Atrium Health Wake Forest Baptist Medical Center

Community Health Needs Assessment Implementation Strategy
Calendar Year 2022 – 2024

Introduction

North Carolina Baptist Hospital, the hospital component of Atrium Health Wake Forest Baptist Medical Center (North Carolina Baptist Hospital herein referred to as "AHWFBMC"), is a North Carolina non-profit corporation and is a part of Atrium Health Wake Forest Baptist ("AHWFB"), a preeminent, internationally recognized academic medical center with balanced excellence in patient care, research and education.

Atrium Health Wake Forest Baptist includes the following:

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

AHWFBMC is accredited by The Joint Commission and has been committed to providing for the health care needs of northwest North Carolina and southwest Virginia since the 1920s.

Vision

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

Mission

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

Culture Commitments

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

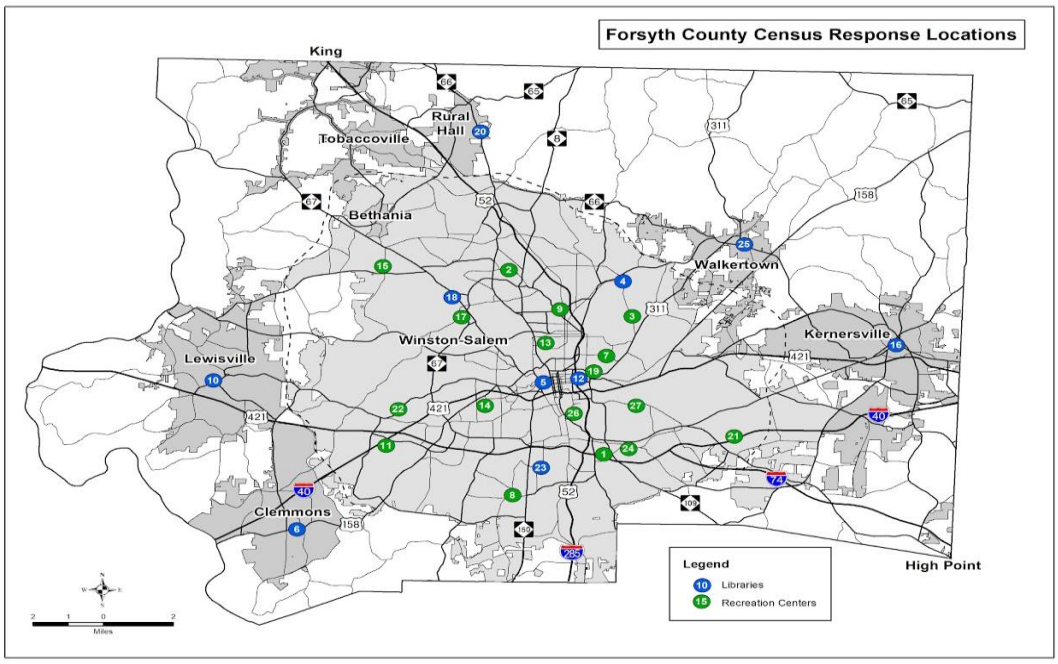
- We create a space where all ***Belong***
- We ***Work as One*** to make great things happen
- We earn ***Trust*** in all we do
- We ***Innovate*** to better the now and create they future
- We drive for ***Excellence -*** always

Mission Alignments: Community Engagement Principles, Population Health, Health Equity, Social Impact

AHWFBMC is committed to improving access, community health, and addressing the needs of our most vulnerable communities. As a result, we will emphasize identifying the ***places*** (e.g., zip codes, census tracts, neighborhoods, streets), ***partners***, ***people***, and aspects of ***poverty*** that we need to engage and address in our communities as we implement strategies.

We strive to be a leader in population health, health equity, and social impact as we look beyond the walls of our hospitals and medical offices to address social, economic, and environmental conditions that contribute to poor health outcomes, shortened lives, and higher health care costs of the communities we serve.

Community Served



AHWFBMC serves a 24 county service area that encompasses two states, North Carolina and Virginia, and a more immediate service area of seven contiguous counties. Forsyth County residents represent 34% of total inpatient admissions and 58% of total emergency department visits for calendar year 2020. AHWFBMC's community served is defined as Forsyth County, North Carolina.

Forsyth County is located in the Triad region of North Carolina. The county covers approximately 408 square miles and has a population of approximately 937 residents per square mile.[1] With 382,295 residents in 146,816 households, Forsyth County is the fourth most populous county in North Carolina. The population is 56.3% white, 27.5% Black or African

[1] https://censusreporter.org/profiles/05000US37067-forsyth-county-nc/

American, 13.3% Hispanic or Latino, 2.6% Asian, and 0.3% other. The population is 52.7% female and 47.3% male. Persons under 18 years of age represent 22.7% of the population while persons 65 years of age and over represent 16.4%. The percentage of persons without health insurance and under the age of 65 years old is 14.2%. In addition, the median household income in 2019 dollars is $51,569. The percent of persons in poverty is 15.2%.[2]

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

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

While Atrium Health Wake Forest Baptist Medical Center's community served is defined at county level, special attention was placed on several defined populations and neighborhoods within the county to understand the diversity of the County's population. In particular, the Medical Center seeks to understand and include communities who are historically marginalized, underserved, and who experience health inequities.

2022-2024 Community Health Needs Assessment

During 2021, AHWFBMC conducted a Community Health Needs Assessment ("CHNA") for the calendar years 2022-2024 to identify the health needs of Forsyth County. The CHNA process involved the collection of primary data from community surveys, conversations, focus groups, and interviews. In addition, secondary data sources were examined that included state level data (e.g., North Carolina State Center for Health Statistics, Healthy North Carolina 2030), county level data (e.g., State of the County Health (SOTCH) Reports from health departments), and community level data (e.g., neighborhood initiatives, community organizations). The process to identify priority health needs and to locate primary and secondary data sources involved close collaboration with partners, particularly the Forsyth County Department of Public Health and Novant Health Forsyth Medical Center. In determining our criteria for priority health needs selection, the highest weights were placed on the health disparities associated with the need, the burden of the health need, the feasibility of possible interventions, and the importance the community placed on addressing the need. Upon completion of the CHNA, results of the assessment were shared with leaders at AHWFB and other key contributors for input.

The following CHNA priorities were identified and approved by the Board of Directors on December 8, 2021.

[2] https://www.census.gov/quickfacts/fact/table/forsythcountynorthcarolina/POP060210
[3] Source: Winston-Salem State University's Center for the Study of Economic Mobility, 2018.

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

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

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

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

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

The 2022-2024 CHNA process found that the community identified social impact and injustice as a significant health priority that greatly influences the health of the community particularly its most vulnerable and underserved populations and individuals. The distribution of behaviors and health outcomes consistently follows social and economic patterns. Furthermore, some barriers to accessing care continue to prevent current programs and initiatives from reaching the populations in need. These challenges present important opportunities for the future. As we move forward as an integrated community of healthcare, social services and community leadership, we can leverage community assets and access to resources from the Atrium Health enterprise to improve the health of residents in Forsyth County.

AHWFBMC acknowledges the importance of all health needs in the Forsyth County community even though the hospital's resources and assets were best aligned to focus on the prioritized health needs addressed above. Community needs that were identified but not prioritized for the 2022-2024 CHNA are as follows:

- Dental health
- Employment or job finding services
- Domestic Violence services
- Sexual health
- Unintentional injuries
- Motor vehicle injuries

- Septicemia
- Human Immunodeficiency Virus (HIV)
- Homicide
- Teen birth rate
- Short-term suspensions
- Incarceration rate
- Access to exercise opportunities

AHWFBMC leadership will continue to partner with community-based and non-profit organizations, public health and other governmental agencies, and the broader community to help address these health needs.

2022-2024 Community Health Needs Assessment Implementation Strategy Development

This accompanying document to AHWFBMC's 2022-2024 CHNA outlines strategies designed to improve health through hospital programming and support for external community initiatives led by community coalitions and organizations. The list of outlined strategies will describe planned actions to address the community health needs that were identified through its CHNA process. In addition, hospital leaders will use this document to communicate the goals, objectives and approaches that the hospital will undertake to address community needs over the next three years, and help the community understand its role in addressing those needs.

The current set of strategies and related resources were identified by reviewing the Atrium Health Wake Forest Baptist Social Impact Inventory, the hospital's Program Inventory, the previous strategies outlined in the 2020-2022 CHNA Implementation Strategy, and other sources of information identified by the CHNA team leads. Additional existing programming and resources were identified through conversations with hospital and community leaders who have leadership responsibilities in addressing the priority health needs in Forsyth County. These existing strategies were evaluated to determine if the hospital could build upon community assets, refocus the existing program to meet prioritized health needs, and reallocate internal resources for the strategies.

After identifying existing strategies & programming that would continue to meet the priority needs of the current CHNA cycle, attention then focused on identifying new strategies that would allow the hospital to:

- be consistent with the hospital's organizational strengths and community capabilities
- assess availability of hospital and/or community resources to carry out the strategy.
- achieve short-term and long-term results
- identify barriers that might exist
- create partnerships and generate community support

In developing new strategies, AHWFBMC initially reflected on how it might effectively lead, compared to being a supportive partner for, other organizations designed to achieve collective impact. Additionally, the three levels of prevention were considered during the development process: 1) Primary prevention – preventing disease from occurring, 2) Secondary prevention – finding and treating the disease early, and 3) Tertiary prevention – targeting people with

symptoms and making them healthy again. Multiple factors were considered that impact health, including individual behavior, community/social supports, and government health policies. Finally, the following evidence-based interventions were investigated:

- Community Health Improvement Navigator, CDC (http://www.cdc.gov/chinav/database/index.html)
- Evidence-based Practice Centers, AHRQ (http://www.ahrq.gov/clinic/epc/)
- Guide to Community Preventive Services, CDC (www.thecommunityguide.org)
- The Cochrane Collaboration (http://www.cochrane.org/)
- County Health Rankings and Roadmaps (www.countyhealthrankings.org/)
- Healthy People interventions and resources (www.healthypeople.gov)
- Healthy North Carolina 2030: https://nciom.org/wp-content/uploads/2020/01/HNC-REPORT-FINAL-Spread2.pdf
- Healthy Communities Institute (www.healthycommunitiesinstitute.com)
- National Resource for Evidence-based Programs and Practices, SAMHSA, US DHHS (www.nrepp.samhsa.gov)

2022-2024 Community Health Needs Assessment Implementation Strategy Action Plan

AHWFBMC addressed each of the community health needs prioritized in the 2022-2024 CHNA when developing its implementation strategy action plan. Specific implementation strategies for each prioritized health need are included below. Over the next three years, additional strategies may be added to this action plan as opportunities arise from the identification of new health trends, health system resources, and community resources and partnerships.

PRIORITIZED HEALTH NEED: ACCESS TO CARE			
Goal	**Strategies**	**Metrics**	**Potential Partners or External Organizations**
Improve access to health care services to underserved and vulnerable populations of all age groups, with a focus on special populations who experience significant financial, health insurance coverage, transportation, location, time, health and health system knowledge, and agency barriers.	**Strategy 1**: Expand and enhance preventative care opportunities to underserved individuals experiencing health care barriers such as lack of insurance, transportation, disability, and other factors through: 1.) *Mobile Health Clinic ("MHC")*, which provides primary care, preventive care, cancer screening, health coaching, and vaccines for flu and COVID-19 at no cost. The MHC is placed in the community at strategic locations to be able to serve those who are historically underserved in their community and assist people experiencing health care access barriers. MHC partners with several community-based organizations and faith communities	• Number of individuals enrolled in mobile care programs • Number of individuals without insurance served by mobile care programs • Number of clinical hours available for community care provided by mobile care programs • Number of preventative health services offered by mobile care programs • Number of routine care visits offered by mobile care programs • Number of colorectal and breast cancer screenings provided by mobile clinic programs • Number of COVID-19 and other vaccines administered by mobile care programs	• Forsyth County Health Department • Love Out Loud • YMCA COACH program • NC Associate of Free and Charitable Clinics • NCDHHS Office of Rural Health • Novant Health Mobile Team • Minster's Conference of Winston Salem and Vicinity • Second Harvest Food Bank • New Communion Mobile Pantry • American Cancer Society • Alzheimer's Disease Research Center • St. John CME Church • Winston Lake YMCA

	to make healthcare accessible for those individuals without health insurance	• COVID-19, flu, and other testing for those with symptoms • Number of referrals to health care facilities for ongoing primary care and specialty care services • Number of lab results provided that assess primary care conditions • Number of prescriptions provided at no cost	• Iglesia Cristiana Sin Fronteras • Sprague Street Community Center
	Strategy 2: Reduce transportation barriers through implementation for transportation navigation at Downtown Health Plaza. The Downtown Transportation Program helps provide transportation, through cab services and bus passes, to members of the community who have difficulties getting to appointments due to unreliable or no transportation of their own. The project also helps the community members connect to transportation resources offered by health insurance and/or Transportation Authority.	• Number and cost of free bus vouchers provided • Number and cost of cab transport services provided • Number of community members receiving services from transportation scheduling team, who provides information about available service to those who express transportation concerns •	• Classic Cab Company • Winston Salem Transportation Authority •
	Strategy 3: Support and expand partnership for federally qualified health clinics and free clinics, including: *1.) Downtown Health Plaza (DHP)* is a large primary care outpatient outreach healthcare facility of AHWFBMC, and is currently the largest Medicaid site in NC. Through multiple clinics and support services, DHP provides access to quality healthcare to the underserved community of downtown Winston-Salem in Forsyth County. Outpatient clinic specialties include Adult Medicine, Pediatrics, and OBGYN. *2.) Highland Avenue Primary Care (HAPC),* seeks to promote community wellness by providing access to primary care services for both the behavioral health and uninsured populations in an underserved area of Winston-Salem. DHP is housed within the same building as Daymark Recovery Services in an underserved area of Winston-Salem. The sliding scale fee structure grants uninsured individuals access to care for a nominal fee. In addition, those with behavioral health	• Number of individuals served • Number of clinic hours of service • Number of specialty clinic visits provided at no cost • Number of preventative/routine care visits provided at no cost (including for vaccinations and testing)	• Novant Health • Forsyth County Govt.

	challenges and without the ability to pay can be seen at no charge.		
PRIORITIZED HEALTH NEED: Social Impact and Injustice			
Goal	**Strategies**	**Metrics**	**Potential Partners or External Organizations**
Address social impact and injustice challenges with a focus on the factors that influence health, with a focus on the following factors that influence health including food insecurity in underserved neighborhoods, race and culture, lack of awareness of resources, inability to work due to medical conditions, lack of affordable housing and poor housing conditions, poverty, and Education (universal Pre-K)	**Strategy 1**: Utilize AHWFB FaithHealth Connectors to serve as health advocates, navigators, and liaisons to community members for social services by getting individuals in need to the right door, at the right time, by: 1. Assisting underserved community members obtain access to resources for food/meals, clothing, medication, housing, primary care, health insurance, education and early childhood needs by navigating community-based services and governmental assistance programs, and connecting them with community members in faith and social networks who provide wellness checks in addition to emotional, social, and spiritual support for holistic well-being 2. Increasing the number of partner congregations connected with community members to limit the effects that social and spiritual factors have on health by providing hope and encouragement for healing	• Number of Connector caregiving encounters with community members • Number of Connector encounters with community members for transportation, food issues, medication issues, and other support • Number of partnering congregations • Number of volunteer hours provided by faith communities in assisting community members • Number of referrals received for community assistance • Number of transportation requests for medical appointments • Number of and cost of transportation services provided to underserved community to health care related appointments	• AHWFB CareNet Services • Hispanic League • Interfaith Alliance of Clemmons & Lewisville • Local Associations of the Baptist State Convention of NC • Local Associations of the General Baptist State Convention • Christ's Beloved Community • The Western Conference of The United Methodist Church • Love Out Loud • Minister's Conference of Winston-Salem & Vicinity • Mars Hill Baptist Church • Union Chapel Baptist Church • Morningstar Missionary Baptist Church • Disciples of Grace Ministries • Iglesia Cristiana Sin Fronteras • Various other congregations • Various community based organizations, nonprofits, and crisis ministries
	Strategy 2: Collaborate with Maya Angelou Center for Health Equity to dismantle systemic inequity and support the health of communities through building and nurturing mutually beneficial and reciprocal relationships; respecting and honoring community as experts and equal partners; engaging, educating, and empowering communities; cultivating formal and informal leadership; creating a	• Number of health promotion activities and church specific programs designed by Congregational Health Ambassadors	• Various African-American congregations and clergy members • Historically Black Colleges and Universities (e.g. Winston-Salem State University, NC A&T State University)

	culture of transparency and fairness in research; and promoting advocacy and policy change. Key programs for collaboration are: 1. The Caregivers College and Black Men's Health Initiative 2. Congregational Health Ambassadors 3. The Triad Pastoral Network (TPN)		
	Strategy 3: Implement community resource hub in collaboration with Find Help	• Number of individuals referred to Find Help • Number of calls made to meet individual/family needs • Number of closed loop referrals - the number of referrals that led to a community member receiving a service	• Novant Health • Find Help • Community-based Organizations (100+)

PRIORITIZED HEALTH NEED: Chronic and Emerging Disease			
Goal	**Strategies**	**Metrics**	**Potential Partners or External Organizations**
Prevent, detect or manage the following chronic and emerging diseases, while limiting long-term complications that may result: cancer, diabetes, heart disease, hypertension, Cerebrovascular disease, and COVID-19	**Strategy 1**: Work with physicians or Advanced Practice Providers (APPs), and community organizations to improve care, prevention and management of diabetes by referring any known member of the community diagnosed with this disease to Gateway to Success program to get better management with their diabetes. The Gateway to Success program is an evidence-based program that uses an integrated care model for diabetes prevention and management for low-income participants diagnosed as pre-diabetic or with Type 2 diabetes. The program helps participants manage or improve their health through life-style changes including good nutrition, weight loss, exercise, and better behavioral health.	• Number of individuals referred to Gateway to Success program. • Number of referred participants improving and/or maintaining A1C levels. • Number of referred participants improving and/or maintaining their BMI levels. • Number of referred participants in individual or group exercise sessions. • Number of referred participants in behavioral health/nutrition education programming • Number of referred participants in one-on-one wellness coaching	• The YMCA of Winston-Salem Forsyth County • Novant Health
	Strategy 2: Improve community approaches to childhood obesity, a precursor to other chronic diseases into adulthood by understanding the social determinants of health influences on weight, tackling root causes of obesity to both promote wellness and to reduce complications and other chronic diseases that may result.	• Number of participants in the culinary medicine program • Number of food security periodic screenings leading to referrals to Brenner FIT • Number of instruction sessions aimed at teaching culinary medicine to medical students & other professionals on the front line	• YMCA of Northwest North Carolina • American Heart Association • Imprints Cares, Parenting Path

	Brenner FIT will be engaged to assist with this strategy. Brenner FIT is an interdisciplinary program focused on evidence-based approaches to preventing and treating childhood obesity and is involved with clinical treatment, research, education, and community engagement. Brenner FIT targets any child and family with concerns about their child's weight, and makes a concerted effort to especially reach children of color and eliminate barriers to care, including distance, language barriers, and lack of insurance reimbursement for core services. The program's community activities are focused on children in urban and under-resourced areas, with a designated bilingual (Spanish) team.	• Number of research projects focused on obesity and community engagement • Number of participants participating in virtual, family-based weight management programming	
	Strategy 3: Manage indigent community members with chronic conditions by deploying care management resources, including Wake Connect. Wake Connect increases access to primary care for indigent community members with complex chronic conditions resulting in frequent ED and IP admissions. By identifying and proactively engaging with these individuals, the program works to enhance coordinated care practices; reduce improper ED utilization; and assist in connecting community members with social service resources. Wake Connect reduces the cost of care by supporting community members' proper use of healthcare services available within the broader community.	• Number of community members enrolled • Number of PCP visits • Percent reduction in ED utilization within select indigent population	• MedCost
	Strategy 4: Collaborate with the Office of Cancer Health Equity's commitment to educate the public about cancer through free community outreach programs focused on cancer prevention, risk reduction, and screening.	• Number of free community engagement and education events (e.g., speaking engagements, presentations) shared in the community by cancer experts • Number of community tobacco education and cessation weekly group sessions conducted by Tobacco Treatment Specialists • Number of participants in each group session	• NC Division of Public Health – Cancer Prevention and Control Branch • Forsyth County Department of Public Health • Various community organizations

PRIORITIZED HEALTH NEED: Maternal and Child Health			
Goal	**Strategies**	**Metrics**	**Potential Partners or External Organizations**
Increase the number of programs and services that are designed to improve the health of mothers and their children.	**Strategy 1**: Ensure all newborns discharged have a place that they can sleep safely at home. Safe Sleep for all Newborns is a program that serves all newborns at Atrium Health Wake Forest Baptist Medical Center (and two network hospital locations) to ensure all discharged newborns have a place where they can sleep safely at home, which is proven to lower sudden infant death syndrome ("SIDS") and infant mortality. Safe Sleep also refers families to Cribs for Kids, which engages a social worker to provide a mobile and easy-to-transport Graco Pack-N-Play.	• Number of newborns identified who do not have a safe place to sleep • Number of families referred to Cribs for Kids. • Number of mobile Pack-N-Play units provided that were funded by the hospital	• Cribs for Kids.
	Strategy 2: Ensure children in the community have proper protection and safety while traveling in vehicles	• Number of car seats distributed to individuals with children	
	Strategy 3: Increase availability of pre- and postnatal care services, especially in high-risk populations, through support programs including Nurse Education and Support Team (NEST), a home visiting program designed to meet the needs of all women residing in Forsyth County, NC. Information and/or referrals for local services and resources are provided within the first few days after delivery by a NEST Coordinator. An assessment is completed in person in a community setting or by video/phone by a NEST Nurse within the first 2-3 weeks postpartum to evaluate and address acute postpartum issues and provide education and support for postpartum women and their families. A follow-up phone call is also made by a NEST Coordinator about six weeks after delivery to determine the need for utilization of additional services, resources, and/or referrals.	• Number of clinical assessments performed for post-partum concerns • Number of hospital readmissions for complications after delivery for postpartum women • Number of community screenings for postpartum depression • Number of postpartum women residing in Forsyth County scheduled to have a nurse home visit two-three weeks after delivery • Number of scheduled/completed two to three week postpartum nurse visits completed. • Number of follow-up calls at 6 weeks post-partum	
	Strategy 4: Connect youth to primary medical and mental health providers through collaboration with and support of the School Health Alliance, an external program that works with the Winston-	• Cost of partnership/collaboration with School Health Alliance	• School Health Alliance • Winston-Salem Forsyth County School System

	Salem Forsyth County School system and the WSFC Social Work Department to build linkages among schools, health care providers, and faith communities to more effectively serve the needs of students and their families. Utilizing the AHWFB mobile health clinic, the program serves students at Cook Elementary, Carver High, Parkland High, and Hanes Middle by providing full medical and mental health screenings, as well as treatment and referrals.	• Number of days the Mobile Health Clinic is utilized by School Health Alliance • Number of medical and mental health screenings conducted	• Forsyth County Health Department • The Salvation Army • Love Out Loud • WSSU RAMS clinic

PRIORITIZED HEALTH NEED: Mental Health and Poly-substance Use			
Goal	**Strategies**	**Metrics**	**Potential Partners or External Organizations**
Improve access to mental health and substance abuse services for vulnerable populations	**Strategy 1**: Assist homeless adults, many of whom experience severe and persistent mental illness and substance abuse issues, with exiting homelessness through access to mental health and/or substance abuse services, other health care services, housing opportunities, employment assistance, disability assistance, or other needed services by providing street outreach and case management through the Empowerment Project. The team will conduct outreach to adult individuals who are homeless or at imminent risk of becoming homeless in Forsyth County, NC. These individuals will be outreached on the streets, shelters, and other community settings. Individuals may receive case management services for up to six months or until the individual is stably connected to a health care provider of his/her choice.	• Number of community outreach encounters completed in a year • Number of people enrolled in case management • Average number of months an individual spends in case management • Number of people assisted with the following: Housing, employment, transportation to medical/dental appointments, food, health insurance • Number of people assisted with mental and/or substance abuse disorders • Cost of support for Bethesda Center • Cost of support for Samaritan Ministries	• United Way's Continuum of Care • City with Dwellings • Samaritan Ministries • Bethesda Center for the Homeless • Experiment in Self Reliance (ESR) • Salvation Army
	Strategy 2: Collaborate with CareNet, a statewide community-based counseling organization affiliated with AHWFBMC, which provides spiritually-integrated counseling care, psychotherapy, and education in local communities.	• Number of clients served • Number of client hours	• CareNet local boards • Screening for Mental Health (nonprofit organization) • Various civic, religious, and professional groups

CHNA Implementation Strategy Updates

Atrium Health Wake Forest Baptist Medical Center will update and sustain this CHNA implementation strategy over the next three-years, paying attention to new community and hospital resources, and evaluating results of community benefit programs. The evaluation will

determine if strategies are being carried out as planned and achieving desired results. As the programs are evaluated, the hospital may:

- Change a program to improve its quality or effectiveness,
- Expand a program to other geographic areas or populations, or
- Eliminate/replace a program with an alternate approach.

CHNA Implementation Strategy Adoption

The Atrium Health Wake Forest Baptist Medical Center Board of Directors approved this Implementation Strategy through a board vote on May 12, 2022.