the Health Resources and Services Administration (HRSA) for the purpose of training primary care residents in medically underserved and community-based settings. This type of training sensitizes the clinicians to the community dynamics affecting the health of their patients and ideally increases the physician workforce in those areas. Studies show that more than a third of physicians who train in community settings remains and establishes their careers in similar settings. The DWCHA GME Consortium, known as Authority Health GME Consortium, is currently funded and approved for 71 slots in four specialties: internal medicine, family medicine, pediatrics, and psychiatry. Training occurs in a variety of settings including community health centers, private physicians and small group practice offices, area hospitals and community mental health agencies. Authority Health GME consortium is currently rotating residents within ten community mental health agencies, three hospitals/health systems, the Detroit VA, and over 50 community health centers and private physician offices. As an innovatively structured graduate medical education training program, Authority Health GME Consortium understands the importance of their trainees needing additional knowledge around public health, population health, and health equity to best prepare them for work with medically underserved populations. In October of 2014, in conjunction with the Office of Public Health Practice at the University of Michigan School of Public Health, the program began incorporating a required two year Certificate in Population Health and Health Equity (CPHHE) for all Authority Health GME Consortium trainees. The first cohort completed the CPHHE program in June of 2016 with positive feedback about the impact of the program, relevance of the information provided, and perception of impact and incorporation into their future practices. The certificating program maximizes the residents’ understanding of how they and their practices fit into the community health spectrum, impact population health, act as advocates, and best serve their patients. The goal of this training is to build residents’ awareness and skills to support and advocate for their patients’ health from a population health perspective. By the end of the two-year program, residents should be able to: describe the fundamentals of population health, understand professional and contextual factors contributing to health inequities, explore best practices for improving population health, apply strategies to eliminate disparities in health outcomes, engage with programs and services to influence population health. Authority Health GME Consortium is continually looking for ways to improve the program. In addition to working to improve the CPHHE for the second cohort which started with the 2016-17 academic year, the program has also implemented an institution-wide research and quality improvement curriculum for all residents. A full-time individual has been employed to work with the residents and faculty on scholarly activity projects. Authority Health GME Consortium has been initially accredited as an ACGME Sponsoring Institution and has full initial accreditation status in its Internal Medicine, Pediatrics, and Psychiatry programs. The Family Medicine program is currently in pre-accreditation status and in the process of its full initial accreditation.

Promoting Inclusivity Through Senior, Low Income Housing Preservation, Promotion

Authority Health has been a member of the Senior Housing Preservation – Detroit (SHP-D) coalition to help achieve its objectives of promoting inclusivity and housing security for low income people in Detroit. It’s a massive challenge, given the absence of federal support for new housing. The increased homeless population, particularly among young mothers and elderly, is a growing problem. Members of the SHP-D coalition have effectively engaged City of Detroit administration in an effort to preserve existing HUD-supported rental properties in the Midtown/Downtown areas of the city, with an expanded vision to support and encourage development of other properties elsewhere in the city. Also, Authority Health joined the Housing Trust Fund Coalition, an outgrowth of the People’s Platform, to advocate for the inclusion of a housing trust fund component of the Inclusionary Housing Ordinance sponsored by Council Member Mary Sheffield and later adopted by City Council. The Housing Development and Preservation Fund, incorporated by the city ordinance, left citizen oversight as an option and was viewed by coalition members as severely under-funded. However, it is a success no less and a foundation for future low income housing preservation and development.
Authority Health GME Consortium has graduated 3 classes of residents and fellows since inception. The first graduating cohort in 2015 only included 5 graduates as those were individuals who entered the program with prior training. In 2016 the program graduated its first class of trainees that had trained exclusively in the Authority Health program, where there were 19 graduates, and in 2017 Authority Health GME Consortium graduated a total of 20 across all its training programs. More than 60 percent of our graduates are working in medically underserved areas or with medically underserved populations.

Health Insurance Navigation and Outreach

Authority Health has been a leader in providing enrollment and navigation services, including training for providers, in the region. Most recently, the division has provided redetermination services for Medicaid health plans. At the core of this function’s capabilities is the deep knowledge of services available to improve access to health care services and other programs that positively influence health.

- Access to Health Care – Authority Health facilitates access to health care services for uninsured and underinsured residents. Through an Interdepartmental Agreement with the Michigan Department of Community Health, Authority Health conducts Medicaid outreach activities in partnership with area health systems, safety net providers, and faith-based community organizations (FBCOs).
- Authority Health is a certified navigation organization with emphasis on Affordable Care Act and Healthy Michigan/Medicaid enrollment, as well as assistance with Medicare and other health and human service programs. The program receives funds through Enroll Michigan and provides enrollment activities through a variety of venues, including the county jail and through arrangements with Medicaid health plans. Authority Health’s outreach staff also provide routine presentations in the community and regularly exhibit at health fairs.
- Enrollment Contracts – Authority Health has affiliations with organizations to provide onsite Medicaid enrollment services.

There were no closed programs this year.

Funding Sources

For fiscal year 2017, Authority Health’s sources of funding came from the community at large and various stakeholders, including: Michigan Department of Community Health/ Federal Government, the Department of Health and Human Services – County of Wayne, The Jewish Fund, the Michigan Consumers for Healthcare and the U.S. Department of Health & Human Services – Health Resources and Services Administration (HRSA), The DMC Foundation and the Children’s Hospital of Michigan Foundation.
Capital Assets and Debt Administration
At the end of the fiscal year, Authority Health had $83,832 invested in furniture and equipment with no additional depreciable assets added during the year.

Interdepartmental Agreement – Medicaid Outreach Services
Authority Health entered into a new agreement with the State of Michigan Department of Community Health for fiscal year 2017.

Contacting Authority Health’s Management
This financial report is intended to provide our stakeholders, benefactors, etc. with a general overview of Authority Health’s finances and to show accountability for the money it receives. If you have questions about this report or need additional information, we welcome you to contact the President and CEO, Chris Allen, at (313) 871-3751.
Resilience is the process that allows us to adapt, individually and collectively, to overcome hard times, and to thrive in a hostile environment. It characterizes the people in the health care safety net, and Authority Health as a public body committed to preserving public health and promoting population health.

The stress that underscores the poor health experienced by many in this region is toxic and is a major contributor to poor population health. It needs to be addressed in terms of social policy, as well as in the way we relate to one-another.

Resilience is the way we thrive.