Community Health Needs Assessment – 2016

Building healthier lives and communities.

Beaumont

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BEAUMONT HEALTH

Beaumont Health is Michigan's largest health care system (based on inpatient admissions and net patient revenue) formed in 2014 to provide patients with compassionate, extraordinary care, no matter where they live in Southeast Michigan.

Beaumont Health was formed through the integration of three southeast Michigan legacy health systems: Beaumont Health System, Botsford Health Care and Oakwood Healthcare.

Mission, Vision and Values

Compassion is a fundamental attribute to be a Beaumont Health physician, employee or volunteer. It is so critically important, compassion is reflected in our mission, vision and values:

Our Mission

Compassionate, extraordinary care every day

Our Vision

To be the leading high-value health care network focused on extraordinary outcomes through education, innovation and compassion

Our Values

- Compassion
- Respect
- Integrity
- Teamwork
- Excellence

Our Mission to serve others is why we exist as an organization. Our Vision is what we want to become. Our Values guide our behavior and actions in everything we do for patients, families, colleagues and communities.

8 hospitals

168 health centers

5,000 physicians

35,000 employees

Beaumont Health contributes to the health and well-being of residents throughout southeast Michigan and beyond.

LETTER FROM THE CEO

In September 2014, three of southeast Michigan's leading health systems — Beaumont, Botsford and Oakwood — joined together in unprecedented fashion to enhance and expand a shared commitment to delivering compassionate, extraordinary health care to millions of residents who call our region home.

Together as Beaumont Health, our dedication to building healthier lives and communities is stronger than ever. Through leading health services, education and extensive community outreach, Beaumont strives daily to improve the overall health and well-being of our patients, their families and our neighbors.

In order to maximize these efforts and better align our resources, every three years we do a comprehensive community assessment to identify the unique health needs of the populations we serve.

The following publication is our 2016 Community Health Needs Assessment, which thoroughly outlines the most pressing health concerns of the communities served by Beaumont Health, and our strategies to address them moving forward. Compiled from several months of research, this document offers an insightful and detailed analysis of our service areas using quantitative data and significant input from a diverse group of residents, health experts and organizations representing a broad cross-section of our region.

As one of Michigan's largest health care systems with eight hospitals, 168 health centers, 5,000 physicians and 35,000 employees serving dozens of communities throughout Macomb, Oakland and Wayne counties, this report serves as an invaluable resource for our entire system as we create healthier communities and redefine standards of care in southeast Michigan.

It is a privilege to serve our region as a leading health care provider. We look forward to many years of delivering high quality health care and wellness services to you and your family with compassionate, extraordinary care every day.

Sincerely,

John T. Fox

Compassionate, extraordinary care every day.

EXECUTIVE SUMMARY

Beaumont Health (Beaumont) understands the importance of serving the health needs of its communities. In order to do that successfully, we must first take a comprehensive look at the issues our patients, their families and neighbors face when making healthy life choices and health care decisions.

Each of the Beaumont legacy hospitals published their first federally compliant community health needs assessment in 2013.

Beginning in January 2016, Beaumont began the process of re-assessing the health needs of the communities served by the eight Beaumont hospital facilities for an updated community health needs assessment. Truven Health Analytics was engaged to help collect and analyze the data for this process, and to compile a final report made publicly available by Dec. 31, 2016.

The community served by Beaumont includes Macomb, Oakland and Wayne counties. These counties comprise the majority of the geography covered by the combined primary service areas of each of the eight hospitals and contain 3.8 million people. Each hospital's primary service area is defined by the contiguous ZIP codes where 80 percent of the hospital's admitted patients live.

A quantitative and qualitative assessment was performed by Truven Health Analytics, an IBM Company (Truven Health). 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.

Input from the community was gathered for the qualitative analysis via focus groups and interviews conducted by Truven Health. Focus group participants and interviewees included community leaders, public health experts and those representing the needs of individuals with chronic diseases, minority, underserved and indigent populations.

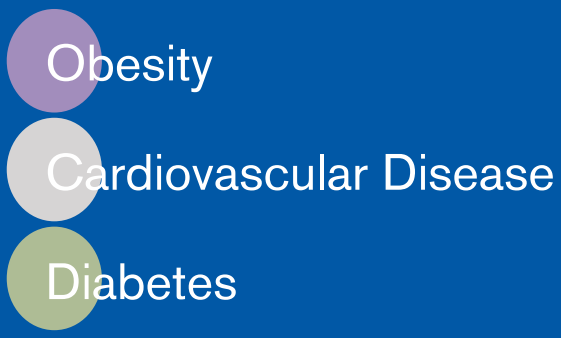
The outcomes of the quantitative and qualitative analyses were aligned to create a comprehensive list of health needs for each community. Next, the health needs were compiled to create a health needs matrix for the community to illustrate where the qualitative and quantitative data correspond and differ.

In June 2016, the Beaumont CHNA Prioritization Workgroup met to review the health needs matrix and prioritize significant needs for the communities. The meeting was moderated by Truven Health and included an overview of the community demographics, summary of health data findings, and review of each community's identified health needs.

Participants all agreed the health needs that deserved the most attention and were considered significant were those identified through both the quantitative analysis as worse than benchmark by a greater magnitude, and highlighted as common themes through the qualitative discussions.

In January 2016, the Beaumont CHNA Steering Committee selected criteria for the Prioritization Workgroup to identify the most significant health needs for each community. Using that criteria, the community's significant health needs were rated and scored. The list of significant health needs was then prioritized based on the overall scores. The session participants subsequently reviewed the prioritized health needs for each community and chose the three community health needs with the highest prioritization scores as those to be addressed by Beaumont through subsequent implementation strategies.

THE HEALTH NEEDS TO BE ADDRESSED BY BEAUMONT INCLUDE:



A description of these needs is included in the body of this report. The hospital facilities will each develop implementation strategies with specific initiatives to address the chosen health needs, to be completed and adopted by Beaumont by April 15, 2017.

A summary report and evaluation of the implementation strategies drafted after the 2013 assessments is included in Appendix E of this document. The Community Health Needs Assessment for Beaumont has been presented and approved by the Beaumont Health board of directors, and the full assessment is available to the public at no cost for download and comment on our website at beaumont.org/chna.

This assessment and corresponding implementation strategies are intended to meet the requirements for community benefit planning and reporting as set forth in federal law, including but not limited to the Internal Revenue Code Section 501(r).

COMMUNITY HEALTH NEEDS ASSESSMENT REQUIREMENT

As a result of the Patient Protection and Affordable Care Act (the PPACA), all tax-exempt organizations operating hospital facilities are required to assess the health needs of their community through a CHNA once every three years. A CHNA is a written document developed for a hospital facility that defines the community served by the organization, explains the process used to conduct the assessment and identifies the salient health needs of the community.

The written CHNA report must include descriptions of the following:

- The community served and how the community was determined.
- The process and methods used to conduct the assessment, including a description of the data, data sources and other information used in the assessment, as well as the methods utilized to collect and analyze the data and information.
- Any organizations with whom the hospital has worked on the assessment.
- How the organization took into account input from persons representing the broad interests of the community served by the hospital, including a description of when and how the hospital consulted with these persons or the organizations they represent.
- The prioritized significant community health needs identified through the CHNA, as well as a description of the process and criteria used in the identification and prioritization process.
- The existing resources within the community available to potentially meet the significant community health needs.
- An evaluation of the impact of any actions that were taken since the hospital's most recent CHNA to address the significant health needs identified in that last CHNA.

PPACA also requires hospitals to adopt an implementation strategy to address prioritized community health needs identified through the assessment. An implementation strategy is a written plan that addresses each of the significant community health needs identified through the CHNA and is a separate but related document to the CHNA report. The written implementation strategy must include:

- list of the prioritized needs the hospital plans to address, and the rationale for not addressing the significant health needs not selected
- description of the planned actions and intended impact for the chosen health needs
- resources the hospital plans to commit to address the health needs
- any planned collaboration between the hospital and other facilities or organizations in addressing the health needs

A CHNA is considered conducted in the taxable year that the written report of its findings as described above, is approved by the hospital's governing body and made widely available to the public. The implementation strategy is considered adopted on the date it is adopted by the governing body. Organizations must adopt their implementation strategy by the fifteenth day of the fifth month following the end of the tax year. CHNA compliance is reported on IRS Form 990, Schedule H.

Beaumont partnered with Truven Health Analytics, an IBM Company (Truven Health), to complete a CHNA for the community served by the following eight Beaumont hospitals.

- Beaumont Hospital, Dearborn
- Beaumont Hospital, Farmington Hills
- Beaumont Hospital, Grosse Pointe
- Beaumont Hospital, Royal Oak
- Beaumont Hospital, Taylor
- Beaumont Hospital, Trenton
- Beaumont Hospital, Troy
- Beaumont Hospital, Wayne

CHNA Steering Committee

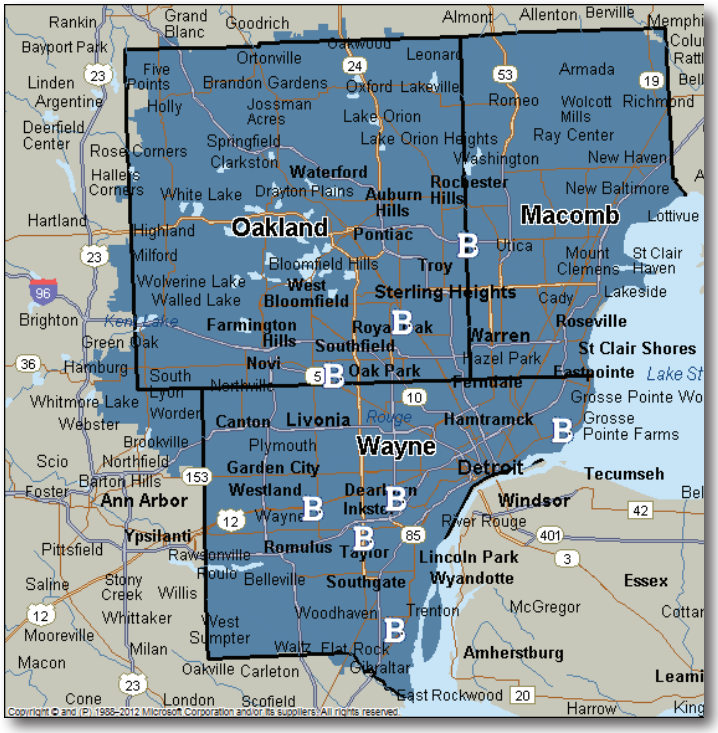
The health system formed a committee to oversee and advise the CHNA process. Beaumont's senior vice president of Government Relations and Community Affairs served as the executive sponsor of the CHNA. The vice president of Community Health and Outreach served as the project manager while the director of Community Health and Outreach served as project coordinator. Members of the CHNA Steering Committee can be found in **Appendix A.**

Consultant qualifications and collaboration

Truven Health and its legacy companies have been delivering analytic tools, benchmarks and strategic consulting services to the health care industry for more than 50 years. Truven Health combines rich data analytics in demographics (including the Community Needs Index developed with Catholic Healthcare West, now Dignity Health), planning and disease prevalence estimates with experienced strategic consultants to deliver comprehensive and actionable CHNAs.

Beaumont community served definition

For the purpose of this assessment, the geographic boundary for this study encompasses the combined, contiguous geography of the Beaumont hospitals' primary service areas. Each hospital's primary service area is defined by the contiguous ZIP codes where 80 percent of the hospital's admissions originate. The combined primary service areas of the eight hospitals includes Macomb, Oakland and Wayne counties in southeastern Michigan. The ZIP codes that define each of the hospital communities can be found in **Appendix B**. In 2015, the total population of the community served by Beaumont was estimated to be 3.8 million people.



Source: Beaumont Health, 2016

Assessment of health needs – methodology and data sources

To assess the health needs of the community served, a quantitative and qualitative approach was taken. In addition to collecting data from public and Truven Health proprietary sources, interviews and focus group were conducted by Truven Health with individuals representing public health, community leaders and groups, public organizations and other providers.

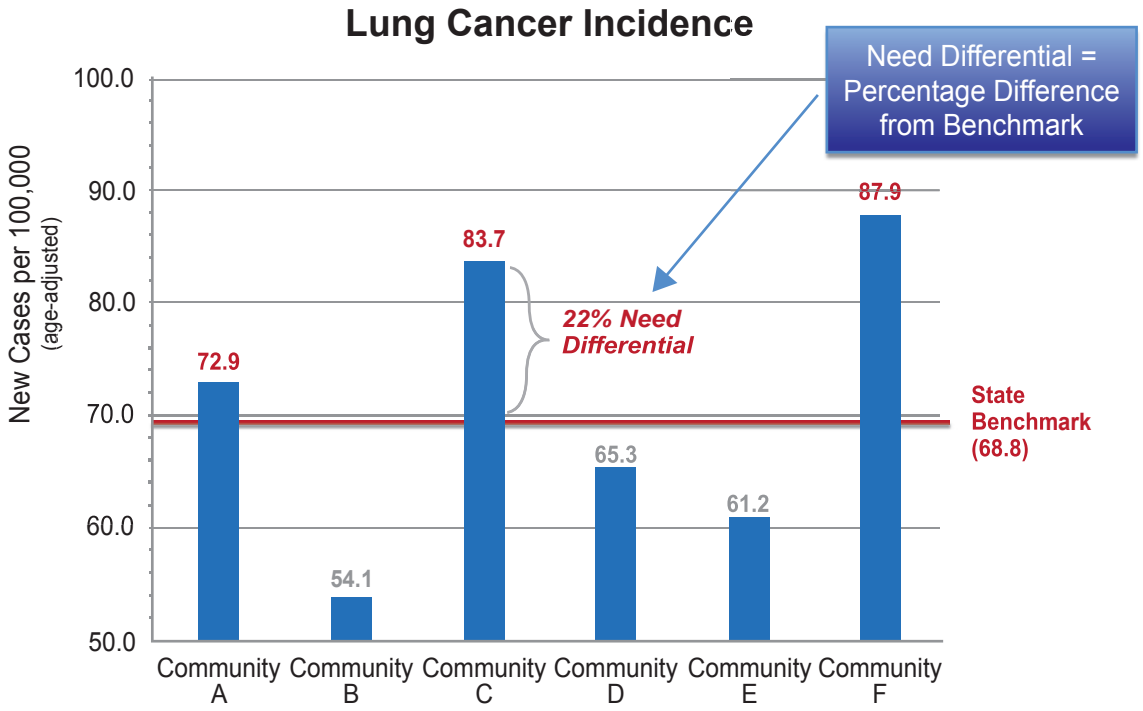
Quantitative assessment of health needs

Public health indicators were collected as community health needs metrics. Eight categories consisting of 119 indicators were collected and evaluated for the counties where data was available. In some cases, more than one measure was collected for an indicator. The categories of indicators collected are included in the table below. A list of the indicators and sources utilized in the quantitative assessment can be found in **Appendix C**.

Population 16 indicators	Mental health 6 Indicators
Health behaviors 17 indicators	Environment 9 indicators
Injury & death 10 indicators	Health outcomes 40 indicators
Prevention 9 indicators	Access to care 12 indicators

To evaluate the public health indicators which indicate a community health need, a benchmark analysis was

Health Indicator Benchmark Analysis Example



Source: Truven Health Analytics, 2016

conducted. Benchmarks collected included (when available) national, state and goal setting benchmarks such as Healthy People 2020 and County Health Rankings Best Performer.

According to the America's Health Rankings, Michigan ranks 35th out of the 50 states. The health status of Michigan compared to other states in the nation identifies many opportunities to impact health within local communities, even for those communities that rank highly within the state. Therefore, the benchmark for the community served was set to the state value. Needs were identified when one or more of the indicators for the community served did not meet state benchmarks. An index of magnitude analysis was then conducted on those indicators that did not meet state benchmarks in order to understand to what degree they differ from the benchmark to show the relative severity of need.

The outcomes of the quantitative data analysis were then compared to the qualitative findings.

Qualitative assessment of health needs (community input)

Between March and April of 2016, Truven conducted eight focus groups (one for each Beaumont community and collectively including 71 participants) and 37 key informant interviews. These were done to collect information from people representing the broad interests of the communities Beaumont serves, and to solicit feedback from leaders and representatives who serve the community and had insight into its needs.

The focus groups and interviews were designed to gain an understanding of the overall health status of the community. Additional objectives of the sessions included greater insight into the individual perceptions of community health needs and the primary drivers contributing to the identified health issues. These forums assisted with identifying other community organizations currently addressing health needs in the community. Interviews were conducted with one to three individuals, and focus groups were structured to collect both large- and small-group feedback.

Participation for the focus groups and interviews was solicited from state, local, tribal or regional governmental public health departments (or equivalent departments or agencies) with knowledge, information or expertise relevant to the health needs of the community. Also included were individuals or organizations serving and/or representing the interests of the medically under served, low-income and minority populations. Community leaders, local groups, public health organizations, health care organizations and other health care providers also participated to represent the broad interest of the communities.

Hospitals are also required to take into consideration written input received on their most recently conducted CHNA and subsequent implementation strategies. Each of the Beaumont legacy organizations made the full report available on their legacy websites and welcomed public comment or feedback on the findings. To date, we have not received such written input, but continue to welcome feedback from the community.

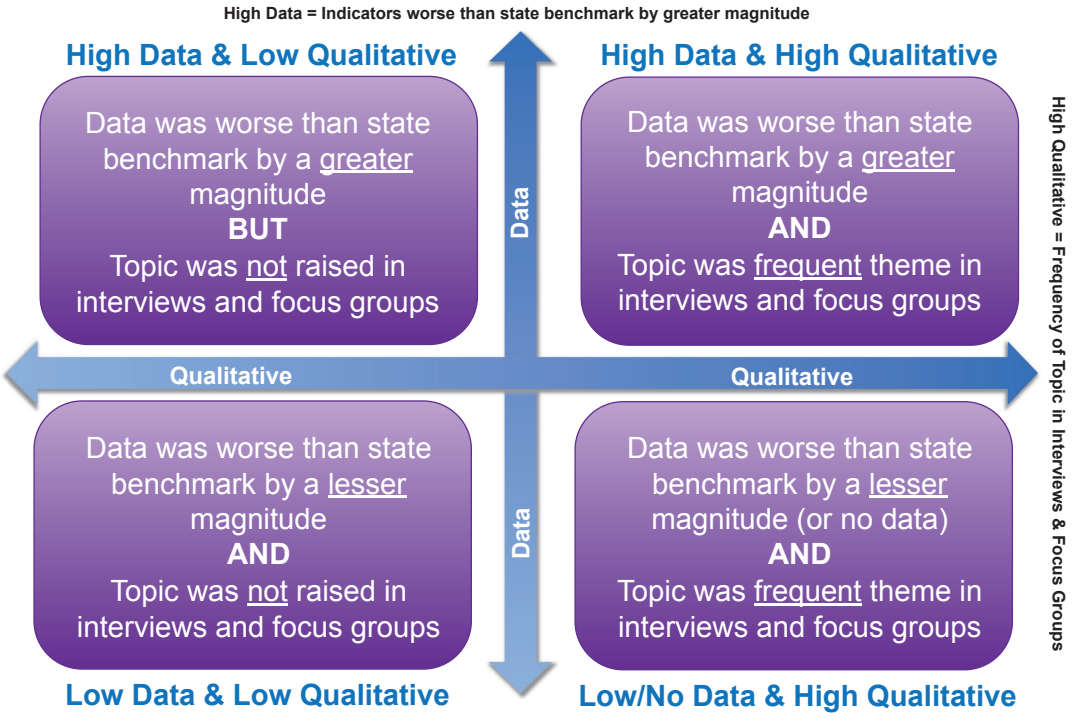
The information collected from the interviewees and focus group participants were organized into primary themes surrounding community needs. The identified needs were then compared to the quantitative data findings.

Methodology for defining community need

The health needs matrix on the following page consolidates information from interviews, focus groups and health indicator data to assist with identification of the significant health needs for the community served.

The upper right quadrant of the matrix is where the qualitative data (interview and focus group feedback) and quantitative data (health indicators) converge.

Putting it all together: The Health Needs Matrix



Source: Truven Health Analytics, 2016

Information gaps

The majority of public health indicators are available at the county level and often do not exceed this level of granularity. In evaluating data for entire counties versus more localized data, it is difficult to understand the health needs for specific populations within a county. It can also be a challenge to tailor programs to address specific community health needs as placement and access to such programs may not actually impact the individuals in need of the service. Truven Health supplemented the health indicator data with Truven Health's ZIP code estimates to assist in identifying specific populations within a community where health needs may be greater.

Existing resources to address health needs

Part of the assessment process included gathering input on community resources potentially available to address the significant health needs identified through the CHNA. A description of these resources can be found in **Appendix D**.

Prioritizing community health needs

The list of priority community health needs was based on the weight of the quantitative and qualitative data identified during the assessment. It also included an evaluation of the severity of each need as it pertains to the state benchmark, the value the community places on the need, and the prevalence of the need within the community. A thorough description of the process can be found in the "Prioritizing Community Health Needs" section of the assessment.

Evaluation of implementation strategy impact

As part of the current assessment, Beaumont conducted an evaluation of the implementation strategies adopted by its legacy facilities as part of the 2013 CHNAs. In 2013, the legacy organizations chose to address the following identified needs:

Beaumont	Botsford	Oakwood
Asthma	Overweight/obesity	Access to care
Diabetes	Physical activity	Diabetes
Drug-related admissions	Mental health	Heart/cardiovascular disease
Obesity	Availability/access to physicians	Obesity
Suicide	Preventive health actions	

Implementation strategies were put into place in 2013 to address the above needs. Those strategies have been evaluated as to effectiveness and impact. Details for that evaluation can be found in **Appendix E** with the report of interventions and activities outlined in the implementation strategy drafted after the 2013 assessment.

Demographic and socio-economic summary

The total population of the community served by Beaumont is not expected to grow over the next five years, which matches the state of Michigan; the distribution by age is also very similar. Overall, the community's median household income (MHI) is lower than both the U.S. and Michigan average, there is a higher proportion of children in poverty, and a higher unemployment rate. Socio-economic variances are more apparent when comparing different counties. Macomb and Oakland counties are generally more favorable than U.S. and state benchmarks, but Wayne County performs significantly worse. The Wayne County MHI is $39,440, 29 percent of children live in poverty, and the unemployment rate is 13 percent.

Demographic and Socio-economic Comparison: Community Served and Benchmarks

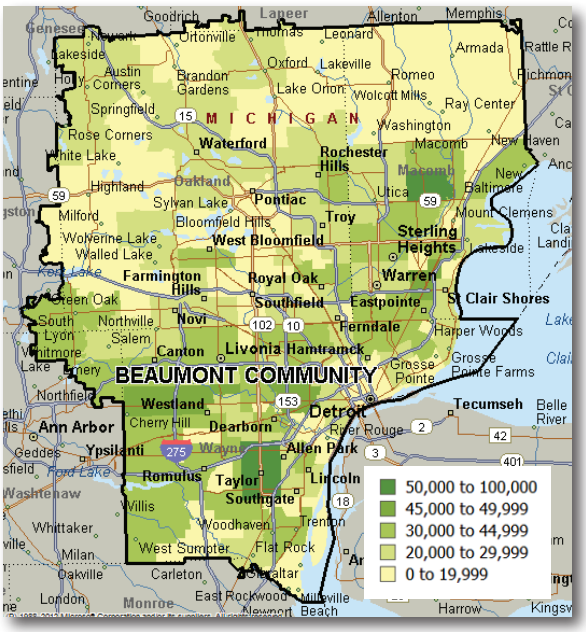
Demographic/ Socio-economic Variable		Benchmarks		Community Served			
		United States	Michigan	Macomb County	Oakland County	Wayne County	Total Beaumont Health Community
Total Current Population		319,459,991	9,907,285	861,726	1,272,430	1,747,955	3,882,111
5 Year Projected Population Change		4%	<1%	2%	3%	-3%	0%
Population 0-17		23%	22%	22%	22%	24%	23%
Population 65+		15%	16%	16%	15%	14%	15%
Woment Age 15-44		20%	19%	19%	19%	20%	19%
Non-White Population		29%	22%	18%	24%	47%	33%
Insurance Coverage	Medicaid	19%	21%	18%	13%	33%	23%
	Uninsured	8%	5%	4%	4%	8%	6%
Median HH Income		$56,682	$47,988	$53,882	$64,511	$39,440	$47,461
Children in Poverty		18%	19%	16%	12%	29%	21%
Limited English		9%	3%	6%	5%	5%	5%
No High School Diploma		13%	10%	11%	6%	15%	11%
Un-employment		7%	8%	7%	6%	13%	9%

Source: Truven Health Analytics, 2016

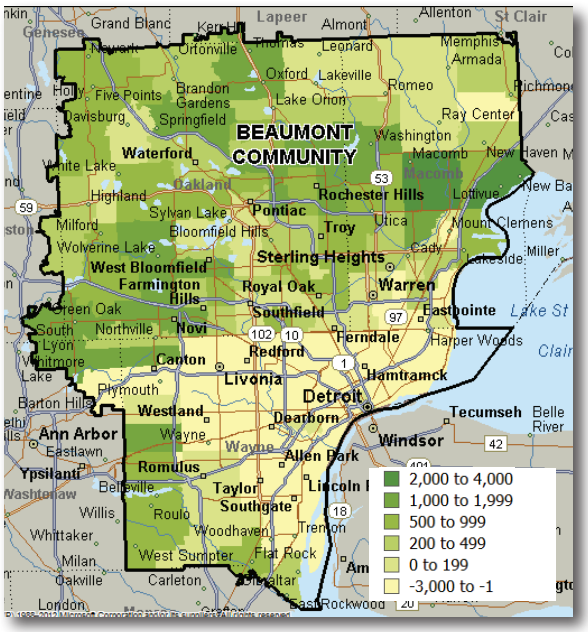
While the total population of most of the Beaumont hospital communities is not projected to grow, the primary markets for Beaumont Hospital, Troy and Beaumont Hospital, Royal Oak are expected to experience a positive population change by 2020. The areas anticipated to grow the most are Macomb ZIP codes 48044 and 48042, and New Baltimore ZIP code 48047. The Dearborn community will experience the greatest contraction in population, primarily from Detroit ZIP codes.

Projected Population Growth

2015 Total Population



5 Year Projected Population Change

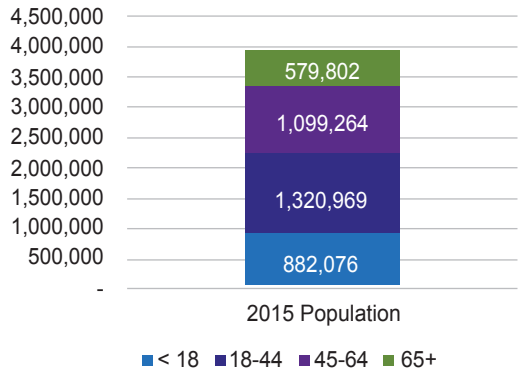


Source: Truven Health Analytics, 2016

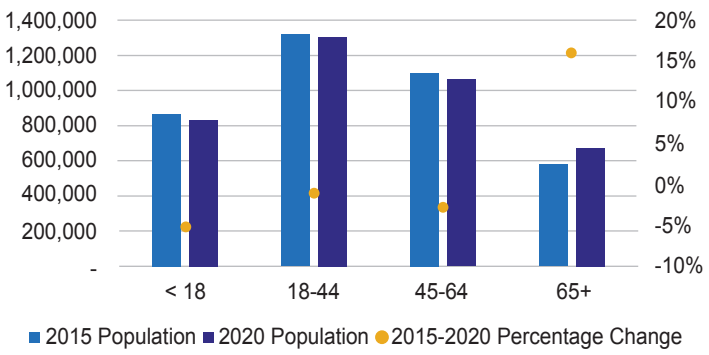
Similar to the U.S. and Michigan population, Beaumont's population is aging rapidly. It is expected that by 2020, the 65+ population will increase by 15 percent. The number of women of child bearing age is expected to decrease by 2 percent in the community; this is more than double the decrease expected in Michigan.

Population Age Cohort

2015 Total Population



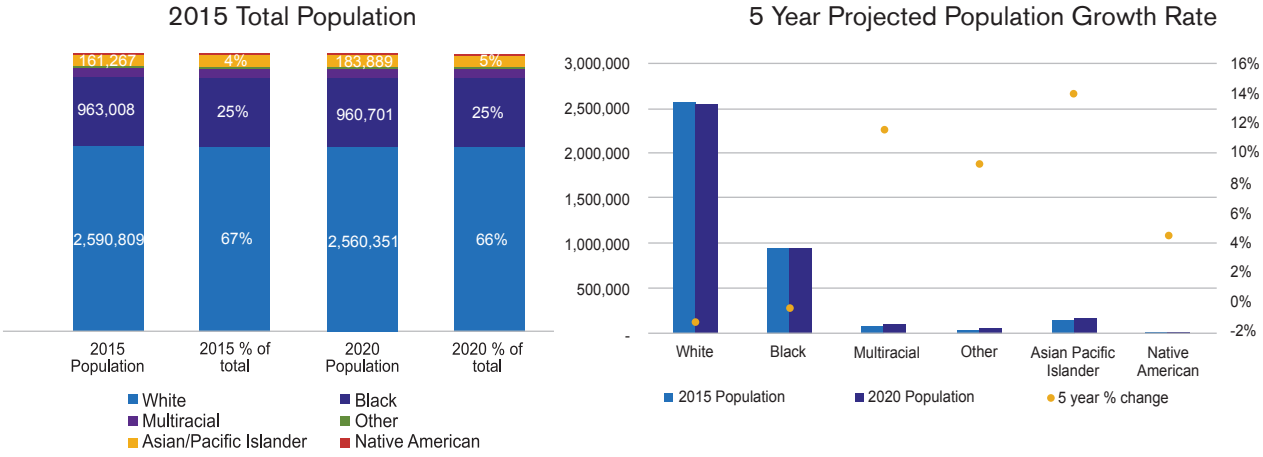
5 Year Projected Population Growth Rate



Source: Truven Health Analytics, 2016

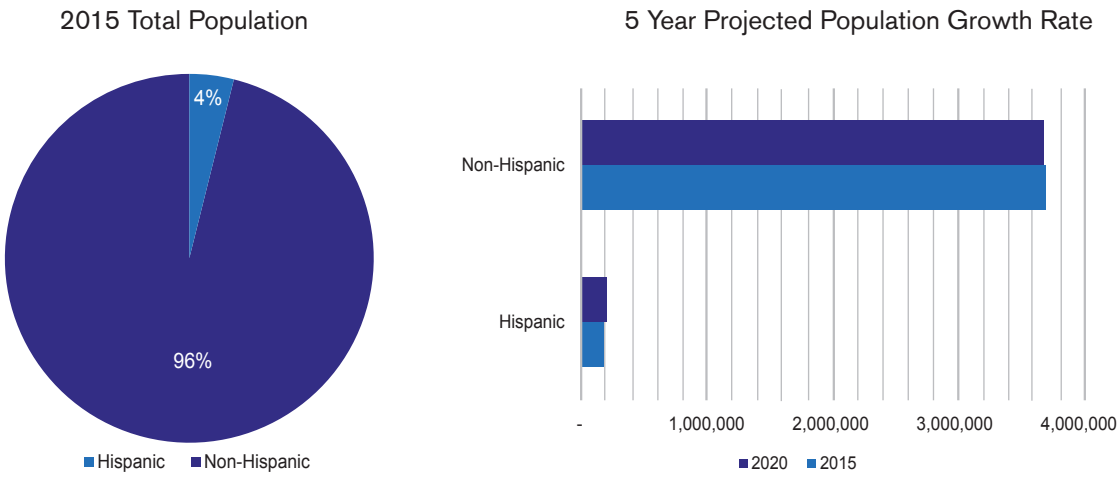
The majority of Beaumont's population is white non-Hispanic; however, the Beaumont community is becoming increasingly diverse. Most minority groups in the community are anticipated to grow by 2020, while the white, black and non-Hispanic population is expected to decrease. The Asian Pacific Islander population will experience the greatest growth, followed by the multiracial population.

Population by Race



Source: Truven Health Analytics, 2016

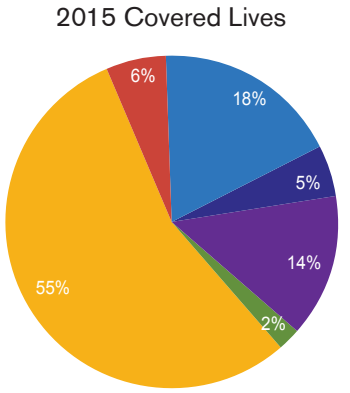
Population by Hispanic Ethnicity

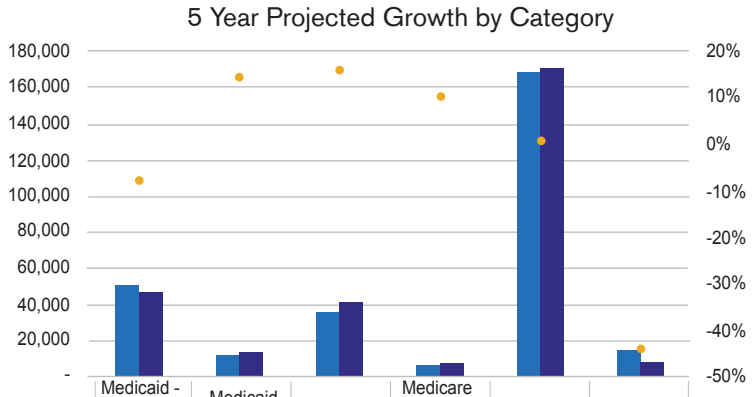


Source: Truven Health Analytics, 2016

The majority of the community is privately insured (55 percent). Twenty-three percent of the community is covered by Medicaid and 14 percent has Medicare coverage. The Medicare population will experience the greatest growth by 2020, with an anticipated increase of 16 percent. Less than 5 percent of the population is uninsured, and the uninsured population is expected to decrease by 44 percent in the next five years.

Estimated Covered Lives by Insurance Category





	Medicaid - Pre Reform	Medicaid Expansion	Medicare	Medicare Dual Eligible	PrivateU	ninsured
2015 Covered Lives	50,672	12,068	35,618	7,220	168,784	15,412
2020 Covered Lives	46,724	13,822	41,333	7,974	170,301	8,655
5 year % change	-8%	15%	16%	10%	1%	-44%

Source: Truven Health Analytics, 2016

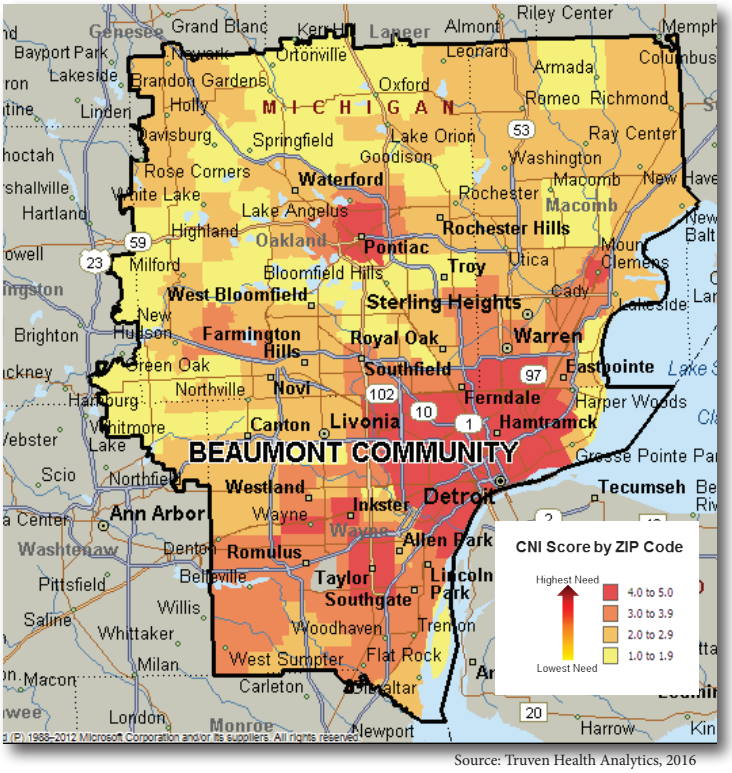
2015 Estimated Uninsured Lives by ZIP Code

Source: Truven Health Analytics, 2016

The uninsured population in the Beaumont community is highest in Detroit and Dearborn ZIP codes 48228 and 48126. Additional areas with high uninsured population include Hamtramck ZIP code 48212 and Detroit ZIP codes 48205, 48219, 48227 and 48224.

The Truven Health Community Need Index (the CNI) is a statistical approach to identifying health needs in a community. The CNI takes into account vital socio-economic factors (income, cultural, education, insurance and housing) about a community to generate a CNI score for every populated ZIP code in the United States. The CNI is measured on a scale of one to five, with five indicating the greatest need. The variables that comprise the CNI score are strongly linked to variations in community health care needs and the score is a good indicator of a community's demand for various health care services. The CNI score by ZIP code identifies specific areas within a community where health care needs may be greater.

2015 Community Need Index by ZIP Code



Source: Truven Health Analytics, 2016

The Beaumont community has an overall CNI score of 3.0, which is comparable to the U.S. median score; the individual hospital communities have CNI scores ranging from 2.4 to 3.7. Specific areas in the overall community that have the highest CNI score of 5.0 include several Detroit ZIP codes, Hamtramck (48212), Highland Park (48203), Pontiac (48342), Ecorse (48229) and River Rouge (48218).

Public health indicators

Public health indicators were collected and analyzed to assess the community's health needs. For each health indicator, a comparison was made between the most recently available community data and benchmarks for the United States and the state of Michigan. A health need was identified when the community indicator did not meet the state's comparative benchmark. The indicators that did not meet the state benchmark for one or more of the Beaumont communities included the following:

Cancer
- discharge rate: cancer (malignant neoplasms)
- cancer diagnosis (all causes)
- breast cancer incidence
- colon cancer incidence
- lung cancer incidence
- overall cancer death rate
- colorectal cancer screening
- breast cancer screening
- prostate cancer screening
- cervical cancer screening

Cardiovascular conditions
- discharge rate: heart disease
- discharge rate: cerebrovascular disease
- hypertension diagnosis
- angina or coronary heart disease diagnosis
- stroke diagnosis
- heart attack diagnosis
- heart disease death rate
- stroke death rate

Prevention
- colorectal cancer screening
- diabetic monitoring
- cancer screenings
- HIV screening
- flu vaccine
- pneumonia vaccine

Diabetes
- diabetes diagnosis
- diabetic monitoring
- diabetes diagnosis Medicare beneficiaries

Health status
- poor or fair health
- poor physical health

Obesity
- adult obesity
- children and adolescents considered obese

Health care access
- no health care coverage
- uninsured adults
- health care costs
- no health care access due to cost
- population to primary care physician ratio
- population to other primary care providers ratio
- population to dentist ratio
- no dental visits in past year
- preventable hospital stays

Healthy lifestyle
- physical inactivity
- low daily fruit/vegetable consumption
- food environment index
- food insecurity
- insufficient sleep

HIV / STIs / teen pregnancy
- HIV prevalence
- sexually transmitted infections
- teen births

Injury and death
- discharge rate: injury and poisoning
- unintentional injury death rate
- premature death
- fatal injuries

Maternal health
- infant mortality
- late or no prenatal care
- births to mothers with no diploma or GED
- Medicaid paid births
- low or very low birth weight
- preterm births

Substance abuse
- drug overdose deaths
- adult smoking
- adults engaging in binge drinking during the past 30 days
- excessive drinking

Mental health
- discharge rate: Psychoses
- population to mental health provider ratio
- poor mental health days
- depression
- suicide rate
- social associations
- lack of social and emotional support

Other conditions
- discharge rate: Septicemia
- discharge rate: Osteoarthrosis and allied disorders
- kidney disease diagnosis
- arthritis diagnosis

Respiratory conditions
- discharge rate: Pneumonia
- chronic obstructive pulmonary disease (COPD) diagnosis
- currently have asthma
- chronic lower respiratory disease (CLRD) death rate
- daily air pollution

Social determinants
- high school graduation
- high school dropouts
- some college
- median household income
- students eligible for free or reduced priced lunch
- residential segregation
- births to unmarried women
- children in poverty
- children in single-parent households
- individuals living below poverty level
- individuals who report being disabled
- unemployment
- violent crime rate
- homicide
- severe housing problems

The community includes 61 Health Professional Shortage Areas and 23 Medically Underserved Areas, as designated by the U.S. Department of Health and Human Services Health Resources and Services Administration.[1] This flags areas that are potentially underserved. **Appendix F** includes the details on each of these designations.

Health Professional Shortage Areas and Medically Underserved Areas and Populations

	Health Professional Shortage Areas (HPSA)				Medically Underserved Area/Population (MUA/P)
COUNTY	Dental Health	Mental Health	Primary Care	TOTAL HPSA	MUA/P
Macomb County	2	1	2	5	2
Oakland County	2	2	2	6	1
Wayne County	16	17	17	50	20
TOTAL	**20**	**20**	**21**	**61**	**23**

Source: Health Resources and Services Administration, 2016

Community input: Focus groups and key informant interviews

Beaumont engaged Truven Health to conduct a series of community focus groups and key stakeholder interviews in order to complete a qualitative assessment of overall health in the community. These sessions were conducted between March and April of 2016. Many of the participants work with at-risk, medically underserved, low-income, minority and chronic disease populations. In addition, participation was solicited from state, local or regional governmental public health representatives with knowledge, information or expertise relevant to the health needs of the communities served by Beaumont. Each focus group represented an individual hospital community and included 71 participants in total. Thirty-seven community representatives with specialized knowledge in community health or experience working with underrepresented populations in the community were also interviewed as key informants.

The focus groups were facilitated by a Truven Health representative and included both large and small group discussions. The sessions were oriented around the following topics:

- assess the health status of the community
- identify the top health needs of the community
- discuss the similarities/differences between the needs identified in the prior exercise and the needs identified in prior assessments
- identify community resources (health/community organizations) that exist to address the top health needs identified

Truven Health also conducted key informant interviews designed to help understand and gain insight into how participants feel about the general health status of the community and the various drivers contributing to health issues.

The qualitative data collected during the community focus groups and key informant interviews provided important insights into the perception of health in the Beaumont community. The participants shared health needs specific to each hospital community, but there were themes that repeatedly surfaced across the eight hospital communities. Eight themes were consistently reported and applicable to the Beaumont system as a whole. The key themes common across the Beaumont community include (in alphabetical order):

[1] *U.S. Department of Health and Human Services, Health Resources and Services Administration, 2016*

- availability of specialty providers
- care coordination
- chronic conditions (cardiovascular, diabetes and respiratory)
- health care access
- health education and literacy
- mental and behavioral health
- obesity
- prevention

Collectively, the themes represent the community's perspectives on the overall health of residents living in Beaumont's service area. Many of these themes were validated by the secondary data in the quantitative assessment. Participants discussed three themes that were not substantiated by secondary data sources: Community access to specialty providers, care coordination and health education. The themes were identified during discussions, but did not have a corresponding data point available for measurement. It is important to note that while these themes are consistent across the Beaumont community, the individual hospital communities have unique populations, contributing factors, and impact on the local community. Focus groups and key informants also identified themes specific to each individual hospital community, which are not necessarily issues for other Beaumont hospitals. The key findings for each Beaumont facility are included in the individual hospital sections in the latter part of this report.

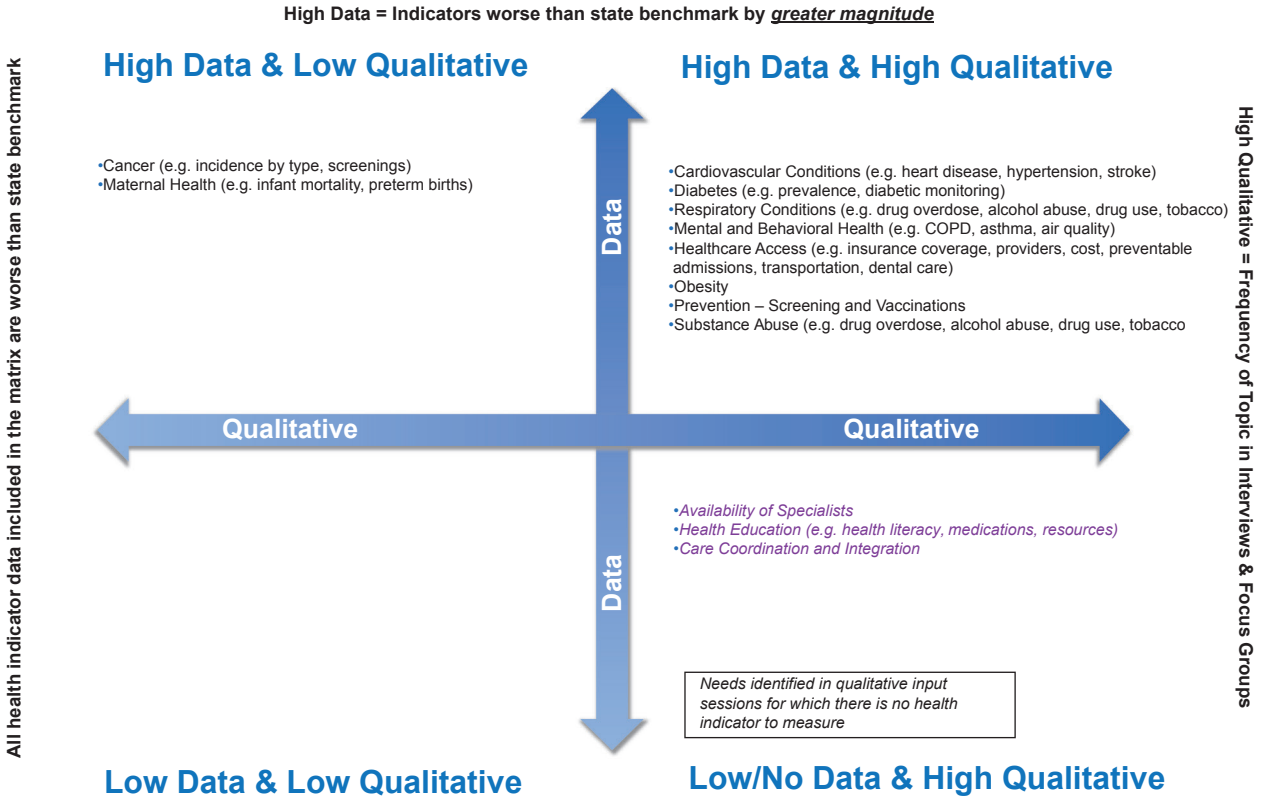
The interview and focus group participants and the populations they serve for each community are documented in **Appendix G**.

Health needs matrix

Quantitative and qualitative data were analyzed and displayed as a health needs matrix to help identify the most significant community health needs for the Beaumont community. During the assessment, specific needs were marked when an indicator for a community did not meet the corresponding state benchmark. Then, an index of magnitude analysis was conducted to determine the degree of difference from the benchmark to show relative severity. The results of this quantitative analysis were combined with the qualitative findings from the community input sessions to bring forth a list of health needs for each of the Beaumont hospital communities. These health needs were then classified into one of four quadrants within the health needs matrix: High data, low qualitative; low data, low qualitative; low data, high qualitative; or high data, high qualitative.

The results were then aggregated across the communities in order to identify the predominant health needs for the overall Beaumont community. The following pages show the resulting matrix for the Beaumont community served. Needs appeared on the overall matrix if they were common across the eight Beaumont hospital communities. Additionally, needs are placed in the high data quadrants if any of the communities demonstrated an indicator value that differed from the benchmark by a greater magnitude.

Beaumont Health Community Health Needs Matrix



Source: Truven Health Analytics, 2016

Note: Needs in the lower right quadrant of the matrix which are highlighted in purple text are those identified in the qualitative input for which there is not a corresponding quantitative measure

Prioritizing community health needs

In order to identify and prioritize the significant needs of each of the communities, Beaumont used a comprehensive method of taking into account all available relevant data, including community input.

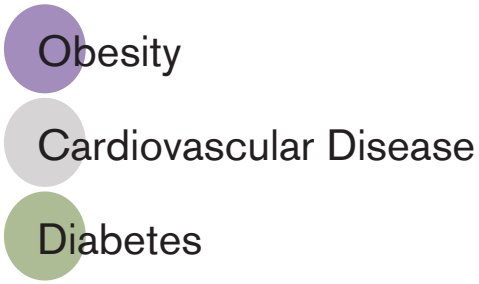
In January 2016, the CHNA Steering Committee identified five criteria for prioritizing health needs identified through the assessment: Importance, alignment, resources, magnitude and vulnerable populations. Importance of the problem to the community ensures the priorities chosen reflect the community experience. Alignment with the health system's strengths is important to ensure we leverage our ability to make an impact. The criteria of resources acknowledges that we need to work within the capacity of our organization's budget, partnerships, infrastructure, and ability to access a limited pool of funding. To be sure we reach the most people, the criteria of magnitude considers the number of people the problem affects either actually or potentially. Lastly, in order to address the health disparities that exist, we consider the impact of the problem on vulnerable populations. Members of the CHNA Steering Committee can be found in **Appendix A**.

On June 9, 2016, a prioritization session was held with representatives from across Beaumont, moderated by Truven Health. The goal was to review the assessment

findings for the community, establish the significant health needs, and then to prioritize those needs using the prioritization criteria established by the steering committee. A summary of demographics, health data findings and health needs matrix were reviewed during this session. This overview also included an explanation of the quadrants of the health needs matrix. Prioritization session participants can be found in **Appendix H.**

After a robust discussion, the participants agreed that the needs in the upper right quadrant of the matrix (those identified as high data/high qualitative) were significant. Session participants broke out into four sub-groups. In the sub-groups, the Beaumont community's significant health needs were individually rated on each of the five previously identified criteria utilizing a scale of one (low) to 10 (high). The scores by each sub-group were summed for each need, creating an overall score. The scores by need were then averaged across all four sub-groups to create an overall score for each need. The list of significant health needs was than prioritized based on the overall scores.

The session participants subsequently reviewed the prioritized health needs for the community and made a recommendation as to which of the prioritized significant health needs Beaumont should address. The recommendation was based on the three needs with the highest overall score. The resulting community health needs to be addressed by Beaumont Health include:



Description of the health needs to be addressed by Beaumont

Obesity

Obesity is a complex medical condition that can have a significant impact on physical and emotional well-being. Individuals are considered obese when their weight exceeds the range accepted as medically healthy, measured by having a Body Mass Index (BMI) of 30 or higher. Obesity is linked to increased rates of other chronic conditions, including Type II diabetes, high blood pressure, hyperlipidemia, stroke, coronary heart disease and cancer. Obesity is associated with the county's leading causes of preventable death.[2] Obesity is a health concern because of its association with poor health outcomes and reduction in the quality of life.

Recent trends in the prevalence of obesity in America is equally concerning. According to the National Institutes of Health, obesity rates in the United States have more than doubled over the last 50 years.[3] In 2014, more than one-third (34.9 percent or 78.6 million) of U.S. adults were considered obese.[4] Obesity is a problem in Michigan; the state spends almost $3 billion annually in medical costs associated with obesity.[5] The percentage of adults that report a BMI of 30 or more in the State of Michigan (31 percent) is slightly lower than national rates (35 percent).[6] Rates in Southeast Michigan are mixed. Wayne and Macomb counties report higher rates of obese adults, at 34 percent and 33 percent, respectively.[7] Oakland County reports adult obesity rates below state rates at 26 percent.[8] Southeast Michigan reports higher rates of children with obesity. Childhood obesity is defined as a BMI at or above the 120 percent of the 95th percentile for children of the same age and sex.[9] The Centers for Disease Control and Prevention (CDC) reports childhood obesity rates at 13 percent nationally and 14 percent for the State of Michigan. Southeast Michigan's childhood obesity rates are significantly higher than state and national rates.

[2] *http://www.cdc.gov/obesity/data/adult.html*
[3] *http://www.heart.org/HEARTORG/HealthyLiving/WeightManagement/Obesity/Understanding-the-American-Obesity-Epidemic_UCM_461650_Article.jsp#.V4WLDk3fMkI*
[4] *http://www.cdc.gov/obesity/data/adult.html*
[5] *http://www.michigan.gov/documents/healthymichigan/Making_a_Difference_in_Obesity_Priority_Strategies_2014_-_2018_BE_ACTIVE_EAT_HEALTHY_Publish_4_21_14_454433_7.pdf*
[6] *http://www.michigan.gov/mdhhs/0,5885,7-339-71550_5104_5279_39424---,00.html*
[7] *http://www.countyhealthrankings.org/*
[8] *http://www.countyhealthrankings.org/*
[9] *http://www.countyhealthrankings.org/dhood.html*

Detroit City reports childhood obesity rates at 23 percent (county level information is not reported).[10]

Experts attribute increases in obesity to lower levels of physical activity and poor choices related to food and nutrition. Behavioral statistics on physical activity are consistent with Michigan's obesity rates. The percentage of adults reporting no leisure-time physical activity in Michigan is 24 percent compared to national rates of 23 percent.[11] Wayne County reports the areas highest rates of adults with limited physical activity (26 percent) and the highest rates of adult obesity (34 percent). Macomb County reports rates of adults with limited physical activity at the state rate of 24 percent. Oakland County reports the lowest rates of limited physical activity (20 percent) and the lowest rates of obese adults (26 percent).[12]

Statistics related to access to healthy food options and the ability to make sound nutrition decisions are mixed in Southeast Michigan. Fifteen percent of Americans report that they lack adequate access to food.[13] The percent of people who lack access to food in Michigan is slightly higher at 16 percent. Oakland and Macomb counties have rates of Americans without adequate access to food at 14 percent. Wayne County reports 21 percent of the population as having inadequate access to food. Another measure of community food security in the United States is the percent of low-income residents living in close proximity to grocery stores. Nationally, 57 percent of low-income Americans report not living near a grocery store. The State of Michigan reports dramatically lower rates, with only 6 percent of low-income Americans reporting limited access to grocery stores. Rates of low-income residents with limited access to grocery stores in Southeast Michigan are even lower; Wayne and Oakland counties report rates at 4 percent, Macomb County reports rates at 5 percent.[14]

Focus group participants discussed obesity as a top health concern for communities in the Beaumont service area. Representatives felt that there was a need to increase community education initiatives to provide residents with a better understanding of obesity and its impact on overall health. Education around nutrition and healthy food choices were also identified as an opportunity for improving the health of Southeast Michigan residents.

Cardiovascular disease

Heart disease is the leading cause of death in America.[15] Cardiovascular disease is a category of diseases and conditions that include coronary artery disease, high blood pressure, cardiac arrest, congestive heart failure, arrhythmia, peripheral artery disease, stroke and congenital heart disease. More than 27.6 million Americans are diagnosed with cardiovascular disease. The community input for Beaumont's service area identified cardiovascular disease as a community priority because it has a major impact on overall health, and is preventable in many cases.

The percent of adults who reported ever being told by a doctor that they had angina or coronary heart disease in the Beaumont service area is similar to the rate reported at state (5 percent) and national levels (4 percent).[16] Six percent of adults in Macomb County report having been diagnosed with angina or coronary heart disease. Oakland County reports the rate of adults diagnosed with angina or coronary heart disease at 5 percent. Wayne County reports rates separately for the city of Detroit and Wayne County (excluding Detroit). Wayne County (excluding Detroit) reports 4 percent of adults are diagnosed with angina of coronary heart disease, with rates in Detroit slightly higher at 5 percent.[17] Southeast Michigan's rate of heart disease diagnosis is relatively consistent with state and national rates, but the area's death rate due to heart disease is much higher. In 2013, heart disease deaths for the State of Michigan were 199.9 per 100,000 (national death rates were reported at 169.8 per 100,000).[18] Deaths attributed to

[10] *http://www.cdc.gov/healthyyouth/data/yrbs/index.htm*
[11] *http://www.countyhealthrankings.org/*
[12] *http://www.countyhealthrankings.org/*
[13] *Percentage of population who are low-income and do not live close to a grocery store*
[14] *http://www.countyhealthrankings.org/*
[15] *http://www.cdc.gov/heartdisease/facts.htm*
[16] *http://www.michigan.gov/mdhhs/0,5885,7-339-71550_5104_5279_39424---,00.html*
[17] *http://www.michigan.gov/mdhhs/0,5885,7-339-71550_5104_5279_39424---,00.html*
[18] *http://www.healthindicators.gov/*

heart disease were significantly higher for communities in the Beaumont service area. Wayne County reports rates at 293.4 per 100,000, Oakland County reports rates at 210.6 per 100,000 and Macomb County reports rates at 269.2 per 100,000.[19] The counties death rates due to heart disease are between 5 percent and 47 percent higher that statewide rates.

Focus group participants discussed the need for prevention and education initiatives aimed at improving the impact of heart disease on the community. These programs should coordinate with other related initiatives (addressing obesity in the community) to increase overall effectiveness.

Diabetes

Diabetes is the seventh leading cause of death in the United States.[20] In 2014, more that 29.1 million people were living with diabetes in the United States — that's 1 out of 11 people.[21] The disease is diagnosed when blood glucose levels are above normal and the body cannot make enough insulin, causing sugar to build up in your blood. The disease is associated with blindness, kidney failure, stroke, and the loss of toes, feet and legs.[22] Communities with high populations of diabetic and pre-diabetic residents must address the gaps in care effectively and efficiently, because the disease poses a significant burden on overall health.

In 2013, the percentage of Medicare fee-for-service beneficiaries with diabetes was 27 percent. The State of Michigan reports rates at 30 percent. Southeastern Michigan reports higher rates of Medicare fee-for-service beneficiaries with diabetes; Oakland County reports rates at 31 percent, Macomb County reports rates at 33 percent, and Wayne County reports rates at 37 percent.[23]

Focus group participants believe that the overall health of diabetic residents can be improved with increased community education initiatives. Programs should focus on how to effectively manage diabetes, prevention education, and overall health and nutrition education.

CHNA implementation strategy

In addition to identifying and prioritizing significant community health needs through the CHNA process, PPACA requires creating and adopting an implementation strategy. An implementation strategy is a written plan addressing each of the community health needs identified through the CHNA. The implementation strategy must also include a list of the prioritized needs the hospital plans to address and the rationale for not addressing the other identified health needs.

The implementation strategy is considered implemented on the date it is adopted by the hospital's governing body. The CHNA implementation strategy is filed along with the organization's IRS Form 990, Schedule H and must be updated annually. A summary of Beaumont's implementation strategy for the significant community health needs they have chosen to address can be found at beaumont.org/chna.

Summary

Beaumont conducted a CHNA beginning January 2016 to identify the health needs of the community it serves. Using both qualitative community feedback as well as publically available and proprietary health data, Beaumont was able to identify and prioritize community health needs for the community served by its hospital facilities. With the goal of improving the health of the community, implementation plans with specific tactics and time frames have been developed for the health needs Beaumont has chosen to address for the community it serves. Beaumont's community health priorities will be addressed through strategies and activities described in the implementation strategy. Beaumont's leaders will participate in developing work plans and establishing metrics to measure progress. Beaumont will build on existing community programs and partnerships to address the health needs identified through the CHNA process.

[19] *http://www.healthindicators.gov/*
[20] *ttp://www.cdc.gov/diabetes/library/socialmedia/infographics.html*
[21] *http://www.cdc.gov/diabetes/library/socialmedia/infographics.html*
[22] *http://www.cdc.gov/diabetes/library/socialmedia/infographics.html*
[23] *http://www.healthindicators.gov/*

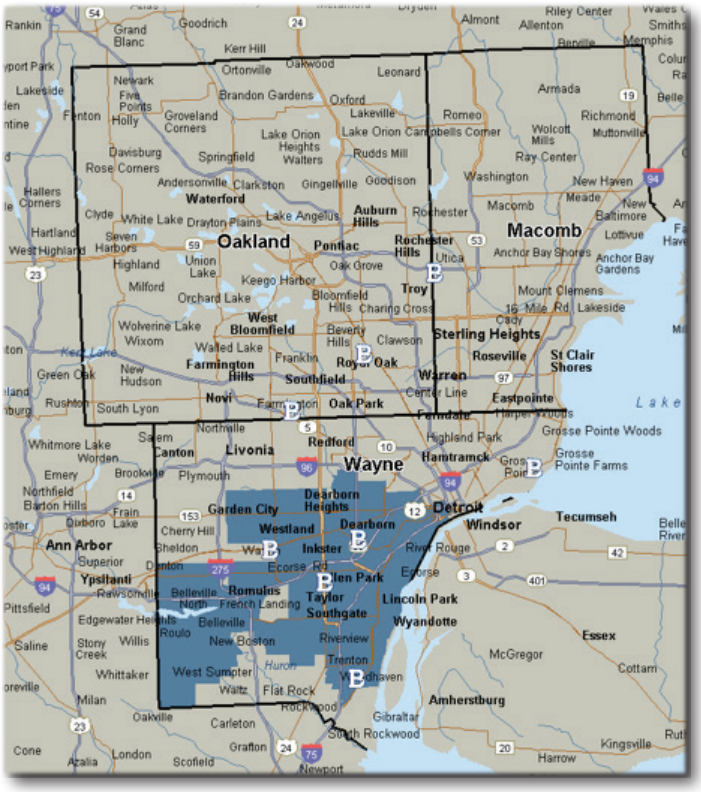
The overall Beaumont community is the aggregate of individual hospital communities. It is important to note that individual hospital communities overlap. The Beaumont hospitals are located in, and each serve, some portion of Macomb, Oakland and Wayne counties. Beaumont approached the CHNA process as a collaborative effort between their hospitals but have also included information specific to each hospital community where the data collection was able to provide hospital community specific information. The health needs that Beaumont has chosen to address are common across all eight hospital communities, but understanding localized data is key to creating and customizing the CHNA implementation strategies to the unique characteristics of the diverse communities served by Beaumont.

BEAUMONT HOSPITAL, DEARBORN

Beaumont Hospital, Dearborn (formerly Oakwood Hospital - Dearborn) has proudly served residents across southeastern Michigan since 1953. It became part of Beaumont Health in September 2014. With 632 beds, Beaumont Hospital, Dearborn is a major teaching and research hospital and home to three medical residency programs in partnership with the Wayne State University School of Medicine. Beaumont, Dearborn is verified as a Level II trauma center and has been recognized for clinical excellence and innovation in the fields of orthopedics, neurosciences (Stroke Center of Excellence), women's health, heart and vascular care, and cancer care.

Community served

The Beaumont Hospital, Dearborn community (Beaumont, Dearborn) is defined as the contiguous ZIP codes that comprise 80 percent of inpatient discharges. To the right is a map that highlights the community served (in blue) as a portion of the overall Beaumont community. A table which lists the ZIP codes included in the community definition can be found in **Appendix B.**

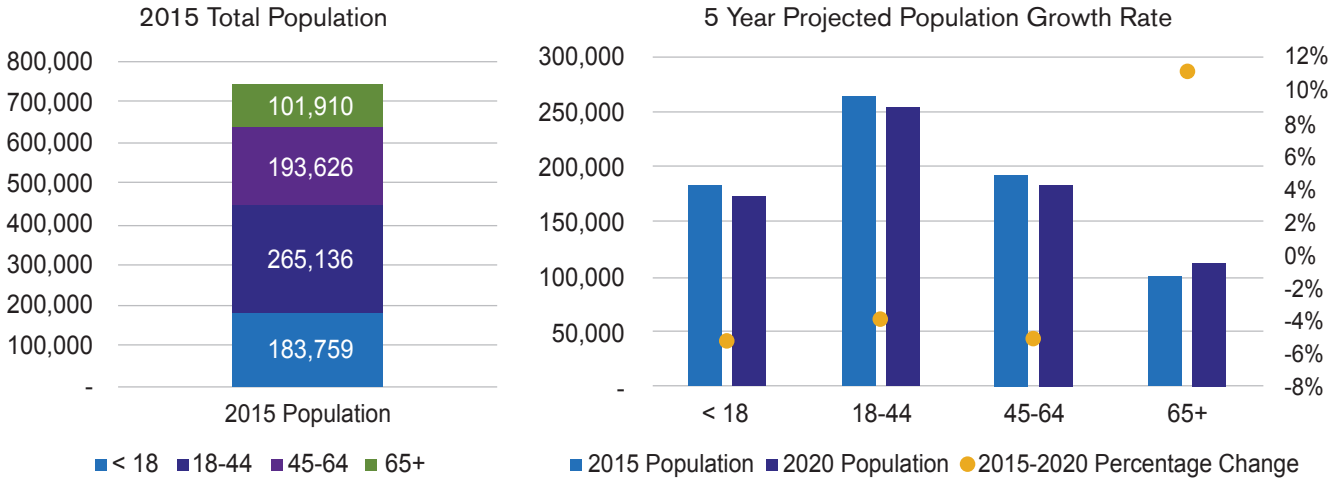


Source: Beaumont Health, 2016

Demographic and socio-economic summary

The population for Beaumont, Dearborn is expected to decrease by 2 percent (17,955 lives) over the next five years. The decrease will primarily impact ZIP codes around Detroit. The age composition of Dearborn is representative of that in the state of Michigan and the country as a whole. The cohort aged 65 years and older makes up the smallest segment of the population (only 14 percent), however, it is expected to experience the most growth over the next five years. This age group is expected to increase 11 percent (11,389 lives) while the other age groups are expected to decrease 4 to 5 percent. Due to the community's aging population, need for health care services in the community will likely increase in the upcoming years.

Population by Age Cohort

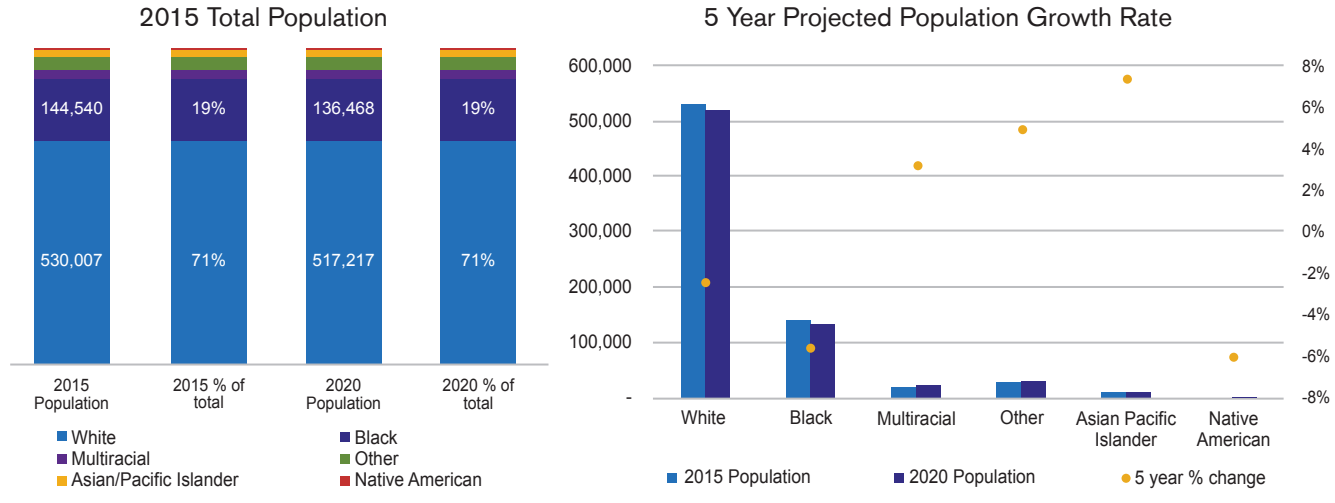


Source: Truven Health Analytics, 2016

The community is primarily white (71 percent) and black (19 percent). Despite its apparent lack of diversity from a racial perspective, the city of Dearborn, has the highest proportion of Arab Americans in the country. [24] Persons of Arab ancestry make up 8.5 percent of the Beaumont, Dearborn community population, or 61,572 lives. The Arab population is most highly concentrated in Dearborn (ZIP codes 48126 and 48120) and Dearborn Heights (ZIP code 48127), with more than 76 percent of the Arab population residing in these three ZIP codes.

The community is expected to become increasingly diverse over the next five years. The white population is expected to decrease by 2 percent (12,790 lives), and the black population will decrease by 6 percent (8,072 lives). The Asian/Pacific Islander population will experience the largest increase (7 percent), while the other and multiracial communities will increase by 5 percent and 3 percent respectively. The graphs below display the community's population breakdown by race and the projected five-year change in racial composition.

Population by Race

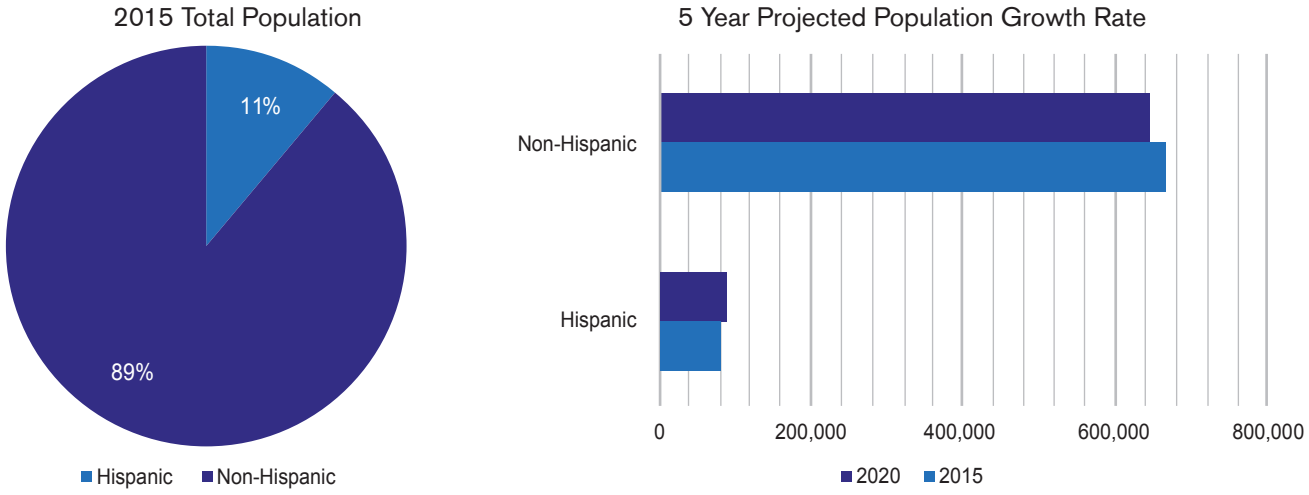


Source: Truven Health Analytics, 2016

[24] *U.S. Census Bureau, 2010*

The community is largely non-Hispanic (89 percent), but has a proportionately larger Hispanic population than Michigan. Hispanics currently comprise 11 percent of the Beaumont, Dearborn population and are expected to grow by 5 percent (4,271 lives) over the next five years.

Population by Hispanic Ethnicity



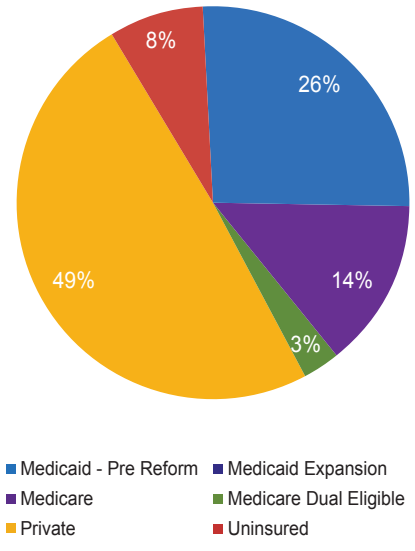
Source: Truven Health Analytics, 2016

The majority of the Beaumont, Dearborn community population is privately insured. Forty-six percent of Dearborn has private insurance; this includes people who are purchasing health insurance through the insurance exchange marketplace (5 percent), those who are buying directly from an insurance provider (3 percent), and those who receive insurance through an employer (38 percent). Approximately one third of the population has Medicaid (31 percent), 13 percent has Medicare, and 6 percent are Medicare and Medicaid dual eligible.

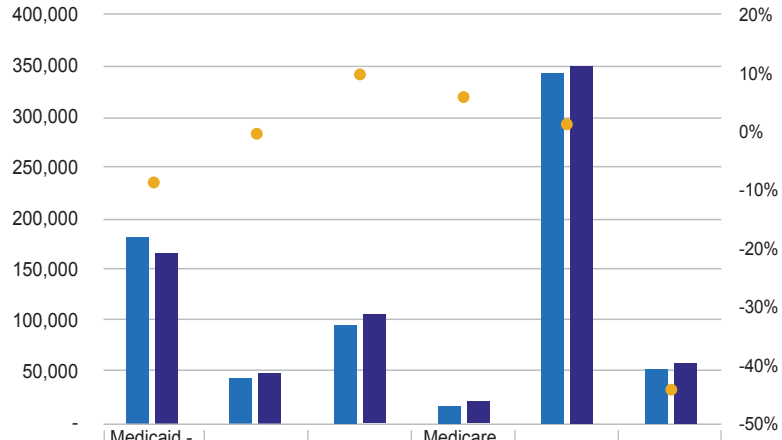
The Medicare population will experience the greatest growth and is expected to increase 10 percent by 2020. This is primarily fueled by a growing 65 and older population in the community. The private insurance category is projected to increase at a slower rate. The number of people purchasing insurance via PPACA health insurance exchanges is projected to increase by 82 percent, driving most of the growth. Overall, the Medicaid population will decrease by 4 percent; however, the number of people receiving Medicaid coverage due to the PPACA Medicaid expansion will increase by 12 percent. This change is projected to impact the uninsured population as well. In this community currently, 7 percent of the population is uninsured; however, the proportion of the population that is uninsured is expected to decrease dramatically over the next five years (-44 percent).

Estimated Covered Lives by Insurance Category

2015 Total Population



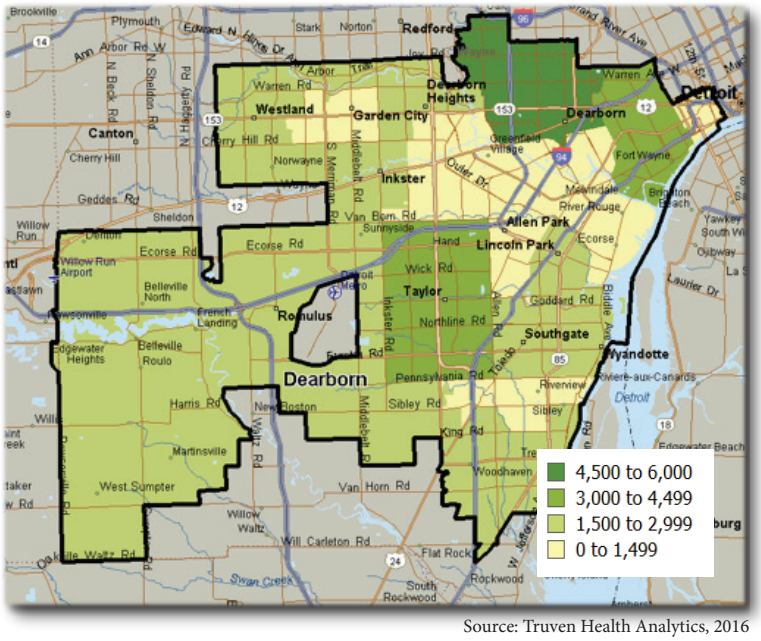
5 Year Projected Population Growth Rate



	Medicaid - Pre Reform	Medicaid Expansion	Medicare	Medicare Dual Eligible	Private	Uninsured
2015 Covered Lives	183,533	45,593	97,638	19,423	343,699	54,546
2020 Covered Lives	167,903	51,193	107,441	20,631	348,773	30,534
5 year % change	-9%		10%	6%	1%	-44%

Source: Truven Health Analytics, 2016

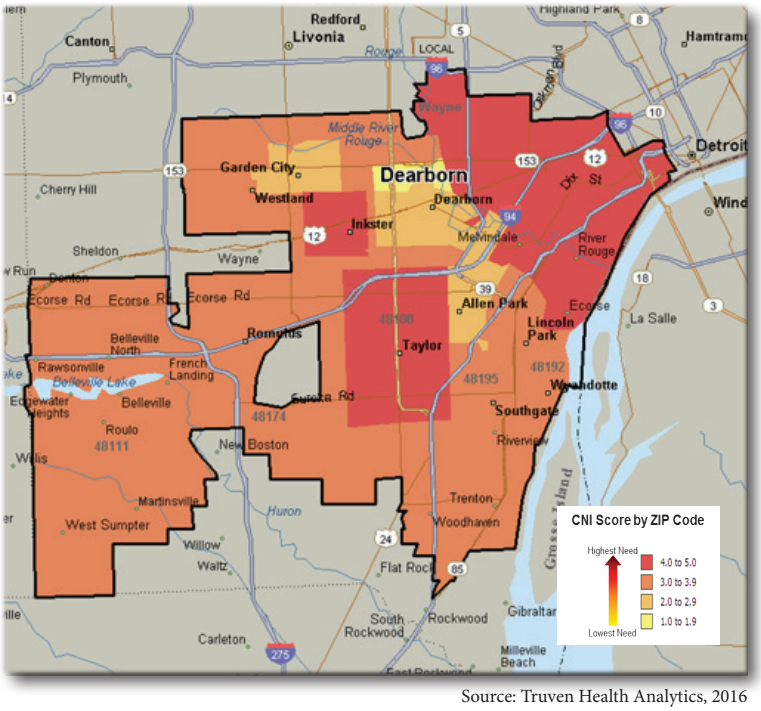
2015 Estimated Uninsured Lives by ZIP Code



Source: Truven Health Analytics, 2016

The following ZIP codes comprise the largest number of individuals that are uninsured: 48228 (Detroit) and 48126 (Dearborn).

2015 Community Need Index by ZIP Code



Source: Truven Health Analytics, 2016

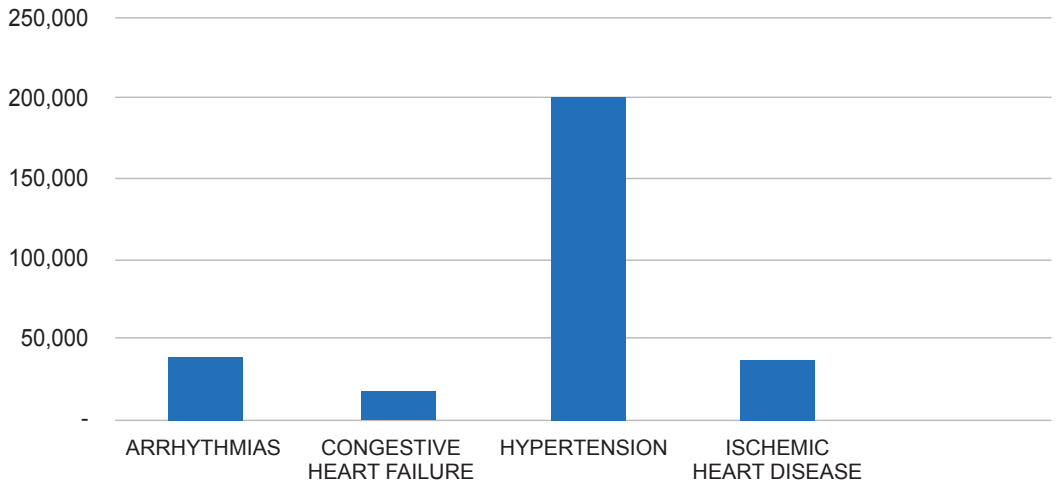
The Beaumont community has an overall CNI score of 3.0. The Beaumont, Dearborn community's CNI is 3.7, the highest CNI score of the eight hospital communities. The areas with the highest anticipated need include River Rouge, Ecorse, Taylor, Inkster, and southwest Detroit.

Truven Health community data

Truven Health Analytics supplemented the publically available data with estimates of localized disease prevalence of heart disease and cancer as well as emergency department visit estimates.

Truven Health's heart disease estimates identified hypertension as the most prevalent heart disease diagnosis in the Beaumont, Dearborn community; arrhythmias and ischemic heart disease are the next highest volumes.

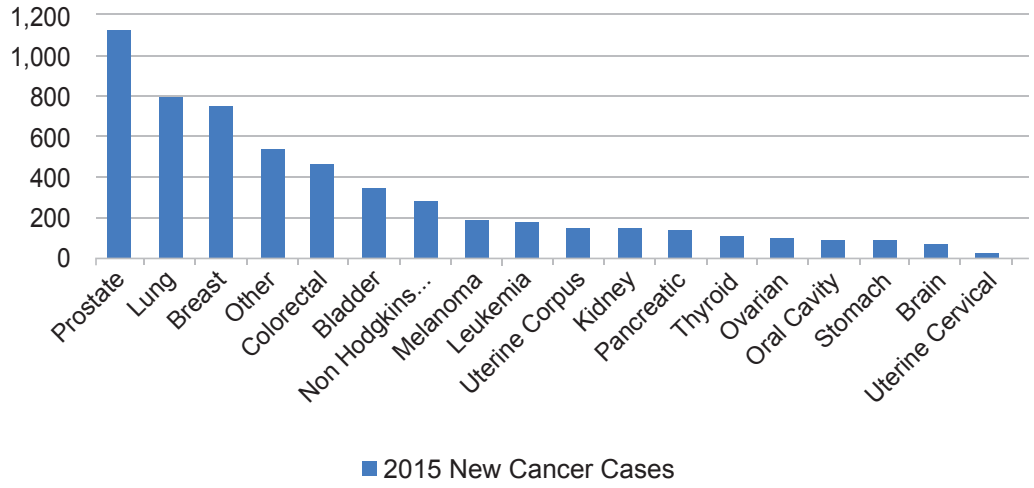
2015 Estimated Heart Disease Cases



Source: Truven Health Analytics, 2016

Compared to state and national estimates, the community has a higher proportion of new breast and colorectal cancer cases. These two, followed by lung cancer, make up the three most frequently diagnosed cancers in the community estimated to occur during 2015.

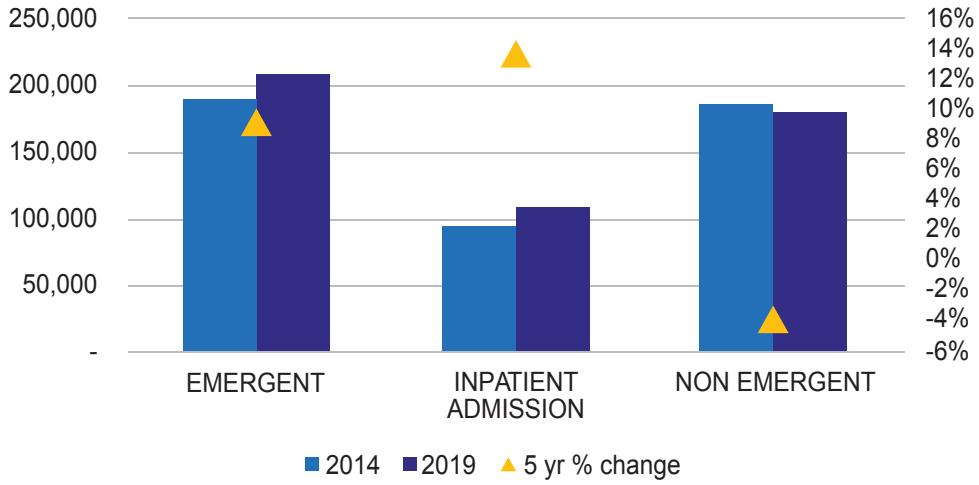
2015 Estimated New Cancer Cases



Source: Truven Health Analytics, 2016

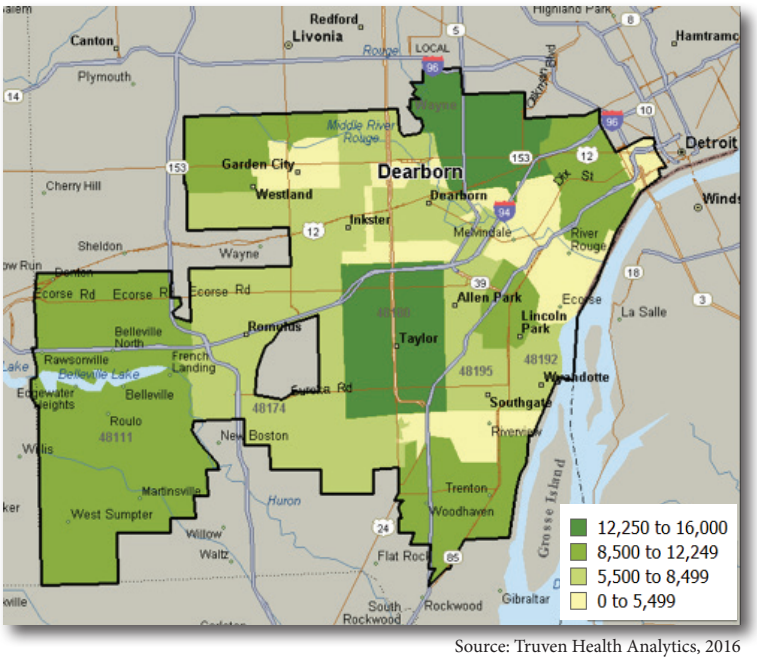
Emergent emergency department (ED) visits are expected to increase 8 percent by 2019, while non-emergent ED visits are projected to decrease by 5 percent (6,780 ED visits). Non-emergent ED visits are lower acuity visits that present in the ED but possibly can be treated in other more appropriate, less intensive outpatient settings. Non-emergent ED visits can be an indication that there are systematic issues with access to primary care or managing chronic conditions. Detroit (ZIP code 48228) has the highest number of non-emergent ED visits and accounts for approximately 9 percent of the total non-emergent ED visits in the Dearborn area.

Emergent and Non-Emergent ED Visits



Source: Truven Health Analytics, 2016

2014 Estimated Non-Emergent Visits by ZIP Code



Source: Truven Health Analytics, 2016

Community input

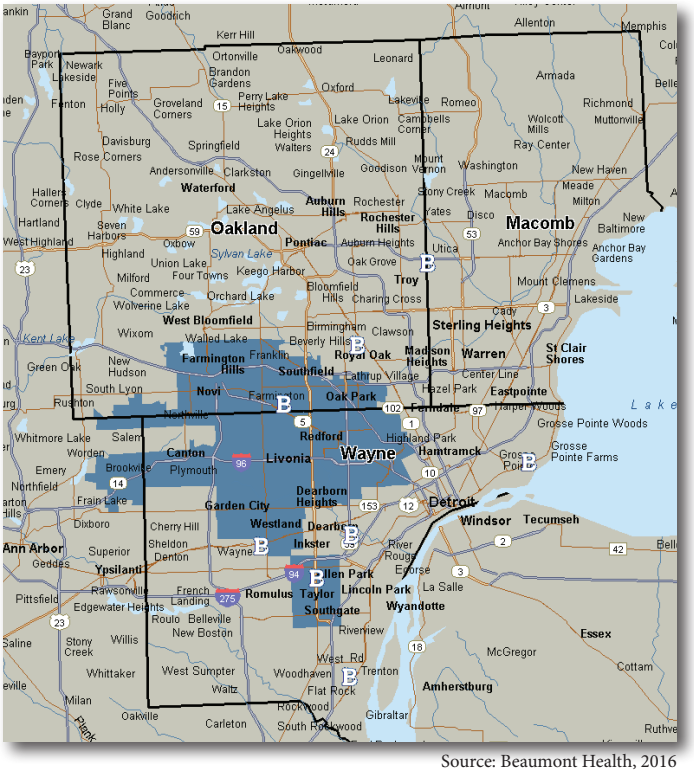
A summary of the focus group conducted for the Beaumont, Dearborn community can be found in **Appendix I**.

BEAUMONT HOSPITAL, FARMINGTON HILLS

Beaumont Hospital, Farmington Hills (formerly Botsford Hospital) opened on Jan. 19, 1965 as a 200-bed community hospital named Botsford General Hospital. Today, the hospital is a 330-bed facility with Level II trauma status. It is a major osteopathic teaching facility with 20 accredited residency and fellowship programs with 180 residents and fellows. Beaumont Hospital, Farmington Hills is the base teaching hospital for Michigan State University College of Osteopathic Medicine and for Arizona College of Osteopathic Medicine.

Community served

The Beaumont Hospital, Farmington Hills community (Beaumont, Farmington Hills) is defined as the contiguous ZIP codes that comprise 80 percent of inpatient discharges. To the right is a map that highlights the community definition (in blue) as a portion of the overall Beaumont community. A table which lists the ZIP codes included in the community definition can be found in **Appendix B**

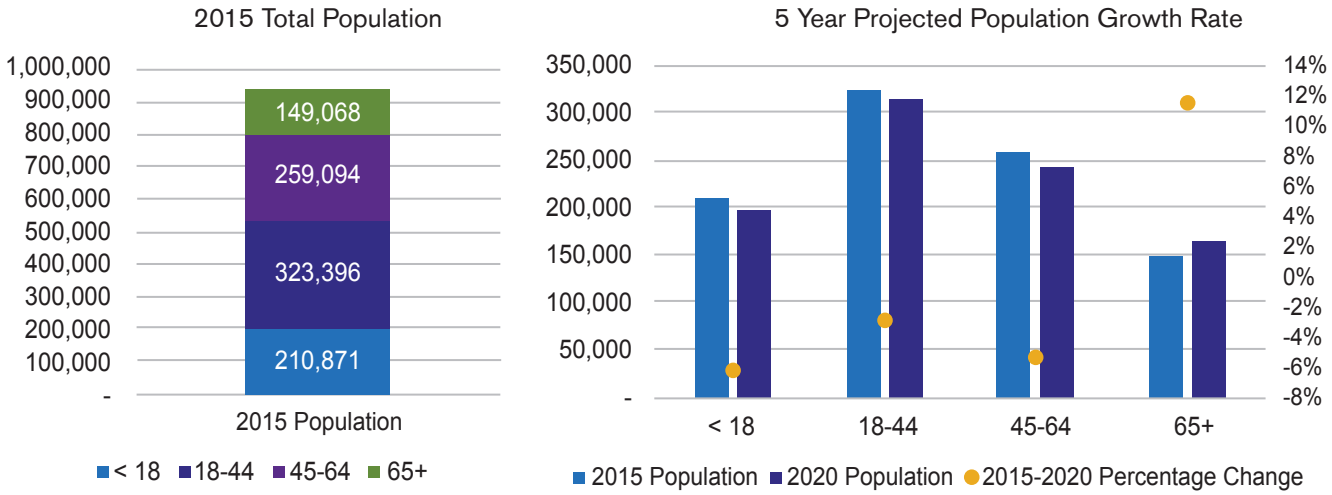


Source: Beaumont Health, 2016

Demographic and socio-economic summary

Beaumont, Farmington Hills' population is expected to decrease 2 percent (18,000 lives) by 2020. The portion of the community that includes the city of Detroit will experience the greatest contraction, while Novi will grow slightly. The age composition of the community is similar to the state of Michigan and the country. The cohort aged 65+ makes up the smallest segment of the population (16 percent), but is expected to experience the most growth over the next five years. This age group is expected to increase approximately 12 percent while the other age groups are expected to decrease 4 to 6 percent. As the community ages, it is likely that need for health care services will also increase.

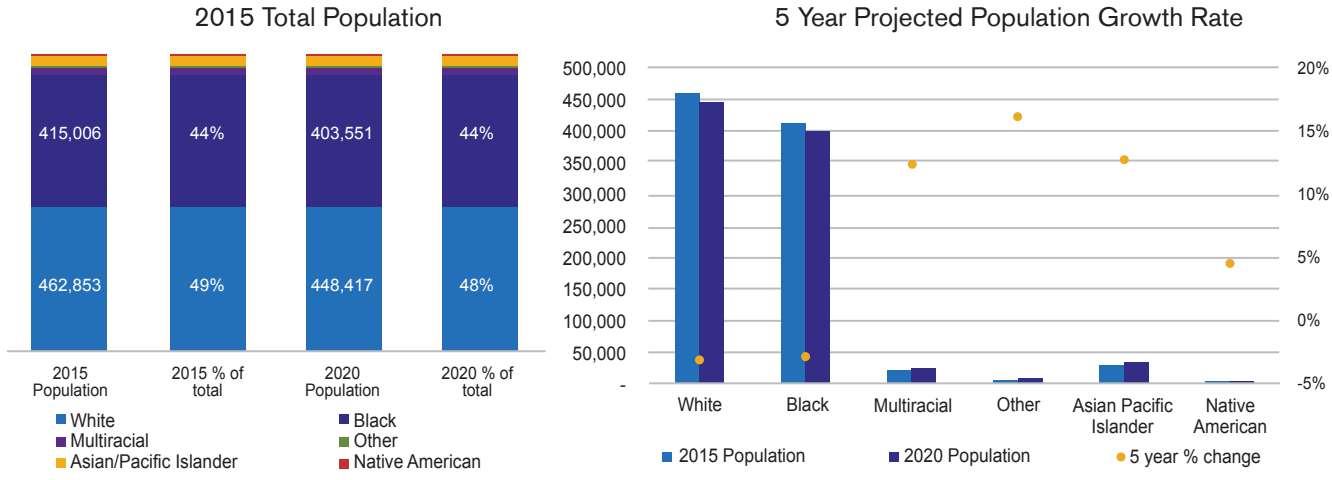
Population by Age Cohort



Source: Truven Health Analytics, 2016

Beaumont, Farmington Hills' population is much more diverse relative to both the Michigan and U.S. population. The two largest groups by race are white (49 percent) and black (44 percent), and both are expected to decrease approximately 3 percent in the next five years. All other minority groups are projected to increase; Asian Pacific Islanders will experience the most growth, closely followed by the multiracial group.

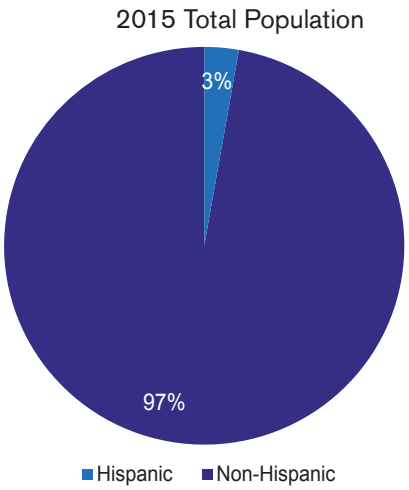
Population by Race

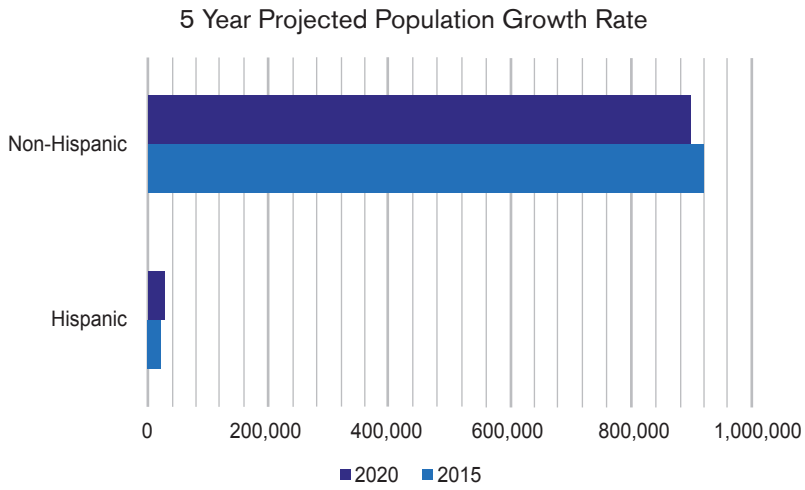


Source: Truven Health Analytics, 2016

Hispanics currently comprise only 3 percent of the community's population, but is expected to grow slightly over the next five years.

Population by Hispanic Ethnicity





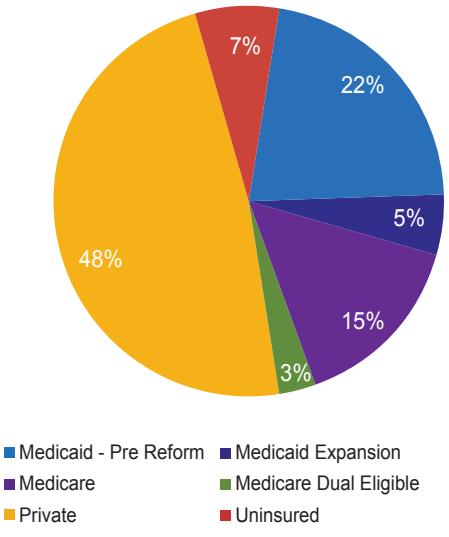
Source: Truven Health Analytics, 2016

Forty-eight percent of the Beaumont, Farmington Hills community is privately insured; this includes people who are purchasing health insurance through the insurance exchange marketplace (4 percent), those who are buying directly from an insurance provider (4 percent), and those who receive insurance through an employer (40 percent). Compared to state and national levels, the community has a higher proportion of people who are insured by either Medicare or Medicaid. Over one fourth of the community has Medicaid (27 percent) and 15 percent has Medicare.

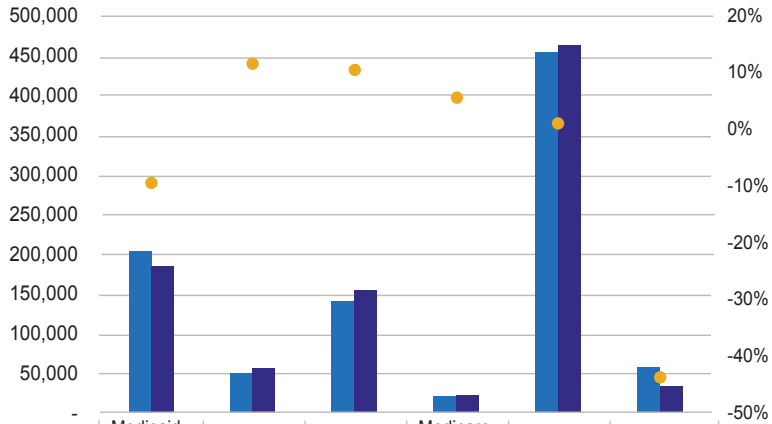
The Medicare population is projected to increase by 10 percent, primarily due to growth in the 65+ population. The private insurance category overall is also projected to increase, though only by 1 percent. However, there will be a shift within the private insurance category as the number of people purchasing insurance via PPACA health insurance exchanges is projected to increase by 82 percent. Overall, the Medicaid population will decrease by 5 percent, but there will be a shift within Medicaid as well as the number of people receiving Medicaid coverage due to the PPACA Medicaid expansion which will increase by 12 percent.

Estimated Covered Lives by Insurance Category

2015 Total Population



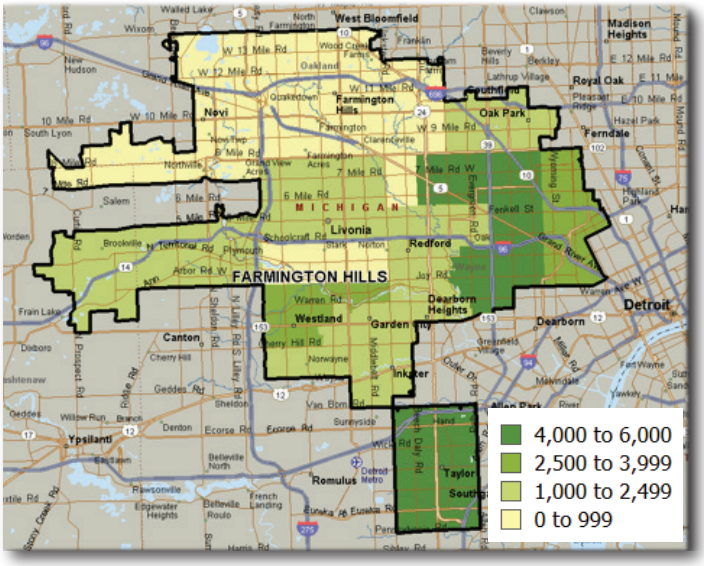
5 Year Projected Population Growth Rate



	Medicaid - Pre Reform	Medicaid Expansion	Medicare	Medicare Dual Eligible	Private	Uninsured
2015 Covered Lives	204,915	52,311	141,569	24,192	457,139	62,304
2020 Covered Lives	186,015	58,554	156,318	25,619	462,844	35,244
5 year % change	-9%	12%	10%	6%	1%	-43%

Source: Truven Health Analytics, 2016

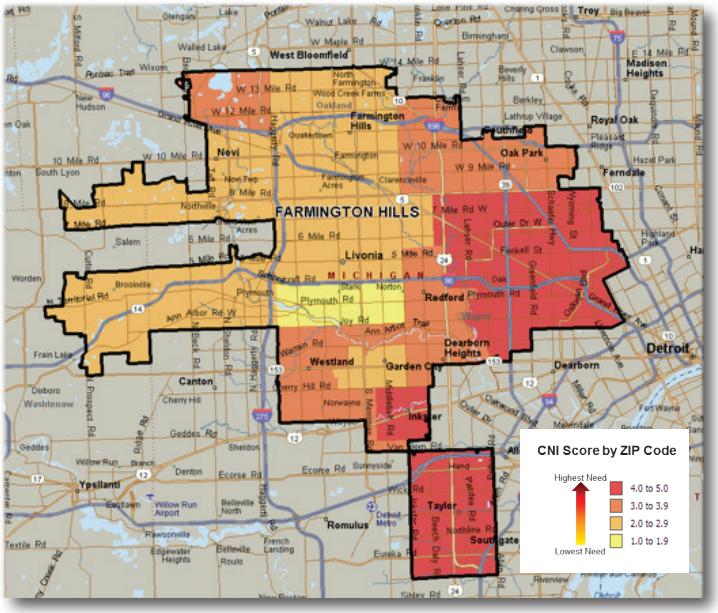
2015 Estimated Uninsured Lives by ZIP Code



Source: Truven Health Analytics, 2016

In the Beaumont, Farmington Hills community, 7 percent of the population is uninsured but projected to decrease by 43 percent in the next five years due, in part, to Medicaid expansion. The portion of the population that is uninsured is highest in ZIP codes 48228 and 48126.

2015 Community Need Index by ZIP Code



Source: Truven Health Analytics, 2016

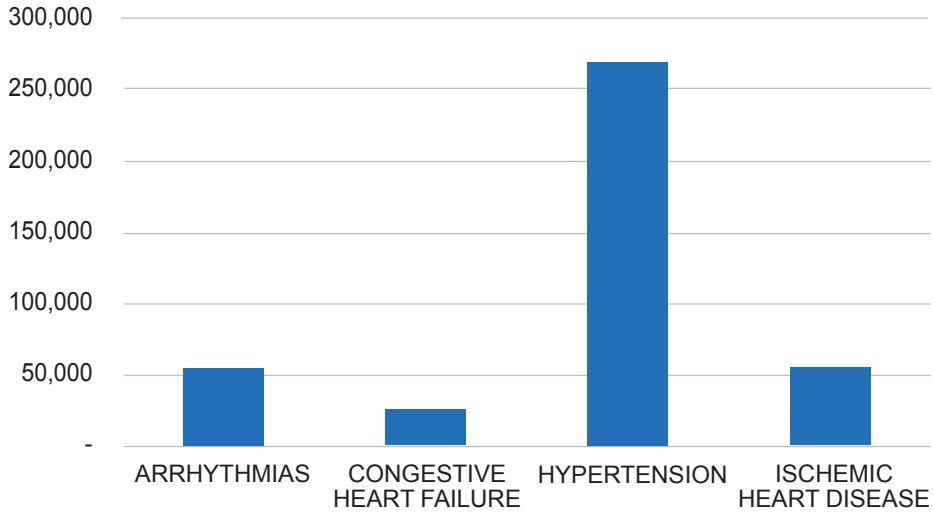
The Beaumont, Farmington Hills CNI score is 3.5. The areas with the highest anticipated need include ZIP codes in the city of Detroit and in Taylor.

Truven Health community data

Truven Health Analytics supplemented the publically available data with estimates of localized disease prevalence of heart disease and cancer as well as emergency department visit estimates.

Hypertension is the most prevalent heart disease in the community and accounts for 67 percent of new heart disease cases. New hypertension cases are heavily concentrated in the Taylor (16,898 cases) and Westland (13,757 cases) communities.

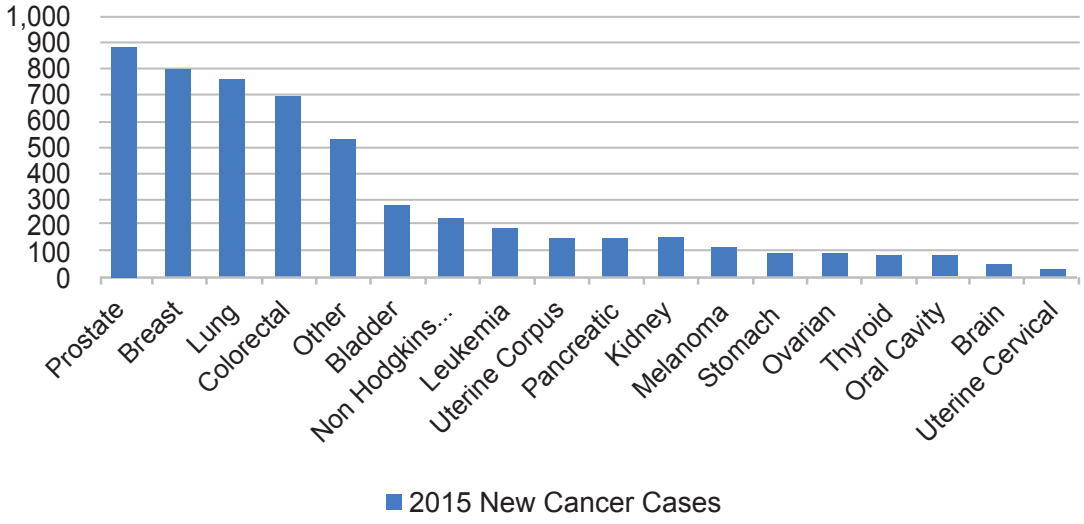
2015 Estimated Heart Disease Cases



Source: Truven Health Analytics, 2016

Compared to state and national estimates, Beaumont, Farmington Hills has a higher proportion of prostate and breast cancer. These two, followed by lung cancer, make up the three most frequently diagnosed cancers in the community during 2015.

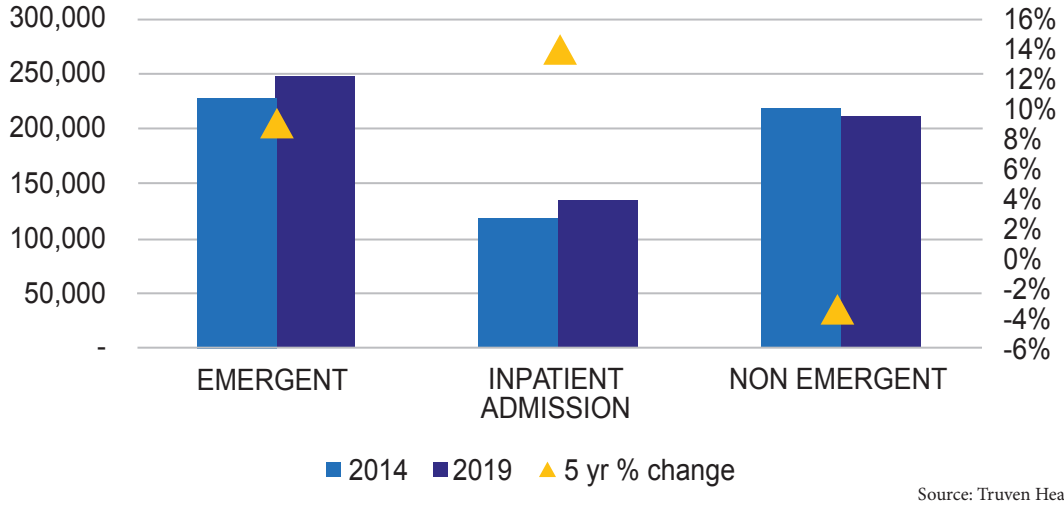
2015 Estimated New Cancer Cases



Source: Truven Health Analytics, 2016

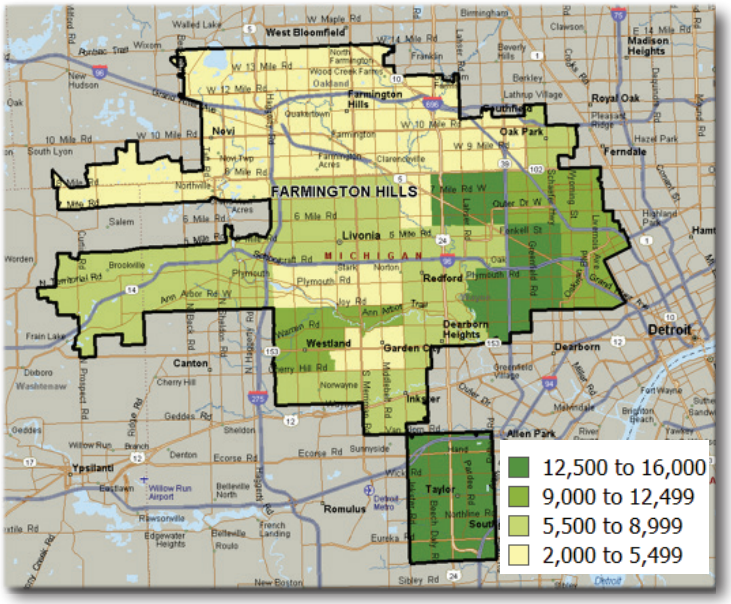
Emergent ED visits are expected to increase almost 10 percent by 2019, while non-emergent ED visits are projected to decrease by 4 percent. Non-emergent, ED visits are lower acuity visits that present in the ED but possibly can be treated in other more appropriate, less intensive outpatient settings. Non-emergent ED visits can be an indication that there are systematic issues with access to primary care or managing chronic conditions.

Emergent and Non-Emergent ED Visits



Source: Truven Health Analytics, 2016

2014 Estimated Non-Emergent Visits by ZIP Code



Source: Truven Health Analytics, 2016

Non-emergent ED visits are highest in the same areas where the uninsured population is highest. Detroit ZIP code 48228 has the highest number of non-emergent ED visits and accounts for approximately 7 percent of the total non-emergent ED visits in the community.

Community input

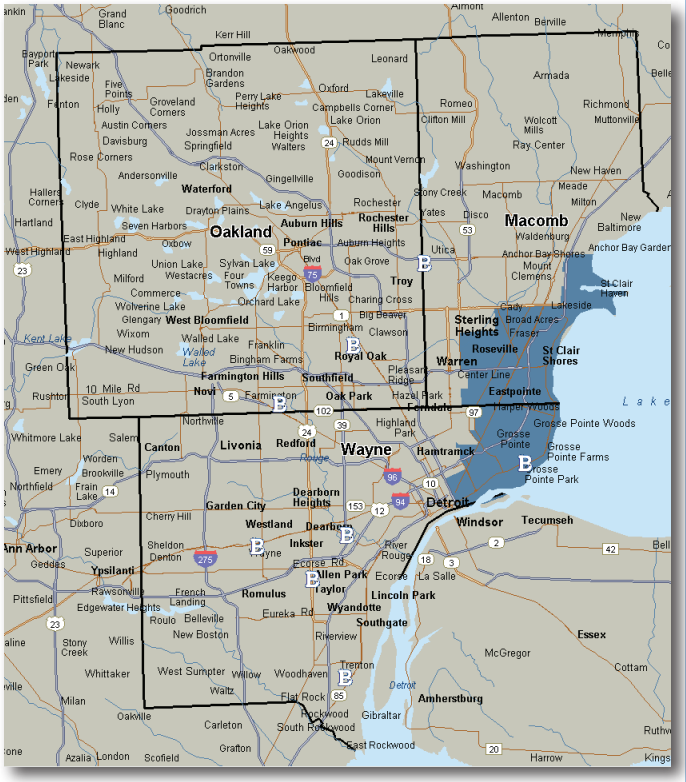
A summary of the focus group conducted for the Beaumont, Farmington Hills community can be found in **Appendix I**.

BEAUMONT HOSPITAL, GROSSE POINTE

Beaumont Hospital, Grosse Pointe is a 250-bed hospital located in the heart of Grosse Pointe. Opened in 1945 by the Sisters of Bon Secours, it was acquired by Beaumont Health System in October 2007, making Beaumont Health System a three-hospital regional health care provider. Beaumont Hospital, Grosse Pointe offers medical, surgical, emergency, obstetric, pediatric and critical care services.

Community served

The Beaumont Hospital, Grosse Pointe community (Beaumont, Grosse Pointe) is defined as the contiguous ZIP codes that comprise 80 percent of inpatient discharges. To the right is a map that highlights the community served (in blue) as a portion of the overall Beaumont community. A table which lists the ZIP codes included in the community definition can be found in **Appendix B**.

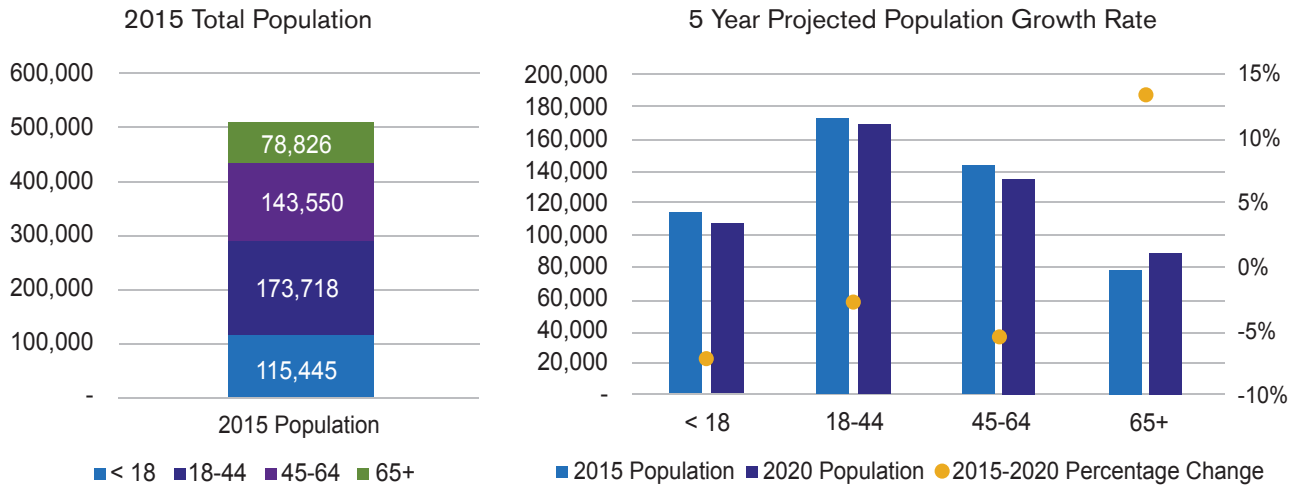


Source: Beaumont Health, 2016

Demographic and socio-economic summary

Beaumont, Grosse Pointe's population is expected to decrease less than 2 percent, with Roseville experiencing slight growth and the surrounding Detroit area experiencing a contraction. The age composition of the community is similar to the state of Michigan and the country. The cohort aged 65+ makes up the smallest segment of the population (15 percent), but is expected to experience the most growth over the next five years. This age group is expected to increase by almost 15 percent while the other age groups are expected to decrease. The pediatric population (<18 years) will experience the largest decrease.

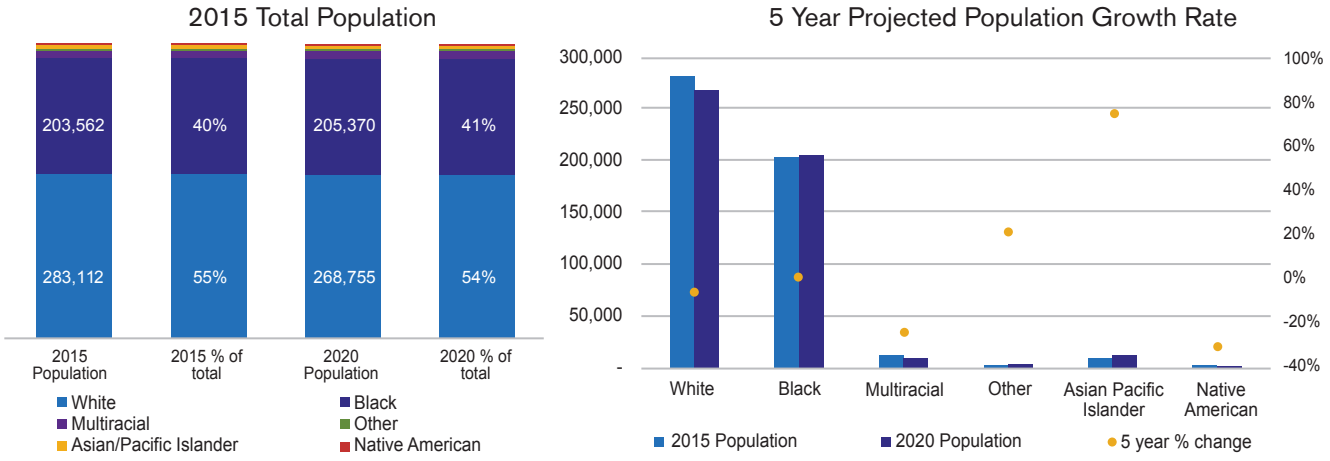
Population by Age Cohort



Source: Truven Health Analytics, 2016

Beaumont, Grosse Pointe's population is primarily white (55 percent) and black (40 percent). The other and Asian Pacific Islander populations are expected to increase, with the Asian Pacific Islander group experiencing the most growth. The impact of these changes on the overall racial composition of the community will be minimal as the racial breakdown will remain relatively stable over the next five years.

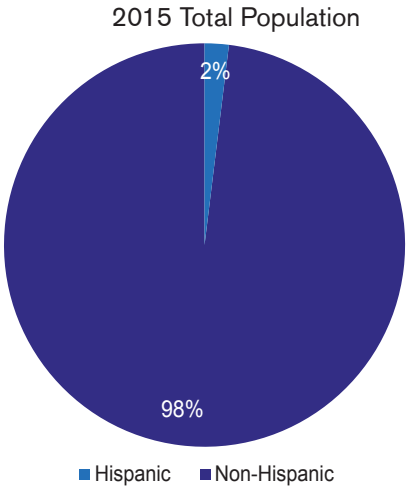
Population by Race

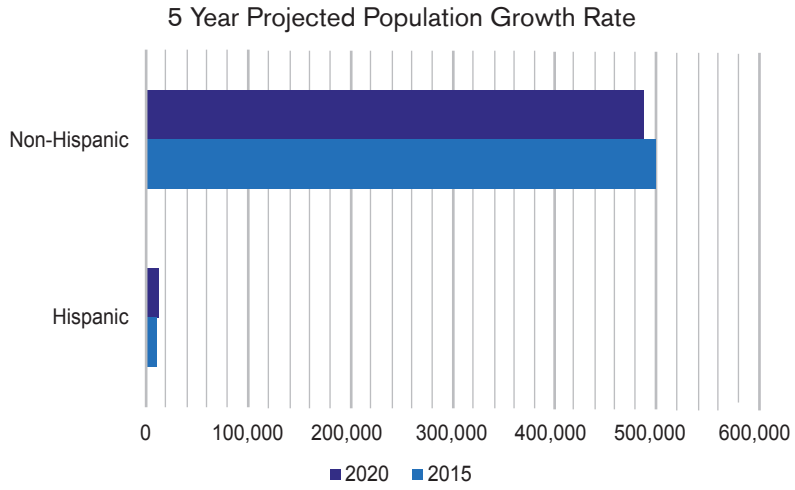


Source: Truven Health Analytics, 2016

The community is predominantly non-Hispanic (98 percent) and has a smaller Hispanic population compared to both the state and national estimates. The Hispanic community will grow only slightly (+1,400 lives) by 2020.

Population by Hispanic Ethnicity





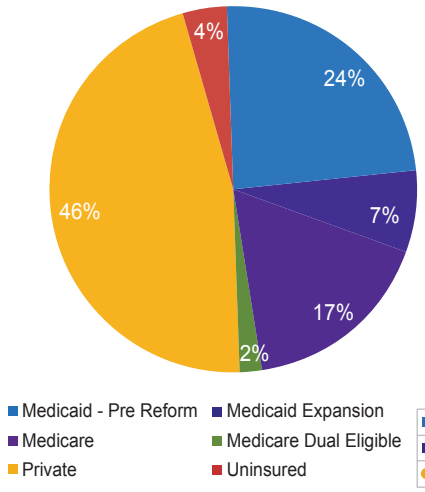
Source: Truven Health Analytics, 2016

Compared to state and U.S. estimates, Beaumont, Grosse Pointe has a smaller percentage of privately insured residents and a larger percentage of Medicaid insured residents. Forty-six percent of the community is privately insured; this includes people who are purchasing health insurance through the insurance exchange marketplace (4 percent), those who are buying directly from an insurance provider (3 percent), and those who receive insurance through an employer (38 percent). Thirty percent of the community has Medicaid and 15 percent has Medicare.

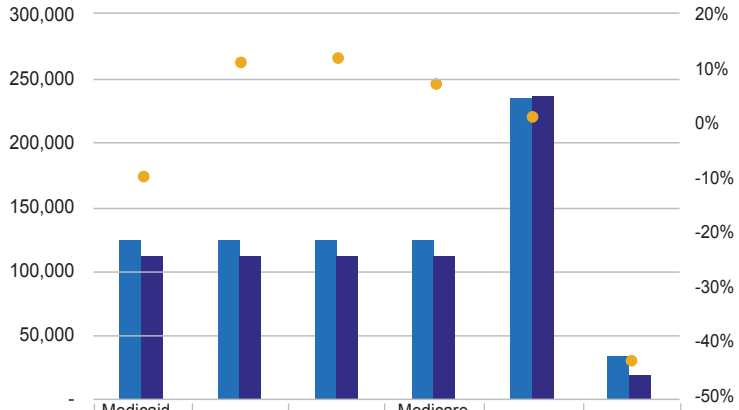
Similar to other Beaumont communities, the Medicare population will experience the greatest growth and is expected to increase 12 percent by 2020. This is primarily fueled by a growing 65+ population in the community. The private insurance category is also projected to increase slightly. The number of people purchasing insurance via PPACA health insurance exchanges is projected to increase by 83 percent. Overall, the Medicaid population will decrease by 5 percent, but the number of people receiving Medicaid coverage due to the PPACAs Medicaid expansion will increase by 11 percent.

Estimated Covered Lives by Insurance Category

2015 Total Population



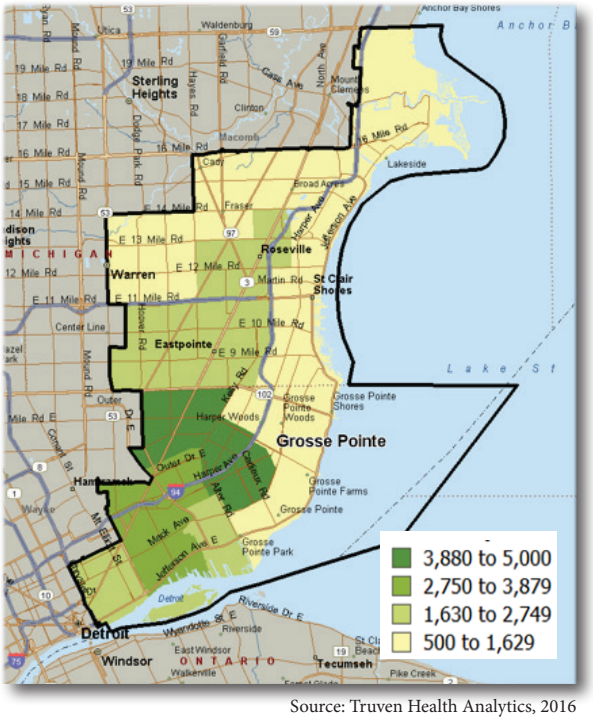
5 Year Projected Population Growth Rate



	Medicaid - Pre Reform	Medicaid Expansion	Medicare	Medicare Dual Eligible	Private	Uninsured
2015 Covered Lives	124,876	30,028	75,871	10,729	234,633	35,402
2020 Covered Lives	113,069	33,462	85,226	11,548	238,330	20,248
5 year % change	-9%	11%	12%	8%	2%	-43%

Source: Truven Health Analytics, 2016

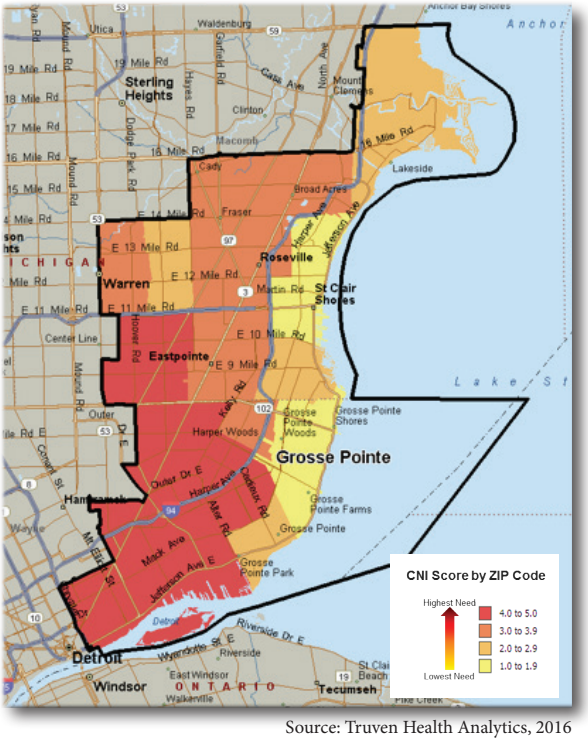
2015 Estimated Uninsured Lives by ZIP Code



Source: Truven Health Analytics, 2016

Seven percent of Beaumont, Grosse Pointe's population is uninsured, and the uninsured population is expected to decrease by 43 percent over the next five years due in part to the expansion of Medicaid in Michigan. The uninsured population is primarily concentrated in areas that include the city of Detroit, in particular ZIP codes 48205 and 48224.

2015 Community Need Index by ZIP Code



Source: Truven Health Analytics, 2016

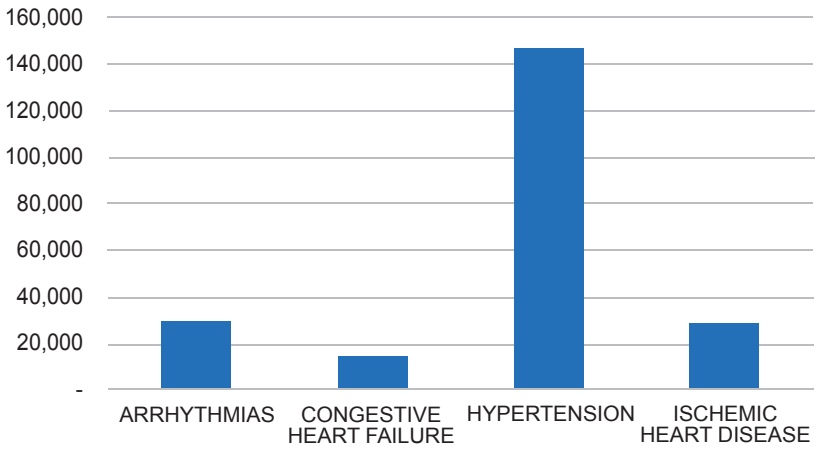
The community's overall CNI score is 3.6, with a marked contrast between areas of relatively low need (CNI score 0-2.9) and very high need (CNI score 3-5). CNI scores are highest in the areas which include Detroit.

Truven Health community data

Truven Health Analytics supplemented the publically available data with estimates of localized disease prevalence of heart disease and cancer as well as emergency department visit estimates.

Hypertension is the most prevalent heart disease in the community and accounts for 67 percent of new heart disease cases. New hypertension cases are heavily concentrated in Roseville (13,369 cases) and Clinton Township (10,151 cases). Arrhythmias are the second most common type of heart disease.

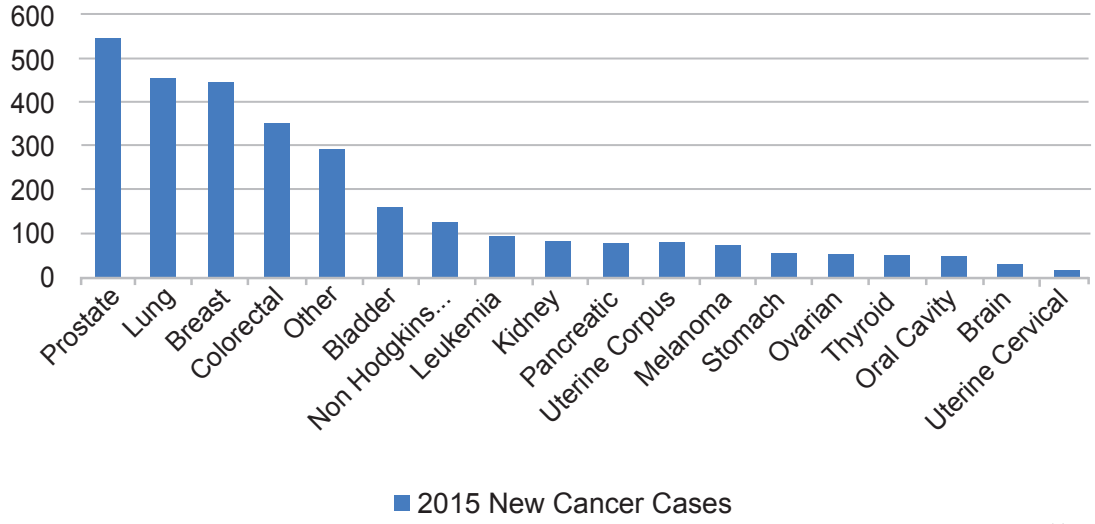
2015 Estimated Heart Disease Cases



Source: Truven Health Analytics, 2016

Compared to state and national estimates, Grosse Pointe has a higher proportion of new prostate, lung, and breast cancer cases. These comprise the three most frequently diagnosed cancers in the community during 2015 and make up almost half of all cancer cases.

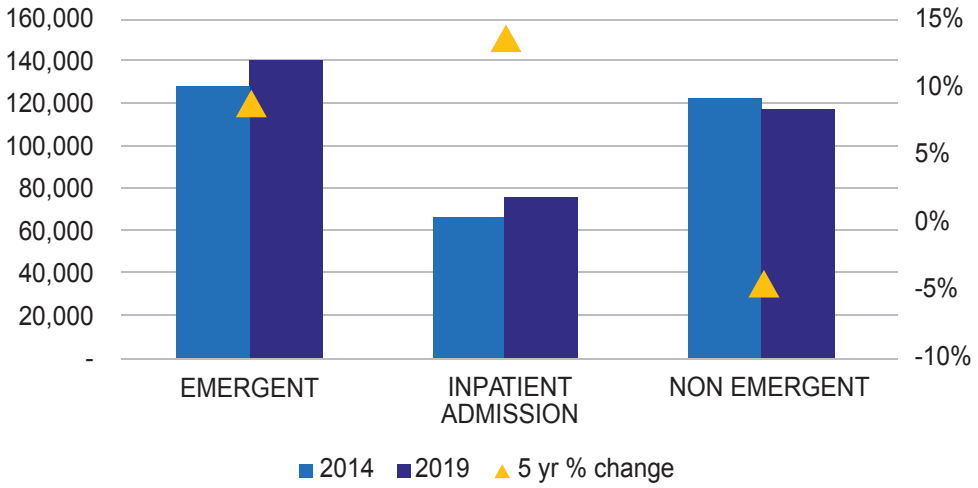
2015 Estimated New Cancer Cases



Source: Truven Health Analytics, 2016

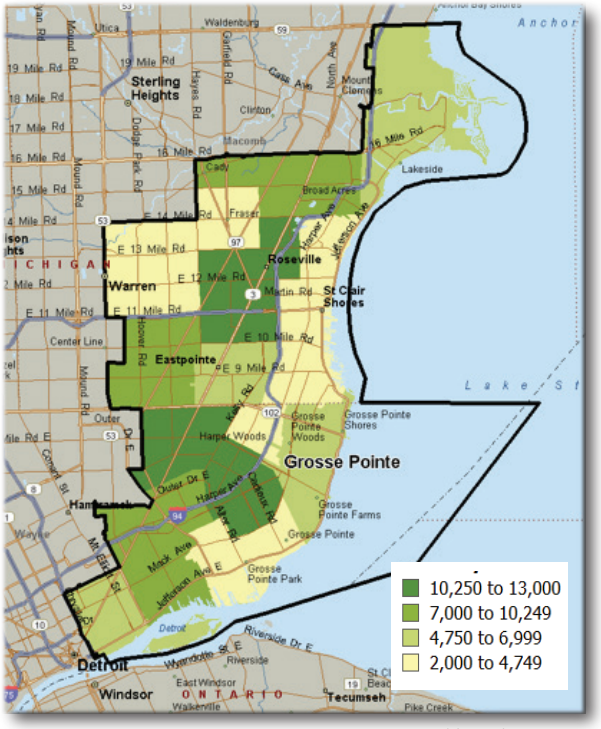
Emergent ED visits are expected to increase 13 percent by 2019, while non-emergent ED visits are projected to decrease by 1 percent.

Emergent and Non-Emergent ED Visits



Source: Truven Health Analytics, 2016

2014 Estimated Non-Emergent Visits by ZIP Code



Source: Truven Health Analytics, 2016

Detroit ZIP codes account for 10 percent (12,384 visits) of the total non-emergent ED visits in the area.

Community input

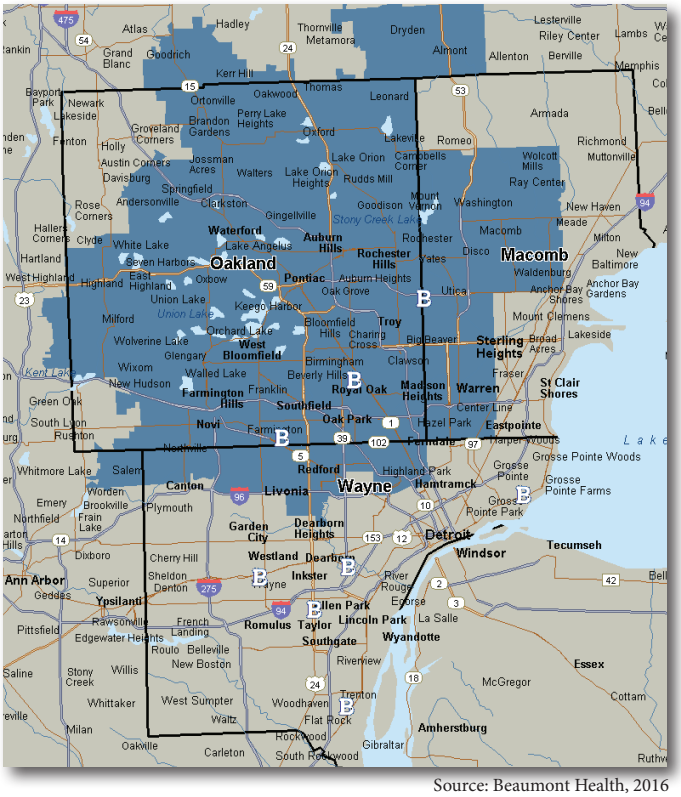
A summary of the focus group conducted for the Beaumont, Grosse Pointe community can be found in **Appendix I**.

BEAUMONT HOSPITAL, ROYAL OAK

Beaumont Hospital, Royal Oak opened on Jan. 24, 1955 as a 238-bed community hospital. Today, the hospital is a 1,082-bed major academic and referral center with Level I adult trauma and Level II pediatric trauma status. A major teaching facility, Beaumont has 40 accredited residency and fellowship programs with 434 residents and fellows at Royal Oak. Beaumont is the exclusive clinical partner for the Oakland University William Beaumont School of Medicine, with more than 1,400 Beaumont doctors on faculty.

Community served

The Beaumont Hospital, Royal Oak community (Beaumont, Royal Oak) is defined as the contiguous ZIP codes that comprise 80 percent of inpatient discharges. To the right is a map that highlights the community definition (in blue) as a portion of the overall Beaumont community. A table which lists the ZIP codes included in the community definition can be found in **Appendix B.**

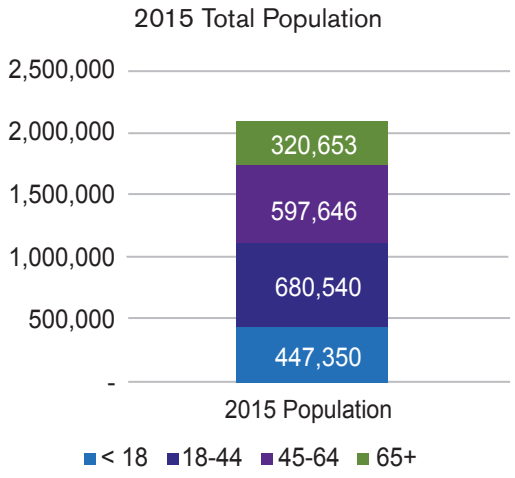


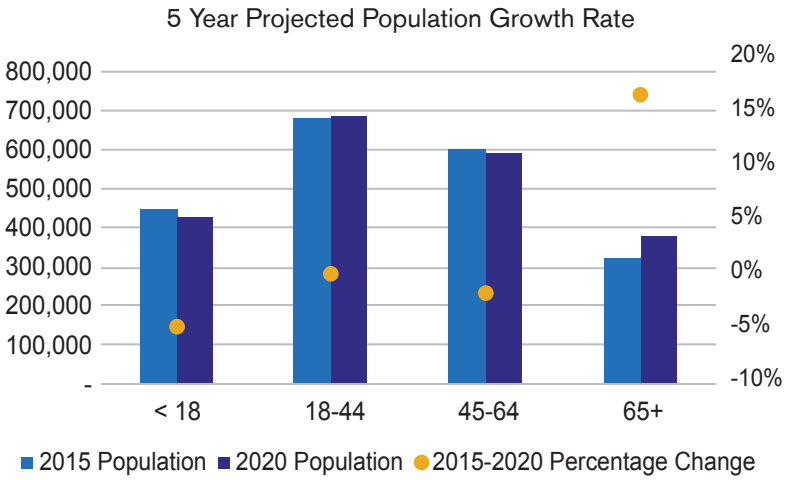
Source: Beaumont Health, 2016

Demographic and socio-economic summary

Beaumont, Royal Oak is the most heavily populated among the eight hospital communities that Beaumont serves, and one of only two areas that will experience growth in the next five years. The age composition of the community is similar to the state of Michigan and the country. The cohort aged 65+ makes up the smallest segment of the population (16 percent), but is expected to experience the most growth over the next five years. This age group will increase 18 percent (57,000 lives) while the 18 to 44 age cohort will grow much slower (+5,000 lives). The 18 and under population will experience the largest decrease (-5 percent).

Population by Age Cohort

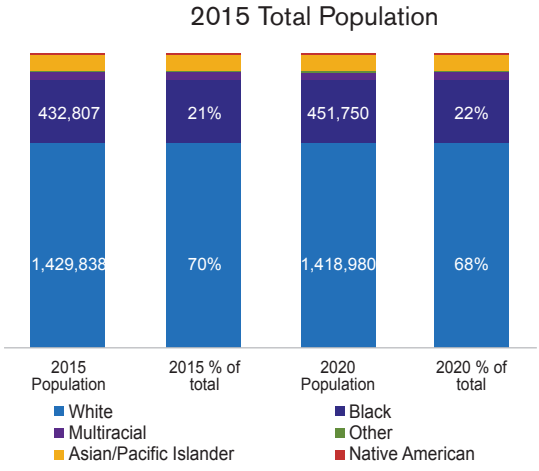


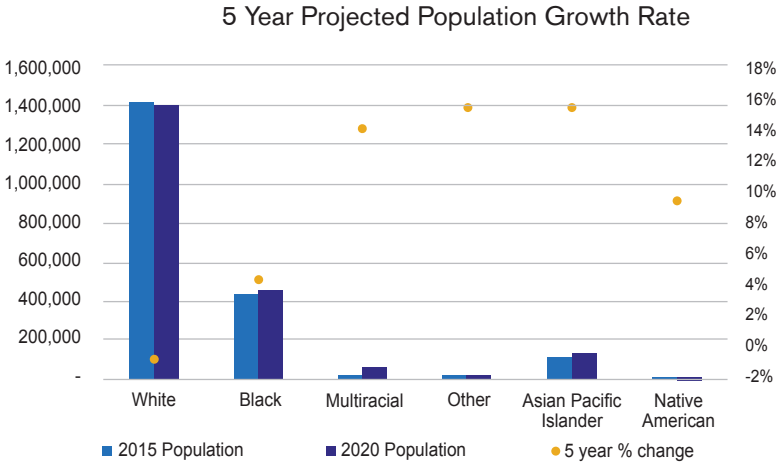


Source: Truven Health Analytics, 2016

Beaumont, Royal Oak's population is predominantly white (70 percent), and the community is home to a large Arab population. The community has 43,762 people of Arab ancestry which make up 2.1 percent of the population. The Arab community is most highly concentrated in Sterling Heights (ZIP code 48310), with 11.8 percent of the community's Arab population residing in this ZIP code. Beaumont Royal Oak is expected to become increasingly diverse as all minority groups are projected to increase by 2020. The Asian Pacific Islander (+17,035 lives) and black population (+18,943 lives) will experience the most growth.

Population by Race

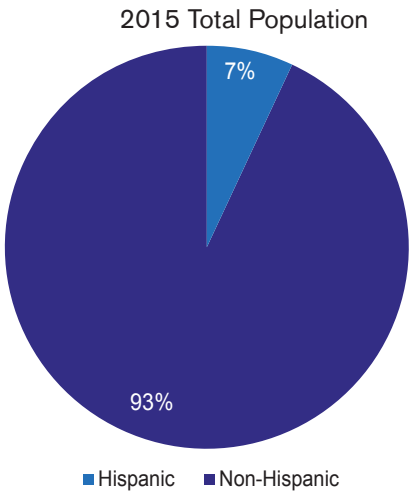


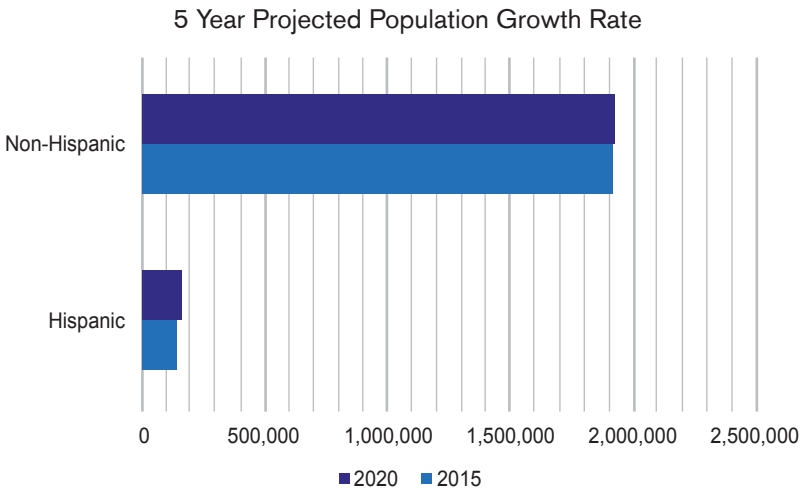


Source: Truven Health Analytics, 2016

The community is largely non-Hispanic, but has a larger percentage than the Michigan state average. Hispanics currently comprise only 3 percent of the community's population, but is expected to grow by more than 21,000 lives in the next five years.

Population by Hispanic Ethnicity





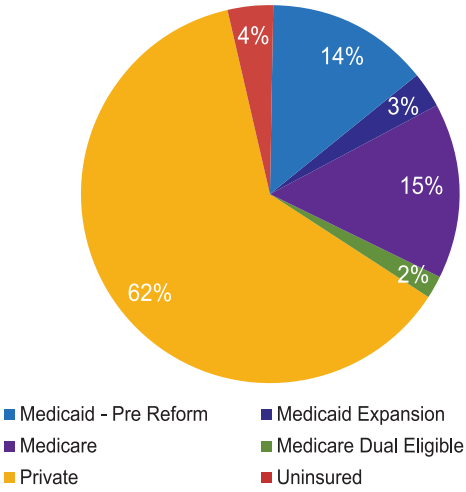
Source: Truven Health Analytics, 2016

The majority of Beaumont, Royal Oak's population is estimated to be privately insured. Compared to state and national estimates, the community has a higher percentage of privately insured residents and a lower percentage of residents with Medicaid. Sixty-two percent of the community has private insurance, 17 percent has Medicaid, and 15 percent has Medicare coverage.

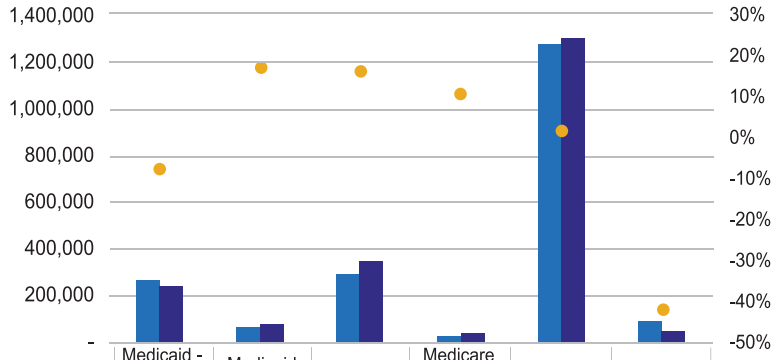
The proportion of people insured by Medicaid is expected to decrease while the proportion with private and Medicare coverage will increase 2 percent and 17 percent respectively. The increases in these insurance categories are most likely due to a growing number of people purchasing insurance via PPACA health insurance exchanges and an aging population.

Estimated Covered Lives by Insurance Category

2015 Total Population



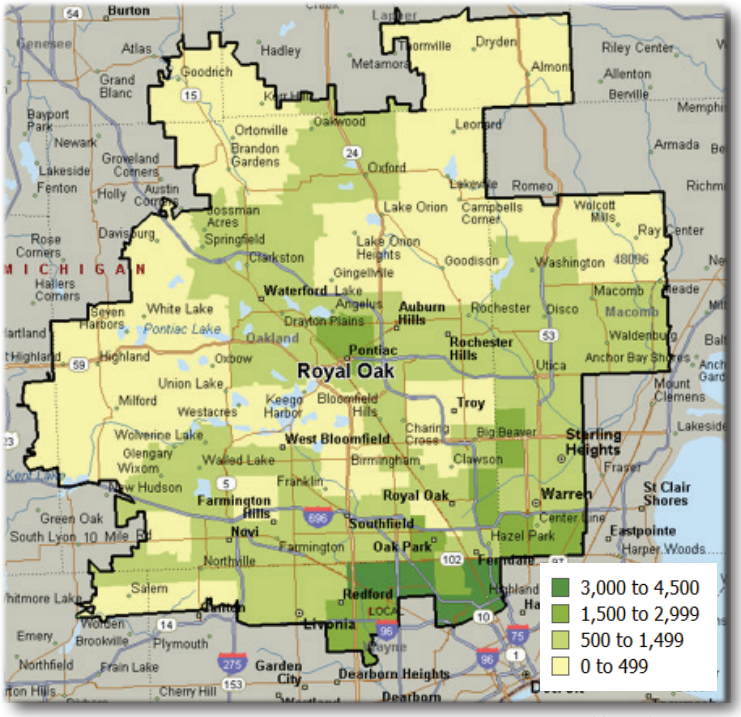
5 Year Projected Population Growth Rate



	Medicaid - Pre Reform	Medicaid Expansion	Medicare	Medicare Dual Eligible	Private	Uninsured
2015 Covered Lives	275,024	69,603	301,153	35,961	1,276,489	87,958
2020 Covered Lives	254,367	81,652	351,638	39,915	1,302,772	51,184
5 year % change	-8%	17%	17%	11%	2%	-42%

Source: Truven Health Analytics, 2016

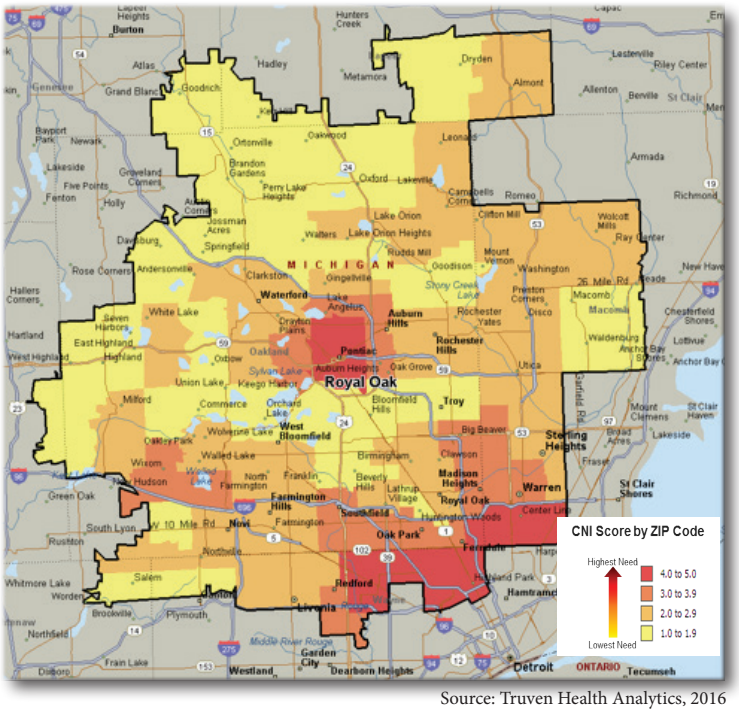
2015 Estimated Uninsured Lives by ZIP Code



Source: Truven Health Analytics, 2016

Beaumont, Royal Oak's uninsured population is very low (only 4 percent) and this number is expected to decrease dramatically (-42 percent) by 2020. The community's uninsured population is primarily concentrated in ZIP codes 48203 (Highland Park) and the Detroit ZIP codes.

2015 Estimated Uninsured Lives by ZIP Code



Source: Truven Health Analytics, 2016

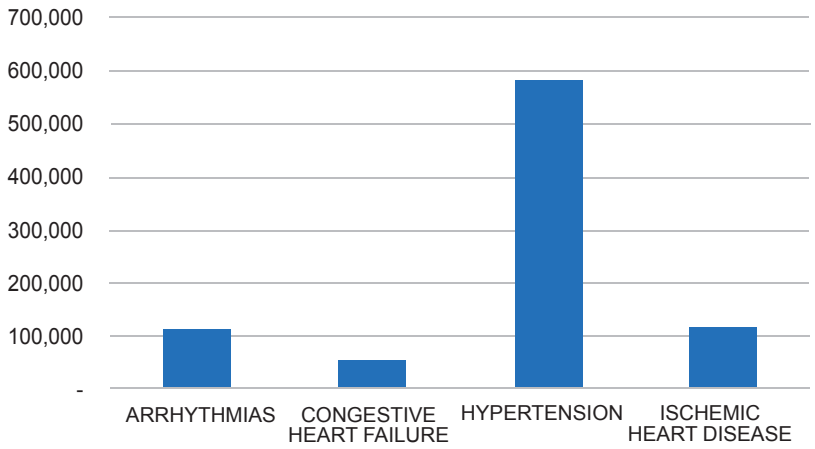
Beaumont, Royal Oak has an overall CNI score of 2.7, the second lowest CNI of the eight Beaumont hospital communities. However, there are ZIP codes that have a score of 5.0 (the highest anticipated need), including Highland Park (48203), Detroit (48238), and Pontiac (48342).

Truven Health community data

Truven Health Analytics supplemented the publically available data with estimates of localized disease prevalence of heart disease and cancer as well as emergency department visit estimates.

Hypertension is the most prevalent heart disease in the community and accounts for 67 percent of new heart disease cases. New hypertension cases are heavily concentrated in the Detroit zip code 48235 (12,636 cases) and Macomb zip code 48044 (14,626 cases) communities.

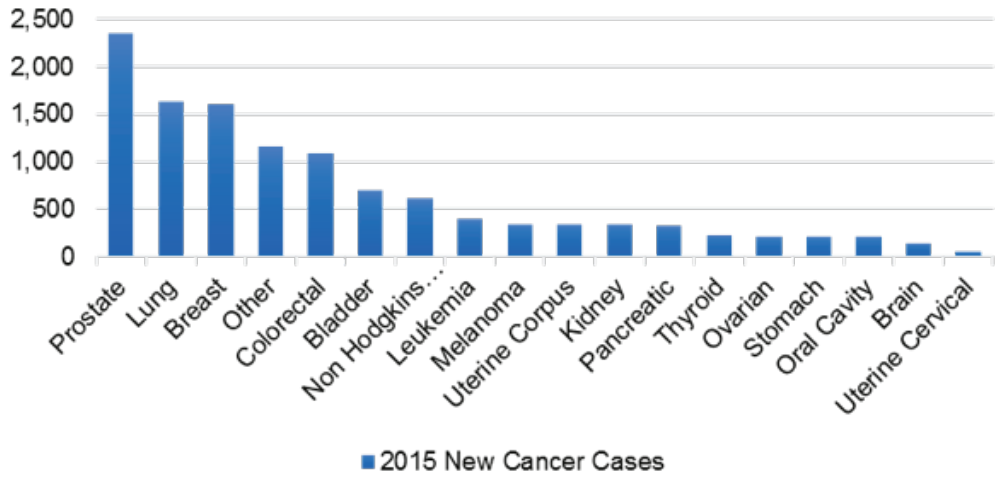
2015 Estimated Heart Disease Cases



Source: Truven Health Analytics, 2016

Compared to state and national estimates, Beaumont, Royal Oak has a higher percentage of prostate and lung cancer cases. Prostate, lung, and breast were the three most frequently diagnosed cancers in the community during 2015 and make up 43 percent of all cancer incidents.

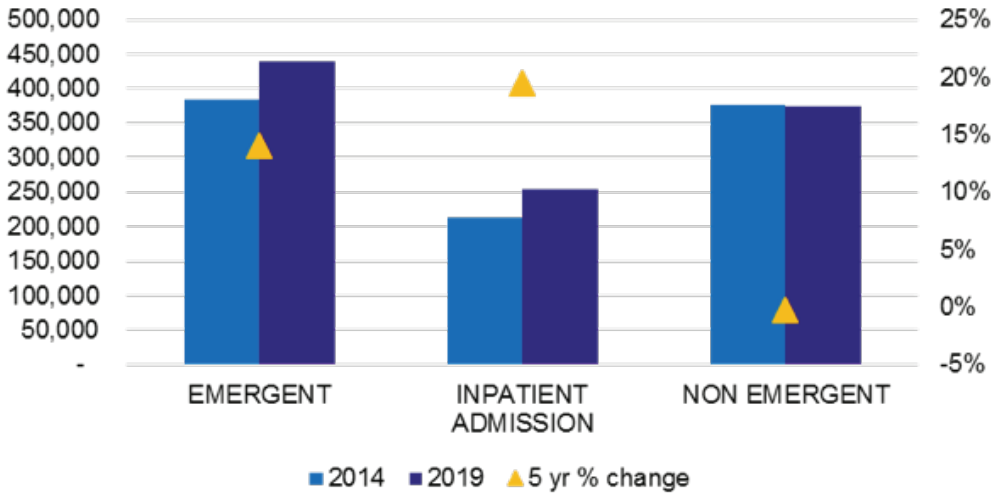
2015 Estimated New Cancer Cases



Source: Truven Health Analytics, 2016

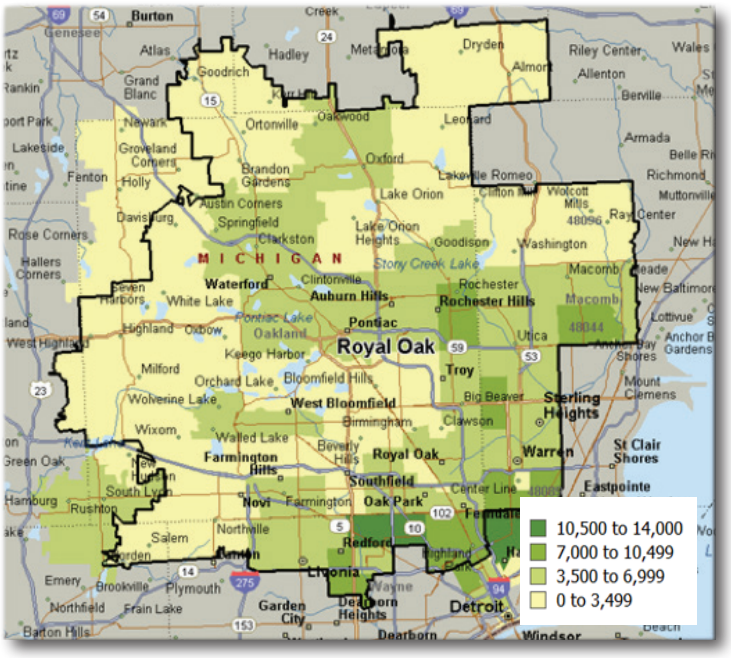
Emergent ED visits are expected to increase over 14 percent by 2019, while non-emergent ED visits will stay relatively stable. Non-emergent, ED visits are lower acuity visits that present in the ED but possibly can be treated in other more appropriate, less intensive outpatient settings. Non-emergent ED visits can be an indication that there are systematic issues with access to primary care or managing chronic conditions.

Emergent and Non-Emergent ED Visits



Source: Truven Health Analytics, 2016

2014 Estimated Non-Emergent Visits by ZIP Code



Source: Truven Health Analytics, 2016

The Detroit portion of the community has the highest number of non-emergent ED visits and accounts for 3 percent of the total non-emergent ED visits in the community.

Community input

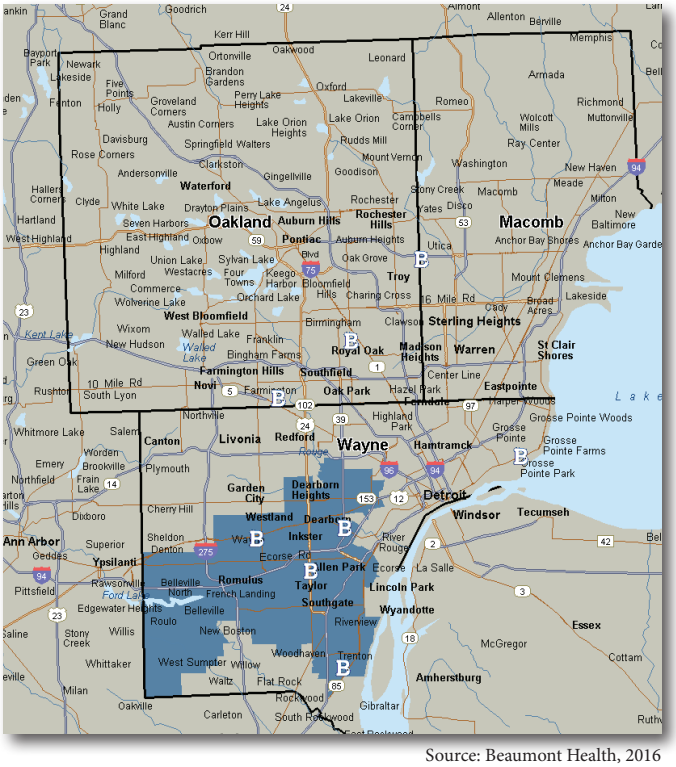
A summary of the focus group conducted for the Beaumont, Royal Oak community can be found in **Appendix I**.

BEAUMONT HOSPITAL, TAYLOR

Beaumont Hospital, Taylor (formerly Oakwood Hospital – Taylor), opened its doors in 1977. This 189-bed hospital provides specialty health care services with outstanding service for residents of Taylor and surrounding communities, including emergency care, speech/language pathology and audiology, a pain management clinic, orthopedic surgery, mental health services, physical medicine and inpatient rehabilitation, and full service radiology with advanced CT and MRI.

Community served

The Beaumont Hospital, Taylor community (Beaumont, Taylor) is defined as the contiguous ZIP codes that comprise 80 percent of inpatient discharges. To the right is a map that highlights the community served (in blue) as a portion of the overall Beaumont community. A table which lists the ZIP codes included in the community definition can be found in **Appendix B.**



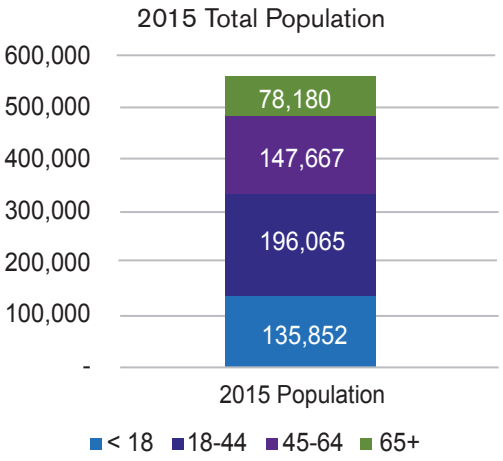
Source: Beaumont Health, 2016

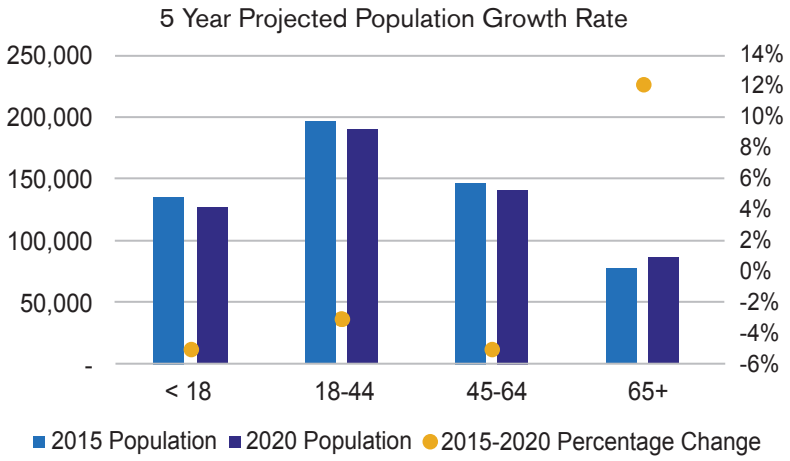
Demographic and socio-economic summary

Beaumont, Taylor's population is projected to decrease 2 percent in five years. Detroit ZIP code 48228 and Taylor (ZIP 48180), the two most populated areas in the community, will experience the greatest decrease in population, while Belleville and Romulus will increase slightly.

The 65 and older cohort makes up the smallest segment of the Taylor population (only 14 percent); however, it is the only group expected to experience an increase in the next five years. The 65 and older age group is projected to increase by 9 percent (9,500 lives), while all other age groups are expected to decrease in size.

Population by Age Cohort



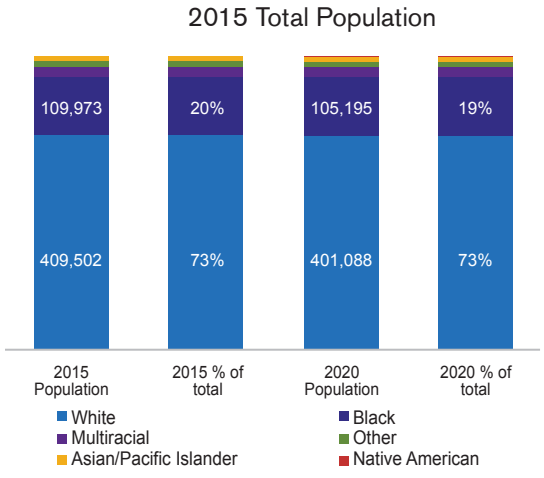


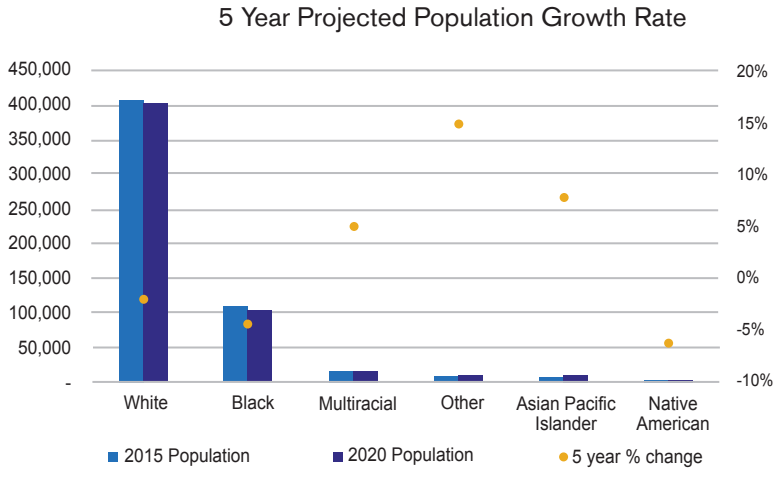
Source: Truven Health Analytics, 2016

The community has a similar racial distribution to the state and national population. Beaumont, Taylor's population is primarily white (73 percent) and black (20 percent). The black population is proportionally higher in Taylor than in Michigan and the nation. The community includes the city of Dearborn, which has the highest concentration of Arab Americans in the country. Persons of Arab ancestry make up 9.6 percent of the community's population, or 52,810 lives. The Arab population is most highly concentrated in the Dearborn ZIP code 48126 and the Dearborn Heights ZIP code 48127, with almost 80 percent of Beaumont, Taylor's Arab population residing in these two ZIP codes.

The overall racial composition of the community will remain relatively stable over the next five years. The Asian Pacific Islander, other, and multiracial groups are projected to increase slightly in the next five years, while all other racial groups are expected to decrease.

Population by Race

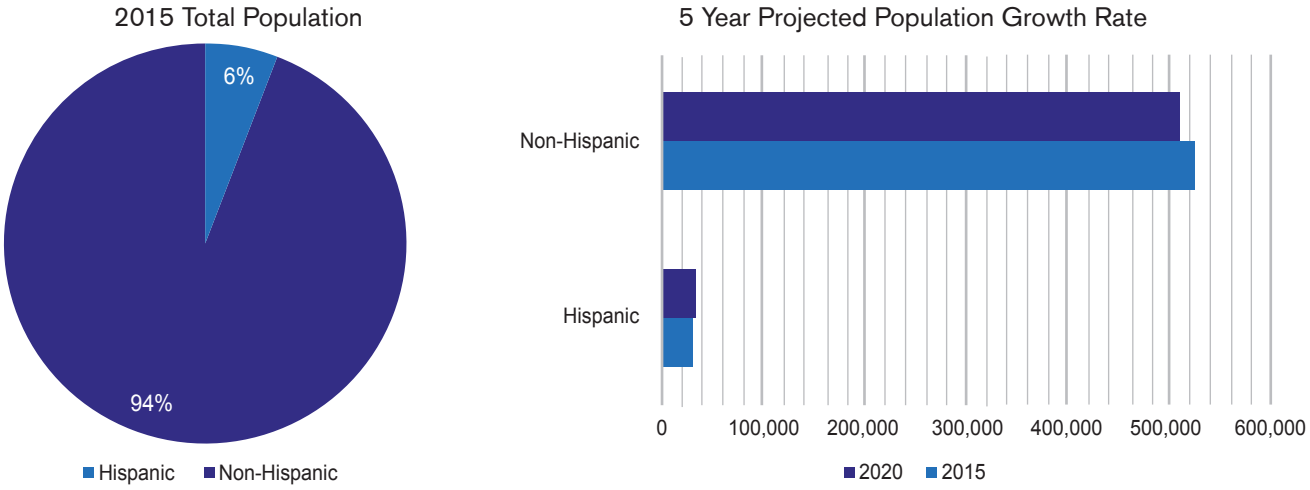




Source: Truven Health Analytics, 2016

Beaumont, Taylor's population is predominantly non-Hispanic with Hispanics making up only 6 percent of the area's population. The community's ethnic composition is similar to the state. This will remain relatively stable, as the Hispanic population is expected to increase only slightly over the next five years.

Population by Hispanic Ethnicity



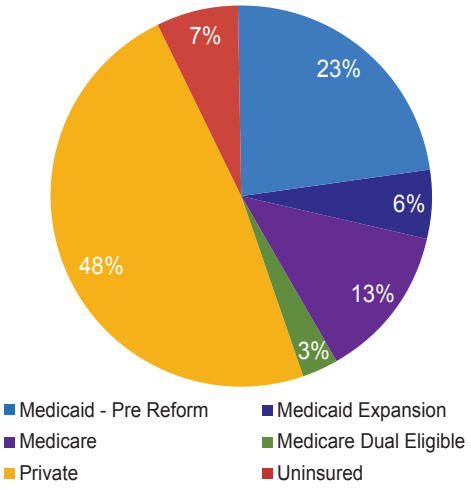
Source: Truven Health Analytics, 2016

Almost half of Beaumont, Taylor's population is privately insured (48 percent). This includes people who are purchasing health insurance through the insurance exchange marketplace (5 percent), those who are buying directly from an insurance provider (4 percent), and those who receive insurance through an employer (40 percent). Compared to state (21 percent) and national (19 percent) levels, the community is home to a larger number of lives covered by Medicaid (29 percent).

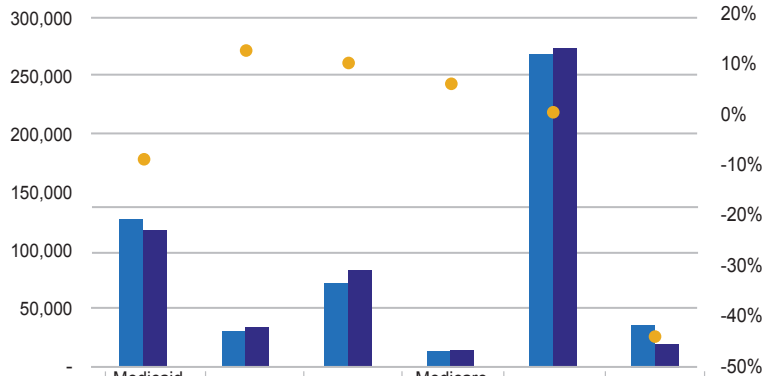
The Medicare population will experience the greatest growth and is expected to increase 11 percent by 2020. This is primarily fueled by a growing 65+ population in the community. The private insurance category is also projected to increase at a slower rate. The number of people purchasing insurance via PPACA health insurance exchanges is projected to increase by 82 percent, driving most of the growth. Overall, the Medicaid population will decrease by 4 percent, but the number of people receiving Medicaid coverage due to the PPACA Medicaid expansion will increase by 14 percent.

Estimated Covered Lives by Insurance Category

2015 Total Population



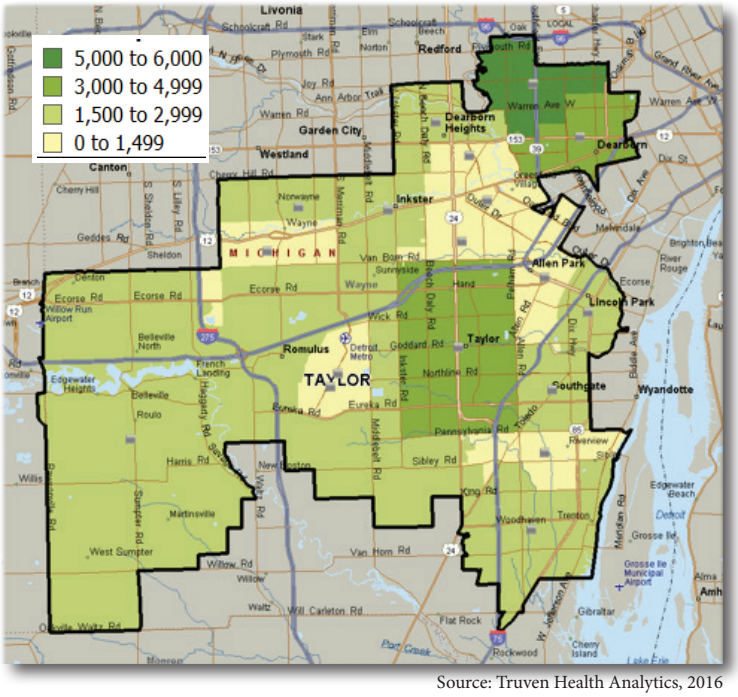
5 Year Projected Population Growth Rate



	Medicaid - Pre Reform	Medicaid Expansion	Medicare	Medicare Dual Eligible	Private	Uninsured
2015 Covered Lives	128,488	31,626	74,915	14,881	269,498	38,356
2020 Covered Lives	118,050	35,897	83,014	15,890	272,916	21,660
5 year % change	-8%	14%	11%	7%	1%	-44%

Source: Truven Health Analytics, 2016

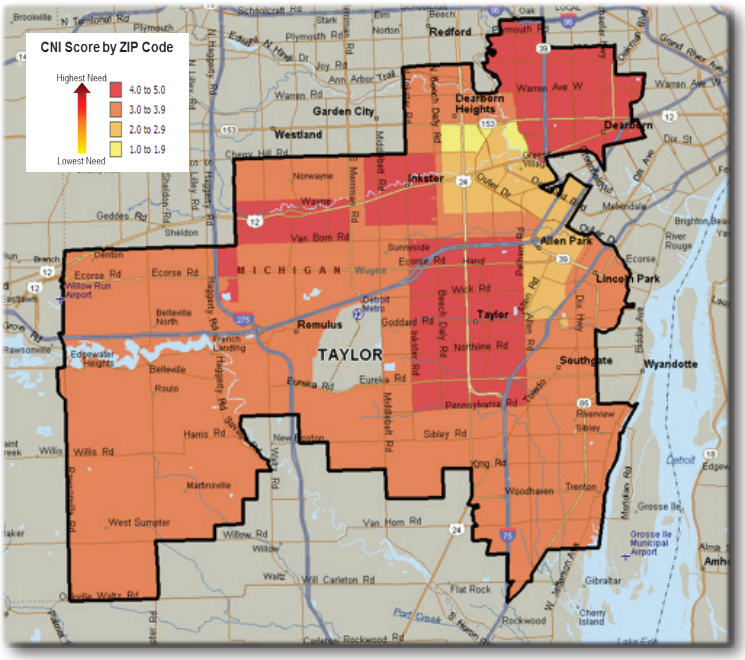
2015 Estimated Uninsured Lives by ZIP Code



Source: Truven Health Analytics, 2016

In the community, 7 percent of the population is uninsured and expected to decrease by almost half in the next five years (-44 percent). The portions of the community that are in Detroit have the highest number of uninsured individuals in the community.

2015 Community Need Index by ZIP Code



Source: Truven Health Analytics, 2016

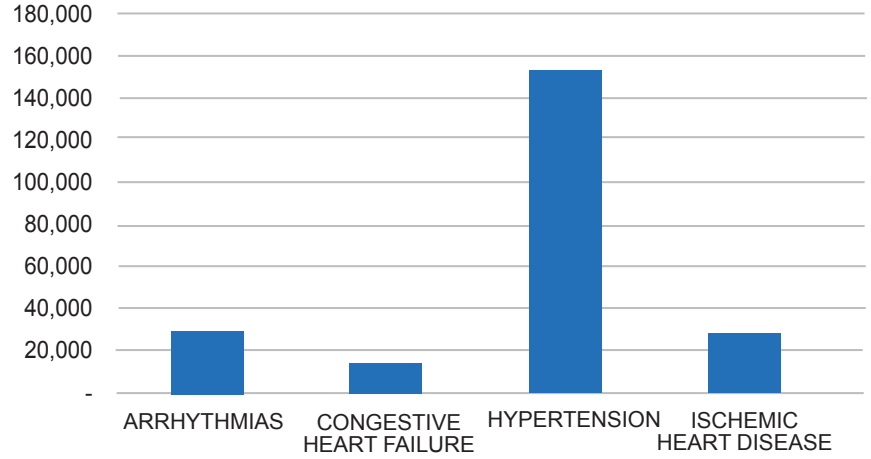
Along with Beaumont, Grosse Pointe, Beaumont, Taylor has the second highest CNI score in the overall Beaumont community at 3.6. The CNI data indicates that the majority of the community has a high level of need.

Truven Health community data

Truven Health Analytics supplemented the publically available data with estimates of localized disease prevalence of heart disease and cancer as well as emergency department visit estimates.

Similar to other Beaumont communities, hypertension is the most prevalent heart disease in the surrounding community. New arrhythmia cases, the second most prevalent heart disease, are heavily concentrated in the Beaumont, Taylor and Beaumont, Trenton areas.

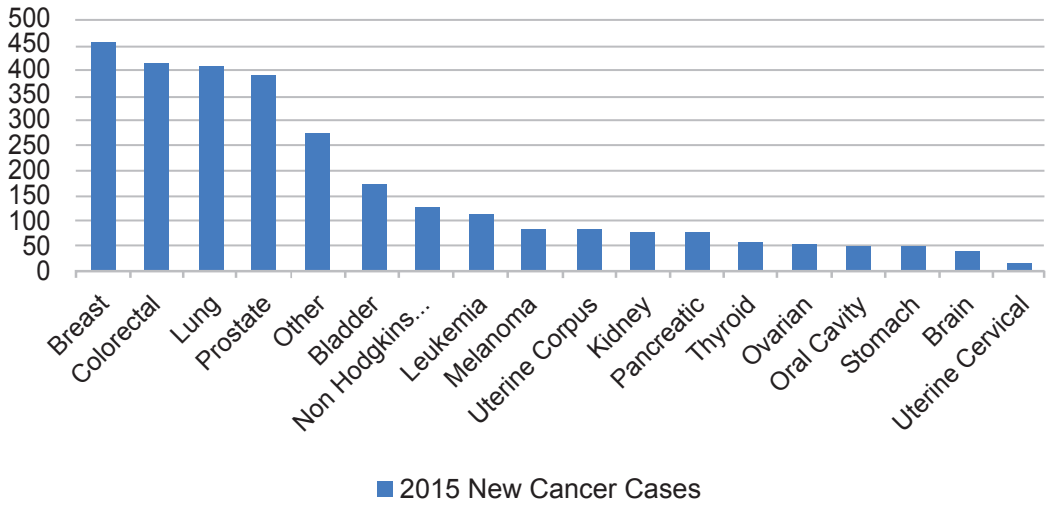
2015 Estimated Heart Disease Cases



Source: Truven Health Analytics, 2016

Overall, the community's distribution of new cancer cases by type is relatively similar to state and national estimates with the exception of colorectal cancer. Beaumont, Taylor has a higher percentage of new colorectal cancer cases compared to the state and national levels.

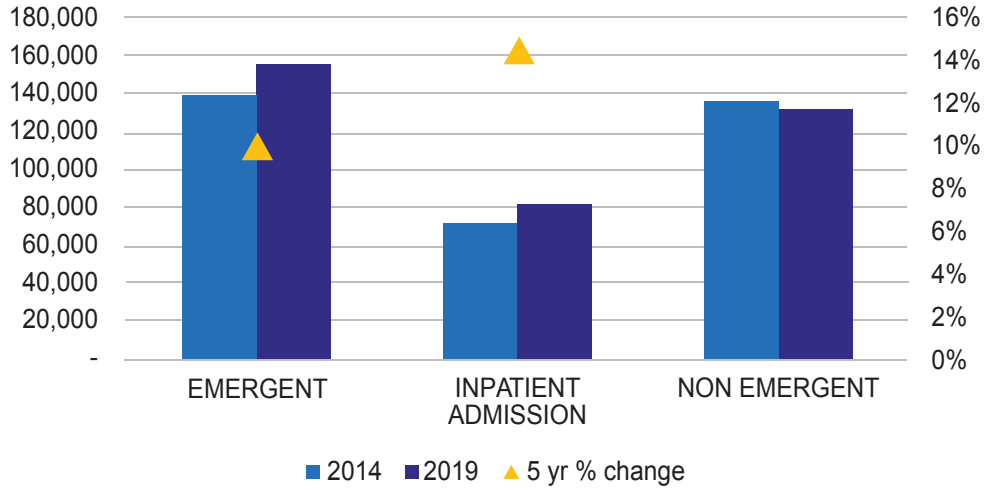
2015 Estimated New Cancer Cases



Source: Truven Health Analytics, 2016

The number of emergent ED visits is expected to increase over 10 percent by 2019 (+13,878 visits), while the number of non-emergent ED visits will likely decrease by less than 5 percent (-4,106 visits).

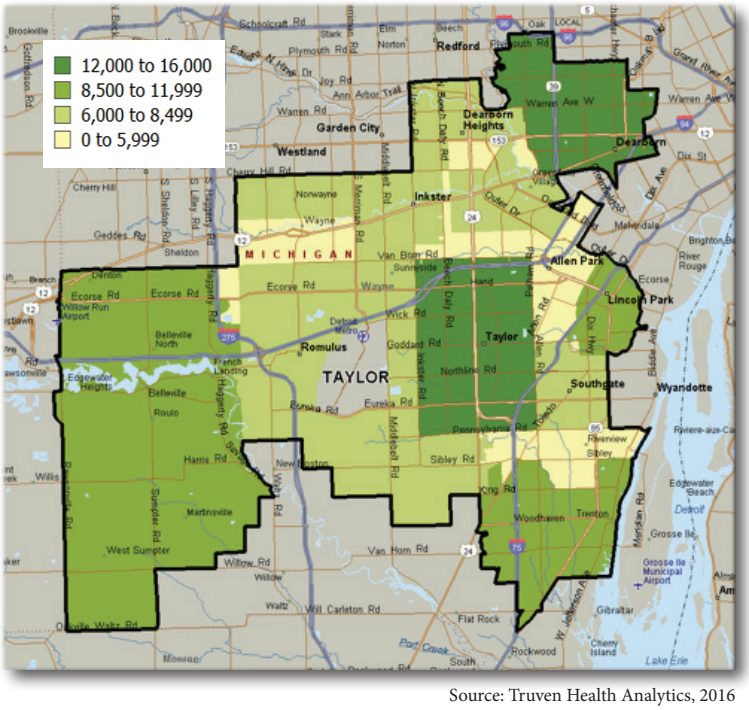
Emergent and Non-Emergent ED Visits



Source: Truven Health Analytics, 2016

The Detroit ZIP codes account for almost 12 percent of non-emergent ED visits in the area (15,914 visits). Non-emergent, ED visits are lower acuity visits that present in the ED but possibly can be treated in other more appropriate, less intensive outpatient settings. Non-emergent ED visits can be an indication that there are systematic issues with access to primary care or managing chronic conditions.

2014 Estimated Non-Emergent Visits by ZIP Code



Source: Truven Health Analytics, 2016

Community input

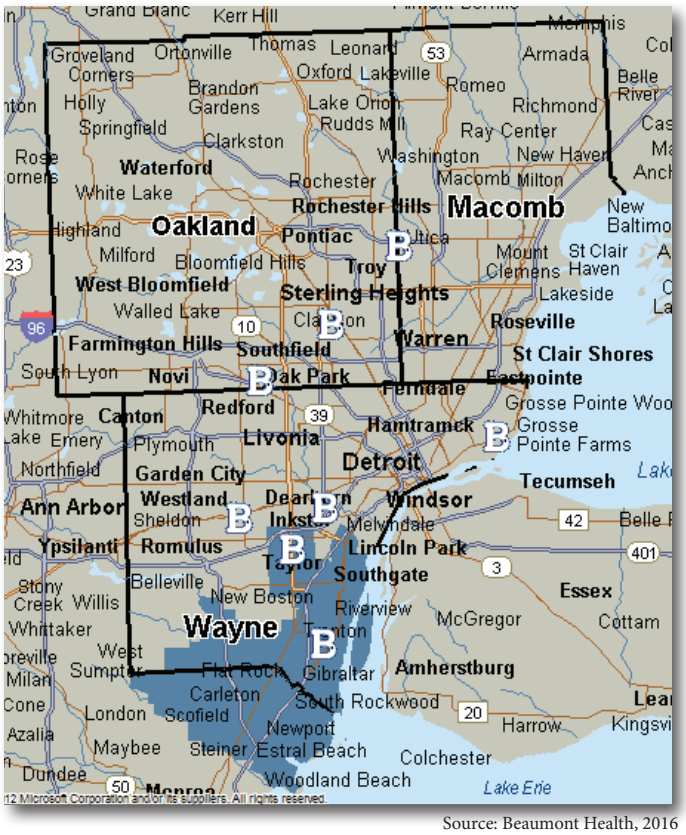
A summary of the focus group conducted for the Beaumont, Taylor community can be found in **Appendix I.**

BEAUMONT HOSPITAL, TRENTON

Beaumont Hospital, Trenton (formerly Oakwood Hospital – Southshore) is a 193-bed community hospital that opened its doors to residents of Trenton and surrounding communities in 1961. Beaumont Hospital, Trenton provides comprehensive medical care for its patients. A recipient of the Governor's Award of Excellence for Improving Care in Hospital Surgical and Emergency Department Settings, Beaumont Hospital, Trenton offers the latest in health services and has the only verified Level II trauma center serving the downriver community. This important distinction means that advanced life-saving procedures are readily available 24/7 for patients with traumatic injuries.

Community served

The Beaumont Hospital, Trenton community (Beaumont, Trenton) is defined as the contiguous ZIP codes that comprise 80 percent of inpatient discharges. To the right is a map that highlights the community served (in blue) as a portion of the overall Beaumont community. A table which lists the ZIP codes included in the community definition can be found in **Appendix B.**



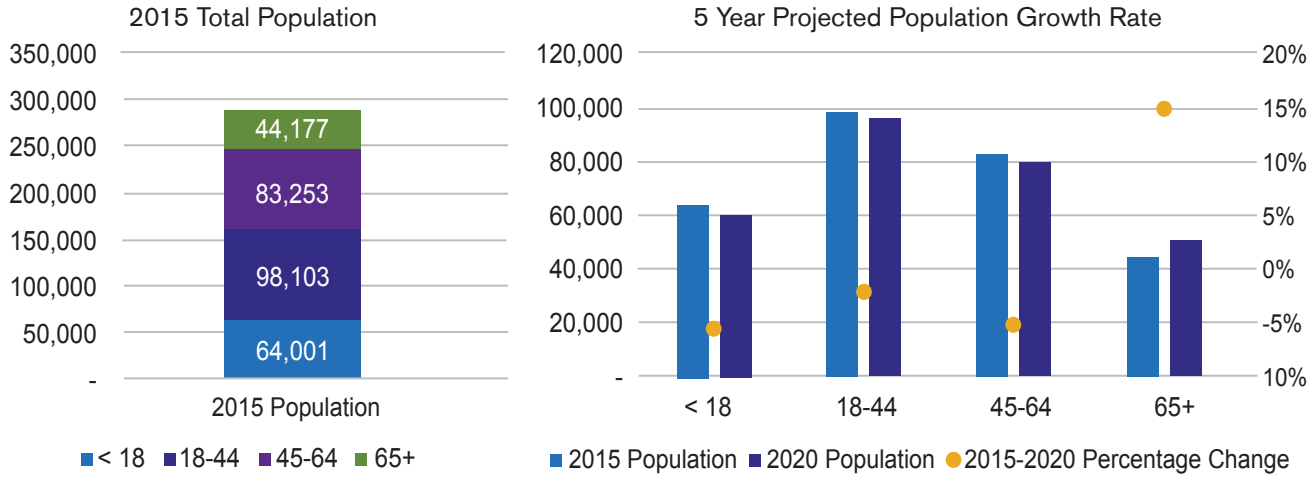
Source: Beaumont Health, 2016

Demographic and socio-economic summary

In the next five years, Beaumont, Trenton's population is expected to decrease by 1 percent. Flat Rock, Rockwood, Newport, and New Boston are expected to grow slightly. Taylor, the most populated ZIP code, will decrease in population.

The age composition of the community is similar to the state of Michigan and the country. The cohort aged 65+ makes up the smallest segment of the population (15 percent), but is the only age group expected to grow over the next five years. This group is expected to increase by 15 percent (6,550 lives) while the other age groups are expected to decrease less than 5 percent.

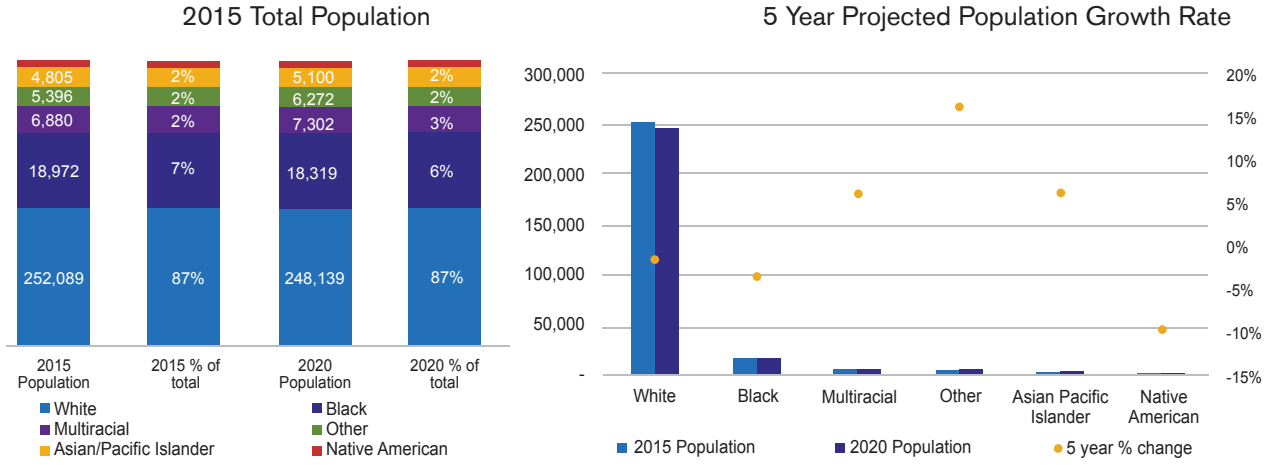
Population by Age Cohort



Source: Beaumont Health, 2016

Beaumont, Trenton has a much higher concentration of whites compared to both the state and national level, as well as other areas in the overall Beaumont community. Beaumont, Trenton's population is 87 percent white; however, this number is expected to decrease slightly in the upcoming years. The other, Asian Pacific Islander, and multiracial groups will experience slight growth by 2020 but this will have minimal impact on the community's population, which is expected to remain predominantly white.

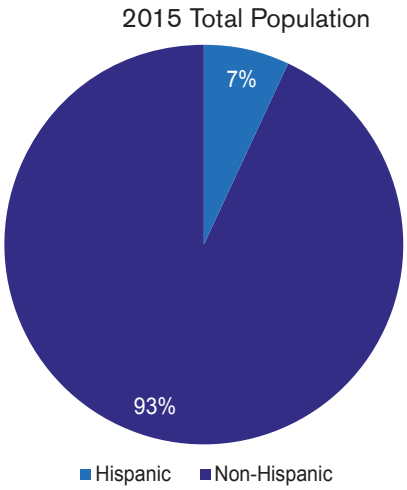
Population by Race

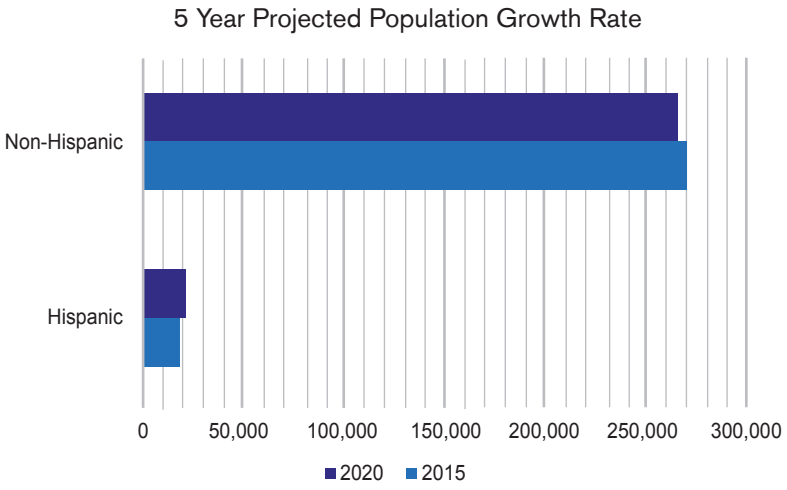


Source: Truven Health Analytics, 2016

The community's population is predominantly non-Hispanic, with Hispanics making up only 7 percent of the area's population. Beaumont, Trenton's ethnic composition is similar of that in the state. This will remain relatively stable, as the Hispanic population is expected to increase only slightly over the next five years.

Population by Hispanic Ethnicity





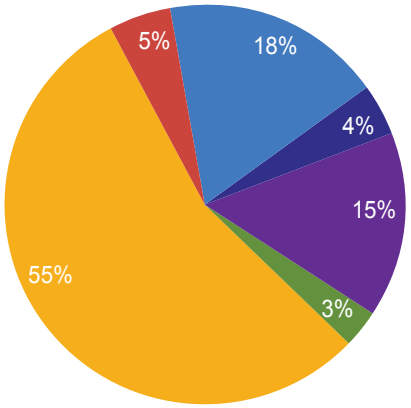
Source: Truven Health Analytics, 2016

Beaumont, Trenton's insurance type distribution is reflective of that in Michigan as a whole. More than half of the population is privately insured, 22 percent is covered by Medicaid, and 15 percent is covered by Medicare. People who are privately insured include those who are purchasing health insurance through the insurance exchange marketplace (5 percent), those who are buying directly from an insurance provider (4 percent), and those who receive insurance through an employer (46 percent).

The number of lives covered by Medicare will experience the greatest growth and is expected to increase by more than 13 percent. This growth is mainly due to an aging population. The proportion of people who are privately insured will remain stable, but the number of people purchasing insurance via PPACA health insurance exchanges is projected to increase by 79 percent. Overall, the Medicaid population will decrease by 4 percent, but the number of people receiving Medicaid coverage due to the PPACA Medicaid expansion will increase by 14 percent.

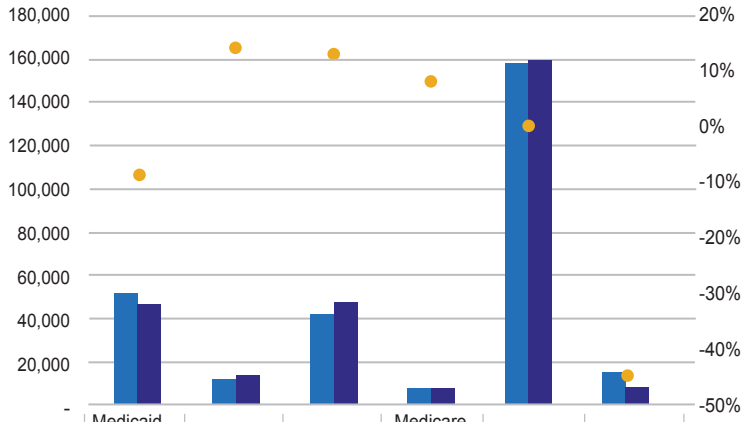
Estimated Covered Lives by Insurance Category

2015 Total Population



Medicaid - Pre Reform
Medicaid Expansion
Medicare
Medicare Dual Eligible
Private
Uninsured

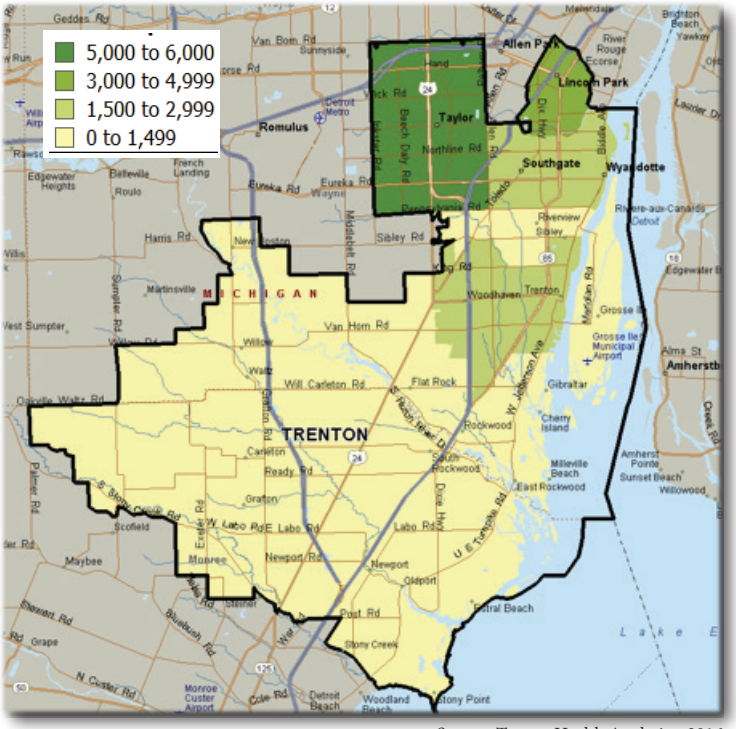
5 Year Projected Population Growth Rate



	Medicaid - Pre Reform	Medicaid Expansion	Medicare	Medicare Dual Eligible	Private	Uninsured
2015 Covered Lives	52,318	12,332	42,447	8,007	158,476	15,955
2020 Covered Lives	47,832	14,095	48,121	8,657	158,816	8,870
5 year % change	-9%	14%	13%	8%	0%	-44%

Source: Truven Health Analytics, 2016

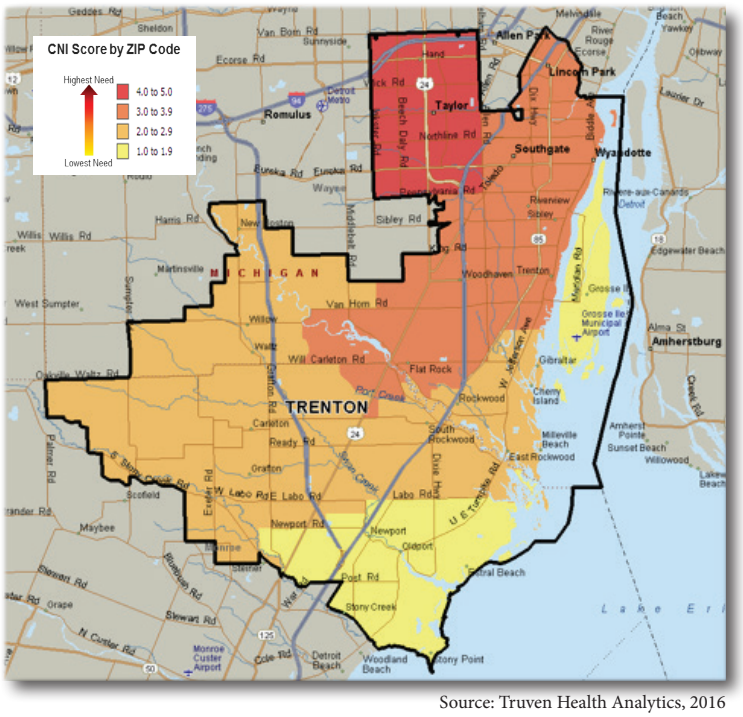
2015 Estimated Uninsured Lives by ZIP Code



Source: Truven Health Analytics, 2016

Five percent of Beaumont, Trenton's population is currently uninsured. It is projected that this number will decrease by 44 percent over the next five years. The uninsured population is most highly concentrated in the Taylor area.

2015 Community Need Index by ZIP Code



Source: Truven Health Analytics, 2016

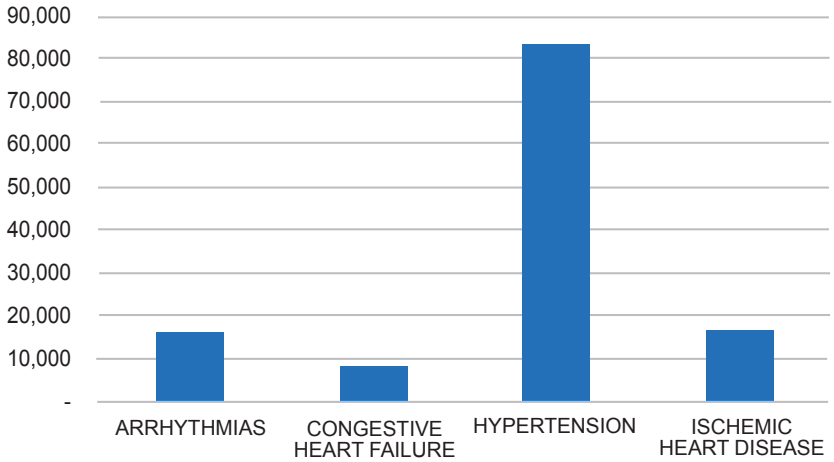
Beaumont, Trenton's community has an overall CNI score of 3.2, making it the third lowest CNI score of all the Beaumont hospital communities. CNI scores appear to be higher in the areas overlapping with the Taylor community, with ZIP code 48180 potentially having the most need.

Truven Health community data

Truven Health Analytics supplemented the publically available data with estimates of localized disease prevalence of heart disease and cancer as well as emergency department visit estimates.

Hypertension is the most prevalent heart disease in the community and accounts for 67 percent of new heart disease cases. New hypertension and arrhythmia cases are heavily concentrated in the community.

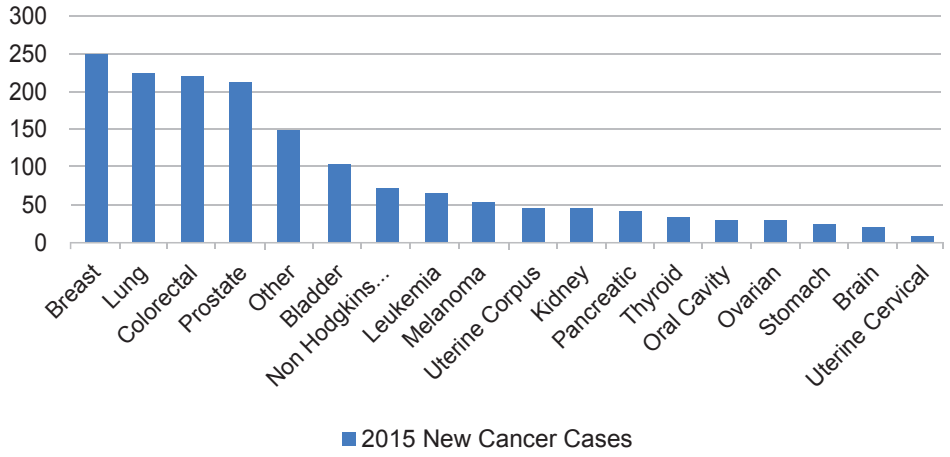
2015 Estimated Heart Disease Cases



Source: Truven Health Analytics, 2016

Compared to state and national estimates, Beaumont, Trenton is estimated to have a lower proportion of new prostate cancer cases and a higher proportion of new lung cancer cases. Breast, lung, and colorectal cancer were the three most commonly diagnosed cancers in 2015.

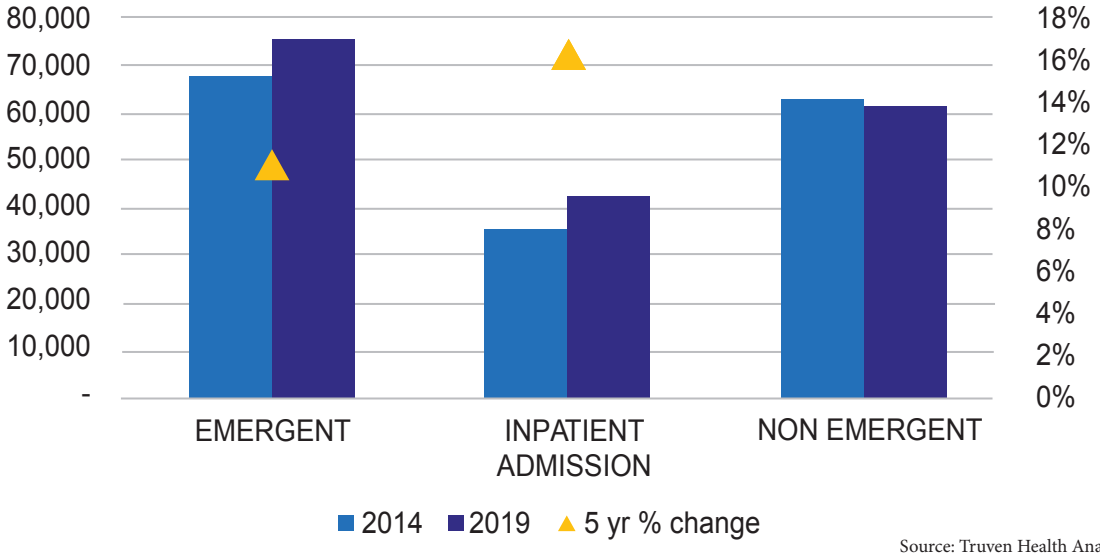
2015 Estimated New Cancer Cases



Source: Truven Health Analytics, 2016

The number of emergent ED visits is expected to increase over 11 percent by 2019, while the number of non-emergent ED visits is expected to decrease slightly.

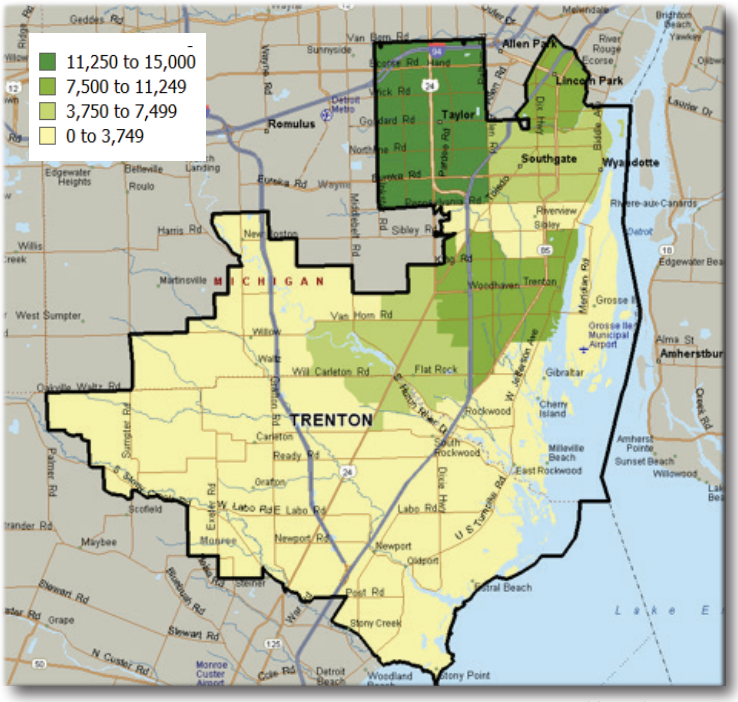
Emergent and Non-Emergent ED Visits



Source: Truven Health Analytics, 2016

Taylor accounts for 22 percent of non-emergent ED visits in the area. Rockwood is expected to experience a slight increase in non-emergent ED visits (+3 percent).

2014 Estimated Non-Emergent Visits by ZIP Code



Source: Truven Health Analytics, 2016

Community input

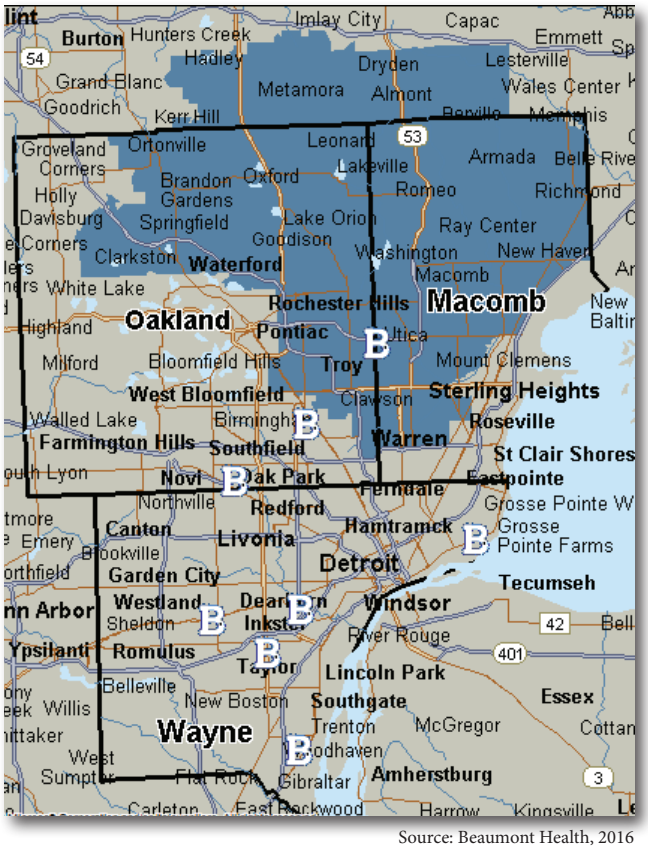
A summary of the focus group conducted for the Beaumont, Trenton community can be found in **Appendix I.**

BEAUMONT HOSPITAL, TROY

In response to the health care needs of a growing community, Beaumont Health System opened a new 200-bed hospital on rural farmland in Troy in 1977. Today, Beaumont Hospital, Troy has grown to 520 beds and offers a comprehensive array of health care services, continuing to develop to meet the needs of the growing communities it serves.

Community served

The Beaumont Hospital, Troy community (Beaumont, Troy) is defined as the contiguous ZIP codes that comprise 80 percent of inpatient discharges. To the right is a map that highlights the community served (in blue) as a portion of the overall Beaumont community. A table which lists the ZIP codes included in the community definition can be found in **Appendix B.**



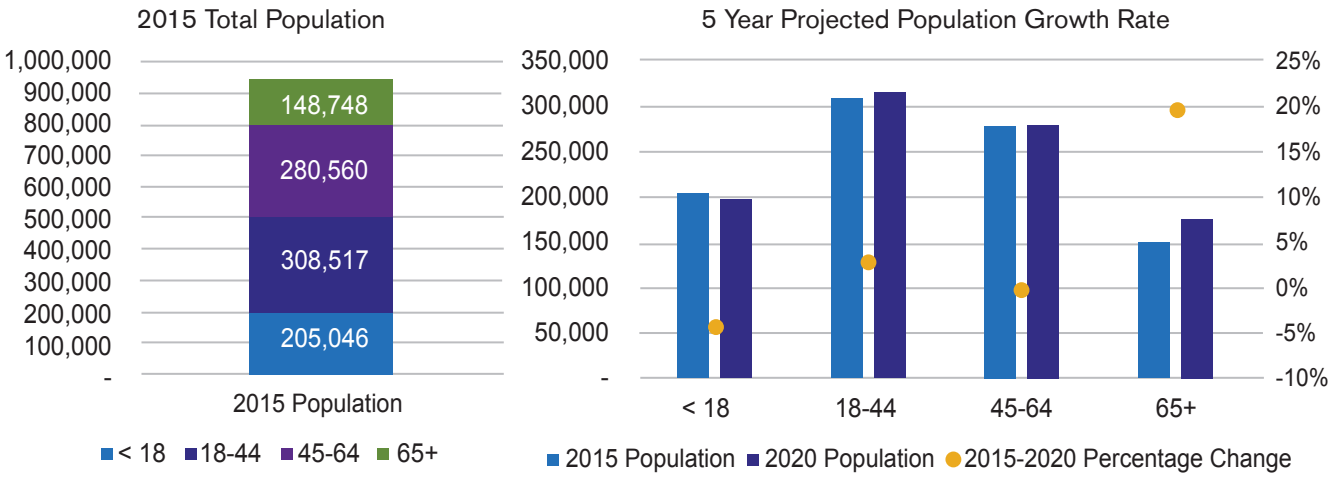
Source: Beaumont Health, 2016

Demographic and socio-economic summary

Along with Royal Oak, Beaumont, Troy is one of the only communities with projected population growth in the next five years; the predicted 3 percent increase is the highest in the overall Beaumont community.

The age distribution in Beaumont, Troy is similar to that seen in Michigan and the U.S. overall. The 18 to 44 age group, which makes up the largest portion of the population, will increase by 3 percent (9,074 lives). Similar to the pattern seen across Beaumont's communities, the 65+ group will experience the greatest growth and is projected to increase by more than 20 percent (29,384 lives). The under 18 population will decrease by 4 percent.

Population by Age Cohort

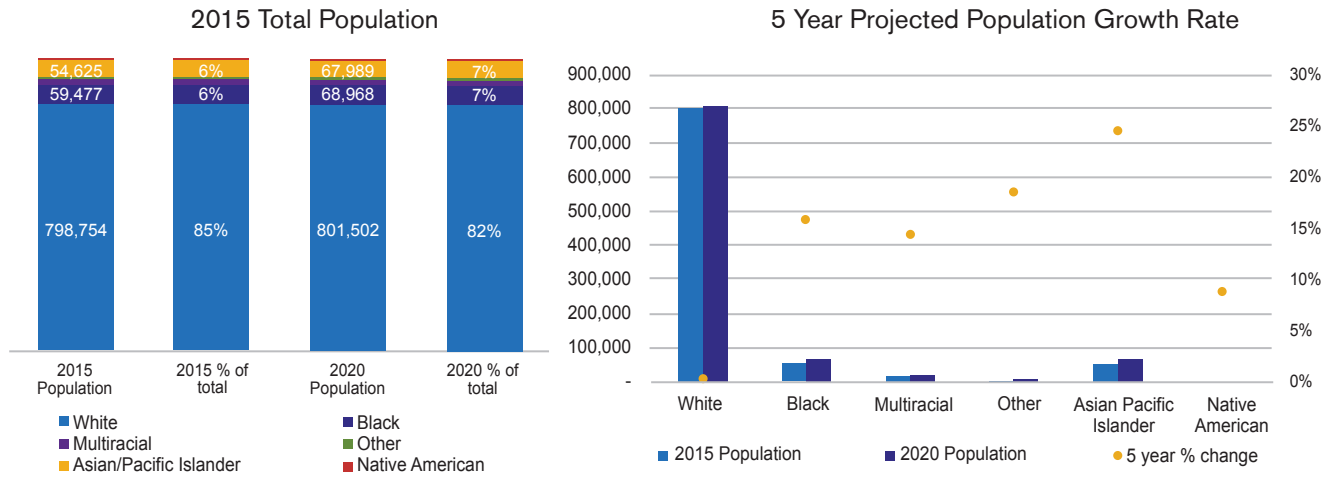


Source: Beaumont Health, 2016

The community's population is 85 percent white, 6 percent black, and 6 percent Asian Pacific Islander. Beaumont, Troy has a higher percentage of whites and Asian Pacific Islanders than both Michigan and the U.S. overall. The community is also home to a relatively large Arab population. Almost 3 percent of the community's population (24,281 lives) is of Arab ancestry. The highest proportion of Beaumont, Troy's Arab population (21.3 percent) resides in Sterling Heights (ZIP code 48310).

The community's population is expected to become increasingly diverse by 2020. With the exception of whites, which will remain relatively stable, all other racial groups are expected to increase by 15 to 25 percent. Asian Pacific Islanders will experience the most growth, increasing by almost 25 percent in the next few years.

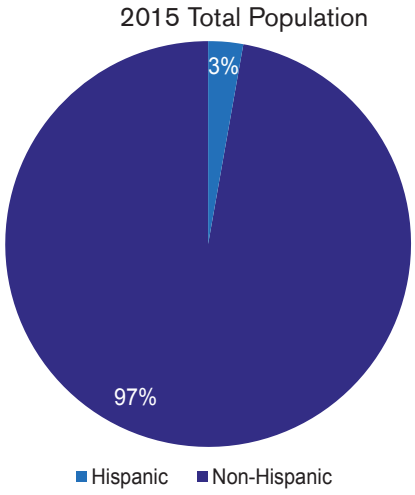
Population by Race

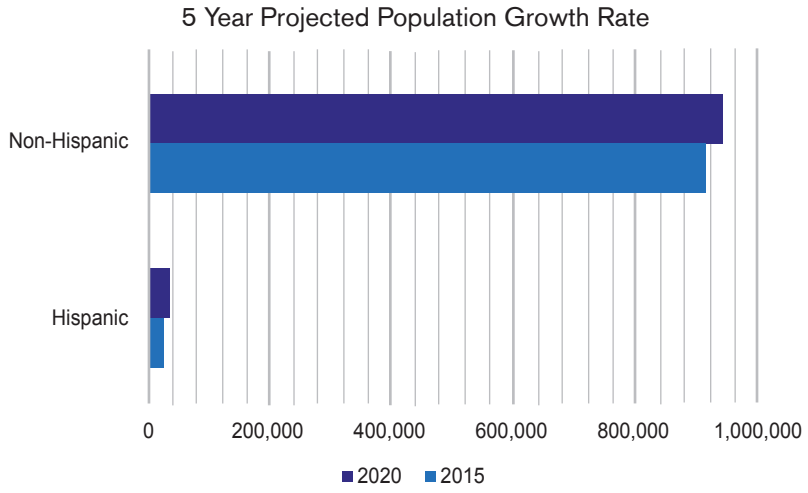


Source: Truven Health Analytics, 2016

Similar to other areas in the Beaumont community, Beaumont, Troy is predominantly non-Hispanic with only 3 percent of the population being Hispanic. In contrast to patterns seen in other communities, Beaumont, Troy is projecting an increase in both the Hispanic and non-Hispanic population over the next five years

Population by Hispanic Ethnicity





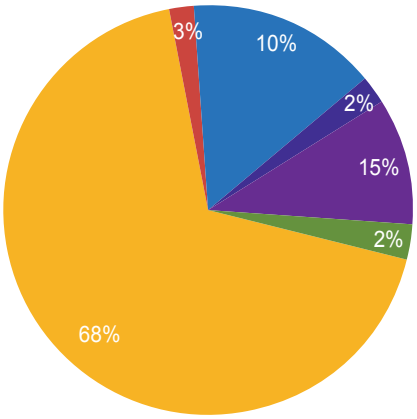
Source: Truven Health Analytics, 2016

Compared to state and national estimates, the community has a higher proportion of privately insured people and a lower proportion of people with Medicaid coverage. Sixty-seven percent of Beaumont, Troy's population has private insurance, 15 percent has Medicare, and only 13 percent is covered by Medicaid. Beaumont, Troy is the only community of the eight comprising Beaumont's overall community with a larger number of people covered by Medicare than Medicaid.

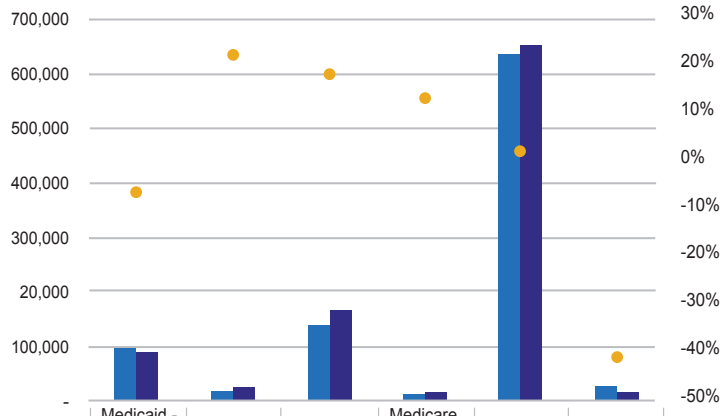
Beaumont, Troy's privately insured and Medicare populations are expected to increase in the next five years. The Medicare population will experience the greatest growth and is projected to increase by almost 20 percent. These changes in insurance coverage are most likely due to a growing number of people purchasing insurance via PPACA health insurance exchanges and an aging population.

Estimated Covered Lives by Insurance Category

2015 Total Population



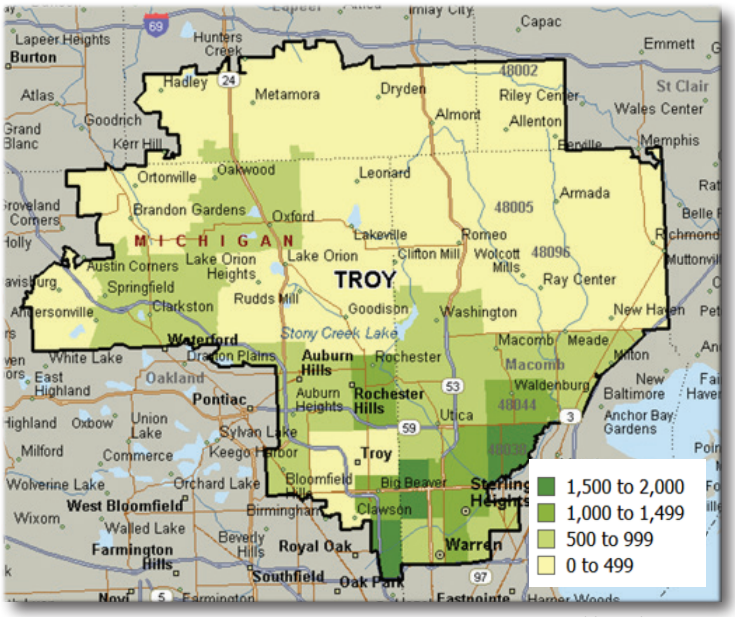
5 Year Projected Population Growth Rate



	Medicaid - Pre Reform	Medicaid Expansion	Medicare	Medicare Dual Eligible	Private	Uninsured
2015 Covered Lives	97,808	22,343	140,648	14,780	636,917	30,376
2020 Covered Lives	91,806	27,418	166,944	16,783	651,973	18,052
5 year % change	-6%	23%	19%	14%	2%	-41%

Source: Truven Health Analytics, 2016

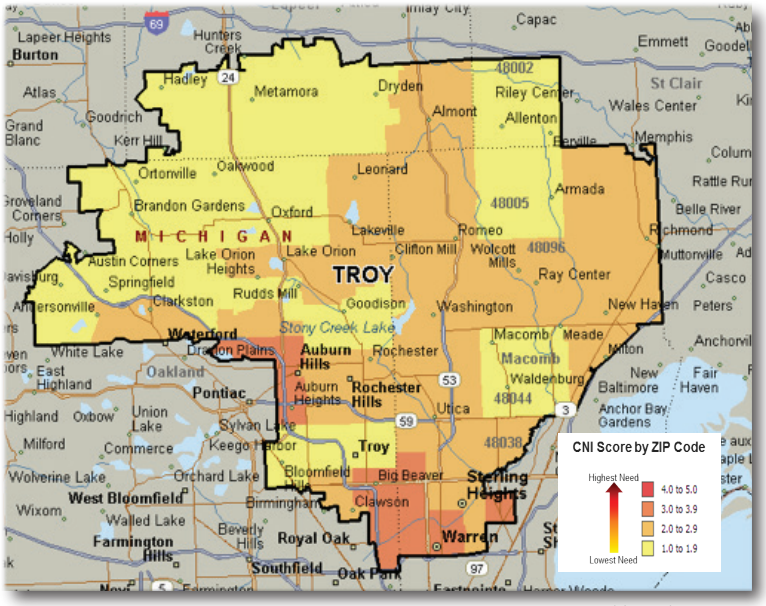
2015 Estimated Uninsured Lives by ZIP Code



Source: Truven Health Analytics, 2016

Only 3 percent of the community's population is uninsured, making it the community within Beaumont's overall community with the lowest proportion of uninsured residents. The uninsured population is expected to decrease by 44 percent in the next five years.

2015 Community Need Index by ZIP Code



Source: Truven Health Analytics, 2016

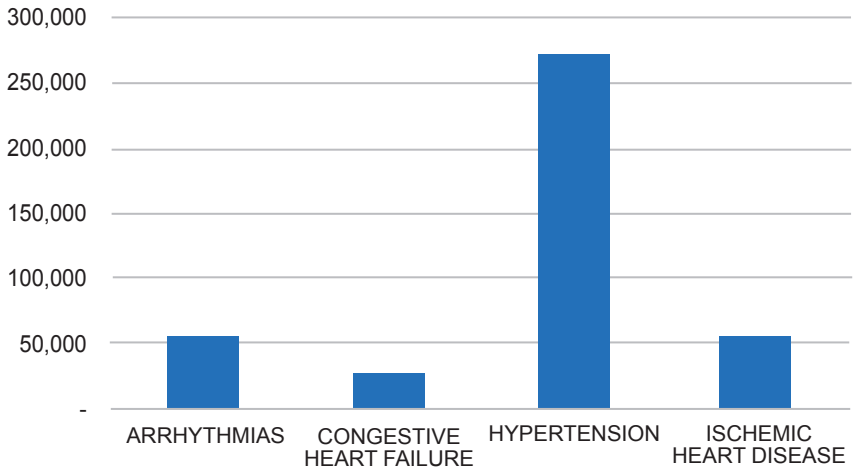
Beaumont, Troy has the lowest CNI score of any Beaumont hospital community with a score of only 2.4. The majority of the community is anticipated to have relatively low need (CNI score <3), however, scores appear to be elevated in the areas surrounding Warren and Auburn Hills.

Truven Health community data

Truven Health Analytics supplemented the publically available data with estimates of localized disease prevalence of heart disease and cancer as well as emergency department visit estimates.

Unsurprisingly, hypertension is the most prevalent heart disease in the community and accounts for 67 percent of new heart disease cases. New hypertension cases are particularly high in the Macomb area (ZIP 48044) with 14,626 new cases in 2015.

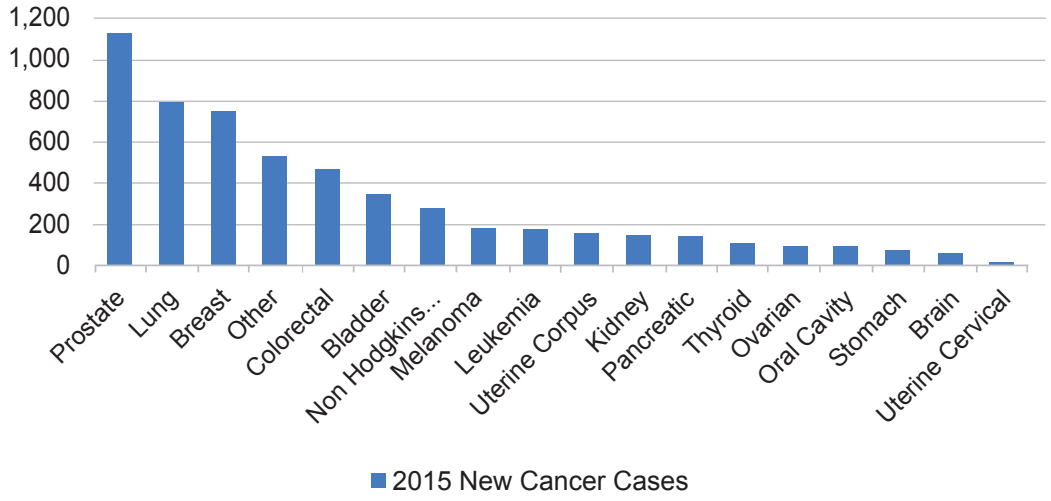
2015 Estimated Heart Disease Cases



Source: Truven Health Analytics, 2016

Compared to state and national estimates, Beaumont, Troy has a higher proportion of new prostate and lung cancer cases and a lower proportion of new colorectal cancer cases. Prostate, lung and breast cancer were the three most commonly diagnosed cancers in 2015.

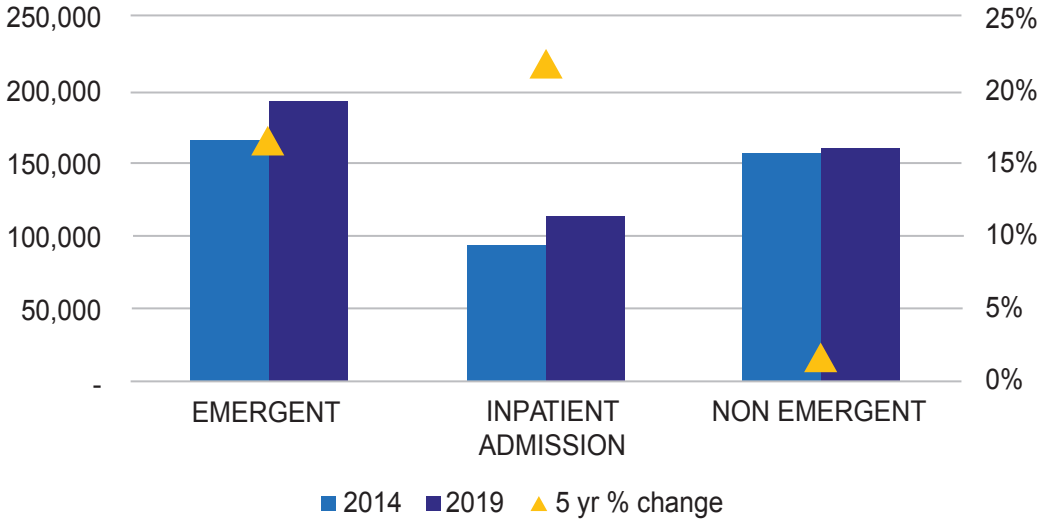
2015 Estimated New Cancer Cases



Source: Truven Health Analytics, 2016

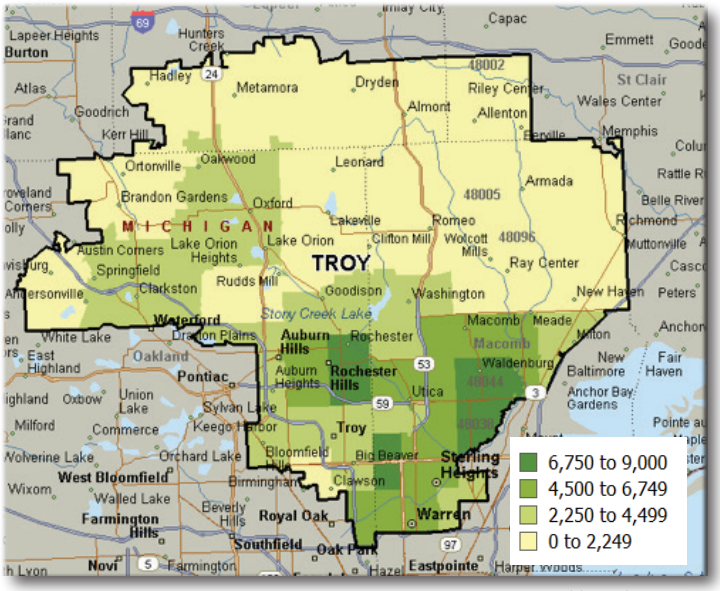
Emergent ED visits in the community are projected to increase 16 percent by 2019, while non-emergent ED visits will increase less than 2 percent.

Emergent and Non-Emergent ED Visits



Source: Truven Health Analytics, 2016

2014 Estimated Non-Emergent Visits by ZIP Code



Source: Truven Health Analytics, 2016

Macomb (ZIP code 48044) has the highest number of non-emergent ED visits and accounts for 5 percent of the total non-emergent ED visits in the community. Non-emergent, ED visits are lower acuity visits that present in the ED but possibly can be treated in other more appropriate, less intensive outpatient settings. Non-emergent ED visits can be an indication that there are systematic issues with access to primary care or managing chronic conditions.

Community input

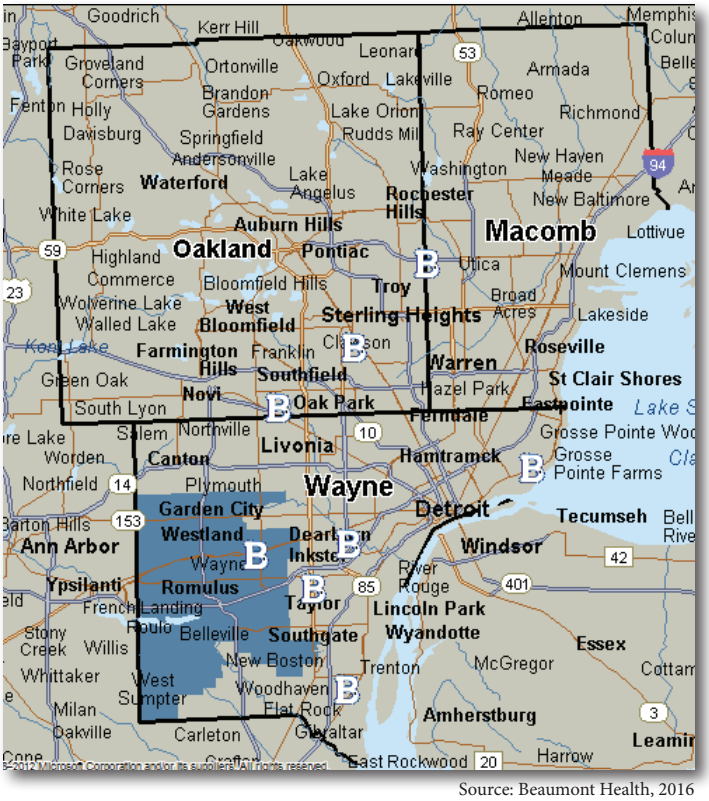
A summary of the focus group conducted for the Beaumont, Troy community can be found in **Appendix I**.

BEAUMONT HOSPITAL, WAYNE

Beaumont Hospital, Wayne (formerly Oakwood Hospital – Wayne) opened its doors to western Wayne County in 1957. This 185-bed, full-service hospital offers high-quality care to the community with compassionate service and state-of-the-art technology. Beaumont Hospital, Wayne is the only hospital in the Wayne, Westland, Garden City, Inkster, and Romulus area that is verified by the American College of Surgeons as a Level III Trauma Center providing prompt assessment, resuscitation, surgery, intensive care and stabilization of injured patients. It also has a dedicated hospice and palliative care unit in partnership with Hospice of Michigan. As the closest hospital to Detroit Metropolitan Airport, Beaumont Hospital, Wayne is prepared to handle a wide variety of health and communicable disease concerns in addition to mass trauma and emergency patients.

Community served

The Beaumont Hospital, Wayne community (Beaumont, Wayne) is defined as the contiguous ZIP codes that comprise 80 percent of inpatient discharges. To the right is a map that highlights the community served (in blue) as a portion of the overall Beaumont community. A table which lists the ZIP codes included in the community definition can be found in **Appendix B**.

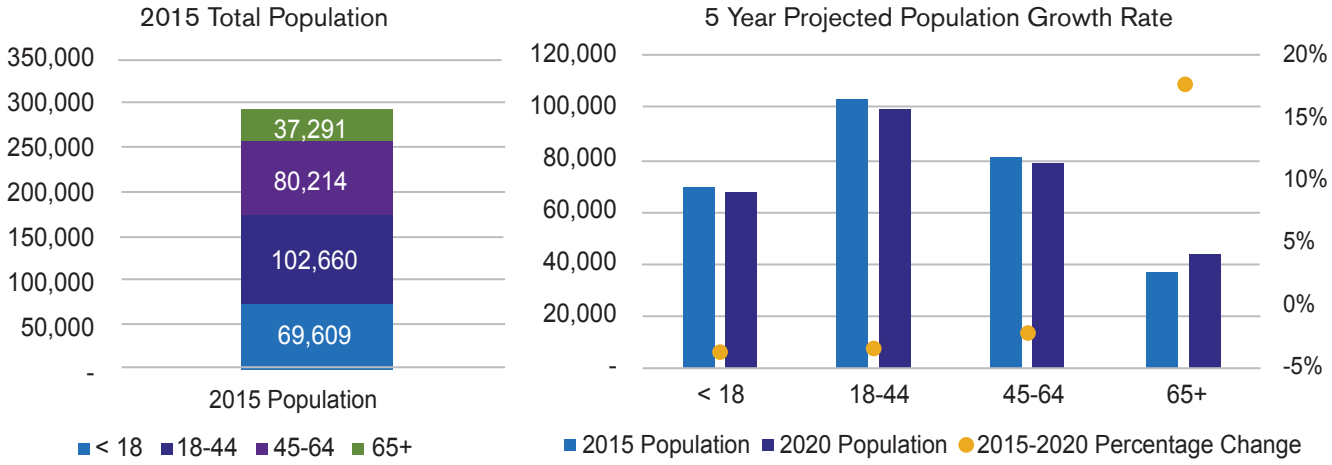


Source: Beaumont Health, 2016

Demographic and socio-economic summary

In contrast to other areas in Beaumont's overall community, Beaumont, Wayne's population will decrease less than 1 percent over the next five years. The community's age distribution is fairly similar to the state and country. The community has a lower percentage of people who are 65+ compared to the state and national levels, however, this group is the only one which is expected to grow in the next five years (+18 percent).

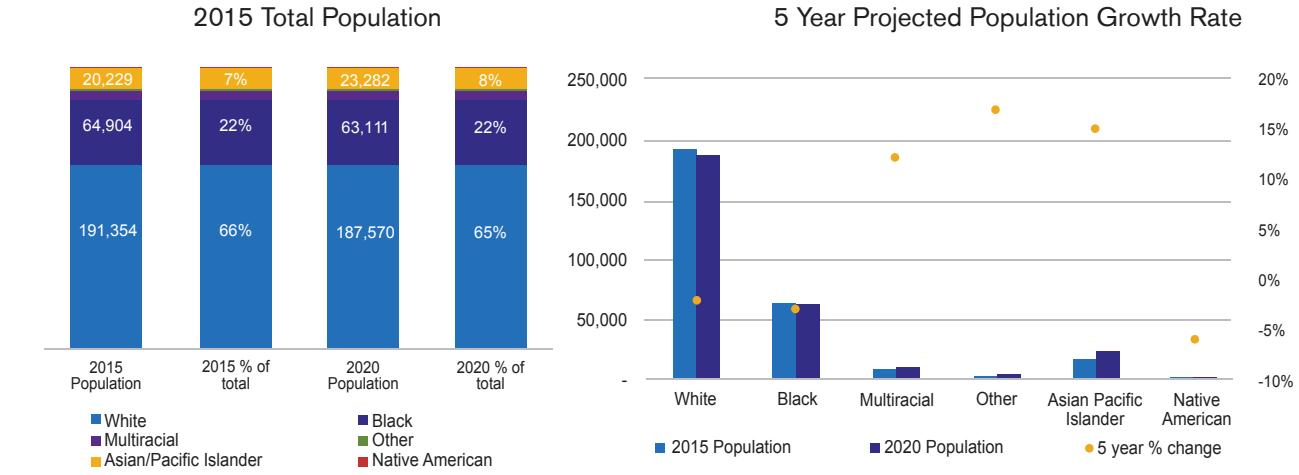
Population by Age Cohort



Source: Truven Health Analytics, 2016

The majority of Beaumont, Wayne's population is white (66 percent). Compared to the state and national levels and other Beaumont communities, this population is more diverse. Twenty-two percent of Beaumont, Wayne's population is black and 7 percent is Asian Pacific Islander. The other, Asian Pacific Islander, and multiracial communities in Wayne are projected to increase in the next five years.

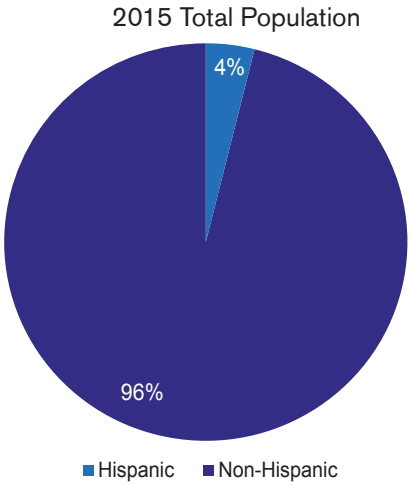
Population by Race

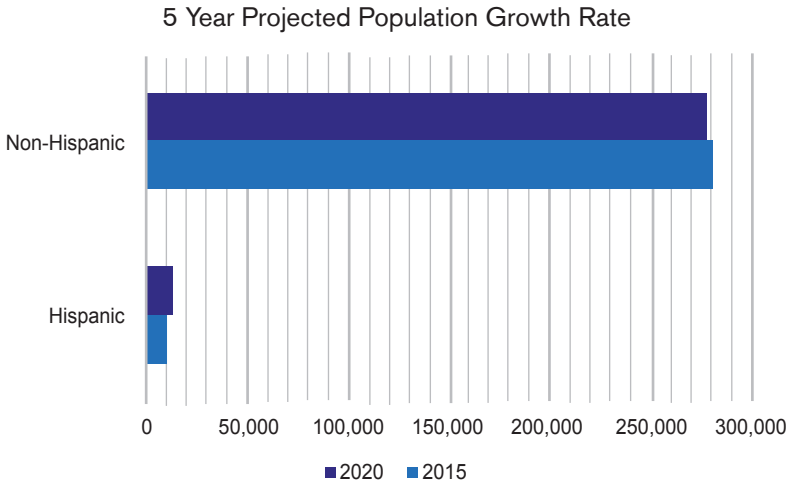


Source: Truven Health Analytics, 2016

Beaumont, Wayne is largely non-Hispanic, with only 4 percent of the community's population being Hispanic. The Hispanic population is expected to grow slightly over the next five years, while the non-Hispanic population will experience a slight decrease.

Population by Hispanic Ethnicity





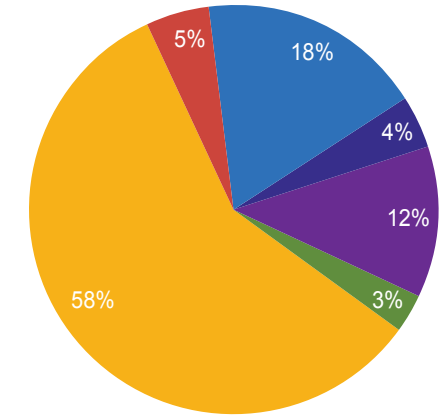
Source: Truven Health Analytics, 2016

Beaumont, Wayne shows a similar insurance type distribution among its population as Michigan and the U.S. Fifty-six percent of the community's population is privately insured. This includes people who are purchasing health insurance through the insurance exchange marketplace (5 percent), those who are buying directly from an insurance provider (4 percent), and those who receive insurance through an employer (49 percent). Twelve percent of the population is covered by Medicare and 22 percent is covered by Medicaid.

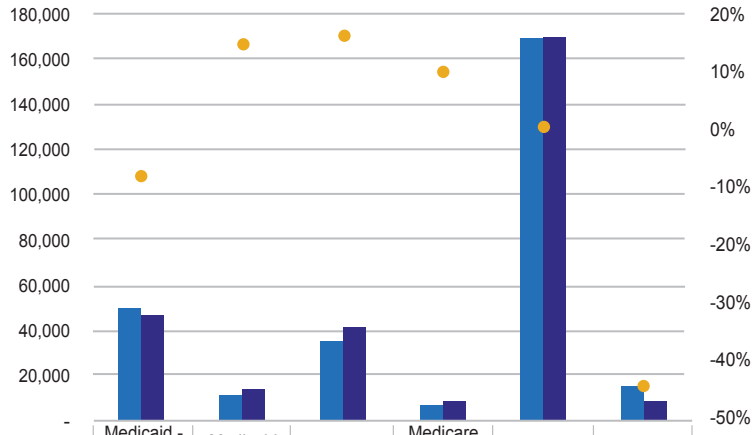
The Medicare population will experience the greatest growth and is expected to increase 16 percent by 2020. This is primarily fueled by a growing 65 and older population in the community. The private insurance category is also projected to increase, though minimally. The number of people purchasing insurance via PPACA health insurance exchanges is projected to increase by 81 percent, driving most of the growth. Overall, the Medicaid population will decrease by 3 percent, but the number of people receiving Medicaid coverage due to the PPACA Medicaid expansion will increase by 15 percent.

Estimated Covered Lives by Insurance Category

2015 Total Population



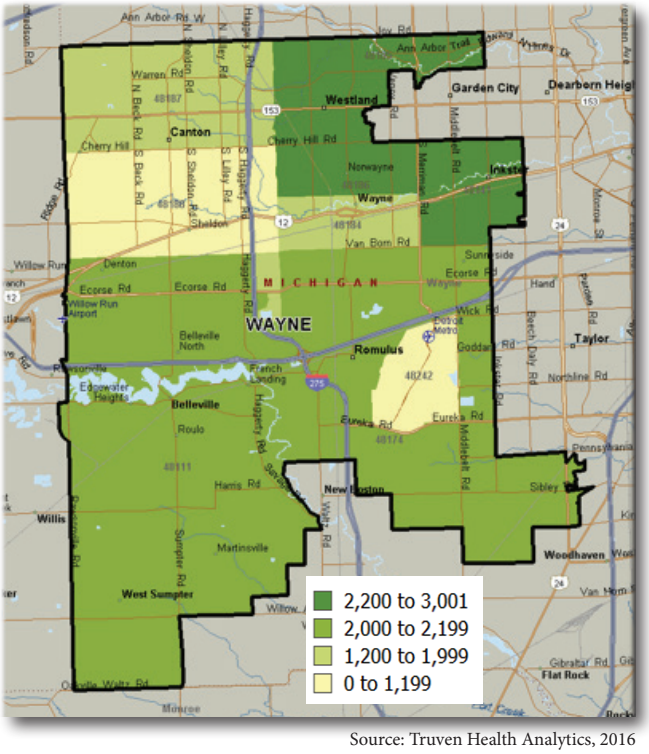
5 Year Projected Population Growth Rate



	Medicaid - Pre Reform	Medicaid Expansion	Medicare	Medicare Dual Eligible	Private	Uninsured
2015 Covered Lives	50,672	12,068	35,618	7,220	168,784	15,412
2020 Covered Lives	46,724	13,822	41,333	7,974	170,301	8,655
5 year % change	-8%	15%	16%	10%	1%	-44%

Source: Truven Health Analytics, 2016

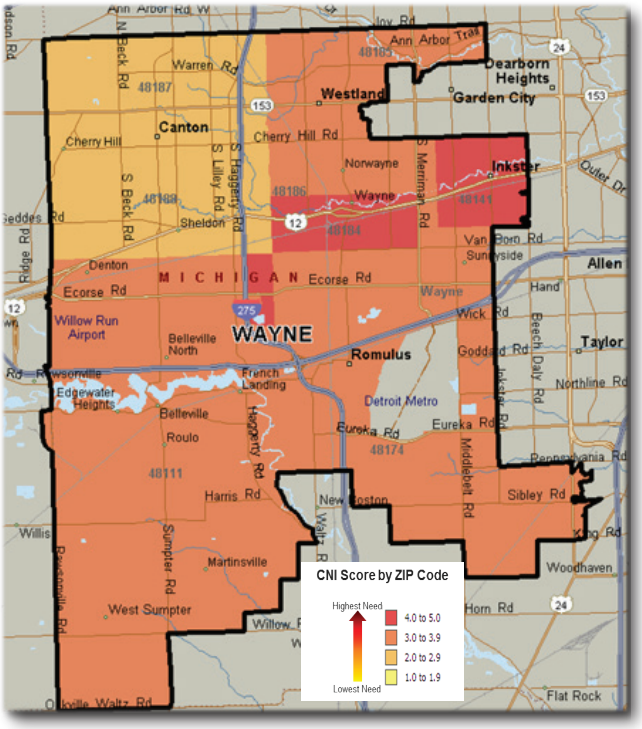
2015 Estimated Uninsured Lives by ZIP Code



Source: Truven Health Analytics, 2016

The majority of Beaumont, Wayne's population is insured. Only 5 percent of the community lacks insurance and this number is expected to decrease by 44 percent in the upcoming years. Westland and Inkster are home to the highest number of uninsured people in the community.

2015 Community Need Index by ZIP Code



Source: Truven Health Analytics, 2016

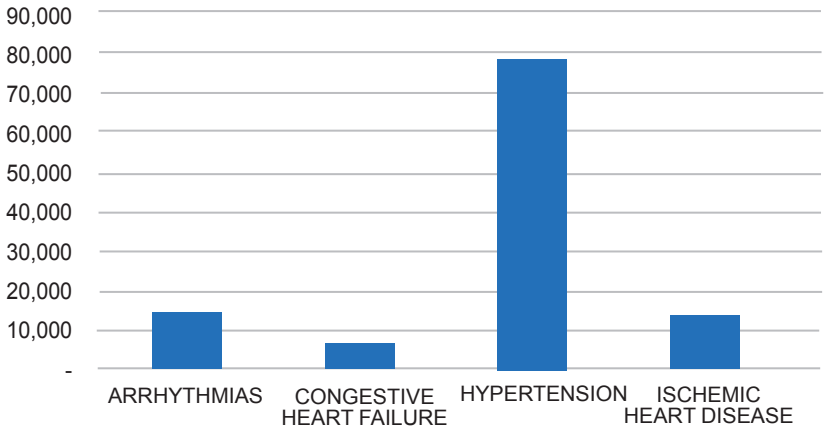
Beaumont, Wayne has an overall CNI score of 3.3, placing it in the mid-range of Beaumont's eight hospital communities. There are potentially higher levels of need across most of the community, with Inkster and Wayne having the highest CNI scores. Canton appears to be the only area in the community with lower levels of anticipated need (CNI score= <2).

Truven Health community data

Truven Health Analytics supplemented the publicly available data with estimates of localized disease prevalence of heart disease and cancer as well as emergency department visit estimates.

Hypertension is the most prevalent heart disease in the community and accounts for 68 percent of new heart disease cases. New hypertension and arrhythmia cases are particularly high in the Belleville area (ZIP code 48111).

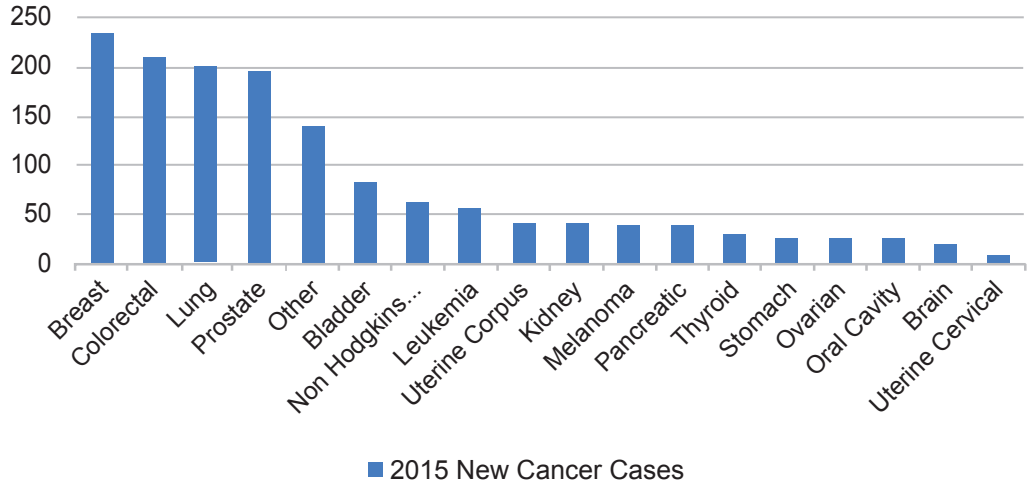
2015 Estimated Heart Disease Cases



Source: Truven Health Analytics, 2016

Compared to state and national estimates, Beaumont, Wayne has a higher proportion of new breast and colorectal cancer cases and a lower proportion of new prostate cancer cases. Breast, colorectal and lung cancer were the three most commonly diagnosed cancers in 2015.

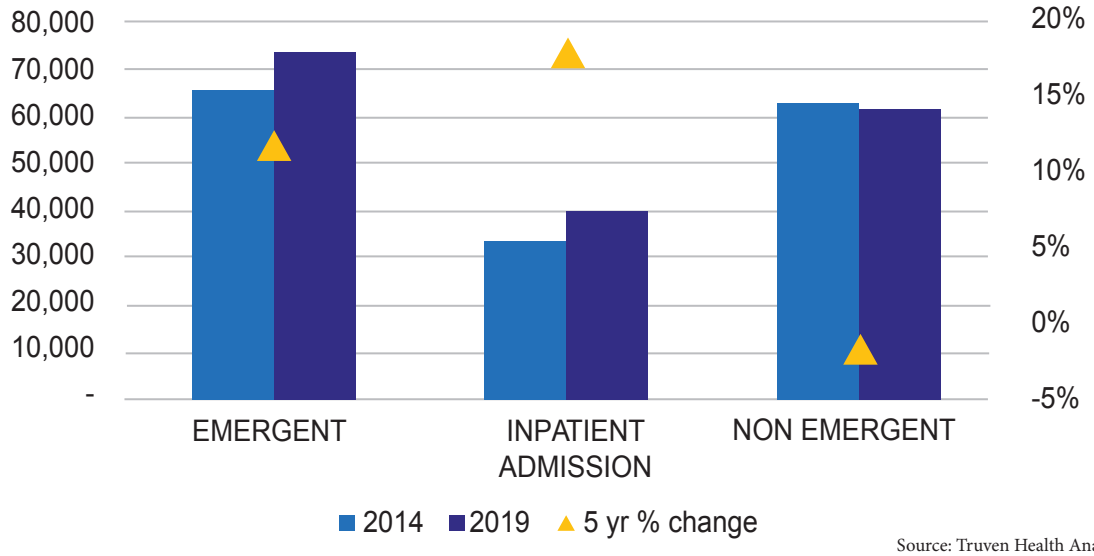
2015 Estimated New Cancer Cases



Source: Truven Health Analytics, 2016

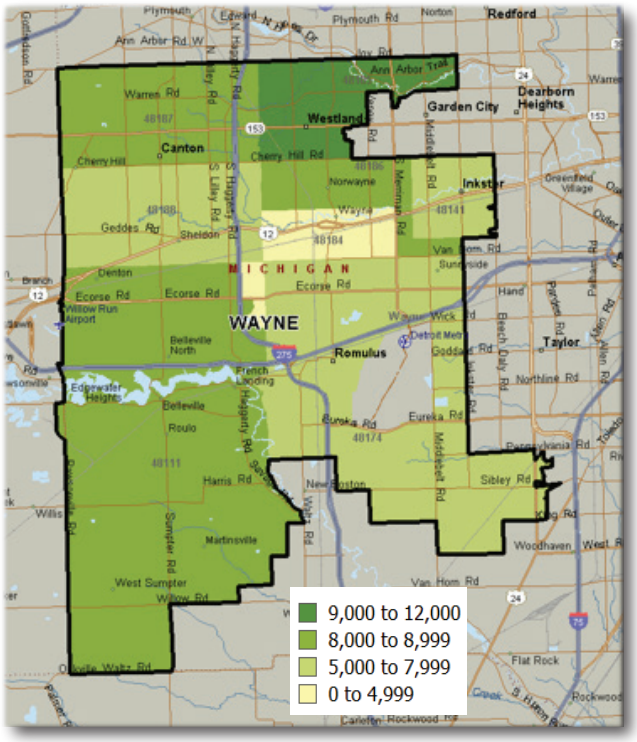
Emergent ED visits in the community are projected to increase 12 percent by 2019, while non-emergent ED visits will decrease by 2 percent.

Emergent and Non-Emergent ED Visits



Source: Truven Health Analytics, 2016

2014 Estimated Non-Emergent Visits by ZIP Code



Source: Truven Health Analytics, 2016

Belleville (ZIP code 48111) has the highest number of non-emergent ED visits and accounts for almost 25 percent of the total non-emergent ED visits in the area. Non-emergent, ED visits are lower acuity visits that present in the ED but possibly can be treated in other more appropriate, less intensive outpatient settings. Non-emergent ED visits can be an indication that there are systematic issues with access to primary care or managing chronic conditions.

Community input

A summary of the focus group conducted for the Beaumont, Wayne community can be found in **Appendix I**.

APPENDIX A

Beaumont Health CHNA Steering Committee

EXECUTIVE SPONSOR
Mary Zatina, SVP Government Relations & Community Affairs

PROJECT MANAGER
Betty Priskorn, VP Community Health & Outreach

PROJECT COORDINATOR
Lindsey West, Director Community Health & Outreach

STEERING COMMITTEE MEMBERS

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Foundation, Beaumont Health

Sally Bailey
Administration
Beaumont, Wayne

Suzy Berschback
Community Relations
Beaumont Health

Jeri Davis
Administration
Beaumont, Farmington Hills

Maureen Elliot
Community Relations
Beaumont Health

Susan Grant
Exec. VP & Chief Nursing Officer
Beaumont Health

Jacklyn McParlane, DO
Emergency Medicine
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Julie Kitchen
Community Relations
Beaumont Health

Naren Kumar
Administration
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Christine Kupovits
Administration
Beaumont, Dearborn

Steve Le Moine
Administration
Beaumont, Dearborn

Alonzo Lewis
Administration
Beaumont, Royal Oak

Judith McNeeley
Corporate & Community Partnerships
Beaumont Health

Christine Stesney-Ridenour
President
Beaumont, Trenton

Anne Nearhood
Community Health & Outreach
Beaumont, Grosse Pointe

Lee Ann Odom
President
Beaumont, Taylor

Constance O'Malley
President
Beaumont, Farmington Hills

Joan Phillips
Administration
Beaumont, Troy

Caroline Schairer
Community Health & Outreach
Beaumont, Farmington Hills

Mary Stahl
Quality Improvement
Oakwood ACO

Nancy Susick
President
Beaumont, Troy

Richard Swaine
President
Beaumont, Grosse Pointe

Peter Tucker, MD
Family Medicine
Beaumont, Royal Oak

Carolyn Wilson
Exec. VP & COO
Beaumont Health

Karen Wright
Strategic Planning
Beaumont Health

ZIP	Dominant County	Post Office Name	Beaumont Overall	Dearborn	Farmington Hills	Grosse Pointe	Royal Oak	Taylor	Trenton	Troy	Wayne
48002	St. Clair County, MI	Allenton								X	
48003	Lapeer County, MI	Almont					X			X	
48005	Macomb County, MI	Armada	X							X	
48009	Oakland County, MI	Birmingham	X				X				
48015	Macomb County, MI	Center Line	X				X				
48017	Oakland County, MI	Clawson	X				X			X	
48021	Macomb County, MI	Eastpointe	X			X					
48025	Oakland County, MI	Franklin	X				X				
48026	Macomb County, MI	Fraser	X			X				X	
48030	Oakland County, MI	Hazel Park	X				X				
48033	Oakland County, MI	Southfield	X		X		X				
48034	Oakland County, MI	Southfield	X		X		X				
48035	Macomb County, MI	Clinton Township	X			X					
48036	Macomb County, MI	Clinton Township	X								
48038	Macomb County, MI	Clinton Township	X							X	
48042	Macomb County, MI	Macomb	X				X			X	
48043	Macomb County, MI	Mount Clemens	X								
48044	Macomb County, MI	Macomb	X				X			X	
48045	Macomb County, MI	Harrison Township	X			X					
48047	Macomb County, MI	New Baltimore	X								
48048	Macomb County, MI	New Haven	X							X	
48050	Macomb County, MI	New Haven	X							X	
48051	Macomb County, MI	New Baltimore	X							X	
48062	Macomb County, MI	Richmond	X							X	
48065	Macomb County, MI	Romeo	X							X	
48066	Macomb County, MI	Roseville	X			X					
48067	Oakland County, MI	Royal Oak	X				X				
48069	Oakland County, MI	Pleasant Ridge	X				X				
48070	Oakland County, MI	Huntington Woods	X				X				
48071	Oakland County, MI	Madison Heights	X				X			X	
48072	Oakland County, MI	Berkley	X				X				
48073	Oakland County, MI	Royal Oak	X				X				
48075	Oakland County, MI	Southfield	X		X		X				
48076	Oakland County, MI	Southfield	X				X				

APPENDIX B

Community Served Definition

ZIP	Dominant County	Post Office Name	Beaumont Overall	Dearborn	Farmington Hills	Grosse Pointe	Royal Oak	Taylor	Trenton	Troy	Wayne
48080	Macomb County, MI	Saint Clair Shores	X			X					
48081	Macomb County, MI	Saint Clair Shores	X			X					
48082	Macomb County, MI	Saint Clair Shores	X			X					
48083	Oakland County, MI	Troy	X				X			X	
48084	Oakland County, MI	Troy	X				X			X	
48085	Oakland County, MI	Troy	X				X			X	
48088	Macomb County, MI	Warren	X			X	X			X	
48089	Macomb County, MI	Warren	X			X	X				
48091	Macomb County, MI	Warren	X				X				
48092	Macomb County, MI	Warren	X				X			X	
48093	Macomb County, MI	Warren	X			X	X			X	
48094	Macomb County, MI	Washington	X				X			X	
48095	Macomb County, MI	Washington	X				X			X	
48096	Macomb County, MI	Ray	X				X			X	
48098	Oakland County, MI	Troy	X				X			X	
48101	Wayne County, MI	Allen Park	X	X				X			
48111	Wayne County, MI	Belleville	X	X				X			X
48117	Monroe County, MI	Carleton							X		
48120	Wayne County, MI	Dearborn	X	X							
48122	Wayne County, MI	Melvindale	X	X							
48124	Wayne County, MI	Dearborn	X	X				X			
48125	Wayne County, MI	Dearborn Heights	X	X				X			
48126	Wayne County, MI	Dearborn	X	X				X			
48127	Wayne County, MI	Dearborn Heights	X	X	X			X			
48128	Wayne County, MI	Dearborn	X	X				X			
48134	Wayne County, MI	Flat Rock	X						X		
48135	Wayne County, MI	Garden City	X	X	X						
48138	Wayne County, MI	Grosse Ile	X						X		
48141	Wayne County, MI	Inkster	X	X	X			X			X
48146	Wayne County, MI	Lincoln Park	X	X				X	X		
48150	Wayne County, MI	Livonia	X		X						
48152	Wayne County, MI	Livonia	X		X		X				
48154	Wayne County, MI	Livonia	X		X		X				
48164	Wayne County, MI	New Boston	X						X		
48165	Oakland County, MI	New Hudson	X								

ZIP	Dominant County	Post Office Name	Beaumont Overall	Dearborn	Farmington Hills	Grosse Pointe	Royal Oak	Taylor	Trenton	Troy	Wayne
48166	Monroe County, MI	Newport							X		
48167	Oakland County, MI	Northville	X		X		X				
48168	Wayne County, MI	Northville	X				X				
48170	Wayne County, MI	Plymouth	X		X						
48173	Wayne County, MI	Rockwood	X						X		
48174	Wayne County, MI	Romulus	X	X				X			X
48178	Oakland County, MI	South Lyon	X								
48179	Monroe County, MI	South Rockwood							X		
48180	Wayne County, MI	Taylor	X	X	X			X	X		
48183	Wayne County, MI	Trenton	X	X				X	X		
48184	Wayne County, MI	Wayne	X					X			X
48185	Wayne County, MI	Westland	X	X	X						X
48186	Wayne County, MI	Westland	X	X	X			X			X
48187	Wayne County, MI	Canton	X								X
48188	Wayne County, MI	Canton	X								X
48192	Wayne County, MI	Wyandotte	X	X					X		
48193	Wayne County, MI	Riverview	X	X				X	X		
48195	Wayne County, MI	Southgate	X	X				X	X		
48201	Wayne County, MI	Detroit	X								
48202	Wayne County, MI	Detroit	X								
48203	Wayne County, MI	Highland Park	X				X				
48204	Wayne County, MI	Detroit	X		X						
48205	Wayne County, MI	Detroit	X			X					
48206	Wayne County, MI	Detroit	X								
48207	Wayne County, MI	Detroit	X			X					
48208	Wayne County, MI	Detroit	X								
48209	Wayne County, MI	Detroit	X	X							
48210	Wayne County, MI	Detroit	X	X							
48211	Wayne County, MI	Detroit	X								
48212	Wayne County, MI	Hamtramck	X								
48213	Wayne County, MI	Detroit	X			X					
48214	Wayne County, MI	Detroit	X			X					
48215	Wayne County, MI	Detroit	X			X					
48216	Wayne County, MI	Detroit	X	X							
48217	Wayne County, MI	Detroit	X	X							

APPENDIX B

Community Served Definition

ZIP	Dominant County	Post Office Name	Beaumont Overall	Dearborn	Farmington Hills	Grosse Pointe	Royal Oak	Taylor	Trenton	Troy	Wayne
48218	Wayne County, MI	River Rouge	X	X							
48219	Wayne County, MI	Detroit	X		X		X				
48220	Oakland County, MI	Ferndale	X				X				
48221	Wayne County, MI	Detroit	X		X		X				
48223	Wayne County, MI	Detroit	X		X		X				
48224	Wayne County, MI	Detroit	X			X					
48225	Wayne County, MI	Harper Woods	X			X					
48226	Wayne County, MI	Detroit	X								
48227	Wayne County, MI	Detroit	X		X						
48228	Wayne County, MI	Detroit	X	X	X			X			
48229	Wayne County, MI	Ecorse	X	X							
48230	Wayne County, MI	Grosse Pointe	X			X					
48234	Wayne County, MI	Detroit	X								
48235	Wayne County, MI	Detroit	X		X		X				
48236	Wayne County, MI	Grosse Pointe	X			X					
48237	Oakland County, MI	Oak Park	X		X		X				
48238	Wayne County, MI	Detroit	X		X		X				
48239	Wayne County, MI	Redford	X		X		X				
48240	Wayne County, MI	Redford	X		X		X				
48242	Wayne County, MI	Detroit	X					X			X
48301	Oakland County, MI	Bloomfield Hills	X				X				
48302	Oakland County, MI	Bloomfield Hills	X				X				
48304	Oakland County, MI	Bloomfield Hills	X				X			X	
48306	Oakland County, MI	Rochester	X				X			X	
48307	Oakland County, MI	Rochester	X				X			X	
48309	Oakland County, MI	Rochester	X				X			X	
48310	Macomb County, MI	Sterling Heights	X				X			X	
48312	Macomb County, MI	Sterling Heights	X				X			X	
48313	Macomb County, MI	Sterling Heights	X				X			X	
48314	Macomb County, MI	Sterling Heights	X				X			X	
48315	Macomb County, MI	Utica	X				X			X	
48316	Macomb County, MI	Utica	X				X			X	
48317	Macomb County, MI	Utica	X				X			X	
48320	Oakland County, MI	Keego Harbor	X				X				
48322	Oakland County, MI	West Bloomfield	X				X				
48323	Oakland County, MI	West Bloomfield	X				X				
48324	Oakland County, MI	West Bloomfield	X				X				
48326	Oakland County, MI	Auburn Hills	X				X			X	

ZIP	Dominant County	Post Office Name	Beaumont Overall	Dearborn	Farmington Hills	Grosse Pointe	Royal Oak	Taylor	Trenton	Troy	Wayne
48327	Oakland County, MI	Waterford	X				X				
48328	Oakland County, MI	Waterford	X				X				
48329	Oakland County, MI	Waterford	X				X				
48331	Oakland County, MI	Farmington	X		X		X				
48334	Oakland County, MI	Farmington	X		X		X				
48335	Oakland County, MI	Farmington	X		X		X				
48336	Oakland County, MI	Farmington	X		X		X				
48340	Oakland County, MI	Pontiac	X				X				
48341	Oakland County, MI	Pontiac	X				X				
48342	Oakland County, MI	Pontiac	X				X				
48346	Oakland County, MI	Clarkston	X				X			X	
48348	Oakland County, MI	Clarkston	X				X			X	
48350	Oakland County, MI	Davisburg	X				X			X	
48356	Oakland County, MI	Highland	X				X				
48357	Oakland County, MI	Highland	X				X				
48359	Oakland County, MI	Lake Orion	X				X			X	
48360	Oakland County, MI	Lake Orion	X				X			X	
48362	Oakland County, MI	Lake Orion	X				X			X	
48363	Oakland County, MI	Oakland	X				X			X	
48367	Oakland County, MI	Leonard	X				X			X	
48370	Oakland County, MI	Oxford	X				X			X	
48371	Oakland County, MI	Oxford	X				X			X	
48374	Oakland County, MI	Novi	X				X				
48375	Oakland County, MI	Novi	X		X		X				
48377	Oakland County, MI	Novi	X		X		X				
48380	Oakland County, MI	Milford	X				X				
48381	Oakland County, MI	Milford	X				X				
48382	Oakland County, MI	Commerce Township	X				X				
48383	Oakland County, MI	White Lake	X				X				
48386	Oakland County, MI	White Lake	X				X				
48390	Oakland County, MI	Walled Lake	X				X				
48393	Oakland County, MI	Wixom	X				X				
48428	Lapeer County, MI	Dryden					X			X	
48438	Genesee County, MI	Goodrich					X				
48442	Oakland County, MI	Holly	X								
48455	Lapeer County, MI	Metamora								X	
48462	Oakland County, MI	Ortonville	X				X			X	

APPENDIX C

Key Health Indicator Sources

Indicator Category	Indicator	Source
Cancer	Breast Cancer Incidence	MI Department of Health and Human Services (MI Community Health Information)
Cancer	Breast Cancer Screening	MI Department of Health and Human Services (MBRFS)
Cancer	Cancer Diagnosis (all causes)	MI Department of Health and Human Services (MBRFS)
Cancer	Cervical Cancer Screening	MI Department of Health and Human Services (MBRFS)
Cancer	Colon Cancer Incidence	MI Department of Health and Human Services (MI Community Health Information)
Cancer	Colorectal Cancer Screening	MI Department of Health and Human Services (MBRFS)
Cancer	Discharge Rate: Cancer (Malignant Neoplasms)	MI Department of Health and Human Services (MI Community Health Information)
Cancer	Lung Cancer Incidence	MI Department of Health and Human Services (MI Community Health Information)
Cancer	Overall Cancer Death Rate	National Vital Statistics System-Mortality (CDC, NCHS)
Cancer	Prostate Cancer Screening	MI Department of Health and Human Services (MBRFS)
Cardiovascular Conditions	Angina or Coronary Heart Disease Diagnosis	MI Department of Health and Human Services (MBRFS)
Cardiovascular Conditions	Discharge Rate: Cerebro-vascular Disease	MI Department of Health and Human Services (MI Community Health Information)
Cardiovascular Conditions	Discharge Rate: Heart Disease	MI Department of Health and Human Services (MI Community Health Information)
Cardiovascular Conditions	Heart Attack Diagnosis	MI Department of Health and Human Services (MBRFS)
Cardiovascular Conditions	Heart Disease Death Rate	National Vital Statistics System-Mortality (CDC, NCHS)
Cardiovascular Conditions	Hypertension Diagnosis	BRFSS (CDC/PHSIPO)
Cardiovascular Conditions	Stroke Death Rate	National Vital Statistics System-Mortality (CDC, NCHS)
Cardiovascular Conditions	Stroke Diagnosis	MI Department of Health and Human Services (MBRFS)
Diabetes	Diabetes Diagnosis	MI Department of Health and Human Services (MBRFS)
Diabetes	Diabetes Diagnosis Medicare Beneficiaries	CMS Chronic Condition Warehouse
Diabetes	Diabetic Monitoring	Dartmouth Atlas of Health Care
Health Status	General Health Fair or Poor	MI Department of Health and Human Services (MBRFS)
Health Status	Poor or Fair Health	Behavior Risk Factor Surveillance System (BRFSS)
Health Status	Poor Physical Health	MI Department of Health and Human Services (MBRFS)
Health Status	Poor Physical Health Days	Behavior Risk Factor Surveillance System (BRFSS)
Healthcare Access	Dentists per 100,000 Population	Area Resource File (HRSA, BHPr)
Healthcare Access	Health Care Costs	Dartmouth Atlas of Health Care
Healthcare Access	No Dental Visits in Past Year	MI Department of Health and Human Services (MBRFS)
Healthcare Access	No Health Care Access due to Cost	MI Department of Health and Human Services (MBRFS)
Healthcare Access	No Health Care Coverage	MI Department of Health and Human Services (MBRFS)
Healthcare Access	Population to Dentist Ratio	Area Health Resource File/National Provider Identification file
Healthcare Access	Population to Other Primary Care Providers Ratio	CMS, National Provider Identification Registry
Healthcare Access	Population to Primary Care Physician Ratio	Area Health Resource File/American Medical Association
Healthcare Access	Preventable Hospital Stays	Dartmouth Atlas of Health Care
Healthcare Access	Primary Care Physicians per 100,000 Population	Area Resource File (HRSA, BHPr)
Healthcare Access	Uninsured Adults	Small Area Health Insurance Estimates
Healthcare Access	Uninsured Children	Small Area Health Insurance Estimates
Healthy Lifestyle: Activity	Access to Exercise Opportunities	Business Analyst, Delorme map data, ESRI, & US Census Tigerline Files
Healthy Lifestyle: Activity	No Exercise	Health Indicators Warehouse (BRFSS)

Indicator Category	Indicator	Source
Healthy Lifestyle: Activity	Physical Inactivity	CDC Diabetes Interactive Atlas
Healthy Lifestyle: Activity	Physical Inactivity	MI Department of Health and Human Services (MiBRFS)
Healthy Lifestyle: Healthy Eating	Food Environment Index	USDA Food Environment Atlas, Map the Meal Gap from Feeding America
Healthy Lifestyle: Healthy Eating	Food Insecurity	Map the Meal Gap
Healthy Lifestyle: Healthy Eating	Limited Access to Healthy Foods	USDA Food Environment Atlas
Healthy Lifestyle: Healthy Eating	Low Daily Fruit/Vegetable Consumption	Health Indicators Warehouse (BRFSS)
Healthy Lifestyle: Other	Insufficient Sleep	Behavior Risk Factor Surveillance System (BRFSS)
HIV	HIV Prevalence	National HIV Surveillance System
Injury and Death	Discharge Rate: Injury & Poisoning	MI Department of Health and Human Services (MI Community Health Information)
Injury and Death	Fatal Injuries	Health Indicators Warehouse (CDC, NCHS)
Injury and Death	Motor Vehicle Crash Deaths	CDC WONDER
Injury and Death	Premature Death	National Center for Health Statistics-Mortality files
Injury and Death	Unintentional Injury Death Rate	National Vital Statistics System-Mortality (CDC, NCHS)
Maternal Health	Births to Mothers w/ Late or No Prenatal Care (New Birth Certificate)	MI Department of Health and Human Services (Division for Vital Records and Health Statistics)
Maternal Health	Births to Mothers Who Are Foreign Born	MI Department of Health and Human Services (Division for Vital Records and Health Statistics)
Maternal Health	Births to Mothers Who Smoked During Pregnancy (New Birth Certificate)	MI Department of Health and Human Services (Division for Vital Records and Health Statistics)
Maternal Health	Births to Mothers with No Diploma or GED	MI Department of Health and Human Services (Division for Vital Records and Health Statistics)
Maternal Health	Infant Deaths, All (per 1,000 live births)	Linked Birth/Infant Death Data Set (CDC/NCHS)
Maternal Health	Infant Mortality	MI Department of Health and Human Services (Division for Vital Records and Health Statistics)
Maternal Health	Infant Mortality by Race: Black Non-Hispanic	Linked Birth/Infant Death Data Set (CDC, NCHS)
Maternal Health	Infant Mortality by Race: Hispanic	Linked Birth/Infant Death Data Set (CDC, NCHS)
Maternal Health	Infant Mortality by Race: White Non-Hispanic	Linked Birth/Infant Death Data Set (CDC, NCHS)
Maternal Health	Low Birth Weight	MI Department of Health and Human Services (Division for Vital Records and Health Statistics)
Maternal Health	Low Birthweight	National Center for Health Statistics-Natality files
Maternal Health	Medicaid Paid Births	MI Department of Health and Human Services (Division for Vital Records and Health Statistics)
Maternal Health	Preterm Births	MI Department of Health and Human Services (Division for Vital Records and Health Statistics)
Maternal Health	Very Low Birth Weight	Centers for Disease Control and Prevention (National Center for Health Statistics
Mental Health	Depression	MI Department of Health and Human Services (MiBRFS)
Mental Health	Discharge Rate: Psychoses	MI Department of Health and Human Services (MI Community Health Information)
Mental Health	Lack of Social and Emotional Support	Health Indicators Warehouse (BRFSS)
Mental Health	Poor Mental Health Days	MI Department of Health and Human Services (MiBRFS)
Mental Health	Population to Mental Health Provider Ratio	CMS, National Provider Identification Registry
Mental Health	Social Associations	County Business Patterns
Mental Health	Suicide Rate	NVSS-M (CDC, NCHS)
Obesity	Adult Obesity	MI Department of Health and Human Services (MiBRFS)
Obesity	Adult Obesity	CDC Diabetes Interactive Atlas
Obesity	Children and Adolescents Considered Obese	Youth Risk Behavior Surveillance System (YRBSS)
Other Conditions	Arthritis Diagnosis	MI Department of Health and Human Services (MiBRFS)
Other Conditions	Discharge Rate: Osteo-arthrosis & Allied Disorders	MI Department of Health and Human Services (MI Community Health Information)
Other Conditions	Discharge Rate: Septicemia	MI Department of Health and Human Services (MI Community Health Information)
Other Conditions	Kidney Disease Diagnosis	MI Department of Health and Human Services (MiBRFS)

Indicator Category	Indicator	Source
Prevention: Other	Seatbelt Use	MI Department of Health and Human Services (MiBRFS)
Prevention: Screenings & Vaccinations	Flu Vaccine	MI Department of Health and Human Services (MiBRFS)
Prevention: Screenings & Vaccinations	HIV Screening	MI Department of Health and Human Services (MiBRFS)
Prevention: Screenings & Vaccinations	No Routine Checkup in Past Year	MI Department of Health and Human Services (MiBRFS)
Prevention: Screenings & Vaccinations	Pneumonia Vaccine	MI Department of Health and Human Services (MiBRFS)
Respiratory Conditions	Air Pollution Ozone Days	PHASE (CDC, EPA, CDC/NCEH, CDC and EPA
Respiratory Conditions	Chronic Lower Respiratory Disease (CLRD) Death Rate	National Vital Statistics System-Mortality (CDC, NCHS)
Respiratory Conditions	Chronic Obstructive Pulmonary Disease (COPD) Diagnosis	MI Department of Health and Human Services (MiBRFS)
Respiratory Conditions	Currently Have Asthma	MI Department of Health and Human Services (MiBRFS)
Respiratory Conditions	Daily Air Pollution	CDC WONDER environmental data
Respiratory Conditions	Discharge Rate: Pneumonia	MI Department of Health and Human Services (MI Community Health Information)
Social Determinants	Births to Unmarried Women	MI Department of Health and Human Services (Division for Vital Records and Health Statistics)
Social Determinants	Children Eligible for Free Lunch	National Center for Education Statistics
Social Determinants	Children in Poverty	U.S. Census Bureau, Small Area Income and Poverty Estimates (SAIPE)
Social Determinants	Children in Single-parent Households	American Community Survey, 5-year estimates
Social Determinants	Confirmed Victims of Abuse and/or Neglect, Ages 0-17	MI Department of Health and Human Services (Children's Protective Services)
Social Determinants	High School Dropouts	Center for Educational Performance Information (CEPI)
Social Determinents	High School Graduation	State sources and the National Center for Education Statistics
Social Determinants	Homicide	CDC WONDER mortality data
Social Determinants	Individuals Living Below Poverty Level	U.S. Census Bureau, 2014 American Community Survey
Social Determinants	Individuals Who Report Being Disabled	MI Department of Health and Human Services (MiBRFS)
Social Determinants	Median Household Income	U.S. Census Bureau, Small Area Income and Poverty Estimates (SAIPE)
Social Determinants	Residential Segregation (black/white)	American Community Survey, 5-year estimates
Social Determinants	Residential Segregation (non-white/white)	American Community Survey, 5-year estimates
Social Determinants	Severe Housing Problems	Comprehensive Housing Affordability Strategy (CHAS) data)
Social Determinants	Some College	American Community Survey, 5-year estimates
Social Determinants	Students Eligible for Free or Reduced Priced Lunch	Michigan Department of Education, Food and Nutrition Services (Office of Nutrition)
Social Determinants	Unemployment	County Health Rankings (Bureau of Labor Statistics)
Social Determinants	Violent Crime Rate	Uniform Crime Reporting, Federal Bureau of Investigation
STIs	Sexually Transmitted Infections	National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention
Substance Abuse	Adult Smoking	MI Department of Health and Human Services (MiBRFS)
Substance Abuse	Adult Smoking	Behavior Risk Factor Surveillance System (BRFSS)
Substance Abuse	Adults Engaging in Binge Drinking During the Past 30 Days	MI Department of Health and Human Services (MiBRFS)
Substance Abuse	Alcohol Impaired Driving Deaths	Fatality Analysis Reporting System
Substance Abuse	Drug Overdose Deaths	CDC WONDER
Substance Abuse	Excessive Drinking	Behavior Risk Factor Surveillance System (BRFSS)
Teen Pregnancy	Births to Teens Under Age 20	MI Department of Health and Human Services (Division for Vital Records and Health Statistics)
Teen Pregnancy	Teen Births	National Center for Health Statistics- Natality files
Water Quality	Drinking Water Violations	Safe Drinking Water Information System

APPENDIX D

Community Resources Available To Potentially Address Significant Health Needs

Visit beaumont.org/chna for information on community resources available to respond to the health needs of the community.

Macomb County, Michigan

- Macomb County, MI – Resources for Health Needs

  beaumont.org/chna

- Macomb County Health Department - Health Services

  health.macombgov.org

Oakland County, Michigan

- Oakland County, MI – Resources for Health Needs

  beaumont.org/chna

- Oakland County Health Division

  oakgov.com/health

Wayne County, Michigan

- Wayne County, MI – Resources for Health Needs

  beaumont.org/chna

- Wayne County Health Department – Health, Veterans and Community Wellness

  waynecounty.com/hhs

Progress of Beaumont Hospital, Dearborn 2013 CHNA Implementation Strategy

The implementation strategy for fiscal years 2014-2016 focused on four priority health needs – access to care, cardiovascular disease, diabetes and obesity. Progress to date is summarized below through the second quarter in 2016. Beaumont Hospital, Dearborn (formerly Oakwood Hospital and Medical Center) will continue to focus in the 2017-2019 implementation strategy on obesity, diabetes and cardiovascular disease. The following progress/outcomes for Beaumont Hospital, Dearborn are described below:

Priority 1: Access to care

Goal: Increase access to care for the uninsured, underinsured or underserved.

- A significant accomplishment in the 2014-2016 implementation strategy was the creation of four multi-sector coalitions using a collective impact model. A Healthy Communities Leadership Coalition was created with 125 key leaders from across the region to develop a strategic plan targeting the priority health needs. Four "Healthy Community" coalitions were formed under this umbrella in partnership with municipalities, school districts, community residents and community partner organizations (Dearborn, Taylor, Trenton and Wayne). Healthy Dearborn is a multi-sector coalition that was formed and currently has over 200 individuals participating to promote access to care, healthy eating and active living. Beaumont provides "backbone support" to these coalitions, providing staff, consultants and access to a wide range of resources including evidence-based programming and data collection.

- To support enrollment in the Health Insurance Marketplace, Beaumont partnered with the Centers for Medicare and Medicaid Services (CMS) and became a Champion for Coverage and employed health insurance navigators to assist those in the community with information and enrollment. Navigators provided community-based assistance in Dearborn for 1,342 individuals with information and enrollment into health insurance plans. OakAssist financial counselors at Beaumont Hospital, Dearborn provided 6,110 individuals with information and enrollment assistance. As collaborative partners – ACCESS, Western Wayne Family Health Centers, Wayne Metropolitan Community Action Agency and the Information Center - are now leading the community effort for enrollment with navigators and assistors; this was not identified as a priority health need by Beaumont Health for 2017-2019.

- To provide access to care for adolescents, Beaumont Health opened a teen health center in River Rouge High School in 2015. This health center, supported by the Michigan Department of Health and Human Services and the Michigan Department of Education, provides primary care, preventive care, comprehensive health assessments, co-management of chronic conditions, health education and mental health care to students in River Rouge and the surrounding communities. In the first year, 254 students were served with 767 visits. The Teen Health Center also provides families with assistance to enroll in Medicaid and Healthy Michigan.

- Beaumont Hospital, Dearborn provided free transportation of 2,264 round trips for individuals.

Priority 2: Cardiovascular disease

Goal: Decrease cardiovascular disease risk factors (blood pressure, cholesterol, glucose, overweight, physical activity, smoking).

- Beaumont Hospital, Dearborn provided heart health screening in the community to 6,162 unduplicated individuals with 11,499

screenings and personalized counseling. On average 40 percent of individuals screened were referred for further follow-up care due to high-risk results. And, 98 percent of survey respondents indicated good/very good understanding of their screening results and understanding of the steps needed to keep their hearts healthy.

- Beaumont Hospital, Dearborn provided smoking cessation counseling and quit kits to 360 individuals.
- To promote weight loss and increase physical activity for healthy hearts, Healthy Dearborn offers a Walk & Roll program. This is a weekly, family-friendly community walk and bike ride through Dearborn's parks and neighborhoods. To date, 325 individuals have participated in this program.
- Beaumont Hospital, Dearborn has provided 536 cardiac rehabilitation sessions free of charge to individuals from the community.

Priority 3: Diabetes

Goal: Reduce rate of new diabetes cases and of diabetes complications through prevention, early detection, and education.

- In partnership with Gleaners Community Food Bank of Southeastern Michigan, Beaumont Hospital, Dearborn provides Share Our Strength's Cooking Matters™ for Adults EXTRA for Diabetes. This six-week class includes the Cooking Matters™ for Adults curricula as described below along with specialized information throughout the course for adults living with diabetes, caretakers of adults living with diabetes, or pre-diabetic adults. These classes were attended by 21 individuals, providing 100 units of education. Participant satisfaction with the classes was 97 percent (Very Good). And, outcome data indicated an aggregate increase in knowledge of 22 percent including significant improvement using nutrition facts on food labels and confidence buying healthy foods for their family on a budget.
- In partnership with the National Kidney Foundation of Michigan, Beaumont Hospital Dearborn provides the My Choice…My Health Diabetes Prevention Program (DPP). This national evidence-based program from the Centers for Disease Control and Prevention (CDC) is supported and promoted by the American Medical Association as one of the most effective ways to help physicians prevent or delay type 2 diabetes in high-risk patients. This year- long program for those with pre-diabetes was provided to 25 individuals with 317 units of education and support. Participants who attended the monthly maintenance sessions following the core course averaged 363 minutes of physical activity per week (2.5 times higher than the CDC benchmark) and they lost an average of 5.3 percent of initial body weight (meeting target).
- In partnership with the National Kidney Foundation of Michigan, Beaumont Hospital, Dearborn provided 11 individuals with 49 units of Diabetes PATH (Personal Action Toward Health). PATH is a national evidence-based program for those with type 2 diabetes and their caregivers. The program is designed to enhance patient confidence in their ability to manage their disease and to work more effectively with their health care providers. Outcome data indicated 89 percent of participants were more confident about handling their health condition after taking the workshop, and showed significant improvements in testing blood sugar seven days a week and exercising more than 150 minutes per week. Participant satisfaction with the classes was 91 percent (Very Good).
- Beaumont Hospital, Dearborn provided a diabetes support group for 151 individuals in the community.
- Managing Your Diabetes education was provided by Beaumont Hospital, Dearborn to 443 individuals in the community.

- Beaumont Hospital, Dearborn provided diabetes screening as part of the heart health screening program in the community to 6,162 unduplicated individuals with 11,499 screenings.

Priority 4: Obesity

Goal: Decrease rate of obesity in children and adults by promoting regular physical activity and healthy eating behaviors.

- In the Beaumont Hospital, Dearborn service area, 2,141 children participated in the CATCH (Coordinated Approach to Child Health) Kids Club program in after-school and summer programs. CATCH Kids Club creates behavior change by enabling children to identify healthy foods, and by increasing the amount of moderate to vigorous physical activity children engage in each day. CATCH Kids Club is based on the CDC Whole School, Whole Community, Whole Child model in which health education, school environment, and family/community involvement work together to support youth in a healthy lifestyle. Evaluation results show a 40 percent increase in the consumption of fruits and vegetables for youth in the program. Student outcome data indicated improvements in multiple measures including a 40 percent increase in the consumption of fruits and vegetables, and increase in exercise or participation in sports activities for at least 20 minutes. And, 96 percent of students reported they almost always or always read nutrition labels on packages after participating in CATCH Kids Club for a school year (up from 4 percent).
- Beaumont Hospital, Dearborn provides nutrition education and "hands-on" cooking classes through a partnership with Gleaners Community Food Bank of Southeastern Michigan to offer Cooking Matters™ in the community and Cooking Matters at the Store™. Cooking Matters™ equips families with the skills they need to stretch their food dollars and prepare healthy meals on a budget. These popular classes have been attended by 194 individuals, with 747 units of service provided. Participant satisfaction with the classes was 97 percent (Very Good). And, outcome data indicated an aggregate increase in knowledge of 22 percent including significant improvement using nutrition facts on food labels and confidence buying healthy foods for their family on a budget.
- Beaumont Hospital, Dearborn sponsors the Dearborn Farmer's Market, providing access to fresh fruits and vegetables to the community. The Power of Produce program is provided to children at the market to educate children in making healthy eating choices. This program allows children to taste new fruits and vegetables, engage in activities to understand where their food comes from and gives children $2 to spend on fresh produce every time they visit the market. In 2016, 569 children have participated to date in the Power of Produce program.

Progress of Beaumont Hospital, Farmington Hills 2013 CHNA Implementation Strategy

The implementation strategy for fiscal years 2014-2016 focused on five priority health needs. Progress to date is summarized below through the second quarter in 2016. Beaumont, Farmington Hills (formerly Botsford Hospital) will continue to focus in the 2017-2019 implementation strategy on obesity, incorporating preventive health actions in addition to the priorities of diabetes and cardiovascular disease.

Priority 1: Obesity

Goal: To create opportunities for education, reinforcing the relationship between life-style choices and managing and maintaining a healthy body weight.

- Over the past 2 ½ years, Beaumont Hospital, Farmington Hills has provided education in the community on nutrition and healthy weights targeting preschoolers, children, adolescents, adults and seniors. These events included presentations to Head Start programs, faith-based organizations, Back to School Fairs, at community libraries and city halls, non-profit organizations and the local Farmer's Market. More than 2,455 individuals were reached with these activities.
- Beaumont Hospital, Farmington Hills in collaboration with South Redford School District operates a School-Based Health Center at Pierce Middle School in Redford. The health center provided 246 youth who were at the 85th percentile or higher for BMI nutrition and exercise education. An eight-session program focusing on healthy eating and active living was also provided to 50 children over the past 3 years.
- Beaumont Hospital, Farmington Hills provided financial and in-kind support to the F2H Fit Challenge – a Farmington and Farmington Hills cities-wide initiative to help the communities achieve better health and encourage a culture of healthy lifestyles. The website created provides information, tools and support for health, wellness and fitness programs.
- In collaboration with Busch's Market, Beaumont, Farmington Hills provided nutrition education at 21 events with 497 individuals attending.

Priority 2: Physical activity

Goal: To develop community involvement in creating opportunities for exercise through activities that are easily accessible, encouraging participation and interest.

- Beaumont Hospital, Farmington Hills has offered "Walk with a Doc" program each month from April through November. This program features education by a physician along with the opportunity for physical activity at Heritage Park in Farmington. In addition to the education provided, 341 individuals participated in the walking program. This program has also included in class demonstrations with participation/involvement in chair based exercises such as yoga and Tai Chi for seniors and handicapped individuals.
- Beaumont Hospital, Farmington Hills has provided sponsorship of events promoting physical activity including fun runs for children and senior fitness events.
- Beaumont Hospital, Farmington Hills has provided presentations/demonstrations and involvement of participants in multiple locations such as church groups and businesses and corporations in class exercise routines with chair yoga, Tai Chi, stair stepper and exercise bands.

Priority 3: Mental health

Goal: To raise understanding and acceptance of mental illness as a health problem that requires medical care, open discussion about symptomology and support for the individual and family without prejudice.

- Ten educational presentations were conducted in the community on various mental health topics. Attendees totaled 1,975 at these events.
- The Developing Meaningful Connections program provides monthly education and support for those experiencing dementia and the caregivers who are experiencing emotional, psychological and social well-being stressors. Approximately 240 individuals have participated since 2014.
- Sponsorships to community organizations included "Connecting Mind and Body" and suicide prevention.

Priority 4: Availability/access to physicians

Goal: To build an understanding of the structure of health care delivery facilitating greater use of health care for health promotion and early diagnosis

- Beaumont Hospital, Farmington Hills in collaboration with South Redford School District operates a school-based health center at Pierce Middle School in Redford. This health center provides comprehensive, integrated health care for ages 10 to 21 and children they may have. Medical care, mental health, lab tests and health education are provided. In the past three years the health center has served more than 1,675 youth providing 6,381 encounters.
- Every community outreach event includes information and handouts on the Affordable Care Act, resources in the community for free and low-cost health care, the Health Insurance Marketplace and Healthy Michigan.

Priority 5: Preventive health actions

Goal: Support transition to individual responsibility for health with education about promotion and prevention that serves to empower positive action.

Objective: Provide the tools individuals and families need to be the managers of their health.

- Beaumont, Farmington Hills collaborated with community partners in events that promote healthy eating and active living. These include the City of Farmington Hills "Fit for Life" program, healthy eating presentations at Farmington Hills Library, nutritional presentations to the Play and Learn with Me program, preventive programs with St. Fabian seniors, health fairs and educational events with the Family Farmington YMCA, Costick Center and City of Farmington Hills and Heritage Park Nature Center.
- Free health screenings with counseling, referral and follow up have been provided to the community at the "Walk with a Doc" events from April to November, at the Farmer's Market, Fall Family Fun Fest, Total Wellness Fair, Fall into Health Expo, National Senior Health and Fitness Fair, Back to School Health Fair, faith-based organizations, and at community partner sites. Over 1,425 screenings were provided.
- Free cancer screenings were provided to 100 individuals in the community.
- Free Student Heart Checks were performed at East Middle School in Farmington Hills for more than 240 students. The student heart check includes a medical history, an EKG and an ultrasound of the heart with counseling and referral.
- Through the Walk with a Doc program 824 individuals have participated in the education component of this program on preventive actions for health.
- Beaumont sponsors the Farmington Farmer's Market which brings fresh fruits and vegetables to the community along with free health screenings and educational information.

Progress of Beaumont Hospital, Grosse Pointe 2013 Implementation Strategy

The implementation strategy for fiscal years 2014-2016 focused on five priority health needs — asthma, diabetes, drug-related admissions, obesity and suicide. Progress to date is summarized below through the second quarter in 2016. Beaumont Hospital, Grosse Pointe will be focusing on diabetes, obesity, and cardiovascular disease for the 2017-2019 implementation strategy. The following progress/outcomes for Beaumont Hospital, Grosse Pointe are described below:

Priority 1: Diabetes

- Beaumont Children's, in partnership with JDRF, has produced a video - Managing Type 1 Diabetes in the School Setting: A Guide for Non-Medical Personnel in Schools to educate school personnel on managing diabetes in the school along with guides for non-medical staff. These materials continue to be distributed to schools free of charge.
- In partnership with Gleaners Community Food Bank of Southeastern Michigan, Beaumont Hospital, Grosse Pointe provides Share Our Strength's Cooking Matters™ for Adults Extra for Diabetes. This six-week class includes the Cooking Matters™ for Adults curricula as described below along with specialized information throughout the course for adults living with diabetes, caretakers of adults living with diabetes, or pre-diabetic adults. These classes are offered free to the community.
- In partnership with the National Kidney Foundation of Michigan, Beaumont Hospital, Grosse Pointe offers Diabetes PATH (PERSONAL ACTION TOWARD HEALTH). Diabetes PATH is a national evidence-based program for those with type 2 diabetes and their caregivers designed to enhance patient confidence in their ability to manage their disease and to work more effectively with their health care providers.
- Beaumont Hospital, Grosse Pointe provided diabetic education to 395 individuals in the community.

Priority 2: Drug-related admissions

- The Beaumont Community Health Coalition operates the American Medicine Chest Challenge – a community-based public health initiative with law enforcement partnership, to raise awareness about the dangers of prescription drug abuse and provide disposal sites for unused, unwanted and expired medication. Collection boxes are placed in the police departments of Grosse Pointe, Grosse Pointe Woods and Grosse Pointe Park. The Coalition provides educational materials and community outreach on the risks of prescription drug abuse.

Priority 3: Obesity

- To address obesity, Beaumont Health partnered with the University of Michigan to implement Project Healthy Schools in Tyrone Elementary School in Harper Woods, Pierce Middle School in Grosse Pointe and Larson Middle School in Troy. Project Healthy Schools encourages healthy habits to reduce childhood obesity and its long term consequences through education, environmental change and measurement. Pre- and post-health behavior questionnaires at all three schools show an increase in both average fruit and vegetable consumption and an increase in both average vigorous and moderate physical activity along with a decrease in screen time and sugary beverage intake.
- Beaumont Hospital, Grosse Pointe has implemented the "Walk with a Doc" program. This program features an educational component by a physician followed by a 45 minute walk. Blood pressure checks are also offered at these events.

- Beaumont Hospital, Grosse Pointe has offered the Health Hero program to those in grades 1-3 to demonstrate the importance of healthy choices. This program helps students build a foundation for a healthier lifestyle and empowers them to make informed decisions when it comes to nutrition, physical activity and behavior. This program has reached 6,764 students in 26 schools, 12 organizations and in 18 cities.

- In partnership with the YMCA and the Beaumont Community Health Coalition, a Girls on the Run™ program for those in 3rd through 8th grade was funded and offered at Parcells Middle School and the Grosse Pointe Neighborhood Club. Running is used to inspire and motivate girls, encourage lifelong health and fitness, and build confidence through accomplishment. To date, 1,044 girls have engaged in Girls on the Run™ with the Beaumont sponsorship.

- Beaumont Hospital, Grosse Pointe provided 955 individuals in the community with education on healthy eating. Sponsorship of the local farmer's market offers opportunities to educate individuals on healthy eating with the fresh produce at the market.

- Beaumont Children's provided 117 children with special needs from throughout Metro Detroit custom-built bicycles no charge to provide physical activity for these youth.

- Beaumont Hospital, Grosse Pointe, in collaboration with the Neighborhood Club Recreation and Wellness Center, the Grosse Pointe Schools System, the Beaumont Community Health Coalition and the Grosse Pointe Chamber of Commerce offered the 60 Days to Health program to encourage healthy living activities throughout the community.

Priority 4: Suicide

- No Bullying Live Empowered (NoBLE) recognizes that all youth exposed to bullying are at risk for both immediate and lifelong problems. Whether someone is bullied, witnesses bullying or bullies others, it can negatively impact their physical and mental health. Beaumont provides integrated education, guidance and support for bullied children and families affected by bullying.

- Beaumont Hospital, Grosse Pointe in partnership with the Beaumont Community Health Coalition has offered Second Step, a program centered on bullying prevention, empathy and communication, emotion management and coping, substance abuse prevention, problem-solving, goal setting and decision making. This program was implemented in the Grosse Pointe school system with 186 students. Evaluation results show an increase in knowledge surrounding typical bullying behaviors and the correct actions to be taken during and after an incident of bullying. Surveys also showed an increased confidence in emotional regulation abilities among students.

- The Beaumont Community Health Coalition in partnership with Beaumont Hospital, Grosse Pointe, Grosse Pointe Schools and the Detroit Wayne Mental Health Authority initiated a Mental Wellness Initiative to address the rise in suicide deaths within the community and increase prevention services for youth 13 -24. This collaborative effort has over 30 members with six action groups based on the program "Preventing Suicide" by SAMSHA.

Priority 5: Asthma

While asthma had been identified as a priority in the 2013 CHNA for Beaumont Hospital, Grosse Pointe, community programming/services were not yet implemented at the time of this report. In the 2016 CHNA prioritization process, it was determined that asthma would not directly be addressed. The CHNA priorities will be obesity, cardiovascular disease and diabetes. This will allow the maximization of resources and greater impact in the community.

Progress of Beaumont Hospital, Royal Oak 2013 Implementation Strategy

The implementation strategy for fiscal years 2014-2016 focused on five priority health needs – asthma, diabetes, drug-related admissions, obesity and suicide. Progress to date is summarized below through the second quarter in 2016. Beaumont Hospital, Royal Oak will be focusing on diabetes, obesity and cardiovascular disease for the 2017-2019 implementation strategy. The following progress/outcomes for Beaumont Hospital, Royal Oak are described below:

Priority 1: Diabetes

- Beaumont Children's in partnership with JDRF produced a video - Managing Type 1 Diabetes in the School Setting: A Guide for Non-Medical Personnel in Schools to educate school personnel on managing diabetes in the school along with guides for non-medical staff.
- Beaumont Hospital, Royal Oak offers Diabetes PATH (PERSONAL ACTION TOWARD HEALTH) in partnership with the National Kidney Foundation of Michigan. Diabetes PATH is a national evidence-based program for those with type 2 diabetes and their caregivers. The program is designed to enhance patient confidence in their ability to manage their disease and to work more effectively with their health care providers.
- Beaumont, Royal Oak provided diabetes education to 180 individuals in the community.

Priority 2: Drug-related admissions

- Beaumont Health and the Association for Hospital Medical Education, in cooperation with the Collaborative on REMS Education developed a continuing education/training program for health care professionals in order to prescribe or dispense opioid analgesics safely and maintain patient access to pain medications.
- Beaumont Health physicians participate in the Oakland County Prescription Drug Abuse Partnership which was created in March 2015 by the Oakland County Health Division to create a coordinated, strategic action plan for reducing prescription drug abuse and overdoses. A SCOPE of Pain training was held in late 2015 to cover three issues: Assessing Chronic Pain and Opioid Misuse Risk, Initiating (or continuing) Opioid Therapy Safely, and Assessing and Managing Aberrant Medication Taking Behavior. More than 100 health care professionals attended this training which included interactive clinical demonstrations and a panel discussion.
- In partnership with the Beaumont Community Health Coalition and the Wayne County Mental Health Authority the "Too Good for Drugs" after-school program was provided in the Brightmoor area of Detroit. This program is designed to address the negative effects of substance abuse, including the misuse of prescription opioids and over-the-counter medications and electronic nicotine delivery systems. The program served 73 youth during the after-school program and during the Mission: City Summer camp in Brightmoor.

Priority 3: Obesity

- Beaumont, Royal Oak provides a Farmer's Market during the summer months, providing locally-grown fruits and vegetables for the community and employees. Nutrition information is provided along with nutritional counseling. Food assistance benefits are accepted at the market.
- Beaumont Hospital, Royal Oak offers free Kid's Cooking Classes for children age 6 and older. This fun, interactive, and educational class is hands-on and led by a registered dietitian in a demonstration kitchen. Approximately 60 children attended these classes each year.

- Beaumont, Royal Oak offers Eat Healthy, Be Active community workshops in partnership with the Food and Drug Administration-Detroit District Office and Michigan State University Extension. More than 30 half-day workshops were held with more than 500 individuals participating. Individuals who participated received educational information, toolkits with recipes, farmer's market information, samples of healthy foods and physical activity demonstrations. Evaluation of the program showed 83 percent of the participants strongly agreed that the workshop showed practical ways to change their diets and increase physical activity.

- Beaumont Hospital, Royal Oak has offered the Health Hero program to those in grades 1 through 3, to demonstrate the importance of healthy choices. This program helps students build a foundation for a healthier lifestyle and empowers them to make informed decisions when it comes to nutrition, physical activity and behavior. This program has reached 6,764 students in 26 schools, 12 organizations and in 18 cities.

- The Power of Produce Club at the Birmingham Farmer's Market was funded by Beaumont, Royal Oak. This program supports children in making healthy eating choices and allows children to taste new fruits and vegetables, engage in activities to understand where their food comes from and gives children $2 to spend on fresh produce every time they visit the market.

Priority 4: Suicide

- No Bullying Live Empowered (NoBLE) program at Beaumont Royal Oak recognizes that all youth exposed to bullying are at risk for both immediate and lifelong problems. Whether someone is bullied, witnesses bullying or bullies others, it can negatively impact their physical and mental health. Beaumont provides integrated education, guidance and support for bullied children and families affected by bullying. NoBLE services and education were provided to 850 individuals.

- Beaumont Hospital, Royal Oak held its third annual mental health fair in partnership with the Easter Seals. This free community event provided education, support and resources on mental health with a focus on breaking the stigma that prevents people from seeking help when they need it. Community members had an opportunity to connect with a variety of leading organizations in the mental health and wellness field. Topics included autism, bipolar disorder, depression, schizophrenia, eating disorders, early intervention for children with trauma, substance abuse, bullying prevention, suicide prevention, domestic violence and skill-building for developmentally disabled.

- Beaumont Health is sponsoring the Michigan Bullying Prevention Conference in the fall of 2016. This conference will provide strategies to strengthen bullying prevention efforts or begin a program in schools and communities. Trauma, suicide and depression are among the topics that will be covered.

- Mental health and depression education was provided to 77 individuals in the community.

Priority 5: Asthma

While asthma had been identified as a priority in the 2013 CHNA for Beaumont Hospital Royal Oak, community programming/services were not yet implemented at the time of this report. In the 2016 CHNA prioritization process, it was determined that asthma would not directly be addressed. The CHNA priorities will be obesity, cardiovascular disease and diabetes. This will allow resources to be maximized, and result in greater impact in the community.

Progress of Beaumont Hospital, Taylor 2013 CHNA Implementation Strategy

The implementation strategy for fiscal years 2014-2016 focused on four priority health needs – access to care, cardiovascular disease, diabetes and obesity. Progress to date is summarized below through the second quarter in 2016. Beaumont Hospital, Taylor (formerly Oakwood Heritage Hospital) will continue to focus in the 2017-2019 implementation strategy on obesity, diabetes and cardiovascular disease. The following progress/outcomes for Beaumont Hospital, Taylor is described below:

Priority 1: Access to care

Goal: Increase access to care for the uninsured, underinsured or underserved.

- A significant accomplishment in the 2014-2016 Implementation Strategy by Beaumont was the creation of four multi-sector coalitions using a collective impact model. Collective impact occurs when organizations from different organizations agree to solve a special social problem using a common agenda, aligning their efforts, and using common measures of success. A Healthy Communities Leadership Coalition was created with 125 key leaders from across the region to develop a strategic plan targeting the priority health needs. Four "Healthy Community" coalitions were formed under this umbrella in partnership with municipalities, school districts, community residents and community partner organizations (Dearborn, Taylor, Trenton and Wayne). Healthy Taylor is a multi-sector coalition that was formed and currently has 116 individuals participating to promote access to care, healthy eating and active living. Beaumont provides "backbone support" to these coalitions, providing staff, consultants, access to a wide range of resources including evidence-based programming and data collection.

- To support enrollment in the Health Insurance Marketplace, Beaumont partnered with the Centers for Medicare and Medicaid Services (CMS) and became a Champion for Coverage and employed health insurance navigators to assist those in the community with information and enrollment. Navigators provided community-based assistance in Taylor for 369 individuals with information and enrollment into health insurance plans. OakAssist financial counselors at Beaumont Hospital, Taylor provided 2,996 individuals with information and enrollment assistance. As of May 2016, Michigan has enrolled 2,303,659 individuals in Medicaid and CHIP — a net increase of 20.48 percent since the first Marketplace Open Enrollment Period and related Medicaid program changes in October 2013.

  As collaborative partners – ACCESS, Western Wayne Family Health Centers, Wayne Metropolitan Community Action Agency and the Information Center - are now leading the community effort for enrollment with navigators and assistors; this was not identified as a priority health need by Beaumont Health for 2017-2019.

- To provide access to care for adolescents, Beaumont Health operates a school wellness program in Truman High School in which 1,454 students received a total of 8,674 services through the program. 100 percent of students seen in the school wellness program were screened for behavioral health needs with 372 (2014-2015) receiving mental health treatment. Medicaid outreach and education were provided to 3,744 individuals with the school and community.

- Beaumont's Taylor Teen Health Center makes a difference in the lives of thousands of young people each year through a variety of school-based and school-linked programs. Serving those ages 10 to 21, the health center provides primary health care, immunizations, family planning services, prevention and health

education and social work services. During the period of this implementation strategy, 2,168 youth have been served with 4,749 visits.

Priority 2: Cardiovascular disease

Goal: Decrease cardiovascular disease risk factors (blood pressure, cholesterol, glucose, overweight, physical activity, smoking).

- Beaumont Hospital, Taylor provided heart health screening in the community to 734 individuals with 1,964 screenings and personalized counseling. On average 40 percent of individuals screened were referred for further follow-up care due to high-risk results. And, 98 percent of survey respondents indicated good/very good understanding of their screening results and understanding of the steps needed to keep their hearts healthy.

- Beaumont Hospital, Taylor provides a "Walk with a Doc" program and "Walk with a City Official" at Heritage Park that includes educational information on healthy eating and active living before a group walk. Participants are given pedometers to encourage their walking.

Priority 3: Diabetes

Goal: Reduce rate of new diabetes cases and of diabetes complications through prevention, early detection, and education.

- In partnership with Gleaners Community Food Bank of Southeastern Michigan, Beaumont, Taylor offers Share Our Strength's Cooking Matters™ for Adults EXTRA for Diabetes. This six-week class includes the Cooking Matters™ for Adults curricula as described below along with an addendum that offers specialized information throughout the course for adults living with diabetes, caretakers of adults living with diabetes or pre-diabetic adults. These classes were attended by 61 individuals, providing 309 units of education. Participant satisfaction with the classes was 97 percent (Very Good). And, outcome data indicated an aggregate increase in knowledge of 22 percent including significant improvement using nutrition facts on food labels and confidence buying healthy foods for their family on a budget.

- In partnership with the National Kidney Foundation of Michigan, Beaumont Hospital, Taylor provides the My Choice…My Health Diabetes Prevention Program (DPP). This national evidence-based program from the Centers for Disease Control and Prevention (CDC) is supported and promoted by the American Medical Association as one of the most effective ways to help physicians prevent or delay type 2 diabetes in high-risk patients. This year- long program for those with pre-diabetes provided 24 individuals with 169 units of education and support. Participants who attended the monthly maintenance sessions following the core course averaged 363 minutes of physical activity per week (2.5 times higher than the CDC benchmark) and they lost an average of 5.3 percent of initial body weight (meeting target).

- In partnership with the National Kidney Foundation of Michigan, Beaumont Hospital, Taylor provided 62 sessions of Diabetes PATH (Personal Action Toward Health). PATH is a national evidence-based program Diabetes PATH is for those with type 2 diabetes and their caregivers designed to enhance patient confidence in their ability to manage their disease and to work more effectively with their health care providers. Outcome data indicated 89 percent of participants were more confident about handling their health condition after taking the workshop, and showed significant improvements in testing blood sugar seven days a week and exercising more than 150 minutes per week. Participant satisfaction with the classes was 91 percent (Very Good).

- Managing Your Diabetes, a free education seminar that discusses diabetes and the vascular complications related to the disease was provided to 22 individuals in the community.
- Diabetes education was provided to 133 individuals in the community at health fairs or non-profit partner events.
- Beaumont Hospital, Taylor provided diabetes screening as part of the heart health screening program in the community to 734 unduplicated individuals with 1,964 screenings.

Priority 4: Obesity

Goal: Decrease rate of obesity in children and adults by promoting regular physical activity and healthy eating behaviors.

- Beaumont Hospital, Taylor provides nutrition education and "hands-on" cooking classes through a partnership with Gleaners Community Food Bank of Southeastern Michigan to offer Cooking Matters™ and Cooking Matters at the Store™ in the community. Cooking Matters™ equips families with the skills they need to stretch their food dollars and prepare healthy meals on a budget. Cooking Matters at the Store™, held at local grocery stores, teaches comparison shopping and understanding nutrition labels. These popular classes have been attended by 144 individuals, with 564 units of service provided. Participant satisfaction with the classes was 97 percent (Very Good). And outcome data indicated an aggregate increase in knowledge of 22 percent including significant improvement using nutrition facts on food labels and confidence buying healthy foods for their family on a budget.
- Cooking Matters™ for Teens will be conducted at the middle school in Taylor in the fall of 2016. This six-week program teaches adolescents in 6th grade and up how to make healthy food choices and prepare healthy meals and snacks.
- The Cooking Matters™ program was adapted for alternative education students in Taylor with 13 students completing the course.
- To promote healthy eating, Beaumont sponsors the Taylor Farmer's Market. The Farmer's Market brings fresh fruit and vegetables to those in the community. Weekly activities to promote health are conducted at the market including "Harvest of the Month" along with health screenings and chronic disease management education.
- Beaumont Hospital, Taylor provided nutrition education and counseling to 364 individuals at community events such as health fairs and non-profit partner events.
- Through Healthy Taylor, neighborhood walking clubs have been formed to encourage walking and provide support encouraging small steps to increase physical activity. To encourage participation, walking kits are given to each group leader containing pedometers, lanyards with walking logs for each individual and tip sheets related to walking.
- Beaumont's Taylor Teen Health Center provides nutrition counseling by a registered dietitian. The Teen Health Center also offered a six-week Stepping Towards Wellness Program to increase physical activity of youth. While 19 individuals participated in the program, outcome data did not support continuation of this program.

Progress of Beaumont Hospital, Trenton 2013 CHNA Implementation Strategy

The implementation strategy for fiscal years 2014-2016 focused on four priority health needs – access to care, cardiovascular disease, diabetes and obesity. Progress to date is summarized below through the second quarter in 2016. Beaumont Hospital, Trenton (formerly Oakwood Southshore Medical Center) will continue to focus in the 2017-2019 implementation strategy on obesity, diabetes and cardiovascular disease. The following progress/outcomes for Beaumont Hospital, Trenton are described below:

Priority 1: Access to care

Goal: Increase access to care for the uninsured, underinsured or underserved.

- A significant accomplishment in the 2014-2016 Implementation Strategy by Beaumont was the creation of four multi-sector coalitions using a collective impact model. A Healthy Communities Leadership Coalition was created with 125 key leaders from across the region to develop a strategic plan targeting the priority health needs. Four "Healthy Community" coalitions were formed under this umbrella in partnership with municipalities, school districts, community residents and community partner organizations (Dearborn, Taylor, Trenton and Wayne). Healthy Trenton is a multi-sector coalition that was formed and currently has 102 members participating to promote access to care, healthy eating and active living. Beaumont provides "backbone support" to these coalitions, providing staff, consultants and access to a wide range of resources including evidence-based programming and data collection.

- To support enrollment in the Health Insurance Marketplace, Beaumont partnered with the Centers for Medicare and Medicaid Services (CMS) and became a Champion for Coverage employing health insurance navigators to assist those in the community with information and enrollment. Navigators provided community-based assistance in Trenton for 287 individuals, including information and enrollment into health insurance plans. OakAssist financial counselors at Beaumont Hospital, Trenton provided 1,397 individuals with information and enrollment assistance. As of May 2016, Michigan has enrolled 2,303,659 individuals in Medicaid and CHIP — a net increase of 20.48 percent since the first Marketplace Open Enrollment Period and related Medicaid program changes in October 2013.

  Collaborative partners – ACCESS, Western Wayne Family Health Centers, Wayne Metropolitan Community Action Agency and the Information Center are now leading the effort for enrollment in the community with navigators and assistors.

Priority 2: Cardiovascular Disease

Goal: Decrease cardiovascular disease risk factors (blood pressure, cholesterol, glucose, overweight, physical activity, smoking).

- Beaumont Hospital, Trenton provided heart health screening in the community to 1,858 unduplicated individuals with 2,546 screenings and personalized counseling. On average 40 percent of individuals screened were referred for further follow-up care due to high-risk results. And, 98 percent of survey respondents indicated good/very good understanding of their screening results and understanding of the steps needed to keep their hearts healthy.

- Beaumont Hospital, Trenton provided smoking cessation counseling and quit kits to 806 individuals.

- Beaumont Hospital, Trenton provided 485 free cardiac rehabilitation sessions for the uninsured and underinsured.

Priority 3: Diabetes

Goal: Reduce rate of new diabetes cases and of diabetes complications through prevention, early detection, and education.

- In partnership with Gleaners Community Food Bank of Southeastern Michigan, Beaumont Hospital, Trenton provides Share Our Strength's Cooking Matters™ for Adults EXTRA for Diabetes. This six-week class includes the Cooking Matters™ for Adults curricula as described below along with specialized information throughout the course for adults living with diabetes, caretakers of adults living with diabetes, or pre-diabetic adults. These classes were attended by 52 individuals, providing 264 units of education. Participant satisfaction with the classes was 97 percent (Very Good). And outcome data indicated an aggregate increase in knowledge of 22 percent including significant improvement using nutrition facts on food labels and confidence buying healthy foods for their family on a budget.
- In partnership with the National Kidney Foundation of Michigan, Beaumont, Trenton provided 34 individuals with 158 units of Diabetes PATH (Personal Action Toward Health). PATH is a national evidence-based program for those with type 2 diabetes and their caregivers. The program is designed to enhance patient confidence in their ability to manage their disease and to work more effectively with their health care providers. Outcome data indicated 89 percent of participants were more confident about handling their health condition after taking the workshop, and showed significant improvements in testing blood sugar seven days a week and exercising more than 150 minutes per week. Participant satisfaction with the classes was 91 percent (Very Good).
- Managing Your Diabetes, a free education seminar that discusses diabetes and the vascular complications related to the disease, was provided to 54 individuals in the community.
- Beaumont Hospital, Trenton provided diabetes education to 586 individuals in the community.
- Beaumont Hospital, Trenton provided diabetes screening as part of the heart health screening program in the community to 1,858 unduplicated individuals with 2,546 screenings.

Priority 4: Obesity

Goal: Decrease rate of obesity in children and adults by promoting regular physical activity and healthy eating behaviors.

- Beaumont Hospital, Trenton provides nutrition education and "hands-on" cooking classes through a partnership with Gleaners Community Food Bank of Southeastern Michigan to offer Cooking Matters™ in the community. Cooking Matters™ equips families with the skills they need to stretch their food dollars and prepare healthy meals on a budget. These popular classes have been attended by 103 individuals, with 548 units of service provided. Participant satisfaction with the classes was 97 percent (Very Good). And outcome data indicated an aggregate increase in knowledge of 22 percent including significant improvement using nutrition facts on food labels and confidence buying healthy foods for their family on a budget.
- The Cooking Matters™ program was adapted to provide nutrition education to 24 special needs students in Trenton from nine school districts.
- Cooking Matter for Teens™ is now offered to the community by Beaumont Hospital, Trenton. This six-week curriculum teaches teenagers how to make healthy food choices and prepare healthy meals and snacks. Teens take home a bag of groceries after each class

so they can practice the recipes taught that day. Classes are currently in progress with 20 youth attending.

- In the Beaumont Hospital, Trenton service area, 324 children participated in the CATCH (Coordinated Approach to Child Health) Kids Club program in after-school and summer programs beginning in the 2016-2017 academic year. CATCH Kids Club creates behavior change by enabling children to identify healthy foods, and by increasing the amount of moderate to vigorous physical activity children engage in each day. CATCH Kids Club is based on the CDC Whole School, Whole Community, Whole Child model in which health education, school environment, and family/community involvement work together to support youth in a healthy lifestyle.

- Beaumont Hospital, Trenton provided nutrition education in the community to 1,114 individuals, who received 1,443 units of education.

- Beaumont provided financial sponsorship for the Trenton Summer Festival along with health screenings, distribution of pedometers and activities to promote health including a Stroll & Roll with bike riding and walking.

- Beaumont's Healthy Trenton launched several initiatives to address obesity. These include:

  Passport to Health – The Passport contains information and activities individuals can use in their daily lives and contains detailed walking maps, active family resources, biking tours, workplace resources and health quizzes. These passports were delivered throughout the community at various events and through Trenton City Hall. The passports are also available for download on the Healthy Trenton website. Those who participate in the Passport to Health receive incentives for healthy eating and active living.

  Farmer's market – A farmer's market was implemented in Trenton, bringing in fresh fruits and vegetables to residents.

  Bike lanes – The Healthy Trenton Coalition worked with the Traffic Safety Commission on preferred shared bike lanes. This project has been approved with funding for implementation.

  Walking/biking tours – Walking/biking tours for a new bike rental program in Elizabeth Park were created. Monthly bike and hike guided tours were successfully launched.

  Successful partnerships – The Healthy Trenton Coalition provided a forum to connect Downriver Linked Greenways, International Wildlife Refuge, Riverside Kayak Connection, Wayne County Parks and Trenton Parks and Recreation. This partnership is designed to encourage citizens to use community parks, trails and recreation amenities to be physically active.

  Toolkit for businesses – A presentation and toolkit for businesses was developed for employers to promote worksite wellness. The City of Trenton is implementing a worksite wellness program to promote health among its employees.

  Social media for health – Beaumont Healthy Trenton launched a website (www.healthytrenton.com) and a Facebook page to connect health resources to community members.

  Healthy food options at restaurants – Restaurants are developing healthy entrees and providing recipes to put on the Healthy Trenton website. To date, two restaurants have featured and highlighted healthy options for eating.

  Health expo – In partnership with St. Paul Lutheran Church, two health expos were held with a 5K walk/runs. Approximately 600 people participate.

Progress of Beaumont Hospital, Troy 2013 Implementation Strategy

The implementation strategy for fiscal years 2014-2016 focused on five priority health needs – asthma, diabetes, drug related admissions, obesity and suicide. Progress to date is summarized below through the second quarter in 2016. Beaumont Hospital, Troy will be focusing on diabetes, obesity, and cardiovascular disease for the 2017-2019 implementation strategy. The following progress/outcomes for Beaumont Hospital, Troy are described below:

Priority 1: Diabetes

- Beaumont Hospital, Troy offers Diabetes PATH (Personal Action Toward Health), a six-week program designed to help people living with type 2 diabetes and their support system live a healthier life. Individuals learn to make an action plan, avoid complications, balance their blood sugar, improve communication skills with their family and health care provider, understand the importance of monitoring their blood sugar, manage symptoms, decrease stress and improve their overall health while increasing their energy. This program is offered free to the community.
- Beaumont Children's, in partnership with JDRF, produced a video - Managing Type 1 Diabetes in the School Setting: A Guide for Non-Medical Personnel in Schools to educate school personnel on managing diabetes in the school along with guides for non-medical staff.
- Diabetes education was provided by Beaumont Hospital, Troy to 140 individuals in the community.

Priority 2: Drug-related admissions

- Beaumont Health and the Association for Hospital Medical Education, in cooperation with the Collaborative on REMS Education developed a continuing education/training program for health care professionals in order to prescribe or dispense opioid analgesics safely and maintain patient access to pain medications.
- Beaumont Health physicians participate in the Oakland County Prescription Drug Abuse Partnership which was created in March 2015 by the Oakland County Health Division to create a coordinated, strategic action plan for reducing prescription drug abuse and overdoses. A SCOPE of Pain training was held in late 2015 to cover three issues: Assessing Chronic Pain and Opioid Misuse Risk, Initiating (or continuing) Opioid Therapy Safely, and Assessing and Managing Aberrant Medication Taking Behavior. More than 100 health care professionals attended this training which included interactive clinical demonstrations and a panel discussion.

Priority 3: Obesity

- To address obesity, Beaumont Hospital, Troy partnered with the University of Michigan to implement Project Healthy Schools in Tyrone Elementary School in Harper Woods, Pierce Middle School in Grosse Pointe, and Larson Middle School in Troy. Project Healthy Schools encourages healthy habits to reduce childhood obesity and its long term consequences through education, environmental change and measurement. Pre- and post-health behavior questionnaires at all three schools show an increase in both average fruit and vegetable consumption and an increase in both average vigorous and moderate physical activity along with a decrease in screen time and sugary beverage intake.
- Beaumont Children's provided 117 children with special needs from throughout Metro Detroit custom-built bicycles at no charge to promote and encourage physical activity for youth with special needs.

Priority 4: Suicide

- No Bullying Live Empowered (NoBLE) recognizes that all youth exposed to bullying are at risk for both immediate and lifelong problems. Whether someone is bullied, witnesses bullying or bullies others, it can negatively impact their physical and mental health. Beaumont provides integrated education, guidance and support for bullied children and families affected by bullying.

- Beaumont Health is sponsoring the Michigan Bullying Prevention Conference in the fall of 2016. This conference will provide strategies to strengthen bullying prevention efforts or begin a program in schools and communities. Trauma, suicide and depression are among the topics that will be covered.

Priority 5: Asthma

While asthma had been identified as a priority in the 2013 CHNA for Beaumont Hospital, Troy, community programming/services were not yet implemented at the time of this report. In the 2016 CHNA prioritization process, it was determined that asthma would not directly be addressed. The CHNA priorities will be obesity, cardiovascular disease and diabetes. This will allow resources to be maximized and result in greater impact in the community.

Progress of Beaumont Hospital, Wayne 2013 Implementation Strategy

The implementation strategy for fiscal years 2014-2016 focused on four priority health needs – access to care, cardiovascular disease, diabetes and obesity. Progress to date is summarized below through the second quarter in 2016. Beaumont, Wayne (formerly Oakwood Annapolis Hospital) will continue to focus in the 2017-2019 implementation strategy on obesity, diabetes and cardiovascular disease. The following progress/outcomes for Beaumont Hospital, Wayne are described below:

Priority 1: Access to care

Goal: Increase access to care for the uninsured, underinsured or underserved.

- A significant accomplishment in the 2014-2016 Implementation Strategy by Beaumont was the creation of four multi-sector coalitions using a collective impact model. A Healthy Communities Leadership Coalition was created with 125 key leaders from across the region to develop a strategic plan targeting the priority health needs. Four "Healthy Community" coalitions were formed under this umbrella in partnership with municipalities, school districts, community residents and community partner organizations (Dearborn, Taylor, Trenton and Wayne). Healthy Wayne is a multi-sector coalition that was formed and currently has 102 members participating to promote access to care, healthy eating and active living. Beaumont provides "backbone support" to these coalitions, providing staff, consultants and access to a wide range of resources including evidence-based programming and data collection.

- To support enrollment in the Health Insurance Marketplace, Beaumont partnered with the Centers for Medicare and Medicaid Services (CMS) and became a Champion for Coverage, employing health insurance navigators to assist those in the community with information and enrollment. Navigators provided community-based assistance in Beaumont, Wayne communities for 740 individuals, including information and enrollment into health insurance plans. OakAssist financial counselors at Beaumont, Wayne provided 5,062 individuals with information and enrollment assistance. As collaborative partners – ACCESS, Western Wayne Family Health Centers, Wayne Metropolitan Community Action Agency and the Information Center - are now leading the community effort for enrollment with navigators and assistors, this was not identified as a priority health need for 2017-2019.

- To increase access to care, in March of 2016 Beaumont Hospital, Wayne partnered with the Wayne County Department of Health, Veterans and Community Wellness to open a federally qualified health center in Wayne. Beaumont physicians and health care professionals provide support to the clinic. Wayne Health Center is open to all individuals but primarily serves residents in the cities of Wayne, Westland, Romulus and Inkster.

- To provide access to care for adolescents, Beaumont Health partnered with the Westwood School District to open a teen health center at Tomlinson Middle School in Inkster. This health center, supported by the Michigan Department of Health and Human Services and the Michigan Department of Education, serves approximately 500 youth in the Westwood School District and the surrounding communities with primary care, preventive care, comprehensive health assessments, co-management of chronic conditions, health education and mental health care. The Teen Health Center also provides families with assistance to enroll in Medicaid and Healthy Michigan.

- To provide access to care for adolescents, Beaumont Health opened a teen health center in Romulus High School in 2015. This health center, supported by the Michigan Department of Health and Human Services and the Michigan Department of Education, provides primary care, preventive care, comprehensive health assessments, co-management of chronic conditions, health education and mental health care to students in Romulus and the surrounding communities. In the first year, 365 students were served with 1,097 visits. The Teen Health Center also provides families with assistance to enroll in Medicaid and Healthy Michigan.

- Beaumont operates the Adams Child and Adolescent Health Center in Westland in partnership with the Wayne-Westland School District. The health center provides primary care, preventive care, comprehensive health assessments, co-management of chronic conditions, health education and mental health care to over 500 students annually. The Child and Adolescent Health Center also provides families with assistance to enroll in Medicaid and Healthy Michigan.

Priority 2: Cardiovascular disease

Goal: Decrease cardiovascular disease risk factors (blood pressure, cholesterol, glucose, overweight, physical activity, smoking).

- Beaumont, Wayne has provided 559 free cardiac rehabilitation sessions for the uninsured or underinsured.

- Beaumont, Wayne provided heart health screening in the community to 2,963 individuals who received 5,836 screenings and personalized counseling. On average 40 percent of individuals screened were referred for further follow-up care due to high-risk results. And, 98 percent of survey respondents indicated good/very good understanding of their screening results and understanding of the steps needed to keep their hearts healthy.

- Smoking cessation counseling and quit kits were provide to 3,561 individuals.

Priority 3: Diabetes

Goal: Decrease rate of new diabetes cases and of diabetes complications through prevention, early detection, and education

- In partnership with Gleaners Community Food Bank of Southeastern Michigan, Beaumont, Wayne offers Share Our Strength's Cooking Matters™ for Adults EXTRA for Diabetes. This six-week class includes the Cooking Matters™ for Adults curricula as described below along with an addendum that offers specialized information throughout the course for adults living with diabetes, caretakers of adults living with diabetes or pre-diabetic adults. These classes were attended by 36 individuals for a total of 196 units of service provided. Participant satisfaction with the classes was 97 percent (Very Good). And outcome data indicated an aggregate increase in knowledge of 22 percent including significant improvement using nutrition facts on food labels and confidence buying healthy foods for their family on a budget.

- In partnership with the National Kidney Foundation of Michigan, Beaumont, Wayne provides the My Choice…My Health Diabetes Prevention Program (DPP). This national evidence-based program from the Centers for Disease Control and Prevention (CDC) is supported and promoted by the American Medical Association as one of the most effective ways to help physicians prevent or delay type 2 diabetes in high-risk patients. This year-long program for those with pre-diabetes was provided to 17 individuals with 82 units of education and support. Participants who attended the monthly maintenance sessions following the core course averaged 363 minutes of physical activity per week (2.5 times higher than the CDC benchmark) and they lost an average of 5.3 percent of initial body weight (meeting target).

- In partnership with the National Kidney Foundation of Michigan, Beaumont Wayne provided 15 individuals with 81 units of Diabetes PATH (Personal Action Toward Health). Diabetes PATH is a national evidence-based program for those with type 2 diabetes and their caregivers designed to enhance patient confidence in their ability to manage their disease and to work more effectively with their health care providers. Outcome data indicated 89 percent of participants were more confident about handling their health condition after taking the workshop, and showed significant improvements in testing blood sugar seven days a week and exercising more than 150 minutes per week. Participant satisfaction with the classes was 91 percent (Very Good). Managing Your Diabetes, a free education seminar that discusses diabetes and the vascular complications related to the disease was provided to 70 individuals in the community.

- Beaumont Hospital, Wayne provided diabetes screening as part of the heart health screening program in the community to 2,963 individuals who received 5,836 screenings.

Priority 4: Obesity

Goal: Decrease rate of obesity in children and adults by promoting regular physical activity and healthy eating behaviors.

- Beaumont Hospital, Wayne provided the CATCH (Coordinated Approach to Child Health) Kids Club program to 312 children in after-school programs. CATCH Kids Club creates behavior change by enabling children to identify healthy foods, and by increasing the amount of moderate to vigorous physical activity children engage in each day. CATCH Kids Club is based on the CDC Whole School, Whole Community, Whole Child model in which health education, school environment, and family/community involvement work together to support youth with healthy lifestyles. Student outcome data indicated improvements in multiple measures including vegetable and fruit consumption, and exercise or participation in sports activities for at least 20 minutes. And, 96 percent of students reported they almost always or always read nutrition labels on packages after participating in CATCH Kids Club for a school year (up from 4 percent).

- A registered dietitian at Beaumont's Westwood Teen Health Center provides individual nutrition counseling to students with a BMI at or above 85 percent. Patients also receive small group sessions focusing on healthy nutrition, cooking on a budget and making healthy choices. Nutrition education and fitness counseling were provided to 293 students.

- Beaumont, Wayne provided nutrition education in the community to 944 individuals.

- Beaumont, Wayne provides nutrition education and "hands-on" cooking classes through a partnership with Gleaners Food Bank of Southeastern Michigan to offer Cooking Matters™ and Cooking Matters at the Store™ in the community. Cooking Matters™ equips families with the skills they need to stretch their food dollars and prepare healthy meals on a budget. Cooking Matters at the Store™, held at local grocery stores, teaches comparison shopping and understanding nutrition labels. These popular classes have been attended by 139 individuals, with 635 units of service provided. Participant satisfaction with the classes was 97 percent (Very Good). And outcome data indicated an aggregate increase in knowledge of 22 percent including significant improvement using nutrition facts on food labels and confidence buying healthy foods for their family on a budget.

- Beaumont sponsors the Wayne Farmer's Market, providing access to fresh fruits and vegetables for the community along with health screenings and information on healthy eating and active living.

- Hosted at Beaumont Hospital, Wayne, the Red October Run was developed to promote and support youth fitness. In addition to running and walking events, children run in a free "Jr. Mile" event. Red October Run offers 5k and 10k running events to youth through targeted training and incentive opportunities. A wellness tent at the run features health, wellness, and nutrition information along with safety education. In the past two years, 2,141 individuals have participated.

Health Professional Shortage Areas (HPSA) [25]

County Name	HPSA ID	HPSA Name	HPSA Discipline Class	Designation Type
Macomb County	126999268A	Mycare Health Center	Primary Care	Comprehensive Health Center
Macomb County	7269992628	Mycare Health Center	Mental Health	Comprehensive Health Center
Macomb County	626999262U	Mycare Health Center	Dental Health	Comprehensive Health Center
Macomb County	12699926OL	MacOmb Correctional Facility	Primary Care	Correctional Facility
Macomb County	6262258202	MacOmb Correctional Facility	Dental Health	Correctional Facility
Oakland County	12699926PV	Oakland Integrated Health Network (Oihn)	Primary Care	Federally Qualified Health Center Look A Like
Oakland County	126999264U	Oakland Primary Health Services	Primary Care	Comprehensive Health Center
Oakland County	72699926CB	Oakland Integrated Health Network (Oihn)	Mental Health	Federally Qualified Health Center Look A Like
Oakland County	7269992663	Oakland Primary Health Services	Mental Health	Comprehensive Health Center
Oakland County	62699926MA	Oakland Integrated Health Network (Oihn)	Dental Health	Federally Qualified Health Center Look A Like
Oakland County	62699926D2	Oakland Primary Health Services	Dental Health	Comprehensive Health Center
Wayne County	12699926PT	Charter County of Wayne	Primary Care	Comprehensive Health Center
Wayne County	12699926PL	The Wellness Plan	Primary Care	Comprehensive Health Center
Wayne County	12699926PF	American Indian Health and Family Svs of Southeast MI	Primary Care	Native American Tribal Population
Wayne County	12699926F9	Covenant Community Care, Inc.	Primary Care	Comprehensive Health Center
Wayne County	126999267W	Detroit Central City Community Mental Health, Inc.	Primary Care	Comprehensive Health Center
Wayne County	126999265A	Western Wayne Family Health Center	Primary Care	Comprehensive Health Center
Wayne County	126999264X	Health Centers Detroit Foundation	Primary Care	Federally Qualified Health Center Look A Like
Wayne County	126999264M	Community Health and Social Services	Primary Care	Comprehensive Health Center
Wayne County	126999264C	Detroit Health Care for the Homeless	Primary Care	Comprehensive Health Center
Wayne County	126999263M	Detroit Community Health Connection	Primary Care	Comprehensive Health Center
Wayne County	72699926C9	Charter County of Wayne	Mental Health	Comprehensive Health Center
Wayne County	72699926C8	Health Centers Detroit Foundation	Mental Health	Federally Qualified Health Center Look A Like
Wayne County	72699926C1	The Wellness Plan	Mental Health	Comprehensive Health Center
Wayne County	72699926BX	American Indian Health and Family Svs of Southeast MI	Mental Health	Native American Tribal Population
Wayne County	7269992686	Covenant Community Care, Inc.	Mental Health	Comprehensive Health Center
Wayne County	7269992674	Western Wayne Family Health Center	Mental Health	Comprehensive Health Center
Wayne County	7269992659	Community Health and Social Services	Mental Health	Comprehensive Health Center
Wayne County	7269992651	Detroit Health Care for the Homeless	Mental Health	Comprehensive Health Center

[25] *U.S. Department of Health and Human Services, Health Resources and Services Administration, 2016*

Health Professional Shortage Areas (HPSA) [25]

County Name	HPSA ID	HPSA Name	HPSA Discipline Class	Designation Type
Wayne County	7269992639	Detroit Community Health Connection	Mental Health	Comprehensive Health Center
Wayne County	726999261U	Detroit Central City Community Mental Health, Inc.	Mental Health	Comprehensive Health Center
Wayne County	62699926M8	Charter County of Wayne	Dental Health	Comprehensive Health Center
Wayne County	62699926M2	The Wellness Plan	Dental Health	Comprehensive Health Center
Wayne County	62699926LZ	American Indian Health and Family Svs of Southeast MI	Dental Health	Native American Tribal Population
Wayne County	62699926G6	Health Centers Detroit Foundation, Inc.	Dental Health	Federally Qualified Health Center Look A Like
Wayne County	62699926G2	Covenant Community Care, Inc.	Dental Health	Comprehensive Health Center
Wayne County	6.26999E+12	Western Wayne Family Health Center	Dental Health	Comprehensive Health Center
Wayne County	62699926C2	Community Health and Social Services	Dental Health	Comprehensive Health Center
Wayne County	62699926B4	Detroit Health Care for the Homeless	Dental Health	Comprehensive Health Center
Wayne County	62699926A1	Detroit Community Health Connection	Dental Health	Comprehensive Health Center
Wayne County	626999262O	Detroit Central City Community Mental Health, Inc.	Dental Health	Comprehensive Health Center
Wayne County	726999260P	East Detroit Service Area	Mental Health	HPSA Geographic
Wayne County	7269992618	Northwest Detroit	Mental Health	HPSA Geographic High Needs
Wayne County	726999262D	Dearborn Service Area	Mental Health	HPSA Geographic High Needs
Wayne County	726999262E	Romulus Service Area	Mental Health	HPSA Geographic
Wayne County	726999262F	Inkster Service Area	Mental Health	HPSA Geographic High Needs
Wayne County	72699926C5	Hamtramck Service Area	Mental Health	HPSA Geographic High Needs
Wayne County	72699926CL	South Detroit Service Area	Mental Health	HPSA Geographic High Needs
Wayne County	126999260Q	Inkster	Primary Care	HPSA Geographic High Needs
Wayne County	1269992657	Eastside Detroit Service Area	Primary Care	HPSA Geographic High Needs
Wayne County	1269992659	Tireman/Chadsey	Primary Care	HPSA Geographic High Needs
Wayne County	126999266O	MacKenzie/Brooks	Primary Care	HPSA Geographic High Needs
Wayne County	1269992662	North Central Detroit/Highland Park	Primary Care	HPSA Geographic High Needs
Wayne County	1269992681	Southwest Detroit Service Area	Primary Care	HPSA Geographic
Wayne County	12699926H8	Brightmoor Service Area	Primary Care	HPSA Geographic High Needs
Wayne County	626999260C	Medicaid Eligible - Northeast Detroit Service Area	Dental Health	HPSA Population
Wayne County	626999260F	Medicaid Eligible - Southeast Detroit Service Area	Dental Health	HPSA Population
Wayne County	626999261F	Low Income - River Rouge City	Dental Health	HPSA Population
Wayne County	626999261J	Low Income - Southwest Detroit	Dental Health	HPSA Population
Wayne County	62699926F2	Medicaid Eligible - Northwest Detroit Service Area	Dental Health	HPSA Population
Wayne County	62699926ML	Ecorse City Service Area	Dental Health	HPSA Geographic High Needs

[25] *U.S. Department of Health and Human Services, Health Resources and Services Administration, 2016*

Medically Underserved Areas and Populations (MUA/P) [26]

County Name	Service Area Name	MUA/P Source Identification Number	Designation Type
Macomb County	CENTER LINE SERVICE AREA	7773	Medically Underserved Area
Macomb County	Macomb Governor Service Area	1595	Medically Underserved Area – Governor's Exception
Oakland County	City of Pontiac Service Area	1587	Medically Underserved Area
Wayne County	Airport/Conner Service Area	6137	Medically Underserved Area
Wayne County	Chene Service Area	6141	Medically Underserved Area
Wayne County	Dearborn Service Area	1605	Medically Underserved Area
Wayne County	Eastside Service Area	1573	Medically Underserved Area
Wayne County	Ecorse/Lincoln Park/River Rouge	7768	Medically Underserved Area
Wayne County	Harmony Village/Grandmont/Cerveny Service Area	1577	Medically Underserved Area
Wayne County	Inkster City Service Area	1578	Medically Underserved Area
Wayne County	Low Inc - Brightmoor / Cody	7270	Medically Underserved Population
Wayne County	Low Inc - Romulus	7201	Medically Underserved Population
Wayne County	Low Inc - Western Detroit	7763	Medically Underserved Population
Wayne County	Mackenzie/ Brooks Service Area	6140	Medically Underserved Area
Wayne County	Northeast Detroit Service Area	7416	Medically Underserved Area
Wayne County	Pershing/Nolan/State Fair/Davison Service Area	1572	Medically Underserved Area
Wayne County	Romulus/Taylor Service Area	1584	Medically Underserved Area
Wayne County	Southwest Detroit Service Area	6138	Medically Underserved Area
Wayne County	Tireman/Chadsey Service Area	6139	Medically Underserved Area
Wayne County	Wayne Service Area	1602	Medically Underserved Area
Wayne County	Wayne Service Area	1603	Medically Underserved Area
Wayne County	Wayne Service Area	1604	Medically Underserved Area
Wayne County	Wayne Service Area	6142	Medically Underserved Area

[26] *U.S. Department of Health and Human Services, Health Resources and Services Administration, 2016*

APPENDIX G

Interview and Focus Group Participants with the Communities and Populations Represented

Interview Participant Role	Interview Participant Organization	Type of Organization	Hospital Community Representing								Category of Representation				
			Dearborn	Farmington Hills	Grosse Pointe	Royal Oak	Taylor	Trenton	Troy	Wayne	Public Health	Medically Underserved Populations	Low Income Populations	Populations w/ Chronic Disease Needs	Minority Populations
Exec VP, CNO (System)	Beaumont Health	Healthcare Providers	X	X	X	X	X	X	X	X					
VP Planning	Beaumont Health	Healthcare Providers	X	X	X	X	X	X	X	X					
VP Post-Acute Care and Diversified Businesses (former Botsford CEO)	Beaumont Health	Healthcare Providers	X	X	X	X	X	X	X	X					
CMO (System)	Beaumont Health	Healthcare Providers	X	X	X	X	X	X	X	X					
President - Beaumont Farmington Hills	Beaumont Health	Healthcare Providers		X											
President - Beaumont Wayne	Beaumont Health	Healthcare Providers								X					
CIO (System)	Beaumont Health	Healthcare Providers	X	X	X	X	X	X	X	X					
President - Beaumont Grosse Pointe	Beaumont Health	Healthcare Providers			X										
President & CEO (System)	Beaumont Health	Healthcare Providers	X	X	X	X	X	X	X	X					
CEO	Metro Detroit YMCA	Non-Profit and Community-Based Organ.	X	X	X	X	X	X	X	X					
SVP Govt Relations & Community Affairs (System)	Beaumont Health	Healthcare Providers	X	X	X	X	X	X	X	X					
President & CEO	United Way, SE Michigan	Non-Profit and Community-Based Organ.	X	X	X	X	X	X	X	X		X	X		X
Chair of Family Medicine Program and Community Health	Beaumont Health	Healthcare Providers			X	X			X						
OUWB, Chief Academic Officer Royal Oak, Troy and Grosse Pointe)	Beaumont Health	Healthcare Providers			X	X				X					
Director	Health & Human Services, Oakland County	Experts in Public Health		X		X			X		X	X	X	X	X
Manager/Health Officer	Health & Human Services, Health Division, Oakland County	Experts in Public Health		X		X			X		X	X	X	X	X
Reporting/Informatics	Health & Human Services, Health Division, Oakland County	Experts in Public Health		X		X			X		X	X	X	X	X
Executive Director	Tri-Community Coalition	Non-Profit and Community-Based Organ.				X								X	
Executive VP & COO, Interim President - Beaumont Royal Oak	Beaumont Health	Healthcare Providers	X	X	X	X	X	X	X	X					
Administration Clinical Ops - Beaumont Dearborn	Beaumont Health	Healthcare Providers	X												
President - Beaumont Trenton	Beaumont Health	Healthcare Providers						X							
President - Beaumont Troy	Beaumont Health	Healthcare Providers							X						
President - Beaumont Dearborn	Beaumont Health	Healthcare Providers	X												
President - Beaumont Taylor	Beaumont Health	Healthcare Providers					X								
Asst Professor	OUWB School of Medicine/Family Medicince Clinic at ST. Clair Shore	Healthcare Providers			X										
Director	Wayne County Department of Health, Veterans & Community Wellness	Experts in Public Health	X		X		X	X		X	X	X	X	X	X
Director & Health Officer	Macomb County Health Department	Experts in Public Health			X				X		X	X	X	X	X
Health System Manager	American Cancer Society	Non-Profit and Community-Based Organ.	X	X	X	X	X	X	X	X				X	
CEO	Wayne Metro Community Action Agency	Non-Profit and Community-Based Organ.	X		X		X	X		X			X		X
President of MAPI Director, Charitable Clinic	Michigan Association of Physicians of Indian Heritage (MAPI)	Healthcare Providers				X				X		X	X	X	X
VP of Program Operations	Oakland Family Services	Non-Profit and Community-Based Organ.		X		X			X				X		X
Director of HIV/AIDS Program	Detroit Health Department	Healthcare Consumer & Consumer Adv.			X							X	X	X	
Executive Director	Interfaith Health and Hope Coalition	Healthcare Providers	X	X	X		X	X		X			X		X
VP Women and Children's Services - Beaumont Royal Oak	Beaumont Health	Healthcare Providers				X									
COO	National Kidney Foundation of Michigan	Non-Profit and Community-Based Organ.	X	X	X	X	X	X	X	X				X	
Chief Programs Officer	Wayne Metro Community Action Agency	Non-Profit and Community-Based Organ.	X		X		X	X		X			X		X
Director	Detroit Department of Health & Wellness Promotion	Public and Other Org.			X						X	X	X	X	X

APPENDIX G

Interview and Focus Group Participants with the Communities and Populations Represented

Focus Group Participant Role	Focus Group Participant Organization	Type of Organization	Beaumont Health Focus Group Attended	Category of Representation				
				Public Health	Medically Underserved Populations	Low Income Populations	Populations w/ Chronic Disease Needs	Minority Populations
CHRC Director	ACCESS	HC Consumers or Consumer Advocate	Dearborn		X	X	X	X
Exec Director	Cabrini Clinic	Healthcare Providers	Dearborn		X	X	X	X
Program Officer	Community Foundation for SE MI	NFP or Community based Org	Dearborn					
Coordinator for Affective Education	Dearborn Public Schools	Public or Other Similar Orgs	Dearborn		X	X	X	X
Program Manager	Gleaners Community Food Bank	NFP or Community based Org	Dearborn		X	X	X	X
Nursing Program Coordinator	Henry Ford College	NFP or Community based Org	Dearborn			X		X
Program Manager	Leaders Advancing and Helping Communities (LAHC)	NFP or Community based Org	Dearborn			X		X
Exec Director	Metro Solutions	NFP or Community based Org	Dearborn					X
Senior Division Supervisor	City of Farmington Hills	Public or Other Similar Orgs	Farmington Hills		X	X	X	X
Mayor	City of Farmington Hills	Public or Other Similar Orgs	Farmington Hills					
Wellness Director	Farmington Family YMCA	NFP or Community based Org	Farmington Hills					
Assistant Chief	Farmington Hills Police	Public or Other Similar Orgs	Farmington Hills					
Director, School/Community Relations	Farmington Hills Public Schools	Public or Other Similar Orgs	Farmington Hills					
President	Farmington-Farmington Hills Neighborhood House	NFP or Community based Org	Farmington Hills		X	X	X	X
Youth Minister; Pastoral Assoc; Adult Faith Formation Coordinator	St. Fabian Church	NFP or Community based Org	Farmington Hills					
Christian Service Coordinator	St. Fabian/St Vincent DePaul	NFP or Community based Org	Farmington Hills		X	X		
Coordinator for Health and Fitness Center	Beamont Grosse Pointe	Healthcare Providers	Grosse Pointe					
Community Affairs	Beaumont Grosse Pointe	Healthcare Providers	Grosse Pointe					
Physician	Beaumont Grosse Pointe	Healthcare Providers	Grosse Pointe					
Pastor	City Covenant Church	NFP or Community based Org	Grosse Pointe		X	X	X	X
Director	City of Detroit District 4 Dept of Neighborhoods	Public or Other Similar Orgs	Grosse Pointe		X	X	X	X
Intern	City of Detroit District 4 Dept of Neighborhoods	Public or Other Similar Orgs	Grosse Pointe		X	X	X	X
Community Engagement Director	Eastside Community Network	NFP or Community based Org	Grosse Pointe		X	X		X
President and CEO	Greater Detroit Health Council	NFP or Community based Org	Grosse Pointe		X	X	X	X
Superintendent	Grosse Pointe Public Schools	Public or Other Similar Orgs	Grosse Pointe					
Exec Director	Neighborhood Club	Other	Grosse Pointe					
Exec Director	Services for Older Citizens	NFP or Community based Org	Grosse Pointe		X	X	X	X
Community Affairs	Beaumont Health	Healthcare Providers	Royal Oak					
CEO	Judson Center	NFP or Community based Org	Royal Oak		X	X	X	X
Exec Director	Lighthouse of Oakland County	NFP or Community based Org	Royal Oak		X	X	X	X
Intern	Royal Oak Community Coalition	NFP or Community based Org	Royal Oak					
Exec Director	Royal Oak Community Coalition	NFP or Community based Org	Royal Oak					
Housing Director	South Oakland Housing Dir	NFP or Community based Org	Royal Oak		X	X	X	X
Grants Mgmt	South Oakland Shelter	NFP or Community based Org	Royal Oak		X	X	X	X

Focus Group Participant Role	Focus Group Participant Organization	Type of Organization	Beaumont Health Focus Group Attended	Category of Representation				
				Public Health	Medically Underserved Populations	Low Income Populations	Populations w/ Chronic Disease Needs	Minority Populations
Exec Director	Christnet Services	NFP or Community based Org	Taylor		X	X	X	X
Exec Director	Great Start Collaborative	NFP or Community based Org	Taylor		X	X	X	X
Exec Director	Penrickton Center for Blind Children	NFP or Community based Org	Taylor					
CEO	The Information Center	NFP or Community based Org	Taylor		X	X	X	X
School Health/Nurse Consultant	Wayne RESA	Public or Other Similar Orgs	Taylor					
School Health Consultant and Regional Health Coordinator	Wayne RESA	Public or Other Similar Orgs	Taylor					
President	Beaumont Health -Trenton	Healthcare Providers	Trenton					
Staywell Wellness Coordinator	Chrysler Trenton	HC Consumers or Consumer Advocate	Trenton					
Parks and Recreation Director	City of Trenton	Public or Other Similar Orgs	Trenton					
Mayor	City of Trenton	Public or Other Similar Orgs	Trenton					
Pastoral Associate	St. Joseph Catholic Church	NFP or Community based Org	Trenton		X	X	X	X
Priest and Pastor	St. Thomas Episcopal Church	NFP or Community based Org	Trenton		X	X		
Fire Fighter and Paramedic	Trenton Fire Dept	Public or Other Similar Orgs	Trenton					
Superintendent	Trenton Public Schools	Public or Other Similar Orgs	Trenton					
Administrator	Wyandotte Center for the Working Uninsured (aka Downriver Community Clinic)	Healthcare Providers	Trenton		X	X	X	X
Prevention Specialist & Tobacco Cessation	ACC (Arab American and Chaldean Council)	NFP or Community based Org	Troy		X	X	X	X
Refugee Health Program	ACC (Arab American and Chaldean Council)	NFP or Community based Org	Troy		X	X	X	X
Director for Special Projects	ACC (Arab American and Chaldean Council)	NFP or Community based Org	Troy		X	X	X	X
Community Affairs	Beaumont Health	Healthcare Providers	Troy					
Recreation Supervisor at SH Senior Center	City of Sterling Heights Parks and Recreation	Public or Other Similar Orgs	Troy					
Mayor	City of Troy	Public or Other Similar Orgs	Troy					
Vice President	Community Housing Network	NFP or Community based Org	Troy			X		
Exec Director	Macomb County Community Mental Health	Public or Other Similar Orgs	Troy	X	X	X	X	
Business Coordinator	Troy Community Coalition	NFP or Community based Org	Troy					
Membership Chair and volunteer	Troy Youth Assistance	NFP or Community based Org	Troy			X		X
not identified	Troy Youth Assistance/TLL	NFP or Community based Org	Troy					
Wayne Westland Parent Liaison; RN	Beaumont (Oakwood Adams CAHC); National Kidney Foundation;	Healthcare Providers	Wayne		X	X		X
Mayor Protem	City of Wayne	Public or Other Similar Orgs	Wayne					
Parks and Recreation Director (retired)	City of Wayne Commission on Aging	Public or Other Similar Orgs	Wayne					
Public Relations Director	Community Living Services	NFP or Community based Org	Wayne		X	X	X	X
Prevention Coordinator	Hegira Programs Inc	NFP or Community based Org	Wayne		X	X	X	X
Clinic Coordinator	Hope Clinic	Healthcare Providers	Wayne		X	X	X	X
Infant Health Supervision	Starfish Family Services	NFP or Community based Org	Wayne		X	X		X
Maternal and Infant Specialist	Starfish Family Services	NFP or Community based Org	Wayne		X	X		X
Co-President	Wayne Rotary Club	NFP or Community based Org	Wayne					
Family Resource Center Director, Homeless Liaison	Wayne Westland Community Schools	Public or Other Similar Orgs	Wayne		X	X		X
HR Director	Wayne Westland Community Schools	Public or Other Similar Orgs	Wayne					

APPENDIX H

CHNA Prioritization Session Representatives

Susan Grant
EVP & Chief Nursing Officer

Sally Bailey
Administrator Clinical Operations
Wayne

Nancy Susick
Hospital President
Troy

Lindsey West
Director Community Health & Outreach

Ruth Sebaly
Community Health & Outreach
(representing BH-Taylor, BH-Trenton)

Colleen Cooper
Community Health & Outreach

Peter Tucker, MD
Dept. Chief of Family Medicine &
Community Health

Lee Ann Odom
Hospital President
Taylor

Joan Phillips
VP Clinical Support Services
Troy

Michelle Anderson
VP Foundation

Lynn Ish-Green
Community Health & Outreach
(representing BH-Wayne)

Theresa Goodrich
Community Health & Outreach

Christine Stesney-Ridenour
Hospital President
Trenton

Constance O'Malley
Hospital President
Farmington Hills

Karen Wright
Director Planning

Caroline Schairer
Community Health & Outreach
(representing BH-Farmington Hills)

Maureen Elliott
Community Affairs

Steve Le Moine
Administrator Clinical Operations
Dearborn

Richard Swaine
Hospital President
Grosse Pointe

Betty Priskorn
VP Community Health & Outreach

Anne Nearhood
Community Health & Outreach
(representing BH-Grosse Pointe)

Caira Prince
Community Health & Outreach

Suzy Berschback
Community Affairs

Beaumont Hospital, Dearborn
March 13, 2016

Executive summary

Beaumont Health System (Beaumont) engaged Truven Health Analytics, Inc. (Truven) to conduct a series of focus groups to assess the community's perception of health needs in Southeast Michigan. The Beaumont, Dearborn focus group included eight participants. The participants included representatives from the local school district, a nursing college, and community agencies operating across the service area, with varying degrees of involvement in public health. Most participants worked with medically underserved, low-income, minorities and/or populations with chronic disease on some level. The focus group was moderated by a Truven representative. The discussions were oriented around the following questions:

1. Assess the health of the community on a scale of 1-5 (1 poor – 5 excellent).
2. Identify the top three health needs of the community.
3. Discuss the similarities/differences between the needs identified in the prior exercise and the needs identified in prior assessments.
4. Identify up to 10 community resources (health/community organizations) that exist to address the top three needs identified.

The focus group participants represented communities and neighborhoods throughout the Dearborn area, and included representation from various nonprofits working with children and families, seniors, low income populations, and minorities. Despite the differences in populations these groups focus on, participants did have some overlap in the identifying the top health needs of the community. Participants identified access to care, obesity and related disorders, mental health, and care coordination and integration as the top health needs for the community.

Access to care

There are many reasons why people can't or don't access health care services. In the Dearborn community the main reasons include language and cultural barriers, homelessness and a lack of providers especially for mental health. Among the cultural barriers the group cited a lack of trust for the system. There are a number of undocumented immigrants in the community who fear deportation and separation from their families, so they forgo necessary health care services. There is also a stigma attached to seeking health care services, especially mental health and substance abuse services. The need to be sensitive to these issues is a must for improving health in the community.

Obesity and obesity-related disorders

Many communities across the U.S. are seeing obesity on the rise. Longer work days, the convenience of processed food, and a lack of physical activity have led to weight gain across all populations and generations, and with it has come a host of disease and conditions including diabetes and hypertension. The Dearborn community has employed programs like walking clubs and healthy cooking classes to curve the onset of obesity and obesity related diseases, though the focus group felt more needs to be done.

Mental health

Mental health and substance abuse issues are evident in the Dearborn community. Depression and anxiety have begun to plague school aged children and adolescents as well as populations that have historically had mental health problems. As in many communities, there is a stigma attached to having a behavioral health problem, which prevents people from accessing the care they need. Dearborn also has a shortage of mental health providers, and there is a lack of integration of mental health screening by primary care physicians.

Care coordination and integration

Patients consistently have difficulty navigating the health care system and understanding its complexities. This has led to people forgoing care or not receiving the services they need. Physician office visits only last a short time, and there is a lack of knowledge on behalf of providers as to what services are out there in the community.

Coordination of care for those with mental health issues was of particular concern to the focus group. Services are not only difficult to access, but a range of services, including prevention, intervention and recovery, are not always available to all populations. Community mental health agencies have been unsuccessful in developing partnerships with other providers in the community.

Conclusion

The focus groups identified access to care, obesity and related diseases, mental health, and care coordination and integration as the top health needs for the Beaumont, Dearborn service area. These issues affect the general population of Dearborn but solutions will need to be tailored to individual populations with attention to their social and cultural needs.

Beaumont Hospital, Farmington Hills
March 15, 2016

Executive summary

Beaumont Health System (Beaumont) engaged Truven Health Analytics, Inc. (Truven) to conduct a series of focus groups to assess the community's perception of health needs in Southeast Michigan. The Beaumont, Farmington Hills focus group included eight participants. The participants represented community agencies operating across the service area with varying degrees of involvement in public health. Most participants work with populations that are medically underserved, low-income, minority, and/or populations with chronic diseases. The focus group was moderated by a Truven representative and was conducted in two parts: the first session with the entire group, the second session with two smaller breakouts. The discussions were oriented around the following questions:

1. Assess the health of the community on a scale of 1 to 5 (1 poor – 5 excellent).
2. Identify the top three health needs of the community.
3. Discuss the similarities/differences between the needs identified in the prior exercise and the needs identified in prior assessments.
4. Identify up to 10 community resources (health/community organizations) that exist to address the top three needs identified.

The focus group participants represented communities and neighborhoods throughout the Farmington Hills area, and included representation from local government, schools, churches and nonprofits working with children and families, disabled, seniors, low income populations, and those with chronic conditions. Despite the different client populations, participants identified overlapping top health needs. In the second session, both smaller breakout groups identified obesity and lack of mental health resources among the top health concerns. One of the groups selected lack of access to preventive care as a third need, while the other believed there was a lack of information between patients, providers, and social service agencies. Lack of communication around resources was cited as a barrier to accessing preventive health services, and these two health needs will be combined in this summary.

Lack of communication and information around resource availability

Access to health care services, particularly preventive care, is seen by the group as critical to keeping a population healthy. Two major barriers to accessing these services were cited: lack of knowledge and information around available services and mobility or transportation issues. Seniors and children were identified as the most vulnerable populations.

Senior population

The senior population in Farmington Hills is the fastest growing population cohort. The community offers many programs for the elderly to age in place. Transportation and mobility issues were cited by both breakout groups as being the primary barrier for seniors to access the health care system. Farmington Hills, like much of southeast Michigan, has limited public transportation options. There were agencies providing transportation for seniors to physician appointments within the community, but limited awareness about these services among seniors and their caretakers.

Children and young families

Focus group participants felt that there was an increasing number of children in the community who were not receiving health screenings. The two main reasons were affordability and lack of knowledge around preventive services.

The cost of care can be a burden on low income families who may be uninsured or underinsured, and often preventive care is foregone completely. Though many insurance products fully cover preventive care without copays or deductibles, many newly insured people were not aware. Additionally, there was no school nurse in the Farmington Hills school system to fill the gap.

Mental health and substance abuse

The discussion around mental health and substance abuse services focused on three main areas: Opiate use, over-prescribed medications, and suicide. Alcohol and tobacco is also prevalent in the community, but were not as big a concern as these three issues.

Opiate use

The use of opiates has increased threefold in the last five years, according to members of the focus group, causing a number of overdoses and deaths. Heroin has become a problem plaguing the region.

Over-prescribed medications

The over-prescribing of medications is a major concern, particularly for children diagnosed with ADD. Instead of teaching children how to cope with stress, we medicate them. This causes them to lack coping skills as they become young adults facing the pressures of college and entry into the workforce. In turn, they begin self-medicating with drugs and alcohol to cope with problems and stress.

Suicide

Depression is present among children and young adults. There is a lack of support available and a stigma associated with seeking mental health and substance abuse services, leading some to see suicide as their only option.

Obesity

Obesity is an issue across many populations and cultures in the country. In Farmington Hills, obesity is present across all age cohorts and socio-economic levels.

Sedentary lifestyle

The Farmington Hills community has a number of parks and recreational facilities, but the population in general is not physically active. Both focus groups cited technology as the culprit with regard to inactivity. Adults in the community are well educated and many have desk jobs, children spend their time playing video games after school, and both children and adults spend a lot of free time on the internet. If there was a way to combine technology with physical activity, it may help get people moving.

Healthy eating

People in Farmington Hills do not take advantage of healthy food options. There are farmers markets and grocery stores within the community, however the convenience of fast food lures many parents away from the kitchen. Fast food is seen as a cheaper alternative to cooking fresh food. It was also cited that free school lunches recently increased from 6 percent to 23 percent.

Conclusion

The focus groups identified a lack of knowledge and communication around resources, mental health and substance abuse, and obesity as the top health need for the Beaumont, Farmington Hills service area. These themes affect multiple populations of varying ages and socio-economic means. For seniors, transportation and knowledge around services available to them as they become less mobile is the greatest need. Low income individuals and families have difficulty accessing preventive care services and often times don't know of resources available to them. Mental health and substance abuse issues are affecting children through early adulthood, and obesity is affecting the population in its entirety.

Beaumont Hospital, Grosse Pointe
March 17, 2016

Executive summary

Beaumont Health System (Beaumont) engaged Truven Health Analytics, Inc. (Truven) to conduct a series of focus groups to assess the community's perception of health needs in Southeast Michigan. The Beaumont, Grosse Pointe focus group included eleven participants. The participants included representatives from community agencies operating across the service area, with varying degrees of involvement in public health. Most participants worked with medically underserved, low-income, minorities and/or populations with chronic disease on some level. The focus group was moderated by a Truven representative and was conducted in two parts. The first session was held with the entire group. Participants were divided into two groups for smaller breakaway discussions for the second session. The discussions were oriented around the following questions:

1. Assess the health of the community on a scale of 1 to 5 (1 poor – 5 excellent).
2. Identify the top three health needs of the community.
3. Discuss the similarities/differences between the needs identified in the prior exercise and the needs identified in prior assessments.
4. Identify up to 10 community resources (health/community organizations) that exist to address the top three needs identified.

The focus group participants represented communities and neighborhoods throughout the Grosse Pointes and Detroit area, and included representation from local government, schools, churches, and nonprofits working with children and families, the disabled, seniors, low income populations, and those with chronic conditions. Despite the differences in populations these groups focus on, participants did have some overlap in the identifying the top health needs of the community. Both groups identified access to care and mental health as top health needs. One of the groups determined nutrition was their third need, while the other believed there were basic social needs to be met and a lack of preventive health education.

Access to care

Access to care was identified as a top health need by each of the breakout groups. Participants sited physician availability as an issue including long wait times for appointments and a lack of physicians accepting new Medicaid patients.

Affordability of care

Though Michigan participated in the expansion of Medicaid, many residents of the community remain uninsured or underinsured. These populations have trouble navigating the health care system, understanding what is covered if they have insurance, and paying for services that have high copays or hit their deductibles. Immunizations and prescription medications were specifically called out as having high perceived costs. Those living in the Detroit zip codes included in the Beaumont, Grosse Pointe service area have the most difficulty accessing care.

Transportation

Transportation was cited as a barrier to accessing care. Public transportation options are limited throughout the community and as a result, the poor, disabled and elderly often struggle to get to providers and pharmacies.

Navigation of the system

Navigation of the health care system was brought up in conjunction with a lack of discharge information and follow up by providers as another barrier to accessing care. Coordination between hospitals and physicians, and between providers and social welfare organizations often does not occur, leaving it up to the individual to determine where to go to have their needs met.

Mental health and substance abuse

Both groups cited mental health issues across populations of all ages and income levels as well as an increase in marijuana and opioid use across the region. In general, there is a shortage of mental health providers and a lack of resources for mental health and substance abuse in the community. In the elderly population, isolation and abuse are causing depression. School-aged children and college-aged adults are also suffering from depression, and stress and isolation have led to drug use and suicide. Heads of single parent households often manage their stress with drug use, and those with gender identity related issues have higher suicide rates. Health care providers should take a more holistic approach to care and see mental/emotional health and wellbeing as part of caring for a population. The community needs more resources and support options for those with mental health and substance abuse issues.

Social needs

Social needs including employment and shelter were discussed in the focus group. The communities in and around Detroit have suffered economically which has led to deplorable living conditions for some and blight throughout the community. There is work being done in some areas to revitalize neighborhoods and remove blight, but funding can be limited. Having basic needs met and a steady income is still a challenge in many areas.

Preventive health and nutrition education

A lack of education around prevention has led to a number of health problems for the community including tobacco use, obesity, diabetes and cardiac diseases. There are a number of grocery stores in the area but many stock unhealthy options. Whole Foods is seen as too expensive. Education around healthy eating, exercise and smoking cessation should be the responsibility of the physicians or nurses for their patient panel. Grosse Pointe schools offer some health education but Detroit schools do not. Detroit also has a very high number of fast food restaurants, which participants see as contributing to the problem of obesity and obesity related diseases like diabetes and heart disease.

Conclusion

The focus groups identified access to care, mental health and substance abuse, meeting basic social needs and lack of preventative health and nutrition education as the top health needs for the Beaumont, Grosse Pointe community. These themes affect multiple populations including; uninsured and underinsured individuals, Detroit city residents, and disabled, the elderly and socio-economically disadvantaged persons. Access barriers include provider availability, affordability, transportation and health system navigation and can specifically impact those with no or limited insurance, the elderly and the disabled. Mental health and substance abuse affects all groups in different ways and solutions will need to be uniquely tailored to each group. Many residents of the communities in and around the city of Detroit face challenges meeting basic social needs such as employment and shelter, which makes health care a lower priority for them. Residents in Detroit who may benefit from much needed preventative health and nutrition education do not have access to those type of resources in their community.

Beaumont Hospital, Royal Oak
March 14, 2016

Executive summary

Beaumont Health System (Beaumont) engaged Truven Health Analytics, Inc. (Truven) to conduct a series of focus groups to assess the community's perception of health needs in Southeast Michigan. The Beaumont, Royal Oak focus group included seven participants. The participants included representatives from community agencies operating across the service area, with varying degrees of involvement in public health. Most participants worked with medically underserved, low-income, minorities and/or populations with chronic disease on some level. The focus group was moderated by a Truven representative. The discussions were oriented around the following questions:

1. Assess the health of the community on a scale of 1 to 5 (1 poor – 5 excellent).
2. Identify the top three health needs of the community.
3. Discuss the similarities/differences between the needs identified in the prior exercise and the needs identified in prior assessments.
4. Identify up to 10 community resources (health/community organizations) that exist to address the top three needs identified.

The focus group participants represented communities and neighborhoods throughout the Royal Oak area, and included representation from various nonprofits working with children and families, the disabled, seniors, low income populations, and those with chronic conditions. Despite the differences in populations these groups focus on, participants did have some overlap in the identifying the top health needs of the community. Participants identified communication and education, integration of care and access to care as the top health needs for the community.

Communication and education

Those who have limited experience with the health care system including the homeless, uninsured and newly insured, or those with new diseases, conditions, or symptoms often don't know how to navigate the system or how to communicate with their providers about what they're experiencing. Improvements in health literacy and community outreach programs could help increase awareness and reduce stigma particularly around mental health. The community also needs to be more educated around the programs and services available to them.

Integration of care

The community would benefit from a more holistic approach to care including better coordination between medical providers and social services. Covenant Community Care and Beaumont collaborate to promote a more integrated approach to care, but more collaboration is needed throughout the community. Clinics are dispersed and patients really need a one-stop shop. They also need to be educated on how to care for themselves at home, and screening should occur regularly to ensure promptness of referrals.

Access to care

Transportation and physical access, particularly for the homeless and the elderly, has been a barrier to receiving care at the appropriate time and in the appropriate place. Transportation options in the suburbs of Detroit are limited. Busses run through Royal Oak but don't necessarily make stops in the community.

Financial barriers to access also exist in the Royal Oak community. Low to middle income populations may have insurance but still put off care because they feel they can't afford the deductibles, copays, and coinsurance. Changes in insurance products have made navigation more complex, and there is a lack of understanding

around the cost of care. Additionally, visit limits can prevent people from accessing care when they need it most, particularly mental health and substance abuse services. For some populations there are income caps and spend down limits associated with seeing these providers, creating additional access barriers.

Conclusion

The focus groups identified communication and education, integration of care, and access to care as the top health need for the Beaumont, Royal Oak service area. These themes affect multiple populations including the homeless, mentally ill, elderly, and the underinsured and uninsured. Though there is overlap in the needs of each of these populations, solutions will need to be uniquely tailored to each.

Beaumont Hospital, Taylor
March 17, 2016

Executive summary

Beaumont Health System (Beaumont) engaged Truven Health Analytics, Inc. (Truven) to conduct a series of focus groups to assess the community's perception of health needs in Southeast Michigan. The Beaumont, Taylor focus group included seven participants. The participants included representatives from community agencies operating across the service area, with varying degrees of involvement in public health. Most participants worked with medically underserved, low-income, minorities and/or populations with chronic disease on some level. The focus group was moderated by a Truven representative. The discussions were oriented around the following questions:

1. Assess the health of the community on a scale of 1 to 5 (1 poor – 5 excellent).
2. Identify the top three health needs of the community.
3. Discuss the similarities/differences between the needs identified in the prior exercise and the needs identified in prior assessments.
4. Identify up to 10 community resources (health/community organizations) that exist to address the top three needs identified.

The focus group participants represented communities and neighborhoods throughout the Taylor area, and included representation from various nonprofits working with children and families, the disabled, seniors, low income populations, and those with chronic conditions. Despite the differences in populations these groups focus on, participants did have some overlap in the identifying the top health needs of the community. Participants identified access to care, education and prevention of acute and chronic diseases, and mental health.

Access to care

Access to care was identified as a top health need. Several barriers to access were identified and include lacking public transportation, long wait times to see certain kinds of physicians and dentists and a lack of dentists accepting Medicaid, a confusion around insurance products, and a general lack of knowledge around how to navigate the health care system.

Access to physicians and dentists

The expansion of Medicaid has helped alleviate access and affordability issues for many Americans, however many populations are still struggling to get the health care services they need. In the Taylor service area there are very few dental providers who will take Medicaid patients, and those that do have long wait times for appointments. There is also a limited number of pediatric subspecialists in the area, and residents needing those services are forced to travel to downtown Detroit or Ann Arbor.

Transportation

Transportation was cited as a barrier to accessing care. Public transportation options are limited throughout the community and are described as "inconvenient" and "time consuming." As a result, people are forgoing necessary care, particularly preventive care.

Understanding insurance and navigation of the system

In the last several years many new insurance products have been brought to the market, and with Medicaid expansion, many individuals and families not previously covered now have insurance. These people often have unanswered questions around what services are covered, who accepts their insurance, is a referral or prior authorization needed, and what will the cost be to them. The complexities around insurance are compounded when patients have multiple providers they are dealing with. Visit limits and cost of services vary across specialties and providers. As a result, these populations are not accessing the system through primary care physicians, and instead seek care at the hospital when a major intervention is needed.

Prevention

A lack of education around prevention has led to a number of health problems for the community including high rates of asthma, infant mortality, diabetes, high blood pressure, COPD and tobacco use. Those having difficulty navigating the health care system are particularly vulnerable as described above. Children and pregnant women were also called out as vulnerable populations who are in need of preventive health services. Issues like asthma and infant mortality become problems when parents and expectant parents don't seek preventive care.

Mental health

Populations across the U.S. have difficulty accessing mental health services due to both a lack of providers and the stigma attached to seeking mental health care. Taylor is no exception. Participants in the focus group believe centers are understaffed and that often times the threshold for accessing mental health services is too high. The homeless population is particularly vulnerable. Additionally, the community sees transportation and difficulties navigating the system affecting access as well as medication compliance in the mentally ill.

Conclusion

The focus groups identified barriers to accessing and navigating the health care system, prevention and mental health as the top health needs for the Beaumont, Taylor service area. These themes affect multiple populations including the newly insured and underinsured, children, expectant mothers, and the homeless. Though there is overlap in the needs of each of these populations, solutions will need to be uniquely tailored to each.

Beaumont Hospital, Trenton
March 17, 2016

Executive summary

Beaumont Health System (Beaumont) engaged Truven Health Analytics, Inc. (Truven) to conduct a series of focus groups to assess the community's perception of health needs in Southeast Michigan. The Beaumont, Trenton focus group included nine participants. The participants included representatives from local government, the local school system, a large employer in the area, and community-based nonprofit agencies operating across the service area, with varying degrees of involvement in public health. Most participants worked with medically underserved, low-income, minorities and/or populations with chronic disease on some level. The focus group was moderated by a Truven representative. The discussions were oriented around the following questions:

1. Assess the health of the community on a scale of 1 to 5 (1 poor – 5 excellent).
2. Identify the top three health needs of the community.
3. Discuss the similarities/differences between the needs identified in the prior exercise and the needs identified in prior assessments.
4. Identify up to 10 community resources (health/community organizations) that exist to address the top three needs identified.

The focus group participants represented communities and neighborhoods throughout the Beaumont, Trenton service area, and included representation from various agencies and nonprofits working with children and families, the disabled, seniors, low income populations, and those with acute and chronic medical conditions. Despite the differences in populations these groups focus on, participants did have some overlap in the identifying the top health needs of the community. Participants identified healthy lifestyle choices, mental health, and better coordination of services to get resources to people in need as the top needs affecting the health of the community.

Healthy lifestyle choices

Lifestyle choices can greatly affect one's ability to stay healthy and combat disease. Engaging in physical activity, making smart food choices, and accessing primary and preventive care on a regular basis can have a direct impact on the likelihood of developing conditions like diabetes and heart disease.

Chronic conditions

The population of Trenton is aging and there has been an increase in the number of people with diabetes, cardiovascular disease, and COPD. Though there are fewer people taking up smoking, and many smokers have quit in recent years, many older adults still smoke and are plagued by emphysema. Younger people who aren't living a healthy, active lifestyle are more likely to face issues with their health in the future. Unfortunately, they don't think about the future cost of their health care needs. Programs like Diabetes PATH have been implemented and are showing signs of success.

Diet and exercise

Public transportation is limited in the Trenton area and focus group participants would describe the community as "car centric." The city is working on creating bike trails as part of a 63-mile linked network of trails.

Healthy food options are limited as there is not a grocery store in Trenton. Participants describe the area as a "food swamp," one saturated with fast food restaurants and unhealthy food choices. Obesity is a growing problem in the community despite schools offering healthier food options. Parents are choosing convenience food over healthier options and children are picking up their bad habits.

Passport to Health was created to give residents information on healthy habits, walking and biking paths, food and nutrition information, and establishing healthy goals. Its success has warranted a digital version that is in the works.

Mental health

Mental and behavioral health issues come in many forms including depressive disorders, psychotic disorders like schizophrenia, those involving memory loss like Alzheimer's disease and substance abuse problems. Populations with all of these mental health issues reside within the Trenton community. There are unique challenges to reaching these populations, especially when they are homeless. Often times help is sought out but insurance only covers medications and not follow up visits.

Top mental health disorders

The top mental health disorders cited by the group included dementia and Alzheimer's in the elderly, depression, which spans all generations, bipolar disorder and schizophrenia which disproportionally affects the homeless. Drug use is also an issue as heroin use is on the rise in the region and many people are at risk of suicide. Participants also said schools have seen an increase in the number of autistic children.

Caring for the mentally ill

There is a general lack of support for those caring for the mentally ill populations in the community. Many families struggle to care for their elderly relatives who suffer from mental illnesses. Hospice is being used inappropriately as way to manage elderly in advance stages of Alzheimer's and dementia.

Navigating the health care system

Navigating the health care system is complex and poses a problem for many people. Many people experiencing a mental illness can't understand the costs associated with care, what insurance covers, what out of pocket costs will be, and what follow up services are covered. Often times this level of complexity is too much, and people forego care or access services through the ED as opposed to going through more appropriate channels.

Coordination of services

Coordination of health care and social services is a challenge in many communities. With the Affordable Care Act came increases in covered lives and a new set of challenges for people who were new to the health care system. They were used to accessing services through the ED when needed and without regard to costs. Now they are responsible for paying deductibles and copays they can't afford. Rising insurance costs have led to more high deductible plans and reductions in coverage for certain services so even those who previously access the system are avoiding care because of high costs.

There are a number of efforts within the community to keep people healthy and teach them how to make healthy choices, set healthy goals, and use the health care system appropriately. Headway has been made in getting people into these programs but there is still a need to engage specific populations and connect resources for better health and wellbeing.

Conclusion

The focus groups identified healthy lifestyle choices, mental health and coordination of services as the top health need for the Beaumont, Trenton service area. These themes affect multiple populations including the elderly, the newly insured and underinsured, and the homeless, and solutions will need to be uniquely tailored to each population.

Beaumont Hospital, Troy
March 17, 2016

Executive summary

Beaumont Health System (Beaumont) engaged Truven Health Analytics, Inc. (Truven) to conduct a series of focus groups to assess the community's perception of health needs in Southeast Michigan. The Beaumont, Troy focus group included twelve participants. The participants included representatives from community agencies operating across the service area, with varying degrees of involvement in public health. Most participants worked with medically underserved, low-income, minorities and/or populations with chronic disease on some level. The focus group was moderated by a Truven representative and was conducted in two parts. The first session was held with the entire group. Participants were divided into two groups for smaller breakaway discussions for the second session. The discussions were oriented around the following questions:

1. Assess the health of the community on a scale of 1 to 5 (1 poor – 5 excellent).
2. Identify the top three health needs of the community.
3. Discuss the similarities/differences between the needs identified in the prior exercise and the needs identified in prior assessments.
4. Identify up to 10 community resources (health/community organizations) that exist to address the top three needs identified.

The focus group participants represented communities and neighborhoods throughout the Troy service area, and included representation from local government, schools, cultural organizations, and nonprofits working with children and families, the disabled, seniors, low income populations, and those with chronic conditions. Despite the differences in populations these groups focus on, participants did have some overlap in the identifying the top health needs of the community. Both groups identified a lack of integration in care delivery as an issue, particularly for mental health and substance abuse patients. The groups also identified prevention, communication and cultural barriers to access, transportation and treatment and follow up support for those with chronic conditions.

Prevention/communication/ continuity of care

Communication and education around prevention are critical components to remaining healthy, but these services are lacking in the Troy community. It was said in one focus group that $1 spent on prevention could save $10 in future health care costs. The main reason people are delaying care is an inability to navigate the system. Other issues include language and cultural barriers, a lack of understanding around insurance coverage and costs, and long wait times to see providers.

Transportation

Transportation is an issue for the most vulnerable populations including seniors and refugees. The lack of available public transportation directly impacts all the other health needs identified in the focus group.

Integrated mental health services

Both groups cited a need for a more integrated approach to mental health and substance abuse services. Access is available at the hospital or institution level, but many people with anxiety, depression and drug problems do not know how to access community mental health providers. The problem is exacerbated by a shortage of psychiatrists in the Troy area, and by transportation issues, cost issues and insurance complexity, and social issues like homelessness or language barriers. Primary care and social service providers need to be able to identify mental health issues, educate and help patients navigate the system. A more holistic approach to mental health including physical health, housing and socio-economic wellbeing should be a priority.

Culturally sensitive access to care

Southeast Michigan has a large Arabic population which includes refugees and immigrants of multiple generations and from various parts of the Middle East and Africa. With no knowledge of the American health care system, these populations need additional assistance in understanding and navigating our health care system. Many do not speak English and use their children as a means for communicating with health care providers, and rely on them to interpret information like medication instructions. Others are the first generation in this country and have no English speaking relatives to help them.

Treatment and follow up for chronic conditions

As seniors are living longer they present new challenges to the health care system. Assisted living facilities are full and many seniors with mental health issues face homelessness. The immigrant population also faces challenges in getting care for chronic conditions. Often it isn't a priority, or language is an issue. Transportation can be a problem for both the senior and immigrant populations as well as homeless. Long wait times to see providers and a lack of navigators to help these patients results in them forgoing follow-up-care and treatment outside the hospital walls.

Conclusion

There was a significant amount of overlap in the needs identified by the focus groups. The need for education, communication, navigation, and integration of care in the arenas of prevention, mental health, chronic conditions and immigrant and refugee health was discussed in detail in both breakout groups. Though only one group cited transportation as a top issue impacting health, it was part of discussions around access and issues facing vulnerable populations in the Troy market.

Several populations were identified as vulnerable including seniors, homeless and low income populations, but immigrants and refugees in the region were most vulnerable as many language and cultural barriers exist with regard to accessing, understanding, and utilizing our health care system. Solutions must be tailored to each population in order to alleviate their specific health needs.

Beaumont Hospital, Wayne
March 16, 2016

Executive summary

Beaumont Health System (Beaumont) engaged Truven Health Analytics, Inc. (Truven) to conduct a series of focus groups to assess the community's perception of health needs in Southeast Michigan. The Beaumont, Wayne focus group included eleven participants. The participants included representatives from community agencies operating across the service area, with varying degrees of involvement in public health. Most participants worked with medically underserved, low-income, minorities and/or populations with chronic disease on some level. The focus group was moderated by a Truven representative and was conducted in two parts. The first session was held with the entire group. Participants were divided into two groups for smaller breakaway discussions for the second session. The discussions were oriented around the following questions:

1. Assess the health of the community on a scale of 1 to 5 (1 poor – 5 excellent).
2. Identify the top three health needs of the community.
3. Discuss the similarities/differences between the needs identified in the prior exercise and the needs identified in prior assessments.
4. Identify up to 10 community resources (health/community organizations) that exist to address the top three needs identified.

The focus group participants represented communities and neighborhoods throughout the Wayne/Westland area, and included representation from local government, schools, and nonprofits working with children and families, the disabled, seniors, low income populations, homeless and uninsured. Despite the differences in populations these groups focus on, participants did have some overlap in the identifying the top health needs of the community. Access to health care was included in both lists. One group identified obesity and behavioral health as top health needs while the other called out transportation, social services and child care as the top needs affecting community health.

Access to health care

Access to health care services including dental services was of concern to all focus group participants. There is a general lack of availability of providers who will see uninsured or Medicaid patients in the community. A mobile dental program for children was started because there are no community dentists that will see Medicaid patients. Wait times for medical providers are extremely long and quality is perceived to be low.

Social determinants of health

The population of Wayne has historically been poorer than other parts of southeast Michigan, leading to a high number blighted properties and rental properties in the area. The community is home to a number of single-parent households and grandparents raising children, as well as homeless and transient populations. These populations are often unemployed or underemployed, uninsured or underinsured and lacking the financial means to pay for health care services. Even those with insurance forego care because they can't afford high deductibles, copays and coinsurance.

Provider availability barriers

In addition to there being only a few providers in the community who will see uninsured and Medicaid patients, there are long wait times to see providers. People working low-paying jobs without benefits cannot afford to take time away from work, especially when they may be waiting hours after arrival to see a physician. Mothers cannot afford to pay for childcare and risk losing their jobs if they need time off from work to care for sick children.

The homeless have particular difficulty accessing care as there are few resources in the community for them, and those agencies that do provide assistance have trouble reaching the homeless and transient populations.

The ED becomes the only source of health care services for these populations as there is a general

belief that they don't need to pay the hospital's bill. The hospital ED however does not provide all health care services to the uninsured (i.e. patients can get a cast put on, but not removed in the ED).

Behavioral health and social services

Communities across the U.S. are experiencing a shortage of behavioral health providers. This coupled with the stigma many cultures still attach to mental health care exacerbates the problems associated with mental illness including unemployment, alcoholism and drug use, homelessness and suicide.

Drug use, particularly heroin use, has increased exponentially over the last several years and is a problem facing several states in the region. A high number of overdose patients are appearing in hospital EDs and the number of deaths due to overdoses has been on the rise.

Human trafficking is an often unknown and undiscussed issue facing communities today. Participants in one of the focus groups believe this is a problem in the Wayne/Westland community and there are inadequate mental health and social service resources for victims of human trafficking.

Obesity

Obesity has become an issue across many populations and cultures in the U.S., contributing to a number of chronic health conditions including diabetes and heart disease. Unhealthy lifestyles coupled with a lack of education around healthy eating has led to participants citing obesity as a top health concern for the community.

Access to healthy food

Healthy food does not appear to be readily accessible to residents of Wayne, particularly low income residents. Described as a "food swamp," there are few accessible grocery stores in the area. Those that do exist display unhealthy convenience food and place little emphasis on fresh foods. The area has one of the highest numbers of fast food restaurants per capita, and fast food is widely seen as a more affordable alternative to cooking fresh food. Participants also noted that there is a high number of children in the Wayne/Westland school system on free or reduced fee lunch programs.

Sedentary lifestyle

A lack of activity in daily life affects the health of many populations. Adults spend their workday sitting at a desk and then in front of the television at home. Children play video games or spend their evenings on the internet instead of playing outside. The Wayne/ Westland area has several parks, but they are not accessible to those without transportation. Additionally, with many adults and children in the community whose basic needs aren't being met, exercise and other types of physical activity are not a priority.

Child care

The inability to provide a safe home, proper nutrition and general physical and emotional support to a child plagues many households in the Wayne/Westland community. Unfortunately, this lack of care results in learning and behavioral issues, chronic diseases, and unhealthy lifestyles as children age into adulthood.

Barriers to entering a shelter

Of particular concern is the breaking up of families when a temporary shelter is needed. Children over age 14 have to go to a same-sex shelter regardless of where their parent or other siblings are placed. Often women and children stay in abuse homes because they have pets they are afraid to leave, as the area has no resources to keep their pets safe.

Barriers to healthy food

Feeding a family can take a large percentage of one's income, especially when that income is at or close to the minimum wage. Fast food, though lacking in nutrients and while being high in fat, sodium, and calories, is seen as a cheaper option to preparing fresh food. The convenience of fast food also drives consumption among families with children. Wayne has few grocery stores and

convenience stores stock unhealthy, non-nutritious options that appeal to children. Focus group participants noted that local shelters and food pantries are limited in food options and often stock expired goods.

Conclusion

The focus group identified access to health care services, mental health and social service needs, obesity and child care needs as the top health need priorities for the Beaumont - Wayne service area. These themes affect multiple populations of varying socio-economic means and solutions will need to be tailored to meet the needs of each individual population affected.

The Patient Protection and Affordable Care Act (the PPACA) requires all tax-exempt hospitals to assess the health needs of their community through a community health needs assessment (CHNA) once every three years. A CHNA is a written document developed for a hospital facility that defines the community served by the organization, explains the process used to conduct the assessment and identifies the salient health needs of the community. In addition, the CHNA must include a description of the process and criteria used in prioritizing the identified significant health needs, and an evaluation of the implementation strategies adopted as part of the most recently conducted (2013) assessment. A CHNA is considered conducted in the taxable year that the written report of its findings, as described above, is approved by the hospital governing body and made widely available to the public. Beaumont Health completed a CHNA in the first half of 2016. The CHNA report was approved by the Beaumont Health board of directors in December 2016. It is available to the public at no cost for download and comment on our website at beaumont.org/chna.

In addition to identifying and prioritizing significant community health needs through the CHNA process, the PPACA requires creating and adopting an implementation strategy. An implementation strategy is a written plan addressing each of the significant community health needs identified through the CHNA. The implementation strategy must include a list of the significant health needs the hospital plans to address and the rationale for not addressing the other significant health needs identified. The implementation strategy (a.k.a. implementation plan) is considered implemented on the date it is approved by the hospital's governing body. The CHNA implementation strategy is filed along with the organization's IRS Form 990, Schedule H and must be updated annually with progress notes.

The Beaumont Health community has been identified as Macomb, Oakland and Wayne counties. The CHNA process identified significant health needs for this community (see box to right).

Significant health needs were identified as those where the qualitative data (interview and focus group feedback) and quantitative data (health indicators) converged. Beaumont Health prioritized these significant community healthcare needs based on the following:

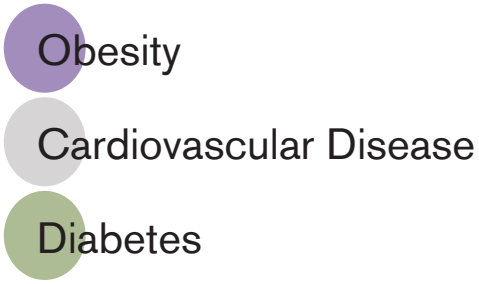
- Importance of the problem to the community ensures the priorities chosen reflect the community experience.
- Alignment with the health system's strengths is important to ensure we leverage our ability to make an impact.
- Resources criteria acknowledges that we need to work within the capacity of our organization's budget, partnerships, infrastructure, and available grant funding.
- To be sure we reach the most people, the criteria of magnitude considers the number of people the problem affects either actually or potentially.

High Data and Qualitative

- **Cardiovascular Conditions**
  (e.g. heart disease, hypertension, stroke)
- **Diabetes**
  (e.g. prevalence, diabetic monitoring)
- **Respiratory Conditions**
  (e.g. COPD, asthma, air quality)
- **Mental and Behavioral Health**
  (e.g. diagnosis, suicide, providers)
- **Healthcare Access**
  (e.g. insurance coverage, providers, cost, preventable admissions, transportation, dental care)
- **Obesity**
- **Prevention– Screenings and Vaccinations**
- **Substance Abuse**
  (e.g. drug overdose, alcohol abuse, drug use, tobacco)

- In order to address the health disparities that exist, we consider the impact of the problem on vulnerable populations.

Through the prioritization process, three significant needs were selected to be addressed via the Beaumont Health CHNA Implementation Strategy:



All other significant health needs were not chosen for a combination of the following reasons:

- The need was not well-aligned with organizational strengths.
- There are not enough existing organizational resources to adequately address the need.
- Implementation efforts would not impact as many community residents (magnitude) as those that were chosen.
- The chosen needs more significantly impact vulnerable populations.

While each of the significant health needs identified through the community health needs assessment process is important, and many are currently addressed by existing programs and initiatives of Beaumont Health or a Beaumont Health partner organization, allocating significant resources to the three priority needs above prevents the inclusion of all health needs in the Beaumont Health CHNA implementation strategy.

Key Approaches of the Implementation Strategy

Beaumont Health is committed to engaging in transformative relationships with local communities to address the social determinants of health and to increase access to high quality health care. We recognize good health extends beyond the doctor's office and hospital. Our work in the community takes a prevention, evidence-based approach with key elements that include:

- Building and Sustaining Multi-Sector Community Coalitions - partnering with leaders of local and state government, public health, community leaders, schools, community-based nonprofits, faith-based organizations, and community residents to achieve measurable, sustainable improvements by using a "collective impact" framework to improve the health and well-being of the diverse communities we serve. These multi-sector coalitions engage in mutually reinforcing activities to build and strengthen partnerships that address the social determinants of health and work towards solutions.
- Addressing social determinants of health and improving access to care for vulnerable populations.
- Working with community partners to supplement CHNA initiatives through grants, programs and policies.
- Partnering with FQHCs (Federally Qualified Health Centers) and free clinics to provide support to the underinsured and uninsured within the economically disadvantaged and medically underserved populations of Beaumont Health.
- Partnering with public Health Departments to align efforts, resources and programs.
- Consideration of sponsorships to organizations for events or activities that address the key health priorities of obesity, cardiovascular disease and diabetes.

The implementation strategy for the chosen health needs of obesity, cardiovascular disease and diabetes are outlined in the following pages.

Over the next three years each Beaumont Health hospital will execute its implementation strategies which will be evaluated and updated on an annual basis.

Beaumont Hospital, Dearborn

OBESITY

GOAL: Decrease rate of obesity in children and adults by promoting healthy eating and active living behaviors
STRATEGY 1: Provide education and services that support healthy eating, active living and maintaining a healthy weight

PROGRAM/ ACTIVITY	DESCRIPTION	ANTICIPATED IMPACT	TARGET AUDIENCE	HOW RESULTS WILL BE MEASURED	PARTNERS
Provide Cooking Matters™ programs	Six-week workshops for adults and teens and single session store tours to equip families with the knowledge and skills they need to shop for and prepare healthy meals on a limited budget. Hosted at libraries, senior centers and community organizations.	Improved nutrition practices, eating habits, healthy meal preparation and food budgeting knowledge and behaviors	Economically disadvantaged populations	▪ Participation rates ▪ Post-test outcome measures such as use of nutrition facts on food labels, adjusting meals to be more healthy, choosing healthy foods at restaurants ▪ Participant survey	Gleaners Community Food Bank of SE Michigan
Provide CATCH Kids Club (Coordinated Approach to Child Health) to prevent childhood obesity	After-school and summer program staff are trained to provide the CATCH nutrition and physical activity program	Improved knowledge and practices to make healthy eating and physical activity decisions	Youth grades K-5	▪ Post-test outcome measures such as fruit and vegetable consumption, exercise, reading nutrition labels	Dearborn Public Schools
Healthy Dearborn coalition	Beaumont Hospital, Dearborn will provide backbone support to the Healthy Dearborn multi-sector community coalition to develop strategies in the community and at worksites for healthy eating and active living	Collaborative partnerships to improve the health and well-being of diverse community members	Community-wide	▪ Number of programs and activities implemented to promote healthy eating and active living ▪ Distribution of Passport to Health	Healthy Dearborn coalition City of Dearborn Dearborn Public Schools
Develop strategies to increase access to fresh fruits and vegetables	Explore support of the Dearborn Farmers Market, the Power of Produce program, the Prescription for Health program, community gardens and in-school nutrition education	Reduction in food insecurity Increase in fresh fruit and vegetable consumption	Community-wide Focus on economically disadvantaged populations	▪ Partnership agreements ▪ Number of participants	City of Dearborn Dearborn Public Schools Healthy Dearborn coalition
Medical outreach and prevention programs offered through Beaumont Teen Health Center, River Rouge	Measure BMI and provide nutrition counseling	Improved nutrition practices of youth	Youth ages 10-21	▪ Number of students screened in health center ▪ Number of students receiving nutrition counseling	River Rouge School District
Provide education on healthy eating, fitness and weight management through the Beaumont Speakers Bureau	Education presentations to community groups	Improved knowledge of obesity prevention and treatment options	Community organizations	▪ Participation rates ▪ Participant survey	

Beaumont Hospital, Dearborn

STRATEGY 2: Increase opportunities for physical activity

Healthy Dearborn coalition	Beaumont Hospital, Dearborn will provide backbone support to the Healthy Dearborn multi-sector community coalition to improve walkability and bikeability of the community and to provide recreational programs and events	Increase in physical activity of children and adults	Community-wide	▪ Number of programs and activities implemented to increase physical activity	Healthy Dearborn coalition City of Dearborn Parks and Recreation

CARDIOVASCULAR DISEASE

GOAL: Decrease cardiovascular disease risk factors and prevent death from sudden cardiac arrest
STRATEGY 1: Provide education programs and services

PROGRAM/ ACTIVITY	DESCRIPTION	ANTICIPATED IMPACT	TARGET AUDIENCE	HOW RESULTS WILL BE MEASURED	PARTNERS
Provide CPR training through the Beaumont Teen Health Center, River Rouge	In partnership with the American Heart Association provide CPR training in assessment, compressions and using an AED (Automatic External Defibrillator)	Increased knowledge and skills to resuscitate teens or adults suffering sudden cardiac arrest	High school students	▪ Number of individuals trained	American Heart Association River Rouge School District
Provide resources and referrals through the Beaumont Quit Smoking Resource Line	To address the cardiovascular disease risk factor of smoking, the Quit Smoking Resource Line provides telephonic assessment, information and referrals to connect smokers to the quit smoking resources, programs and services they need	Increased awareness and knowledge of stop smoking methods and support services	Smokers	▪ Participation rates ▪ Referral rates	
Provide education on cardiovascular health through the Beaumont Speakers Bureau	Education presentations to community groups	Improved knowledge of cardiovascular disease prevention and treatment options	Community organizations	▪ Participation rates ▪ Participant survey	

STRATEGY 2: Provide early detection screenings

Provide heart health screenings	Blood pressure, cholesterol and glucose screenings offered at community locations to identify and counsel individuals with elevated levels	Improved self-management and follow-up care of cardiovascular risk factors	Adults	▪ Screening results ▪ Referrals for follow-up care ▪ Participant survey	Community organizations

DIABETES

GOAL: Decrease rate of new diabetes cases and of diabetes complications
STRATEGY 1: Provide early detection screenings, diabetes prevention programs and diabetes education services

PROGRAM/ ACTIVITY	DESCRIPTION	ANTICIPATED IMPACT	TARGET AUDIENCE	HOW RESULTS WILL BE MEASURED	PARTNERS
Provide diabetes screenings	Screening offered at community locations to identify and counsel individuals with elevated glucose levels	Improved self-management and follow-up care	Adults	▪ Screening results ▪ Referrals for follow-up care ▪ Participant survey	Community organizations
Provide Diabetes PATH (Personal Action Toward Health) workshops	Six-week chronic disease management class hosted in collaboration with libraries, senior centers and community organizations	Improved diabetes self-management	Adults and seniors with diabetes and their caregivers	▪ Participation rates ▪ Post-test outcome measures such as blood sugar testing, physical activity, confidence managing condition ▪ Participant survey	National Kidney Foundation of Michigan
Provide My Choice…My Health Diabetes Prevention Program	12-month lifestyle change program with group coaching hosted in collaboration with libraries, schools and community centers	Prevention of type 2 diabetes	Adults with prediabetes or at high risk of diabetes	▪ Participation rates ▪ Increase in physical activity ▪ Average weight loss ▪ Participant survey	National Kidney Foundation of Michigan
Provide Cooking Matters™ EXTRA for Diabetes programs	Six-week workshops to equip families with the knowledge and skills they need to shop for and prepare healthy meals on a limited budget. Hosted at libraries, senior centers and community organizations	Improved nutrition practices, eating habits, healthy meal preparation and food budgeting knowledge and behaviors	Adults with diabetes or prediabetes	▪ Participation rates ▪ Post-test outcome measures such as use of nutrition facts on food l abels, adjusting meals to be more healthy, choosing healthy foods at restaurants ▪ Participant survey	Gleaners Community Food Bank of SE Michigan
Provide the Diabetes Support Group	Monthly sessions providing support to those with diabetes and their caregivers	Improved self-management	Adults with diabetes	▪ Participation rates	
Provide health education on diabetes through the Beaumont Speakers Bureau	Education presentations to community groups	Improved knowledge of diabetes prevention and treatment options	Community organizations	▪ Participation rates ▪ Participant survey	
Distribute to schools “Managing Type 1 Diabetes in Schools: A Guide for Non-Medical Personnel in Schools”	Online training videos and accompanying guide used in collaboration with schools to provide care to students with type 1 diabetes	Safe and healthy school environment for children with type 1 diabetes	Non-medical school personnel	▪ Online video viewing rates	School systems

Beaumont Hospital, Farmington Hills

OBESITY

GOAL: Decrease rate of obesity in children and adults by promoting healthy eating and active living behaviors
STRATEGY 1: Provide education and services that support healthy eating, active living and maintaining a healthy weight

PROGRAM/ ACTIVITY	DESCRIPTION	ANTICIPATED IMPACT	TARGET AUDIENCE	HOW RESULTS WILL BE MEASURED	PARTNERS
Provide education on healthy eating, fitness and weight management through the Beaumont Speakers Bureau	Education presentations to community members of the Beaumont Generations Senior Program and to community groups	Improved knowledge of obesity prevention and treatment options	Community organizations	▪ Participation rates ▪ Participant survey	
Explore providing Cooking Matters™ programs	Six-week workshops for adults and teens and single session store tours to equip families with the knowledge and skills they need to shop for and prepare healthy meals on a limited budget. Hosted in collaboration with libraries, senior centers and community organizations.	Improved nutrition practices, eating habits, healthy meal preparation and food budgeting knowledge and behaviors	Economically disadvantaged populations	▪ Participation rates ▪ Post-test outcome measures such as use of nutrition facts on food labels, adjusting meals to be more healthy, choosing healthy foods at restaurants ▪ Participant survey	Gleaners Community Food Bank of SE Michigan
Explore designation of a Healthy Community	Beaumont Hospital, Farmington Hills will provide backbone support to the Healthy Communities multi-sector community coalition to develop strategies in the community and at worksites for healthy eating and active living	Collaborative partnerships to improve the health and well-being of diverse community members	Community-wide	▪ Partnership agreements	City and school district
Develop strategies to increase access to fresh fruits and vegetables	Explore support of Farmers Markets, the Power of Produce program, food pantries and the Prescription for Health program	Increase in fruit and vegetable consumption	Community-wide	▪ Partnership agreements ▪ Number of participants	Farmington Farmers Market City of Farmington Hills

STRATEGY 2: Increase opportunities for physical activity

Provide the Walk with the Doc program	Physicians conduct health promotion presentations and lead community walks at local parks	Increased knowledge of healthy lifestyle practices and increased physical activity	Community-wide	▪ Participation rates ▪ Participant survey	City of Farmington Hills Parks

CARDIOVASCULAR DISEASE

GOAL: Decrease cardiovascular disease risk factors and prevent death from sudden cardiac arrest
STRATEGY 1: Provide education programs and services

PROGRAM/ ACTIVITY	DESCRIPTION	ANTICIPATED IMPACT	TARGET AUDIENCE	HOW RESULTS WILL BE MEASURED	PARTNERS
Provide Living at Ease classes	Mindfulness classes to cultivate a happy and healthy life and help alleviate anxiety, depression, stress, chronic pain and other various conditions	Reduction in stress, a risk factor for cardiovascular disease Improved eating behaviors that positively impact obesity and diabetes, risk factors for cardiovascular disease	Community-wide	▪ Perceived Stress Scale ▪ Qualitative measures	
Provide education on cardiovascular health through the Beaumont Speakers Bureau	Education presentations to community groups	Improved knowledge of cardiovascular disease prevention and treatment options	Community organizations	▪ Participation rates ▪ Participant survey	

STRATEGY 2: Provide early detection screenings

Provide blood pressure and stroke screenings	Blood pressure screenings and stroke risk assessments conducted at community events to identify and counsel individuals with high blood pressure and other risk factor for cardiovascular disease	Improved self-management and follow-up care	Adults	▪ Screening results ▪ Referrals for follow-up care	Community organizations
Provide CPR and AED (Automatic External Defibrillator) training	Equipment and training provided to high school students and staff in Farmington Public Schools. Fire department professionals also provide a train-the- trainer program for teachers to coordinate future trainings of new students and staff.	Increased knowledge and skills to resuscitate teens or adults suffering sudden cardiac arrest	High school students and staff	▪ Number of individuals trained	Farmington Public Schools Farmington Hills Fire Department
Explore implementing the Healthy Heart Check Student Heart Screening Program	High school student heart checks to detect abnormal heart structure or abnormal rhythms	Prevent sudden cardiac arrest	Youth ages 13-18	▪ Participation rates ▪ Test results	School systems

Beaumont Hospital, Farmington Hills

DIABETES

GOAL: Decrease rate of new diabetes cases and of diabetes complications
STRATEGY 1: Provide early detection screenings, diabetes prevention programs and diabetes education services

PROGRAM/ ACTIVITY	DESCRIPTION	ANTICIPATED IMPACT	TARGET AUDIENCE	HOW RESULTS WILL BE MEASURED	PARTNERS
Provide Diabetes PATH (Personal Action Toward Health) workshops	Six-week chronic disease management class hosted in collaboration with libraries, senior centers and community organizations	Improved diabetes self-management	Adults and seniors with diabetes and their caregivers	▪ Participation rates ▪ Post-test outcome measures such as blood sugar testing, physical activity, confidence managing condition ▪ Participant survey	National Kidney Foundation of Michigan
Explore providing My Choice…My Health Diabetes Prevention Program	12-month lifestyle change program with group coaching hosted in collaboration with libraries, schools and community centers	Prevention of type 2 diabetes	Adults with prediabetes or at high risk of diabetes	▪ Participation rates ▪ Increase in physical activity ▪ Average weight loss ▪ Participant survey	National Kidney Foundation of Michigan
Explore providing Cooking Matters™ EXTRA for Diabetes program	Six-week workshops to equip families with the knowledge and skills they need to shop for and prepare healthy meals on a limited budget. Hosted in collaboration with libraries, senior centers and community organizations.	Improved nutrition practices, eating habits, healthy meal preparation and food budgeting knowledge and behaviors	Adults with diabetes or prediabetes	▪ Participation rates ▪ Post-test outcome measures such as use of nutrition facts on food labels, adjusting meals to be more healthy, choosing healthy foods at restaurants ▪ Participant survey	Gleaners Community Food Bank of SE Michigan
Provide health education on diabetes through the Beaumont Speakers Bureau	Education presentations to community groups	Improved knowledge of diabetes prevention and treatment options	Community organizations	▪ Participation rates ▪ Participant survey	
Distribute to schools "Managing Type 1 Diabetes in Schools: A Guide for Non-Medical Personnel in Schools"	Online training videos and accompanying guide used in collaboration with schools to provide care to students with type 1 diabetes	Safe and healthy school environment for children with type 1 diabetes	Non-medical school personnel	▪ Online video viewing rate	School systems

Beaumont Hospital, Grosse Pointe

OBESITY

GOAL: Decrease rate of obesity in children and adults by promoting healthy eating and active living behaviors
STRATEGY 1: Provide education and services that support healthy eating, active living and maintaining a healthy weight

PROGRAM/ ACTIVITY	DESCRIPTION	ANTICIPATED IMPACT	TARGET AUDIENCE	HOW RESULTS WILL BE MEASURED	PARTNERS
Provide cooking demonstrations	A chef and registered dietitian provide nutritional information, recipes and cooking demonstrations	Improved knowledge of nutrition and healthy meal preparation	Community-wide		Community organizations
Provide Cooking Matters™ programs	Six-week workshops for adults and teens and single session store tours to equip families with the knowledge and skills they need to shop for and prepare healthy meals on a limited budget. Hosted at libraries, senior centers and community organizations.	Improved nutrition practices, eating habits, healthy meal preparation and food budgeting knowledge and behaviors	Economically disadvantaged populations	▪ Participation rates ▪ Post-test outcome measures such as use of nutrition facts on food labels, adjusting meals to be more healthy, choosing healthy foods at restaurants ▪ Participant survey	Gleaners Community Food Bank of SE Michigan
Explore designation of a Healthy Community	Beaumont Hospital, Grosse Pointe will provide backbone support to the Healthy Communities multi-sector community coalition to develop strategies in the community and at worksites for healthy eating and active living	Collaborative partnerships to improve the health and well-being of diverse community members	Community-wide	▪ Partnership agreements	City and school district
Develop strategies to increase access to fresh fruits and vegetables	Explore support of the Farmers Market, the Power of Produce program and the Prescription for Health program	Reduction in food insecurity Increase in fruit and vegetable consumption	Community-wide Focus on economically disadvantaged populations	▪ Partnership agreements ▪ Number of participants	
Explore providing Mindful Eating program	Mindful eating class in partnership with the Beaumont Weight Control Center to improve awareness, focus and achieve a greater sense of well-being	Improved eating behaviors that positively impact maintaining a healthy weight	Community-wide	▪ Perceived Stress Scale ▪ Qualitative measures	
Provide education on healthy eating, fitness and weight management through the Beaumont Speakers Bureau	Education presentations at town halls and to community groups	Improved knowledge of obesity prevention and treatment options	Community organizations	▪ Participation rates ▪ Participant survey	

Beaumont Hospital, Grosse Pointe

STRATEGY 2: Increase opportunities for physical activity

Provide the Walk with the Doc program	Physicians conduct health promotion presentations and lead community walks at local parks	Increased knowledge of healthy lifestyle practices and increased physical activity	Community-wide	▪ Participation rates	Edsel & Eleanor Ford House, Grosse Pointe Shores

CARDIOVASCULAR DISEASE

GOAL: Decrease cardiovascular disease risk factors and prevent death from sudden cardiac arrest
STRATEGY 1: Provide education programs and services

PROGRAM/ ACTIVITY	DESCRIPTION	ANTICIPATED IMPACT	TARGET AUDIENCE	HOW RESULTS WILL BE MEASURED	PARTNERS
Offer the Beaumont Quit Smoking Program	Four-week program led by a registered respiratory therapist	Reduction in smoking, a risk factor for cardiovascular disease	Smokers	▪ Participation rates ▪ Respiratory therapy staff follow-up at one-month, six-months and 12-months	
Provide education on cardiovascular health through the Beaumont Speakers Bureau	Education presentations at town halls and to community groups	Improved knowledge of cardiovascular disease prevention and treatment options	Community organizations	▪ Participation rates ▪ Participant survey	

STRATEGY 2: Provide early detection screenings

Explore implementing the Healthy Heart Check Student Heart Screening Program	High school student heart checks to detect abnormal heart structure or abnormal rhythms	Prevent sudden cardiac arrest	Youth ages 13-18	▪ Participation rates ▪ Test results	School systems
Offer the 7 for $70 Heart and Vascular Screening	Blood tests, EKG and artery testing to identify risk factors and recommend a course of action	Improved heart and vascular health	Adults	▪ Participation rates ▪ Test results	
Provide stroke screening and education	Blood pressure screening and stroke risk assessment to identify and provide follow-up recommendations for those at increased risk of stroke	Increased knowledge of individual risk factors for stroke and the signs and symptoms of stroke	Adults	▪ Participation rates	Community organizations

DIABETES

GOAL: Decrease rate of new diabetes cases and of diabetes complications
STRATEGY 1: Provide early detection screenings, diabetes prevention programs and diabetes education services

PROGRAM/ ACTIVITY	DESCRIPTION	ANTICIPATED IMPACT	TARGET AUDIENCE	HOW RESULTS WILL BE MEASURED	PARTNERS
Provide Diabetes PATH (Personal Action Toward Health) workshops	Six-week chronic disease management class hosted in collaboration with libraries, senior centers and community organizations	Improved diabetes self-management	Adults and seniors with diabetes and their caregivers	▪ Participation rates ▪ Post-test outcome measures such as blood sugar testing, physical activity, confidence managing condition ▪ Participant survey	National Kidney Foundation of Michigan
Explore providing My Choice…My Health Diabetes Prevention Program	12-month lifestyle change program with group coaching hosted in collaboration with libraries, schools and community centers	Prevention of type 2 diabetes	Adults with prediabetes or at high risk of diabetes	▪ Participation rates ▪ Increase in physical activity ▪ Average weight loss ▪ Participant survey	National Kidney Foundation of Michigan
Explore providing Cooking Matters™ EXTRA for Diabetes programs	Six-week workshops to equip families with the knowledge and skills they need to shop for and prepare healthy meals on a limited budget. Hosted at libraries, senior centers and community organizations.	Improved nutrition practices, eating habits, healthy meal preparation and food budgeting knowledge and behaviors	Adults with diabetes or prediabetes	▪ Participation rates ▪ Post-test outcome measures such as use of nutrition facts on food labels, adjusting meals to be more healthy, choosing healthy foods at restaurants ▪ Participant survey	Gleaners Community Food Bank of SE Michigan
Provide health education on diabetes through the Beaumont Speakers Bureau	Education presentations at town halls and to community groups	Improved knowledge of diabetes prevention and treatment options	Community organizations	▪ Participation rates ▪ Participant survey	
Distribute to schools "Managing Type 1 Diabetes in Schools: A Guide for Non-Medical Personnel in Schools"	Online training videos and accompanying guide used in collaboration with schools to provide care to students with type 1 diabetes	Safe and healthy school environment for children with type 1 diabetes	Non-medical school personnel	▪ Online video viewing rate	School systems

Beaumont Hospital, Royal Oak

OBESITY

GOAL: Decrease rate of obesity in children and adults by promoting healthy eating and active living behaviors
STRATEGY 1: Provide education and services that support healthy eating, active living and maintaining a healthy weight

PROGRAM/ ACTIVITY	DESCRIPTION	ANTICIPATED IMPACT	TARGET AUDIENCE	HOW RESULTS WILL BE MEASURED	PARTNERS
Provide Kids Cooking Classes	Hands-on classes led by a registered dietitian in a demonstration kitchen	Improved knowledge of nutrition practices and healthy meal preparation	Children six years and older	▪ Participation rates ▪ Participant survey	
Explore providing Cooking Matters™ program	Six-week workshops for adults and teens and single session store tours to equip families with the knowledge and skills they need to shop for and prepare healthy meals on a limited budget. Hosted at libraries, senior centers and community organizations.	Improved nutrition practices, eating habits, healthy meal preparation and food budgeting knowledge and behaviors	Economically disadvantaged populations	▪ Participation rates ▪ Post-test outcome measures such as use of nutrition facts on food labels, adjusting meals to be more healthy, choosing healthy foods at restaurants ▪ Participant survey	Gleaners Community Food Bank of SE Michigan
Develop strategies to increase access to fresh fruits and vegetables	Explore support of the Farmers Market, the Power of Produce program and the Prescription for Health program	Reduction in food insecurity Increase in fruit and vegetable consumption	Community-wide Focus on economically disadvantaged populations	▪ Partnership agreements ▪ Number of participants	
Provide education on healthy eating, fitness and weight management through the Beaumont Speakers Bureau	Education presentations to community groups	Improved knowledge of obesity prevention and treatment options	Community organizations	▪ Participation rates ▪ Participant survey	
Host Bike Day for children with special needs	Event providing free, custom adaptive bikes for special needs children	Increased physical activity of children with special needs	Children with special needs	▪ Participation rates	
Explore offering the Walk with the Doc program	Physicians conduct health promotion presentations and lead community walks at local parks	Increased physical activity	Community-wide	▪ Partnership agreement	City of Royal Oak Memorial Park

CARDIOVASCULAR DISEASE

GOAL: Decrease cardiovascular disease risk factors and prevent death from sudden cardiac arrest
STRATEGY 1: Provide education programs and services

PROGRAM/ ACTIVITY	DESCRIPTION	ANTICIPATED IMPACT	TARGET AUDIENCE	HOW RESULTS WILL BE MEASURED	PARTNERS
Provide Food for the Heart Part I and II classes	Classes to lower cholesterol or triglycerides, lower blood pressure, better manage diabetes or lose weight	Improved nutrition practices, eating habits and healthy meal preparation knowledge and behaviors	Adults	▪ Participation rates ▪ Participant survey	
Offer the Beaumont Quit Smoking Program	Seven-week program led by a tobacco treatment specialist	Reduction in smoking, a risk factor for cardiovascular disease	Smokers	▪ Participation rates ▪ Respiratory therapy staff follow-up at one-month, six-months and 12-months	
Provide Mindfulness Classes	Meditation, yoga, mindful eating and mindful communication classes to cultivate a happy and healthy life and help alleviate anxiety, depression, stress, chronic pain and other various conditions	Reduction in stress, a risk factor for cardiovascular disease Improved eating behaviors that positively impact obesity and diabetes, risk factors for cardiovascular disease	Community-wide	▪ Perceived Stress Scale ▪ Qualitative measures	
Offer the WELL Program (Women Exercising to Live Longer)	Six-month exercise and risk reduction program to help women reduce their likelihood of developing heart disease and prevent future cardiac events	Reduction of risk factors such as elevated blood cholesterol, hypertension, sedentary lifestyle and obesity	Women with one or more cardiovascular risk factors	▪ Risk factor assessment ▪ Participation in individualized exercise programs and monthly education and support groups	
Provide education on cardiovascular health through the Beaumont Speakers Bureau	Education presentations to community groups	Improved knowledge of cardiovascular disease prevention and treatment options	Community organizations	▪ Community organizations	

STRATEGY 2: Provide early detection screenings

Provide blood pressure screenings	Blood pressure screenings conducted at community events to identify and counsel individuals with high blood pressure and other risk factor for cardiovascular disease	Improved self-management and follow-up care	Adults	▪ Participation rates	
Implement the Healthy Heart Check Student Heart Screening Program	High school student heart checks to detect abnormal heart structure or abnormal rhythms	Prevent sudden cardiac arrest	Youth ages 13-18	▪ Participation rates ▪ Test results	School systems
Offer the 7 for $70 Heart and Vascular Screening	Blood tests, EKG and artery testing to identify risk factors and recommend a course of action	Improved heart and vascular health	Adults	▪ Participation rates ▪ Test results	

Beaumont Hospital, Royal Oak

DIABETES

GOAL: Decrease rate of new diabetes cases and of diabetes complications
STRATEGY 1: Provide early detection screenings, diabetes prevention programs and diabetes education services

PROGRAM/ ACTIVITY	DESCRIPTION	ANTICIPATED IMPACT	TARGET AUDIENCE	HOW RESULTS WILL BE MEASURED	PARTNERS
Provide the Diabetes Support Group	Monthly sessions providing support to those with diabetes and their caregivers	Improved diabetes self-management	Adults with diabetes	▪ Participation rates	
Provide Diabetes PATH (Personal Action Toward Health) workshops	Six-week chronic disease management class hosted in collaboration with libraries, senior centers and community organizations	Improved diabetes self-management	Adults and seniors with diabetes and their caregivers	▪ Participation rates ▪ Post-test outcome measures such as blood sugar testing, physical activity, confidence managing condition ▪ Participant survey	National Kidney Foundation of Michigan
Explore providing My Choice…My Health Diabetes Prevention Program	12-month lifestyle change program with group coaching hosted in collaboration with libraries, schools and community centers	Prevention of type 2 diabetes	Adults with prediabetes or at high risk of diabetes	▪ Participation rates ▪ Increase in physical activity ▪ Average weight loss ▪ Participant survey	National Kidney Foundation of Michigan
Explore providing Cooking Matters™ EXTRA for Diabetes program	Six-week workshops to equip families with the knowledge and skills they need to shop for and prepare healthy meals on a limited budget. Hosted at libraries, senior centers and community organizations.	Improved nutrition practices, eating habits, healthy meal preparation and food budgeting knowledge and behaviors	Adults with diabetes or prediabetes	▪ Participation rates ▪ Post-test outcome measures such as use of nutrition facts on food labels, adjusting meals to be more healthy, choosing healthy foods at restaurants ▪ Participant survey	Gleaners Community Food Bank of SE Michigan
Provide health education on diabetes through the Beaumont Speakers Bureau	Education presentations to community groups	Improved knowledge of diabetes prevention and treatment options	Community organizations	▪ Participation rates ▪ Participant survey	
Distribute to schools "Managing Type 1 Diabetes in Schools: A Guide for Non-Medical Personnel in Schools"	Online training videos and accompanying guide used in collaboration with schools to provide care to students with type 1 diabetes	Safe and healthy school environment for children with type 1 diabetes	Non-medical school personnel	▪ Online video viewing rate	School systems

Beaumont Hospital, Taylor

OBESITY

GOAL: Decrease rate of obesity in children and adults by promoting healthy eating and active living behaviors
STRATEGY 1: Provide education and services that support healthy eating, active living and maintaining a healthy weight

PROGRAM/ ACTIVITY	DESCRIPTION	ANTICIPATED IMPACT	TARGET AUDIENCE	HOW RESULTS WILL BE MEASURED	PARTNERS
Provide Cooking Matters™ programs	Six-week workshops for adults and teens and single session store tours to equip families with the knowledge and skills they need to shop for and prepare healthy meals on a limited budget. Hosted at libraries, senior centers and community organizations.	Improved nutrition practices, eating habits, healthy meal preparation and food budgeting knowledge and behaviors	Economically disadvantaged populations	▪ Participation rates ▪ Post-test outcome measures such as use of nutrition facts on food labels, adjusting meals to be more healthy, choosing healthy foods at restaurants ▪ Participant survey	Gleaners Community Food Bank of SE Michigan
Explore providing CATCH Kids Club (Coordinated Approach to Child Health) to prevent childhood obesity	After-school and summer program staff are trained to provide the CATCH nutrition and physical activity program	Improved knowledge and practices to make healthy eating and physical activity decisions	Youth grades K-5	▪ Partnership agreement ▪ Number of children participating	Taylor School District
Healthy Taylor coalition	Beaumont Hospital, Taylor will provide backbone support to the Healthy Taylor multi-sector community coalition to develop strategies in the community and at worksites for healthy eating and active living	Collaborative partnerships to improve the health and well-being of diverse community members	Community-wide	▪ Number of programs and activities implemented to promote healthy eating and active living	Healthy Taylor coalition City of Taylor Taylor School District
Develop strategies to increase access to fresh fruits and vegetables	Explore support of the Taylor Farmers Market, the Power of Produce program and the Prescription for Health program	Increase in fruit and vegetable consumption	Community-wide	▪ Partnership agreements ▪ Number of participants	City of Taylor
Medical outreach and prevention programs offered through Beaumont Teen Health Center, Taylor	Measure BMI and provide nutrition counseling	Improved nutrition practices of youth	Youth ages 10-21	▪ Number of students screened in health center ▪ Number of students receiving nutrition counseling	Taylor School District
Medical outreach and prevention programs offered through Beaumont School Wellness Program, Truman	Provide nutrition education	Improved nutrition practices of youth	High school students	▪ Number of students screened in health center ▪ Number of students receiving nutrition counseling	Taylor School District

Beaumont Hospital, Taylor

STRATEGY 2: Increase opportunities for physical activity

Healthy Taylor coalition	Beaumont Hospital, Taylor will provide backbone support to the Healthy Taylor multi-sector community coalition to improve walkability and bikeability of the community and to provide recreational programs and events	Increase in physical activity of children and adults	Community-wide	▪ Number of programs and activities implemented to increase physical activity	Healthy Taylor coalition City of Taylor Parks and Recreation Downriver Family YMCA
Offer Healthy Taylor Walk with the Doc and Walk with the City Official program	Physicians conduct health promotion presentations and lead community walks at local parks along with walks led by City of Taylor and state officials	Increased knowledge of healthy lifestyle practices and increase in physical activity	Community-wide	▪ Participation rates ▪ Participant survey	City of Taylor
Conduct Healthy Taylor Let's Walk Taylor Together program	Expand neighborhood and employee walking groups and provide educational support	Increased knowledge of healthy lifestyle practices and increase in physical activity	Community-wide	▪ Participation rates ▪ Tracking logs	City of Taylor

CARDIOVASCULAR DISEASE

GOAL: Decrease cardiovascular disease risk factors and prevent death from sudden cardiac arrest
STRATEGY 1: Provide education programs and services

PROGRAM/ ACTIVITY	DESCRIPTION	ANTICIPATED IMPACT	TARGET AUDIENCE	HOW RESULTS WILL BE MEASURED	PARTNERS
Provide CPR training through the Beaumont Teen Health Center, Taylor and Beaumont School Wellness Program, Truman	In partnership with the American Heart Association provide CPR training in assessment, compressions and using an AED (Automatic External Defibrillator)	Increased knowledge and skills to resuscitate teens or adults suffering sudden cardiac arrest	High school students	▪ High school students	American Heart Association Taylor School District
Provide resources and referrals through the Beaumont Quit Smoking Resource Line	To address the cardiovascular disease risk factor of smoking, the Quit Smoking Resource line provides telephonic assessment, information and referrals to connect smokers to the quit smoking resources, programs and services they need	Increased awareness and knowledge of stop smoking methods and support services	Smokers	▪ Participation rates ▪ Referral rates	
Provide the Aphasia Support Group	Monthly sessions providing support and education on cardiovascular disease and stroke prevention	Improved self-management	Adults who have speech difficulties (aphasia) from a stroke	▪ Participation rates	
Provide education on cardiovascular health through the Beaumont Speakers Bureau	Education presentations to community groups	Improved knowledge of cardiovascular disease prevention and treatment options	Community organizations	▪ Participation rates ▪ Participant survey	

STRATEGY 2: Provide early detection screenings

Provide heart health screenings	Blood pressure, cholesterol and glucose screenings offered at community locations to identify and counsel individuals with elevated levels	Improved self-management and follow-up care	Adults	▪ Screening results ▪ Referrals for follow-up care ▪ Participant survey	Community organizations
Explore implementing the Healthy Heart Check Student Heart Screening Program	High school student heart checks to detect abnormal heart structure or abnormal rhythms	Prevent sudden cardiac arrest	Youth ages 13-18	▪ Participation rates ▪ Test results	School systems

DIABETES

GOAL: Decrease rate of new diabetes cases and of diabetes complications
STRATEGY 1: Provide early detection screenings, diabetes prevention programs and diabetes education services

PROGRAM/ ACTIVITY	DESCRIPTION	ANTICIPATED IMPACT	TARGET AUDIENCE	HOW RESULTS WILL BE MEASURED	PARTNERS
Provide diabetes screenings	Screenings offered at community locations to identify and counsel individuals with elevated glucose levels	Improved self-management and follow-up care	Adults	▪ Screening results ▪ Referrals for follow-up care ▪ Participant survey	Community organizations
Provide Diabetes PATH (Personal Action Toward Health) workshops	Six-week chronic disease management class hosted in collaboration with libraries, senior centers and community organizations	Improved diabetes self-management	Adults and seniors with diabetes and their caregivers	▪ Adults and seniors with diabetes and their caregivers	National Kidney Foundation of Michigan
Provide My Choice…My Health Diabetes Prevention Program	12-month lifestyle change program with group coaching hosted in collaboration with libraries, schools and community centers	Prevention of type 2 diabetes	Adult with prediabetes or at high risk of diabetes	▪ Participation rates ▪ Increase in physical activity ▪ Average weight loss ▪ Participant survey	National Kidney Foundation of Michigan
Provide Cooking Matters™ EXTRA for Diabetes programs	Six-week workshops to equip families with the knowledge and skills they need to shop for and prepare healthy meals on a limited budget. Hosted at libraries, senior centers and community organizations.	Improved nutrition practices, eating habits, healthy meal preparation and food budgeting knowledge and behaviors	Adults with diabetes or prediabetes	▪ Participation rates ▪ Post-test outcome measures such as use of nutrition facts on food labels, adjusting meals to be more healthy, choosing healthy foods at restaurants ▪ Participant survey	Gleaners Community Food Bank of SE Michigan
Provide health education on diabetes through the Beaumont Speakers Bureau	Education presentations to community groups	Improved knowledge of diabetes prevention and treatment options	Community organizations	▪ Participation rates ▪ Participant survey	
Distribute to schools “Managing Type 1 Diabetes in Schools: A Guide for Non-Medical Personnel in Schools”	Online training videos and accompanying guide used in collaboration with schools to provide care to students with type 1 diabetes	Safe and healthy school environment for children with type 1 diabetes	Non-medical school personnel	▪ Online video viewing rate	Area schools

Beaumont Hospital, Trenton

OBESITY

GOAL: Decrease rate of obesity in children and adults by promoting healthy eating and active living behaviors
STRATEGY 1: Provide education and services that support healthy eating, active living and maintaining a healthy weight

PROGRAM/ ACTIVITY	DESCRIPTION	ANTICIPATED IMPACT	TARGET AUDIENCE	HOW RESULTS WILL BE MEASURED	PARTNERS
Provide Cooking Matters™ programs	Six-week workshops for adults and teens and single session store tours to equip families with the knowledge and skills they need to shop for and prepare healthy meals on a limited budget. Hosted at libraries, senior centers and community organizations.	Improved nutrition practices, eating habits, healthy meal preparation and food budgeting knowledge and behaviors	Economically disadvantaged populations	▪ Participation rates ▪ Post-test outcome measures such as use of nutrition facts on food labels, adjusting meals to be more healthy, choosing healthy foods at restaurants ▪ Participant survey	Gleaners Community Food Bank of SE Michigan
Provide CATCH Kids Club (Coordinated Approach to Child Health) to prevent childhood obesity	After-school and summer program staff are trained to provide the CATCH nutrition and physical activity program	Improved knowledge and practices to make healthy eating and physical activity decisions	Youth grades K-5	▪ Post-test outcome measures such as fruit and vegetable consumption, exercise, reading nutrition labels	City of Trenton Parks and Recreation Trenton Public Schools
Healthy Trenton coalition	Beaumont Hospital, Trenton will provide backbone support to the Healthy Trenton multi-sector community coalition to develop strategies in the community and at worksites for healthy eating and active living	Collaborative partnerships to improve the health and well-being of diverse community members	Community-wide	▪ Number of programs and activities implemented to promote healthy eating and active living ▪ Distribution of Passport to Health	Healthy Trenton coalition City of Trenton Trenton Public Schools
Develop strategies to increase access to fresh fruits and vegetables	Explore support of the Trenton Farmers Market, the Power of Produce program and the Prescription for Health program	Reduction in food insecurity Increase in fruit and vegetable consumption	Community-wide Focus on economically disadvantaged populations	▪ Partnership agreements ▪ Number of participants	City of Trenton
Provide education on healthy eating, fitness and weight management through the Beaumont Speakers Bureau to the community	Education presentations to community groups upon request	Improved knowledge of obesity prevention and treatment options	Community organizations	▪ Participation rates ▪ Participant survey	

STRATEGY 2: Increase opportunities for physical activity

Healthy Trenton coalition	Beaumont Hospital, Trenton will provide backbone support to the Healthy Trenton multi-sector community coalition to improve walkability and bikeability of the community and to provide recreational programs and events	Increase in physical activity of children and adults	Community-wide	▪ Number of programs and activities implemented to increase physical activity	Healthy Trenton coalition City of Trenton Parks and Recreation Wayne County Parks Traffic Safety Commission

CARDIOVASCULAR DISEASE

GOAL: Decrease cardiovascular disease risk factors and prevent death from sudden cardiac arrest
STRATEGY 1: Provide education programs and services

PROGRAM/ ACTIVITY	DESCRIPTION	ANTICIPATED IMPACT	TARGET AUDIENCE	HOW RESULTS WILL BE MEASURED	PARTNERS
Provide resources and referrals through the Beaumont Quit Smoking Resource Line	To address the cardiovascular disease risk factor of smoking, the Quit Smoking Resource line provides telephonic assessment, information and referrals to connect smokers to the quit smoking resources, programs and services they need	Increased awareness and knowledge of stop smoking methods and support services	Smokers	▪ Participation rates ▪ Referral rates	
Provide education on cardiovascular health through the Beaumont Speakers Bureau	Education presentations to community groups	Improved knowledge of cardiovascular disease prevention and treatment options	Community organizations	▪ Participation rates ▪ Participant survey	

STRATEGY 2: Provide early detection screenings

Provide heart health screenings	Blood pressure, cholesterol and glucose screenings offered at community locations to identify and counsel individuals with elevated levels	Improved self-management and follow-up care	Adults	▪ Screening results ▪ Referrals for follow-up care ▪ Participant survey	Community organizations
Explore implementing the Healthy Heart Check Student Heart Screening Program	High school student heart checks to detect abnormal heart structure or abnormal rhythms	Prevent sudden cardiac arrest	Youth ages 13-18	▪ Participation rates ▪ Test results	School systems

Beaumont Hospital, Trenton

DIABETES

GOAL: Decrease rate of new diabetes cases and of diabetes complications
STRATEGY 1: Provide early detection screenings, diabetes prevention programs and diabetes education services

PROGRAM/ ACTIVITY	DESCRIPTION	ANTICIPATED IMPACT	TARGET AUDIENCE	HOW RESULTS WILL BE MEASURED	PARTNERS
Provide diabetes screenings	Screening offered at community locations to identify and counsel individuals with elevated glucose levels	Improved self-management and follow-up care	Adults	▪ Screening results ▪ Referrals for follow-up care ▪ Participant survey	Community organizations
Provide Diabetes PATH (Personal Action Toward Health) workshops	Six-week chronic disease management class hosted in collaboration with libraries, senior centers and community organizations	Improved diabetes self-management	Adults and seniors with diabetes and their caregivers	▪ Participation rates ▪ Post-test outcome measures such as blood sugar testing, physical activity, confidence managing condition ▪ Participant survey	National Kidney Foundation of Michigan
Provide My Choice…My Health Diabetes Prevention Program	12-month lifestyle change program with group coaching hosted in collaboration with libraries, schools and community centers	Prevention of type 2 diabetes	Adults with prediabetes or at high risk of diabetes	▪ Participation rates ▪ Increase in physical activity ▪ Average weight loss ▪ Participant survey	National Kidney Foundation of Michigan
Provide Cooking Matters™ EXTRA for Diabetes programs	Six-week workshops to equip families with the knowledge and skills they need to shop for and prepare healthy meals on a limited budget. Hosted at libraries, senior centers and community organizations.	Improved nutrition practices, eating habits, healthy meal preparation and food budgeting knowledge and behaviors	Adults with diabetes and prediabetes	▪ Participation rates ▪ Post-test outcome measures such as use of nutrition facts on food labels, adjusting meals to be more healthy, choosing healthy foods at restaurants ▪ Participant survey	Gleaners Community Food Bank of SE Michigan
Provide health education on diabetes through the Beaumont Speakers Bureau to the community	Education presentations to community groups upon request	Improved knowledge of diabetes prevention and treatment options	Community organizations	▪ Participation rates ▪ Participant survey	
Distribute to schools "Managing Type 1 Diabetes in Schools: A Guide for Non-Medical Personnel in Schools"	Online training videos and accompanying guide used in collaboration with schools to provide care to students with type 1 diabetes	Safe and healthy school environment for children with type 1 diabetes	Non-medical school personnel	▪ Online video viewing rate	School systems

Beaumont Hospital, Troy

OBESITY

GOAL: Decrease rate of obesity in children and adults by promoting healthy eating and active living behaviors
STRATEGY 1: Provide education and services that support healthy eating, active living and maintaining a healthy weight

PROGRAM/ ACTIVITY	DESCRIPTION	ANTICIPATED IMPACT	TARGET AUDIENCE	HOW RESULTS WILL BE MEASURED	PARTNERS
Provide Kids Cooking Classes	Hands-on classes led by a registered dietitian in a demonstration kitchen through Beaumont Weight Control Centers	Improved knowledge of nutrition practices and healthy meal preparation	Children six years and older	▪ Participation rates ▪ Participant survey	
Explore providing Cooking Matters™ programs	Six-week workshops for adults and teens and single session store tours to equip families with the knowledge and skills they need to shop for and prepare healthy meals on a limited budget. Hosted at libraries, senior centers and community organizations	Improved nutrition practices, eating habits, healthy meal preparation and food budgeting knowledge and behaviors	Economically disadvantaged populations	▪ Participation rates ▪ Post-test outcome measures such as use of nutrition facts on food labels, adjusting meals to be more healthy, choosing healthy foods at restaurants ▪ Participant survey	Gleaners Community Food Bank of SE Michigan
Explore designation of a Healthy Community	Beaumont Hospital, Troy will provide backbone support to the Healthy Communities multi-sector community coalition to develop strategies in the community and at worksites for healthy eating and active living	Collaborative partnerships to improve the health and well-being of diverse community members	Community-wide	▪ Partnership agreements	City and school district
Develop strategies to increase access to fresh fruits and vegetables	Explore support of the Farmers Market, the Power of Produce program and the Prescription for Health program	Reduction in food insecurity Increase in fruit and vegetable consumption	Community-wide Focus on economically disadvantaged populations	▪ Program plans ▪ Partnership agreements	
Provide education on healthy eating, fitness and weight management through the Beaumont Speakers Bureau	Education presentations to community groups	Improved knowledge of obesity prevention and treatment options	Community organizations	▪ Participation rates ▪ Participant survey	

STRATEGY 2: Increase opportunities for physical activity

Host Bike Day for children with special needs	Event providing free modified bikes to children with special needs	Increased physical activity of children with special needs	Children with special needs	▪ Participation rates	
Provide fitness classes	Monthly fitness classes for adults through Sola Life and Fitness	Increased physical activity	Community-wide	▪ Participation rates	

Beaumont Hospital, Troy

Provide senior wellness education	Individual assessments, wellness and fitness presentations, health fairs, fall risk reduction programs and an onsite Beaumont wellness liaison at the Orion Wellness Center provide seniors with strategies for fall risk reduction and support to maintain physically active lives	Increased physical activity and wellness with fall risk reduction	Seniors	▪ Participation rates	Orion Township Community Center
Host Family Fun Days at baseball games	Health information is provided to attendees of baseball games at Jimmy John's Field throughout the season and baseball players provide modified sports activities to children with special needs	Increased physical well-being of children and families challenged by illness or disability	Children challenged by illness or disability	▪ Participation rates	United Shore Professional Baseball League
Explore offering the Walk with the Doc program	Physicians conduct health promotion presentations and lead community walks at local parks	Increased knowledge of healthy lifestyle practices and increased physical activity	Community-wide	▪ Partnership agreement	City of Sterling Heights

CARDIOVASCULAR DISEASE

GOAL: Decrease cardiovascular disease risk factors and prevent death from sudden cardiac arrest
STRATEGY 1: Provide education programs and services

PROGRAM/ ACTIVITY	DESCRIPTION	ANTICIPATED IMPACT	TARGET AUDIENCE	HOW RESULTS WILL BE MEASURED	PARTNERS
Provide Food for the Heart Part I and II classes	Classes to lower cholesterol or triglycerides, lower blood pressure, better manage diabetes or lose weight	Improved nutrition practices, eating habits and healthy meal preparation knowledge and behaviors	Adults	▪ Participation rates ▪ Participant survey	
Provide Mindfulness Classes	Meditation, yoga, mindful eating and mindful communication classes to cultivate a happy and healthy life help alleviate anxiety, depression, stress, chronic pain and other various conditions	Reduction in stress, a risk factor for cardiovascular disease Improved eating behaviors that positively impact obesity and diabetes, risk factors for cardiovascular disease	Community-wide	▪ Perceived Stress Scale ▪ Qualitative measures	
Offer the Beaumont Quit Smoking Program	Seven-week program led by a tobacco treatment specialist	Reduction in smoking, a risk factor for cardiovascular disease	Smokers	▪ Participation rates ▪ Respiratory therapy staff follow-up at one-month, six-months and 12-months	

Teach the American Academy of Family Physicians Tar Wars tobacco-free education program	Physicians provide education to elementary school children on the dangers of tobacco use	Decrease in tobacco use among pre-teens to improve health and reduce lifelong smoking habits, a risk factor for cardiovascular disease	Fourth and fifth grade students	▪ Number of classrooms ▪ Participation rates	Troy School District
Provide education on cardiovascular health through the Beaumont Speakers Bureau	Education presentations to community groups	Improved knowledge of cardiovascular disease prevention and treatment options	Community organizations	▪ Participation rates ▪ Participant survey	
Provide the Cane and Able Stroke Support Group	Monthly sessions providing support and education on cardiovascular disease, stroke prevention and stroke recovery	Increased education and re-entry into the community for post-stroke individuals and their families	Adults who have had a stroke	▪ Participation rates	
Provide the Aphasia Support Group	Monthly sessions providing support and education on cardiovascular disease, stroke prevention and stroke recovery	Improved self-management	Adults who have had a stroke and develop speech difficulties aphasia)	▪ Participation rates	
Provide the Guiding Heart Support Group	Monthly group offering education and support for individuals with cardiac disease	Increased awareness and education for management of cardiovascular diseases	Adults with diagnosed cardiac problems	▪ Participation rates	
Provide Automatic External Defibrillator (AED) training program	AED instruments are placed in community organizations and training is provided	Increased knowledge and skills to resuscitate teens or adults suffering sudden cardiac arrest	Community-wide non-profit organizations	▪ Number of units placed ▪ Number of individuals trained	American Heart Association

STRATEGY 2: Provide early detection screenings

Implement the Healthy Heart Check Student Heart Screening Program	Implement the Healthy Heart Check Student Heart Screening Program	Prevent sudden cardiac arrest	Youth ages 13-18	▪ Participation rates ▪ Test results	School systems
Offer the 7 for $70 Heart and Vascular Screening	Blood tests, EKG and artery testing to identify risk factors and recommend a course of action	Improved heart and vascular health	Adults	▪ Participation rates ▪ Test results	

DIABETES

GOAL: Decrease rate of new diabetes cases and of diabetes complications
STRATEGY 1: Provide early detection screenings, diabetes prevention programs and diabetes education services

PROGRAM/ ACTIVITY	DESCRIPTION	ANTICIPATED IMPACT	TARGET AUDIENCE	HOW RESULTS WILL BE MEASURED	PARTNERS
Provide the Diabetes Support Group	Monthly sessions providing support to those with diabetes and their caregivers	Improved diabetes self-management	Adults with diabetes	▪ Participation rates	

Beaumont Hospital, Troy

Provide Diabetes PATH (Personal Action Toward Health) workshops	Six-week chronic disease management class hosted in collaboration with libraries, senior centers and community organizations	Improved diabetes self-management	Adults and seniors with diabetes and their caregivers	▪ Participation rates ▪ Post-test outcome measures such as rate of blood sugar testing at home, physical activity and confidence managing condition ▪ Participant survey	National Kidney Foundation of Michigan
Explore providing My Choice…My Health Diabetes Prevention Program	12-month lifestyle change program with group coaching hosted in collaboration with libraries, schools and community centers	Prevention of type 2 diabetes	Adults with prediabetes or at high risk of diabetes	▪ Participation rates ▪ Weekly physical activity rate ▪ Average weight loss ▪ Participant survey	National Kidney Foundation of Michigan
Explore providing Cooking Matters™ EXTRA for Diabetes programs	Six-week workshops to equip families with the knowledge and skills they need to shop for and prepare healthy meals on a limited budget. Hosted at libraries, senior centers & community organizations.	Improved nutrition practices, eating habits, healthy meal preparation and food budgeting knowledge and behaviors	Adults with diabetes or prediabetes	▪ Participation rates ▪ Post-test outcome measures such as use of nutrition facts on food labels, adjusting meals to be more healthy, choosing healthy foods at restaurants ▪ Participant survey	Gleaners Community Food Bank of SE Michigan
Provide health education on diabetes through the Beaumont Speakers Bureau	Education presentations to community groups	Improved knowledge of diabetes prevention and treatment options	Community organizations	▪ Participation rates ▪ Participant survey	
Distribute to schools “Managing Type 1 Diabetes in Schools: A Guide for Non-Medical Personnel in Schools”	Online training videos and accompanying guide used in collaboration with schools to provide care to students with type 1 diabetes	Safe and healthy school environment for children with type 1 diabetes	Non-medical school personnel	▪ Online video viewing rate	School systems

Beaumont Hospital, Wayne

OBESITY

GOAL: Decrease rate of obesity in children and adults by promoting healthy eating and active living behaviors
STRATEGY 1: Provide education and services that support healthy eating, active living and maintaining a healthy weight

PROGRAM/ ACTIVITY	DESCRIPTION	ANTICIPATED IMPACT	TARGET AUDIENCE	HOW RESULTS WILL BE MEASURED	PARTNERS
Provide Cooking Matters™ programs	Six-week workshops for adults and teens and single session store tours to equip families with the knowledge and skills they need to shop for and prepare healthy meals on a limited budget. Hosted at libraries, senior centers and community organizations.	Improved nutrition practices, eating habits, healthy meal preparation and food budgeting knowledge and behaviors	Economically disadvantaged populations	▪ Participation rates ▪ Post-test outcome measures such as use of nutrition facts on food labels, adjusting meals to be more healthy, choosing healthy foods at restaurants ▪ Participant survey	Gleaners Community Food Bank of SE Michigan
Conduct cooking classes for children and adults	Hands-on classes led by a registered dietitian in a demonstration kitchen at the Beaumont Weight Control Center, Canton	Improved knowledge of nutrition practices and healthy meal preparation	Children and adults	▪ Participation rates	
Provide CATCH Kids Club (Coordinated Approach to Child Health) to prevent childhood obesity	After-school and summer program staff are trained to provide the CATCH nutrition and physical activity program	Improved knowledge and practices to make healthy eating and physical activity decisions	Youth grades K-5	▪ Post-test outcome measures such as fruit and vegetable consumption, exercise, reading nutrition labels	Westwood Community School District
Healthy Wayne coalition	Beaumont Hospital, Wayne will provide backbone support to the Healthy Wayne multi-sector community coalition to develop strategies in the community and at worksites for healthy eating and active living	Collaborative partnerships to improve the health and well-being of diverse community members	Community-wide	▪ Number of programs and activities implemented to promote healthy eating and active living	Healthy Wayne coalition City of Wayne Wayne-Westland Community Schools
Develop strategies to increase access to fresh fruits and vegetables	Explore support of the Wayne Farmers Market, Power of Produce program and the Prescription for Health program	Reduction in food insecurity Increase in fruit and vegetable consumption	Community-wide Focus on economically disadvantaged populations	▪ Partnership agreements ▪ Number of participants	City of Wayne Wayne Chamber of Commerce
Medical outreach and prevention programs offered through the Beaumont Child & Adolescent Health Center, Adams	Measure BMI and provide nutrition counseling	Improved nutrition practices of youth	Youth ages 10-21	▪ Number of students screened in health center ▪ Number of students receiving nutrition counseling	Wayne-Westland Community Schools
Medical outreach and prevention programs offered through the Beaumont Teen Health Center, Romulus	Measure BMI and provide nutrition counseling	Improved nutrition practices of youth	Youth ages 10-21	▪ Number of students screened in health center ▪ Number of students receiving nutrition counseling	Romulus Community Schools

Beaumont Hospital, Wayne

Medical outreach and prevention programs offered through the Beaumont Teen Health Center, Inkster	Measure BMI and provide nutrition counseling	Improved nutrition practices of youth	Youth ages 10-21	▪ Number of students screened in health center ▪ Number of students receiving nutrition counseling	Westwood Community School District
Provide education on healthy eating, fitness and weight management through the Beaumont Speakers Bureau	Education presentations to community groups	Improved knowledge of obesity prevention and treatment options	Community organizations	▪ Participation rates ▪ Participant survey	

STRATEGY 2: Increase opportunities for physical activity

Healthy Wayne coalition	Beaumont Hospital, Wayne will provide backbone support to the Healthy Wayne multi-sector community coalition to improve walkability and bikeability of the community and to provide recreational programs and events	Increase in physical activity of children and adults	Community-wide	▪ Number of programs and activities implemented to increase physical activity	Healthy Wayne coalition City of Wayne Wayne-Westland Community Schools

CARDIOVASCULAR DISEASE

GOAL: Decrease cardiovascular disease risk factors and prevent death from sudden cardiac arrest
STRATEGY 1: Provide education programs and services

PROGRAM/ ACTIVITY	DESCRIPTION	ANTICIPATED IMPACT	TARGET AUDIENCE	HOW RESULTS WILL BE MEASURED	PARTNERS
Provide CPR training through the Beaumont Child & Adolescent Health Center, Adams, the Beaumont Teen Health Center, Romulus and the Beaumont Teen Health Center, Inkster	In partnership with the American Heart Association provide CPR training in assessment, compressions and using an AED (Automatic External Defibrillator)	Increased knowledge and skills to resuscitate teens or adults suffering sudden cardiac arrest	High school students	▪ Number of individuals trained	American Heart Association Wayne-Westland Community Schools Romulus Community Schools Westwood Community School District
Provide resources and referrals through the Beaumont Quit Smoking Resource Line	To address the cardiovascular disease risk factor of smoking, the Quit Smoking Resource line provides telephonic assessment, information and referrals to connect smokers to the quit smoking resources, programs and services they need	Increased awareness and knowledge of stop smoking methods and support services	Smokers	▪ Participation rates ▪ Referral rates	
Provide education on cardiovascular health through the Beaumont Speakers Bureau	Education presentations to community groups	Improved knowledge of cardiovascular disease prevention and treatment options	Community organizations	▪ Participation rates ▪ Participant survey	

STRATEGY 2: Provide early detection screenings

Provide heart health screenings	Blood pressure, cholesterol and glucose screenings offered at community locations to identify and counsel individuals with elevated levels	Improved self-management and follow-up care	Adults	▪ Screening results ▪ Referrals for follow-up care ▪ Participant survey	Community organizations

DIABETES

GOAL: Decrease rate of new diabetes cases and of diabetes complications
STRATEGY 1: Provide early detection screenings, diabetes prevention programs and diabetes education services

PROGRAM/ ACTIVITY	DESCRIPTION	ANTICIPATED IMPACT	TARGET AUDIENCE	HOW RESULTS WILL BE MEASURED	PARTNERS
Provide diabetes screenings	Screening offered at community locations to identify and counsel individuals with elevated glucose levels	Improved self-management and follow-up care	Adults	▪ Screening results ▪ Referrals for follow-up care ▪ Participant survey	Community organizations
Provide Diabetes PATH (Personal Action Toward Health) workshops	Six-week chronic disease management class hosted in collaboration with libraries, senior centers and community organizations	Improved diabetes self-management	Adults and seniors with diabetes and their caregivers	▪ Participation rates ▪ Post-test outcome measures such as blood sugar testing, physical activity, confidence managing condition ▪ Participant survey	National Kidney Foundation of Michigan
Provide My Choice…My Health Diabetes Prevention Program	12-month lifestyle change program with group coaching hosted in collaboration with libraries, schools and community centers	Prevention of type 2 diabetes	Adults with prediabetes or at high risk of diabetes	▪ Participation rates ▪ Increase in physical activity ▪ Average weight loss ▪ Participant survey	National Kidney Foundation of Michigan
Provide Cooking Matters™ EXTRA for Diabetes programs	Six-week workshops to equip families with the knowledge and skills they need to shop for and prepare healthy meals on a limited budget. Hosted in collaboration with libraries, senior centers and community organizations.	Improved nutrition practices, eating habits, healthy meal preparation and food budgeting knowledge and behaviors	Adults with diabetes or prediabetes	▪ Participation rates ▪ Post-test outcome measures such as use of nutrition facts on food labels, adjusting meals to be more healthy, choosing healthy foods at restaurants ▪ Participant survey	Gleaners Community Food Bank of SE Michigan
Provide health education on diabetes through the Beaumont Speakers Bureau	Education presentations to community groups	Improved knowledge of diabetes prevention and treatment options	Community organizations	▪ Participation rates ▪ Participant survey	
Distribute to schools “Managing Type 1 Diabetes in Schools: A Guide for Non-Medical Personnel in Schools”	Online training videos and accompanying guide used in collaboration with schools to provide care to students with type 1 diabetes	Safe and healthy school environment for children with type 1 diabetes	Non-medical school personnel	▪ Online video viewing rate	School systems