CONE HEALTH®
The Network for Exceptional Care

2019 Community Health Needs Assessment Implementation Plan 2020-2022

Table of Contents

2019 Cone Health Community Health Needs Assessment Executive Summary

Every three years, Cone Health works with community partners in Alamance, Guilford and Rockingham counties to assess the social, medical and economic health of our communities. For the first time this year, Cone Health presents this information in a regional Community Health Needs Assessment (CHNA) format, which was adopted by the Cone Health Board of Trustees on September 15, 2019. Information in the 2019 CHNA includes:

- *Key Frameworks for Understanding Health Outcomes:* A description of the scientific basis for a "whole person" conception of health that includes social drivers such as education, income, and housing, and how these drivers are visible in the health outcomes in our communities.
- *Demographics and Population Information:* It is important to note that median income in Alamance ($47,900), Guilford ($52,300) and Rockingham ($46,200) is lower than the state of NC ($52,800). Household income influences many issues that impact health, such as insurance coverage, housing availability, nutritional practices, childcare options and educational attainment. Rockingham has the largest aging population (20% over 65), and Guilford has the most racially and ethnically diverse (49.5%) residents.
- *Life Expectancy and Leading Causes of Death*: Cancer and heart disease together account for almost 40% of deaths in our region. We observe alarming disparities in life expectancy by race and geography, evidence of the influence of social determinants of health. Infant mortality is improving in Alamance County, but has increased in Guilford (9.8/1000) and the disparity in black (13.3/1000) and white (6.1/1000) rates has grown.

Priority Health Concerns identified in the Community Health Needs Assessment are summarized below.

Priority Health Concern	*Why Is This Important?*	*What do We Know About These Issues in our Region?*	*What are We Working on in our Communities?*
Prevention of Chronic Disease, Especially Diabetes	Chronic disease contributes to leading causes of death, increases healthcare costs, and shortens lives.	We have a high volume of diseases that could be prevented through lifestyle changes.	Increasing access to healthy food, walkable communities, and health education.
Prevention of Addiction and Promoting Strong Mental Health	Behavioral health affects physical health and a person's fundamental sense of well-being.	The last decade has seen a dramatic rise in depression and in rates of addiction, especially opioids.	Integrating behavioral health into primary care, and using a harm reduction approach to helping people with addiction.
Access to High Quality, Affordable Healthcare	Regular care with trusted providers prevents illness, improves life expectancy, and reduces costs.	12% of adults under 65 are uninsured, and our region's provider coverage is at or below state average.	Opening new clinics in areas with medical needs and strengthening our community's safety net.
Creating the Living Conditions that Nurture Health	Humans flourish in safe, clean and supportive environments that promote health.	Greensboro is considered the nation's third most challenging city for people with asthma.	Linking health and human services providers to help patients; improving housing and neighborhood quality.
Eliminating Bias and Discrimination in Healthcare	Eliminating bias reflects our core values of caring and promotes equitable opportunity in our society.	Disease mortality rates, infant mortality, and rates of preventive care reflect racial/ethnic disparities.	Identifying the root causes of unequal health outcomes and changing protocols to improve health for all.

The complete Community Health Needs Assessment documents for Alamance, Guilford and Rockingham counties are available at http://www.conehealth.com/about-us/community-health-assessment/.

2019 Community Health Needs Assessment Implementation Plan Overview

Cone Health participates actively in county assessment teams. In 2018-19, local teams analyzed available data from trusted sources; collected new data through focus groups, surveys (phone, door-to-door and electronic) and interviews; and conducted community forums to identify priority health concerns. Tables below display the methods used in each community to gather and analyze data, and the crosswalk between each county's and Cone Health's system-wide priorities. Cone Health seeks to be responsive to local concerns and to streamline efforts to work cooperatively as a health system and a region to effectively address common challenges.

METHODS

	Alamance	**Guilford**	**Rockingham**
Population Survey	Elon University Poll with 337 respondents	Key Informant Surveys – 579 invitations; 208 responses	Door to door survey with 169 interviews
Focus Groups	Female Head of Household, LatinX, Occaneechi Saponi Tribe council & members, LGBTQ individuals, people with disabilities		African-American men and women, At-risk Youth/Young Adults, Business Community, Faith Community, Homeless Citizens, Mental Health/Substance Abuse, Parks and Recreation, Unemployed Citizens.
Secondary Data Sources	United State Census NC DHHS State Center for Health Statistics University of Wisconsin Population Health Institute County Health Rankings Vital Records from local health departments Cone Health Link Piedmont Health Counts Center for Housing and Community Studies at the University of North Carolina Greensboro		
Community Input	Community Based Participatory Research, Community Forum (130 participants)	4 Key Informant Assessment Workshops (89 total attendees)	Community Health Assessment Priority Identification Meeting

PRIORITY AREAS per County and for Cone Health's Region

Alamance	**Guilford**	**Rockingham**
Access to Care Access to Healthcare Education Economy	Healthy Eating and Active Living Social Determinants of Health Behavioral Health Maternal and Child Health	Mental Health and Substance Abuse: Opioids Physical Activity and Nutrition: Diabetes Social Determinants of Health: Diabetes
Cone Health		
• Prevention of Chronic Disease, especially Diabetes • Prevention of Addiction and Promoting Strong Mental Health • Access to High Quality, Affordable Healthcare • Promoting Living Conditions that Contribute to Health • Eliminating Bias and Discrimination in Healthcare		

Crosswalk Between Priority Areas Identified in Alamance, Guilford and Rockingham County Assessments and Priorities Identified in Cone Health Community Health Needs Assessment					
	Prevention of Chronic Disease, especially Diabetes	Prevention of Addiction and Promoting Strong Mental Health	Access to High Quality, Affordable Healthcare	Promoting Living Conditions that Contribute to Health	Eliminating Bias and Discrimination in Healthcare
Alamance					
Access to Care	x	x	x		x
Education				x	
Economic Issues				x	
Guilford					
Maternal and Child Health	x	x	x	x	x
Behavioral Health		x	x		x
Healthy Eating and Active Living	x			x	
Social Determinants of Health			x	x	x
Rockingham					
Mental Health/ Substance Abuse: Opioids		x	x		x
Physical Activity and Nutrition: Diabetes	x		x	x	
Social Determinants of Health: Education				x	x

In this implementation plan, we address these concerns in three sections:

- We describe several initiatives to address these priority areas.
- We describe additional outreach and education programs that support healthy communities.
- We highlight the many collaborative groups that work together in our communities to address health issues. Our participation in and support of these groups allow us to leverage resources to broaden our scope of impact, and generate innovation in addressing challenging health issues such as chronic disease and social determinants of health. These groups are likely to develop additional implementation strategies, and will contribute to our work as we begin the next community assessment process in 2021.

Relationship to Affiliated Foundation Focus Areas and Strategic Initiatives

Cone Health's purpose is to connect health care and well-being. Our vision is that a tradition of health and well-being is woven into the fabric of our communities. We hold ourselves accountable to the values of caring for our patients, caring for each other, and caring for our community. "Caring for our community" means that we engage our communities with integrity and transparency. We embrace our responsibility to promote health and well-being.

This implementation plan includes key evidence-based strategies designed to address health priorities determined in the Community Health Needs Assessment, but this plan does not exist in a vacuum. This plan strives to complement the work of community health needs assessment planning processes; the focus areas of our affiliated foundations in Greensboro and Alamance County; and Cone Health strategic goals. Careful stewardship of resources requires that we collaborate and communicate with these many sites of activity and effort, and best practices research teaches us that alignment of these multiple streams is necessary to meet our shared goals.

Cone Health Strategic Initiatives
Cone Health's strategic plan includes four domains: People, Culture, Access and Growth, and Patient Value. Community benefit guidelines, per the Affordable Care Act and IRS rules, distinguish between regular healthcare operations and activities that are deemed to be of community benefit. It is important to note that community benefit investments require resource commitments on the part of Cone Health that fulfill our organization's responsibilities to our community as a tax-exempt organization. Activities deemed to be of community benefit offer resources above and beyond standard care, such as programs to promote prevention of illness, or resolution of social, emotional and physical health needs. These activities are widely accessible to community members, many of whom may not even be patients of the health system. Before the shift in healthcare from volume to value, this regulatory distinction between healthcare operations and community benefit was clearer. As Cone Health continues its transformation to deeper investment in value-based care, community benefit activities and Cone Health's strategic initiatives grow ever more aligned.

There are multiple initiatives within Cone Health's strategic plan that reflect our commitment to promote health and well-being. They may be found in the Access and Growth domain, such as tactics to increase access to healthcare, integrate behavioral health into primary care, and improve social drivers of health. They may also be found in the Culture and Patient Value domains, with tactics that focus on health equity. Additional longstanding programs and commitments are detailed in the Continuing Programs section of this document. In addition, in 2019, Cone Health created the Community and Corporate Well-Being Division. This division includes leadership in Healthy Communities, Wellness, Corporate Well-being, and Health Equity, and will facilitate the strategic vision to focus our investment and impact in key drivers of health outcomes.

Focus Areas of Affiliated Foundations
Cone Health Foundation and Impact Alamance are supporting organizations of Cone Health with their own Boards of Directors, endowments, and focus areas to address critical health needs in Greensboro and Alamance County, respectively. Both foundations contribute resources and assistance to county-level community health assessment groups, participate in health-related coalitions, and help to spur innovation and collaboration in our communities. Our relationships are reciprocal; Cone Health employees also serve on boards and action teams to promote foundation goals.

- **Cone Health Foundation** works in four priority areas: access to health care; adolescent pregnancy prevention; HIV; and substance abuse and mental health. Key goals include the promotion of the integration of primary care and behavioral health care; prevention of primary and repeat teen pregnancy; increasing the proportion of people in Greensboro who know their HIV status and increasing the proportion of people with HIV who are in continuous care; and promoting access to evidence-based treatment for individuals with co-occurring substance abuse and mental health disorders.
- **Impact Alamance** has two strategic priorities: Healthy Kids and Healthy Communities. Healthy Kids focuses on investments in early childhood literacy and health, and in building healthy environments with sidewalks, trails, and opportunities for children and families to get moving and active; a signature initiative here is the Alamance County Wellness Collaborative. Healthy Communities focuses on bringing together multi-disciplinary teams to align resources and goals to strengthen educational outcomes. Launched in 2016 by Impact Alamance, Alamance Achieves facilitates these goals through a cradle-to-career collective impact network.

Priority Initiatives

Overview

1. Intent: Implement evidence-based strategies to address regional priorities
    a. Prevention of Chronic Disease, especially Diabetes
    b. Prevention of Addiction and Promoting Strong Mental Health
    c. Access to High Quality, Affordable Healthcare
    d. Promoting Living Conditions that Contribute to Health
    e. Eliminating Bias and Discrimination in Healthcare .

2. Intent: Strengthen local and regional collaboration between health and human service partners
    a. To improve our capacity to identify critical health priorities
    b. To implement effective strategies to improve population health.

Prevention of Chronic Disease, Especially Diabetes

Chronic disease is an important health priority. It affects a high volume of people, reducing quality of life and causing premature death. Our collective ability to combat chronic disease is indicative of our health system's capacity to transform from an episodic, "sick care" system to a comprehensive and coordinated network that provides the resources, support, education and living conditions that promote wellness.

Chronic disease refers to illnesses that persist for one year or more and require ongoing medical attention. The CDC has identified four risk factors (excessive alcohol use, poor nutrition, lack of physical activity, and tobacco use) as the major risk factors of the major chronic diseases (heart disease, cancer and diabetes).

A health system that is optimized to reduce chronic disease is able to provide information, lifestyle coaching, medical care, and other assistance to help people take action to reduce their risk of chronic disease. This involves experts in nutrition, physical activity, behavioral psychology and cultural competence working alongside traditional medical providers to promote adoption of healthy behaviors.

Outcome	**Process Goals**	**Partners**	**Lead Hospital(s) and Contributing Departments**
By 2022, increase opportunities for the community to access affordable physical and nutritional educational opportunities, especially in underserved areas.	– Expand access to evidence-based education for people recently diagnosed with diabetes or pre-diabetes. – Expand options in Cone Health food environment that promote and offer healthy choices. – Expand offerings of free, fun and accessible fitness and physical activity classes	Local health departments, faith leaders, YMCA, Rockingham County Diabetes Task Force, City of Mebane, local parks and recreation agencies	Alamance Regional Medical Center, Moses Cone Hospital, Wesley Long Hospital, Annie Penn Hospital, Community and Corporate Well-Being, Nutrition and Diabetes Education Services
By 2022, increase community access to evidence-based smoking cessation services.	– Expand availability of smoking cessation classes by providing telephonic options for cessation counseling. – Offer provider certification in tobacco cessation counseling.	American Cancer Society, local health departments	Alamance Regional Medical Center, Moses Cone Hospital, Wesley Long Hospital, Annie Penn Hospital, Cardiovascular Services, Cancer Centers

Eliminating Bias and Discrimination in Healthcare

Health disparities are defined as gaps in quality of health or health care. Many factors that affect health can have disproportionate effects on vulnerable groups, such as those with low socioeconomic status, women, racial and ethnic minorities, people who are disabled, and those who are LGBTQ. (*Health Affairs*, Vol 37, No. 3: Advancing Health Equity, March 2018). It is difficult to document incidence of bias itself, but our region's outcomes reveal the need to address it.

Approaching patients with an equity mindset rather than an equality protocol requires transformative change in healthcare. Physicians and other clinicians - including social workers and care managers - play a large role in determining which individual patients need which care variations to achieve equal health outcomes. Providers can learn to become more aware of their own bias and act to reduce it. Health systems can stratify their quality and safety data by race, ethnicity, and language preference to identify and eliminate disparities that may affect these groups.

Disparities are rooted in a history of discriminatory practices. Cone Health is committed to addressing these disparities by including community voices and fostering diverse leadership, sharing power in decision making, addressing root causes and social determinants of health, and establishing reliable measurements to achieve equity in health outcomes.

,

Outcome	**Process Goals**	**Partners**	**Lead Hospital(s) and Contributing Departments**
By 2022, partner with the community to increase access to health screenings for groups with identified disparities.	– Establish system response for persons in the community who experience barriers to participation in screenings, especially for colorectal, cervical and breast cancer.	local health departments, local interpreter agencies, churches and temples	Wesley Long Hospital, Women and Children's Center at Moses Cone, Cone Health Medical Group, Department of Health Equity, Medical Executive Committee, Women's Health Service Lines
By 2022, change clinical processes to respond to known disparities.	– Adopt a more inclusive blood pressure model for identifying hypertension in pregnant women. – Develop patient education to assess blood pressure after discharge, via a phone app. – Establish cultural competency CME instruction and attestation process for credentialled and employed physicians.	Greensboro AHEC, local OB providers, American Heart Association	

Prevention of Addiction and Promoting Strong Mental Health

Mental health disorders such as depression and anxiety are among the most prevalent chronic diseases in our community, affecting approximately 20% of adults. Nonetheless, because of cultural stigma and misunderstanding of the origins of mental health problems, many people are reluctant to seek help and lack knowledge of available resources. Addiction is also widespread across our region. The two most commonly used substances are tobacco (just under 20% of adults are smokers) and alcohol. Around 16% of adults in our region report having engaged in heavy drinking or binge drinking in the previous month. Around 28% of motor vehicle collisions involve alcohol. Opioids are less commonly used than alcohol and tobacco, but receive focus and attention because of the rapid increase in opioid misuse and because of their lethality. For example, of the 151 known overdoses in 2018 in Rockingham County, 24 were fatal.

Outcome	**Process Goals**	**Partners**	**Lead Hospital(s) and Contributing Departments**
By 2022, Cone Health increases access points for urgent and non-urgent behavioral health services.	– Construction of 24/7/365 Behavioral Health Crisis Center serving adults and adolescents in Guilford County – Integration of Behavioral Health services into primary care at additional sites in three counties; increase BH visits to comprise 10% of clinic visits at these sites	Guilford County Behavioral Health Crisis Collaborative, Guilford County, Sandhills Center, NC DHHS	Behavioral Health Hospital, Wesley Long Hospital and Alamance Regional Medical Center, Cone Health Medical Group, Congregational Nursing, Social Work, Marketing, Enterprise Project Management Office, Analytics
By 2022, Cone Health increases engagement in community initiatives to prevent opioid misuse and prevent mental health disorders	– Engage staff and resources with community-led initiatives in Guilford, Alamance, Rockingham to prevent and treat opioid use disorder – Improve process for appropriate Emergency Department patients to access new diversion center in Alamance County – Support implementation (in Guilford. Rockingham and Alamance counties) of Strong Minds, Strong Communities, a National Institute of Mental Health and UNCG project to reduce mental health disparities for racial/ethnic and linguistic minorities.	Alamance County Justice Advisory Council, UNCG, GC STOP, AC HOPE, Rockingham Opioid Task Force, local emergency medical services providers	

Promoting Living Conditions that Contribute to Health

The World Health Organization defines social determinants of health as "the conditions in which people are born, grow, work, live and age, and the wider set of forces and systems shaping the conditions of daily life." In practice, we think of these as fundamental living conditions that affect how we act, what we do, and what is readily available to us; these are issues such as housing quality, affordable transportation, and access to affordable healthy foods. We may be used to understanding our health outcomes as a result of knowledge, discipline, and attitudes. If we take a broader view, we can both help individuals to change their own behaviors, and work together to create positive community changes that will lead to healthier outcomes for all. If we focus on community conditions, we can make changes to neighborhoods, such as high quality housing, better lighting and security measures in the park, convenient and affordable nutrition access or new sidewalk construction that will benefit a larger number of people. Both individual and community change are essential. We are more familiar with individual change in healthcare, but community change represents a critical opportunity to collaborate with partners in business and economic development, public health, human services, planning, public safety, transportation and parks and recreation agencies to have greater impact on a larger scale. Our implementation plan includes initiatives to focus on individual outcomes by integrating social determinants into clinical care, and on community conditions through a multi-sector collaborative process.

Outcome	**Process Goals**	**Partners**	**Lead Hospital(s) and Contributing Departments**
By 2022, clinical services will more deeply integrate social needs into patient screening, diagnosis and treatment	– Develop standard work for social determinants screenings and NCCARE360 referrals. – Complete pilot projects in o Aging Gracefully (home repairs to prevent injury) o Asthma and Housing (removing housing-related triggers for children with asthma) o Food Access and Readmissions (targeting patients with food insecurity in addition to Chronic Obstructive Pulmonary Disease and End Stage Renal Disease) o Permanent Supportive Housing – Develop mechanisms for scaling promising pilots to serve larger numbers of patients and community members.	Unite Us, Community Housing Solutions, Greensboro Housing Coalition, Meals on Wheels agencies, Second Harvest, Out of the Garden project, local city and county governments	Moses Cone Hospital and Wesley Long Hospital, SDOH Screening Committee, Care Coordination, Patient Access, Congregational Nursing, Emergency Department, Behavioral Health, Revenue Cycle, LEAN Office, Analytics
By 2022, Cone Health will increase engagement in community partnerships to improve systems that promote resolution of	– Identify geographic areas where respiratory visits and housing quality are linked; work with property owners, advocates and cities to address housing concerns – Work with local transit systems to design improved and expanded	Invest Health Greensboro, UNCG, Greensboro Housing Coalition, local city and county	

high priority social needs: housing, transportation and food	services that provide access to health services, grocery stores, places of employment, and parks and recreation sites – Strengthen the local food system, using data from food insecurity screenings to identify areas of high need and processes to integrate local producers	governments, Piedmont Triad Regional Council	

Access to High Quality, Affordable Healthcare

For decades, Cone Health has been inspired by the vibrancy of our community, and by the generosity of Bertha Cone's founding gift to our health system on the basis that "No patient should be refused admittance because of inability to pay." Improving access to care is an important historic commitment of our organizations, and Cone Health provides hundreds of millions of dollars annually in unreimbursed healthcare, through Patient Financial Assistance and other programs. In recent years, we have begun to look more closely at the opportunities for care and barriers to care for community members in our geographic area. Initiatives such as the Guilford Community Care Network and Care Connect Rockingham seek to help community members with financial challenges to access high quality primary and specialty care, have annual wellness visits and immunizations, and participate in recommended preventive screenings, such as mammograms and colorectal cancer screenings. This targets our resources towards care that keeps people well, and helps to avoid preventable Emergency Department visits and hospitalizations. This goal has existed for Cone Health from its founding; we list below the new process goals, as well as our clinical sites and partnerships that have long-standing commitments to improving access to care.

Outcome	**Process Goals**	**Partners**	**Lead Hospital(s) and Contributing Departments**
By 2022, increase access to primary care for uninsured patients who face financial and geographical barriers.	– Map existing primary care access points (Cone Health and community partners) to determine geographic disparities in access. – Develop mobile clinical services plan to better serve areas without convenient local access – Expand patient base for Care Connect Rockingham and increase specialty care access for Guilford Community Care Network – Expand capacity at Open Door Clinic of Burlington after move to new building in 2021 – Review/revise financial assistance policy to streamline processes and help patients establish ongoing primary care relationships with local providers.	Local Federally Qualified Health Center (FQHC) agencies, free clinics, local health departments	Alamance Regional Medical Center, Moses Cone Hospital, Cone Health Medical Group, Patient Access, Revenue Cycle, Healthy Communities

Access to Clinical Care at Cone Health

All residents of our community may access Cone Health services regardless of ability to pay. Patients who are uninsured and need financial assistance may apply to Cone Health's financial assistance program, which includes discounts and other forms of assistance for those who quality. The following clinics and service lines have a historic and enduring commitment to providing care designed to serve patients for whom financial challenges affect access to healthcare and other health needs, such as food, housing and transportation.

- Behavioral Health Hospital
- Behavioral Health Inpatient Unit at Alamance Regional
- Care Connect Rockingham
- Clara F. Gunn Center
- Tim and Carolynn Rice Center for Child and Adolescent Health
- Community Health and Wellness Center
- Family Medicine Faculty Practice and Residency Program
- Internal Medicine Center and Residency Teaching Service
- Medication Management Clinic
- Patient Care Center
- Regional Center for Infectious Disease
- Renaissance Family Medicine
- Women's Hospital Faculty Practice

Community Partnerships to Improve Access to Care

Alamance Cares	Alamance Cares is focused on stopping the spread of HIV/AIDS and other sexually transmitted diseases through awareness, education, and testing in Alamance and surrounding North Carolina counties. Alamance Cares offers education and free HIV, hepatitis C and syphilis testing in Alamance, Caswell and Rockingham counties.
Alamance Eldercare	Eldercare envisions a community in which older adults and their caregivers have access to the resources and support needed to live full and independent lives. There is no charge for their services, which include care management, Community Alternatives Program (CAP-DA) for Medicaid - eligible adults with disabilities, family caregiver support services, connections to resources, and options planning. Alamance Eldercare offers evidence-based programs in falls prevention and caregiver support.
Congregational Nursing and Congregational Social Work Education Initiative (CSWEI)	Our Congregational Nursing program is a unique, specialized nursing practice established 15 years ago as a collaborative relationship between Cone Health and our area's faith communities. Our 48 Congregational Nurses promote harmony of body, mind and spirit in achieving and maintaining individual health with a focus on disease prevention and reducing health risk behaviors. The CSWEI partners social work students with Congregational Nurses to serve immigrants and refugees, older adults, and individuals and families who lack permanent housing. *Congregational Nurses and Social Workers continue to connect people to primary care providers, dispense free flu vaccinations (over 800 annually) and provide transportation and referrals for food and other services. They work with NC MedAssist to provide screenings and physical examinations at the spring and fall Over-The-Counter Medication Giveaway events, serving hundreds of community members.*
Free Clinic of Rockingham County	The mission of the Free Clinic of Rockingham County is to provide access to health care that compassionately meets the essential medical, dental and pharmacy needs of low income, uninsured citizens of Rockingham County. Annie Penn Hospital assisted The Free Clinic of Rockingham County in its

	transition to the Cone Health Link electronic medical record system. The Free Clinic has begun behavioral health integration and is a strong partner to the PENN Program and the Care Connect program.
Guilford Community Care Network	Guilford Community Care Network provides access to specialty care for the uninsured through their signature "Orange Card" program and works to promote utilization of primary care to avoid preventable ED utilization. GCCN has expanded its dental access program, and has additional specialty care programs in endocrinology and dermatology. Orange Card holders also have access to fresh produce weekly through a partnership with the Greensboro Farmer's Curb Market. GCCN celebrated 15 years in 2018, and is consistently rated among the most successful access-to-care networks in North and South Carolina.
Open Door Clinic of Alamance County	Open Door Clinic offers free primary care health services to uninsured residents of Alamance County. This helps to reduce the cost of healthcare by treating the uninsured for chronic and acute disease, preventing non-acute utilization of the Emergency Department. Open Door Clinic will move to a new facility in 2021, doubling its capacity to care for low income, uninsured patients. New services: adult dental access, on-site behavioral health counseling, endocrinology, ophthalmology, the Diabetes Prevention Program and collaboration with Medication Management Clinic to provide medication access.
PENN (People Engaged in Neighborhood Nursing)	PENN Program nurses engage the faith communities in Reidsville, NC and Rockingham County to provide outreach, education, and screenings to immigrants and refugees, older adults, and individuals and families who lack permanent housing. PENN nurses have been instrumental in connecting people across Rockingham to services, through their outreach at agencies such as the Salvation Army and Lot 2540. PENN supports the Clara F. Gunn Center at the New Reidsville Housing Authority.

Cross-Cutting Initiatives

Intent: Strengthen local and regional collaboration between health and human service partners to improve our capacity to identify critical health priorities and implement effective strategies to improve population health.

Our region possesses many wonderful assets, including dedicated leaders, diverse cultures, abundant natural resources, and forward-thinking business and industry. We also have considerable concerns about our region's quality of life and prosperity, and a commitment to improving opportunities and outcomes for all. Health systems have a critical role to play in bringing together partners for collaborative brainstorming, resource sharing, and problem-solving. It is our belief that building stronger networks is a key strategy for quality improvement.

As we work toward identifying and screening for the social needs in our community, it is essential to have robust systems of response that offer reliable and effective services to referred persons who require non-clinical remedies to help them meet their clinical goals. Developing networks through the Healthy Opportunities Pilot boosts our community's ability to continue building our network of agencies to address the social determinants of health identified through Medicaid Transformation. NCCARE360 is a promising online referral platform which relies on adding resources to be successful.

We have also identified a need for better local health data, and none of our counties can accomplish its work without making improvements in this area. Because of changes to the NC DHHS survey methodology, we lack local health data on key metrics, such as obesity, physical activity, smoking rates, and other prevalence rates. By working together, we can pool resources to develop local information systems, and have developed Piedmont Health Counts to collect local data and track progress on collective action plans.

We also recognize the need to train together on new methods of accomplishing population health goals, to move us towards improved methods of developing strategies that will truly move the collective needle. While Alamance and Rockingham counties are of a population size that allows for efficient collaborative creation, Guilford's many resources create pockets of activity that may not always be connected. We will devote time and effort toward creating partnerships that allow us to have a collective impact on well being in our community.

Outcome	**Process Goals**	**Partners**	**Lead Hospital(s) and Contributing Departments**
By 2022, regional partners in the Triad will increase capacity for integration of health and human services sectors.	– Increase the active users and agencies engaged in NCCARE360 – Conduct annual seminar on priority topics and innovation in community health and human services. – Develop Healthy Opportunities Pilot and implement integrated services	Unite Us, NC DHHS, local United Ways agencies, local Human Service Agencies, Piedmont Triad Regional Council	Community and Corporate Well-Being, Care Coordination, Analytics, Cardiovascular Services, Behavioral Health, Lean Office, AHEC
By 2022, regional partners in the Triad will increase capacity to have meaningful data	– Expand and enhance access to local health data, to provide county-level health data across our region and guide data-driven accountability and decision-making.	NC DHHS, Duke Endowment, local health departments, UNCG, Greensboro	

that drives decision making and intervention design.	– Develop connections and capabilities internally to Cone and with community partners (such as Guilford Community Indicators Project, statewide data project for Community Health Assessments) – Generate and analyze data to evaluate progress on identified social determinants of health	Community Foundation, United Way agencies	

Outreach and Education Programs

Cone Health works throughout our communities to provide speakers, information, navigation and prevention activities that promote healthy mind, body and spirit.

A Message and a Meal	In partnership with St. James Presbyterian Church in Greensboro, Cone Health offers a free hot meal, and health education every Sunday afternoon. Since its inception in October 2015, we have provided over 7000 meals and hundreds of screenings (blood glucose, blood pressure, HIV) as well as on-site links to primary care appointments. Partnerships with the Kellin Foundation, Out of the Garden Project, Renaissance Family Medicine and other local care providers bring weekly health education, services and fellowship to our neighbors.
Be Healthy Now	Be Healthy Now (BHN) has grown over the years from a 9-week wellness program to a year-round wellness community. In 2016 and 2017, people participated in the 9-week wellness programs as teams or individuals. Registered participants attended lectures, fitness classes, and events to keep up with a point system that was rewarded with prizes for achieving their goals. In 2018, BHN became a year-long program that provides more options to promote healthy eating, active living, and stress reduction. BHN now provides free fitness activities almost every day of the week. Since 2018, BHN has increased its outreach to the LatinX community by creating bilingual materials and hosting events in places where this community feels comfortable. BHN coordinates two weekly exercise classes, Zumba and Soul Line Dancing, in local community centers, with an average attendance of 30, and monthly nutrition and cooking classes.
Educational Events	Cone Health offers educational opportunities to the broader community on a variety of health topics. Opportunities include physician/provider lectures, mental health education series, Wellness-on-Demand videos, etc.
Elon Service Year Fellowship	The Elon-Alamance Health Partners (EAHP) program and the Kenan Community Impact Fellows, a partnership between Elon University and Alamance Regional, offers recent Elon graduates the opportunity to engage in one year of meaningful service work to improve the health of residents in Alamance County. Fellows receive strong mentorship and take on leadership roles at Alamance Regional, the Alamance County Health Department, Healthy Alamance, and Impact Alamance. The Elon Service Year Fellowship has 20 alumni, 13 of whom are living in NC, and all of whom have continued in health and human services careers. Four alumni have entered medical school, and eight are currently in graduate programs in North Carolina in nursing, public health, planning, social work and public administration.
Free and Low Cost Health Screenings	Provides free or low cost screenings (breast, cervical, prostate, and skin cancers; vascular disease; diabetes; obesity; cholesterol; blood pressure; low dose CT for lung cancer) for those in the community that do not have health insurance coverage, a medical home, and/or access to medical providers.

Project Search	The Project Search High School Transition Program supports students with significant intellectual disabilities to gain competitive, marketable and transferable skills to enable them to apply for employment in our community after graduation from high school. Project Search interns are supported by a special education teacher, job coaches and Cone Health employees as they complete rotations in hospital departments.
QuitSmart Smoking Cessation	A free four-session class that utilizes the QuitSmart methodology and materials, plus personalized coaching offered to the community in both lunch and evening sessions.
Safe Kids	Safe Kids has the primary goal of keeping children safe. Safe Kids works to reduce preventable injuries from motor vehicles, sports, drownings, falls, burns, and poisonings with the right education, awareness and planning. Safe Kids Alamance County and Safe Kids Guilford aim to educate children and their families on preventable childhood injuries. They coordinate the community to provide car seat checks, bike rodeos and pedestrian safety, medication safety through Operation Medicine Drops, fire safety with our local fire departments, and hyperthermia awareness through hot car displays and outreach education. They provide home safety resources for families that may need baby gates, a safe sleep place for their newborn, outlet covers, and TV and furniture tip-over wall brackets.
Support Groups	Cone Health offers support to members of our community experiencing the following: – Alzheimer's and Related Disorders – Amputee Support – Arthritis – Bariatric Surgery – Birth of a Baby – Brain Injury – Cancer: Breast Cancer, Cancer Transitions, Community Cancer Survivorship Series, KidsCan, Prostate Cancer – Heart Disease – Ostomy – Parkinson’s Disease – Stroke

Community Networks to Promote Health

Collaboration with community partners, government and nonprofit agencies, activists and volunteers are essential to accomplishing our goals and fulfilling our commitment to promote health and well-being. Our implementation plan includes continued, active service on the following coalitions. Each of these coalitions features inclusive and diverse membership representing engaged local and regional service providers, and each coalition has either a strategic plan or action plan, in which Cone Health is an active participant.

Alamance Achieves	Alamance Achieves began convening community leaders in 2015 to improve our community's "power grid" of successful programs focused on children's health and educational outcomes. This cradle-to-career network establishes shared metrics, accountability systems, and continuous improvement processes to identify what works in Alamance County and expand this to reach all children. Alamance Achieves has moved from concept to implementation, establishing a steering committee, a Community Transformation Council, hiring its team, and publishing a baseline report in 2018 on the community's common goals from cradle to career. Alamance Achieves has launched the kindergarten readiness network to focus on early childhood developments. In spring 2019, community partners launched Ready Freddy – an eight-week program that aims to support families as they prepare for their child's successful transition into school.
Alamance Network for Inclusive Healthcare	The Network brings together agencies within Alamance County who provide medical care to low-income, uninsured, and vulnerable populations. Through a collaborative effort, the group works to minimize barriers that inhibit access to comprehensive, quality health care services in order to improve the health of uninsured and underinsured residents of the community. The Network developed a strategic plan in 2017 based on two goals: increasing residents' access to affordable transportation, and better coordinating care between our agencies. Advocacy brought extended bus hours, a new bus shelter, and a sidewalk linking the shelter to local safety net practices. Members pooled resources to establish adult dental access. The network is currently focused on implementation of NCCARE360 in Alamance County and integrating social drivers into clinical care.
Alamance Racial Equity Alliance	The Alamance Racial Equity Alliance is a community of anti-racist people that encourages the transformation of thought through collective learning, meaningful relationships, and community events. The goal is to end racism. AREA offers four sessions of the Racial Equity Institute Phase 1 training annually, and the Groundwater presentation at least once a year. Hundreds of Alamance County leaders have participated in this important experience. Members gather monthly to explore ways to work together to end racism.
Alamance Wellness Collaborative	The Wellness Collaborative is a multidisciplinary coalition convened by Impact Alamance and Healthy Alamance that works to implement built environment strategies and policy changes, such as developing more sidewalks, bike paths, trails, and greenways, to increase physical activity

	and provide better access to healthy foods. The Alamance Wellness Collaborative has had numerous accomplishments since 2016. Some of the most notable include the implementation of the community use policy for school playgrounds; creation of tobacco free policies in Graham, Mebane, Elon and Burlington; adoption of Health in all Policies Resolutions by the cities of Burlington and Elon; an increase in the number of bike lanes, trails and greenways in Mebane, Burlington and Elon.
Be Healthy Rockingham	Be Healthy Rockingham brings together health agencies, community organizations, businesses, and concerned citizens who work together to improve access to high quality nutrition, opportunities for physical activity, and smoke-free environments. Be Healthy Rockingham assisted in establishing the West Rock Farmers' Market, and supported the acceptance of SNAP/EBT payment. They have collaborated with 15 organizations to develop the Be Healthy Rockingham community- wide campaign for healthy eating and active living. In collaboration with the Dan River Basin Association, Be Healthy Rockingham has offered an "Adventure Series" with activities like trails, tubing, and bicycling for all ages and experience levels.
Central Carolina Health Network	Central Carolina Health Network is a leader in reducing the spread of HIV through education and prevention, expanding access to quality care for those persons living with HIV/AIDS. CCHN has expanded services into Alamance County, with improved access to specialty care. There are additional testing and counseling options available in Rockingham, and stronger housing programs in Guilford.
Community Action for Healthy Babies (Guilford County)	CAHB is a consortium of local agencies working to ensure that all women in Guilford County have access to and utilize healthcare before, during, and after pregnancy; and their babies are born at a healthy birth weight. CAHB has grown in participation, and was asked to advise national leaders working to develop the Get Ready Guilford Initiative. The CAHB worked with Greensboro AHEC to offer a day-long continuing education program on perinatal mood disorders, and is currently developing a new strategic plan.
Greensboro Health Disparities Collaborative	The mission of the Greensboro Health Disparities Collaborative is to establish structures and processes that respond to, empower and facilitate communities in defining and resolving issues related to disparities in health. GHDC implemented the ACCURE Study at the Cone Health Cancer Center and in Pittsburgh, PA, to address implicit bias in healthcare that results in inequitable treatment outcomes for black and white cancer patients. ACCURE processes eliminated the racial disparity in lung cancer outcomes and improved rates of treatment completion for black and white patients. These protocols are now being solidified and expanded at Cone Health. GHDC also provides community education and conducts research designed to empower community members to eliminate health disparities.
Healthy Alamance	Healthy Alamance is a partnership between Alamance County Health Department and Alamance Regional, whose mission is to mobilize resources to develop and support a healthy, nurturing community. Healthy Alamance envisions an Alamance County in which everyone has the

	opportunity to be their healthiest and happiest. Healthy Alamance has fostered two successful coalitions, one focused on improvements to the built environment to foster health eating and active living, and the other to build a just local food system. Healthy Alamance has promoted the Authentically Alamance brand to promote the local economy, managed and grown the North Park Farmer's Market, sponsored a Black Entrepreneur's Collective, and a health equity coalition.
Collaborative Cottage Grove	Collaborative Cottage Grove brings together primary care providers, community health workers, housing advocates, university researchers, and community activists and residents to improve management of chronic disease, neighborhood housing and economic conditions in the Cottage Grove community in Greensboro, NC. The Cottage Grove Collaborative received funding from BCBSNC Foundation's Community-Centered Health program and the BUILD Health Challenge 2.0 and 3.0 to address structural issues that created a heavy burden of asthma and diabetes in the Cottage Grove neighborhood. Partners successfully advocated for improvements in housing quality, playgrounds, bike lanes, and a healthy homes program for children with asthma. HUD Secretary Ben Carson, MD visited the community in 2018 to kick off Healthy Homes month, and the group's work was featured on PBS NewsHour.
Ready for School, Ready for Life	This collaborative effort brings together the whole community to create an innovative early childhood system that's responsive to the needs of families today and in the future. Goals include connecting parents with resources, driving continuous improvement across the system, expanding early literacy resources, and ensuring that service providers are responsive to family voice. In 2018, Guilford County's Get Ready Guilford Initiative was selected for a $32.5 million multi-year investment from Blue Meridian Partners to pilot and grow an initiative to improve outcomes for children. This will expand three existing and proven programs that serve families prenatally through age 3 (Guilford Family Connects, HealthySteps and Nurse-Family Partnership); develop a navigation system to connect families with effective services prenatally through age 3; and work with local programs in a Continuous Quality Improvement (CQI) effort to build capacity for using data in service delivery and decision-making.
Rockingham County Diabetes Task Force	The Task Force consists of area healthcare providers, educators, and advocates dedicated to identifying pre-diabetics and individuals diagnosed with Type 2 Diabetes, as well as improving resources, access to health care, and overall quality of life. The Diabetes Task Force of Rockingham County is responsible for bringing together all the providers in the county focused on decreasing long-term complications from diabetes and improving the lives of those living with the disease. The task force continues to hold the yearly Rock Your Health wellness fair with well over 200 participants. In the coming year, the task force will have its first annual Camp Oakhaven and will give children living with diabetes the opportunity to learn about their condition, grow personally, and improve their health.