# Atrium Health Wake Forest Baptist High Point Medical Center

## Community Health Needs Assessment Implementation Strategy

## Calendar Year 2022 – 2024

**Introduction**

High Point Regional Health, doing business as Atrium Health Wake Forest Baptist High Point Medical Center ("AHWFB-HPMC"), a North Carolina non-profit corporation, is a component member of Atrium Health Wake Forest Baptist ("AHWFB"), a preeminent, internationally recognized academic medical center with balanced excellence in patient care, research, and education. As part of AHWFB, AHWFB-HPMC has the resources of a nationally recognized academic medical center at its doorstep, enabling the hospital to offer world-class health care, close to home.

AHWFB-HPMC has a deep, rich history in the community that began in 1904. As the organization grew over time, the hospital developed into the health system that we have today. That growth has helped AHWFB-HPMC continue to fulfill its mission to provide exceptional health services to the people of its region of greater than 600,000 people. AHWFB-HPMC operates a 351 licensed bed hospital and provides many services to our community including: the Hayworth Cancer Center, Piedmont Joint Replacement Center, the Congdon Heart and Vascular Center, Esther R. Culp Women's Center, Neuroscience Center, Imaging Services, Orthopedic Services, Inpatient Pediatrics, Birth Center, Urgent Care, the Stroke Center, Pain & Spine Management, Rehabilitation Services, Behavioral Health and the Fitness Center.

**Vision**

Atrium Health Wake Forest Baptist High Point Medical Center's vision is to be the first and best choice for care.

**Mission**

Atrium Health Wake Forest Baptist High Point Medical Center's mission is to improve health, elevate hope and advance healing – for all.

**Culture Commitments**

Atrium Health Wake Forest Baptist High Point Medical Center's culture commitments include the following:

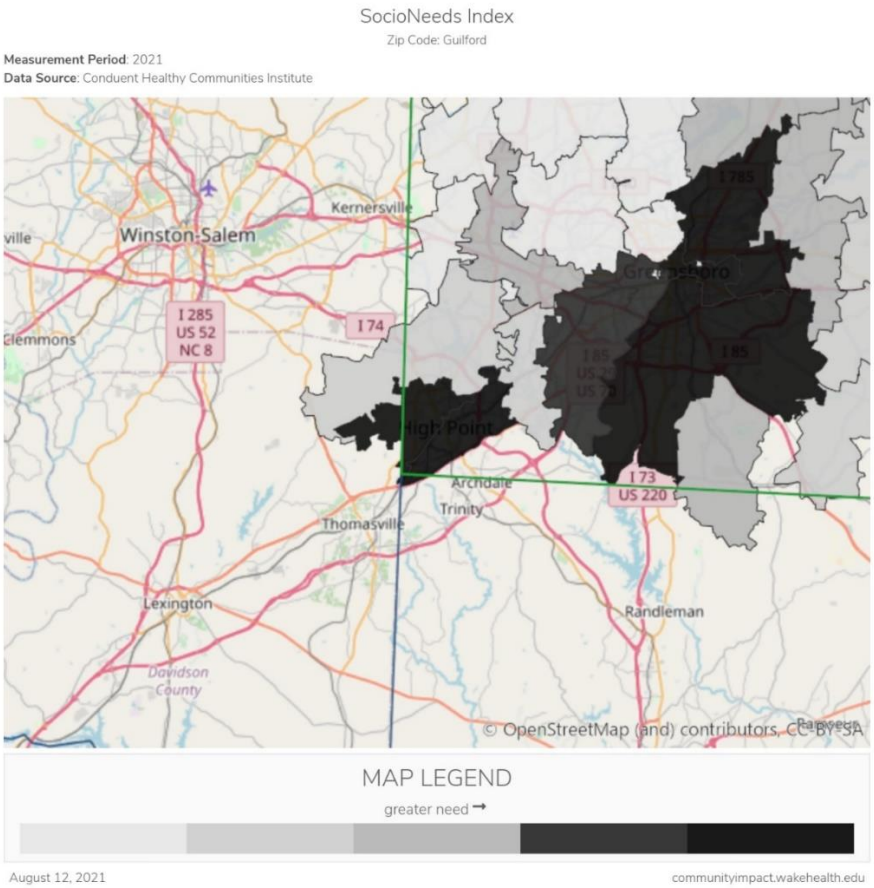
- We create a space where all ***Belong***
- We ***Work as One*** to make great things happen
- We earn ***Trust*** in all we do
- We ***Innovate*** to better the now and create the future
- We drive for ***Excellence -*** always

**Mission Alignments: Community Engagement Principles, Population Health, Health Equity, Social Impact**

AHWFB-HPMC is committed to improving access, community health, and addressing the needs of our most vulnerable communities. As a result, we will emphasize identifying the ***places*** (e.g., zip codes, census tracts, neighborhoods, streets), ***partners, people***, and aspects of ***poverty*** that we need to engage and address in our communities as we implement strategies.

We strive to be a leader in population health, health equity, and social impact as we look beyond the walls of our hospitals and medical offices to address social, economic, and environmental conditions that contribute to poor health outcomes, shortened lives, and higher health care costs of the communities we serve.

**Community Served**




High Point, NC is spread across four counties in North Carolina: Guilford, Forsyth, Davidson and Randolph. AHWFB-HPMC defines its service area to include the following zip codes: 27205, 27260, 27262, 27263, 27265, 27282, 27292, 27317, 27350, 27360, 27370, and 27407. These encompass the greater High Point community including Archdale, Trinity, Jamestown and other southwestern portions of Guilford County. However, the majority of inpatient admissions and emergency visits are provided to

Guilford County residents, representing 50% and 52% respectively of the total patient volume for calendar year 2020.

In order to allocate resources and maximize the effectiveness of community initiatives, AHWFB-HPMC chooses to narrow the focus to Guilford County for purposes of CHNA and CHNA implementation strategy to focus special attention to neighborhoods that are geographically proximate to the hospital campus, having a poverty rate approaching 18%, high percentage of charity care patients, and a density of high-risk patients who demonstrate poor health indicators. These communities are primarily located in the High Point zip codes of 27260 and 27262, which are identified as areas with the greatest need areas on the SocioNeeds Index map (Figure 1).

According to the US Census Bureau, the population of Guilford County in 2019 was 537,174. There has been a trend of continuous growth in the County, with regular yearly increase since 2012 when the population was 500,471. The US Census Bureau reports that in 2019 there were 31,278 persons (5.8%) under age 5, with 118,934 persons (22.1%) under age 18, and 83,442 persons (15.5%) over age 65. The County's racial distribution in 2019 is reported as follows, in descending order by percentage of total: 49.4% White, 35.4% Black or African American, 8.4% Hispanic or Latino, 5.3% Asian, and 1.5% Other. (US Census Bureau, 2019). Females account for 52.7% of the total population.

Relative to other NC counties, Guilford has a high number of people over age 25 with a high school degree or higher at 89.1% (compared to State and National values of 87.8% and 88.0%, respectively). This number continues to trend upwards. Moreover, the County has a high percentage of persons over age 25 with a bachelor's degree or higher at 36.0% (compared to State and National values of 31.3% and 32.1%, respectively). This data was measured from 2015 – 2019 by the American Community Survey. However, education levels vary significantly by zip code. In zip code 27260, 20-100% of residents over 25 years old do not have a High School Diploma, 30-33% have only a high school diploma and only 1-13% have obtained a Bachelor's degree or higher. Education level can be a predictor of ability to obtain a job, afford quality health insurance, and be able to address health needs as they arise.

In Guilford County, the median household income from 2015 – 2019 was $53,261, and 15.8% of the population lived below the poverty level (American Community Survey, 2021). The median household income in 27260 is $28,384 compared to the Guilford County of $53,261.

## 2022-2024 Community Health Needs Assessment

During 2021, AHWFB-HPMC conducted a Community Health Needs Assessment ("CHNA") for the calendar years 2022-2024 to identify the health needs of Guilford County. The CHNA process involved the collection of primary data from community surveys, conversations and focus groups. In addition, secondary data sources were examined that included state level data (e.g., North Carolina State Center for Health Statistics, Healthy North Carolina 2030), county level data (e.g., State of the County Health (SOTCH) Reports from health departments), and community level data (e.g., neighborhood initiatives, community organizations). The process to identify priority health needs and to locate primary and secondary data sources involved close collaboration with partners, particularly the Guilford County Department of Public Health and the High Point YWCA. In determining our criteria for priority health needs selection, the highest weights were placed on the health disparities associated with the need, the burden of the health need, the feasibility of possible interventions, and the importance the community

placed on addressing the need. Upon completion of the CHNA, results of the assessment were shared with leaders at AHWFB-HPMC and other key contributors for input.

The following CHNA priorities were identified and approved by the Board of Directors on December 16, 2021 for the 2022-2024 calendar years:

- **Access to Care:** with a focus on special populations, including women & children, as well as Medicaid/Medicare/Uninsured Populations, and those experiencing mental health and substance abuse disorders
- **Social Drivers of Health Equity and Social Injustice:** with a focus on food security and other social determinants of health
- **Chronic and Emerging Disease Management/Prevention:** with a focus on Cancer, Kidney Disease, Respiratory Disease, Diabetes

The 2022-2024 CHNA process found that social impact and injustice was identified by the community as a significant health priority that greatly influences the health of the community particularly its most vulnerable and underserved populations and individuals. The distribution of behaviors and health outcomes consistently follows social and economic patterns. Furthermore, some barriers to accessing care continue to prevent current programs and initiatives from reaching the populations in need. These challenges present important opportunities for the future. As we move forward as an integrated community of healthcare, social services and community leadership, we can leverage community assets and access to resources from the Atrium Health enterprise to improve the health of residents in Guilford County.

AHWFB-HPMC acknowledges the importance of all health needs in the Guilford County community even though the hospital's resources and assets were best aligned to focus on the prioritized health needs addressed above. Community needs that were identified but not prioritized for the 2022-2024 CHNA are as follows:

- Age-adjusted death rate due to homicide
- Sexually transmitted diseases
- Single parent households

AHWFB-HPMC leadership will continue to partner with community-based and non-profit organizations, public health and other governmental agencies, and the broader community to help address these health needs.

**2022-2024 Community Health Needs Assessment Implementation Strategy Development**

This accompanying document to AHWFB-HPMC's 2022-2024 CHNA outlines strategies designed to improve health through hospital programming and support for external community initiatives led by community coalitions and organizations. The list of outlined strategies will describe planned actions to address the community health needs that were identified through its CHNA process. In addition, hospital leaders will use this document to communicate the goals, objectives and approaches that AHWFB-HPMC will undertake to address community needs over the next three years, and help the community understand its role in addressing those needs.

The current set of strategies and related resources were identified by reviewing the AHWFB Social Impact Inventory, the AHWFB-HPMC's Program Inventory, the previous strategies outlined in the 2020-2022 CHNA Implementation Strategy, and other sources of information identified by the CHNA team leads. Additional existing programming and resources were identified through conversations with hospital and community leaders who have leadership responsibilities in addressing the priority health needs in Guilford County. These existing strategies were evaluated to determine if the hospital could build upon community assets, refocus the existing program to meet prioritized health needs, and reallocate internal resources for the strategies.

After identifying existing strategies & programming that would continue to meet the priority needs of the current CHNA cycle, attention then focused on identifying new strategies that would allow the hospital to:

- be consistent with the hospital's organizational strengths and community capabilities
- assess availability of hospital and/or community resources to carry out the strategy.
- achieve short-term and long-term results
- identify barriers that might exist
- create partnerships and generate community support

In developing new strategies, AHWFB-HPMC initially reflected on how it might effectively lead, compared to being a supportive partner for, other organizations designed to achieve collective impact. Additionally, the three levels of prevention were considered during the development process: 1) Primary prevention – preventing disease from occurring, 2) Secondary prevention – finding and treating the disease early, and 3) Tertiary prevention – targeting people with symptoms and making them healthy again. Multiple factors were considered that impact health, including individual behavior, community/social supports, and government health policies. Finally, the following evidence-based interventions were investigated:

- Community Health Improvement Navigator, CDC (http://www.cdc.gov/chinav/database/index.html)
- Evidence-based Practice Centers, AHRQ (http://www.ahrq.gov/clinic/epc/)
- Guide to Community Preventive Services, CDC (www.thecommunityguide.org)
- The Cochrane Collaboration (http://www.cochrane.org/)
- County Health Rankings and Roadmaps (www.countyhealthrankings.org/)
- Healthy People interventions and resources (www.healthypeople.gov)
- Healthy North Carolina 2030: https://nciom.org/wp-content/uploads/2020/01/HNC-REPORT-FINAL-Spread2.pdf
- Healthy Communities Institute (www.healthycommunitiesinstitute.com)
- National Resource for Evidence-based Programs and Practices, SAMHSA, US DHHS (www.nrepp.samhsa.gov)

## 2022-2024 Community Health Needs Assessment Implementation Strategy Action Plan

AHWFB-HPMC addressed each of the community health needs prioritized in the 2022-2024 CHNA when developing its implementation strategy action plan. Specific implementation strategies for each prioritized health need are included below. Over the next three years, additional strategies may be added to this action plan as opportunities arise from the identification of new health trends, health system resources, and community resources and partnerships.

| PRIORITIZED HEALTH NEED: ACCESS TO CARE | | | |
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| **Goal** | **Strategies** | **Metrics** | **Potential Partners or External Organizations** |
| Improve access to care with a focus on special populations including women & children, un- and under insured and mental health & substance abuse disorders. | **Strategy 1**: Host a second community Maternal Health Summit with the goal of developing a process map of services available in the community and hospital. | • Completion of Maternal Health Summit<br>• # Participants<br>• Complete process map of services | • Ready Ready<br>• YWCA<br>• Every Baby Guilford<br>• Guilford Child Development<br>• Foundation for a Healthy High Point |
| | **Strategy 2**: Implement a Maternal Health Navigator program to support connecting pregnant women and new moms to resources to support a healthy pregnancy and birth outcomes. | • Implementation of program.<br>• Number of participants<br>• Health outcomes which could include infant mortality, incidence of low birth weights, breast-feeding rates. | • Foundation for a Healthy High Point |
| | **Strategy 3**: Provide support for mental health services including social work visits after an overdose and payment of discharge medications | • Patients served<br>• Number of Readmissions<br>• Cost of discharge meds<br>• Number of social work visits | • Caring Services<br>• Family Services<br>• United Way<br>• Community Clinic<br>• Foundation for a Healthy High Point |
| | **Strategy 4**: Collaboration with and financial support of the Community Clinic of High Point to provide access to care for uninsured residents. | • Annual visits and financial support for services provided | • Community Clinic of High Point |

| PRIORITIZED HEALTH NEED: SOCIAL IMPACT AND INJUSTICE | | | |
|---|---|---|---|
| **Goal** | **Strategies** | **Metrics** | **Potential Partners or External Organizations** |
| Address social impact and injustice with a focus on addressing food insecurity, income inequality and education. | **Strategy 1**: Expand the services provided through the Food Pantry at the Hayworth Cancer Center including working with Growing High Point to provide fresh produce. | • Client served<br>• Cost of items donated | • Growing High Point - Growdega<br>• Greater High Point Food Alliance |
| | **Strategy 2**: Utilize AHWFB FaithHealth and other resources to focus efforts to provide services in the 27260 and 27262 zip codes. | • Patient served through AHWFB FaithHealth | • AHWFB FaithHealth<br>• Greater High Point Food Alliance<br>• Foundation for a Healthy High Point<br>• United Way |

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| | **Strategy 3**: Participate in the Guilford County Apprentice Program (GAP) in Pharmacy, Engineering and potentially other modalities by providing post-secondary education and training to local high school students | • Number of participants<br>• Cost of program funding & participation | • GAP<br>• Guilford Country Community College |

| **PRIORITIZED HEALTH NEED: CHRONIC AND EMERGING DISEASES** | | | |
|---|---|---|---|
| **Goal** | **Strategies** | **Metrics** | **Potential Partners or External Organizations** |
| Address chronic and emerging diseases with a focus on supporting chronic disease management and preparedness to address emerging diseases in our community. | **Strategy 1**: Collaborate with community partners to develop strategies to promote healthy and active lifestyles to prevent chronic disease.<br>1. Development of a coalition focusing on healthy eating/active living and chronic disease prevention<br>2. Health education programs including those offered through the Millis Health Education Center and the Fitness Center to the community<br>3. Financial support of community services | • Chronic disease rates including diabetes, heart disease, cancer, stroke and respiratory diseases.<br>• Implementation of new programs based on recommendations from coalition.<br>• Participation rates for existing/new programs | • Duke Endowment<br>• Foundation for a Healthy High Point<br>• Greater High Point Food Alliance<br>• Growing High Point |
| | **Strategy 2**: Provide health education through the Millis Health Education Center focusing on children in elementary school. Multiple topics are offered including nutrition, body systems, dental health, puberty, anti-bullying and germ prevention. | • Chronic disease rates including diabetes, heart disease, cancer, stroke and respiratory diseases.<br>• Participation rates for existing/new programs | • Theatre Art Gallery<br>• Poe Center<br>• High Point Junior League<br>• YWCA |
| | **Strategy 3:** Provide health education through the Fitness Center focusing on adults and senior citizens with topics including nutrition, overall health, chronic disease management and physical activity. | • Chronic disease rates including diabetes, heart disease, cancer, stroke and respiratory diseases.<br>• Participation rates for existing/new programs | |

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| | **Strategy 4**: Maintain continued readiness to shift priorities to address emerging diseases by providing support for our community this could be any many forms including PPE, testing, treatment and vaccines. | *these can vary based on the needs of the situation.<br>• Number of vaccines provided to community members tracking support staff to run clinics<br>Number of tests provided to the community tracking support staff needed | • Guilford County Health Department |

**CHNA Implementation Strategy Updates**

Atrium Health Wake Forest Baptist High Point Medical Center will update and sustain this CHNA implementation strategy over the next three-years, paying attention to new community and hospital resources, and evaluating results of community benefit programs. A tracking tool with these strategies and others will be maintained with an update of metrics annually. The evaluation will determine if strategies are being carried out as planned and achieving desired results. As the programs are evaluated, the hospital may:

- Change a program to improve its quality or effectiveness,
- Expand a program to other geographic areas or populations, or
- Eliminate/replace a program with an alternate approach.

**CHNA Implementation Strategy Adoption**

The Atrium Health Wake Forest Baptist High Point Medical Center Board of Directors approved this Implementation Strategy through a board vote on May 9, 2022.