COMMUNITY HEALTH NEEDS ASSESSMENT – 2016 IMPLEMENTATION STRATEGY 2017-2019

Henry Ford Health System

Henry Ford Macomb Hospital

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EXECUTIVE SUMMARY

Henry Ford Macomb Hospital completed a comprehensive Community Health Needs Assessment (CHNA) adopted by the Henry Ford Macomb (HFM) Board of Directors in October 2016, and by the HFHS Board of Directors in December 2016. HFM 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 CHNA was conducted in 2016 in partnership with the Macomb County Health Department and their Community Health Assessment and Improvement Plan teams. Several significant health needs within the service area of Henry Ford Macomb Hospital were identified. 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 Macomb'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 three most significant health issues to be addressed:

1. **Healthy Lifestyles: Weight Management/ Obesity/Diet and Nutrition**
2. **Substance Abuse & Mental Health**
3. **Diabetes**

Hospital Implementation Strategy

Henry Ford Macomb will focus on developing and supporting initiatives, and measure their effectiveness to improve these 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 transform lives and communities. The Hospital reserves the right to amend this implementation strategy as circumstances warrant.

In terms of significant health needs that will not be addressed, Henry Ford Macomb acknowledges the wide range of health concerns that emerged from the CHNA process, and determined it could most effectively focus on those health needs that were determined to be most urgent and essential to the health of the community as well as within its ability to influence. While most of these additional health issues are currently being addressed by existing programs and initiatives of HFM or a partner organization, HFM will not take new or specific, additional actions related to the following health needs:

- Chronic diseases – Because many chronic diseases such as high blood pressure, cardiac diseases and cancer are closely related to weight issues, many of these will be addressed indirectly through strategies and activities aimed at reducing obesity, and promoting weight management, healthy diet and nutrition. Efforts to improve behavioral health should also indirectly improve chronic disease issues including a person's emotional ability to manage chronic medical issues. For these reasons, HFM will not take new actions to address chronic diseases.
- Health insurance enrollment – HFM will continue to assist patients with insurance enrollment and access to other financial supports through its patient financial services programs, but will not be taking new or specific actions to address this need until the full impact of the Affordable Care Act and its next iteration can be measured and specific barriers identified.
- Infant Mortality – HFM will continue to partner with the Macomb County Health Department to address infant mortality, as this area continues to be slightly above state averages in Macomb County.

CHNA IMPLEMENTATION STRATEGY Fiscal Years 2017-2019	
Hospital Facility:	Henry Ford Macomb Hospital
CHNA Significant Health Need:	**Healthy Lifestyles**
CHNA Reference Pages:	13, 15, 16, 17, 21, 22, 28 & 29

BRIEF DESCRIPTION OF NEED: Overweight or obesity is a particular area in need of improvement within the Tri-County area. Approximately 66% of Michigan and Tri-County residents are either obese or overweight, a slight decrease from the 2013 assessment. In Macomb County, reported rates of obesity and overweight were 66.2%, slightly higher than state average of 65.8%. This is an area of particular concern given that obesity is linked with many adverse health outcomes such as hypertension, type 2 diabetes, coronary heart disease, stroke, and sleep apnea. Another area in need of improvement is the consumption of fruit and vegetables. In 2013, an estimated 37.7% of adults in Michigan reported consuming fruits less than one time a day, and 24.8% reported consuming vegetables less than once daily.[1] The Centers for Disease Control & Prevention (CDC) found that 68.4% of adolescent children ate fruits or drank fruit juice less than 2 times per day during the 7 days prior to the study. 88.4% ate vegetables less than 3 times per day and 27.6% drank a can, bottle or glass of soda or pop at least one time per day during the week prior to the study[2].

The Healthy Lifestyles category describes the System's overall attention to wellness-based initiatives in an effort to address priorities involving obesity, hypertension, and related indicators. Specifically, a system-wide approach toward addressing weight management, nutrition, access to healthy food, physical activity, tobacco use and smoking cessation is included. Multiple programs tackling different aspects of each indicator are coordinated across business units and departments, and in coordination with an array of local community partners. Specific areas of focus include:

- **Obesity/Overweight -** a health concern due to its link to chronic conditions such as cardiovascular disease and diabetes.
- **Nutrition/Eating Disorders -** a health concern as evidenced by obesity rates, preventable hospitalizations for dehydration and generally poor health status.
- **Access to affordable healthy food** - a health need also evidenced by obesity rates, preventable hospitalizations for dehydration and generally poor health status.

GOAL: *Promote health and reduce chronic disease especially among vulnerable populations.*

PROJECT OBJECTIVES:
1. Increase consumption of fruits and vegetables in children in Macomb County in partnership with the SNAP (Supplemental Nutrition Assistance Program) Education program in selected schools that have greater than 50% free and reduced-priced meal enrollment.
2. Through partnership with Primary Care Providers (PCP), reduce Body Mass Index (BMI) in 50% of clients, including low-income clients, that participate in BMI measurements pre- and post- in the Henry Ford Macomb Center for Weight Management program.

[1] 2013 Behavioral Risk Factor Survey, Michigan Department of Community Health

[2] http://www.cdc.gov/obesity/stateprograms/fundedstates/pdf/michigan-state-profile.pdf

ACTIONS TO ACCOMPLISH GOAL:
1. Track BMI at the beginning and end of the program. Track PCP referrals and sustain a minimum of 20% referral base of clients from Primary Care physicians involved in a program at the Center for Weight Management.
2. Continue financially supporting School Health Programs that provide nutrition education to youth in schools in Macomb County with a focus on schools with a high SNAP (Supplemental Nutrition Assistance Program) Education population.
3. Survey participants of SNAP-Ed to determine behavior changes.
4. Promote and support community activities that advocate for healthy lifestyles and increased physical activity.

EVALUATION & INTENDED IMPACT

	Evaluation Metric	Intended Impact
1	Surveys to demonstrate an increase in fruit and vegetable (F/V) consumption in the target population.	Increase in reported F/V consumption
2	Number of clients that have a reduction in BMI.	Reduce BMI in 50% of clients who participate in the Center for Weight Management program

HENRY FORD MACOMB PROGRAMS AND RESOURCES:

Continued financial support of Michigan Nutrition Network and SNAP-Ed partner
Support for staffing and materials for the programs described

COLLABORATIVE PARTNERS:

Michigan Nutrition Network assists with the evaluation process of SNAP-Ed participants
Generation with Promise, HFHS, is a collaborative partner with the SNAP-Ed programming
Macomb County Schools
Macomb County Health Department
Advancing Macomb, a Macomb County leadership group

CHNA IMPLEMENTATION STRATEGY Fiscal Years 2017-2019	
Hospital Facility:	Henry Ford Macomb Hospital
CHNA Significant Health Need:	**Drug, Alcohol Abuse & Mental Health**
CHNA Reference Pages:	12, 15, 16, 17, 18, 21, 22, 28 & 29

BRIEF DESCRIPTION OF NEED: Macomb County survey respondents expressed a desire to address mental health, drug and alcohol abuse. State and local data also support this feedback for this focus. Macomb County residents have a slightly lower rate of poor mental health (12%) against the state average of 12.6%. In addition, based on escalating mortality, ER visits, demand for addiction services, and crime figures, opioid addiction has become a significant focus by state and local health care and community agencies.

This category captures the System's overall attention to Opioid Addiction and Mental Health initiatives in an effort to address priorities involving opioid abuse, improved mental health, and a reduction in suicide rates. Multiple programs tackling different aspects of each indicator are coordinated across business units and departments, and in coordination with an array of local community partners. Specific areas of focus include:

- **Drug/Alcohol Abuse** is a health concern due to the rates of liver and kidney disease affecting the community.
- **Mental Health/Suicide** is a health need due to the level of self-inflicted injuries and suicide as a top cause of death in Michigan.

GOAL: *Improve the behavioral health status of at-risk populations in the community, including those who have mental health and/or substance abuse conditions.*

PROJECT OBJECTIVES:
1. Improve early detection of suicide with education and awareness training.
2. Improve transition of care for patients in the Emergency Department (ED) with co-occurring substance use disorders by connecting individuals to treatment services, resources; and coordinate care with the Wellness Coach program in the ED.
3. Increase accessibility and use of Naloxone to save lives and reverse overdoses related to opioid abuse in collaboration with Operation Rx, a community-wide collaborative.

ACTIONS TO ACCOMPLISH GOAL:
1. Continue collaborative partnership with community program OperationRx to support the goals of the coalition through leadership resource support, funding and education.
2. Track the use of Naloxone in Macomb County.
3. Pilot the "Recovery Coach Program" in the ED in partnership with CARE
4. Partner with Macomb Suicide Prevention Coalition with active participation in at least one of their initiatives.
5. Support community-based Mental Health First Aid (MHFA) trainings, providing instructors and training sites as well as marketing these opportunities for training.

EVALUATION & INTENDED IMPACT

	Evaluation Metric	Intended Impact
1.	Increase the number of lives saved with Naloxone use, by increasing the distribution of the drug to institutions, community organizations and first responders.	Fewer lives lost due to accidental drug overdose
2.	Increase referrals to treatment for patients seen in the ED with drug-seeking and opioid related issues, in order to decrease recidivism rates.	Increase of drug-seeking patients connected to treatment with improved chances of recovery.

HENRY FORD MACOMB PROGRAMS AND RESOURCES:

Staff time to support Operation Rx, Wellness Coaches and Suicide Prevention initiatives

COLLABORATIVE PARTNERS:

OperationRx
Macomb County Suicide Prevention Coalition
CARE of Southeast Michigan
Macomb County Health Department
Community Mental Health
Macomb County Office of Substance Abuse

CHNA IMPLEMENTATION STRATEGY
Fiscal Years 2017-2019

Hospital Facility:	Henry Ford Macomb Hospital
CHNA Significant Health Need:	**Diabetes**
Reference Pages:	4, 12, 13, 14, 15, 17, 18, 19, 21, 22, 28, 29, 30,
Name of Project:	Improving Access to Community-Based Diabetes Prevention Programs (DPP)

BRIEF DESCRIPTION OF NEED: In the 2013 Henry Ford Health System Community Health Needs Assessment (CHNA), diabetes was identified as a System priority. Since then, the Called to Care Project was launched, and for those populations engaged, there was a 10% decrease in A1C, a 5.6% decrease from the previous year. Unfortunately, when reviewing the 2016 CHNA data, there's still significant disparity in diabetes for African Americans in Michigan, with 38.7 deaths/100,000 state wide, 15 more than the state rate of 23.7/100,000. While Macomb has seen a decline in prevalence of diabetes, it is still a leading cause of death in the community, with 25.8 deaths/100,000. While Henry Ford has made a difference, we still have more work to do.

Limited access to healthy foods and obesity are two of the issues contributing to the diabetes epidemic sweeping Macomb County and the state. Nearly one-quarter (24.5 percent) of Macomb County adults reported having limited food access, with almost 47.0 % of those with household incomes below $20,000 reporting limited access to fresh fruits and vegetables compared to 18.0 % of those with household incomes of $75,000 or more. 55% of African Americans in Macomb County are obese as are 31% of whites[1.]

For such vulnerable populations, strong connections to community diabetes resources are needed in order to improve outcomes. From 2015-present, the HFM Faith Community Nursing Network and Ambulatory Services departments have joined with the Greater Detroit Area Health Council and Macomb County Health Department to provide community-based Diabetes Prevention Programs (DPP), developed by the CDC, which address the major health risks for Type 2 diabetes – obesity, inactivity and poor nutrition. These classes have produced better results than medications with long-lasting results (24% of participants have a 15-year delay in development of Type 2 diabetes).

The intervention is in place (DPP class schedule for 2016); however, the classes have not been filled. A gap exists, as evidenced by the low number of patients who receive referrals to diabetes education programs from Primary Care Providers (PCPs) [2] – only 20 from June 2016-December 31, 2016. According to data, fewer than half of PCPs referred diagnosed patients to diabetes-to-diabetes self-management education resources despite the evidence of the benefits of such education programs. Quality checks have found that PCPs often are without knowledge of referral resources for patients and are unable to identify their prediabetes patient population without appropriate tools. A prediabetes registry and quality improvement campaign have been initiated to address these important barriers to access to proven preventative interventions.

Sources

1. Macomb County Health Department. (2015). Health Behaviors and Risk Factors in Macomb County: Results of the 2015 Macomb County Behavioral Risk Factor Survey [Data Set] Retrieved from http://health.macombgov.org/Health-DataStatistics
2. Enaz Gucciardi, PhD MSc, Vivian Wing-Sheung Chan, HBSc PhD (c) Mariella Fortugno, BASc, Sobia Khan, HBSc MPH (c), Stacey Horodezny, BAA RDI, Susan J. Swarzack, BScN MPA RN (2011). Primary Care Physician Referral Patterns to Diabetes Education Programs in Southern Ontario, Canada. *Canadian Journal of Diabetes,* Volume 35, Issue 3, 262-268

GOAL: ***Increase the number of provider referrals of patients with prediabetes symptoms to CDC Diabetes Prevention Program (DPP) by implementing a prediabetes registry with special attention to vulnerable populations.***

PROJECT OBJECTIVES:
1. Use the prediabetes registry to refer qualified patients to DPP classes nearest to them, giving special recruitment attention to vulnerable population (race, income).
2. Prepare to meet CDC quality measures for DPP class interventions in 2018.

ACTIONS TO ACCOMPLISH GOAL:
1. Complete registry pilot with 4 ambulatory sites • Ambulatory staff education – March 2017 • Review of referral and feedback processes – March 2017 • Preliminary provider to process feedback and adjustments – April 2017 • Evaluate changes in the numbers of referrals, referees enrolling, and feedback communications completed
2. Develop strategies to address the vulnerable populations identified. • Focused follow-up with those referred who meet vulnerable population criteria - Use zip codes identified by the CHNA and criteria for vulnerable population focus - Use race as criterion for vulnerable population focus
3. Expand registry use to 11 ambulatory sites

EVALUATION & INTENDED IMPACT

	Evaluation Metric	**Intended Impact**
1	Number of referrals to DPP Classes by HFM providers	Increase diabetes prevention education
2	Percentage of patients who successfully meet CDC requirements in managing their pre-diabetes (weight loss, decrease in A1C and BMI; increase in physical activity)	Increase in preventive behaviors

HENRY FORD MACOMB PROGRAMS AND RESOURCES:

Henry Ford Macomb Faith Community Nursing Network

Ambulatory Services Quality Nurse/Division Chief – Ambulatory Services & Population Health Director

HFHS Information Technology - EPIC department (Electronic Medical Record)

COLLABORATIVE PARTNERS:

Macomb County Health Department
Greater Detroit Area Health Council (GDHAC)
HFHS Corporate Diabetes Care Steering Committee

ADOPTION OF IMPLEMENTATION STRATEGIES

Approved by the HENRY FORD MACOMB HOSPITAL CORPORATION BOARD OF TRUSTEES on MARCH 23, 2017.

The final, approved versions of the 2016 Community Health Needs Assessment and the 2017-2019 Implementation Strategies are available electronically at www.henryford.com. Printed copies are also available in the Henry Ford Health System Corporate Offices, located at One Ford Place, Detroit, MI 48202.