Community Health Needs Assessment

Implementation Strategy 2023-2025

HENRY FORD HEALTH℠

The following Implementation Plans were approved by the Henry Ford Health Board of Directors on May 19th, 2023

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Henry Ford Detroit Hospital

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Henry Ford Detroit Hospital
Executive Summary

Henry Ford Detroit Hospital completed a comprehensive Community Health Needs Assessment (CHNA) that was adopted by the Henry Ford Health (HFH) Board of Directors in December 2022. Henry Ford Detroit 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 considered input from community members and various community organizations.

Health Needs of the Community

The Henry Ford Health 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 enterprise-wide. Health needs were prioritized based on several criteria including the importance given to particular health issues by survey participants, statistical data from the State of Michigan and other sources, as well as input from HFH leaders. Henry Ford Detroit Hospital's resources and overall alignment with the Henry Ford Health 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 enterprise, and the third priority was chosen specifically for Henry Ford Detroit Hospital and its unique community needs.

1. **Chronic Disease Prevention and Management**
2. **Behavioral Health and Substance Use Disorder**
3. **Infant Mortality**

Henry Ford Health 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 enterprise. 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 enterprise-wide strategies and metrics.

Hospital Implementation Strategy

Henry Ford Detroit Hospital will focus on developing and supporting initiatives and measuring their effectiveness to improve the aforementioned health priorities. 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.

CHNA IMPLEMENTATION STRATEGY
2023-2025

Hospital Facility:	Henry Ford Detroit Hospital
CHNA Significant Health Need:	Chronic Disease Prevention and Management
CHNA Reference Pages:	31-37, 46-56, 59-69

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, 32.7% of residents do not get any physical activity in their leisure time, compared to 23.3% in Michigan as a whole, and 39.9% of Detroit residents are obese, compared to a state average of 34.7%. Lifestyle factors can also contribute to the onset of diabetes. In Detroit, 13% of residents have ever been told they have diabetes compared to a state average of 11.7%. The Diabetes death rate in Detroit is 38.3, the 8th leading cause of death in the city. Diabetes accounts for many preventable hospitalizations in Detroit – it is the leading cause of preventable hospitalizations in the city and 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, 27.9% of residents report their general health as fair or poor compared to 17.9% 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:

Prevent the incidence of highly prevalent chronic diseases and increase community members' capacity to manage chronic disease, while addressing the socio-economic conditions which contribute to chronic diseases and behaviors that cause them.

Project Objectives:

1. Improve health status of population served
2. Reduce Disparities in A1C and Blood Pressure Control among African American patients
3. Increase % of social needs screenings with 'closed loop' referrals

Strategies to Accomplish Goal:

Activity to Accomplish
1. Evaluate and identify improvement opportunities to ensure Diabetes Self-Management Education and Support (DSMES) programs are achieving equity in access and outcomes for communities of color.
2. Continue to enhance programming and evaluate and identify improvement opportunities to ensure Diabetes Prevention (DPP) Programs are achieving equity in access and outcomes for communities of color.
3. Engage provider organizations in systematic clinical improvements to reduce racial disparities in hypertension and/or diabetes control.
4. Henry Ford Health will partner with community organizations via a community information exchange (CIE) to close 50% of the social needs gaps identified (referrals made) within populations screened by 2025.
5. By 2025, Henry Ford Health will invest $15 million through intermediaries into projects that positively impact social determinants of health (SDOH) across the markets we serve. Investments will yield returns that may be below general market expectations, but sufficient to replenish funding for future rounds of investment.

SMART Evaluation Metrics:

	Metric	Accountable Council/Leader	Target	
			Measure	Date
1	Increase DSME engagements – initial assessments that result from total referrals – by 5% annually.	Population Health Management/P. Milan	5% increase over 2022 baseline	12/31/23
	Increase volume of Black participants completing DSME by 5% annually.		5% increase over 2022 baseline	12/31/23
2	Achieve either 5% increase annually OR reach 40% of participants that **complete** DPP achieve one or both of the following two outcomes: 1. at least 5% weight loss 2. at least 4% weight loss and at least 150 minutes/week on average of physical activity	B. Blum-Alexander	5% increase over baseline or reach 40%	12/31/23
	Increase completion rates among Black DPP participants 10% by 2025.		10% increase over baseline	12/31/25
3	Complete at least 1 activity annually directed at identifying, tracking, communicating, educating or otherwise engaging providers to reduce racial disparities in HTN and/or HA1c control.	PEPC, Primary Health	1 activity	12/31/23
4	Achieve 30% 'closure rate' for SDOH referrals in 2023; 40% in 2024 and 50% by 2025.	High Performing Network Council/K. Wisdom & A. Schultz	30% closure rate	12/31/23
5	$15 million invested by 2025.	CHANCE/R. Damschroder	$15 million	12/31/2025

CHNA IMPLEMENTATION STRATEGY
2023-2025

Hospital Facility:	Henry Ford Detroit Hospital
CHNA Significant Health Need:	Behavioral Health and Substance Use Disorder
CHNA Reference Pages:	56-57, 59-66

Brief Description of Need:

Since the last Community Health Needs Assessment was conducted in 2019, the prevalence of self-reported poor mental health status has improved in every community that Henry Ford Health serves except Wayne County (not including the City of Detroit). In Detroit, the prevalence of poor mental health is now 17.8%, compared to 15.4% 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. Overdose deaths from all drugs and opioids continue to burden our communities. In 2020, Wayne County saw an all-drug overdose death rate of 45.62 per 100,000 and an opioid overdose death rate of 40.22 per 100,000. Wayne County was the only County in the four-county area where opioid drug overdoses increased less than state average. Amongst the ten leading causes of death in Michigan and Detroit, drug overdose deaths are categorized as “unintentional injuries,” a category which is the fourth leading cause of death in Detroit, with a death rate of 103.4 per 100,000, compared to a rate of 56.2 in Michigan as a whole. The unintentional injury death rate increased significantly in Detroit by 43.4%. 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 behavioral health access and adapt services to improve mental health and reduce substance use disorder.

Project Objectives:

1. Improve health status of Behavioral Health patients
2. Reduce Behavioral Health readmissions
3. Prevent opioid overdose deaths in populations served

Strategies to Accomplish Goal:

Activity to Accomplish
1. Provide depression screening for all those seeking psychiatric care.
2. Patients suffering from Opiate Use Disorder (OUD), not in remission, will be prescribed Naloxone as a safety measure to prevent morbidity and mortality.
3. Improve access in our psychiatric specialty clinics and in our Collaborative Care model for adult patients.

SMART Evaluation Metrics:

	Metric	**Accountable Council/Leader**	**Target**	
			Measure	**Date**
1	90% of patients seen in BHS will have depression screening as defined by the PHQ-9 annually.	Behavioral Health/C. Frank	90%	12/31/23
2	35% of non-cancerous patients receiving with an opioid prescription (>= 50 MME/day) with high-risk conditions prescribed Naloxone in the last 365 days	Pain Committee	35%	12/31/23
3	Specialty Clinics: 25% of patients seen within 10 days.	Behavioral Health/C. Frank	25%	12/31/23
	Adult Collaborative Care 42% of patients seen within 10 days and 4% same day	Behavioral Health/C. Frank	42%/4%	12/31/23

CHNA IMPLEMENTATION STRATEGY
2023-2025

Hospital Facility:	Henry Ford Detroit Hospital
CHNA Significant Health Need:	Infant Mortality
CHNA Reference Pages:	57-59

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 6.6 per 1,000 live births. In Detroit, the infant mortality rate for all infants is 14.1 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 5.3, compared to a rate of 15.8 for black infants in Detroit. The infant mortality rate for Black infants in Detroit is 3x the rate for white infants in Detroit, and 12% higher than the infant mortality rate for Black infants across Michigan. Since the 2019 CHNA, Detroit's Black infant mortality increased 9% while the white infant mortality rate decreased 42%, and for all races increased 3.7%.

Goal:

Support the clinical and community conditions necessary for positive birth outcomes and experiences and the lessening of racial infant mortality disparities.

Project Objectives:

1. Prevent infant deaths
2. Reduce disparities in infant mortality
3. Improve quality of perinatal care

Strategies to Accomplish Goal:

Activity to Accomplish
1. Improve prenatal and pediatric assessments of all patients by identifying and addressing SDOH and providing improved care navigation.
2. Expand Implicit bias education/training to all HFHS Obstetric, Pediatric/Neonatology nursing and providers (includes Reducing Unconscious Bias, and Imperative (RUBI) curriculum).
3. Ensure OBGYN patients are receiving respectful care.
4. Scale WIN Network: Detroit enhanced model of group prenatal care to additional sites.
5. Establish a model for providing follow-up services and referrals to resources for Medicaid preterm births at Henry Ford Hospital that can be disseminated across the region and ensure maternal-child team members are able to connect the impact of these services to the hospital's infant mortality rate.

SMART Evaluation Metrics:

	Metric	Accountable Leader	Target	
			Measure	Date
1	Increase SDOH screening volume in Women's Health and Pediatrics by 5% annually.	D. Pitts, G. Goyert, M. Condon	5% increase over baseline	12/31/23
2	Train at least 90% of Women's Health Services and Pediatrics team members by 2025.	K. Wisdom, D. Pitts, U. Shah	90%	12/31/25
3	Increase % of patients reporting their provider treated them with respect (Consumer Assessment of Healthcare Providers and Systems (CAHPS)) by 5% by 2025.	D. Pitts, U. Shah	5% increase over baseline	12/31/25
4	Scale WIN Network: Detroit enhanced group prenatal care to two additional sites, including one Federally Qualified Health Center, by 2025.	K. Wisdom	2 additional sites, including 1 FQHC	12/31/25
5	Provide follow-up service and referrals for at least 30% of Medicaid infants born preterm that deliver at Henry Ford Hospital and provide infrastructure for maternal-child team members to track hospital's infant mortality rate by 2025.	D. Pitts/K. Wisdom/U. Shah	30% of preterm Medicaid infants	12/31/25

ADOPTION OF IMPLEMENTATION STRATEGIES

Approved by the Henry Ford Detroit Hospital Board of Trustees on March 30, 2023.

The final, approved versions of the 2022 Community Health Needs Assessment and the 2023-2025 Implementation Strategies are available electronically at www.henryford.com/about/community-health.

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

Community Health Needs Assessment

Implementation Strategy 2023-2025

HENRY FORD HEALTH℠

Henry Ford Jackson Hospital

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Henry Ford Jackson Hospital
Executive Summary

Henry Ford Jackson Hospital completed a comprehensive Community Health Needs Assessment (CHNA) that was adopted by the Henry Ford Health (HFH) Board of Directors in December 2022. Henry Ford Jackson 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 considered input from community members and various community organizations.

Health Needs of the Community

The Henry Ford Health 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 enterprise-wide. Health needs were prioritized based on several criteria including the importance given to particular health issues by survey participants, statistical data from the State of Michigan and other sources, as well as input from HFH leaders. Henry Ford Jackson Hospital's resources and overall alignment with the Henry Ford Health 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 enterprise, and the third priority was chosen specifically for Henry Ford Jackson Hospital and its unique community needs.

1. **Chronic Disease Prevention and Management**
2. **Behavioral Health and Substance Use Disorder**
3. **Infant Mortality**

Henry Ford Health 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 enterprise. 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 enterprise-wide strategies and metrics.

Hospital Implementation Strategy

Henry Ford Jackson Hospital will focus on developing and supporting initiatives and measuring their effectiveness to improve the aforementioned health priorities. 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.

CHNA IMPLEMENTATION STRATEGY
2023-2025

Hospital Facility:	Henry Ford Jackson Hospital
CHNA Significant Health Need:	Chronic Disease Prevention and Management
CHNA Reference Pages:	31-37, 46-56, 59-69

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 Jackson County, 23.5% of residents do not get any physical activity in their leisure time, compared to 23.3% in Michigan as a whole, and 35.1% of Jackson County residents are obese, compared to a state average of 34.7%. This is a decrease from the 2019 CHNA. Lifestyle factors can also contribute to the onset of diabetes. In Jackson County, 12.2% of residents have ever been told they have diabetes compared to a state average of 11.7%, which is an improvement from 2019. The Diabetes death rate in Jackson County is 22.9, the 8th leading cause of death in the county and has remained stagnant. Diabetes accounts for many preventable hospitalizations in Jackson County – it is the leading cause of preventable hospitalizations in the County and 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 Jackson County, 17.8% of residents report their general health as fair or poor, and this figure has improved since 2019. 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 because 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. At Henry Ford Allegiance Health, 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:

Prevent the incidence of highly prevalent chronic diseases and increase community members' capacity to manage chronic disease, while addressing the socio-economic conditions which contribute to chronic diseases and behaviors that cause them.

Project Objectives:

1. Improve health status of population served
2. Reduce Disparities in A1C and Blood Pressure Control among African American patients
3. Increase % of social needs screenings with 'closed loop' referrals

Strategies to Accomplish Goal:

Activity to Accomplish
1. Evaluate and identify improvement opportunities to ensure Diabetes Self-Management Education and Support (DSMES) programs are achieving equity in access and outcomes for communities of color.
2. Continue to enhance programming and evaluate and identify improvement opportunities to ensure Diabetes Prevention (DPP) Programs are achieving equity in access and outcomes for communities of color.
3. Engage provider organizations in systematic clinical improvements to reduce racial disparities in hypertension and/or diabetes control.
4. Henry Ford Health will partner with community organizations via a community information exchange (CIE) to close 50% of the social needs gaps identified (referrals made) within populations screened by 2025.
5. By 2025, Henry Ford Health will invest $15 million through intermediaries into projects that positively impact social determinants of health (SDOH) across the markets we serve. Investments will yield returns that may be below general market expectations, but sufficient to replenish funding for future rounds of investment.

SMART Evaluation Metrics:

	Metric	Accountable Council/Leader	Target	
			Measure	Date
1	Increase DSME engagements – initial assessments that result from total referrals – by 5% annually.	Population Health Management/P. Milan	5% increase over 2022 baseline	12/31/23
	Increase volume of Black participants completing DSME by 5% annually.		5% increase over 2022 baseline	12/31/23
2	Achieve either 5% increase annually OR reach 40% of participants that **complete** DPP achieve one or both of the following two outcomes: 1. at least 5% weight loss 2. at least 4% weight loss and at least 150 minutes/week on average of physical activity	B. Blum-Alexander	5% increase over baseline or reach 40%	12/31/23
	Increase completion rates among Black DPP participants 10% by 2025.		10% increase over baseline	12/31/25
3	Complete at least 1 activity annually directed at identifying, tracking, communicating, educating or otherwise engaging providers to reduce racial disparities in HTN and/or HA1c control.	PEPC, Primary Health	1 activity	12/31/23
4	Achieve 30% 'closure rate' for SDOH referrals in 2023; 40% in 2024 and 50% by 2025.	High Performing Network Council/K. Wisdom & A. Schultz	30% closure rate	12/31/23
5	$15 million invested by 2025.	CHANCE/R. Damschroder	$15 million	12/31/2025

CHNA IMPLEMENTATION STRATEGY
2023-2025

Hospital Facility:	Henry Ford Jackson Hospital
CHNA Significant Health Need:	Behavioral Health and Substance Use Disorder
CHNA Reference Pages:	56-57, 59-66

Brief Description of Need:

Since the last Community Health Needs Assessment was conducted in 2019, the prevalence of self-reported poor mental health status has improved in the state of Michigan. In Jackson County, the prevalence of poor mental health is now 15.5%, compared to 15.4% throughout the entire state of Michigan. Jackson County's suicide death rate exceeds the Michigan state average, with a rate of 16.3 per 100,000, exceeding the state average of 14.0. Overdose deaths from all drugs and opioids continue to burden our communities. In 2020, Jackson County saw an all-drug overdose death rate of 11.47 per 100,000 and an opioid overdose death rate of 7.65 per 100,000. From 2019 to 2020, the age-adjusted rate of all drug overdose deaths increased 7% in Jackson County, and opioid overdose deaths increased 303%. Continued resources and attention must be focused on this issue to make a sustained impact. Amongst the ten leading causes of death in Michigan and Jackson County, drug overdose deaths are categorized as "unintentional injuries," a category which is the fourth leading cause of death in Michigan on average, with a death rate of 56.2 per 100,000. In Jackson County, the death rate for unintentional injuries is 33.2 per 100,000. 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 Allegiance Health, 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 behavioral health access and adapt services to improve mental health and reduce substance use disorder.

Project Objectives:

1. Improve health status of Behavioral Health patients
2. Reduce Behavioral Health readmissions
3. Prevent opioid overdose deaths in populations served

Strategies to Accomplish Goal:

Activity to Accomplish
1. Provide depression screening for all those seeking psychiatric care.
2. Patients suffering from Opiate Use Disorder (OUD), not in remission, will be prescribed Naloxone as a safety measure to prevent morbidity and mortality.
3. Improve access in our psychiatric specialty clinics and in our Collaborative Care model for adult patients.

SMART Evaluation Metrics:

	Metric	**Accountable Council/Leader**	**Target**	
			Measure	**Date**
1	90% of patients seen in BHS will have depression screening as defined by the PHQ-9 annually.	Behavioral Health/C. Frank	90%	12/31/23
2	35% of non-cancerous patients receiving with an opioid prescription (>= 50 MME/day) with high-risk conditions prescribed Naloxone in the last 365 days	Pain Committee	35%	12/31/23
3	Specialty Clinics: 25% of patients seen within 10 days.	Behavioral Health/C. Frank	25%	12/31/23
	Adult Collaborative Care 42% of patients seen within 10 days and 4% same day	Behavioral Health/C. Frank	42%/4%	12/31/23

CHNA IMPLEMENTATION STRATEGY
2023-2025

Hospital Facility:	Henry Ford Jackson Hospital
CHNA Significant Health Need:	Infant Mortality
CHNA Reference Pages:	57-59

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 6.6 per 1,000 live births. In Jackson County, the infant mortality rate for all infants is 5.3 per 1,000 live births, however great disparities between infant mortality rates of black and white infants exists. For white infants in Jackson County, the infant mortality rate is 3.5, compared to a rate of 16.3 for Black infants in Jackson County. The infant mortality rate for black infants in Jackson County is over 4x the rate for white infants in Jackson County, and 15% higher than the infant mortality rate for black infants across Michigan. Since the last CHNA cycle, the overall, white, and black infant mortality rate in Jackson County has improved. From 2018 to 2020, Black infant mortality decreased 19% in Jackson County. However, Black infant mortality remains higher than state average which is 14.1 per 1,000 live births. The Black-white infant mortality disparity in Jackson County is the highest disparity of the four-county area. The black infant mortality rate in Jackson County is the highest infant mortality rate in any region that Henry Ford Health System serves.

Goal:

Support the clinical and community conditions necessary for positive birth outcomes and experiences and the lessening of racial infant mortality disparities.

Project Objectives:

1. Prevent infant deaths
2. Reduce disparities in infant mortality
3. Improve quality of perinatal care

Strategies to Accomplish Goal:

Activity to Accomplish
1. Improve prenatal and pediatric assessments of all patients by identifying and addressing SDOH and providing improved care navigation.
2. Expand Implicit bias education/training to all HFHS Obstetric, Pediatric/Neonatology nursing and providers (includes Reducing Unconscious Bias, and Imperative (RUBI) curriculum).
3. Ensure OBGYN patients are receiving respectful care.
4. Scale WIN Network: Detroit enhanced model of group prenatal care to additional sites.

SMART Evaluation Metrics:

	Metric	Accountable Leader	Target	
			Measure	Date
1	Increase SDOH screening volume in Women's Health and Pediatrics by 5% annually.	D. Pitts, G. Goyert, M. Condon	5% increase over baseline	12/31/23
2	Train at least 90% of Women's Health Services and Pediatrics team members.	K. Wisdom, D. Pitts, U. Shah	90%	12/31/25
3	Increase % of patients reporting their provider treated them with respect (Consumer Assessment of Healthcare Providers and Systems (CAHPS)) by 5%.	D. Pitts, U. Shah	5% increase over baseline	12/31/25
4	Scale WIN Network: Detroit enhanced group prenatal care to two additional sites, including one Federally Qualified Health Center, by 2025.	K. Wisdom	2 additional sites, including 1 FQHC	12/31/25

ADOPTION OF IMPLEMENTATION STRATEGIES

Approved by the Henry Ford Jackson Hospital Board of Trustees on March 15, 2023.

The final, approved versions of the 2022 Community Health Needs Assessment and the 2023-2025 Implementation Strategies are available electronically at www.henryford.com/about/community-health.

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

Community Health Needs Assessment

Implementation Strategy 2023-2025

HENRY FORD HEALTH℠

Henry Ford Macomb Hospital

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Henry Ford Macomb Hospital
Executive Summary

Henry Ford Macomb Hospital completed a comprehensive Community Health Needs Assessment (CHNA) that was adopted by the Henry Ford Health (HFH) Board of Directors in December 2022. Henry Ford Macomb 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 considered input from community members and various community organizations.

Health Needs of the Community

The Henry Ford Health 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 enterprise-wide. Health needs were prioritized based on several criteria including the importance given to particular health issues by survey participants, statistical data from the State of Michigan and other sources, as well as input from HFH leaders. Henry Ford Macomb Hospital's resources and overall alignment with the Henry Ford Health 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 enterprise, and the third priority was chosen specifically for Henry Ford Macomb Hospital and its unique community needs.

1. **Chronic Disease Prevention and Management**
2. **Behavioral Health and Substance Use Disorder**
3. **Cancer**

Henry Ford Health 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 enterprise. 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 enterprise-wide strategies and metrics.

Hospital Implementation Strategy

Henry Ford Macomb Hospital will focus on developing and supporting initiatives and measuring their effectiveness to improve the aforementioned health priorities. 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.

CHNA IMPLEMENTATION STRATEGY
2023-2025

Hospital Facility:	Henry Ford Macomb Hospital
CHNA Significant Health Need:	Chronic Disease Prevention and Management
CHNA Reference Pages:	31-37, 46-56, 59-69

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 Macomb County, 24.2% of residents do not get any physical activity in their leisure time, compared to 23.3% in Michigan as a whole, and 32.7% of Macomb County residents are obese, compared to a state average of 34.7%. Lifestyle factors can also contribute to the onset of diabetes. In Macomb County, 12.6% of residents have ever been told they have diabetes compared to a state average of 11.7%. The Diabetes death rate in Macomb County is 32.7, the 8th leading cause of death in the county. In Macomb County, the prevalence of diabetes has increased and diabetes death rate has increased by 16.4%. Diabetes accounts for many preventable hospitalizations in Macomb County – it is the leading cause of preventable hospitalizations in the County and the entire 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 Macomb County, 17.2% of residents report their general health as fair or poor which is lower than the states estimated prevalence of 17.9%. 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. At Henry Ford Macomb 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:

Prevent the incidence of highly prevalent chronic diseases and increase community members' capacity to manage chronic disease, while addressing the socio-economic conditions which contribute to chronic diseases and behaviors that cause them.

Project Objectives:

1. Improve health status of population served
2. Reduce Disparities in A1C and Blood Pressure Control among African American patients
3. Increase % of social needs screenings with 'closed loop' referrals

Strategies to Accomplish Goal:

Activity to Accomplish
1. Evaluate and identify improvement opportunities to ensure Diabetes Self-Management Education and Support (DSMES) programs are achieving equity in access and outcomes for communities of color.
2. Continue to enhance programming and evaluate and identify improvement opportunities to ensure Diabetes Prevention (DPP) Programs are achieving equity in access and outcomes for communities of color.
3. Engage provider organizations in systematic clinical improvements to reduce racial disparities in hypertension and/or diabetes control.
4. Henry Ford Health will partner with community organizations via a community information exchange (CIE) to close 50% of the social needs gaps identified (referrals made) within populations screened by 2025.
5. By 2025, Henry Ford Health will invest $15 million through intermediaries into projects that positively impact social determinants of health (SDOH) across the markets we serve. Investments will yield returns that may be below general market expectations, but sufficient to replenish funding for future rounds of investment.

SMART Evaluation Metrics:

	Metric	Accountable Council/Leader	Target	
			Measure	Date
1	Increase DSME engagements – initial assessments that result from total referrals – by 5% annually.	Population Health Management/P. Milan	5% increase over 2022 baseline	12/31/23
	Increase DSME completion by Black participants (number of Black participants who complete the program) by 5% annually.		5% increase over 2022 baseline	12/31/23
2	Achieve either 5% increase above baseline in the following benchmarks annually OR reach 40% of participants that **complete** DPP achieve one or both of the following two outcomes annually: 1. at least 5% weight loss 2. at least 4% weight loss and at least 150 minutes/week on average of physical activity	B. Blum-Alexander	5% increase over baseline or reach 40%	12/31/23
	10% increase in Black DPP participants that **complete** the program by 2025		10% increase over baseline	12/31/25
3	At least 1 activity directed at identifying, tracking, communicating, educating or otherwise engaging providers to reduce racial disparities in HTN and/or HA1c control will be completed per year.	PEPC, Primary Health	1 activity	12/31/23
4	Achieve 30% 'closure rate' for SDOH referrals in 2023; 40% in 2024 and 50% by 2025.	High Performing Network Council/K. Wisdom & A. Schultz	30% closure rate	12/31/23
5	$15 million invested by 2025.	CHANCE/R. Damschroder	$15 million	12/31/2025

CHNA IMPLEMENTATION STRATEGY
2023-2025

Hospital Facility:	Henry Ford Macomb Hospital
CHNA Significant Health Need:	Behavioral Health and Substance Use Disorder
CHNA Reference Pages:	56-57, 59-66

Brief Description of Need:

Since the last Community Health Needs Assessment was conducted in 2019, the prevalence of self-reported poor mental health status has improved in every community that Henry Ford Health System serves except Wayne County. In Macomb County, the prevalence of poor mental health is now 15.2%, compared to 15.4% throughout the entire state of Michigan. Macomb County's suicide death rate is 12.6 per 100,000, which is lower compared to the state of Michigan's suicide death rate of 14.0. Overdose deaths from all drugs and opioids continue to burden our communities. In 2020, Macomb County saw an all-drug overdose death rate of 37.9 per 100,000 and an opioid overdose death rate of 30.89 per 100,000. The percent of drug overdose deaths caused by opioids in Macomb County is 81.5%, which is higher than the state of Michigan average of 79.2%. Macomb's opioid death rate is 41.8% higher than state average. The opioid and all drug overdose death rates in Macomb County are higher than the entire state of Michigan. From 2019 to 2020, the age-adjusted rate of drug overdose deaths increased 23.6% in Macomb County. Amongst the ten leading causes of death in Michigan and Macomb County, drug overdose deaths are categorized as "unintentional injuries," a category which is the fourth leading cause of death in Michigan on average, with a death rate of 56.2 per 100,000. In Macomb, this death rate is 57 per 100,000. 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 Macomb 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 behavioral health access and adapt services to improve mental health and reduce substance use disorder.

Project Objectives:

1. Improve health status of Behavioral Health patients
2. Reduce Behavioral Health readmissions
3. Prevent opioid overdose deaths in populations served

Strategies to Accomplish Goal:

Activity to Accomplish
1. Provide depression screening for all those seeking psychiatric care.
2. Patients suffering from Opiate Use Disorder (OUD), not in remission, will be prescribed Naloxone as a safety measure to prevent morbidity and mortality.
3. Improve access in our psychiatric specialty clinics and in our Collaborative Care model for adult patients.

SMART Evaluation Metrics:

	Metric	**Accountable Council/Leader**	**Target**	
			Measure	**Date**
1	90% of patients seen in BHS will have depression screening as defined by the PHQ-9 annually.	Behavioral Health/C. Frank	90%	12/31/23
2	35% of non-cancerous patients receiving with an opioid prescription (>= 50 MME/day) with high-risk conditions prescribed Naloxone in the last 365 days	Pain Committee	35%	12/31/23
3	Specialty Clinics: 25% of patients seen within 10 days.	Behavioral Health/C. Frank	25%	12/31/23
	Adult Collaborative Care goal is 42% within 10 days and 4% same day	Behavioral Health/C. Frank	42%/4%	12/31/23

CHNA IMPLEMENTATION STRATEGY
2023-2025

Hospital Facility:	Henry Ford Macomb Hospital
CHNA Significant Health Need:	Cancer
CHNA Reference Pages:	51-56, 64-67, 70

Brief Description of Need:

In Macomb County, the age-adjusted death rate from al invasive cancers in 2019 was 160.6, compared to the Michigan rate of 156.4. Cancer is the second-leading cause of death in Macomb County and in the state of Michigan. The age-adjusted death rates from invasive cancers including breast, colorectal, lung, and prostate are higher in Macomb County than in the state of Michigan. The percent estimated prevalence of the population in Macomb County who have had a breast cancer screening, cervical cancer screening, colorectal cancer screening, and prostate cancer screening are better than Michigan state averages, according to the Michigan Behavioral Risk Factor Survey 2018-2020. The breast cancer screening, cervical cancer screening, and colorectal cancer screening prevalence has improved in Macomb County since the 2019 CHNA. We know that minority populations often experience barriers to healthcare access and healthy lifestyle behaviors and as a result may be less likely to receive timely cancer screenings and experience poorer health outcomes that contribute to prevalence of cancer. At Henry Ford Macomb 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 equity in cancer screening and enrollment to treatment for prostate, breast, lung, and colorectal cancer types.

Project Objectives:

1. Increase cancer screening volume
2. Reduce disparities in Cancer Screening Rates
3. Increase survival rate/reduce cancer mortality rates

Strategies to Accomplish Goal:

Activity to Accomplish
1. Increase prostate cancer screening volume.
2. Increase breast cancer screening volume.
3. Increase lung cancer screening volume.
4. Increase colorectal cancer screening volume.
5. Hold events to increase awareness and education around cancer screening for breast, lung, colon, prostate cancer.

SMART Evaluation Metrics:

	Metric	Accountable Council/Leader	Target	
			Measure	Date
1	Increase total prostate cancer screening volume for all patients by 1.5% and for Black patients by 1.5% by December 31, 2023.	E. Walker/C. Hwang/D. Long	Black population: 901 All Total: 8,831	12/31/23
2	Increase Breast Cancer Screening volume by 3.8% and for Black patients by 3.8% by December 31, 2023.	J. Bensenhaver/D. Long	Black population: 3,010 All Total: 25,532	12/31/23
3	Increase Lung Cancer Screening volume by 4.6% and for Black patients by 4.6% by December 31, 2023.	M. Simoff/ L. Saugrich	Black population: 120 All Total: 2,286	12/31/23
4	Increase Colorectal Cancer Screening volume by 6.3% and for Black patients by 6.3% by December 31, 2023.	K. Brown/ Donna Long, RN	Black population: 626 All Total: 4,504	12/31/23
5	Hold one even per region annually that addresses at least one of the priority cancer types (breast, lung, colorectal, prostate).	M. Schermerhorn/C. Bissell/D. Long	1 event	12/31/23

ADOPTION OF IMPLEMENTATION STRATEGIES

Approved by the Henry Ford Macomb Hospital Board of Trustees on April 12th, 2023.

The final, approved versions of the 2022 Community Health Needs Assessment and the 2023-2025 Implementation Strategies are available electronically at www.henryford.com/about/community-health.

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

Community Health Needs Assessment

Implementation Strategy 2023-2025

HENRY FORD HEALTH℠

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Henry Ford West Bloomfield Hospital
Executive Summary

Henry Ford West Bloomfield Hospital completed a comprehensive Community Health Needs Assessment (CHNA) that was adopted by the Henry Ford Health (HFH) Board of Directors in December 2022. Henry Ford West Bloomfield 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 considered input from community members and various community organizations.

Health Needs of the Community

The Henry Ford Health 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 enterprise wide. Health needs were prioritized based on several criteria including the importance given to particular health issues by survey participants, statistical data from the State of Michigan and other sources, as well as input from HFH leaders. Henry Ford West Bloomfield Hospital's resources and overall alignment with the Henry Ford Health 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 enterprise, and the third priority was chosen specifically for Henry Ford West Bloomfield Hospital and its unique community needs.

1. **Chronic Disease Prevention and Management**
2. **Behavioral Health and Substance Use Disorder**
3. **Cancer**

Henry Ford Health 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 enterprise. 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 enterprise-wide strategies and metrics.

Hospital Implementation Strategy

Henry Ford West Bloomfield Hospital will focus on developing and supporting initiatives and measuring their effectiveness to improve the aforementioned health priorities. 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.

CHNA IMPLEMENTATION STRATEGY
2023-2025

Hospital Facility:	Henry Ford West Bloomfield Hospital
CHNA Significant Health Need:	Chronic Disease Prevention and Management
CHNA Reference Pages:	31-37, 46-56, 59-69

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 Oakland County, 18.3% of residents do not get any physical activity in their leisure time, compared to 23.3% in Michigan as a whole, and 29.3% of Oakland County residents are obese, compared to a state average of 34.7%. Lifestyle factors can also contribute to the onset of diabetes. In Oakland County, 10.3% of residents have ever been told they have diabetes compared to a state average of 11.7%. The Diabetes death rate in Oakland County is 22.0, the 8th leading cause of death in the county. Diabetes accounts for many preventable hospitalizations in Oakland County – it is the leading cause of preventable hospitalizations in the County. 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 Oakland County, 14.2% of residents report their general health as fair or poor. 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 because 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. At Henry Ford West Bloomfield 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:

Prevent the incidence of highly prevalent chronic diseases and increase community members' capacity to manage chronic disease, while addressing the socio-economic conditions which contribute to chronic diseases and behaviors that cause them.

Project Objectives:

1. Improve health status of population served
2. Reduce Disparities in A1C and Blood Pressure Control among African American patients
3. Increase % of social needs screenings with 'closed loop' referrals

Strategies to Accomplish Goal:

Activity to Accomplish
1. Evaluate and identify improvement opportunities to ensure Diabetes Self-Management Education and Support (DSMES) programs are achieving equity in access and outcomes for communities of color.
2. Continue to enhance programming and evaluate and identify improvement opportunities to ensure Diabetes Prevention (DPP) Programs are achieving equity in access and outcomes for communities of color.
3. Engage provider organizations in systematic clinical improvements to reduce racial disparities in hypertension and/or diabetes control.
4. Henry Ford Health will partner with community organizations via a community information exchange (CIE) to close 50% of the social needs gaps identified (referrals made) within populations screened by 2025.
5. By 2025, Henry Ford Health will invest $15 million through intermediaries into projects that positively impact social determinants of health (SDOH) across the markets we serve. Investments will yield returns that may be below general market expectations, but sufficient to replenish funding for future rounds of investment.

SMART Evaluation Metrics:

	Metric	Accountable Council/Leader	Target	
			Measure	**Date**
1	Increase DSME engagements – initial assessments that result from total referrals – by 5% annually.	Population Health Management/P. Milan	5% increase over 2022 baseline	12/31/23
	Increase DSME completion by Black participants (number of Black participants who complete the program) by 5% annually.		5% increase over 2022 baseline	12/31/23
2	Achieve either 5% increase OR reach 40% of participants that **complete** DPP achieve one or both of the following two outcomes annually: 1. at least 5% weight loss 2. at least 4% weight loss and at least 150 minutes/week on average of physical activity	B. Blum-Alexander	5% increase over baseline or reach 40%	12/31/23
	10% increase in Black DPP participants that **complete** the program by 2025		10% increase over baseline	12/31/25
3	At least 1 activity directed at identifying, tracking, communicating, educating or otherwise engaging providers to reduce racial disparities in HTN and/or HA1c control will be completed per year.	PEPC, Primary Health	1 activity	12/31/23
4	Achieve 30% 'closure rate' for SDOH referrals in 2023; 40% in 2024 and 50% by 2025.	High Performing Network Council/K. Wisdom & A. Schultz	30% closure rate	12/31/23
5	$15 million invested by 2025.	CHANCE/R. Damschroder	$15 million	12/31/2025

CHNA IMPLEMENTATION STRATEGY
2023-2025

Hospital Facility:	Henry Ford West Bloomfield Hospital
CHNA Significant Health Need:	Behavioral Health and Substance Use Disorder
CHNA Reference Pages:	56-57, 59-66

Brief Description of Need:

Since the last Community Health Needs Assessment was conducted in 2019, the prevalence of self-reported poor mental health status has improved in every community that Henry Ford Health System serves except Wayne County. In Oakland County, the prevalence of poor mental health is now 13.5%, compared to 15.4% throughout the entire state of Michigan. Amongst surveyed community stakeholders in Oakland County, mental health and substance use disorder were both ranked amongst the top three most pressing health needs of the community. Oakland County's suicide death rate is 12.1 per 100,000. Overdose deaths from all drugs and opioids continue to burden our communities. In 2020, Oakland County saw an all-drug overdose death rate of 16.43 per 100,000 and an opioid overdose death rate of 7.34 per 100,000. From 2019 to 2020, the age-adjusted rate of drug overdose deaths increased 31.7% in Oakland County. One of the highest increases in opioid overdose death rates was in Oakland County with a 236% increase from 2019 to 2020. Amongst the ten leading causes of death in Michigan and Oakland County, drug overdose deaths are categorized as "unintentional injuries," a category which is the third leading cause of death in Michigan on average, with a death rate of 56.2 per 100,000. However, this decreased in Oakland County, with a death rate of 28.2 per 100,000. 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 West Bloomfield 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 behavioral health access and adapt services to improve mental health and reduce substance use disorder.

Project Objectives:

1. Improve health status of Behavioral Health patients
2. Reduce Behavioral Health readmissions
3. Prevent opioid overdose deaths in populations served

Strategies to Accomplish Goal:

Activity to Accomplish
1. Provide depression screening for all those seeking psychiatric care.
2. Patients suffering from Opiate Use Disorder (OUD), not in remission, will be prescribed Naloxone as a safety measure to prevent morbidity and mortality.
3. Improve access in our psychiatric specialty clinics and in our Collaborative Care model for adult patients.

SMART Evaluation Metrics:

	Metric	**Accountable Council/Leader**	**Target**	
			Measure	**Date**
1	90% of patients seen in BHS will have depression screening as defined by the PHQ-9 annually.	Behavioral Health/C. Frank	90%	12/31/23
2	35% of non-cancerous patients receiving with an opioid prescription (>= 50 MME/day) with high-risk conditions prescribed Naloxone in the last 365 days	Pain Committee	35%	12/31/23
3	Specialty Clinics: 25% of patients seen within 10 days.	Behavioral Health/C. Frank	25%	12/31/23
	Adult Collaborative Care goal is 42% within 10 days and 4% same day	Behavioral Health/C. Frank	42%	12/31/23

CHNA IMPLEMENTATION STRATEGY
2023-2025

Hospital Facility:	Henry Ford West Bloomfield Hospital
CHNA Significant Health Need:	Cancer
CHNA Reference Pages:	51-56, 64-67, 70

Brief Description of Need:

In Oakland County, the age-adjusted death rate from al invasive cancers in 2019 was 140.1. Cancer is the second-leading cause of death in Oakland County and in the state of Michigan. Since the last Community Health Needs Assessment in 2019, cervical cancer screening prevalence and colorectal screening prevalence improved in all regions Henry Ford Health serves. According to the Michigan Behavioral Risk Factor Survey 2018-2020, the percent estimated prevalence of breast cancer screening and prostate cancer screening worsened in Oakland County since the 2019 CHNA. We know that minority populations often experience barriers to healthcare access and healthy lifestyle behaviors and as a result may be less likely to receive timely cancer screenings and experience poorer health outcomes that contribute to prevalence of cancer. At Henry Ford West Bloomfield 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 equity in cancer screening and enrollment to treatment for prostate, breast, lung, and colorectal cancer types.

Project Objectives:

1. Increase cancer screening volume
2. Reduce disparities in Cancer Screening Rates
3. Increase survival rate/reduce cancer mortality rates

Strategies to Accomplish Goal:

Activity to Accomplish
1. Increase prostate cancer screening volume.
2. Increase breast cancer screening volume.
3. Increase lung cancer screening volume.
4. Increase colorectal cancer screening volume.
5. Hold events to increase awareness and education around cancer screening for breast, lung, colon, prostate cancer.

SMART Evaluation Metrics:

	Metric	Accountable Council/Leader	Target	
			Measure	Date
1	Increase total prostate cancer screening volume for all patients by 1.5% and for Black patients by 1.5% by December 31, 2023.	E. Walker/C. Hwang/D. Long	Black population: 1,600 All Total: 8,995	12/31/23
2	Increase Breast Cancer Screening volume by 3.8% and for Black patients by 3.8% by December 31, 2023.	J. Bensenhaver/D. Long	Black population: 4,310 All Total: 18,727	12/31/23
3	Increase Lung Cancer Screening volume by 4.6% and for Black patients by 4.6% by December 31, 2023.	M. Simoff/ L. Saugrich	Black population: 109 All Total: 965	12/31/23
4	Increase Colorectal Cancer Screening volume by 6.3% and for Black patients by 6.3% by December 31, 2023.	K. Brown/ Donna Long, RN	Black population: 1,680 All Total: 7,369	12/31/23
5	Hold one even per region annually that addresses at least one of the priority cancer types (breast, lung, colorectal, prostate).	M. Schermerhorn/C. Bissell/D. Long	1 event	12/31/23

ADOPTION OF IMPLEMENTATION STRATEGIES

Approved by the Henry Ford West Bloomfield Hospital Board of Trustees on March 10, 2023.

The final, approved versions of the 2022 Community Health Needs Assessment and the 2023-2025 Implementation Strategies are available electronically at www.henryford.com/about/community-health.

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

Community Health Needs Assessment

Implementation Strategy 2023-2025

HENRY FORD HEALTH℠

Henry Ford Wyandotte Hospital

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Henry Ford Wyandotte Hospital
Executive Summary

Henry Ford Wyandotte Hospital completed a comprehensive Community Health Needs Assessment (CHNA) that was adopted by the Henry Ford Health (HFH) Board of Directors in December 2022. Henry Ford Wyandotte 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 considered input from community members and various community organizations.

Health Needs of the Community

The Henry Ford Health 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 enterprise wide. Health needs were prioritized based on several criteria including the importance given to particular health issues by survey participants, statistical data from the State of Michigan and other sources, as well as input from HFH leaders. Henry Ford Wyandotte Hospital's resources and overall alignment with the Henry Ford Health 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 enterprise, and the third priority was chosen specifically for Henry Ford Wyandotte Hospital and its unique community needs.

1. **Chronic Disease Prevention and Management**
2. **Behavioral Health and Substance Use Disorder**
3. **Cancer**

Henry Ford Health 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 enterprise. 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 enterprise-wide strategies and metrics.

Hospital Implementation Strategy

Henry Ford Wyandotte Hospital will focus on developing and supporting initiatives and measuring their effectiveness to improve the aforementioned health priorities. 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.

CHNA IMPLEMENTATION STRATEGY
2023-2025

Hospital Facility:	Henry Ford Wyandotte Hospital
CHNA Significant Health Need:	Chronic Disease Prevention and Management
CHNA Reference Pages:	31-37, 46-56, 59-69

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 Wayne County (excluding City of Detroit), 23.2% of residents do not get any physical activity in their leisure time, compared to 23.3% in Michigan as a whole, and 36.8% of Wayne County (excluding City of Detroit) residents are obese, compared to a state average of 34.7%. Lifestyle factors can also contribute to the onset of diabetes. In Wayne County (excluding City of Detroit), 12.9% of residents have ever been told they have diabetes compared to a state average of 11.7%. The Diabetes death rate in Wayne County is 32.6, the 8th leading cause of death in the County. Diabetes accounts for many preventable hospitalizations in Wayne County – it is the leading cause of preventable hospitalizations in the County and 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 Wayne County (excluding City of Detroit), 19.2% of residents report their general health as fair or poor compared to 17.9% 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 because 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. At Henry Ford Wyandotte 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:

Prevent the incidence of highly prevalent chronic diseases and increase community members' capacity to manage chronic disease, while addressing the socio-economic conditions which contribute to chronic diseases and behaviors that cause them.

Project Objectives:

1. Improve health status of population served
2. Reduce Disparities in A1C and Blood Pressure Control among African American patients
3. Increase % of social needs screenings with 'closed loop' referrals

Strategies to Accomplish Goal:

Activity to Accomplish
1. Evaluate and identify improvement opportunities to ensure Diabetes Self-Management Education and Support (DSMES) programs are achieving equity in access and outcomes for communities of color.
2. Continue to enhance programming and evaluate and identify improvement opportunities to ensure Diabetes Prevention (DPP) Programs are achieving equity in access and outcomes for communities of color.
3. Engage provider organizations in systematic clinical improvements to reduce racial disparities in hypertension and/or diabetes control.
4. Henry Ford Health will partner with community organizations via a community information exchange (CIE) to close 50% of the social needs gaps identified (referrals made) within populations screened by 2025.
5. By 2025, Henry Ford Health will invest $15 million through intermediaries into projects that positively impact social determinants of health (SDOH) across the markets we serve. Investments will yield returns that may be below general market expectations, but sufficient to replenish funding for future rounds of investment.

SMART Evaluation Metrics:

	Metric	Accountable Council/Leader	Target	
			Measure	**Date**
1	Increase DSME engagements – initial assessments that result from total referrals – by 5% annually.	Population Health Management/P. Milan	5% increase over 2022 baseline	12/31/23
	Increase DSME completion by Black participants (number of Black participants who complete the program) by 5% annually.		5% increase over 2022 baseline	12/31/23
2	Achieve either 5% increase OR reach 40% of participants that **complete** DPP achieve one or both of the following two outcomes annually: 1. at least 5% weight loss 2. at least 4% weight loss and at least 150 minutes/week on average of physical activity	B. Blum-Alexander	5% increase over baseline or reach 40%	12/31/23
	10% increase in Black DPP participants that **complete** the program by 2025		10% increase over baseline	12/31/25
3	At least 1 activity directed at identifying, tracking, communicating, educating or otherwise engaging providers to reduce racial disparities in HTN and/or HA1c control will be completed per year.	PEPC, Primary Health	1 activity	12/31/23
4	Achieve 30% 'closure rate' for SDOH referrals in 2023; 40% in 2024 and 50% by 2025.	High Performing Network Council/K. Wisdom & A. Schultz	30% closure rate	12/31/23
5	$15 million invested by 2025.	CHANCE/R. Damschroder	$15 million	12/31/2025

CHNA IMPLEMENTATION STRATEGY
2023-2025

Hospital Facility:	Henry Ford Wyandotte Hospital
CHNA Significant Health Need:	Behavioral Health and Substance Use Disorder
CHNA Reference Pages:	56-57, 59-66

Brief Description of Need:

Since the last Community Health Needs Assessment was conducted in 2019, the prevalence of self-reported poor mental health status has improved in all regions except Wayne where there was no change. In Wayne County (excluding City of Detroit), the prevalence of poor mental health is now 16.8%, compared to 15.4% throughout the entire state of Michigan. Amongst surveyed community stakeholders in Wayne County, mental health was ranked amongst the top three most pressing health needs of the community. Wayne County's suicide death rate is 12.6 per 100,000. Overdose deaths from all drugs and opioids, continue to burden our communities. In 2019-2020, Wayne County saw an all-drug overdose death rate of 45.62 per 100,000 and an opioid overdose death rate of 40.22 per 100,000. From 2019 to 2020, the age-adjusted rate of drug overdose deaths was 5.8% in Wayne County. Wayne County was the only County in the four-county area where opioid drug overdoses increased less than state average. Amongst the ten leading causes of death in Michigan and Wayne County, drug overdose deaths are categorized as "unintentional injuries," a category which is the fourth leading cause of death in Michigan on average, with a death rate of 56.2 per 100,000. In Wayne County, this death rate is 77.2 per 100,000. 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 Wyandotte 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 behavioral health access and adapt services to improve mental health and reduce substance use disorder.

Project Objectives:

1. Improve health status of Behavioral Health patients
2. Reduce Behavioral Health readmissions
3. Prevent opioid overdose deaths in populations served

Strategies to Accomplish Goal:

Activity to Accomplish
1. Provide depression screening for all those seeking psychiatric care.
2. Patients suffering from Opiate Use Disorder (OUD), not in remission, will be prescribed Naloxone as a safety measure to prevent morbidity and mortality.
3. Improve access in our psychiatric specialty clinics and in our Collaborative Care model for adult patients.

SMART Evaluation Metrics:

	Metric	**Accountable Council/Leader**	**Target**	
			Measure	**Date**
1	90% of patients seen in BHS will have depression screening as defined by the PHQ-9 annually.	Behavioral Health/C. Frank	90%	12/31/23
2	35% of non-cancerous patients receiving with an opioid prescription (>= 50 MME/day) with high-risk conditions prescribed Naloxone in the last 365 days	Pain Committee	35%	12/31/23
3	Specialty Clinics: 25% of patients seen within 10 days.	Behavioral Health/C. Frank	25%	12/31/23
	Adult Collaborative Care goal is 42% within 10 days and 4% same day	Behavioral Health/C. Frank	42%	12/31/23

CHNA IMPLEMENTATION STRATEGY
2023-2025

Hospital Facility:	Henry Ford Wyandotte Hospital
CHNA Significant Health Need:	Cancer
CHNA Reference Pages:	51-56, 64-67, 70

Brief Description of Need:

In Wayne County, the age-adjusted death rate from al invasive cancers in 2019 was 168.2, compared to the Michigan rate of 156.4. Cancer is the second-leading cause of death in Wayne County and in the state of Michigan. The age-adjusted death rates from invasive cancers including breast, colorectal, lung, and prostate are higher in Wayne County than in the state of Michigan. The percent estimated prevalence of the population in Wayne County (excluding City of Detroit) who have had a breast cancer screening, prostate cancer screening, and colorectal cancer screening are worse than Michigan state averages, according to the Michigan Behavioral Risk Factor Survey 2018-2020. However, cervical cancer screening improved in Wayne County (excluding City of Detroit). We know that minority populations often experience barriers to healthcare access and healthy lifestyle behaviors and as a result may be less likely to receive timely cancer screenings and experience poorer health outcomes that contribute to prevalence of cancer. At Henry Ford Wyandotte 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 equity in cancer screening and enrollment to treatment for prostate, breast, lung, and colorectal cancer types.

Project Objectives:

1. Increase cancer screening volume
2. Reduce disparities in Cancer Screening Rates
3. Increase survival rate/reduce cancer mortality rates

Strategies to Accomplish Goal:

Activity to Accomplish
1. Increase prostate cancer screening volume.
2. Increase breast cancer screening volume.
3. Increase lung cancer screening volume.
4. Increase colorectal cancer screening volume.
5. Hold events to increase awareness and education around cancer screening for breast, lung, colon, prostate cancer.

SMART Evaluation Metrics:

	Metric	Accountable Council/Leader	Target	
			Measure	Date
1	Increase total prostate cancer screening volume for all patients by 1.5% and for Black patients by 1.5% by December 31, 2023.	E. Walker/C. Hwang/D. Long	Black population: 315 All Total: 4,280	12/31/23
2	Increase Breast Cancer Screening volume by 3.8% and for Black patients by 3.8% by December 31, 2023.	J. Bensenhaver/D. Long	Black population: 1,246 All Total: 13,950	12/31/23
3	Increase Lung Cancer Screening volume by 4.6% and for Black patients by 4.6% by December 31, 2023.	M. Simoff/ L. Saugrich	Black population: 58 All Total: 1,518	12/31/23
4	Increase Colorectal Cancer Screening volume by 6.3% and for Black patients by 6.3% by December 31, 2023.	K. Brown/ Donna Long, RN	Black population: 207 All Total: 1,706	12/31/23
5	Hold one even per region annually that addresses at least one of the priority cancer types (breast, lung, colorectal, prostate).	M. Schermerhorn/C. Bissell/D. Long	1 event	12/31/23

ADOPTION OF IMPLEMENTATION STRATEGIES

Approved by the Henry Ford Wyandotte Hospital Board of Trustees on March 9th, 2023.

The final, approved versions of the 2022 Community Health Needs Assessment and the 2023-2025 Implementation Strategies are available electronically at www.henryford.com/about/community-health.

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