Atrium Health
Wake Forest Baptist

WAKE FOREST BAPTIST MEDICAL CENTER
COMMUNITY HEALTH NEEDS ASSESSMENT
2022 – 2024

Section I: Introduction

North Carolina Baptist Hospital (dba Atrium Health Wake Forest Baptist Medical Center), a North Carolina non-profit corporation, is a component member of Atrium Health Wake Forest Baptist, a preeminent, internationally recognized academic medical center with balanced excellence in patient care, research and education.

Atrium Health Wake Forest Baptist includes the following:

1. An integrated clinical health system – anchored by Atrium Health Wake Forest Baptist Medical Center, an 885-bed tertiary-care hospital in Winston-Salem – that includes Brenner Children's Hospital, five community hospitals, more than 300 primary and specialty care locations and more than 2,700 physicians; and
2. Wake Forest School of Medicine, the academic core of the Atrium Health Enterprise and a recognized leader in experiential medical education and groundbreaking research that includes Wake Forest Innovations, a research enterprise focused on advancing health care through new medical technologies and biomedical discovery.

Atrium Health Wake Forest Baptist Medical Center is accredited by The Joint Commission and has been committed to providing for the health care needs of northwest North Carolina and southwest Virginia since the 1920s.

Vision

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

Mission

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

Culture Commitments

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

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

Mission Alignment

As Atrium Health Wake Forest Baptist Medical Center strives to be a leader in population health, we must look beyond the walls of our hospitals and medical offices to address those social, economic, and environmental conditions that contribute to poor health outcomes, shortened lives, and higher health care costs of the patients we serve. This needs assessment is based on a set of best practices for community health assessments with the purpose of identifying regional priority areas to focus on for calendar year 2022–2024. The process was designed to rely on existing public data, directly engage community stakeholders, and collaborate with local public health resources, other health providers, and community partners (such as faith networks and other nonprofit organizations) relevant to the social factors underlying patterns of access.

Health Equity Focus

Health equity means increasing opportunities for everyone to live the healthiest life possible, no matter who we are, regardless of race, ethnicity, gender, age, education, or income level. In the United States, health gaps are persistent and many are increasing, due to persistent barriers in our society and culture. These barriers include the social determinants of health such as discrimination, poverty, lack of access to high quality jobs, education, housing, and other living environments. Increasing health equity leads to a healthier and more equitable society that contributes to well-being of individuals, families, communities, and the country as a whole.

Social Impact Focus

Atrium Health Wake Forest Baptist Medical Center's social impact strategy has gained energy as the institution begins to confront its own pattern of racial exclusion that mirrors inequities in the broader community. Our social impact strategy is visible in the community benefit process, which now includes all facilities in an operational team that monitors our collective impact across all communities with a focus on micro-geographies and sustained partners among non-profit, faith and business. As an academic medical center, many of our service lines (especially family medicine, pharmacy, care management and the ED) have been long involved with the people most affected by social inequity-- -These service lines welcome the increasingly coordinated social impact efforts as a signature characteristic of Atrium Health Wake Forest Baptist Medical Center.

Section II: Definition of Community Served

Community Demographics

Forsyth County is located in the Triad region of North Carolina. The county covers approximately 408 square miles and has a population of approximately 937 residents per square mile.[1] With 382,295 residents in 146,816 households, Forsyth County is the fourth most populous county in North Carolina. The population is 56.3% white, 27.5% Black or African American, 13.3% Hispanic or Latino, 2.6% Asian, and 0.3% other. The population is 52.7% female and 47.3% male. Persons under 18 years of age represent 22.7% of the population while persons 65 years of age and over represent 16.4%. The percentage of persons without health insurance and under the age of 65 years old is 14.2%. In addition, the median household income in 2019 dollars is $51,569. The percent of persons in poverty is 15.2%.[2]

Forsyth County is ranked third from last in the United States in terms of economic mobility. This means that if you are born poor in this county, the odds of getting out of poverty are worse than nearly anywhere else in the entire country. One reason for the lack of economic mobility in Forsyth County is that fewer new jobs are being created for workers with only a high school diploma. Of the 11.6 million jobs created since the Great Recession, 99% have targeted workers with at least some postsecondary education.[3]

According to the *2020 Forsyth County, State of the County Health (SOTCH) Report,* chronic diseases and health conditions are the leading causes of death in Forsyth County. Although the rate has decreased to 157.9 (per 100,000) between 2015 and 2019, cancer remains the number one cause of death in Forsyth County. Mental health continues to be a health crisis for Forsyth County, although the number of residents who visited the Emergency Department (ED) for mental health reasons in 2020 (2,318) declined from the previous year's total (2,746).

Target Communities Served

Atrium Health Wake Forest Baptist Medical Center serves a 24 county service area that encompasses two states, North Carolina and Virginia, and a more immediate service area of seven contiguous counties. Forsyth County residents represent 34% of total inpatient admissions and 58% of total emergency department visits for calendar year 2020. For the purposes of this CHNA, Atrium Health Wake Forest Baptist Medical Center's community served is defined as Forsyth County, North Carolina.

[1] https://censusreporter.org/profiles/05000US37067-forsyth-county-nc/
[2] https://www.census.gov/quickfacts/fact/table/forsythcountynorthcarolina/POP060210
[3] Source: Winston-Salem State University's Center for the Study of Economic Mobility, 2018.

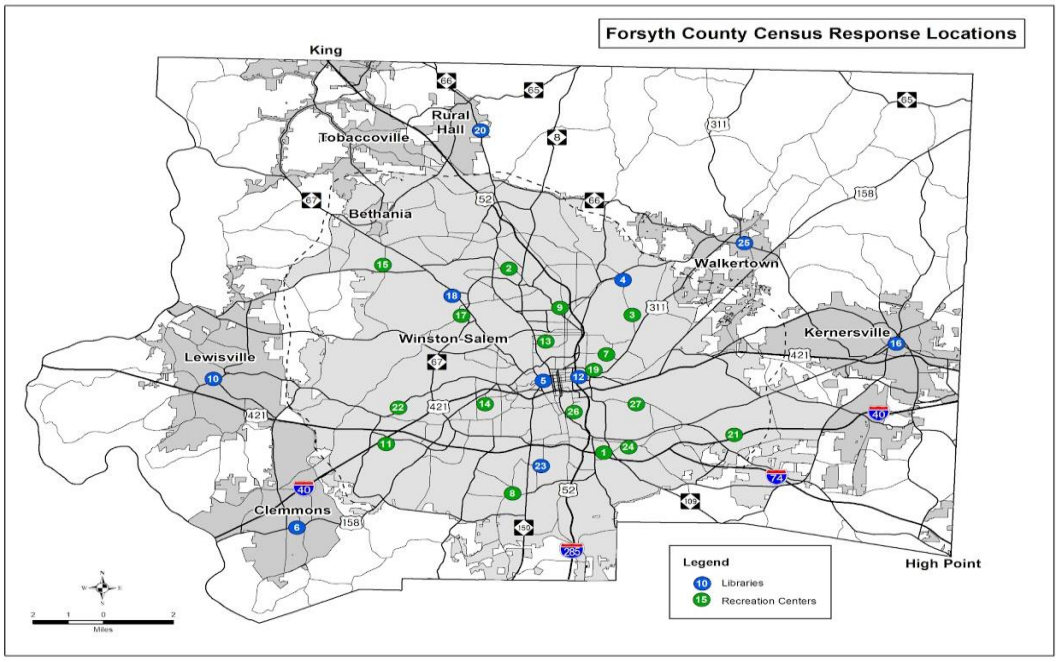


Image Courtesy of Forsyth Futures

While Atrium Health Wake Forest Baptist Medical Center's community served is defined at county level, there will also be special attention placed on several defined populations and neighborhood initiatives within the county to understand the diversity of the County's population. In particular, the Medical Center seeks to understand and include communities who are historically marginalized, underserved, and who experience health inequities. The following data highlights the populations, zip codes, and neighborhoods that define the community at a micro level, defined by zip codes and neighborhoods that are most burdened by racial and ethnic disparities, health disparities, and health inequities.

Atrium Health Wake Forest Baptist Medical Center Patient Population

2020 Demographics

			Race					Ethnicity		Economics			
Zip Code	*City*	*2020 Population*	*White*	*Black*	*Asian*	*Other*	*Multi-Race*	*Hispanic*	*Non-Hispanic*	*Median HH Income*	*% of HHs Below Poverty*	*NCBH Charity Care*	*NCBH Charity Care As % of All Payments*
Forsyth County													
27009	Belews Creek	2,906	86.3%	9.7%	0.6%	2.0%	1.3%	3.7%	96.3%	$ 77,111	14.5%	$ 29,534	1.4%
27012	Clemmons	30,362	84.2%	8.0%	3.9%	2.1%	1.8%	5.3%	94.7%	$ 84,497	10.8%	$ 1,011,048	3.7%
27023	Lewisville	13,845	86.2%	7.1%	2.9%	1.7%	2.0%	4.3%	95.7%	$ 82,975	14.6%	$ 190,486	1.6%
27040	Pfafftown	12,112	82.9%	11.2%	1.8%	2.1%	1.9%	4.2%	95.8%	$ 75,775	14.3%	$ 157,686	1.2%
27045	Rural Hall	9,434	73.8%	18.2%	0.8%	5.4%	1.9%	9.2%	90.8%	$ 60,891	14.2%	$ 1,394,305	15.4%
27050	Tobaccoville	4,317	84.9%	10.3%	0.7%	2.7%	1.4%	4.4%	95.6%	$ 66,672	14.4%	$ 393,375	10.2%
27051	Walkertown	8,039	75.1%	17.9%	0.8%	4.3%	1.8%	6.1%	93.9%	$ 55,215	22.3%	$ 371,518	5.1%
27101	Winston Salem	22,216	36.8%	53.0%	1.4%	6.4%	2.4%	10.6%	89.4%	$ 38,701	32.5%	$ 4,694,888	17.6%
27103	Winston Salem	36,719	60.8%	21.9%	4.4%	10.1%	2.9%	16.1%	83.9%	$ 55,186	22.9%	$ 3,515,384	10.2%
27104	Winston Salem	29,195	74.7%	15.1%	5.2%	2.7%	2.3%	6.5%	93.5%	$ 70,868	17.2%	$ 841,236	2.6%
27105	Winston Salem	40,858	23.6%	61.1%	1.1%	11.9%	2.4%	16.4%	83.6%	$ 37,243	33.8%	$ 9,322,558	18.8%
27106	Winston Salem	53,174	61.7%	25.1%	3.3%	7.4%	2.4%	12.0%	88.0%	$ 57,491	21.2%	$ 3,835,561	7.7%
27107	Winston Salem	50,032	52.8%	29.7%	1.0%	13.7%	2.8%	20.4%	79.6%	$ 51,132	25.3%	$ 8,141,901	19.4%
27110	Winston Salem	2,492	21.2%	75.5%	1.0%	0.6%	1.8%	3.3%	96.7%	$ 7,499	66.7%	-	-
27127	Winston Salem	38,893	53.3%	32.1%	2.5%	9.2%	2.8%	14.9%	85.1%	$ 54,828	23.4%	$ 5,591,249	14.3%
27284	Kernersville	56,864	78.3%	12.3%	2.4%	4.7%	2.2%	8.7%	91.3%	$ 67,235	17.3%	$ 1,984,457	5.8%
	Total:	411,458	61.7%	26.1%	2.6%	7.3%	2.4%	11.8%	88.2%	$ 59,264	21.6%	$ 41,475,183	10.8%

This patient population data was collected by Atrium Health Wake Forest Baptist Medical Center's Business & Market Intelligence department. As shown in the table, there are three zip codes (27101 and 27105) with a high percentage of people of color who are economically disadvantaged. Atrium Health Wake Forest Baptist Medical Center's Downtown Health Plaza (a medical service location where community members were surveyed) and the Boston-Thurmond neighborhood are both located in the 27101 zip code. The Cleveland Avenue Homes neighborhood is located in the 27105 zip code. Zip code 27110 is excluded because this population is exclusively tied to Winston-Salem State University.

Cleveland Avenue Homes Community

There are a total of 220 target households (506 target residents) in the Cleveland Avenue Homes Community, as described with the following demographic data:

- *Age:*
    - There are 220 adults aged 18-64, of which 6.32% (32) are ages 18-24, 23.72% (120) are ages 25-44, and 13.44% (68) are ages 45-64.
    - Target residents aged 65 and older make up 3.75% (19) of the total population.
    - There are 267 children ages 0 to 17, of which 14.62% (74) are ages 0-3, 8.5% (43) are ages 4-5, 22.92% (116) are ages 6-12, and 6.72% (34) children are 13-17.
- *Race, Ethnicity, Gender:*
    - Ninety-two percent (465) of target residents are Black; 3.6% (18) identify as Other Combination, 4% (18) are White, 0.6% (3) identify as American Indian or Alaskan Native, 0.4% (2) are Native Hawaiian or Other Pacific Islander; and 1.6% (8) are Hispanic.
    - Seventy percent (353) of target residents identified as female, and 84.75% (189) of heads of households (HOHs) are female.
- *Income and Benefits:*
    - Only 31% (68) of target households have income from employment.
    - Average household income for target households is currently low, at $8,145 per year compared to $29,011 in the North East Winston Choice Neighborhood footprint and $40,148 in the City of Winston-Salem.
    - Currently, 26.01% (58) of target households report no income.
    - Twenty-nine percent (65) of head of households are disabled.

Thirty-nine percent (87) of target households receive either social security income or a Pension.[4]**Boston-Thurmond Neighborhood: Boston-Thurmond United**

[4] "People Strategy Report" - survey conducted by Urban Strategies, Inc. and the Housing Authority of Winston-Salem

Boston-Thurmond is a historically African American neighborhood, located just north of downtown Winston-Salem. The community consists of an estimated 3,700 residents including approximately 1,135 children between the ages of 0-17. Of those residents, 654 households include one or more individuals over the age of 60. A 2016 report conducted by Forsyth Futures examined responses to a neighborhood survey in hopes of building relationships and sharing the experiences of residents. Several challenges and opportunities were highlighted related to the areas of neighborhood, housing, food access, health and wellness, income and employment, life span and development, and transportation. The survey tool consisted of questions related to food access, income, employment, and health status a and a total of 195 surveys were included in the analysis.

Some of the surveys key findings include:

- 44% of individuals reported sometimes or more worry or stress about the cost of healthy food.
- 45% of respondents stated that they experience some instances of low mood, depressive symptoms or negative feelings.
- 36% of respondents reported some form of worry or stress related to rent or mortgage[5]

Section III: Process and Methods Used to Conduct the CHNA

Primary Data Sources

For the collection of primary data, a variety of data collection methods including surveys, community interviews, conversations, and focus groups were utilized.

- **Community Survey**

In 2021, a joint community survey was created by Novant Health Forsyth Medical Center and Atrium Health Wake Forest Baptist Medical Center that sought community input by disseminating the survey to patients and clients of the following community clinics and community based organizations that service underserved populations:

  - Highland Avenue Primary Care Clinic – a primary care site led by Atrium Health Wake Forest Baptist and Novant Health Forsyth Medical Center
  - Community Care Center – the largest free clinic in North Carolina
  - Downtown Health Plaza – an Atrium Health Wake Forest Baptist primary care practice that serves one of the largest Medicaid populations in North Carolina
  - Crisis Control Ministry - one of the largest emergency assistance providers in Forsyth County, NC

The Forsyth Community Health Needs Assessment survey was administered to community members at a community location, the Downtown Health Plaza, in Winston Salem. This survey was a short electronic-based questionnaire, and data was obtained between July 28, 2021 and

[5] Boston-Thurmond Neighborhood Survey Key Findings Report conducted by Forsyth Futures

October 10, 2021. A total of 50 community members participated in the survey with a large representation being female (58%) vs. male (24%). Thirty (60%) of the respondents were between 40-65+ years of age. Forty percent described their race as being Black or African American, 20% White or Caucasian, 16% Asian, and 24% unidentified as they had left that answer to the question blank. Thirty percent of those completing the questionnaire had graduated high school with 36% of respondents having at least some level of college education or higher. Regarding income, 28 respondents (56%) reported a household income of at least $49,999, 38% earned less than $25,000 annually, and 20% participants reported earning less than $10,000

When survey respondents were prompted to identify the health considerations to be of greatest concern to the well-being to the Forsyth County community, common themes emerged. The primary concerns identified by 22 participants was **chronic disease, such as cancer, diabetes, and heart disease**. Also, of significant concern to the respondent population are **access to healthy foods, access to COVID-19 vaccines, dental care, and mental health issues**. Infectious diseases, family planning, accidental issues, and family/relationship support were not seen to be as pressing of an issue as compared to the others.

Survey respondents were asked to select community health services they felt needed more strengthening attention to better serve the community, Twenty-three respondents selected **dental care** services as one that is in need of strengthening with **health care coverage/health insurance, mental health services, and public health services** following in order of priority. While access to COVID-19 vaccines were seen to be a concern to the county's well-being, the health service of providing those vaccines was one of the least selected health services in need of strengthening.

When asked to provide their opinion on which five community support services most need strengthening, a large number of survey respondents said **homeless services, transportation, and employment or job finding services**. Also of importance to the respondents were **services related to domestic violence, substance use and having a food security.** Services that were not prioritized in the findings were family planning services, water and air quality, and public safety.

- **Community Interview: Ms. Mattie Young**

Ms. Mattie Young, who is also known as the "Mayor of Cleveland Avenue Homes," spoke with Atrium Health Wake Forest Baptist Medical Center's Associate Vice President of the FaithHealth Division on September 15, 2020. Ms. Young is 93 years-old and has lived in the same apartment at the corner of 15th and 17th streets in Winston-Salem for 47 years. She is also an assistant minister at a local church for over four decades, and is valued for her advice and truth telling among residents in the Cleveland Avenue community.

After listening to Ms. Young assess various aspects of the neighborhood during the conversation, she stated that there are two areas related to health that need to be addressed:

1. Better incentives to help residents more conveniently access primary care: While Ms. Young believes that there are enough primary care practices and locations throughout the area, she feels that something must be done to encourage people to use the practices that are already available to them.
2. Chronic disease prevention education and intervention: Ms. Young stated that she can identify residents who could go door-to-door in the neighborhood to "check blood pressures" and provide some level of primary chronic disease prevention education and intervention targeting key risk factors. These residents could receive education that would be similar to the education received by individuals who assume Community Health Worker roles.

- **Community Conversation from the Community Health Alliance Mobile Clinic**

The clinical leader of Atrium Health Wake Forest Baptist Medical Center's Community Health Alliance mobile primary care clinic participated in five community conversations in four underserved communities over several months between 2018 and 2019. As indicated in the clinical leader's report of these conversations, *"The Integration of Community Voice in Mobile Health"*, the main themes that emerged were connected by their associations with social drivers of health, which are governed by broader socio-ecological conditions of where residents live and their relative status in society. The report further notes that because Medicaid expansion has not yet occurred in North Carolina, access to health care has been limited for participants who do not participate in employee sponsored health care plans, or who cannot afford health coverage through the Affordable Care Act.

- **Focus Groups and Community Interviews**

In 2020, Atrium Health Wake Forest Baptist's Comprehensive Cancer Center within the Wake Forest School of Medicine conducted a qualitative data analysis of health equity in East Winston-Salem. Atrium Health Wake Forest Baptist collaborated with Gramercy Research Group to conduct 14 semi-structured interviews and 4 focus group discussions with cancer patients, caregivers, community stakeholders, and providers to understand their knowledge, attitudes, beliefs, and experiences around access to general and cancer-specific healthcare and research in the East Winston community. Forty-nine community members participated in the interviews and focus groups.

The most commonly mentioned barrier to accessing general healthcare and cancer care in East Winston was the high cost of healthcare, both for individuals with and without private health insurance. Other barriers included health and cancer-specific knowledge, as well as knowledge of the healthcare system; transportation; fear of finding out that something is wrong; time to attend medical appointments; the perception that African Americans get worse treatment than others; and beliefs about the efficacy of specific cancer treatments. The number of local resources for general and cancer care was cited as a facilitator to access by some; however, patient awareness of these resources may limit their use. Being proactive and advocating for oneself to receive high-quality healthcare was similarly described as a facilitator by some, while a lack of self-advocacy was described as a barrier by others. Participants shared that they, their loved ones, and people in the East Winston community make decisions about where to access general healthcare based on the advice of family and friends, in addition to being "assigned" by their health insurance plans to seek care within specific networks. Patients, caregivers, stakeholders, and physicians alike shared that people rely mainly on provider referrals, typically within their care network, to make decisions about where to access cancer care.[6]

- **Comments from 2020 - 2022 CHNA**

All CHNA and Implementation reports along with county indicator tracking is available on the Atrium Health Wake Forest Baptist website- https://www.wakehealth.edu/About-Us/Serving-Our-Communities/Needs-Assessments-and-Implementation-Reports. No comments from the public have been received to date. All future comments will be incorporated into future CHNA and implementation strategies and reports.

[6] "Research supported in part by the Qualitative and Patient-Reported Outcomes Developing Shared Resource of the Wake Forest Baptist Comprehensive Cancer Center's NCI Cancer Center Support Grant P30CA012197 and the Wake Forest Clinical and Translational Science Institute's NCATS Grant UL1TR001420.

Secondary Data Sources - Literature Review

Secondary data collection methods focused on a literature review of reports and documents from the following sources:

- *Cleveland Avenue Choice Neighborhoods People Strategy Document - Housing Authority of Winston-Salem*

The Choice Neighborhood Initiative Transformation Plan for the North East Winston Choice Neighborhood addresses the specific needs of the target households living in Cleveland Avenue Homes (CAH). To reach residents who are not typically involved in community planning, a door-to-door needs assessment survey was conducted, resulting in 148 interviews with a response rate of 60.66%. The survey addressed all members of the household and captured current circumstances, needs, and preferences in eight focal areas: Housing and Neighborhoods, Development, Employment and the Economy, Education, Safety, Health, Transportation, and Improving Quality of Life. In addition to the survey data, USI analyzed property management data to understand the demographic profile of targeted households. In addition, it obtained secondary data from the US Census, Winston-Salem/Forsyth County Schools, and the Winston-Salem Police Department to understand crime, public health, education, and labor force characteristics. This needs assessment revealed the following challenges for the Cleveland Avenue community.

Employment Barriers: When asked to identify challenges to employment, 58% of respondents cited a medical condition, 30.16% reported training and education, 11.11% reported jobs are not available, and 33.33% reported lack of childcare or transportation.

Health Data: 89% of survey respondents reported having health insurance, including 78.5% of adults and 99% of dependents. 91.07% of respondents reported getting an annual wellness checkup, and 94.3% of respondents reported having access to a medical clinic or primary care physician. A little over 4% percent of respondents reported accessing the emergency room when they have a medical need.

Education: 25% of survey respondents reported not having a high school diploma or equivalent. 50% reported having a high school diploma or GED. 39% percent of the respondents recognized a need for high quality after school and summer programs for teens or children.

- *Partnership for Prosperity*

The Partnership for Prosperity conducted a series of Issue Forums during the summer of 2019. These forums were focused on each of the major issues identified in the Poverty Thought Force 2017 report - hunger, housing, health care, jobs and education – as well as transportation, which the thought force recognized as cutting across all the other issues. The issue forums revealed several broad areas of need:

  - tenant rights in terms of evictions and deplorable housing conditions;

- better bus routes and more access to cars;
- better health care;
- universal pre-K;
- ease the benefits cliff (a reduction or loss of public benefits as a result of new or increased income that does not fully compensate for, or exceed, the loss of public benefits).;
- better awareness, coordination and communication in the poverty fight;
- better awareness of resources to help; and
- a living wage.

- *Forsyth Futures – Community Briefing: The Local Impact of COVID-19*

In July 2020, Forsyth Futures published a web-based Community Briefing on the economic impact of COVID-19 in the local community. The briefing is available to the public at https://www.forsythfutures.org/covid-19/. It includes an interactive dashboard of economic indicators, like unemployment, most requested types of need (based on 211 calls) and estimates of the numbers and demographics of Forsyth County residents who may be particularly vulnerable to the economic impacts of COVID-19. There were several key findings, including:

- An estimated 42% of all residents (and 59% of children in Forsyth County) would likely experience poverty if workers in their households employed in at-risk jobs were to lose those jobs. The risk disproportionately impacts African American and Hispanic/Latino residents.
- About 50% of adult workers in Forsyth County are employed in fields or occupations that are likely to experience job loss as a result of COVID-19.
- Feeding America estimates that 19% of all Forsyth County residents and 27% of children are experiencing food insecurity.
- About 38% of Forsyth County residents live in households where housing is rented. An estimated 64% of residents in households that rent their homes and 77% of children in households that rent would experience a housing cost burden if workers with at-risk jobs in their households were to lose those jobs.
- An estimated 61% of adult Hispanic/Latino males and 43% of adult Hispanic/Latina females do not have health insurance, which puts their families at significant financial risk if they contract COVID-19 and incur unexpected medical costs.[7]

- *2020 Forsyth County, State of the County Health (SOTCH) Report*

The 2020 Forsyth County State of the County Health (SOTCH) Report provides an overview of changes in Forsyth County's population health since the 2019 SOTCH Report and provides an update on each Community Health Improvement Plan (CHIP) that was implemented after the 2017 Community Health Assessment (CHA). These CHIPs are aimed at reducing infant mortality,

[7] https://www.forsythfutures.org/covid-19/

improving oral health among populations ages 0-5 years and improving sexual health among populations ages 15-24 years. The 2020 SOTCH also informs the Forsyth community about major changes in mortality and morbidity factors (such as cancer, mental health, and diabetes), and highlights emerging issues and new initiatives (such as poly-substance overdose).

Poly-substance overdose remains an emerging issue for Forsyth County. While it is not yet dominating health discourse, public health practitioners should take notice. During the COVID-19 pandemic, 81 residents received service for poly-substance overdose at the County's Emergency Departments. This health issue requires immediate prevention/intervention planning because residents report taking not only illegal drugs of interest, but also common products that are found in most households.[8]

- *North Carolina State Center for Health Statistics, 2019 Leading Causes of Death*

These statistics describe North Carolina's total and cause-specific deaths at the state and county level. In addition, major site-specific cancer deaths and total infant deaths are tabulated and mapped. This edition includes the number of deaths and unadjusted death rates for 2019 and the number of deaths and unadjusted and age-adjusted death rates for 2015-2019.

In 2019, the following data was found relative to particular causes of death in Forsyth County (death rates per 100,000 population):

- Heart Disease: 666 deaths, 174.2 death rate
- Cerebrovascular Disease: 198 deaths, 51.8 death rate
- Cancer: 729 deaths, 190.7 death rate
- Human Immunodeficiency Virus (HIV) Disease: 7 deaths, 1.8 death rate
- Septicemia: 63 deaths, 16.5 death rate
- Diabetes Mellitus: 120 deaths, 31.4 death rate
- Pneumonia and Influenza: 66 deaths, 17.3 death rate
- Chronic Lower Respiratory Diseases: 179 deaths, 46.8 death rate
- Chronic Liver Disease and Cirrhosis: 48 deaths, 12.6 death rate
- Nephritis, Nephrotic Syndrome and Nephrosis: 80 deaths, 20.9 death rate
- Motor Vehicle Injuries: 49 deaths, 12.8 death rate
- All Other Unintentional Injuries: 201 deaths, 52.6 death rate
- Suicide: 40 deaths, 10.5 death rate
- Homicide: 34 deaths, 8.9 death rate
- Alzheimer's Disease: 171 deaths, 44.7 death rate
- Infant Death: 43 deaths, 9.8 death rate[9]

[8] *Forsyth County Department of Public Health, Epidemiology & Surveillance Unit. (2021).* ***2020 Forsyth County, State of the County Health (SOTCH) Report****. Forsyth County Department of Public Health. Winston-Salem, NC. Accessed [October 10, 2021].*

[9] *North Carolina Department of Health and Human Services - North Carolina State Center for Health Statistics, 2019 North Carolina Vital Statistics, Volume 2: Leading Causes of Death, Published January 2021*

- *Healthy North Carolina 2030*

In parallel with the national Healthy People initiative run by the United States Department of Health and Human Services, the North Carolina Department of Health and Human Services (NC DHHS) has released Healthy North Carolina (HNC) goals at the beginning of each decade since 1990. HNC is a set of health indicators with 10-year targets designed to guide state efforts to improve health and well-being. Identifying key indicators and targets allows NC DHHS, the Division of Public Health (DPH), local health departments, and other partners across the state to work together toward shared goals.

Overall, 21 health indicators were chosen across the topics of Social & Economic Factors, Physical Environment, Health Behaviors, Clinical Care, and Health Outcomes. The 21 health indicators were:

1. Individuals Below 200% FPL
2. Unemployment
3. Short-Term Suspensions
4. Incarceration Rate
5. Adverse Childhood Experiences
6. Third Grade Reading Proficiency
7. Access to Exercise Opportunities
8. Limited Access to Healthy Food
9. Severe Housing Problems
10. Drug Overdose Deaths
11. Tobacco Use
12. Excessive Drinking
13. Sugar-Sweetened Beverage Consumption
14. HIV Diagnosis
15. Teen Birth Rate
16. Uninsured
17. Primary Care Clinicians
18. Early Prenatal Care
19. Suicide Rate
20. Infant Mortality
21. Life Expectancy[10]

[10] https://nciom.org/healthy-north-carolina-2030/

Section IV: Identification and Prioritization of Community Health Need

In summarizing the data that were obtained through primary and secondary data sources, many community health needs emerged as follows:

- Cancer
- Diabetes
- Heart Disease
- Food insecurity
- Access to COVID-19 vaccines
- Dental care
- Mental Health
- Health care coverage/health insurance among certain race/ethnic groups
- Public Health services
- Homeless services
- Employment or job finding services
- Domestic violence services
- Substance abuse & poly-substance misuse
- Cerebrovascular Disease
- Incentives to promote access
- Medicaid expansion/benefits cliff
- Cost of health care
- Lack of health and health system knowledge and awareness of resources
- Transportation barriers to access
- Fear of medical outcomes
- Time to attend medical appointments
- Perception/beliefs about medical treatment equity for minorities
- Lack of self-advocacy
- Health centers and grocery stores in underserved neighborhoods
- Better, higher quality health care
- Hypertension and need for blood pressure monitoring in public housing neighborhoods
- Chronic Lower Respiratory Disease
- Medical conditions prevent some from working (disability)
- Housing cost and conditions
- Universal pre-K
- Poverty, need for a living wage
- Threat of job loss due to COVID-19
- Infant mortality
- Sexual health
- Unintentional injuries

Process

The Atrium Health Wake Forest Baptist Medical Center Community Health Benefit Council and partners utilized evidence-based data collection methodologies to listen to and engage community members to better understand their primary health needs including the *Community-Based Participatory Approach* (CBPA). CBPA is a methodology that emphasizes collaborative partnerships between community members, organizations, and academic researchers to help identify local knowledge, work through strategies to solve problems, and develop programs that have potential for sustainability within communities. Community conversations are effective ways to engage with communities when building relationships for program development. They are informal and serve to authentically engage members of communities, while generating local knowledge, promoting co-learning, and assisting with collaborative development of strategies. CBPA is characterized by:

- Problem identification - by providing input on key problems to be addressed, understanding of key issues;

- Design and planning - by helping to shape program aims and objectives, providing input on the program goals, and insight on the provision of culturally appropriate care; and

- Implementation - by participating in the design of the intervention and collaborating both formally and informally.

Importantly, the process to identify priority health needs and to locate primary and secondary data sources involved close collaboration with partners, particularly the Forsyth County Department of Public Health and Novant Health Forsyth Medical Center. Tactics and strategies for collaboration were discussed that focused on efficient methods to obtain primary and secondary data to inform the Community Health Needs Assessment. Conversations with Forsyth Department of Public Health and Novant Health Forsyth Medical Center led to three solutions:

1. Atrium Health Wake Forest Baptist Medical Center would utilize the most recent data published by the health department. In this case, Atrium Health Wake Forest Baptist Medical Center would review and include data published in the 2020 State of the County Health (SOTCH) Report.
2. Incorporate resident surveys conducted in partnership with Novant Health Forsyth Medical Center
3. Community leaders and organizations who represent the broad interests of the community and who have been involved in county-wide needs assessments and conversations would be consulted to inform the process and identify community health needs.

Criteria

In determining our criteria, the highest weights were placed on the health disparities associated with the need, the burden of the health need, the feasibility of possible interventions, and the importance the community places on addressing the need (as evidenced by responses to surveys, interviews, and other qualitative feedback).

The importance the community places on the addressing specific needs was determined the need through the avenues listed in the progress to date section including the community survey, conversations, and interviews remain..

Criteria listed in the following chart, along with corresponding weighted values, were used to determine the health priorities selected by Atrium Health Wake Forest Baptist Medical Center.

Criteria	Weighted Value
Identified as a county priority	2
Disparity exists within census tract/zip code/county/market	3
AHWFB steering/leadership perceive as a priority	2
Great potential to improve health status	3
Positive visibility for Atrium Health Wake Forest Baptist Medical Center	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 goal of community engagement for Atrium Health Wake Forest Baptist Medical Center, which includes guiding principles for addressing the priorities that influence the health of communities.

Guiding Principles

- Focus on the place where need is concentrated.
    - Health in targeted neighborhoods served focusing on access to care, social drivers and barriers, and chronic diseases and key health conditions including cancer, heart disease, mental health, and others.
    - Prioritize zip codes 27101 and 27105 for place-based community impact. According to hospital data, these are zip codes where patients reside that have a high percentage of people of color based on race and ethnicity, and who are economically disadvantaged based on income, poverty status, and the amount of charity care provided by the hospital.

- Tighten Social Service/Other Agency partnerships. Support, sustain, and enhance community resource agencies that care for the social and behavioral health needs of our patients and residents. These partners include the Forsyth County Department of Public Health, Novant Health Forsyth Medical Center, and many others.

- Strengthen patients and partners through a focus on health education and literacy. Programs and initiatives provided 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.

Prioritized Health Needs

To address the community health needs identified in the Community Health Needs Assessment (CHNA), recommendations were prioritized on primary data gathered through the resident surveys and key information interviews, secondary data findings, criteria, and guiding principles. In addition, feedback from the health system's Community Health Benefit council committee members and senior and executive leadership were taken into consideration. Feedback included leadership perspectives that provide further detail about the prioritized community health needs including current trends. These views of public health leaders who have dedicated their careers to addressing these community health priorities are documented in the Appendix.

The following health needs were prioritized for Atrium Health Wake Forest Baptist Medical Center for 2022-2024:

1. **Access to Care:** with a focus on special populations who experience significant financial, health insurance coverage, transportation, location, time, health and health system knowledge, and agency barriers

2. **Social Impact and Injustice:** with a focus on the following factors that influence health
    a. Food insecurity in underserved neighborhoods
    b. Race and culture
    c. Lack of awareness of resources
    d. Inability to work due to medical conditions
    e. Lack of affordable housing and poor housing conditions
    f. Poverty
    g. Education – universal Pre-K

3. **Chronic and emerging diseases, and key health conditions and indicators** including:
    a. Cancer
    b. Diabetes
    c. Heart Disease
    d. Hypertension
    e. Cerebrovascular disease
    f. COVID-19

4. **Maternal and Child Health and Infant Mortality**

5. **Mental Health and Poly-substance Use**

Community Needs that were not Prioritized

While we acknowledge the importance of all community health needs in the Forsyth County community, the hospital's resources and assets were best aligned to focus on the prioritized health needs addressed above. Community needs that were identified but not prioritized for the 2022 – 2024 CHNA are as follows:

- Dental health
- Employment or job finding services
- Domestic Violence services
- Sexual health
- Unintentional injuries
- Motor vehicle injuries
- Septicemia
- Human Immunodeficiency Virus (HIV)
- Homicide
- Teen birth rate
- Short-term suspensions
- Incarceration rate
- Access to exercise opportunities

Atrium Health Wake Forest Baptist Medical Center leaders will continue to partner with community and non-profit organizations, including public health, other governmental agencies, and the broader community to help address these health needs. A comprehensive list of available resources to meet these needs are listed in Section V.

Section V: Additional Community Resources to Address Health Needs

Organization/Program	Type of Resource	Key Resources	Type of Partnership	Website
The Shalom Project	Community	Free clinic, food, clothing, diabetes education, medication assistance	Clinical, Referral Pathway, Education/Training	https://theshalomprojectnc.org/medical-clinic
Community Care Center	Community	Free clinic	Clinical, Referral Pathway	https://carectr.org/
School Health Alliance	Community	School Based Comprehensive Health Centers and Mobile Unit	Clinical	https://shaforsyth.com/
New Stories Group	Community	Free dental clinic	Referral Pathway	https://newstoriesgroup.org/
Cleveland Avenue Dental Center	Community	Dental care for all ages, Medicaid	Referral Pathway	https://www.forsyth.cc/PublicHealth/cadc/
Community Mosque Free Health Clinic	Community	Free clinic	Clinical, Referral Pathway	https://communitymosque.com/
Forsyth County Dept. of Public Health	Community	Immunizations, STD clinic, Family Planning Clinic, WIC Program, Wise Woman, SNAP, Medicaid services, Dental	Some Clinical, Preventive Care, Referral Pathways	https://www.co.forsyth.nc.us/publichealth/
Forsyth Tech Community College Dental Education Clinic	Community	Low cost dental care	Clinical, Preventive Care, Referral Pathways	https://www.forsythtech.edu/student-services/student-resources/dental-clinic/

Organization/Program	Type of Resource	Key Resources	Type of Partnership	Website
Centenary UMC – Love Thy Neighbor	Community	Food (meals), Medical and Dental Care	Clinical, Referral Pathways	https://www.centenary-ws.org/youth-ministry
Planned Parenthood	Community	Women's reproductive health needs	Clinical, Preventive Care, Referral Pathways	https://www.plannedparenthood.org/health-center/north-carolina/winston-salem/27103/winston-salem-health-center-2845-90860
Smile Starters	Community	Dental care for children, Medicaid and Health Choice	Clinical, Preventive Care, Referral Pathways	https://www.smilestarterdental.com/
Novant Health – Today's Woman OB/GYN	Community	Free pregnancy tests, OB/GYN care, ultrasound, lab tests	Clinical, Preventive, Referral Pathways	https://www.nhtodayswomanobgyn.org/
United Health Centers	Community	Prenatal care, behavioral health, chronic illness, educations, dental care	Clinical, Referral Pathways, Education/Training	https://uhcenters.org/
Trellis Supportive Care	Community	Hospice care, palliative care, grief counseling	Referral Pathways, Clinical Care	https://www.trellissupport.org/
Agape Care & Share	Community	Food, clothing, blood pressure screening, life and career skills training, Christian counseling	Referral Pathways, Preventive Care, Education/Training	None
Anthony's Plot	Community	Faith-based worshipping and advocacy community, resource guide	Referral Pathways	https://anthonysplot.org/

Organization/Program	Type of Resource	Key Resources	Type of Partnership	Website
Crisis Control Ministry	Community	Emergency/Crisis services	Referral Pathways	https://www.crisiscontrol.org/
Bethesda Center	Community	Men and Women's shelter, supportive services		https://www.bethesdacenter.org/
Catholic Charities	Community	Food, spiritual counseling, pastoral care	Referral Pathways	https://ccdoc.org/en/
Disability Advocates	Community	Help with disability claims	Referral Pathways	http://www.dannc.org/
Experiment in Self Reliance	Community	Food, financial education, temporary transitional housing for working homeless	Referral Pathways, Education/Training	https://eisr.org/
Family Services	Community	Child development, advancing safety and success of families, and build a sustainable community	Referral Pathways	https://familyservicesforsyth.org/
Goodwill of NWNC	Community	Job training, scholarships available	Referral Pathways	https://www.goodwillnwnc.org/
Habitat for Humanity	Community	Low-income housing	Referral Pathways	https://habitatforsyth.org/
HARRY Community Outreach Services	Community	Career development, emergency assistance, job placement, case management, housing assistance	Referral Pathways, Education/Training	https://www.harry4you.org/welcome
YWCA – Hawley House	Community	Women's Substance Abuse Recovery facility	Clinical, Preventive Care, Referral Pathways	http://www.ywcaws.org/what-we-do/empower-women/hawley-house/

Organization/Program	Type of Resource	Key Resources	Type of Partnership	Website
Hosanna House of Transition	Community	Shelter, counseling, and job placement to homeless, recovering drug addicts and ex-offenders	Preventive Care, Referral Pathways, Education/Training	https://www.samaritanforsyth.org/the-empowerment-project/
Housing Authority of Winston-Salem	Community	Low-income housing help (Section 8)	Referral Pathways	https://haws.org/
Legal Aid of North Carolina	Community	Legal services	Referral Pathways	https://www.legalaidnc.org/about-us/offices/winston-salem
Senior Services	Community	Meals on Wheels, crafts, physical activity, music, educational programs	Referral Pathways, Education/Training, Caregiving	https://www.seniorservicesinc.org
Next Step Ministries	Community	Assistance for victims of domestic violence and their children	Referral Pathways	https://www.nextstepdv.org/
The Potter's House	Community	Prison re-entry, furniture, kids programs	Referral Pathways, Education/Training	https://www.pottershousewsnc.com/
Winston-Salem/Forsyth County Schools – Project HOPE and Backpack program	Community	Help with school enrollment, supplies, referrals and transportation services for homeless students and their families, addressing child hunger	Referral Pathways	https://www.wsfcs.k12.nc.us/Page/106155 https://forsythbackpackprogram.org/
Piedmont Triad Regional Council – Project Re-entry	Community	Pre-release and post-release programs, housing, job placement, counseling	Preventive Care, Referral Pathways, Education/Housing	https://www.ptrc.org/services/criminal-justice/project-re-entry

Organization/Program	Type of Resource	Key Resources	Type of Partnership	Website
Salvation Army	Community	Food, clothing, bill help, emergency shelter, veterans services, Center of Hope Shelter for homeless families and single women, residential re-entry for ex-offenders	Education/Training, Referral Pathways	https://www.salvationarmycarolinas.org/winston-salem/
Samaritan Inn	Community	Men's overnight shelter, supportive services	Referral Pathways	https://www.samaritanforsyth.org/samaritan-inn/
The Shepherd's Center	Community	Transportation, social support, medication and housing assistance	Referral Pathways, Education/Training, Caregiving	https://www.shepherdscenter.org/
Sunnyside Ministry	Community	Housing, utility assistance, clothing, medical care (physicals), immunizations, health education	Clinical, Referral Pathways, Education/Training	https://sunnysideministry.org/
Urban League	Community	Employment, clothing, vouchers	Referral Pathways, Education/Training	https://wsurban.org/
U.S. Department of Veterans Affairs – Benefits Administration	Community	Veterans benefits and outreach	Referral Pathways	https://www.benefits.va.gov/winstonsalem/
Forsyth County Department of Social Services – Work First	Community	Emergency assistance for families in crisis	Referral Pathways	https://forsyth.cc/DSS/TEAM_WFcash_assistance.aspx
Winston-Salem Rescue Mission	Community	Food, clothing, medical care, dental extractions, 24-hour shelter for men	Clinical, Preventive, Referral Pathways	https://wsrescue.org/

Organization/Program	Type of Resource	Key Resources	Type of Partnership	Website
Love Out Loud	Community	Over 80 churches, 200 community organizations that connect with those who need support and resources, Atrium Health WFBH's FaithHealth Fellow supports pregnant women by referring them to health department programs and supporting children by increasing enrollment in pre-K programs	Referral Pathways	http://www.loveoutloudws.com/
Hispanic League	Community	Foster diversity and raise awareness, improve quality of life for Hispanics/Latinos	Referral Pathways	https://www.hispanicleague.org/
Second Harvest Food Bank	Community	Addresses hunger, food insecurity, and hunger & health	Referral Pathways	https://www.secondharvestnwnc.org/
Addiction Recovery Care Association (ARCA)	Community	Substance abuse and detoxification treatment, referrals accepted 34/7	Clinical, Preventive Care, Referral Pathways	https://www.arcanc.org/
Cancer Services	Community	Medical financial assistance, equipment, supplies, transportation to treatments, peer support, patient advocacy	Referral Pathways	https://cancerservicesonline.org/

Organization/Program	Type of Resource	Key Resources	Type of Partnership	Website
Daymark Recovery Services	Community	Behavioral health services	Mental health and substance abuse treatment	https://www.daymarkrecovery.org/locations/forsyth-center
Novant Behavioral Health Services	Community	Behavioral health services	Referral Pathways	https://www.novanthealth.org/forsyth-medical-center/services/behavioral-health.aspx
Partners Health Management	Community	Screening, triage and referrals for mental health, developmental disabilities and substance abuse services	Referral Pathways	https://www.partnersbhm.org/
Forsyth County Dept. of Public Health	Community	Immunizations, STD clinic, Family Planning Clinic, WIC Program, Wise Woman, SNAP, Medicaid services, Dental	Some Clinical, Preventive Care, Referral Pathways	https://www.co.forsyth.nc.us/publichealth/
The Empowerment Project	Community and Health System	Mental health services to homeless adults	Clinical, Preventive Care, Referral Pathways; partly funding through Atrium Health WFBMC	https://www.samaritanforsyth.org/the-empowerment-project/
I Can House	Community	Advocacy, resources, training and referral navigation for persons and families dealing with autism, Asperger's syndrome and other developmental disabilities	Referral Pathways, Education/Training	https://icanhouse.org/

Organization/Program	Type of Resource	Key Resources	Type of Partnership	Website
Insight Human Services	Community	Clinical facilities, psychiatric services, substance abuse treatment	Clinical, Preventive Care, Referral Pathways	https://insightnc.org/
Mental Health Association	Community	Mental health treatment, Advocacy and Support Groups	Clinical, Preventive Care, Referral Pathways, Education/Training	https://www.triadmentalhealth.org/
Dream Center – Outreach Alliance for Babies, Inc.	Community	Baby Safe Sleep Kits and other necessities to address infant mortality and child development	Referral Pathways	https://dreamcenterforsyth.com/resources/
Oxford Houses	Community	Addiction recovery house	Preventive Care, Referral Pathways	https://oxfordhousenc.org/
Salem Pregnancy Center	Community	Free pregnancy tests, parenting classes, vouchers for infant needs	Screening, Preventive Care, Education/Training	https://salempregnancy.org/
YMCAs	Community	Health education and physical activity programs, senior and youth programs, Diabetes prevention education	Referral Pathways, Preventive Care	https://ymcanwnc.org/

Section VI: Progress to Date on 2020 - 2021 Priorities

Atrium Health Wake Forest Baptist Medical Center made progress toward the 2020-2022 CHNA priorities of Access to Care, Chronic Disease Management and Prevention, Behavioral Health and Substance Dependency, and Maternal and Child Health. Atrium Health Wake Forest Baptist Medical Center continues to align with the Davidson, Davie, Forsyth, Guilford, and Wilkes County Health Departments and leads and/or participates in a wide variety of partnerships and local coalitions.

1. **Access to Care**

For this priority, the actions highlighted in the 2020-2022 Implementation Report were for Atrium Health Wake Forest Baptist to:

1. Encourage appropriate Emergency Department utilization through care coordination across community, hospital and primary care
2. Improve access to community-centered social and health education services and regular source of health care
3. Improve access to transportation to health care services

<u>FaithHealth Supporters of Health and Connectors</u>

In addition, Atrium Health Wake Forest Baptist Medical Center would engage vulnerable communities and patients through **FaithHealth Supporters of Health and Connectors** who serve biopsychosocial spiritual needs, support life and health challenges, and connect patients with the community assets of social networks including communities of faith. During fiscal year 2021, FaithHealth Supporters of Health **served 650 clients** in the community. FaithHealth Connectors **provided 10,786 caregiving encounters**. FaithHealth Connectors' volunteers **provided 8,428 hours of volunteer service** while the Connectors also leveraged the assets and resources of a **network of 531 congregations.**

During 2020 and 2021, several Supporters of Health and Connectors were reassigned to new roles as Community Health Workers to serve under a new COVID-19 response program led by the NC Division of Health and Human Services' Office of Rural Health. Atrium Health Wake Forest Baptist's FaithHealth Community Health Workers were responsible for connecting North Carolinians to medical and social support resources, including diagnostic testing, primary care, case management, nutrition assistance, and mental health services. They also provided education on the 3 Ws, supplied communities with Personal Protective Equipment (PPE), informed community members of testing locations, and scheduled appointments at vaccination clinics. Between August 2020 and June 2021, FaithHealth's Community Health Workers were able to achieve the following:

- **2,924** clients served
- **3,789** referrals sent to community resources
- **2,185** closed loop (e.g., verified resources received) referrals sent to community resources

- **5,854** telehealth (e.g., phone, text, email) encounters reported
- **206** clients were reported on Medicaid (only from December 2020 to June 2021)
- **5,770** individuals received vaccination education
- **216** reminders for 2nd doses of the COVID-19 vaccine
- **127** vaccine education events facilitated (only from January 2021 to June 2021)
- **3,136** clients attended vaccine education events held (only from January 2021 to June 2021)
- **1,878** individuals were registered for the COVID-19 vaccine (only from January 2021 to June 2021)
- **848** individuals were scheduled for the COVID-19 vaccine (only from January 2021 to June 2021)
- **65** vaccination events were held (only from January 2021 to June 2021)

Highland Avenue Primary Care Clinic

Atrium Health Wake Forest Baptist Medical Center addressed access to care by improving access to regular sources of health care for the underserved community. At the time of the 2020-2022 CHNA, the medical center partnered with Novant Health to provide preventive care at the **Highland Avenue Primary Care Clinic** by offering same-day or next-day appointments, regular checkups for children, annual physicals for adults, women's health services, chronic care, and vaccines to avoid preventable illnesses. In 2019, the Forsyth Primary Care Collaborative was created to open the Highland Avenue Primary Care Clinic in East Winston, a traditionally underserved area of the community. The public private partnership involving Forsyth County government for space rental includes a 8,339-square-foot low-cost clinic that serves patients of all ages, and allows patients to pay for services on an income-based, sliding fee scale. 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.

Community Health Alliance Mobile Clinic

The "mobile health clinic" was created through a partnership between the School Health Alliance of Forsyth County and Atrium Health Wake Forest Baptist Medical Center to provide medical, nursing, nutrition, mental health, health education services to both adults and children in underserved communities, and screening for sexually transmitted infections in collaboration with the Forsyth County Department of Public Health. As a result, Atrium Health Wake Forest Baptist Medical Center formed the **Community Health Alliance mobile clinic**. Established in 2019, 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. The mobile clinic is an outreach effort provided with support by the North Carolina Baptist Hospital Foundation of Atrium Health Wake Forest Baptist Medical Center. It provides 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. The services include primary, preventive and chronic care, labs, colorectal screening, prescriptions, flu and COVID-19 vaccines, referrals for mammograms, dental care, vision care, and food vouchers.

The highlights for the Community Health Alliance mobile clinic for 2021 were the following:

- **Primary and urgent care to over 500 uninsured individuals in 6 communities**
- **45 mammograms**
- **52 dental and 50 eye care visits with United Health Centers and LensCrafters partnership**
- **Over 500 COVID-19 vaccines in underserved communities**
- **Delivered over 20,000 meals and 5,000 produce boxes to 130 older adults with food insecurity since March 2020 with Fresh Food Rx**

- **Partnering with Winston Salem State University mobile market starting June 2021**

Outpatient Transportation Coordinator

There was progress made by Atrium Health Wake Forest Baptist Medical Center in terms of improving access to transportation to health care services to address access to care barriers. The primary strategy was to align community transportation resources with Downtown Health Plaza, OPD Medicine, and Family Medicine (Piedmont Plaza) patients when transportation needs are identified during appointment scheduling through the Access Center. As a result, a position was created to serve as a point of contact for patients who lack transportation or who have inconsistent transportation to medical appointments. This position functions as a transportation coordinator who can assess specific needs, determine relevant transportation resources based on that assessment, and provide patients with direct access to transportation services that partner with Atrium Health Wake Forest Baptist Medical Center.

The data in the table below represent the number of transportation encounters that were managed by the transportation coordinator for Downtown Health Plaza, OPD Medicine, Family Medicine, and Winston East Pediatrics patients from May 2019 to November 2021.

	2019	2020	2021 Through 11/30/2021	**2019-2021**
DHP	564	639	888	**2091**
OPD	70	47	41	**158**
PPI	140	218	194	**552**
WEP			2	**2**
	774	904	1125	**2803**

2,803 patient encounters included securing cab transportation, completing applications for Trans Aid or Half Fare transportation, setting up Medicaid transportation, setting up transportation w/other insurance carriers, and referrals to Faith Health.

In the near future, Atrium Health Wake Forest Baptist will collaborate with a company that will offer providers and potentially patients a platform that will provide patients access to convenient, cost-effective, safe, reliable rides. This will be an on-demand ride-ordering solution that is a single access point for scheduling transportation, leading to better access to health care and other important services.

2. Chronic Disease Management and Prevention

The progress made by Atrium Health Wake Forest Baptist Medical Center in this priority area led by the Office of Cancer Health Equity and the Maya Angelou Center for Health Equity, resulted in enhanced community outreach and education, culturally and linguistically appropriate cancer navigation, removal of barriers to access, and focus on diseases that disproportionally impact racial and ethnic minorities. In addition, the Gateway to Success program, BestHealth, and Brenner FIT provide education and support programs to reduce diabetes prevalence and to promote weight management.

<u>The Office of Cancer Health Equity (OCHE)</u>

The OCHE is committed to educating the public about cancer. It offers free community outreach programs to educate community members about cancer prevention, risk reduction, screening and more. The health care professionals and cancer experts are available to speak on a variety of topics, and each presentation is tailored to the specific audience.

The Rural Community Cancer Outreach Program (RCCOP) addresses cancer-related rural health disparities in our catchment area, with particular attention to Northwest North Carolina. RCCOP focuses on 1) reducing tobacco exposure via prevention and cessation resources and policy advocacy; 2) increasing access to care by addressing the supportive care needs of cancer patients and survivors and; 3) capacity building with primary care providers to increase care coordination closer to home. RCCOP activities include:

- Tobacco education and cessation groups
- Community health education across the cancer control continuum
- Navigation for Atrium Health Wake Forest Baptist Comprehensive Cancer Center patients
- Continuing medical education
- Community engagement activities

A Stakeholder Advisory Committee composed of local health departments, non-profits, and other community organizations guides the work of RCCOP. The committee provides feedback and insight on program activities.

The OCHE plays a vital role in addressing the inequities that underserved populations can face during their cancer experience by offering non-clinical navigation services to our African American and Hispanic cancer patients, including support to individuals coming from rural areas.

Population health navigators provide culturally and linguistically competent navigation services to cancer patients, families, and caregivers to help them overcome health care system and social barriers, facilitating timely access to quality medical and supportive care from diagnosis through their cancer treatment. In addition, research support is delivered through patient education, providing our underserved cancer patients with general information about the role of research in cancer care.

The tobacco program in the OCHE focuses on expanding outreach efforts to underserved areas in our community that have higher tobacco use rates by addressing regional tobacco cessation capacity. Tobacco use is the leading modifiable risk factor for cancer and 70% of our priority counties have elevated smoking rates, most having a tobacco use percentage above the national average of 17.1%. The purpose of this program is to reduce the prevalence of smoking and improve cancer incidence and mortality rates.

The program serves our communities by:

- Educating public about the health risks of tobacco and resources to help quit
- Developing partnerships to help guide program planning, implementation, and evaluation
- Building capacity in clinical settings to help improve internal tobacco cessation processes
- Facilitating tobacco cessation groups: this evidence-based group program provides support and resources to those motivated to quit. Weekly sessions led by a certified Tobacco Treatment Specialist are discussion-based, including subjects such as health risks, cravings/triggers, stress management, nutrition, and exercise.

<u>Maya Angelou Center for Health Equity (MACHE)</u>

The mission of MACHE is to dismantle systemic inequity and support the health of communities through:

- Building and nurturing mutually beneficial and reciprocal relationships
- Respecting and honoring community as experts and equal partners
- Engaging, educating, and empowering communities
- Cultivating formal and informal leadership
- Creating a culture of transparency and fairness in research
- Promoting advocacy and policy change

MACHE's progress and strength in addressing chronic disease in our community can be seen in its outreach to black men, congregations, and pastors in an effort to improve their health and quality of lives.

The Caregivers College and Black Men's Health Initiative was developed to motivate older African American men to engage in healthy lifestyle behaviors. The project focuses on outreach and community partnering with two groups frequently excluded from targeted outreach efforts to engage racial/ethnic minorities, African American men and African American caregivers. MACHE created reciprocal and dignified partnerships in severely disenfranchised African American communities in Winston-Salem, NC, targeting those communities with:

- Higher burden of Alzheimer's Disease
- Lower literacy about Alzheimer's Disease
- Lower access to health information, health resources and health care

MACHE harnesses resources made possible through partnerships with the faith-based community, and Historically Black Colleges such as Winston-Salem State University and the Center for Outreach in Alzheimer's Aging and Community Health (COAACH) at NC A&T State University.

For MACHE's outreach to congregations, it established roles called **Congregational Health Ambassadors**. The role of the Congregational Health Ambassadors (CHA) is to assure constant communication and continuity between faith leaders and congregations, faculty and staff at the Maya Angelou Center for Health Equity (MACHE) and affiliated faculty and staff. These individuals leverage the experiences, infrastructure, human resources and energy of the faith community to meet the health needs of their faith families. In concert with their pastor and health ministries, CHAs are involved in identifying and selecting health promotion activities and creating the soul or energy around them. CHAs design church-specific programs and tailor the activities to suit the congregations' needs.

The Triad Pastoral Network (TPN) establishes asset-based trusted partnerships among regional faith leaders, and between faith leaders and the Maya Angelou Center for Health Equity (MACHE). The partnership identifies health priorities, and sets agendas relative to the spiritual, physical, mental, and emotional health of their congregations and communities. These

partnerships lay the groundwork and facilitate the advancement of healthier faith communities and neighborhoods regionally, and particularly within African-American and other underserved communities.

A survey of 37 pastors in TPN discovered that the top health topics discussed at their churches are diabetes, heart disease & stroke, healthy cooking/eating/nutrition, cancer, obesity, physical activity/fitness classes, and Alzheimer's Disease/dementia. As a result, MACHE tailors its chronic disease management and prevention strategies in collaboration with TPN based on these findings.

Brenner FIT

Brenner FIT increases education and awareness of nutrition and healthy lifestyle choices for uninsured and Medicaid patients and families. Serving patients and families through a variety of programs and initiatives- cooking classes, CSA food share program/meals, health fairs, and treatment programs.

Highlights from 2019-2020 were:

- **Supported a resilient population that is 75% Medicaid-insured and 39% food insecure**
- Began video visits with families in April 2020
- **Offered 103 classes to Brenner FIT families**
- Completed exciting upgrades to the Teaching Kitchen, including more-functional tables, expanded dining space and improved appearance
- **Offered 64 classes (activity, nutrition and cooking) to the community with over 835 people participating**
- **Addressed food insecurity needs when the pandemic began by providing 500 food bags (nearly 6,000 meals) and 360 prepared meals to food-insecure families**
- **Reached over 4.6 million people through media**

3. Behavioral Health and Substance Dependency

Two of the main goals for this priority area were achieved by Atrium Health Wake Forest Baptist Medical Center's ability to increase the number of individuals utilizing CareNet services and to increase the number of patients receiving integrated behavioral health screening and treatment.

In addition, there was progress made in continuing the work of The Empowerment Project to provide outreach 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. The community outreach includes the provision of case management 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.

<u>CareNet Counseling</u>

CareNet Counseling is part of Atrium Health Wake Forest Baptist's FaithHealth Division. It is committed to improving the health of the mind, body, spirit and community through spiritually-integrated counseling, psychotherapy, research, and education. CareNet is engaging in several strategic priorities in an effort to further enhance its capacity to provide behavioral health services to vulnerable communities across the state. In terms of progress, CareNet increased access to primary care in the communities it serves by adding telehealth services, partnering with primary care physician practices to provide integrated, co-located, collaborative and consultative care services, and locating many of its services in rural/underserved areas.

Moreover, the COVID-19 pandemic drastically increased the behavioral health needs of the communities CareNet serves over the last 18 months. In response, CareNet **increased its service delivery by 15% during FY21, serving approximately 7,500 individuals and families through 45,000 counseling sessions**. These services were provided through a blend of telehealth and in office services. Also in response to pandemic stress, CareNet partnered with the North Carolina Department of Agriculture to provide subsidized services to uninsured and underinsured agriculture workers across the state. This aligns with its mission of caring for underserved groups in underserved areas.

CareNet has also been invited by a regional funder to develop a program for adding psychiatric prescribers to our service lines to increase the number of these specialty providers across the state while addressing the growing opioid and substance use issues through Medication Assisted Treatment.

<u>The Empowerment Project</u>

The Empowerment Project operates as a street outreach program for homeless adults and families experiencing mental health struggles or substance use disorders. By helping

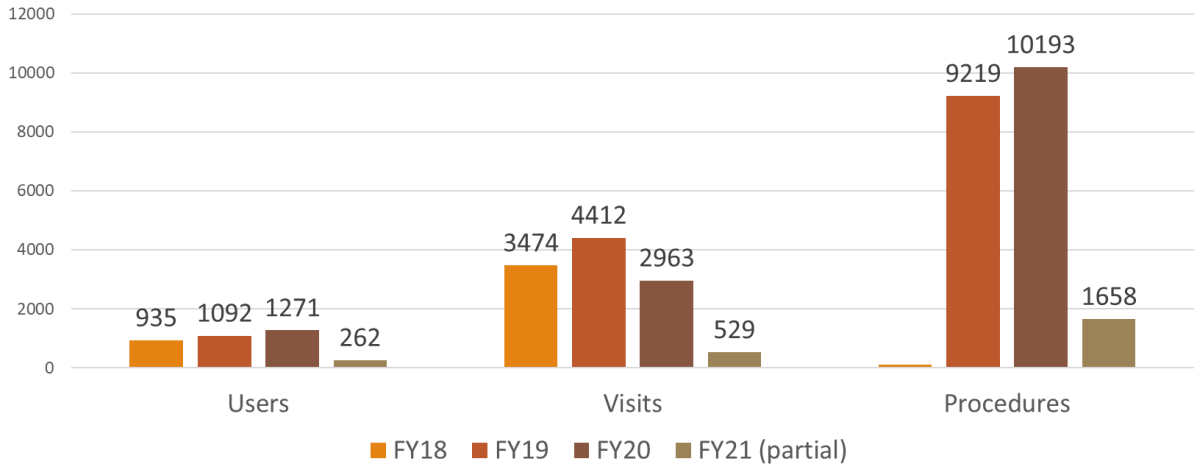
participants navigate through a system of services, referrals and resources in our community, these support channels enable permanent housing, health and income options. By partnering with the Atrium Health Wake Forest Baptist Medical Center's FaithHealth Division, individuals and families receive spiritual support through ministries of growth, hope and healing. During fiscal year 2021, the Empowerment Team had **436 individual outreach encounters** with community members without housing.

4. Maternal and Child Health

Atrium Wake Forest Baptist Medical Center increased the number of programs and services that are designed to improve the health of mothers and their children. While School Health Alliance for Forsyth County and the Downtown Health Plaza are historical partnerships and services that provide care in school-based health centers and in a primary care site respectively, Family Connects, the Safe Sleep Initiative, and the Love Out Loud Fellowship are recently created community-based programs that serve the health and social needs of these unique populations.

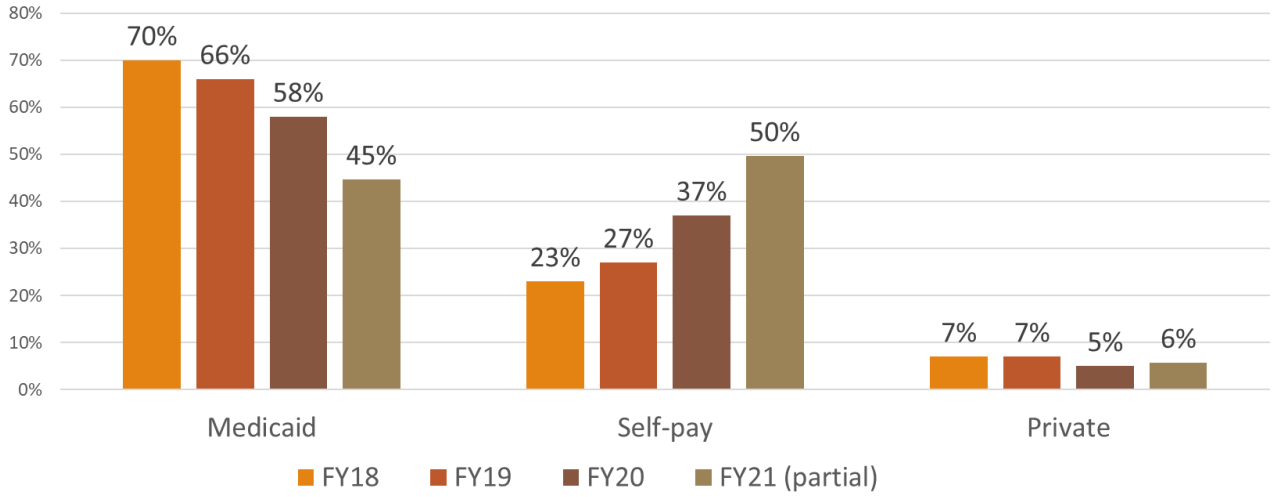
<u>School Health Alliance for Forsyth County</u>

Atrium Health Wake Forest Baptist Medical Center offers medical and research direction for the School Health Alliance (SHA) for Forsyth County to operate school-based health centers and programs in partnership with schools and other community health organizations to provide medical and mental health services that promote the health and educational success of school-aged children and adolescents. SHA provided care to 1,271 users who had 2,963 visits and underwent 10,193 procedures during FY20.



One of the biggest challenges that the SHA has recently seen in the community is an increasing percentage of students served by SHA that are uninsured. As a result, SHA explored partnerships with other community organizations to get students and families enrolled for Medicaid or connected to other health coverage opportunities. The following graph highlights

the increase in the percentage of uninsured served by SHA over three and a half fiscal years (as the numbers for FY21 are for just the partial year).



Despite national and local declines in Medicaid enrollment, SHA continues to provide medical and mental health services that promote the health and educational success for an increasing number of school-aged children and adolescents each year.

Family Connects

During 2020, Atrium Health Wake Forest Baptist Medical Center established and began implementing the Family Connects home visiting program in collaboration with Novant Health Forsyth Medical Center. This program serves Forsyth County families delivering at the Birth Center at Atrium Health Wake Forest Baptist Medical Center to perform basic clinical assessments (e.g., blood pressure, infant weight, assessment for edema, breastfeeding latch), and conduct an evaluation of service 4 delivery to inform quality improvement and model effectiveness in improving health outcomes for mothers and their young children.

The next goal is to conduct an evaluation of service delivery to inform quality improvement and model effectiveness in improving health outcomes for mothers and their young children. The program plans to serve 1,500 families in the first full year ramping up to 3,000 families by the third year of implementation.

Safe Sleep

Sleep-related deaths, including Sudden Infant Death Syndrome, are the 3rd leading cause of mortality for infants 1-12 months of age in NC. From discussions with the Forsyth County Department of Public Health, Atrium Health Wake Forest Baptist Medical Center's Employee Assistance Program, and colleagues passionate about child health across the medical center, it was determined that an urgent child health need should be addressed in a doable and meaningful way without duplicating on-going activities. During these discussions, the Forsyth

County Infant Mortality Reduction Committee stated that it would soon announce a safe sleep campaign. As a result, Atrium Health Wake Forest Baptist Medical Center believed that it was an opportune time to address safe sleep across the medical center and community.

The Safe Sleep initiative was implemented in October 2020 across the mother-baby units at Atrium Health Wake Forest Baptist Medical Center's Birth Center, High Point Medical Center and Wilkes Medical Center. The medical center wanted to ensure that all newborns that were discharged have a place that they can sleep safely at home. Recommendations that newborns sleep in their own space (bassinet or crib with firm flat mattress) on their back has lowered sudden infant death syndrome and infant mortality. While most newborns have a safe space to sleep when they go home, it was discovered that some at our birthing hospitals do not.

In the first year, 52 families were identified who did not have a safe place for their newborn to sleep. As a result, Atrium Health Wake Forest Baptist Medical Center provided these families with Graco Pack 'N Plays. They are designed to serve as a play yard, bassinet, diaper changing station, or a combination of all three that compactly breaks down and tucks away into an easy-to-carry bag for travel. There were 37 distributed in Winston-Salem, 8 in High Point, and 10 in Wilkes County.

Love Out Loud Fellow

Within sight of Atrium Health Wake Forest Baptist Medical Center's new birthing center are neighborhoods where the children brought into the world enter into lives almost certain to be marked by poverty, poor education and lifetime health struggles. COVID-19 has only acerbated these challenges. However, it has also sharply highlighted a distinctive ally of our medical center, the vibrant faith networks led and animated by Love Out Loud (LOL). This network includes 240 cooperating congregations and 300 collaborating non-profit and business partners. Atrium Health Wake Forest Baptist Medical Center is already a partner in many ways, but it further cemented the working relationship by building the capacity of LOL relevant to the short and long term early childhood strategy through this fellowship position.

This part-time position is housed within LOL, which works to transform our community (greater Winston-Salem) by connecting and mobilizing its people and resources. This highly relational position serves as a community advocate and partner in the early childhood space, with relational connection between the parallel work of Atrium Health Wake Forest Baptist Medical Center's FaithHealth division and LOL.

The position focuses on three major goals: 1) community connection, 2) system change, and 3) expanded services. Community connection involves advocating and partnering in the Pre-K / early-childhood education and Pediatric holistic care space with multiple organizations, including but not limited to P*re-K Priority, Great Expectations, Brenner FIT, Parenting PATH*, and *Help Me Grow.* Also, the position works alongside residents to share learnings and asset map Informal Care Arrangements, which include childcare provided by individuals who are not licensed or regulated childcare providers, or individuals working in licensed and regulated

childcare or early education facilities. Regarding systems change, the position assists in creating / advocating for single portal of entry and information for early-childhood systems and resources. Finally, the positions role in expanding services is to identify strategies to eliminate disparities and close the gap in preventive care (i.e. Safe Sleep and WIC enrollment) to enhance child health and well-being.

The Love Out Loud Fellow, which is supported by Atrium Health Wake Forest Baptist Medical Center's NC Baptist Hospital Foundation and FaithHealth Division, has also provided important insights and outreach within local underserved minority neighborhoods like the Cleveland Avenue Homes community. For example, the LOL fellow visits with residents and makes referrals to health department programs supporting pregnant women in a more streamlined way. The Fellow reached out to residents to increase enrollment in a variety of pre-K programs and learned much about this process. This work contributed to invitations to the Fellow and all members of the team being invited to a new Forsyth County Early Education Task Force.

Section VII: Sharing the CHNA and Communicating Priorities to Stakeholders

It is vital that the broader community, including community-based organizations, the faith community, grassroots leaders, and members of resident-led initiatives, understand that the assessment can be a powerful tool when utilized effectively. Therefore, Atrium Health Wake Forest Baptist team members will provide workshops to community members who are interested in learning how to access this report and other informational resources available on the new Community Impact Website. To further expand our reach, when appropriate, we will partner with the Forsyth County Department of Public Health to disseminate the full report. Internal stakeholders with significant community partnership (e.g. NC Baptist Hospital Foundation, Philanthropy, and others) will also be invited to participate in learning opportunities. Internal communications and the Intranet will also serve as a platform to educate internal team members about the availability of the report and key findings. Several team members are also affiliated with community organizations through involvement on boards, committees, and other service positions. As such, it is expected that these individuals will continue efforts to publicize the CHNA and serve as an educational resource as opportunities arise to do so.

APPENDIX

1. Access to Care

Maternal and Child Health Populations

Why is this important and what are current trends and significant changes?
Leadership perspective shared by Katherine Poehling, M.D., M.P.H., Professor, Pediatrics, and Director of Pediatric Population Health:
"It is important to provide support needed so that all mothers, children and families have a great start. Access to Care for Special Populations includes making clinics accessible for all as well as addressing needs of families we serve. Addressing needs of families is an important focus as gaps in basic needs negatively impact family wellness and health outcomes and are an important contributor to health disparities. We expand Access to Care in a variety of ways. Examples include Brenner Fit Academy in many locations including rural, expanding access to pregnant women at both United Health Center and Downtown Health Plaza, and expanding mental health support by integration in primary care clinics like the Downtown Health Plaza and Highland Avenue Primary Care, a joint venture with Novant Health. We address basic needs in a variety of ways. Examples include partnering with the Health Department for WIC/SNAP and for pregnancy support of mothers in need, offering home health nurse-visiting program for all women who deliver in the Birth Center and reside in Forsyth county, and enabling all newborns to have a safe sleep option across birthing locations at Wake Forest Baptist Health--Winston-Salem, High Point, and Wilkesboro. Recognizing it takes a village to raise a child, we collaborate with many to support needs of mothers, children, and families."

Behavioral Health and Substance Use Disorder Populations

Why is this important and what are current trends and significant changes?
Leadership perspective shared by Bryan Hatcher, LCSW, President, CareNet Counseling:
"*National data indicates that on average 25% of the US population deals with a mental health struggle each day. The Covid-19 pandemic has exaggerated this metric through isolating, creating uncertainty, causing financial distress, and often providing no outlet from stressors that cause or elevate mental health issues. It is also recognized that socio-economic factors and adverse events across the lifespan tend to increase the intensity of mental health issues for individuals and communities, and that individuals and communities of color and/or living in poverty have less access to resources to address mental health issues. CareNet Counseling serves communities across the state of North Carolina by providing counseling, support and educational services to those in need. We intentionally seek to provide services in communities that are underserved, and we provide free and subsidized services to those with less resources in order to increase access and improve outcomes. During the Covid-19 pandemic, we have increased our use of telehealth services as a means of being available to those in need more quickly and with less risk of transmitting the virus."*

Medicaid, Medicare, and Uninsured Populations

Why is this important and what are current trends and significant changes?
Leadership perspective shared by Jennifer Houlihan, M.S.P., M.A., Vice President of Population Health and Value Based Care:
In addressing access to care for these populations, "population health would use chronic disease management as a way to engage patients in their plan of care and to support/navigate care gaps, adherence, etc. It is nuanced, and we want to understand prevalence, patient data trends, and type of clinical offerings we provide to help people with their diagnoses and treatment from an acute vs. chronic perspective."

2. Social Impact and Injustice

Why is this important and what are current trends and significant changes?
Leadership perspective shared by Rev. Gary Gunderson, M.Div., D.Div., D.Min.:
"Our social impact strategy has gained energy as the institution has begun to confront our own pattern of race and exclusion that mirrors that in the community. This is visible in the community benefit process, which now includes all facilities in an operational team that monitors our collective impact with a focus on micro-geographies, sustained partners among non-profit, faith and business. As an AMC, we have many faculty and service lines long involved with the people most affected--especially family medicine, pharmacy, care management and the ED--who have welcomed the increasingly coordinated social impact of WFBH and even more to have this as a signature of the new Atrium Health.

As WFBH continues to advance its vision of being a leader in social impact and population health, we continue to extend beyond the walls of our hospitals and medical offices and address those social, economic, and environmental conditions that contribute to poor health outcomes, shortened lives, and higher health care costs of the patients we serve. We also continue to adapt our approach as we learn and build new bridges and insights across a number of diverse communities."

3. Chronic and Emerging Diseases

Cancer

Why is this important and what are current trends and significant changes?
Leadership perspective shared by Ronny Bell, Ph.D., Professor, Social Sciences and Health Policy, and Director, Office of Cancer Health Equity:
"*Cancer is a disease that has a devastating impact on our community. Not only is cancer the second leading cause of death, it also contributes to significant financial and caregiver burden. Cancer can disproportionately impact racial and ethnic minority populations as well as populations living in poverty and in rural areas. We are fortunate to have Wake Forest Baptist Comprehensive Cancer Center (WFBCCC), recognized by the National Cancer Institute as a designated comprehensive cancer center, serving our community through research, education*

and community engagement. As Director of the Office of Cancer Health Equity, I am committed to our mission of ensuring that everyone should have an equal chance of surviving cancer, regardless of race/ethnicity, income status, sexual orientation, gender identity, or geographic location. Our programming includes patient navigation, community engaged research and education, policy advocacy and partnerships. While COVID has impacted some of our engagement activities, we are committed to continuing to serve our communities remotely and keeping everyone safe."

Stroke

Why is this important and what are current trends and significant changes?
Leadership perspective shared by Sabina Gesell, Ph.D., Associate Professor, Social Sciences and Health Policy, and by Pam Duncan, Ph.D., Professor, Neurology:
"*There has been a significant decline in the frequency and severity of stroke events nationwide over the last several decades. However, in the stroke belt the risk of stroke is 34% higher than in the rest of the country, there is a higher prevalence of hypertension, and two to four times the stroke mortality. North Carolina and other southern states are in the stroke belt.*

Atrium Health Wake Forest Baptist Medical Center has led efforts over the last few years to improve secondary prevention and stroke risk factors. Recovery and secondary prevention after stroke can be a long process and it is critical that stroke survivors and their families know how to take their medications consistently, engage socially, are active and avoid falling, and control their blood pressure. This year, Wake Forest completed a study of 40 North Carolina hospitals to determine the best way to care for stroke survivors after their return home to maximize their recovery and independence, as well as prevent another hospital admission. The care model was informed by patients and caregivers, patient advocates, social service providers and clinicians in our community and across NC to ensure that the intervention met patients' complex needs and addressed the health issues that mattered most to them. As a result of this study, some hospitals across the state changed their post-acute stroke care to be more patient-centered.

The study revealed that patients who got the COMPASS care model had a significant improvement in home blood pressure monitoring, which is critical to prevent a recurrent stroke. High blood pressure affects almost half of all adults in the US and now one in four strokes is a recurrent stroke. Subsequently, Wake Forest launched a second study to determine how best to support patients so that they control blood pressure within the 30 days following a stroke. This study will recruit a large number of patients after a stroke in nine health systems across the Stroke Belt, with a focus on identifying which method of blood pressure control works best for African-American patients, older patients, and patients with disabilities. Both studies were funded by the Patient Centered Outcomes Research Institute."