2013

Community Health Needs ASSESSMENT

HIGH POINT REGIONAL
UNC HEALTH CARE

Our Vision

High Point Regional Health, with our partners, will provide the highest quality, cost-effective, patient-centered care to promote the health and well-being of the people of the communities we serve by:

Being the health care organization of choice for integrated health services across a seamless continuum of care;

Being the recognized leader in the provision of the highest quality value based health care;

Attracting and retaining talented employees, physicians and volunteersdedicated to delivering exceptional patient experiences.

Our Mission

To provide exceptional health services to the people of our region.

Our Values

Teamwork, Compassion, Integrity

HIGH POINT REGIONAL
UNC HEALTH CARE

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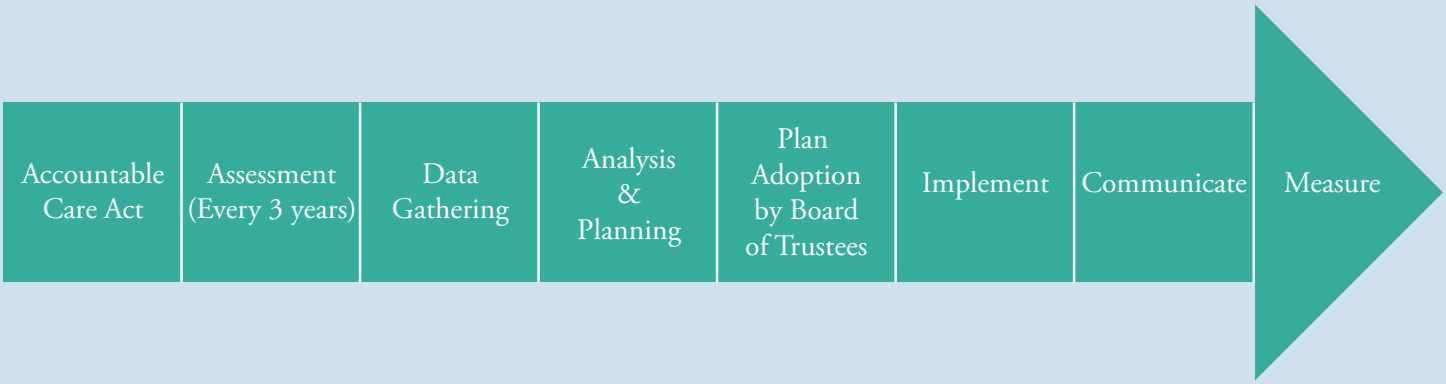
Why is High Point Regional Assessing the Health Needs of Our Community?

As a part of the federal Patient Protection and Affordable Care Act, the IRS requires each non-profit (Section 501(c) (3)) hospital to conduct a community health needs assessment (CHNA) every three years. In 2013 Guilford County Department of Public Health (GCDPH), High Point Regional Health and Cone Health collaborated to fulfill this requirement. With guidance from University of North Carolina at Greensboro's Center for Social, Community and Health Research and Evaluation (CSCHRE), these three collaborating partners used a participatory approach to document the health status of residents and the availability of resources in Guilford County, North Carolina.

The purpose of this effort was to collect data on health needs within the county, identify priority health issues and produce potential recommendations to address these needs. Ultimately, High Point Regional wants to ensure our efforts are directed at the health issues that are most pressing in the communities we serve. And, this is the right thing to do for the people in these communities.

This diagram shows the steps followed in the Community Health Needs Assessment



High Point Regional defines its primary service area at the zip code level, encompassing the greater High Point community, including Archdale and Trinity, plus Jamestown and other southwestern portions of Guilford County, North Carolina.

This report is a summary of the findings from the 2013 Community Health Needs Assessment. It is available for public use. High Point Regional will maintain hard copies of the full report. In addition to this executive summary, an electronic version of the full report can be found at **HighPointRegional.com**

Data Gathering and Sources

How was the CHNA data gathered and what sources were used?

A steering committee was developed comprised of representatives from High Point Regional, Cone Health, GCDPH and the CSCHRE. In order to represent the broad interests of the communities we serve, the steering committee ensured the engagement of community members, local citizens and representatives from other entities with special knowledge of or expertise in public health in the CHNA process.

Both quantitative and qualitative data was collected and assessed at the county-level and sub-county geographic levels of census tract and zip code. Assessing health needs involved collection and assessment of a wide range of data on measures of health and health-related factors including morbidity and mortality, health behaviors, clinical care, social and economic factors and environmental factors.

Data for this CHNA was collected from a variety of sources, including:

- Select secondary data, including leading causes of death and indicators related to communicable disease, chronic degenerative disease, maternal and infant health and injury mortality was provided by the Guilford County Department of Public Health's Health Surveillance and Analysis Unit;
- Additional secondary data for mortality, birth outcomes, communicable diseases and health risk factors were obtained from the North Carolina State Center for Health Statistics;
- The 2007-2011 American Community Survey (ACS);
- Crime in North Carolina, 2011, Annual Summary Report of 2011 Uniform Crime Reporting Data, NC Department of Justice, State Bureau of Investigation;
- State of North Carolina Department of Health and Human Services, Division of Public Health; State Center for Health Statistics;
- 2011-2012 Guilford County Youth Risk Behavior Survey, Guilford Education Alliance;
- County Health Rankings, http://countyhealthrankings.org ;
- Guilford County Community Health Assessment; 2010. Guilford County Department of Public Health, NC County Health Databook, NC State Center for Health Statistics;
- US Department of Agriculture Economic Research Service, 2011 and 2012 data;
- 2012 Guilford County Corner Store Assessment, Guilford County Department of Public Health.

The Patient Protection and Affordable Care Act also provided a list of required and optional hospital level measures identified by the US Department of Health and Human Services. Data on these indicators, which are regularly tracked by High Point Regional, were compiled by the GCDPH. High Point Regional also considered data which identified health issues causing the greatest number of hospitalizations in the communities we serve.

Focus Groups, Surveys and Meetings

How did High Point Regional listen to the communities we serve?

Focus Groups:
Members of the Center for Social, Community and Health Research and Evaluation (CSCHRE) facilitated all focus group discussions in early 2013. Focus groups were held at High Point Regional with local service providers working for non-profit organizations and our staff. In the same setting, low-income clients also participated in their own focus group. An additional focus group with low-income/Medicaid clients took place at Triad Adult and Pediatric Medicine, a Federally Qualified Health Center-Look Alike, located in High Point. Three Guilford County focus groups addressed special health care topics including mental health and women's health issues. Three focus groups were conducted with immigrants and refugees currently living in Guilford County, including Spanish-speaking residents at St. Mary's Church in High Point, where most of the participants were also a part of the congregation; French-speaking African refugees at Ashton Woods Community Development Center in Greensboro; and Nepali-speaking Bhutanese refugees at Glen Haven Community Development Center in Greensboro.

Community Meetings:
To support participation from all areas of the county and to facilitate identification of health issues specific to particular areas of the county, Guilford County was divided into six different regions. Public opinion regarding the priority health issues facing Guilford County was gauged during a series of six community meetings in the last quarter of 2012. These meetings were advertised through local media outlets and open to the public. Because High Point Regional's services extend to the Archdale/Trinity communities, a meeting was also held in Archdale in western Randolph County.

Facilitators at these meetings shared recent county and sub-county, community-specific health data based on the indicators in the County Health Rankings. Attendees shared their views about health issues and health needs in their communities. Meeting participants also identified resources, assets and barriers to improvement for each health factor area, as well as regional or county-wide unmet needs.

Guilford County Online Health Issue Prioritization Survey:
From mid-January 2013 through March 1, 2013, GCDPH conducted an online survey which allowed for additional community input from those who may not have had an opportunity to attend one of the scheduled community meetings. Links to the survey were provided on the Guilford County website. The public was also informed of the survey via a press release that went to all county media outlets and which also included the web link to the survey. During that time 51 persons completed the survey.

Guilford County Community Health Needs Assessment "Connecting the Dots" Meeting:
A half-day community health assessment "Connecting the Dots" meeting was held in March 2013. This meeting had a dual purpose of informing community partners about the community health needs assessment and engaging these partners in ranking community health needs and identifying potential best practice strategies for improvement to address six potential areas of need. Participants at community meetings were invited because of special knowledge of or expertise in public health and/or leadership regarding the session topic areas or their representation of medically underserved, low income and minority populations. Community agencies and leaders engaged included: United Way of Guilford County, North Carolina A&T State University, Cone Health Foundation, Ragsdale YMCA, New Arrivals Institute, Heartside Home Care, The Fitness Center at High Point Regional, Piedmont Health Services, Senior Resources of Guilford, Partnership for Community Care, Guilford County Department of Public Health, Center for New North Carolinians, Guilford Coalition on Adolescent Pregnancy Prevention, University of North Carolina – Greensboro Public Health Education Department, Cone Health Congregational Nursing Program, Center for Youth, Family and Community Partnerships and the UNCG Communication Studies Department.

Analysis of All Inputs

How was all that information analyzed to help High Point Regional focus on what may have the most impact on the health of our community?

The process of prioritizing health issues for the Community Health Needs Assessment involved several steps. The first step included a community prioritization process. Participants at the community meetings as well as participants in the online survey reviewed data on a set of indicators of Morbidity and Mortality, Health Behaviors, Clinical Care, Social and Economic Factors and Environmental Factors. Respondents ranked each of the following health indicators on a five-point scale from "little importance" through "extremely important."

Our Communities Primary Health Issues

Guilford County Priority Health Issues

Morbidity and Mortality	Clinical Care
Premature death	Uninsured
Chronic disease mortality	Primary care physicians
Poor or fair health	Preventive hospital stays
Poor physical health days	Diabetic screening
Poor mental health days	Mammography screening
Low birth weight babies	

Health Behaviors	Social and Economic Factors
Adult smoking	High school graduation
Adult obesity	Completed some college
Physical inactivity	Unemployment
Excessive drinking	Children in poverty
Sexually transmitted infections	Inadequate social support
Motor vehicle crash death rate	Children in single-parent families
Teen birth rate	Violent crime rate

Environmental Factors
Air pollution particulate matter days
Air pollution ozone days
Access to recreational facilities
Limited access to healthy food
Fast food restaurants

The leading issues that emerged from the community prioritization of these issues are shown below.

Community Prioritization Ranking—Top Ten Issues	
Health-Related Issue	**Rank**
Child poverty	1
Unemployment	2
Adult obesity	3
Lack of health insurance	4
Low access to healthy food	5
Chronic disease	6
Violent crime	7
Lack of physical activity	8
High school graduation	9
Sexually transmitted infections	10

To gain additional perspective on the health issues facing the CHNA assessment area, an additional prioritization approach was utilized. In mid-April 2013, an expert panel of 11 public health professionals met to prioritize these same health issues using the Hanlon Prioritization method.

Name	Organization	Area of Expertise
Ms. Hannah Wright	GCDPH	Nutrition and Obesity
Dr. Joseph Telfair	UNC-G CSCHRE	Maternal and Child Health; Community-based Health; Genetics; Blood Disorders
Alice Ma, MPH	UNC-G	Public Health Systems
Shuying Sha, MA	UNC-G CSCHRE	Public Health Systems
Dr. Mark Smith	GCDPH	Community Health Assessment; GIS Analysis; Epidemiology; Sexually Transmitted Infections; Maternal and Child Health; Chronic Disease Risk Factors; Social Determinants of Health
Paula Cox, MS	GCDPH	Environmental Health; Healthy Homes
Laura Mrosla, MPH, MSW	GCDPH	Maternal and Child Health; Teen Pregnancy Prevention; Sexuality Education; Adolescent Health; Community Health Assessment
Dr. William Dudley	UNC-G	Cancer, Public Health Statistics
Gracielee Weaver, MPH	UNC-G	Public Health Statistics
Holly Sienkiewicz, MA	UNC-G CSCHRE	Immigrant and Refugee Health
Ms. Natasha Tyson	UNC-G CSCHRE	Sexually Transmitted Infections

The Hanlon method is a respected approach to health issue prioritization that takes into account the size or magnitude of a health issue, the severity of the health issue and the feasibility of addressing the issue. The issues that were included were based on issues that rose to the top from the community prioritization. The results of the Hanlon prioritization were:

Hanlon Prioritization Ranking	
Health-Related Issue	**Priority Ranking**
Chronic disease	1
Teen pregnancy	2
Obesity, nutrition and physicial inactivity	3
Sexually transmitted infections	4
Tobacco use	5
Access to healthy foods	6
Poor birth outcomes	7
Access to clinical care	8
Violent crime	9
Poverty and unemployment	10

The priorities determined by these two groups led to a merged set of priority health issues. The top seven priority health issues in Guilford County were determined to be:

Chronic Disease

Healthy Pregnancy

Access to Clinical Care

Sexually Transmitted Infections

Poverty and Unemployment

Violent Crime

Access to Healthy Food

Our 3-Year Community Health Needs Implementation Strategies

What are the primary health issues High Point Regional is compelled to address?

Decisions as to which of the many valid and deserving issues will be addressed by High Point Regional over the course of the next one to three years and were weighed against several factors, including the size of the problem, the burden the problem is causing to the communities we serve, the urgency of solving the problem, and effectiveness of potential ways to solve the problem. Additional consideration was given to whether High Point Regional has the expertise and resources to effectively address the issue, either alone or in partnership with other community resources. Ultimately our decisions also rested on whether these priorities were within the scope of High Point Regional's mission to provide exceptional health services to the people of our region.

Using the previously mentioned factors, plus considering available resources both from High Point Regional and those already in existence in the community, three issues emerged as areas which will be addressed through a three-year implementation strategy:

- **Access to Clinical Care with an Emphasis on Mental Health Care**
- **Healthy Pregnancy(which may encompass both poor birth outcomes and teen pregnancy issues)**
- **Chronic Disease Management and Prevention**

Once these three priorities were established and potential actions proposed, approval to begin this important work was obtained from the High Point Regional senior leadership team and the High Point Regional Board of Trustees in September, 2013.

Access to Clinical Care: Mental Health

High Point Regional's Response: What is Currently Working

High Point Regional has offered a full continuum of behavioral health services to our community for the past 25 years. We address the mental health needs of our community through inpatient and outpatient psychiatric services, behavioral assessment services and psychiatric consultation services.

The Smith Psychiatric Center provides inpatient psychiatric care to adults suffering from a wide array of mental health and substance abuse issues. Medical detoxification is provided to those in need of this service. Patients in this level of care receive a comprehensive psychiatric evaluation by board certified psychiatrists and behavioral health-trained nurse practitioners. Patients are admitted for stabilization of their mental health or substance abuse crisis through medication management, group therapy and individual therapy. A comprehensive discharge plan is developed by our master's level therapists to ensure each patient maintains ongoing recovery from their chronic illness.

Our inpatient center has 28 beds and is a locked facility, allowing for treatment of involuntarily committed patients. The unit provides care to an average of 23 patients per day with an average length of stay of four days. Patients from seven of the 11 Local Management Entities (LMEs) throughout North Carolina receive inpatient care at the Smith Psychiatric Center.

Psychiatric consultation services are also provided throughout High Point Regional by our board certified psychiatrists as needed. Each patient is provided a comprehensive psychiatric evaluation with medication management and treatment recommendations as needed.

Regional Psychiatric Associates is High Point Regional's outpatient psychiatric clinic located within a block of the main hospital campus. The clinic opened in June, 2001 in an effort to better meet the behavioral health needs of our community. Care is provided to children, adolescents and adults suffering from both psychiatric and substance abuse illnesses. Regional Psychiatric Associates is staffed with three psychiatrists, two nurse practitioners, and five licensed therapists. Services provided include psychiatric evaluation, medication management, individual therapy, family therapy, couples therapy and substance abuse counseling. Providers care for approximately 125 patients every clinic day.

In an effort to better meet the needs of community members who may be experiencing a behavioral health crisis, High Point Regional opened the Emergency Department Behavioral Health unit in February 2013. This allows more effective and efficient care for these patients in a safe space designated just for this high risk population. The area is staffed 24/7 with a nurse practitioner, a certified nursing assistant, and a master's level therapist. Each patient receives a comprehensive behavioral assessment which leads to treatment recommendations and placement either as an inpatient or with services in our community. Approximately 275 patients are seen in our Emergency Department Behavioral Health unit each month.

Addressing What is Standing in the Way of
Exceptional Health Care in the Communities We Serve

Effectively addressing mental health issues in our community means targeting efforts at the entire continuum of care: prevention, treatment and post-treatment. The data from the Community Health Needs Assessment as well as our own patient care data have identified gaps which High Point Regional will begin to address, in collaboration with many other community partners, over the next three years.

Phase I

Patients being treated at High Point Regional for mental health or substance abuse issues receive exceptional care. But once those patients leave our doors their access to the needed medication, follow-up care and even the basic necessities of housing and food are very often limited or nonexistent. To address these issues, High Point Regional will collaborate with community partners to build a better system in our community to support behavioral health patients after hospitalization.

Identified Need	Potential Measures & Resources to be Committed
Develop a better system to support mental health patients post-hospitalization	1. Pursue funding for a partnering agency to provide case management services and medication management services to the indigent and underserved population. 2. Develop a system to ensure mental health patients have access to medications post-hospitalization to facilitate ongoing recovery from their chronic illness and avoid readmission. 3. Pursue community resources to develop adequate housing opportunities for mental health patients post-hospitalization.

Phase II

In the past several years numerous behavioral health services in our community have ceased operations. Currently there is no crisis emergency service available to serve the High Point area after hours or on weekends. When patients experience a behavioral health crisis during these hours, their only resource for care and stabilization is to present to the Emergency Department at High Point Regional. To address this issue, High Point Regional will collaborate with community partners to ensure access to crisis emergency services 24/7 outside of the Emergency Department.

Identified Need	Potential Measures & Resources to be Committed
Improve access to crisis emergency services in addition to Emergency Department treatment	1. Collaborate with area Local Management Entities (LMEs) to develop a user-friendly system for patients to access mental health care 24/7. 2. Pursue state funds available to assist community agencies in implementing telepsychiatry to address mental health crisis emergency support.

Phase III

Root causes of behavioral health issues must be addressed in order for our community to begin to change behaviors that put their mental and physical health at risk. High Point Regional's ultimate goal is to reduce the need for behavioral health care in the communities we serve.

Identified Need	Potential Measures & Resources to be Committed
Increase wellness and prevention education specific to behavioral health	1. Partner with local school system to provide mental health/anger management programs as a form of prevention and early intervention. 2. Partner with local worship centers to provide education on mental illness to better equip them to support their members. 3. Collaborate with physician practices in the communities we serve to pursue any opportunities for integrating behavioral health into their practice.

Healthy Pregnancy

High Point Regional's Response: What is Currently Working

Women have unique health care needs and concerns. That's why High Point Regional has devoted the fifth floor of the hospital's newest section exclusively to women. The result—the Esther R. Culp Women's Center is a hub of health care and educational activity for women of all ages.

Over the last three years High Point Regional has welcomed an average of 1,600 newborns each year. Our Childbirth Suite includes six labor-delivery-recovery rooms, three triage rooms, one Caesarean-section (C-Section) operating room and one C-Section recovery room. The High Point Regional Nursery supports 30 bassinets and six Level II bassinets for babies facing more complex health challenges. The exclusively female postpartum unit currently has 30 beds and also supports post-gynecological surgery and medical patients.

Fifteen obstetric physicians on staff represent four individual physician practices. Pediatrician coverage for newborn care is available 24/7/365.

Newborn infants requiring more intensive care are transported to Brenner Children's Hospital by a highly trained neonate transport team which is available at all times.

Current educational opportunities for our community include:

- **Expectant Parenting Classes**: A series of classes that help enrich the experience of being a new parent. Topics include labor, birth and pain control, Caesarean birth and postpartum information, infant feeding / breast feeding and newborn care.

- **Prepared Childbirth Classes**: A natural childbirth class that uses a "hands on" approach to prepare expectant couples for their experience. Parents-to-be explore and practice breathing and relaxation techniques throughout the various stages of labor and delivery, discuss what to expect when coming to the hospital, learn how to determine when to call the care giver and how to determine the beginnings of labor, how to cope with and understand the unexpected how to develop a birth plan, as well as how to care for their newborn and post-delivery care for mom.

- **Expectant Parents and Family Tours:** These give our moms-to-be and their families the opportunity to become familiar with their upcoming journey through our hospital.

- **Mommy & Me Support Group**: These free classes and support group are for moms and babies (0-six months of age) presented by nurses, lactation consultants and guest speakers. These relaxed and informal sessions provide opportunities for learning and support. The goals are to strengthen the parent-infant bond and promote development of strong parenting skills. Plus, it is a great way for new mothers to meet other mothers and babies that are experiencing some of the same challenges and rewards. Sessions include plenty of time for questions and individual concerns.

- **The Newborn Channel**: This resource delivers essential newborn and parenting information to help prepare new moms when they need it most. New parents and their families have easy access to highly trusted, professionally endorsed content on topics such as infant and mom care, siblings and family living, work-life balance, smoking cessation, sudden infant death syndrome and much more. Programs and transcripts from the Newborn Channel are also available for new parents on demand before, during and after their hospital stay.

- **Concerning Women:** This initiative is a free monthly lecture series designed to discuss health topics of concern to women of all ages. All lectures are held at the Millis Regional Health Education Center and serve an average of 500 women each year.

Online educational resources are also provided through the **Esther R. Culp Women's Center** website.

Addressing What is Standing in the Way of
Healthy Pregnancies in the Communities We Serve

Numerous Barriers and Disparities

Women who do not receive adequate prenatal care risk pregnancy-related complications that will go undetected or will not be identified soon enough. This can lead to potentially serious consequences for both the mother and her baby.

There are numerous barriers that prevent healthy pregnancies and healthy babies in our community. Lack of timely prenatal care, no access to a regular health care provider, insufficient or lack of health insurance, inadequate educational levels, poor nutrition, and limited financial resources often put mothers and babies at higher risk of poor outcomes. Alcohol, tobacco and illegal drug use and abuse can also be major factors.

Often there is a lack of knowledge about what programs are available to ensure a healthy pregnancy and positive outcomes and how to access these services and resources. Concerns about health insurance and finances, a lack of transportation, and even language and cultural barriers often discourage women from seeking the help they need. Poor birth outcomes are higher in certain population categories such as teenagers, the unemployed and minority populations. These differences are likely the result of many factors. These include pre-pregnancy health behaviors and health status, which are influenced by a variety of environmental and social factors.

In Guilford County, as in North Carolina as a whole, racial disparities exist in every measure of healthy pregnancies and healthy babies. From 2007 through 2011, Guilford County's Black non-Hispanic population had the highest incidence of low birth weight and very low birth weight infants, as well as the highest fetal, neonatal, post-neonatal and infant death rates (NC County Health Data Book, 2013; NC State Center for Health Statistics).

Breastfeeding Barriers

The experience of breastfeeding is special for so many reasons – the joyful bonding of mother and baby, the cost savings, and the health benefits for both mother and baby. There is strong evidence-based research that proves breastfeeding is far superior to formula feedings for both baby and mother. Health impacts on the baby include lower risk of ear and respiratory infections; dermatitis, gastrointestinal disorders and childhood obesity. Positive impacts on the mother's health include faster recovery from pregnancy, lower risk of breast cancer and osteoporosis. For every 1,000 babies not breastfed, there is an excess of 2,033 physician visits, 212 days in the hospital and 609 medication prescriptions (*2007.Ball, T., & Wright, A. (1999). Health care costs of formula-feeding in the first year of life. Pediatrics, 103(4):871-876.*).

Yet even though breastfeeding is a healthy choice, barriers still exist. These can include:

- *The hospital experience and early discharge:* Ensuring early intervention during the hospital stay that promotes successful lactation is important. Additionally, most new mothers now go home within a day or two of giving birth and certainly before breastfeeding is well established. An early follow-up visit within forty-eight hours is recommended by the American Academy of Pediatrics. However, such follow-up is far from universal, and many women who encounter breastfeeding difficulties after going home do not receive the extra help they require.

- *Insufficient access to lactation services:* As more women choose to breastfeed, more lactation concerns surface that require specialized counseling and management. Lactation consultants are relatively new members of the health care team who provide breastfeeding education and consultation for breastfeeding problems. While the need for lactation counseling continues to grow, medical insurance companies may view specialized breastfeeding services as an elective expense that is not reimbursed. However, recent research showing that breastfeeding reduces health care costs may prompt insurance companies to start paying for lactation consultation services.

- *A prior generation of mothers who bottle-fed their children:* This makes it difficult for them to give their daughters and daughters-in-law practical advice or direct assistance when it comes to nursing babies. At best, they can provide encouragement and support, but little practical help. At worst, unfamiliarity with breastfeeding may cause a grandmother to unwittingly sabotage its success.

- *Early return to employment:* Although many options exist for employed mothers to maintain lactation, ranging from on-site child care to expressing breast milk at the work place, employment may still represent a logistical and societal barrier to successful breastfeeding.

- *Lifestyle issues:* Successful breastfeeding is best fostered when mothers and babies are kept in close proximity and when infants are allowed to nurse in an unrestricted fashion. This may be best achieved through knowing how to deal with the unpredictability of nursing and knowing how to nurse discreetly in public.

Teen Pregnancy

Teen pregnancy may result in other unique obstacles. Teenagers may face the barriers of fear of consequences and shame for being pregnant, both powerful motivators that may lead to the teen not receiving any health care until she has progressed far into her pregnancy. This may result in complications down the road for both the teen mother and her baby.

A significant racial disparity in teen pregnancy exists in North Carolina and this inequality is mirrored in Guilford County. According to the North Carolina State Center for Health Statistics, the highest teen pregnancy rates in Guilford County were in the Hispanic population (57.8 per 1,000), followed by the Black non-Hispanic population (54.4 per 1,000).

Addressing these many barriers to healthy pregnancies in the communities served by High Point Regional Health will require significant effort by our caregivers as well as many community partners. The following implementation strategies will begin addressing these barriers.

Phase I

Identified Need	Potential Measures & Resources to be Committed
Improve pregnancy health in the communities we serve.	1. Promote the participation in the Nurse-Family Partnership Program. 2. Implement full-time inpatient lactation consulting services. 3. Provide earlier access to prenatal care for Guilford County Health Department patients through Regional Physicians Women's Health practice. 4. Investigate opportunities to implement prenatal yoga and postpartum exercise at High Point Regional.

Phase II

Identified Need	Potential Measures & Resources to be Committed
Address teen pregnancy in the communities we serve.	1. Identify and collaborate with existing community resources dedicated to addressing teen pregnancy. 2. Collaborate with the Family Life Education Service and the Guilford County Department of Public Health to offer the *Wise Guys®* and *Smart Girls® Life Skills Training* programs for teenagers and other education for teenagers and their parents in our community.

Phase III

Identified Need	Potential Measures & Resources to be Committed
Improve infant and child health and development by helping parents provide responsible and competent care for their children.	1. Evaluate the feasibility of offering the "Fathers Matter" program and High Point Regional. 2. Promote the participation in the Nurse-Family Partnership Program. 3. Pursue excellence in breastfeeding education by becoming a certified center for breastfeeding support.

High Point Regional's Esther R. Culp Women's Center will work collaboratively with the Nurse-Family Partnership to increase awareness and use of this very important resource in our community.

The Nurse-Family Partnership helps transform the lives of vulnerable first-time moms and their babies. Through ongoing home visits from registered nurses, low-income, first-time moms receive the care and support they need to have a healthy pregnancy, provide responsible and competent care for their children, and become more economically self-sufficient. From pregnancy until the child turns two years old, Nurse-Family Partnership Nurse Home Visitors form a much-needed, trusting relationship with the first-time moms, instilling confidence and empowering them to achieve a better life for their children – and themselves.

An evidence-based community health program, Nurse-Family Partnership's outcomes include long-term family improvements in health, education, and economic self-sufficiency. Their goals are to:

- Improve pregnancy outcomes by helping women engage in preventative health practices, including obtaining thorough prenatal care from their healthcare providers, improve their diet, and reduce their use of tobacco, alcohol and illegal substances.
- Improve child health and development by helping parents provide responsible and competent care for their children.
- Improving the economic self-sufficiency of the family by helping parents develop a vision for their own future, plan future pregnancies, continue their education and find work.

Lactation Consulting Service: Anticipated to start in October 2013, a full time Lactation Consulting service will provide in-patient access to a Certified Lactation Consultant seven days per week. This program will provide educational information to patients, staff, physicians and OB physician offices that will highlight the importance of breastfeeding. One-on-one patient consultation will be provided in the mother's room. Outpatient Lactation Services are also planned to start at a later date.

Fathers Matter: The Family Life Education Services, a division of the Children's Home Society of North Carolina, provides "Fathers Matter", a free support and educational program for men who are expecting a child or have a child under the age of three years old. This six week program offers nine hours of educational information to help men be better fathers and more responsible for their actions and behaviors. Topics include Child Safety; Child Health Tips; Importance of Fatherhood; Encouraging Brain Development in Children; Creating Influence, and Positive Discipline that Works.

This evidence-based program has been shown to dramatically improve communication between fathers and their families as well as increase involvement in their children's lives. The positive outcomes also include improved knowledge about parenting skills and effective discipline techniques. High Point Regional will offer this program in early 2014.

Teen Pregnancy: School programs for teenagers that help educate our youth about important life decisions and the consequences of making bad choices are provided by The Family Life Education Service (*Wise Guys®*) and the Guilford County Department of Public Health (*Smart Girls® Life Skills Training*).

Prenatal Yoga and Postpartum Exercise Programs: Women experience many physical and emotional changes throughout pregnancy. Practicing prenatal yoga on a regular basis can help manage those changes. Creating a strong body during pregnancy is also very important in postpartum recovery. High Point Regional will investigate the opportunity to add these exercise and yoga programs to the programs already offered by the Esther R. Culp Women's Center.

Chronic Disease Management and Prevention

High Point Regional's Response: What is Currently Working

Chronic diseases are diseases of long duration and generally slow progression. Heart disease, chronic lung diseases and diabetes are among the top ten leading causes of death in Guilford County and they are all examples of a chronic health condition – a medical issue that a person may have to deal with for years.

Chronic health conditions are some of our most common and costly health problems. They take a physical, emotional and financial toll on the individuals who have them as well as their family members. Patients and caregivers often struggle with quality of life issues as well as lost or reduced productivity at work and at home.

Although they are the most common and costly health problems, chronic diseases are also the most preventable. Lifestyle factors such as smoking, diet and physical activity levels can impact chronic disease risk.

High Point Regional offers a variety of screenings, education, behavior modification / self care services and other resources aimed at meeting the needs of our community for the prevention and treatment of chronic diseases.

Chronic Disease Prevention and Education:

Thousands of children visit the **Millis Regional Health Education Center** each year to experience its unique form of "Edu-tainment." The information they learn helps create a healthier future for area youth. The total number of children learning about health-related topics since the center opened in 1988 is now over 100,000.

Millis Regional Health Education Center

The Millis Center, located at 600 N. Elm Street in High Point, is a service of High Point Regional and is devoted to helping school students of all ages, church groups, local organizations and individuals learn about the human body and how to keep themselves healthy. The Millis Center curriculum follows the North Carolina Standard Course of Study. To schedule a visit, call (336) 878-6713 for more information.

The **"Food, Fitness and Fun"** program offered through the Millis Center to school aged children reached more than 1,500 students from 28 schools in 2012 and 700 students from another 13 schools through August 2013.

High Point Regional provides community education and screening events related to chronic disease to churches, businesses and community groups, reaching over 600 community members in 2012 and increasing outreach to more than 10,000 community members in 2013 to date.

Being physically active is a key to the prevention and treatment of most chronic diseases. **The Fitness Center at High Point Regional** is a medically-based fitness facility located on our main campus in the Carolina Regional Heart Center. The Fitness Center staff has expertise in fitness as well as exercise physiology, sports science, nutrition, nursing and medicine. The staff works with each member to design an individual program to provide motivation to stick with it. The Fitness Center was one of the first Medically Directed Fitness Centers in the country to become certified through the Medical Fitness Association.

The Fitness Center provides a discount to community members who are referred by their doctor through the **Exercise is Medicine** program. During this 12-week program the patient has an initial screening and exercise prescription, based on goals and health history, culminating in orientation to their exercise regimen at The Fitness Center. As participants progress, a follow-up evaluation is done to highlight improvements. That information is shared with the referring physician.

The Fitness Center also provides the **CancerFITT** program to enhance energy levels and quality of life of those currently going through or have recently completed treatment for cancer. A certified Cancer Exercise Specialist provides guidance through individualized exercises, relaxation / stress management and education.

Through a partnership with Healthways and the **SilverSneakers** program, The Fitness Center offers all SilverSneakers members a free membership which includes access to group exercise classes (additional fee-based programs and service are not included). SilverSneakers is a lifestyle management program offering subsidized fitness center membership for any Medicare-eligible individuals (65 years and older) who are affiliated with one of the many partnering insurance providers. Regular participation in the program has been proven to help older adults manage their health and increase strength, balance and endurance. To find out if your health plan participates in SilverSneakers, please contact your plan administrator or visit the SilverSneakers website at http://www.silversneakers.com.

The Fitness Center at High Point Regional also spearheads **Get Healthy High Point**, a city-wide effort emphasizing weight management. Embracing the preventative medicine model, Get Healthy High Point provides the catalyst to help people begin to choose and/or reinforce those healthy lifestyle choices necessary for a better quality of life. At the core of this campaign is a series of free weight management challenges open to anyone living or working in High Point.

High Point Regional also serves the Kernersville community with **The Fitness Center at Kernersville**, located at 861 Old Winston Road. The Fitness Center at Kernersville includes indoor/outdoor pools, whirlpool, sauna, cardiovascular equipment, weight machines, free weights, two gymnasiums for basketball or volleyball, indoor/outdoor walking track, racquetball courts, aerobics studio, cycling room, outdoor volleyball courts, locker/towel facilities, the C. LaRue Hoops Academy and childcare.

Chronic Disease Treatment and Management:

Chronic disease care is provided by High Point Regional's Emergency Department, through inpatient treatment, by our Discharge Clinic, at **Regional Physician's Diabetes Health and Wellness Center**, and through our Regional Physicians practices. High Point Regional and our Regional Physicians practices have charity and prompt pay discount programs to assist patients who are uninsured. Additionally, High Point Regional provides support for the efforts of the Community Clinic of High Point as well as the Triad Adult and Pediatric Medicine Federally Qualified Health Center-Look Alike.

Patients who are uninsured and need assistance obtaining medications at discharge are assisted through High Point Regional's social work department and our onsite **Retail Pharmacy**. Any uninsured person in our community can also access the **MedAssist Program** through the Community Clinic of High Point.

Regional Physicians' Diabetes Health and Wellness Center (DHWC) is certified by the American Diabetes Association and offers a full range of diabetes education and assistance with behavior modification. Free services are offered to the patients of our local uninsured clinic and uninsured patients referred from the Community Clinic of High Point. Scholarships funded through the generosity of High Point Regional's employees are available for low income patients referred by community providers. A limited supply of glucose meters, testing strips and syringes is available to patients at the DHWC.

Heart disease affects more than 17 million people and is still one of the top killers in the United States. Situated within High Point Regional's Fitness Center, and supervised by a professional staff of cardiologists, nurses, exercise physiologists, dieticians and mental health counselors, **Heart Strides Cardiac Rehab** offers the heart patient a pathway to a better quality of life.

Utilizing structured exercise progressions, an informative education component and lifestyle awareness tools, the Heart Strides program establishes a good foundation for participants to make healthier lifestyle choices, leading to a more productive future. The exercise is done in a supervised group setting with each participant having a personalized exercise prescription based on their health concerns and fitness level. Heart Strides offers education and membership to High Point Regional's medically supervised Fitness Center and also offers scholarships to patients who would not otherwise be able to participate in the program.

Chronic Obstructive Pulmonary Disease (COPD) is a progressive disease of the airways that is characterized by a gradual loss of lung function. The term COPD includes chronic bronchitis, asthma or emphysema, or combinations of these conditions. It represents the fourth leading cause of death in the United States. High Point Regional's **Heart Strides Pulmonary Rehab** is a multi-disciplinary program of care for patients with chronic respiratory impairment that is individually tailored and designed to optimize positive outcomes and a better quality of life. Using a team approach, our patients work closely with doctors, nurses, respiratory therapists, exercise specialists, dietitians and others to improve their day-to-day lives. A certified **QuitSmart** facilitator is available to provide tobacco cessation counseling to both the cardiac and pulmonary rehab patients.

Additionally, the QuitSmart program is offered through High Point Regional to members of the community periodically throughout the year for a nominal cost. Call (336) 878-6888 for more information or to enroll.

Addressing what is Standing in the Way of
Exceptional Chronic Disease Management in the Communities We Serve

Individual, cultural, financial and environmental factors all contribute to and create barriers for patients who need to make crucial lifestyle changes in order to take ownership of their health and properly manage their chronic disease. Tobacco use, poor diet, lack of physical activity, alcohol and drug use, emotional issues, depression, anger, stress, despair, financial issues, housing, low literacy, availability of healthy food and making the proper food choices, safety of the neighborhood, transportation availability, and unemployment can all play a role in the development of chronic diseases and the ability to manage them.

Motivational interviewing techniques are routinely used by the staff at High Point Regional in an attempt to determine our patients' readiness to change behaviors or to help find community assistance to address the barrier. But many of these hurdles cannot be overcome on an individual basis and the collaboration of many community entities will be a key factor in breaking through these barriers.

High Point Regional's mission is to provide exceptional health services to the people of our region. The Community Health Needs Assessment has identified the gaps and barriers to achieving this goal as it relates to chronic diseases in the communities we serve. To address these gaps and barriers, High Point Regional will lead the way and engage other community partners in our efforts.

Phase I

Identified Need	Potential Measures & Resources to be Committed
Increase efforts aimed at prevention and early detection of chronic disease.	1. Implement the North Carolina *Wise Women* Program. 2. Expand the utilization of Millis Regional Health Education Center programs that address chronic disease prevention. 3. Expand and increase the use of the chronic disease treatment and prevention programs offered through The Fitness Centers. 4. Expand the scope of the Regional Physician's Diabetes Health and Wellness Center program to better integrate services across the continuum of care. 5. Increase awareness of and encourage High Point Regional workforce to volunteer their time for community events which address chronic disease prevention and treatment.

Phase II

Identified Need	Potential Measures & Resources to be Committed
Increase knowledge about and coordination of available services and resources which address chronic disease throughout the communities we serve.	1. Develop a collaborative community team, engaging High Point Regional and community partners to identify and better coordinate all efforts addressing chronic disease in our community. 2. Develop a Chronic Disease Knowledge Resource Center available through High Point Regional's Contact Center.

Community Needs Not Currently Addressed by High Point Regional

The Community Health Needs Assessment brought to light many issues which are deserving of focus. Fortunately there are many organizations in our community which are working diligently to address many of these disparities. High Point Regional used a systematic process to decide where we could have the greatest impact and show measurable results as a long term outcome of this plan, either alone or in partnership with others in the communities we serve.

Areas of exclusion in this current plan include:

Priority Needs Not Addressed	Reasons For Exclusion
Poverty and Unemployment	High Point Regional lacks expertise in this area; outside the scope of our Mission; community efforts already exist.
Violent Crime	High Point Regional lacks expertise in this area; outside the scope of our Mission; community efforts already exist.
Access to Healthy Food	High Point Regional lacks expertise in this area; outside the scope of our Mission; community efforts already exist.
Sexually Transmitted Infections	Community efforts already exist; High Point Regional resource contraints.

A History of Total Care: High Point Regional's Contributions to Our Community

High Point Regional has a deep, rich history in the community that began in 1904. As the organization grew over time, success has always been defined by how well we take care of the people of our community. We believe that everyone has a right to high quality health care and we are committed to providing that to our community regardless of their financial ability to pay for services.

High Point Regional merged with UNC Health Care, a not-for-profit integrated health care system, on April 1, 2013. UNC Health Care is helping ensure that High Point Regional continues to advance in clinical care and remain competitive while they help position the organization for a stronger future. Under the merger, UNC Health Care is providing $150 million for capital improvements and $50 million for the establishment of a newly formed Community Health Fund. High Point Regional remains a private, not-for-profit entity and maintains a separate Foundation to provide philanthropic support for ongoing patient care, technology and capital needs of the hospital.

Taking the message of good health into the community is also a charge we take very seriously. High Point Regional Health's efforts to have a positive impact on the health of our community include community outreach programs, clinics, and in-kind donations.

Charity and Uncompensated Care Provided by High Point Regional Health	FY10	FY11	FY12
Net Patient Service Revenue (Audit)	$274,365,709	$269,343,333	$264,486,362
Provision for Uncollectible Accounts	($39,281,338)	($39,317,380)	($18,822,883)
Adjusted Net Patient Service Revenue	$235,084,371	$230,025,953	$245,663,479
Net Operating Income	$346,926	$29,021	$3,661,316
Caring for Our Community			
Charity Care (at Actual Cost)	$7,059,950	$8,554,300	$18,150,170
Uncompensated Care (at Actual Cost)	$14,313,180	$13,091,953	$6,426,421
Un-reimbursed Care (at Actual Cost Less Payments)	$15,257,818	$17,317,677	$13,242,925
Community Care Contributions	$36,630,948	$38,963,930	$37,819,516
Other Community Investment			
Community Health Improvement Services & Community Benefit Operations	$988,200	$828,553	$637,937
Health Professions Education	$644,014	$502,112	$518,324
Research Costs	$71,719	$165,338	$80,280
Cash & In-Kind Contributions to Community Groups	$349,726	$293,627	$333,412
Community Building Activities	$65, 583	$86,677	$81,234
Total Community Contributions	$2,119,278	$1,876,307	$1,651,187
Total Community Investment	$38,750,226	$40,840,237	$39,470,703
Community Investment as a Percentage of:			
Net Patient Service Revenues	16.48%	17.75%	16.07%
Net Operating Income	11,169.59%	140,726.50%	1,078.05%
Other Community Investment - % of Operating Income	610.87%	6,465.34%	45.10%


HIGH POINT
REGIONAL
UNC HEALTH CARE