

Community Health Needs Assessment – 2016

Beaumont Hospital, Royal Oak Implementation Strategy 2018 Update



Building healthier lives and communities.

Beaumont

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

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

The Beaumont Health community has been identified as Macomb, Oakland and Wayne counties. The CHNA process identified significant

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

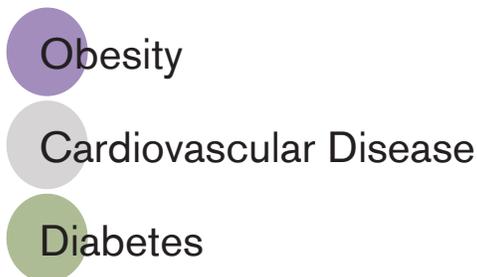
- Importance of the problem to the community ensures the priorities chosen reflect the community experience.
- Alignment with the health system's strengths is important to ensure we leverage our ability to make an impact.
- Resources criteria acknowledges that we need to work within the capacity of our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

High Data and Qualitative

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

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

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



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

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

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

Key Approaches of the Implementation Strategy

Beaumont Health is committed to engaging in transformative relationships with local communities to address the social determinants of health and

to increase access to high quality-health care. We recognize good health extends beyond the doctor's office and hospital. Our work in the community takes a prevention, evidence-based approach with key elements that include:

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

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

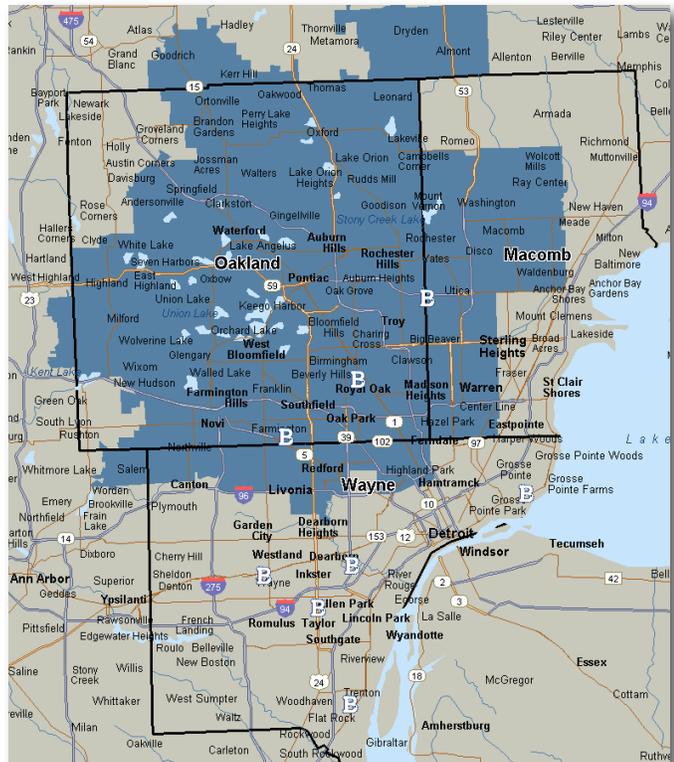
Over the next three years each Beaumont Health hospital will execute its implementation strategies, which will be evaluated and updated on an annual basis.

BEAUMONT HOSPITAL, ROYAL OAK

Beaumont Hospital, Royal Oak opened on Jan. 24, 1955 as a 238-bed community hospital. Today, the hospital is a 1,100-bed major academic and referral center with Level I adult trauma and Level II pediatric trauma status. A major teaching facility, Beaumont has 55 accredited residency and fellowship programs with 454 residents and fellows at Royal Oak. Beaumont is the exclusive clinical partner for the Oakland University William Beaumont School of Medicine, with more than 1,400 Beaumont doctors on faculty.

Community served

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



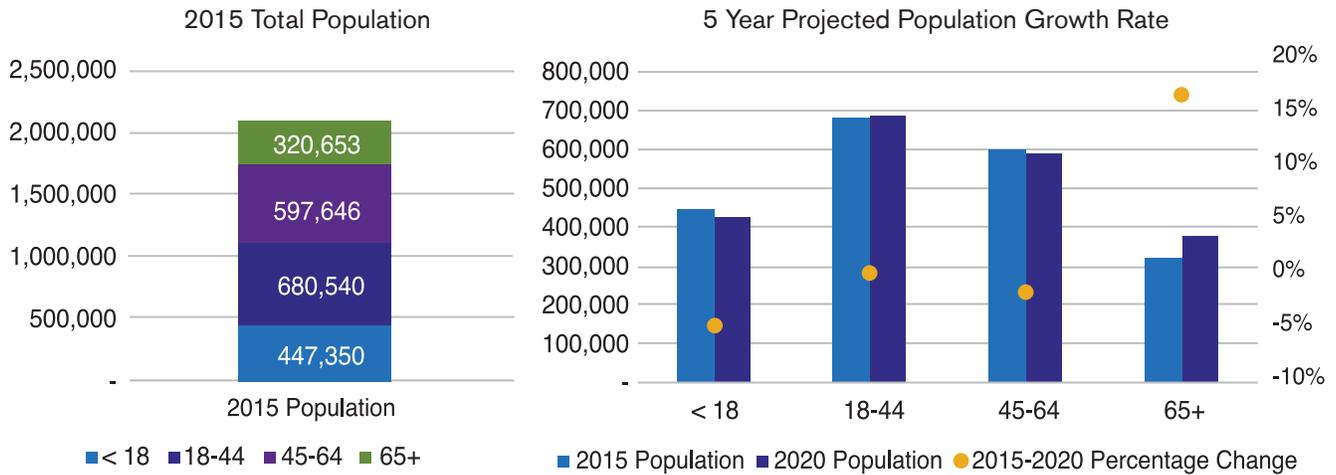
Source: Beaumont Health, 2016

Demographic and socio-economic summary

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

BEAUMONT HOSPITAL, ROYAL OAK

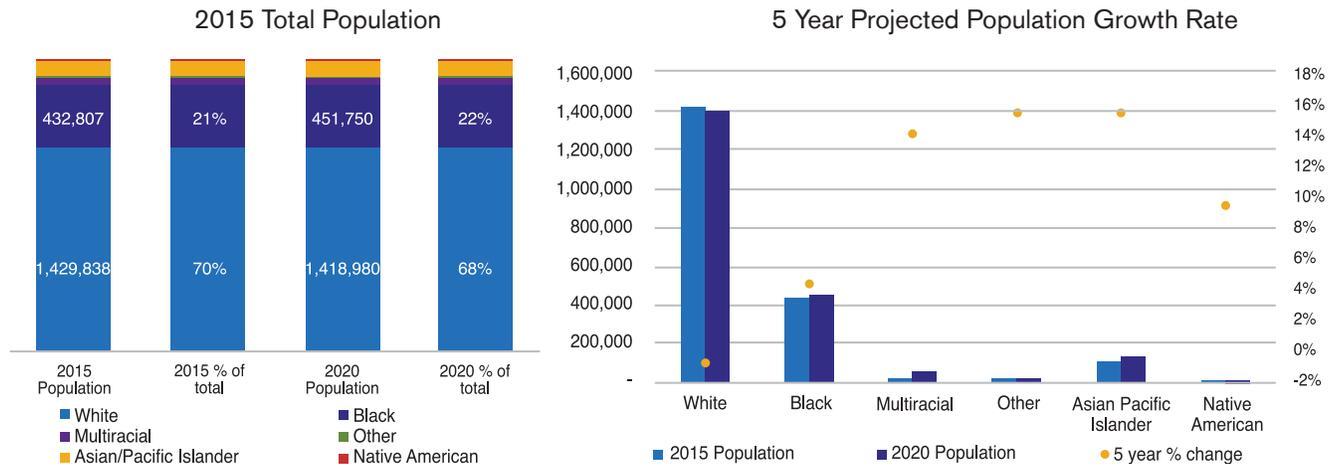
Population by Age Cohort



Source: Truven Health Analytics, 2016

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

Population by Race

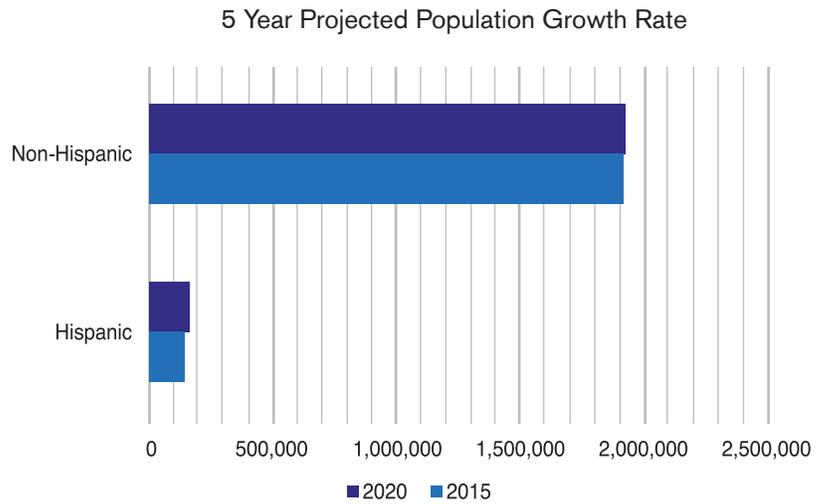
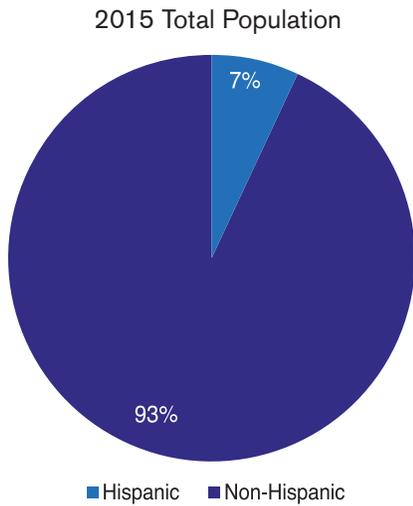


Source: Truven Health Analytics, 2016

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

BEAUMONT HOSPITAL, ROYAL OAK

Population by Hispanic Ethnicity



Source: Truven Health Analytics, 2016

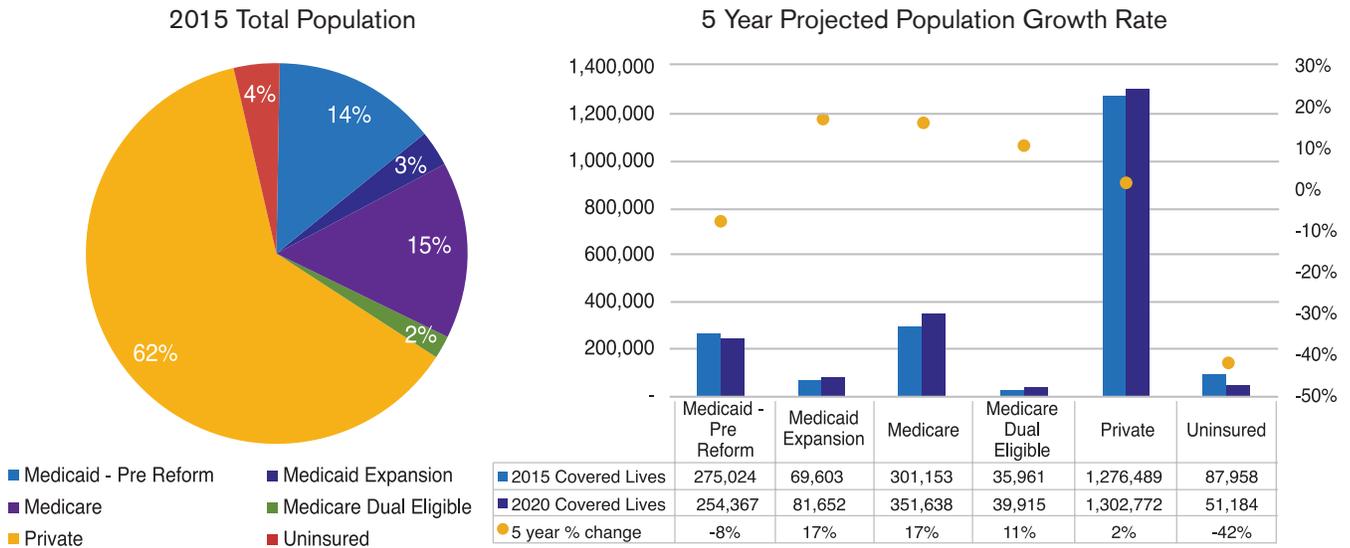
The majority of Beaumont, Royal Oak's population is estimated to be privately insured. Compared to state and national estimates, the community has a higher percentage of privately insured residents and a lower percentage of residents with Medicaid. Sixty-two percent of the community has private insurance,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

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



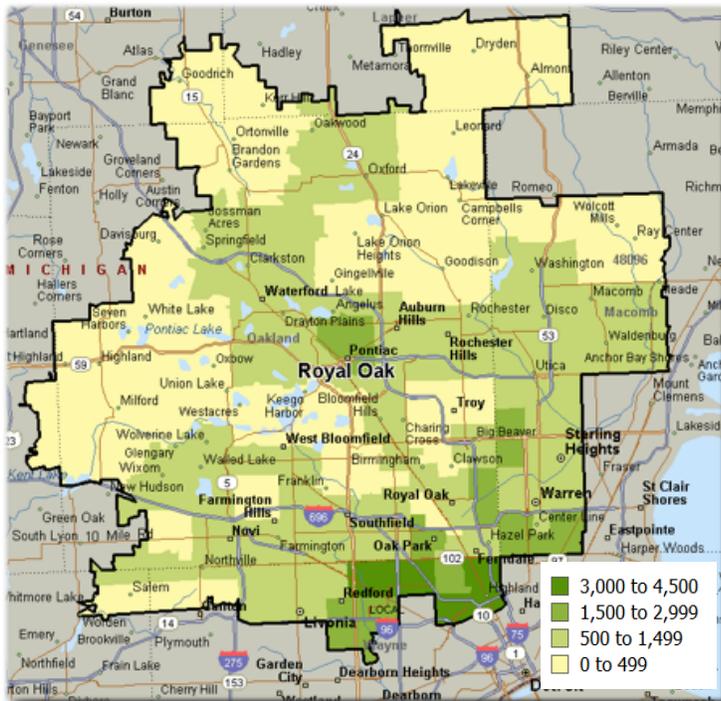
BEAUMONT HOSPITAL, ROYAL OAK

Estimated Covered Lives by Insurance Category



Source: Truven Health Analytics, 2016

2015 Estimated Uninsured Lives by ZIP Code

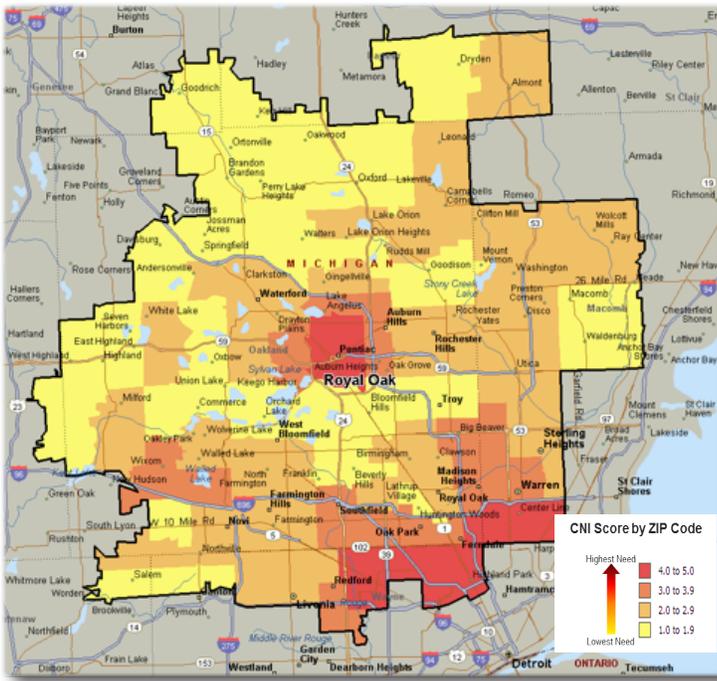


Source: Truven Health Analytics, 2016

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

BEAUMONT HOSPITAL, ROYAL OAK

2015 Community Needs Index by ZIP Code



Source: Truven Health Analytics, 2016

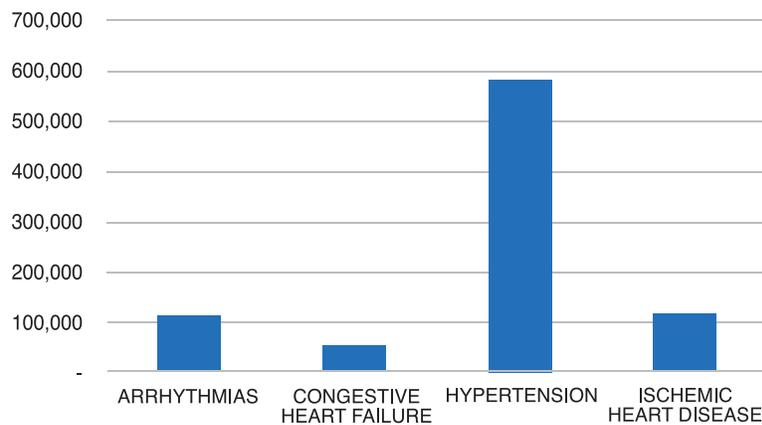
Beaumont, Royal Oak has an overall CNI score of 2.7, the second lowest CNI of the eight Beaumont hospital communities. However, there are ZIP codes that have a score of 5.0 (the highest anticipated need), including Highland Park (48203), Detroit (48238), and Pontiac (48342).

Truven Health community data

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

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

2015 Estimated Heart Disease Cases

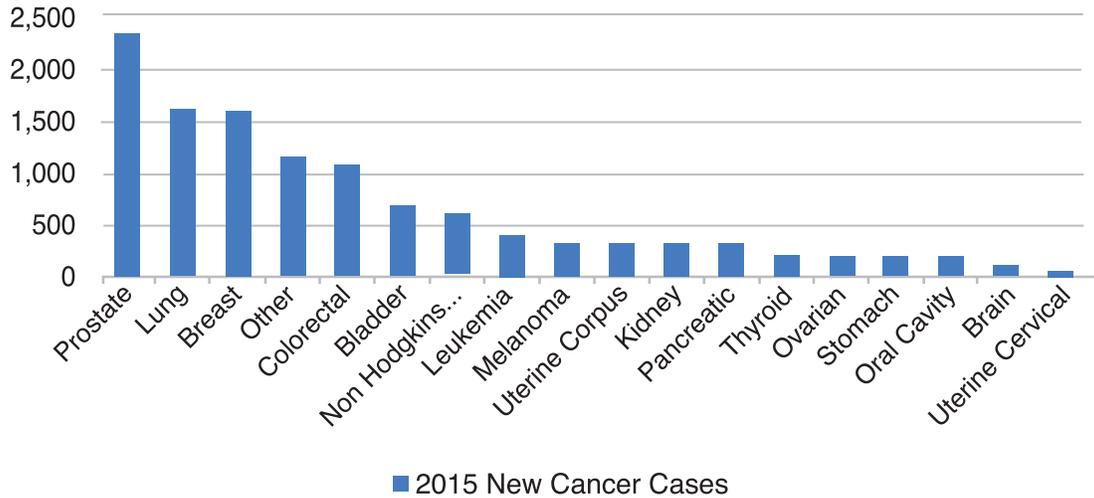


Source: Truven Health Analytics, 2016

BEAUMONT HOSPITAL, ROYAL OAK

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

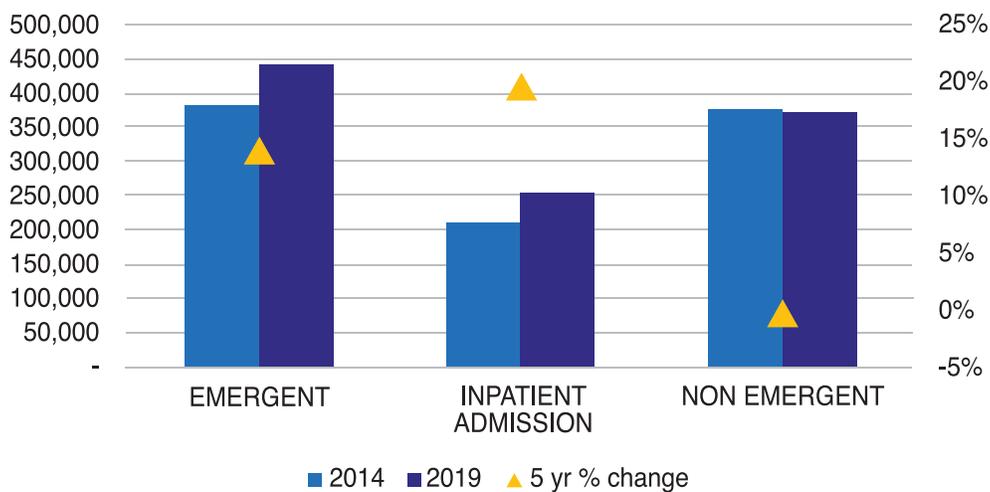
2015 Estimated New Cancer Cases



Source: Truven Health Analytics, 2016

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

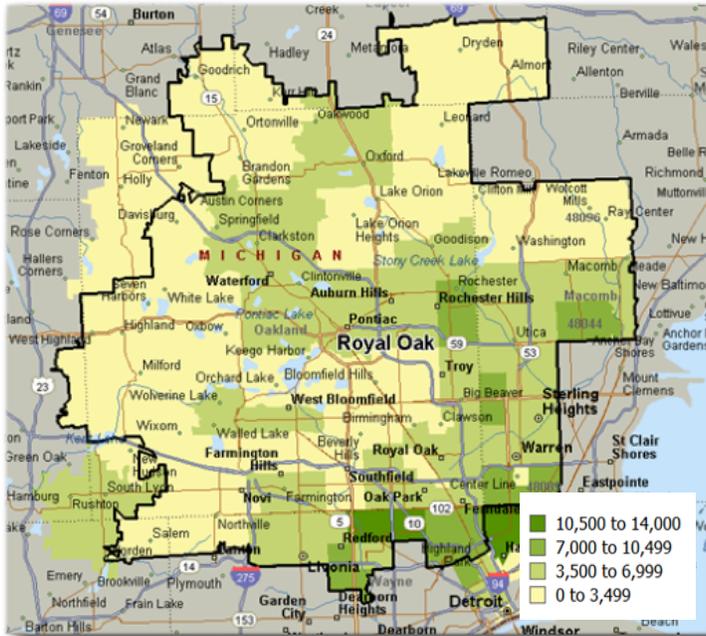
Emergent and Non-Emergent ED Visits



Source: Truven Health Analytics, 2016

BEAUMONT HOSPITAL, ROYAL OAK

2014 Estimated Non-Emergent Visits by ZIP Code



Source: Truven Health Analytics, 2016

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

Community input

A summary of the focus group conducted for the Beaumont, Royal Oak community can be found in **Appendix I** of the **CHNA Full Report** located at beaumont.org/chna.

CHNA IMPLEMENTATION STRATEGY

2018 Update

Beaumont Hospital, Royal Oak

OBESITY

GOAL: Decrease rate of obesity in children and adults by promoting healthy eating and active living behaviors.

STRATEGY 1: Provide education and services that support healthy eating, active living and maintaining a healthy weight.

PROGRAM/ACTIVITY	DESCRIPTION	ANTICIPATED IMPACT	TARGET AUDIENCE	HOW RESULTS WILL BE MEASURED	PARTNERS
Provide kids cooking classes	Hands-on classes led by a registered dietitian in a demonstration kitchen.	Improved knowledge of nutrition practices and healthy meal preparation	children 6 years and older	<ul style="list-style-type: none"> • participation rates • participant survey 	
Provide kids gardening and cooking classes	Hands-on classes led by registered dietitians and gardening enthusiasts. Each child will plant microgreens and herbs from seed. After planting, everyone will move into the kitchen to prepare pizza and salad using fresh greens and herbs.	Improved nutrition practices, eating habits and healthy meal preparation knowledge and behaviors	children 6 years and older	<ul style="list-style-type: none"> • participation rates 	
Provide Cooking Matters™ program	Six-week workshops and single-session store tours for adults and teens to equip families with the knowledge and skills they need to shop for and prepare healthy meals on a limited budget. Hosted at libraries, senior centers and community organizations.	Improved nutrition practices, eating habits, healthy meal preparation and food budgeting knowledge and behaviors	economically disadvantaged populations	<ul style="list-style-type: none"> • participation rates • post-test outcome measures such as use of nutrition facts on food labels, adjusting meals to be more healthy, choosing healthy foods at restaurants • participant survey 	Gleaners Community Food Bank of SE Michigan
Provide grocery store tours	One-time workshop available to all community members to learn how to successfully navigate the grocery store to make healthy, affordable choices.	Improved comprehension of nutrition labels and making the healthiest, most affordable choices	adults	<ul style="list-style-type: none"> • participation rates/volume 	
Explore strategies to increase access to fresh fruits and vegetables	Explore support of the Farmer's Market, the Power of Produce program and the Prescription for Health program.	Reduction in food insecurity and increase in fruit and vegetable consumption	community-wide: focusing on economically disadvantaged populations	<ul style="list-style-type: none"> • partnership agreements • number of participants 	
Provide education on healthy eating, fitness and weight management through the Beaumont Speakers Bureau	Education presentations to community groups.	Improved knowledge of obesity prevention and treatment options	community organizations	<ul style="list-style-type: none"> • participation rates • participant survey 	

CHNA IMPLEMENTATION STRATEGY

2018 Update

OBESITY

STRATEGY 2: Increase opportunities for physical activity.

PROGRAM/ACTIVITY	DESCRIPTION	ANTICIPATED IMPACT	TARGET AUDIENCE	HOW RESULTS WILL BE MEASURED	PARTNERS
Host Bike Day for children with special needs	Event providing free, custom and adaptive bikes for special needs children.	Increased physical activity of children with special needs	children with special needs	<ul style="list-style-type: none"> participation rates, participation ages and participation diagnoses 	
Provide the Walk with a Doc program	Physicians conduct health promotion presentations and lead community walks at local parks.	Increased physical activity	community -wide	<ul style="list-style-type: none"> partnership agreement participation rates 	City of Royal Oak, City of Berkley
Provide Beaumont Gets Walking programs	Walking programs to increase physical activity as well as social interaction among neighbors and community members.	Increased physical activity and increased social interaction among neighbors and community members	community -wide	<ul style="list-style-type: none"> participation rates walking log metrics 	City of Royal Oak, Oakland Mall
Provide the Enhance Fitness program	A low-cost, evidence-based group exercise program that helps older adults, at all levels of fitness and socioeconomic status, become more active, energized and empowered to sustain independent lives.	Improved physical activity practices	adults and seniors	<ul style="list-style-type: none"> participation rates fitness test – baseline, two to three weeks, four months participant survey 	

CARDIOVASCULAR DISEASE

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

STRATEGY 1: Provide education programs and services.

PROGRAM/ACTIVITY	DESCRIPTION	ANTICIPATED IMPACT	TARGET AUDIENCE	HOW RESULTS WILL BE MEASURED	PARTNERS
Provide Food for the Heart Part I and II classes	Classes to lower cholesterol or triglycerides, lower blood pressure, better manage diabetes or lose weight.	Improved nutrition practices, eating habits and healthy meal preparation knowledge and behaviors	adults	<ul style="list-style-type: none"> participation rates 	
Offer the Beaumont Quit Smoking program	Seven-week program led by a tobacco treatment specialist.	Reduction in smoking, a risk factor for cardiovascular disease	smokers	<ul style="list-style-type: none"> participation rates respiratory therapy staff follow-up at one-month, six-months and 12-months 	
Provide mindfulness classes	Meditation, yoga, mindful eating and mindful communication classes to help alleviate anxiety, depression, stress, chronic pain and other various conditions to cultivate a happy and healthy life.	Reduction in stress, a risk factor for cardiovascular disease and improved eating behaviors that positively impact obesity and diabetes, risk factors for cardiovascular disease	community-wide	<ul style="list-style-type: none"> perceived stress scale qualitative measures 	

CHNA IMPLEMENTATION STRATEGY

2018 Update

CARDIOVASCULAR DISEASE - *continued*

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

STRATEGY 1: Provide education programs and services.

PROGRAM/ACTIVITY	DESCRIPTION	ANTICIPATED IMPACT	TARGET AUDIENCE	HOW RESULTS WILL BE MEASURED	PARTNERS
Offer the WELL Program (Women Exercising to Live Longer)	Six-month exercise and risk reduction program to help women reduce their likelihood of developing heart disease and prevent future cardiac events.	Reduction of risk factors such as elevated blood cholesterol, hypertension, sedentary lifestyle and obesity	women with one or more cardiovascular risk factors	<ul style="list-style-type: none"> risk factor assessment participation in individualized exercise programs and monthly education and support groups 	
Provide the Guiding Hearts Support Group	Monthly support group open to the community to offer education about cardiovascular health and provide support to patients, families and community members dealing with heart health issues.	Support for patients, families and community members dealing with heart health issues and increased awareness about heart disease	any community member interested in cardiovascular health and heart patients	<ul style="list-style-type: none"> participation rates 	
Provide education on cardiovascular health through the Beaumont Speakers Bureau	Education presentations to community groups.	Improved knowledge of cardiovascular disease prevention and treatment options	community organizations	<ul style="list-style-type: none"> participation rates participant survey 	

STRATEGY 2: Provide early detection screenings

Provide blood pressure screenings	Conduct blood pressure screenings at community events to identify and counsel individuals with high blood pressure and other risk factors for cardiovascular disease.	Improved self-management and follow-up care	adults	<ul style="list-style-type: none"> participation rates 	
Implement the Student Heart Check program	High school student heart checks to detect abnormal heart structure or abnormal rhythms.	Prevent sudden cardiac arrest	youth ages 13-18	<ul style="list-style-type: none"> participation rates test results 	school systems
Offer the 7 for \$70 Heart and Vascular Screening	Blood tests, EKG and artery testing to identify risk factors and recommend a course of action.	Improved heart and vascular health	adults	<ul style="list-style-type: none"> participation rates 	

CHNA IMPLEMENTATION STRATEGY

2018 Update

DIABETES

GOAL: Decrease rate of new diabetes cases and of diabetes complications.

STRATEGY 1: Provide early detection screenings, diabetes prevention programs and diabetes education services.

PROGRAM/ACTIVITY	DESCRIPTION	ANTICIPATED IMPACT	TARGET AUDIENCE	HOW RESULTS WILL BE MEASURED	PARTNERS
Provide Diabetes Support Group	Quarterly sessions providing support to those with diabetes and their caregivers.	Improved diabetes self-management	adults with diabetes	<ul style="list-style-type: none"> • participation rates/volume 	
Provide Diabetes PATH (Personal Action Toward Health) workshops	Six-week chronic disease management class hosted in collaboration with libraries, senior centers and community organizations.	Improved diabetes self-management	adults and seniors with diabetes and their caregivers	<ul style="list-style-type: none"> • participation rates • post-test outcome measures such as blood sugar testing, physical activity, confidence managing condition • participant survey 	National Kidney Foundation of Michigan The Senior Alliance Area Agency on Aging 1-B
Provide National Diabetes Prevention Program	12-month lifestyle change program with group coaching hosted in collaboration with libraries, schools and community centers.	Prevention of Type 2 diabetes	adults with prediabetes or at high risk for diabetes	<ul style="list-style-type: none"> • participation rates • increase in physical activity • average weight loss • participant survey 	
Provide Cooking Matters™ EXTRA for Diabetes program	Six-week workshops to equip families with the knowledge and skills they need to shop for and prepare healthy meals on a limited budget. Hosted at libraries, senior centers and community organizations.	Improved nutrition practices, eating habits, healthy meal preparation and food budgeting knowledge and behaviors	adults with diabetes or prediabetes	<ul style="list-style-type: none"> • participation rates • post-test outcome measures such as use of nutrition facts on food labels, adjusting meals to be more healthy and choosing healthy foods at restaurants • participant survey 	Gleaners Community Food Bank of SE Michigan
Provide health education on diabetes through the Beaumont Speakers Bureau	Education presentations to community groups.	Improved knowledge of diabetes prevention and treatment options	community organizations	<ul style="list-style-type: none"> • participation rates • participant survey 	