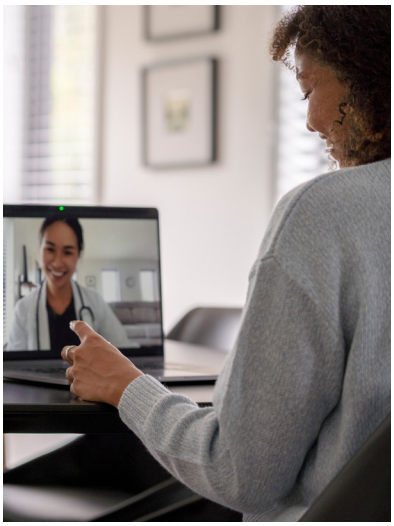


2022 COMMUNITY HEALTH NEEDS ASSESSMENT

Building Healthier Lives and Communities

Beaumont

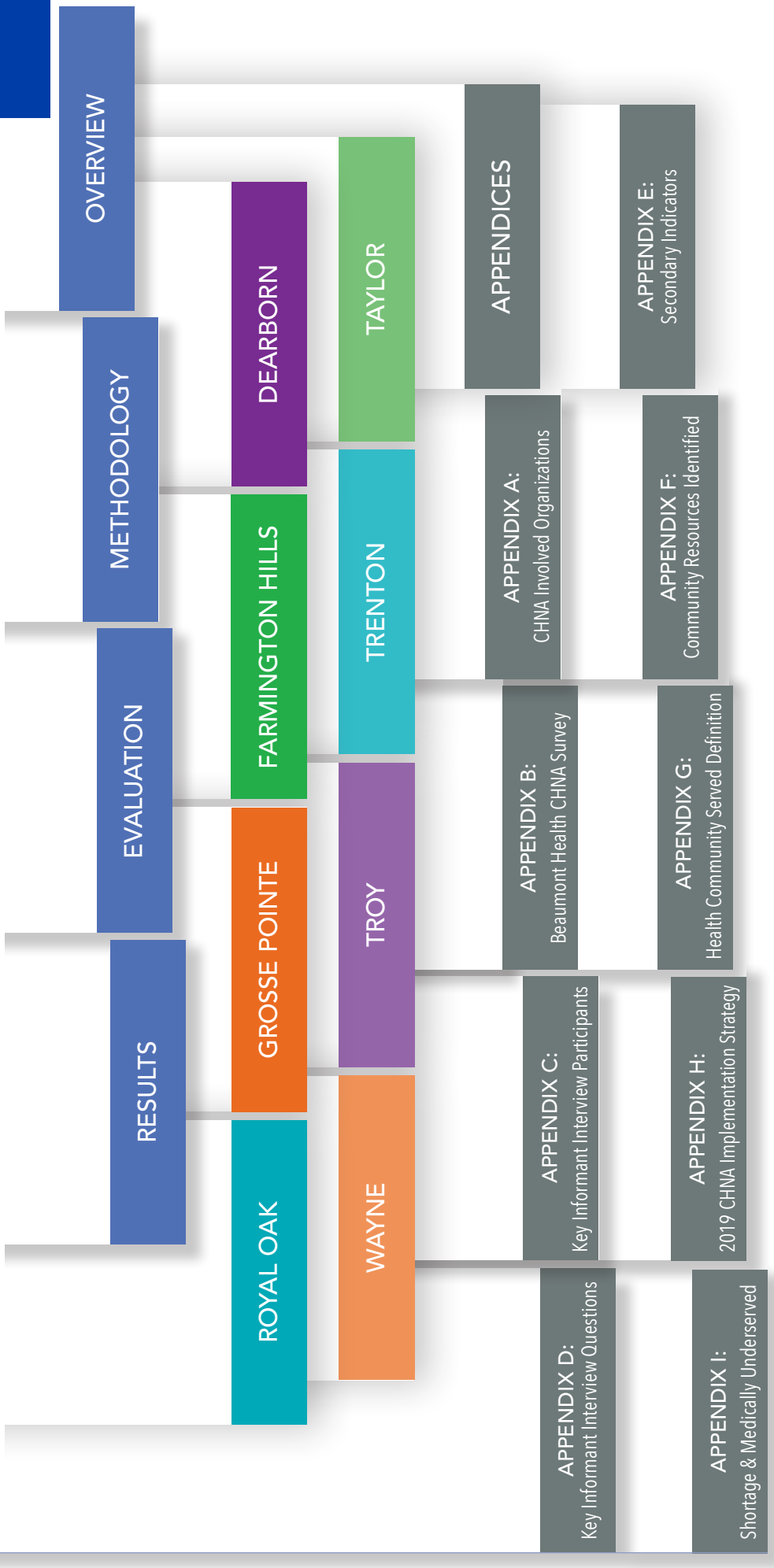
Quick Click Tabs

BEAUMONT HEALTH/
COREWELL HEALTH
Mission, Vision, Values

LETTER FROM CEO

EXECUTIVE SUMMARY

NEEDS ASSESSMENT
REQUIREMENT



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Corewell Health™

We can make health better.

People are at the heart of everything we do, and the inspiration for our legacy of outstanding outcomes, innovation, strong community partnerships, philanthropy and transparency. Corewell Health is a not-for-profit health system that provides health care and coverage with an exceptional team of 60,000+ dedicated people—including more than 11,500 physicians and advanced practice providers and more than 15,000 nurses providing care and services in 22 hospitals, 300+ outpatient locations and several post-acute facilities—and Priority Health, a provider-sponsored health plan serving more than 1.2 million members. Through experience and collaboration, we are reimagining a better, more equitable model of health and wellness.

By the numbers

Numbers are only part of our story. They help demonstrate our positive impact on lives across Michigan.

60,000+
Team Members

11,500+
Affiliated, Independent and Employed Physicians and Advanced Practice Providers

15,000+
Nurses

$100 Million
Health Equity Funding
(Over 10 years)

300+
Ambulatory/ Outpatient Locations

22
Hospital Facilities

5,000+
Licensed Beds

$100 Million
Venture Capital Fund
(Over 10 years)

1.2+ Million
Health Plan Members

7,000+
Employers Contracted by Priority Health

$14 Billion
Enterprise

One system of care and coverage

For more information, visit **corewellhealth.org**

beaumont.org
Corewell Health East

spectrumhealthlakeland.org
Corewell Health South

spectrumhealth.org
Corewell Health West

priorityhealth.org
Priority Health

Locations

- Hospitals
- Priority Health

After Beaumont Health completed the data collection, the priority planning sessions, and the implementation planning sessions, but before the Implementation Plans were active, the health system went through a rebranding which included a name change to Corewell Health. During the implementation of the 2023-2025 plans, the system will be referred to as Corewell Health and evaluation reports will refence the 2022 Beaumont Health CHNA, but will be branded Corewell Health.

Letter from the CEO

CEO's message to the community

We are pleased to share with you the 2022 Community Health Needs Assessment (CHNA). Every three years we participate in a CHNA process to update our approach to community health and wellness. For the past 12 months we have collaborated with community partners and the communities we serve to gain an understanding of the current health-related needs of our service area. Our CHNA approach had oversight from an advisory board comprised of both community leaders and hospital representatives who lead the efforts in collecting data, listening to the community, and selecting the priorities.

Our CHNA has historically focused on condition specific needs (diabetes, obesity, cardiovascular disease), but through our comprehensive collection of data this cycle, the needs of our community shifted to focus efforts more upstream and to get to the root causes of behaviors and health conditions. Over the next three years, Corewell Health East and our community partners will focus on three priority areas: health education, access to care, and behavioral health. We know these past few years have been challenging – mentally, physically, and financially – and these priority areas support the challenges and needs our communities are facing. This report will detail the data and findings that guided us to these priorities and includes our plans to address these areas over the next three years.

Corewell Health East would like to thank everyone that contributed to the CHNA, including the Advisory Committee and Implementation Planning Team members. We hope this assessment is beneficial to those in the service area and look forward to continuing collaborative work to best address the needs of our communities.

Thank you,

Benjamin Schwartz, M.D.
President & CEO
Corewell Health East

Corewell Health™

Executive Summary

Beaumont Health understands the importance of serving the health needs of its communities. To understand the health concerns and needs that patients, their families and neighbors face when making health life choices and health care decisions, Beaumont Health implemented a Community Health Needs Assessment.

Beginning in January 2022, Beaumont along with community partners began the process. The eight Beaumont hospitals were involved and considered throughout the assessment. Beaumont, with the help of community partners, collected and analyzed data to capture the community's voice and identify the greatest health needs of Macomb, Oakland and Wayne Counties. Prioritization of the needs collected through data resulted in three categories of needs with specific concerns.

The 2022 health needs to be addressed by Beaumont include:

- Behavioral Health
  - Mental health well-being
  - Substance misuse
- Health Education
  - Culturally appropriate health education
  - Community connectedness
  - Education on community infrastructure that supports health
- Access to Care
  - Discrimination & inequity in healthcare
  - System navigation (cost/insurance for care)

Community Health Needs Assessment Requirement

As a result of the Patient Protection and Affordable Care Act, all tax-exempt organizations operating hospital facilities are required to assess the health needs of their community through a Community Health Needs Assessment once every three years.

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 sources and dates of the data and other information, as well as the analytical methods applied to identify significant community health needs
- 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 health needs identified through the CHNA, as well as a description of the process and criteria used in prioritizing the identified significant needs
- the existing health care facilities, organizations, and other resources within the community available to meet the significant community health needs
- an evaluation of the impact of any actions that were taken, since the hospital facility's most recent CHNA, to address the significant health needs identified in that last CHNA

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. The Patient Protection and Affordable Care Act 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:

- a list of the prioritized needs the hospital plans to address and the rationale for not addressing other significant health needs identified
- actions the hospital intends to take to address the chosen health needs
- the anticipated impact of these actions and the plan to evaluate such impact; for example, identifying data sources that will be used to track the plan's impact
- programs and resources the hospital plans to commit to address the health needs
- any planned collaboration between the hospital and other facilities or organizations to address the health needs

The implementation strategy, or 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.

Overview: Process & Timeline

Process & Timeline

Framework

Beaumont Health system assessed the needs of the communities they served by conducting a Community Health Needs Assessment (CHNA) aligned with the American Hospital Association Community Health Improvement (ACHI) Community Health Assessment Toolkit. More information on this toolkit can be found here: https://www.healthycommunities.org/resources/community-health-assessment-toolkit.

Consultation

Michigan Public Health Institute (MPHI) was consulted to collaborate with Beaumont Health and relevant partners to complete the 2022 Community Health Assessment (CHNA). MPHI helped facilitate the CHNA process, collect data, analyze, and report the findings.

Groups Involved

A variety of groups were involved in the CHNA process, providing guidance, input, and expertise along the way. A complete list of organizations represented within each group can be found in Appendix A: Involved Organizations.

Steering Committee	Advisory Group	Partner Group	Implementation Strategy Planning Team
Core team to make decisions and guide the process.	Provides general over-sight, recommendations, and expertise throughout the process.	Broad group of partners to engage and inform as we go along, to obtain wider community buy-in.	Beaumont Health staff (representation of each service area) and group of partners to brainstorm and help select objectives, possible partnerships and resources to contribute to the implementation strategy plans.

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% of the hospital's admissions originate. The combined primary service areas of the eight hospitals principally include Macomb, Oakland, and Wayne counties in Southeast Michigan. In 2022, the total population of the community served by Beaumont was estimated to be 3.9 million people.

Steps and Timeline

In alignment with the ACHI framework, Beaumont's CHNA comprised the following steps, activities, and timeline.

ACHI Framework Step	Activities	Timeline
Reflect and strategize	Core team meetings	January – February
Identify and engage partners	Partners identified	February – March
Define the community	• Priority populations identified • Data collection strategies finalized	March
Collect and analyze data	• Secondary data summarized • Primary data collected and analyzed • Findings reviewed • Asset mapping completed	March – July
Prioritize community health issues	• Prioritization criteria developed • Prioritization meeting completed	August
Document and communicate results	CHNA report developed	September – October
Plan implementation strategies	Action planning sessions completed	September – October

Reflect and Strategize/Identify and Engage Partners

The Steering Committee kicked off planning in January of 2022 by reflecting on the 2019 CHNA process and findings. This group developed a strategy, project plan, and timeline as well as a list of possible partners to engage in the process. This extensive list included individuals and organizations who work closely with the communities Beaumont serves, with a focus on those individuals and groups representing priority populations. At this point in the process, the Steering Committee utilized this list to form the Advisory Group, which including individuals who work in the several Beaumont Health service areas, the local public health departments, and several community organizations representing medically underserved, low-income, and priority populations.

Overview: Process & Timeline

Define the Community

The Advisory Group began meeting in March of 2022. During this time the group defined and discussed the community being served, identifying any priority populations to keep in focus throughout the CHNA process.

Collect and Analyze Data

Concurrent to the Advisory Group defining the community, the Steering Committee finalized data collection strategies with input from the Advisory Group. Data collection started in March. The Advisory and Partner Groups helped with primary data collection by distributing the community survey and recruiting participants key informant interviews and focus groups.

Additionally, the Steering Committee reviewed potential secondary indicators of health in the community, compiling an extensive list of possible indicators, and narrowing that list based on available current data. The Advisory Group helped to compile data on existing community and hospital resources and assets that could support community health through an Asset Mapping activity. Beaumont partnered with MPHI to collect primary and secondary data and conduct analysis.

Prioritize Community Health Needs

Once MPHI analyzed data and organized results, the Advisory Group, along with additional partners, convened in August to review data and identify priorities. This group provided input on identified themes emerging from data and participated in rating potential priorities on a variety of facets to determine final priorities.

Document and Communicate Results

During September and October, the Steering Committee, in partnership with MPHI, developed this report summarizing the CHNA process, community data, and identified priorities. Health System leadership will review and approve this report, and the final report and Implementation Strategies will be shared with the community at large.

Plan Implementation Strategies

Following identification of priorities, the Steering Committee convened groups representing Beaumont's eight facilities and services areas to develop implementation strategies in alignment with identified priorities and goals. These Implementation Strategies detail the actions, responsible groups and individuals, and other details related to how each facility will address priorities to improve health in the communities Beaumont serves.

Assessment of Health Needs

Community Voice

To capture the voice of the community, the Steering Committee organized and implemented three main data collection activities, including a community-wide survey, key informant interviews, and focus groups. Each data collection activity is described in more detail in this section of the report.

Community Survey

Beaumont conducted a 25-question community health needs assessment survey to gather information from residents who live within Beaumont service areas. The survey captured opinions on what health issues respondents felt were a priority to be addressed in their communities. Survey respondents also provided information about how they felt about the overall health and safety of their community, as well as their level of access to needed health services and resources. The survey questions can be found in Appendix B: Community Survey Questions.

MPHI distributed the survey electronically using REDCap, a HIPAA compliant and secure online survey system. Beaumont hospitals with partner organizations promoted the survey in their clinics and through social media channels between March 15 and May 6, 2022. There were a total of 1,781 responses to the survey, after MPHI removed responses from non-Michigan residents and blank responses. Of the individuals who responded, 89% lived within a Beaumont service area.

All questions were analyzed by MPHI in aggregate; however, four questions were stratified by Beaumont service area (Dearborn, Farmington Hills, Grosse Pointe, Royal Oak, Taylor, Trenton, Troy, and Wayne). Stratification by service areas were not mutually exclusive, meaning some responses were included in the analysis of more than one service area. The four questions analyzed by service area included:

1. Top 3 medical conditions to be addressed
2. Top 3 health issues to be addressed
3. Top 5 community factors negatively impacting health
4. Top 5 barriers to receiving healthcare services

MPHI analyzed all quantitative survey data using descriptive statistics with Pivot Tables in Microsoft Excel. Qualitative survey data were analyzed thematically using NVivo qualitative analysis software and Microsoft Excel.

Key Informant Interviews

Based on questions developed by the Steering Committee, MPHI developed an online questionnaire and distributed it to both organizations working closely with the communities Beaumont Health system serves and those that were reflective of Beaumont's priority populations. The questionnaire captured key informants' thoughts and opinions on the health and related needs of the community. All participants were provided an opportunity to discuss or expand on responses with a telephone if they desired. A list of participating organizations can be found in Appendix C: Key Informant Interview Participants.

Methodology: Assessment of Health Needs

MPHI collected key informant responses through REDCap. All questions were open-ended, and the questionnaire took anywhere from 20 – 50 minutes to complete. Respondents were provided the opportunity to start responses and revisit again before submitting, so they did not have to complete the questionnaire all at once. All responses were optional and kept confidential. A list of the questions asked is included in Appendix D: Key Informant Interview Questions. MPHI exported responses from REDCap into NVivo for analysis to identify common themes across interview responses.

Focus Groups

The Steering Committee worked with Beaumont Community Health Managers to organize a focus group in each of Beaumont's service areas. The Community Health Managers recruited members of the community to participate. MPHI staff facilitated the one-hour focus groups virtually via Zoom, recording all focus groups. A note taker from MPHI was present and captured main points of the discussion. MPHI uploaded all focus group notes in NVivo qualitative analysis software and analyzed results to identify common themes.

Secondary Data

To help illustrate the health needs of the communities Beaumont Health serves, the Steering Committee reviewed health indicators in the 2019 Community Health Needs Assessment (CHNA). The 2019 CHNA indicators included 202 data elements grouped into 13 categories, disaggregated by county (Macomb, Oakland, and Wayne) where possible. Indicator categories included the following:

- Access to Care
- Cancer
- Conditions/Diseases
- Environment
- Health Behaviors
- Health Status
- Infectious Conditions/Diseases
- Injury and Death
- Maternal and Child Health
- Mental Health
- Population
- Preventable Hospitalizations
- Prevention

The Steering Committee worked collaboratively to identify where more recent data were available and to remove outdated indicators, creating a new list of data elements for possible inclusion in this CHNA. From there, data were compiled and checked against five criteria to narrow down indicators to include in the CHNA. Criteria for final indicator selection included selecting indicators where data revealed:

- Disparities between population groups
- Rates trending worse over time
- The Beaumont service area below state or national average
- Falling short of goals for performance (e.g., Healthy People 2030)
- Current performance related to previous organization or CHNA priorities

Information Gaps (Limitations)

Community input was valuable and considered in every step of the CHNA process. The Steering Committee was intentional in involving the communities Beaumont Health System serves. The priority populations, identified during the Defining the Community phase of the CHNA process, were actively considered and asked to participate in data collection activities. However, participation from communities of interest was limited in all primary data collection activities. Limitations related to each primary data collection activity included:

Key Informant Interviews: Participants were instructed to provide as much detail as possible in their responses to the online questionnaire. However, responses the evaluation team received via this instrument were brief, and individuals did not indicate an interest in opportunities to expand on their answers. Another limitation included level of participation in Key Informant Interviews. Participation was lower than anticipated, despite the Steering Committee sending multiple reminders to complete the questionnaire.

Focus Groups: Focus groups were designed to capture more contextual information from community members on health in the community, with a special interest of engaging community members representing identified priority populations. However, those who participated in the focus groups included individuals who work closely with the community, including the identified priority populations.

Survey: While community partners helped to distribute the survey to reach a representative group of respondents, the demographics of respondents were not representative of the communities Beaumont serves. Therefore, results are not representative of the priorities and needs of all community members.

Prioritizing Community Health Needs

On July 27, 2022, the Advisory Group and other partner organizations gathered to review data collected through the CHNA process. To view a list of organizations included in the Advisory Group and Partner Group visit Appendix A: Involved Organizations. The group received a data summary document that included the identified community health needs that arose across data sources, along with compiled findings from each data collection method. To focus the conversation, the Steering Committee identified themes that emerged from the CHNA data as the most prevalent health needs in communities served by Beaumont facilities. These themes included (in no particular order):

- Mental Health
- Substance Misuse
- Income/Poverty
- Access to Care: Cost/Insurance
- Health Education
- Access to Care: System Navigation
- Transportation
- Community Connectedness
- Discrimination in Healthcare/Culturally Responsive Care
- Community Infrastructure that Supports Health (access to safe, quality opportunities for physical activity, access to parks/ recreation, and access/proximity to nutritious food)

Methodology: Assessment of Health Needs

During the prioritization meeting, the group reflected on data and identified health needs. After reviewing data, facilitators asked the group to rate each need on three Likert scales:

- Disparities in Health Outcomes:
  Does this need impact different groups of people disproportionately?
  - (1) Low disparities: there is a minimal difference in the way this need impacts different groups of people.
  - (10) High disparities: there is a large difference in the way this need impacts different groups of people.
- Urgency: Does the need require swift actions to intervene?
  - (1) Low urgency: not as critical to address.
  - (10) High urgency: requires swift action.
- Feasibility of Possible Interventions: Is this need difficult to address? Does Beaumont Health System with community partners have the capacity to make progress?
  - (1) Low feasibility: difficult to address, Beaumont Health System with community partners does not have the capacity to address.
  - (10) High feasibility: easy to address, Beaumont Health System with community partners has the capacity to address.

The Steering Committee met to discuss the results of the prioritization meeting and considered all suggestions from the Advisory Group. They reviewed identified needs and combined items to establish three (3) priority areas, which will be described in the CHNA and addressed through future implementation strategy plans:

- Behavioral Health
  - Mental health well-being
  - Substance misuse
- Access to Care
  - Discrimination & inequity in healthcare
  - System navigation (cost/insurance for care)
- Health Education
  - Culturally appropriate health education
  - Community connectedness
  - Education on community infrastructure that supports health

All other identified health needs not directly addressed through the implementation strategy plans include: • Income/Poverty • Transportation

Although the above identified health needs will not be directly addressed through the implementation strategy plans, Beaumont will consider them while implementing the strategies for the other prioritized needs. Reasons for not addressing these needs include:

- The need was not well-aligned with organizational strengths
- There are not enough existing organizational resources to adequately address the need and it scored low for feasibility during the prioritization session
- Other facilities or organizations in the community are addressing them
- A lack of identified effective interventions to address the need were given

Existing Resources To Address Health Needs

Part of the assessment process included gathering input on community resources and assets potentially available to address the significant health needs identified through the CHNA. Beaumont facilitated a community asset mapping activity to help collect this information.

On June 29, 2022, the Advisory Group gathered and brainstormed assets in the communities and within the hospital system that can support community health improvement. An online collaborative tool, Miro, was used to facilitate and capture input from the group. The group focused on 4 different areas while brainstorming assets in the community and in the Beaumont Hospital System:

- Individuals
- Organizations
- Physical Resources
- Traditions and policies

Once priority areas were selected, the core group organized and discussed which resources apply to which identified health needs. This list can be found in Appendix F: Community Resources Identified to Potentially Address Health Needs.

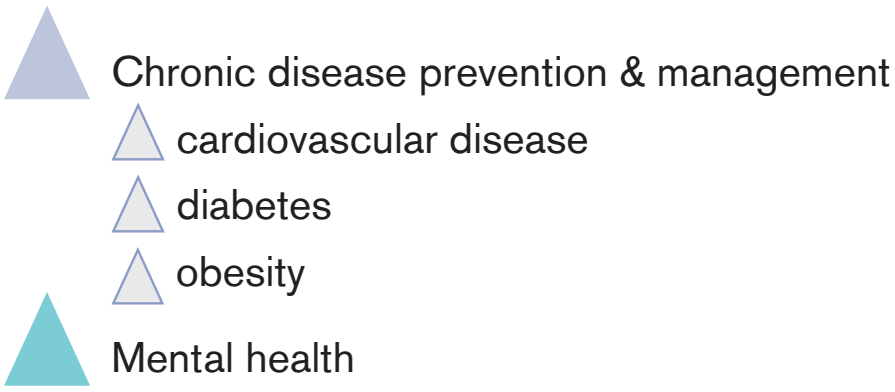
Evaluation: Prior CHNA Implementation Strategies

Prior CHNA Implementation Strategies

Evaluation of prior CHNA implementation strategies

As part of the current assessment, Beaumont conducted an evaluation of the implementation strategies adopted by hospital facilities as part of the 2019 CHNA. In 2019, Beaumont chose to address the following identified needs:

The health needs to be addressed by Beaumont included:



Implementation strategies were put into place in 2020 to address the above needs. Those strategies have been evaluated as to effectiveness and impact. Details for that evaluation can be found in Appendix H with the report of interventions and activities outlined in the implementation strategy drafted following the 2019 assessment.

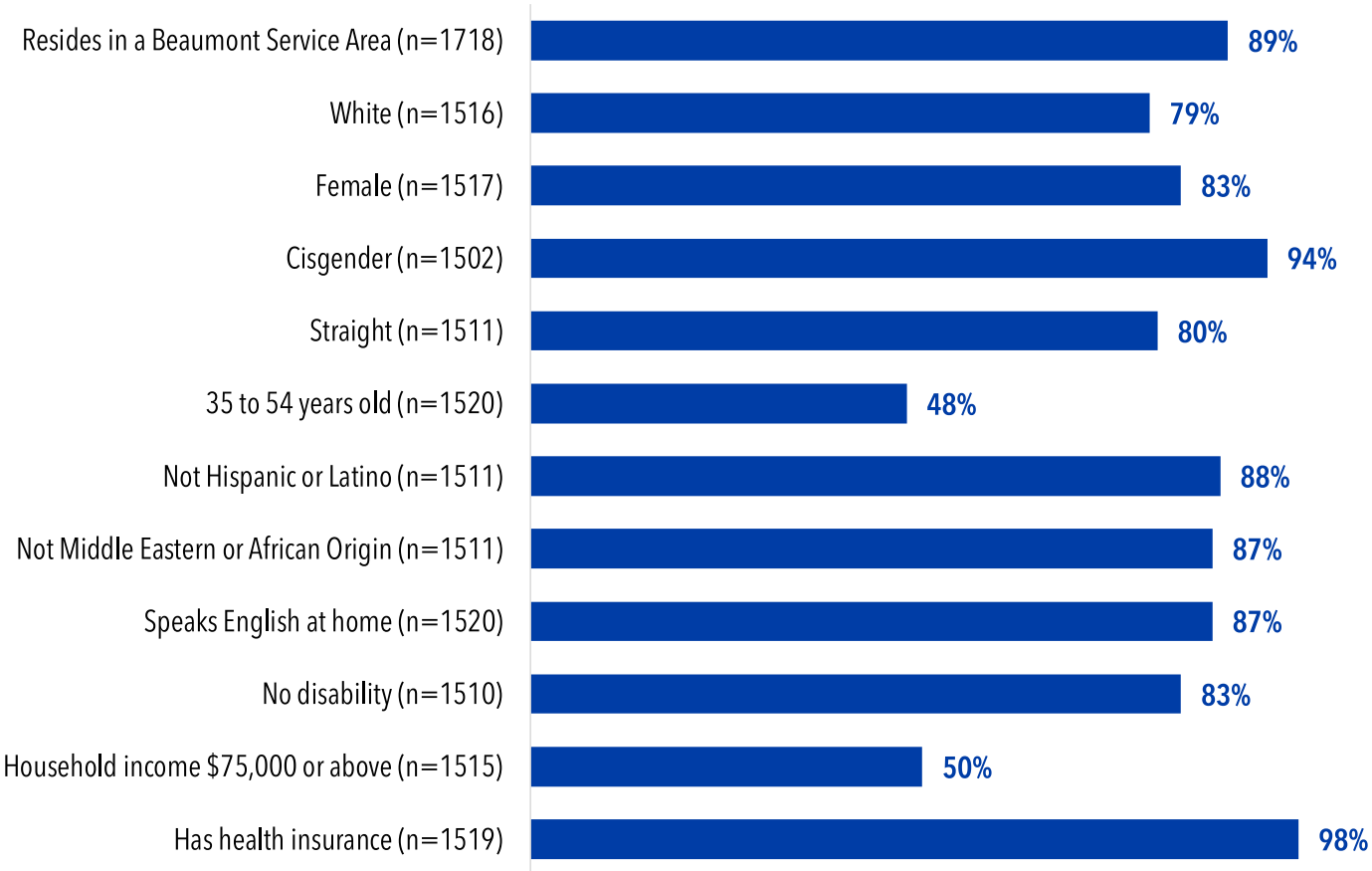
Community Survey

The community survey captured opinion information from people who live in the Beaumont service areas. Topics covered in the survey include community resources to support health, health needs, and community needs.

Demographics

Survey results were not reflective of the communities Beaumont Health System serves. 79% of survey respondents reported being white and only 5% were black, 10% were of Hispanic or Latino heritage, and only 3% were of African or Middle Eastern origin. 83% of respondents were female, 80% were heterosexual, 93% spoke English as their primary language, 83% did not have a disability, 50% had an annual household income of $75,000 or above, and 98% had health insurance. *(See the below chart and following pages for full responses by demographic categories.)*

Respondent Demographics

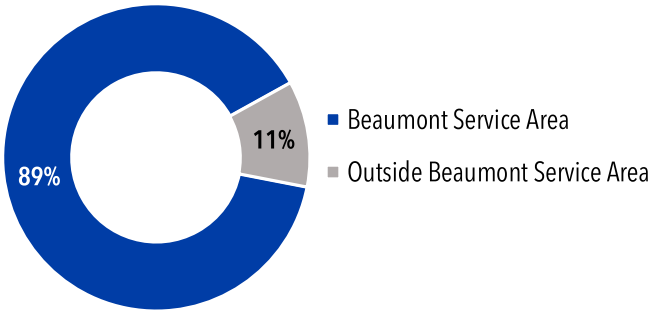


Community Survey

Full responses by demographic category are included in the following graphs:

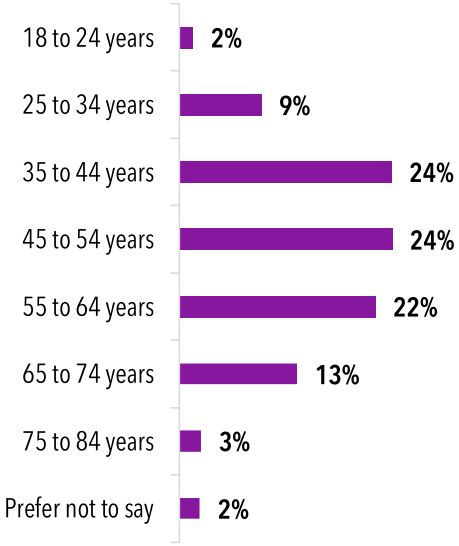
Percent of Respondents Residing in a Beaumont Service Areas

(n=1781)

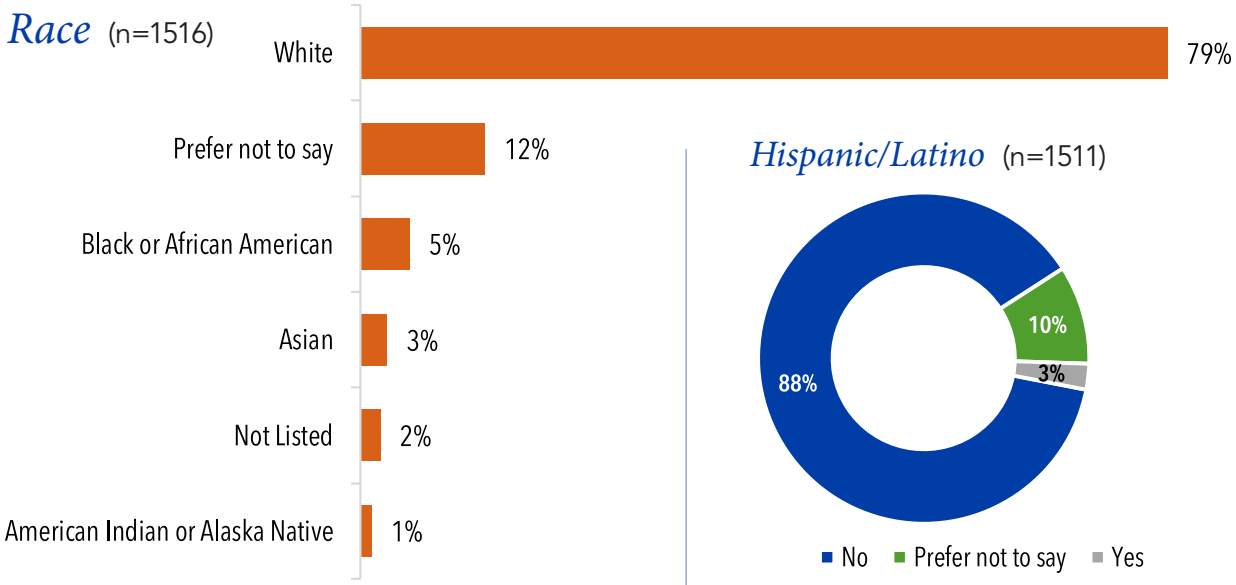


Age

(n=1520)

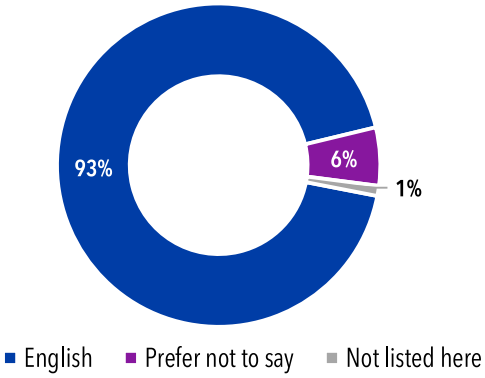


Race (n=1516)

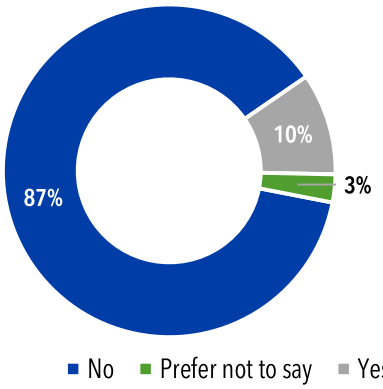


Hispanic/Latino (n=1511)

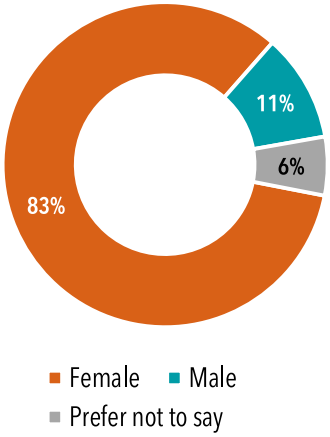
Language at Home (n=1520)



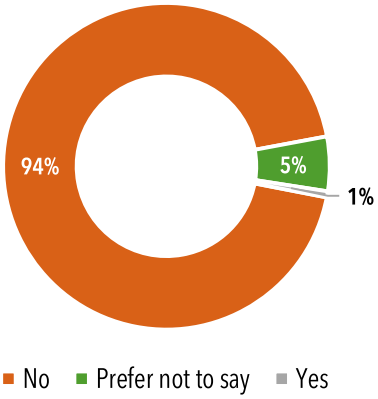
Middle Eastern or African Origin (n=1511)



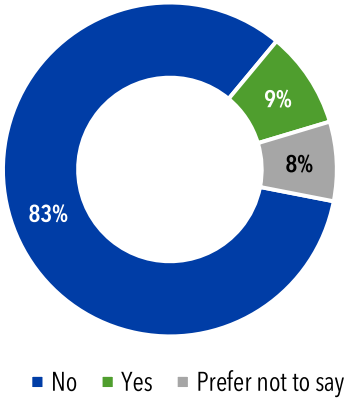
Gender
(n=1517)



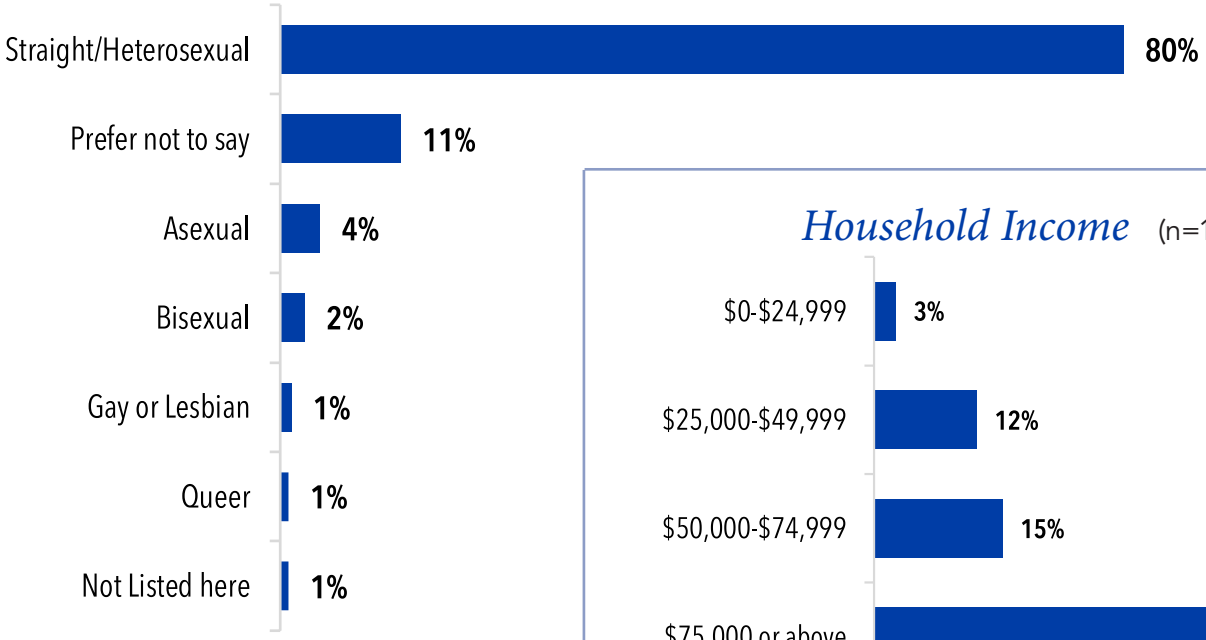
Transgender
(n=1502)



Disability
(n=1510)

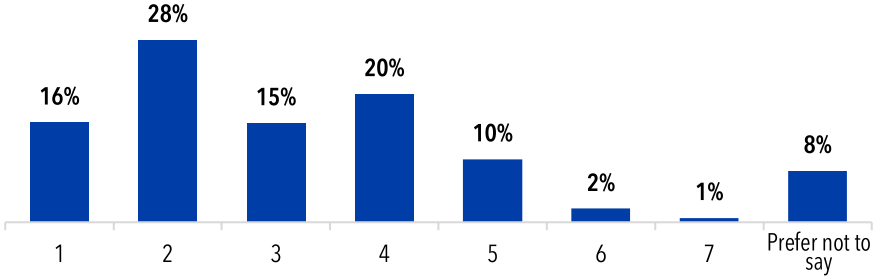


Sexual Orientation (n=1511)



Household Income (n=1515)

Household Size (n=1518)



Community Survey

Most Important Medical Concerns That Need to be Addressed within Communities

Top Three Medical Concerns in all Beaumont Service Areas (n= 1746)

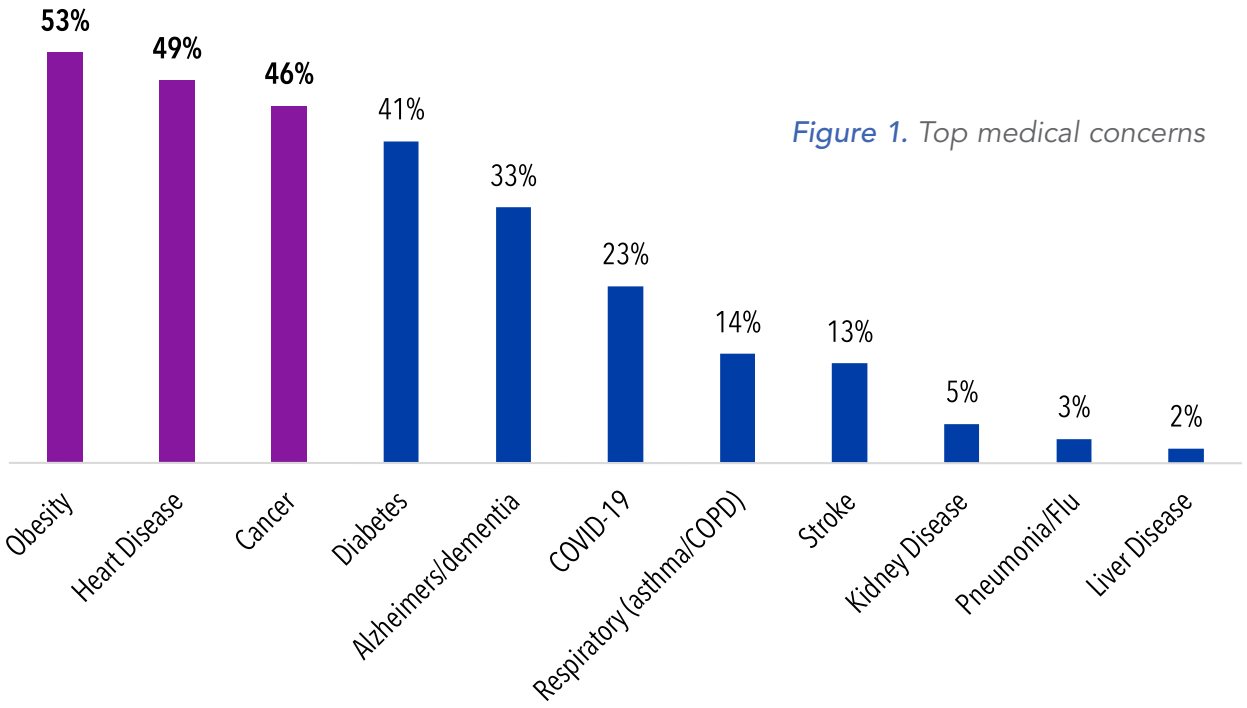


Figure 1. Top medical concerns

Survey respondents chose the top three medical concerns in their communities from a list of options. 53% of respondents indicated obesity was the top concern, followed by heart disease and cancer, with 49% and 46% of respondents choosing those health conditions, respectively (n=1746) (Figure 1).

When stratified by Beaumont service area (Figure 2), Grosse Pointe, Royal Oak and Troy also indicated obesity, heart disease, and cancer as the top three health concerns. Dearborn, Farmington Hills, Taylor, Trenton, and Wayne included diabetes in their top three health concerns. For Dearborn, Farmington Hills, Taylor, and Wayne, this replaced Cancer from their top three, and for Trenton, heart disease was replaced.

All (n=1746)	Obesity (53%), Heart Disease (49%), Cancer (46%)
Dearborn (n=526)	Obesity (53%), Diabetes (48%), Heart Disease (46%)
Farmington Hills (n=338)	Obesity (56%), Heart Disease (50%), Diabetes (49%)
Grosse Pointe (n=292)	Cancer (50%), Heart Disease (50%), Obesity (41%)
Royal Oak (n=743)	Obesity (53%), Heart Disease (52%), Cancer (44%)
Taylor (n=460)	Obesity (52%), Diabetes (47%), Heart Disease (45%)
Trenton (n=160)	Obesity (56%), Cancer (50%), Diabetes (48%)*
Troy (n=309)	Heart Disease (53%), Obesity (52%), Cancer (47%)
Wayne (n=163)	Obesity (58%), Diabetes (52%)*, Heart Disease (46%)

Figure 2. Top Medical Concerns by Beaumont Service Area

**Indicates at least 7% difference compared to the average across all Beaumont service areas.*

Top Three Health and Wellbeing Concerns in all Beaumont Service Areas

(n= 1754)

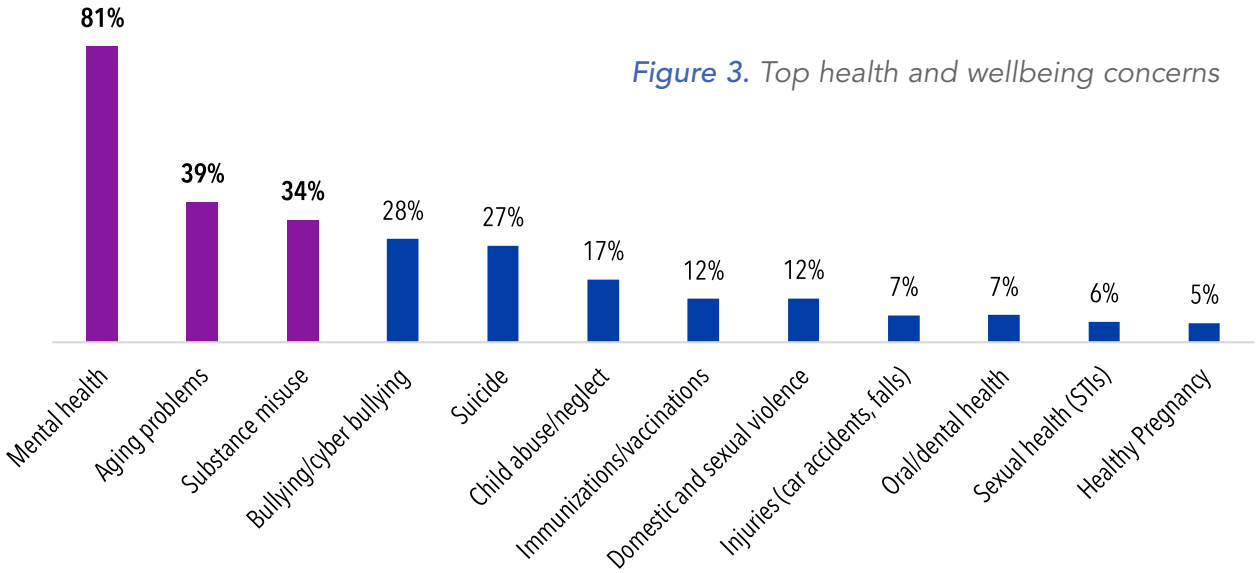


Figure 3. Top health and wellbeing concerns

Survey respondents chose the top three health and wellbeing concerns to be addressed in their communities from a list of options. More than four out of five respondents (81%) chose mental health as their top priority, followed by aging problems (39%), and substance misuse (34%) (Figure 3). When stratified by service area results stayed consistent, with all service areas ranking mental health, aging problems, and substance misuse as the top three health and wellbeing concerns, **except** for the Wayne service area (n=164), which indicated mental health (85%) as the top concern, followed by bullying/ cyberbullying/harassment (38%), and substance misuse (30%).

Community Factors Negatively Impacting Health

Top Five Community Factors Negatively Impacting Health Across all Beaumont Service Areas (n= 1672)

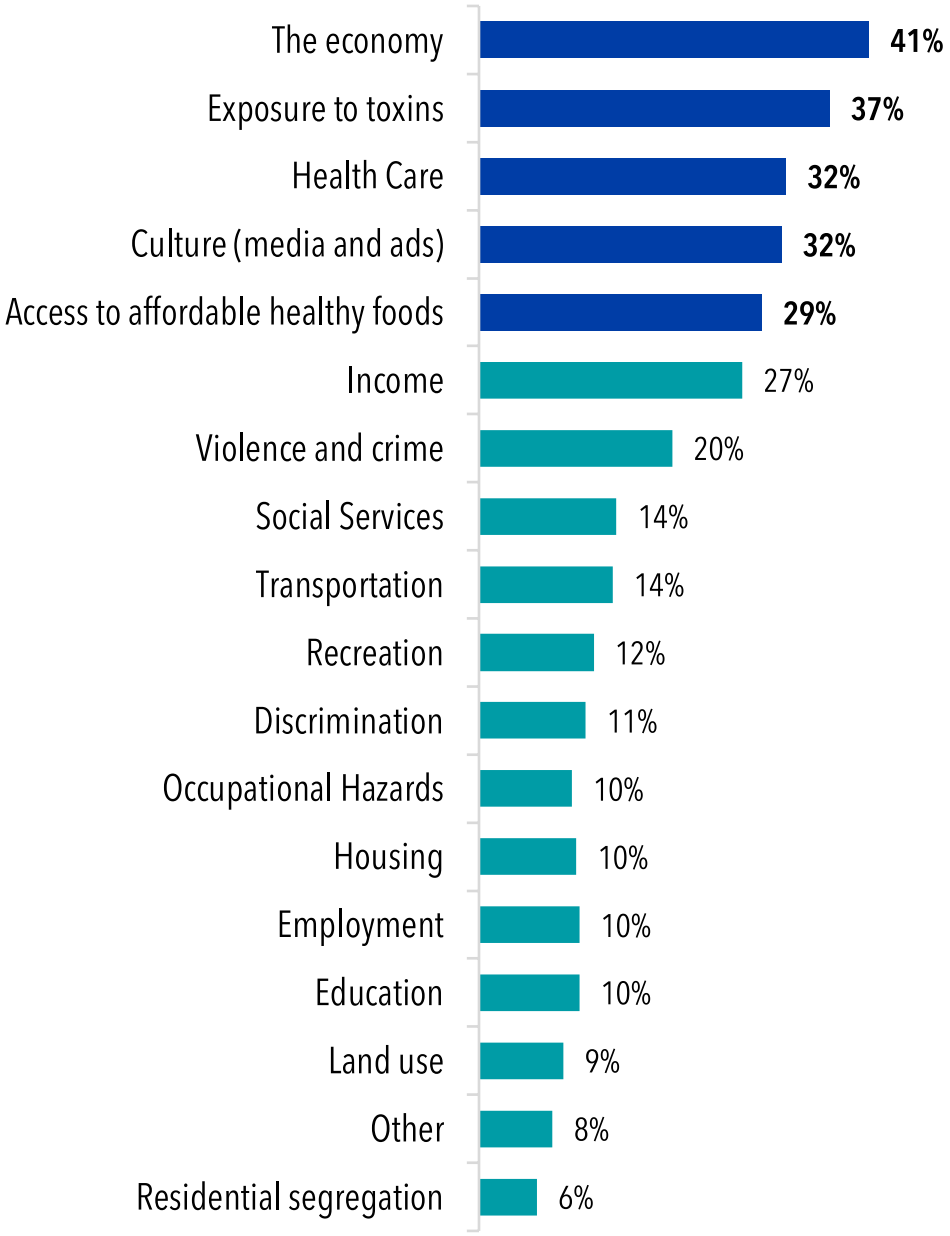


Figure 4. Top Community Factors Negatively Impacting Health

Respondents chose the top five factors in their community that most negatively impacted their overall health and wellbeing from a list of options (Figure 4). Responses showed the economy was the top-rated community factor, with 41% of respondents indicating it most negatively impacted their health. The economy was followed by exposure to toxins (37%), health care (32%), culture (media and ads) (32%), and access to affordable and healthy foods (29%).

When stratified by service areas Royal Oak and Troy were the only two service areas that economy, exposure to toxins, health care, culture (media and ads), and access to affordable and healthy foods were the top five priorities (Figure 5). Dearborn, Farmington Hills, Grosse Pointe, Taylor, Trenton, and Wayne included income in their top five priorities (with Farmington Hills listing income as an additional top factor, for a total of six). This addition replaced culture as a top priority for Dearborn, Taylor, and Trenton, affordable and healthy food in Grosse Pointe, and exposure to toxins in Wayne.

All (n=1672)	Economy (41%), Toxins (37%), Health Care (32%), Culture (32%), Affordable Food (29%)
Dearborn (n=507)	Economy (40%), Toxins (36%), Affordable Food (36%)*, Income (36%)*, Health Care (32%)
Farmington Hills (n=327)	Economy (39%), Affordable Food (34%), Culture (33%), Income (33%), Toxins (31%), Health Care (31%)
Grosse Pointe (n=268)	Toxins (40%), Economy (34%)*, Health Care (34%), Culture (28%), Income (26%)
Royal Oak (n=700)	Economy (38%), Toxins (35%), Culture (34%), Health Care (31%), Affordable Food (30%)
Taylor (n=460)	Economy (40%), Toxins (40%), Affordable Food (36%)*, Income (34%)*, Health Care (33%)
Trenton (n=160)	Economy (42%), Affordable Foods (42%)*, Toxins (42%), Income (39%)*, Health Care (38%)
Troy (n=275)	Economy (42%), Culture (38%), Toxins (33%), Health Care (32%), Affordable Food (25%)
Wayne (n=158)	Economy (41%), Income (41%)*, Affordable Food (37%), Health Care (33%), Culture (28%)

Figure 5. *Top community factors negatively impacting health by Beaumont service area*

**Indicates at least 7% difference compared to the average across all Beaumont service areas.*

Barriers to Health Care Services

Top Five Barriers to Health Care Services Across all Beaumont Service Areas (n= 1528)

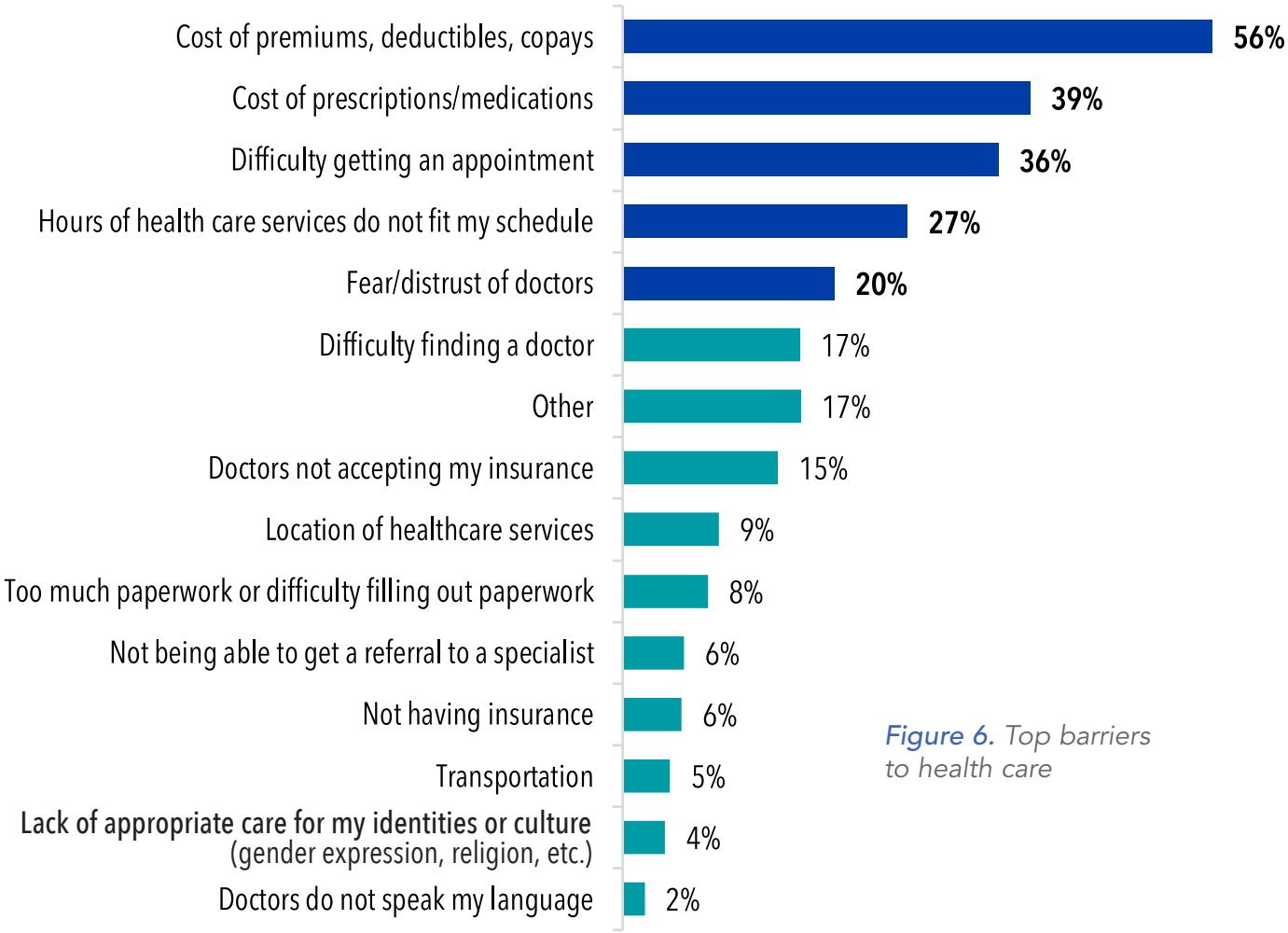


Figure 6. Top barriers to health care

Respondents chose their top five barriers that made it harder for them to obtain health care services in their communities from a list of choices (Figure 6). Over half of respondents (56%) chose cost of services including premiums, deductibles, and co-pays as the most significant barrier. Following cost of services, respondents reported cost of prescriptions (39%), difficulties with getting appointments (36%), hours of health care services not fitting with schedules (27%), and fear and distrust of doctors (20%) as their other top barriers.

17% of respondents chose "other," in response to this question. When asked to elaborate, respondents reported health insurance and the healthcare service were too difficult to navigate (timely appointments, offices not returning phone calls/office communication) or they did not have coverage. Respondents also stated they did not feel listened to when they saw their doctor and it was deterring them from going again, or providers did not look at health holistically and were more likely to prescribe medications for symptoms than identify root causes.

All service areas except for Dearborn, Grosse Pointe, and Trenton identified appointment costs, cost of prescriptions, difficulties with getting appointments, hours of health care services not fitting with their schedules, and fear and distrust of doctors as the top five health barriers (Figure 7). "Other" was included as a barrier for Dearborn and Trenton, and Grosse Pointe indicated difficulties finding a doctor was a top barrier to health care services.

All (n=1720)	Appt Costs (56%), Rx Costs (39%), Difficulties getting an appt (36%), Clinic Hours (27%), Medical Mistrust (20%)
Dearborn (n=511)	Appt Costs (57%), Rx Costs (40%), Difficulties getting an appt (29%)*, Clinic Hours (26%), Other (20%)
Farmington Hills (n=334)	Appt Costs (59%), Rx Costs (42%), Difficulties getting an appt (33%), Clinic Hours (30%), Medical Mistrust (18%)
Grosse Pointe (n=292)	Appt Costs (50%), Difficulties getting an appt (48%)*, Rx Costs (36%), Clinic Hours (27%), Difficulties finding doctor (23%)
Royal Oak (n=736)	Appt Costs (57%), Rx Costs (39%), Difficulties getting an appt (35%), Clinic Hours (29%), Medical Mistrust (22%)
Taylor (n=447)	Appt Costs (57%), Rx Costs (39%), Difficulties getting an appt (29%)*, Clinic Hours (26%), Other (21%)
Trenton (n=156)	Appt Costs (61%), Rx Costs (40%), Difficulties getting an appt (33%), Clinic Hours (24%), Other (20%)
Troy (n=301)	Appt Costs (54%), Rx Costs (36%), Difficulties getting an appt (35%), Clinic Hours (30%), Medical Mistrust (26%)
Wayne (n=156)	Appt Costs (58%), Rx Costs (41%), Difficulties getting an appt (34%), Clinic Hours (30%), Medical Mistrust (18%)

Figure 7. *Top Barriers to health care by Beaumont service area*

**Indicates at least 7% difference compared to the average across all Beaumont service areas.*

Community Survey

Access to Health Services

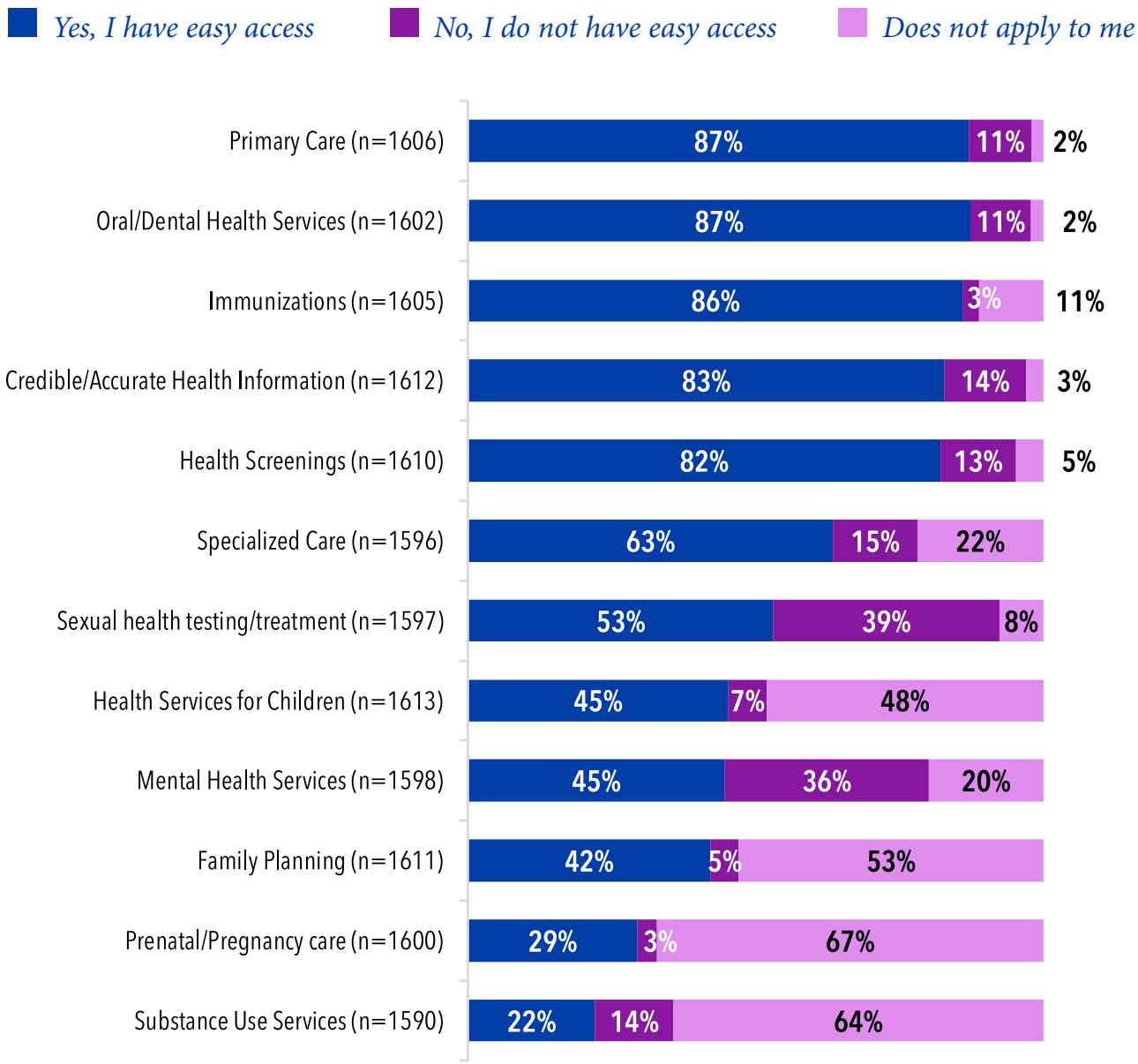


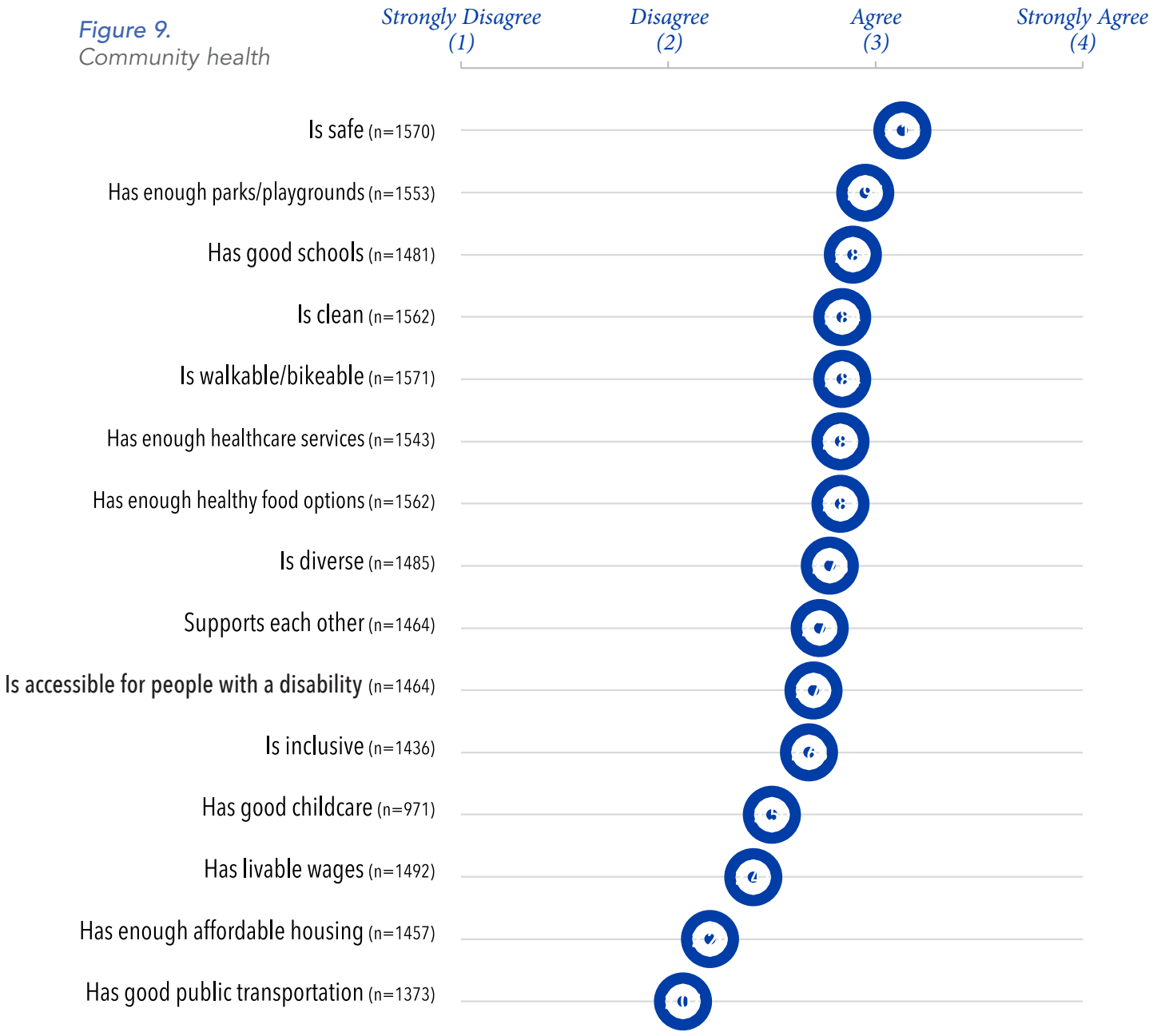
Figure 8. Perceived access to health care services

When asked about access to health care services, most respondents shared they had easy access to primary care (87%), oral/dental health services (87%), immunizations (83%), credible/accurate health information (83%), health screenings (82%), and specialized care (63%) (Figure 8). Respondents felt they had the least access to sexual health testing and treatment (39%) and mental health services (36%).

Community Supports for Health

Respondents rated their community on a variety of factors on a scale from 1 (strongly disagree) to 4 (strongly agree) with an option to select "not applicable," as well (Figure 9). Respondents who selected "not applicable" were excluded from analyses. The highest rated community factor was "my community is safe," with an average agreement response of 3.13, whereas the lowest rated community factors were "my community has good public transportation," (2.07) and "my community has enough affordable housing" (2.20).

Figure 9.
Community health



Community Survey

Available Programs and Services

Respondents shared their level of agreement with a list of statements regarding level of services and resources available for special populations in their communities on a scale from 1 (strongly disagree) to 4 (strongly agree) with an option to choose "unsure" as well (Figure 10).

Figure 10. Available programs and services

Percent of Respondents "Unsure" if there are Enough Resources for the Following Groups in their Communities

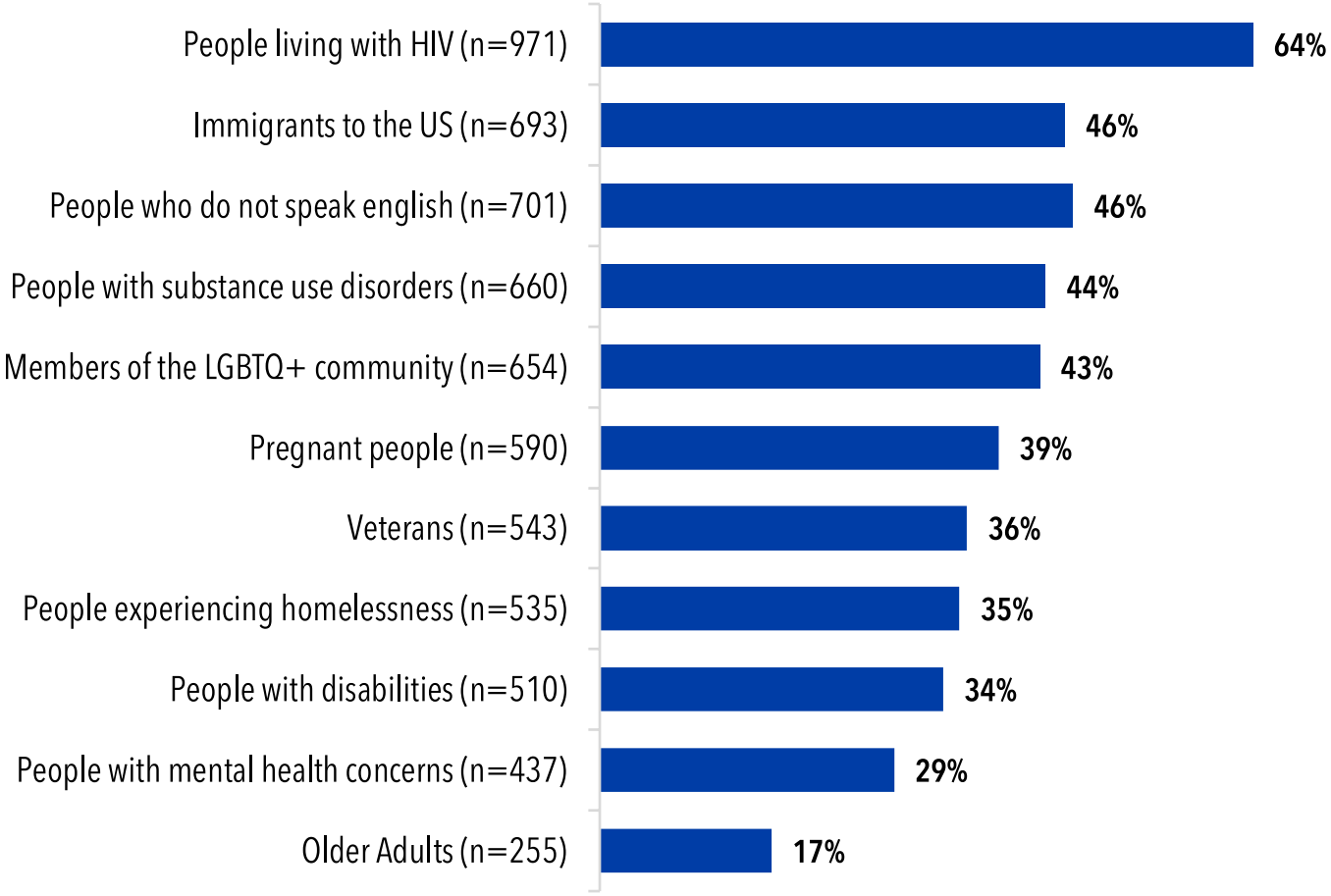


Figure 11. Uncertainty about available resources

Many respondents indicated they were "unsure" if their community had enough resources for specific populations (Figure 11). For those who indicated their agreement level, only one special population had an average of 3 or greater indicating agreement: pregnant people (3.01). Respondents disagreed there were enough programs and services for the other special populations included.

Community Survey

Primary Place of Healthcare Services

Primary place of health care (n= 1528)

When asked where they primarily access health care in their community, most respondents reported they receive primary health care from their family doctor (77%) (Figure 12).

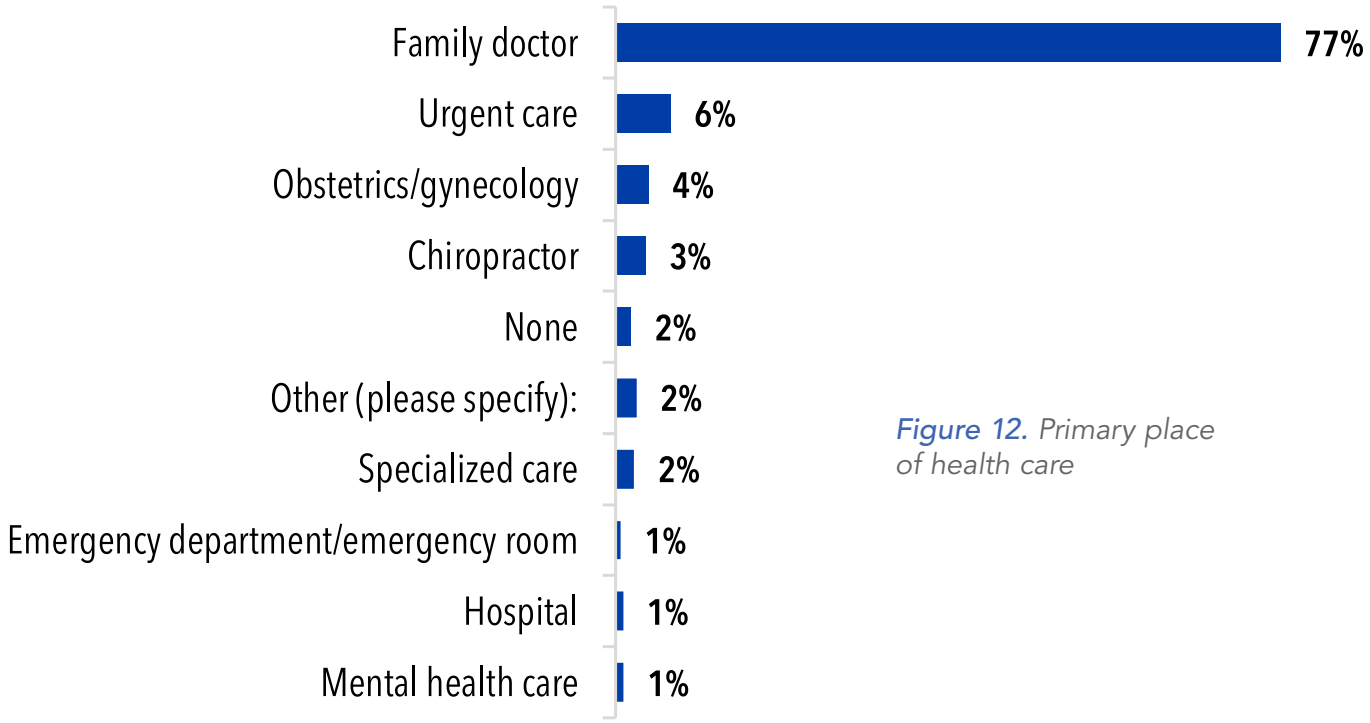


Figure 12. Primary place of health care

For respondents who chose "other," they primarily reported seeing a naturopathic/homeopathic practitioner.

COVID-19 Healthcare Related Concerns

COVID-19 Related Concerns (n= 1528)

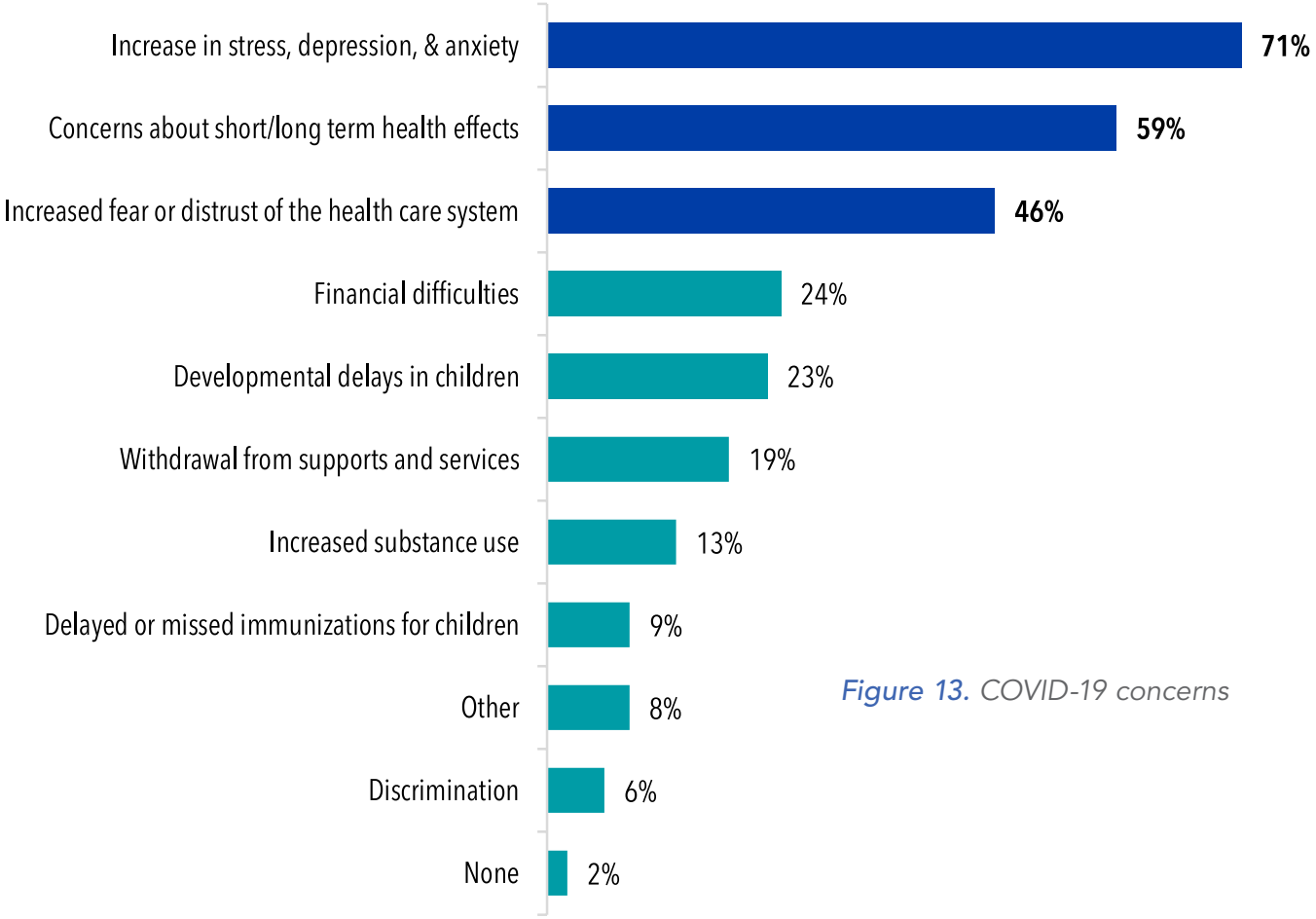


Figure 13. COVID-19 concerns

When asked about top concerns related to the COVID-19 pandemic, respondents reported an increase in stress, depression, and anxiety (71%); concerns about long- and short-term health effects (59%); and increased fear or distrust of the health care system (46%) (Figure 13).

Respondents who chose "other" noted their concerns were related to missed screenings or preventative care, increased wait time to see a doctor, de-prioritization of non-COVID related health issues, and restrictions in doctors' offices including mask mandates and requiring negative tests to be seen by a provider.

Community Survey

Additional Considerations

Respondents were given one open-ended question to provide any additional comments or insight on their experiences with health in their community, personal health, and thoughts on accessing health care services. Common themes across the 511 responses included, in no particular order:

Community Concerns

Affordable Housing: Lack of affordable housing in communities created more stress in respondents' lives and negatively impacts their health.

Air Quality: Some respondents expressed concern about air quality around their homes. Specifically, respondents were concerned about how local landfills, lack of tress, planes, and the automobile industry impacted the quality of the air in the area.

Childcare Services: Respondents noted general difficulties finding affordable childcare services, specifically difficulties finding childcare services needed to attend doctors' appointments for their personal health and were unable to bring children with them.

Government Officials: A handful of respondents mentioned their government officials were not representative of their communities and were not working to address issues in the community. Other respondents expressed disapproval of government officials who had eliminated public services in the area.

> *"They are eliminating public transportation services that benefit everyone and the effect will limit the ability of people within my community to travel outside the community as well as those who want to come in. Residents do not want this to occur, and the public officials did not listen, they voted to eliminate it anyway."*

Health Insurance: Several respondents expressed concern and dissatisfaction with their health insurance plan or not having insurance at all. Among respondents who mentioned health insurance, not being able to afford a health insurance plan was a main concern. Some expressed their desire for universal health care coverage. Other respondents stated their health insurance did not cover specific medical services, such as dental care or mental health. One respondent suggested that many of the medical choices he had to make were based on what his insurance covered and thus his care had not been person-centered. Some respondents stated they were too poor to purchase their own health insurance but did not qualify for Medicaid based on their income.

Healthy Foods: Multiple respondents suggested making healthy food more accessible by having more locations where they can purchase food and offering lower prices. One respondent suggested hosting more farmers markets. A couple additional respondents shared there were a lot of fast-food restaurants in their community, but not enough healthy alternatives.

Pedestrian Safety: Several respondents expressed concern regarding pedestrian safety. The most common concern was a lack of sidewalks available in their area. Additionally, they noted sidewalks in several places were not in proper condition for people, especially the elderly, to walk on. Cars and bushes blocking the sidewalk are an additional hazard, forcing people to step onto the road to get around them, causing unsafe walking conditions.

Respondents also shared concerns about drivers causing unsafe walking conditions, sharing that drivers are often not looking out for pedestrians. This was exemplified by cars blocking crosswalks and young drivers being distracted. Some respondents also suggested that law enforcement needed to do a better job enforcing the law to protect pedestrians and prevent accidents.

Recreational Areas: Respondents shared a desire to have more and better equipped recreational areas in open spaces such as parks, bike lanes, playgrounds, and trails. One respondent shared a concern about their community tearing down houses and other buildings to build parking lots instead of using those spaces to add green spaces.

Social Programs: Respondents reported a lack of social programs in their communities. The social programs respondents suggested they would like to see in their communities were: homeless shelters, after-school programs, palliative care, nutrition education, substance abuse rehabilitation, senior care programs, recreational programs (walking groups, arts, theaters in the park), and physical activity programs.

Substance Use: Respondents noted concerns about teen drinking and use of illegal substances due to COVID restrictions or lack of safe recreational areas. This included concerns about the level of available services to address these issues.

Water Quality: Some of the respondents expressed concern about the quality of the water in nearby rivers, streams, and lakes. Additionally, one respondent noted concern about lead in the water.

Mental Health

Access: Many respondents mentioned the need for more mental health services in the area to increase access to mental health providers and facilities. Suggestions included having mental health emergency hotlines, mental health professionals at schools, more mental health facilities, and better coverage of mental health services by insurance plans. Others shared their perception of increased need for mental health providers to treat children who were impacted by COVID-19 and subsequent restrictions.

> *"There is a serious lack of emergency mental health services. Adults and children experiencing a mental health crisis do not have adequate services. ER and police are not reasonable substitutes."*
>
> *"Easy, affordable access to mental health care. Mental Health taken as a serious medical condition."*
>
> *"Access to mental health services should be available to everyone!"*

Community and Provider Education: A few respondents expressed the need to educate healthcare professionals and community members about mental health issues and shared a wish for additional opportunities for these educational activities.

Key Informant Interview/Focus Group

Results: Key Informant Interview/Focus Group

Mental health emerged as a critical need across all data sources, especially the focus group and key informant interviews. Other themes regarding factors that inhibit community members' ability to lead healthy lives emerging from the data included cost of health care services, trouble navigating the health care system, community infrastructure that does not support healthy living, substance misuse, discrimination in health care settings, lack of appropriate health education resources, lack of affordable and reliable transportation, low income, poverty, and decreasing community connectedness.

The following are the primary themes shared across key informant interviews and focus groups:

Mental Health

Mental health emerged as a need across all data sources. The focus group and key informant interview findings specifically highlighted the need for insurance coverage for mental health services as well as affordable mental health services. Participants also noted that navigating mental health resources can be confusing and cumbersome, and generally, more resources are needed across communities. Pandemic-related stress and lack of social contact due to social distancing restrictions also contributed to participants feeling isolated. Findings showed this problem existed for all age groups, and stigma surrounding mental illness added additional barriers to accessing care.

Access to Care: Cost/Insurance

Key informant interview and focus group participants shared concerns about access and cost of health care services and prescriptions, citing these as major barriers to accessing care. High costs were noted as related to being uninsured or under-insured, high-deductible insurance plans, and high copays. Due to the high costs of care, some reported community members have been forced to choose between receiving health care or meeting other basic needs such as food or rent. Individuals may have also delayed preventative services, treatment, and overall care due to cost concerns. Insurance barriers also pose a challenge as insurance coverage has limited the ability of patients to find doctors close to home who accepted their insurance. This was noted as a difficulty especially for those on public health insurance, such as Medicaid. Participants noted that some insurances may not cover certain types of care, including mental health services or dental care. Additionally, some participants noted lack of insurance may prevent individuals from having a primary care provider, which could lead up to them utilizing the Emergency Department for health concerns as an alternative.

Access to Care: System Navigation

Participants reported navigating paperwork, insurance coverage, locating services and clinics, and understanding steps necessary to receive services were all barriers to care. Participants stated inconsistent communication and education from health care professionals could cause patients to "fall through the cracks." They also shared that many community members did not have awareness of existing resources available in their communities or how to utilize them. Overall, participants felt there was not enough support for patients to navigate the healthcare system effectively or efficiently.

Substance Misuse

Substance misuse was seen as a prominent issue in communities, including the rates of opioid use and tobacco use, as well as vaping specifically among youth populations. Participants felt that additional resources for those struggling with substance misuse were needed. Suggestions included safe use programs, needle exchange programs, harm reduction education, and treatment services. Participants felt that stigma for receiving treatment services contributed to substance misuse problems in communities and prevented people from accessing care. Pandemic-related stress was also cited as an issue that contributed to substance misuse.

Discrimination in Health Care/Culturally Appropriate Care

Findings from the key informant interviews and focus groups showed that lack of culturally competent care may have caused barriers to receiving needed health care services. Specifically, participants shared that more translators are needed in health care settings, especially among communities with large Hispanic or Arabic populations. Further, participants stated that there was a need for health education materials, both paper and electronic, to be translated into languages other than English. Some respondents felt that patients may not be honest with providers about what language(s) they speak for fear of discrimination. Lastly, some populations, including BIPOC and women, have experienced having their health concerns or pain dismissed, denied, or minimized, leading to these populations having less trust in providers or the healthcare system.

Health Education

Participants stated a need for health education, especially for patients regarding their treatment plans and diagnoses. It was also noted that education and communication should be shared in methods and languages that all patients can understand, including for older adults who may find this more challenging. Participants mentioned that sharing of health information has been impacted by COVID-19, making health education opportunities and resources less available. Participants shared hope that communities would be re-connected to opportunities for health education and resources post-pandemic.

Low Income/Poverty

Participants shared that individuals with low income and those experiencing poverty were more likely to experience health disparities and challenges, leading to difficulties with their ability to live a healthy life. They noted that communities with higher rates of poverty often have less resources available and experience a lack of access to healthy food, transportation, safe spaces for recreation, primary care, and health care services. Focus group and key informant interview participants shared that many in the community did not earn a livable wage which prevents access to needed resources.

Key Informant Interview/Focus Group

Community Infrastructure that Supports Health

Participants felt that community infrastructure was a factor that affected community health, particularly related to access to recreation spaces and nutritious food. Some stated unsafe neighborhoods could lead to discomfort utilizing recreation opportunities and other resources in the community. Participants also stated some communities lacked safe outdoor spaces for physical activity and enjoying nature which had a negative impact on physical and mental health. Participants shared environmental factors, such as poor air or water quality, could also lead to poor health. Lastly, participants shared that some areas have sidewalks and paths in disrepair, leading to difficult or unsafe opportunities for walking and biking.

Community food access was also shared as a concern by participants, as some neighborhoods may not have grocery stores nearby. These neighborhoods may also have a higher prevalence of food sources that do not offer healthy foods, including gas stations, convenience stores, or fast-food chains. They also shared that lower-income community members may lack reliable transportation to access healthy food options or food pantries. Even if transportation is not an issue, participants shared that healthy foods tend to be costlier than non-healthy alternatives. Participants also stated that food access decreased during the pandemic, as many food pantries were forced to close.

Transportation

Transportation as a major barrier to receiving health care services was cited across focus groups and interviews, including access to transportation and associated costs such as bus fares or costs associated with car ownership. Certain populations were noted as being more vulnerable to transportation difficulties, including the elderly or those living with disabilities. Those who did not have their own vehicles or access to public transportation may have experienced the need to rely on family members or friends to get them to and from doctors' appointments. Public transportation was not available in all communities, and often included limited stops. Participants also shared that even in communities with public transportation, some community members may not utilize it because they felt unsafe doing so.

Community Connectedness

Social support systems were mentioned as important positive contributors to physical and mental health across focus groups and key informant interviews. Social networks could lead to better understanding of available services and support to seek needed care. Places and groups such as churches and faith-based organizations, libraries, recreational teams, and other community activities could provide a sense of belonging and purpose. Participants shared this was especially important now, since COVID-19 led to isolation for many and reduced social connection.

Results: Secondary Indicators

To contribute to identification of health needs in Beaumont's service area, the Steering Committee reviewed potential secondary indicators of health in the community, compiling an extensive list of possible indicators and narrowing that list based on available current data. MPHI collected and organized secondary data for the Steering Committee and Advisory Group to review. Data related to indicators related to the identified priorities are included below. Additional secondary indicators included on the finalized indicator list are in Appendix E: Secondary Indicators.

Behavioral Health

Indicators of behavioral health include those related to mental health and substance misuse.

Mental Health and Wellbeing

Poor Mental Health Days

The Behavioral Risk Factor Surveillance System captures information related to adults reporting 14 or more days of poor mental health per month. Those who report this are described as being in frequent mental distress and identifies individuals who are experiencing more chronic, and likely severe, mental health issues.

Poor Mental Health, 2018 – 2020 Combined	
Michigan	15.4%
Macomb	15.2%
Oakland	13.5%
Wayne (exc. Detroit)	16.8%

Figure 14. Poor Mental Health 2018-2020

Source: BRFS Annual Report 2020

In Michigan, about 15.4% of those who responded to the BRFS between 2018 and 2020 report experiencing 14 or more days per month of poor mental health. In Beaumont's service area, Oakland County has the lowest percentage at 13.5% and Wayne County, excluding Detroit, has the highest percentage in the service area at 16.8%.

Secondary Indicators

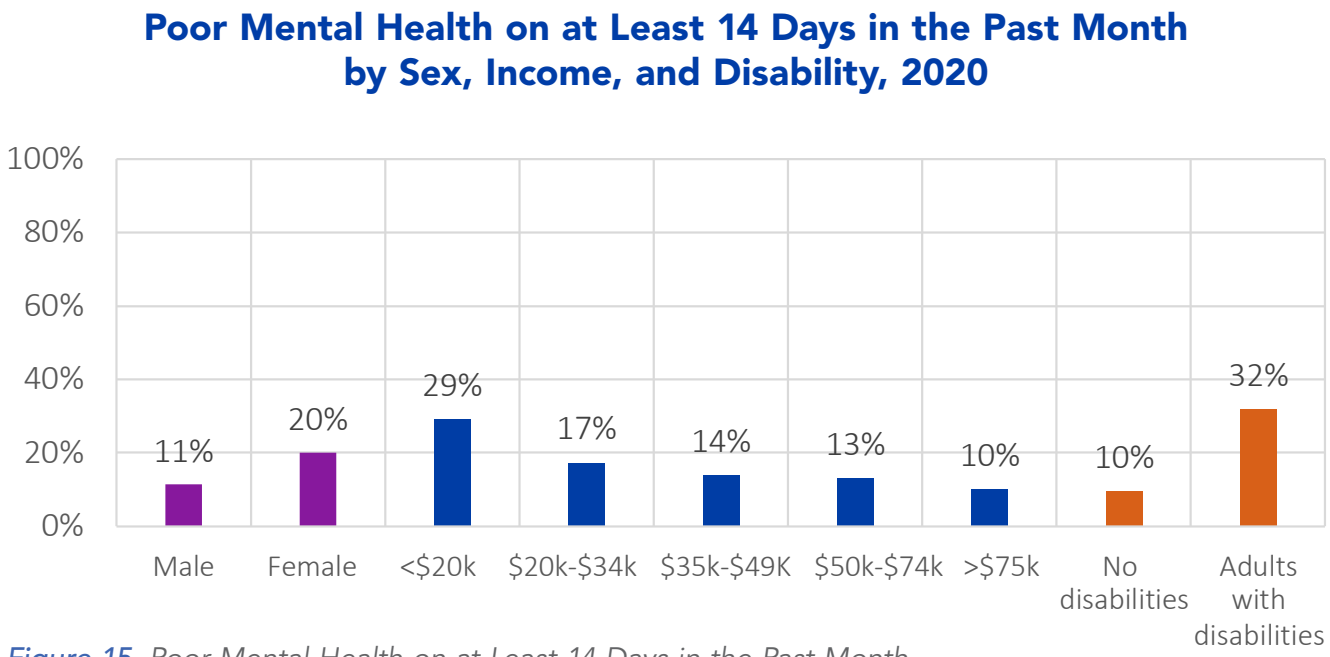


Figure 15. Poor Mental Health on at Least 14 Days in the Past Month

Source: BRFS Annual Report 2020

When looking at differences by demographics, we can see that females, individuals with lower income, and adults living with disabilities are more likely to report poor mental health.

Mental Health Providers

The ratio of population to mental health providers is an important indicator of access to mental health care.

Location	Ratio of Population to Mental Health Providers (2021)
US Top Performers	250:1
Michigan	330:1
Macomb	470:1
Oakland	260:1
Wayne	310:1

Figure 16. Ratio of Population to Mental Health Providers

Source: County Health Rankings: CMS, National Provider Identification

Overall, there is about one mental health care provider for every 330 people living in Michigan. Two counties in Beaumont's service area have greater access, with Wayne County having one provider per 310 people living in the county and Oakland County being close to the ratio for top U.S. performers with one provider per 260 people living in the county. Macomb County's ratio is well below the ratio for Michigan overall, with one provider per 470 people living in the county.

Mental Health Treatment

Data related to mental health treatment includes both those receiving counseling or therapy as well as those taking medication to treat their mental health concerns.

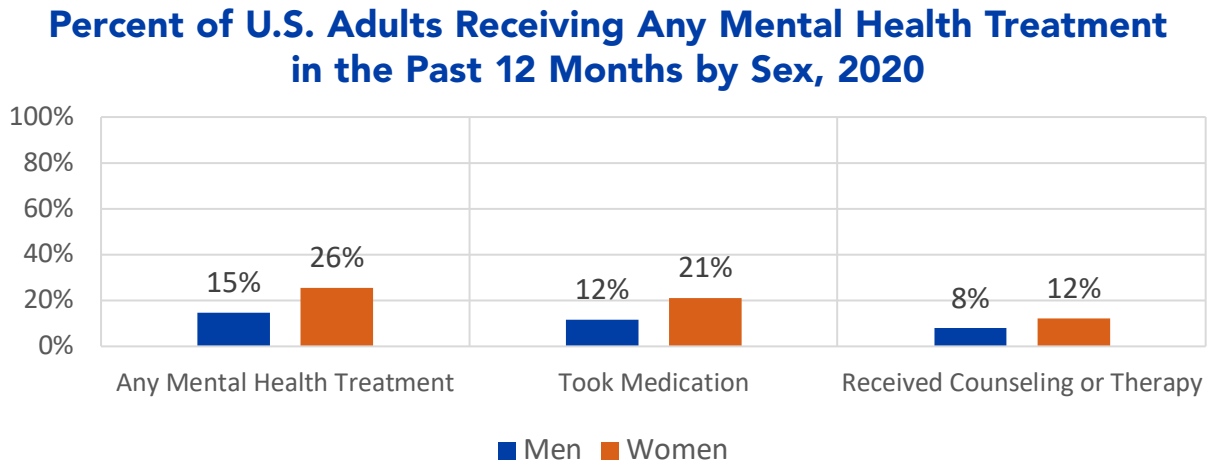


Figure 17. U.S. Adults Receiving Any Mental Health Treatment in the Past 12 Months by Sex

Source: NCHS Data Brief No. 419, October 2021

When looking at differences in individuals accessing mental health treatment by sex, we can see that women are more likely to receive any mental health treatment than men.

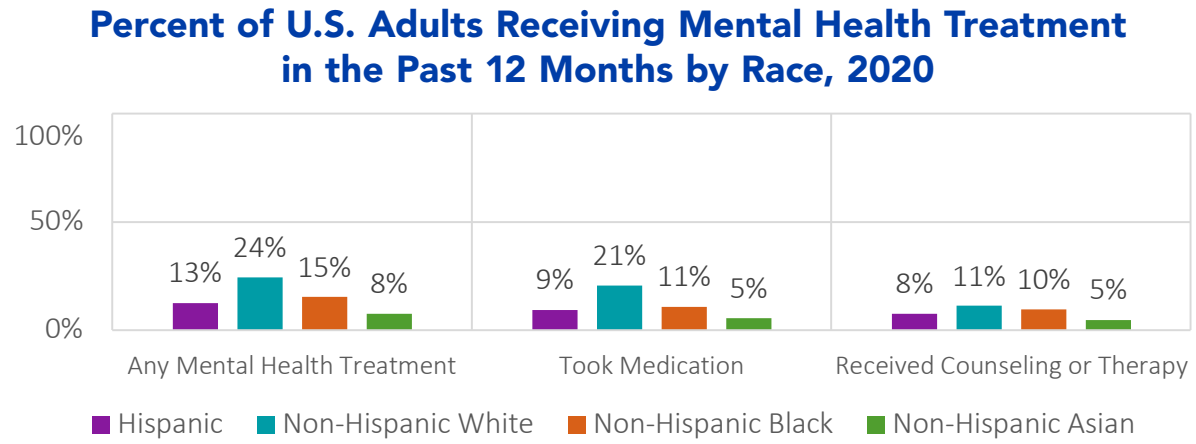


Figure 18. U.S. Adults Receiving Any Mental Health Treatment in the Past 12 Months by Race

Source: NCHS Data Brief No. 419, October 2021

There are also differences for individuals receiving mental health treatment between race and ethnicity groups. White, Non-Hispanic individuals are almost twice as likely as any other race or ethnicity group to be treating their mental health with medication. There are similarities across race and ethnicity groups in those receiving counseling or therapy, with approximately 11% of Non-Hispanic white individuals receiving counseling or treatment, followed by 10% of Non-Hispanic Black, and 8% of Hispanic adults. Non-Hispanic Asian adults were least likely to report receiving counseling or therapy for mental health treatment at 5%.

Secondary Indicators

Substance Misuse

Misuse of substances such as alcohol, prescription medication, or illicit drugs is harmful to an individual's health. Additionally, use of tobacco is also a strong risk factor for poorer health outcomes. According to the American Public Health Association (APHA), approximately "88,000 people die each year from alcohol related injuries, the third most common preventable cause of death in the United States."

Opioid Dispensing

Prescription opioids are often used to treat pain and can be an important component of treatment when used appropriately. However, according to the CDC, "serious risks are associated with their use…including misuse, opioid use disorder (addiction), overdoses, and death."

Knowing the rates of opioid prescriptions is an important indicator of access to opioids in the service area. While rates of opioid prescriptions have declined since 2012, there are still high rates of opioid prescriptions across the U.S.

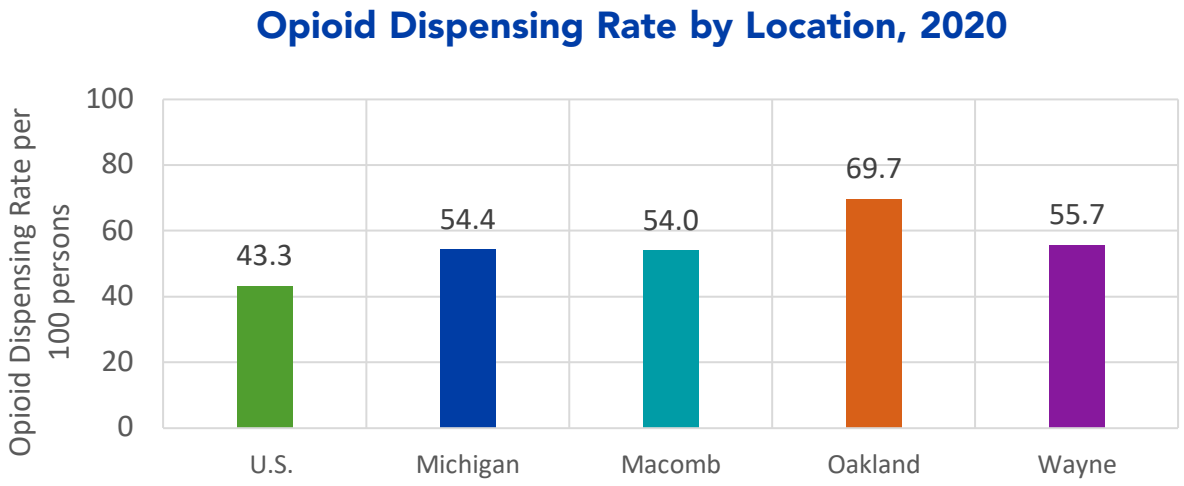


Figure 19. Opioid Dispensing Rate by Location

Source: CDC Injury Center

When looking at the number of opioid prescriptions per 100 persons in the U.S., Michigan, and the Beaumont service area, Oakland County has a relatively high opioid dispensing rate with 69.7 prescriptions for every 100 individuals in the county in 2020. Rates in Macomb and Wayne Counties are similar to the rate for Michigan as a whole, 54.0, 55.7, and 54.4 respectively. All rates shown are higher than the U.S. dispensing rate of 43.3 per 100 individuals.

Binge Drinking in the Past Month

Binge Drinking is defined as five or more drinks on one occasion for males and four or more drinks on one occasion for females. The CDC states that "binge drinking is a harmful risk behavior associated with serious injuries and multiple diseases," including increased risk of alcohol use disorder.

Binge Drinking in the Past Month by Sex, 2020

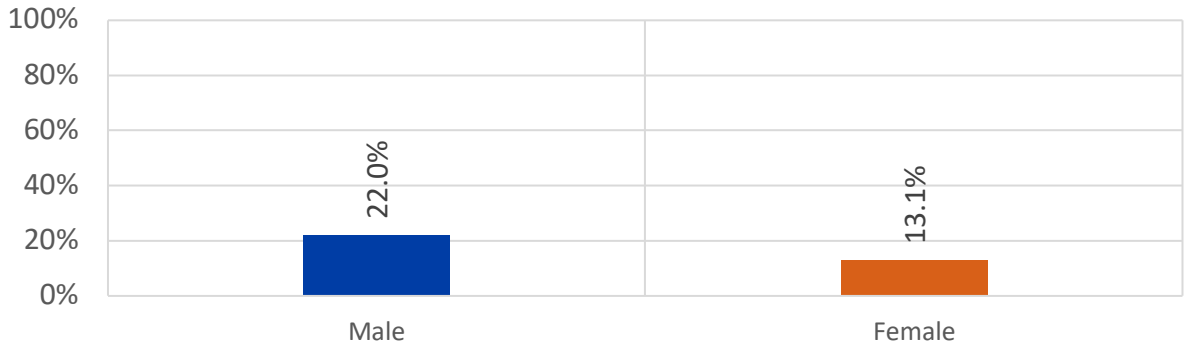


Figure 20. Binge Drinking in the Past Month by Sex

Source: BRFS Annual Report 2020

When looking at differences in demographic factors, 22.0% of males reported binge drinking in the past month as compared to 13.1% of females.

Binge Drinking in the Past Month by Race, 2020

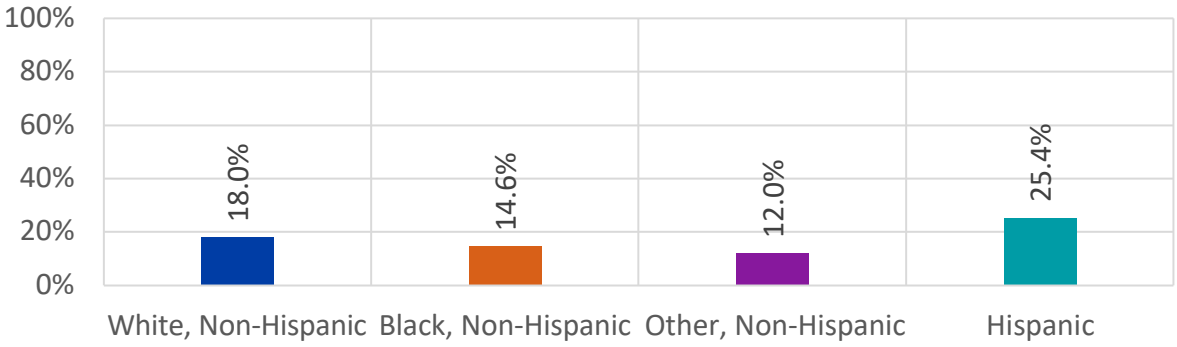


Figure 21. Binge Drinking in the Past Month by Race

Source: BRFS Annual Report 2020

Differences in binge drinking rates by race and ethnicity are also present, with Hispanic individuals much more likely to report binge drinking at nearly a quarter of respondents reporting binge drinking in the past month, followed by White Non-Hispanic individuals (18.0%), Black Non-Hispanic individuals (14.6%), and other Non-Hispanic individuals (12.0%).

Secondary Indicators

Needing But Not Receiving Treatment

Individuals Reporting Needing, but not Receiving, Treatment for Illicit Drug Use in the Past Year, US & MI, 2019 - 2020		
Location	Teens (12-17)	Adults (18+)
Michigan	5.7%	7.6%
US	4.8%	6.4%

Figure 22. Individuals Reporting Needing, but not Receiving, Treatment for Illicit Drug Use in the Past Year

Source: SAMHSA National Survey on Drug Use and Health, 2019 and 2020

For those individuals who need substance use disorder treatment, almost 6% of teens and 8% of adults report not being able to receive needed treatment. These rates were higher in Michigan than in the U.S. overall.

Adolescent Substance Misuse

According to the National Institute on Alcohol Abuse and Alcoholism, "alcohol is the most widely used substance among America's youth," and can lead to "aggressive behavior, property damage, injuries, violence, and deaths." Adolescent misuse of alcohol and other drugs can interfere with brain development and increases risk of developing substance use disorders later in life.

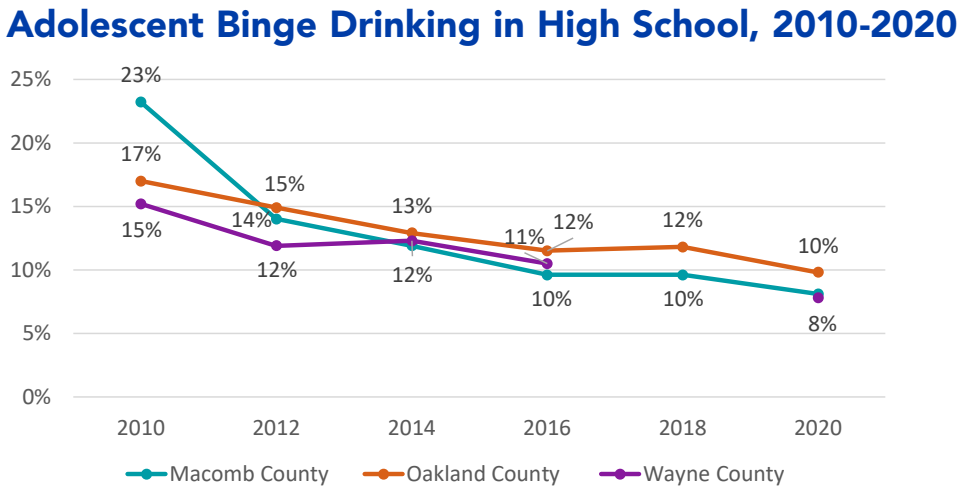


Figure 23. Adolescent Bing Drinking in High School

Source: Michigan Profile for Healthy Youth (MiPHY) Data is not available for Wayne County in 2018

Overall, rates of adolescents reporting binge drinking in high school have decreased over time. However, rates of reported binge drinking remains higher over time for high school students in Oakland County than those in Macomb and Wayne Counties.

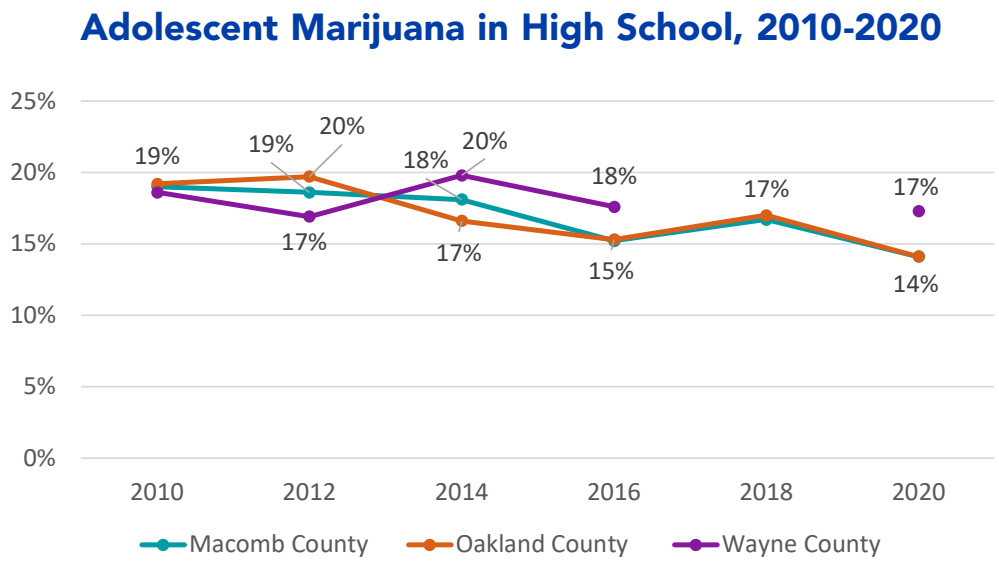


Figure 24. Adolescent Marijuana in High School

Source: Michigan Profile for Healthy Youth (MiPHY) Data is not available for Wayne County in 2018

When looking at rates of high school students in Beaumont's service area who report using marijuana, there are similar rates across counties and time, with Wayne County high school students reporting slightly higher rates than their counterparts Macomb and Oakland Counties.

Secondary Indicators

Health Education

Community Connectedness

Social Associations

According to the County Health Rankings, "minimal contact with others and limited involvement in community life are associated with increased morbidity and early mortality." Additionally, those found to have stronger social networks are more likely to make healthy lifestyle choices. A measure of this is Social Association rates, which is the number of events in a given time period (generally one or more years) divided by the average number of people at risk during that period.

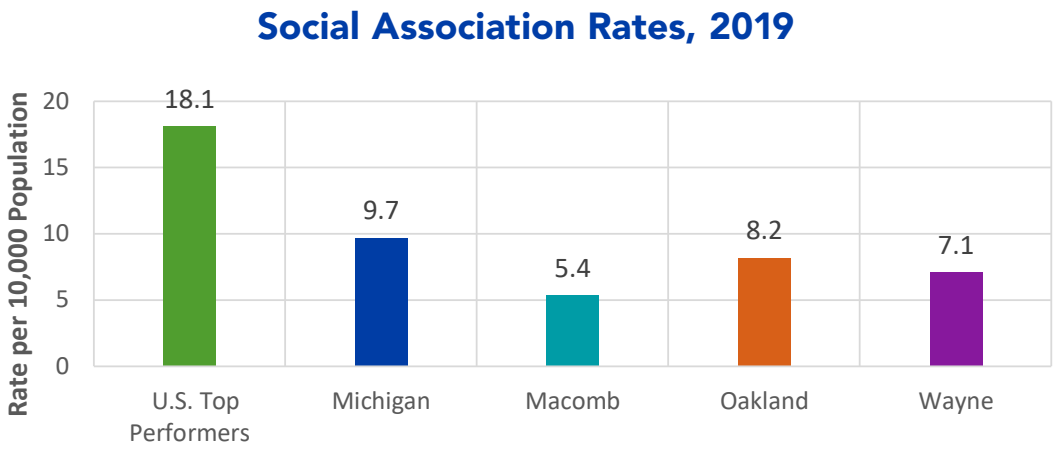


Figure 25. Social Association Rates

Source: County Health Rankings/County Business Patterns

In Michigan, Social Association rates are about 9.7 per 10,000 population. Rates in Beaumont's service area are lower than state average. Rates are lowest in Macomb County (5.4 per 10,000 population) and highest in Oakland County (8.2 per 10,000 population).

Education on Community Infrastructure that Supports Health

Access to Food

When measuring access to healthy foods, the County Health Rankings measure the percentage of population who are low-income and do not live close to a grocery store to assess access to supermarkets which traditionally provide healthier options than those at convenience stores, or smaller grocery stores. Lack of access to healthy foods, such as fresh fruits and vegetables is linked to obesity and premature mortality.

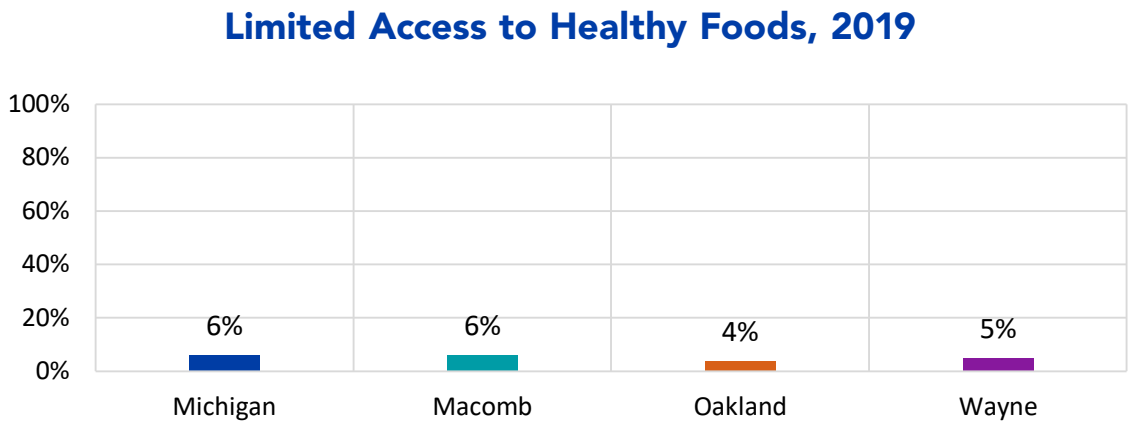


Figure 26. Limited Access to Healthy Foods

Source: County Health Rankings/Limited Access to Healthy Foods

In Beaumont's service area, Macomb has the highest percentage of individuals with lack of access to healthy foods (6%) and Oakland has the lowest (4%).

An additional measure of access to healthy foods is the Food Environment Index, which ranges from 0 (worst) to 10 (best) and equally weighs two indicators of the food environment:

1) Limited access to healthy foods estimates the percentage of the population that is low income and does not live close to a grocery store. Low income is defined as having an annual family income of less than or equal to 200 percent of the federal poverty threshold for the family size. Living close to a grocery store is defined differently in rural and nonrural areas; in rural areas, it means living less than 10 miles from a grocery store whereas in nonrural areas, it means less than 1 mile.

2) Food insecurity estimates the percentage of the population that did not have access to a reliable source of food during the past year. A two-stage fixed effects model was created using information from the Community Population Survey, Bureau of Labor Statistics, and American Community Survey to estimate food insecurity.

Secondary Indicators

Location	Food Environment Index, 2019 (0: worst, 10: best)
U.S. Top Performers	8.8
Michigan	7.1
Macomb	8.0
Oakland	8.5
Wayne	7.4

Figure 27. *Food Environment Index*

Source: County Health Rankings/ Food Environment Index

Beaumont's service area has a higher food environment index than the State of Michigan (7.1), however it is lower than the US top performers (8.8). Wayne has the lowest food environment index (7.4) of the three counties, meaning they have less access to healthy foods and greater rates of food insecurity than the other two counties.

Physical Activity

Participants in the survey and focus groups highlighted a need for access to safe places to be physically active. Physical activity is an important part of a healthy life, with those engaging in more physical activity having a lower risk of obesity, chronic illness, and premature mortality. Safe recreational activities, access to infrastructure, and poverty can also influence one's ability to be physically active. An indicator of this access from the County Health Rankings, is a measure of the percent of the population in a county who live reasonably close to a park or recreational facility for physical activity – including residing in a census block that is within a half mile of a park, an urban census block that is within one mile of a recreational facility, or a rural census block that is within three miles of a recreational facility.

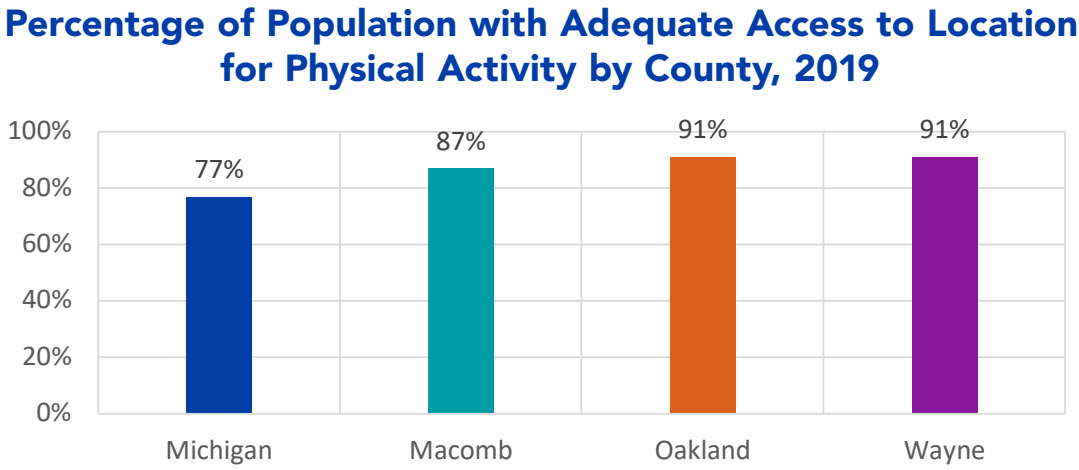


Figure 28. *Adequate Access to Locations for Physical Activity*

Source: County Health Rankings - BRFS & US Census

All three counties have a higher percentage of population with adequate access to locations for physical activity than the rate for Michigan overall. Of the three counties, Macomb showed least access, with 87% of the population having adequate access to locations for physical activity.

Another indicator of physical activity in Beaumont's service area is the percentage of adults reporting no leisure time physical activity.

Percentage of Adults (18+) Reporting No Leisure-Time Physical Activity by County, 2019

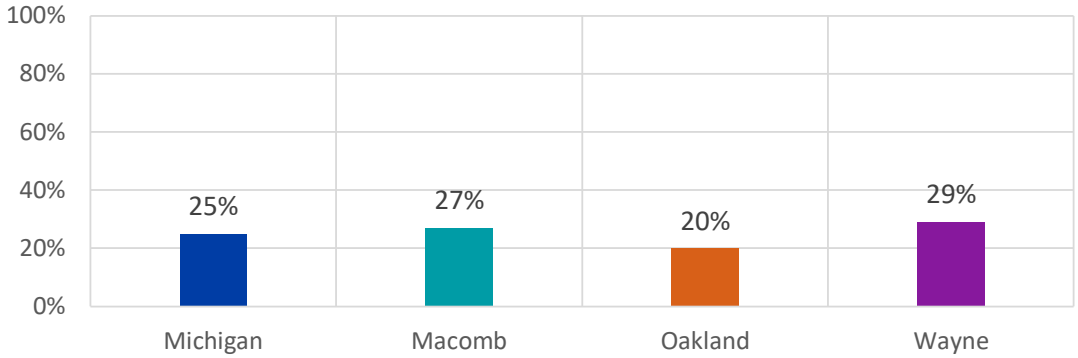


Figure 29. Reporting No Leisure-Time Physical Activity

Source: County Health Rankings - BRFS & US Census

Macomb (27%) and Wayne (29%) Counties have a higher percentage of adults reporting of no leisure-time physical activity in the past month than the State of Michigan (25%). Oakland County (20%) is has a lower rate than the state and the other counties in Beaumont's service area.

Air Pollution

Air pollution can be measured by the density of fine particulate matter in the ozone. Exposure to a higher amount of particulate matter can be damaging to one's health. According to the County Health Rankings negative consequences of living in a place that has a higher average, daily density of fine particulate matter include decreased lung function, chronic bronchitis, asthma, and other adverse pulmonary effects.

Area	Average daily density of fine particulate matter in micrograms per cubic meter (PM2.5), 2018
Range in Michigan	5.4 - 11.7
Michigan	7.4
Macomb	7.8
Oakland	8.2
Wayne	11.7

Figure 30. Daily Density of Fine Particulate Matter

Source: County Health Rankings - Environmental Public Health Tracking Network

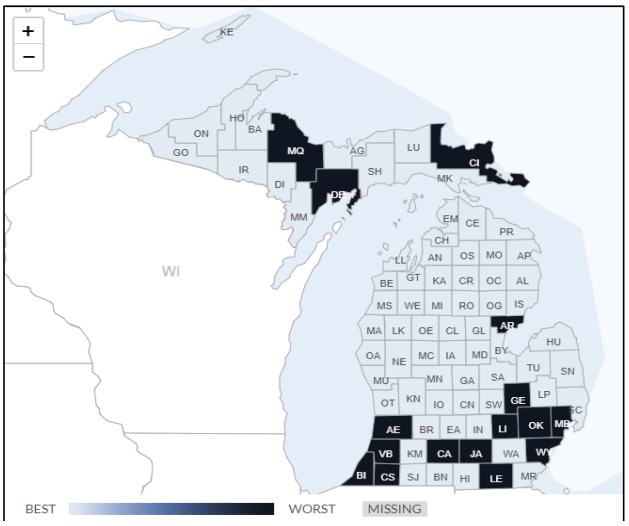
When looking at the average daily density rates across Michigan, Wayne County has the highest rate at 11.7, much higher than the other counties in the service area. Macomb (7.8) and Oakland (8.2) have a higher average than the state of Michigan (7.4), with Oakland County rates being the next highest after Wayne County.

Secondary Indicators

Drinking Water

Access to healthy drinking water can help prevent illness, birth defects, and death. According to County Health Rankings, drinking water violations are associated with health care expenditures.

All three counties in Beaumont's service area had at least one health-related drinking water violation recorded in 2020.



Drinking Water Violations in Michigan, 2020

Figure 31.
Drinking Water Violations

Source: County Health Rankings - EPA

Access to Care

Having access to needed care is "essential for preventive and primary care, and when needed, referrals to appropriate specialty care."[1] The ratio of population to primary care physicians is a way to measure this access, showing the number of individuals served by one physician in a county if the population was equally distributed across physicians.

Location	Ratio of Population to Primary Care Physicians (2019)
Range in Michigan	12,590:1 – 570:1
Michigan	1,250:1
Macomb	1,840:1
Oakland	690:1
Wayne	1,340:1

Figure 32. Ratio of Population to Primary Care Physicians

Source: County Health Rankings - Area Health Resource File/ American Medical Association

Figure 32 shows the ratio of population to primary care physicians in Beaumont's service area and for Michigan as a whole. The ratio for Macomb (1,840:1) and Wayne (1,340:1) Counties are higher than the average ratio for the State of Michigan (1,250:1), making access to a primary care physician more difficult. Oakland County (690:1), however, has the second lowest ratio in the state with nearly two- to three-times fewer individuals per primary care physician than the other counties in Beaumont's service area.

[1] https://www.countyhealthrankings.org/app/michigan/2022/measure/factors/4/description

System Navigation (Cost/Insurance for Care)

Barriers to care due to affordability and access to care due to lack of insurance and affordable cost of care emerged as a theme from the survey and focus groups. Not having insurance can present a barrier to accessing health care services, and those who are uninsured are shown to be more likely to experience poorer health.

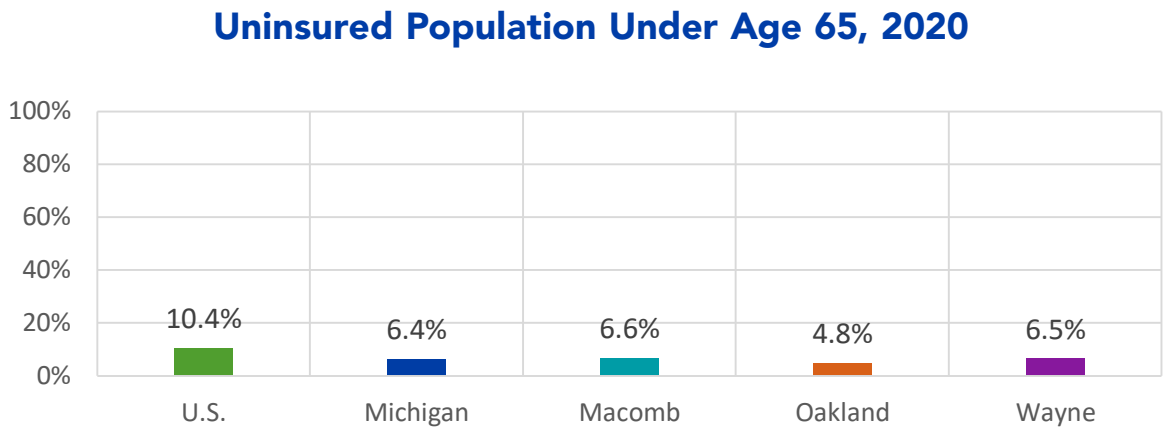


Figure 33. Uninsured Population Under Age 65

Source: U.S. Census

The State of Michigan and the three counties Beaumont covers has a lower uninsured population percentage than the U.S. (10.4%). While Macomb (6.6%) and Wayne (6.5%) County had slightly higher rates of uninsured individuals than the Michigan average (6.4%), both counties were in the top ten counties in the state for health insurance coverage. Oakland (4.8%) had the second lowest percentage of uninsured individuals in Michigan.

2022 COMMUNITY HEALTH NEEDS ASSESSMENT

Building Healthier Lives and Communities

Beaumont, Dearborn

Priority #1 *Behavioral Health*

Goal #1: Address behavioral health needs, including mental well-being and substance use disorders.

OBJECTIVES/STRATEGIES

- Create support groups based on need available to the community
- Create education sessions on behavioral health strategies for the community
- Establish a Naloxone distribution program within the emergency center
- In collaboration with community partners, participate/host medication take back days annually from 2023-2025
- Provide Mental Health First Aid education to 250 community leaders/members annually
- Teen Health Center/SWP/E3 LMSW's/LPC will provide mental health counseling services to a minimum of 50 unduplicated users/students and 500 mental health visits per year per site
- Offer quarterly virtual smoking cessation classes at no-cost to community members

ANTICIPATED OUTCOMES

- Increased knowledge and awareness of mental health
- Decreased substance use
- Increased referrals for behavioral health
- Improved access to mental health services

PARTNERS

ACCESS
Families Against Narcotics
Health plan providers
Hegira Health
Local cities and municipalities
Local health departments
Local school districts
Religious organizations
Taylor Substance Abuse Task Force

RESOURCES

Beaumont, Dearborn will commit both financial and in-kind resources, including staff time, charitable contributions and employee volunteerism.

Priority #2 *Health Education*

Goal #1: Increase knowledge on health and social resources to improve community wellness.

OBJECTIVES/STRATEGIES

- Conduct an assessment/review and update the current state of cultural competency education within the Dearborn Hospital
- Improve relationships with community organizations
- Increase enrollment in chronic disease prevention and management programs by 15% by 2025
- Employ a community health worker model to support community connectedness and health education by 2024
- Establish a child passenger safety technician training model by June 2023

ANTICIPATED OUTCOMES

- Increased community education
- Increased knowledge and awareness of community resources
- Improve health outcomes and increase prevention screenings
- Decrease new incidence of diabetes
- Increased evidence-based programs offered to community members
- Increased understanding of health conditions
- Reduced health disparities in communities

PARTNERS

Car dealerships
Local cities and municipalities
Local health departments
Local school districts
Michigan Community Health Worker Alliance
Nonprofit partners
Police and fire departments
Safe Kids of Michigan

RESOURCES

Beaumont, Dearborn will commit both financial and in-kind resources, including staff time, charitable contributions and employee volunteerism.

Goal #2: Increase the number of youth who receive health education in the schools and community.

OBJECTIVES/STRATEGIES

- 3,500 high risk youth will receive evidenced-based health education inside schools and communities
- Implement the Making Proud Choices curriculum to at least 100 youth annually

ANTICIPATED OUTCOMES

- Increased youth receiving treatment
- Increased health knowledge

PARTNERS

Local school districts

RESOURCES

Beaumont, Dearborn will commit both financial and in-kind resources, including staff time, charitable contributions and employee volunteerism.

Priority #3 *Access to Care*

Goal #1: Enhance access to and coordination of care through community-based efforts.

OBJECTIVES/STRATEGIES

- Conduct an assessment/review and update the current state of cultural competency education within the Dearborn hospital
- Create awareness of existing resources and how to use them to improve navigating the healthcare system
- Increase patient satisfaction scores
- Increase the percent of students with access to school food pantries
- Increase use of Beaumont Community Resource Network (BCRN) in the community by 25%
- Increase community based organization claim rate on BCRN by 50%
- Increase the number of staff who use BCRN

ANTICIPATED OUTCOMES

- Reduced barriers to accessing care
- Increased use of healthcare services
- Increased referrals and navigation to disease prevention and management resources
- Reduce preventable utilization of emergency department
- Increased access to screenings

PARTNERS

Find Help	Hospital departments
Gleaners	Local community partners
Hospital community health team	Local schools

RESOURCES

Beaumont, Dearborn will commit both financial and in-kind resources, including staff time, charitable contributions and employee volunteerism.

Goal #2: Increase the number of high-risk youth who receive medical, mental health, and prevention services inside Teen Health Centers/School-Based Health Centers.

OBJECTIVES/STRATEGIES	ANTICIPATED OUTCOMES
• A total of 500 unduplicated youth will receive services • A total of 1,500 visits will be conducted	• Increased youth receiving services • Increased access to services

PARTNERS

Local school districts

RESOURCES

Beaumont, Dearborn will commit both financial and in-kind resources, including staff time, charitable contributions and employee volunteerism.

2022 COMMUNITY HEALTH NEEDS ASSESSMENT

Building Healthier Lives and Communities

Beaumont, Farmington Hills

Priority #1 *Behavioral Health*

Goal #1: Address behavioral health needs, including mental well-being and substance use disorders.

OBJECTIVES/STRATEGIES

- Integrate behavioral health in primary/specialty care
- Remove barriers connecting to substance misuse treatment
- In collaboration with community partners, participate/host medication take back days annually from 2023-2025
- Provide Mental Health First Aid education to 250 community leaders/members annually
- Teen Health Center/SWP/E3 LMSW's/LPC will provide mental health counseling services to a minimum of 50 unduplicated users/students and 500 visits per year per site
- Offer quarterly virtual smoking cessation classes at no-cost to community members

ANTICIPATED OUTCOMES

- Increased knowledge and awareness of mental health
- Decreased substance use
- Increased referrals for behavioral health
- Improved access to mental health services

PARTNERS

Addiction Medicine Consultant	Hegira Health
Affirmations	Local cities and municipalities
Common Ground	Local health departments
Families Against Narcotics	Local school districts
Farmington SAFE	Oakland County Community Health Network

RESOURCES

Beaumont, Farmington Hills will commit both financial and in-kind resources, including staff time, charitable contributions and employee volunteerism.

Additional resources include: Robust case management and social work teams, Beaumont Integrative Medicine, crisis hotlines, Beaumont behavioral health, opiate screening on admission, in-house substance abuse coordinators, SAMHSA National Hotline, private practice facilities, trained Mental Health First Aid instructors on site, relationship with other instructors in SE Michigan.

Priority #2 *Health Education*

Goal #1: Increase knowledge on health and social resources to improve community wellness.

OBJECTIVES/STRATEGIES

- Provide education on overt discrimination and implicit bias to reduce hesitancy to access needed care among groups that experience discrimination in the Farmington Hospital communities
- Improve relationships with community organizations
- Provide education on one's community and how it impacts health
- Increase enrollment in chronic disease prevention and management programs by 15% by 2025
- Employ a community health worker model to support community connectedness and health education by 2024
- Establish a child passenger safety technician training model by June 2023

ANTICIPATED OUTCOMES

- Increased community education
- Increased knowledge and awareness of community resources
- Improve health outcomes and increase prevention screenings
- Decrease new incidence of diabetes
- Increased evidence-based programs offered to community members
- Increased understanding of health conditions
- Reduced health disparities in communities

PARTNERS

Car dealerships
CARES
Farmington Library
Local cities and municipalities
Local health departments
Michigan Community Health Worker Alliance
Nonprofit partners
Public Safety
Safe Kids of Michigan

RESOURCES

Beaumont, Farmington Hills will commit both financial and in-kind resources, including staff time, charitable contributions and employee volunteerism. **Additional resources include:** Trauma Injury Prevention Coordinators, Government Affairs team, Internal Community Health Committees.

Goal #2: Increase the number of youth who receive health education in the schools and community.

OBJECTIVES/STRATEGIES

- 900 high risk youth will receive evidenced-based health education inside schools and communities

ANTICIPATED OUTCOMES

- Increased youth receiving treatment
- Increased health knowledge

PARTNERS

Local school districts

RESOURCES

Beaumont, Farmington Hills will commit both financial and in-kind resources, including staff time, charitable contributions and employee volunteerism.

Priority #3 *Access to Care*

Goal #1: Enhance access to and coordination of care through community-based efforts.

OBJECTIVES/STRATEGIES

- Review areas where discrimination and implicit bias may cause hesitancy to access needed care among groups that experience discrimination in the communities we serve
- Review structural barriers to improve navigation (paperwork, insurance, etc.)
- Remove barriers connecting to substance misuse treatment
- Increase patient satisfaction scores
- Increase the percent of students with access to school food pantries
- Increase use of Beaumont Community Resource Network (BCRN) in the community by 25%
- Increase community based organization claim rate on BCRN by 50%
- Increase the number of staff who use BCRN

ANTICIPATED OUTCOMES

- Reduced barriers to accessing care
- Increased use of healthcare services
- Increased referrals and navigation to disease prevention and management resources
- Reduce preventable utilization of emergency department
- Increased access to screenings
- Reduced food insecurity

PARTNERS

Find Help	Hospital departments
Gleaners	Local community partners
Hospital community health team	Local schools

RESOURCES

Beaumont, Farmington Hills will commit both financial and in-kind resources, including staff time, charitable contributions and employee volunteerism.

Goal #2: Increase the number of high-risk youth who received medical, mental health, and prevention services inside Teen Health Centers/School-Based Health Centers.

OBJECTIVES/STRATEGIES	ANTICIPATED OUTCOMES
• A total of 500 unduplicated youth will receive services • A total of 1,500 visits will be conducted	• Increased youth receiving services • Increased access to services

PARTNERS

Local school districts

RESOURCES

Beaumont, Farmington Hills will commit both financial and in-kind resources, including staff time, charitable contributions and employee volunteerism.

2022 COMMUNITY HEALTH NEEDS ASSESSMENT

Building Healthier Lives and Communities

GROSSE POINTE

Beaumont, Grosse Pointe

Priority #1 *Behavioral Health*

Goal #1: Address behavioral health needs, including mental well-being and substance use disorders.

OBJECTIVES/STRATEGIES

- Remove barriers to connecting to mental health care and substance misuse treatment
- Reduce stigma surrounding mental health
- In collaboration with community partners, participate/host medication take back days annually from 2023-2025
- Provide Mental Health First Aid education to 250 community leaders/members annually
- Teen Health Center/SWP/E3 LMSW's/LPC will provide mental health counseling services to a minimum of 20 unduplicated users/students and 60 visits per year
- Create a behavioral health screening questionnaire
- Create and share literature about mental health resources to normalize and reduce stigma
- Offer quarterly virtual smoking cessation classes at no-cost to community members

ANTICIPATED OUTCOMES

- Increased knowledge and awareness of mental health
- Decreased substance use
- Increased referrals for behavioral health
- Improved access to mental health services

PARTNERS

CARE of Southeastern Michigan
Community mental health agencies
Detroit/Wayne Mental Health Authority
Families Against Narcotics
Family Center of GP/Harper Woods
Healthy Grosse Pointe and Harper Woods Coalition
Hegira Health
Local cities and municipalities
Local health departments
Local school districts
Moodlifters
SAMHSA

RESOURCES

Beaumont, Grosse Pointe will commit both financial and in-kind resources, including staff time, charitable contributions, and employee volunteerism.

Additional resources include: Mental health hospital/residency program, Tele-medicine/ psych consults more quickly, Kevin's Song, trained Mental Health First Aid instructors on site, relationship with other instructors in SE Michigan.

Priority #2 *Health Education*

Goal #1: Increase knowledge on health and social resources to improve community wellness.

OBJECTIVES/STRATEGIES

- Provide education and training to providers/staff on overt discrimination and implicit bias to reduce hesitancy to access needed care among groups that experience discrimination in the Grosse Pointe communities
- Increase awareness of resources in the community
- Improve relationships with community organizations
- Provide education on one's community and how it impacts health, specifically a safe and quality environment for physical activity and access to healthy food
- Increase enrollment in chronic disease prevention and management programs by 15% by 2025
- Employ a community health worker model to support community connectedness and health education by 2024
- Establish a child passenger safety technician training model by June 2023
- Create learning modules, training guides, and positive programming for staff and new hires at Beaumont Health on cultural competency
- Implement SAMHSA 8 Dimensions of Wellness Model

ANTICIPATED OUTCOMES

- Increased community education
- Increased knowledge and awareness of community resources
- Improve health outcomes and increase prevention screenings
- Decrease new incidence of diabetes
- Increased evidence-based programs offered to community members
- Increased understanding of health conditions
- Reduced health disparities in communities

PARTNERS

American Cancer Society
American Heart Association
Car dealerships
Chamber of commerce
Connecting the Pointes
Faith based organizations
Farmers markets
Grosse Pointe War Memorial
Healthy Grosse Pointe and Harper Woods Coalition
Local libraries
Local cities and municipalities
Local health departments
Michigan Community Health Worker Alliance
NAACP
Nonprofit partners
Parks and recreation departments
Police and fire departments
Safe Kids of Michigan
The Family Center
The Ford House
The Helm
The Neighborhood Club
Wayne State University

RESOURCES

Beaumont, Grosse Pointe will commit both financial and in-kind resources, including staff time, charitable contributions and employee volunteerism. **Additional resources include:** Beaumont online learning system, internal DEI teams.

Priority #2 *Health Education (cont.)*

Goal #2: Increase the number of youth who receive health education in the schools and community.	
OBJECTIVES/STRATEGIES	
• 100 high risk youth will receive evidenced-based health education inside schools and communities	
ANTICIPATED OUTCOMES	PARTNERS
• Increased youth receiving treatment • Increased health knowledge	Local school districts
RESOURCES	
Beaumont, Grosse Pointe will commit both financial and in-kind resources, including staff time, charitable contributions and employee volunteerism.	

Priority #3 *Access to Care*

Goal #1: Enhance access to and coordination of care through community-based efforts.	
OBJECTIVES/STRATEGIES	
• Review areas where discrimination and implicit bias may cause hesitancy to access needed care among groups that experience discrimination in the communities Grosse Pointe hospital serves • Improve support to navigate the healthcare system through Community Health Workers • Increase patient satisfaction scores • Increase the percent of students with access to school food pantries • Increase use of Beaumont Community Resource Network (BCRN) in the community by 25% • Increase community based organization claim rate on BCRN by 50% • Increase the number of staff who use BCRN	
ANTICIPATED OUTCOMES	PARTNERS
• Reduced barriers to accessing care • Increased use of healthcare services • Increased referrals and navigation to disease prevention and management resources • Reduce preventable utilization of emergency department • Increased access to screenings • Reduced food insecurity	Find Help Hospital departments Hospital volunteer department Local schools NAACP
RESOURCES	
Beaumont, Grosse Pointe will commit both financial and in-kind resources, including staff time, charitable contributions and employee volunteerism.	

Goal #2: Increase the number of high-risk youth who received medical, mental health, and prevention services inside Teen Health Centers/School-Based Health Centers.		
OBJECTIVES/STRATEGIES	ANTICIPATED OUTCOMES	PARTNERS
• A total of 100 unduplicated youth will receive services • A total of 250 visits will be conducted	• Increased youth receiving services • Increased access to services	Local school districts
RESOURCES		
Beaumont, Grosse Pointe will commit both financial and in-kind resources, including staff time, charitable contributions and employee volunteerism.		

2022 COMMUNITY HEALTH NEEDS ASSESSMENT

Building Healthier Lives and Communities

Beaumont, Royal Oak

Priority #1 *Behavioral Health*

Goal #1: Address behavioral health needs, including mental well-being and substance use disorders.

OBJECTIVES/STRATEGIES

- Remove barriers to connecting to mental health care
- Create a behavioral health screening questionnaire
- Create and share literature about mental health resources to normalize and reduce stigma
- Increase outpatient access to behavioral health services
- Decrease rates of substance misuse, especially among youth
- Remove barriers connecting to substance misuse treatment
- In collaboration with community partners, participate/host medication take back days annually from 2023-2025
- Provide Mental Health First Aid education to 250 community leaders/members annually
- Offer quarterly virtual smoking cessation classes at no-cost to community members

ANTICIPATED OUTCOMES

- Increased knowledge and awareness of mental health
- Decreased substance use
- Increased referrals for behavioral health
- Improved access to mental health services

PARTNERS

Families Against Narcotics
Hegira Health
Local cities and municipalities
Local health departments
Local school districts
Oakland Community Health Network
Substance Use Prevention Partnership
Troy Coalition: Substance Use Community Coalition

RESOURCES

Beaumont, Royal Oak will commit both financial and in-kind resources, including staff time, charitable contributions and employee volunteerism.

Additional resources include: hospital social workers, hospital psychiatrists, trained Mental Health First Aid instructors on site, relationship with other instructors in SE Michigan, Corewell Health (previously Beaumont Health) Smoking Cessation Program.

Priority #2 *Health Education*

Goal #1: Increase knowledge on health and social resources to improve community wellness.

OBJECTIVES/STRATEGIES

- Review and update cultural competency materials that reflect the Royal Oak hospital communities- both materials provided to patients/individuals and education materials for providers
- Increase enrollment in chronic disease prevention and management programs by 15% by 2025
- Employ a community health worker model to support community connectedness and health education by 2024
- Establish a child passenger safety technician training model by June 2023
- Create learning modules, training guides, and positive programming for staff and new hires at Beaumont Health on cultural competency
- Increase awareness of resources in the community
- Provide education on one's community and how it impacts health

ANTICIPATED OUTCOMES

- Increased community education
- Increased knowledge and awareness of community resources
- Improve health outcomes and increase prevention screenings
- Decrease new incidence of diabetes
- Increased evidence-based programs offered to community members
- Increased understanding of health conditions
- Reduced health disparities in communities

PARTNERS

American Cancer Society
American Heart Association
AmeriCorps
Car dealerships
CARE of Southeastern Michigan
Chambers of commerce
Local cities and municipalities
Local health departments
Michigan Fitness Foundation
Michigan Community Health Worker Alliance
Nonprofit partners
Oakland University William Beaumont School of Medicine
Police and fire departments
Safe Kids of Michigan
Troy Community Coalition

RESOURCES

Beaumont, Royal Oak will commit both financial and in-kind resources, including staff time, charitable contributions and employee volunteerism.

Additional resources include: DEI Hospital Committee, Oakland County Health Division Speaker's Team, Beaumont Community Resource Network.

Priority #3 *Access to Care*

Goal #1: Enhance access to and coordination of care through community-based efforts.

OBJECTIVES/STRATEGIES

- Increase patient satisfaction scores
- Increase the percent of students with access to school food pantries
- Review areas where discrimination and implicit bias may cause hesitancy to access needed care among groups that experience discrimination in the communities Royal Oak hospital serves
- Improve support to navigate the healthcare system
- Increase use of Beaumont Community Resource Network (BCRN) in the community by 25%
- Increase community based organization claim rate on BCRN by 50%
- Increase the number of staff who use BCRN

ANTICIPATED OUTCOMES

- Reduced barriers to accessing care
- Increased use of healthcare services
- Increased referrals and navigation to disease prevention and management resources
- Reduce preventable utilization of emergency department
- Increased access to screenings
- Reduced food insecurity

PARTNERS

Find Help
Gleaners
Hospital community health team
Hospital departments
Human resources department
Local community partners
Local schools

RESOURCES

Beaumont, Royal Oak will commit both financial and in-kind resources, including staff time, charitable contributions and employee volunteerism.

2022 COMMUNITY HEALTH NEEDS ASSESSMENT

Building Healthier Lives and Communities

Beaumont, Taylor

Priority #1 *Behavioral Health*

Goal #1: Address behavioral health needs, including mental well-being and substance use disorders.

OBJECTIVES/STRATEGIES

- Increase outpatient access to behavioral health services
- Integrate behavioral health in primary/specialty care
- Reduce stigma surrounding mental health
- Remove barriers connecting to mental health care
- Reduce stigma surrounding substance misuse and treatment
- Remove barriers connecting to substance misuse treatment
- In collaboration with community partners, participate/host medication take back days annually from 2023-2025
- Provide Mental Health First Aid education to 250 community leaders/members annually
- Teen Health Center/SWP/E3 LMSW's/LPC will provide mental health counseling services to a minimum of 200 unduplicated users/students and 2,000 visits per year
- Offer quarterly virtual smoking cessation classes at no-cost to community members
- Follow up with 90% of survivors with the Quick Response Team
- Increase use of educational materials to promote Beaumont Health resources on behavioral health
- Increase participation in community events to discuss stigma and mental health
- Implement Michigan Opioid Use Disorder (MOUD) strategies
- Implement bicycle program to help connect patients to a clinic within 24 hours

ANTICIPATED OUTCOMES

- Increased knowledge and awareness of mental health
- Decreased substance use
- Increased referrals for behavioral health
- Improved access to mental health services
- Increased community education resources

PARTNERS

23rd and 25th District Drug Courts
Beaumont Behavioral Health Center
Detroit Wayne Integrated Health Network
Downriver for Veterans
Families Against Narcotics
Hegira Health
Local cities and municipalities
Local health departments
Local school districts
Starfish Family Services
Taylor Substance Abuse Task Force
Taylor Teen Health Center
The Guidance Center
The Information Center
Wayne Metro

RESOURCES

Beaumont, Taylor will commit both financial and in-kind resources, including staff time, charitable contributions and employee volunteerism.

Additional resources include: Beaumont Quick Response Teams (QRT), Taylor Teen Health Center, trained Mental Health First Aid instructors on site, relationship with other instructors in SE Michigan

Priority #2 *Health Education*

Goal #1: Increase knowledge on health and social resources to improve community wellness.

OBJECTIVES/STRATEGIES

- Provide education on overt discrimination and implicit bias to reduce hesitancy to access needed care among groups that experience discrimination in the Taylor hospital communities
- Increase awareness of resources in the community
- Improve relationships with community organizations
- Provide education on one's community and how it impacts health
- Increase enrollment in chronic disease prevention and management programs by 15% by 2025
- Employ a community health worker model to support community connectedness and health education by 2024
- Establish a child passenger safety technician training model by June 2023
- Host an annual safety day to share resources and educate the community
- Increase participation in community events to share resources and promote wellness
- Increase percent of staff that complete implicit bias training

ANTICIPATED OUTCOMES

- Increased community education
- Increased knowledge and awareness of community resources
- Improve health outcomes and increase prevention screenings
- Decrease new incidence of diabetes
- Increased evidence-based programs offered to community members
- Increased understanding of health conditions
- Reduced health disparities in communities

PARTNERS

Car dealerships
Local cities and municipalities
Local health departments
Michigan Community Health Worker Alliance
Nonprofit partners
Police and fire departments
Safe Kids of Michigan

RESOURCES

Beaumont, Taylor will commit both financial and in-kind resources, including staff time, charitable contributions and employee volunteerism.

Goal #2: Increase the number of youth who receive health education in the schools and community.

OBJECTIVES/STRATEGIES

- 12,000 high risk youth will receive evidenced-based health education inside schools and communities
- Implement the Making Proud Choices curriculum to at least 15 youth annually

ANTICIPATED OUTCOMES

- Increased youth receiving treatment
- Increased health knowledge

PARTNERS

Local school districts

Beaumont, Taylor will commit both financial and in-kind resources, including staff time, charitable contributions and employee volunteerism.

Priority #3 *Access to Care*

Goal #1: Enhance access to and coordination of care through community-based efforts.

OBJECTIVES/STRATEGIES

- Review areas where discrimination and implicit bias may cause hesitancy to access needed care among groups that experience discrimination in the communities served
- Create awareness of existing resources and how to use them
- Increase patient satisfaction
- Increase the percent of students with access to school food pantries
- Increase use of Beaumont Community Resource Network (BCRN) in the community by 25%
- Increase community based organization claim rate on BCRN by 50%
- Increase the number of staff who use BCRN
- Reduce household food insecurity and hunger
- Eliminate very low food security in children
- Increase fruit consumption by people aged 2 years and over
- Increase vegetable consumption by people aged 2 years and older

ANTICIPATED OUTCOMES

- Reduced barriers to accessing care
- Increased use of healthcare services
- Increased referrals and navigation to disease prevention and management resources
- Reduce preventable utilization of emergency department
- Increased access to screenings
- Reduced food insecurity

PARTNERS

Farmers markets
Find Help
Gleaners
Hospital community health team
Hospital departments
Local community partners
Local schools

RESOURCES

Beaumont, Taylor will commit both financial and in-kind resources, including staff time, charitable contributions and employee volunteerism.

Goal #2: Increase the number of high-risk youth who received medical, mental health, and prevention services inside Teen Health Centers/School-Based Health Centers .

OBJECTIVES/STRATEGIES

- A total of 1,150 unduplicated youth will receive services
- A total of 3,800 visits will be conducted

ANTICIPATED OUTCOMES

- Increased youth receiving services
- Increased access to services

PARTNERS

Local school districts

RESOURCES

Beaumont, Taylor will commit both financial and in-kind resources, including staff time, charitable contributions and employee volunteerism.

2022 COMMUNITY HEALTH NEEDS ASSESSMENT

Building Healthier Lives and Communities

Beaumont, Trenton

Priority #1 *Behavioral Health*

Goal #1: Address behavioral health needs, including mental well-being and substance use disorders.

OBJECTIVES/STRATEGIES

- Increase outpatient access to behavioral health services
- Integrate behavioral health in primary/specialty care
- Reduce stigma surrounding mental health
- Remove barriers connecting to mental health care
- Reduce stigma surrounding substance misuse and treatment
- Remove barriers connecting to substance misuse treatment
- In collaboration with community partners, participate/host medication take back days annually from 2023-2025
- Provide Mental Health First Aid education to 250 community leaders/members annually
- Offer quarterly virtual smoking cessation classes at no-cost to community members
- Review options to pilot/implement Telepsych in the Emergency Department
- Increase use of educational materials to promote Beaumont Health resources on behavioral health
- Increase participation in community events to discuss stigma and mental health

ANTICIPATED OUTCOMES

- Increased knowledge and awareness of mental health
- Decreased substance use
- Increased referrals for behavioral health
- Improved access to mental health services
- Increased community education resources

PARTNERS

Beaumont Behavioral Health Center
Detroit Wayne Integrated Health Network
Families Against Narcotics
Hegira Health
Local cities and municipalities
Local health departments
Local school districts
Starfish Family Services
Taylor Teen Health Center
The Guidance Center
The Information Center
Wayne Metro

RESOURCES

Beaumont, Trenton will commit both financial and in-kind resources, including staff time, charitable contributions and employee volunteerism.

Additional resources include: Taylor Teen Health Center, trained Mental Health First Aid instructors on site, relationship with other instructors in SE Michigan.

Priority #2 *Health Education*

Goal #1: Increase knowledge on health and social resources to improve community wellness.

OBJECTIVES/STRATEGIES

- Provide education on overt discrimination and implicit bias to reduce hesitancy to access needed care among groups that experience discrimination in the Trenton hospital communities
- Increase awareness of resources in the community
- Improve relationships with community organizations
- Provide education on one's community and how it impacts health
- Increase enrollment in chronic disease prevention and management programs by 15% by 2025
- Employ a community health worker model to support community connectedness and health education by 2024
- Establish a child passenger safety technician training model by June 2023
- Host an annual safety day to share resources and educate the community
- Increase participation in community events to share resources and promote wellness
- Increase percent of staff that complete implicit bias training

ANTICIPATED OUTCOMES

- Increased community education
- Increased knowledge and awareness of community resources
- Improve health outcomes and increase prevention screenings
- Decrease new incidence of diabetes
- Increased evidence-based programs offered to community members
- Increased understanding of health conditions
- Reduced health disparities in communities

PARTNERS

Car dealerships
Local cities and municipalities
Local health departments
Michigan Community Health Worker Alliance
Nonprofit partners
Police and fire departments
Safe Kids of Michigan

RESOURCES

Beaumont, Trenton will commit both financial and in-kind resources, including staff time, charitable contributions and employee volunteerism.

Priority #3 *Access to Care*

Goal #1: Enhance access to and coordination of care through community-based efforts.

OBJECTIVES/STRATEGIES

- Review areas where discrimination and implicit bias may cause hesitancy to access needed care among groups that experience discrimination in the communities served
- Create awareness of existing resources and how to use them
- Increase patient satisfaction scores
- Increase the percent of students with access to school food pantries
- Increase use of Beaumont Community Resource Network (BCRN) in the community by 25%
- Increase community based organization claim rate on BCRN by 50%
- Increase the number of staff who use BCRN

ANTICIPATED OUTCOMES

- Reduced barriers to accessing care
- Increased use of healthcare services
- Increased referrals and navigation to disease prevention and management resources
- Reduce preventable utilization of emergency department
- Increased access to screenings
- Reduced food insecurity

PARTNERS

Find Help	Hospital departments
Gleaners	Local community partners
Hospital community health team	Local schools

RESOURCES

Beaumont, Trenton will commit both financial and in-kind resources, including staff time, charitable contributions and employee volunteerism.

2022 COMMUNITY HEALTH NEEDS ASSESSMENT

Building Healthier Lives and Communities

Beaumont, Troy

Priority #1 *Behavioral Health*

Goal #1: Address behavioral health needs, including mental well-being and substance use disorders.

OBJECTIVES/STRATEGIES

- Remove barriers connecting to mental health care
- Create a behavioral health screening questionnaire
- Create and share literature about mental health resources to normalize and reduce stigma
- Increase outpatient access to behavioral health services
- Decrease rates of substance misuse, especially among youth
- Remove barriers connecting to substance misuse treatment
- In collaboration with community partners, participate/host medication take back days annually from 2023-2025
- Provide Mental Health First Aid education to 250 community leaders/members annually
- Offer quarterly virtual smoking cessation classes at no-cost to community members

ANTICIPATED OUTCOMES

- Increased knowledge and awareness of mental health
- Decreased substance use
- Increased referrals for behavioral health
- Improved access to mental health services

PARTNERS

Families Against Narcotics
Hegira Health
Local cities and municipalities
Local health departments
Local school districts
Oakland Community Health Network
Substance Use Prevention Partnership

RESOURCES

Beaumont, Troy will commit both financial and in-kind resources, including staff time, charitable contributions and employee volunteerism.

Additional resources include: hospital social workers, hospital psychiatrists, trained Mental Health First Aid instructors on site, relationship with other instructors in SE Michigan, Corewell Health (previously Beaumont Health) Smoking Cessation Program.

Priority #2 *Health Education*

Goal #1: Increase knowledge on health and social resources to improve community wellness.

OBJECTIVES/STRATEGIES

- Review and update cultural competency materials that reflect the community Troy hospital serves - both materials provided to patients/individuals and education materials for providers
- Increase enrollment in chronic disease prevention and management programs by 15% by 2025
- Employ a community health worker model to support community connectedness and health education by 2024
- Establish a child passenger safety technician training model by June 2023
- Create learning modules, training guides, and positive programming for staff and new hires at Beaumont Health on cultural competency
- Increase awareness of resources in the community
- Increase membership in community coalitions by 10%
- Provide education on one's community and how it impacts health
- Create safe and quality environments for physical activity

ANTICIPATED OUTCOMES

- Increased community education
- Increased knowledge and awareness of community resources
- Improve health outcomes and increase prevention screenings
- Decrease new incidence of diabetes
- Increased evidence-based programs offered to community members
- Increased understanding of health conditions
- Reduced health disparities in communities

PARTNERS

American Cancer Society
American Heart Association
AmeriCorps
Car dealerships
CARE of Southeastern Michigan
Chambers of commerce
Local cities and municipalities
Local health departments
Michigan Fitness Foundation
Michigan Community Health Worker Alliance
Nonprofit partners
Oakland University William Beaumont School of Medicine
Police and fire departments
Safe Kids of Michigan
Troy Community Coalition

RESOURCES

Beaumont, Troy will commit both financial and in-kind resources, including staff time, charitable contributions and employee volunteerism.

Additional resources include: DEI Hospital Committee, Oakland County Health Division Speaker's Team, Beaumont Community Resource Network

Priority #3 *Access to Care*

Goal #1: Enhance access to and coordination of care through community-based efforts.

OBJECTIVES/STRATEGIES

- Increase patient satisfaction scores
- Increase the percent of students with access to school food pantries
- Review areas where discrimination and implicit bias may cause hesitancy to access needed care among groups that experience discrimination in the communities Troy hospital serves
- Improve support to navigate the healthcare system
- Increase use of Beaumont Community Resource Network (BCRN) in the community by 25%
- Increase community based organization claim rate on BCRN by 50%
- Increase the number of staff who use BCRN

ANTICIPATED OUTCOMES

- Reduced barriers to accessing care
- Increased use of healthcare services
- Increased referrals and navigation to disease prevention and management resources
- Reduce preventable utilization of emergency department
- Increased access to screenings
- Reduced food insecurity

PARTNERS

Find Help
Gleaners
Hospital community health team
Hospital departments
Human resources department
Local community partners
Local schools

RESOURCES

Beaumont, Troy will commit both financial and in-kind resources, including staff time, charitable contributions and employee volunteerism.

2022 COMMUNITY HEALTH NEEDS ASSESSMENT

Building Healthier Lives and Communities

Beaumont, Wayne

Priority #1 *Behavioral Health*

Goal #1: Address behavioral health needs, including mental well-being and substance use disorders.

OBJECTIVES/STRATEGIES

- Increase outpatient access to behavioral health services
- Integrate behavioral health in primary/specialty care
- Reduce stigma surrounding mental health
- Remove barriers connecting to mental health care
- Reduce stigma surrounding substance misuse and treatment
- Remove barriers connecting to substance misuse treatment
- In collaboration with community partners, participate/host medication take back days annually from 2023-2025
- Provide Mental Health First Aid education to 250 community leaders/members annually
- Teen Health Center/SWP/E3 LMSW's/LPC will provide mental health counseling services to a minimum of 380 unduplicated users/students and 3,625 visits per year
- Offer quarterly virtual smoking cessation classes at no-cost to community members
- Review options to pilot/implement Telepsych in the Emergency Department
- Increase use of educational materials to promote Beaumont Health resources on behavioral health
- Increase participation in community events to discuss stigma and mental health

ANTICIPATED OUTCOMES

- Increased knowledge and awareness of mental health
- Decreased substance use
- Increased referrals for behavioral health
- Improved access to mental health services
- Increased community education resources

PARTNERS

Beaumont Behavioral Health Center
Detroit Wayne Integrated Health Network
Families Against Narcotics
Hegira Health
Local cities and municipalities
Local health departments
Non-profit partners
Local school districts
Starfish Family Services
Taylor Teen Health Center
The Guidance Center
The Information Center
Wayne Metro

RESOURCES

Beaumont, Wayne will commit both financial and in-kind resources, including staff time, charitable contributions and employee volunteerism.

Additional resources include: Beaumont Quick Response Teams (QRT), Taylor Teen Health Center, trained Mental Health First Aid instructors on site, relationship with other instructors in SE Michigan

Priority #2 *Health Education*

Goal #1: Increase knowledge on health and social resources to improve community wellness.

OBJECTIVES/STRATEGIES

- Provide education on overt discrimination and implicit bias to reduce hesitancy to access needed care among groups that experience discrimination in the Wayne hospital communities
- Increase awareness of resources in the community
- Improve relationships with community organizations
- Provide education on one's community and how it impacts health
- Increase enrollment in chronic disease prevention and management programs by 15% by 2025
- Employ a community health worker model to support community connectedness and health education by 2024
- Establish a child passenger safety technician training model by June 2023
- Host an annual safety day to share resources and educate the community
- Increase participation in community events to share resources and promote wellness
- Increase percent of staff that complete implicit bias training

ANTICIPATED OUTCOMES

- Increased community education
- Increased knowledge and awareness of community resources
- Improve health outcomes and increase prevention screenings
- Decrease new incidence of diabetes
- Increased evidence-based programs offered to community members
- Increased understanding of health conditions
- Reduced health disparities in communities

PARTNERS

Car dealerships
Local cities and municipalities
Local health departments
Michigan Community Health Worker Alliance
Nonprofit partners
Police and fire departments
Safe Kids of Michigan

RESOURCES

Beaumont, Wayne will commit both financial and in-kind resources, including staff time, charitable contributions and employee volunteerism.

Goal #2: Increase the number of youth who receive health education in the schools and community.

OBJECTIVES/STRATEGIES

- 900 high risk youth will receive evidenced-based health education inside schools and communities
- Implement the Making Proud Choices curriculum to at least 100 youth annually

ANTICIPATED OUTCOMES

- Increased youth receiving treatment
- Increased health knowledge

PARTNERS

Local school districts

RESOURCES

Beaumont, Wayne will commit both financial and in-kind resources, including staff time, charitable contributions and employee volunteerism.

Priority #3 *Access to Care*

Goal #1: Enhance access to and coordination of care through community-based efforts.

OBJECTIVES/STRATEGIES

- Review areas where discrimination and implicit bias may cause hesitancy to access needed care among groups that experience discrimination in the communities served
- Create awareness of existing resources and how to use them
- Increase patient satisfaction scores
- Increase the percent of students with access to school food pantries
- Increase use of Beaumont Community Resource Network (BCRN) in the community by 25%
- Increase community based organization claim rate on BCRN by 50%
- Increase the number of staff who use BCRN

ANTICIPATED OUTCOMES

- Reduced barriers to accessing care
- Increased use of healthcare services
- Increased referrals and navigation to disease prevention and management resources
- Reduce preventable utilization of emergency department
- Increased access to screenings
- Reduced food insecurity

PARTNERS

Find Help	Hospital departments
Gleaners	Local community partners
Hospital community health team	Local schools

RESOURCES

Beaumont, Wayne will commit both financial and in-kind resources, including staff time, charitable contributions and employee volunteerism.

Goal #2: Increase the number of high-risk youth who received medical, mental health, and prevention services inside Teen health Centers/School-Based Health Centers.

OBJECTIVES/STRATEGIES	ANTICIPATED OUTCOMES
• A total of 2,000 unduplicated youth will receive services • A total of 7,000 visits will be conducted	• Increased youth receiving services • Increased access to services

PARTNERS

Local school districts

RESOURCES

Beaumont, Wayne will commit both financial and in-kind resources, including staff time, charitable contributions and employee volunteerism.

2022 COMMUNITY HEALTH NEEDS ASSESSMENT

Building Healthier Lives and Communities

Appendices

Beaumont Health CHNA Advisory Group Members

Gilly Anderson	Chief Nursing Officer	Beaumont Trenton
Corey Beckwith	Community Partner	ACCESS
Anthony Childs	Chief Nursing Officer	Beaumont Wayne
Jeff Cook	Community Health	Beaumont Health
Kristine Donahue	President	Beaumont TTW
Susan Grant	Executive Vice President, Chief Nursing Officer	Beaumont Health
Kim Guesman	Chief Nursing Officer	Beaumont Farmington Hills
Helena Hardin	Chief Nursing Officer	Beaumont Taylor
Vicki Hollingsworth	Vice President, Clinical Operations	Beaumont Royal Oak
Carolyn Hribar	Community Partner	Oakland County Health Division
Amanda LaVoie	Senior Director Support Services	Beaumont Troy
Todd Lipa	Community Partner	CARES of Farmington Hills
Whitney Litzner	Community Health	Beaumont Health
Leslie Meyer	Vice President, Patient and Family Experience	Beaumont Health
Imana Minard	Director of Nursing	Beaumont Farmington Hills
Quentin Moore	Community Health	Beaumont Health
Holli Najor	Director, Respiratory Care Therapy	Beaumont Grosse Pointe
Lee Ann Odom	President, Administration - Operations	Beaumont Health
Michael Randall	Community Partner	American Heart Association
Ross Rogers	Information Technology	Beaumont Health
Marlene Seltzer	Medical Director NoBLE Program	Beaumont Health
Sam Shopinski	Community Partner	National Kidney Foundation of Michigan
Maria Swiatkowski	Community Partner	Macomb County Health Department
Madiha Tariq	Community Partner	ACCESS
Theresa Tejada	Community Partner	National Kidney Foundation of Michigan
Lindsay TerHaar	Community Partner	Oakland County Health Division
Karen Wright	Strategic Planning	Beaumont Health
Carolyn Zuniga	Community Partner	Hegira Health Inc.

Beaumont Health CHNA Partner Organizations

Arab Community Center for Economic and Social Services (ACCESS) Community Health and Research Center (CHRC)	*Church of the Divine Child*
Affirmations	*Clawson Senior Center*
American Arab Chamber of Commerce	*Dearborn Area Chamber of Commerce*
American Cancer Society	*Dearborn Library*
American Heart Association	*Dearborn Police Department*
ARC of Western Wayne County, The	*Dearborn Public Schools*
Association of Chinese Americans	*Dearborn, City of*
Assumption Cultural Center	*Detroit Abloom*
Auburn Hills, City of- Department of Senior Services	*Downriver Cycling Club*
Bangladeshi American Public Affairs Commission	*Downriver Family YMCA*
Beaumont Dearborn Hospital	*Easterseals of Michigan*
Beaumont Farmington Hills Hospital	*East Dearborn Downtown Development Authority (DDA)*
Beaumont Grosse Pointe Hospital	*Ecology Center*
Beaumont Royal Oak Hospital	*Farmington Chamber of Commerce*
Beaumont Taylor Hospital	*Farmington Community Library*
Beaumont Trenton Hospital	*Farmington Family YMCA*
Beaumont Troy Hospital	*Farmington Farmers Market*
Beaumont Wayne Hospital	*Farmington Hills*
Bike Dearborn	*Farmington Hills Church of God*
Birmingham Family YMCA	*Farmington Hills Library*
Cabrini Clinic	*Farmington Hills Nature Center*
CARE of Southeastern Michigan	*Farmington Hills Police Dept*
CARES (Community. Action. Resources. Empowerment. Services.) of Farmington Hills	*Farmington Hills, City of*
Catholic Charities of Southeast Michigan	*Farmington Public Schools*
Centro Multicultural La Familia	*Ferndale Pride*
Chaldean Chamber	*Ferndale, City of*
Chaldean Community Foundation	*First Presbyterian Church*
Christ Church of Grosse Pointe	*FirstStep*
	Forgotten Harvest
	Full Circle

Beaumont Health CHNA Partner Organizations cont.

Gleaners Community Food Bank	*MyCare Health Center*
Grosse Pointe Chamber	*NAACP (National Association for the Advancement of Colored People)*
Grosse Pointe Library Foundation	*National Kidney Foundation of Michigan*
Grosse Pointe News	*Neighborhood Club*
Grosse Pointe Pedalers	*New Detroit*
Grosse Pointe Public Library	*Oak Park Recreation/Farmers Market*
Grosse Pointe Public School System	*Oak Park, City of*
Grosse Pointe Public School System	*Oakland Community Health Network*
Grosse Pointe Times	*Oakland County*
Grosse Pointe War Memorial	*Oakland County Circuit Court - Youth Assistance*
Grosse Pointe Woods Parks & Recreation	*Oakland County Health Division*
Guidance Center, The	*Oakland Family Services*
Habitat for Humanity - Macomb	*Penrickton Center for Blind Children*
Habitat for Humanity - Oakland	*Redford, Charter Township of*
Hegira Health, Inc.	*Royal Oak First United Methodist Church*
Helm Life, The	*Royal Oak Public Library*
Honor Community Health	*Royal Oak Schools*
Huntington Woods Parks and Recreation Department	*Royal Oak Youth Assistance*
International Wildlife Refuge - Detroit River	*Salvation Army*
Jewish Family Services	*Salvation Army Wayne-Westland Corps.*
Jewish Hospice and Chaplaincy Network	*Samaritas*
JVS	*Senior Alliance, The*
Lakes Area Chamber of Commerce	*Southern Wayne County Regional Chamber*
Leaders Advancing & Helping Communities (LAHC)	*Southwestern Outer Drive Association (SODA) Neighborhood Association*
Lighthouse of Oakland County	*Sprout Store*
Macomb County Health Department	*St. Mary Parish*
Michigan Anti-Defamation League	*Stand With Trans*
Mothering Justice	

Beaumont Health CHNA Partner Organizations cont.

Starfish Family Services	*Troy School District*
Sterling Heights, City of - Parks and Recreation	*Troy, City of*
Suburban Mobility Authority for Regional Transportation (SMART)	*United Way for Southeastern Michigan*
Taylor Library	*University of Michigan-Dearborn*
Taylor School District	*Wayne County*
Taylor, City of	*Wayne County Community College District (WCCCD)*
Trenton Library	*Wayne County Department of Health*
Trenton Public Schools	*Wayne Metropolitan Community Action Agency*
Trenton, City of	*Wayne Metropolitan Community Action Agency*
Tri-Community Coalition	*Western Wayne Family Health Centers*
Troy Stage Nature Center	*Westland, City of*
Troy Chamber of Commerce	*Woodside Bible Church*
Troy Fitness Center	*Wyandotte Youth Assistance Program*
Troy Historic Village	*Yemen American Benevolent Assn*
Troy Library	*YMCA*

Beaumont | Beaumont Health CHNA survey

Overview

Beaumont Health is conducting a Community Health Needs Assessment (CHNA) survey to better understand the health concerns and needs in the community. The information obtained from the CHNA will be used in the development of an action plan to improve the health of local community members in Macomb, Oakland, Wayne counties where Beaumont Health has a presence.

Your responses to the survey are optional and anonymous. Any information collected will be reported in summary only.

1. What is the ZIP code where you live? Enter 5-digit ZIP code (for example, 48034) or leave blank if you are unsure.

2. What city do you live in? [required]

3. Which of these medical issues do you feel are most important and need to be addressed in your community? Please select up to three options.

- ☐ Alzheimer's disease/dementia
- ☐ Cancer
- ☐ Chronic lower respiratory disease (such as asthma and COPD)
- ☐ COVID-19 (novel coronavirus)
- ☐ Diabetes
- ☐ Heart disease
- ☐ Kidney disease
- ☐ Liver disease
- ☐ Obesity
- ☐ Pneumonia/flu
- ☐ Stroke

4. What additional health issues do you feel are most important and should be addressed in your community? Please select up to three options.

- ☐ Aging problems (falls, dementia, etc.)
- ☐ Anxiety, depression, and other mental health issues
- ☐ Bullying/cyber bullying/harassment
- ☐ Child abuse and neglect
- ☐ Domestic and sexual violence
- ☐ Healthy pregnancy
- ☐ Immunizations/vaccines
- ☐ Injuries (car/traffic accidents, falls)
- ☐ Oral/dental health
- ☐ Sexual health (Sexually Transmitted Infections, family planning)
- ☐ Substance misuse
- ☐ Suicide
- ☐ Other (please specify):

5. Which of the following community factors negatively impact your health the most? Please select up to five options.

- ☐ Health care
- ☐ Social services
- ☐ Access to affordable healthy foods
- ☐ Recreation
- ☐ Transportation
- ☐ Exposure to toxins (water and air quality)
- ☐ Occupational hazards
- ☐ Housing
- ☐ Employment
- ☐ Income
- ☐ Education
- ☐ The economy
- ☐ Land use
- ☐ Residential segregation
- ☐ Discrimination
- ☐ Culture (media and ads)
- ☐ Violence/crime
- ☐ Other (please specify):

6. Which of the following options make it harder for you to get health care services? Please select up to five options.

- ☐ Cost of premiums, deductibles, copays
- ☐ Cost of prescriptions/medications
- ☐ Difficulty finding a doctor
- ☐ Difficulty getting an appointment
- ☐ Doctors do not speak my language
- ☐ Doctors not accepting my insurance
- ☐ Fear or distrust of doctors/the medical system
- ☐ Hours of health care services do not fit my schedule
- ☐ Lack of appropriate care for my identities or culture (gender expression, religion, etc.)
- ☐ Location of health care services
- ☐ Not being able to get a referral to a specialist
- ☐ Not having insurance
- ☐ Too much paperwork or difficulty filling out paperwork
- ☐ Transportation
- ☐ Other (please specify):
- ☐ Nothing, I have no difficulties

7. Please indicate whether you think you have easy access to each of the following: **No**, I do not have easy access; **Yes**, I have easy access; **Does not apply**

- Credible and accurate health information
- Family planning
- Health screenings (diabetes, heart disease, cancer)
- Health services for children
- Immunizations
- Mental health services
- Oral/dental health services
- Prenatal care/health care for pregnancy
- Primary care
- Sexual health testing and treatment
- Specialized care (diabetes, heart disease, etc.)

8. Please indicate your level of agreement with each of the following statements:
My community… **Strongly Disagree; Disagree; Agree; Strongly Agree; Not Applicable**

- Is safe
- Is clean (air, water quality, etc.)
- Is accessible for people with disabilities
- Is walkable/bikeable
- Has enough parks and playgrounds
- Has enough health care services
- Has enough healthy food options
- Has good public transportation
- Has livable wages
- Has enough affordable housing
- Has good schools
- Has good childcare
- Supports each other
- Is inclusive
- Is diverse

9. There are enough programs, services, and support available for the following:
Strongly Disagree; Disagree; Agree; Strongly Agree; Unsure

- Immigrants to the United States
- Members of the LGBTQ+ community
- Older adults
- People experiencing homelessness
- People living with HIV
- People with disabilities
- People with substance use disorders
- People with mental health concerns
- People who do not speak English
- Pregnant people
- Veterans

10. What is the primary place you receive healthcare?

- ☐ Chiropractor
- ☐ Emergency department/ emergency room
- ☐ Family doctor
- ☐ Health department
- ☐ Hospital
- ☐ Mental health care
- ☐ Obstetrics/gynecology
- ☐ Physical therapy
- ☐ Specialized care
- ☐ Substance use disorder treatment
- ☐ Urgent care
- ☐ Other (please specify):
- ☐ None

11. What do you think are the 3 most important health-related concerns associated with the COVID-19 pandemic?

- ☐ Concerns about short/long term health effects of COVID-19 disease
- ☐ Delayed or missed immunizations for children
- ☐ Developmental delays in children
- ☐ Discrimination
- ☐ Financial difficulties
- ☐ Increase in stress, depression, & anxiety
- ☐ Increased fear or distrust of the health care system
- ☐ Increased substance use
- ☐ Withdrawal from supports and services
- ☐ Other (please specify):
- ☐ None [mutually exclusive]

The following section will ask you about your demographic information.

This information helps us understand who has taken the survey so we can ensure we are reaching the diverse communities served by Beaumont Hospital. It also allows us to identify if there are any unique needs for specific demographics so we can our improve services and your experience. All information in this survey, including the demographics section, will be kept anonymous.

12. What is your age?

- ○ 18 to 24 years
- ○ 25 to 34 years
- ○ 35 to 44 years
- ○ 45 to 54 years
- ○ 55 to 64 years
- ○ 65 to 74 years
- ○ 75 to 84 years
- ○ 85 years and older
- ○ Prefer not to say

13. Are you of Hispanic, Latino, or Spanish origin?

○ Yes ○ No ○ Prefer not to say

14. Are you of Middle Eastern or North African origin?

○ Yes ○ No ○ Prefer not to say

15. What is your race? Please select all that apply.

- ○ American Indian or Alaska Native
- ○ Asian
- ○ Black or African American
- ○ Native Hawaiian or Other Pacific Islander
- ○ White
- ○ Not listed here (please specify):
- ○ Prefer not to say [mutually exclusive]

16. What is the primary language you speak at home?

- ◯ English
- ◯ Spanish
- ◯ Arabic
- ◯ Not listed here (please specify):
- ◯ Prefer not to say

17. What is your gender?

- ◯ Female
- ◯ Male
- ◯ Non-binary
- ◯ Prefer to self-describe (please specify):
- ◯ Prefer not to say

18. Transgender is an umbrella term that refers to people whose gender identity is different from that typically associated with their assigned sex at birth. Do you identify as transgender?

◯ Yes ◯ No ◯ Prefer not to say

19. What is your sexual orientation?

- ◯ Asexual
- ◯ Bisexual
- ◯ Gay or Lesbian
- ◯ Queer
- ◯ Questioning
- ◯ Straight/Heterosexual
- ◯ Not listed here (please specify):
- ◯ Prefer not to say

20. Do you identify as someone with a disability?

◯ Yes ◯ No ◯ Prefer not to say

21. What is the highest level of education that you have achieved?

- ◯ Less than high school, no diploma
- ◯ High school graduate or GED
- ◯ Some college, no degree
- ◯ Trade school/vocational training
- ◯ Associate's degree
- ◯ Bachelor's degree
- ◯ Graduate or Professional degree
- ◯ Not listed here (please specify):
- ◯ Prefer not to say

22. What is your annual household income before taxes (including all wages, tips, unemployment, and benefits e.g., SNAP, WIC, etc.)?

- ◯ $0-$24,999
- ◯ $25,000-$49,999
- ◯ $50,000-$74,999
- ◯ $75,000 or above
- ◯ Prefer not to say

23. How many people, including yourself, are supported by this income?

- ◯ [1-10]
- ◯ Over 10
- ◯ Prefer not to say

24. Do you have health insurance?

- ◯ Yes
- ◯ No, but I did at an earlier time/previous job
- ◯ No, I have never had health insurance

25. What else would you like to share about the health concerns and needs in your community?

We value your input and thank you for your responses.

Thank You

Individuals representing the below organizations participated in key informant interviews:
American Cancer Society
Beaumont Health
CARE of Southeastern Michigan
Christnet
Detroit Area Agency
Detroit Disability Power
Macomb County Health Department
Neighborhood Club Grosse Pointe
Neighborhood Service Organization
Oakland County Health Division
Oakland County Neighborhood & Housing Development
Services to Enhance Potential (STEP)
Troy Historic Village
Western Wayne Family Health Centers

Appendix D • Key Informant Interview Questions

I. Community Needs

a. **Thinking about your organization and your role, describe the community you serve.**

b. **What are the greatest health-related concerns for the community you serve?** (This can include medical issues, mental health concerns, abuse/neglect, sexual health, substance misuse, pregnancy health, injuries, diseases, etc.)

c. **Please describe the underlying factors causing the health needs in this community.** (Think about social or economic conditions that influence health in the community. Please be specific. Examples of factors include: transportation, housing, social services, access to healthy foods, discrimination, employment, education, etc.)

d. **What barriers does your community face when it comes to accessing health care services?** (Please be specific – for example, if you state "insurance," what about insurance is a barrier – Being uninsured? The cost of insurance? etc.)

e. **How has COVID-19 impacted the needs of the community you serve?** (If you already mentioned COVID-19 in a previous question, do you have anything to add? Impacts can include: health (physical and mental), employment, education, housing, etc.)

II. Health Equity in the Community

Health equity is when everyone has what they need to attain a full, healthy life and no one is kept from achieving this for any reason. What one person needs may be the same or different from what other people need.

a. **Think about the people that your organization serves who experience relatively good health and those who experience poor health. What specific differences are you observing?** What causes these differences? (Consider upstream factors – social and institutional inequities, living conditions, employment, education, access to green space, incarceration rate, literacy rate, etc.)

b. **What assets are currently available in the community you serve that can address the barriers to health equity you previously mentioned?** (Assets can include resources, policies, businesses, programs, activities, etc.)

III. Solutions

a. **What actions could Beaumont Health take to create positive change in the community you serve?**

IV. Conclusion

a. **Are there any additional comments you would like to share about the community you serve and/or about how Beaumont Health can improve health in that community?**

Demographic and socioeconomic comparison: community served and state/U.S. benchmarks

Average Age and Income	National	Michigan	Beaumont Health	Dearborn	Farmington	Grosse Pointe	Royal Oak	Taylor	Trenton	Troy	Wayne
Average Household Income	$103,625.84	$89,956.00	$97,153.04	$74,361.50	$94,698.33	$75,045.33	$108,661.30	$81,213.47	$94,414.81	$118,754.47	$92,817.51
Average Age	40	40.9	40.6	38.4	41.3	40.3	41.3	39.7	41.6	41.5	39.4
Population and Gender	**National**	**Michigan**	**Beaumont Health**	**Dearborn**	**Farmington**	**Grosse Pointe**	**Royal Oak**	**Taylor**	**Trenton**	**Troy**	**Wayne**
Total Populatoin	334,279,739	10,079,475	3,922,505	670,874	923,010	495,510	2,172,367	548,565	228,340	901,574	322,415
5 Year projected change	3.21%	1.33%	1.01%	-0.13%	0.41%	-0.31%	1.53%	0.18%	1.32%	2.76%	1.09%
Female Population	50.76%	50.76%	51.39%	51.32%	52.45%	52.18%	51.27%	51.44%	51.30%	50.87%	51.65%
Male Population	49.24%	49.24%	48.61%	48.68%	47.55%	47.82%	48.73%	48.56%	48.70%	49.13%	48.35%
Population and Gender	**National**	**Michigan**	**Beaumont Health**	**Dearborn**	**Farmington**	**Grosse Pointe**	**Royal Oak**	**Taylor**	**Trenton**	**Troy**	**Wayne**
Age Groups 00-17	21.98%	21.16%	21.64%	24.97%	21.03%	22.16%	20.59%	23.24%	20.46%	20.23%	23.02%
Age Groups 65-UP	17.50%	18.82%	17.87%	15.95%	19.09%	17.64%	18.53%	17.32%	19.15%	18.47%	16.02%

**Excludes population age<5, **Excludes population age<25*

Source: Sg2 Market Demographics; Claritas Pop-Facts® 2022

Demographic and socioeconomic comparison: community served and state/U.S. benchmarks (cont.)

Ethnicity/Race	National	Michigan	Beaumont Health	Dearborn	Farmington	Grosse Pointe	Royal Oak	Taylor	Trenton	Troy	Wayne
Asian & Pacific Islander Non-Hispanic	6.09%	3.53%	5.48%	1.86%	6.17%	1.63%	7.53%	2.08%	2.37%	8.62%	8.26%
Black Non-Hispanic	12.45%	13.65%	24.16%	18.25%	39.26%	46.25%	20.84%	13.12%	8.14%	6.41%	20.21%
Hispanic	19.26%	5.69%	5.15%	12.54%	3.06%	2.28%	3.90%	7.70%	5.44%	3.64%	4.26%
White Non-Hispanic	58.82%	73.97%	62.28%	64.16%	48.75%	46.37%	64.93%	73.92%	81.46%	78.96%	63.65%
All Others	3.38%	3.15%	2.92%	3.19%	2.76%	3.47%	2.79%	3.19%	2.60%	2.37%	3.63%
Language*	**National**	**Michigan**	**Beaumont Health**	**Dearborn**	**Farmington**	**Grosse Pointe**	**Royal Oak**	**Taylor**	**Trenton**	**Troy**	**Wayne**
Only English at Home	78.18%	90.13%	84.95%	77.20%	84.98%	95.79%	83.79%	80.81%	92.96%	80.93%	86.31%
Household Income	**National**	**Michigan**	**Beaumont Health**	**Dearborn**	**Farmington**	**Grosse Pointe**	**Royal Oak**	**Taylor**	**Trenton**	**Troy**	**Wayne**
<$15K	8.82%	9.32%	9.91%	12.41%	11.21%	13.15%	8.04%	10.26%	7.02%	5.08%	7.96%
>$100K	35.76%	30.54%	33.62%	24.17%	31.86%	22.56%	38.43%	27.84%	35.03%	44.72%	32.42%
Education Level**	**National**	**Michigan**	**Beaumont Health**	**Dearborn**	**Farmington**	**Grosse Pointe**	**Royal Oak**	**Taylor**	**Trenton**	**Troy**	**Wayne**
Less than High School	4.90%	2.73%	3.10%	5.68%	2.41%	2.43%	2.78%	3.99%	2.03%	3.07%	2.18%
High School Degree	26.92%	29.00%	26.68%	34.42%	25.13%	32.15%	23.37%	34.21%	34.07%	23.29%	29.29%
Bachelor's Degree or Greater	30.70%	28.00%	30.58%	17.87%	33.06%	19.85%	36.22%	19.94%	21.74%	36.81%	28.64%

**Excludes population age<5, **Excludes population age<25*

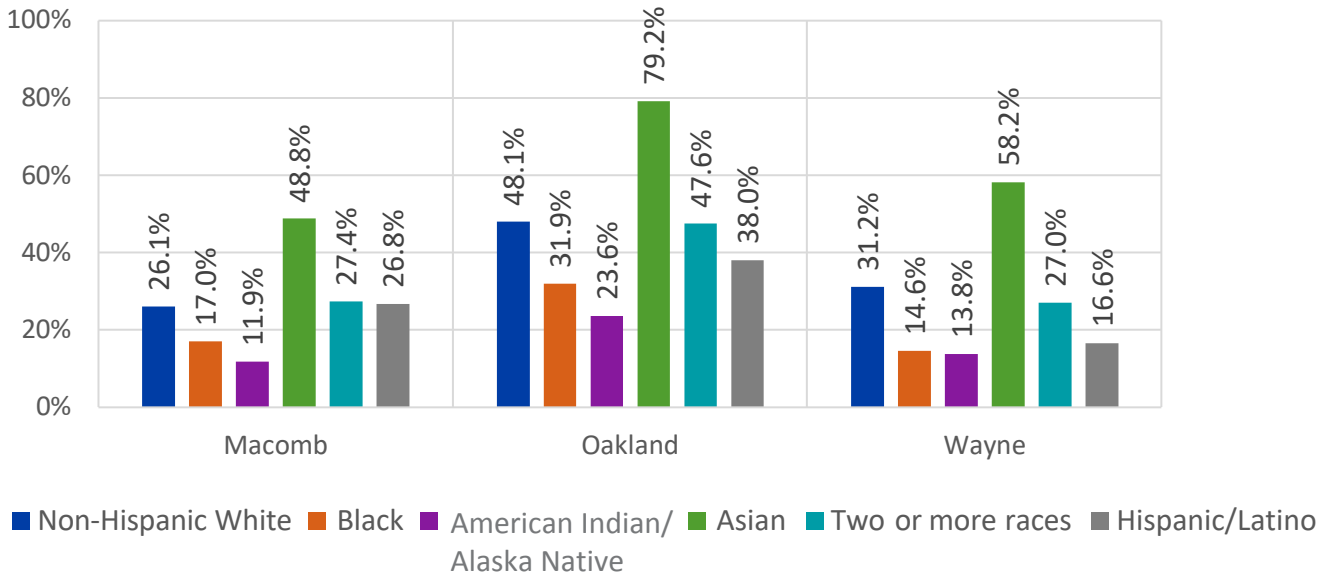
Source: Sg2 Market Demographics; Claritas Pop-Facts® 2022

According to population statistics, the overall Beaumont community is expected to grow 1.01% in five years. This is slightly lower than the projected growth for the state and much lower than the United States overall (3.21%). The average age is in line with both the state and national medians. Average household income for the overall community is higher than the state, but lower than the United States; however, there is income disparity within the community served.

Demographics

Educational Attainment

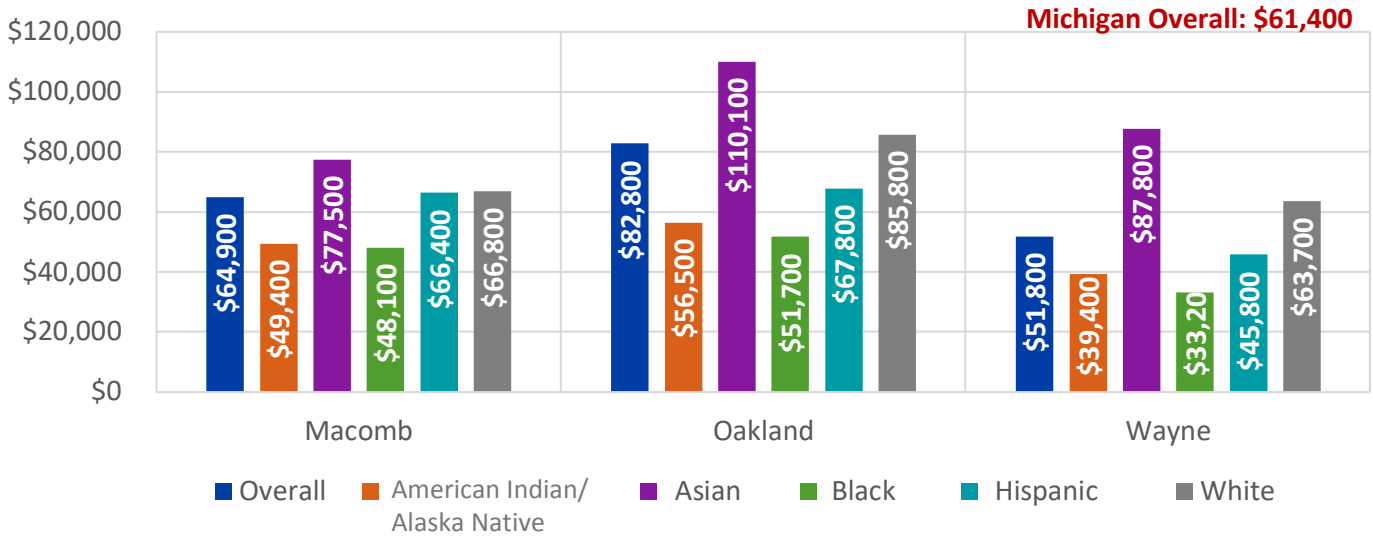
Bachelor's Degree or Higher (Age 25+) by Race/Ethnicity, 2020



Source: US Census - ACS

Income

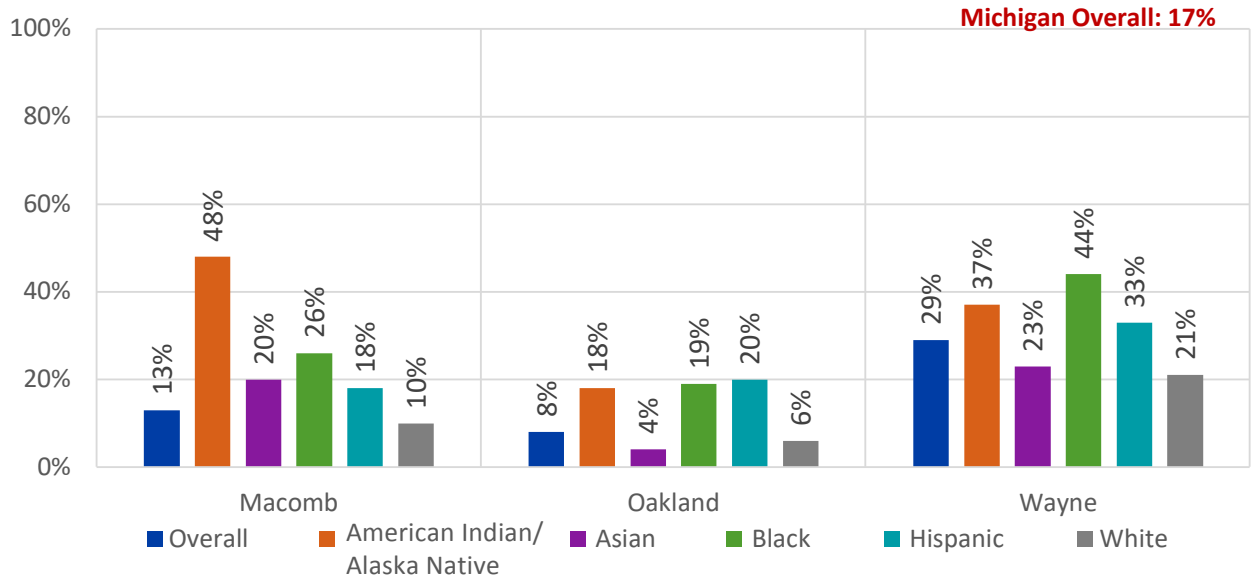
Median Household Income by County and Race, 2020



Source: County Health Rankings - Small Area Income and Poverty Estimates

Children in Poverty

Percentage of people under age 18 in poverty, by County and Race, 2020



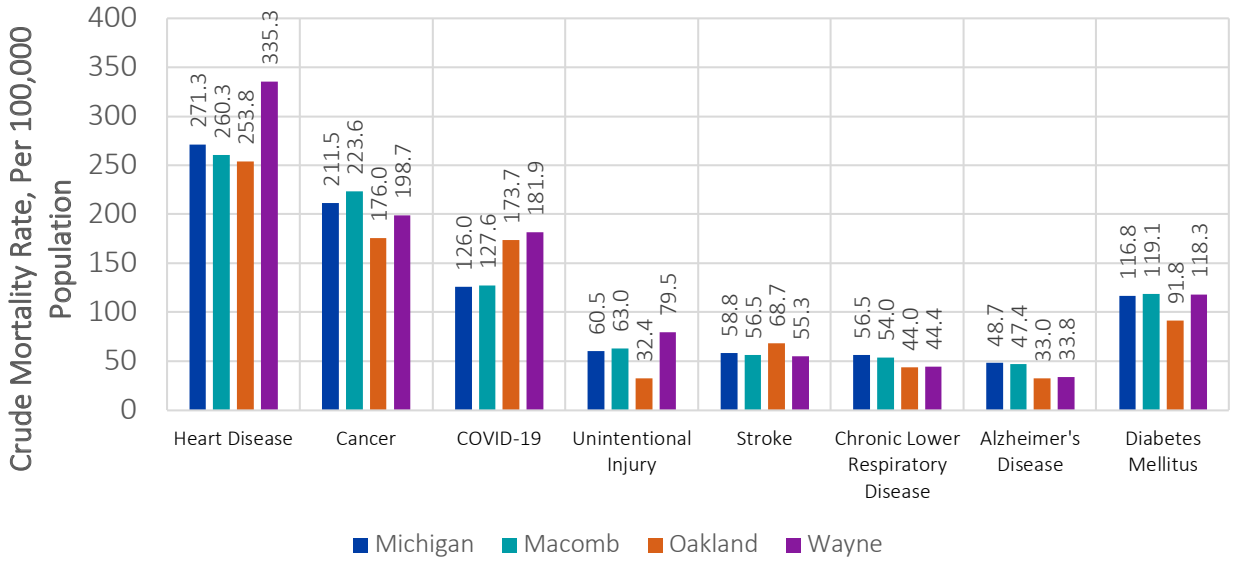
Source: [County Health Rankings - Small Area Income and Poverty Estimates]

Health Status

Indicators of health status give information regarding leading causes of death and related incidence of chronic disease in Michigan and the Macomb, Oakland, and Wayne Counties.

Cause of Death

Leading Causes of Death by County, 2020



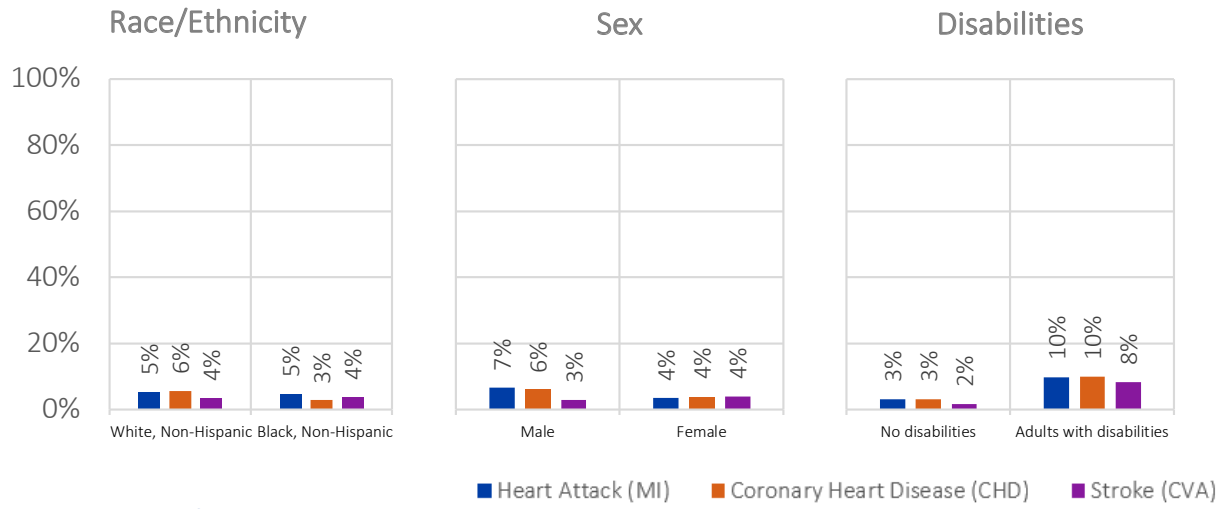
Source: [Michigan Vital Statistics, MDHHS]

Heart Disease

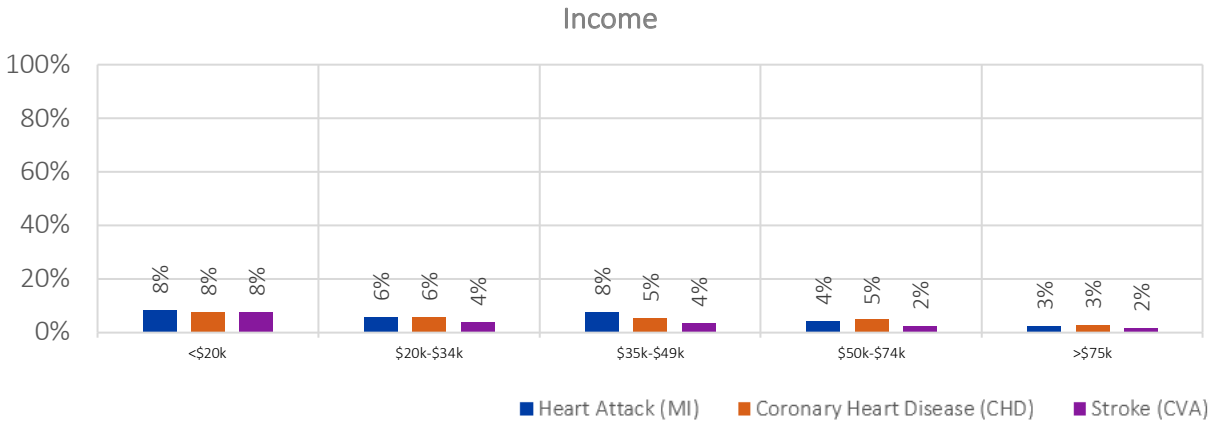
Percentage ever told they had any cardiovascular disease by County, 2020	
Michigan	9.7%
Macomb	9.8%
Oakland	8.4 %
Wayne (exc. Detroit)	10.9 %

Source: BRFS Annual Report 2020

Percentage ever told heart attack, coronary heart disease, or stroke, in Michigan, 2020



Source: BRFS Annual Report 2020

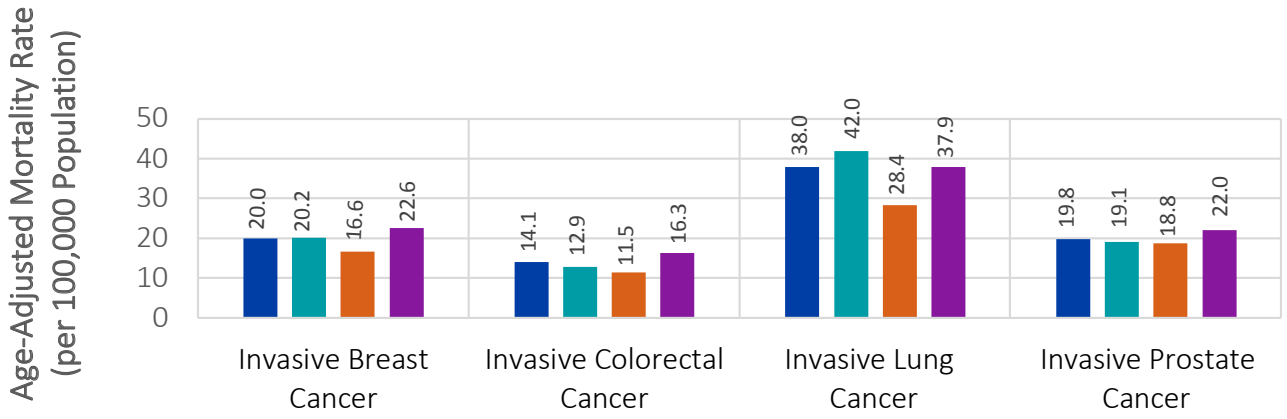


Source: BRFS Annual Report 2020

APPENDICES

Cancer

Age Adjusted Cancer Mortality Rates by County, 2020



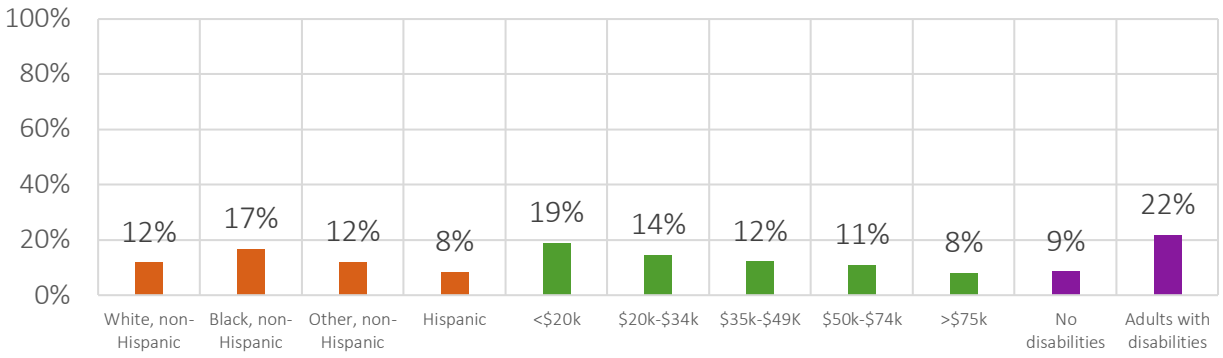
Source: U.S. Cancer Statistics Working Group. U.S. Cancer Statistics Data Visualizations Tool, based on 2021 submission data (1999-2019): U.S. Department of Health and Human Services, Centers for Disease Control and Prevention and National Cancer Institute; https://www.cdc.gov/cancer/dataviz released in June 2022.

Diabetes

Ever Told Diabetes, 2018 – 2020 Combined	
Michigan	11.7%
Macomb	12.6%
Oakland	10.3%
Wayne (exc. Detroit)	12.9%

Source: BRFS Annual Report 2020

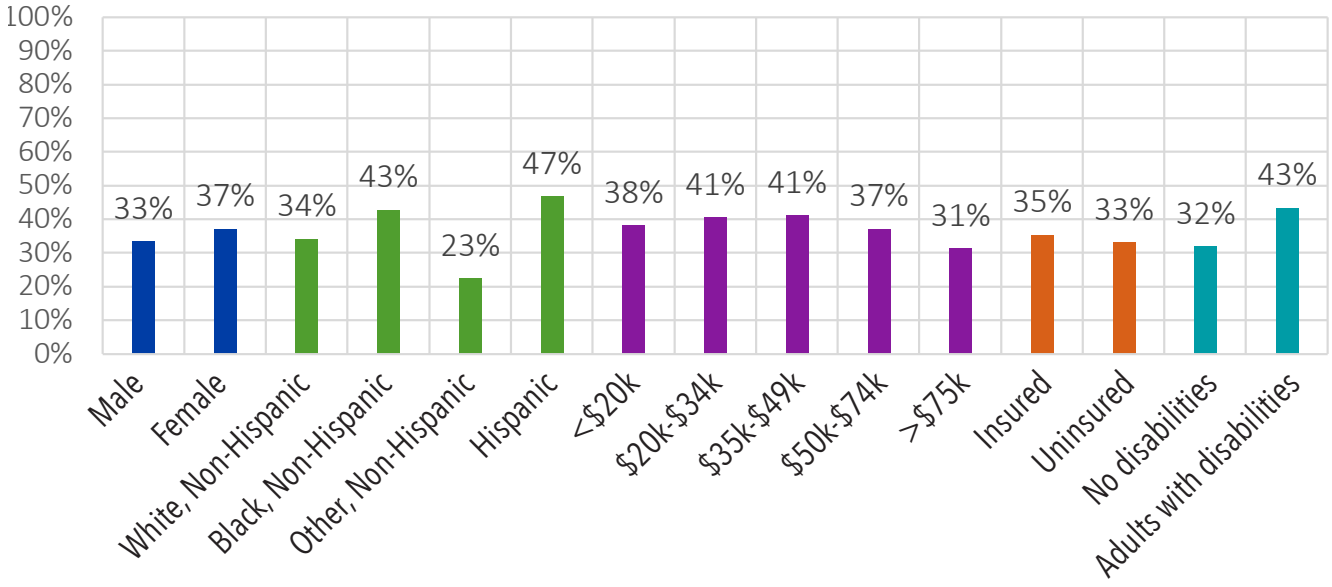
Ever told diabetes by Race, Income, and Disabilitiy, 2020



Source: BRFS Annual Report 2020

Obesity

Percentage of Obesity in Michigan by Sex, Race, Income, Insured, and Disability, 2020



Source: BRFS Annual Report 2020

Morbidity and Mortality

Years of Potential Life Lost (YPLL)

YPPL by Geographic Location, 2022	
U.S. Top Performers	5,600
Michigan	9,097
Macomb County	7,700
Oakland County	5,700
Wayne County	11,300

The number of years of potential life lost is calculated as the number of years between the age at death and 75 years of age for persons dying before their 75th year. Rates are per 100,000 population under 75 years of age.

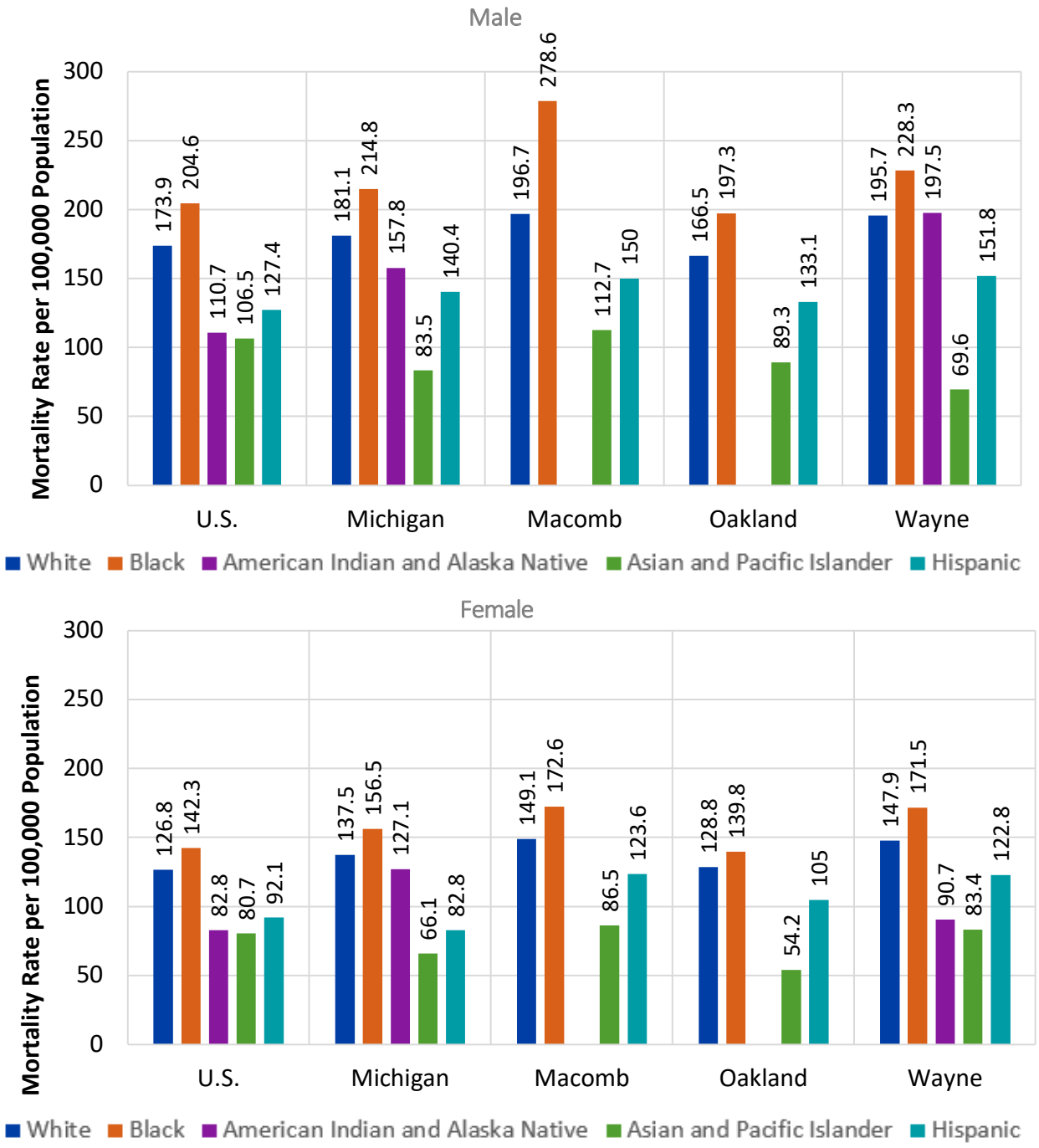
Source: County Health Rankings

MI Overall YPLL by Sex and Race								
All Races			White			Black		
Total	Male	Female	Total	Male	Female	Total	Male	Female
9,097.3	11,390.7	6,816.4	7,802.5	9,701.4	5,887.2	16,051.0	20,836.1	11,610.5

Source: MI Vital Records

Cancer Deaths

Rates of Cancer Deaths by Sex, Race, and Ethnicity, All types of Cancer (2015-2019)



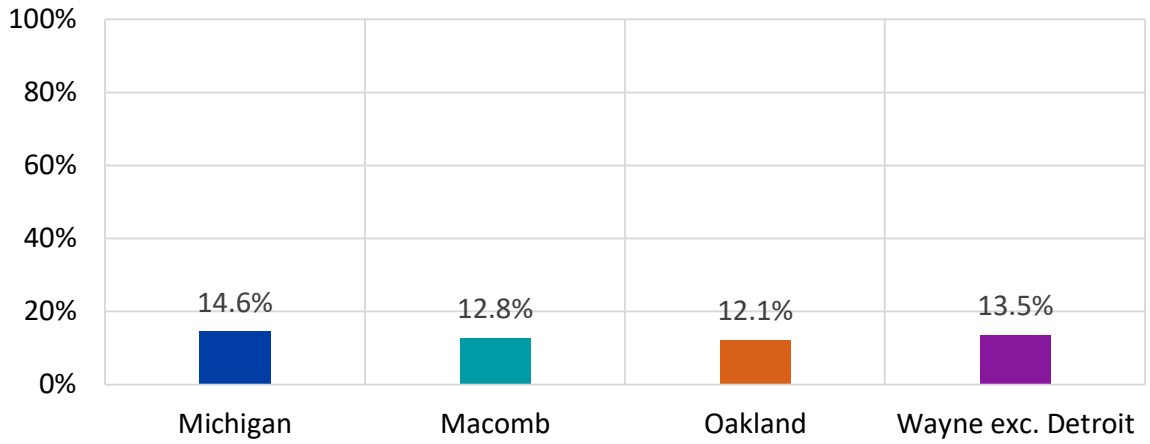
Data for Native American/Alaska Native for Macomb and Oakland Counties were suppressed (the number was too low to report and could be identifiable because of the small rate)

Source: U.S. Cancer Statistics Working Group. U.S. Cancer Statistics Data Visualizations Tool: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention and National Cancer Institute

Access to Care

Health Care Providers

No Personal Health Care Provider, 2018-2020 Combined



Source: BRFS Annual Report 2020

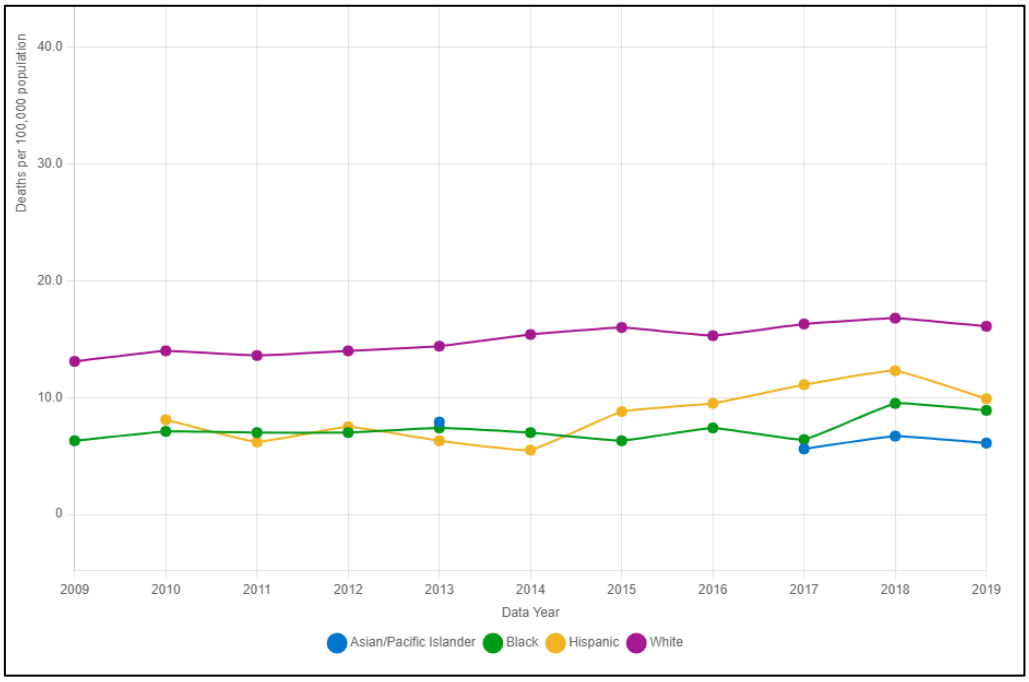
Mental Health

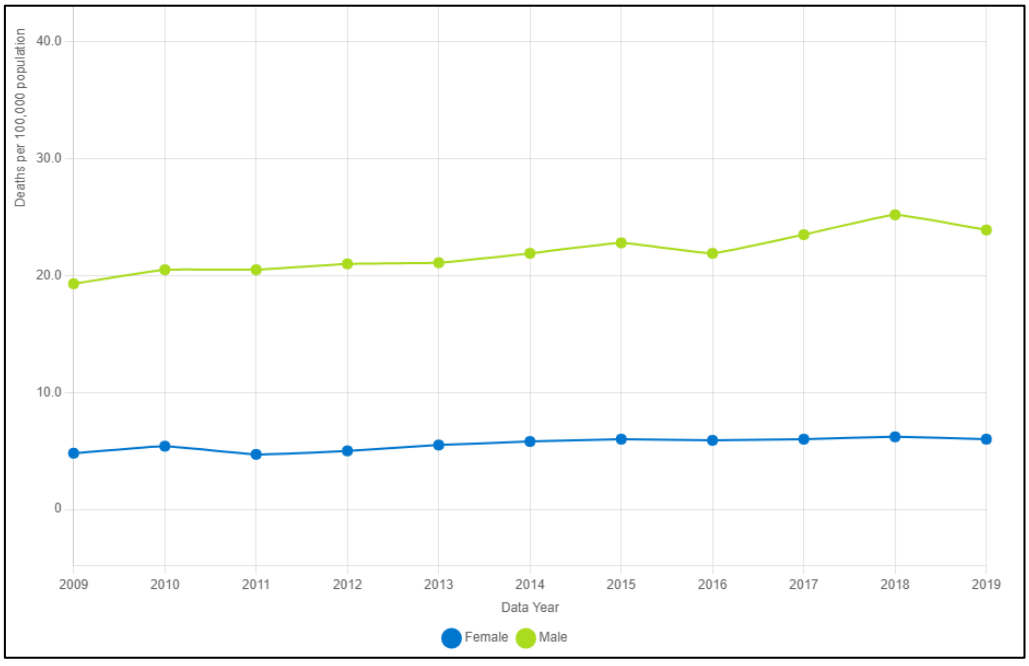
Suicide

Number of suicide deaths by sex and county (2020)				
	Michigan	Macomb County	Oakland County	Wayne County
Total	**1,432**	**123**	**155**	**218**
Male	1,130	97	108	172
Female	302	26	47	46

Source: MDHHS Vital Statistics

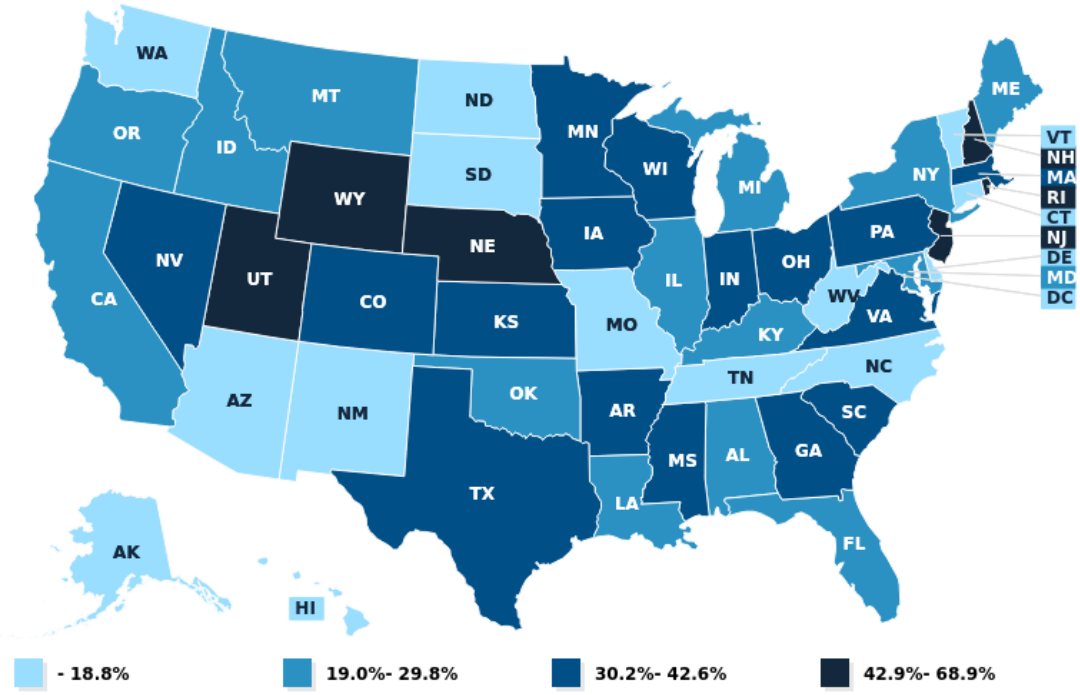
Suicide Rate – death due to intentional self-harm per 100,000 population by race and gender (2009-2019)





Source: America's Health Rankings/CDC Wonder

Mental Health Care health professional shortage areas (HPSAs): Percent of need met, as of September 30, 2021



Source: Kaiser Family Foundation State Health Facts

Conditions/Diseases

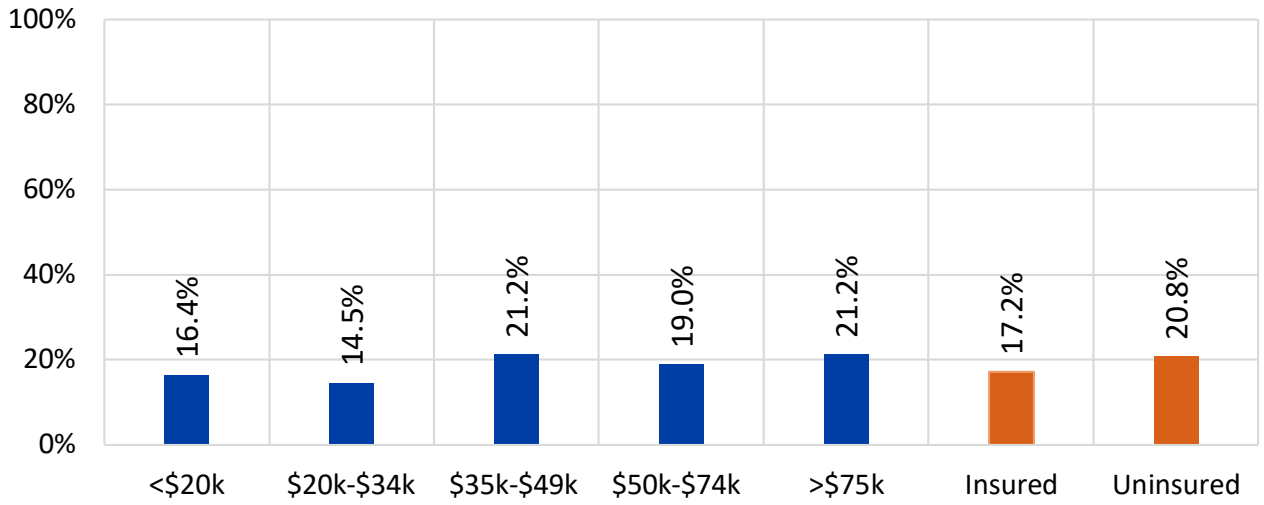
Number of Gonorrhea Cases by Race and County of Residence, Michigan Residents (2020)						
County	Total	Non-Hispanic White	Non-Hispanic Black	Hispanic	Other Race	Not Reported
Michigan	**23,414**	**4,768**	**13,285**	**724**	**1,204**	**3,433**
Macomb	1,437	256	720	17	142	302
Oakland	1,713	262	783	35	170	463
Wayne	8,868	616	6,191	91	527	1,443

Source: Michigan Disease Surveillance System, Division of HIV & STI Programs, MDHHS

Substance Misuse

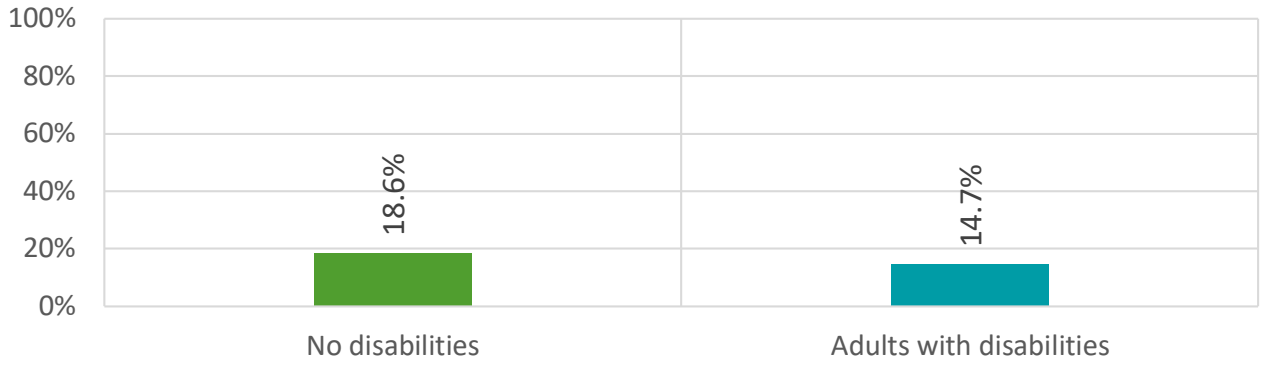
Binge Drinking

Binge Drinking in the Past Month, 2020



Source: BRFS Annual Report 2020

Binge Drinking in the Past Month - without and with disabilities, 2020



Source: BRFS Annual Report 2020

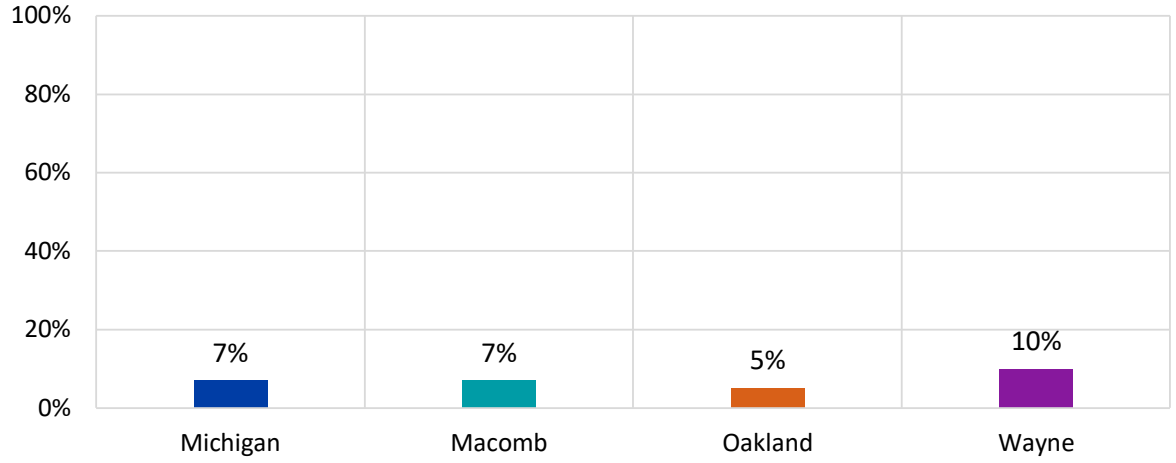
Binge Drinking, 2018 – 2020 Combined	
Michigan	17.9%
Macomb	17.6%
Oakland	18.1%
Wayne (exc. Detroit)	17.3%

Source: BRFS Annual Report 2020

Family and Social Support

Disconnected Youth

Percent of teens and young adults ages 16-19 who are neither working nor in school, 2019

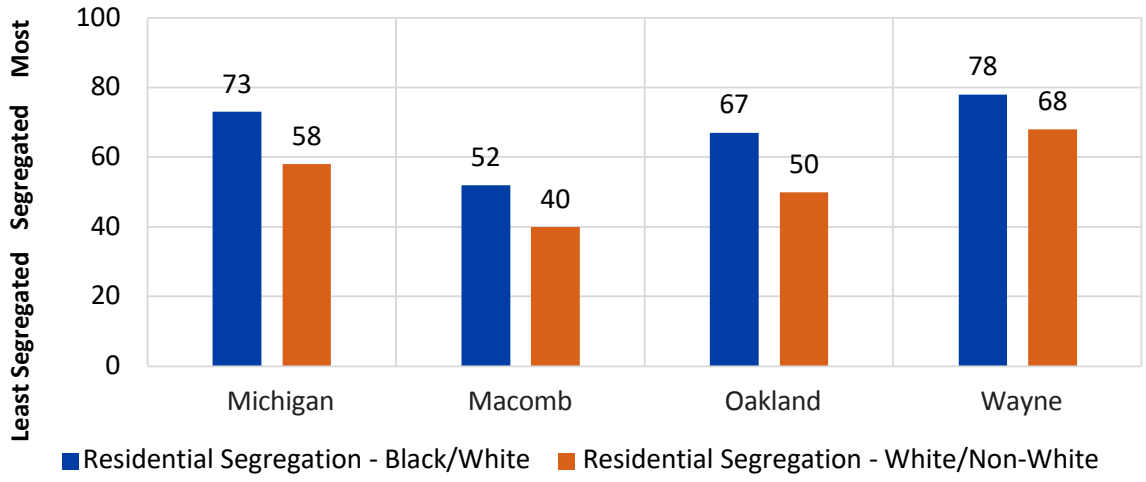


Source: County Health Rankings - American Community Survey

Residential Segregation

The residential segregation index ranges from 0 (complete integration) to 100 (complete segregation). The index score can be interpreted as the percentage of either Black or White residents that would have to move to different geographic areas in order to produce a distribution that matches that of the larger area.

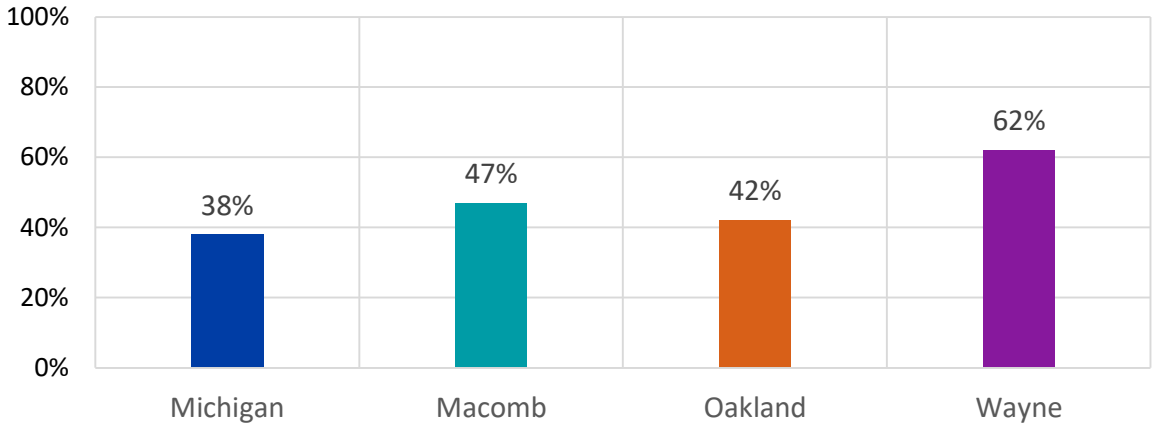
Residential Segregation, by County, 2016-2020



Source: County Health Rankings/County Business Patterns

Childcare

Childcare costs for a household with two children as a percent of median household income, by county 2020-2021



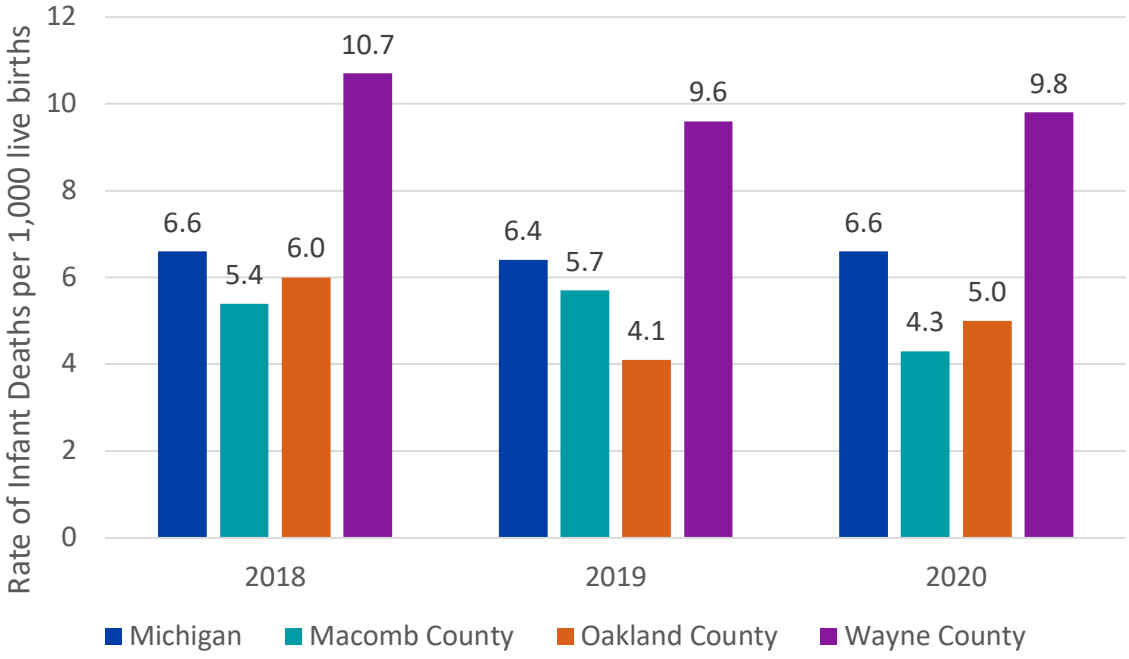
Source: County Health Rankings/Living Wage Calculator - US Census

Maternal and Child Health

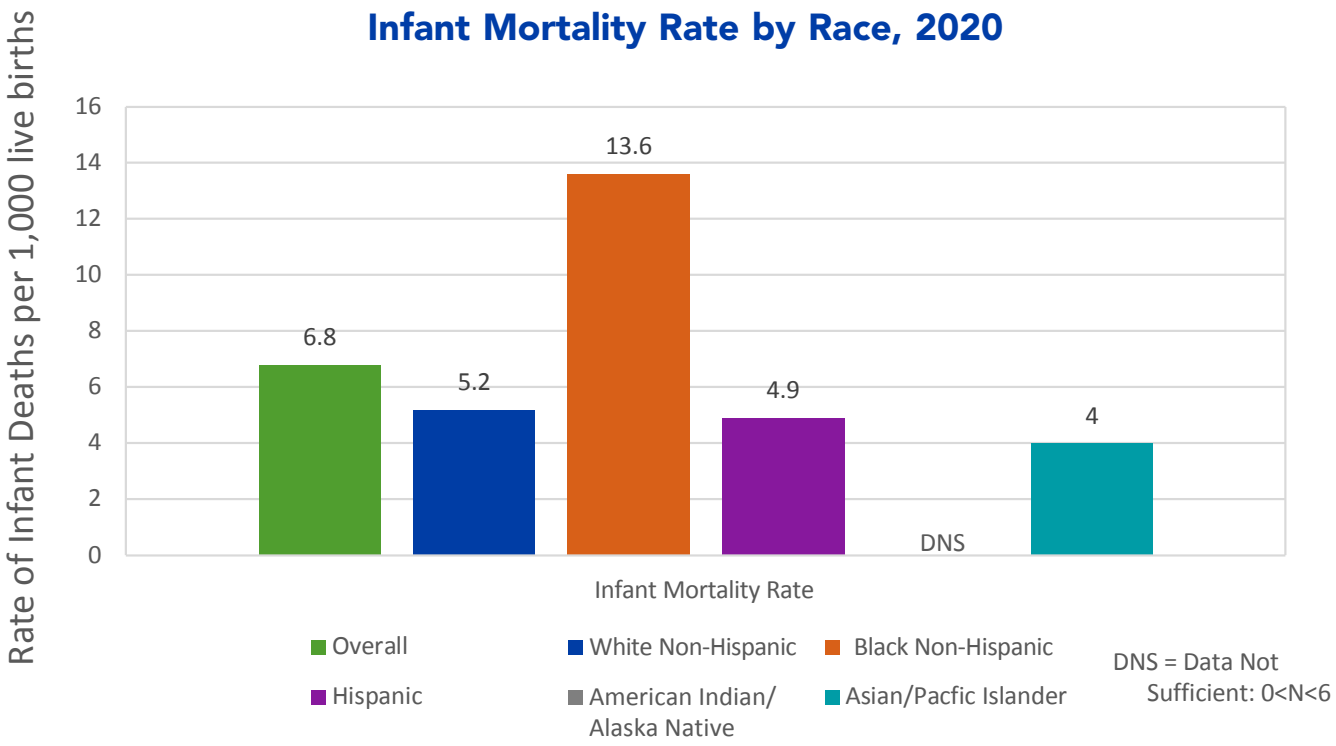
Infant Mortality Rate

Infant mortality is defined as a death of a baby before his or her first birthday and is expressed as a rate per 1,000 live births.

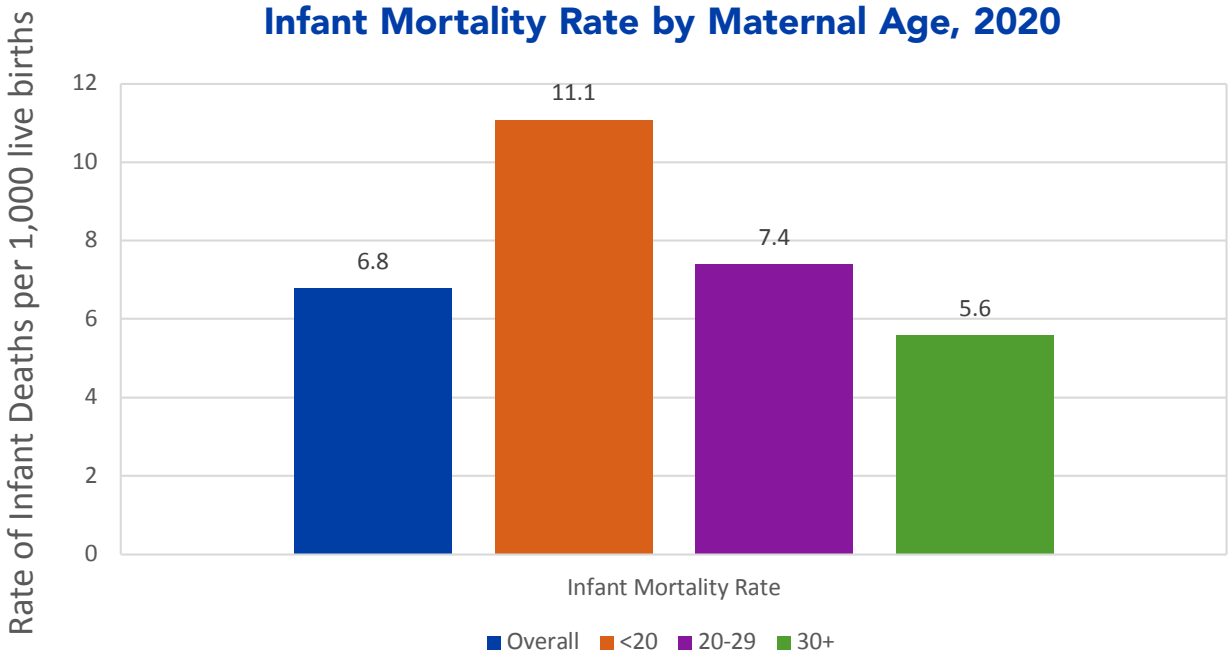
Infant Mortailty Rate by County, 2020



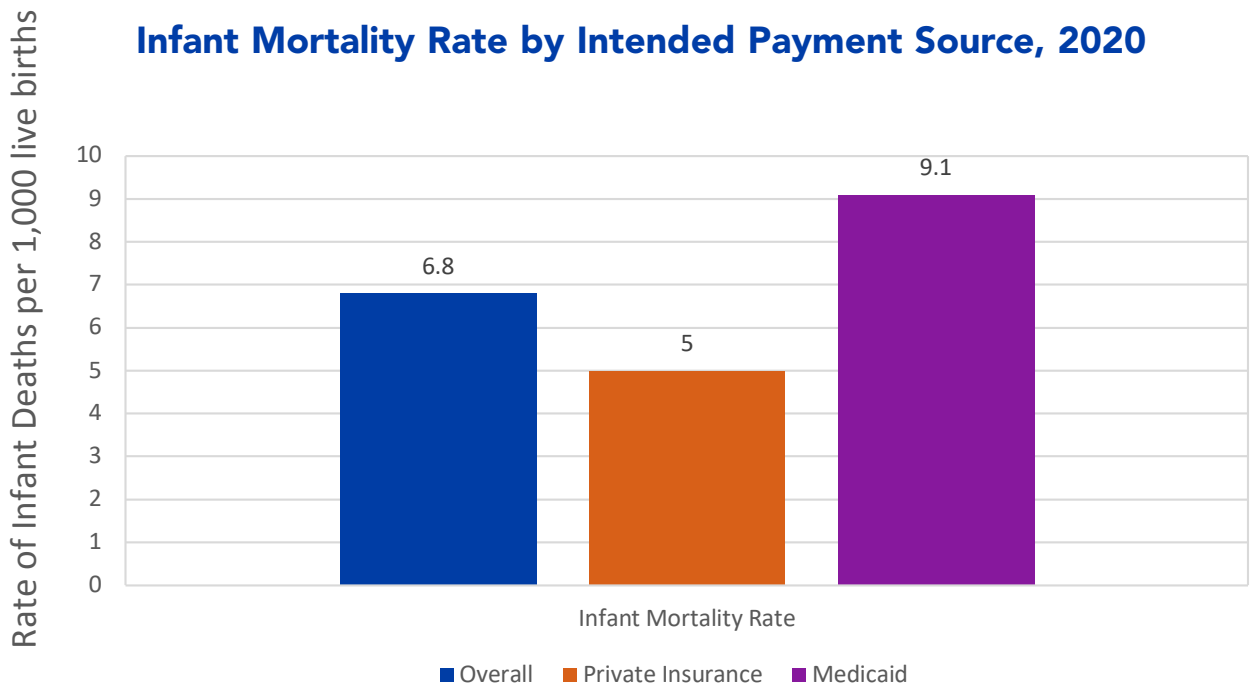
Source: MDHHS Vital Stats



Source: Maternal and Child Health, 2020 Infant Health Statistics, Michigan



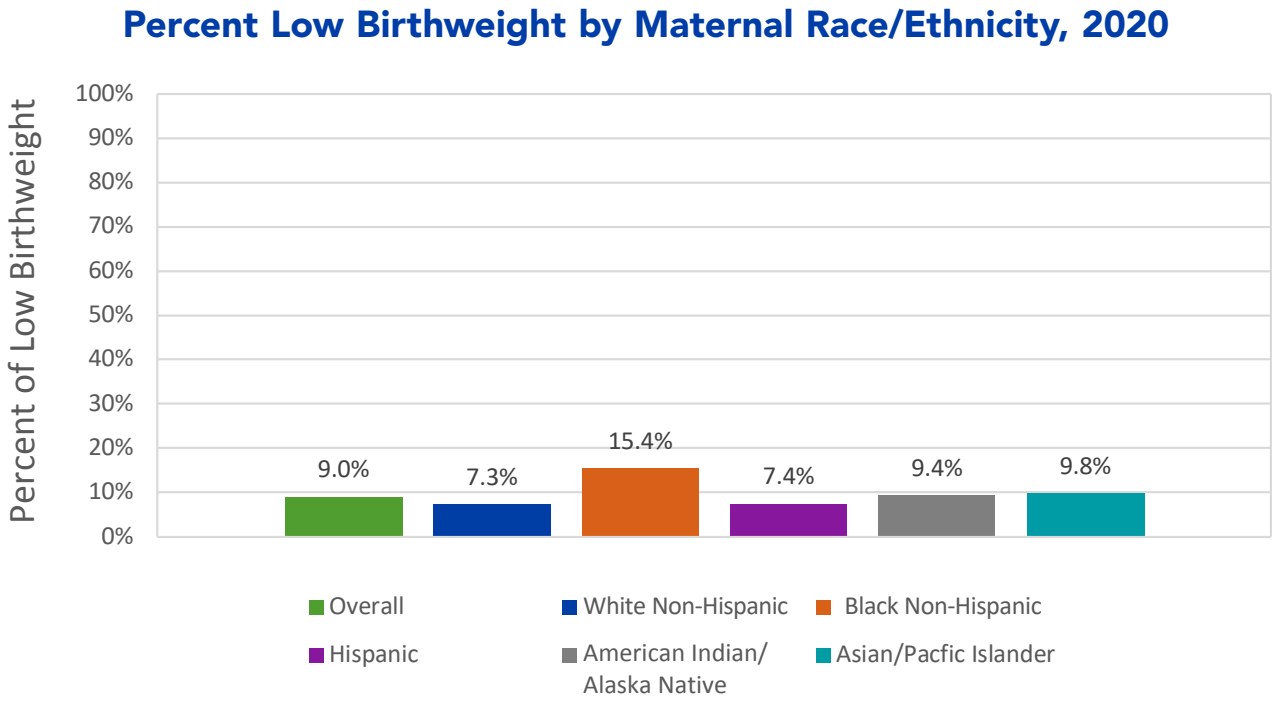
Source: Maternal and Child Health, 2020 Infant Health Statistics, Michigan



Source: Maternal and Child Health, 2020 Infant Health Statistics, Michigan

Low Birthweight

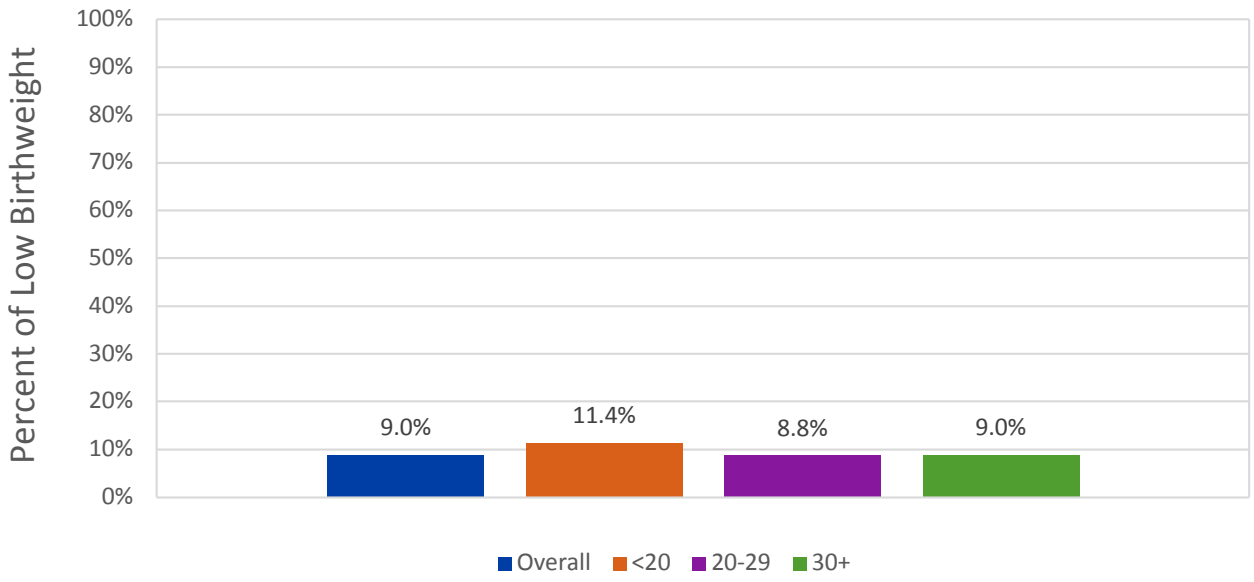
Low birthweight is defined as the number of births with baby birthweight <2,500 grams per 100 live births.



Source: Maternal and Child Health, 2020 Infant Health Statistics, Michigan

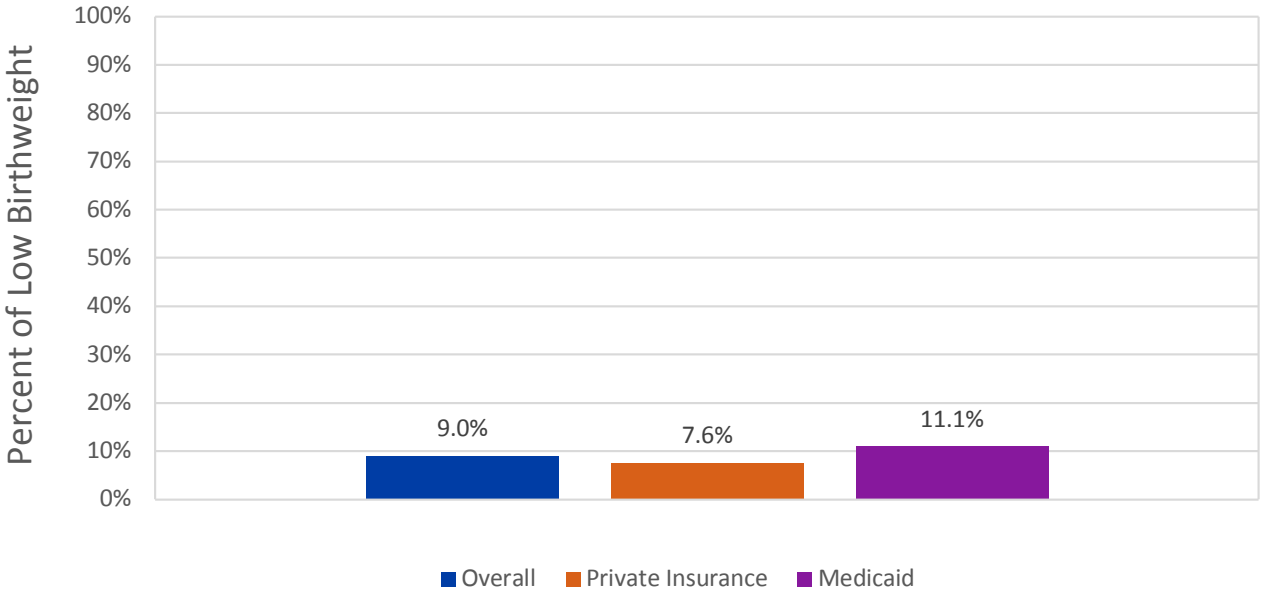
APPENDICES

Percent Low Birthweight by Maternal Age, 2020



Source: Maternal and Child Health, 2020 Infant Health Statistics, Michigan

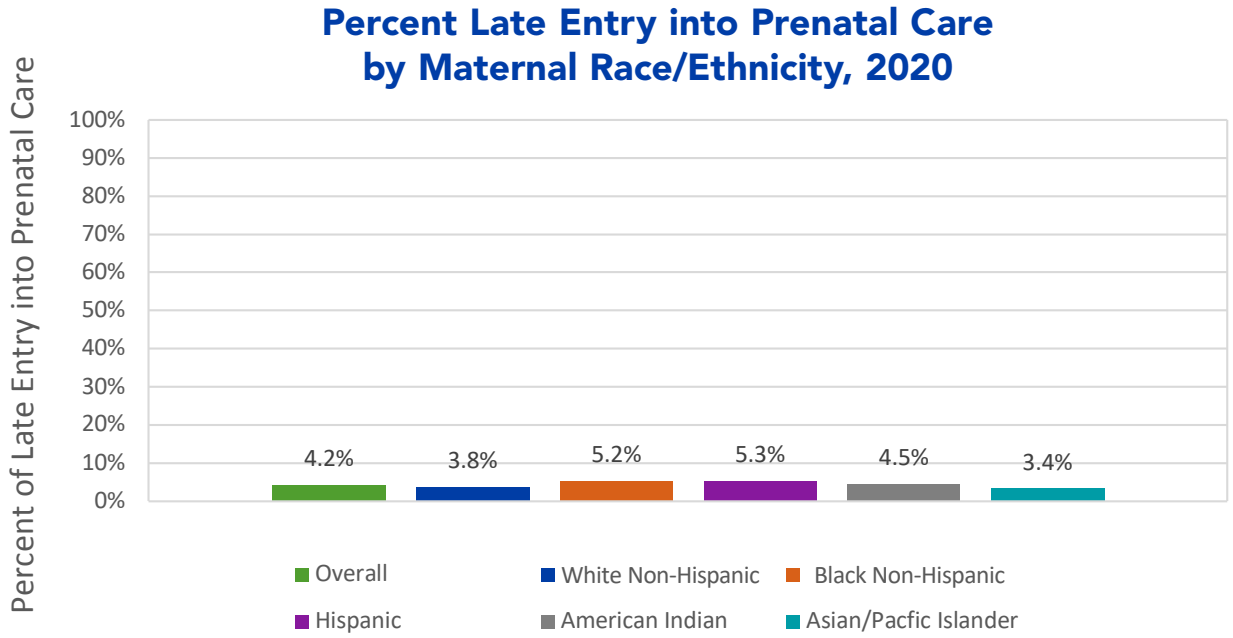
Percent Low Birthweight by Intended Payment Source, 2020



Source: Maternal and Child Health, 2020 Infant Health Statistics, Michigan

Prenatal Care

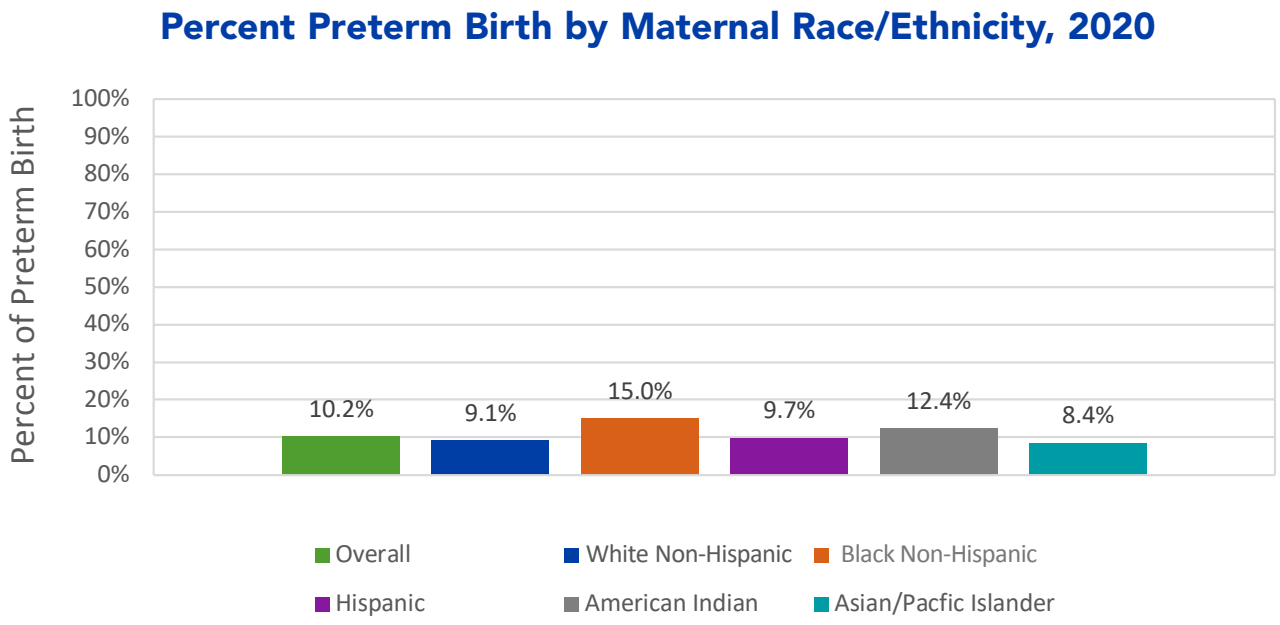
Late entry into prenatal care refers to starting prenatal care in the 7th – 9th month of gestation.



Source: Maternal and Child Health, 2020 Infant Health Statistics, Michigan

Preterm Birth

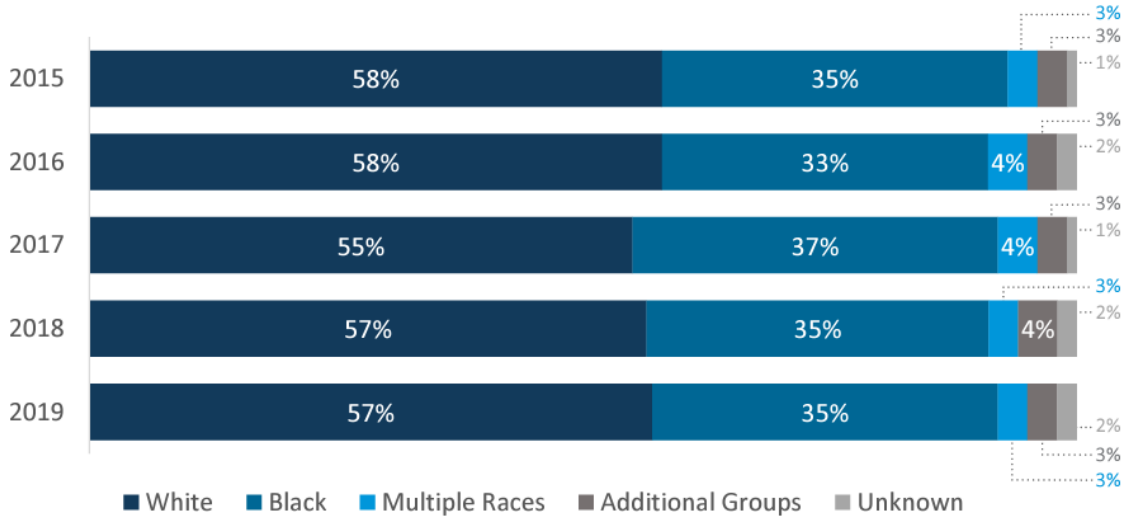
Preterm birth rate is defined as a number of births delivered before 37 completed weeks of gestation per 100 live births. Gestational age is based on the obstetric estimate of gestation.



Source: Maternal and Child Health, 2020 Infant Health Statistics, Michigan

Child Deaths

Michigan Resident Child Deaths by child's race and year of death (2015-2019)



Note: *Additional groups includes American Indian children and Asian or Pacific Islander children as well as children of all other races.*

Source: Keeping Kids Alive

Rate of Death for Michigan Resident Children By Child's Bridged Race (2015-2019)	
Child's Bridged Race	Rate of Death per 100,000 Children
White	41.9
Black	106.1
Asian or Pacific Islander	30.7
American Indian	45.4

Source: Keeping Kids Alive

Area Agency on Aging 1-B
aaa1b.org

ACCESS (Arab Community Center for Economic and Social Services)
accesscommunity.org

American Cancer Society
cancer.org

American Heart Association
heart.org

AmeriCorps
americorps.gov

Beaumont Behavioral Health Center
beaumontbh.com

Beaumont Community Resource Network
communityresource.beaumont.org

Beaumont Health Community Health
beaumont.org/community

Common Ground
commongroundhelps.org

Detroit Area Agency on Aging
detroitseniorsolution.org

Healthy Grosse Pointe and Harper Woods Coalition
healthygphw.org

Hegira Health
hegirahealth.org

Macomb County Health Department
health.macombgov.org

Michigan Department of Health and Human Services (MDHHS)
michigan.gov/mdhhs

Michigan Community Health Worker Alliance
michwa.org

Michigan Fitness Foundation
michiganfitness.org

National Association of Community Health Centers
nachc.org

National Kidney Foundation of Michigan
nkfm.org

Oakland University William Beaumont School of Medicine
oakland.edu/medicine

Oakland County Health Division
oakgov.com/health

Oakland Community Health Network
oaklandchn.org

Safe Kids of Michigan
safekids.org

Taylor Substance Abuse Task Force
taylortaskforce.com

Taylor Teen Health Center
beaumont.org/locations/beaumont-teen-health-center-taylor

The Guidance Center
guidance-center.org

The Information Center
theinfocenter.org

The Senior Alliance
thesenioralliance.org

Troy Community Coalition
troy.k12.mi.us/community-links/tccoalition

United Way of Michigan 211
Mi211.org

Wayne County Department of Health, Human, and Veterans Services
waynecounty.com/departments/hhvs/wellness/provider-information.aspx

ZIP code	PO name	Dominant county	Beaumont overall	Dearborn	Farmington Hills	Grosse Pointe	Royal Oak	Taylor	Trenton	Troy	Wayne
48002	Allenton	St. Clair	X							X	
48003	Almont	Lapeer	X				X			X	
48005	Armada	Macomb	X							X	
48009	Birmingham	Oakland	X				X				
48015	Center Line	Macomb	X				X				
48017	Clawson	Oakland	X				X				
48021	Eastpointe	Macomb	X			X					
48025	Franklin	Oakland	X				X				
48026	Fraser	Macomb	X			X	X				
48030	Hazel Park	Oakland	X				X				
48033	Southfield	Oakland	X		X		X				
48034	Southfield	Oakland	X		X		X				
48035	Clinton Township	Macomb	X			X					
48038	Clinton Township	Macomb	X							X	
48042	Macomb	Macomb	X				X			X	
48044	Macomb	Macomb	X				X			X	
48045	Harrison Township	Macomb	X			X					
48047	New Baltimore	Macomb	X							X	
48051	New Baltimore	Macomb	X							X	
48065	Romeo	Macomb	X				X			X	
48066	Roseville	Macomb	X			X	X				
48067	Royal Oak	Oakland	X				X				
48069	Pleasant Ridge	Oakland	X				X				
48070	Huntington Woods	Oakland	X				X				
48071	Madison Heights	Oakland	X				X			X	
48072	Berkley	Oakland	X				X				
48073	Royal Oak	Oakland	X				X				
48075	Southfield	Oakland	X		X		X				
48076	Southfield	Oakland	X				X				

ZIP code	PO name	Dominant county	Beaumont overall	Dearborn	Farmington Hills	Grosse Pointe	Royal Oak	Taylor	Trenton	Troy	Wayne
48080	Saint Clair Shores	Macomb	X			X					
48081	Saint Clair Shores	Macomb	X			X					
48082	Saint Clair Shores	Macomb	X			X					
48083	Troy	Oakland	X				X			X	
48084	Troy	Oakland	X				X			X	
48085	Troy	Oakland	X				X			X	
48088	Warren	Macomb	X				X				
48089	Warren	Macomb	X			X	X				
48091	Warren	Macomb	X				X				
48092	Warren	Macomb	X				X			X	
48093	Warren	Macomb	X				X				
48094	Washington	Macomb	X				X			X	
48095	Washington	Macomb	X				X			X	
48096	Ray	Macomb	X							X	
48098	Troy	Oakland	X				X			X	
48101	Allen Park	Wayne	X	X				X			
48111	Belleville	Wayne	X								X
48117	Carleton	Monroe	X						X		
48120	Dearborn	Wayne	X	X							
48122	Melvindale	Wayne	X	X				X			
48124	Dearborn	Wayne	X	X				X			
48125	Dearborn Heights	Wayne	X	X				X			
48126	Dearborn	Wayne	X	X				X			
48127	Dearborn Heights	Wayne	X	X	X			X			
48128	Dearborn	Wayne	X	X				X			
48134	Flat Rock	Wayne	X	X				X	X		
48135	Garden City	Wayne	X		X						X
48138	Grosse Ile	Wayne	X					X	X		

ZIP code	PO name	Dominant county	Beaumont overall	Dearborn	Farmington Hills	Grosse Pointe	Royal Oak	Taylor	Trenton	Troy	Wayne
48141	Inkster	Wayne	X	X				X			X
48146	Lincoln Park	Wayne	X	X				X			
48150	Livonia	Wayne	X		X						
48152	Livonia	Wayne	X		X		X				
48154	Livonia	Wayne	X		X		X				
48164	New Boston	Wayne	X	X				X	X		
48166	Newport	Monroe	X						X		
48167	Northville	Oakland	X		X		X				
48168	Northville	Wayne	X		X		X				
48170	Plymouth	Wayne	X		X						
48173	Rockwood	Wayne	X					X	X		
48174	Romulus	Wayne	X	X				X	X		X
48179	South Rockwood	Monroe	X					X	X		
48180	Taylor	Wayne	X	X				X			
48183	Trenton	Wayne	X	X				X	X		
48184	Wayne	Wayne	X	X				X			X
48185	Westland	Wayne	X		X						X
48186	Westland	Wayne	X	X							X
48187	Canton	Wayne	X								X
48188	Canton	Wayne	X								X
48192	Wyandotte	Wayne	X	X				X	X		
48193	Riverview	Wayne	X	X				X	X		
48195	Southgate	Wayne	X	X				X	X		
48203	Highland Park	Wayne	X				X				
48204	Detroit	Wayne	X		X						
48205	Detroit	Wayne	X			X					
48207	Detroit	Wayne	X			X					
48209	Detroit	Wayne	X	X							

ZIP code	PO name	Dominant county	Beaumont overall	Dearborn	Farmington Hills	Grosse Pointe	Royal Oak	Taylor	Trenton	Troy	Wayne
48210	Detroit	Wayne	X	X							
48212	Hamtramck	Wayne	X				X				
48213	Detroit	Wayne	X			X					
48214	Detroit	Wayne	X			X					
48215	Detroit	Wayne	X			X					
48217	Detroit	Wayne	X	X				X			
48218	River Rouge	Wayne	X	X				X			
48219	Detroit	Wayne	X		X		X				
48220	Ferndale	Oakland	X				X				
48221	Detroit	Wayne	X		X		X				
48223	Detroit	Wayne	X		X		X				
48224	Detroit	Wayne	X			X					
48225	Harper Woods	Wayne	X			X					
48227	Detroit	Wayne	X		X						
48228	Detroit	Wayne	X	X	X						
48229	Ecorse	Wayne	X	X				X			
48230	Grosse Pointe	Wayne	X			X					
48234	Detroit	Wayne	X			X	X				
48235	Detroit	Wayne	X		X		X				
48236	Grosse Pointe	Wayne	X			X					
48237	Oak Park	Oakland	X				X				
48238	Detroit	Wayne	X		X						
48239	Redford	Wayne	X		X		X				
48240	Redford	Wayne	X		X		X				
48242	Detroit	Wayne	X	X				X	X		X
48301	Bloomfield Hills	Oakland	X				X				
48302	Bloomfield Hills	Oakland	X				X				
48304	Bloomfield Hills	Oakland	X				X			X	

ZIP code	PO name	Dominant county	Beaumont overall	Dearborn	Farmington Hills	Grosse Pointe	Royal Oak	Taylor	Trenton	Troy	Wayne
48306	Rochester	Oakland	X				X			X	
48307	Rochester	Oakland	X				X			X	
48309	Rochester	Oakland	X				X			X	
48310	Sterling Heights	Macomb	X				X			X	
48312	Sterling Heights	Macomb	X				X			X	
48313	Sterling Heights	Macomb	X				X			X	
48314	Sterling Heights	Macomb	X				X			X	
48315	Utica	Macomb	X				X			X	
48316	Utica	Macomb	X				X			X	
48317	Utica	Macomb	X				X			X	
48320	Keego Harbor	Oakland	X				X				
48322	West Bloomfield	Oakland	X		X		X				
48323	West Bloomfield	Oakland	X		X		X				
48324	West Bloomfield	Oakland	X				X				
48326	Auburn Hills	Oakland	X				X			X	
48327	Waterford	Oakland	X				X				
48328	Waterford	Oakland	X				X				
48329	Waterford	Oakland	X				X				
48331	Farmington	Oakland	X		X		X				
48334	Farmington	Oakland	X		X		X				
48335	Farmington	Oakland	X		X		X				
48336	Farmington	Oakland	X		X		X				
48340	Pontiac	Oakland	X				X				
48341	Pontiac	Oakland	X				X				
48342	Pontiac	Oakland	X				X				
48346	Clarkston	Oakland	X				X				
48348	Clarkston	Oakland	X				X			X	
48357	Highland	Oakland	X				X				

ZIP code	PO name	Dominant county	Beaumont overall	Dearborn	Farmington Hills	Grosse Pointe	Royal Oak	Taylor	Trenton	Troy	Wayne
48359	Lake Orion	Oakland	X				X			X	
48360	Lake Orion	Oakland	X				X			X	
48362	Lake Orion	Oakland	X				X			X	
48363	Oakland	Oakland	X				X			X	
48367	Leonard	Oakland	X				X			X	
48370	Oxford	Oakland	X				X			X	
48371	Oxford	Oakland	X				X			X	
48374	Novi	Oakland	X		X		X				
48375	Novi	Oakland	X		X		X				
48377	Novi	Oakland	X		X		X				
48380	Milford	Oakland	X				X				
48381	Milford	Oakland	X				X				
48382	Commerce Township	Oakland	X				X				
48383	White Lake	Oakland	X				X				
48386	White Lake	Oakland	X				X				
48390	Walled Lake	Oakland	X		X		X				
48393	Wixom	Oakland	X		X		X				
48428	Dryden	Lapeer	X				X			X	
48444	Imlay City	Lapeer	X							X	
48455	Metamora	Lapeer	X				X			X	
48462	Ortonville	Oakland	X				X			X	

Progress of Beaumont, Dearborn
2019 CHNA

The implementation strategy for fiscal years 2020-2022 focused on two priority health needs – chronic disease prevention and management (cardiovascular disease, diabetes and obesity), and mental health. Progress for these priority needs for years 2020-2022 is summarized below. These strategies were built upon the programs and initiatives established in the 2019 CHNA.

To achieve the most impact in the community, Beaumont Hospital, Dearborn continued work with Healthy Dearborn, a multi-year initiative that expands access to the community of programs and services designed to encourage healthy eating and active living. Healthy Dearborn had strong support and partnerships including the City of Dearborn, Dearborn Public Schools and many individuals including nonprofits and community members. Action teams of the coalition include Healthy Foods, Healthy Environments for Physical Activity, Healthy at Work, Healthy Schools, Health Disparities/Health Equity, Inclusive Health Committee for People with Disabilities, and Healthy Communications. The following progress/outcomes for Beaumont, Dearborn are described below:

Priority 1: Chronic Disease prevention and management (cardiovascular disease, diabetes, obesity)

Goal 1: Decrease rates of chronic disease in children and adults by promoting healthy eating and active living behaviors.

- Distributed 1,016 lbs. of seeds in partnership with Gleaners, the City of Dearborn, University of Michigan-Dearborn, and MSU Extension to Dearborn residents for gardening. Formally known as the "seed library," Healthy Dearborn provided monthly virtual gardening lessons from May to October, with over 200 participants. All participants were provided with additional gardening information and healthy recipe ideas.
- The school action team worked to ensure that all Dearborn Public School students were meeting the state recommended standard for physical activity and consuming the recommended amount of daily fresh fruits and vegetables.
- Beaumont Hospital Dearborn sponsored the Dearborn Farmers Market, providing access to fresh fruits and vegetables to the community. Beaumont provided staff support, marketing, and outreach for the market.
- In 2020, the Healthy Dearborn coalition partnered with Taste the Local Difference and the Michigan Department of Health and Human Services to purchase 20 bikes and 3 bike racks for Brome Eatery employees to use throughout the day. As part of their workplace wellness program, Healthy Dearborn provided support for local businesses to adopt a workplace wellness program that fosters a healthy work environment.
- Partnered on the City of Dearborn's Multimodal Transportation Plan to improve connectivity of people and resources throughout Dearborn. Dearborn students created a policy brief on "Multi Modal Transit and Health."

- Developed a Dearborn Healthy Street's pilot to help all residents find safe, healthy ways to get outside, recreate, exercise and access essential services by providing greater access to public right of ways traditionally used for motor vehicle transportation.
- Implemented a Walk n' Roll and Bike Share program through social media outlets and partners. Walk n' Roll occurred during the months of May through October and had over 1,200 participants during this CHNA cycle.
- In September 2021, the Safe Routes to School's program launched through Healthy Dearborn. 8,387 Dearborn students have participated in the SRTS program across 10 elementary schools. Additionally, 2 bikes were awarded to students, 4 bike racks were installed at schools, and hundreds of water bottles and t-shirts were awarded to students for participating.
- Beaumont Health partnered with the Michigan Fitness Foundation to implement the Safe Routes to Health AmeriCorps program. The focus of the program was to connect community residents to health, wellness, and physical activity. One member was hired to provide support for Beaumont Dearborn community activities and events related to CHNA strategies.
- Walk with Ease (WWE) was provided in partnership with the National Kidney Foundation of Michigan during the 2020-2022 implementation years. The WWE program was designed for adults with arthritis and older adults. The program teaches participants how to safely make physical activity part of their everyday life. Participants walk on their own schedule at their own pace with a goal of building to 30 minutes of walking at least three times weekly.

Goal 2: Decrease cardiovascular disease risk factors and prevent death from sudden cardiac arrest.

- Beaumont Dearborn staff provided education on cardiovascular health to community groups through the Beaumont speakers bureau and at additional events throughout the Dearborn service area. Health professionals provided a total of 12 hours of health-related information on chronic disease management and other prevention education was provided to 640 attendees.
- Implemented over the three-year span of the CHNA, the hypertension self-management program is an eight-week evidence-based workshop designed to provide the individual with information, tips, and tools to help them take control of their blood pressure. Participants learned about the basics of hypertension, stress management, the importance of nutrition, and incorporating physical activity.
- During 2020-2022, 71 persons received a heart health screening.

Goal 3: Decrease rate of new diabetes cases and of diabetes complications.

- Beaumont Dearborn provided the national Diabetes Prevention Program (DPP) for the community. DPP is a free, research-based program for those who want to prevent Type 2 diabetes. The program focuses on lifestyle changes related to healthy eating and physical activity, as well as problem solving and coping skills. The diabetes prevention program has been proven to be twice as effective as medication alone at preventing Type 2 diabetes. This program consists of 16 weekly sessions, followed by monthly maintenance sessions. This year- long program for those with pre-diabetes was provided to over 800 individuals with weight loss of over 5% after 12 months in the Dearborn service area.

- The Diabetes Personal Action Toward Health (Diabetes PATH) program is an evidence-based self-management program developed for those with chronic pain and diabetes. Diabetes path is designed specifically to enhance patient confidence in their ability to manage their disease and to work more effectively with their health care providers which reduces both outpatient visits and hospitalizations. The class is for those with either Type 2 diabetes or chronic pain and their caregivers. Participants met for six weeks, and the program was provided to almost 100 individuals in the Dearborn service area.

Priority 2: Mental Health

Goal 1: Decrease rate of mental health and substance use disorders.

- Beaumont Dearborn provided physical and mental health services to youth in the community at the Taylor and River Rouge teen health centers and through a wellness program at Truman High School. At Taylor Teen Health Center, nearly 70,000 students received services, nearly 12,000 students at River Rouge teen health center, and at Truman High School, nearly 13,000 students received services (primary care and/or behavioral health services). Mental and behavioral health education programming was provided to 7,206 students. Taking Pride in Prevention programming was provided to 2,392 students.
- Beaumont Health continued its extensive expansion of behavioral health services in 2021 by opening a new Behavioral Health Hospital and welcoming the inaugural class for Beaumont's first psychiatry residency program. In addition, partnerships with local human service organizations were vetted and pursued to expand the services available to the community. The continuum of care strategic plan continued to evolve in 2021 and included proposed expansion of inpatient and outpatient services to better meet the needs of community members across the lifespan. ■

Progress of Beaumont, Farmington Hills
2019 CHNA

The implementation strategy for fiscal years 2020-2022 focused on two priority health needs – chronic disease prevention and management (cardiovascular disease, diabetes and obesity), and mental health. Progress for these priority needs for years 2020-2022 is summarized below. These strategies were built upon the programs and initiatives established in the 2019 CHNA.

To achieve the greatest impact in the community, Beaumont Hospital, Farmington Hills worked closely with community organizations to expand access to the community of programs and services. The following progress/outcomes for Beaumont, Farmington Hills are described below:

Priority 1: Chronic Disease prevention and management (cardiovascular disease, diabetes, obesity)

Goal 1: Decrease rates of chronic disease in children and adults by promoting healthy eating and active living behaviors.

- In 2020, Beaumont's Healthy Farmington-Farmington Hills coalition provided five community meetings that represented residents and representatives of local government, schools, business, health care, social service, faith based and other community organizations. In total, 30 individuals participated in coalition activities.
- Collaborated with the Farmington Farmers Market during the summer for 3 hours each week providing education on topics such as health eating, active living, heart health, diabetes prevention, stroke education, and behavioral health. 1,500 community members were impacted and over 500 pedometers were distributed.
- In addition to providing education at the Farmers Market, Beaumont provided the Farmington Farmers Market Walkabout's with pedometers, shoe lights, drawstring bags, and water bottles. 358 persons participated in the Walkabout's, walking a total of 658 miles during the market season.
- Wellness Walk and Talk sessions, including approximately 30 participants, were held in partnership with the Farmington Hills Nature Center (Heritage Park), with temperature and health screening, facial masks, outdoor classroom sessions and social distancing implemented as safety precaution. In 2022 sessions added topics of heart disease, diabetes, and obesity.
- The Walk With Ease (WWE) program, an evidence-based program, reached over 100 participants in the greater Farmington community. The WWE program was designed for adults with arthritis and older adults. The program combines self-paced walks and discussions about health-related topics.

Goal 2: Decrease cardiovascular disease risk factors and prevent death from sudden cardiac arrest.

- Implemented over the three-year span of the CHNA, the hypertension self-management program is an eight-week evidence-based workshop designed to provide the individual with information, tips, and tools to help them take control of their blood pressure. Participants learned about the basics of hypertension, stress management, the importance of nutrition, and incorporating physical activity.

- During 2020-2022, 72 persons participated in Heart Health Screenings.

Goal 3: Decrease rate of new diabetes cases and of diabetes complications.

- Beaumont Farmington Hills provided the national Diabetes Prevention Program (DPP) for the community. DPP is a free, research-based program for those who want to prevent Type 2 diabetes. The program focuses on lifestyle changes related to healthy eating and physical activity, as well as problem solving and coping skills. The diabetes prevention program has been proven to be twice as effective as medication alone at preventing Type 2 diabetes. This program consists of 16 weekly sessions, followed by monthly maintenance sessions. This year- long program for those with pre-diabetes was provided to over 1,100 individuals with weight loss of over 5% after 12 months in the Farmington Hills service area.
- In partnership with the National Kidney Foundation of Michigan and the Area Agency on Aging 1B, the Diabetes Personal Action Toward Health (Diabetes PATH) program is an evidence-based self-management program developed for those with chronic pain and diabetes. Diabetes PATH is designed specifically to enhance patient confidence in their ability to manage their disease and to work more effectively with their health care providers which reduces both outpatient visits and hospitalizations. The class is for those with either Type 2 diabetes or chronic pain and their caregivers. Participants met for six weeks, and the program was provided to almost 150 individuals in the Farmington Hills service area.

Priority 2: Mental Health

Goal 1: Decrease rate of mental health and substance use disorders.

- Awarded an additional year of service, including $35,000 in funding, to continue the Greater Farmington Youth Substance Abuse Coalition (GFYSAC) with support from the Alliance of Coalitions for Healthy Communities.
- Facilitated two free Narcan trainings with the cities of Farmington Hills and Farmington, educating 115 community members on safely using Narcan.
- Beaumont Farmington Hills supported an annual drug take back day with the City of Farmington, the City of Farmington Hills, and City of Farmington Hills police and fire departments.
- In coordination with Beaumont's Drug Takeback Day, provided 1,400 Deterra liquid drug disposal pouches to prevent diversion and abuse of unused liquid medications to the cities of Farmington Hills and Farmington.
- Beaumont Farmington Hills provides physical and mental health services to youth in the community at the Redford teen health centers. At Redford teen health center, over 8,000 students received services (primary care and/or behavioral health services).
- Beaumont Health continued its extensive expansion of behavioral health services in 2021 by opening a new Behavioral Health Hospital and welcoming the inaugural class for Beaumont's first psychiatry residency program. In addition, partnerships with local human service organizations were vetted and pursued to expand the services available to the community. The continuum of care strategic plan continued to evolve in 2021 and included proposed expansion of inpatient and outpatient services to better meet the needs of community members across the lifespan. ■

Progress of Beaumont, Grosse Pointe
2019 CHNA

The implementation strategy for fiscal years 2020-2022 focused on two priority health needs – chronic disease prevention and management (cardiovascular disease, diabetes, and obesity), and mental health. Progress for these priority needs for years 2020-2022 is summarized below. These strategies were built upon the programs and initiatives established in the 2019 CHNA.

To achieve the greatest impact in the community, Beaumont Hospital, Grosse Pointe worked closely with community organizations to expand access to the community of programs and services. The following progress/outcomes for Beaumont, Grosse Pointe are described below:

Priority 1: Chronic Disease prevention and management (cardiovascular disease, diabetes, obesity)

Goal 1: Decrease rates of chronic disease in children and adults by promoting healthy eating and active living behaviors.

- Partnered with the Grosse Pointe School System to build a model school garden program for Defer Elementary School in Grosse Pointe Park.
- Detroit Abloom Wellness Park offered Beaumont's Food is Medicine program, healthy cooking, yoga, and meditation. Health experts gave a 20–30-minute cooking demonstration and time afterwards to share a meal. Over 400 participants enjoyed 18 weeks of cooking demos.
- Beaumont Grosse Pointe leads a multi-sector coalition that currently has 30 individuals participating to promote healthy eating and active living to address cardiovascular disease, diabetes, and obesity.
- Over 100 individuals participated in nutrition education/healthy cooking classes. 12 classes were offered.
- Pointe Peddlers weekly cycling group is a structured opportunity for riders and walkers to participate in a socially distant, masked, outdoor bike-ride to encourage and inspire physical activity through a social environment and group support. Cyclists complete a 5 to 6 mile ride and the group rides or walks at a comfortable pace attracting over 1,200 people to various routes throughout the Grosse Pointes, Harper Woods and Detroit.
- Partnered with the Grosse Pointe and Harper Woods school districts' vision for a school walkability program, Safe Routes to Schools program.
- Health Community Grosse Pointe/Harper Woods (GPHW) offered a drop-in weekly yoga and meditation series. The sessions were offered every Saturday; outside and socially distanced with masks, under the pavilion. Sessions ran June through October.
- The Walk With Ease (WWE) program, an evidence-based program reached over 80 individuals during 2020-2022. WWE was designed for adults with arthritis and older adults. The program teaches participants how to safely make physical activity part of their everyday life.
- Beaumont Health partnered with the Michigan Fitness Foundation to implement the Safe Routes to Health AmeriCorps program. The focus of the program was to connect community residents

to health, wellness, and physical activity. One member was hired to provide support for community activities and events related to CHNA strategies.

- Drop-in weekly yoga, meditation and tai chi programs were offered under the outdoor pavilion at Detroit Abloom. Yoga sessions had 192 participants, tai chi had 192 participants, and meditation had 96 participants over the 16-week sessions.
- Community nutrition education was provided to increase awareness of principles of healthy eating, nutrition education booths and presentations are provided by registered dietitians at community events upon request and in collaboration with schools, senior centers, faith-based organizations, community agencies and service organizations. In 2020 266 individuals participated. Self-help, fitness and exercise classes were also offered with 463 individuals participating.

Goal 2: Decrease cardiovascular disease risk factors and prevent death from sudden cardiac arrest.

- Beaumont Health offered weekly free meditation sessions in an outdoor setting by Dr. Lakshmi Saleem in the underserved neighborhood of Jefferson-Chalmers in Detroit.
- Implemented over the three-year span of the CHNA, the hypertension self-management program is an eight-week evidence-based workshop designed to provide the individual with information, tips, and tools to help them take control of their blood pressure. Participants learned about the basics of hypertension, stress management, the importance of nutrition, and incorporating physical activity.

Goal 3: Decrease rate of new diabetes cases and of diabetes complications.

- Beaumont Grosse Pointe, in partnership with community centers, senior centers, and other community organizations provided the national Diabetes Prevention Program (DPP) for the community. DPP is a free, research-based program for those who want to prevent Type 2 diabetes. The program focuses on lifestyle changes related to healthy eating and physical activity, as well as problem solving and coping skills. The diabetes prevention program has been proven to be twice as effective as medication alone at preventing Type 2 diabetes. This program consists of 16 weekly sessions, followed by monthly maintenance sessions. This year- long program for those with pre-diabetes was provided to over 500 individuals with weight loss of over 5% after 12 months in the Grosse Pointe service area.
- In partnership with libraries, senior centers, and community organizations, the Diabetes Personal Action Toward Health (Diabetes PATH) program is an evidence-based self-management program developed for those with chronic pain and diabetes. Diabetes PATH is designed specifically to enhance patient confidence in their ability to manage their disease and to work more effectively with their health care providers which reduces both outpatient visits and hospitalizations. The class is for those with either Type 2 diabetes or chronic pain and their caregivers. Participants met for six weeks, and the program was provided to almost 50 individuals in the Grosse Pointe service area.
- Diabetes education was provided to 271 individuals in the community.

Priority 2: Mental Health

Goal 1: Decrease rate of mental health and substance use disorders.

- Beaumont Health continued its extensive expansion of behavioral health services in 2021 by opening a new Behavioral Health Hospital and welcoming the inaugural class for Beaumont's first psychiatry residency program. In addition, partnerships with local human service organizations were vetted and pursued to expand the services available to the community. The continuum of care strategic plan continued to evolve in 2021 and included proposed expansion of inpatient and outpatient services to better meet the needs of community members across the lifespan.
- Question, Persuade, Refer (QPR) suicide prevention training was offered. The program designed for community members to learn how to take action when you are concerned someone is at risk for suicide. The QPR training, in partnership with Detroit Wayne Integrated Health Authority, had 133 participants in the training.
- Parents who Host Lose the Most campaign reminds parents of the dangers of underage drinking and discourages parents from providing alcohol to teens. Window decals were provided for local liquor stores and banners were displayed at the high schools for their graduation ceremonies and other key locations.
- Suicide awareness walks and mental health education were provided to 250 persons. ■

Progress of Beaumont, Royal Oak
2019 CHNA

The implementation strategy for fiscal years 2020-2022 focused on two priority health needs – chronic disease prevention and management (cardiovascular disease, diabetes and obesity), and mental health. Progress for these priority needs for years 2020-2022 is summarized below. These strategies were built upon the programs and initiatives established in the 2019 CHNA.

To achieve the greatest impact in the community, Beaumont Hospital, Royal Oak worked closely with community organizations to expand access to the community of programs and services. The following progress/outcomes for Beaumont, Royal Oak are described below:

Priority 1: Chronic Disease prevention and management (cardiovascular disease, diabetes, obesity)

Goal 1: Decrease rates of chronic disease in children and adults by promoting healthy eating and active living behaviors.

- To best address the conditions, behaviors, and socioeconomic and environmental factors that drive health, Beaumont Royal Oak leads a multi-sector coalition that currently has 12 individuals participating to promote healthy eating and active living to address cardiovascular disease, diabetes, and obesity. Coalition members include local government leadership, community residents, the local school system, businesses, nonprofit organizations, faith-based organizations, medical providers, insurance providers, and those representing chronic disease organizations.
- Physical activity opportunities were provided to support risk reduction. The Beaumont Gets Walking Program was offered with the mission of improving health, fitness, and quality of life through daily physical activity. The walking program included neighborhood walking groups, Walk with a Doc and the utilization of the Carrot App, an online step tracking tool with 30 individuals participating in one of the activities.
- Youth physical activity and lifestyle behavior education opportunities were offered through the CATCH Physical Activity program. The program provides children with fun, physical education/activities, specifically aimed at increasing their moderate-to-vigorous physical activity while at preschool. The lesson plans and physical education activities, combined with spirited music, colorful hand puppets and other stimulating visuals, create an environment where physical activity, health education, and healthy eating behaviors are valued and taught with over 768 kids participating.
- The Walk With Ease (WWE) program, an evidence-based program, reached 12 participants in Royal Oak. WWE was designed for adults with arthritis and older adults. The program teaches participants how to safely make physical activity part of their everyday life. Participants walk on their own schedule at their own pace with a goal of building to 30 minutes of walking at least three times weekly.
- Beaumont Health partnered with the Michigan Fitness Foundation to implement the Safe Routes to Health AmeriCorps program. The focus of the program was to connect community residents to health, wellness, and physical activity. One member was hired to provide support for Beaumont Royal Oak community activities and events related to CHNA strategies.

Goal 2: Decrease cardiovascular disease risk factors and prevent death from sudden cardiac arrest.

- The Become Smoke Free program assists individuals in their efforts to quit smoking. The seven-week program is led by a treatment specialist in a supportive environment to help participants stop smoking. The program focuses on risks associated with tobacco use, physical and psychological dependence on smoking, exploring personal reasons for smoking and strategies to manage the side effects of quitting. Lifestyle changes are also incorporated into this program for post program management of a smoke free life. The program includes a one, three, six and 12-month follow up by a respiratory therapist and engaged 31 participants.
- The Women Exercising to Live Longer program is a six-month exercise and risk reduction program to help women reduce their likelihood of developing heart disease and prevent future cardiac events by reducing risk factors, sedentary lifestyle behaviors and obesity. This program was implemented in 2020 and 2021.
- Beaumont Royal Oak staff provided education on cardiovascular health to community groups through the Beaumont speakers bureau and at additional events throughout the Royal Oak service area.
- Implemented over the three-year span of the CHNA, the hypertension self-management program is an eight-week evidence-based workshop designed to provide the individual with information, tips, and tools to help them take control of their blood pressure. Participants learned about the basics of hypertension, stress management, the importance of nutrition, and incorporating physical activity.
- A student heart check program targeted to high school students, ages 13-18, in an effort to detect abnormal heart structure or abnormal rhythms and prevent sudden cardiac arrest was implemented in 2020-2022.
- The 7 for $70 heart and vascular screenings for adults to identify risk factors in cardiovascular disease was implemented in 2020. Seven tests are offered for $70 including blood tests, artery testing, EKG, and lifestyle are examined to recommend a course of action for improved heart and vascular health.

Goal 3: Decrease rate of new diabetes cases and of diabetes complications.

- Beaumont Royal Oak, in partnership with community centers, senior centers, and other community organizations, provided the national Diabetes Prevention Program (DPP) for the community. DPP is a free, research-based program for those who want to prevent Type 2 diabetes. The program focuses on lifestyle changes related to healthy eating and physical activity, as well as problem solving and coping skills. The diabetes prevention program has been proven to be twice as effective as medication alone at preventing Type 2 diabetes. This program consists of 16 weekly sessions, followed by monthly maintenance sessions. This year- long program for those with pre-diabetes was provided to nearly 1,000 individuals with weight loss of over 5% after 12 months in the Royal Oak service area.

- In partnership with libraries, senior centers, and community organizations, the Diabetes Personal Action Toward Health (Diabetes PATH) program is an evidence-based self-management program developed for those with chronic pain and diabetes. Diabetes PATH is designed specifically to enhance patient confidence in their ability to manage their disease and to work more effectively with their health care providers which reduces both outpatient visits and hospitalizations. The class is for those with either Type 2 diabetes or chronic pain and their caregivers. A diabetes support group provides monthly sessions designed to improve diabetes self-management for adults with diabetes and their caregivers.

Priority 2: Mental Health

Goal 1: Decrease rate of mental health and substance use disorders.

- Beaumont Health continued its extensive expansion of behavioral health services in 2021 by opening a new Behavioral Health Hospital and welcoming the inaugural class for Beaumont's first psychiatry residency program. In addition, partnerships with local human service organizations were vetted and pursued to expand the services available to the community. The continuum of care strategic plan continued to evolve in 2021 and includes proposed expansion of inpatient and outpatient services to better meet the needs of community members across the lifespan.
- Student education for mental health, mental wellness, depression, and coping skills occurred with 43 students participating in the educational presentations.
- Additional mental health and wellbeing education occurred through various courses as mindfulness in the classroom, anti-bullying seminars, coping/anxiety workshops, drug recovery workshops, vaping education, drug prevention, worry warrior's sessions, and mental health seminars. 31 education sessions occurred with 2,650 participants.
- Beaumont Royal Oak supported an annual drug take back day with the City of Royal Oak. ■

Progress of Beaumont, Taylor

2019 CHNA

The implementation strategy for fiscal years 2020-2022 focused on two priority health needs – chronic disease prevention and management (cardiovascular disease, diabetes, and obesity), and mental health. Progress for these priority needs for years 2020-2022 is summarized below. These strategies were built upon the programs and initiatives established in the 2019 CHNA.

To achieve the most impact in the community, Beaumont Hospital, Taylor established strong partnerships including the City of Taylor, Taylor Public Schools and over 120 individuals including nonprofits and community members. The following progress/outcomes for Beaumont, Taylor are described below:

Priority 1: Chronic Disease prevention and management (cardiovascular disease, diabetes, obesity)

Goal 1: Decrease rates of chronic disease in children and adults by promoting healthy eating and active living behaviors.

- Walk With Ease (WWE) was offered by Beaumont Taylor as a six week physical activity program during 2020-2022 that helps participants reduce pain and improve overall health by building up to 30 minutes of walking at least 3 days per week.
- A drop-in weekly yoga series was conducted with two partners, Western Wayne Family Health Center and Downriver Church. Over 100 persons participated in the yoga series.
- Beaumont Health partnered with the Michigan Fitness Foundation to implement the Safe Routes to Health AmeriCorps program. The focus of the program was to connect community residents to health, wellness, and physical activity. Three members were hired to provide support for Beaumont Trenton, Taylor, and Wayne community activities and events related to CHNA strategies.

Goal 2: Decrease cardiovascular disease risk factors and prevent death from sudden cardiac arrest.

- Implemented over the three-year span of the CHNA, the hypertension self-management program is an eight-week evidence-based workshop designed to provide the individual with information, tips, and tools to help them take control of their blood pressure. Participants learned about the basics of hypertension, stress management, the importance of nutrition, and incorporating physical activity.

Goal 3: Decrease rate of new diabetes cases and of diabetes complications.

- Beaumont Taylor provided the national Diabetes Prevention Program (DPP) for the community. DPP is a free, research-based program for those who want to prevent Type 2 diabetes. The program focuses on lifestyle changes related to healthy eating and physical activity, as well as problem solving and coping skills. The diabetes prevention program has been proven to be twice as effective as medication alone at preventing Type 2 diabetes. This program consists of 16 weekly sessions, followed by monthly maintenance sessions. This year- long program for those with pre-diabetes was provided to over 300 individuals with weight loss of over 5% after 12 months in the Taylor service area.
- In partnership with libraries, senior centers, and community organizations, the Diabetes Personal Action Toward Health (Diabetes PATH) program is an evidence-based self-management program developed for those with chronic pain and diabetes. Diabetes PATH is designed specifically to enhance patient confidence in their ability to manage their disease and to work more effectively with their health care providers which reduces both outpatient visits and hospitalizations. The class is for those with either Type 2 diabetes or chronic pain and their caregivers. For each session, participants met for six weeks. Over 30 individuals participated in the program.

Priority 2: Mental Health

Goal 1: Decrease rate of mental health and substance use disorders.

- Beaumont Child and Adolescent Health Centers/Teen Health Centers promote the health of children, adolescents, and their families by providing important primary, preventative, and early intervention health care services. Our centers provide primary care, preventative care, comprehensive health assessment, vision and hearing screening, medication, immunization, treatment of acute illness, co-management of chronic illness, health education and mental health care. Over 4,000 students received service through these centers. Beaumont currently has a total of 12 CAHC/Teen Health Center/E3 Mental Health sites in Taylor, Inkster, Romulus, River Rouge, Redford, Dearborn Heights, and Westland. All the Beaumont CAHC's have established community and youth advisory councils made up of parents, community members, school officials, and youth and health professionals. The council assists the CAHC staff to enhance program outcomes to better meet the health needs of our students. Advisory Councils include over 30 various members.
- During the pandemic, schools closed their doors; students had to participate in distance learning from their homes. To meet the health needs of the students, Beaumont successfully implemented a tele-health/counseling program, conducting 870 telehealth/counseling patient visits.
- Through a grant with MDHHS, Beaumont was able to develop a Quick Response Team (QRT) consisting of a family support coordinator, a law enforcement officer (plain clothed) and one peer recovery coach. Within 72 hours of a reported overdose, the survivor is visited by the QRT. The team uses their experience to assist the individuals and their families as they navigate a very complex system. If the individual is not open to treatment, the QRT leaves a resource packet, Narcan, as well as information for their family, who are eligible to accept any resources provided. Strong relationships with our community partners increase coordination and efficiency of services

for our clients and families. In addition, our family support coordinators work with any youth to provide additional support, increase their protective factors and healthy coping strategies.

- A Harm Reduction/Safe Syringe program was implemented that focused on the opportunity to positively impact our communities with a harm reduction program to service residents to reduce overdose deaths and reduce and treat Hepatitis and HIV infections. This program was an extension of the Quick Response Team (QRT) program, giving us the ability to increase our outreach, educate our communities, as well as dispelling myths and reducing the stigma associated with substance use disorders and HIV infection. In addition, providing PrEP/PEP/ Vaccination education and referrals to those at highest risk.
- Beaumont Health continued its extensive expansion of behavioral health services in 2021 by opening a new Behavioral Health Hospital and welcoming the inaugural class for Beaumont's first psychiatry residency program. In addition, partnerships with local human service organizations were vetted and pursued to expand the services available to the community. The continuum of care strategic plan continued to evolve in 2021 and included proposed expansion of inpatient and outpatient services to better meet the needs of community members across the lifespan. ■

Progress of Beaumont, Trenton
2019 CHNA

The implementation strategy for fiscal years 2020-2022 focused on two priority health needs – chronic disease prevention and management (cardiovascular disease, diabetes, and obesity), and mental health. Progress for these priority needs for years 2020-2022 is summarized below. These strategies were built upon the programs and initiatives established in the 2019 CHNA.

To achieve the most impact in the community, Beaumont Hospital, Trenton established strong partnerships including the City of Trenton, Trenton Public Schools and over 120 individuals including nonprofits and community members. The following progress/outcomes for Beaumont, Trenton are described below:

Priority 1: Chronic Disease prevention and management (cardiovascular disease, diabetes, obesity)

Goal 1: Decrease rates of chronic disease in children and adults by promoting healthy eating and active living behaviors.

- Over 200 individuals participated in nutrition education.
- Beaumont Health partnered with the Michigan Fitness Foundation to implement the Safe Routes to Health AmeriCorps program. The focus of the program was to connect community residents to health, wellness, and physical activity. Three members were hired to provide support for the Beaumont Trenton, Taylor, and Wayne community activities and events related to CHNA strategies.
- Lifestyle behaviors were promoted through Beaumont Gets Walking, a neighborhood walking program. Walking groups registered with the City of Trenton along with an identified leader. They were provided with a walking group toolkit consisting of pedometers, lanyards and walking logs for each group member along with tip sheets. Each time the group walked, they recorded it on their log. A total of 649 people participated in Trenton.
- Walk With Ease (WWE) was offered by Beaumont Trenton as a six week physical activity program during 2020-2022 that helps participants reduce pain and improve overall health by building up to 30 minutes of walking, at least 3 days per week.

Goal 2: Decrease cardiovascular disease risk factors and prevent death from sudden cardiac arrest.

- Implemented over the three-year span of the CHNA, the hypertension self-management program is an eight-week evidence-based workshop designed to provide the individual with information, tips, and tools to help them take control of their blood pressure. Participants learned about the basics of hypertension, stress management, the importance of nutrition, and incorporating physical activity.

Goal 3: Decrease rate of new diabetes cases and of diabetes complications.

- Beaumont Trenton provided the national Diabetes Prevention Program (DPP) for the community. DPP is a free, research-based program for those who want to prevent Type 2 diabetes. The program focuses on lifestyle changes related to healthy eating and physical activity, as well as problem solving and coping skills. The diabetes prevention program has been proven to be twice as effective as medication alone at preventing Type 2 diabetes. This program consists of 16 weekly sessions, followed by monthly maintenance sessions. This year-long program for those with pre-diabetes was provided to over 1,000 individuals with weight loss of over 5% after 12 months in the Trenton service area.
- In partnership with the National Kidney Foundation of Michigan and the Area Agency on Aging 1B, the Diabetes Personal Action Toward Health (Diabetes PATH) program is an evidence-based self-management program developed for those with chronic pain and diabetes. Diabetes PATH is designed specifically to enhance patient confidence in their ability to manage their disease and to work more effectively with their health care providers which reduces both outpatient visits and hospitalizations. The class is for those with either Type 2 diabetes or chronic pain and their caregivers. Participants met for six weeks, and the program was provided to over 30 individuals in the Trenton service area.

Priority 2: Mental Health

Goal 1: Decrease rate of mental health and substance use disorders.

- Beaumont Health continued its extensive expansion of behavioral health services in 2021 by opening a new Behavioral Health Hospital and welcoming the inaugural class for Beaumont's first psychiatry residency program. In addition, partnerships with local human service organizations were vetted and pursued to expand the services available to the community. The continuum of care strategic plan continued to evolve in 2021 and includes proposed expansion of inpatient and outpatient services to better meet the needs of community members across the lifespan.
- Beaumont Trenton and local law enforcement agencies hosted multiple medication drop off days for unused or expired medication. Almost 50 pounds of medication were collected. ■

Progress of Beaumont, Troy
2019 CHNA

The implementation strategy for fiscal years 2020-2022 focused on two priority health needs – chronic disease prevention and management (cardiovascular disease, diabetes, and obesity), and mental health. Progress for these priority needs for years 2020-2022 is summarized below. These strategies were built upon the programs and initiatives established in the 2019 CHNA.

To achieve the greatest impact in the community, Beaumont Hospital, Troy worked closely with community organizations to expand access to the community of programs and services. The following progress/outcomes for Beaumont, Troy are described below:

Priority 1: Chronic Disease prevention and management (cardiovascular disease, diabetes, obesity)

Goal 1: Decrease rates of chronic disease in children and adults by promoting healthy eating and active living behaviors.

- Beaumont Troy staff provided education on cardiovascular health to community groups through the Beaumont speakers bureau and at additional events throughout the Troy service area. Education was provided to 65 attendees.
- The Beaumont Troy Walking to Wellness program, in collaboration with the Troy Nature Center, had 480 unique individuals participate in the Walking to Wellness program, with 45 individuals participating on a regular basis.
- A total of 110 people participated in weekly outdoor museum yoga classes. Weekly class size ranged from 17 to 43 participants, with 25-30 being the average class size.
- The Walk With Ease (WWE) program, an evidence-based program, reached 12 participants in Troy. The WWE program was designed for adults with arthritis and older adults. The program teaches participants how to safely make physical activity part of their everyday life. Participants walk on their own schedule at their own pace with a goal of building to 30 minutes of walking at least three times weekly.
- Heart health and diabetes screenings were provided to 418 individuals.
- Beaumont Health partnered with the Michigan Fitness Foundation to implement the Safe Routes to Health AmeriCorps program. The focus of the program was to connect community residents to health, wellness, and physical activity. One member was hired to provide support for the Beaumont Troy community activities and events related to CHNA strategies.

Goal 2: Decrease cardiovascular disease risk factors and prevent death from sudden cardiac arrest.

- Implemented over the three-year span of the CHNA, the hypertension self-management program is an eight-week evidence-based workshop designed to provide the individual with information, tips, and tools to help them take control of their blood pressure. Participants learned about the basics of hypertension, stress management, the importance of nutrition, and incorporating physical activity.

Goal 3: Decrease rate of new diabetes cases and of diabetes complications.

- Beaumont Troy provided the national Diabetes Prevention Program (DPP) for the community. DPP is a free, research-based program for those who want to prevent Type 2 diabetes. The program focuses on lifestyle changes related to healthy eating and physical activity, as well as problem solving and coping skills. The diabetes prevention program has been proven to be twice as effective as medication alone at preventing Type 2 diabetes. This program consists of 16 weekly sessions, followed by monthly maintenance sessions. This year-long program for those with pre-diabetes was provided to over 400 individuals with weight loss of over 5% after 12 months in the Dearborn service area.
- The Diabetes Personal Action Toward Health (Diabetes PATH) program is an evidence-based self-management program developed for those with chronic pain and diabetes. Diabetes PATH is designed specifically to enhance patient confidence in their ability to manage their disease and to work more effectively with their health care providers which reduces both outpatient visits and hospitalizations. The class is for those with either Type 2 diabetes or chronic pain and their caregivers. Participants meet for six weeks, and the program was provided to over 80 individuals in the Troy service area.

Priority 2: Mental Health

Goal 1: Decrease rate of mental health and substance use disorders.

- Beaumont Health continued its extensive expansion of behavioral health services in 2021 by opening a new Behavioral Health Hospital and welcoming the inaugural class for Beaumont's first psychiatry residency program. In addition, partnerships with local human service organizations were vetted and pursued to expand the services available to the community. The continuum of care strategic plan continued to evolve in 2021 and includes proposed expansion of inpatient and outpatient services to better meet the needs of community members across the lifespan.
- In 2021 Beaumont Troy partnered with the Stage Nature Center to develop a three-year mindfulness program. This program is to help people experiencing isolation and depression, anxiety, or stress to cope with mental health challenges due to the pandemic and help their well-being by immersing them in nature. ■

Progress of Beaumont, Wayne
2019 CHNA

The implementation strategy for fiscal years 2020-2022 focused on two priority health needs – chronic disease prevention and management (cardiovascular disease, diabetes, and obesity), and mental health. Progress for these priority needs for years 2020-2022 is summarized below. These strategies were built upon the programs and initiatives established in the 2019 CHNA.

To achieve the most impact in the community, Beaumont, Wayne established Healthy Wayne and Westland, a multi-year initiative that expands access to the community of programs and services designed to encourage healthy eating and active living. Healthy Wayne and Westland has strong support and partnerships including the City of Wayne, the City of Westland, other cities and municipalities, Wayne-Westland Schools, nonprofits, and other community members.
The following progress/outcomes for Beaumont, Wayne are described below:

Priority 1: Chronic Disease prevention and management (cardiovascular disease, diabetes, obesity)

Goal 1: Decrease rates of chronic disease in children and adults by promoting healthy eating and active living behaviors.

- Healthy lifestyle classes were hosted for the community in 1-hour sessions. These included topics such as healthy nutrition, understanding of a well-balanced meal, healthy recipes, and creating a well-stocked pantry.
- The National Kidney Foundation of Michigan (NKFM) guided the healthy coalition through a Promoting Active Communities Assessment, where opportunities for community activity related improvements were identified. Results shared between communities included the need for safe walking, biking, and vehicle pick up/drop off at school, active transportation storage, safe routes to school, increase number of crosswalks, increase number of speed limit signs, and making school amenities available for public use.
- Walk With Ease (WWE) was offered by Beaumont Hospital Wayne, in partnership with the National Kidney Foundation of Michigan, as a six-week physical activity program to help participants reduce pain and improve overall health by building up to 30 minutes of walking, at least 3 days per week.
- Free yoga opportunities were offered in Wayne courtesy of Healthy Wayne partners from Lifetime Fitness Center of Canton. Several series of free yoga classes were conducted in Goudy Park, at the Wayne Public Library, Wayne Historical Museum and at Franklin Middle School. These community physical activity classes reached over 40 people.
- Beaumont Health partnered with the Michigan Fitness Foundation to implement the Safe Routes to Health AmeriCorps program. The focus of the program was to connect community residents to health, wellness, and physical activity. Three members were hired to provide support for Beaumont Trenton, Taylor, and Wayne community activities and events related to CHNA strategies.

Goal 2: Decrease cardiovascular disease risk factors and prevent death from sudden cardiac arrest.

- Implemented over the three-year span of the CHNA, the hypertension self-management program is an eight-week evidence-based workshop designed to provide the individual with information, tips, and tools to help them take control of their blood pressure. Participants learned about the basics of hypertension, stress management, the importance of nutrition, and incorporating physical activity.

Goal 3: Decrease rate of new diabetes cases and of diabetes complications.

- Beaumont Wayne provided the national Diabetes Prevention Program (DPP) for the community. DPP is a free, research-based program for those who want to prevent Type 2 diabetes. The program focuses on lifestyle changes related to healthy eating and physical activity, as well as problem solving and coping skills. The diabetes prevention program has been proven to be twice as effective as medication alone at preventing Type 2 diabetes. This program consists of 16 weekly sessions, followed by monthly maintenance sessions. This year-long program for those with pre-diabetes was provided to over 300 individuals with weight loss of over 5% after 12 months in the Wayne service area.
- In partnership with libraries, senior centers, and community organizations, the Diabetes Personal Action Toward Health (Diabetes PATH) program is an evidence-based self-management program developed for those with chronic pain and diabetes. Diabetes PATH is designed specifically to enhance patient confidence in their ability to manage their disease and to work more effectively with their health care providers which reduces both outpatient visits and hospitalizations. The class is for those with either Type 2 diabetes or chronic pain and their caregivers. For each session, participants met for six weeks.

Priority 2: Mental Health

Goal 1: Decrease rate of mental health and substance use disorders.

- Beaumont Health continued its extensive expansion of behavioral health services in 2021 by opening a new Behavioral Health Hospital and welcoming the inaugural class for Beaumont's first psychiatry residency program. In addition, partnerships with local human service organizations were vetted and pursued to expand the services available to the community. The continuum of care strategic plan continued to evolve in 2021 and includes proposed expansion of inpatient and outpatient services to better meet the needs of community members across the lifespan.
- Adams Middle School saw over 5,000 students for primary and outreach services. Romulus Middle & High School saw over 13,000 students for primary care and outreach work. Westwood Middle School & Annapolis High School saw nearly 3,000 students for mental health, primary and outreach services. The Wayne Memorial Teen Center also saw over 100 students for pregnancy prevention.
- Beaumont Hospital Wayne and local law enforcement agencies hosted multiple medication drop off days in between 2020-2022 for unused or expired medication. Close to 20 pounds of materials were collected. ■

Health Professional Shortage Areas (HPSA)

County name	HPSA ID	HPSA name	HPSA discipline class	Designation type
Macomb	6262258202	Macomb Correctional Facility	Dental Health	Correctional Facility
Macomb	626999262U	MyCare Health Center	Dental Health	Federally Qualified Health Center
Macomb	7261412261	Macomb Correctional Facility	Mental Health	Correctional Facility
Macomb	7269992628	MyCare Health Center	Mental Health	Federally Qualified Health Center
Macomb	7267881227	LI - South Macomb SA	Mental Health	Low Income Population HPSA
Macomb	1263696236	CF-Macomb	Primary Care	Correctional Facility
Macomb	126999268A	MyCare Health Center	Primary Care	Federally Qualified Health Center
Macomb	1268825786	LI-South Macomb SA	Primary Care	Low Income Population HPSA
Oakland	62699926MA	Oakland Integrated Healthcare Network	Dental Health	Federally Qualified Health Center
Oakland	72699926CB	Oakland Integrated Healthcare Network	Mental Health	Federally Qualified Health Center
Oakland	7261657716	LI-Pontiac SA	Mental Health	Low Income Population HPSA
Oakland	7269183495	LI - Southeast Oakland SA	Mental Health	Low Income Population HPSA
Oakland	12699926PV	Oakland Integrated Healthcare Network	Primary Care	Federally Qualified Health Center
Oakland	1264463200	LI - Pontiac SA	Primary Care	Low Income Population HPSA
Oakland / Wayne	1263564321	LI-Oak Park SA	Primary Care	Low Income Population HPSA
Wayne	62699926A1	Detroit Community Health Connection	Dental Health	Federally Qualified Health Center
Wayne	62699926G2	Covenant Community Care, Inc.	Dental Health	Federally Qualified Health Center
Wayne	62699926M8	Wayne, County of	Dental Health	Federally Qualified Health Center
Wayne	62699926C2	Community Health and Social Services Center, Inc.	Dental Health	Federally Qualified Health Center
Wayne	6265627689	Institutute for Population Health, Inc.	Dental Health	Federally Qualified Health Center
Wayne	626999262O	Detroit Central City Community Mental Health, Incorporated	Dental Health	Federally Qualified Health Center
Wayne	62699926E5	Western Wayne Family Health Centers	Dental Health	Federally Qualified Health Center
Wayne	62699926M2	Wellness Plan, The	Dental Health	Federally Qualified Health Center
Wayne	62699926B4	Detroit Health Care For The Homeless	Dental Health	Federally Qualified Health Center

Health Professional Shortage Areas (HPSA)

County name	HPSA ID	HPSA name	HPSA discipline class	Designation type
Wayne	62699926G6	Health Centers Detroit Foundation, Inc.	Dental Health	Federally Qualified Health Center Look-alike
Wayne	62699926LZ	American Indian Health & Family Services of Southeastern Michigan, Inc.	Dental Health	Indian Health Service, Tribal Health, and Urban Indian Health Organizations
Wayne	6261766507	LI-Northeast Detroit SA	Dental Health	Low Income Population HPSA
Wayne	6264805600	LI-Northwest Detroit SA	Dental Health	Low Income Population HPSA
Wayne	6267840518	LI-Southeast Detroit SA	Dental Health	Low Income Population HPSA
Wayne	6267143040	LI-Southwest Detroit SA	Dental Health	Low Income Population HPSA
Wayne	7269992639	Detroit Community Health Connection	Mental Health	Federally Qualified Health Center
Wayne	7269992686	Covenant Community Care, Inc.	Mental Health	Federally Qualified Health Center
Wayne	72699926C9	Wayne, County of	Mental Health	Federally Qualified Health Center
Wayne	7269992659	Community Health and Social Services Center, Inc.	Mental Health	Federally Qualified Health Center
Wayne	7261912511	Institutute for Population Health, Inc.	Mental Health	Federally Qualified Health Center
Wayne	726999261U	Detroit Central City Community Mental Health, Incorporated	Mental Health	Federally Qualified Health Center
Wayne	7269992674	Western Wayne Family Health Centers	Mental Health	Federally Qualified Health Center
Wayne	72699926C1	Wellness Plan, The	Mental Health	Federally Qualified Health Center
Wayne	7269992651	Detroit Health Care For The Homeless	Mental Health	Federally Qualified Health Center
Wayne	72699926C8	Health Centers Detroit Foundation, Inc.	Mental Health	Federally Qualified Health Center Look-alike
Wayne	7264448010	Southwest Detroit SA	Mental Health	High Needs Geographic HPSA
Wayne	7269895104	Hamtramck Service Area	Mental Health	High Needs Geographic HPSA
Wayne	72699926BX	American Indian Health & Family Services of Southeastern Michigan, Inc.	Mental Health	Indian Health Service, Tribal Health, and Urban Indian Health Organizations
Wayne	7266108062	LI-Lincoln Park SA	Mental Health	Low Income Population HPSA
Wayne	7261003426	LI - East Detroit SA	Mental Health	Low Income Population HPSA
Wayne	7264208535	LI - Dearborn/Inkster/Wayne City SA	Mental Health	Low Income Population HPSA

Health Professional Shortage Areas (HPSA)

County name	HPSA ID	HPSA name	HPSA discipline class	Designation type
Wayne	7267899615	LI - Northwest Detroit/Redford SA	Mental Health	Low Income Population HPSA
Wayne	126999263M	Detroit Community Health Connection	Primary Care	Federally Qualified Health Center
Wayne	12699926F9	Covenant Community Care, Inc.	Primary Care	Federally Qualified Health Center
Wayne	12699926PT	Wayne, County of	Primary Care	Federally Qualified Health Center
Wayne	126999264M	Community Health and Ssocial Services Center, Inc.	Primary Care	Federally Qualified Health Center
Wayne	1261749098	Institutute for Population Health, Inc.	Primary Care	Federally Qualified Health Center
Wayne	126999267W	Detroit Central City Community Mental Health, Incorporated	Primary Care	Federally Qualified Health Center
Wayne	126999265A	Western Wayne Family Health Centers	Primary Care	Federally Qualified Health Center
Wayne	12699926PL	Wellness Plan, The	Primary Care	Federally Qualified Health Center
Wayne	126999264C	Detroit Health Care For The Homeless	Primary Care	Federally Qualified Health Center
Wayne	126999264X	Health Centers Detroit Foundation, Inc.	Primary Care	Federally Qualified Health Center Look-alike
Wayne	1264477200	Northwest Detroit SA	Primary Care	High Needs Geographic HPSA
Wayne	1263948863	Southwest Detroit SA	Primary Care	High Needs Geographic HPSA
Wayne	1269743343	Inkster City	Primary Care	High Needs Geographic HPSA
Wayne	12699926PF	American Indian Health & Family Services of Southeastern Michigan, Inc.	Primary Care	Indian Health Service, Tribal Health, and Urban Indian Health Organizations
Wayne	1269125352	LI-Wayne City	Primary Care	Low Income Population HPSA
Wayne	1261428461	LI-Redford/Dearborn/Taylor SA	Primary Care	Low Income Population HPSA
Wayne	1267731725	LI - East Detroit/Hamtramck/Highland Park SA	Primary Care	Low Income Population HPSA

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Medically Underserved Areas and Populations (MUA/P)

County	MUA/P ID	Service Area Name	Designation Type	Rural Status
Macomb	01595	Macomb Governor Service Area	Medically Underserved Area – Governor's Exception	Non-Rural
Macomb	07773	Center Line Service Aarea	Medically Underserved Area	Non-Rural
Oakland	01587	City of Pontiac Service Area	Medically Underserved Area	Non-Rural
Wayne	01572	Pershing/Nolan/State Fair/Davison Service Area	Medically Underserved Area	Non-Rural
Wayne	01573	Eastside Service Area	Medically Underserved Area	Non-Rural
Wayne	01577	Harmony Village/Grandmont/Cerveny Service Area	Medically Underserved Area	Non-Rural
Wayne	01578	Inkster City Service Area	Medically Underserved Area	Non-Rural
Wayne	01584	Romulus/Taylor Service Area	Medically Underserved Area	Non-Rural
Wayne	01603	Wayne Service Area	Medically Underserved Area	Non-Rural
Wayne	01604	Wayne Service Area	Medically Underserved Area	Non-Rural
Wayne	01605	Dearborn Service Area	Medically Underserved Area	Non-Rural
Wayne	06137	Airport/Conner Service Area	Medically Underserved Area	Non-Rural
Wayne	06138	Southwest Detroit Service Area	Medically Underserved Area	Non-Rural
Wayne	06139	Tireman/Chadsey Service Area	Medically Underserved Area	Non-Rural
Wayne	06140	Mackenzie/ Brooks Service Area	Medically Underserved Area	Non-Rural
Wayne	06141	Chene Service Area	Medically Underserved Area	Non-Rural
Wayne	06142	Wayne Service Area	Medically Underserved Area	Non-Rural
Wayne	07201	Low Inc - Romulus	Medically Underserved Population	Non-Rural
Wayne	07270	Low Inc - Brightmoor / Cody	Medically Underserved Population	Non-Rural
Wayne	07416	Northeast Detroit Service Area	Medically Underserved Area	Non-Rural
Wayne	07763	Low Inc - Western Detroit	Medically Underserved Population	Non-Rural
Wayne	07768	Ecorse/Lincoln Park/River Rouge	Medically Underserved Area	Non-Rural

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2022
COMMUNITY HEALTH NEEDS ASSESSMENT

Building Healthier Lives and Communities

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