Wake Forest®
Baptist Health

Community Health Needs Assessment (CHNA)
FY 2017-2019
North Carolina Baptist Hospital
Davie Medical Center
Lexington Medical Center

I. System Executive Summary

Health System Summary

Wake Forest Baptist Health is a is a not-for-profit regional health system dedicated to the prevention and treatment of illness through its three acute care hospitals, family of primary care and specialty clinics, care coordination services and community health improvement efforts in western North Carolina. WFBH offers expertise in more than 100 areas of medicine, encompassing comprehensive preventive and highly specialized care for all ages.

WFBH encompasses a total 1,060 acute care and rehabilitation beds across its three acute care hospitals: North Carolina Baptist Hospital in Forsyth County, NC (885 beds), Lexington Medical Center in neighboring Davidson County (94 beds) and Davie Medical Center in neighboring Davie County (81 beds). Overall, Wake Forest Baptist Medical Center serves a 24-county region in northwestern North Carolina and southwestern Virginia. It also draws patients from across the nation for select services.

In addition to its three acute care hospitals, WFBH operates two urgent care centers, 11 emergency departments, 27 primary care and 114 specialty clinics, 16 dialysis centers, and freestanding imaging and endoscopy centers.

With more than 13,000 employees, it is the largest employer in Forsyth County. The Wake Forest Baptist Health staff includes 1,215 physicians, 2,985 registered nurses, 578 residents, 129 fellows and more than 1,500 other professional clinicians.

Overall in FY 2015, Wake Forest Baptist Health had 43,844 inpatient admissions, 108,583 Emergency Department visits and 1,111,409 outpatient encounters (ambulatory visits and outpatient departments).

Wake Forest Baptist Health has a long history of working to improve health in the community and continues broad-based efforts to reach underserved populations across its service area. Indeed, the hospital was established by the North Carolina Baptist Convention in 1923 with a specific intent of improving the health of those affected by poverty and what we now call “social determinants.” The Medical Center’s annual Community Benefits report reflects this commitment. In Fiscal 2015, the most recent year for which figures are available, the Medical Center spent $376.3 million in community benefits to support these areas: subsidized health costs, community health outreach, charity care, research, and education.

Needs Assessment Process

The needs assessment plan was based on a set of best practices for community health assessments with the purpose of identifying two to three regional priority areas to focus on for FY 2017–2018. The process was designed to rely on existing public data, directly engage community stakeholders and collaborate with local public health, other health providers as well as community partners such as faith networks relevant to the social factors underlying patterns of access. The WFBH assessment was conducted in three stages: (1) data review (primary and secondary data), (2) setting priorities, and (3) community assets inventory.

The CHNA process occurred from spring 2015 – spring 2016. CHNA plans were finalized in June 2016 upon final presentation of the assessment to the Wake Forest Baptist Health Board of Directors.

The following is a description of the assessment steps and timeline created by the CHNA Team.

1. **Data Review and Prioritization**

   The data review and priority-setting phase began with the compilation of existing health-related data. Stakeholders reviewed multiple data sets including Forsyth, Davidson and Davie County public health needs assessments, North Carolina Indicators for Community Health Assessment, internal disease registries, and County Health Rankings. An internal steering committee and senior leadership reviewed a set of criteria to develop the priority rankings. The prioritization process identified the following three priority challenges for the community:

   - *Access/Lack of Medical Services/Screenings*
   - *Chronic Disease- Cancer, Diabetes, Obesity*
   - *Behavioral/Mental Health Distress*

2. **Community Assets Inventory**

   FaithHealthNC provided community engagement through a comprehensive asset mapping strategy based on an approach developed in South Africa and refined in Memphis designed to build community partnerships on the assets that exist, instead of just needs. The mapping developed an inventory of existing programs and services within the region related to the priority areas identified in the needs assessment. The inventory included the location of the program (hospital, clinic or community service) as well as the nature of the intangible factors, especially trust, that determine access and collaboration among community partners. The purpose of the inventory was to identify:

   - Gaps in services and opportunities for new work
   - Where and with whom there is a lot of work already being done
   - Opportunities for partnership and/or collaboration

3. **Priority Recommendations**

   On June 8, 2016 the Wake Forest Baptist Health Board approved the following three priority areas for WFBH for FY 2017-2019 three year cycle:

   1) Access/Lack of Medical Services/Screenings

   2) Chronic Disease - Cancer, Diabetes, Heart Disease, Obesity

   3) Behavioral/Mental Health Distress

   The detailed report and supporting data will be made available on the WFBH internet site. Based on the priorities identified, WFBH will develop an implementation strategy to identify the means through which the healthy system plans to address needs that are consistent with the charitable mission as part of its community benefit programs from FY 2017 through 2019. Beyond the programs that will be addressed in the implementation strategy, which will be completed by November 2016, WFBH will continue to address many of the priorities by providing care to all, regardless of the ability to pay.

Community Health Needs Assessment- North Carolina Baptist Hospital

II. Introduction

North Carolina Baptist Hospital (NCBH) is a component member of Wake Forest Baptist Medical Center (Medical Center), a preeminent, internationally recognized academic medical center with balanced excellence in patient care, research and education. NCBH is a leading provider of healthcare in western North Carolina and has served the state's and region's population since 1923. It is northwest North Carolina's sole academic medical center and provides care to a 19 county region. NCBH is a North Carolina not- for-profit corporation that owns and operates an 885 bed, teaching hospital located in Forsyth County, North Carolina. As a component member of the Medical Center, NCBH shares the Medical Center's mission and vision.

Mission

Wake Forest Baptist Medical Center's mission is to improve the health of our region, state and nation by:

1) Generating and translating knowledge to prevent, diagnose and treat disease.
2) Training leaders in health care and biomedical science.
3) Serving as the premier health system in our region, with specific centers of excellence recognized as national and international care destinations.

Vision

Wake Forest Baptist Medical Center is a preeminent, internationally recognized academic medical center of the highest quality with balanced excellence in patient care, research and education.

III. Purpose of Community Health Needs Assessment (CHNA)

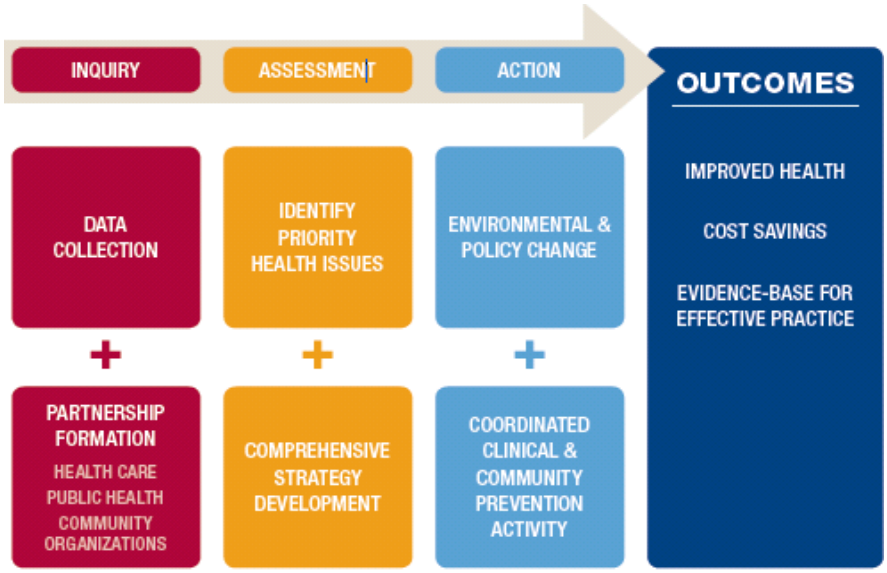
NCBH has a long history of engaging our communities in identifying health issues and implementing strategies to address the needs of the community. Ongoing, unprecedented increases in the demand for healthcare are challenging for communities and healthcare providers in this era of limited fiscal resources. Those resource limits are acerbated by the increasing clarity about the broad and long term nature of the factors that affect health status far beyond access to clinical care. In order to fulfill our mission and the requirements of the Affordable Healthcare Act for non-profit hospitals, NCBH has conducted its second needs assessment for the 2016-2019 timeframe. This assessment is central to NCBH's community benefit/social accountability plan. By determining and examining the service needs and gaps in our community, NCBH can develop responses to address them through our community benefit plan and resources.

With the growing burden of chronic disease, the medical and public health communities are reexamining their roles and opportunities for more effective prevention and clinical interventions. The potential to significantly improve chronic disease prevention and impact morbidity and mortality from chronic conditions is enhanced by adopting strategies that incorporate a social ecology and place based perspective, realigning the patient-physician relationship, integrating population health perspectives into the chronic care model, and effectively engaging communities.

A Community Health Needs Assessment (CHNA) is an approach to collecting, analyzing and using data, including community input, to identify barriers to the health and well-being of its residents and communities, leading to the development of goals and targeted action plans to achieve those goals. To undertake this mandate, NCBH formed an internal Community Benefit Steering Committee with representation from various departments and disciplines. Specifically, the Committee was charged to:

- Develop a comprehensive needs assessment and aligned with the WFBH's Strategic Plan
- Develop an implementation plan
- Monitor plan implementation and institute corrective measures if needed
- Evaluate the effectiveness of individual projects and the impact of community benefit initiatives as a whole
- Communicate the plan to external and internal audiences

The Community Benefit Steering Committee recommended using the following model to guide planning and programmatic efforts, and to explain to internal and external stakeholders the rationale for the Community.



IV. Description of Community Served and How it was Determined

As an academic medical center and regional referral center, NCBH serves a 24 county service area that encompasses two states, North Carolina and Virginia. NCBH's principal primary service area is illustrated in the map below and encompasses seven contiguous counties representing an approximate 40-mile radius. However, the majority of inpatient admissions and emergency visits are provided to Forsyth County residents, representing 30% and 64% respectively of the total patient volume for calendar year 2015.

In order to allocate resources and maximize the effectiveness of community initiatives, for the purpose of conducting the Community Health Needs Assessment, NCBH chose to narrow the focus to Forsyth County as well as neighborhoods that:

- Are geographically proximate to the main hospital campus
- Have a poverty rate >20%
- High percentage of charity care
- Have a density of high-risk patients who demonstrate poor health indicators (health disparities)
- Have individuals and organizations with developed and historical relationships with NCBH such as Faith Health and United Way or have the potential for partnering to address specific health and social issues.

As indicated in the map (below), these communities include neighborhoods along the eastern Highway 52 corridor and east Winston Salem (primarily zip codes 27201, 27105, 27107; Census Tracts 3.01, 3.02, 4, 5,6, 7, 8.01, 8.02 16.02, 17, 19.01

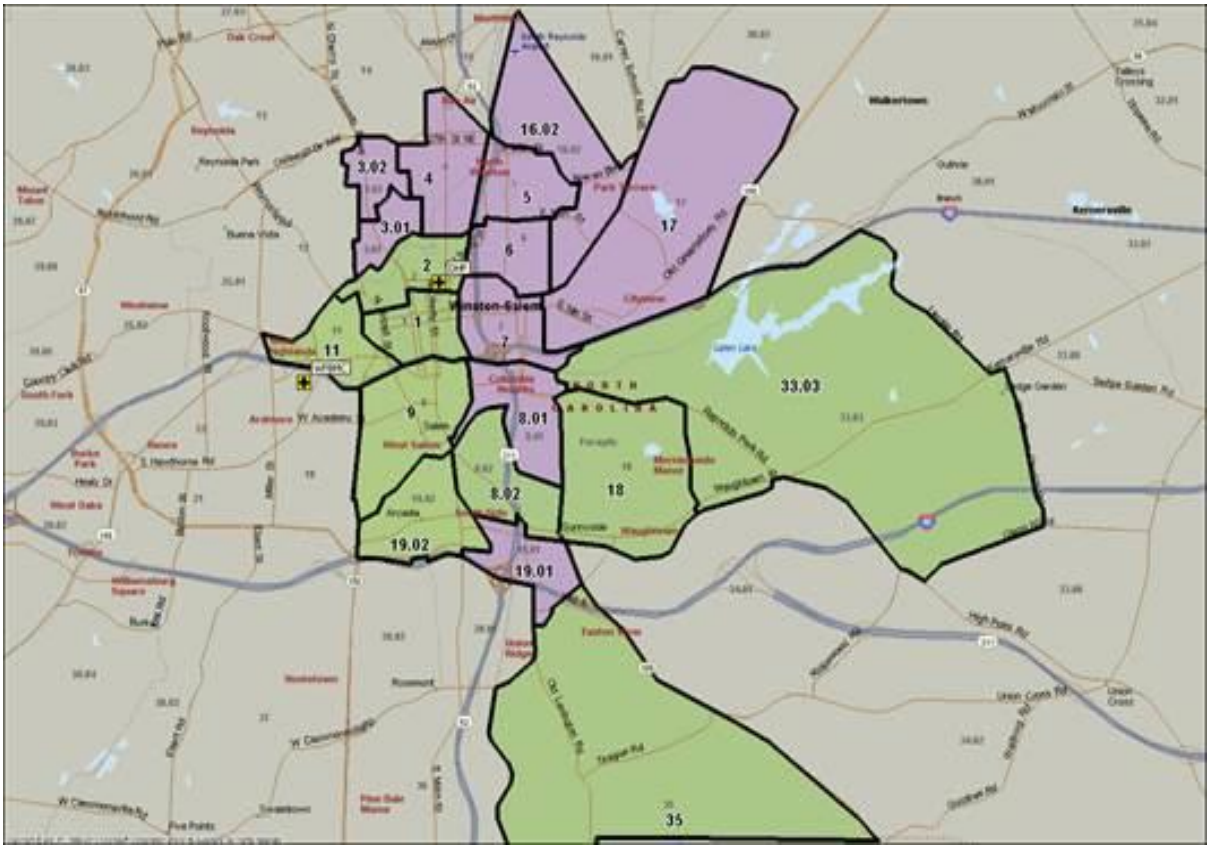
Community Benefit Area

According to the official 2014 census, Forsyth County is the fourth largest county in North Carolina with approximately 365,00 residents. According to the County Health Rankings and Roadmaps 2015, the population of the county is 58% non-Hispanic white, 27.1% non-Hispanic African American, 12.4% Hispanic or Latino, and 2.1% Asian. In addition, 14.1% residents in Forsyth County speak a language other than English in their home County Health Rankings 2015). The median income of the county is $45,274 with the percentage of the population below poverty at 18.6%. When comparing to the focused census tract neighborhoods the demographics shift significantly. The percent of residents in poverty is more than double that of the county and household income is significantly lower as indicated in the table below.

Census tract	Zip Code	Pop	White	Black	Hispanic	Asian	% Below Poverty	Median HH Income	NCBH Charity Care Pts	% of Pop-NCBH Charity Care
3.01	27101	1,433	16%	84%	7.54%	0%	36%	$19,167	286	20%
3.02	27105	1,715	6%	90%	6%	0%	42%	$25,457	381	22%
4	27105	3,519	8%	83%	17%	0%	26%	$26,439	604	17%
5	27105	2,606	7%	86%	12.20%	0%	59%	$12,962	623	24%
6	27101	2,250	3%	97%	0.23%	0%	54%	$15,957	373	17%
7	27101	1,582	0.88%	99%	-	0%	47%	$12,992	382	24%
8.01	27101	2,300	4%	68%	26.74%	0.26%	57%	$24,799	64	3%
8.02	27107	1,704	32.10%	37.44%	26.82%	0.94%	40%	$17,632	245	14%
16.02	27101	3,318	7%	92%	7.00%	0%	51%	$17,898	579	17%
17	27101	5,491	22.00%	66%	33.00%	0.86%	43%	$34,755	686	12%

19.01	27107	1,682	27%	28%	42.00%	-	40%	$26,806	275	16%

The distressed census tracts/neighborhoods (shaded in purple below) represent 7.6% of all residents of Forsyth County but approximately 18% of the total county's population below poverty; three of the census tracts are in the top ten distressed census tracts as indicated by the University of North Carolina Study of Distressed areas – Waughtown, Columbia Heights, East Winston and Northeast Winston. These eleven census tracts also contain the majority concentration of charity care patients for North Carolina Baptist Hospital in 2015 -4,500 patients/25% of the total.



Neighborhood resources, ethnic diversity and fragmentation of services within Forsyth County pose formidable organizational challenges in community benefit programming. NCBH's approach to community benefit adopts a comprehensive notion of health drivers that are spread across domains of behavioral risk, social and economic circumstances, environmental exposures, and medical care. The balance and effects of many of these determinants, e.g., availability of healthy foods, parks and other safe places to play and exercise, exposure to environmental irritants, and safe housing, are specific to Forsyth County and are built into the Community Benefit Plan.

V. Process and Methods Used to Conduct the CHNA

NCBH highly values the principles of community engagement (see table below) articulated by the Centers for Disease Control and has built its community benefit efforts on a community engagement model.

Principles of Community Engagement:

Principle	Key elements
Set Goals	• Clarify the purposes/goals of the engagement effort • Specify populations and/or communities
Study Community	• Economic conditions • Political structures • Norms and values • Demographic trends • History • Experience with engagement efforts • Perceptions of those initiating the engagement activities
Build Trust	• Establish relationships • Work with the formal and informal leadership • Seek commitment from community organizations and leaders • Create processes for mobilizing the community
Encourage self-determination	• Community self-determination is the responsibility and right of all people • No external entity should assume that it can bestow on a community the power to act in its own self-interest

Principle	Key elements
Establish partnerships	• Equitable partnerships are necessary for success
Respect diversity	• Utilize multiple engagement strategies • Explicitly recognize cultural influences
Identify community assets and develop capacity	• View community structures as resources for change and action • Provide experts and resources to assist with analysis, decision-making, and action • Provide support to develop leadership training, meeting facilitation, skill building
Release control to the community	• Include as many elements of a community as possible • Adapt to meet changing needs and growth
Make a long-term commitment	• Recognize different stages of development and Provide ongoing technical assistance

Source: Principles of Community Engagement: Edition 2. Clinical and Translational Science Awards Consortium Community Engagement Key Function Committee Task Force on the Principles of Community Engagement. 2011;11-778[2].

Literature Review and Secondary Data Sources:

More than ten secondary data sources were reviewed including:

1) Wake Forest Baptist Medical Center Community Dashboard/Healthy Communities Institute: http://www.wakehealth.edu/HCI/?hcn=CommunityDashboard
2) County Health Rankings and Roadmaps: http://www.countyhealthrankings.org/
3) 2014 State of the County Health: https://www.forsyth.cc/PublicHealth/Documents/2014_CHA_REPORT.pdf
4) US Census Bureau 2010 Census
5) US Census Bureau 2014 American Community Survey
6) NC Center for Health Statistics
7) Centers for Disease Control- Youth Risk Behavior Surveillance System (YRBSS) 2010–2012
8) Behavior Risk Factor Surveillance System (BRFSS) 2014

9) Healthy People 2020
10) Healthy North Carolina 2020
11) Center for Medicare and Medicaid
12) Forsyth Futures Report: Understand Access to Health Care: Forsyth County, NC 2014
13) Forsyth County's Community Food System, 2013
14) Status of Homelessness in Forsyth County, November 2014

Primary Data Sources:

Wake Forest Baptist Health (WFBH) Strategic Plan
The WFBH 3-Year Strategic Plan was reviewed and potential areas of alignment with community benefit strategies were identified.

Wake Forest Baptist Health (WFBH) Healthy Planet Disease Registries
Patient level data stored in the WFBH Epic electronic medical record (EMR) chronic disease registries was reviewed to understand the prevalence of chronic disease within the patient populations managed by WFBH. The table below provides counts by registry with obesity, hypertension, diabetes and cancer accounting for the largest number of patients.

Patient Counts by Chronic Disease/County of Residency	Forsyth	Davie	Davidson
Obesity	33,670	4,781	11,318
Hypertension	27,107	3,217	8,687
Diabetes	12,520	1,449	4,270
Cancer	11,885	1,106	1,564
Asthma	8,897	829	1,865
Behavioral Health	4,066	204	1,294
COPD	3,224	487	1,846
Chronic Kidney Disease	3,180	322	1,282
Heart Failure	2,316	303	1,132
TOTAL	**106,865**	**12,698**	**33,258**

Patients can be represented in more than one registry*.**

Community Input – Resident Surveys (conducted by Forsyth County Health Department
The Forsyth County Health Opinion survey was conducted in April 2014 of 224 residents utilizing the Centers for Disease Control cluster sampling methodology across 40 census blocks randomly sampled through ArcGIS CASPER toolkit provided by the CDC to provide a sample that would represent the Forsyth County demographics; race and ethnicity as well as education of the sample population were generally very similar to the County overall making the results more generalizable.

The issues that most affect the quality of life reported by residents of Forsyth County were identified as low income/poverty and homelessness. Roughly 1 in 5 residents were also concerned with violent crime, dropping out of school and discrimination/racism. Residents felt the top three services that needed the most improvement were mostly economic: the availability of employment, positive teen activities and

higher paying employment. Residents also cited the need for additional health behavior information about eating well/nutrition, stopping substance abuse and exercise fitness. Likely related to these concerns and requests for additional information included the high frequency of chronic conditions such as high blood pressure, high cholesterol, depression/anxiety and overweight/obesity. One cross-cutting objective of The Healthy North Carolina 2020 identified was to increase the percentage of adults who report good, very good or excellent health to 90.1%. Roughly 75% of respondents report good, very good or excellent health in Forsyth County. A high percentage of respondents reported not having any health insurance (18.7%), even with the advent of the Affordable Care Act with the most common reasons cited were financial or unwillingness to participate. A summary of the indicator data ranking can be found in Exhibit 1.

FaithHealthNC Community Asset Mapping

Throughout the summer of 2014, Faith Health NC engaged in community asset mapping of Forsyth County's vulnerable communities utilizing the CHAMP (Community Health Assets Partnership) model with the goals of improving peoples' access to healthcare and listening to the healthcare providers and, more importantly, the voice of the healthcare seekers, the consumers of healthcare. FaithHealthNC provided a total of eight community health mapping of neighborhoods workshops within zip codes 27101 and 27105 (namely- East Winston, Peters Creek Parkway) throughout summer of 2014 in order to engage and discover positive health and faith based assets within the communities. Highlighted findings included that participants were concerned with access to reliable transportation and physical access to health care facilities, access to education and knowledge specifically from churches and local organizations as well as having the finances and insurance to receive the care needed. Providers were primarily concerned with education, access to primary care providers and accountability, self-responsibility and self-efficacy. Separated in three diverse groups, the participants ranked each community asset on a scale from one to five, one being poor and five being great. As a whole, participants ranked the highest in regards to their contributions to care access followed by medicine/prescription services. The lowest ranking assets were food sources followed by public transportation.

Four workshops were also held specifically with the Hispanic community in July 2014 given the continued growth of the Hispanic population, which has increased by nearly 10% since 2010. The most frequently mentioned challenges among all Hispanic groups included cost of healthcare, documentation status (access to pharmacy, insurance, and transportation), lack of public transportation, racism, lack of care and respect, and education (more Spanish literature). Participants from all three consumer workshops reported the lack of insurance for undocumented parents ultimately hurts the health of their insured, US born children. Consumers also felt that more Spanish literature on prescriptions, brochures, etc. was necessary to receive the same access to healthcare as English-speaking Americans. Contrarily, providers felt that education about resources was the most prominent challenge to the Hispanic community. Both groups felt that compassionate care and respect were a crucial aspect to good health care, and the seeker participants discussed many instances in which systematic and organizational racism has affected their ability to obtain quality care. (Full reports from the individual mapping exercises are available at faithhealthnc.org)

Comments from 2013-2015 CHNA

All CHNA and Implementation reports along with county indicator tracking is available on the WFBH website- http://www.wakehealth.edu/HCI/ . No written comments from the public have been received to date. All future comments and feedback will be incorporated into future CHNA and implementation strategies and reports.

VI. Identification and Prioritization of Community Health Need

To address the community health needs identified in the CHNA, recommendations for initiatives were prioritized based on secondary data findings, primary data gathered through FaithHealthNC and Health Department workshop and survey findings as well as the feedback from the WFBH CHNA steering committee and senior leadership. The identified priority health needs and recommended initiatives were then grouped into the following three domains:

- Access to care /Health screening and early detection
- Chronic disease management
- Behavioral/Mental Health Distress

The following prioritization criteria and weighting was used to identify community benefit priorities:

Criteria	Weighted Value
Identified as a county priority	2
Disparity exists within census tract/zip code/county/market	3
WFBH steering/leadership perceive as a priority	2
Great potential to improve health status	3
Positive visibility for WFBH	1
High # of patients/residents can/would be impacted	2
Feasibility/resources availability /existing relationships	2
Supports WFBH Strategic Plan objectives	2
Synergy with current supported initiatives- FaithHealthNC, United Way	2
Coordinates/complements with County Health Department assessment priorities	1
Total points	**20**

A strategic framework was also developed with the ultimate goal of community engagement for WFBH, which includes guiding principles for addressing the conditions/priorities that influence the health of communities and contribute to better health of the population served.

Guiding Principles

- ***Focus on the places where need is concentrated.*** Health in targeted neighborhoods served- obesity, diabetes- healthy eating/ exercise/ working with nutritious foods
- ***Tighten Social Service, Faith and Other Agency partnerships-*** Support/sustain enhance community resource agencies that care for the social and behavioral health needs of our patients and residents. This includes Southside FQHC, United Way Funded Agencies, Second Harvest Food Bank and the many hundreds of faith groups already involved in the lives of our patients and neighborhoods.
- ***Strengthen patients and partners through health education and literacy focus.*** Programs and initiatives provide the opportunity to build the capacity of patients and community members to blend the very best of health science with their own

intelligence and wisdom to make the choices that advance health of themselves and those they love.

The Community Benefit steering committee along with the Executive Team developed the final priorities which are summarized in the table below.

Domain	**Priority Health Areas to Address**
Access to Care	Decrease ED Utilization for uninsured/charity care patients
Access to Care	Increase WFBH patients with health insurance /usual source of care
Access to Care	Increase WFBH patients with access to transportation to clinic appointments
Access to Care	Increase primary care access points in east Winston
Chronic Disease Management	Healthy Lifestyle Behaviors and Community Environment - Screening and linking patients to food pantries
Chronic Disease Management	Increase self-management education opportunities for patients and residents with diabetes
Chronic Disease Management	Increase primary care group visits for diabetic and obesity patients
Chronic Disease Management	Increase patients and Wake employees enrolled in chronic care management programs
Chronic Disease Management	Health Screening and Early Detection: Provide Mammography/Women's Cancer community screenings
Behavioral/Mental Health Distress	Decrease ED Utilization for behavioral health related conditions
Behavioral/Mental Health Distress	Increase education of basic mental health issues and resiliency strategies for community agency and laypersons supports

Given the high level of charity care, percent below poverty and number of co-morbidities as noted in the Wake Chronic Disease Registry data for obesity, diabetes, and hypertension- the following zip codes and census tracts were prioritized for place based/community impact:

- Zip Codes- 27101, 27105, 27107
- Census Tracts- 3.01, 3.02, 4, 5, 6, 7, 8.01, 8.02 16.02, 17, 19.01

VII. Community Facilities and Other Resources

A detailed list of community resources for the NCBH and WFBH service area counties of Davie, Davidson and Forsyth Counties is provided below.

EXTERNAL PARTNERSHIPS WITH WAKE FOREST BAPTIST MEDICAL CENTER-COMMUNITY BENEFIT REPORT-2016

ATC (Access to Care) **CDM (Chronic Disease Management) ***BH (Behavioral Health)*HLBCE (Healthy Lifestyle Behaviors and Community Environment) *****HSED (Health Screening and Early Detection)**

Organization	County	Domain	Key Resources	Type of Partnership
Advocacy Center of Davie County	Davie	Access to Care*	Food, Utility, Medication, Housing Assistance	Referral Pathways
CenterPoint Human Services	Davie	Healthy Lifestyle Behaviors and Community Environment***; Behavioral Health****	Wellness Center training and other programs	Education/Training, Preventive
County Public Library	Davie	ATC	Education, Resource Center	Referral Pathways
Davie Domestic Violence and Rape Center	Davie	ATC, BH	Legal Services, Counseling, Advocacy	Referral Pathways, Clinical, Caregiving, Education/Training, Prevention Focus
Dept. of Social Services	Davie	ATC, CDM, Health Screening and Early Detection******	Medical and Preventive Care, Immunizations, WIC, SNAP, Disability	Education/Training, Referral Pathways, Limited Medical, mostly Preventive Care
See FaithHealth listing for 6 partners	Davie	Chronic Disease Management**, ATC , HSED	Training, Caregiving, Food, Utility, Housing Assistance, Gas Vouchers, Soup Kitchens, Breakfast Fund collected from several local churches monthly to fund relief efforts across the county	Referral Pathways, Caregiving
Family Promise	Davie	ATC	Food, Housing assistance, job skills, education; target homeless families with children	Referral Pathways
Hands of Hope (free Clinic)	Davie, Yadkin	CDM, ATC, HSED	Medical Care, Food and Medication Assistance	Clinical, Referral Pathways, Education/Training
Just Hope, Inc. (United Way of Davie County)	Davie	ATC	Transitional housing for homeless, food assist	Referral Pathways, Caregiving
Meals on Wheels (through Senior Services)	Davie	ATC	Food Assist; Social Support with Home Visits	
Mocksville Civitan Club	Davie	ATC	Food, Housing, Utility Assistance	Referral Pathways
Salvation Army	Davie	ATC	Housing, Utility and Medication Assistance; Workforce Development, Rehabilitation	Education/Training, Referral Pathways, Caregiving
Smart Start	Davie	ATC, HSED	Early Childhood Development; Domestic Violence	Education/Training, Referral Pathways, Caregiving
Storehouse for Jesus	Davie	ATC, HLBCE, BH, HSED	Medical Care, Medication Assistance, Clothing, Food, Counseling, Barber	Clinical; Caregiving; Referral Pathways
The Davie Foundation	Davie	HLBCE, HSED	Healthy Davie Initiative, supports Women's Health, Healthy lifestyles and collaborates with churches	Referral Pathways, Funding other partners
The Davie County School System	Davie	HLBCE, ATC, HSED	Food assistance, counseling, healthcare, education	Education/Training, Preventive Care, Referral Pathways

Organization	County	Domain	Key Resources	Type of Partnership
The ARC of Davidson County	Davidson	ATC, BH	Services for children and adults with disabilities	Referral pathways; funded by employee donations through United Way
Carolina Cancer Services	Davidson	ATC	Emotional, financial, physical, and caregiving support for persons with cancer, as well as device and supply assistance	Referral pathways, social support
Charity League of Lexington	Davidson	ATC, HLBCE	Health, education improvement efforts for children	Education/training, scholarships
Crisis Ministry of Davidson County	Davidson	ATC	Transitional Housing, Utility and food assistance, navigation to clothing, work, etc.	Referral Pathways, caregiving
Davidson County Community College	Davidson	ATC, HSED	Higher Education, Wellness Efforts, Workforce Development	Education/Training
Davidson County Dept. of Senior Services	Davidson	ATC, CDM, HSED	Transportation, Classes, Resource guides	Education/Training, Referral Pathways, Preventive Care
Davidson County Dept. of Social Services	Davidson	ATC, CDM, HSED	Immunizations, WIC, SNAP, Disability	Education/Training, Referral Pathways, Limited Medical, mostly Preventive Care
Davidson County Medical Ministries Clinic	Davidson	ATC, CDM, HSED	Medical and Dental Care, Medication Assistance	Referral Pathways, Medical, Dental and Preventive Care
Davidson County Schools	Davidson	ATC, BH, HSED	Education, Counseling, Food, Care for Exceptional Children	Education/Training; Referral Pathways
Davidson County Transportation	Davidson	ATC	Transportation for students, seniors, the disabled, those on MCD	Referral Pathways
Davidson Works	Davidson	ATC	Workforce Development	Referral Pathways
Daymark Recovery Services	Davidson	ATC, BH	Counseling for mental health and SA issues; crisis intervention	Clinical, Education/Training
Faith Communities: 37 partners (see FaithHealthNC for full listing)	Davidson	ATC, CDM, HLBCE, , HSED	Training, Caregiving, Food, Utility, Clothing, Housing Assistance, Gas Vouchers, Soup Kitchens	Caregiving; Referral Pathways
Family Services of Davidson County	Davidson	ATC, BH	Counseling, Advocacy, Legal Assistance	Referral Pathways
Farmers' Markets	Davidson	CDM, HLBCE	Food Assistance	Referral Pathways
Good Shepherd Clothes Closet	Davidson	HLBCE	Clothing	Referral Pathways
Goodwill Industries of NW North Carolina and Career Connections	Davidson	HLBCE	Employment and Training Programs; Workforce Development	Referral Pathways
Health Dept. of Davidson County	Davidson	ATC, CDM, HLBCE, HSED	Medical and Preventive Care; Environmental Health; WIC; Health Education	Clinical, Preventive, Referral Pathways; Education/Training
Lions Club International	Davidson	ATC, CDM, HLBCE, HSED	Sight and Hearing Programs, Children and Youth Programs, Disaster Relief, Community and Environment Programs, Advocacy	Education/Training, Preventive Care, Eye and Ear Care; Referral Pathways
Meals on Wheels	Davidson	ATC, CDM, HLBCE	Food, Home visits to seniors	Referral Pathways
Monarch NC	Davidson	ATC, BH	Behavioral Health services; accepts walk-ins	Clinical; Referral Pathways
Open Hands Ministry	Davidson	ATC	Food, Clothing, Medical Supplies, Furniture Assistance	Referral Pathways, Caregiving

Organization	County	Domain	Key Resources	Type of Partnership
Parks and Recreations in both Lexington and Thomasville	Davidson	CDM, HLBCE	Public Facilities for Physical Activity, Sports and other programs, Walking and Nature programs	Referral Pathways; Education/Training
Pastors Pantry	Davidson	CDM, HLBCE	Food Assistance	Referral Pathways
Positive Wellness Alliance	Davidson	CDM, HLBCE	Service for persons with AIDS, in the areas of transportation, case management, education	Referral Pathways
School Systems in both Lexington and Thomasville	Davidson	HLBCE, HSED	Education, Food, Counseling	Education/Training; Referral Pathways
The Salvation Army	Davidson	CDM, HLBCE	Food, Utility, Housing Assistance, Rehabilitation, Veterans Services	Education/Training; Referral Pathways
YMCAs in both Lexington and Thomasville	Davidson	ATC, CDM, HLBCE, HSED	Youth Development, After School and sports programs; health education for youth and seniors	Education/Training; Referral Pathways
Addiction Recovery Care Association (ARCA)	Forsyth	ATC, BH	Substance abuse and detoxification treatment, referrals accepted 24/7	Clinical, Preventive Care, Referral Pathways
Agape Care & Share	Forsyth	ATC, CDM, HLBCE, BH, HSED	Food, Clothing, Blood Pressure Screening, Life and Career skills training, Christian counseling	Referral Pathways, Preventive Care, Education/Training
AIDS Care Services	Forsyth	ATC	Housing and Supportive Services for HIV+ Adults	Referral Pathways
American Legion	Forsyth	ATC, HLBCE	Advocacy, Healthcare Information, Benefits, Employment	Referral Pathways, Education/Training
American Veterans (AmVets)	Forsyth	ATC, HLBCE	Advocacy	Referral Pathways, Education/Training
Anthony's Plot	Forsyth	ATC	Faith-based Worshipping and Advocacy Community, Super Resource guide (upon what much of this guide was populated)	Referral Pathways
Associates in Christian Counseling	Forsyth	ATC, BH	Counseling	Clinical, Referral Pathways
Baptist House	Forsyth	ATC, BH	Home for adult women with mental handicaps	Clinical, Referral Pathways
Battered Women's Shelter	Forsyth	ATC	Contact Family Services for appointment	Referral Pathways
Behavioral Services-Novant	Forsyth	ATC, BH	Detoxification and Mental Health services	Clinical, Preventive Care, Referral Pathways
Bethany Baptist Church Clinic	Forsyth	ATC, CDM, HSED	Medical Care, School and sports physical, pediatric care, small lab; some free medication	Clinical, Referral Pathways, Preventive Care
Bethesda Center	Forsyth	ATC	Men and Women's overnight and Day shelter, supportive services	Referral Pathways
Campbell Disability Center	Forsyth	ATC	Help for those denied Social Security Benefits	Referral Pathways
Cancer Services	Forsyth	ATC, CDM, HSED	Medical financial assistance, equipment, supplies, transportation to treatments, peer support, patient advocacy	Referral Pathways
Catholic Social Services	Forsyth	ATC, BH	Food, Spiritual counseling, Pastoral Care	Referral Pathways, Clinical, Preventive

Organization	County	Domain	Key Resources	Type of Partnership
CenterPoint	Forsyth	ATC, BH, HSED	Screening, triage and referrals for publically funded mental health, developmental disabilities and substance abuse services.	Clinical, Preventive Care, Referral Pathways
Cleveland Avenue Dental Center (Forsyth Co. Dept. of Public Health)	Forsyth	ATC	Dental care for all ages, Medicaid Health Choice and Carolina Access	Clinical, Preventive, Referral Pathways
Community Care Center & DEAC Clinic	Forsyth	ATC, CDM, HSED	Medical Care, cardiology, dental, dermatology, endocrinology, gastroenterology, gynecology, neurology	Clinical, Preventive Care, Referral Pathways
Community Mosque Clinic	Forsyth	ATC, CDM, HSED	Chronic Care Management, limited acute care, physicals, medication samples, limited labs	Clinical, Preventive Care, Referral Pathways
Crisis Control Ministries	Forsyth	ATC, CDM, HLBCE	Food, Clothing, Utility, Bills, and Medication Assistance	Referral Pathways, Education/Training
Community Choices/WISH	Forsyth	ATC, BH	Help for women with substance abuse issues	Referral Pathways, Preventive Care
Daymark Recovery Services	Forsyth	ATC, BH	Mental health and substance abuse treatment, regardless of payer status	Clinical, Preventive Care, Referral Pathways
De'Asja's House	Forsyth	ATC	Transitional housing, life skills training and supportive community to homeless women & children	Referral Pathways, Education/Training
Disability Advocates	Forsyth	ATC	Help with disability claims	Referral Pathways
Experiment in Self-Reliance	Forsyth	ATC, HLBCE	Food, Financial Education, Temporary Housing for working homeless to transition them to permanent housing	Referral Pathways, Education/Training
Eureka House	Forsyth	ATC, HLBCE	Prison re-entry, housing, job placement, $125/week	Preventive Care, Referral Pathways
Faith Community Partners (see FaithHealth for listing of 59 partners)	Forsyth	ATC, CDM, HLBCE, HSED	Training, Caregiving, Food, Utility, Clothing, Housing Assistance, Gas Vouchers, Soup Kitchens	Caregiving, Preventive, Referral Pathways
Faith Seeds Community	Forsyth	ATC, HLBCE	Prison re-entry, housing, job placement	Education/Training, Referral Pathways
Family Promise	Forsyth	ATC, HLBCE	Shelter, meals, comprehensive support services and assistance to homeless families, with a day center	Referral Pathways, Education/Training
Fellowship Home	Forsyth	ATC, BH	Detoxification, long-term programs for men and women with substance abuse issues	Clinical, Preventive Care, Referral Pathways
Friendship Vision House	Forsyth	ATC, BH	Residential long-term treatment, outpatient, partial hospitalization/day treatment, sliding scale fee	Clinical, Preventive Care, Referral Pathways
Forsyth County Dept. of Public Health	Forsyth	ATC, CDM, HLBCE, HSED	Immunizations, STD clinic, Family Planning Clinic, WIC program, Woman Wise, Food Stamps, Medicare, Medicaid	Some Clinical, Preventive Care, Referral Pathways
Forsyth Tech Dental Clinic	Forsyth	ATC	Low cost Dental Care	Clinical, Preventive Care, Referral Pathways
Goodwill of NWNC	Forsyth	ATC, HLBCE	Job training, scholarships available	Referral Pathways
Habitat for Humanity	Forsyth	ATC, HLBCE	Basic housing for low-income people	Referral Pathways

Organization	County	Domain	Key Resources	Type of Partnership
Healthy Carolinas	Forsyth	ATC	Dental Crisis Fund to meet Emergency Dental needs of children, ages 5-18 yo	Clinical, Preventive Care, Referral Pathways
HARRY Community Outreach Services	Forsyth	ATC, HLBCE	Career development, Emergency assistance, Job placement, Case management, Housing assistance	Referral Pathways, Education/Training
Hawley House-YMCA	Forsyth	ATC, BH	Women's Substance Abuse Recovery Facility	Clinical, Preventive Care, Referral Pathways
Homeless Opportunities & Treatment (HOT) Project-Samaritan Ministries	Forsyth	ATC, BH	Mental health services to homeless adults	Clinical, Preventive Care, Referral Pathways; Partly funded through WFSOM Dept. of Psychiatry grants
Hosanna House of Transition	Forsyth	ATC, HLBCE	Shelter, counseling, and job placement to homeless, recovering drug addicts and ex-offenders	Preventive Care, Referral Pathways, Education/Training
Housing Authority of Winston-Salem	Forsyth	ATC, HLBCE	Low-income housing help (Section 8)	Referral Pathways
I Can House	Forsyth	ATC, BH	Advocacy, resources, training and referral navigation for persons and families dealing with autism, Asperger' syndrome and other pervasive developmental disorders	Referral Pathways, Education/Training
Insight Human Services	Forsyth	ATC, BH	Clinical facilities, psychiatric services, substance abuse treatment, sliding scale fees	Clinical, Preventive Care, Referral Pathways
Ivy House: Center for Self-Sufficiency	Forsyth	ATC, HLBCE, BH	Homeless offenders or those being released from jail or prison without a stable housing plan. Must also have a mental health or substance abuse concern.	Preventive Care, Referral Pathways, Education/Training
JobLink Career Center	Forsyth	ATC, HLBCE	Job search assistance	Referral Pathways
Legal Aid of North Carolina	Forsyth	ATC	Legal Services	Referral Pathways
Love Thy Neighbor	Forsyth	ATC, CDM, HSED	Food (Meals), Medical and Dental Care	Clinical, Referral Pathways
Med-Aid	Forsyth	ATC, CDM	Medication Assistance	Referral Pathways
Meals on Wheels	Forsyth	ATC, CDM	Delivered Meals	Referral Pathways
Mental Health Association	Forsyth	ATC, BH	Mental Health Treatment, Advocacy and Support Groups	Clinical, Preventive Care, Referral Pathways, Education/Training
Next Step Ministries	Forsyth	ATC	Assistance for victims of domestic violence and their children	
Outreach Alliance for Babies	Forsyth	ATC	Baby clothing and supplies	Referral Pathways
Oxford House	Forsyth	ATC, BH	Addiction Recovery House	Preventive Care, Referral Pathways
Pearl Resources Unlimited	Forsyth	ATC, HLBCE	Financial education programs, youth programs, parenting seminars, Food, Housing, Angels Embrace Program	Referral Pathways, Education/Training
Planned Parenthood	Forsyth	ATC, HSED	Women's reproductive health needs	Clinical, Preventive Care, Referral Pathways
Positive Wellness Alliance	Forsyth	ATC, CDM, HLBCE	Emergency assistance for housing, utilities, medications, food, transportation	Referral Pathways
Potter's House	Forsyth	ATC, HLBCE	Prison re-entry, furniture help, kids programs	Referral Pathways, Education/Training
Prodigals Community	Forsyth	ATC, BH	Residential alcohol and drug recovery	Preventive Care, Referral Pathways

Organization	County	Domain	Key Resources	Type of Partnership
Project HOPE (Winston Salem, Forsyth County School System)	Forsyth	ATC, HLBCE	Help with school enrollment, supplies, referrals and transportation services for homeless students and their families	Referral Pathways
Project Re-entry	Forsyth	ATC, HLBCE, BH	Pre-release and Post-release programs, housing, job placement, counseling	Preventive Care, Referral Pathways, Education/Housing
Rehab Assistance	Forsyth	ATC, BH	Offer rehab assistance funds	Referral Pathways
Salem Pregnancy Center	Forsyth	ATC, HSED	Free pregnancy tests, parenting classes, vouchers for infant needs	Screening and Preventive Care, Education/Training
Salvation Army	Forsyth	ATC, CDM, HLBCE	Food, Clothing, Bill Help, Emergency Shelter, Veterans Services, Center of Hope Shelter for homeless families and single women, Residential Re-Entry Center for ex-offenders	Education/Training; Referral Pathways
Samaritan Inn	Forsyth	ATC, HLBCE	Men's overnight shelter, supportive services	Referral Pathways
Senior Services	Forsyth	ATC, CDM, HLBCE	Meals, Crafts, Physical Activity, Music, Educational Programs	Referral Pathways, Education/Training, Caregiving
Shepherd's Center	Forsyth	ATC, CDM, HLBCE, HSED	Transportation, Social Support, Medication and Housing Assistance	Referral Pathways, Education/Training, Caregiving
Shalom Project	Forsyth	ATC, CDM, HSED	Food, Clothing, Medical Care, pregnancy tests, STD testing, physicals, diabetes education, some medication assistance, Community Knowledge Center provides computer time and training	Clinical, Referral Pathways, Education/Training
Smile Starters	Forsyth	ATC	Dental care for children ages 1-20 yo, Medicaid and Health Choice	Clinical, Preventive Care, Referral Pathways
Southside United Health & Wellness Center	Forsyth	ATC, CDM, HSED	General Medicine, prenatal care	Clinical, Referral Pathways, Education/Training
Step One	Forsyth	ATC, BH	Substance abuse treatment, detoxification	Clinical, Preventive Care, Referral Pathways
Stepping Stones Ministries	Forsyth	ATC, HLBCE	Referral based shelter for couples and families	Referral Pathways
Sunnyside Ministries	Forsyth	ATC, CDM	Housing, Utility Assistance, Clothing, Medical Care (physicals, except sports), immunizations, health education	Clinical, Referral Pathways, Education/Training
Today's Woman Health & Wellness Center	Forsyth	ATC, CDM, HSED	Free pregnancy tests, OB/GYN care, ultrasound, lab tests	Clinical, Preventive, Referral Pathways
Urban League	Forsyth	ATC	Employment, Clothing, Vouchers	Referral Pathways, Education/Training
U.S. Dept. of Veterans Affairs and VA Clinic	Forsyth	ATC, CDM, HLBCE, HSED	Veterans Benefits and Homeless Veterans Outreach, Medical Care for veterans	Clinical, Preventive, Referral Pathways
U.S. Social Security Office	Forsyth	ATC	Social Security cards, Social Security Benefits	Referral Pathways
Veterans of Foreign Wars (VFW)	Forsyth	ATC	Advocacy with benefits	Referral Pathways
Work First	Forsyth	ATC	Emergency Assistance for families in crisis	Referral Pathways

Organization	County	Domain	Key Resources	Type of Partnership
Winston-Salem Rescue Mission	Forsyth	ATC, CDM, BH, HSED	Food, Clothing, Medical Care, Chronic conditions, acute care, physicals, Immunizations, medication assistance, dental extractions only, Alpha Acres (Yadkin county) long-term residential A&D rehabilitation program, 24-hour shelter for homeless men, Supportive Services	Clinical, Preventive, Referral Pathways
Your Hope NC	Forsyth	ATC	Domestic Violence Advocacy	Referral Pathways
YMCAs	Forsyth	ATC,CDM, HLBCE, HSED	Health education and physical activity programs, senior and youth programs, Diabetes prevention education	Referral Pathways, Preventive Care; grant funding for DM work is a collaboration with WFSOM

VIII. Progress to Date on 2013 Priorities

NCBH and WFBH have made progress toward the original 2013-2015 CHNA priorities of Physical Activity and Nutrition, Chronic Disease Prevention and Management, Access to Care and Behavioral Health. WFBH continues to align with the Davie, Davidson and Forsyth County Health Departments and leads and/or participates in a wide variety of partnerships and local coalitions. The health system has been responsive to the chronic health needs of the community by providing free care to its residents and provides an annual $4 million in subsidy funding for the Downtown Health Plaza, a Level 3 NCQA site and National Health Service Corp site. During FY15, Downtown Health Plaza had over 67,000 patient visits, including 28,800 adults, 27% of which are self-pay; 19,400 OB/GYN patients, 41% are self-pay; and 18,900 pediatric patients, 8% of which are self-pay. Many of the self-pay patients are managing chronic diseases such as diabetes, kidney failure and heart failure, and DHP provides care and counseling at no cost for these conditions. Specifically DHP provides significant benefit to the community through the following initiatives: Collaboration with Northwest Community Care Network through onsite pediatric and internal medicine case managers; as a participating WIC site; provides a community garden providing fresh vegetables and herbs to patients; provides a free food pantry to patients; offers a co-located mental health counselor for children in partnership with The Children's Home; and a co-located parent educator program in partnership with Imprints to help families address developmental delays. DHP also coordinates with Northwest Community Care Network and Centerpoint to provide an innovative comprehensive care management for a high risk population (inclusive of the uninsured) through an intensive care coordination program (higher risk for readmissions and ED visits). DHP also provides an annual Share the Health FREE Health Fair, providing free health screenings and other health-related services available to everyone (adults and children) regardless of age, insurance coverage, and income level or immigration status. The health fair serves approximately 650 children and adults on an annual basis.

Brenner FIT (Families in Training) has the longest track record and the most experience in providing prevention and treatment programs for overweight and obese populations in the hospital's service area. In FY 2015, Brenner FIT provided the following:

- ✓ Received 584 referrals; began treatment of 130 new patients; Increased orientation attendance by 49%
- ✓ Initiated redesign of Brenner FIT's clinical treatment, developing additional experiential education components and increasing clinic volume

- ✓ Gave 13 academic presentations with over 600 professionals in attendance
- ✓ Reached over 1,900 individuals through community education
- ✓ Featured 11 times in both regional and national media totaling over $900,000 in value for the medical center and reaching nearly 9 million individuals
- ✓ Taught nearly 1,100 school children Brenner FIT's message
- ✓ Participated in 15 community health fairs reaching an estimated 68,000 individuals
- ✓ Offered 91 cooking classes, teaching 1,202 community members about healthy eating
- ✓ Offered 45 classes focused on physical activity reaching 562 community members
- ✓ Contributed to academic and medical literature through 7 journal publications and 5 research presentations

The hospital also provides a number of public educational programs through BEST Health. Below is an annual three year recap of the community classes and education provided by BEST Health.

Best Health Events	**2013 (FY 13)**		**2014 (FY 14)**		**2015 (FY 15)**	
	# Screenings	***# Attendees***	***# Screenings***	***# Attendees***	***# Screenings***	***# Attendees***
Exercise Classes	18 - classes	114	16 - classes	96	26- Classes	300
Diabetes Prevention	5-classes	47	7-classes	42	19-classes	150
Health Risk Screenings	3-screenings	106	4-screenings	193	4-screenings	172
Heart Classes	62- classes	128	58 - classes	130	96 - classes	215
Cancer Prevention	9-classes & 1-screening	149 (class) & 31 (screening)	4- classes	77	5- classes	20

In addition, WFBH continues to provide mental health screenings and services through CareNet to all patients/all payers including uninsured and underinsured across a broad region. This includes integrated behavioral health services at five clinics located in Forsyth County and surrounding areas. CareNet specializes in faith-integrated counseling that assists the client in identifying and incorporating his or her own faith resources, values, and support systems into the counseling process. Outpatient counseling is provided to a variety of individual, couple, and family emotional/spiritual health issues; other services provided include coaching, consultation, educational workshops, retreats, and seminars. Below is an annual three year recap of the CareNet volume totals, as well as the break out by Medicaid and uninsured payer mix.

CareNet Center	2013 (FY 13)		2014 (FY 14)		2015 (FY 15)	
	Medicaid	Uninsured	Medicaid	Uninsured	Medicaid	Uninsured
Burlington					26	241
Fayetteville	182	1863	628	1711	908	594
Greenville	134	627	124	706	443	707
Harnett	290	944	498	1337	639	634
Lumberton	775	458	1202	208	1010	127
Mt. Airy	74	248	167	341	159	235
Statesville	22	1040	85	1389	190	1382
Wilkes	570	621	1046	506	1217	345
Wilmington	127	1115	197	1000	235	594
Winston Salem	549	1891	2181	2002	2249	2680
Total	2723	8807	6128	9200	7076	7539
% of Total Visits	7%	23%	14%	21%	14%	15%
Total Visits	38,948		44,745		50,487	

Community Health Needs Assessment- Davie Medical Center

II. Introduction

Davie Medical Center (DMC) is a not-for-profit facility and is part of Wake Forest Baptist Medical Center (Medical Center), a preeminent, internationally recognized academic medical center with balanced excellence in patient care, research and education. Davie Medical Center includes Davie Medical Center Mocksville and Davie Medical Center Bermuda Run. Davie Medical Center – Bermuda Run includes a 60,000 square foot medical office plaza and a 101,000 square foot emergency department and outpatient surgical center. Davie Medical Center - Mocksville has served the health needs of Davie County and nearby areas since 1956. Previously known as Davie County Hospital, it became part of Wake Forest Baptist Health in 2007. In the spring of 2017, Davie Medical Center will open a 78,200 square foot 50-bed inpatient facility that will include acute care for the elderly (ACE) and a joint replacement program.

Mission

The mission of Davie Medical Center is to improve the health of our region by:

- Providing excellent care and an exceptional experience
- Promoting health and wellness through community partnerships
- Connecting people to the world class expertise of Wake Forest Baptist Medical Center

Vision

To be a medical center of choice, promoting health and serving as a destination for excellence inpatient care.

III. Purpose of Community Health Needs Assessment (CHNA)

Davie Medical Center has a long history of engaging our communities in identifying health issues and implementing strategies to address the needs of the community. Ongoing, unprecedented increases in the demand for healthcare are challenging for communities and healthcare providers in this era of limited fiscal resources. In order to fulfill our mission and the requirements of the Affordable Healthcare Act for non-profit hospitals, Davie Medical Center has conducted its second needs assessment for the 2016-2019 timeframe. This assessment is central to Davie Medical Center's community benefit/social accountability plan. By determining and examining the service needs and gaps in our community, Davie Medical Center can develop responses to address them through our community benefit plan and resources.

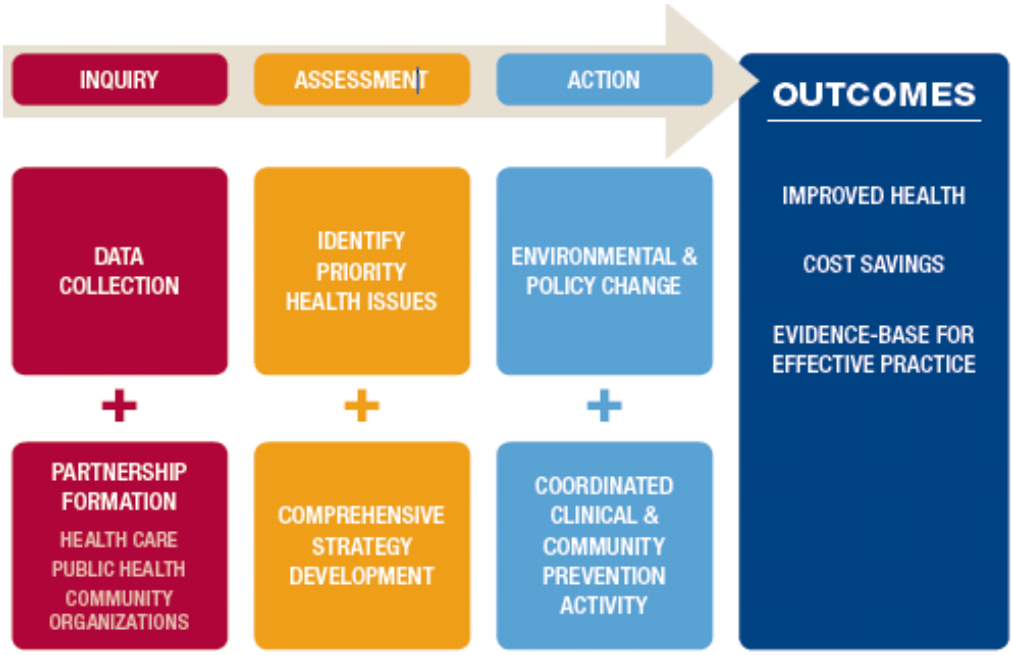
With the growing burden of chronic disease, the medical and public health communities are reexamining their roles and opportunities for more effective prevention and clinical interventions. The potential to significantly improve chronic disease prevention and impact morbidity and mortality from chronic conditions is enhanced by adopting strategies that incorporate a social ecology and place based perspective, realigning the patient-physician relationship, integrating population health perspectives into the chronic care model, and effectively engaging communities.

A Community Health Needs Assessment (CHNA) is an approach to collecting, analyzing and using data, including community input.

To identify barriers to the health and wellbeing of its residents and communities, leading to the development of goals and targeted action plans to achieve those goals. To undertake this mandate, Wake Forest Baptist Health formed an internal Community Benefit Steering Committee with representation from various departments and disciplines. Specifically, the Committee was charged to:

- Develop a comprehensive needs assessment and align with the WFBH's Strategic Plan
- Develop an implementation plan
- Monitor plan implementation and institute corrective measures if needed
- Evaluate the effectiveness of individual projects and the impact of community benefit initiatives as a whole
- Communicate the plan to external and internal audiences

The Community Benefit Steering Committee recommended using the following model to guide planning and programmatic efforts, and to explain to internal and external stakeholders the rationale for the Community.



IV. Description of Community Served and How it was Determined

Community Profile

Davie County is located in the Piedmont Triad region of North Carolina. Widely rural, the county is characterized by rolling farmland. The nearest metropolitan area is Winston-Salem, located just 12 miles to the northeast. Davie County is bounded on the north by Yadkin County, on the northeast by Forsyth County, on the west by Iredell County, and to the south by Rowan County. There are seven townships in Davie County. Mocksville is by far the largest municipality with 5,104 residents[1] and is also the county seat. However over 80% of the county's population is contained within unincorporated areas[2]. Davie County is bisected by Interstate 40, which provides convenient access to Greensboro, Charlotte and Raleigh - just 34, 40, and 98 miles away, respectively. Approximately 54% of working Davie County residents travel outside the county to their employer on a daily basis[3]. Of those, 62% work in Forsyth County.

Davie County covers 264 square miles and has a population of approximately 41,500, or 156 residents per square mile[1]. It is the 60th largest county in North Carolina (of 100 counties)[4]. Davie experienced unprecedented growth between 2000 and 2010, at almost 2% annually. This is significant compared to the Piedmont Triad's average growth rate for that same time period, at just 1.2%.

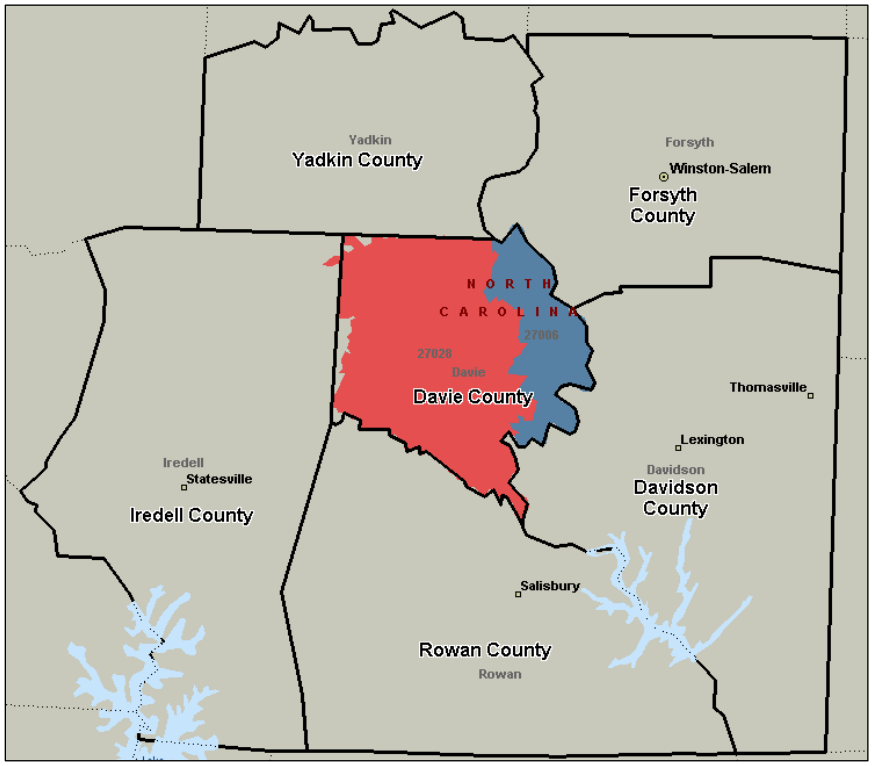
[1] http://www.census.gov/quickfacts/table/PST045215/3743720

[2] According to the United States Census Bureau (July 1, 2015), Davie County, North Carolina has approximately 41,753 residents. http://www.census.gov/quickfacts/table/PST045215/37059,00,3743720

[3] The median income of the county is $49,591 with the percentage of the population below poverty at 13.8%. Do we have a source for the commute data??

[4] http://www.osbm.nc.gov/demog/county-estimates

There are pockets of the county where the majority of the population growth occurred, chiefly in the eastern part of the county that borders Winston-Salem. However, portions of Mocksville also experienced substantial growth during this time period. It is projected that Davie County will grow to approximately 52,400 residents by 2030[4]. Davie County is primarily comprised of three zip codes: 27028, 27006, and 27014 (PO Box).



Davie Medical Center – Bermuda Run is located in eastern Davie County, North Carolina. Davie Medical Center – Mocksville is centrally located in Davie County.

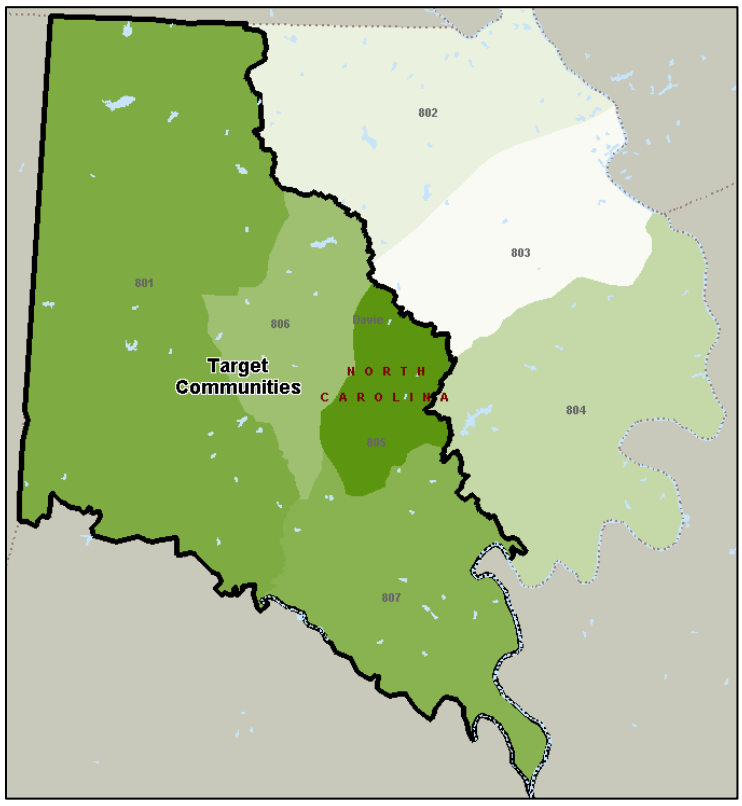
Davie Medical Center – Mocksville had a total of 221 inpatient discharges during WFBH FY 2015. Of those discharges, approximately 50% originated from five counties: Forsyth, Davidson, Wilkes, Stokes, and Guilford. Davie County accounted for approximately 1% of inpatient discharges from Davie Medical Center – Mocksville. The Emergency Department at Davie Medical Center – Bermuda Run had over 11,000 visits during WFBH FY 2015, of which approximately 70% originated from Davie County. Forsyth and Yadkin Counties rounded out another approximate 20% of ED visits. Within Davie County, the majority of the ED visits (approximately 70%) originated from zip code 27028 which also comprised approximately 50% of total ED visits.

Outpatient surgeries at Davie Medical Center – Bermuda Run totaled approximately 3,000 during WFBH FY 2015. Of those cases, approximately 80% originated from eight counties: Forsyth, Davie, Guilford, Davidson, Stokes, Surry, Yadkin, and Randolph. Davie County accounted for approximately 14% of outpatient surgeries, with the distribution more or less evenly split between zip codes 27028 and 27006.

In order to allocate resources and maximize the effectiveness of community initiatives, for the purpose of conducting the Community Health Needs Assessment, Davie Medical Center chose to narrow the focus to Davie County as well as neighborhoods that:

- Are geographically proximate to Davie Medical Center
- Have a density of high-risk patients who demonstrate poor health indicators (health disparities)
- Have individuals and organizations with developed and historical relationships with Davie Medical Center such as Faith Health and United Way or have the potential for partnering to address specific health and social issues

As indicated in the map (below), these communities include Census Tracts 801, 805, 806, and 807.



Neighborhood resources, ethnic diversity and fragmentation of services within Davie County pose formidable organizational challenges in community benefit programming. DMC's approach to community benefit adopts a comprehensive notion of health determinants that are spread across domains of behavioral risk, social and economic circumstances, environmental exposures, and medical care. The balance and effects of many of these determinants, e.g., availability of healthy foods, parks and other safe places to play and exercise, exposure to environmental irritants, and safe housing, are specific to Davie County and are built into the Community Benefit Plan.

V. Process and Methods Used to Conduct the CHNA

Davie Medical Center worked closely with the Davie County Health Department to gain insight on the health needs of the community. Healthy Carolinians of Davie County and many other agencies throughout the community also contributed. The Community Health Needs Assessment is the result of efforts to assess the health needs of Davie County, as required at least every four years by the North Carolina Department of Health & Human Services. The purpose of the Community Health Assessment is to provide an understanding of the current health status and needs of Davie County, along with community strengths, assets and potential resources to address those needs.

Principles of Community Engagement:

Principle	Key elements
Set Goals	• Clarify the purposes/goals of the engagement effort • Specify populations and/or communities
Study Community	• Economic conditions • Political structures • Norms and values • Demographic trends • History • Experience with engagement efforts • Perceptions of those initiating the engagement activities
Build Trust	• Establish relationships • Work with the formal and informal leadership • Seek commitment from community organizations and leaders • Create processes for mobilizing the community
Encourage self-determination	• Community self-determination is the responsibility and right of all people • No external entity should assume that it can bestow on a community the power to act in its own self-interest

Principle	Key elements
Establish partnerships	• Equitable partnerships are necessary for success
Respect diversity	• Utilize multiple engagement strategies • Explicitly recognize cultural influences
Identify community assets and develop capacity	• View community structures as resources for change and action • Provide experts and resources to assist with analysis, decision-making, and action • Provide support to develop leadership training, meeting facilitation, skill building
Release control to the community	• Include as many elements of a community as possible • Adapt to meet changing needs and growth
Make a long-term commitment	• Recognize different stages of development and Provide ongoing technical assistance

Source: Principles of Community Engagement: Edition 2. Clinical and Translational Science Awards Consortium Community Engagement Key Function Committee Task Force on the Principles of Community Engagement. 2011;11-778[2].

Literature Review and Secondary Data Sources:

More than ten secondary data sources were reviewed including:

1) Wake Forest Baptist Medical Center Community Dashboard/Healthy Communities Institute: http://www.wakehealth.edu/HCI/?hcn=CommunityDashboard
2) County Health Rankings and Roadmaps: http://www.countyhealthrankings.org/
3) 2014 State of the County Health: http://www.daviecountync.gov/DocumentCenter/View/1818
4) US Census Bureau 2010 Census
5) US Census Bureau 2014 American Community Survey
6) NC Center for Health Statistics

7) Centers for Disease Control - Youth Risk Behavior Surveillance System (YRBSS) 2010–2012
8) Behavior Risk Factor Surveillance System (BRFSS) 2014
9) Healthy People 2020
10) Healthy North Carolina 2020
11) Center for Medicare and Medicaid

Primary Data Sources:

Wake Forest Baptist Health (WFBH) Strategic Plan

The WFBH 3-Year Strategic Plan was reviewed and potential areas of alignment with community benefit strategies were identified.

Community Input – Resident Surveys (conducted by Davie County Health Department)

The Davie County Community Health Assessment was conducted in April 2014. The CHNA team decided to get as many convenience surveys as could be gathered for the assessment. The group decided to use SurveyMonkey to gather information. Some county participants completed the survey online and some completed a paper survey with responses then entered into Survey Monkey. Surveys were either emailed and/or hand delivered to:

- Storehouse for Jesus
- Davie County Health Department
- Library
- All County Employees
- Davie County School staff
- Healthy Carolinians Committee

There were a little over 200 community members that completed a questionnaire regarding their health status, health behaviors, and factors that impact their quality of life. The Hispanic (non-English) population was surveyed mostly at A Storehouse for Jesus and Davie County Health Department. Methodology for the 2014 Davie Community Needs Assessment process was initiated in 2014 with the meeting of the Healthy Carolinians Committee that includes representatives from many local agencies. The survey was distributed online, through email and was also administered as a paper and pen survey. It was broadly advertised and distributed to the general public through a local magazine, website and newspaper.

FaithHealthNC Community Asset Mapping

FaithHealth NC held two workshops in Davie County in 2016 comprised of people and organizations providing religious, health and social services in the community.

Two workshops were held in 2016. Basic stats for Davie County include:

- Population: 41,420
- Median age: 42

- Race/Ethnicity: Caucasian 85.5%, Latino 6.1% and African American 6.2%
- 18.2% are without health insurance
- 13.8% live under the poverty level
- 85.4% have a high school education
- Median income is $50,463

By working with the two groups, health seeker and health provider groups, participants identified the most important factors contributing and working against health in the community. Providers identified how partnerships and resources could contribute to improve health.

Key findings in these work groups included:

- Food insecurities, inadequate emergency care, schools are a main source for offering services to families and are major advocates for children, and the hospital and community college are partnering to provide services.
- In addition, the groups identified that services are concentrated in Mocksville and many cannot access this care. Poorer neighborhoods seemed to be neglected. Dental care, transportation and housing needs for the homeless are key issues. Lack of transportation, lack of finances, proximity to healthcare and depression are factors that work against the well-being in the community.

From these meetings, next steps were identified. Major players in the community will be identified. There will be a focus on transportation for access to care.

Comments from 2013-2015 CHNA

All CHNA and Implementation reports along with county indicator tracking are available on the WFBH website- http://www.wakehealth.edu/HCI/ and http://www.wakehealth.edu/Davie-Medical-Center/About/Community-Benefits/Community-Benefits.htm. No comments from the public have been received to date. All future comments will be incorporated into future CHNA and implementation strategies and reports.

VI. Identification and Prioritization of Community Health Need

To address the community health needs identified in the CHNA, recommendations for initiatives were prioritized based on secondary data findings, primary data gathered through FaithHealthNC and Health Department workshop and survey findings as well as the feedback from the WFBH CHNA steering committee and senior leadership. The identified priority health needs and recommended initiatives were then grouped into the following three domains:

- Access to care /Health screening and early detection
- Chronic disease management
- Behavioral/Mental Health Distress

The following prioritization criteria and weighting was used to identify community benefit priorities:

Criteria	Weighted Value
Identified as a county priority	2
Disparity exists within census tract/zip code/county/market	3
WFBH steering/leadership perceive as a priority	2
Great potential to improve health status	3
Positive visibility for WFBH	1
High # of patients/residents can/would be impacted	2
Feasibility/resources availability /existing relationships	2
Supports WFBH Strategic Plan objectives	2
Synergy with current supported initiatives- FaithHealthNC, United Way	2
Coordinates/complements with County Health Department assessment priorities	1
Total points	**20**

A strategic framework was also developed with the ultimate goal of community engagement for WFBH, which includes guiding principles for addressing the conditions/priorities that influence the health of communities and contribute to better health of the population served.

Guiding Principles

- ***Focus on the places where need is concentrated.*** Health in targeted neighborhoods served- obesity, diabetes- healthy eating/ exercise/ working with nutritious foods
- ***Tighten Social Service, Faith and Other Agency partnerships-*** *S*upport/sustain enhance community resource agencies that care for the social and behavioral health needs of our patients and residents. This includes Southside FQHC, United Way Funded Agencies, Second Harvest Food Bank and the many hundreds of faith groups already involved in the lives of our patients and neighborhoods.
- ***Strengthen patients and partners through health education and literacy focus.*** Programs and initiatives provide the opportunity to build the capacity of patients and community members to blend the very best of health science with their own intelligence and wisdom to make the choices that advance health of themselves and those they love.

The Community Benefit steering committee along with the Executive Team developed the final priorities which are summarized in the table below.

Domain	Priority Health Areas to Address
Access to Care	Decrease ED Utilization for uninsured/charity care patients
Access to Care	Increase WFBH patients with health insurance /usual source of care
Access to Care	Increase WFBH patients with access to transportation to clinic appointments
Access to Care	Increase primary care access points in east Winston
Chronic Disease Management	Healthy Lifestyle Behaviors and Community Environment - Screening and linking patients to food pantries
Chronic Disease Management	Increase self-management education opportunities for patients and residents with diabetes
Chronic Disease Management	Increase primary care group visits for diabetic and obesity patients
Chronic Disease Management	Increase patients and Wake employees enrolled in chronic care management programs
Chronic Disease Management	Health Screening and Early Detection: Provide Mammography/Women's Cancer community screenings
Behavioral/Mental Health Distress	Decrease ED Utilization for behavioral health related conditions
Behavioral/Mental Health Distress	Increase education of basic mental health issues and resiliency strategies for community agency and laypersons supports

Given the high level of charity care, percent below poverty and number of co-morbidities as noted in the Wake Chronic Disease Registry data for obesity, diabetes, and hypertension, the following census tracts were prioritized for place based/community impact: 801, 805, 806, and 807.

VII. Community Resources to Address Need

A list of community resources for Davie County health related resource are provided below:

- **County Public Library**
- **Storehouse for Jesus** -organization offers a variety of services including a food pantry, clothes closet, medication help, clinic, a counselor and barber. They are located on Hwy. 64. They began assisting with medications in 1993 in a small house, and expanded to another facility. The new clinic was opened in 2000. The organization is staffed entirely by volunteers.
- **Salvation Army** - 622 N. Main Street #211, Mocksville, NC. They help with utility bills, rent, mortgage, and prescriptions.
- **Mocksville Civitan Club** – This is a volunteer-based community club that meets at the Presbyterian Church. Their focus is on helping the community and surrounding areas.
- **Department of Social Services** – This organization helps with bills, Medicaid, food stamps, "work first" program, child support, etc. They cooperate with surrounding agencies to provide services, and give a hand up to people who need assistance. The community embraces service in Davie County and tries to help others. The representative voiced that the biggest gap is the need for more people to serve and more staff for their organization. There is a struggle with the adult population being "Ready to be treated." There is also a struggle with resources available for children. Trust is a problem due to political rhetoric. Kids and adults live in fear of deportation if they are seeking services while being undocumented. There is a need for official licensed interpreters.
- **Advocacy Center of Davie County** – This group helps people who have "fallen through the gaps." They began with First Presbyterian Church downtown. They are located in a little house beside the First Presbyterian Church and are a faith-based organization fully compliant with 501 c (3) status. The organization receives money from churches in Davie County and some grants. They help people with rent and utilities who are in danger of homelessness. DSS is a referral for the Advocacy Center. They are open Tuesday, Wednesday and Thursday (9:30-2:30). They do background checks and financial checks, and offer budgeting help. They do not help the homeless, but do provide care for people who do not qualify for any other help in the community.
- **Hillsdale Methodist** – The church staffs a benevolent phone line (answered twice a day). They give Food Lion cards to help with food and gas cards for help with gas. They have a soup ministry.
- **Smart Start** – This is an early childhood education program which also works in home with domestic violence families. They are present in the high schools and early childhood resource centers. It is state funded.
- **Center Point Human Services** - They are located at 142 Gaither Street, Mocksville, NC. They connect people with wellness resources and tools for physical and mental health. They encourage people to socialize, and are open 8 am – 5 pm, Monday through Friday.
- **Davie Domestic Violence and Rape Center** – They are located at 123 S. Main Street, Mocksville, NC. They serve anyone who comes to them in intimate partner relationships and those who have been sexually assaulted. One of their goals is to establish a rape response program inn Davie County. Currently, county residents have to go to Forsyth County for this

service. They outreach to schools and provide prevention work through puppet shows and age appropriate child abuse prevention programs, including the "Speak Up and Be Safe" program that teaches middle school students about abuse. They teach teens about healthy vs. unhealthy relationships. Their goal is to help the community understand the dynamics of abusive relationships. This is a county agency, one of three in the entire state. 20% of staff salaries come from the county; they rely on grants for the other 80%.

- **Oak Grove UMC** – Oak Grove realizes the challenge of losing membership and the closing of churches. They want to "re-think church." They want to be relevant to the times and community members' needs. They believe they are called to step out into the community as a calling from Christ and are accepting the task of working to re-connect with the community. This includes helping people make connections with the resources they need. Currently, much of their funding is raised through community dinners.
- **Farmington United Methodist and Wesley Chapel United Methodist** – These churches try to provide support for the agencies that are in Davie County, and provide volunteers for different agencies. Farmington started in 1881 and Wesley Chapel is older than that. The most common needs appear to be utilities, food, rent, etc.
- **First Baptist Church –** The church hosts a "Narcotics Anonymous" program that is available for those with substance abuse problems.
- Care Net in Davie County
- **Mocksville Second Presbyterian Church –** The church helps people to map out how they are going to access help. They are also part of an informal faith community organization that helps to raise money for local charities and organizations. They have a large worship gathering with other churches twice a year and the money raised during this service goes out into the community. Pastor Terry is aware that people do not have access to certain services in Davie County, and the church tries to connect people with those services.
- **Oak Grove United Methodist Church** – Oak Grove helps with transportation for community members and is trying to revamp that ministry. They have members who work with hospice and the elderly.
- **United Methodist Church FaithHealth Connector** - Donna Cook.
- **Just Hope Inc. United Way of Davie County** - This organization works with the homeless. They are based in Advance. They help to provide money for motel rooms for the homeless. They provide food to individuals that don't qualify for traditional services. They deliver groceries to those without reliable transportation, and for the elderly who don't drive. There is an application process.
- **Family Promise** – This is a Not for Profit Organization providing job skills, education, food and housing. Their clients are homeless families with children.
- **Meals on Wheels**

VIII. Progress to Date on 2013 Priorities

The following tables below provide detailed updates of the 2013-2015 CHNA priority progress.

1) Educate the Davie Community on the principles of proper nutrition and physical Activity

Best Health Events	FY 13, 14, 15
BestHealth Classes provided at Davie Medical Center focused on exercise and nutrition	9 events reaching 71 people
Cooking Classes	6 events reaching 68 people
Walking Trail	Opened Fall of 2014

2) Offer programs to help residents lower their risk for heart disease.

Best Health Events	FY 13, 14, 15
Best Health/screenings	12 events, 422 screened
Community Education	23 events, 271 screened

3) Access to Care

Through a variety of efforts through the Davie e-newsletter, the patient collateral pieces and our DMC website, the access to care is provided via the WFBH access center 888-716-WAKE line. Transportation to care is still an issue for Davie County but with the addition of services in Davie County, residents can now have access to the multitude of services provided at the Mocksville and Bermuda Run campuses as well as the Urgent Care location in Davie County.

Community Health Needs Assessment- Lexington Medical Center

II. Introduction

Lexington Medical Center (LMC) is a not-for-profit facility which operates 94 acute care beds and serves as a satellite provider of Wake Forest Baptist Health specialty services including digestive health, ENT Head and Neck surgery among others. As part of Wake Forest Baptist Health, Lexington Medical Center has the resources of a nationally recognized academic medical center at its doorstep, enabling the facility to offer world-class health care here, close to home. The medical center operates 14 physician practices and a public pharmacy. Lexington Medical Center is accredited by The Joint Commission and has been committed to providing for the health care needs of Davidson County since the 1920s. Lexington Medical Center serves the city of Lexington, North Carolina and the greater Davidson County area.

Mission

To improve the health of our region by:

- Providing excellent care and an exceptional experience
- Promoting health and wellness through community partnerships
- Connecting people to the world class expertise of Wake Forest Baptist Medical Center

Vision

To be a medical center of choice, promoting health and serving as a destination for excellence in patient care.

III. Purpose of Community Health Needs Assessment (CHNA)

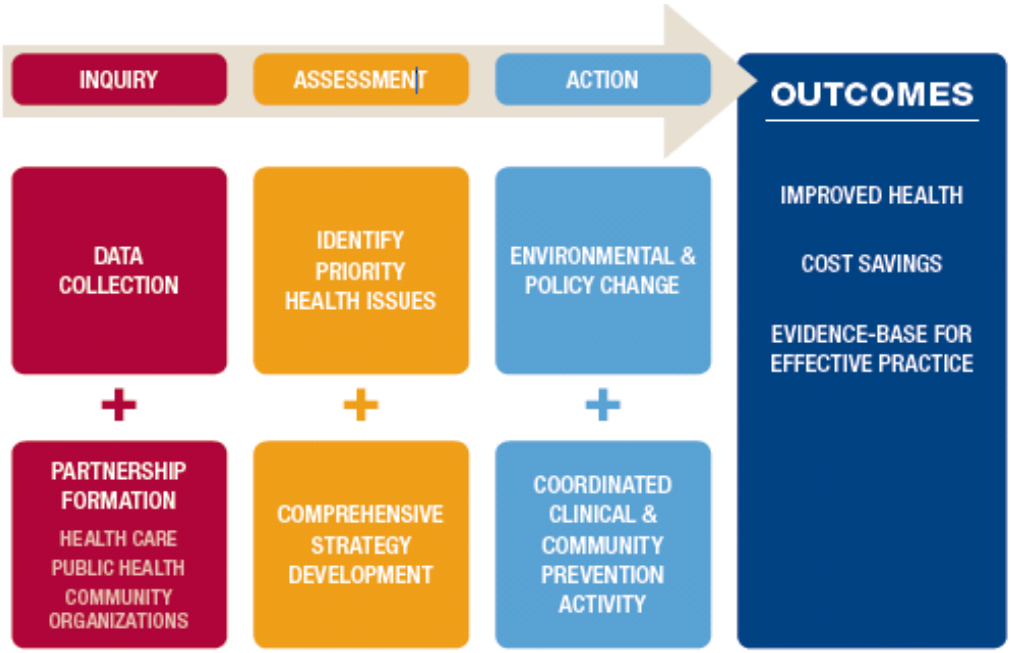
LMC has a long history of engaging and partnering in its community to identify and address the health needs of the community. Ongoing, unprecedented increases in the demand for healthcare are challenging for communities and healthcare providers in this era of limited fiscal resources. In order to fulfill our mission and the requirements of the Affordable Healthcare Act for non-profit hospitals, LMC has conducted its second needs assessment for the 2016-2019 timeframe. This assessment is central to LMC's and WFBH's community benefit/social accountability plan. By determining and examining the service needs and gaps in our community, NCBH can develop responses to address them through our community benefit plan and resources.

With the growing burden of chronic disease, the medical and public health communities are reexamining their roles and opportunities for more effective prevention and clinical interventions. The potential to significantly improve chronic disease prevention and impact morbidity and mortality from chronic conditions is enhanced by adopting strategies that incorporate a social ecology and place based perspective, realigning the patient-physician relationship, integrating population health perspectives into the chronic care model, and effectively engaging communities.

A Community Health Needs Assessment (CHNA) is an approach to collecting, analyzing and using data, including community input,
To identify barriers to the health and well-being of its residents and communities, leading to the development of goals and targeted action plans to achieve those goals. To undertake this mandate, WFBH formed an internal Community Benefit Steering Committee with representation from various departments and disciplines. Specifically, the Committee was charged to:

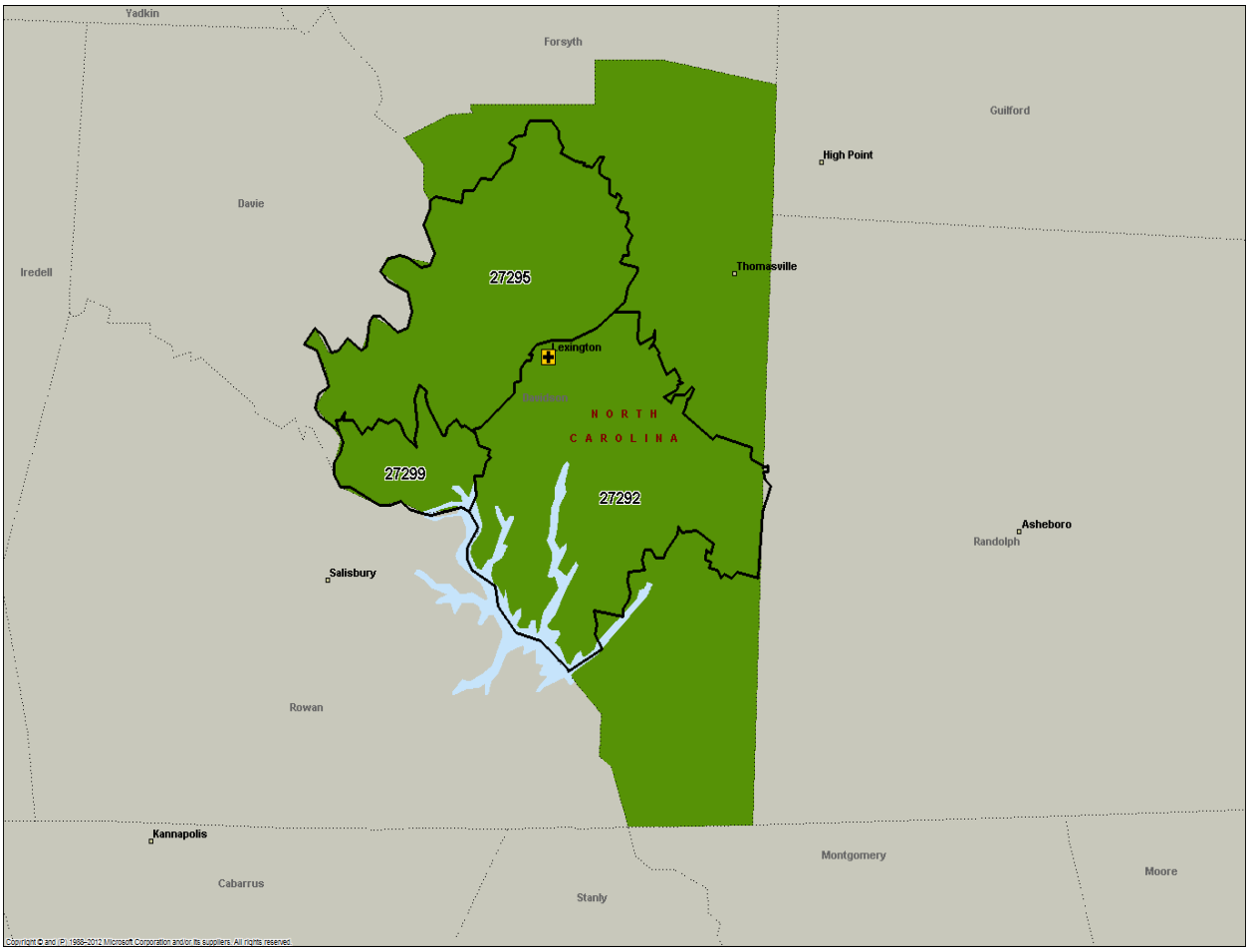
- Develop a comprehensive needs assessment and aligned with the WFBH's Strategic Plan
- Develop an implementation plan
- Monitor plan implementation and institute corrective measures if needed
- Evaluate the effectiveness of individual projects and the impact of community benefit initiatives as a whole
- Communicate the plan to external and internal audiences

The Community Benefit Steering Committee recommended using the following model to guide planning and programmatic efforts, and to explain to internal and external stakeholders the rationale for the Community.



IV. Description of Community Served and How it was Determined

Lexington Medical Center is located in central Lexington in Davidson County, North Carolina. As a community hospital, Lexington Medical Center serves a geographic area that includes the city of Lexington and the surrounding area. The majority of patients reside within a four zip code area in Davidson County. Those zip codes include 27292, 27295, 27239, 27360.



Community Benefit Area

According to the official 2014 census, Davidson County has approximately 164,000 residents. The population of the county is 86.9% non-Hispanic white, 9.4% non-Hispanic African American, 6.8% Hispanic or Latino, and 1.5% Asian. Davidson County is less diverse than the population of North Carolina. In addition, 6.9% of residents in Davidson County speak a language other than English in their home. The median income of the county is $43,083 with the percentage of the population below poverty at 16.3%. The 2014 census indicated in Davidson County there was a smaller proportion of persons in most age groups under the age of 44 and a larger proportion of persons over the age of 44 than compared to the proportions of persons in these age groups in North Carolina.

Neighborhood resources, ethnic diversity and fragmentation of services within Davidson County pose formidable organizational challenges in community benefit programming. Lexington Medical Center's approach to community benefit adopts a comprehensive notion of health determinants that are spread across domains of behavioral risk, social and economic circumstances, environmental exposures, and medical care. The balance and effects of many of these determinants, e.g., availability of healthy foods, parks and other safe places to play and exercise, exposure to environmental irritants, and safe housing, are specific to Davidson County and are built into the Community Benefit Plan.

V. Process and Methods Used to Conduct the CHNA

LMC values the principles of community engagement (see table below) articulated by the Centers for Disease Control and has built its community benefit efforts on a community engagement model.

Principles of Community Engagement

Principle	Key elements
Set Goals	• Clarify the purposes/goals of the engagement effort • Specify populations and/or communities
Study Community	• Economic conditions • Political structures • Norms and values • Demographic trends • History • Experience with engagement efforts • Perceptions of those initiating the engagement activities
Build Trust	• Establish relationships • Work with the formal and informal leadership • Seek commitment from community organizations and leaders • Create processes for mobilizing the community
Encourage self-determination	• Community self-determination is the responsibility and right of all people • No external entity should assume that it can bestow on a community the power to act in its own self-interest

Principle	Key elements
Establish partnerships	• Equitable partnerships are necessary for success
Respect diversity	• Utilize multiple engagement strategies • Explicitly recognize cultural influences
Identify community assets and develop capacity	• View community structures as resources for change and action • Provide experts and resources to assist with analysis, decision-making, and action • Provide support to develop leadership training, meeting facilitation, skill building
Release control to the community	• Include as many elements of a community as possible • Adapt to meet changing needs and growth
Make a long-term commitment	• Recognize different stages of development and Provide ongoing technical assistance

Source: Principles of Community Engagement: Edition 2. Clinical and Translational Science Awards Consortium Community Engagement Key Function Committee Task Force on the Principles of Community Engagement. 2011;11-778[2].

Literature Review and Secondary Data Sources

More than fifteen secondary data sources were reviewed including:

- United States Census Bureau
- Log Into North Carolina (LINC)
- NC Office of State Budget and Management
- NC Department of Commerce
- Employment Security Commission of NC
- NC Division of Aging and Adult Services
- NC Department of Public Instruction
- NC Department of Justice
- NC Department of Juvenile Justice and Delinquency Prevention
- NC Department of Administration
- NC Division of Medical Assistance
- NC Division of Child Development
- NC State Board of Elections
- NC Division of Health Services Regulation

- Cecil G. Ships Center for Health Services Research
- Annie E. Casey Foundation Kids Count Data Center
- Davidson County Department of Social Services

Primary Data Sources:

Wake Forest Baptist Health (WFBH) Strategic Plan

The WFBH 3-Year Strategic Plan was reviewed and potential areas of alignment with community benefit strategies were identified.

Community Input – Community Survey Monkey

The Davidson County Community Health survey was conducted in summer of 2015 and designed as an on-line, Sureveymonkey. The survey solicited respondents' concerns about community health problems, unhealthy behaviors, and community social issues. Respondents were also queried as to their medical care access, personal health, and personal health behaviors. The survey instrument advised the participants that their responses would be confidential and not linked, By September 28, 2015, 962 surveys had been completed.

Survey highlights include the following:

- Obesity/overweight was the most commonly identified health problem in Davidson County, selected by 60% of respondents.
- Diabetes and Cancer were the next most commonly selected health problems, each selected by around 53% of participants.
- Aging problems and heart disease/heart attack were each selected by around 50% of respondents.
- Drug abuse was selected by more than three-quarters (78%) of respondents as the most important unhealthy behavior in Davidson County.
- Alcohol abuse was the second most commonly identified unhealthy behavior, chosen by 63% of respondents.
- The next most commonly identified unhealthy behaviors were lack of exercise/poor physical fitness (~59%) followed by poor eating habits (50%).

FaithHealthNC Community Asset Mapping

Throughout the summer of 2014, Faith Health NC engaged in community asset mapping of Davidson' County's vulnerable communities utilizing the CHAMP (Community Health Assets Partnership) model with the goals of improving peoples' access to healthcare and listening to the healthcare providers and, more importantly, the voice of the healthcare seekers, the consumers of healthcare. FaithhealthNC provided a total of two community health mapping of neighborhoods workshops at the First Presbyterian Church in Lexington, NC. Major health factors identified includes poor mental health care access, access to care, social service bureaucracy, unemployment and lack of money and lack of transportation on the weekends. Identified assets included service ministries, hospitals, government supported health services and self-help services.

Comments from 2013-2015 CHNA

All CHNA and Implementation reports along with county indicator tracking is available on the WFBH and LMC websites- http://www.wakehealth.edu/HCI/ and http://lexington.wakehealth.edu/Community-Health.htm . No comments from the public have been received to date. All future comments will be incorporated into future CHNA and implementation strategies and reports.

VI. Identification and Prioritization of Community Health Need

To address the community health needs identified in the CHNA, recommendations for initiatives were prioritized based on secondary data findings, primary data gathered through FaithHealthNC and Health Department workshop and survey findings as well as the feedback from the WFBH CHNA steering committee and senior leadership. The identified priority health needs and recommended initiatives were then grouped into the following three domains:

- Access to care /Health screening and early detection
- Chronic disease management
- Behavioral/Mental Health Distress

The following prioritization criteria and weighting was used to identify community benefit priorities:

Criteria	Weighted Value
Identified as a county priority	2
Disparity exists within census tract/zip code/county/market	3
WFBH steering/leadership perceive as a priority	2
Great potential to improve health status	3
Positive visibility for WFBH/LMC	1
High # of patients/residents can/would be impacted	2
Feasibility/resources availability /existing relationships	2
Supports Strategic Plan objectives	2
Synergy with current supported initiatives- FaithHealthNC, United Way	2
Coordinates/complements with County Health Department assessment priorities	1
Total points	**20**

A strategic framework was also developed with the ultimate goal of community engagement for WFBH, which includes guiding principles for addressing the conditions/priorities that influence the health of communities and contribute to better health of the population served.

Guiding Principles

- ***Place based/Geo focus-*** Health in targeted neighborhoods served- obesity, diabetes- healthy eating/ exercise/ working with nutritious foods
- ***Tighten Social Service /Other Agency partnerships-*** *S*upport/sustain enhance community resource agencies that care for the social and behavioral health needs of our patients and residents (Southside, United Way Funded Agencies, Second Harvest Food Bank, etc.)
- ***Health Education & Literacy focus-*** Programs and initiatives provide the opportunity to educate patients and community members

The Community Benefit steering committee along with the Executive Team developed the final priorities which are summarized in the table below.

Domain	**Priority Health Areas to Address**
Access to Care	Decrease ED Utilization for uninsured/charity care patients
Access to Care	Increase WFBH patients with health insurance /usual source of care
Access to Care	Increase WFBH patients with access to transportation to clinic appointments
Chronic Disease Management	Healthy Lifestyle Behaviors and Community Environment - Screening and linking patients to food pantries
Chronic Disease Management	Increase self-management education opportunities for patients and residents with diabetes
Chronic Disease Management	Increase primary care group visits for diabetic and obesity patients
Chronic Disease Management	Increase patients and LMC/Wake employees enrolled in chronic care management programs
Chronic Disease Management	Health Screening and Early Detection: Provide Mammography/Women's Cancer community screenings
Behavioral/Mental Health Distress	Decrease ED Utilization for behavioral health related conditions
Behavioral/Mental Health Distress	Increase education of basic mental health issues and resiliency strategies for community agency and laypersons supports

VII. Community Resources to Address Need

Many government agencies and community organizations maintain on-line resource directories to help the citizens of Davidson County locate the organizations and services they need. Among them are:

- Davidson County Department of Senior Services Community Resource Directory

The county department of Senior Services maintains an on-line directory of resources of interest—but not limited—to senior citizens. It can be located via the following URL: http://www.co.davidson.nc.us/media/PDFs/20/SrSvcsCOMMUNITYRESOURCEDIRECTORY032311.pdf

- Davidson County Health Department Resource List

The Davidson County Health Department maintains an on-line resource list arranged topically by kind of service offered. It can be located at: http://www.dchdnc.com/Docs/HealthED/ResourceList%20.pdf.

- United Way of Davidson County

The United Way maintains an alphabetized list of links to partner agencies, most of which provide advocacy or direct assistance to the public. The list is accessed via: http://uwdavidson.org/Partner_Agencies.php.

- 2-1-1 of Davidson County

With the help of the United Way, many communities in NC, including Davidson County, help maintain a local "2-1-1" phone information system to help citizens locate health and human services and resources as varied as employment assistance, food pantries, or homeless shelters. A call to NC 2-1-1 is free, confidential, available all day, every day, and in any language. In addition, there is an on-line gateway to NC 2-1-1 that provides links to a listing of county resources via the following URL: http://www.nc211.org/index.php/component/cpx/?task=search.advanced.

- Davidson County Assistance Programs

This unnamed source provides information on local charities, non-profit agencies, and other organizations that can provide economic assistance, such as help in paying rent, mortgage, and utility bills, finding free food, and other forms of aid. The website is indexed by type of aid needed. It can be located at: http://www.needhelppayingbills.com/html/davidson_county_assistance_pro.html.

- Davidson County Government Services

The Davidson County government website provides a page with links to a directory of the programs and services provided by twenty-six county departments, covering topics like Planning, Administration, Taxes, Recycling, Child Care, Permits, Deeds, Senior Care, Health and Well Being, Transportation and much more. The Directory also shows where these services are

located in the county and how to find them. It includes maps and driving directions to services, as well as phone numbers and the times services are available. The URL is: http://www.co.davidson.nc.us/dcg/ProgramsAndServices.aspx.

VIII. Progress to Date on 2013 Priorities

The following tables below provide detailed updates of the 2013-2015 CHNA priority progress.

Specific Action	Annual Baseline	Growth Target	Intervention Strategies	Tactics	Collaborative Partners	2016 Update
1.a. Body and Mind Intervention	3 Classes at 20 each	3 classes at 25 each with 90% completion rate	Increase # of participants receiving education and participating in classes to achieve their personally set goals	Targeted outreach of at risk populations; identification of best utilized times for offerings	J. Smith Young YMCA	2 classes offered a year with 20 participants and a 100% completion rate.
1.b. FUN for Kids - Fitness, Understanding , Nutrition	New Program to replace old program	2 classes with 10-20 participants each	Educational program designed to teach children and their families healthy nutrition, exercise and healthy living habits	Fully developed, comprehensive program to improve the health and daily habits of children and their families	J. Smith Young YMCA, other community partners	Program discontinued due to lack of funding and participant interest.
1.c. HelpPD	NA	Offer 2 groups with 10-15 participants each – expected completion rate 50%	Education, weight loss and exercise program with the goal of decreasing weight by 7% to prevent the onset of type II diabetes.	Education on health habits, food journals, weekly group meetings for first half of the program and monthly maintenance after, goal of 10,000 steps a day	J. Smith Young YMCA; Wake Forest Baptist Health HelpPD research group	Program on hold until a new Diabetes Educator is hired.
1.d. Lunch and Learns	5 offered	7 offered	Increase number of participants and offerings	Create creative means of educating on Obesity and healthy living, identify at risk populations	J. Smith Young YMCA, PPG, City of Lexington and Davidson County Employees	Lunch and Learns grown to 10 per year with a minimum of 40 participants per session.

1.e. Davidson County, Lexington City Schools Healthy Kids Initiative	650 students served	20% increase in number of students	Reach most at risk population of students and schools with highest level of title 1 funding	Continue to serve at risk population while identifying new needs, and offering education to higher level grades	Davidson County Schools and Lexington City Schools	Expanding to 7 schools a year with over 650 student participants. Currently evaluating and updating curriculum.
1.f. BMI Screenings	200 participants	20% increase	Increase number of participants	Identify new events and locations for screenings	Various Community Partners	BMI screening included in every hospital screening in the community and on the LMC campus.

1) Physical Activity/Nutrition & Obesity

2) Tobacco Cessation

Specific Action	Baseline	% Growth Target	Intervention Strategies	Tactics	Collaborative Partners	2016 Update
2.a. Tobacco Cessation Classes	Offered 2 class but were unable to fill classes	2 classes	Increase the number of participants to enable the completion of at least 2 classes	Identify new populations of potential participants	Local employers	Tobacco cessation classes not offered. Two members of the respiratory services department trained to deliver tobacco cessation classes. Will be able to utilize for community event and inpatient education.

2.b. Davidson County, Lexington City Schools Healthy Kids Initiative	No tobacco education offered in prior years	700 students	Reach most at risk population of students and schools with highest level of title 1 funding	Add \impacts of tobacco usage to the healthy habits portion of the curriculum	Davidson County and Lexington City Schools	Expanding to 7 schools a year with over 650 student participants. Currently evaluating and updating curriculum.
2.c. Middle/High School Tobacco Education Program		New program	Work with physician to create approved curriculum to educate middle school aged children on the impacts of tobacco usage	Provide education to at least 2 at risk schools	Physicians and Schools	Program still in development. Lacking funding to develop
2.d. Inpatient education and NC Quit Line Referrals	Not previously tracked	90% of appropriate patients receive information	Monitor dissemination of tobacco cessation information and referrals to NC Quit Line	Offer information to all inpatient tobacco users, and provide referrals upon request		Two members of the respiratory services department trained to deliver tobacco cessation classes. More people to be trained in the upcoming year. Provide NC Quit Line materials at community events.
2.e. Extend amount of tobacco cessation information provided to the community	Not currently included in community education	3 new avenues	Provide education and NC Quit Line information to identified at risk populations	Offer information at 2 screening events and in pre-natal packets to all patients		Two members of the respiratory services department trained to deliver tobacco cessation classes. More people to be trained in the upcoming year.

3) Access to Care

Specific Action	Baseline	Growth Target	Intervention Strategies	Tactics	Collaborative Partners	2016 Update
3.a. Community Day	70 participants with 2 screenings offered	20% increase with more screenings	Free offering to Davidson County residents for a variety of preventative screenings	Screenings offered include EKGs, lab work, etc. with clinical staff available for consult		70 participants with 5 screenings offered: Aneurysm screening, Bone density screening, Carotid ultrasound screening, Mammogram, Stroke screening
3.b. Access Committee – Transportation Survey	New initiative	New initiative	Improve the transportation system for Davidson County residents	Transportation survey conducted at a variety of locations to target at risk populations (ex: DSS, libraries, Family Services, etc.)	Healthy Communities Coalition, Davidson County Department of Transportation, Davidson County Health Department, Davidson Medical Ministries, United Way of Davidson County and more	Send a representative to serve on the monthly committee.
3.c. Insurance Exchange Information Sessions	New initiative	5 sessions offered	LMC will provide information of the Insurance exchanges to increase the number of people with insurance and ultimately increasing their access to care	LMC will offer in collaboration with Community partners, insurance exchange education sessions at local libraries in all parts of the county, to educate at risk populations on the opportunity to obtain health insurance	Health Communities Coalition Access Committee, Davidson County Libraries, other third party experts on the Marketplace	Initiative discontinued due to lack of community interest and participation.

3.d. Community Screenings	7 screenings	10% increase in participation	Increase the availability of screenings to the county	Offer a wide variety of types of screenings to make preventative care available to at risk populations	J. Smith Young YMCA, Community Partners	Continue to host these 7 screenings in the community. Have increased our ability to host screenings by purchasing a portable machine that produces full lipid profiles with glucose within 5 minutes.
3.e. Community Flu Shots	New Program	Offer 100 Flu Shots	Improve access to preventative care to the community	Offer Flu Shots outside of the medical provider setting	J. Smith Young YMCA	Continue to offer over 100 flu shots in the community by targeting corporate partners.
3.f. Lunch and Learns	5 offered	7 offered	LMC aims to provide community education on a variety of Health and Wellness topics	Provide healthcare education outside of the medical provider setting, targeting at risk populations	J. Smith Young YMCA, Davidson County, City of Lexington, community groups and churches and other local employers	Lunch and Learns grown to 10 per year with a minimum of 40 participants per session.
3.g. Faith Health North Carolina	New initiative	30 participating churches	Utilize the faith community to extend the reach of preventative healthcare and meet the needs of daily healthy living to prevent hospitalization	Collaborate with churches in the community to provide resources to assist with at risk population needs. Create a network of resources to help the provider and minimize hospitalizations	Davidson County Churches and Faith Community, WFBH Faith and Health Ministries, and LMC Department of Pastoral Care	Participate with FaithHealth NC when necessary and appropriate. We refer community members to FaithHealth and FaithHealth refers community members to our community events when necessary.