EXHIBIT A

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Community Health Needs Implementation Strategy
July 2019 – June 2022

Adopted by the Ascension Providence Rochester Board of Trustees on May 14, 2019

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Ascension Providence Rochester Implementation Strategy

Implementation Strategy Narrative

Overview

Ascension Providence Rochester Hospital (APRH), a member of Ascension, is a non-profit Catholic health system. It is our mission to serve all persons with special attention to those who are poor and vulnerable. We are dedicated to all that we serve creating strong relationships with our community, our physicians, and our associates. APRH is established as an industry leader not only in providing high-quality healthcare but also as an organization that strives to improve the health of our community.

Ascension Providence Rochester Hospital is a 290-bed all-inclusive medical facility serving communities in Oakland, Macomb, and Lapeer counties; providing service to both urban and rural areas. Job growth and the inflation rate have remained relatively flat, whereas unemployment has shown a slight decrease. The cost of healthcare continues to rise; many employers are reducing benefits or cost shifting to employees as a means to save costs. This results in higher co-pays and deductibles for the patient. This increase in out-of-pocket expenditures is acting as a deterrent in seeking health care services as a result.

Demographically, APRH's primary and secondary service areas' current population is 286,937. The population (286,937) is predicted to increase by 10.2% by 2035. In 2017, the average median household income was $85,055 while an average of 5.8% of households had an income less than $15,000. From 2015 to 2035, the composition of adults age 65+ is projected to increase from 15.7% to 22.7%. In 2017, 6.2% of all persons and 6.6% of children residing in the APRH service area were living at or below poverty.

Ascension Providence Rochester Hospital resides in a highly competitive market in Southeast Michigan. There are three other hospital systems within a six-mile radius that provide competing primary, secondary, and tertiary health care services. APRH's presence with only 290 beds is substantial in that it captures 34% of the market share in its core service area. As of October 2015, APRH joined Ascension, the largest not for profit health system in the nation. APRH's core service area is comprised of three zip codes, and is one of the top three providers in its total service area with 36 zip codes. Key collaborators for APRH include Ascension affiliates in the Southeast Michigan Market including Ascension St. John, Ascension Macomb-Oakland Hospital, Ascension Providence Hospital-Southfield Campus, Ascension Providence Hospital-Novi Campus, and Ascension Genesys Hospital, in addition to long-standing partnerships with Oakland University School of Nursing and the Wayne State School of Medicine.

The methodology for survey assessment involved the distribution of two assessment tools: a community survey and a key stakeholder survey. The surveys were distributed electronically via email and hard copies during the months of September through November 2018. The survey tools were developed to assess the needs of the community and the individual needs and health status of the responders. The intention of the survey topic selection was to assess a general overview of the community needs. The survey takers were asked to select the health challenges that they face personally and the challenges that they feel their community faces.

Community stakeholders of different ages, socioeconomic status, occupations, and cultural backgrounds were invited to participate. APRH established an Advisory Board with members from all sectors of our community. The Advisory Board, including Ad Hoc members, assisted in the distribution of the survey.

Online and paper methodology was used to ensure a wide distribution of the survey allowing all community stakeholders the opportunity to participate. The survey was distributed electronically by email invitations sent to Advisory Board members and all sectors of the community. Paper surveys were available at all community events during the months of September through November 2018. To specifically identify the needs of the underserved population in our community, surveys were also distributed at area mobile food bank locations.

The survey questions were designed to gather information about the specific concerns of the individual and the individual's perception of the needs within the community

In addition to the survey results, secondary data was analyzed from local, state, and federal community health initiatives. Data was collected and analyzed with the assistance of Gary Petroni, Executive Director, Center for Population Health/Southeastern Michigan Health Association consultants using a variety of sources including MDHHS, BRFSS 2016 and 2015; MIDB, 2017; U.S. Census Bureau, ACS Estimates 2012-2016; SEMCOG Regional Development Forecast Population Projections, 2015-2045; Center for Educational Performance and Information, 2018; and MDHHS Community Health Information, 2013-2017.

Needs That Will Be Addressed

Cardiac Health

Respondents identified cardiac health as the top area of concern. This priority is consistent with local and state data gathered by Michigan Department of Health and Human Services (MDHHS) and data national from U. S. Department of Health and Human Services reporting heart disease as the leading cause of death at the local, state and national level.

Healthy Lifestyle: **Improve nutrition, increase physical activity and reduce diabetes.**

Respondents identified several needs related to obesity including concerns to improve nutrition and diabetes. This priority is consistent with Oakland County's Energizing Connections for Healthier Oakland (ECHO) assessment and initiatives, Michigan's Health and Wellness Four Healthy Behaviors initiative and Healthy People 2020 initiatives. Identification of obesity, poor nutrition, and lack of physical activity as a priority community health need aligns APRH with local, state and national initiatives. In addition, other health needs of concern (cancer, high blood pressure, stroke, and heart disease) would reduce risk factors with initiatives that address healthy lifestyles.

Mental Wellness: Stress, anxiety, mental health services, substance abuse rehabilitation services, teen crisis services.

Respondents identified stress, anxiety, mental health services, suicide, and substance abuse treatment (alcohol, drugs, and tobacco), as areas of concern. This priority is consistent with Oakland County's Energizing Connections for Healthier Oakland (ECHO) assessment and initiatives, Michigan Department of Community Health Strategic Priorities and Healthy People 2020 initiatives. APRH is working to strengthen these factors through education classes and youth-led community improvement initiatives.

Needs That Will Not Be Addressed

Identified needs that will not be addressed were determined by availability of services in the community. Chronic diseases with substantial support in the community such as cancer, lung disease and arthritis are supported by strong APRH programs with a variety of available resources in addition to the support of the American Cancer Society, American Lung Association and the Arthritis Foundation.

Summary of Implementation Strategy

Prioritized Need #1: Cardiac Health

GOAL: Improve cardiovascular health in the community

Action Plan

STRATEGY 1: Improve cardiovascular health in the community by increasing utilization of the cardiac clinic.
BACKGROUND INFORMATION: • *This strategy's target population is adults at risk for cardiovascular disease.* • *This policy will address health disparities and barriers to care by providing cardiovascular screenings, education, and support to adults at risk for cardiovascular disease. It is also one of the top three health strategies to address for Michigan Market and Ascension Providence Rochester.* • *The strategy is informed by evidence found in BRFSS health indicators, Michigan's 4 X 4 Plan, Healthy People 2020, and APR's Community and Stakeholder Survey.*
RESOURCES: • *Hospital (H); Community Partners (CP); Physicians (P); Volunteers (V); Cardiac Clinic Lead (CCL); program budget, materials staff* • Strategy/actions built into annual budgeting/ISOFP: Yes – Cardiac Clinic is budgeted
COLLABORATION: • Wayne State University • Rochester Area Neighborhood House • Older Persons Commission • Primary Care Physicians

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STRATEGY 1: Improve cardiovascular health in the community by increasing utilization of the cardiac clinic.
• Transition of Care Coalition Partners • Oakland County Health Department • Wayne County Health Department
1. By February 2020, create curriculum for cardiac clinic patients using evidence-based materials. 2. By February 2020, identify and train appropriate personnel for cardiac clinic. 3. By February 2020, create a packet promotional material. 4. By July 2020, create a workplan to increase referrals to cardiac clinic. 5. By July 2020, create an awareness campaign to promote the cardiac clinic to providers, community partners and broader community. 6. By July 2022, increase community awareness and promote healthy lifestyle by providing 6 programs/events per year.
ANTICIPATED IMPACT: I. By February 2020, APR will create an evidence-based program, train appropriate personnel and create promotional materials for the cardiac clinic. II. By July 2020, APR will create a workplan and an awareness campaign to promote the cardiac clinic. III. By July 2022, APR will improve the health status of targeted population by increasing the volume of patients in the cardiac clinic by 10% and increase community awareness by providing 6 programs/events per year (18 total) promoting healthy lifestyles.

Alignment with Local, State & National Priorities (Long-Term Outcomes for Prioritized Need #1)

OBJECTIVE:	LOCAL / COMMUNITY PLAN:	STATE PLAN:	"HEALTHY PEOPLE 2030" (or OTHER NATIONAL PLAN):
I, II, III	Increase education and promotion of a healthy lifestyle to control blood pressure and lower cholesterol levels *(ECHO-Oakland County CHIP; Macomb County Health Improvement Plan).*	Promote healthy lifestyle choices encouraging healthy food, increasing physical activity, and regular monitoring of health. *(Michigan Health and Wellness 4 X 4 Plan).*	Reduce the number of coronary heart disease deaths by 8% from 129.2 coronary heart deaths per 100,000 to 103.4. *(Healthy People 2020 Heart Disease and Stroke).*

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Prioritized Need #2: Healthy Lifestyle

GOAL: Improve overall health by increasing awareness of healthy lifestyles

Action Plan

STRATEGY 1: Increase the number of CDC evidence-based Diabetes Prevention Program (DPP) for at risk individuals to reduce the progression to Type 2 diabetes.

BACKGROUND INFORMATION

- *This strategy's target population is individuals at risk for Type 2 diabetes.*
- *This policy will address health disparities and barriers to care by providing an evidence-based program proven to reduce the progression to Type 2 diabetes. It is also one of the top three health strategies to address for Michigan Market and Ascension Providence Rochester.*
- *The strategy is informed by evidence found in BRFSS health indicators, Michigan's 4 X 4 Plan, Healthy People 2020, and APR's Community and Stakeholder Survey.*

RESOURCES:

- *Hospital (H); Community Partners (CP); Physicians (P); DPP Lead (DPPL); Volunteers (V); program budget, materials, staff*
- Strategy/actions built into annual budgeting/ISOFP: Yes – DPP is budgeted for two Cohorts per fiscal year.

COLLABORATION:

- Wayne State University
- North Oakland YMCA
- Oakland University
- Older Persons Commission
- Primary Care Physicians
- Transition of Care Coalition Partners
- Oakland County Health Department
- Wayne County Health Department

ACTIONS:

1. By February 2020, train additional DPP Lifestyle coaches.
2. By February 2020, identify and train volunteers to provide ancillary program support.
3. By February 2020, create an awareness campaign to promote DPP to providers, community partners and broader community.
4. By July 2020, create a workplan to increase referrals from PCP's.
5. By July 2021, identify community partners host sites for DPP.
6. By July 2022, increase the number of DPP offered each fiscal year.

STRATEGY 1: Increase the number of CDC evidence-based Diabetes Prevention Program (DPP) for at risk individuals to reduce the progression to Type 2 diabetes.
ANTICIPATED IMPACT: I. By February 2020, APR will train additional Lifestyle coaches, volunteers and create promotional materials for DPP. II. By July 2020, APR will create a workplan to increase referrals to DPP from PCP's. III. By July 2021, APR will identify partners to host DPP in the community. IV. By July 2022, APR will improve the health status of targeted population by increasing the number of DPP offered from 2 to 4 per fiscal year.

Alignment with Local, State & National Priorities (Long-Term Outcomes for Prioritized Need #2)

OBJECTIVE:	LOCAL / COMMUNITY PLAN:	STATE PLAN:	"HEALTHY PEOPLE 2030" (or OTHER NATIONAL PLAN):
I, II, III, IV	Increase education and promotion of a healthy lifestyle around health eating and physical activity *(ECHO-Oakland County CHIP; Macomb County Health Improvement Plan).*	Promote healthy lifestyle choices encouraging healthy food, increasing physical activity, and regular monitoring of health. *(Michigan Health and Wellness 4 X 4 Plan).*	Reduce by 10% the number of individuals at risk for Type 2 diabetes by promoting healthy food, increasing physical activity and lowering A1C. *(Healthy People 2020 D-1).*

Prioritized Need #3: Mental Wellness

GOAL: Improve overall mental health and wellness in our community

Action Plan

STRATEGY 1: Reduce stigma and increase community awareness of mental wellness.
BACKGROUND INFORMATION • *This strategy's target population is all members of our community.* • *This policy will address health disparities of mental illness by increasing awareness programs and providing education and resources to the community.* • *The strategy is informed by evidence found in BRFSS health indicators, ECHO – Oakland County CHIP, Macomb County Health Improvement Plan, Community Guide and Healthy People 2020*

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STRATEGY 1: Reduce stigma and increase community awareness of mental wellness.

RESOURCES:
- *This strategy's target population is all members of our community.*
- *This policy will address health disparities of mental illness by increasing awareness programs and providing education and resources to the community.*
- *The strategy is informed by evidence found in BRFSS health indicators, ECHO – Oakland County CHIP, Macomb County Health Improvement Plan, Community Guide and Healthy People 2020*

COLLABORATION:
- Wayne State University
- North Oakland YMCA
- Oakland University
- Older Persons Commission
- Rochester Community Schools
- Easterseals of Michigan
- Oakland County Health Department
- Wayne County Health Department

ACTIONS:
1. Create designated Task Force to conduct phone or in-person meetings that convene partners involved in planning and organizing community campaign.
2. By February 2020, create a community survey for targeted population.
3. By February 2020, create an awareness campaign.
4. By July 2020, analyze survey data, to determine best communication routes for campaign.
5. By July 2021, create community list of services/resources.
6. By July 2022, conduct community awareness/education programs.

ANTICIPATED IMPACT:

I. By February 2020, Task Force will create a community survey for a targeted population to determine services needed, how to communicate information and awareness of available resources.

II. By July 2020, Task Force will analyze survey data and create 3 communication routes for campaign.

III. By July 2021, Task Force will create a community resource list with 10 available services/resources for targeted population.

IV. By July 2022, Task Force will improve the mental wellness of targeted population by providing 4 community awareness/education programs.

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Alignment with Local, State & National Priorities (Long-Term Outcomes for Prioritized Need #3)

OBJECTIVE:	LOCAL / COMMUNITY PLAN:	STATE PLAN:	"HEALTHY PEOPLE 2030" (or OTHER NATIONAL PLAN):
II, III, IV	Improve awareness of mental illness and resources. *(ECHO-Oakland County CHIP; Macomb County Health Improvement Plan)*.	Reduce disparities in health outcomes. *(Michigan Department of Mental Health).* Improve the average number of poor mental health days; overall average in Michigan 4.4, top in US 3.1. *(What Works for Health, County Health Ratings)*	By 2020, reduce the proportion of adults age 18 years and older who experience major depressive episodes by 10% from 6.5% to 5.8%. *(Healthy People 2020 MHMD-4.2).*