



Atrium Health
Wake Forest Baptist



2025

High Point Medical Center

High Point Medical Center
Community Health Needs Assessment

601 N Elm St.
High Point, NC 27262

Letter from the Leader

At Advocate Health, which Atrium Health is a part of, we are redefining care for you, for us, for all. This purpose calls us to see health not just as a service, but as a shared journey, with everyone playing a part, from discovery to everyday moments.

This Community Health Needs Assessments (CHNA) is a roadmap for the future we are working toward, centered on strong partnerships that lead to real and lasting solutions.

Throughout the CHNA process, we strive to listen deeply, learn continuously, and act boldly to the changing needs and strengths of a community. Here at High Point Medical Center and across the communities we serve, we are working together with other health systems, health departments and community organizations, engaging with our neighbors and analyzing local data, so we can provide the best possible care that extends beyond our hospital walls.

As we close another CHNA cycle, we are inspired by the profound difference we make each day – across our hospitals, clinics and communities. From groundbreaking research and exceptional clinical care to meaningful patient programs and cutting-edge innovations, our work is shaped by the communities we serve – and together, we are shaping healthier futures for all.

We are deeply grateful to the many individuals and organizations who contributed to this assessment. Your perspectives and partnership are essential to improving the health and wellbeing of our communities, and we are proud to stand beside you in this work.

Publishing this CHNA is not the end of the conversation but an invitation to keep it going. We welcome your feedback, ideas, or suggestions. At the end of this report, you will find an email where you can share your thoughts on how we can strengthen community programs and strategies to better serve you and your community.

Let's move forward - together - toward better health for all.



Steve Smoot
Division President/Southeast
Advocate Health



James Hoekstra, MD, FACEP
President, High Point Medical Center

Table of Contents

I. Executive Summary.....	04
II. Description of Atrium Health Wake Forest Baptist and High Point Medical Center.....	05
A. Atrium Health Wake Forest Baptist.....	05
B. High Point Medical Center.....	05
III. 2025 Community Health Needs Assessment	06
A. Community Definition	06
B. How the CHNA was Conducted	09
C. Summary of CHNA Findings.....	12
IV. Prioritization of Health-Related Issues	20
A. Priority Setting Process.....	20
B. Health Needs Selected	20
C. Health Needs Not Selected.....	20
V. Approval of Community Health Needs Assessment.....	21
VI. Vehicle for Community Feedback.....	21
VII. Evaluation of Impact from Previous CHNA	22
VIII. Appendices	23
Appendix 1: 2025 Community Survey.....	23
Appendix 2: Community Resources Available for Significant Needs.....	23
Appendix 3: Sources	24

EXECUTIVE SUMMARY

High Point Medical Center is an active member of the Central Carolina Community Collaborative. The collaborative includes health systems, health departments, and numerous community organizations that work to align data sources and implement programs to impact the health and well-being of their communities. In 2025, the collaborative aligned data sets, survey execution, and the report template design with the future goal of creating improvement plans together for a broader impact.

In the summer of 2025, ad hoc members of High Point Medical Center met to review the community health assessment data, based on the following components:

Community Health Survey (primary data): An online survey was conducted from February 14 – April 28, 2025, where residents completed questions related to top health needs in the community, individuals' perception of their overall health, access to health services, and social drivers of health. In this convenience sample, nearly 7,500 residents from the region completed the survey, including 44 respondents specifically from the Davie Medical Center service area.

Key Informants Interviews (primary data): Within the 2024 CHNA cycle, 17 key informant interviews were conducted by email with key leaders to identify the top social drivers of health and health conditions/behaviors in the community. These interviews were revisited and incorporated in the current CHNA cycle to build on previously identified insights.

Metopio (secondary data): Advocate Health has a contract with Metopio, a robust digital platform that curates data from public and proprietary sources for information on health behaviors and health risks, health outcomes, health care utilization, demographics, and community-level drivers of health like economic, housing, employment, and environmental conditions. Data for each indicator is presented by race, ethnicity, and gender when the data is available (Metopio: <https://public.metopio.io>).

County Health Rankings and Roadmaps: Guilford County 2025 (secondary data): A compilation of data using county-level measures from a variety of national and state data sources.

In 2025, High Point Medical Center considered the following criteria in determining the health needs to prioritize:

- Size/seriousness of the problem
- Effectiveness of available interventions
- Available resources to address the health issue
- The health care system is adequately situated to address the health issue
- Meets a defined community need as identified through data
- Potential for issues to impact other health and social issues
- Ability to effectively address or impact health issues through collaboration

In addition, High Point Medical Center evaluated the impact of the initiatives identified in its previous Community Health Implementation Strategy (CHIS).

As a result, High Point Medical Center prioritized the following significant health needs to address in our 2026-2028 implementation strategy:

- Social Drivers of Health: Food Security
- Chronic Disease and Prevention: Heart Disease and Stroke

The 2025 CHNA was presented to the Atrium Health Wake Forest Baptist High Point Medical Center Board, the authorizing body of the hospital. The board approved the report on 2.19.26.

ATRIUM HEALTH WAKE FOREST BAPTIST

[Atrium Health Wake Forest Baptist](#) is a preeminent academic health system based in Winston-Salem, North Carolina, and is part of [Advocate Health](#), the third-largest nonprofit health system in the United States. Atrium Health Wake Forest Baptist's two main components are an integrated clinical system – anchored by Atrium Health Wake Forest Baptist Medical Center, an 885-bed tertiary-care hospital in Winston-Salem that includes [Atrium Health Levine Children's Brenner Children's Hospital](#), five community hospitals, more than 300 primary and specialty care locations and more than 2,700 physicians – and [Wake Forest University School of Medicine](#), the academic core of Advocate Health, and a recognized leader in experiential medical education and groundbreaking research, including [Wake Forest Innovations](#), a commercialization enterprise focused on advancing health care through new medical technologies and biomedical discovery. Atrium Health Wake Forest Baptist employs more than 22,000 teammates, part of Advocate Health's more than 160,000 teammates. Committed to redefining care for all, Atrium Health Wake Forest Baptist provides \$1.2 billion in community benefits. Follow us on [Facebook](#), [Instagram](#) and [X](#).

HIGH POINT MEDICAL CENTER

Atrium Health Wake Forest Baptist High Point Medical Center is part of Atrium Health Wake Forest Baptist; a regional academic health system affiliated with Wake Forest University School of Medicine. With a legacy dating back to 1904, the hospital has grown into one of the region's premier healthcare providers, serving a population of more than 600,000 across High Point, North Carolina, and surrounding communities.

Rooted in a patient-first philosophy, High Point Medical Center offers advanced medical care through a broad network of physician offices and specialized centers, with expert care from Atrium Health Wake Forest Baptist doctors and staff. From maternity and neurosciences to orthopedics, cancer care, and heart and vascular services, the hospital is designed to meet the evolving needs of the community with compassion, innovation, and clinical excellence. Its commitment to personalized care is reflected in every aspect of the patient experience—from modern facilities and integrated services to a culture that prioritizes comfort, satisfaction, and outcomes.



Cancer Care



Heart Care



Maternity Services



Orthopedics

2025 COMMUNITY HEALTH NEEDS ASSESSMENT

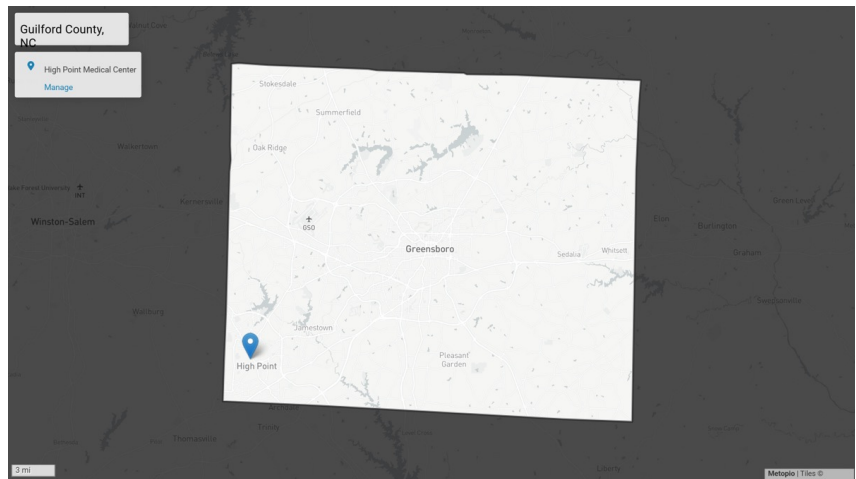
A Community Health Needs Assessment (CHNA) is an analysis of the population, resources, services, health care statuses, health care outcomes, and other data within a defined community or service area that helps identify potential health issues being experienced by community members. Every nonprofit hospital is required to complete a CHNA every three years under the [Patient Protection and Affordable Care Act \(ACA\)](#), to demonstrate that a hospital is committed to promoting health.

A CHNA report is designed to inform a wide range of groups to learn more about a community's health and most urgent needs. It is a key tool for promoting health for all, as it lifts the community voice and encourages collaboration between different groups to create focused strategies to address the health needs identified in the CHNA.

Community Definition

For the purposes of this assessment, "community" is defined as Guilford County. For the remainder of the report Atrium Health Wake Forest Baptist High Point Medical Center will also be referenced as High Point Medical Center.

High Point Medical Center serves communities within Guilford County, North Carolina, a diverse and historically rich region located in the Piedmont area of the state. The county spans over 650 square miles of gently rolling hills and elevated plateaus, with major urban centers including Greensboro and High Point. Guilford County is the third-most populous county in North Carolina and features a mix of urban, suburban, and rural communities, each with unique health needs and challenges.



Understanding who lives in a community is an important part of the CHNA process. A community is more than just a place on a map - it's made up of the people who live there, their shared experiences, and their differences. These differences can include things like age, income, education, race or ethnicity, and what people know about health. Learning about these details helps us see what specific health problems people face and what support they may need.

Note about the data:

- 1-year data is used where available for large counties (65,000+ residents) to provide the most recent and relevant data. This High Point Medical Center report used 1-year data where available. Some stratification tables required a multi-year data set.
- Multi-year data is used for small counties (under 65,000 residents) to reduce short-term fluctuations and the margin of error.

Guilford County Data Estimates

Population

549,866

The population has increased by 10.8% between the 2010 and 2020 decennial census.

Gender

47.5% Male

52.5% Female

Median Age

37.8 years

Race/Ethnicity

Non-Hispanic White 45.9%

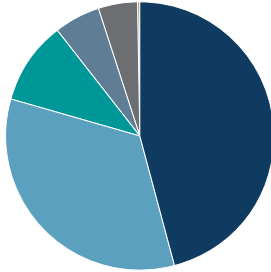
Hispanic or Latino 33.4%

Two or more races 10.2%

NH Black 5.5%

Asian 4.8%

Native American 0.1%



Population by Age Group

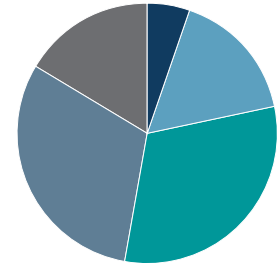
Infants 0-4 5.5%

Juveniles 5-17 16.3%

Young Adults 18-39 31.1%

Middle-Age 40-64 30.8%

Seniors 65+ 16.3%



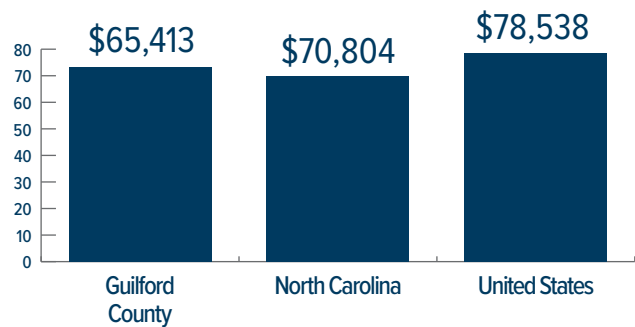
Primary language at Home, other than English

7.0% Spanish

3.2% Asian Languages



Median Household Income



Education

Individuals with a high school degree



91.8% Guilford County

90.6% North Carolina

89.8% United States

Individuals with a bachelor's degree or higher



38.0% Guilford County

36.8% North Carolina

36.2% United States

Population Living Below Poverty Level

15.0% Guilford County

13.2% North Carolina

12.4% United States

Household/Family



8.2% Single Parent Families

30.1% Seniors Living Alone

Employment

Unemployment rate

3.5% Guilford County

4.8% North Carolina

5.2% United States



Social Drivers of Health

Social drivers of health are the things in our everyday lives that can help us stay healthy or make it harder to be healthy. These include where we live, the food we eat, the schools we go to, the jobs our families have, and whether we can see a doctor when we need to.

Social Drivers of Health can also cause **health differences** between groups of people. For example, if someone lives far from a store with healthy food, it's harder for them to eat well. This can lead to health problems like heart disease or diabetes. Just telling people to eat healthy isn't enough—we need to make sure they have what they need to make healthy choices. That's why people who work in health, schools, housing, and transportation must work together to help everyone live a healthy life.

Social Conditions at a Glance

To better understand these factors and identify health inequities in a community, Advocate Health has partnered with Metopio, a software company that focuses on how communities are connected through people and places. Metopio's tools use data to show how different factors in each area influence health. It uses the latest data to create visual tools that focus on specific communities and hospital service areas.

The following section contains descriptions of four important indices found in Metopio. These indices combine various data points to compare areas in the community, helping to identify disparities caused by social factors that impact health. This approach allows health improvement efforts to be focused where they are most needed.

Social Vulnerability Index (SVI)

The SVI shows how vulnerable a community is based on 15 social factors like unemployment, disability, and minority status. Scores range from 0 (least vulnerable) to 100 (most vulnerable). (Source: Metopio, CDC, 2022)

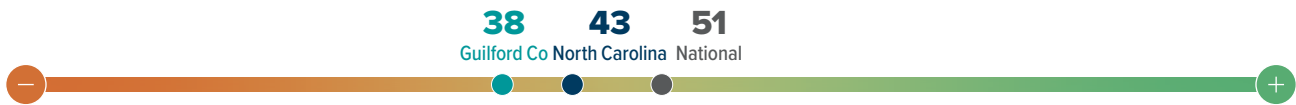
The SVI for Guilford County is higher than the state and national averages, indicating a lower community resilience and availability of resources.



Childhood Opportunity Index

The COI measures how well neighborhoods support children’s healthy growth. Scores range from Very Low (1–19) to Very High (80–100). (Source: Metopio, [Diversitydatakids.org](https://diversitydatakids.org), 2017–2021)

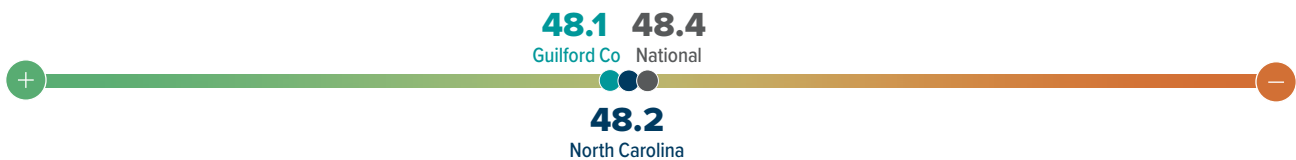
The COI for Guilford County is lower than the state and national average. The data suggests that children in the area face limited access to key resources that support healthy development, such as quality education, safe housing, and economic stability.



Hardship Index

This index shows how much hardship a community faces. It includes things like unemployment, poverty, and crowded housing. Higher scores mean more hardship. (Source: Metopio, U.S. Census Bureau, ACS, 2018–2022)

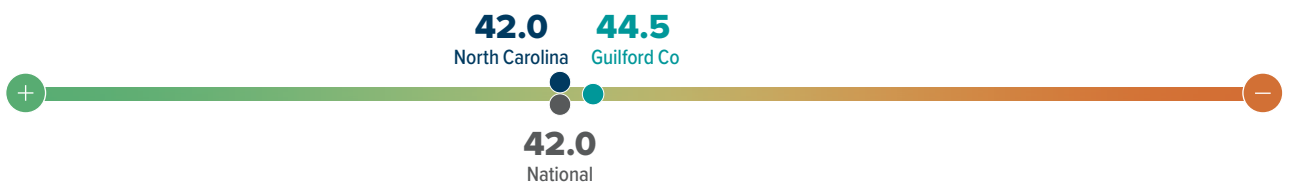
The Hardship Index reveals similarities between Guilford County and the state and country. The data suggests that the community faces about the same hardship as others across the state and country on average.



ALICE Index

ALICE stands for Asset Limited, Income Constrained, Employed. It shows the percentage of working households that earn above the poverty line but still can’t afford basic needs like housing, food, and childcare. The data presented is the percentage of households living below the ALICE threshold.

The data suggests that Guilford County has a similar proportion of households facing financial hardship than the state and the country.



How the CHNA Was Conducted

Purpose and Process

Every three years, High Point Medical Center along with the Central Carolina Community Collaborative conducts a Community Health Needs Assessment (CHNA) across Central North Carolina. The CHNA serves as the foundation from which the hospitals and local health departments develop their respective community health improvement strategies. These findings are also intended to inform a broader audience – community health centers, government health agencies, public health departments, philanthropists, community-based organizations, and civic leaders - about the top health issues facing our community. This 2025 cycle is a back-to-back cycle to align with the Central Carolina Community Collaborative.

Partnership: The Central Carolina Community Collaborative

The Central Carolina Community Collaborative launched in 2024, is funded by the Duke Endowment to amplify our local community voice through the Community Health Needs Assessment process. The members of the collaborative are dedicated to improving health outcomes, enhancing the quality of life in Central North Carolina and ensuring all community members can achieve their highest level of health. We bring together diverse voices including health systems, public health departments, academic institutions, United Way agencies and other community-based organizations to identify needs, share resources, and implement meaningful solutions.

The CCCC includes:

Health Systems



Public Health



Community Organizations



Regional CHNA Approach: This Community Health Needs Assessment was strengthened by the use of shared data resources and collaborative platforms that enhanced both the depth and accessibility of our analysis. We are especially grateful for the Central Carolina Community Collaborative’s support in leveraging the **Atlas** site—a regional data-sharing hub that promotes transparency and cross-sector alignment. [CCCC Atlas](#)

Additionally, the **Metopio** platform played a critical role in visualizing complex health and demographic data, enabling stakeholders to explore trends, disparities, and community assets in an interactive and user-friendly format. These tools not only informed our findings but also empowered partners and residents to engage with data in meaningful ways, fostering a more informed and connected approach to community health improvement.

Data Sources, Collection and Analysis



Community Surveys

To engage the High Point Medical Center community, a brief survey was distributed from February 14 to April 28, 2025 to residents and promoted via social media, websites, community partners and local events and engagement. The survey aimed to identify obstacles to ideal health and opportunities for improvement, resulting in nearly 7,500 surveys taken throughout the Central Carolina Community Collaborative footprint and 44 surveys locally. Convenience sampling was used for this survey, and participants were selected based on ease of access or availability. The data was then analyzed and compiled to understand the needs of the community.



Key Informant Interviews

To learn more specifics about the community's needs, stakeholders and leaders who have broad knowledge of the health of the community were interviewed by email as part of this process. Participants were chosen because of their ability to identify the primary concerns of the populations with whom they work, as well as of the community overall, and 17 participants completed the interviews. The interviews were conducted as part of the 2024 CHNA cycle and the data was incorporated as part of this 2025 cycle to ensure continuity in understanding the community's key health drivers.



County Health Rankings & Roadmaps

County Health Rankings & Roadmaps (CHR&R), a program of the University of Wisconsin Population Health Institute, draws attention to why there are differences in health within and across communities. The program highlights policies and practices that can help everyone be as healthy as possible. CHR&R aims to grow a shared understanding of health, equity and the power of communities to improve health for all. This work is rooted in a long-term vision where all people and places have what they need to thrive. *(County Health Rankings & Roadmaps, About Us, 2025)*



Secondary Data

Central Carolina Community Collaborative has a contract with Metopio to provide an internet-based data resource for their hospitals. This robust platform offers curated data from public and proprietary sources for information on health behaviors and health risks, health outcomes, health care utilization, demographic, and community-level drivers of health like economic, housing, employment, and environmental conditions. Data for each indicator is presented by race, ethnicity, and gender when the data is available (*Metopio: <https://public.metopio.io>*). All data collected through Metopio was quantitative and included data comparisons between county, the state of North Carolina and United States data.

Limitations of the Assessment

This report gives us a lot of helpful information about the health of people in the community. But it does not tell us everything. Some groups of people couldn't take part, like people without homes, people in jails, or people who don't speak English or Spanish, or Creole which were the languages supported by the survey. Respondents were also more likely to be insured, have a college education, be Caucasian and female. Through community collaboration and engagement our teams will be intentionally working with underrepresented populations to amplify the community voice in the implementation strategy phase of the work.

Also, even though the report talks about many health and social topics, it does not cover every sickness or health problem.

Summary of Findings

Overall Health Status

Overall, the health outcomes of Guilford County are slightly better than the average county in the state and the average county in the nation. (County Health Rankings and Roadmaps, 2025)

However, many disparities – or differences in outcomes - exist between groups of populations in nearly every social and health issue, especially for Black, Indigenous and People of Color (BIPOC) populations. These disparities are often caused by barriers that these communities face. Health inequities are the unfair differences in health that can be avoided, measured and are often linked to injustice (AMA, 2021). Racism, both in systems and in personal interactions, is a key reason for these health inequities and the disparities in disease burden (CDC, 2024).

Before exploring the data on specific health issues in the following sections, it is important to understand that a person's health is influenced by many factors beyond their control. It is not just about personal choice. In fact, nearly 70 percent of a community's health is shaped by things such as where someone lives, works, plays, and learns (County Health Rankings & Roadmaps, 2014). These social drivers of health include socioeconomic status, access to education, housing, food security, environmental conditions and policies that shape institutions and society.

As you look at the data in the following sections, it is important to remember that these health issues are connected to many of these broader social and environmental factors.

Mortality

The top three leading causes of death in Guilford County are:

All Ages:

Cancer
Diseases of the heart
Other unintentional injuries

Ages 0-19:

Conditions originating in the perinatal period
Homicide
Congenital abnormalities (birth defects)

(North Carolina County Health Data Book 2025)

Life Expectancy

The average life expectancy among residents:

- Guilford County: 76.2 years
- North Carolina: 75.9 years
- United States: 77.1 years

(County Health Rankings & Roadmaps, Alleghany, North Carolina)

Overall, the service area has seen a decrease in life expectancy from 78.4 in 2019.

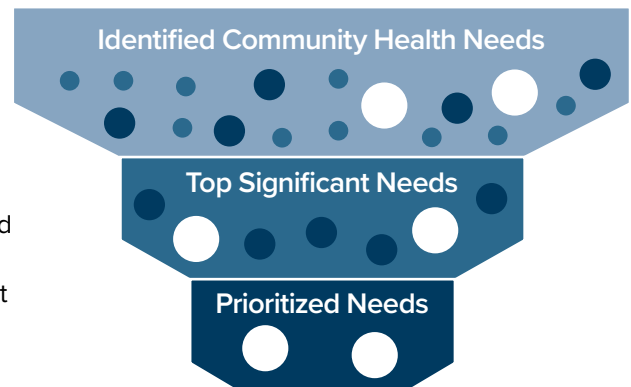
Identified Significant Needs

Even with the progress and support in the community, challenges remain. While local programs and services have helped improve health, there are still gaps in care and unmet needs. This section looks at the biggest health concerns found in this assessment and areas where more support is needed to help the community stay healthy.

The health needs identified in this CHNA cover a variety of factors, including health outcomes, social drivers, and health behaviors, which are all closely connected.

Health outcomes are the measurable results of a community’s overall health, such as rates of chronic diseases, infant deaths, or life expectancy. These outcomes are greatly influenced by the **social drivers of health** like income, education, employment, and access to healthcare. These factors can either help or hurt a person’s ability to stay healthy. **Health behaviors**, like physical activity, diet, smoking, and substance use, also affect health outcomes. These behaviors are often shaped by the social environment, such as community norms, available resources, and socioeconomic status.

There are many health needs within a community, which can make it difficult to know where to focus efforts. This is why community input is so important during the CHNA process. It helps guide our organization and the broader community in prioritizing the most important issues to address. For a health need to be considered significant, it should reflect a pressing concern for the community, align with public health priorities, and be supported by data. Additionally, using secondary data helps identify the root causes of health disparities within the significant need, which allows us to develop targeted solutions to improve health outcomes.



Top Health Concerns in Guilford County

The following needs, listed below in alphabetical order, represent the significant health needs of the community based on the information gathered through the assessment process.

Areas of Opportunity Found Through the Assessment	
Alcohol & Substance Use	<ul style="list-style-type: none"> • Drug overdose ED visits • Drug overdose mortality • Substance use hospitalization rate • Alcohol use hospitalization rate
Chronic Disease & Prevention	<ul style="list-style-type: none"> • Alzheimer's disease, cancer, diabetes, heart disease, and stroke mortality • Stroke, heart failure, and heart attack hospitalization rates
Community Safety	<ul style="list-style-type: none"> • Homicide mortality rate • Juvenile delinquency • Motor vehicle injury • Assault by firearms hospitalization & emergency department visit rates
Maternal & Child Health	<ul style="list-style-type: none"> • Infant mortality • Fetal mortality • Low and very low birth weight • Preterm births
Social Drivers of Health	<ul style="list-style-type: none"> • Low food access • Housing insecurity • Lack of transportation

The following pages summarize the top identified needs – also known as significant needs - from the CHNA process.

Why is this important? Alcohol and substance use (including tobacco, illegal mood-altering drugs and misusing prescription drugs) contribute to preventable health issues and are linked to social and economic issues. Alcohol and substance use are also closely linked to mental health challenges, including depression, anxiety, and trauma-related disorders. These conditions often co-occur, making recovery difficult without proper support.

Significant Need Reasoning

The rate of **drug overdose emergency department visits** in North Carolina is 161.8 per 100,000 people. In **Guilford County, the rate is significantly higher** at 187.1, indicating a local hotspot for such incidents.

In **Guilford County, 27.1% of driving deaths have involved alcohol.** This rate is higher than 24.6% in North Carolina and 26.3% in the United States.

Key Findings

- Drug overdose mortality in Guilford County, North Carolina is higher than both the state and national averages. The county's rate of 33.8 deaths per 100,000 people exceeds North Carolina's rate of 33.6 and the United States' rate of 29.2.
- The alcohol-related mortality rate for Guilford County is 13.1 deaths per 100,000, higher than both the state rate of 11.6 and the national rate of 12.8.
- The substance use hospitalization rate for Guilford County is 107.5 per 100,000, higher than North Carolina's rate of 89.5.

Contributing Factors

Treatment and support for drug and alcohol use are not easily accessible to all people, especially for populations that are experiencing low income or have limited resources within their community.

- Barriers & Challenges:
 - » Lack of culturally competent providers
 - » Cost of care
 - » Lack of awareness of services
 - » Stigma
 - » Concern for repercussions
 - » Lack of insurance



HIGHLIGHTED DISPARITIES

Drug Overdose Mortality Rate*	
Guilford County	33.8
18-39 Years	53.7
40-64 Years	53.6

(*deaths per 100,000 residents)

Why is this important? Chronic Diseases are long-term health problems that often develop slowly from genetic, environmental, and lifestyle factors. Some common ones are heart disease, diabetes, cancer, and asthma. These diseases can make daily life harder and often need ongoing medical care. Over half of Americans have at least one chronic disease. ([CDC, 2024](#)).

Significant Need Reasoning

Heart disease is the second leading cause of death for Guilford County. (NC Data Book, 2025)

Secondary data shows high mortality rates for chronic diseases in Guilford County, including Alzheimer’s, cancer, diabetes, heart disease, stroke, and COVID-19.

Hospitalization rates for heart failure and heart attack are higher in Guilford County than in North Carolina overall.

Key Findings

- The top two leading causes of death are chronic diseases: cancer and heart disease. (NC Data Book, 2025)

Disease Mortality Rates

(Deaths per 100,000 residents)

	Guilford County	North Carolina	United States
Alzheimer’s	35.5	32.4	27.7
Cancer	175	151.1	141.8
Chronic Lower Respiratory Disease	31.8	37.9	33.4
COVID-19	16.4	13.5	11.9
Diabetes	31.1	25.3	22.4
Heart Disease	174.1	161.6	166.5
Stroke	50.3	45.5	39.1

**While COVID-19 is not considered a chronic disease, it is important to show the impact.*

Contributing Factors

Many chronic diseases can be prevented with healthy habits. But people with more money, education, and support tend to live longer and avoid these conditions. Without these resources, people often have worse health and shorter lives. For some, eating healthy or staying active is tough because of limited access to good food, busy schedules, or mental health struggles. Things like working multiple jobs or not having stable housing also make it harder to stay healthy. It’s important to understand that making healthy choices isn’t always easy – and it’s not equal for everyone.

- Barriers & Challenges:
 - » No exercise (% of adults)
 - Guilford County **23.8%**
 - North Carolina **22.6%**
 - United States **23.1%**
 - » Percent of residents that have low food access
 - Guilford County **61.17%**
 - North Carolina **47.07%**
 - United States **50.24%**



HIGHLIGHTED DISPARITIES

Stroke hospitalization rate

(hospitalizations per 100,000)

- 154.5** Guilford County
- 151.9** Non-Hispanic White
- 193.9** Non-Hispanic Black

Stroke mortality (deaths per 100,000)

- 52.7** Guilford County
- 47.6** North Carolina
- 39** Non-Hispanic Black

Diabetes mortality

(deaths per 100,000)

- 31.7** Guilford County
- 32** Non-Hispanic White
- 41.7** Non-Hispanic Black

Why is this important? Community safety is a foundational element to health because it directly affects physical and mental well-being. When people feel safe in their neighborhoods, they are more likely to engage in outdoor activities, access local services, and build strong connections. Violence and crime can lead to chronic stress, trauma, and reduced access to care, especially for vulnerable populations.

Significant Need Reasoning

The **second leading cause of death** in Guilford County for ages 0-19 is **homicide**.
(North Carolina County Health Data Book, 2025)

Homicide mortality rate is significantly higher in Guilford County than the state and county averages, with a disparity in deaths among Non-Hispanic Black people.

In Guilford County, the **assault by firearms hospitalization rate** is 17.2 per 100,000 residents, **nearly doubled** the North Carolina rate of 9.8.

Key Findings

- The homicide mortality in Guilford County is 12.3 deaths per 100,000, significantly higher than the state rate of 8.6 and the national rate of 7.4.
- The juvenile delinquency rate in Guilford County is 47.2 per 1,000 juveniles, compared to 28.8 for North Carolina.
- Guilford County has a motor vehicle injury ED visit rate of 1,180.2 per 100,000 people, compared to 1,059.1 in North Carolina.

Contributing Factors

Community safety can be affected by things like not having enough streetlights, broken sidewalks, or places where people feel unsafe. When neighborhoods do not have good housing, parks, or places to play, it can make people feel worried or scared. Safety also depends on people working together and trusting each other, like neighbors helping neighbors. When everyone feels safe, it is easier to stay healthy and happy.

- Barriers & Challenges:
 - » Built environment: poor lighting, lack of sidewalks, deteriorating infrastructure
 - » Limited access to parks and recreational spaces
 - » Exposure to pollution or frequent environmental disasters
 - » Poverty
 - » Unemployment
 - » Housing instability
 - » Food insecurity
 - » Substance use
 - » Limited access to mental health
 - » Gun violence



HIGHLIGHTED DISPARITIES

Homicide Mortality

(deaths per 100,000)
12.3 Guilford County
3.1 Non-Hispanic White
27.2 Non-Hispanic Black

Violent deaths*

24.7 Guilford County
36.2 15-24 years
46.1 25-34 years
38.7 35-44 years

Assault by firearms ED visits*

36.8 Guilford County
81.3 18-39 years

The rates for gun violence and domestic violence for Guilford County and High Point are disproportionately high

– Key Informant Interview, Community Stakeholder

(*per 100,000 residents)

Why is this important? Maternal and child health focuses on the health and well-being of women during pregnancy, childbirth, and the postpartum period, as well as the health of infants and children. It encompasses access to quality prenatal care, safe delivery services, and early childhood health interventions to reduce disparities and improve long-term outcomes for families.

Significant Need Reasoning

The leading cause of death in Guilford County in ages 0-19 is **conditions originating in the perinatal period**. The third leading cause of death in this age group is **birth defects**. (NC Data Book, 2025)

The **infant mortality and fetal mortality rates and rate of low and very low birth weight rates** are higher in Guilford County than North Carolina and the United States.

Key Findings

- Guilford County has an infant mortality rate of 7.8 deaths per 100,000 live births, higher than the North Carolina rate of 6.7 and the United States rate of 5.5.
- Of live births in Guilford County 10.3% have a low birth weight. North Carolina had 9.4% of live births at low birth weight and the United States, 8.5%.
- Of live births in Guilford County 11.6% were preterm births, higher than 10.8% and 10.3% in North Carolina and the United States respectively.

Contributing Factors

Maternal and infant health issues are shaped by a complex interplay of social, economic and systemic factors. Sometimes it is hard to find doctors or get appointments especially if people do not have transportation or insurance. All these things together can make it tough for moms and babies to be healthy.

- Barriers & Challenges:
 - » Poverty and economic inequality
 - » Transportation to care
 - » Food insecurity
 - » Housing instability
 - » Insurance coverage gaps
 - » Fragmented care systems
 - » Cost of services
 - » Education and knowledge of care through pregnancy
 - » Childcare gaps
 - » Language and cultural barriers

HIGHLIGHTED DISPARITIES

	Fetal mortality rate*	Infant mortality rate*
Guilford County	8.9	8.4
Non-Hispanic Black	12.1	13
Asian or Pacific Islander	10.7	–

(*per 1,000 deliveries)

(*per 1,000 live births)



Why is this important? Economic stability and reliable transportation enable access to medical care, nutritious food, safe housing and employment – all of which directly influence physical and mental well-being. Without these resources, individuals often delay care, experience higher rates of chronic illness, and face greater health disparities. Together they shape the foundation for equitable and sustainable health outcomes.

Significant Need Reasoning

6.8% of households in Guilford County do not have access to a vehicle. This is higher than 5.3% in North Carolina.

Over 60% of residents in Guilford County experienced low food access, significantly higher than 47.1% in North Carolina and 50.2% in the United States.

Key Findings

- Housing insecurity in Guilford County, North Carolina, stands at 15.3%, which is higher than the state's overall rate of 14.3%.
- Very low food access is a significant issue in Guilford County, with a rate of 24.6%, which is higher than both the state and national averages. In North Carolina, the rate is 22.5%, while the United States overall experiences a rate of 21.2%.

Contributing Factors

Lack of access to transportation is tied to several health indicators, as it affects access to care, food, and employment opportunities. Food insecurity, specifically very low food access, contributes to chronic disease and is further exacerbated by the poverty rate in the area.

- Barriers & Challenges
 - » Infrastructure deficiencies
 - » Zoning and land use policies
 - » Gentrification and displacement
 - » Funding challenges
 - » Program fragmentation among federal, state, and local services
 - » Not enough attention to the issue
 - » Lack of community support



HIGHLIGHTED DISPARITIES

Food Insecurity

(deaths per 100,000)

- 15.2%** Guilford County
- 29.0%** Non-Hispanic Black
- 22.0%** Hispanic or Latino

Housing Cost Burden

(deaths per 100,000)

- 30.4%** Guilford County
- 38.9%** Non-Hispanic Black
- 45.6%** Native American
- 47.2%** Pacific Islander/Native Hawaiian

Social determinants of health are a major problem for us. Affordable housing, food insecurity, lack of transportation, and many people unable to access healthcare due to financial problems.

Community Member, Survey Response

AREAS TO WATCH

We are closely monitoring emerging data indicators that may signal rising community concerns. While these issues have not yet reached priority status, continued tracking will help determine whether they warrant deeper analysis or targeted intervention in future assessments.



Alcohol & Substance Use: Drug overdose mortality in Guilford County, North Carolina is higher than both the state and national averages. The county's rate of 33.8 deaths per 100,000 people exceeds North Carolina's rate of 33.6 and the United States' rate of 29.2. In Guilford County, 27.1% of driving deaths have been involved with alcohol. This rate is higher than 24.6% in North Carolina and 26.3% in the United States. The data indicates a need for more attention to preventative measures in this area.



Community Safety: The second leading cause of death in Guilford County for ages 0-19 is homicide. The juvenile delinquency rate in Guilford County is 47.2 (per 1,000 juveniles) compared to 28.8 for NC. The homicide mortality in Guilford County is 12.3 deaths per 100,000, significantly higher than the state rate of 8.6 and the national rate of 7.4, indicating a need for heightened safety and increased interventions in this area.



Disaster preparedness was asked for the first time in the survey, and it was discovered that just over 30% of the service area does not feel prepared for a disaster.



As these reports are finalized, the region is experiencing an outbreak of measles. Ongoing surveillance will focus on disease spread and trends in vaccination uptake.

PRIORITIZATION OF HEALTH-RELATED ISSUES

PRIORITY SETTING PROCESS

In October 2025, an ad hoc group of leaders from High Point Medical Center prioritized significant needs based on the criteria below.

Size/seriousness of the problem

Effectiveness of available interventions

Available resources to address the health issue

Health care system adequately situated to address the health issue

Meets a defined community need as identified through data

Potential for issue to impact other health and social issues

Ability to effectively address or impact health issue through collaboration

Significant Health Needs Selected

Using these criteria, High Point Medical Center prioritized the significant health needs to address in the 2026-2028 implementation strategy:



**Social Drivers of Health:
Food Security**



**Chronic Disease and Prevention:
Heart Disease and Stroke**



HEALTH NEEDS NOT SELECTED

Alcohol & Substance Use

Alcohol and substance use continues to be a significant health concern in the High Point community, contributing to emergency department visits, mental health challenges, and social instability. While the need is evident, it was not selected as a top priority for this CHNA cycle due to the complexity of addressing substance use without expanded behavioral health infrastructure and long-term funding. Additionally, other health issues emerged as more actionable within the scope of current community resources and partnerships. High Point Medical Center remains committed to supporting regional efforts and advocacy aimed at reducing substance-related harm.

Community Safety

While community safety is an important priority, many issues are being addressed through existing local initiatives and organizations. High Point Medical Center will continue to partner with other agencies to address the need but focus on more direct health outcomes.

Maternal and Infant Health

At High Point Medical Center, we address these conditions every day through our clinical services, including screenings, education, and ongoing care. Because this work is already embedded in our daily operations and community intervention, maternal and infant health were not prioritized as standalone focus areas in the CHNA but will continue to be worked on outside of the CHIS.

APPROVAL OF COMMUNITY HEALTH NEEDS ASSESSMENT

The 2025 CHNA was presented to the Wake Forest Baptist High Point Medical Center Board, the authorizing body of the hospital. The board approved the report on 2.19.26.

VEHICLE FOR COMMUNITY FEEDBACK

Community input is essential to the success and relevance of this Community Health Needs Assessment (CHNA). Residents, stakeholders, and organizations are encouraged to review the findings and share their feedback. Comments, suggestions, and questions can be submitted by using the email below. Feedback will be reviewed and considered in future planning efforts.

Please send an email to us at: CHNA@advocatehealth.org

This report can be viewed online at Atrium Health Wake Forest Baptist's Community Health Needs Assessment Report webpage via the following link:

[Needs Assessments and Implementation Reports | Atrium Health Wake Forest Baptist](#)

A copy of this report may also be requested by contacting the hospital's Community Health Department.

EVALUATION OF IMPACT FROM PREVIOUS CHNA

*Note: Because this report is a back-to-back cycle to align with the Central Carolina Community Collaborative, the numbers are for ten months as of October 2025.

Priority 1: Social Drivers of Health

- Enhanced identification of needs through SDOH screening in the HPMC Emergency Department:
 - » High Point Medical Center screened 316 patients for social drivers of health, enabling timely connection to community resources and support services. These screenings helped identify non-medical barriers that contribute to health issues and repeated visits.
- Improved nutritional support through the Hayworth Cancer Center Food Pantry:
 - » Access to essential non-perishable food items was provided, serving 139 patients and helping reduce food insecurity during cancer treatment.
- Increased access to care through transportation assistance at the Hayworth Cancer Center:
 - » Patients were offered transportation support to ensure they could access critical appointments, benefiting 31 patients by providing 237 rides to and from appointments at Hayworth Cancer Center, trips to the emergency department, scans and other health related appointments. By providing rides and assistance, we help ensure patients can attend appointments, stay on track with treatment, and reduce the stress that often accompanies travel logistics.

Priority 2: Maternal and Infant Health

- Supported new mothers through the Bundle of Joy program:
 - » The program distributed 1,004 diaper-bag backpacks containing essential newborn items such as diapers, wipes, a thermometer, a swaddle, a onesie, and more. Each backpack unzips to transform into a safe sleeping bed for infants, giving new mothers both vital supplies and a secure sleep option during the most challenging early days of caregiving. Every patient who delivers at HPMC receives a Bundle of Joy backpack upon discharge.
- Reduced food insecurity through the Joyful Shelf pantry:
 - » Patients were provided access to a free, no-questions-asked food pantry located inside the Atrium Health Wake Forest Baptist OB/GYN Clinic on Quaker Lane. Stocked with non-perishable items, Joyful Shelf served 167 patients, allowing each visitor to select up to 10 items per visit to support nourishment during pregnancy and postpartum care.
- Expanded patient support with the addition of an OB Navigator:
 - » An OB Navigator was added to the care team in October to offer personalized prenatal and postpartum support. This hands-on guidance improves maternal and infant health outcomes by ensuring patients stay engaged in prenatal care, feel supported, and receive timely interventions when challenges arise

Priority 3: Chronic Disease and Prevention: Heart Disease and Stroke

- Expanded access to cardiac rehabilitation through Heart Strides scholarships:
 - » Scholarships were awarded to 41 patients during the evaluation period, giving patients access to personalized exercise plans aimed at improving fitness, reducing cardiac risk, and enhancing quality of life. Participants received assessments of dietary habits and quality-of-life perceptions related to heart disease, along with weekly education on topics including: how the heart works, cardiac medications, signs and symptoms of heart attack, risk awareness and risk-reduction strategies, benefits of exercise, impacts of diet, and stress management.
- Improved home monitoring through FaithHealth support:
 - » Through FaithHealth support, High Point Medical Center distributed 15 scales and 16 blood pressure cuffs enabling patients to monitor blood pressure and weight at home—key tools for managing chronic conditions and preventing complications. By providing these items, we empower patients to stay engaged in their care, prevent complications, and reduce avoidable hospital visits.
- Strengthened patient support through Heart Failure Navigators:
 - » Heart Failure Navigators provided individualized recovery assistance and consulted with 502 patients. This dedicated guidance reduces the risk of readmissions, improves adherence to treatment plans, and empowers patients to recognize and manage symptoms early.
- Increased early detection through community stroke-prevention services:
 - » High Point Medical Center delivered 75 free blood pressure screenings through the Stroke Program, helping identify elevated risk and connect community members to appropriate follow-up care.
- Enhanced Community Wellness Through Fitness Center Scholarships:
 - » High Point Medical Center awarded 5 scholarships to support ongoing physical activity, helping participants strengthen cardiovascular health and sustain long-term lifestyle changes.

APPENDICES

Appendix 1: Central Carolina Community Collaborative Survey

To view the High Point Medical Center Community Health Assessment report, which includes summaries of the community feedback, descriptions of the data collection methods and the members of the collaborative, along with the full survey reports, visit: <https://cccc.metop.io/community-health-reports-and-plans>

Appendix 2: Community Resources Available for Significant Needs

The resources under each significant need are not a complete list. For more community resources, please visit please visit the Atrium Health Community Resource Hub: <https://www.atriumhealthcommunityresourcehub.org>

Alcohol & Substance Use

Organization	Website	Contact
TruHealing High Point	https://www.truhealingcenters.com/addiction-treatment-locations/north-carolina/high-point/	336-447-6056
Caring Services High Point	http://www.caring-services.org	336-886-5594
Family Services of the Piedmont	http://www.fspcares.org	336-889-6161
Foundations Health High Point	http://www.myfoundationshealth.com	336-899-8889

Chronic Disease & Prevention

Organization	Website	Contact
Community Clinic of High Point	http://www.cchpnc.com	336-841-7194
Triad Adult and Pediatric Medicine	http://www.tapmedicine.com	336-355-9920
Triad Health Project	http://www.triadhealthproject.org	336-884-4116
Guilford Community Care Network	http://www.guilfordcch.org	336-895-4900

Community Safety

Organization	Website	Contact
Guilford County Family Justice Center	https://www.guilfordcountync.gov/government/departments-and-agencies/family-justice-center	336-641-7233
Mental Health Associates of the Triad	https://mha-triad.org	336-884-4116
UNCG Eviction Mediation	https://chcs.uncg.edu/programs/eviction-mediation-program/	336-334-3731
YWCA Ready 2 Ride	http://www.ywcahp.com	336-882-4126

Maternal & Infant Health

Organization	Website	Contact
Care Management Center for High Risk Pregnancies	https://www.guilfordcountync.gov/government/departments-and-agencies/department-health-and-human-services/public-health/community-health-services	336-641-7511
Every Baby Guilford	https://www.guilfordcountync.gov/government/departments-and-agencies/department-health-and-human-services/public-health/every-baby-guilford	336-641-7556
Macedonia Family Re-sources and Food Pantry	https://www.macedoniacenter.org/food-pantry	336-883-0300
C3 Community Collaboration for Children, Inc.	https://c3forchildren-hp.org/	336-823-4970

Social Drivers of Health

Organization	Website	Contact
Open Door Ministries	https://www.opendoorministrieshp.org/	336-885-0191
The Salvation Army of High Point	https://southernusa.salvationarmy.org/high-point/	1-800-725-2769
Macedonia Family Re-source Center	https://www.macedoniacenter.org/	336-883-0300
Helping Hands High Point	https://www.helpinghandshighpoint.org/	336-886-2327

Appendix 3: Sources

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Thank You

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