Community Health Needs Assessment

2025

Corewell Health™

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Community Survey (n=2,291)

Listening Session Participants (n=42)

Focus Group Participants (n=47)

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Introduction and Purpose

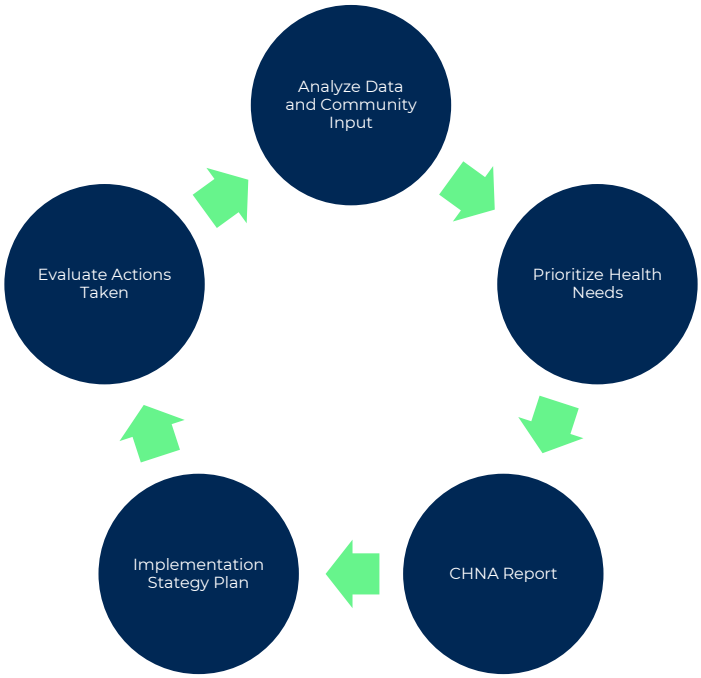
is pleased to present its 2025 Community Health Needs Assessment (CHNA).

Hospitals operated by Corewell Health in Southeast Michigan include:

- Corewell Health Dearborn Hospital
- Corewell Health Beaumont Grosse Pointe Hospital
- Corewell Health Farmington Hills Hospital
- Corewell Health Beaumont Troy Hospital
- Corewell Health Trenton Hospital
- Corewell Health Taylor Hospital
- Corewell Health Wayne Hospital
- Corewell Health William Beaumont University Hospital

A Community Health Needs Assessment (CHNA) is an all-inclusive data collection and analysis tool used to determine key health needs in a community. The 2010 Patient Protection and Affordable Care Act (ACA) mandated not-for-profit hospital organizations to conduct a community health needs assessment every three years to maintain their status as a not-for-profit provider with the U.S. Internal Revenue Service (IRS). Figure 1 depicts the (CHNA) process and how the cycle continues after the report is completed.

Figure 1: CHNA Cycle



The Community Health Needs Assessment (CHNA) provides Corewell Health in Southeast Michigan with a comprehensive understanding of the health status, needs, disparities, and priorities of the population it serves. The insights gained from this assessment will inform the development and implementation of targeted, evidence-based strategies aimed at enhancing health outcomes and overall quality of life for residents across Wayne, Macomb and Oakland counties.

This report includes a description of:

- The community demographic and population served;
- The process and methods used to obtain, analyze, and synthesize primary and secondary data;
- The significant health needs in the community, taking into account the needs of uninsured, low-income, and marginalized groups;
- The process and criteria used in identifying certain health needs as significant and prioritizing those significant community needs.

Acknowledgements

For the 2025 Community Health Needs Assessment cycle, Corewell Health in Southeast Michigan worked with Conduent/Healthy Communities Institute (HCI) for professional assistance with planning and report development.

Hospital Leadership

Lamont Yoder, RN, President, Corewell Health in Southeast Michigan

Community Benefit Leadership/Team

David Kurili, MPH, CHNA and Community Benefit Manager

Kari Woloszyk, MPH, CHNA and Community Benefit Manager East

Leslie Meyer, MA, CPXP, Senior Director, Health Equity and Community Health East

Lora Coats, BBA, Specialist, CHNA and Community Benefits

Rebecca Moore, MPH, CHES, CPST, Community Health Program Manager

Community Input

The development of the 2025 Community Health Needs Assessment (CHNA) was a collective effort by Corewell Health in Southeast Michigan employees, residents, faith-based and civic leaders, educators, health care professionals, and community-serving organizations with a deep understanding of our residents' issues and needs.

Corewell Health in Southeast Michigan gratefully acknowledges this dedicated group for generously contributing their time and expertise to help guide this CHNA process.

Consultants

Corewell Health in Southeast Michigan collaborated with the Conduent Healthy Communities Institute (HCI) to support report preparation for its 2025 CHNA. HCI works with clients nationwide to drive community health outcomes by assessing needs, developing focused strategies, identifying appropriate intervention programs, establishing monitoring systems and implementing performance evaluation processes. To learn more about Conduent HCI, please visit conduent.com/community-population-health.

About Corewell Health

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.

Mission: Improve health, instill humanity, and inspire hope.

Vision: A future where health is simple, affordable, equitable, and exceptional.

Values: Compassion. Collaboration. Clarity. Curiosity. Courage.

Facility Information

Corewell Health Dearborn Hospital

Corewell Health Dearborn Hospital has proudly served residents across Southeast Michigan since 1953. With 632 beds, Corewell Health Dearborn Hospital is a major teaching and research hospital and home to three medical residency programs in partnership with Wayne State University School of Medicine. Corewell Health Dearborn Hospital is verified as a Level II trauma center and accredited by The Joint Commission as a primary stroke center. The hospital is also known for clinical excellence and innovation in the fields of orthopedics, neurosciences, women: heart and vascular and cancer care.

Corewell Health Beaumont Grosse Pointe Hospital

Corewell Health Beaumont Grosse Pointe Hospital is a 280-bed acute care campus located in the heart of Grosse Pointe. Opened in 1945 by the Sisters of Bon Secours, it was acquired by Beaumont Health System in October 2007. Corewell Health Beaumont Grosse Pointe Hospital offers medical, surgical, emergency, obstetric and critical care services. Corewell Health Beaumont Grosse Pointe Hospital is also home to The James and Patricia Anderson Surgical Center, a leading-edge, hybrid surgical suite offering advanced learning, technological advancements and a wide array of procedures ranging from traditional to minimally invasive approaches.

Corewell Health Farmington Hills Hospital

Corewell Health Farmington Hills Hospital opened on Jan. 19, 1965 as a 200-bed facility known then as Botsford General Hospital. Today, Corewell Health Farmington Hills Hospital is a 305-bed teaching facility with Level II trauma status.

Corewell Health Beaumont Troy Hospital

In response to the health care needs of a growing community, in 1977, Beaumont opened a new 189-bed hospital on rural farmland in Troy. Today, Corewell Health Beaumont Troy Hospital has grown to 530 licensed beds and offers a comprehensive array of health care services, continuing to develop to meet the needs of the growing communities it serves.

Corewell Health Trenton Hospital

Corewell Health Trenton Hospital is a 193-bed acute care teaching hospital that sponsors nine university-affiliated residency programs. The hospital opened its doors to Trenton and its surrounding communities in 1961. It became part of Beaumont Health in September 2014. In addition to providing comprehensive medical and surgical care for its patients, the hospital offers all private beds, a medical and surgical intensive care unit, and obstetrical care.

Corewell Health Taylor Hospital

Corewell Health Taylor Hospital is a 148-bed hospital that is a recognized health care leader in the Metro Detroit area. Proudly serving Taylor and surrounding communities since 1977, it offers specialty services including 24-hour emergency care, wound care and hyperbaric oxygen therapy, a surgical pavilion, a pain management clinic, orthopedic surgery, inpatient rehabilitation facility and full-service radiology, including advanced CT with cardiac scoring, Fixed MRI including pacemaker, cinema vision and ultrasound (MSK and elastography).

Corewell Health Wayne Hospital

Corewell Health Wayne Hospital opened its doors to western Wayne communities in 1957. This full-service hospital is the only hospital in the Wayne, Westland, Garden City, Canton, Inkster and Romulus area verified by the American College of Surgeons as a Level III Trauma Center. The hospital has a longstanding partnership with Detroit Metropolitan Airport and the Centers for Disease Control and Prevention to handle a wide variety of health and communicable disease concerns including mass trauma and emergency patients.

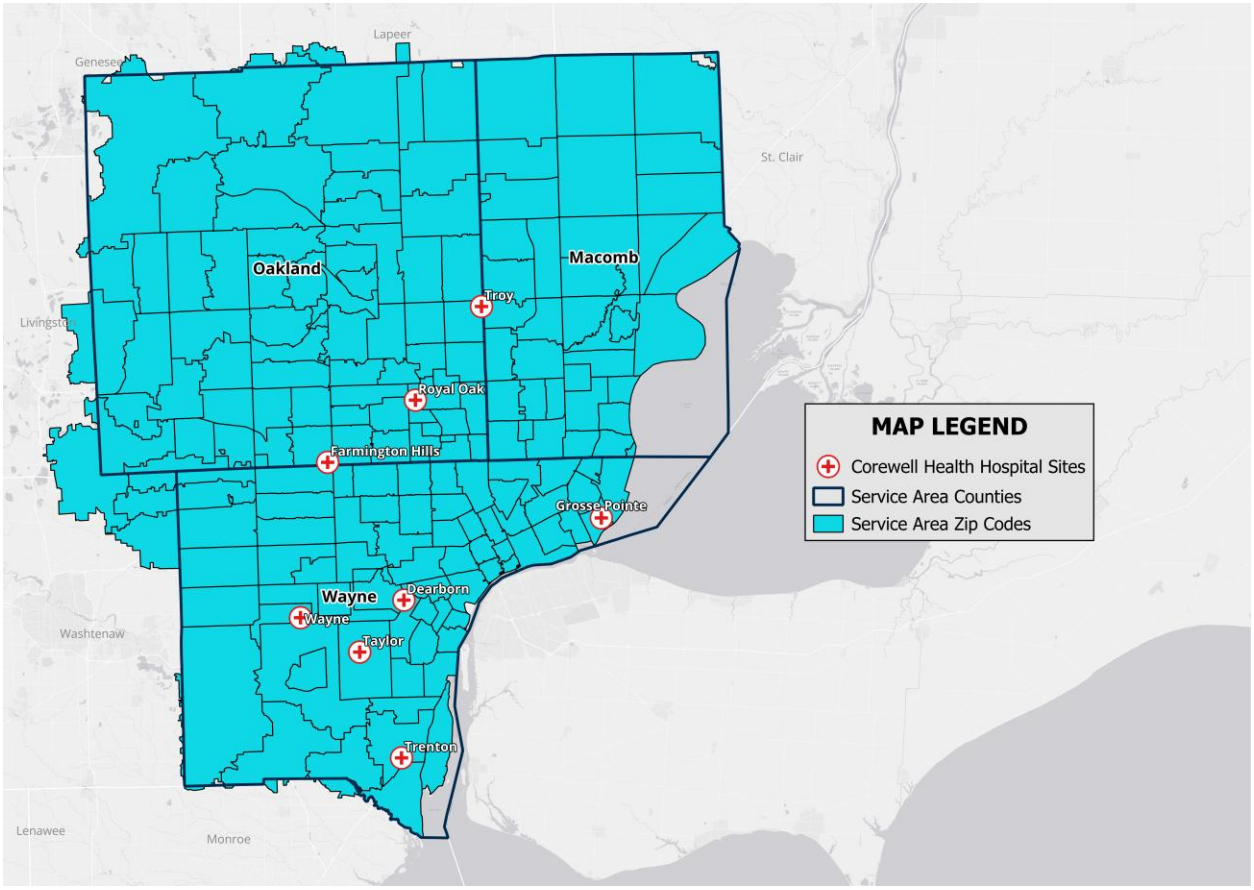
Corewell Health William Beaumont University Hospital

Corewell Health William Beaumont University Hospital, formally Royal Oak, opened on Jan. 24, 1955. Today it is a major academic and referral center with Level I adult trauma and Level II pediatric trauma status. It is a nationally ranked 1131 bed non-profit acute care teaching hospital, providing tertiary care and health care services to the metro Detroit region. This is the flagship facility of Corewell Health and is affiliated with the Oakland University William Beaumont School of Medicine, as the primary teaching affiliate. Beaumont Children's Hospital, now Corewell Health Children's, was announced in 2009. Eighty-three sub-specialists, a 40-bed pediatric unit, eight-bed pediatric ICU and 64-bed NICU had been in place since 2004.

Primary Service Area

Corewell Health in Southeast Michigan serves a geographic region that includes Wayne, Macomb, and Oakland counties. The primary service areas (PSAs), illustrated in Figure 2 below, are defined by 231 ZIP Codes spanning these three counties.

Figure 2: Corewell Health in Southeast Michigan Primary service area



Looking Back: Evaluation of Progress Since Prior CHNA

A key component of the 2025 Community Health Needs Assessment (CHNA) involves evaluating the progress made on priority areas identified in previous CHNA cycles. Because the CHNA process follows a three-year cycle, it is essential to reflect on past initiatives to understand their effectiveness and impact. By assessing the actions taken and outcomes achieved, Corewell Health can build on successes, identify areas for improvement, and strategically align efforts for the current CHNA cycle. The following previous implementation strategy impact reports listed here and found in Appendix E outline the progress and evaluation from the prior CHNA.

- Corewell Health Dearborn Hospital
- Corewell Health Farmington Hills Hospital
- Corewell Health Beaumont Grosse Pointe Hospital
- Corewell Health Taylor Hospital
- Corewell Health Trenton Hospital
- Corewell Health Beaumont Troy Hospital
- Corewell Health Wayne Hospital
- Corewell Health William Beaumont University Hospital

Community Feedback from Preceding CHNA and Implementation Plan

The 2022 Community Health Needs Assessment Reports and Implementation Strategies are available to the public via the website Community Health Needs Assessments | Healthier Communities | About | Corewell Health.

No comments were received on the preceding CHNA at the time this report was written.

To facilitate community input during this assessment cycle, Corewell Health in Southeast Michigan has designated the email address **CHNA@corewellhealth.org** for receiving comments and feedback related to the Community Health Needs Assessment.

Demographics

The demographics of a community significantly impact its health profile.[1] Different cultural and socioeconomic groups may have unique needs and require varied approaches to health improvement efforts. The following section explores the demographic profile of the community served by Corewell Health in Southeast Michigan including the economic, environmental, and social drivers of health. The social drivers of health are the non-medical factors that influence health outcomes. They are the conditions in which people are born, grow, work, live and age, and the wider set of forces and systems shaping the conditions of daily life. These forces and systems include economic policies and systems, development agendas, social norms, social policies, and political systems.[2]

Unless otherwise indicated, all demographic estimates are sourced from Claritas® (2024 population estimates). Claritas demographic estimates are primarily based on U.S. Census and American Community Survey (ACS) data. Claritas uses proprietary formulas and methodologies to calculate estimates for the current calendar year.

In addition to these highlights, detailed findings from the secondary data analysis can be found in Appendix C.

Demographic Profile

Macomb County

Macomb County, located in Southeast Michigan, is a diverse region with urban, suburban, and rural communities. It has a population of over 870,000, with a growing senior demographic. Key industries include manufacturing, defense, and health care.[3]

Oakland County

Oakland County, located in Southeast Michigan just north of Detroit, is one of the state's most populous counties with over 1.25 million residents. It includes a mix of urban, suburban, and rural communities across 62 municipalities, covering approximately 910 square miles.[4]

Wayne County

[1] National Academies Press (US); 2002. 2, Understanding Population Health and Its Determinants. Available from: ncbi.nlm.nih.gov/books/NBK221225/

[2] World Health Organization. Social Determinants of Health. who.int/health-topics/social-determinants-of-health#tab=tab_1

[3] Macomb County Michigan. Health Department data and reports

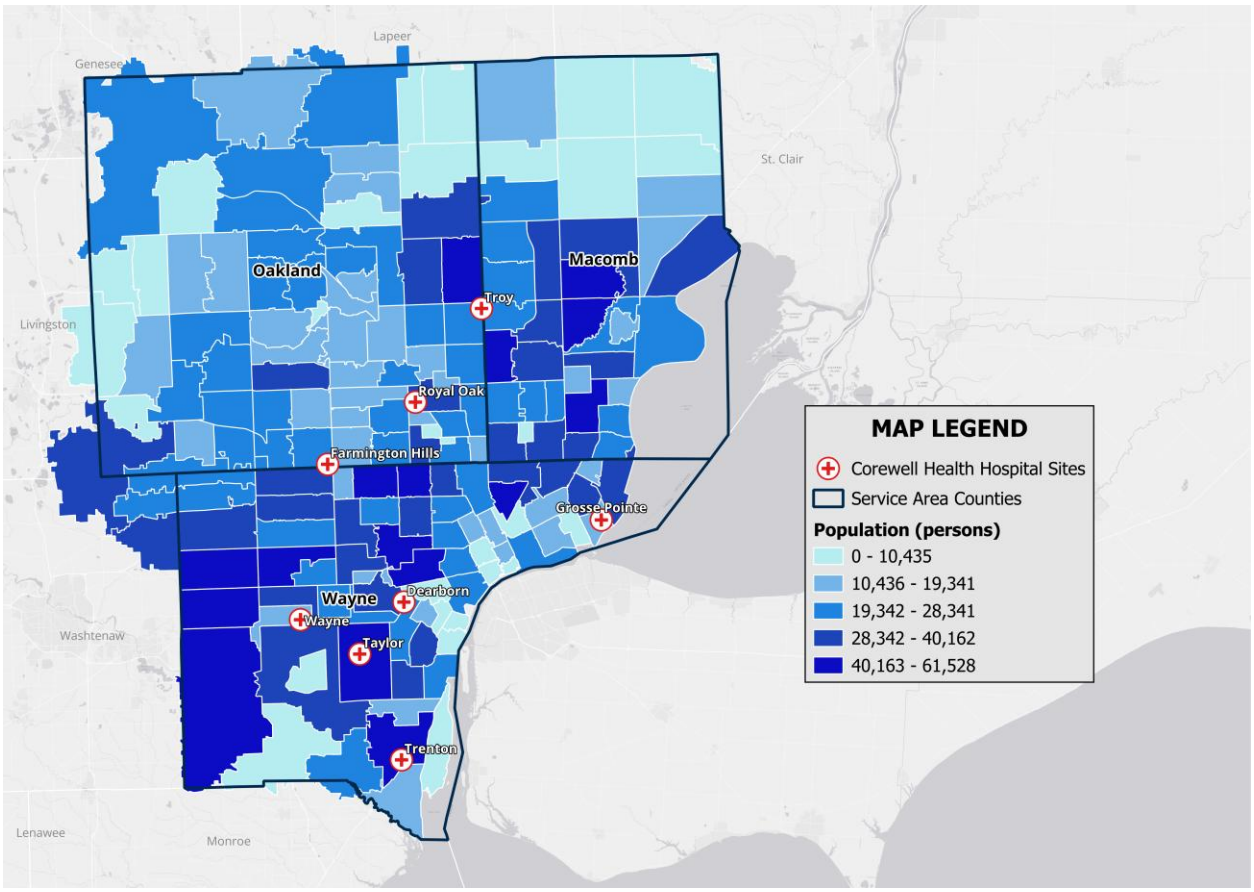
[4] Oakland County Michigan. Facts and Stats | Oakland County, MI

Wayne County, located in Southeast Michigan and home to Detroit, is the most populous county in the state with approximately 1.76 million residents. It spans 612 square miles and borders Macomb, Oakland, Washtenaw, and Monroe counties, as well as Essex County in Ontario, Canada.[5]

Population

The Corewell Health in Southeast Michigan service area includes 875,654 residents in Macomb County, 1,271,424 in Oakland County, and 1,738,234 in Wayne County, the most populous of the three. Figure 3 illustrates the population distribution across the service area by ZIP code.

Figure 3: Corewell Health in Southeast Michigan primary service area population distribution by zip code

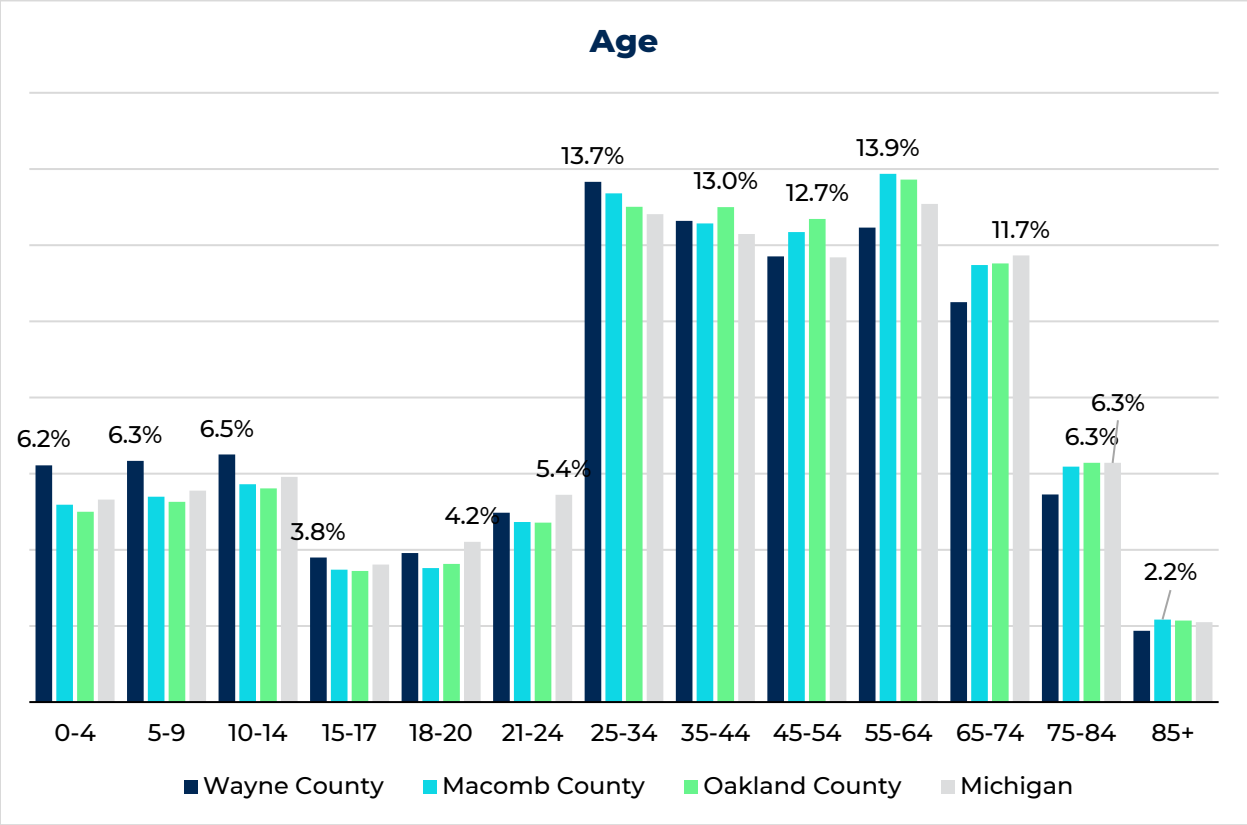


[5] Wayne County Profile. PCNA Overall Rank 1 - Wayne County Profile

Age

Figure 4 illustrates the age distribution of the population within Corewell Health's primary service area counties, compared to the overall population of Michigan. The distributions are largely similar, with the majority of individuals falling between the ages of 25 and 74.

Figure 4: population by age: Corewell Health in Southeast Michigan service area

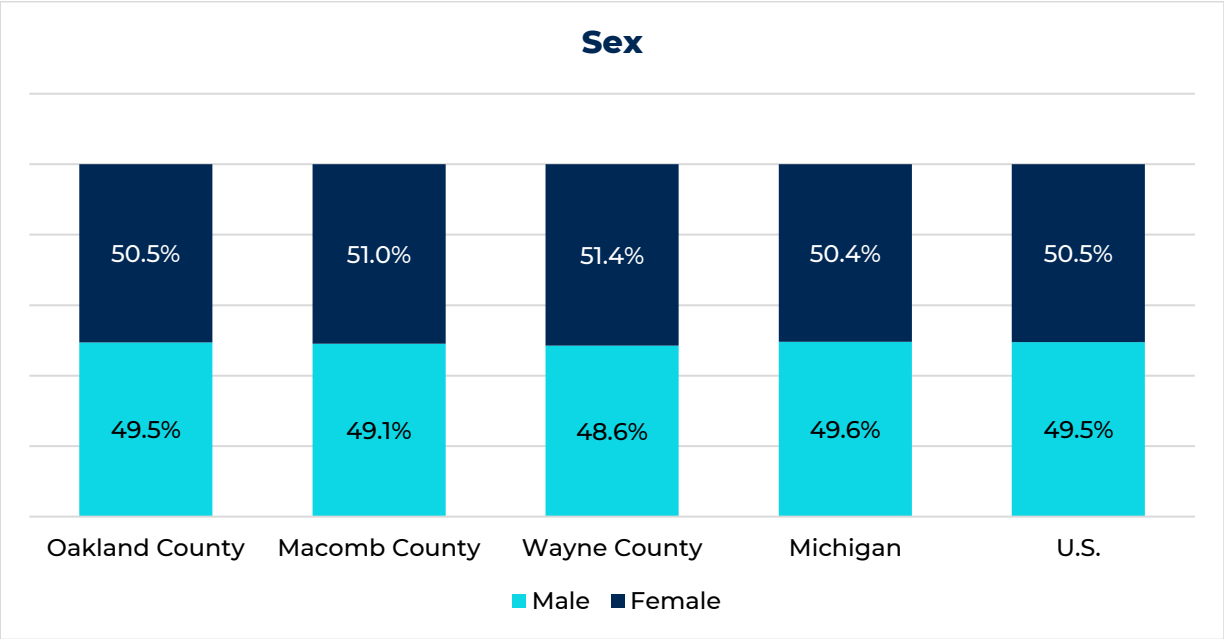


Data labels show the highest percentage in each age group

Sex

As seen in Figure 5, all three counties are similar to the state of Michigan and the nation.

Figure 5: population by sex: service area, state, and nationwide comparisons

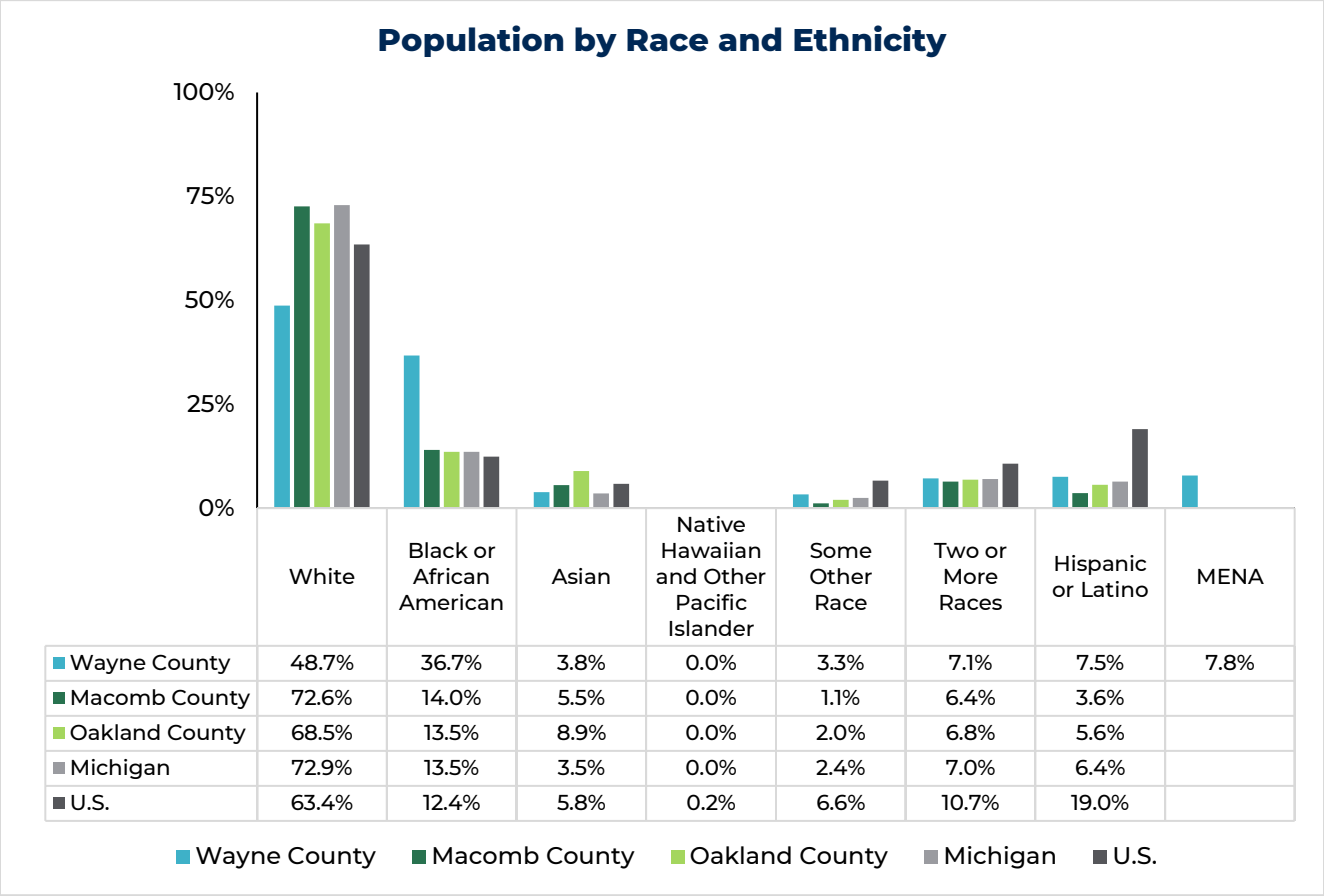


Race and Ethnicity

Considering the racial and ethnic composition of a population is important in planning for future community needs, particularly for schools, businesses, community centers, health care, and childcare. Analysis of health and social determinants of health data by race/ethnicity can also help identify disparities in housing, employment, income, and poverty.

Within the Corewell Health in Southeast Michigan service area, Macomb and Oakland counties reflect statewide demographics, with the majority of residents identifying as White. In contrast, as shown in Figure 6, Wayne County has a significantly higher percentage of residents identifying as Black or African American (36.7%) compared to both the state of Michigan (13.5%) and the national average (12.4%). Wayne County also has the highest proportion of Hispanic/Latino residents among the three counties in the service area at 7.5%. Additionally, 7.8% of Wayne County's population identifies as Middle Eastern or North African (MENA), with about one-third of that group being of Lebanese descent.[6]

Figure 6: population by Race and Ethnicity



	White	Black or African American	Asian	Native Hawaiian and Other Pacific Islander	Some Other Race	Two or More Races	Hispanic or Latino	MENA
Wayne County	48.7%	36.7%	3.8%	0.0%	3.3%	7.1%	7.5%	7.8%
Macomb County	72.6%	14.0%	5.5%	0.0%	1.1%	6.4%	3.6%	
Oakland County	68.5%	13.5%	8.9%	0.0%	2.0%	6.8%	5.6%	
Michigan	72.9%	13.5%	3.5%	0.0%	2.4%	7.0%	6.4%	
U.S.	63.4%	12.4%	5.8%	0.2%	6.6%	10.7%	19.0%	

U.S. value taken from American Community Survey (2019-2023)
MENA value for Wayne County taken from 3.5 Million Reported Middle Eastern and North African Descent in 2020

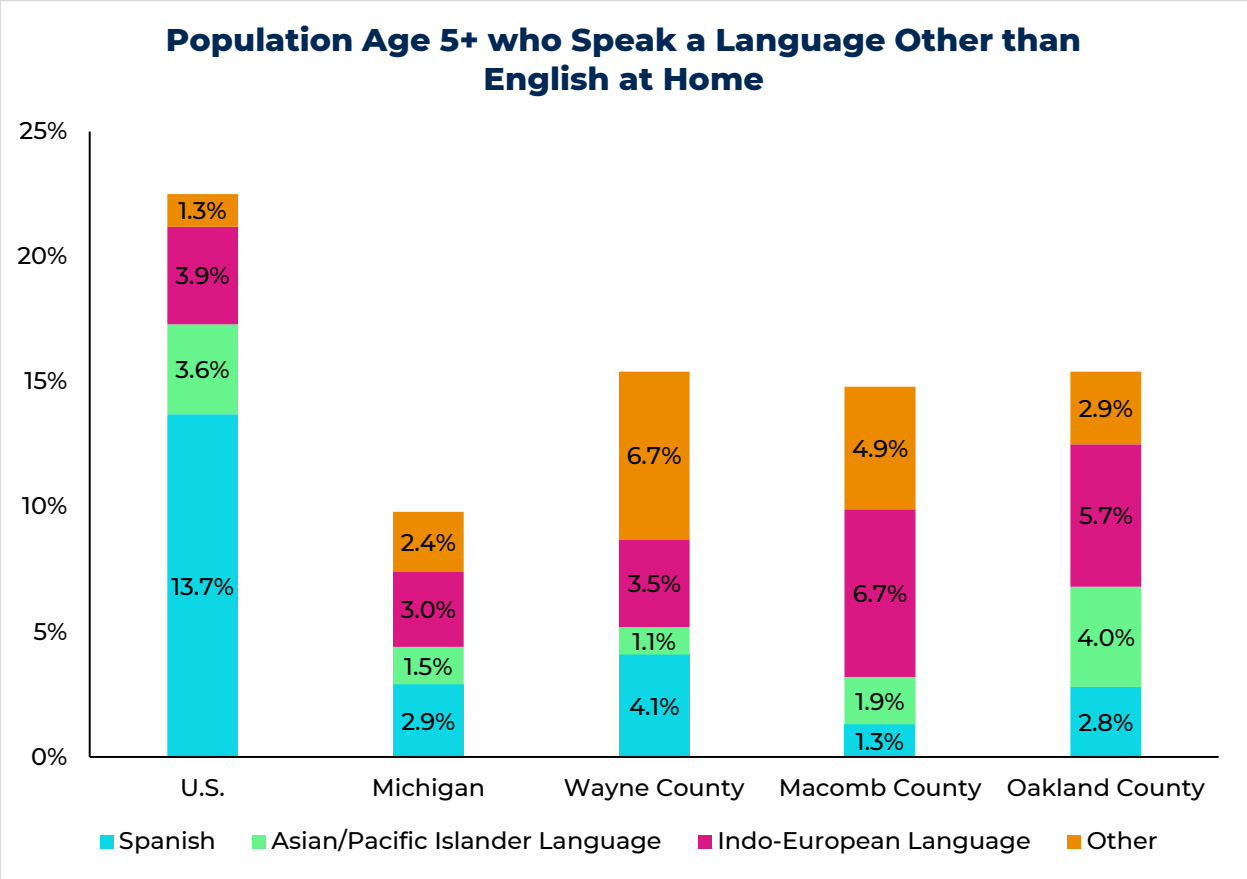
[6] 3.5 Million Reported Middle Eastern and North African Descent in 2020

Language and Immigration

As shown in Figure 7, approximately 85% of residents in the Corewell Health in Southeast Michigan service area speak only English at home. About 190,000 Arabic speakers live in Detroit-Warren-Dearborn metro area in Michigan. They represent about 13% of all Arabic speakers in the U.S. and 91% of those in Michigan.[7]

Wayne County has the highest percentage of residents who speak Spanish at home (4.1%), which is higher than the state average but significantly lower than the national average.

Figure 7: language other than English at home



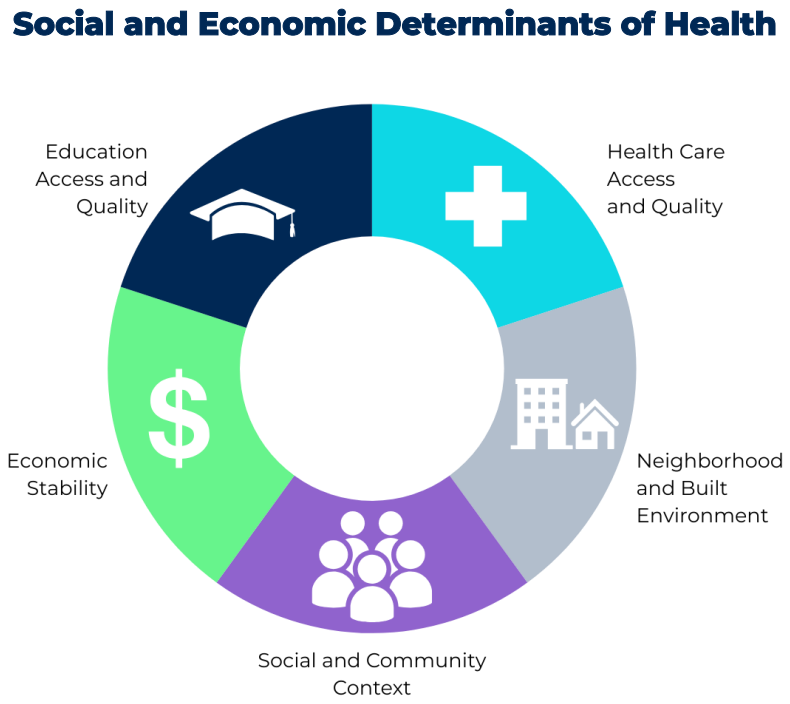
U.S. value taken from American Community Survey (2019-2023)

[7] Facts about Arabic speakers in the US | Pew Research Center

Social and Economic Determinants of Health

This section explores the economic, environmental and social determinants of health for Macomb, Oakland, and Wayne counties. Social determinants are the conditions in which people are born, live, learn, work, play, worship and age. These wider sets of forces and systems shape the conditions of daily life. The Social Determinants of Health (SDOH) can be grouped into domains. Figure 8 shows the Healthy People 2030 Social Determinants of Health domains.[8] It should be noted that county-level data can sometimes mask what could be going on at the ZIP code level in many communities. While indicators may be strong at the county level, ZIP code level analysis can reveal disparities.

Figure 8: Healthy People 2030 social determinants of health domains



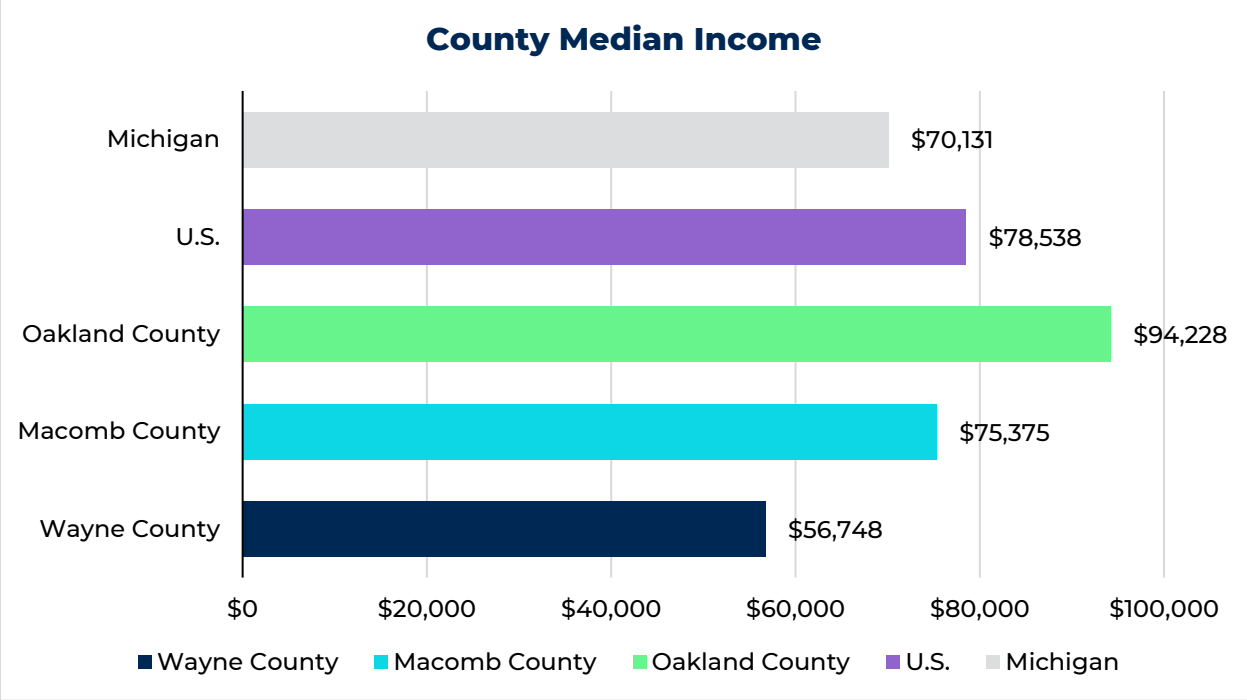
[8] Social Determinants of Health; odphp.health.gov/healthypeople/priority-areas/social-determinants-health

Income

Income has been shown to be strongly associated with morbidity and mortality, influencing health through various clinical, behavioral, social, and environmental factors. Those with greater wealth are more likely to have higher life expectancy and reduced risk of a range of health conditions including heart disease, diabetes, obesity, and stroke. Poor health can also contribute to reduced income by limiting one's ability to work.

Figure 9 illustrates the median household income across the Corewell Health in Southeast Michigan service area, with comparisons to state and national benchmarks. Notable disparities exist between counties within the region. For example, the median household income in Wayne County is $37,480 less than in Oakland County. Macomb County most closely aligns with both the state and national median income levels.

Figure 9: median household income by: county, state and U.S. comparisons



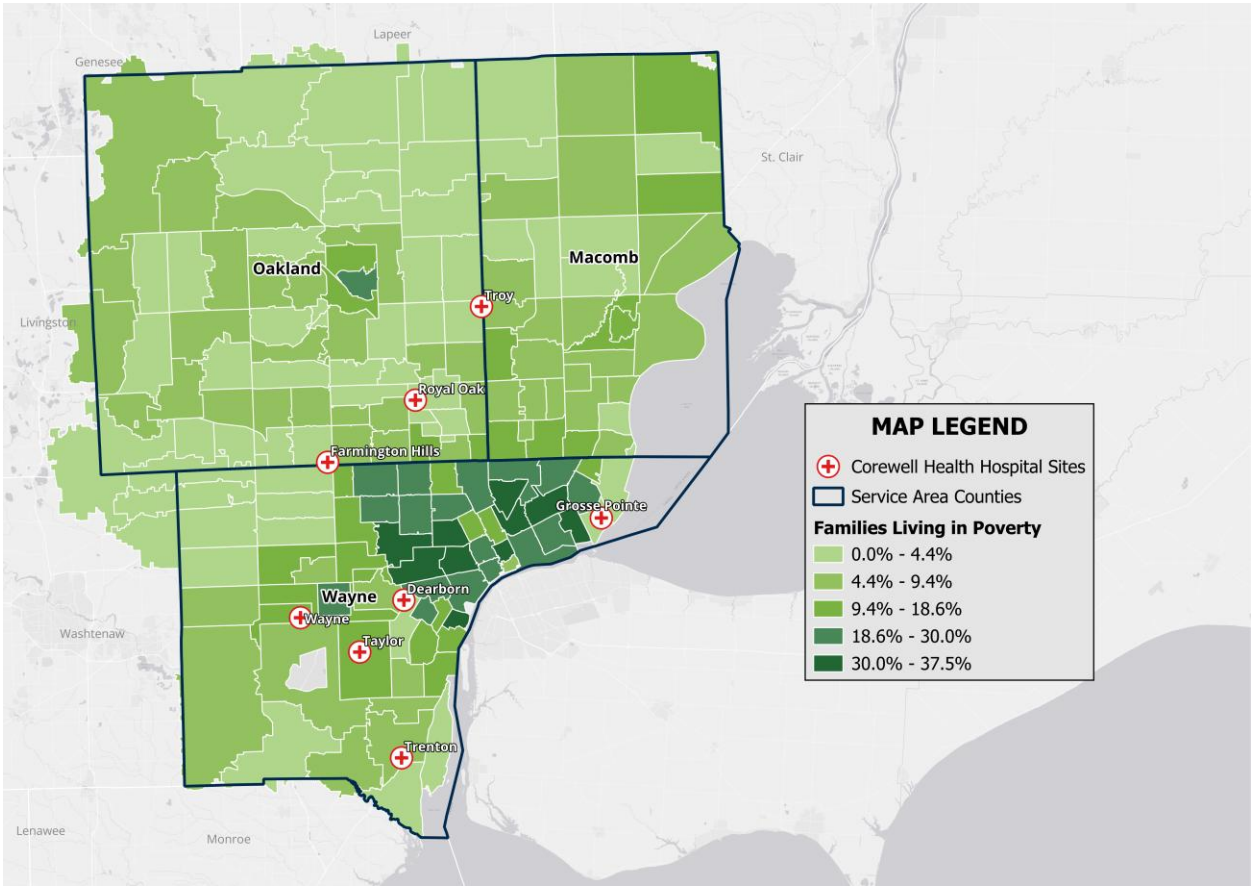
U.S. value taken from American Community Survey (2019-2023)

Poverty

Federal poverty thresholds are set every year by the Census Bureau and vary by size of family and ages of family members. People living in poverty are less likely to have access to health care, healthy food, stable housing, and opportunities for physical activity. These disparities mean people living in poverty are more likely to experience poorer health outcomes and premature death from preventable diseases.[9]

Figure 10 displays a map showing the percentage of families living below the poverty level by ZIP code. Darker green areas indicate higher concentrations of families living in poverty. Wayne County has the highest poverty rate in the Corewell Health in Southeast Michigan service area at 16.0%, nearly double the rates for both Michigan (9.0%) and the United States (8.7%).

Figure 10: percent of families living below poverty level by zip code



The percentage of families living below poverty for each ZIP code in the service area is provided in Table 1. The ZIP code in the service area with the highest concentration of poverty is 48211 where 37.5% of families live below poverty level.

[9] U.S. Department of Health and Human Services, Healthy People 2030. health.gov/healthypeople/objectives-anddata/browse-objectives/economic-stability/reduce-proportion-people-living-poverty-sdoh-01

Table 1. Families living in poverty: Corewell Health in Southeast Michigan primary service area

ZIP Code	% of Families in Poverty	ZIP Code	% of Families in Poverty	ZIP Code	% of Families in Poverty	ZIP Code	% of Families in Poverty	ZIP Code	% of Families in Poverty
48211	37.5	48184	14.2	48034	6.9	48065	4.2	48315	2.3
48213	37.3	48091	13.7	48313	6.8	48065	4.2	48320	2.3
48212	36.1	48237	12.6	48313	6.8	48381	4.2	48170	2.3
48210	36	48036	12.5	48326	6.8	48383	4.1	48173	2.3
48228	35.8	48062	12.2	48393	6.7	48322	3.9	48178	1.9
48215	34.6	48192	12.1	48075	6.6	48324	3.9	48462	1.9
48204	34.5	48229	12.1	48076	6.6	48371	3.9	48304	1.8
48201	33.1	48048	12	48111	6.3	48152	3.9	48370	1.8
48126	31.3	48217	11.9	48005	6.2	48101	3.8	48025	1.7
48218	30.8	48186	11.5	48183	6.2	48390	3.7	48067	1.6
48208	30	48310	11.1	48350	6.1	48236	3.6	48095	1.3
48141	29.9	48089	10.9	48094	6	48081	3.4	48072	1.3
48238	29.9	48030	10.8	48094	6	48009	3.4	48095	1.3
48203	29.6	48240	10.6	48015	5.9	48187	3.4	48098	1.3
48120	28.4	48128	10.4	48380	5.9	48309	3.3	48164	1.3
48224	28.3	48043	10.3	48124	5.9	48348	3.3	48168	1.3
48205	28.2	48239	10.2	48314	5.8	48356	3.3	48360	1.2
48209	27.1	48185	10.1	48033	5.8	48359	3.2	48154	1.2
48342	26.4	48045	9.4	48082	5.7	48375	3.2	48070	1.1
48216	26.2	48135	9.1	48165	5.6	48329	3.1	48363	1.1
48234	26.2	48026	8.6	48047	5.5	48374	3.1	48069	0.7
48122	26.1	48195	8.6	48083	5.5	48301	3	48306	0.5
48235	25.7	48071	8.5	48220	5.4	48042	2.8	48050	0
48227	23.9	48193	8.5	48038	5.2	48042	2.8		
48223	22.8	48051	8.4	48346	5.1	48335	2.8		
48207	22.6	48174	8.4	48382	5.1	48316	2.7		
48214	22.4	48066	8.1	48096	5	48073	2.7		
48219	22.2	48134	8.1	48377	5	48316	2.7		
48206	18.6	48386	7.9	48323	4.9	48230	2.7		
48021	18.2	48035	7.8	48088	4.8	48044	2.6		
48341	18	48093	7.6	48084	4.8	48044	2.6		
48125	17.3	48317	7.6	48302	4.8	48362	2.6		
48146	17.2	48317	7.6	48327	4.8	48138	2.6		
48221	17.2	48312	7.5	48331	4.8	48017	2.5		
48202	17	48080	7.4	48442	4.7	48085	2.5		
48340	16.1	48328	7.4	48334	4.6	48150	2.5		
48127	15.9	48357	7.3	48188	4.5	48167	2.4		
48225	14.8	48226	7.1	48307	4.4	48367	2.4		
48180	14.6	48092	7	48336	4.3	48315	2.3		

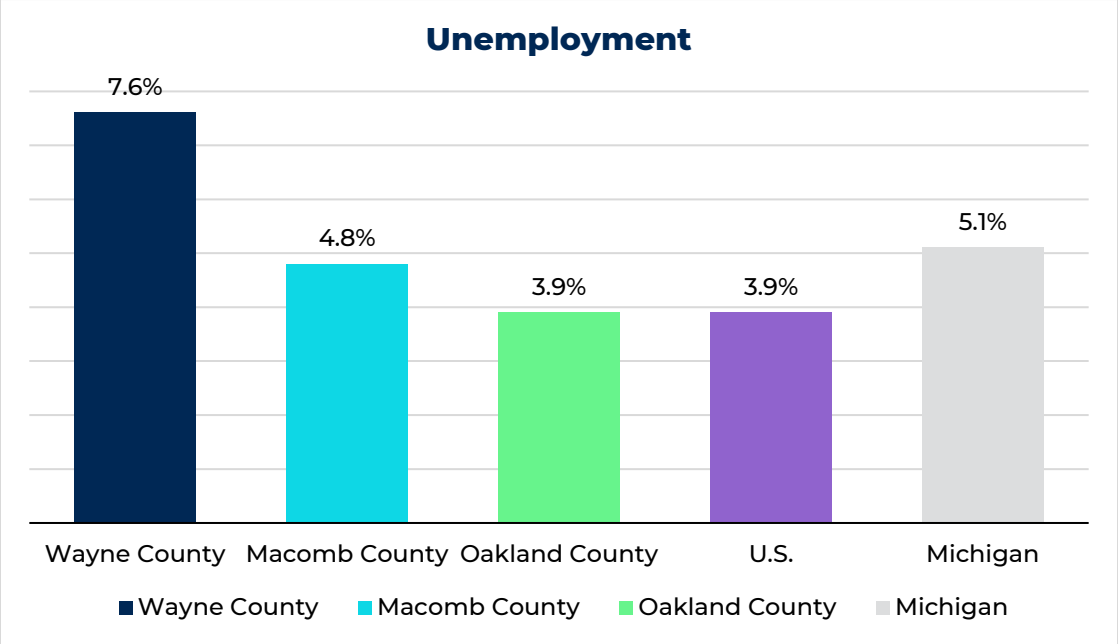
Employment

A community's employment rate is a key indicator of the local economy. An individual's type and level of employment impacts access to health care, work environment, health behaviors, and health outcomes. Stable employment can help provide benefits and conditions for maintaining good health. In contrast, poor or unstable work and working conditions are linked to poor physical and mental health outcomes.[10]

Unemployment and underemployment can limit access to health insurance coverage and preventive care services. Underemployment is described as involuntary part-time employment, poverty-wage employment, and insecure employment.[11] Type of employment and working conditions can also have significant impacts on health. Work-related stress, injury, and exposure to harmful chemicals are examples of ways employment can lead to poorer health.[12]

Figure 11 illustrates the percentage of the population aged sixteen and over who are unemployed across the Corewell Health in Southeast Michigan service area. Wayne County has the highest unemployment rate at 7.6%, nearly double the rate of Michigan (3.9%). In contrast, Oakland County has the lowest unemployment rate in the region, matching the state average at 3.9%.

Figure 11: population 16+ unemployed: county, state, and U.S.



U.S. value taken from American Community Survey (2019-2023)

[10] U.S. Department of Health and Human Services, Healthy People 2030. health.gov/healthypeople/objectives-anddata/social-determinants-health/literature-summaries/employment
[11] Healthy People 2023. Employment - Healthy People 2030 | odphp.health.gov
[12] NIOSH Study 2021. cdc.gov/niosh/updates/upd-11-18-21.html

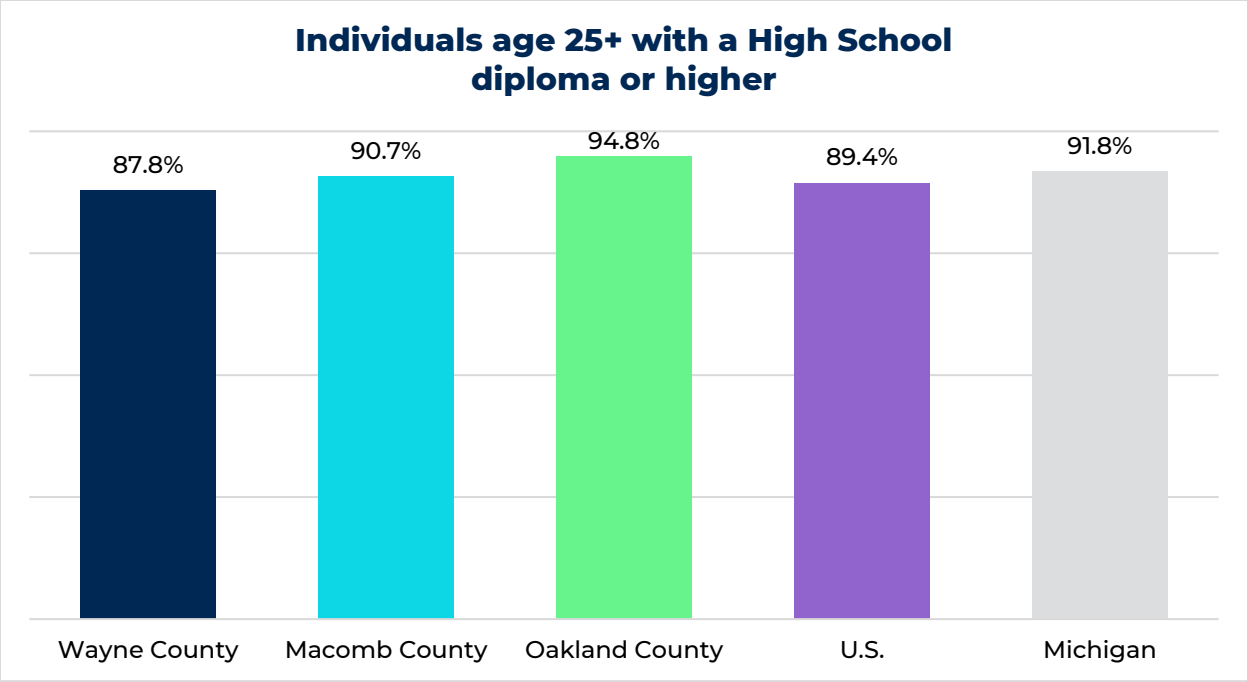
Education

Education is an important indicator for health and wellbeing across the lifespan. Education can lead to improved health by increasing health knowledge, providing better job opportunities and higher income, and improving social and psychological factors linked to health. A high school diploma in particular is a requirement for many employment opportunities and for higher education. Not graduating high school is linked to a variety of negative health impacts, including limited employment prospects, low wages, and poverty.[13] Further, people with higher levels of education are likely to live longer, to experience better health outcomes, and practice health-promoting behaviors.[14]

Figure 12 highlights educational attainment among residents aged twenty-five and older within the Corewell Health in Southeast Michigan primary service area. Wayne County falls below both the state and national averages for individuals who have earned a high school diploma or higher, as well as a bachelor's degree or higher.

In contrast, Figure 13 shows Oakland County significantly exceeds the state and national averages for residents with a bachelor's degree or higher, with 50.3% of adults holding at least a four-year degree.

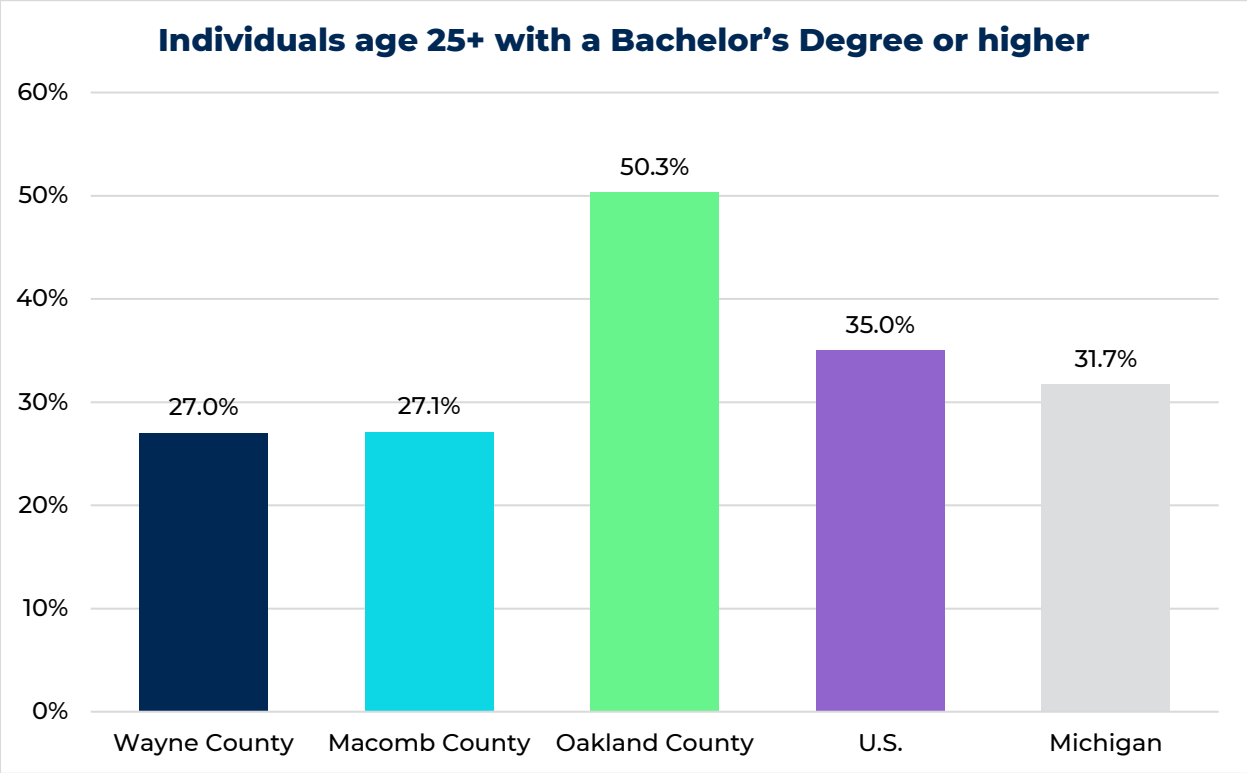
Figure 12: Corewell Health in Southeast Michigan primary service area population by educational attainment, individuals age 25+ with a high school diploma or higher



U.S. value taken from American Community Survey (2019-2023)

[13] U.S. Department of Health and Human Services, Healthy People 2030. health.gov/healthypeople/priority-areas/social-determinants-health
[14] Robert Wood Johnson Foundation, Education and Health. rwjf.org/en/library/research/2011/05/educationmatters-for-health.html

Figure 13: Corewell Health in Southeast Michigan primary service area population by educational attainment, individuals age 25+ with a bachelor's degree or higher



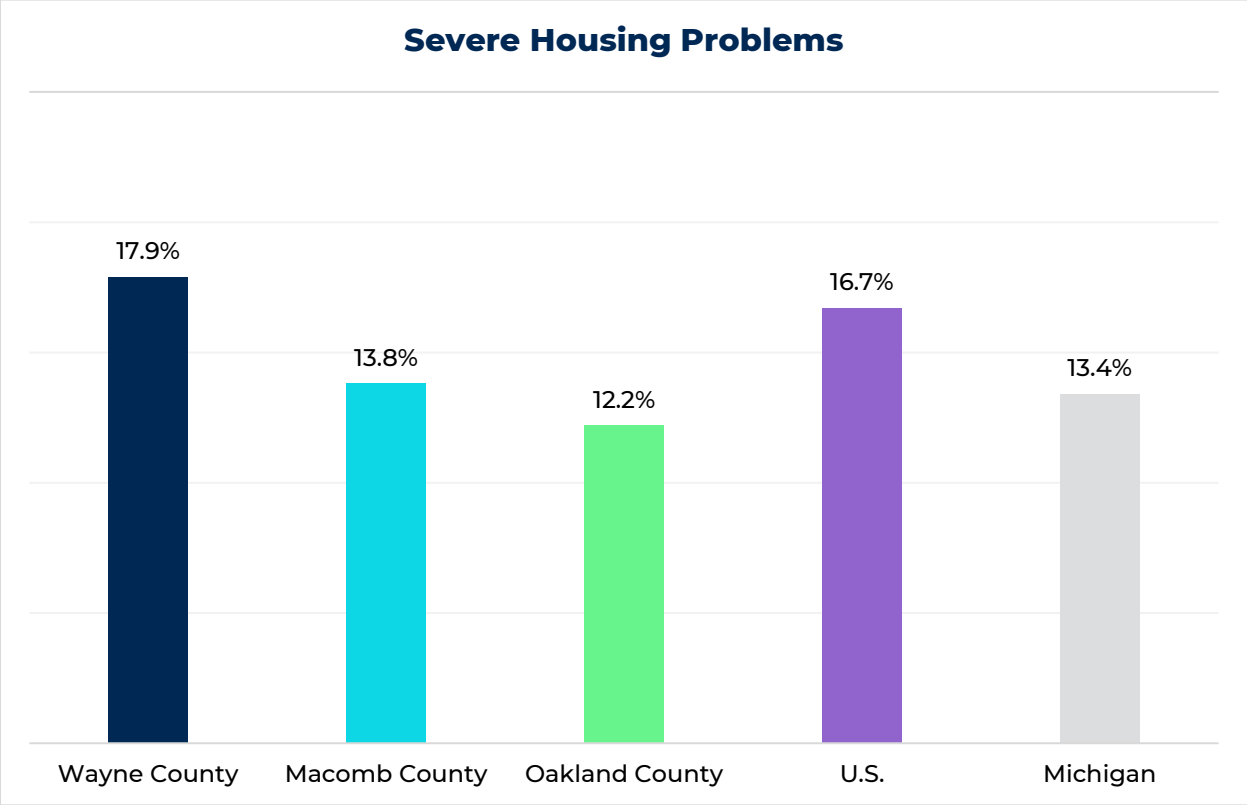
U.S. value taken from American Community Survey (2019-2023)

Housing

Safe, stable, and affordable housing provides a critical foundation for health and wellbeing. Exposure to health hazards and toxins in the home can cause significant damage to an individual or family's health.[15]

Figure 14 shows the percentage of severe housing problems across the Corewell Health in Southeast Michigan service area. Wayne County reports the highest rate at 17.9%, indicating that households there are more likely to experience at least one of the following issues: overcrowding, high housing costs, lack of a kitchen, or lack of plumbing facilities.

Figure 14: households with severe housing problems



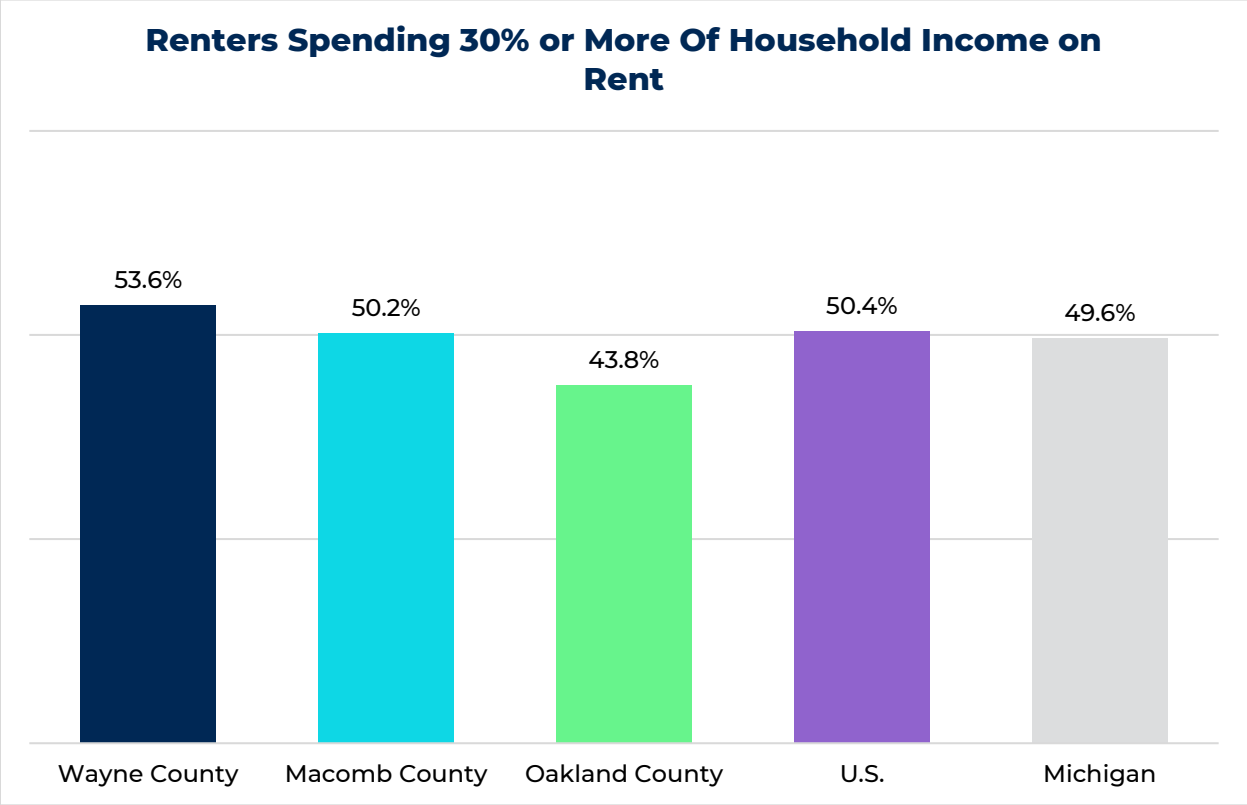
County, state, and U.S. values taken from County Health Rankings (2016-2020)

[15] County Health Rankings, Housing and Transit. countyhealthrankings.org/explore-health-rankings/measures-data-sources/county-health-rankings-model/health-factors/physical-environment/housing-and-transit

When families must spend a large portion of their income on housing, they may not have enough money to pay for things like healthy food or health care. This is linked to increased stress, mental health problems and an increased risk of disease.[16]

Figure 15 illustrates the percentage of renters in the Corewell Health in Southeast Michigan service area who spend 30% or more of their household income on rent. Wayne County and Macomb County are generally aligned with state and national averages. In contrast, Oakland County reports a significantly lower percentage, with 43.8% of renters spending 30% or more of their income on housing.

Figure 15: renters spending 30% or more of household income on rent: county, state, and U.S. comparisons



County, State, and U.S. values taken from American Community Survey (2019-2023)

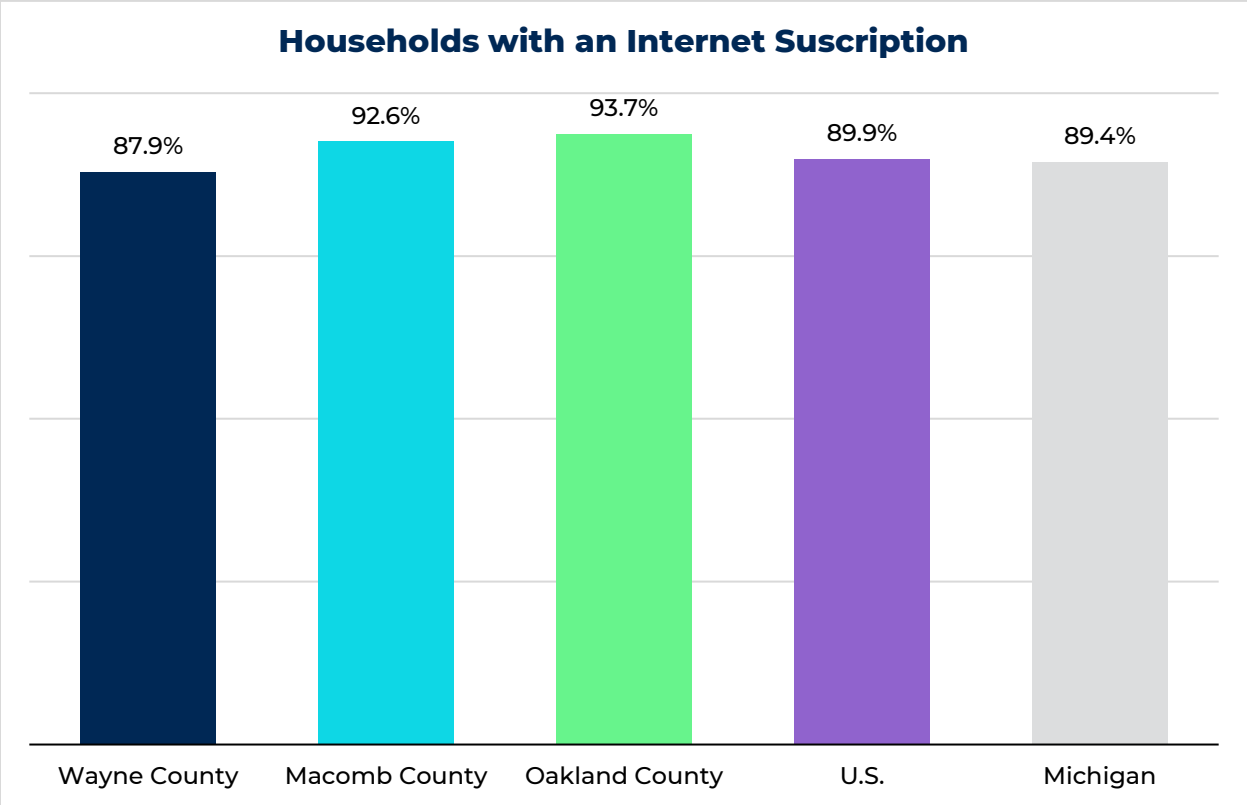
[16] U.S. Department of Health and Human Services, Healthy People 2030. health.gov/healthypeople/objectives-and-data/browse-objectives/housing-and-homes/reduce-proportion-families-spend-more-30-percent-income-housing-sdoh-04

Neighborhood and Built Environment

Internet access is essential for basic health care access, including making appointments with providers, getting test results, and accessing medical records. Access to the internet also helps expand health care access through home-based telemedicine services, which has been particularly critical during the COVID-19 pandemic.[17] Internet access may also help individuals seek employment opportunities, conduct remote work, and participate in online educational activities.[9]

Figure 16 presents the percentage of households with an internet subscription across the Phoebe Sumter service area. Wayne County has the lowest subscription rate in the region at 87.9%, which falls below both the state and national averages for internet access.

Figure 16: households with an internet subscription



County, State, and U.S. values taken from American Community Survey (2019-2023)

[17] U.S. Department of Health and Human Services, Healthy People 2030. health.gov/healthypeople/objectives-and-data/browse-objectives/neighborhood-and-built-environment/increase-proportion-adults-broadband-internet-hchit-05

Primary and Secondary Methodology and Key Findings

Overview

The 2025 Community Health Needs Assessment (CHNA) for Macomb, Oakland, and Wayne counties utilized a combination of primary and secondary data sources to identify and analyze current health-related challenges affecting the region.

Secondary data was obtained from publicly available sources, including federal, state, and local health departments. These health indicators provided valuable context and supported the interpretation of community input.

Primary data was gathered directly from community members through both in-person and virtual listening sessions and focus groups. Outreach activities included county-wide survey campaigns, eight focus groups, and three listening sessions. When appropriate, data collection was conducted in both English, Spanish, and Arabic to ensure inclusivity and broader representation.

Secondary Data Sources and Analysis

Secondary data used for this assessment were collected and analyzed with Conduent Healthy Communities Institute (HCI).

HCI's Data Scoring Tool systematically summarizes multiple comparisons and ranks indicators based on the highest need. For each indicator, the Michigan Counties' value was compared to a distribution of state and U.S. counties, state and national values, Healthy People 2030 targets, and significant trends, illustrated in Table 2. Each indicator was then given a score based on the available comparisons. These scores range from 0 to 3, where 0 indicates the best outcome and three indicates the worst outcome. Availability of each type of comparison varies by indicator and is dependent upon the data source, comparability with data collected from other communities, and changes in methodology over time. These indicators were grouped into topic areas for a higher-level ranking of community health needs.

Tables 3-5 show the health and quality of life topic scoring results for each county in the Corewell Health in Southeast Michigan service area.

Table 2. Secondary data scoring

Counties
U.S. Counties
MI Value
U.S. Value
HP2030
Trend

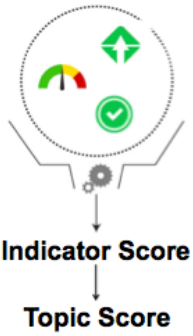


Table 3. Macomb county secondary data topic scoring results

Health and Quality of Life Topics	Score
Diabetes	2.09
Older Adults	2.07
Other Conditions	1.90
Heart Disease and Stroke	1.81
Respiratory Diseases	1.81
Mental Health and Mental Disorders	1.70
Alcohol and Drug Use	1.63
Physical Activity	1.63
Education	1.62
Cancer	1.60
Wellness and Lifestyle	1.42
Women's Health	1.40
Sexually Transmitted Infections	1.40
Prevention and Safety	1.36
Environmental Health	1.35
Children's Health	1.31
Economy	1.27
Community	1.22
Immunizations and Infectious Diseases	1.20
Maternal, Fetal and Infant Health	1.19
Health Care Access and Quality	1.16
Oral Health	0.95

Table 4. Wayne county secondary data topic scoring results

Health and Quality of Life Topics	Score
Sexually Transmitted Infections	2.35
Diabetes	2.20
Economy	2.08
Wellness and Lifestyle	1.95
Children's Health	1.84
Education	1.84
Prevention and Safety	1.80
Respiratory Diseases	1.79
Immunizations and Infectious Diseases	1.79
Older Adults	1.78
Maternal, Fetal and Infant Health	1.76
Other Conditions	1.69
Cancer	1.67
Heart Disease and Stroke	1.66
Community	1.63
Alcohol and Drug Use	1.55
Environmental Health	1.55
Physical Activity	1.53
Mental Health and Mental Disorders	1.51
Women's Health	1.37
Health Care Access and Quality	1.33
Oral Health	1.22

Table 5. Oakland county secondary data topic scoring results

Health and Quality of Life Topics	Score
Older Adults	1.64
Other Conditions	1.56
Heart Disease and Stroke	1.43
Women's Health	1.30
Physical Activity	1.30
Environmental Health	1.25
Sexually Transmitted Infections	1.23
Cancer	1.22
Diabetes	1.20
Children's Health	1.16
Alcohol and Drug Use	1.09
Economy	1.08
Respiratory Diseases	1.07
Community	1.04
Mental Health and Mental Disorders	1.01
Prevention and Safety	0.94
Education	0.93
Immunizations and Infectious Diseases	0.91
Maternal, Fetal and Infant Health	0.87
Health Care Access and Quality	0.85
Wellness and Lifestyle	0.81
Oral Health	0.68

Primary Data Collection and Analysis

The Community Health Needs Assessment (CHNA) seeks to understand the most pressing health concerns as identified by residents of Macomb, Oakland, and Wayne counties. To ensure community voices were central to the assessment, multiple opportunities were provided for residents to share their perspectives.

Primary data was collected through an online survey, listening sessions and a series of focus groups to promote inclusiveness and accessibility. These engagement efforts were designed to capture a diverse range of experiences and insights from across the community.

Virtual listening sessions and in-person focus groups were coordinated with the support of local community organizations. These partners played a vital role in promoting the survey, recruiting participants, and managing coordination to facilitate meaningful participation in the focus groups.

As part of the data collection process, a community mapping activity was conducted to visually identify health-related assets, gaps, and needs across Macomb, Oakland, and Wayne counties.

Community Partner Assessment

Listening Sessions and Asset Mapping

Corewell Health Southeast Michigan, in collaboration with Conduent HCI, conducted listening sessions and a community asset mapping activity with key partners to gather both quantitative and qualitative data on health needs across Macomb, Oakland, and Wayne counties. Conduent HCI administered an online survey to collect initial input, followed by a virtual discussion to explore deeper insights and feedback. Corewell Health's Southeast Michigan CHNA team identified and invited a diverse group of community partners to participate in these sessions.

The primary goal of the listening sessions and asset mapping activity was to identify health needs, gaps, available resources, and opportunities to strengthen collaboration within the communities served by Corewell Health Southeast Michigan. A total of thirty-two individuals responded to the online listening session survey, and a total of forty-two participated in the virtual sessions across all counties. Participants represented a broad range of sectors, including education, nonprofit, philanthropy, state and local government, for-profit organizations, health care, and justice/law enforcement.

During the recorded sessions, facilitators asked participants targeted questions about survey results, top community health concerns, barriers to care, community strengths, and available resources. Feedback was documented and analyzed to inform the CHNA process and guide future planning efforts.

Transcripts from the listening sessions were analyzed using a structured codebook to identify recurring themes and significant observations. The frequency with which

specific health topics were mentioned helped assess the relative importance of various health and social needs. Notes from the sessions were uploaded to Qualtrics, a web-based qualitative data analysis tool, to support systematic coding and interpretation. The detailed results from the listening sessions are presented in Appendix B and the asset mapping results are in Appendix C. Table 6 summarizes the key health needs identified through this process.

Table 6. Listening Session key health needs

Top Health Concerns/Issues	Barriers to Access	Most Affected Populations
Mental Health	Transportation	Older Adults/Seniors
Access to health care	Language barriers	LGBTQ+
Housing Insecurity	Stigma	People with disabilities
Food Insecurity	Understaffed facilities	Low-income

Community Survey

Community input was collected through an online and paper survey available in English, Spanish, and Arabic, conducted from July 7 to Aug. 25, 2025. The survey included fifty-two questions focused on identifying top health concerns, perceptions of personal health, access to health care services, and the influence of social and economic determinants of health.

To promote participation across Macomb, Oakland, and Wayne counties, outreach efforts included mass emails, social media posts, targeted email blasts to partner organizations, and distribution of QR codes at in-person events. Corewell Health in Southeast Michigan team members, along with internal and external teams, played a key role in amplifying survey visibility and encouraging community engagement.

A total of 2,291 responses were received:

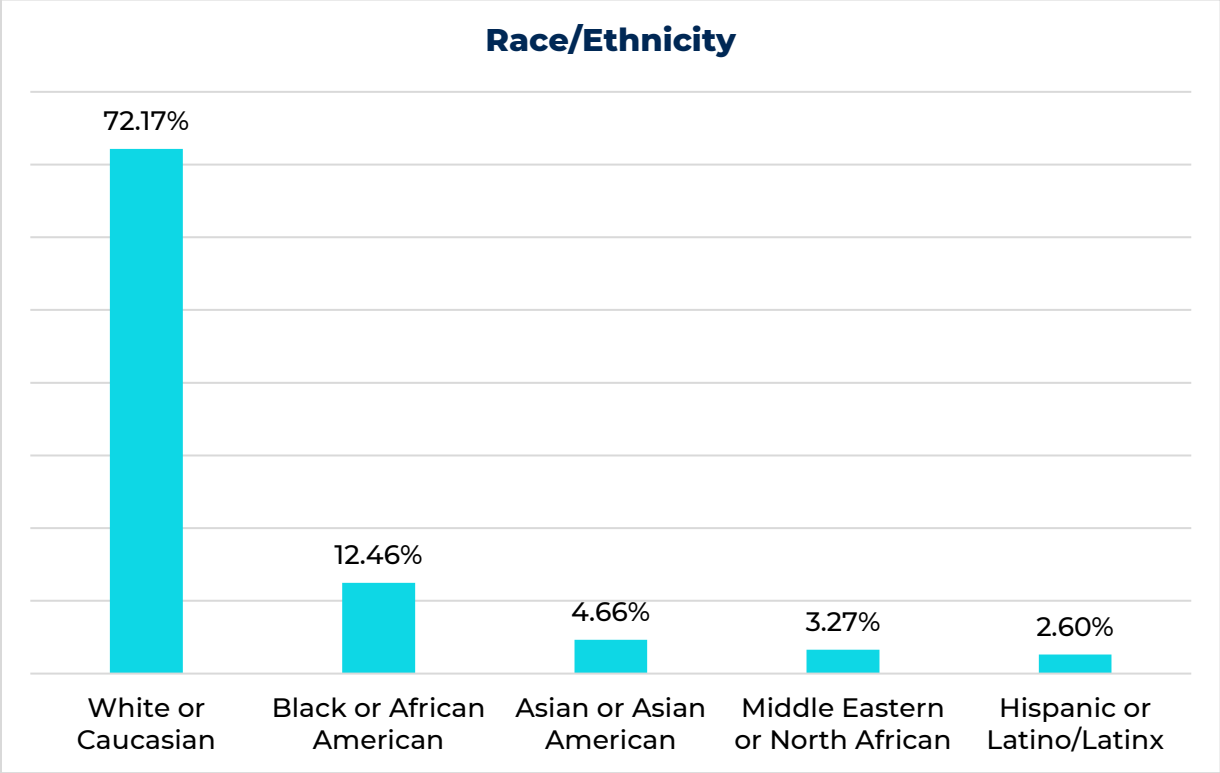
- Macomb County: 537 responses
- Oakland County: 761 responses
- Wayne County: 993 responses

Survey response rates across the service area exceeded the target threshold of 384 responses per county, ensuring a strong and representative sample for analysis.

Surveys were completed in English and Arabic. Approximately 72% of survey respondents described themselves as White or Caucasian, 12.46% as Black or African American, 4.66% as Asian or Asian American, 3.27% Middle Eastern and 3.60% Hispanic or Latino/Latinx (Figure 17). Most respondents identified as female (Figure 18), and the largest age group ranged from 54 to 64, followed by 35 to 44 (Figure 19).

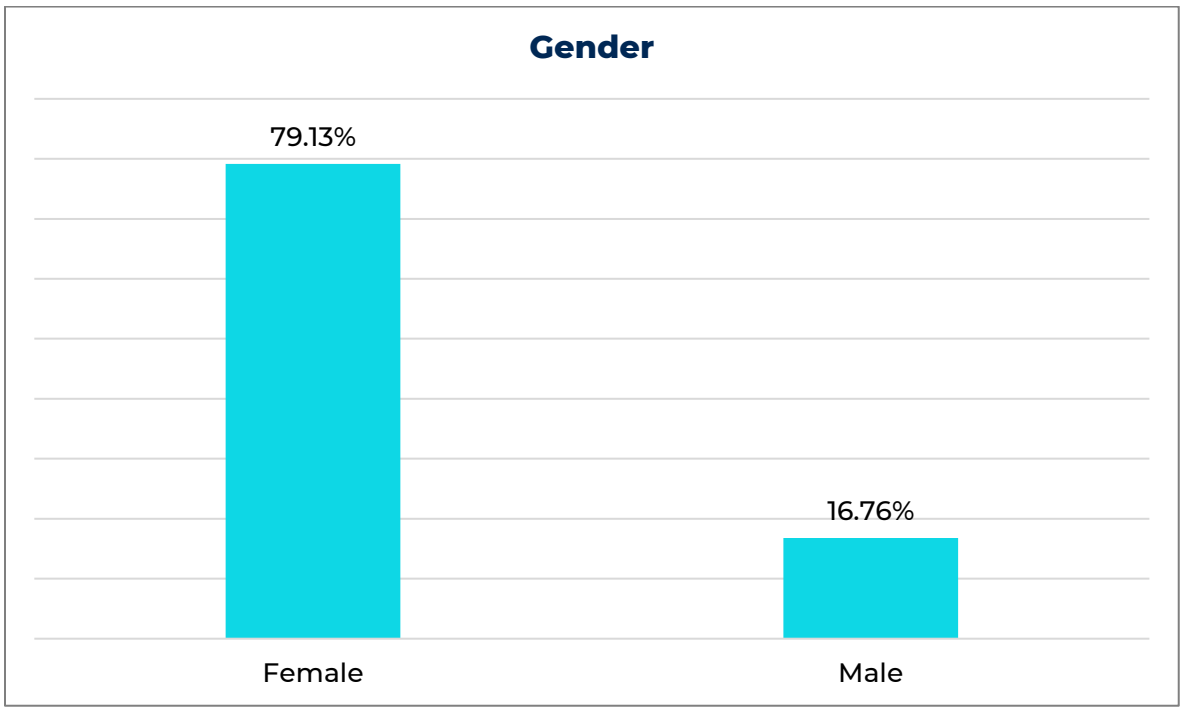
33.94% had a bachelor's degree, followed by 18.51% with a master's degree and 19.24% with a high school diploma/GED (Figure 20).

Figure 17: Race/Ethnicity of survey respondents



*Responses labeled as "Other" or "Preferred not to answer," including free-text race/ethnicity, are excluded from this graph due to low response rates.

Figure 18: gender



*Responses labeled as “Other” or “Preferred not to answer,” including free-text gender identifications, are excluded from this graph due to low response rates.

Figure 19: age of respondents

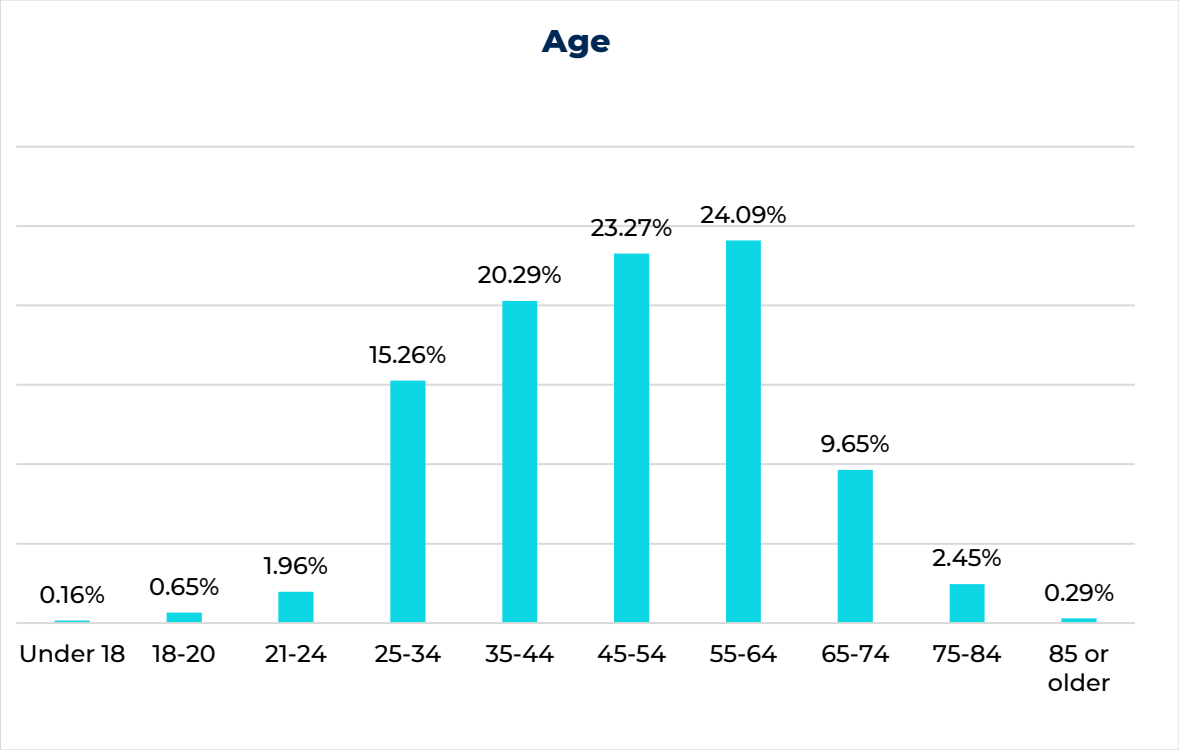
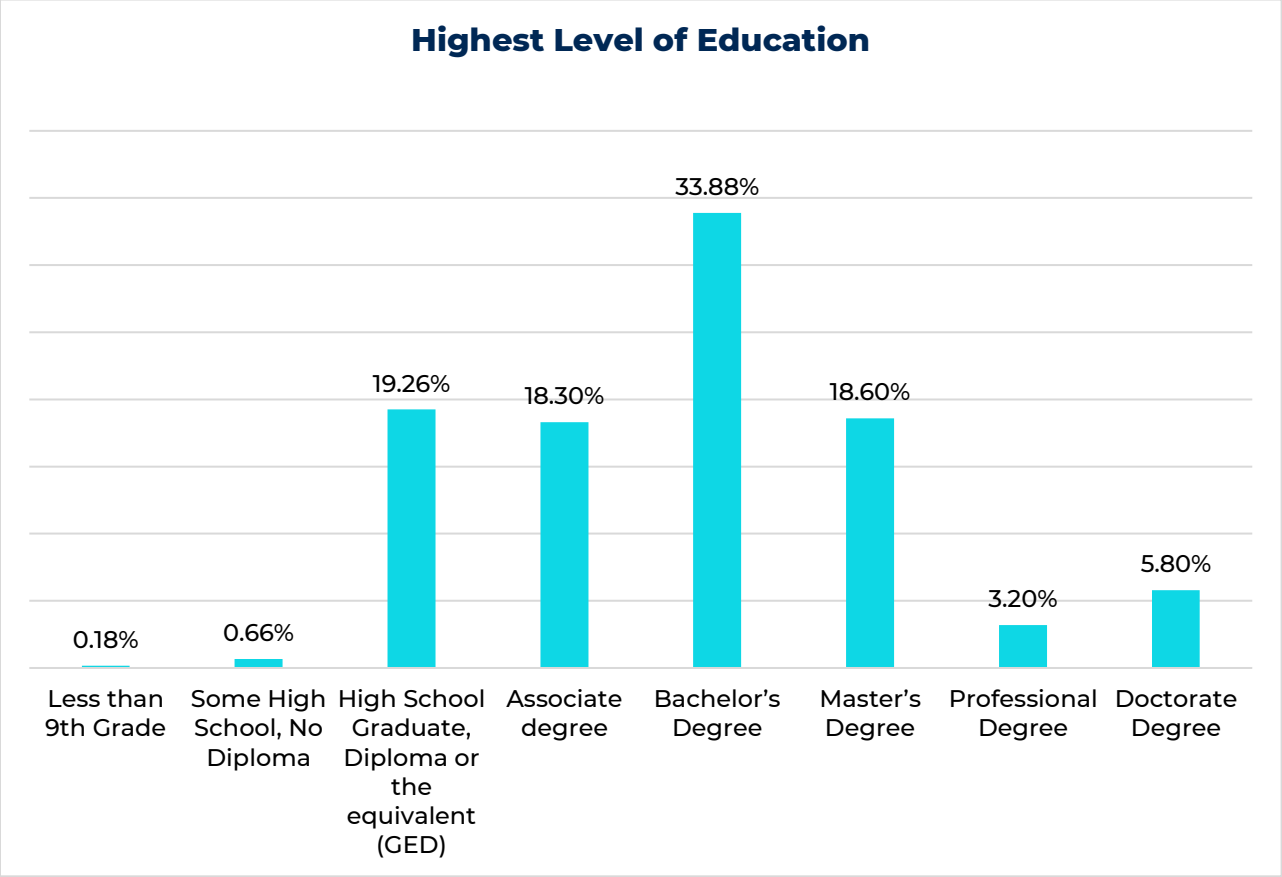


Figure 20: highest level of education



Community Survey Analysis Results

The community survey asked participants to identify the most important health and quality of life issues affecting their communities. Figure 21 shows the top five most important health issues reported, mental health and mental disorders, including anxiety, depression, and suicide, which were selected by 50.84% of respondents. Access to affordable health care services, such as the availability of doctors, wait times, and service options, was the second most cited issue at 35.95%. Weight status, specifically individuals who are overweight or obese, was identified by 27.76% of participants. Alcohol and drug use followed at 24.84%, and nutrition and healthy eating rounded out the top five at 19.67%. These findings reflect the community's priorities and will help guide future planning and resource allocation efforts.

Figure 21: Most Important health issues

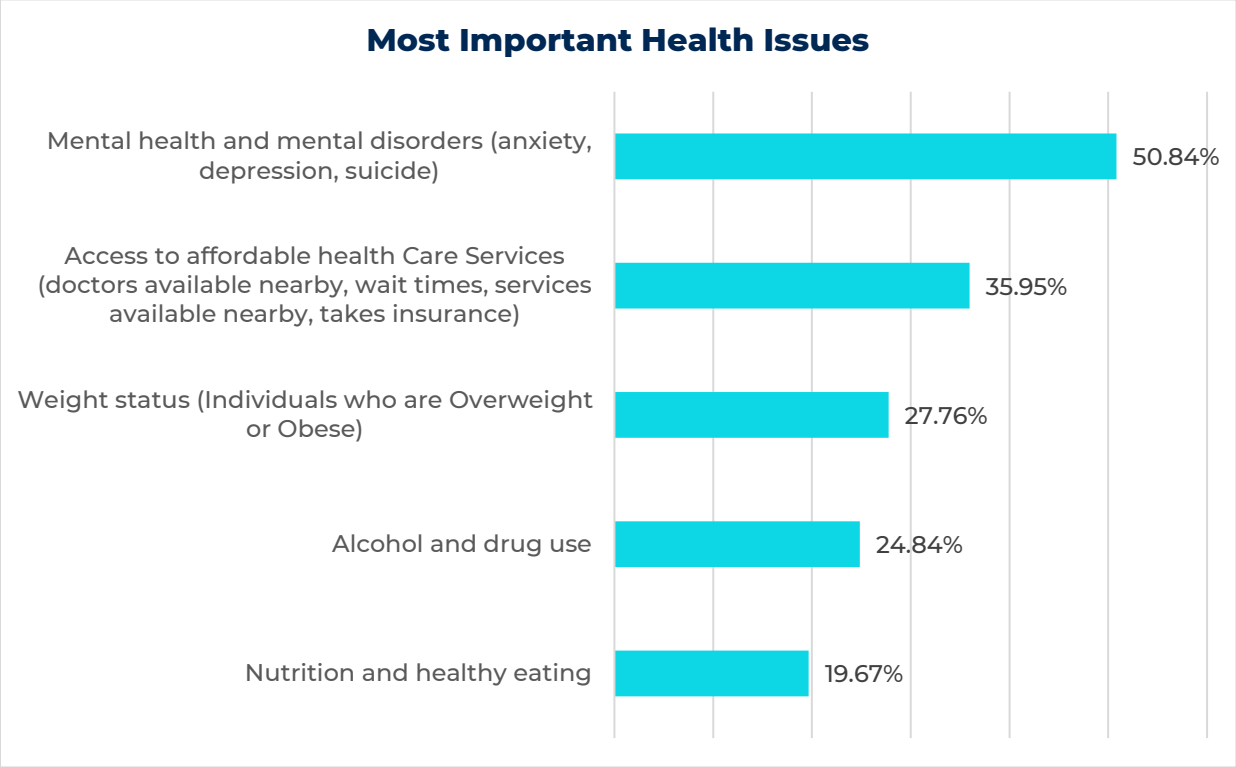
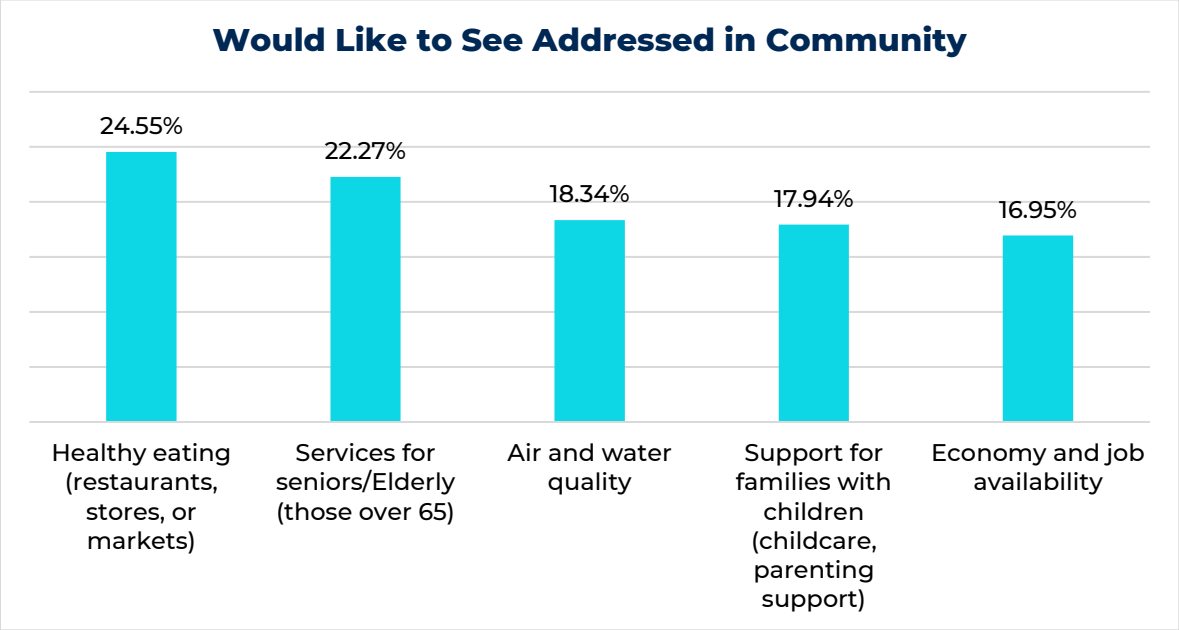


Figure 22 illustrates the top issues that survey respondents would like to see addressed within their communities. The most frequently cited priority was improving access to healthy eating options, such as healthier choices at restaurants, grocery stores, and local markets (24.55%). This was followed by increased services and support for seniors aged sixty-five and older (22.27%), and concerns about environmental health, specifically air and water quality (18.34%). Respondents also emphasized the need for greater support for families with children, including access to childcare and parenting resources (17.94%), as well as improvements in economic development and job availability (16.95%). These responses reflect a strong desire for both health-related improvements and broader social support across the counties surveyed.

Figure 22: most liked to see addressed



Focus Groups

To gain deeper insight into community members' perceptions, attitudes, experiences, and beliefs about health, eight in-person focus groups were conducted between July 21 and Aug. 8, 2025. These sessions were designed to reflect the unique perspectives of each group and are not intended to represent the views of other groups or the broader population.

Eight focus groups were scheduled: six in English, one in Spanish, and one in Arabic. Six were completed in English, one in Arabic, and one in Spanish. Focus groups were facilitated by Conduent HCI and Corewell Health in Southeast Michigan team members. Participants included residents and individuals working in Macomb, Oakland, and Wayne counties. In total, forty-seven individuals took part in the sessions, which lasted between 60 and 90 minutes. Table 7 provides a summary of the eight complete focus groups.

During each session, facilitators asked seven guiding questions to prompt discussion around key community health issues, barriers to health, and local strengths. Responses were recorded, transcribed, and uploaded to a web-based qualitative analysis platform and Qualtrics. Transcripts were tagged, coded, and filtered by topic, using a pre-established codebook, organized by themes, and analyzed to identify significant patterns and observations. The relative importance of health and social needs was assessed in part by the frequency with which topics emerged across all focus groups.

Table 7: focus groups completed

Location	Population	County	Number of Participants	Date
Redford Interfaith Relief	Residents	Wayne	4	July 21, 2025
Downriver YMCA	Residents	Wayne	5	July 22, 2025
Macomb Community College	Residents	Macomb	4	July 23, 2025
Love Life Family Christian Center	Residents	Wayne	9	July 24, 2025
IMAM	Residents	Wayne	4	July 26, 2025
Southwest Detroit Business Association	Residents	Wayne	4	July 31, 2025

Location	Population	County	Number of Participants	Date
Brilliant Detroit	Residents	Wayne	6	July 30, 2025
Honor Community Health	Residents	Oakland	11	July 30, 2025
Total			47	

Themes Across All Focus Groups

Table 8 below summarizes the main themes and topics that trended across the focus group conversations. Appendix B details the main themes trending across focus group conversations.

Table 8: focus group top themes

Top Health Concerns/Issues	Barriers to Accessing Services/Resources	Most Affected Populations
Mental Health	Mistrust in health care system	Seniors/Older Adults
Transportation	Long waits	Non-English Speakers
Diabetes	Financial constraints, high insurance costs	Low income
Access to health care (affordability)	Shortage of providers (mental health/substance abuse services	Homelessness (families/youth)
Housing insecurity	Lack of inpatient hospitals (northern Macomb County)	Foster children

Data Considerations

Several limitations of the data should be considered when reviewing the findings presented in this report. Although the topics by which data are organized cover a wide range of health and health-related areas, within each topic, there is a varying scope and depth of secondary data indicators and primary data findings.

Regarding the secondary data, some health topic areas have a robust set of indicators, but for others, there may be a limited number of indicators for which data is available. The Index of Disparity 2, used to analyze the secondary data, is also limited by data availability. In some instances, there are no subpopulation data for some indicators, and for others, there are only values for a select number of race/ethnic groups.

For the primary data, the extent of findings is dependent upon who was selected to be a key informant. Additionally, the community survey was a convenient sample, which means results may be vulnerable to selection bias and make the findings less generalizable. However, findings did show that the community survey participant sample was representative of the overall demographics of Macomb, Oakland and Wayne Counties. For all data, efforts were made to include a wide range of secondary data indicators and community member expertise areas.

Data Synthesis and Prioritization

To develop a comprehensive understanding of the most pressing health needs, findings from all four data sources were systematically reviewed to identify areas of convergence. Based on this integrated analysis, a structured prioritization session was conducted to finalize the key health needs.

Table 9 presents the eleven significant health needs (listed alphabetically), along with the data sources that identified each need as significant. Secondary data highlighted six needs. Focus group discussions revealed ten areas of concern, listening session participants identified six priority topics, and the community survey pointed to ten areas of need.

Table 9: synthesis results

Health and Quality of Life Category	Data Source
Access to health care	Survey, Listening Sessions (LS), Focus Groups (FG)
Diabetes	Secondary, Survey, FG
Environmental (Water and Air Quality)	Secondary, Survey, FG
Food Insecurity/Healthy Eating	Survey, LS, FG
Heart Disease and Stroke	Secondary, Survey, FG
Housing Insecurity	Survey, LS, FG
Mental Health	Secondary, Survey, LS, FG
Obesity/Weight Status	Survey, LS, FG
Senior/Older Adults	Secondary, Survey, LS, FG
Substance Misuse	Secondary, Survey, LS, FG
Transportation	Survey, LS, FG

Once the synthesis of data was complete, Corewell Health in Southeast Michigan reviewed the results to ensure alignment across the organization. To enhance clarity, consistency, and coordination of care, they revised and standardized the terminology used to describe community health needs. This update ensures that all departments, teams, and facilities are unified in how they identify and address these needs system wide.

The finalized list in Table 10 reflects the updated terminology and outlines the health needs that will be ranked during prioritization.

Table 10: Final list of health needs

Health Needs
Chronic Diseases
Community Safety
Economic Security
Education
Environmental Quality
Food Environment
Health Care Access
Mental Health
Neighborhood and Built Environment
Physical Wellness
Social Cohesion

Prioritization

To better understand activities to address the most pressing health needs in the community, Corewell Health in Southeast Michigan and community partners participated in a prioritization session.

Participants

Those involved in the process were asked to prioritize health needs using their community and clinical knowledge. Participants included:

Name	Role	Organization
Amanda LaVoie, R.D., M.S. FACHE	Senior Director	Hospital Operations, Corewell Health Beaumont Troy
Brad Lukas	Chief Nursing Officer	Corewell Health Beaumont Troy Hospital
Brenden Bell	Associate Director of Programs and Services	Affirmations
Cathy De Leo	Client Support Specialist	Farmington-Farmington Hills Neighborhood House
Chika Obianwu, MPH, MSW	Director	Healthier Communities, Corewell Health in Southeast Michigan
Chineva Early, Ph.D.	Founder/Executive Director	Bettye Harris Foundation
David Kurili	Manager	CHNA and Community Benefit, HEAATT Corewell Health
Debra A. Guido-Allen	President	Corewell Health Dearborn Hospital
Derk F. Pronger, FACHE	President	Corewell Health Beaumont Grosse Pointe Hospital and Farmington Hills Hospital
Dr. Daniel Carey, M.D., MHCM	President	Corewell Health William Beaumont University Hospital
Erin B., Macleod-Smith, LMSW	Manager	Mental Health Care, Corewell School-Based Health Clinics
Hatahit Wael	Deputy Director for Public Health, Community Health and Research Center	ACCESS (Arab Community Center for Economic and Social Services)
Jamie Anderson	Community Engagement Manager	Honor Community Health
Jerry Price	Advisor	Corewell Health Belonging
Jihad H. Taleb, MPA	Executive Manager	Imam Mahdi Association of Marajeya
Joel B. Flugstad	Director	Market Development, Corewell Health

Name	Role	Organization
Kari L., Woloszyk, MPH	Manager	CHNA and Community Benefits, Corewell Health
Kelsey Merz	Public Health Educator	Oakland County Health Department
Kimberly Wisdom, Ph.D.	Senior Vice President of Community Health and Equity and Chief Wellness and Diversity Officer	Henry Ford Health
Kristine M. Donahue, RN, BSN, MSA	President	Corewell Health, Taylor, Trenton, and Wayne hospitals
LaQuitia Jackson	Health Equity Coordinator	Wayne County Health Department
Lauren Burgett, M.MSN, RN, NEA-BC	Chief Nursing Officer	Corewell Health Farmington Hills Hospital
Leslie D. Meyer, MA, CPXP	Senior Director	Healthier Communities, Corewell Health in Southeast Michigan
Linda Bazzi	Healthy Living Program Coordinator	Leaders Advancing and Helping Communities
Lora J. Coats	Project Specialist	Healthier Communities, Corewell Health in Southeast Michigan
Maria Swiatkowski	Division Director, Community Health Planning and Promotion	Macomb County Health Department
Miguel Barajas, MPH, CHES, PMP	Health Planning and Promotion Manager	Wayne County Health, Human, and Veterans Services Department
Nancy A. Susick, MSN, RN, NE-BC, FACHE	President/Interim President	Corewell Health Beaumont Troy and Corewell Health Beaumont Grosse Pointe hospitals
Rachel Gilchrist	Manager	Strategy and Operations, Corewell Health
Rebecca H. Moore, MPH, CHES, CPST	Community Health Program Manager	Healthier Communities, Corewell Health in Southeast Michigan
Rita R. Little, MS, CHES, CLC, CPST, CHW	Program Manager	Healthier Communities, Corewell Health in Southeast Michigan
Roel Hinojosa	Manager	Hospitality, Corewell Health
Sam Shopinski	Senior Program Manager	National Kidney Foundation of Michigan

Name	Role	Organization
Sayyid Sameer Ali, MA, BCC	Director	Islamic Pastoral Care, (RISE) Resilience, Identity, Support, and Empowerment at I.M.A.M.
Shalita N. Moore, MHA, BS, CLSSBB, CT, RT®	Senior Hospital Operations	Corewell Health Dearborn Hospital
Sheri L. Testani, DNPc, BAA, BHK, RN, CHPO, NE-BC	Chief Nursing Officer	Corewell Health Beaumont Hospital Grosse Pointe Hospital
Steven J., Witkowski, RN, BSN, MSA, CNOR	Senor Director Operations	Corewell Health Dearborn Hospital
Suzanne M. Berschback	Program Manager	Healthier Communities, Corewell Health in Southeast Michigan
Terri Czerwinski, MSN, RN	Director	Safe and Healthy Schools Wayne RESA
Theresa D. Donoghue	Director	Corewell Health School-Based Health Clinics
Tori L., Smith, M.Ed.	Program Manager	Healthier Communities, Corewell Health in Southeast Michigan
Vanessa B. Briggs	Vice President	Healthier Communities, Corewell Health
Yoland Hill-Ashford, MSW	Director	Public Health Programs, Detroit Health Department

Process

After the presentation, participants were provided with an online link to complete a scoring exercise. This exercise asked them to rank the most significant health needs using a defined set of criteria.

For this activity, participants considered the following criteria: System Influence, Availability of Resources, Community Benefit, and Community Partnership. Participants reviewed each of the criteria, then assigned a score of 1-3 to each health topic and criterion, with a higher score indicating a greater need for that topic to be prioritized.

The criteria for prioritization included:

1. **System Influence**
   - This criterion refers to the extent that Corewell Health can make a difference by addressing a certain health need. Health needs that closely align with Corewell Health's ability to influence should be prioritized over health needs that may fall outside of the health system's scope. Keep in mind, however, that certain community partners who are experts in a particular need can be engaged in partnership in order to address certain needs, depending on the needs' level of priority.

2. **Availability of Resources**
   - This criterion refers to the extent to which time and budget are accessible to address each issue. Ranking the list of health issues from highest to lowest based on the availability of resources ensures that the most resource-supported issues are prioritized for action.

3. **Community Benefit**
   - The investment and capture of community benefit activities are an IRS requirement for not-for-profit health systems like Corewell Health. Community benefit activities respond to a demonstrated health-related community need and seek to achieve at least one community benefit objective:
     - Improve access to health services
     - Enhance public health
     - Advance generalizable knowledge
     - Relieve or reduce the burden of government burden or other community efforts to improve health

4. **Community Partnership**
   - Community partnerships are essential for effectively addressing significant health needs. By collaborating with local organizations, Corewell Health can leverage shared resources, expertise, and community insights to identify and prioritize the most pressing health issues. These partnerships enable a more comprehensive and inclusive

approach to health care, ensuring that the needs of diverse populations are met and that interventions are sustainable and impactful.

Once all responses were submitted, the results were sent to the Corewell Health in Southeast Michigan team. They reviewed the results and finalized the list of prioritized health needs. The following list represents the five health needs that will be the focus of the upcoming Community Health Needs Assessment (CHNA) cycle.

Prioritized Health Needs

Chronic Diseases

Health Care Access

Mental Health

Physical Wellness

Food Environment

Prioritized Significant Health Needs

The following section describes each of the prioritized health needs to understand how findings from primary and secondary data led to the health area becoming a priority health need for Corewell Health Southeast Michigan. The five health needs are presented in alphabetical order.

Prioritized Health Topic #1: Chronic Diseases

Secondary Data

Prostate cancer incidence is the leading health concern across all three counties in the service area. The Medicare population faces numerous chronic disease challenges, particularly in Macomb County, where rates are elevated for diabetes, heart failure, cancer, stroke, ischemic heart disease, atrial fibrillation, hyperlipidemia, and hypertension. In Wayne County, age-adjusted death rates from several chronic conditions are also indicators of concern, including heart disease, prostate cancer, diabetes, cerebrovascular disease and colorectal cancer.

Those indicators scoring at or above 1.75 were categorized as indicators of concern and are listed in Table 11 below.

Table 111. PSA Data Scoring Results for Chronic Disease

SCORE	INDICATOR	UNITS	WAYNE COUNTY	HP2030	MI	U.S.	MI Counties	U.S. Counties	Trend
2.64	Prostate Cancer Incidence Rate	cases/ 100,000 males	135.9	--	114.7	113.2			
2.50	Diabetes: Medicare Population	percent	29	--	25	24			--
2.50	Heart Failure: Medicare Population	percent	15	--	13	11			--
2.42	Age-Adjusted Death Rate due to Heart Disease	deaths/ 100,000 population	259.4	--	205.9	--		--	--
2.28	Age-Adjusted Death Rate due to Prostate Cancer	deaths/ 100,000 males	21.1	16.9	19	19	--		
2.25	Age-Adjusted Death Rate due to Diabetes	deaths/ 100,000 population	30.3	--	26.1	--		--	

SCORE	INDICATOR	UNITS	WAYNE COUNTY	HP2030	MI	U.S.	MI Counties	U.S. Counties	Trend
2.19	Colorectal Cancer Incidence Rate	cases/ 100,000 population	40.7	--	35.4	36.4			
2.17	Age-Adjusted Death Rate due to Cerebrovascular Disease (Stroke)	deaths/ 100,000 population	48.4	33.4	44.7	--		--	--
2.08	Adults who Have Taken Medications for High Blood Pressure	percent	77.7	--	--	78.2			--
2.03	Lung and Bronchus Cancer Incidence Rate	cases/ 100,000 population	66.8	--	58.8	53.1			
1.92	Adults who Experienced a Stroke	percent	4.3	--	--	3.6			--
1.89	High Blood Pressure Prevalence	percent	39.6	41.9	--	32.7			--
1.86	Adults 20+ with Diabetes	percent	10.9	--	--				
1.86	All Cancer Incidence Rate	cases/ 100,000 population	478.5	--	441.4	444.4			
1.83	Hypertension: Medicare Population	percent	68	--	66	65			--
1.83	Ischemic Heart Disease: Medicare Population	percent	23	--	22	21			--
1.83	Age-Adjusted Death Rate due to Colorectal Cancer	deaths/ 100,000 population	14.9	8.9	13.4	12.9			
1.75	Colon Cancer Screening: USPSTF Recommendation	percent	65.1	--	--	66.3			--

SCORE	INDICATOR	UNITS	OAKLAND COUNTY	HP2030	MI	U.S.	MI Counties	U.S. Counties	Trend
2.64	Prostate Cancer Incidence Rate	cases/ 100,000 males	140.3	--	114.7	113.2			
2.50	Ischemic Heart Disease: Medicare Population	percent	25	--	22	21			--
2.50	Stroke: Medicare Population	percent	7	--	6	6			--
2.33	Breast Cancer Incidence Rate	cases/ 100,000 females	141.5	--	127	129.8			
2.17	Cancer: Medicare Population	percent	13	--	12	12			--
2.17	Age-Adjusted Death Rate due to Cerebrovascular Disease (Stroke)	deaths/ 100,000 population	47	33.4	44.7	--		--	
1.86	All Cancer Incidence Rate	cases/ 100,000 population	471.7	--	441.4	444.4			
1.75	Age-Adjusted Death Rate due to Heart Disease	deaths/ 100,000 population	189.3	--	205.9	--		--	--

SCORE	INDICATOR	UNITS	MACOMB COUNTY	HP2030	MI	U.S.	MI Counties	U.S. Counties	Trend
2.75	Prostate Cancer Incidence Rate	cases/ 100,000 males	127.1		114.7	113.2			
2.50	Atrial Fibrillation: Medicare Population	percent	17		15	14			--
2.50	Heart Failure: Medicare Population	percent	15		13	11			--
2.50	Ischemic Heart Disease: Medicare Population	percent	28		22	21			--
2.50	Stroke: Medicare Population	percent	7		6	6			--
2.33	Diabetes: Medicare Population	percent	28		25	24			--
2.33	Hypertension: Medicare Population	percent	72		66	65			--
2.33	Breast Cancer Incidence Rate	cases/ 100,000 females	140.7		127	129.8			
2.25	Age-Adjusted Death Rate due to Diabetes	deaths/ 100,000 population	31.6		26.1			--	
2.19	All Cancer Incidence Rate	cases/ 100,000 population	490.6		441.4	444.4			
2.17	Cancer: Medicare Population	percent	13		12	12			--
2.03	Lung and Bronchus Cancer Incidence Rate	cases/ 100,000 population	68.3		58.8	53.1			
2.00	Age-Adjusted Death Rate due to Cerebrovascular Disease (Stroke)	deaths/ 100,000 population	43.5	33.4	44.7			--	--
2.00	Hyperlipidemia: Medicare Population	percent	69		63	66			--

Primary Data

Chronic diseases are defined as conditions lasting one year or more that require ongoing medical attention or limit daily activities of daily living or both. Chronic diseases are the leading causes of death and disability in the United States. They are also the leading drivers of the nation's health care costs.[18]

Chronic diseases such as cancer, diabetes, heart disease and stroke remain major health concerns. In Southeast Michigan, the prevalence of these conditions is particularly significant in Macomb, Oakland and Wayne counties. According to the community health survey, diabetes, cancer, heart disease and stroke were identified as top health issues. Chronic diseases, diabetes, heart disease and cancer surfaced as a major concern in community focus groups.

The quote below reflects a desire for treatment plans that address the underlying causes (such as diet, exercise, and stress) rather than relying on medication to manage symptoms.

"I want a plan that gets me healthy, not one that keeps me on drugs for years." - Focus Group Participant

[18] About Chronic Disease. CDC.gov

Prioritized Health Topic #2: Health Care Access

Secondary Data

Preventable hospital stays among the Medicare population were the top indicator of concern in each county. This measure reflects the quality and accessibility of primary health care services. High rates of preventable hospitalizations suggest that outpatient care may be inadequate, leading individuals to rely on hospitals for conditions that could be managed in a primary care setting. The rate of primary care providers in Wayne and Macomb Counties falls below both state and national averages.

Those indicators scoring at or above 1.50 were categorized as indicators of concern and are listed in Table 12 below.

Table 12. PSA Data Scoring Results for health care access and quality

SCORE	INDICATOR	UNITS	WAYNE COUNTY	HP2030	MI	U.S.	MI Counties	U.S. Counties	Trend
2.50	Preventable Hospital Stays: Medicare Population	discharges/ 100,000 Medicare enrollees	4880	--	3367	2769			--
2.00	Michigan Substance Use Vulnerability Index	percent	98.8	--	50	--	--	--	--
1.75	Adults who Visited a Dentist	percent	62.9	--		63.9			--
1.67	Primary Care Provider Rate	providers/ 100,000 population	70.1	--	78.4	74.9			

SCORE	INDICATOR	UNITS	OAKLAND COUNTY	HP2030	MI	U.S.	MI Counties	U.S. Counties	Trend
2.33	Preventable Hospital Stays: Medicare Population	discharges/ 100,000 Medicare enrollees	3507	--	3367	2769			--

SCORE	INDICATOR	UNITS	MACOMB COUNTY	HP2030	MI	U.S.	MI Counties	U.S. Counties	Trend
2.50	Preventable Hospital Stays: Medicare Population	discharges/ 100,000 Medicare enrollees	4336		3367	2769			--
1.69	Primary Care Provider Rate	providers/ 100,000 population	54.3		78.4	74.9			--

Community Health Index

Conduent's Community Health Index (CHI) uses socioeconomic data to estimate which ZIP Codes are at greatest risk for poor health outcomes, such as preventable hospitalization or premature death. Each ZIP code is ranked based on its index value to identify relative levels of need. Table 13 provides the index values and local ranking for each ZIP code. The ZIP Codes with the highest level of socioeconomic need in the Corewell Health in Southeast Michigan service area are 48211 (99.9), 48210 (99.8), 48212 (99.6), and 48209 (99.6). The map in Figure 23 illustrates the ZIP Codes with the highest level of socioeconomic need (as indicated by the darkest shade of blue).

Figure 23. Community Health Index (CHI)

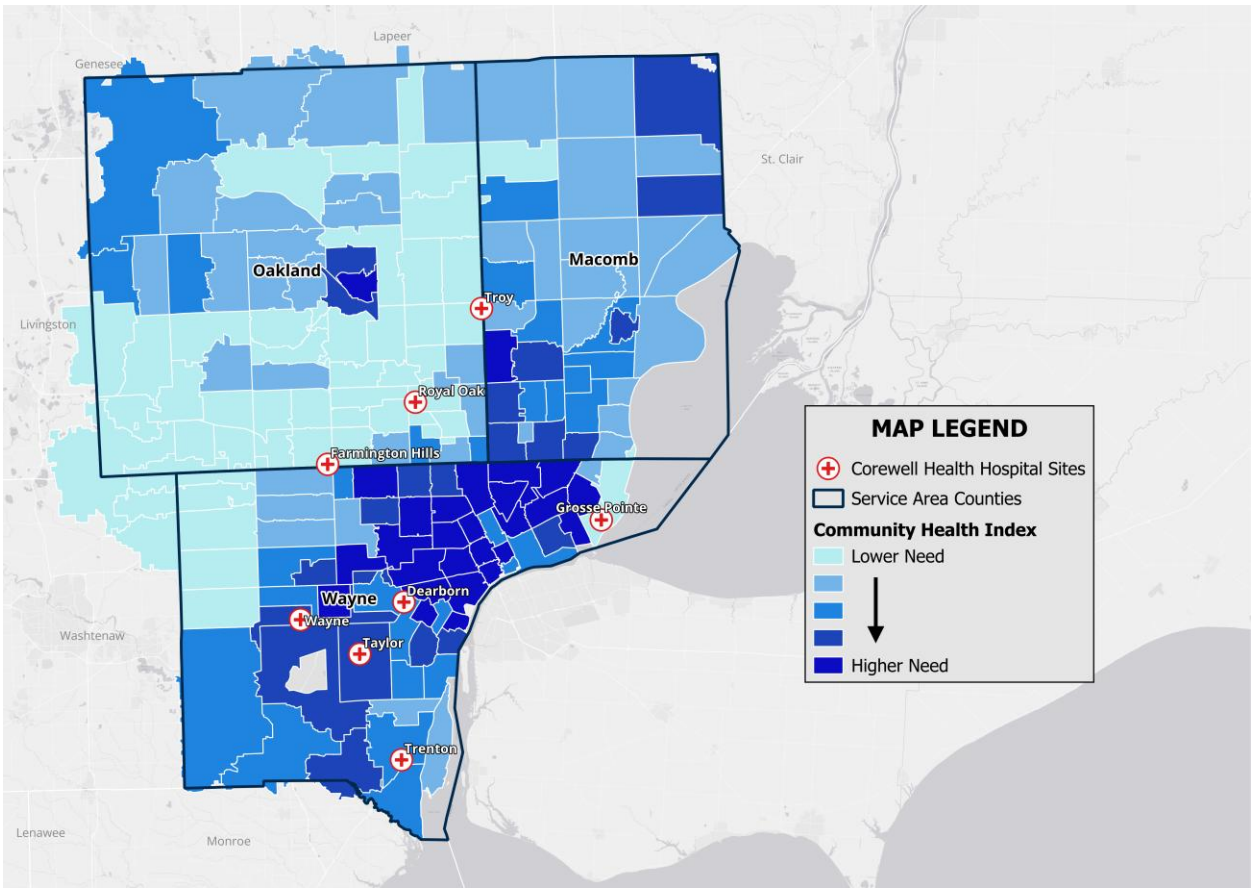


Table 13. Community Health Index Values by ZIP Code

ZIP Code	CHI	ZIP Code	CHI	ZIP Code	CHI	ZIP Code	CHI
48211	99.9	48312	69	48051	31.5	48323	9.9
48210	99.8	48313	65.2	48386	31.4	48320	9.8
48212	99.6	48313	65.2	48322	31	48033	9.7
48209	99.6	48036	64.6	48220	30.9	48348	9.4
48213	99.1	48207	63	48065	29.8	48034	9.2
48228	99.1	48030	62.4	48065	29.8	48377	9.1
48126	99	48185	60.9	48316	29.1	48095	8.5
48122	99	48093	60.5	48316	29.1	48095	8.5
48208	98.7	48226	59.2	48356	28.8	48393	8.2
48238	98.7	48202	59	48044	28.7	48324	7.8
48120	98.6	48192	58.9	48044	28.7	48307	7.7
48218	98.4	48111	57.9	48138	28.1	48165	7.6
48204	98.3	48066	56.3	48050	27.4	48363	7.5
48227	97.5	48026	56	48350	27.1	48072	7.4
48201	97	48240	55.6	48327	26.8	48085	7.2
48224	96.2	48124	54.9	48045	26.7	48302	6.8
48215	96.1	48088	54.2	48367	26.2	48084	6.7
48234	95.8	48357	53.9	48017	24.9	48167	6.7
48206	95.5	48383	53.9	48390	23.5	48178	6.2
48127	95	48186	53.3	48042	23.3	48375	5.8
48203	94.7	48035	51.7	48042	23.3	48335	5.3
48205	94.7	48237	51.1	48371	23.1	48009	5
48141	94.3	48442	47	48081	23	48069	4.9
48342	94	48317	46.2	48038	22.9	48230	4.3
48219	90.8	48317	46.2	48359	22.8	48098	3.7
48216	90.4	48195	45.5	48015	22.6	48304	3.5
48310	89.6	48094	45	48080	21.9	48168	3.1
48229	87.3	48094	45	48005	21.2	48306	2.9
48235	86.9	48101	45	48346	19.8	48301	2.7
48125	86.2	48183	44.3	48462	19.6	48025	1.8
48184	85.3	48217	43.5	48075	19.3	48070	0.8
48135	83.5	48173	42.2	48360	18.9	48374	0.7
48089	82.5	48164	42.2	48370	17.9		
48340	81.1	48152	40.4	48326	16.2		
48223	80.8	48150	39.7	48336	15.9		
48221	80.4	48314	39	48380	15.4		
48180	79.4	48071	38.6	48331	14.4		
48091	78.5	48193	38.5	48170	12.2		
48214	77.4	48082	38.1	48076	11.8		
48062	77.4	48328	37.4	48334	11.8		
48146	76.7	48047	37	48188	11.7		

ZIP Code	CHI	ZIP Code	CHI	ZIP Code	CHI	ZIP Code	CHI
48043	76.7	48239	34.7	48309	11.5		
48341	76.6	48154	34.6	48187	11.3		
48128	74.6	48225	33.9	48067	11.3		
48092	74.2	48083	33.9	48382	11.2		
48048	73.7	48096	32.7	48362	11.1		
48021	72.7	48329	31.7	48381	10.9		
48174	70.7	48315	31.6	48073	10.4		
48134	70.5	48315	31.6	48236	10.3		

Primary Data

Access to health care refers to the ability of individuals to obtain timely, affordable and appropriate health services when needed, including preventive, primary, specialty and behavioral health care[19].

Access to Care was a top health need identified in the community survey, listening session and focus group sessions. Barriers included transportation, language, financial costs (health care services are too expensive, making it difficult for residents to afford necessary care), hours of operation did not fit their schedule, insurance not accepted, and they did not feel comfortable or confident navigating the health system or seeking providers.

Among survey respondents, 27% indicated they disagreed or strongly disagreed that there are affordable health care services in their community, and 60% indicated the cost of health care was too high and they could not afford to pay. Below is a quote from a listening session participant expressing their experiences working with community members and what challenges they face when seeking services.

"People don't know the service exists…having the service is wonderful, but if the people can't get to them, they're useless." -Listening Session Participant

[19] Health Care Access. rand.org

Prioritized Health Topic #3: Mental Health

Secondary Data

Oakland County reported the fewest concerning indicators related to mental health and substance misuse within the service area. Alzheimer's disease or dementia among the Medicare population scored above 2.00 in all three counties. Additionally, adult binge drinking rates exceeded the national average across the service area. In Wayne and Macomb Counties, liquor store density was the top concern. Other notable issues in these counties included frequent poor mental health days, depression among the Medicare population, and high death rates from opioid-related drug poisoning.

Indicators scoring 1.50 or higher were classified as indicators of concern and are listed in Table 14 below.

Table 14. PSA Data Scoring Results for mental health and mental disorders and Alcohol and Drug Use

SCORE	INDICATOR	UNITS	WAYNE COUNTY	HP2030	MI	U.S.	MI Counties	U.S. Counties	Trend
2.36	Liquor Store Density	stores/ 100,000 population	25.6	--	15.7	10.9			
2.33	Poor Mental Health: Average Number of Days	days	6.1	--	5.6	--			
2.14	Death Rate due to Opioid-Related Drug Poisoning	deaths/ 100,000 population	45.1	--	25.3	--		--	
2.08	Poor Mental Health: 14+ Days	percent	18.7	--	--	15.8			--
2.00	Michigan Substance Use Vulnerability Index	percent	98.8	--	50	--	--	--	--
2.00	Alzheimer's Disease or Dementia: Medicare Population	percent	7	--	7	6			--
1.58	Adults who Binge Drink	percent	16.8	--	--	16.6			--
1.58	Adults Ever Diagnosed with Depression	percent	23.3	--	--	20.7			--

SCORE	INDICATOR	UNITS	OAKLAND COUNTY	HP2030	MI	U.S.	MI Counties	U.S. Counties	Trend
2.00	Alzheimer's Disease or Dementia: Medicare Population	percent	7	--	7	6			--
1.75	Adults who Binge Drink	percent	17.4	--	--	16.6			--

SCORE	INDICATOR	UNITS	MACOMB COUNTY	HP2030	MI	U.S.	MI Counties	U.S. Counties	Trend
2.64	Liquor Store Density	stores/ 100,000 population	19.1	--	15.7	10.9			
2.50	Alzheimer's Disease or Dementia: Medicare Population	percent	8	--	7	6			--
2.08	Poor Mental Health: 14+ Days	percent	18.1	--	--	15.8			--
2.00	Death Rate due to Opioid-Related Drug Poisoning	deaths/ 100,000 population	31.3	--	25.3	--		--	
2.00	Poor Mental Health: Average Number of Days	days	5.7	--	5.6	--			
1.92	Adults Ever Diagnosed with Depression	percent	25.1	--	--	20.7			--
1.75	Adults who Binge Drink	percent	17.9	--	--	16.6			--
1.67	Depression: Medicare Population	percent	18	--	18	17			--

Mental Health Index

Conduent's Mental Health Index (MHI) uses socioeconomic data to estimate which ZIP Codes are at greatest risk for poor mental health. Each ZIP code is ranked based on its index value to identify relative levels of need. Table 15 provides the index values and local ranking for each ZIP code. The ZIP Codes in the Corewell Health in Southeast Michigan service area with the highest risk for poor mental health are 48213, 48204, 48238, 48203, and 48227 all with an index score of 99.9. The map in Figure 24 illustrates that the ZIP Codes with the highest risk for poor mental health (as indicated by the darkest shade of purple).

Figure 24. Mental health index: Corewell Health in Southeast Michigan primary service area

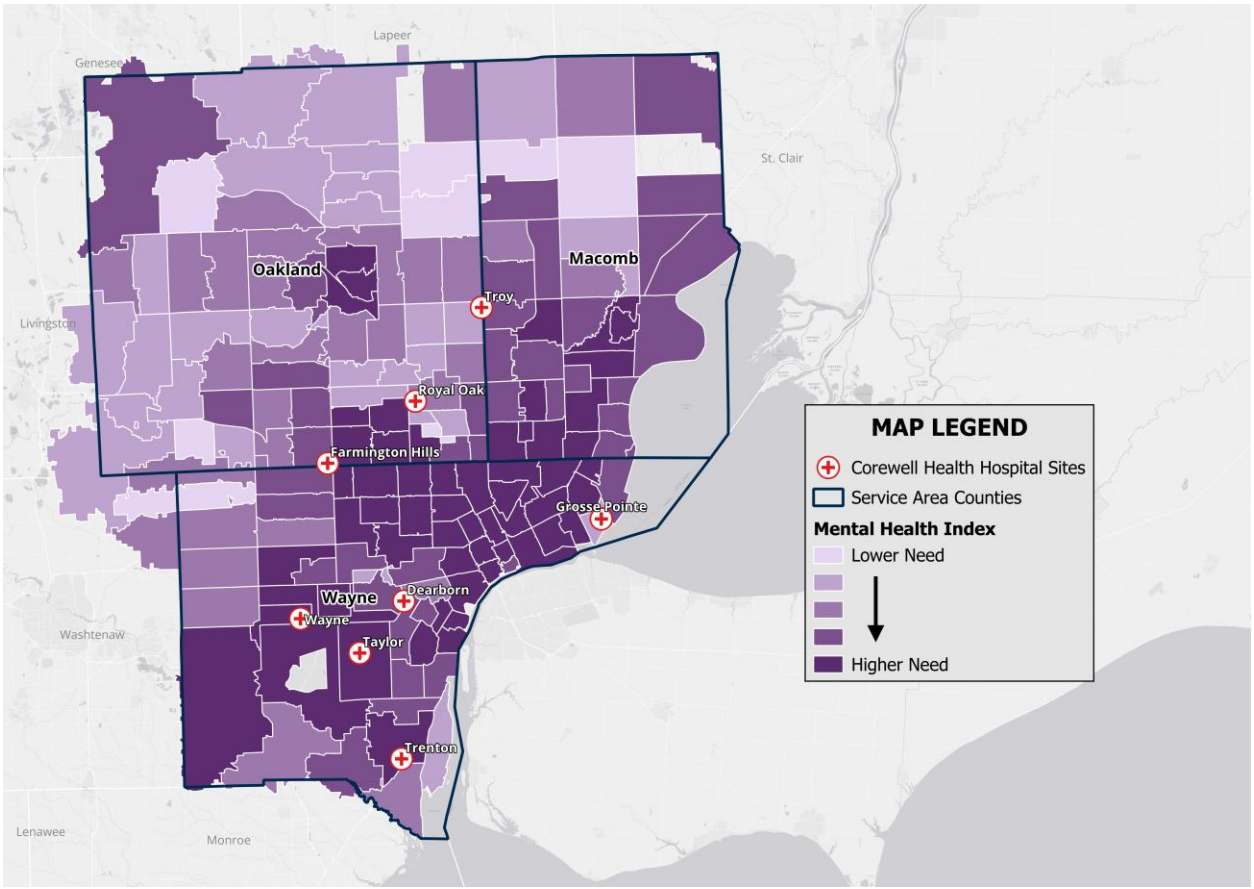


Table 15. Mental Health Index Values by ZIP Code

ZIP Code	MHI	ZIP Code	MHI	ZIP Code	MHI	ZIP Code	MHI
48213	99.9	48146	86.2	48094	64.9	48360	33
48204	99.9	48186	86.1	48336	64.9	48178	32.5
48238	99.9	48035	85.7	48051	63.4	48165	31.6
48203	99.9	48076	85	48317	63	48067	31.4
48227	99.9	48212	84.5	48317	63	48381	31.1
48235	99.8	48111	84.5	48047	62.9	48356	30.4
48219	99.8	48216	84.2	48314	62.6	48025	30.3
48206	99.8	48125	83.4	48326	58.8	48380	29.5
48228	99.7	48313	83.4	48120	57.2	48072	28.8
48234	99.7	48313	83.4	48327	56.8	48393	28.6
48207	99.7	48183	83.4	48173	56.8	48085	27
48215	99.6	48030	82.8	48316	56.7	48128	26.9
48208	99.6	48122	79.9	48316	56.7	48382	26.5
48224	99.6	48135	79.9	48390	56.3	48230	26.2
48214	99.5	48322	79.7	48329	56.3	48301	25.8
48221	99.5	48328	78.2	48170	53.5	48359	22.7
48223	99.4	48038	78.2	48383	53.4	48084	22
48201	99.3	48045	77.5	48017	52.2	48042	21.6
48205	99.3	48192	77.1	48304	51.7	48042	21.6
48141	99.2	48195	76.6	48386	51	48462	19.3
48342	98.9	48071	76.6	48302	50.4	48168	17.6
48202	98.8	48226	76.6	48307	50.3	48350	16
48034	97.7	48334	75.8	48150	49.6	48306	15.1
48225	97.5	48442	75.6	48331	49	48374	11.8
48341	97.4	48152	74.1	48323	48.9	48363	10.7
48211	97.2	48062	73.8	48346	48.6	48096	10
48021	97.2	48082	72.7	48187	48.2	48069	9
48218	97	48377	72.5	48073	47.4	48095	7.1
48229	96.9	48127	72.4	48367	46.9	48095	7.1
48217	96.9	48092	72.1	48335	46.6	48070	5.2
48237	96.5	48101	71.5	48357	46.3		
48340	95.1	48315	71.5	48083	45.5		
48036	95	48315	71.5	48309	45.1		
48033	94.9	48081	71.3	48164	42.9		
48066	94.7	48088	71.2	48005	42.3		
48075	94.4	48236	70.8	48188	42.1		
48089	93.9	48193	70.4	48044	40.4		
48240	93.8	48026	70.3	48044	40.4		
48184	93.4	48080	70.2	48167	40.4		
48180	92.4	48048	69.9	48362	39.4		
48185	91.8	48310	69.7	48348	38.7		

ZIP Code	MHI	ZIP Code	MHI	ZIP Code	MHI	ZIP Code	MHI
48174	91	48312	69.7	48065	38.5		
48210	90.1	48126	68.4	48065	38.5		
48043	90.1	48220	67.5	48371	37		
48091	88.9	48320	67	48009	35.8		
48239	87.5	48124	66.5	48375	35.7		
48093	87.3	48134	66.4	48324	34.6		
48209	86.9	48154	65.4	48098	33.5		
48015	86.9	48094	64.9	48138	33.4		

Primary Data

Mental health was consistently identified as a top health concern through the survey, focus groups and listening sessions. In the survey, 50.84% of respondents listed mental health and mental disorders, such as anxiety, depression, and suicide, as one of the most important health problems in the community. Additionally, 13.23% of respondents reported that there was a time they needed or considered seeking mental health or substance use treatment but did not receive services. The most frequently cited reasons for not accessing care included the high cost of services, uncertainty about where to go for help, and clinic or provider hours that did not align with their availability or work schedules.

Concerns about access to mental health care extended to children as well. Approximately 40% of survey respondents indicated that their children were unable to receive mental health services in the past 12 months. The primary barriers were the cost of services, lack of insurance coverage and long wait times.

Participants in focus groups and listening sessions emphasized the need for increased education and awareness around mental health, including a better understanding of what mental health is and how to manage it. Populations identified as most affected included youth, seniors and men. The quote below describes a moment of emotional crisis and the life-saving impact of reaching out for help from a focus group participant.

“I just felt like ending it. But I reached out to my therapist, and I am glad I did because she was very helpful.” -Focus group participant

Alcohol and drug use were identified as significant health concerns by survey respondents. Approximately 25% of participants listed substance use (alcohol and drug use) as one of the most pressing health issues in the community. Among respondents, 48% reported using alcohol, 11% reported using marijuana and 10% reported using edibles. Additionally, 28% indicated that they live/lived with someone who was a problem drinker or alcoholic. Focus group and listening session participants also expressed concern about substance use in the community and emphasized the need for more accessible substance use treatment centers. The quote below expresses growing concern within the community about addiction, highlighting it as an increasingly prevalent issue that needs attention.

“Addiction is another rising problem in the community.” -Focus group participant

Prioritized Health Topic #4: Physical Wellness

Secondary Data

Workers Who Walk to Work was the leading indicator of concern across all three counties in the service area. Additionally, Wayne and Macomb Counties showed poor outcomes for adult sedentary behavior. While obesity was a concern in every country, all remained at or below the Healthy People 2030 target.

Indicators scoring 1.50 or higher were classified as indicators of concern and are listed in Table 16 below.

Table 162. PSA Data Scoring Results for Physical Activity and Weight Status

SCORE	INDICATOR	UNITS	WAYNE COUNTY	HP2030	MI	U.S.	MI Counties	U.S. Counties	Trend
2.31	Workers who Walk to Work	percent	1.7	--	2	2.4			
1.97	Adults 20+ Who Are Obese	percent	35.4	36	--	--			
1.86	Adults 20+ who are Sedentary	percent	24.1	--	--	--			

SCORE	INDICATOR	UNITS	OAKLAND COUNTY	HP2030	MI	U.S.	MI Counties	U.S. Counties	Trend
2.50	Workers who Walk to Work	percent	1.1	--	2	2.4			
1.56	Adults 20+ Who Are Obese	percent	28.7	36	--	--			

SCORE	INDICATOR	UNITS	MACOMB COUNTY	HP2030	MI	U.S.	MI Counties	U.S. Counties	Trend
2.36	Workers who Walk to Work	percent	1	--	2	2.4			
2.11	Adults 20+ Who Are Obese	percent	36	36	--	--			
1.69	Adults 20+ who are Sedentary	percent	20.4	--	--	--			

Primary Data

Weight status, specifically individuals who are overweight or obese, was identified by 28% of survey respondents as one of the most important health problems in the community. When asked to rate their own health, 10% of respondents described it as unhealthy or very unhealthy, while 80% rated their health as healthy or somewhat healthy. Healthy eating—specifically access to healthy restaurants, stores, or markets—was selected as the number one issue to be addressed in the community. This suggests broader concerns around nutrition, including limited access to healthy food options, the need for improved availability and increased nutritional education. Despite some positive self-assessments, weight and overall health were consistently raised as top concerns during focus groups and listening sessions.

“We need programs designed to lose weight or maintain weight.” -Focus group participants

Prioritized Health Topic #5: Food Environment

Secondary Data

Child food insecurity and assistance eligibility were key concerns across all counties. In Wayne County, the child food insecurity rate was approximately ten percentage points higher than both the state and national averages. In Oakland and Macomb Counties, a higher proportion of food-insecure children were ineligible for assistance compared to state and national levels. These children live in households earning above 185% of the federal poverty level, making them likely ineligible for federal nutrition programs.

All indicators relating to food insecurity and weight status are listed in Table 17 below.

Table 173. PSA Data Scoring Results for Food Environment

SCORE	INDICATOR	UNITS	WAYNE COUNTY	HP2030	MI	U.S.	MI Counties	U.S. Counties	Trend
2.64	Child Food Insecurity Rate	percent	27	--	17.9	18.5			
1.86	Food Insecurity Rate	percent	15.4	--	14.2	13.5			
1.03	Food Insecure Children Likely Ineligible for Assistance	percent	26	--	28	30			
1.11	Food Environment Index		7.6	--	7.1	--			

SCORE	INDICATOR	UNITS	OAKLAND COUNTY	HP2030	MI	U.S.	MI Counties	U.S. Counties	Trend
2.64	Food Insecure Children Likely Ineligible for Assistance	percent	45	--	28	30			
0.50	Child Food Insecurity Rate	percent	10.9		17.9	18.5			
0.64	Food Insecurity Rate	percent	11	--	14.2	13.5			
0.61	Food Environment Index		8.6	--	7.1	--			

SCORE	INDICATOR	UNITS	MACOMB COUNTY	HP2030	MI	U.S.	MI Counties	U.S. Counties	Trend
2.47	Food Insecure Children Likely Ineligible for Assistance	percent	34	--	28	30			
0.83	Child Food Insecurity Rate	percent	16	--	17.9	18.5			
0.83	Food Insecurity Rate	percent	12.6	--	14.2	13.5			
0.78	Food Environment Index		8.1	--	7.1	--			

Food Insecurity Index

Conduent's Food Insecurity Index (FII) uses socioeconomic data to estimate which ZIP Codes are at greatest for poor food access. Table 18 shows that the ZIP code with the highest risk of food insecurity in the Corewell Health in Southeast Michigan service area is 48228 with an index score of 99.3.

FIGURE 25. Food Insecurity Index

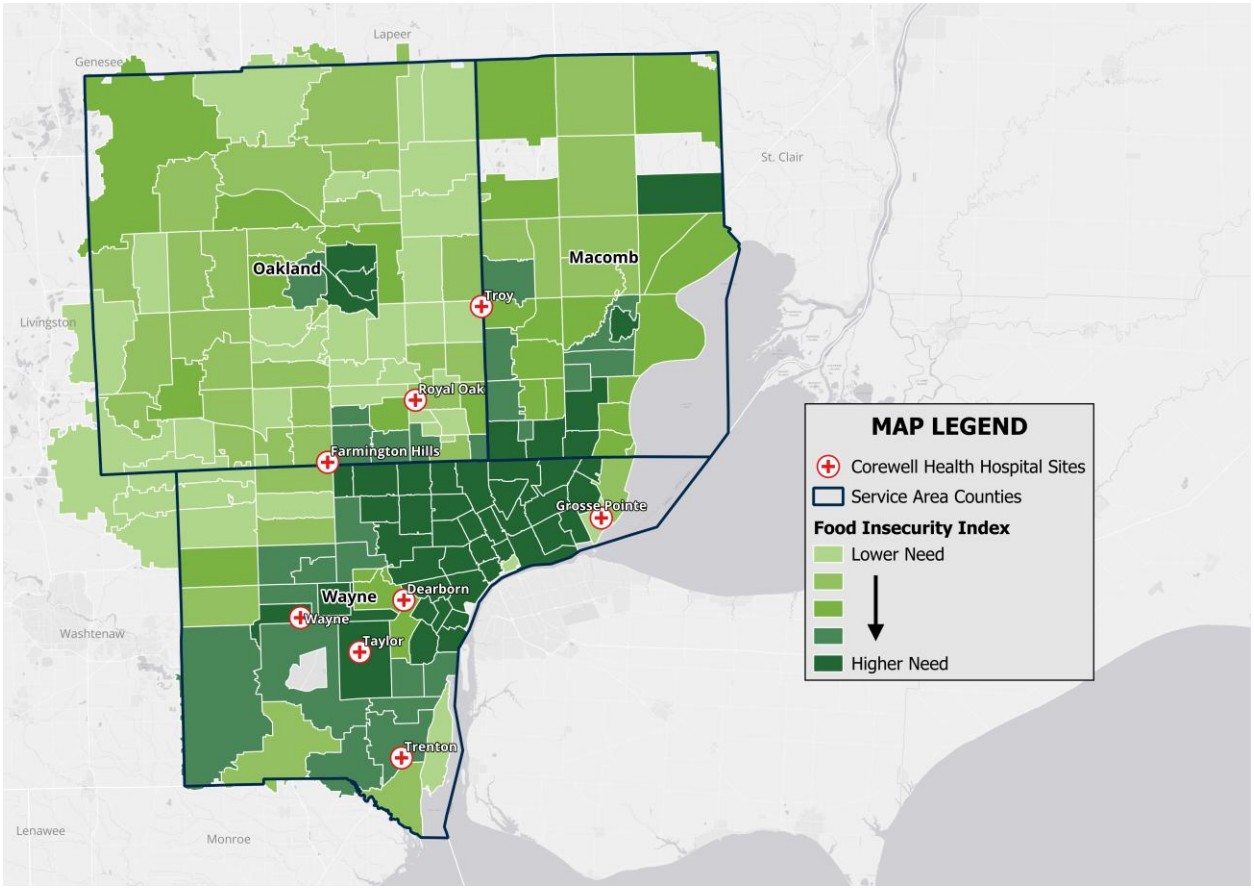


Table 18. Food Insecurity Index Values by ZIP Code

ZIP Code	FII	ZIP Code	FII	ZIP Code	FII	ZIP Code	FII
48228	99.3	48239	77.7	48081	32.2	48178	10.6
48218	99.2	48186	75.4	48346	32	48226	10
48213	98.7	48237	75.1	48065	31.4	48170	9.2
48210	98.7	48030	74.5	48065	31.4	48167	7.6
48238	98.7	48036	74.2	48390	29.4	48367	7
48209	98.7	48035	73.7	48044	29.2	48380	6.5
48208	98.6	48192	70.4	48044	29.2	48085	6.5
48342	98.6	48185	69.5	48165	28.4	48067	5.9
48204	98.3	48310	68.3	48083	28	48072	5.9
48224	98.3	48015	65.7	48383	27.5	48009	5.8
48234	98.3	48195	65.6	48386	26.9	48309	5.7
48141	98.2	48092	63.5	48377	25.4	48025	5.4
48211	98	48026	62.7	48336	24.4	48323	5.2
48235	98	48034	62.5	48307	24.2	48370	4.6
48227	98	48075	61.8	48152	24	48331	4.5
48205	97.8	48328	61.2	48381	23.6	48360	4.3
48215	97.7	48033	60.1	48350	23.3	48230	4.2
48212	97.1	48317	58.9	48005	23.2	48324	3.9
48201	97.1	48317	58.9	48357	22.8	48168	3
48223	96.4	48134	58.1	48173	22.7	48302	2.6
48206	95.9	48111	56.8	48382	22.1	48098	2.2
48203	95.8	48135	56.7	48334	22.1	48374	2.1
48126	94.7	48193	55.3	48220	22	48304	2
48219	94.4	48183	55.1	48329	21.9	48301	1.6
48340	92.1	48051	52.6	48188	21.6	48138	1.6
48214	91.8	48128	51	48150	20.6	48306	1
48122	91.6	48045	48.7	48335	20.4	48363	0.7
48021	91.4	48062	47.6	48316	19.6	48070	0.6
48341	90.4	48071	47.4	48316	19.6	48069	0.2
48216	90.1	48080	47.3	48315	18.8		
48217	90.1	48393	45.1	48315	18.8		
48089	90	48076	44.8	48042	17.8		
48221	89.8	48312	44.3	48042	17.8		
48225	89.4	48327	43.7	48084	17.5		
48184	88	48101	42.6	48371	16.9		
48202	86.5	48124	41.2	48320	16.7		
48229	86.3	48442	40.1	48359	16.1		
48207	86.1	48038	39.5	48322	14.7		
48048	86.1	48088	39.1	48236	14.6		
48091	85.8	48326	38.8	48164	13.8		
48240	83.5	48313	38.7	48348	13.6		

ZIP Code	FII	ZIP Code	FII	ZIP Code	FII	ZIP Code	FII
48043	83	48313	38.7	48073	13.6		
48125	82.3	48093	38.6	48362	13.5		
48180	82.1	48047	37.8	48375	13.3		
48120	81.8	48187	34.8	48096	12.8		
48146	81.6	48314	34.3	48462	12.2		
48066	81.6	48082	32.9	48017	11.5		
48174	79	48094	32.4	48356	11.3		
48127	78.8	48094	32.4	48154	11		

Primary Data

Approximately 20% of survey respondents identified nutrition and healthy eating as important health concerns in their community. This may reflect a need for better access to fresh, nutritious food options, increased resources and education around healthy eating, and improvements in school food environments. When asked which areas they would most like to see addressed, 25% of respondents selected healthy eating in restaurants, stores, and markets. During focus groups and listening sessions, participants echoed these concerns, citing limited access to healthy food, poor nutrition, and food insecurity as top health-related challenges in the community.

"You have to eat unhealthily to survive; healthy choices are not affordable."
– Focus group participants

Nonprioritized Significant Health Needs

The health needs that will not be explicitly addressed in the upcoming Implementation Strategy reports are Education, Community Safety, Social Cohesion, Economic Security, Environmental Quality, and Neighborhood and Built Environment. Compared to the needs that will be addressed, these six health needs were not ranked as high in terms of four prioritization criteria: (1) system influence, (2) availability of resources, (3) community benefit, and (4) community partnership - as voted on by over forty internal and external Corewell Health in Southeast Michigan partners. In addition, there are currently leading community partners/stakeholders who are addressing needs such as Community Safety, Economic Security, and Social Cohesion, for example. Though not selected as priority areas, some of the Nonprioritized needs will be indirectly addressed through enhancing access to health care and by partnering with lead organizations outside of the upcoming implementation strategy who are addressing these areas.

Nonprioritized Health Need #1: Education

Based on secondary data scoring, Education ranked lowest in Wayne County, placing sixth with a score of 1.84.

In Wayne and Oakland Counties, the primary concern was the student-to-teacher ratio. In Macomb County, the top concern was the availability of center-based childcare, with only 6.1 centers per 1,000 children under age 5, including those located in schools and religious institutions.

Top Education Indicators of Concern by County:

- **Wayne County**: Student-to-Teacher Ratio
- **Oakland County**: Student-to-Teacher Ratio
- **Macomb County**: Child Care Centers

Nonprioritized Health Need #2: Community Safety

According to secondary data scoring, the *Prevention and Safety* topic scored below 1.50 in Oakland and Macomb, but Wayne County had a higher score of 1.80, suggesting more pressing issues in this area.

Top Prevention and Safety Indicators of Concern:

- **Wayne County:** Age-adjusted death rate due to unintentional injuries
- **Oakland County:** Severe housing problems (low concern score of 1.28)
- **Macomb County:** Severe housing problems

Nonprioritized Health Need #3: Social Cohesion

Community health is not a significant concern in Oakland and Macomb Counties, with both scoring below 1.50 based on secondary data. In contrast, Wayne County scored 1.63, indicating a moderate level of concern. A key issue in Wayne County is the number of older adults living alone, which may reflect challenges such as social isolation, limited caregiving support, and increased vulnerability among seniors.

In Oakland and Macomb Counties, social association ranks as a top concern. This metric reflects the number of membership organizations per 10,000 residents, including business, labor, political, professional, athletic, civic, volunteer, and religious groups.

Key Social Indicators of Concern by County:

- **Wayne County:** People aged 65 and older living alone
- **Oakland County:** Social associations
- **Macomb County:** Social associations

Nonprioritized Health Need #4: Economic Security

Among the three counties in the service area, Wayne County had the poorest performance in the Economy health topic, ranking third with a score of 2.08. Wayne County shows a high concentration of poverty-related indicators, especially among vulnerable populations such as children, veterans, and seniors.

Oakland County's concerns are more focused on housing affordability and access to assistance, particularly for food-insecure children who may not qualify for aid.

Macomb County has fewer high scoring indicators, but there is a primary focus on housing costs for owners without mortgages, which may reflect fixed-income challenges among older or retired residents.

Top Economic Indicators of Concern by County:

- **Wayne County:**
    - Households receiving cash public assistance
    - Students eligible for the free lunch program
    - Veterans living below the poverty level
    - Child food insecurity rate
    - People aged 65+ living below the poverty level
    - Households spending 50% or more of income on housing

- **Oakland County:**
    - Median monthly owner costs (households without a mortgage)
    - Median monthly costs for mortgaged owners
    - Food-insecure children likely ineligible for assistance
    - Median household gross rent
- **Macomb County:**
    - Median monthly owner costs (households without a mortgage)

Nonprioritized Health Need #5: Environmental Quality

Based on secondary data, all three counties scored below the threshold of 2.00 in *Environmental Health*; however, Wayne County shows a higher level of concern in Environmental Health compared to Oakland and Macomb. Air quality and respiratory health are recurring concerns across all counties, with asthma prevalence appearing in each. Proximity to highways is a shared environmental exposure risk, likely contributing to respiratory issues. Wayne County's elevated score and broader range of indicators suggest greater environmental stressors, possibly due to urban density and industrial activity.

Key Indicators of Concern:

- **Wayne County**:
    - Air pollution due to particulate matter
    - Adults with current asthma
    - Proximity to highways
- **Oakland County**:
    - Asthma prevalence in the Medicare population
    - Proximity to highways
- **Macomb County**:
    - Adults with current asthma
    - Asthma prevalence in the Medicare population

Nonprioritized Health Need #6: Neighborhood and Built Environment

Several indicators from the environmental health topic also reflect challenges in the neighborhood and built environment, particularly in housing conditions and community-level infrastructure. Older housing stock in Wayne County may pose risks related to lead exposure, structural safety, and energy inefficiency. Liquor store density in Wayne and Macomb Counties may reflect broader socioeconomic challenges and community-level stressors. Severe housing problems are present in both Oakland and Macomb, indicating issues such as overcrowding, lack of plumbing or kitchen facilities, or high housing costs.

Key Indicators of Concern:

- **Wayne County**:
    - Houses built prior to 1950
    - Liquor store density
- **Macomb County**:
    - Liquor store density
    - Severe housing problems
- **Oakland County**:
    - Severe housing problems

Conclusion

This Community Health Needs Assessment (CHNA), conducted for Corewell Health Southeast Michigan, utilized a comprehensive approach that combined both secondary data sources and primary data collection—including surveys, focus groups, and listening sessions—to identify the most pressing health needs within the community. The assessment revealed five key priority areas:

- Chronic Diseases
- Health Care Access
- Mental Health
- Physical Wellness
- Food Environment

These priorities reflect the complex and interconnected nature of health challenges facing the community, many of which are influenced by social determinants such as income, education, and access to resources. The insights gained through this CHNA will directly inform the development of Corewell Health's Southeast Michigan 2026–2028 Implementation Strategy. This strategy will outline targeted, evidence-based initiatives designed to address the identified health needs, reduce disparities, and promote long-term improvements in community health and well-being.

Corewell Health in Southeast Michigan remains committed to working collaboratively with local partners, stakeholders, and residents to ensure that the strategies developed are responsive, equitable, and sustainable. By aligning efforts with community voices and data-driven priorities, Corewell Health in Southeast Michigan aims to foster a healthier, more resilient community for all.

If you have any questions or comments regarding this report, please send feedback to **CHNA@corewellhealth.org**.

Appendices Summary

The following support documents are shared separately on corewellhealth.org/about/healthier-communities/community-health-needs-assessments

A. Secondary Data (Methodology and Data Scoring Tables)

A detailed overview of the Conduent HCI data scoring methodology and indicator scoring results from the secondary data analysis.

B. Community Partner Assessment Tools

Quantitative and qualitative community feedback data collection tools that were vital in capturing community feedback during this collaborative CHNA:

- Community Survey Questions
- Focus Group Guide
- Focus Group Findings Summary
- Listening Session Questions
- Listening Session Findings Summary

C. Community Resources

This document highlights existing resources that organizations are currently using and available widely in the community. These resources were a result of the asset mapping activity.

D. Potential Community Partners

The tables in this section highlight potential community partners who were identified during the qualitative data collection process for this CHNA.

E. Previous Implementation Strategy Impact Reports

These reports identify the impact of actions to address the significant health needs addressed in the following 2023-2025 Corewell Health in Southeast Michigan hospital reports:

- Corewell Health Dearborn Hospital
- Corewell Health Farmington Hills Hospital
- Corewell Health Beaumont Grosse Pointe Hospital
- Corewell Health Taylor Hospital
- Corewell Health Trenton Hospital
- Corewell Health Beaumont Troy Hospital
- Corewell Health Wayne Hospital
- Corewell Health William Beaumont University Hospital

Community Health Needs Assessment

Appendices

Corewell Health™

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Appendix A: Secondary Data Scoring Tables

Topic Scores: Wayne County

Results from the secondary data topic scoring can be seen in Tables 1 and 2 below. The highest scoring health need in Wayne County was Sexually Transmitted Infections with a score of 2.35.

Table 1: Health Topic Scores: Wayne County

Health Topic	Score
Sexually Transmitted Infections	2.35
Diabetes	2.20
Wellness and Lifestyle	1.95
Children's Health	1.84
Prevention and Safety	1.80
Respiratory Diseases	1.79
Immunizations and Infectious Diseases	1.79
Older Adults	1.78
Maternal, Fetal and Infant Health	1.76
Mortality Data	1.74
Other Conditions	1.69
Cancer	1.67
Heart Disease and Stroke	1.66
Alcohol and Drug Use	1.55
Physical Activity	1.53
Mental Health and Mental Disorders	1.51
Women's Health	1.37
Health Care Access and Quality	1.33
Oral Health	1.22

Table 2: Quality of Life Topic Scores: Wayne County

Quality of Life Topic	Score
Economy	2.08
Education	1.84
Community	1.63
Environmental Health	1.55

Topic Scores: Oakland County

Results from the secondary data topic scoring can be seen in Tables 3 and 4 below. The highest scoring health needs in Oakland County was Older Adults with a score of 1.64.

Table 3: Health Topic Scores: Oakland County

Health Topic	Score
Older Adults	1.64
Other Conditions	1.56
Heart Disease and Stroke	1.43
Women's Health	1.30
Physical Activity	1.30
Sexually Transmitted Infections	1.23
Cancer	1.22
Diabetes	1.20
Children's Health	1.16
Alcohol and Drug Use	1.09
Respiratory Diseases	1.07
Mental Health and Mental Disorders	1.01
Mortality Data	0.95
Prevention and Safety	0.94
Immunizations and Infectious Diseases	0.91
Maternal, Fetal and Infant Health	0.87
Health Care Access and Quality	0.85
Wellness and Lifestyle	0.81
Oral Health	0.68

Table 4: Quality of Life Topic Scores: Oakland County

Quality of Life Topic	Score
Environmental Health	1.25
Economy	1.08
Community	1.04
Education	0.93

Topic Scores: Macomb County

Results from the secondary data topic scoring can be seen in Tables 5 and 6 below. The highest scoring health needs in Macomb County was Diabetes with a score of 2.09.

Table 5: Health Topic Scores: Macomb County

Health Topic	Score
Diabetes	2.09
Older Adults	2.07
Other Conditions	1.90
Heart Disease and Stroke	1.81
Respiratory Diseases	1.81
Mental Health and Mental Disorders	1.70
Alcohol and Drug Use	1.63
Physical Activity	1.63
Cancer	1.60
Wellness and Lifestyle	1.42
Women's Health	1.40
Sexually Transmitted Infections	1.40
Prevention and Safety	1.36
Children's Health	1.31
Immunizations and Infectious Diseases	1.20
Maternal, Fetal and Infant Health	1.19
Health Care Access and Quality	1.16
Oral Health	0.95

Table 6: Quality of Life Topic Scores: Macomb County

Quality of Life Topic	Score
Education	1.62
Environmental Health	1.35
Economy	1.27
Community	1.22

All Indicator Scores by Topic Area

Below is a complete list of all indicators that were scored as part of the secondary data analysis. Indicators are grouped under their respective health and quality of life topic areas and include information about both the indicator data source and measurement period. Please refer to Table 7 below as a reference key for indicator data sources.

Table 7: Wayne County Indicator Scoring Data Source Key

Key	Data Source
1	American Community Survey 5-Year
2	American Lung Association
3	Annie E. Casey Foundation
4	CDC - PLACES
5	Centers for Disease Control and Prevention
6	Centers for Medicare and Medicaid Services
7	County Health Rankings
8	Feeding America
9	Michigan Department of Health and Human Services
10	Michigan Substance Use Data Repository
11	National Cancer Institute
12	National Center for Education Statistics
13	National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention
14	National Environmental Public Health Tracking Network
15	Purdue Center for Regional Development
16	U.S. Bureau of Labor Statistics
17	U.S. Census - County Business Patterns
18	U.S. Census Bureau - Small Area Health Insurance Estimates
19	U.S. Environmental Protection Agency
20	United For ALICE

Table 8: All Wayne County Secondary Data Indicators

SCORE	ALCOHOL and DRUG USE	UNITS	WAYNE COUNTY	HP2030	MI	U.S.	MEASUREMENT PERIOD	Source
2.36	Liquor Store Density	stores/ 100,000 population	25.6		15.7	10.9	2022	17
2.14	Death Rate due to Opioid-Related Drug Poisoning	deaths/ 100,000 population	45.1		25.3		2021	10
2.00	Michigan Substance Use Vulnerability Index	percent	98.8		50		2022	9
1.58	Adults who Binge Drink	percent	16.8			16.6	2022	4
1.19	Mothers who Smoked During Pregnancy	percent	6.2	4.3	8.5	3.7	2022	9
0.94	Adults who Drink Excessively	percent	18.8		20.1		2022	7
0.67	Alcohol-Impaired Driving Deaths	percent of driving deaths with alcohol involvement	25.3		28.9		2018-2022	7

SCORE	CANCER	UNITS	WAYNE COUNTY	HP2030	MI	U.S.	MEASUREMENT PERIOD	Source
2.64	Prostate Cancer Incidence Rate	cases/ 100,000 males	135.9		114.7	113.2	2017-2021	11
2.28	Age-Adjusted Death Rate due to Prostate Cancer	deaths/ 100,000 males	21.1	16.9	19	19	2018-2022	11
2.19	Colorectal Cancer Incidence Rate	cases/ 100,000 population	40.7		35.4	36.4	2017-2021	11
2.03	Lung and Bronchus Cancer Incidence Rate	cases/ 100,000 population	66.8		58.8	53.1	2017-2021	11

1.86	All Cancer Incidence Rate	cases/ 100,000 population	478.5		441.4	444.4	2017-2021	11
1.83	Age-Adjusted Death Rate due to Colorectal Cancer	deaths/ 100,000 population	14.9	8.9	13.4	12.9	2018-2022	11
1.75	Colon Cancer Screening: USPSTF Recommendation	percent	65.1			66.3	2022	4
1.67	Age-Adjusted Death Rate due to Breast Cancer	deaths/ 100,000 females	22.3	15.3	20.3	19.3	2018-2022	11
1.67	Age-Adjusted Death Rate due to Cancer	deaths/ 100,000 population	164	122.7	158.3	146	2018-2022	11
1.67	Breast Cancer Incidence Rate	cases/ 100,000 females	129.4		127	129.8	2017-2021	11
1.50	Cancer: Medicare Population	percent	12		12	12	2023	6
1.50	Mammography Screening: Medicare Population	percent	48		51	39	2023	6
1.50	Oral Cavity and Pharynx Cancer Incidence Rate	cases/ 100,000 population	12.2		11.8	12	2017-2021	11
1.33	Age-Adjusted Death Rate due to Lung Cancer	deaths/ 100,000 population	39.7	25.1	38.3	32.4	2018-2022	11
1.11	Mammogram in Past 2 Years: 50-74	percent	77	80.3		76.5	2022	4
0.92	Adults with Cancer (Non-Skin) or Melanoma	percent	7.4			8.2	2022	4
0.92	Cervical Cancer Screening: 21-65	Percent	84.9			82.8	2020	4

SCORE	CHILDREN'S HEALTH	UNITS	WAYNE COUNTY	HP2030	MI	U.S.	MEASUREMENT PERIOD	Source
2.64	Child Food Insecurity Rate	percent	27		17.9	18.5	2022	8
2.25	Child Abuse Rate	cases/ 1,000 children	15.4		11.4		2023	3

2.25	Child Mortality Rate: Under 20	deaths/ 100,000 population under 20	80.5		54.2		2019-2022	7
2.08	Child Care Centers	per 1,000 population under age 5	6.8		8.9	7	2022	7
1.03	Food Insecure Children Likely Ineligible for Assistance	percent	26		28	30	2022	8
0.78	Children with Health Insurance	percent	97.6		97.4		2022	18

SCORE	COMMUNITY	UNITS	WAYNE COUNTY	HP2030	MI	U.S.	MEASUREMENT PERIOD	Source
2.64	People 65+ Living Alone	percent	32.6		28.5	26.5	2019-2023	1
2.42	Median Monthly Owner Costs for Households without a Mortgage	dollars	597		587	612	2019-2023	1
2.39	Social Associations	membership associations/ 10,000 population	7		9.5		2022	7
2.31	Workers who Walk to Work	percent	1.7		2	2.4	2019-2023	1
2.25	Child Abuse Rate	cases/ 1,000 children	15.4		11.4		2023	3
2.25	Median Household Gross Rent	dollars	1087		1084	1348	2019-2023	1
2.17	People Living Below Poverty Level	percent	20.1	8	13.1	12.4	2019-2023	1
2.14	Linguistic Isolation	percent	3		1.8	4.2	2019-2023	1
2.08	Children in Single-Parent Households	percent	37.4		25	24.8	2019-2023	1
2.08	Children Living Below Poverty Level	percent	29.7		17.5	16.3	2019-2023	1

2.08	Young Children Living Below Poverty Level	percent	31.3		19.3	17.6	2019-2023	1
2.03	Youth not in School or Working	percent	2.4		1.9	1.7	2019-2023	1
2.00	Michigan Substance Use Vulnerability Index	percent	98.8		50		2022	9
1.92	Mortgaged Owners Median Monthly Household Costs	dollars	1512		1521	1902	2019-2023	1
1.86	Total Employment Change	percent	3.6		4.5	5.8	2021-2022	17
1.75	Median Household Income	dollars	59521		71149	78538	2019-2023	1
1.64	Female Population 16+ in Civilian Labor Force	percent	55.4		57.3	58.7	2019-2023	1
1.58	Median Housing Unit Value	dollars	170200		217600	303400	2019-2023	1
1.58	People 25+ with a High School Diploma or Higher	percent	87.9		91.9	89.4	2019-2023	1
1.58	Per Capita Income	dollars	33956		39538	43289	2019-2023	1
1.53	Mean Travel Time to Work	minutes	25		24.4	26.6	2019-2023	1
1.53	Population 16+ in Civilian Labor Force	percent	54.2		57.8	59.8	2019-2023	1
1.50	Workers Commuting by Public Transportation	percent	2.2	5.3	1	3.5	2019-2023	1
1.42	People 25+ with a Bachelor's Degree or Higher	percent	26.9		31.8	35	2019-2023	1
1.33	Solo Drivers with a Long Commute	percent	34.9		33.2		2019-2023	7
1.08	Death Rate due to Motor Vehicle Collisions	deaths/ 100,000 population	11.1		10.9		2016-2022	7
1.08	Households with an Internet Subscription	percent	87.9		89.4	89.9	2019-2023	1

1.08	Households with One or More Types of Computing Devices	percent	93.7		94.4	94.8	2019-2023	1
1.08	Persons with an Internet Subscription	percent	90.6		91.8	92	2019-2023	1
1.08	Persons with Health Insurance	percent	94.3	92.4	94.5		2022	18
1.00	Digital Distress		1				2022	15
0.83	Digital Divide Index	DDI Score	20		40.1	50	2022	15
0.67	Alcohol-Impaired Driving Deaths	percent of driving deaths with alcohol involvement	25.3		28.9		2018-2022	7
0.58	Workers who Drive Alone to Work	percent	73		75.6	70.2	2019-2023	1
0.50	Broadband Quality Score	BQS Score	68.6		47.4	50	2022	15

SCORE	DIABETES	UNITS	WAYNE COUNTY	HP2030	MI	U.S.	MEASUREMENT PERIOD	Source
2.50	Diabetes: Medicare Population	percent	29		25	24	2023	6
2.25	Age-Adjusted Death Rate due to Diabetes	deaths/ 100,000 population	30.3		26.1		2020-2022	9
1.86	Adults 20+ with Diabetes	percent	10.9				2021	5

SCORE	ECONOMY	UNITS	WAYNE COUNTY	HP2030	MI	U.S.	MEASUREMENT PERIOD	Source
2.92	Households with Cash Public Assistance Income	percent	3.6		2.8	2.7	2019-2023	1
2.92	Students Eligible for the Free Lunch Program	percent	65.9		50	43.6	2023-2024	12

2.92	Veterans Living Below Poverty Level	percent	12.1		7.6	7.2	2019-2023	1
2.64	Child Food Insecurity Rate	percent	27		17.9	18.5	2022	8
2.64	People 65+ Living Below Poverty Level	percent	13.7		9.3	10.4	2019-2023	1
2.50	Households Spending 50% or More of Household Income on Housing	percent	16.2		12.2	14.3	2019-2023	1
2.42	Median Monthly Owner Costs for Households without a Mortgage	dollars	597		587	612	2019-2023	1
2.39	Renters Spending 30% or More of Household Income on Rent	percent	53.6	25.5	49.6	50.4	2019-2023	1
2.36	Adults with Disability Living in Poverty	percent	34		27.1	24.6	2019-2023	1
2.36	Families Living Below Poverty Level	percent	15.3		8.8	8.7	2019-2023	1
2.36	Homeowner Vacancy Rate	percent	1.8		0.9	1	2019-2023	1
2.33	Families Living Below 200% of Poverty Level	Percent	31.5		22.3	22.4	2019-2023	1
2.33	People Living Below 200% of Poverty Level	percent	38.3		29.3	28.5	2019-2023	1
2.33	Unemployed Veterans	percent	4.3		3.3	3.2	2019-2023	1
2.25	Median Household Gross Rent	dollars	1087		1084	1348	2019-2023	1
2.17	People Living Below Poverty Level	percent	20.1	8	13.1	12.4	2019-2023	1
2.14	Unemployed Workers in Civilian Labor Force	percent	6.5		6	4.5	45689	16
2.08	Children Living Below Poverty Level	percent	29.7		17.5	16.3	2019-2023	1

2.08	Young Children Living Below Poverty Level	percent	31.3	19.3	17.6	2019-2023	1
2.03	Youth not in School or Working	percent	2.4	1.9	1.7	2019-2023	1
2.00	Households that are Above the Asset Limited, Income Constrained, Employed (ALICE) Threshold	percent	48.1	59		2022	20
1.92	Mortgaged Owners Median Monthly Household Costs	dollars	1512	1521	1902	2019-2023	1
1.86	Food Insecurity Rate	percent	15.4	14.2	13.5	2022	8
1.86	Households Living Below Poverty Level	percent	20	13		2022	20
1.86	Total Employment Change	percent	3.6	4.5	5.8	2021-2022	17
1.83	Households that are Asset Limited, Income Constrained, Employed (ALICE)	percent	31.9	28		2022	20
1.83	Severe Housing Problems	percent	17.9	13.4		2017-2021	7
1.75	Median Household Income	dollars	59521	71149	78538	2019-2023	1
1.64	Female Population 16+ in Civilian Labor Force	percent	55.4	57.3	58.7	2019-2023	1
1.58	Median Housing Unit Value	dollars	170200	217600	303400	2019-2023	1
1.58	Per Capita Income	dollars	33956	39538	43289	2019-2023	1
1.53	Population 16+ in Civilian Labor Force	percent	54.2	57.8	59.8	2019-2023	1
1.36	Size of Labor Force	persons	823586			45689	16
1.03	Food Insecure Children Likely Ineligible for Assistance	percent	26	28	30	2022	8

1.00	Gender Pay Gap	cents on the dollar	0.8		0.7	0.7	2019-2023	1

SCORE	EDUCATION	UNITS	WAYNE COUNTY	HP2030	MI	U.S.	MEASUREMENT PERIOD	Source
2.19	Student-to-Teacher Ratio	students/ teacher	17.4		16.6	15.2	2023-2024	12
2.08	Child Care Centers	per 1,000 population under age 5	6.8		8.9	7	2022	7
1.89	High School Graduation	percent	80.6	90.7	82.9		2023	3
1.86	Veterans with a High School Diploma or Higher	percent	92.9		94.9	95.2	2019-2023	1
1.58	People 25+ with a High School Diploma or Higher	percent	87.9		91.9	89.4	2019-2023	1
1.42	People 25+ with a Bachelor's Degree or Higher	percent	26.9		31.8	35	2019-2023	1

SCORE	ENVIRONMENTAL HEALTH	UNITS	WAYNE COUNTY	HP2030	MI	U.S.	MEASUREMENT PERIOD	Source
2.36	Houses Built Prior to 1950	percent	34.9		21.5	16.4	2019-2023	1
2.36	Liquor Store Density	stores/ 100,000 population	25.6		15.7	10.9	2022	17
2.25	Adults with Current Asthma	percent	12.5			9.9	2022	4
2.25	Air Pollution due to Particulate Matter	micrograms per cubic meter	10.7		6.7		2020	7
2.25	Proximity to Highways	percent	7.1		4.1		2020	14
1.89	Annual Particle Pollution		5				2020-2022	2

1.83	Severe Housing Problems	percent	17.9	13.4		2017-2021	7
1.75	Annual Ozone Air Quality		5			2020-2022	2
1.64	Recognized Carcinogens Released into Air	pounds	269777.6			2023	19
1.64	Weeks of Moderate Drought or Worse	weeks per year	16			2021	14
1.50	Asthma: Medicare Population	percent	7	7	7	2023	6
1.47	Daily Dose of UV Irradiance	Joule per square meter	2953	3021		2020	14
1.36	Number of Extreme Heat Days	days	11			2023	14
1.36	Number of Extreme Heat Events	events	8			2023	14
1.36	Number of Extreme Precipitation Days	days	4			2023	14
1.36	PBT Released	pounds	1769946.2			2023	19
1.11	Food Environment Index		7.6	7.1		2025	7
0.83	Digital Divide Index	DDI Score	20	40.1	50	2022	15
0.75	Access to Exercise Opportunities	percent	96	85.6		2025	7
0.75	Access to Parks	percent	85.4	59.6		2020	14
0.50	Broadband Quality Score	BQS Score	68.6	47.4	50	2022	15

SCORE	HEALTH CARE ACCESS and QUALITY	UNITS	WAYNE COUNTY	HP2030	MI	U.S.	MEASUREMENT PERIOD	Source
2.50	Preventable Hospital Stays: Medicare Population	discharges/ 100,000 Medicare enrollees	4880		3367	2769	2023	6

2.00	Michigan Substance Use Vulnerability Index	percent	98.8		50		2022	9
1.75	Adults who Visited a Dentist	percent	62.9			63.9	2022	4
1.67	Primary Care Provider Rate	providers/ 100,000 population	70.1		78.4	74.9	2021	7
1.42	Adults without Health Insurance	percent	7			10.8	2022	4
1.17	Non-Physician Primary Care Provider Rate	providers/ 100,000 population	120.5		148.9		2024	7
1.11	Adults with Health Insurance: 18-64	percent	93		93.4		2022	18
1.08	Adults who have had a Routine Checkup	percent	79.1			76.1	2022	4
1.08	Persons with Health Insurance	percent	94.3	92.4	94.5		2022	18
0.86	Dentist Rate	dentists/ 100,000 population	77		80.2	73.5	2022	7
0.78	Children with Health Insurance	percent	97.6		97.4		2022	18
0.50	Mental Health Provider Rate	providers/ 100,000 population	365.1		356.1		2024	7

SCORE	HEART DISEASE and STROKE	UNITS	WAYNE COUNTY	HP2030	MI	U.S.	MEASUREMENT PERIOD	Source
2.50	Heart Failure: Medicare Population	percent	15		13	11	2023	6
2.42	Age-Adjusted Death Rate due to Heart Disease	deaths/ 100,000 population	259.4		205.9		2020-2022	9

2.17	Age-Adjusted Death Rate due to Cerebrovascular Disease (Stroke)	deaths/ 100,000 population	48.4	33.4	44.7		2020-2022	9
2.08	Adults who Have Taken Medications for High Blood Pressure	percent	77.7			78.2	2021	4
1.92	Adults who Experienced a Stroke	percent	4.3			3.6	2022	4
1.89	High Blood Pressure Prevalence	percent	39.6	41.9		32.7	2021	4
1.83	Hypertension: Medicare Population	percent	68		66	65	2023	6
1.83	Ischemic Heart Disease: Medicare Population	percent	23		22	21	2023	6
1.53	Age-Adjusted Hospitalization Rate due to Heart Attack	hospitalizations/ 10,000 population 35+ years	31.3		30.8		2020	14
1.50	Stroke: Medicare Population	percent	6		6	6	2023	6
1.42	Cholesterol Test History	percent	85.9			86.4	2021	4
1.17	Hyperlipidemia: Medicare Population	percent	61		63	66	2023	6
1.08	Adults who Experienced Coronary Heart Disease	percent	7.3			6.8	2022	4
1.08	Age-Adjusted Death Rate due to Heart Attack	deaths/ 100,000 population 35+ years	45.8		48.4		2021	14
1.08	High Cholesterol Prevalence	percent	35			35.5	2021	4
1.00	Atrial Fibrillation: Medicare Population	percent	14		15	14	2023	6

SCORE	IMMUNIZATIONS and INFECTIOUS DISEASES	UNITS	WAYNE COUNTY	HP2030	MI	U.S.	MEASUREMENT PERIOD	Source
2.50	Chlamydia Incidence Rate	cases/ 100,000 population	791		429.5	492.2	2023	13
2.36	Gonorrhea Incidence Rate	cases/ 100,000 population	337.1		152.2	179.5	2023	13
2.19	Syphilis Incidence Rate	cases/ 100,000 population	16.3		8.4	15.8	2023	13
2.00	Age-Adjusted Death Rate due to Influenza and Pneumonia	deaths/ 100,000 population	20		11.9		2020-2022	9
0.83	Flu Vaccinations: Medicare Population	percent	45		44	3	2023	6
0.83	Pneumonia Vaccinations: Medicare Population	percent	9		9	9	2023	6

SCORE	MATERNAL, FETAL and INFANT HEALTH	UNITS	WAYNE COUNTY	HP2030	MI	U.S.	MEASUREMENT PERIOD	Source
2.47	Preterm Births	percent	11.6	9.4	10.4	10.4	2022	9
2.39	Babies with Low Birthweight	percent	11.4		9.2	8.6	2022	9
2.22	Infant Mortality Rate	deaths/ 1,000 live births	10	5	6.5		2018-2022	9
1.67	Teen Pregnancy Rate	pregnancies/ 1,000 females aged 15-19	35.2	31.4	21.2		2022	9
1.58	Teen Birth Rate: 15-19	live births/ 1,000 females aged 15-19	17		11.5	13.6	2022	9
1.19	Mothers who Smoked During Pregnancy	percent	6.2	4.3	8.5	3.7	2022	9
0.83	Mothers who Received Early Prenatal Care	percent	77		76.3	75.3	2022	9

SCORE	MENTAL HEALTH and MENTAL DISORDERS	UNITS	WAYNE COUNTY	HP2030	MI	U.S.	MEASUREMENT PERIOD	Source
2.33	Poor Mental Health: Average Number of Days	days	6.1		5.6		2022	7
2.08	Poor Mental Health: 14+ Days	percent	18.7			15.8	2022	4
2.00	Alzheimer's Disease or Dementia: Medicare Population	percent	7		7	6	2023	6
1.58	Adults Ever Diagnosed with Depression	percent	23.3			20.7	2022	4
1.39	Age-Adjusted Death Rate due to Suicide	deaths/ 100,000 population	12.6	12.8	14.4		2018-2022	9
1.33	Depression: Medicare Population	percent	17		18	17	2023	6
0.86	Age-Adjusted Death Rate due to Alzheimer's Disease	deaths/ 100,000 population	25.2		34.4		2018-2022	9
0.50	Mental Health Provider Rate	providers/ 100,000 population	365.1		356.1		2024	7

SCORE	OLDER ADULTS	UNITS	WAYNE COUNTY	HP2030	MI	U.S.	MEASUREMENT PERIOD	Source
2.64	People 65+ Living Alone	percent	32.6		28.5	26.5	2019-2023	1
2.64	People 65+ Living Below Poverty Level	percent	13.7		9.3	10.4	2019-2023	1
2.64	Prostate Cancer Incidence Rate	cases/ 100,000 males	135.9		114.7	113.2	2017-2021	11
2.50	Diabetes: Medicare Population	percent	29		25	24	2023	6
2.50	Heart Failure: Medicare Population	percent	15		13	11	2023	6

2.17	Chronic Kidney Disease: Medicare Population	percent	21		20	18	2023	6
2.17	COPD: Medicare Population	percent	15		13	11	2023	6
2.00	Alzheimer's Disease or Dementia: Medicare Population	percent	7		7	6	2023	6
1.83	Hypertension: Medicare Population	percent	68		66	65	2023	6
1.83	Ischemic Heart Disease: Medicare Population	percent	23		22	21	2023	6
1.83	Rheumatoid Arthritis or Osteoarthritis: Medicare Population	percent	37		36	36	2023	6
1.50	Asthma: Medicare Population	percent	7		7	7	2023	6
1.50	Cancer: Medicare Population	percent	12		12	12	2023	6
1.50	Mammography Screening: Medicare Population	percent	48		51	39	2023	6
1.50	Osteoporosis: Medicare Population	percent	11		11	12	2023	6
1.50	Stroke: Medicare Population	percent	6		6	6	2023	6
1.33	Depression: Medicare Population	percent	17		18	17	2023	6
1.17	Hyperlipidemia: Medicare Population	percent	61		63	66	2023	6
1.00	Atrial Fibrillation: Medicare Population	percent	14		15	14	2023	6
0.86	Age-Adjusted Death Rate due to Alzheimer's Disease	deaths/ 100,000 population	25.2		34.4		2018-2022	9
0.75	Adults 65+ with Total Tooth Loss	percent	9.5			12.2	2022	4

SCORE	ORAL HEALTH	UNITS	WAYNE COUNTY	HP2030	MI	U.S.	MEASUREMENT PERIOD	Source

1.75	Adults who Visited a Dentist	percent	62.9			63.9	2022	4
1.50	Oral Cavity and Pharynx Cancer Incidence Rate	cases/ 100,000 population	12.2		11.8	12	2017-2021	11
0.86	Dentist Rate	dentists/ 100,000 population	77		80.2	73.5	2022	7
0.75	Adults 65+ with Total Tooth Loss	percent	9.5			12.2	2022	4

SCORE	OTHER CHRONIC CONDITIONS	UNITS	WAYNE COUNTY	HP2030	MI	U.S.	MEASUREMENT PERIOD	Source
2.17	Chronic Kidney Disease: Medicare Population	percent	21		20	18	2023	6
1.83	Rheumatoid Arthritis or Osteoarthritis: Medicare Population	percent	37		36	36	2023	6
1.50	Osteoporosis: Medicare Population	percent	11		11	12	2023	6
1.25	Adults with Arthritis	percent	29			26.6	2022	4

SCORE	PHYSICAL ACTIVITY	UNITS	WAYNE COUNTY	HP2030	MI	U.S.	MEASUREMENT PERIOD	Source
2.31	Workers who Walk to Work	percent	1.7		2	2.4	2019-2023	1
1.97	Adults 20+ Who Are Obese	percent	35.4	36			2021	5
1.86	Adults 20+ who are Sedentary	percent	24.1				2021	5
0.75	Access to Exercise Opportunities	percent	96		85.6		2025	7

SCORE	PREVENTION and SAFETY	UNITS	WAYNE COUNTY	HP2030	MI	U.S.	MEASUREMENT PERIOD	Source
2.50	Age-Adjusted Death Rate due to Unintentional Injuries	deaths/ 100,000 population	78.6	43.2	58.9		2020-2022	9

1.83	Severe Housing Problems	percent	17.9		13.4		2017-2021	7
1.08	Death Rate due to Motor Vehicle Collisions	deaths/ 100,000 population	11.1		10.9		2016-2022	7

SCORE	RESPIRATORY DISEASES	UNITS	WAYNE COUNTY	HP2030	MI	U.S.	MEASUREMENT PERIOD	Source
2.25	Adults with Current Asthma	percent	12.5			9.9	2022	4
2.25	Proximity to Highways	percent	7.1		4.1		2020	14
2.17	COPD: Medicare Population	percent	15		13	11	2023	6
2.03	Lung and Bronchus Cancer Incidence Rate	cases/ 100,000 population	66.8		58.8	53.1	2017-2021	11
2.00	Adults who Smoke	percent	18.4	6.1		12.9	2022	4
2.00	Age-Adjusted Death Rate due to Influenza and Pneumonia	deaths/ 100,000 population	20		11.9		2020-2022	9
1.75	Adults with COPD	Percent of adults	9.1			6.8	2022	4
1.50	Asthma: Medicare Population	percent	7		7	7	2023	6
1.33	Age-Adjusted Death Rate due to Lung Cancer	deaths/ 100,000 population	39.7	25.1	38.3	32.4	2018-2022	11
0.58	Age-Adjusted Death Rate due to Chronic Lower Respiratory Diseases	deaths/ 100,000 population	34.4		39.9		2020-2022	9

SCORE	SEXUALLY TRANSMITTED INFECTIONS	UNITS	WAYNE COUNTY	HP2030	MI	U.S.	MEASUREMENT PERIOD	Source
2.50	Chlamydia Incidence Rate	cases/ 100,000 population	791		429.5	492.2	2023	13
2.36	Gonorrhea Incidence Rate	cases/ 100,000 population	337.1		152.2	179.5	2023	13

2.19	Syphilis Incidence Rate	cases/ 100,000 population	16.3		8.4	15.8	2023	13

SCORE	WELLNESS and LIFESTYLE	UNITS	WAYNE COUNTY	HP2030	MI	U.S.	MEASUREMENT PERIOD	Source
2.33	Insufficient Sleep	percent	41.3	26.7		36	2022	4
2.08	Self-Reported General Health Assessment: Poor or Fair	percent	20.8			17.9	2022	4
1.92	Life Expectancy	years	72.9		76.2		2020-2022	7
1.92	Poor Physical Health: Average Number of Days	days	4.5		4		2022	7
1.89	High Blood Pressure Prevalence	percent	39.6	41.9		32.7	2021	4
1.58	Poor Physical Health: 14+ Days	percent	14.3			12.7	2022	4

SCORE	WOMEN'S HEALTH	UNITS	WAYNE COUNTY	HP2030	MI	U.S.	MEASUREMENT PERIOD	Source
1.67	Age-Adjusted Death Rate due to Breast Cancer	deaths/ 100,000 females	22.3	15.3	20.3	19.3	2018-2022	11
1.67	Breast Cancer Incidence Rate	cases/ 100,000 females	129.4		127	129.8	2017-2021	11
1.50	Mammography Screening: Medicare Population	percent	48		51	39	2023	6
1.11	Mammogram in Past 2 Years: 50-74	percent	77	80.3		76.5	2022	4
0.92	Cervical Cancer Screening: 21-65	Percent	84.9			82.8	2020	4

Table 9: Oakland County Indicator Scoring Data Source Key

Key	Data Source
1	American Community Survey 5-Year
2	American Lung Association
3	Annie E. Casey Foundation
4	CDC - PLACES
5	Centers for Disease Control and Prevention
6	Centers for Medicare and Medicaid Services
7	County Health Rankings
8	Feeding America
9	Michigan Department of Health and Human Services
10	Michigan Substance Use Data Repository
11	National Cancer Institute
12	National Center for Education Statistics
13	National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention
14	National Environmental Public Health Tracking Network
15	Purdue Center for Regional Development
16	U.S. Bureau of Labor Statistics
17	U.S. Census - County Business Patterns
18	U.S. Census Bureau - Small Area Health Insurance Estimates
19	U.S. Environmental Protection Agency
20	United For ALICE

Table 10: Oakland County Secondary Data Indicators

SCORE	ALCOHOL and DRUG USE	UNITS	OAKLAND COUNTY	HP2030	MI	U.S.	MEASUREMENT PERIOD	Source
1.75	Adults who Binge Drink	percent	17.4			16.6	2022	4
1.47	Death Rate due to Opioid-Related Drug Poisoning	deaths/ 100,000 population	16.9		25.3		2021	10
1.42	Liquor Store Density	stores/ 100,000 population	15.1		15.7	10.9	2022	17
1.00	Michigan Substance Use Vulnerability Index	percent	10.7		50		2022	9
0.94	Adults who Drink Excessively	percent	19.8		20.1		2022	7
0.53	Mothers who Smoked During Pregnancy	percent	3.3	4.3	8.5	3.7	2022	9
0.50	Alcohol-Impaired Driving Deaths	percent of driving deaths with alcohol involvement	23.4		28.9		2018-2022	7

SCORE	CANCER	UNITS	OAKLAND COUNTY	HP2030	MI	U.S.	MEASUREMENT PERIOD	Source
2.64	Prostate Cancer Incidence Rate	cases/ 100,000 males	140.3		114.7	113.2	2017-2021	11
2.33	Breast Cancer Incidence Rate	cases/ 100,000 females	141.5		127	129.8	2017-2021	11
2.17	Cancer: Medicare Population	percent	13		12	12	2023	6
1.86	All Cancer Incidence Rate	cases/ 100,000 population	471.7		441.4	444.4	2017-2021	11

1.61	Age-Adjusted Death Rate due to Prostate Cancer	deaths/ 100,000 males	18.2	16.9	19	19	2018-2022	11
1.61	Mammogram in Past 2 Years: 50-74	percent	76	80.3		76.5	2022	4
1.25	Adults with Cancer (Non-Skin) or Melanoma	percent	8.8			8.2	2022	4
1.19	Colorectal Cancer Incidence Rate	cases/ 100,000 population	36.1		35.4	36.4	2017-2021	11
1.08	Colon Cancer Screening: USPSTF Recommendation	percent	69.7			66.3	2022	4
0.92	Cervical Cancer Screening: 21-65	Percent	85			82.8	2020	4
0.86	Oral Cavity and Pharynx Cancer Incidence Rate	cases/ 100,000 population	11.6		11.8	12	2017-2021	11
0.83	Age-Adjusted Death Rate due to Breast Cancer	deaths/ 100,000 females	19	15.3	20.3	19.3	2018-2022	11
0.83	Mammography Screening: Medicare Population	percent	52		51	39	2023	6
0.61	Age-Adjusted Death Rate due to Colorectal Cancer	deaths/ 100,000 population	11.8	8.9	13.4	12.9	2018-2022	11
0.53	Lung and Bronchus Cancer Incidence Rate	cases/ 100,000 population	51.1		58.8	53.1	2017-2021	11
0.33	Age-Adjusted Death Rate due to Cancer	deaths/ 100,000 population	137.3	122.7	158.3	146	2018-2022	11
0.17	Age-Adjusted Death Rate due to Lung Cancer	deaths/ 100,000 population	29.1	25.1	38.3	32.4	2018-2022	11

SCORE	CHILDREN'S HEALTH	UNITS	OAKLAND COUNTY	HP2030	MI	U.S.	MEASUREMENT PERIOD	Source
2.64	Food Insecure Children Likely Ineligible for Assistance	percent	45		28	30	2022	8

1.42	Child Care Centers	per 1,000 population under age 5	8.6		8.9	7	2022	7
0.86	Child Abuse Rate	cases/ 1,000 children	5		11.4		2023	3
0.78	Children with Health Insurance	percent	98		97.4		2022	18
0.75	Child Mortality Rate: Under 20	deaths/ 100,000 population under 20	35.9		54.2		2019-2022	7
0.50	Child Food Insecurity Rate	percent	10.9		17.9	18.5	2022	8

SCORE	COMMUNITY	UNITS	OAKLAND COUNTY	HP2030	MI	U.S.	MEASUREMENT PERIOD	Source
2.92	Median Monthly Owner Costs for Households without a Mortgage	dollars	757		587	612	2019-2023	1
2.75	Mortgaged Owners Median Monthly Household Costs	dollars	1933		1521	1902	2019-2023	1
2.58	Median Household Gross Rent	dollars	1319		1084	1348	2019-2023	1
2.50	Workers who Walk to Work	percent	1.1		2	2.4	2019-2023	1
2.22	Social Associations	membership associations/ 10,000 population	8		9.5		2022	7
2.22	Workers Commuting by Public Transportation	percent	0.3	5.3	1	3.5	2019-2023	1
2.17	Total Employment Change	percent	3.1		4.5	5.8	2021-2022	17
2.03	People 65+ Living Alone	percent	29.4		28.5	26.5	2019-2023	1
2.00	Linguistic Isolation	percent	2.6		1.8	4.2	2019-2023	1

1.67	Solo Drivers with a Long Commute	percent	40.9		33.2		2019-2023	7
1.25	Mean Travel Time to Work	minutes	26		24.4	26.6	2019-2023	1
1.00	Digital Distress		1				2022	15
1.00	Michigan Substance Use Vulnerability Index	percent	10.7		50		2022	9
0.86	Child Abuse Rate	cases/ 1,000 children	5		11.4		2023	3
0.75	Death Rate due to Motor Vehicle Collisions	deaths/ 100,000 population	5.7		10.9		2016-2022	7
0.75	Persons with Health Insurance	percent	95.3	92.4	94.5		2022	18
0.69	Children in Single-Parent Households	percent	18.9		25	24.8	2019-2023	1
0.69	Female Population 16+ in Civilian Labor Force	percent	60.4		57.3	58.7	2019-2023	1
0.69	Population 16+ in Civilian Labor Force	percent	63.3		57.8	59.8	2019-2023	1
0.69	Youth not in School or Working	percent	1		1.9	1.7	2019-2023	1
0.58	Workers who Drive Alone to Work	percent	73.4		75.6	70.2	2019-2023	1
0.50	Alcohol-Impaired Driving Deaths	percent of driving deaths with alcohol involvement	23.4		28.9		2018-2022	7
0.50	Broadband Quality Score	BQS Score	68.9		47.4	50	2022	15
0.50	Digital Divide Index	DDI Score	11.4		40.1	50	2022	15

0.42	Households with an Internet Subscription	percent	93.7		89.4	89.9	2019-2023	1
0.42	Households with One or More Types of Computing Devices	percent	96.6		94.4	94.8	2019-2023	1
0.42	People 25+ with a High School Diploma or Higher	percent	94.9		91.9	89.4	2019-2023	1
0.42	Persons with an Internet Subscription	percent	95.4		91.8	92	2019-2023	1
0.36	Children Living Below Poverty Level	percent	8.8		17.5	16.3	2019-2023	1
0.33	People Living Below Poverty Level	percent	7.7	8	13.1	12.4	2019-2023	1
0.25	Median Housing Unit Value	dollars	320400		217600	303400	2019-2023	1
0.08	Median Household Income	dollars	95296		71149	78538	2019-2023	1
0.08	People 25+ with a Bachelor's Degree or Higher	percent	50.2		31.8	35	2019-2023	1
0.08	Per Capita Income	dollars	55114		39538	43289	2019-2023	1
0.08	Young Children Living Below Poverty Level	percent	9		19.3	17.6	2019-2023	1

SCORE	DIABETES	UNITS	OAKLAND COUNTY	HP2030	MI	U.S.	MEASUREMENT PERIOD	Source
1.42	Age-Adjusted Death Rate due to Diabetes	deaths/ 100,000 population	21		26.1		2020-2022	9
1.17	Diabetes: Medicare Population	percent	24		25	24	2023	6
1.00	Adults 20+ with Diabetes	percent	6.8				2021	5

SCORE	ECONOMY	UNITS	OAKLAND COUNTY	HP2030	MI	U.S.	MEASUREMENT PERIOD	Source
2.92	Median Monthly Owner Costs for Households without a Mortgage	dollars	757		587	612	2019-2023	1
2.75	Mortgaged Owners Median Monthly Household Costs	dollars	1933		1521	1902	2019-2023	1
2.64	Food Insecure Children Likely Ineligible for Assistance	percent	45		28	30	2022	8
2.58	Median Household Gross Rent	dollars	1319		1084	1348	2019-2023	1
2.42	Unemployed Veterans	percent	3.6		3.3	3.2	2019-2023	1
2.33	Gender Pay Gap	cents on the dollar	0.6		0.7	0.7	2019-2023	1
2.17	Total Employment Change	percent	3.1		4.5	5.8	2021-2022	17
1.50	Households Spending 50% or More of Household Income on Housing	percent	11.7		12.2	14.3	2019-2023	1
1.36	Size of Labor Force	persons	679312				45689	16
1.28	Severe Housing Problems	percent	12.2		13.4		2017-2021	7
1.25	People 65+ Living Below Poverty Level	percent	8.2		9.3	10.4	2019-2023	1
1.14	Households Living Below Poverty Level	percent	9.5		13		2022	20
1.14	Households that are Above the Asset Limited, Income Constrained, Employed (ALICE) Threshold	percent	66.9		59		2022	20
1.06	Renters Spending 30% or More of Household Income on Rent	percent	43.8	25.5	49.6	50.4	2019-2023	1

0.97	Households with Cash Public Assistance Income	percent	2.2	2.8	2.7	2019-2023	1
0.97	Unemployed Workers in Civilian Labor Force	percent	4.3	6	4.5	45689	16
0.92	Students Eligible for the Free Lunch Program	percent	33.9	50	43.6	2023-2024	12
0.86	Households that are Asset Limited, Income Constrained, Employed (ALICE)	percent	23.6	28		2022	20
0.81	Veterans Living Below Poverty Level	percent	5.4	7.6	7.2	2019-2023	1
0.69	Female Population 16+ in Civilian Labor Force	percent	60.4	57.3	58.7	2019-2023	1
0.69	Population 16+ in Civilian Labor Force	percent	63.3	57.8	59.8	2019-2023	1
0.69	Youth not in School or Working	percent	1	1.9	1.7	2019-2023	1
0.64	Families Living Below Poverty Level	percent	4.9	8.8	8.7	2019-2023	1
0.64	Food Insecurity Rate	percent	11	14.2	13.5	2022	8
0.53	Adults with Disability Living in Poverty	percent	20.4	27.1	24.6	2019-2023	1
0.50	Child Food Insecurity Rate	percent	10.9	17.9	18.5	2022	8
0.50	Families Living Below 200% of Poverty Level	Percent	13.3	22.3	22.4	2019-2023	1
0.50	People Living Below 200% of Poverty Level	percent	18.1	29.3	28.5	2019-2023	1
0.36	Children Living Below Poverty Level	percent	8.8	17.5	16.3	2019-2023	1

0.33	People Living Below Poverty Level	percent	7.7	8	13.1	12.4	2019-2023	1
0.25	Median Housing Unit Value	dollars	320400		217600	303400	2019-2023	1
0.08	Homeowner Vacancy Rate	percent	0.5		0.9	1	2019-2023	1
0.08	Median Household Income	dollars	95296		71149	78538	2019-2023	1
0.08	Per Capita Income	dollars	55114		39538	43289	2019-2023	1
0.08	Young Children Living Below Poverty Level	percent	9		19.3	17.6	2019-2023	1

SCORE	EDUCATION	UNITS	OAKLAND COUNTY	HP2030	MI	U.S.	MEASUREMENT PERIOD	Source
1.86	Student-to-Teacher Ratio	students/ teacher	16.6		16.6	15.2	2023-2024	12
1.42	Child Care Centers	per 1,000 population under age 5	8.6		8.9	7	2022	7
1.19	High School Graduation	percent	88.4	90.7	82.9		2023	3
0.58	Veterans with a High School Diploma or Higher	percent	96.1		94.9	95.2	2019-2023	1
0.42	People 25+ with a High School Diploma or Higher	percent	94.9		91.9	89.4	2019-2023	1
0.08	People 25+ with a Bachelor's Degree or Higher	percent	50.2		31.8	35	2019-2023	1

SCORE	ENVIRONMENTAL HEALTH	UNITS	OAKLAND COUNTY	HP2030	MI	U.S.	MEASUREMENT PERIOD	Source
2.50	Asthma: Medicare Population	percent	8		7	7	2023	6
2.08	Proximity to Highways	percent	4.6		4.1		2020	14

1.64	PBT Released	pounds	785.5			2023	19
1.64	Weeks of Moderate Drought or Worse	weeks per year	14			2021	14
1.61	Air Pollution due to Particulate Matter	micrograms per cubic meter	7.5	6.7		2020	7
1.61	Annual Ozone Air Quality		4			2020-2022	2
1.42	Liquor Store Density	stores/ 100,000 population	15.1	15.7	10.9	2022	17
1.36	Number of Extreme Heat Days	days	13			2023	14
1.36	Number of Extreme Precipitation Days	days	3			2023	14
1.36	Recognized Carcinogens Released into Air	pounds	7504.6			2023	19
1.33	Daily Dose of UV Irradiance	Joule per square meter	2939	3021		2020	14
1.28	Severe Housing Problems	percent	12.2	13.4		2017-2021	7
1.25	Adults with Current Asthma	percent	10.3		9.9	2022	4
1.25	Annual Particle Pollution		1			2020-2022	2
1.08	Number of Extreme Heat Events	events	8			2023	14
0.92	Access to Parks	percent	65	59.6		2020	14
0.75	Access to Exercise Opportunities	percent	96.4	85.6		2025	7
0.61	Food Environment Index		8.6	7.1		2025	7
0.50	Broadband Quality Score	BQS Score	68.9	47.4	50	2022	15
0.50	Digital Divide Index	DDI Score	11.4	40.1	50	2022	15
0.25	Houses Built Prior to 1950	percent	12.9	21.5	16.4	2019-2023	1

SCORE	HEALTH CARE ACCESS and QUALITY	UNITS	OAKLAND COUNTY	HP2030	MI	U.S.	MEASUREMENT PERIOD	Source
2.33	Preventable Hospital Stays: Medicare Population	discharges/ 100,000 Medicare enrollees	3507		3367	2769	2023	6
1.42	Adults who have had a Routine Checkup	percent	78.5			76.1	2022	4
1.00	Michigan Substance Use Vulnerability Index	percent	10.7		50		2022	9
0.78	Adults with Health Insurance: 18-64	percent	94.4		93.4		2022	18
0.78	Children with Health Insurance	percent	98		97.4		2022	18
0.75	Adults who Visited a Dentist	percent	73.7			63.9	2022	4
0.75	Adults without Health Insurance	percent	4.2			10.8	2022	4
0.75	Persons with Health Insurance	percent	95.3	92.4	94.5		2022	18
0.64	Primary Care Provider Rate	providers/ 100,000 population	137.8		78.4	74.9	2021	7
0.36	Dentist Rate	dentists/ 100,000 population	112.4		80.2	73.5	2022	7
0.33	Mental Health Provider Rate	providers/ 100,000 population	459.8		356.1		2024	7
0.33	Non-Physician Primary Care Provider Rate	providers/ 100,000 population	195.1		148.9		2024	7

SCORE	HEART DISEASE and STROKE	UNITS	OAKLAND COUNTY	HP2030	MI	U.S.	MEASUREMENT PERIOD	Source
2.50	Ischemic Heart Disease: Medicare Population	percent	25		22	21	2023	6
2.50	Stroke: Medicare Population	percent	7		6	6	2023	6
2.17	Age-Adjusted Death Rate due to Cerebrovascular Disease (Stroke)	deaths/ 100,000 population	47	33.4	44.7		2020-2022	9
1.75	Age-Adjusted Death Rate due to Heart Disease	deaths/ 100,000 population	189.3		205.9		2020-2022	9
1.67	Hyperlipidemia: Medicare Population	percent	66		63	66	2023	6
1.58	Adults who Have Taken Medications for High Blood Pressure	percent	79.8			78.2	2021	4
1.50	Atrial Fibrillation: Medicare Population	percent	15		15	14	2023	6
1.50	Hypertension: Medicare Population	percent	66		66	65	2023	6
1.33	Heart Failure: Medicare Population	percent	12		13	11	2023	6
1.25	Age-Adjusted Hospitalization Rate due to Heart Attack	hospitalizations/ 10,000 population 35+ years	31.7		30.8		2020	14
0.94	Age-Adjusted Death Rate due to Heart Attack	deaths/ 100,000 population 35+ years	46.1		48.4		2021	14
0.92	Cholesterol Test History	percent	89.5			86.4	2021	4
0.92	High Cholesterol Prevalence	percent	32.3			35.5	2021	4
0.83	High Blood Pressure Prevalence	percent	31.5	41.9		32.7	2021	4

0.75	Adults who Experienced a Stroke	percent	2.9			3.6	2022	4
0.75	Adults who Experienced Coronary Heart Disease	percent	5.9			6.8	2022	4

SCORE	IMMUNIZATIONS and INFECTIOUS DISEASES	UNITS	OAKLAND COUNTY	HP2030	MI	U.S.	MEASUREMENT PERIOD	Source
1.33	Chlamydia Incidence Rate	cases/ 100,000 population	296.4		429.5	492.2	2023	13
1.19	Gonorrhea Incidence Rate	cases/ 100,000 population	103.2		152.2	179.5	2023	13
1.17	Syphilis Incidence Rate	cases/ 100,000 population	6.7		8.4	15.8	2023	13
0.75	Age-Adjusted Death Rate due to Influenza and Pneumonia	deaths/ 100,000 population	9.9		11.9		2020-2022	9
0.50	Flu Vaccinations: Medicare Population	percent	52		44	3	2023	6
0.50	Pneumonia Vaccinations: Medicare Population	percent	11		9	9	2023	6

SCORE	MATERNAL, FETAL and INFANT HEALTH	UNITS	OAKLAND COUNTY	HP2030	MI	U.S.	MEASUREMENT PERIOD	Source
1.11	Babies with Low Birthweight	percent	8.2		9.2	8.6	2022	9
1.08	Preterm Births	percent	9.4	9.4	10.4	10.4	2022	9
0.89	Mothers who Received Early Prenatal Care	percent	84.3		76.3	75.3	2022	9
0.86	Teen Birth Rate: 15-19	live births/ 1,000 females aged 15-19	4.6		11.5	13.6	2022	9
0.83	Infant Mortality Rate	deaths/ 1,000 live births	4.7	5	6.5		2018-2022	9

0.78	Teen Pregnancy Rate	pregnancies/ 1,000 females aged 15-19	12	31.4	21.2		2022	9
0.53	Mothers who Smoked During Pregnancy	percent	3.3	4.3	8.5	3.7	2022	9

SCORE	MENTAL HEALTH and MENTAL DISORDERS	UNITS	OAKLAND COUNTY	HP2030	MI	U.S.	MEASUREMENT PERIOD	Source
2.00	Alzheimer's Disease or Dementia: Medicare Population	percent	7		7	6	2023	6
1.33	Depression: Medicare Population	percent	17		18	17	2023	6
1.11	Age-Adjusted Death Rate due to Suicide	deaths/ 100,000 population	11.8	12.8	14.4		2018-2022	9
0.92	Adults Ever Diagnosed with Depression	percent	19.2			20.7	2022	4
0.92	Poor Mental Health: 14+ Days	percent	14.3			15.8	2022	4
0.89	Poor Mental Health: Average Number of Days	days	4.9		5.6		2022	7
0.58	Age-Adjusted Death Rate due to Alzheimer's Disease	deaths/ 100,000 population	24.1		34.4		2018-2022	9
0.33	Mental Health Provider Rate	providers/ 100,000 population	459.8		356.1		2024	7

SCORE	OLDER ADULTS	UNITS	OAKLAND COUNTY	HP2030	MI	U.S.	MEASUREMENT PERIOD	Source
2.64	Prostate Cancer Incidence Rate	cases/ 100,000 males	140.3		114.7	113.2	2017-2021	11
2.50	Asthma: Medicare Population	percent	8		7	7	2023	6

2.50	Ischemic Heart Disease: Medicare Population	percent	25	22	21	2023	6
2.50	Stroke: Medicare Population	percent	7	6	6	2023	6
2.33	Osteoporosis: Medicare Population	percent	13	11	12	2023	6
2.17	Cancer: Medicare Population	percent	13	12	12	2023	6
2.03	People 65+ Living Alone	percent	29.4	28.5	26.5	2019-2023	1
2.00	Alzheimer's Disease or Dementia: Medicare Population	percent	7	7	6	2023	6
1.83	Rheumatoid Arthritis or Osteoarthritis: Medicare Population	percent	37	36	36	2023	6
1.67	Hyperlipidemia: Medicare Population	percent	66	63	66	2023	6
1.50	Atrial Fibrillation: Medicare Population	percent	15	15	14	2023	6
1.50	Hypertension: Medicare Population	percent	66	66	65	2023	6
1.33	Depression: Medicare Population	percent	17	18	17	2023	6
1.33	Heart Failure: Medicare Population	percent	12	13	11	2023	6
1.25	People 65+ Living Below Poverty Level	percent	8.2	9.3	10.4	2019-2023	1
1.17	Chronic Kidney Disease: Medicare Population	percent	18	20	18	2023	6
1.17	Diabetes: Medicare Population	percent	24	25	24	2023	6
0.83	COPD: Medicare Population	percent	11	13	11	2023	6

0.83	Mammography Screening: Medicare Population	percent	52		51	39	2023	6
0.75	Adults 65+ with Total Tooth Loss	percent	7.1			12.2	2022	4
0.58	Age-Adjusted Death Rate due to Alzheimer's Disease	deaths/ 100,000 population	24.1		34.4		2018-2022	9

SCORE	ORAL HEALTH	UNITS	OAKLAND COUNTY	HP2030	MI	U.S.	MEASUREMENT PERIOD	Source
0.86	Oral Cavity and Pharynx Cancer Incidence Rate	cases/ 100,000 population	11.6		11.8	12	2017-2021	11
0.75	Adults 65+ with Total Tooth Loss	percent	7.1			12.2	2022	4
0.75	Adults who Visited a Dentist	percent	73.7			63.9	2022	4
0.36	Dentist Rate	dentists/ 100,000 population	112.4		80.2	73.5	2022	7

SCORE	OTHER CHRONIC CONDITIONS	UNITS	OAKLAND COUNTY	HP2030	MI	U.S.	MEASUREMENT PERIOD	Source
2.33	Osteoporosis: Medicare Population	percent	13		11	12	2023	6
1.83	Rheumatoid Arthritis or Osteoarthritis: Medicare Population	percent	37		36	36	2023	6
1.17	Chronic Kidney Disease: Medicare Population	percent	18		20	18	2023	6
0.92	Adults with Arthritis	percent	26.4			26.6	2022	4

SCORE	PHYSICAL ACTIVITY	UNITS	OAKLAND COUNTY	HP2030	MI	U.S.	MEASUREMENT PERIOD	Source
2.50	Workers who Walk to Work	percent	1.1		2	2.4	2019-2023	1
1.56	Adults 20+ Who Are Obese	percent	28.7	36			2021	5

0.92	Access to Parks	percent	65		59.6		2020	14
0.75	Access to Exercise Opportunities	percent	96.4		85.6		2025	7
0.75	Adults 20+ who are Sedentary	percent	16.1				2021	5

SCORE	PREVENTION and SAFETY	UNITS	OAKLAND COUNTY	HP2030	MI	U.S.	MEASUREMENT PERIOD	Source
1.28	Severe Housing Problems	percent	12.2		13.4		2017-2021	7
0.78	Age-Adjusted Death Rate due to Unintentional Injuries	deaths/ 100,000 population	28.8	43.2	58.9		2020-2022	9
0.75	Death Rate due to Motor Vehicle Collisions	deaths/ 100,000 population	5.7		10.9		2016-2022	7

SCORE	RESPIRATORY DISEASES	UNITS	OAKLAND COUNTY	HP2030	MI	U.S.	MEASUREMENT PERIOD	Source
2.50	Asthma: Medicare Population	percent	8		7	7	2023	6
2.08	Proximity to Highways	percent	4.6		4.1		2020	14
1.25	Adults with Current Asthma	percent	10.3			9.9	2022	4
1.00	Adults who Smoke	percent	11.9	6.1		12.9	2022	4
0.86	Age-Adjusted Death Rate due to Chronic Lower Respiratory Diseases	deaths/ 100,000 population	29.4		39.9		2020-2022	9
0.83	COPD: Medicare Population	percent	11		13	11	2023	6
0.75	Adults with COPD	Percent of adults	5.7			6.8	2022	4
0.75	Age-Adjusted Death Rate due to Influenza and Pneumonia	deaths/ 100,000 population	9.9		11.9		2020-2022	9
0.53	Lung and Bronchus Cancer Incidence Rate	cases/ 100,000 population	51.1		58.8	53.1	2017-2021	11
0.17	Age-Adjusted Death Rate due to Lung Cancer	deaths/ 100,000 population	29.1	25.1	38.3	32.4	2018-2022	11

SCORE	SEXUALLY TRANSMITTED INFECTIONS	UNITS	OAKLAND COUNTY	HP2030	MI	U.S.	MEASUREMENT PERIOD	Source
1.33	Chlamydia Incidence Rate	cases/ 100,000 population	296.4		429.5	492.2	2023	13
1.19	Gonorrhea Incidence Rate	cases/ 100,000 population	103.2		152.2	179.5	2023	13
1.17	Syphilis Incidence Rate	cases/ 100,000 population	6.7		8.4	15.8	2023	13

SCORE	WELLNESS and LIFESTYLE	UNITS	OAKLAND COUNTY	HP2030	MI	U.S.	MEASUREMENT PERIOD	Source
0.92	Life Expectancy	years	79.1		76.2		2020-2022	7
0.83	High Blood Pressure Prevalence	percent	31.5	41.9		32.7	2021	4
0.83	Insufficient Sleep	percent	31.1	26.7		36	2022	4
0.75	Poor Physical Health: 14+ Days	percent	10.3			12.7	2022	4
0.75	Poor Physical Health: Average Number of Days	days	3.4		4		2022	7
0.75	Self-Reported General Health Assessment: Poor or Fair	percent	12.7			17.9	2022	4

SCORE	WOMEN'S HEALTH	UNITS	OAKLAND COUNTY	HP2030	MI	U.S.	MEASUREMENT PERIOD	Source
2.33	Breast Cancer Incidence Rate	cases/ 100,000 females	141.5		127	129.8	2017-2021	11
1.61	Mammogram in Past 2 Years: 50-74	percent	76	80.3		76.5	2022	4
0.92	Cervical Cancer Screening: 21-65	Percent	85			82.8	2020	4

SCORE	WOMEN'S HEALTH	UNITS	OAKLAND COUNTY	HP2030	MI	U.S.	MEASUREMENT PERIOD	Source
0.83	Age-Adjusted Death Rate due to Breast Cancer	deaths/ 100,000 females	19	15.3	20.3	19.3	2018-2022	11
0.83	Mammography Screening: Medicare Population	percent	52		51	39	2023	6

Table 11: Macomb County Indicator Scoring Data Source Key

Key	Data Source
1	American Community Survey 5-Year
2	American Lung Association
3	Annie E. Casey Foundation
4	CDC - PLACES
5	Centers for Disease Control and Prevention
6	Centers for Medicare and Medicaid Services
7	County Health Rankings
8	Feeding America
9	Michigan Department of Health and Human Services
10	Michigan Substance Use Data Repository
11	National Cancer Institute
12	National Center for Education Statistics
13	National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention
14	National Environmental Public Health Tracking Network
15	Purdue Center for Regional Development
16	U.S. Bureau of Labor Statistics
17	U.S. Census - County Business Patterns
18	U.S. Census Bureau - Small Area Health Insurance Estimates
19	U.S. Environmental Protection Agency
20	United For ALICE

Table 12: All Macomb County Secondary Data Indicators

SCORE	ALCOHOL and DRUG USE	UNITS	MACOMB COUNTY	HP2030	MI	U.S.	MEASUREMENT PERIOD	Source
2.64	Liquor Store Density	stores/ 100,000 population	19.1		15.7	10.9	2022	17
2.00	Death Rate due to Opioid-Related Drug Poisoning	deaths/ 100,000 population	31.3		25.3		2021	10
1.75	Adults who Binge Drink	percent	17.9			16.6	2022	4
1.44	Adults who Drink Excessively	percent	20.7		20.1		2022	7
1.33	Michigan Substance Use Vulnerability Index	percent	46.4		50		2022	9
1.19	Mothers who Smoked During Pregnancy	percent	6.8	4.3	8.5	3.7	2022	9
1.08	Alcohol-Impaired Driving Deaths	percent of driving deaths with alcohol involvement	25.2		28.9		2018-2022	7

SCORE	CANCER	UNITS	MACOMB COUNTY	HP2030	MI	U.S.	MEASUREMENT PERIOD	Source
2.75	Prostate Cancer Incidence Rate	cases/ 100,000 males	127.1		114.7	113.2	2017-2021	11
2.33	Breast Cancer Incidence Rate	cases/ 100,000 females	140.7		127	129.8	2017-2021	11
2.19	All Cancer Incidence Rate	cases/ 100,000 population	490.6		441.4	444.4	2017-2021	11
2.17	Cancer: Medicare Population	percent	13		12	12	2023	6
2.03	Lung and Bronchus Cancer Incidence Rate	cases/ 100,000 population	68.3		58.8	53.1	2017-2021	11

1.53	Colorectal Cancer Incidence Rate	cases/ 100,000 population	38.1		35.4	36.4	2017-2021	11
1.53	Oral Cavity and Pharynx Cancer Incidence Rate	cases/ 100,000 population	12.6		11.8	12	2017-2021	11
1.50	Age-Adjusted Death Rate due to Breast Cancer	deaths/ 100,000 females	20.5	15.3	20.3	19.3	2018-2022	11
1.50	Age-Adjusted Death Rate due to Cancer	deaths/ 100,000 population	162.6	122.7	158.3	146	2018-2022	11
1.50	Age-Adjusted Death Rate due to Lung Cancer	deaths/ 100,000 population	40.5	25.1	38.3	32.4	2018-2022	11
1.44	Age-Adjusted Death Rate due to Colorectal Cancer	deaths/ 100,000 population	13.5	8.9	13.4	12.9	2018-2022	11
1.33	Mammography Screening: Medicare Population	percent	50		51	39	2023	6
1.25	Adults with Cancer (Non-Skin) or Melanoma	percent	8.6			8.2	2022	4
1.25	Age-Adjusted Death Rate due to Prostate Cancer	deaths/ 100,000 males	18.6	16.9	19	19	2018-2022	11
1.08	Colon Cancer Screening: USPSTF Recommendation	percent	70.5			66.3	2022	4
0.94	Mammogram in Past 2 Years: 50-74	percent	78.9	80.3		76.5	2022	4
0.92	Cervical Cancer Screening: 21-65	Percent	85.1			82.8	2020	4

SCORE	CHILDREN'S HEALTH	UNITS	MACOMB COUNTY	HP2030	MI	U.S.	MEASUREMENT PERIOD	Source
2.47	Food Insecure Children Likely Ineligible for Assistance	percent	34		28	30	2022	8
2.25	Child Care Centers	per 1,000 population under age 5	6.1		8.9	7	2022	7

0.92	Child Mortality Rate: Under 20	deaths/ 100,000 population under 20	44.2		54.2		2019-2022	7
0.83	Child Food Insecurity Rate	percent	16		17.9	18.5	2022	8
0.78	Children with Health Insurance	percent	97.4		97.4		2022	18
0.58	Child Abuse Rate	cases/ 1,000 children	4.7		11.4		2023	3

SCORE	COMMUNITY	UNITS	MACOMB COUNTY	HP2030	MI	U.S.	MEASUREMENT PERIOD	Source
2.58	Median Monthly Owner Costs for Households without a Mortgage	dollars	630		587	612	2019-2023	1
2.39	Social Associations	membership associations/ 10,000 population	5.4		9.5		2022	7
2.36	Workers who Walk to Work	percent	1		2	2.4	2019-2023	1
2.25	Median Household Gross Rent	dollars	1175		1084	1348	2019-2023	1
2.19	Youth not in School or Working	percent	2.7		1.9	1.7	2019-2023	1
2.17	People 65+ Living Alone	percent	30.2		28.5	26.5	2019-2023	1
2.14	Linguistic Isolation	percent	3.3		1.8	4.2	2019-2023	1
2.08	Mortgaged Owners Median Monthly Household Costs	dollars	1587		1521	1902	2019-2023	1
1.72	Workers Commuting by Public Transportation	percent	0.6	5.3	1	3.5	2019-2023	1
1.67	Solo Drivers with a Long Commute	percent	41.2		33.2		2019-2023	7
1.64	Children in Single-Parent Households	percent	22.9		25	24.8	2019-2023	1

1.58	Mean Travel Time to Work	minutes	26.8	24.4	26.6	2019-2023	1
1.42	People 25+ with a Bachelor's Degree or Higher	percent	27.2	31.8	35	2019-2023	1
1.36	People 25+ with a High School Diploma or Higher	percent	90.8	91.9	89.4	2019-2023	1
1.33	Michigan Substance Use Vulnerability Index	percent	46.4	50		2022	9
1.25	Workers who Drive Alone to Work	percent	77.8	75.6	70.2	2019-2023	1
1.08	Alcohol-Impaired Driving Deaths	percent of driving deaths with alcohol involvement	25.2	28.9		2018-2022	7
1.00	Digital Distress		1			2022	15
1.00	Population 16+ in Civilian Labor Force	percent	60.1	57.8	59.8	2019-2023	1
0.92	Median Housing Unit Value	dollars	231400	217600	303400	2019-2023	1
0.86	Female Population 16+ in Civilian Labor Force	percent	58.8	57.3	58.7	2019-2023	1
0.75	Death Rate due to Motor Vehicle Collisions	deaths/ 100,000 population	7.6	10.9		2016-2022	7
0.75	Per Capita Income	dollars	39467	39538	43289	2019-2023	1
0.69	Children Living Below Poverty Level	percent	13.7	17.5	16.3	2019-2023	1
0.69	Young Children Living Below Poverty Level	percent	15.6	19.3	17.6	2019-2023	1
0.58	Child Abuse Rate	cases/ 1,000 children	4.7	11.4		2023	3
0.58	Median Household Income	dollars	76399	71149	78538	2019-2023	1
0.50	Broadband Quality Score	BQS Score	69.4	47.4	50	2022	15
0.50	Digital Divide Index	DDI Score	14.6	40.1	50	2022	15

0.50	Total Employment Change	percent	7.9		4.5	5.8	2021-2022	17
0.47	Persons with Health Insurance	percent	94.5	92.4	94.5		2022	18
0.44	People Living Below Poverty Level	percent	9.8	8	13.1	12.4	2019-2023	1
0.42	Households with an Internet Subscription	percent	92.6		89.4	89.9	2019-2023	1
0.42	Households with One or More Types of Computing Devices	percent	95.2		94.4	94.8	2019-2023	1
0.42	Persons with an Internet Subscription	percent	94.6		91.8	92	2019-2023	1

SCORE	DIABETES	UNITS	MACOMB COUNTY	HP2030	MI	U.S.	MEASUREMENT PERIOD	Source
2.33	Diabetes: Medicare Population	percent	28		25	24	2023	6
2.25	Age-Adjusted Death Rate due to Diabetes	deaths/ 100,000 population	31.6		26.1		2020-2022	9
1.69	Adults 20+ with Diabetes	percent	9.2				2021	5

SCORE	ECONOMY	UNITS	MACOMB COUNTY	HP2030	MI	U.S.	MEASUREMENT PERIOD	Source
2.58	Median Monthly Owner Costs for Households without a Mortgage	dollars	630		587	612	2019-2023	1
2.47	Food Insecure Children Likely Ineligible for Assistance	percent	34		28	30	2022	8
2.25	Households with Cash Public Assistance Income	percent	2.9		2.8	2.7	2019-2023	1
2.25	Median Household Gross Rent	dollars	1175		1084	1348	2019-2023	1
2.25	Students Eligible for the Free Lunch Program	percent	52		50	43.6	2023-2024	12

2.19	Youth not in School or Working	percent	2.7		1.9	1.7	2019-2023	1
2.08	Mortgaged Owners Median Monthly Household Costs	dollars	1587		1521	1902	2019-2023	1
2.06	Renters Spending 30% or More of Household Income on Rent	percent	50.2	25.5	49.6	50.4	2019-2023	1
2.06	Severe Housing Problems	percent	13.8		13.4		2017-2021	7
1.83	Gender Pay Gap	cents on the dollar	0.7		0.7	0.7	2019-2023	1
1.81	Unemployed Workers in Civilian Labor Force	percent	5.5		6	4.5	45689	16
1.67	Households Spending 50% or More of Household Income on Housing	percent	12.3		12.2	14.3	2019-2023	1
1.36	Households that are Asset Limited, Income Constrained, Employed (ALICE)	percent	28.3		28		2022	20
1.17	Households that are Above the Asset Limited, Income Constrained, Employed (ALICE) Threshold	percent	61.7		59		2022	20
1.14	People 65+ Living Below Poverty Level	percent	8.6		9.3	10.4	2019-2023	1
1.03	Unemployed Veterans	percent	2.9		3.3	3.2	2019-2023	1
1.00	Households Living Below Poverty Level	percent	10		13		2022	20
1.00	Population 16+ in Civilian Labor Force	percent	60.1		57.8	59.8	2019-2023	1
0.92	Median Housing Unit Value	dollars	231400		217600	303400	2019-2023	1
0.86	Female Population 16+ in Civilian Labor Force	percent	58.8		57.3	58.7	2019-2023	1
0.83	Child Food Insecurity Rate	percent	16		17.9	18.5	2022	8

0.83	Families Living Below 200% of Poverty Level	Percent	20.1		22.3	22.4	2019-2023	1
0.83	Food Insecurity Rate	percent	12.6		14.2	13.5	2022	8
0.75	Per Capita Income	dollars	39467		39538	43289	2019-2023	1
0.69	Children Living Below Poverty Level	percent	13.7		17.5	16.3	2019-2023	1
0.69	Families Living Below Poverty Level	percent	7.3		8.8	8.7	2019-2023	1
0.69	Homeowner Vacancy Rate	percent	0.8		0.9	1	2019-2023	1
0.69	Young Children Living Below Poverty Level	percent	15.6		19.3	17.6	2019-2023	1
0.67	Veterans Living Below Poverty Level	percent	5.9		7.6	7.2	2019-2023	1
0.58	Median Household Income	dollars	76399		71149	78538	2019-2023	1
0.50	People Living Below 200% of Poverty Level	percent	25.1		29.3	28.5	2019-2023	1
0.50	Total Employment Change	percent	7.9		4.5	5.8	2021-2022	17
0.44	People Living Below Poverty Level	percent	9.8	8	13.1	12.4	2019-2023	1
0.36	Adults with Disability Living in Poverty	percent	19.5		27.1	24.6	2019-2023	1

SCORE	EDUCATION	UNITS	MACOMB COUNTY	HP2030	MI	U.S.	MEASUREMENT PERIOD	Source
2.25	Child Care Centers	per 1,000 population under age 5	6.1		8.9	7	2022	7
2.19	Student-to-Teacher Ratio	students/ teacher	17.2		16.6	15.2	2023-2024	12
1.42	People 25+ with a Bachelor's Degree or Higher	percent	27.2		31.8	35	2019-2023	1

1.42	Veterans with a High School Diploma or Higher	percent	94.2		94.9	95.2	2019-2023	1
1.36	People 25+ with a High School Diploma or Higher	percent	90.8		91.9	89.4	2019-2023	1
1.06	High School Graduation	percent	87.6	90.7	82.9		2023	3

SCORE	ENVIRONMENTAL HEALTH	UNITS	MACOMB COUNTY	HP2030	MI	U.S.	MEASUREMENT PERIOD	Source
2.64	Liquor Store Density	stores/ 100,000 population	19.1		15.7	10.9	2022	17
2.50	Asthma: Medicare Population	percent	8		7	7	2023	6
2.08	Adults with Current Asthma	percent	11.7			9.9	2022	4
2.06	Severe Housing Problems	percent	13.8		13.4		2017-2021	7
1.75	Annual Ozone Air Quality		F				2020-2022	2
1.64	Weeks of Moderate Drought or Worse	weeks per year	10				2021	14
1.58	Proximity to Highways	percent	3.6		4.1		2020	14
1.36	Number of Extreme Heat Days	days	10				2023	14
1.36	Number of Extreme Heat Events	events	7				2023	14
1.36	Number of Extreme Precipitation Days	days	3				2023	14
1.36	PBT Released	pounds	26.1				2023	19
1.36	Recognized Carcinogens Released into Air	pounds	115069.9				2023	19
1.33	Daily Dose of UV Irradiance	Joule per square meter	2975		3021		2020	14
1.25	Access to Parks	percent	57.7		59.6		2020	14

1.25	Annual Particle Pollution		A			2020-2022	2
0.78	Food Environment Index		8.1	7.1		2025	7
0.75	Access to Exercise Opportunities	percent	96.8	85.6		2025	7
0.61	Air Pollution due to Particulate Matter	micrograms per cubic meter	6	6.7		2020	7
0.50	Broadband Quality Score	BQS Score	69.4	47.4	50	2022	15
0.50	Digital Divide Index	DDI Score	14.6	40.1	50	2022	15
0.36	Houses Built Prior to 1950	percent	8.4	21.5	16.4	2019-2023	1

SCORE	HEALTH CARE ACCESS and QUALITY	UNITS	MACOMB COUNTY	HP2030	MI	U.S.	MEASUREMENT PERIOD	Source
2.50	Preventable Hospital Stays: Medicare Population	discharges/ 100,000 Medicare enrollees	4336		3367	2769	2023	6
1.69	Primary Care Provider Rate	providers/ 100,000 population	54.3		78.4	74.9	2021	7
1.42	Adults who have had a Routine Checkup	percent	78.1			76.1	2022	4
1.42	Adults without Health Insurance	percent	6.1			10.8	2022	4
1.33	Michigan Substance Use Vulnerability Index	percent	46.4		50		2022	9
1.33	Non-Physician Primary Care Provider Rate	providers/ 100,000 population	99.4		148.9		2024	7
1.25	Adults who Visited a Dentist	percent	65.7			63.9	2022	4
1.17	Mental Health Provider Rate	providers/ 100,000 population	243.6		356.1		2024	7
0.78	Children with Health Insurance	percent	97.4		97.4		2022	18
0.50	Adults with Health Insurance: 18-64	percent	93.5		93.4		2022	18

0.47	Persons with Health Insurance	percent	94.5	92.4	94.5		2022	18
0.08	Dentist Rate	dentists/ 100,000 population	93.8		80.2	73.5	2022	7

SCORE	HEART DISEASE and STROKE	UNITS	MACOMB COUNTY	HP2030	MI	U.S.	MEASUREMENT PERIOD	Source
2.50	Atrial Fibrillation: Medicare Population	percent	17		15	14	2023	6
2.50	Heart Failure: Medicare Population	percent	15		13	11	2023	6
2.50	Ischemic Heart Disease: Medicare Population	percent	28		22	21	2023	6
2.50	Stroke: Medicare Population	percent	7		6	6	2023	6
2.33	Hypertension: Medicare Population	percent	72		66	65	2023	6
2.00	Age-Adjusted Death Rate due to Cerebrovascular Disease (Stroke)	deaths/ 100,000 population	43.5	33.4	44.7		2020-2022	9
2.00	Hyperlipidemia: Medicare Population	percent	69		63	66	2023	6
1.64	Age-Adjusted Death Rate due to Heart Disease	deaths/ 100,000 population	201.2		205.9		2020-2022	9
1.58	Adults who Have Taken Medications for High Blood Pressure	percent	79.5			78.2	2021	4
1.53	Age-Adjusted Hospitalization Rate due to Heart Attack	hospitalizations/ 10,000 population 35+ years	33.1		30.8		2020	14
1.50	High Blood Pressure Prevalence	percent	36.1	41.9		32.7	2021	4
1.42	Adults who Experienced a Stroke	percent	3.9			3.6	2022	4
1.42	High Cholesterol Prevalence	percent	36.7			35.5	2021	4
1.25	Adults who Experienced Coronary Heart Disease	percent	7.4			6.8	2022	4

1.25	Age-Adjusted Death Rate due to Heart Attack	deaths/ 100,000 population 35+ years	47.7		48.4		2021	14
1.08	Cholesterol Test History	percent	86.8			86.4	2021	4

SCORE	IMMUNIZATIONS and INFECTIOUS DISEASES	UNITS	MACOMB COUNTY	HP2030	MI	U.S.	MEASUREMENT PERIOD	Source
1.53	Age-Adjusted Death Rate due to Influenza and Pneumonia	deaths/ 100,000 population	12.3		11.9		2020-2022	9
1.53	Syphilis Incidence Rate	cases/ 100,000 population	8.7		8.4	15.8	2023	13
1.47	Chlamydia Incidence Rate	cases/ 100,000 population	362.7		429.5	492.2	2023	13
1.19	Gonorrhea Incidence Rate	cases/ 100,000 population	121.9		152.2	179.5	2023	13
0.83	Pneumonia Vaccinations: Medicare Population	percent	9		9	9	2023	6
0.67	Flu Vaccinations: Medicare Population	percent	47		44	3	2023	6

SCORE	MATERNAL, FETAL and INFANT HEALTH	UNITS	MACOMB COUNTY	HP2030	MI	U.S.	MEASUREMENT PERIOD	Source
2.50	Babies with Low Birthweight	percent	9.9		9.2	8.6	2022	9
2.14	Preterm Births	percent	11	9.4	10.4	10.4	2022	9
1.19	Mothers who Smoked During Pregnancy	percent	6.8	4.3	8.5	3.7	2022	9
0.78	Infant Mortality Rate	deaths/ 1,000 live births	5.1	5	6.5		2018-2022	9
0.67	Teen Pregnancy Rate	pregnancies/ 1,000 females aged 15-19	16.4	31.4	21.2		2022	9
0.58	Teen Birth Rate: 15-19	live births/ 1,000 females aged 15-19	6.6		11.5	13.6	2022	9

0.50	Mothers who Received Early Prenatal Care	percent	83.3		76.3	75.3	2022	9

SCORE	MENTAL HEALTH and MENTAL DISORDERS	UNITS	MACOMB COUNTY	HP2030	MI	U.S.	MEASUREMENT PERIOD	Source
2.50	Alzheimer's Disease or Dementia: Medicare Population	percent	8		7	6	2023	6
2.08	Poor Mental Health: 14+ Days	percent	18.1			15.8	2022	4
2.00	Poor Mental Health: Average Number of Days	days	5.7		5.6		2022	7
1.92	Adults Ever Diagnosed with Depression	percent	25.1			20.7	2022	4
1.67	Depression: Medicare Population	percent	18		18	17	2023	6
1.17	Age-Adjusted Death Rate due to Alzheimer's Disease	deaths/ 100,000 population	30.4		34.4		2018-2022	9
1.17	Mental Health Provider Rate	providers/ 100,000 population	243.6		356.1		2024	7
1.11	Age-Adjusted Death Rate due to Suicide	deaths/ 100,000 population	14.1	12.8	14.4		2018-2022	9

SCORE	OLDER ADULTS	UNITS	MACOMB COUNTY	HP2030	MI	U.S.	MEASUREMENT PERIOD	Source
2.75	Prostate Cancer Incidence Rate	cases/ 100,000 males	127.1		114.7	113.2	2017-2021	11
2.50	Alzheimer's Disease or Dementia: Medicare Population	percent	8		7	6	2023	6
2.50	Asthma: Medicare Population	percent	8		7	7	2023	6
2.50	Atrial Fibrillation: Medicare Population	percent	17		15	14	2023	6

SCORE	OLDER ADULTS	UNITS	MACOMB COUNTY	HP2030	MI	U.S.	MEASUREMENT PERIOD	Source
2.50	Chronic Kidney Disease: Medicare Population	percent	23		20	18	2023	6
2.50	Heart Failure: Medicare Population	percent	15		13	11	2023	6
2.50	Ischemic Heart Disease: Medicare Population	percent	28		22	21	2023	6
2.50	Stroke: Medicare Population	percent	7		6	6	2023	6
2.33	COPD: Medicare Population	percent	16		13	11	2023	6
2.33	Diabetes: Medicare Population	percent	28		25	24	2023	6
2.33	Hypertension: Medicare Population	percent	72		66	65	2023	6
2.17	Cancer: Medicare Population	percent	13		12	12	2023	6
2.17	People 65+ Living Alone	percent	30.2		28.5	26.5	2019-2023	1
2.17	Rheumatoid Arthritis or Osteoarthritis: Medicare Population	percent	39		36	36	2023	6
2.00	Hyperlipidemia: Medicare Population	percent	69		63	66	2023	6
1.67	Depression: Medicare Population	percent	18		18	17	2023	6
1.50	Osteoporosis: Medicare Population	percent	11		11	12	2023	6
1.33	Mammography Screening: Medicare Population	percent	50		51	39	2023	6
1.17	Age-Adjusted Death Rate due to Alzheimer's Disease	deaths/ 100,000 population	30.4		34.4		2018-2022	9
1.14	People 65+ Living Below Poverty Level	percent	8.6		9.3	10.4	2019-2023	1
0.92	Adults 65+ with Total Tooth Loss	percent	9.9			12.2	2022	4

SCORE	ORAL HEALTH	UNITS	MACOMB COUNTY	HP2030	MI	U.S.	MEASUREMENT PERIOD	Source
1.53	Oral Cavity and Pharynx Cancer Incidence Rate	cases/ 100,000 population	12.6		11.8	12	2017-2021	11
1.25	Adults who Visited a Dentist	percent	65.7			63.9	2022	4
0.92	Adults 65+ with Total Tooth Loss	percent	9.9			12.2	2022	4
0.08	Dentist Rate	dentists/ 100,000 population	93.8		80.2	73.5	2022	7

SCORE	OTHER CHRONIC CONDITIONS	UNITS	MACOMB COUNTY	HP2030	MI	U.S.	MEASUREMENT PERIOD	Source
2.50	Chronic Kidney Disease: Medicare Population	percent	23		20	18	2023	6
2.17	Rheumatoid Arthritis or Osteoarthritis: Medicare Population	percent	39		36	36	2023	6
1.50	Osteoporosis: Medicare Population	percent	11		11	12	2023	6
1.42	Adults with Arthritis	percent	29.3			26.6	2022	4

SCORE	PHYSICAL ACTIVITY	UNITS	MACOMB COUNTY	HP2030	MI	U.S.	MEASUREMENT PERIOD	Source
2.36	Workers who Walk to Work	percent	1		2	2.4	2019-2023	1
2.11	Adults 20+ Who Are Obese	percent	36	36			2021	5
1.69	Adults 20+ who are Sedentary	percent	20.4				2021	5
1.25	Access to Parks	percent	57.7		59.6		2020	14
0.75	Access to Exercise Opportunities	percent	96.8		85.6		2025	7

SCORE	PREVENTION and SAFETY	UNITS	MACOMB COUNTY	HP2030	MI	U.S.	MEASUREMENT PERIOD	Source
2.06	Severe Housing Problems	percent	13.8		13.4		2017-2021	7
1.28	Age-Adjusted Death Rate due to Unintentional Injuries	deaths/ 100,000 population	57.7	43.2	58.9		2020-2022	9
0.75	Death Rate due to Motor Vehicle Collisions	deaths/ 100,000 population	7.6		10.9		2016-2022	7

SCORE	RESPIRATORY DISEASES	UNITS	MACOMB COUNTY	HP2030	MI	U.S.	MEASUREMENT PERIOD	Source
2.50	Asthma: Medicare Population	percent	8		7	7	2023	6
2.33	COPD: Medicare Population	percent	16		13	11	2023	6
2.08	Adults with Current Asthma	percent	11.7			9.9	2022	4
2.03	Lung and Bronchus Cancer Incidence Rate	cases/ 100,000 population	68.3		58.8	53.1	2017-2021	11
2.00	Adults who Smoke	percent	18.9	6.1		12.9	2022	4
1.75	Adults with COPD	Percent of adults	9.5			6.8	2022	4
1.58	Proximity to Highways	percent	3.6		4.1		2020	14
1.53	Age-Adjusted Death Rate due to Influenza and Pneumonia	deaths/ 100,000 population	12.3		11.9		2020-2022	9
1.50	Age-Adjusted Death Rate due to Lung Cancer	deaths/ 100,000 population	40.5	25.1	38.3	32.4	2018-2022	11
0.75	Age-Adjusted Death Rate due to Chronic Lower Respiratory Diseases	deaths/ 100,000 population	37.5		39.9		2020-2022	9

SCORE	SEXUALLY TRANSMITTED INFECTIONS	UNITS	MACOMB COUNTY	HP2030	MI	U.S.	MEASUREMENT PERIOD	Source
1.53	Syphilis Incidence Rate	cases/ 100,000 population	8.7		8.4	15.8	2023	13
1.47	Chlamydia Incidence Rate	cases/ 100,000 population	362.7		429.5	492.2	2023	13
1.19	Gonorrhea Incidence Rate	cases/ 100,000 population	121.9		152.2	179.5	2023	13

SCORE	WELLNESS and LIFESTYLE	UNITS	MACOMB COUNTY	HP2030	MI	U.S.	MEASUREMENT PERIOD	Source
2.00	Insufficient Sleep	percent	38.2	26.7		36	2022	4
1.50	High Blood Pressure Prevalence	percent	36.1	41.9		32.7	2021	4
1.42	Poor Physical Health: 14+ Days	percent	13.7			12.7	2022	4
1.42	Self-Reported General Health Assessment: Poor or Fair	percent	19.2			17.9	2022	4
1.25	Life Expectancy	years	76.3		76.2		2020-2022	7
0.92	Poor Physical Health: Average Number of Days	days	4		4		2022	7

SCORE	WOMEN'S HEALTH	UNITS	MACOMB COUNTY	HP2030	MI	U.S.	MEASUREMENT PERIOD	Source
2.33	Breast Cancer Incidence Rate	cases/ 100,000 females	140.7		127	129.8	2017-2021	11
1.50	Age-Adjusted Death Rate due to Breast Cancer	deaths/ 100,000 females	20.5	15.3	20.3	19.3	2018-2022	11
1.33	Mammography Screening: Medicare Population	percent	50		51	39	2023	6
0.94	Mammogram in Past 2 Years: 50-74	percent	78.9	80.3		76.5	2022	4
0.92	Cervical Cancer Screening: 21-65	Percent	85.1			82.8	2020	4

Appendix B: Community Partner Assessment Tools

Corewell Health in Southeast Michigan Community Health Survey

Welcome to the Corewell Health community health survey. The information collected in this survey will allow community organizations across Macomb, Oakland, and Wayne counties to better understand the health needs in your community. The knowledge gained will be utilized to develop programs that benefit the entire community. We can better understand community needs by gathering the voices of community members like you to share with us the issues that you feel are most important.

REMINDER: You must be at least 18 years old to complete this survey. We estimate that it will take 10 minutes to complete. Survey results will be available and shared broadly in the community within the following year. The responses that you provide will remain anonymous and will not be attributed to you personally in any way. Your participation in this survey is entirely voluntary. If you have any questions, please contact the Corewell Health Community Health Need Assessment (CHNA) team by email at CHNA@corewellhealth.org. Thank you very much for your input and your time!

Q1 - In what ZIP Code do you live? Please write your five-digit ZIP Code on the line below.

ZIP Code: _____

Q2 - In what county do you live? Select one.

- ☐ Macomb
- ☐ Oakland
- ☐ Wayne
- ☐ Other (please specify) _____

Q3 - What is your age? Select one.

- ☐ Under 18
- ☐ 18-20
- ☐ 21-24
- ☐ 25-34
- ☐ 35-44
- ☐ 45-54
- ☐ 55-64
- ☐ 65-74
- ☐ 75-84

- ☐ 85 or older
- ☐ Prefer not to answer

I. In this survey, “community” refers to the major areas where you live, shop, play, work, and get services.

Q4 - How would you rate your community as a healthy place to live? Select one.

- ☐ Very Unhealthy
- ☐ Unhealthy
- ☐ Somewhat Healthy
- ☐ Healthy
- ☐ Very Healthy

Q5 - In the following list, what do you think are the three most important “health problems” in your community? (Those problems that have the greatest impact on overall community health.)
Select up to 3.

- ☐ Access to affordable health care services (doctors available nearby, wait times, services available nearby, takes insurance)
- ☐ Alcohol and drug use
- ☐ Auto immune diseases (Multiple Sclerosis, Crohn’s disease, etc.)
- ☐ Cancer
- ☐ Children's health
- ☐ Chronic pain
- ☐ Diabetes
- ☐ Family planning services (birth control)
- ☐ Heart disease and stroke
- ☐ Injury and violence
- ☐ Maternal and infant health
- ☐ Men’s health (ex. prostate exam, prostate health)
- ☐ Mental health and mental disorders (anxiety, depression, suicide)
- ☐ Nutrition and healthy eating
- ☐ Older adults (hearing/vision loss, arthritis, etc.)
- ☐ Oral health and access to dentistry services (dentists available nearby)
- ☐ People living with disabilities
- ☐ Physical activity
- ☐ Quality of health care services available
- ☐ Respiratory/lung diseases (asthma, COPD, etc.)
- ☐ Sexually transmitted diseases/infections (STDs/STIs)
- ☐ Teen and adolescent health
- ☐ Tobacco use (including e-cigarettes, chewing tobacco, etc.)
- ☐ Weight status (individuals who are overweight or obese)
- ☐ Women’s health (ex. mammogram, pap exam)
- ☐ Other (please specify) _____

Q6 - In your opinion, which of the following would you most like to see addressed in your community? Select up to 3.

- ☐ Access to higher education (2-year or 4-year degrees)
- ☐ Air and water quality Cancer
- ☐ Accessible sidewalks and other structures for those living with disabilities
- ☐ Ability to access safe parks and walking paths
- ☐ Bike lanes

- ☐ Crime and Crime Prevention (robberies, shootings, other violent crimes)
- ☐ Discrimination or inequity based on race/ethnicity, gender, age, sex
- ☐ Domestic Violence and Abuse (intimate partner, family, or child abuse)
- ☐ Economy and job availability
- ☐ Education and schools (Pre-K to 12th grade)
- ☐ Emergency Preparedness
- ☐ Inequity in jobs, health, housing, etc. for underserved populations
- ☐ Food insecurity or hunger
- ☐ Healthy Eating (restaurants, stores, or markets)
- ☐ Homelessness and unstable housing
- ☐ Injury Prevention (traffic safety, drowning, bicycling and pedestrian accidents)
- ☐ Neighborhood Safety
- ☐ Persons who've experienced physical and/or emotional trauma
- ☐ Safe housing
- ☐ Services for Seniors/Elderly (those over 65)
- ☐ Social isolation/feeling lonely
- ☐ Support for families with children (childcare, parenting support)
- ☐ Transportation
- ☐ Other (please specify) _____

Q7 - Below are some statements about health care services in your community. Please rate how much you agree or disagree with each statement. Select one option in each row below.

	Strongly Agree	Agree	Feel Neutral	Disagree	Strongly Disagree
There are good-quality health care services in my community	☐	☐	☐	☐	☐
There are affordable health care services in my community	☐	☐	☐	☐	☐
I am connected to a primary care doctor or health clinic that I am happy with	☐	☐	☐	☐	☐
I can access the health care services that I need within a reasonable time frame and distance from my home or work	☐	☐	☐	☐	☐
I feel like I can advocate for my health care (I feel heard and seen by my health care provider)	☐	☐	☐	☐	☐
I know where to find the health care resources or information I need when I need them	☐	☐	☐	☐	☐
Individuals in my community can access health care services regardless of race, gender, sexual orientation, immigration status, etc.	☐	☐	☐	☐	☐

Q8 – Where do you get most of your health information? Select all that apply.

- ☐ Community organization/agency

- ☐ Doctor or health care provider
- ☐ Facebook
- ☐ X (Twitter)
- ☐ Instagram
- ☐ TikTok
- ☐ YouTube
- ☐ Family or friends
- ☐ Health department
- ☐ Hospital
- ☐ Internet
- ☐ Library
- ☐ Newspaper/magazine
- ☐ Radio
- ☐ Church/mosque/other faith-based organization
- ☐ School or college
- ☐ TV
- ☐ Workplace
- ☐ Other (please specify) _____

Q9 - How would you rate your own personal health in the past 12 months? Select one.

- ☐ Very Unhealthy
- ☐ Unhealthy
- ☐ Somewhat Healthy
- ☐ Healthy
- ☐ Very Healthy

Q10 - Do you currently have a health insurance plan/health coverage? Select one.

- ☐ Yes – PLEASE ANSWER Q11
- ☐ No – SKIP TO Q12
- ☐ I don't know – SKIP TO Q12

Q11 - Which type(s) of health plan(s) do you use to pay for your health care services? Select all that apply.

- ☐ Medicaid
- ☐ Medicare
- ☐ Insurance through an employer (HMO/PPO) - either my own or partner/spouse/parent
- ☐ Insurance through the Health Insurance Marketplace/Obamacare/Affordable Care Act (ACA)
- ☐ Private Insurance I pay for myself (HMO/PPO)
- ☐ Indian Health Services
- ☐ Veteran's Administration
- ☐ COBRA
- ☐ I pay out of pocket/cash
- ☐ Some other way (please specify) _____

Q12 - In the past 12 months, was there a time when you needed health care services but did not get the care that you needed? Select one.

- ☐ Yes – PLEASE ANSWER Q13
- ☐ No, I got the services that I needed – SKIP TO Q14

☐ Does not apply, I did not need health care services in the past year – SKIP TO Q14

PLEASE GO TO THE NEXT PAGE

Q13 - Select the top reason(s) that you did not receive the health care services that you needed in the past 12 months. Select all that apply.

- ☐ The cost was too high, and I couldn't afford to pay.
- ☐ I did not have health insurance coverage.
- ☐ My insurance was not accepted by the provider or facility.
- ☐ I didn't have access to a personal vehicle or other reliable transportation.
- ☐ Public transportation options (e.g., bus routes or schedules) didn't work for me.
- ☐ The clinic or provider's hours didn't match my availability or work schedule.
- ☐ I couldn't find childcare, which prevented me from going.
- ☐ The wait time for an appointment was too long.
- ☐ There were no doctors or clinics located near where I live.
- ☐ I wasn't sure where to go to get the care I needed.
- ☐ I had difficulty communicating due to a language barrier.
- ☐ Cultural or religious beliefs made it difficult to seek care.
- ☐ I didn't feel comfortable or confident in the health care system or providers.
- ☐ I had a previous negative experience with health care services.
- ☐ I couldn't find a provider who shared or understood my background (e.g., race, ethnicity, gender).
- ☐ I couldn't find a provider who had training relevant to my needs.
- ☐ Other (please specify) _____

Q14-How confident are you in your ability to do the following on your own?
Please select one response for each item.

Task	Not at all confident	Slightly confident	Somewhat confident	Very confident	Completely confident
Scheduling and attending health care appointments, finding a provider, filling a prescription, and knowing where to go for services	☐	☐	☐	☐	☐
Understanding and dealing with your health insurance provider (e.g., coverage, statements, disputing claims)	☐	☐	☐	☐	☐

Task	Not at all confident	Slightly confident	Somewhat confident	Very confident	Completely confident
Finding reliable health-related advice or information about your condition	☐	☐	☐	☐	☐
Using virtual health care services (e.g., scheduling online visits, messaging providers, using apps or patient portals)	☐	☐	☐	☐	☐
Filling out medical forms by yourself (e.g., insurance forms, questionnaires, doctor's office paperwork)	☐	☐	☐	☐	☐

Q15 - In the past 12 months, was there a time that you needed or considered seeking mental health services or alcohol/substance abuse treatment but did not get services? Select one.

- ☐ Yes – PLEASE ANSWER Q16
- ☐ No, I got the services that I needed – SKIP TO Q17
- ☐ Does not apply, I did not need services in the past year – SKIP TO Q17

Q16 - Select the top reason(s) that you did not receive mental health services or alcohol/substance use treatment. Select all that apply.

- ☐ The cost was too high, and I couldn't afford to pay.
- ☐ I did not have health insurance coverage at the time.
- ☐ My insurance was not accepted by the provider or facility.
- ☐ I didn't have access to a personal vehicle or other reliable transportation.
- ☐ Public transportation options (e.g., bus routes or schedules) didn't work for me.
- ☐ The clinic or provider's hours didn't match my availability or work schedule.
- ☐ I couldn't find childcare, which prevented me from going.
- ☐ The wait time for an appointment was too long.
- ☐ There were no doctors or clinics located near where I live.
- ☐ I wasn't sure where to go to get the care I needed.
- ☐ I had difficulty communicating due to a language barrier.
- ☐ Cultural or religious beliefs made it difficult to seek care.
- ☐ I didn't feel comfortable or confident in the health care system or providers.
- ☐ I had a previous negative experience with health care services.

- ☐ I couldn't find a provider who shared or understood my background (e.g., race, ethnicity, gender).
- ☐ I couldn't find a provider that had training relevant to my needs.
- ☐ Other (please specify) _____

Q17 - In the past 12 months, did you go to a hospital Emergency Department (ED)? Select one.

- ☐ Yes – PLEASE ANSWER Q18 AND Q19
- ☐ No, I have not gone to the hospital ED – SKIP TO Q20

Q18 - Please select the number of times you have gone to the ED in the past 12 months. Select one.

- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4
- ☐ 5
- ☐ 6 or more (please specify number) _____

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Q19 - What were the main reasons that you went to the Emergency Department (ED) instead of a doctor's office or clinic? Select all that apply.

- ☐ After clinic hours/it was a weekend
- ☐ I don't have a regular doctor/clinic
- ☐ I don't have health insurance
- ☐ I feel more comfortable accessing care in the ED instead of at a doctor's office or clinic
- ☐ I had concerns about cost or co-pays
- ☐ It was an emergency/life-threatening situation
- ☐ There was a long wait for an appointment with my regular doctor
- ☐ I needed food, shelter, or other resources
- ☐ My doctor (or other provider) told me to go
- ☐ Other (please specify) _____

Q20 - How many children (under age 18) currently live in your home? Select one.

- ☐ None – SKIP TO Q26
- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4
- ☐ 5
- ☐ 6 or more

II. **If there are any children under 18 that live in your home, please answer Q21 through Q25.**

Q21 - Which type(s) of health plans(s) do children in your home have to cover the costs of health care services? Select all that apply**.**

- ☐ Medicaid/Children's Health Insurance Program (CHIP)
- ☐ Insurance through an employer (HMO/PPO) - either my own or partner/spouse
- ☐ Insurance through the Health Insurance Marketplace/Obamacare/Affordable Care Act (ACA)
- ☐ Private Insurance I pay for myself (HMO/PPO)
- ☐ Indian Health Services
- ☐ Veteran's Administration
- ☐ COBRA
- ☐ I pay out of pocket/cash
- ☐ Some other way (please specify) _____

PLEASE GO TO NEXT PAGE

Q22 - Have the children (under 18) in your home experienced any of the following health issues?
Select all that apply.

- ☐ No, the child/children have not faced any health issues
- ☐ Childhood disabilities/special needs
- ☐ Allergies
- ☐ Asthma
- ☐ Autoimmune diseases
- ☐ Behavior challenges/ mental health
- ☐ Birth-related (ex. low birth weight, premature, prenatal)
- ☐ Cancer
- ☐ Child abuse/child neglect
- ☐ Child/children overweight
- ☐ Child/children underweight
- ☐ Diabetes/pre-diabetes/ high blood sugar
- ☐ Drug or alcohol use
- ☐ Hearing and /or vision
- ☐ Injuries or accidents that required immediate medical care (ex. sports injuries, bicycle accidents)
- ☐ Heart disease or other heart conditions
- ☐ Nervous system disorders
- ☐ Sexually transmitted disease
- ☐ Stroke
- ☐ Teen pregnancy
- ☐ Using tobacco, e-cigarettes, or vaping
- ☐ Other (please specify) _____

Q23 - In the past 12 months, was there a time when children in your home needed medical care or other health related services but did not get the services that they needed? Select one.

- ☐ Yes – PLEASE ANSWER Q24 AND Q25
- ☐ No, they got the services that they needed – SKIP TO Q26
- ☐ Does not apply, the child/children did not need services – SKIP TO Q26

Q24 - Which of the following services were the children in your home not able to get in the past 12 months when they needed them? Select all that apply.

- ☐ Alcohol or other substance abuse treatment
- ☐ Dental care (routine cleaning or urgent care)
- ☐ Emergency care services
- ☐ Mental health services
- ☐ Nutrition services
- ☐ Prescription medications
- ☐ Routine care/treatment for ongoing or chronic condition – ex. allergies, respiratory conditions, diabetes
- ☐ Scheduled vaccination(s)
- ☐ Services for special needs
- ☐ Sick visit/urgent care visit
- ☐ Well child visit/check-up
- ☐ Other (please specify) _____

PLEASE GO TO NEXT PAGE

Q25 - Select the top reason(s) that children in your home did not get the medical/health care services that they needed in the past 12 months. Select all that apply.

- ☐ The cost was too high, and I couldn't afford to pay.
- ☐ I did not have health insurance coverage.
- ☐ My insurance was not accepted by the provider or facility.
- ☐ I didn't have access to a personal vehicle or other reliable transportation.
- ☐ Public transportation options (e.g., bus routes or schedules) didn't work for me.
- ☐ The clinic or provider's hours didn't match my availability or work schedule.
- ☐ I couldn't find childcare, which prevented me from going.
- ☐ The wait time for an appointment was too long.
- ☐ There were no doctors or clinics located near where I live.
- ☐ I wasn't sure where to go to get the care my child needed.
- ☐ I had difficulty communicating due to a language barrier.
- ☐ Cultural or religious beliefs made it difficult to seek care.
- ☐ I didn't feel comfortable or confident in the health care system or providers.
- ☐ I had a previous negative experience with health care services.

- ☐ I couldn't find a provider who shared or understood my child's background *(e.g., race, ethnicity, gender) or had training relevant to my child's needs.*
- ☐ Other (please specify) _____

Q26 - Below are some statements about employment and education in your community. Please rate how much you agree or disagree with each statement. Select one option in each row below.

	Strongly Agree	Agree	Feel Neutral	Disagree	Strongly Disagree
There are plenty of jobs available for those who are over 18 years old	☐	☐	☐	☐	☐
There are plenty of jobs available for those who are 14 to 18 years old	☐	☐	☐	☐	☐
There are job trainings or employment resources for those who need them	☐	☐	☐	☐	☐
There are resources for individuals in my community to start a business (financing, training, real estate, etc.)	☐	☐	☐	☐	☐
Childcare (daycare/preschool) resources are affordable and available for those who need them	☐	☐	☐	☐	☐
The K-12 schools in my community are well funded and provide good quality education	☐	☐	☐	☐	☐
Our local University/Community College provides quality education at an affordable cost	☐	☐	☐	☐	☐

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Q27 - Which is your current employment status? Select one.

- ☐ Employed, working full-time – SKIP TO Q29
- ☐ Employed, working part-time – SKIP TO Q29
- ☐ Not working by choice – SKIP TO Q29
- ☐ Out of work, looking for work – PLEASE ANSWER Q28
- ☐ Out of work, but NOT currently looking for work – PLEASE ANSWER Q28
- ☐ Unable to work – PLEASE ANSWER Q28
- ☐ A student – SKIP TO 29
- ☐ Retired – SKIP TO 29

Q28 – Do any of the following reasons make it difficult for you to find or keep a job? Select any that apply.

- ☐ I was attending school
- ☐ The available jobs did not pay a wage that allowed me to care for myself and my family
- ☐ I cannot find childcare
- ☐ The cost of childcare is too high

- ☐ I am a care giver for a family member
- ☐ Full-time work takes too much time from my schedule
- ☐ Part-time work is not enough pay
- ☐ I was furloughed or am temporarily unemployed
- ☐ Shift work does not work with my schedule
- ☐ I do not have transportation to get to work
- ☐ Positive drug test/drug screen
- ☐ Criminal history
- ☐ Under 18 years old
- ☐ Have not received my high school diploma or GED
- ☐ Physically disabled
- ☐ I did not have a fair chance to get a job
- ☐ Other (please specify) _____

Q29 - Below are some statements about housing, transportation, and safety in your community. Please rate how much you agree or disagree with each statement. Select one option in each row below

	Strongly Agree	Agree	Feel Neutral	Disagree	Strongly Disagree
There are affordable places to live in my community	☐	☐	☐	☐	☐
Streets in my community are typically clean, and buildings are well maintained	☐	☐	☐	☐	☐
I feel safe in my own neighborhood	☐	☐	☐	☐	☐
Crime is not a major issue in my neighborhood	☐	☐	☐	☐	☐
There is a feeling of trust in Law Enforcement in my community	☐	☐	☐	☐	☐
Transportation is easy to get to if I need it	☐	☐	☐	☐	☐

Q30 - What transportation do you use most often to go places? Select one.

- ☐ Drive my own car
- ☐ Hitchhike
- ☐ Walk
- ☐ Ride a bicycle
- ☐ Ride a motorcycle or scooter
- ☐ Take a bus
- ☐ Take a taxi or ride share service (Uber/Lyft)
- ☐ Use medical transportation/specialty van transport
- ☐ Use senior transportation
- ☐ Someone drives me
- ☐ Other (please specify) _____

Q31 - Which of the following categories best reflects your current living situation? Select one.

- ☐ Live alone in a home (house, apartment, condo, trailer, etc.)
- ☐ Live in a home with another person such as a partner, sibling(s), or roommate(s)
- ☐ Live in a home that includes a spouse or partner AND a child/children under age 25
- ☐ Live in a multi-generational home (home includes grandparents or adult children age 25+)
- ☐ Live in a home with more than one family (more than one family lives in the home)
- ☐ Live in an assisted living facility or adult foster care
- ☐ Long-term care/nursing home
- ☐ Temporarily staying with a relative or friend
- ☐ Staying in a shelter or are homeless (living on the street)
- ☐ Living in a tent, recreational vehicle (RV), or couch-surfing
- ☐ Hotel/motel (long-term stay)
- ☐ Other (please specify) _____

Q32 - Does your current housing situation meet your needs? Select one.

- ☐ Yes – SKIP TO Q37
- ☐ No – ANSWER Q33

Q33 - What issues do you have with your current housing situation? Select all that apply.

- ☐ Eviction concerns (prior, current, or potential)
- ☐ Current housing is temporary, need permanent housing
- ☐ Mortgage is too expensive
- ☐ Need assisted living or long-term care
- ☐ Rent/facility is too expensive
- ☐ Too far from town/services
- ☐ Too run down or unhealthy environment (ex. mold, lead)
- ☐ Too small /crowded, problems with other people
- ☐ Unsafe, high crime
- ☐ Other (please specify) _____

Q34 - In the past 2 years, was there a time when you (and your family) were living on the street, in a car, or in a temporary shelter? Select one.

- ☐ Yes, 1 or 2 times in the past 2 years
- ☐ Yes, 3 or more times in the past 2 years
- ☐ No

Q35 - In the past 12 months, has the utility company shut off your service for not paying your bills? Select one.

- ☐ Yes
- ☐ No
- ☐ Does not apply - I do not pay utility bills

Q36 - Are you worried or concerned that in the next 2 months you (and your family) may not have stable housing that you own, rent, or stay in as part of a household? Select one.

- ☐ Yes
- ☐ No

Q37 - Below are some statements about access to food and resources in your community. Please rate how much you agree or disagree with each statement. Select one option in each row below.

	Strongly Agree	Agree	Feel Neutral	Disagree	Strongly Disagree
I am able to prepare my own food	☐	☐	☐	☐	☐
I can get to a grocery store when I need food or other household supplies	☐	☐	☐	☐	☐
Affordable healthy food options are easy to purchase at nearby corner stores, grocery stores or farmer's markets	☐	☐	☐	☐	☐
In my neighborhood it is easy to grow/harvest and eat fresh food from a home garden	☐	☐	☐	☐	☐
Local restaurants serve healthy food options	☐	☐	☐	☐	☐
We have good parks and recreational facilities	☐	☐	☐	☐	☐
There are good sidewalks or trails for walking safely	☐	☐	☐	☐	☐
It is easy for people to get around regardless of abilities	☐	☐	☐	☐	☐
Air and water quality are safe in my community	☐	☐	☐	☐	☐

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Q38 - In the past 12 months, did you worry about whether your food would run out before you got money to buy more? Select one.

- ☐ Often
- ☐ Sometimes
- ☐ Never

Q39 - In the past 12 months, was there a time when the food that you bought just did not last, and you did not have money to get more? Select one.

- ☐ Often
- ☐ Sometimes
- ☐ Never

Q40 - In the past 12 months, did you or someone living in your home receive emergency food from a church, a food pantry, or a food bank, or eat in a soup kitchen? Select one.

- ☐ Often
- ☐ Sometimes

- ☐ Never

Q41 – Have any of the following happened to you in the past year while seeking or receiving health care in your community? Select all that apply.

- ☐ You are treated with less courtesy or respect than other people
- ☐ People act as if they think you are not smart
- ☐ People act as if they are afraid of you
- ☐ You are threatened or harassed
- ☐ People criticized your accent or the way you speak
- ☐ No, I have not had any of these experiences

Q42 - What do you think is the main reason(s) for these experiences? Select all that apply.

- ☐ Your ancestry or national origins
- ☐ Your race
- ☐ Your religion
- ☐ Your weight
- ☐ Some other aspect of your physical appearance
- ☐ Your education or income level
- ☐ The language you speak
- ☐ Your gender
- ☐ Your age
- ☐ Your height
- ☐ Your sexual orientation
- ☐ A physical disability
- ☐ I have not had these experiences

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Q43-Have you used any of the following substances? Select all that apply.

- ☐ None
- ☐ Alcohol
- ☐ Marijuana
- ☐ Smoking
- ☐ Edibles
- ☐ Prescription drugs (used in a way not as prescribed by a doctor)
- ☐ Opiates (Oxycodone, Fentanyl, Codeine)
- ☐ Crystal meth (methamphetamine)
- ☐ Tobacco/Nicotine (including e-cigarettes, nicotine pouches, etc.)
- ☐ Heroin
- ☐ Cocaine
- ☐ Crack cocaine
- ☐ Other_____

III. Please answer a few questions about yourself so that we can see how different types of people feel about local health issues.

Q44 – Which of the following best describes you? Select all that apply.

- ☐ American Indian or Alaskan Native
- ☐ Asian or Asian American
- ☐ Black or African American
- ☐ Hispanic/Latino/Latinx
- ☐ Middle Eastern/North African
- ☐ Native Hawaiian or other Pacific Islander
- ☐ White or Caucasian
- ☐ Prefer not to answer
- ☐ Some other race (please specify) _____

Q 45 – What is your gender identity? Select one.

- ☐ Female
- ☐ Male
- ☐ Transgender Female
- ☐ Transgender Male
- ☐ Non-binary
- ☐ Prefer not to answer
- ☐ An identity not listed here (please specify) _____

Q46 – What is your sexual orientation? Select one.

- ☐ Heterosexual or Straight
- ☐ Gay
- ☐ Lesbian
- ☐ Bisexual
- ☐ Pansexual
- ☐ Queer
- ☐ Don't know
- ☐ Prefer not to answer
- ☐ An orientation not listed here (please specify)

_____

Q47 - What is the highest level of education you have completed? Select one.

- ☐ Did not attend school
- ☐ Less than 9th Grade
- ☐ Some High School, No Diploma
- ☐ High School Graduate, Diploma or the equivalent (GED)
- ☐ Associate degree

- ☐ Bachelor's Degree
- ☐ Master's Degree
- ☐ Professional Degree
- ☐ Doctorate Degree

Q48 - How much total combined money did all members of your household earn in the previous year? Select one.

- ☐ Less than $15,000
- ☐ $15,000 to $24,999
- ☐ $25,000 to $34,999
- ☐ $35,000 to $49,999
- ☐ $50,000 to $74,999
- ☐ $75,000 to $99,999
- ☐ $100,000 to $124,999
- ☐ More than $125,000
- ☐ Prefer not to answer

Q49 - What language do you mainly speak at home? Select one.

- ☐ Speak English
- ☐ Speak Spanish
- ☐ Speak Arabic
- ☐ Speak Asian / Pacific Islander Language
- ☐ Speak Indo-European Language
- ☐ Speak other language (please specify) _____

Q50 - Do you identify with any of the following statements? Select all that apply.

- ☐ I have a disability
- ☐ I am active-duty Military
- ☐ I am a Veteran
- ☐ I am a member of the National Guard/Reserve
- ☐ I am an immigrant or refugee
- ☐ Prefer not to answer
- ☐ I do not identify with any of these

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Q51 – Including yourself, how many people currently live in your household?

- ☐ 1 (only me)
- ☐ 2
- ☐ 3
- ☐ 4
- ☐ 5
- ☐ 6 or more (please specify number) _____

ADVERSE CHILDHOOD EXPERIENCES

The final question is about ACEs, adverse childhood experiences, that happened during your childhood. This information will allow us to better understand how problems that may occur early in life can have a health impact later in life. This is a sensitive topic, and some people may feel uncomfortable with these questions. If you prefer not to answer these questions, you may skip them.

For this question, please think back to the time BEFORE you were 18 years of age.

Q52 – From the list of events below, please check the box next to events you experienced BEFORE the age of 18. Choose all that apply.

- ☐ Lived with anyone who was depressed, mentally ill, or suicidal
- ☐ Lived with anyone who was a problem drinker or alcoholic
- ☐ Lived with anyone who used illegal street drugs or who abused prescription medications
- ☐ Lived with anyone who served time or was sentenced to serve time in prison, jail, or other correctional facility
- ☐ Parents were separated or divorced
- ☐ Parents or adults experienced physical harm (slap, hit, kick, etc.)
- ☐ Parent or adult physically harmed you (slap, hit, kick, etc.)
- ☐ Parent or adult verbally harmed you (swear, insult, or put down)
- ☐ Adult or anyone at least 5 years older touched you sexually
- ☐ Adult or anyone at least 5 years older made you touch them sexually
- ☐ Adult or anyone at least 5 years older forced you to have sex
- ☐ I did not experience any of these

Thank you for taking the time to participate in this community survey. Your feedback and insight are vital as we work to improve and address issues impacting our community's health.

END OF SURVEY

Focus Group Findings Summary

County	Top Health Concerns/Issues	Causes	Barriers To Accessing Care	Most Affected Populations	Resources and Strengths
Macomb	Mental health/Anxiety Poor nutrition/Food insecurity Access to health care Chronic diseases Dental care Vision care	COVID-19 Medicaid policy restrictions Poverty Lack of education Lack of transportation Digital divide Misinformation Distrust	Staffing shortages Lack of transportation Lack of inpatient facilities (northern Macomb) Lack of primary care and specialty services High costs	Homeless Single parents Youth Seniors Individuals with disabilities Immigrants LGBTQ+ People of color Low-income individuals and families Northern Macomb residents	Churches/Faith-based organizations Youth Mentorship Community/Open space (basketball courts) PACE (senior services) Workforce training programs Community college
Oakland	Mental health Substance use Food insecurity Lack of access to nutritional food Housing insecurity Health literacy	Stigma Lack of education Lack of early education Generational trauma Distrust	Language Lack of Transportation Lack of support/mental health	Homeless Teen parents Low-income individuals/families	Churches Nonprofits Volunteers CARES program Farmers markets
Wayne	Mental Health Substance Misuse Chronic Diseases (cancer, diabetes, high blood pressure, stroke) Overweight/obesity Housing Insecurity Environment (flooding, mold, power outages, lack of public infrastructure) Food insecurity	Food desert (geographic areas where residents have limited access to affordable healthy foods) Unhealthy options (fast food) Liquor stores Transportation limitations Cost of living/high cost of housing affordability Medicaid challenges/ navigating the system	Shortage of providers Transportation Underinsured Cost of Care	Seniors Children and Youth Low income (working poor) Veterans Single parents LGBTQ+ Non-English speakers Homeless Individuals with disabilities Individuals living in the inner city	Food Pantries Parks and Recreation Programs Sense of belonging Collaboration Redford Interfaith Relief Township Leisure Department Public libraries National Kidney Foundation American Heart Association

		Lack of empathy Social isolation Distrust in the health care system Limited outreach from health care systems			

Recommendations

Macomb County

- Make grants more accessible to smaller nonprofits.
- Allow funding for organizations without full-time employees.
- Provide tiered funding to help organizations grow.
- Increase federal funding for social services.
- Encourage collaboration between nonprofits.
- Educate faith-based organizations on how to access funding through integrated auxiliaries.
- Deploy mobile units
- Build clinics in schools and churches
- Provide early education for young mothers
- Teach children healthy habits at a young age (early childhood education)
- Normalize and destigmatize health issues (mental health, sex education) and conversations
- Establish a collaborative network among community organizations to support health events and share resources.
- Enhance health education efforts to ensure residents are aware of available health resources and how to access them.
- Explore the development of culturally sensitive elder care facilities that provide dignified care for the elderly.
- Organize regular health screening events and ensure that participants without insurance receive follow-up care.

Oakland County

- Churches and nonprofits offer food, events, and support to the community.
- Community members volunteering.
- Funding for continued programs like CARES and farmers markets providing essential services to the community.

Wayne County

- Need for:
    - Free health screenings
    - Cooking and exercise classes
    - Community health workers
    - Case managers and social workers
    - Affordable housing and senior living options
- Identify and propose solutions to improve transportation access for residents, particularly those who miss medical appointments due to a lack of transportation.
- Develop a plan to address the high cost of medical care and improve access to affordable health care services.
- Create initiatives to raise awareness and provide support for mental health and addiction issues within the community.
- Implement programs to reduce cultural and language barriers in accessing health care services.
- Partnerships with universities bring students into the community/work experience.
- Semester-long projects focused on health education and enrollment.
- Monthly workshops led by dietitians or nursing students.
- Outreach and awareness of community programs/resources
- Conduct continuous focus groups to learn about community changes
- Support for insurance enrollment
- Need for nutritional classes/education

Listening Session QUESTIONS
Corewell Health
COMMUNITY HEALTH NEEDS ASSESSMENT
Online session

1. **Please tell us a little about the organization you work for and the geographic location it serves.**

2. **What is your organization's health-related focus?**

3. **In <u>your</u> opinion, what are the top 3 health issues affecting residents in Macomb, Wayne, and Oakland counties?**
4. **What do you think are the leading factors that contribute to these health issues in your community?**

5. **Which groups (or populations) in your community seem to struggle the most with the health issues that you've identified?**
    a. *Are there specific challenges that impact <u>low-income, under-served/uninsured</u>, <u>racial or ethnic groups</u>, <u>age or gender groups</u> in the community?*
    b. *How does it impact their lives?*

6. **What geographic parts or neighborhoods of the county/community have greater health or social need(s)?**

7. **What barriers or challenges might prevent someone in the community from accessing health care or social services?**

8. **Could you tell us about some of the strengths and resources in your community that address these issues, such as groups, partnerships/initiatives, services, or programs?**
    a. *What services or programs could potentially have an impact on the needs that you've identified if they are not yet in place?*

9. **Is there anything additional that should be considered for assessing the needs of the community?**

Opening Script:

Thank you for taking the time to speak with us in support of the Community Health Needs Assessment for Oakland, Wayne, and Macomb counties, conducted by Conduent Healthy Communities Institute (HCI) on behalf of Corewell Health. We anticipate that this discussion will last no more than one hour. You have been invited to take part in this focus group because of your experience living and/or working in Oakland, Wayne or Macomb Counties. The focus of this Community Health Needs Assessment is on how to improve health in the community and understand what challenges residents are facing. We are going to ask a series of questions related to health issues in the community. We hope to get through as many questions as possible and hear each of your perspectives as much as time allows.

For this discussion group, I will invite you to share as much or as little as you feel comfortable sharing with the others in the group. The results of this assessment will be made available to the public. We will be taking notes on your responses, but your names will not be associated with any direct quotes. Your identity will be kept confidential, so please share your honest opinions.

We do have a few ground rules for this discussion that I would like to discuss with you. It is important that everyone has a chance to be heard, so we ask that only one person talk at a time (the most important ground rule for today). We may also call on you to ensure everyone has a chance to speak, but if you have nothing to share, please just say "pass." Finally, please respect the opinions of others, as the point of the discussion is to collect various points of view. And remember, there are no right or wrong answers, so please share them freely and openly. Does anyone have any questions before we get started?

Okay, let's get started by going around and introducing ourselves. Please tell everyone your first name, what community you live in, and if you are interested in sharing, your involvement in the community (could be your job or volunteer work for example).

Thank you for introducing yourselves. Now we will start our discussion.

GENERAL HEALTH QUESTIONS

1. **What is the top health-related problem that residents are facing in your community that you would change or improve?**
   [*Probe 1: Why do you think this is the most important health issue?]*

2. **What do you think is the cause of this problem in your community?**
   [Probe 1: What would you do to address this problem? What is needed to address this problem?]

3. **From the health issues and challenges we've just discussed, which do you think are the hardest to overcome?**
   [Probe: Are some of these issues more urgent or important than others? If so, why?]

4. **Are there groups in your community that are facing particular health issues or challenges? Which groups are these?**

[*Probe: Are these health challenges different if the person is a particular age, or gender, race or ethnicity? Or lives in a certain part of the county for example?]*

5. **What do you think causes residents to be healthy or unhealthy in your community?**
   [*Probe 1: What types of things influence their health, to make it better or worse?]*
   [*Probe 2: What might prevent someone from accessing care for these health challenges? Examples could include lack of transportation, lack of health insurance coverage, doctor's office hours, language or cultural barriers, etc.]*

6. **What are the greatest strengths in your community? What resources are available for residents in your community?**
   [Probe 1: Are there specific community organizations or agencies that you see taking a strong leadership role for improving the health of particular groups in your community?]
   [*Probe 2: Do you see residents taking advantage of them? Why or why not?]*
   [*Probe 3: What additional programs and resources do you think are needed to best meet the needs of residents in XXXX County?]*

CLOSING QUESTION

7. **Can you think of any other ways we could improve the health of residents in the community that we have not already talked about today?**
   [Probe: Is there anything else you would like to add that we haven't discussed?]

CONCLUSION

CLOSURE SCRIPT: Thank you very much for your time and willingness to share your experiences with us today. We will include your comments in our data to describe how health can be improved for residents in your community. Please remember, your name will not be connected to any of the comments you made today. Please let us know if you have any questions or concerns about this.

I also wanted to let you know that we are currently conducting an online Oakland, Wayne, and Macomb County Community Health Survey that is a part of this Community Health Needs Assessment process. If you would be interested in participating in the survey or are willing to help share the link with your organization, community partners, friends, or family who live, work, or play in Oakland, Wayne, or Macomb Counties, it would be greatly appreciated.

Listening Session Findings Summary

County	Top Health Concerns/Issues	Barriers/Challenges	Most Affected Populations	Geographic Areas with most need	Opportunities and Solutions
Macomb	Behavioral and Mental Health Chronic Diseases Housing and food insecurity Transportation Dental and vision care	Lack of transportation Cost of health care Language Lack of education Lack of technology literacy/lack of technology Stigma Discrimination Medicaid confusion (when applying or reapplying) Limited provider networks for Medicaid enrollees	Older Adults/Seniors, LGBTQ+, People with developmentally disabilities, immigrants, underrepresented groups, limited English speakers, People experiencing homelessness	Southern Macomb (Warren, Roseville, Eastpointe, Center Line), Northern Macomb (New Haven), Central Macomb (Mount Clemens, Clinton Township)	Cross-county service access (e.g., across Eight Mile) Community-based wellness programs for older adults Mutual aid networks for food, housing, and transportation Updated, vetted resource directories Invest in AI implementation to reduce staff burden Expanded outreach and education on available services
Oakland	Mental Health Substance Use Housing and food insecurity Lack of affordable childcare	Stigma, anxiety, isolation/disconnected from each other (youth), Lack of funding for services, Lack of transportation, lack of technology literacy/lack of technology, Lack of trust in health systems, high deductible plans, Cultural and language barriers, over reliance on organizational assistance to access services, overwhelming staff, inadequate staff, less staff to meet needs of community	Youth, Young Adults/College students, Older Adults/Seniors, Low-income families, Immigrants, Refugees, People with developmentally disabilities	Rural areas in the northern and western county, Pontiac, Oak Park, Madison Heights, Hazel Park, Royal Oak Township, Wixom, Walled Lake, Micro communities within affluent areas (Rochester)	Centralize navigation and coordination of services by creating a neutral, funded entity Improve real time collaboration to reduce duplication, Leverage existing program, integrate health education with local providers Use schools as hubs for culturally appropriate outreach Shift from short term grants to sustained investments Strengthening grassroots coalitions and referral networks

Wayne	Mental Health Health care affordability Food insecurity Transportation Environmental exposure (lead, carcinogen)	Mistrust in health systems, stigma around mental health, high costs of care, limiting access to health care, lack of in person services, lack of transportation, fear of accessing services due political environment, fear for their safety, termination of federal funding	Older Adults/Seniors, immigrants, low-income families, youth (mental health), working poor (not able to make ends meet), homebound individuals, everyone in the community,	Downriver communities, Tyler, 48180, River Rouge, Garden City, south and east sides of Dearborn, entire county, East Detroit, Redford, 48240, 48239	Develop programs and initiatives by leveraging community strengths (collaboration, resources sharing, diversity, resilience) Expand affordable health care options Reduce mental health stigma Implement tailored outreach programs for populations most affected by health issues Enhance resource awareness and navigation Expand roles of community health workers and navigators to help build trust and improve system navigation Create platforms for organizations to work together, share resources, and address complex community challenges collectively Work alongside public health agencies to address environmental concerns (air and water quality)

Appendix C: Community Resources and Asset Map

Name	Category	Address	Location
Alliance Of Coalitions for Healthy Communities	Behavioral Health (Mental health and Substance Use)	5505 Corporate Dr Suite 301, Troy, MI 48098	Oakland
Campus Community Care Team (C3)	Behavioral Health (Mental health and Substance Use)	44575 Garfield Road, Clinton Township, MI 48038	Macomb
Common Ground	Behavioral Health (Mental health and Substance Use)	1200 North Telegraph Road, Building 32E, Pontiac, MI 48341	Oakland
Growthworks	Behavioral Health (Mental health and Substance Use)	271 South Main Street, Plymouth MI 48170	Wayne
Hegira Health	Behavioral Health (Mental health and Substance Use)	8623 N. Wayne Rd, Suites 104/220/310, Westland, MI 48185	Wayne
Imam Mahdi Association of Marjaeya	Behavioral Health (Mental health and Substance Use)	22000 Garrison St second floor, Dearborn, MI 48124	Macomb/Oakland/Wayne
Live Rite Structured Recovery Corp	Behavioral Health (Mental health and Substance Use)	27700 Gratiot Ave Suite 201, Roseville, MI 48066	Macomb
Macomb Community College-Uwill	Behavioral Health (Mental health and Substance Use)	14500 12 Mile Rd, Warren, MI 48088	Macomb
Macomb County Jail Mental Health Facility (Upcoming)	Behavioral Health (Mental health and Substance Use)		Macomb

Macomb County Mental Health Department	Behavioral Health (Mental health and Substance Use)	19800 Hall Rd. Clinton Township, MI 48038	Macomb
Substance Abuse and Mental Health Services Administration (SAMHSA) Certified Community Behavioral Health Clinics (CCBHC) Demonstration Program	Behavioral Health (Mental health and Substance Use)		Macomb/Oakland/Wayne
The Deen Institute for Wellness	Behavioral Health (Mental health and Substance Use)	Dearborn, MI 48124	Wayne
The Guidance Center	Behavioral Health (Mental health and Substance Use)	13101 Allen Road, Southgate, MI 48195	Wayne
The Judson Center	Behavioral Health (Mental health and Substance Use)	12200 E. 13 Mile Road, Suite 200 Warren, MI 48093	Macomb/Oakland/Wayne
Affirmations LGBTQ+ Community Center	Community Services	290 W Nine Mile Rd, Ferndale, MI 48220	Macomb/Oakland/Wayne
BFDI Training Institute	Community Services	6689 Orchard Lake Road, #264 | West Bloomfield, MI 48322	Oakland
Brilliant Detroit	Community Services	5675 Larkins Street, Detroit, MI 48210	Oakland/Wayne
Brilliant Detroit Brightmoor Hub	Community Services	15509 Heyden Street, Detroit, MI 48223	Oakland/Wayne
Brilliant Detroit Central Hub	Community Services	803 Hazelwood Street, Detroit, MI 48202	Oakland/Wayne
Brilliant Detroit Chandler Park Hub	Community Services	5312 Newport Street, Detroit, MI 48213	Oakland/Wayne
Brilliant Detroit Cody Rouge Hub	Community Services	7425 Fielding Street, Detroit, MI 48228	Oakland/Wayne

Brilliant Detroit Fitzgerald Neighborhood Hub	Community Services	16919 Prairie Street, Detroit, MI 48221	Oakland/Wayne
Centro Multicultural La Familia	Community Services	91 N Saginaw St, Pontiac, MI 48342	Oakland
Chaldean Community Foundation	Community Services	3601 15 Mile Rd, Sterling Heights, MI 48310	Macomb/Oakland/Wayne
Community Housing Network	Community Services	196 North Rose Street, Suite 30, Mount Clemens, MI 48043	Oakland
Easter Seals MORC Clinton Township	Community Services	15600 19 Mile Road, Clinton Township, MI 48038	Macomb
Easter Seals MORC Headquarters	Community Services	2399 E Walton Blvd, Auburn Hills, MI 48326	Macomb/Oakland/Wayne
Easter Seals Pontiac – Centro Latino	Community Services	1685 Baldwin Rd, Suite 100, Pontiac, MI 48340	Oakland
Equality Michigan	Community Services	19641 W 7 Mile Road, Detroit, MI 48219	Macomb/Oakland/Wayne
Farmington Goodfellows	Community Services	31455 W 11 Mile Road, Farmington Hills, MI 48336	Oakland
Farmington- Farmington Hills Neighborhood House	Community Services	29260 Grand River Avenue (Jon Grant Community Center, Fire Station #3), Farmington Hills, MI 48336	Oakland
Gender Identity Network Alliance	Community Services	Warren, Michigan	Macomb
Gianna House	Community Services	21357 Redmond Ave, Eastpointe, MI 48021	Macomb
HOMES Coalition	Community Services	Multi-County Collaborative	Macomb/Oakland/Wayne

Jewish Family Service of Metro Detroit	Community Services	6555 West Maple Road, West Bloomfield, MI 48322	Oakland
LAHC- Leaders Advancing and Helping Communities	Community Services	5275 Kenilworth St, Dearborn, MI 48126	Wayne
LGBT Detroit	Community Services	20025 Greenfield Rd, Detroit, MI 48235	Wayne
Lighthouse	Community Services	46156 Woodward Avenue Pontiac, MI 48342	Oakland
Matrix Human Services	Community Services	1400 Woodbridge Street, Detroit, MI 48207	Wayne
MCC Detroit	Community Services	290 W Nine Mile Rd, Ferndale, MI 48220	Wayne
MiGen- Michigan LGBTQ+ Elders Network	Community Services	290 W. 9 Mile Rd, Ferndale, MI 48220	Macomb/Oakland/Wayne
Neighborhood House	Community Services	1720 S Livernois Rd, Rochester Hills, MI 48307	Oakland
Oakland County Foster Closet	Community Services	24400 Sinacola suite B, Farmington Hills, MI 48335	Oakland
Oakland Family Services (Pontiac)	Community Services	114 Orchard Lake Rd, Pontiac, MI 48341	Macomb/Oakland/Wayne
Oakland Family Services (Royal Oak)	Community Services	26862 Woodward Ave, Suite 103, Royal Oak, MI 48067	Macomb/Oakland/Wayne
Oakland Livingston Human Service Agency (OLHSA)	Community Services	196 Cesar E. Chavez Avenue P.O. Box 430598 Pontiac, MI 48343-0598	Oakland
Pontiac Community Foundation	Community Services	79 Oakland Ave, Pontiac, MI 48342	Oakland

Ruth Ellis Center	Community Services	95 Victor St, Highland Park, MI 48203	Wayne
SEMCOG, the Southeast Michigan Council of Governments	Community Services	1001 Woodward Ave Ste 1400, Detroit, MI 48226	Macomb/Oakland/Wayne
St. Vincent De Paul	Community Services	3000 Gratiot Avenue, Detroit, MI 48207	Wayne
Stand With Trans	Community Services	23332 Farmington Rd #84 Farmington, MI 48336	Macomb/Oakland/Wayne
Sterling Heights African American Coalition	Community Services	40555 Utica Rd., Sterling Heights, MI	Macomb
The Arab Community Center for Economic and Social Services (ACCESS)	Community Services	6451 Schaefer Road, Dearborn, MI 48126	Wayne
The Bettye Harris Foundation	Community Services	18121 E 8 Mile, Eastpointe, MI, United States, Michigan	Macomb/Oakland/Wayne
The Information Center	Community Services	20400 Superior Rd, Taylor, MI 48180	Macomb/Oakland/Wayne
The Southeast Michigan Community Alliance (SEMCA)	Community Services	25363 Eureka Rd, Taylor, MI 48180	Wayne
The W.K. Kellogg Foundation	Community Services	Detroit, MI 48266	Wayne
Transgender Michigan	Community Services	24590 George Ave, Dearborn Heights, MI 48127	Macomb/Oakland/Wayne
United Way of Southeastern Michigan	Community Services	3011 W Grand Blvd #500, Detroit, MI 48202	Macomb/Oakland/Wayne
Wayne Metro Community Action Agency	Community Services	7310 Woodward, Suite 114 Detroit, MI 48202	Wayne
Automation Alley	Economic Development	2675 Bellingham Rd, Troy, MI 48083	Oakland

Detroit Employment Solutions Corporation	Economic Development	115 Erskine Street, 2nd Floor, Detroit, MI 48201	Wayne
Detroit Employment Solutions Corporation MICHIGAN WORKS!	Economic Development	115 Erskine, 2nd Floor Detroit, MI 48201	Wayne
Detroit Regional Partnership	Economic Development	1001 Woodward Ave Suite 800, Detroit, MI 48226	Wayne
Macomb County Planning and Economic Development	Economic Development	1 South Main St. Mount Clemens, MI 48043	Macomb
Macomb-St. Clair MICHIGAN WORKS!	Economic Development	21885 Dunham Rd, Suite 11 Clinton Township, MI 48036	Macomb
Michigan Manufacturing Technology Center	Economic Development	45501 Helm St, Plymouth, MI 48170	Macomb/Oakland/Wayne
Oakland County MICHIGAN WORKS!	Economic Development	2100 Pontiac Lake Road Waterford, MI 48323	Oakland
Velocity	Economic Development	6633 18 Mile Rd, Sterling Heights, MI 48314	Macomb
Camp Scrubs Macomb Community College	Education and Youth Programs	44575 Garfield Road Clinton Township, MI 48038-1139	Macomb
Carehouse of Oakland County	Education and Youth Programs	131 Market Street, Mount Clemens, MI 48043	Oakland
Center for Success- Detroit	Education and Youth Programs	2470 Collingwood St, Suite 102, Detroit, MI 48206	Wayne
Center for Success- Pontiac Branch	Education and Youth Programs	245 E Rundell St, Pontiac, MI 48342	Oakland
Corewell Health Teen Health Center - Taylor	Education and Youth Programs	20352 Eureka Road, Taylor, MI 48180	Wayne
Detroit at Work	Education and Youth Programs	9301 Michigan Avenue, Detroit, MI 48210	Macomb

Detroit Public Schools	Education and Youth Programs	100 Mack Avenue, Detroit, MI 48201	Wayne
Development Centers (First listed affiliate under Detroit At Work)	Education and Youth Programs	17321 Telegraph Rd. Detroit, MI 48219	Wayne
Eastern Michigan University Bright Futures	Education and Youth Programs	203 Boone Hall, Eastern Michigan University, Ypsilanti, MI 48197	Wayne
Greater West Bloomfield Community Coalition	Education and Youth Programs	P.O Box 250072 West Bloomfield, MI 48325-0072	Oakland
Grogan Elementary (Dearborn Heights)	Education and Youth Programs	13300 Burns St, Southgate, MI 48195	Wayne
Let Me See Your Hands	Education and Youth Programs	18121 E Eight Mile Rd Suite 105B, Eastpointe, MI 48021	Macomb/Oakland/Wayne
Macomb Community College	Education and Youth Programs	44575 Garfield Rd, Clinton Township, MI 48038	Macomb/Oakland/Wayne
Macomb Intermediate School District (MISD)	Education and Youth Programs	44001 Garfield Rd #1100, Clinton Township, MI 48038	Macomb
Michigan School Safety Initiative	Education and Youth Programs		Macomb/Oakland/Wayne
Oakland County Intermediate School District (ISD)	Education and Youth Programs	2111 Pontiac Lake Rd, Waterford Township, MI 48328	Oakland
Oakland University	Education and Youth Programs	201 Meadow Brook Rd, Rochester, MI 48309	Oakland
Riverview High School	Education and Youth Programs	12431 Longsdorf St, Riverview, MI 48193	Wayne
South Redford School District	Education and Youth Programs	26141 Schoolcraft, Redford, MI 48239	Wayne

Springboard Collaborative	Education and Youth Programs	5675 Larkins Street, Detroit, MI 48210	Wayne
University of Michigan Dearborn	Education and Youth Programs	4901 Evergreen Rd, Dearborn, MI 48128	Wayne
Wayne County Community College District	Education and Youth Programs	801 W Fort St, Detroit, MI 48226	Wayne
Wayne County Regional Educational Service Agency	Education and Youth Programs	33500 Van Born Road Wayne, MI 48184-2497	Wayne
Wayne State University	Education and Youth Programs	42 W Warren Ave, Detroit, MI 48202	Wayne
Wayne-Westland Community Schools	Education and Youth Programs	36745 Marquette, Westland, Michigan 48185	Wayne
American Cancer Society- local Michigan Chapter apart of North Region	Health care and Public Health	PO Box 10069 Detroit , MI 48210	Macomb/Oakland/Wayne
Ascension Health	Health care and Public Health	17700 23 Mile Rd, Macomb, MI 48044	Macomb
Ascension Macomb-Oakland Hospital	Health care and Public Health	11800 E. 12 Mile Road Warren, MI 48093	Macomb
Baby Resource Network of Macomb County	Health care and Public Health	25401 Harper Ave, St Clair Shores, MI 48081	Macomb
Children's Hospital of Michigan	Health care and Public Health	3901 Beaubien St, Detroit, MI 48201	Wayne
City of Dearborn Department of Public Health	Health care and Public Health	16901 Michigan Ave, Dearborn, MI 48126	Wayne
Corewell Health (Taylor location)	Health care and Public Health	10000 Telegraph Road, Taylor, MI 48180	Wayne
Corewell Health Family Medicine (Taylor clinic)	Health care and Public Health	9340 Telegraph Road, Taylor, MI 48180	Wayne
Corktown Health	Health care and Public Health	1726 Howard Street, Detroit, MI 48216	Wayne

Detroit Health Department	Health care and Public Health	100 Mack Avenue, 3rd Floor, Detroit, MI 48201	Wayne
Detroit Health Department-Vision to Learn Program	Health care and Public Health	100 Mack Ave, Detroit, MI 48201	Wayne
Detroit Wayne Integrated Health Network	Health care and Public Health	707 W. Milwaukee Ave. Detroit, MI 48202	Wayne
Healthy Downriver Coalition	Health care and Public Health	19401 Northline Rd, Bldg 5, Southgate, MI 48195	Wayne
Healthy Macomb Community Health Assessment and Improvement Plan Coalition	Health care and Public Health	1 South Main St. Mount Clemens, MI 48043	Macomb
Henry Ford Health System	Health care and Public Health	2799 W Grand Blvd, Detroit, MI 48202	Macomb, Oakland, Wayne
JARC	Health care and Public Health	6735 Telegraph Rd Suite 100, Bloomfield Hills, MI 48301	Oakland
Karmanos Cancer Institute	Health care and Public Health	4100 John R St, Detroit, MI 48201	Wayne
Macomb County Community Mental Health	Health care and Public Health	43740 Groesbeck, Clinton Township, MI	Macomb
Macomb County Health Department - Central Health Center	Health care and Public Health	43525 Elizabeth Road Mount Clemens, MI 48043	Macomb
Macomb County Health Department - Southeast Family Resource Center	Health care and Public Health	25401 Harper Avenue St. Clair Shores, MI 48081	Macomb
Macomb County Health Department - Southwest Health Service Center	Health care and Public Health	27690 Van Dyke Ave. Warren, MI 48093	Macomb
MALEHA (environmental health)	Health care and Public Health		Macomb/Oakland/Wayne

McLaren Macomb	Health care and Public Health	1000 Harrington St, Mt Clemens, MI 48043	Macomb/Oakland
McLaren Oakland	Health care and Public Health	50 Perry St, Pontiac, MI 48342	Oakland
MedNetOne	Health care and Public Health	4986 Adams Rd # D, Oakland Township, MI 48306	Oakland
National Kidney Foundation of Michigan	Health care and Public Health	1169 Oak Valley Dr, Ann Arbor, MI 48108	Macomb/Oakland/Wayne
Oakland Community Health Network	Health care and Public Health	5505 Corporate Drive Troy, MI 48098	Oakland
Oakland County Health and Human Services	Health care and Public Health	1200 N. Telegraph Road, Pontiac, MI 48341	Oakland
Oakland County Health Department	Health care and Public Health	1200 N Telegraph Bldg. 34 East Pontiac, MI 48341	Oakland
Program of All-Inclusive Care for the Elderly (PACE) Southeast Michigan	Health care and Public Health	21700 Northwestern Highway Suite 900 Southfield, MI 48075	Macomb
Region 2 North Health care Coalition	Health care and Public Health	1000 W University Dr #203, Rochester Hills, MI 48307	Oakland
RxKids	Health care and Public Health	47450 Woodward Avenue, Pontiac, Michigan 48342	Oakland
Southeast Michigan Perinatal Quality Improvement Coalition (SEMPQIC)	Health care and Public Health	Multi-County Collaborative	Macomb/Oakland/Wayne
The Luke Clinic	Health care and Public Health	7354 Whitaker Street Detroit, MI 48209	Wayne
Trinity Health Livonia Hospital	Health care and Public Health	36475 Five Mile Rd, Livonia, MI 48154	Wayne

Trinity Health Oakland Hospital	Health care and Public Health	44405 Woodward Ave, Pontiac, MI 48341	Oakland
Wayne County Department of Health, Human and Veterans Services (HHVS)	Health care and Public Health	500 Griswold St 10th floor, Detroit, MI 48226	Wayne
Wayne Health	Health care and Public Health	400 Mack AveDetroit, MI 48201	Wayne
Xpress Urgent Care	Health care and Public Health	23000 Telegraph Rd, Brownstown Township, MI 48134	Wayne
Cooking Matters / Culinary Programming	Nutrition and Food Access	2131 Beaufait Street, Detroit, MI 48207	Macomb/Oakland/Wayne
Farmington Farmers Market	Nutrition and Food Access	33113 Grand River Avenue, Farmington, MI 48336	Oakland
Fish and Loaves Community Food Pantry (Taylor)	Nutrition and Food Access	15000 W Eight Mile Road, Oak Park, MI 48237	Wayne
Forgotten Harvest	Nutrition and Food Access	15000 W Eight Mile Rd, Oak Park, MI 48237	Oakland
Gleaners Community Food Bank	Nutrition and Food Access	2131 Beaufait St, Detroit, MI 48207	Macomb/Oakland/Wayne
Heartfelt Harvest	Nutrition and Food Access	33317 Orchard St, Farmington, MI 48336	Oakland
Meals on Wheels- Macomb County	Nutrition and Food Access	21885 Dunham Road, Suite 6 Clinton Township, MI 48036	Macomb
Meals on Wheels- Wayne County	Nutrition and Food Access	3600 Commerce Court, Bldg E Wayne, MI	Wayne
Metro Food Rescue	Nutrition and Food Access	6928 East Knollwood Circle West Bloomfield, MI 48322	Oakland

Neighborhood House Food Pantry	Nutrition and Food Access	1315 N Pine St, Rochester, MI 48307	Oakland
Pontiac Meals On Wheels	Nutrition and Food Access	248 South Telegraph Rd. Pontiac, MI 48341	Oakland
Redford Interfaith Relief	Nutrition and Food Access	18499 Beech Daly, Redford Township, MI 48240	Wayne
Western Oakland Meals on Wheels	Nutrition and Food Access	11600 Grand River Ave Brighton, MI 48116	Oakland
Western Wayne Food Policy Council	Nutrition and Food Access	4444 2nd Avenue Detroit, MI 48201	Wayne
Ageways Nonprofit Senior Services	Older Adult Programs	29100 Northwestern Hwy Suite 400, Southfield, MI 48034	Macomb/Oakland
Brownstown Senior/Community Center	Older Adult Programs	21311 Telegraph Road Trenton, MI 48183	Wayne
Detroit Area Agency on Aging (DAAA)	Older Adult Programs	1333 Brewery Park Blvd, Suite 200, Detroit, MI 48207	Wayne
Eton Senior Recreation Center	Older Adult Programs	4900 Pardee Avenue, Dearborn Heights, MI 48125	Wayne
Ford Senior Center	Older Adult Programs	6750 Troy St, Taylor, MI 48180	Wayne
Maplewood Manor Senior Apts.	Older Adult Programs	15270 S Plz Dr, Taylor, MI 48180	Wayne
MORE Program (formerly SOAR)	Older Adult Programs	29995 W. 12 Mile Rd. Farmington Hills, MI 48334	Oakland
The Senior Alliance	Older Adult Programs	3200 Greenfield Rd Suite 100, Dearborn, MI 48120	Wayne

William Ford Senior Activities Center	Older Adult Programs	6750 Troy Street, Taylor, MI 48180	Wayne
City of Riverview Parks and Recreation Departments	Parks and Recreation	14100 Civic Park Drive, Riverview, MI 48193	Wayne
City of Southgate Parks and Recreation Departments	Parks and Recreation	14700 Reaume Parkway, Southgate, MI 48195	Wayne
City of Trenton Parks and Recreation Departments	Parks and Recreation	3101 West Road, Trenton, MI 48183	Wayne
Clinton River Watershed Council	Parks and Recreation	1115 W Avon Road, Rochester Hills, MI 48309	Oakland
Heritage Park (City of Taylor)	Parks and Recreation	12111 Pardee Rd, Taylor, MI 48180	Wayne
Richmond Lenox EMS Shuttle Service	Transportation Services	34505 32 Mile Rd, Richmond, MI 48062	Macomb
SMART Bus Services	Transportation Services	202 Sherman Drive, Royal Oak / Buhl Building, 535 Griswold Street, Lobby, Detroit	Macomb/Oakland/Wayne
The Suburban Mobility Authority for Regional Transportation (SMART)	Transportation Services	535 Griswold Street Suite 600 Detroit, MI 48226	Macomb/Oakland/Wayne

Asset Map

Link-Corewell Health Asset Map - Google My Maps

Prioritization Participants

Name	Role	Organization
Amanda LaVoie, R.D., M.S. FACHE	Senior Director	Hospital Operations, Corewell Health Beaumont Troy Hospital
Brad Lukas	Chief Nursing Officer	Corewell Health Beaumont Troy Hospital
Brenden Bell	Associate Director of Programs and Services	Affirmations
Cathy De Leo	Client Support Specialist	Farmington-Farmington Hills Neighborhood House
Chika Obianwu, MPH, MSW	Director	Healthier Communities, Corewell Health Southeast
Chineva Early, PhD	Founder/Executive Director	Bettye Harris Foundation
David Kurili	Manager	CHNA and Community Benefit, HEAATT Corewell Health
Debra A. Guido-Allen	President	Corewell Dearborn Hospital
Derk F. Pronger, FACHE	President	Corewell Health Beaumont Grosse Pointe Hospital and Farmington Hills Hospital
Dr. Daniel Carey, MD, MHCM	President	Corewell Health William Beaumont University Hospital
Erin B., Macleod-Smith, LMSW	Manager	Mental Health Care, Corewell School-Based Health Clinics
Hatahit Wael	Deputy Director for Public Health, Community Health and Research Center	ACCESS (Arab Community Center for Economic and Social Services)

Jamie Anderson	Community Engagement Manager	Honor Community Health
Jerry Price	Advisor	Corewell Health Belonging
Jihad H. Taleb, MPA	Executive Manager	Imam Mahdi Association of Marajeya
Joel B. Flugstad	Director	Market Development, Corewell Health
Kari L., Woloszyk, MPH	Manager	CHNA and Community Benefits, Corewell Health
Kelsey Merz	Public Health Educator	Oakland County Health Department
Kimberly Wisdom, PhD	Senior Vice President of Community Health and Equity and Chief Wellness and Diversity Officer	Henry Ford Health
Kristine M. Donahue, RN, BSN, MSA	President	Corewell Health, Taylor, Trenton, and Wayne Hospitals
LaQuitia Jackson	Health Equity Coordinator	Wayne County Health Department
Lauren Burgett, M.MSN, RN, NEA-BC	Chief Nursing Officer	Corewell Health Farmington Hills Hospital
Leslie D. Meyer, MA, CPXP	Senior Director	Healthier Communities, Corewell Health Southeast
Linda Bazzi	Healthy Living Program Coordinator	Leaders Advancing and Helping Communities
Lora J. Coats	Project Specialist	Healthier Communities, Corewell Health Southeast
Maria Swiatkowski	Division Director, Community Health Planning and Promotion	Macomb County Health Department

Miguel Barajas, MPH, CHES, PMP	Health Planning and Promotion Manager	Wayne County Health, Human, and Veterans Services Department
Nancy A. Susick, MSN, RN, NE-BC, FACHE	President/Interim President	Corewell Health Beaumont Troy and Corewell Health Beaumont Grosse Pointe hospitals
Rachel Gilchrist	Manager	Strategy and Operations, Corewell Health
Rebecca H. Moore, MPH, CHES, CPST	Community Health Program Manager	Healthier Communities, Corewell Health Southeast
Rita R. Little, MS, CHES, CLC, CPST, CHW	Program Manager	Healthier Communities, Corewell Health Southeast
Roel Hinojosa	Manager	Hospitality, Corewell Health
Sam Shopinski	Senior Program Manager	National Kidney Foundation of Michigan
Sayyid Sameer Ali, MA, BCC	Director	Islamic Pastoral Care, (RISE) Resilience, Identity, Support, and Empowerment at I.M.A.M.
Shalita N. Moore, MHA, BS, CLSSBB, CT, RT®	Senior Hospital Operations	Corewell Health Dearborn Hospital
Sheri L. Testani, DNPc, BAA, BHK, RN, CHPO, NE-BC	Chief Nursing Officer	Corewell Health Beaumont Grosse Pointe Hospital
Steven J., Witkowski, RN, BSN, MSA, CNOR	Senor Director Operations	Corewell Health Dearborn Hospital
Suzanne M. Berschback	Program Manager	Healthier Communities, Corewell Health Southeast
Terri Czerwinski, MSN, RN	Director	Safe and Healthy Schools Wayne RESA

Theresa D. Donoghue	Director	Corewell School-Based Health Clinics
Tori L., Smith, M.Ed.	Program Manager	Healthier Communities, Corewell Health Southeast
Vanessa B. Briggs	Vice President	Healthier Communities, Corewell Health
Yoland Hill-Ashford, MSW	Director	Public Health Programs, Detroit Health Department

Appendix D: Potential Community Partners

Ascension Health
Detroit at Work
Farmington Farmers Market
Fish and Loaves Community Food Pantry (Taylor)
Henry Ford Health System
Macomb Community College
Macomb County Health Department
Macomb County Mental Health Department
Macomb Intermediate School District (MISD)
McLaren Health Care
Meals on Wheels
MORE Program
Neighborhood House
Neighborhood House Food Pantry
PACE Senior Services
Richmond Lenox EMS Shuttle Service
SMART Bus Services
Taylor Teen Center

Appendix E: Previous Implementation Strategy Impact Reports

Each hospital outlined specific actions to address the significant health needs identified in the 2023–2025 Corewell Health East Implementation Strategy plan. A summary of these actions is provided below for each hospital.

Corewell Health Dearborn Hospital

Health Education

Chronic Disease Prevention Interventions

Impact of Strategy

Aligning with our regional strategy to provide programs in Chronic Disease Management and Prevention, we have successfully implemented several evidence-based programs, including the Diabetes Prevention Program and the Hypertension Control Program in partnership with multiple community-based organizations in Oakland, Macomb and Wayne counties.

Since 2017, we have grown our Diabetes Prevention Program (DPP) across the service region to offer classes in-person and virtual with community partners. We have also launched multiple accessible classes offered in Spanish and for those experiencing vision impairments. As part of the National DPP partnership, the program supported participants at risk for Type 2 Diabetes by providing education and resources to improve eating habits, food choices and overall lifestyle changes.

Another prevalent chronic condition across the region is high blood pressure. We continued offering the evidence-based Hypertension Control Program, focused on managing high blood pressure for those with diagnosed conditions or with multiple risk factors for developing hypertension. Classes were offered both in-person and virtually with community partners.

Managing chronic health conditions at home has been a priority for the system to reduce both outpatient visits and hospitalizations. We have successfully continued to offer the Personal Action Toward Health (PATH) classes, which have included both diabetes and chronic pain classes. These classes have been shown to enhance participants' confidence in the ability to manage their disease and to work more effectively with their health care provider to improve value-based care.

Action

By Dec. 31, 2025, a community health worker model will be implemented to support health education and chronic disease interventions.

Measurable Impact

A Community Health Worker model was established with staff hired to implement chronic disease interventions within the community.

Action

By Dec. 31, 2025, enrollment in chronic disease prevention and management programs will increase by 15%.

Measurable Impact

The number of participants in chronic disease prevention and management programs increased by 15%.

Action

By Dec. 31, 2025, offer chronic disease management programs in at least one accessible format.

Measurable Impact

The Diabetes Prevention Program was offered in Spanish and for those blind/visually impaired.

Car Seat Safety

Impact of Strategy

Car Seat Safety enhances child passenger safety by deploying trained technicians across communities to conduct car seat checks and provide education. The initiative aims to reduce injury risks for children during transportation by ensuring proper car seat installation and usage. Standing car seat safety checks were provided each month for free on-site with community partners. Free car seats were also provided to families in need.

Action

By June. 30, 2024, establish a car seat safety technician training model.

Measurable Impact

Five courses were conducted, resulting in 81 participants successfully completing the training and qualifying as technicians.

Action

By Dec. 31, 2025, provide monthly car seat safety checks with at least two community partners.

Measurable Impact

Provided monthly car seat safety checks with two community partners.

Cultural Competency

Impact of Strategy

The concepts of cultural competence and patient-centered care intersect in meaningful ways. Providing care to patients with diverse values, beliefs and behaviors, including the tailoring of health care delivery to meet patients' social, cultural and linguistic needs, reduces racial and ethnic disparities in health care. By acknowledging the importance of culture, we have successfully incorporated strategies and trainings that build cross-cultural relations, expand cultural knowledge, and adapt services to meet culturally unique needs.

Action

By December 31, 2023, assess and review existing cultural competency resources.

Measurable Impact

Conducted a cultural competency assessment.

Action

By December 31, 2025, develop and offer cultural competency courses.

Measurable Impact

Developed and offered cultural competency courses for staff.

Community Engagement

Impact of Strategy

Everyone who works in a health system, not just clinical staff, can play a role in shifting culture from one that can feel transactional, to one that feels centered around caring and connection. By listening and connecting to patients, and most importantly building and maintaining relationships, we are building a more equitable, compassionate, and healing health care system. We have successfully collaborated across health and social service providers to develop strong community-clinical linkages that address the behavioral and social drivers of health.

Action

By December 31, 2025, establish an Internal Community Health Committee to build relationships with the community.

Measurable Impact

Launched a Dearborn Hospital Internal Community Health Committee to support building connections with the community.

Access to Care

School-Based Food Pantries and Hygiene Closets

Impact of Strategy

The School-Based Food Pantry and Hygiene Closet initiative has successfully advanced efforts to improve health equity through improved access to basic needs. School food pantries and hygiene closets were created across Wayne County schools that were open and available to all students during school hours. Wrap-around services and referral pathways were created for students and families with limited resources, including connecting them with our Teen Health Centers for additional care. School staff were also trained to connect families with broader support services through the Beaumont Community Resource Network, addressing needs like housing, employment, and transportation.

Action

By Dec. 31, 2025, the number of schools participating in Wayne County will increase from 11 to 45 schools.

Measurable Impact

The number of schools participating in the food pantry and hygiene closet program increased to 46.

Action

By Dec. 31, 2025, all nine Corewell Teen Health Centers will have a hygiene closet.

Measurable Impact

All nine Teen Health Centers implemented hygiene closets on-site that were open to all students.

Beaumont Community Resource Network

Impact of Strategy

Powered by Findhelp, the Beaumont Community Resource Network (BCRN) offered a free social service platform to reduce barriers for free and/or reduced-cost programs in the community. From social workers, nurses, and case managers, BCRN helped community members access essential services and basic needs through a confidential and secure platform. BCRN has grown from a small pilot project to a system-wide initiative, aligning with the Social Determinants of Health (SDoH) and health equity priorities of the Corewell system, integrating community-clinical linkages for improved health outcomes.

Action

By Dec. 31, 2025, the Beaumont Community Resource Network will increase its reach by 25%.

Measurable Impact

The Beaumont Community Resource Network increased reach by 47%.

Action

By Dec. 31, 2025, the Beaumont Community Resource Network will increase community-based organization claim rate by 50%.

Measurable Impact

Community-based organizations increased claim rate by 75%.

Patient Experience

Impact of Strategy

Measuring quality and satisfaction of care is an indispensable element for adequate resource management and promotes patient-centered care that is tailored to a patient's needs and expectations. We are continually improving our patient-centered experience by assessing outputs and evaluating the satisfaction of each patient. Assessing patient satisfaction has provided valuable and unique insights into daily hospital care and quality.

Action

By December 31, 2025, increase patient satisfaction scores.

Measurable Impact

Efforts are underway to increase patient satisfaction scores through the development of a regional plan.

Behavioral Health

Mental Health First Aid

Impact of Strategy

Adult and Youth Mental Health First Aid programs train adults to recognize and respond to signs of mental health and substance use challenges in adults and youth respectively, using the ALGEE action plan which includes assessing risk, listening nonjudgmentally, providing reassurance, and encouraging professional help and self-support strategies. The youth program includes an additional focus on trauma, substance use, self-care, social media, and bullying impacts for ages 12-18.

Action

By Dec. 31, 2025, provide training to 50 community members to be certified in adult Mental Health First Aid.

Measurable Impact

Provided training to 71 community members on adult Mental Health First Aid.

Action

By Dec. 31, 2025, provide training to 25 community members to be certified in youth Mental Health First Aid.

Measurable Impact

Provided training to 38 community members on youth Mental Health First Aid.

Teen Center Mental/Behavioral Health Programs

Impact of Strategy

The Child and Adolescent Health Centers/Teen Health Centers promote the health of children, adolescents, and their families by providing 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. Services provided are designed specifically for children and adolescents aged 5 through 21 and are aimed at achieving the best possible physical, intellectual, and emotional health status. With 18 points of service across Wayne County, we have successfully established community and youth

advisory councils that support program development for improved health outcomes that are aligned with student needs.

Action

By Dec. 31, 2025, Teen Health Center/SWP/E3 LMSW's/LPC will provide mental health counseling services to a minimum of 20 unduplicated students and 60 visits per year.

Measurable Impact

Mental Health Counseling services were provided to more than 20 unduplicated students and exceeded 60 visits per year.

Action

By Dec. 31, 2023, two new Expanding, Enhancing, Emotional Health school-based sites will be opened.

Measurable Impact

Opened three new Expanding, Enhancing and Emotional school-based sites.

Action

By Dec. 31, 2025, open one full clinic in partnership with a school district in Wayne County.

Measurable Impact

Opened the Harper Woods School Health Clinic.

Action

By Dec. 31, 2025, provide mental health therapy and resources to four new schools and one new school district that reaches elementary, middle, and high school population.

Measurable Impact

Provided mental health therapy and resources to four new schools, including one new district, for elementary, middle and high school students.

Medication Take Back

Impact of Strategy

In partnership with the Drug Enforcement Agency (DEA), Take Back Day is a coordinated day across the United States where communities partner with law enforcement to collect unneeded and unused medications for safe destruction. This effort helps to prevent accidental health risks by eliminating the opportunity for someone other than the person prescribed to take them. Participation in drug take back programs has helped prevent drug abuse and accidental poisoning while also preserving our water resources.

Action

By Dec. 31, 2025, participate in annual medication take back days.

Measurable Impact

Participated in annual medication take back days.

Action

By Dec. 31, 2025, partner with community-based organizations to increase the number medication take backs days offered in a calendar year.

Measurable Impact

Developed new partnerships to offer additional medication take back days in the community.

Behavioral Health Resources

Impact of Strategy

Multiple behavioral health initiatives have been launched to develop strategies that align resources, education, and outreach within the community. These efforts have successfully developed support groups, educational sessions, and distribution programs in partnership with community partners.

Action

By Dec. 31, 2025, develop support groups based on need available to the community.

Measurable Impact

Facilitated 34 support groups for the community to attend.

Action

By Dec. 31, 2025, create education sessions on behavioral health strategies for the community.

Measurable Impact

Education sessions were created for behavioral health.

Action

By Dec. 31, 2025, establish a Naloxone distribution program within the emergency department.

Measurable Impact

Naloxone was distributed within the emergency department.

Smoking Cessation Program

Impact of Strategy

The Tobacco and Nicotine Treatment Program offers a series of virtual tobacco and nicotine treatment services made available at no cost to patients and the community. The three courses serve as progression from stage 1 to 3, ultimately gaining the skills and knowledge to quit tobacco. Classes include “Let’s Talk Tobacco”, “Let’s Quit Tobacco” and “Let’s Stay Quit”. These programs were offered virtually through referrals and community networks.

Action

By Dec. 31, 2025, offer virtual smoking cessation programs to the community.

Measurable Impact

Virtual smoking cessation classes were offered in the community.

Corewell Health Farmington Hills Hospital

Health Education

Chronic Disease Prevention Interventions

Impact of Strategy

Aligning with our regional strategy to provide programs in Chronic Disease Management and Prevention, we have successfully implemented several evidence-based programs, including the Diabetes Prevention Program and the Hypertension Control Program in partnership with multiple community-based organizations in Oakland, Macomb and Wayne counties.

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Action

By Dec. 31, 2025, a community health worker model will be implemented to support health education and chronic disease interventions.

Measurable Impact

A Community Health Worker model was established with staff hired to implement chronic disease interventions within the community.

Action

By Dec. 31, 2025, enrollment in chronic disease prevention and management programs will increase by 15%.

Measurable Impact

The number of participants in chronic disease prevention and management programs increased by 15%.

Action

By Dec. 31, 2025, offer chronic disease management programs in at least one accessible format.

Measurable Impact

The Diabetes Prevention Program was offered in Spanish and for those blind/visually impaired.

Car Seat Safety

Impact of Strategy

Car Seat Safety enhances child passenger safety by deploying trained technicians across communities to conduct car seat checks and provide education. The initiative aims to reduce injury risks for children during transportation by ensuring proper car seat installation and usage. Standing car seat safety checks were provided each month for free on-site with community partners. Free car seats were also provided to families in need.

Action

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Measurable Impact

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Action

By Dec. 31, 2025, provide monthly car seat safety checks with at least two community partners.

Measurable Impact

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Cultural Competency

Impact of Strategy

The concepts of cultural competence and patient-centered care intersect in meaningful ways. Providing care to patients with diverse values, beliefs and behaviors, including the tailoring of health care delivery to meet patients' social, cultural and linguistic needs, reduces racial and ethnic disparities in health care. By acknowledging the importance of culture, we have successfully incorporated strategies and training that build cross-cultural relations, expand cultural knowledge, and adapt services to meet culturally unique needs.

Action

By December 31, 2023, assess and review existing cultural competency resources.

Measurable Impact

Conducted a cultural competency assessment.

Action

By December 31, 2025, develop and offer cultural competency courses.

Measurable Impact

Developed and offered cultural competency courses for staff.

Community Engagement

Impact of Strategy

Everyone who works in a health system, not just clinical staff, can play a role in shifting culture from one that can feel transactional, to one that feels centered around caring and connection. By listening and connecting to patients, and most importantly building and maintaining relationships, we are building a more equitable, compassionate, and healing health care system. We have successfully collaborated across health and social service providers to develop strong community-clinical linkages that address the behavioral and social drivers of health.

Action

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Measurable Impact

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Access to Care

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Impact of Strategy

The school-Based Food Pantry and Hygiene Closet initiative has successfully advanced efforts to improve health equity through improved access to basic needs. School food pantries and hygiene closets were created across Wayne County schools that were open and available to all students during school hours. Wrap-around services and referral pathways were created for students and families with limited resources, including connecting them with our Teen Health Centers for additional care. School staff were also trained to connect families with broader support services through the Beaumont Community Resource Network, addressing needs like housing, employment, and transportation.

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All nine Teen Health Centers implemented hygiene closets on-site that were open to all students.

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Action

By Dec. 31, 2025, the Beaumont Community Resource Network will increase reach by 25%.

Measurable Impact

The Beaumont Community Resource Network increased reach by 47%.

Action

By Dec. 31, 2025, the Beaumont Community Resource Network will increase community-based organization claim rate by 50%.

Measurable Impact

Community-based organizations increased claim rate by 75%.

Action

By Dec. 31, 2025, provide outreach and education to community organizations.

Measurable Impact

Provided outreach and education to improve community health impact.

Cultural Competency

Impact of Strategy

The concepts of cultural competence and patient-centered care intersect in meaningful ways. Providing care to patients with diverse values, beliefs and behaviors, including the tailoring of health care delivery to meet patients' social, cultural and linguistic needs, reduces racial and ethnic disparities in health care. By acknowledging the importance of culture, we have successfully incorporated strategies and training that build cross-cultural relations, expand cultural knowledge, and adapt services to meet culturally unique needs.

Action

By December 31, 2023, assess and review existing cultural competency resources.

Measurable Impact

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By December 31, 2025, develop and offer cultural competency courses.

Measurable Impact

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Behavioral Health

Mental Health First Aid

Impact of Strategy

Adult and Youth Mental Health First Aid programs train adults to recognize and respond to signs of mental health and substance use challenges in adults and youth respectively, using the ALGEE action plan which includes assessing risk, listening nonjudgmentally, providing reassurance, and encouraging professional help and self-support strategies. The youth program includes an additional focus on trauma, substance use, self-care, social media, and bullying impacts for ages 12-18.

Action

By Dec. 31, 2025, provide training to 50 community members to be certified in adult Mental Health First Aid.

Measurable Impact

Provided training to 71 community members on adult Mental Health First Aid.

Action

By Dec. 31, 2025, provide training to 25 community members to be certified in youth Mental Health First Aid.

Measurable Impact

Provided training to 38 community members on youth Mental Health First Aid.

Teen Center Mental/Behavioral Health Programs

Impact of Strategy

The Child and Adolescent Health Centers/Teen Health Centers promote the health of children, adolescents, and their families by providing 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. Services provided are designed specifically for children and adolescents aged 5 through 21 and are aimed at achieving the best possible physical, intellectual, and emotional health status. With 18 points of service across Wayne County, we have successfully established community and youth

advisory councils that support program development for improved health outcomes that are aligned with student needs.

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Measurable Impact

Mental Health Counseling services were provided to more than 20 unduplicated students and exceeded 60 visits per year.

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Action

By Dec. 31, 2025, open one full clinic in partnership with a school district in Wayne County.

Measurable Impact

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By Dec. 31, 2025, provide mental health therapy and resources to four new schools and one new school district that reaches elementary, middle, and high school population.

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Medication Take Back

Impact of Strategy

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effort helps to prevent accidental health risks by eliminating the opportunity for someone other than the person prescribed to take them. Participation in drug take back programs has helped prevent drug abuse and accidental poisoning while also preserving our water resources.

Action

By Dec. 31, 2025, participate in annual medication take back days.

Measurable Impact

Participated in an annual medication take back day.

Action

By Dec. 31, 2025, partner with community-based organizations to increase the number medication take backs days offered in a calendar year.

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Developed new partnerships to offer additional medication take back days in the community.

Behavioral Health Resources

Impact of Strategy

Multiple behavioral health initiatives have been launched to develop strategies that align resources, education, and outreach within the community. These efforts have successfully developed support groups, educational sessions, and distribution programs in partnership with community partners.

Action

By Dec. 31, 2025, develop support groups based on need available to the community.

Measurable Impact

Facilitated 4 support groups for the community to attend.

Action

By Dec. 31, 2025, create education sessions on behavioral health strategies for the community.

Measurable Impact

Education sessions were created for behavioral health.

Action

By Dec. 31, 2025, establish a Naloxone distribution program within the emergency department.

Measurable Impact

Naloxone was distributed within the emergency department.

Smoking Cessation Program

Impact of Strategy

The Tobacco and Nicotine Treatment Program offers a series of virtual tobacco and nicotine treatment services made available at no cost to patients and the community. The three courses serve as a progression from stage 1 to 3, ultimately gaining the skills and knowledge to quit tobacco. Classes include “Let’s Talk Tobacco”, “Let’s Quit Tobacco” and “Let’s Stay Quit”. These programs were offered virtually through referrals and community networks.

Action

By Dec. 31, 2025, offer virtual smoking cessation programs to the community.

Measurable Impact

Virtual smoking cessation classes were offered in the community.

Corewell Health Beaumont Grosse Pointe Hospital

Health Education

Chronic Disease Prevention Interventions

Impact of Strategy

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Measurable Impact

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Action

By Dec. 31, 2025, offer chronic disease management programs in at least one accessible format.

Measurable Impact

The Diabetes Prevention Program was offered in Spanish and for those blind/visually impaired.

Car Seat Safety

Impact of Strategy

Car Seat Safety enhances child passenger safety by deploying trained technicians across communities to conduct car seat checks and provide education. The initiative aims to reduce injury risks for children during transportation by ensuring proper car seat installation and usage. Standing car seat safety checks were provided each month for free on-site with community partners. Free car seats were also provided to families in need.

Action

By June. 30, 2024, establish a car seat safety technician training model.

Measurable Impact

Five courses were conducted, resulting in 81 participants successfully completing the training and qualifying as technicians.

Action

By Dec. 31, 2025, provide monthly car seat safety checks with at least two community partners.

Measurable Impact

Provided monthly car seat safety checks with two community partners.

Community Engagement

Impact of Strategy

Everyone who works in a health system, not just clinical staff, can play a role in shifting culture from one that can feel transactional, to one that feels centered around caring and connection. By listening and connecting to patients, and most importantly building and maintaining relationships, we are building a more equitable, compassionate, and healing health care system. We have successfully collaborated across health and social service providers to develop strong community-clinical linkages that address the behavioral and social drivers of health.

Action

By December 31, 2025, establish an Internal Community Health Committee to build relationships with the community.

Measurable Impact

Launched a Grosse Pointe Hospital Internal Community Health Committee to support building connections with the community.

Raising Resilient Children

Impact of Strategy

Raising Resilient Children utilizes the Triple P, or Positive Parenting Program, one of the most effective evidence-based parenting programs. By providing parents and caregivers with children who are birth to 16 years old simple and practical strategies to help build strong, healthy relationships, they can confidently manage children's behavior and prevent problems developing. Launched in 2024, the program has been offered both in-person and virtually across Wayne, Oakland and Macomb counties.

Action

By Dec. 31, 2025, the Raising Resilient Children program will be launched in Oakland, Macomb and Wayne County.

Measurable Impact

Raising Resilient Children program successfully launched in the tri-county region.

Action

By Dec. 31, 2025, enroll at least 100 families in the Raising Resilient Program.

Measurable Impact

Enrolled 186 families in the Raising Resilient Program.

Action

By Dec. 31, 2025, implement SAMHSA's 8 Dimensions of Wellness Model with community partners.

Measurable Impact

Implemented SAMHSA's 8 Dimensions of Wellness Model with community partners.

Access to Care

School-Based Food Pantries and Hygiene Closets

Impact of Strategy

The School-Based Food Pantry and Hygiene Closet initiative has successfully advanced efforts to improve health equity through improved access to basic needs. School food pantries and hygiene closets were created across Wayne County schools that were open and available to all students during school hours. Wrap-around services and referral pathways were created for students and families with limited resources, including connecting them with our Teen Health Centers for additional care. School staff were also trained to connect families with broader support services through the Beaumont Community Resource Network, addressing needs like housing, employment, and transportation.

Action

By Dec. 31, 2025, the number of schools participating in Wayne County will increase from 11 to 45 schools.

Measurable Impact

The number of schools participating in the food pantry and hygiene closet program increased to 46.

Action

By Dec. 31, 2025, all nine Corewell Teen Health Centers will have a hygiene closet.

Measurable Impact

All nine Teen Health Centers implemented hygiene closets on-site that were open to all students.

Beaumont Community Resource Network

Impact of Strategy

Powered by Findhelp, the Beaumont Community Resource Network (BCRN) offered a free social service platform to reduce barriers for free and/or reduced-cost programs in the community. From social workers, nurses, and case managers, BCRN helped community members access essential services and basic needs through a confidential and secure platform. BCRN has grown from a small pilot project to a system-wide initiative, aligning with the Social Determinants of Health (SDoH) and health equity priorities of the Corewell system, integrating community-clinical linkages for improved health outcomes.

Action

By Dec. 31, 2025, the Beaumont Community Resource Network will increase reach by 25%.

Measurable Impact

The Beaumont Community Resource Network increased reach by 47%.

Action

By Dec. 31, 2025, the Beaumont Community Resource Network will increase community-based organization claim rate by 50%.

Measurable Impact

Community-based organizations increased claim rate by 75%.

Cultural Competency

Impact of Strategy

The concepts of cultural competence and patient-centered care intersect in meaningful ways. Providing care to patients with diverse values, beliefs and behaviors, including the tailoring of health care delivery to meet patients' social, cultural and linguistic needs, reduces racial and ethnic disparities in health care. By acknowledging the importance of culture, we have successfully incorporated strategies and trainings that build cross-cultural relations, expand cultural knowledge, and adapt services to meet culturally unique needs.

Action

By December 31, 2023, assess and review existing cultural competency resources.

Measurable Impact

Conducted a cultural competency assessment.

Action

By December 31, 2025, develop and offer cultural competency courses.

Measurable Impact

Developed and offered cultural competency courses for staff.

Patient Experience

Impact of Strategy

Measuring quality and satisfaction of care is an indispensable element for adequate resource management and promotes patient-centered care that is tailored to a patient's needs and expectations. We are continually improving our patient-centered experience by assessing outputs and evaluating the satisfaction of each patient. Assessing patient satisfaction has provided valuable and unique insights into daily hospital care and quality.

Action

By December 31, 2025, increase patient satisfaction scores.

Measurable Impact

Efforts are underway to increase patient satisfaction scores through the development of a regional plan.

Community Health Workers

Impact of Strategy

Community health workers (CHWs) help patients — particularly those with multiple chronic diseases, including mental health and substance use disorders — to address barriers to their health including housing, safety, and understanding their medications. By creating trusting relationships, CHWs have helped patients navigate appointments, provided home visits, and closely communicated needs with their providers. We have successfully engaged patients in setting their own goals and building their efficacy to take care of their health.

Action

By Dec. 31, 2025, a community health worker model will be implemented to support health education and chronic disease interventions.

Measurable Impact

A Community Health Worker model was established with staff hired to implement chronic disease interventions within the community.

Behavioral Health

Mental Health First Aid

Impact of Strategy

Adult and Youth Mental Health First Aid programs train adults to recognize and respond to signs of mental health and substance use challenges in adults and youth respectively, using the ALGEE action plan which includes assessing risk, listening nonjudgmentally, providing reassurance, and encouraging professional help and self-support strategies. The youth program includes an additional focus on trauma, substance use, self-care, social media, and bullying impacts for ages 12-18.

Action

By Dec. 31, 2025, provide training to 50 community members to be certified in adult Mental Health First Aid.

Measurable Impact

Provided training to 71 community members on adult Mental Health First Aid.

Action

By Dec. 31, 2025, provide training to 25 community members to be certified in youth Mental Health First Aid.

Measurable Impact

Provided training to 38 community members on youth Mental Health First Aid.

Teen Center Mental/Behavioral Health Programs

Impact of Strategy

The Child and Adolescent Health Centers/Teen Health Centers promote the health of children, adolescents, and their families by providing 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. Services provided are designed specifically for children and adolescents aged 5 through 21 and are aimed at achieving the best possible physical, intellectual, and emotional health status. With 18 points of service across Wayne County, we have successfully established community and youth

advisory councils that support program development for improved health outcomes that are aligned with student needs.

Action

By Dec. 31, 2025, Teen Health Center/SWP/E3 LMSW's/LPC will provide mental health counseling services to a minimum of 20 unduplicated students and 60 visits per year.

Measurable Impact

Mental Health Counseling services were provided to more than 20 unduplicated students and exceeded 60 visits per year.

Action

By Dec. 31, 2023, two new Expanding, Enhancing, Emotional Health school-based sites will be opened.

Measurable Impact

Opened three new Expanding, Enhancing and Emotional school-based sites.

Action

By Dec. 31, 2025, open one full clinic in partnership with a school district in Wayne County.

Measurable Impact

Opened the Harper Woods School Health Clinic.

Action

By Dec. 31, 2025, provide mental health therapy and resources to four new schools and one new school district that reaches elementary, middle, and high school population.

Measurable Impact

Provided mental health therapy and resources to four new schools, including one new district, for elementary, middle and high school students.

Medication Take Back

Impact of Strategy

In partnership with the Drug Enforcement Agency (DEA), Take Back Day is a coordinated day across the United States where communities partner with law enforcement to collect unneeded and unused medications for safe destruction. This

effort helps to prevent accidental health risks by eliminating the opportunity for someone other than the person prescribed to take them. Participation in drug take back programs has helped prevent drug abuse and accidental poisoning while also preserving our water resources.

Action

By Dec. 31, 2025, participate in annual medication take back days.

Measurable Impact

Participated in annual medication take back days.

Action

By Dec. 31, 2025, partner with community-based organizations to increase the number medication take backs days offered in a calendar year.

Measurable Impact

Developed new partnerships to offer additional medication take back days in the community.

Behavioral Health Resources

Impact of Strategy

Multiple behavioral health initiatives have been launched to develop strategies that align resources, education, and outreach within the community. These efforts have successfully developed support groups, educational sessions, and distribution programs in partnership with community partners.

Action

By Dec. 31, 2025, remove barriers to connecting to mental health care and substance misuse treatment.

Measurable Impact

Trained staff on the Beaumont Community Resource and referring patients to mental health care and substance misuse treatment resources.

Action

By Dec. 31, 2025, create education sessions on behavioral health strategies for the community.

Measurable Impact

Education sessions were created for behavioral health to reduce mental health stigma.

Action

By Dec. 31, 2025, create behavioral health screening questionnaire.

Measurable Impact

Created behavioral health screening questionnaire.

Smoking Cessation Program

Impact of Strategy

The Tobacco and Nicotine Treatment Program offers a series of virtual tobacco and nicotine treatment services made available at no cost to patients and the community. The three courses serve as a progression from stage 1 to 3, ultimately gaining the skills and knowledge to quit tobacco. Classes include “Let’s Talk Tobacco”, “Let’s Quit Tobacco” and “Let’s Stay Quit”. These programs were offered virtually through referrals and community networks.

Action

By Dec. 31, 2025, offer virtual smoking cessation programs to the community.

Measurable Impact

Virtual smoking cessation classes were offered in the community.

Corewell Health Taylor Hospital

Health Education

Chronic Disease Prevention Interventions

Impact of Strategy
Aligning with our regional strategy to provide programs in Chronic Disease Management and Prevention, we have successfully implemented several evidence-based programs, including the Diabetes Prevention Program and the Hypertension Control Program in partnership with multiple community-based organizations in Oakland, Macomb and Wayne counties.

Since 2017, we have grown our Diabetes Prevention Program (DPP) across the service region to offer classes in-person and virtual with community partners. We have also launched multiple accessible classes offered in Spanish and for those experiencing vision impairments. As part of the National DPP partnership, the program supported participants at risk for Type 2 Diabetes by providing education and resources to improve eating habits, food choices and overall lifestyle changes.

Another prevalent chronic condition across the region is high blood pressure. We continued offering the evidence-based Hypertension Control Program, focused on managing high blood pressure for those with diagnosed conditions or with multiple risk factors for developing hypertension. Classes were offered both in-person and virtually with community partners.

Managing chronic health conditions at home has been a priority for the system to reduce both outpatient visits and hospitalizations. We have successfully continued to offer the Personal Action Toward Health (PATH) classes, which have included both diabetes and chronic pain classes. These classes have been shown to enhance participants' confidence in the ability to manage their disease and to work more effectively with their health care provider to improve value-based care.

Action

By Dec. 31, 2025, a community health worker model will be implemented to support health education and chronic disease interventions.

Measurable Impact

A Community Health Worker model was established with staff hired to implement chronic disease interventions within the community.

Action

By Dec. 31, 2025, enrollment in chronic disease prevention and management programs will increase by 15%.

Measurable Impact

The number of participants in chronic disease prevention and management programs increased by 15%.

Action

By Dec. 31, 2025, offer chronic disease management programs in at least one accessible format.

Measurable Impact

The Diabetes Prevention Program was offered in Spanish and for those blind/visually impaired.

Car Seat Safety

Impact of Strategy

Car Seat Safety enhances child passenger safety by deploying trained technicians across communities to conduct car seat checks and provide education. The initiative aims to reduce injury risks for children during transportation by ensuring proper car seat installation and usage. Standing car seat safety checks were provided each month for free on-site with community partners. Free car seats were also provided to families in need.

Action

By June. 30, 2024, establish a car seat safety technician training model.

Measurable Impact

Five courses were conducted, resulting in 81 participants successfully completing the training and qualifying as technicians.

Action

By Dec. 31, 2025, provide monthly car seat safety checks with at least two community partners.

Measurable Impact

Provided monthly car seat safety checks with two community partners.

Community Engagement

Impact of Strategy

Everyone who works in a health system, not just clinical staff, can play a role in shifting culture from one that can feel transactional, to one that feels centered around caring and connection. By listening and connecting to patients, and most importantly building and maintaining relationships, we are building a more equitable, compassionate, and healing health care system. We have successfully collaborated across health and social service providers to develop strong community-clinical linkages that address the behavioral and social drivers of health.

Action

By December 31, 2025, increase awareness of resources in the community through community-building.

Measurable Impact

Trained staff and community members on navigating care and referrals through the Beaumont Community Resource Network.

Action

By December 31, 2025, participate in annual community safety days.

Measurable Impact

Co-hosted annual safety days with community partners.

Access to Care

School-Based Food Pantries and Hygiene Closets

Impact of Strategy

The School-Based Food Pantry and Hygiene Closet initiative has successfully advanced efforts to improve health equity through improved access to basic needs. School food pantries and hygiene closets were created across Wayne County schools that were open and available to all students during school hours. Wrap-around services and referral pathways were created for students and families with limited resources, including connecting them with our Teen Health Centers for additional care. School staff were also trained to connect families with broader support services through the Beaumont Community Resource Network, addressing needs like housing, employment, and transportation.

Action

By Dec. 31, 2025, the number of schools participating in Wayne County will increase from 11 to 45 schools.

Measurable Impact

The number of schools participating in the food pantry and hygiene closet program increased to 46.

Action

By Dec. 31, 2025, all nine Corewell Teen Health Centers will have a hygiene closet.

Measurable Impact

All nine Teen Health Centers implemented hygiene closets on-site that were open to all students.

Beaumont Community Resource Network

Impact of Strategy

Powered by Findhelp, the Beaumont Community Resource Network (BCRN) offered a free social service platform to reduce barriers for free and/or reduced-cost programs in the community. From social workers, nurses, and case managers, BCRN helped community members access essential services and basic needs through a confidential and secure platform. BCRN has grown from a small pilot project to a system-wide initiative, aligning with the Social Determinants of Health (SDoH) and health equity priorities of the Corewell system, integrating community-clinical linkages for improved health outcomes.

Action

By Dec. 31, 2025, the Beaumont Community Resource Network will increase reach by 25%.

Measurable Impact

The Beaumont Community Resource Network increased reach by 47%.

Action

By Dec. 31, 2025, the Beaumont Community Resource Network will increase community-based organization claim rate by 50%.

Measurable Impact

Community-based organizations increased claim rate by 75%.

Cultural Competency

Impact of Strategy

The concepts of cultural competence and patient-centered care intersect in meaningful ways. Providing care to patients with diverse values, beliefs and behaviors, including the tailoring of health care delivery to meet patients' social, cultural and linguistic needs, reduces racial and ethnic disparities in health care. By acknowledging the importance of culture, we have successfully incorporated strategies and trainings that build cross-cultural relations, expand cultural knowledge, and adapt services to meet culturally unique needs.

Action

By December 31, 2023, assess and review existing cultural competency resources.

Measurable Impact

Conducted a cultural competency assessment.

Action

By December 31, 2025, develop and offer cultural competency courses.

Measurable Impact

Developed and offered cultural competency courses for staff.

Patient Experience

Impact of Strategy

Measuring quality and satisfaction of care is an indispensable element for adequate resource management and promotes patient-centered care that is tailored to a patient’s needs and expectations. We are continually improving our patient-centered experience by assessing outputs and evaluating the satisfaction of each patient. Assessing patient satisfaction has provided valuable and unique insights into daily hospital care and quality.

Action

By December 31, 2025, increase patient satisfaction scores.

Measurable Impact

Efforts are underway to increase patient satisfaction scores through the development of a regional plan.

Behavioral Health

Mental Health First Aid

Impact of Strategy

Adult and Youth Mental Health First Aid programs train adults to recognize and respond to signs of mental health and substance use challenges in adults and youth respectively, using the ALGEE action plan which includes assessing risk, listening nonjudgmentally, providing reassurance, and encouraging professional help and self-support strategies. The youth program includes an additional focus on trauma, substance use, self-care, social media, and bullying impacts for ages 12-18.

Action

By Dec. 31, 2025, provide training to 50 community members to be certified in adult Mental Health First Aid.

Measurable Impact

Provided training to 71 community members on adult Mental Health First Aid.

Action

By Dec. 31, 2025, provide training to 25 community members to be certified in youth Mental Health First Aid.

Measurable Impact

Provided training to 38 community members on youth Mental Health First Aid.

Teen Center Mental/Behavioral Health Programs

Impact of Strategy

The Child and Adolescent Health Centers/Teen Health Centers promote the health of children, adolescents, and their families by providing 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. Services provided are designed specifically for children and adolescents aged 5 through 21 and are aimed at achieving the best possible physical, intellectual, and emotional health status. With 18 points of service across Wayne County, we have successfully established community and youth advisory councils that support program development for improved health outcomes that are aligned with student needs.

Action

By Dec. 31, 2025, Teen Health Center/SWP/E3 LMSW's/LPC will provide mental health counseling services to a minimum of 20 unduplicated students and 60 visits per year.

Measurable Impact

Mental Health Counseling services were provided to more than 20 unduplicated students and exceeded 60 visits per year.

Action

By Dec. 31, 2023, two new Expanding, Enhancing, Emotional Health school-based sites will be opened.

Measurable Impact

Opened three new Expanding, Enhancing and Emotional school-based sites.

Action

By Dec. 31, 2025, open one full clinic in partnership with a school district in Wayne County.

Measurable Impact

Opened the Harper Woods School Health Clinic.

Action

By Dec. 31, 2025, provide mental health therapy and resources to four new schools and one new school district that reaches elementary, middle, and high school population.

Measurable Impact

Provided mental health therapy and resources to four new schools, including one new district, for elementary, middle and high school students.

Medication Take Back

Impact of Strategy

In partnership with the Drug Enforcement Agency (DEA), Take Back Day is a coordinated day across the United States where communities partner with law enforcement to collect unneeded and unused medications for safe destruction. This effort helps to prevent accidental health risks by eliminating the opportunity for someone other than the person prescribed to take them. Participation in drug take

back programs has helped prevent drug abuse and accidental poisoning while also preserving our water resources.

Action

By Dec. 31, 2025, participate in annual medication take back days.

Measurable Impact

Participated in annual medication take back days.

Action

By Dec. 31, 2025, partner with community-based organizations to increase the number medication take backs days offered in a calendar year.

Measurable Impact

Developed new partnerships to offer additional medication take back days in the community.

Behavioral Health Resources

Impact of Strategy

Multiple behavioral health initiatives have been launched to develop strategies that align resources, education, and outreach within the community. These efforts have successfully developed support groups, educational sessions, and distribution programs in partnership with community partners.

Action

By Dec. 31, 2025, remove barriers to connecting to mental health care and substance misuse treatment.

Measurable Impact

Trained staff on the Beaumont Community Resource and referring patients to mental health care and substance misuse treatment resources.

Action

By Dec. 31, 2025, education sessions on behavioral health strategies for the community will be created, including Michigan Opioid Use Disorder (MOUD) strategies.

Measurable Impact

Education sessions and strategies were created for behavioral health to reduce mental health stigma.

Action

By Dec. 31, 2025, partner with the Quick Response Team to improve patient care.

Measurable Impact

Partnered with Quick Response Team.

Smoking Cessation Program

Impact of Strategy

The Tobacco and Nicotine Treatment Program offers a series of virtual tobacco and nicotine treatment services made available at no cost to patients and the community. The three courses serve as a progression from stage 1 to 3, ultimately gaining the skills and knowledge to quit tobacco. Classes include “Let’s Talk Tobacco”, “Let’s Quit Tobacco” and “Let’s Stay Quit”. These programs were offered virtually through referrals and community networks.

Action

By Dec. 31, 2025, offer virtual smoking cessation programs to the community.

Measurable Impact

Virtual smoking cessation classes were offered in the community.

Health Education

Chronic Disease Prevention Interventions

Impact of Strategy

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Action

By Dec. 31, 2025, a community health worker model will be implemented to support health education and chronic disease interventions.

Measurable Impact

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Action

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Measurable Impact

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Impact of Strategy

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Action

By December 31, 2025, increase awareness of resources in the community through community-building.

Measurable Impact

Trained staff and community members on navigating care and referrals through the Beaumont Community Resource Network.

Action

By December 31, 2025, participate in annual community safety days.

Measurable Impact

Co-hosted annual safety days with community partners.

Access to Care

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Impact of Strategy

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Action

By December 31, 2023, assess and review existing cultural competency resources.

Measurable Impact

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Action

By December 31, 2025, develop and offer cultural competency courses.

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Patient Experience

Impact of Strategy

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Measurable Impact

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Behavioral Health

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Impact of Strategy

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Teen Center Mental/Behavioral Health Programs

Impact of Strategy

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back programs has helped prevent drug abuse and accidental poisoning while also preserving our water resources.

Action

By Dec. 31, 2025, participate in annual medication take back days.

Measurable Impact

Participated in annual medication take back days.

Action

By Dec. 31, 2025, partner with community-based organizations to increase the number medication take backs days offered in a calendar year.

Measurable Impact

Developed new partnerships to offer additional medication take back days in the community.

Behavioral Health Resources

Impact of Strategy

Multiple behavioral health initiatives have been launched to develop strategies that align resources, education, and outreach within the community. These efforts have successfully developed support groups, educational sessions, and distribution programs in partnership with community partners.

Action

By Dec. 31, 2025, remove barriers to connecting to mental health care and substance misuse treatment.

Measurable Impact

Trained staff on the Beaumont Community Resource and referring patients to mental health care and substance misuse treatment resources.

Action

By Dec. 31, 2025, review options to implement Telepsych in the Emergency Department.

Measurable Impact

A Telepsych pilot was reviewed for implementation in the Emergency Department.

Smoking Cessation Program

Impact of Strategy

The Tobacco and Nicotine Treatment Program offers a series of virtual tobacco and nicotine treatment services made available at no cost to patients and the community. The three courses serve as a progression from stage 1 to 3, ultimately gaining the skills and knowledge to quit tobacco. Classes include “Let’s Talk Tobacco”, “Let’s Quit Tobacco” and “Let’s Stay Quit”. These programs were offered virtually through referrals and community networks.

Action

By Dec. 31, 2025, offer virtual smoking cessation programs to the community.

Measurable Impact

Virtual smoking cessation classes were offered in the community.

Health Education

Chronic Disease Prevention Interventions

Impact of Strategy

Aligning with our regional strategy to provide programs in Chronic Disease Management and Prevention, we have successfully implemented several evidence-based programs, including the Diabetes Prevention Program and the Hypertension Control Program in partnership with multiple community-based organizations in Oakland, Macomb and Wayne counties.

Since 2017, we have grown our Diabetes Prevention Program (DPP) across the service region to offer classes in-person and virtual with community partners. We have also launched multiple accessible classes offered in Spanish and for those experiencing vision impairments. As part of the National DPP partnership, the program supported participants at risk for Type 2 Diabetes by providing education and resources to improve eating habits, food choices and overall lifestyle changes.

Another prevalent chronic condition across the region is high blood pressure. We continued offering the evidence-based Hypertension Control Program, focused on managing high blood pressure for those with diagnosed conditions or with multiple risk factors for developing hypertension. Classes were offered both in-person and virtually with community partners.

Managing chronic health conditions at home has been a priority for the system to reduce both outpatient visits and hospitalizations. We have successfully continued to offer the Personal Action Toward Health (PATH) classes, which have included both diabetes and chronic pain classes. These classes have been shown to enhance participants' confidence in the ability to manage their disease and to work more effectively with their health care provider to improve value-based care.

Action

By Dec. 31, 2025, a community health worker model will be implemented to support health education and chronic disease interventions.

Measurable Impact

A Community Health Worker model was established with staff hired to implement chronic disease interventions within the community.

Action

By Dec. 31, 2025, enrollment in chronic disease prevention and management programs will increase by 15%.

Measurable Impact

The number of participants in chronic disease prevention and management programs increased by 15%.

Action

By Dec. 31, 2025, offer chronic disease management programs in at least one accessible format.

Measurable Impact

The Diabetes Prevention Program was offered in Spanish and for those blind/visually impaired.

Car Seat Safety

Impact of Strategy

Car Seat Safety enhances child passenger safety by deploying trained technicians across communities to conduct car seat checks and provide education. The initiative aims to reduce injury risks for children during transportation by ensuring proper car seat installation and usage. Standing car seat safety checks were provided each month for free on-site with community partners. Free car seats were also provided to families in need.

Action

By June. 30, 2024, establish a car seat safety technician training model.

Measurable Impact

Five courses were conducted, resulting in 81 participants successfully completing the training and qualifying as technicians.

Action

By Dec. 31, 2025, provide monthly car seat safety checks with at least two community partners.

Measurable Impact

Provided monthly car seat safety checks with two community partners.

Community Engagement

Impact of Strategy

Everyone who works in a health system, not just clinical staff, can play a role in shifting culture from one that can feel transactional, to one that feels centered around caring and connection. By listening and connecting to patients, and most importantly building and maintaining relationships, we are building a more equitable, compassionate, and healing health care system. We have successfully collaborated across health and social service providers to develop strong community-clinical linkages that address the behavioral and social drivers of health.

Action

By December 31, 2025, increase awareness of resources in the community through community-building.

Measurable Impact

Trained staff and community members on navigating care and referrals through the Beaumont Community Resource Network.

Action

By December 31, 2025, increase membership in community coalitions by 10%.

Measurable Impact

Increased membership in community coalitions by 10%.

Community Health Workers

Impact of Strategy

Community health workers (CHWs) help patients — particularly those with multiple chronic diseases, including mental health and substance use disorders — to address barriers to their health including housing, safety, and understanding their medications. By creating trusting relationships, CHWs have helped patients navigate appointments, provided home visits, and closely communicated needs with their providers. We have successfully engaged patients in setting their own goals and building their efficacy to take care of their health.

Action

By Dec. 31, 2025, a community health worker model will be implemented to support health education and chronic disease interventions.

Measurable Impact

A Community Health Worker model was established with staff hired to implement chronic disease interventions within the community.

Access to Care

School-Based Food Pantries and Hygiene Closets

Impact of Strategy

The School-Based Food Pantry and Hygiene Closet initiative has successfully advanced efforts to improve health equity through improved access to basic needs. School food pantries and hygiene closets were created across Wayne County schools that were open and available to all students during school hours. Wrap-around services and referral pathways were created for students and families with limited resources, including connecting them with our Teen Health Centers for additional care. School staff were also trained to connect families with broader support services through the Beaumont Community Resource Network, addressing needs like housing, employment, and transportation.

Action

By Dec. 31, 2025, the number of schools participating in Wayne County will increase from 11 to 45 schools.

Measurable Impact

The number of schools participating in the food pantry and hygiene closet program increased to 46.

Action

By Dec. 31, 2025, all nine Corewell Teen Health Centers will have a hygiene closet.

Measurable Impact

All nine Teen Health Centers implemented hygiene closets on-site that were open to all students.

Beaumont Community Resource Network

Impact of Strategy

Powered by Findhelp, the Beaumont Community Resource Network (BCRN) offered a free social service platform to reduce barriers for free and/or reduced-cost programs in the community. From social workers, nurses, and case managers, BCRN helped community members access essential services and basic needs through a

confidential and secure platform. BCRN has grown from a small pilot project to a system-wide initiative, aligning with the Social Determinants of Health (SDoH) and health equity priorities of the Corewell system, integrating community-clinical linkages for improved health outcomes.

Action

By Dec. 31, 2025, the Beaumont Community Resource Network will increase reach by 25%.

Measurable Impact

The Beaumont Community Resource Network increased reach by 47%.

Action

By Dec. 31, 2025, the Beaumont Community Resource Network will increase community-based organization claim rate by 50%.

Measurable Impact

Community-based organizations increased claim rate by 75%.

Cultural Competency

Impact of Strategy

The concepts of cultural competence and patient-centered care intersect in meaningful ways. Providing care to patients with diverse values, beliefs and behaviors, including the tailoring of health care delivery to meet patients' social, cultural and linguistic needs, reduces racial and ethnic disparities in health care. By acknowledging the importance of culture, we have successfully incorporated strategies and trainings that build cross-cultural relations, expand cultural knowledge, and adapt services to meet culturally unique needs.

Action

By December 31, 2023, assess and review existing cultural competency resources.

Measurable Impact

Conducted a cultural competency assessment.

Action

By December 31, 2025, develop and offer cultural competency courses.

Measurable Impact

Developed and offered cultural competency courses for staff.

Patient Experience

Impact of Strategy

Measuring quality and satisfaction of care is an indispensable element for adequate resource management and promotes patient-centered care that is tailored to a patient's needs and expectations. We are continually improving our patient-centered experience by assessing outputs and evaluating the satisfaction of each patient. Assessing patient satisfaction has provided valuable and unique insights into daily hospital care and quality.

Action

By December 31, 2025, increase patient satisfaction scores.

Measurable Impact

Efforts are underway to increase patient satisfaction scores through the development of a regional plan.

Behavioral Health

Mental Health First Aid

Impact of Strategy

Adult and Youth Mental Health First Aid programs train adults to recognize and respond to signs of mental health and substance use challenges in adults and youth respectively, using the ALGEE action plan which includes assessing risk, listening nonjudgmentally, providing reassurance, and encouraging professional help and self-support strategies. The youth program includes an additional focus on trauma, substance use, self-care, social media, and bullying impacts for ages 12-18.

Action

By Dec. 31, 2025, provide training to 50 community members to be certified in adult Mental Health First Aid.

Measurable Impact

Provided training to 71 community members on adult Mental Health First Aid.

Action

By Dec. 31, 2025, provide training to 25 community members to be certified in youth Mental Health First Aid.

Measurable Impact

Provided training to 38 community members on youth Mental Health First Aid.

Medication Take Back

Impact of Strategy

In partnership with the Drug Enforcement Agency (DEA), Take Back Day is a coordinated day across the United States where communities partner with law enforcement to collect unneeded and unused medications for safe destruction. This effort helps to prevent accidental health risks by eliminating the opportunity for someone other than the person prescribed to take them. Participation in drug take back programs has helped prevent drug abuse and accidental poisoning while also preserving our water resources.

Action

By Dec. 31, 2025, participate in annual medication take back days.

Measurable Impact

Participated in annual medication take back days.

Action

By Dec. 31, 2025, partner with community-based organizations to increase the number medication take backs days offered in a calendar year.

Measurable Impact

Developed new partnerships to offer additional medication take back days in the community.

Behavioral Health Resources

Impact of Strategy

Multiple behavioral health initiatives have been launched to develop strategies that align resources, education, and outreach within the community. These efforts have successfully developed support groups, educational sessions, and distribution programs in partnership with community partners.

Action

By Dec. 31, 2025, remove barriers to connecting to mental health care and substance misuse treatment.

Measurable Impact

Trained staff on the Beaumont Community Resource and referring patients to mental health care and substance misuse treatment resources.

Action

By Dec. 31, 2025, create education sessions on behavioral health strategies for the community.

Measurable Impact

Education sessions were created for behavioral health to reduce mental health stigma.

Action

By Dec. 31, 2025, create behavioral health screening questionnaire.

Measurable Impact

Created behavioral health screening questionnaire.

Smoking Cessation Program

Impact of Strategy

The Tobacco and Nicotine Treatment Program offers a series of virtual tobacco and nicotine treatment services made available at no cost to patients and the community. The three courses serve as a progression from stage 1 to 3, ultimately gaining the skills and knowledge to quit tobacco. Classes include “Let’s Talk Tobacco”, “Let’s Quit Tobacco” and “Let’s Stay Quit”. These programs were offered virtually through referrals and community networks.

Action

By Dec. 31, 2025, offer virtual smoking cessation programs to the community.

Measurable Impact

Virtual smoking cessation classes were offered in the community.

Corewell Health Wayne Hospital

Health Education

Chronic Disease Prevention Interventions

Impact of Strategy

Aligning with our regional strategy to provide programs in Chronic Disease Management and Prevention, we have successfully implemented several evidence-based programs, including the Diabetes Prevention Program and the Hypertension Control Program in partnership with multiple community-based organizations in Oakland, Macomb and Wayne counties.

Since 2017, we have grown our Diabetes Prevention Program (DPP) across the service region to offer classes in-person and virtual with community partners. We have also launched multiple accessible classes offered in Spanish and for those experiencing vision impairments. As part of the National DPP partnership, the program supported participants at risk for Type 2 Diabetes by providing education and resources to improve eating habits, food choices and overall lifestyle changes.

Another prevalent chronic condition across the region is high blood pressure. We continued offering the evidence-based Hypertension Control Program, focused on managing high blood pressure for those with diagnosed conditions or with multiple risk factors for developing hypertension. Classes were offered both in-person and virtually with community partners.

Managing chronic health conditions at home has been a priority for the system to reduce both outpatient visits and hospitalizations. We have successfully continued to offer the Personal Action Toward Health (PATH) classes, which have included both diabetes and chronic pain classes. These classes have been shown to enhance participants' confidence in the ability to manage their disease and to work more effectively with their health care provider to improve value-based care.

Action

By Dec. 31, 2025, a community health worker model will be implemented to support health education and chronic disease interventions.

Measurable Impact

A Community Health Worker model was established with staff hired to implement chronic disease interventions within the community.

Action

By Dec. 31, 2025, enrollment in chronic disease prevention and management programs will increase by 15%.

Measurable Impact

The number of participants in chronic disease prevention and management programs increased by 15%.

Action

By Dec. 31, 2025, offer chronic disease management programs in at least one accessible format.

Measurable Impact

The Diabetes Prevention Program was offered in Spanish and for those blind/visually impaired.

Car Seat Safety

Impact of Strategy

Car Seat Safety enhances child passenger safety by deploying trained technicians across communities to conduct car seat checks and provide education. The initiative aims to reduce injury risks for children during transportation by ensuring proper car seat installation and usage. Standing car seat safety checks were provided each month for free on-site with community partners. Free car seats were also provided to families in need.

Action

By June. 30, 2024, establish a car seat safety technician training model.

Measurable Impact

Five courses were conducted, resulting in 81 participants successfully completing the training and qualifying as technicians.

Action

By Dec. 31, 2025, provide monthly car seat safety checks with at least two community partners.

Measurable Impact

Provided monthly car seat safety checks with two community partners.

Community Engagement

Impact of Strategy

Everyone who works in a health system, not just clinical staff, can play a role in shifting culture from one that can feel transactional, to one that feels centered around caring and connection. By listening and connecting to patients, and most importantly building and maintaining relationships, we are building a more equitable, compassionate, and healing health care system. We have successfully collaborated across health and social service providers to develop strong community-clinical linkages that address the behavioral and social drivers of health.

Action

By December 31, 2025, increase awareness of resources in the community through community-building.

Measurable Impact

Trained staff and community members on navigating care and referrals through the Beaumont Community Resource Network.

Action

By December 31, 2025, participate in annual community safety days.

Measurable Impact

Co-hosted annual safety days with community partners.

Access to Care

School-Based Food Pantries and Hygiene Closets

Impact of Strategy

The School-Based Food Pantry and Hygiene Closet initiative has successfully advanced efforts to improve health equity through improved access to basic needs. School food pantries and hygiene closets were created across Wayne County schools that were open and available to all students during school hours. Wrap-around services and referral pathways were created for students and families with limited resources, including connecting them with our Teen Health Centers for additional care. School staff were also trained to connect families with broader support services through the Beaumont Community Resource Network, addressing needs like housing, employment, and transportation.

Action

By Dec. 31, 2025, the number of schools participating in Wayne County will increase from 11 to 45 schools.

Measurable Impact

The number of schools participating in the food pantry and hygiene closet program increased to 46.

Action

By Dec. 31, 2025, all nine Corewell Teen Health Centers will have a hygiene closet.

Measurable Impact

All nine Teen Health Centers implemented hygiene closets on-site that were open to all students.

Beaumont Community Resource Network

Impact of Strategy

Powered by Findhelp, the Beaumont Community Resource Network (BCRN) offered a free social service platform to reduce barriers for free and/or reduced-cost programs in the community. From social workers, nurses, and case managers, BCRN helped community members access essential services and basic needs through a confidential and secure platform. BCRN has grown from a small pilot project to a system-wide initiative, aligning with the Social Determinants of Health (SDoH) and health equity priorities of the Corewell system, integrating community-clinical linkages for improved health outcomes.

Action

By Dec. 31, 2025, the Beaumont Community Resource Network will increase reach by 25%.

Measurable Impact

The Beaumont Community Resource Network increased reach by 47%.

Action

By Dec. 31, 2025, the Beaumont Community Resource Network will increase community-based organization claim rate by 50%.

Measurable Impact

Community-based organizations increased claim rate by 75%.

Cultural Competency

Impact of Strategy

The concepts of cultural competence and patient-centered care intersect in meaningful ways. Providing care to patients with diverse values, beliefs and behaviors, including the tailoring of health care delivery to meet patients' social, cultural and linguistic needs, reduces racial and ethnic disparities in health care. By acknowledging the importance of culture, we have successfully incorporated strategies and trainings that build cross-cultural relations, expand cultural knowledge, and adapt services to meet culturally unique needs.

Action

By December 31, 2023, assess and review existing cultural competency resources.

Measurable Impact

Conducted a cultural competency assessment.

Action

By December 31, 2025, develop and offer cultural competency courses.

Measurable Impact

Developed and offered cultural competency courses for staff.

Patient Experience

Impact of Strategy

Measuring quality and satisfaction of care is an indispensable element for adequate resource management and promotes patient-centered care that is tailored to a patient’s needs and expectations. We are continually improving our patient-centered experience by assessing outputs and evaluating the satisfaction of each patient. Assessing patient satisfaction has provided valuable and unique insights into daily hospital care and quality.

Action

By December 31, 2025, increase patient satisfaction scores.

Measurable Impact

Efforts are underway to increase patient satisfaction scores through the development of a regional plan.

Behavioral Health

Mental Health First Aid

Impact of Strategy

Adult and Youth Mental Health First Aid programs train adults to recognize and respond to signs of mental health and substance use challenges in adults and youth respectively, using the ALGEE action plan which includes assessing risk, listening nonjudgmentally, providing reassurance, and encouraging professional help and self-support strategies. The youth program includes an additional focus on trauma, substance use, self-care, social media, and bullying impacts for ages 12-18.

Action

By Dec. 31, 2025, provide training to 50 community members to be certified in adult Mental Health First Aid.

Measurable Impact

Provided training to 71 community members on adult Mental Health First Aid.

Action

By Dec. 31, 2025, provide training to 25 community members to be certified in youth Mental Health First Aid.

Measurable Impact

Provided training to 38 community members on youth Mental Health First Aid.

Teen Center Mental/Behavioral Health Programs

Impact of Strategy

The Child and Adolescent Health Centers/Teen Health Centers promote the health of children, adolescents, and their families by providing 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. Services provided are designed specifically for children and adolescents aged 5 through 21 and are aimed at achieving the best possible physical, intellectual, and emotional health status. With 18 points of service across Wayne County, we have successfully established community and youth advisory councils that support program development for improved health outcomes that are aligned with student needs.

Action

By Dec. 31, 2025, Teen Health Center/SWP/E3 LMSW's/LPC will provide mental health counseling services to a minimum of 20 unduplicated students and 60 visits per year.

Measurable Impact

Mental Health Counseling services were provided to more than 20 unduplicated students and exceeded 60 visits per year.

Action

By Dec. 31, 2023, two new Expanding, Enhancing, Emotional Health school-based sites will be opened.

Measurable Impact

Opened three new Expanding, Enhancing and Emotional school-based sites.

Action

By Dec. 31, 2025, open one full clinic in partnership with a school district in Wayne County.

Measurable Impact

Opened the Harper Woods School Health Clinic.

Action

By Dec. 31, 2025, provide mental health therapy and resources to four new schools and one new school district that reaches elementary, middle, and high school population.

Measurable Impact

Provided mental health therapy and resources to four new schools, including one new district, for elementary, middle and high school students.

Medication Take Back

Impact of Strategy

In partnership with the Drug Enforcement Agency (DEA), Take Back Day is a coordinated day across the United States where communities partner with law enforcement to collect unneeded and unused medications for safe destruction. This effort helps to prevent accidental health risks by eliminating the opportunity for someone other than the person prescribed to take them. Participation in drug take

back programs has helped prevent drug abuse and accidental poisoning while also preserving our water resources.

Action

By Dec. 31, 2025, participate in annual medication take back days.

Measurable Impact

Participated in annual medication take back days.

Action

By Dec. 31, 2025, partner with community-based organizations to increase the number medication take backs days offered in a calendar year.

Measurable Impact

Developed new partnerships to offer additional medication take back days in the community.

Behavioral Health Resources

Impact of Strategy

Multiple behavioral health initiatives have been launched to develop strategies that align resources, education, and outreach within the community. These efforts have successfully developed support groups, educational sessions, and distribution programs in partnership with community partners.

Action

By Dec. 31, 2025, remove barriers to connecting to mental health care and substance misuse treatment.

Measurable Impact

Trained staff on the Beaumont Community Resource and referring patients to mental health care and substance misuse treatment resources.

Action

By Dec. 31, 2025, create education sessions on behavioral health strategies for the community.

Measurable Impact

Education sessions were created for behavioral health to reduce mental health stigma.

Action

By Dec. 31, 2025, review options to implement Telepsych in the Emergency Department.

Measurable Impact

A Telepsych pilot was reviewed for implementation in the Emergency Department.

Smoking Cessation Program

Impact of Strategy

The Tobacco and Nicotine Treatment Program offers a series of virtual tobacco and nicotine treatment services made available at no cost to patients and the community. The three courses serve as a progression from stage 1 to 3, ultimately gaining the skills and knowledge to quit tobacco. Classes include “Let’s Talk Tobacco”, “Let’s Quit Tobacco” and “Let’s Stay Quit”. These programs were offered virtually through referrals and community networks.

Action

By Dec. 31, 2025, offer virtual smoking cessation programs to the community.

Measurable Impact

Virtual smoking cessation classes were offered in the community.

Health Education

Chronic Disease Prevention Interventions

Impact of Strategy

Aligning with our regional strategy to provide programs in Chronic Disease Management and Prevention, we have successfully implemented several evidence-based programs, including the Diabetes Prevention Program and the Hypertension Control Program in partnership with multiple community-based organizations in Oakland, Macomb and Wayne counties.

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Another prevalent chronic condition across the region is high blood pressure. We continued offering the evidence-based Hypertension Control Program, focused on managing high blood pressure for those with diagnosed conditions or with multiple risk factors for developing hypertension. Classes were offered both in-person and virtually with community partners.

Managing chronic health conditions at home has been a priority for the system to reduce both outpatient visits and hospitalizations. We have successfully continued to offer the Personal Action Toward Health (PATH) classes, which have included both diabetes and chronic pain classes. These classes have been shown to enhance participants' confidence in the ability to manage their disease and to work more effectively with their health care provider to improve value-based care.

Action

By Dec. 31, 2025, a community health worker model will be implemented to support health education and chronic disease interventions.

Measurable Impact

A Community Health Worker model was established with staff hired to implement chronic disease interventions within the community.

Action

By Dec. 31, 2025, enrollment in chronic disease prevention and management programs will increase by 15%.

Measurable Impact

The number of participants in chronic disease prevention and management programs increased by 15%.

Action

By Dec. 31, 2025, offer chronic disease management programs in at least one accessible format.

Measurable Impact

The Diabetes Prevention Program was offered in Spanish and for those blind/visually impaired.

Car Seat Safety

Impact of Strategy

Car Seat Safety enhances child passenger safety by deploying trained technicians across communities to conduct car seat checks and provide education. The initiative aims to reduce injury risks for children during transportation by ensuring proper car seat installation and usage. Standing car seat safety checks were provided each month for free on-site with community partners. Free car seats were also provided to families in need.

Action

By June. 30, 2024, establish a car seat safety technician training model.

Measurable Impact

Corewell hosted a technician training on-site for 20 individuals to become certified car seat safety technicians.

Action

By Dec. 31, 2025, provide monthly car seat safety checks with at least two community partners.

Measurable Impact

Provided monthly car seat safety checks with two community partners.

Cultural Competency

Impact of Strategy

The concepts of cultural competence and patient-centered care intersect in meaningful ways. Providing care to patients with diverse values, beliefs and behaviors, including the tailoring of health care delivery to meet patients' social, cultural and linguistic needs, reduces racial and ethnic disparities in health care. By acknowledging the importance of culture, we have successfully incorporated strategies and trainings that build cross-cultural relations, expand cultural knowledge, and adapt services to meet culturally unique needs.

Action

By December 31, 2023, assess and review existing cultural competency resources.

Measurable Impact

Conducted a cultural competency assessment.

Action

By December 31, 2025, develop and offer cultural competency courses.

Measurable Impact

Developed and offered cultural competency courses for staff.

Community Engagement

Impact of Strategy

Everyone who works in a health system, not just clinical staff, can play a role in shifting culture from one that can feel transactional, to one that feels centered around caring and connection. By listening and connecting to patients, and most importantly building and maintaining relationships, we are building a more equitable, compassionate, and healing health care system. We have successfully collaborated across health and social service providers to develop strong community-clinical linkages that address the behavioral and social drivers of health.

Action

By December 31, 2025, establish an Internal Community Health Committee to build relationships with the community.

Measurable Impact

Launched a William Beaumont University Hospital Internal Community Health Committee to support building connections with the community.

Community Health Workers

Impact of Strategy

Community health workers (CHWs) help patients — particularly those with multiple chronic diseases, including mental health and substance use disorders — to address barriers to their health including housing, safety, and understanding their medications. By creating trusting relationships, CHWs have helped patients navigate appointments, provided home visits, and closely communicated needs with their providers. We have successfully engaged patients in setting their own goals and building their efficacy to take care of their health.

Action

By Dec. 31, 2025, a community health worker model will be implemented to support health education and chronic disease interventions.

Measurable Impact

A Community Health Worker model was established.

Access to Care

School-Based Food Pantries and Hygiene Closets

Impact of Strategy

The school-Based Food Pantry and Hygiene Closet initiative has successfully advanced efforts to improve health equity through improved access to basic needs. School food pantries and hygiene closets were created across Wayne County schools that were open and available to all students during school hours. Wrap-around services and referral pathways were created for students and families with limited resources, including connecting them with our Teen Health Centers for additional care. School staff were also trained to connect families with broader support services through the Beaumont Community Resource Network, addressing needs like housing, employment, and transportation.

Action

By Dec. 31, 2025, the number of schools participating in Wayne County will increase from 11 to 45 schools.

Measurable Impact

The number of schools participating in the food pantry and hygiene closet program increased to 46.

Action

By Dec. 31, 2025, all nine Corewell Teen Health Centers will have a hygiene closet.

Measurable Impact

All nine Teen Health Centers implemented hygiene closets on-site that were open to all students.

Beaumont Community Resource Network

Impact of Strategy

Powered by Findhelp, the Beaumont Community Resource Network (BCRN) offered a free social service platform to reduce barriers for free and/or reduced-cost programs in the community. From social workers, nurses, and case managers, BCRN helped community members access essential services and basic needs through a confidential and secure platform. BCRN has grown from a small pilot project to a system-wide initiative, aligning with the Social Determinants of Health (SDoH) and health equity priorities of the Corewell system, integrating community-clinical linkages for improved health outcomes.

Action

By Dec. 31, 2025, the Beaumont Community Resource Network will increase reach by 25%.

Measurable Impact

The Beaumont Community Resource Network increased reach by 47%.

Action

By Dec. 31, 2025, the Beaumont Community Resource Network will increase community-based organization claim rate by 50%.

Measurable Impact

Community-based organizations increased claim rate by 75%.

Patient Experience

Impact of Strategy

Measuring quality and satisfaction of care is an indispensable element for adequate resource management and promotes patient-centered care that is tailored to a patient's needs and expectations. We are continually improving our patient-centered experience by assessing outputs and evaluating the satisfaction of each patient.

Assessing patient satisfaction has provided valuable and unique insights into daily hospital care and quality.

Action

By December 31, 2025, increase patient satisfaction scores.

Measurable Impact

Efforts are underway to increase patient satisfaction scores through the development of a regional plan.

Behavioral Health

Mental Health First Aid

Impact of Strategy

Adult and Youth Mental Health First Aid programs train adults to recognize and respond to signs of mental health and substance use challenges in adults and youth respectively, using the ALGEE action plan which includes assessing risk, listening nonjudgmentally, providing reassurance, and encouraging professional help and self-support strategies. The youth program includes an additional focus on trauma, substance use, self-care, social media, and bullying impacts for ages 12-18.

Action

By Dec. 31, 2025, provide training to 50 community members to be certified in adult Mental Health First Aid.

Measurable Impact

Provided training to 71 community members on adult Mental Health First Aid.

Action

By Dec. 31, 2025, provide training to 25 community members to be certified in youth Mental Health First Aid.

Measurable Impact

Provided training to 38 community members on youth Mental Health First Aid.

Medication Take Back

Impact of Strategy

In partnership with the Drug Enforcement Agency (DEA), Take Back Day is a coordinated day across the United States where communities partner with law enforcement to collect unneeded and unused medications for safe destruction. This

effort helps to prevent accidental health risks by eliminating the opportunity for someone other than the person prescribed to take them. Participation in drug take back programs has helped prevent drug abuse and accidental poisoning while also preserving our water resources.

Action

By Dec. 31, 2025, participate in annual medication take back days.

Measurable Impact

Participated in annual medication take back days.

Action

By Dec. 31, 2025, partner with community-based organizations to increase the number medication take backs days offered in a calendar year.

Measurable Impact

Developed new partnerships to offer additional medication take back days in the community.

Behavioral Health Resources

Impact of Strategy

Multiple behavioral health initiatives have been launched to develop strategies that align resources, education, and outreach within the community. These efforts have successfully developed support groups, educational sessions, and distribution programs in partnership with community partners.

Action

By Dec. 31, 2025, develop support groups based on need available to the community.

Measurable Impact

Facilitated 18 support groups for the community to attend.

Action

By Dec. 31, 2025, create education sessions on behavioral health strategies for the community.

Measurable Impact

Education sessions were created for behavioral health.

Action

By Dec. 31, 2025, remove barriers to connecting to mental health care and substance misuse treatment.

Measurable Impact

Trained staff on the Beaumont Community Resource and referring patients to mental health care and substance misuse treatment resources.

Action

By Dec. 31, 2025, create behavioral health screening questionnaire.

Measurable Impact

Created behavioral health screening questionnaire.

Smoking Cessation Program

Impact of Strategy

The Tobacco and Nicotine Treatment Program offers a series of virtual tobacco and nicotine treatment services made available at no cost to patients and the community. The three courses serve as a progression from stage 1 to 3, ultimately gaining the skills and knowledge to quit tobacco. Classes include “Let’s Talk Tobacco”, “Let’s Quit Tobacco” and “Let’s Stay Quit”. These programs were offered virtually through referrals and community networks.

Action

By Dec. 31, 2025, offer virtual smoking cessation programs to the community.

Measurable Impact

Virtual smoking cessation classes were offered in the community.