Community Health Needs Assessment 2013
Specializing in Improving the Health and Lives of Wayne County Families for Years to Come

In 2013 Oakwood celebrated its 60th year of delivering compassionate, specialized care to the families and communities of Southeast Michigan. For more than six decades our organization has played a proud role in shaping these communities through our steadfast commitment to improving the overall health of its residents.

Every day, our team of Oakwood-affiliated physicians, staff and volunteers touch the lives of people throughout the Southeast Michigan region. Through our four acute care hospitals, more than 60 outpatient sites and extensive community outreach, last year we served some 35 communities touching almost one million lives. While we are extremely proud of our work so far, Oakwood is committed to doing more.

In order for us to provide patient-centered care, it has to be aligned with the unique health needs of the communities we serve. Oakwood completed a comprehensive health needs assessment of our service areas utilizing data analysis from more than 100 health indicators and conducting several focus groups and interviews throughout our service area. This analysis and noteworthy results are outlined in great detail in the following report.

Our 2013 Community Health Needs Assessment will guide our health system over the next three years so we will be ready to address the most urgent health issues for our diverse populations of patients. This data will serve as a tremendous asset for both our patients and caregivers as we work together to create healthier individuals and communities across our service area.

As we at Oakwood look forward to many more years of providing excellent care, healing and health to our communities, this Community Health Needs Assessment will be instrumental in improving the overall health of the families we serve now and in the future.

Sincerely,

Brian M. Connolly
President & CEO, Oakwood Healthcare
Oakwood Healthcare Mission, Vision and Values

MISSION
Provide excellence in care, healing and health to the individuals and communities we serve.

VISION
Oakwood will become the preferred and recognized leader in quality, service and value as an independent healthcare system.

VALUES
In fulfilling our mission, we place special emphasis on the values of:

- Compassion
- Respect
- Excellence
- Diversity
- Ownership
Introduction to Community Health Needs Assessment

As a result of the Patient Protection and Affordable Care Act (PPACA), all tax-exempt hospitals are required to assess the health needs of their community through a Community Health Needs Assessment (CHNA) once every three years. A CHNA is a written document developed for a hospital that includes a description of the community served by the hospital; the process used to conduct the assessment including how the hospital took into account input from community members including those with special knowledge of or expertise in public health; identification of any persons with whom the hospital has worked on the assessment; and the significant health needs identified through the assessment process.

The written CHNA Report must include descriptions of the following:
- The community served and how the community was determined
- The process and methods used to conduct the assessment including sources and dates of the data and other information as well as the analytical methods applied to identify community health needs
- How the organization took into account input from persons representing the broad interests of the community served by the hospital, including a description of when and how the hospital consulted with these persons or the organizations they represent
- The prioritized community health needs identified through the CHNA as well as a description of the process and criteria used in prioritizing the identified needs
- The existing health care facilities and other resources within the community available to meet community health needs

The CHNA requirement also includes that hospitals must adopt an Implementation Strategy to meet the significant community health needs identified through the assessment. An Implementation Strategy is a written plan that addresses each of the significant community health needs identified through a CHNA.

The written Implementation Strategy must include the following:
- List of the prioritized needs the hospital plans to address and the rationale for not addressing other significant health needs identified
- Actions the hospital intends to take to address the chosen health needs
- The anticipated impact of these actions and the plan to evaluate such impact (e.g. identify the data sources you will use to track the plan’s impact)
- Identify the programs and resources the hospital plans to commit to address the health need
- Describe any planned collaboration between the hospital and other facilities or organizations in addressing the health need
A CHNA is considered conducted in the taxable year that the written report of its findings, as described above, is approved by the hospital governing body and made widely available to the public. The Implementation Plan is considered implemented on the date it is approved by the governing body. Conducting the CHNA and approval of the Implementation Strategy must occur in the same fiscal year. CHNA compliance is reported on IRS Form 990, Schedule H.
Community Health Needs Assessment Overview and Methodologies

The Community Health Needs Assessment (CHNA) is a requirement of all tax-exempt (501(c)(3)) hospitals beginning with fiscal year 2013. As part of the IRS Form 990, Schedule H, individually licensed not-for-profit hospitals are required to assess the health needs of their community, prioritize the significant health needs identified, and develop implementation plans for the prioritized health needs they’ve chosen to address.

Oakwood Healthcare partnered with Truven Health Analytics to complete a Community Health Needs Assessment for the following Oakwood hospitals:

- Oakwood Annapolis Hospital
- Oakwood Heritage Hospital
- Oakwood Hospital & Medical Center
- Oakwood Southshore Medical Center

Steering Committee

Oakwood Healthcare created a steering committee to provide oversight and guidance during the CHNA process. In addition to these activities the steering committee evaluated and chose the consultant partner, the criteria utilized in the prioritization process, as well as provided assistance in the implementation planning. Steering committee executive sponsors were David Campbell, Executive Vice President, Operations, System Strategy and Growth; and Mary Zatina, Senior Vice President, Government Relations and Corporate Communications; project managers included Betty Priskorn, Corporate Director, Community Outreach and Lindsey West, Manager, Community Health.

Additional Steering Committee members included the following:

- Nancy Gray, Administrator
  Women’s Service Line
- Edith Hughes, President
  Oakwood Southshore Medical Center
- Carla O’Malley, Executive Director
  Foundation
- Norma Rye, Accounting & Report Specialist
  Accounting
- Sandra Schmitt, Manager
  Nursing Development
- Mary Stahl, Director
  Quality Improvement and Clinical Outcomes
  - Oakwood Accountable Care Organization, LLC
- Renee Watson, Supervisor
  Accounting
- Karen Wright, Director
  Strategic Planning
- Jonathan Zimmerman, MD
  Program Director, Internal Medicine

Consultant Qualifications

Truven Health Analytics and its legacy companies have been delivering analytic tools, benchmarks, and strategic consulting services to the healthcare industry for more than 50 years. Truven Health combines rich data analytics in demographics, planning, and disease prevalence estimates with experienced strategic consultants to deliver comprehensive and actionable Community Health Needs Assessments.
Defining the Community Served

CHNA regulation requires each hospital to define their “community served” for the purposes of the assessment. The Oakwood Healthcare hospital communities are defined as ZIP codes that comprise 80% of inpatient discharges and are contiguous. The overall Oakwood Healthcare Community is the aggregate of each hospital’s community. It is important to note that individual hospital communities overlap. Oakwood Healthcare hospitals are located in Wayne County, Michigan, and the community they serve consists of ZIP codes in Wayne County with some overlap into northeastern Monroe County, Michigan. Oakwood Healthcare approached the CHNA process as a collaborative effort between their hospitals but have also included information specific to each hospital community where the data collection was able to provide hospital community specific information.

Assessment of Health Needs – Methodology and Data Sources

To assess health needs of the Oakwood Healthcare communities, a quantitative and qualitative approach was used. In addition to collecting data from a number of public and Truven Health proprietary sources, interviews (both in-person and telephone) and focus groups were conducted with individuals representing community leaders/groups, public organizations, patients, providers, and Oakwood Healthcare representatives from the hospital and corporate levels. Oakwood Healthcare is conducting a hospital-based needs assessment and did not collaborate with any other providers at this time.

More than 100 indicators were analyzed from the following quantitative data sources:

<table>
<thead>
<tr>
<th>Data Source</th>
<th>Methodology</th>
<th>Data Sources</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annie E. Casey Foundation, Kids Count Database</td>
<td></td>
<td>Michigan Department of Community Health, Vital Records and Health Data Development Section (CHNA)</td>
</tr>
<tr>
<td>Census County Business Patterns</td>
<td></td>
<td>Starfish Family Services</td>
</tr>
<tr>
<td>Behavior Risk Factor Surveillance System (BRFSS)</td>
<td></td>
<td>Substance Abuse and Mental Health Services Admin (SAMHSA) via SEMCA</td>
</tr>
<tr>
<td>Bureau of Labor Statistics</td>
<td></td>
<td>Truven Health</td>
</tr>
<tr>
<td>CDC &amp; EPA Public Health Air Surveillance Evaluation (PHASE)</td>
<td></td>
<td>US Census</td>
</tr>
<tr>
<td>CDC WONDER</td>
<td></td>
<td>US Census American Community Survey, 5-year estimates</td>
</tr>
<tr>
<td>CDC, National Center for Health Statistics (NCHS)</td>
<td></td>
<td>US Census Small Area Health Insurance Estimates</td>
</tr>
<tr>
<td>CDC, NCHS Linked Birth / Infant Death Data Set</td>
<td></td>
<td>US Census Small Area Income and Poverty Estimates</td>
</tr>
<tr>
<td>CDC: Youth Risk Behavior Surveillance System (YRBSS)</td>
<td></td>
<td>USDA Food Environment Atlas</td>
</tr>
</tbody>
</table>

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Qualitative Assessment of Health Needs

To take into account the input of persons representing the broad interests of the community, Truven Health conducted interviews (both one-on-one and small groups) as well as focus groups in February 2013. The interview questionnaire was designed to understand how participants feel about the general health status of the community and the various drivers contributing to health issues. Forty-six interviews were completed for the CHNA process for Oakwood Healthcare. Individuals were grouped into the following categories to ensure broad participation: community leaders/groups, public health and other health care organizations, other providers (including physicians), and Oakwood Healthcare representatives (corporate and hospital).

Five focus groups were also conducted to solicit feedback from community members. Focus groups were designed to familiarize community members with the CHNA process and gain a better understanding of the community’s perspective of significant health needs. Focus groups were formatted for individual as well as small-group feedback and also helped identify other community organizations already addressing health needs in the community.

On the next page is a table containing the 103 interview and focus group participants:
<table>
<thead>
<tr>
<th>Community Leaders/ Groups</th>
<th>Public and Other Organizations</th>
<th>Other Providers</th>
<th>Oakwood Healthcare</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brink, Linda (YMCA of Metropolitan Detroit, FG)</td>
<td>Adams, Nathan (City of Wayne-Westland, FG)</td>
<td>Abrini, Linda (Western Wayne Family Health Centers, I)</td>
<td>Adamen, Troy (OHS Dir ED OSMC, FG)</td>
</tr>
<tr>
<td>Daly, John (Community Member, OSMC Board, FG)</td>
<td>Ahmed, Ismail (University of Michigan Dearborn, I)</td>
<td>Manum, Tiffany (University of Michigan Dearborn, I)</td>
<td>Medvec, Barb (OHS SVP &amp; CMD, I)</td>
</tr>
<tr>
<td>Farnsli, Mona (ACCESS, I)</td>
<td>Allen, Chris (Detroit Wayne County Health Authority, I)</td>
<td>McCarthy, Kathy (Canton Township - Leisure Services, FG)</td>
<td>Represents Minority Populations</td>
</tr>
<tr>
<td>Fawaz, Ned (Islamic Center of America, I)</td>
<td>Anthony, Veronica (City of Detroit Department of Health and Wellness Promotion, I)</td>
<td>Meyers, Carol (Wayne Metropolitan Community Action Agency, I)</td>
<td>Represents Minority Populations</td>
</tr>
<tr>
<td>Gay, Steve (The Guidance Center, FG)</td>
<td>Cardina, Nikki (American Cancer Society, I)</td>
<td>Miller, Mark (Michigan Department of Community Health, I)</td>
<td>Medvec, Barb (OHS SVP &amp; CMD, I)</td>
</tr>
<tr>
<td>Kalniski, Ruth (National Kidney Foundation, FG)</td>
<td>Dawart, Brian (Riverview Fire Department, FG)</td>
<td>Owens, Darline D. (Southeast Michigan Community Alliance, I)</td>
<td>Represents LT PPO and Medicare HMO</td>
</tr>
<tr>
<td>Khalifa, Rose (Metro Healthcare, I)</td>
<td>Davit, Debbie (City of Trenton, FG)</td>
<td>Dargie, Joanne (Comfort Keepers, FG)</td>
<td>Represents LT PPO and Medicare HMO</td>
</tr>
<tr>
<td>McKinney Farrand, Maria (The News Herald, Dearborn Press and Guide, FG)</td>
<td>Duckworth, John E. Rev. Dr. Gethsemane Missionary Baptist Church, I</td>
<td>Decker, Mary (Hope Clinic, Inc., FG)</td>
<td>Represents LT PPO and Medicare HMO</td>
</tr>
<tr>
<td>Nagy, Jennifer (American Cancer Society, I)</td>
<td>Dunford, Carla (Dearborn Community Conference, FG)</td>
<td>Dettalla, Joe (Southwest Solutions, I)</td>
<td>Represents LT PPO and Medicare HMO</td>
</tr>
<tr>
<td>Smithbauer, Karen Wilson (OHS Foundation Board OHS Women's Health Advisory Council, I)</td>
<td>English, Robert (City of Wayne, FG)</td>
<td>Gehle, M.D., Michael (OHS EVP Physician Planning &amp; Operations, I)</td>
<td>Represents LT PPO and Medicare HMO</td>
</tr>
<tr>
<td>Watson, Maggie (The Senior Alliance, AAAC, FG)</td>
<td>Geisbert, Patricia (City of Trenton, FG)</td>
<td>Gelfand, Judith A. (OHS SVP &amp; CMD, I)</td>
<td>Represents LT PPO and Medicare HMO</td>
</tr>
<tr>
<td>Wolterton, Brian (YMCA of Metropolitan Detroit, FG)</td>
<td>Harke, Tony (Great Start Collaborative, I)</td>
<td>Golob, Thomas (OHS SVP &amp; CMD, I)</td>
<td>Represents LT PPO and Medicare HMO</td>
</tr>
<tr>
<td>Young, Belinda (Maxo Corporation, FG)</td>
<td>Howe, Katherine (Henry Ford Community College, I)</td>
<td>Hasan, Galal (OHS SVP &amp; CMD, I)</td>
<td>Represents LT PPO and Medicare HMO</td>
</tr>
<tr>
<td></td>
<td>Irizarry, Edith (Wayne County Health and Human Services, I)</td>
<td>Inositsk, Suzanne (Atraia Health, I)</td>
<td>Represents LT PPO and Medicare HMO</td>
</tr>
<tr>
<td></td>
<td>Jensen, Milch (City of Riverview Fire Department, FG)</td>
<td>Jaffe, Gary (OHS EVP, OSMC, I)</td>
<td>Represents LT PPO and Medicare HMO</td>
</tr>
<tr>
<td></td>
<td>Kitsikos, Edith (Wayne County Health and Human Services, I)</td>
<td>Janacek, Virginie (Wayne County Dept of Public Health, I)</td>
<td>Represents LT PPO and Medicare HMO</td>
</tr>
<tr>
<td></td>
<td>Macag, Allen (Wayne Police Department, FG)</td>
<td>Johnson, Warren (OHS EVP, OSMC, I)</td>
<td>Represents LT PPO and Medicare HMO</td>
</tr>
</tbody>
</table>

* Represents Public Health
* Represents Medically Underserved Populations
* Represents Low Income Populations
* Represents Populations with Chronic Disease Needs
* Represents Minority Populations
Quantitative Assessment of Health Needs

In addition to the qualitative feedback, quantitative health indicators were collected and analyzed to assess community health needs. One hundred-six indicators were evaluated for each of the counties or towns (depending on level of data available) in the Oakwood Healthcare community served. The categories and indicators included the following:

<table>
<thead>
<tr>
<th>Health Behaviors</th>
<th>Health Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Adult Obesity</td>
<td>• General Health Fair or Poor (2)</td>
</tr>
<tr>
<td>• Childhood Obesity</td>
<td>• Average number of unhealthy days in past month</td>
</tr>
<tr>
<td>• Physical Inactivity (2)</td>
<td>• Poor Physical Health</td>
</tr>
<tr>
<td>• Percent Consuming less than 5 fruits/vegetables per day</td>
<td>• Michigan Leading Hospital Discharges (Discharge Rates):</td>
</tr>
<tr>
<td>• Adult Smoking</td>
<td>- Heart Disease</td>
</tr>
<tr>
<td>• Adolescent Smoking</td>
<td>- Injury &amp; Poisoning</td>
</tr>
<tr>
<td>• Adults Binge Drinking</td>
<td>- Infectious &amp; Parasitic Diseas</td>
</tr>
<tr>
<td>• Illicit Drug Use</td>
<td>- Meningitis</td>
</tr>
<tr>
<td>• Marijuana Use</td>
<td>- Rheumatic</td>
</tr>
<tr>
<td>• Prescription Drug (Nonmedicinal) Use</td>
<td>- Cerebrovascular Disease</td>
</tr>
<tr>
<td>• Drove Motor Vehicle After Drinking</td>
<td>- Cancer (All causes) Incidence</td>
</tr>
<tr>
<td>• Seatbelt Use</td>
<td>- Breast Cancer Incidence</td>
</tr>
<tr>
<td>• Births to Teens Under Age 10</td>
<td>- Colon Cancer Incidence</td>
</tr>
<tr>
<td>• HIV Positive</td>
<td>- Lung Cancer Incidence</td>
</tr>
<tr>
<td>• Sexually Transmitted Infections</td>
<td>- Adults with Diabetes</td>
</tr>
<tr>
<td>• Incidence Rate</td>
<td>- Adults with Hypertension</td>
</tr>
<tr>
<td>• Prevention</td>
<td>- Adults with Coronary Heart Disease or Angina</td>
</tr>
<tr>
<td>• Colorectal Screening</td>
<td>- Adults with Stroke</td>
</tr>
<tr>
<td>• Diagnostic Screening</td>
<td>- Adults with any Cardiovascular Disease</td>
</tr>
<tr>
<td>• Mammography Screening</td>
<td>- Adults with Asthma</td>
</tr>
<tr>
<td>• Prostate Cancer Screening</td>
<td>- Adults with Arthritis</td>
</tr>
<tr>
<td>• Cervical Cancer Screening</td>
<td>- Infant Mortality (2)</td>
</tr>
<tr>
<td>• No Routine Checkups in Past Year</td>
<td>- Infant Mortality by Race (1)</td>
</tr>
<tr>
<td>• Flu Vaccine 4+</td>
<td>- Births to Mothers with Late or No Prenatal Care</td>
</tr>
<tr>
<td>• Pneumonia Vaccine 6+ (2)</td>
<td>- Births With Less than Adequate Prenatal Care</td>
</tr>
<tr>
<td>• Environment</td>
<td>- Births to Mothers Who Smoked During Pregnancy</td>
</tr>
<tr>
<td>• Number of Recreational and Fitness Facilities</td>
<td>- Births to Mothers Who Are Foreign Born</td>
</tr>
<tr>
<td>• Percentage of Fast Food Restaurants</td>
<td>- Births to Mothers with No Diploma or GED</td>
</tr>
<tr>
<td>• Limited Access to Healthy Foods</td>
<td>- Medicaid Paid Births</td>
</tr>
<tr>
<td>• Students Eligible for Free Lunch</td>
<td>- Low Birth Weight (2)</td>
</tr>
<tr>
<td>• Households with No Vehicle Available</td>
<td>- Very Low Birth Weight</td>
</tr>
<tr>
<td>• Daily Participation Matter Days</td>
<td>- Preterm Births</td>
</tr>
<tr>
<td>• Air Pollution Ozone Days</td>
<td>- Preterm Births</td>
</tr>
</tbody>
</table>

Information Gaps

The majority of health indicators are only available at the county level. This presents a number of challenges as health indicators were evaluated across multiple counties. In evaluating data for entire counties versus ZIP code level data, it is difficult to understand the health needs for specific population pockets within a county. It is also a challenge to tailor programs to address community health needs as placement and access to those programs in one part of the county may or may not actually impact the population who truly need the service. Truven Health supplemented health indicator data with ZIP code estimates to assist in identifying specific populations within a community where health needs may be greater.

Prioritizing Community Health Needs

The CHNA prioritization process utilized a modified version of a method developed by Hanlon and his colleagues (see Hanlon & Pickett, 1990). First, the Oakwood Healthcare CHNA Steering Committee
selected the criteria by which to prioritize the health needs. The committee reviewed a list of 12 criteria commonly used in needs prioritization, had a robust discussion regarding which criteria was most appropriate for prioritizing community needs, and then used a multi-voting process to determine the five criteria for rating Oakwood Healthcare community health needs. The five criteria included:
• Magnitude of the need – the number of people impacted by the problem
• Severity of the need – the risk of morbidity and mortality associated with the problem
• Alignment of the problem with organizational strengths
• The organization has existing resources to address the problem (including dollars, ability to partner, organization infrastructure/leadership support, and organization capacity)
• Ability to measure change – organization impact on the need can be monitored and measured

In addition to the five criteria, the committee emphasized the underlying foundation of the prioritization process should be a focus on serving vulnerable populations.

Using qualitative feedback from the interviews and focus groups, as well as the health indicator data, the issues currently impacting the community were consolidated and assembled in the matrix on the following page to assist in identifying the significant health needs.

To prioritize the health needs identified in the matrix, Truven Health facilitated a prioritization session with Oakwood Healthcare representatives. Participants included:
• Sally Bailey, Manager, Case Utilization Management, Oakwood Annapolis Hospital
• David Campbell, Executive Vice President, Operations, System Strategy and Growth, Oakwood Healthcare
• Brian Connolly, President and CEO, Oakwood Healthcare
• Mark Deming, Administrator, Finance, Oakwood Heritage Hospital
After reviewing the identified community needs, Oakwood Healthcare representatives agreed to focus prioritization on the upper right quadrant of the matrix where the qualitative data (interview and focus group feedback) and quantitative data (health indicators) converged. The group then reviewed the criteria selected by the steering committee and used affinity voting to prioritize the list of significant community health needs. The group then discussed which of those high priority needs were most appropriate for Oakwood Healthcare to address as a healthcare system.

**Health Needs to be Addressed by Oakwood**
The group identified the following health care needs as priorities for Oakwood Healthcare:
1) Heart/Cardiovascular Disease
2) Diabetes
3) Obesity
4) Access to Care

While each of the health needs identified in the prioritization process is important and many are currently addressed by programs and initiatives of Oakwood Healthcare, allocating significant resources to the four priority needs above prevents the inclusion of all health needs in the Oakwood Implementation Plans.

**Summary**
Oakwood Healthcare conducted a Community Health Needs Assessment beginning January 2013 to identify and begin to address the health needs of the communities they serve. Using both qualitative community feedback, as well as publically available and proprietary health indicators, Oakwood Healthcare was able to identify and prioritize community health needs for their hospital system. Oakwood will address four priority health needs including Heart/Cardiovascular Disease, Diabetes, Obesity, and Access to Care.
Key Findings

This community health needs assessment revealed similar themes for the individual communities served by each of the Oakwood Healthcare hospitals. Prevention/Lifestyle choices, chronic condition/disease rates, access, mental health, and health providers/services were among the top needs across the facilities.

The interviews and focus groups revealed that the majority of individuals feel that the health status of the community they represent is fair to poor. Much of this is attributed to chronic diseases as well as lifestyle choices and lack of preventive health efforts. The need for more healthcare providers and services as well as improved access to health care was identified as the top needs across all those interviewed. Not surprisingly, barriers to good health include socioeconomic factors as well as access issues. The elderly and minority populations were identified as those being most at risk.

Taking into account the quantitative health indicators along with the community feedback, Oakwood Healthcare prioritized the community healthcare needs identified and has chosen to address the following prioritized needs:

1. Chronic Disease: Heart/Cardiovascular Disease
2. Chronic Disease: Diabetes
3. Lifestyle/Prevention: Obesity
4. Access to Care

The remainder of this report will provide a summary of findings for Oakwood Healthcare as well as detailed findings specific to each of the four hospitals.
Community Served

The overall Oakwood Healthcare community served is defined as the ZIP codes that comprise 80% of inpatient discharges and are contiguous. The Oakwood Healthcare community served is the aggregate of each hospital’s community. It is important to note that individual hospital communities overlap.
Community Served Demographics

Population is declining in the Oakwood Healthcare community at a greater rate than Michigan overall. OHH and OHMC are seeing the largest decrease in 5-year population projections. The Oakwood Healthcare community is less racially diverse than the US but more diverse than the state. Among the Oakwood Healthcare hospital communities, OAH is the most racially diverse while OSMC is the least. Compared to Michigan, the Oakwood Healthcare community has a higher proportion of Medicaid/Uninsured and the OHH community contains the highest proportion of these groups.

### Benchmarks/Oakwood Community

<table>
<thead>
<tr>
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<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>United States</td>
<td>313,095,504</td>
<td>3.9%</td>
<td>24%</td>
<td>13%</td>
<td>20%</td>
<td>37%</td>
<td>15%</td>
<td>16%</td>
<td>15%</td>
<td>16%</td>
<td>$49,559</td>
</tr>
<tr>
<td>Michigan</td>
<td>9,856,448</td>
<td>-0.7%</td>
<td>24%</td>
<td>13%</td>
<td>20%</td>
<td>21%</td>
<td>16%</td>
<td>13%</td>
<td>16%</td>
<td>13%</td>
<td>$47,187</td>
</tr>
<tr>
<td>Oakwood Health System Overall</td>
<td>942,556</td>
<td>-4.4%</td>
<td>25%</td>
<td>12%</td>
<td>20%</td>
<td>27%</td>
<td>19%</td>
<td>16%</td>
<td>15%</td>
<td>16%</td>
<td>$47,199</td>
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<tr>
<td>Oakwood Annapolis Hosp</td>
<td>290,088</td>
<td>-2.2%</td>
<td>26%</td>
<td>10%</td>
<td>21%</td>
<td>34%</td>
<td>15%</td>
<td>12%</td>
<td>15%</td>
<td>12%</td>
<td>$53,892</td>
</tr>
<tr>
<td>Oakwood Heritage Hosp</td>
<td>563,302</td>
<td>-5.0%</td>
<td>25%</td>
<td>13%</td>
<td>20%</td>
<td>27%</td>
<td>19%</td>
<td>16%</td>
<td>19%</td>
<td>16%</td>
<td>$44,709</td>
</tr>
<tr>
<td>Oakwood Hospital &amp; Medical Center</td>
<td>755,086</td>
<td>-5.8%</td>
<td>25%</td>
<td>13%</td>
<td>21%</td>
<td>29%</td>
<td>22%</td>
<td>18%</td>
<td>22%</td>
<td>18%</td>
<td>$42,608</td>
</tr>
<tr>
<td>Oakwood Southshore MC</td>
<td>291,621</td>
<td>-3.0%</td>
<td>23%</td>
<td>13%</td>
<td>20%</td>
<td>13%</td>
<td>15%</td>
<td>13%</td>
<td>15%</td>
<td>13%</td>
<td>$49,508</td>
</tr>
</tbody>
</table>

The OHMC community, followed by the OHH community, has the greatest social barriers—known demographic and socioeconomic factors that contribute to health disparities—when compared to Michigan and Oakwood Healthcare community overall.
Community – Interviews & Focus Groups

Interviews and a focus group were conducted for each of the Oakwood Healthcare hospital communities. In addition, a fifth focus group and set of interviews were conducted with individuals who had insight into the overall community served by Oakwood Healthcare.

Interviewees and focus group participants for the overall Oakwood Healthcare community were categorized into representative groups. In the chart below, an “I” indicates an interview and “FG” indicates participation in a focus group. For individuals outside Oakwood Healthcare, representative organizations have been listed.

<table>
<thead>
<tr>
<th>Community Leaders/Groups</th>
<th>Public and Other Organizations</th>
<th>Other Providers</th>
<th>Oakwood Healthcare</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fawaz, Ned (Islamic Center of America, I)</td>
<td>Ahmed, Ismail (University of Michigan Dearborn, I)</td>
<td>Boleare, Kalisha (Focus: Hope, FG)</td>
<td>Medvec, Barb (OHS SVP &amp; CNO, I)</td>
</tr>
<tr>
<td>Kaleniecki, Ruth (National Kidney Foundation, I)</td>
<td>Allen, Chris (Detroit Wayne County Health Authority, I)</td>
<td>Meyers, Carol (Wayne Metropolitan Community Action Agency, FG)</td>
<td>Connolly, Brian (OHS President &amp; CEO, I)</td>
</tr>
<tr>
<td>Khalifa, Rose (Metro Healthcare, I)</td>
<td>Anthony, Veronica (City of Detroit Department of Health and Wellness Promotion, I)</td>
<td>Miller-Anderson, Susan (The Information Center, FG)</td>
<td>DeLano, Jessica &amp; Greenwell, Wendy (OHS Managed Care, I)</td>
</tr>
<tr>
<td>Wolverton, Brian (YMCA of Metropolitan Detroit, FG)</td>
<td>How, Kathleen (Henry Ford Community College, I)</td>
<td>Miles, Carolyn (International Gospel Center Svcs, FG)</td>
<td>Sengstock M.D., David (OHS Prog Dir Geriatrics, I)</td>
</tr>
<tr>
<td>Imes, Glenn (Michigan Department of Community Health, I)</td>
<td>Taneja, Vinny (Wayne County Dept of Public Health, I)</td>
<td>Miles, Chris (International Gospel Center Svcs, FG)</td>
<td>Stellini, Sue (OHS SlA Cardiology, I)</td>
</tr>
<tr>
<td>Kilina, Edith (Wayne County Health and Human Services, I)</td>
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</table>

In order to analyze the qualitative feedback, interview responses were aggregated into categories by theme in order to group similar responses together and focus group participants reached consensus through group exercises.
Community Health Needs Assessment - 2013

Community - Interviews and Focus Groups

In the interview process, the majority of individuals gave the current health status of the community a grade of “C,” closely followed by “D” on an A-F scale. The major issues contributing to this health status include prevention/lifestyle choices, chronic diseases, and lack of education.

For the overall Oakwood healthcare community, the top five health needs identified in the interview process include:

1. Prevention/Lifestyle (including obesity, nutrition, smoking, and screenings)
2. Condition/Disease Rates (including heart disease/hypertension, diabetes, asthma)
3. Access to Care (including barriers to seeking or receiving care)
4. Healthcare providers/services (including geriatrics and other specialists)
5. Mental Health

Barriers to good health care in this community include access to care, insurance coverage, inadequate transportation, financial resources, and prevention/lifestyle. Minorities were identified as the top vulnerable group that will need special attention when addressing health needs.

Focus group participants were asked to grade the health of the community based on an A-F scale, provide feedback in terms of that grade, and work in small groups to determine the top three health needs of the community. For the overall Oakwood Healthcare group, the average grade for the health of the community was a C. Much of this was attributed to chronic disease, lack of healthy eating and nutrition, barriers to understanding health and disease management, and lack of insurance.

Positive feedback included availability of screenings and mobile health units in the community, as well as the presence of local parks, community centers, and community gardens.

The focus group split into three smaller groups to determine the top three health needs of the community. Group 1 selected socioeconomic barriers, proper nutrition, and obesity. Group 2 selected lack of participation in primary care, lack of transportation and inadequate financial resources. Group 3 selected nutrition, blight (abandoned buildings), and accessible clinics. Group 4 selected behavioral health (mental health and substance abuse), adequate healthcare (for dental care, Medicaid and homeless), and preventative health.

In the same small groups, focus group participants were asked to identify community resources that could help address the health issues in the community. Some of the resources identified include:

- YMCA
- Colleges/School Systems
- Churches
- Hospitals
- Teen Health Centers
- Police and Fire Services
- Senior Centers
- FQHCs
- Detroit/Wayne Co Mental Health
- Focus Hope
- The Information Center
- SEMCA
- The Guidance Center
- Senior Alliance
- Detroit Area on Aging
- United Way and 2-1-1

The Oakwood Healthcare Appendix A – B includes a more comprehensive list of existing community resources available to address the health needs of the community.
Oakwood Annapolis Hospital

Oakwood Annapolis Hospital is a 221-bed teaching hospital providing western Wayne County residents with quality general medical and specialty services in a state-of-the-art healthcare environment since 1957. OAH’s offerings include 24-hour emergency care and Level III Trauma services; minimally invasive and da Vinci robotic surgical services; laboratory and advanced imaging services such as open MRI; and heart catheterization. OAH also features one of the region’s leading comprehensive birthing centers offering private labor and delivery suites as well as a dedicated hospice and palliative care unit.

Community Served and Demographics

The OAH community is defined as the ZIP codes that comprise 80% of inpatient discharges and are contiguous. Below is a map that highlights the OAH community (in blue) as it relates to the overall Oakwood Healthcare community. Also included is a table which details the ZIP codes included in the community definition.
The OAH community served population is approximately 290,088. By 2017, this population is projected to decrease by 2.2%. While the largest portion of the population is made up of White Non-Hispanics (192,698), in the next five years, the largest percentages of growth will be in the Asian population (+11%, +2,181 individuals).

The 18-44 age group constitutes the largest portion of the OAH community served, followed by the 45-64 age group.

The age 65+ population is projected to have the largest percentage of growth in the next 5 years.

The median household income for the OAH community served is $52,316. More than 60% of individuals have private insurance; either employer sponsored insurance (55%) or individually purchased (5%). Another 15% are covered by Medicaid, 13% are uninsured and 12% are covered by Medicare or are Medicare Dual Eligible.
Community Health Needs Assessment – 2013

Interviews & Focus Groups

Interviewees and focus group participants were categorized into representative groups. In the chart below, an “I” indicates an interview and “FG” indicates participation in a focus group. For individuals outside Oakwood Healthcare, representative organizations have been listed.

<table>
<thead>
<tr>
<th>Community Leaders/Groups</th>
<th>Public and Other Organizations</th>
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<th>OHS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Duckworth, John E. Rev. Dr. (Gethsemani Missionary Baptist Church, I)</td>
<td>McCarthy, Kathy (Canton Township - Leisure Services, FG)</td>
<td>Bize, Theresa (First Step, FG)</td>
<td>Hillbom, Rick (OHS COO Outpatient, I)</td>
</tr>
<tr>
<td>English, Robert (City of Wayne, FG)</td>
<td>Williams, Jeanette (Canton Township - Leisure Services, FG)</td>
<td>Webb, Sarah (Comfort Keepers, FG)</td>
<td>Parker, Sandra (OHS Inkster Teen Health Center, FG)</td>
</tr>
<tr>
<td>Maciag, Allen (Wayne Police Department, FG)</td>
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</table>

- Represents Public Health
- Represents Medically Underserved Populations
- Represents Low Income Populations
- Represents Populations with Chronic Disease Needs
- Represents Minority Populations

In order to analyze the qualitative feedback, interview responses were aggregated into categories by theme in order to group similar responses together and focus group participants reached consensus through group exercises.

In the interview process, the majority of individuals gave the current health status of the community a grade of either “C” or “D” on an A-F scale. The major issues contributing to this health status include chronic disease rates, lifestyle choices, financial resources, access issues, increasing need, and health literacy.

For the OAH community, the top three health needs identified in the interview process include:
1. Prevention/Lifestyle (*including obesity, preventative care and screenings*)
2. Condition/Disease Rates (*including diabetes, heart disease/hypertension*)
3. Mental Health

Barriers to good health care in this community include inadequate transportation, financial resources, access and the economy. Children were identified as the top vulnerable group that will need special attention when addressing health needs.
Focus group participants were asked to grade the health of the community based on an A-F scale, provide feedback in terms of that grade, and work in small groups to determine the top three health needs of the community. For the OAH group, the average grade for the health of the community was a C. Much of this was attributed to the lack of healthy food/exercise, lack of access to healthcare and transportation, and a breakdown in socioeconomic infrastructure (broken families, drug abuse, gun control, etc.).

Some of the positive feedback included OAH’s strong partnerships in the community, school based health centers, an upswing in the farmer’s market and community gardens, health fairs offered by faith based organizations and the feeling that there is an abundance of resources that exist already.

The focus group split into three smaller groups to determine the top three health needs of the community. Group 1 selected transportation, basic health, and long term opportunities (job security, education, etc.). Group 2 selected access and coordination, community education, and long term community health data. Group 3 selected access to health resources, education, and violence prevention.

In the same small groups, focus group participants were asked to identify community resources that could help address the health issues in the community. Some of the resources identified include:

- Faith Based Organizations
- Justice System
- Veterans
- Health Systems
- School Systems
- Department of Social Services
- Care Transitions Coalition
- Government
- Food Pantry
- Farmers Market
- Aging and Disability Resource Center
- Insurance Companies
- Community Gardens
- Employers
- First Step

The Oakwood Healthcare Appendix A – B includes a more comprehensive list of existing community resources available to address the health needs of the community.

Health Indicators

Truven Health Analytics supplemented the publically available data with estimates of disease prevalence for heart disease and cancer, emergency department visit estimates, and the community need index.

Heart disease estimates indicate a prevalence of 96,037 cases for the OAH community served. The majority (70%) of the 2011 estimates of heart disease prevalence indicate hypertension as the primary diagnosis. Other diagnoses include arrhythmias (12%), ischemic heart disease (12%), and congestive heart failure (6%).
The 2011 cancer incidence estimates reveal at least 200 new cases of each of the following types of cancer: lung and breast. For the community served, there were an estimated 1,347 new cancer cases in 2011.

The Truven Health Community Need Index (CNI) is a statistical approach to identifying health needs in a community. The CNI takes into account vital socioeconomic factors \textit{(income, cultural, education, insurance and housing)} about a community to generate a CNI score for every populated ZIP code in the United States. The CNI is strongly linked to variations in community healthcare needs and is a strong indicator of a community’s demand for various healthcare services. The CNI score by ZIP code identifies specific areas within a community where healthcare needs may be greater.

Overall, the OAH community served had a CNI of 3.2 on a scale of 1.0 (lowest needs) – 5.0 (highest needs). Compared to the other Oakwood communities, OAH has the second lowest CNI score.
Community Health Needs Assessment – 2013

Oakwood Annapolis Hospital

Prioritized Health Needs
From the OAH campus, Eric Widner, President; David Campbell, Executive Vice President, Operations, System Strategy and Growth; Sally Bailey, Manager, Case Utilization Management; and Lindsey West, Manager, Community Health, participated in the prioritization meeting with other Oakwood Healthcare representatives in which the needs of the Oakwood Healthcare community were prioritized. The Oakwood Healthcare representatives then chose which of the significant community health needs were most appropriate for Oakwood Healthcare to address as a healthcare system.

Oakwood Healthcare has chosen to address the following prioritized community health needs: heart/cardiovascular disease, diabetes, obesity and access to care.

Summary
This community health needs assessment revealed similar themes for the individual communities served by each of the Oakwood Healthcare hospitals. Taking into account the quantitative health indicators along with the community feedback, four prioritized health needs for the Oakwood Healthcare community were identified. The community health needs assessment identified a number of health issues for the OAH community related to chronic diseases, lifestyle choices, and/or socioeconomic environmental factors. OAH worked with other Oakwood Healthcare stakeholders to determine which of the prioritized community health needs Oakwood Healthcare and OAH plan to address. With the goal of improving the health of the community, implementation plans with specific tactics and time frames will be developed to address these health needs.
Oakwood Heritage Hospital

Oakwood Heritage Hospital (OHH) has been committed to making customer satisfaction its top priority since 1977. OHH has earned recognition as the leading total joint replacement hospital in the region. The hospital also excels in clinical quality and innovation in the areas of heart attack, heart failure, pneumonia, and surgical care. OHH has been awarded the National Top Performer Award by the Joint Commission two years in a row. The hospital has recently invested in more than $30 million in expansion and renovation projects.

Community Served and Demographics

The OHH community is defined as the ZIP codes that comprise 80% of inpatient discharges and are contiguous. Below is a map that highlights the OHH community (in green) as it relates to the overall Oakwood Healthcare community. Also included is a table which details the ZIP codes included in the community definition.
The OHH community served population is approximately 563,302. By 2017, this population is projected to decrease by 5%. While the largest portion of the population is made up of White Non-Hispanics (413,906), in the next 5 years, the largest percentage of growth will be in the other race-ethnicity category (+13%, +1,248 individuals). All other ethnicities will experience a decline in population.

The 18-44 age group constitutes the largest portion of the OHH community served, followed by the 45-64 age group.

The age 65+ population is projected to have the largest percentage of growth in the next 5 years.
The median household income for the OHH community served is $45,631. More than 49% of individuals have private insurance; either employer sponsored insurance (45%) or individually purchased (4%). Another 19% are covered by Medicaid, 16% are uninsured and 16% are covered by Medicare or are Medicare Dual Eligible.

**Interviews & Focus Groups**

Interviewees and focus group participants were categorized into representative groups. In the chart below, an “I” indicates an interview and “FG” indicates participation in a focus group. For individuals outside Oakwood Healthcare, representative organizations have been listed.

<table>
<thead>
<tr>
<th>Community Leaders/ Groups</th>
<th>Public and Other Organizations</th>
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<th>OHS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brooks, Linda (YMCA of Metropolitan Detroit, FG)</td>
<td>Waechter, Jeremy (Taylor Substance Abuse Task Force, FG)</td>
<td>Stoyanovitch, Diane (Interfaith Health and Hope, FG)</td>
<td>Smith, Kelly (OHS Pres OHH, I)</td>
</tr>
<tr>
<td>Gay, Steve (The Guidance Center, FG)</td>
<td>Waens, Ron (Southgate Rotary Club, FG)</td>
<td>Winnis, Theresa (Taylor Schools, FG)</td>
<td>Williams, Kathy (St. Paul UCC Health Ministries, FG)</td>
</tr>
<tr>
<td>Malkowski, Elizabeth (Tendercare of Taylor, FG)</td>
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</table>

In order to analyze the qualitative feedback, interview responses were aggregated into categories by theme in order to group similar responses together and focus group participants reached consensus through group exercises. The interview feedback and responses for OHH have been included in the focus group qualitative assessment.

Focus group participants were asked to grade the health of the community based on an A-F scale, provide feedback in terms of that grade, and work in small groups to determine the top three health needs of the community. For the OHH group, the average grade for the health of the community was a C. Much of this was attributed to the prevalence of serious mental health issues, lifestyle choices, the affordability of healthcare, transportation, shortage of primary care physicians, and low levels of health literacy and education. However, many participants said OHH’s partnership with area schools was a positive attribute.

The focus group split into three smaller groups to determine the top three health needs of the community. Group 1 selected basic wellness/preventive care, access to mental health services, and community feedback (*what does the community want or need*). Group 2 selected mental health, chronic illness,
and education. Group 3 selected mental health, childhood health issues (obesity, nutrition, etc.) and chronic illness in the elderly population.

In the same small groups, focus group participants were asked to identify community resources that could help address the health issues in the community. Some of the resources identified include:

- Wayne Metro
- The Information Center
- Local Health Departments
- Education System
- Food Banks
- Faith Based Organizations
- Home Health/Hospice
- Guidance Center
- Community Care Services
- Early On
- Urgent Care
- Hospitals
- Medicaid
- MAPI Free Clinic
- Mental Health Clinic
- World Medical Relief
- Nursing Rehabilitation
- YMCA
- Head Start
- MI Child

The Oakwood Healthcare Appendix A – B includes a more comprehensive list of existing community resources available to address the health needs of the community.

Health Indicators

Truven Health Analytics supplemented the publically available data with estimates of disease prevalence for heart disease and cancer, emergency department visit estimates, and the community need index.

Heart disease estimates indicate a prevalence of 203,423 cases for the OHH community served. The majority (69%) of the 2011 estimates of heart disease prevalence indicate hypertension as the primary diagnosis. Other diagnoses include arrhythmias (12%), ischemic heart disease (13%), and congestive heart failure (6%).

The 2011 cancer incidence estimates reveal at least 400 new cases of each of the following types of cancer: lung and breast. For the community served, there were an estimated 2,953 new cancer cases in 2011.

Emergency Room visits are slated to grow by about 75 between 2012 and 2017.
The Truven Health Community Need Index (CNI) is a statistical approach to identifying health needs in a community. The CNI takes into account vital socioeconomic factors (income, cultural, education, insurance and housing) about a community to generate a CNI score for every populated ZIP code in the United States. The CNI is strongly linked to variations in community healthcare needs and is a strong indicator of a community’s demand for various healthcare services. The CNI score by ZIP code identifies specific areas within a community where healthcare needs may be greater.

Overall, the OHH community served had a CNI of 3.5 on a scale of 1.0 (lowest needs) – 5.0 (highest needs). Compared to the other Oakwood Healthcare communities, OHH has the second highest score.

Prioritized Health Needs
From the OHH campus, Kelly Smith, President, Oakwood Heritage Hospital; Mark Deming, Administrator, Finance; Mary Zatina, Senior Vice President of Government Relations and Corporate Communications; and Karen Wright, Director of Strategic Planning, participated in the prioritization meeting with other Oakwood Healthcare representatives in which the needs of the Oakwood Healthcare community were prioritized. The Oakwood Healthcare representatives then chose which of the significant community health needs were most appropriate for Oakwood Healthcare to address as a healthcare system.

Oakwood Healthcare has chosen to address the following prioritized community health needs: heart/cardiovascular disease, diabetes, obesity and access to care.
Community Health Needs Assessment - 2013
Oakwood Heritage Hospital

Summary
This community health needs assessment revealed similar themes for the individual communities served by each of the Oakwood Healthcare hospitals. Taking into account the quantitative health indicators along with the community feedback, four prioritized health needs were identified for the Oakwood Healthcare community. The community health needs assessment for the OHH community served revealed a number of health issues related to disease management, lifestyle choices, and/or socioeconomic or environmental factors. OHH worked with other Oakwood Healthcare stakeholders to determine which of the prioritized community health needs OHH and Oakwood Healthcare plan to address. With the goal of improving the health of the community, implementation plans with specific tactics and time frames will be developed to address these health needs.
Oakwood Hospital & Medical Center

Oakwood Hospital & Medical Center (OHMC) has served residents across southeastern Michigan for more than 50 years and has been recognized for clinical excellence and innovation. OHMC is a major teaching and research hospital and home to three medical residency programs in partnership with Wayne State University School of Medicine. The hospital was also named one of the 10 Best Hospitals in Michigan by U.S. News & World Report, includes a Level 2 Trauma Center, and excels in the fields of orthopedics, neurosciences, women’s health, heart and vascular, and cancer care.

Community Served and Demographics

The OHMC community is defined as the ZIP codes that comprise 80% of inpatient discharges and are contiguous. The overall Oakwood Healthcare community is the aggregate of each hospital’s community. It is important to note that individual hospital communities overlap. Below is a map that illustrates the OHMC community served (in red) as it relates to the overall Oakwood Healthcare community. Also included is a table which details the ZIP codes included in the community definition.
The OHMC community served population is approximately 755,086. By 2017, this population is projected to decrease by 5.8% - the slowest growing community among the Oakwood Healthcare facilities. While the largest portion of the population is made up of White Non-Hispanics (536,771), in the next five years, the largest percentage of growth will be in the other race-ethnicity category (+4%, +1,086 individuals). All other populations will decrease in the next five years.

The 18-44 age group constitutes the largest portion of the OHMC community served, followed by the 45-64 age group.
The age 65+ population is projected to have the largest percentage of growth in the next 5 years.

The median household income for the OHMC community served is $46,620. Over 45% of individuals have private insurance; either employer sponsored insurance (42%) or individually purchased (3%). Another 22% are covered by Medicaid, 18% are uninsured and 15% are covered by Medicare or are Medicare Dual Eligible.

**Interviews & Focus Groups**

Interviewees and focus group participants were categorized into representative groups. In the chart below, an “I” indicates an interview and “FG” indicates participation in a focus group. For individuals outside Oakwood Healthcare, representative organizations have been listed.

In order to analyze the qualitative feedback, interview responses were aggregated into categories by theme in order to group similar responses together and focus group participants reached consensus through group exercises.

In the interview process, the majority of individuals gave the current health status of the community a grade of a D on an A-F scale. The major issues contributing to this health status include lifestyle choices, alcohol and drug abuse, access, mental health and education.
Community Health Needs Assessment – 2013
Oakwood Hospital & Medical Center

For the OHMC community, the top three health needs identified in the interview process include:
1. Access
2. Condition/Disease Rates (including diabetes, heart disease, and cancer)
3. Mental Health

Barriers to good health care in this community include diversity and the economy. The minority populations and poor were identified as vulnerable groups that will need special attention when addressing health needs.

Focus group participants were asked to grade the health of the community based on an A-F scale, provide feedback in terms of that grade, and work in small groups to determine the top three health needs of the community. For the OHMC group, the average grade for the health of the community was a C. Much of this was attributed to mental health issues, violence in the area, and access to healthcare.

The focus group split into two smaller groups to determine the top three health needs of the community. Group 1 selected mental health, violence prevention, and the “sandwich generation” (those caring for grandchildren and/or elderly parents). Group 2 selected exercise, insurance awareness, and “go to” resources.

In the same small groups, focus group participants were asked to identify community resources that could help address the health issues in the community. Some of the resources identified include:

- Wayne Metro
- Oakwood Taylor Teen Health Center
- Faith Based Organizations
- The Information Center
- Hospital Systems
- Education System
- Guidance Center
- Michigan Breast and Cervical Cancer Control Program
- American Diabetes Association
- American Heart Association
- Centers for Medicare and Medicaid Services
- Food Pantries
- Federally Qualified Health Clinics
- Salvation Army
- Civic Clubs

The Oakwood Healthcare Appendix A – B includes a more comprehensive list of existing community resources available to address the health needs of the community.

Health Indicators
Truven Health Analytics supplemented the publically available data with estimates of disease prevalence for heart disease and cancer, emergency department visit estimates, and the community need index.
Heart disease estimates indicate a prevalence of 275,029 cases for the OHMC community served. The majority (69%) of the 2011 estimates of heart disease prevalence indicate hypertension as the primary diagnosis. Other diagnoses include arrhythmias (12%), ischemic heart disease (13%), and congestive heart failure (6%).

The 2011 cancer incidence estimates reveal an estimated 3,954 new cancer cases. At least 600 of these cases are lung and breast cancer.

Emergency Room visits are slated to decrease by about 1,321 between 2012 and 2017.

The Truven Health Community Need Index (CNI) is a statistical approach to identifying health needs in a community. The CNI takes into account vital socioeconomic factors (income, cultural, education, insurance and housing) about a community to generate a CNI score for every populated ZIP code in the United States. The CNI is strongly linked to variations in community healthcare needs and is a strong indicator of a community’s demand for various healthcare services. The CNI score by ZIP code identifies specific areas within a community where healthcare needs may be greater.

Overall, the OHMC community served had a CNI of 3.7 on a scale of 1.0 (lowest needs) – 5.0 (highest needs). Compared to the other Oakwood Healthcare communities, OHMC has the highest need.
Prioritized Health Needs
From the OHMC campus, Brian Connolly, President and CEO, Oakwood Healthcare; Doug Welday, Executive Vice President, Oakwood Healthcare & President Oakwood Hospital and Medical Center; Jonathan Zimmerman, Program Director of Internal Medicine; and Barb Medvec, Senior Vice President and Chief Nursing Officer, Oakwood Healthcare; participated in the prioritization meeting with other Oakwood Healthcare representatives in which the needs of the Oakwood Healthcare community were prioritized. The Oakwood Healthcare representatives then chose which of the significant community health needs were most appropriate for Oakwood Healthcare to address as a healthcare system.

Oakwood Healthcare has chosen to address the following prioritized community health needs: heart/cardiovascular disease, diabetes, obesity and access to care.

Summary
This community health needs assessment revealed similar themes for the individual communities served by each of the Oakwood Healthcare hospitals. Taking into account the quantitative health indicators along with the community feedback, four prioritized health needs for the Oakwood Healthcare community were identified. The community health needs assessment for the OHMC community served revealed a number of health issues related to disease management, lifestyle choices, and/or socioeconomic or environmental factors. OHMC worked with other Oakwood Healthcare stakeholders to determine which of the prioritized community health needs Oakwood Healthcare and OHMC plan to address. With the goal of improving the health of the community, implementation plans with specific tactics and time frames will be developed to address these health needs.
Oakwood Southshore Medical Center

Oakwood Southshore Medical Center (OSMC) is ranked within the top 20 Best Hospitals in the Metro Detroit Area and provides comprehensive medical care to area residents. The hospital recently completed a $64 million renovation of its facilities and is the only Level 2 Trauma Center serving the Downriver community.

Community Served and Demographics
The OSMC community is defined as the ZIP codes that comprise 80% of inpatient discharges and are contiguous. The overall Oakwood Healthcare community is the aggregate of each hospital’s community. It is important to note that individual hospital communities overlap. Below is a map that highlights the OSMC community (in orange) as it relates to the overall Oakwood Healthcare community. Also included is a table which details the ZIP codes included in the community definition.
The OSMC community served population is approximately 291,621. By 2017, this population is projected to decrease by 3%. While the largest portion of the population is made up of White Non-Hispanics (254,559), in the next five years, the largest percentages of growth will be in the other race-ethnicity category (+16%, +946 individuals).

The 18-44 age group constitutes the largest portion of the OSMC community served, followed by the 45-64 age group.

The 65+ population is projected to have the largest percentage of growth in the next 5 years.
The median household income for the OSMC community served is $46,621. More than 56% of individuals have private insurance; either employer sponsored insurance (52%) or individually purchased (4%). Another 15% are covered by Medicaid, 13% are uninsured and 16% are covered by Medicare or are Medicare Dual Eligible.

**Interviews & Focus Groups**

Interviewees and focus group participants were categorized into representative groups. In the chart below, an “I” indicates an interview and “FG” indicates participation in a focus group. For individuals outside Oakwood Healthcare, representative organizations have been listed.

In order to analyze the qualitative feedback, interview responses were aggregated into categories by theme in order to group similar responses together and focus group participants reached consensus through group exercises.

In the interview process, the majority of individuals gave the current health status of the community a grade of “C” on an A-F scale. The major issues contributing to this health status include health providers/services, access, education, lifestyle choices, and family composition.

For the OSMC community, the top health needs identified in the interview process include:
1. Prevention/Lifestyle (*including obesity and healthcare screenings*)
2. Health Providers/Services (*including trauma services and urgent/primary care*)

The lack of awareness of existing resources was the top barrier to good healthcare. The elderly population was identified as the top vulnerable group that will need special attention when addressing health needs.
Focus group participants were asked to grade the health of the community based on an A-F scale, provide feedback in terms of that grade, and work in small groups to determine the top three health needs of the community. For the OSMC group, the average grade for the health of the community was a C. Much of this was attributed to the lack of health education, mental health issues, the environment, and lifestyle choices.

The focus group split into three smaller groups to determine the top three health needs of the community. Group 1 selected health disparities, education/awareness, and communication. Group 2 selected education, mental health facility, and substance abuse rehabilitation facility. Group 3 selected mental health, environmental conditions *(contributing to cancer or asthma)*, and fitness/nutrition for cardiac diseases.

In the same small groups, focus group participants were asked to identify community resources that could help address the health issues in the community. Some of the resources identified include:

- Parks & Recreation
- Faith Based Organizations
- Technology
- Education System
- Home Health
- Guidance Center
- Christ Net
- Senior Centers
- AARP
- Head Start
- Meals on Wheels
- Hospitals
- Circle of Care
- YMCA
- Health Fairs

The Oakwood Healthcare Appendix A – B includes a more comprehensive list of existing community resources available to address the health needs of the community.

**Health Indicators**

Truven Health Analytics supplemented the publically available data with estimates of disease prevalence for heart disease and cancer, emergency department visit estimates, and the community need index.

Heart disease estimates indicate a prevalence of 107,182 cases for the OSMC community served. The majority (69%) of the 2011 estimates of heart disease prevalence indicate hypertension as the primary diagnosis. Other diagnoses include arrhythmias (12%), ischemic heart disease (13%), and congestive heart failure (6%).

The 2011 cancer incidence estimates reveal an estimated 1,550 new cancer cases; with at least 200 new cases attributed to lung and breast cancer.
Emergency Room visits are slated to grow by about 1,500 between 2012 and 2017.

The Truven Health Community Need Index (CNI) is a statistical approach to identifying health needs in a community. The CNI takes into account vital socioeconomic factors (income, cultural, education, insurance and housing) about a community to generate a CNI score for every populated ZIP code in the United States. The CNI is strongly linked to variations in community healthcare needs and is a strong indicator of a community’s demand for various healthcare services. The CNI score by ZIP code identifies specific areas within a community where healthcare needs may be greater.

Overall, the OSMC community served had a CNI of 3.0 on a scale of 1.0 (lowest needs) – 5.0 (highest needs). Compared to the other Oakwood Healthcare communities, OSMC has the lowest need.
Community Health Needs Assessment – 2013
Oakwood Southshore Medical Center

Prioritized Health Needs
From the OSMC campus, Edith Hughes, President; Carla O’Malley, Executive Director of Foundation; Jan Sladewski, Supervisor of Patient Relations; and Betty Priskorn, Corporate Director of Community Outreach, participated in the prioritization meeting with other Oakwood Healthcare representatives in which the needs of the Oakwood Healthcare community were prioritized. The Oakwood Healthcare representatives then chose which of the significant community health needs were most appropriate for Oakwood Healthcare to address as a healthcare system.

Oakwood Healthcare has chosen to address the following prioritized community health needs: heart/cardiovascular disease, diabetes, obesity and access to care.

Summary
This community health needs assessment revealed similar themes for the individual communities served by each of the Oakwood Healthcare hospitals. Taking into account the quantitative health indicators along with the community feedback, four prioritized health needs for the Oakwood Healthcare community were identified. The community health needs assessment for the OSMC community served revealed a number of health issues related to health providers/services, lifestyle choices, access, and education. OSMC worked with other Oakwood Healthcare stakeholders to determine which of the prioritized community health needs Oakwood Healthcare and OSMC plan to address. With the goal of improving the health of the community, implementation plans with specific tactics and time frames will be developed to address these health needs.
CHNA Implementation Strategy

In addition to identifying and prioritizing significant community health needs through the Community Health Needs Assessment (CHNA) process, PPACA requires creating and adopting an Implementation Strategy. An Implementation Strategy is a written plan addressing each of the community health needs identified through the CHNA. The Implementation Strategy must also include a list the prioritized needs the hospital plans to address and the rationale for not addressing the other identified health needs.

The Implementation Strategy is considered implemented on the date it is approved by the hospital’s governing body. The CHNA Implementation Strategy is filed along with the organization’s IRS Form 990, Schedule H and must be updated annually. Below is a summary of Oakwood Healthcare’s Implementation Strategy for the significant community health needs they have chosen to address.

Community Health Need: Heart & Cardiovascular Disease

Heart disease is one of the top five causes of death as well as leading causes of hospitalizations in Michigan. The Oakwood Healthcare community heart disease death rate and heart disease hospital discharge rate both exceed the overall state rate. In addition, the rate of adults diagnosed with heart disease in the Oakwood Healthcare community exceeds that of the state.

Oakwood Healthcare Initiative: Decrease cardiovascular disease risk factors (blood pressure, cholesterol, glucose, overweight, physical inactivity, smoking)

Strategies and Related Activities

- Provide screening and education services
  - Oakwood Heart Health Screening Program
  - Oakwood Speakers Bureau
  - Oakwood Medical Avatar

- Collaborate with local organizations to expand outreach of cardiovascular programs
  - Explore collaboration with American Heart Assn Heart 360: Get to the Goal hypertension initiative targeting the African American community with screenings, education, and follow-up

- Provide education and support services
  - Oakwood and The Senior Alliance Care Transition Intervention program for Medicare patients with Congestive Heart Failure and Heart Attack (Acute MI)
  - Oakwood Infant/Child CPR classes
Community Health Needs Assessment – 2013

CHNA Implementation Strategy

Community Health Need: Diabetes
Individuals with diabetes are at risk for several acute complications and are at greater risk of obesity, hypertension and heart disease. The rate of adults diagnosed with diabetes exceeds the state benchmark for portions of the Oakwood Healthcare community. Additionally, the percentage of diabetics in the Oakwood Healthcare community who receive screenings to monitor the long-term management of their disease falls below the state level.

Oakwood Healthcare Initiative: Decrease rate of new diabetes cases and of diabetes complications through prevention, early detection, and education

Strategies and Related Activities
• Provide screening and education services
  – OHS Metabolic and Nutrition Disorders program at Oakwood Annapolis Hospital
  – Oakwood Diabetes Screening program
  – Oakwood Diabetes Prevention workshops
  – Oakwood Speakers Bureau
  – OHS Diabetes Support Group at OHMC

• Collaborate with community agencies to increase programming
  – Partner with the National Kidney Foundation of MI to provide the Diabetes - PATH (Personal Action Toward Health) program in communities with high Community Need Index (CNI) scores
  – Partner with the National Kidney Foundation of MI to provide the National Diabetes Prevention Program in communities with high CNI scores
  – Cooking Matters Extra for Diabetes™ classes in collaboration with Gleaners Community Food Bank of SE Michigan in communities with high CNI scores
  – In collaboration with The Senior Alliance, explore expanding the Care Transitions Intervention program to Medicare patients with diabetes

Community Health Need: Obesity
Obesity increases the risk of many other chronic health conditions, including other conditions which impact the health of the Oakwood healthcare community such as diabetes and heart disease. The proportion of the Oakwood Healthcare community that is considered obese exceeds that of the state of Michigan.

Oakwood Healthcare Initiative: Decrease rate of obesity in children and adults by promoting regular physical activity and healthy eating behaviors.
Strategies and Related Activities

- Provide education on healthy eating, physical activity, and weight management
  - Oakwood CATCH Kids Club (Coordinated Approach to Child Health) after-school physical activity and nutrition program in collaboration with schools and with YMCA of Metro Detroit
  - Oakwood Cooking Matters™ classes in collaboration with Gleaners Community Food Bank of SE Michigan in communities with high CNI scores
  - Nutrition counseling at Oakwood Taylor Teen Center, Oakwood Inkster Teen Center, and Adams Child & Adolescent Health Center-Westland
  - Oakwood Taylor Teen Center Stepping towards Wellness program
  - Oakwood Weight Loss Program
  - Oakwood Vtrim® online Weight Management
  - Oakwood Losing for Good group coaching
  - Oakwood Lose Weight Your Way 12 week program with coaching
  - Oakwood Wellness Center for eligible community members and employees
  - Oakwood Speakers Bureau
  - Oakwood Red October Run
  - Oakwood myNutratek™ program

- Collaborate with local municipalities and coalitions to expand outreach of obesity prevention and weight management programs
  - Oakwood “Healthy Community” designation
  - Wayne County MOTION coalition child obesity and treatment coordination

Community Health Need: Access to Care

Individuals with access to care are more likely to receive preventative services and treatment for existing conditions thus avoiding downstream morbidity and mortality. The rate of adults and children without health insurance exceeds the state levels for portions of the Oakwood Healthcare community. In addition, the ratio of primary care physicians to overall population within the Oakwood Healthcare community comes in under state-wide levels.

Oakwood Healthcare Initiative: Increase access to care for the uninsured, underinsured or underserved

Strategies and Related Activities

- Oakwood School and Community based Child and Adolescent Health Centers and School Wellness Programs
  - Oakwood Adams Child & Adolescent Health Center, Westland
  - Oakwood Inkster Teen Center
  - Oakwood Taylor Teen Center
  - Provide primary healthcare, mental health services, health promotion, disease prevention education and referral services
  - Medicaid education and outreach activities in schools and the community
Community Health Needs Assessment – 2013

CHNA Implementation Strategy

• Oakwood Center for Exceptional Families
  - Provide primary healthcare, social work, mental health, physical therapy and referral services to children with special needs

• Provide services through the Oakwood Healthcare Center – Westland Clinic for Infectious Disease
  - Clinical services to out-Wayne County residents with active/suspected tuberculosis
  - Medical care for HIV patients in the Detroit metropolitan area
  - Assistance with healthcare plan enrollment

• Enhance access to primary care
  - Partnerships with Western Wayne Federally Qualified Health Centers (FQHCs), Hope Clinic, Covenant Community Care, Faith-based Outreach
  - Explore addition of Community Health Workers

• Oakwood Foundation to provide financial support to Oakwood hospitals for resources and supports for the low-income, underinsured, or uninsured
  - Funding support for patients in need of resources of other supports

Oakwood Healthcare Initiative: Assist individuals with enrollment into Medicaid or other healthcare plans

Strategies and Related Activities
• Medicaid and Health Plan enrollment for individuals
  - OakAssist
  - Partnership with ACCESS for Health Care Navigator
  - Partnership with Western Wayne Federally Qualified Health Centers (FQHCs) (Taylor & Inkster)
  - Partner with Enroll America
  - Partner with CMS as a “Champion of Coverage”

Oakwood Healthcare Initiative: Increase awareness of health resources

Strategies and Related Activities
• Increase community members’ knowledge of the healthcare and safety net resources that are currently available in the community
  - Post Oakwood Healthcare Resource Guide on website
  - Obtain funding to create Healthy Communities Advisory Committee
Communicating CHNA Results

The CHNA Report is available to the community on the Oakwood Healthcare website oakwood.org/chna and is downloadable. To obtain a copy, contact the Oakwood Department of Community Health at 313.586.5348. A plan to present a summary of the results to community groups has also been developed.

Planning for Action and Monitoring Progress

Oakwood Healthcare community health priorities will be addressed through strategies and activities described in the Implementation Strategy. Oakwood Healthcare leaders will participate in developing work plans and establishing metrics to measure progress. Oakwood Healthcare will build on existing community programs and partnerships to address the health needs identified through the Community Health Needs Assessment process.