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Community Health Needs Assessment- North Carolina Baptist Hospital

I. Introduction

North Carolina Baptist Hospital (NCBH) is a component member of Wake Forest Baptist Health (WFBH), 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 24 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

As a part of Wake Forest Baptist Health (WFBH), NCBH's mission is to improve the health of our region, state and nation by:

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

Vision

As a part of Wake Forest Baptist Health (WFBH), NCBH is a preeminent learning health system that promotes better health for all through collaboration, excellence and innovation.

II. Purpose of Community Health Needs Assessment (CHNA)

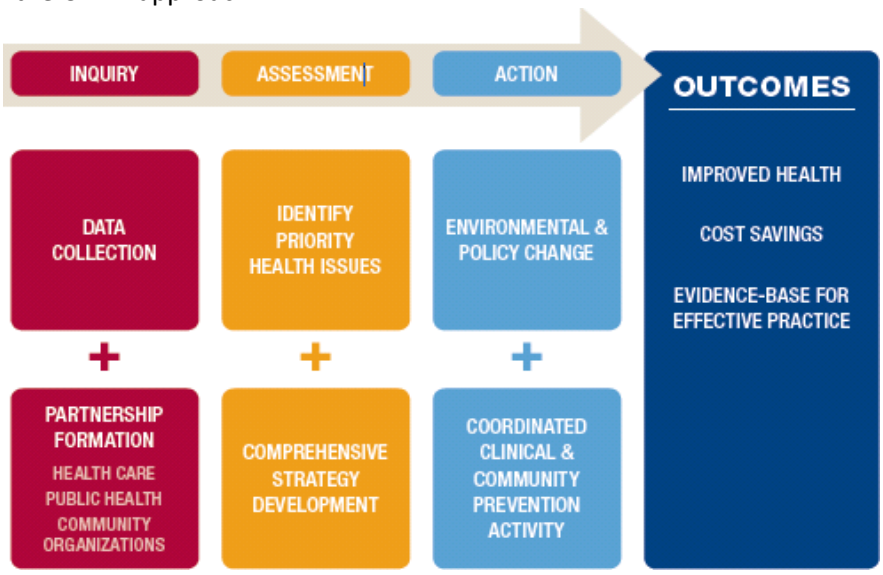
NCBH has a long history of engaging our communities in identifying health issues and implementing strategies to address the needs of the community. Ongoing, unprecedented increases in the demand for healthcare are challenging for communities and healthcare providers in this era of limited fiscal resources. Those resource limits are exacerbated 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 third needs assessment for the 2020-2022 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 exploring opportunities for more effective prevention and clinical interventions at population health scale. 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 (including the FaithHealth Division; Population Health Department; Division of Public Health Sciences; Financial Services Department; and Strategic Planning Department), as well as several external health and human services community partners. The Committee was specifically tasked to:

- Develop a comprehensive needs assessment aligned with 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 CHNA approach.



III. Description of Community Served and How it was Determined

As part of 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 encompasses seven contiguous counties. However, the majority of inpatient admissions and emergency visits are provided to Forsyth County residents, representing 31.1% and 59.6% respectively of the total patient volume for calendar year 2018.

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 near 20%
- Have 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 Novant Health Forsyth Medical Center and Forsyth County Department of Public Health, or have the potential for partnering to address specific health and social issues like Imagine Forsyth.

These communities are primarily located in the following zip codes: 27101, 27103, 27105, 27106, 27107, and 27127. Within these zip codes, as part of the community benefit implementation strategy, NCBH will further define its focus and identify specific census tracts and neighborhoods for additional targeted programming and action. Within these high charity care zip codes, we are also emphasizing self-pay patients for more intentional outreach and data collection.

Community Benefit Area

According to the United States Census Bureau's July 1, 2018 population estimate, Forsyth County is the fourth largest county in North Carolina with approximately 379,099 residents. According to the County Health Rankings and Roadmaps 2018, the population of the county is 57.1% non-Hispanic white, 25.7% non-Hispanic African American, 12.7% Hispanic or Latino, and 2.5% Asian. The county's median household income is $49,000 with the percentage of the population below poverty at 18%. When comparing the overall county population with the population living in the targeted zip codes, those living in the targeted zip codes have a higher percentage of households living below poverty, having lower median household incomes, and accounting for more NCBH Charity Care as indicated in the table below.

2018 Population Demographics - Forsyth County

Sources: Truven (Market Expert), Crimson Market Advantage (Demographics Module), WFBMC DSS (Strata)
Network Growth, Strategy, & Business Development (Chris Safley p. 6-3967) 2/15/2019

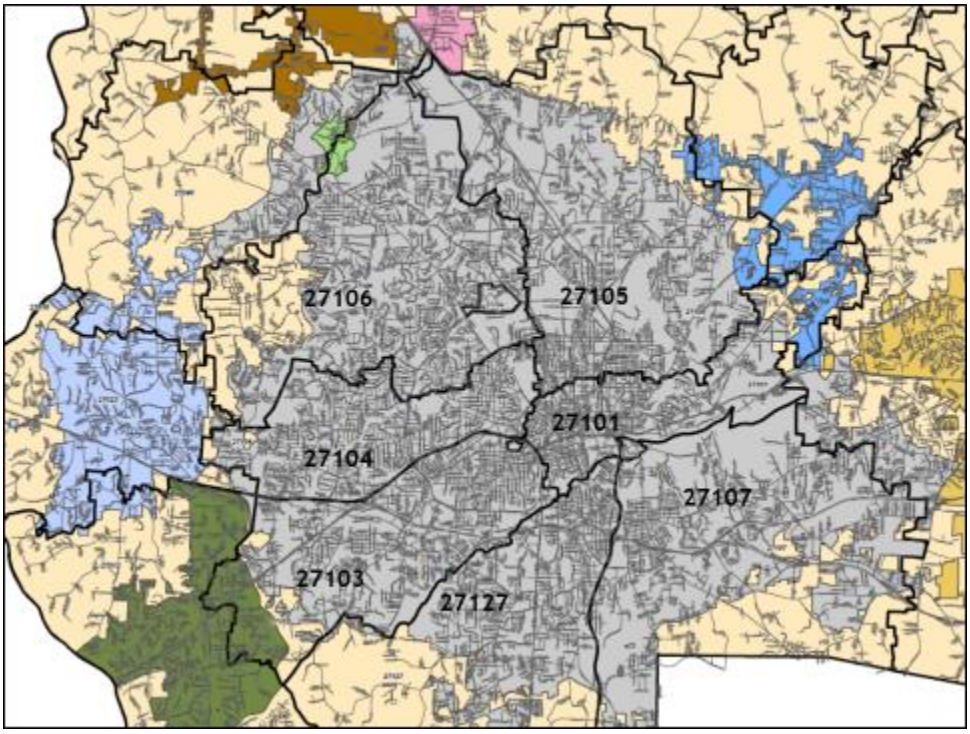
Zip Code	City	2018 Population	White	Black	Hispanic	Asian	% of HH's Below Poverty	Median HH Income	NCBH Charity Care	NCBH Charity Care vs Payments %
27009	Belews Creek	2,996	88.8%	6.8%	3.0%	0.3%	13.0%	$ 69,788	$ 238,068	7.8%
27012	Clemmons	27,954	84.7%	5.9%	4.1%	3.6%	8.5%	$ 80,740	$ 1,531,227	5.4%
27023	Lewisville	12,975	88.0%	4.1%	3.7%	2.4%	8.8%	$ 84,581	$ 883,349	5.5%
27040	Pfafftown	11,505	84.4%	8.5%	3.4%	1.7%	11.7%	$ 72,550	$ 1,037,638	7.9%
27045	Rural Hall	9,096	71.1%	17.9%	8.6%	0.6%	13.9%	$ 53,425	$ 1,015,647	7.6%
27050	Tobaccoville	4,057	88.2%	6.4%	3.5%	0.5%	13.2%	$ 60,471	$ 409,165	10.6%
27051	Walkertown	7,580	74.6%	16.1%	6.8%	0.4%	18.4%	$ 52,351	$ 1,257,472	12.6%
27101	Winston Salem	20,538	36.5%	48.2%	11.1%	1.4%	39.5%	$ 30,104	$ 7,659,516	19.8%
27103	Winston Salem	36,260	54.6%	20.9%	17.6%	4.2%	19.0%	$ 49,925	$ 7,905,495	16.4%
27104	Winston Salem	30,149	72.0%	14.5%	6.0%	5.2%	14.9%	$ 66,125	$ 3,233,499	7.8%
27105	Winston Salem	39,662	19.1%	59.0%	17.9%	1.0%	34.5%	$ 31,841	$ 16,665,235	21.2%
27106	Winston Salem	51,218	58.2%	22.7%	13.5%	3.0%	19.8%	$ 52,538	$ 7,238,059	11.7%
27107	Winston Salem	50,546	46.6%	28.0%	21.9%	0.9%	23.2%	$ 44,462	$ 11,423,143	21.1%
27110	Winston Salem	2,320	0.6%	94.2%	1.2%	0.3%	66.7%	$ 87,500	$ 2,614	9.1%
27127	Winston Salem	38,044	49.5%	29.3%	15.9%	2.6%	17.4%	$ 50,245	$ 6,109,008	12.5%
27284	Kernersville	55,487	75.7%	11.2%	9.0%	2.0%	14.7%	$ 62,114	$ 4,119,617	9.2%

The distressed zip codes represent 62.3% of all residents of Forsyth County, but approximately 81.1% of NCBH's Charity Care in Forsyth County. The percentage of households in poverty in these zip codes range from 17.4% (27127) to 39.5% (27101).

These distressed zip codes contain neighborhoods that are located within 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.

Special Populations - Self-Pay

Since 2012, the FaithHealth Division has been tracking aggregate self-pay costs in 5 target under-served zip codes (27101, 27103, 27105, 27107, 27127), concentrating its "ground game" work with Supporters of Health and Connectors in these neighborhoods. In the summer of 2018, the FaithHealth team began working with Novant Forsyth Medical Center's community benefit and outreach staff. The Novant team requested that we begin to monitor two additional zip codes (27104, 27106), areas where they had a large concentration of uncompensated care. Those zip codes are highlighted in the Figure below.



In reviewing the top diagnoses for self-pay patients in the seven target zip codes above, we noted that infectious disease (HIV was most frequent), while prevention/wellness examinations for both adults and children were in the top four. Chronic diseases of hypertension and diabetes mellitus were in the top eleven. Five diagnoses were related to maternal health: four being focused on normal pregnancy monitoring and one for post-partum follow-up. Remaining diagnoses were related to general symptoms often seen in outpatient settings: upper respiratory infection, low back pain and headache. Drug level monitoring and specified aftercare rounded out the remainder.

Given the high level of charity care, un/underinsured, percent below poverty and number of

co-morbidities as noted in the data gathered from the Strategic Planning and Financial Services Departments, the following zip codes were prioritized for place based/community impact:

- Zip Codes: 27101, 27105, 27107

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. This plan reflects a commitment between health systems, including Forsyth County Public Health and numerous social services organizations, to partner with one another and community members for greater impact.

IV. 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) US Census Bureau 2010 Census
4) US Census Bureau 2017 American Community Survey
5) NC Center for Health Statistics
6) Centers for Disease Control- Youth Risk Behavior Surveillance System 2017
7) NCDHH Behavior Risk Factor Surveillance System (BRFSS) 2013- 2017
8) Healthy People 2020
9) Healthy North Carolina 2020
10) Centers for Medicare and Medicaid
11) Forsyth Futures Report: Understand Access to Health Care: Forsyth County, NC 2014
12) Status of Homelessness in Forsyth County, November 2014

Primary Data Sources:

Wake Forest Baptist Health (WFBH) Strategic Plan

The WFBH strategic goals and imperatives were 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 tables below provide counts by registry of our most common chronic diseases in Forsyth County, as of January 31, 2019. Some persons are listed in more than one registry.

2019 Registry Data	Forsyth County	Total
Asthma	11,478	36,686
Behavioral Health	1,537	1,953
Cancer	10,140	55,140
Chronic Obstructive Pulmonary Disease	5,924	35,008
Congestive Heart Failure	3,474	15,800
Diabetes	17,590	90,310
Hypertension	35,454	155,948
Obesity	41,750	176,952
GRAND TOTAL	**127,347**	**567,797**

Community Input – Resident Surveys conducted by the Forsyth County Department of Public Health

The Forsyth County Health Opinion Survey was administered via the Forsyth County Health Department's website and Facebook page from January 31st to May 31st, 2017 in both English and in Spanish. Additionally, a Quick Response (QR) code was created in order to allow Forsyth County residents a way to access the survey using their smart phones or tablets. These codes were also given out at shopping centers and grocery stores throughout the County to increase access and participation. To ensure that vulnerable populations were also able to participate, in-person surveys were conducted between March 1st and July 31st, 2017. All respondents surveyed were at least 18 years of age and 427 residents participated in the 2017 survey. Black/African-American, non-Hispanic and Hispanic populations were oversampled because these populations were identified as at risk for the major health issues identified.

Based on issues reported by residents of Forsyth County and the Department of Public Health's resources, Forsyth County Department of Public Health prioritized the following four health needs to be addressed in its upcoming three-year cycle:

1. **Chronic diseases with a focus on physical activity**
2. **Oral health (age 0-5 years)**
3. **Sexual health**
4. **Maternal and infant health**

FaithHealthNC Community Asset Mapping

In 2014, FaithHealthNC engaged in community asset mapping of Forsyth County's vulnerable communities utilizing the CHAMP (Community Health Assets Partnership) model with the goals of improving people's 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 workshops of neighborhoods located within zip codes 27101 and 27105 (namely- East Winston, Peters Creek Parkway) throughout the 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, and 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)

As a supplement to the comprehensive asset mapping conducted in 2014, small and targeted focus groups were conducted by FaithHealth and the Novant Health Forsyth Medical Center community benefit team at Morningstar Baptist Church and Iglesia Cristiana Sin Fronteras in the summer of 2018. Located in high-need zip codes (27107 and 27106,) these churches have strong ties to NCBH through FaithHealth. A guided discussion included questions and prompts pertaining to health; barriers to care; community health and wellness assets; and perceptions of the quality of care and hospitals. An analysis was conducted to identify themes from the participants' comments and discussion.

Response Themes
Participants cited multiple challenges relating to healthcare including cost; a lack of awareness and education of health-related services and issues, as well as perception of customer service. Maintaining good nutrition was cited as an issue due to barriers associated with cooking; the high costs of nutritious foods, and the convenience of fast food. Many participants noted that they had experienced a lack of satisfactory customer service from providers and clinic staff, which was attributed to cultural differences and a lack of general education and cultural competency among healthcare providers. These experiences often resulted in feelings of mistrust and fear. Coupled with high healthcare and medication costs, long wait times, and a general lack of comfort navigating the service system, many indicated that they would either postpone or not seek medical treatment. Additionally, several indicated that work was their primary priority as they felt that they had to work in order support their families.

2017-2019 CHNA
All CHNA and Implementation reports along with county indicator tracking is available on the WFBH website- http://www.wakehealth.edu/HCI/. All future comments and feedback will be incorporated into future CHNA and implementation strategies and reports.

V. 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 domains:

- **Access to Care**
- **Chronic disease management and prevention**
- **Behavioral health and substance dependency**
- **Maternal and child health**

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	2
Coordinates/complements with County Health Department assessment priorities	1
Total points	**20**

As part of WFBH, NCBH has developed a strategic framework with the ultimate goal of impactful and effective community engagement. This 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 focusing on obesity, diabetes, healthy eating and nutritious foods, and physical activity
- ***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 United Health Centers 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 vulnerable communities
Chronic Disease Management & Prevention	Healthy Lifestyle Behaviors and Community Environment - Screening and linking patients to screenings, physical activity promotion and healthy living classes
Chronic Disease Management & Prevention	Increase self-management education opportunities for patients and residents with chronic disease
Chronic Disease Management & Prevention	Increase primary care group visits for diabetic and obesity patients
Chronic Disease Management & Prevention	Increase patients and Wake employees enrolled in chronic care management programs
Chronic Disease Management & Prevention	Health Screening and Early Detection: Provide Mammography/Women's Cancer community screenings
Behavioral Health & Substance Dependency	Decrease ED Utilization for behavioral health related conditions
Behavioral Health & Substance Dependency	Increase education of basic mental health issues and resiliency strategies for community agency and laypersons supports
Behavioral Health & Substance Dependency	Increase strategies to prevent opioid related overdose and misuse
Maternal & Child Health	Increase availability of pre and postnatal care services especially in high-risk populations
Maternal & Child Health	Increase education for women on the benefits of good pre-conception health and early prenatal care

The additional domain of maternal and child health results from the July 2018 state approval allowing WFBH to deliver low-risk pregnancies. The hospital has always provided delivery services for high-risk pregnancies. Forsyth County has one of the highest infant mortality rates in the state, and a key part of addressing these issues is to ensure that women have immediate and on-site access to maternal care as well as the resources of Brenner Children's Hospital.

VI. Community Facilities and Other Resources

A detailed list of community resources for the NCBH service area 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
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	Referral Pathways

			Benefits	
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 486 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 y.o.	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 y.o., Medicaid and Health Choice	Clinical, Preventive Care, Referral Pathways
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
United Health Centers	Forsyth	ATC, CDM, HSED	General Medicine, prenatal care	Clinical, Referral Pathways, Education/Training
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
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

VII. Progress to Date on 2017 Priorities

NCBH and WFBH have made progress toward 2017-2019 CHNA priorities of Access to Care, Chronic Disease Management, and Behavioral/Mental Health Distress. 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.

DOMAIN: ACCESS TO CARE

The anticipated impact of the following actions may include: reduction in emergency department visits; increase in the number of insured adults; improvement in access to and utilization of culturally appropriate primary care; reduction of health disparities; and reduction in transportation barriers to receiving medication and care.

Action: Encourage appropriate Emergency Department utilization through care coordination across community, hospital and primary care

- Assess non-emergent and ambulatory care use and develop strategies to reduce the use of emergency services for this population through community and hospital initiatives. Explore models, such as care coordination programs for the charity care population, to address high utilizers/non-emergent care use and seek funding to support recommended model/intervention

  WakeHealth Connect is a managed care program established in 2017. This program was created in order to increase access to primary care; enhance coordinated care practices; reduce improper ED utilization; and assist in connecting patients with social service resources. WakeHealth Connect is designed to establish a regular source of primary care and improve patients' health by enhancing coordinated care practices among primary care providers, nurse navigators, and patients. This design allows for increased continuity of care, builds positive provider-patient rapport, and fosters self-efficacy in patients to take responsibility for their health. By providing coverage, not insurance, for primary care service at no cost to the patient, WakeHealth Connect reduces the cost of care by supporting patients' proper use of WFBH's services. WakeHealth Connect provides its participants with 100% covered primary care visits, as well as specialty visits with the accompanying Referral/Authorization form signed by a participant's primary care provider. All participants are first approved for hospital Charity Care. By building a relationship between a primary care provider, a nurse navigator, and these patients, our mission is to establish a pathway to care and improve the patient's total health, while simultaneously decanting the Medical Center's current capacity restraints and reducing the financial burden of caring for these patients.
  WakeHealth Connect has three primary goals:

  - Improve access to primary care
  - Reduce improper E.D. utilization by this population
  - Assist in connecting patients to social services

- Continue to support the CarePlus care coordination model to reduce ED and IP admissions for Medicaid and Self Pay/Uninsured patients at DHP

  Care Plus is now in its sixth year at Downtown Health Plaza. It provides multidisciplinary team based primary care and care coordination to frequently admitted patients from Wake Forest Baptist Health safety net practices. It is imbedded at Downtown Health Plaza and the multidisciplinary team includes medical providers, nursing, a licensed clinical social worker, a

patient navigator, a part time psychologist, a chaplain resident and a patient services representative. It collaborates closely with a psychiatrist and pharmacist. The care model includes more frequent visits, some home visits, outreach, and a focus on both social determinants of health and mental health.

Since its inception, Care Plus has enrolled approximately 360 patients in the program. Characteristics of enrolled patients provide compelling evidence of why such a broad team is needed to optimally serve these patients. In addition to a high prevalence of poverty with its related food insecurity, difficulty with affording medications and transportation challenges, the enrolled patients have an average of five comorbid conditions, take on average 12 medications at the time of enrollment. In addition, 69% have mental health diagnoses, 38% have substance use issues, and patients have a considerable prevalence of cognitive challenges with 38% scoring less than or equal to 21 on a Montreal Cognitive Assessment.

To date, Care Plus metrics have focused on comparing ED and hospital utilization after enrollment to the same patients' historical utilization prior to enrollment. A comprehensive analysis is underway, but preliminary results show that overall when we compare admissions the year prior to enrollment to the first year of enrollment admissions decrease by 49.5%. When the analysis is limited to patients that remain in the program for at least 12 months, the decrease in admissions in the first year is 39.5 % compared to their historical selves and the decrease in ED visits is 30.2 %. Care Plus has also shown sustained benefit in enrolled patients, with evidence of ED utilization rates over the population decreasing from a median of 0.41 ED visits per month prior to enrollment to 0.22 ED visits per month after enrollment (47% reduction).

Action: Improve access to Community Centered Social and Health Education Services and regular source of health care

- Continue partnership discussions with Novant to create a primary care clinic in East Winston for the self-pay/uninsured and Medicaid population

  WFBH partnered with Novant Health to open the Highland Avenue Primary Care Clinic in East Winston, a traditionally underserved area of the community. The 8,339-square-foot low-cost clinic serves patients of all ages and allows patients to pay for services on an income-based, sliding fee scale. The facility has 12 exam rooms, a procedure room, and X-rays and lab work are conveniently provided on-site. The clinic is located next to a 24-hour behavioral health urgent care facility, operated by Daymark Recovery Services, and Cardinal Innovations Healthcare's Triad Community Office and Wellness Center. The Forsyth County Department of Public Health has identified mental health as one of its top three priority health issues, and is committed to supporting initiatives like this, which are aimed at increasing access, improving care, and reducing the number of people who visit the emergency department for mental health services. The partnership of both WFBH and Novant health systems demonstrates a strong commitment to addressing both physical and mental health needs and maximizing impact through innovative partnerships.

- Continue to explore the use of a mobile medical clinic in low access WFBH service areas

  The mission of the mobile program is to provide quality care for underserved communities in Forsyth County for the purposes of improving health of vulnerable populations, including older

adults, to reduce utilization of the emergency room for primary care conditions, and to address social determinants of health by developing effective and coordinated interventions within the mobile program. The mobile clinic is an outreach effort provided with support by the North Carolina Baptist Hospital Foundation. The program is set up to provide free, high quality healthcare in areas that have high rates of stroke and heart disease deaths, as well as high rates of poverty and food insecurity. This was a partnership between Wake Forest School of Medicine leadership to establish e-charting capabilities for the program, leadership alignment within the institution, and a volunteer framework for medical students and hospital faculty/staff to participate in the program. The program received funding in partnership with the School Based Health Alliance (SHA) and Forsyth County Health Department (FCHD) from the North Carolina Office of Rural Health (ORH). The director of the Mobile Clinic program established an advisory council, and in partnership with MapForsyth have developed the first comprehensive map of free and charitable clinics of Forsyth County, easily identify areas of need, as well as current access to health care and is available online at www.mapforsyth.org

- Updates:
    - December 2018: mobile unit secured for clinic build with first fabrication meeting scheduled for next week (1/14)
    - Nurse Practitioner hired through partnership with SHA to provide care for children in schools during the daytime hours 8-3, and in community on Tuesday evening from 3-7 and Friday mornings from 8-12. Awaiting formalization of hiring status at WFBH to start providing care on adult side of partnership
    - Monies secured through grant funding for partial time of behavioral health specialist, waiting on clinic start to implement
    - Partnership with Forsyth County Health Department to provide nutritionist onsite when starting care
    - Partnership with Wake Forest School of Medicine (WFSM) DEAC Clinic to provide medical student support at sites of care
    - Submitted Health Resources and Services Administration (HRSA) grant for development of program to care for complex needs of older adults at mobile sites of care and to evaluate effectiveness of program
    - Working with WFSM DEAC and Population Health team to develop e-charting capabilities
- Projected Impact:
    - Projections based on starting March 2019 in partnership with the Forsyth County Fire Department. The mobile clinic will be available on Tuesday evenings from 3-7pm and on Fridays from 8-12 each week. During those days, an estimate of 8 patients will be seen in 4 hours with one provider, and closer to 15 with two. So conservative estimates would be seeing 15-20 patients per week, with a target of 500 patient encounters by the end of 2019. Target communities will be Bethesda and Shattalon (near North Forsyth).

- Develop pilot for NCBH charity care patients with chronic conditions for care management services including linkages with primary care

  WakeHealth Connect is a managed care program established in 2017. This program was created in order to increase access to primary care; enhance coordinated care practices; reduce improper ED utilization; and assist in connecting patients with social service resources. WakeHealth Connect is designed to establish a regular source of primary care and improve patients' health by enhancing coordinated care practices among primary care providers, nurse navigators, and patients. This design allows for increase continuity of care, builds positive provider-patient rapport, and fosters self-efficacy in patients to take responsibility for their health. By providing coverage, not insurance, for primary care service, at no cost to the patient, Additionally, WakeHealth Connect reduces the cost of care by supporting patients' proper use of Medical Center's services. WakeHealth Connect provides its participants with 100% covered primary care visits, as well as specialty visits with the accompanying Referral/Authorization form signed by a participant's primary care provider. All participants are first approved for hospital Charity Care. By building a relationship between a primary care provider, a nurse navigator, and these patients, our mission is to establish a pathway to care and improve the patient's total health, while simultaneously decanting the Medical Center's current capacity restraints and reducing the financial burden of caring for these patients. WakeHealth Connect has three primary goals:

  1. Improve access to primary care
  2. Reduce improper E.D. utilization by this population
  3. Assist in connecting patients to social services

- Continue to provide community engagement support through 5 Supporters of Health, 311 congregational partners, 25 Connectors across the service area (including Forsyth, Davie and Davidson counties) and 7 FaithHealth fellows

  FaithHealth engages many thousands of vulnerable lives every quarter in a wide range of ways while teaching others and continuing to innovate amid partnerships with government and other health systems. 445 congregations, representing 76,068 members, now actively share in the care of patients when they return to their communities across 27 counties. In our poorest communities of Winston-Salem, six full-time Supporters of Health care for 594 cumulative individuals, including 33 recently added in the first quarter of FY19. FaithHealth continues to see steady declines in the number of ED visits for Supporter of Health clients and declines in the overall cost of charity care in the 5 targeted zip codes annually, with current quarterly total at $4,016,713. FaithHealth managed 135 referral cases from service lines within all Medical Center campuses in the first quarter of FY19 (692 cumulative from FY18 to FY19), for social supports, transportation and follow-up care after discharge. Fourteen FaithHealth Fellows work across 10 systems. This education and spread strategy includes their supervision of 38 Connectors serving in 25 counties. Connectors report an average of 2,260 care-giving encounters. Our highest performing Connector teams this quarter reported 799 transportation, food, medication assistance, and support encounters. FaithHealth volunteers provided 1,398 hours of caring service, 26,714 cumulative hours.

Action: Improve Access to Transportation to Health Care Services

- Explore providing transportation for patients through UberCentral or another similar model

  In early FY19, a cross-disciplinary group met several times to develop operational guidance to offer transportation services in the ambulatory setting focusing as a pilot on the high patient need clinics of the Downtown Health Plaza, OPD Medicine and Family Medicine (Piedmont Plaza). Funding from the NC Baptist Hospital Foundation through the Department of Population Health will support 1.5 FTE of Patient Navigator who interfaces with the Access Center to assist patients at the point of appointment scheduling and the cost of taxi/bus fares.

  Implementation funding became available in early December 2018. Outcomes in December 2018: 41 DHP Adult Medicine patients used the transportation services for a cost of $15 per patient and OPD had 21 patients access this service at a cost of $17 per patient. Awaiting the hiring of 1.0 FTE Patient Navigator to begin Family Medicine support. Outcomes to be measured will include patient keeping primary and specialty care appointments, use of the Emergency Department for non- acute issues and enrollment in community resources such as Trans-Aid and Medicaid Transportation

DOMAIN: CHRONIC DISEASE MANAGEMENT

The anticipated impact of the following actions may include: improved health behaviors, disease management and health status through greater continuity of care with health care providers (including improved adherence to treatment recommendations and improved communication with health care providers).

Action: Improve the capacity of community based organizations and health care providers to support efforts related to chronic disease prevention and management

- Continue to support FaithHealth community health workers to address chronic disease management and community health programming.

  In our poorest communities, six full-time Supporters of Health care for 594 cumulative individuals, including 33 recently added in the first quarter of FY19. Many of the individuals served are receiving emotional and social support for the management of many health conditions and diagnoses including, but not limited to, hypertension and diabetes. The Supporters of Health promote access to healthy foods and encourage healthy eating among other strategies based on their Community Health Advocacy and Community Health Worker trainings.

Action: Provide education and support programs to reduce diabetes prevalence and/or improve diabetes management

- Refer pre-diabetic and early onset diabetic patients at Downtown Health Plaza to the YWCA Diabetes Integrated programs and related educational programs offered by WFBH and other community-based organizations.

  The goal of the Gateway to Success Program (GTS), located at the YWCA's Gateway Sports & Wellness Center, is to help low-moderate-resourced participants with diabetes manage and improve their health through lifestyle changes including good nutrition, weight loss, exercise and behavioral health. Physicians at the Downtown Health Plaza (DHP) refer patients to the program. There is a one-month orientation at the Gateway before a participant is "on-boarded" to the

official GTS program—an intensive year of lifestyle coaching by a team including a behavioral health specialist, dietician, wellness coach, and fitness coaches. Biometric screenings of Hgb A1C (an indicator of diabetes management), BMI (Body Mass Index) and a general wellness assessment is conducted quarterly. Participants receive membership at the Gateway for up to three years.

The outcomes at the end of the fiscal year 2017-2018 (88 GTS participants enrolled) on the 69 participants who completed year one and had a first assessment in year two are as follows:

- 49/69 (71%) maintained or improved (decreased) their Body Mass Index (BMI) score
- 59/69 (86%) maintained or improved (decreased) their A1C (blood test related to diabetes) score
- 51/66 (77%) either improved or maintained their Wellness Score

- Continue to provide BestHealth diabetes prevention and nutrition education to the community.

  Since, July 2018 - Relaunch the BestHealth brand as WFBH's over overarching health & wellness program for community, corporate partners and WFBH employees. Grow brand awareness by investing in the well-being of our community while Wake Forest Baptist becomes synonymous with achieving your BestHealth.

  - **BestHealth For Business** – Corporate Partners
  - **BestHealth** - Community

  BestHealth offers community programs to improve the health of the community by providing awareness of services offered by Wake Forest Baptist Health. BestHealth supports strategic service line initiatives to increase physician and service visibility as well as programs designed to meet the community needs and requests.

  <u>Continue to support community education through BestHealth</u>

  - Increase email list subscribers via grassroots efforts in the communities that we serve. Doing so allows for enhanced monitoring (e.g. thank you email/ follow-up nurturing email) of interaction and utilization by subscriber.
  - Key Statistics as of 2018
    - 21,137 BestHealth subscribers (formerly members)
    - 14,481 newsletter subscribers with an average open rate of 19%
    - Health Risk Assessments – 696 completed heart test; 484 completed stroke test
    - 82 health and wellness events took place from 2017-2018, inclusive of High Point, Greensboro, Wilkes and Lexington

BestHealth Community outreach events Jan 2017 to Dec 2018	
(health fairs, lunch & learns, meetings w/ local businesses such as YMCA)	
Health Fairs	19
Lunch & Learns/Referral Dinners	57
Public service appearances Jan 2017 to Dec 2018	
(news interviews, local presentations, FB live events w/ reach and views data)	
News Interviews	8
Local presentations	15
FB live # of events	8
FB live events reaches	161,364
FB live events views	51,325

Action: Provide education and support programs to reduce obesity prevalence and/or improve obesity management

- Continue to support Brenner FIT to increase education and awareness of nutrition and healthy lifestyle choices for uninsured and Medicaid patients and families

Brenner Fit Programs	**FY2017**	**FY2018**
Patient referrals in Brenner FIT, increase 23%	624	786
Patients that initiated treatment, increased by 28%	159	203
The number of local community members that were reached through health fairs, community events, and the newly added live social media streams, increased by nearly 700%	5477	38,060
Offered community-based cooking classes, increasing by 13%	209	236
# of participants in cooking classes, increased by 7%	2896	3100
Rural outreach program (Brenner FIT Academy)	58 families	28 families
Academic publications	6	10
Number of families provided meals (for a family of 4) through our partnership with local CSA and with the Downtown Health Plaza, increased by 600% through a new grant received.	209	1274
Volunteer hours	1300	1200

The majority of Brenner FIT Patients receive Medicaid and are of minority background.

DOMAIN: BEHAVIORAL/ MENTAL HEALTH DISTRESS

The anticipated impact of the following actions may include: decrease in ED visits related to behavioral health, increase in the number of individuals utilizing CareNet services and increases in the number of patients at primary care practices and Downtown Health Plaza providing integrated behavioral health screening and treatment.

- Build capacity among lay persons in the community in the areas of mental health first aid, community resiliency model and suicide prevention programs (e.g., Soul Shop for faith communities)

  The Division of FaithHealth's Department of Education sought to build capacity for community resiliency in several ways. If offered quarterly Clergy Educational events, topics included mental health topics and resiliency. Through these efforts, 80 clergy received one hour of education. It also offered a monthly "Building Resiliency in Uncertain Times" over a period of six months in late 2016-early 2017. Eight community members received 90 minutes of education through this endeavor. It featured the topic of resiliency twice in its monthly FaithHealth Divisional Rounds, which are open to the community as well. Chaplain Dana Patrick taught basic principles of resilience to 26 attendees for one hour. It also purchased and offered a viewing "Resilience: the Biology of Stress and the Science of Hope" in Divisional Rounds, which had 25 attendees. The documentary also served as an educational offering for FaithHealth Connectors, who are community leaders engaged in FaithHealth work across the state. Fifteen Connectors received 1.5 hours of education on resilience. FaithHealth Education plans to offer more viewings and discussions of this remarkable documentary in the coming year.

  In April 2017, leaders in the FaithHealth Division convened a meeting of medical center staff and community leaders in social service organizations who are interested in building community resilience and trauma-informed care. Community leaders met monthly to share ideas, resources and strategy.

  CareNet Counseling, as part of the FaithHealth Division, has provided community behavioral health education in the area of suicide prevention and additionally in the area of addiction education and prevention. Based on the successful Soul Shop training (suicide prevention for the faith community) of 210 faith leaders, counselors, first responders and laypersons in April of 2016, CareNet provided two additional trainings in Soul Shop in 2017, this time focusing the training for those who interact with youth in the community. It trained 125 participants in two sessions in Soul Shop for Youth.

  Because opioid addiction and the behavioral crises and desperation that result from this dependence intersect closely with suicide, CareNet focused its trainings in the community for 2018 on addiction. On April 26, 2018, CareNet held an education session and panel discussion in Kernersville, NC with 110 participants. Additionally, CareNet participated in sponsoring a two-day event on December 13 and 14, 2018, which focused on prevention strategies for the faith community. There were 85 people in attendance.

- Continue to expand integrated care model currently operating at Downtown Health Plaza and Family Medicine Piedmont Plaza

  CareNet is either integrated or co-located in the following WFBH clinics or has plans to do so in the coming months – Downtown Health Plaza, Clemmons Pediatrics, Outpatient Department, Lexington Pediatrics, Executive Health, Corporate Health, Wilkes Internal Medicine, Wilkes Regional Medical Center, Davie Medical Center, Lexington Medical Center and Family Medicine.

  Additionally, CareNet participates in the WFBH Integrated Care IPU, and is announcing a new CareNet Integrated Care Coordinator position in the coming months.

- Continue work of Dr. Liz Arnold with fragile homeless persons

  Although Forsyth County has made tremendous strides in decreasing its chronically homeless population (down 58% since 1996), there were still 82 chronically homeless persons and 407 total homeless persons at a recent "Point in Time" count conducted in 2017 by the United Way and others. Those who are homeless or seeking housing have specialized needs in terms of help accessing mental health and/or substance abuse services, housing opportunities, employment or disability assistance, health care or other miscellaneous services. The Empowerment Project serves to meet those needs in Forsyth County.

  Since its inception five years ago, the very small staff (3 FTE Behavioral Specialists, part-time Program Director and administrative support) of the Empowerment Project (TEP) has provided outreach services to over 1,200 persons and case management to approximately 800 persons of record. TEP behavioral specialist staff is deeply respected in this community, by both other provider and agency stakeholders and consumers alike. They serve a niche in the community that no other groups do (e.g., provide rides to hearings or shelters; seek out individuals under bridges, in parking lots or in wooded areas) and are willing to go the extra mile in supporting persons in a wrap-around recovery and strengths model.

  The goal of TEP is to help homeless adults exit homelessness by assisting them with accessing mental health and/or substance abuse services, housing opportunities, employment or disability assistance, health care, or other needed services. Outreach is provided to the target population of adults with known or suspected mental illness, a substance abuse disorder, or a co-occurring mental illness and substance abuse disorder. Individuals, couples and families are outreached on the streets, shelters, and other community settings. Individuals in need of case management services receive case management services up to six months or until the individual is stably connected to a provider of his/her choice.

  In addition, funds are used for client assistance in securing housing and other services. These include the following: security deposits for housing and utilities, client identification (such as state issued identification cards), bus passes, birth certificates, and co-pays for medication.