

**Community Health Needs Assessment 2019
Implementation Strategy
Fiscal Years 2019-2021**



HENRY FORD HOSPITAL

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Henry Ford Hospital Executive Summary

Henry Ford Hospital completed a comprehensive Community Health Needs Assessment (CHNA) that was adopted by the Henry Ford Health System (HFHS) Board of Directors in December 2019. Henry Ford Hospital performed the CHNA in adherence with certain federal requirements for not-for-profit hospitals set forth in the Affordable Care Act and by the Internal Revenue Service. The assessment took into account input from community representatives, community members, and various community organizations.

Health Needs of the Community

The Henry Ford Health System community has been identified as the City of Detroit and Wayne, Oakland, Macomb, and Jackson counties. The CHNA process identified significant health needs for this community, with two priorities designated to be addressed system-wide. Health needs were prioritized based on several criteria including the importance given to particular health issues by survey and focus group participants, statistical data from the State of Michigan, as well as input from HFHS and community leaders. Henry Ford Hospital's resources and overall alignment with the Henry Ford Health System mission, vision, goals, and strategic priorities were taken into consideration when identifying the top two most significant health issues to be addressed. The following first two health priorities were chosen for the entire Henry Ford Health System, and the third priority was chosen specifically for Henry Ford Hospital and its unique community needs.

- 1. Healthy Lifestyles and Diabetes Prevention**
- 2. Mental Health and Substance Use Disorder**
- 3. Infant Mortality**

Henry Ford Health System works to leverage its resources, partnerships, and market share across the counties it serves to make large-scale community impact. An important factor in the success of Henry Ford's ability to make this large-scale impact is the individual contributions of each hospital within the System. It is our goal through these Implementation Plans to push each hospital to set ambitious goals that will improve our communities' outcomes and access to resources, while coalescing each hospital around aligned System-wide strategies and metrics.

Hospital Implementation Strategy

Henry Ford Hospital will focus on developing and supporting initiatives and measuring their effectiveness to improve the aforementioned health needs. The following implementation strategy specifies community health needs that the Hospital/Health System has determined it will address, in partnership with other agencies and organizations, consistent with our mission and vision, to become the trusted partner in health for our communities. The Hospital reserves the right to amend this implementation strategy as circumstances warrant.

Henry Ford Health System and Henry Ford Hospital acknowledges the numerous and wide range of health needs that exist in our communities served, and we acknowledge that there are certain health needs identified in the CHNA that were not chosen as priorities. We have

determined that our implementation plans are only able to effectively address the most pressing needs identified by our stakeholders and in relevant data. The selected priorities were analyzed through the lens of social determinants of health and health equity, as well as health system resources, and represent the key health issues which are under-addressed with the most compelling data. While Henry Ford Health System and Henry Ford Hospital provides supportive clinical services in these areas, they will not be included as areas of primary community activity as it relates to the Implementation Plans.

- Kidney Disease
- Family Planning
- Asthma
- Alzheimer's Disease

CHNA IMPLEMENTATION STRATEGY

Fiscal Years 2019-2021

Hospital Facility: Henry Ford Hospital

CHNA Significant Health Need: Healthy Lifestyles and Diabetes Prevention

CHNA Reference Pages: 33-34, 37-38

Brief Description of Need:

Lifestyle factors such as alcohol and drug use, smoking cigarettes, lack of physical activity, poor nutrition, and obesity are known to greatly impact onset of disease and chronic illness. Preventive practices such as regular health screenings, physicals, and dental care are known to positively impact these health outcomes. These lifestyle factors and people’s ability to partake in preventative health practices are greatly dependent on the social determinants of health. Social determinants of health are the conditions in which people are born, grow, live, work and age. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels. Examples of social determinants of health include access to housing, food, education, transportation, and more. As income and education increase, the practice of risky behaviors often decreases. In Detroit, 34.7% of residents do not get any physical activity in their leisure time, compared to 24.9% in Michigan as a whole, and 37.2% of Detroit residents are obese, compared to a state average of 31.4%. Lifestyle factors can also contribute to the onset of diabetes. In Detroit, 13.1% of residents have ever been told they have diabetes compared to a state average of 10.8%. The Diabetes death rate in Detroit is 27.6, the 6th leading cause of death in the city. Diabetes accounts for many preventable hospitalizations in Detroit – it is the third leading cause of preventable hospitalizations in the city, compared to the fourth-leading cause in the state of Michigan. Certain behaviors such as lack of physical activity, poor nutrition, tobacco use, and not seeking appropriate preventive care can result in developing chronic disease and illness. In Detroit, 27.5% of residents report their general health as fair or poor compared to 17.5% in the state of Michigan. The social determinants of health can pose barriers to good health for all types of people. Across all races, ethnicities, genders, and geographic locations, people face struggles due to their social conditions. Often, people of color face significant struggles due to the social determinants of health as a result of the unequal distribution of power and resources across populations. Addressing both the social determinants of health and racial inequities are vital to improving the health of communities. We know that minority populations often experience more barriers to healthy lifestyles and as a result, see worse health outcomes and decreased preventive

health behaviors. The City of Detroit's residents are predominately black, and any effort to improve the health of the people of Detroit must also be an effort to improve the social determinants of health at play in its residents' lives. At Henry Ford Hospital, work is being done to build the infrastructure to stratify patient and health outcomes data by demographic characteristics, to better understand and address the barriers vulnerable populations face to achieving optimal health.

Goal:

Improve the overall health and wellbeing of the populations we serve by enhancing their ability to overcome barriers to healthy lifestyles, reducing health risk behaviors and preventing diabetes.

Project Objectives:

1. Improve health status of population served
2. Reduce % of population served with BMI > 30
3. Improve % of population served with pre-diabetes who are referred for (received) appropriate support

Strategies to Accomplish Goal:

Activity to Accomplish	Time Frame
1. Implement Diabetes Prevention Program (DPP)	2020-2022
2. Implement programs to improve nutrition and access to fresh produce for SNAP-eligible and other vulnerable populations	2020-2022
3. Develop and implement social needs screening and referrals	2020-2022
4. Leverage Henry Ford Health System's investments as an anchor institution to address Social Determinants of Health (SDOH) needs in our communities	2020-2022
5. Develop inventory of trauma-informed practices and resiliency/resources to address risk and ACES (Adverse Childhood Events)	2020-2022

SMART Evaluation Metrics:

Metric		Target	
		Measure	Date
1	30% of DPP participants completing program achieve 5-7% weight loss annually	30% achieving weight loss of 5-7%	1/1/2021
2	Provide at least 24 educational sessions to SNAP-eligible participants annually	24 SNAP educational sessions	1/1/2021
3	Increase screening volume for social needs (food insecurity, housing, financial assistance, etc) by 5% in HFHS clinics/settings annually	5% increase over baseline	1/1/2021
4	Invest 1% of HFHS investment portfolio in place-based SDOH priorities by 2022	1% invested	By 2022
5	Develop 1 inventory focused on trauma-informed approaches to wellness	1 inventory	By 2022

Programs and Resources Needed

- Coordination of Diabetes Prevention Program
- Learning About Nutrition through Activities (LANA) – early childhood 8 session curriculum
- Healthy Schools Healthy Communities six session curriculum in elementary schools
- Linking Lessons five sessions in middle and high schools
- Student Action Teams in middle and high schools
- Youth Wellness Ambassadors leading policy, systems and environmental change strategies
- Cooking Matters for Adults, Teens, Families and Parents, and Cooking Matters at the Store Tours
- Eat Smart Live Strong for seniors
- Fresh Prescription – six sessions and \$15 card loads each time
- Farmers Market Education for 16 weeks

Collaborative Partners (Names and Organizations):

- U.S. Department of Agriculture (USDA) through State of Michigan and the Michigan Fitness Foundation
- Eastern Market Corporation
- CHASS Center
- Samaritan Center
- American Indian Health and Family Services
- Joy-Southfield Community Development Corporation
- Authority Health
- Wayne State
- Detroit Health Department
- Gleaners Community Foodbank of Southeast Michigan
- Healthy Kids, Healthy Michigan
- National Kidney Foundation of Michigan
- Peaches and Greens
- Greater Detroit Area Health Council

CHNA IMPLEMENTATION STRATEGY Fiscal Years 2019-2021
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Hospital Facility: Henry Ford Hospital

CHNA Significant Health Need: Mental Health and Substance Use Disorder

CHNA Reference Pages: 33-35

Brief Description of Need:

Since the last Community Health Needs Assessment was conducted in 2016, the prevalence of self-reported poor mental health status has increased in every community that Henry Ford Health System serves. In Detroit, the prevalence of poor mental health is now 18.5%, compared to 16.2% throughout the entire state of Michigan. Amongst surveyed community stakeholders in Detroit, mental health was ranked amongst the top three most pressing health needs of the community. Detroit’s suicide death rate is 8.9 per 100,000. Overdose deaths from all drugs and opioids in particular continue to burden our communities. In 2017, Wayne County saw an all-drug overdose death rate of 42.71 per 100,000 and an opioid overdose death rate of 36.27 per 100,000. From 2016 to 2017, the age-adjusted rate of drug overdose deaths increased 11.9% in Wayne County. Amongst the ten leading causes of death in Michigan and Detroit, drug overdose deaths are categorized as “unintentional injuries,” a category which is the third leading cause of death in Detroit, with a death rate of 72.1 per 100,000, compared to a rate of 50.8 in Michigan as a whole. We know that minority populations often experience barriers to healthcare access and healthy lifestyle behaviors and as a result can have unique challenges to achieving good mental health. At Henry Ford Hospital, work is being done to build the infrastructure to stratify patient and health outcomes data by demographic characteristics, to better understand and address the barriers vulnerable populations face to achieving optimal mental health.

Goal:

Improve the mental health status of at-risk populations in the community and prevent substance use disorder.

Project Objectives:

1. Reduce opioid prescribing by HFHS providers
2. Improve access to behavioral health services in HFHS service area
3. Prevent opioid overdose deaths in populations served

Strategies to Accomplish Goal:

Activity to Accomplish	Time Frame
1. Implement alternative to opioid prescribing guidelines	2020-2022
2. Expand delivery of Medication Assisted Treatment (MAT) in Primary Care Provider (PCP) sites	2020-2022
3. Increase accessibility and use of Narcan to save lives and reverse overdoses related to opioid abuse in partnership with community collaboratives	2020-2022
4. Improve access to Behavioral Health (BH) services by integrating behavioral health services within primary care and transitioning stable BH patients back to primary care	2020-2022

SMART Evaluation Metrics:

Metric		Target	
		Measure	Date
1	Reduce opioid pills/patches and Milligram Morphine Equivalent (MMEs) prescribed by 20%, annually	20% decrease from baseline	1/1/2021
	Decrease # of chronic opioid patients (taking opioid daily) by 20%	20% decrease from baseline	1/1/2021
2	Increase percentage of patients with access to MAT by 10%	10% increase from baseline	1/1/2021
3	Increase percentage of Narcan resource distribution by 5% annually	5% increase over baseline	1/1/2021
4	Increase % patients with access to BH services within 7 days by 5%	5% increase over baseline	1/1/2021

Programs and Resources Needed:

- HFHS collaboration with primary care, emergency department, pain medicine and addiction medicine.
- Enhance telemedicine capabilities to ensure access of care to patients and families
- Educational sessions for HFHS staff and employees as to the risk of opiate use and alternatives for chronic non-cancerous pain
- Development of web-based materials for tracking opiate use and alternatives of care.

Collaborative Partners (Names and Organizations):

- Regional Community Mental Health agencies
- HFHS Volunteer Services
- Judge Linda Davis and Dr. Anthony Colucci
- Maplegrove Community Education
- Law enforcement groups as identified

<p style="text-align: center;">CHNA IMPLEMENTATION STRATEGY Fiscal Years 2019-2021</p>
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Hospital Facility: Henry Ford Hospital

CHNA Significant Health Need: Infant Mortality

CHNA Reference Pages: 32

Brief Description of Need:

Infant mortality is defined as the death of an infant before their first birthday. Across Michigan, the infant mortality rate for all infants is 6.7 per 1,000 live births. In Detroit, the infant mortality rate for all infants is 13.6 per 1,000 live births, however great disparities between infant mortality rates of black and white infants exist. For white infants in Detroit, the infant mortality rate is 9.2, compared to a rate of 14.5 for black infants in Detroit. The infant mortality rate for black infants in Detroit is 57% higher than the rate for white infants in Detroit, and over two times the infant mortality rate for infants across Michigan. Since the last CHNA cycle, the infant mortality rate in Detroit has seen no meaningful change.

Goal:

Coordinate and support efforts that create opportunities to reduce the leading causes of infant mortality and reduce disparities, including preterm birth and low birth weight deliveries.

Project Objectives:

1. Improve prenatal care adequacy rates
2. Reduce preterm and low birthweight births among populations served

Strategies to Accomplish Goal:

Activity to Accomplish	Time Frame
1. WIN Network: Detroit's group prenatal care (GPC) program aims to reduce infant mortality and improve birth outcomes.	2020-2022
2. Implement social needs screening and referrals	2020-2022
3. Improve equity in care by implementing Trauma-Informed and/or Implicit/Unconscious Bias Training within Women's Health/OB teams	2020-2022
4. Provide follow-up services and referrals to resources for Medicaid preterm or low birthweight births at Henry Ford Hospital	2020-2022

SMART Evaluation Metrics:

Metric		Target	
		Measure	Date
1	Reach at least 250 GPC patients at Henry Ford Medical Center New Center One and Henry Ford Medical Center Ford Road Amongst GPC patients, maintain a preterm birth rate that is 20% lower than that of the City of Detroit (14.6 in 2018)	250 patients reached Preterm birth rate 11.68	1/1/2021
2	Increase screening volume for social needs (food insecurity, housing, financial assistance, etc) by 5% in HFHS clinics/settings annually	5% increase from baseline	1/1/2021
3	Train at least 75% OB/Women’s Health team members Increase % of patients reporting their provider treated them with respect (Consumer Assessment of Healthcare Providers and Systems (CAHPS)) by 5%	75% of team trained 5% increase over baseline	1/1/2021
4	Provide follow-up service and referrals for at least 50% of Medicaid infants born preterm or low birthweight that deliver at Henry Ford Hospital	Successful resource referrals for at least 50% of targeted patients	Start by 10/1/2020

Programs and Resources Needed:

- Space to hold group prenatal care
- Community Health Workers and group prenatal care supplies
- Communication and referral processes for local providers
- Processes to expand SDOH screening to Obstetric patients
- Sustainable funding models and demonstration of value proposition to stakeholders such as Medicaid Health Plans
- Leadership support for training Women's Health Services staff members on unconscious bias
- Unconscious bias training materials including binders, printed materials

Collaborative Partners (Names and Organizations):

- Detroit Regional Infant Mortality Reduction Task Force partners
- Centering Healthcare Institute
- Black Mothers' Breastfeeding Association
- Detroit Health Department
- Maternal Infant Health Programs
- Gleaners
- Institute for Population Health
- Wayne State University
- Michigan Public Health Institute
- Michigan Department of Health and Human Services

ADOPTION OF IMPLEMENTATION STRATEGIES

Approved by the Henry Ford Hospital Board of Trustees on March 31, 2020.

The final, approved versions of the 2019 Community Health Needs Assessment and the 2019-2021 Implementation Strategies are available electronically at www.henryford.com/about/community-health.

Printed copies are also available in the Henry Ford Health System Corporate Offices, located at One Ford Place, Detroit, MI 48202.

To submit written comments on the CHNA or to obtain a printed copy of the report, contact Henry Ford Health System at communityevents@hfhs.org.