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2022 Community Health Needs Assessment Implementation Plan 2023 - 2025

Overview

A Community Health Needs Assessment offers a snapshot of health and well-being in a locale, region, state, or other geography. In the assessment's chapters, you will read about this current state in the Cone Health service area with a primary focus on the counties where the health system has multiple facilities. The 2022 Community Health Needs Assessment (CHNA) includes data, statistics, and community voice.

This year, Cone Health collected primary data via community surveys and individual community interviews. For the survey, Cone worked with a local research firm to conduct a community survey with 650 people in Guilford, Alamance, and Rockingham counties. The questions were different from prior years in that we attempted to understand the why, versus simply the what.

You will also see insights from individual interviews with over 50 people, who spoke to us on a very personal level about their lives and health. Many of the interviews lasted an hour and began with a question about what respondents find most challenging. Food and housing are top of mind for most and are the two primary factors that impact people's ability to manage their health and well-being. The challenge then becomes interpreting what it all means and how we work together with the community to address identified needs through a health equity lens.

Health inequities occur when people cannot achieve optimal health because of unjust and avoidable conditions, such as barriers to food, transportation, housing, and health care. Because of the practices that flourished, minority communities and historically marginalized populations continue to experience higher rates of illness and death from heart disease, diabetes, hypertension, and other chronic diseases (Yancey-Bragg, 6A). Achieving health equity requires recognizing and addressing a confluence of factors that are complex to untangle. While the relationship between health disparities and historical barriers in education, employment, wealth, and housing can be difficult to unravel, they are also readily identifiable in the lived experiences of our patients and community members.

Below is a crosswalk of Cone Health's priorities and each counties' focus areas from their most recent assessment. Cone Health leaders and community members considered the priorities in each county across the region, as well as input from the individual community interviews and survey, to develop Cone Health assessment priorities that are inclusive of the community priorities. Table 6 depicts the ten community priorities (left hand column) and five Cone Health priorities (top column).

In this assessment, we took a close look at some of the most substantial and important disparities in our geography. They are significant because the data shows material differences in rates of disease, income, access to needed services and more. They are important because these disparities influence and impact both the quality and length of life. There is no health-related issue more urgent than rectifying the current situation, where social factors are so influential that they determine the health and life expectancy of our friends, families, and neighbors. The following implementation plan seeks to address the amalgam of responses that will impact life expectancy and the five drivers of life expectancy.

The Implementation Plan for 2023 – 2025 is a bold step toward offering a combination of immediate remedies and audacious goals. Ideally, approaching our community's needs from every angle will be what changes the landscape of health for people in a significant way.

Source: Yancey-Bragg, N. (July 28, 2021). Results vary on racism declarations: Hundreds of cities deemed issue a public health crisis. Times-News, 6A.

Table 6. Crosswalk Between Priority Areas Identified in Alamance, Guilford and Rockingham County Assessments and Priorities Identified in the Cone Health Community Health Needs Assessment					
	Deliver Holistic Treatment and Upstream Prevention of Chronic Disease, especially Diabetes and Heart Disease	Ensure Access to Appropriate Behavioral Health Services	Provide Healthcare that is Available, Accessible, and Affordable	Promote Healthy Living Conditions by Addressing Social Determinants of Health	Eliminate Bias and Discrimination to Build Trust with Patients and Community
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 Use Disorder: Opioids		x	x		x
Physical Activity and Nutrition: Diabetes	x		x	x	
Social Determinants of Health: Education				x	x

Deliver Holistic Treatment and Upstream Prevention of Chronic Disease, especially Diabetes and Heart Disease

Heart disease and cancer, along with other chronic diseases, remains an important health priority. They affect a high volume of people, reduce quality of life and cause premature death, some of which is preventable. The major chronic diseases (heart disease, cancer, diabetes) share common risk factors – excessive alcohol use, poor nutrition, lack of physical activity, and tobacco use (CDC). In many cases, taking measures to address these four risk factors offer benefits to prevent other less deadly chronic diseases.

Our collective ability to combat chronic disease and promote wellness through a comprehensive and coordinated network that provides resources, support, education, and safe living conditions is the keystone for transformation from episodic sick care to a value-based system of care. A health system that is optimized to reduce chronic disease recognizes the necessity to remove the barriers to care. This involves an individualized approach that meets the patients where they are, as well as systemic solutions that help people with accessibility, availability and affordability of the health care that allows them to take action to reduce their risk of chronic disease.

Identified Need	Tactic(s)	Community Partner(s)	Hospital Lead and Contributing Department(s)	Outcome(s)
By 2025, reduce blood pressure disparity between adult African American and White patients with hypertension.	• Monitor Blood Pressure Protocol Competency • Develop Hypertension Management • Track weekly compliance for the Elevated BP protocol • Monitor number or percent of referrals to the hypertension clinic	Rockingham County Diabetes Task Force, GCCN, Care Connect, Open Door Clinic	Cone Health Medical Group (ambulatory clinical sites, particularly those delivering primary care)	By 2025, the blood pressure disparity between adult African American and White patients with hypertension is less than 5%.

Ensure Access to Appropriate Behavioral Health (BH) Services

This issue remains important because of the relationship of mental health to a person's overall physical health and his/her fundamental sense of well-being and meaning. In recent years, greater attention has been given to understanding mental health and its interaction with other health conditions. For example, maternal health advocates have elevated our awareness of issues such as post-partum depression, to improve early diagnosis and access to treatment. Specialists in many disciplines, such as cardiology and endocrinology, recognize the complex interactions between mental health and heart disease, diabetes, and obesity. This issue is also important because of the growing numbers of people who are diagnosed with behavioral health disorders.

Identified Need	Tactic(s)	Community Partner(s)	Hospital Lead and Contributing Department(s)	Outcome(s)
By 2025, Cone Health increases access points for urgent and nonurgent behavioral health services.	Integration of Behavioral Health services into primary care at identified sites in three counties.	Guilford County Behavioral Health Crisis Collaborative, Vaya, Sandhills Center	Cone Behavioral Health Department, Alamance Regional Medical Center, Cone Health Medical Group, Congregational Nursing, Social Work, Data Analytics	Increase BH visits to comprise 10% of clinic visits at three identified sites
By 2025, Cone Health increases engagement in community initiatives to prevent opioid misuse and respond to mental health disorders	• Engage staff and resources with community-led initiatives in Guilford, Alamance, Rockingham to prevent and treat opioid use disorder. • Select a representative to serve on JAC in Alamance and engage with Rockingham's mental health assessment. • Create a process for appropriate Emergency Department patients to access new diversion center in Alamance County.	Alamance County Justice Advisory Council (JAC), UNCG, GC STOP, AC HOPE, Rockingham Opioid Task Force, local emergency medical services providers, local health departments, Guilford and Rockingham County Post Overdose	Cone Health hospitals, particularly ARMC & Annie Penn, Cone Health Behavioral Health, Emergency Departments	Decrease in overdoses for all opioids by 5%, per Trends in Emergency Department (ED) Visits (as measured by CDC dashboard). Reduce overdose deaths to 20.7, per Healthy People 2030.

	• Support implementation (in Guilford. Rockingham and Alamance counties) of Strong Minds, Strong Communities	Response Teams (PORT)		Reduce mental health disparities for racial/ethnic and linguistic minorities.
By 2025, decrease the documented discrepancy between need and utilization of mental health services in Latino Families.	• Provide cultural-sensitive assessment and Interventions for ADD and ADHD to Latino youth and their families. • Identify/increase bilingual and bicultural mental health providers. • Facilitate relationships and educational opportunities to overcome negative beliefs and emotions related to mental health services, distrust toward providers, and lack of knowledge related to mental illnesses.	ABSS, Vaya, Sandhills Center, area mental health service providers	Cone Health Behavioral Health providers, Rice Center for Children	Increase in Latino parents who seek out professional mental health services for their children.

Source:
Schneider, Brian W., "ADHD Problem Recognition for Latino Parents: The Role of Cultural Factors and Parental Cognitions" (2012). Dissertations (1934 -). 216. https://epublications.marquette.edu/dissertations_mu/216

Provide Healthcare that is Available, Accessible, and Affordable

Health equity is achieved when every person has the opportunity to "attain his or her full health potential" and no one is "disadvantaged from achieving this potential because of social position or other socially determined circumstances." Health inequities are reflected in differences in length of life; quality of life; rates of disease, disability, and death; severity of disease; and access to treatment" (CDC). Value-based care is predicated on the ability to improve equity and eliminate disparities. Ultimately, this means digging in to remove barriers to care and offer remediation for the social determinants of health that prohibit well-being.

Identified Need	Tactic(s)	Community Partner(s)	Hospital Lead and Contributing Department(s)	Outcome(s)
By 2025, increase access to primary care for uninsured patients who face financial and geographical barriers.	• Review/assess mobile clinical services to serve areas without convenient local access • Expand patient base for Care Connect Rockingham • Increase specialty care access for Guilford Community Care Network clients • Expand capacity at Open Door Clinic of Burlington • Develop a centralized resource for patients and our communities to connect with Cone Health (24/7/365 access; digital health). • Address preventable delays in care for uninsured patients and improve access to specialty care for uninsured patients. • Provide medical care to students by expanding school telehealth in Greensboro	Local Federally Qualified Health Center (FQHC) agencies, free clinics, local health departments, Guilford County elementary schools, area churches and neighborhood associations	Alamance Regional Medical Center, Moses Cone Hospital, Annie Penn Hospital, Cone Health Medical Group, Cone Health Community Care and Residency Clinics, Patient Access, Revenue Cycle, Healthy Communities Steering Committee, Cone Health ITS	Increase number of unique patients Increase in number of uninsured patients who are seen by a Primary Care Provider Improve access to specialty care for uninsured patients Increase in # of digital engagements Decrease in ED visits for uninsured patients # of Title 1 elementary schools providing school telehealth

				Decrease in ED visits for school-aged children
By 2025, partner with the community to increase access to health screenings for groups with identified disparities.	• Establish/review system response for persons in the community who experience barriers to participation in screenings, especially for colorectal, cervical and breast cancer. • Create schedule of mobile cancer screenings at community sites where there are known disparities. • Increase visibility of BCCCP and other free/low-cost programs for uninsured and underinsured.	Area churches and neighborhood associations	Mobile Medicine Program, BCCCP	Increase in number of cancer screenings for populations who experience disparities
By 2026, establish Health Hub in the Chavis Public Library.	By June 2024: Deploy a team that includes a social worker, 3 community health workers (CHW), 1 Advanced Practice Provider (APP) and 1 behavioral health therapist. Upfit Chavis Library Launch Health Hub Programming, including telehealth, mobile medicine, and other services Begin remote patient monitoring By June 2025: Recruit additional APP and 3 CHW Create medical exam room at Chavis and parking pad for Mobile Medicine vehicles By June 2026: Gather input from community about existing and future services Launch Cone wellness, nutrition and exercise programs, and purchase medically approved fitness equipment, at the new	Triad Adult & Pediatric Medicine (TAPM), GCCN, Mustard Seed Clinic, City of Greensboro Public Libraries and Parks & Rec	Ambulatory & MedCenter Administration, Center for Health Equity, Mobile Medicine Program	Increase in # of digital engagements Reduce blood pressure control disparity between adult African American and White patients with hypertension from 68.6% to 71.9%. Increase % of people connected to a provider, from 78.3% to 82%. Decrease % of people with HTN >140/90, from 35.4% to 27.9%.

	Windsor Chavis Nocho Community Complex Launch healthy lifestyle and related speaker series			Increase % of people screened for diabetes, from 23.8% to 31.8%.
By 2025, offer pharmacy services that are accessible and affordable for uninsured/underinsured patients.	• Contract with TAPM in new Community Health & Wellness Pharmacy location to ensure access for TAPM patients • Implement Atlas ~~product~~ to screen, identify and connect patients with external medication and financial assistance resources • Use low-cost formulary for uninsured and underinsured patients	TAPM	Retail and Specialty Pharmacy Services, Oncology Pharmacy, ITS, Revenue Cycle	# patients receiving either medication access or direct funding $ amount of financial assistance benefit provided to patients

Promote Healthy Living Conditions by Addressing Social Determinants of Health

A conversation about health and well-being must include conversations about the deep-rooted causes, including redlining, policies of segregation, and other forms of racism that still exist today. The entanglement of education, income and wealth, and the subsequent disparities that occur with the lack of these resources, is a telling example about the need to weave in solutions for these community inequities with interventions designed to improve health and well-being.

	Tactic(s)	Community Partner(s)	Hospital Lead and Contributing Department(s)	Outcome(s)
By 2025, clinical services will more deeply integrate social needs into patient screening, diagnosis, and treatment	• Utilize, grow, and mature the application of NCCARE360 to connect SDOH partnerships. • Create a dashboard that aggregates population health data to inform tactical response to targeted outcomes based on identified areas of key focus. • Develop a Healthy Communities Steering Committee to develop and provide a structure and infrastructure that will leverage existing offerings for expansions, enhancement, and prioritization of initiatives.	Unite Us, Foundation for Health Leadership & Innovation (FHLI), Policy and Impact Center	Care Coordination, Transitions of Care, Social Work Patient Access, Congregational Nursing, Behavioral Health, Revenue Cycle, Data Analytics, Center for Health Equity	# of newly enrolled/trained partners who provide and connect patients to resources that address SDOH # of SDOH screenings completed # of referrals made by social work and case management # of referrals closed by community partners
By 2025, increase opportunities for the communities to access affordable physical, nutrition, and nutritional educational opportunities, especially in	• Partner with strategically located area churches and neighborhood organizations to create sustainable pop-up food programs. • Use model at Sagewell to replicate in underserved areas.	Invest Health Greensboro (housing), UNCG, Greensboro Housing Coalition, local city and county governments,	Congregational Nursing, Center for Health Equity, Brito Food Program	Increase in number of churches/neighborhood organizations who operate self-sustainable food programs and nutritional education offerings. Creation of Chavis Center Hub.

underserved areas.	• Work with community partners to offer relevant nutrition education classes - in strategic locations.	Piedmont Triad Regional Council, neighborhood associations, Area Health Departments		
By 2025, offer patients with complex housing and other issues an avenue to obtain no-cost legal services.	• Create medical-legal services to offer eligible patients • Assist with loss of housing/eviction/poor housing conditions/appeals for benefits/assistance with applying for Medicaid • Assist patients applying for disability	Legal Aid	Center for Health Equity, Care Managers, Social Workers and Care Guides	Reduce emergency visits and readmissions for patients who are experiencing housing issues
By 2025, provide equitable transportation services so that patients are able to obtain necessary health services.	• Ensure that oncology patients receiving treatment at Cone Health Cancer Centers are screened for transportation needs and connected to services as needed • Utilize Uber Health for ambulatory patients without resources who require non-emergency medical transportation • Connect patients with managed Medicaid plans to plan-based transportation benefits	Local transportation providers and vendors, Managed Medicaid transportation providers, local taxi and public transportation systems	Cone Health Cancer Centers, Cone Health Community Care and Residency Clinics, Center for Health Equity	Contribute to reduced Length of Stay (LOS) from 3.40 to 3.30 days Contribute to an increase in virtual visits from 56,837 to 57,962. Decrease no-show rate for patients referred to a PCP who have transportation barriers

Eliminate Bias and Discrimination to Build Trust with Patients and Community

If we connect these pieces, we must recognize that there are deep generational influences that divide those who had 400 years of intergenerational transfer of wealth and those who experienced racism and discrimination for 350 of those years. We must acknowledge the reality of the trajectory these circumstances created for many people and address the real issues that improve health and well-being. It is through this lens that we should consider how we weave these dynamics into our transformation to value-based care.

Identified Need	Tactic(s)	Community Partner(s)	Hospital Lead and Contributing Department(s)	Outcome(s)
By 2025, create a systems response to ensure healthcare interactions that are culturally sensitive and help develop trust	Increase % of staff who can articulate the "why" of health equity goals and buy-in on its importance 100% of employees who offer patient care will complete anti-bias and cultural competence training by end of FY 2023 Implement new DEI microlearning curriculum for clinical staff in 2nd quarter Deploy a monthly DEI leader toolkit to 100% of patient care leaders Jan 23 – Dec 23	Racial Equity Institute, Guilford Health Disparities Coalition	DEI, HR, Managers, Talent Acquisition, People and Culture, Hiring Panels, Center for Health Equity	Reduction in the number of patients who report negative experiences in patient satisfaction survey Reduction in the number of negative experiences reported to the Office of Patient Experience from African American, Hispanic/Latino, Asian and patients who are more than one race, as well as patients who have experienced bias during their care
By 2025, change clinical processes to respond to known disparities.	Institute earlier pharmacy interventions once a patient is diagnosed with prediabetes: o Metformin early o Dietary changes (Diabetes Center/Nutritional Center referrals) Remove barriers to medication access and access to monitoring supplies for patients once diagnosed with diabetes: o Access to longer acting insulin analogues for all, especially socioeconomically challenged.	Alamance, Guilford and Rockingham Health Departments, GCCN, Care Connect, Open Door Clinic	Mobile Medicine, CHMG Practices including physicians, nurses and other personnel; pharmacists CHMG practices: Western Rockingham Family Medicine Community Health & Wellness	Decrease ED visits (from 1.46 visits to 1.25 visits) and admissions (from .54 IP stays to .25 IP stays) for black and brown patients diagnosed with prediabetes and diabetes. Optimize therapy(ies) to achieve <140/90 blood pressure.

	o Find the most convenient, tailored medication for diabetics so control is easy. o Take on the process of qualifying our patients for medication vouchers and increase access through Medicaid qualification. o Help patients enroll in Medicare Part D. Engage CHMG practices in pharmacist intervention to optimize therapy for hypertension.		MC Family Medicine Clinic LeBauer Green Valley	

Other Emerging Issues:

The number three driver of life expectancy is homicide. Also prevalent in the Alamance County community discussion was violence in schools, bullying and guns. While this topic was not a large part of the assessment, it is clearly top of mind for many people. It is critical that Cone Health be "at the table" and partner in each of our communities to address this highly visible and devastating cause of death.

Identified Need	Tactic(s)	Community Partner(s)	Hospital Lead and Contributing Department(s)	Outcome(s)
Partner with local governments to expand Community-Focused Violence Intervention and Prevention Program	Provide internship support for community outreach for CVPI program Explore potential to create trauma counselor position at Moses Cone Hospital	City of Greensboro (Police Department)	Center for Health Equity Trauma Service at Moses Cone Hospital	Increased awareness of the prevalence and impact of gun violence on local community
Address violence and bullying in schools, and gun violence in the community.	Partner with Alamance County community groups to connect those interested with existing initiatives and programs.	CHNA community group, Burlington PD, ABSS	Center of Health Equity	Increased awareness of the prevalence and impact of gun violence on local community