Community Health Needs Assessment – 2016

Beaumont Hospital, Taylor Implementation Strategy

2018 Update

Building healthier lives and communities.

Beaumont

P19360g6_19360_082718

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:

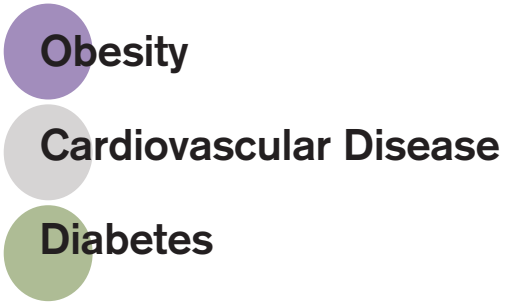
- Importance of the problem to the community ensures the priorities chosen reflect the community experience.
- Alignment with the health system's strengths is important to ensure we leverage our ability to make an impact.
- Resources criteria acknowledges that we need to work within the capacity of our 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)
- **Health Care 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.

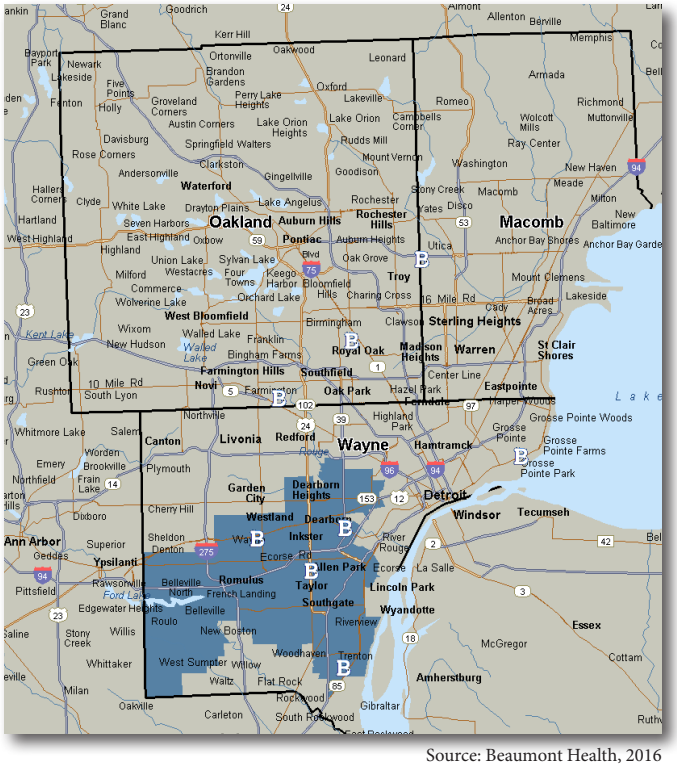
The implementation strategy for the chosen health needs of obesity, cardiovascular disease and diabetes are outlined in the following pages.

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, 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** of the **CHNA Full Report** located at **beaumont.org/chna**



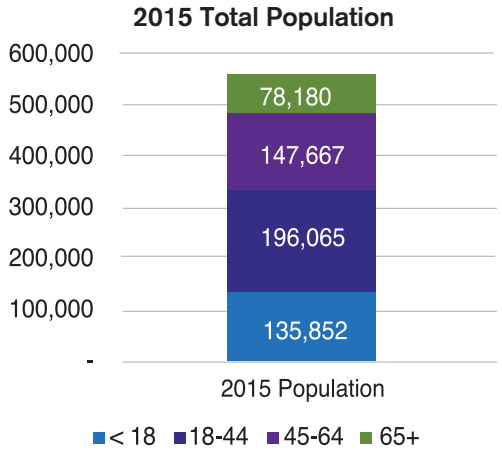
Source: Beaumont Health, 2016

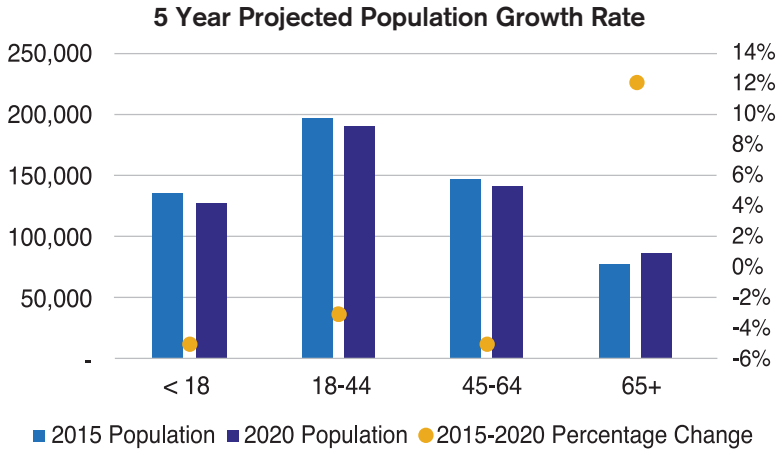
Demographic and socio-economic summary

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



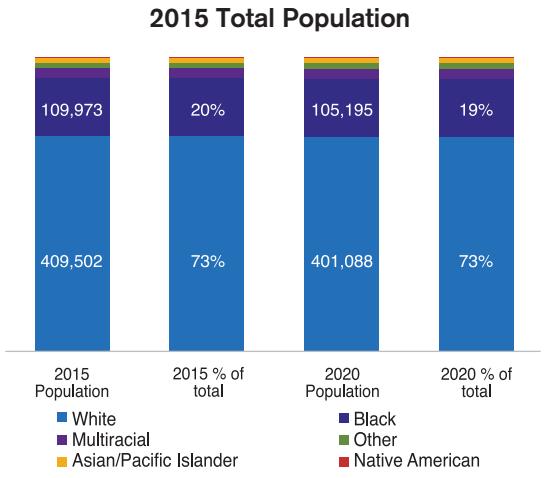


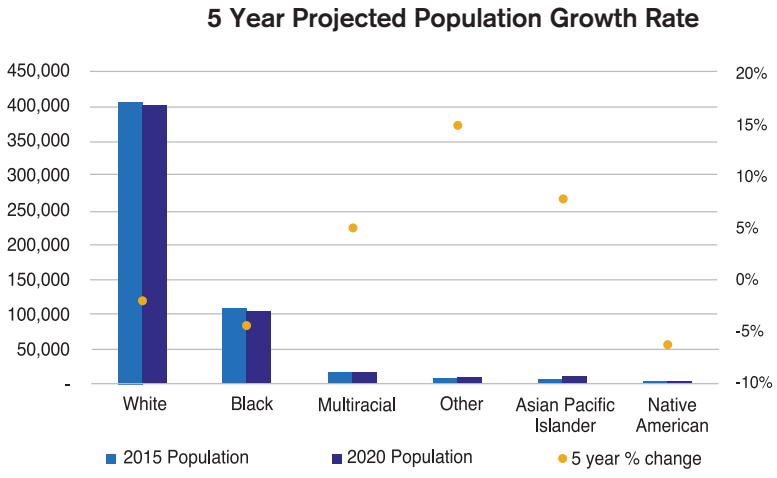
Source: Truven Health Analytics, 2016

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



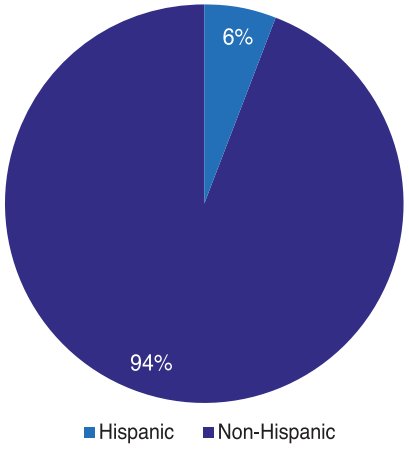


Source: Truven Health Analytics, 2016

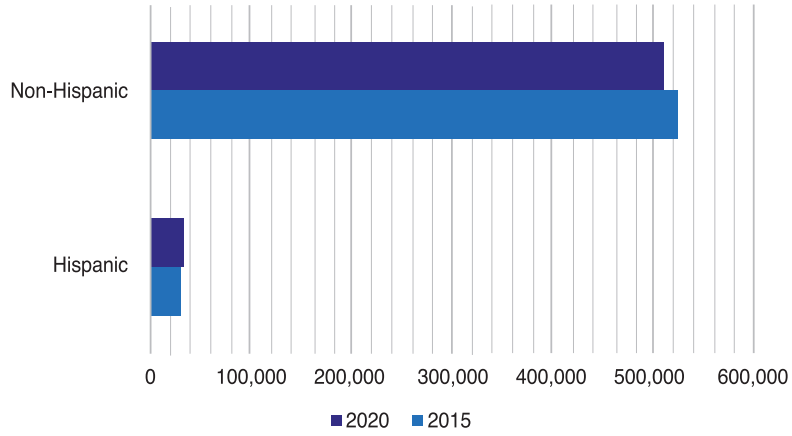
Beaumont, Taylor's population is predominantly non-Hispanic with Hispanics making up only 6 percent of the area's population. The community's ethnic composition is similar to the state. This will remain relatively stable, as the Hispanic population is expected to increase only slightly over the next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

Population by Hispanic Ethnicity

2015 Total Population



5 Year Projected Population Growth Rate



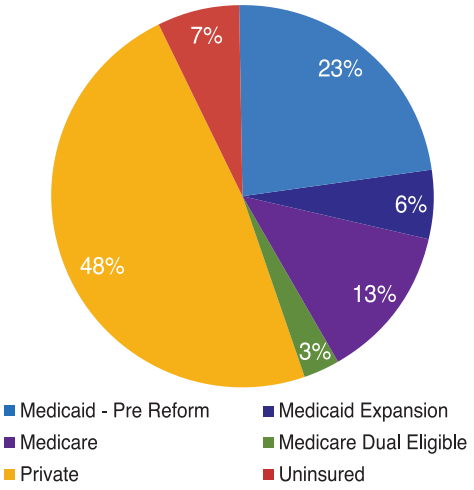
Source: Truven Health Analytics, 2016

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).

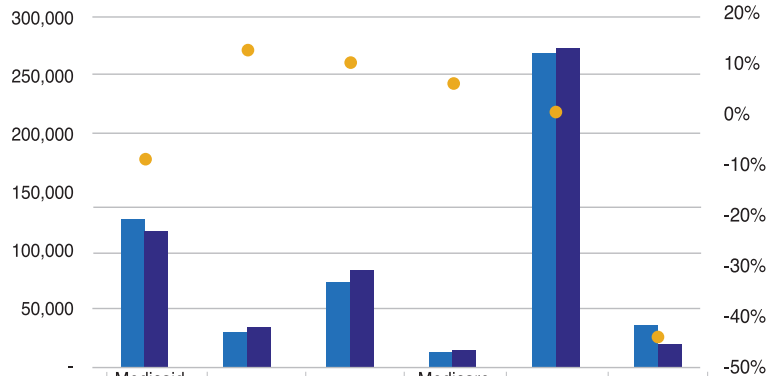
The Medicare population will experience the greatest growth and is expected to increase 11 percent by 2020. This is primarily fueled by a growing 65+ population in the community. The private insurance category is also projected to increase at a slower rate. The number of people purchasing insurance via 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



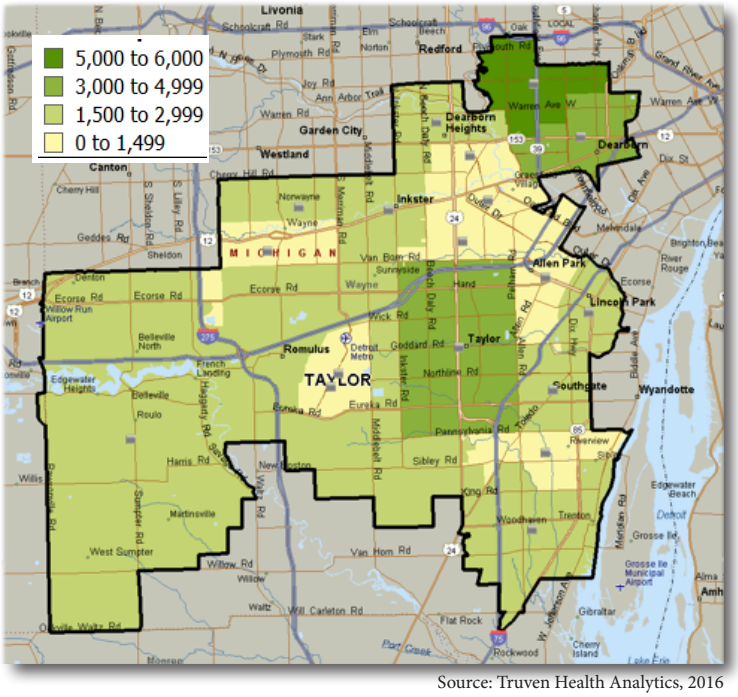
5 Year Projected Population Growth Rate



	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

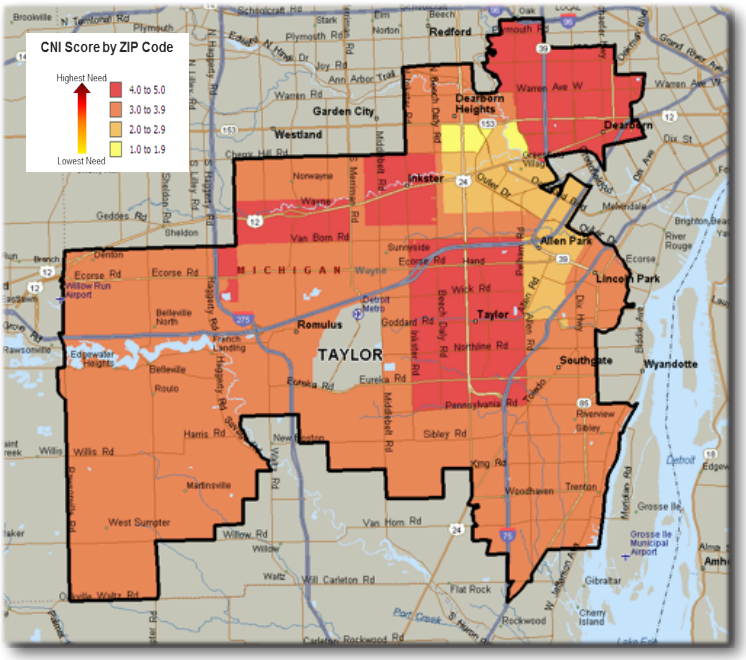
2015 Estimated Uninsured Lives by ZIP Code



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

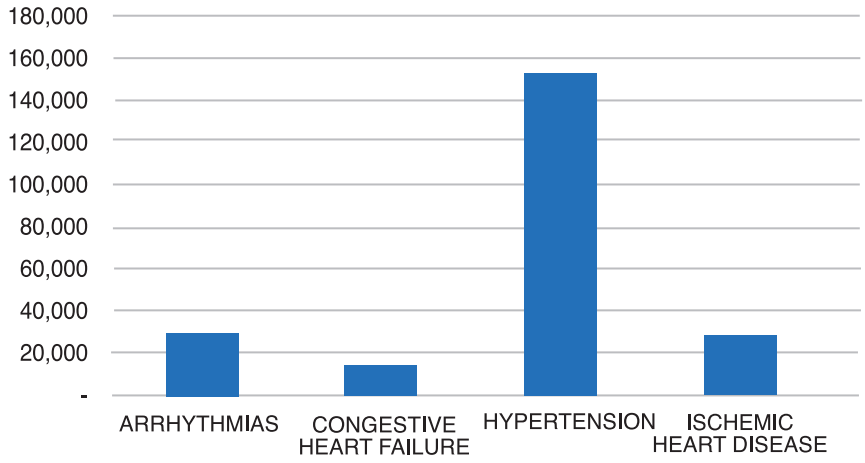
Along with Beaumont, Grosse Pointe, Beaumont, Taylor has the second highest CNI score in the overall Beaumont community at 3.6. The CNI data indicates that the majority of the community has a high level of need.

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.

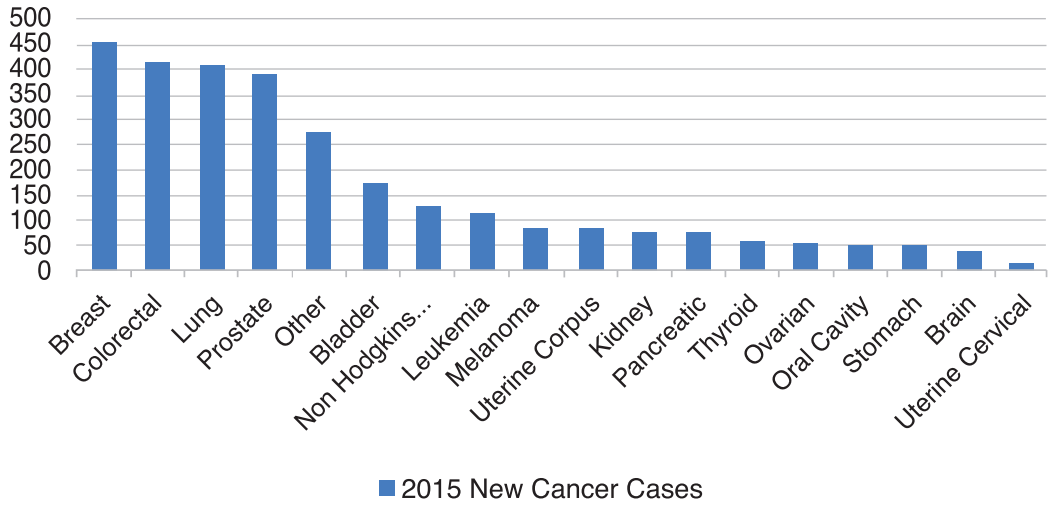
2015 Estimated Heart Disease Cases



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.

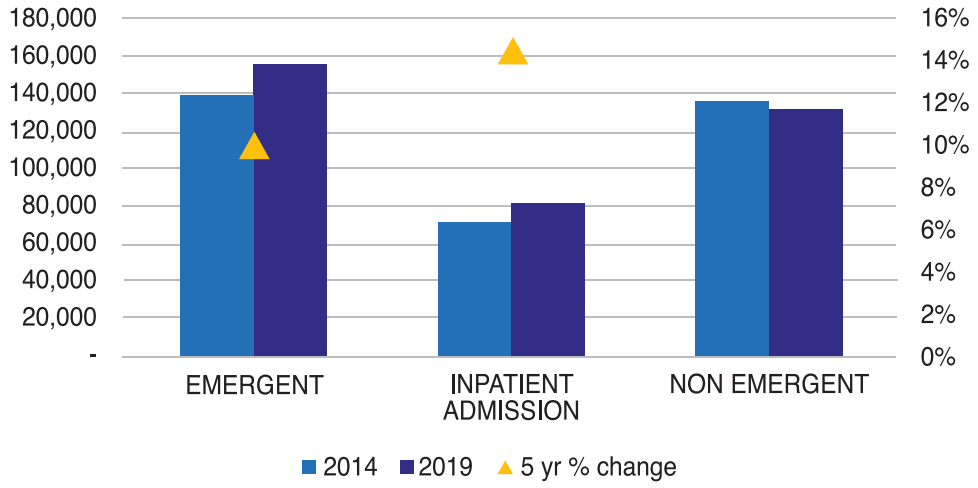
2015 Estimated New Cancer Cases



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).

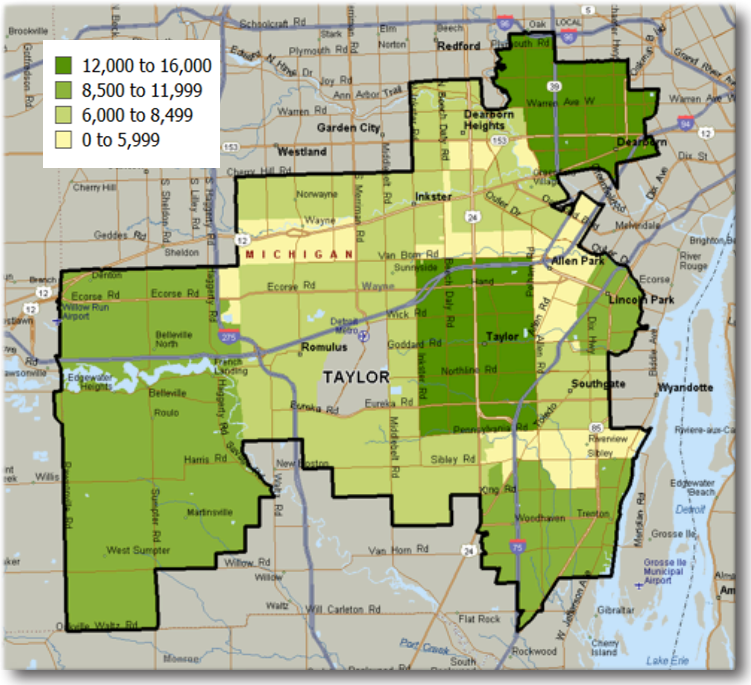
Emergent and Non-Emergent ED Visits



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 of the CHNA Full Report located at beaumont.org/chna

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
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 work-sites 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	Support the Taylor Farmer's Market and the Power of Produce program.	Increase in fruit and vegetable consumption	community-wide	• partnership agreements • number of participants	Taylors Farmers Market, Inc.
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
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 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

OBESITY - *continued*

STRATEGY 2: Increase opportunities for physical activity.

Provide Healthy Taylor Beaumont Gets Walking programs	Walking programs to increase physical activity as well as social interaction among neighbors and community members such as community walks at local parks led by City of Taylor and state officials and neighborhood and employee walking groups.	Increased knowledge of healthy lifestyle practices and increase in physical activity	community-wide	• participation rates • participant survey • tracking logs	City of Taylor 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, 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	• number of individuals trained	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

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	• participation rates • post-test outcome measures such as blood sugar testing, physical activity, confidence managing condition • participant survey	National Kidney Foundation of Michigan
Provide the National 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	
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	